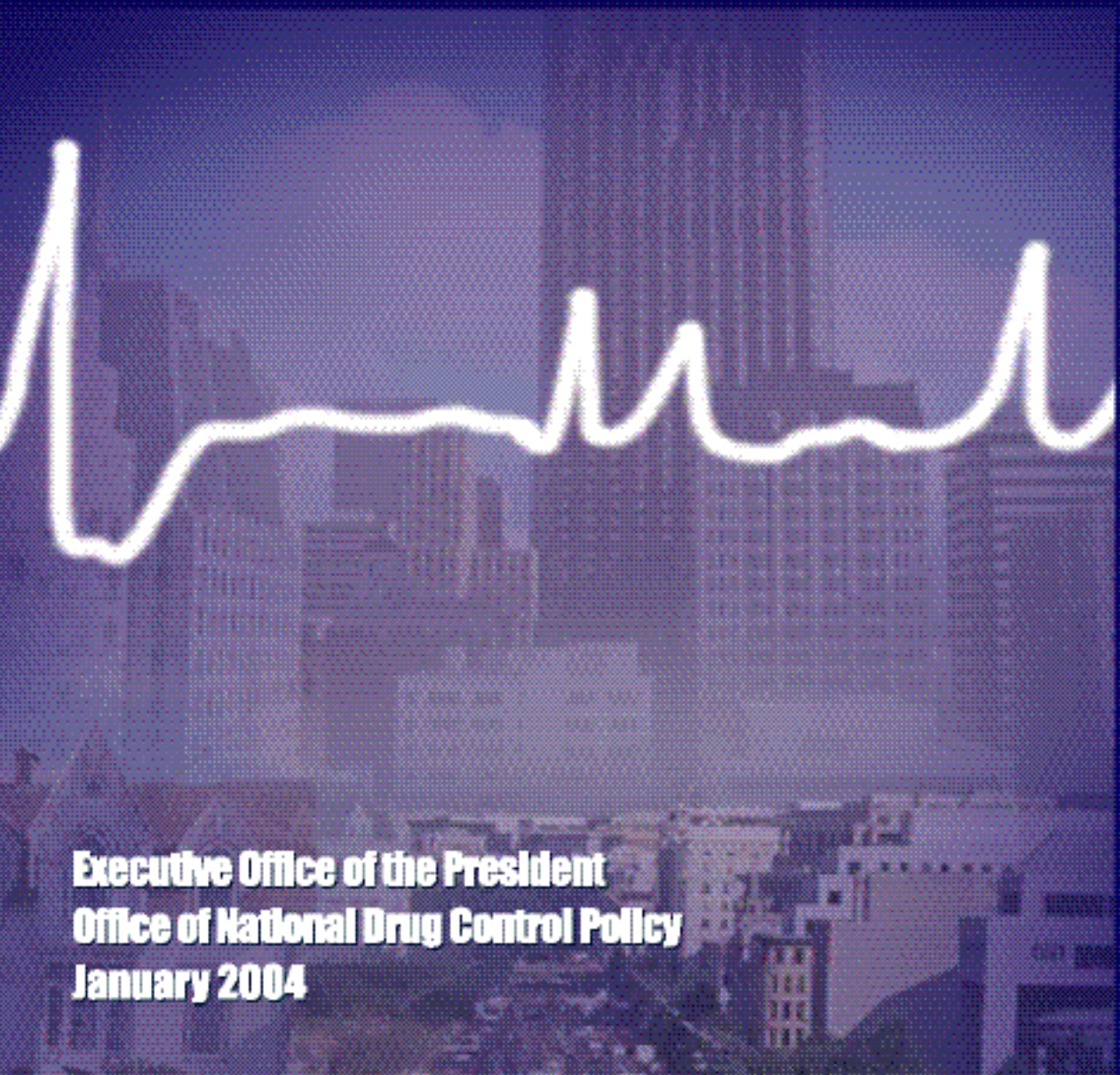
PULSE CHECK

Drug Markets and Chronic Users in 25 of America's Largest Cities

Special Topic: Local Drug Markets—A Decade of Change



Executive Office of the President
Office of National Drug Control Policy
January 2004

PULSE CHECK

Trends in Drug Abuse
January 2004

Executive Office of the President
Office of National Drug Control Policy
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The Office of National Drug Control Policy (ONDCP) acknowledges the contributions made by the 97 *Pulse Check* sources who voluntarily prepared for and participated in the in-depth discussions that are the basis for this report. Their names (unless they requested anonymity) appear in an appendix. Information presented in this publication reflects the views of those sources, and not necessarily those of the Federal Government.

Marcia Meth and Rebecca Chalmers of Johnson, Bassin & Shaw, Inc., produce the *Pulse Check* for ONDCP, under Contract Number 282-98-0011, Task Order Number 11. Anne McDonald Pritchett, Office of Planning and Budget, ONDCP, serves as the project director and editor for *Pulse Check*.

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

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INTRODUCTION

The President has stated goals of reducing drug use among all Americans by 10 percent in 2 years and 25 percent in 5 years. As part of the strategy to accomplish this, the Office of National Drug Control Policy (ONDCP) has developed this special edition of *Pulse Check* to complement its current 25-Cities Initiative, which engages local officials and concerned citizens in 25 of American's largest cities. Though drug use has harmed all cities, America's largest cities have been particularly hard hit. Local leaders and teams of local citizens and officials in those cities will be aided in identifying problems they can address by referring to this expanded *Pulse Check*, with its new "city snapshot" format.

ONDCP has been publishing *Pulse Check* since 1992, with the goal of providing timely information on drug abuse and drug markets. The report aims to describe chronic drug users, emerging drugs, new routes of administration, varying use patterns, changing demand for treatment, drug-related criminal activity, drug markets, and shifts in supply and distribution patterns. *Pulse Check* regularly addresses four drugs of serious concern: marijuana, heroin, crack cocaine/powder cocaine, and methamphetamine. Additionally, *Pulse Check* continues to monitor the problems of "ecstasy" (methylenedioxymethamphetamine or MDMA), the diversion and abuse of OxyContin® (a controlled-release formulation of the pharmaceutical opiate oxycodone), and other drugs of concern.

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 Survey on Drug Use and Health 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 25 *Pulse Check* Sites

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 intended as a quantitative measure of the prevalence of drug abuse or its consequences. Any interpretations or conclusions 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 focuses on the drug abuse situation in 25 specific sites throughout the Nation. Though these sites cross a broad range of geographic areas, including Census regions and divisions, 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 100 sources across the three disciplines, 97 provided information for this *Pulse Check* issue. The information presented in this report is based solely on the observations and perceptions of those 97 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 97.

Due to rounding of percentages, values on pie charts may not add up to 100.

Any contradictory reports within an individual site are not necessarily a *Pulse Check* limitation. Quite the contary, recruiting four sources per site was incorporated into the project design to reflect diversity within each site. 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 25 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 in two waves, during December 2002 through January 2003 and March through May 2003, from telephone conversations with 97 sources, representing 25 sites across the various regions of the country. These individuals discussed their perceptions of the drug abuse situation as it was during the fall months of 2002 and in comparison to a period 6 months earlier, during spring of that year.

The law enforcement sources who provided information include 24 narcotics officers from local police departments, field office agents of the Drug Enforcement Administration (DEA), and representatives of High Intensity Drug Trafficking Areas (HIDTAs). One law enforcement source (from Cincinnati) did not respond.

The epidemiologists and ethnographers are 25 researchers associated either with local health departments, university-based research groups, or other community health organizations. Some of those 25 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 providers from 24 non-methadone programs and 24 methadone programs across the 25 sites. Two treatment sources did not respond (Miami, methadone; and Portland, OR, non-methadone).

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 policymakers 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.

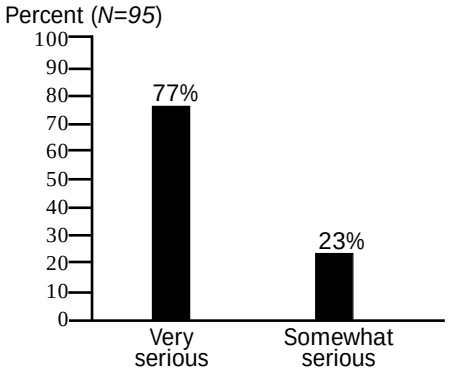
PULSE CHECK

NATIONAL SNAPSHOT

PULSE CHECK NATIONAL SNAPSHOT*

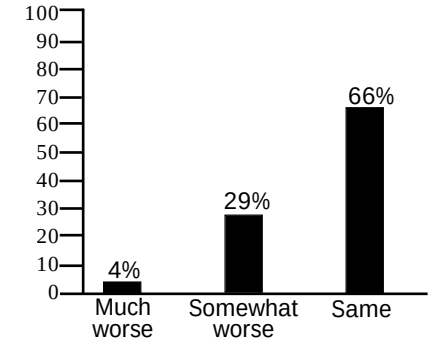
This report is based on discussions with 97 epidemiologists, ethnographers, law enforcement officials, and methadone and non-methadone treatment providers from 25 *Pulse Check* sites. Telephone discussions with these individuals, conducted in two waves, during December 2002 through January 2003 and March through May 2003, reveal that overall, when comparing fall 2002 with the previous spring period, the majority of *Pulse Check* sources believe their communities' drug abuse problem to be very serious but stable. *(Exhibits 1 and 2)*

Exhibit 1. How serious is the perceived drug problem in the 25 *Pulse Check* communities? (Fall 2002)



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

Exhibit 2. How has the perceived drug problem changed? (Spring vs fall 2002)



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

KEY FINDINGS: LOCAL DRUG MARKETS—A DECADE OF CHANGE

Over the past decade, various communities have used a range of anti-drug strategies with varying degrees of success. The following are just a few examples:

- Food stamps: Innovative technologies in lieu of paper, such as debit cards, vouchers, or electronic transfer, have disrupted food stamps-for-drugs trading in several cities, including Atlanta, Denver, Detroit, Houston, Philadelphia, and Pittsburgh.
- Task forces: Task forces of varying composition and focus have been used effectively over the past decade in all 25 *Pulse Check* cities.
- Drug courts: The majority of *Pulse Check* sites have some sort of drug court program, and sources in those areas generally consider them highly effective.

Illicit drug dealers have employed different marketing tactics over the past decade, such as the examples below, posing varying degrees of challenge to detection and disruption efforts:

- Detection and disruption efforts have not been hampered much by dealers' use of unique packaging or brand names.
- Throwaway cell phones and other developments in digital communications technology have posed the greatest challenge to law enforcement efforts. Some sources believe that phone companies are offering new technologies to the public before offering counter-technologies to law enforcement.

Several changes have contributed to the widespread availability, use, and consequences of marijuana over the past decade:

- The decline in social disapproval of marijuana (by peers, parents, etc.) and the decline in users' perception of its harmfulness have had an impact on its widespread use and availability over the past 10 years.
- In order to obtain marijuana, youth are increasingly engaging in risky or criminal activities, such as trading sex, guns, or shoplifted merchandise for the drug.
- Law enforcement sources consider the promotion of marijuana as "medicine" as a more significant problem than do their epidemiologic/ethnographic counterparts.
- Many *Pulse Check* sources believe the media have reported marijuana-related issues responsibly. However one source (Miami[L]) believes that some local media "are quick to report on legalization efforts and medicinal uses" of marijuana but not on its harmful effects.
- Because marijuana prices have remained generally stable over the past 10 years, sources do not attribute increased use to price declines.

HIGHLIGHTS: CURRENT DRUG MARKETS AND CHRONIC USERS

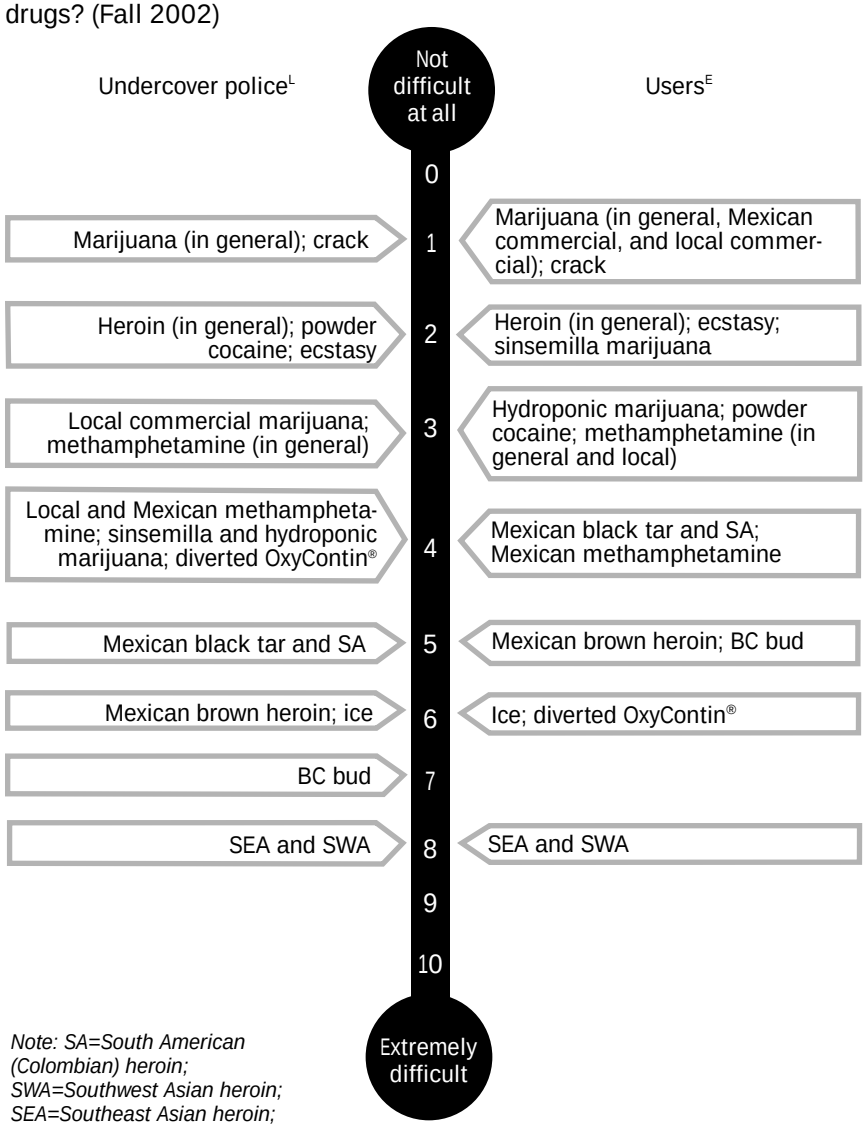
The illicit drug situation is characterized by several key features:

- Overall, law enforcement and epidemiologic/ethnographic respondents are remarkably similar in their perceptions of how difficult it is to buy various drugs across the country.[L,E] *(Exhibit 3)*

**The following symbols appear throughout this chapter to indicate type of respondent: [L]Law enforcement, [E]Epidemiologic/ethnographic, [N]Non-methadone treatment, and [M]Methadone treatment.*

- Marijuana and crack are the illicit drugs most easily purchased by users and undercover police across the country. They are followed, in descending order, by heroin, ecstasy, powder cocaine, methamphetamine, and diverted OxyContin® (oxycodone hydrochloride controlled-release).[L,E] *(Exhibits 3 and 4)*
- Marijuana remains the country's most widely abused illicit drug, as reported by 37 sources in 22 cities. *(Exhibits 5 and 6)*
- Crack remains a serious problem in 18 cities, according to 28 sources primarily in the Northeast, South, and Midwest. It is considered the most commonly used drug by 16 sources in 12 cities. *(Exhibits 5 and 6)*
- Methamphetamine is reported as an emerging or intensifying problem in 15 cities. *(Exhibit 7)* Furthermore, sources in eight cities, particularly in the West, consider it to be the drug contributing to the most serious consequences. And sources in five western cities consider it the most commonly abused drug. *(Exhibits 5 and 6)*
- Sources in 18 *Pulse Check* cities believe their communities do not have any emerging drug problems. *(Exhibit 7)*
- Methylenedioxymethamphetamine (MDMA or ecstasy) continues to emerge or intensify as a problem in 16 cities. *(Exhibit 7)*
- Increased law enforcement efforts and media attention have somewhat reduced the supply of diverted OxyContin® in some cities. Nevertheless, it continues to emerge or intensify as a problem in 15 cities. *(Exhibit 7)* In some cases, people who have become addicted to it are switching to either heroin or diverted methadone.

Exhibit 3. How difficult is it for undercover police and users to buy drugs? (Fall 2002)



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

Sources: [L]Law enforcement respondents' mean ratings; [E]Epidemiologic/ethnographic respondents' mean ratings

- Diverted methadone and phencyclidine (PCP) are reported as emerging problems in several cities. *(Exhibits 7, 8, and 9)*
- Heroin is the drug associated with the most serious consequences—such as overdose deaths and involvement in emergency department episodes—as perceived by nearly half (44) of the *Pulse Check* sources in 22 cities. *(Exhibits 5 and 6)*
- Illicit drug prices generally remained stable between spring and fall 2002, with a few exceptions, such as declines in heroin and methamphetamine prices in some western cities. (*Exhibits 10a–10f*)

SEPTEMBER 11 FOLLOWUP

- More than 60 percent of respondents believe that the September 11 attacks have had no continuing effects on the drug abuse situation.
- The most commonly mentioned post-September 11 effects include the following: supplies of some drugs have declined in some cities; some trafficking routes have shifted away from the East Coast; vehicular and other means of transport have sometimes replaced air shipment; many sources perceive a shift in law enforcement priorities from drugs to homeland security; and some drug users in treatment continue to experience elevated levels of mental health disorders.
- One source in Detroit notes that because of increased security measures, users believe that they may have increased difficulty obtaining drugs or maintaining their personal drug supply. They are therefore more willing to use a variety of drugs or to make their own drugs.[N]

Exhibit 4. How difficult is it for undercover police and users to buy drugs (0–10 scale, 0=not difficult at all, 10=extremely difficult)? (Fall 2002)

	City	Heroin	Crack	HCl	MJ	Meth	X	Oxy
Northeast	Boston, MA	1.5	0.5	0.5	0.5	8.5	0.5	1.5
	New York, NY	0	0	0	0	3.5	2	3.5
	Philadelphia, PA	1.5	1	4.75	1.75	8.75	3.75	5.75
	Pittsburgh, PA	1.75	2	2	1.5	2.25	4	2.25
South	Atlanta, GA	2.5	0	3	0	2	2	[a]10
	Baltimore, MD	0	0	1.5	0	[a]7	3	6.5
	Dallas, TX	0	0	0	0	0	0	0.5
	Houston, TX	2.5	1	2	0.5	5	1.5	9
	Miami, FL	5	0.5	0	0.5	4.5	0	4
	Tampa/St.Petersburg, FL	2	0	1.5	0.5	5	1	3
	Washington, DC	0	0	7.5	0	[a]7	3	6.5
Midwest	Chicago, IL	1.5	1.5	4	1.5	8.5	4.5	10
	Cleveland, OH	3	0.5	2	0.5	[a]6	2	4.5
	Detroit, MI	3	1	3	0	2.5	3.5	7.5
	Minneapolis/St. Paul, MN	3	0.5	1	0.5	1.5	3	[b]3
	St. Louis, MO	2	1	1.5	1.5	3.5	1	6.5
West	Denver, CO	3.5	2	4	0	1.25	4.5	9
	Los Angeles, CA	4.5	1	1	0.5	1.25	1.25	5.75
	Phoenix, AZ	0	[a]0	[a]0	0	0	2.5	[a]3
	Portland, OR	1	[a]0	2	0.5	1	[a]3	[a]3
	Sacramento, CA	[a]0	[a]0	[a]0	[a]0	[a]0	[a]0	[a]4
	San Diego, CA	0.75	0.75	3.75	0.75	0.25	3.25	6.5
	San Francisco, CA	0.5	0.5	4	0.5	1	1.5	4.25
	Seattle, WA	2.5	3	[a]5	0.5	2	2.5	5
	Averages	1.75	0.7	2.25	0.5	3.4	2.2	5.2

[a]Only the law enforcement rating is used because the epidemiologic/ethnographic respondent did not provide this information.
[b]Only the epidemiologic/ethnographic rating is used because the law enforcement respondent did not provide this information.

Notes: Cincinnati is excluded from this analysis because the law enforcement source was a non-respondent, and the epidemiologic/ethnographic source did not provide this information; HCl= powder cocaine, MJ=marijuana, Meth=methamphetamine, X=ecstasy, Oxy=diverted OxyContin®

Sources: Mean ratings given by law enforcement and epidemiologic/ethnographic respondents

HIGHLIGHTS OF TREATMENT ISSUES

The discussions with epidemiologic/ethnographic and treatment respondents yielded insights into treatment issues in the 25 *Pulse Check* sites. These issues included methadone maintenance treatment availability and capacity, drug treatment referrals, treatment of marijuana users over the past decade, and the impact of California's Proposition 36 on specific treatment programs.

METHADONE TREATMENT AVAILABILITY

As reported in past *Pulse Check* issues, about half of epidemiologic/ethnographic respondents consider methadone maintenance to be available in selected areas only, while the others consider it available throughout their areas.

Between spring and fall 2002, public treatment has become more available in seven *Pulse Check* cities: Baltimore, Minneapolis/St. Paul, Philadelphia, Pittsburgh, Seattle, Tampa/St. Petersburg, and Washington, DC. Conversely, it has become less available due to State budget cuts in Portland (OR), San Francisco, and St. Louis. Private methadone maintenance availability declined in three cities (Cleveland, Minneapolis/St. Paul, and

San Francisco) and increased in four (Baltimore, Detroit, Tampa/St. Petersburg, and Washington, DC).

Nine respondents report adequate capacity of public methadone maintenance, while 10 (in Baltimore, Boston, Chicago, Cincinnati, Detroit, Pittsburgh, St. Louis, San Francisco, Seattle, and Washington, DC) report waiting lists of 1–24 months. Between spring and fall 2002, public methadone maintenance capacity has remained relatively stable in most *Pulse Check* cities, with increases reported in Pittsburgh and declines in Portland (OR) and St. Louis.

REFERRALS TO DRUG ABUSE TREATMENT

- According to *Pulse Check* treatment sources, most heroin users in methadone programs are individually referred. By contrast, in the non-methadone programs, about half of the heroin clients are individual referrals, and approximately half are court or criminal justice referrals.
- Crack and methamphetamine clients in non-methadone programs are slightly more likely to be court and criminal justice referrals than to be individually referred.
- Marijuana clients in 18 of the non-methadone programs are predominantly court and criminal justice referrals. Some sources specify that marijuana court referrals are for possession only (as in Baltimore, Cincinnati, Houston, Los Angeles, St. Louis, San Francisco, and Seattle). Others specify that they include referrals for both possession and sales (as in Atlanta, Sacramento, and Washington, DC).
- Only powder cocaine clients are more likely to be individually referred than court referred to non-methadone treatment.
- Several sources in the Northeast (in Baltimore, New York, and Philadelphia) report increased criminal justice referrals for all drugs. For marijuana in particular, drug court referrals have increased in San Francisco, and referrals from mental health centers (mostly for generalized anxiety) have increased in Chicago.

TREATMENT FOR MARIJUANA USERS: THE PAST 10 YEARS

- Challenges involved in treating marijuana-using clients over the past 10 years have increased and include earlier initiation of marijuana use, increased marijuana potency, and a decline in users' perception of harm.
- Some treatment sources believe that increased court referrals involving marijuana have had the positive effect of getting people into treatment earlier (Philadelphia[N] and San Diego[N]). Another source believes that this increase has made treatment more difficult because of the emphasis on sellers, rather than users. "Drug distributors are harder to treat: they don't accept they have a problem and often resist treatment" (Atlanta[N]).

IMPACT OF PROPOSITION 36

Since its implementation in July 2001, California's Substance Abuse and Crime Prevention Act, known as Proposition 36, has diverted more than 37,000 people, usually those arrested for petty crimes or drug possession, into treatment. Respondents view this initiative as having a major impact on treatment programs in several *Pulse Check* cities:

- A Sacramento treatment respondent states that these new clients include many older drug users with mental health problems (especially schizophrenia) who are new to treatment. These new client characteristics have made treatment in Sacramento more complex.[M]
- The Sacramento methadone treatment source also reports general increases in treatment caseloads and court referrals due to Proposition 36. That program saw "100 new cases that they would not have without 'Prop. 36'."
- In Sacramento, males have increased as a proportion of treatment admissions. Before Proposition 36, females dominated because they were referred to treatment through child welfare cases.[E]
- Younger users, more females, and more users new to treatment are presenting for drug treatment, especially heroin abuse, as reported in Los Angeles.[E]
- Also in Los Angeles, more methamphetamine users are presenting to treatment due to the changes in funding established by Proposition 36.[E]
- Some sources are wary of Proposition 36 because they aren't sure whether treatment centers have enough capacity or whether they "are staffed properly" (Los Angeles[L]). One respondent suggests replacing Proposition 36 with drug courts (San Francisco[L]). By contrast, the epidemiologic respondent in Sacramento believes Proposition 36 has been successful.

HIGHLIGHTS BY SPECIFIC ILLICIT DRUG

The 97 discussions yielded key findings about marijuana, crack, powder cocaine, heroin, methamphetamine, diverted methadone, other diverted synthetic opioids, ecstasy, PCP, and other drugs.

MARIJUANA

- Big picture: Marijuana remains the country's most widely abused illicit drug, as reported by 37 sources in 22 cities. *(Exhibits 5 and 6)* Sources in non-methadone programs report stable percentages of marijuana-using clients in treatment, with only three exceptions: a slight decline in Atlanta and slight increases in Chicago and Sacramento. In the methadone programs, declines are reported in Boston and Cleveland, while a slight increase is reported in Chicago.
- Ease of purchase: Marijuana is the most easily purchased drug across the country (0.5 average rating).[L,E] Its availability remains relatively stable since the previous reporting period, except in Portland (OR),[L] San Francisco,[L] and Seattle,[L] where purchasing the drug has become less difficult.
- The different varieties: Mexican commercial grade marijuana is the most common variety. It can be purchased with little or no difficulty (0–1 rating) in 14 *Pulse Check* cities: Baltimore,[E] Boston,[L,E] Chicago,[L,E] Dallas,[E] Denver,[E] Detroit,[E] Houston,[E] Los Angeles,[E] Minneapolis/St. Paul,[E] Phoenix,[E] Pittsburgh,[L] San Diego,[E] Seattle,[E] and Washington, DC.[L] No changes in availability are reported.

  Local commercial grade marijuana is the next most common variety (2.42 average ratings by law enforcement and epidemiologic/ethnographic respondents across all sites). It can be purchased with little or no difficulty (0–1 average ratings) in all but four *Pulse Check* cities: Boston, Chicago, Philadelphia, and St. Louis. (This information was not available for Cincinnati.) Its availability remains relatively stable, with one exception: purchasing it has become less difficult in Portland (OR) as outdoor "grows" have increased dramatically.[L]

  Sinsemilla (seedless marijuana) can be purchased with little or no difficulty in 13 *Pulse Check* cities: Atlanta,[L] Baltimore,[L] Dallas,[L,E] Los Angeles,[E] Miami,[L] Minneapolis/St. Paul,[E] New York,[L,E] Phoenix,[E] Portland (OR),[L] St. Louis,[L] San

Exhibit 5. What are the most serious drug problems in the 25 *Pulse Check* cities, by type of source?

	Drug	Most commonly abused?[a]			Most serious consequences?			
		L	E	N	L	E	N	M
Northeast	Boston, MA	MJ	MJ	H	HCl	Crack	H	H
	New York, NY	Cocaine[b]	MJ	Crack	Crack	Crack	Crack	Crack
	Philadelphia, PA	MJ	MJ	Crack	H	H	Crack	H
	Pittsburgh, PA	H	H	H	H	H	H	H
South	Atlanta, GA	Crack	MJ	Crack	Crack	Crack	Crack	H
	Baltimore, MD	MJ	H	H	H	H	Crack	Benzos
	Dallas, TX	MJ	MJ	H	H	Crack	H	H
	Houston, TX	MJ	Crack	Crack	H	Crack	Crack	H
	Miami, FL	MJ	MJ	Crack	Crack	Opiates	Crack	NR
	Tampa/St. Petersburg, FL	Crack	H	MJ	Cocaine[b]	Crack	H	Oxy
	Washington, DC	MJ	MJ	Crack	Crack	H	H	H
Midwest	Chicago, IL	Crack	MJ	Crack	Crack	H	Crack	H
	Cincinnati, OH	NR	MJ	MJ	NR	Crack	H	H
	Cleveland, OH	Crack	Crack	H	Crack	Crack	Crack	H
	Detroit, MI	MJ	MJ	Crack	H	H	Crack	H
	Minneapolis/St. Paul, MN	Crack	MJ	MJ	Crack	H	MJ	H
	St. Louis, MO	MJ	MJ	MJ	Crack	Crack	Meth	H
West	Denver, CO	MJ	MJ	Meth	Meth	HCl	Meth	H
	Los Angeles, CA	Crack	MJ	MJ	Crack	H	Meth	H
	Phoenix, AZ	MJ	Meth	Meth	Meth	Meth	Meth	H
	Portland, OR	MJ	Meth	NR	H	H	NR	H
	Sacramento, CA	Meth	Meth	Meth	Meth	Meth	Meth	Meth
	San Diego, CA	Meth	MJ	Meth	Meth	Meth	Meth	H
	San Francisco, CA	MJ	MJ	H	Meth	H	Meth	H
	Seattle, WA	MJ	MJ	MJ	Meth	H	MJ	H

[a]Heroin is almost always, by definition, the most commonly used drug in methadone programs, so methadone treatment sources are excluded from this question.
[b]Unspecified form
Sources: [L]Law enforcement respondents, [E]Epidemiologic/ethnographic respondents, [N]Non-methadone treatment respondents, and [M]Methadone treatment respondents
Note: HCl=Powder cocaine; MJ=Marijuana; H=Heroin; Meth=Methamphetamine; Benzos=Benzodiazepines; Oxy=OxyContin®; NR=Not reported

Exhibit 6. What are the most serious drug problems in the 25 *Pulse Check* cities, 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	10	7	44	22
Crack	16	12	28	17
Powder cocaine	0	0	2	1
Marijuana	37	22	2	2
Methamphetamine	9	5	17	8
Diverted OxyContin®	0	0	1	1
Benzodiazepines	0	0	1	1
Cocaine (Unspecified)	1	1	1	1

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

Francisco,[L] Seattle,[E] and Washington, DC.[E] Since the last reporting period, purchasing sinsemilla has become less difficult in Chicago,[L] New York,[L] and Portland,[L] and more difficult in Cleveland[L] and Philadelphia.[E]

Hydroponically grown marijuana can be purchased with little or no difficulty in 10 *Pulse Check* cities: Dallas,[E] Los Angeles,[E] Miami,[L] Minneapolis/St. Paul,[E] New York,[L,E] Portland (OR),[L] Sacramento,[L] San Francisco,[L] Phoenix,[E] and Seattle.[E] Purchasing it has become more difficult in Los Angeles[L] and less difficult in Chicago,[L] New York,[L] San Francisco,[L] and Washington, DC.[L]

British Columbian marijuana ("BC bud") can be purchased with little or no difficulty in 6 *Pulse Check* cities, mostly in the West: Dallas,[E] Los Angeles,[E] Minneapolis/St. Paul,[L,E] Portland (OR),[L] Sacramento,[L] and Seattle.[E] Purchasing it has become less difficult in Minneapolis/St. Paul,[L] Portland (OR),[L] and St. Louis;[E] conversely, it has become more difficult in Cleveland[L] and San Francisco[L].

- User changes: The age of marijuana users appears stable since the last reporting period, with only a few exceptions: younger people are initiating marijuana use in New York,[E] Phoenix,[E] and San Diego.[N] In some cities, such as Philadelphia,[E] marijuana is increasingly involved in emergency department episodes.
- Local market changes: Market changes reported in three *Pulse Check* cities are associated with sales of BC bud: Canadian-based Southeast Asian gangs are increasingly selling BC bud in Seattle and Portland (OR). These young adults and adolescents are associated with violence and gang activity, and some also import and sell ice.[L] Similarly, recent gang activity in relation to sales of BC bud from Seattle is reported in Minneapolis/St. Paul.[L]
- Purity and price *(Exhibit 10d)*: Reported THC levels range from 1–10 percent for commercial grade marijuana to as much as 30 percent for BC bud (as reported in San Diego).[E] Between spring and fall 2002, THC levels increased in Pittsburgh[E] and St. Louis.[L]

  Most ounce prices for commercial grade marijuana are about $100. Between spring and fall 2002, marijuana prices remained relatively stable with a few exceptions: they increased in three *Pulse Check* cities (Boston,[L] Miami,[E] and St. Louis[L]—at the pound level), and declined in Chicago[E] (at lower quantity levels) and Denver[E] (at the pound level).

CRACK COCAINE

- Big picture: Two sources (in Phoenix[N] and Washington, DC[L]) believe crack is no longer the most commonly abused drug in their communities. Another two (in Baltimore[L] and Washington, DC[N]) believe it is no longer the drug with the most serious consequences. Elsewhere, crack is named as the drug with the most serious consequences in 17 cities, according to 28 sources primarily in the Northeast, South, and Midwest. *(Exhibits 5 and 6)* In the West, only one source (Los Angeles[L]) considers it as such. Treatment sources generally report stable treatment percentages for crack. However, non-methadone sources report some slight increases in Atlanta, Dallas, Minneapolis/St. Paul, Philadelphia, Seattle, and Washington, DC. In the methadone programs, slight decreases are reported in Chicago and Cincinnati, while slight increases are reported in Cleveland and St. Louis.
- Ease of purchase: Since the previous reporting period, purchasing crack has become slightly more difficult in Philadelphia,[E] again due to Operation Safe Streets, and it has become less difficult in San Francisco.[L] Its availability remains relatively stable elsewhere. Across the country, crack follows marijuana as the most easily purchased drug (0.7 average rating).[L,E] *(Exhibits 3 and 4)*
- User changes: The crack-using population continues to age, as reported in many cities. Only two new user populations are reported. In Cleveland, users are getting younger.[E] And in St. Louis, younger people are entering treatment at the methadone source's clinic.[M]
- Local market changes: In Atlanta[L], cell phone involvement in crack sales is relatively new, and sales have increased on college campuses. In Minneapolis/St. Paul,[L] Mexican nationals are newly involved in processing powder cocaine into crack. These "cooks" then sell the product to street dealers. In Boston, older sellers tend to "mellow out," while younger dealers are more involved in crime.[E]
- Purity and price *(Exhibit 10b)*: Purity ranges from 30 to 85 percent, with most purity levels in the middle of that range.

  The most common unit of crack sold in most *Pulse Check* cities is one rock, approximately 0.1–0.2 grams. Prices depend mostly on the size of the rock sold and range from $2 to $40, with the standard rock priced around $10.

  In two Western cities (Denver and Los Angeles), street-level crack prices have declined due to decreased purity. Additionally, in San Francisco, the cost of larger purchases (10 rocks) has declined.[L]

Rock prices have increased in New York, where the ethnographic source suspects that dealers are trying to sell larger quantities at higher prices to reduce the number of transactions and thereby lower the risk of being arrested.

In Baltimore, crack sales have changed from requiring buyers to purchase rocks of certain sizes and prices (such as one rock for $10) to allowing buyers to specify the exact size and price (for example, breaking a piece off a rock and selling it for $7).[E]

POWDER COCAINE

- Big picture: Powder cocaine use has declined somewhat in reporting non-methadone treatment programs in Denver and Sacramento, both among the overall treatment population and among first-time clients. In the methadone programs, the number of users has declined in Phoenix and increased in Chicago and Pittsburgh. Elsewhere, treatment figures appear stable. Powder cocaine is often used as part of a polydrug use pattern. For example, in Miami, club drug users now take powder cocaine to bolster ecstasy.[E]
- Ease of purchase: Since the previous reporting period, purchasing powder cocaine has become more difficult in Atlanta[L] and Philadelphia[E] and less difficult in Chicago,[E] Cleveland,[E] and San Francisco.[L] Its availability remains relatively stable elsewhere. While not as easily purchased as crack, powder cocaine is still relatively easy to purchase across the country (2.25 average rating).[L,E] *(Exhibits 3 and 4)*
- User changes: Characteristics of cocaine users remained stable.
- Local market changes: Powder cocaine markets have remained relatively stable in *Pulse Check* cities, although one source in Atlanta reports the emerging use of e-mail and Internet communication for powder cocaine sales.[L]
- Purity and price *(Exhibit 10c)*: Powder cocaine purity ranges from 30–60 percent in Washington, DC, to as much as 95 percent in Philadelphia. Between spring and fall 2002, purity remained relatively stable with three exceptions in the West: it increased in Denver and San Francisco at ounce levels[E] and in San Diego at the kilogram level.[L]

  Powder cocaine prices range from $25–$35 per gram in New York to $75–$150 in Detroit. In most cities, 1 gram costs about $100. Between spring and fall 2002, prices were stable except in Houston and San Francisco where they declined, and in Sacramento, where gram prices declined, while kilogram prices increased.[L]

HEROIN

- Big picture: Heroin has overtaken crack as the drug related to the most serious consequences—such as its impact on users' health, lifestyle, and families—in Baltimore[L] and Washington, DC[N]. It has overtaken diverted OxyContin® as the most commonly abused drug in Pittsburgh.[N] *Pulse Check* sources in non-methadone treatment programs report declines in Dallas, Denver, and Sacramento; sources report increases in primary heroin abusers in Houston, New York, Philadelphia, Pittsburgh, and Washington, DC[N]. The percentage of primary heroin abusers in the methadone programs is generally stable, except for slight increases in Baltimore, Cleveland, Detroit, and Pittsburgh.
- Ease of purchase: Since the previous reporting period, purchasing heroin has become more difficult in Los Angeles[L] and Philadelphia[E] and less difficult in Pittsburgh[E] and Portland, OR[L]. The availability decline in Philadelphia is attributed to the Operation Safe Streets law enforcement effort.[E] Elsewhere, heroin availability remains relatively stable. Heroin follows marijuana and crack as one of the most easily purchased drugs across the country: on a 0–10 scale, with 0 being "not difficult at all," law enforcement and epidemiologic/ethnographic sources rate it at an overall average of 1.75. *(Exhibits 3 and 4)*
- The different varieties: High purity snortable white South American (Colombian) heroin still predominates throughout the Northeast and in many cities in the South (Atlanta, Baltimore, Miami, and Washington, DC) and the Midwest (Chicago, Cleveland, and Detroit). Lower purity Mexican black tar heroin predominates throughout the West and in some cities in the Midwest (Minneapolis/St. Paul and St. Louis) and South (Dallas and Houston). Southeast Asian heroin is rarer, but it is moderately obtainable in Boston, Cleveland, and New York. Southwest Asian heroin, also rarer, is moderately obtainable in Baltimore, Cleveland, Dallas, and New York.[L]

  Some cities have split availability: in Cleveland, for example, white heroin is available on the East Side (in the Black community), and brown heroin is available on the West Side (in the Hispanic and White communities).[E]
- User changes: Some new heroin users are switching from or alternating use with diverted OxyContin®, as reported in Boston[E] and Cincinnati.[E]

New and younger heroin users are reported in many cities, including Boston,[N] Chicago,[N] Cleveland,[E,M] Dallas,[E] Houston,[N,M] Los Angeles,[E] Pittsburgh,[E] Portland (OR),[E] Sacramento,[E] and San Diego.[E,N] In San Diego's North County, about 15 percent of drug court clients are first-time young injecting drug users from upper-middle socioeconomic families.[N] However, that group may be declining, possibly due to the increased focus of a recent special task force.[E] In Cleveland, many well-educated upper-socioeconomic adolescents use heroin.[N]

In Pittsburgh, where adolescent opiate enrollment in treatment has increased 45 percent over the past 5 years, overdose deaths and violent murders among adolescents high on heroin have been increasing. Schools are trying to control the situation by holding grieving sessions and awareness nights.[E]

- Local market changes: The heroin market in Boston continues to decentralize, with dealers becoming more independent. Many users support their habit by selling.[E] Furthermore, sales for all available drugs (including heroin) continue to move "underground," with increased beeper and cell phone use to facilitate sales.[L]

  In New York, polydrug sales (including heroin, crack, and powder cocaine sales) continue to increase, and the use of Internet and other communications technology has risen for all drug sales.[L]

  In Washington, DC, five new open-air markets for heroin have emerged. These markets are operated by sellers 16–18 years old.[E]

  In Baltimore[E] and Washington, DC,[L] more younger adults are selling heroin (in addition to the older adult sellers), and they are increasingly involved in violence.[L] In Baltimore, the increased violence has been specifically linked to heroin-selling street gangs.[E]

- Purity and price *(Exhibit 10a)*: Similar to reports in the last *Pulse Check*, South American heroin ranges from 40 to 95 percent (excluding heroin in Washington, DC, which is highly adulterated), with both extremes reported in Philadelphia. Mexican black tar heroin ranges from 5 to 64 percent pure. Purity remained relatively stable between spring and fall 2002, except for increases in purity levels of Mexican black tar heroin in Houston[L] (and most of Texas) and Sacramento[L] and declines in Chicago.[E]

  Sources continue to report a wide range of heroin adulterants (especially lactose-based additives and baby laxatives), but no new adulterants are noted.

  One dose (about 0.1 gram) of heroin sells for as little as $4–$6 in Boston and as much as $30 in Atlanta. Between spring and fall 2002, heroin prices declined in many *Pulse Check* cities: Mexican black tar heroin prices declined in four western cities (Dallas,[L] Denver,[E] San Diego,[L,E] and San Francisco[L]), and South American white heroin prices declined in Atlanta[L] and Boston.[E] By contrast, heroin prices increased in Los Angeles[E] (at the ounce level) and Minneapolis/St. Paul[L] (at the gram level).

METHAMPHETAMINE

- Big picture: Methamphetamine is reported as an emerging or intensifying problem in 15 cities. *(Exhibit 7)* Furthermore, sources in eight cities, particularly in the West, consider it the drug contributing to the most serious consequences. And sources in five cities consider it the most commonly abused drug. *(Exhibits 5 and 6)* Treatment sources generally report stable percentages of methamphetamine-using clients, except for declines in Sacramento[N] and San Diego[M] and slight increases in Chicago,[N] Cleveland,[M] Philadelphia,[N] Minneapolis/St. Paul,[M] San Francisco,[M] and Seattle.[N]

- Ease of purchase: With a 3.4 average rating, methamphetamine is not very difficult to purchase overall.[L,E] *(Exhibits 3 and 4)* It is most easily purchased in the West. Elsewhere, it can also be purchased with little or no difficulty in Dallas,[L,E] Detroit,[L] Minneapolis/St. Paul,[L] and Pittsburgh.[E]

  Since the last reporting period, purchasing methamphetamine has become easier in 10 cities in all four regions: Atlanta,[L,E] Chicago,[E] Detroit,[L] Miami,[L,E] New York,[L] Pittsburgh,[E] Portland (OR),[L] San Francisco[L], Tampa/St. Petersburg,[L] and Washington, DC.[L] Several respondents elaborate on the supply increase in their cities:

  - Atlanta: "The methamphetamine supply might have increased because the cocaine supply (crack and powder) has declined. It also might be related to the increased Hispanic community in Atlanta."[L] "Availability fluctuates rapidly."[E]
  - Miami: The law enforcement source reports methamphetamine use has increased among a small gay user group.
  - New York[L]: A growing number of meth labs and seizures are reported, and the drug is increasingly involved in emergency department episodes. But all numbers are still low compared with other drugs.

Exhibit 7. What new problems have emerged or intensified during fall 2002?

Methamphetamine	Ecstasy/Club Drugs	Diverted OxyContin®	Diverted methadone	PCP
Atlanta, GA[E] Chicago, IL[L,E,N] Dallas, TX[E] (substance misnamed "ice") Denver, CO[E] Detroit, MI[E] Houston, TX[L] (ice) Miami, FL[L,E] (ice) New York, NY[L] Pittsburgh, PA[L] Sacramento, CA[E] ("yaba") San Francisco, CA[L] (ice) Seattle, WA[L,N] (ice) Tampa/St. Petersburg, FL[L] Washington, DC[L]	Atlanta, GA[L] Baltimore, MD[L] Boston, MA[L] Chicago, IL[E,M] Cleveland, OH[L] Dallas, TX[L] Denver, CO[L,E] Los Angeles, CA[L,E] Miami, FL[N] Minneapolis/St. Paul, MN[N] New York, NY[M] Philadelphia, PA[E,M] Pittsburgh, PA[N] Phoenix, AZ[L] San Diego, CA[E,N] Washington, DC[E]	Atlanta, GA[M] Boston, MA[L,N] Chicago, IL[N] Cincinnati, OH[N] Cleveland, OH[M] Denver, CO[M] Houston, TX[N] Miami, FL[N] Philadelphia, PA[E,M] Phoenix, AZ[M] Pittsburgh, PA[E] Portland, OR[L] San Diego, CA[E] Seattle, WA[E,M] Tampa/St. Petersburg, FL[E]	Chicago, IL[N] Cincinnati, OH[M] Detroit, MI[E] Houston, TX[N] Miami, FL[E] Minneapolis/St. Paul, MN[M] Pittsburgh, PA[E] Portland, OR[L] (ODs) Tampa/St. Petersburg, FL[M]	Houston[E] (+ embalming fluid) Minneapolis/St. Paul, MN[M] (+ embalming fluid) Philadelphia, PA[L,E] Phoenix, AZ[N] St. Louis, MO[E] San Diego, CA[N] Washington, DC[L,E,M]

Other Emerging Drug Problems	None	
Alprazolam (Xanax®): Tampa/St. Petersburg, FL[E] Carisoprodol (Soma®): San Diego, CA[N] Codeine: Houston, TX[E] Dextromethorphan products ("triple C"): Denver, CO[E]; Houston, TX[E]; Portland, OR[L] and Tampa/St. Petersburg, FL[N,M] Hash: Houston, TX[E] Heroin: Cleveland, OH[M] and Pittsburgh, PA[L,E] Khat*: Minneapolis/St. Paul, MN[L] and St. Louis, MO[L] Marijuana: Chicago, IL[M] and Washington, DC[L] Narcotic analgesics: St. Louis, MO[E] Prescription pills: Minneapolis/St. Paul[E] and New York, NY[E] Sildenafil (Viagra®): Miami, FL[E] (+ methamphetamine)	Baltimore, MD[M] Boston, MA[M] Cincinnati, OH[E,M] Dallas, TX[N,M] Denver, CO[N] Detroit, MI[L,N,M] Houston, TX[M] Los Angeles, CA[N,M] New York, NY[N]	Philadelphia, PA[N] Pittsburgh, PA[M] Phoenix, AZ[E] Portland, OR[E,M] St. Louis, MO[L,N,M] Sacramento, CA[L,N,M] San Diego, CA[L,M] San Francisco, CA[E,M] Washington, DC[N]

**Khat is a natural stimulant from the Catha edulis plant, found in a flowering evergreen tree or large shrub from East Africa and Southern Arabia. Its leaves contain psychoactive substances chemically similar to d-amphetamine.*
Sources: [L]Law enforcement respondents; [E]Epidemiologic/ethnographic respondents; [N]Non-methadone treatment respondents; [M]Methadone treatment respondents

- The different varieties: Locally produced methamphetamine has become easier to purchase in six cities: Atlanta,[L,E] Detroit,[E] Pittsburgh,[E] Portland (OR),[L] San Francisco,[L] and Tampa/St. Petersburg.[L]

  Mexican methamphetamine has become easier to purchase in Miami,[L] Portland (OR),[L] San Francisco,[L] and Washington, DC.[L] It has become more difficult to purchase in Cleveland.[L]

  The ease of purchasing ice, highly pure smokable methamphetamine, has increased in 11 *Pulse Check* cities: Atlanta,[L,E] Dallas,[L] Houston,[L] Miami,[E] Minneapolis/St. Paul,[L] Pittsburgh,[E] Portland (OR),[L] St. Louis,[E] San Francisco,[L] Seattle,[L,E] and Washington, DC.[L] Conversely, it has become more difficult to purchase ice in Cleveland[L] and New York.[E]

- User changes: At an adolescent facility in Los Angeles, females coming into treatment are nearly all primary methamphetamine users.[E] In Minneapolis/St. Paul, high school counselors are reporting use by younger age groups.[E] In Sacramento, the percentage of young adults among methamphetamine users has increased, while the percentage of older adults has declined.[E] Some Hispanic adolescents in New York are snorting methamphetamine ("bling bling") purchased from one young man selling it in $20 packets, but those reports are limited to one neighborhood.[E]

  Hispanics have continued to emerge as a user population in San Diego since about 1995, when they began producing and marketing methamphetamine. In addition to the mainstream use in the West, methamphetamine use is reported in some gay communities in cities

such as Boston,[E] Chicago,[E] Dallas,[E] Miami,[E] and New York.[E] In Miami, use is spreading from the gay and "techno dance" scenes to females and heterosexual males who use it with ecstasy to enhance endurance, resulting in a dramatic increase in risky sexual behavior.[E]

- Local market changes: In Atlanta, more methamphetamine is sold in central city areas than previously.[E] In St. Louis, production continues to move from rural into central city areas, and sellers and producers see the central city as an "untapped market."

  Outside the central city areas of Portland (OR), methamphetamine has replaced cocaine in sales and use, and between spring and fall 2002, the number of "superlabs" increased.[L]

  While Atlanta's methamphetamine market is controlled primarily by Mexican nationals, the number of independent sellers is increasing.[E]

- Purity and price *(Exhibit 10e)*: Purity ranges from 8–12 percent in Denver[E] to 95 percent in Seattle,[L] with most purity hovering around 30–40 percent in reporting *Pulse Check* cities. Purity declined in three western cities (Sacramento,[L] San Diego,[L] and Denver[E]), increased in Los Angeles,[E] and remained relatively stable elsewhere.

  As in the last *Pulse Check*, methamphetamine gram prices are most commonly reported at about $100, but they range from $20–$60 in Seattle to $330 in Chicago. Prices are typically lower in the West than in other U.S. regions.

  Prices remained relatively stable since spring 2002, except in the West, where they declined in three cities: Los Angeles,[L,E] Phoenix,[L] and Sacramento.[L] In Atlanta, the price of ice declined.

DIVERTED METHADONE

Diverted methadone is emerging as a problem in nine cities, many in the South and Midwest. *(Exhibits 7 and 8)* Some respondents elaborate:

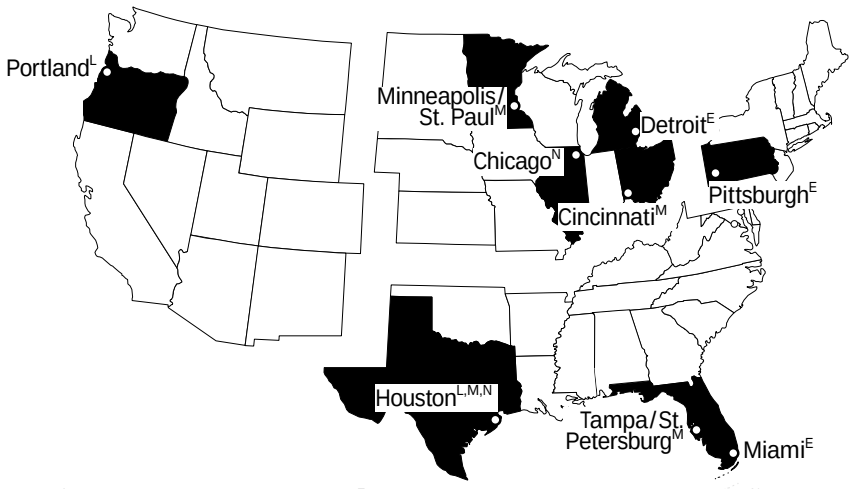
- Methadone-induced deaths have increased in Miami (first-half-2002 data), where an emerging group of addicts abuse tablets believed to be diverted from pain management prescriptions—not the liquid that is dispensed at methadone clinics. These addicts are predominantly White middle-socioeconomic males, older than 35 years.[E]

- Methadone diverted from pain management clinics is also an issue in Tampa/St. Petersburg.[M] In the methadone clinic with which the *Pulse Check* source is affiliated, methadone-positive intake drug screens used to be very rare, but they jumped to 26 percent positive in the last quarter of 2002—in keeping with the dramatic increase in emergency department episodes and deaths involving methadone. Drugs have become widely available on the street since pain management clinics have been "opening right and left" because it is such a profitable business. Typically, someone with chronic pain goes to a pain management clinic, gets addicted, gets expelled from the program, goes to a methadone clinic where the addiction becomes fairly controlled, but then goes to a different pain management clinic to get additional drugs to "start a business."[M]

- In Pittsburgh, diverted methadone has become an increasing problem over the past 5 years.[E,M] One source rates the drug as "not at all" difficult to purchase.[E] For-profit methadone treatment centers have proliferated, but the State has not established dosage guidelines. Some of the methadone is diverted by patients who do not swallow their entire dose, and then sell the rest. Others sell their take-home medication. Heroin addicts often buy diverted methadone in order to detox themselves. OxyContin® addicts use methadone to "control their fix"—another reason for the growing demand for diverted methadone.[E,M]

- Methadone diversion has increased in Cincinnati, and now methadone is readily available on the street.[M] A for-profit methadone

Exhibit 8. Where is diverted methadone emerging as a problem? (Fall 2002)



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

clinic recently opened in nearby Indiana, which has a less regulated methadone take-home policy than most States. Methadone-related deaths have recently increased, especially among younger users (18–20 years old) who may not understand the potency of the methadone bought on the street.[M]

- In Dallas, methadone continues to be diverted by people who are "cheeking and selling it."[E] While this practice has not increased, an increase is reported of people dying after combining methadone with alprazolam (Xanax®).

OTHER DIVERTED SYNTHETIC OPIOIDS

- Big picture: After increasing during the previous reporting period, diverted OxyContin® use and activity has declined in Washington, DC, because of major law enforcement action.[E] The diversion problem has not reached some cities, such as San Francisco.[E] However, the diverted product continues to emerge or intensify as a problem in 15 *Pulse Check* cities. *(Exhibit 7)* Treatment sources report slight increases in 14 cities: Baltimore,[M] Boston,[N] Chicago,[N] Cincinnati,[N] Cleveland,[M] Denver,[M] Detroit,[N] Houston,[N,M] New York,[M] Philadelphia,[N] Phoenix,[M] Pittsburgh,[N] San Francisco,[M] and Seattle.[N,M]

- Ease of purchase: Diverted OxyContin® is moderately difficult to purchase across the country (5.2 average rating).[L,E] Purchasing it is particularly easy in Boston,[L] Dallas,[L] New York,[L] Pittsburgh,[E] San Francisco,[L] and Tampa/St. Petersburg.[L]

  Since the previous reporting period, purchasing diverted OxyContin® has become more difficult in several cities, such as the following:

  - Baltimore:[L] It has become less available because of increased awareness of the problem by law enforcement, the manufacturer, the medical community, and pharmacists. Many pharmacies no longer carry it, and they post notices to that effect.
  - Boston:[E] The cost of the drug increased, causing demand to decline, causing supply to decline.
  - Cleveland:[E] Doctors and pharmacists have become more stringent with prescriptions, so less is available on the street, and price has increased.
  - Miami:[E] With the recent crackdown, more people are aware of the problem, and fewer doctors are prescribing the drug.
  - Philadelphia:[L] Enforcement action has made a difference, with many large diversion cases.
  - San Diego:[L] Increased focus by law enforcement has made a difference. For example, a main supplier in Tijuana was arrested.
  - Washington, DC:[E] Following major law enforcement activity, availability has declined, especially around methadone clinics where it used to be sold.

  By contrast, respondents in several cities believe it has become easier to purchase diverted OxyContin®: Cleveland,[L] New York,[L] Pittsburgh,[E] Portland (OR),[L] St. Louis,[L] San Francisco,[L] and Seattle.[L]

- User changes: One source in Cincinnati believes that OxyContin® abuse has peaked in the area and is either leveling off or declining.[M] Another source in that city adds that users have switched to heroin because diverted OxyContin® is becoming more expensive and more difficult to purchase, but they would prefer OxyContin®.[E] Similarly, in Miami, as diverted OxyContin® declines in availability, addicts are shifting to other narcotics, such as diverted methadone.[E] A substitution effect is also noted in Boston: while pharmacy robberies have declined, users are switching to other oxycodone products (such as Percocet®), clonazepam (Klonopin®), or heroin. An emerging group of OxyContin® abusers is still reported in Boston, often including the younger siblings of older addicts.[E] More older adults in rural areas surrounding Dallas are starting to abuse the drug.[E]

  Oxycodone is increasingly mentioned in emergency department episodes in several cities, such as St. Louis,[E] Philadelphia[E] (where it also is involved in increased mortality), and Minneapolis/St. Paul[E] (where it is also increasingly mentioned in mortality, poison control, and law enforcement data).

- Price: Diverted OxyContin® is typically sold by the 20- or 40-milligram tablet, with most prices remaining at $1 per milligram. However, prices are as low as $0.50 per milligram, as reported in six *Pulse Check* cities (Boston[E], Los Angeles,[L] Philadelphia,[L] Phoenix,[L] Tampa/St. Petersburg,[L] and Washington, DC[E]), and as high as $2 per milligram in two cities (Philadelphia[E] and Washington, DC[L]).

  Between spring and fall 2002, diverted OxyContin® prices remained relatively stable, except in Washington, DC, where prices declined.[E]

ECSTASY

- Big picture: Ecstasy continues to emerge or intensify as a problem in 16 cities. *(Exhibit 7)* Non-methadone treatment sources report some declines in ecstasy use in Seattle and Washington, DC, but numbers have increased slightly in Chicago and Houston and more sharply in Minneapolis/St. Paul. In Washington, DC, after increasing for the past few reporting periods, ecstasy use and activity have leveled off as the rave scene there has quieted down.[E] In some cities, such as San Diego,[E] the number of ecstasy users is still low, but the drug gets a lot of media attention.

- Ease of purchase: Since the last reporting period, purchasing ecstasy has become more difficult in Chicago,[L] where seizure activity has declined compared to 1 year earlier, and in Pittsburgh,[L] where law enforcement recently broke up a trafficking organization. By contrast, purchasing ecstasy has become less difficult in 10 *Pulse Check* cities: Atlanta,[L,E] Baltimore,[L] Cleveland,[L] Minneapolis/St. Paul,[L] New York,[E] Pittsburgh,[E] San Diego,[L] San Francisco,[L] Seattle,[L] and Washington, DC.[L] On average across the country, ecstasy can be purchased with about the same ease as powder cocaine (2.2 average rating).[L,E] *(Exhibits 3 and 4)*

- User changes: The age of ecstasy users appears stable, with a few exceptions. In Boston, the number of users in private schools continues to increase.[E] In the Houston non-methadone program, ecstasy use is starting at a younger age.[N] It is also becoming common among a subculture of young gay adolescents in that city.[E] In Tampa/St. Petersburg, more younger users are reported over the past 5 years.[E] But the methadone source in that city believes that people are outgrowing the drug as they mature.[M]

- Local market changes: The ecstasy market continues to expand beyond the club scene. For example, in St. Louis and Seattle, it is reported as more mainstream and in the suburbs.[L] In Washington, DC,[L] open-air markets and street sales of ecstasy have emerged. In Atlanta, ecstasy sales have emerged in the city proper.[L] And in Portland (OR),[L] the number of raves has declined.

  Ecstasy seller characteristics remain relatively stable, with changes in a few cities. Sellers in Miami are becoming less open than they were in the past, "learning how to avoid law enforcement."[L] Sales have increased in the Black community in Washington, DC.[L] Asian gangs new to Los Angeles are rapidly taking over the ecstasy market.[E] While Atlanta's ecstasy market is generally controlled by overseas groups, the number of local independent sellers is increasing.[E]

- Price *(Exhibit 10f)*: One tablet of ecstasy is the most common unit sold, and prices range from $7.50–$15 in Dallas to $25–$40 in Chicago. A New York respondent reports lower prices for ecstasy sold on streets rather than in nightclubs, and several sources report much lower prices for large-quantity purchases (1,000 pills, "boats," are the wholesale unit sold in many *Pulse Check* cities).

  Prices remained relatively stable between spring and fall 2002, with two sources in the Northeast reporting price increases, possibly due to decreased supply, and one source (in Atlanta) reporting price drops. In most *Pulse Check* cities, prices have declined over the past several years.

  Although respondents do not report ecstasy purity, several describe increased adulterants, such as methamphetamine (in Atlanta,[E] Phoenix,[E] and San Diego[L]), heroin (in Phoenix[E]), caffeine (in San Diego[L]), and ketamine, gamma hydroxybutyrate (GHB), and dextromethorphan (in Atlanta). Sources report a wide variety of drugs sold as ecstasy and a decline in the amount of ecstasy found in tablets in two Midwest cities (Detroit and Minneapolis/St. Paul).

PCP

- PCP is emerging or reemerging as a problem in seven *Pulse Check* cities *(Exhibit 9)*: Houston,[E] Minneapolis/St. Paul,[M] Phoenix,[E,N] Philadelphia,[L] St. Louis,[E] San Diego,[N] and Washington, DC.[E,M]

- In Philadelphia, emergency department episodes involving PCP have increased, particularly for individuals in their late teens.[E]

- In St. Louis, it is used by an emerging group of young Black users, particularly females.[E]

- PCP is sometimes sold as a liquid in vials. Often, cigarettes or marijuana blunts are dipped in PCP and then sold. And sometimes, as in Houston and Minneapolis/St. Paul, it is combined with embalming fluid and/or marijuana.

- Law enforcement personnel in Washington, DC, are concerned about PCP's reemergence. Arrests have increased.[E]

OTHER DRUGS

- Gamma hydroxybutyrate (GHB): GHB has declined in availability in Detroit,[E] Miami,[E] and St. Louis.[L] In Dallas, adolescents are increasingly using it, instead of flunitrazepam (Rohypnol), for drug-assisted

Exhibit 9. Where is PCP emerging as a problem? (Fall 2002)

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

rape.[E] It is involved in some deaths and drug-assisted rape incidents in San Diego, but use appears stable because word has gotten out about its volatility and lethal potential.[E]

- Ketamine ("special K"): Ketamine availability has declined in San Diego since the arrest of a main supplier in Mexico (80 percent of the ketamine in the United States comes from Mexico via San Diego).[L] The drug is well known, but not pervasive, among youth in Baltimore.[L]

- Over-the-counter dextromethorphan products: Adolescents in many *Pulse Check* cities are increasingly abusing cold medications containing dextromethorphan (often found in Coricidin® products, commonly referred to as "triple C"). Taken in large quantities, dextromethorphan can produce effects similar to those of ecstasy. It is sometimes combined with alcohol or other drugs. In Tampa/St. Petersburg, incidents are reported of adolescents taking 20 to 43 tablets at a time, sometimes in combination with another over-the-counter medication, dimenhydrinate (Dramamine®). Overdoses and thefts from groceries and pharmacies are increasingly reported in that city.[N,M] Similarly, in Portland (OR), the product has been involved in overdoses among youth (12–17 years old) who are consuming it in large quantities.[L] In Houston, where adolescents use the product with alcohol, enhancing its effect, "it's easy to get, not controlled, and relatively cheap."[E] Dextromethorphan abuse is also increasing in Denver, where it is called "DXM" and is used as a club drug. Abuse of the product is also reported in Detroit.[E]

- Alprazolam (Xanax®): Sources in two Florida cities (Miami and Tampa/St. Petersburg) report increasing abuse of the drug. Additionally, the practice of using the drug in combination with prescription opiates or ecstasy has increased in Miami.[E]

- Abused sildenafil (Viagra®): In some cities, such as Miami[E] and Pittsburgh,[E] ecstasy and sildenafil are often combined. This combination is associated with high-risk sexual activity. In Miami, sildenafil is also increasingly used in combination with marijuana and methamphetamine. The increase in new abusers is particularly marked among adolescent males.[E]

- Hashish: The drug is reemerging in Houston, where the same people who used it 10 years ago now take it as "dessert" after marijuana to "kick it up a notch." The increase coincides with increased availability since the Taliban (who had suppressed hashish production and export) were ousted from Afghanistan.[E]

- Khat: Khat is an emerging drug among Minneapolis/St. Paul's Somalian community, which is the largest in the country.[L] This natural stimulant, which loses potency in 48 hours, has leaves that contain psychoactive ingredients structurally and chemically similar to d-amphetamine. It is overnight-mailed or shipped in luggage on airplanes from Kenya.[E] The drug has also increasingly appeared on the St. Louis drug market, with three seizures by law enforcement during fall 2002. It is being transported via overnight mail services, a method that city's law enforcement has not seen before.[L]

Exhibit 10a. What are the prices and purity levels of different types of heroin in *Pulse Check* cities? (Fall 2002)

		Most common Street Unit			1 Gram
	City/Source	Unit	Price	Purity	Price
Mexican black tar or brown	Dallas, TX[L]	1 oz	$800–$2,000	5–6%	$150–$250
	Denver, CO[L]	One balloon (0.1 g)	$20	NR	$100
	Denver, CO[E]	1 oz	$1,500–$3,000	8–64%	$100–$150
	Houston, TX[L]	1 oz	$1,000–$2,500	13–58%	$100–$150
	Los Angeles, CA[L]	One balloon (0.1 g)	$20	NR	NR
	Los Angeles, CA[E]	1 oz ("pedazo")	$700–$800	NR	NR
	Minneapolis/St. Paul, MN[L]	NR	NR	NR	$300–$400
	Phoenix, AZ[L]	One twenty (100–200 mg)	$20	NR	$100–$200
	Sacramento, CA[L]	0.25 oz	$20–$40	16–18%	NR
		1 oz	$500–$800		
	San Diego, CA[L,E]	One ten (0.1 g)	$10	14–70%	$50–$100
		One forty (0.4 g)	$40		
		1 oz	$600–$1,200		
	San Francisco, CA[E]	One bag (0.25 g)	$10–$20	NR	NR
	San Francisco, CA[L]	One balloon, one bag (0.1–0.25 g)	$10	17%	$60
	Seattle, WA[L]	0.1 g	$90–$120	14–58%	NR
		1 oz	$600–$300		
South American (Colombian) white	Atlanta, GA[L]	One hit	$30	NR	$300
	Atlanta, GA[E]	20-bag (2–3 g)	$20	>50%	NR
	Boston, MA[L]	One bundle (0.1 g)	$4–$6	>80%	NR
	Boston, MA[E]	0.5 g	$50–$75	NR	$80–$150
	Chicago, IL[L]	One hit (0.2 g)	$20	NR	$150
	Cleveland, OH[L]	One bag (bindle)	$20	NR	NR
	Cleveland, OH[E]	Dime bag (0.1 g)	$10–$20	NR	NR
	Miami, FL[L]	1 oz	$2,100	NR	NR
	New York, NY[L]	One bag	$10–$14	NR	$60–$80
	New York, NY[E]	One packet (0.1 g)	$10	>60%	NR
	Philadelphia, PA[E]	One hit	$10	NR	$20–$100 (bundle)
	Philadelphia, PA[L]	One bag (<1 g)	$10–$20	40–95%	$67–$300
		10 bags (one bundle)	$70–$200		
	Pittsburgh, PA[L]	One bundle (10 bags)	$180–$200	60–90%	$300–$600
	Washington, DC[E]	Bags (of "scrambled," adulterated)	$8, $10, $12	23%	$120–$150
	Washington, DC[L]	Dime bag (50–75 mg)	$10	10–15%	NR
Unspecified Type	Chicago, IL[E] (white powder with unknown source)	Dime bag	$10	NR	$50–$300
	Cleveland, OH[E]	Dime bag (0.1 g)	$10–$20	NR	NR
	Baltimore, MD[L,E]	10-bag, one capsule	$10	NR	NR
	Detroit, MI[E]	One hit	$10–$12	NR	NR
		One bundle (10 hits)	$100–$200	NR	NR
	Detroit, MI[L]	Dime bag (0.1 g)	$10	NR	$100–$150
	Los Angeles, CA[E]	NR	NR	NR	100–$150
	Minneapolis/St. Paul, MN[E]	One bindle	$10–$50	NR	$300–$400[L]
	New York, NY[E]	One packet (0.1 g)	$10	NR	NR
	Philadelphia, PA[E]	One hit	$10	NR	NR
	San Francisco, CA[L]	One bag (0.01–0.25 g)	$10	17%	$60
	St. Louis, MO[L]	NR	NR	NR	$100
	St. Louis, MO[E]	NR	NR	NR	$250–$600
	Tampa/St. Petersburg, FL[L]	0.25 g	$20	NR	$80

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

Exhibit 10b. How much does one rock of crack cocaine cost in *Pulse Check* cities? (Fall 2002)

	City/Source	Unit (slang term)	Price
Northeast	Boston, MA[L]	One jum (0.1 g)	$10
	Boston, MA[E]	One jum (approximately four hits)	$20–$40
	New York, NY[L,E]	One vial, one bag	$10–$20
	Philadelphia, PA[L,E]	One vial, one rock (0.5–0.1 g)	$3–$10
	Pittsburgh, PA[L,E]	One rock	$5, $10, $20
South	Atlanta, GA[L]	One rock	$10, $20
	Atlanta, GA[E]	One rock	$5
	Baltimore, MD[L,E]	One rock, one vial	$10
	Dallas, TX[L]	One rock	$10–$40
	Miami, FL[L]	One rock	$10–$20
	Tampa/St Petersburg, FL[L]	One rock (0.1–0.2 g)	$20
	Washington, DC[L,E]	Dime bag (75 mg), one rock	$10
Midwest	Chicago, IL[L]	One rock (0.2 g)	$20–$25
	Chicago, IL[E]	One rock	$5–$20
	Cleveland, OH[L]	One rock	$20
	Cleveland, OH[E]	One rock	$10
	Detroit, MI[L]	One rock (0.1 g)	$10
	Detroit, MI[E]	One rock	$5–$25
	Minneapolis/St. Paul, MN[L,E]	One rock	$20
	St. Louis, MO[L,E]	One rock	$20
West	Denver, CO[L]	One rock	$20
	Los Angeles, CA[L,E]	One rock (0.2 g)	$10–$20
	Phoenix, AZ[L]	200–300 mg ("twenty")	$20
	Sacramento, CA[L]	One rock (0.2 g)	$20
	San Diego, CA[L,E]	0.1 g ("tens")	$10
	San Francisco, CA[L]	One rock (0.1 g)	$6–$10
	San Francisco, CA[E]	One rock	$2–$20
	Seattle, WA[L]	1 g	$100

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

Exhibit 10c. How pure is powder cocaine, and how much does it cost? (Fall 2002)

	City/Source	Purity	Gram Price	Ounce Price
Northeast	Boston, MA[L]	NR	$50–$60	NR
	New York, NY[L]	NR	25–$35	$600–$1,000
	Philadelphia, PA[L]	40–95%	$100–$125	$800–$1,300
	Pittsburgh, PA[L]	50–70%	$75–$100	NR
South	Baltimore, MD[L]	NR	$90–$100	NR
	Dallas, TX[L]	NR	$50–$100	NR
	Houston, TX[L]	NR	$60–$100	$400–$650
	Miami, FL[L]	NR	NR	$650
	Tampa/St. Petersburg, FL[L]	NR	$50	$700–$850
	Washington, DC[L,E]	30–60%	$50–$100	NR
Midwest	Chicago, IL[L]	NR	$125	NR
	Chicago, IL[E]	NR	$50–$150	NR
	Detroit, MI[L,E]	NR	$75–$150	NR
	Minneapolis/St. Paul, MN[E]	NR	$100	NR
	St. Louis, MO[L,E]	77%	$100–$125	NR
West	Denver, CO[L]	NR	$100	NR
	Denver, CO[E]	30–90% (g); 65-85% (oz)	$100–$125	$500–$900
	Los Angeles, CA[L]	80%	$100	NR
	Sacramento, CA[L]	78%	$80	$500–$600
	San Diego, CA[L,E]	54–90%[L]; 68–72%[E]	$40–$80	$300
	San Francisco, CA[L]	64%	$100	$400–$600
	Seattle, WA[L]	57–68%	$80–$100	$45–$700

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

Exhibit 10d. How much does marijuana cost? (Fall 2002)

	City/Source	Type	Price/Unit	Ounce price
Northeast	Boston, MA[L]	NR	NR	$325
	Boston, MA[E]	NR	$20/0.125-oz bag	NR
	New York, NY[L,E]	Commercial	$5/bag $1,000–$2,000/lb	$100–$200
		Hydroponic	$20/bag $3,000–$5,000/lb	$300–$1,200
	Philadelphia, PA[L]	Commercial	NR	$150–$200
	Philadelphia, PA[E]	NR	$5/bag	NR
	Pittsburgh, PA[L]	NR	NR	$90–$150
South	Atlanta, GA[L]	Sinsemilla	$10/bag	NR
	Atlanta, GA[E]	Commercial	$10/dime bag (2–3 g)	$120
	Baltimore, MD[L]	NR	$1–$3/joint $10–$12/blunt	$100
	Dallas, TX[L]	Mexican commercial	$2/joint	NR
	Houston, TX[L]	Mexican commercial	$5/g $300–$500/lb	NR
		Sinsemilla	$600/lb	NR
	Tampa/St. Petersburg[L]	NR	$40/0.25 oz	$1,100–$1,200
	Washington, DC[L]	NR	$20/bag (750 mg)	NR
	Washington, DC[E]	Commercial	$5–$10/bag (a few joints) $10–$20/blunt	$100
		Hydroponic	NR	$480
Midwest	Chicago, IL[E]	NR	$5–$10/bag	$80–$200
	Cleveland, OH[L]	NR	NR	$200 (about 10–12 blunts)
	Cleveland, OH[E]	NR	$5–$10/blunt	$100
	Detroit, MI[L]	NR	$10/bag (1 g)	NR
	Detroit, MI[E]	NR	$50–$200/0.25 oz	NR
	Minneapolis/St. Paul, MN[L]	Commercial BC bud	$700/lb $7,000–$12,000/lb	NR NR
	Minneapolis/St. Paul, MN[E]	NR	$5/joint	NR
	St. Louis, MO[L]	NR	$1,000–$1,100/lb	$100
West	Denver, CO[L]	NR	NR	$100–$200
	Denver, CO[E]	Mexican and local commercial	NR	$200–$300
	Los Angeles, CA[L]	Commercial	$10/dime bag (1 g)	NR
	Phoenix, AZ[L]	Commercial	$20/dime bag (6–7 g)	$60–$80
	Sacramento, CA[L]	Commercial	$25/g	$200–$250
	San Diego, CA[L]	Mexican commercial Sinsemilla	$5/nickel bag (0.5–1 g) $150/0.25 oz $300/0.5 oz	$600–$1,000 $450
	San Diego, CA[E]	Commercial BC bud	NR $3,000–$5,000/lb	$60–$100 NR
	Seattle, WA[L]	Mexican commercial BC bud	$500–$700/lb $2,800–$4,000/lb	NR NR

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

Exhibit 10e. How much does methamphetamine cost? (Fall 2002)

	City/Source	Gram Price	Price/Unit
Northeast	Boston, MA[L]	$100	NR
	New York, NY[L]	$100–$300	$10–$20/pill $1,600–$6,000/oz
	Philadelphia, PA[L]	$100	NR
	Pittsburgh, PA[L]	$100–$200	$45/0.25 g
South	Atlanta, GA[L]	NR	$10, $20/hit
	Dallas, TX[L]	$70–$100	NR
	Houston, TX[L]	NR	$500–$800/oz $6,000–$11,000/lb $18,000–$20,000/kg
	Washington, DC[L]	$140	NR
Midwest	Chicago, IL[L]	$330	NR
	Cleveland, OH[L]	$75	NR
	Minneapolis/St. Paul, MN[L,E]	$100	$1,000/oz
	St. Louis, MO[L]	$100	NR
	St. Louis, MO[E]	NR	$700–$1,300/oz
West	Denver, CO[L,E]	$80–$110	$700–$1,000/oz
	Los Angeles, CA[L]	NR	$125/1/16 oz
	Los Angeles, CA[E]	NR	$450–$550/oz
	Phoenix, AZ[L]	NR	$80–$110/1/16 oz ("teener") $120–$180/1/8 oz
	Sacramento, CA[L]	$80	$300–$600/oz
	San Diego, CA[L]	$50–$75	$20/0.25 g $500/oz
	San Diego, CA[E]	$40–$100	$3,500–$5,500/lb
	San Francisco, CA[L]	$130	$170/1/16 oz $300/1/8 oz
	Seattle, WA[L]	$20–$60	$350–$650/oz

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

Exhibit 10f. How much does a pill (one dose) of ecstasy cost? (Fall 2002)

	City/Source	Price per pill
Northeast	Boston, MA[L,E]	$20–$25
	New York, NY[L]	$20–$28
	New York, NY[E]	$12–$25 (street) $25–$35 (clubs)
	Philadelphia, PA[L,E]	$15–$30
	Pittsburgh, PA[L]	$15–$30
South	Atlanta, GA[E]	$15–$20
	Baltimore, MD[L]	$18–$20
	Dallas, TX[L]	$7.50–$15
	Houston, TX[L]	$20–$30
	Miami, FL[L]	$11–$18
	Tampa/ St. Petersburg, FL[L]	$12–$15
	Washington, DC[L,E]	$18–$35
Midwest	Chicago, IL[L,E]	$25–$40
	Cleveland, OH[L,E]	$8–$20
	Detroit, MI[L,E]	$20–$40
	Minneapolis/ St. Paul, MN[L,E]	$20
	St. Louis, MO	$20–$30
West	Denver, CO[L,E]	$15–$25
	Los Angeles, CA[L]	$20–$40
	Phoenix, AZ[L]	$20–$30
	Sacramento, CA[L]	$20
	San Diego, CA[L,E]	$15–$25
	San Francisco, CA	$10–$20
	Seattle, WA[L]	$10–$20

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

SPECIAL TOPIC

LOCAL DRUG MARKETS: A DECADE OF CHANGE

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LOCAL DRUG MARKETS: A DECADE OF CHANGE

The last issue of *Pulse Check* examined local drug markets which, like any economic markets, are subject to a wide variety of influences. The current issue expands upon that topic by exploring other aspects of the current markets and comparing them with the markets of 10 years ago.

As key informants and opinion leaders in their communities, *Pulse Check* sources are well positioned to describe past and present drug markets, pinpoint their vulnerabilities, and comment on tactics that have or have not disrupted them. Therefore, during our two waves of telephone discussions, conducted December 2002 through January 2003 and March through May 2003, we asked these individuals to discuss a series of market-related topics relevant to their specific areas of expertise.

All 97 respondents were asked to discuss the degree to which street-level drug transactions involve cash versus the exchange of specific goods and services. They were also asked to discuss any changes in such transactions over the past 10 years.

The law enforcement and epidemiologic/ethnographic respondents were also asked to discuss and rate the following:

- Various illicit marketing tactics used by dealers, and to what degree they have complicated efforts to detect or disrupt drug activity over the past 10 years
- Community strategies used to address the increased complexities of drug markets, and their success in doing so
- Additional community measures being planned for the future and any recommendations
- The extent to which various items have contributed to the widespread availability and use of marijuana over the past 10 years

Non-methadone and methadone treatment sources, similarly, were asked to discuss and rate the following:

- Changes in local drug markets and in the nature of drug users over the past 10 years, and the impact of those changes on the drug abuse problem
- Problems that have complicated the treatment of marijuana-using clients, particularly youth

Finally, as a followup to the last two *Pulse Check* issues, all 97 respondents discussed any continuing effects of the September 11 attacks and their aftermath on their communities' drug abuse problem.

Highlights from these discussions include the following:

In exchange for drugs...

- Cash, by far, is the most common currency exchanged for drugs, followed by sex and shoplifted merchandise.
- The exchange of drugs for food stamps has declined in several cities over the past decade because of the use of innovative technologies—such as debit cards, vouchers, or electronic transfers—aimed at preventing abuse and diversion.
- In order to obtain marijuana, youth are increasingly engaging in risky or criminal activities, such as trading sex, guns, or shoplifted merchandise.

Illicit marketing strategies

- Detection and disruption efforts have not been hampered much by dealers using unique packaging or by their increased or decreased use of brand names.
- Sources are divided in their views about relocation of drug markets within communities: many believe it poses a challenge to detection and disruption efforts, many believe it has no effect, and many even view it as a positive outcome of disruption efforts.
- Throwaway cell phones and other developments in digital communications technology, by far, have posed the greatest challenge to market detection and disruption efforts. Some sources believe that phone companies are offering new technologies to the public before offering counter-technologies to law enforcement.

Fighting back: Community tactics

- Task forces of varying composition and focus have been used effectively over the past decade in all 25 *Pulse Check* cities.
- The majority of *Pulse Check* sites have some sort of drug court program, and sources in those areas generally consider them highly effective.
- Precursor laws are rated as moderately successful in cities where they are enacted.
- Efforts to monitor prescription drug diversion have met with great to moderate success in many cities.
- Overall, drug-free zone laws are considered moderately effective, but opinions vary widely.

- About half of the *Pulse Check* sites have provided law enforcement personnel with drug user recognition education (DRE), and those programs have proven generally effective.

The nature of drug users: Complicating changes

- Drug abuse problems over the past decade have been particularly complicated by the lack of housing opportunities for recovering treatment clients.
- Other frequently mentioned complications to disrupting illegal drug markets include a lack of jobs and job training opportunities for recovering clients and an increasing availability of new and substitute drugs.

Continued widespread marijuana availability and use: Contributing changes

- The decline in social disapproval of marijuana (by peers, parents, etc.) has had an impact on its widespread use and availability over the past 10 years.
- The decline in users' perception of marijuana's harmfulness is viewed as exacerbating the marijuana problem.
- Law enforcement sources consider the promotion of marijuana as "medicine" as a more significant problem than do their epidemiologic/ethnographic counterparts.
- Because marijuana prices have remained generally stable over the past 10 years, sources do not attribute increased use to price declines.

Treatment for marijuana users: The past 10 years

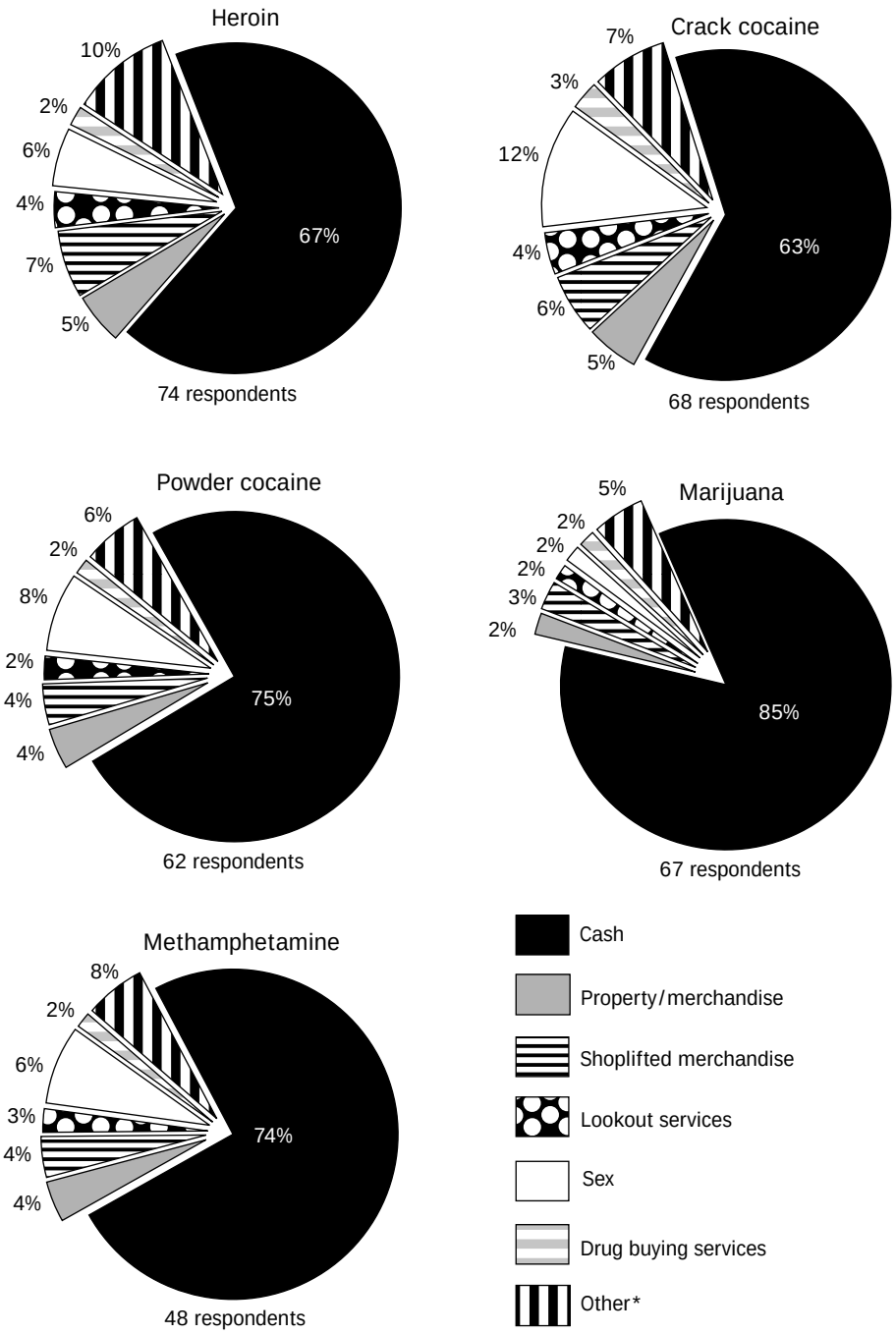
- Challenges involved in treating marijuana-using clients over the past 10 years have increased and include earlier initiation of marijuana use, increased marijuana potency, and a decline in users' perception of harm.
- The news media and increased court referrals appear to have had little complicating effect on marijuana users in treatment.

September 11 followup

- More than 60 percent of respondents believe that the September 11 attacks have had no continuing effects on the drug abuse situation.
- The most commonly mentioned post-September 11 effects include the following: supplies of some drugs have declined in some cities; some trafficking routes have shifted away from the East Coast; vehicular and other means of transport have sometimes replaced air shipment; many sources perceive a shift in law enforcement priorities from drugs to homeland security; and some drug users in treatment continue to experience elevated levels of mental health disorders.

The remainder of this chapter elaborates on these highlights.

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



Based on their knowledgeable sense of the street scene, all sources were asked to "guesstimate" what percentage of their communities' street-level transactions involves cash and what percentage involves exchanging other specific goods or services. About three-quarters of the sources (74 of 97) responded to this question.

Their combined estimates yield several overall findings for drugs in general:

- *The majority of drug transactions are "cash only," particularly in the case of marijuana.*
- *Sex is commonly exchanged for drugs, particularly crack (an estimated 12 percent of transactions), powder cocaine (nearly 8 percent), and methamphetamine (more than 6 percent).*
- *Shoplifted merchandise is the next most commonly exchanged item, particularly for heroin (nearly 7 percent of transactions) and crack (nearly 6 percent).*

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

** "Other" includes items accounting for 2 percent or less of transactions for all five drugs, such as guns, other drugs, drug transport, drug theft, food stamps, injecting services, and lookout services. It also includes items specifically added by some respondents, such as pawning (Dallas), dealing (Boston, Houston), panhandling (San Francisco), bad checks (San Francisco), trading one's children (Cleveland), shoplifted merchandise converted to cash (Minneapolis/St. Paul), stolen precursor chemicals (Dallas, Minneapolis/St. Paul), methamphetamine manufacture (Dallas; Portland, OR), and mail theft (Seattle).*

HEROIN sales involve the exchange of a range of goods and services in addition to cash:

- Cash: Nearly all heroin transactions in Washington, DC, are cash only. Other particularly high "cash-only cities" (average estimates of 80 percent and higher) are Atlanta, Cincinnati, Denver, New York, and San Diego.
- Shoplifted merchandise: More than one-fifth of heroin transactions in San Francisco involve shoplifted merchandise, in the combined opinions of that city's four *Pulse Check* sources. Such transactions are also common (estimates of 10–22 percent) in Atlanta, Boston, Phoenix, St. Louis, and Seattle.
- Sex: Sex-for-heroin appears to be most common (10–13 percent of transactions) in Cincinnati, Houston, Phoenix, and Portland (OR).
- Injecting services: Sometimes addicts need help in injecting, so they offer heroin to other addicts in exchange for that service. Such is the case in Houston, where respondents estimate more than 18 percent of heroin is obtained in that manner.
- Drug buying services: In Boston and Seattle, users commonly go out to buy heroin for other users, then keep a portion of the drug for themselves (estimates of 14 percent and 10 percent, respectively, of transactions).
- Other drugs: In Cincinnati, other drugs are traded for heroin in an estimated 10 percent of transactions.
- Other: One source in Dallas[N] believes that 50 percent of heroin transactions involve pawning merchandise to obtain drugs or cash for drugs.

CRACK is more likely than the other drugs to be traded for items other than cash:

- Cash: Cities with particularly high estimated percentages of "cash-only" transactions (80 percent and higher) are Denver, Los Angeles, Portland, San Diego, and Washington, DC. By contrast, items other than cash are traded for crack more than half the time in Boston, Dallas, Houston, Phoenix, San Francisco, and Seattle.
- Sex: Respondents in 15 of the 25 *Pulse Check* sites estimate particularly high average percentages (10–40 percent) of crack transactions involving sex: Atlanta, Baltimore, Boston, Cincinnati, Dallas, Detroit, Houston, Miami, Minneapolis/St. Paul, New York, Phoenix, Pittsburgh, St. Louis, San Francisco, and Seattle.
- Shoplifted merchandise: Substantial proportions of crack transactions involve shoplifted merchandise (estimates of 10–17 percent) in Boston, Dallas, Houston, St. Louis, and Seattle.
- Other stolen merchandise: More valuable stolen merchandise, such as electronic equipment, is commonly exchanged for crack (estimates of 10–13 percent) in New York, Phoenix, and Seattle.
- Property or merchandise: Respondents in Phoenix and St. Louis estimate particularly high percentages (13 percent and 10 percent, respectively) of crack transactions involve these items.
- Drug buying services: As in the case of heroin, drug buying services in exchange for crack are fairly common in Boston and Seattle (estimates of 25 percent and 10 percent of transactions, respectively).
- Other: In Seattle, fairly large proportions of crack transactions involve food stamps, drug transport services, and theft of the drug from dealers or other users (approximately 10 percent each).

POWDER COCAINE transactions are more diverse than those for other drugs: a wide range of goods and services—such as drug transport, food stamps, and guns, to name just a few—account for small portions of transactions (average estimates of 1–10 percent per item). Only the most frequently traded items are described below:

- Cash: Sources in nearly half (12 of 25) of the *Pulse Check* sites believe that the vast majority (80 percent) of powder cocaine transactions are cash only.
- Sex: One source in Houston[E] believes that as much as 80 percent of the powder cocaine in the area is traded for sex. The practice is also fairly common in Philadelphia, Phoenix, and Seattle (average estimates of 10–13 percent of transactions).
- Property or merchandise: These items are often traded for powder cocaine (10–14 percent of transactions) in Dallas, Phoenix, and Portland (OR). At the wholesale level, vehicles are often traded for drugs in Houston: for example, a used car might be traded for a kilogram of cocaine.
- Guns: In Houston,[L] at the wholesale level, a Drug Enforcement Administration (DEA)/Federal Bureau of Investigation (FBI) guns-for-cocaine investigation in fall 2002 yielded $25 million of military-grade weapons and many arrests of right-wing Colombian paramilitaries.

- Other (estimates of 10 percent of transactions): Other commodities sometimes exchanged for powder cocaine include shoplifted merchandise in Atlanta and Boston, other stolen merchandise in Phoenix, and other drugs in Cincinnati.

MARIJUANA, compared with other drugs, is less likely to be traded for items other than cash:

- Cash: Sources believe that cash is the only commodity accepted for marijuana in Boston, Cincinnati, Denver, and Seattle; and nearly all marijuana transactions (an estimated 95–99 percent of transactions) involve cash in Detroit, Portland, and Washington, DC. Cash transactions for marijuana are least common in Phoenix. Nevertheless, cash still accounts for an estimated 65 percent of marijuana transactions in that city.
- Gifts: One source in Seattle believes that half of the youth who use marijuana pay for it in cash, while the other half get it as a "gift" to get them hooked on it.
- Other: Throughout the 25 *Pulse Check* sites, only three items are reported as traded for marijuana to any substantial degree (10 percent estimates for each): property or merchandise in Cleveland, other drugs in Sacramento, and food stamps in Chicago.

METHAMPHETAMINE transactions sometimes involve more unusual items:

- Cash: All methamphetamine transactions in Chicago involve cash, as do nearly all in Detroit and Washington, DC.
- Sex: One source in Houston believes that 50 percent of that city's methamphetamine is sold for cash, and the other 50 percent is traded for sex. In Miami, nearly 13 percent of methamphetamine transactions are believed to involve sex. The drug is fairly new to that area, so it is often introduced into sexual situations, like parties. The epidemiologic source there expects that practice to decline.
- Methamphetamine manufacture: Unlike most other illicit drugs, methamphetamine can be manufactured by the user, which is common in Dallas and Portland (OR).
- Stolen precursor chemicals: These items are frequently traded for methamphetamine in Dallas.
- Gifts: Since methamphetamine is often used in a group setting in San Francisco, it is frequently given away in clubs by friends and acquaintances.
- Other: Property or merchandise is frequently traded for methamphetamine in Phoenix, Sacramento, and Seattle. Shoplifted merchandise is commonly traded in San Francisco and Seattle.

BEYOND CASH: WHAT HAS CHANGED OVER THE PAST 10 YEARS?

Sources were also asked whether any of these specific types of transactions have changed over the past 10 years. Their responses yield a few recurring themes:

- Cash: Cash-only transactions have increased in some cities, such as Chicago and New York; conversely, they have declined in Boston.
- Sex: The practice of exchanging sex for drugs has increased in Atlanta, Detroit (heroin), Minneapolis/St. Paul (marijuana, heroin), Phoenix, Portland (OR) (heroin), and St. Louis (crack or methamphetamine). It has declined in Houston (crack), Philadelphia (crack), Sacramento, and San Francisco (crack).
- Food stamps: The use of innovative technologies in lieu of paper, such as debit cards, vouchers, or electronic transfers, has disrupted food stamps-for-drugs trading in several cities, including Atlanta, Denver, Detroit, Houston, Philadelphia, and Pittsburgh.
- Marijuana-youth issues: In order to obtain marijuana, youth are increasingly engaging in risky or criminal activities, such as trading sex or shoplifted merchandise in Minneapolis/St. Paul and trading guns in Dallas.

These changes, as well as others that are more site specific, are described in the narrative surrounding the map on the next page.

BEYOND CASH: WHAT HAS CHANGED

SEATTLE
No changes are reported over the years.[N]

PORTLAND, OR
Female addicts are using less cash, less property, and more sex in exchange for heroin. The number of portable meth labs has greatly increased.[E]

SACRAMENTO
Sex for drugs has declined due to fear of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) and hepatitis C. The exchange of shoplifted merchandise for drugs has declined because retail store exchange policies have made it harder to "return" shoplifted items for cash.[N]

SAN FRANCISCO
Sex for crack has declined slightly.[E]

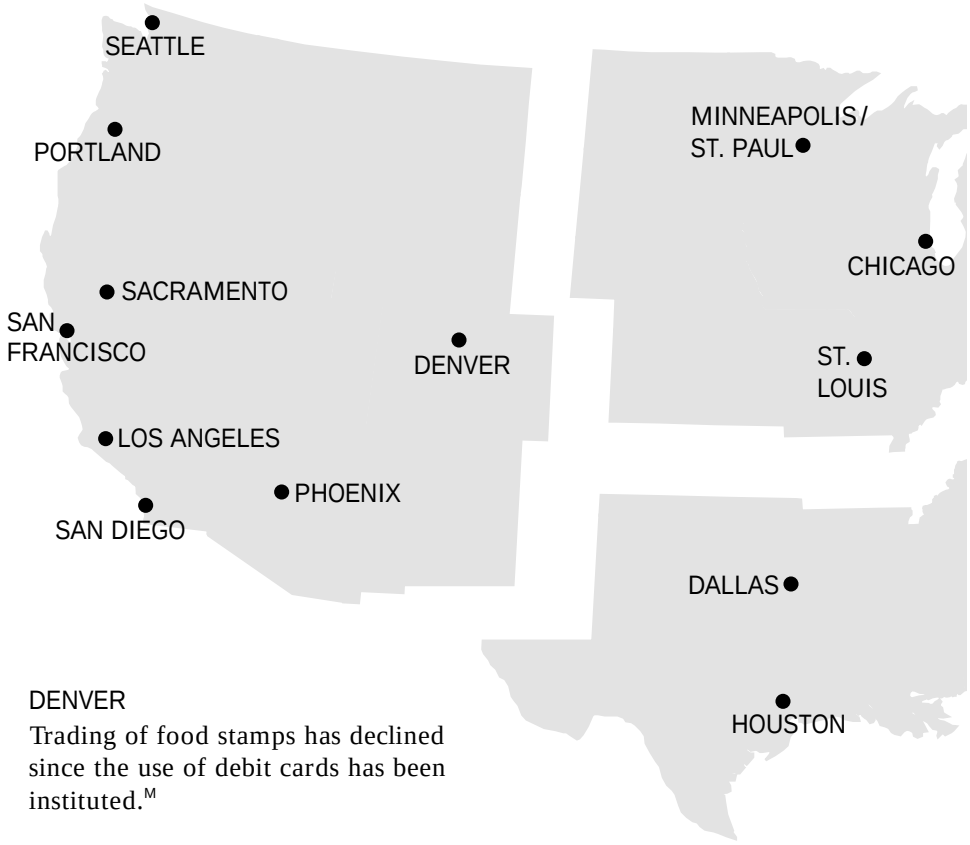
LOS ANGELES
Little has changed over the past 10 years. "Cash is still king."[E]

SAN DIEGO
Methamphetamine manufacturing has declined because task force activities have reduced the size and number of labs, pushing them into neighboring areas.[N]

PHOENIX
Phoenix's high auto theft rate is probably due to the increase in methamphetamine users who need the money.[E] Sex for drugs is no longer limited to female users only: males are now just as likely to resort to it.[M] Cash exchanges have declined, while increases are noted in transactions involving home robberies, identity theft, fraudulent documents, and chemicals for manufacturing.[N]

MINNEAPOLIS/ST. PAUL
Young people are increasingly shoplifting in order to trade merchandise, such as CDs, for marijuana.[E] Sex for marijuana is a new phenomenon. Drug theft ("ripping off dealers or friends") has increased.[N] Trading stolen precursors for methamphetamine is a relatively new phenomenon.[E]

Sex for heroin has increased. Opium users in the Hmong community increasingly use welfare checks to support their $250-per-month habits.[M] At higher levels, suppliers increasingly "front" kilos of drugs to dealers, allowing them to pay after selling the drugs.



DENVER
Trading of food stamps has declined since the use of debit cards has been instituted.[M]

DALLAS
Youth are increasingly trading guns for marijuana. Many purchase these guns at a large annual gun show.[E] Distribution of free drugs has increased—a practice aimed at gaining and maintaining market share.[N] Middleman involvement in transactions also has increased: "You gotta know somebody who knows somebody."[N] Methamphetamine users have become increasingly involved in the manufacturing process.[N]

HOUSTON
As dealers have become more aware of HIV risks, they have allowed fewer "rock stars" (women or men) to hang out in crack houses in order to trade sex for crack.[N] Texas' new food stamp system, which uses debit cards instead of paper, has disrupted the ability to trade food stamps for drugs.[N]

OVER THE PAST 10 YEARS? *(continued)*

DETROIT

Guns and food stamps have declined as commodities exchanged for drugs; the provision of lookout services in exchange for drugs has increased slightly.[E] Michigan's switch to vouchers for food stamps has made it more difficult to trade them for drugs.[N] Sex for heroin has increased, largely due to the increase in female substance abusers. "Prostitution used to be for money; now it's for drugs."[M]

CLEVELAND

Sex for crack remains common: nearly all prostitutes are crack addicts.[E]

CHICAGO

Injecting services for heroin have declined over the past 10 years because needle exchange programs have made shooting galleries irrelevant.[E] Dealers don't want merchandise any more: they just want cash.[N]

CINCINNATI

No changes are reported over the years.

ST. LOUIS

Sex for crack or methamphetamine has increased. Common settings include truck stops, libraries, and book stores.[E] "Crack used to be cash only; now the use of sex and exchange of merchandise have become more common."[L]

BOSTON

"As police activity has disrupted sales and driven markets underground, criminal activity has escalated while straight cash transactions have declined. For example, users are more likely to fence shoplifted merchandise and use the proceeds to buy drugs."[E]

NEW YORK

Drug transactions have become increasingly "cash only." The larger organizations of the past sometimes sold drugs on consignment. But today's smaller, more independent street-level dealers can't recoup any outlay quickly enough to do so.[E]

PITTSBURGH

Food stamps are traded less commonly than in the past.[E] Users are increasingly stealing property and merchandise (shoplifting of meat has become especially common), pawning it, and using the cash proceeds to buy drugs.[L,E,M]

PHILADELPHIA

Sex for crack has declined, while the exchange of property for crack has increased—more electronic equipment, particularly CD players and CDs, are being traded.[E] Food stamps are not as widely traded as in the past because many people are no longer eligible for them.[M] Injecting services have declined because snorting has increased.[M]

BALTIMORE

In some cases, trading guns for drugs has become more widespread. Use of middlemen to buy drugs has also become more common.[L]

ATLANTA

Food stamps have declined as a tradable commodity: electronic transfer has made it more difficult to manipulate the system. Shoplifting also has declined due to increased law enforcement. Sex for drugs, however, has increased.[N]

WASHINGTON, DC

Guns and violence have increased greatly.[E]

TAMPA/ST. PETERSBURG

Diverted prescription drugs (such as alprazolam and OxyContin®) have become increasingly traded for other drugs, especially for methamphetamine.[E]

MIAMI

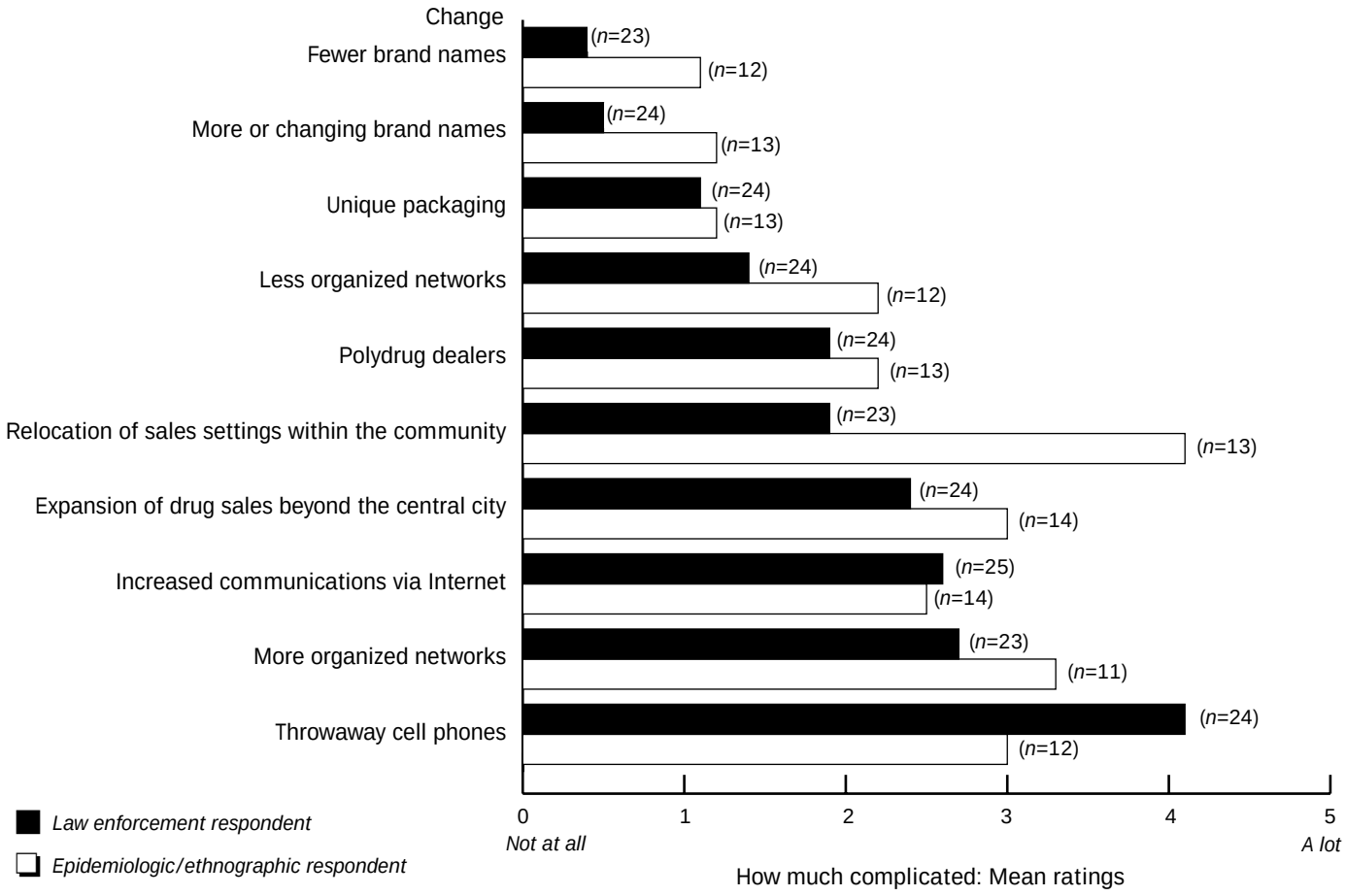
The provision of lookout services in exchange of drugs has declined over the past decade because of the decline in street sales.[E] With the advent of ecstasy, sexual exchange between male sellers and female buyers has increased.[L]

ILLICIT DRUG MARKETING STRATEGIES: CHANGES OVER THE PAST 10 YEARS

In an attempt to market illicit drugs and at the same time stay one step ahead of law enforcement, dealers have introduced a variety of marketing innovations, strategies, and tools over the past 10 years. *Pulse Check* law enforcement and epidemiologic/ethnographic sources discussed the specific strategies listed below and rated the extent to which they have complicated detection and disruption efforts in their communities.

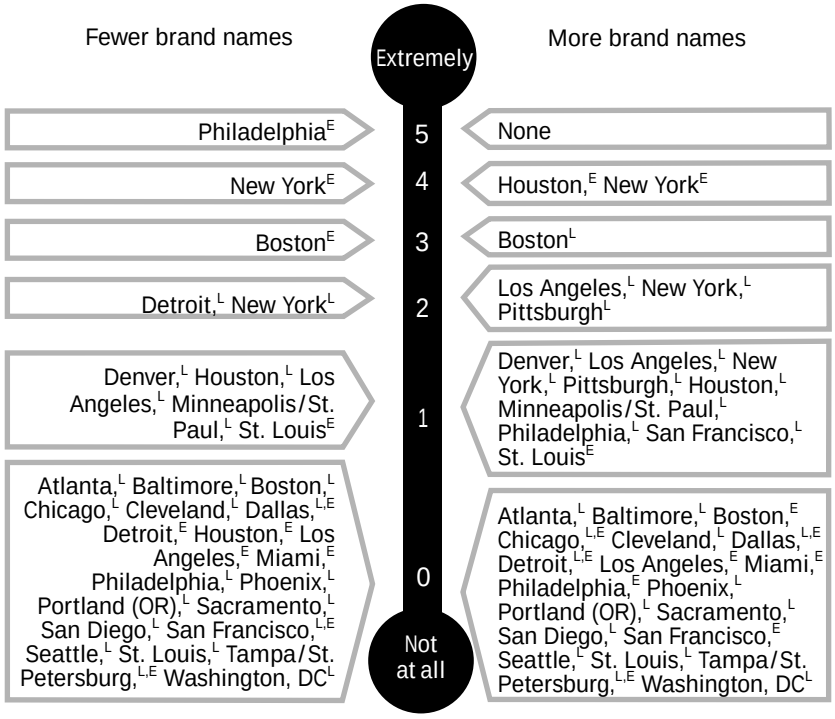
- *Law enforcement and epidemiologic/ethnographic sources generally agree that detection and disruption efforts have not been hampered much by dealers using unique packaging or by their increased or decreased use of brand names.*
- *Epidemiologic/ethnographic sources tend to view relocation of drug markets within communities as a challenge to detection and disruption efforts. Law enforcement sources are more divided in their opinions. Many believe that this type of movement has no effect, and many even view it as a positive outcome of disruption efforts.*
- *According to law enforcement sources, throwaway cell phones and other developments in digital communications technology, by far, have posed the greatest challenge to market detection and disruption efforts.*

To what degree have the following illicit marketing innovations or tools complicated efforts to detect or disrupt drug activity over the past 10 years? (Mean of 0–5 ratings)



Source: Mean of ratings given by law enforcement and epidemiologic/ethnographic respondents

Dealers using brand names: To what extent has it complicated detection and disruption efforts? (0–5 ratings)



Brand names: What they have to say...

- *Boston:[E] Over the past 10 years, it has become less easy to attach specific brands to specific people.*
- *Chicago:[E] Brand names have increased over the past 10 years, but they have not affected disruption efforts.*
- *New York:[L] Depending on what an organization is doing, the number of brand names can increase or decline. Either way, disruption efforts are not complicated.*

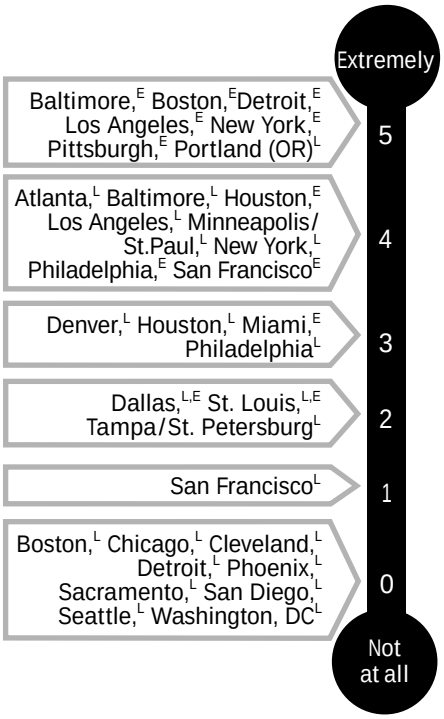
Sources: [L]Law enforcement respondents; [E]Epidemiologic/ethnographic respondents
Note: The law enforcement sources from Miami and Pittsburgh did not provide a rating, nor did the epidemiologic/ethnographic sources from Atlanta, Baltimore, Chicago, Cleveland, Denver, Minneapolis/St. Paul, Phoenix, Pittsburgh, Portland, Sacramento, San Diego, Seattle, and Washington, DC.

Markets relocating within the community: To what extent has it complicated detection and disruption efforts? (0–5 ratings)

Relocation of sales settings within the community: What they have to say...

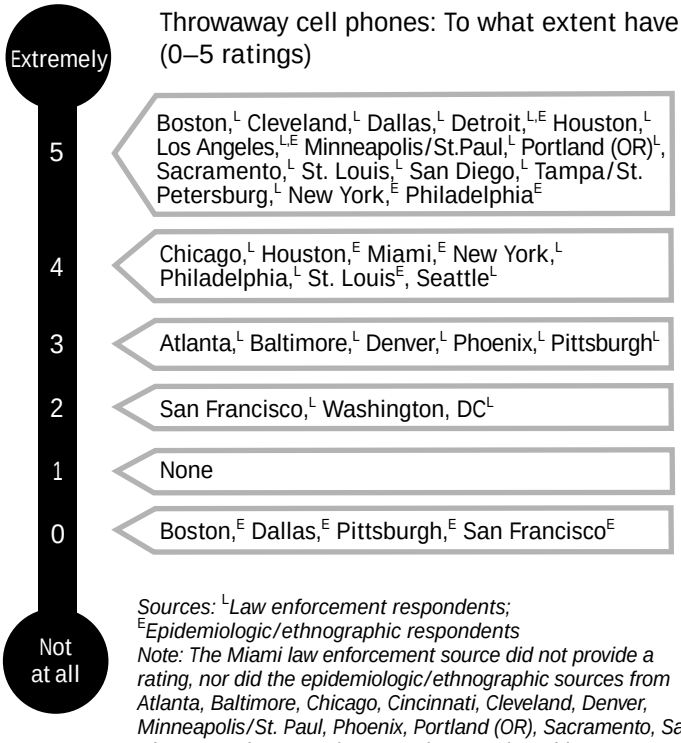
Shifting markets can be viewed in several ways: as a positive outcome of disruption efforts (as in Philadelphia), as having little effect (Dallas), or as a challenge to those efforts (Boston).

- *Philadelphia:[E] Markets have relocated as a result of Operation Safe Streets, ongoing since May 2002. Residents were given a phone number to call if markets moved to new corners. Dealing has moved indoors and into cars, with more home deliveries, cell phone use, and other indoor dealings. This change has had an impact on users: people are more reluctant to go to indoor locations, knock on strangers' doors, or get home deliveries, because of the possibility of getting "ripped off."*
- *Dallas:[E] Sales locations are moving fast, but police are keeping up.*
- *Detroit:[L] Markets do "pop over," but they are easily identified.*
- *Boston:[E] Sales locations keep changing. The more police activity there is, the more they change. And the more they change, the harder they are to find.*
- *Chicago:[E] Some parts of the city are stable; other parts are less so.*
- *Denver:[E] Dealers move from known areas to selling in cars or to new areas.*
- *New York:[L] The effects of relocation depend on where the markets are moving: if they move indoors, disruption becomes harder.*



Sources: [L]Law enforcement respondents; [E]Epidemiologic/ethnographic respondents
Note: The law enforcement sources from Miami and Pittsburgh did not provide a rating, nor did the epidemiologic/ethnographic sources from Atlanta, Chicago, Cleveland, Denver, Minneapolis/St. Paul, Phoenix, Portland (OR), Sacramento, San Diego, Seattle, Tampa/St. Petersburg, and Washington, DC.

Throwaway cell phones: To what extent have they complicated detection and disruption efforts? (0–5 ratings)



Sources: [L]Law enforcement respondents; [E]Epidemiologic/ethnographic respondents
Note: The Miami law enforcement source did not provide a rating, nor did the epidemiologic/ethnographic sources from Atlanta, Baltimore, Chicago, Cincinnati, Cleveland, Denver, Minneapolis/St. Paul, Phoenix, Portland (OR), Sacramento, San Diego, Seattle, Tampa/St. Petersburg, and Washington, DC.

Throwaway cell phones: What they have to say...

- *Baltimore:[L] Digital communications (cell phones) have caused more complications than anything else over the past 10 years: they have provided sellers a degree of protection, and they have completely changed the nature of law enforcement interception.*
- *St. Louis:[L] People are becoming more cautious about using cell phones, especially since recent movies and the media have revealed law enforcement techniques (such as cloning phones and cloning pagers) to the public. Therefore, more are using disposable phones, cell phones with two-way radio communication features, and calling cards with prepaid minutes. These new technologies make it hard to write an affidavit on wiretaps. Phone companies are supposed to supply the government with technology to combat each new technology, but they are offering it to the public first.*

Other marketing strategy changes over the past 10 years. Sources attribute little to moderate success to dealers in complicating law enforcement efforts by using the strategies listed below.

- Increased communications via Internet: The Internet's impact is hard to measure because it is hard to track, as noted by one source (Portland, OR[L]). Another source (Detroit[L]) believes that law enforcement is way behind dealers and users technologically, especially at the local and State levels, and especially regarding club drugs. Another (New York[L]) agrees that traffickers are "one-up" over law enforcement personnel, who are just starting to get Internet training. That source, however, expects the problem to lessen as the knowledge gap closes.

  The Internet is mentioned specifically in conjunction with club drugs and designer drugs (Boston,[E] Chicago,[L] and Minneapolis/St. Paul[L]), and even more specifically with regard to GHB among younger users (Tampa/St. Petersburg[E]). One source mentions the Internet in relation to paraphernalia (Pittsburgh[L]), and another reports its use among smugglers (Miami[L]).

- Expansion of drug sales beyond the central city: Over the past 10 years, markets have stayed within the city confines of San Francisco.[E] The reverse is true in Dallas,[E] where markets have moved into the city from the outside. The situation is somewhat more complex in Pittsburgh,[L] which is a series of townships that have conglomerated over the years, and where "nice neighborhoods" have turned into "drug neighborhoods" as the economic situation has declined. Sources have little to say about whether such changes have affected detection and disruption efforts.

- Less organized or more organized networks: Tampa/St. Petersburg's "meth squad" has disrupted that city's methamphetamine network.[E] Elsewhere, the degree of network organization has remained stable in many areas, including Dallas[E] (except for methamphetamine in rural areas), New York[L] (where the market remains highly organized), and San Francisco.[E] In Boston,[E] networks have become more fragmented, so fewer people know one another, making it more difficult to find informants. Similarly, in Chicago, the law enforcement source believes it has become more difficult to identify who is doing what. By contrast, Chicago's epidemiologic source believes that drug activity has become more organized over the years, although this change has not necessarily complicated law enforcement efforts.

- Polydrug dealing: Polydrug dealing has increased over the past 10 years in several cities, including Boston,[E] Chicago,[E] and Pittsburgh.[L] Sources, however, do not believe this change has complicated disruption activities.
- Unique packaging: In the many cities where drugs are packaged in a variety of unique ways, law enforcement and epidemiologic/ethnographic sources generally believe that such packaging does little to hamper disruption efforts. Rather, the reverse is often true. For example, the law enforcement source in New York believes that the many types of unique packaging in that city make it easier to identify sources.
- Additional strategies: In addition to the above strategies, some law enforcement and epidemiologic/ethnographic sources report the following innovations: use of mobile delivery and prearranged meetings (Detroit[E]); false floors and other compartments in vehicles, such as cavities beneath car windshields (Houston[L]); and use of women and children in cars to transport drugs (Phoenix[E]).

FIGHTING BACK: HOW SUCCESSFUL HAVE DIFFERENT COMMUNITY TACTICS BEEN OVER THE PAST 10 YEARS?

Over the past 10 years, communities have employed a range of tactics to address the increased complexities of drug markets. Law enforcement and epidemiologic/ethnographic sources were asked whether their communities have tried any of the tactics listed below and, if so, to describe them and rate their success.

Onsite lab tests. Onsite lab tests can be administered in many ways, in many settings and contexts, and on both substances and humans. In cities where such tests are administered, law enforcement and epidemiologic/ethnographic sources generally rate them as highly successful:

- Chicago:[L] After an undercover buy, street tests can verify whether a substance is illegal—helping the evidence hold up for convictions.
- Los Angeles:[E] Onsite crime labs are highly successful.
- Minneapolis/St. Paul:[L] Field testing helps in prosecution.
- Tampa/St. Petersburg:[E] When a needle is found, it can be tested immediately for methamphetamine, enabling quick identification and rapid response.
- San Diego[L] and Washington, DC:[L] Field testing has been highly successful for more than 18 and 30 years, respectively.
- Houston:[L] Field kits used for seizures are only moderately successful because they sometimes test positive for the wrong drug.
- Miami:[E] At DUI stops, when a driver's alcohol level is low, the driver is then tested for illegal drugs onsite. Such testing aids in convictions because it combines experts' observations with actual urine testing.
- Pittsburgh:[E] Parents now use store-bought drug tests for their children.
- Sacramento: Within the past year, the children's protective services program, in conjunction with drug courts, have started administering onsite breathalizers and urine screens to parents when their children are removed from their care.[E] Presumptive field tests help identify the drugs present.[L]

Not all cities use onsite drug testing kits. In New York,[L] for example, such kits don't hold up in court, so samples are always sent to outside laboratories. Similarly, drug samples in Pittsburgh are sent to regional labs.

Task forces. Task forces of varying compositions and focuses are reported as a key innovation in all 25 P*ulse Check* sites. Law enforcement and epidemiologic/ethnographic sources generally give them high success ratings. Below are just a few examples:

- Dallas:[L] Because of budgetary restraints, the DEA relies heavily on task forces with State and local counterparts.
- Denver:[L] The formation of larger task forces has increased the ability to investigate large criminal drug operations.
- Los Angeles:[E] The many small departments have small budgets, so getting involved in a task force stretches each dollar.
- Miami:[E] The High Intensity Drug Trafficking Area (HIDTA) has created task forces for heroin and other drugs, and the State has task forces on club drugs and on prescription abuse. All have been highly successful.
- Minneapolis/St. Paul: Multidisciplinary law enforcement task forces enable pooling of resources and funding, so even small towns can go after bigger dealers. Such task forces are essential as drug sales move out of central city areas.[E] The county sheriff's office and the Minneapolis Police Department work together, so they double their human resources for large cases, such as wiretaps.[L]

- New York:[L] The city has an unprecedented level of task force cooperation compared with the rest of the country, with at least 15 task forces between the police and the DEA or HIDTA. Also, Mobile Enforcement Teams (MET) of special agents go to communities for a few months at a time to address specific problems as needed.
- Philadelphia:[L] The DEA task force program has included different groups whose combined expertise has made a difference.
- St. Louis:[E] Several methamphetamine task forces have been established statewide, mostly through law enforcement agencies, to address clandestine labs, precursor chemicals, and policy regarding ephedrine and cough medicine sales.
- San Diego: The Meth Strike Force, ongoing since March 1996, has led to additional efforts, such as the Meth Hotline (for reporting suspected cooks, turning in dealers, and obtaining help for users) and the Drug Endangered Children program (for dealing with children of methamphetamine dealers and manufacturers).[E] The San Diego Narcotics Task Force, one of the first in the Nation, includes representatives from every police agency in the county, under the DEA umbrella, plus occasional participation by various other agencies such as the border patrol. The Violent Gang Task Force draws representatives from Federal, State, and local entities toward a common goal.
- Tampa/St. Petersburg:[E] A Meth Squad has been introduced and has successfully seized many labs in a nearby rural county that serves as the source for Tampa's methamphetamine supply.
- Washington, DC:[L] A newly formed homicide-narcotics task force has already shown signs of success.

Drug courts. The majority of *Pulse Check* sites have some sort of drug court program, and sources in those areas generally consider them highly effective. Below are several examples.

- Chicago: Nonviolent offenders are given the alternative of drug school or drug counseling instead of incarceration. Data show a drop in recidivism over a year for program completers.[E] State's attorneys and judges are becoming more attuned to the concept and are beginning to understand it a little better.[L]
- Miami:[E] The judicial monitoring program's first phase was for nonviolent offenders without a previous record. Now it includes people with prior records as well as a juvenile drug court, so it also captures the chronic, more acute addictive population and the newer users.
- Boston:[E] Drug courts are effective for middle-class people with low levels of dependency, more solid support systems, education, and chances of employment. But this source believes they don't work for hard-core central city addicts, who have a different relationship with legal authorities.
- Sacramento:[E] The program includes an adult court, a dependency drug court, and a Proposition 36 drug court. It is also planning a juvenile drug court, with a team in place while awaiting funding.
- San Diego:[E] Six courts are in operation: one juvenile, one dependency, and four adult courts. Additional funds are sought to further expand.
- San Francisco:[E] With increased availability of treatment, drug court is now obligatory, rather than voluntary as in the past.
- St. Louis:[E] Missouri is third in the country in the number of drug courts.
- Seattle:[L] Drug courts are proliferating. They are reducing drug-related incarceration and recidivism.

Crack house (nuisance abatement) laws. Law enforcement and epidemiologic/ethnographic sources range widely in their assessment of such laws' efficacy—from very poor to fairly high ratings, with the majority somewhere in between. Some examples follow:

- Miami:[E] Since the Miami Coalition Crack House Demolition program began in 1989, more than 600 crack houses have been knocked down. More demolitions occurred during the early phases; later, more landlords began correcting the problem.
- San Francisco:[L] Large crack sweeps have been conducted with combined local, State, and Federal efforts, including HIDTA funding, the National Guard, and equipment such as radios and pole cameras.
- Dallas:[E] When crack houses are bought and then bulldozed, people just move to other locations.
- Detroit:[L] In some cases, these laws have been used on rave sites.
- Minneapolis/St. Paul:[E] These laws have not been effective because crack houses are mobile and transitory.
- Philadelphia:[E] The Clean and Seal Operation more than 10 years ago boarded up many crack houses. But many have since been broken into and reverted to places of drug use ("abandominiums").

Precursor laws. These laws are generally rated as moderately successful in cities where they are enacted.

- Seattle:[E] Declines in meth labs may be due to precursor laws and enforcement.

- Sacramento:[L] Supplies of iodine, red phosphorous, and hydriotic acid are now controlled. Also, an HIDTA officer is assigned to go to supply houses, feed stores, and home improvement stores to educate workers, provide threshold limits on volume sales, and give them a phone number for calling in tips on who is buying and what is bought.
- Los Angeles:[E] New legislation includes a civil fine for companies who break laws (as opposed to criminal fines), increased penalties for small clandestine labs, and laws addressing child abuse and neglect by methamphetamine manufacturers.
- San Diego: City and county ordinances have led to training for retail workers in limiting ephedrine sales to six retail-sized packages.[E] The precursor laws of the early 1990s made it difficult to acquire ephedrine, red phosphorous, and hydriotic acid, with several results: local "cookers" who used to buy chemicals from chemical companies started extracting themselves, thus labs became smaller; many labs spread out into rural areas across the country; and Mexican manufacturers started coming into the area.[L]
- St. Louis:[E] Ephedrine sales and availability of ephedrine-based products have declined because retail workers are learning to flag people who buy excessive amounts.
- Minneapolis/St. Paul:[E] Minnesota was one of the first States with laws concerning anhydrous ammonia.
- Dallas:[L] Texas recently enacted some laws making it harder to obtain some of the chemicals essential to making methamphetamine. Traffickers, however, are finding other types of chemicals. For example, they steal anhydrous ammonia from rural farms.
- Detroit:[L,E] Michigan changed its laws a few years ago to control ephedrine and pseudoephedrine above certain quantities. However, enforcement has been difficult. Pseudoephedrine flows from Canada by the truckload, making Detroit a transshipment point for the superlabs in the West.

Prescription drug monitoring. Efforts to monitor prescription drug diversion have met with moderate to great success in many cities, according to law enforcement and epidemiologic/ethnographic sources:

- Boston:[E] Following a barrage of pharmacy robberies a few years ago, mostly involving OxyContin®, pharmacists have become more vigilant. It is harder to fill prescriptions for Schedule II and III drugs than it was 2 or 3 years ago.
- Chicago:[E] Illinois has been a triplicate prescription State for more than 10 years.
- Detroit: Michigan's switch to triplicate prescription pads a few years ago has increased accountability. Diversion occurs less frequently than in many other States.[L] The triplicate program is about to be replaced with a high-tech electronic system that will expand to all drug schedules. Resources will be needed to implement the system.[E]
- Houston:[L] Diversion investigators inspect pharmacies, check forged prescriptions, and perform many other monitoring activities. An example is a recent cutting-edge investigation involving an Internet pharmacy case in San Antonio.
- Los Angeles:[E] While there is no triplicate prescription program, pharmacists can call a hotline monitored by a DEA tactical diversion team.
- New York:[L] A diversion unit targets diversion of prescription drugs from hospitals.
- Pittsburgh:[E] The Department of Welfare is monitoring diverted OxyContin[E] for medical plans and has made doctors reexamine their prescribing practices.
- St. Louis:[E] The "Scam of the Month" newsletter, no longer in publication, was highly effective.
- Seattle:[E] OxyContin® diversion has leveled off since its sales have been monitored by the State.

Sentencing changes. Sources in Philadelphia[E] and Chicago[L] believe sentencing reductions involving diversion to treatment have been particularly effective in their communities. Sources vary more in assessing the impact of increased sentences.

- Philadelphia:[E] The Forensic Intensive Recovery (FIR) program, started 8 or 9 years ago in an effort to reduce prison overcrowding, has led the way for forced treatment programs across the country. Low-level criminals are evaluated after serving half of their sentence, and then they are conditionally released to treatment (sometimes under electronic monitoring).
- Seattle:[L,E] A new State initiative will reduce sentences for some minor drug offenses (except those involving methamphetamine) to allow diversion into treatment courts.
- Chicago: Penalties have become more severe: thresholds for possession are lower, and sentences are longer. One source believes this measure has been highly successful[L], while the other believes it has not.[E]
- St. Louis:[E] Stiffer penalties for possession of precursors and for methamphetamine manufacture and distribution have been moderately successful.

Drug-free zone laws. The majority of the *Pulse Check* sites have protected zones, often around schools and recreational facilities, where anyone arrested for drug possession or sales is sentenced more severely. Overall, law enforcement and epidemiologic/ethnographic sources consider this type of measure to be moderately effective, but their opinions range widely, as in the following examples:

- Sacramento:[L] The Safe Schools program, together with the School Resources Officers program, hires off-duty uniformed police to post signs, educate in schools, and help enforce the drug-free zone laws.
- Chicago:[E] Dealers do observe the drug-free zone laws.
- Houston: Neighborhoods are taking back their areas through vigils, neighborhood watch groups, evening marches, media attention, and exposing crack houses to media. But they are just pushing drug activity back and forth between neighboring areas. When they ease their efforts, the problem returns.[E] Drug-free zone laws are more useful as a tool for prosecutors than as a deterrent.[L]
- Dallas:[E] Youth are still getting caught selling drugs in schools.
- Washington, DC:[L] It is not unusual to see someone selling drugs while standing beneath a drug-free-zone sign.

Drug user recognition education (DRE) for law enforcement. About half of the *Pulse Check* sites, including the following, train some law enforcement personnel to recognize drug users, with effective outcomes.

- Denver:[L] State DRE traffic enforcement has allowed law enforcement to identify and prosecute those driving under the influence of illegal drugs.
- Sacramento:[L] The Safe Schools program and the School Resources Officers program (described above) include a DRE component. All in-house narcotic teams are DRE certified. All patrol officers are offered voluntary training, but it is not mandated.
- Detroit:[E] DRE training is particularly effective for State police patrol officers who work at road stops.
- San Diego:[E] DRE training for law enforcement has become an outgrowth of the Meth Strike Force and its partners. Training is also available for educators, parents, and other interested parties.

Additional tactics. In addition to the above measures, some law enforcement and epidemiologic/ethnographic sources describe some unique tactics tried by their communities over the past 10 years, as in the following examples:

- Criminal drug conspiracy operations for street corner cases (Chicago[L]): This 3-month tactic uses covert investigative tools, such as wiretapping and videotaping, to identify every person involved in a street corner operation. Each person is subsequently charged with the total weight of all the drugs recovered, so each person gets the same charge.
- Crack house tours (Minneapolis/St. Paul[E]): These walking tours of neighborhoods are intended to humiliate people seen at crack houses.
- Local summit activities (San Diego[E]): Annual substance abuse summits, involving schools, the sports community, the media, and adolescents, have evolved from 1-or 2-day conferences to year-round outreach and prevention activities, including monthly meetings. This year's focus has been on substance abuse and sports, with local sports figures talking to the adolescents. Involving youth in planning activities has been a particularly effective strategy.

Suggested innovations. Several sources recommend a variety of tactics that would enhance their specific communities' efforts in meeting unique challenges.

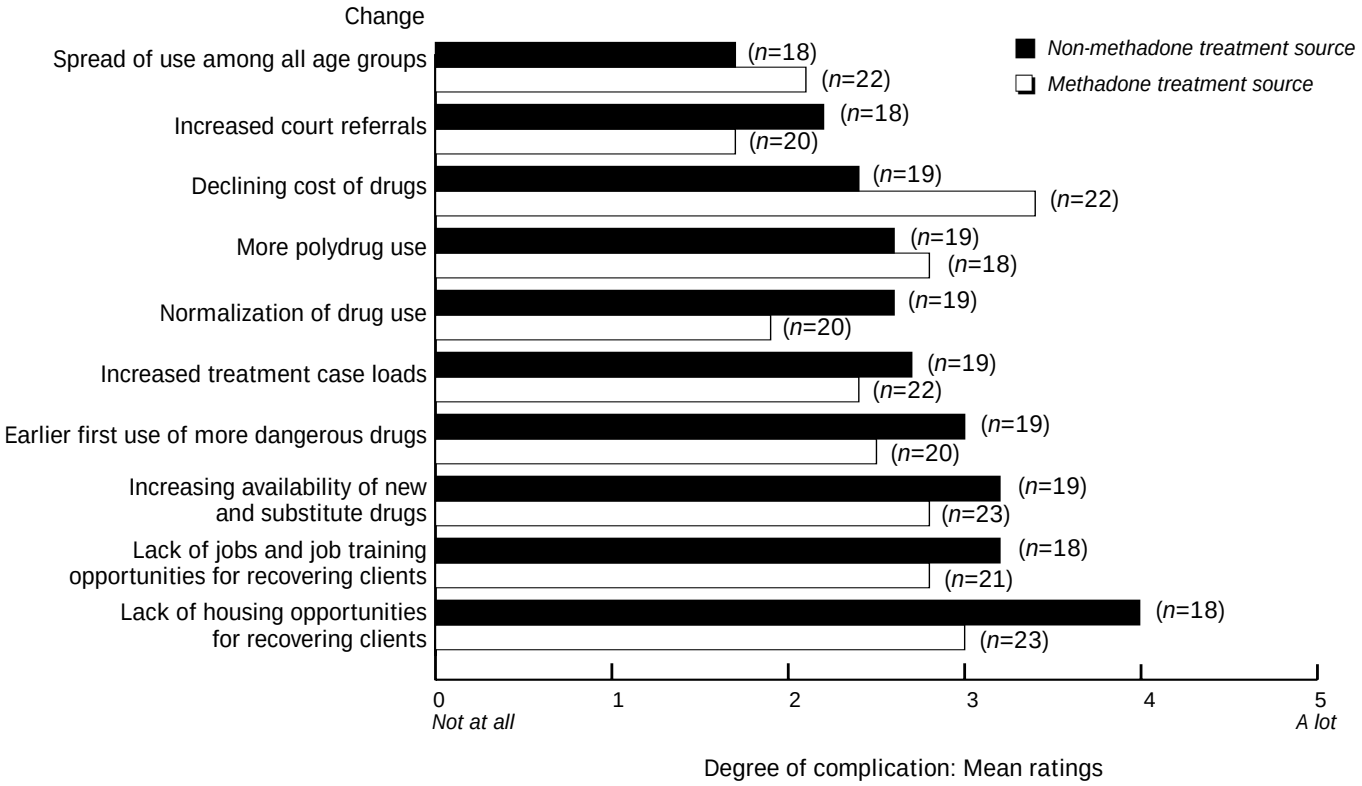
- Atlanta:[L] Enhance communication between local, Federal, and regional task forces.
- Detroit:[E] Develop a monitoring program to address the proliferation of diverted or misprescribed methadone from pain clinics.
- Houston:[E] Develop a system for tracking and monitoring gang activity, and implement a graffiti abatement program. These suggestions are in response to recent gang activity, presumably drug related, which has included a rash of car break-ins, car thefts, and graffiti incidents.
- Miami:[E] Expand and enhance the drug testing program at DUI (driving under the influence) stops, both for research purposes and to get convictions, to test for other drugs even when alcohol levels are high.
- Miami:[E] Rather than tear down crack houses, confiscate them from owners and then rent them cheaply to treatment programs that would rebuild them.
- Miami:[E] Schedule sildenafil citrate (Viagra®).
- Miami:[L] Expand scheduling of checkpoints and roadblocks to meet the challenge posed by clubs that are open 24 hours a day.
- Miami[L] and Minneapolis/St. Paul[L]: Send only users—not dealers—to drug court.

- Minneapolis/St. Paul:[E] Develop enhanced cross-pharmacy, cross-State tracking systems.
- Minneapolis/St. Paul:[E] Encourage retail sellers to voluntarily limit sales of pseudoephedrine and other ephedrine products.
- Minneapolis/St. Paul:[L] Add resources to follow up after the forgery unit forwards cases of prescription fraud.
- Los Angeles:[E] Get out the message about the neurotoxicity of ecstasy.
- St. Louis:[E] Add training to pharmacy school curricula on subjects such as prescription abuse, scams, and different diversion techniques.
- Sacramento:[L] Develop more community outreach programs.
- San Diego:[E] Expand the Meth Strike Force to address other drugs.
- Tampa/St. Petersburg:[E] Form an epidemiologic network, similar to those in other areas, to collect specific data, disseminate it, alert the community to emerging problems, and allow for rapid response.

THE NATURE OF DRUG USERS: CHANGES OVER THE PAST 10 YEARS

- *Overall, non-methadone and methadone treatment sources agree that their communities' drug abuse problems over the past 10 years have been particularly complicated by the lack of housing opportunities for recovering clients.*
- *Other complications frequently mentioned by both types of treatment sources include a lack of jobs and job training opportunities for recovering clients and an increasing availability of new and substitute drugs.*
- *Methadone treatment sources also believe that the declining cost of drugs has contributed to the drug problems in their communities.*

Changes in the nature of users and the market: To what degree have they made the drug abuse problem more complex over the past 10 years? (Mean of 0–5 ratings)



Source: Mean of ratings given by non-methadone and methadone treatment respondents

The comments below describe some of the specific changes that have complicated—or, in some cases, simplified—the problem over the past 10 years.

Increased court referrals. Many treatment sources agree that court referrals have increased, but most of them also agree that this increase has not complicated the treatment situation. Several believe this change has helped in their efforts to treat people, as in the following examples.

- Houston:[N] Many adolescents, pregnant women, and other special needs populations are court referred.
- Minneapolis/St. Paul:[M] Clients in a focus group convened for *Pulse Check* stated that court referral to treatment helped get them on track and gave them a push to "get cleaned up."

Declining cost of drugs. Drug prices in St. Louis have not declined over the past 10 years, and in Atlanta, heroin price and purity have actually increased. Declines, however, are reported by treatment sources in several cities. Methadone treatment sources, in particular, believe that the declining cost of drugs has played a major role in their communities' drug abuse problem.

- Baltimore:[N,M] Crack and heroin have become cheaper than ever.
- Boston:[M] Heroin cost has declined from $20 per bag 10 years ago to $1 per bag now—less expensive than opiate pills.
- Chicago: Cocaine prices have dropped to $2 per rock.[N] Heroin prices have declined, so more people are using it, and they are using more of it.[M]
- Cincinnati:[M] Heroin has become cheaper and more available.
- Detroit:[M] The more a dealer can buy and cut, the lower the cost, and the more he or she can sell—and the more a user can buy.
- Houston: A "starter rock" of crack has declined from $10 a few years ago to $2.[N] With cheaper and purer heroin coming from South America, the cost of supporting a habit has declined from $100 per day to $20 per day.[M]
- Minneapolis/St. Paul:[M] Heroin prices have declined from $5 to $1 per milligram.
- New York:[M] It has become more cost effective to snort, rather than inject, heroin because of the increased purity per unit.
- Philadelphia:[N,M] Heroin prices have declined steadily over the past 10 years, while purity has increased.
- Pittsburgh:[N] Heroin costs have declined.
- Sacramento:[M] Heroin, crack, and methamphetamine prices have dropped dramatically.
- San Francisco: Heroin has declined both in cost and purity.[M] Designer drug prices have become low.[N]

More polydrug use. Treatment sources generally believe that polydrug use has only moderately complicated the drug abuse problem. In several cities, such as Boston,[M] Pittsburgh,[N] and San Francisco,[N] such use is a significant problem and has been stable over the past decade. It has, however, increased in some cities.

- Atlanta: Heroin users are increasingly mixing their heroin with marijuana, cocaine, and benzodiazepines.[M] Cocaine, marijuana, and crack are more commonly used in combination (by about one-third of clients) than in the past.[N]
- Chicago:[N] Heroin and cocaine combinations have increased.
- Cleveland:[M] Heroin is increasingly combined with crack or powder cocaine.
- Houston:[M] Alprazolam (Xanax®) is increasingly used by methadone clients.
- Minneapolis/St. Paul: Polydrug use has increased, but it hasn't changed anything. According to focus group members, "you can't 'blow' (inject heroin) without a 'mo' (powder cocaine)," and a high dose of methadone is frequently taken with crack "on the side."[M] Polydrug use makes it hard to determine what clients are using.[N]
- San Francisco:[M] Older clients (in their fifties) are more likely to be heroin-only users, but younger clients are more likely to use "speed," opiates, and benzodiazepines.

Earlier first use of more dangerous drugs. Age of first use has gone up in San Diego[N] (from 11 to 13). The reverse seems to be occurring, however, in several other sites:

- Baltimore,[N] Philadelphia[M]: These treatment programs are seeing increasing numbers of younger users.
- Boston:[M] A growing number of people under 18 are seeking methadone services and being turned away from programs, which are not supposed to serve them.
- Chicago:[M] None of the clients in an adolescent treatment program were heroin users 10 years ago. Now 30 percent of the adolescent clients are heroin users.
- Cincinnati:[M] The program has been seeing younger heroin abusers over the past 5 years.

- Dallas:[N] Age of onset is dropping annually. Marijuana use is now starting at age 10–12.
- Houston: Because purity has increased, youth snort heroin or squirt it up their noses ("shebanging").[M] One program is getting 12-year-old referrals who have started with cocaine—something not seen 10 years ago.[N]
- New York:[M] Younger people are using heroin and inhalants.
- Pittsburgh:[N] Heroin use is beginning at younger ages.

Increasing availability of new and substitute drugs. The drugs listed below have become newly or increasingly available in the various cities over the past 10 years, sometimes replacing other drugs. Treatment providers generally believe these new drugs have moderately complicated the drug abuse situation.

- Atlanta:[M] Diverted OxyContin®
- Baltimore:[N] Crack and diverted OxyContin®
- Boston:[M] Diverted OxyContin®
- Chicago:[N] Methamphetamine and ecstasy
- Cincinnati[M] and Tampa/St. Petersburg:[M] Diverted OxyContin® and, several years ago, MS Contin® (morphine sulfate)
- Cleveland: Heroin, crack, ice, and crystal methamphetamine
- Dallas:[N] Designer drugs
- Denver:[M] Club drugs and methamphetamine[N]; some fentanyl
- Houston: Prescription drugs, especially oxycodone and hydrocodone (Vicodin®)
- Los Angeles: Diverted OxyContin® and clonazepam (Klonopin®)
- Minneapolis/St. Paul: Smokable heroin among young adults;[N,M] methamphetamine, ecstasy and gamma hydroxybutyrate (GHB)[N]
- New York:[M] Designer drugs—but localized in neighborhoods and subcultures, not citywide
- Philadelphia: Diverted OxyContin®;[N,M] alprazolam, ecstasy[M]
- Phoenix:[M] Diverted OxyContin®
- Pittsburgh:[N] Ecstasy and diverted OxyContin®
- St. Louis:[N] Rise in crack, heroin, and more recently, the rise in methamphetamine
- Sacramento:[N] Ecstasy and GHB
- San Francisco: Ecstasy and GHB;[N] diverted OxyContin® and other prescription drugs[M]

Lack of jobs and job training opportunities for recovering clients. Job opportunities have actually increased in New York[M], particularly since 1996 legislation increased the focus on work as part of recovery. In some other cities, however, treatment sources paint a different picture.

- Cleveland:[M] Potential employers can't legally discriminate because of past drug abuse, but they still do not hire recovering clients.
- Philadelphia:[M] Methadone patients are not allowed in job training programs.
- St. Louis:[N] It is easy to find low-skill, low-paying jobs, but it is difficult for clients to pull themselves up after years of drug addiction and find high-skill sustainable jobs.
- Sacramento: Prospective employers are increasingly using drug testing. One-third of recovering clients are unemployed.[N] Training programs are in place, but the job market in general is crumbling.[M]

Lack of housing opportunities for recovering clients. Recovery houses in Philadelphia provide sufficient housing opportunities. Elsewhere, treatment sources view this growing need as one of the more serious complications in the drug abuse situation over the past 10 years.

- Chicago: Most clients are unable to find housing, so they often move in with dealers or users.[N] They have no safe place to live after treatment, so they go back to the same neighborhoods, with the same family members, and the same friends—all of whom use drugs.[M]
- Cleveland:[M] Opiate addicts have few to no housing opportunities because people don't trust them.
- Dallas:[N] Homelessness "has created terrible problems."
- Houston:[N] Users are becoming homeless more quickly than in the past—often within 6 months of the onset of their cocaine or heroin use. Increasing their length of stay in treatment would help because they have no stable environment to return to.
- New York:[M] Lack of housing has been an ongoing "rock-bottom" problem, so it has not worsened over the past 10 years.
- St. Louis: Treatment staff say it is increasingly difficult to find places for clients to go because more people are in need of housing but fewer places are available.
- Sacramento:[M] The problem of homeless clients is severe and worsening.
- San Diego:[N] Most clients don't qualify for HUD funds, so they lack sober living environments.

- San Francisco: Clients tend to live in single residency hotel rooms in the worst parts of town where drug use is high.[N] The number of recovery home slots is limited, especially for those on methadone.[M]

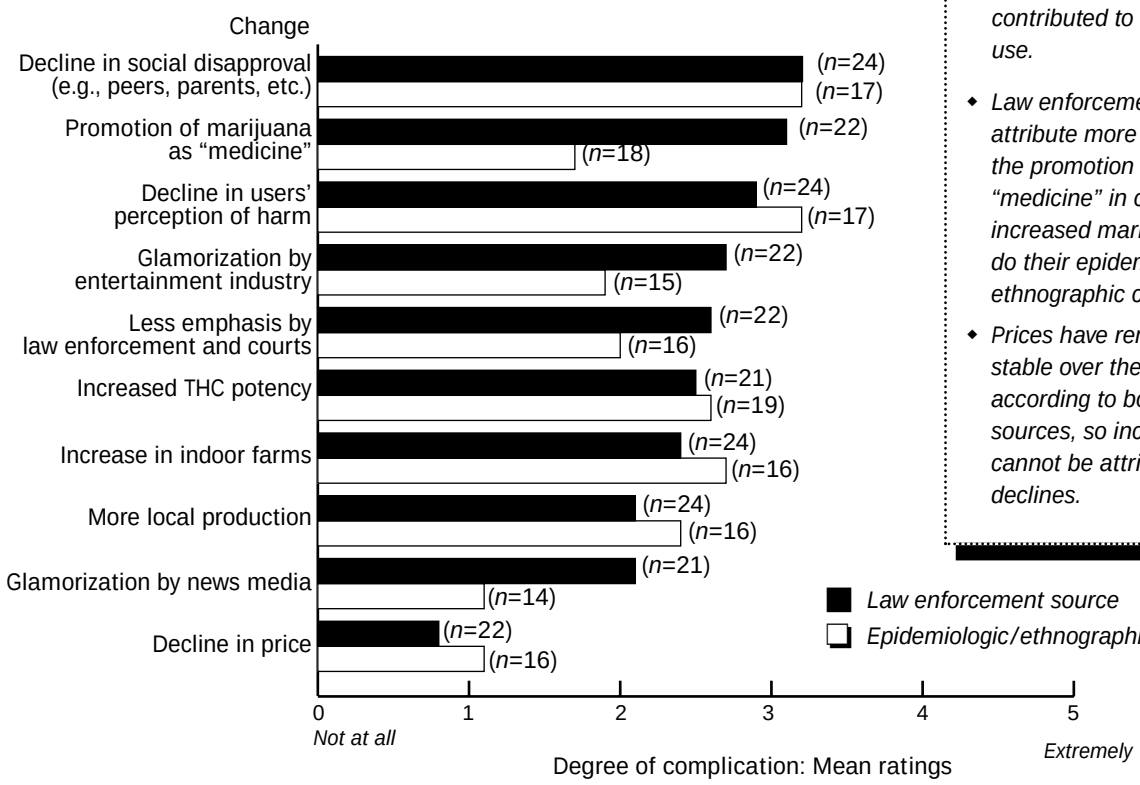
Additional changes. In discussing 10-year changes in the drug market and the nature of drug users, some treatment sources mentioned additional changes unique to their cities.

- Multigenerational users: In Baltimore,[M] clients frequently come from families with long histories of drug use. The *Pulse Check* source is personally treating children of former patients.
- Drug use during pregnancy: In Cleveland,[M] women have increasingly used heroin, crack, and powder cocaine during pregnancy.
- Co-occurring disorders: Increases in psychiatric disorders have complicated treatment in many cities, such as Atlanta,[M] Dallas,[N,M] and St. Louis.[N] Similarly, the increase in hepatitis C among clients has complicated treatment, as mentioned in Denver and New York.[M] Increasing medical and dental problems, sometimes associated with an aging addicted population, are mentioned in several cities, including Baltimore, San Diego, and San Francisco.[N]
- Funding declines: Public funds in Pittsburgh[N] have declined for treating those with no insurance, reducing treatment opportunities for many. In Dallas,[N] treatment resources have declined following a 10-percent cut in public funding.

WIDESPREAD MARIJUANA AVAILABILITY AND USE: CONTRIBUTING CHANGES OVER THE PAST 10 YEARS

- *Law enforcement and epidemiologic/ethnographic sources tend to agree that the decline in social disapproval of marijuana (by peers, parents, etc.) has had an impact on its widespread use and availability over the past 10 years.*

Marijuana: To what extent have the following changes contributed to its widespread availability and use over the past 10 years? (Mean of 0–5 ratings)



- *Both types of sources also generally believe that the decline in users' perception of marijuana's harmfulness has contributed to its increased use.*
- *Law enforcement sources attribute more importance to the promotion of marijuana as "medicine" in contributing to increased marijuana use than do their epidemiologic/ethnographic counterparts.*
- *Prices have remained generally stable over the past 10 years, according to both types of sources, so increasing use cannot be attributed to price declines.*

Source: Mean of ratings given by law enforcement and epidemiologic/ethnographic respondents

The comments below reflect the beliefs of some *Pulse Check* law enforcement and epidemiologic/ethnographic sources:

Decline in social disapproval. Law enforcement and epidemiologic/ethnographic sources tend to agree that the decline in social disapproval of marijuana (by peers, parents, etc.) has had an impact on its widespread use and availability over the past 10 years:

- Baltimore:[L] Peer pressure among juveniles has played an important role.
- Houston:[E] People who smoke marijuana think of it as an herb that doesn't affect their driving. They use it recreationally and believe it is safer than alcohol.
- New York:[L] We have not been effective in changing people's perceptions.
- Philadelphia:[E] According to a recent youth survey, social approval of marijuana use continues to increase. Many users are children of users from the sixties and seventies generation, who have a more tolerant attitude toward the drug.
- San Francisco:[L] The public is still largely unaware of the negative consequences of marijuana use.

Promotion of marijuana as "medicine." Only a few sources have specific comments regarding this issue:

- New York:[E] The debate about "medical" marijuana has contributed to the notion that it is harmless.
- Sacramento: One source believes Proposition 215 is ambiguous about laying down thresholds for "compassionate use" and that it contains many loopholes.[L] The other source adds that since no prescription is needed, just a recommendation from a doctor, the proposition creates havoc in some situations. For example, in dependency drug courts, some people are reprimanded severely, and then someone comes in with a doctor recommendation. Similarly, providers have problems using a zero tolerance model when someone in the room is "smelling of pot."[E]

Decline in users' perception of harm. One source in St. Louis[L] believes people are becoming more aware of marijuana's harmfulness. Others, however, do not share that opinion:

- Dallas:[L] People feel marijuana is "no big deal." They do not think of it as a gateway drug.
- Minneapolis/St. Paul:[E] In the past, the perception of harm was declining. But for the past 3 years it has been in a holding pattern.
- New York:[L] People don't realize marijuana's potency. They still view it as the same drug of 10 years ago.
- San Diego:[E] The misperception that marijuana is not harmful is not new—it has always been a problem. Youth need continued pressure to say no to marijuana.
- San Francisco:[E] Harm perception has declined since 20 years ago, but it has remained relatively unchanged over the past 10 years.

Glamorization by entertainment industry. Only low to moderate importance is attached to this phenomenon, with a few exceptions as listed below.

- Houston:[E] Not only are more people in the music business using marijuana, they also are including it in their songs, which sends a bad message to youth. Also, more athletes are using marijuana.
- Pittsburgh:[E] The rap, "hip hop," and MTV cultures have many references to marijuana.
- San Francisco:[L] The entertainment industry in California has become desensitized to marijuana use.

Less emphasis by law enforcement and courts. Sources in some cities, including New York,[L] Seattle,[E] and Tampa/St. Petersburg,[L] believe that emphasis on marijuana has not declined. In Chicago,[E] many offenders are being sent to treatment for marijuana use. Other sources have different opinions:

- Cleveland: One source[E] believes that law enforcement officials feel "marijuana is not really worth the paperwork." The other[L] agrees that penalties are light.
- Dallas:[L] Marijuana is given low priority over other types of drugs.
- Houston:[L] Local prosecutors don't take Federal cases anymore because they were not getting reimbursed.
- Phoenix:[L] Prosecutors don't seem to care about marijuana.
- Sacramento:[L] Because of Proposition 215, the "medical marijuana law," the district attorney opts not to prosecute many marijuana cases. Federal prosecutors sometimes come in instead.
- San Diego:[E] In a recent focus group, users agreed that "everyone turns a blind eye, even though it's everywhere."

Increased potency. In discussing marijuana's increased use and availability over the past 10 years, law enforcement and epidemiologic/ethnographic sources attribute only a moderate amount of importance to the drug's increased potency.

Increase in indoor farms. Several sources report increases in indoor farms. Nevertheless, many find this increase only moderately associated with the widespread marijuana use and availability over the past 10 years.

- Dallas: Marijuana is grown in closets, bedrooms, and bathtubs: "Anywhere you can put a grow light."[E] Indoor growth yields increased THC content and is easier to conceal. It is becoming easier to obtain growing equipment from catalogues, head shops, and other sources.[L]
- Houston:[L] Indoor grows are rare along the border because of the prevalence of Mexican marijuana. But they increase as one goes northward.
- Los Angeles:[E] Indoor production has made marijuana stronger and more difficult to detect. It allows large quantities to be grown in small spaces.
- Minneapolis/St. Paul:[E] The short growing season does not allow for much outside growth.
- New York:[L] Interdiction is more difficult when marijuana is grown indoors. Over the last 3 years, high-quality hydroponic marijuana—much of it indoor grown—has increased.
- Sacramento:[L] Grow houses are increasing in number, and bigger businesses are catering to them with retail merchandise that supports inside growth.
- San Diego:[E] Some increase in indoor farming has led to higher grade, less detectable marijuana.
- Tampa/St. Petersburg:[L] Most marijuana is grown inside.

More local production. The amount of locally produced marijuana has remained stable in some cities, such as Minneapolis/St. Paul[L] and Tampa/St.Petersburg.[L,E] In Detroit, greater amounts do not necessarily reflect an increase, but rather more detection.

- Miami:[L] Competition has lowered the price of local hydroponic marijuana.
- Dallas:[E] With the economy down, many people grow marijuana for income.

Glamorization by news media. Only a few sources have comments on this subject, including the following:

- Los Angeles:[L] Some media are quick to report stories about legalization efforts and use of marijuana for "medicinal" purposes, but they are not as quick in reporting "the other side."
- Minneapolis/St. Paul:[E] The mainstream media perpetuate the public debate regarding the harmfulness of marijuana. For example, articles in teen magazines present the subject as a matter of debate, rather than fact.
- San Francisco:[L] This source believes the media are slanted in reporting marijuana as "medicine."

Decline in price. Price declines do not seem to be a factor in the increased use and availability of marijuana over the past 10 years. Price has remained unchanged in several cities, including Minneapolis/St. Paul,[E] New York,[L] Philadelphia,[E] St. Louis,[L] San Diego,[L] San Francisco,[L] and Seattle. In New York,[E] similarly, prices have not declined, but they vary more in range, so prices at the lower levels allow more youth to get involved. Prices have actually increased in some cities, such as St. Louis (because of a recent shortage) and Chicago.

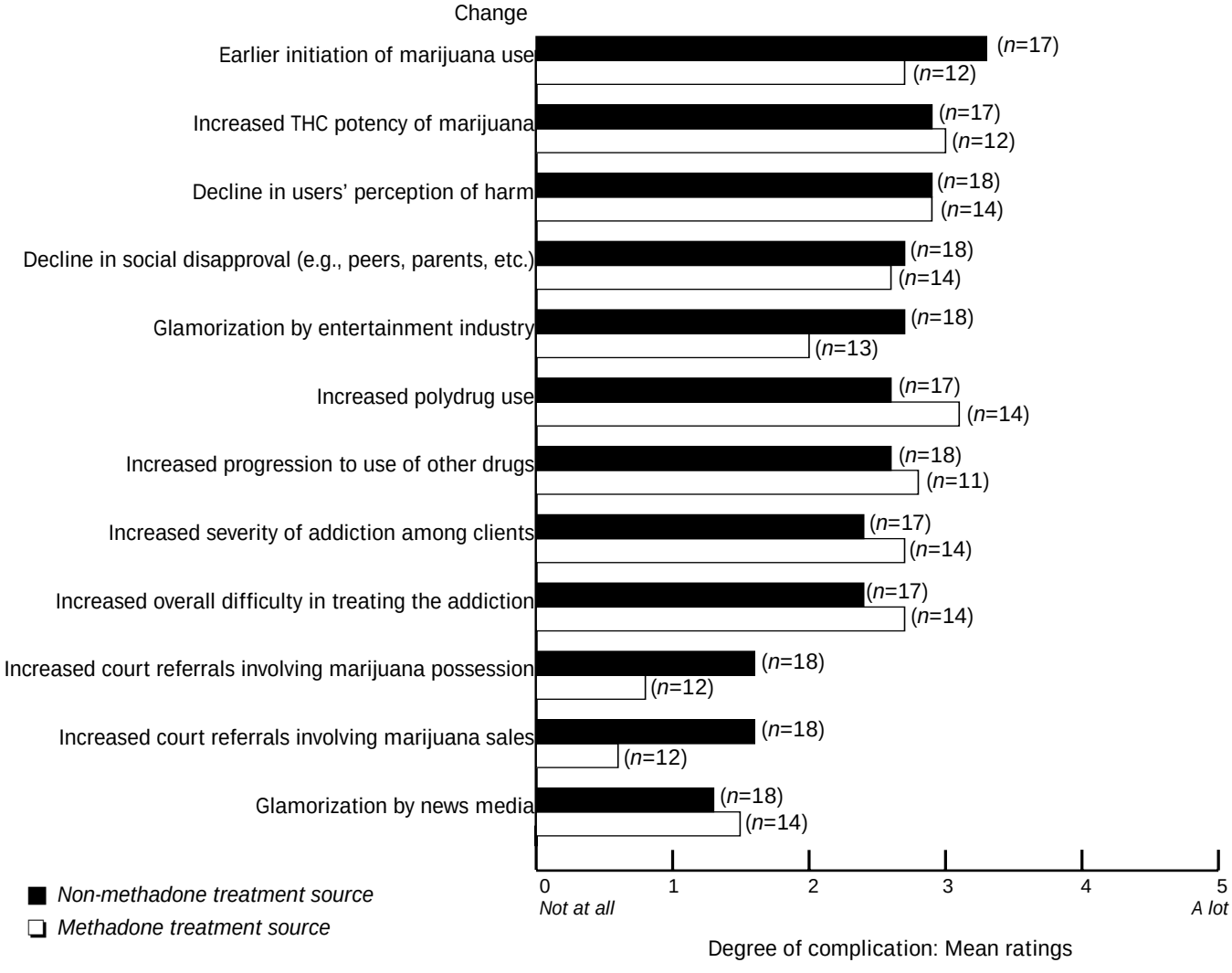
Additional changes. Some sources mention additional changes that have contributed to the widespread use and availability of marijuana over the past 10 years:

- Increased movement of marijuana from Mexico to San Diego[E] and Houston[L]
- Deteriorating family and social relationships (St. Louis[E])
- Easier access to information on marijuana over the Internet, especially among teens (Baltimore[L])
- Promotion of hemp products to youth (Minneapolis/St. Paul[E])

TREATMENT FOR MARIJUANA USERS: THE PAST 10 YEARS

- *In discussing changes that have complicated the treatment of marijuana-using clients over the past 10 years, non-methadone and methadone treatment providers alike tend to place a fairly high degree of importance on earlier initiation of marijuana use, on increased tetrahydrocannabinol (THC) potency, and–like their law enforcement and epidemiologic/ethnographic counterparts–on a decline in users' perception of harm.*
- *Methadone treatment sources also believe that increased polydrug use has played a fairly important role in making treatment more complex.*
- *The news media and increased court referrals appear to have had little complicating effect. Some sources even believe they have had a positive effect.*

To what extent have changes in the following problems complicated the treatment of marijuana-using clients, particularly youth, over the past 10 years? (Mean of 0–5 ratings)



Source: Mean of ratings given by non-methadone and methadone treatment respondents

Earlier initiation of marijuana use. One source, in St. Louis,[M] believes that though many people initiate marijuana use earlier, treatment has not been complicated. Other sources, however, believe earlier initiation to be more problematic. Non-methadone sources, in particular, assign a higher overall rating to this change than to any other change that has complicated treatment over the past decade.

- Boston:[M] Alcohol, cigarettes, and marijuana are among the first substances used by children as young as 9.
- Cleveland:[M] Elementary school children are using marijuana.
- Denver[N] and St. Louis:[N] Clients are getting younger and younger.
- Sacramento:[N] Initiation age ranges from 9 to 13 years.

Increased THC potency. Higher marijuana potency has posed several challenges to treatment.

- Minneapolis/St. Paul:[N] THC content is much higher compared with what it was 20—rather than 10—years ago.
- Philadelphia: Marijuana is two to three times stronger than it was in the 1970s.[N] Clients don't recognize THC withdrawal symptoms, mistakenly believing their methadone is not effective.
- Pittsburgh:[N] Higher THC content has caused an increase in withdrawal symptoms.
- San Francisco:[N] More clients are coming in because it is increasingly difficult to stop using marijuana and because it has more intense side effects.

Decline in users' perception of harm. Many *Pulse Check* treatment sources, like their law enforcement and epidemiologic/ethnographic counterparts, believe this misperception to be a fairly serious problem.

- Chicago:[N] Clients generally believe that marijuana causes no harm and that it may actually have social benefits.
- Cleveland,[M] Minneapolis/St. Paul,[M] and Pittsburgh[N]: Society still isn't convinced about marijuana's harmful effects.
- New York[N] and Philadelphia[M]: The perception of harm has not declined because clients never thought it was harmful.
- San Francisco:[M] Perception of harm is especially low at this clinic.

Decline in social disapproval. Parent and peer attitudes toward marijuana use appear to present a challenge in treating marijuana-using youth.

- Chicago:[N] Peers and parents smoke it, so it's not just a decline in disapproval, but actually an increase in approval.
- Cleveland:[M] Parents of many clients smoke marijuana.
- Pittsburgh:[N] Many parents also used marijuana when they were young, so they don't treat it seriously.
- St. Louis:[N] An inconsistency exists between parental acceptance and institutional disapproval of marijuana use.
- Tampa/St. Petersburg:[N] Parents are not as concerned as they should be.
- Sacramento:[N] In some social scenes, people are looked down upon if they don't use marijuana.

Glamorization by entertainment industry. One particularly recurring theme throughout the treatment sources' comments concerns the harmful effects of rap music.

- Atlanta:[N] The glamorization of marijuana use is more apparent in the music culture and rap subculture than in films and TV.
- Boston:[M] Some TV programs show teenagers in situations where they are obviously (though not explicitly) smoking marijuana.
- Cleveland:[M] The music culture has glamorized marijuana more than the movie industry.
- Chicago:[N] Marijuana has become more fashionable in the community mostly because of the rap culture.
- Houston:[N] Rappers are always rapping about "tokin'" and "smokin.'" Furthermore, stars who use drugs get a lot of publicity.
- Minneapolis/St. Paul:[N] Rap videos, in particular, glamorize marijuana use. For example, one video shows someone smoking a blunt and drinking a Hennessy.
- Philadelphia:[N] Gangster rap videos are a big problem. They glorify a lifestyle involving marijuana. In these videos, "it's in your face," and youth don't have the discernment to evaluate these messages like adults.
- Pittsburgh:[N] Rather than deterring youth from marijuana use, the rap and entertainment industry encourages it.
- St. Louis:[N] The rap and hip-hop genre has contributed to the use, normalization, and glamorization of marijuana.

Increased polydrug use. A few sources name specific combinations:

- Atlanta[N] and Chicago[N]: Marijuana is increasingly used with crack.
- Baltimore:[M] The majority of patients come in cocaine-positive.

- Cleveland:[M] Clients show decreased allegiance to any one drug.
- Pittsburgh:[N] Clients use marijuana simultaneously with heroin, diverted OxyContin®, and ecstasy.

Increased progression to use of other drugs. Treatment sources, overall, attribute a moderate degree of significance to this aspect of the problem.

- Chicago:[M] According to this clinic's biopsychosocial screening, marijuana is now a gateway drug to alcohol, rather than the other way around as in the past.
- New York[M] and Philadelphia[M]: By the time methadone programs see marijuana users, they have already progressed to other drugs.
- Pittsburgh:[N] Many clients progress from marijuana to heroin, diverted OxyContin®, or ecstasy use.
- St. Louis:[N] The earlier people start with one drug, the earlier they usually start with others.
- San Francisco:[N] Newer patterns include more dangerous combinations, including methamphetamine or ecstasy.
- Seattle:[N] Marijuana clients are branching off into use of prescription drugs, such as diverted OxyContin®, and use of methamphetamine. All clients who use crack, methamphetamine, and heroin used marijuana before.

Increased severity of addiction among clients. One source (Cleveland[M]) believes that marijuana use seems to be leveling off. Another (St. Louis[M]) believes that increased severity of addiction applies mostly to drugs other than marijuana. Other treatment sources, however, perceive increases in amount consumed, availability, and potency—all of which lead to increased addiction severity.

- Baltimore:[N] Users gradually increase their intake by progressing from joints to blunts.
- Boston:[M] Continued use of marijuana interferes with the success of methadone treatment.
- Chicago[N] and Pittsburgh[N]: Addiction severity has increased because of increased marijuana availability.
- Houston,[N] Philadelphia,[N] and Pittsburgh[N]: Addiction severity has increased because THC potency has increased.
- St. Louis:[N] The increase in adolescents using marijuana on a daily basis and at a younger age contributes to the addiction severity.

Increased court referrals involving marijuana possession. Comments on this subject are mixed:

- Boston:[M] Drug courts don't generally refer to methadone programs.
- Dallas:[N] Court referrals have increased, but that hasn't complicated treatment.
- Denver[N] and Detroit:[N] Court referrals have remained stable.
- St. Louis:[N] If anything, court referrals may have declined. Laws haven't changed, but more and more youth tell how police stop them, take their marijuana away, and just give them a warning.
- Philadelphia[M] and San Diego:[N] Increased court referrals have had the positive effect of getting people into treatment earlier.

Increased court referrals involving marijuana sales. Only a few treatment sources have comments on this subject.

- Atlanta:[N] Drug distributors are harder to treat because they don't accept that they have a problem and are therefore more resistant to treatment.
- Cleveland:[M] More "heat" is placed on users than on dealers. More pressure on dealers is needed.

Glamorization by news media. Some sources believe the news media have played a positive role, while others disagree.

- Atlanta:[N] The news media give pretty accurate information.
- Boston:[M] The news media appear to support medicalization and decriminalization of marijuana.
- Cleveland:[M] Overall, the media has been more responsible in exposing the consequences of marijuana.
- Seattle:[N] ONDCP's anti-drug ads are having an impact on youth and adults.

More than 60 percent (46 of 75) of the Pulse Check *sources who responded to this question believe that the attacks have had no continuing effects on the drug abuse situation. The remaining responses deal with several recurring themes:*

- *Supplies of some drugs have declined in some cities–for example, cocaine in Atlanta and Houston and unadulterated ecstasy in Miami; supplies of other drugs have increased–for example, methamphetamine in Atlanta and "wets" (marijuana plus embalming fluid) and hashish in Houston.*
- *Some trafficking routes have shifted, usually to avoid flying directly to the East Coast.*
- *Vehicular and other means of transport have replaced air shipment in some cities.*
- *Many sources perceive a shift in law enforcement priorities from drugs to homeland security.*
- *Many drug users in treatment, especially those with existing mental issues, continue to experience elevated levels of anxiety, depression, and post-traumatic stress disorder (PTSD). Some related prescription drug abuse is reported.*

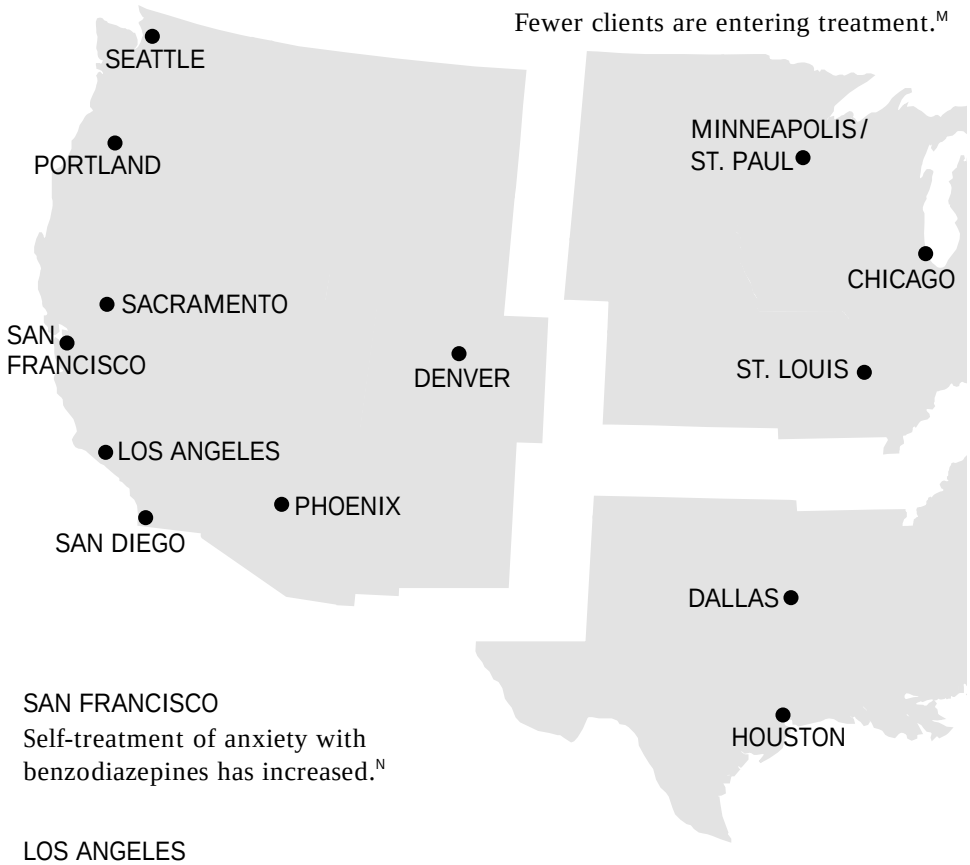
SEPTEMBER 11 FOLLOWUP:
HAVE THE ATTACKS AND THEIR AFTERMATH HAD ON THE

SEATTLE
Border seizures of marijuana from Canada have increased.[E]

PORTLAND, OR
On the West Coast, the outflow of drug proceeds (cash and goods) to Mexico has increased because law enforcement is concentrating more on what is coming into the United States.[L]

MINNEAPOLIS/ST. PAUL
Some of the best narcotics officers have been reassigned to homeland security.[E] Before the war in Iraq, methadone patients hoarded methadone because they were scared, worried about the war, depressed, or felt that "I'm going to die anyway, I might as well have a good time."[M]

DENVER
Fewer clients are entering treatment.[M]



SAN FRANCISCO
Self-treatment of anxiety with benzodiazepines has increased.[N]

LOS ANGELES
Law enforcement resources, reallocated to security/terrorist duty, are beginning to come back to narcotics duty. But some still have not returned. And those who are returning are finding more drugs than ever because dealers have been acting without fear of arrest.[L]

SAN DIEGO
Trafficking at airports has been downscaled because of increased security measures.[L]

PHOENIX
Anxiety and depression might have become more severe among drug users.

DALLAS
Some trafficking organizations may be transiting through Dallas to the East Coast because security measures are tighter on the East Coast.[L] Treatment enrollment is slightly elevated.[M]

SACRAMENTO
The law enforcement technical support system has shifted priorities. For example, wiretaps are used more for detecting terrorism activities than for drug activities.[L] When people with a drug problem get frightened, they use more drugs—as was the case before the Iraq war.[M] Referrals through the dual diagnosis program (mental health) have increased.[N]

WHAT CONTINUING EFFECTS, IF ANY, DRUG ABUSE PROBLEM (EITHER FOR BETTER OR WORSE)?

CHICAGO
Depression and anxiety have increased among clients and have stayed at that elevated level.[N]

ST. LOUIS
Traffickers are using motor vehicles rather than carrying drugs on planes via body strapping, body packing, or in luggage.[L]

HOUSTON
Since September 11, crack availability has declined, "wets" availability has increased, and marijuana price has increased. Hashish, whose production and export had been suppressed by the Taliban in Afghanistan, has now increased in the United States. More alcohol and marijuana use among the middle class is attributed to anxiety, an impending feeling of doom, and escapism.[E]

DETROIT
Pseudoephedrine trafficking is linked to terrorist groups who use it to fund their activities. The law enforcement focus on the area has increased because of its large Middle Eastern population.[L] Border security has increased, with more awareness of traffic volume.[E,N] Users know their supplies can get disrupted, so they are more willing to use multiple drugs, switch to whatever drugs are available, or make their own drugs.[E]

CLEVELAND
Increases among clients are noted in opiate addiction, alcohol abuse, and antidepressant use.[M]

CINCINNATI
No continuing effects are reported.

ATLANTA
The powder and crack cocaine supplies have declined; the methamphetamine supply has increased.[L] Mental health symptoms increased somewhat, as they did again after the war in Iraq.[N]

TAMPA/ST. PETERSBURG
Treatment staff perceive a decrease in funding.[N]

MIAMI
Increasing prescription drug abuse, while not entirely linked to September 11, has coincided with trafficking crackdowns. More adulterated products are being sold as ecstasy since the Benelux supply route was cut off.[E]

BOSTON
No continuing effects are reported.

NEW YORK
Southwest Asian heroin prices have been dropping, purity has been rising, and more groups have been getting involved in trafficking the drug. Traffickers afraid to fly directly to New York have been going to other cities and using rail, bus, car, and other transportation means. Some traffickers have broken shipments down, making them smaller, so interdiction doesn't stop all traffic.[L]

PHILADELPHIA
With increasing unemployment, a sense of hopelessness and depression has been increasing. Before the war in Iraq, many adopted a "why bother" attitude, saying "we're going to war anyhow."[M]

BALTIMORE
Suppliers' ability to use airports has been curtailed substantially, but they use other means of transportation. Switching law enforcement efforts to antiterrorism has limited resources for drug abuse efforts.[L]

WASHINGTON, DC
Traffickers still do not ship by plane, but they find other means of transport. Whenever the terror alert is high, law enforcement officers come across more drugs, but as soon as an alert goes down everything goes back to normal.[L]

PITTSBURGH
Many people with PTSD in the recovering population have been vulnerable and have not had a support system available. Economic strain is an added stressor.[E]

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PULSE CHECK

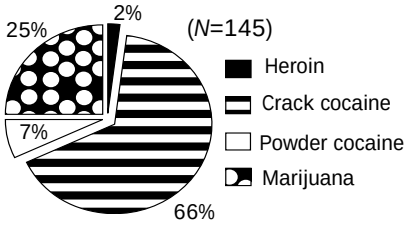
CITY SNAPSHOTS

ATLANTA METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 4,112,198
- Median age: . . . . . 32.9 years
- Race (alone):
  - White 64.2%
  - Black 29.6%
  - American Indian/ Alaska Native 0.7%
  - Asian/Pacific Islander 3.8%
  - Other race 3.6%
  - Two or more races 1.7%
- Hispanic (of any race): . . . 6.5%
- Unemployment rate: 3.5%
- Median household income: $51,948
- Families below poverty level with children <18 years: 11.8%

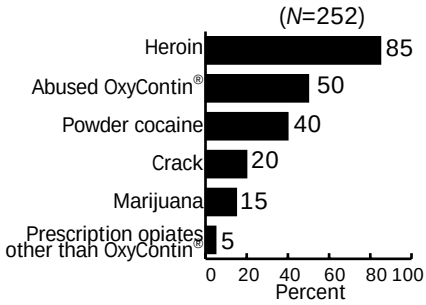
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

What drugs do clients in a methadone program abuse+? (Fall 2002)



+Includes any use, whether as a primary, secondary, or tertiary drug; responses for methamphetamine and ecstasy were "very small."

Source: Methadone treatment respondent

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

Three[L,N,M] of four *Pulse Check* respondents believe the city's overall drug problem is very serious and stable, and one believes it is somewhat serious but somewhat worse.[E]

Respondents report several changes in Atlanta's drug abuse scene:

- South American heroin, the most common form available, became more difficult for undercover officers to buy.[E]
- Tuberculosis cases among methadone clients, although somewhat high in Atlanta compared with other cities, decreased due to increased surveillance and treatment.[N,M]
- Shoplifting in order to obtain goods or cash to be exchanged for cocaine declined over the past 10 years due to increased law enforcement.[N]
- Although hepatitis C diagnoses are increasing, they may be due to increased awareness and testing for the disease.[N]
- In general, heroin use increased; however, the number of new heroin users declined.[E]
- Opiate-related overdoses increased, perhaps because OxyContin® (oxycodone controlled-release) abusers often switch to heroin and then overdose.[M]
- Heroin is often cut with diverted OxyContin® or powder cocaine—both new phenomena.[M]
- OxyContin® abuse among methadone treatment admissions increased slightly, and 50 percent of all methadone admissions now abuse the drug.[M]
- Marijuana use in general increased slightly;[E] however, marijuana use among non-methadone treatment admissions declined.[N]
- All forms of methamphetamine (including ice) are less difficult to buy.[L,E] The increased supply and availability of methamphetamine may be related to the decreased supply of cocaine.[L]
- As reported in several other *Pulse Check* cities, methamphetamine use increased dramatically. Its use increased at nightclubs and raves.[E]
- Locally based sellers of methamphetamine manufactured in small, local labs increased.[E]
- Methylenedioxymethamphetamine (MDMA or ecstasy) has been less difficult to buy as the supply increased.[L,E]
- Ecstasy use increased dramatically, as did the variety of use settings.[E]
- Independent dealers who sell locally pressed ecstasy tablets increased, and prices declined.[E]

Three sources agree that crack is the drug related to the most serious consequences.[L,E,N] The sources differ in their perception of which drug is most commonly abused.

- *Since spring 2002, crack has increased slightly as a primary drug among non-methadone treatment admissions while marijuana has declined slightly.*[N]
- *OxyContin® abuse among methadone treatment clients increased between spring and fall 2002.*[M] *One-fifth of the clients report it as a primary problem, and half of the clients report any use.*[M]

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

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

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

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

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

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

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

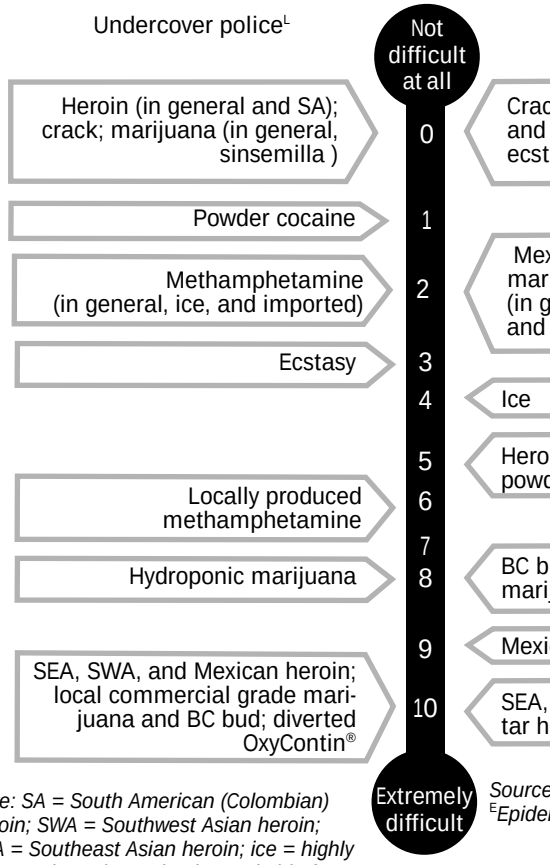
Drug related to the second most serious consequences:
- Methamphetamine[L]
- Heroin[E]
- Marijuana[N]
- Crack[M]

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

New or emerging problems:
- Ecstasy[L]
- Methamphetamine[E]
- OxyContin® abuse continues to increase[M]

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

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



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

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

Some drugs were more difficult to buy between spring and fall 2002:
- *South American heroin*[L]
- *Crack and powder cocaine ("The supply has dwindled substantially since September 11, 2001."*[L]*)*

Two drugs were less difficult to buy since spring 2002:
- *Methamphetamine*[L,E] *(as reported by 10 other* Pulse Check *respondents in 8 other cities)*
- *Ecstasy*[L,E] *(as reported in New York and Pittsburgh)*

The law enforcement source believes that the increased methamphetamine supply may be due to the decreased cocaine supply, and the epidemiologic source notes that within a 6-month period, methamphetamine availability fluctuates rapidly.[E]

HEROIN

Heroin availability declined, but use increased:

- South American heroin, the most common form available in Atlanta, has become more difficult for undercover officers to buy between spring and fall 2002.[E]
- In general, heroin use increased; however, new heroin users declined.[E]

COCAINE

Three sources report crack as the drug relating to the most serious consequences, but most indicators show cocaine use and activity have declined:

- Crack and powder cocaine have become more difficult for undercover officers to buy between spring and fall 2002.[L]
- Crack cocaine use in general has declined since spring 2002;[E] however, crack cocaine non-methadone treatment admissions increased slightly.[N]
- Crack cocaine sales on college campuses increased between spring and fall 2002.[L]

MARIJUANA

Marijuana use in general increased slightly.[E] However, marijuana use among non-methadone treatment admissions declined.[N]

METHAMPHETAMINE

Nearly all reports point to increasing use and activity of the drug:

- All forms of methamphetamine (including ice) are less difficult to buy.[L,E] The increased supply and availability of methamphetamine may be related to the decreased supply of cocaine.[L]
- Methamphetamine use increased dramatically. Its use is more common at nightclubs and raves than it was in spring 2002.[E]
- New methamphetamine users increased. They often use the drug by heating it and, using a plastic tube, inhaling the vapor through the nose—a practice referred to as "hotrailing."[E]

MDMA (ECSTASY)

- Ecstasy became less difficult to buy between spring and fall 2002 as the supply increased.[L,E]
- Ecstasy use increased dramatically, the variety of use settings increased, and the drug is now used by Whites and Blacks equally.[E]
- Recent adulterants include ketamine, gamma hydroxybutyrate (GHB), methamphetamine, amphetamine, and dextromethorphan.[E]

ABUSED OXYCONTIN®

- Among methadone treatment admissions, primary OxyContin® abuse increased.[M]
- Opiate-related overdoses increased, perhaps because OxyContin® abusers often switch to heroin use and then overdose on heroin.[M]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity

- The *Pulse Check* non-methadone treatment source is with a program that is nearly at full capacity (145 of 160 treatment slots filled). Crack remains the most common drug used, followed by marijuana. *(See pie chart on the first page of this chapter.)*
- The non-methadone treatment source notes that outpatient slots are available, but residential slots often are not, and capacity has declined due to funding cuts.[N]
- The methadone treatment source is with a private methadone center that is 84-percent full (252 of 300 treatment slots filled).[M] Although heroin remains the most common primary drug of abuse (at 75 percent), primary OxyContin® abusers constitute 20 percent of clients.[M] Furthermore, 50 percent of the clients in that program report either primary, secondary, or tertiary abuse of OxyContin.® *(See pie chart on the first page of this chapter.)*
- The methadone treatment source notes an increase in treatment demand not matched by increased treatment capacity.[M]

Negative health consequences of drug abuse

- HIV/AIDS, hepatitis C, and drug-related overdoses are the most common negative health consequences among methadone treatment admissions, and all three have increased since spring 2002.[M] HIV/AIDS may be rising due to increased injecting drug use; the apparent rise in hepatitis C is due to increases in injecting drug use and testing for the disease.
- Tuberculosis among methadone clients, although somewhat high in Atlanta compared with other cities, decreased between spring and fall 2002 due to increased surveillance and treatment.[N,M]
- HIV/AIDS among non-methadone treatment clients increased slightly due to more common heterosexual transmission among young adults.[N]
- Cardiovascular problems related to cocaine use are increasing because people are taking higher doses of cocaine.[N]
- High-risk pregnancies among non-methadone treatment clients (especially wealthier clients) are relatively common and detected more often because of increased testing.[N]
- The methadone source reports that the number of dually diagnosed clients increased in the past 10 years. These clients are difficult to refer to mental health centers because many do not take clients who are on methadone.[M]
- Mood disorders among treatment clients, which are the most common comorbid disorders, increased due to improved diagnostic techniques.[N,M]
- Antisocial or conduct disorders increased among methadone treatment clients and may be related to increased methamphetamine or OxyContin® abuse.[M]

Barriers to treatment

- Among non-methadone treatment clients, the most common barrier to treatment is inadequate housing during and after treatment. This problem has increased since spring

2002. "Atlanta is a homeless magnet, and many people emigrate here from other places."[N]

- Adolescent programs in Atlanta have been recently discontinued.[N]
- Medicaid has stopped providing transportation; thus, the non-methadone program offers less money for it now.[N]
- Violent behavior among presenting clients and lack of trained staff to treat comorbidity are uncommon problems and have further declined since spring 2002. The source reports more and better trained staff to treat comorbid illnesses.[N]
- The methadone treatment source claims that treatment cost is their number-one barrier and has increased as a problem since spring 2002.[M]
- Other common barriers to methadone treatment include limited slot capacity (an increasing problem due to higher demand for treatment), lack of transportation or money for transportation, cultural barriers among Hispanics (a problem that has grown as the Hispanic population has increased in Atlanta), and the social stigma of treatment (especially among OxyContin® abusers, who are typically new to treatment for any drug).[M]

Increased complications for drug treatment over the past 10 years

- Increasing availability of new drugs: The emergence of OxyContin® as a drug of abuse has made it much more difficult to treat clients.[M]
- More polydrug use: Both treatment respondents report polydrug use (crack and powder cocaine and marijuana among non-methadone clients; and heroin, cocaine, marijuana, and benzodiazepines among methadone clients) as increasing steadily in the past 10 years.[N,M]
- Lack of housing, jobs, and job training opportunities for recovering clients: Treatment respondents agree that resources for recovering clients have declined in the past 10 years and especially in the past 2 years.[N,M]

WHO USES ILLICIT DRUGS?

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

Who's most likely to use cocaine?

	Crack			Powder cocaine		
Characteristic	E	N	M	E	N	M
Age group (years)	>30	>18	>30	>30	>30	>30
Mean age (years)	32	30	NR	30	NR	NR
Gender	Split evenly	60% male	Split evenly	60% male	Split evenly	60% male
Race/ethnicity	Black	White	Black	White and Black	Black	Black
Socioeconomic status	Low	Low	Low	Low and middle	Low	Low
Residence	Central city	Central city	Central city	Central city and suburbs	Central city	Central city
Referral source	N/A	Criminal justice	Individual	N/A	Individual	Individual
Level of education completed	N/A	High school	High school	N/A	High school	High school
Employment at intake	N/A	Unemployed	Unemployed	N/A	Part time	Part time

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

- *Crack cocaine ("pop" or "rock") use declined between spring and fall 2002[E]; however, crack cocaine non-methadone treatment admissions increased somewhat over the same time period.*
- *Smoking crack in combination with marijuana is a common practice.[E,N]*
- *Among new powder cocaine users, use increased somewhat since spring 2002.[E] These new users are more likely than the general powder cocaine-using population to be Black young adults of low-middle socioeconomic status who live in the central city. The new users often smoke powder cocaine in combination with marijuana.[E]*

- *In general, heroin use increased between spring and fall 2002.*[E]
- *Sources agree that most heroin ("boy," "little boy," and "mac") users are males older than 30 of low socioeconomic status who live in the central city.*[E,N,M]
- *New heroin users, who declined in number since spring 2002, are more likely than the general heroin-using population to be White young adults of middle socioeconomic status who snort the drug.*[E]

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	>30
Mean age (years)	32	NR	NR
Gender	80% male	Male	62% male
Race/ethnicity	Black	Black	White
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Individual	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Unemployed	Full and part time

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

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs taken	Powder cocaine (speedball)	Powder or crack cocaine (speedball)	Crack cocaine or benzodiazepines (in combination)
Publicly or privately?	Privately	Publicly	Privately
Alone or in groups?	Both	Alone	Alone

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

- *Sources agree that injecting is the most common route of heroin administration in Atlanta.*[E,N,M]
- *Cocaine is often injected with heroin as a speedball.*[E,N,M]
- *Sources report no changes in use characteristics.*

- *Marijuana use in general increased slightly since spring 2002;*[E] *however, marijuana use among non-methadone treatment admissions declined.*[N]
- *Marijuana is often smoked in joints, blunts, and pipes.*[E,N,M]
- *Respondents report no changes in marijuana user and use characteristics between spring and fall 2002.*

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	13–30	18–30	>18
Mean age (years)	18	NR	NR
Gender	60% male	60% male	70% male
Race/ethnicity	White and Black	Black	White
Socioeconomic status	All	Low	Middle
Residence	All	Central city	Central city
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Unemployed	Full time

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

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

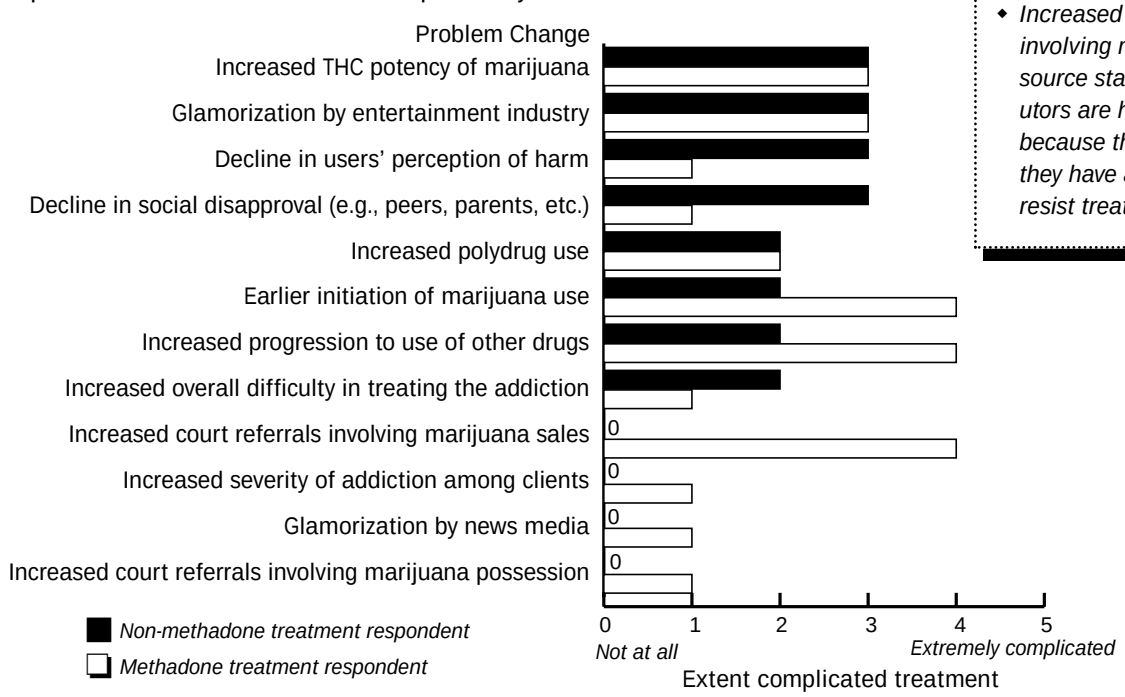
Marijuana, used either alone or with other drugs, is associated with the following consequences, which remained stable between spring and fall 2002:

- Drug-related arrests[N]
- Dropping out of school[N]
- Unemployment rates[N]
- Short-term memory loss[M]
- Poor workplace performance[M]

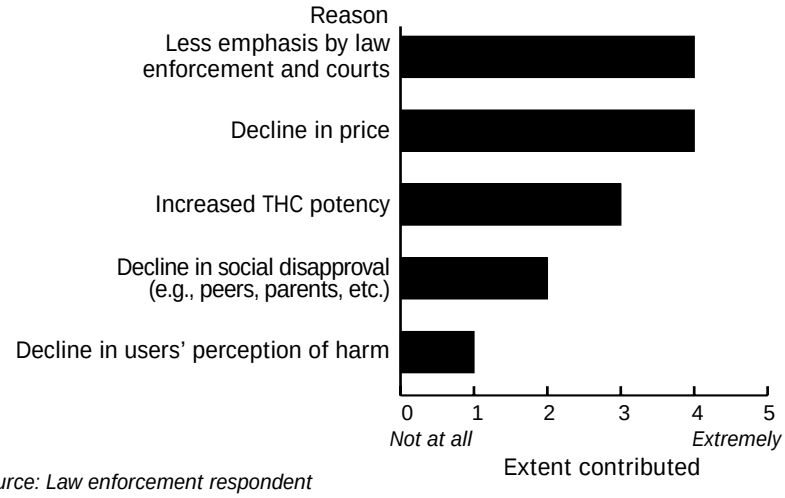
What they have to say...

- *Increased THC potency of marijuana: Rated as somewhat of a problem in treating marijuana clients, the increased potency of the drug has caused "greater dependence on marijuana" than it has in the past.*[N,M]
- *Increased court referrals involving marijuana sales: One source states that "drug distributors are harder to treat because they don't accept that they have a problem and often resist treatment."*[N]

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



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



Source: Law enforcement respondent

What they have to say...

- *Less emphasis by law enforcement and courts and decline in the price of marijuana contribute most to increased marijuana activity.*[L]
- *THC potency has increased 7 percent over the past 10 years, which is seen as somewhat responsible for increased marijuana use.*[L]
- *The law enforcement source believes that indoor marijuana farms, promotion of marijuana as "medicine," and glamorization by the entertainment industry and news media are not related to increased marijuana activity.*

Who's most likely to use methamphetamine, and how do they take the drug?

Characteristic	E
Age group (years)	13–30
Gender	Split evenly
Race/ethnicity	White
Socioeconomic status	Middle
Residence	Suburbs and rural areas
Primary route of administration	Snorting
Other drugs taken	Ecstasy (in combination and sequentially to "kick it up")
Publicly or privately?	Both
Alone or in groups?	Both

Source: [E]Epidemiologic/ethnographic respondent

- *Methamphetamine use in general increased dramatically since spring 2002.*[E]
- *Methamphetamine users tend to be White, 13–30 years old, and split equally between genders.*[E]
- *New methamphetamine users are younger than the general methamphetamine-using population (adolescents versus adolescents and young adults) and are more likely to use the drug publicly and in groups.*[E]
- *New methamphetamine users often heat the drug and, using a plastic tube, inhale the vapor through the nose—a practice referred to as "hotrailing."*[E]
- *The use of methamphetamine with ecstasy has increased, especially at nightclubs and raves.*[E]

Who's most likely to use ecstasy?

Characteristic	E
Age group (years)	13–30
Gender	60% male
Race/ethnicity	White and Black
Socioeconomic status	Middle
Residence	Suburbs

Source: [E]Epidemiologic/ethnographic respondent

- *Ecstasy use increased dramatically between spring and fall 2002.*[E]
- *Most ecstasy users are male adolescents and young adults who are equally likely to be White or Black.*[E]
- *Although ecstasy is most often used in public places, the epidemiologic source reports an increase in use in private residences and increased diversity in the places where people use the drug.*[E]

- *OxyContin® abuse among methadone treatment admissions increased somewhat since spring 2002. Half of all methadone admissions now abuse the drug.*[M]
- *OxyContin® abusers tend to be White adults older than 30 who live in the suburbs.*[E,M]
- *Oral administration is most common, and combining hydrocodone (Vicodin®) with OxyContin® is a common practice.*[M]

Who's most likely to abuse OxyContin®?

Characteristic	E	M
Age group (years)	>30	>30
Gender	NR	55% male
Race/ethnicity	White	White
Socioeconomic status	NR	Middle
Residence	Suburbs	Suburbs

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

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin and crack cocaine are most often sold in central city areas, and powder cocaine, methamphetamine, and ecstasy are most often sold in central city and suburban areas.[L] Since spring 2002, methamphetamine and ecstasy sales increased in central city areas.[E]

Drug sales in Atlanta, excluding methamphetamine sales, often take place on streets and in open-air markets. Three known open-air drug markets exist in Atlanta neighborhoods: Pittsburgh, Mechanicsville Community, and Vine City ("The Bluff"). The number of buyers who go to the two former markets declined, but the open-air market in Vine City has become busier.

Along with open-air market sales, heroin sales occur in a variety of mostly public settings:

- Crack houses and shooting galleries[L,E]
- Public housing developments[L,E]
- Hotels/motels[L,E]
- Around shopping malls[L]
- Private residences[E]
- Around drug or alcohol treatment clinics[E]

Crack and marijuana are sold at all heroin sales locations plus the following:

- In or around schools[L,E]
- College campuses[L,E]
- Nightclubs and bars[L,E]
- Playgrounds and parks[L]
- Private parties[L,E]
- Raves[L,E]
- Concerts[L,E]
- Around supermarkets[L]
- Inside cars[L]
- Around drug or alcohol treatment clinics (excluding marijuana)[E]

Crack cocaine sales on college campuses increased between spring and fall 2002.[L]

Methamphetamine and ecstasy sales occur in more private settings than do heroin sales:

- Private residences[L,E]
- Nightclubs and bars[L,E]
- Private parties[L,E]
- Raves[E]
- Concerts[L,E]
- Hotels/motels[L]
- The Internet (excluding ecstasy)[E]

Additionally, ecstasy is sold around shopping malls, in or around schools,[L,E] and on college campuses.[E]

Use settings for the various drugs tend to mirror their sales settings. Between spring and fall 2002, one source notes two changes in use settings: methamphetamine use is now more common at nightclubs and raves, and ecstasy is used in a wider variety of settings.

HOW DO DRUGS GET FROM SELLER TO BUYER?

To purchase heroin, crack and powder cocaine, or marijuana, a buyer must know in what neighborhoods (open-air markets), public housing developments, or shopping malls drugs are available. The buyer goes to a known location and approaches a dealer openly for a hand-to-hand exchange of the drug.[L,E]

Along with out-in-the-open sales, powder cocaine and marijuana are often purchased via delivery: sellers may be involved with the same buyers for several years, and buyers contact dealers (via cell phones and e-mail) to set up a delivery to their private residences.[L,E]

In addition to street sales, marijuana is sold in some settings (college campuses and schools) via acquaintance networks. At certain venues (raves and concerts), buyers can "ask around" about where to purchase marijuana, and someone will direct them to a dealer for a hand-to-hand exchange of the drug.[L]

Methamphetamine sales are more private than other drug sales in Atlanta: a mutual acquaintance must introduce buyers to sellers to facilitate a sale, or a buyer must know a nightclub or bar where methamphetamine is sold.[L]

Ecstasy is sold in a variety of ways, including at open-air markets similar to heroin sales, and the following:

1. A buyer goes to a particular nightclub, bar, concert, or rave and "asks around" for the drug.[L,E]
2. Ecstasy dealers have private parties at private residences where the drug is sold and used.[L]
3. Buyers call their "regular" dealer to have the drug delivered.[E]

WHO SELLS HEROIN, CRACK AND POWDER COCAINE, AND MARIJUANA?

Most heroin, crack cocaine, and marijuana dealers (who often sell all three drugs) are young adults organized into loose-knit gangs whose members tend to live in the same neighborhoods and obtain drugs from the same supplier.[L] Many sales also involve "runners," adolescents who act as liaisons between sellers and buyers.[E]

Most powder cocaine dealers are adults older than 30 who are organized and connected to the trafficking organizations.[L]

WHO SELLS METHAMPHETAMINE AND ECSTASY?

Methamphetamine sellers are divided into two groups based on the type of methamphetamine sold:[E] (1) methamphetamine manufactured in large Mexican labs is sold by adults older than 30 whose organization is controlled by Mexican trafficking groups; (2) methamphetamine manufactured in small, local labs is sold by independent young adults, a group that increased since spring 2002.

Ecstasy dealers may be organized and affiliated with ecstasy traffickers, or else independents who sell locally pressed pills.[L,E] Independent dealers increased between spring and fall 2002.[E]

How pure are heroin, cocaine, and marijuana, and how much do they cost?

Drug	Unit	Purity	Price
South American heroin	"20 bag" One hit 1 g	>50% NR	$20[E] $30[L] $300[L]
Crack	One rock	NR	$5, $10, $20[L,E]
Powder cocaine	One bag	60%	$5[E]
Marijuana (commercial grade or sinsemilla)	Dime bag (2–3 g) 1 oz	NR NR	$10[L,E] $120[E]

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

Most prices and purity levels remained stable between spring and fall 2002 with a few exceptions:

- *Heroin prices declined at all unit levels.*[L]
- *Heroin is often cut with OxyContin® or powder cocaine—both new phenomena since spring 2002.*[M]
- *Crack cocaine dealers often "run specials" such as two rocks for one on Sundays.*[E]

How much do methamphetamine and ecstasy cost?

Drug	Unit	Price
Methamphetamine (powder)	One hit	$10, $20[L]
Ecstasy	One pill	$15–$20[E]

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

- *Methamphetamine purity is about 34 percent at most unit levels. Price and purity have remained relatively stable between spring and fall 2002.*[E]
- *Ecstasy prices have declined from $20–$25 to $15–$20 per pill. Recent adulterants include ketamine, GHB, methamphetamine, amphetamine, and dextromethorphan.*[E]

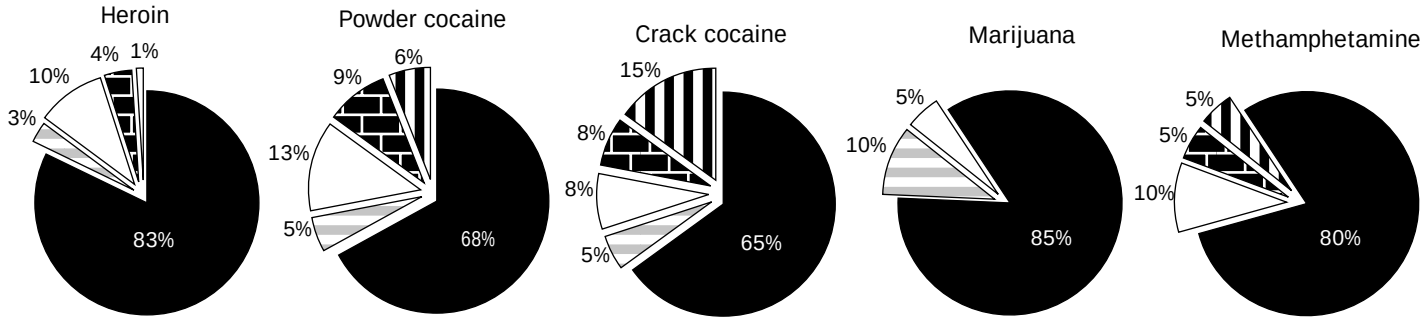
Which drug sellers are associated with which crimes?

Crime	Heroin	Powder cocaine	Crack cocaine	Marijuana	Metham-phetamine	Ecstasy
Prostitution			✓	✓		
Gang-related activity	✓	✓	✓		✓	
Violent criminal acts: robberies and burglaries	✓	✓	✓	✓	✓	
Nonviolent criminal acts: shoplifting	✓	✓	✓	✓	✓	✓
No other crimes associated		✓				✓

Sources: Law enforcement respondent; Epidemiologic/ethnographic respondent

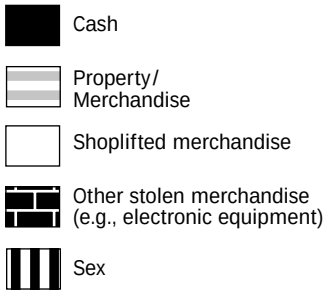
Drug dealers are associated with a wide variety of crimes in Atlanta, including robberies, burglaries, gang-related crimes, shoplifting, and prostitution.[L,E]

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



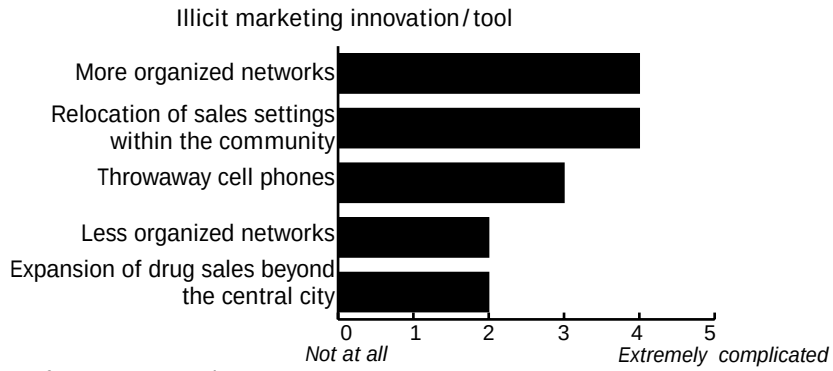
What they have to say...

- *Like in nearly all* Pulse Check *cities, cash remains the number-one means of exchange for drugs.*[N,M]
- *One source reports that sex in exchange for crack and powder cocaine increased over the past 10 years.*[N]
- *Although still accounting for nearly 10 percent of all cocaine exchanges, shoplifting as a mode of exchange declined over the past 10 years due to increased law enforcement.*[N]
- *As reported in several* Pulse Check *cities, food stamps are no longer used in exchange for drugs because people are not able to manipulate the new electronic version of food stamps.*[N]



Source: Mean of response ratings given by non-methadone and methadone treatment respondents. The non-methadone respondent did not provide information on methamphetamine exchanges.

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



Source: Law enforcement respondent

What they have to say...

- *Drug marketing innovations that have posed the greatest challenges for narcotics enforcement include more organized sales networks, relocations of sales settings within the community, and throwaway cell phones.*[L]

COMMUNITY INNOVATIONS AND TOOLS OVER THE PAST 10 YEARS: HOW SUCCESSFUL HAVE THEY BEEN?

- Task forces: Like in many *Pulse Check* cities, task forces rate as the most successful law enforcement innovation for combating drug activity. The law enforcement source suggests even more communication between local law enforcement and regional and Federal task forces.
- Drug courts: Over the past 10 years, the number of drug courts has increased, and Atlanta now has county- and municipal-level drug courts.[N]

SEPTEMBER 11 FOLLOWUP

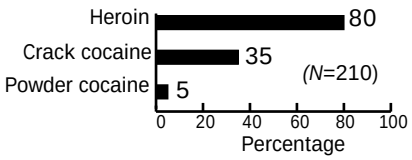
The law enforcement source reports a large decline in the supply of crack and powder cocaine since September 11, 2001. The methamphetamine supply, which has increased recently, may be substituting for the lack of cocaine. The non-methadone treatment source reports a general increase in mental health disorders and comorbidity among treatment clients.[N]

BALTIMORE PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 2,552,994
- Median age: . . . . . 36.6 years
- Race (alone):
  - White: 67.3%
  - Black: 27.4%
  - American Indian/ Alaska Native: 0.3%
  - Asian/Pacific Islander: 2.7%
  - Other race: 0.7%
  - Two or more races: . . . 1.5%
- Hispanic (of any race): 2.0%
- Unemployment rate: 3.3%
- Median household income: $49,938
- Families below poverty level with children <18 years: 10.3%

*Source: U.S. Census 2000**

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



Notes: These numbers may include client reports of two primary drugs of abuse. No clients report marijuana, methamphetamine, or ecstasy as a primary drug of abuse.[N]

Source: Non-methadone treatment respondent

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

Two of the *Pulse Check* respondents believe that Baltimore's drug problem is stable,[L,E] while the two treatment respondents report a worsening situation.[N,M] All four agree, however, that the city's overall drug problem is either somewhat[L,E] or very[N,M] serious. Some changes are reported since spring 2002:

- Abuse of OxyContin® (oxycodone hydrochloride controlled-release) appears to have decreased somewhat since the spring[E,N] The drug is no longer considered a new or emerging drug, but rather part of the drug culture.[E]
- OxyContin® is now most commonly diverted through prescription fraud, as opposed to pharmacy burglaries as was the case in past reporting periods.[L]
- The percentage of primary heroin users in treatment increased.[M]
- Methylenedioxymethamphetamine (MDMA or ecstasy) remains easily accessible to adolescents in school settings.[L,E]
- Ecstasy has penetrated the traditional drug market, especially suburban and rural youth.[L]
- Marijuana dealers have recently begun selling joints dipped in phencyclidine (PCP).[L]
- Juveniles are involved in distributing marijuana, often through "underground networks."[L]

Three of the four respondents indicate that heroin is the city's most widely abused drug, and all concur that crack cocaine is the second most widely abused drug in Baltimore. The methadone treatment source reports benzodiazepines as the drugs related to the most serious consequences—unlike nearly all other *Pulse Check* methadone sources, who consider heroin as such.

Most widely abused drug:
Heroin[E,N,M]
Marijuana[L]

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

Second most widely abused drug:
Crack cocaine[L,E,N,M]

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

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

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

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

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

New or emerging problems:
Ecstasy is penetrating the traditional drug market.[L]
Diverted OxyContin® has grown from a new/emerging drug to a part of the traditional drug culture.[E]

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

Three sources consider heroin to be Baltimore's most widely abused drug,[E,N,M] and two associate the most serious drug-related consequences with the drug.[L,E]

- The percentage of primary heroin users in treatment increased, with 70 percent representing return clients within the methadone program.[M]
- Demand for heroin is increasing.[L]
- New street names for heroin appeared in Baltimore since the spring: (1) "dope"[N] and (2) "the bomb," which refers to heroin from Washington, DC, that has an estimated purity of 20 percent.[L]

COCAINE

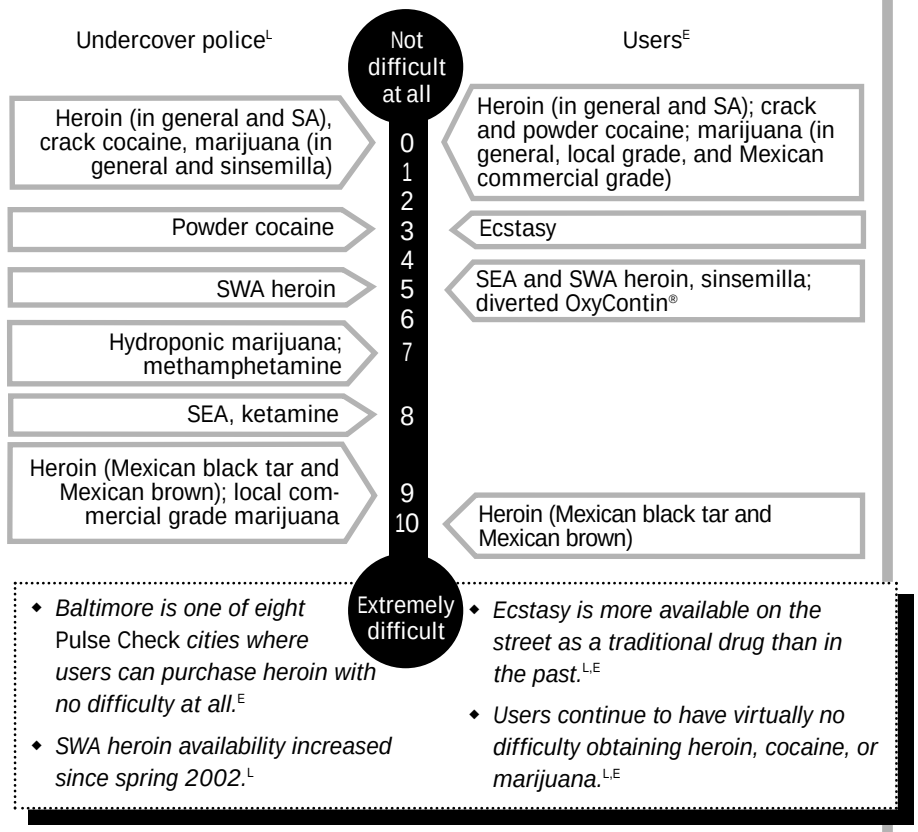
All four respondents consider crack cocaine to be Baltimore's second most widely abused drug, and three associate it with the second most serious drug-related consequences. The crack problem has, however, remained stable since spring 2002, and abuse of powder cocaine remains stable at very low levels.[N,M]

MARIJUANA

The marijuana problem in Baltimore appears stable, although use remains at high levels.[E,N]

- Marijuana is the primary drug of abuse among preadolescents and adolescents.[E]
- Marijuana dealers recently began selling joints dipped in PCP.[L]

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



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

Note: SA=South American (Colombian) heroin; SWA=Southwest Asian heroin; SEA=Southeast Asian heroin

METHAMPHETAMINE

Methamphetamine use remains stable at very low levels among treatment clients,[N,M] and is fairly difficult to purchase on the street.[L,E]

- The methamphetamine that does appear on the drug market generally comes from west of Baltimore.
- There is some evidence of a few small labs within the city.

MDMA (ECSTASY)

Ecstasy use remains stable at low levels,[N,M] but is increasingly available on the street.[L,E]

OTHER DRUGS

- Diverted OxyContin®: After a large increase in primary OxyContin® abusers in the non-methadone program last spring, the numbers have declined to nearly zero. This is partly attributable to the non-methadone clinic's move into a "heavy heroin neighborhood" during the reporting period. The ethnographic/epidemiologic respondent similarly notes a slight decrease in abusers of OxyContin®.
- Ketamine: While ketamine abuse is not pervasive in Baltimore, the drug is well known among youth.[L]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone treatment facility has the capacity to serve 160 clients; however, its current enrollment exceeds capacity at 210. Among these clients, the primary drug of abuse is heroin, with crack cocaine the distant second *(see bar chart on the first page of this chapter)*. This clinic relocated during the reporting period, accounting for some of the changes seen among treatment clients *(see the Other Drugs arrow on the previous page)*.
- The methadone treatment facility can serve up to 620 clients, with a current enrollment of 597. Seventy percent of the program's treatment population are return clients for primary heroin abuse.[M]
- While treatment is somewhat more available through both public and private clinics in Baltimore, methadone programs continue to have waiting lists several months long.[E,M]

Consequences of drug use

- The number of clients with hepatitis C increased significantly in the non-methadone program, largely attributable to the clinic's new location: a significant number of clients come to treatment directly from jail, where hepatitis C prevalence is great.[N] In the methadone program, hepatitis C diagnoses remain stable at high levels.[M]
- An increase in drug-related automobile accidents is noted among methadone treatment clients.[M]

Co-occurring disorders

- A lack of trained staff to treat comorbid clients increased as a major barrier to treatment within the methadone program, due to insufficient funding for staff and the increased severity of patient problems.[M]
- The rate of clients with dual diagnoses in the methadone program remains high, at 80 percent. Mood disorders account for the majority of the mental health issues.[M]
- Comorbidity (psychosis, mood disorders, post-traumatic stress disorder [PTSD], and physical and sexual abuse) increased among clients in the non-methadone treatment program. This is due to more effective identification of dual diagnoses by new staff trained to treat comorbid disorders.[N]

WHO USES ILLICIT DRUGS?

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

- *The education level of heroin users declined, with more clients in the methadone program achieving less than a GED (general equivalency diploma).*[M]
- *While the majority of heroin users in treatment are male (65 percent), new treatment clients are more evenly distributed between males and females.*[M]
- *The primary referral source for heroin users in the methadone program is now the criminal justice system. Previously, most clients were self-referred or came from the health care system. This change is attributable to a recent anticrime push by the Baltimore Health Department that involves many heroin users.*[M] *Similar shifts are reported in other* Pulse Check *cities.*

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	>30
Mean age (years)	35	37	40
Gender	Male	70% male	65% male
Race/ethnicity	Black	Black	White and Black
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Criminal justice
Level of education completed	N/A	Did not complete school	Did not complete school
Employment at intake	N/A	Unemployed	Unemployed

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

- *While the typical heroin user takes the drug alone, most new treatment clients use heroin in groups and with friends.*[N,M] *Also, these new clients tend to snort the drug, while the overall treatment population snorts and injects heroin equally.*[M]
- *Common adulterants to heroin include baking soda, quinine, rat poison, Ajax® cleanser, arsenic, and benzodiazepines.*[N]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Snorting	Snorting and injecting
Other drugs taken	Powder cocaine	Powder cocaine	Crack cocaine
Publicly or privately?	Both	Privately	Privately
Alone or in groups?	In groups	Alone	Alone

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

- *An emerging practice of injecting crack cocaine is noted.*[E]
- *Crack cocaine users often take the drug along with heroin.*[N]
- *Common adulterants to both forms of cocaine include baking soda, quinine, rat poison, Ajax® cleanser, arsenic, and benzodiazepines.*[N]

Who's most likely to use cocaine?

	Crack cocaine			Powder cocaine
Characteristic	E	N	M	N
Age group (years)	18–30	>30	>30	>30
Mean age (years)	NR	35	35	35
Gender	Male	60% female	Female	60% female
Race/ethnicity	Black	Black	Black	Black
Socioeconomic status	Low	Low	Low	Low
Residence	Central city	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Criminal justice	Criminal justice
Level of education completed	N/A	Did not complete school	Did not complete school	Did not complete school
Employment at intake	N/A	Unemployed	Unemployed	Unemployed

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

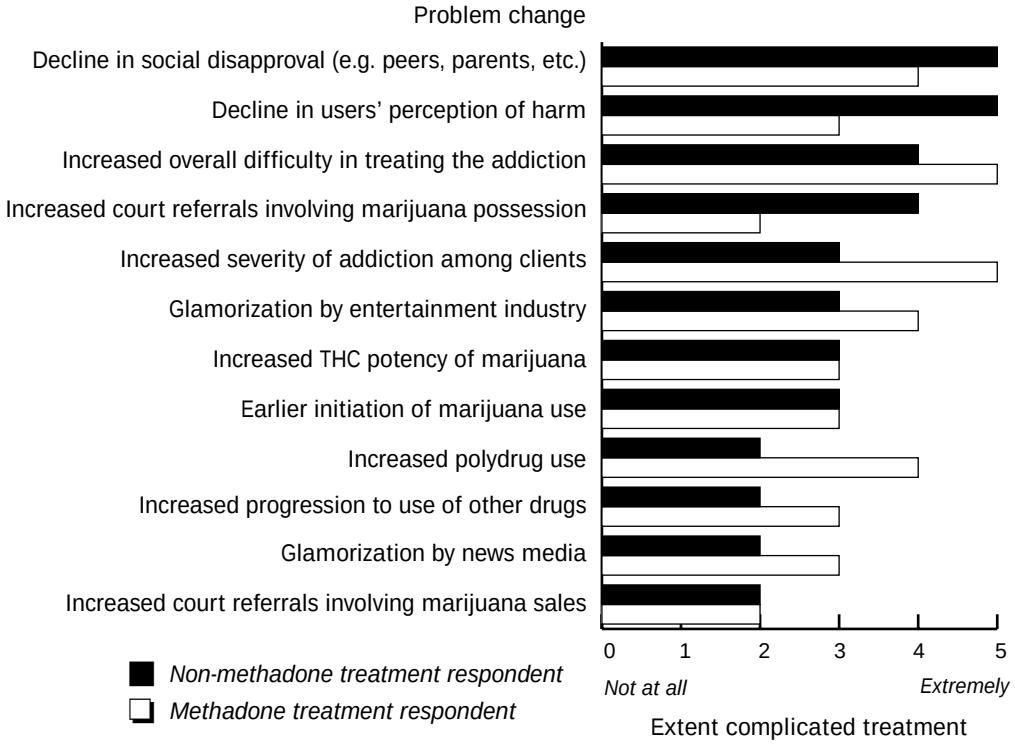
- *Primary marijuana users are younger than users of other drugs: they are typically adolescents and young adults. Marijuana is the most widely abused drug for these age groups.*[E,N]
- *Primary marijuana users who are referred to treatment by the criminal justice system are generally arrested for possession of marijuana as opposed to selling the drug.*[N]
- *As in most* Pulse Check *cities, marijuana use occurs across age groups.*

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	13–17	18–30	>30
Gender	Male	95% male	70% male
Race/ethnicity	Black	Black	Black
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Criminal justice
Level of education completed	N/A	Did not complete school	Junior High
Employment at intake	N/A	Unemployed	Unemployed

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

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



WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

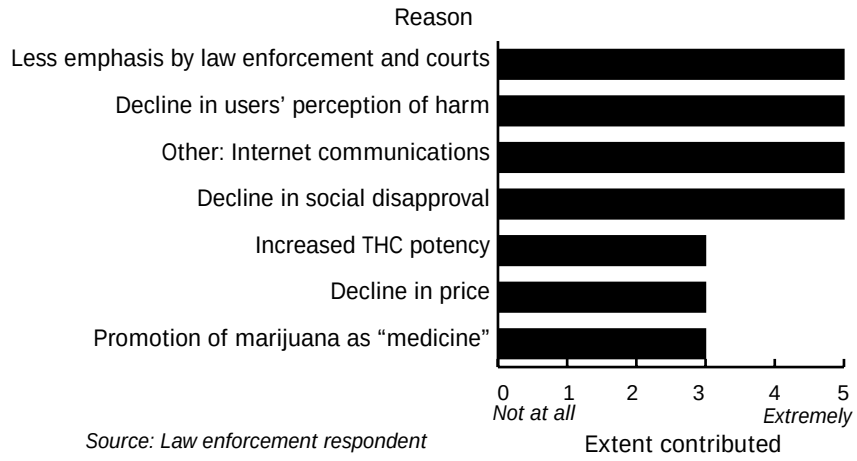
Respondents associate marijuana, used either alone or with other drugs, with the following consequences, which remained stable between spring and fall 2002:

- Drug-related arrests[N,M]
- Short-term memory loss[N,M]
- Deteriorating family and social relationships[N]
- Poor academic performance[M]
- Poor workplace performance[M]
- Unemployment rates[N]

What they have to say...

- *Perception of harm/social disapproval: Two factors that particularly complicate treatment of marijuana-using clients are the declines in users' perception of harm[N] and in social disapproval of marijuana use—perceptions shared by treatment sources in many* Pulse Check *cities.*[N,M]
- *Treatment difficulty: Because marijuana abusers in treatment now are younger than the rest of the treatment population, they have few life experiences without drug use, making it more difficult to treat their addiction.*[N]
- *Polydrug use: Polydrug use among marijuana users is far more common than it was a decade ago, increasing the severity of their addiction and making it more difficult to treat them.*[M]
- *Entertainment industry: Glamorization of marijuana use is cited as a major contributor to the increased difficulty in treating marijuana addiction. This includes primarily the music industry (including music videos) and movies.*[N,M]

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



Source: Law enforcement respondent

WHO'S MOST LIKELY TO USE ECSTASY?

- Ecstasy users in Baltimore are primarily young adults using privately in groups or among friends;[E,M] males and females are equally likely to use the drug.[E]
- Blacks residing in the central city are growing as an ecstasy-using population,[E,M] shifting from primarily White users living in more suburban and rural areas.[E]
- Primary ecstasy users are generally more educated than primary users of other drugs.[M]

What they have to say...

- *Law enforcement/courts: Compared with many other* Pulse Check *cities, the Baltimore law enforcement and court system seems to place less emphasis on marijuana (according to average ratings by* Pulse Check *law enforcement sources).*
- *Perception of harm: Widespread availability and use of marijuana among youth has been substantially affected by a decline in users' perception of harm. Further, not only has there been a notable decline in social disapproval of marijuana use, but there is now significant peer pressure to smoke marijuana.*[L]
- *Internet: Communications over the Internet make information about marijuana easily accessible and has increased pressure to use the drug.*[L]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin, cocaine, and marijuana are sold throughout the city in all of these settings:[L,E]

- Streets/open-air markets
- Crack houses/shooting galleries
- Private residences
- Public housing developments
- College campuses
- Nightclubs/bars
- Shopping malls
- Playgrounds/parks
- Private parties
- Raves
- Concerts
- Hotels/motels
- Around drug treatment clinics
- Inside cars

Cocaine is also used in these settings, with the exception of college campuses, shopping malls, raves, and around drug treatment clinics. While heroin is sold in these varied settings, it is generally used in the streets, in crack houses/shooting galleries, private residences, public housing developments, playgrounds/parks, hotels/motels, and inside cars.

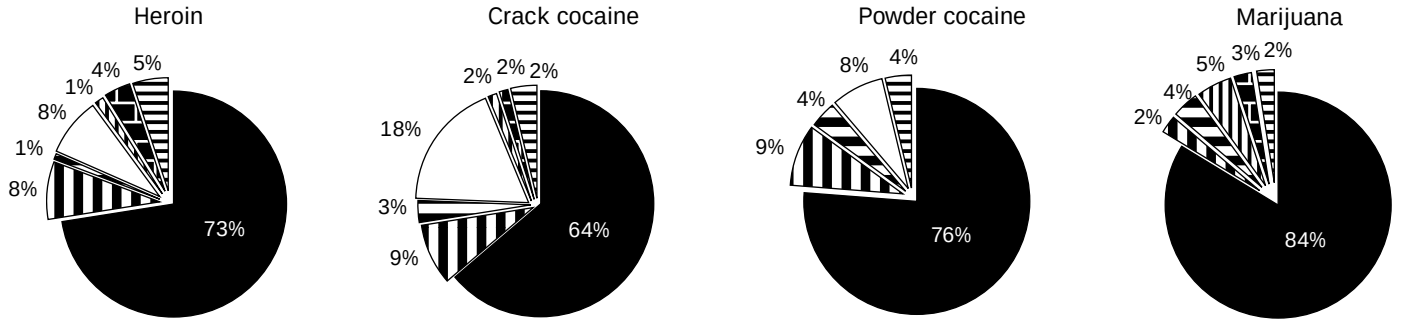
In addition to all the locations listed above, marijuana is also sold in school settings.[L] Users smoke the drug in all of the sale settings except for schools, shopping malls, and around drug treatment clinics.[E]

Ecstasy sales have moved into many of these traditional drug markets, including the streets, private residences, schools and colleges, nightclubs/bars, shopping malls, playgrounds/parks, private parties, at raves and concerts, and inside cars. The drug is also used in all of these settings, except for playgrounds/parks and concerts.[L,E]

HOW DO DRUGS GET FROM SELLER TO BUYER?

- Transactions involving heroin and cocaine generally take place in the central city,[E] although cocaine sales also occur in large numbers in the suburbs.[L]
- Heroin and cocaine users often have one dealer, who will get whatever they request through either open-air markets or telephone communications.[E] Users often go to a known market area to find such a dealer.[L] The dealer sometimes takes the money for the drugs and then directs the user where to pick them up.[L]
- Some dealers distribute free drugs to "testers" early in the morning, and then count on word-of-mouth to bring them more buyers throughout the day based on the quality or purity of the drug.[E]
- Marijuana and ecstasy sales take place in all areas of Baltimore. Dealers often sell these two drugs only.[L,E]
- While ecstasy users formerly needed to know a dealer personally, the drug is becoming more common on the street.[L]
- Diverted OxyContin® is typically acquired through prescription fraud, with one person giving addicts fraudulent prescriptions to fill; the user then returns the filled prescription to the dealer, who gives some back to the user and sells the rest.[L]

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



What they have to say...

- *As in all* Pulse Check *cities, cash remains the primary currency for drug transactions in Baltimore.*[L,E,N,M]
- *While the exchange of sex for drugs is a common practice for drugs like heroin and cocaine, it is virtually unheard of among marijuana users.*[L,E,N,M]
- *Receiving marijuana as payment for providing drug buying services is more common for marijuana transactions than for those involving other drugs.*[M]

- Cash
- Shoplifted merchandise
- Property/Merchandise
- Sex
- Drug buying services
- Lookout services
- Other: Includes items accounting for less than 3 percent of transactions for all four drugs, such as other drugs, transporting the drugs, food stamps, and injecting services.

Note: The epidemiologic/ethnographic source provided information about heroin only.

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

WHO'S SELLING HEROIN?

- Heroin sellers in Baltimore range from adolescents and young adults operating independently[E] to adults working within organized structures.[L]
- An increasing level of violence is associated with heroin dealers, due to gangs seeking new "territories" within the city.[E]
- Heroin dealers sometimes sell heroin and powder cocaine in one bag for speedballing.[E]

WHO'S SELLING COCAINE?

- Dealers of both crack and powder cocaine work within structured organizations and are often involved in prostitution, gang-related activity, and violent criminal acts.[L,E]
- Crack dealers are younger than powder cocaine dealers.[L,E]
- Powder cocaine dealers often pack the drug in pills and lace it with heroin.[E]

WHO'S SELLING MARIJUANA?

- Persons of all ages, from preadolescents to adults, sell marijuana.[L,E]
- Marijuana dealers are likely to use the drug as well,[L,E] and are often involved in both violent and nonviolent criminal acts.[L]

WHO'S SELLING METHAMPHETAMINE?

- Sales of methamphetamine are very low throughout Baltimore, but there are some indications of lab activity in the city.[L]
- Those who do sell the drug are young adults working independently.[L]

WHO'S SELLING ECSTASY?

- Adolescents continue to represent the vast majority of ecstasy dealers,[E] although young adults also commonly deal the drug.[L]
- Most ecstasy dealers work independently.[L]

How much does heroin cost?

Unit	Price
Vial	$5–$10[E]
Bag	$10[L]
Capsule	$10[L]

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

All reported prices are stable between spring and fall 2002.

How much does cocaine cost?

Form	Unit	Price
Crack	Rock	$5–$10[L,E]
Powder	Vial/"baggie"	$5–$10[E]
	1 g	$90–$100[L]
	3–5 g	$270–$500[L]

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

- *All reported prices are stable between spring and fall 2002.*
- *Dealers will break off a particular size of rock depending on how much money the user can pay.*[E]

How much does marijuana cost?

Unit	Price
Joint	$1–$3
Blunt	$10–$12
Ounce	$100
Pound of sinsemilla	$3,700–$4,700

Source: Law enforcement respondent

All reported prices are stable between spring and fall 2002.

Who's selling other drugs, and how much do they cost?

Drug	Unit	Price
Diverted OxyContin®	1 mg	$1[L]
	1 pill	$30[E]
Ecstasy	1 pill	$18–$20[L]

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

- *All prices are stable between spring and fall 2002.*
- *Unlike many other cities such as Philadelphia and Detroit, diverted OxyContin® dealers in Baltimore typically use the drug themselves, and are also involved in both prostitution and property crimes.*[L,E]
- *Young adults working independently are the primary dealers of ketamine, which they obtain through burglaries of veterinary clinics.*[L]

Which drug sellers are associated with which crimes?

Crime	Heroin	Crack cocaine	Powder cocaine	Marijuana	Diverted OxyContin®	Ketamine
Gang-related activity	✓	✓	✓			
Violent criminal acts	✓	✓	✓	✓		
Nonviolent criminal acts	✓	✓	✓	✓	✓	✓
Prostitution	✓	✓	✓		✓	

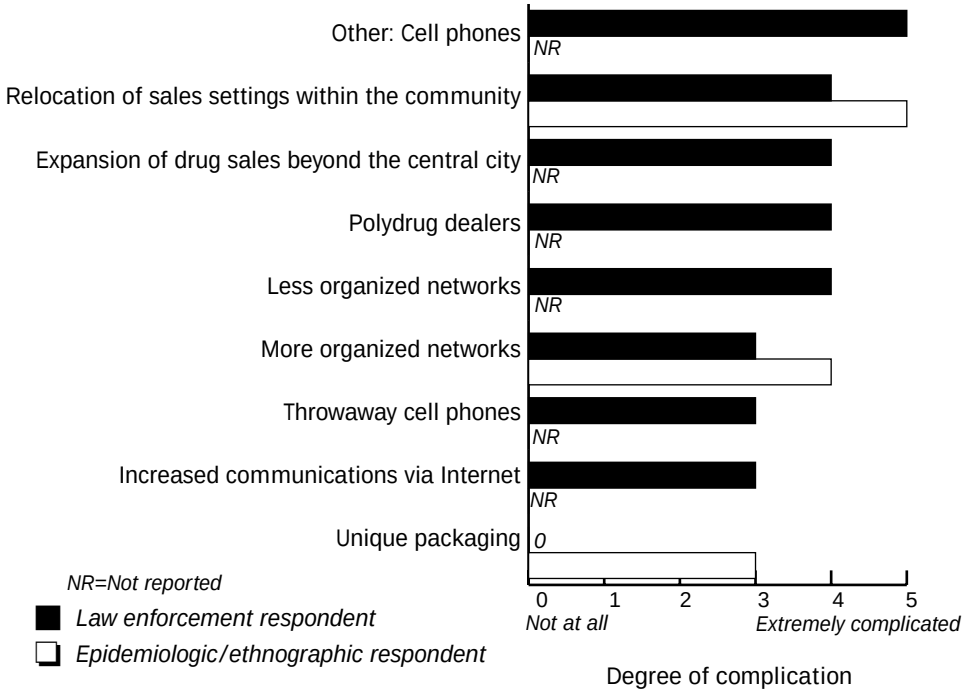
Sources: Law enforcement and epidemiologic/ethnographic respondents

THE MARKET PERSPECTIVE: A 10–YEAR VIEW

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

What they have to say...

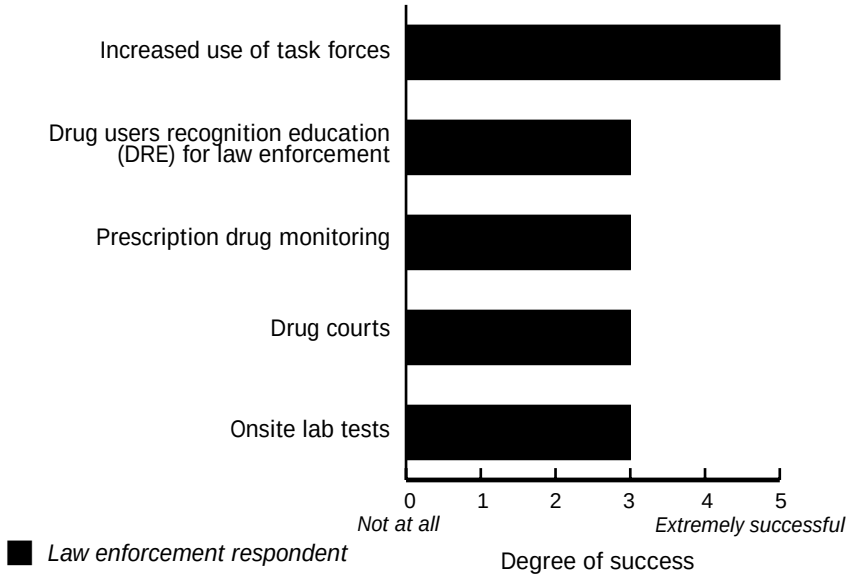
- *A Baltimore source articulates a belief shared by the vast majority of sources in other* Pulse Check *cities: The proliferation of cellular phones over the past decade has caused more problems than anything else in law enforcement efforts to disrupt drug activity. It has changed the ways that law enforcement can intercept transactions and provides sellers with a degree of protection.*[L]
- *The relocation of sales settings within the community represents a substantial complication of efforts to detect or disrupt drug activity in Baltimore.*[E]



What they have to say...

- *Like other* Pulse Check *cities, Baltimore has used task forces effectively. Regional task forces, in particular, can readjust their focus as needed.*[L]
- *Drug courts have been largely successful, but resources are currently limited. Law enforcement is seeking to expand the drug courts into several jurisdictions.*[L]
- *While onsite lab tests located on police premises have been beneficial, law enforcement points to a need for availability of reliable portable kits to all officers working in the field.*[L]
- *Law enforcement stresses that the key to reducing drug supply and sales is to somehow reduce dealers' profit margin.*[L]

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



SEPTEMBER 11 FOLLOWUP

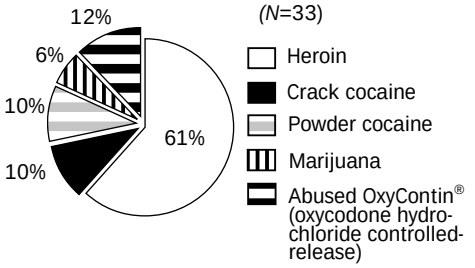
Three of the four *Pulse Check* sources believe that the September 11 attacks and their aftermath have had no continuing effects on the drug abuse problem in Baltimore. The law enforcement respondent, however, notes two continuing effects also noted by *Pulse Check* sources in other cities. First, the switch in law enforcement focus to antiterrorist efforts has limited resources for fighting the city's drug problem. Second, while increased scrutiny at airports has curtailed drug trafficking in that venue, suppliers have simply increased their use of other means of transportation.

BOSTON PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 3,406,829
- Median age: . . . . . 36.3 years
- Race (alone):
  - White: 82.5%
  - Black: 7.0%
  - American Indian/ Alaska Native: 0.2%
  - Asian/Pacific Islander: 4.9%
  - Other race: 3.0%
  - Two or more races: 2.4%
- Hispanic (of any race): . . . 5.9%
- Unemployment rate: 2.9%
- Median household income: $55,183
- Families below poverty level with children <18 years: 8.6%

*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent; responses for primary ecstasy and methamphetamine use were zero.

Heroin remains the most common primary drug of abuse among non-methadone treatment admissions, and OxyContin® abuse increased slightly between spring and fall 2002.[N]

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

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

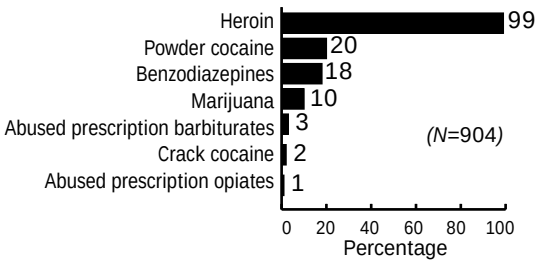
Three of the *Pulse Check* sources believe that the area's overall drug abuse problem has remained stable at high levels,[L,E,N] while the methadone treatment respondent believes it has worsened. Sources report several specific developments:

- Three drug abuse-related health consequences have declined since spring, including tuberculosis (due to improved testing and treatment),[N] suicide (due to increased crisis intervention among younger clients),[N] and high-risk pregnancies.[M]
- Diverted OxyContin® availability declined, it is more difficult to purchase, and pharmacy robberies continue to decline.[L,E,N] These declines are most likely due to media coverage of its abuse and increased law enforcement attention. However, Boston is now witnessing the "substitution effect": because the drug is no longer widely available, OxyContin® abusers are switching to other forms of oxycodone (Percocet®), clonazepam (Klonopin®), fentanyl, or heroin.[E] One respondent explains that OxyContin® abusers are switching to "whatever drug is most available."[N]
- Among methadone treatment admissions, marijuana use declined slightly.[M]
- Gamma hydroxybutyrate (GHB) has become more difficult to purchase.[E]
- Methylenedioxymethamphetamine (MDMA or ecstasy) use increased slightly, but at a slower rate than it has in the past.[E]
- Cocaine (crack and powder) use increased. This resurgence may have occurred because adolescents and young adults who began using heroin several years ago have switched to cocaine use.[E]

Several marketing methods for heroin and cocaine sales have changed:

- Many drug sales have moved indoors to inconspicuous or anonymous places, such as rooftops, hallways, and restaurants.[E]
- Sales are increasingly "underground" and are facilitated by beepers and cell phones.[L]
- Heroin and powder cocaine sales continued to become more decentralized, and the numbers of independent dealers increased.[L,E]
- Polydrug sellers (typically of heroin and crack and powder cocaine) continued to increase.[E]

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



Among methadone treatment admissions, marijuana use declined slightly and benzodiazepine abuse declined dramatically since spring 2002. Among methadone clients new to treatment, powder cocaine use increased slightly.

+Includes any use, whether as a primary, secondary, or tertiary drug; responses for methamphetamine and ecstasy were "very low."

Source: Methadone treatment respondent

THE BIG PICTURE (continued)

The most widely abused drugs in Boston are marijuana (as in 21 other *Pulse Check* cities) and heroin (as in only 6 other *Pulse Check* cities). The drugs related to the most serious consequences include heroin, powder cocaine, and crack. OxyContin®[L,N] and ecstasy[L] abuse and activity continue to emerge.

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

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

Second most widely abused drug:
- Powder cocaine[L,N,M]
- Crack cocaine[E]

Powder cocaine replaced marijuana as the second most widely abused drug.[N]

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

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

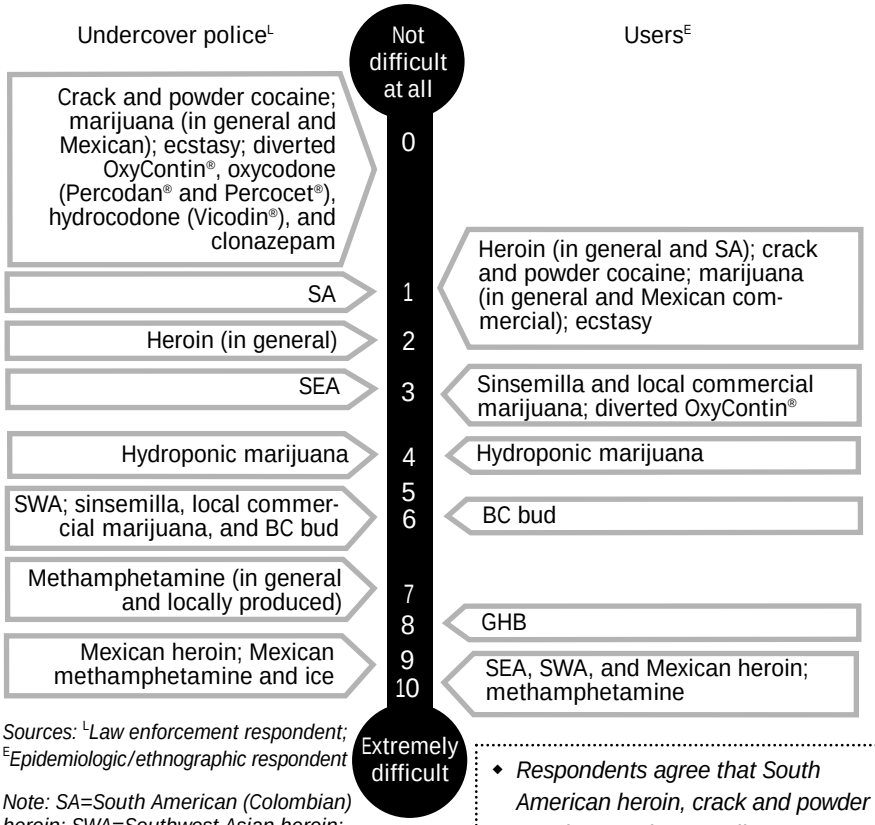
Drug related to the second most serious consequences:
- Heroin[L,E]
- Crack cocaine[N]
- Powder cocaine[M]

Crack replaced powder cocaine as the drug related to the second most serious consequences.[N]

New or emerging problems:
- OxyContin® abuse continues to increase.[L,N]
- Ecstasy use continues to increase.[L]

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

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



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

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

- *Respondents agree that South American heroin, crack and powder cocaine, Mexican marijuana, ecstasy, and diverted OxyContin® are relatively easy to purchase in Boston.*[L,E]
- *As in three other* Pulse Check *cities (Cleveland, Miami, and Washington, DC), users found it more difficult to purchase diverted OxyContin® in fall 2002. Its high price caused demand to drop, which then caused supply to drop. Sales of other diverted oxycodone products, such as Percocet®, have taken the place of OxyContin® sales.*[E]
- *Since spring 2002, users have found GHB harder to purchase.*[E]

HEROIN

- Heroin use remained stable at relatively high levels, with increases among young adult users.[E,N]
- OxyContin® and other prescription opiate abusers are increasingly switching to heroin use.[E]

COCAINE

- Cocaine (crack and powder) use increased between spring and fall 2002. This resurgence may have occurred because adolescents and young adults who began using heroin several years ago have switched to cocaine use.[E]
- Among methadone admissions new to treatment, powder cocaine use increased between spring and fall 2002—a consistent finding across Massachusetts.[M]

MARIJUANA

Marijuana remains one of the most widely used and available drugs in Boston; however, among methadone treatment admissions, marijuana use declined slightly between spring and fall 2002. Moreover, this group of users aged slightly, and males increased dramatically.[M]

METHAMPHETAMINE

Methamphetamine use remains low, and treatment admissions who use methamphetamine are negligible.

MDMA (ECSTASY)

Ecstasy use increased slightly since spring 2002, but at a slower rate than it has in the past.[E] Adolescent use of the drug is increasing at a faster rate than young adult use.

DIVERTED OXYCONTIN®

- While diverted OxyContin® remains somewhat available, abusers found it more difficult to purchase in fall 2002. Its high price caused demand to drop, which then caused supply to drop.[E]
- Because of its high price and decreased availability, abusers have increasingly switched from OxyContin® abuse to other prescription opiate or heroin abuse.[L,E]
- Non-methadone admissions to treatment for OxyContin® ("OCs") abuse have increased slightly, but among the general population, OxyContin® abuse has leveled off.[N]

OTHER DRUGS

- Benzodiazepines: Although benzodiazepine abuse among methadone treatment clients remains relatively high, the proportion has declined dramatically between spring and fall 2002.[M]
- GHB: GHB became harder to purchase between spring and fall 2002.[L]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone respondent is with an inpatient facility that treats adult males and is at 100 percent capacity (33 of 33 slots). Heroin remains the most common primary drug of abuse *(see pie chart on the first page of this chapter)*, and treatment percentages are stable, with the exception of an increase in OxyContin® abuse.[N]
- The methadone treatment respondent is with a facility that operates at about 90 percent capacity (904 of 1,000 slots).[M] Twenty percent of its heroin clients also use powder cocaine, and 18 percent abuse benzodiazepines *(see bar graph on the first page of this chapter)*.
- Methadone maintenance treatment is available throughout the Boston area, but there are waiting lists: 1–2 months for public treatment and 3–4 months for private treatment. Capacity and treatment availability remained stable between spring and fall 2002.[E]

Consequences of drug use

- Hepatitis C and drug overdoses remain the most common drug abuse-related health consequences among non-methadone treatment clients. Hepatitis C detection has increased, most likely due to new and improved testing and increased awareness of the problem. Drug overdoses are most often related to heroin and OxyContin® abuse, typically among young, inexperienced drug users.
- Several drug abuse-related health consequences have declined since spring 2002, including tuberculosis (due to improved testing and treatment) and suicide (due to increased crisis intervention among younger clients).[N]
- Among methadone treatment clients, the most common drug abuse-related health consequence is hepatitis C, which continues to increase, as do related medical problems such as liver cancer. Because the average age of clients is increasing, age-related medical problems have intensified. High-risk pregnancies declined slightly between spring and fall 2002.[M]

Barriers to treatment

- Limited slot capacity remains the number-one barrier to non-methadone treatment, and it has increased as a problem since spring 2002.[N] The lack of residential recovery homes for clients has also increased as a problem.

- Although lack of transportation, money for transportation, and insurance coverage has remained relatively stable as a problem, the methadone treatment respondent believes that in 2003 it may increase due to upcoming cuts in insurance coverage for drug treatment.[M]

Comorbidity and recidivism

- The most common co-occurring disorders among methadone treatment clients remain antisocial or conduct disorders and mood disorders, all of which continue to increase.[M] Psychosis, although occurring at lower levels than conduct and mood disorders, also continues to increase.
- Nearly all primary heroin admissions in the non-methadone treatment program have received treatment (for heroin or any drug) previously, and about 25 percent of methadone clients have received treatment previously.[M]

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	18–30	>30
Mean age (years)	37	30	42.2
Gender	Male	100% male*	58% male
Race/ethnicity	White	White	White
Socioeconomic status	Low	Middle	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Alcohol/drug abuse care provider	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Unemployed	Unemployed

**The non-methadone program serves only males.*

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

- *Sources agree that most heroin users are White males who live in the central city.[E,N,M] Treatment sources agree that most heroin admissions are high school graduates and are currently unemployed.[N,M]*
- *The emerging group of heroin users are Whites who have recently switched from OxyContin® abuse to injecting heroin.[E]*
- *New heroin users are much younger than the general heroin-using population (mean age of 20 years versus 37 years).[E]*
- *Between spring and fall 2002, heroin treatment admissions are younger, and more are referred by the criminal justice system.[N]*

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs taken	Cocaine (speedball); benzodiazepines, prescription opiates, and marijuana	Marijuana (in combination)	Powder cocaine (speedball), crack (sequentially), benzodiazepines ("BZs"), marijuana (in combination)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	In groups	Alone	Alone

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

- *Sources agree that injecting is the most common route of heroin administration in Boston.[E,N,M]*
- *Among young heroin admissions, snorting is the most common route of administration, but these users often switch to injecting as they age.[N]*
- *Speedball injection is common, but the use of crack in speedballs has leveled since spring 2002.[E]*

Who's most likely to use cocaine?

Characteristic	Crack cocaine			Powder cocaine		
	E	N	M	E	N	M
Age group (years)	>18	18–30	>30	>30	>30	>30
Mean age (years)	30	NR	30.1	35	NR	40.2
Gender	60% male	100% male*	55% male	70% male	100% male*	55% male
Race/ethnicity	Black	White	White	White	White	White
Socioeconomic status	Low	Low	Low	Middle	Low, middle	Low
Residence	Central city	Central city	Central city	Suburbs	Central city, suburbs	Central city
Referral source	N/A	Criminal justice, alcohol/drug abuse care provider	Individual	N/A	Alcohol/drug abuse care provider	Individual
Level of education completed	N/A	2-year college	High school	N/A	2-year college	High school
Employment at intake	N/A	Unemployed	Unemployed	N/A	Unemployed	Unemployed

**The non-methadone program serves only males.*

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

- *Cocaine (crack and powder) use increased between spring and fall 2002. This resurgence may have occurred because adolescents and young adults who began using heroin several years ago have switched to cocaine use.*[E]
- *Among methadone admissions new to treatment, powder cocaine use increased between spring and fall 2002—a consistent finding across Massachusetts.*[M]
- *Among methadone treatment admissions, crack and powder cocaine users aged slightly, and females increased (from 40 to 45 percent) between spring and fall 2002.*[M]
- *Two respondents agree that crack users are younger, more likely to live in the central city, and of lower socioeconomic status than powder cocaine users.*[E,N]
- *Other drugs commonly used sequentially with crack or powder cocaine include heroin,*[E,M] *marijuana,*[E] *benzodiazepines,*[E,N] *and prescription opiates.*[E]

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	18–30	18–30	>30
Mean age (years)	25	NR	40
Gender	60% male	100% male*	72% male
Race/ethnicity	White	White	White
Socioeconomic status	Middle	Low, middle	Low
Residence	Suburbs	Central city, suburbs	Central city
Referral source	N/A	Criminal justice (for marijuana sales), alcohol/drug abuse care provider	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Unemployed	Unemployed

**The non-methadone program serves only males.*

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

- *Most marijuana users in Boston are young adult Whites who live in the central city and suburbs.*[E,N]
- *New marijuana users are younger than the general marijuana-using population (mean age of 16 versus 25 years). Marijuana use is on the rise among this new group.*[E]
- *Among methadone treatment admissions, marijuana use declined slightly between spring and fall 2002. Moreover, this group of users aged slightly, and males increased dramatically.*[M]

How do users take marijuana?

Characteristic	E	N	M
Primary delivery vehicle	Joints	Joints	Joints
Other drugs taken	Powder cocaine, OxyContin®, benzodiazepines, ecstasy, lysergic acid diethylamide (LSD)	Phencyclidine (PCP) (in combination)	Heroin (sequentially)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	In groups	In groups	In groups

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

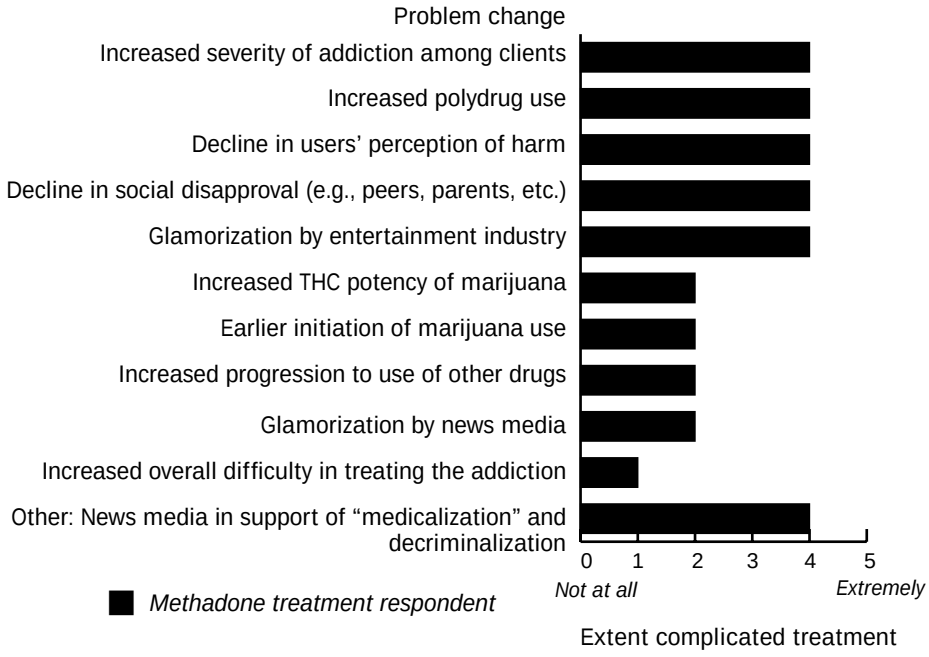
- *Sources agree that joints are the most common route of marijuana administration in Boston.*[E,N,M]
- *New, adolescent marijuana users are switching from joints to blunts and bongs. Typically Whites use bongs, and Blacks use blunts.*[E]
- *Sources agree that other drugs are commonly used with marijuana. The non-methadone treatment respondent states: "By the time marijuana users are referred to treatment, they tend to use many other drugs."*

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

- Drug-related arrests[E]
- Automobile accidents[E,N]
- Short-term memory loss[N,M]
- Deteriorating family or social relationships[E]
- Poor academic performance[M]
- School absenteeism or truancy[E,M]
- Poor workplace performance[M]
- Lack of motivation[M]

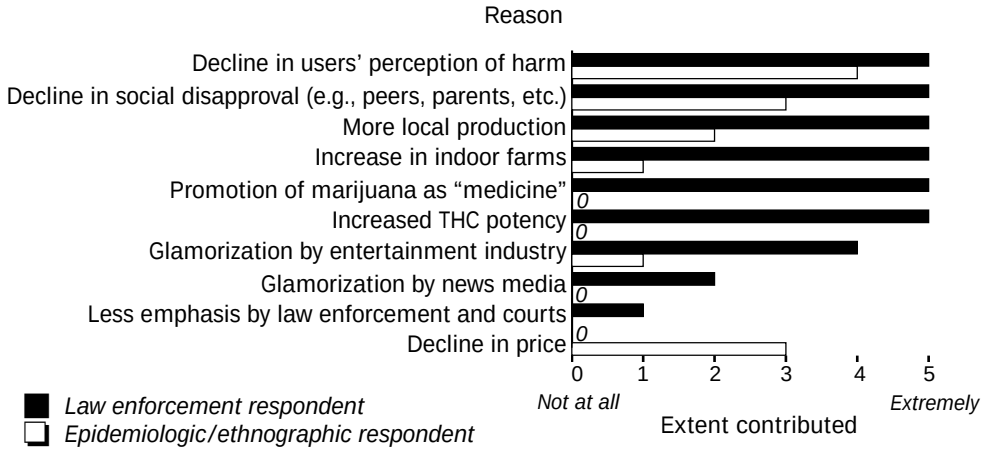
Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



What they have to say...

The methadone treatment source cites several changes as complicating treatment dramatically, including increased severity of addiction among clients, increased polydrug use, decline in users' perception of harm, decline in social disapproval, glamorization by the entertainment industry, and the news media's support of "medicalization" and decriminalization of the drug.[M]

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



What they have to say...
As in nearly all Pulse Check *cities, respondents in Boston agree that declines in users' perception of harm and in social disapproval of marijuana have contributed to widespread use of the drug.*

Who's most likely to use ecstasy?

Characteristic	E
Age group (years)	18–30
Mean age (years)	25
Gender	Split evenly
Race/ethnicity	White
Socioeconomic status	Middle
Residence	Suburbs

Source: [E]Epidemiologic/ethnographic respondent

- *Ecstasy use increased slightly between spring and fall 2002, but at a slower rate than it has in the past.[E] Adolescent use of the drug is increasing at a faster rate than young adult use.*
- *Use among private high school students continues to increase.[E]*
- *Use among the treatment population is very low.[N,M]*
- *Most ecstasy is taken orally, but anecdotal reports of crushing the tablets, adding water, and heating the solution for injection increased. Other drugs, such as heroin and ketamine, are sometimes added to the injectable solution.[E]*
- *Ecstasy is commonly used with marijuana, LSD, GHB, heroin, and ketamine.[E]*

Who's most likely to abuse OxyContin®?

Characteristic	E	N	M
Age group (years)	>18	18–30	>30
Mean age (years)	35	16–30	41
Gender	70% male	100% male*	58% female
Race/ethnicity	White	White	White
Socioeconomic status	Low	Low, middle	Low
Residence	Central city, rural	Central city	Central city

**The non-methadone program serves only males.*

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

- *Although non-methadone admissions to treatment for OxyContin® ("OCs") abuse increased slightly, OxyContin® abuse has leveled off in the general population.[N]*
- *As with non-methadone treatment admissions for heroin, OxyContin® abusers are younger.[N] The ethnographic source states that most emerging OxyContin® abusers are the younger siblings of OxyContin® abusers.*
- *Diverted OxyContin® availability declined, most likely to due to media coverage of its abuse. However, Boston is now witnessing the "substitution effect": because the drug is no longer widely available, OxyContin® abusers are switching to other forms of oxycodone, clonazepam, fentanyl, or heroin.[E] The non-methadone treatment respondent explains that OxyContin® abusers are switching to "whatever drug is most available."*
- *Oral administration is the most common route of OxyContin® administration, followed by snorting and injecting.[E] The methadone treatment respondent reports the common practices of snorting crushed tablets and injecting the drug by crushing tablets, shaking the powder in cold water, and cooking the solution (a process known as "cold shake").*

WHO'S MOST LIKELY TO USE OTHER DRUGS?

- Methamphetamine: Use and treatment admissions are low in Boston, with the exception of sporadic reports of methamphetamine use among gay couples.[E]
- Benzodiazepines (Alprazolam [Xanax®] and clonazepam [Klonopin]®): Nearly 20 percent of methadone treatment clients also abuse benzodiazepines, but that proportion declined dramatically between spring and fall 2002. Benzodiazepine use among females declined, possibly because females are more compliant than males with a new policy of the treatment program: clients who use benzodiazepines without a prescription are eventually discharged.
- GHB: Use is relatively low, but reported as common among strippers.[E]
- Promethazine (Phenergan®): Methadone clients abuse this phenthiazine, known as "finnegan," to potentiate their methadone.[E]
- Barbiturates: Methadone clients abuse barbiturates, such as phenobarbital and migraine medications, by combining them with opiates. About 3 percent of methadone clients (a stable percentage between spring and fall 2002) abuse them as secondary or tertiary drugs.[M]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS SOLD?

All drugs available in Boston—including heroin, crack, powder cocaine, marijuana, methamphetamine (when available), diverted OxyContin®, ecstasy, and GHB—are sold in private residences, at private parties, or inside cars.[L] All drugs available, except for club drugs, are sold on the streets and around public housing developments.[L,E] In addition to the settings listed above, heroin, crack, powder cocaine, and marijuana are also sold in crack houses and shooting galleries, playgrounds and parks, and around supermarkets.[L]

Drug sales in high schools and on college campuses are common for powder and crack cocaine, marijuana, ecstasy, and diverted OxyContin®. Drug sales in nightclubs and bars, raves, and concerts are common for powder and crack cocaine, marijuana, methamphetamine, ecstasy, diverted OxyContin®, and GHB. Powder cocaine, marijuana, and ecstasy are sometimes sold via the Internet.[L]

The epidemiologic respondent claims that many drug sales have moved indoors to inconspicuous or anonymous places, such as rooftops, hallways, and restaurants.

HOW DO DRUGS GET FROM SELLER TO BUYER?

According to the law enforcement source:

Heroin, powder and crack cocaine, marijuana, and diverted OxyContin® are sold in a similar manner: a dealer has a small customer or clientele list, a buyer on the list contacts a dealer via beeper or cell phone, and the dealer delivers the drug to the buyer's residence. The small size of the clientele list protects dealers from law enforcement. These sales are increasingly "underground" and are facilitated by beepers and cell phones.

Methamphetamine and GHB are sold hand to hand via acquaintance networks. Most ecstasy is sold around schools via acquaintance networks, typically before the drugs are used in nightclubs and bars.

According to the epidemiologic source:

Buyers collect lists of phone numbers of active heroin and cocaine dealers. When buyers want these drugs, they call a dealer to arrange a meeting for the exchange of the drug indoors.

In the central city, heroin and powder cocaine sales take place in open-air markets, but these markets have become decentralized in the past few years. Thus, the introduction of beepers and cell phones to set up meetings between buyers and sellers in public places has occurred. In the suburbs, meetings for the exchange of powder cocaine are more "casual" and take place almost exclusively in apartments.

Marijuana and ecstasy sales are similar to the delivery method for heroin and cocaine sales, but meetings for the exchange of marijuana and ecstasy usually take place in private residences of buyers or sellers.

WHO SELLS DRUGS?

The law enforcement source states that most drug sellers in Boston are independent adults who sell only one type of drug.

The epidemiologic source states that heroin and powder and crack cocaine sellers fall into two groups: independent adults older than 30 and organized young adults, with an increase in the numbers of independent sellers and addicts who support their habits via drug sales. Over the past 2 years, polydrug sellers (typically of heroin, crack, and powder cocaine) have increased.

Marijuana, ecstasy, and diverted OxyContin® sellers are independent young adults.[E]

How is OxyContin® diverted and sold illegally?

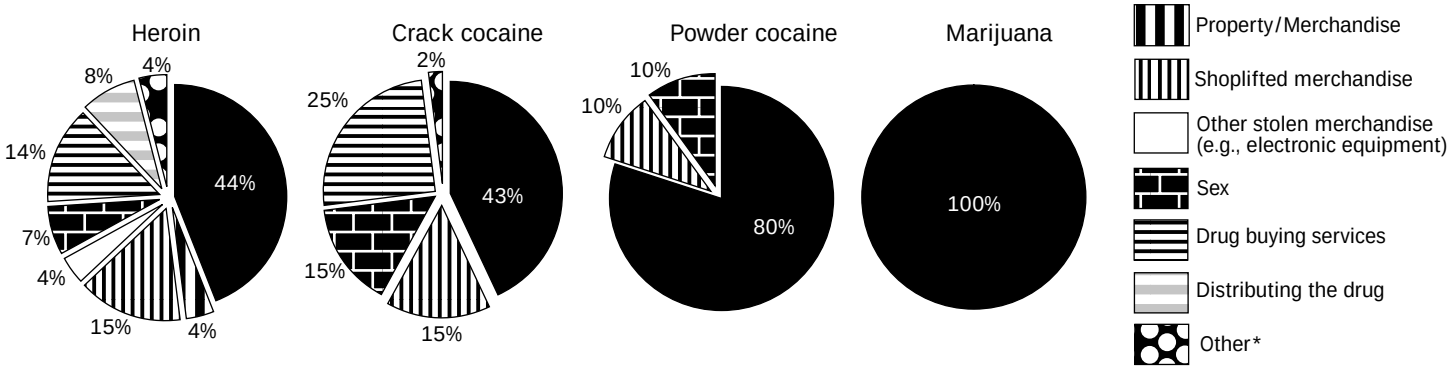
OxyContin® is diverted in a variety of ways:

- Unscrupulous doctors, some who exchange OxyContin® prescriptions for sex[L,E]
- "Doctor shopping"[L]
- Doctors who misprescribe the drug[L]
- Pharmacy robberies[L]
- Falsified prescriptions[L]
- Prescription thefts from individuals[L]

Additionally, OxyContin® is obtained from local health providers who prescribe it to people with legitimate ailments. These people use part of the drug and sell part of it illegally.[N] A new way to divert OxyContin® has emerged in fall 2002: well-dressed people pose as prospective real estate clients. When a real estate agent shows a "client" a house, the client rifles through medicine cabinets to steal OxyContin®.[L]

Fortunately, pharmacy robberies continue to decline, and many pharmacies now display signs stating that they no longer sell OxyContin®.[L,E,N]

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



- *As in most* Pulse Check *cities, cash is the most common means of exchange for illegal drugs in Boston. However, drug buying services, shoplifted merchandise, and sex are relatively prevalent as modes of exchange for heroin and crack cocaine.*
- *The ethnographic source notes that shoplifted merchandise is usually exchanged for cash, which is then used to buy illegal drugs.*[E]

** "Other" includes items accounting for 2 percent or less of transactions for each of the five drugs, such as transporting the drug, stealing the drug, food stamps, and injecting services.*

Source: Mean of response ratings given by epidemiologic/ethnographic and methadone treatment respondents; the methadone treatment respondent provided percentages only for heroin exchanges.

How much does South American heroin* cost?

Unit	Price
One bindle (0.1 g)	$4–$6[L]
One bag	$10[M]
0.5 g	$50–$75[E]
One bundle (10 bags)	$80[E]
1 g	$80–$150[E]

**Purity 60–96%*[L,E]

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

- *Between spring and fall 2002, the most common unit of heroin sold declined in quantity from 1 to 0.5 grams.*[E]
- *Smaller quantities of heroin declined in price (from $100–$150 to $80–$150 per gram). This may be a marketing ploy for new buyers.*[E]
- *Over the last 10 years, heroin prices declined (from $20 to $10 per bag—a lower price than for prescription opiate pills).*[M]

How much does cocaine cost?

Form	Unit	Price
Crack	One "jum" (small rock, 0.1 g	$10[L]
	One "bump," "jum" (approximately four hits)	$20–$40[E]
	1 g	$50–$60[E]
Powder	0.25 g	$20[E]
	1 g	$50–$60[E]
	Eightball (4 g)	$200–$250[L]

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

Crack and powder cocaine prices remained relatively stable between spring and fall 2002.[L,E]

How much does marijuana cost?

Unit	Price
0.125 oz	$20[E]
0.33-oz bag	$50[E]
1 oz	$100–$125[E] $325[L]

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

- *Marijuana prices increased dramatically since the last* Pulse Check.[L]
- *The number of indoor grows ("hydrogrows"), the amount of marijuana grown, and the level of THC continues to increase.*[L]

How much do various other drugs cost?

Drug	Unit	Price
Methamphetamine	1 g	$100[L]
Ecstasy	One pill or tablet	$20–$25[L,E]
Diverted OxyContin®	20-mg pill 80-mg pill	$10–$20[E] $80[L]
Oxycodone (Percocet®)	5-mg pill	$5[E]
Special K	One capful One bottle (1 oz)	$5[L] $50[L]

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

- *Nearly all prices for other drugs remained stable.*
- *Although ecstasy prices are stable, undercover officers "continue to see more of it."*[L]

Which drug sellers are associated with which crimes?

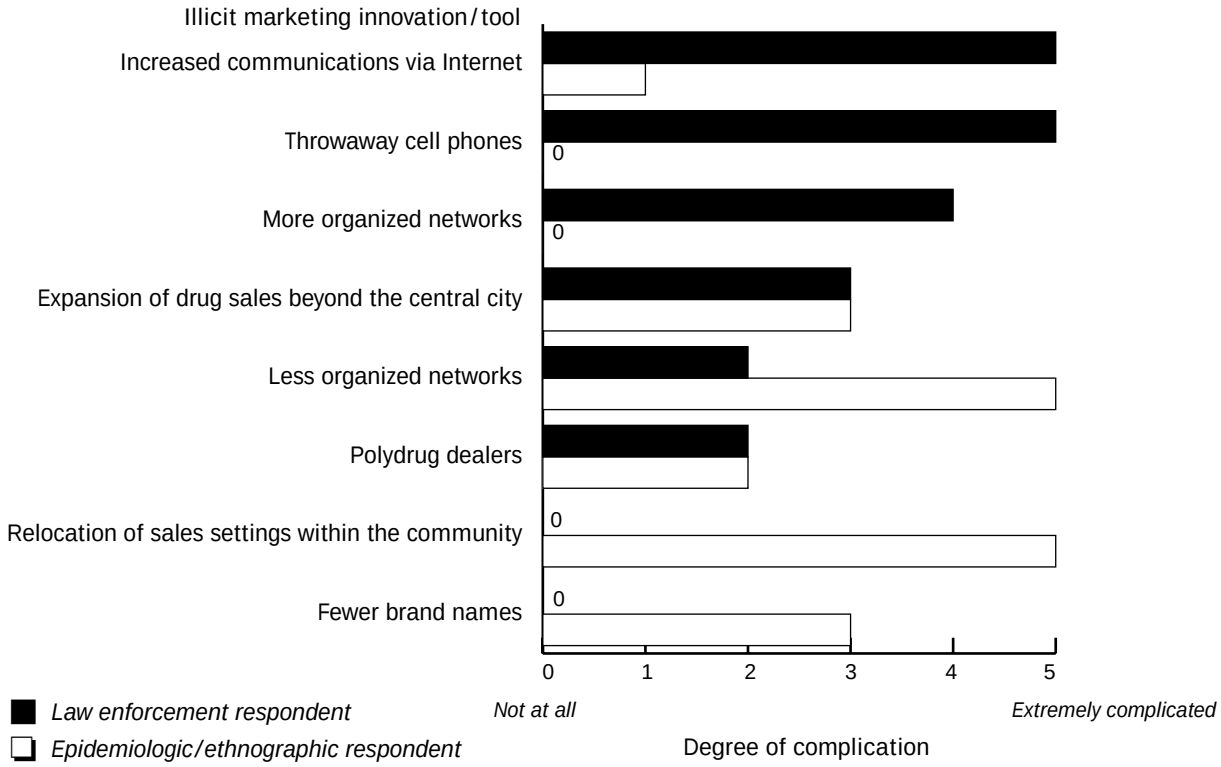
Crime	Heroin	Crack cocaine	Powder cocaine	Marijuana	Metham-phetamine	Ecstasy	Diverted OxyContin®
Prostitution	✓	✓	✓				
Gang-related activity	✓	✓	✓				
Violent criminal acts (armed robbery, assault and battery, extortion)	✓	✓	✓		✓		✓
Nonviolent criminal acts: (shoplifting, petty theft, petty embezzling[E]; robberies, prescription theft, larceny, forged prescriptions[L])		✓		✓		✓	✓
Domestic violence	✓	✓	✓		✓		
Drug-assisted rape					✓		
No crimes associated				✓		✓	

Sources: Law enforcement and epidemiologic/ethnographic respondents

- *Illegal drug sales in Boston are associated with a wide variety of crimes, including prostitution, gang-related activity, armed robbery, extortion, assault, petty theft, shoplifting, larceny, and domestic violence.*[L,E]
- *Crack dealers (especially young adults) are more involved in crimes than any other drug dealers.*[E]

THE MARKET PERSPECTIVE: A 10–YEAR VIEW

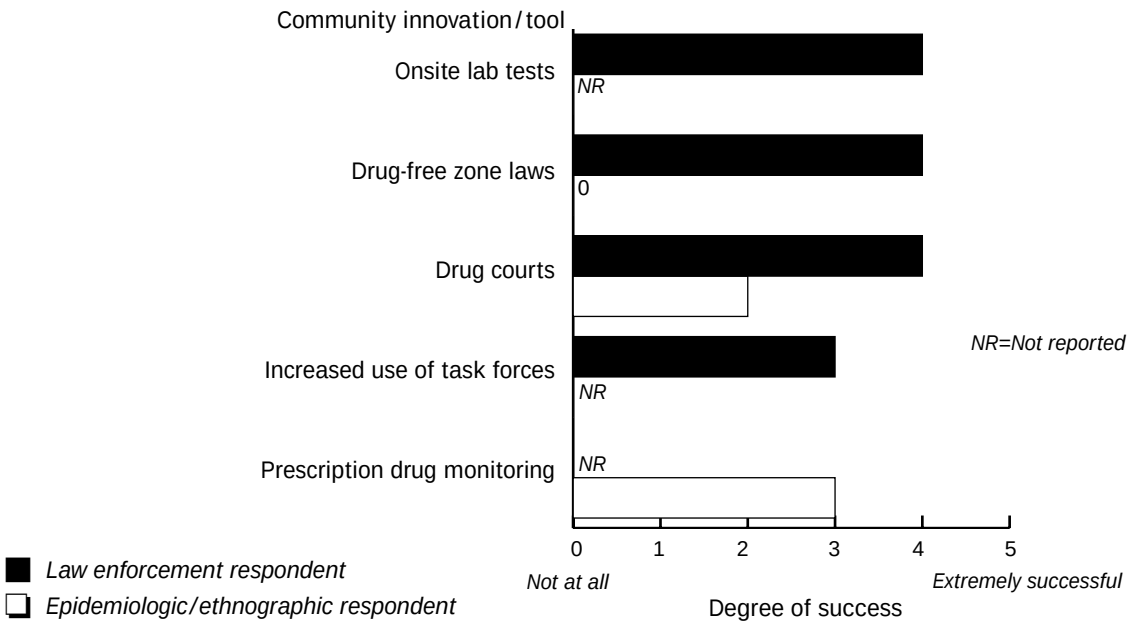
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in Boston?



What they have to say...

- *Less organized networks: Networks are more fragmented now, which has led to fewer police informants.*[E]
- *Fewer brand names: The decline in the use of brand names for illegal drugs has made it more difficult for law enforcement to connect certain drugs to specific dealers.*[E]
- *Polydrug dealers: As reported in the "Who Sells Drugs?" section, dealers who sell both heroin and cocaine have increased over the past 2 years.*[E]

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



What they have to say...

- *Task forces: Although task force use has not increased over the past 10 years, task forces include interaction between local and State police, the Federal Bureau of Investigation (FBI), and the Drug Enforcement Administration (DEA). As in most other* Pulse Check *cities, the law enforcement source rates task forces as relatively successful in combating drug abuse.*
- *Prescription drug monitoring: OxyContin® has become harder to obtain from pharmacies due to the increased attention paid to the problem by pharmacists.*[E]
- *Drug courts: The epidemiologic source believes that drug courts are especially effective for middle class people with low levels of drug dependency, solid support systems, high education levels, and high chances of employment.*[E]

SEPTEMBER 11 FOLLOWUP

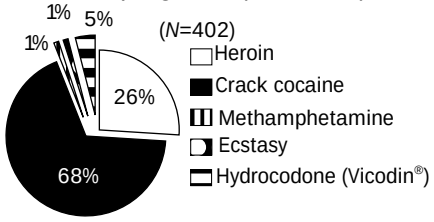
All four Boston *Pulse Check* sources believe that the September 11 attacks and their aftermath have had no effects on the drug abuse problem.[L,E,N,M]

CHICAGO PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 8,272,768
- Median age: . . . . . 33.7 years
- Race (alone):
  - White 65.8%
  - Black 18.9%
  - American Indian/ Alaska Native 0.3%
  - Asian/Pacific Islander 4.6%
  - Other race 8.2%
  - Two or more races 2.3%
- Hispanic (of any race): 17.1%
- Unemployment rate: 6.2%
- Median household income: $51,680
- Families below poverty level with children <18 years: 11.4%

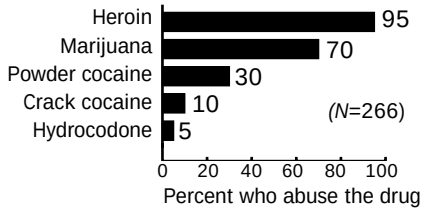
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



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

Source: Methadone treatment respondent

- *The use of methadone as a substitute for heroin, or in addition to heroin, emerged as a new problem among non-methadone treatment clients.*[N]
- *The use of crack cocaine among methadone treatment clients decreased somewhat, but the use of powder cocaine and marijuana increased slightly between spring and fall 2002.*[M]

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

All four *Pulse Check* respondents agree that Chicago's drug problem is stable. However, they also believe it remains very serious. Despite the overall stability in the drug problem, several developments are reported since spring 2002:

- As reported in eight other *Pulse Check* cities, methadone abuse (both as a substitute for and in addition to heroin) is increasing.[N] It accounts for 5 percent of treatment clients in both the non-methadone and methadone programs.[N,M]
- While the numbers of methamphetamine[L,E,N] and methylendioxymethamphetamine (MDMA or ecstasy)[L,N] users numbers remain low, they are increasing.
- Marijuana use among methadone clients is emerging as a new treatment problem.[M]
- As in many other *Pulse Check* cities, the incidence of hepatitis C among treatment clients has increased to high levels.[N,M]
- Treatment providers observe a dramatic increase in high-risk sexual behaviors and drug use.[N]

The drug market (especially for heroin) has also changed in several ways:

- Overall, drugs have become more available since spring 2002 *(see diagram on the following page)*.[L,E]
- Seizures of brown heroin, presumably Mexican, are up 50 percent from 2001; however, white heroin still accounts for the bulk of heroin available on the street.[L]
- The Drug Enforcement Administration (DEA) recently seized a small sample of base heroin (not hydrochloride), which is common in Europe. When smoked, this base form delivers the drug almost as quickly as injected heroin.[E]
- DEA data indicate an increase in the amount of methamphetamine arriving from Mexico.[E]

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

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

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

Between spring and fall 2002, powder cocaine replaced crack as the second most widely abused drug among methadone clients.[M]

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

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

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

Between spring and fall 2002, powder cocaine replaced crack as the drug related to the second most serious consequences among methadone clients.[M]

New or emerging problems:
- Methamphetamine[L,E,N]
- Ecstasy[E,M]
- Diverted OxyContin® (oxycodone hydrochloride controlled-release)[N]
- Abused methadone[N]
- Marijuana[M]

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

Overall, the heroin problem is fairly stable, but some increases are noted:

- The number of younger heroin users entering treatment has increased. These clients are typically referred by the mental health system.[N]
- Heroin use among the overall drug-using population and among new drug users appears to be increasing.[E]

COCAINE

The cocaine problem is stable in Chicago, although treatment providers note two changes:

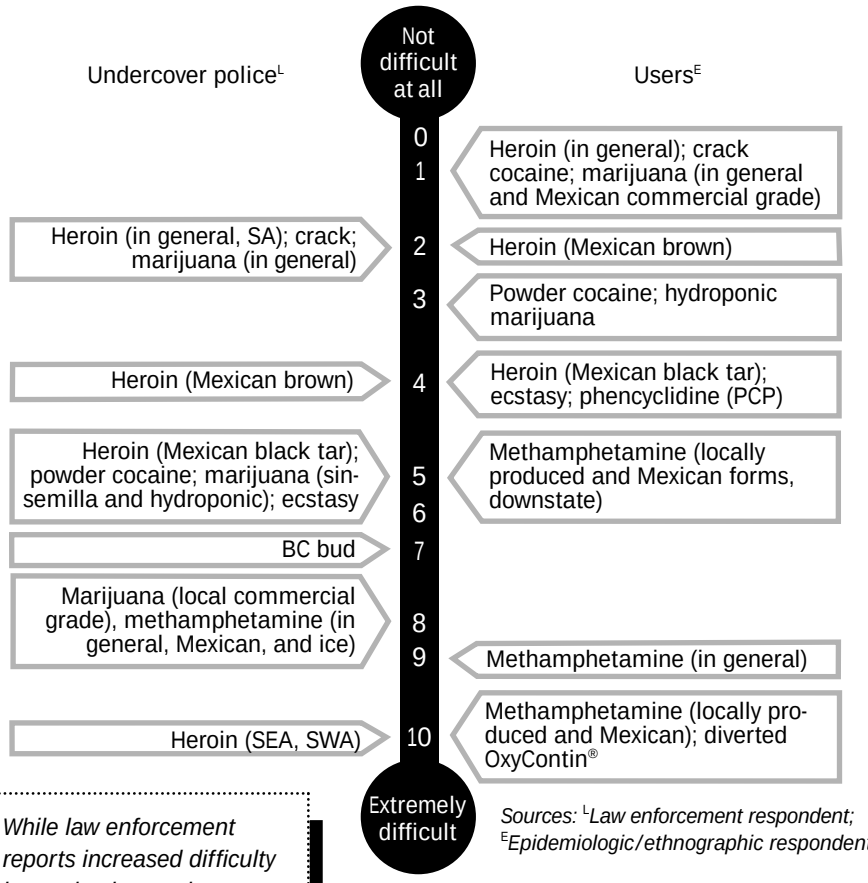
- Among primary heroin users in treatment, those also using crack cocaine have decreased since spring 2002, while those using powder cocaine have increased.[M]
- More sales of crack cocaine take place within the community, as opposed to traditional drug markets.[N]

MARIJUANA

Several increases are noted among marijuana users in treatment:

- Hospital emergency department mentions for marijuana remain stable.[E]
- The number of adolescents and young adults using marijuana is increasing.[N]
- Heroin users in treatment have increased their use of marijuana as a secondary or tertiary drug.[M]
- The rate of depression and generalized anxiety disorder has increased significantly among primary marijuana users in the non-methadone treatment program.[N]

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



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

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

- *While law enforcement reports increased difficulty in purchasing methamphetamine, users report that it is becoming easier.*[L,E]
- *It is more difficult for undercover agents to purchase ecstasy.*[L]
- *Undercover law enforcement found it easier to purchase Mexican brown heroin in the fall.*[L] *Even though it is still relatively difficult to find Mexican brown heroin on the street, users know where to find it.*[E]
- *Purchasing sinsemilla and hydroponic marijuana has become less difficult.*[L]
- *It has become easier for users to purchase powder cocaine.*[E]

METHAMPHETAMINE

The methamphetamine problem in Chicago is small, but growing:[L,E,N]

- The number of methamphetamine users in treatment has increased somewhat, although the numbers remain very low *(see pie chart on the first page of this chapter)*.[N]
- Methamphetamine use in Chicago's gay male community is increasing.[E]
- Law enforcement agencies seized 53 kilograms of methamphetamine in Chicago during 2002.[L]

MDMA (ECSTASY)

While overall use of ecstasy remains low,[E,N] the number of ecstasy users in treatment is increasing.[N]

OTHER DRUGS

- Diverted OxyContin®: While the number of clients in treatment remains negligible (less than 1 percent of the treatment population), the number seeking treatment for abuse of OxyContin® has increased slightly since spring 2002.[N]
- Diverted hydrocodone (Vicodin®): A slight increase in clients seeking treatment for hydrocodone use is noted.[N] These clients generally receive the drug for treatment of chronic pain, but become addicted and then seek to purchase it illegally.[N] Five percent of non-methadone and methadone treatment clients use the drug—more than those in treatment for methamphetamine, ecstasy, or diverted OxyContin® combined.[N,M]
- Diverted methadone: Treatment providers report a high level of illegal methadone use among clients[N,M]—representing 5 percent of methadone treatment clients.[M]
- Phencyclidine (PCP): Use of PCP is stable, and remains most common among young adult males living in the central city.[E]
- Diverted alprazolam (Xanax®): Abuse of alprazolam is also stable. The drug is abused equally among males and females and among Whites, Blacks, and Hispanics. These users, who take alprazolam along with alcohol, are typically lower income adults living in the central city.[E]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone treatment facility can serve 498 clients and has a current enrollment of 402. For these clients, the primary drug of abuse is crack cocaine, with heroin the distant second *(see pie chart on the first page of this chapter)*. Treatment percentages for methamphetamine, ecstasy, diverted OxyContin®, hydrocodone, and methadone have all increased between spring and fall 2002, but they remain extremely low when compared with those for heroin and cocaine.[N]
- The methadone treatment facility has the capacity to serve 253 clients. It is currently operating over capacity, serving 266. Ninety percent of clients in the methadone treatment program are self-referred, similar to the generally high self-referral rates in methadone clinics across other *Pulse Check* sites.[M]
- Funding cuts and the closing of two major Chicago hospitals (which served indigent high-risk patients) have made already limited slot capacity an even greater barrier to treatment in the community.[N] The waiting list at most public clinics is at least a month, while most private programs have adequate slots available.[E]

Barriers to treatment

- Age restrictions became a more significant barrier to drug treatment because of the increase in juveniles needing such treatment.[N]
- The lack of child care remains a common barrier to treatment in the non-methadone program, despite the fact that the facility has an onsite licensed day care program. There are not enough slots in the facility to meet demand.[N]

Post-treatment Issues

- Most clients have no safe place to go following treatment, so they end up living with old friends who are users or dealers, which places them back into their old living patterns.[N,M]
- Currently, there are not enough tailored recovery support services for men, particularly fathers.[N]
- Recovering users who are also ex-offenders find it difficult to secure jobs following treatment, leading to continued instability and stress.[N]

Consequences of drug use

- Hepatitis C is pervasive among clients in treatment, having increased since spring 2002.[N,M] "Just about everyone [in the methadone program] is positive."[M] Fortunately, testing is now more widespread,[M] with the non-methadone program offering onsite testing.[N]
- The number of clients reporting drug-related automobile accidents increased, corresponding to an increase in DUI (driving under the influence) arrests in the State.[N]
- The number of HIV-positive clients has increased since the spring in the non-methadone program, likely due to the start of onsite testing and, therefore, increased diagnoses.[N]
- The incidence of tuberculosis among treatment clients is also up since spring 2002, although it is still not very common.[M]
- The methadone treatment respondent assesses clients as being more physically ill than in the past. This is due partly to clients with undiagnosed hepatitis C and to HIV-positive clients who are living longer but are declining in health. A positive effect, however, is that through drug treatment, these

individuals gain access to primary health care facilities.[M] Poor dental hygiene is becoming more common as well.[N]

Co-occurring disorders

- A lack of staff qualified to treat dually diagnosed clients has increased as a significant barrier to effective treatment. The increase in comorbidity over the past year puts more pressure on existing staff,[N] and it is difficult to find qualified mental health professionals willing to work for the pay available in drug treatment settings.[M]
- The rate of psychiatric diagnoses among treatment clients increased to extremely high levels in the non-methadone program. This increase includes antisocial, conduct, and mood disorders, as well as psychosis, suicidal thoughts/attempts, post-traumatic stress disorder (PTSD), and attention deficit hyperactivity disorder (ADHD). The increase is due to many factors: better screening and identification of mental disorders, decreased slots available within the mental health system, and—with respect to PTSD—trauma related to a drug lifestyle.[N]
- The rate of dual diagnoses among methadone treatment clients remained stable at low levels, with the exception of mood disorders, which remained stable at high levels.[M]

Changes over the past 10 years

- Treatment respondents note that during the past decade, youth began using more dangerous drugs, particularly heroin.[N,M] The methadone respondent estimates that, among drug-using teenagers, 30 percent use heroin regularly, compared with none 10 years ago.[M]
- As in several other *Pulse Check* cities, the declining cost of drugs represents a significant complication to Chicago's drug problem.[N,M] A rock of crack costs just $2,[N] and heroin has become inexpensive enough for more people to use it in greater amounts.[M]
- Chicago's drug problem is further complicated by the increased practice of polydrug use, particularly the combination of heroin and cocaine.[N]
- Increasing caseloads are a major obstacle to treating the community's drug problem, as is the case in several other *Pulse Check* cities.[N,M]

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	18–30, >30	>30	>30
Mean age (years)	35	31	39
Gender	65% male	52% female	Split evenly
Race/ethnicity	Black	Black	Black
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Individual	Individual
Level of education completed	N/A	None	High school
Employment at intake	N/A	Unemployed	Unemployed

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

- *Younger heroin users have entered treatment since spring 2002.*[N]
- *The number of female heroin users entering treatment increased at the non-methadone program. The respondent attributes this to the availability of programs for females at their facility.*[N]

- *The epidemiologic respondent notes that nearly all new users begin by snorting heroin, particularly new White users, but many soon shift to injecting. Young Blacks, however, tend to continue snorting the drug.*[E]
- *Speedballing may be more prevalent among Black than among White users.*[E]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Snorting and injecting	Snorting	Snorting
Other drugs taken	Powder and crack cocaine (speedball)	None	Powder cocaine (speedball)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	Alone and in groups	Alone	Alone

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

Who's most likely to use cocaine?

	Crack			Powder cocaine	
Characteristic	E	N	M	E	M
Age group (years)	>30	>30	>30	>30	>30
Mean age (years)	38	31	39	NR	39
Gender	60% male	52% female	Split evenly	60% male	Split evenly
Race/ethnicity	Black	Black	Black	NR	Black
Socioeconomic status	Low	Low	Low	Low	Low
Residence	Central city	Central city	Central city	Central city	Central city
Referral source	N/A	Individual	Individual	N/A	Individual
Level of education completed	N/A	None	High school	N/A	High school
Employment at intake	N/A	Unemployed	Unemployed	N/A	Unemployed

Note: The non-methadone respondent did not provide information for powder cocaine.

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

Sources report two shifts in cocaine use between spring and fall 2002:

- *Powder cocaine users report an increase in smoking rather than snorting the drug.*[M]
- *More treatment clients report using marijuana along with crack than in spring 2002. This may be attributable to more crack being distributed in traditional marijuana settings.*[N]

- *As in nearly all* Pulse Check *cities, marijuana use occurs in all segments of society.*
- *The number of clients entering treatment for marijuana has increased since the spring. This increase is predominantly among adolescents—the rate of primary marijuana use among adolescents in treatment is 6 percent, compared with less than 1 percent for the overall treatment population.*[N]
- *While most clients enter treatment on their own initiative, an increasing number come from mental health centers, particularly individuals diagnosed with generalized anxiety disorder.*[N]
- *Marijuana users are smoking more joints laced with PCP.*[E]

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	18–30	18–30	18–30
Mean age (years)	Twenties	NR	NR
Gender	Split evenly	60% male	Split evenly
Race/ethnicity	Split evenly: White, Black, and Hispanic	Black	Black
Socioeconomic status	All	Low	Low
Residence	All areas (city, suburbs, rural, areas)	Central city	Central city
Referral source	N/A	Individual	Individual
Level of education completed	N/A	None	High school
Employment at intake	N/A	Unemployed	Unemployed

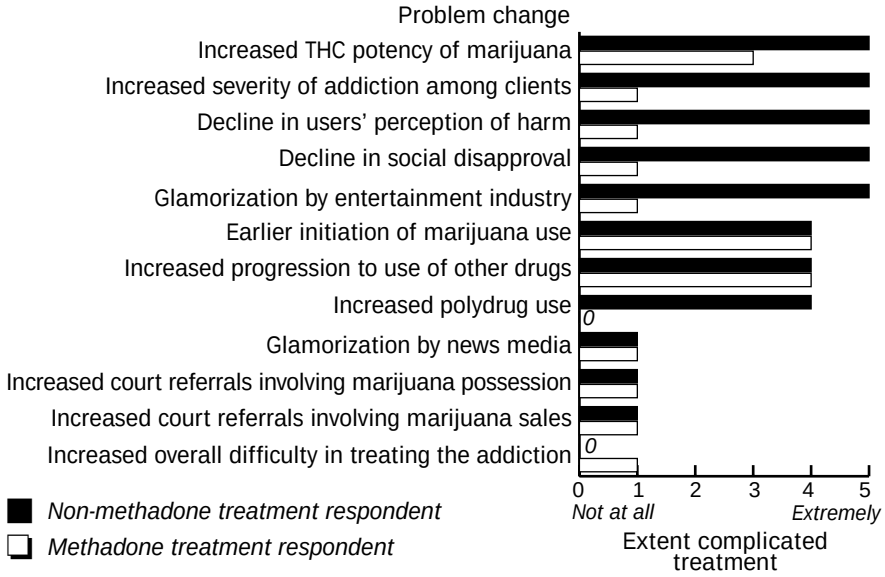
Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

- Drug-related emergency department visits[E]
- High-risk pregnancies[N]
- Short-term memory loss[N]
- Dual diagnoses, particularly depression and anxiety[N]
- Deteriorating family and social relationships[M]
- Poor workplace performance[M]
- Workplace absenteeism[M]
- Unemployment rates[M]

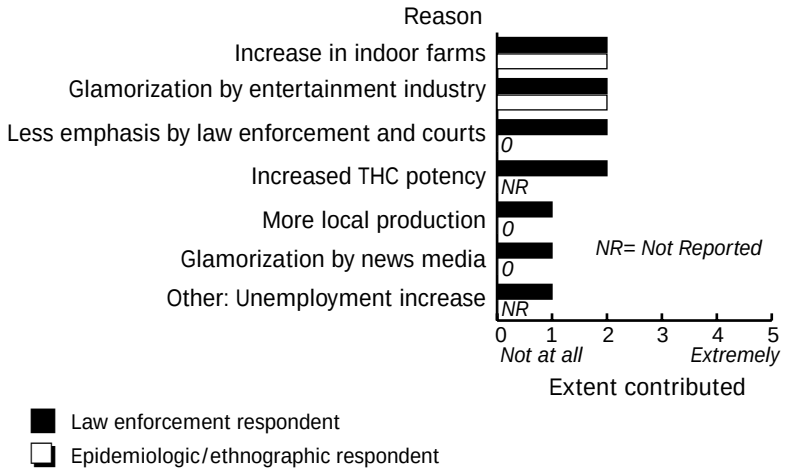
Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



What they have to say:

- *Perception of harm: As with many other* Pulse Check *cities, the decline in both users' perception of harm and social disapproval associated with marijuana has significantly complicated the treatment of marijuana-using clients.*[N]
- *Progression from marijuana to other drugs: Rather than alcohol serving as a gateway to marijuana use, marijuana now appears to be a gateway drug to alcohol.*[M]
- *Entertainment industry: The music industry—rap in particular—has glamorized marijuana use, making treatment of marijuana-using clients much more difficult.*[N]
- *Polydrug use: The increased polydrug use by marijuana users over the past 10 years is seen most often in the combination of crack with marijuana.*[N]

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



What they have to say...

- *Emphasis by law enforcement and courts: Chicago is one of four* Pulse Check *cities where sources believe law enforcement emphasis on marijuana has not declined. Rather, law enforcement has played a positive role in the situation by sending more marijuana users to treatment over the past 10 years.*[E]
- *Glamorization: Normalization, more than glamorization, of marijuana use by the entertainment industry contributes to the increased availability and use of the drug.*[E]

Who's most likely to use methamphetamine?

Characteristic	E	N
Age group (years)	18–30	18–30
Gender	Male	95% male
Race/ethnicity	White	White
Socioeconomic status	Low/middle	Middle
Residence	Rural areas	Central city
Referral source	N/A	Mental health system
Level of education completed	N/A	High school
Employment at intake	N/A	Full time

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

- *Compared with the overall treatment population at the non-methadone treatment program, methamphetamine users are more likely to be male, White, middle class, better educated, and employed full time.*[N]
- *The proportion of White users in treatment for primary methamphetamine use is higher than their proportion in the overall Chicago population.*

Who's most likely to use ecstasy?

Characteristic	E	N
Age group (years)	18–30	18–30
Mean age (years)	25	NR
Gender	Split evenly	95% male
Race/ethnicity	White	White
Socioeconomic status	Middle	Middle
Residence	Suburbs	Central city
Referral source	N/A	Mental health system
Level of education completed	N/A	High school
Employment at intake	N/A	Full time

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

- *In contrast to the overall treatment population at the non-methadone treatment program, ecstasy users are predominantly White, middle class, better educated, and employed full time.*[N]
- *Generally, ecstasy users do not combine ecstasy with other drugs,*[N] *but some occasionally take it with nitrous oxide.*[E]
- *Unlike primary users of most other drugs, ecstasy users most often take the drug in public.*[N]
- *The proportion of White users in treatment for primary ecstasy use is higher than their proportion in the overall Chicago population.*

WHO'S MOST LIKELY TO USE OTHER DRUGS?

- Methadone: Abusers of methadone range from young adults to older adults, are generally Black, and are split nearly evenly between males and females.[N]
- Hydrocodone: Abusers of hydrocodone are typically young adults and adults.[N,M] While abusers in non-methadone treatment are predominantly male, White, and middle class,[N] abusers in the methadone program are split evenly between males and females, and most are Black and of low socioeconomic status.[M]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

While the overall heroin-using population purchases the drug in the streets, private residences, public housing developments, playgrounds and parks, and around supermarkets, new heroin users purchase the drug either in street markets or private residences.[E] Heroin appears to be the only drug still sold in crack houses or shooting galleries in Chicago.[L]

Cocaine is sold in most of the same settings as heroin, and also in school settings and on college campuses.[L]

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

Marijuana is generally used and sold in the streets/open-air markets, private residences, and public housing developments; on college campuses; and at private parties.[L,E] It is also sold in nightclubs/bars and at raves and concerts.[L]

The majority of methamphetamine transactions occur in private residences, but new and emerging users are also buying and using in nightclubs and bars.[E]

Ecstasy is typically sold and used in private residences, nightclubs, and bars; at raves and concerts; and on college campuses. The drug is also sold, but not used, in open-air markets, in school settings, and through package deliveries.[L,E]

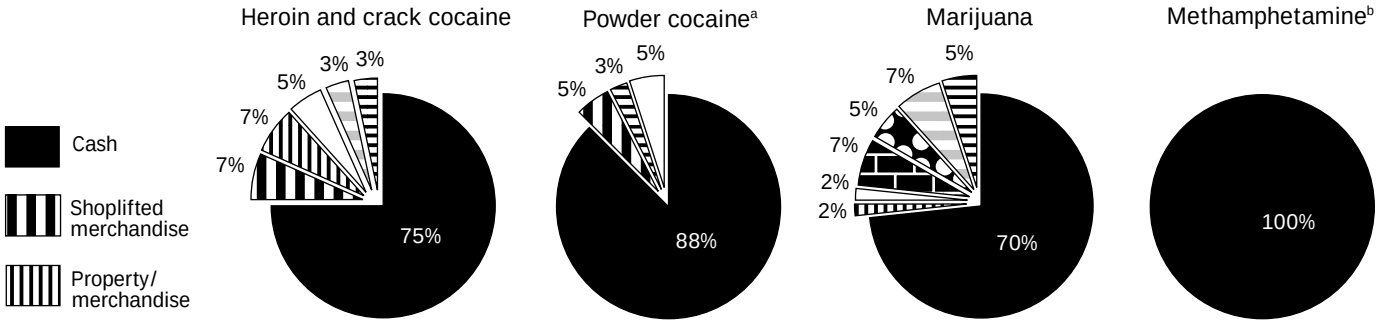
HOW DO DRUGS GET FROM SELLER TO BUYER?

- The same dealers generally sell both heroin and cocaine, but most transactions involving heroin and crack take place in the central city, while powder cocaine is sold in all areas of the city.[E] Most of these transactions occur face-to-face through prearranged meetings. Cell phones, beepers, and pagers are common tools for communications between seller and buyer.[L,E]

Cocaine buyers also know where they can go to purchase the drug on the street without prior arrangements.[E]

- Marijuana sales take place in all areas of Chicago—central city, suburbs, and rural areas. Dealers sometimes conduct business on the same street where heroin and cocaine are sold, but they are generally not involved in the sale of the other drugs.[E]
- For heroin, cocaine, and marijuana, several layers of people tend to be involved in the transactions. For example, a buyer may go to one location to ask for the drug, follow directions to another location to pay, and then meet someone else to take possession of the drug. These transactions take place in either fairly open street settings or in more discreet locations such as stairwells, particularly in public housing areas.[L]
- Methamphetamine sales occur primarily in the central city, either through meetings arranged via telephone or in social settings between seller and buyer.[E] The number of meth labs operating in Chicago is believed to be very small; law enforcement has not seen any new meth production since a number of seizures in spring 2002.[L]
- Dealers sell ecstasy in both the central city and the suburbs through prearranged meetings, friend/acquaintance networks, on the street, or by simply walking around semipublic settings such as nightclubs or raves.[L,E] In the latter case, "hawkers" walk through the setting announcing "caps" or "rolls" to advertise their product.[E] These dealers often sell gamma hydroxybutyrate (GHB) and lysergic acid diethylamide (LSD) along with ecstasy. Ecstasy transactions that do take place on the street are usually in different locations from heroin and crack sales.[L]
- Law enforcement officials occasionally identify OxyContin® being diverted through the postal system, but they have not detected traditional dealing of the drug.[L]
- Most drug seizures by the DEA involve truckloads of multiple drugs—mostly heroin and cocaine, as well as methamphetamine.[E]

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



What they have to say...

- *The practice of exchanging heroin for injecting services has declined significantly over the past 10 years because needle exchange programs have made shooting galleries "irrelevant."*[E]
- *While the practice of sex-for-drugs is nonexistent among male crack cocaine users, this practice accounts for up to 20 percent of crack cocaine purchases by females, similar to reports in other* Pulse Check *cities.*[N]
- *Female marijuana users use sex as payment for the drug up to 5 percent of the time, as opposed to males, who do not use this practice at all.*[N]
- *An estimated 60 percent of female marijuana users exchange food stamps for marijuana, while only 20 percent of males do so.*[N]
- *Rather than exchanging stolen merchandise for drugs, many users sell stolen merchandise and use the cash to purchase drugs.*[E] *Most dealers no longer want merchandise for drugs; they prefer cash payment.*[N]
- *As in most* Pulse Check *cities, cash, by far, remains the most common means of paying for illegal drugs.*

[a]*The non-methadone treatment respondent did not provide data for powder cocaine.*
[b]*The methamphetamine data are provided by the non-methadone treatment respondent only.*

Source: Mean of response ratings given by law enforcement, non-methadone treatment, and methadone treatment respondents; the epidemiologic/ethnographic respondent did not provide quantitative data.

Which drug sellers are associated with which crimes?

Crime	Heroin	Crack cocaine	Powder cocaine	Marijuana	Methamphetamine	Ecstasy	GHB
Gang-related activity	✓	✓	✓	✓			
Violent criminal acts	✓	✓	✓				
Nonviolent criminal acts		✓	✓	✓			
Prostitution	✓	✓					
Domestic violence	✓						
No crimes associated					✓	✓	✓

Sources: Law enforcement respondent; epidemiologic/ethnographic respondent

How much does heroin cost?

Unit	Price
Dime bag	$10[E]
One hit	$20[L]
1 g	$150[L]
	$50–$300[E]

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

- *According to the DEA, the purity of white powder heroin (the most common form) has decreased between spring and fall 2002.*[E]

How much does cocaine cost?

Form	Unit	Price
Crack	One rock	$2[N]
		$5–$20[E]
	0.2 g	$20–$25[L]
	1 g	$123[L]
	1 g	$50–$150[E]
Powder	One bag	$5–$20[E]
	0.2 g	$20[L]
	1 g	$125[L]
		$50–$150[E]

Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent

- *In most cases, powder cocaine is available in large quantities rather than small doses.*[L]
- *All reported prices are stable between spring and fall 2002.*

How much does marijuana cost?

Form	Unit	Price
Commercial grade	1 oz	$6[L]
In general	Loose bag	$5–$10[E]
	1 oz	$80–$200
Hydroponic	1 oz	$30[L]

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

- *The lower end of the price range for an ounce of marijuana has declined since the spring.*[E]

WHO'S SELLING HEROIN?

Heroin dealers are generally adolescents and young adults working as part of a structured organization.[L,E]

WHO'S SELLING COCAINE?

- Dealers of both powder and crack cocaine range from adolescents to older adults; they usually work as part of an organized structure.[L,E]
- On the whole, cocaine dealers are not typically users of the drug,[E] although dealers identified through law enforcement typically are.[L]

WHO'S SELLING MARIJUANA?

- As with heroin and cocaine, marijuana dealers are most often adolescents and young adults working both independently and within structured organizations.[L,E]
- Marijuana dealers are almost always users of the drug.[L,E]

WHO'S SELLING METHAMPHETAMINE, AND HOW MUCH DOES IT COST?

- Individuals selling methamphetamine typically work independently,[L,E] although some work as part of an organized structure.[L] They are usually adolescents and young adults who use the drug themselves.[E]
- The majority of methamphetamine dealers identified by law enforcement are not local residents; rather, they come from out of town and set up shop in hotels to sell the drug.[L]
- The price of methamphetamine is stable at $330 per gram.[L]

WHO'S SELLING ECSTASY, AND HOW MUCH DOES IT COST?

- Ecstasy dealers, like methamphetamine dealers, work independently and usually use the drug. However, they are slightly older, with adolescents not commonly involved in selling ecstasy.[L,E]
- The price of ecstasy is stable, estimated at $25 per 30-mg pill,[L] or ranging from $20 to $40.[E]

HOW MUCH DO VARIOUS OTHER DRUGS COST?

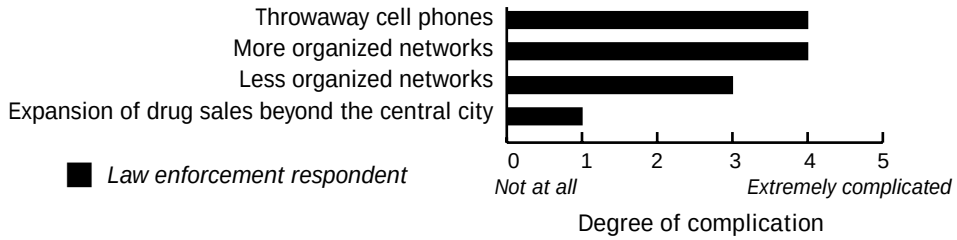
- No pricing information for diverted OxyContin® is available.[L,E]
- A capful of liquid GHB currently sells for $5.[L]

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

What they have to say...

- *Advances in technology over the past decade have impacted community efforts to crack down on drug trafficking in Chicago. The use of cell phones in particular—as in all other* Pulse Check *cities—has presented a significant barrier. Also, while the Internet has not become a barrier in disrupting traditional drug trafficking, it is used for transactions involving newer, designer drugs.*[L]
- *The increased organization of some drug networks has complicated efforts to detect and disrupt drug activity in Chicago. On the other hand, the increase in more loosely organized networks has also made it more difficult to identify who is involved in those structures.*[L]
- *Chicago is one of only a handful of* Pulse Check *cities where changing brand names and an increased number of these names over the past 10 years have created some difficulty in detecting drug transactions.*[E]

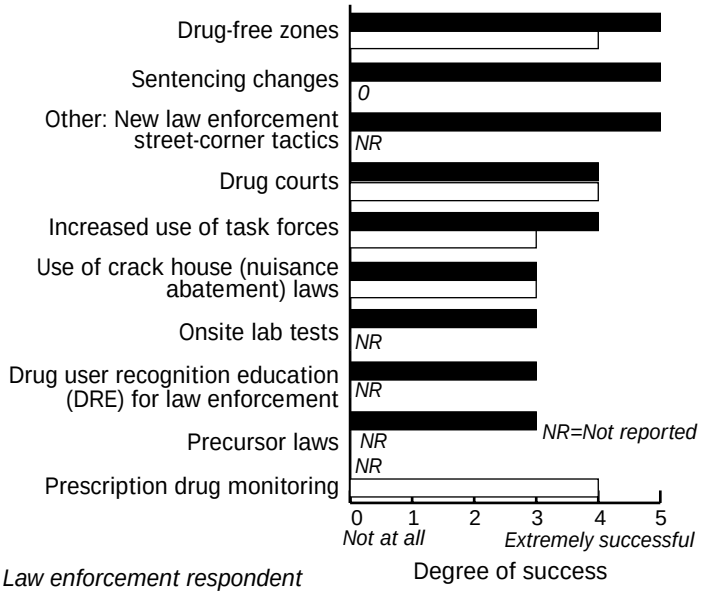
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in Chicago?



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

What they have to say...

- *Task forces have proven effective in Chicago, as in all other Pulse Check cities. The increased use of task forces involving Federal and State agencies has resulted in large drug seizures and significant arrests.*[L,E]
- *Increased communication and interaction among various law enforcement agencies have had a positive effect in disrupting drug activity in the city.*[L]
- *As reported in most* Pulse Check *cities where drug courts are available, Chicago respondents consider them successful tools for combating drug use and activity.*[LE] *As an alternative to incarceration, drug courts have sentenced users to drug school or counseling, resulting in reduced recidivism for program completers.*[E]
- *The use of onsite lab tests has provided stronger evidence for undercover operations to convict those involved in drug sales.*[L]
- *Chicago law enforcement began criminal drug conspiracy operations to disrupt street markets. In these 3-month operations, law enforcement works to identify all parts of the drug chain, using covert investigative tools to tie in the numerous people involved in a street-corner operation. Each person identified is subsequently charged with the same crime, based on the total weight of the drugs recovered.*[L]



SEPTEMBER 11 FOLLOWUP

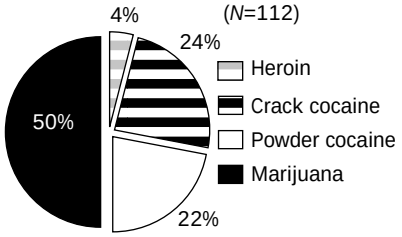
Three of the four *Pulse Check* sources believe that the September 11 attacks and their aftermath have had no continuing effects on the drug problem in Chicago.[L,E,M] The non-methadone respondent, however, notes that after increasing just after the attacks, the incidence of depression and anxiety has remained at that increased level, contributing to an increased rate of suicidal thoughts/attempts among treatment clients.[N]

CINCINNATI PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 1,646,395
- Median age: . . . . . 35.1 years
- Race (alone):
  - White 84.1%
  - Black 13.0%
  - American Indian/ Alaska Native 0.2%
  - Asian/Pacific Islander 1.2%
  - Other race 0.4%
  - Two or more races 1.1%
- Hispanic (of any race): . . . 1.1%
- Unemployment rate: 2.9%
- Median household income: $44,248
- Families below poverty level with children <18 years: 11.1%

*Source: U.S. Census 2000**

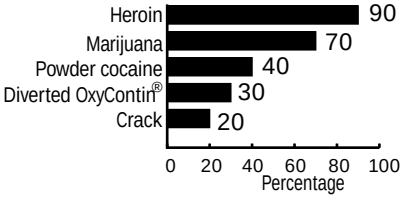
What are the primary drugs of abuse among clients in a non-methadone treatment program? (Fall 2002)



Note: Methamphetamine, methylenedioxymethamphetamine (MDMA or ecstasy), and abused OxyContin® (oxycodone hydrochloride controlled-release) percentages were less than one.

Source: Non-methadone treatment respondent

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



+Includes any use, whether as a primary, secondary, or tertiary drug; methamphetamine use is reported as "very low."

Source: Methadone treatment respondent

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. When possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

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

Two of three *Pulse Check* sources believe the illegal drug problem in Cincinnati is very serious[E,M], and one believes it is somewhat serious. Two of three sources consider the problem as somewhat worse[N,M], and one believes that it is stable.[E]

Respondents report several changes in the drug abuse scene:

- Crack and powder cocaine use in general declined slightly between spring and fall 2002.[E]
- OxyContin® "has already peaked in Cincinnati, so it's beginning to level off."[M]
- Diverted OxyContin® has received much media and law enforcement attention recently and is harder to obtain.[E]
- A for-profit methadone clinic opened nearby (in Indiana) with a more liberal methadone take-home policy. Since then, methadone diversion has increased, the diverted drug is now widely available on the streets, and methadone-related overdose deaths have increased (especially among young users [18–20 years]).[M]
- Violent crimes relating to drug sales and activity have increased.[N]

The greatest changes in drug abuse concern heroin:

- Historically, Cincinnati is a "pill-shooting town," but in the past few years heroin has emerged.[M]
- Heroin use has increased dramatically, especially among Whites.[E] The increase is most likely due to OxyContin® abusers switching to heroin use as diverted OxyContin® becomes less available.[E,M]
- Some OxyContin® abusers are switching to methadone or other prescription opiates when they can't obtain OxyContin®.[M]

- *Between spring and fall 2002, primary drug of abuse proportions among non-methadone treatment admissions remained relatively stable, with the exception of abused OxyContin®, which increased slightly.*[N]
- *Between spring and fall 2002, most drug use remained stable among methadone treatment admissions, with the exception of two decreases: crack use and OxyContin® abuse declined.*[M]

Most widely abused drug:

Marijuana[E,N]
Heroin[M]

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

Second most widely abused drug:

Crack[E,N]
Diverted OxyContin® and other prescription opiates[M]

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

Drug related to the most serious consequences:

Crack[E]
Heroin[N,M]

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

Drug related to the second most serious consequences:

Heroin and other opiates[E]
Crack[N]
Diverted OxyContin®[M]

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

New or emerging problems:

Heroin use increasing[E]
Diverted OxyContin®[N]

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

Note: These symbols appear throughout this city profile to indicate type of respondent. The law enforcement source in Cincinnati did not respond.

HEROIN

Heroin use has increased dramatically, especially among Whites.[E] *The increase is most likely due to OxyContin® abusers switching to heroin use as diverted OxyContin® becomes less available.*[E]

COCAINE

- Crack and powder cocaine use in general decreased slightly between spring and fall 2002.[E] Crack use among methadone treatment admissions also declined.[M]
- Although powder cocaine use in general declined, use among females and Whites increased.[E]

MARIJUANA

Marijuana use remains high, and it is considered the most widely abused drug by two of three sources.[E,N]

METHAMPHETAMINE

Methamphetamine use remains low.

MDMA (ECSTASY)

Ecstasy use remains relatively low.

ABUSED METHADONE

As reported in several other Pulse Check *cities, methadone diversion and abuse have increased:*

- Since a for-profit methadone clinic opened nearby (in Indiana) with a more liberal methadone take-home policy, methadone diversion has increased.[M]
- Diverted methadone is now widely available on the streets.[M]
- Methadone-related overdose deaths have increased (especially among young users [18–20 years]).[M]

ABUSED OXYCONTIN®

After peaking in the last several years, OxyContin® abuse is beginning to level off:

- Abuse declined slightly among methadone treatment admissions.[M] (By contrast, among non-methadone treatment admissions OxyContin® abuse increased slightly.[N])
- Diverted OxyContin® has received a lot of media and law enforcement attention recently and is harder to obtain.[E]
- Most primary OxyContin® abusers in the methadone treatment program are new to opiates and not addicted to heroin, but once addicted to OxyContin,® they often switch to heroin, methadone, or other prescription opiates if they can't obtain OxyContin®.[M]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- The *Pulse Check* non-methadone treatment respondent's program, which operates at about 85 percent capacity (89 of 104 treatment slots filled) sees a variety of drug clients, most of whom use marijuana, followed by cocaine (crack or powder) (*see the pie chart of the first page of this chapter*). That source reports a slight increase in OxyContin® abuse between spring and fall 2002.[N]
- The methadone treatment respondent is with a facility that operates at its maximum capacity of 120 methadone maintenance clients.[M] Many of its clients have secondary and tertiary drug problems (*see bar chart of the first page of this chapter*).
- Methadone maintenance is available only in selected areas of the community; in fact, only one public methadone treatment center exists in Cincinnati.[E] Methadone treatment programs have large waiting lists, and treatment availability remained stable between spring and fall 2002.[E]
- The non-methadone treatment source notes several drug-related consequences as relatively high, including drug-related auto accidents (which have increased recently), high-risk pregnancies, drug overdoses, and tuberculosis.[N] The methadone treatment source notes that hepatitis C is very common and that awareness of it increased recently due to improved testing.[M] That source also notes that high-risk pregnancies have increased slightly between spring and fall 2002.

- Although comorbid disorders are relatively stable since spring 2002, several are reported as common, including antisocial or conduct disorders,[N,M] psychosis[N], mood disorders,[N,M] and suicidal thoughts/attempts[N]. The non-methadone source notes that the dual diagnosis program receives "more referrals than it can handle."[N]

WHO USES ILLICIT DRUGS?

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

- *Heroin use has increased dramatically between spring and fall 2002, especially among Whites.[E] The increase is most likely due to OxyContin® abusers switching to heroin use as diverted OxyContin® becomes less available.[E]*
- *New heroin users are more likely than the general heroin-using population to be of a higher economic status (middle versus low) and from the suburbs.[E]*
- *Many young methadone clients present as male-female couples.[M]*
- *Users new to treatment are more likely than the general methadone treatment population to be male (split evenly versus 60 percent female).[M]*

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	18–30
Mean age (years)	38	41	28
Gender	Split evenly	60% male	60% female
Race/ethnicity	White	White	White and Black
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	None	High school
Employment at intake	N/A	Part time	Unemployed

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

- *Injecting is the most common route of administration for heroin (known as "smack," "boy," and "H") in Cincinnati; however, among new heroin users, snorting predominates.[E,N,M]*
- *Sources report no other changes in heroin user or use characteristics between spring and fall 2002.*

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs taken	Diverted OxyContin® (as a substitute)	Marijuana	Powder cocaine (speedball) marijuana (sequentially)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	Alone	Alone	In groups

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

Who's most likely to use cocaine?

	Crack			Powder cocaine		
Characteristic	E	N	M	E	N	M
Age group (years)	>30	>30	18–30	>30	18–30	>30
Mean age (years)	38	39	NR	34	NR	NR
Gender	Split evenly	69% male	Split evenly	54% female	60% male	Split evenly
Race/ethnicity	Black	Black	White and Black	White	White	White and Black
Socioeconomic status	Low	Low	Low	Middle	Low	Low
Residence	Central city	Central city	Central city	Central city	Central city	Central city
Referral source	N/A	Criminal justice	Criminal justice	N/A	Criminal justice	Individual
Level of education completed	N/A	None	High school	N/A	High school	High school
Employment at intake	N/A	Unemployed	Unemployed	N/A	Part time	Unemployed

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

- *Crack and powder cocaine use decreased slightly between spring and fall 2002.[E] Crack use among methadone treatment admissions also declined.[M]*
- *Powder cocaine use among females and Whites increased.[E]*
- *Marijuana is often taken in combination with crack and powder cocaine.[E,N] Alprazolam (Xanax®) is often taken sequentially after cocaine.[M] And crack and powder cocaine are often used interchangeably.[N]*
- *Among methadone treatment admissions, most powder cocaine is injected with heroin in a speedball.[M]*

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	All	18–30	18–30
Mean age (years)	23	NR	NR
Gender	60% male	Split evenly	60% female
Race/ethnicity	Black	White and Black	White and Black
Socioeconomic status	Low	Middle	Low
Residence	Central	Central city	Central city and suburbs
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Full time	Unemployed

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

- *As in most* Pulse Check *cities, marijuana use in Cincinnati cuts across demographics.*
- *Marijuana (known by many slang terms, a new one of which is "chronic") is smoked in blunts and joints.[E,N,M]*
- *About 80 percent of marijuana-using adolescents are male, but there is a shift toward more female use.[E]*
- *Sources report no other changes in user or use characteristics between spring and fall 2002.*

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

The epidemiologic respondent associates marijuana, used either alone or with other drugs, with the following consequences, which remained stable between spring and fall 2002:

- Drug-related arrests[N]
- Automobile accidents[N]
- Deteriorating family and social relationships[N]
- Poor academic performance[E,N]
- School absenteeism, truancy, and dropping out of school[E,N]

Who's most likely to use methamphetamine?

Characteristic	N
Age group (years)	>30
Mean age (years)	35
Gender	Split evenly
Race/ethnicity	White
Socioeconomic status	Low
Residence	Central city
Referral source	Criminal justice
Level of education completed	None
Employment at intake	Unemployed

Sources: [N]Non-methadone treatment respondent

- *Methamphetamine use in Cincinnati is very low.*[N,E]
- *Most methamphetamine is smoked, and users are adults older than 30.*[N]
- *Sources report no changes in user or use characteristics between spring and fall 2002.*

WHO'S MOST LIKELY TO USE ECSTASY?

- Ecstasy use is relatively low and stable. Most users are young, White adults (18–30 years old) of middle income who live in the suburbs.[E]
- Ecstasy users are not showing up in public treatment. But the drug is a common "recreational drug," often taken with other club drugs.[E]

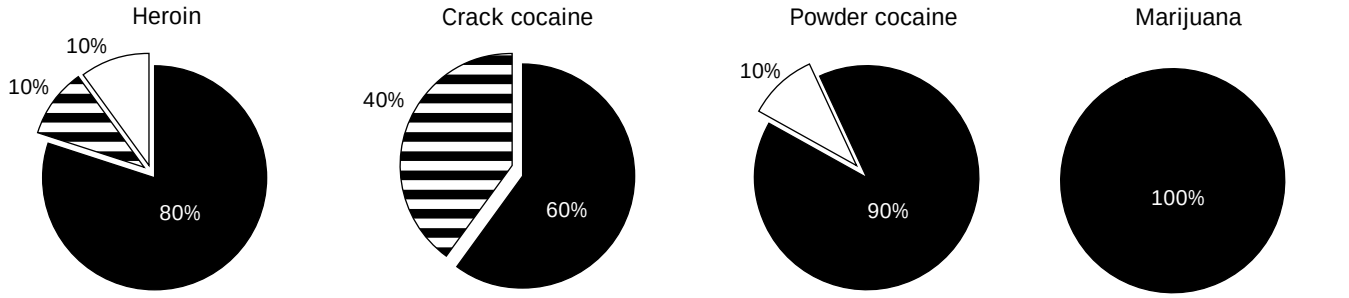
Who's most likely to abuse OxyContin®?

Characteristic	E	M
Age group (years)	>30	>30
Mean age (years)	35	32
Gender	60% female	60% female
Race/ethnicity	White	White and Black
Socioeconomic status	Low	Middle
Residence	Central city	Central city and suburbs
Route of administration	Oral and snorting	Injecting and snorting
Other drugs taken	Heroin (as a substitute) marijuana or club drugs (in combination)	Heroin or other prescription opiates (as substitutes)

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

- *OxyContin® abuse has received much media and law enforcement attention recently, and the diverted drug has become harder to obtain.*[E]
- *OxyContin® abuse "has already peaked in Cincinnati, so it's beginning to level off," and methadone treatment admissions declined between spring and fall 2002.*[M]
- *By contrast, OxyContin® admissions to the non-methadone treatment program increased slightly between spring and fall 2002, although these admissions are relatively low.*[N]
- *Many OxyContin® abusers users have switched to heroin because diverted OxyContin® is more expensive and more difficult to obtain than heroin.*[E]
- *Most primary OxyContin® abusers in the methadone treatment program are new to opiates and not addicted to heroin. But once addicted to OxyContin® they often switch to heroin, methadone, or other prescription opiates if they can't obtain OxyContin®.*[M]
- *OxyContin® is often abused at concerts and nightclubs.*[E]
- *Abusers are increasingly younger and White.*[E]
- *Most abusers snort or use the drug orally; some inject the drug.*[E]
- *Marijuana and other club drugs are often used in combination with the drug.*[E]

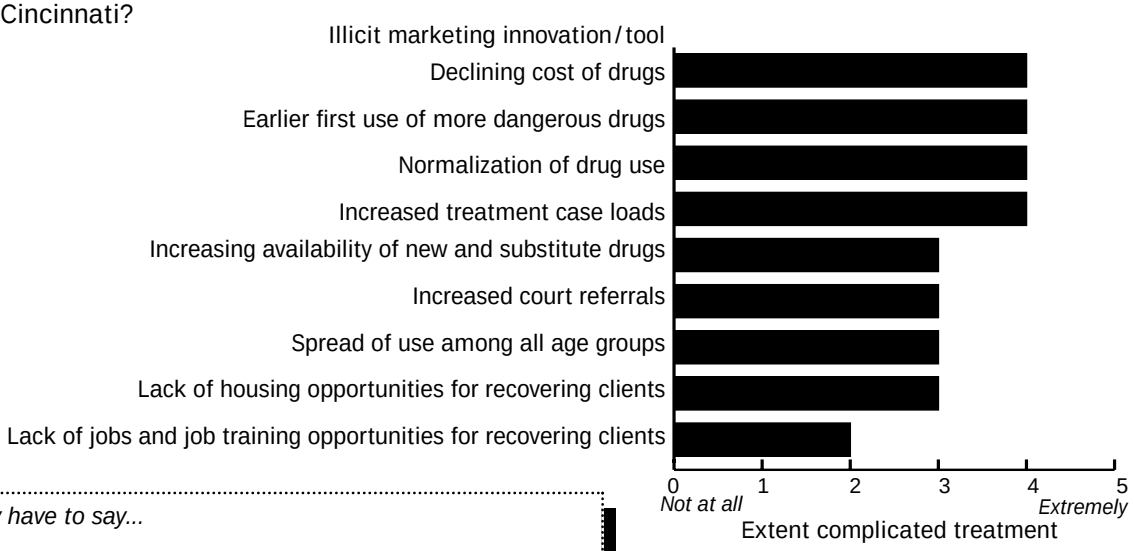
Beyond cash: What else is accepted in exchange for drugs?



- *As in nearly all* Pulse Check *cities, cash is the most common currency exchanged for illegal drugs in Cincinnati.*[M]
- *The practice of exchanging sex for crack cocaine is relatively high; at an estimated 40 percent of all exchanges,*[M] *it appears more common than in most other* Pulse Check *cities (although this estimate is based on the response of only one source).*

Source: Methadone treatment respondent

Drug marketing innovations and drug users' characteristics: To what degree have they complicated treatment efforts in Cincinnati?



Source: Methadone treatment respondent

What they have to say...

- *Increasing availability of new and substitute drugs: New opioids (especially OxyContin®) have complicated methadone treatment.*[M]
- *Declining cost of drugs: Heroin is more available, and its price has declined.*[M]
- *Earlier first use of more dangerous drugs: Over the past 5 years, heroin users have become younger.*[M]
- *Normalization of drug use: The increased use of marijuana and club drugs, especially among the younger population, may be due to the perceived acceptance of illegal drug use.*[M]
- *Increased court referrals: New drug courts in the last 10 years have increased the number of people in treatment and made treatment more complex.*[M]

SEPTEMBER 11 FOLLOWUP

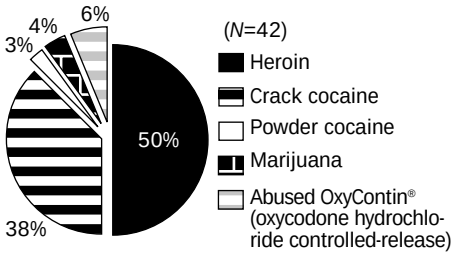
None of the three Cincinnati *Pulse Check* sources believes that the September 11 attacks and their aftermath have had any effects on the drug abuse problem.[E,N,M]

CLEVELAND PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 2,250,871
- Median age: . . . . . 37.3 years
- Race (alone):
  - White 76.9%
  - Black 18.5%
  - American Indian/ Alaska Native 0.2%
  - Asian/Pacific Islander 1.4%
  - Other race 1.4%
  - Two or more races 1.6%
- Hispanic (of any race): . . . 3.3%
- Unemployment rate: 3.4%
- Median household income: $42,089
- Families below poverty level with children <18 years: 13.1%

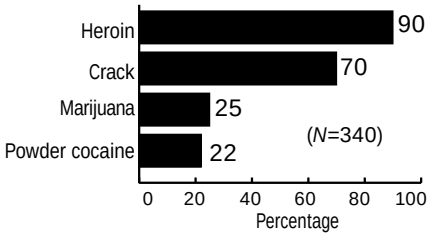
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



+Includes any use, whether as a primary, secondary, or tertiary drug; responses for methamphetamine, OxyContin®, and benzodiazepine abuse were less than 1 percent.

Source: Methadone treatment respondent

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. When possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

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

All four respondents consider Cleveland's illegal drug problem very serious, and one[M] considers it somewhat worse. However, respondents do report positive trends:

- As in many *Pulse Check* cities, task forces are rated as highly successful in combating illegal drug activity in Cleveland.[L,E]
- Marijuana use among methadone treatment admissions decreased slightly.[M] That source believes that the media has become more responsible about marijuana by increasingly exposing the negative consequences of its use.[M]
- Several drugs, including two types of marijuana and two types of methamphetamine, are more difficult for undercover officers to buy.[L]

Sources also point to other developments:

- Polydrug use, which is the norm, increased. Drug users' decreasing "allegiance" to one drug has made treatment more difficult.[M]
- More cocaine (crack and powder) is coming into the area, it is easier to buy, prices have dropped, and the drug may be more marketable.[L,E]
- Powder cocaine use in general increased.[E] Among methadone treatment clients, crack use increased slightly, especially among females.[M]
- One respondent reports that diverted OxyContin® availability has declined because doctors and pharmacists are more stringent with prescriptions.[E] Other respondents, however, report abuse and activity as increasing.
- Heroin activity seems to be increasing: diverted OxyContin® users often switch to heroin, which is cheaper and easier to buy.[E,M]
- Among treatment admissions, methamphetamine use is low.[N,M] Declines are reported in one treatment program,[N] while a slight increase is reported in the other.[M]
- Methylenedioxymethamphetamine (MDMA or ecstasy) activity increased. The drug is easier to buy, but much that is sold is not really ecstasy.[L]
- Among non-methadone treatment admissions, tramadol (Ultram®) abuse increased.[N]
- Phencyclidine (PCP) use has begun to emerge among Blacks.[M]

Crack and heroin remain the most widely abused drugs and are related to the most serious consequences.

- *One program's typical clients are polydrug users who tend to use "whatever is available, easy to obtain, and cheap as their drug of choice."*[N]
- *Among non-methadone treatment clients, percentages for primary drugs of abuse remained relatively stable between spring and fall 2002.*[N]
- *Marijuana use among methadone treatment admissions decreased.*[M] *By contrast, abuse of several drugs increased, including heroin, crack, powder cocaine (among admissions new to treatment), and three drugs that still remain at low levels of use: methamphetamine, OxyContin®, and benzodiazepines.*

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

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

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

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

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

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

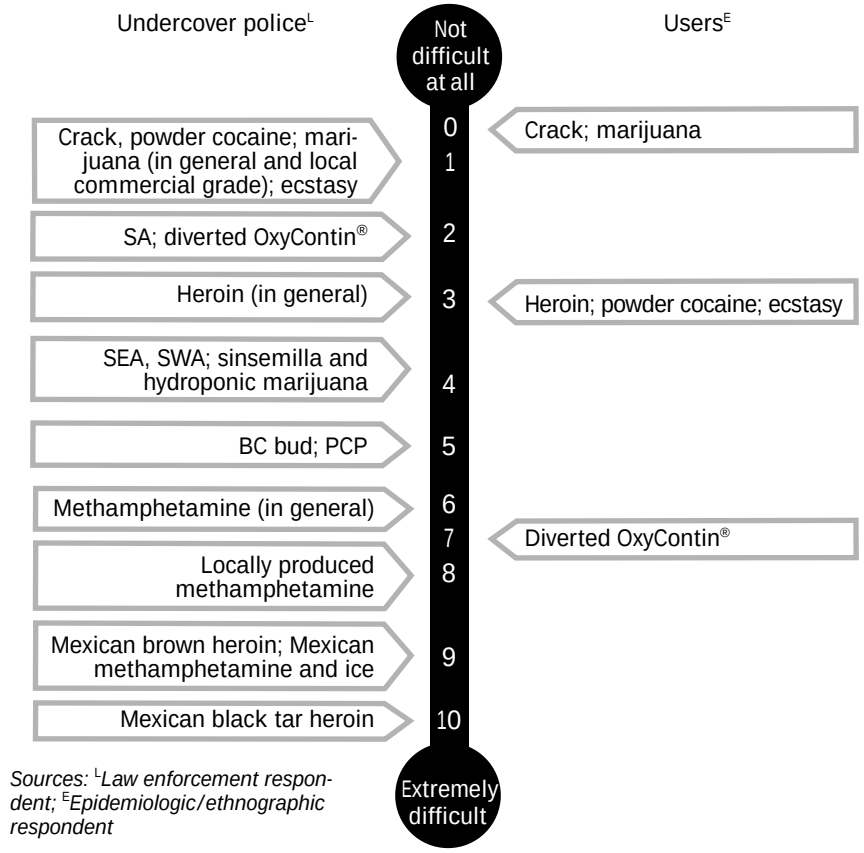
Drug related to the second most serious consequences:
- Heroin[L,E,N]
- Powder cocaine[E]
- Crack[M]

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

New or emerging problems:
- Ecstasy[L]
- Abused OxyContin®[M]

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

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



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

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

- *Several drugs are more difficult for undercover officers to buy since spring 2002:*[L] *sinsemilla, BC bud, Mexican methamphetamine, and ice.*
- *Diverted OxyContin® has become more difficult for users to buy on the street. Doctors and pharmacists are more stringent with prescriptions, and street prices have increased.*[E]
- *As reported in five other* Pulse Check *cities (New York, St. Louis, San Francisco, Seattle, and Portland, OR), diverted OxyContin® has become less difficult for undercover officers to buy since spring 2002.*[L]
- *Sources agree that heroin, cocaine, marijuana, and ecstasy remain relatively easy to buy.*[L,E]
- *As reported in seven other* Pulse Check *cities (Atlanta, Baltimore, Minneapolis, San Diego, San Francisco, Seattle, and Washington, DC), ecstasy has become easier for undercover officers to buy.*[L]
- *Powder cocaine has become less difficult for users to buy. Between spring and fall 2002, prices have dropped, and the drug may be more marketable.*[E]
- *In a 6-month period, heroin availability fluctuates: "droughts" are typically related to large law enforcement busts.*[E]

HEROIN

Two reports indicate that heroin activity and use are increasing:

- Methadone treatment admissions for heroin increased between spring and fall 2002.[M]
- Diverted OxyContin® abusers are switching to heroin because diverted OxyContin® is more expensive than heroin and more difficult to buy.[E,M]

COCAINE

Several observations suggest increased cocaine activity and use:

- The cocaine supply in Cleveland increased, and the drug is easier to buy.[L,E]
- In general, powder cocaine use increased since spring 2002.[E]
- Among methadone treatment clients, crack use increased slightly, especially among females who start taking heroin at an early age.[M]

MARIJUANA

Marijuana use remains relatively stable, according to most respondents. Among methadone treatment admissions, it decreased slightly between spring and fall 2002.[M]

METHAMPHETAMINE

Methamphetamine use and activity are low in Cleveland.

- Among non-methadone treatment admissions, methamphetamine use continues to decline from its peak several years ago.[N]
- Among methadone treatment admissions use increased slightly between spring and fall 2002.[M]

MDMA (ECSTASY)

Ecstasy activity has increased:

- The drug is easier to buy (but much that is sold is not really ecstasy).[L]
- However, ecstasy use and treatment admissions remain low.

DIVERTED OXYCONTIN®

One respondent reports that diverted OxyContin® availability declined due to doctors and pharmacists being more stringent with prescriptions.[E] *Other respondents, however, report diverted OxyContin® abuse and activity as increasing:*

- Diverted OxyContin® has become less difficult for undercover officers to buy.[L]
- OxyContin® abuse, in general, increased.[E]
- The non-methadone treatment respondent's program tends to see OxyContin® abusers "in droves." In the program's chronic pain division, 90 percent of clients abuse the drug.[N]
- One source "suspect[s] that OxyContin® will become a rising concern in Cleveland" and suggests that "physicians be alerted to its consequences and specifically trained to refer clients to opiate addiction programs."[M]

OTHER DRUGS

- Benzodiazepines: Abuse increased among methadone treatment admissions, especially among females.[M]
- Tramadol: Abuse increased among non-methadone treatment admissions.[N] People "doctor shop" for it or buy it on the street and then come into treatment for detox.
- PCP: The practice of dipping cigarettes in liquid PCP has begun to emerge among Blacks.[M]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone treatment respondent's program, which operates at about 75 percent capacity (42 of 56 inpatient and outpatient slots filled), sees mostly heroin clients, followed closely by crack cocaine clients (*see the pie chart on the first page of this chapter*).
- The methadone treatment respondent is with a public facility that operates over capacity, with 340 of 300 slots filled.[M] Beyond that specific facility, methadone maintenance treatment is available only in selected areas of the city, and public programs are at full capacity.[E] Cleveland has no private methadone clinics.
- Treatment respondents agree that limited slot capacity is the main barrier to treatment. One respondent explains that "opiate addiction and use have increased but funds have not."[M]
- One source reports increases in barriers to treatment: lack of trained staff to treat comorbidity among clients (due to lack of integrated training for counselors) and lack of child care for clients.[M]

Consequences of drug use

- The treatment sources note that hepatitis C and drug overdoses are common among clients.[N,M] The methadone treatment source further notes that several health consequences have increased since spring 2002, including HIV/AIDS (especially among males who have sex with males and are also injecting drug users), drug-related automobile accidents (due to increased polydrug use), high-risk pregnancies (because drug use among females has increased), drug overdoses (due to increased polydrug

use), and tuberculosis (due to increased homelessness and poor health care).[M] The non-methadone treatment source adds that heart attacks (related to cocaine use) and narcotic-related withdrawal sicknesses (including deaths caused by breathing difficulties) are relatively common health problems within the treatment program.[N]

- Several comorbid disorders are common among treatment clients, including mood disorders,[N,M] suicidal thoughts and attempts,[N] borderline personality disorders,[N] eating disorders,[N] and post-traumatic stress disorder (PTSD) related to childhood abuse[N].

Increased complications for drug treatment over the past 10 years

- Increasing availability of new and substitute drugs: The increasing availability of heroin, crack, and ice over the past 10 years has complicated methadone treatment dramatically.[M]
- More polydrug use: The increased combination of heroin and crack or powder cocaine and the declining price of crack cocaine over the past 10 years have made methadone clients more difficult to treat.[M]

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	18–30	>30
Mean age (years)	40	24	40
Gender	70% male	60% male	70% male
Race/ethnicity	White and Black	White	White
Socioeconomic status	Low	High	Low
Residence	Central city	All	Central city
Referral source	N/A	Other heroin addicts	Individual
Level of education completed	N/A	High school and 2-year college	High school
Employment at intake	N/A	Unemployed	Part time

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

- *Heroin use, in general, increased between spring and fall 2002.[E] Heroin (now referred to as "dog food" or "garbage") use among methadone treatment admissions increased.[M]*
- *Between spring and fall 2002, heroin admissions to the methadone program are increasingly younger, female, and Black.[M]*
- *New heroin users are much more likely than the general heroin-using population to be young adults (early twenties versus 40 years), female (equally split between genders versus 70 percent male), and of a higher socioeconomic status.[E]*
- *New heroin users buy the drug in the central city but use it in the suburbs.[E]*
- *Many well-educated adolescents of upper socioeconomic status use heroin.[M]*
- *Heroin users are referred to the non-methadone treatment program by other heroin addicts and by heroin dealers whose supply "runs out."[N]*

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting and snorting	Injecting	Injecting
Other drugs taken	Powder or crack cocaine (speedball)	Cocaine (speedball); prescription opiates (as substitutes)	Crack (speedball)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	In groups	Alone	In groups

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

- *Injecting is the most common route of heroin administration in Cleveland. Speedball use is common.*[E,N,M]
- *New users tend to snort heroin. They often use other drugs.*[E]
- *Between spring and fall 2002, polydrug use increased, especially powder or crack cocaine with heroin in a speedball and prescription opiates abused as heroin substitutes.*[M]

Who's most likely to use cocaine?

	Crack			Powder cocaine		
Characteristic	E	N	M	E	N	M
Age group (years)	>30	>30	18–30	18–30	>30	18–30
Mean age (years)	35	30–50	27	NR	30–50	28
Gender	Male	Split evenly	60% male	Split evenly	Split evenly	70% male
Race/ethnicity	Black	White and Black	Black	White	White, Black, and Hispanic (any race)	White
Socioeconomic status	Low	High	Low	Middle	High	Middle
Residence	Central city	All	Central city	Suburbs	Suburbs	Suburbs
Referral source	N/A	Individual	Criminal justice	N/A	Individual	Criminal justice
Level of education completed	N/A	4-year college	None	N/A	4-year college	High school
Employment at intake	N/A	Part time	Unemployed	N/A	Full time	Part time

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

- *In addition to injecting heroin in speedballs, crack users often smoke "crumbs" of crack in marijuana blunts.*[E]
- *Among methadone treatment clients, crack use increased slightly, especially among females who start taking heroin at an early age. The most common route of administration among methadone clients is injecting, especially with heroin in a speedball.*[M]
- *In general, powder cocaine ("connie") use increased since spring 2002.*[E]
- *Among non-methadone treatment admissions, snorting and injecting are the most common routes of administration for powder cocaine.*[N]

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	>13	18–30	>30
Mean age (years)	Wide age range	Wide age range	42
Gender	Split evenly	Split evenly	77% male
Race/ethnicity	White and Black	White and Black	Black
Socioeconomic status	All	Middle	Low
Residence	All	All	Central city
Referral source	N/A	Other health care provider	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Full time	Part time

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

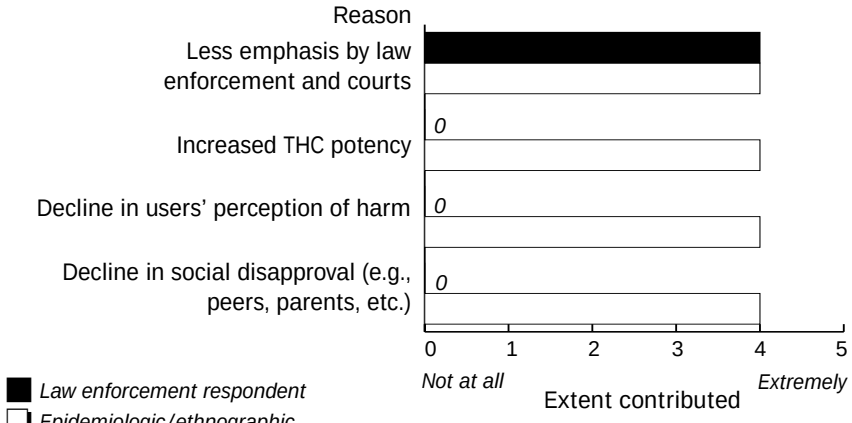
- *Marijuana use among methadone treatment admissions decreased slightly between spring and fall 2002.[M] New terms for marijuana include "sticky icky" and "trees."[M]*
- *In rural and suburban areas, most marijuana is smoked in joints; in central city areas, most is smoked in blunts.[E]*
- *A small percentage of non-methadone treatment clients use marijuana only, but most other drug clients use marijuana as a secondary or tertiary drug. Furthermore, insurance companies prefer not to pay for treatment if marijuana is the primary drug.[N]*
- *"Wet" is a new term for a marijuana combination that users are smoking; it could refer to marijuana joints or blunts dipped in embalming fluid or in PCP, but users are not sure.[E]*

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

Marijuana, used either alone or with other drugs, is associated with the following consequences, which remained stable between spring and fall 2002:

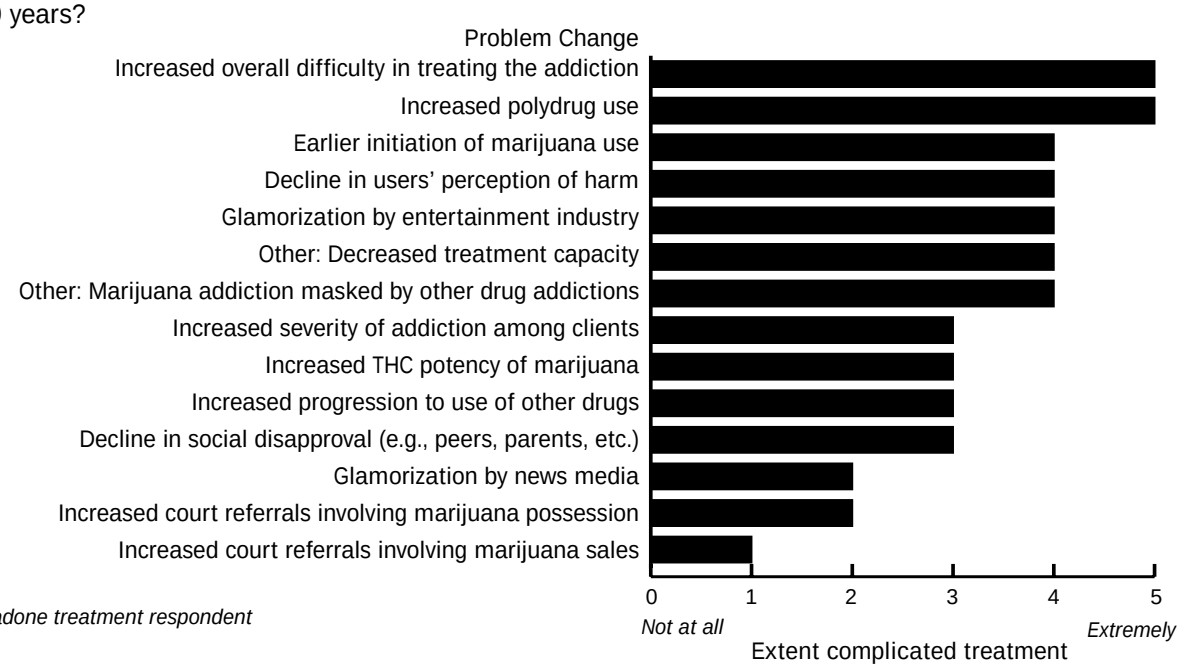
- Drug-related deaths[M]
- Drug-related emergency room visits[M]
- Drug-related arrests[E,M]
- Automobile accidents[M]
- High-risk pregnancies[M]
- Short-term memory loss[M]
- Deteriorating family and social relationships[M]
- Poor academic performance[M]
- School absenteeism, truancy, and dropping out of school[M]
- Poor workplace performance[M]
- Workplace absenteeism[M]

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



- *The law enforcement and epidemiologic/ethnographic sources differ widely in their opinions.*
- *They do agree on one belief: law enforcement and the courts have placed less emphasis on marijuana over the years.*
- *The law enforcement respondent adds that the penalties for marijuana possession or sales are too light.*

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



Source: Methadone treatment respondent

What they have to say...

- *Increased polydrug use: The decreasing "allegiance" of drug users to one drug, including marijuana, has made treatment more difficult over the past 10 years.*[M]
- *Decreased treatment capabilities for THC addiction: Too few programs treat THC as a primary addiction, particularly for adult clients. Moreover, THC addiction is often masked by other drug addictions (such as heroin, cocaine, or alcohol) and not treated.*[M]
- *Glamorization by news media: The methadone treatment source believes that the media has become more responsible about marijuana by increasingly exposing the negative consequences of its use.*[M]

Who's most likely to use methamphetamine?

Characteristic	N	M
Age group (years)	18–30	18–30
Mean age (years)	18–20	26
Gender	80% male	80% male
Race/ethnicity	White	White
Socioeconomic status	High	Middle
Residence	Suburbs	Suburbs
Referral source	Emergency room and parents	Individual
Level of education completed	4-year college	High school
Employment at intake	Full-time students	Part time

Sources: [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Among treatment admissions, methamphetamine ("tina") use is low.*[N,M] *Among methadone treatment admissions, use increased slightly between spring and fall 2002,*[M] *but among non-methadone treatment admissions, methamphetamine use continues to decline from its peak several years ago.*[N]
- *Non-methadone clients inject methamphetamine and take many other drugs (such as marijuana, heroin, and prescription pills) in combination with the drug.*[N]
- *Most methadone treatment clients take the drug orally and as a substitute for heroin.*[M]

- *The epidemiologic source claims that ecstasy use is low in Cleveland.*[E] *Ecstasy use among non-methadone treatment admissions is secondary and tertiary to other drugs, especially benzodiazepines.*[N]
- *Most ecstasy users are adolescent or young adult females.*[E,N]
- *Sources report no changes in use or user characteristics between spring and fall 2002.*

Who's most likely to use ecstasy?

Characteristic	E	N
Age group (years)	13–30	18–30
Mean age (years)	NR	18–24
Gender	Split evenly	70% female
Race/ethnicity	White and Black	White
Socioeconomic status	Low and middle	High
Residence	All	Suburbs
Referral source	N/A	Emergency rooms and parents
Level of education completed	N/A	High school
Employment at intake	N/A	Full-time students

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

Who's most likely to abuse OxyContin®?

Characteristic	E	N
Age group (years)	18–30	18–30
Gender	Split evenly	Split evenly
Race/ethnicity	White	White
Socioeconomic status	Low and middle	Middle and High
Residence	Central city and suburbs	Central city and rural areas
Route of administration	Oral	Injecting

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

- *In general, OxyContin® abuse increased since spring 2002.*[E]
- *The non-methadone treatment respondent's program tends to see OxyContin® abusers "in droves," causing the proportion of clients over time to "fluctuate wildly." That program also has a chronic pain division in which 90 percent of clients abuse OxyContin®. Over the past 2 years, OxyContin® abuse increased dramatically.*[N]
- *Many abusers start out taking the drug orally, as prescribed. They then move to snorting or injecting.*[E]
- *Most OxyContin® abusers are young adults: "once they reach an older age, they have already moved on to heroin."*[E]
- *Most OxyContin® abusers switch to heroin use because OxyContin is more expensive and more difficult to buy.*[E]
- *Opiate abusers take "whatever is available": OxyContin® abusers often use heroin as a substitute, and heroin users often take OxyContin® as a substitute.*[N]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Illegal drugs in Cleveland are sold mostly in the central city, with the exceptions of methamphetamine and diverted OxyContin® (sales are equally distributed in all geographic areas) and ecstasy (sales occur mostly in the suburbs).[L]

Heroin, powder cocaine, marijuana, ecstasy, and especially crack are sold on streets and in open-air markets[L] as well as at the following locations:

- Crack houses and shooting galleries (excluding ecstasy)[L,E]
- Private residences[L,E]
- Public housing developments[L,E]
- In or around schools[L]
- Nightclubs and bars[L,E]
- Private parties[L,E]
- Raves[L]
- Concerts (excluding heroin)[L]
- Hotels/motels[L]
- Around drug treatment clinics (excluding ecstasy)[L]
- Inside cars[L]

Additionally, ecstasy is often sold on college campuses.[L,E]

Methamphetamine and diverted OxyContin® are not typically sold on streets or in open-air markets, but sales take place at the following locations:[L]

- Private residences
- Public housing developments
- Nightclubs and bars
- Raves
- Concerts
- Hotels/motels
- Around drug treatment clinics (excluding methamphetamine)
- Inside cars

HOW DO ILLEGAL DRUGS GET FROM BUYER TO SELLER?

To purchase heroin and crack and powder cocaine, buyers may go to an open-air market to exchange the drug hand to hand on the street or contact a dealer via cell phones, landline phones, or two-way pagers to set up a meeting for exchange of the drug.[L,E] Crack, in particular, is available at open-air markets, and dealers will "walk up to buyers' cars to sell it."[E]

Most ecstasy sales are venue oriented (at raves, concerts, and nightclubs), and buyers "ask around" at these locations to find a dealer and make the exchange hand to hand.[L]

Abusers buy most OxyContin® from dealers on the street, who obtain the drug either by legal prescription or by stealing it from their families or acquaintances.[E]

WHO SELLS ILLEGAL DRUGS?

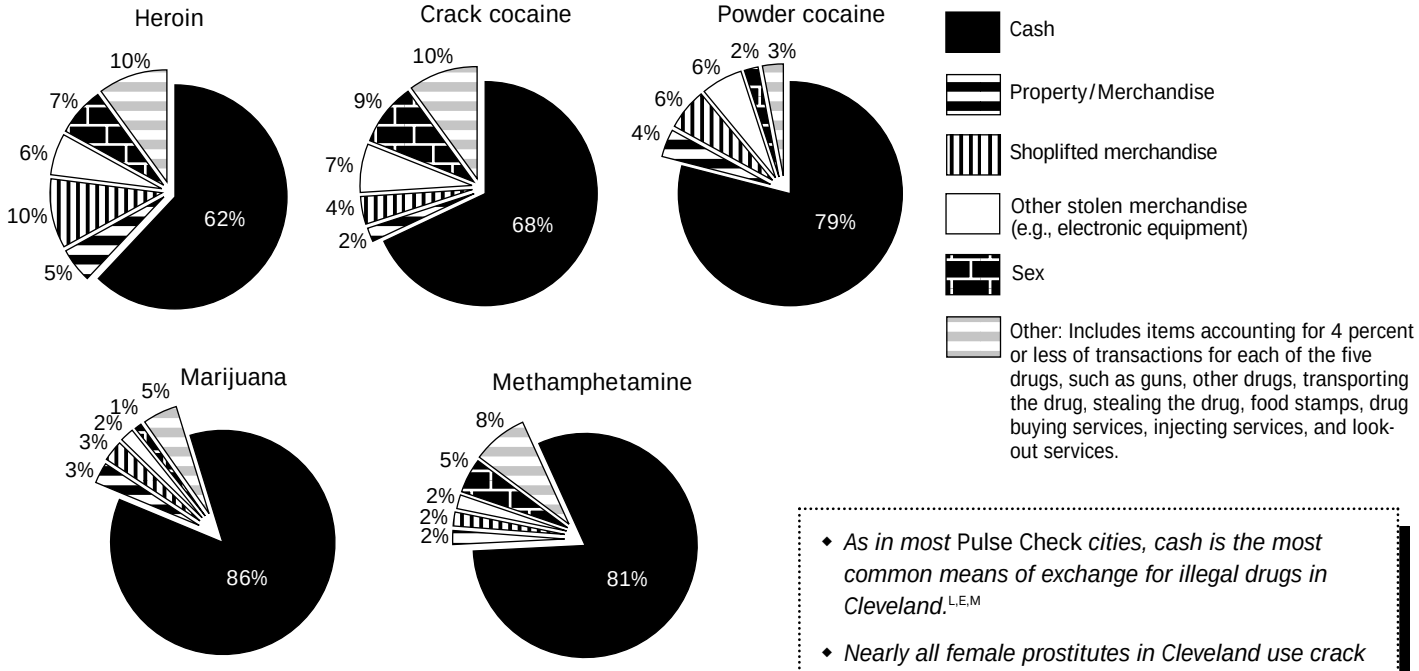
Heroin, crack, and powder cocaine dealers are organized, often into street gangs. Most heroin and powder cocaine dealers are older than 30, whereas most crack cocaine dealers are 18–30 years old.

Most crack and powder cocaine dealers sell only cocaine, but dealers who primarily sell heroin often deal cocaine as well.[L]

Heroin and powder cocaine dealers are often involved in prostitution and violent crimes such as robberies. In addition, powder cocaine dealers are involved in escort services and gang-related activity.[L]

Most other dealers who sell drugs such as marijuana, methamphetamine, ecstasy, diverted OxyContin®, and PCP are independent young adults (18–30 years).[L]

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



Source: Mean of response ratings given by law enforcement, epidemiologic/ethnographic, and methadone treatment respondents. The non-methadone treatment respondent did not provide percentages for any drugs.

- *As in most* Pulse Check *cities, cash is the most common means of exchange for illegal drugs in Cleveland.*[L,E,M]
- *Nearly all female prostitutes in Cleveland use crack and exchange sex for the drug.*[E]

How much do illegal drugs cost?

Drug	Unit	Price
South American heroin	0.1 g (dime bag)	$10–$20[E]
	One bag (1 g)	$20[L]
Crack cocaine	One rock	$10–$20[L,E]
Powder cocaine	0.1 g	$20[E]
	Eightball	$180[L]
Marijuana	One blunt	$5–$10[E]
	1 oz (10–12 blunts)	$100–$200[L,E]
"Wets" (marijuana blunts dipped in formaldehyde or PCP)	One blunt	$10–$20[E]
PCP	One bottle	$40–$100[L]
Methamphetamine	1 g	$75[L]
Ecstasy	One pill	$15–$20[L] $8–$10[E]
Diverted OxyContin®	20-, 40-mg pills	$20, $40[E]

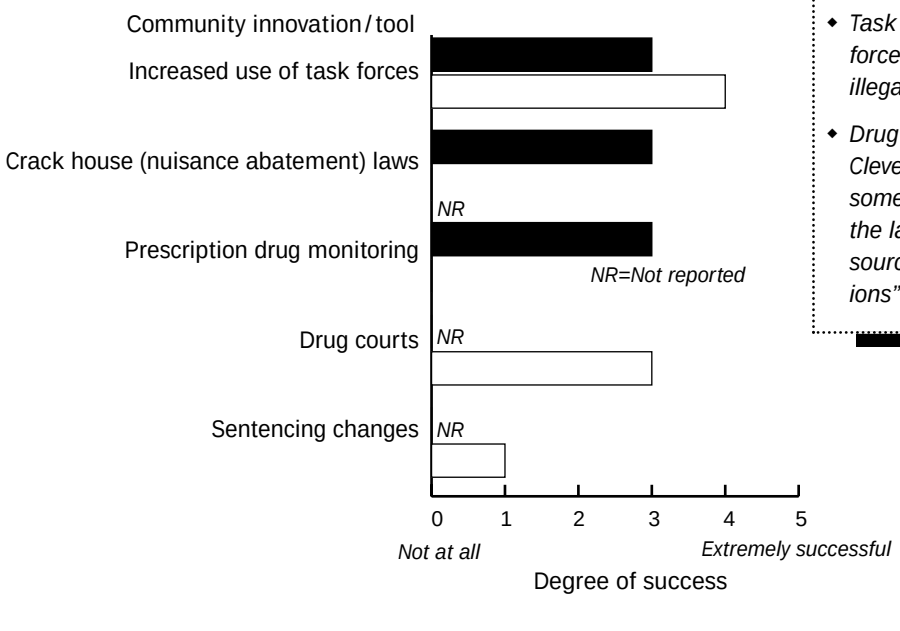
Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

- *Drug prices in Cleveland remained relatively stable between spring and fall 2002.*
- *Respondents did not report drug purity, but they identified several adulterants new in fall 2002: baby formula is a new heroin adulterant; fingernail polish remover is a new crack adulterant; and twigs are now sold in packages and blunts of marijuana.*[N]

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

As in many *Pulse Check* cities, the use of throwaway cell phones has made it much harder over the past 10 years to disrupt drug activity in Cleveland.[L]

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



What they have to say...

- *Task forces: As in many* Pulse Check *cities, task forces are rated as highly successful in combating illegal drug activity in Cleveland.*[L,E]
- *Drug courts: Drug courts, which have existed in Cleveland for the past 3–5 years, are described as somewhat successful in combating drug activity by the law enforcement respondent. The epidemiologic source states that experts have "conflicting opinions" about the effects of drug courts.*

SEPTEMBER 11 FOLLOWUP

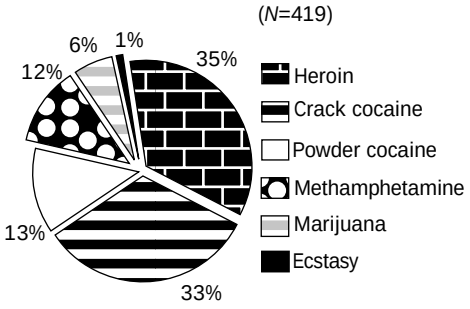
Three of the four Cleveland *Pulse Check* sources believe that the September 11 attacks and their aftermath have had no effects on the drug abuse problem. The methadone treatment respondent believes that the increase in opiate addiction may be due to increased anxiety levels. That source further states that antidepressants, prescribed or bought from the streets, are increasingly used.

DALLAS PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 3,519,176
- Median age: . . . . . 31.8 years
- Race (alone):
  - White 67.2%
  - Black 15.1%
  - American Indian/ Alaska Native 0.6%
  - Asian/Pacific Islander 4.1%
  - Other race 10.7%
  - Two or more races 2.4%
- Hispanic (of any race): 23.0%
- Unemployment rate: 3.4%
- Median household income: $55,854
- Families below poverty level with children <18 years: 11.6%

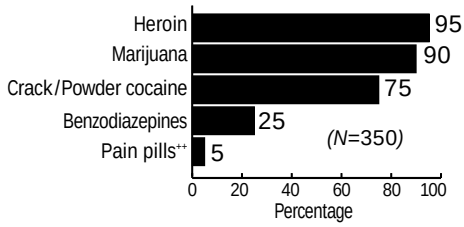
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



[+]Includes any use, whether as a primary, secondary, or tertiary drug; responses for methamphetamine and ecstasy were "very small."

[++]Hydrocodone products (Vicodin®, Lortab®, Lorcet®)

Source: Methadone treatment respondent

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

All four *Pulse Check* sources believe the city's overall drug problem has remained stable since the previous reporting period, particularly the situation regarding cocaine, heroin, and marijuana. Three of the sources consider the city's drug problem very serious, and the law enforcement source describes it as "somewhat serious." Because of the different populations with whom they have contact, the sources vary in their perception of which drugs are most commonly abused and which have the most serious consequences:

- One source names crack as the drug with the most serious consequences because it is associated with violence, health problems, and loss of family support. Methamphetamine follows in consequences because the cold fusion and "Nazi" production methods use toxic substances such as rat poison, liquid fertilizer, matches, lithium batteries, and Drano®. The resulting effects, such as health problems, legal issues, and violence, are intensified because recipes involving such substances proliferate over the Internet.[E]
- Another source names heroin as the drug with the most serious consequences because of high relapse rates among treatment clients. Crack follows in consequences because of its links to criminal activity.[N]
- An unidentified substance, mislabeled "ice," is increasingly reported at clubs and circuit parties in the gay community. The Drug Enforcement Administration (DEA) will be testing this substance, whose effects differ from those of "speed."[E]
- Compared with 5 years ago, the most widely abused drug among clients in one program has shifted from crack to heroin. Short-term trends, however, are stable.[N]
- Methylendioxymethamphetamine (MDMA or ecstasy) and gamma hydroxybutyrate (GHB) continue as emerging problems.[L]

Most widely abused drug:
Marijuana[L,E]
Heroin[N,M]

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

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

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

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

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

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

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

New or emerging problems:
Ecstasy and GHB use continues.[L]

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

With the city's close proximity to the border, and with continued high demand, Mexican black tar heroin remains the primary threat. However, as Colombian traffickers have been trying to expand their market (possibly trying to avoid the tightened security on the East Coast), South American heroin has become increasingly available over the last year. Southwest Asian white heroin is also more easily obtainable.[L]

While heroin users are predominantly older Black injectors from central city areas, an emerging group of young, White, more affluent smokers from the suburbs (mean age 17.5 years) is increasingly experimenting with heroin.[E]

COCAINE

Overall, the number of crack and powder cocaine users remains stable, and no new user groups are reported.[E]

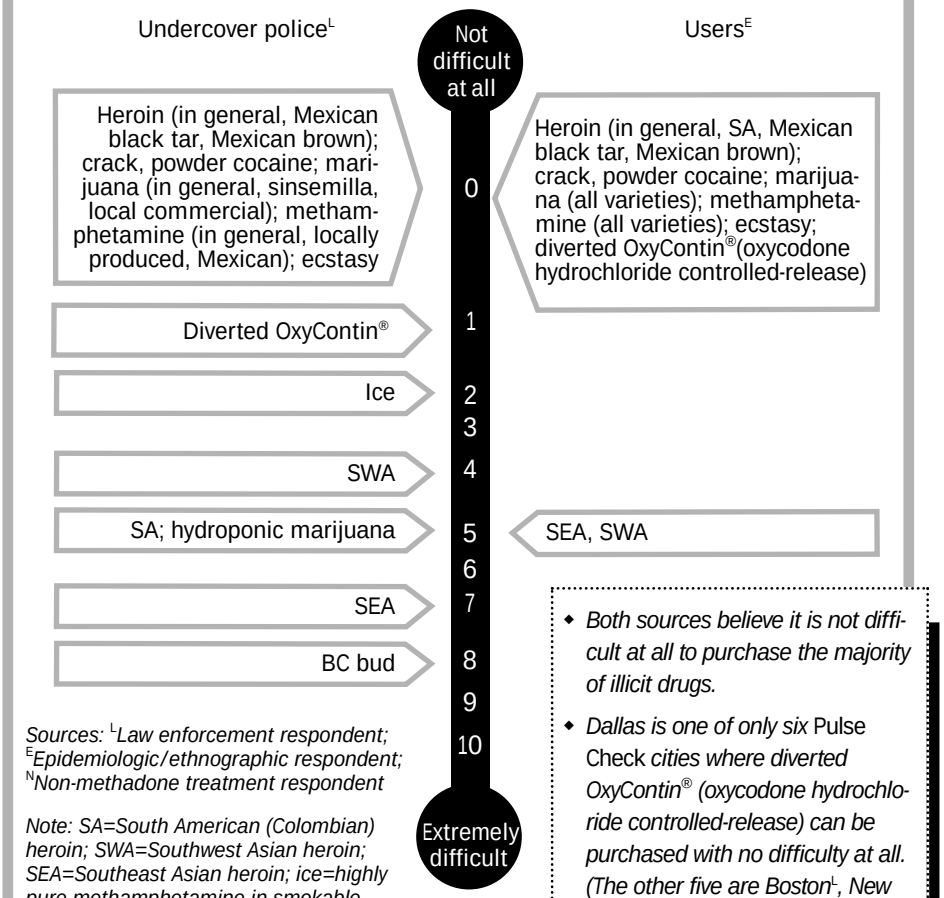
The percentage of clients in treatment for a primary crack problem declined somewhat since the last reporting period (to 19 percent); among first-time admissions, however, that percentage increased slightly (to 16 percent).[N] The treatment percentage for powder cocaine remains stable.[N]

MARIJUANA

Overall, the number of marijuana users remains stable, and no new or emerging groups are reported.[E] Marijuana user characteristics remain stable.[E,N]

The exchange of guns for marijuana has increased. "More youngsters are trading and carrying." Many of these youth get their guns from a large gun show that comes through Dallas annually.[E]

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



Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent

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

- *Both sources believe it is not difficult at all to purchase the majority of illicit drugs.*
- *Dallas is one of only six* Pulse Check *cities where diverted OxyContin® (oxycodone hydrochloride controlled-release) can be purchased with no difficulty at all. (The other five are Boston[L], New York[L], Pittsburgh[E], San Francisco[L], and Tampa/St. Petersburg[L]).*

- *Undercover officers find it easier to purchase SA and SWA white heroin in fall 2002 than in the previous spring due to greater street availability and new trafficking groups.*[L]
- *Additionally, the non-methadone treatment source describes three recent heroin dry spells: one after September 11, and two during the second half of 2002. Each lasted a few weeks, causing increases in price and number of users seeking detox, and then leveled out.*[N]
- *Ice is also more easily purchased by undercover officers than previously. It is more available, and more organizations are moving the drug.*[L]
- *The epidemiologic source reports no change in ease of user drug purchases. One treatment source, however, reports an increase in crack availability.*[N]

METHAMPHETAMINE

Ice, which had not been encountered for a while, has become more available as more Mexican organizations have become involved, and demand is increasing because of lower prices.

Increases in use are reported, both among methamphetamine users in general and within the gay community, which is an emerging user group.[E]

Only one source reports a decline: Non-methadone treatment clients report that availability and quality may have declined because of recent police action on labs. Nevertheless, they report the drug as widely available and cheaper than powder cocaine.[N]

MDMA (ECSTASY)

Two sources note related increases among sellers and users:

- Ecstasy sellers used to be primarily White males. But an increase is reported in the number of Asian-American, Black, and Mexican traffickers, and the market is now expanding into night clubs in Black communities.[L]
- While ecstasy users are predominantly White, some increase is noted in the Black community.[E]

OTHER DRUGS

- Gamma hydroxybutyrate (GHB): Adolescents are reportedly using it more, sometimes instead of flunitrazepam (Rohypnol®), to commit drug assisted rape.[E]
- Alprazolam (Xanax®) plus methadone: This combination is increasingly reported in methadone clinics and often results in fatalities.[E] No increase, however, is reported for methadone alone: users still resort to the standard practice of "cheeking" and selling the drug.[E]
- Diverted OxyContin®: While users tend to be young adult (18–30 years), White, suburban males, adults in rural areas are increasingly starting to use the drug.[E] An increase is also noted among club-goers.[N] Tablets are usually ingested orally, but a slight increase is noted in crushing and injecting.[E] "Blue" refers to the combination of OxyContin® plus almost any other drug, from crack to a depressant.[N]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- Methadone maintenance treatment is available throughout the Dallas area and remained stable between spring and fall 2002. Both public and private programs have adequate capacity, which is unchanged since the previous reporting period.
- The *Pulse Check* non-methadone treatment source directs a program whose enrollment of 101 residential clients and 142 outpatients is below its capacity of 120 residential clients (determined by square footage for licensing by the Single State Agency and the Texas Commission on Alcohol and Drug Abuse) and 300 outpatients (determined by program schedule and licensing counselor-to-patient ratio). Slightly more than one-third of the clients in treatment from September 1 through November 30, 2002, reported heroin as their primary drug of abuse, and another third reported crack cocaine as such (*see pie chart on the first page of this chapter*).
- The methadone treatment source is president of a program whose 350 outpatient clients at the time of the *Pulse Check* discussion were below its 400 outpatient capacity (determined by the State law's counselor-to-patient ratio). The vast majority (90 percent) of the opiate users in the program also use marijuana, and three-quarters of them also use some form of cocaine (*see bar graph on the first page of this chapter*). Five percent of the methadone patients use pain pills, such as hydrocodone products (Vicodin®, Lortab®, Lorcet®), as their primary drug of abuse. These individuals generally became addicted because of some health condition that required pain management—underscoring the need for educating doctors and dentists about drug addiction.[M]

Co-occurring disorders

- Incidence of HIV/AIDS and hepatitis C has stabilized because of effective intervention programs in the city.[N,M]
- Dual diagnoses involving antisocial disorder or conduct disorder declined among clients in the non-methadone program because the program has a history of dealing with this population and has improved its screening process. The program has a high but stable number of dually diagnosed clients with psychosis because two central screening facilities in the area refer them for detox.[N]

Barriers to treatment

- Cases of violent behavior among presenting clients have declined because the program has an improved screening process and a history of dealing with this population.[N]
- One program does not lack transportation or money for transportation because managed care covers some of the costs.[N] The other program notes the transportation barrier as fairly common but stable.[M]
- Hispanics are underrepresented in treatment programs throughout the city for several reasons: a cultural distrust of engaging in official activities; the availability of church-based counseling; a lack of education about resources; and a

lack of professional Hispanic staff to engage Hispanic users.[N]

- Lack of training and adequate reimbursement for professional staffing to deal with comorbidity causes one program to have a slight but stable staffing problem.[N] The other program's lack of trained staff to treat clients with psychiatric problems has increased: as the treatment community's awareness of the problem is growing, the program is struggling to find staff to deal with it.[M]
- One respondent notes the lack of education, and the misinformation about what treatment and addiction are, within the medical community and in the general population.[M]

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	>30
Mean age (years)	35	39	47 (median)
Gender	60% male	76% male	56% male
Race/ethnicity	Black	White	White
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Individual; Council on AOD	Individual
Level of education completed	N/A	High school	Junior high
Employment at intake	N/A	Unemployed	50% employed, 50% unemployed

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

- *Two user groups are reported: the older, poorer, Black injectors from central city areas; and an emerging group of young, White, more affluent smokers from the suburbs (mean age 17.5 years). The latter group has increased somewhat.*[E]
- *A slight decline in the percentage of clients in treatment for primary heroin abuse does not reflect the street situation. Rather, it is related to changes in the managed care system's definition of treatment priorities.*[N]
- *Whites and Blacks constitute 48 percent and 40 percent, respectively, of the heroin users.*
- *North of Dallas, in the Plano area, the younger, more affluent, suburban heroin-using population is stabilizing. Fewer deaths are reported than in the past because of increasing awareness about heroin.*[M]
- *Most clients have been addicted to heroin for more than 20 years, since their twenties.*

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs taken	Alprazolam, powder cocaine, crack, methamphetamine, over-the-counter medications	Powder cocaine	Marijuana, crack, benzodiazepines, pain pills
Publicly or privately?	Privately	Publicly and privately	Privately
Alone or in groups?	Alone	Alone	Alone and in groups/ among friends

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

- *The older injectors combine heroin with powder or crack cocaine (speedballs, "he-she," or "boy-girl") or alprazolam. The younger smokers mix their "chiva" with "speed" or over-the-counter medications.[E] A variety of other combinations are reported* (see box below).[N]
- *The younger emerging group tends to use heroin more publicly than the older injectors, who prefer more private settings, such as shooting galleries (though some use heroin in parks).[E]*
- *White and Black heroin users tend to inject. Mexican users, however, tend to snort or smoke.[M]*
- *One-quarter of the methadone patients use diazepam or alprazolam as well as heroin. These individuals usually start out with a co-occurring medical condition for which they obtain a benzodiazepine prescription—underscoring the need for educating doctors and dentists about drug addiction.[M]*

A "lexicon" of heroin combinations

Clients at the program directed by the *Pulse Check* non-methadone treatment source provided the following list of slang names for various drug combinations that include heroin:

"Beast":	Heroin plus lysergic acid diethylamide (LSD)
"China white" or "TNT":	Heroin plus fentanyl
"Cotton brothers":	Heroin plus cocaine plus morphine
"The five way":	Heroin plus snorted cocaine plus methamphetamine plus flunitrazepam plus alcohol
"LBJ":	Heroin plus LSD plus phencyclidine (PCP)
"Mud":	Heroin plus opium
"Sleeper and red devil":	Heroin plus a depressant
"Blanco":	Heroin plus cocaine
"Bombita":	Heroin plus amphetamine
"El diablito":	Heroin plus cocaine plus marijuana plus PCP smoked
"Poro":	Heroin plus PCP
"Goma":	Black tar heroin plus opium
"Homicide":	Heroin cut with strychnine
"Hot heroin":	Heroin poison to give a police informant
"Red rock" or "red rum":	Heroin plus barbitol plus strychnine plus caffeine
"Scramble":	Low purity heroin plus crack
"Spike":	Heroin cut with strychnine for injecting use

Source: Non-methadone treatment respondent

Who's most likely to use cocaine?

	Crack cocaine		Powder cocaine		Cocaine (unspecified)
Characteristic	E	N	E	N	M
Age group (years)	18–30	>30	18–30	>30	>30
Mean age (years)	25	37	28	34	47 (median)
Gender	60% male	72% male	70% male	62% male	56% male
Race/ethnicity	Black	Black	White	White	White
Socioeconomic status	Low	Low	Middle	Low	Low
Residence	Central city	Central city	Suburbs	Central city	Central city
Referral source	N/A	Individual; Council on AOD	N/A	Individual	Individual
Level of education completed	N/A	High school	N/A	High school	Junior high
Employment at intake	N/A	Unemployed	N/A	Unemployed	50% employed, 50% unemployed

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

- *The percentage of clients in treatment for a primary crack problem declined somewhat since spring 2002 (to 19 percent); among first-time admissions, however, that percentage increased slightly (to 16 percent).*[N]
- *The treatment percentage for powder cocaine remained stable.*[N]
- *The percentage of males admitted for primary crack abuse increased—"probably a random blip."*[N]
- *User characteristics remained stable between spring and fall 2002.*[E]
- *Some users are beginning to inject crack, using lemon juice or vinegar to liquefy it. As a result, an increase is reported in skin infections around injection sites.*[E]
- *Some methadone patients mix cocaine with heroin or marijuana.*[M]
- *The combination of crack plus marijuana, according to clients at the program directed by the* Pulse Check *non-methadone treatment source, has several slang names, including "bazooka," "cocktail," "crack bash," "juice joint," "primo turbo," "woolie," and "woolie blunt." "Cigamos" refers to crack plus tobacco.*[N]
- *The non-methadone clients also report several slang names for combinations that include powder cocaine plus various other drugs: speedball (plus methamphetamine or plus heroin); "beam me up scottie" (plus PCP); "shabu" (plus ice or methamphetamine); "spaceball" (plus PCP); and "wicky" (plus PCP plus marijuana).*[N]

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	18–30	18–30	>30
Mean age (years)	19.5	24	47 (median)
Gender	55% male	91% male	56% male
Race/ethnicity	White	White	White
Socioeconomic status	Middle	Low	Low
Residence	Suburbs	Central city	Central city
Referral source	N/A	Individual	Individual
Level of education completed	N/A	High school	Junior high
Employment at intake	N/A	Unemployed	50% employed, 50% unemployed

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

- *Marijuana use cuts across all age and racial groups.*[E]
- *User characteristics remained stable between spring and fall 2002.*[E,N]
- *The methadone clinic no longer imposes consequences (such as loss of privileges) on clients for using marijuana: otherwise, the majority of its clients would drop out of the program.*[M]

- *While marijuana is most often smoked in joints, blunts are also common.*[E]
- *Marijuana combined with embalming fluid is known as "water."*[E]
- *Marijuana combined with crack is known as a "primo."*[E]
- *A variety of other drug combinations including marijuana are listed below.*

How do users take marijuana?

Characteristic	E	N	M
Primary delivery vehicle	Joints	Joints	NR
Other drugs taken	Embalming fluid, crack cocaine (sometimes powder cocaine)	Cocaine, methamphetamine	Heroin, pain pills, cocaine
Publicly or privately?	Publicly	Publicly and privately	NR
Alone or in groups?	In groups/ among friends	In groups/ among friends	NR

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

A "lexicon" of marijuana combinations

Clients at the program directed by the *Pulse Check* non-methadone treatment source provided the following list of slang names for various drug combinations that include marijuana:

"Wet":	Marijuana plus embalming fluid
"Syrup":	Marijuana plus cough syrup
"Bad seed":	Marijuana plus peyote
"Chronic" or "kryptonite":	Marijuana plus crack
"Herb and al":	Marijuana plus alcohol
"Hydro":	Marijuana plus amphetamine or ecstasy
"Killer," "parsley," "frios," "yerba mala," or "zoom"	Marijuana plus PCP

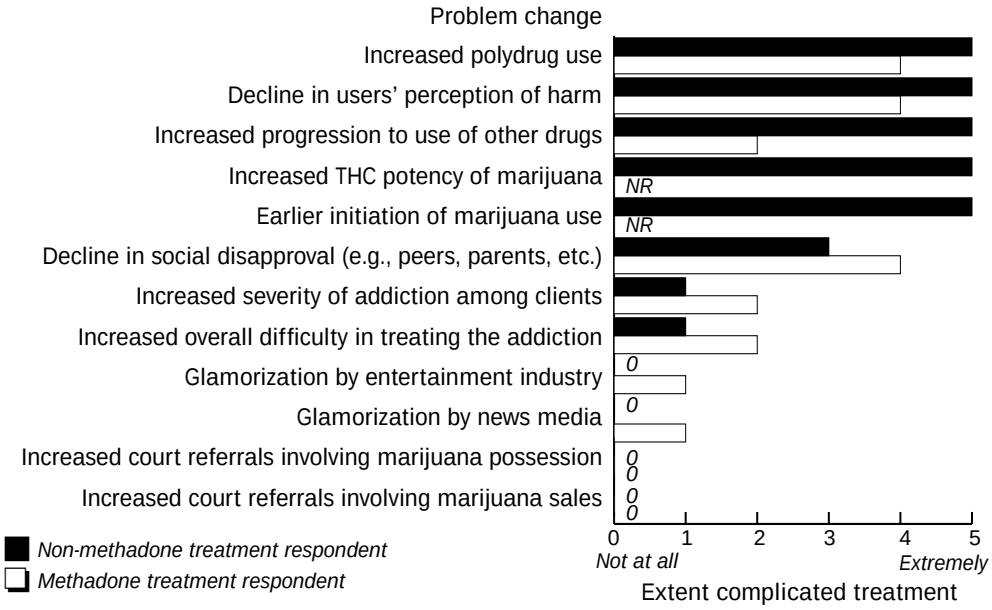
Source: Non-methadone treatment respondent

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

- Drug-related deaths[M]
- Drug-related emergency room visits[M]
- Drug-related arrests[M]
- Automobile accidents[E]
- High-risk pregnancies[E]
- Poor academic performance[E]
- Dropping out of school[E]
- Poor workplace performance[E,N]
- Deteriorating family and social relationships[N]

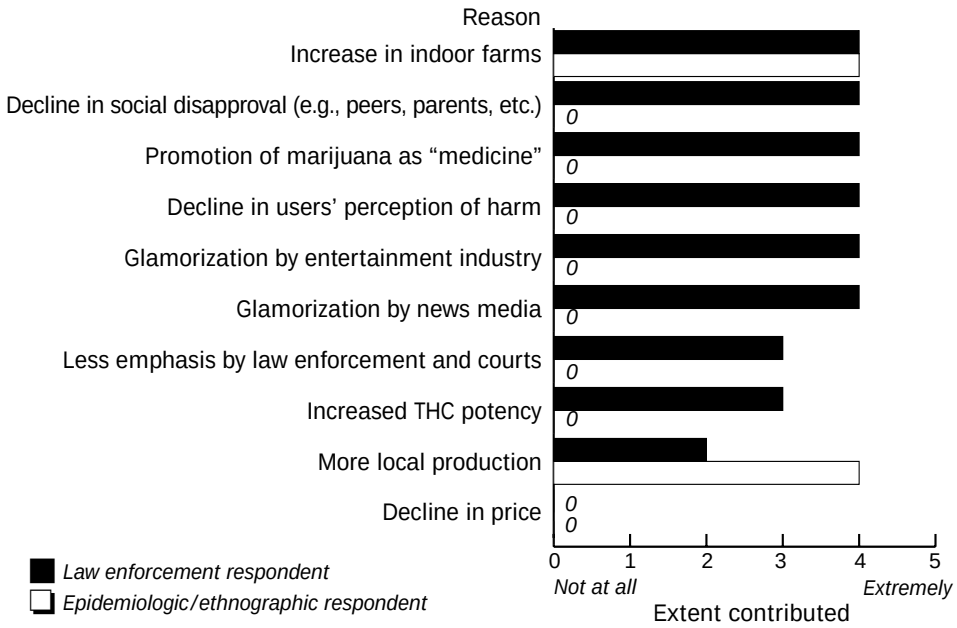
Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



What they have to say...

- *Court referrals have increased.*[N] *In some cities (such as Philadelphia), respondents consider that change to have had a positive effect on treatment; in others (such as Atlanta), respondents believe that change has had a negative effect; in Dallas, however, that change has not complicated treatment in any way.*
- *Like many other* Pulse Check *respondents, both Dallas treatment sources agree that the news media appear to have had little complicating effect.*

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



What they have to say...

- *Indoor farms: From closets to bedrooms to bathtubs–marijuana is increasingly grown "anywhere you can put a grow light."*[E] *It is becoming easier to obtain equipment from catalogs, head shops, and other sources. Indoor grows yield increased THC content.*[L]
- *Harm perception: "The public feels it's no big deal. They don't think of it as a gateway drug."*[L] *This remark echoes the sentiment of the majority of* Pulse Check *respondents.*
- *Social disapproval: One source believes that parents' and peers' opinions make little difference in marijuana use.*[E] *By contrast, another believes–like the vast majority of* Pulse Check *respondents–that marijuana's increasing social acceptability has contributed to widespread use.*[L]
- *Law enforcement/court emphasis: One source believes marijuana is given low priority relative to other types of drugs.*[L]
- *More local production: With the decline in the economy, many use marijuana production for income.*[E] *It is becoming easier to conceal, and therefore harder to detect local production.*[L]
- *Prices: Like in many other* Pulse Check *cities, prices have not changed.*[E]

Who's most likely to use methamphetamine?

Characteristic	E	N
Age group (years)	18–30	>30
Mean age (years)	25	35
Gender	80% male	58% male
Race/ethnicity	White	White
Socioeconomic status	Middle	Low
Residence	Suburbs	Suburbs, rural areas*
Referral source	N/A	Individual
Level of education completed	N/A	High school
Employment at intake	N/A	Unemployed

**Rural and suburban areas are about a mile apart.*

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

- *Few methamphetamine users take heroin, so the number enrolled in the methadone program is very small.*[M]
- *Increases are reported, both among methamphetamine users in general and within the gay community, which is an emerging user group.*[E]
- *To cover the cost of their drug use, users are increasingly obtaining recipes from the Internet, cooking methamphetamine themselves, and trying to sell it.*[E]
- *First-time methamphetamine admissions include a higher percentage of males than methamphetamine admissions overall (72 versus 58 percent).*
- *Client characteristics remained stable between spring and fall 2002.*[N]

How do users take methamphetamine?

Characteristic	E	N
Primary route of administration	Smoking	Injecting
Other drugs taken	Marijuana	Marijuana
Publicly or privately?	Publicly	Privately
Alone or in groups?	In groups/ among friends	Alone

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

- *While smoking predominates, many users inject methamphetamine.*[E]
- *One source observes that methamphetamine users generally don't take other drugs—"they like to stay up and feel the buzz."*[E]
- *According to non-methadone treatment clients, however, methamphetamine is combined with PCP (in "jet fuel"), sildenafil (Viagra®) (in "tina"), and marijuana plus a depressant (in a "christmas tree").*[N]

- *Ecstasy is not a drug used by methadone patients, who are much older than the ecstasy-using population.*[M]
- *While ecstasy users are predominantly White, some increase is noted in the Black community.*[E]
- *Some ecstasy users also use heroin, amphetamine, and ketamine and other sedatives.*[N] *A variety of slang terms for various ecstasy combinations are listed in the following box.*
- *Client characteristics remained stable between spring and fall 2002.*[N]

Who's most likely to use ecstasy?

Characteristic	E	N
Age group (years)	18–30	18–30
Mean age (years)	NR	25
Gender	50% male	75% male
Race/ethnicity	White	White
Socioeconomic status	Middle	Low
Residence	Suburbs	Central city
Referral source	N/A	Individual
Level of education completed	N/A	Junior high
Employment at intake	N/A	Unemployed

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

A "lexicon" of ecstasy combinations

Clients at the program directed by the *Pulse Check* non-methadone treatment source provided the following list of slang names for various drug combinations that include ecstasy:

Ecstasy plus amphetamine:	"B-bombs," "diamonds," "hugs and kisses," "super X," "waffle dust"
Ecstasy plus LSD:	"Candy flipping," "troll"
Ecstasy plus PCP:	"Elephant flipping"
Ecstasy plus depressants:	"Disco biscuit"
Ecstasy plus depressants in gel form:	"Jellies"
Ecstasy plus heroin:	"H-bomb"
Ecstasy plus sildenafil:	"Hammerheading"
Ecstasy plus nitrous oxide:	"Nox"
Ecstasy plus flunitrazepam:	"Rib"
Ecstasy plus crack:	"Roca"
Ecstasy plus mescaline:	"Love flipping"

Source: Non-methadone treatment respondent

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin is sold primarily in central city areas[L,E] in a host of locations:

- On the streets[L,E]
- In open-air markets[L,E]
- Around supermarkets[L,E]
- In hotels or motels[L,E]
- In crack houses/shooting galleries[E]
- In private residences[E]
- In public housing developments[E]
- Around drug or alcohol treatment clinics[E]

Those sales settings are also generally use settings. The new young smokers, however, do not make their deals on the street or in crack houses or shooting galleries. Compared with the older injectors, they are more likely to make deals in cars, private residences, nightclubs and bars, and private parties.

Crack sales are equally distributed among central city, suburban, and rural areas.[L] Sales settings, and usually use locations, include the following:

- On the streets[L,E]
- In open-air markets[L,E]
- Inside private residences[L,E]
- In public housing developments[L,E]
- In crack houses or shooting galleries[E]
- In hotels or motels[E]
- Inside cars[L]
- In nightclubs or bars[L]

Powder cocaine is sold in central city[E] and suburban[L,E] areas in indoor locations, which are usually also use settings:

- Inside private residences[L,E]
- In public housing developments[L]
- In nightclubs or bars[L,E]
- At private parties[L,E]
- In hotels or motels[L,E]
- Inside cars[L]
- At concerts[E]

Marijuana is equally likely to be sold in central city, suburban, and rural areas[L,E] in a wide variety of outdoor and indoor locations where it is often also used:

- On the streets[L,E]
- In open-air markets[L,E]
- Inside private residences[L,E]
- In public housing developments[L,E]
- In or around elementary, junior high, or high schools[L]
- On college campuses[L]
- In nightclubs or bars[L,E]
- In or around shopping malls[L]
- In playgrounds or parks[L]
- At private parties[L,E]
- At raves[L]
- At concerts[L,E]
- In hotels or motels[L,E]

Methamphetamine is usually sold in rural areas[L,E] in both outdoor and indoor sales and use settings, although gay users tend to make their deals only in the indoor locations:

- On the streets[E]
- In open-air markets[E]
- Inside private residences[L,E]
- In nightclubs or bars[L,E]
- At private parties[E]
- In hotels or motels[L]
- Inside cars[E]

Local methamphetamine is manufactured in both rural and city areas in "box labs" and in other clandestine labs in trailers, residences, fields, and a variety of other locations. The "Nazi" (quick-cooking) production method is the most common,[L] but the "cold method," which uses red phosphorus, is also reported.[E] Many users manufacturer their own drug by getting recipes over the Internet and stealing liquid fertilizer from farms and feed stores.[E]

The ecstasy market is located in both central city and suburban locations, both outdoors and indoors:

- On the streets[L]
- In open-air markets[L]
- Inside private residences[L,E]
- In public housing developments[E]
- In or around elementary, junior high, or high schools[L]
- On college campuses[L]
- In nightclubs or bars[L,E]
- At private parties[L]
- At raves[L]
- At concerts[L]
- Inside cars[E]
- Through the mail[L]

Diverted OxyContin® is sold in central city, suburban, and rural areas, usually inside private residences or at private parties.[L]

WHO'S SELLING DRUGS, AND HOW?

Nearly all drug deals are hand-to-hand transactions, with the exception of ecstasy, which is sold either person to person or through the mail. Dealers generally communicate with their buyers, suppliers, and fellow dealers via cell phone. Ecstasy dealers use both cell phones and the Internet for communications.

- Heroin dealers generally operate within an organized structure. They tend to be older than 30, are not very likely to use their own drug, and they also sell other drugs, such as methamphetamine, crack cocaine, and marijuana.[L] "One on one" refers to gangs selling cocaine and heroin in the central city.
- Crack cocaine dealers, like heroin dealers, belong to organized structures. But they are younger (18–30) and are somewhat likely to use their own drug. They also sometimes sell marijuana.[L]
- Powder cocaine dealers are similar to crack dealers, with two exceptions: they are not very likely to use their own drug, and they sell methamphetamine and marijuana in addition to the powder cocaine.[L]
- Marijuana dealers generally belong to gangs. They tend to be older than 30, are somewhat likely to use their own drug, and are involved in polydrug sales. More new seller groups are being investigated than in the past.[L]
- Methamphetamine dealers, unlike dealers of most other drugs, operate independently. They tend to be young adults (18–30 years) who are very likely to use their own drug, and they sell no other drugs.[L]
- Ecstasy dealers, like marijuana dealers, operate within a gang structure. They tend to be young adults (18–30 years) who are somewhat likely to use their drug. They sell a variety of other drugs, including GHB, ketamine, PCP, LSD, powder cocaine, marijuana, and methamphetamine. Ecstasy sellers used to be primarily White males. But an increase is reported in the number of Asian-American, Black, and Mexican traffickers, and the market is now expanding into nightclubs in Black communities.[L]
- Diverted OxyContin® dealers operate independently. They are generally young adults who are very likely to use their own drug and to sell other diverted prescription drugs, such as hydrocodone products and benzodiazepines.

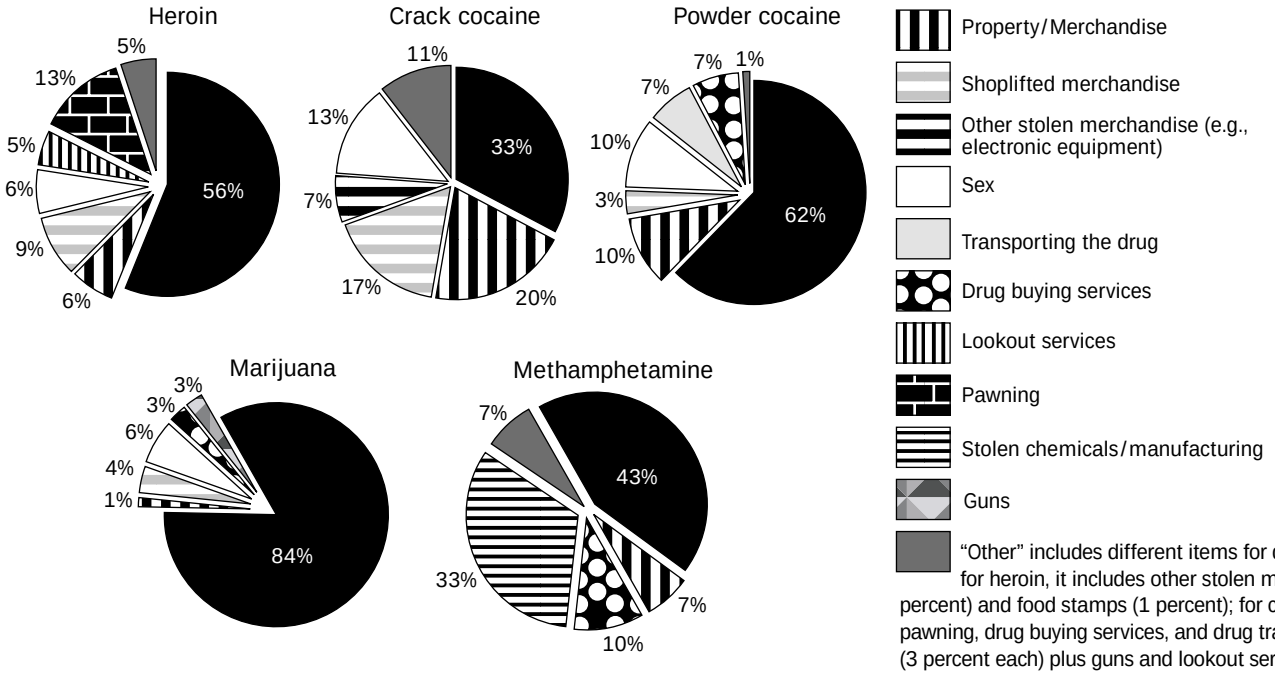
Which drug sellers are associated with which crimes?

Crime	Heroin	Crack cocaine	Powder cocaine	Marijuana	Methamphetamine	Ecstasy
Gang-related activity		✓		✓		✓
Violent criminal acts	✓	✓	✓			
Nonviolent criminal acts	✓		✓		✓	

Sources: Law enforcement respondent; epidemiologic/ethnographic respondent

- *Dealers in diverted OxyContin® are often involved in theft[E], as are methamphetamine dealers.[L] They are also involved in fraud.[L]*
- *Assault is the violent crime most associated with heroin, crack, and powder cocaine dealers.[L]*
- *Some heroin users are also sometimes involved in violent crime.[E]*

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



"Other" includes different items for different drugs: for heroin, it includes other stolen merchandise (4 percent) and food stamps (1 percent); for crack, it includes pawning, drug buying services, and drug transport services (3 percent each) plus guns and lookout services (<1 percent each); for powder cocaine, it includes guns and other drugs (<1 percent each); and for methamphetamine, it includes shoplifted merchandise and drug transport services (3 percent each) plus other stolen merchandise (<1 percent).

Source: Mean of response ratings given by law enforcement, epidemiologic/ethnographic, non-methadone treatment, and methadone treatment respondents; the epidemiologic/ethnographic source did not provide percentages for cocaine exchanges; the methadone treatment source did not provide information for methamphetamine exchanges.

- *Cash-only transactions appear much fewer in Dallas compared with those in the other* Pulse Check *cities, except in the case of marijuana. Conversely, a greater number of transactions in Dallas involve exchanging various goods and services, particularly for crack and methamphetamine.*
- *Clients in the non-methadone program, in particular, do not conduct cash transactions because they are an indigent group.[N]*
- *Dealers are increasingly distributing free drugs in order to gain and maintain market share.[N]*
- *Middleman transactions (drug buying services) have increased because, according to non-methadone clients, "you gotta know somebody who knows somebody."[N]*
- *Users are increasingly becoming involved in the manufacturing process in order to obtain methamphetamine.[N]*
- *The exchange of guns for marijuana has increased. "More youngsters are trading and carrying." Many of these youth get their guns from a large gun show that comes through Dallas annually.[E]*

- *Heroin ounce prices rose after September 11, 2001, but returned to earlier levels in the late spring.*[L,N]
- *Heroin purity at the kilogram level increased slightly between spring and fall 2002.*[L]
- *Prices for ice are lower as availability increases with the growing involvement of Mexican organizations.*[L]
- *Heroin is sometimes adulterated with diphenhydramine (Benadryl®).*[L,N] *Other adulterants are listed below.*
- *Bags of 1,000 ecstasy pills are known as "K-lots."*[L]
- *All other reported prices and purity levels remained stable between spring and fall 2002.*[L]

How much do illegal drugs cost?

Drug	Unit	Price
Mexican black tar heroin	0.25 g 1 g 1 oz[a] 1 kg[b]	$20–$25[N] $150–$250[L] $800–$2,000[L] $35,000–$45,000[L]
Powder cocaine	1 g	$50–$100[L]
Crack cocaine	One rock	$10–$40[L]
Mexican marijuana	One cigarette 1/4 oz 1 lb	$2[L] $25–$124[N] $450–$750[L]
Methamphetamine	1 g 1 oz (ice)	$70–$100[L] $700[L]
Ecstasy	One pill Bags (1,000 pills)	$7.50–$15[L] $9,000[L]

[a]*5–6% pure,* [b]*22–28% pure*

Sources: [L]*Law enforcement respondent;* [N]*Non-methadone treatment respondent*

WHAT SUBSTANCES ARE USED AS ADULTERANTS?

Clients at the program directed by the *Pulse Check* non-methadone treatment source provided the following list of adulterants they have encountered in various drugs:

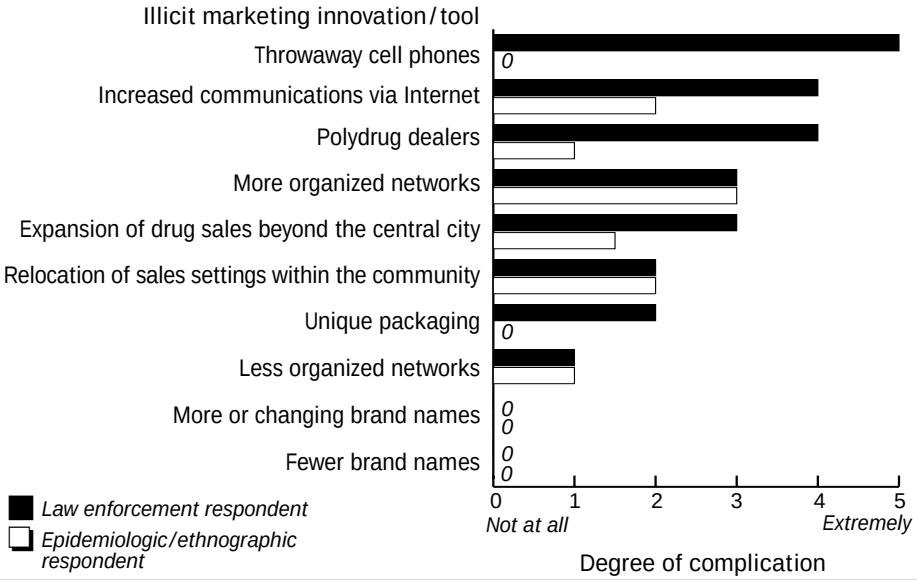
- Heroin: Baking soda, epsom salts, diphenhydramine
- Crack: "Pseudocaine" refers to crack cut with phenylpropanolamine; "stacks" refers to crack adulterated with ecstasy (or the other way around), although it also refers to ecstasy adulterated with heroin; and "chocolate ecstasy" refers to crack made brown by adding chocolate milk during production.
- Powder cocaine: Baby laxatives, alprazolam, baking soda
- Methamphetamine: Baby laxatives, dextrose, niacin, sugar, red sulphur (crack cut with red sulphur is known as "red phosphorous"), Drano® crystals, ephedrine

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

What they have to say...

- *As in most other* Pulse Check *cities, brand name changes have had little impact on detection or disruption activities, but throwaway cell phones have posed a challenge.*
- *Even though sales settings often relocate within the community, police are keeping up with them.*[E]
- *Rather than expanding beyond the central city, drug sales have been moving from the outside in.*[E]
- *The Internet is used primarily for passing recipes and for setting up parties and raves.*[E]
- *Networks have not changed in their degree of organization, except for methamphetamine networks in rural areas.*[E]

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



COMMUNITY INNOVATIONS AND TOOLS OVER THE PAST 10 YEARS: HOW SUCCESSFUL HAVE THEY BEEN?

Compared with respondents in other *Pulse Check* cities, those in Dallas seem to consider their community's antidrug strategies as less effective.

- Task forces: Because of budgetary constraints, the DEA relies heavily on task forces with State and local counterparts.[L] Unlike the majority of *Pulse Check* respondents, the epidemiologic/ethnographic source believes that these joint efforts are not changing the level of drug activity.[E]
- Precursor laws: Texas recently enacted legislation making it harder to obtain some of the chemicals essential to making methamphetamine. But traffickers are finding other types of chemicals, such as anhydrous ammonia, which they steal from rural farms.[L]
- Drug courts: Texas has recently enacted a program with a limited number of drug courts. It is too early to assess their effectiveness.[L]
- Prescription drug monitoring: "Doctor shopping" remains a chronic problem.[E]
- Crack house laws: Crack houses are being bought and bulldozed, but the people who frequent them just move to other locations.[E]
- Drug-free zone laws: Despite these laws, youth are still selling drugs in schools and are being arrested for it.[E]
- Sentencing changes: Texas has one of the largest criminal populations in jail, but that has had no impact on the drug situation.[E]
- Recommendation: County jails, which are constantly full and are facing major cuts across the board, need more educational and treatment services.[E]

SEPTEMBER 11 FOLLOWUP

Heroin prices increased for a short time after September 11 but subsequently came back down.[L,N]

Additionally, three possible longer term effects are noted:

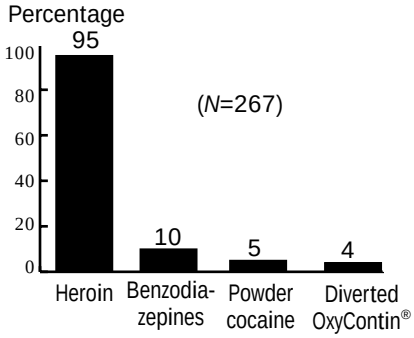
- Some trafficking organizations may be transiting through Dallas because security measures are tight on the East Coast.[L]
- Some nonprofit organizations that are hurting financially attribute their hardships to both the economic slump and the diversion of funds to New York.[E]
- Methadone treatment enrollment spiked a few months after September 2001 and into early 2002 and is continuing at a slightly higher level than usual. Some of this slight elevation might be related to a supply decline resulting from the general tightening of the borders and the initial war in Afghanistan, when the poppy fields were burned.[M]

DENVER PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 2,109,282
- Median Age: . . . . . 34.1 years
- Race:
  - White 79.4%
  - Black 5.5%
  - American Indian/ Alaska Native 0.9%
  - Asian/Pacific Islander 0.4%
  - Other race 8.1%
  - Two or more races 3.0%
- Hispanic (of any race): 18.8%
- Unemployment rate: 2.8%
- Median household income: $51,191
- Families below Poverty Level with Children <18 years: 8.3%

*Source: U.S. Census 2000**

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



+Includes any use, whether as a primary, secondary, or tertiary drug; responses for crack, methamphetamine, and ecstasy were "0"; response for marijuana was "don't know."

Source: Methadone treatment respondent

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

All four *Pulse Check* sources believe the overall drug problem in Denver has remained stable. A few changes, however, are reported:

- According to the non-methadone treatment source, treatment percentages there have remained relatively stable between spring and fall 2002, with slight decreases in heroin and powder cocaine as primary drugs of abuse and a decrease in the abuse of prescription drugs.
- According to one treatment source, after increasing substantially last year, methamphetamine use and admissions may be leveling off.[N] However, other sources report that methamphetamine use has increased substantially as the drug has become more available, and the availability and use of ice (high-purity, smokable methamphetamine) may be increasing.[L,E] According to one source, methamphetamine has replaced crack as the second most widely abused drug.[L]
- Local meth labs continue to increase, especially those using the "cold method" with anhydrous ammonia and the "Nazi" or quick-cooking method that can produce higher purity methamphetamine.[E]
- Use of club drugs, especially methylenedioxymethamphetamine (MDMA or ecstasy), but also including dextromethorphan (DXM), ketamine, and gamma hydroxybutyrate (GHB), continues to increase.[E,L]
- Abuse of OxyContin® (oxycodone hydrochloride controlled-release) continues to emerge.[M]

Three sources[L,E,N] consider the illegal drug problem very serious, and one[M] considers it somewhat serious. The drug associated with the most serious consequences varies by source: two sources[L,M] name methamphetamine as contributing to the most serious consequences, one source[E] names powder cocaine, and one[M] names heroin. Two sources[L,E] believe that marijuana continues as the most widely abused drug, another[N] names methamphetamine, and the methadone treatment source—not surprisingly—names heroin.

Most widely abused drug:
Marijuana[L,E]
Methamphetamine[N]
Heroin[M]

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

Second most widely abused drug:
Powder cocaine[E,M]
Methamphetamine[L]
Crack[N]

Changes between spring and fall 2002: Methamphetamine has replaced crack .[L]

Drug related to the most serious consequences:
Methamphetamine[L,N]
Powder cocaine[E]
Heroin[M]

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

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

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

Emerging drugs:
Ecstasy activity continues to increase.[L]
Club drug activity continues to increase.[E]
Diverted OxyContin®[M]

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

The heroin problem may be dissipating, according to several indicators:

- The number of primary heroin admissions to treatment has declined, and the number of primary heroin users new to treatment has declined substantially.[N]
- Heroin use and sales on college campuses have declined.[E]

COCAINE

Overall, the powder and crack cocaine problems appear relatively stable. The non-methadone treatment source reports a slight decline in powder cocaine use.

MARIJUANA

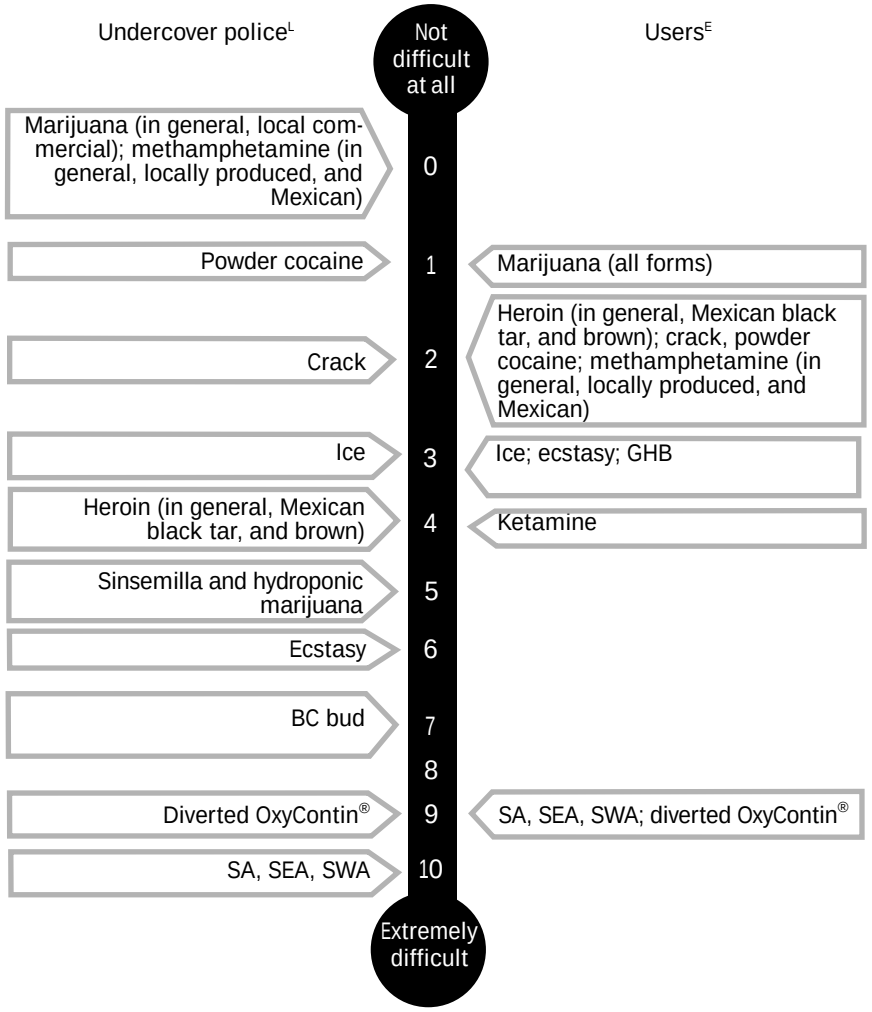
Marijuana sales and use remain relatively stable.[L,E,N,M] *Marijuana remains widely available and is considered the most abused drug by two sources.*[L,E]

METHAMPHETAMINE

Methamphetamine use indicators are mixed:

- After increasing dramatically in spring 2002, methamphetamine treatment admissions seem to be leveling off.[N]
- Methamphetamine use has increased, and there are more mentions of ice.[E]
- Local labs manufacturing methamphetamine using the "Nazi method" have increased in the past 6 months and are making a higher purity form of the drug. Local labs that manufacture ice have also increased.[E]

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



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

- *As reported in the majority of* Pulse Check *cities, marijuana is not difficult at all for users and undercover police to purchase.*[L,E] *Mexican heroin, powder and crack cocaine, and methamphetamine are also relatively easy to purchase.*
- *Since spring 2002, sources report no changes in the difficulty of purchasing drugs.*

MDMA (ECSTASY)

The methadone treatment source reports no use among clients, and the non-methadone treatment source reports low levels of secondary and tertiary use among clients. However, two sources report increasing club drug activity.[L,E]

DIVERTED OXYCONTIN®

Although diverted OxyContin® remains difficult to buy on the street, abuse has increased since spring 2002 (as it has in 14 other Pulse Check *cities):*

- The methadone treatment source reports an increase in primary and secondary OxyContin® abusers, nearly all of whom are new to treatment for any drug.[M]
- Of the 2–3 percent of admissions in the methadone treatment clinic who were primary OxyContin® abusers, most were older than 30, White, and split evenly between genders. Clients tend to be suburban residents of middle socioeconomic status who abuse OxyContin® only and take it orally.[M]

OTHER DRUGS

- GHB and ketamine: GHB and ketamine are relatively easy to buy, and availability remains stable. GHB sells for $5–$10 per capful.[E]
- Benzodiazepines: No clients at the methadone treatment program are primary benzodiazepine users, but about 10 percent (a relatively stable proportion) use the drug as a substitute for heroin.[M]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- The *Pulse Check* non-methadone treatment respondent, whose 20-bed inpatient facility operates at maximum capacity, reports methamphetamine as the primary drug of abuse among the majority of clients. Treatment percentages there have remained relatively stable between spring and fall 2002, except for slight decreases in heroin and powder cocaine as primary drugs of abuse, a leveling off in methamphetamine as a primary drug of abuse (after increasing dramatically during the previous 6 months), and a decrease in the abuse of prescription drugs.
- The methadone treatment respondent is with a facility that is nearly at maximum capacity (267 slots filled of 300), with capacity based on funding and staff. Nearly all clients (95 percent) abuse heroin as their primary drug, and 4–5 percent abuse OxyContin® as their primary drug. *(See bar chart on the first page of this chapter.)* Common secondary and tertiary drugs abused include benzodiazepines (among 10 percent of clients) and powder cocaine (among 5 percent of clients).
- Methadone treatment is available only in selected parts of the metropolitan area. Public and private methadone treatment facilities reportedly have adequate capacity, and treatment availability has remained stable between early and late 2002.[E]
- The non-methadone treatment provider reports a recent increase in drug abuse admissions (especially among female clients) who report suicidal thoughts and attempts. Lack of trained staff to treat comorbidity remains a common problem, as does limited slot capacity. The non-methadone treatment provider also believes that the recent decline in the Federal and State economies has limited the services that drug treatment facilities are able to provide.
- As reported by many methadone treatment sources across P*ulse Check* cities, hepatitis C has increased among drug abusers. The increase is most likely due to improved testing. The methadone source also reports an increase in severe abscesses among heroin injectors, most likely caused by a change in the way heroin has been adulterated or processed by distributors. Mood disorders, especially depression and bipolar disorders, are a common problem and have increased in the last 6 months. The methadone source explains that more people are being screened for the disorders; thus, more are being diagnosed and treated.

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	18–30	>30
Mean age (years)	37	NR	30–35
Gender	68% male	Split evenly	60% male
Race/ethnicity	66% White; 20% Hispanic (any race)	White	White
Socioeconomic status	Low and middle	Low	Low
Residence	Central city and suburbs	Suburbs	Suburbs
Referral source	N/A	Alcohol/drug abuse or other health care providers	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Part time	Unemployed

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

- *Two sources report heroin users as most likely to be White, non-Hispanic males over 30 of low to middle socioeconomic status.*[E,M]
- *Predominant user characteristics appear stable between spring and fall 2002.*[E,N,M]
- *Heroin users new to treatment have a much younger mean age than those among the overall treatment population (28.2 versus 37 years); furthermore, a higher proportion of heroin users new to treatment are White compared with users among the general treatment population (72 versus 66 percent).*[E]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Smoking	Injecting
Other drugs taken	Powder cocaine (speedball)	Powder cocaine (speedball)	Powder cocaine (speedball); benzodiazepines (as a substitute)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	Alone and in groups	Alone	Alone

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

Use patterns appear stable with two exceptions:

- *Snorting and injecting (versus smoking) heroin continue to increase, especially among heroin users new to treatment.*[E]
- *Heroin users new to treatment tend to either snort or smoke (evenly split). Among heroin users in general, injection as a route of administration continues to decline.*[N]

Who's most likely to use cocaine?

Characteristic	Crack		Powder cocaine	
	E	N	E	N
Age group (years)	<30	18–30	<30	18–30
Mean age (years)	34.9	NR	35	NR
Gender	55% male	70% female	67% male	Male
Race/ethnicity	37% White; 29% Black; 26% Hispanic (any race)	Black	48% White	Black
Socioeconomic status	Low	Low	Low and middle	Low
Residence	Central city	Central city	Distributed equally among all areas	Central city
Referral source	N/A	Criminal justice and social services	N/A	Criminal justice, other health care providers, and social services
Level of education completed	N/A	Junior high	N/A	High school
Employment at intake	N/A	Unemployed	N/A	Full time

Note: The methadone treatment source reported no primary, secondary, or tertiary crack admissions to treatment, no primary powder cocaine admissions to treatment, and 13 secondary and tertiary powder cocaine admissions (5 percent of total admissions).

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

Sources report several shifts in cocaine user characteristics between spring and fall 2002:

- *Among powder cocaine users in general, Blacks have increased slightly. Among powder cocaine users new to treatment, Whites have decreased as Hispanics and Blacks have increased.[E]*
- *Heroin admissions who use powder cocaine as a secondary drug tend to be younger than heroin-only users.[M]*
- *Among crack users new to treatment, Whites and those of middle socioeconomic status are increasing, and the mean age is rising.[E]*

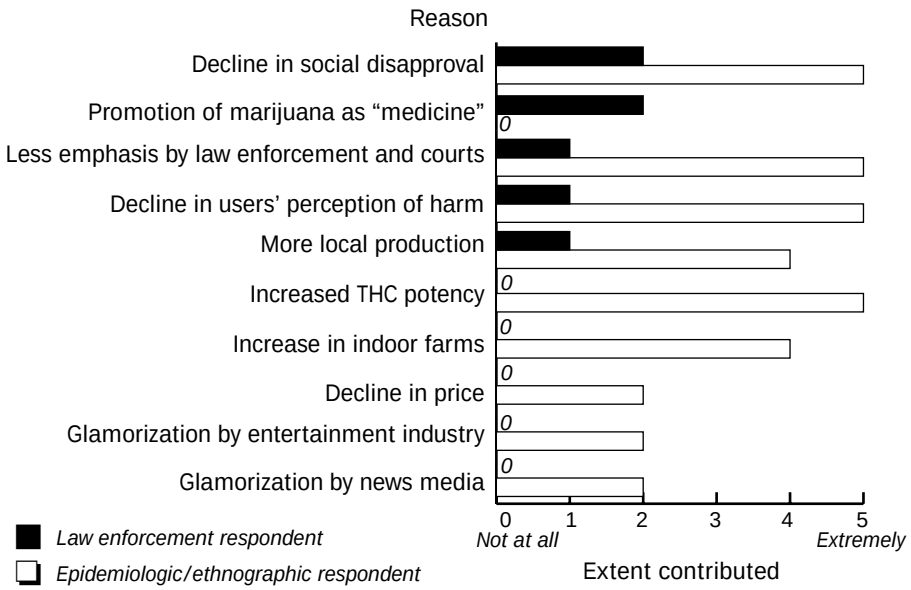
Who's most likely to use marijuana?

Characteristic	E	N
Age group (years)	18–30	18–30
Mean age (years)	24.8	NR
Gender	75% male	Split evenly
Race/ethnicity	54% White; 11% Black; 26% Hispanic (any race)	White and Black split evenly
Socioeconomic status	Divided evenly among all	Middle
Residence	Divided evenly among all areas	Suburbs
Referral source	N/A	Criminal justice and other health care providers
Level of education completed	N/A	High school
Employment at intake	N/A	Full time

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

- *Marijuana use continues to span all races, ethnicities, socioeconomic strata, and geographic areas of the city.*
- *Marijuana users new to treatment tend to be much younger (mean age of 16.7 years) than marijuana treatment admissions in general (mean age of 24.8 years).[E]*
- *Increased THC potency and earlier initiation of marijuana use have complicated treatment for marijuana-using clients. This source believes that glamorization of marijuana use by both the entertainment industry and news media has decreased in the past 10 years.[N]*

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



What they have to say...

- *Indoor farms: Indoor growth is becoming more difficult to detect, with larger quantities of marijuana grown in smaller spaces.*[E]
- *Increased THC: The increase of high-quality BC bud ("kind bud") on the market has contributed to the increased THC level of marijuana in Denver. In addition, certain varieties of marijuana from Alaska have a THC content of up to 29 percent.*[E]

WHAT ELSE DO USERS TAKE WITH MARIJUANA?

As in other cities, users often take many other drugs with or around marijuana. For example, methamphetamine is often taken sequentially after marijuana, and a new practice has emerged of dipping marijuana joints in formaldehyde (the dipped joints are called "wets").[N] Another source reports that some marijuana joints are laced with crack cocaine and referred to as "premos."[E]

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

Respondents associate marijuana, used either alone or with other drugs, with the following consequences, which appear stable between spring and fall 2002:

- Drug-related deaths (in which one of the drugs is marijuana)[E]
- Drug-related emergency room visits[E]
- Drug-related arrests[E,N]
- Automobile accidents[E]
- Short-term memory loss[E,N]
- Deteriorating family/social relationships[E,N]
- Poor academic performance[E,N]
- School absenteeism, truancy, or dropping out of school[E]
- Poor workplace performance[E]
- Workplace absenteeism[E,N]

Who's most likely to use methamphetamine?

Characteristic	E	N
Age group (years)	>30	18–30
Median age (years)	30	NR
Gender	53% male	Split evenly
Race/ethnicity	80% White; 13% Hispanic	White
Socioeconomic status	Low and middle	Middle
Residence	Divided evenly among all areas	Suburbs and rural
Referral source	N/A	Individual and social services
Level of education completed	N/A	High school
Employment at intake	N/A	Full time

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

Sources report several shifts in user characteristics between spring and fall 2002:

- *Females as a proportion of methamphetamine treatment admissions are increasing, and the gender split is now even.*[N]
- *Methamphetamine use is spreading from rural and suburban areas to all areas, including the central city.*[N]
- *The proportion of Hispanic methamphetamine users has increased as the proportion of Whites has declined.*[E]
- *Many blue collar workers use the drug to stay awake and work longer hours.*[E]

HOW ARE PEOPLE USING METHAMPHETAMINE?

Methamphetamine is primarily smoked and is often used sequentially with marijuana.[E,M] The epidemiologic source notes that smoking (52 percent) and injecting (31 percent) have increased as routes of methamphetamine administration, while snorting (14 percent) has declined.

WHO'S USING ECSTASY?

Ecstasy users tend to be adolescents and young adults of both genders. Whites are more likely to use ecstasy than other races/ethnicities and are overrepresented compared with the general population. Ecstasy users are primarily of middle or high socioeconomic background and reside mostly in central cities and suburbs. Common combinations include "candy flipping" (ecstasy combined with lysergic acid diethylamide [LSD]) and "kitty flipping" (ecstasy combined with ketamine).[E] Sources report no changes in user or use characteristics.

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin, crack and powder cocaine, marijuana, and methamphetamine are sold in a variety of public and commercial venues including the following:[L,E]

- Streets/open-air markets
- Crack houses/shooting galleries (excluding methamphetamine)
- Public housing developments
- Around drug treatment clinics (excluding crack and methamphetamine)
- Playgrounds/parks
- Around supermarkets
- Parking lots (excluding cocaine)

Drugs are also sold through prearranged meetings via cell phones in more private areas:[L,E]

- Private residences
- Hotels/motels
- Nightclubs and bars
- College campuses
- Inside cars

Additionally, methamphetamine and ecstasy are sold at raves and concerts, and marijuana is sometimes sold via the Internet. Although most sales settings have remained similar between spring and fall 2002, sales of heroin in open-air markets and on college campuses have declined.[E]

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

WHO SELLS ILLEGAL DRUGS, AND HOW DO DRUGS GET FROM SELLER TO BUYER?

Most dealers in Denver are polydrug dealers likely to distribute heroin, powder and crack cocaine, marijuana, and methamphetamine. Most are associated with Mexican trafficking organizations.[E] However, the trafficking organizations don't have much oversight on street sales and street-level dealers (who are organized into autonomous "street cells"). Drugs sold by these polydrug dealers are sold hand-to-hand in streets or through meetings prearranged via cell phones.

Moreover, Mexican trafficking organizations transport adolescents and young adults from Mexico and Central America to Denver and provide them with cheap motel rooms and cars from which to sell the drugs.[E] If these sellers are apprehended by the police they are deported, and no leads connect them to the trafficking organizations.

Which drug sellers are associated with which crimes?

Crime	Heroin	Powder cocaine	Crack cocaine	Marijuana	Methamphetamine	Ecstasy
Prostitution	✓		✓			
Gang-related activity	✓	✓	✓		✓	✓
Violent criminal acts: assaults	✓	✓	✓	✓	✓	✓
Non violent criminal acts: fraud and theft					✓	
Domestic violence					✓	
Drug-assisted rape						✓
No crimes associated		✓		✓		

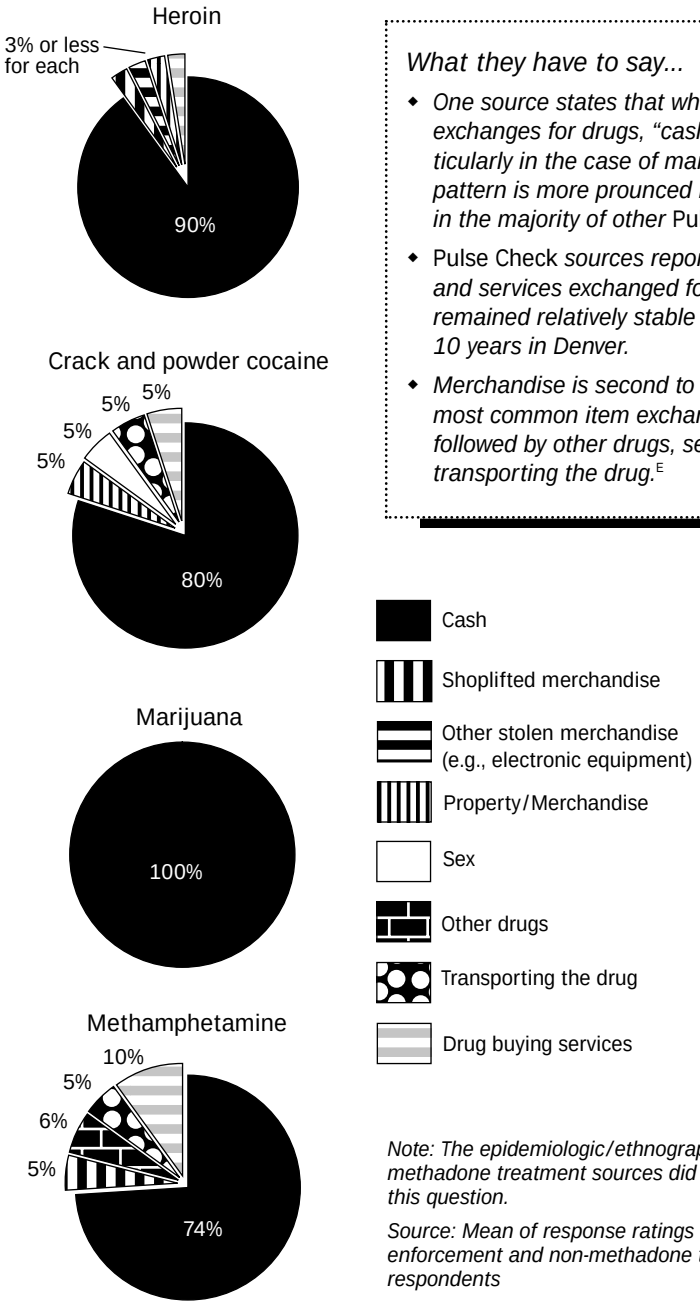
Source: [L]Law enforcement and [E] Epidemiologic/ethnographic respondents

- *Dealers who sell primarily methamphetamine tend to be associated with more types of crime—including domestic violence—than other drug dealers.*
- *Heroin and crack dealers continue to be associated with prostitution, street gangs, and violent assaults.*

Based on the drug sold, several differences in sales persist:

- Dealers who sell primarily crack are more independent than heroin or powder cocaine dealers, and crack distribution is becoming more intertwined with street gangs.[E]
- Dealers who sell primarily marijuana tend to be less sophisticated in communication techniques than heroin and cocaine dealers.[E] Marijuana dealers are also less likely than other dealers to be involved in gangs and prostitution.
- Two tiers of methamphetamine sellers exist: (1) independent lab owners who distribute methamphetamine only, and (2) distributors involved in polydrug sales (mentioned above) who are connected to Mexican meth labs and trafficking organizations.[E]
- Dealers involved primarily in methamphetamine sales tend to be "harder to deal with" than dealers who primarily sell heroin, cocaine, or marijuana. Buyers trying to purchase methamphetamine are said to be "chasing the bag." Moreover, methamphetamine sales are less likely to occur on the street than heroin or cocaine sales.[E]
- Unlike sellers of other drugs, ecstasy sellers tend to sell only ecstasy. Ecstasy sales are run both by independent sellers and street gangs, and sales are often venue-oriented (at nightclubs, raves, and concerts) as they are in many cities. However, some sales do occur on the streets hand to hand. According to the epidemiologic source, Asian gangs who sell ecstasy have emerged in fall 2002 and have nearly taken over the ecstasy market.

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



What they have to say...

- *One source states that when it comes to exchanges for drugs, "cash is king"—particularly in the case of marijuana.[E] This pattern is more prounced in Denver than in the majority of other* Pulse Check *cities.*
- Pulse Check *sources report that goods and services exchanged for drugs have remained relatively stable over the past 10 years in Denver.*
- *Merchandise is second to cash as the most common item exchanged for drugs, followed by other drugs, sex, guns, and transporting the drug.*[E]

Note: The epidemiologic/ethnographic and methadone treatment sources did not respond to this question.

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

HOW PURE ARE ILLEGAL DRUGS, AND HOW MUCH DO THEY COST?

How pure is Mexican black tar heroin, and how much does it cost?

Unit	Purity	Price
1 g	NR	$100[L]
	8–64%	$100–$150[E]
1 oz	40%	$1,500–$3,000[E]

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

- *The most common form of heroin is Mexican black tar, and its purity on the street varies widely.*
- *Since spring 2002, purity and most prices have remained stable, with the exception of prices at the ounce level, which have declined slightly.*[E]

How pure is cocaine, and how much does it cost?

Form	Unit	Purity	Price	Change?
Crack	One rock ("yay")	NR	$20[L] $10–$20[E]	None Prices down from $20–$30 since spring 2002
	1 oz	NR	$900–$1,000[E]	Prices down from $900–$1,250 since spring 2002
Powder	1 g	NR 30–90%	$100[L] $100–$125[E]	None None
	1 oz	65–85%	$500–$900[E]	Purity up since spring 2002

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

- *Powder cocaine prices were stable between spring and fall 2002, but purity increased at the ounce level.*[E]
- *Crack prices declined at lower (rock) levels and higher (ounce) levels.*[E]
- *Most crack cocaine is processed from powder locally.*[L,E] *The epidemiologic source states that much more of it is being processed locally than during the last reporting period.*

How potent is marijuana, and how much does it cost?

Form	Unit	THC content	Price
Commercial grade	1 oz	NR 3–10%	$100–$200[L] $200–$300[E]
"Kind bud" (high-quality hydroponic), BC bud	1 oz	16–20%	$700–$1,000[E]

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

- *Most sources report stable marijuana prices in fall 2002, with one exception: pound prices for commercial grade marijuana declined slightly since spring.*[E]
- *Marijuana in general is not difficult to purchase. Local commercial grade is the most common form available, followed by sinsemilla and hydroponic, both of which are somewhat difficult to purchase.*[L]
- *A wide variety of marijuana is available for purchase, including commercial grade, sinsemilla, BC bud, and hydroponic.*[E]

How pure is methamphetamine, and how much does it cost?

Unit	Purity	Price
1 g	NR	$100[L]
1 g	8–12%	$80–$100[E]
1 oz	8–12%	$700–$1,000[E]

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

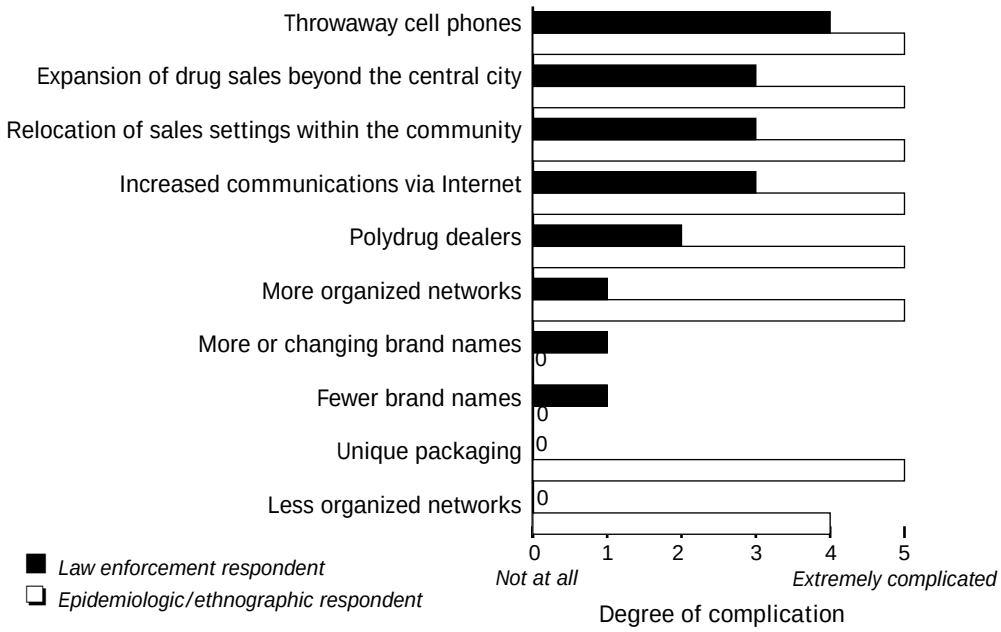
- *Mexican methamphetamine is low quality and looks like peanut brittle, while local methamphetamine has a higher purity and is mostly powder.*[E]
- *Locally produced and Mexican varieties of methamphetamine are not difficult at all to buy, and ice is only slightly more difficult to buy than the lower purity form.*[L,E]
- *Purity at the gram and ounce levels declined between spring and fall 2002 (from 10–20 percent to 8–12 percent).*[E]

How much does ecstasy cost?

Ecstasy prices are stable at $15–$25 per pill[L,E]*. When sold in large quantities, pills cost $10–$12 each.*[E]

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

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



What they have to say...

- *As reported in many* Pulse Check *sites, throwaway cell phones have created problems for law enforcement because they cannot be wiretapped.*[E] *Also, they tend to complicate efforts for tracing high-level dealers more than those for locating street-level dealers.*[L]
- *According to the law enforcement source, unique packaging of drugs is rare in Denver. The epidemiologic source agrees, with one exception: in the past 10 years, the compression of marijuana into tighter packages helps conceal the drugs.*

COMMUNITY INNOVATIONS AND TOOLS OVER THE PAST 10 YEARS

Several innovations over the past 10 years have helped combat illegal drug activity and use:

- Increased use of task forces:[L,E] Additions of larger task forces have increased law enforcement's ability to investigate large criminal drug operations.[L] Small police departments often have small budgets, but task forces have helped. For example, if a task force obtains a drug seizure, the amount of money involved is split among those agencies involved in the task force.[E]
- Precursor laws: New State laws have increased penalties for small, clandestine labs. Child abuse and neglect laws have been expanded to address the manufacturing of methamphetamine around children.[L,E] Additionally, there is now a civil fine for companies that sell large amounts of methamphetamine precursors to individuals.[E]
- Drug-free zone laws: Selling within 1,000 feet of a school enhances sentencing, and probationers must stay away from certain "risk areas."[E]
- Drug courts: Only one drug court exists in the metropolitan area. Although the drug court is seen as very effective by the epidemiologic source, it will be phased out to a regular court of law within the next year.[E]
- Air reconnaissance support from the National Guard: Air surveillance operations in conjunction with counterdrug operations have allowed narcotics enforcement to fully identify drug source and supply routes.[L]

SEPTEMBER 11 FOLLOWUP

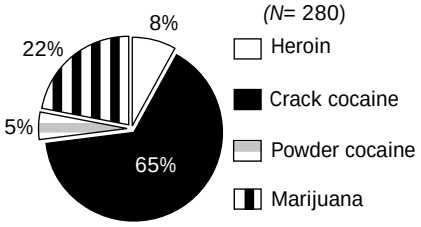
None of the four Denver *Pulse Check* sources believes that the September 11 attacks and their aftermath have had any continuing effects on the drug abuse problem.

DETROIT PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 4,441,551
- Median age: . . . . . 35.5 years
- Race (alone):
  - White 71.2%
  - Black 22.9%
  - American Indian/ Alaska Native 0.3%
  - Asian/Pacific Islander 2.3%
  - Other race 1.1%
  - Two or more races 2.1%
- Hispanic (of any race): 2.9%
- Unemployment rate: 5.9%
- Median household income: $49,175
- Families below poverty level with children <18 years: 14.8%

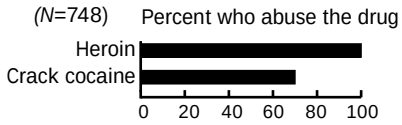
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



+Includes primary, secondary, and tertiary use

Source: Methadone treatment respondent

- *Treatment percentages among non-methadone clients are stable for all drugs of abuse between spring and fall 2002. Crack cocaine remains the most common primary drug of abuse.*[N]
- *The methadone treatment program reports an increase in the number of primary heroin users since spring 2002.*[M]

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

Overall, three of the four *Pulse Check* respondents state that Detroit's drug problem is stable, with the fourth perceiving a slight worsening in the situation. All four agree, however, that the current drug problem remains very serious. Some changes are reported since spring 2002, both positive and negative:

- The number of crack cocaine users is decreasing somewhat, possibly because users perceive the drug as less popular or of lower status.[E]
- Demand for gamma hydroxybutyrate (GHB) has declined.[E]
- Diverted methadone is increasingly available on the street. As in eight other *Pulse Check* cities, it is described as an emerging drug of abuse.[E]
- The prevalence of methamphetamine continues to increase throughout Detroit as it does in other *Pulse Check* cities. Labs are spreading out throughout the State. Currently, the problem in Detroit is not as great as in western Michigan.[E]
- The number of violent deaths associated with drug abuse has increased to a high level, primarily involving children caught in the crossfire.[N]
- Hepatitis C diagnoses have increased significantly, perhaps attributable to more aggressive screening within treatment programs.[M]

The drug market has also changed in several ways:

- The number of methamphetamine seizures by State police is expected to double between 2001 and 2002.[E]
- Pseudoephedrine, a precursor for methamphetamine, is now trafficked over the Internet.[L]
- More diverted OxyContin® (oxycodone hydrochloride controlled-release) appears to be arriving from Canada.[E]

While all the *Pulse Check* respondents agree that Detroit's drug problem is very serious, they differ on the most widely abused drug based on the different populations with which they work. However, they generally agree that heroin is associated with the most serious consequences.[L,E,M]

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

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

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

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

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

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

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

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

New or emerging problems:
Methamphetamine[E]
Abused methadone[E]

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

The overall use of heroin is stable, but some negative developments are noted:

- There is increasing evidence of heroin abuse in the suburbs.[E]
- Hospital emergency room mentions involving heroin increased, and a record number of deaths in Detroit/Wayne County involved the drug in 2002.[E]
- The number of heroin users increased in the methadone program, but this was due to the referral of clients from other recently closed methadone programs in the area.[M]

COCAINE

While the use of crack cocaine remains pervasive (see pie and bar charts on the first page of this chapter), *two changes are noted:*

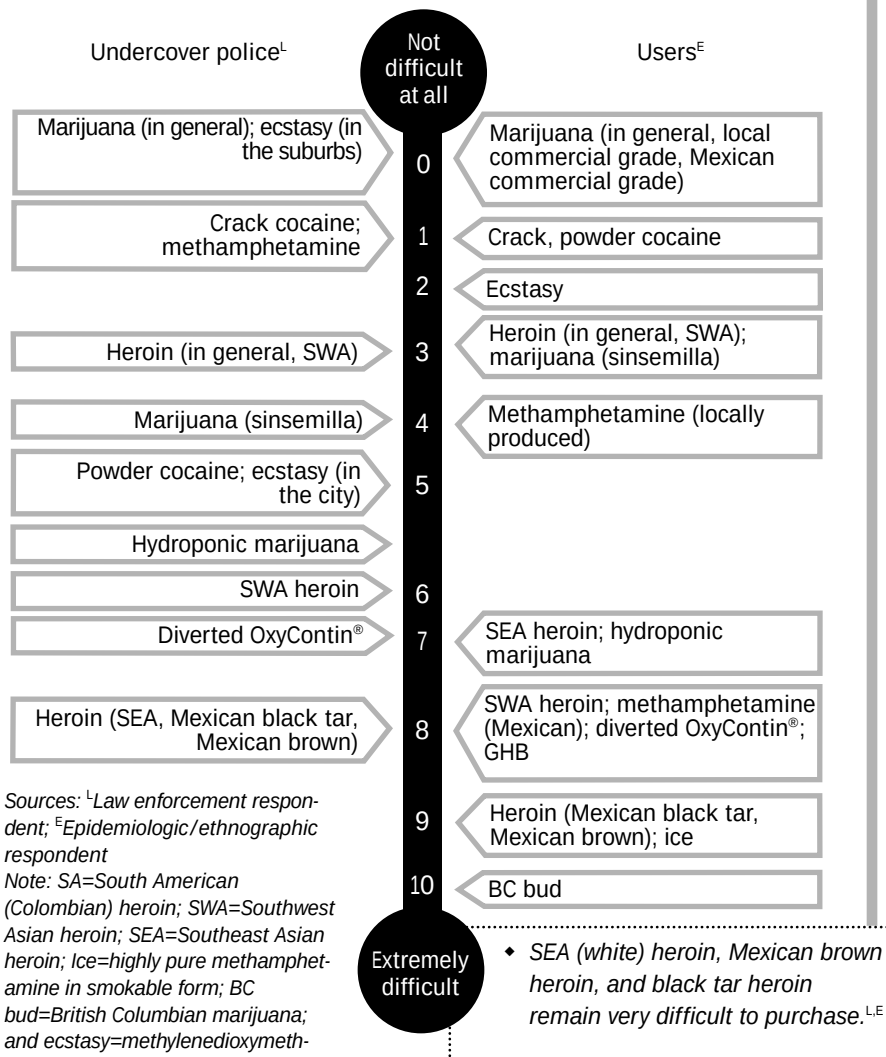
- The combination of crack cocaine with marijuana (or some form of tobacco), called "51," is increasingly used.[N,M]
- Outdoor use of crack cocaine (for example, in parks) decreased during fall 2002 due to the cold climate in Detroit.[M]

MARIJUANA

The marijuana problem in Detroit appears stable, although use remains at high levels.[E,N]

- Two respondents continue to consider marijuana the city's most widely abused drug,[L,E] and another considers it the second most widely abused drug.[N]
- Marijuana is often used in combination with alcohol and crack cocaine.[N]

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



Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent
Note: SA=South American (Colombian) heroin; SWA=Southwest Asian heroin; SEA=Southeast Asian heroin; Ice=highly pure methamphetamine in smokable form; BC bud=British Columbian marijuana; and ecstasy=methylenedioxymethamphetamine or MDMA

- *SEA (white) heroin, Mexican brown heroin, and black tar heroin remain very difficult to purchase.*[L,E]
- *Undercover law enforcement officers have found it easier to purchase methamphetamine during this reporting period.*[L]
- *While marijuana remains widely available throughout the city, there is somewhat of a seasonal effect: in Detroit's cold fall/winter climate, small local plots decline in productivity, leading to a slight decline in availability.*[E]
- *The availability of diverted OxyContin® varies, but the drug is still not widely available in the city.*[E]
- *It is more difficult to purchase GHB.*[E]

METHAMPHETAMINE

Few methamphetamine users enter treatment, but the drug is becoming more prevalent.

- Methamphetamine use continues to increase, and new users are increasingly female.[E]
- Most users make the drug themselves in small labs or receive it from friends, rather than purchase it from a dealer.[E]

MDMA (ECSTASY)

Use of ecstasy remains stable at low levels,[N,M] but two changes are reported:

- Seizures of ecstasy increased.[E]
- Purity declined during the reporting period, and a variety of other drugs are being sold as ecstasy.[E]

OTHER DRUGS

- Diverted OxyContin®: Many pharmacies now post signs stating that they do not stock OxyContin® in order to prevent burglaries.[L] Sellers continue to work independently and are not very likely to abuse the drug.[L,E]
- GHB: There is reduced demand for GHB since the spring.[E] Those who do sell the drug range from adolescents to young adults, and they typically work as part of a larger organization.[L]
- Dextromethorphan (in Coricidin HBP®): The number of individuals abusing this over-the-counter drug has decreased slightly.[E]

OTHER DRUGS

- Diverted methadone: Availability is increasing.[E]
- Hydrocodone (Vicodin®): The number of individuals in treatment for abusing this opiate has increased somewhat, possibly indicating an increase in demand.

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- The *Pulse Check* non-methadone treatment facility serves an average 300 outpatients each month. Among these clients, the primary drug of abuse is crack cocaine, with marijuana the distant second *(see pie chart on the first page of this chapter)*. Treatment percentages for all drugs remained stable between spring and fall 2002.[N]
- The methadone treatment facility can accommodate 750 clients (an increase from 600 just 3 years ago), and is operating at full capacity. While the number of heroin users in treatment has increased since spring 2002, this increase is largely due to referrals from recently closed area methadone programs.[M]
- Detroit has a central diagnostic and referral system contracted by the city Health Department's Bureau of Substance Abuse.
- While the capacity of private treatment programs has increased somewhat,[E] limited slot capacity remains the most significant barrier to treatment.[M]
- A lack of transportation remains a common barrier for individuals needing drug treatment.[N]
- Motivation among treatment clients continues to be an issue: since most clients are referred through the criminal justice system, they view treatment as punishment.[N]
- Treatment providers cite the need for increased funds for both prevention and longer courses of treatment to reduce recidivism and improve long-term outcomes.[N]
- After clients complete treatment, they need stable "recovering communities" that provide support and reinforcement as a part of daily life.[N] Some practitioners report that recovering users find it difficult to manage in halfway houses when they have just completed treatment.[N]
- The methadone program recently instituted an in-house testing program for hepatitis C. Also, mobile units now test individuals throughout the community for the disease.[M]
- The rate of human immunodeficiency virus (HIV) remains very low among clients in the methadone program. As one of the few programs in the city that routinely test clients, it checks approximately 600 individuals each year.[M]

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	>30
Mean age (years)	40	45	38
Gender	60% male	90% male	55% male
Race/ethnicity	White	Black	Black
Socioeconomic status	Low/Middle	Low	Low
Residence	Central city/suburbs	Central city	Central city
Referral source	N/A	Criminal justice	Criminal justice
Level of education completed	N/A	Junior high	Junior high
Employment at intake	N/A	Unemployed	Unemployed

Note: *Only four clients in the non-methadone program report heroin as their primary drug of abuse (two men and two women, whose mean age is 36).*

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

For the most part, characteristics of heroin users remain stable. The typical user is older than 30, male, Black, of low socioeconomic status, and lives in the central city.[N,M] Fewer heroin users seeking treatment are younger than 30.[M]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Snorting/ Injecting	Snorting	Injecting
Other drugs taken	Powder cocaine	Crack, marijuana	Crack, marijuana
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	Both	Alone	In groups

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

- *Methadone treatment clients tend to inject heroin, while non-methadone treatment clients tend to snort the drug.[N,M]*
- *Users in both methadone and non-methadone programs continue to take the drug along with crack cocaine and marijuana.[N,M]*
- *The shooting gallery environment for the sale and use of heroin has waned in popularity. The drug is sold more often on the street and then used in private locations.[M]*

Who's most likely to use cocaine?

Characteristic	Crack			Powder cocaine	
	E	N	M	E	N
Age group (years)	>30	18–30	>30	>30	>30
Mean age (years)	NR	28	38	30	40
Gender	50% male	55% female	65% male	50% male	75% male
Race/ethnicity	White	Black	Black	White	Black
Socioeconomic status	All	Low	Low	All	NR
Residence	All areas	Central city	Central city	All areas	Central city
Referral source	N/A	Detroit Health Department's Diagnostic & Referral system	Detroit Health Department's Diagnostic & Referral system	N/A	Criminal justice
Level of education completed	N/A	Junior high	Junior high/high school	N/A	Junior high
Employment at intake	N/A	Unemployed	Unemployed	N/A	Unemployed

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

- *Cocaine users are typically Black, of lower socioeconomic status, and reside in the central city.[N,M]*
- *Crack cocaine users in methadone programs tend to be older than 30 and predominantly male.[M] In non-methadone programs, however, they tend to be young adults and the majority are female; they are also slightly less educated.[N]*
- *Powder cocaine users are typically older Black males living in the central city.[N]*
- *Users take cocaine with marijuana, alcohol, or heroin.[N]*

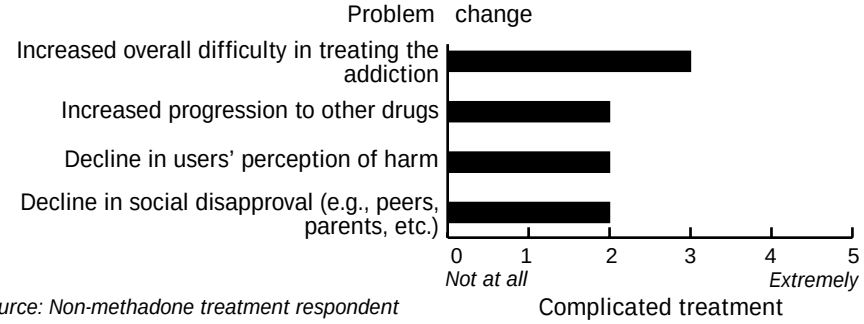
Who's most likely to use marijuana?

Characteristic	E	N
Age group (years)	13–17, 18–30, >30	Young adults
Mean age (years)	30	26
Gender	50% male	80% male
Race/ethnicity	White	Black
Socioeconomic status	All	Low
Residence	All	Central city
Referral source	N/A	Criminal justice
Level of education completed	N/A	Junior high
Employment at intake	N/A	Full time

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

- *As reported by the majority of* Pulse Check *sources (in 22 cities), two Detroit sources consider marijuana the most widely abused drug.*[L,E]
- *Marijuana users range from adolescents to young adults,*[E] *although users who enter treatment for primary marijuana use are typically young adults.*[N]
- *Marijuana users in treatment are predominantly male.*[N]

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



Source: Non-methadone treatment respondent

- *Declines in users' perception of harm and social disapproval of marijuana use have made treatment of marijuana-using clients more difficult.*[N] *The normalization of drug use in general has also complicated the city's drug problem.*[N]
- *The progression from marijuana to other drugs creates difficulty in treating marijuana-using clients.*[N]
- *There are still not enough treatment facilities to address the marijuana problem, particularly among adolescents.*[N]

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

- Drug-related emergency room visits[E]
- Drug-related arrests[E,N]
- Automobile accidents[E]
- Short-term memory loss[E,N]
- Deteriorating family or social relationships[E,N]
- Poor academic performance[E]
- School absenteeism or truancy[E]
- Dropping out of school[E]
- Workplace absenteeism[E]
- Unemployment rates[N]

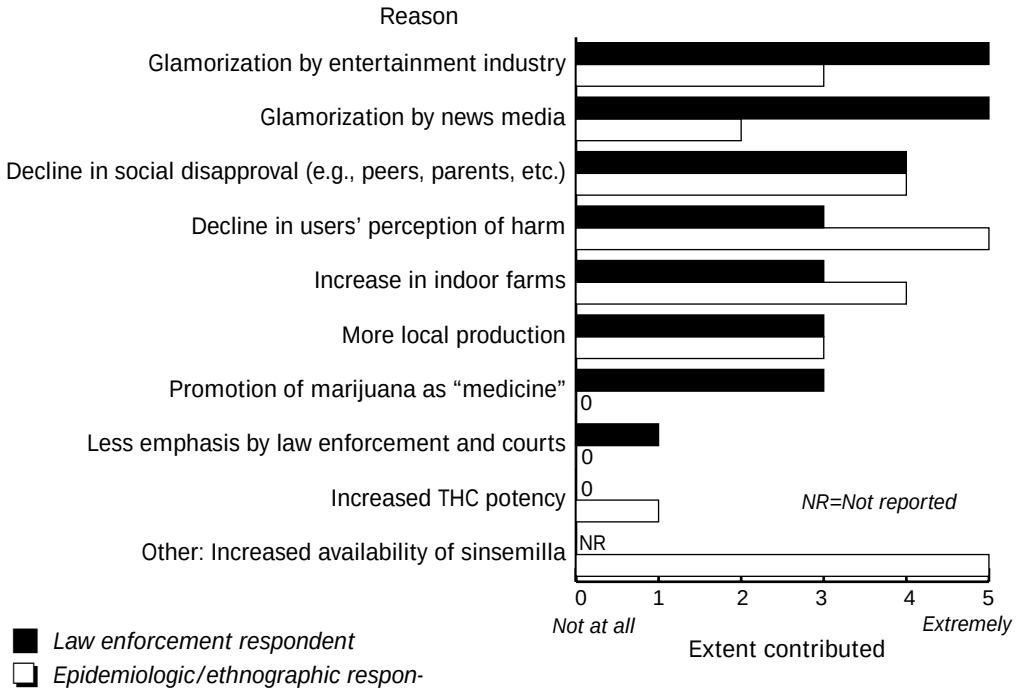
WHO'S MOST LIKELY TO USE METHAMPHETAMINE?

- Methamphetamine users are typically White young adults who live in the suburbs or rural areas.[E]
- While all routes of administration are reported, more users now smoke the drug. Users commonly take methamphetamine in combination with marijuana.[E]
- Most users make the drug themselves or share with friends, rather than purchase it from a dealer.[E]

WHO'S MOST LIKELY TO USE ECSTASY?

Ecstasy users are typically White young adults from the middle and upper income levels who live in suburban and rural areas.[E]

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



What they have to say...

- *Declines in users' perception of harm and social disapproval by peers and parents have significantly contributed to the widespread use of marijuana.*[L,E]
- *Glamorization of marijuana use by both the entertainment industry and the news media has contributed to significant increases in marijuana use over the past decade.*[L,E]
- *Marijuana availability has increased somewhat due to an increase in indoor farms and local production.*[L,E]
- *A proposed law to legalize marijuana use for medicinal purposes did not make it to the ballot in Detroit.*[L]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Marijuana is used and sold "everywhere" in the city.[L,E]

Also pervasive are heroin, crack cocaine, and powder cocaine, which are used and sold in the following venues:[L,E]

- Streets/open-air markets
- Crack houses/shooting galleries
- Private residences
- Playgrounds/parks
- Private parties
- Around drug treatment clinics
- Inside cars

New or emerging heroin users do not generally take the drug in outdoor settings like parks and playgrounds as do typical heroin users; they also purchase the drug in a new place: around drug or alcohol treatment clinics.[E]

Methamphetamine is sold in private residences, public housing developments, nightclubs/bars, inside cars, and in hotels/motels. It is generally used in private residences, inside cars, and at concerts.[E]

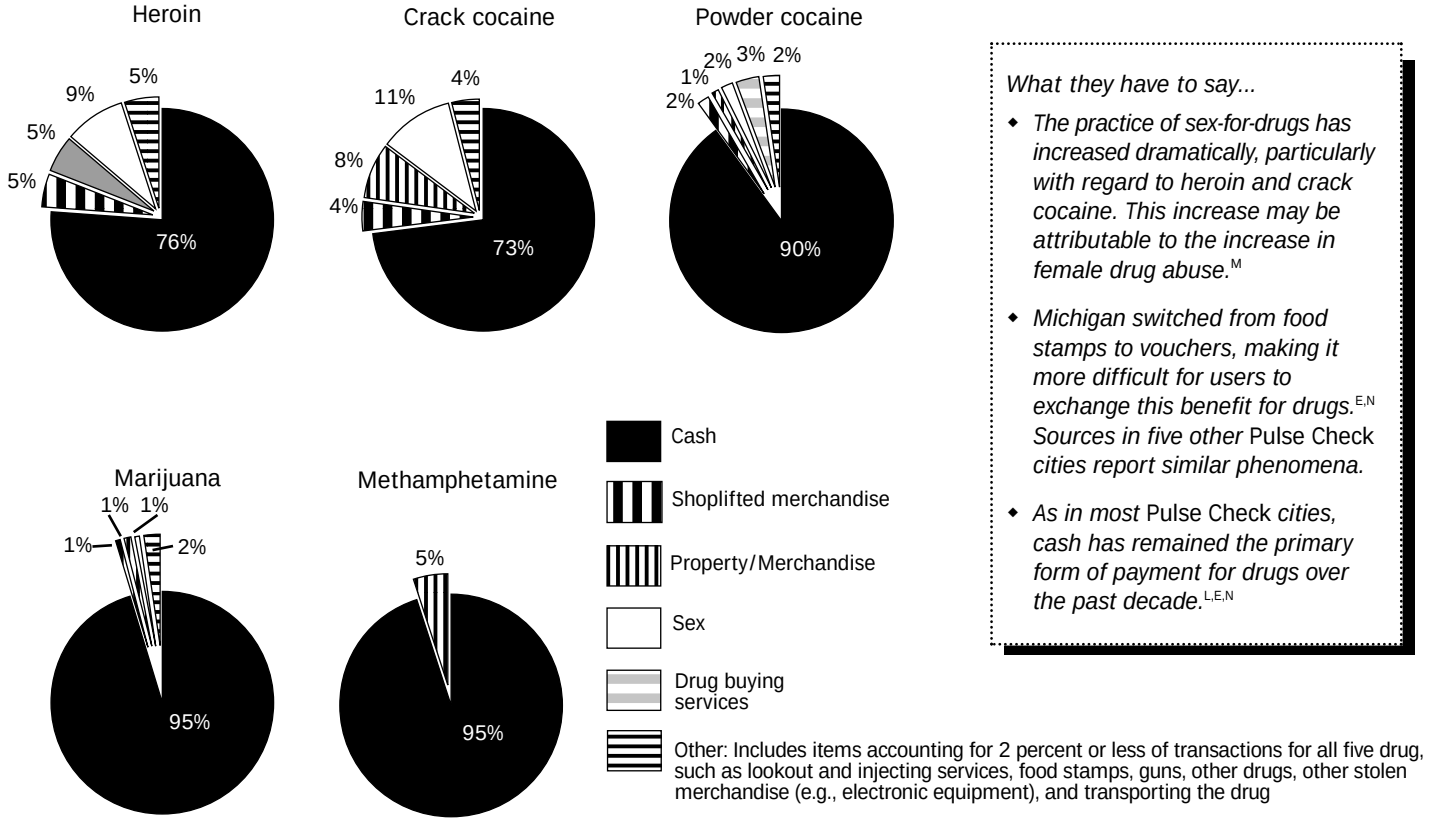
Ecstasy is both sold and used in private residences, on college campuses, and at private parties, raves, and concerts. It is also sold around elementary, junior high, and high schools; at nightclubs and bars; inside cars; and via the Internet.[L,E]

Sales of diverted OxyContin® generally take place in rural areas.[L]

HOW DO DRUGS GET FROM SELLER TO BUYER?

- Heroin is sold primarily in the central city through prearranged meetings or through drop-offs at designated locations.[E]
- Dealers sell both forms of cocaine in the central city, suburbs, and rural areas.[E] Transactions usually take place directly between sellers and users and are sometimes prearranged. They communicate via cell phones or intermediaries.[E]
- Methamphetamine is typically made by users in small mobile labs using the "Nazi" method.[L,E] Users who do not make their own generally barter something for it or receive it through friends.[E]
- Ecstasy dealers operate in the suburbs, communicating with most users through word of mouth at the sales setting.[E] The dealers communicate with their suppliers through the Internet.[E]
- Diverted OxyContin® is generally sold through direct meetings in suburbs or rural areas.[E]

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



What they have to say...

- *The practice of sex-for-drugs has increased dramatically, particularly with regard to heroin and crack cocaine. This increase may be attributable to the increase in female drug abuse.*[M]
- *Michigan switched from food stamps to vouchers, making it more difficult for users to exchange this benefit for drugs.*[E,N] *Sources in five other* Pulse Check *cities report similar phenomena.*
- *As in most* Pulse Check *cities, cash has remained the primary form of payment for drugs over the past decade.*[L,E,N]

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

Which drug sellers are associated with which crimes?

Crime	Heroin	Crack cocaine	Powder cocaine	Marijuana	Metham-phetamine	Ecstasy	Diverted OxyContin®	GHB
Gang-related activity	✓	✓		✓				
Violent criminal acts	✓	✓	✓					
Nonviolent criminal acts	✓	✓	✓	✓	✓	✓		✓
Prostitution	✓	✓	✓	✓				
Domestic violence			✓		✓			
Drug-assisted rape						✓		
No crimes associated						✓	✓	

Sources: Law enforcement respondent; epidemiologic/ethnographic respondent

Both sellers and users of heroin and cocaine are involved in nonviolent crimes such as breaking and entering, burglaries, and larceny.[E]

WHO'S SELLING HEROIN?

- Heroin dealers are quite varied. They range in age from young adults (18–30) to older adults (>30) who work either independently or as part of a larger organization.[L,E]
- Heroin dealers typically use the drug themselves.[L,E]
- Sellers are often involved in prostitution, gang-related activity, and violent crimes,[L] as well as nonviolent criminal acts such as robberies and breaking and entering.[L,E]

How much does heroin* cost?

Unit	Price
0.2 g	$10[L]
One hit	$10–$12[E]
1 g	$100–$150[L]
One bundle (10 hits)	$100–$200[E]

**Unspecified source and form*

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

All reported prices are stable between spring and fall 2002.

WHO'S SELLING COCAINE?

- Dealers of powder and crack cocaine are also varied in demographics and structure. They range in age from young adults to older adults, and work either independently or as part of an organization.[L,E]
- Powder cocaine dealers are often involved in nonviolent criminal acts such as breaking and entering, robbery, and larceny.[L,E] Prostitution and domestic violence are also common among these dealers.[L]
- Crack cocaine dealers are typically involved in prostitution, gang-related activity, violent criminal acts, and nonviolent criminal acts.[L,E]

How much does cocaine cost?

Form	Unit	Price
Powder	1 g	$75–$100[L] $75–$125[E]
Crack	One rock	$10[L] $50–$200[E]

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

All reported prices are stable between spring and fall 2002.

WHO'S SELLING MARIJUANA?

- Marijuana dealers range in age from young adults (18–30) to older adults (>30). They work either independently or as part of an organization.[E]
- Many marijuana dealers are part of a larger organization that has a "lock" on a particular area of the city.[L]
- Marijuana dealers almost always use the drug themselves.[L]
- While marijuana dealers are not generally involved in violent crimes, they are sometimes involved in nonviolent criminal acts as well as prostitution and gang activity.[L,E]

How much does marijuana cost?

Unit	Price
One bag	$10[L]
1/4 oz	$50–$200[E]
1/2 oz	$100–$400[E]
1 lb	$750–$3,000[L]

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

- *The wide variability in the price of marijuana reflects the availability and grade of the drug.*[L]
- *All reported prices are stable between spring and fall 2002.*

WHO'S SELLING METHAMPHETAMINE?

- Methamphetamine dealers are either younger and older users working independently,[E] or younger non-users working within a larger organization and catering to a specific area of town.[L]
- Methamphetamine dealers are often involved in nonviolent criminal acts as well as domestic abuse.[E]

WHO'S SELLING ECSTASY?

- Ecstasy dealers range in age from adolescents to young adults. They generally use the drug themselves. They operate independently or within an organized structure that has a specific territory within the city.[L,E]
- Ecstasy dealers often sell the drug in exchange for sex, as well as for money.[E]
- In addition to nonviolent criminal acts, ecstasy dealers are also commonly involved in drug-assisted rape.[L]

How much does ecstasy cost?

Unit	Price
One pill	$20–$30[L] $20–$40[E]

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

All reported prices are stable between spring and fall 2002.

How much does diverted OxyContin® cost?

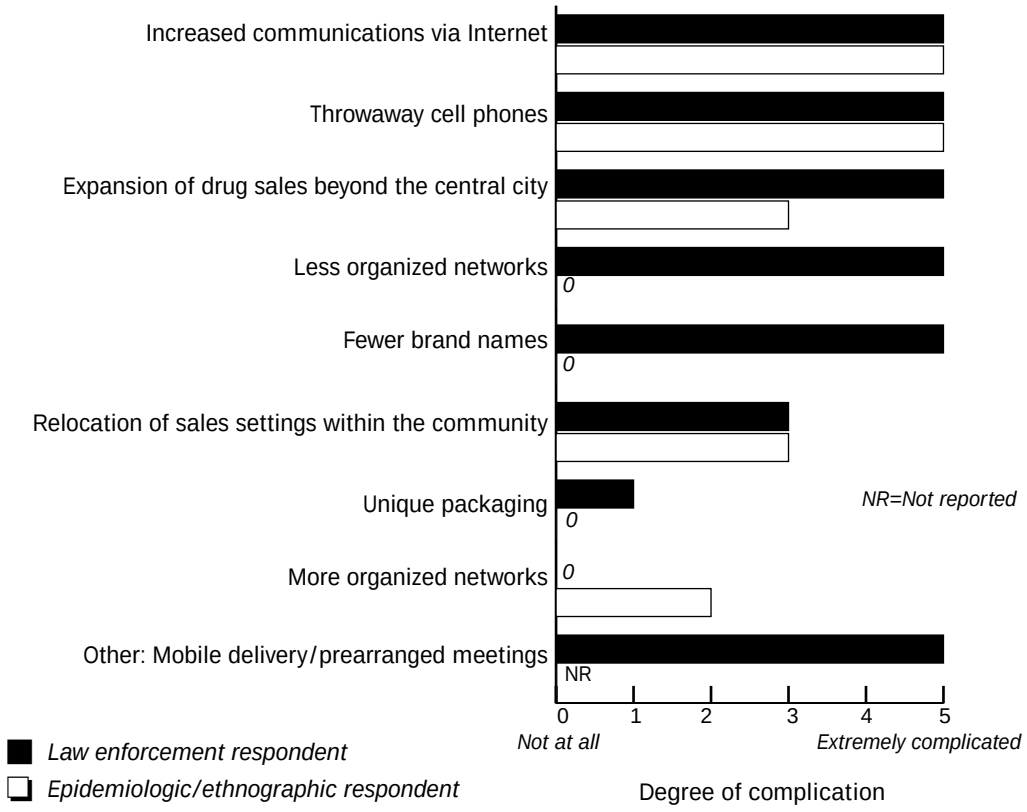
Unit	Price
1 mg	$1[L]
40 mg	$40–$60[E]

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

According to one source, the price of diverted OxyContin® has risen up $1 to $1–$2 per milligram.[E] All other reported prices are stable between spring and fall 2002.

THE MARKET PERSPECTIVE: A 10–YEAR VIEW

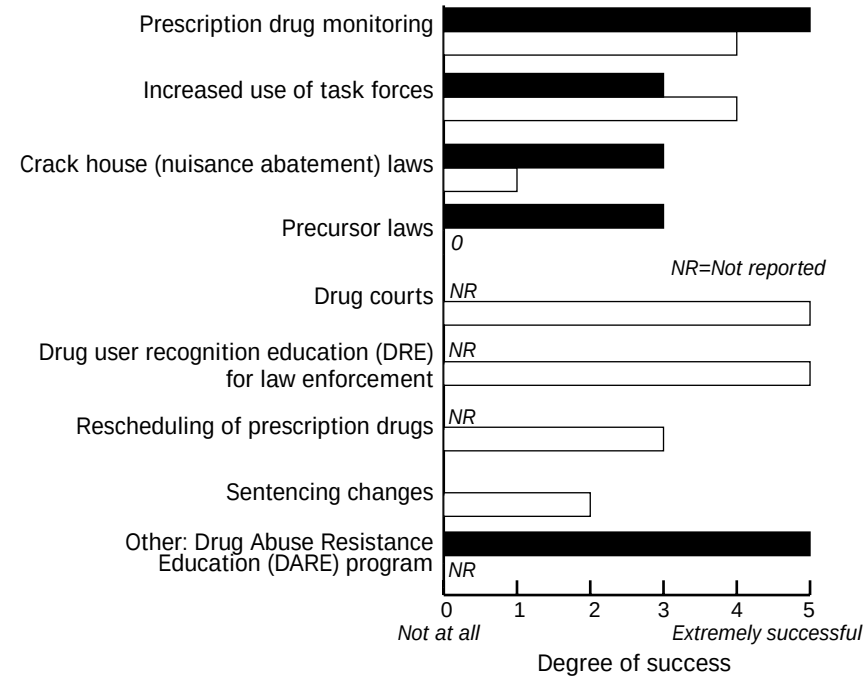
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in Detroit?



What they have to say...

- *Drugs are more available today than in a long time, which has led to an increase in the number of users.*[M]
- *As mentioned in the majority of* Pulse Check *cities, technological advances over the past decade, particularly throwaway cell phones and communication via the Internet, have severely complicated efforts to disrupt drug activity.*[L,E]
- *More organized networks that are both expanding drug sales beyond the central city and relocating sales settings within the community have complicated efforts to address the problem.*[E]
- *Unique packaging of drugs has diminished over the past decade,*[L,E] *making it somewhat easier to crack down on dealers. However, the use of brand names has also decreased, which makes it more difficult to identify the sources supplying the drugs.*[L]

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



What they have to say...

- *Local task forces throughout the State have been successful in addressing the increasingly complex drug market.*[L,E]
- *Because of Detroit's location as a port city on the Canadian border, it has historically been a transshipment point for ephedrine and pseudoephedrine. However, precursor laws for ephedrine and pseudoephedrine have significantly slowed the flow of these drugs from Canada.*[L]
- *Prescription drug monitoring through the Triplicate Prescription Program (TPP) has been largely successful. It will soon be replaced by the Official Prescription Program.*[E]
- *Nuisance abatement laws have succeeded in shutting down some rave promoters.*[L]
- *One source expresses concern about pain clinics, given the recent proliferation of methadone as a drug of abuse.*[E]

SEPTEMBER 11 FOLLOWUP

Both positive and negative effects are still being felt as a result of the terrorist attacks of September 11, 2001:

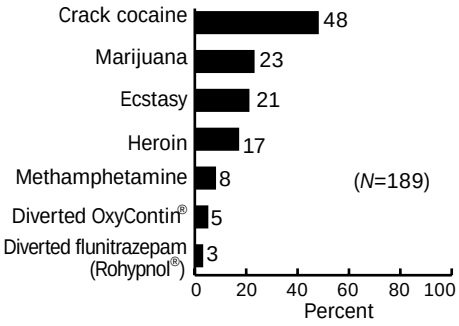
- Drug use: Users in treatment indicate that the terror attacks have not impacted their desire to use drugs.[M] However, because of increased security measures, users are aware that they may have increased difficulty maintaining their personal drug supply. They are therefore more willing to use a variety of drugs or to make their own drugs.[N]
- Changing trafficking patterns: Tighter border security continues to contribute to an increased number of arrests for transporting drugs, which is significant for this port/border city.[E,N]

HOUSTON PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 4,177,646
- Median Age: . . . . . 31.6 years
- Race (alone):
  - White: 61.1%
  - Black: 17.5%
  - American Indian/ Alaska Native: 0.4%
  - Asian/Pacific Islander: 5.3%
  - Other race: 12.9%
  - Two or more races: . . . 2.8%
- Hispanic (of any race): 29.9%
- Unemployment rate: 4.1%
- Median household income: $44,665
- Families below poverty level with children <18 years: 14.8%

*Source: U.S. Census 2000**

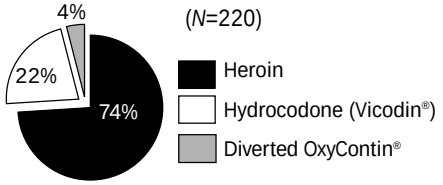
What are the primary drugs of abuse among clients in a non-methadone treatment program? (Fall 2002)



Note: These numbers may include client reports of two primary drugs of abuse.

Source: Non-methadone treatment respondent

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



Source: Methadone treatment respondent

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

Three of the *Pulse Check* respondents consider Houston's drug problem very serious.[L,E,N] Two sources consider the problem stable,[L,N] while two observe a worsening situation.[E,M]

Houston's many multiple-agency task forces continue to successfully address the unique challenges posed by the city's proximity to the Mexican border. These task forces include professionals from local law enforcement, the U.S. Border Patrol, FBI drug squads, U.S. Customs, and the High Intensity Drug Trafficking Area (HIDTA).[L]

Several developments are reported in the drug market:

- Operation White Terror, a joint effort by the DEA and FBI, resulted in many arrests in connection with the seizure of $25 million in military-grade weapons that were being used in guns-for-cocaine transactions.[L]
- A large increase is noted in the presence of hashish in Houston, coinciding with the defeat of the Taliban in Afghanistan, which had forbidden hashish production. Some Afghans now grow and export the drug to generate income.[E]
- As mentioned in several other *Pulse Check* cities, an increase in diverted methadone on the street is observed.[N]

Many changes are also observed in Houston's drug-using population:

- Hotlines and emergency departments have encountered large numbers of injecting drug users who have mixed diluted bleach with heroin or cocaine. These users present with arms turning black and report adding the bleach to protect themselves against HIV transmission.[E]
- Marijuana use increased somewhat, particularly among new drug users.[E]
- More marijuana users, particularly new users, report combining the drug with formaldehyde,[E,N] referred to as "wet,"[E,N] "water,"[E] or "fry."[E,N] Marijuana and formaldehyde are also increasingly combined with phencyclidine (PCP)[E] (similar to reports in Minneapolis/ St. Paul[M]).
- "Triple C" is the term for Coricidin HBP®, an increasingly abused over-the-counter cold medication containing dextromethorphan, as reported in three other *Pulse Check* sites (Denver,[E] Portland, [OR][L], and Tampa/St. Petersburg[N,M].)
- New street names have appeared for various drugs since the spring:[N] "chalk" or "po coke" for methamphetamine; "clarity" for methylenedioxymethamphetamine (MDMA or ecstasy); and "hillbilly high" for abused OxyContin® (oxycodone controlled-release).

Overall, respondents identify crack cocaine[E,N] and heroin[L,M] as the drugs related to the most serious consequences in Houston. Many drugs are also emerging as new or growing problems in the city.

- *Primary abuse of heroin has increased since the spring 2002 among non-methadone treatment clients.*[N]
- *The methadone program is unusual in that nearly one-quarter of its clients report hydrocodone, rather than heroin, as a primary drug of abuse.*

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

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

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

Second most widely abused drug:
- Marijuana[N]
- Ecstasy (<30 years)[L]
- Cocaine (>30 years)[L]
- PCP[E]
- Hydrocodone[M]

Change reported between spring and fall 2002: PCP replaced "wet" or "water" (combination of formaldehyde and marijuana).[E]

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

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

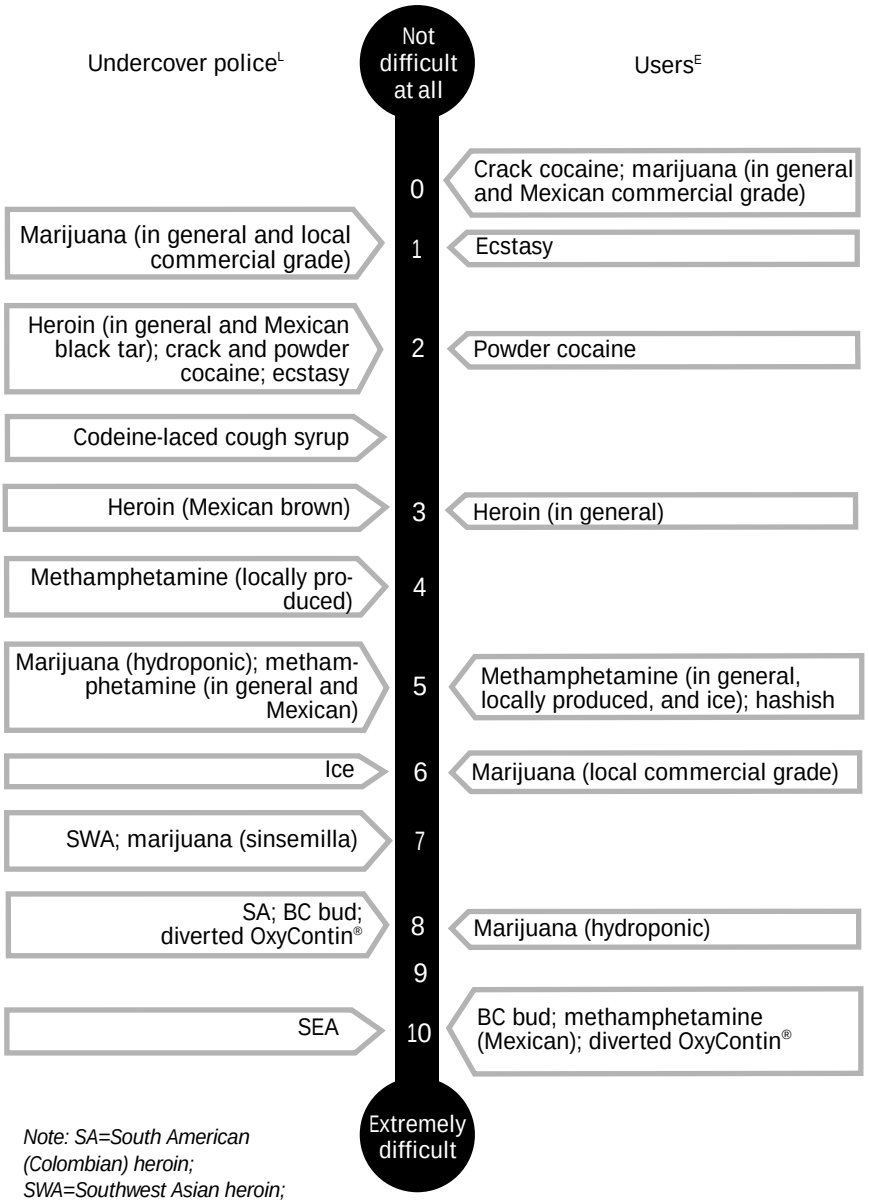
Drug related to the second most serious consequences:
- Methamphetamine[L]
- PCP[E]
- Heroin[N]
- Benzodiazepines[M]

Change reported between spring and fall 2002: PCP replaced "wet" or "water" since the spring.[E]

New or emerging problems:
- Diverted OxyContin®[N]
- Diverted methadone[N]
- Hashish[E]
- "Water" or "wet"[E]
- Ice[L]

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

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



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

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

- *It has become less difficult for users to purchase hashish since spring 2002, although they typically need to know a dealer personally in order to obtain the drug.*[E]
- *While Colombian white heroin is reported on the street, law enforcement has not encountered it.*[L]
- *As with four other cities in the* Pulse Check *South region, it became less difficult for undercover law enforcement to purchase ice.*[L]
- *There is anecdotal evidence that users are moving from cocaine to ecstasy because it is less expensive and more readily available.*[L]

HEROIN

Heroin treatment numbers are mixed, but users' characteristics indicate an overall increase in Houston's heroin problem.[N]

- Primary heroin use in the methadone program has continued to decline slowly over the past 2 years, with corresponding increases in primary hydrocodone and OxyContin® abuse.[M] However, primary heroin abuse among non-methadone treatment clients increased since spring 2002.[N]
- Primary heroin users present to treatment at younger ages,[N,M] and clients report younger ages of first-time use.[N]
- Clients in treatment report becoming addicted more quickly to heroin than in the past.[N] This effect may be due to increased heroin purity, as reported by other sources.[L,E]

COCAINE

Crack cocaine is considered the most common primary drug of abuse among both young adults and adults.[N] *But neither crack nor powder cocaine is a drug of abuse among methadone treatment clients.*[M]

- Crack cocaine use is stable among treatment clients,[N,M] although an increase in crack use is noted in Houston overall since spring 2002.[E]
- New crack users are increasingly younger.[E]
- Crack users in treatment report taking the drug with alprazolam (Xanax®) instead of with diazepam, which had been more common. This new combination is called "handlebars."[N]

MARIJUANA

Marijuana is the most common primary drug of abuse among preadolescents and adolescents in Houston.[N]

- Marijuana use is stable among drug treatment clients.[N,M]
- However, negative consequences associated with marijuana use are reported by youth at younger ages: signs and symptoms of marijuana abuse are occurring at a mean age of 13 years.[N]
- New users do not perceive marijuana as an illicit drug due to media coverage of its use as "medicine." New users therefore view the drug as safe.[E]
- The practice of smoking "wet" or "water" (marijuana with formaldehyde) has increased recently.[E,N] This practice can cause serious brain damage.[E]

METHAMPHETAMINE

Methamphetamine use is stable at very low levels.[E,N,M] However, primary methamphetamine users are increasingly female and middle class.[N]

MDMA (ECSTASY)

Ecstasy use remains high among treatment clients,[N] *and appears to be growing among some segments of the Houston population.*[E]

- Ecstasy users are initiating use of the drug at younger ages.[N]
- Ecstasy use is growing among a subculture of gay youth in Houston.[E]

OTHER DRUGS

- Diverted OxyContin®: The proportion of primary OxyContin® abusers in treatment increased since spring 2002.[N,M] More treatment clients use diverted OxyContin® as a substitute for heroin,[N] while others use it sequentially with hydrocodone or alprazolam.[M]
- Methadone: The amount of diverted methadone on the street has increased since spring 2002.[N]
- PCP: Use is up in Houston.[E]
- Hashish: Use of hashish increased sharply. It is used often to accentuate the effects of marijuana.[E]
- Flunitrazepam (Rohypnol®): While treatment numbers remain low when compared with other drugs, a large increase is noted in the proportion of clients in treatment for abuse of flunitrazepam. While most flunitrazepam treatment clients are male (98 percent), these young men also give the drug to females as a date-rape drug, often after alcohol or marijuana use.[N]
- Dextromethorphan (in Coricidin HBP Cough & Cold®): A large increase is noted in the number of adolescents abusing this over-the-counter medication ("triple C"), particularly in combination with alcohol. It is easily obtainable and relatively inexpensive.[E] This particular brand contains the highest concentration of dextromethorphan, making it the most popular among users.
- Codeine (in the form of cough syrups): Codeine is being added to cola drinks, with pockets of epidemics within the city.[E]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone treatment source is with a facility that has the capacity to serve 196, and a current enrollment of 189. Crack cocaine is the most common primary drug of abuse among its clients (*see bar chart on the first page of this chapter*). Interestingly, more users are in non-methadone treatment for primary ecstasy abuse than for primary heroin abuse.[N]
- The methadone treatment source is with a program whose capacity is 230, with current enrollment at 220. This program is unusual in that only three-quarters of its clients report heroin as their primary drug of abuse (*see pie chart at the bottom of this chapter's first page*). Most of the remaining clients report hydrocodone as their primary drug. Also unlike in other *Pulse Check* cities, neither crack nor powder cocaine are significant secondary or tertiary drugs among these clients. Rather, half of them also abuse marijuana, and one-quarter abuse alprazolam.
- Whites are overrepresented in the methadone program despite the the area's predominantly Hispanic population. The respondent explains that Hispanic and Black drug users do not seek treatment because of a lack of trust in treatment programs.[M]
- Maintenance methadone treatment is available in only select areas of Houston. Three or four private clinics are within close proximity to each other; there are no other methadone clinics and no public clinics in the city at all.[E]

Consequences of drug use

- Heroin and cocaine users who inject now present at emergency rooms and hotlines with black patches on their arms as the result of mixing the drug with diluted bleach. They add the bleach to protect themselves from HIV transmission.[E]
- Further, heroin users who inject either intravenously or intramuscularly present at treatment with more abscesses, indicating more adulterants (bleach or other substances) in the drug.[M]
- Drug-related automobile accidents are stable at very high levels among Houston treatment clients: more people are driving while under the influence of drugs rather than alcohol.[N]
- The incidence of tuberculosis in Houston, and among drug treatment clients in particular, is on the rise. Hepatitis C is stable, but remains at high levels,[N] as high as 85 percent in the methadone program.[M]

Co-occurring disorders

- In general, Houston's drug treatment programs are not equipped to treat dually diagnosed clients effectively.[M]

Changes over the past 10 years

- The declining cost of crack cocaine over the past decade (from $10 to $2 per "starter rock") has severely complicated the drug abuse problem in Houston.[N]
- The abuse of prescription drugs is at peak levels, particularly for OxyContin® and hydrocodone. Further, addiction to these licit drugs is more difficult to treat.[N]
- Both the declining cost of drugs and the increased availability of new and substitute drugs have severely complicated Houston's drug problem, particularly among youth.[N,M] Younger users can now afford more dangerous drugs such as heroin,[M] which is also more pure than it was a decade ago, and crack.[N] Adolescents as young as 12 are entering treatment for cocaine—something not seen 10 years ago.[N]
- Treatment programs have to increase the length of stay for recovering clients because they lack stable housing opportunities in the community. Clients who are released into an unstable environment and then relapse tend to become homeless within 6 months.[N]
- The increased purity of heroin in recent years has led to a new practice, particularly among youth, of squirting the drug up their noses ("shebanging").[M]
- Polydrug abuse has increased, particularly among heroin users, who use prescription drugs like alprazolam along with, or in place of, heroin.[M]

WHO USES ILLICIT DRUGS?

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

- *Younger clients are entering treatment for heroin abuse.*[M]
- *While most primary heroin users are self-referred, an increasing number are now referred by other treatment providers.*[N]

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	18–30; >30
Mean age (years)	35	33	27
Gender	Split evenly	Split evenly	55% male
Race/ethnicity	White	Black	White
Socioeconomic status	Low	Low	Middle
Residence	Central city	Central city and rural areas	Central city
Referral source	N/A	Individual	Individual
Level of education completed school	N/A	High school	High school
Employment at intake	N/A	Unemployed	Full time

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

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs taken	Powder cocaine (speedball or "cocoa"); methamphetamine (speedball)	Powder cocaine	Hydrocodone, alprazolam
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	In groups	Alone	Alone

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

- *While injecting is the most common route of administration for heroin users,*[N,M] *some users report the practice of shebanging.*[M]
- *Less speedballing (combining heroin with cocaine) is reported since the spring.*[N]
- *Primary heroin users often take hydrocodone or alprazolam in sequence with heroin. The combination of heroin and alprazolam is called "bars."* [M]

- *Crack users in Houston overall are more likely to be female (60 percent), particularly new or emerging crack users (90 percent).*[E]
- *Powder cocaine users in treatment are typically older, Black, low-income adults,*[N] *while powder cocaine users throughout the city are White, higher income adolescents.*[E]
- *Crack users sometimes take alprazolam and/or hydrocodone along with crack. Alprazolam has replaced diazepam in this practice. The combination of crack and alprazolam is called "*handlebars."[N]
- *Users often combine powder cocaine with heroin ("boy,"*[N] *"bellushi,"*[N] *speedball,*[N] *or eightball*[E]*). Speedballing is considered a "party thing," common among groups of friends.*[N]

Who's most likely to use cocaine?

	Crack cocaine		Powder cocaine	
Characteristic	E	N	E	N
Age group (years)	18–30, >30	>30	13–17	>30
Mean age (years)	26	37	NR	35
Gender	60% female	Split evenly	65% male	Split evenly
Race/ethnicity	Black	Black	White	Black
Socioeconomic status	Low	Low	High	Low
Residence	Central city	Central city	Rural	Central city
Referral source	N/A	Individual	N/A	Individual
Level of education completed	N/A	Did not complete school	N/A	High school
Employment at intake	N/A	Unemployed	N/A	Unemployed

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

- *The epidemiologic/ethnographic respondent has heard reports of users taking crack cocaine in a combination called "cheese," and powder cocaine in a combination called "white girl" or "white pony"; however, the other components of these combinations are unknown.*[E]
- *Crack users are often involved in prostitution, gang-related activity, and violent criminal acts such as drive-by shootings.*[E]

Who's most likely to use marijuana?

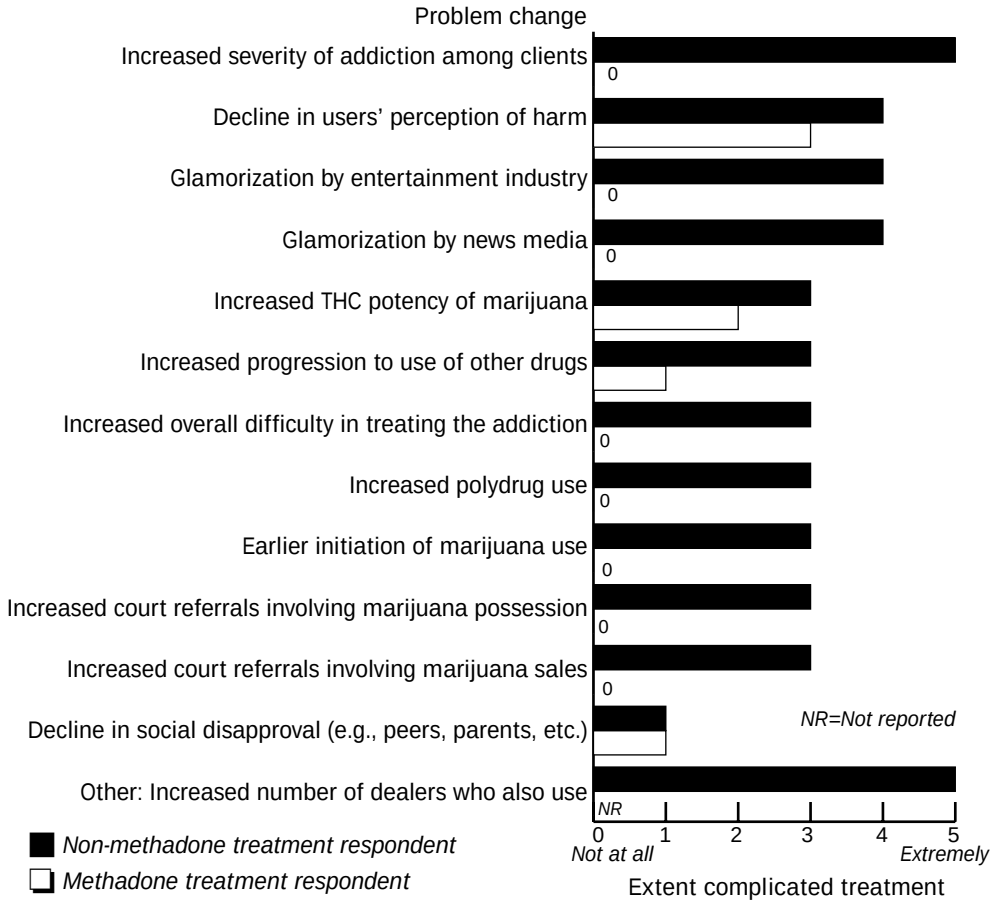
Characteristic	E	N	M
Age group (years)	18–30, >30	13–17	>30
Mean age (years)	NR	15	42
Gender	Split evenly	Split evenly	80% male
Race/ethnicity	White, Black, Hispanic (any race)	NR	White
Socioeconomic status	Middle	Low	Middle
Residence	Central city	Central city, rural areas	Central city
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	Junior high or high school	High school
Employment at intake	N/A	Unemployed	Full time

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

- *While the overall marijuana-using population in Houston includes young adults and older adults ("aging hippies"), most new and emerging users are adolescents.[E] This trend is similar to that noted in Dallas.[N]*
- *More marijuana users in treatment are smoking blunts instead of joints since spring 2002.[N]*
- *In the community overall, marijuana users generally either smoke the drug in blunts or pipes.[E]*

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

- *As a result of the decreased perception of harm associated with marijuana, people are using it at younger ages. Further, the marijuana that youth smoke today is more potent it was 10 years ago.[N]*
- *Rap songs about marijuana use ("tokin" and "smokin"), as well as the publicity given to celebrities who use drugs, have complicated treatment of young marijuana users.[N]*
- *Over the past decade, marijuana use by dealers has increased, shedding light on a dual addiction: addiction to the drug and addiction to fast money. As a result, there is great difficulty in treating dealers, because this is how they make their living.[N]*



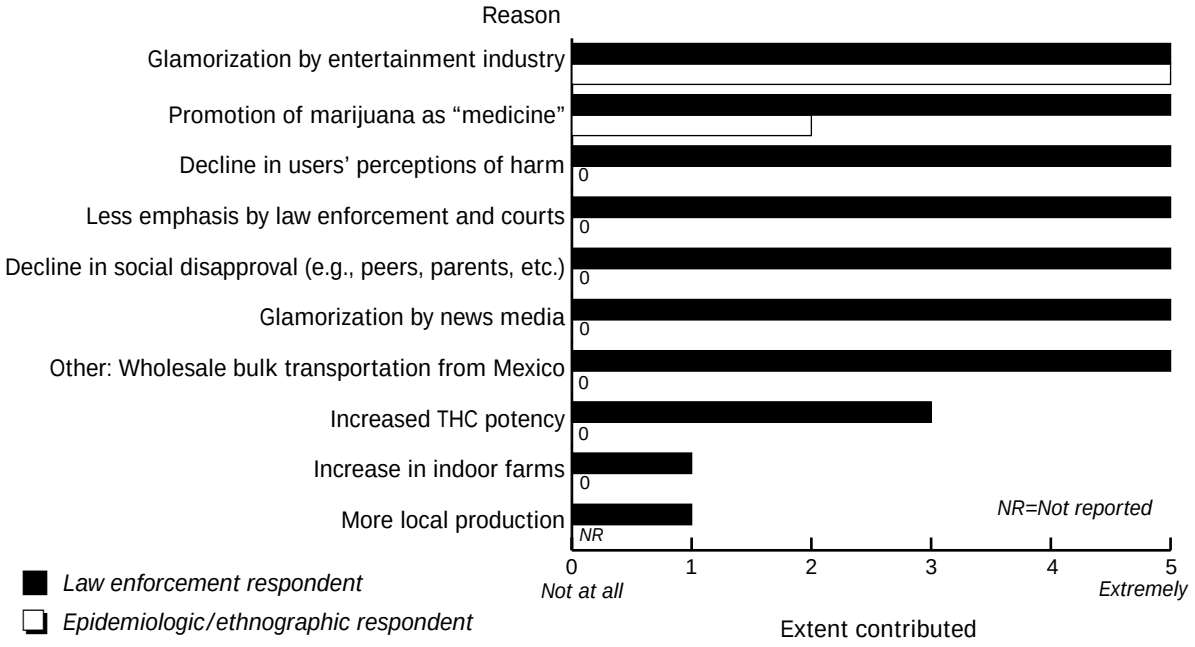
WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

Respondents associate marijuana, used either alone or with other drugs, with the following consequences:

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

Since spring 2002, clients are reporting these negative consequences at younger ages.[N]

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



What they have to say...

Houston respondents share the concerns of respondents from other sites about the impact of declines in users' perceptions of harm and in social disapproval, and the promotion of marijuana as "medicine." They note other specific issues as well:

- *Because Mexican marijuana is so prevalent in Houston, local production does not impact availability of marijuana in the city.*[L,E]
- *Marijuana use continues to increase among individuals who do not perceive it as a drug. Media attention to the decriminalization of marijuana for "medicinal" purposes is a significant contributor to this phenomenon.*[E]
- *Users consider marijuana as simply an herb that has no effect on driving and other activities; they consider it safer to use than alcohol.*[E]
- *The widespread availability of marijuana in Houston is largely due to the fact that multi-ton shipments arrive wholesale from Mexico.*[L]
- *The glamorization of marijuana use by two facets of the entertainment industry has worsened the marijuana problem among young people in particular:*[E]
  - *Musicians promote marijuana use in their songs.*
  - *More athletes are found to be using marijuana.*

Who's most likely to use ecstasy?

Characteristic	E	N
Age group (years)	13–17	13–17
Mean age (years)	NR	15
Gender	Split evenly	Female
Race/ethnicity	White	White, Black and Hispanic (any race)
Socioeconomic position	Middle/high	Low and middle
Residence	Central city	Central city
Referral source	N/A	Criminal justice, individual, and public schools
Level of education completed	N/A	Junior high or high school
Employment at intake	N/A	Unemployed

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

- *Ecstasy users in treatment report earlier ages of first use.*[N]
- *Ecstasy use has grown in a subculture of young gay youth in Houston.*[E]
- *Ecstasy users are just as likely to use the drug alone as in groups/among friends.*[E]

Who's most likely to abuse other drugs?

Characteristic	Methamphetamine[N]	OxyContin®	Alprazolam[M]	Hashish[E]	Coricidin HBP®[E]	Flunitrazepam[N]
Age group (years)	13–17, 18–30	18–30[M], >30[N]	>30	>30	13–17	13–17, 18–30
Mean age (years)	NR	34[N]	NR	45	NR	18
Gender	60% female	Split evenly[N,M]	55% male	75% male	Split evenly	98% male
Race/ethnicity	White	White and Black[N], White[M]	NR	White	White, Black, and Hispanic (any race)	White
Socioeconomic position	Low/middle	Low,[N] middle[M]	NR	Middle	Low	Middle

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

- Methamphetamine: *More females are in treatment for primary methamphetamine abuse than in spring 2002. Also, more primary methamphetamine users in treatment are middle class and reside in rural areas, although the majority still reside in the suburbs.*[N]
- Diverted OxyContin® *Abusers of OxyContin® take the drug either alternately with diazepam*[N] *or in combination with alprazolam*[N,M] *or hydrocodone.*[M] *Some also use the drug as an alternative to heroin when heroin is not available.*[N]
- Alprazolam: *While adults older than 30 are the most common abusers of alprazolam, new clients in treatment for the drug are young adults. Alprazolam abusers typically abuse hydrocodone as well.*[M]
- Hashish: *Hash users either mix the drug with marijuana or smoke it in a pipe by itself. Marijuana users often take hash as "dessert" to increase their high.*[E]
- Dextromethorphan cold medications: *A large increase is noted in the number of youth abusing Coricidin HBP Cough & Cold® ("triple C"). Youth often take the cough syrup with alcohol.*[E]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin transactions take place in street markets[L,E] and private residences[L] located primarily in the central city.[L] Use is fairly limited to shooting galleries; new heroin users, however, also use the drug in abandoned warehouses in the city.[E]

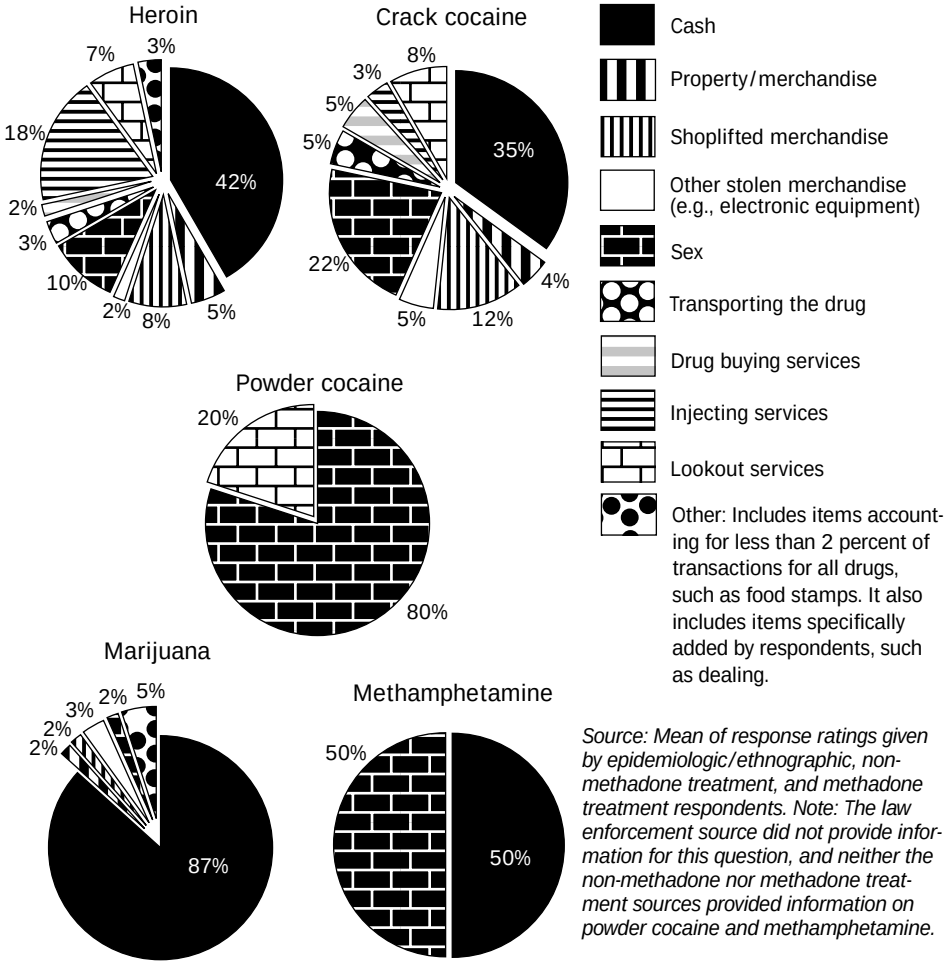
Crack and powder cocaine sales are equally distributed throughout all areas of Houston (central city, suburbs, and rural areas),[E] although sales identified by law enforcement are primarily located in the central city.[L] The two drugs are sold in many of the same settings, including street markets, crack houses, public housing developments, private parties, hotels/motels, and inside cars.[L,E] Crack is also sold in nightclubs/bars and playgrounds/parks,[E] while powder cocaine transactions take place on college campuses and at raves.[L,E] Transactions involving both forms of cocaine occur most often in the central city.[L]

Crack users typically take the drug in crack houses, playgrounds/parks, private parties, and inside cars. Powder cocaine use takes place in fewer settings: private residences, public housing developments, and hotels/motels.[E]

Marijuana is sold throughout Houston's central city, suburbs, and rural areas,[E] in settings such as street markets, private residences, public housing developments, college campuses, nightclubs/bars, raves, concerts, and hotels/motels.[L,E] However, it is generally used only in private residences, public housing developments, and around supermarkets.[E] New marijuana users also commonly buy and use the drug in and around schools and at private parties.[E]

Dealers sell methamphetamine in street markets, private residences, nightclubs/bars, and at concerts.[L] Ecstasy transactions take place in private residences, nightclubs/bars, private parties, raves, and concerts.[L,E] Nearly all of these venues serve as use settings for ecstasy as well.[E]

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



Source: Mean of response ratings given by epidemiologic/ethnographic, non-methadone treatment, and methadone treatment respondents. Note: The law enforcement source did not provide information for this question, and neither the non-methadone nor methadone treatment sources provided information on powder cocaine and methamphetamine.

What they have to say...

- *The practice of exchanging sex for drugs has declined significantly over the past decade due to increased awareness of HIV. In past years, men and women known as "rock stars" frequented crack houses to trade sex for crack; this practice is very rare now.*[N]
- *As reported in several* Pulse Check *sites, recent changes in Texas's food stamp program have significantly cut down on the practice of trading food stamps for drugs. The State has gone from a paper system to one similar to a debit card. Some users do, however, exchange food for drugs.*[N]
- *Dealers sometimes exchange large items, such as automobiles, for a kilogram of cocaine at the wholesale level; they also may "front a shipment in exchange for jewelry."*[L]
- *Operation White Terror, conducted by the DEA and the FBI, addressed the problem of large guns-for-cocaine transactions. Many arrests in the fall involved seizing of approximately $25 million in military-grade weapons.*[L]
- *While cash is the most common form of payment for powder cocaine in most cities, one Houston respondent estimates that 80 percent of transactions involve the exchange of sex for the drug.*[E]

HOW DO DRUGS GET FROM SELLER TO BUYER?

Heroin buyers typically approach dealers on known corners for hand-to-hand transactions. Sometimes they negotiate over price. When communicating with suppliers, heroin dealers use cell or pay phones and pagers.[L]

Transactions involving crack cocaine and marijuana are equally distributed throughout all areas of Houston,[E] although most transactions identified by law enforcement take place in the central city.[L] As with heroin, crack users often approach dealers on a known corner and negotiate a sale.[L] Dealers of crack and marijuana also arrange deliveries or pick-ups of the drug with buyers.[E] To purchase powder cocaine, buyers generally have to know someone; these transactions generally occur in the central city.[L]

Dealers primarily selling methamphetamine also sell drugs such as ecstasy and marijuana. The methamphetamine found in Houston is typically produced locally in small mobile ("box") labs or in labs hidden in warehouses and moved often.[E]

Ecstasy dealers also distribute powder cocaine, marijuana, gamma hydroxybutyrate (GHB), and ketamine.[L]

WHO'S SELLING HEROIN?

- Heroin dealers in Houston are typically part of either Black or Hispanic gangs or organizations.[L]
- Heroin dealers often give away free samples of marijuana as a marketing device to attract business.[L]

How pure is heroin, and how much does it cost?

Unit	Purity	Price
1 g (Black tar-most common)	28% average (range: 13–58%)	$150
1 oz (Black tar-most common)	28% average (range: 13–58%)	$1,000–$2,500
1 kg (Black tar-most common)	28% average (range: 13–58%)	$39,000–$60,000
1 oz (Mexican brown)	NR	$1,000–$1,200
1 kg (Colombian)	NR	$62,000

Source: Law enforcement respondent

- *All reported prices are stable since spring 2002.*[L]
- *Heroin purity is up statewide between 2001 and 2002, which has led to a large increase in overdoses.*[L]

How much does cocaine cost?

Form	Unit	Price
Crack	1 g	$100
	1 oz	$325–$600
	1 kg	$1,300–$1,800
Powder	1 g	$60–$100
	1 oz	$400–$650
	1 kg	$14,000–$18,500

Source: Law enforcement respondent

- *All reported prices are stable since spring 2002.*[L]
- *The price of cocaine depends on the quantity purchased, the relationship between buyer and seller, and how far the sale takes place from border checkpoints.*[L]

How much does marijuana cost?

Unit	Price
1 g (Mexican-most common)	$5
1 oz (Mexican-most common)	$100
1 lb (Mexican-most common)	$300–$500
0.25 lb (hydroponic)	$120
1 lb (sinsemilla)	$600

Source: Law enforcement respondent

All reported prices are stable since spring 2002.

WHO'S SELLING COCAINE?

- Crack cocaine dealers are typically young adults working independently.[E]
- Powder cocaine dealers often sell ecstasy as well, while crack dealers are more likely to distribute marijuana and cough syrup.[L]

WHO'S SELLING MARIJUANA?

- Marijuana dealers are typically older adults working either independently or as part of a larger organization. They are somewhat likely to be marijuana users as well.[E]
- These dealers are generally not involved in any criminal activity other than dealing.

How much does methamphetamine cost?

Unit	Price
1 oz	$500–$800
1 lb	$6,000–$11,000
1 kg	$18,000–$20,000

Source: Law enforcement respondent

All reported prices are stable since spring 2002.

How much does ecstasy cost?

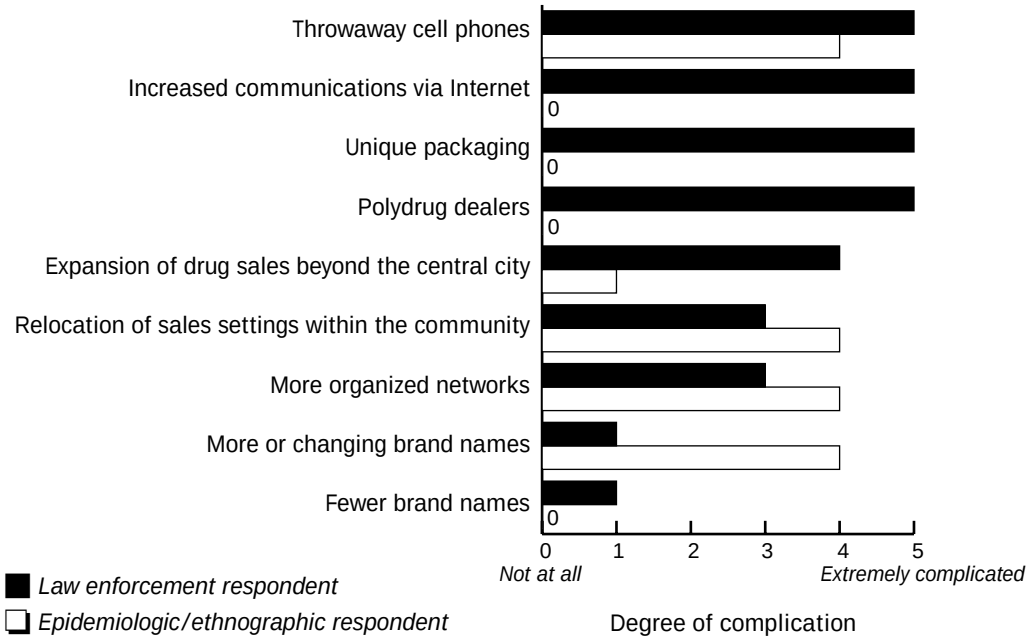
Unit	Price
1 tablet	$8 (wholesale) $20–$30 (at raves)
500 tablets	$3,500–$10,000
1,000 tablets	$8,000

Source: Law enforcement respondent

All reported prices are stable since spring 2002.

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

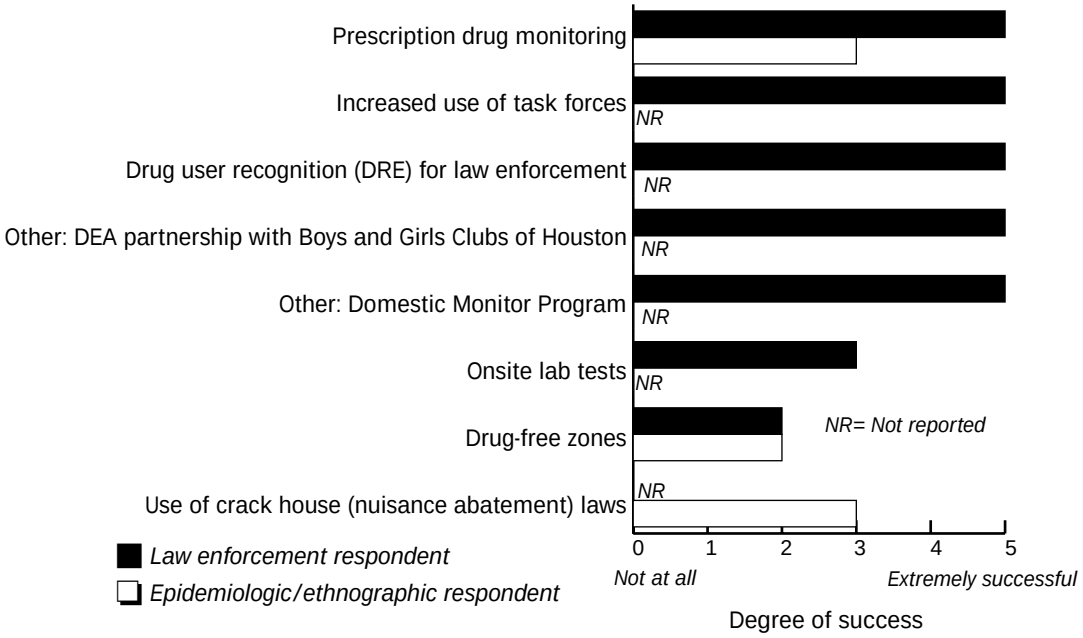
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in Houston?



What they have to say...

- *Unique packaging by dealers seems to have posed a greater challenge to law enforcement in Houston than in most other* Pulse Check *cities.*
- *By contrast, similar to reports in other cities, detection and disruption efforts have not been hampered much by increased or decreased use of brand names.*[L]
- *Wholesale dealers have developed two additional ways to avoid detection:*[L]
  - *Hiding drugs in false floors and other vehicle compartments.*
  - *Liquifying the drug and storing it in a bottle or saturating clothing with it, and then reconverting it after reaching the destination.*

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



- *A mentoring program representing a partnership between the DEA and the Boys and Girls Clubs of Houston has been largely successful in steering youth away from drugs and improving academic performance. The program alternates activities between education and recreation, and pairs each student with a mentor.*[L]
- *The Domestic Monitor Program has been very successful as a baseline to measure heroin purity.*[L]
- *One source recommends more controls on the distribution of alprazolam because the detox process is so dangerous, involving seizures and hallucinations.*[M]
- *Tracking and monitoring gang activity more closely would help to cut down on drug activity in Houston, as well as crimes associated with gangs and drug use, such as car thefts and graffiti.*[E]
- *While all* Pulse Check *cities report successful use of task forces to fight the drug problem, Houston's task forces are unique: they involve numerous agencies that are effective in meeting the challenges associated with the city's geographic location near the Mexican border. These task forces include professionals from local law enforcement, the U.S. Border Patrol, FBI drug squads, U.S. Customs, and the HIDTA.*[L]

SEPTEMBER 11 FOLLOWUP

While neither of the *Pulse Check* treatment respondents note any continuing effects on their clients as a result of the September 11 attacks, the law enforcement and epidemiologic/ethnographic sources observe a continued impact on Houston's drug problem:

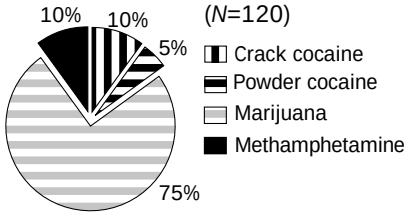
- Emerging drugs: Hashish had not been detected in Houston in a decade, but it is now reemerging as a problem. This reemergence is attributed to removal of the Taliban from power in Afghanistan following the September 11 attacks. The Taliban previously suppressed hashish production; Afghans now sell the drug again to generate income.[E]
- Drug use: Abuse of alcohol and marijuana continues at high levels among the middle class since September 11, reflecting increased levels of anxiety and escapism.[E]
- Drug trafficking: The Coast Guard's emphasis continues to be on security rather than interdiction.[L]

LOS ANGELES PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 9,519,338
- Median age: . . . . . 32.0 years
- Race (alone):
  - White 48.7%
  - Black 9.8%
  - American Indian/ Alaska Native 0.8%
  - Asian/Pacific Islander 12.2%
  - Other race 23.5%
  - Two or more races 4.9%
- Hispanic (of any race): 44.6%
- Unemployment rate: 5.0%
- Median household income: $42,189
- Families below poverty level with children <18 years: 19.9%

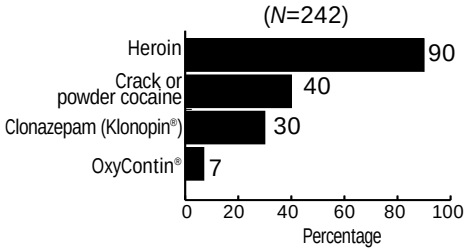
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

What drugs do clients in a methadone program abuse+? (Fall 2002)



+Includes any use, whether as a primary, secondary, or tertiary drug; response for methamphetamine was "very small"; response for ecstasy was "0"; this program does not track marijuana use.

Source: Methadone treatment respondent

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

Two *Pulse Check* sources[L,M] believe the city's overall drug problem has remained stable, and two[E,N] believe it has increased somewhat. Similarly, two sources[L,N] believe the overall drug problem is very serious, and two[E,M] believe it is somewhat serious. A few developments are noted:

- With the new Proposition 36, younger users, females, and those never before in treatment are increasingly entering treatment.[E]
- The number of people entering Los Angeles treatment programs for primary crack cocaine use declined slightly.[E]
- The number of admissions to the methadone treatment program increased.[M]
- An increasing number of primary methamphetamine users entered treatment.[E]
- Methylenedioxymethamphetamine (MDMA or ecstasy) use as a secondary or tertiary drug increased somewhat.[N]
- Raves, where ecstasy is the drug of choice, have become more prevalent and mainstream.[L] Ecstasy use is also spreading to private settings, such as residences and parties.

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

- Undercover police have had more difficulty purchasing heroin and hydroponic marijuana.[L]
- Crack prices and purity have declined.[L,E]
- Methamphetamine purity increased, and prices declined.[L,E]

Drugs reported as most widely abused include marijuana, crack, and heroin. Ecstasy and gamma hydroxybutyrate (GHB) use is still emerging.[L,E]

- *Treatment percentages in the non-methadone program remained relatively stable between spring and fall 2002, with the exception of an increase in secondary and tertiary ecstasy use.*
- *The number of methadone treatment admissions, in general, increased between spring and fall 2002.*

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

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

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

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

New or emerging problems:
Ecstasy use continues to increase.[L,E]
GHB use continues to increase.[E]

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

Heroin use patterns and market activity appear stable. Two demographic shifts are reported:

- Fewer Blacks (who still predominate) and more Whites and Hispanics are in treatment.[E]
- Young males increased among new heroin treatment clients.[M]

CRACK COCAINE

Two declines are noted:

- Crack cocaine treatment admissions declined slightly between spring and fall 2002.[E]
- Crack prices and purity declined.[L,E]

POWDER COCAINE

No changes are reported in use or market activity between spring and fall 2002.

MARIJUANA

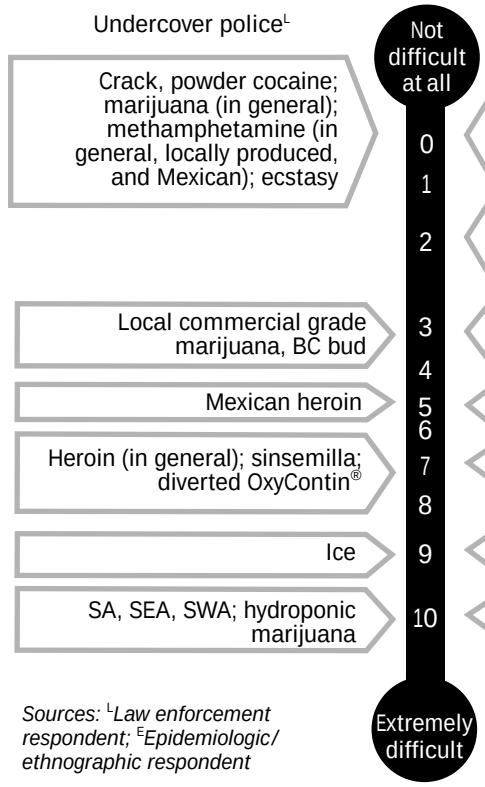
No changes are reported in use or market activity between spring and fall 2002.

METHAMPHETAMINE

Several indicators show an increase in methamphetamine use and activity between spring and fall 2002:

- The number of primary methamphetamine users presenting to treatment increased.[E]
- Methamphetamine purity increased, as prices declined.[L,E]

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



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

Note: SA = South American (Colombian) heroin; SWA = Southwest Asian heroin; SEA = Southeast Asian heroin; ice = highly pure methamphetamine in smokable form; BC bud=British Columbian marijuana; and OxyContin® =oxycodone hydrochloride controlled-release

- *As in other western* Pulse Check *cities, sources agree that it is extremely difficult to purchase white powder heroin (Colombian and Asian).*[L,E]
- *Undercover police have had more difficulty purchasing heroin (in general) and hydroponic marijuana since spring 2002.*[L]
- *Sources agree that crack, marijuana, and methamphetamine are relatively easy to purchase.*[L,E]

MDMA (ECSTASY)

Several indicators show an increase in ecstasy use between spring and fall 2002:

- Ecstasy use as a secondary or tertiary drug increased somewhat.[N]
- Raves, where ecstasy is the drug of choice, have become more prevalent and mainstream.[L]
- Ecstasy use is also becoming more prevalent in private settings, such as residences and parties.[E]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- The *Pulse Check* non-methadone treatment respondent, whose 120-slot facility of 12–24-year-olds operates at full capacity, reports marijuana as the primary drug of abuse among three-quarters of that program's clients *(see pie chart on the first page of this chapter)*. Treatment percentages appear relatively stable between spring and fall 2002.[N]
- The non-methadone treatment source reports an increase in slot capacity since spring 2002, although waiting lists remain a problem.
- The methadone treatment respondent is with a private facility that is at half capacity (220 of 500 slots filled). The number of admissions increased between spring and fall 2002.[M]
- Methadone maintenance treatment is available throughout the metropolitan area. Public and private methadone treatment availability remained adequate and stable between spring and fall 2002.[E]
- Nearly all females entering adolescent treatment centers are primary methamphetamine users; nearly all males are primary marijuana users.[E]
- The most common barrier (and an increasingly common one) to methadone treatment is a financial one. The treatment program is private, and thus it is difficult for clients to pay.[M]
- The most common impediment to treatment in the non-methadone facility, which treats adolescents and young adults, is a language barrier. Many clients and parents of clients speak only Spanish, while many staff speak only English.[N]

WHO USES ILLICIT DRUGS?

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

- *Two sources agree that heroin users tend to be adults older than 30 and male.*[E,M]
- *More Whites and Hispanics and fewer Blacks have presented to treatment for heroin use over the past few* Pulse Check *reporting periods.*[E]
- *All heroin-using clients in the non-methadone treatment program are secondary or tertiary users of the drug.*
- *New heroin treatment clients are likely to be male and much younger than the overall treatment population.*[M]

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	18–30	>30
Mean age (years)	35–46	NR	38
Gender	65% male	Split evenly	60% male
Race/ethnicity	40% Black 30% White 30% Hispanic (any race)	Hispanic (any race)	50% White 40% Hispanic (any race)
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Suburbs
Referral source	NA	Criminal justice and other health care provider	Individual
Level of education completed	NA	High school	None
Employment at intake	NA	Unemployed	Unemployed

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

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	90% inject	Injecting followed by smoking	Injecting
Other drugs taken	Crack, benzodiazepines	Marijuana (sequentially)	Crack, powder cocaine (speedball), clonazepam (Klonopin®)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	Alone	Alone and in groups	Alone

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

- *Injecting is, by far, the most common route of heroin administration.*[E,N,M] *Smoking is also common.*[N]
- *Heroin users often combine crack, marijuana, or benzodiazepines with heroin.*[E,N,M]
- *Use patterns appear stable between spring and fall 2002.*

Who's most likely to use cocaine?

Characteristic	Crack			Powder cocaine		
	E	N	M	E	N	M
Age group (years)	>30	13–30	>30	>30	13–30	>30
Mean age (years)	35–38	NR	NR	NR	NR	NR
Gender	60% male	Split evenly	Split evenly	Male	Split evenly	Split evenly
Race/ethnicity	Black	Hispanic (any race)	White and Black	White	Hispanic (any race)	White and Hispanic (any race)
Socioeconomic status	Middle	Low	Middle	Middle	Low	Middle
Residence	Central city	Central city	Suburbs	Suburbs	Central city	Suburbs
Referral source	N/A	Criminal justice, other health care provider, and parental	Individual	N/A	Criminal justice and school	Individual
Level of education completed	N/A	Junior high	None	N/A	Junior high	None
Employment at intake	N/A	Unemployed and full-time student	Unemployed	N/A	Unemployed and full-time student	Unemployed

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

- *The epidemiologic source notes a slight decrease in the number of people coming into Los Angeles treatment programs for primary crack cocaine use.*
- *Two sources*[E,M] *agree that most cocaine users are adults older than 30, but the cocaine-using population in the non-methadone treatment program includes mostly adolescents and young adults.*
- *Cocaine users often take marijuana in combination with crack.*[E,N] *Powder cocaine may be rolled in a marijuana joint, which is then referred to as a "premo."*[N]
- *Sources report no changes in cocaine user demographics between spring and fall 2002.*

- *As in other cities, marijuana users tend to span a broad range of demographics.*
- *Sources report no changes in user characteristics between spring and fall 2002.*

Who's most likely to use marijuana?

Characteristic	E	N
Age group (years)	13–30	13–17
Gender	Male	Split evenly
Race/ethnicity	White and Black	Hispanic (any race)
Socioeconomic status	Middle	Low
Residence	Central city and suburbs	Central city
Referral source	N/A	Criminal justice, school, parental
Level of education completed	N/A	Junior high or high school
Employment at intake	N/A	Unemployed and full-time students

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; the methadone treatment respondent did not provide information on marijuana use.

- *Marijuana is taken in a variety of ways (including joints, pipes, blunts, and bongs) and contexts.*[E,N]
- *Sources report no changes in marijuana use patterns between spring and fall 2002.*

How do users take marijuana?

Characteristic	E	N
Primary delivery vehicle	Varies widely	Varies widely
Other drugs taken	Phencyclidine (PCP) in combination	Powder cocaine (premo)
Publicly or privately?	Both	Both
Alone or in groups?	Both	Both

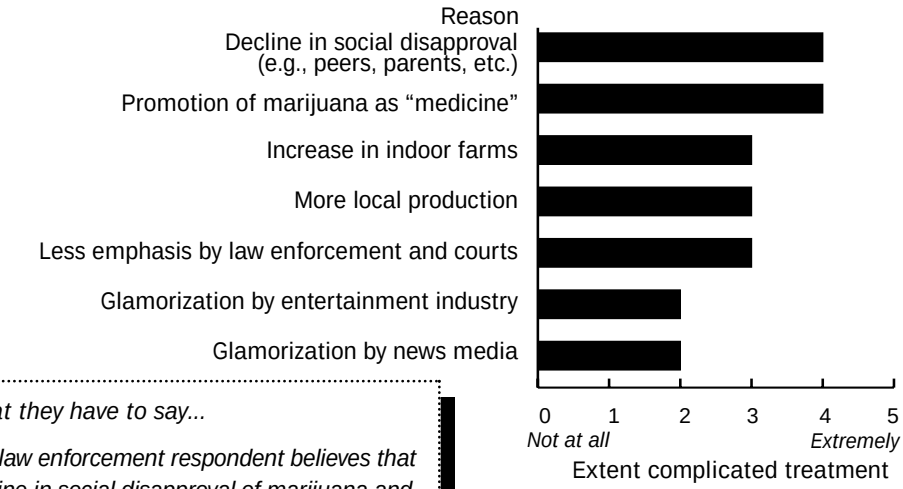
Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; the methadone treatment respondent did not provide information on marijuana use.

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

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

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



Source: Law enforcement respondent

What they have to say...

The law enforcement respondent believes that decline in social disapproval of marijuana and the promotion of marijuana as "medicine" are the main contributors to increased marijuana use over the past 10 years.

Who's most likely to use methamphetamine?

Characteristic	E	N
Age group (years)	>18	18–30
Mean age (years)	28–32	NR
Gender	55% male	Split evenly
Race/ethnicity	White	Hispanic (any race)
Socioeconomic status	Low and middle	Low
Residence	Suburbs	Central city
Referral source	N/A	Criminal justice, other health care provider, parental
Level of education completed	N/A	High school
Employment at intake	N/A	Unemployed and full-time students

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; the methadone treatment respondent did not provide information on methamphetamine use.

- *An increasing number of primary methamphetamine users presented for treatment in the last 6 months. This source believes the increase is fueled by Proposition 36.*[E]
- *Females entering adolescent treatment centers are nearly all primary methamphetamine users, while males are nearly all primary marijuana users.*[E]

- *Several routes of methamphetamine administration are reported: according to the epidemiologic source, smoking is most common, followed by snorting and injecting; according to the non-methadone treatment source, snorting is most common, followed by injecting.*
- *Adolescent methamphetamine users tend to take "a little bit of everything," including marijuana, lysergic acid diethylamide (LSD), and ecstasy.*[E]

How do users take methamphetamine?

Characteristic	E	N
Primary route of administration	Smoking	Snorting
Other drugs taken	Marijuana (in combination)	Marijuana (sequentially)
Publicly or privately?	Privately	Both
Alone or in groups?	Alone	Both

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; the methadone treatment respondent did not provide information on methamphetamine use.

Who's most likely to use ecstasy?

Characteristic	E	N
Age group (years)	13–30	>30
Mean age (years)	18–20	NR
Gender	Split evenly	Females
Race/ethnicity	White	Hispanic (any race)
Socioeconomic status	Middle and high	Low
Residence	Central city and suburbs	Central city
Referral source	N/A	Other health care provider and school
Level of education completed	N/A	High school
Employment at intake	N/A	Unemployed

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; the methadone treatment respondent did not provide information on ecstasy use.

- *Ecstasy use as a secondary or tertiary drug increased somewhat between spring and fall 2002.*[N]
- *Drugs combined with ecstasy include methamphetamine, GHB, ketamine, and LSD. When "coming down" from ecstasy, users often take benzodiazepines or antidepressants.*[E]

WHO'S MOST LIKELY TO ABUSE OXYCONTIN®?

- Primary OxyContin® abusers constitute about 5 percent of the methadone treatment population—a stable percentage since spring 2002.[M]
- OxyContin® abusers' mean age is about 40 years, 70 percent are male, and nearly all are White.[M]
- Sources report no changes in OxyContin® abuser characteristics between spring and fall 2002.

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin and crack cocaine are sold in a variety of public and commercial places, including the following:

- Streets and open-air markets[L,E]
- Crack houses and shooting galleries[L,E]
- Public housing developments[L,E]
- Playgrounds and parks[E]
- Around drug or alcohol treatment clinics[E]
- Inside cars[E]

Additionally, crack is sold inside private residences and hotels/motels.[E]

Powder cocaine sales settings tend to be more private and include the following:

- Inside private residences[L,E]
- Nightclubs and bars[L]
- Private parties[L]
- Public housing developments[E]

Marijuana sales settings are similar to heroin and crack sales settings, with the addition of the following:[L,E]

- In or around schools
- College campuses
- Nightclubs and bars
- Raves
- Supermarkets

Methamphetamine and ecstasy sales occur in a variety of public and commercial places:

- Streets and open-air markets[L,E]
- Inside private residences[L,E]
- Nightclubs and bars[E]
- Private parties[E]
- Raves[E]

Additionally, methamphetamine is sold around playgrounds and parks, hotels and motels, supermarkets, and inside cars.[E] Web sites that focus on male-to-male sex sell methamphetamine online.[E]

Along with the list above, ecstasy sales settings also include college campuses and gay circuit parties.[E]

The epidemiologic source notes that ecstasy is becoming more prevalent in private settings, such as residences and parties.

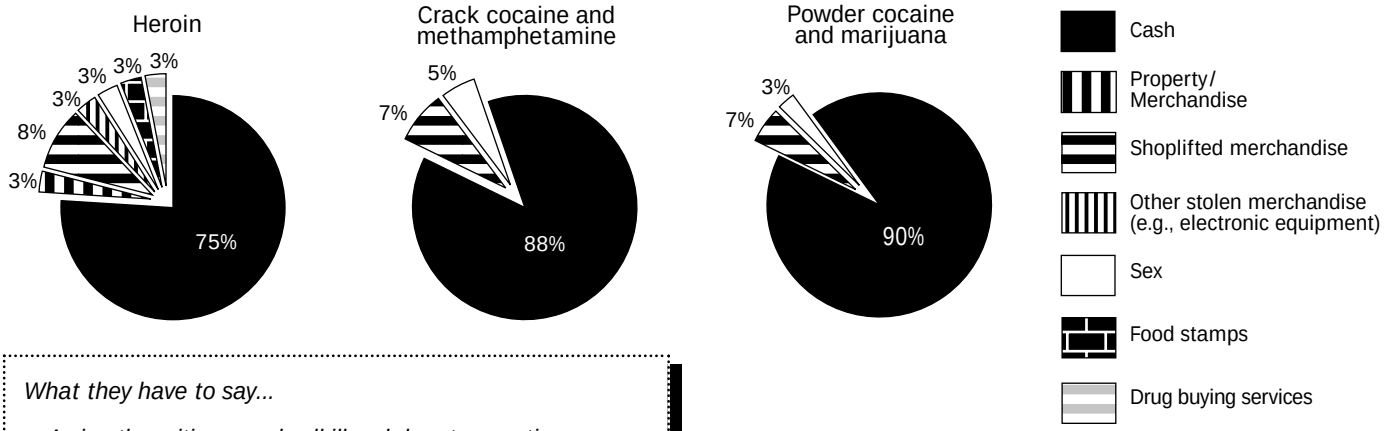
OxyContin® is obtained or diverted from the Internet and doctors' offices.[L]

HOW DO DRUGS GET FROM SELLER TO BUYER?

Although open-air drug markets exist in Los Angeles, most drug sales occur when a buyer contacts a dealer via cell phone to arrange for a delivery.[L] Individual dealers tend to sell one type of drug, with a few exceptions: dealers who primarily sell heroin may also sell crack and powder cocaine, and dealers who sell primarily powder cocaine may also sell marijuana.

The sales method for diverted OxyContin® differs from that for other drugs. Buyers and sellers visit Internet chat rooms to arrange meetings for drug sales.[L]

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



What they have to say...

- *As in other cities, nearly all illegal drug transactions (75–90 percent) involve cash.*[L,N,M]
- *Sources report no changes in means of exchange for illegal drugs over the past 10 years.*

Source: Mean of response ratings given by law enforcement, non-methadone treatment, and methadone treatment respondents. The methadone treatment source provided information for heroin only, and the epidemiologic/ethnographic source did not respond.

Which drug sellers are associated with which crimes?

Crime	Heroin	Crack and powder cocaine	Marijuana	Metham-phetamine	Ecstasy
Gang-related activity	✓	✓	✓		
Violent criminal acts	✓	✓	✓	✓	
Non violent criminal acts	✓	✓	✓	✓	✓
Domestic violence				✓	✓
Other: child endangerment				✓	

Sources: Law enforcement and epidemiologic/ethnographic respondents

Illegal drug dealers in Los Angeles continue to be highly involved in crime. Heroin, cocaine, and marijuana sales often involve gangs and violent criminal acts. Methamphetamine sales often involve domestic violence and child endangerment.

Who's most likely to sell illegal drugs?

Primary drug sold	Affiliation		Age (years)	
	L	E	L	E
Heroin	Independent	Organized: Mexican trafficking organizations	18–30	13–30
Crack	Independent and organized	Organized: local street gangs	13–30	13–30
Powder cocaine	Independent and organized	Organized: Mexican trafficking organizations	13–30	13–30
Marijuana	Independent and organized	Independent	13–17	13–30
Methamphetamine	Independent and organized	Independent and organized	>18	13–30
Ecstasy	Independent	NR	13–30	NR
Diverted OxyContin®	Independent and organized	NR	18–30	NR

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

- *Drug sellers tend to be fairly young, and the organization of the seller groups varies widely across the city.*[L,E]
- *The sales scene in Los Angeles has remained relatively stable between spring and fall 2002.*[L,E]

How much do illegal drugs cost?

Drug	Unit	Purity	Price
Mexican black tar or brown heroin	One balloon (0.1 g)	NR	$20[L]
	One "pedazo"	NR	$700–$800[E]
Crack cocaine	0.2 g	NR	$10[L]
	1 oz	78%	$500–$600[E]
Powder cocaine	1 g	80%	$100[L]
Marijuana (commercial grade)	Dime bag (1 g)	NR	$10[L]
Methamphetamine	1/16 oz	40%	$125[L]
	1 oz	30–35%	$450–$550[E]
Ecstasy	One pill (40 mg)	NR	$10–$20
		NR	$25–$40

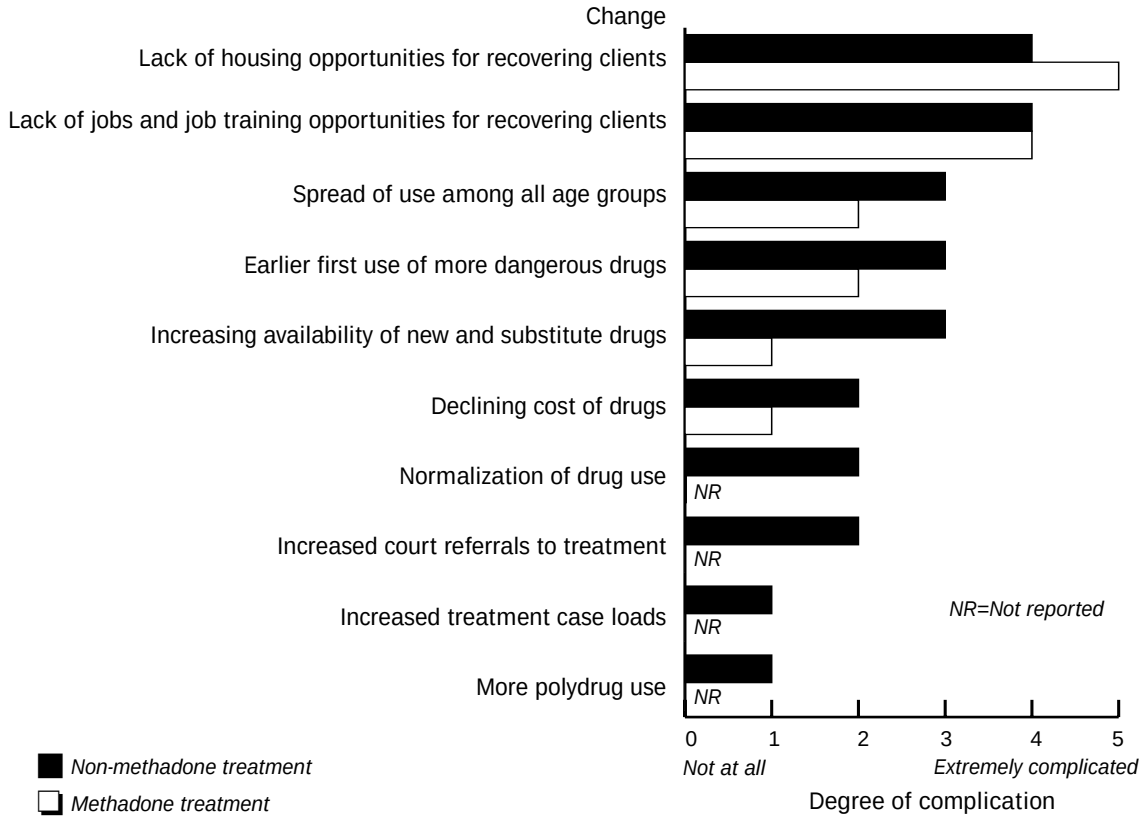
Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

Most reported drug purity and prices remained stable in the past 6 months, with two exceptions:

- *Crack cocaine prices and purity declined.*[L,E]
- *Methamphetamine purity increased, and prices declined.*[L,E]

THE USE AND MARKET PERSPECTIVES: A 10-YEAR VIEW

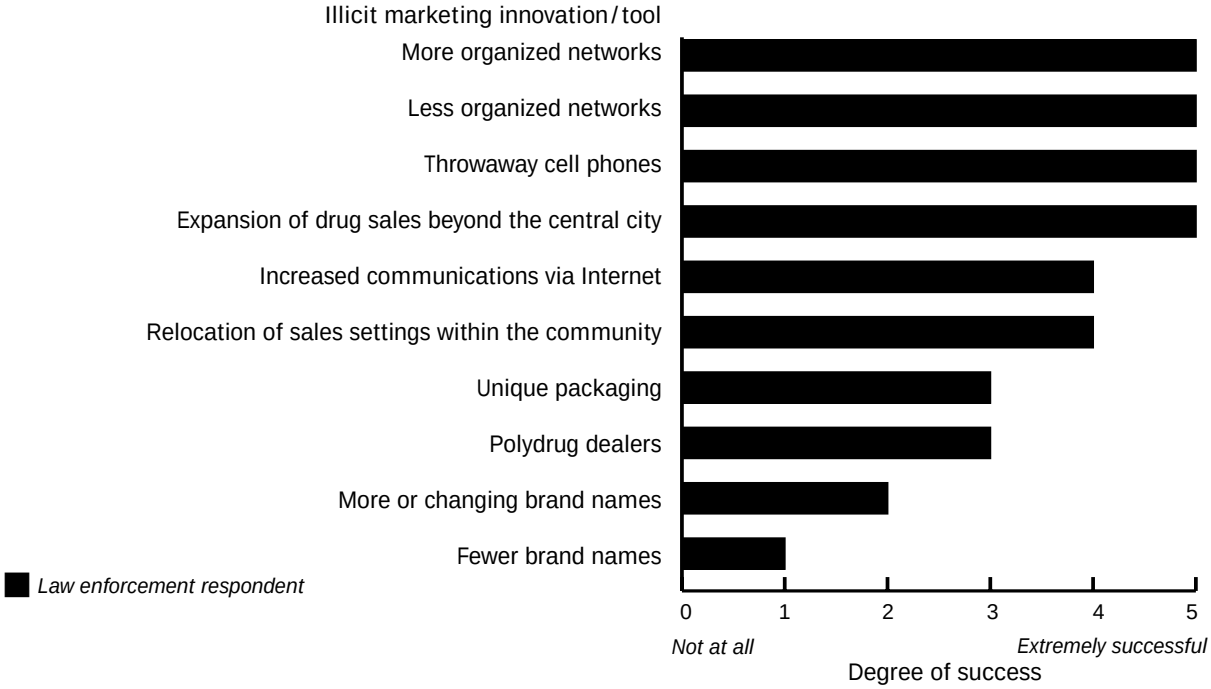
Over the past 10 years, to what degree have the following changes in the drug market and in the nature of drug users made your community's drug abuse problem more complex?



What they have to say...

- *Consistent with comments in the majority of other* Pulse Check *sites, treatment sources agree that the largest problems exacerbating the community's illegal drug problem are the lack of housing opportunities, jobs, and job training opportunities for recovering clients.*[N,M]
- *The methadone treatment source adds that clients who increasingly present with primary OxyContin® abuse and with secondary clonazepam abuse have made methadone treatment more difficult over the past 5 years.*[M]

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



What they have to say...

- *As in the majority of* Pulse Check *sites, detection and disruption efforts have not been hampered much by dealers using unique packaging or by the increased or decreased use of brand names.*
- *Again, consistent with* Pulse Check *cities across the country, throwaway cell phones and the reorganization of dealer networks rate as the most common innovations that have complicated law enforcement efforts to disrupt drug activity.*[L]
- *On the other hand, increased use of task forces, crack house (nuisance abatement) laws, and methamphetamine precursor laws have been fairly successful in combating illegal drug use and activity in the past 10 years.*[L]

SEPTEMBER 11 FOLLOWUP

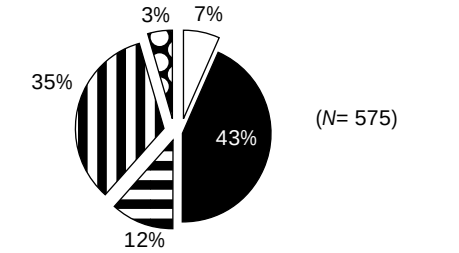
The law enforcement source notes that shipments of all drugs are steady despite a brief decline following September 11, 2001. Moreover, after September 11, many narcotics officers were diverted to security/antiterrorist duty. The absence of the officers allowed drug dealers to feel that they could deal drugs without being arrested. Now that officers are returning to narcotics duty, they are finding more drugs on the street than before September 11.[L]

MIAMI PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 2,109,282
- Median age: . . . . . 34.1 years
- Race (alone):
  - White 79.4%
  - Black 5.5%
  - American Indian/ Alaska Native 0.2%
  - Asian/Pacific Islander 1.4%
  - Other race 4.6%
  - Two or more races 3.8%
- Hispanic (of any race): 57.3%
- Unemployment rate: 5.0%
- Median household income: $35,966
- Families below poverty level with children <18 years: 19.3%

*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

Treatment percentages for primary drugs of abuse remained stable between spring and fall 2002.[N]

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

The three responding *Pulse Check* sources report the illegal drug problem in Miami as somewhat worse.[L,E,N] Sources report specific changes between the two reporting periods:

- Crack cocaine use has decreased somewhat. Powder cocaine use among new drug users is on the rise.[E]
- Heroin and diverted prescription opiates replaced powder and crack cocaine as the drugs associated with the most serious consequences.[E]
- As reported in 13 other *Pulse Check* cities, methamphetamine use continues to increase. One source reports it as a "P and P" or "party and play" drug often used in combination with ecstasy and sildenafil citrate (Viagra®).[E] That source further states that methamphetamine is often associated with high-risk sexual activity. Another source reports that, in particular, ice (a high-purity, smokable form of methamphetamine) is increasingly available.[L]
- Use of methylenedioxymethamphetamine (MDMA or ecstasy) and OxyContin® (oxycodone hydrochloride controlled-release) continues to increase.[N]
- Ecstasy and club drug users are now using powder cocaine to bolster the effects of club drugs. Club drugs are now used in settings beyond just clubs and raves. As the venues shift, the varieties of drugs used and combined are increasing.[E]

Two sources cite the illegal drug problem as very serious.[E,N] One source cites it as somewhat serious.[L] Because of the different perspective each brings, the sources differ in their perception of which drug is most widely abused and which leads to the most serious consequences.

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

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

Second most widely abused drug:
- Crack and powder cocaine[L,E]
- Crack[L]
- Marijuana[N]

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

Drug related to the most serious consequences:
- Crack and ecstasy used in combination[L]
- Crack[N]
- Heroin and diverted prescription opiates[E]

Changes between spring and fall 2002: Heroin and prescription opiates replaced powder and crack cocaine.[E]

Drug related to the second most serious consequences:
- Ecstasy[L]
- Crack and powder cocaine[E]
- Heroin[N]

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

New or emerging problems:
- Methamphetamine and ice[L,E]
- Ecstasy and diverted OxyContin®[N]
- Diverted sildenafil citrate (Viagra®) used in combination with methamphetamine[E]

Sources: [L]Law enforcement, [E]Epidemiologic/ ethnographic, [N]Non-methadone treatment
Note: These symbols appear throughout this city profile to indicate type of respondent. The methadone treatment source in Miami did not respond.

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ ethnographic sources reflect the metropolitan area.*

HEROIN

- The numbers of heroin users admitted to treatment remained relatively stable.[N]
- Users find it easier to purchase South American heroin than previously.[E]
- Along with prescription opiates, heroin replaced cocaine as the drug related to the most serious consequences.[E]

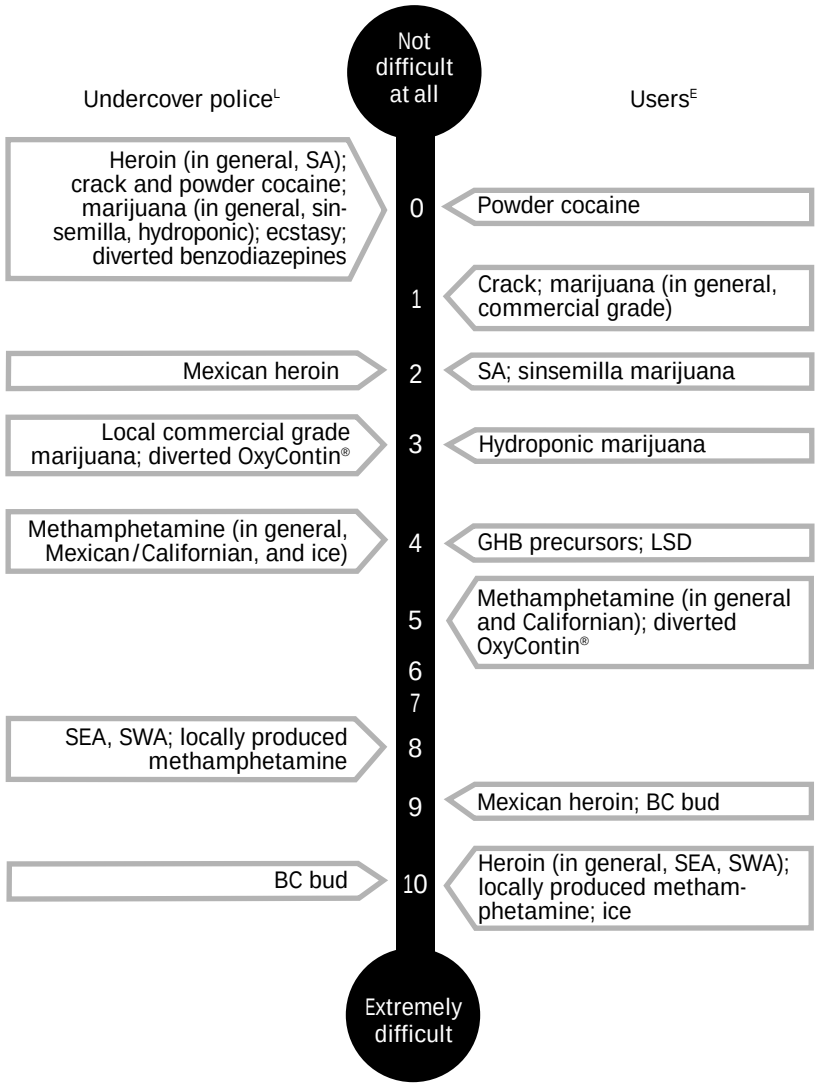
COCAINE

- Crack cocaine use decreased between spring and fall 2002.[E]
- Crack (followed by marijuana) is the most common primary drug of abuse in this non-methadone treatment program.[N]
- Powder cocaine use among new users increased somewhat between spring and fall 2002.[E] These individuals tend to be club drug users who now take cocaine to bolster ecstasy (to "bump up").

MARIJUANA

- Marijuana use remains widespread. Two of three sources believe it is the most widely used drug in Miami.[L,E]
- Marijuana activity, use, and user characteristics remained relatively stable between spring and fall 2002.[L,E,N]

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



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

- *Diverted OxyContin® is now more difficult for users to purchase because fewer doctors are prescribing it: they are more aware of its abuse. However, many OxyContin® abusers have switched to diverted methadone.*[E]
- *Undercover police purchased methamphetamine and ice more easily in fall 2002 than in the previous spring, particularly within the gay community.*[L]
- *As reported in three other* Pulse Check *cities (Atlanta, Chicago, and Pittsburgh), users can purchase methamphetamine more easily.*[E]
- *Users can purchase South American white heroin more easily.*[E]
- *Gamma hydroxybutyrate (GHB) analogs and lysergic acid diethylamide (LSD) are more difficult for users to purchase.*[E]

METHAMPHETAMINE

- Methamphetamine continues to increase in availability.[L,E] Ice, in particular, is increasingly available, especially within the gay community.[L]
- Methamphetamine use continues to increase dramatically. Its use in combination with ecstasy and sildenafil has also increased.[E]

MDMA (ECSTASY) AND OTHER CLUB DRUGS

- Although ecstasy use continues to increase, the numbers of users in treatment remain low and stable.[N]
- Club drugs are now used in settings beyond just clubs and raves. As the venues shift, the varieties of drugs used and combined are increasing.[E]

DIVERTED PRESCRIPTION OPIATES

- Diverted OxyContin® is more difficult to buy now than in the past, and abusers may have consequently switched to diverted methadone.[E]
- Along with heroin, prescription opiates replaced cocaine as the drugs related to the most serious consequences.[E]
- Methadone abuse has increased, especially among new users. An increase in deaths involving the drug occurred in the first half of 2002. Methadone tablets are believed to be diverted from pain management prescriptions (not clinics).
- OxyContin® abuse among admissions to treatment is increasing.[N] Its abuse in combination with alprazolam (Xanax®) and methadone has increased.[E]
- One source reports that pain management clinics are prescribing OxyContin® improperly.

OTHER DRUGS

- Diverted Xanax®: Alprazolam abuse and misuse have increased, as has the practice of using the drug in combination with prescription opiates or ecstasy.[E]
- Viagra®: Abuse of sildenafil has increased, especially among new drug users and in combination with marijuana, ecstasy, or methamphetamine. Moreover, the increase among new users is particularly marked among adolescent males.[E]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- Availability of public methadone treatment has remained relatively stable between spring and fall 2002, but for private treatment, availability has increased.[E] Public methadone treatment programs reportedly have adequate capacity; private programs have a waiting list of about 1 month, although capacity for private programs has increased somewhat since spring 2002.[E]
- The *Pulse Check* non-methadone treatment respondent, whose 300-slot facility operates at full capacity, reports crack cocaine as the primary drug of abuse among 43 percent of clients followed by marijuana at 35.4 percent (*see pie chart on the first page of this chapter*). Treatment percentages remained stable between spring and fall 2002.[N]
- The non-methadone treatment provider lists HIV/AIDS and hepatitis C as relatively common illnesses among clients. Moreover, that source states that hepatitis C is not only high among injecting drug clients but also among clients who snort drugs: "Snorting powder cocaine through a straw in a group is another common mode of passing on the disease."
- Comorbid diagnoses among clients have remained relatively stable between spring and fall 2002, but many are stable at relatively high levels, including antisocial or conduct disorder, mood disorders, suicidal thoughts/attempts, and post-traumatic stress disorder (PTSD).[N]
- The number-one barrier to treatment for the non-methadone treatment program is limited slot capacity. The program has a waiting list and a "waiting list for the waiting list."[N]
- Methadone treatment is available in selected areas only.

WHO USES ILLICIT DRUGS?

The *Pulse Check* epidemiologic and non-methadone treatment sources were asked to describe the populations most likely to use heroin, cocaine, marijuana, methamphetamine, and ecstasy. They were also asked to depict any emerging user groups and to report on how the drugs are used. As shown in the following pages, user characteristics vary from drug to drug. Further, because of the different perspective each brings, the three responding sources sometimes describe quite different populations and use patterns for each drug.

Who's most likely to use heroin?

Characteristic	E	N
Age group (years)	18–30	>30
Mean age (years)	NR	44
Gender	80% male	69% male
Race/ethnicity	White	White
Socioeconomic status	Low	NR
Residence	Suburbs	Central city
Referral source	N/A	Individual
Level of education completed	N/A	High school
Employment at intake	N/A	Unemployed

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

- *Heroin users tend to be White, non-Hispanic males.*[E,N]
- *New users tend to be Hispanic adolescents of middle economic status.*[E]
- *No sources report shifts in demographics between spring and fall 2002.*

How do users take heroin?

Characteristic	E	N
Primary route of administration	Injecting	Injecting
Other drugs taken	Powder cocaine (speedball) Diverted OxyContin®	NR
Publicly or privately?	Privately	Both
Alone or in groups?	Alone	Both

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

- *Heroin users tend to inject. No changes in route of administration are noted.*[E,N]
- *Other drugs commonly taken include powder cocaine (injected in a speedball) and diverted OxyContin® (as a substitute for or sequentially with heroin).*[E]
- *New heroin users often use ecstasy sequentially after heroin.*[E]

- *Although powder and crack cocaine users tend to be older than 30, they differ demographically in other ways: crack users are more likely than powder cocaine users to be female, and they are more likely to be Black and of low socioeconomic status.*[E,N]
- *Powder cocaine users new to treatment tend to be much younger than treatment clients overall (23.87 years versus 38.71 years). Also, users new to treatment are more often Hispanics and females than treatment clients overall.*[N]
- *Powder cocaine use among new users has increased somewhat between spring and fall 2002.*[E] *These individuals tend to be club drug users who now take cocaine to bolster ecstasy (to "bump up").*
- *Other drugs commonly taken with crack include heroin or alprazolam sequentially*[E] *and ecstasy.*[L]
- *Sources reported no shifts in crack or powder cocaine demographics between spring and fall 2002.*[E,N]

Who's most likely to use cocaine?

Characteristic	Crack		Powder cocaine	
	E	N	E	N
Age group (years)	>30	>30	>30	>30
Mean age (years)	NR	40.25	37	38.71
Gender	Evenly split	59% male	65% male	65% male
Race/ethnicity	Black	Black	White	Black
Socioeconomic status	Low	Low	Middle	Low
Residence	Central city and rural areas	Central city	Suburbs	Central city
Referral source	N/A	Individual	N/A	Individual
Level of education completed	N/A	High school	N/A	High school
Employment at intake	N/A	Unemployed	N/A	Unemployed

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

- *While Hispanics remain the predominant marijuana user group, use cuts across all ethnic groups.*[E,N] *Whites are represented about equally to the general population, and Blacks are overrepresented compared with the general population.*[E]
- *The average age of marijuana users in the general population is about 32 years*[E]*; the average age of marijuana users in the non-methadone treatment program is about half that (15.66 years).*[N]

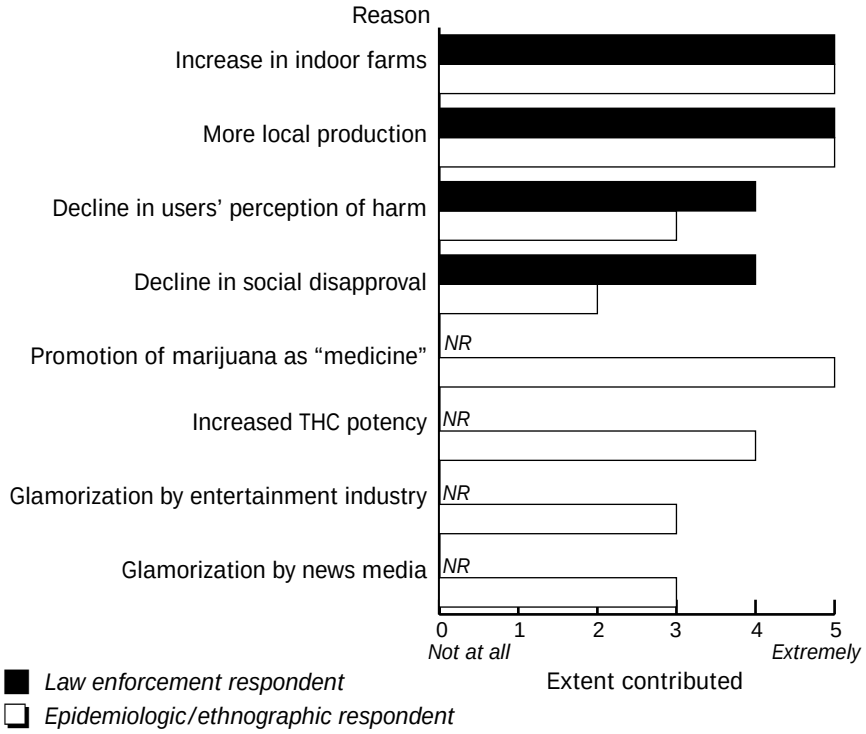
Who's most likely to use marijuana?

Characteristic	E	N
Age group (years)	18–30	13–17
Mean age (years)	32	15.66
Gender	70% male	65% male
Race/ethnicity	Hispanic (any race)	Hispanic (any race)
Socioeconomic status	All	Low
Residence	All	Central city
Referral source	N/A	Criminal justice
Level of education completed	N/A	High school
Employment at intake	N/A	Full time

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

- *Marijuana is most often smoked in joints, but blunts, bongs, and pipes are also common.*[E]
- *Sildenafil is often abused sequentially with marijuana, especially among adolescent males. This combination is a carryover from the practice of combining ecstasy with sildenafil.*[E]
- *Respondents report no shifts in marijuana user or use characteristics.*

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



- *Law enforcement and epidemiologic sources agree that the increase in indoor farms and more local production of marijuana has greatly contributed to the widespread use and availability of marijuana over the past 10 years.*
- *The law enforcement respondent believes that some local media "are quick to report on legalization efforts and 'medicinal' uses [of marijuana]," but not on its harmful effects.*

NR=Not reported

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

- Drug-related deaths (in which one of the drugs is marijuana)
- Drug-related emergency room visits
- Drug-related arrests
- Automobile accidents
- Short-term memory loss
- High-risk pregnancies
- Deteriorating family/social relationships
- Poor academic performance
- School absenteeism, truancy, or dropping out of school
- Poor workplace performance
- Workplace absenteeism
- Unemployment rates
- High-risk sexual behavior

MARIJUANA-USING CLIENTS:

To what extent have changes in marijuana and marijuana use patterns complicated treatment over the past 10 years?

According to the non-methadone treatment source, increased THC potency and earlier initiation of marijuana use have complicated treatment for marijuana-using clients. Moreover, this source believes that glamorization of marijuana use by the entertainment industry and news media has declined in the past 10 years.

Who's most likely to use methamphetamine?

Characteristic	E	N
Age group (years)	>30	>30
Mean age (years)	33	35
Gender	Male	80% male
Race/ethnicity	White	White
Socioeconomic status	Middle	NR
Residence	Suburbs	Central city
Referral source	NA	Individual
Level of education completed	NA	2-year college
Employment at intake	NA	Full time

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

- *The number of users increased dramatically between spring and fall 2002.*[E]
- *Methamphetamine users tend to be adult, White, non-Hispanic males.*[E,N]
- *Use is spreading from the gay male and the techno-dance scenes to females and heterosexual males.*[E]
- *Methamphetamine use is associated with a dramatic increase in high-risk sexual behavior.*[E]

How do users take methamphetamine?

Characteristic	E	N
Primary route of administration	Snorting	Injecting
Other drugs taken	Ecstasy ("hugs and kisses") Sildenafil ("crystal d--k")	NR
Publicly or privately?	Privately	Both
Alone or in groups?	In groups/among friends	Both

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

- *Methamphetamine is taken in a variety of ways in Miami, including snorting, injecting, and smoking the high-purity form of the drug (ice).*[L,E,N]
- *Methamphetamine is often used in combination with other drugs including marijuana, ecstasy, and sildenafil.*[L,E]

Who's most likely to use ecstasy?

Characteristic	E	N
Age group (years)	18–30	NR
Mean age (years)	24	18
Gender	Split evenly	Male
Race/ethnicity	White	White
Socioeconomic status	Middle	NR
Residence	Suburbs	Central city

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

- *Ecstasy use continues mostly among White, non-Hispanic young adults.*[E,N]
- *Ecstasy users tend to take a variety of drugs in combination, including marijuana, GHB, alprazolam ("Zany bars"), cocaine, methamphetamine, and ketamine.*[E]
- *Sources report no shifts in user characteristics between spring and fall 2002.*

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Nearly all illegal drug sales in Miami reportedly occur in central city areas. Heroin, powder cocaine, and crack are sold in a variety of places, including the following:[L,E]

- Streets/open-air markets
- Crack houses/shooting galleries
- Private residences
- Public housing developments
- Nightclubs and bars
- College campuses
- Playgrounds and parks
- Private parties
- Raves
- Hotels and motels

Additionally, powder cocaine is sold around elementary, junior high, or high schools, around drug treatment clinics, and in parking lots. Both forms of cocaine are also sold around shopping malls and supermarkets.

Marijuana and ecstasy are also sold on the streets and in open-air markets as well as at the following venues:

- Public housing developments
- College campuses
- Nightclubs and bars
- Raves
- Concerts
- Hotel and motels

Methamphetamine is not typically sold on the streets; however, it is sold at private residences, college campuses, nightclubs and bars, private parties, raves, and hotels/motels. OxyContin® is often misprescribed at pain management clinics,[E] which "are popping up on every corner"; thus, the availability of the drug illegally has increased.[L]

HOW DO DRUGS GET FROM SELLER TO BUYER?

Dealers on the street often sell heroin, diverted OxyContin®, crack, powder cocaine, and marijuana. Dealers in nightclubs and bars may sell heroin, powder cocaine, ecstasy, GHB, prescription drugs, and marijuana.

- Heroin, powder and crack cocaine, and diverted OxyContin®: These drugs are sold using similar techniques: certain neighborhoods are known for drug dealing; a buyer goes to one neighborhood, makes an acquaintance on the street who tells the buyer where and from whom to get the drug, and the drug is then exchanged hand to hand. After the initial sale, the buyer may contact a dealer by beeper, cell phone, or two-way-communication cell phone to set up a meeting for the exchange of the drug.[L,E] Additionally, powder cocaine sales may be venue oriented (in nightclubs and party scenes), and sales by these dealers may include alprazolam, ecstasy, and marijuana.[E] Crack cocaine sales are more out in the open than heroin and powder cocaine sales.[L]
- Marijuana: Sales methods vary widely depending on the venue. For example, at bars or nightclubs, potential buyers can ask around for the location of dealers. As with heroin and powder and crack cocaine, in certain neighborhoods, buyers may ask around for the location of dealers. Communication modes also vary and include in person, cell phones, beepers, and two-way-communication cell phones. Marijuana sales, according to one source, are very open.[L]
- Methamphetamine and ecstasy: Sales for these drugs are less open than for other drugs. One source states that "you must know the crowd to be able to buy," and dealers communicate with buyers in person, by beeper, cell phones, two-way-communication cell phones, the Internet, and e-mail. That source also notes that ecstasy sales are becoming less open than in the past and that ecstasy dealers are "learning how to avoid law enforcement."[L]

Which drug sellers are associated with which crimes?

Crime	Heroin	Powder and crack cocaine, marijuana, and ecstasy	Methamphetamine
Prostitution	✓	✓	
Gang-related activity	✓	✓	
Violent criminal acts	✓	✓	
Nonviolent criminal acts		✓	
Domestic violence	✓	✓	✓
Drug-assisted rape	✓	✓	✓

Source: Law enforcement respondent

According to the law enforcement respondent, illegal drug sellers in Miami are highly involved in other crimes. Powder and crack cocaine, marijuana, and ecstasy dealers are especially involved in a variety of violent and nonviolent criminal acts.

WHO SELLS DRUGS?

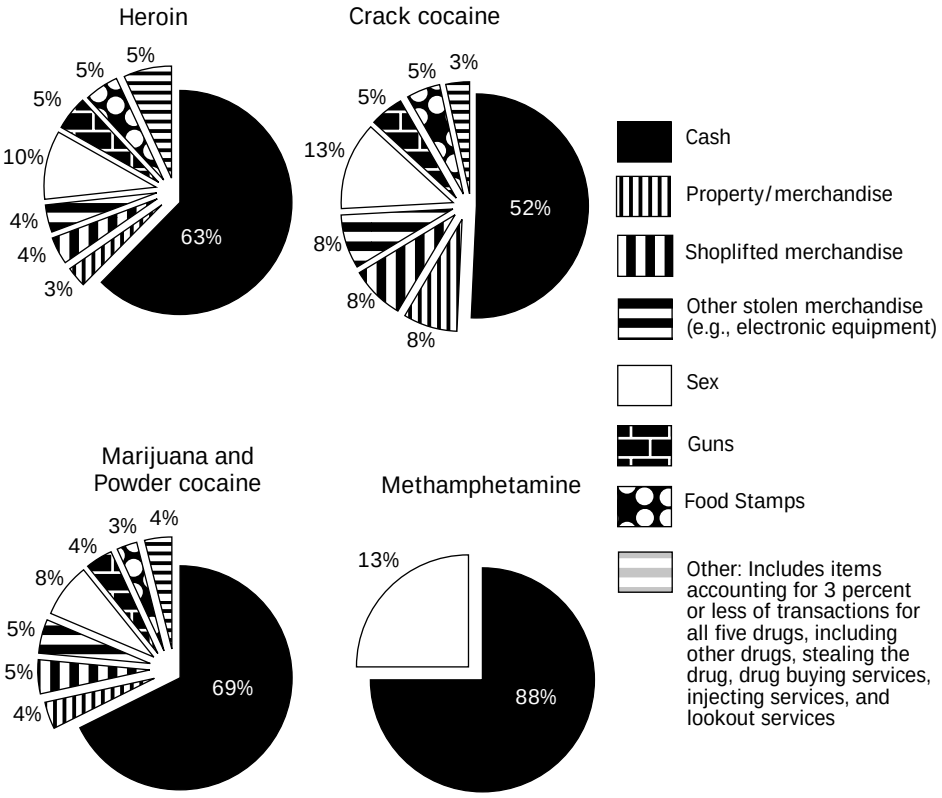
According to the epidemiologic source...

Illegal drug dealers tend to be 18–30 years old, and their level of organization depends on the type of drug sold. For example, heroin, powder cocaine, and methamphetamine dealers tend to be independent, whereas crack cocaine, ecstasy, GHB, and diverted OxyContin® dealers are organized. Marijuana dealers are organized into small sales teams of five independents who work for a grower.

According to the law enforcement source...

- Heroin, powder, and crack cocaine dealers are organized into small groups, including some street gang members, but the sales groups are not controlled by the gangs. Heroin sellers tend to be 18–30 years old. Powder and crack cocaine dealers tend to be somewhat younger and often include adolescents.
- Marijuana sellers are more organized than heroin, powder cocaine, and crack sellers. The organization protects the grow houses and is more hierarchical than loosely organized heroin, powder cocaine, and crack organizations. Sellers tend to be 13–30 years old, and growers tend to be older (18–30 years old).
- Methamphetamine and ecstasy sellers are organized in loose acquaintance networks.
- Diverted OxyContin® sellers are organized. Sellers recruit several addicts or users on Medicare. The sellers take those users to fill their prescriptions. Those who fill their prescriptions keep some of the drug for personal use and sell the rest to their accompanying seller who, in turn, sells the drug illegally.

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



What they have to say...

- *Although cash is reportedly the most common item exchanged for illegal drugs, several other goods and services are commonly exchanged for drugs, particularly shoplifted merchandise, sex, and other drugs.*[L,E]
- *Sex exchanged for crack cocaine or methamphetamine is relatively common.*[E] *The epidemiologic source explains that methamphetamine is a relatively new drug to Miami and is being introduced in sexual situations and parties.*
- *The law enforcement source explains that women pay very little cash for club drugs (especially ecstasy). Often they receive the drugs as a gift or in exchange for sex.*

Source: Mean of response ratings given by law enforcement and epidemiologic/ethnographic respondents.

How much do illegal drugs cost?

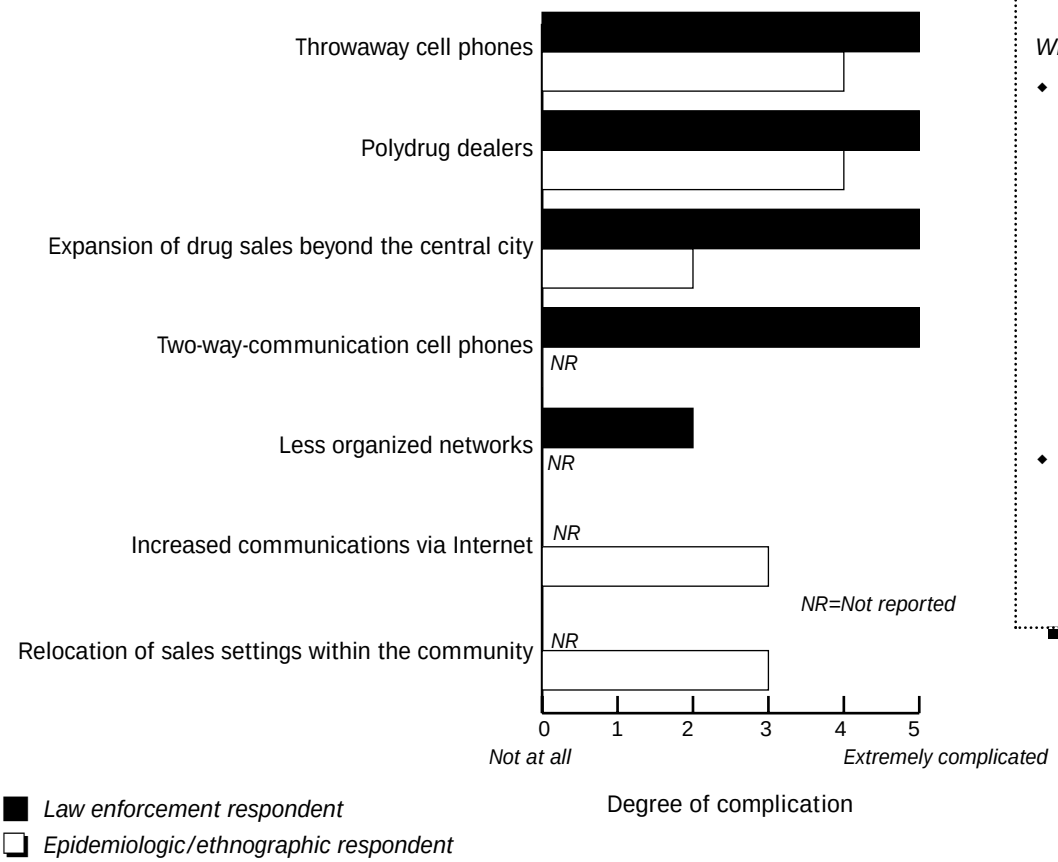
Drug	Unit sold	Price
Colombian heroin	1 oz	$2,100
Crack	One rock	$10–$20
Powder cocaine	1 oz	$650
Ecstasy	One pill	$11–$18

Source: Law enforcement respondent

Reported drug prices in Miami remained relatively stable between spring and fall 2002.[L,E] Sources did not report on specific prices for marijuana, but the epidemiologic respondent stated that marijuana prices increased in the past 6 months. The increase is most likely due to the higher THC levels of hydroponic marijuana and the customers' demands for these high-potency levels.

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

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



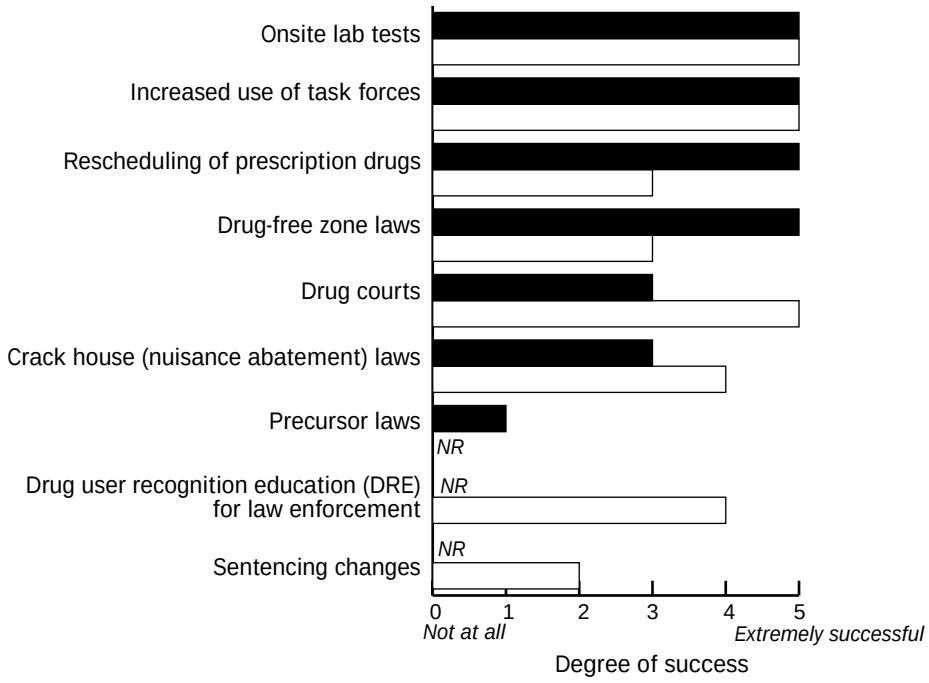
What they have to say...

- *Throwaway phones greatly contribute to difficulty in disrupting drug activity in Miami.[L,E] These phones make it particularly difficult to track those involved in higher level drug smuggling, and two-way-communication cell phones have recently added to the difficulty in tracking drug distributors.[L]*
- *Polydrug dealers are also a particular problem for law enforcement, especially in the club and rave scenes.[L,E]*

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

What they have to say...

- *Onsite lab tests: Rated as extremely successful by law enforcement and epidemiologic sources, onsite lab tests can be interpreted as testing the substance itself or testing a person for substance use. Often, during driving while intoxicated (DWI) stops, officers test drivers for drugs.*[E]
- *Increased use of task forces: As reported in most* Pulse Check *cities, sources rate task forces, which include State task forces on club drugs and prescription drug abuse and High Intensity Drug Trafficking Areas (HIDTA) task forces for heroin and other drugs, as extremely successful.*[L,E]
- *Prescription drug monitoring: Both sources agree that more prescription drug monitoring is needed. The epidemiologic source believes that new prescription drug monitoring legislation will pass during 2003.*[L,E]



SEPTEMBER 11 FOLLOWUP

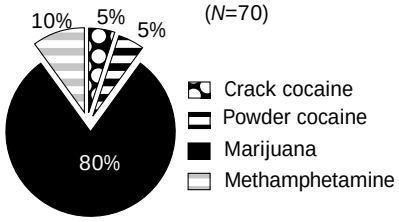
Since the September 11 attacks, Miami's ecstasy supply has been unstable. The supply from the Belgium and Luxemburg region route was cut off, and more adulterated products sold as ecstasy are now on the market.

MINNEAPOLIS/ST. PAUL METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 2,968,806
- Median age: . . . . . 34.2 years
- Race (alone):
  - White. 86.1%
  - Black 5.3%
  - American Indian/ Alaska Native 0.7%
  - Asian/Pacific Islander 4.1%
  - Other race 1.6%
  - Two or more races 2.1%
- Hispanic (of any race): . . . 3.3%
- Unemployment rate: 3.5%
- Median household income: $54,304
- Families below poverty level with children <18 years: 6.5%

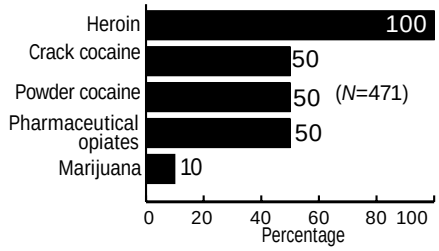
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



+Includes any use, whether as a primary, secondary, or tertiary drug; program does not test for marijuana, so figure is based on self-reports; pharmaceutical opiates include hydromorphone (Dilaudid®), butorphanol tartrate (Stadol®), hydrocodone (Vicodin®), and oxycodone (Percodan®, Percocet®).

Source: Methadone treatment respondent

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

Two of the *Pulse Check* sources believe that the area's overall drug problem has remained stable,[E,N] while the other two believe it has worsened somewhat.[L,M] Specifically, several developments are reported:

- Heroin, crack and powder cocaine, marijuana, and methamphetamine are being sold on the streets or in open-air markets—a major development over the past few years in a metropolitan area that never used to have a street scene.[L,E]
- As mentioned in eight other *Pulse Check* cities, diverted methadone is an emerging problem.[M] Local pain clinics have been shifting from prescribing OxyContin® (oxycodone hydrochloride controlled-released) to prescribing methadone. Many patients referred from methadone treatment to a higher level of care go, instead, to pain clinics, feigning pain. Physicians at these clinics then prescribe the drug—not because they are unscrupulous, but because they are naive in identifying people with coexisting opioid problems.
- Cooking methamphetamine in rented hotel rooms and in cars is a recently increasing trend.[L]
- Undercover police find it easier to purchase BC bud (British Columbian marijuana) since the previous reporting period because of a new pipeline to Seattle.[L] Three other sources in *Pulse Check* cities report a similar change (Seattle,[L] St. Louis,[E] and Portland, OR[L]). While marijuana dealers tend to operate independently, recent gang activity is also reported in relation to BC bud—again, similar to reports in Seattle.[L]
- The use of "sherms" and "water" (phencyclidine [PCP], embalming fluid, and marijuana combined) has increased over the past few months (similar to an increase reported in Houston[E]), according to methadone patients in a small telephone focus group jointly conducted by the methadone treatment source and the *Pulse Check* discussant.[F] The epidemiologic source also reports an increase in this combination ("wet sticks" or "dipped joints").[E]
- Khat is an emerging drug among the area's Somalian community, which is the largest in the country.[L]
- An increase is reported in pills sold as "ecstasy" that actually contain no methylenedioxymethamphetamine (MDMA).[E]

Three of the *Pulse Check* sources believe the area's overall drug problem is very serious, while one[M] describes it as "somewhere between somewhat and not very serious." Because of the different perspective each brings, the sources vary in their perception of which drugs are most commonly abused and which have the most serious consequences. For example, the law enforcement source considers crack the drug related to the most serious consequences because of its association with homicides. Similarly, the methadone treatment source

Spring vs fall 2002...

- *Crack and methamphetamine increased slightly as primary drugs of abuse in the non-methadone program.*
- *Treatment percentages in the methadone program remained relatively stable.*

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

THE BIG PICTURE *(continued)*

considers benzodiazepines the drugs with the most serious consequences second to heroin, because of their involvement in overdoses when combined with opiates, and also names cocaine, because of its involvement in crime.

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

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

Second most widely abused drug:
- Powder cocaine[L,M]
- Crack[E,M]
- Methamphetamine[N]

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

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

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

Drug related to the second most serious consequences:
- Heroin[L]
- Marijuana[E]
- Methamphetamine[N,F]
- Benzodiazepines, cocaine[M]

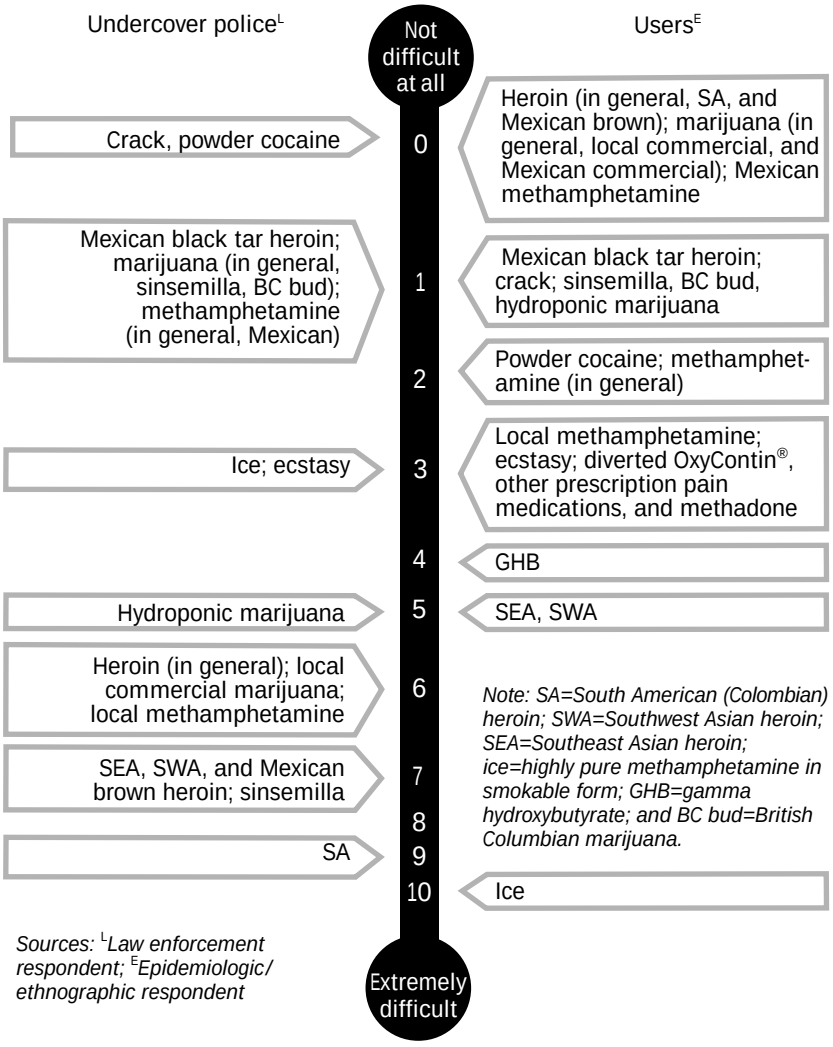
No reported changes between spring and fall 2002[L,E,N,M]

New or emerging problems:
- Khat[L]
- Diverted/abused prescription pain medications[E]
- Ecstasy[N]
- Methadone diverted from pain clinics[M]
- "Sherms" and "water" (PCP + embalming fluid + marijuana)[F]

Sources: [L]Law enforcement, [E]Epidemiologic/ethnographic, [N]Non-methadone treatment, [M]Methadone treatment, and [F]Focus group respondents

Note: These symbols appear throughout this city profile to indicate type of respondent.

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



Note: SA=South American (Colombian) heroin; SWA=Southwest Asian heroin; SEA=Southeast Asian heroin; ice=highly pure methamphetamine in smokable form; GHB=gamma hydroxybutyrate; and BC bud=British Columbian marijuana.

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

- *Minneapolis/St. Paul is one of eight* Pulse Check *cities where users can purchase heroin (in general) with no difficulty at all. It is also one of five cities where users can purchase Mexican methamphetamine with no difficulty at all.*[E]
- *BC bud is fairly easy to purchase, by both users and undercover police, as is the case in only a handful of other* Pulse Check *cities.*
- *Undercover police find it less difficult to purchase BC bud since the previous reporting period because of a new pipeline to Seattle.*[L] *Only three other cities report a similar change (Seattle,*[L] *St. Louis,*[E] *and Portland, OR*[L]*).*
- *Users and undercover police can purchase most drugs with a fairly similar degree of ease, with two exceptions: users find it more difficult than undercover police to purchase ice; conversely, undercover police find it more difficult than users to purchase SA and Mexican brown heroin.*
- *Users find it less difficult to purchase diverted prescription pain medications in fall 2002 than in the previous spring.*[E]

HEROIN

- Purity has increased, price is low, and supplies are plentiful.[E,M]
- Opiate-related deaths continue to increase, recently surpassing cocaine-related deaths for the first time.[E]
- Increases are reported in overdoses, smoking and snorting, and use in the suburbs.[E]
- Street sales have increased. The area never used to have a street scene.[E]

COCAINE

- While crack is readily available, and it increased slightly as a primary drug of abuse between spring and fall 2002, it is "an adult drug. Kids look down on it." The few adolescents who use it tend to be hooked up with older people and have moved off the street and into the business.[N]
- The number of crack users has declined somewhat, among both younger and older adults.[E]
- The number of clients in treatment for powder cocaine abuse has remained stable.[N]

MARIJUANA

- The number of marijuana users has increased somewhat among younger and older adolescents.[E]
- More people are in treatment for marijuana than for other drugs.[E]
- Minneapolis/St. Paul has the highest marijuana-positive arrestee urinalysis levels among all the cities in the Arrestee Drug Abuse Monitoring (ADAM) program.
- Marijuana use has increased in the suburbs.[E]
- The use of marijuana combined with PCP and formaldehyde ("wet sticks" or "dipped joints") has increased.[E]

METHAMPHETAMINE

- According to high school counselors, use is moving into younger age groups.[E]
- The percentage of clients who are methamphetamine users has increased somewhat.[N]

MDMA (ECSTASY)

- The number of ecstasy users has increased somewhat.[E]
- Use is increasing in both suburban and rural areas.[E]
- The percentage of clients who use ecstasy as a secondary or tertiary drug has increased sharply (to 30 percent), both in the general treatment population and among first-time clients.[N]

DIVERTED OXYCONTIN®

- Diverted OxyContin® is increasingly mentioned in emergency department, medical examiner, poison control, and law enforcement data.[E]
- While 90 percent of abusers are White, American Indians are overrepresented at 10 percent. Users tend to be older than 30 and reside in central city, suburban, and rural areas. Injecting is the primary route of administration.[E]
- For the first time, 5 percent of new clients in the methadone program abuse OxyContin® as their primary drug, and 10 percent abuse it as a primary, secondary, or tertiary drug. Further, among intakes (not regular clients), about one-third of pharmaceutical addicts abuse OxyContin®. These individuals are middle-class suburban "medical addicts, not street people," who take the drug orally and get it through physicians at pain clinics.[M]

OTHER DRUGS

- Misuse of pain medication was diagnosed in a series of 44 pain clinic patients who entered methadone treatment. Their problems included "lost" prescriptions, early prescription refills, and unsuccessful pain treatment. About half of them subsequently dropped out of the pain clinics, indicating that they have addictive disorders and are using the methadone as a substitute.
- Abuse of other pharmaceutical opiates, including hydromorphone (Dilaudid®), butorphanol tartrate (Stadol®), hydrocodone (Vicodin®), and oxycodone formulations (Percodan® and Percocet®) accounts for a steady 15 percent of primary drug problems in the methadone program. The majority (60 percent) of these clients are female.[M]
- Opium is shipped from California once a month to the area's large Hmong refugee population, many of whom use welfare checks to support their $250-per-month habit.[M]
- Khat is overnight-mailed or shipped in luggage on airplanes from Kenya to Somali refugees in the Minneapolis/St. Paul area. This natural stimulant, which loses potency in 48 hours, has leaves that contain psychoactive ingredients structurally and chemically similar to d-amphetamine.[E]

- Gamma hydroxtbutyrate (GHB) and ketamine continue to be used by White, sophisticated, suburban "clubbers," although they are occasionally used in the central city. GHB is part of the weekend rave drug culture among a group of young gay males.[M]
- Flunitrazepam (Rohypnol) is occasionally, but more rarely, used by clubbers.[N]
- Lysergic acid diethylamide (LSD) use, which rebounded in the 1990s, continues a low upward trend. Once used primarily by Whites, it is now getting into other racial/ethnic groups.[N]
- PCP is "out there," but the large supplies of LSD might detract from its use.[N]
- Methylphenidate (Ritalin®) is sold to friends by adolescents who have legitimate prescriptions. Cells of adolescent users crush and snort the pharmaceutical.[N]
- Ephedra-based drugs are combined experimentally with other drugs. Users tend to be White and sometimes hook up with methamphetamine dealers or producers who get them supplies.[N]
- Other substances: Five different area school counselors report that youth scrape off sulfuric acid that has accumulated on car batteries, roll it, and smoke it. They call it "lithium." Snorting Kool Aid® is another practice reported in schools.

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- Treatment capacity and availability: At the time of the *Pulse Check* discussion, the non-methadone treatment respondent's program was operating slightly under its capacity of 85 beds. This program serves adolescent boys, accounting for the high percentage of marijuana and the absence of heroin as a primary drug of abuse (*see pie chart on the first page of this report*). Because its demographics represent the school system population, this program is well positioned to alert the community to new and emerging drug problems and user groups.[N] The methadone treatment respondent is with a two-site program operating slightly under its capacity of 500 (which is a staffing criterion, based on historical experience with neighbors, logistics, and caseloads).[M] While all clients at the program use heroin, large proportions also use crack, powder cocaine, or prescription opiates (*see bar chart on the first page of this report*). Furthermore, sometimes those drugs are the primary drugs of abuse, rather than heroin.

  Methadone maintenance treatment is available throughout the Minneapolis/St. Paul area. Treatment availability in public programs has remained stable between spring and fall 2002, but fewer slots are available in private programs. Both public and private programs have adequate capacity.[E]
- Recidivism: In the non-methadone program, 50 percent of crack clients, 33 percent of powder cocaine clients, 25 percent of marijuana clients, and 10 percent of methamphetamine clients are return clients.[N] In the methadone program, 98 percent of the heroin clients have had prior non-methadone treatment, and 70 percent have had prior methadone treatment.[M]
- Women in treatment: While nearly half of the heroin clients in this program are female, most other programs have a 3:1 male-to-female ratio.[M] Women are more interested in full-service hospital-based programs than other community-based programs.[M]
- Marijuana use: More people in the area are in treatment for marijuana than for any other drug.
- Consequences of drug use: One treatment source notes that high-risk pregnancies are stable at high levels, elaborating that five to eight boys in treatment at any time are fathers or prospective fathers. Many of those teens have multiple children from multiple mothers.[N]

  Criminal behavior has increased as a result of drugs: Younger teens are committing more serious offenses—something not seen 5 years ago. They act out and are involved in car theft, gang activity, guns in school, violence in school, drive-by shootings, and drug sales. These youth are increasingly certified as adults and are treated as such in the criminal justice system.[N]

  Methadone overdoses doubled (from 6 to 12) in the last year.[M]
- Co-occurring disorders: Antisocial disorders or conduct disorders are the most common co-occurring disorders among the adolescents in this program.[N] Mood disorders have increased, as have suicidal thoughts. In the past year, two adolescents (not in the program) committed suicide.[N] Mood disorders in the other *Pulse Check* source's program[M] are stable at a high rate (41 percent of people at admission). The hepatitis C rate has

increased to 92 percent now that the program is testing for the disease. Tuberculosis cases increased (from 0 to 6), mostly among Hmong clients. Diagnoses of other serious medical conditions are stable at high levels in this aging population, with advanced cases of diabetes, liver disease, and other age-related comorbidity. The program recently began assessing clients for chronic pain, which has increased.[M]

- Barriers to treatment: The most serious barrier is the delay prior to treatment: with the current 2- to 4-week referral process, many drug users drop off before their number comes up.[M] Many adolescent drug users have low-income working parents with inadequate insurance that prohibits treatment. Others are from families with no insurance, and some have no permanent address, move frequently, live in shelters, and frequent soup kitchens.[N]
- Changes over the past 10 years: The largest changes include the following: the increase in polydrug use, which makes it hard to "get to the bottom of what they're using";[N] the increased availability and purity of heroin, its declining cost,[M] and the corresponding use of smokable heroin by young adults;[N] the advent of designer drugs, such as ecstasy and GHB;[N] and the increase in methamphetamine.

WHO USES ILLICIT DRUGS?

The *Pulse Check* epidemiologic, non-methadone treatment, and methadone treatment sources were asked to describe the populations most likely to use heroin, cocaine, marijuana, methamphetamine, and ecstasy. They were also asked to depict any emerging user groups and to report on how the drugs are used. As shown in the following pages, user characteristics vary by drug. Further, because of the different perspective each brings, the three sources sometimes describe quite different populations and use patterns for each drug.

- *Heroin use in the suburbs has increased slightly.*[E]
- *While nearly half of the heroin clients in this program are female, most other programs have a 3:1 male-to-female ratio. Women appear more interested in full-service hospital-based programs than other community based programs.*[M]

Who's most likely to use heroin?

Characteristic	E	M
Age group (years)	>30	>30
Mean age (years)	35	42
Gender	70% male	53% male
Race/ethnicity	White	White
Socioeconomic status	NR	Low
Residence	Central city	All areas
Referral source	N/A	County assessment
Level of education completed	N/A	High school
Employment at intake	N/A	Unemployed

Note: Heroin is not a drug of abuse at the non-methadone program, which serves adolescent boys.

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

How do users take heroin?

Characteristic	E	M
Primary route of administration	Injecting	Snorting
Other drugs taken	Powder cocaine (speedballs), methadone	Benzodiazepines
Publicly or privately?	Privately	Privately
Alone or in groups?	Alone	Alone

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

- *Injecting has declined, while snorting and smoking have increased.*[E]
- *Methadone overdoses have increased.*[E]
- *Heroin injectors use in networks of 4–6 users.*[M]
- *Clonazepam (Klonopin®, or "pins") is the most commonly used benzodiazepine.*[M]

Who's most likely to use cocaine?

Characteristic	Crack			Powder cocaine		
	E	N	M	E	N	M
Age group (years)	>30	13–17*	>30	>30	13–17*	>30
Mean age (years)	31	17*	42	34	16*	42
Gender	70% male	100% male*	53% male	70% male	100% male*	53% male
Race/ethnicity	Black	Black	White	50% White, 50% Black	All	White
Socioeconomic status	NR	Low	Low	NR	Low/Middle	Low
Residence	Central city	Central city	All areas	All areas	Suburbs	All areas
Referral source	N/A	Criminal justice	County assessment	N/A	Criminal justice	County assessment
Level of education completed	N/A	Junior high	High school	N/A	Junior high	High school
Employment at intake	N/A	Unemployed	Unemployed	N/A	Full-time student	Unemployed

**The non-methadone program serves adolescent boys.*

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

- *The percentage of crack users has declined somewhat, among both younger and older adults.*[E]
- *Among first-time admissions, the percentage in treatment for crack has declined somewhat. Among the overall treatment population, the percentage for crack has increased slightly, but the numbers are low. The percentage of clients in treatment for powder cocaine abuse has remained stable.*[N]
- *While crack is readily available, it is "an adult drug. Kids look down on it." The few adolescents who use it tend to be hooked up with older people, and have moved off the street and into the business.*[N]
- *Crack and powder cocaine as primary drugs of abuse each account for 12.5 percent of clients in the methadone program. These percentages have remained stable.*[M] *However, focus group participants from that program believe that powder cocaine snorting and injecting have increased, while crack use has declined. They attribute this change to the declining cost and increasing purity of powder cocaine.*[F]
- *Among powder cocaine users, Whites are underrepresented and Blacks are overrepresented relative to the general population.*[E]
- *Among methadone clients, a higher percentage of primary cocaine (crack and powder) are Blacks than among primary heroin users.*[M]
- *While powder cocaine is usually snorted, smoking has increased.*[E] *Both snorting and smoking are reported among powder cocaine users in treatment.*[N]
- *Crack is often combined with marijuana, while powder cocaine is combined with heroin in speedballs.*[E] *Powder cocaine users in treatment combine the drug with marijuana.*[N]
- *Crack users in the methadone program take a "high dose of methadone plus crack on the side."*[F] *Powder cocaine users in the program inject that drug with heroin, stating, "You can't 'blow' [inject heroin] without a 'mo' [powder cocaine]."*

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	13–17	13–17*	>30
Mean age (years)	15	NR	NR
Gender	Evenly split	100% male*	75% male
Race/ethnicity	White	White	White
Socioeconomic status	Middle	Low/middle	Low
Residence	Suburbs, rural areas	Central city, suburbs	All areas
Referral source	N/A	Criminal justice	County assessment
Level of education completed	N/A	Junior high	High school
Employment at intake	N/A	Full-time student	Unemployed

**The non-methadone program serves adolescent boys.*

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

- *The number of marijuana users has increased somewhat, among both younger and older adolescents.*[E]
- *More people are in treatment for marijuana than for other drugs.*[E]
- *Marijuana use has increased in the suburbs.*[E]
- *While Whites predominate, marijuana use crosses all races/ethnicities.*[N]
- *Treatment percentages remain stable for primary, secondary, and tertiary marijuana use.*[N,M]

- *The use of marijuana combined with PCP and embalming fluid ("wet sticks" or "dipped joints") has increased.*[E]
- *Methadone clients who use marijuana do not take other drugs. Most are successfully recovering, functional methadone patients.*

How do users take marijuana?

Characteristic	E	N	M
Primary delivery vehicle	"One-hitter pipes"	"One-hitter bongs"	Joints
Other drugs taken	PCP and embalming fluid	"Crank" (methamphetamine), hashish, opium, PCP, embalming fluid	None
Publicly or privately?	Both	Both	Privately
Alone or in groups?	In groups/ among friends	Both	Alone

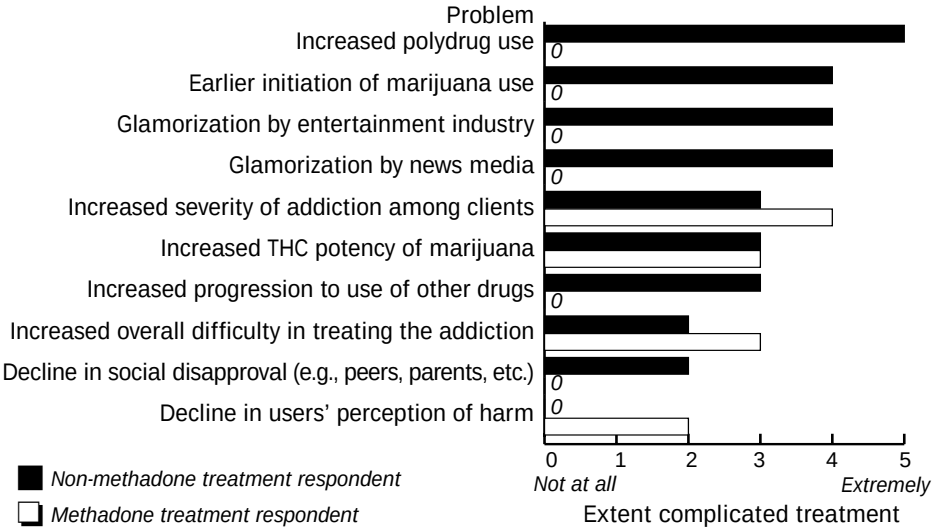
Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

One source lists "amotivational syndrome" as a negative consequence of marijuana use, describing users with this syndrome as "underemployed, inactive, using marijuana as a substitute for hobbies or social activities, and generally not doing as well in life as they should be doing." Additionally, respondents associate marijuana, used either alone or with other drugs, with the following consequences, which remained stable between spring and fall 2002:

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

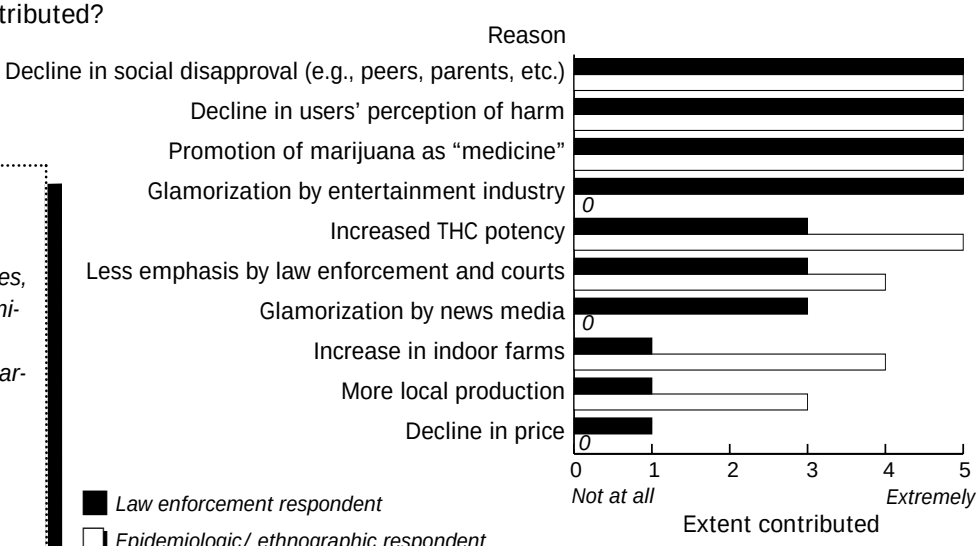
Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



What they have to say...

- *Marijuana potency has increased only moderately compared with 10 years ago, but it has increased sharply compared with 20 years ago.*[N]
- *The non-methadone respondent attributes greater impact to the news media's glamorization of marijuana than do the majority of respondents in other* Pulse Check *cities.*
- *In general, changes over the past decade seem to have had greater impact on marijuana users in the non-methadone program than those in the methadone program.*

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



What they have to say...

- *In agreement with the majority of respondents in other* Pulse Check *cities, both the law enforcement and epidemiologic respondents believe that three changes over the past decade have particularly contributed to marijuana's widespread availability and use: the decline in social disapproval, the decline in users' perception of harm, and the promotion of marijuana as "medicine."*[L,E]
- *While the decline in users' perception of harm has had a huge impact over the past 10 years, this perception has been stable for the past 3 years.*[E]
- *Mainstream media, particularly magazines that target youth, have perpetuated the public debate regarding the harmfulness of marijuana. By exploring the issue in debate form, rather than presenting the scientific facts, they have contributed greatly to the widespread use of marijuana.*[E]
- *Indoor farms have had an impact because, outdoor farming is difficult with the short growing season.*[E]
- *Promotion of hemp products to youth has also contributed greatly to widespread marijuana use and availability.*[E]
- *As in the majority of* Pulse Check *cities, declining price has not affected use or availability. On the contrary, most prices have remained stable over the past 10 years, and some have actually gone up.*[L,E]

Who's most likely to use methamphetamine?

Characteristic	E	N
Age group (years)	18–30	13–17*
Mean age (years)	27	NR
Gender	60% male	100% male
Race/ethnicity	White	White
Socioeconomic status	NR	Low, middle
Residence	Suburbs, rural areas	Central city, suburbs
Referral source	N/A	Criminal justice
Level of education completed	N/A	Junior high
Employment at intake	N/A	Unemployed or full-time student

**The non-methadone program serves adolescent boys.*

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

- *The percentage of clients who are methamphetamine users has increased somewhat.*[N]
- *According to high school counselors, use is moving into younger age groups.*[E]
- *The new group of adolescent users includes an equal number of girls and boys.*[E]
- *While methamphetamine-using clients are predominantly White, a large proportion of the program's Hmong population also use the drug.*[N] *(The Minneapolis/St. Paul area has the Nation's largest Hmong population, and one-third of the program's clients are of that race/ethnicity.)*[N]

- *Methadone clients generally do not use methamphetamine.*[M]
- *Smoking is generally the primary route of administration.*[E] *Eighty percent of the methamphetamine-using clients smoke the drug; the other 20 percent snort it.*[N]
- *Snorting methamphetamine is known as "getting glassed."*[E]

Who's most likely to use ecstasy?

Ecstasy users are predominantly young (13–17 years) White males (about 60 percent) who live in central city, suburban, and rural areas.[E,N] While ecstasy-using clients are primarily White, the program has a fair representation of Blacks, Hispanics, and Asian/Pacific Islanders.[N] No ecstasy users are reported in the methadone program.[M] A few changes are reported:

- The number of ecstasy users has increased somewhat.[E]
- Use is increasing in both suburban and rural areas.[E]
- The percentage of clients who use ecstasy as a secondary or tertiary drug has increased sharply (to 30 percent), both in the general treatment population and among first-time clients.[N]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin, crack, and powder cocaine are sold in central city and suburban areas. Marijuana, methamphetamine, and ecstasy are also sold in those areas, and in rural areas as well. Diverted OxyContin® is sold in central city and rural areas.

The law enforcement and epidemiologic sources agree that heroin, crack and powder cocaine, marijuana, and methamphetamine are all sold on the streets or in open-air markets—a major development over the past few years in a metropolitan area that never used to have a street scene. Both sources also agree that those drugs, plus ecstasy, are sold in the following settings—most of which, according to the epidemiologic source, are also settings for drug use:

- Inside cars
- In private residences
- On college campuses
- In nightclubs and bars
- In playgrounds and parks

Heroin, crack, and powder cocaine are also sold in crack houses or shooting galleries; additionally, they are sold in shopping malls, at raves, and at concerts, as are marijuana and ecstasy; they are also sold in hotels and motels, as are methamphetamine and ecstasy; and they are sold in public housing developments, as is methamphetamine.

Methamphetamine is not just used and sold in rented hotel rooms and in cars: it is also cooked in those settings—another recently increasing trend.[L]

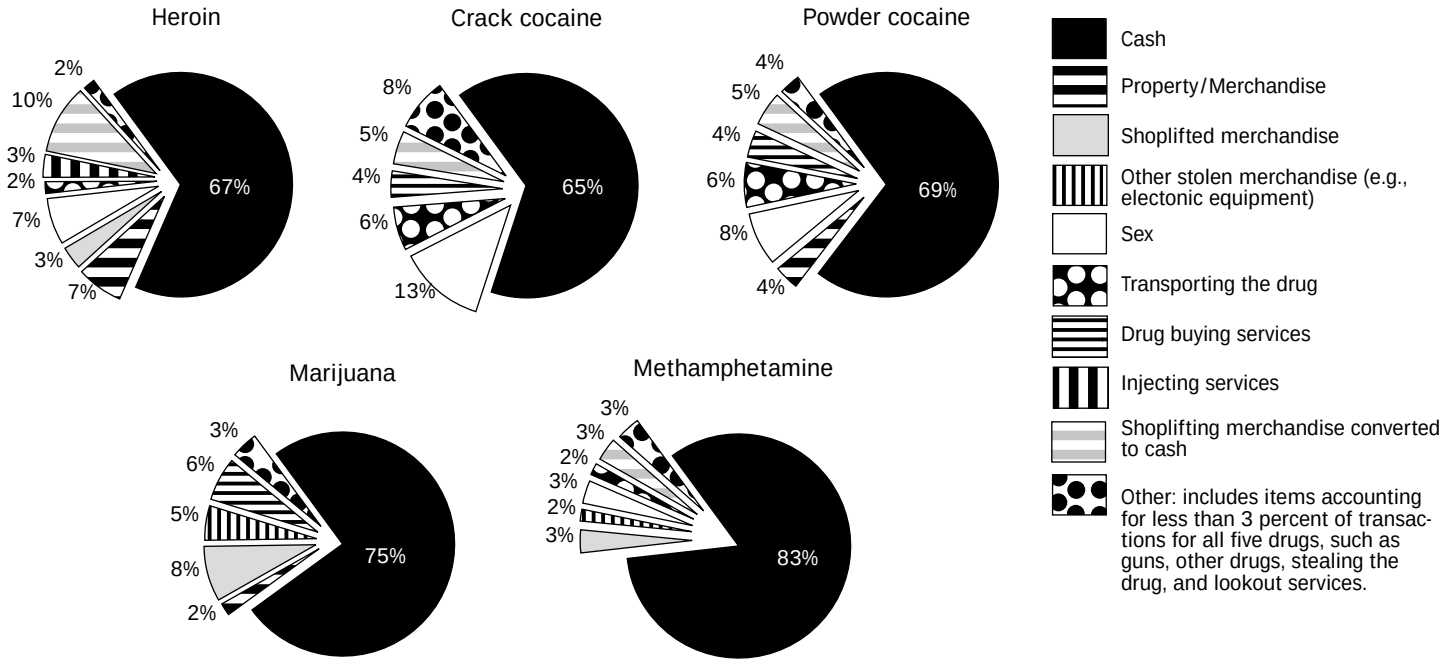
HOW DO DRUGS GET FROM SELLER TO BUYER?

- Heroin, crack, and powder cocaine can be purchased in several ways, including the following:[L]
  1. The buyer goes to a location known for the type of drug being sold (sometimes multiple drugs in one location) and asks someone where to find that particular drug.
  2. The buyer and seller then identify one another via eye contact or body language.
  3. The actual transaction is usually hand to hand.

  In the case of powder cocaine, the connection is also sometimes made in clubs. Sometimes cell phones or two-way communication devices are also involved.
- Marijuana and methamphetamine can be purchased similarly on the street, but they are also commonly obtained via acquaintance networks, word of mouth, and prearranged meetings.
- Ecstasy is obtained via word of mouth within a closed network, often at parties, sporting events, or school events. It is also purchased by mail or by dropoff in a public place.
- Diverted OxyContin® is obtained via word of mouth.
- GHB is obtained by word of mouth or via the Internet or e-mail.

As shown below, the majority of these transactions involve cash, especially in the case of methamphetamine. A variety of other commodities, however, are often exchanged—particularly in the case of crack and heroin.

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



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

What they have to say...

- *As drug use–especially of marijuana–has increased among young people over the last decade, shoplifting of items such as compact discs (CDs) has increased.*[E]
- *The exchange of sex for heroin has increased over the past 10 years.*[M]
- *Stolen farm equipment is often used in exchange for methamphetamine.*[E]
- *The exchange of stolen precursor chemicals for methamphetamine is a relatively new phenomenon.*[E]
- *While street-level transactions tend to be cash-only, at higher levels drugs are increasingly "fronted": a supplier typically gives a kilogram of a drug to a seller, who goes out and sells it, and then returns to the supplier with the cash payment.*[L]
- *An increase is reported in "ripping off" drugs from dealers or friends.*[N]
- *An increasing number of incidents involve teens who buy cars from crack addicts for small amounts of money (typically $50) and then go joyriding.*[N]
- *Hmong refugees use welfare checks to support their opium smoking–a $250-per-month habit. The drug comes from California once per month.*[M]

WHO'S SELLING DRUGS?

- Heroin:[L] Reports over the past year or two describe Nigerian sources coming through Chicago, as well as Mexican sources. Generally, heroin sellers still tend to operate independently and usually sell only heroin, although some sell powder cocaine. They are generally 20–40 years old, but some are in their forties. They are very likely to use their own drug.
- Crack cocaine:[L] All crack used to be processed locally by Black gangs; now, Mexicans cook up about 20 percent of the supply and sell it to the local gangs. These gang members are either adolescents or young adults who do not sell any other drugs and are somewhat likely to use their own drug.
- Powder cocaine:[L] Powder cocaine dealers are generally part of gangs or cartels. They are young adults who sometimes also sell methamphetamine and marijuana (and, in rare cases, heroin). They are very likely to use their own drug.
- Marijuana:[L] Marijuana dealers tend to operate independently, although recent gang activity is reported in connection to BC bud. Sellers are young adults who sometimes also sell powder cocaine. They are very likely to use their own drug.
- Methamphetamine:[L] Methamphetamine dealers are usually part of Mexican gangs. They are young adults who sometimes also sell powder cocaine. They are somewhat likely to use their own drug.
- Ecstasy:[L] Dealers are usually part of organized crime groups from Las Vegas, Los Angeles, and other big cities. They tend to be young adults who are somewhat likely to use their own drug. Sales activity has reportedly increased recently.

Which drug sellers are associated with which crimes?

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

Source: Law enforcement respondent

Gang activity is generally associated with powder and crack cocaine. While marijuana dealers tend to operate independently, recent gang activity is reported in relation to BC bud.

How much does heroin cost?

Form	Unit	Price
Mexican	Bindle	$10–$50[E]
	Paper	$50[M]
	1 g	$300–$400[L]
Unspecified "powder"	NR	$20–$25[M]

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

- *Purity has increased, price has declined, and supply is plentiful, especially over the last year or two.*[E,M]
- *The gram price has increased since last year (from $200 to $300).*[L]

How much does cocaine cost?

Form	Unit	Price
Crack	Rock	$20[L,M]
	1 g	$100[L]
	1 oz	$900–$1,200[L]
Powder	1 g	$100[E]
	1 oz	$800–$1,200[L]
	1 kg	$20,000–$30,000[L]

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

All reported prices are stable between spring and fall 2002.

How much does marijuana cost?

Form	Unit	Price
Local	Joint	$5[E]
	1.5 oz	$300[L]
	1 lb	$700[L]
BC bud	1 lb	$7,000–$12,000[L]

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

- *Prices listed in the table are stable between spring and fall 2002.*
- *Focus group participants believe that "weed" quality has increased, while the price has declined. A dime bag ($10) of hydroponic marijuana used to be enough for just one joint; now it has enough for two or three joints.*[F]

How much does methamphetamine cost?

Unit	Price
1 g	$100[L,E]
1 oz	$1,000[L]
1 lb	$12,000–$15,000[L]
1 kg	s$20,000–$30,000[L]

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

- *All reported prices are stable between spring and fall 2002.*
- *Adulteration with dimethylsulphone (DMSO, or "horse medicine") is stable.*[E]

How much do various other drugs cost?

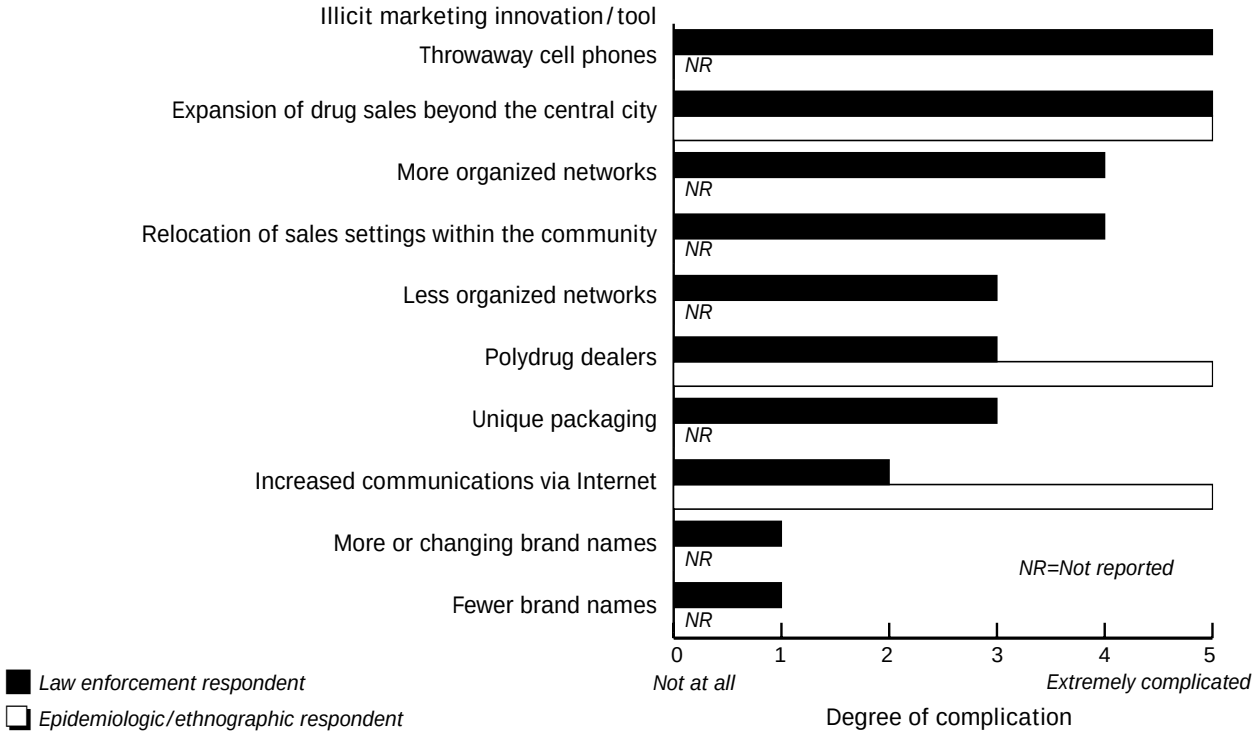
Drug	Unit	Price
Ecstasy	One pill	$20[L,E]
Diverted OxyContin®	1 mg	$1[E]
GHB	2 oz (2 dosage units)	$20[E]

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

- *An increase is reported in pills sold as "ecstasy" that actually contain no MDMA.*[E]
- *All reported prices are stable between spring and fall 2002.*

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

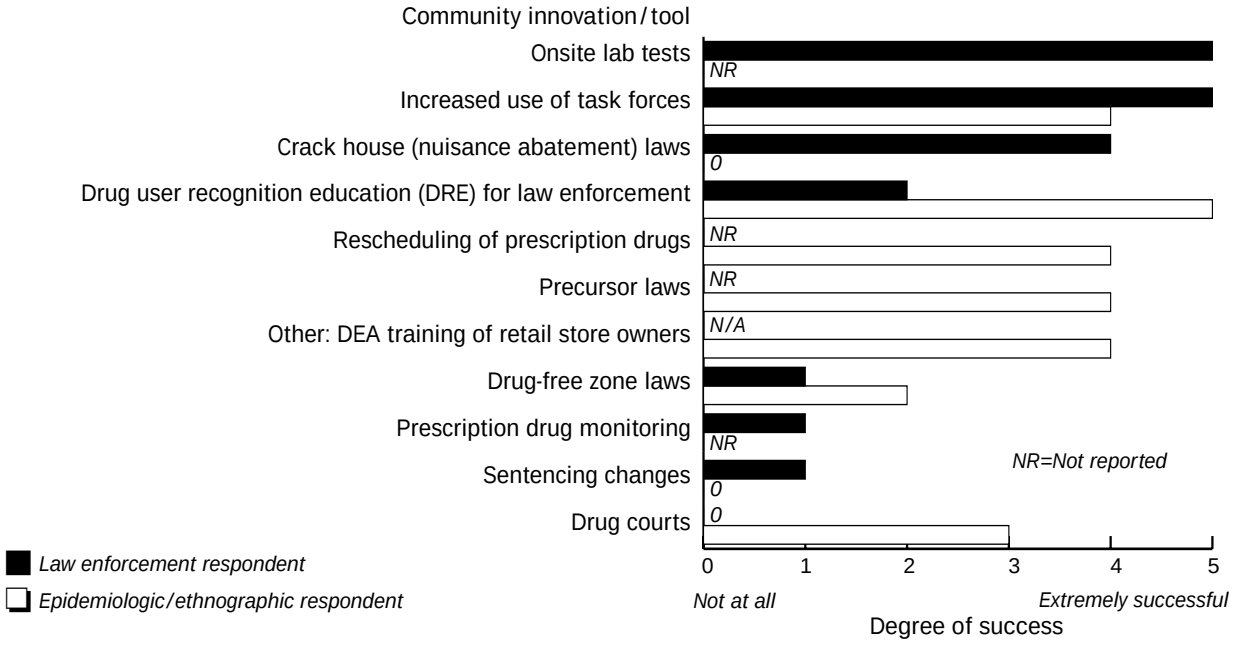
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in Minneapolis/St. Paul?



What they have to say...

- *As in the majority of* Pulse Check *cities, the increased or decreased use of brand names by dealers has had little impact on law enforcement detection and disruption efforts.*[L]
- *Throwaway cell phones, by contrast, have posed a great challenge to market detection and disruption efforts—again, similar to reports in the majority of other* Pulse Check *cities.*[L]
- *One source believes that Internet communications have posed a great problem in market detection and disruption.*[E] *Another source, however, believes this effect is limited to club drugs.*[L]

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



What they have to say...

- *Task forces: The county sheriff's office and the Minneapolis Police Department pool their resources for large cases, such as wiretaps.*[L] *As drug sales move out of central city areas, more pooling of resources through multidisciplinary law enforcement task forces is enabling small towns to go after bigger dealers.*[E]
- *Precursor laws: Minnesota was one of the first States with laws on anhydrous ammonia.*[E] *Also, this source recommends encouraging retail sellers to voluntarily limit sales of pseudoephedrine and other ephedrine products.*[E]
- *Training of retail store owners: The DEA's extensive training of hardware and other retail store owners regarding meth lab ingredients and people who purchase them has significantly increased the reporting of suspicious activity to law enforcement.*[E]
- *Crack house (nuisance abatement) laws: One source believes these laws are not effective because crack houses are mobile and transitory.*[E] *Another believes that city ordinances have been effective, despite increased licensing issues. For example, a new ordinance requiring landlords to evict renters arrested on their property for narcotics charges is controversial, but it does move drug activity out.*[L]
- *Prescription drug monitoring: The Forgery Unit forwards cases to the Narcotics Unit, but more resources are needed to follow up.*[L]
- *Drug courts: The law enforcement source is one of the few* Pulse Check *respondents who believes drug courts to be ineffective, primarily because they treat users and dealers in the same way. Some dealers get four or five chances. Many cases are therefore prosecuted federally in order to avoid drug court.*[L] *The epidemiologic source considers drug courts somewhat more effective and recommends having an alcohol court.*[E]
- *Drug user recognition (DRE) for law enforcement: One source rates DRE in-service classes as minimally effective, stating that training could be improved if it were biannual and ongoing because of changing drug trends.*[L] *Another source rates DRE as highly effective and recommends expanding the training to more officers.*[E]

SEPTEMBER 11 FOLLOWUP

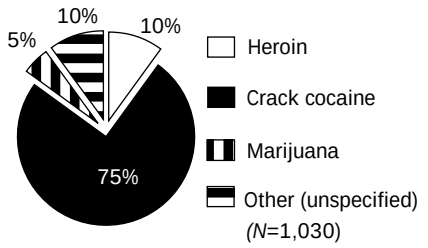
One source notes that during the first 6 months after September 11, 2001, increased border security slowed down the Mexican influx and drove up prices—but subsequently, everything went "back to normal."[L] Another believes that some of the best narcotics officers have been reassigned to Homeland Security.[E] During the *Pulse Check* discussion just before the war in Iraq, the methadone treatment source reported methadone patients hoarding the drug. One focus group participant elaborated: "People are scared, worried about the war, depressed." Another added: "People say, 'I'm going to die anyway, so I might as well have a good time.' Or maybe that's just an excuse..."

NEW YORK PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

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

*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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

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

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

Only a few changes are reported:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

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

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

COCAINE

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

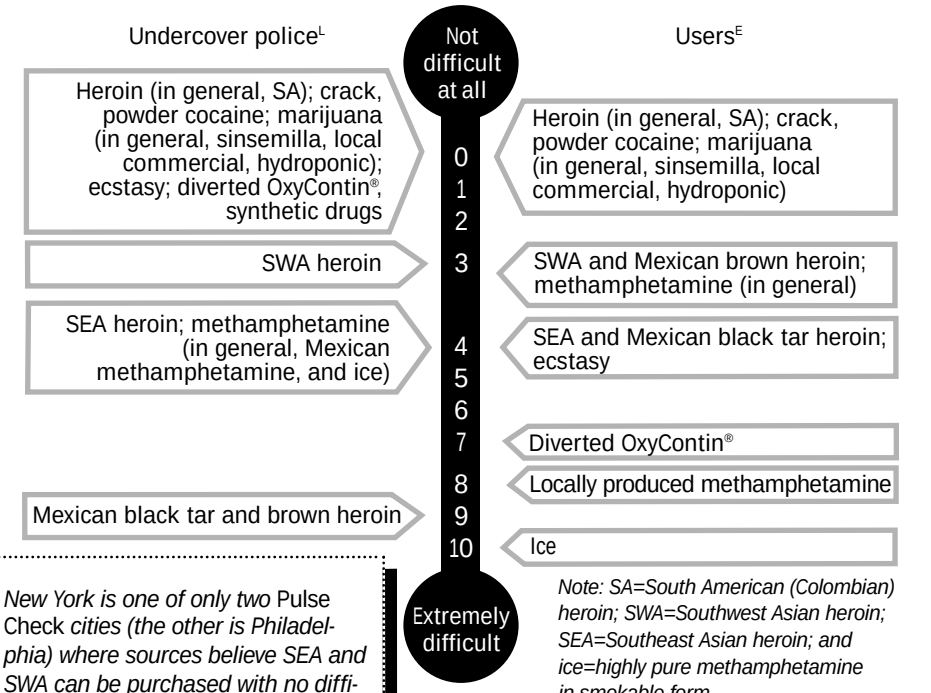
- Crack remains the drug associated with the most serious consequences in the city.[L,E,N,M]
- Two sources consider crack the city's most widely abused drug.[L,N]

MARIJUANA

Between spring and fall 2002, three shifts are reported:

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

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



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

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

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

METHAMPHETAMINE

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

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

MDMA (ECSTASY)

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

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

OTHER DRUGS

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

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

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

WHO USES ILLICIT DRUGS?

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

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

Who's most likely to use heroin?

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

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

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

How do users take heroin?

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

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

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

Who's most likely to use cocaine?

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

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

Who's most likely to use marijuana?

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

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

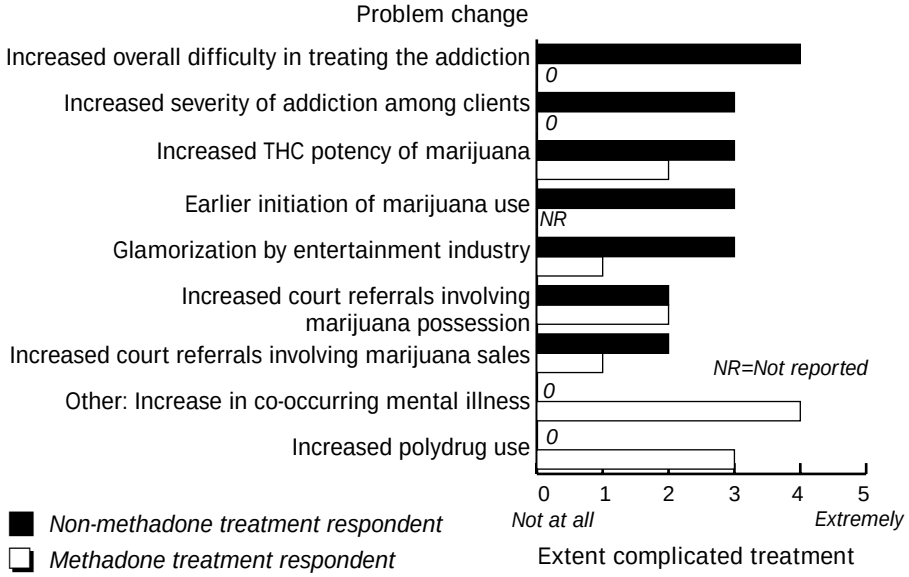
- *Marijuana users tend to be young adult males, primarily Black or Hispanic.*[E,N,M]
- *Marijuana users in the methadone program tend to have more education than those in the non-methadone program.*[N,M]
- *User characteristics appear relatively stable between spring and fall 2002.* [E,N,M]

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

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

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



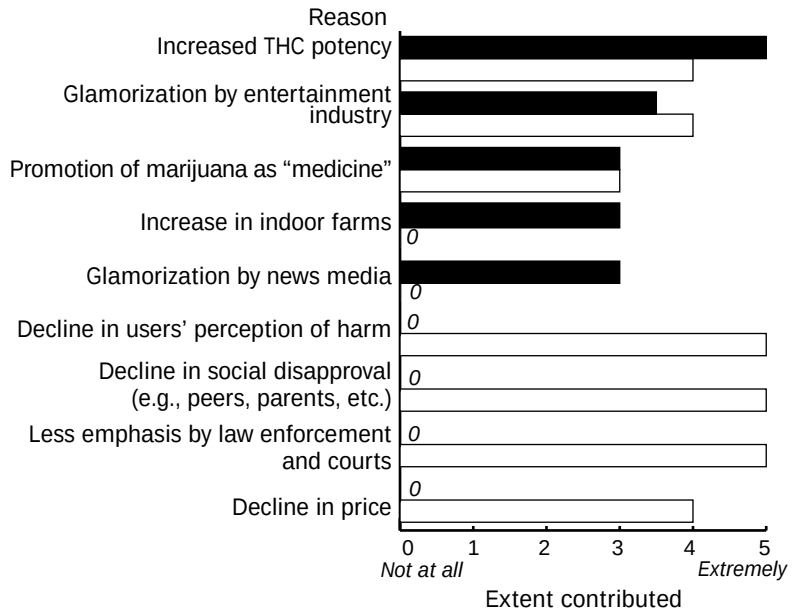
What they have to say...

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

What they have to say...

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

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



WHO'S MOST LIKELY TO USE METHAMPHETAMINE?

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

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

WHO'S MOST LIKELY TO USE ECSTASY?

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

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

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

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

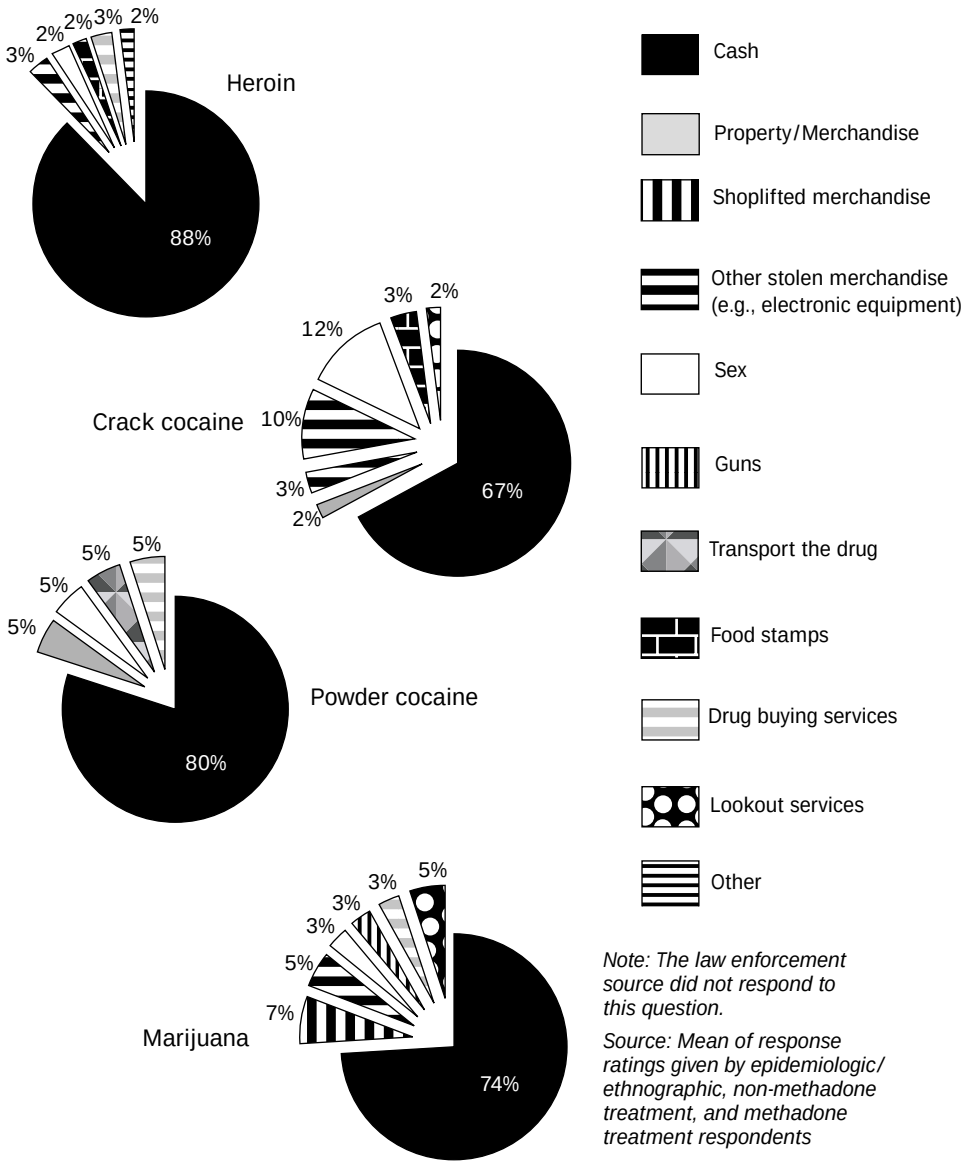
Except for crack, all of those drugs are also sold at raves and around drug treatment clinics. Additionally, marijuana and ecstasy are available in schools (elementary, junior high, or high schools). Methamphetamine sales venues are limited to private residences, nightclubs and bars, and raves.

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

HOW DO DRUGS GET FROM SELLER TO BUYER?

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

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



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

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

What they have to say...

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

WHO'S SELLING HEROIN?[L]

At the trafficking level:

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

At the street level:

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

WHO'S SELLING COCAINE?[L]

Crack cocaine:

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

Powder cocaine:

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

WHO'S SELLING MARIJUANA?[L]

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

How much does marijuana cost?

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

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

All reported prices are stable between spring and fall 2002.

Which drug sellers are associated with which crimes?

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

Source: Law enforcement respondent

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

How much does heroin cost?

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

All reported prices are stable between spring and fall 2002.

[a]SA=South American (Colombian); SWA=Southwest Asian; SEA=Southeast Asian
[b]Purity 85–96%; [c]Purity >60%
Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

How much does cocaine cost?

Form	Unit	Price
Crack	One vial	$10–$20[L]
	One bag	$10 and $20[E]
	1 g	$25–$45[L]
	Eightball	$175[L]
	1 oz	$1,000–$1,500[L]
Powder	bag	$20–$25[L]
		$25–$50[E]
	1 g	$25–$35[L]
	Eightball	$120–$150[L]
	1 oz	$600–$2,000[L]
	1 kg	$22,000–$24,000[L]

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

Between spring and fall 2002:

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

How much does methamphetamine cost?

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

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

All reported prices are stable between spring and fall 2002.

How much do various other drugs cost?

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

Sources: [L]Law enforcement respondent

All reported prices are stable between spring and fall 2002.

WHO'S SELLING ECSTASY?

The law enforcement source reports:

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

How much does ecstasy cost?

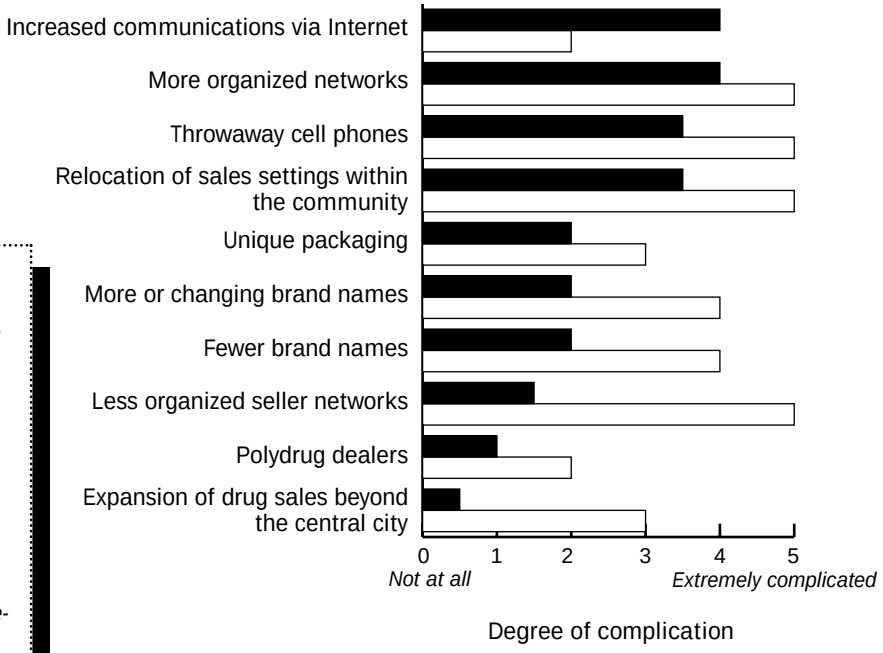
Unit	Price
Pill (wholesale)	$1.50–$13[L]
Pill (street)	$12–$25[E]
Pill (retail)	$20–$28[L]
Pill (clubs)	$25–$35[E]

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

All reported prices are stable between spring and fall 2002.

THE MARKET PERSPECTIVE: A 10–YEAR VIEW

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



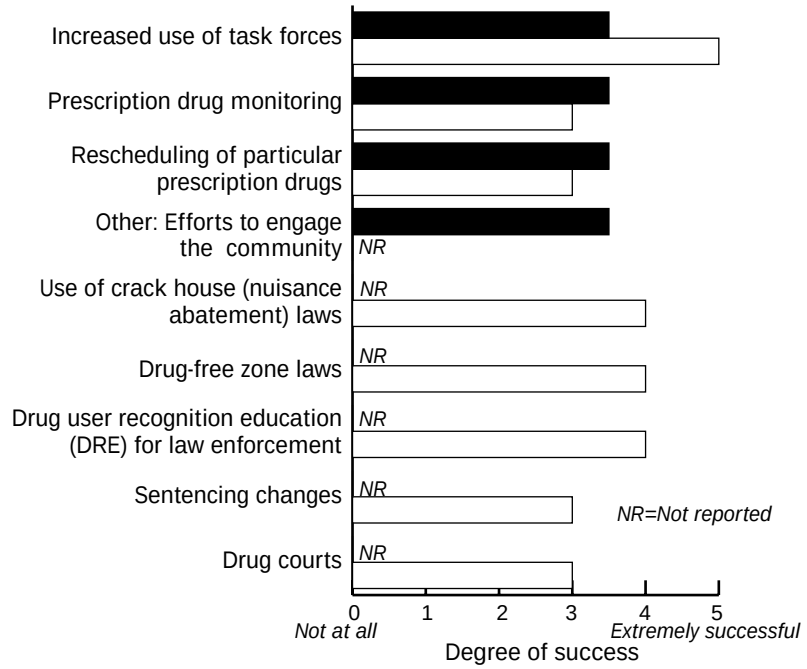
What they have to say...

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

What they have to say...

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

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



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

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

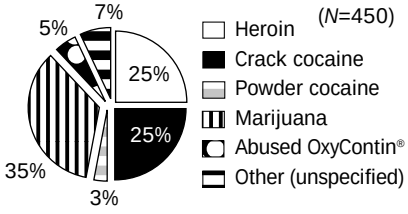
- Changing trafficking patterns: Overall, September 11 did not have a major impact on drug trafficking. However, informants report that some traffickers are afraid to fly directly to JFK Airport, so they go to other cities and use rail, bus, car, and other means of transportation. Some traffickers have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

PHILADELPHIA PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

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

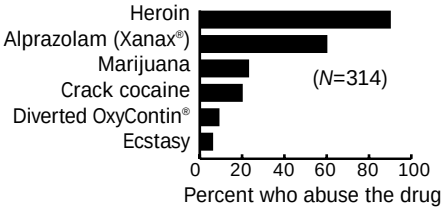
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



+Includes primary, secondary, and tertiary use

Source: Methadone treatment respondent

Between spring and fall 2002:

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

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

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

Positive developments are noted with respect to the drug market:

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

Some increases are noted among users:

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

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

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

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

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

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

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

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

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

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

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

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

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

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

COCAINE

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

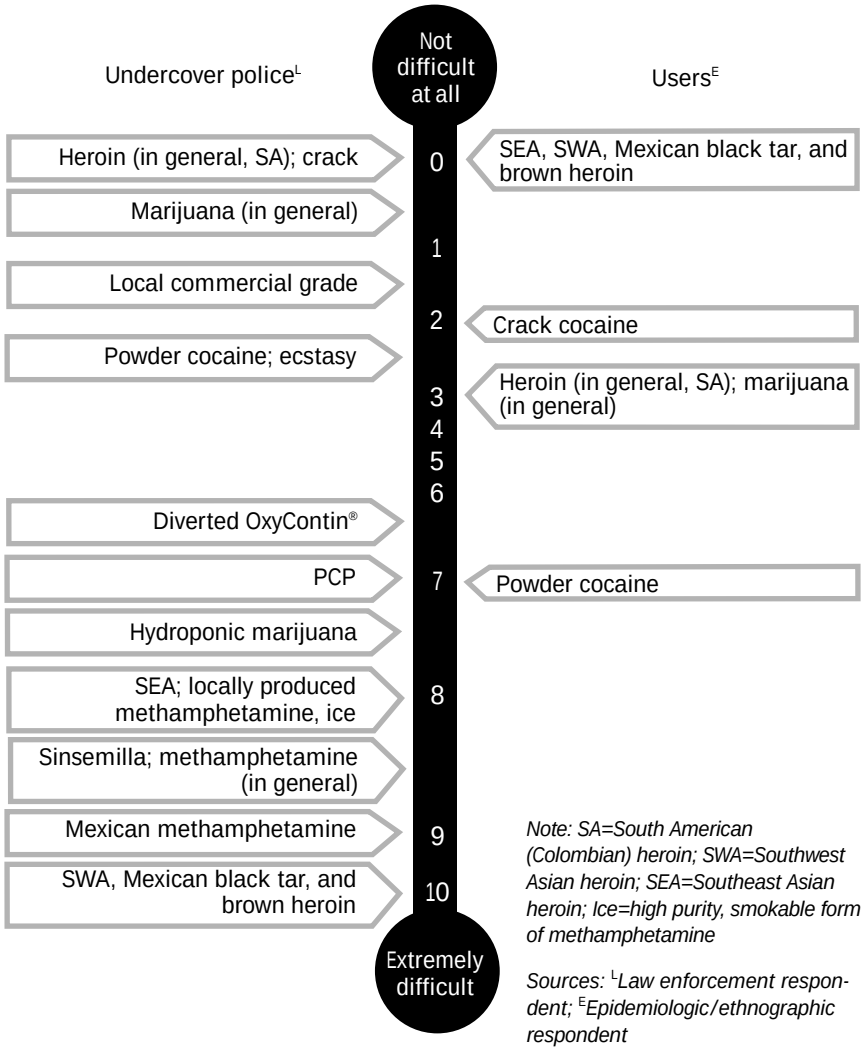
- Among non-methadone treatment clients, crack cocaine remains the most common primary drug of abuse.[N]
- The percentage of crack users in both the overall and first-time treatment populations increased slightly.[N]
- Powder cocaine users are increasingly snorting, rather than injecting, the drug.[E]

MARIJUANA

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

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

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



Note: SA=South American (Colombian) heroin; SWA=Southwest Asian heroin; SEA=Southeast Asian heroin; Ice=high purity, smokable form of methamphetamine

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

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

METHAMPHETAMINE

The methamphetamine problem remains stable at low levels.

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

MDMA (ECSTASY)

Ecstasy indicators are mixed for the reporting period.

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

OTHER DRUGS

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

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

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

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	18–30	18–30	18–30; >30
Mean age (years)	29	26	48
Gender	67% male	60% male	55% male
Race/ethnicity	White	Black	White
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Recovery houses	Individual
Level of education completed	N/A	Junior high	Junior high
Employment at intake	N/A	Unemployed	Unemployed

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

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

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

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

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

How do users take heroin?

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

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

Who's most likely to use cocaine?

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

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

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

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	18–30	18–30	>30
Mean age (years)	29	26	37
Gender	78% male	60% male	NR
Race/ethnicity	Black	Black	White and Black
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Recovery houses	Individual
Level of education completed	N/A	Junior high	Junior high
Employment at intake	N/A	Unemployed	Unemployed

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

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

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

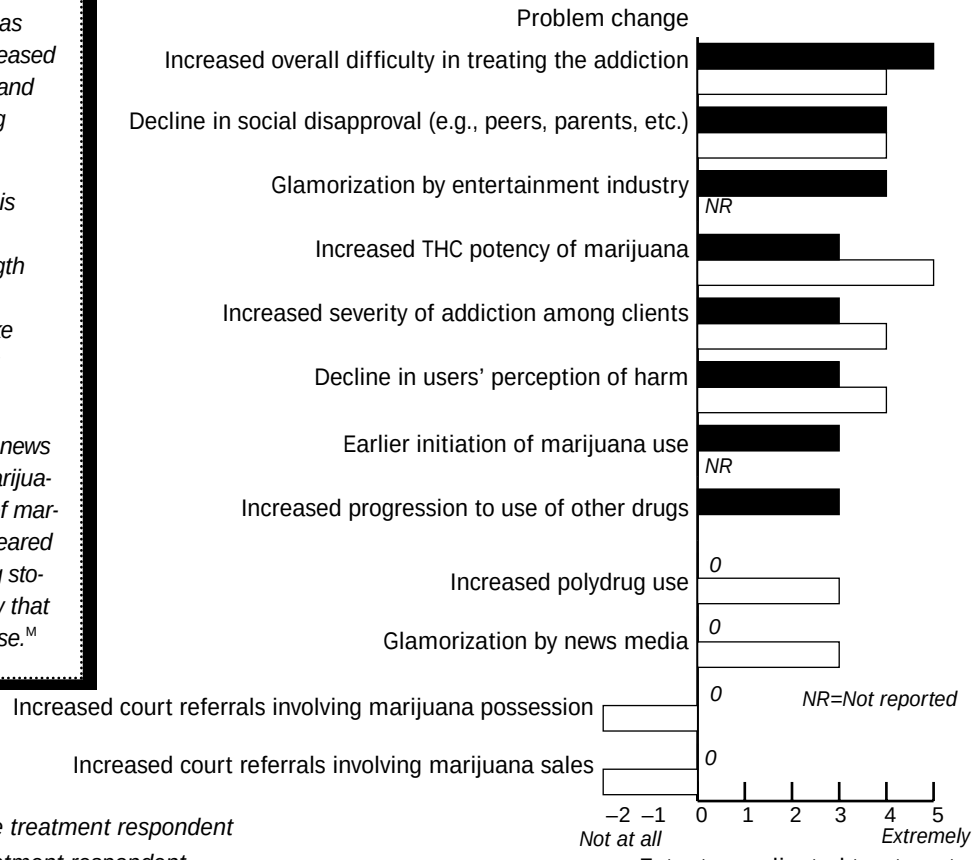
Respondents associate marijuana, used either alone or with other drugs, with the following consequences, which remained stable between spring and fall 2002:[N,M]

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

What they have to say...

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

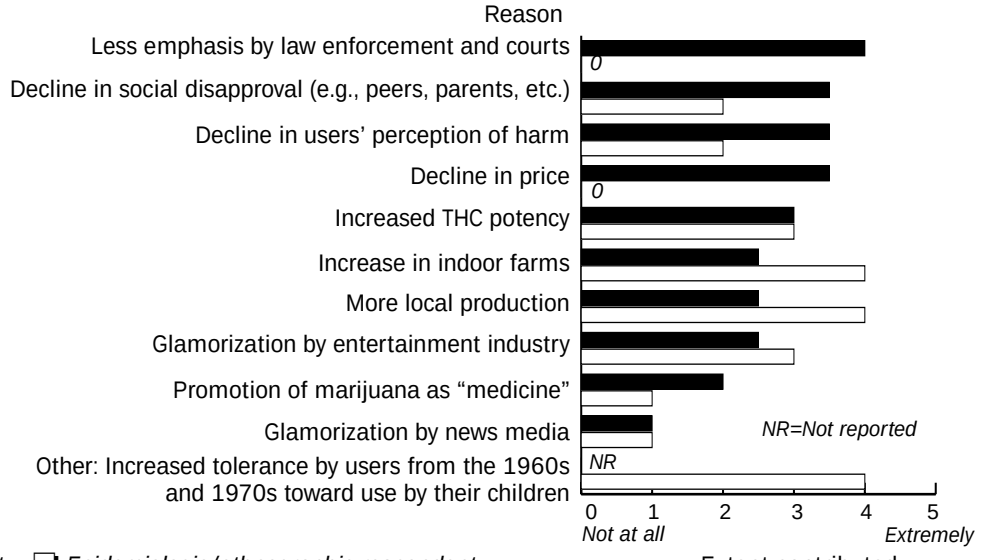
Marijuana-using clients: To what extent have changes in the following areas complicated their treatment over the past 10 years?



What they have to say...

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

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

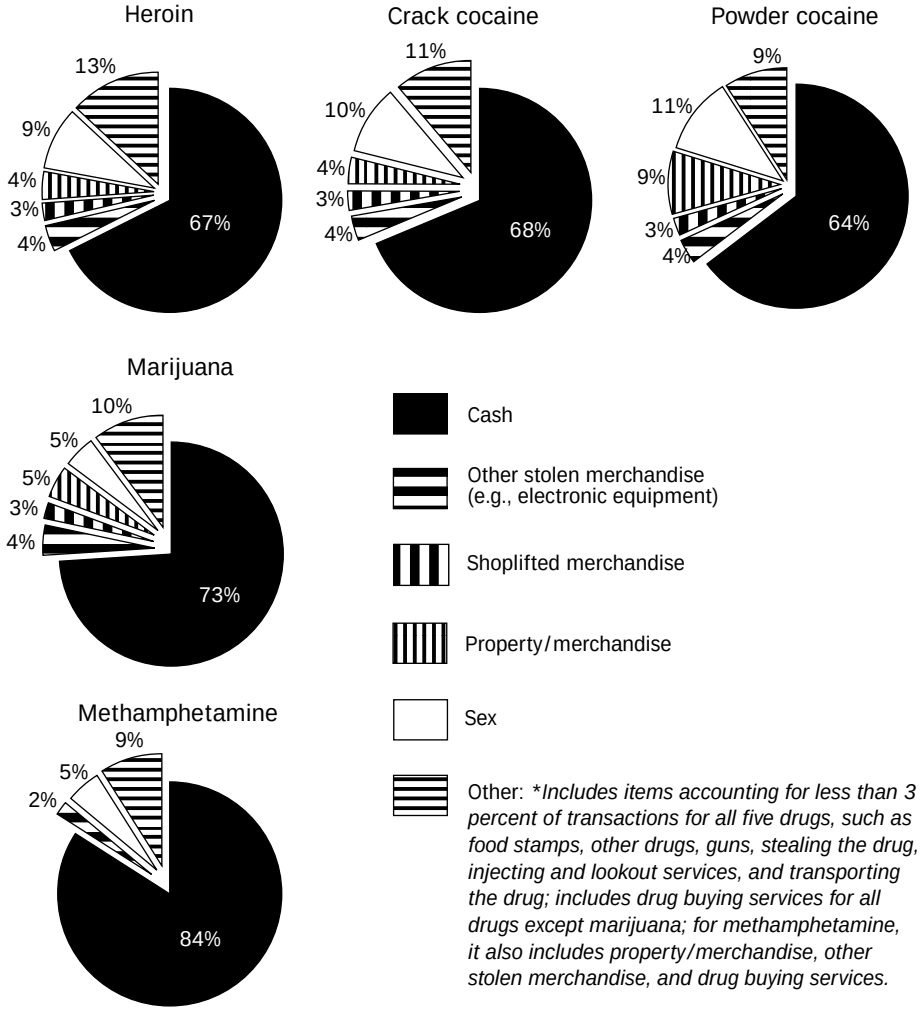


THE MARKET PERSPECTIVE

HOW DO DRUGS GET FROM SELLERS TO BUYERS?

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

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



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

What they have to say...

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

WHERE ARE DRUGS USED AND SOLD?

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

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

WHO'S SELLING HEROIN?

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

WHO'S SELLING COCAINE?

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

How much does heroin cost?

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

SA=South American (Colombian)
Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

All reported prices are stable between spring and fall 2002.

How much does cocaine cost?

Form	Unit	Price
Crack	One "trey"	$3[E]
	One rock or vial	$3–$10[L]
	One rock	$5[E]
	1 g	$18–$26[L]
Powder	One bag	$10–$20[L]
		$20[E]
	1 g (multigram purchase)	$30[L]
	1 g	$100–$125[L]
	1 oz	$800–$1,300[L]

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

All reported prices are stable between spring and fall 2002.

Which drug sellers are associated with which crimes?

Crime	Heroin	Crack cocaine	Powder cocaine	Marijuana	Methamphetamine	Ecstasy	Diverted OxyContin®	GHB	PCP	Ketamine
Gang-related activity					✓					
Violent criminal acts	✓	✓	✓		✓					
Nonviolent criminal acts	✓	✓	✓		✓					✓
No crimes associated				✓		✓	✓	✓	✓	

Source: Law enforcement respondent

WHO'S SELLING MARIJUANA?

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

WHO'S SELLING ECSTASY?

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

How much does commercial grade marijuana cost?

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

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

All reported prices are stable between spring and fall 2002.

How much does ecstasy cost?

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

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

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

How much do other drugs cost?

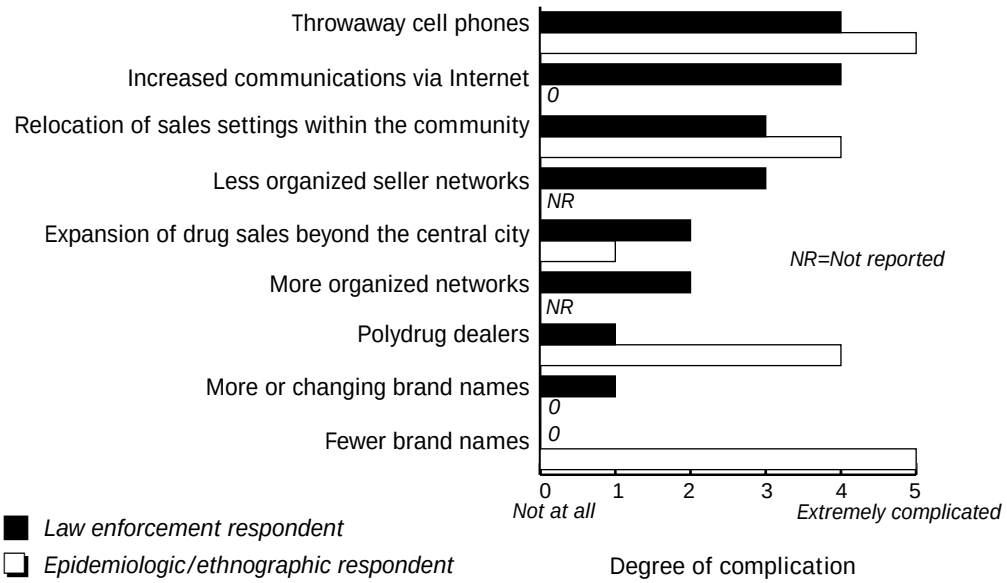
Drug	Unit	Price
Diverted OxyContin®	1 mg	$0.50–$1.25[L] $1–$2[E]
PCP	One bag One fluid oz	$5[L] $250–$350[L]
GHB	One vial or dosage unit	$10–$20[L]
Ketamine	One vial or dosage unit	$10–$20[L]

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

Diverted OxyContin® has risen in price from $1 to $1–$2 per milligram, and is usually sold as 20- and 40-milligram pills.[E] *All other reported prices are stable between spring and fall 2002.*

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

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



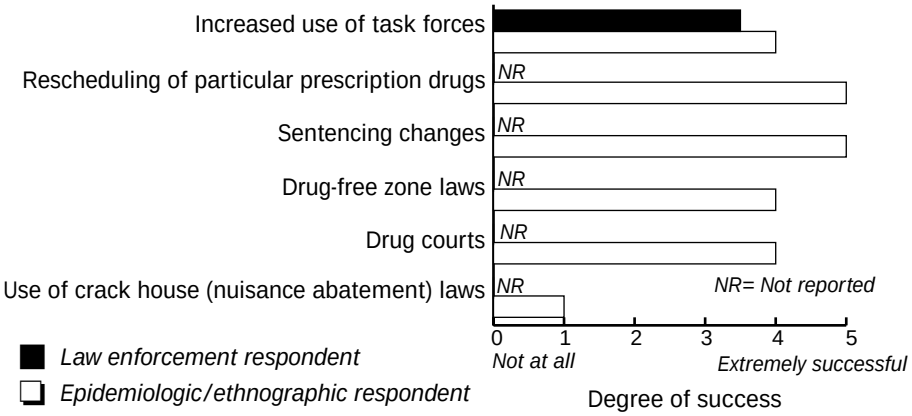
What they have to say...

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

What they have to say...

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

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



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

SEPTEMBER 11 FOLLOWUP

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

PHOENIX METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 3,251,876
- Median age: . . . . . 33.2 years
- Race (alone):
  - White 77.0%
  - Black 3.7%
  - American Indian/ Alaska Native 2.2%
  - Asian/Pacific Islander 2.2%
  - Other race 12.1%
  - Two or more races 2.9%
- Hispanic (of any race): 25.1%
- Unemployment rate: 3.1%
- Median household income: $44,752
- Families below poverty level with children <18 years: 12.7%

*Source: U.S. Census 2000**

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

Three of the city's *Pulse Check* sources consider the drug problem very serious.[L,E,N] Two[L,M] consider it stable, and two consider it somewhat worse since spring 2002.[E,N]

Sources report several positive changes in drug use and activity:

- Recent increased use of task forces, precursor laws, and crack house (nuisance abatement) laws has been relatively successful in combating drug activity.[L]
- HIV/AIDS among methadone treatment clients has decreased due to community services and prevention education.[M]
- Crack and powder cocaine indicators show declines: cocaine use in general declined;[E] powder cocaine use declined among methadone treatment admissions;[M] and periodically during the last 6 months, crack was not available for purchase.[E]

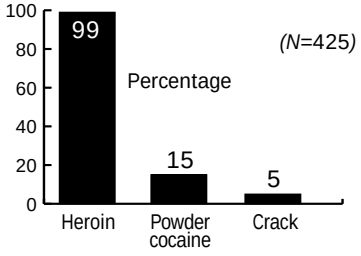
Sources report other changes related to specific drugs of abuse:

- Heroin has become more adulterated, and therefore more toxic.[E]
- Marijuana use increased in general, and particularly among preadolescents.[E]
- Abuse of some prescription opiates increased: primary OxyContin® admissions to the methadone program increased,[M] diverted methadone became less difficult to purchase (as reported in several other *Pulse Check* cities), and methadone-related deaths increased.[E]

Methamphetamine use and activity in particular have changed:

- Use and sales are common in Phoenix and have increased.[L,E]
- Non-methadone treatment admissions increased.[N]
- Mexican nationals who distribute methamphetamine from large operations based in Mexico and California have replaced independent dealers who sell methamphetamine manufactured in small, local "mom and pop" labs.[L]
- Most methamphetamine available in Phoenix is produced by the red phosphorus method; however, labs using the "Nazi" or quick-cooking method increased.[L]
- Methamphetamine prices at all levels declined.[E]

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

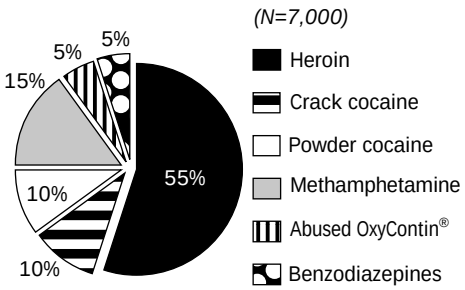


+Includes any use, whether as a primary, secondary, or tertiary drug; response for methamphetamine was "very low"; response for methylenedioxymethamphetamine (MDMA or ecstasy) was zero; marijuana use is not tracked, but reported as "fairly high."

Source: Methadone treatment respondent

- *Powder cocaine use among methadone treatment admissions decreased slightly between spring and fall 2002.*[N]
- *Primary OxyContin® (oxycodone hydrochloride controlled-release) abusers accounted for 1 percent of methadone treatment admissions—a slight increase from the spring.*[M]

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



Source: Non-methadone treatment respondent

Among non-methadone treatment admissions, the proportion of primary methamphetamine users increased slightly between spring and fall 2002. Proportions for the primary use of other drugs remained relatively stable.[N]

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

THE BIG PICTURE *(continued)*

Although the most widely abused drug reported varies by source, three sources report methamphetamine as the drug related to the most serious consequences. New or emerging drugs include ecstasy (as reported in 15 other *Pulse Check* cities), phencyclidine (PCP) (as reported in 6 other cities), and diverted OxyContin® (as reported in 14 other cities).

Most widely abused drug:
- Methamphetamine[E,N]
- Marijuana[L]
- Heroin[M]

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

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

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

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

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

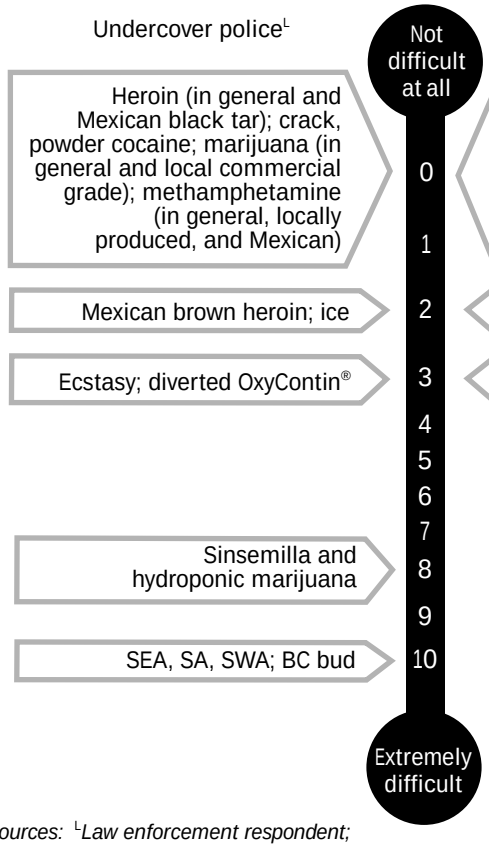
Drug related to the second most serious consequences:
- *Crack*[L,E,N]
- *Benzodiazepines*[M]

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

New or emerging problems:
- Ecstasy activity increased[L]
- PCP[N]
- Diverted OxyContin®[M]

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

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



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

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

- *As in more than half (15) of* Pulse Check *cities, marijuana remains extremely easy to buy.*[E]
- *Mexican black tar heroin and methamphetamine are extremely easy for users and undercover officers to buy.*[L,E]
- *Crack is sometimes unavailable for short periods of time.*[E]
- *Users have found PCP and diverted methadone less difficult to buy since spring 2002.*[E]
- *Users and undercover police found other drug availability stable between spring and fall 2002.*[L,E]

HEROIN

Mexican black tar heroin remains extremely easy to buy, and use remains stable.[L,E] Heroin has become more adulterated and more toxic in the past 6 months.[E]

COCAINE

In general, cocaine use (crack and powder) decreased slightly between spring and fall 2002, and crack is sometimes completely unavailable for short periods of time.[E] Among methadone treatment clients, powder cocaine use declined.[M]

MARIJUANA

Marijuana remains widely available,[L,E] and use increased between spring and fall 2002.[E] One source reports that marijuana use among preadolescents is now a common phenomenon.[E]

METHAMPHETAMINE

Most sources cite methamphetamine use and activity as relatively high, and its use in general has increased in the last 6 months.[E] Non-methadone treatment admissions increased slightly between spring and fall 2002.[N]

MDMA (ECSTASY)

Ecstasy activity and use appear to be increasing, and the drug continues to emerge in Phoenix.[L]

OTHER DRUGS

- Diverted OxyContin®: Abuse of OxyContin®, which is considered an emerging drug of abuse, has increased among methadone treatment admissions.[M] The drug continues to be diverted through fraudulent prescriptions and pharmacy thefts.[L,E]
- Diverted methadone: Methadone, often diverted, has become less difficult to buy between spring and fall 2002, and related deaths increased.[E]
- PCP: Considered an emerging drug of abuse, PCP ("sherm," "slum," "cool or kool," and "dust")[N] is less difficult to buy since spring 2002.[E] Its use has increased somewhat, especially among young adult Black males, who smoke the drug in combination with cigarettes or marijuana.[E]
- Abused steroids: One source reports increased abuse of anabolic steroids, especially among young adult White males who use it for bodybuilding purposes.[E]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone respondent is with a facility that treated more than 7,000 patients in 2002 in its outpatient detoxification, outpatient, and outreach programs. Heroin remains the most common primary drug of abuse (*see pie chart on the first page of this chapter*), and treatment percentages were stable with the exception of an increase in the methamphetamine treatment proportion.[N]
- The methadone treatment respondent is with a facility that operates at about 70 percent capacity (425 of 600 slots).[M] About 20 percent of its heroin clients also use some form of cocaine (*see bar graph on the first page of this chapter*). The facility targets the Hispanic population in Phoenix and focuses on comprehensive services.

Consequences of drug use and co-occurring disorders

- The methadone treatment source states that HIV/AIDS among drug treatment clients decreased due to increased community services and prevention education in Phoenix.
- The most serious drug abuse-related health consequence is hepatitis C, which is increasing according to treatment sources.[N,M] The methadone treatment source explains that the program "treats clients under the assumption that they are positive for hepatitis C." The non-methadone treatment source also views drug-related automobile accidents, high-risk pregnancies (due to an increase in sex for drugs on the streets), drug overdoses (due to the increase of drug potency and polydrug use), and abscesses as particularly common and increasing. Needle sharing and contaminated needles continue as common causes of drug-related illnesses.[N]
- The most common co-occurring disorders among drug treatment clients remain antisocial and conduct disorders, psychoses, mood disorders, and suicidal thoughts or attempts. The non-methadone treatment source explains that gaps in coordination of treatment services (e.g., detoxification, addiction counseling, and social services) make it difficult to treat clients with dual diagnoses.

Barriers to treatment

- The non-methadone treatment source reports several barriers to treatment that increased between spring and fall 2002: limited slot capacity, lack of trained staff to treat comorbidity, violent behavior among presenting clients, and lack of transportation or money for transportation.
- The methadone treatment source cites lack of bilingual staff (Spanish and English speaking), especially those who treat co-occurring disorders, as a common barrier to treatment.

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	>30
Mean age (years)	Midforties	34	35
Gender	66% male	55% male	55% male
Race/ethnicity	50% White 40% Hispanic (any race) 10% Native American	Hispanic (any race)	45% White 45% Hispanic (any race) 10% Black
Socioeconomic status	NR	Middle	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Individual	Individual
Level of education completed	N/A	Junior high school	High school
Employment at intake	N/A	Unemployed and part time ("odd jobs")	Unemployed

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

- *Most heroin users are males older than 30 who live in the central city.*[E,N,M]
- *Heroin (now often referred to as "lady") use among females has increased over the last 5 years.*[M]
- *The Medicaid program was expanded recently, and more methadone admissions are insured by Medicaid than in spring 2002. The Medicaid-insured population is of a lower socioeconomic status, less likely to be employed, and has more other illnesses than non-Medicaid clients.*[M]
- *Users new to non-methadone treatment are more likely than the general heroin-using population to be White (versus Hispanic), from the suburbs (versus the central city), and using only heroin (versus speedball use).*[N]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs taken	Powder cocaine (speedball) methamphetamine (in combination)	Powder cocaine (speedball)	Powder cocaine (speedball) benzodiazepines (sequentially)
Publicly or privately?	NR	Privately	Privately
Alone or in groups?	Both	Alone	In groups

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

- *Heroin users in Phoenix tend to inject Mexican black tar heroin.*[E,N,M]
- *Speedball use (powder cocaine injected with heroin) remains common.*[E,N,M]
- *Among methadone treatment clients, smoking has increased as a route of heroin administration since spring 2002.*[M]
- *Sources report no other changes in heroin use patterns since spring 2002.*

Who's most likely to use cocaine?

Characteristic	Crack			Powder cocaine		
	E	N	M	E	N	M
Age group (years)	>30	>30	18–30	>30	>30	>30
Mean age (years)	NR	34	NR	NR	34	NR
Gender	Female	Split evenly	Split evenly	Male	Split evenly	55% male
Race/ethnicity	Black	Hispanic (any race)	Black	65% White 15% Hispanic	White	White and Hispanic (any race)
Socioeconomic status	Low	Low	Low	NR	Middle	Low
Residence	Central city	Central city	Central city	Central city	Suburbs	Central city
Referral source	N/A	Individual	Individual	N/A	Individual	Individual
Level of education completed	N/A	Junior high school	None	N/A	Junior high school	High school
Employment at intake	N/A	Unemployed	Part time	N/A	Unemployed	Unemployed

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

- *The epidemiologic respondent reports a decrease in crack and powder cocaine use since spring 2002.*[E]
- *Similar to heroin users, crack and powder cocaine users are most likely to be adults older than 30 of low socioeconomic status who live in the central city.*
- *Crack cocaine users are more likely than powder cocaine users to be Black or Hispanic and female.*
- *Powder cocaine users new to non-methadone treatment are much younger than the general powder cocaine-using population (mean age of 26 versus 34 years), and they are more likely to be from the suburbs.*[N]
- *Between spring and fall 2002, powder cocaine use declined among methadone treatment clients. The methadone treatment source explains that most "heroin addicts didn't realize that cocaine was often present in heroin....Suppliers no longer cut heroin with cocaine because it's too expensive"; thus, the amount of powder cocaine a methadone treatment client ingests declined.*[M]

How do users take cocaine?

Characteristic	Crack			Powder cocaine		
	E	N	M	E	N	M
Primary route of administration	Smoking	Smoking	Smoking	Snorting	Injecting	Injecting
Other drugs taken	Varies	Heroin (as a substitute)	Marijuana (in combination)	Heroin (speedball) methamphetamine (in combination)	Heroin (speedball)	Heroin (speedball)
Publicly or privately?	NR	Publicly	Publicly	Privately	Privately	NR
Alone or in groups?	NR	In groups	Alone	NR	Alone	NR

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

- *Sources agree that if crack is unavailable in Phoenix, other drugs are used as substitutes: "Crack users often use any other drug available as a substitute";[E] heroin is often taken as a substitute for crack.[N]*
- *Marijuana is often taken sequentially with crack: heroin- and crack-using methadone treatment admissions often smoke marijuana while on methadone maintenance (when they no longer use heroin).[M]*
- *According to the epidemiologic source, powder cocaine is most often snorted, but it is also commonly injected with heroin (speedball), and used in combination with methamphetamine.[E] According to both treatment sources, injecting is the most common route of administration for powder cocaine, most often with heroin in a speedball.[N,M]*
- *Respondents report no changes in cocaine use patterns between spring and fall 2002.*

Who's most likely to use marijuana?

Characteristic	E
Age group (years)	13–30
Gender	65% male
Race/ethnicity	55% White 27% Hispanic 12% Black
Socioeconomic status	Low and middle
Residence	All

Source: [E]Epidemiologic/ethnographic respondent

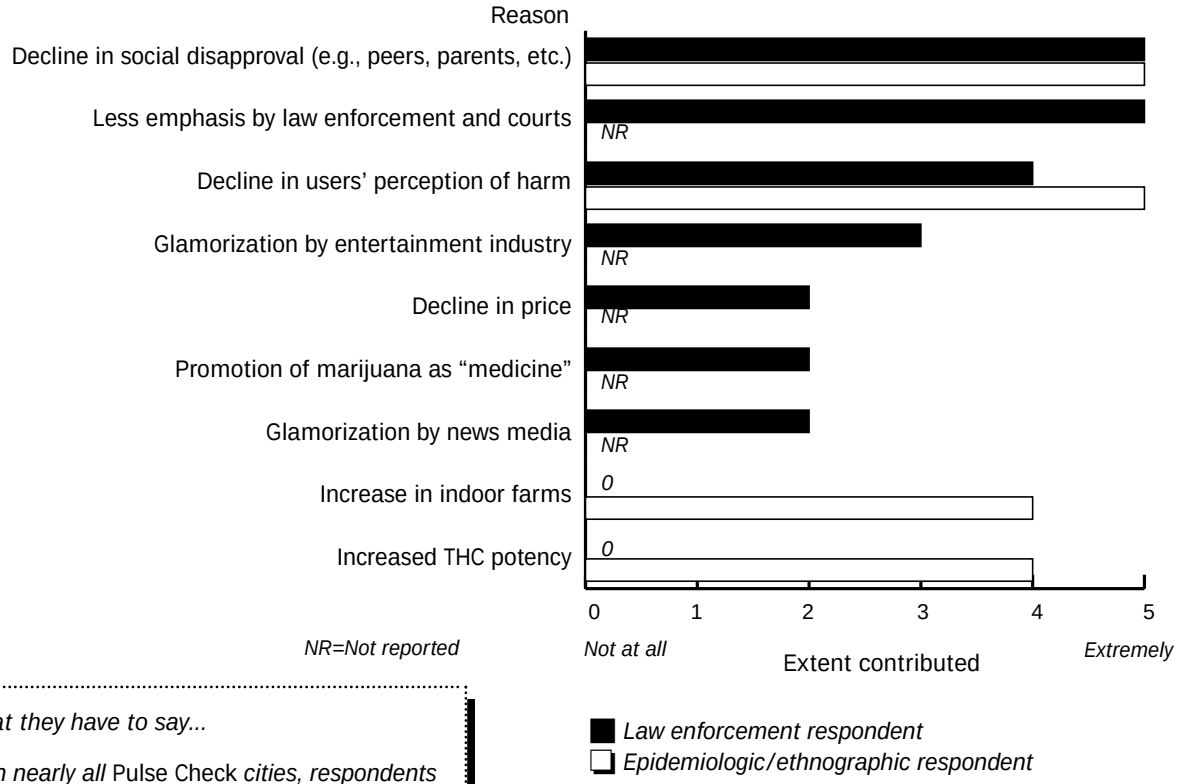
- *In general, marijuana use increased since spring 2002.[E]*
- *The methadone treatment source reports fairly high use among its clients, but this program does not track marijuana user demographics.[M]*
- *Preadolescents now use marijuana.[E]*
- *Among new marijuana users, females, Whites, and those of middle socioeconomic status increased between spring and fall 2002.[E]*
- *Most marijuana users in Phoenix smoke the drug in joints; it is also a secondary substance and a substitute for many other drugs.[E]*

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

The epidemiologic respondent associates marijuana, used either alone or with other drugs, with the following consequences, which remained stable between spring and fall 2002:

- Drug-related arrests
- Automobile accidents
- Illnesses, especially flu and asthma
- High-risk pregnancies
- Short-term memory loss
- Deteriorating family and social relationships
- Poor academic performance
- School absenteeism, truancy, or dropping out of school
- Unemployment rates

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



What they have to say...

As in nearly all Pulse Check *cities, respondents agree that decline in social disapproval of marijuana has greatly contributed to widespread use of the drug.*[L,E]

Who's most likely to use methamphetamine, and how do they use the drug?

Characteristic	E	N
Age group (years)	>30	18–30
Mean age (years)	31–35	26
Gender	Split evenly	Split evenly
Race/ethnicity	White	White
Socioeconomic status	Low	Middle
Residence	All	Suburbs
Referral source	N/A	Individual
Level of education completed	N/A	Junior high school
Employment at intake	N/A	Unemployed

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

- *In general, between spring and fall 2002, use of methamphetamine (known as "crank" and "go fast" in Phoenix) increased, as did non-methadone treatment admissions.*[E,N]
- *Methamphetamine users tend to be White and split evenly between genders.*[E,N]
- *Methamphetamine and powder cocaine users seem to live in opposite ends of the city: most methamphetamine use occurs in the East Valley, and most powder cocaine use occurs in South Phoenix.*[E]
- *Injecting is the primary route of administration among methamphetamine users in Phoenix, followed by smoking.*[E,N,M]
- *Heroin or cocaine is often used in combination with methamphetamine.*[E]
- *User and use characteristics remained stable between fall and spring 2002.*

Who's most likely to use ecstasy?

Most ecstasy users are White young adults (18–30 years) of middle socioeconomic status who live in the central city or suburbs.[E] Ecstasy is most often taken in private settings, in groups, and among friends. The drug is often used in combination with marijuana.[E] Respondents report no changes in use or user characteristics since spring 2002.

Other Drugs

- Abused OxyContin®: OxyContin® treatment admissions increased between spring and fall 2002.[M] Most non-methadone primary OxyContin® admissions are suburban White adults of middle socioeconomic status who are equally likely to be male or female.[N] The drug is taken orally, often in combination with marijuana. Another form of oxycodone (Percodan®) is often abused as a substitute for OxyContin®.[M]
- Abused benzodiazepines: Alprazolam (Xanax®), diazepam, and clonazepam (Klonopin®) are commonly abused benzodiazepines. Treatment client demographics are similar to those of OxyContin® clients.[N]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

The majority of drug sales in Phoenix occur in central city areas, with heroin and powder cocaine sales concentrated in the central city, and crack, marijuana, methamphetamine, and ecstasy sales spread equally across all areas of the city.

Heroin, crack and powder cocaine, and marijuana are sold in a variety of public and private settings:

- Crack houses/shooting galleries[L,E]
- Private residences[L,E]
- Inside cars[L,E]
- Streets and open-air markets[L,E]
- Public housing developments (excluding heroin)[L,E]
- Hotels/motels (excluding heroin)[L,E]
- Around drug or alcohol treatment clinics (excluding powder cocaine)[E]

Additionally, powder cocaine is sold on college campuses and in nightclubs and bars.[L,E] Marijuana is also sold at raves and concerts.[L]

Methamphetamine is sold in the following settings:

- Private residences[L,E]
- Hotels/motels[L,E]
- Inside cars[L,E]
- Around schools[L]
- College campuses[L]
- Private parties[L]
- Streets and open-air markets[E]
- Public housing developments[E]

Ecstasy is sold in the following settings:

- College campuses[L,E]
- Private parties[L,E]
- Raves[L,E]
- Concerts[L,E]
- Private residences[L]
- Around schools[L]
- Nightclubs and bars[E]
- Private parties[E]

HOW DO DRUGS GET FROM SELLERS TO BUYERS?

What follows is a typical drug-buying scenario for most drugs, including heroin, crack and powder cocaine, methamphetamine (sold by organized dealers), and marijuana:[L]

- A buyer is introduced to a dealer via a mutual acquaintance.
- The dealer gives the buyer his or her pager number.
- The buyer contacts the dealer via pager to request drugs and set up a meeting for the exchange of the drug.
- The buyer and dealer meet (often in the buyer's private residence or car) to exchange the drug hand to hand.

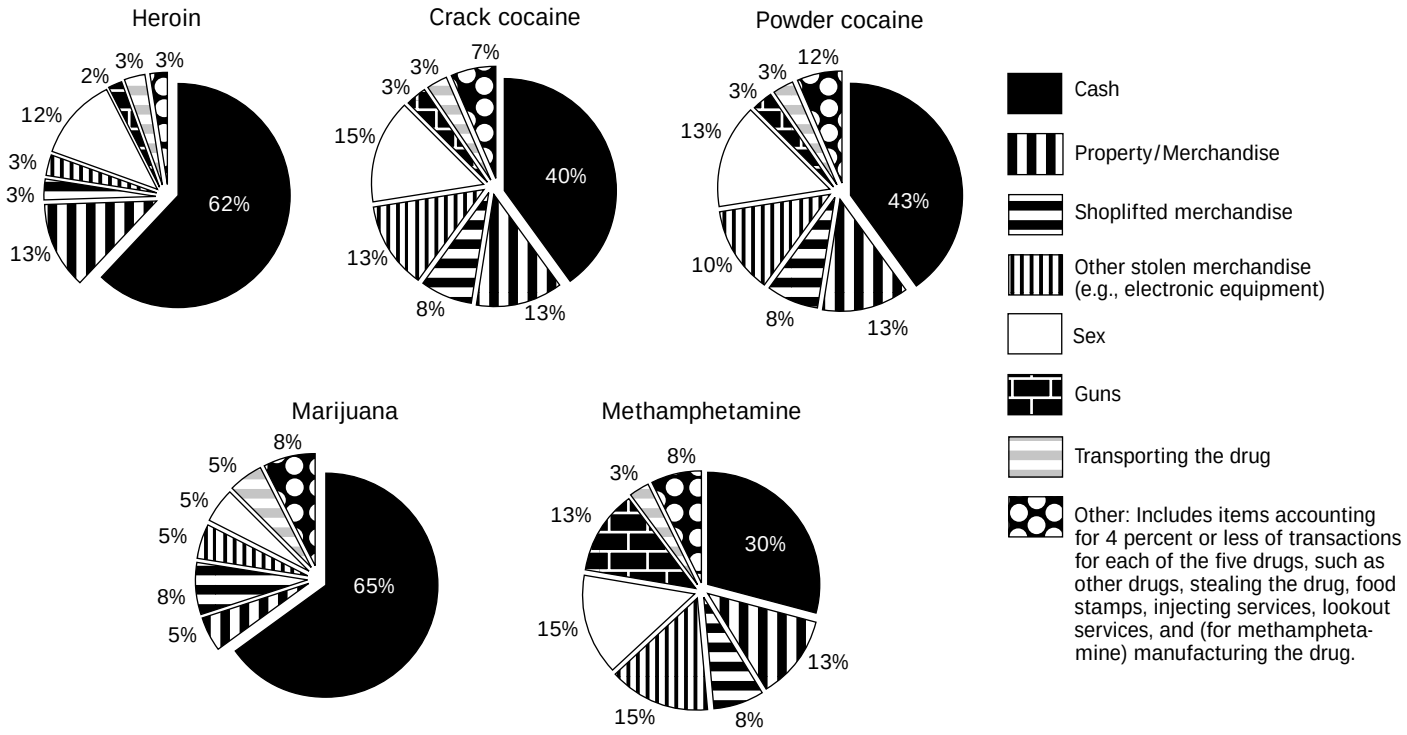
Additionally, to obtain crack, buyers may simply enter crack houses to purchase the drug.

WHO SELLS ILLEGAL DRUGS?

Most drug dealers in Phoenix are polydrug distributors who sell heroin, powder and crack cocaine, and methamphetamine (produced by large Californian or Mexican meth labs). These organized sellers are young adults associated with Mexican trafficking organizations.

Drugs sold mostly by independent dealers include marijuana, methamphetamine (produced by independent, local meth labs), ecstasy, and diverted OxyContin®. These dealers tend to sell only one type of drug, with the exception of ecstasy dealers, who often sell ketamine or gamma hydroxybutyrate (GHB).

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



Source: Mean of response ratings given by law enforcement, non-methadone treatment, and methadone treatment respondents; the methadone treatment respondent provided percentages for heroin exchanges only.

- *Respondents report that cash is the most common means of exchange for illegal drugs—but less so compared with other* Pulse Check *cities. One source notes that over the past 10 years cash exchanges for drugs declined.*[N]
- *Methamphetamine, in particular is much less likely to be obtained via cash than in other cities. Common items exchanged for the drug include stolen merchandise (such as electronic equipment and cars), sex (especially between female buyers and male dealers), guns, stolen identities and fraudulent documents, and chemicals for manufacturing methamphetamine. The exchange of stolen identities, fraudulent documents, and methamphetamine precursors for methamphetamine increased over the past 10 years.*[N]
- *Ten years ago, buyers who exchanged sex for heroin were predominantly female; now they are just as likely to be male.*[M]
- *The non-methadone treatment source reports that among outpatient detoxification clients, the practice of sending fellow users out to buy drugs in exchange for a "cut" of those drugs is much more common than among general outpatient clients. This practice has increased over the past 10 years.*

Which drug sellers are associated with which crimes?

Crime	Heroin	Powder cocaine	Crack cocaine	Marijuana	Metham-phetamine	Ecstasy
Violent criminal acts: home invasions and homicides	✓	✓	✓		✓	
Violent criminal acts: aggravated assaults				✓	✓	✓
Nonviolent criminal acts: property crimes				✓		✓
Domestic violence					✓	

Sources: Law enforcement respondent

Illegal drug sales are associated with many violent and nonviolent crimes.[L] The law enforcement source describes methamphetamine sales, in particular, as linked to high levels of violent crimes (such as aggravated assaults, homicides, robberies, and domestic violence).

How much do illegal drugs cost?

Drug	Unit	Price
Mexican black tar heroin	100–200 mg ("a twenty")	$20
	1 g	$100–$120
Crack	200–300 mg	$20
Powder cocaine	0.25 g	$20
	1.77 g ("teener")	$40–$60
	3.5 g	$80–$100
Commercial grade marijuana	6–7 g (dime bag)	$20
	1 oz	$60–$80
Methamphetamine	1.77 g (teener)	$80–$110
	0.125 oz (eightball)	$120–$180
Ecstasy	One pill	$20–$30
Diverted OxyContin®	40-mg pill	$20–$25

Source: Law enforcement respondent

- *Between spring and fall 2002, drug prices remained relatively stable with one exception: all methamphetamine prices declined.[L] The law enforcement source further states that heroin prices declined drastically over the past 5 years.*
- *Sources did not give drug purity levels, but the epidemiologic source reports that heroin has become more adulterated (and more toxic) since spring 2002, and that ecstasy sold at raves is sometimes laced with heroin or methamphetamine.*

COMMUNITY INNOVATIONS AND TOOLS OVER THE PAST 10 YEARS: HOW SUCCESSFUL HAVE THEY BEEN?

The law enforcement source reports that increased use of task forces, precursor laws, and crack house (nuisance abatement) laws have been relatively successful in combating drug activity in Phoenix.

Patrol precincts have uniform neighborhood enforcement teams specifically designed to take care of all problems within one neighborhood. These teams work with narcotics detectives to solve problems in that neighborhood. This program has been ongoing for 5 years, but "has really taken off in the past 2 years."[L]

SEPTEMBER 11 FOLLOWUP

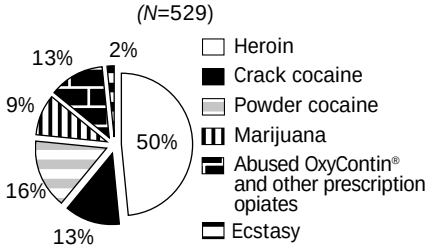
Three of four Phoenix *Pulse Check* sources believe that the September 11 attacks and their aftermath have had no effects on the drug abuse problem.[L,N,M] The epidemiologic source states that anxiety and depression among the general population and the drug-using population may be more common and more severe, causing increased comorbidity among drug treatment clients.

PITTSBURGH METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 2,358,695
- Median age: . . . . . 40.0 years
- Race (alone):
  - White: 89.5%
  - Black: 8.1%
  - American Indian/ Alaska Native: 0.1%
  - Asian/Pacific Islander: 1.1%
  - Other race: 0.3%
  - Two or more races: 0.9%
- Hispanic (of any race): 0.7%
- Unemployment rate: 2.6%
- Median household income: $37,467
- Families below poverty level with children <18 years: 12.7%

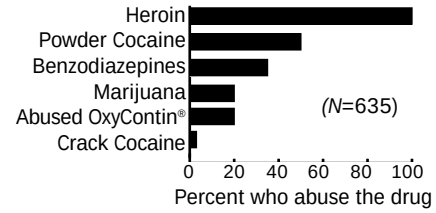
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



+Includes any use, whether as a primary, secondary, or tertiary drug; responses for methamphetamine and ecstasy were zero.

Source: Methadone treatment respondent

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

Three of the city's *Pulse Check* sources consider the drug problem very serious,[E,N,M] and three consider it to be somewhat worse.[L,E,N] Opiate use and activity, in particular, have changed:

- All sources report that heroin use and activity have increased. Both treatment sources report an increase in heroin-using clients.[N,M]
- Heroin-related deaths have risen drastically since spring 2002.[E]
- Heroin use among adolescents, young adults, and females has increased dramatically.[E] Heroin snorting has increased, especially among these populations.[L,E]
- Heroin purity has increased[L] as Colombian white powder heroin availability has grown.[E] Heroin brand names are becoming more common as seller groups become more organized.[L]
- The abuse of OxyContin® (oxycodone hydrochloride controlled-release) has increased significantly.[E]
- Diverted methadone is considered easy to buy, and its use has increased.[E]
- Many OxyContin® abusers are switching to abusing methadone because diverted OxyContin® is more difficult to obtain.[N]

Methamphetamine use appears low and stable, but lab activity and sales have increased. Most methamphetamine is sold north of Pittsburgh, but sales are beginning to move south, and several labs have been seized within the city.[L,E]

Cocaine and marijuana use and activity remain at high but stable levels.

All four sources report heroin as the most widely abused drug and the drug related to the most serious consequences.

Most widely abused drug:
Heroin[L,E,N,M]

Changes between spring and fall 2002: Heroin replaced diverted OxyContin®.[N]

Second most widely abused drug:
Crack[L,E]
Prescription opiates[N]
Powder cocaine[M]

Changes between spring and fall 2002: Prescription opiates replaced crack.[N]

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

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

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

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

New or emerging problems:
Methamphetamine activities have increased, and heroin purity has increased.[L]
Diverted Oxycontin® and methadone and powder (snortable) heroin[E]
Methylenedioxymethamphetamine (MDMA or ecstasy) and other club drugs [N]

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

- *Among non-methadone treatment admissions, the proportion of primary heroin and OxyContin® abusers increased somewhat between spring and fall 2002. Proportions for the primary use of other drugs remained relatively stable.*
- *The number of primary heroin users admitted to the methadone treatment program increased somewhat. Methadone percentages for secondary and tertiary drugs were relatively stable, except for powder cocaine, which increased slightly.*

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

All sources report that heroin use and activity have increased since spring 2002:

- All sources report that heroin is the most widely abused drug and the drug related to the most serious consequences.
- Heroin snorting (especially among younger users) has increased.[L,E]
- Heroin purity has increased,[L] as has Colombian white powder heroin availability.[E]

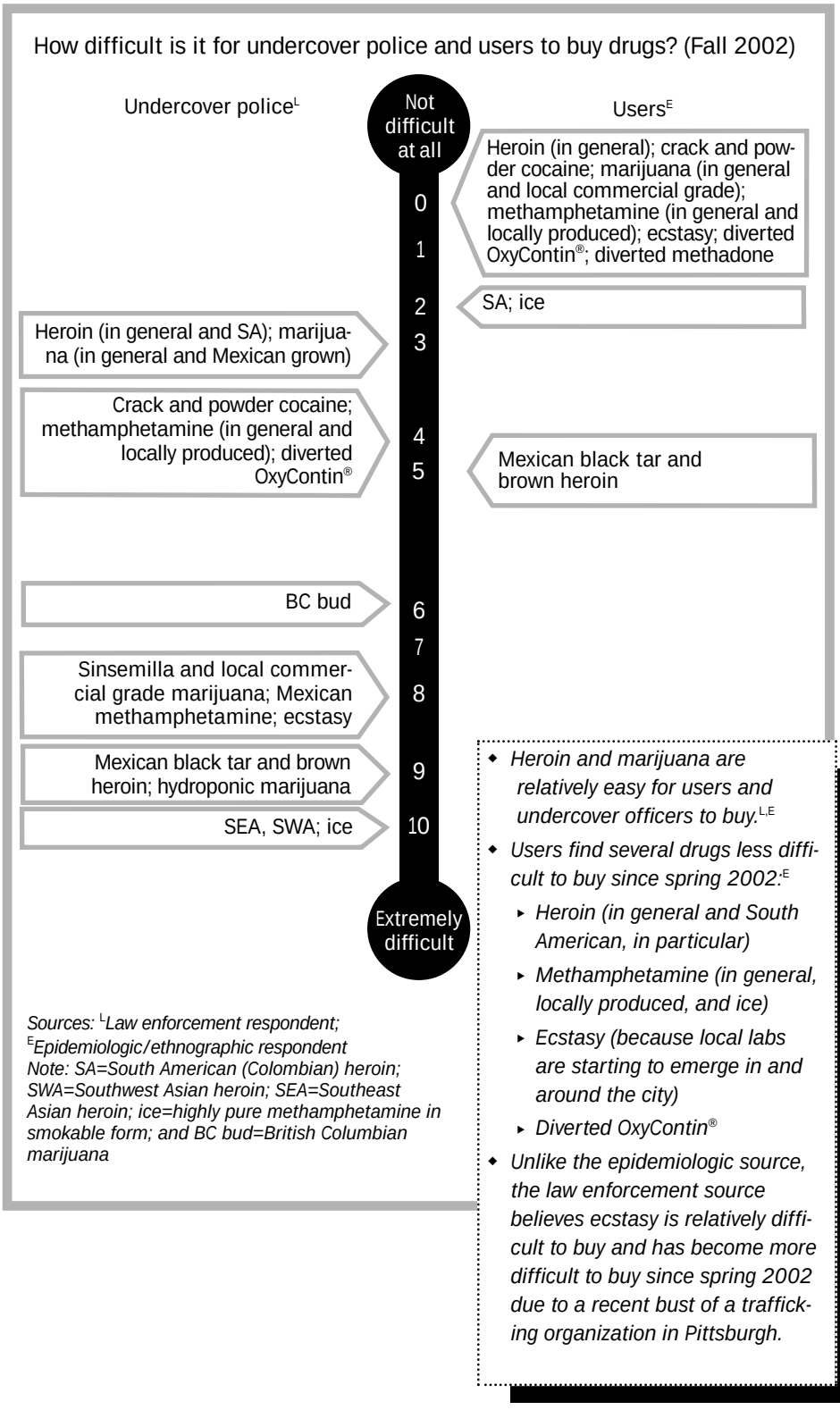
COCAINE

Use of crack and powder cocaine is stable at high levels:

- "The force driving the continuing high levels of powder and crack cocaine use is diminishing treatment capacity across the city."[E]
- Nearly half of the heroin admissions to methadone treatment also use powder cocaine, usually by injecting the drug in combination with heroin. This proportion of secondary and tertiary powder cocaine users increased between spring and fall 2002.

MARIJUANA

As in the majority of *Pulse Check* cities, sources report stable marijuana use and sales activity at high levels.[L,E]



METHAMPHETAMINE

Methamphetamine activity has been increasing:

- Most methamphetamine is sold north of Pittsburgh, but sales are starting to move south.[L]
- Methamphetamine use is stable at low levels; however, two labs were recently detected in the city and use is emerging on college campuses.[E]
- Methamphetamine (locally produced powder and ice) has become less difficult to buy since spring 2002.[E]

MDMA (ECSTASY)

Most sources consider ecstasy use as relatively low and stable. The non-methadone source states that it is an emerging drug in Pittsburgh.

OTHER DRUGS

- Diverted OxyContin®: OxyContin® is considered an emerging drug of abuse.[E] Non-methadone treatment percentages increased between spring and fall 2002. As many as 20 percent of primary heroin clients in the methadone program abuse OxyContin® as a heroin substitute or in combination with heroin.[M]
- Diverted methadone: Diverted methadone is considered easy to buy, and its abuse has increased.[E] Many OxyContin® addicts are switching to diverted methadone because diverted OxyContin® is more difficult to obtain.
- Benzodiazepines: As many as 35 percent of heroin users in the methadone treatment program (a stable percentage) abuse a benzodiazepine as a secondary or tertiary drug.

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- The *Pulse Check* non-methadone treatment respondent, whose facility's 1,170-slot capacity is fully utilized, reports that most clients abuse heroin as their primary drug *(see pie chart on the first page of this chapter)*. Most young adult (age 18–30) admissions primarily abuse heroin, while most adults older than 30 primarily abuse prescription opiates—although heroin use has increased among that age group as well. Treatment percentages in the non-methadone program remained relatively stable between fall and spring 2002, except for an increase in heroin and diverted OxyContin® as primary drugs of abuse.
- About half of primary heroin treatment admissions to the non-methadone program are repeat clients for drug abuse treatment. The recidivism rate for other drugs is much lower (between 5 and 20 percent).
- The methadone treatment respondent, whose 655-slot capacity is almost fully utilized, reports an increase since spring 2002 in demand for heroin treatment, especially among young adults (age 18–30), and an increase in the proportion of clients who also abuse powder cocaine as a secondary or tertiary drug.
- Methadone treatment is available only in selected areas of the city, typically in the central city. Public and private methadone treatment are more available than they were 6 months ago, but both types of programs have long waiting lists. Capacity for methadone programs has grown in response to the drastic increase in demand and because programs tend to be very profitable.[E] A large non-methadone treatment provider in the area recently closed, so remaining non-methadone treatment programs have filled and nearly all have waiting lists.
- Hepatitis C among injecting drug users continues to be a major concern for treatment providers, with prevalence rates up to 90 percent. Moreover, heroin overdoses have increased somewhat since spring 2002 due to the greater availability of high-purity heroin.[N]
- Antisocial, conduct, and mood disorders are increasingly problems for drug clients, as is the lack of trained staff to treat comorbidity.[N,M]
- The methadone treatment source reports that an increase in polydrug use and mental health disorders among clients is of major concern. The non-methadone treatment source reports a dramatic rise in heroin use among the younger population. Treatment of this population is made more difficult by decreased funding for treatment and the amount of time allowed for treatment due to recent cuts in public funding and managed care.

WHO USES ILLICIT DRUGS?

The *Pulse Check* epidemiologic, non-methadone treatment, and methadone treatment sources were asked to describe the populations most likely to use heroin, cocaine, marijuana, methamphetamine, and ecstasy. They were also asked to describe any emerging user groups and to report on how the drugs are used. As shown in the following pages, user characteristics vary by drug. Further, because of the different perspective each brings, the three sources sometimes describe quite different popula-

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

The Pittsburgh epidemiologic respondent shares examples of the impact of the increased use of heroin:

- Treatment for heroin has increased throughout the city.
- Heroin-related deaths are up drastically since spring 2002, including several violent murders by young adults who were using heroin.
- High schools are trying to control the heroin problem by holding "grieving sessions" regarding heroin-related deaths and heroin awareness nights.
- In the last 5 years, adolescent opiate use has increased by 45 percent, according to local surveys. Most of these youth are snorting powder heroin.

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	13–30	>30
Mean age (years)	25–40	23	34
Gender	Male	60% male	62% male
Race/ethnicity	White	White and Black	65% White
Socioeconomic status	Middle	Low and middle	Low
Residence	Suburbs	Suburbs	Central city
Referral source	N/A	Varies widely	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Varies widely	Unemployed

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

- *All three sources agree that males predominate as heroin users, but the two treatment sources report a relatively high proportion of female users (38–40 percent), and the epidemiologic source reports that females have been increasingly using the drug since spring 2002.*
- *Use among middle-class adolescents and young adults has increased dramatically since spring 2002. A new trend among high school students is the attempt to snort the drug while in class. Moreover, those who snort heroin tend to switch quickly to injecting the drug.*[E]
- *Heroin clients in the non-methadone treatment program differ from clients in the methadone program: the non-methadone treatment program serves mostly heroin clients of low and middle socioeconomic status in the suburbs, while the methadone program serves clients of low socioeconomic status in the central city. The epidemiologic source reports that heroin (and crack and powder cocaine) is often purchased in the city, but targeted to the suburban community.*

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Snorting and injecting	Injecting
Other drugs taken	Powder or crack cocaine (speedball)	NR	Powder cocaine ("double dutch")
Publicly or privately?	Publicly	Privately	Privately
Alone or in groups?	In groups/ among friends	In groups/ among friends	Alone

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

- *Injecting is the most common route of administration;*[E,M] *however, heroin snorting has increased as a route of administration since spring 2002. In fact, among new heroin users, it is the most common way to take the drug.*[E]
- *Heroin and powder cocaine injected in combination has increased since spring 2002.*[M]
- *No other changes in heroin use patterns are reported since spring 2002.*[E,N,M]

Who's most likely to use cocaine?

- *Sellers tend to "push" crack cocaine on Black females (especially prostitutes) as a sex enhancer. Females are increasingly using crack, and the gender gap is not as large as that for heroin.*[E]
- *The number of white collar workers using crack cocaine has increased slightly since spring 2002.*[E]

	Crack		Powder cocaine	
Characteristic	E	N	E	N
Age group (years)	18–30	>18	>30	>18
Mean age (years)	18–25	30	NR	35
Gender	Male	70% male	Male	70% male
Race/ethnicity	Black	White and Black	White and Black	White and Black
Socioeconomic status	Low	Low and middle	Middle and high	Middle and high
Residence	Central city	Central city	Suburbs and central city	Suburbs
Referral source	N/A	Criminal justice, individual, and other alcohol/drug abuse care provider	N/A	Varies
Level of education completed	N/A	High school	N/A	4-year college
Employment at intake	N/A	Unemployed	N/A	Full and part time

Note: Due to the low proportion of crack use (primary, secondary, and tertiary) the methadone treatment source did not provide demographic user information. The demographic information for secondary and tertiary powder cocaine users in treatment is identical to that of heroin users.

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

Who's most likely to use marijuana?

Characteristic	E	N
Age group (years)	18–30	13–30
Mean age (years)	NR	22
Gender	Male	Split evenly
Race/ethnicity	White	White and Black
Socioeconomic status	All	Middle and high
Residence	All	Suburbs
Referral source	N/A	Criminal justice, individual, and school
Level of education completed	N/A	Junior high and high school
Employment at intake	N/A	Full-time students

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

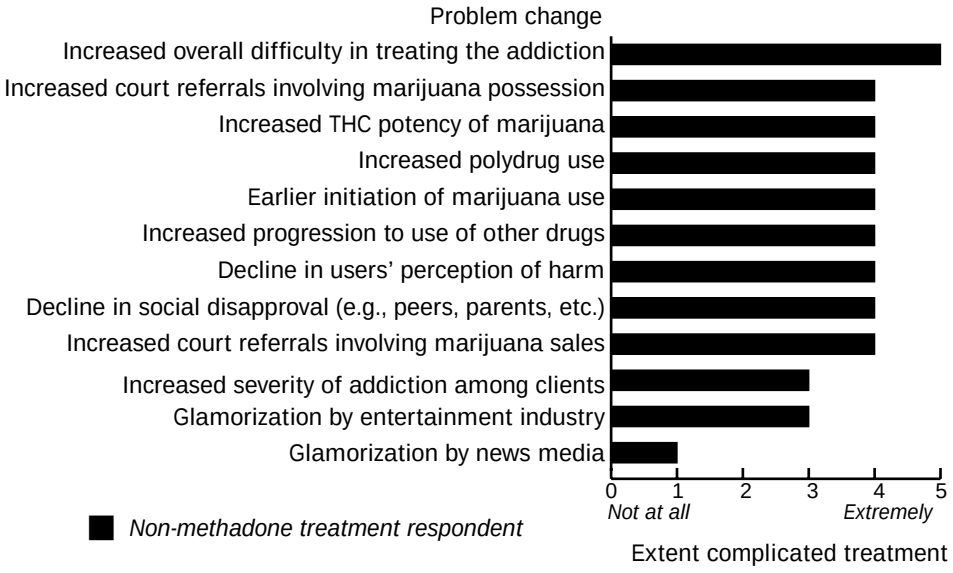
- *New users of marijuana have increased since spring 2002. These users tend to be adults older than 50.*[E]
- *Sources reported no other changes in marijuana user characteristics between spring and fall 2002.*
- *Marijuana is most often smoked in joints* [E,N] *and continues to be laced with ecstasy.*[E]

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

- Drug-related emergency room visits, especially related to respiratory illnesses[E]
- Drug-related arrests[N]
- Automobile accidents[E]
- Short-term memory loss[E]
- Deteriorating family and social relationships[E]
- Poor academic performance[E,N]
- School absenteeism or truancy[E,N]
- Dropping out of school[E]
- Poor workplace performance[E,N]
- Workplace absenteeism[E]

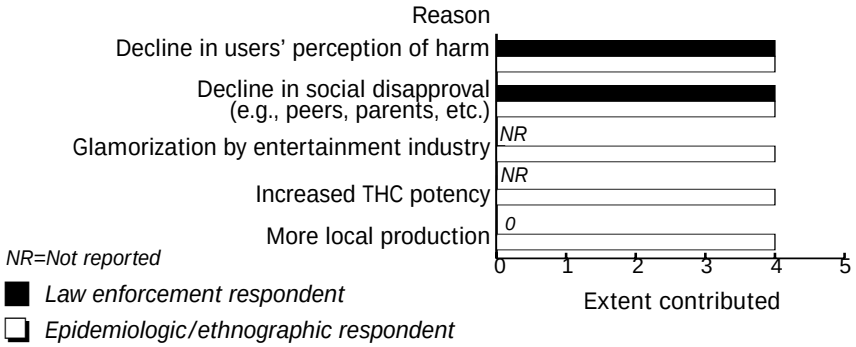
Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



What they have to say...

- *Increased severity of addiction among clients: Increased addiction to marijuana may be caused by greater availability of the drug and increased potency, which in turn causes increased withdrawal symptoms.*[N]
- *Increased difficulty in treating the addiction: Along with increased addiction to marijuana, limits on treatment time for marijuana users by many managed care programs may make clients more difficult to treat.*[N] *By comparison,* Pulse Check *respondents in other cities generally attribute less importance to this aspect of the problem.*
- *Increased polydrug use and increased progression to use of other drugs: Marijuana users are increasingly using other drugs of abuse simultaneously or moving on to the abuse of other drugs, such as heroin, OxyContin®, and ecstasy.*[N]

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



What they have to say...

- *As in the majority of* Pulse Check *cities, sources agree that the decline in users' perception of harm and the decline in social disapproval of marijuana have increased the widespread availability and use of marijuana.*[L,E]
- *Both sources also agree that the price of marijuana over the last 10 years has not declined.*[L,E]

WHO'S MOST LIKELY TO USE METHAMPHETAMINE, AND HOW IS IT USED?

Methamphetamine users are most often young adult (18–30 years) White males of low to middle socioeconomic status who live in rural areas. The drug is mostly smoked (often in combination with marijuana), although some is taken orally. Methamphetamine use and sales are emerging on college campuses.[E]

WHO'S MOST LIKELY TO ABUSE OXYCONTIN®, AND HOW DO THEY ABUSE THE DRUG?

White adults of low and middle socioeconomic status who live in suburban and rural areas are most likely to abuse OxyContin®.[E,N] Abuse of the drug has increased significantly between spring and fall 2002.[E]

Depending on the drug most readily available, heroin users often switch to OxyContin® abuse, and OxyContin® abusers often switch to heroin or methadone abuse.[E,M] In particular, many heroin addicts with chronic pain abuse OxyContin®.[M] Similarly, the non-methadone treatment source reports that heroin users are increasingly switching to OxyContin® abuse, typically by snorting and injecting the drug.

WHO'S MOST LIKELY TO ABUSE METHADONE, AND HOW DO THEY ABUSE THE DRUG?

Heroin addicts often buy diverted methadone to detoxify themselves.[E] Frequently, methadone treatment clients will not swallow the entire daily dose of methadone in order to sell the remainder illegally.[M] The epidemiologic source states that diverted methadone has increased as a problem in the last 5 years due to the proliferation of for-profit methadone treatment centers and the fact that the State does not fix dosage standards for these clinics.

THE MARKET PERSPECTIVE

WHERE ARE ILLEGAL DRUGS USED AND SOLD?

- Most heroin, crack, powder cocaine, and marijuana sales occur in the central city on the streets; however, the drugs are sold in a variety of other locations including the following:[L,E]
  - Crack houses or shooting galleries
  - Private residences
  - Public housing developments
  - Inside cars

Additionally, cocaine and marijuana are sold around schools, college campuses, nightclubs and bars, raves, and concerts, and at private parties. A new sales venue for powder and crack cocaine is pizza delivery restaurants: when customers place a pizza order, they can request powder or crack cocaine. The drugs are delivered to buyers' houses inside pizza boxes.[E]

Methamphetamine is sold in private residences and on college campuses, and ecstasy is sold in private residences, public housing developments, and nightclubs/bars; on college campuses; at private parties, raves, and concerts; and inside cars.[L]

HOW DO DRUGS GET FROM SELLERS TO BUYERS?

Sales methods often vary by drug:

- Heroin and cocaine: In addition to typical street corner sales in neighborhoods known for drug activity, heroin, crack cocaine, or powder cocaine may be purchased in several ways, including the pizza delivery method discussed previously.
- Marijuana: Sales methods vary widely. Dealers who sell primarily marijuana may also sell prescription pills, such as diverted hydrocodone (Vicodin®) and methylphenidate (Ritalin®).[E]
- Methamphetamine: Buyers go directly to the lab sites, most of which are in rural areas, to purchase the drug.[L]
- Ecstasy: Sales tend to be venue oriented (at parties and nightclubs). A buyer at a party may "simply ask around" for ecstasy, referred to as "eve," "X," and "peace."[L] Ecstasy sellers often distribute ecstasy with sildenafil (Viagra®); other drugs sold include ketamine, lysergic acid diethylamide (LSD), and mescaline.[L]
- Diverted OxyContin®: The drug is diverted mostly through fraudulent prescriptions, and doctors reportedly write false prescriptions for sex.[L] There is a small illegal market for the diverted drug, and it sells for $1 per milligram. People increasingly use the Internet to fill prescriptions for OxyContin® and to sell it illegally. Most of the people who divert the drug use it themselves.[L] Other diverted prescription opiates, such as meperidine (Demerol®) and codeine, are often sold with the drug.[E]

WHO'S SELLING HEROIN AND CRACK COCAINE?

According to the law enforcement source:

- Most sellers are organized as loose-knit street gangs or "crews."
- Dealers are predominantly young adults (18–30 years) who are very likely to use the drug.

According to the epidemiologic source:

- Dealers can be grouped into two categories: street gangs or people who are connected to Colombian traffickers.
- Sellers can also be grouped into two age categories: young adults and adults older than 30. The younger sellers are somewhat likely to use the drug; in fact, for this group, heroin use often precedes heroin sales.

The law enforcement source states that heroin, powder cocaine, and crack are often sold by the same dealers. The epidemiologic source further reports that on the streets individual dealers may sell only one drug, but that at private residences and parties, they often sell heroin, crack, and powder cocaine.

WHO'S SELLING POWDER COCAINE?

- Powder cocaine sellers fall into two groups: (1) independent sellers who sell the drug on the street, and (2) organized sellers who deliver the drug to buyers.[E]
- Most powder cocaine dealers are adults older than 30 and somewhat likely to use the drug.[E]

WHO'S SELLING MARIJUANA?

According to the law enforcement source:

- Marijuana sellers fall into two groups: (1) independent and (2) organized sellers, but they are not as organized as heroin, powder cocaine, and crack sellers.
- Sellers tend to be young adults (18–30 years) and are very likely to use the drug.

According to the epidemiologic source:

- Most marijuana dealers are independent, with a wide age range, and are very likely to use the drug.

WHO'S SELLING METHAMPHETAMINE?

- Methamphetamine sellers tend to own the labs that produce the methamphetamine. Most sellers are adults older than 30.[L]
- Methamphetamine sellers are not as structured as heroin and cocaine sellers; however, the sales structure may become more organized as the drug becomes increasingly common.[L]

How much does cocaine cost?

Form	Unit	Price
Crack	One rock	$5[E]
		$5–$20[L]
	1 g	$80–$100[L]
Powder	One bag	$5–$15[E]
	1 g	$75–$100[L]
	0.25 oz	$280–$350[L]

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

- *Powder and crack cocaine prices fluctuate within the given range depending on purity and availability.*[L]
- *When buyers are new to a dealer, dealers often offer them special low prices for a bag of powder cocaine. The price then quickly rises from $5 per bag to $10 or $15 per bag for subsequent sales.*[E]

How pure is South American heroin, and how much does it cost?

Unit	Purity	Price
One bag	NR	$20[M]
One bundle (10 small bags)	60–90%	$180–$200[L]
1 g	60–90%	$300–$600[L]

Sources: [L]Law enforcement respondent; [M]Methadone treatment respondent

- *Most heroin available in Pittsburgh is high-purity, snortable Colombian white. According to the epidemiologic source, Colombian heroin is less difficult to buy in fall 2002 than it was in spring 2002.*[E]
- *The recent increase in heroin overdoses further suggests that the drug is of high purity.*[E]
- *Heroin is often cut with fentanyl, a synthetic narcotic.*[M]
- *The bags of heroin are stamped with logos, such as "fly high," "mo money," and "on de run." Users often refer to heroin by these brand names as well as the standard street names ("H," "dope," "junk," and "mac").*[E,M]
- *Sources report stable prices between spring and fall 2002.*[L,E]

Which drug sellers are associated with which crimes?

Crime	Heroin	Crack	Powder	Marijuana	Methamphetamine	Ecstasy
Prostitution	✓	✓	✓			
Gang-related activity		✓				
Violent criminal acts: assaults	✓	✓	✓	✓		
Nonviolent criminal acts: fraud and theft	✓	✓	✓		✓	
Domestic violence			✓			
No crimes associated						✓

Sources: Law enforcement respondent epidemiologic/ethnographic respondent

- *Marijuana sellers are less involved in other crimes than sellers of other drugs.*[L,E]
- *Crack cocaine sellers continue to be involved in many crimes, including prostitution, gang-related activity, assaults, fraud, and theft.*[L,E]

HOW MUCH DOES MARIJUANA COST?

Most marijuana available in Pittsburgh is commercial grade and is imported from the Western United States.[L] One ounce of commercial grade marijuana sells for $90–$150, and prices have remained relatively stable since spring 2002.[L] New names for marijuana this reporting period include "schwag" and "hydro."[N]

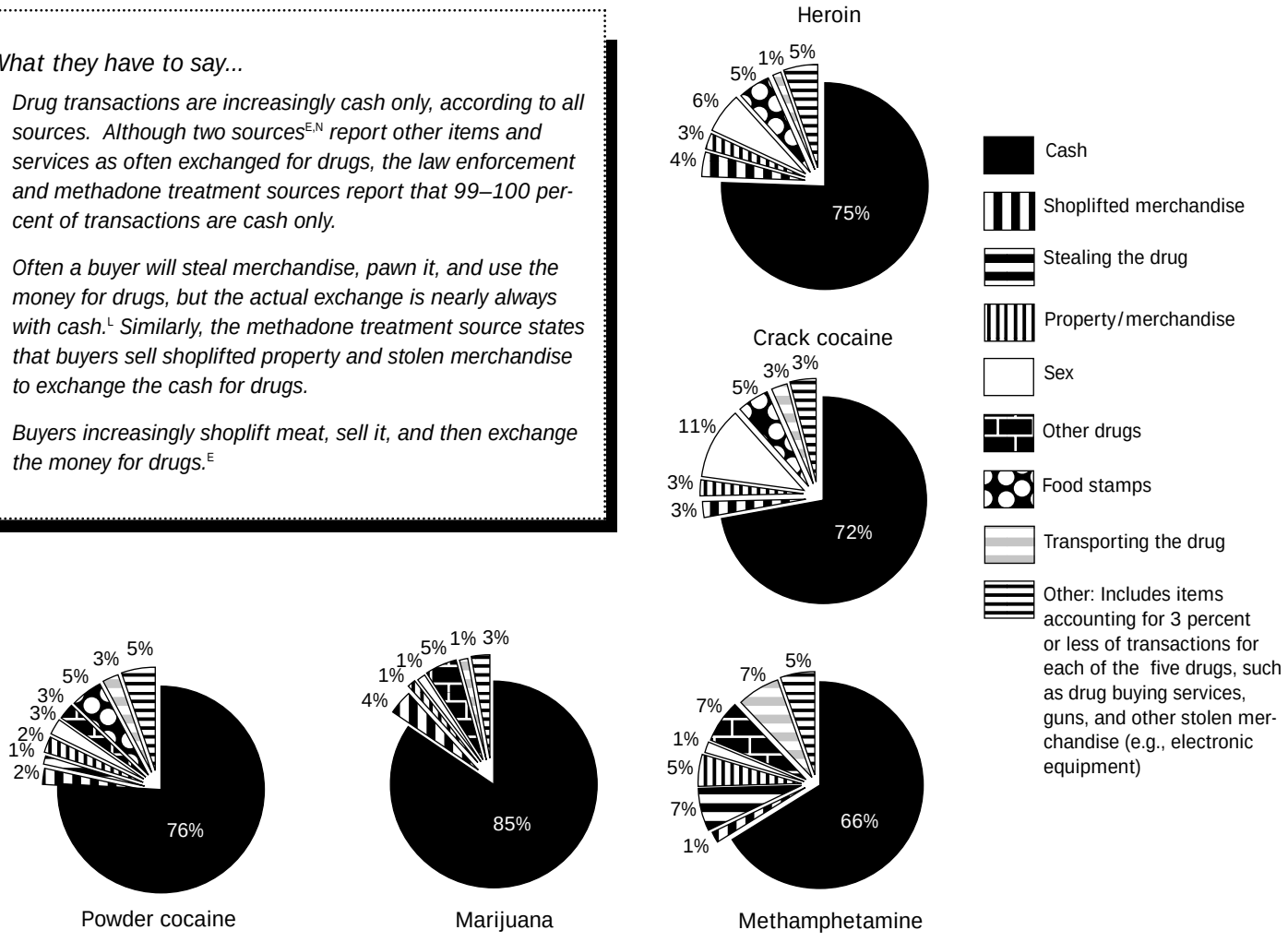
HOW MUCH DOES METHAMPHETAMINE COST, AND HOW IS IT MANUFACTURED?

Locally produced powder methamphetamine costs $100–$200 per gram, and is sold at the quarter-gram level for $45.[L] Most methamphetamine is produced locally in small, mobile labs ("box labs"). An increasing number of labs, especially north of Pittsburgh in farms or mobile home areas, have been detected in fall 2002.[L,E]

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

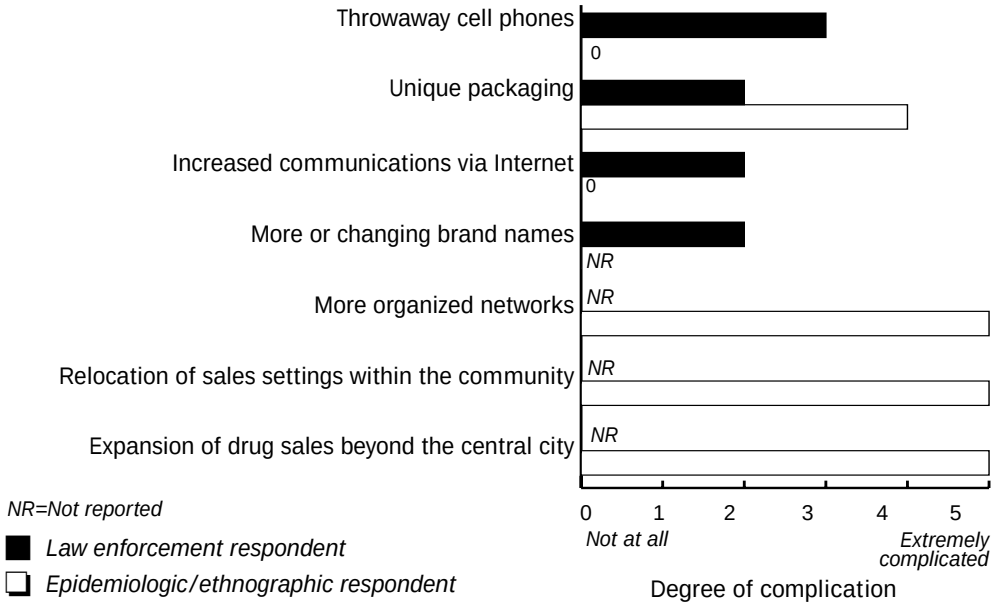
What they have to say...

- *Drug transactions are increasingly cash only, according to all sources. Although two sources[E,N] report other items and services as often exchanged for drugs, the law enforcement and methadone treatment sources report that 99–100 percent of transactions are cash only.*
- *Often a buyer will steal merchandise, pawn it, and use the money for drugs, but the actual exchange is nearly always with cash.[L] Similarly, the methadone treatment source states that buyers sell shoplifted property and stolen merchandise to exchange the cash for drugs.*
- *Buyers increasingly shoplift meat, sell it, and then exchange the money for drugs.[E]*



Source: Mean of response ratings given by law enforcement, epidemiologic/ethnographic, non-methadone treatment, and methadone treatment respondents; the non-methadone treatment source did not provide information for methamphetamine exchanges.

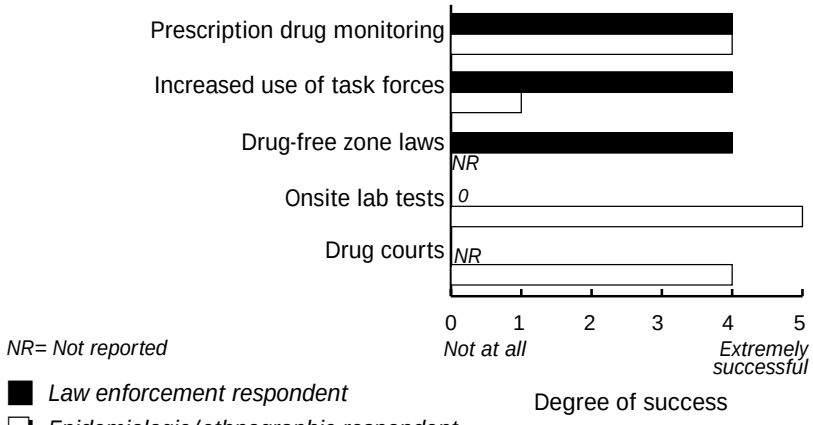
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in Pittsburgh?



What they have to say...

- *Expansion of drug sales beyond the central city: As the economic situation in Pittsburgh has declined, middle class neighborhoods have turned into "drug neighborhoods."*[L] *Few* Pulse Check *sources elsewhere attribute such a high degree of importance to this type of expansion.*
- *More organized networks and unique packaging: Heroin is generally packaged by brand names that indicate the dealer, selling organization, and quality of the drug. The brands are becoming more common as the seller groups become more organized.*[L]

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



What they have to say...

- *Onsite lab tests: The law enforcement source rates the ability to test illegal drugs seized onsite as very low. Unlike in most other* Pulse Check *cities, local law enforcement "must send drugs to a regional office for testing." The epidemiologic source rates store-bought urine tests as very successful because parents are testing their children for drugs.*
- *Prescription drug monitoring: Both sources regard prescription drug monitoring efforts as successful. "The Department of Welfare is monitoring the prescriptions of OxyContin® for Medicaid plans, which is forcing doctors to revise their prescribing practices."*[E]

SEPTEMBER 11 FOLLOWUP

None of the four Pittsburgh *Pulse Check* sources believes that the September 11 attacks and their aftermath have had any effects on the drug abuse problem.

PORTLAND PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 1,918,009
- Median age: . . . . . 34.8 years
- Race (alone):
  - White . . . . . 84.5 %
  - Black. . . . . 2.7 %
  - American Indian/ Alaska Native 0.9%
  - Asian/Pacific Islander 5.4%
  - Other race 3.8%
  - Two or more races 3.3%
- Hispanic (of any race):. . . 7.4%
- Unemployment rate: 3.9%
- Median household income:. $47,007
- Families below poverty level with children <18 years: 9.7%

*Source: U.S. Census 2000**

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

Two of three *Pulse Check* respondents[L, M] believe the city's overall drug problem is very serious, and one[E] believes it is somewhat serious.

Sources report several positive changes in illegal drug activity in Portland:

- The increased use of task forces has been successful in combating drug distribution.[L,E]
- Methylenedioxymethamphetamine (MDMA or ecstasy) use may be leveling off: The drug remains available at raves in the suburbs, but the number of raves decreased.[L]

Heroin and other opiate abuse and activity appear to be increasing:

- New heroin users increased. This group of new users tends to present to treatment as male-female couples.[E]
- OxyContin® (oxycodone hydrochloride controlled-release) abuse increased somewhat,[E] and diverted OxyContin® became more available.[L]
- Methadone-related overdose deaths increased, especially those with heroin or OxyContin® present.[L] This occurrence may be due to budget cuts in the methadone treatment programs: methadone treatment clients may be "trying to stretch the methadone with heroin or other drugs."[L]
- Hydrocodone (Vicodin®) abuse has increased somewhat. Most new users are young mothers without a history of drug use. These users may be feigning illness to obtain the drug from doctors, pain management clinics, or dentists.[E]

Methamphetamine use and production increased:

- New methamphetamine users, who tend to be gay males of middle to high socioeconomic status, increased.[E]
- Methamphetamine use replaced cocaine use in non-urban areas of Portland.[L]
- Methamphetamine "superlab" seizures have increased (from 4 to 10 superlabs). Moreover, local labs continue to produce ice (high-purity, smokable methamphetamine), and that form of the drug is preferred by users.

New marijuana sales groups are emerging:

- Organized dealers from Mexico and California who import the drug to Portland
- Organized dealers (mostly biker and Asian groups) from Canada who import British Columbian marijuana (BC bud).

The most widely abused drug reported varies by source, but all respondents agree that heroin is the drug related to the most serious consequences. Emerging drugs of abuse include OxyContin® (as reported in 14 other *Pulse Check* cities) and dextromethorphan (in Coricidin HBP® cold tablets). Ecstasy, gamma hydroxybutyrate (GHB), and ketamine continue to be available since emerging in spring 2002.[L]

Most widely abused drug:
- Marijuana[L]
- Methamphetamine[E]
- Heroin[M]

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

Second most widely abused drug:
- Heroin[L, E]
- Methamphetamine[M]

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

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

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

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

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

New or emerging problems:
- Methadone overdoses[L]
- Dextromethorphan[L]
- Diverted OxyContin®[L]

Sources: [L]Law enforcement, [E]Epidemiologic/ ethnographic, and [M]Methadone treatment respondents
Note: These symbols appear throughout this city profile to indicate type of respondent. The non-methadone treatment source did not respond.

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. When possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

Heroin use and activity have increased slightly:

- Smoking the drug is increasing as a route of administration.[E,M]
- The number of new users increased between spring and fall 2002.[E]
- Heroin-related overdose deaths increased 6 percent between 2001 and 2002.[E]

COCAINE

Crack activity and use are low and stable. Powder cocaine activity and use are relatively high and stable.

MARIJUANA

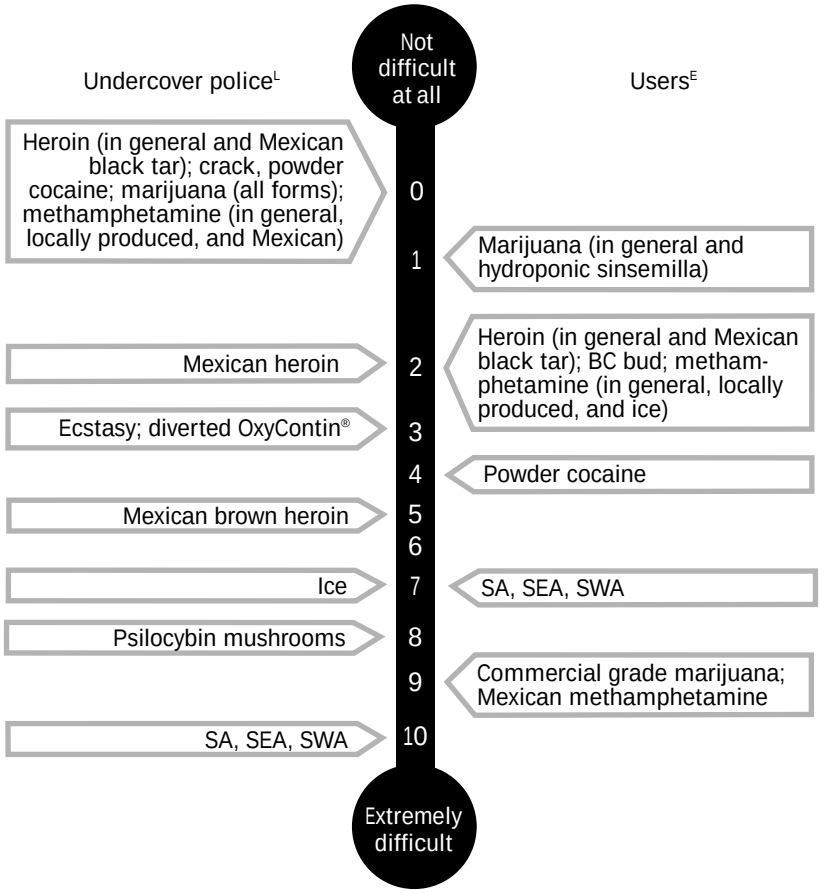
Marijuana use and activity remain relatively stable at high levels. BC bud is increasingly available as imports from Canada have increased.[L]

METHAMPHETAMINE

Methamphetamine use and activity have increased:

- Some increase is reported among new methamphetamine users who tend to be gay males of middle to high socioeconomic status.[E]
- Methamphetamine use has replaced cocaine use in nonurban areas of Portland.[L]
- Methamphetamine superlab seizures have increased since spring 2002, and local labs continue to produce ice.

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



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

- *Both sources agree that Mexican black tar heroin, marijuana, and methamphetamine are relatively easy to obtain.*[L,E]
- *Several drugs are less difficult for undercover officers to buy in fall 2002: Mexican black tar heroin; marijuana (all forms, especially BC bud); methamphetamine (all forms, including ice); and diverted OxyContin®.*
- *Portland is one of only three* Pulse Check *cities where it has become easier to obtain BC bud. (The other two are Minneapolis/St. Paul*[L] *and St. Louis).*[E]
- *The epidemiologic source states that between fall and spring 2002 the difficulty of obtaining drugs remained stable.*
- *Commercial grade marijuana is difficult to obtain because few sellers carry it. High potency BC bud and hydroponic marijuana have taken over the market.*[E]

PRESCRIPTION OPIATES

- Diverted OxyContin®: Between spring and fall 2002, OxyContin® abuse has increased somewhat,[E] and the drug become more available.[L] Heroin addicts may be substituting OxyContin® for heroin.[E]
- Methadone: Methadone-related overdose deaths have increased, especially those with heroin or OxyContin® present.[L]
- Hydrocodone (Vicodin®): Abuse has increased somewhat. Most new users are young mothers without a history of drug use.[E]

OTHER DRUGS

- Ecstasy: Ecstasy use is relatively low and stable. Raves appeared less common in fall 2002 than during spring 2002.[L]
- Dextromethorphan tablets (in Coricidin HBP®): Among 12–17-year-olds, dextromethorphan-related overdoses increased.[L]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- The *Pulse Check* methadone treatment respondent, whose 680 outpatient and residential facility operates over capacity, reports stable drug use. Methamphetamine continues as the most common secondary drug of abuse among primary heroin clients.[M]
- Methadone maintenance treatment is available throughout the metropolitan area, but in fall 2002, public and private treatment programs have few or no slots available. The epidemiologic source states that funding has been seriously impacted by State budget cuts and Medicaid budget changes and that many methadone clinics have had to close.[E]
- Hepatitis C among clients in the methadone treatment program remains a common problem, and prevalence has increased since spring 2002. Common comorbid illnesses among methadone treatment clients include mood and personality disorders, which have remained stable.
- Barriers to methadone treatment include limited slot capacity and lack of transportation or money for transportation. Slot capacity has become more limited due to a funding crisis within the State.[M]

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	M
Age group (years)	>30	>18
Mean age (years)	NR	36
Gender	Split evenly	58% male
Race/ethnicity	White	White
Socioeconomic status	Low	Low
Residence	Central city	Suburbs
Referral source	N/A	Individual
Level of education completed	N/A	High school
Employment at intake	N/A	Unemployed

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

- *The methadone treatment source reports no changes in heroin user demographics since spring 2002.*
- *The epidemiologic source reports some increase in new heroin users. This group of new users tends to present to treatment as male-female couples.*
- *Heroin users new to methadone treatment tend to be young adults of middle-to-high socioeconomic status and from the suburbs, while heroin users overall tend to be adults older than 30 who are of low socioeconomic status and live in the central city.*[M]

How do users take heroin?

Characteristic	E	M
Primary route of administration	Injecting	Injecting
Other drugs taken	Powder cocaine (speedball)	Cocaine
Publicly or privately?	Both	Privately
Alone or in groups?	Alone	Alone

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

Most heroin users in Portland inject; however, several populations are switching to smoking:

- *New heroin users (especially suburban youth) tend to smoke the drug.[E]*
- *Some older heroin users have switched to smoking heroin due to collapsed veins.[M]*

WHO'S MOST LIKELY TO USE COCAINE?

Crack is not a large problem in Portland.[E]

Powder cocaine users tend to be older than 30, split evenly between the genders, White, and of low socioeconomic status.[E] Sources report no changes in user characteristics since spring 2002.[E]

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

Marijuana, used either alone or with other drugs, is associated with drug-related arrests and poor academic performance (especially among new marijuana users). These consequences remained stable between spring and fall 2002.[E]

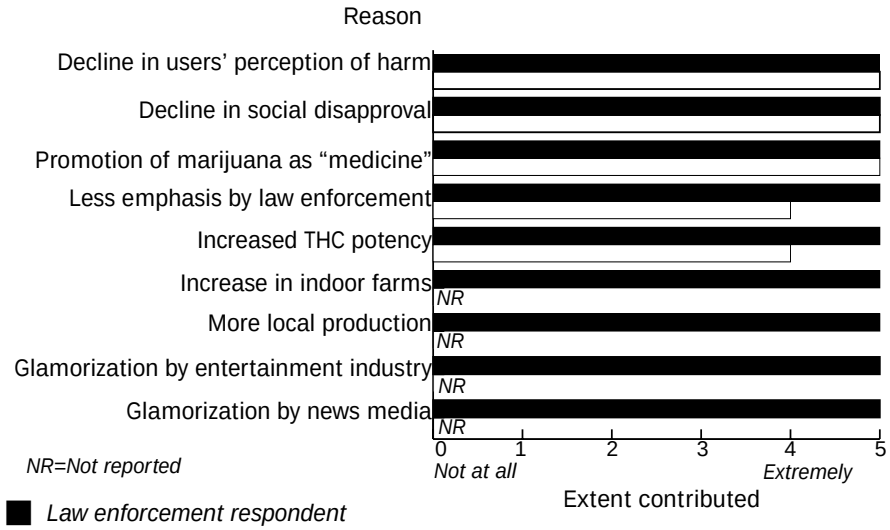
Who's most likely to use marijuana, and how is the drug used?

Characteristic	E
Age group (years)	>30
Gender	Split evenly
Race/ethnicity	White, Black, and Hispanic (any race)
Socioeconomic status	Low and middle
Residence	All areas
Primary delivery vehicle	Bongs and pipes
Public or private?	Both
Alone or in groups?	In groups

Source: [E]Epidemiologic/ethnographic respondent

- *Marijuana use has remained relatively stable between spring and fall 2002.[E]*
- *A new group of marijuana users includes homeless youth and young adults in college.[E]*
- *Due to the high THC content of marijuana in Portland, bongs and pipes are the most common delivery vehicles for the drug.[E]*

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



What they have to say...

- *These two sources agree that the decline in users' perception of harm, the decline in social disapproval of marijuana, and the promotion of marijuana as "medicine" have contributed greatly to the widespread availability and use of marijuana.[L,E]*
- *Less emphasis by law enforcement and courts also rates as greatly contributing to the widespread use of marijuana.[L,E] The epidemiologic source believes that marijuana possession laws in Portland are too lenient.[E] (Marijuana possession is a ticketed offense and not a misdemeanor.)*

Who's most likely to use methamphetamine, and how is the drug used?

Characteristic	E
Age group (years)	>30
Gender	Split evenly
Race/ethnicity	White
Socioeconomic status	Low
Residence	Central city and rural
Primary delivery vehicle	Injecting
Other drugs taken	Marijuana (sequentially), heroin (speedball), ketamine, ecstasy, or GHB (in combination)
Public or private?	Private
Alone or in groups?	Both

Source: Epidemiologic/ethnographic respondent

- *Some increase is reported among new methamphetamine users who tend to be gay males of middle-to-high socioeconomic status. This new group tends to smoke the drug and often uses ketamine, ecstasy, or GHB in combination with methamphetamine.*[E]
- *Drug users who take methamphetamine and marijuana are referred to as "tweekers."*[E]

WHO'S MOST LIKELY TO USE ECSTASY?

Ecstasy use is present in gay and adolescent communities in Portland.

Who's most likely to abuse OxyContin®, and how is it abused?

Characteristic	E
Age group (years)	>18
Gender	70% male
Race/ethnicity	White
Socioeconomic status	Low
Residence	Central city
Primary route of administration	Injecting and oral
Other drugs taken	Heroin (as a substitute or sequentially)

Source: Epidemiologic/ethnographic respondent

- *Between spring and fall 2002, OxyContin® abuse has increased somewhat.*[E]
- *Now that funding for methadone treatment programs has been cut, the epidemiologic respondent believes that an increase in the abuse of OxyContin® could occur. Heroin users increasingly are substituting OxyContin® for heroin.*[E]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin and powder and crack cocaine are sold mostly in central city areas at the following locations:[L]

- Streets/open-air markets
- Crack houses and shooting galleries
- Inside private residences
- Public housing developments
- In or around schools and college campuses
- Private parties
- Hotels/motels
- Inside cars

Additionally, heroin is sold around drug treatment clinics, and powder cocaine is sold at nightclubs, bars, and concerts.[L]

Methamphetamine is sold in open-air markets, inside private residences (referred to as "drug houses"), and inside cars.[L]

Ecstasy is typically sold at raves in the suburbs, although the law enforcement source states that few raves have been held since spring 2002.[L]

HOW DO DRUGS GET FROM SELLER TO BUYER?

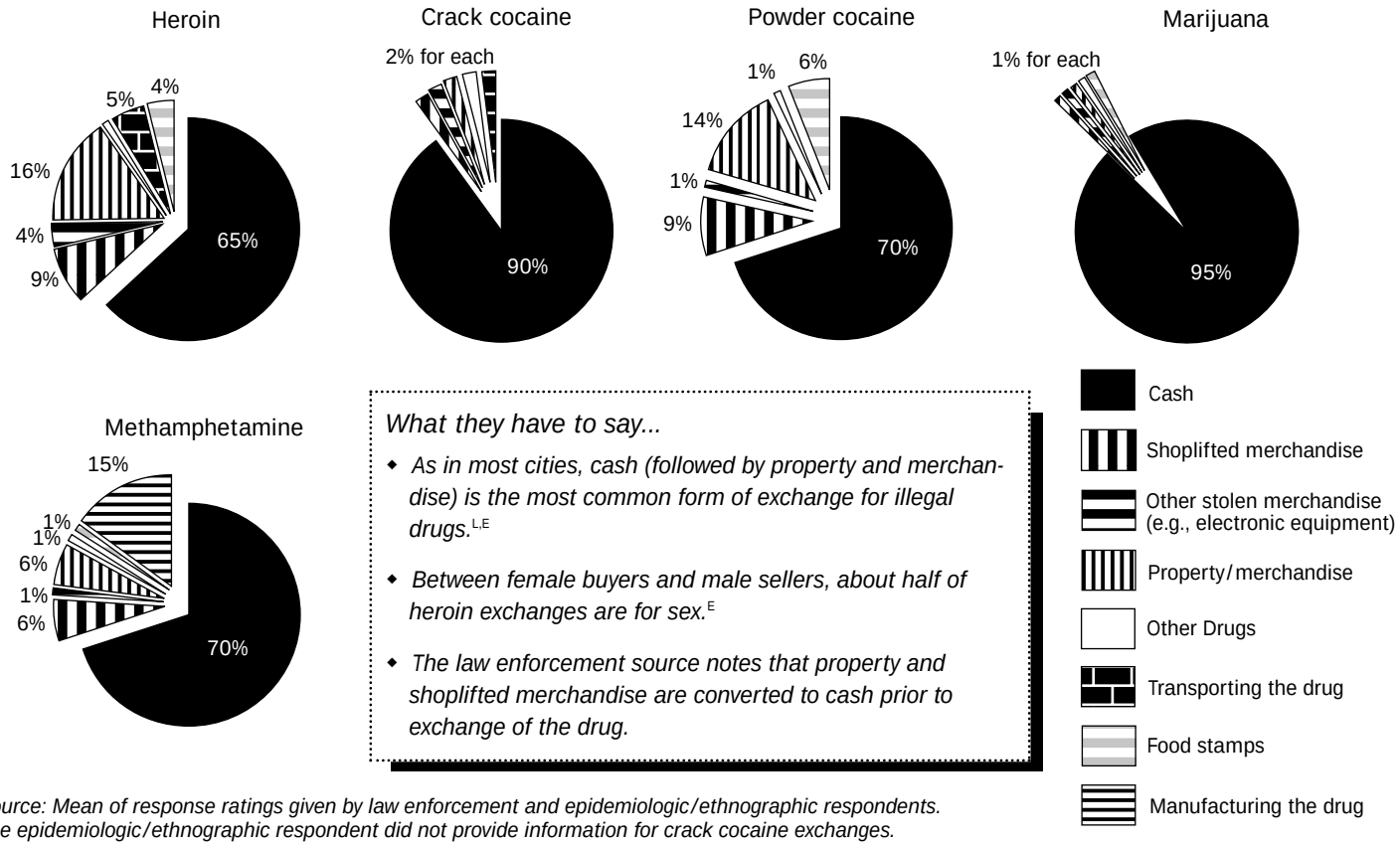
Heroin, crack, powder cocaine, and marijuana can be purchased in several ways, including the following:[L]

- A buyer may approach a seller at an open-air market in downtown Portland for a hand-to-hand exchange.
- A buyer may contact a seller via cell phone for drug delivery.

Additionally, powder cocaine sales may include Internet communication between buyer and seller.

Methamphetamine sales, which occur mostly in suburban and rural areas, tend to take place at local residences.

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



Source: Mean of response ratings given by law enforcement and epidemiologic/ethnographic respondents. The epidemiologic/ethnographic respondent did not provide information for crack cocaine exchanges.

WHO SELLS HEROIN, CRACK, AND POWDER COCAINE?

- Heroin and powder cocaine sellers are mostly young adults (18–30 years) organized into small "cells" or groups. Within the group, a "leader" supplies street sellers with small quantities of the drug to sell. The quantity is small enough to swallow or get rid of easily.
- Crack sellers are organized similarly to heroin sellers, but they tend to be more street-gang oriented.

WHO SELLS MARIJUANA?

Marijuana sellers fall into several groups, including the following:

- Independent dealers who sell marijuana grown in small, local "grows"
- Organized dealers who sell marijuana grown in large, local grows that produce high-quality marijuana
- Organized dealers from Mexico and California who import the drug into Portland; this sales group's market share has increased dramatically since spring 2002.
- Organized dealers (mostly biker and Asian groups) from Canada who import BC bud; these groups have emerged since spring 2002.

WHO MANUFACTURES AND SELLS METHAMPHETAMINE?

Methamphetamine sellers tend to be young adults (18–30 years) who fall into one of several groups:[L,E]

- Independent sellers who sell small amounts of the drug produced in small local labs
- Methamphetamine users who manufacture their own "stash" in "backpack labs" (small, portable meth labs)
- Highly organized sellers who deal methamphetamine from large superlabs in Portland or who sell imported methamphetamine from superlabs in California or Mexico.

WHO SELLS ECSTASY?

Ecstasy sellers tend to be adolescents (13–17 years) who sell the drug at organized raves, which have decreased since spring 2002. GHB is often sold by ecstasy dealers.

Which drug sellers are associated with which crimes?

Crime	Heroin, Powder and Crack Cocaine, and Marijuana	Metham-phetamine	Ecstasy
Prostitution	✓	✓	
Gang-related activity	✓	✓	
Violent criminal acts: robberies	✓	✓	
Nonviolent criminal acts	✓	✓	
Domestic violence		✓	
Drug-assisted rape		✓	✓
Child abuse and neglect	✓	✓	

Source: Law enforcement respondent

- *While all illegal drug sellers in Portland are associated with many crimes other than drug sales, methamphetamine sellers continue to be involved in the most crimes, including domestic violence and drug-assisted rape.*[L]
- *The law enforcement source adds that illegal drug sellers are often involved in child abuse and neglect.*

How pure are illegal drugs, and how much do they cost?

Drug	Unit	Purity	Price
Mexican black tar heroin	One balloon (0.2–0.4 g) 1 g 1 oz	68–70%	$20 $40–$100 $800–$1,250
Crack	One rock (0.1 g) 1 g	62–83%	$10 $45–$100
Powder cocaine	One balloon 1 oz	83%	$20–$40 $400–$650
Marijuana (local or BC bud)	One bag (1 oz)	23–33% THC	$250+
Methamphetamine	1/16 oz (“teener”) 1 oz	8–42%	$120–$150 $550–$600
Ecstasy	One pill	NR	$15–$20
Diverted OxyContin®	One pill	N/A	$50

Source: Law enforcement respondent

- *Heroin, crack, and powder cocaine prices decreased at all unit levels between spring and fall 2002. Purity remained relatively stable.*[L]
- *Prices and purity for other drugs remained relatively stable between spring and fall 2002.*[L]

DRUG MARKETING INNOVATIONS AND TOOLS OVER THE PAST 10 YEARS: TO WHAT DEGREE HAVE THEY COMPLICATED EFFORTS TO DETECT OR DISRUPT DRUG ACTIVITY IN PORTLAND?

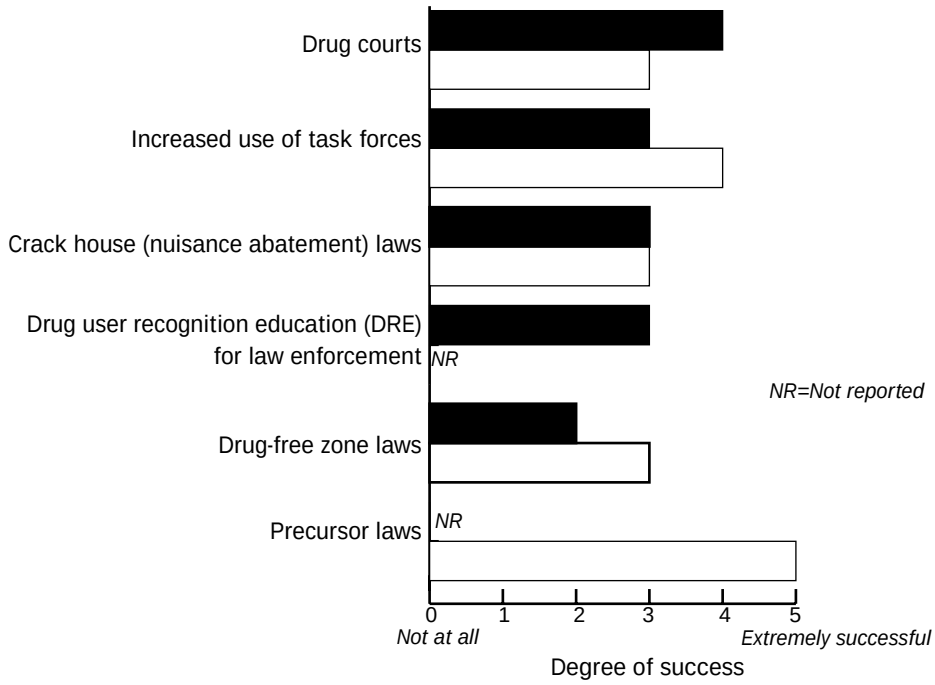
The law enforcement source states that the following have greatly contributed to difficulties in detecting or disrupting drug activity over the last 10 years:

- Throwaway cell phones
- More organized distribution networks
- Polydrug dealers
- Expansion of drug sales beyond the central city
- Relocation of sales settings within the community

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

What they have to say...

- *Task forces: As in most* Pulse Check *cities, respondents agree that the increased use of task forces has been somewhat successful in combating drug distribution.*[L,E]
- *Precursor laws: The epidemiologic source states that new precursor laws have forced methamphetamine manufacturers to change the way they make the drug. The law enforcement source believes that because the precursor laws are new, their success cannot yet be measured.*



SEPTEMBER 11 FOLLOWUP

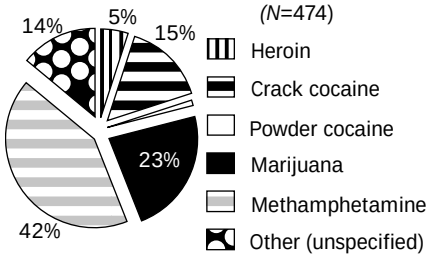
None of the three Portland *Pulse Check* respondents believes that the September 11 attacks and their aftermath have had any effects on the drug abuse problem.

SACRAMENTO PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 1,628,197
- Median age: . . . . . 35.1 years
- Race (alone):
  - White. 70.2%
  - Black 7.7%
  - American Indian/ Alaska Native 1.1%
  - Asian/Pacific Islander 9.4%
  - Other race 6.5%
  - Two or more races 5.2%
- Hispanic (of any race): 14.4%
- Unemployment rate: 3.9%
- Median household income: $46,602
- Families below poverty level with children <18 years: 13.1%

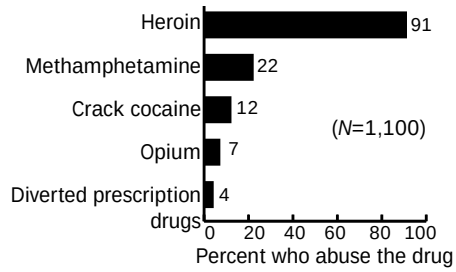
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



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

Source: Methadone treatment respondent

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

Three of the *Pulse Check* respondents agree that Sacramento's drug problem is stable,[L,E,M] while the fourth reports a worsening situation.[N] Three agree that the problem is very serious.[E,N,M] Several developments are reported since spring 2002:

- The methamphetamine situation has improved somewhat in that legislation has made it more difficult for manufacturers to obtain precursors.[L]
- Proposition 36, which took effect July 2001, mandates probation with treatment for nonviolent drug offenders (until their third conviction, when the law limits incarceration to 30 days).
- Proposition 36 has helped to send many users to treatment rather than to prison. This influx, however, has further limited treatment availability, particularly for indigents.[N]
- More males are entering treatment since the passage of Proposition 36, correlating to more male involvement in the criminal justice system.[E]
- The proportion of primary powder cocaine and primary heroin users in treatment has decreased somewhat since the spring.[N] However, the use of heroin among White youth is increasing.[E]
- Abuse of yaba (containing 80 percent methamphetamine) is increasing. The yaba found in Sacramento comes from Asia and is marketed to Sacramento's Asian population.[E]
- Stimulant use, particularly of methamphetamine and crack, is increasing among Asian clients.[M]
- More marijuana is produced by local businesses who use their legitimate business to support their marijuana production.[L]

Overall, methamphetamine is considered the most widely abused drug in Sacramento by three of the four respondents.[L,E,N] It is the only *Pulse Check* city where all four sources associate methamphetamine with the most serious drug-related consequences.

Most widely abused drug:
Methamphetamine[L,E,N]
Heroin[M]

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

Second most widely abused drug:
Crack cocaine[L,N,M]
Methamphetamine[M]
Marijuana[E]

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

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

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

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

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

New or emerging problem:

Yaba (a form of methamphetamine) use is increasing, particularly among the Asian population.[E]

Heroin use is increasing among White youth.[E]

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

- *Overall, the proportion of primary methamphetamine and crack users decreased but the methamphetamine proportion increased among new treatment clients.*[N]
- *Methamphetamine use has declined slightly among methadone clients.*[M]
- *Smoked opium is the primary drug of abuse among 7 percent of methadone clients.*[M]

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

Overall, the heroin problem is fairly stable, with two changes noted:

- The proportion of primary heroin users in non-methadone treatment has decreased since 2002.[N]
- Throughout the city, heroin use appears to be increasing among White youth.[E]

COCAINE

The proportion of primary powder cocaine users in treatment has declined since spring 2002, among both the overall treatment population and new treatment clients.[N]

MARIJUANA

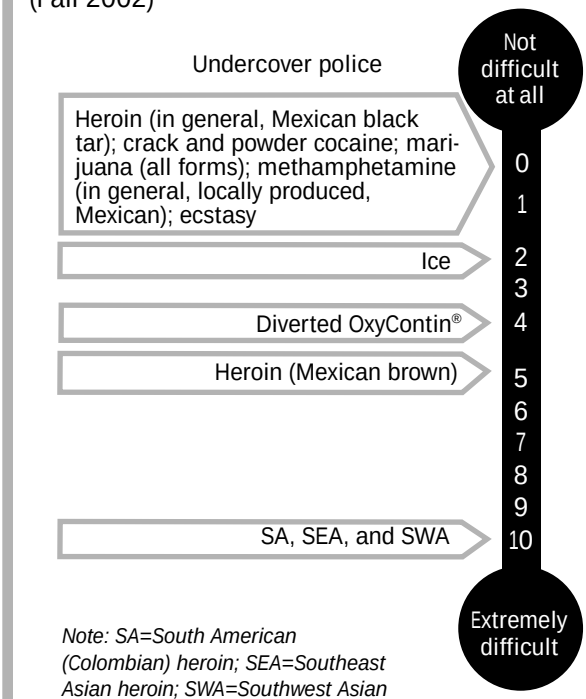
- Marijuana is the primary drug of abuse among preadolescents (13 and younger) and adolescents (13–17) in Sacramento.[N]
- The proportion of primary marijuana users in treatment has increased since spring 2002, likely due to the impact of Proposition 36.[N]

METHAMPHETAMINE

Both declines and increases are noted:

- Manufacturers find it difficult to obtain precursors, so they build labs to make their own by breaking down pills.

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



- *As in most western cities, undercover police have no difficulty purchasing methamphetamine or black tar heroin.*
- *Overall, no changes in availability are reported since the spring.*[L]

Note: SA=South American (Colombian) heroin; SEA=Southeast Asian heroin; SWA=Southwest Asian heroin; ice=highly pure methamphetamine in smokable form; and OxyContin®=Oxycodone hydrochloride controlled-release

Source: Law enforcement respondent

- The overall proportion of primary methamphetamine users in treatment has decreased somewhat since spring 2002. It has, however, increased among individuals new to treatment.[N]
- Methamphetamine use appears to be increasing, particularly among young adults.[E]
- The drug is produced in numerous settings throughout Sacramento, including small mobile labs, other clandestine labs, and large operations, using both the "cold" (red phosphorus) and "Nazi" (quick-cooking) methods.[L]

MDMA (ECSTASY)

- Since emerging as a new drug 5 years ago, ecstasy has become part of the city's traditional drug market.[L]
- Use among treatment clients remains stable at low levels.[N,M]

OTHER DRUGS

- The abuse of diverted OxyContin® and other prescription drugs such as hydrocodone (Vicodin®) remains stable at low levels.[M]
- Opium abuse remains a small, but stable, problem among methadone treatment clients.[M]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone treatment source is with a facility that can serve 425 outpatients, 40 residential clients, and 18 detox patients. The program currently serves 418 outpatients, 40 residential clients, and 16 detox patients. The most common primary drug of abuse among these clients is methamphetamine *(see pie chart on the first page of this chapter)*, in contrast to most other *Pulse Check* cities.[N]
- The methadone treatment respondent is with a three-clinic program whose overall capacity is 1,275. Current enrollment is 1,100. Unlike methadone clients in many other *Pulse Check* cities, these heroin users' most common secondary drug of abuse is methamphetamine *(see bar graph on the first page of this chapter)*.[M]

Co-occurring disorders

- Staff are better trained to treat comorbidities than they were in the past, making treatment more available to clients with dual diagnoses.[N]
- An estimated 25–50 percent of clients have mental health issues in addition to their drug addiction.[N]
- Noted increases in antisocial, conduct, and mood disorders are due to more effective diagnostic efforts in some treatment programs.[N]
- While antisocial and conduct disorders are common upon admission, once clients are on methadone the disorders tend to disappear.[M]
- Clients referred to treatment through Proposition 36 are often older users with mental health problems; most are also new to treatment.[M]
- Some treatment providers observe an increase in psychosis among clients. This change is attributed to Proposition 36, because mental illness—particularly schizophrenia—is common among arrestees.[M]

Barriers to treatment

- Limited slot capacity, which remains the primary barrier to treatment, has worsened since spring 2002 in some treatment programs.[N]
- A lack of transportation is increasing as a barrier to treatment due to the weakened economy.[M]
- Lack of funding remains a significant barrier to treatment for indigent patients.[M]
- A significant Russian population resides in Sacramento, but drug users in this community often do not enter treatment due to cultural and language barriers.[M]
- A lack of housing and employment opportunities for recovering clients represents a serious complication to users' long-term recovery.[N,M]

Consequences of drug use

- High-risk pregnancy has decreased since spring 2002 among methadone treatment clients, although it is still not uncommon.[M]
- Drug-related car accidents are stable at low levels as a result of stiffer legal consequences.[N]
- Prevention efforts and early detection of HIV/AIDS has kept the number of HIV-positive clients either stable at, or decreasing to, low levels.[N,M]
- The incidence of hepatitis C increased to high levels among treatment clients, likely due to followup testing efforts by program staff.[N] Nearly 100 percent of injecting drug users are positive for hepatitis C.[M]
- Heroin users present with more severe abscesses as a result of injecting heroin cut with pectin (a fruit preservative).[M]

Changes over the past 10 years

- Significant price declines for heroin, crack cocaine, and methamphetamine have exacerbated the drug problem.[M]
- The city's drug problem increased in complexity with the availability of new and substitute drugs such as ecstasy, gamma hydroxybutyrate (GHB), and club drugs.[N]
- A significant change in the past decade has been the spread of drug use among youth—club drugs and alcohol in particular.[N]
- Proposition 36 has added to the complexity of Sacramento's drug problem by dramatically increasing court referrals.[N,M] This influx of clients added 100 new treatment cases to the methadone program,[M] and has increased the need for more residential treatment programs.[N]

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	18–30	>30
Mean age (years)	NR	NR	42
Gender	56% male	73% male	60% male
Race/ethnicity	White	White	White
Socioeconomic status	NR	Middle	Low
Residence	NR	Central city	Central city
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	Junior high	High school
Employment at intake	N/A	Unemployed	Unemployed

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

- *The proportion of primary heroin users in treatment decreased since spring 2002. This decline may be related to changes in slot capacity rather than declines in use.*[N]
- *The proportion of females in treatment for primary heroin use is higher among clients new to treatment than among the overall heroin treatment population.*[N]
- *While Whites represent the majority of primary heroin users in methadone treatment, Hispanic clients represent 20 percent, twice the proportion of Black clients.*[M]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs	NR	Crack (speedball)	Methamphetamine
Publicly or privately?	NR	Privately	Privately
Alone or in groups?	NR	Alone	Alone

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

- *Users sometimes adulterate heroin with lactose, instant coffee, horseshoe pack, quinine, and sugar,*[N] *as well as shoe polish and various dyes.*[M]
- *Dealers often cut heroin with methamphetamine; as a result, treatment clients often test positive for methamphetamine even though they claim to use only heroin.*[M]
- *Primary heroin users new to treatment are more likely to be polydrug users, in contrast to the overall heroin treatment population.*[M]

Who's most likely to use cocaine?

Characteristic	Crack Cocaine			Powder cocaine	
	E	N	M	E	N
Age group (years)	>30	13–17	>30	>30	18–30
Mean age (years)	NR	NR	42	NR	NR
Gender	Split evenly	60% male	60% male	Split evenly	64% male
Race/ethnicity	Black	Black	White	Black	Black
Socioeconomic status	NR	Low	Low	NR	Middle
Residence	NR	Central city	Central city	NR	Central city
Referral source	N/A	Criminal justice	Criminal justice	N/A	Criminal justice
Level of education completed	N/A	High school	High school	N/A	High school
Employment at intake	N/A	Unemployed	Unemployed	N/A	Unemployed

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

- *Blacks represent an increasing proportion of cocaine users, rising from 69 percent to 75 percent between spring and fall 2002.*[E]
- *Primary crack cocaine users often combine marijuana (THC or weed) with crack.*[N]
- *Primary powder cocaine users often combine the drug with opiates (speedball).*[N]
- *Crack and powder cocaine users add adulterants to the cocaine such as baking powder, baking soda, ether (for crack), and infant laxatives (for powder cocaine).*[N]

- *While the majority of primary marijuana users are young adults, more than 20 percent are adolescents.*[E]
- *Primary marijuana users in treatment are most often referred by the criminal justice system for both possession and sale of the drug.*[N]

Who's most likely to use marijuana?

Characteristic	E	N
Age group (years)	18–30	18–30
Gender	61% male	58% male
Race/ethnicity	White	White/Black
Socioeconomic status	NR	Middle
Residence	NR	Central city
Referral source	N/A	Criminal justice
Level of education completed	N/A	Junior high
Employment at intake	N/A	Unemployed

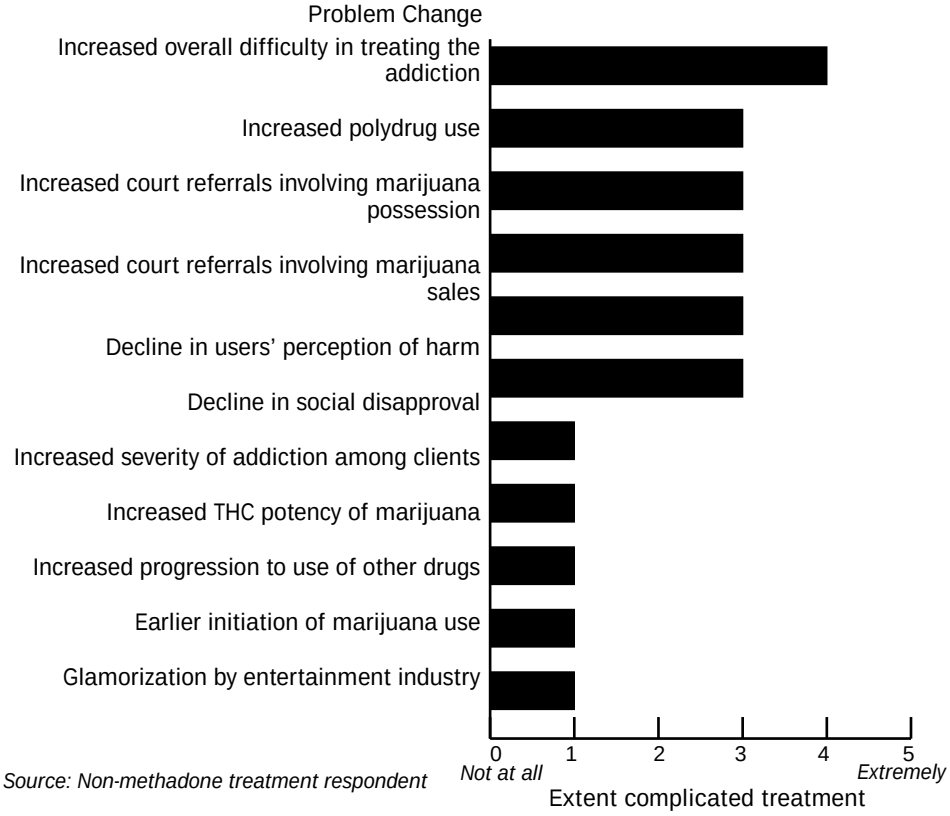
Sources: [E]Epidemiologic/ethnographic respondent and [N]Non-methadone treatment respondent

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

- Drug-related arrests
- Automobile accidents
- Short-term memory loss
- Deteriorating family and/or social relationships
- Poor academic performance
- School absenteeism or truancy
- Dropping out of school
- Poor workplace performance
- Workplace absenteeism
- Unemployment rates

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



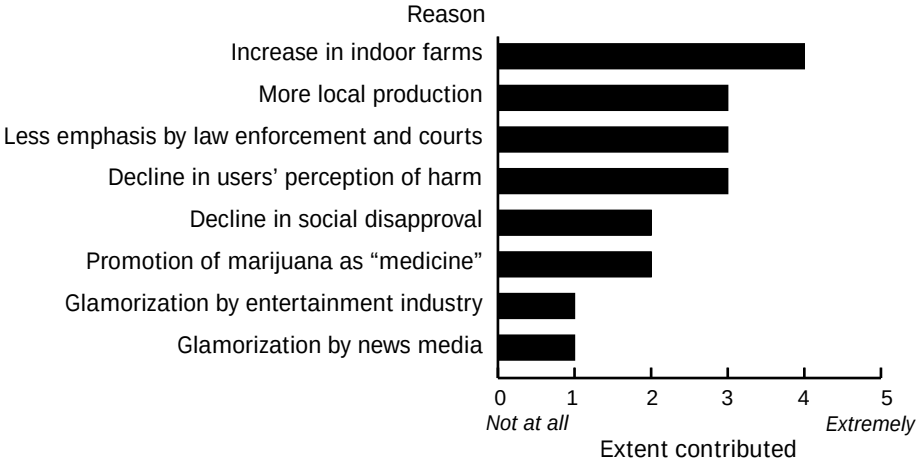
Source: Non-methadone treatment respondent

- *Perception of harm: The legalization of marijuana for "medicinal" purposes has added to a decline in society's perception of harm associated with the drug.*[N]
- *Social disapproval: Not only has social disapproval associated with marijuana use declined over the past 10 years, but in some social settings, individuals are looked down upon if they do not use the drug.*[N]
- *Earlier initiation of marijuana use: Earlier first use among youth age 9–13 has made treating the addiction more difficult.*[N]
- *Polydrug use: Polydrug use is "everywhere."*[N]
- *THC levels: The THC level in marijuana has increased over the past 10 years, complicating treatment. In fact, among many users, "THC" is the "in" drug.*[N]

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

What they have to say...

- *As in many other* Pulse Check *cities, glamorization by the news media has played a relatively minor role in increasing marijuana use and availability.*
- *Indoor farms run by larger businesses have increased; these businesses sell retail merchandise that supports the marijuana production inside.*[L]
- *Proposition 215, which legalized marijuana for "compassionate use," is ambiguous because it doesn't set forth specific thresholds; there are also many loopholes in the legislation.*[L]



Source: Law enforcement respondent

Who's most likely to use methamphetamine?

Characteristic	E	N	M
Age group (years)	>30	18–30, >30	>30
Mean age (years)	NR	NR	42
Gender	Split evenly	53% male	60% male
Race/ethnicity	White	White	White
Socioeconomic position	NR	Low	Low
Residence	NR	Central city	Central city
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	Junior high	High school
Employment at intake	N/A	Unemployed	Unemployed

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

- *Methamphetamine users in Sacramento are older than those in other* Pulse Check *cities (such as Chicago and Detroit).*[E,N,M] *However, the user population is now shifting toward younger adults.*[E]
- *The most common route of administration among methamphetamine users varies among different populations, from smoking*[E,N] *to injecting.*[M]
- *The majority of methamphetamine users in treatment are referred by the criminal justice system as a result of Proposition 36.*[N]

WHO'S MOST LIKELY TO USE OTHER DRUGS?

- Diverted prescription drugs: Seventy percent of abusers of diverted prescription drugs (primarily hydrocodone) are women. Most prescription drug abusers initially receive the drug for treatment of chronic pain and then become addicted. These clients typically have mental disorders and are very difficult to treat.[M]
- Opium: Primary abusers of smoked opium represent 7 percent of methadone treatment clients. These individuals are older than 30, split evenly between male and female, and are predominantly Asian/Pacific Islander. Treatment providers note an increase in the abuse of methamphetamine and crack among these clients.[M]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS SOLD?

Heroin and crack cocaine are sold in many of the same settings, including:[L]

- Streets/open-air markets
- Crack houses/shooting galleries
- Private residences
- Public housing developments
- College campuses
- Private parties
- Nightclubs/bars
- Hotels/motels
- Inside cars

Powder cocaine is sold in most of the same settings as heroin and crack, with the exception of crack houses/shooting galleries, public housing developments, and hotels/motels. Crack cocaine is sold around local schools.[L]

Marijuana transactions take place in most of the same settings as the other drugs.[L]

Methamphetamine and ecstasy are sold in fewer settings, including in private residences, nightclubs/bars, and inside cars. Methamphetamine is also sold on the streets and in hotels/motels, while ecstasy is sold on college campuses and at raves and concerts.[L]

HOW DO DRUGS GET FROM SELLER TO BUYER?

Drug transactions in Sacramento nearly always take place hand to hand from seller to buyer.[L]

Sellers of all drugs communicate with both buyers and suppliers in various ways: in person and by the telephone, cell phone, pager, and two-way e-mail pager.[L]

While powder cocaine, marijuana, and ecstasy dealers generally sell just one drug, dealers of heroin, crack cocaine, and methamphetamine typically sell all three.[L]

Which drug sellers are associated with which crimes?

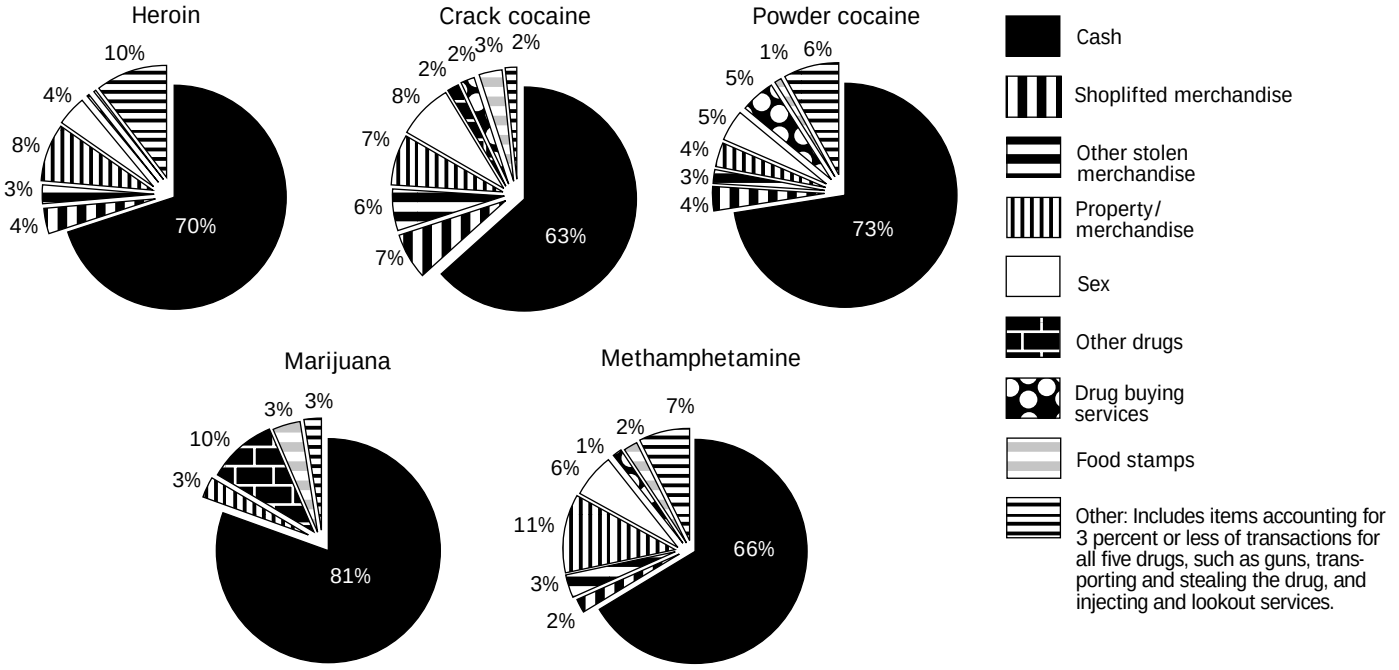
Crime	Heroin	Crack cocaine	Powder cocaine	Marijuana	Metham-phetamine	Ecstasy	Diverted OxyContin®
Gang-related activity		✓	✓				
Violent criminal acts	✓	✓	✓		✓		
Nonviolent criminal acts	✓	✓		✓	✓		
No crimes associated						✓	✓

Source: Law enforcement respondent

Marijuana sellers are often involved in nonviolent criminal acts such as receiving stolen property and committing burglaries. They are also commonly charged with driving under the influence (DUI).[L]

THE CHANGING DRUG MARKET: THE LAST 10 YEARS

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



Source: Mean of response ratings given by law enforcement, non-methadone treatment, and methadone treatment respondents; the epidemiologic/ethnographic respondent did not respond to this question; the methadone treatment respondent provided data for heroin, crack cocaine, and methamphetamine only.

What they have to say...

- *As reported in three other* Pulse Check *cities (Houston, Philadelphia, and San Francisco), the practice of exchanging sex for drugs has declined over the past decade due to the risk of HIV/AIDS and hepatitis C.*[N,M]
- *Many users ship stolen property and merchandise to Mexico in exchange for drugs such as heroin, crack cocaine, and methamphetamine.*[M]
- *Exchanging stolen merchandise for cash is much more difficult today due to stores' more stringent return policies, therefore reducing the practice of stealing goods to pay for drugs.*[N,M]

WHO'S SELLING HEROIN?

Heroin dealers tend to be young adults working as part of structured organizations, particularly Mexican nationals, Mexican gangs, and Asian gangs.[L]

WHO'S SELLING COCAINE?

Crack and powder cocaine dealers tend to be young adults involved in larger organizations. Crack dealers are typically part of traditional Black street gangs, while powder cocaine dealers are often Mexican nationals or members of Mexican or Asian gangs. Most of the crack cocaine sold in Sacramento is locally processed.[L]

WHO'S SELLING MARIJUANA?

Most marijuana dealers are young adults working independently and are almost always users themselves. Some members of organized crime also sell marijuana in order to have it as part of their "menu."[L]

WHO'S SELLING METHAMPHETAMINE ?

Methamphetamine dealers are generally young adults working within a larger organization. These dealers are often users of the drug.[L]

WHO'S SELLING ECSTASY, AND HOW MUCH DOES IT COST?

- Ecstasy dealers are generally young adults working independently, who are not involved in other criminal activity; they are almost always ecstasy users as well.[L]
- Ecstasy currently sells for $80 per pill.

WHO'S SELLING OTHER DRUGS?

Individuals who sell diverted OxyContin® do so independently. Some are users of the drug themselves, and they are generally not involved in any other criminal activity.[L]

How much does heroin cost?

Unit (Black tar heroin)	Price
0.25 g	$20–$40
1 g	$90–$100
1 oz	$500–$800

Source: Law enforcement respondent

- *The ounce price of black tar heroin (the most common form) changed from $600–$750 in spring 2002 to a wider range of $500–$800 in fall 2002.*[L]
- *Purity of black tar heroin is 16–18 percent, representing an increase between spring and fall 2002.*[L]

How much does cocaine cost?

Form	Unit	Price
Crack	0.2 g	$20
	1 g	$100
	1 oz	$450–$750
Powder	1 oz	$500–$600
	1 g	$80
	1 kg	$14,000–$17,000

Source: Law enforcement respondent

- *The price for a gram of powder cocaine decreased from $100 to $80 between spring and fall 2002, while the price of a kilogram increased from $10,000–$15,000 to $14,000–$17,000.*[L]
- *The price of crack cocaine is unchanged.*[L]
- *Powder cocaine purity is 78 percent, while crack cocaine purity ranges from 60 to 85 percent.*[L]

How much does marijuana cost?

Unit	Price
1 g	$25
1 oz	$200–$250
1 lb	$1,000–$1,200

Source: Law enforcement respondent

All reported prices are stable between spring and fall 2002.

How much does methamphetamine cost?

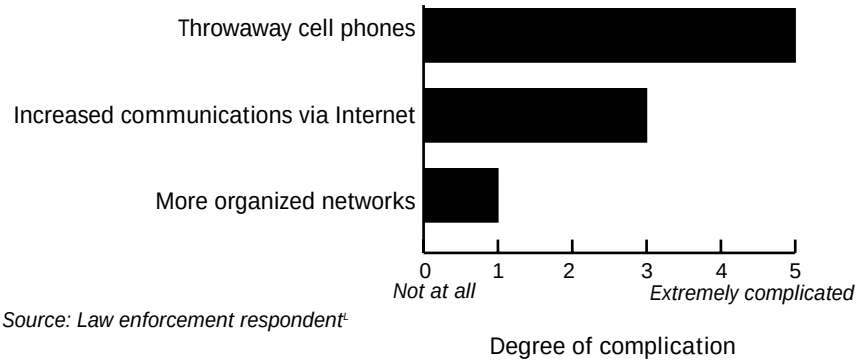
Unit	Price
1 g	$80
1 oz	$300–$600

Source: Law enforcement respondent

- *The ounce price of methamphetamine declined between spring and fall 2002.*[L]
- *Methamphetamine purity also declined slightly to approximately 20 percent.*[L]

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

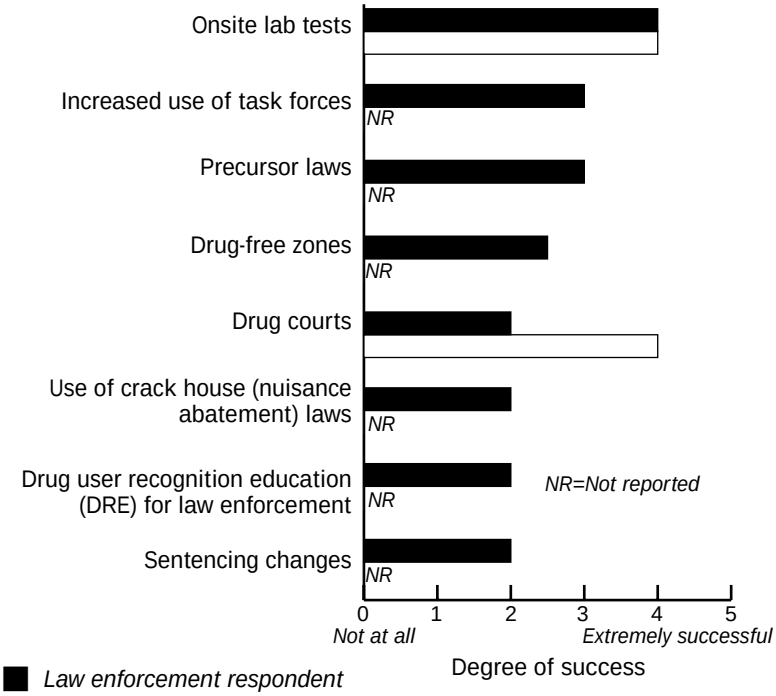
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in Sacramento?



Source: Law enforcement respondent[L]

- *Detection and disruption efforts have not been hampered much by more organized networks.*
- *As in many cities across the Nation, advancing technologies such as cell phones and the Internet have seriously complicated law enforcement's ability to detect and disrupt drug activity.*[L]

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



SEPTEMBER 11 FOLLOW UP

Three of the four *Pulse Check* respondents note continuing effects of the September 11 attacks and their aftermath on Sacramento's drug problem.[L,N,M]

- The law enforcement respondent notes that a shift in priority from combating the drug problem to fighting terrorism has put law enforcement at a disadvantage, particularly with respect to technical support systems such as wiretaps.[L]
- A continued impact on mental health is evidenced by a sustained increase in referrals through a dual diagnosis program.[N] This pattern is likely due to frightened users turning more heavily to drugs for relief.[M]

What they have to say...

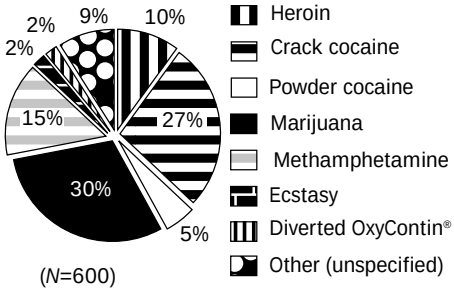
- *The methamphetamine situation has improved somewhat in that legislation has made it more difficult for manufacturers to obtain precursors.*[L]
- *Onsite lab tests are very successful in disrupting Sacramento's drug markets.*[L,E] *This is beneficial not just to law enforcement, but also to child protective services, because it helps to ensure that parents are not continuing drug activity while their children are in out-of-home placements.*[E]
- *Sacramento law enforcement has three task forces focused specifically on methamphetamine. They also operate task forces with the Drug Enforcement Administration (DEA), High Intensity Drug Trafficking Area (HIDTA), California Multi-Jurisdictional Methamphetamine Enforcement Team (Cal-MMET), and Crack Rock Impact Sacramento (CRIPS).*[L]
- *All narcotic teams operating within law enforcement are DRE certified; these individuals then train patrol officers.*[L]
- *As reported in the majority of* Pulse Check *cities, drug courts have met with great success.*[E] *Adult and dependency drug courts operate currently. A juvenile drug court is now awaiting funding.*[E]

ST. LOUIS METROPOLITAN STATISTICAL AREA PROFILE:

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

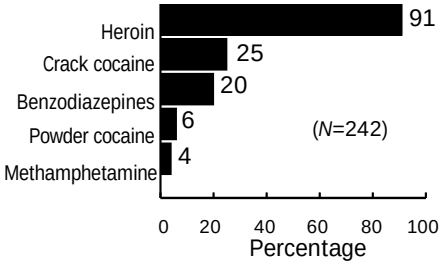
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



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

Source: Methadone treatment respondent

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

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

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

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

SPRING 2002 VS FALL 2002

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

Most widely abused drug:
Marijuana[L,E,N]
Heroin[M]

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

Second most widely abused drug:
Crack[L,E,M]
Methamphetamine[N]

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

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

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

Drug related to the second most serious consequences:
Crack cocaine[N,M]
Methamphetamine[L]
Marijuana[E]

Changes between spring and fall 2002: Methamphetamine has replaced heroin as the drug associated with the second most serious consequences.[L]

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

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

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

COCAINE

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

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

MARIJUANA

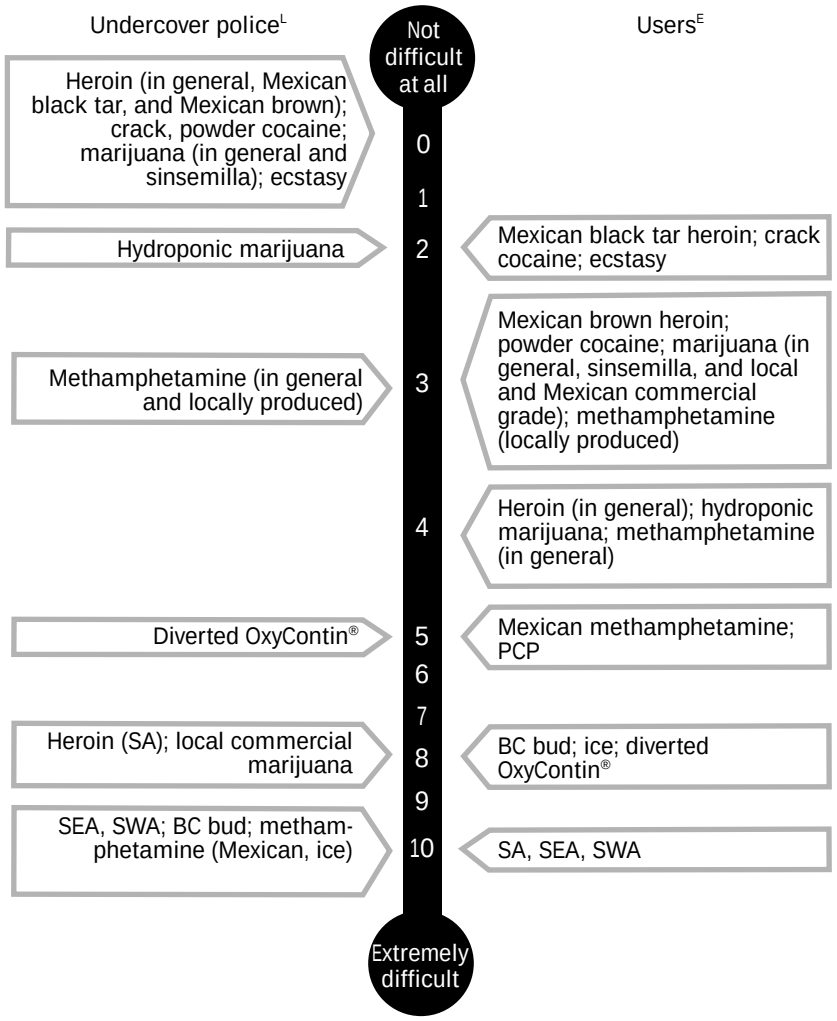
Three of the four respondents consider marijuana St. Louis's most widely abused drug.[L,E,N] *Use among treatment clients, however, is stable.*

METHAMPHETAMINE

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

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

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



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

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

MDMA (ECSTASY)

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

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

OTHER DRUGS

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

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

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

Barriers to treatment

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

Consequences of drug use

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

Co-occurring disorders

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

spring among methadone treatment clients.[M]

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

WHAT HAS CHANGED OVER THE PAST 10 YEARS?

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

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

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

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

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

How do users take heroin?

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

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

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

Who's most likely to use cocaine?

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

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

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

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

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

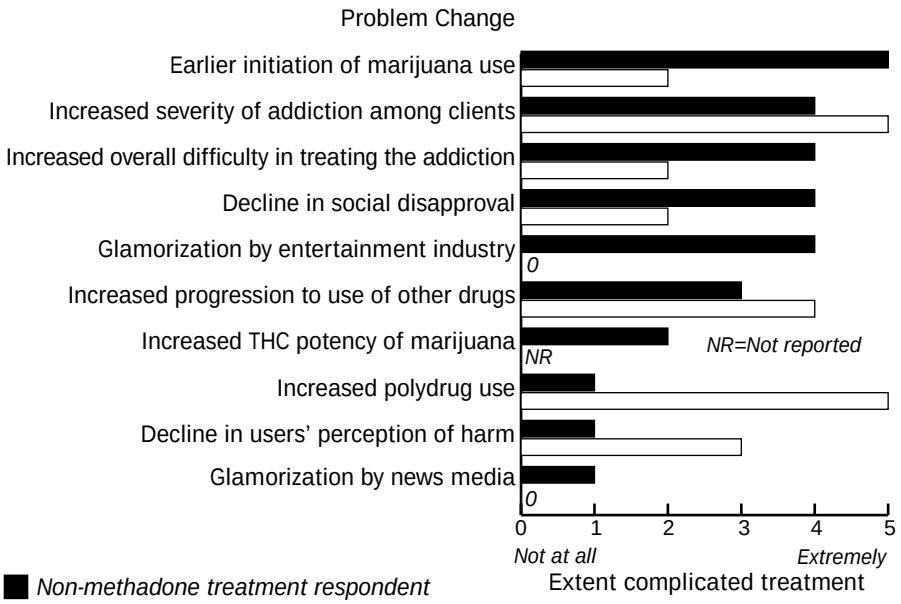
- *Primary marijuana users in treatment generally have a history of abusing hallucinogens, licit drugs, and ecstasy.*[N] *Marijuana users often take crack cocaine, methamphetamine, or alcohol when they smoke marijuana.*[E]
- *Whites and Blacks are equally represented among primary marijuana abusers,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

Who's most likely to use marijuana?

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

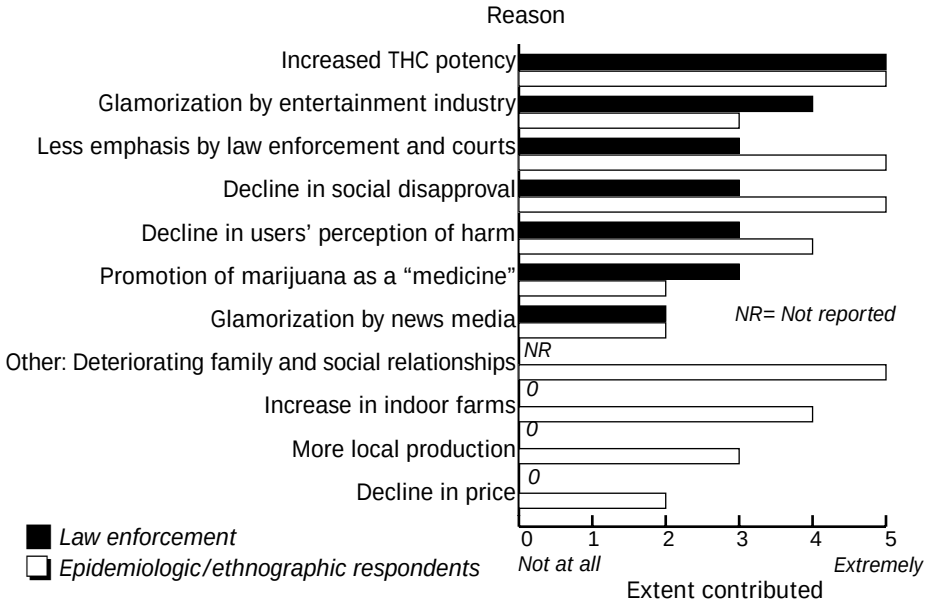
Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondents

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



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

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



What they have to say...

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

Who's most likely to use methamphetamine?

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

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

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

Who's most likely to use ecstasy?

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

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

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

WHO'S MOST LIKELY TO USE OTHER DRUGS?

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

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

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

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

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

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

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

HOW DO DRUGS GET FROM SELLER TO BUYER?

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

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

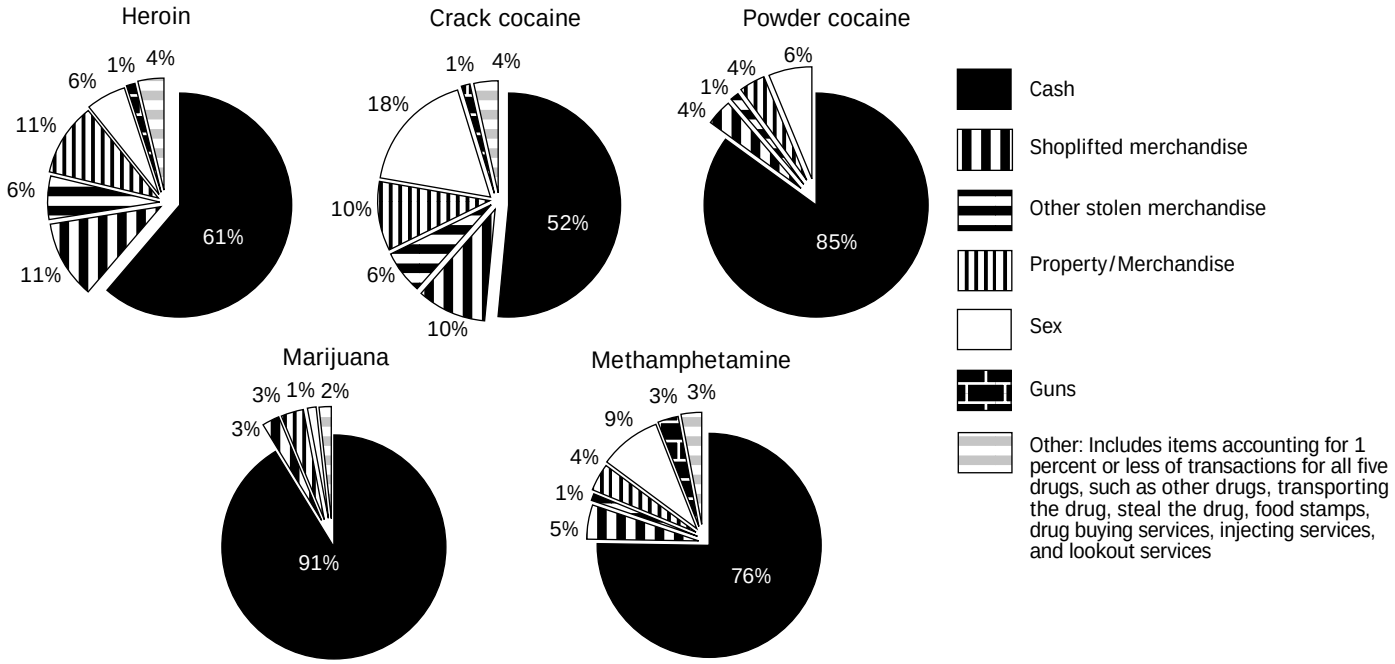
have more of a relationship with their buyers than other drug dealers; they are often family members, friends, or acquaintances.[E] Most marijuana found in St. Louis is locally produced in basements using the hydroponic method.[L] The marijuana grown outdoors typically comes from Mexico.[L]

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

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

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

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



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

What they have to say...

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

Which drug sellers are associated with which crimes?

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

Sources: Law enforcement respondent; epidemiologic/ethnographic respondent

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

WHO'S SELLING HEROIN?

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

How much does heroin cost?

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

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

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

WHO'S SELLING COCAINE?

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

How much does cocaine cost?

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

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

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

WHO'S SELLING MARIJUANA?

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

How much does marijuana cost?

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

Source: [L]Law enforcement respondent

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

WHO'S SELLING METHAMPHETAMINE?

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

How much does methamphetamine cost?

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

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

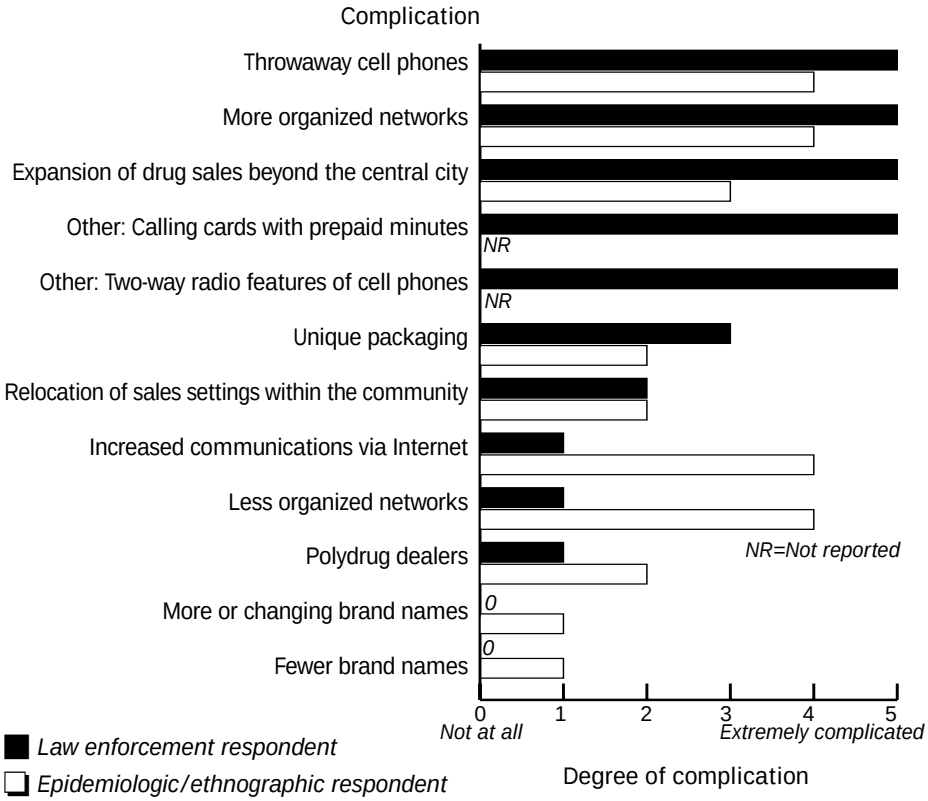
- *The cost of methamphetamine is higher in the suburban and rural areas than in the central city.*[E]
- *Generally, methamphetamine is sold in increments priced at $100 and higher.*[L]

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

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

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

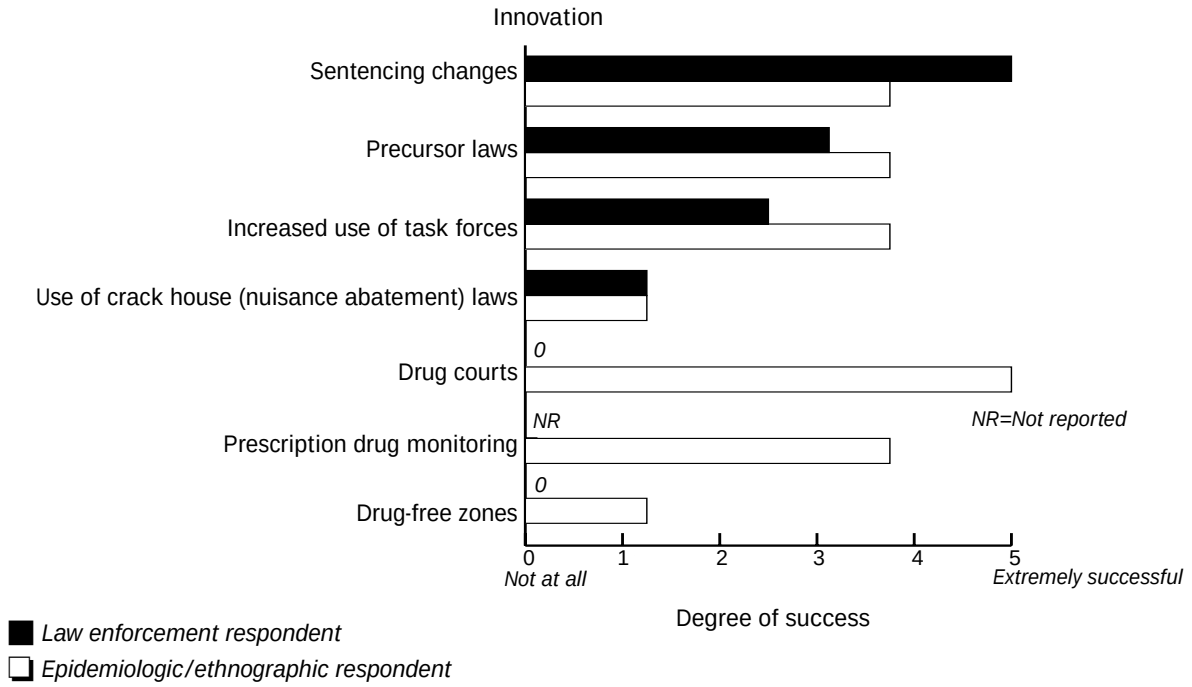
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in St. Louis?



What they have to say...

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

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



What they have to say...

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

SEPTEMBER 11 FOLLOWUP

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

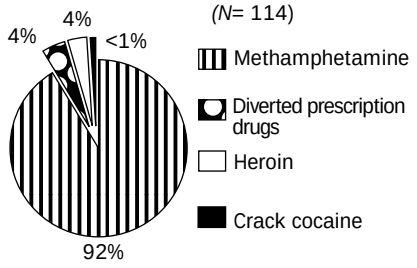
- Drug trafficking: Tightened security as a result of the September 11 attacks has continued to change the way drugs are transported. Rather than carrying drugs aboard airplanes in luggage and on their person, traffickers are relying more on automobile transport.[L]
- Drug use: Although not exclusively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

SAN DIEGO METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 2,813,833
- Median age: . . . . . 33.2 years
- Race (alone):
  - White 66.5%
  - Black 5.7%
  - American Indian/ Alaska Native 0.9%
  - Asian/Pacific Islander 9.4%
  - Other race 12.8%
  - Two or more races 4.7%
- Hispanic (of any race): 26.7%
- Unemployment rate: 3.6%
- Median household income:. $47,067
- Families below poverty level with children <18 years: 13.3%

*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

Treatment percentages in this program remained relatively stable between spring and fall 2002.

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

Three of the four *Pulse Check* sources believe the city's overall drug problem has remained stable. The non-methadone treatment source, who considers the city's drug problem very serious, believes it has become somewhat worse. The methadone treatment source likewise believes the situation to be very serious, while the epidemiologic and law enforcement sources rate the problem at a lesser "somewhat serious."

Only a few changes since spring 2002 are associated with use:

- Use of methylenedioxymethamphetamine (MDMA or ecstasy), phencyclidine (PCP), and carisoprodol (Soma®) now is reported occasionally among treatment admissions.[N]
- Use of gamma hydroxybutyrate (GHB) remains at low levels, probably because word has gotten out about the drug's volatility and lethal potential. Nevertheless, it continues to be involved in some deaths and drug-assisted rapes.[E]

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

- What people are calling "ice" and "glass" is a marketing phenomenon: a new presentation of the same methamphetamine seen for years.[L]
- Increased focus by law enforcement has made it more difficult to purchase diverted OxyContin® (oxycodone hydrochloride controlled-release). A particularly effective deterrent was the arrest of a major supplier in Tijuana.[L]
- A Drug Enforcement Administration (DEA) operation in September 2002 caused ketamine shipments to dry up, supplies to decline, and prices to triple.[L]

Because of the different perspective each brings, the sources vary in their perception of which drugs are most commonly abused and which have the most serious consequences. For example, the epidemiologic and law enforcement sources agree that methamphetamine is the drug related to the most serious consequences. However, they differ about the second most serious drug problem. The epidemiologic source names heroin because it is associated with the most serious health consequences. The law enforcement source names marijuana because of its pervasiveness.

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

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

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

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

New or emerging problems:
Ecstasy[E,N]
GHB, "whispers" of diverted OxyContin®[E]
PCP, carisoprodol (Soma®)[N]

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

The heroin problem appears relatively stable between spring and fall 2002:

- Upper middle-class White youth, reported as an emerging group 3 or 4 years ago, are declining as heroin users—possibly due to the focus of a local multi-agency task force composed of law enforcement, education, treatment, and prevention specialists.[E]
- Approximately 15 percent of drug court referrals in the northern section of San Diego are first-time young injecting users from wealthy families.[N]

COCAINE

Use of crack appears to be low and stable. Only one possible change is reported regarding powder cocaine:

- A spring 2002 focus group and a newspaper article reported couriers delivering powder cocaine to suburban areas. These reports may just be "blips": they have not been detected in any datasets, nor have any incidents been mentioned since.[E]

MARIJUANA

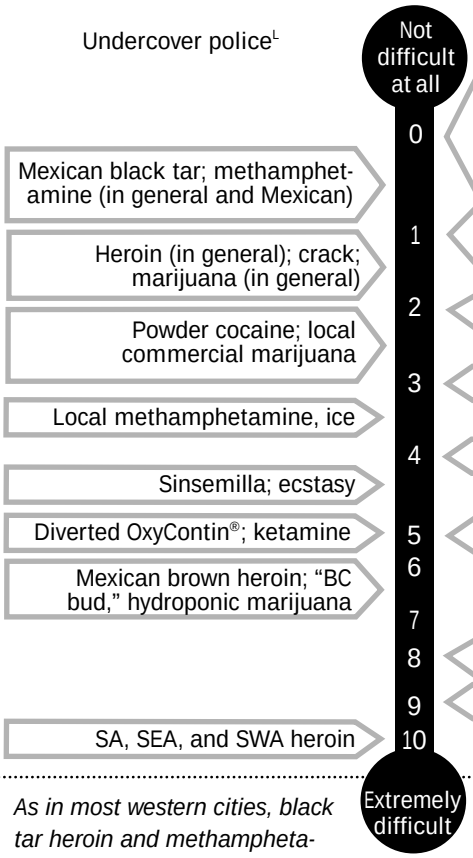
No changes are reported between spring and fall 2002, either in use or marketing. The drug, either alone or used with other drugs, continues to be involved in negative consequences.

METHAMPHETAMINE

Two declines are reported, along with some shifts among users:

- Precursor laws have led to supply declines: local manufacturers have been forced to develop pill reduction labs to extract their own pseudoephedrine. Some labs make their own iodine because iodine sales have been curtailed in feed stores. Some make their own hydriotic acid. Most methamphetamine is now from Mexican labs that use the red phosphorous reduction method.
- The percentage of methamphetamine users among methadone clients declined somewhat between the two latest available reporting periods: from 25 percent to 19 percent of both overall and first-time admissions.[M]
- Hispanics continue to emerge as methamphetamine users.[E]
- One source notes a shift over the past 5 years from snorting methamphetamine to smoking it.[N]

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



- *As in most western cities, black tar heroin and methamphetamine are easily obtainable. And, conversely, it is extremely difficult to purchase white heroin*
- *Both users and undercover police can purchase black tar heroin, crack, most methamphetamine forms, and commercial marijuana with relatively similar ease. More variation is reported for powder cocaine and higher grades of marijuana—possibly because they are used by more specific populations.*
- *Undercover police can purchase ice and ecstasy more easily in fall 2002 than in the previous spring.*[L]
- *Conversely, undercover police find it more difficult than before to purchase diverted OxyContin® and ketamine.*
- *From the user perspective, no changes are reported in ease of purchase for any drugs.*[E]

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

ECSTASY

A few slight increases are reported between spring and fall 2002:

- Despite much media attention and a slight increase in the number of users, ecstasy use remains low.[E]
- Undercover police can purchase the drug more easily than previously.
- Shipments at the "boat" level (1,000 pills) and higher come from the Los Angeles area.

DIVERTED OXYCONTIN®

Availability appears to have declined between spring and fall 2002:

The pharmaceutical's manufacturer is presumably exporting less of it to Mexico. Consequently, less is diverted back into the United States from Tijuana pharmacies—either via small-time dealers or by Internet hookup.[L]

KETAMINE

A DEA operation in September 2002 caused ketamine shipments to dry up, supplies to decline, and prices to triple. A Mexico City manufacturer and his Tijuana pharmacy distributor were put out of business, and raw materials were seized. This law enforcement accomplishment has national repercussions because more than 80 percent of the ketamine in the United States comes from Mexico via San Diego.[L]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone treatment respondent's program, which operates at its maximum capacity of 100 contract-funded clients plus aftercare clients, covers a county where methamphetamine predominates. Thus, methamphetamine is the primary drug of abuse among the vast majority of clients *(see pie chart on the first page of this report)*.[N]
- The methadone treatment respondent is with a facility that operates close to its maximum capacity of 375 patients, as allowed by the State.[M] Beyond that specific facility, methadone maintenance treatment is available throughout the area, and programs have adequate capacity. Public and private methadone treatment availability and capacity remained stable between early and late 2002.[E]
- Slot capacity in general is increasingly limited. Increased demand, combined with no new bed funding and "NIMBYism," have resulted in many wait lists. The respondent sees a need to make more beds available in the community through increased funding rather than through shortened stays.[N]

Community collaboration

One treatment source reports that the court and treatment systems have worked together to address local drug problems more effectively. The respondent perceives a need for similar collaboration between the treatment and prevention communities as well as with parents, grandparents, and the community at large.[N]

Recidivism

Nearly all marijuana and methamphetamine clients have been in treatment in the past, although only a handful are return clients to this particular program.[N]

Consequences of drug use

- One source notes increases in high-risk pregnancies, drug-related automobile accidents, and cases of hepatitis C among treatment clients. Incidence of drug-related tuberculosis remains relatively low, but it increases as one gets closer to the U.S.–Mexican border.[N]
- Another source similarly reports high-risk pregnancy as a relatively common consequence of drug abuse among treatment clients. The source also notes that new users generally do not have hepatitis C, but about 99 percent of the "old timers" are positive for the disease. "The hepatitis C problem," remarks the respondent, "seems worse than AIDS. Help is needed."[M]
- Methamphetamine clients tend to come in with numerous medical and dental problems.[N] Chronic heart problems are fairly common among older methadone patients.[M]

Co-occurring disorders

- The number of patients presenting with psychosis, mood disorders, and violent behavior has increased, probably due to their long-term use of methamphetamine.[N]
- Antisocial disorders and conduct disorders, very common among methadone patients, tend to disappear once the patients are on methadone.[M]

CHANGES OVER THE PAST 10 YEARS

- One treatment source believes that San Diego's drug abuse problem has been moderately exacerbated over the past decade by the declining price of heroin and by earlier initiation of heroin use.[M]

- The other treatment source names several particularly significant changes: increased treatment caseloads because so many people are trying to get into treatment; lack of detox; lack of residential treatment; an increase in medical and dental problems among clients because they don't qualify for benefits; and lack of "sober living" housing opportunities for recovering clients. This source also names some more moderately complicating changes: the "normalization" of drug use within family history and structure; an increase in polydrug use; the spread of drug use among all age groups; and the lack of jobs and job training opportunities for recovering clients.[N]

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	M
Age group (years)	>30	>30
Mean age (years)	35	45
Gender	70% male	61% male
Race/ethnicity	White	White
Socioeconomic status	Low	NR
Residence	Central city	Suburbs
Referral source	N/A	Individual
Level of education completed	N/A	High school
Employment at intake	N/A	50% full time, 50% unemployed

Sources: [E]Epidemiologic/ethnographic respondent; [M]methadone treatment respondent
Note: Only four clients in the non-methadone program report heroin as their primary drug of abuse: two men and two women, whose mean age is 36).

- *The methadone treatment source describes a somewhat older, less male-dominated, population than the broader heroin-using population described by the epidemiologic source.*
- *Upper middle-class White youth, reported as an emerging group 3 or 4 years ago, are declining as heroin users–possibly due to the focus of a multi-agency task force aimed at this specific new user group in the northern sector of San Diego County.*[E]
- *However, approximately 15 percent of drug court referrals in north county are first-time young injectors from wealthy families.*[N]
- *Mean age is tending to be slightly lower than in the past because of youth in their late teens who joined the user population a few years ago.*[E]
- *Among new admissions, more males are being noted than usual.*[M]

How do users take heroin?

Characteristic	E	M
Primary route of administration	Injecting	Injecting
Other drugs taken	Cocaine ("speedball"); methamphetamine (speedball)	Methamphetamine (speedball)
Publicly or privately?	Both	Privately
Alone or in groups?	Both	Alone

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

- *Injecting is also the primary route of administration among the four primary heroin clients.*[N]
- *Use patterns appear stable between spring and fall 2002.*[M]

Who's most likely to use cocaine?

Characteristic	Crack	Powder cocaine
Age group (years)	>30	18–30
Mean age (years)	36.5	NR
Gender	60% male	NR
Race/ethnicity	Black	White
Socioeconomic status	Low	Middle
Residence	Central city	Suburbs

Source: [E]Epidemiologic/ethnographic respondent
Note: Only one crack user and no powder cocaine users are in treatment at the non-methadone program. None are reported in the methadone program.

- *Crack users and powder cocaine users are two separate populations, different in all respects.*[E]
- *User characteristics appear stable between spring and fall 2002.*[E]

- *None of the marijuana users in either program reports that drug as a primary problem.*[N,M]
- *While marijuana users in treatment are predominantly Hispanic, marijuana use cuts across all racial/ethnic groups.*[N]
- *Only one change is reported: "More younger kids are coming in."*[N]

Who's most likely to use marijuana?

Characteristic	E	N
Age group (years)	18–30	18–30
Mean age (years)	26.5	31
Gender	80% male	65% male
Race/ethnicity	Hispanic (any race)	NR
Socioeconomic status	All	NR
Residence	Suburbs	NR

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent
Note: The methadone treatment source did not provide this information.

How do users take marijuana?

Characteristic	E	N
Primary delivery vehicle	Joints	Joints, bongs
Other drugs taken	Alcohol, methamphetamine	Methamphetamine
Publicly or privately?	Both	Both
Alone or in groups?	Both	Both

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent
Note: The methadone treatment source did not provide this information.

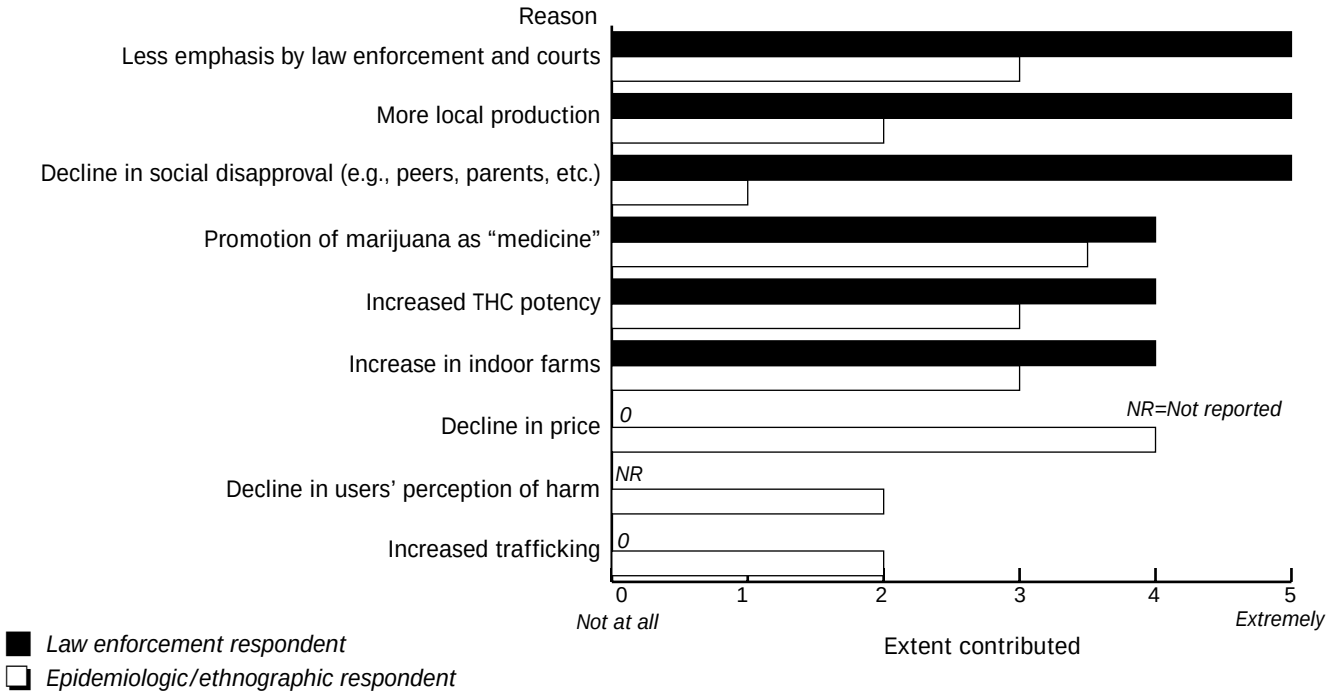
- *Both responding sources describe similar use patterns.*[E,N]
- *Use patterns appear stable between spring and fall 2002.*[E,N]

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

One source lists "amotivational syndrome" as a negative consequence of marijuana use, pointing out that the younger users, who are increasingly admitted to treatment, never get employed. Sometimes this lack of motivation is a family norm. Additionally, respondents associate marijuana, used either alone or with other drugs, with the following consequences, which remained stable between spring and fall 2002:

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

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



What they have to say...

- *Price: As reported in most other* Pulse Check *cities, price has not declined, so it is not a contributing factor.*[L]
- *Indoor farms: A moderate increase in indoor farms has resulted in higher grade marijuana and less detectable operations.*[E]
- *Law enforcement/court emphasis: At a recent focus group, users agreed that "everyone turns a blind eye, even though it's everywhere."*[E]
- *Perception of harm: The misperception of marijuana as harmless has "always been a problem. We need to continue pressuring youth on 'no marijuana.'"*[E]
- *Medical marijuana: "It hasn't made that big a difference, though it has given a platform to normalists."*[E]
- *Trafficking: Increased movement of marijuana from Mexico to San Diego has resulted in increased availability over the past decade.*[E]

Who's most likely to use methamphetamine?

Characteristic	E	N	M
Age group (years)	>30	>30	>30
Mean age (years)	32	31	45
Gender	50% male	65% male	50% male
Race/ethnicity	White	White	White
Socioeconomic status	Low	Middle	Low
Residence	Suburbs	Suburbs and rural areas	Suburbs
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Unemployed	50% full-time, 50% unemployed

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

- *All sources describe a predominantly White user population.[E,N,M] However, Hispanics have been emerging as methamphetamine users since about 1995, when they got into production and marketing. Use among that population continues to increase steadily.[E]*
- *Court referrals "have become huge" over the past 5 years.[N]*

How do users take methamphetamine?

Characteristic	E	N	M
Primary route of administration	Smoking	Smoking	Injecting
Other drugs taken	Marijuana, alcohol	Marijuana, ("mota," "smoke")	Heroin (speedball)
Publicly or privately?	Privately	Both	Privately
Alone or in groups?	In groups/ among friends	Both	Alone

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

- *In earlier years, methamphetamine used to be snorted. The shift to smoking continues.[E]*
- *The gradual shift from snorting to smoking is due to the younger users coming in. Injecting and snorting, however, are still common.[N]*
- *Injecting is the primary route of administration among methadone patients, who–unlike most methamphetamine users–tend to combine methamphetamine with heroin. Snorting is also common among this population.*

Who's most likely to use ecstasy?

Characteristic	E
Age group (years)	18–30
Mean age (years)	19
Gender	50% male
Race/ethnicity	White
Socioeconomic status	Middle
Residence	Suburbs

Note: No ecstasy use is reported in the two treatment programs.
Source: [E]Epidemiologic/ethnographic respondent

- *Despite much media attention and a slight increase in the number of users, ecstasy use remains low.[E]*
- *While ecstasy users are rare in this program, the problem is larger on the north coast.[N]*

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin and crack are generally sold in central city areas. Powder cocaine and ecstasy are sold in both central city and suburban areas. Marijuana and methamphetamine are equally likely to be sold in central city, suburban, and rural areas. The majority of the following specific sales settings are also use settings:

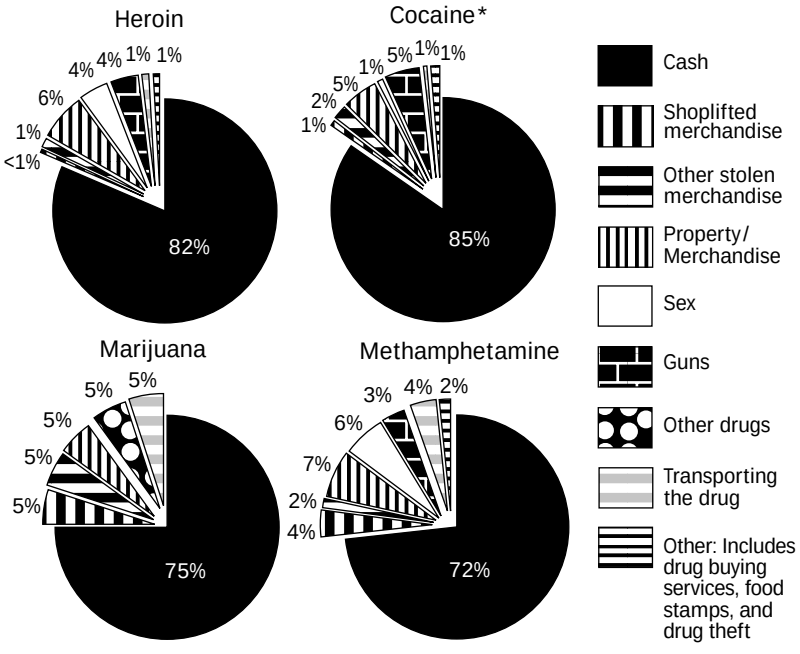
- Heroin is sold on the streets and in open-air markets,[L,E] in crack houses/shooting galleries,[L] in private residences,[L] in public housing developments,[E] in shopping malls,[L] in hotels/motels,[L,E] around drug treatment clinics,[L] and inside cars.[L,E]
- Crack is generally sold in the streets and in open-air markets[L] or in crack houses.[L]
- Powder cocaine is sold predominantly in private residences[L,E] but also in the streets and open-air markets[L] and on beaches.[L]
- Marijuana has the largest range of sales settings: streets/open-air markets,[L,E] crack houses/shooting galleries,[L] private residences,[L,E] public housing developments,[L,E] in or around schools,[L,E] college campuses,[L,E] nightclubs and bars,[L] shopping malls,[L] playgrounds/parks,[L] private parties,[L,E] raves,[L] concerts,[L,E] around supermarkets,[L] hotels/motels,[L,E] around drug treatment clinics,[L] and inside cars.[L,E]
- Methamphetamine sales settings include the streets and open-air markets,[L] inside private residences,[L,E] public housing developments,[E] nightclubs and bars,[L] private parties,[L] around drug treatment clinics,[L] and inside cars.[L]
- Ecstasy is sold on the streets and in open-air markets,[E] on college campuses,[L] in nightclubs and bars,[L,E] at private parties,[L,E] at raves,[L,E] at concerts,[L] in hotels/motels,[L] and inside cars.[L]

HOW DO DRUGS GET FROM SELLER TO BUYER?

Illegal drugs are generally sold hand to hand. In the case of heroin, for example, such transactions often involve runners at prearranged meetings in public places such as shopping malls. Cell phones, land lines, and pagers play an important communications role in sales involving heroin, powder cocaine, and marijuana. Marijuana sales also involve the Internet and parcel delivery, as do sales of diverted OxyContin® and ketamine. Ecstasy sales involve cell phones, pagers, and e-mail. Methamphetamine transactions involve less sophisticated communications, such as land lines. Crack transactions are even more "low-tech": they are likely to involve word of mouth and purchasers knowing which street corners to approach.

As shown below, the majority of these transactions involve cash. A variety of other commodities and services, however, are often exchanged—particularly in the case of methamphetamine. The most commonly mentioned items are property or merchandise (for all drugs), shoplifted or stolen merchandise (for marijuana), sex (for cocaine), and guns (for cocaine).

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



Note: The epidemiologic source did not respond to this question.
**Responses were the same for both crack and powder cocaine.*

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

What they have to say...

- *As in other* Pulse Check *cities, the majority of drug transactions are "cash only." Crack, powder cocaine, and heroin transactions are even more frequently cash only than in many other cities.*
- *Ten years ago, when labs were bigger, methamphetamine manufacturing was another service exchanged for drugs. Such transactions are a thing of the past because a large law enforcement task force has effectively reduced the size and number of labs, pushing them into neighboring areas.*[N]
- *No other changes are reported in the nature of drug transactions over the past 10 years.*

WHO'S SELLING HEROIN?

The sales structure, controlled by Hispanics, operates as follows:[L]

- An individual who controls a large area takes the heroin to "dope houses."
- At the dope houses, the heroin is divided into street-level units.
- The dope houses send runners, mostly young Hispanic males, to the buyers.
- Alternatively, buyers pick up heroin at a dope house.

Sellers are not very likely to use their own heroin. Some also sell powder cocaine.

How much does heroin cost?

Form	Unit	Purity	Price
Black tar	0.1 g ("tens")	14–70%	$10[L]
	3 g ("twenties")	14–70%	$20[L]
	0.4 g ("forties")	14–70%	$40[L]
	1 g	12–60%	$50–$100[E]
	1 oz	NR	$600–$1,200[L]
	25 g ("Mexican ounce")	NR	$1,400–$1,500[L]
Mexican brown tar	1 g	12–60%	$100–$150[E]

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

- *The current ounce price ($600–$1,200) represents a decline from the previous reporting period ($800–$1,500).*[L]
- *All other reported prices are stable.*[L,E]

WHO'S SELLING COCAINE?

Powder cocaine sales have the same sales structure and involve the same people as heroin. Crack sellers, by contrast, generally deal only in crack, and they belong to one of two organizational structures:[L]

- The same organizations as those who sell heroin and powder cocaine
- Street gang members

How much does cocaine cost?

Form	Unit	Purity	Price
Powder	1/10 g	NR	$10[L]
	3 g	NR	$20–$30[L]
	1 g	68–72%[E]	$40–$80[L,E]
	1 oz	54–90%[L]	$300[L]
	1 kg	83%[L]	$12,500–$18,000[L]
Crack	0.1 g ("tens")	NR	$10[L,E]
	0.2 g ("twenties")	NR	$20[L]
	1 oz	68–70%	NR[L]

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

- *All reported powder and crack cocaine prices are stable between spring and fall 2002.*
- *Powder cocaine purity at the kilogram level has increased since the last reporting period.*

WHO'S SELLING MARIJUANA?

Marijuana sellers tend to operate independently. They have the following characteristics:[L]

- They are generally young adults.
- They are very likely to use their own drug.
- They do not sell other drugs.

How much does marijuana cost?

Form	Unit	Price
Mexican weed	2-1 g ("Nickel bag")	$5[L]
	1-3 g ("Dime bag")	$10[L]
	1 oz	$60–$100[L,E]
Sinsemilla	3 oz	$150[L]
	2 oz	$300[L]
	1 oz	$180–$250[E]
	1 oz	$450[L]
Domestic bud	1 lb*	$3,000–$5,000[L,E]

**Up to 30% THC*
Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

All reported prices appear stable between spring and fall 2002.

WHO'S SELLING METHAMPHETAMINE?

Methamphetamine sellers operate at two levels:[L]

- Organized Hispanic groups sell at higher-than-ounce levels.
- Younger, independent sellers operate at the ounce and lower levels. These individuals are very likely to use their own drug.

Some methamphetamine sellers also sell marijuana.

How much does methamphetamine cost?

Unit	Price
3 g	$20[L]
1 g[a]	$40–$100[E]
1 g	$50–$75[L]
1 oz	$500–$1,000[L]
1 lb[b]	$3,500–$5,500[E]
1 lb	$6,000–$10,000[L]
1 lb ice[c]	$9,000–$11,000[L]

[a] Purity 30–40%
[b] Purity 93–97%
[c] Purity 50–90%
Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

What people are calling "ice" and "glass" is a new presentation of the same substance seen for years. In the early 1990s, high-purity methamphetamine was coming from local labs. Around 1995, shortly after the Mexicans took over, purity started going down but prices remained the same. Around 2000, this supposed "ice" was introduced at increased prices. Within the last year or so it started being cut again—with the vitamin supplement dimethylsulfone (MSM). Prices, however, remain at elevated levels, while purity ranges widely.[L]

Which drug sellers are associated with which crimes?

Crime	Heroin	Powder cocaine	Crack cocaine	Marijuana	Methamphetamine
Gang-related activity			✓		
Violent criminal acts			✓		
Nonviolent criminal acts (burglaries, petty thefts)	✓	✓	✓	✓	
Domestic violence					✓
Smuggling aliens	✓	✓	✓		

Source: Law enforcement respondent

- *While crack is not considered one of the major drugs in San Diego, its involvement in criminal activity exceeds that of other drugs.*
- *Methamphetamine is the only drug associated with domestic violence.*

WHO'S SELLING ECSTASY?

A two-tiered system is reported:[L]

- Sellers "at the high end of the chain" are organized.
- Street-level sellers operate more independently. They are very likely to use their own drug.
- College-educated White males control sales of ecstasy, along with ketamine, GHB, and diverted OxyContin®.
- Some sellers also sell powder cocaine and diverted sildenafil (Viagra®)

How much does ecstasy cost?

Unit	Price
One pill	$15–$25[E]
One pill	$20[L]
"Boat" (1,000 pills)	$6,000–$10,000[L,E]

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

- *Reported prices appear stable between spring and fall 2002.*

How much do various other drugs cost?

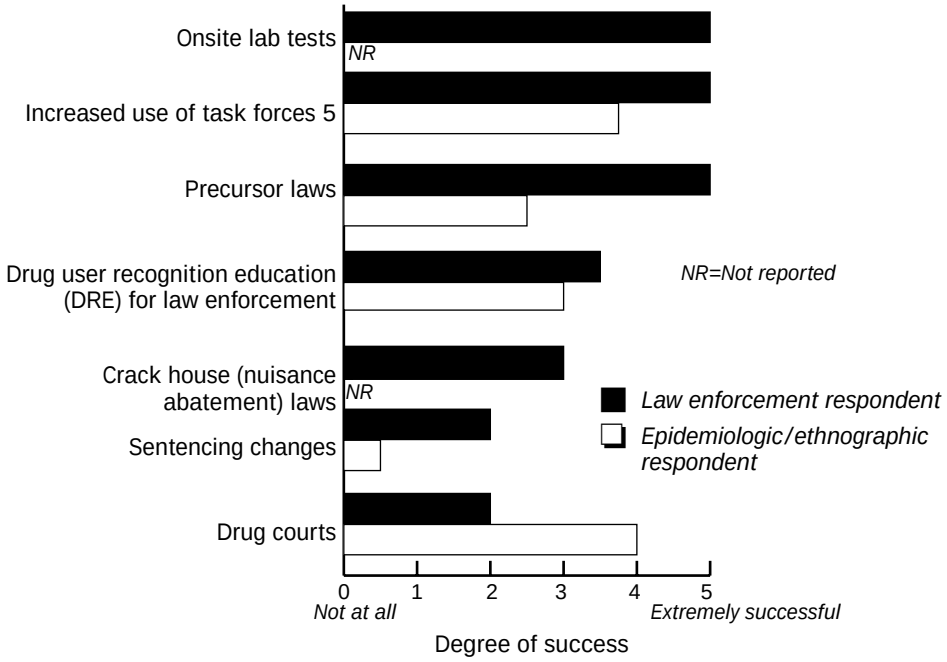
Drug	Unit	Price
Diverted OxyContin®	20-mg pill	$20[L,E]
Ketamine	0.2 g	$20–$25[L]

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

- *Reported prices for these drugs appear stable between spring and fall 2002.*
- *Price information on diverted OxyContin® comes from Imperial County.*

THE MARKET PERSPECTIVE: A 10–YEAR VIEW

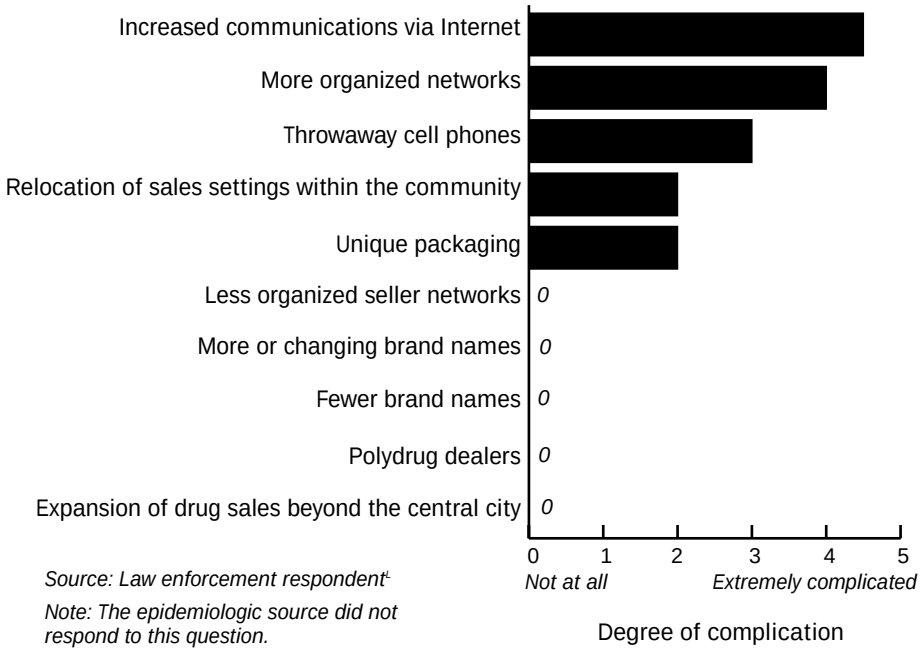
Community innovations and tools over the past 10 years: How successful have they been?



What they have to say...

- *Onsite lab tests: "Narco band" packages have been used effectively in the field for 18 years.*
- *Task forces: The San Diego Narcotics Task Force, one of the first of its kind in the Nation, has representatives from every police agency in San Diego County, under the umbrella of the DEA. Various other agencies, such as the Border Patrol, participate from time to time.[L] The Violent Gang Task Force draws members from Federal agencies, such as the Federal Bureau of Investigation (FBI) and the Bureau of Alcohol, Tobacco and Firearms (ATF), and representatives from State and local entities.[L] The Meth Strike Force, ongoing since March 1996, has led to programs such as the Meth Hotline (which the public uses to report suspected cooks, turn in dealers, and obtain help for users) and the Drug Endangered Children program (which includes removing children of dealers for medical review, testing, and possible placement in the care of another family member or a foster family).[E] A Club Drug Task Force is just getting started in the county.[E]*
- *Precursor laws: Making it tougher to acquire ephedrine, red phosphorus, iodine, and hydriotic acid forced the local manufacturers of the early 1990s to extract these precursors themselves. Labs thus became smaller and spread to the rural areas across the country. Thus, San Diego lost its dubious distinction as "Meth Capital of the World."[L]*
- *Drug courts: Six operating courts include one for juveniles, one for dependency, and four for adults. Additional revenues are being sought to expand the system.[E] One source opines that drug courts are not a deterrent because they give criminals a "free walk the first time."[L]*
- *Drug user recognition education: DRE has been ongoing and moving to neighboring counties through the Meth Strike Force and its partners. In addition to being available to law enforcement, it has been available to educators, parents, and other interested parties.[E]*
- *Local summit activities (not rated): Annual substance abuse summits involving schools, the sports community, the media, and adolescents, have evolved from 1- or 2-day conferences to year-round outreach and prevention activities, including monthly meetings. This year's focus has been on substance abuse and sports, with local sports figures talking to the adolescents. Involving youth in planning activities has been a particularly effective strategy.[E]*
- *Prevention funding process (not rated): Over the past 2 years, the county has moved toward larger funding allocations to fewer providers. Prevention collaboratives throughout the region now focus on cohesive strategies all across the county, with more community responsibilities.[E]*

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



Source: Law enforcement respondent[L]

Note: The epidemiologic source did not respond to this question.

What they have to say...

- *As in the majority of* Pulse Check *cities, detection and disruption activities have not been hampered by dealers increasingly or decreasingly using brand names.*
- *Technological communications advances have posed the most challenges to detection and disruption efforts.*

SEPTEMBER 11 FOLLOWUP

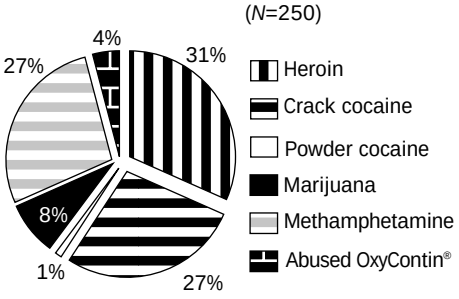
Three of the four *Pulse Check* sources believe that the September 11 attacks and their aftermath have had no continuing effects on the drug abuse problem. The law enforcement respondent, however, notes curtailed air trafficking as a result of airport security measures.

SAN FRANCISCO PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 1,731,183
- Median age: . . . . . 37.3 years
- Race (alone):
  - White 58.6%
  - Black 5.3%
  - American Indian/ Alaska Native 0.4%
  - Asian/Pacific Islander 23.5%
  - Other race 7.7%
  - Two or more races 4.5%
- Hispanic (of any race): 16.8%
- Unemployment rate: 2.5%
- Median household income: $63,297
- Families below poverty level with children <18 years: 7.6%

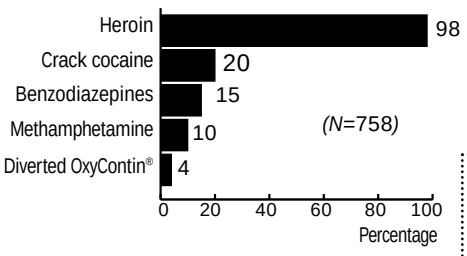
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



+Includes any use, whether as a primary, secondary, or tertiary drug; this program does not track marijuana use.

Source: Methadone treatment respondent

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

Use patterns of illegal drugs have remained relatively stable between spring and fall 2002, with a few exceptions:

- Methylenedioxymethamphetamine (MDMA or ecstasy) use has decreased among methadone treatment admissions.[M]
- Heroin user characteristics have changed slightly: Hispanic and Black users have decreased,[E] female users have increased,[E] and more users are unemployed.[N]
- Methamphetamine and OxyContin® (oxycodone hydrochloride controlled-release) abuse has increased among methadone treatment admissions.[M]

Although most use patterns remain relatively stable, respondents report several changes in the drug market:

- Mexican brown heroin is more difficult for undercover officers to buy.[L]
- Many drugs are less difficult for undercover officers to buy.[L]
- Methamphetamine-related arrests have increased.[L]
- Ecstasy sales in public housing developments have emerged in the past 6 months.[L]
- Internet communication between buyers and sellers of both methamphetamine and ecstasy has increased.[L,E]

Three of the city's *Pulse Check* sources consider the drug problem very serious[L,N,M] (as do 77 percent of all *Pulse Check* respondents), and three consider it stable.[E,N,M] One source believes the illegal drug problem is much worse since spring 2002.[L]

Heroin and marijuana remain the most commonly abused drugs in San Francisco. (By comparison, only eight other *Pulse Check* respondents—not including methadone treatment respondents—report heroin as the most commonly abused drug, and nearly half report marijuana as the most widely abused drug). The drugs relating to the most serious consequences in San Francisco remain methamphetamine and heroin. Ice, the high-purity, smokable form of methamphetamine, is an emerging drug in the city.[L]

Between spring and fall 2002, drug use among clients in the methadone treatment program remained relatively stable with two exceptions: ecstasy use decreased slightly and methamphetamine and OxyContin® abuse increased slightly.[M]

Most widely abused drug:
Marijuana[L,E]
Heroin[N,M]

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

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

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

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

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

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

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

New or emerging problem:
Ice

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

Two respondents report heroin as the most common drug of abuse[L,M] and the drug related to the most serious consequences[E,M]. Heroin use remains high and stable.

COCAINE

Powder cocaine use and activity remain low, while crack cocaine use and activity remain high.

MARIJUANA

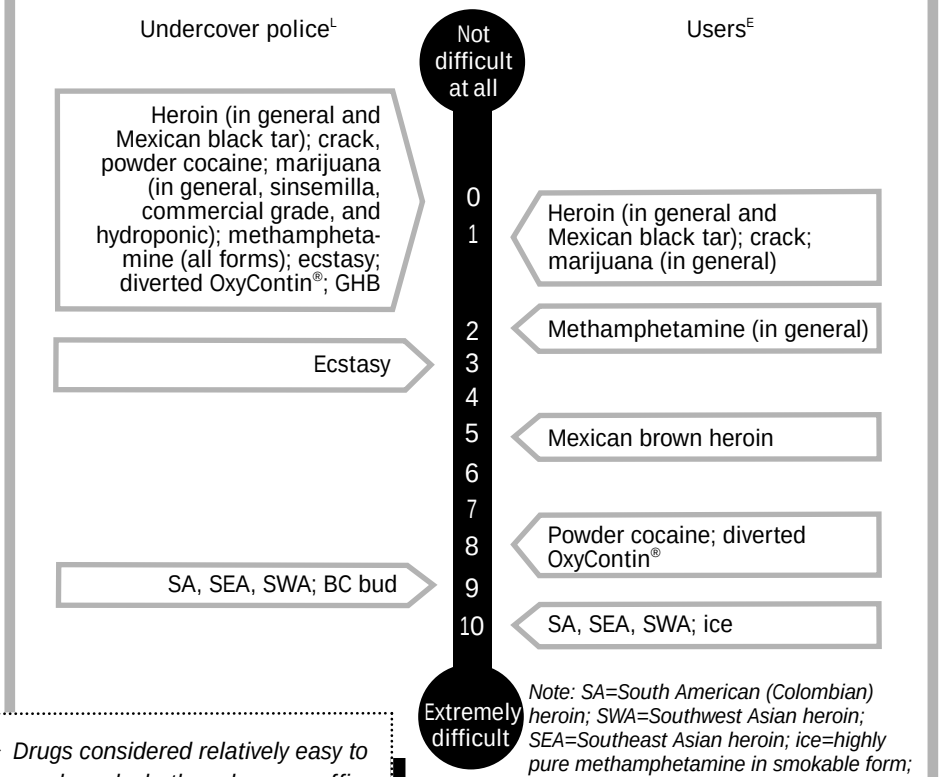
Marijuana use remains high and stable. Two sources report that it remains the most widely abused drug.[L, N]

METHAMPHETAMINE

Methamphetamine use is at high levels, and use and activity are increasing:

- Two sources report it as the drug contributing to the most serious consequences in San Francisco.[L, N]
- Methamphetamine use among methadone treatment clients increased slightly between spring and fall 2002.[M]
- One source reports increased use, especially in the gay community.[L]
- Methamphetamine arrests increased between spring and fall 2002.[L]
- Methamphetamine injection may be on the rise.[E]
- Ice is considered an emerging drug of abuse.[L]

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



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

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

- *Drugs considered relatively easy to purchase by both undercover officers and buyers include heroin, crack, marijuana, methamphetamine, and ecstasy.[L,E]*
- *As in other western* Pulse Check *cities, Mexican black tar heroin is the most common type of heroin available.[L,E]*
- *Undercover officers have found it easier to purchase Mexican black tar in the last 6 months, but Mexican brown has been more difficult to purchase.[L]*
- *Several other drugs have become easier for undercover officers to purchase in the last 6 months: cocaine, marijuana (in general and hydroponic), methamphetamine (all forms, including ice), ecstasy, diverted OxyContin®, and gamma hydroxybutyrate (GHB).[L]*

MDMA (ECSTASY)

Ecstasy use has decreased among methadone treatment admissions.[M] Ecstasy sales are starting to take place in public housing developments.[L]

DIVERTED OXYCONTIN®

Diverted OxyContin® sales increased.[L] Primary and secondary OxyContin® abuse has increased among methadone treatment admissions.

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone treatment respondent's program, which operates at its maximum capacity of 250 slots plus a waiting list, sees a variety of drug clients, most of whom use heroin, methamphetamine, or crack cocaine as their primary drug of abuse *(see pie chart on the first page of this chapter)*.
- Limited slot capacity and lack of trained staff to treat comorbidity are the most common barriers to non-methadone treatment. Those problems are increasing due to budget and funding cuts. Furthermore, there is an increasing awareness of special needs populations, but the program doesn't have resources for higher staff salaries.[N]
- The methadone treatment respondent is with a facility that operates close to its maximum capacity of 700 methadone maintenance and 100 detoxification clients.[M] Many of its clients have secondary and tertiary drug problems *(see bar chart on the first page of this chapter)*.
- Methadone maintenance treatment is available only in selected areas of the community, and public programs have large waiting lists.[E]
- The most common barrier to methadone treatment is the lack of funding: the *Pulse Check* methadone treatment source's program is private and for profit, so patients without medical insurance typically cannot afford treatment.
- The epidemiologic source states that the difficulty of obtaining public methadone treatment is "dramatic," and the demand has increased over the years as the heroin users have aged. That source further states that the only way for potential clients to get on a waiting list is to present with multiple diagnoses, such as heroin addiction plus tuberculosis. Moreover, methadone treatment availability has declined in the past 6 months because the Department of Public Health is reducing treatment slots.[E]

Consequences of drug use

- The treatment sources note that drug abuse-related health consequences are relatively stable, but several are noted as high, including the following: HIV/AIDS[N,M] hepatitis C,[N,M] abscesses[M] (due to the decreasing purity and increasing adulterants of heroin), dental neglect[M], poor nutrition[M], and skin rashes[M].
- Several co-occurring disorders have increased between spring and fall 2002, including the following: psychosis, which is related to methamphetamine and its wider availability,[N] and antisocial or conduct disorder, which is not that common but is time consuming for staff.[M] Mood disorders remain the most common comorbid diagnosis among non-methadone treatment clients.

Increased complications for drug treatment over the past 10 years

- Increasing availability of new drugs: Designer drugs, such as ecstasy and GHB, have complicated treatment drastically, according to one treatment source.[N] Increases in OxyContin® and other prescription drug abuse have made methadone treatment more difficult.[M]
- Increased treatment case loads: "Increases in treatment loads create less flexibility for staff to tailor treatment services to clients."[N]
- Lack of housing opportunities for recovering clients: According to the non-methadone treatment source, most post-treatment housing tends to be single-residency hotel rooms in low socioeconomic areas of the city where drug use is high, making it difficult for recovering addicts to abstain from drug use. The methadone treatment respondent reports a limited number of recovery home slots, especially slots that accept methadone treatment outpatients.
- Lack of jobs and job training opportunities for recovering clients: Treatment respondents report that "rents have increased, and the economy has worsened,"[M] and "there is a general lack of resources for drug treatment."[N]

WHO USES ILLICIT DRUGS?

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

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	>18
Mean age (years)	38	NR	NR
Gender	75% male	60% male	60% male
Race/ethnicity	White	White	White
Socioeconomic status	Low	Low	Low
Residence	Central city	Central city	Central city
Referral source	N/A	Individual	Criminal justice, other alcohol/drug abuse care providers, and other health care providers
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Unemployed	Varies widely

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

- *Heroin users tend to be adults older than 30[E,N] and White males.[E,N,M]*
- *Most heroin use characteristics are stable between spring and fall 2002, with the following exceptions: Hispanic and Black users have decreased;[E] female users have increased;[E] and more users are unemployed.[N]*
- *Heroin users new to treatment are more likely than the general heroin-using population to be younger, of middle socioeconomic status, referred to treatment by the criminal justice system, better educated, and employed.[N]*

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Injecting	Injecting
Other drugs taken	Crack diluted with lemon (speedball)	Powder cocaine (speedball)	Crack cocaine (speedball); methamphetamine in combination
Publicly or privately?	Publicly	Privately	Privately
Alone or in groups?	In groups	Alone	Both

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

- *In San Francisco, injecting is the most common route of heroin administration, and cocaine injected with heroin (speedball) is a common practice.[E,N,M]*
- *Smoking as a route of heroin administration has increased in the past several years.[N] Sources report no other changes in method of use since spring 2002.*
- *Methadone treatment clients often request sildenafil (Viagra®) because opiates tend to decrease sexual performance.[M]*

Who's most likely to use crack cocaine?

Characteristic	E	N	M
Age group (years)	>30	>30	18–30
Mean age (years)	32	40	NR
Gender	60% male	70% male	60% male
Race/ethnicity	Black	Black	NR
Socioeconomic status	Low	Low	NR
Residence	Central city	Central city	NR
Referral source	N/A	Individual	NR
Level of education completed	N/A	High school	NR
Employment at intake	N/A	Unemployed	NR

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

- *Crack users tend to be Black males older than 30.[E,N] Sources report no changes in crack use or user characteristics.*
- *Crack users new to non-methadone treatment are more likely than the general crack-using population to be female (70 versus 30 percent).[N]*
- *Sources report low use of powder cocaine in San Francisco.[E,N,M]*

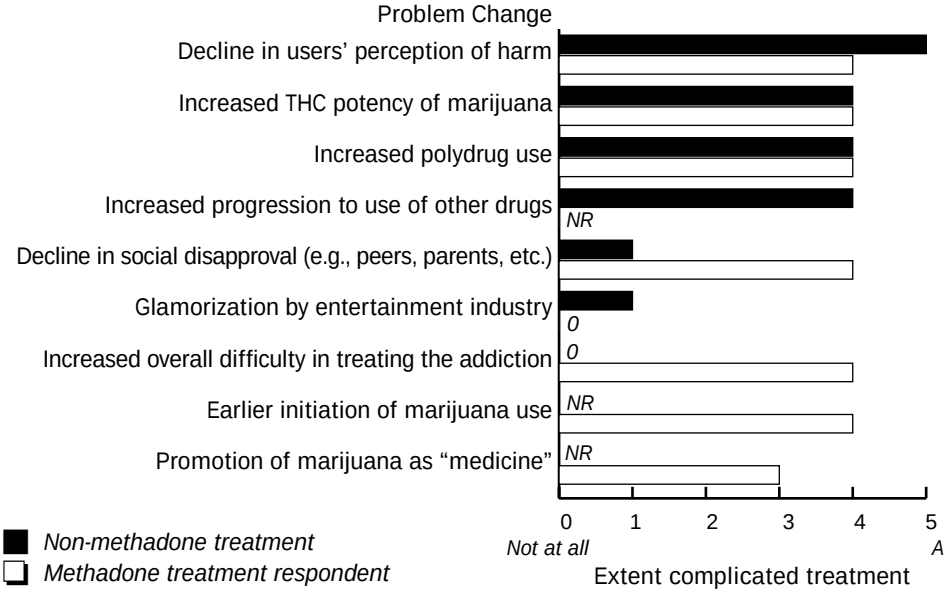
Who's most likely to use marijuana?

Characteristic	N
Age group (years)	18–30
Gender	70% male
Socioeconomic status	Middle
Residence	Central city
Referral source	Criminal justice
Level of education completed	2-year college
Employment at intake	Full time

Source: [N]Non-methadone treatment respondent

- *Non-methadone treatment clients for primary marijuana use are more likely than their other drug-using counterparts to be adolescents or young adults.[N]*
- *Marijuana is most often smoked in joints, blunts, and pipes.[E,N]*
- *Sources report no changes in marijuana use or user characteristics since spring 2002.*

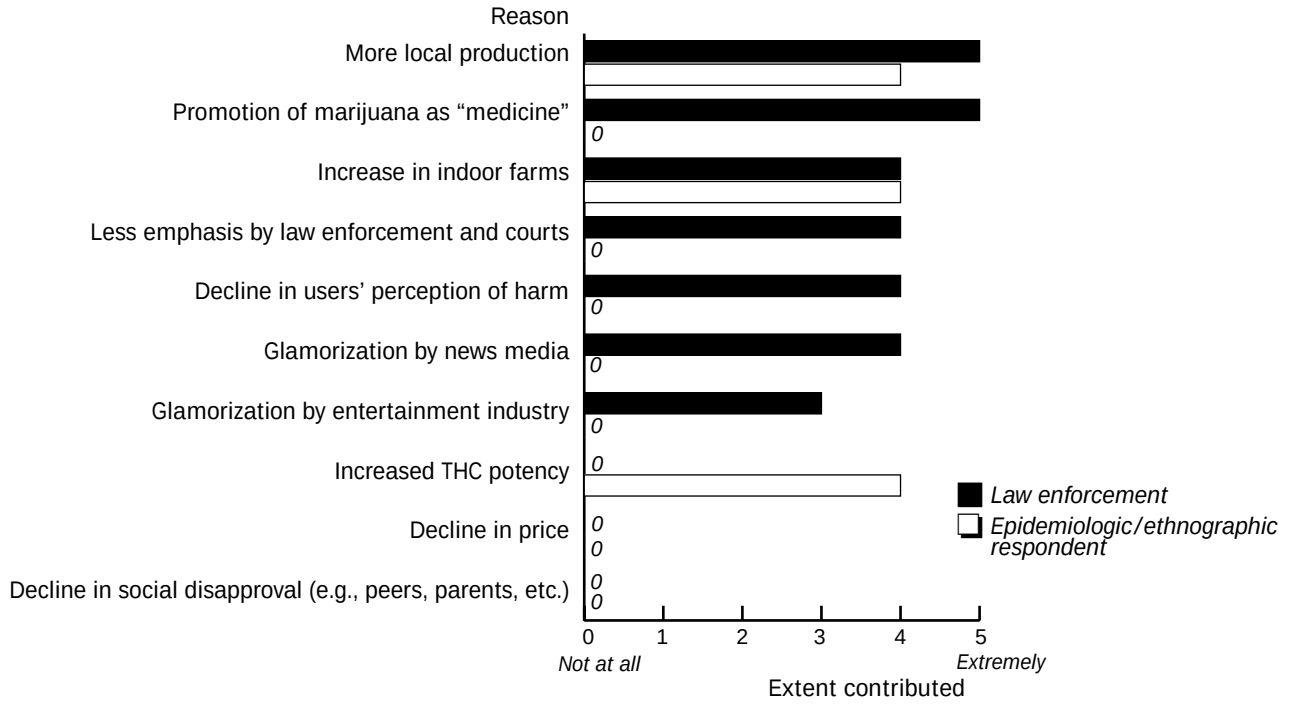
Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



What they have to say...

- *Increased court referrals involving marijuana possession and sales have had a positive effect of getting people into treatment earlier.[N]*
- *Marijuana-using clients who report problems with being able to stop using or with side effects have increased over the past 10 years.[N]*
- *More dangerous marijuana combinations (especially marijuana plus methamphetamine or ecstasy) have increased over the past 10 years.[N]*

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



What they have to say...

- *Increase in indoor farms: Indoor farms have made it easier for people to conceal marijuana growth.*[L]
- *More local production, less emphasis by law enforcement and courts, and promotion of marijuana as "medicine": The law enforcement source believes that each of these problems has increased marijuana use and activity over the past 10 years and that each is related to the introduction of Proposition 215 ("medical" marijuana legislation).*[L]
- *Decline in social disapproval: Unlike the majority of respondents in other* Pulse Check *cities, sources in San Francisco either believe that this decline has not had an impact or that it has not taken place at all.*[L,E]

Who's most likely to use methamphetamine?

Characteristic	E	N
Age group (years)	18–30	18–30
Mean age (years)	27	NR
Gender	60% male	75% male
Race/ethnicity	White	White
Socioeconomic status	Low	Middle
Residence	Central city	Central city
Referral source	N/A	Individual
Level of education completed	N/A	2-year college
Employment at intake	N/A	Part time

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

- *Most methamphetamine users are young adult White males.*[E,N]
- *New methamphetamine non-methadone treatment clients are more likely to be female than the general methamphetamine-using population (50 versus 25 percent).*[N]
- *Methadone treatment clients who use methamphetamine have similar characteristics to those who use heroin only. That source reports some increase in methamphetamine use.*[M]

How do users take methamphetamine?

Characteristic	E	N
Primary route of administration	Injecting followed by oral use	Injecting followed by smoking
Other drugs taken	NR	Benzodiazepines
Publicly or privately?	Publicly	Publicly and privately
Alone or in groups?	In groups	Alone

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

- *The most common route of methamphetamine administration in San Francisco is injecting, followed by smoking and oral use.*[E,N]
- *Methamphetamine clients new to treatment are more likely than the general methamphetamine-using population to smoke the drug and to take it in public and in groups.*[N] *That source reports that new methamphetamine users often start using the drug in nightclubs, but often move to use alone and in private.*
- *The epidemiologic source notes that methamphetamine injection may be increasing.*[E]

- *Between spring and fall 2002, ecstasy use decreased among methadone treatment clients.*[M]
- *Among non-methadone treatment clients, all ecstasy use is secondary or tertiary.*[N]
- *Ecstasy users tend to be White young adults and evenly split between genders.*[E,N] *However, the epidemiologic source notes that ecstasy use in San Francisco spans social classes and includes "street gang members as well as upper class kids."*
- *Marijuana is often taken in combination with ecstasy.*[E,N]
- *Respondents report no changes in ecstasy use or user characteristics since spring 2002.*

Who's most likely to use ecstasy?

Characteristic	E	N
Age group (years)	18–30	18–30
Mean age (years)	22	NR
Gender	55% male	Split evenly
Race/ethnicity	White	White
Socioeconomic status	Low and middle	Middle
Residence	Central city	Central city
Level of education completed	N/A	2-year college
Employment at intake	N/A	Full time

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

Who's most likely to abuse OxyContin®?

Characteristic	N	M
Age group (years)	>30	>18
Gender	80% male	60% male
Race/ethnicity	White	White
Socioeconomic status	Low and middle	Low
Residence	Central city	Central city and suburbs

Sources: [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Between spring and fall 2002, diverted OxyContin® use among methadone treatment admissions increased somewhat.*[M]
- *Treatment sources report that most OxyContin® abusers take the drug orally and do not use other drugs; however, the methadone source states that OxyContin® abusers often switch to heroin use.*

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Most drugs (including heroin, crack, marijuana, methamphetamine, ecstasy, and diverted OxyContin®) are available in streets and open-air markets located in the central city areas of San Francisco.[L,E]

Heroin, crack, and marijuana are also sold in the following locations:

- Inside cars[L,E]
- Crack houses/shooting galleries[L,E]
- Private residences[E]
- Playgrounds and parks[E]
- Hotels/motels[L,E]
- Around supermarkets[L]
- Public housing developments[L,E]

Drugs commonly sold at nightclubs and bars, raves, concerts, and private parties include marijuana, methamphetamine, and ecstasy.[L,E]

Additionally, marijuana and ecstasy are often sold in or around schools and college campuses.[L,E] Ecstasy sales in public housing developments have emerged in the past 6 months.[L]

Diverted OxyContin® sales occur around public housing developments, over the Internet, and inside cars.[L]

HOW DO ILLEGAL DRUGS GET FROM SELLER TO BUYER?

To purchase heroin, crack, marijuana, and ecstasy, buyers typically go to a neighborhood known for drug sales, locate a street dealer, and purchase the drug hand to hand on the street.[L,E] Typically dealers nod or say a code phrase indicating that they are selling drugs.[L]

To buy methamphetamine, buyers typically contact dealers via cell phones or the Internet to arrange a meeting, at which the drug is exchanged hand to hand.[E]

Internet communication and sales between buyers and sellers of both methamphetamine and ecstasy have increased over the past 6 months.[L,E] Diverted OxyContin® is also sold over the Internet.

Who sells illegal drugs?

According to the law enforcement source...

- Heroin, powder and crack cocaine, and ecstasy sellers tend to be 18–30-year-olds who are organized, often into street gangs. Dealers who sell primarily heroin or crack often sell other drugs (including marijuana and methamphetamine). Dealers who sell primarily ecstasy often sell methamphetamine and sildenafil as well.
- Marijuana sellers may be organized or independent; in Haight-Ashbury, most are independent heroin addicts who sell marijuana to support their heroin addiction.
- Sellers of methamphetamine and diverted OxyContin® are independent young adults.

According to the epidemiologic source...

Most drug dealers (heroin, crack, marijuana, and ecstasy) are young adults who operate independently. They tend to sell only one type of drug. Heroin and crack dealers are somewhat likely to use their own drugs, while marijuana and ecstasy dealers are very likely to do so.

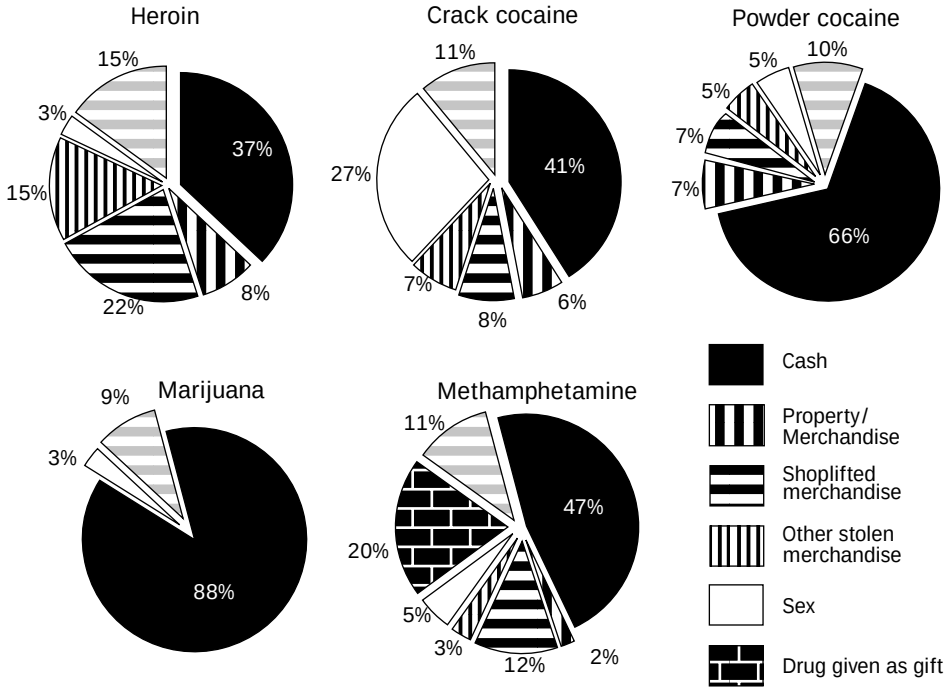
- *Violent criminal acts associated with drug sales include homicides, turf wars, and assaults.*[L]
- *As in many cities where methamphetamine is widely available, criminal acts associated with methamphetamine sales vary widely; in San Francisco, sales are particularly associated with sex work.*[L,E]

Which drug sellers are associated with which crimes?

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

Source: Law enforcement and epidemiologic/ethnographic respondents.

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



Other: Includes items accounting for 4 percent or less of transactions for each of the five drugs, such as guns, other drugs, transporting the drug, stealing the drug, food stamps, drug buying services, injecting services, lookout services, and forged checks

Source: Mean of response ratings given by law enforcement, epidemiologic/ethnographic, non-methadone treatment, and methadone treatment respondents; the epidemiologic/ethnographic source did not provide percentages for cocaine exchanges; the methadone treatment source did not provide information for methamphetamine exchanges.

- *Cash remains the most common means of exchange for illicit drugs; however, it is much less dominant in San Francisco than in most other* Pulse Check *cities. Other common modes of exchange vary by drug.*
- *For the most part, the means of exchange for drugs have remained stable over the past 10 years, with one exception: sex exchanged for crack cocaine has decreased.*[E]
- *The epidemiologic source states that begging or panhandling is the single biggest supplier for cash to buy heroin, crack, and methamphetamine.*[E]

How pure are illegal drugs, and how much do they cost?

Drug	Unit	Purity	Price
Mexican black tar heroin	One bag (0.1–0.25 g)	17%	$10[L]
	0.25 g	NR	$10–$20[E]
	1 g	17%	$60[L]
Crack	One rock (0.1 g)	74%	$6–$10[L]
	One rock	NR	$5–$20[E]
	0.25 g	74%	$25[L]
	One packet, 10 rocks (1 g)		$80[L]
Powder cocaine	One bindle (0.13–0.25 g)	64%	$15–$25[L]
	1 oz		$400–$600[L]
Marijuana	Dime bag	1–6% THC	$10[L]
	0.13 oz		$60[L]
Methamphetamine	1 g	57–80%	$130[L]
	0.13 oz		$170[L]
	0.06 oz		$300[L]
Ecstasy	One tablet	NR	$10–$20[L]
Diverted OxyContin®	40-mg pill	N/A	$10[L]
	80-mg pill	N/A	$20[L]

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

Between spring and fall 2002, the purity of most drugs remained relatively stable.[L,E] *The epidemiologic source states that Mexican black tar heroin purity increased slightly in 2002.*

Between spring and fall 2002, drug prices remained relatively stable, with two exceptions:

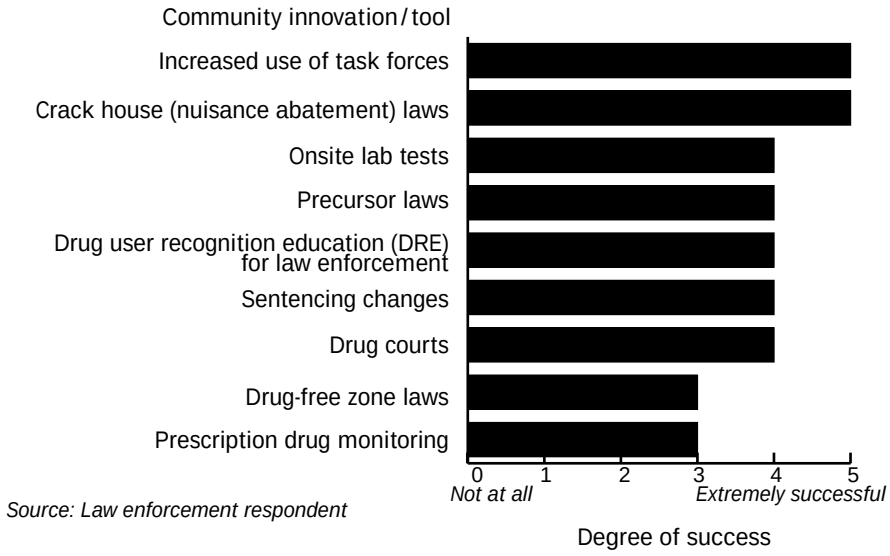
- *Heroin prices declined from $95–$100 per gram to $60 per gram.*[L]
- *Powder cocaine and crack prices declined at ounce levels.*[L]

New marketing and buying phenomena include the following:

- *Heroin dealers now sell cocaine and heroin packaged together for speedball use.*[N]
- *Crack users tend to pool their money to buy the drug.*[N]

THE CHANGING DRUG MARKET: THE LAST 10 YEARS

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



Source: Law enforcement respondent

What they have to say...

- *Task forces: Increased cooperative efforts between local, State, and Federal offices over the past 10 years have successfully combated illegal drug activity.*[L] *In particular, local police help in lab processing gives task forces more time for narcotics investigations. Other task forces mentioned include the Campaign Against Drug Abuse (CADA) and Project Safe Neighborhood. The law enforcement source further suggests more task force use for interdiction programs to target the importation of drugs via parcels, buses, and trains. High Intensity Drug Trafficking Area (HITDA) funding for radios, police cameras, and other equipment and the increased cooperation between local, State, and Federal agencies and the National Guard have been directly responsible for large "crack sweeps."*[L]
- *Drug courts:* Pulse Check *respondents rate drug court programs as very successful in combating drug use and activity.*[L,E] *One limitation is the lack of treatment programs to which a judge can refer offenders.*[E]
- *Onsite lab tests: The law enforcement source views onsite lab tests, including chemical field and phosphine gas meter tests, as extremely helpful tools.*
- *Crack house laws: The U.S. Department of Housing and Urban Development (HUD) and law enforcement practice of evicting drug users and sellers and closing crack houses for health violations, fire noncompliance, and excessive garbage has proved extremely helpful in combating crack activity in certain San Francisco neighborhoods.*[L]
- *Prescription drug monitoring program: The law enforcement source sees the prescription drug monitoring program in San Francisco as somewhat successful. He suggests increased manpower in the diversion program and increased arrests of street sellers and buyers of diverted prescription drugs.*[L]

SEPTEMBER 11 FOLLOWUP

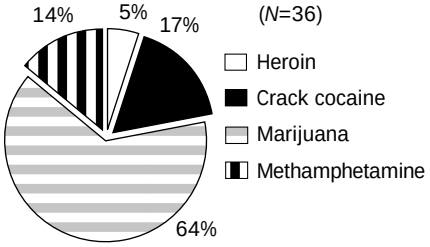
With one exception, the San Francisco *Pulse Check* sources believe that the September 11 attacks and their aftermath have not had any effects on the drug abuse problem. The non-methadone treatment respondent reports an increase in admissions who are self-treating anxiety with benzodiazepines.

SEATTLE PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population:. . . 2,414,616
- Median age: . . . . . 35.5 years
- Race (alone):
  - White . . . . . 78.6 %
  - Black. . . . . 4.4 %
  - American Indian/ Alaska Native 1.0%
  - Asian/Pacific Islander 9.9%
  - Other race 2.4%
  - Two or more races 3.9%
- Hispanic (of any race):. . . 5.2%
- Unemployment rate: 3.2%
- Median household income: $58,395
- Families below poverty level with children <18 years: 12%

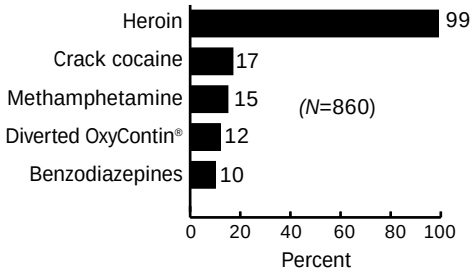
*Source: U.S. Census 2000**

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



Source: Non-methadone treatment respondent

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



Source: Methadone treatment respondent
+Includes any use, whether as a primary, secondary, or tertiary drug; no clients reportedly use powder cocaine; marijuana use is not recorded.

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

Three *Pulse Check* sources[L,E,M] believe the city's overall drug problem has remained stable; the non-methadone treatment source believes the drug problem has grown somewhat worse.

Some changes are reported:

- Task forces, particularly for methamphetamine, have been successful. A decline in meth labs may be due to precursor laws and law enforcement efforts.[L]
- Drug-related incarceration and recidivism have declined as a result of the proliferation of drug courts.
- Heroin has replaced crack as the second most widely abused drug in the city.[E]
- Crack use has increased among the non-methadone treatment population, while powder cocaine use may be decreasing.[N]
- Methamphetamine use continues to increase.[L,N] Ice (high quality, smokable methamphetamine), in particular, is emerging.[L]
- Diverted OxyContin® (oxycodone hydrochloride controlled-release) activity has increased.[L] It is considered an emerging drug of abuse by two sources.[E,M]

All four sources consider the city's drug problem very serious, with marijuana cited as the most widely abused drug by most sources. The drug related to the most serious consequences varies by source.

- *Marijuana remains the most common primary drug of abuse among non-methadone clients, followed by crack and methamphetamine.*
- *Prescription pills remain the most common secondary and tertiary drugs of abuse among heroin users in the methadone treatment program.*

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

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

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

Changes between spring and fall 2002: Heroin replaced crack as the second most widely abused drug.[E]

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

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

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

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

New or emerging problems:
- Methamphetamine[L,N] (ice)
- Diverted OxyContin®[E,M]

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

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. When possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

The heroin problem remained relatively stable between spring and fall 2002:

- Injectable Mexican black tar heroin remains the most available form of the drug and is relatively easy to purchase.[L,E]
- Heroin remains the drug related to the most serious consequences according to two sources[E,N] and has replaced crack as the second most widely abused drug according to one source.[E]

COCAINE

The two forms of the drug show opposite trends:

- Crack is cited as the drug related to the most serious consequences by one source. That source reports that the percentage of primary crack users has increased between fall and spring 2002.[N]
- Powder cocaine use remains low and may be decreasing.[N]

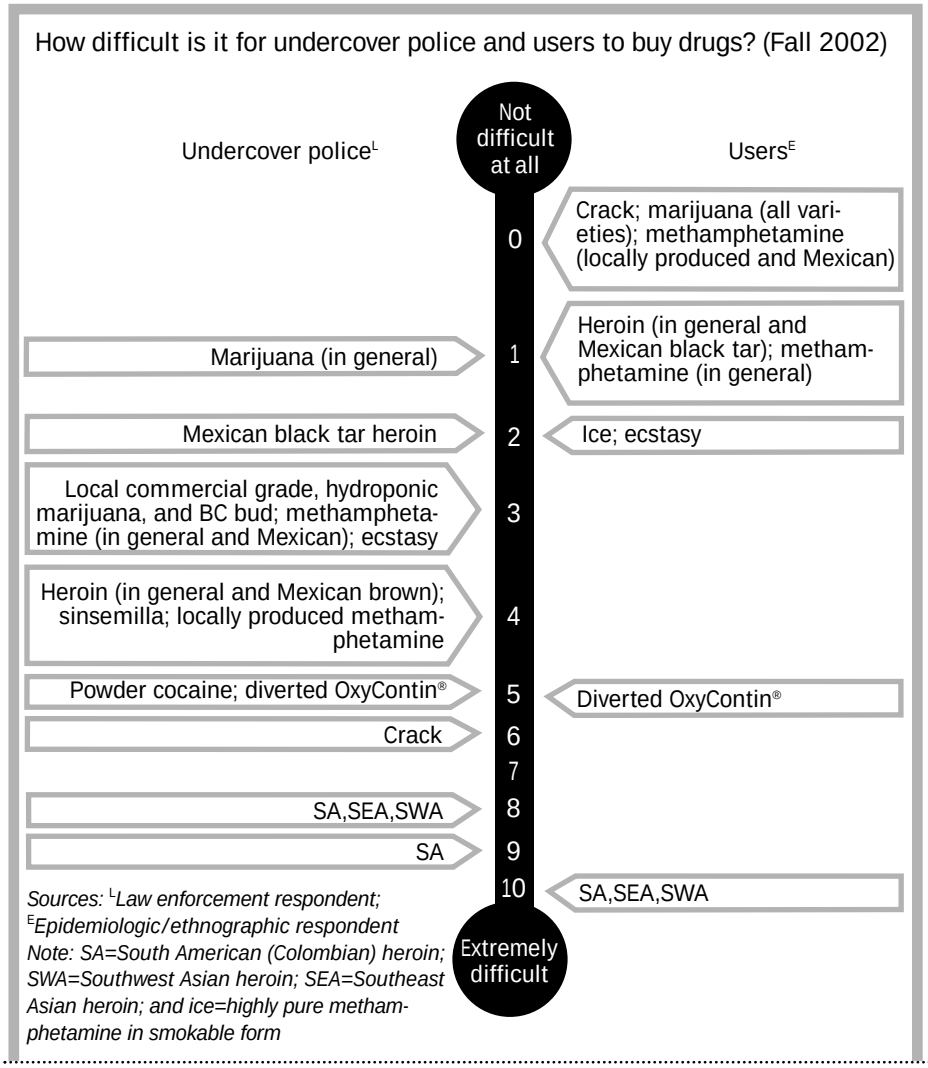
MARIJUANA

Most sources[L,E,N] consider marijuana the most widely used drug in the city. It is easier for undercover officers to purchase than in the past, especially British Columbian marijuana (BC bud), which comes from Canada.[L]

METHAMPHETAMINE

Methamphetamine use and activity have increased according to several Pulse Check *sources:*

- The law enforcement source believes that the drug is related to the most serious consequences.
- Two sources claim that methamphetamine—particularly ice—is easier to purchase than in the past.[L,E] Two sources consider methamphetamine—particularly ice—as increasing or emerging.[L,N]
- Methamphetamine is related to high-risk behaviors associated with HIV/AIDS among males who have sex with males.[E]



- *Although ease-of-purchase ratings for various drugs differ according to source, marijuana is considered one of the easiest drugs to purchase.*[L,E]
- *Marijuana (in general and BC bud) is considered less difficult for undercover officers to purchase than in the past.*[L] *Only three other sources in* Pulse Check *cities report similar increases in BC bud (Minneapolis/St. Paul,*[L] *St. Louis,*[E] *and Portland, OR*[L]*).*
- *Mexican black tar heroin is also considered relatively easy to purchase.*[L,E]
- *Ice (mostly imported from Canada) is considered less difficult to purchase during these 6 months than during the previous 6 months.*[L,E]
- *Ecstasy and diverted OxyContin® are less difficult for undercover officers to purchase than in the previous 6 months.*[L,E]

MDMA (ECSTASY)

Although its use and activity have leveled off in the past 6 months, ecstasy is still considered an emerging drug of abuse by Pulse Check *sources.*

- Ecstasy (methylenedioxymethamphetamine or MDMA) use is stable, but as reported in spring 2002, the drug is increasingly used in streets and schools in addition to raves and nightclubs.
- Ecstasy continues to be related to high-risk behaviors associated with HIV/AIDS among men who have sex with men.[E]
- Treatment clients who use ecstasy continue to be few. Between spring and fall 2002, use among clients has decreased somewhat.[N]

OTHER DRUGS

- Diverted OxyContin®:
  - Two sources consider diverted OxyContin® an emerging drug of abuse.[E,M]
  - Both treatment sources report an increasing percentage of users since spring 2002.[N,M]
  - Injecting diverted OxyContin® has increased between spring and fall 2002, and deaths related to the drug have increased dramatically.[E]
  - Diversion activity has increased between spring and fall 2002, but activity is still at a relatively low level.[L]
- Phencyclidine (PCP):
  - PCP seizures and emergency department visits related to PCP increased between spring and fall 2002.[L]
  - Possession of PCP is more commonly involved in arrests than in the past.

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- The *Pulse Check* non-methadone treatment respondent, whose 43-slot program operates at nearly full capacity, reports marijuana as the primary drug of abuse among more than half of that program's clients *(see pie chart on the first page of this chapter)*. Treatment percentages for primary crack, methamphetamine, and OxyContin® abusers increased somewhat, and percentages for primary powder cocaine and ecstasy users decreased somewhat between spring and fall 2002.
- The methadone treatment respondent is with a facility operating at nearly full capacity (860 of 875 treatment slots). Prescription pills are commonly abused by clients in the program *(see bar chart on the first page of this chapter)*.
- Methadone maintenance treatment is available throughout the area. Public treatment availability increased between spring and fall 2002, but a 24-month waiting list is standard. Private methadone treatment availability has remained relatively stable between spring and fall 2002 and appears to be underutilized.[E]
- The non-methadone treatment respondent reports an increase in clients with HIV/AIDS, most likely due to a new referral source to treatment: a nearby HIV/AIDS shelter. High-risk pregnancies among clients in that program have decreased recently, most likely due to more prevention education.[N]
- Common comorbid disorders among non-methadone treatment clients include antisocial, conduct, and mood disorders, all of which have remained relatively stable between spring and fall 2002.[N]

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	>30	>30
Gender	Male	Female	Split evenly
Race/ethnicity	White	White	White
Socioeconomic status	Low	NR	Low
Residence	Central city	NR	Central city
Referral source	N/A	NR	Individual followed by criminal justice
Level of education completed	N/A	NR	High school
Employment at intake	N/A	NR	Unemployed

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

- *According to* Pulse Check *sources, heroin users tend to be older than 30, White non-Hispanics who live in the central city and are of low socioeconomic status.*
- *Fewer heroin clients are employed in fall 2002 than during the previous spring.[M] No other changes in heroin user characteristics are reported.[E,N,M]*

- Among non-methadone clients, limited slot capacity, a common barrier to treatment, has increased within the last 6 months due to cuts in State funding for treatment. Lack of parental involvement with youth in treatment is also a relatively common, yet stable, problem within the non-methadone treatment population. Lack of trained staff to treat comorbidity has decreased as a problem in the last 6 months because staff are increasingly attending training and workshops to address comorbidity.[N]

- In the methadone treatment program, limited slot capacity remains the most common barrier to treatment. Lack of money for transportation remains a problem for private payees who are unemployed.[M]

WHO USES ILLICIT DRUGS?

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

How do users take heroin?

Characteristic	E	M
Primary route of administration	Injecting	Injecting
Other drugs taken	Powder cocaine (speedball)	Powder cocaine (speedball)
Publicly or privately?	Both	Privately
Alone or in groups?	Both	Alone

Note: Due to the low percentage of primary heroin users in the non-methadone treatment program, that source did not provide responses to these questions.

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

- *Use patterns appear stable between spring and fall 2002.*
- *Most heroin is injected. Injecting powder cocaine in combination with heroin (speedball) remains common.*[E,N]

Who's most likely to use cocaine?

	Crack cocaine			Powder cocaine
Characteristic	E	N	M	E
Age group (years)	>30	>18	>18	>30
Gender	NR	Male	Split evenly	NR
Race/ethnicity	White	White	White	White
Socioeconomic status	Low	Low	Low	Low
Residence	Central city	Suburbs	Central city	Central city
Referral source	N/A	Criminal justice	Individual followed by criminal justice	N/A
Level of education completed	N/A	High school	High school	N/A
Employment at intake	N/A	Unemployed	Unemployed	N/A

Note: The characteristics cited by the methadone treatment source are for those who use heroin as a primary drug and crack as a tertiary or secondary drug. No powder cocaine use was reported by the methadone treatment source. Very low powder cocaine use was reported by the non-methadone treatment source, and use characteristics were not reported.

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

Characteristics remain stable among the predominant user groups. However, some changes in general percentages and among users new to treatment were reported:

- *Primary crack use has increased somewhat since spring 2002.*[N]
- *According to the non-methadone treatment source, powder cocaine use is low and has decreased since spring 2002. However, according to the epidemiologic source, powder cocaine use among users new to treatment has increased, and these users are increasingly younger.*

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	All	13–30	>18
Gender	70% male	Male	Male
Race/ethnicity	White	White	White
Socioeconomic status	All	Low	Low
Residence	All	Suburbs	Central city
Referral source	N/A	Criminal justice (among adults); School (among youth)	NR
Level of education completed	N/A	Junior high and high school	High school
Employment at intake	N/A	Unemployed (among adults); Full-time students (among youth)	NR

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

- *Marijuana users tend to be White, non-Hispanic males of all age groups.*
- *Marijuana user characteristics have remained relatively stable between spring and fall 2002.*[E,N,M]

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

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

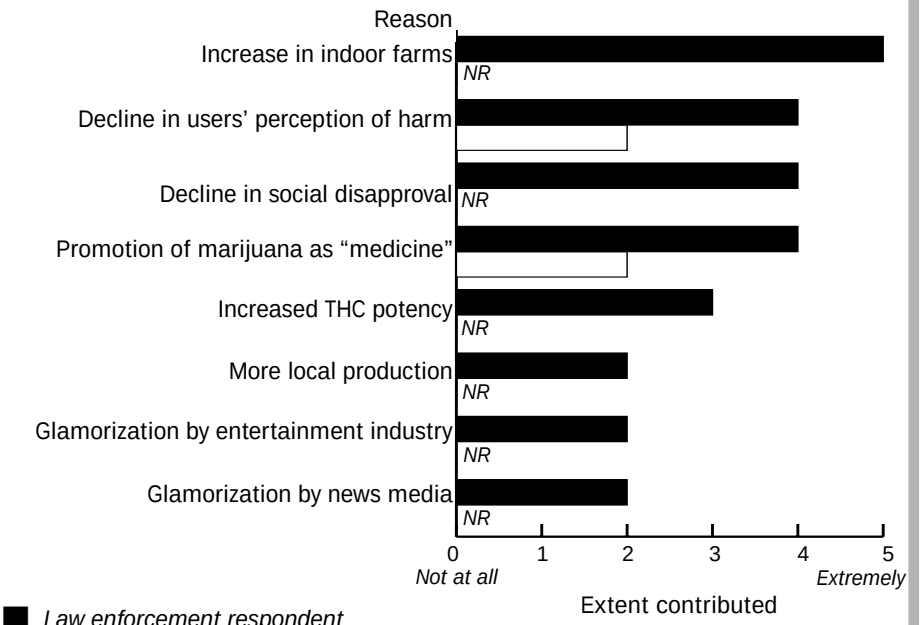
- Drug-related emergency room visits[E]
- Drug-related arrests[E,N,M]
- Short-term memory loss[N,M]
- Deteriorating family/social relationships[N]
- Poor academic performance[N]
- School absenteeism or truancy[N]
- Poor workplace performance[M]
- Unemployment rates[N]
- Workplace absenteeism[M]

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

The non-methadone treatment source reports several problems that have increased complications in treating marijuana-using clients in the past 10 years:

- Increased severity of addiction among clients
- Increased THC potency of marijuana
- Earlier initiation of marijuana use
- Increased progression to use of other drugs: The non-methadone treatment source states that many marijuana users seem to branch off to prescription drug abuse (including OxyContin®) and methamphetamine use.
- Decline in users' perception of harm
- Decline in social disapproval (e.g., peers, parents, etc.)
- Glamorization by entertainment industry

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



What they have to say...

The increase in indoor farms is the number-one contributor to marijuana use and activity.[L] *By contrast, sources in other* Pulse Check *cities tend to attribute somewhat lesser importance to this change.*

Who's most likely to use methamphetamine?

Characteristic	E	N	M
Age group (years)	>18	>30	18–30
Gender	Split evenly	Male	Split evenly
Race/ethnicity	White	White	White
Socioeconomic status	Low	Low	Low
Residence	All	Suburbs	Suburbs
Referral source	N/A	Criminal justice	Criminal justice and individual
Level of education completed	N/A	Junior high	High school
Employment at intake	N/A	Unemployed	Unemployed

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

- *Methamphetamine users tend to be White non-Hispanics of low socioeconomic status who live in the suburbs.*[N,M]
- *Smoking and injecting are the most common routes of administration for methamphetamine use. Smoking has increased over the past several years.*[E]
- *No changes in characteristics are reported.*[E,N,M]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Streets and open-air markets where buyers can purchase heroin, powder and crack cocaine, marijuana, and sometimes methamphetamine, still exist in certain neighborhoods in the central city. But the law enforcement source states that they are relatively confined and limited in number. Other sales settings for heroin, cocaine, marijuana, and methamphetamine include the following:[L]

- Private residences
- Public housing developments
- College campuses (excluding crack)
- Nightclubs and bars
- Playgrounds and parks
- Hotels and motels
- Inside cars

Methamphetamine and marijuana are additionally sold around schools, at raves, and at concerts. Crack is additionally sold in crack houses. Ecstasy is sold in private residences, schools, nightclubs, and bars; on college campuses; and at private parties, raves, and concerts.[L]

HOW DO DRUGS GET FROM SELLER TO BUYER?

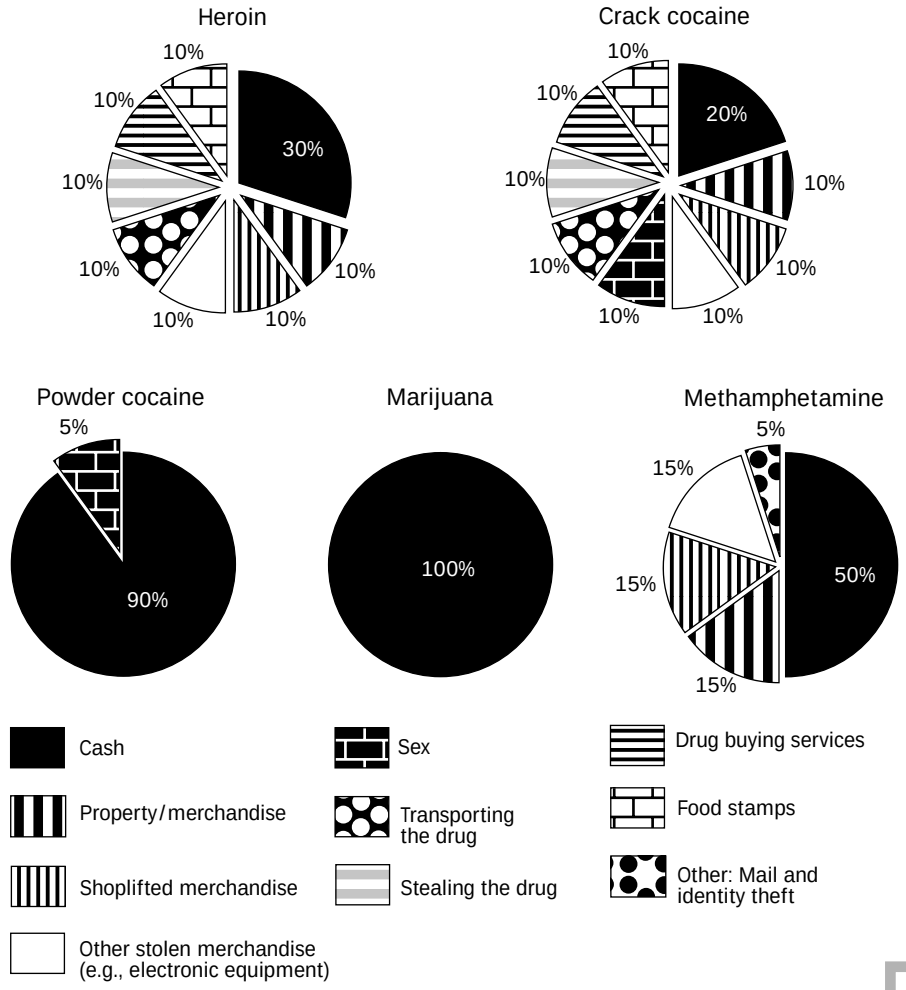
Other than obtaining drugs via open-air markets, buyers can purchase heroin and cocaine by setting up a meeting with dealers via cell phone or through a person who serves as a "go-between" (an intermediary between a dealer and a buyer). Marijuana is exchanged similarly, but the exchanges seem to be more interpersonal than for other drugs.[L]

Methamphetamine sales involve acquaintance networks: buyers "must know someone who knows someone" to set up meetings for hand-to-hand transactions, typically outside meth labs.[L] Dealers communicate with buyers via land line phones and face to face and often also sell marijuana. Many local manufacturers of methamphetamine make small batches of the drug for themselves and for acquaintances.[E]

Similar to methamphetamine sales, ecstasy sales tend to occur through acquaintance networks, and the drug is exchanged hand to hand. Additionally, the sales are often venue oriented: buyers often ask the person at the door to a party or nightclub about drug sales, and that person directs a buyer to a dealer; furthermore, sometimes sellers simply approach buyers at venues. Ecstasy dealers often also sell gamma hydroxybutyrate (GHB), marijuana, and sometimes methamphetamine.

Diverted from doctors offices and through prescription forgeries, OxyContin® is often purchased illegally, with sellers and buyers communicating face to face and by cell phones and land line phones.[L]

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



What they have to say...

- *Cash remains the most common means of transactions.*[L]
- *However, compared with other* Pulse Check *cities overall, other items and services are more likely to be exchanged for crack, heroin, and methamphetamine.*
- *On the other hand, marijuana transactions appear to be all cash—compared with about 85 percent average across all* Pulse Check *cities.*
- *The law enforcement source explains that often methamphetamine users loot neighborhood mailboxes for paychecks and other forms of currency in order to buy methamphetamine.*[L]

Source: Mean of response ratings given by law enforcement and epidemiologic/ethnographic respondents. The epidemiologic/ethnographic respondent did not provide information for crack cocaine exchanges.

WHO SELLS ILLEGAL DRUGS?

Heroin and cocaine sellers tend to be organized, and two types of street sellers exist: (1) go-between addicts who act as liaisons between buyers and the dealer who possesses the drugs, and (2) the actual drug dealers who possess the drugs. Heroin and powder cocaine dealers tend to be 18–30 years old, and crack dealers tend to be adolescents.[L]

Unlike heroin and cocaine dealers, marijuana dealers are both independent and organized. A recent influx of Southeast Asian gangs based in Canada is involved in BC bud sales in Seattle. These sellers are more associated with violent criminal acts and street gang activity than other marijuana sellers. They also import ice from Canada for sale in Seattle.[L]

Ecstasy dealers tend to be independent youth (13–18 years). Diverted OxyContin® sellers are also independent, but they are more likely to be older than 30 years.[L]

Which drug sellers are associated with which crimes?

Crime	H	P	Cr	MJ	Meth	X
Gang- related activity	✓		✓	✓		
Violent criminal acts: assaults			✓	✓		
Nonviolent criminal acts: fraud and theft	✓		✓	✓		
No crimes associated		✓				✓

Source: Law enforcement respondent
H=Heroin; P=Powder cocaine; Cr=Crack cocaine; MJ=Marijuana; Meth=Methamphetamine; X=Ecstasy

BC bud sellers are more associated with violent crime and gang action than other marijuana sellers.

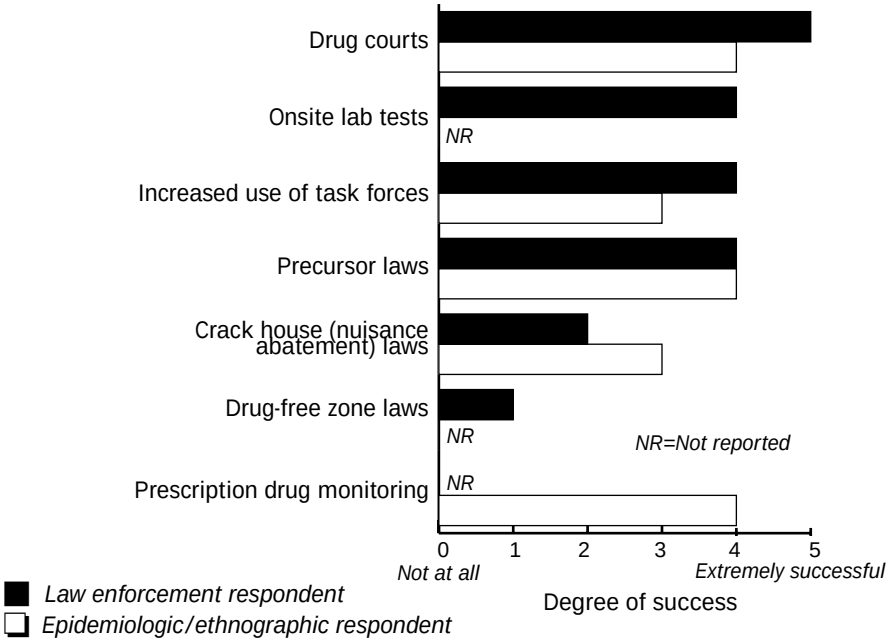
How pure are illegal drugs and how much do they cost?

Drug	Unit	Purity	Price
Mexican black tar heroin	1/10 g 1 oz	14–58%	$90–120 $600–$1,300
Crack cocaine	1 g	40–85%	$100
Powder cocaine	1 g	57–68%	$80–$100
Mexican commercial grade marijuana	1 lb	2–3%	$500–$700
Hydroponic marijuana	1 lb	12–18%	$2,400–$3,200
BC bud	1 lb	NR	$2,800–$4,000
"Nazi method" methamphetamine	1 g	95%	$20–$60
"Red phosphorus" methamphetamine	1 g	75%	$20–$60
Ecstasy	150–250-mg pill	NR	$20–$30

Source: Law enforcement respondent

- *Between spring and fall 2002, drug purity and prices remained relatively stable.*[L]
- *Ecstasy adulterants are less toxic than they were in spring 2002. Dealers now substitute other pills for ecstasy and sell them as ecstasy. Ecstasy pills are cheaper at raves ($10–$20 per pill) than they are in the community ($20–$30 per pill).*[L]

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



- Task forces: *Like in most other* Pulse Check *cities, task forces, particularly those for methamphetamine, have been successful in the Seattle area. Furthermore, a decline in local meth labs may be due to stringent precursor laws and successful law enforcement efforts.*[E]
- Drug courts: *The proliferation of drug courts seems to be having a positive effect on the community by reducing drug-related incarceration and recidivism.*[L]

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

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

According to the law enforcement source, dealers have used the following drug marketing innovations:

- Increased communications via Internet
- More organized networks
- Throwaway cell phones
- Polydrug dealers
- Expansion of drug sales beyond the central city

By contrast, disruption and detection efforts have not been hampered by increases or decreases in network organization or the number of brand names. Also, like in most other *Pulse Check* cities, these efforts have not been hampered by unique packaging.

SEPTEMBER 11 FOLLOWUP

None of the four Seattle *Pulse Check* sources believes that the September 11 attacks and their aftermath have had any long-term effects on the drug abuse problem.

TAMPA/ST. PTERSBURG METROPOLITAN STATISTICAL AREA PROFILE:

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

*Source: U.S. Census 2000**

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

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

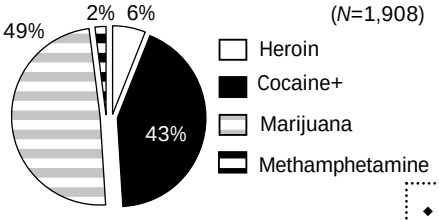
- A Meth Squad has been introduced and has successfully seized many labs in a nearby rural county that serves as the source for Tampa's methamphetamine supply.[E] Nevertheless, methamphetamine continues to be reported as an emerging problem.[L]
- Community efforts are gearing up to combat another emerging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

Several longer term changes are reported:

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

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

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

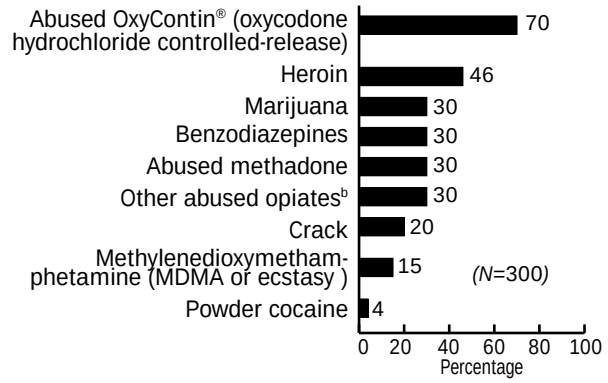


+The program doesn't distinguish between crack and powder cocaine, but crack is the predominant form of cocaine used.

Source: Non-methadone treatment respondent

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

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



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

[b]*Includes hydrocodone, morphine, and fentanyl patches*

Source: Methadone treatment respondent

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

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

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

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

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

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

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

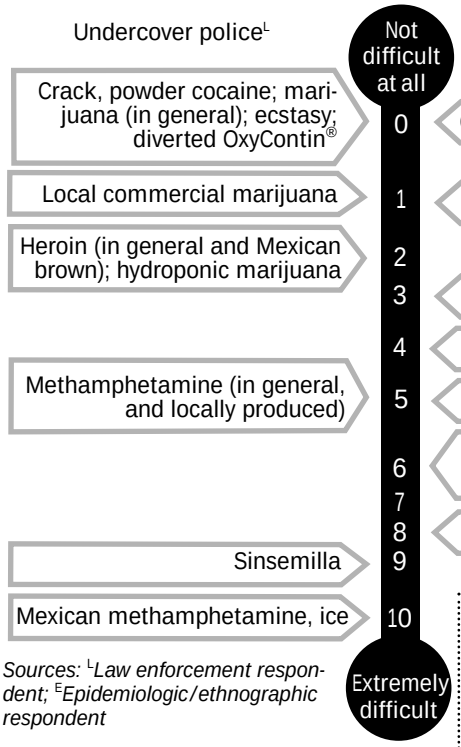
Drug related to the second most serious consequences:
- Heroin[L,M]
- Prescription pills[E]
- Crack[N]

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

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

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

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



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

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

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

HEROIN

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

COCAINE

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

MARIJUANA

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

METHAMPHETAMINE

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

MDMA (ECSTASY)

Two sources observe very different populations:

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

DIVERTED METHADONE

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

DIVERTED OXYCONTIN®

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

OTHER DRUGS

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

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

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

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

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

when used by opiate-naive people, can have dangerous consequences. Often even opiate-experienced people are methadone naive because they don't know exactly how they will react.[M] The other treatment source similarly reports an increase in drug overdoses, attributing them to more potent illegal drugs.[N]

Both treatment sources note an increase in drug-related automobile accidents, most involving young adolescents who "hang out" with older teens or parents.[N,M]

Tuberculosis, while fairly rare, may have increased slightly. Both treatment sources believe the increase might be related to increased homelessness.[N,M]

- Decreased barrier to treatment: Because of increased training, more people are aware of comorbidity problems and how to approach them, thus decreasing what had been a relatively common barrier to treatment.[N,M]
- Changes over the past 10 years: More than any other change over the past decade, the appearance of MS Contin® (morphine sulfate) and OxyContin® on the drug scene has been the most complicating factor in the community's drug abuse problem.[N,M] Other important changes include the earlier first use of more dangerous drugs,[N,M] the normalization of drug use,[N] increased court referrals to treatment,[N] and increased polydrug use.[N]

WHO USES ILLICIT DRUGS?

The *Pulse Check* epidemiologic, non-methadone treatment, and methadone treatment sources were asked to describe the populations most likely to use heroin, cocaine, marijuana, methamphetamine, and ecstasy. They were also asked to describe any emerging user groups and to report on how the drugs are used. As shown on the following pages, user characteristics vary by drug. Further, because of the different perspective each brings, the three sources sometimes describe quite different populations and use patterns for each drug. For example, all methadone clients are primary opiate users who may use drugs other than opiates in a secondary or tertiary manner.

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	18–30	>30	>30
Gender	NR	69% female	65% male
Race/ethnicity	NR	White	White
Socioeconomic status	Low	Middle	Middle
Residence	Central city	Suburbs	Suburbs
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	NR	Full time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Among first-time methadone admissions, approximately 15 percent report heroin as their primary drug of abuse.*[M]
- *Atypical of non-methadone programs described in most other* Pulse Check *sites, the majority of primary heroin abusers in this program are female.*[N]
- *Atypical of methadone programs described in most other* Pulse Check *sites, only 19 percent of the clients are primary heroin abusers– while about half are primary OxyContin® abusers.*
- *No changes are reported in the numbers or characteristics of users between spring and fall 2002.*

- *While injecting is the most common primary route of administration, smoking has increased over the past 5 years,*[E] *and a substantial number of methadone patients snort heroin.*[M]
- *Snorting, however, is the most common route of administration among the non-methadone clients.*[N]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Snorting	Injecting
Other drugs taken	NR	NR	Powder cocaine (speedballs)
Publicly or privately?	Privately	NR	Privately
Alone or in groups?	In groups/ among friends	NR	Both

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

Who's most likely to use cocaine?

Characteristic	Crack cocaine			Powder cocaine	
	E	N*	M	E	M
Age group (years)	>30	>30	>30	18–30	18–30
Mean age (years)	34	NR	NR	NR	NR
Gender	60% male	53% female	NR	Split evenly	Split evenly
Race/ethnicity	Black	White	White	White	White
Socioeconomic status	Middle	Middle	Low/middle	Middle	Low/middle
Residence	Central city	Suburbs	Suburbs	Central city/Suburbs	Suburbs
Referral source	N/A	Criminal justice	Individual	N/A	Individual
Level of education completed	N/A	High school	High school	N/A	High school
Employment at intake	N/A	NR	Full time	N/A	Full time

**The program doesn't distinguish between crack and powder cocaine, but crack is the predominant form of cocaine used.*

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Since the last reporting period, the number of crack users has increased slightly, while the number of powder cocaine users has declined slightly.*[E]
- *Treatment percentages, however, remained stable, as did client demographics and use patterns.*[N,M]
- *Methadone clients combine powder cocaine with heroin (in speedballs), but they use crack without other drugs.*[M]

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	13–17, 18–30	13–17	18–30
Mean age (years)	23–24	NR	NR
Gender	NR	62% male	Split evenly
Race/ethnicity	White, Black	White	White
Socioeconomic status	Low/middle	Middle	Low/middle
Residence	All	Suburbs	Suburbs
Referral source	N/A	Criminal justice	Individual
Level of education completed	N/A	Junior high	High school
Employment at intake	N/A	NR	Full time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

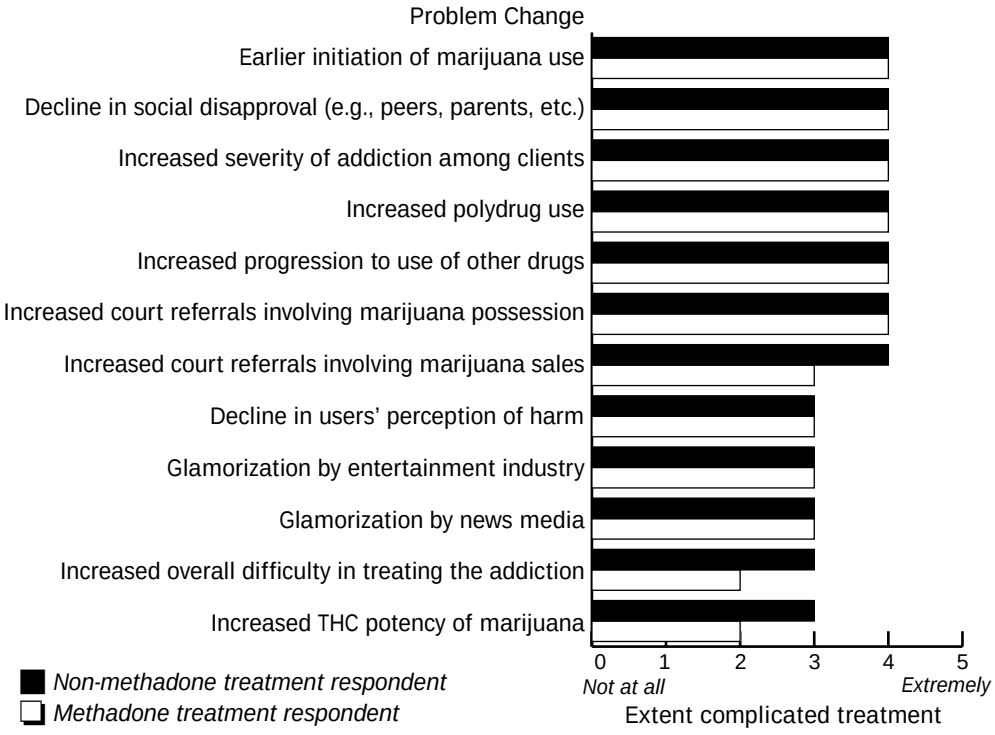
- *Nearly half of the clients in the non-methadone treatment program report marijuana as their primary drug of abuse.*[N]
- *The percentages of primary, secondary, or tertiary marijuana use remained stable in both treatment programs between spring and fall 2002.*[N,M]
- *Clients in both treatment programs generally smoke marijuana in joints,*[N,M] *although blunts are common in a related juvenile facility.*[M]
- *Joints and blunts are the most common delivery vehicles. Younger, lower socioeconomic central city users tend to use blunts. Suburban, middle-to-upper socioeconomic users tend to use pipes.*[E]
- *Sources report no specific marijuana combinations.*

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

Marijuana, in combination with other drugs, has recently been involved in an increasing number of deaths and emergency department episodes.[E] It is also associated with the following consequences, either alone or with other drugs:

- Drug-related arrests[E,M]
- Automobile accidents[E,N]
- High-risk pregnancies[E,N]
- Short-term memory loss[E,M]
- Deteriorating family and social relationships[E,M]
- Poor academic performance[E,M]
- School absenteeism or truancy[E,M]
- Dropping out of school[E]
- Poor workplace performance[E]
- Workplace absenteeism[E]
- Unemployment rates[E]

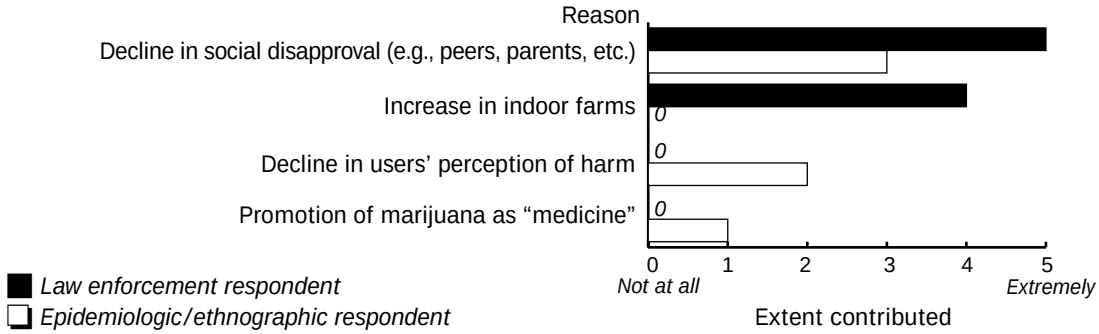
Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



What they have to say...

- *The two treatment sources are remarkably similar in their opinions about which changes have most and least complicated the treatment of marijuana users.*
- *Like many of their counterparts in other* Pulse Check *cities, both treatment sources attribute importance to the earlier initiation of marijuana use. By contrast, Tampa/St. Petersburg sources attribute somewhat greater importance than sources in most other* Pulse Check *cities to increased court referrals involving marijuana possession.*
- *With regard to the decline in social disapproval, one source elaborates: "Parents are not as concerned as they should be."*[N]

Widespread marijuana availability and use over the past 10 years: To what extent have the following contributed?



What they have to say...

- *Similar to the average opinion of their counterparts in other* Pulse Check *cities, the sources place the decline in social disapproval of marijuana as the most significant change over the past 10 years.*[L,E]
- *As reported in many other* Pulse Check *cities, prices have remained stable, and thus have not contributed to increases in marijuana use or availability.*[L]
- *Law enforcement and court emphasis has remained stable over the past 10 years–unlike in many other* Pulse Check *cities, where such emphasis has declined.*[L]
- *Most marijuana continues to be grown indoors.*[L]
- *Local production is at about the same level as it was 10 years ago.*[L,E]

WHO'S MOST LIKELY TO USE METHAMPHETAMINE, AND HOW DO THEY TAKE IT?

Methamphetamine users tend to be White[E,N] young adults (18–30 years)[E] or older adults (older than 30).[E,N] They are equally likely to be male or female,[E,N] they are generally from middle socioeconomic backgrounds,[E,N] and they live either in rural[E] or suburban[N] areas. Primary methamphetamine users account for only about 2 percent of clients in the non-methadone program, and the methadone program has no methamphetamine users. The epidemiologic source reports a stable number of users.

Clients in the non-methadone program generally take methamphetamine orally.[N] The epidemiologic source, however, reports that injecting is the most common primary route of administration, followed by smoking and snorting. The drug is generally taken privately in small groups or among friends, and it is sometimes taken with marijuana or alprazolam[E].

Who's most likely to use ecstasy?

Characteristic	E	M
Age group (years)	All groups	13–17, 18–30
Mean age (years)	22	NR
Gender	Split evenly	Split evenly
Race/ethnicity	White	White
Socioeconomic status	Middle	Low/middle
Residence	All areas	Suburbs
Referral source	N/A	Individual
Level of education completed	N/A	Junior high
Employment at intake	N/A	Full time

Sources: [E]Epidemiologic/ethnographic respondent; [M]Methadone treatment respondent

- *Ecstasy use is not recorded on intake to the non-methadone program.*[N]
- *Approximately 15 percent of clients in the methadone program use ecstasy.*[M]
- *Ecstasy users also take other club drugs,*[M] *powder cocaine,*[E] *and prescription pills such as clonazepam (Klonopin®) and alprazolam.*[E]
- *Two sources observe very different populations. One has been seeing increasingly younger users over the past 5 years.*[E] *Another believes the people "outgrow it [ecstasy], mature out."*[M] *Further, that source perceives a decline, even among younger people.*

WHO'S MOST LIKELY TO USE OTHER DRUGS?

- Diverted OxyContin®: The many methadone clients whose primary drug of abuse is OxyContin® tend to be male (about 65 percent), White, and older than 30 years. They tend to live in the suburbs, come from both low and middle socioeconomic backgrounds, and are equally likely to snort or inject the drug.[M] The epidemiologic source agrees that users tend to be White middle-socioeconomic suburbanites, but reports that abusers tend to take the drug orally and that they come from all age groups, with an average age of early twenties. Many of these people start out with legitimate prescriptions for pain, and then become addicted. This source cites an example of one young professional woman, with no history of drug use, who took the drug as prescribed after kidney surgery and subsequently became addicted.[E]
- Abused benzodiazepines: Alprazolam abusers tend to be White[E,N,M] females[E,N]. The epidemiologic source observes more younger abusers (17–25 years) than do the non-methadone (older than 30) and methadone (18–30 and older than 30) treatment sources. Pills are sometimes consumed with alcohol.
- Other abused opiates: A stable proportion of about 30 percent of clients in the methadone program abuse hydrocodone, morphine, or fentanyl patches. They tend to be White, suburban, low-to-middle socioeconomic young adults and older adults and are equally likely to be male or female.[M]

THE MARKET PERSPECTIVE

WHO'S SELLING DRUGS, AND HOW?

Most drugs are sold hand to hand at meetings prearranged through an intermediary. Cell phones are generally involved.[L,E] Additionally, mail transactions are reported for methamphetamine, OxyContin® (both pills and "scripts"), and alprazolam (both pills and scripts).[E]

Dealers in Tampa/St. Petersburg tend to sell more than one drug:[L]

- Heroin dealers also sell crack and powder cocaine.
- Crack dealers also sell powder, cocaine, marijuana, and ecstasy.
- Powder cocaine dealers also sell crack, marijuana, and ecstasy, as well as diverted pharmaceutical drugs.
- Marijuana dealers also sell crack, powder cocaine, and diverted pharmaceuticals.
- Ecstasy dealers also sell diverted pharmaceuticals.

According to the law enforcement source, street-level sellers of heroin, crack, powder cocaine, and marijuana tend to be young adults (18–30 years) who operate independently. Ecstasy sellers also operate independently, but they include adolescents as well as young adults. Heroin sellers are somewhat likely to use their own drug; crack, powder cocaine, marijuana, and ecstasy sellers are very likely to do so.[L]

The epidemiologic source paints a somewhat different picture. Crack dealers are organized, and they are generally older than 30. They are involved in gang-related activity, violent criminal acts, nonviolent criminal acts such as theft, domestic violence, and drug-assisted rape. Marijuana dealers do resemble the other source's description and are involved in nonviolent criminal acts such as theft and shoplifting. Ecstasy dealers are reported as organized, rather than independent, and they are involved in nonviolent criminal acts and drug-assisted rape.[E]

Methamphetamine sellers, unlike other drug dealers, are part of out-of-town organizations. They tend to be older than 30, are very likely to use the drug, and also sell ecstasy.[L,E] They are involved in prostitution and in nonviolent criminal acts, such as theft and burglary.[E]

Diverted OxyContin® is commonly sold by individuals who obtain their own prescriptions legitimately. They tend to be older than 30, and they do not sell other drugs.[L] They are involved in nonviolent criminal acts and in drug-assisted rape.[E]

Diverted alprazolam dealers generally operate independently, are either young adults or older adults, are somewhat likely to use the drug, and are involved in nonviolent crime and drug-assisted rape.[E]

WHERE ARE DRUGS SOLD AND USED?

Heroin and crack markets are generally located in central city areas, powder cocaine markets in both central city and suburban areas, and methamphetamine markets mostly in suburban areas. Marijuana and ecstasy sales are equally distributed among all areas (central city, suburban, and rural).[L]

Most illegal drugs (including heroin, cocaine, marijuana, methamphetamine, and ecstasy) are sold in the following locations:[L,E]

- In streets and open-air markets
- Crack houses/shooting galleries (excluding marijuana and ecstasy)
- Nightclubs and bars (excluding heroin)
- Private residences
- Public housing developments
- Playgrounds and parks
- Private parties
- Hotels/motels

How much do drugs cost?

Drug	Unit	Price
Heroin	1/4 g	$20
	1 g	$80
Powder cocaine	1 g	$50
Crack cocaine	0.1–0.2 g	$20
Marijuana	1/4 oz	$40
	1 oz	$1,100–$1,200
Ecstasy	One tablet	$12–$15
Diverted Oxycontin®	40 mg	$20
	80 mg	$40
Hydrocodone	One tablet	$3–$4

Source: Law enforcement respondent

No changes are reported in any price or purity levels between spring and fall 2002.

- Around supermarkets
- Inside cars

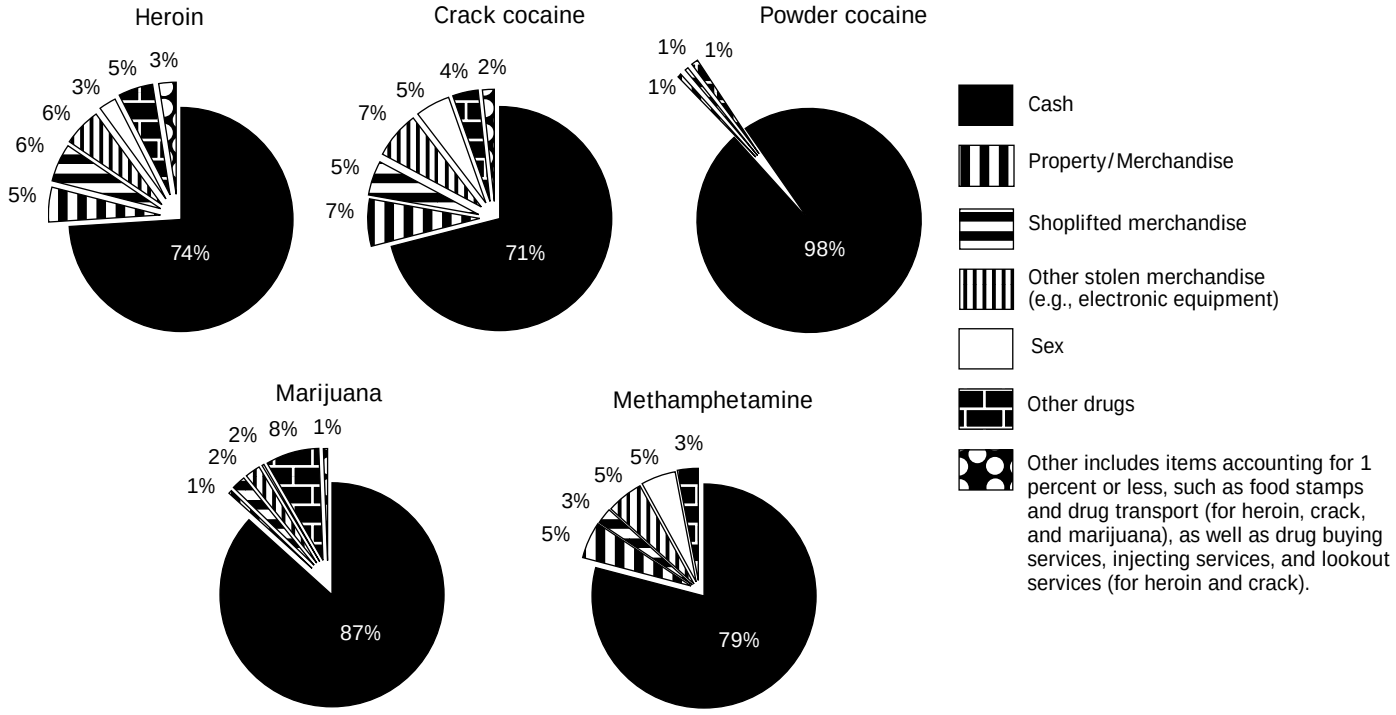
Additional sales settings include the following:[E]

- Around drug treatment clinics: Heroin, crack, marijuana, and ecstasy
- In or around schools: Heroin, marijuana, and ecstasy
- Raves: Heroin, marijuana, methamphetamine, and ecstasy
- College campuses and concerts: Powder cocaine, methamphetamine, and ecstasy
- Shopping malls: Marijuana, methamphetamine, and ecstasy

Diverted OxyContin® is generally sold in the suburbs, inside private residences.[L]

Most use settings mirror sales settings, with the exceptions of playgrounds and parks, around supermarkets, and shopping malls.[E]

Beyond cash: What else is accepted in exchange for drugs?



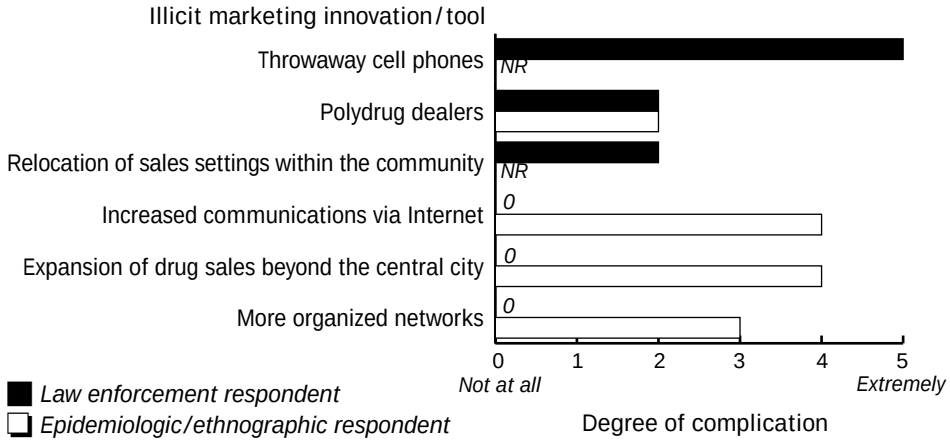
Source: Mean of response ratings given by law enforcement, epidemiologic/ethnographic, non-methadone treatment, and methadone treatment respondents

What they have to say...

- *As in the vast majority of* Pulse Check *cities, most transactions are cash only, particularly in the case of powder cocaine.*
- *The practice of exchanging sex for drugs is less common in Tampa/St. Petersburg than in the majority of other* Pulse Check *cities.*
- *One source notes an increase, over the past decade, in the exchange of diverted prescription drugs—such as alprazolam and OxyContin®—for illicit drugs[E]. Such exchanges are particularly common for methamphetamine[E] and marijuana[M].*

THE MARKET PERSPECTIVE: A 10-YEAR VIEW

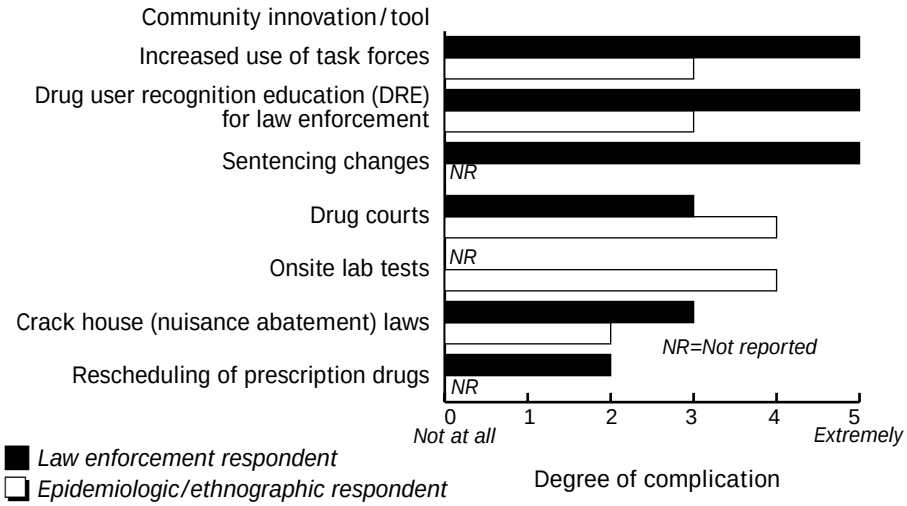
Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt drug activity in Tampa/St. Petersburg?



What they have to say...

- *As in the vast majority of* Pulse Check *cities, throwaway cell phones have posed the greatest impediment to detection and disruption efforts.*[L]
- *Most dealers have remained independent, so increased or decreased network organization has not posed as much of a challenge as in other cities.*[L] *Moreover, even though methamphetamine dealers, unlike most other drug dealers, do work within an organized structure, that network has been disrupted by the community's Meth Squad.*[E]
- *Increased communications via the Internet have posed a growing challenge especially among younger users and with regard to gamma hydroxybutyrate (GHB).*

Community innovations and tools over the past 10 years: How successful have they been?



What they have to say...

- *Task forces: A Meth Squad has been introduced and has successfully seized many labs in a nearby rural county that serves as the source for Tampa's methamphetamine supply.*[E]
- *Sentencing changes: Minimum mandatory sentences and higher bail for trafficking have proven effective.*[L]
- *DRE: Tampa/St. Petersburg, along with about half of the* Pulse Check *cities, has a DRE program. As in those cities, sources believe it successfully trains law enforcement personnel to recognize drug users.*[L,E]
- *Onsite lab tests: When a needle is found, it can be tested immediately for methamphetamine, enabling quick identification and rapid response.*[E]

SEPTEMBER 11 FOLLOWUP

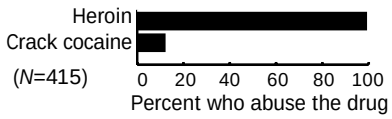
Except for a staff perception of decreased funding in the non-methadone program,[N] the September 11 attacks and their aftermath have had no continuing aftereffects on the drug abuse situation in Tampa/St. Petersburg.

WASHINGTON, DC, PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 4,923,153
- Median age: . . . . . 34.9 years
- Race (alone):
  - White: 60.1%
  - Black: 26.0%
  - American Indian/ Alaska Native: 0.3%
  - Asian/Pacific Islander: 6.8%
  - Other race: 3.9%
  - Two or more races: 2.9%
- Hispanic (of any race): 8.8%
- Unemployment rate: 3.0%
- Median household income: $62,216
- Families below poverty level with children <18 years: 7.2%

*Source: U.S. Census 2000**

What drugs do clients in a methadone program use?+ (Fall 2002)



+Includes any use, whether as a primary, secondary, or tertiary drug; the percentage for benzodiazepine abuse is "high" but not reported; the percentage for OxyContin® abuse was less than one; the percentages for all other drugs were zero.

Source: Methadone treatment respondent

THE BIG PICTURE: WHAT'S CHANGED? (SPRING 2002 VS FALL 2002)

Three of four *Pulse Check* respondents consider the illegal drug problem very serious,[L,E,N] and one considers it somewhat serious.[M] Three respondents consider the problem as stable,[L,E,M] and one considers it somewhat worse[N].

Sources report several positive changes:

- After reports of increases in the last few *Pulse Checks*, abuse of OxyContin® (oxycodone hydrochloride controlled-release) declined, availability declined, and it has become more difficult for users to buy.[E]
- After increasing for the past few half-years, methylenedioxymethamphetamine (MDMA or ecstasy) use and activity have leveled off, fewer raves are being held, and ecstasy use among non-methadone treatment admissions has declined.[E,N]
- Although most facilities have waiting lists, methadone treatment has become more available.[E]
- Hepatitis C among methadone clients declined due to more education and prevention.[M]
- Onsite lab tests (field tests) and the increased use of task forces have been highly successful in combating the drug abuse problem in Washington, DC.[L]

The use and sales of several drugs show signs of increasing:

- After a 15-year lull, phencyclidine (PCP) has returned to Washington, DC.[E]
- Heroin sales, availability, use, and treatment admissions have increased.[L,E,N,M]
- Five open-air markets, primarily for heroin, are new to the city since spring 2002.[E]
- Adolescent and young adult heroin sellers have increased and are associated with more violence.[L,E]
- South American and Mexican brown heroin have become easier to buy.[L]
- Crack use increased, and unemployment among crack users increased.[N]
- Marijuana use, in general, increased.[L, E]
- Methamphetamine is becoming easier to purchase.[L]

Most widely abused drug:
- Marijuana[L,E]
- Crack[N]
- Heroin[M]

Changes between spring and fall 2002: Heroin replaced benzodiazepines in the methadone treatment program.[M]

Second most widely abused drug:
- Crack[L,E]
- Marijuana[N]
- Benzodiazepines[M]

Changes between spring and fall 2002: Benzodiazepines replaced crack in the methadone treatment program.[M]

Drug related to the most serious consequences:
- Heroin[E,N,M]
- Crack[L]

Changes between spring and fall 2002: Heroin replaced crack.[N]

Drug related to the second most serious consequences:
- Crack[E,N,M]
- Heroin[L]

Changes between spring and fall 2002: Heroin replaced marijuana.[L]

New or emerging problems:
- PCP
- Methamphetamine and ecstasy use and activity are increasing.[L]

Sources: [L]Law enforcement, [E]Epidemiologic/ethnographic, [N]Non-methadone treatment, and [M]Methadone treatment respondents

Note: These symbols appear throughout this city profile to indicate type of respondent.

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

Heroin sales, availability, use, and treatment admissions are relatively high and have increased:[L,E,N,M]

- Five open-air markets are new to the city since fall 2002. Most of these markets are primarily for heroin sales and are run by adolescents (16–18 years).[E]
- Adolescent and young adult heroin sellers have increased, and more violence is associated with these younger dealers.[L,E]
- South American and Mexican brown heroin have become easier to buy.[L]

COCAINE

- Crack use remains high and has increased among non-methadone treatment admissions.
- Powder cocaine use remains relatively low in the Washington, DC, area.

MARIJUANA

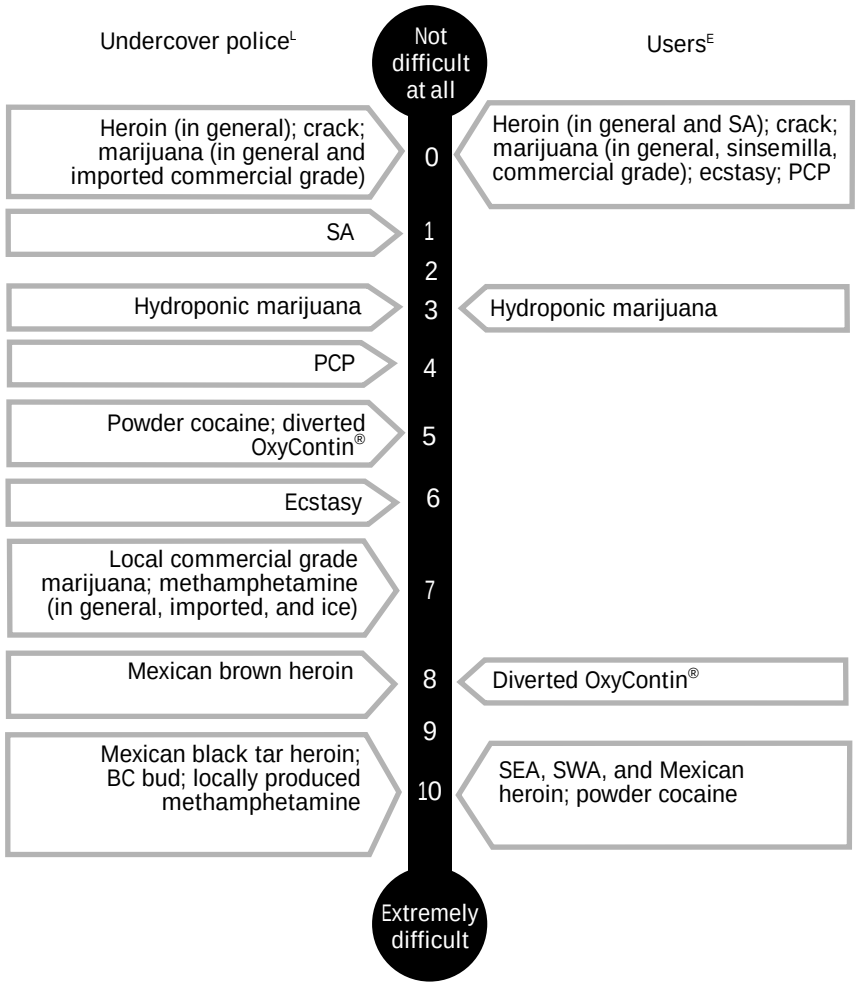
Marijuana use remains high and has increased.

- Adults older than 30 are increasingly using the drug.[E]
- Hydroponic marijuana has become easier to purchase.[E]

METHAMPHETAMINE

- Methamphetamine activity and use remain relatively low.
- One source, however, regards it as an emerging drug that is becoming more readily available.[L]

How difficult is it for undercover police and users to buy drugs? (Fall 2002)



Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent
Note: SA = South American (Colombian) heroin; SWA = Southwest Asian heroin; SEA = Southeast Asian heroin; ice = highly pure methamphetamine in smokable form; and BC bud = British Columbian marijuana.

- *Respondents agree that heroin (in general and South American), crack cocaine, and marijuana (in general, commercial grade, and hydroponic) are relatively easy to buy.*[L,E]
- *As in three other* Pulse Check *cities (Boston, Cleveland, and Miami) between spring and fall 2002, diverted OxyContin® has become more difficult for abusers to buy.*[E]
- *Respondents report that several drugs are easier to buy since spring 2002:*
  - *South American and Mexican brown heroin*[L]
  - *Hydroponic marijuana*[L]
  - *Methamphetamine (in general, imported, and ice)*[L]
  - *Ecstasy*[L]
  - *PCP*[L,E]

MDMA (ECSTASY)

- After increasing for the past few half-years, ecstasy use and activity have leveled off, fewer raves are being held, and ecstasy use among non-methadone treatment admissions has declined.[E,N]
- On the other hand, ecstasy is easier to purchase, is considered an emerging drug by one source, and street or open-air market sales have increased.[L]

DIVERTED OXYCONTIN®

- After reports of increases in the last few issues of *Pulse Check*, OxyContin® abuse has declined.
- Availability has declined, and it has become more difficult for users to buy, particularly around methadone clinics, where it used to be sold.[E]

PCP

Several reports show increased PCP use and activity:

- PCP use has increased dramatically.[E]
- PCP-related arrests are up.[L,E]
- The drug is easier to buy.[L,E]
- The number of sellers has increased.[L]
- Small, local PCP labs have increased—unlike 15 years ago, when the drug was popular in Washington, DC, and most was imported from outside the city.[E]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity

- The *Pulse Check* non-methadone treatment respondent reports that among the 300 clients in that program, crack is the most common drug of abuse, followed by marijuana. That source further reports increases in heroin and crack use and a decline in ecstasy use among treatment clients.[N]
- The methadone treatment respondent is with a facility that operates at 90 percent capacity (415 of 460 slots filled) (*see bar chart on the first page of this chapter*). Beyond that specific facility, methadone maintenance treatment is available throughout the area, but programs (public and private) have large waiting lists.[E] However, methadone treatment is reportedly more available during fall 2002 than it was during spring 2002.[E]

Barriers to treatment and consequences of drug use

- The most common barrier to methadone treatment remains limited slot capacity.
- Another common barrier is the inability of the methadone treatment program to test for OxyContin® abuse, which makes it difficult to know if a client abuses the drug and what type of treatment is appropriate.[M]
- The most common health-related consequences of drug abuse among methadone treatment admissions remain HIV/AIDS and hepatitis C; however, hepatitis C has declined in the past 6 months due to more education and prevention. Renal failure, most likely related to alcohol abuse among heroin addicts, increased between spring and fall 2002.[M]

Increased complications for drug treatment over the past 10 years

- The lack of housing opportunities for people on methadone maintenance treatment makes recovery difficult. Many transitional housing and "sober living" environments do not accept tenants who are on methadone maintenance treatment.[M]
- Other changes in drugs and drug use over the past 10 years that have made treatment more difficult include the following: the declining cost of drugs (related specifically to the low cost of crack),[N] the earlier first use of more dangerous drugs (related specifically to PCP use),[N] the spread of drug use among all age groups (related specifically to the use of marijuana blunts among adolescents and young adults),[N] and the lack of jobs and job training opportunities for recovering clients.[M]

WHO USES ILLICIT DRUGS?

The *Pulse Check* epidemiologic, non-methadone treatment, and methadone treatment sources were asked to describe the populations most likely to use heroin, cocaine, marijuana, methamphetamine, and ecstasy. They were also asked to describe any emerging user groups and to report on how the drugs are used. As shown on the following pages, user characteristics vary by drug. Further, because of the different perspective each brings, the three sources sometimes describe quite different populations and use patterns for each drug. For example, all methadone clients are primary opiate users who may use drugs other than opiates in a secondary or tertiary manner.

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	18–30	>30
Mean age (years)	35+	NR	46
Gender	Male	Split evenly	66% male
Race/ethnicity	Black	Black	Black
Socioeconomic status	Low	Low	Low
Residence	Central city	Central City	Central city
Referral source	N/A	Criminal justice, individual, alcohol/drug abuse care provider, employer	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Part time	Unemployed

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Between spring and fall 2002, heroin use increased among non-methadone clients and new drug users.*[E,N]
- *Most heroin users are Black adults older than 30 who are of low socioeconomic status.*[E,M]
- *New heroin users display different characteristics than the general heroin-using population: they are younger (18–30 years versus older than 35), more likely to be White and of higher socioeconomic status, and more likely to reside in the suburbs.*[E]

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Snorting	Injecting
Other drugs taken	Crack (speedball)	NR	Benzodiazepines; crack
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	Alone	In groups	Alone

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Most heroin users in Washington, DC, inject the drug.*[E,M]
- *New heroin users tend to snort or inject the drug, and they do not take any other drugs.*[E]
- *Crack used in combination with heroin (speedball) remains a common practice.*[E,M]
- *Between spring and fall 2002, heroin combinations have changed: marijuana plus heroin used to be a common combination, but methadone treatment admissions have switched to alcohol use with heroin.*[M]

Who's most likely to use cocaine?

	Crack			Powder cocaine
Characteristic	E	N	M	N
Age group (years)	18–30	>18	>30	NR
Gender	Female	Split evenly	Male	Split evenly
Race/ethnicity	Black	White and Black	Black	Black
Socioeconomic status	Low	Middle	Low	Middle
Residence	Central city	Central city	Central city	Central city
Referral source	N/A	Criminal justice, individual, and other alcohol/drug abuse care provider, employer	Individual	Criminal justice, individual, alcohol/drug abuse care provider, employer
Level of education completed	N/A	High school	NR	High school
Employment at intake	N/A	Part time	NR	Part time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Among non-methadone treatment admissions, crack use increased between spring and fall 2002. Unemployment among crack users also increased.*[N]
- *After methadone clients who use crack undergo treatment, they stop using crack with heroin (speedball) and smoke crack alone.*[M]
- *Powder cocaine use is relatively low in Washington, DC.*[E,N,M] *Sources report no changes in user characteristics.*

Who's most likely to use marijuana?

Characteristic	E	N
Age group (years)	18–30	All
Gender	Male	Split evenly
Race/ethnicity	Black	Black
Socioeconomic status	All	Low
Residence	Central city and suburbs	Central city
Referral source	N/A	Criminal justice, individual, alcohol/drug abuse care provider, employer
Level of education completed	N/A	Junior high
Employment at intake	N/A	Part time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent

- *Marijuana use, in general, has increased, and adults older than 30 years are increasingly using the drug.*[E]
- *As in many* Pulse Check *cities, marijuana user characteristics span a wide range of ages and socioeconomic statuses.*[E,N]
- *New users are more likely than the general marijuana-using population to be adults older than 30 and of middle socioeconomic status.*[E]
- *Marijuana is most often smoked in blunts and joints.*[E,N]

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

Marijuana, used either alone or with other drugs, is associated with the following consequences, which remained stable between spring and fall 2002:

- Drug-related deaths[N]
- Drug-related arrests[E,N]
- Automobile accidents[N]
- High-risk pregnancies[N]
- Short-term memory loss[N]
- Deteriorating family and social relationships[N]
- Poor academic performance[N]
- School absenteeism, truancy, or dropping out of school[N]
- Poor workplace performance[N]
- Workplace absenteeism[N]

SEVERAL CHANGES OVER THE PAST 10 YEARS HAVE GREATLY COMPLICATED TREATMENT FOR MARIJUANA-USING CLIENTS:[N]

- Increased severity of addiction among clients
- Increased overall difficulty in treating the addiction
- Earlier initiation of marijuana use
- Decline in users' perception of harm
- Decline in social disapproval
- Glamorization by the entertainment industry
- Increased court referral involving marijuana possession and sales

WHO'S MOST LIKELY TO USE METHAMPHETAMINE?

Methamphetamine use is low in Washington, DC, and no changes in user characteristics are reported.[E,N,M]

OTHER DRUGS

- Diverted OxyContin®: Most OxyContin® abusers are heroin addicts who take OxyContin® as a heroin substitute.[E] They tend to be older than 30, male, White and Black, of low socioeconomic status, and they inject the drug. OxyContin® use has decreased dramatically between spring and fall 2002.
- PCP: PCP use has increased dramatically between spring and fall 2002. Most users are 13–30 years old, male, Black, of low to middle socioeconomic status, and live in the central city. Arrests are up for PCP, which is sold as a liquid in vials. Users dip menthol cigarettes or cigars in the liquid and smoke the cigarette or cigar, known as "big dipper."[E]
- Alprazolam (Xanax®): Methadone treatment clients often use benzodiazepines sequentially with heroin and alcohol.[M]

Who's most likely to use ecstasy?

Characteristic	E	N
Age group (years)	18–30	18–30
Gender	Male	Split evenly
Race/ethnicity	White	Black
Socioeconomic status	Middle and high	Middle
Residence	Central city	Central city
Referral source	N/A	Criminal justice
Level of education completed	N/A	High school
Employment at intake	N/A	Full time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent

- *After increasing for the past few half-years, ecstasy use and activity leveled off between spring and fall 2002 and are now fairly stable. The rave scene has also "quieted down."*[E]
- *Among non-methadone treatment admissions, ecstasy use decreased.*[N]
- *Ecstasy users tend to be young adults of middle to high socioeconomic status who reside in the central city.*[N,E]
- *Respondents report no changes in user or use demographics since spring 2002.*

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Most drugs are used and sold in the central city, and most (heroin, crack and powder cocaine, marijuana, ecstasy, diverted OxyContin®, and PCP) are sold at open-air markets and on street corners. The law enforcement source estimates there are 50 open-air markets in Washington, DC. The epidemiologic respondent reports five new open-air markets in the city since spring 2002. Most of these markets are for heroin sales in particular and are run by adolescents (16–18 years).[E] Besides open-air markets, heroin is also sold at the following locations:

- Inside private residences[L]
- Around public housing developments[L,E]
- Schools[L]
- Drug treatment clinics[L,E]

Crack is sold in similar locations, including the following:

- Crack houses[L,E]
- Inside private residences[L]
- Public housing developments[L,E]
- Schools[L]
- Playgrounds and parks[L,E]
- Inside cars[L,E]

Powder cocaine, which is not very available in Washington, DC, is sold in nightclubs and bars.[L]

Marijuana is sold at a wide variety of locations:

- Private residences[L,E]
- Public housing developments[L,E]
- Schools[L,E]
- College campuses[L]
- Nightclubs and bars[L]
- Playgrounds and parks[L,E]
- Private parties[L,E]
- Raves and concerts[L]
- Inside cars[L]

Most methamphetamine sales are confined to private residences, nightclubs, and bars.[L]

Ecstasy sales occur in private residences,[E] nightclubs and bars,[L,E] and raves.[L,E] However, the number of raves has leveled off since spring 2002.[E]

In addition to open-air market sales, OxyContin® (most of which is diverted from pharmacies outside the city) is sold around drug treatment clinics. PCP sales are out in the open and nearly all occur on the street.[L]

HOW DO ILLEGAL DRUGS GET FROM SELLER TO BUYER?

Typically, heroin and crack buyers search for open-air markets and buy the drugs hand to hand. Drugs sold with heroin include diverted OxyContin®, methadone, other prescription opiates, and sometimes crack. Dealers who sell primarily crack tend to sell no other drugs.[L]

Marijuana is also sold out in the open, often on street corners. Dealers approach buyers for hand-to-hand exchanges of the drug.[L,E] Additionally, buyers may call marijuana dealers to arrange a meeting for exchanging the drug.[E]

Most ecstasy sales are venue oriented (in nightclubs or raves). Buyers approach known dealers or are directed to dealers by acquaintances at these venues.[L,E] Some ecstasy is sold similarly to heroin (in open-air markets), and these types of ecstasy sales increased between spring and fall 2002.[L] Other drugs sold by ecstasy dealers include gamma hydroxybutyrate (GHB) and lysergic acid diethylamide (LSD).

WHO SELLS ILLEGAL DRUGS?

Sellers of most drugs in Washington, DC, are independent young adults (18–30 years) and adults (>30 years). Crack sellers tend to be more organized (typically into loose neighborhood groups, known as "crews") than their other drug counterparts.[L,E]

Older heroin dealers are likely to be heroin addicts, and most diverted OxyContin® dealers tend to be prescription drug or heroin addicts.[E]

Respondents report several changes in sales groups between spring and fall 2002:

- Young adult heroin sellers have increased, and more violence is associated with these younger dealers.[L,E]
- Young adult Blacks (as opposed to Whites) are increasingly selling ecstasy.[L] Furthermore, nightclub owners, bartenders, or bouncers tend to know ecstasy dealers and allow them to sell the drug in their establishments.[E]
- The number of PCP dealers has increased.[L,E] Most dealers manufacture the PCP in their own small, local labs.[E]

BEYOND CASH: WHAT ELSE IS ACCEPTED IN EXCHANGE FOR DRUGS?

The law enforcement source states that over the last 10 years, 99 percent of transactions for all drugs have used cash. Property and merchandise exchange accounts for the other 1 percent.[L]

Which drug sellers are associated with which crimes?

Crime	Heroin	Crack	Powder cocaine	Marijuana	Methamphetamine	Ecstasy	PCP
Prostitution		✓					
Gang-related activity	✓	✓					
Violent criminal acts	✓	✓		✓			✓
Nonviolent criminal acts	✓		✓				✓
No crimes associated					✓	✓	

Sources: Law enforcement respondent; epidemiologic/ethnographic respondent

- *Heroin and crack cocaine sellers are involved in a wide variety of crimes, including gang-related crimes, assaults, petty theft, and larceny.*[L,E]
- *Violent crimes associated with PCP sales increased between spring and fall 2002.*[L]
- *Diverted OxyContin® is not generally associated with criminal activity.*

How pure are illegal drugs and much do they cost?

Drug	Unit	Purity	Price
South American heroin	1 mg (highly adulterated)	23%	$1.05[E]
	Dime bag (50–75 mg)	10–15%	$10[L]
	1 g	60–70%	$120–$140[L]
	1 g (highly adulterated)	23%	$120–$150[E]
Crack cocaine	One rock	NR	$10[E]
	Dime bag (75 mg)	30–60%	$10[L]
	1 g	30–60%	$100[L]
Powder cocaine	Dime bag (100–150 mg)	30%	$10[L,E]
	1 g	30–60%	$50–$100[L,E]
Marijuana (commercial grade)	One bag (three joints)	NR	$5–$10[E]
	One blunt	NR	$10–$20[E]
	One bag (750 mg)	NR	$20[L]
Marijuana (hydroponic)	1 oz	NR	$480[E]
Methamphetamine (powder or ice)	1 g	NR	$140[L]
Ecstasy	One pill	NR	$18–$35[L,E]
Diverted OxyContin®	20-mg pill	N/A	$30–$40[L]
	40-mg pill	N/A	$40–$80[L,E]
PCP (liquid)	One vial	NR	$20–$50[E]
	One dipped cigarette	NR	$25[L]
	1 oz	NR	$350–$500[L]

Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

- *South American (Colombian) heroin is sold in two forms in Washington, DC: highly adulterated ("scramble" at about 23 percent pure) and unadulterated ("bone" at 40–80 percent pure).*[E]
- *PCP is typically sold in vials (referred to as "dippers") with ounces of marijuana. Menthol cigarettes dipped in PCP are also sold.*[L]
- *Between spring and fall 2002, drug purity and prices remained stable with one exception: diverted OxyContin® prices declined.*[E]

COMMUNITY INNOVATIONS AND TOOLS OVER THE PAST 10 YEARS: HOW SUCCESSFUL HAVE THEY BEEN?

The law enforcement respondent rates two law enforcement tools as highly successful in combating the drug abuse problem in Washington, DC: onsite lab tests (field tests) and the increased use of task forces. The newest task force is a homicide-narcotics task force that has already been quite successful.[L]

SEPTEMBER 11 FOLLOWUP

None of the four *Pulse Check* respondents in Washington, DC, believes that the September 11 attacks and their aftermath have had any long-term effects on the drug abuse problem. The law enforcement source states that although drug dealers continue to avoid airplanes for transporting drugs into Washington, DC, they find other ways to import drugs, and the drug supply is stable.

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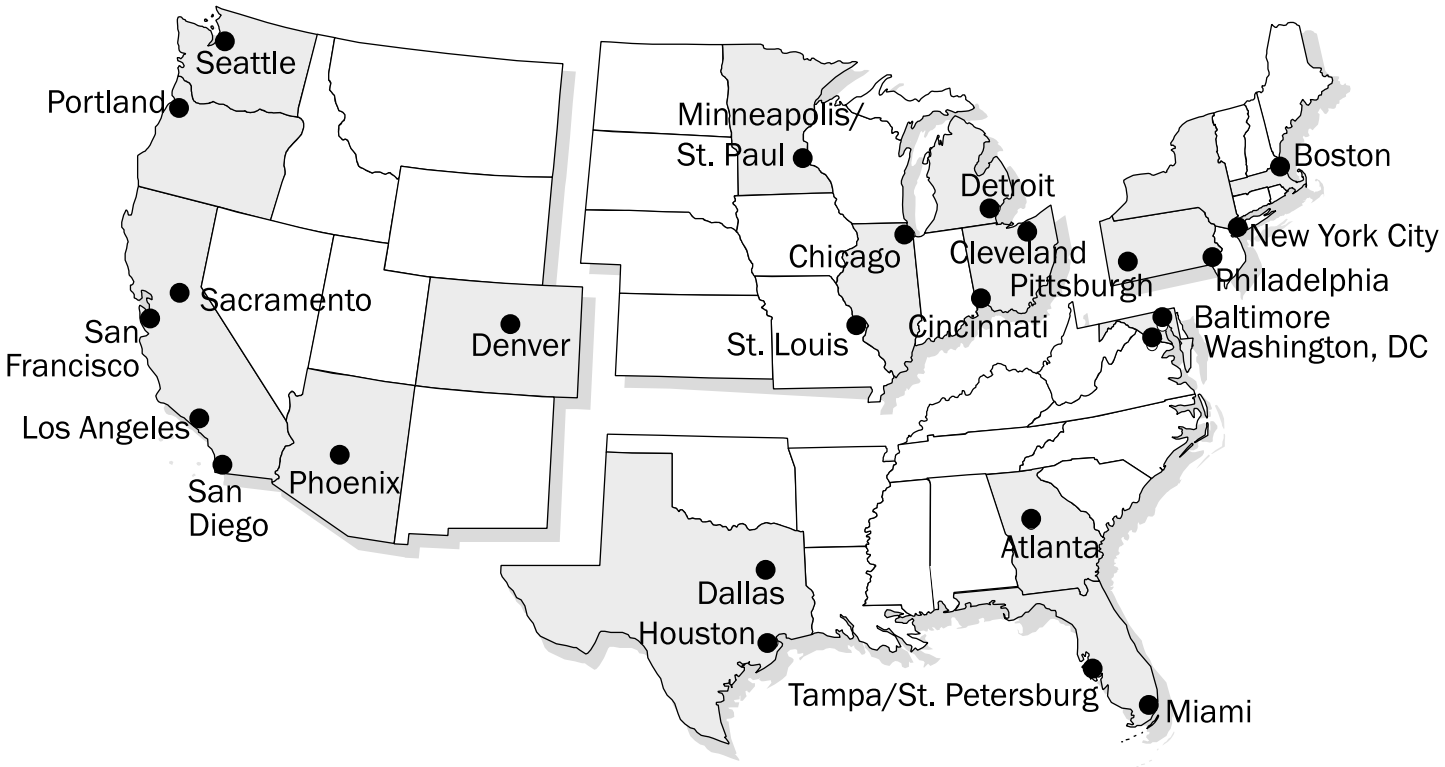
PULSE CHECK



APPENDICES

APPENDIX 1: METHODOLOGY

How were the sites selected? *(See map in the Introduction)* A total of 25 sites were studied for this issue of *Pulse Check*, to correspond with ONDCP's current 25-Cities Initiative, which includes the largest cities within America's 25 most populous metropolitan areas. Though drug use has harmed all cities, America's largest cities have been particularly hard hit. These cities include the following 12, which have been reported on in the past four issues of *Pulse Check*:

Baltimore, MD*
Boston, MA
Chicago, IL
Denver, CO
Detroit, MI
Miami, FL
Los Angeles, CA
New York, NY
Philadelphia, PA
St. Louis, MO
Seattle, WA
Washington, DC

They also include the following 13 newly added cities:

Atlanta, GA
Cincinnati, OH
Cleveland, OH
Dallas, TX
Houston, TX
Minneapolis/St. Paul, MN
Phoenix, AZ
San Diego, CA
San Francisco, CA
Pittsburgh, PA
Portland, OR
Sacramento, CA
Tampa/St. Petersburg, FL

How do the 25 sites vary? While these 25 sites were purposely selected, they nevertheless represent a broad cross-section of geographic regions and demographic characteristics, as highlighted in Appendix 2. For example, their unemployment rates range from a 2.5 percent low in San Francisco to a 6.2 percent high in Chicago and Philadelphia. Their poverty levels (for persons younger than 18) range from 6.5 percent in Minneapolis/St. Paul to 23.3 percent in New York. The racial/ethnic breakdowns in the 25 sites further exemplify their diversity: White representation ranges from 48.7 percent in Los Angeles and 48.8 percent in New York to 89.5 percent in Pittsburgh; Black representation ranges from 4.4 percent in Seattle to 29.6 percent in Atlanta; and Hispanic (of any race) representation ranges from less than 1 percent in Pittsburgh to 57.3 percent in Denver.

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 25 sites: an ethnographer or epidemiologist, a law enforcement official, a non-methadone treatment provider, and a methadone treatment provider. As in the existing 12 *Pulse Check* sites, ethnographers and epidemiologists in the 13 new sites were recruited based on several possible criteria: past participation in the *Pulse Check* program; membership in the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG); research activities in local universities; or service in local community programs. We recruited law enforcement officials—again as in the past—by contacting local police department narcotic units, Drug Enforcement Administration (DEA) local offices, and High Intensity Drug Trafficking Areas (HIDTA) directors.

To identify knowledgeable treatment sources, we consulted with experts in the field in the 13 newly added sites. This purposeful means of selecting treatment sources has been part of the *Pulse Check* methodology since the January–June 2001 issue. Some of the treatment sources in the 12 existing sites had been selected previously via a random selection methodology (described in the Mid-Year 2000 issue methodology appendix). Those sources were retained in order to preserve continuity.

All sources from the 13 new sites were identified and recruited during March through May 2003, and telephone discussions were conducted with them throughout that period. This wave of identification, recruitment, and discussion followed a first wave of discussions, held December 2002 through January 2002, with sources in the 12 existing sites.

Altogether, we have identified and recruited 99 of the potential 100 sources in the 25 Pulse Check sites: one treatment source could not be identified (Portland, OR, non-methadone). For this *Pulse Check* issue, we successfully obtained information from 97 of those 99 sources: a response rate of 98 percent. Two participants were unavailable for this round of discussions: the Cincinnati law enforcement official, and the Miami methadone provider.

What kind of data were collected, and how? For each of the 97 responding sources, we conducted a single telephone discussion lasting about 1 hour. We asked sources to explore with us their perceptions of any change in the drug abuse situation between spring and fall 2002. We discussed a broad range of topic areas with these individuals, as delineated in Appendix 4. Not surprisingly, ethnographic and epidemiologic sources were 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. Many 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, and other local market activities; they were not asked to discuss user groups and characteristics.

**Baltimore has been a Pulse Check site in the last three issues*

APPENDIX 2: POPULATION DEMOGRAPHICS IN THE 25 *PULSE CHECK* SITES

	Pulse Check Sites	Total population	Median age (Years)	Race percent: White	Black	American Indian/ Alaska Native	Asian Pacific Islander	Other	Two or more	Percent Hispanic (any race)	Unemployment rate	Median household rate	Percent persons under 18 below poverty level
Northeast	Boston, MA PMSA	3,406,829	36.3	82.5	7.0	0.2	4.9	3.0	2.4	5.9	2.9	$55,183	8.6
	New York, NY PMSA	9,314,235	34.6	48.8	24.6	0.5	9.2	12.2	4.6	25.1	5.1	$41,053	23.3
	Philadelphia, PA PMSA	5,100,931	36.4	72.1	20.1	0.2	3.4	2.5	1.6	5.1	6.2	$47,536	14.4
	Pittsburgh, PA MSA	2,358,695	40.0	89.5	8.1	0.1	1.1	0.3	0.9	0.7	2.6	$37,467	12.7
South	Atlanta, GA PMSA	4,112,198	32.9	64.2	29.6	0.7	3.8	3.6	1.7	6.5	3.5	$51,948	11.8
	Baltimore, MD PMSA	2,552,994	36.6	67.3	27.4	0.3	2.7	0.7	1.5	2.0	3.3	$49,938	10.3
	Dallas, TX PMSA	3,519,176	31.8	67.2	15.1	0.6	4.1	10.7	2.4	23.0	3.4	$55,854	11.6
	Houston, TX PMSA	4,177,646	31.6	61.1	17.5	0.4	5.3	12.9	2.8	29.9	4.1	$44,665	14.8
	Miami, FL PMSA	2,109,282	34.1	79.4	5.5	0.2	1.4	4.6	3.8	57.3	5.0	$35,966	19.3
	Tampa/St. Petersburg, FL MSA	2,395,997	40.0	82.9	10.2	0.3	2.0	2.7	2.0	10.4	2.9	$37,406	12.7
	Washington, DC PMSA	4,923,153	34.9	60.1	26.0	0.3	5.8	3.8	2.9	8.8	3.0	$62,216	7.2
Midwest	Chicago, IL PMSA	8,272,768	33.7	65.8	18.9	0.3	4.6	8.2	2.3	17.1	6.2	$51,680	11.4
	Cleveland, OH PMSA	2,250,871	37.3	79.6	18.5	0.2	1.4	1.4	1.6	3.3	3.4	$42,089	13.1
	Cincinnati, OH PMSA	1,646,395	35.1	84.1	13.0	0.2	1.2	0.4	1.1	1.1	2.9	$44,248	11.1
	Detroit, MI PMSA	4,441,551	35.5	71.2	22.9	0.3	2.3	1.1	2.1	2.9	5.9	$49,175	14.8
	Minneapolis/ St. Paul, MN MSA	2,968,806	34.2	86.1	5.3	0.7	4.1	1.6	2.1	3.3	3.5	$54,304	6.5
	St. Louis, MO MSA	2,603,607	36.0	78.3	18.3	0.2	1.4	0.5	1.2	1.5	3.7	$44,437	11.2
West	Denver, CO PMSA	2,109,282	34.1	79.4	5.5	0.2	1.4	4.6	3.8	57.3	5.0	$35,966	19.3
	Los Angeles, CA PMSA	9,519,338	32.0	48.7	9.8	0.8	12.2	23.5	4.9	44.6	5.0	$42,189	19.9
	Phoenix, AZ MSA	3,251,876	33.2	77.0	3.7	2.2	2.2	12.1	2.9	25.1	3.1	$44,572	12.7
	Portland, OR MSA	1,918,009	34.8	84.5	2.7	0.9	5.4	3.8	3.3	7.5	3.9	$47,007	9.7
	Sacramento, CA PMSA	1,628,197	35.1	70.2	7.7	1.1	9.4	6.5	5.2	14.4	3.9	$46,602	13.1
	San Diego, CA MSA	2,813,833	33.2	66.5	5.7	0.9	9.4	12.8	4.7	26.7	3.6	$47,067	13.3
	San Francisco, CA PMSA	1,731,183	37.3	58.6	5.3	0.4	23.5	7.7	4.5	16.8	2.5	$63,297	7.6
	Seattle, WA PMSA	2,414,616	35.5	78.6	4.4	1.0	9.9	2.4	3.9	5.2	3.2	$58,395	12

Source: 2000 U.S. Census, 2000 data
Note: The census data in this table are provided as a frame of reference for the information given by Pulse Check *sources. Whenever possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan areas.*

Pulse Check Site	Epidemiology/Ethnography	Law Enforcement
Atlanta, GA	**Tara McDonald and Miriam Boeri** Georgia State University Department of Sociology	**Sergeant Asa Walker** Atlanta Police Department
Baltimore, MD	**James Peterson** Organization prefers anonymity	**Robert J. Penland** Washington-Baltimore HIDTA
Boston, MA	**George Arlos** Harvard University Department of the History of Science	**Lieutenant Francis W. Armstrong, Jr.** Boston Police Department Drug Control Division
Chicago, IL	**Larry Ouellet, PhD** EPI/BIO COIP School of Public Health	**Individual prefers anonymity** Chicago Police Department, Organized Crime Division, Narcotic and Gang Investigations Section
Cincinnati, OH	**Tim Lawrence** Hamilton Country Alcohol and Drug Board	**Nonrespondent**
Cleveland, OH	**Individual prefers anonymity** University of Akron Institute for Health and Social Policy	**Individual prefers anonymity** Ohio HIDTA
Dallas, TX	**James Rucker, BA, LCDC** Greater Dallas Council of Alcohol and Drug Abuse	**Robert Evans** Dallas Drug Enforcement Administration
Denver, CO	**Bruce D. Mendelson, MPA** Colorado Department of Human Services Alcohol and Drug Abuse Division	**Curt Williams and Rob McGregor** Denver Police Department Fugitive Location and Apprehension Group
Detroit, MI	**Richard F. Calkins** Michigan Department of Community Health Division of Quality Management and Planning	**Individual prefers anonymity** Southeast Michigan HIDTA
Houston, TX	**Ann Robison, PhD** Montrose Counseling Center	**James Prendergast** DEA Houston Field Division
Los Angeles, CA	**Beth Finnerty, MPH** University of California, Los Angeles Integrated Substance Abuse Programs (ISAP)	**Eric Lillo** Los Angeles Police Department
Miami, FL	**James N. Hall** Up Front Drug Information Center	**Eladio Paez** City of Miami Police Department
Minneapolis/St. Paul, MN	**Carol L. Falkowski** Hazelden Foundation	**Lieutenant Daniel Grout** Minneapolis Police Narcotics Unit
New York, NY	**John A. Galea, MA** New York State Office of Alcoholism and Substance Abuse Services Street Studies Unit	**Individual prefers anonymity** Drug Enforcement Administration New York Division Unified Intelligence (S-13)
Philadelphia, PA	**Samuel J. Cutler** Behavioral Health System Coordinating Office for Drug and Alcohol Abuse Programs	**Individual prefers anonymity** Drug Enforcement Administration Philadelphia Field Division Divisional Intelligence Group
Phoenix, AZ	**Ilene L. Dode, PhD** EMPACT—Suicide Prevention Center, Inc.	**Individual prefers anonymity** Phoenix Police Department
Pittsburgh, PA	**Michael T. Flaherty, PhD and Janice Pringle, PhD** Institute for Research, Education, and Training in Addictions (IRETA)	**Prefers Anonymity**
Portland, OR	**Bret Fuller , PhD** Department of Public Health & Preventive Medicine Oregon Health & Science University	**Chuck Karl and Ken Reuben** Oregon HIDTA
Sacramento, CA	**Sharon DiPirro-Beard, MFT, RD** County of Sacramento Department of Health and Human Services Alcohol and Drug Services Division	**Lieutenant Bob Lozito** Sacramento County Sheriff's Department
San Diego, CA	**Prefers Anonymity**	**Rick Ellington** Drug Enforcement Administration, Team II
San Francisco, CA	**Prefers Anonymity**	**Craig Buehler** California State Narcotics
Seattle, WA	**Caleb Banta-Green** Alcohol and Drug Abuse Institute at the University of Washington	**Steve Freng** Maine Drug Enforcement Administration
St. Louis, MO	**James M. Topolski, PhD** Missouri Institute of Mental Health	**Detective Leo Rice** St. Louis Police Department, Narcotics Division
Tampa/St. Petersburg, FL	**Carrie Elk, PhD** Institute for the Prevention and Prosecution of Drug Facilitated Rape	**Sergeant Dale Carnell** Pinellas County Sheriff's Office
Washington, DC	**Jerry Brown** Department of Health HIV/AIDS Administration	**Sergeant John Brennan** Washington, D.C., Police Department Major Narcotics

Pulse Check Site	Non-Methadone Treatment	Methadone Treatment
Atlanta	**Onaje Salim, MA, LAPC, MAC** Fulton County ADTC	**Ned Etherington, and** **Cathy Etherington** Alliance Recovery Center
Baltimore, MD	**Adrienne Britton-Robinson, BA, CAC, and** **George Larry, MA** Total Health Care	**Cindy Shaw-Wilson, LCADC** Institute for Behavior Resources (IBR Reach)
Boston, MA	**Judy McDonough** Gavin House	**Lawrence O'Toole** Habit Management
Chicago, IL	**Dan Lustig** Hay Market Center	**Individual prefers anonymity** Cornell Interventions
Cincinnati, OH	**Pam McClain** Talbert House	**Individual prefers anonymity** Central Community Health Board
Cleveland, OH	**Individual prefers anonymity** Cleveland Clinic Alcohol and Drug Recovery Center	**Ron Winbush and Dr. Deborah Watson** Community Action Against Addiction (CAAA)
Dallas, TX	**Doug Denton** Homeward Bound, Inc.	**Individual prefers anonymity** West Texas Counseling and Rehabilitation Program of Dallas
Denver, CO	**Tim McCarthy** Arapahoe House	**Pamela J. Manuele, RN, BSN, ANPC, CCJS** Comprehensive Addiction Treatment Services
Detroit, MI	**Peter Mason** Renaissance West Community Health Services	**Octavius Sapp, CAC** City of Detroit, Department of Human Services Drug Treatment Program
Houston, TX	**Pamela Sampson, MS** Riverside General Hospital, Administration	**Steven V. Tapscott, MA** Texas Treatment Center
Los Angeles, CA	**Peter deGyarfas** Substance Abuse Treatment Program Division of Adolescent Medicine Children's Hospital of Los Angeles	**Individual prefers anonymity** Aegis Medical System
Miami, FL	**Joseph A. Martinez, JD and Michael Miller, PhD** The Village South, Inc. Addiction Treatment Center	**Nonrespondent**
Minneapolis/St. Paul, MN	**Michael Milligan and Michael Kenney** Boys Totem Town	**Greg Carlson** Hennepin Faculty Associates
New York, NY	**Prefers anonymity**	**Individual prefers anonymity** Lower Eastside Service Center
Philadelphia, PA	**Chris Sweeney** Northeast Treatment	**Sari Trachtenberg** NARP Thomas Jefferson University Division of Substance Abuse
Phoenix, AZ	**Dale Rinard and Penny Free Burke** TERROS	**Chuck Neff** Valle del Sol
Pittsburgh, PA	**Kenneth Ramsey, PhD** Gateway Rehabilitation Center	**Marlene Burks** Tadiso Inc
Portland, OR	**Source not Identified**	**Tim Hartnett** CODA
Sacramento, Ca	**Trisha Stanionis** The Effort, Inc.	**John McCarthy, MD** Bi-Valley Medical Clinic
San Diego, CA	**Roxy Walnum** East County Center for Change	**Kathy Goyette** San Diego Health Alliance
San Francisco, CA	**Greg Hayner, PharmD** Haight-Ashbury Free Clinics, Inc.	**Laurene Spencer, MD** BAART-Geary Street Clinic
Seattle, WA	**Ramona Graham** Center for Human Services	**Victoria Evans** Therapeutic Health Services
St. Louis, MO	**Mike Morrison** Bridgeway Counseling	**Cheryl Gardine** DART
Tampa/St. Petersburg, FL	**Mark Vargo, PhD** Operation PAR, Research Department	**Andre Benson, MD** Operation Par
Washington, D.C.	**James Shepard** Organization prefers anonymity	**LaTonya Sullivan** Organization prefers anonymity

APPENDIX 4: DISCUSSION AREAS BY SOURCE TYPE*

Topic	L	E	M	N
SPECIAL SECTION. LOCAL DRUG MARKETS: A DECADE OF CHANGE				
During the last reporting period, among street-level transactions involving each listed drug,**what percentage involved exchanging any of the following items: cash, property/merchandise, shoplifted merchandise, other stolen merchandise, sex, guns, other drugs, transporting drugs, stealing the drug, food stamps, drug buying services, injecting services, lookout services, other?	✓	✓	✓	✓
Have there been any changes in any of these specific types of transactions over the past 10 years?	✓	✓	✓	✓
Over the past 10 years, to what degree have specific illicit marketing innovations or tools complicated efforts to detect or disrupt drug activity in your community?	✓	✓		
Over the past 10 years, to what degree have specific changes in the drug market and in the nature of drug users made your community's drug abuse problem more complex?			✓	✓
Over the past 10 years, has your community tried any specific innovations, changes, or tools to address increased complexities of drug markets?	✓	✓		
Over the past 10 years, to what extent have specific changes contributed to the widespread availability and use of marijuana?	✓	✓		
Over the past 10 years, to what extent have changes in specific problems complicated the treatment of marijuana-using clients, particularly youth?			✓	✓
What continuing effects, if any, have the September 11 attacks and their aftermath had on the drug abuse problem?	✓	✓	✓	✓
THE SNAPSHOT				
How serious is the current illegal drug problem in your community?	✓	✓	✓	✓
How has the illegal drug problem changed in your community?	✓	✓	✓	✓
THE PERCEPTION				
During the current and last reporting periods, what was the most commonly abused drug in your community? Second most commonly abused drug? What drug was related to the most serious consequences? Second most serious consequences? Is any new problem drug appearing in your community?	✓	✓	✓	✓
THE DRUG**				
How difficult is it for undercover officers/users to buy drugs (and various forms of each drug)?***	✓	✓		
Has it become more difficult, less difficult, or the same, to buy drugs since the last reporting period?	✓	✓		
During this reporting period, has there been a time when undercover officers/buyers could not buy drugs?	✓	✓		
What are the most common and second most common units of sale and corresponding standard units of the drug?	✓	✓		
What is the purity range for each 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?	✓	✓		
Are there any adulterants? If yes, please list and indicate if any are new this reporting period.	✓	✓		
Why have price, purity, or adulterants changed or remained stable?	✓	✓		
What is the source for your price, purity, and adulterant information?	✓	✓		
How is the drug locally manufactured, processed, diverted, or grown?	✓	✓		
Have there been any changes in the local manufacturing process since the last reporting period?	✓	✓		
THE MARKET PERSPECTIVE**				
What is the predominant affiliation of local, street-level sellers?	✓	✓		
What is the predominant age range of local, street-level sellers?	✓	✓		
How likely are sellers to use their own drugs?	✓	✓		
In what type of other crimes are sellers involved?	✓	✓		
Have there been any changes in seller characteristics since the last reporting period?	✓	✓		
Are there any new seller groups this reporting period?	✓	✓		
What is the geographical area where most street-level sales of each drug occur?	✓	✓		
Where is each drug sold?	✓	✓		
How does each drug get from seller to buyer?	✓	✓		
How do dealers communicate with buyers, suppliers, and other dealers?	✓	✓		
Are other drugs sold by this type of dealer? If yes, please list the drugs.	✓	✓		
Have any of the drug scene characteristics changed since the last reporting period? If yes, please describe.	✓	✓		
THE USERS PERSPECTIVE: Predominant characteristics**				
How did the number of users change since the last reporting period?		✓		
What are the total number and percentage of primary users for this drug? All use (including primary, secondary, and tertiary)?			✓	✓
Have these percentages or numbers changed since the last reporting period?			✓	✓
What percentage of the drug clients are return clients for that drug?			✓	✓
What percentage of the drug clients are return clients for any drug?			✓	✓
What is the predominant age range of the drug users? Mean age? Has either of these changed since the last reporting period?		✓	✓	✓

THE USERS PERSPECTIVE: Predominant characteristics** (continued)	L	E	M	N
What is the predominant gender (provide percentages if possible), and has it changed since the last reporting period?		✓	✓	✓
What is the predominant racial/ethnic group, and has it changed since the last reporting period? Is this group underrepresented, overrepresented, or about equal compared with the general population in your area?		✓	✓	✓
What is the predominant socioeconomic position, and has it changed since the last reporting period?		✓	✓	✓
What is the most common geographical residence, and has it changed since the last reporting period?		✓	✓	✓
What is the predominant route of administration, and has it changed since the last reporting period?		✓	✓	✓
What are the drugs commonly taken with this drug? Are they taken sequentially, in combination with, or as a substitute for the drug? What are the street names for this combination or practice? Have there been any changes?		✓	✓	✓
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 is the most common referral source, and has it changed since the last reporting period?			✓	✓
What is the predominant education level, and has it changed since the last reporting period?			✓	✓
What is the predominant employment status, and has it changed since the last reporting period?			✓	✓
What are the common negative consequences of marijuana use (asked for marijuana only)?		✓	✓	✓
THE USERS: New/emerging users**				
How did the number of new or emerging users change since the last reporting period? If increased, repeat the first 10 questions under "the users: predominant characteristics" for the new/emerging user group.	✓			
What are the total number and percentage of users new to treatment? Have these numbers or percentages changed since the last reporting period?			✓	✓
How did the number of users new to treatment change since the last reporting period? If increased, repeat all questions under "the users: predominant characteristics" for the new-to-treatment user group.			✓	✓
METHADONE DIVERSION/TREATMENT				
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?		✓		
DRUG ABUSE RELATED CONSEQUENCES, COMORBIDITY, AND BARRIERS TO TREATMENT				
How common are specific drug-related consequences among clients in your program? Have these drug-related consequences increased, decreased, or remained stable since the last reporting period?			✓	✓
How common are specific psychiatric comorbid diagnoses in your program? Have these comorbid disorders increased, decreased, or remained stable since the last reporting period?			✓	✓
How common are specific barriers to treatment? Have these barriers to treatment increased, decreased, or remained stable since the last reporting period?		✓	✓	
TREATMENT BACKGROUND				
How do you define program capacity?			✓	✓
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.			✓	✓

[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, marijuana, methamphetamine, ecstasy, diverted OxyContin®, and any other drugs (specify) for each of the discussion areas.*
****Law enforcement sources were asked about undercover officers' ability to buy drugs; epidemiologic/ethnographic sources were asked about users' ability to buy drugs.*

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PULSE CHECK

Drug Markets and Chronic Users in 25 of America's Largest Cities

January 2004