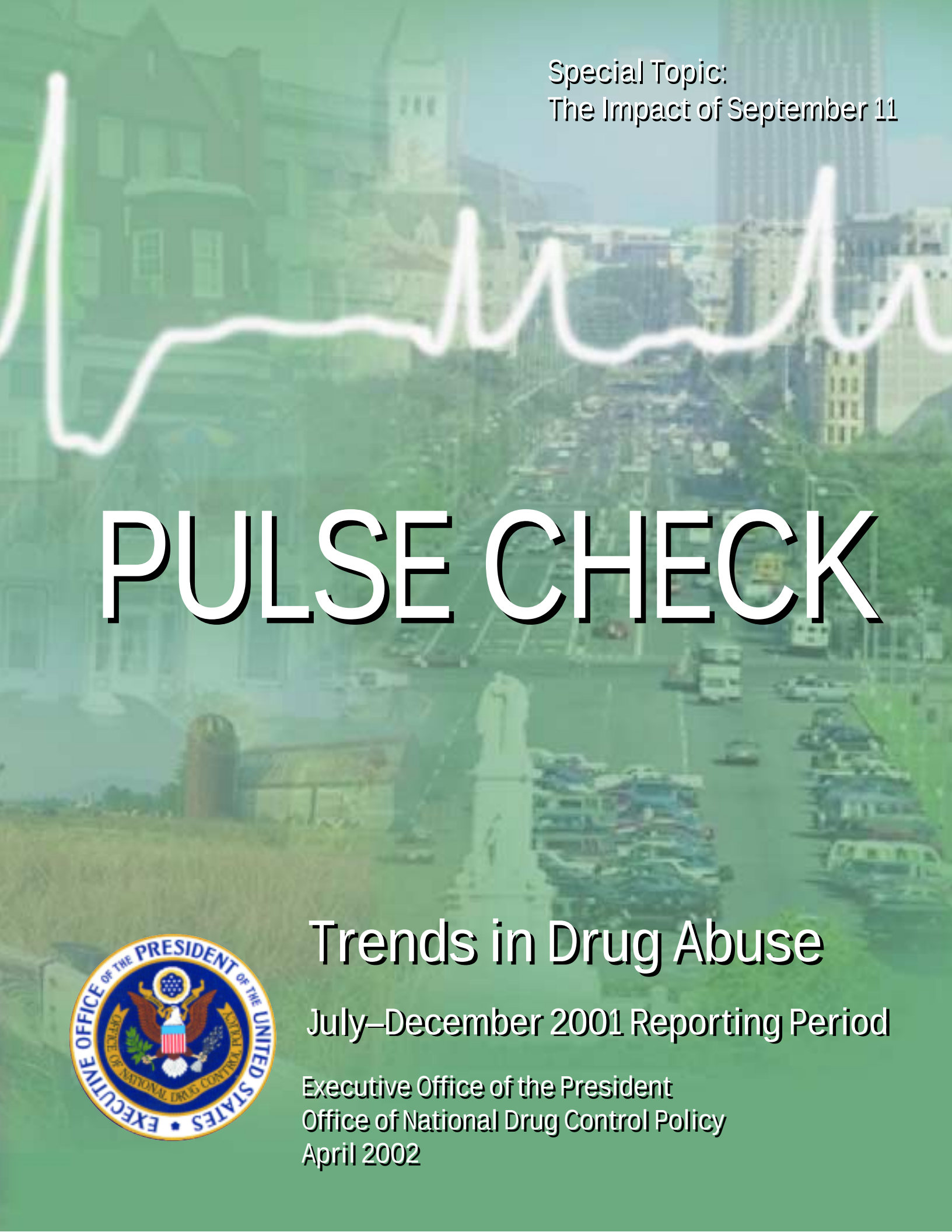

Special Topic:
The Impact of September 11

PULSE CHECK

Trends in Drug Abuse

July–December 2001 Reporting Period

Executive Office of the President
Office of National Drug Control Policy
April 2002

PULSE CHECK

Trends in Drug Abuse
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Executive Office of the President
Office of National Drug Control Policy
Washington, DC 20503
NCJ 193398

ACKNOWLEDGEMENTS

The Office of National Drug Control Policy (ONDCP) acknowledges the contributions made by the 75 *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 10. Anne McDonald Pritchett, Office of Planning and Budget, ONDCP, serves as the project director and editor for *Pulse Check*.

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

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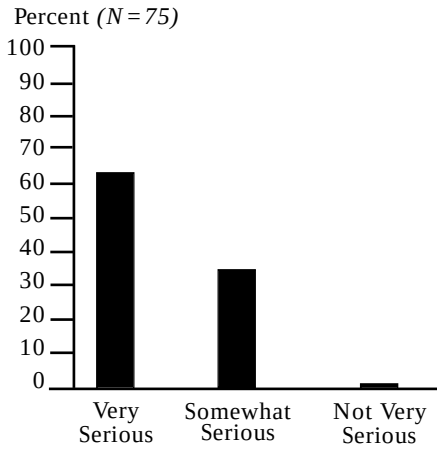
PULSE CHECK HIGHLIGHTS[+]

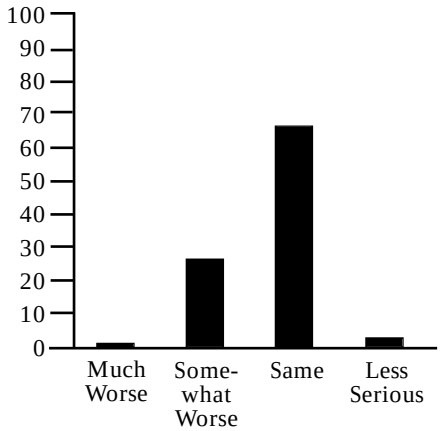
This report is based on discussions with 75 epidemiologists, ethnographers, law enforcement officials, and methadone and non-methadone treatment providers from 20 *Pulse Check* sites. Telephone discussions with these individuals, conducted between November 2001 and January 2002, reveal that overall, when comparing spring and fall 2001, 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 20 *Pulse Check* communities (fall 2001)?



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

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



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

The illicit drug situation is characterized by several key features:

- The September 11 terrorist attacks and subsequent events had varied short- and long-term effects on illegal drug availability, trafficking routes and modes, local marketing strategies, and use patterns in 16 of the 20 sites.
- Heroin has surpassed crack as the drug associated with the most serious consequences, as perceived by 27 sources in 17 sites. (*Exhibits 3 and 4*)
- The number of female heroin users has increased in four cities, where sources are increasingly seeing gender equity among a number of chronic drug users.
- Marijuana remains the most widely abused illicit drug, as reported by 35 sources in 18 sites. Sources in two sites report it as the drug with the most serious consequences. (*Exhibits 3 and 4*)
- Methamphetamine continues to be reported as an emerging problem in several sites. (*Exhibit 5*) Furthermore, 14 sources in 8 cities consider it the drug contributing to the most serious consequences, doubling from only 4 cities since the last *Pulse Check*, and replacing crack in 2 instances. *(Exhibits 3 and 4)*
- Most respondents continue to link methamphetamine sellers to domestic violence, more so than with any other drug. *(Exhibit 6)*
- The emerging diversion and abuse problem involving OxyContin®, a controlled-release formulation of the pharmaceutical opiate oxycodone, has spread to all but two sites and is associated with serious consequences. (*Exhibits 5 and 7*)
- OxyContin® abuse and diverted sales continue to emerge in the rave and nightclub scenes in seven cities: Boston, Detroit, Memphis, Miami, New Orleans, Philadelphia, and Sioux Falls.
- "Ecstasy" (methylenedioxymethamphetamine or MDMA) continues to be an emerging problem in the majority of sites. (*Exhibit 5*)

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

HIGHLIGHTS FROM THE SPECIAL TOPIC SECTION: THE IMPACT OF SEPTEMBER 11

- After September 11, availability of illegal drugs, particularly heroin, declined in 12 cities: Baltimore, Columbia (SC), Denver, Detroit, El Paso, Honolulu, Memphis, Miami, New Orleans, New York, Seattle, and Sioux Falls.
- Because heroin availability declined after September 11, heroin users are increasingly substituting prescription drugs for heroin in Baltimore, Columbia (SC), El Paso, and New York.
- Heightened security at U.S. points of entry may have changed drug trafficking modes or routes in seven cities: Denver, Honolulu, Miami, New York, Portland (ME), St. Louis, and Seattle.
- Signs of increased drug abuse were described in nine cities: Boston, Columbia (SC), Honolulu, Miami, New York, Portland (ME), St. Louis, Seattle, and Washington, DC. These signs include increases in demand for treatment, requests for services, and attempts to self-medicate illicitly for anxiety or depression.
- Trafficking shifts in some border areas, such as Detroit, Portland (ME), and El Paso, were only short term and soon reverted to "business as usual." Similarly, short-term market effects, such as price gouging, "super sales," and drug adulteration, were reported in Boston, Miami, New York, and Washington, DC.

Exhibit 3. What are the most serious drug problems in the 20 *Pulse Check* sites, by type of source?*

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

**Heroin is almost always, by definition, the most commonly used drug in methadone programs, so methadone treatment sources are excluded from this question.*
Note: HCl = Powder cocaine; MJ = Marijuana; H = Heroin; Meth = Methamphetamine; Benzos = Benzodiazepines; Oxy = OxyContin®; Cocaine = unspecified whether crack or HCl; NR = nonrespondent

Exhibit 4. What are the most serious drug problems in the 20 *Pulse Check* sites, by number of sources and sites?

Drug	Most commonly abused?*		Most serious consequences?	
	No. of sources	No. of sites	No. of sources	No. of sites
Heroin	5	5	27	17
Crack	12	8	19	12
Powder cocaine	1	1	5	4
Marijuana	35	18	1	1
Methamphetamine	4	4	14	8
Diverted OxyContin®	0	0	5	3
Benzodiazepines	0	0	2	2
Alcohol	1	1	2	2

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

HIGHLIGHTS BY SPECIFIC ILLICIT DRUG

The 75 discussions also yielded key findings about heroin, crack, powder cocaine, marijuana, methamphetamine, synthetic opioids, and ecstasy.

HEROIN

- Availability increased in only seven sites (Boston, Chicago, Detroit, El Paso, Miami, New Orleans, and Portland [ME]), declined in two (Denver and Honolulu), and remained stable elsewhere. Increases generally involve high-purity South American (Colombian) white heroin, which remains the most common. Mexican black tar still predominates in the West.
- Street-level prices are generally stable, except for increases in Denver and Seattle and declines in El Paso and Washington, DC. Purity levels are also generally stable, except for increases in Boston, El Paso, and Portland and declines in Denver, New Orleans, and Seattle.
- Drug sales increasingly involve referrals, beepers, cell phones, prearranged meeting places, home deliveries, and multi-tiered market structures.
- Use is increasing among younger people. Many are suburban Whites, particularly in areas around Baltimore, Chicago, Denver, St. Louis, and Washington, DC.
- Female users are increasing in some cities (Denver, Memphis, New Orleans, and Portland [ME]).

Exhibit 5. What new problems have emerged or intensified during fall 2001?

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

Other Emerging Drug Problems	None
Benzodiazepines: Los Angeles, CA[L]; Seattle, WA[E]	Billings, MT[E]
Clonidine (Catapres®): Baltimore, MD[M]	Chicago, IL[E]
Dextromethorphan (sold as ecstasy): Memphis, TN[E]	Columbia, SC[M]
Diverted methadone: Detroit, MI[E]; Portland, ME[E]	Denver, CO[N]
Diverted pharmaceuticals: Boston, MA[E]	Detroit, MI[L,M]
Fentanyl*: Boston, MA[E,M]	El Paso, TX[L,N]
Hallucinogens: Los Angeles, CA[L]	Los Angeles, CA[N]
Herbal supplements: Memphis, TN[E]	Miami, FL [M,N]
Heroin: Billings, MT[N]; Boston, MA[E] (ODs); Denver, CO[E] (young White suburbanite deaths); Memphis, TN[E]	New Orleans, LA[E,N]
	New York, NY[L]
	Portland, ME[N]
Injecting: Sioux Falls, SD[N]	St. Louis, MO[L]
Khat**: Boston, MA[L]	Seattle, WA[M]
PCP: Washington, DC[E]	Sioux Falls, SD[L]
	Washington, DC[L,M]

**Fentanyl is a powerful synthetic opiate often confused with heroin, responsible for overdose deaths, and often found in patch form.*
***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 ingredients structurally and chemically similar to d-amphetamine.*

- Although injecting still predominates, snorting and smoking have increased in many sites, often among younger users in suburban areas. In Boston and New York, however, some people are shifting from snorting to injecting.

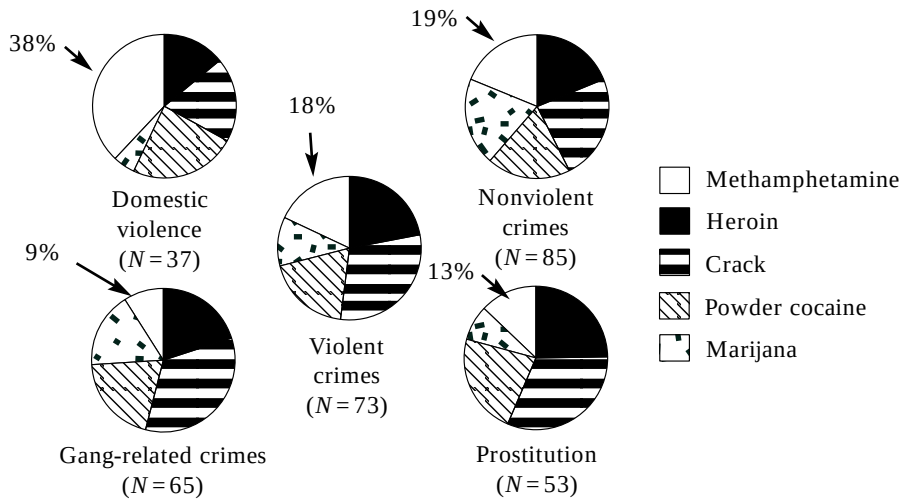
CRACK COCAINE

- Availability remains generally wide and stable. Increases are perceived in only three cities (Chicago, Detroit, and El Paso) and declines in another three (Boston, Denver, and Honolulu).
- Street-level prices are generally stable.
- Only a few sales scene changes are reported. In Columbia, SC, for example, young marijuana users increasingly sell crack.
- Crack continues to be sold mainly in central city areas, but suburban and rural areas are sometimes mentioned. In Memphis, sales are moving from the city into the suburbs and rural areas.
- Billings is the only site where adolescent users have increased.
- Nearly half of the sources report males and females as equally likely to use crack—more so than any other illicit drug except ecstasy, as reported previously.
- Crack-marijuana combinations have declined in Baltimore and Boston but increased in Memphis.

POWDER COCAINE

- Availability remains wide, with increases in only three cities (Columbia [SC]), El Paso, and Portland [ME]) and declines in two (Honolulu and Washington, DC).
- Price and purity levels are stable.
- Although powder cocaine is sold primarily in central city locations, it is more likely than crack to be sold in suburban or rural areas. Use is up in suburbs around Memphis and New Orleans and in Denver's rural areas.
- Like heroin users, powder cocaine users tend to be White males, older than 30. Only a few changes are reported in user characteristics. For example, in a Columbia, SC, treatment program, female adolescent novice users have been increasing. The source notes that "the perceived risk of cocaine is dropping among the clients."

Exhibit 6.
In what other crimes are methamphetamine and other illicit drug sellers involved across *Pulse Check* cities?



Sources: Law enforcement and epidemiologic/ethnographic respondents

MARIJUANA

- Availability remains wide. Only four increases (in Boston, Columbia [SC], Denver, and Honolulu) and only one decline (in Chicago) are reported.
- Indoor hydroponic growing operations have increased in Boston, Memphis, and Philadelphia.
- Prices are stable except for a slight increase in Portland, ME, and a decline in El Paso.
- Users are becoming younger (sometimes younger than 13) in Billings, Boston, Chicago, Columbia (SC), Miami, Philadelphia, and Sioux Falls. Female users have increased in New Orleans, Philadelphia, and Sioux Falls.
- Flavored blunt wraps are a commercial product recently

Exhibit 7. How has the perceived drug problem changed (spring 2001 vs fall 2001)?

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

Site/Source	Spring 2001	Fall 2001
Boston, MA[L]	Crack	Powder cocaine
Memphis, TN[L]	Crack	Methamphetamine
Miami, FL[E]	OxyContin®	Heroin
Miami, FL[L]	Cocaine	OxyContin®
Portland, ME[L]	Pharmaceutical opiates	Heroin/Pharmaceutical opiates (OxyContin®)
Portland, ME[E]	Heroin	OxyContin®
Portland, ME[M]	Benzodiazepines	OxyContin®
St. Louis, MO[N,M]	Crack	Methamphetamine
Seattle, WA[L]	Heroin	Methamphetamine

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

Site/Source	Spring 2001	Fall 2001
Boston, MA[L]	Powder cocaine	Marijuana
Boston, MA[M]	Benzodiazepines	Crack
Columbia, SC[E]	Crack	Marijuana
Columbia, SC[L]	Marijuana	Crack
Columbia, SC[M]	Heroin	OxyContin®
Memphis, TN[L]	Crack	Methamphetamine
Portland, ME[L]	Heroin/Pharmaceutical opiates	Marijuana
Portland, ME[M]	Heroin/Other opiates	Heroin
Portland, ME[N]	Cocaine	Heroin
Washington, DC[M]	Crack	Heroin

introduced in New York and Philadelphia. These tobacco leaves are moister, fresher, slower burning, and viewed as less messy than gutted cigars.

- Five treatment sources (in Columbia [SC], El Paso, Miami, Seattle, and Washington, DC) mention clients who smoke joints that, without their knowledge, have been laced with crack.
- Compared with other drug users, marijuana users are still more likely to reside in all locations (central city, suburban, and rural areas).

METHAMPHETAMINE

- Methamphetamine has replaced crack as the most serious drug problem according to sources in Memphis and St. Louis and has replaced heroin according to the law enforcement source in Seattle.
- Methamphetamine remains available predominantly in the West. However, availability has increased in all regions.
- The number of users has increased in nine cities: Billings, Columbia (SC), Denver, Memphis, Miami, New Orleans, St. Louis, Seattle, and Washington, DC.
- As reported previously, most respondents link methamphetamine sellers to domestic violence, more so than any other drug.
- Several user characteristics have changed: females increased in Honolulu and Memphis; adults (>30 years) increased in Memphis and Washington, DC, and adolescents increased in Honolulu and Los Angeles; and Hispanics increased in Los Angeles and New York.

DIVERTED SYNTHETIC OPIODS

- Oxycontin® was the synthetic opioid most frequently mentioned by *Pulse Check* sources as being diverted.
- Nearly half of law enforcement and epidemiologic/ethnographic sources report increased availability of diverted OxyContin®. Availability is highest in the Northeast and South.
- Diversion of OxyContin® has intensified in Billings (an emerging illegal market), Boston (increased pharmacy robberies), and New York (street sales reported for the first time).
- Diversion and abuse of OxyContin® are not limited to rural areas: central city, suburban, and rural areas are mentioned equally by sources across all sites.
- Abuse of OxyContin® has increased in 13 sites: Billings, Boston, Columbia (SC), Denver, Honolulu, Los Angeles, Memphis, New Orleans, Philadelphia, Portland (ME), St. Louis, Seattle, and Sioux Falls.
- OxyContin® abusers remain predominantly young adults (18–30 years) or adults (older than 30). However, adolescent (13–17 years) abusers predominate in Columbia (SC), New Orleans, and Sioux Falls, and they are emerging in Boston.
- Heroin is often substituted for OxyContin®, particularly in eastern cities. By contrast, in some cities, heroin users may be switching to OxyContin®. In Miami, it is often sold in the same neighborhoods as crack.

- In some sites, abusers of OxyContin® are often current or former abusers of other prescription drugs, typically benzodiazepines or opiates.

ECSTASY AND CLUB DRUGS

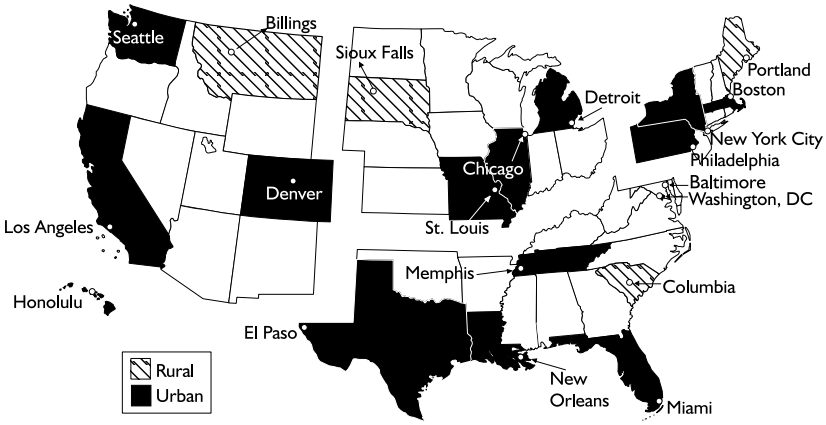
- Ecstasy continues to be the most available club drug, followed by gamma hydroxybutyrate (GHB), ketamine, and Rohyphol® (flunitrazepam). Ecstasy availability continues to increase in most sites, while other club drug availability is mostly stable.
- Sales and use settings continue to expand from raves, nightclubs/bars, and private residences and parties to streets and in or around high schools.
- User and seller populations also continue to expand and now include non-Whites and Hispanics. Additionally, adolescent sellers and users have increased in many cities.
- Heroin, crack, and powder cocaine are now sold and used with ecstasy.
- Two new precursors to GHB (GHV [gamma hydroxyvalerate] and GVL [gamma valeroactone]) are being sold as nutritional supplements in health food stores, on the Internet, at raves, and in nightclubs/bars.

INTRODUCTION

Since 1992, the Office of National Drug Control Policy (ONDCP) has published the *Pulse Check*, a source for timely information on drug abuse and drug markets. The report aims to describe 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: heroin, crack cocaine/powder cocaine, marijuana, and methamphetamine. Additionally, due to their spread across the country, *Pulse Check* continues to monitor the problems of "ecstasy" (methylenedioxy-methamphetamine or MDMA) and other club drugs, as well as the diversion and abuse of OxyContin®, a controlled-release formulation of the pharmaceutical opiate oxycodone.

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

The 20 *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 interpretation or conclusion drawn from *Pulse Check* must be viewed carefully and in conjunction with other more quantifiable direct and indirect measures of the drug abuse problem.

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

Pulse Check focuses on the drug abuse situation in 20 specific sites throughout the Nation. Though considerable effort was made to select sites across a broad range of geographic areas, including Census regions and divisions, urban and rural States, racial/ethnic coverage, and high intensity drug trafficking areas, *Pulse Check* cannot be viewed as a national study, and information cannot be reasonably aggregated up to a national level.

Of the 80 sources identified and recruited across the three disciplines, 75 provided information for this *Pulse Check* issue.

The information presented in this report is based solely on the observations and perceptions of those 75 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 75.

Any contradictory reports within an individual site are not necessarily a *Pulse Check* limitation. Just as the site sampling methodology was designed to reflect the country's geographic and population diversity, recruiting four sources per site was incorporated into the design to reflect diversity within each of the 20 sites. For example, a law enforcement source in one site might perceive cocaine to be the community's most serious problem, while an ethnographic source at that same site might consider the most serious problem to be heroin. And they would both be right—because each might come in contact with different populations or each might deal with a specific geographic neighborhood.

Information from treatment sources is particularly susceptible to variance because some facilities target specific populations. Furthermore, treatment providers from methadone and non-methadone programs are likely to have very different perspectives on their communities' drug problems because their respective clientele differ in the nature of their drug problems and in their demographic characteristics. It is for this reason that two treatment sources were selected from each of the 20 sites—one from a methadone program, and one from a non-methadone program.

Taken together, all four sources at each site provide a richer picture of the drug problem's nature.

Current Sources and Reporting Periods

The current report includes information gathered during November 2001 through January 2002 from telephone conversations with 75 sources, representing 20 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 2001 and in comparison to a period 6 months earlier, during spring 2001.

The law enforcement sources who provided information include 19 narcotics officers from local police departments, field office agents of the Drug Enforcement Administration (DEA), and representatives of High Intensity Drug Trafficking Areas (HIDTAs). The law enforcement source from Baltimore was unable to participate in this round of discussions.

The epidemiologists and ethnographers are 20 researchers associated either with local health departments, university-based research groups, or other community health organizations. Some of those 20 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 36 providers from 19 non-methadone programs and 17 methadone programs across the 20 sites. Those providers include two non-methadone sources each from Billings and Sioux Falls because those cities do not have methadone programs. They do not include another four individuals who were unable to participate in this round of discussions: the methadone treatment source from Memphis; and the non-methadone treatment sources from Baltimore, Honolulu, and Memphis.

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

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

SEPTEMBER 11 AND ITS AFTERMATH: ASSESSING THE IMPACT ON DRUG ABUSE[+]

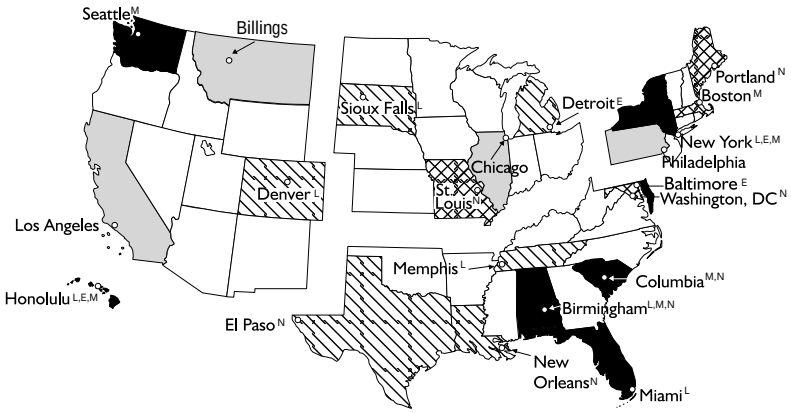
As the Nation deals with the wide-ranging effects of the September 11 attacks and subsequent events, several data sources have begun to show the impact upon drug abuse. For example, according to data provided by NDCHealth (NYSE:NDC, an Atlanta-based healthcare information services company), new prescriptions (retail and mail-order) for several categories of drugs increased sharply between early September and early October 2001: benzodiazepines increased 11 percent nationally, 14 percent in Washington, DC, and 23 percent in New York City; antidepressants increased 3 percent, 12 percent, and 18 percent, respectively, for the three areas; and sleep aids (nonbarbiturates, sedatives, and others) increased a dramatic 11 percent, 14 percent, and 26 percent, respectively.

In an effort to continue assessing the terrorist attacks' impact on drug abuse (short term and long term), ONDCP explored the issue during the 75 *Pulse Check* phone discussions conducted from late November 2001 through early January 2002. Sources in all but four cities—Billings, Chicago, Los Angeles, and Philadelphia—described combinations of diverse effects, such as disruptions in drug trafficking patterns, anxiety among patients already in treatment for drug abuse, increased treatment admissions among youth, and increased diversion and abuse of prescription drugs.

Loosely categorized, the described effects can be summarized in four overall findings:

- Availability of illegal drugs, particularly heroin, declined in 12 of the 20 *Pulse Check* cities: Baltimore, Columbia (SC), Denver, Detroit, El Paso, Honolulu, Memphis, Miami, New Orleans, New York, Seattle, and Sioux Falls. *(Exhibit 1)*
- Drug trafficking modes or routes have shifted in 6 of the 20 cities: Honolulu, Miami, New York, Portland (ME), St. Louis, and Seattle.
- Some short-term changes in local marketing strategies were noted in Boston, Miami, New York, and Washington, DC.
- Signs of increased drug abuse were described in 9 of the 20 cities: Boston, Columbia (SC), Honolulu, Miami, New York, Portland (ME), St. Louis, Seattle, and Washington, DC. These signs include increases in demand for treatment. *(Exhibit 1)*

Exhibit 1.
How have availability of and demand* for illegal drugs reportedly changed across the 20 *Pulse Check* cities since September 11?**



- Availability of illegal drugs declined and demand* increased
- Availability of one or more illegal drugs (typically includes heroin) declined
- Demand* for illegal drugs increased
- No changes reported in availability of or demand for illegal drugs

*"Increased demand," in this case, reflects any increases in the number of treatment admissions, requests for services, and attempts to self-medicate for anxiety or depression.
**Changes do not reflect any short-term effects that disappeared within the first few weeks after September 11.

Changes in Illegal Drug Availability, Trafficking Patterns, and Market Strategies

Heightened security since September 11 at U.S. airports, borders, and other points of entry may have caused declines in the availability of

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

illegal drugs (especially heroin) on the streets of many *Pulse Check* cities:

- **Baltimore, MD**[E]: During the period immediately after September 11, no changes in the illegal drug trade were observed; however, by late September, heroin started to "dry up on the street." Moreover, drug-related violence increased during late September and early October due, in part, to declining heroin availability. The problem was reportedly compounded when law enforcement resources were shifted away from street drug activity and toward terrorist prevention activities.
- **Columbia, SC**[N,M]: Heroin availability has declined, and prices have increased.
- **Denver, CO**[L,E]: Heroin availability has declined slightly because fewer drugs are coming across the Mexican border, and heroin users are reportedly having more difficulty finding the drug on the street. Drug trafficking has also been slightly limited due to airport security. Furthermore, heroin and powder cocaine prices have increased, and their purities have declined.
- **Detroit, MI**[E]: In general, drugs are less available.
- **El Paso, TX**[N]: Because fewer people are smuggling heroin from Mexico due to increased border security since September 11, its availability has decreased.
- **Honolulu, HI**[L,E,M]: The Honolulu drug trade's dependence on air traffic is evidenced by how drugs dried up on the street during the days following September 11, when all planes were grounded. Even through air travel has resumed, heroin and cocaine seizures and availability remain lower than pre-September 11 levels because, with heightened security, fewer people are smuggling the drugs via the airport. Additionally, methadone clinics report an increase in client intake since September 11, suggesting a decline in heroin availability on the street.
- **Memphis, TN**[L]: Heroin, crack, and powder cocaine availability has declined, most likely because law enforcement officials have intercepted these drug shipments more often and because post offices and packages are more scrutinized since the anthrax threats began.
- **Miami, FL**[L,E]: The law enforcement source suggests that increased airport security has led to reduced heroin trafficking activities. Reportedly, street-level heroin, crack, and powder cocaine have been harder to obtain since September 11, but marijuana continues to be widely available because much of it is produced locally. The Miami epidemiologic source concurs that clients in some treatment facilities have reported some shortages of illegal drugs.
- **New Orleans, LA**[N]: Drug availability, in general, has declined.
- **New York, NY**[L,E]: The law enforcement source suggests that since September 11 cocaine has been harder to obtain. Additionally, according to street researchers, prices for heroin, crack, powder cocaine, and marijuana have remained level with pre-September 11 prices, but the quantity of drugs sold per sale has declined. Moreover, the cost of diverted prescription drugs, such as Elavil® (amitriptyline, an antidepressant), has increased from $2–$3 to $5. Increases in security and police activity have disrupted the flow of drugs from suppliers to dealers to users: suppliers cannot get their normal supply of drugs; dealers' supplies are in turn restricted; and users are paying more because their bags contain reduced amounts.
- **Seattle, WA**[M]: Due to increased border security, heroin and cocaine availability has declined. Furthermore, when users cannot obtain the drugs, they often go to treatment, and admissions to the methadone clinics have increased since September 11.
- **Sioux Falls, SD**[L]: Undercover operations with high-level methamphetamine dealers suggest that drugs are harder to obtain due to increased U.S. border control, and prices for larger amounts of the drug have increased. However, the number of small local methamphetamine labs has increased recently, perhaps to compensate for the lower levels of methamphetamine entering the United States.

In addition to reduced availability of illegal drugs, heightened security at U.S. points of entry may have altered drug trafficking modes or routes in many *Pulse Check* cities:

- **Honolulu, HI**[L,E]: Law enforcement efforts are beginning to focus more on mail and marine smuggling because fewer people are smuggling heroin and cocaine via the airport.

- **Miami, FL**[E]: Some drug trafficking has shifted from air to sea via cruise ships.
- **New York, NY**[L]: Trafficking shipments planned for the city prior to September 11 have shifted to other cities, such as Seattle (via vehicle from Canada) or Baltimore (via air).
- **Portland, ME**[L,E] **and Seattle, WA**[L]: Heroin and cocaine traffickers are making fewer trips across the Canadian border due to increased law enforcement security, but they are smuggling larger amounts of drugs per trip.
- **St. Louis, MO**[L]: Drug smugglers are more often using trains and buses to transport drugs than they were before September 11; according to sellers in custody, traffickers are avoiding air transport due to heightened airport security.

New anti-terrorist laws may affect illegal drug marketing practices.

St. Louis[L]: New wiretap laws are affecting how illegal drug dealers are using cell phones. They are being more cautious, "dropping" phones more frequently, changing phones, using several different phones, and watching what they say over the phones.

Some drug trafficking shifts immediately after September 11 were just short term. In Detroit, for example, according to the law enforcement source, the supply of illegal drugs from Canada declined because of increased security at the border a few weeks after the September 11 attacks, but has returned to previous levels. Similarly, in El Paso, according to the epidemiologic source, the drug supply declined on the streets, even for crack, due to heightened border control measures immediately after September 11; however, soon thereafter, it was "business as usual." In Portland (ME) according to the law enforcement source, shortly after the September 11 attacks, the influx of drugs declined, but by December, the supply of illegal drugs resumed to pre-September 11 levels. Even in Washington, DC, where local drug dealers were more cautious about bringing drugs in shortly after September 11 due to heightened security at entry points, by December, the local drug trade returned to pre-September 11 levels.

The September 11 terrorist attacks also had short-term effects on local illegal drug market strategies, such as price gouging, as reported in several *Pulse Check* cities:

- **Boston, MA**[E]: Two weeks after the attacks, the purity levels of heroin and powder cocaine dropped sharply, and a few dealers blamed this drop on the attacks.
- **Miami, FL**[E]: In a few cases, dealers have been trying to price gouge, but not because of any apparent major drug shortage.
- **New York, NY**[E]: According to street researchers, immediately after September 11, drug dealers (especially heroin dealers) took advantage of the situation and operated openly in the street. One user commented that, "the day of the disaster, it was like a super-sale day." This pattern continued in some areas. Moreover, several days after the disaster, a street researcher in The Bronx observed heroin users waiting in line in the street to purchase their drugs.
- **Washington, DC**[E]: Heroin and crack availability and purity declined for about 4–6 weeks after the attacks. Marijuana, methamphetamine, and ecstasy were also less available for a week or two, possibly due to transportation difficulties.

Changes in Illegal Drug Use Patterns and Demand

Because heroin availability has declined in many *Pulse Check* cities since September 11, heroin users are increasingly substituting diverted prescription drugs for heroin in some cities:

- **Baltimore, MD**[E]: An emergency department nurse noticed more overdoses from drugs other than heroin, particularly OxyContin® and other prescription opiates. This source suggests that the shift is related to the decline in heroin availability after September 11.
- **Columbia, SC**[M]: Diverted OxyContin® use has increased due to the declining availability of heroin.
- **El Paso, TX**[N]: Heroin addicts are increasingly substituting Rohypnol® (flunitrazepam) for heroin because it has been easier than heroin to smuggle across the Mexican border since September 11 and is, thus, more accessible.
- **New York, NY**[M]: An in-house staff survey in the large program where the *Pulse Check* methadone treatment source is situated showed notable increases since September 11 in the abuse of prescription

drugs, in people seeking more medications while in treatment, and in people requesting prescriptions for such medications. Additionally, increases were noted in secondary use of substances such as cocaine.

The number of treatment admissions or requests for services increased in the following cities after the September 11 attacks, suggesting a possible increase in drug use, a decline in drug availability on the street, or both:

- **Columbia, SC**[N,M]
- **Honolulu, HI**[M]
- **New York, NY**[E]
- **Seattle, WA**[N,M]
- **Washington, DC**[N]

Increases in Treatment Demand: A Closer Look

New York, NY[E]: An outreach worker states that since September 11 the number of people reporting for detoxification has increased markedly. Most detoxification programs in the city have become full.

Seattle, WA[N]: Requests for mental health services increased 35 percent since September 11, with 20 percent of these for substance abuse treatment.

Additional indicators of increased demand or declining drug availability include an increased number of calls from those in need of drug treatment in Columbia (SC) (according to the methadone treatment source) and an increase in treatment program retention rates in El Paso (according to the epidemiologic source).

Many *Pulse Check* sources report increases in drug use, sometimes among people who are self-medicating for anxiety or depression associated with the September 11 attacks:

- **Boston, MA**[M]: Since September 11, clients in treatment report to have increasingly combined heroin and cocaine in "speedballs."
- **Columbia, SC**[M]: Use of all illicit drugs has increased, and the general mood of illicit drug users is that "they're going for broke," and that since the attacks they "have nothing to lose."
- **Miami, FL**[E]: According to anecdotal information from pharmacists and mental health and treatment professionals, both legitimate and illegal use of prescription drugs have increased since September 11, mostly involving people seeking benzodiazepines and sleep aids in an attempt to self-medicate and deal with added stress.
- **Portland, ME**[N]: Depression and hopelessness have intensified among older clients who were already depressed before September 11, and whatever drugs those clients were using, they tended to use more of them after September 11. In some cases, the events triggered users to seek substance abuse treatment.
- **St. Louis, MO**[N]: Use of methamphetamine, diverted OxyContin®, ecstasy, and alcohol has increased and may be due to people seeking to self-medicate after the events on September 11.

Pulse Check sources also report an increase in social and psychological problems among drug treatment clients following September 11. Treatment sources in many cities, including Boston, Billings, Portland (ME), and Washington, DC, report increased levels of anxiety, depression, and hopelessness among treatment clients. Additionally, sources in Boston, Columbia (SC), Detroit, El Paso, Portland (ME), Seattle, and Washington, DC, also mention increases since September 11 in the numbers of relapses among chronic drug users.

Effects on Youth Who Use Drugs:

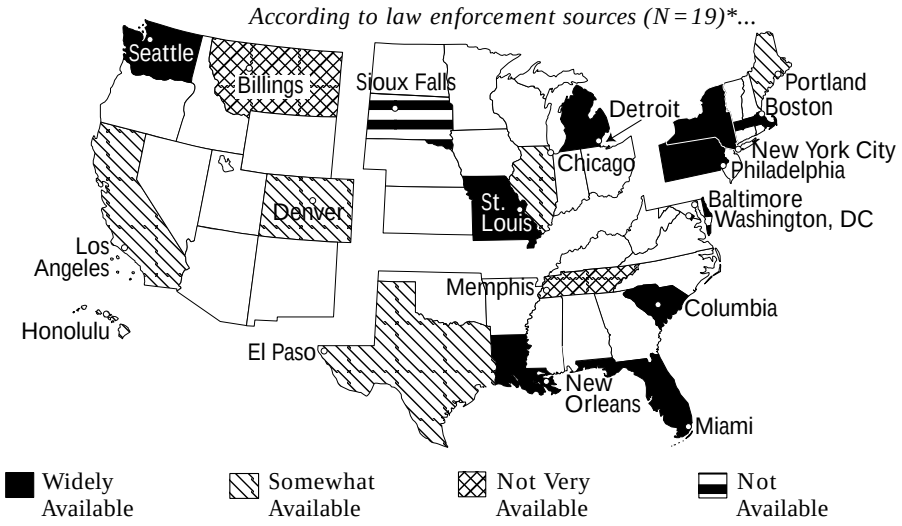
- **Los Angeles, CA**[L]: Club drug seizures have increased, as has the popularity and number of raves. "It is plausible that adolescents and young adults are using club drugs and attending raves in order to shake off September 11."
- **Portland, ME**[N]: Younger clients associate the events of September 11 with taking ecstasy: "We hate the world we're growing into, so we might as well party."
- **Sioux Falls, SD**[E]: In a school district with more than 18,000 middle school and high school students, the number of adolescents (13–17 years) admitted to inpatient settings for substance abuse treatment (typically involving methamphetamine or heavy marijuana use) has increased sharply since September 11. Many of these admissions are court ordered, but many youth are also voluntarily coming forward. Thus, it is difficult to determine whether youth have increased their drug use or are getting caught more frequently. Additionally, since September 11, an increase has been noted among youth in suicidal thoughts and depression issues in conjunction with their substance abuse.

HEROIN[+]

Heroin has surpassed crack as the drug associated with the most serious consequences—that is, medically, legally, societally, or otherwise—as perceived by 27 sources in 17 sites: Boston, New York, Philadelphia, and Portland (ME) in the Northeast; Baltimore, Columbia (SC), El Paso, Miami, New Orleans, and Washington, DC, in the South; Chicago, Detroit, and St. Louis in the Midwest; and Denver, Honolulu, Los Angeles, and Seattle in the West. In five of those cities—Baltimore, Boston, Chicago, Philadelphia, and Portland—sources also consider heroin the most widely used illicit drug (methadone treatment sources, however, are excluded from that count because heroin is, by definition the most commonly used drug in their programs).

Compared with the last *Pulse Check* reporting period, the Miami epidemiologic source believes that heroin has replaced diverted OxyContin® as the drug with the most serious consequences. Two sources in Portland, ME, believe that heroin has replaced either other opiates or cocaine as the most commonly abused drug, and the Washington, DC, methadone treatment source believes it has replaced crack as such. Additionally, some aspect of heroin abuse is considered as an emerging problem in four cities: Billings, Boston, Denver, and Memphis.

Exhibit 1.
How available is heroin across the 20 *Pulse Check* cities (fall 2001)?



**The law enforcement source in Baltimore did not respond.*

HEROIN: THE DRUG

How available is heroin, in its various forms, across the country? *(Exhibits 1, 2, and 3)* Approximately half of the *Pulse Check* law enforcement sources (10 of 19) and epidemiologic/ethnographic sources (11 of 20) consider heroin to be widely available in their communities. Sources in the Northeast and South are about twice as likely to report wide availability as their counterparts in the Midwest and West.

As in the past two *Pulse Check* reports, high-purity snortable South American (Colombian) white heroin is the most common type, cited as widely available by law enforcement and epidemiologic/ethnographic sources in 10 cities across the Northeast, South, and Midwest (Baltimore, Boston, Chicago, Columbia [SC], Detroit, Miami, Philadelphia, Portland [ME], New York, and Washington, DC). Mexican black tar, a lower purity, injectable heroin, is ranked as widely available by sources in six cities, mostly in the West (Denver, Honolulu, El Paso, Los Angeles, St. Louis, and Seattle); and sources in four of those cities (Denver, El Paso, Los Angeles, and St. Louis) similarly rate Mexican brown heroin

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

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

Increased
Boston, MA[E]
Chicago, IL[L]
Detroit, MI[L]
El Paso, TX[E]
Miami, FL[E]
New Orleans, LA[E]
Portland, ME[E]

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

Decreased
Denver, CO[L]
Honolulu, HI[L,E]

**The Baltimore law enforcement source did not respond.*

as widely available. Southeast Asian heroin is considered widely available in only two cities (New Orleans and Washington, DC), and Southwest Asian heroin is the least common form, with wide availability reported only in New Orleans.

Heroin availability remained stable between spring and fall 2001, according to the majority of law enforcement (15 of 19) and epidemiologic/ethnographic (14 of 20) sources. Increases are reported in only seven sites across the Northeast, South, and Midwest, while declines are reported in two sites, both in the West. Similarly, the various forms of heroin remain generally stable in availability, with any exceptions listed in exhibit 3. The St. Louis epidemiologic source, who has been monitoring the possible introduction of white Nigerian heroin into the city, reports no more seizures since the last *Pulse Check*.

How pure is heroin across the country? *(Exhibit 4)* According to law enforcement and epidemiologic/ethnographic sources, street-level Colombian heroin ranges from a low of 40 to 90 percent, with both extremes reported in Philadelphia. Street-level Mexican black tar heroin purity ranges from 14 percent in Seattle to 70 percent in Billings. Purity levels have remained generally stable since the last reporting period, except for increases in Boston, El Paso, and Portland (ME) and declines in Denver, New Orleans, and Seattle.

A wide range of heroin adulterants continue to be reported by law enforcement and epidemiologic/ethnographic sources, particularly in the Northeast and South. The most recent harmful adulterants reported are cocaine in Portland (ME), a roach spray in New York, and a shaving of ecstasy enclosed in a bag of heroin in New York.

What are street-level heroin prices across the country? *(Exhibit 4)* As reported in the last *Pulse Check*, sales units of 0.1 gram still cost as little as $4 for Colombian heroin in Boston to as much as $120 for Mexican black tar in Seattle. Prices are generally stable since the last reporting period, except for increases in Denver and Seattle and declines in

Exhibit 3.
Which heroin varieties have changed in availability (spring 2001 vs fall 2001)?*

Increased

Colombian
Boston, MA[E]
Chicago, IL[L,E]
Detroit, MI[L]
El Paso, TX[L]
Miami, FL[E]
New Orleans, LA[L]
Portland, ME[E]

Mexican black tar
El Paso, TX[E]
New Orleans, LA[E]

Southeast Asian
Detroit, MI[E]
New Orleans, LA[L,E]

Southwest Asian
Chicago, IL[E]
Detroit, MI[E]
New Orleans, LA[L]
New York, NY[L]

Decreased

Colombian
Denver, CO[L]
Honolulu, HI[L]
St. Louis, MO[L]

Mexican black tar
Honolulu, HI[E]
New York, NY[E]

Southeast Asian
Baltimore, MD[E]
Chicago, IL[E]
Honolulu, HI[L]
New York, NY[E]
St. Louis, MO[L]

Southwest Asian
Baltimore, MD[E]
Honolulu, HI[L]
New York, NY[E]

**The Baltimore law enforcement source did not respond.*

El Paso and Washington, DC. A few other shifts, however, are noted:

- **Baltimore, MD**[E]: White heroin is being sold in larger capsules than during the last reporting period. Thus, even though capsule prices have increased from $6 (or two for $10) to $10, actual prices have remained fairly stable.
- **Chicago, IL**[E]: The price range for a gram of white powder has widened, from $100–$200 during the last reporting period to $60–$275 during the current period.
- **Los Angeles, CA**[L]: The price range for a 0.25 gram "hit" has narrowed, from $20–$40 to $30–$35.
- **New York, NY**[L]: Cheaper Southwest Asian heroin is about to pose a significant challenge to Colombian heroin.

Exhibit 4. What are the prices and purity levels of different types of heroin in 19 *Pulse Check* cities?*

		MOST COMMON STREET UNIT				1 GRAM	
	City/Source	Unit	Size	Purity/*Change***	Price/*Change***	Purity/*Change***	Price/*Change***
South American (Colombian) white	Baltimore, MD[E]	capsule	NR	NR/NR	$10/↔		
	Boston, MA[L]	"bundle"	0.1 gm	80%+/↑	$4–$6/↔		
	Chicago, IL[L]	"hit"	0.2 gm	NR/NR	$20/↔	NR/NR	$150/↔
	Columbia, SC[L]	"bindle"	0.2 gm	62%/↔	$20–$25/↔	NR/NR	$125–$130/↔
		"bundle"	2 gm	NR/NR	$225/↔		
	Detroit, MI[L]	"dime"	0.1 gm	NR/NR	$10/↔	NR/NR	$100–$150/↔
	Miami, FL[L]	NR	1 gm			NR/NR	$120/↓
	Miami, FL[E]	"bag"	NR	NR/↔	$10/↔	NR/↔	$150–$200/↔
	New York, NY[L]	"bag"	1 hit	80–90%/↔	$10–$14/↔		
	New York, NY[E]	"bag"	0.1 gm	60%+/↔	$10/↔		
	Philadelphia, PA[L]	"bag"	0.3 gm	40–90%/↔	$10–$20/↔		
		"bundle"	10–13 bags	40%/↔	$100–$120/↔	70–75%/↔	$85–$95/↔
	Philadelphia, PA[E]	"hit"	NR	73%/NR	$10/NR		
	Portland, ME[L]	"bag"	0.1 gm	70%+/↑	$25–$30/↔		
		"bundle"	1 gm			70%+/↑	NR/NR
Mexican black or brown tar	Billings, MT[L]	"bindle"	1 gm			50–70%/↔	$260/↔
	Denver, CO[L]	"balloon"	0.2 gm	20–30/↓	$25–$30/↑		
	Denver, CO[E]	NR	1 gm			36%/↔	$50–$100/↔
	El Paso, TX[L]	NR	0.1 gm	NR/NR	$20/↔		
	El Paso, TX[E]	"dime", "dieme"	2-3 person hit	NR/↑	$2.50–$3.00/↓		
	Honolulu, HI[L]	"bindle"	0.1 gm	NR/NR	$50–$75/↔	NR/NR	$150–$300/↔
	Honolulu, HI[E]	"paper"	0.25 gm	NR/NR	$50–$75/↔		
		NR	0.25 oz	NR/NR	$750/↔		
	Los Angeles, CA[L]	"hit"	0.25 gm	NR/NR	$30–$35/↔	NR/↑	$90–$100/↓
	Memphis, TN[L]	NR	0.1 gm	NR/NR	$50–$50/↔	NR/NR	$400–$450/↓
	Seattle, WA[L]	NR	0.1 gm	14–58%/↔	$90–$120/NR		
	Seattle, WA[E]	NR	1 mg	21%/↓	$1.15/↑	NR/↔	$30–$50/↔
	St. Louis, MO[L]	NR	1 gm			NR/NR	$100/↔
Unspecified	Boston, MA[E]	"bag" (powder)	0.1 gm	NR/NR	$10/↔		
		"bundle" (powder)	10-bag	NR/NR	$60–$80/↔		
	Chicago, IL[E]	"dime bag"	NR	NR/NR	$10/↔		
	Detroit, MI[E]	"hit" (white)	NR	10–50%/↔	$10–$12/↔		
		"bundle" (white)	NR	10–50%/↔	$100–$150/↔		
	New Orleans, LA[L]	"hit"	.45 gm	7%/↓	$20–$25/↔		
		"paper"	0.12 gm	7%/↓	$10/↔		
	Washington, DC[L]	"dime bag" (white)	50–75 mg	10–15%/↔	$10/↔	60–70%/↔	$120–$140/↔
	Washington, DC[E]	"scramble" (white)	bag	23%/↔	$10/↔		
		"bone" or "raw"	bag	40–80%/↔	$30–$40/↔		
		"scramble" (white)	1 mg	23%/↔	$1.05/↓	23%/NR	$120–$150/↔

Sources: Law enforcement and epidemiologic/ethnographic respondents
**Respondents in Sioux Falls did not provide this information. **Arrows indicate up, down, or stable between spring and fall 2001.*
NR = not reported

How is heroin referred to across the country? *(Exhibit 5)* Street names and dealer brand names proliferate in the Northeast and the South and are rarer in the Midwest and the West. Since the last *Pulse Check*, many of the more recent brand or street names relate to the September 11 terrorist attacks, particularly in New York ("twin towers," "9/11," "world trade center," and "WTC") and in Washington, DC ("bin laden"). "Red devil" and "bulldog" are new street names in Portland (ME), and pink heart logos are new in Columbia (SC). In Philadelphia, where brand names change frequently, 18 new ones have been identified since the previous reporting period (including "old navy," "bomb," "one way," "life," and "one hundred percent"). Brand names also change frequently in Washington, DC, typically when a dealer's product gets a bad reputation or becomes too well known by law enforcement. In Boston and Detroit, however, dealers are using fewer brands or labels than in the past for fear that drugs can be traced back to them.

How is heroin packaged? The most common packaging across the country, as reported in the last *Pulse Check*, continues to be plastic, cellophane, glassine, or coin bags, often the "zipper" type. These bags sometimes come in colors for dealer identification, as reported in Boston, Portland (ME), and Washington, DC, while in Chicago some bags have a small candy or popcorn kernel inside to identify the sellers and the heroin purity. Other common packaging includes plastic or cellophane wrap, wax paper, foil, and balloons. Some unusual packaging is reported during this period: condoms in New York; watertight "seal-a-meal" type of closures, small enough to be swallowed, in some of Boston's outlying communities (such as Lawrence and Lowell) and in Portland (ME); balloons that can be put into a cheek and swallowed if necessary in El Paso; brown packaging tape inside of duct tape in Billings; and "speedwrapping," in Boston, which involves 10 untaped bags laid on top of one another, rolled, and held together with a rubber band. Since the last *Pulse Check*, the Baltimore ethnographic source reports fewer cellophane bags on the street.

HEROIN: THE SELLERS

Who sells heroin? *(Exhibit 6)* Law enforcement sources tend to report heroin dealers as young adults (18–30 years) who work independently. Adults older than 30, however, are reported as the predominant sellers in Billings, Honolulu, and Washington, DC, while dealers in El Paso and Portland (ME) are equally likely to be from either age group. Organized sales structures are reported in Chicago, Denver, Memphis, Miami, and Seattle, while both independent and organized dealers operate in El Paso and Philadelphia.

Epidemiologic/ethnographic sources are more likely than their law enforcement counterparts to report more than one kind of sales structure, sometimes quite separate but sometimes intricately related, as in the following examples:

- **Boston, MA[E]**: Two distinct groups sell heroin: independents, who tend to be older adults and are

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

H, boy, dope, smack, big H, horse, dog food, s--t, heron, train, 747, doogie, stuff, chiva, carga, foil, papers, jerry springer, he, manteca, joint (bag of dope), billie (bag of dope), scramble (lower purity), bone (higher purity), raw (higher purity), negro, doozy, tammy, diesel, white, mud, **bin laden**

Murder one, white dragon, no limit, the real one, playboy, skull and crossbones, pluto, ***pink hearts***

**Italics refer to dealer brands, which are sometimes interchanged with user street names. Bolded names are new this reporting period.*
Sources: Law enforcement, epidemiologic/ethnographic, and treatment respondents

very likely to use the drug; and organized dealers who are generally younger adults and are only somewhat likely to use the drug. The organized dealers use beepers and pagers, arrange meetings with clients, and hire steady middlemen and runners on bikes. A third sales system consists of addicts who act as liaisons: they spend their days procuring heroin for other users and, in the process, increase the price or take some heroin "off the top."

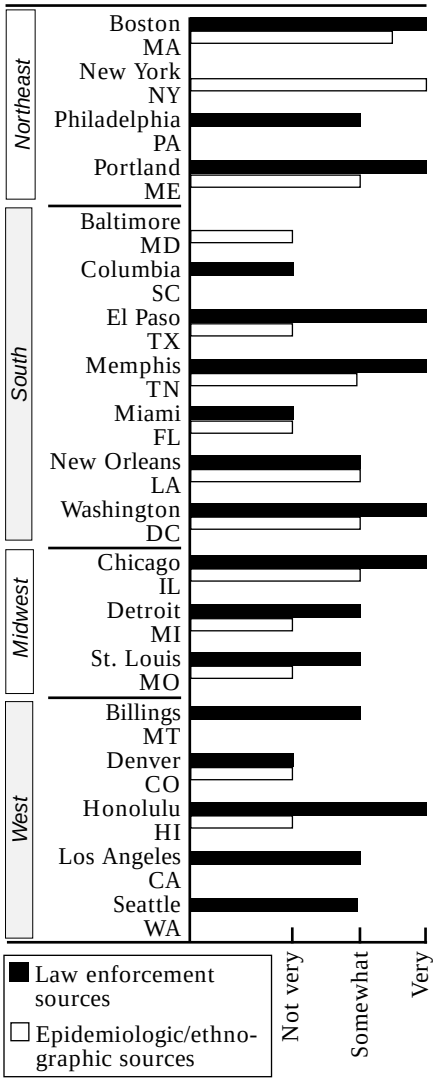
- **Denver, CO**[E]: Mexican nationals control polydrug distribution to small autonomous street sellers, with little oversight once the drugs get on the street.
- **Honolulu, HI**[E]: On Oahu, sellers tend to be older and independent. On Hawaii, Maui, and Kauai, they tend to be adolescents who are flown in from Mexico, stay for 3 or 4 months, and then leave.
- **New Orleans, LA**[E]: A series of loose connections consist of dealers who have four or five sellers each.
- **Washington, DC**[E]: Independent addicts tend to be older adults who sell heroin in order to support their habits, while organized "crews" of younger adults are not very likely to use the drug.

Since the last *Pulse Check*, no major changes are reported among the sellers in the various cities, with one possible exception: the Baltimore ethnographic source mentions unsubstantiated reports of some "young guys" trying to take over part of the market.

How is street-level heroin sold?

Caution and wariness rule drug sales in many cities: referrals, beepers, cell phones, prearranged meeting places, home deliveries, and multi-tiered market structures are playing increasing roles, as in the following examples:

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



Sources: Law enforcement and epidemiologic/ethnologic respondents
**Any missing bar implies that one source did not provide this information. Neither source in Sioux Falls provided this information.*

- **Boston, MA**[L,E]: Sales continue to go more underground than in the past, with more beeper use and home deliveries. Sellers have a customer list, with a small clientele.
- **Baltimore, MD**[E]: Sellers won't sell to anyone they don't know. Instead of hand-to-hand sales, a system of "touters" and "runners" adds layers between the buyer and seller. The touter deals directly with the buyer, receiving money and handing over the drugs; the runner deals with the seller (although sometimes the touters and runners are the same, depending on the complexity of a particular market). Most runners are young males on miniature bicycles. Therefore, in some neighborhoods, police patrol areas on bicycles.
- **Chicago, IL**[L]: In order to reduce risk, several layers of people are often involved in a drug sale. In some locations, especially in public housing areas, the buyer asks for the drug on one floor, pays on the next floor, and then is told by someone where to go to obtain the drug. Some open drug markets, however, still exist in certain neighborhoods.
- **El Paso, TX**[L,E]: Sellers are "very paranoid" and won't sell to strangers. A buyer needs a contact to make introductions. Cell phones and drive-by meetings are common, and open-air markets are rare.
- **New Orleans, LA**[E]: Deliveries and meetings are commonly arranged via beepers, cell phones, and home phones. Code words are used over the phone to designate names and locations. Street sellers use referrals.
- **Seattle, WA**[L]: Buyers need to know where to go. Beepers and cell phones are common. Open-air markets are relatively confined and limited in number, but they still exist.

By contrast, in some cities heroin sales are still more open. Washington, DC, for example, has more than 100 open-air markets, and sellers approach potential customers. In certain Philadelphia neighborhoods, one can simply drive by, roll down the car window, and buy drugs hand-to-hand.

What other drugs do heroin dealers sell? *(Exhibit 7)* Heroin dealers continue to sell additional drugs in nearly every *Pulse Check* city. Only a few changes are reported since the last *Pulse Check*:

- **Baltimore, MD**[E]: Marijuana, while not regularly distributed by heroin sellers, is reported as occasionally "floating in and out" during this reporting period.
- **Boston, MA**[E]: Sales of both heroin and crack, which used to be rare, have increased during the past year.
- **New York, NY**[L,E]: The trend toward polydrug sales continues. Ecstasy is increasingly being sold by heroin dealers, along with their other staples: crack, powder cocaine, and marijuana. An increasing number of arrests involve all five drugs.
- **St. Louis, MO**[E]: Instead of the one-stop-shops reported in the last *Pulse Check*, with heroin, crack, and marijuana sold "as if in a candy store," now it is more common for buyers to place an order for other drugs ahead of time.
- **Washington, DC**[L]: Many crack dealers are thinking of switching to heroin because they don't have to sell as much to make the same profit and because the penalties are not as strict.

Exhibit 7. What other drugs do heroin dealers sell?*

	City	Crack	Powder Cocaine	Marijuana	Other	No other drug sold
Northeast	Boston, MA	✓				
	New York, NY	✓	✓	✓	Ecstasy	
	Philadelphia, PA					✓
	Portland, ME				OxyContin® Other pharmaceutical opiates	
South	Baltimore, MD		✓	✓		
	Columbia, SC	✓				
	El Paso, TX	✓	✓	✓	Rohypnol	
	Memphis, TN				Morphine, hydromorphone (Dilaudid®), other opiates	
	Miami, FL	✓	✓		Ecstasy	
	New Orleans, LA	✓	✓	✓		
	Washington, DC	✓	✓			
Midwest	Chicago, IL	✓	✓			
	Detroit, MI	✓		✓		
	St. Louis, MO	✓	✓	✓		
West	Billings, MT	✓			Methamphetamine	
	Denver, CO	✓	✓	✓	Methamphetamine	
	Honolulu, HI	✓		✓	Methamphetamine	
	Los Angeles, CA	✓	✓			
	Seattle, WA	✓	✓	✓		

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

What type of crimes are related to the heroin sales scene? According to law enforcement and epidemiologic/ethnographic sources, heroin sellers in 12 *Pulse Check* cities engage in some form of violent crime: Boston, New York, and Philadelphia in the Northeast; Baltimore, El Paso, Memphis, New Orleans, and Washington, DC, in the South; Chicago, Detroit, and St. Louis in the Midwest; and Denver in the West. Sometimes, these crimes are related to turf protection (Baltimore) and involve internal killings (New Orleans). Other specific violent crimes mentioned include gun sales (Philadelphia), robberies (New Orleans), assaults (New York), and use of weapons (St. Louis). The Boston ethnographer, however, notes that drug-related violence has been declining over the last few years.

Gang-related activities are reported by law enforcement or epidemiologic/ethnographic sources in all four regions: New York in the East; Baltimore, El Paso, and Memphis in the South; Chicago and Detroit in the Midwest; and Denver and Seattle in the West.

Prostitution, on the part of either users or sellers, is reported by law enforcement or epidemiologic/ethnographic sources in all *Pulse Check* cities except for Billings, Miami, Seattle, and Washington, DC.

Heroin sellers, users, or both often engage in numerous other forms of nonviolent crimes, as reported by law enforcement or epidemiologic/ethnographic sources in all *Pulse Check* cities except Chicago and Memphis. Typical crimes, often on the part of the users, include burglaries, petty

larceny, and thefts (Billings, Los Angeles, New York, Philadelphia, and St. Louis); shoplifting (El Paso and Washington, DC—in the latter, meat shoplifting is a common activity, with the perpetrators commonly called "cattle rustlers"); panhandling (New York); disorderly conduct (New York); car theft (El Paso); and check cashing (Detroit). Nonviolent crimes specific to sellers include pharmaceutical diversion (Portland, ME) and money laundering (Miami).

Where is heroin sold? Law enforcement and epidemiologic/ethnographic sources generally agree that most heroin sales take place in central city areas, as reported in past *Pulse Checks*. Additionally, suburban or rural areas are occasionally mentioned in El Paso, Memphis, Miami, New York, Portland (ME), and St. Louis. In Philadelphia, suburbanites often buy heroin from central city dealers, and then resell the drug in the suburbs. Conversely, people from Boston often travel to outlying cities (such as Lawrence and Lowell) to buy heroin because purity is higher there than in the city.

Sales on the street are reported by all 18 law enforcement sources who discussed this question (the Sioux Falls source did not). The next most commonly reported sales settings are public housing developments (in all sites except Detroit and Portland) and private residences (in 14 sites). Less than half of the sources name other sales settings:

- **Crack houses**: All sites in the Northeast except Portland; Columbia (SC), Memphis, and Miami in the South; only Chicago in the Midwest; and Honolulu and Los Angeles in the West.
- **Inside cars**: All sites in the Northeast except Philadelphia; Memphis, Miami, and Washington, DC, in the South; and all sites in the West except Los Angeles.
- **Playgrounds or parks**: Boston and New York in the Northeast; Memphis and Washington, DC, in the South; Chicago and St. Louis in the Midwest; and Billings and Honolulu in the West.
- **Nightclubs or bars**: New York in the Northeast; Memphis and Miami in the South; Chicago and St. Louis in the Midwest; and Billings, Honolulu, and Seattle in the West.
- **Private parties**: Boston and New York in the Northeast; Memphis and Miami in the South; St. Louis in the Midwest; and Billings in the West.
- **Hotels or motels**: New York in the Northeast; Memphis and Miami in the South; St. Louis in the Midwest; and Billings, Denver, and Los Angeles in the West.
- **Around alcohol or drug treatment clinics**: New York and Philadelphia in the Northeast; Memphis and Washington, DC, in the South; St. Louis in the Midwest; and Honolulu in the West.
- **In or around schools**: New York in the Northeast; Miami and Washington, DC, in the South; Chicago and St. Louis in the Midwest; and Billings in the West.

The settings least commonly mentioned by law enforcement sources are raves (in Billings, Miami, New York, and Portland [ME]), college campuses (in Billings, Miami, New York, and Seattle), in or around shopping malls (in Billings, Miami, New York, and St. Louis), in or around supermarkets (in Billings, Columbia [SC], and New York), and in alleyways (in Philadelphia). The Boston ethnographic source adds that benzodiazepines, rather than heroin, are sold around drug or alcohol treatment clinics.

Only a few changes in sales settings are reported since the last *Pulse Check*:

- **Baltimore, MD**[E]: Law enforcement efforts are causing sellers and users to keep shifting their street locations.
- **Honolulu, HI**[E]: Heroin sales and use in beach parks have recently declined because police have been clearing those areas. Some of this market disruption is a side effect of more police using laptop computers: they tend to write their reports in beach parks.
- **Washington, DC**[L,E]: Recent media coverage has focused on the visible sales of drugs, usually pills (particularly pharmaceutical opiates), but sometimes heroin. Many such sales have historically taken place around treatment clinics. Legislative efforts are under way to stiffen penalties for selling drugs near treatment clinics, similar to penalties for selling within 1,000 feet of schools, public housing, parks, and playgrounds.

HEROIN: THE USERS

Who uses heroin? *(Exhibit 8)* Overall, as reported in previous *Pulse Checks*, the predominant heroin users tend to be White males, older than 30, who live in central city areas. However, as the table shows, much variation occurs across the different sites and source categories. Furthermore, younger adults (18–30 years) are frequently named as the predominant group or else constitute substantial proportions of users. Clients in

methadone programs are more likely than those in non-methadone programs to be high school graduates and to be employed.

According to epidemiologic/ethnographic sources, the most noticeable shifts since the last *Pulse Check* involve increasing heroin use among younger people, many of whom are suburban Whites:

- **Baltimore, MD**[E]: While users in the central city are primarily older adults (>30 years), those in the suburbs are primarily young adults (18–30). Adolescent users (<18) continue to increase in suburbs.
- **Chicago, IL**[E]: Heroin users are primarily young adult Black males of low socioeconomic background, who reside in the central city. However, an emerging group is reported, also young adult males, but they are White, low and middle socioeconomic, suburban residents.
- **Denver, CO**[E]: While the predominant users continue to be White male older adults in the central city, an emerging group continues to grow: White male suburban high school students and young adults. Eight deaths in a recent 6-

Exhibit 8.
What demographic groups predominate among heroin users, according to different *Pulse Check* sources?*

		Age			Race/Ethnicity			Residence		
	City	E	N	M	E	N	M	E	N	M
Northeast	Boston, MA	>30	18–30	>30	Whites	Whites	Whites	Central city	Central city	Suburbs
	New York, NY	>30	>30	>30	**Hispanics**	Black; **Hispanics**	**Hispanics**	Central city	Central city	Central city
	Philadelphia, PA	18–30; >30	18–30	18–30	Whites	Whites; Blacks	Whites; Blacks	Central city	Central city	Central city
	Portland, ME	>30	18–30	>30	Whites	Whites	Whites	Central city	Central city	All
South	Baltimore, MD	>30	NR	>30	**Whites**	NR	Blacks	Central city	NR	Central city
	Columbia, SC	>30	Low numbers	18–30	Whites; **Blacks**	Low numbers	**Whites**	Central city	Low numbers	Suburbs
	El Paso, TX	18–30	>30	18–30	Hispanics	Hispanics	Hispanics	Central city	Central city; Suburbs	Central city
	Memphis, TN	18–30; >30	NR	NR	Whites	NR	NR	Central city	NR	NR
	Miami, FL	18–30	>30	18-30; >30	**Whites**	**Hispanics**	White; Hispanics	Central city	Central city	Central city
	New Orleans, LA	>30	18–30; >30	18–30	**Blacks**	Blacks	**Whites**	Central city	Central city	Suburbs
	Washington, DC	>30	18–30	>30	Blacks	Blacks	Blacks	Central city	Central city	Central city
Midwest	Chicago, IL	18–30	>30	>30	**Blacks**	**Blacks**	Blacks	Central city	Central city	Central city
	Detroit, MD	>30	18–30	>30	Whites	Blacks	Blacks	Central city; Suburbs	Central city	Central city
	St. Louis, MO	18–30; >30	18–30	>30	White, Blacks	**Blacks;** Hispanic	Whites	Central city	Central city; Suburbs	Suburbs
	Sioux Falls, SD**	18–30	18–30 Low numbers	NA	Whites	Whites Low numbers	NA	Suburbs; Rural	Central city Low numbers	NA
West	Billings, MT**	13–17	18–30 18–30	NA	Whites	Whites; **American Indians** Whites	NA	Central city	Central city; rural Central city	NA
	Denver, CO	>30	>30	18–30	Whites	Whites	Whites	Central city	Suburbs	Central city
	Honolulu, HI	>30	NR	18–30	**Whites**	NR	**Whites**	Central city	NR	Central city
	Los Angeles, CA	18–30	Low numbers	>30	Whites; **Hispanics**	Low numbers	Blacks; Hispanics	Suburbs	Low numbers	Central city
	Seattle, WA	>30	18–30	>30	Whites	Whites	Whites	Central city	Suburbs	Central city

Sources: Epidemiologic/ethnographic (E), non-methadone treatment (N), and methadone treatment (M) respondents
**Shaded boxes indicate that a given heroin-using racial/ethnic group is overrepresented relative to that city's general population. Not all sources, however, had this information available.*
***Billings and Sioux Falls have no methadone programs, so two non-methadone sources reported from each.*

month period involved users from that emerging group.

- **St. Louis, MO**[E]: Older users are low socioeconomic central city residents; younger users have more diverse socioeconomic status and live both in the central city and the suburbs.
- **Washington, DC**[E]: In addition to the predominant adult user group, an emerging young adult group of snorters has two subgroups: suburban, mid-socioeconomic Whites; and central city, low-socioeconomic Blacks. Heroin users of all ages, however, are increasingly moving to the suburbs.

Increases among young people are not, however, limited to the suburbs:

- **Boston, MA**[E]: Aside from the traditional aging cohort of mid-socioeconomic blue-collar Whites in their thirties, several populations of younger users have continued to emerge over the past few years: younger adult blue-collar Whites who are switching to heroin after abusing prescription pills (mostly the Percocet® form of oxycodone); the late-teenage sons and younger brothers of the oxycodone abusers who are going straight to heroin abuse; and Hispanic users in their twenties, who live in the central city, in the suburbs, and in surrounding cities (Lowell and Lynne) and also sell heroin.
- **Chicago, IL**[E]: Young adults, who are the predominant heroin users, seem to getting even younger as a group.
- **Miami, FL**[E]: Heroin is showing up in adolescent fatalities.
- **New Orleans, LA**[E]: Increases are reported in both the >30 group, suggesting an aging cohort, and in the 20–24 group.
- **Portland, ME**[E]: While adults (>30) are the predominant users, a younger (16–22 years) group continues to emerge. Their numbers, however, remain low. Another possible new user group to watch for are older OxyContin® users who might switch to heroin.

Similarly, several treatment sources report that although heroin-using clients in their programs are most likely to be older than 30, users in their twenties are increasing:

- **Billings, MT**[N]
- **Boston, MA**[M]
- **Portland, ME**[M]
- **St. Louis, MO**[M]

Other residence shifts and variations are noted:

- **Billings, MT**[N]: Whites, who reside in the central city, and American Indians, who tend to live in rural areas, are equally likely to use heroin.
- **Memphis, TN**[E]: In the last *Pulse Check*, heroin users were reported as residing primarily in central city areas. However, with the increasing spread to the suburbs, users are now equally likely to reside in either area.
- **New Orleans, LA**[E]: Three major housing projects were recently torn down, and their residents were relocated throughout the area. As a result, treatment, arrest, and crime numbers have declined but not because the problem has declined: rather it has been scattered, along with any relevant data. These shifts are expected to turn up in various datasets over the next 6 months.

Besides the increases among Whites in some suburban areas, only one other racial/ethnic shift is reported: according to the Philadelphia epidemiologic source, Hispanics are increasingly using heroin. Whites, however, are still the predominant users in that city.

Two shifts in Chicago...

The non-methadone treatment source notes two recent increases among heroin clients:

- The number with comorbid illnesses, such as depression, suicidal, anxiety, and some psychosis
- The number of treatment referrals of people who have been serving hard time in the penitentiary

Males are generally more likely to use heroin than females. Several *Pulse Check* sources, however, report that both sexes are equally likely to use: the epidemiologic/ethnographic sources in Los Angeles, Memphis, and Sioux Falls; the non-methadone treatment sources in Chicago, Denver, Detroit, Portland (ME), St. Louis, and Washington, DC; and the methadone treatment sources in Baltimore, Chicago, Columbia (SC), New Orleans, and Seattle. Furthermore, women are increasingly using heroin in some cities:

- **Denver, CO**[M]: While the majority of heroin-using clients are males, they are increasingly moving toward an even gender split.

- **Memphis, TN**[E]: In the last *Pulse Check*, heroin users were reported as predominantly males; however, with an increase in female users, the two genders are now evenly split.
- **New Orleans**[E]: Females continue to increase.
- **Portland, ME**[E]: Males continue to predominate, but an increase among females has been noted since the last *Pulse Check*, particularly in the homeless population.

How do users administer heroin? *(Exhibit 9)* As reported in past *Pulse Check* issues, injecting remains the most commonly reported route of administration overall. Snorting, however, does predominate in many sites, particularly in the Northeast and Midwest. Since the last *Pulse Check* reporting period, snorting and smoking have increased in some sites, often among younger users and in suburban, rather than central city, areas:

- **Baltimore, MD**[E]: While injecting predominates in central city areas, snorting ("bipping") predominates in the suburbs.
- **Boston, MA**[E]: The emerging group of young Hispanic users tend to snort heroin. By contrast, the older users have a long history of injection: sometimes their veins collapse, so they inject under the skin or into a muscle, making them prone to infections.
- **Boston, MA**[M]: More snorting is reported among younger users.
- **Denver, CO**[E,M]: Injection remains the predominant route, but snorting and smoking are more common among the emerging group of young adults in the suburbs.

Exhibit 9.
How do users administer heroin?

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

**Respondent considers injecting and snorting as approximately equal.*
NOTE: The Columbia (SC), Los Angeles, and one of the Sioux Falls non-methadone treatment sources did not provide this information.

- **Honolulu, HI**[E]: "Chasing the dragon" is occasionally reported.
- **Miami, FL**[M]: Younger clients are more likely to snort because of AIDS concerns.
- **New Orleans, LA**[L,E]: Snorting has increased slightly since the last reporting period, but injecting, by far, remains the predominant route of administration.
- **New York, NY**[N]: Snorting continues an upward trend.
- **Philadelphia, PA**[M]: Snorting continues to increase because of increased purity.
- **St. Louis, MO**[E]: Snorting predominates among younger users, while injecting is more common among older ones. In rural areas, however, injection still predominates.
- **Washington, DC**[E]: While injecting predominates, snorting and smoking have increased.

Some people, however, are shifting from snorting to injecting:

- **Boston, MA**[N]: The program's snorting-to-injecting ratio since the last reporting period has changed from 70:30 to 55:45. This increase in injecting might be due either to declining purity or increased tolerance.
- **New York, NY**[E]: Young people in the suburbs continue to shift from snorting to injecting. In the city, however, this trend is not being seen. One explanation is that more drugs are available and it is easier to "hustle" drugs in the city, whereas on Long Island these young users have to "make do" with what they've got unless they want to make the trip into the city. By injecting, they "get more bang for the buck" when they don't have enough drugs to satisfy their needs.

Pilot needle program in New York...

New York, NY[E]: In a program piloted in February 2001, pharmacies can voluntarily decide to sell needles. It is still too early to assess the impact.

What other drugs do heroin users take? In some cities, polydrug use is the norm. In Philadelphia, for example, the non-methadone source explains that all clients are polydrug users: they use whatever they can get

their hands on, whatever is available. Heroin and crack are the most common drugs used in that city, as in many others. Several shifts and variations are reported in cocaine use by heroin addicts, particularly in the Northeast and South:

- **Baltimore, MD**[E]: While "speedball" (heroin plus powder cocaine) injecting is common, older, more chronic users avoid cocaine use.
- **Boston, MA**[E]: The predominant older users inject speedballs containing crack or, if available, powder cocaine. Use of alcohol and cocaine is emerging among young Hispanics.
- **Denver, CO**[E]: The predominant, older, heroin-using group uses powder cocaine in speedballs; the emerging users tend to use cocaine less frequently and sequentially with heroin.
- **El Paso, TX**[E]: The combination of heroin plus powder cocaine is known as a "belushi."
- **Memphis, TN**[E]: The only heroin combination reported in the last *Pulse Check* involved crack (speedballs). During this reporting period, however, powder cocaine has been replacing crack in speedballs.
- **Miami, FL**[E]: Heroin and powder cocaine are usually injected in speedball combinations; however, snorting a line of each is also reported.
- **Portland, ME**[E]: Speedballs are no longer reported.
- **Philadelphia, PA**[E]: Heroin users are experimenting more with powder cocaine.
- **Washington, DC**[E]: The emerging young adult users also occasionally use powder cocaine and crack.

Several sources report changes in prescription drug abuse among heroin addicts:

- **Baltimore, MD**[E]: Because heroin availability is down since the last *Pulse Check*, abuse of benzodiazepines, such alprazolam (Xanax®), and prescription opiates has increased.
- **Boston, MA**[E]: The emerging group of young blue-collar Whites often shift into heroin use from oxycodone, other oral opioids, and benzodiazepines. Recent increases in heroin overdose mortality are related to polydrug abuse, particularly involving clonazepam (Klonopin®).
- **Memphis, TN**[E]: The opioid hydromorphone (Dilaudid®) is reported during this period as either combined with heroin or taken immediately afterwards as a "chaser." Several other drugs (including methamphetamine, amphetamines, and PCP) are similarly reported.
- **New York**[M]: Interest in and abuse of diverted OxyContin® has increased. Abuse of benzodazepines, amitriptyline (Elavil®, an antidepressant), and phenobarbital continues.
- **Portland, ME**[E]: Methadone is increasingly reported as a heroin substitute.
- **Seattle, WA**[E]: Sequential swallowing of clonazepam or alprazolam with heroin has increased since the last *Pulse Check*.
- **Washington, DC**[E]: Hydromorphone and diverted OxyContin® are sometimes used as heroin substitutes, while alprazolam, clonazepam, and other diverted pharmaceuticals are used either to boost or "take off the rough edges from" heroin.

A few shifts involve use of marijuana:

- **Denver, CO**[E]: The emerging group uses marijuana as a secondary drug.
- **New Orleans**[L]: Younger users are lacing marijuana cigarettes with heroin.
- **Washington, DC**[E]: The emerging young adult group take marijuana sequentially.

The Miami epidemiologic source notes that heroin is sometimes used to "parachute down" after using ecstasy. Ecstasy is not cited by any other source.

Where and with whom is heroin used? Heroin use continues to take place primarily in private, small group settings, according to the majority of epidemiologic/ethnographic, non-methadone treatment, and methadone treatment sources. Several changes or interesting observations are noted since the last *Pulse Check*:

- **Boston, MA**[E]: The most common use settings are private residences and public restrooms. Group use is more common than solo use for several reasons: poor users tend to pool their resources; more affluent users see it as a social drug; and when people use heroin in groups, fatalities are less likely to occur.
- **Boston, MA**[M]: The emerging group of younger clients are starting to use heroin in more public settings.

- **El Paso, TX**[E]: Multigenerational use and sales within families are common in this city, whose unique culture is apparent in all aspects of how drugs are sold and used.
- **Honolulu, HI**[E]: Heroin users commonly use in public, but public use has declined.
- **Memphis, TN**[E]: Heroin users are increasingly taking the drug privately, in small groups: during the last *Pulse Check* reporting period, public and private use were equally likely; during the current period, private use predominates. In the last *Pulse Check*, solo use was reported as predominant; now, users are equally likely to take heroin both while alone and in groups, among friends.
- **Miami, FL**[N]: Emerging use settings include clubs, parks, parties, and hotels/motels.
- **New Orleans, LA**[E]: Before their recent demolition, abandoned areas around housing projects were frequently the scene of heroin use. Now use is shifting to the back rooms of private residences, particularly porches in backs of "shotgun houses" (a type of housing design with a series of rooms connected without any hallways).

HEROIN: THE COMMUNITY

How do heroin clients wind up in treatment? Heroin users in methadone programs are much more likely to be self-referred than court referred (as reported by 14 versus 4 sources). Conversely, those in non-methadone programs are much more likely to be court referrals than self-referrals (12 versus 5 sources).

How available is methadone treatment in *Pulse Check* communities? Methadone maintenance is still not available in Billings or Sioux Falls. As reported in the last *Pulse Check*, in the remaining cities, about half of the epidemiologic/ethnographic sources—mainly in the South—consider methadone to be available in selected areas only, while the other half consider it to be available throughout their areas. About half (9 of 17) of those sources report waiting lists for admission to public methadone programs, while the other 8 report adequate capacity. Only one epidemiologic source (in Honolulu) reports a waiting list for private methadone treatment, while the Baltimore source reports that private programs have too much capacity.

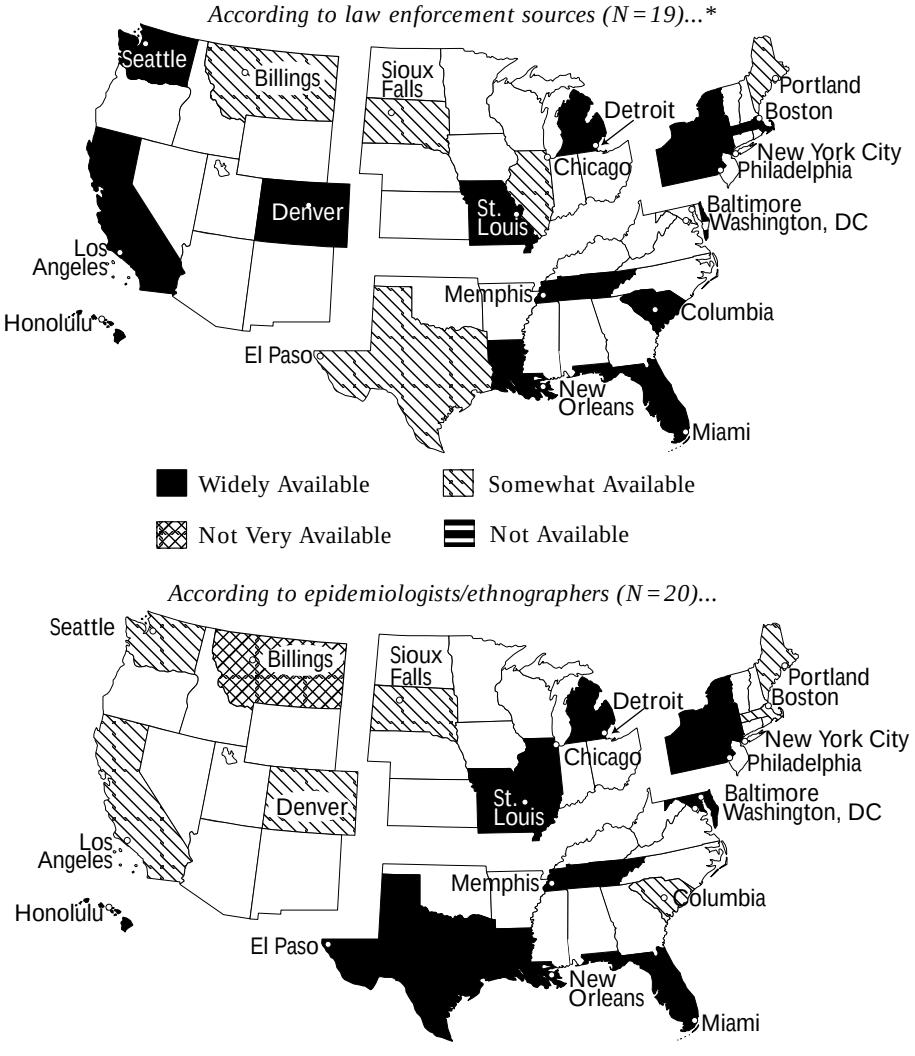
Since the last *Pulse Check* reporting period, public methadone treatment has become more available in Chicago and somewhat more available in Baltimore and Washington, DC. Private methadone treatment has become more available in Chicago, Detroit, and Portland (ME), and somewhat more available in Denver and Seattle. Public program slot capacity has declined somewhat in Boston and Detroit and increased greatly in Baltimore; private capacity has increased somewhat in Columbia (SC) and Seattle and increased greatly in Denver and Portland.

CRACK COCAINE[+]

Crack is named as the drug with the most serious consequences in *Pulse Check* communities by 19 sources in 12 cities: Boston and New York in the Northeast; Columbia (SC), El Paso, Memphis, Miami, New Orleans, and Washington, DC, in the South; Chicago, Detroit, and St. Louis in the Midwest; and Los Angeles in the West. In eight of those cities—Chicago, Columbia, Detroit, Los Angeles, Miami, New Orleans, New York, and Washington, DC—sources also consider crack the most widely used illicit drug.

Compared with the last *Pulse Check* reporting period, the Boston law enforcement source believes that powder cocaine has replaced crack as the drug with the most serious consequences, the Miami law enforcement source believes that diverted OxyContin® has done so, and sources in Memphis and St. Louis perceive that methamphetamine has done so. The Memphis law enforcement source also believes that methamphetamine has replaced crack as that community's most widely used illicit drug. Conversely, the Boston methadone treatment source believes that crack has replaced benzodiazepines as the most commonly abused drug, and the Columbia law enforcement source believes that it has replaced marijuana.

Exhibit 1.
How available is crack cocaine across the 20 *Pulse Check* cities (fall 2001)?



**The Baltimore law enforcement source did not respond.*

CRACK: THE DRUG

How available is crack cocaine across the country? *(Exhibits 1 and 2)* The majority of law enforcement (14 of 19) and epidemiologic/ethnographic (12 of 20) *Pulse Check* sources consider crack to be widely available in their communities. Sources in 10 cities describe it as "somewhat available": Boston and Portland (ME) in the Northeast; Columbia (SC) and El Paso in the South; Chicago and Sioux Falls in the Midwest; and Billings, Denver, Los Angeles, and Seattle in the West. The Billings epidemiologic source is the only one who describes it as "not very available."

According to the majority of law enforcement and epidemiologic/ethnographic sources, crack availability remained stable between spring and fall 2001, with increases perceived in only three cities (Chicago, Detroit, and El Paso) and declines in another three (Boston, Denver, and Honolulu). In Washington, DC, after dipping briefly, crack availability has returned to earlier levels.

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

How and where is crack cocaine made? Crack continues to be processed locally in many *Pulse Check* communities, either by users or by local distributors, as noted in previous *Pulse Check* issues. In Billings, Portland (ME), and Sioux Falls, however, law enforcement sources report that crack is processed before arriving in the community. Crack in Sioux Falls used to come from California, but for the past year or two has been coming mostly from Kansas City and Omaha. In Denver, all crack used to be processed locally, but now only small quantities are, while larger quantities come in preprocessed from Mexico. Both local and outside crack are also reported in Los Angeles and Washington, DC.

The New York ethnographic source notes that different dealers cook crack with different substances. More users there are starting to cook their own crack because quality varies from seller to seller and has generally declined since the last *Pulse Check* reporting period.

What are crack cocaine prices and purity levels across the country? *(Exhibit 3)* As the table shows, street-level prices have remained generally stable across the country since the last *Pulse Check* reporting period. Rocks still tend to be sold in sizes of approximately 0.1 and 0.2 grams and sell for approximately $10 and $20, respectively, according to law enforcement and epidemiologic/ethnographic sources.

Gram prices, like street prices, have also remained stable between spring and fall 2001. About half the *Pulse Check* law enforcement sources report on gram prices for crack cocaine in their communities:

- Billings, MT: $125–$150
- Chicago, IL: $123
- Columbia, SC: $100
- Honolulu, HI: $100–$250
- Los Angeles, CA: $80
- New Orleans, LA: $40–$50
- New York, NY: $24–$30
- Seattle, WA: $100
- Washington, DC: $100

Only a few street-level purity percentages are reported:

- Billings, MT[L]: 50–70 percent pure
- Denver, CO[L]: 40–50 percent per rock (down)
- Los Angeles, CA[E]: 80–85 percent, unit unspecified (stable)
- New York, NY[L]: 58 percent per rock (stable)
- Philadelphia, PA[L]: 80 percent per rock (stable)
- Portland, ME[L]: 80 percent per rock (stable)
- Washington, DC[L]: 30–60 percent per "dime bag" (stable)

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

**The Baltimore law enforcement source did not respond.*

How is crack referred to across the country? *(Exhibit 4)* As reported in the last *Pulse Check*, slang names for crack seem particularly common in the South and, to a lesser extent, in the Northeast. They are rare in the Midwest and the West. One of the few new names mentioned is "CDs," as reported by the Philadelphia law enforcement source.

How is crack packaged and marketed? The most commonly reported packaging, across all four regions, remains small plastic, cellophane, glassine, or coin bags, often the "zipper" type. Loose rocks are the next most common, followed by vials. Foil packaging is mentioned only occasionally, as are balloons and folded bindles of paper or other material. Since the last *Pulse Check*, one of the few changes reported is in St. Louis, where the epidemiologic source reports foil wrapping for the first time, in addition to the cellophane bags and loose rocks reported previously. The New York ethnographic source continues to report a movement away from vials, which used to dominate crack packaging, and toward cellophane baggies whose colors represent different groups or individual distributors. Conversely, the Baltimore ethnographic source reports that the most common form of packaging is vials whose different color tops represent different dealers.

Exhibit 3.
What are crack cocaine price levels in the 20 *Pulse Check* cities?

		MOST COMMON STREET UNIT		
	City/Source	Unit	Size	Price/*Change***
Northeast	Boston, MA[L]	"jum" (small rock)	0.1 gm	$10/↔
	Boston, MA[E]	"bump," rock, "jum"	NR	$20, $40, $50/↔
	New York, NY[L]	rock	NR	$7–$10/↔
		vial	NR	$20/↔
	New York, NY[E]	vial, rock	NR	$10/↔
	Philadelphia, PA[L]	rock	0.5–0.7 oz	$5–$10/↔
	Philadelphia, PA[E]	rock	NR	$5/↔
	Portland, ME[L]	rock	0.1–0.5 oz	$50/↔
South	Baltimore, MD[E]	rock in a vial	NR	$5–$10/NR
	El Paso, TX[L]	rock	0.25 gm	$20/↔
	El Paso, TX[E]	rock	NR	$20/↔
	Memphis, TN[L]	rock	0.2 gm	$20/↔
	Memphis, TN[E]	rock	NR	$5–$20/↔
	Miami, FL[L]	rock	NR	$10–$20/NR
	Miami, FL[E]	rock	NR	$10–$20/↔
	New Orleans, LA[L]	rock	0.48 gm	$20/↔
		rock	NR	$10/↔
	Washington, DC[L]	"dime bag"	75 mg	$10/↔
	Washington, DC[E]	rock	NR	NR/↔
		"eightball"	NR	$125–$130/NR
Midwest	Chicago, IL[L]	rock	0.2 gm	$20–$25/↔
	Chicago, IL[E]	rock	NR	$5–$20/↔
	Detroit, MI[L]	rock	0.1 gm	$10/↔
	Detroit, MI[E]	rock	NR	$20/↔
	St. Louis, MO[L]	rock	NR	$20/↔
	Sioux Falls, SD[L]	small rock	0.3–0.5 gm	$100/↔
West	Billings, MT[L]	NR	0.25 gm	NR/NR
	Denver, CO[L]	rock	0.1–0.2 gm	$25–$45/↑
	Denver, CO[E]	rock	NR	$20–$30/↔
		NR	1 oz	$800–$1,200/↔
	Honolulu, HI[L]	rock	0.25 gm	$25–$30/↔
	Honolulu, HI[E]	NR	0.25 gm	$25–$30/↔
		NR	0.25 oz	$400/↔
	Los Angeles, CA[L]	rock	0.2 gm	$20/↔
	Los Angeles, CA[E]	NR	NR	NR/NR
	Seattle, WA[E]	rock	0.1–0.125 gm	$20/↔
		rock	0.2–0.25 gm	$40/↔

Sources: Law enforcement and epidemiologic/ethnographic respondents
**Respondents in Sioux Falls did not provide this information.*
***Arrows indicate up, down, or stable between spring and fall 2001.*
NR= not reported

"Black tops are good today": Changing colors, changing preferences, changing locations...

Baltimore, MD[E]: Different color tops on vials represent different dealers. Each day, users select their "color of the day" (that is, where and from whom they buy crack) based upon word of mouth and the word of "touters," who stand out on street and advertise the drug. Recommendations and preferences change on a daily basis, and touters move from location to location because of shifting law enforcement presence.

CRACK: THE SELLERS

Who sells crack? Young adults (18–30 years) continue to be the predominant crack sellers in nearly all *Pulse Check* cities, according to law enforcement and epidemiologic/ethnographic sources. Additionally, adolescents sometimes sell crack (as in Baltimore, Chicago, Columbia [SC], Detroit, Los Angeles, and Seattle), as do older adults (in Boston, Detroit, and Sioux Falls). As reported in previous issues, these individuals sometimes operate independently and sometimes as part of an organized sales structure, while some cities have both types of structures. Little has changed since the last *Pulse Check*, with only a few exceptions:

- **Columbia, SC**[L]: Marijuana users in their teens to early twenties are increasingly becoming involved in crack sales.
- **Denver, CO**[L]**:** Mexican nationals are bringing in larger amounts, and local distributors in the Black community are becoming organized and are selling larger quantities.
- **Memphis, TN**[E]: Crack sales are becoming less organized, with more independent sellers reported.

As reported in the last *Pulse Check*, crack sellers are somewhat or very likely to use their own drug, according to the majority (13 of 17) law enforcement sources who discussed this question; epidemiologic/ethnographic sources, however, generally consider crack sellers as less likely to do so.

How is street-level crack sold? Crack sales are conducted in ways similar to those described for heroin: hand-to-hand sales are commonly mentioned, as are sales involving beepers or cell phones, runners,

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

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

prearranged meetings, deliveries, and referrals. Some variations, however, are reported. In Philadelphia, for example, crack is often exchanged for money, sexual favors, or merchandise. And in Chicago, the seller sometimes holds a rock in the mouth and transfers it to the buyer's mouth.

Only three changes are noted since the last *Pulse Check* reporting period. Beepers are increasingly used in Boston as sales continue to move more underground. Similarly, electronic communications are increasingly used in Los Angeles. And Columbia (SC) street sellers who deal in crack and marijuana are becoming more cautious about to whom they sell, probably because of increased law enforcement pressure—typically, they no longer sell to buyers in cars.

What type of crimes are related to the crack sales scene? Crack sellers are frequently involved in violent crime, as reported by the majority of law enforcement (12 of 16) and epidemiologic/ethnographic (10 of 13) sources who discussed this question. Some of the crimes specified include turf wars (in Sioux Falls and Washington, DC), assaults and robberies (in New York), and armed robberies and holdups (in St. Louis and Sioux Falls). Nearly every source who mentions violent crime also mentions gang-related activities.

The vast majority of sources also mention prostitution and nonviolent crimes. Some sources specify the nonviolent crimes: larcenies, robberies, car break-ins, and increased counterfeiting in Columbia, SC; burglaries and car thefts in Sioux Falls; thefts and burglaries in Billings; petty theft in Boston; and intimidation in New York. Domestic violence is mentioned in Boston, El Paso, Honolulu, Memphis, New York, and St. Louis. Users, as well as sellers, are often mentioned in relation to some of these crimes.

Where is crack cocaine sold? Central city areas, as reported in the last *Pulse Check*, are the most common locations for crack sales. Suburban areas (or both central city and suburban areas), however, are mentioned by law enforcement or epidemiologic/ethnographic sources in Detroit, El Paso, Miami, and Los Angeles. All three types of areas—central city, suburban and rural—are named in Billings, Memphis, New York, and Portland (ME). The vast majority of sources report that crack is sold both indoors and outdoors. Only a few changes are reported since the last reporting period:

- **Boston, MA[E]**: Crack sales have moved more indoors.
- **Detroit, MI[L]**: Indoor versus outdoor sales vary, depending on the season and on the dealer.
- **Memphis, TN[E]**: Crack sales are moving out of the city and into the suburbs and rural areas.

Only one source reports any changes in the specific settings for crack sales. In Memphis, the epidemiologic source notes two new settings: restaurants, where "the cook does the dealing, and the customers and waiters smoke crack in the back" (particularly in the suburbs); and shelters and group homes, where prescription pills are sometimes bartered for crack.

Other specific settings for crack sales have not changed since the last *Pulse Check*. Public housing developments, private residences, cars, and crack houses are still mentioned by law enforcement and epidemiologic/ethnographic sources in nearly every city. Private parties, nightclubs/bars, parks/playgrounds, in or around schools, and hotels/motels are mentioned in approximately half of the cities. Less commonly mentioned settings are college campuses (in seven cities), in or around shopping malls (six cities), around drug or alcohol treatment clinics (six cities), raves (in Billings, Miami, Honolulu,

and New York), and in or near supermarkets (in Columbia, Miami, New York, and Philadelphia). New York has the widest range of crack sales settings, followed by Memphis and Philadelphia.

What other drugs do crack dealers sell? Polydrug sales among crack sellers appear to be on the decline: compared with the last *Pulse Check*, more law enforcement sources (8 versus 10) and more epidemiologic/ethnographic sources (3 versus 6) report that no other drugs are sold. Three increases are reported, however, since the last *Pulse Check*:

- **Memphis, TN**[E]: In addition to powder cocaine, as reported previously, crack dealers are also selling marijuana during the current reporting period.
- **Miami, FL**[L]: Diverted Oxy-Contin® is now available in the same places where crack is sold.
- **Washington, DC**[L]: In addition to marijuana, as reported previously, crack dealers are also selling ecstasy.

New York crack sellers still sell the widest range of drugs, including heroin, powder cocaine, marijuana, and ecstasy.

CRACK: THE USERS

Who uses crack? *(Exhibits 5, 6, and 7)* The majority of epidemiologic/ethnographic and treatment sources report that crack users are most likely to be young adults (18–30 years), central city residents, from low socioeconomic backgrounds, with a few variations in some cities as shown in the exhibits. Methadone treatment sources tend to report older users than non-methadone treatment sources. Blacks are twice as likely as Whites to be reported as the predominant user group. Although males are the predominant users according to slightly more than half the sources, nearly half report that males and females are equally likely to use crack—more so than any other illicit drug except ecstasy, as reported in the last *Pulse Check*. Nearly all methadone treatment sources report that crack users in their programs have completed high school; by contrast, the majority of non-methadone sources report that crack-using clients have only completed junior high. Crack users tend to be unemployed, according to both kinds of *Pulse Check* treatment sources.

Many sources, like the Boston ethnographic source, report a static pool of users that is neither growing nor shrinking. Others, like the one from the New York methadone program, note a slight decline in overall use. Overall, crack users have remained relatively stable as a group since the last *Pulse Check* reporting period, with only a few minor changes and interesting variations in age, gender, race/ethnicity, and residence area.

How do users take crack? Crack is nearly always smoked. However, isolated cases of injection are occasionally reported:

- **Baltimore, MD**[E]: When injectors can't find powder cocaine, they recook crack and inject it.

Exhibit 5.
What age group is most likely to use crack?

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

Sources: Epidemiologic/ethnographic (E), non-methadone treatment (N), and methadone treatment (M) respondents
Note: Some sources name more than one age group.

Since the last ***Pulse Check*** reporting period, only a few changes are reported in crack user characteristics:

Age changes:

- **Billings, MT[N]**: Crack use has increased, especially among adolescent users in treatment.
- **Denver, CO[E]**: The population continues to age.
- **Washington, DC[E]**: While the predominant group is older than 30, an emerging group of young adults (18–30 years) who smoke crack in marijuana joints ("wooties") is occasionally reported.

Gender distribution changes:

- **Columbia, SC[E]**: Crack users have declined overall in number, particularly females: during the last *Pulse Check* reporting period, males and females were equally likely to smoke the drug; during the current period, males outnumber females.
- **Seattle, WA[E]**: In the last *Pulse Check*, crack users were reported as evenly split between males and females. However, the number of males involved in crack-related deaths and emergency department mentions has increased somewhat recently. Conversely, cocaine-positive urinalyses have declined among male arrestees.
- **New Orleans, LA[E]**: Female crack users have increased slightly.

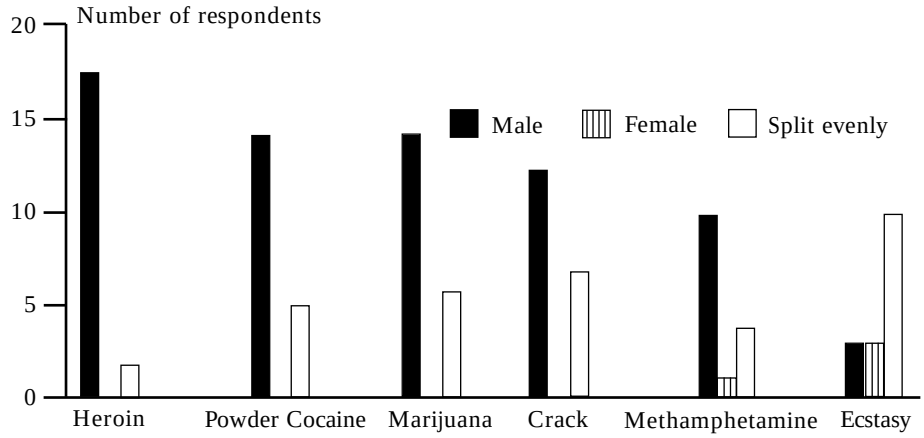
Race/ethnicity distribution change:

- **Philadelphia, PA[E]**: Hispanic representation, which is second to Black representation, has leveled off.

Residence changes:

- **Billings, MT[N]**: White crack users tend to reside in the central city; American Indian users generally live in rural areas.
- **Honolulu, HI[E]**: Crack use has increased slightly in suburban areas, possibly among a slightly younger group than those in the central city, where most crack users still reside.
- **Memphis, TN[E]**: While crack users reside primarily in central city areas, suburban crack users are increasingly emerging as a polysubstance user group.
- **St. Louis, MO[E]**: Older users tend to be low-socioeconomic central city residents; younger users are more diverse socioeconomically and live both in the suburbs and central city areas.

Exhibit 6. Which genders are the predominant users of specific drugs in the 20 *Pulse Check* cities?



Source: Epidemiologic/ethnographic respondents

- **Boston, MA[E]**: Heroin addicts smoke crack, but primary "speedballers" inject it.
- **Sioux Falls, SD[N]**: Clients occasionally inject crack.
- **Washington, DC[E]**: Cocaine injectors are finding it increasingly difficult to find powder cocaine, so they are increasingly shooting crack instead.

The majority of non-methadone treatment sources continue to report that crack users in their programs tend to take the drug daily, while less frequent usage is reported in Denver, Los Angeles, Portland (ME), St. Louis, Sioux Falls, and Seattle. As reported in the last *Pulse Check*, crack users in methadone programs appear to take the drug less frequently than those in non-methadone programs: daily use in methadone programs is reported only in Baltimore, Chicago, and Los Angeles.

What other drugs do crack users take? Since the last *Pulse Check*, several changes are reported in the kind of other drugs and drug combinations taken by crack users:

- **Baltimore, MD[E]**: The use of "woolies" (crack combined with marijuana, usually in a joint but sometimes in a blunt) has declined slightly.
- **Billings, MT[N]**: Clients are increasingly abusing prescription drugs with crack.
- **Boston, MA[E]**: "Oolies" (marijuana joints laced with crack or powder cocaine) have been replaced by sequential use of marijuana and cocaine (either form).

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

	City	E	N	M
Northeast	Boston, MA	**Blacks**	Whites	NR
	New York, NY	**Blacks**	Blacks	Hispanics
	Philadelphia, PA	Blacks	Whites; Blacks; Hispanics	Numbers low
	Portland, ME	Whites	Hispanics	Numbers low
South	Baltimore, MD	Blacks	NR	Blacks
	Columbia, SC	Blacks	Numbers low	Blacks
	El Paso, TX	**Blacks**	**Black;** Hispanics	Numbers low
	Memphis, TN	**Blacks**	NR	NR
	Miami, FL	**Blacks**	**Blacks**	NR
	New Orleans, LA	**Blacks**	Blacks	Whites
	Washington, DC	**Blacks**	Blacks	Blacks
Midwest	Chicago, IL	**Blacks**	**Blacks**	Blacks
	Detroit, MI	Whites	Blacks	Blacks
	St. Louis, MO	**Blacks**	**Blacks**	Whites
	Sioux Falls, SD**	Whites	Whites	NA
			Numbers low	
West	Billings, MT**	Whites	Whites; American Indians	NA
			Whites	
	Denver, CO	Whites	Black	Numbers low
	Honolulu, HI	Whites; Asians	NR	**Whites**
	Los Angeles, CA	**Blacks**	Hispanics	Blacks; Hispanics
	Seattle, WA	**Blacks**	Whites	Whites

Sources: Epidemiologic/ethnographic (E), non-methadone treatment (N), and methadone treatment (M) respondents
**Shaded boxes indicate that a given heroin-using racial/ethnic group is overrepresented relative to that city's general population. Not all sources, however, had this information available.*
***Billings and Sioux Falls have no methadone programs, so two non-methadone sources reported from each.*

- **Honolulu, HI**[E]: Sometimes crack is used as an alternative to methamphetamine, but methamphetamine is usually cheaper.
- **Memphis, TN**[E]: Two new phenomena are crack combined with marijuana in a blunt ("sherman stick") or with alcohol. The drug is also sometimes taken sequentially with pharmaceutical pills, particularly alprazolam.
- **Seattle, WA**[E]: Benzodiazepines are emerging as a kind of drug taken by the crack-using population to "take the edge off."
- **St. Louis, MO**[M]: After using crack, many clients are using a variety of health food products and diuretics in an effort to "cleanse the system" before urinalysis.
- **Washington, DC**[E]: Crack smoked in marijuana joints ("wooties") is occasionally reported.

Where and with whom is crack used? As reported in past issues, crack generally tends to be used indoors, in private, and in small groups or among friends, according to the majority of epidemiologic/ethnographic and treatment sources. A few minor changes in settings or contexts since the last *Pulse Check* are reported in a handful of cities:

- **Honolulu, HI**[E]: Like the heroin market, the crack market on beach parks has been disrupted as a side effect of police typing reports in beach parks on their new laptop computers.
- **Memphis, TN**[E]: Crack is increasingly used in public and within groups since the last *Pulse Check* reporting period, when private and solo use were more predominant.
- **New Orleans, LA**[E]: Raves have disappeared since a controversial theater was shut down last year and its owner recently tried, heavily fined, and not allowed to reopen.
- **Washington, DC**[E]: Some seasonal fluctuations are reported, with more use in alleyways as the weather gets warmer.

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POWDER COCAINE[+]

Two sources in Denver (law enforcement and epidemiologic) and one in Boston (law enforcement) are the only ones who name powder cocaine as the drug with the most serious consequences, whether medically, legally, societally, or otherwise. Two additional sources (in El Paso and Seattle) mention cocaine without distinguishing between crack and powder. No single source names powder cocaine as the most widely abused drug.

Compared with the last *Pulse Check*, the Boston law enforcement source perceives that powder cocaine has replaced crack as the drug with the most serious consequences but that marijuana has replaced powder cocaine as the most widely abused drug.

How available is powder cocaine across the country? *(Exhibits 1 and 2)* The majority of the *Pulse Check* law enforcement sources (14 of 19) and nearly half of the epidemiologic/ethnographic sources (9 of 20) consider powder cocaine widely available in their communities. The remaining sources describe it as "somewhat available," with four exceptions: sources in Chicago, Los Angeles, and St. Louis describe it as "not very available"; and one source in Honolulu believes powder cocaine is not available at all. The Washington, DC, epidemiologic source elaborates that the drug is somewhat available in clubs but not very available on the street.

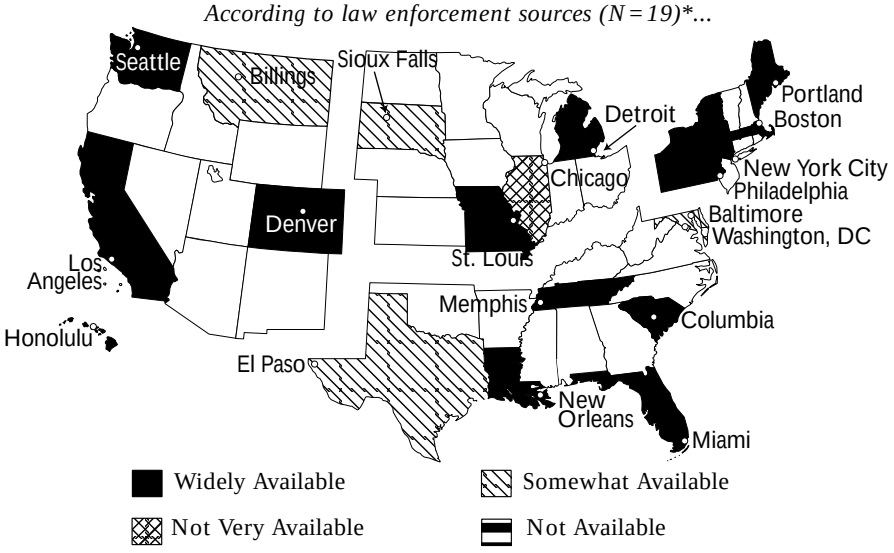
According to the majority of law enforcement and epidemiologic/ethnographic sources, powder cocaine availability remained stable between spring and fall 2001, with increases perceived in only three cities (Columbia [SC], El Paso, and Portland [ME]) and declines in two (Honolulu and Washington, DC).

What are powder cocaine prices and purity levels across the country? *(Exhibit 3)* Although prices range widely across the country, the most common gram price, as reported in the last *Pulse Check*, is still approximately $100. Only one price change is reported since the last issue: a slight decline in Memphis, which has the lowest gram price of all the sites.

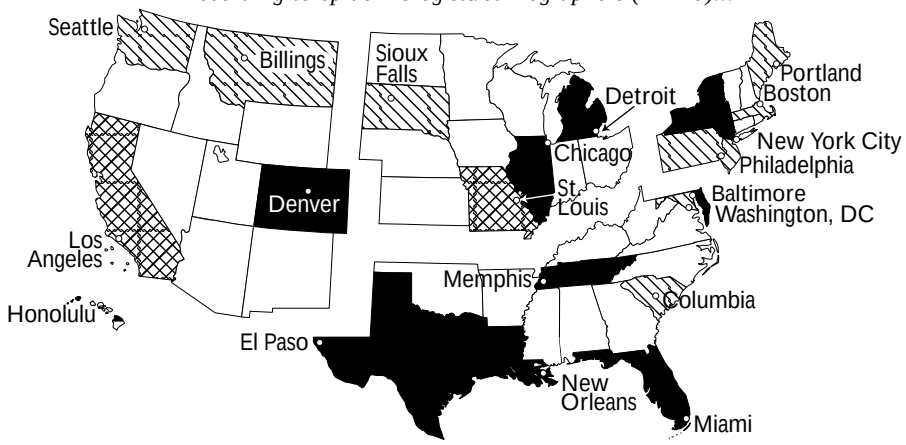
Gram purity levels have increased in Portland (ME) and declined in Denver. "Eightball" (1/8 ounce) purity levels have increased in Washing-ton, DC, and declined in Seattle.

Exhibit 1.
How available is powder cocaine across the 20 *Pulse Check* cities (fall 2001)?

According to law enforcement sources (N = 19)...*



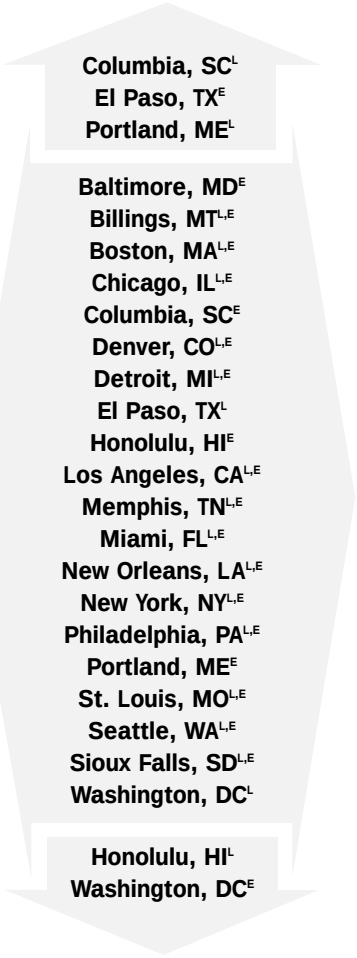
According to epidemiologists/ethnographers (N = 20)...



**The law enforcement source in Baltimore did not respond.*

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

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



**The Baltimore law enforcement source did not respond.*

Exhibit 3.
How much do grams and "eightballs" of powder cocaine cost in 15 *Pulse Check* cities?*

		GRAMS		"EIGHTBALLS" (1/8 OUNCE)	
	City	Price/Change**	Purity/Change**	Price/Change	Purity/Change
Northeast	Boston, MA[L]	$60/↔	60%/NR	$200–$250/↔	60%/↔
	Boston, MA[E]	$40/↔	NR/NR	$180/↔	NR/NR
	New York, NY[L]	$28–$30/↔	75%/↔		
	Philadelphia, PA[L]	$100–$125/↔	60–80%/↔	$120/NR	60–80%/↔
	Portland, ME[L]	$80–$100/NR	40–60%/↑		
South	Memphis, TN[L]	$20/↓	NR/NR		
	Memphis, TN[E]	$45–$100/↔	NR/NR		
	Miami, FL[E]	$20/↔	NR/NR		
	Washington, DC[L]	$100/↔	30–60%/↔		
	Washington, DC[E]	$50–$100/NR	NR/NR	$150–$335/↑	NR/NR
Midwest	Chicago, IL[L]	$125/↔	NR/NR		
	Chicago, IL[E]	NR/NR	50–140%/↔		
	Detroit, MI[L]	$75–$100/↔	NR/↔		
	Detroit, MI[E]	$75–$125/NR	NR/↔		
	St. Louis, MO[L]	$100/↔	NR/NR		
	Sioux Falls, SD[L]	$100/↔	↔/NR	$275/↔	NR/NR
West	Billings, MT[L]	$100/↔	50–70%/↔		
	Denver, CO[L]	$100/↔	20–40%/↓		
	Denver, CO[E]	$80–$100/↔	50–90%/↔		
	Honolulu, HI[L]	$100–$120/↔	NR/NR		
	Honolulu, HI[E]			$250–$350/NR	NR/NR
	Los Angeles, CA[L]	$80–$85/↔	80%/↔		
	Seattle, WA[L]	$80–$100/NR	57–58%/↔		
	Seattle, WA[E]	$30/↔	NR/↔	$80–$100/↔	NR/↔

Sources: Law enforcement (L) and epidemiologic/ethnographic (E) respondents
**Respondents in Baltimore, Billings, El Paso, and New Orleans did not provide this information.*
***Arrows indicate up, down, or stable between spring and fall 2001.*
NR= not reported

Ounce-level purity in Miami has declined due to increasing use of adulterants, such as caffeine (new this reporting period) and "any white powder." "Any powder" is also reported in Chicago, and a wide range of other adulterants are reported elsewhere: inositol (a crystalline stereoisomeric cyclic alcohol) in El Paso and St. Louis; manitol (similar to inositol) in El Paso and Memphis; baby laxatives in Baltimore and Memphis; chalk, laundry detergent, procaine (an herbal supplement ingredient), and rat poison in Memphis; meat tenderizer (which leads to severe skin abscesses) in Boston; corn starch and crushed vitamin C in El Paso; and talcum or baby powder in Billings, El Paso, and Washington, DC.

How is powder cocaine referred to and packaged across the country? *(Exhibit 4)* "Yao," reported by the methadone treatment source in Seattle, is one of the few new slang names mentioned since the last *Pulse Check*. As in the past, and as in the case of crack, slang names seem to proliferate among users in the South more than in the other regions.

Various types of plastic bags are still the most common packaging, and no packaging changes are reported since the last *Pulse Check*. Other commonly reported forms include tinfoil, vials, capsules, and balloons. Some more unusual forms are reported: bricks (wax paper bound with brown sticky wrapping tape), perfume containers, and motor oil jugs in Billings;

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

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

vacuum-sealed plastic in Denver; "pony packs" (folded pieces of paper) and cigarette packs in Memphis; and dollar bills in New York (if a $20 bag is packaged in a dollar bill, the price goes up to $21). Fewer labels or logos are reported during this period than in the past: in Denver, plastic wrapping sometimes has scorpions or stars; in Memphis, labels are used only on large (kilogram) amounts; and in Miami, some logos appear on bags sold in head shops.

POWDER COCAINE: THE SELLERS

Who sells powder cocaine? Young adults (18–30 years), either exclusively or with another age group, are named as powder cocaine sellers by all law enforcement and epidemiologic/ethnographic sources except for one: the El Paso epidemiologic source names adults older than 30 as the predominant sellers. Older adults (along with younger adults) also sell the drug in Boston, Chicago, and Portland (ME), while adolescents sell it in Baltimore, Chicago, and Los Angeles.

As noted in the last *Pulse Check*, law enforcement sources tend to report that powder cocaine sellers operate independently, while epidemiologic/ethnographic sources tend to report both independent and organized sales structures. Only one change is reported: the Memphis epidemiologic source notes that independent sellers have increased, while sales groups appear less organized.

Law enforcement sources generally believe that powder cocaine dealers are either very likely or somewhat likely to use their own drug. Only in two cities do they believe that dealers are not very likely to do so: in Denver and Miami. Four epidemiologic/ethnographic sources believe that dealers are not very likely to use their drug: in Baltimore, Boston, Denver, and New Orleans. Only one change is reported since the last *Pulse Check*: the Memphis epidemiologic source reports that dealers are less likely to use their drug than before.

What type of crimes are related to the powder cocaine scene? Powder cocaine dealers are less likely to be involved in violent crime than crack dealers, according to law enforcement sources (8 versus 12) and epidemiologic/ethnographic sources (6 versus 10). Similarly, gang-related activity and prostitution are less frequently associated with powder cocaine than with crack. Domestic violence, however, is named more frequently in relation to powder cocaine than to crack: in nine cities (Boston, Detroit, El Paso, Honolulu, Memphis, New York, Portland [ME], St. Louis, and Sioux Falls) versus six. In discussing powder cocaine, sources tend to name nonviolent crime slightly more often than violent crime. Some specify the crimes: shoplifting in Boston; burglary or theft in Billings, El Paso, and Memphis; auto thefts, break-ins, and larcenies in Columbia, SC; residing as or transporting illegal aliens in El Paso; money laundering in Miami; and domestic disputes in Sioux Falls.

What other drugs do powder cocaine dealers sell? Powder cocaine dealers also sell marijuana in 15 of the 20 *Pulse Check* cities (the 5 exceptions are Baltimore, Chicago, New Orleans, Philadelphia, and Washington, DC), according to law enforcement and epidemiologic/ethnographic sources. They sell crack in nine cities (including five in the South), heroin in seven (including three in the West), ecstasy or other club drugs in another seven (five of which are in the South), and methamphetamine in four (three of which are in the West).

A fine distinction...

New York still has the widest range of drugs obtainable at single locations—heroin, crack, powder cocaine, marijuana, and ecstasy—but the ethnographic source notes a fine distinction: it is heroin sellers who sell all five drugs. Dealers who specialize in any of the other drugs don't necessarily sell anything but that drug.

Compared with the last *Pulse Check*, marijuana sales by powder cocaine dealers are newly reported in Boston, El Paso, Los Angeles, Memphis, and Portland (ME). Ecstasy or other club drugs are newly reported in Columbia (SC), El Paso, and Washington, DC. Sometimes the drug sold is driven by the sales setting: in Columbia, for example, ecstasy and powder cocaine are only likely to be sold together in nightclubs, while marijuana is more likely to be sold with powder cocaine on the street. Similarly, in New Orleans, powder cocaine sellers also sell heroin in central city areas, but in the suburbs they sell only powder cocaine.

Where is powder cocaine sold?

Powder cocaine is sold primarily in central city locations in the majority of *Pulse Check* cities, as reported in past issues. Other types of locations, however, are more frequently reported for powder cocaine sales than for crack sales. Suburban areas (or both central city and suburban areas) are mentioned in Boston, Los Angeles, New Orleans, and Seattle, while all three types of areas—central city, suburban, and rural—are named in Chicago, Denver, Detroit, El Paso, Miami, New York, and Portland (ME). The only change mentioned since the last *Pulse Check* is in Memphis, where the epidemiologic source notes that powder cocaine sales are moving out of the city and into the suburbs and rural areas.

Powder cocaine is equally likely to be sold either indoors or outdoors, according to about half of the law enforcement (9 of 19) and epidemiologic/ethnographic (7 of 13) sources who provided this information. In the remaining cities, indoor sales are reported more often than outdoor sales. Outdoor sales, however, still predominate in Miami, New Orleans, Philadelphia, and Sioux Falls. The specific settings for powder cocaine sales are as varied as those for heroin and crack, with no changes reported since the last *Pulse Check*. In Memphis, however, while the types of selling locations have not changed, powder cocaine is sold in more places overall.

POWDER COCAINE: THE USERS

Who uses powder cocaine?

(Exhibit 5) Like heroin users, powder cocaine users tend to be White males, older than 30, who live in central city areas—particularly as reported by epidemiologic/ethnographic sources. More variations are reported by

Exhibit 5.
What racial/ethnic group is most likely to use specific drugs?*

		Heroin		Crack		Powder Cocaine	
	City	E	N	E	N	E	N
Northeast	Boston, MA	Whites	Whites	**Blacks**	Whites	**Whites**	Whites
	New York, NY	**Hispanics**	Blacks; **Hispanics**	**Blacks**	Blacks	**Blacks**	Blacks; Hispanics
	Philadelphia, PA	Whites	Whites; Blacks	Blacks	Whites; Blacks; Hispanics	NR	NR
	Portland, ME	Whites	Whites	Whites	Hispanics	Whites	Whites
South	Baltimore, MD	**Whites**	NR	Blacks	NR	**Blacks;** Hispanics	NR
	Columbia, SC	Whites; **Blacks**	Numbers Low	Blacks	Numbers Low	Whites; Blacks	Whites
	El Paso, TX	Hispanics	Hispanics	**Blacks**	**Blacks;** Hispanics	**Whites;** Hispanics	Hispanics
	Memphis, TN	Whites	NR	**Blacks**	NR	**Whites;** Blacks	NR
	Miami, FL	**Whites**	**Hispanics**	**Blacks**	**Blacks**	Whites	Hispanics
	New Orleans, LA	**Blacks**	Blacks	**Blacks**	Blacks	Whites	NR
	Washington, DC	Blacks	Blacks	**Blacks**	Blacks	Blacks	Blacks
Midwest	Chicago, IL	**Blacks**	**Blacks**	**Blacks**	**Blacks**	**Blacks**	Blacks**;** Hispanics
	Detroit, MI	Whites	Blacks	Whites	Blacks	Whites	Blacks
	St. Louis, MO	Whites; Blacks	**Blacks;** Hispanics	**Blacks**	**Blacks**	Whites	Whites
	Sioux Falls, SD**	Whites	Whites Numbers Low	Whites	Whites Numbers Low	Whites	Whites; American Indians
West	Billings, MT**	Whites	Whites; American Indians Whites	Whites	Whites; American Indians Whites	Whites	Whites
	Denver, CO	Whites	Whites	Whites	Blacks	Whites	Blacks
	Honolulu, HI	**Whites**	NR	**Whites;** Asians	NR	NR	NR
	Los Angeles, CA	Whites; **Hispanics**	Numbers Low	**Blacks**	Hispanics	Whites	Hispanics
	Seattle, WA	Whites	Whites	**Blacks**	Whites	**Whites**	Whites

Sources: Epidemiologic/ethnographic (E) and non-methadone treatment (N) respondents
**Shaded boxes indicate that a given drug-using population is overrepresented relative to that city's general population. Not all sources, however, had this information available.*
***Billings and Sioux Falls have no methadone treatment programs, so two non-methadone sources reported from each.*

Since the last ***Pulse Check*** reporting period, only a few changes are reported in the age, gender, race/ethnicity, and residence area of users:

Age:

- **Boston, MA[N]:** Young adults and older adults are equally likely to use powder cocaine—during the last *Pulse Check* reporting period, only young adults were named as the predominant group. This change, however, might simply be a case of the older clients increasingly admitting to powder cocaine use.
- **Columbia, SC[E]:** Young adults and older adults are equally likely to use powder cocaine—again, a change from the last *Pulse Check*, when only young adults were named as the predominant group. But this change could be just a random fluctuation because the numbers are small, since most cocaine use involves crack rather than powder.
- **Washington, DC[E]:** While the predominant users are Black adult (>30 years) male injectors, an emerging group is reported: young adult (18–30 years) White male snorters.

Race/ Ethnicity:

- **Columbia, SC[E]:** Whites and Blacks are equally likely to use powder cocaine. During the last *Pulse Check* reporting period, only Blacks were named as the predominant group. Again, the numbers are small, so this change could be just a random fluctuation.
- **Denver, CO[E]:** Hispanic users of powder cocaine are overrepresented relative to the general population, and their representation in treatment has increased slightly since the last *Pulse Check*. Whites, however, are still the predominant users.
- **Philadelphia, PA[E]:** Hispanic representation has increased. However, Whites are still the predominant powder cocaine users.

Gender:

- **Columbia, SC[N]:** While users are predominantly adolescent males, the number of female novice users has been increasing. It is possible that they are not using more, but rather they are admitting to use because, as the *Pulse Check* source states, "the perceived risk of cocaine is dropping among the clients."

Residence:

- **Denver, CO[E]:** Although powder cocaine users reside primarily in central city areas, some users reside in the suburbs, and increases are reported in rural areas since the last *Pulse Check*.
- **Memphis, TN[E]:** With the increasing use of powder cocaine in suburban areas, the suburbs have now overtaken central city areas (as reported in the last *Pulse Check*) as the predominant place of residence.
- **New Orleans, LA[E]:** In addition to central city areas, much powder cocaine use also takes place in the suburbs. Treatment figures show particular increases in East Baton Rouge.

treatment sources. For example, non-methadone treatment sources seem to report younger users: adolescents are the predominant powder cocaine users among clients in the Columbia (SC), Los Angeles, and Sioux Falls non-methadone programs, and young adults (18–30 years) are the predominant users in another six programs. Methadone treatment sources are more likely than other sources to mention female users of powder cocaine: 7 out of 12 responding methadone treatment sources report that males and females are equally likely to use the drug. Racial/ ethnic distributions among powder cocaine users, as the table shows and as reported in past *Pulse Check*s, are more similar to those of heroin users than to those of crack users.

How do powder cocaine users take their drug? Snorting remains the primary route of administration for cocaine powder according to all but four sources: injecting is named as the predominant route by the Washington, DC, epidemiologic source, the El Paso non-methadone treatment source, and the methadone treatment sources in Baltimore and El Paso. Injecting or smoking are also occasionally mentioned elsewhere as a minority choice. The Boston ethnographic source names two other unusual, but not new, routes of administration and rituals: local affluent college students sometimes slit vitamin E capsules, pack them densely with powder cocaine, and use them as suppositories; and both males and females sometimes rub powder cocaine into the genitalia, claiming that the anesthetic effects on the mucous membranes alters the sexual experience.

Only a few changes in route of administration are reported since the last *Pulse Check*:

- **Denver, CO[E]**: A resurgence in snorting powder cocaine as opposed to crack smoking is reported.
- **El Paso, TX[E]**: While snorting predominates, users often progress from snorting to smoking to injecting.

- **New Orleans, LA[E]:** While the predominant users are Whites who snort the drug, some Blacks report smoking the drug, suggesting they might be turning it into crack.
- **St. Louis, MO[E]:** A slight (2 percent) recent increase in smoking among patients admitted for cocaine (unspecified) use might indicate an increase in use of powder cocaine. However, crack continues to account for at least 90 percent of cocaine use.

Non-methadone vs methadone clients: How often do they use powder cocaine?

Clients in non-methadone treatment programs are more likely to use powder cocaine on a daily basis than those in methadone treatment programs. Those in methadone programs are more likely to binge intermittently.

Exhibit 6.
What other drugs do powder cocaine users take?

Powder Cocaine + Marijuana	Powder Cocaine + Heroin	Powder Cocaine + Benzodiazepines	Powder Cocaine + Methamphetamine	Powder Cocaine + Ecstasy
Baltimore, MD[E]	Baltimore, MD[E]	Boston, MA[E,N]	Billings, MT[E]	Miami, FL[E]
Billings, MT[N]	Billings, MT[E]	Memphis, TN[E]	St. Louis, MO[N]	Portland, ME[N]
Boston, MA[E]	Boston, MA[E]	Portland, ME[E]		
Chicago, IL[E]	Chicago, IL[E,N]			
Denver, CO[E]	Denver, CO[E]			
Detroit, MI[E]	El Paso, TX[E,N]			
El Paso, TX[E,N]	Miami, FL[E]			
Los Angeles, CA[E,N]	New York, NY[E]			
Memphis, TN[E]	Philadelphia, PA[E]			
Miami, FL[E]	Seattle, WA[E]			
New York, NY[E]	Washington, DC[E]			
Philadelphia, PA[E]				
Portland, ME[E]				
St. Louis, MO[E,N]				
Sioux Falls, SD[N]				
Washington, DC[E,N]				

Sources: Epidemiologic/ethnographic (E) and non-methadone treatment (N) respondents

What other drugs do powder cocaine users take? *(Exhibit 6)* Heroin combined with powder cocaine is often referred to as a "speedball." In El Paso, it is also known as a "belushi." In addition to the epidemiologic/ethnographic and non-methadone treatment sources listed in the table, this combination is also reported, not surprisingly, by the majority of methadone treatment sources. Interestingly, however, none of the methadone treatment sources report the combination of marijuana and powder cocaine. That combination, sometimes referred to as a "primo," is also known as a "p-dog" in Los Angeles and as a "coolie" in New York. The Boston ethnographic source notes that, since the last *Pulse Check*, "oolies" (joints laced with crack or powder cocaine) are gone, and instead, marijuana and cocaine (either form) are used sequentially.

Oral opioids (including diverted OxyContin® and Percocet®) are mentioned only by the Boston ethnographic source. The other drugs listed—benzodiazepines, methamphetamine, and ecstasy—are more likely to be taken sequentially, as a substitute, or as a secondary drug, rather than in combination with powder cocaine. For example, in Billings, powder cocaine is incidental to methamphetamine use. In St. Louis, powder cocaine users are increasingly substituting methamphetamine because it has become more available. In Miami, ecstasy users often begin their evening with a line of cocaine.

Where and with whom is powder cocaine used? As reported previously, powder cocaine still tends to be used indoors, in private, and in small groups among friends, although methadone treatment sources report more solitary use than do other sources. Private residences remain the most commonly reported specific use settings, followed, in descending order, by parties, cars, nightclubs or bars, and public housing developments.

Compared with the last *Pulse Check* reporting period, only two changes in specific use settings are reported. The Memphis epidemiologic source reports that powder cocaine use has increased on college campuses, and it is sold in more places in general. In Sioux Falls, the epidemiologic source believes that use in hotel/motel settings may be increasing: during several recent methamphetamine lab busts in such venues, users were also found to be in possession of powder cocaine.

MARIJUANA[+]

Baltimore and New Orleans are the only two cities where no *Pulse Check* source names marijuana as their community's most widely abused drug. In the other 18 *Pulse Check* cities, 35 law enforcement, epidemiologic/ethnographic, and non-methadone treatment sources name marijuana as such. By contrast, Columbia, SC, is the only city where a source (non-methadone) considers marijuana to be the drug contributing to the most serious consequences.

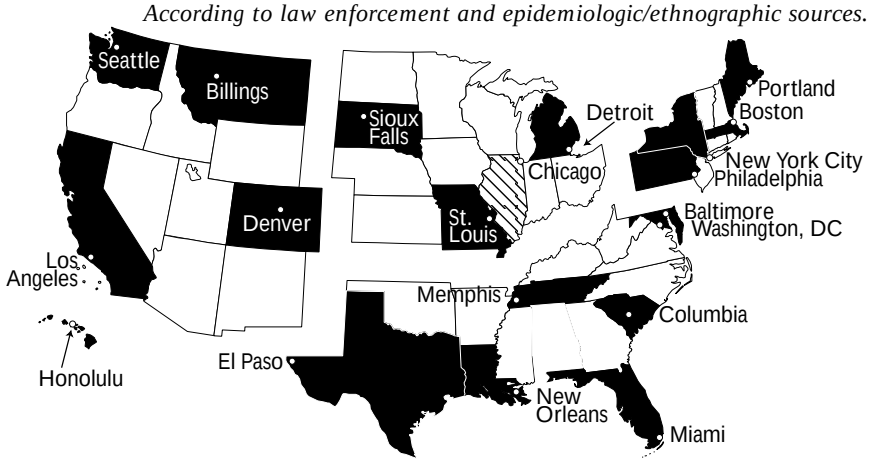
Compared with the last *Pulse Check* reporting period, the Boston law enforcement source believes that marijuana has replaced powder cocaine as the most widely abused illicit drug, the Columbia (SC) epidemiologic source believes it has replaced crack, and the Portland (ME) law enforcement source believes it has replaced heroin and pharmaceutical opiates. Conversely, the Columbia law enforcement source believes that crack has replaced marijuana as such.

MARIJUANA: THE DRUG

How available is marijuana, in its various forms, across the country? *(Exhibits 1, 2, and 3)* All but one of the 39 responding law enforcement and epidemiologic/ethnographic sources consider marijuana widely available in their communities, similar to reports in the last two *Pulse Check* issues. The exception is in Chicago, where the law enforcement source considers the drug not very available. Moreover, that source is the only one who perceives a decline in marijuana availability between spring and fall 2001. Only four increases are perceived (in Boston, Columbia [SC], Denver, and Honolulu). Similarly, the numerous varieties have remained generally stable in availability, with only a few shifts as noted in exhibit 3.

Exhibit 1.
How available is marijuana across the 20 *Pulse Check* cities (fall 2001)?*

According to law enforcement and epidemiologic/ethnographic sources...



Widely Available, according to both source types

Widely Available, according to the epidemiologic/ethnographic source; not very available according to the law enforcement source

**The law enforcement source in Baltimore did not respond.*

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

Boston, MA[E]
Columbia, SC[E]
Denver, CO[L]
Honolulu, HI[E]

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

Chicago, IL[L]

**The Baltimore law enforcement source did not respond.*

As reported in the last *Pulse Check*, locally produced commercial grade marijuana remains the most common variety, ranked as widely available by 23 law enforcement and epidemiologic/ethnographic sources in all but 4 of the 20 *Pulse Check* cities: Boston, Chicago, Detroit, and El Paso.

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

Exhibit 3.
Which marijuana varieties have changed in availability (spring 2001 vs fall 2001)?*

Sinsemilla
Boston, MA[E]
Chicago, IL[L]

Local commercial grade
Honolulu, HI[E]

Mexican
Boston, MA[E]
Denver, CO[L]

BC bud
Los Angeles, CA[E]

Hydroponic
Boston, MA[L,E]
Memphis, TN[L]
New York, NY[E]
Washington, DC[L]

Sinsemilla
Denver, CO[L]
Memphis, TN[E]

Local commercial grade
Chicago, IL[L]
New Orleans, LA[L]

Mexican
Chicago, IL[L]
Seattle, WA[E]

BC bud
Honolulu, HI[E]
Memphis, TN[E]

Hydroponic
Columbia, SC[L]
New Orleans, LA[L]

**The Baltimore law enforcement source did not respond.*

Mexican commercial grade marijuana is the second most common variety, cited as widely available by 19 sources in 14 cities: Boston, New York, and Philadelphia in the Northeast; Baltimore, Columbia (SC), El Paso, Memphis, and New Orleans in the South; Detroit, St. Louis, and Sioux Falls in the Midwest; and Billings, Denver, and Los Angeles in the West. Sinsemilla (seedless marijuana) is the third most common variety, with wide availability cited by 13 sources in 10 cities: New York and Portland (ME) in the Northeast; Memphis, Miami, and New Orleans in the South; St. Louis in the Midwest; and Billings, Denver, Honolulu, and Seattle in the West.

Hydroponically grown marijuana is considered widely available by seven sources in six cities (Boston, Memphis, Miami, New York, Seattle, and Washington, DC). As reported in the last *Pulse Check*, British Columbian ("BC bud") is least commonly considered widely available, with only three sources reporting it as such (in Baltimore, Billings, and New York).

How is domestic marijuana grown? The majority of responding law enforcement sources (10 of 17) report that local marijuana is grown indoors. Epidemiologic/ethnographic sources generally report both indoor and outdoor operations. Some changes in local "grows" are reported:

- **Boston, MA[L]:** While most marijuana comes from Canada via Hell's Angels, the number of local indoor "hydrogrows" has increased, as have the amounts grown and the tetrahydrocannabinol (THC) levels.
- **Detroit, MI[L]:** Increasingly, plants are started indoors and subsequently moved outdoors.
- **Memphis, TN[L]:** Some soil grows are reported, but more indoor grows of hydroponic are reported than in the past.
- **Philadelphia, PA[L]:** While most marijuana is not grown locally, the number of indoor hydroponic grows is increasing.
- **Portland, ME[L]:** Large outdoor grows of high-grade marijuana are reported in the summer. Organized groups with small plots are reportedly getting together in order to bypass laws aimed at large plots. Maine has become a competitive supply source for New England and Canada.

What are street-level prices, purity levels, and adulterants across the country? *(Exhibit 4)* Except for a slight increase in Portland, ME, and a decline in El Paso, all prices listed in the table remained stable between spring and fall 2001. Only a few THC levels are reported: 12 percent per 1/4 ounce of "hydro" in Miami; 4–6 percent per ounce of Mexican commercial and >15 percent for an ounce of BC bud in Denver; 4–6 percent per joint or "dime bag" of Mexican in Los Angeles; and 15–22 percent per gram of sinsemilla in Honolulu.

Five treatment sources—in Columbia (SC), El Paso, Miami, Seattle, and Washington, DC—mention clients who smoke joints that, without their knowledge, have been laced with crack. Sometimes the clients realize it afterward, and sometimes they just assume they have bought especially potent marijuana. In El Paso, both heroin and cocaine have shown up in drug tests, even though the clients, who admit to marijuana use, swear they have not used the other drugs. Staff are inclined to believe these clients because when they stop their marijuana use, their urine tests clean.

Instances of cocaine-lacing, as well as PCP-lacing, have also been increasing in Washington, DC. PCP adulteration is also reported in Chicago. The New York ethnographic source reports that when dealers cook crack, they take the leftover water and add it to marijuana to enhance it: the final product is called "elo." Pesticides are mentioned as adulterants in Memphis. Some more benign adulterants are reported, including oregano, parsley, and tea flakes. In El Paso, dealers sell marijuana cut with oregano to new users only.

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

			MOST COMMON STREET UNIT		1 OUNCE
	City/Source	Type	Unit	Price/*Change***	Price/*Change***
Northeast	Boston, MA[L]	Sinsemilla	1 oz		$80–$100/↔
	Boston, MA[E]	NR	Bag	$20/↔	
		NR	"Elbow"	$300–$350/↔	
	New York, NY[L]	Commercial	1 oz		$100–$200/↔
		Sinsemilla and Hydro	1 oz		$300–$1,200/↔
	New York, NY[E]	Hydro	Bag	$20/↔	
		Bio	Bag	$10/NR	
	Philadelphia, PA[L]	Commercial	1 oz		$150–$200/↔
	Philadelphia, PA[E]	NR	Bag	$10/↔	
	Portland, ME[L]	High grade	1 oz		$175–$225/↑
South	Columbia, SC[L]	Mexican or Local commercial	3–4 g	$10/↔	$180/↔
	El Paso, TX[L]	Mexican commercial	1/4 oz	$20/↔	
	El Paso, TX[E]	NR	Baggie	$20/↓	
	Memphis, TN[L]	NR	1/4 oz	$25/↔	$100/↔
	Memphis, TN[E]	NR	1/8 oz	$15–$20/↔	
	Miami, FL[E]	Hydro	1/4 oz	$100–$200/↔	$150–$200/↔
	New Orleans, LA[L]	SW commercial	Joint	$5/↔	$500/↔
	Washington, DC[E]	Commercial	Blunt	$10–$20/↔	$100/↔
		"Kindbud" or Hydro	1 bag	$10–$20/↔	$480/↔
Midwest	Chicago, IL[E]	NR	Bag	$5–$10/↔	$100–$200/↔
	Detroit, MI[L]	NR	Bag (1 g)	$10/↔	
	Sioux Falls, SD[L]	Mexican commercial	1/4 lb	$350–$450/↔	$100–$200/↔
	St. Louis, MO[L]	NR	Bag	$20/↔	$100/↔
West	Billings, MT[L]	Sinsemilla	1 oz		$100/↔
	Denver, CO[L]	Commercial	1 oz		$50/↔
	Denver, CO[E]	Mexican commercial	1 oz		$200/↔
		Local hydroponic	1 oz		$200–$400/↔
		BC bud	1 oz		$600/↔
	Honolulu, HI[L]	Sinsemilla	1 g	$25/↔	
	Honolulu, HI[E]	NR	Joint	$5–$20/↔	
		NR	1 g	$25/↔	$400–$800/↔
	Los Angeles, CA[L]	Mexican commercial	Joint	$10/↔	$200–$250/NR
	Los Angeles, CA[E]	Mexican, Local, and Hydro	Joint	$10/NR	NR
	Seattle, WA[E]	Local hydroponic	1 g	$15–$25/↔	
		Local hydroponic	1/8 oz	$40–$50/↔	$325–$400/↔

**Respondents in Baltimore did not provide this information.*
***Arrows indicate up, down, or stable between spring and fall 2001.*
NOTE: Respondents generally did not provide purity levels.
NR = not reported

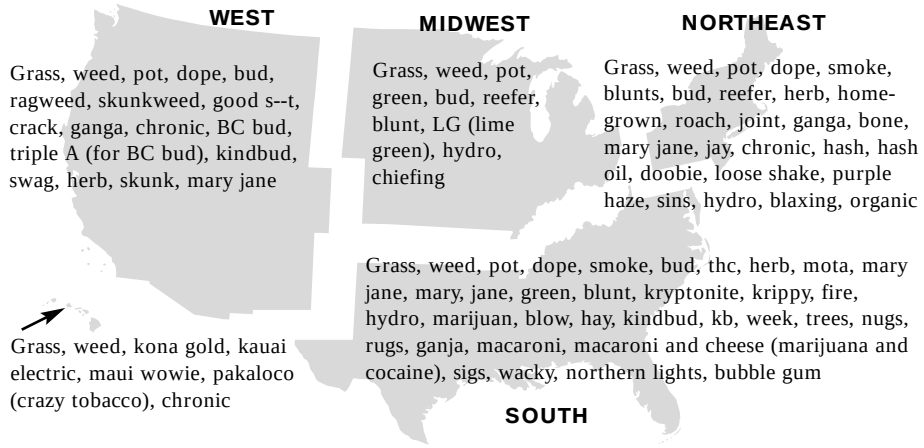
How is marijuana referred to and packaged across the country? *(Exhibit 5)* Among the many slang terms for marijuana or marijuana smoking across *Pulse Check* sites, a few new ones are reported: "blaxing" (a high school term for smoking) in Boston; "rugs" in Columbia, SC; "hay" in Memphis; "macaroni" in Miami, where "macaroni and cheese" refers to a $5 pack of marijuana and a "dime" bag of cocaine; "purple haze" in New York; and "LG" (lime green) and "chiefing" (smoking) in St. Louis. In some cities, slang names sometimes refer to the type of marijuana, while dealer brand names often refer to the place of origin, but the two often overlap. In Washington, DC, for example, some dealer designations include "northern lights" (for marijuana from Canada), "Jamaican" (from Jamaica), and "bubble gum" (from Tennessee).

Plastic zipper or sandwich bags remain the most common marijuana packaging, as reported in previous *Pulse Check*s. The only reported change is in Columbia, SC, where the law enforcement source reports that marijuana used to be rolled up in tinfoil but now tends to be sold in small zipper "head shop" bags of various sizes and colors.

MARIJUANA: THE SELLERS

Who sells marijuana? Law enforcement and epidemiologic/ethnographic sources generally name young adults (18–30 years) as the predominant marijuana sellers in their communities. Older adults (>30), however, are named in Portland (ME), while adolescents

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



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

are named in Baltimore and New Orleans. In some cities, such as Billings, Boston, Denver, El Paso, Los Angeles, and St. Louis, two or more age groups are named. These sellers are very or somewhat likely to use their own drug, according to nearly every law enforcement and epidemiologic/ethnographic source. They are more likely to be involved in non-violent crimes, such as thefts, than in violent crimes. And, as reported in past *Pulse Check*s, they are more likely to operate independently than as part of organized operations. However, organizations with varying degrees of structure do exist in several cities. Since the last reporting period, only a few changes are reported:

- **Denver, CO[L]:** While young adults are the primary sellers, older adults are emerging as a new seller group.
- **Miami, FL[L]:** An emerging group of sellers is reported: Cuban refugees who are beginning to set up marijuana grow houses.
- **Portland, ME[L]:** The somewhat loose organization of older adult sellers is becoming more organized. Some younger adults, however, operate independently.
- **Washington, DC[E]:** The number of organized "crews" has been decreasing, as has marijuana trafficking in general, because selling ½ pound or more of marijuana is now considered a felony, rather than a misdemeanor.

What other drugs do marijuana dealers sell? Law enforcement and epidemiologic/ethnographic sources continue to report that crack and powder cocaine are the drugs most commonly sold by marijuana dealers (in Boston, Billings, Columbia (SC), Denver, Detroit, Honolulu, Los Angeles, Memphis, Miami, New Orleans, New York, St. Louis, and Sioux Falls). Additionally, marijuana is sold with ecstasy (in Boston, Honolulu, Memphis, Miami, and New York), with heroin (in Denver, New Orleans, New York, and St. Louis), with methamphetamine (in Denver, Honolulu, and Sioux Falls), with Rohypnol® (in El Paso), with prescription pills (in Memphis), and with PCP (in New Orleans). In Baltimore, heroin is only occasionally sold with marijuana, "when they come across a deal," according to the ethnographic source. In Chicago, heroin and cocaine are sometimes sold on the same street as marijuana, but not by the same person.

Where is marijuana sold? As reported in past *Pulse Check*s, marijuana, more than other drugs, tends to be sold both indoors and outdoors and in all types of geographic areas—central city, suburban, and rural. The specific sales settings remain varied, with only a handful of changes since the last *Pulse Check*:

- **Honolulu, HI[E]:** Marijuana sales have declined in public housing developments because of increased police efforts in those areas, with major "cleanups" and "walk-throughs" over the past 18 months.
- **Memphis, TN[E]:** Marijuana availability in distribution networks has increased in several areas, particularly in less overt settings, such as in nightclubs, at shopping malls, over the Internet, in playgrounds and parks, at private parties, in hotels/motels, around supermarkets, inside cars, and in the workplace.
- **Miami, FL[E]:** Marijuana transactions, like cocaine and ecstasy transactions, used to be conducted primarily in private homes, but have been gradually shifting to prearranged rendezvous, deliveries, and exchanges.

MARIJUANA: THE USERS

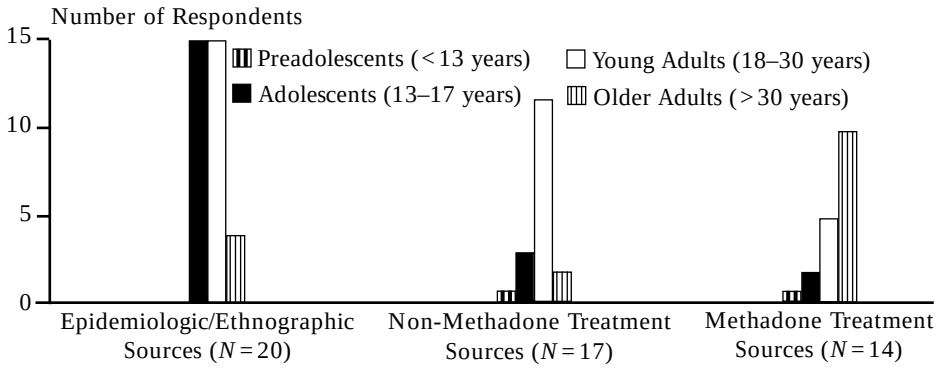
Who uses marijuana? *(Exhibits 6, 7, and 8)* The differences between the *Pulse Check* source categories are most apparent with regard to the marijuana user populations they describe. For example, epidemiologic/ethnographic sources tend to report

that marijuana users are most likely to be males, are equally likely to be either adolescents (13–17 years) or young adults (18–30), and are equally likely to reside in central city, suburban, and rural areas. Non-methadone treatment sources, however, tend to report that users are predominantly young adult males who live in the central city. By contrast, methadone treatment sources tend to describe users who are older than 30 years, are equally likely to be either males or females, and most commonly reside in the central city. Furthermore, methadone treatment sources are more likely than their non-methadone counterparts to report that marijuana users have completed high school.

The different sources, however, are more uniform in reporting racial/ethnic distributions: Whites and Blacks tend to be the predominant marijuana users in approximately equal numbers of cities, according to all the sources. Similarly, all sources generally agree that marijuana use cuts across all socioeconomic groups, although, during this reporting period, low socioeconomic status is slightly more represented than high and middle status.

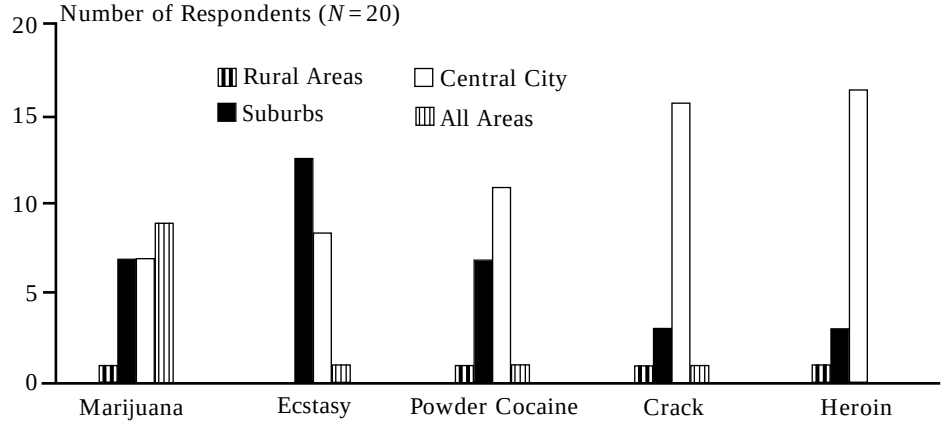
Compared with users of other drugs, marijuana users are more likely to reside in all locations (central city, suburban, and rural areas), according to epidemiologic/ethnographic sources in nine cities: Chicago, Denver, Detroit, Honolulu, Memphis, New Orleans, Portland (ME), St. Louis, and Seattle. They are also more likely than users of other drugs to be referred to treatment through courts or the criminal justice system, schools, and employers, according to non-methadone treatment sources.

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



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

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



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

How do marijuana users take marijuana? As reported in the last *Pulse Check*, joints remain the most common vehicle for smoking marijuana. However, blunts (hollowed-out cigars filled with marijuana) are more common than joints in many cities, as reported by epidemiologic/ethnographic and non-methadone treatment sources. According to methadone treatment sources, however, Baltimore is the only city where blunts are more common than joints. Other, less commonly reported delivery systems include pipes and bongs (in Denver, El Paso, Los Angeles, Miami, St. Louis, and Seattle), bowls with four or five pipes (in Seattle), and baked brownies (in Honolulu and Portland [ME]). Small pipes are known as "one-hitters" in St. Louis. In Philadelphia, blunts are sometimes dipped in honey.

Several epidemiologic/ethnographic sources note changes in blunt or joint use since the last *Pulse Check* reporting period:

- **Boston, MA:** Because anti-tobacco laws are being increasingly enforced, blunt use over the past year has declined among adolescents, who

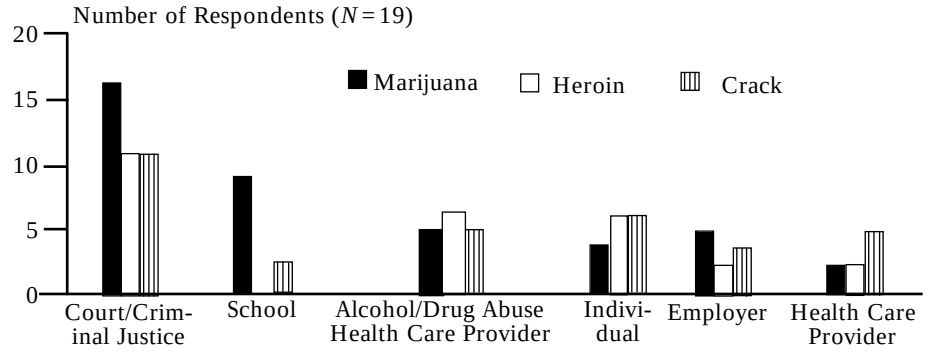
Marijuana users, as a group, have changed in several ways since the last ***Pulse Check*** reporting period:

Age:	➤ **Billings, MT[N]:** Marijuana users are becoming younger—some initiate use as early as 8 years.
	➤ **Boston, MA[E]:** Many marijuana users older than 30 are "maturing out"—a term used by Charles Winnick in 1964 to describe giving up drugs because other things become more important. Young adults are the predominant users, but use is not uncommon among adolescents as young as 13 years.
	➤ **Chicago, IL[L]:** The program is seeing more adolescent marijuana users because it is changing in order to include them.
	➤ **Columbia, SC[E]**: While adolescents are the predominant user group, the number of young adults has increased slightly since the last *Pulse Check* reporting period, possibly due to random fluctuations.
	➤ **Miami, FL[E]:** The emerging group of preadolescents (< 13 years) perceive regular marijuana use as less harmful than do older youth, possibly because debates over medical marijuana are sending mixed messages to youth. According to the State school survey, middle school (sixth, seventh, and eighth grade) marijuana use has increased.
	➤ **Memphis, TN[E]:** Marijuana use appears evenly distributed among adolescents, young adults, and older adults. An increase, however, is noted among older adults.
	➤ **Philadelphia, PA[E]:** More younger and fewer older people are initiating marijuana use.
Gender:	➤ **New Orleans, LA[E]:** Females have been increasingly using marijuana: they now nearly equal the number of male users.
	➤ **Philadelphia, PA[E]:** Females continue to increase among marijuana users.
	➤ **Sioux Falls, SD[E]:** A new user group is reported: White preadolescent (< 13 years) suburban girls from middle socioeconomic backgrounds who smoke joints at home, at private parties, and in hotel/motel settings.
Race:	➤ **Columbia, SC[E]:** The percentage of users who are White has increased slightly since the last *Pulse Check* reporting period. However, Whites remain underrepresented, and users are still more likely to be Black.
	➤ **Memphis, TN[E]:** In a reversal since the last *Pulse Check*, Blacks, rather than Whites, are the predominant marijuana user group.
	➤ **Washington, DC[E]:** Hispanic users have increased, but Black central city users still predominate, followed by White middle-socioeconomic clubgoers.
Socioeconomic Status:	➤ **Philadelphia, PA[E]:** Users are predominantly from low socioeconomic backgrounds, but those from mid-socioeconomic backgrounds are increasing.
Residence:	➤ **Boston, MA[E]:** Marijuana use is increasing in rural areas, but central city and suburban areas still predominate.
	➤ **Memphis, TN[E]:** With people increasingly moving to the suburbs and rural areas, marijuana users are equally likely to reside in those areas as well as in the central city—which was the predominant area reported in the last *Pulse Check*.

find it easier to buy joint rolling paper than to buy tobacco products. Blunts are still common, however, among users in their twenties and thirties.

- **Memphis, TN:** Blunts have slightly overtaken joints as the predominant vehicle of marijuana administration since the last *Pulse Check* reporting period.
- **Miami, FL:** Marijuana is now smoked primarily in pipes and bongs, representing a shift over the past few years. Joints have become rarer because they involve more people and are thus more detectable; blunts have become less popular because they are too expensive.
- **New Orleans, LA:** Marijuana is smoked predominantly in joints, but blunts are occasionally reported (although they are not called blunts), mostly among out-of-towners.
- **New York, NY:** When blunts first appeared on the scene, users would gut commercial cigars and refill them with marijuana. Soon thereafter, users began rolling their own blunts in frontal leaves, which were available in two colors. They

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



Sources: Non-methadone treatment respondents
NOTE: Many respondents list more than one referral source.

then switched to an unrolled wrap sold in a plastic bag. The latest development is a rolled commercial wrap, packaged in cellophane similar to a small cigar, that comes in flavors such as cognac and chocolate. These wraps are commercially available for $1 apiece in stores and on the Internet.

- **Philadelphia, PA:** The blunt wrap, a new product introduced in October 2001, is a tobacco leaf that is moister, fresher, slower burning, and less messy than gutted cigars, whose preparation requires sharp objects or fingernails. A five-pack sells for $2 over the Internet and in stores, and one wrap sells for $1 on street corners. Wraps come in several flavors, including vanilla, chocolate, and honey. They are known on the street as "snoop dogs" or "snoops," after the person who first promoted the product.

What other drugs do marijuana users take? As reported in past *Pulse Check*s, some marijuana users take a wide range of additional drugs—including crack, powder cocaine, heroin, PCP, ecstasy, and even embalming fluid—sometimes sequentially and sometimes in combination. Since the last report, several changes are reported in this aspect of marijuana use:

- **Baltimore, MD[E]:** According to unconfirmed reports, marijuana and ecstasy are being used sequentially.
- **Boston, MA[E]:** Minority high school students are increasingly using both marijuana and ecstasy.
- **Boston, MA[M]:** Some clients are using marijuana as a mild substitute for heroin, sometimes to manage anger.
- **Boston, MA[N]:** To enhance poorer quality marijuana, some clients are alternately using marijuana and powder cocaine.
- **Columbia, SC[N]:** Using marijuana and ecstasy sequentially, while not a new practice, is increasingly reported. The use of "wets"—marijuana plus embalming fluid—is becoming increasingly routine.
- **Memphis, TN[E]:** Increased marijuana use is part of a general increase in polydrug use. Users seem to be in constant search of another drug that will create a slightly different effect. Several substances are newly reported during this period as taken in combination with or sequentially with marijuana: alcohol, prescription drugs (particularly benzodiazepines), and powder cocaine. "Sherman sticks" are the name for the newly reported combination of marijuana plus powder cocaine.
- **Miami, FL[L]:** Younger users are lacing marijuana cigarettes with heroin.
- **Seattle, WA[E]:** The practice of combining marijuana with embalming fluid is becoming more rare.
- **Sioux Falls, SD[E]:** Several users who were combining marijuana with a substance called "red rock" thought they had bought opium: testing, however, showed that the substance was actually methamphetamine.

Where and with whom is marijuana used? Epidemiologic/ethnographic and non-methadone treatment sources tend to report that marijuana is equally likely to be used either publicly or privately. Methadone treatment sources, however, tend to report more private than public use. They also generally report that users smoke marijuana while alone, while non-methadone treatment sources tend to report more small-group use. The majority of epidemiologic/ethnographic sources, however, report that solo and small-group use are equally likely.

Only a few sources describe any changes in where or with whom marijuana users smoke their drug:

- **Billings, MT[E]:** Raves have increased, but they are still generally drug free: users tend to smoke

marijuana in the car on the way to and from the raves.

- **Memphis, TN[E]:** Marijuana is increasingly used in private and while alone. Public use and social use were reported as predominant during the last *Pulse Check* reporting period; during the current period, however, marijuana is equally likely to be used both in public and in private, both while alone and in groups among friends.
- **New Orleans, LA[E]:** Two shifts have occurred. On the one hand, use has declined around schools because of new stricter laws. On the other hand, overt smoking has increased, even near treatment centers and police facilities.
- **Philadelphia, PA[E]:** For the first time, marijuana use is reported at "speakeasies." These organized events, which take place in private residences where participants need to know someone to get in, usually involve jazz music, a pool table, card games, a room for sex, and staged fights. Participants are predominantly older (>30 years) Blacks. Until recently, substance use at these events was usually limited to alcohol (moonshine).

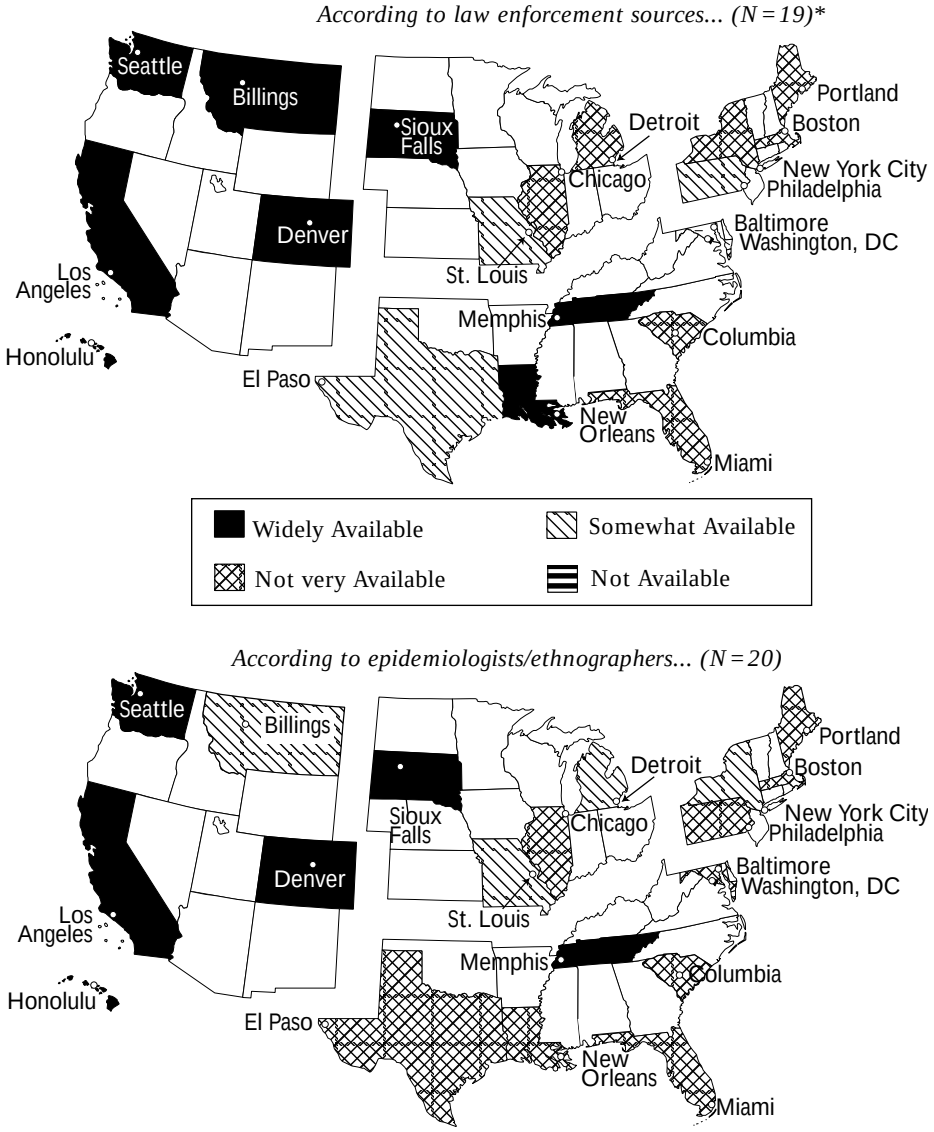
METHAMPHETAMINE[+]

Methamphetamine continues to be considered the most widely abused drug by the law enforcement source in Billings, the epidemiologic source in Honolulu, and the non-methadone treatment source in Denver. Since the last reporting period, one additional source (this time in the South) reports it as the most widely abused drug: the Memphis law enforcement source. Although it is considered the most widely abused drug in only 4 cities, 14 sources in 8 *Pulse Check* cities (Billings, Denver, Honolulu, Los Angeles, Memphis, St. Louis, Seattle, and Sioux Falls), mostly western, consider it the drug contributing to the most serious consequences. Four of those sources from four cities (Los Angeles, Memphis, St. Louis, and Seattle) have been added since the last *Pulse Check*. Furthermore, methamphetamine is reportedly emerging or continuing to trend upward in Columbia (SC), New Orleans, Seattle, and Sioux Falls.

METHAMPHETAMINE: THE DRUG

How available is methamphetamine, in its various forms, across the country? *(Exhibits 1 and 2)* Similar to reports in the last *Pulse Check*, more than half (22 of 39) of law enforcement and epidemiologic/ethnographic respondents report methamphetamine as widely or somewhat available. Availability varies widely by region. In the West, it continues to be widely available according to all but one source (the epidemiologic source in Billings); in the Midwest, it ranges from not very available (in Chicago) to widely available (in Sioux Falls); in the South, it ranges from not very available to widely available; and in the Northeast, it is not very available, according to nearly all respondents. Since the last reporting period, methamphetamine availability increased according to 13 law enforcement and epidemiologic/ethnographic respondents in 11 *Pulse Check* cities: Boston, Chicago (where it increased in the North Side gay community), Columbia (SC), Denver, Detroit, Los Angeles, Miami, New York, Portland (ME), Sioux Falls,

Exhibit 1.
How available is methamphetamine across the 20 *Pulse Check* cities (fall 2001)?*



**The law enforcement source in Baltimore did not respond.*

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

and Seattle. Availability declined, according to only two respondents (the epidemiologists in El Paso and Honolulu). Unlike reports in the last *Pulse Check*, availability trends were not based upon regional patterns: increases occurred in all regions in fairly equal proportions.

Locally produced and Mexican methamphetamine are about equally available, according to most respondents. "Ice," nearly 100 percent pure methamphetamine, continues to be unavailable in most cities, except in Honolulu (where it is considered widely available by both the law enforcement and epidemiologic sources), Los Angeles and Memphis (where it is considered somewhat available by the law enforcement sources), and Washington, DC (where it considered somewhat available by the ethnographic source). Similar to reports in the last *Pulse Check*, most available methamphetamine is reportedly produced in "box labs," small, mobile, clandestine labs. Additionally, methamphetamine labs run by large operations in Mexico and California produce some of the methamphetamine available in Los Angeles, Memphis, Philadelphia, St. Louis, and Seattle.

Since the last reporting period, the number of small, local methamphetamine labs seized increased in eight *Pulse Check* cities:

- **Billings, MT**[L,E]
- **Boston, MA**[L]
- **Denver, CO**[L]
- **Detroit, MI**[L]
- **Los Angeles, CA**[L]
- **Portland, ME**[L]
- **Seattle, WA**[E]
- **Sioux Falls, SD**[L,E,N]

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

Increased
Boston, MA[L]
Chicago, IL[L,E]
Columbia, SC[L]
Denver, CO[L]
Detroit, MI[E]
Los Angeles, CA[E]
Miami, FL[E]
New York, NY[E]
Portland, ME[E]
Sioux Falls, SD[E]
Seattle, WA[L,E]

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

Stayed the same
El Paso, TX[E]
Honolulu, HI[E]

**The Columbia (SC) epidemiologic/ ethnographic source did not provide this information; the Baltimore law enforcement source did not respond.*

Methamphetamine production methods have changed in two *Pulse Check* cities:

- **Memphis, TN**[L]: Manufacturers are producing more amphetamines than methamphetamine. The new technique, referred to as "crush and rush," does not filter the starch out of the ephedrine or pseudoephedrine tablets. This method eliminates steps and is quick, but the methamphetamine it produces is less pure.
- **St. Louis, MO**[E]: The red phosphorus method has declined because people began notifying the police when customers bought more than one box of red matchsticks.

What are street-level methamphetamine prices and purity levels across the country?

(Exhibit 3) According to nearly all law enforcement and epidemiologic/ ethnographic respondents, methamphetamine price levels, ranging from $20–$60 per gram in Seattle to $330 per gram in Chicago, remained stable since the last reporting period. Exceptions include Honolulu, where according to the epidemiologic source, prices declined at the 1/4 gram and gram levels; and Sioux Falls, where prices increased for larger amounts of the drug because it has been more difficult to transport due to increased border security since September 11.

Purity was reported in only five cities and was mostly stable since the last reporting period, ranging from 10–70 percent in Denver to 75–95 percent in Seattle. Adulterants reported include sugar substitutes in St. Louis and a newly reported adulterant in Billings: a white powder preservative used for canning fruit that is making some non-methadone treatment clients sick. Moreover, the Seattle law enforcement source states that Mexican methamphetamine has decreased in purity since the last reporting period because it is being diluted with methylsulfonomethane.

How is methamphetamine referred to and packaged across the country?

(Exhibit 4) Across the country, methamphetamine continues to be referred to as "meth," "speed,"

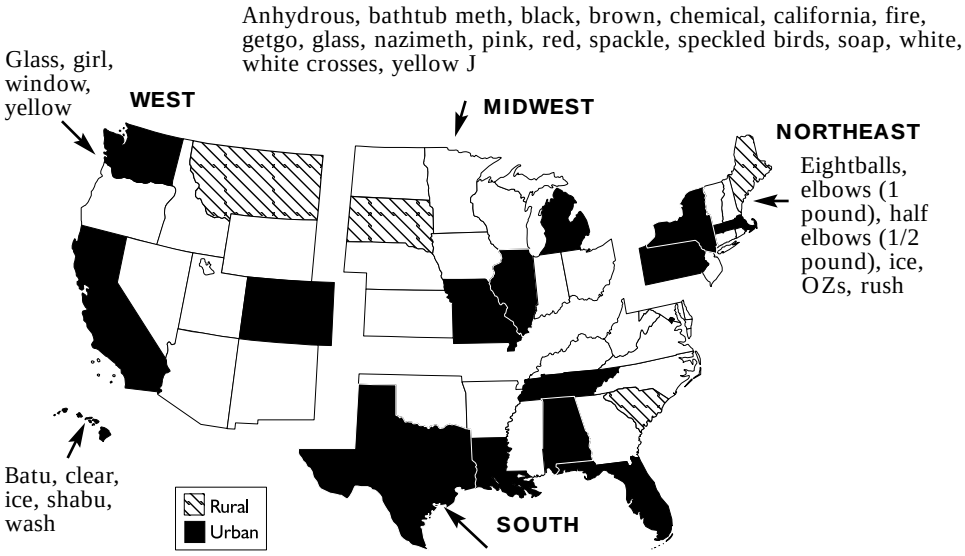
Exhibit 3.
How much does methamphetamine cost in 14 *Pulse Check* cities?

	City	Gram price	Purity (%)
Northeast	Boston, MA	$100	NR
	Philadelphia, PA	$100	<25
South	Columbia, SC	$175	NR
	Memphis, TN	$90–$125	NR
	New Orleans, LA	$100	NR
	Washington, DC	$100–$140	NR
Midwest	Chicago, IL	$330	NR
	St. Louis, MO	$100	NR
	Sioux Falls, SD	$80–$100	NR
West	Billings, MT	$100	33
	Denver, CO	$90–$100	10–70
	Honolulu, HI	$100–$300	NR
	Los Angeles, CA	$80–$100	15–35
	Seattle, WA	$20–$60	95 (Nazi)
			75 (Red phosphorus)

Sources: Law enforcement and epidemiologic/ethnographic respondents
NR = not reported

"crank," or "crystal." Other slang terms continue to vary by region and are often based on the color or consistency of the available methamphetamine. For example, the crystal form of methamphetamine is called "blade" in Memphis because it can cut the nose when snorted, and another type of methamphetamine in that city is called "cinnamon" because it is pink. "Christmas tree" or "holiday meth" in the South continues to refer to green methamphetamine produced using Drano® crystals; "crystal glass" in Washington, DC, refers to crystal shards of methamphetamine; and "hydro" in Washington, DC, refers to high-quality methamphetamine. Since the last reporting period, no new slang terms have been reported in *Pulse Check* cities. Similarly, no new packaging has been reported since the last *Pulse Check*.

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



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

METHAMPHETAMINE: THE SELLERS

Who sells methamphetamine?

According to law enforcement and epidemiologic/ethnographic respondents, nearly all street-level methamphetamine seller characteristics remained stable since the last reporting period. Most respondents in non-Western areas agree that street-level methamphetamine sellers are predominantly independent. Most respondents in Western areas agree that sellers of locally produced methamphetamine are independent, but sellers of Mexican produced methamphetamine are organized. The Denver law enforcement source states that, in general, methamphetamine sellers have become more organized since the last reporting period. In several *Pulse Check* cities (Billings, Detroit, and El Paso), local methamphetamine sellers are also the manufacturers.

The age of street-level methamphetamine sellers continues to vary by region: in the Northeast, they tend to be adults (>30 years); in the Midwest, they tend to be either adults or young adults (18–30 years); and in the South and West, they tend to be young adults. Only the law enforcement source in New Orleans mentioned adolescents (13–17 years) as the predominant age group of methamphetamine sellers. As reported in the last

Pulse Check, most law enforcement and epidemiologic/ethnographic respondents agree that methamphetamine sellers are very likely to use the drug, and sources in two cities (Denver and St. Louis) explain that independent sellers are more likely to use the drug than their organized counterparts.

In what other crimes are street-level methamphetamine sellers involved?

Methamphetamine sellers continue to be somewhat or very likely to be involved in other crimes, most commonly domestic violence, nonviolent crimes, and violent crimes. As reported in the last *Pulse Check* (*and illustrated in exhibit 6 of the highlights section)*, methamphetamine sellers seem particularly involved in domestic violence, accounting for 38 percent of the domestic violence among drug sellers, compared with only 24 percent for powder cocaine and 19 percent for crack, according to law enforcement and epidemiologic/ethnographic respondents. For example, the Honolulu epidemiologist states that methamphetamine is involved in half of the domestic violence and sexual assault cases. Other crimes related to methamphetamine sales have remained relatively static since the last reporting period, except in Sioux Falls, where the epidemiologic source reports that domestic violence and child abuse issues have increased, and in Memphis, where the epidemiologist states that reports of violent acts and sellers involved in gang-related activity have declined.

What other drugs do methamphetamine sellers sell?

Methamphetamine sellers often sell other drugs: only in four *Pulse Check* cities (Boston, Columbia [SC], Philadelphia, and St. Louis) do they reportedly sell only methamphetamine. Other drugs sold in other *Pulse Check* cities include marijuana (in Billings, Denver, Detroit, Honolulu, Los Angeles, Portland [ME], Seattle, and Sioux Falls); crack (in Billings, Denver, Honolulu, and Sioux Falls); powder cocaine (in Denver, El Paso, New Orleans, and Washington, DC); heroin (in Denver, Honolulu, and Portland); and club drugs, such as ecstasy, GHB, and ketamine (in El Paso, Portland, and Washington, DC). The Memphis epidemiologic source states that methamphetamine dealers also sell prescription pills, a new development during the current reporting period; elsewhere, other drugs sold by methamphetamine dealers have not reportedly changed.

How and where is street-level methamphetamine sold?

According to law enforcement and epidemiologic/ethnographic respondents in many *Pulse Check* cities, dealers sell methamphetamine more clandestinely than they do other drugs, such as heroin, crack, and powder cocaine. Often, as reported in 10 *Pulse Check* cities (Billings, Boston, Columbia [SC], Honolulu, Memphis, New Orleans, St. Louis, Seattle, Sioux Falls, and Washington, DC), mutual acquaintances introduce methamphetamine buyers to sellers, and they set up meetings for the sale. In certain neighborhoods in Philadelphia, the drug is sold in open-air markets located in specific neighborhoods, as are crack, powder cocaine, and marijuana. In Portland (ME), methamphetamine sales are similar to open-air market sales, except that they take place only at raves. In Detroit, sellers deliver the drug directly to the buyer.

The geographic location of methamphetamine sales continues to vary widely by region, according to law enforcement and epidemiologic/ethnographic respondents, with sales occurring in all areas of cities (central, suburban, and rural) in the Northeast and West, suburbs in most southern cities, and rural areas in the Midwest. Only in Memphis has the geographic location of methamphetamine sales reportedly changed since the last reporting period: sales in that city are increasingly broadening to include not only the central city, but also suburban and rural areas. Similar to reports in the last *Pulse Check*, the most frequently mentioned specific settings for methamphetamine sales across *Pulse Check* cities are private residences, followed by private parties and nightclubs or bars. Respondents also frequently mention streets, public housing developments, cars, hotels/motels, college campuses, and raves. In Honolulu, dealers have been trying to sell methamphetamine in and around schools, but preadolescents are not interested, according to the epidemiologic source. The settings of methamphetamine sales have remained stable since the last reporting period, with exceptions in two cities: in Sioux Falls, the sale (and use) of methamphetamine in hotels and motels has increased, and in Washington, DC, the number of settings where the drug is sold (and used) has increased.

METHAMPHETAMINE: THE USERS

Who uses methamphetamine?

Methamphetamine users tend to be males, according to most epidemiologic/ethnographic and treatment sources. In the Northeast, they tend to be adults (>30 years), but elsewhere they tend to be young adults

(18–30 years). The youngest age group (13–17 years) was mentioned as the predominant user group by several sources: the non-methadone treatment sources in Columbia (SC), Los Angeles, and Sioux Falls and the epidemiologic and methadone treatment sources in Billings. According to nearly all respondents, Whites are the predominant methamphetamine users, and they are often overrepresented compared with the general population. The predominant socioeconomic status of methamphetamine users ranges from low to middle and varies by city. Predominant user residence varies by region, with central cities predominating in the Northeast, central city and suburban areas predominating in the South, all areas mentioned equally in the Midwest, and mostly central cities and suburbs in the West.

Where is methamphetamine used? Similar to the last *Pulse Check*, the most frequently mentioned user settings, according to epidemiologic/ethnographic respondents, are private parties and private residences. Other common settings include cars, nightclubs and bars, college campuses, raves, and hotels or motels. The largest number of user settings is reported in the West; the fewest user settings are reported in the Northeast. Since the last reporting period, user settings have remained relatively stable, except in Memphis and Washington, DC, where methamphetamine user settings have expanded, as reported above in the methamphetamine sellers section.

How and with what other drugs do users take methamphetamine? Route of administration for methamphetamine varies widely, often with several routes of administration predominating per city, according to epidemiologic/ethnographic respondents. Smoking is more common in the West than in non-western areas, and snorting is more common in non-western areas than in the West. Oral ingestion and injection are common in all regions; in all regions, novice users often shift from snorting or smoking to injecting. Since the last reporting period, according to epidemiologic/ethnographic and treatment sources, the route of administration for methamphetamine use has changed in several *Pulse Check* cities: smoking and oral use have increased in Billings and Memphis; injection has increased in Denver and Washington, DC; and snorting has increased in Sioux Falls.

Methamphetamine use has increased in a number of ***Pulse Check*** cities:

According to treatment respondents, since the last reporting period, novice users (those using methamphetamine for less than 1 year before entering treatment) increased in seven cities, none of which were in the Northeast:

- **Billings, MT[N]**
- **Columbia, SC[N]**
- **Denver, CO[N]**
- **New Orleans, LA[M]**
- **Sioux Falls, SD[N,M]**
- **St. Louis, MO[N]**
- **Seattle, WA[M]**

Similarly, the numbers of methamphetamine users have increased in six *Pulse Check* cities:

- **Denver, CO[E]**
- **Memphis, TN[E]**
- **Miami, FL[E]**
- **New Orleans, LA[M]**
- **Seattle, WA[E]**
- **Washington, DC[E]**

By contrast, the non-methadone treatment source in Los Angeles states that the numbers may have declined slightly because adolescents are starting to believe that methamphetamine is dangerous.

Methamphetamine user characteristics changed in many ***Pulse Check*** cities across the Nation:

According to epidemiologic/ethnographic and treatment sources...

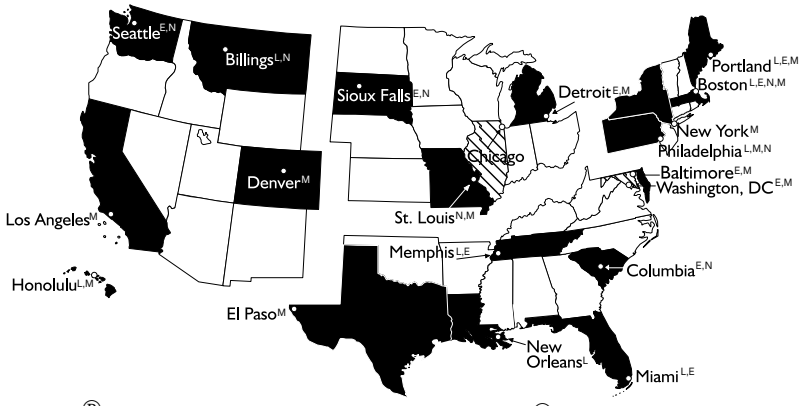
- Females are increasingly using methamphetamine in Memphis and Honolulu.
- Shifts in age are reported in two regions: the South, where adults (>30 years) have increased, and the West, where adolescents (13–17 years) have increased:
  - **Memphis, TN[E]**: Younger adults predominate, but adults are increasing.
  - **Washington, DC[E]**: The number of adult users has increased: that group and young adults (18–30 years) are the predominant users.
  - **Honolulu, HI[E]**: Young adults predominate, but novice adolescent users have increased.
  - **Los Angeles, CA[E]**: Young adults predominate, but adolescent users have increased.
- Hispanics are emerging as methamphetamine users in Los Angeles and New York.
- Emerging methamphetamine users are from the central cities and rural areas in Memphis and St. Louis. In Los Angeles, where most users reside in rural areas, suburbs are emerging as user residences.

As reported in the last *Pulse Check* by epidemiologic/ethnographic respondents, methamphetamine users also take a variety of other drugs. The most common drugs used in combination with methamphetamine continue to be marijuana, ecstasy (as reported in Memphis, where the combination is new this reporting period; Miami, where the combination is referred to as "super x" and "hugs and kisses"; and Washington, DC, where it is also used sequentially with a variety of other club drugs), and benzodiazepines (as in Memphis, where the combination is new this reporting period; Portland [ME]; and Seattle, where the combination has increased since the last reporting period).

DIVERTED SYNTHETIC OPIOIDS[+]

The last issue of *Pulse Check* addressed the illegal diversion and abuse of synthetic opioids, with most sources specifically citing one particular prescription opiate, OxyContin® (oxycodone hyrdrochloride controlled-release). OxyContin® tablets are prescribed to patients suffering from severe persistent pain—a legitimate medical need. However, as reports of abuse and diversion of OxyContin® across the country continue, *Pulse Check* also continues to monitor and report on developments concerning this drug.

Exhibit 1.
Where are the diversion and abuse of OxyContin® emerging across the 20 *Pulse Check* cities?



■ OxyContin® reported as emerging in fall 2001

▨ OxyContin® not reported as emerging in fall 2001

How serious is OxyContin® abuse and diversion, and where is OxyContin abuse emerging across the country? *(Exhibit 1)*

OxyContin® is considered the most serious illicit drug problem in three *Pulse Check* cities: Miami, New Orleans, and Portland (ME). Moreover, one source (the methadone source in Columbia [SC]) considers it the most widely abused drug. As reported in the last *Pulse Check*, more sources (law enforcement, epidemiologic/ethnographic, methadone treatment, and non-methadone treatment) report OxyContin® as the emerging drug of abuse in their communities than any other drug this reporting

Comments by ***Pulse Check*** sources highlight that OxyContin® diversion and abuse are increasing in many cities across the Nation:

- **Billings, MT[L,N]:** According to the law enforcement source, diverted OxyContin® availability and abuse are up dramatically. Both Billings non-methadone treatment sources agree that OxyContin® abuse continues to increase, and one points out that the emergence of an illegal market for the drug underscores its increasing abuse.
- **Columbia, SC[N]:** Most of the younger abusers have been using it for a few years, but now they actively seek it, whereas previously they were just using it when it was available.
- **Honolulu, HI[L]**: "Honolulu's drug market is slowly keeping up with national trends with diverted OxyContin®."
- **Memphis,TN[L]:** Since the last reporting period, diverted OxyContin® sales have increased markedly, and the drug is often associated with the use of club drugs.
- **Miami, FL[L,E]:** OxyContin® has shifted from limited sales in private residences to being a "street drug," according to the epidemiologic source. Similarly, according to the law enforcement source, OxyContin® is now available in the same neighborhoods and settings where crack is available.
- **New Orleans, LA[L]**: "OxyContin® is emerging, and we would like to get a grip on it before it becomes a problem like crack cocaine did in 1987."
- **New Orleans, LA[M,N]**: Most of the clients in treatment for OxyContin® abuse are there because their doctors, who had been writing their prescriptions, have been arrested. Now that abusers' sources are dry they have to come in for treatment.
- **New York, NY[E]**: "During this reporting period, OxyContin® has been sighted on the street for the first time, in two incidents where field researchers were approached by sellers."

By contrast, in two cities (both in the Northeast), OxyContin® diversion or abuse may be declining:

- **Philadelphia, PA[L]:** Media coverage and publicity, increased law enforcement focus, and arrests of key violators may have made potential diverters reconsider selling the drug.
- **Portland, ME[E]:** Diverted OxyContin® availability has declined, most likely because "tightened controls have made it more difficult to obtain OxyContin® than in the past."

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

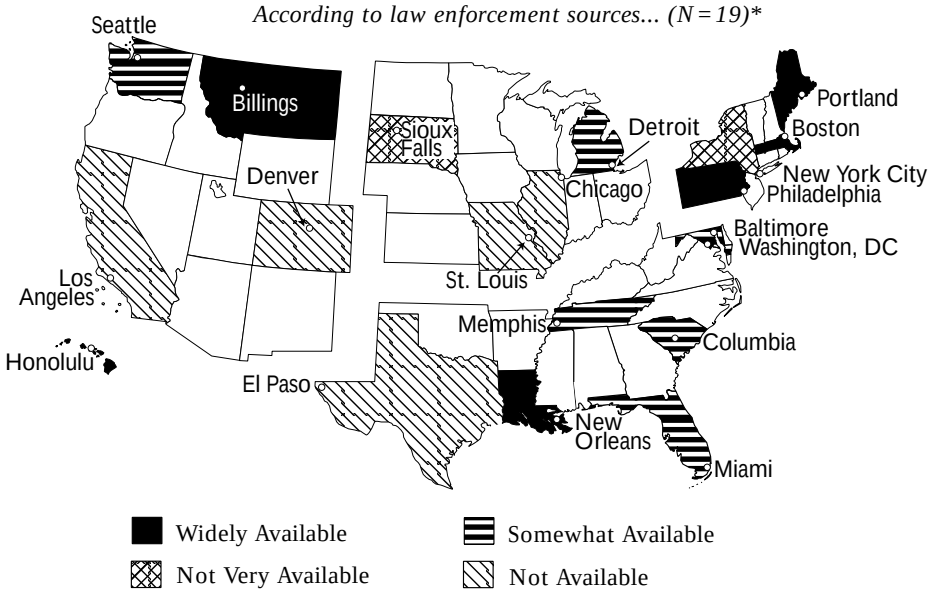
period: 29 of 75 sources in 18 of 20 *Pulse Check* cities report OxyContin® as an emerging drug of abuse. Only in Chicago (where it remains unavailable) and Washington, DC (where it is somewhat available) was OxyContin® not reported as emerging during this reporting period.

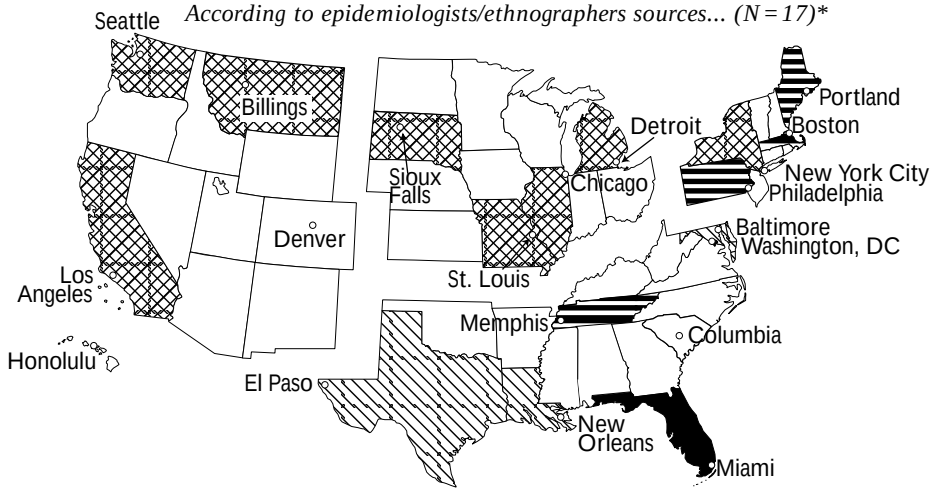
DIVERTED OXYCONTIN®: THE DRUG

How available is diverted OxyContin®? *(Exhibits 2 and 3)*

Across the Nation, more than half (51 percent) of law enforcement and epidemiologic/ethnographic sources report OxyContin® as somewhat or widely available. Moreover, OxyContin® availability continues to increase markedly: 45 percent of respondents report increasing availability, and only one (the Portland [ME] epidemiologic source) reports declining availability. Sources in the Northeast and South continue to report wider availability than sources elsewhere, and more southern sources report increases in availability than do their northeastern, midwestern, and western counterparts. The Philadelphia epidemiologic source adds that demand for the drug in that city is higher than supply, particularly because of law enforcement crackdowns.

Exhibit 2.
How available is diverted OxyContin® across the 20 *Pulse Check* cities (fall 2001)?





**The law enforcement source in Baltimore did not respond, and the epidemiologic/ethnographic sources in Columbia (SC), Denver, and Honolulu did not provide this information.*

How much does diverted OxyContin® cost, and how is it referred to and packaged?

According to law enforcement and epidemiologic/ethnographic sources, OxyContin® continues to cost $1 per milligram in most reporting *Pulse Check* cities (Boston, Detroit, Miami, Philadelphia, Portland [ME], and Washington DC), with no price changes reported since the last *Pulse Check*. Pills cost $100 per 40 milligrams in New Orleans and $40 per 20 milligrams in Billings. According to the Memphis epidemiologic source, OxyContin® is often bartered rather than sold, sometimes for crack, other prescription drugs, or ecstasy.

Where available, diverted OxyContin® continues to be referred to as "oxy" or "OCs." Other slang terms vary by city: in Philadelphia it is referred to simply as "O"; in New Orleans, it is referred to as "ox"; and in Columbia (SC), it is referred to as "kicker," a new term since the last reporting period. In some cities, slang terms refer to the number of milligrams in a pill; for example, in Miami, an OxyContin® pill is often called a

Exhibit 3.
How has diverted OxyContin® availability changed (spring 2001 vs fall 2001)?*

**The Baltimore law enforcement source did not respond, and the Columbia (SC), Denver, Honolulu, and New Orleans epidemiologic/ethnographic sources did not provide this information.*

"40" or an "80," and in New Orleans, a pill is called a "40-bar."

As reported in the last *Pulse Check*, most diverted OxyContin® is sold as loose pills, although prescription containers are also used in Honolulu, Memphis, and Portland. In Boston, the diverted pills are packaged in small, brown envelopes; and in Billings, they continue to be packaged in miniature coin zipper bags. Packaging has not changed since the last *Pulse Check*, according to law enforcement and epidemiologic/ethnographic respondents.

DIVERTED OXYCONTIN®: THE SELLERS

How is OxyContin® diverted?

According to law enforcement sources, OxyContin® continues to be diverted from pharmacies in a variety of ways within *Pulse Check* communities. The most frequently mentioned diversion method is forging prescriptions, as reported in Boston, Columbia (SC), Denver, Miami, New Orleans, New York, Philadelphia, Portland (ME), and Washington, DC; followed by doctor shopping in Billings, Boston, Honolulu, New York, Philadelphia, Portland, and Sioux Falls; patients filling legal and legitimate prescriptions but selling some of the pills in Billings, Detroit, New Orleans, New York, and Washington, DC; doctors prescribing it illegally for a fee or misprescribing it in Boston, Honolulu, New York, Philadelphia, and Seattle; and pharmaceutical robberies in Boston, Detroit, New York, and Portland. In some southern cities, including Columbia and Memphis, diverted OxyContin® may be shipped from the Northeast. Additionally, in Boston, some OxyContin® is being stolen from people with legitimate prescriptions. In Portland, pharmacists are targeting elderly people with valid prescriptions and burglarizing their homes.

Most diversion methods have remained the same since the last *Pulse Check*, except in Boston, where robberies have increased, and people are now paying others to rob pharmacies for them. Moreover, diversion has increased in Billings, Boston, and New York; however, in Portland, after increasing during the last year, diversion may have leveled off.

How is diverted OxyContin® sold?

Diverted OxyContin® is sold in a variety of ways, depending on the city in which it is sold. For example, in Billings, Memphis, and New Orleans, private meetings between buyers and sellers take place via introductions, using beepers and cell phones. In Philadelphia and Washington, DC, most sales take place in open-air markets outside treatment centers or homeless shelters. According to the Columbia (SC) law enforcement source, buyers go to "pill houses," residences where pills are illicitly sold, to buy the drug. According to the Boston law enforcement source, dealers have a small set of customers with whom they are familiar, customers page dealers to place an order, and dealers and customers meet at customers' houses where the exchange takes place. According to the Boston epidemiologist, buyers find elderly, minority heroin or cocaine users in poor health. These older drug users obtain OxyContin® prescriptions from doctors and then sell the pills to young Whites.

Who sells diverted OxyContin®?

According to nearly all law enforcement and epidemiologic/ethnographic respondents, sellers of diverted OxyContin® are mostly independent. Exceptions are in Miami, where the sellers are organized, and in New Orleans, where they are loosely organized gangs. Sellers tend to be young adults (18–30 years) or adults

(>30 years), according to all respondents, with both age groups mentioned an equal number of times. Sellers are often chronic drug users in many *Pulse Check* cities, including Honolulu and Washington, DC (where they use heroin) and Memphis (where emerging sellers tend to abuse pharmaceutical depressants and opiates). Similarly, according to 11 of 16 law enforcement and epidemiologic/ethnographic respondents, diverted OxyContin® sellers are somewhat or very likely to use the drug themselves.

The only reported change in diverted OxyContin® sellers' characteristics is that they are increasingly younger, as reported by two sources: the law enforcement source in Boston and the epidemiologic source in Memphis.

In what other crimes are diverted OxyContin® sellers involved? Besides the ones mentioned above, diverted OxyContin® sellers continue to be involved in a wide array of crimes, specifically prostitution, gang-related activities, and violent crimes in Baltimore; theft, burglaries, and prostitution in Billings; burglary, theft, purse snatching, and drug-assisted rape in New Orleans; domestic violence in Portland (ME); and theft in Washington, DC.

What other drugs do diverted OxyContin® sellers sell? Diverted OxyContin® sellers often sell additional drugs, according to all law enforcement and epidemiologic/ethnographic respondents. As reported in the last *Pulse Check*, other prescription opiates and heroin are the most common other drugs sold, as reported in eight cities: Boston, Columbia (SC), Honolulu, Memphis, Miami, Philadelphia, Portland (ME), and Washington, DC. Other drugs sold include marijuana and methamphetamine in Billings; cocaine in Boston; crack, powder cocaine, and marijuana in Detroit; crack in Miami; and club drugs (ecstasy and GHB) in New Orleans, where OxyContin® is typically associated with the club drug scene.

Where is diverted OxyContin® sold? The geographical location of OxyContin® sales varies by city: central city areas predominate in five cities, suburbs predominate in four cities, and all areas are equally dominant in three cities. Diverted OxyContin® continues to be sold most often in private residences, followed by streets and around treatment clinics. Sales are also common around public housing developments, inside cars, and in nightclubs and bars. The reported number of diverted OxyContin® sales settings is highest in Memphis and Miami. The settings for OxyContin® sales have remained relatively stable since the last reporting period, with one notable exception: according to the epidemiologic source in Miami, OxyContin® has shifted from limited sales in private residences to being a "street drug." Furthermore, according to the law enforcement source in Miami, OxyContin® is available in the same neighborhoods and settings (mostly the street) where crack is available.

OXYCONTIN®: THE ABUSERS

Where has OxyContin® abuse increased? *(Exhibit 4)* Continuing an upward trend, according to nearly all (16 of 18) methadone and non-methadone treatment respondents, the number of novice abusers of OxyContin® in treatment (defined as any drug treatment client who has recently begun abusing OxyContin®) has increased since the last reporting period. However, unlike the last reporting period, when most increases were reported in the South, during fall 2001, increases occurred in all U.S. regions and most often in the West.

Exhibit 4.
How has the number of novice OxyContin® treatment clients changed (spring 2001 vs fall 2001)?

**Billings has two non-methadone treatment sources.*

Epidemiologic/ethnographic respondents also report increases in OxyContin® abuse:

- **Boston, MA:** OxyContin® abuse has become more prevalent, especially among young, working class polydrug users of low socioeconomic backgrounds.
- **Memphis, TN:** The drug is increasingly abused, especially among young adult polydrug users.
- **Philadelphia, PA:** The numbers of abusers and adverse reactions have increased.

- **Seattle, WA:** Indicators point to increasing abuse, and the number of rural treatment clients has increased.
- **Sioux Falls, SD**: The number of emerging abusers has increased.

Who abuses OxyContin®?

According to most epidemiologic/ethnographic and treatment respondents, the young adult (18–30 years) and adult (>30 years) age groups predominate among OxyContin® abusers, especially among novice abusers in the West. Adolescents (13–17) predominate, especially among emerging or novice abusers, according to three sources in three cities: Columbia (SC), New Orleans, and Sioux Falls. Males predominate in most areas, but females predominate and are emerging in Columbia, St. Louis, and Seattle. Whites predominate in most cities, and socioeconomic status varies by city and ranges from low in Honolulu and Washington, DC, to upper-middle (especially among novice abusers) in El Paso, New Orleans, and Seattle.

The geographic residence of OxyContin® abusers also varies by city. Central city residences predomnate in seven cities across the Nation. Suburbs predominate in several western cities and in New Orleans, St. Louis, and Sioux Falls. Both rural areas and suburbs predominate in four cities across the Nation. And rural areas predominate in Columbia and Portland (ME). According to the non-methadone treatment source in Philadelphia, OxyContin® spread from Montgomery County into the city this reporting period, and according to the methadone treatment source in Columbia, rural areas have overtaken the suburbs as predominant abuser residences this reporting period.

Where is OxyContin® taken?

Similar to reports in the last *Pulse Check*, epidemiologic/ethnographic and treatment respondents state that OxyContin® abuse in private is more common than its abuse in public, and the drug is more often abused alone than in groups or among friends. Also similar to the last *Pulse Check*, OxyContin® is reportedly most often abused in private residences, followed by private parties and around public housing developments. According to epidemiologists/ethnographers and treatment providers, emerging settings include shopping malls in Billings and Seattle, cars in Portland (ME), raves in New Orleans, and nightclubs and parties in Memphis. The Sioux Falls epidemiologic source reports that increased abuse in hotel/motel and private party settings might be related to methamphetamine labs: during lab busts, sometimes OxyContin® is also found.

Changes in abuser characteristics include increasing numbers of younger abusers and increasing numbers of females.

- OxyContin® abusers are increasingly younger in three cities:
  - **Boston, MA**[N]: Although young adults predominate, the emerging age is 13–17 years.
  - **Memphis, TN**[E]: Young adults have overtaken adults as the predominant group.
  - **New Orleans, LA**[N]: OxyContin® abuse dramatically increased, especially among young adults in their twenties.
- Females are increasing in two cities:
  - **Memphis, TN**[E]
  - **Philadelphia, PA**[N]

How is OxyContin® taken?

According to most epidemiologic/ethnographic sources, OxyContin® is ingested orally. Exceptions include Baltimore, where injecting predominates followed by snorting; Detroit, where snorting predominates; and Washington, DC, where injecting predominates. According to the epidemiologic source in Boston, where oral use predominates, some users wash or peel off the coating, fold it in a piece of paper, crush it, and snort the powder. Similar to their epidemiologic counterparts, most treatment providers report oral ingestion as the predominant route of OxyContin® administration. Exceptions include snorting in Boston, Columbia (SC), Denver, and Portland (ME); snorting and injecting in Miami and New York; injection in New Orleans; and injecting and oral use in St. Louis.

How are heroin and OxyContin® abuse related?

Heroin is reported as a common OxyContin® substitute in 10 *Pulse Check* cities: Baltimore, Boston, Detroit, Miami, New Orleans, New York, Philadelphia, Portland (ME), St. Louis, and Washington, DC. The use of heroin as a substitute for OxyContin® is a new phenomenon in New Orleans and St. Louis.

By contrast, OxyContin® is used as a heroin substitute in many cities:

- **Baltimore, MD**[E]**:** OxyContin® abuse has increased, and diverted OxyContin® is more available, especially because heroin is less available.
- **New Orleans, LA**[N]**:** OxyContin® addicts tend to already be "pill poppers," but some heroin addicts are trying the drug or switching to it, which has caused several overdoses. Heroin is less pure, so when

they inject OxyContin®, they often overdose.

- **Philadelphia, PA[E]:** OxyContin® is in great demand by heroin users because it eliminates the need for needles and it comes in a controlled measured amount, so users don't have to worry about adulterants.
- **Philadelphia, PA[N]:** OxyContin® abusers have characteristics similar to those of heroin users and tend to be heroin or crack users.
- **Portland, ME[E]:** OxyContin® abusers in northern rural Maine are shifting to heroin because it is more cheap and available. In Portland, by contrast, some heroin users are shifting to OxyContin®.
- **Portland, ME[M]:** OxyContin® abusers aren't necessarily switching to heroin, but some heroin users are switching to OxyContin®.

How are OxyContin® and other drug abuse related? OxyContin® is used in combination with marijuana in Billings, Columbia (SC), Detroit, and Memphis. It is combined with methamphetamine or powder cocaine in Memphis, a new phenomenon in that city this reporting period.

Other prescription drugs, particularly benzodiazepines, are often used in combination with OxyContin®, as reported in four *Pulse Check* cities: Boston, where the trend is increasing; Miami; New Orleans; and Philadelphia. Moreover, other prescription drug abuse may be related to OxyContin® abuse in other ways:

- **Billings, MT[N]:** OxyContin® abusers tend to be former users of pills such as benzodiazepines or other prescription drugs for pain.
- **Boston, MA[E]:** "Young working and lower working-class polydrug users are adding it to their repertoire of pills. These users have been taking other prescription opiates for many years."
- **Denver, CO[M]:** Novice abusers in treatment tend to be people who start using OxyContin® for chronic pain, are not typically heroin users, but may have used other prescription opiates for several years.
- **Los Angeles, CA[M]:** "'Pill poppers' are switching from whatever prescription opiate they typically take to OxyContin®."
- **Sioux Falls, SD[N]:** OxyContin® abusers are not heroin users, but they tend to be abusers of other prescription drugs.

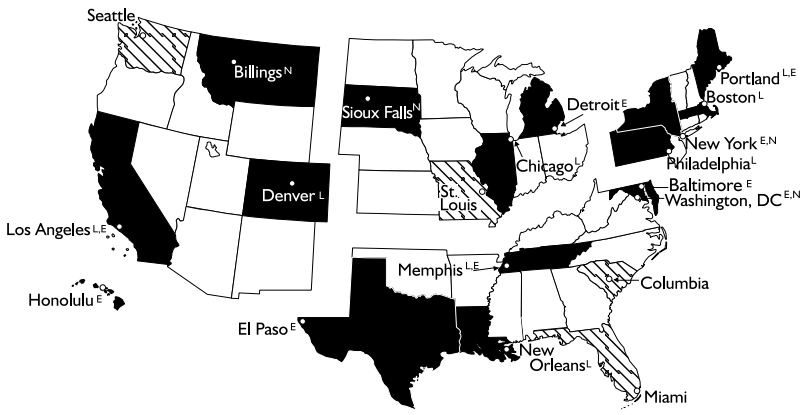
ECSTASY AND CLUB DRUGS[+]

The club or rave experience typically involves music, dancing, and socializing and usually lasts through the night. Drugs commonly used in these settings include ecstasy (methylenedioxymethamphetamine or MDMA); GHB (gamma hydroxybutyrate) and its chemical precursors, GBL (gamma butyrolactone) and BDL (1,4 butanediol); ketamine; Rohypnol® (flunitrazepam, a benzodiazepine no longer marketed in the United States); nitrous oxide (laughing gas); LSD (lysergic acid diethylamide, "acid"); psilocybin mushrooms ("shrooms"); and DXM (dextromethorphan, a mild hallucinogen in some over-the-counter cough medications). Club drugs are commonly combined with one another and with other illicit drugs or alcohol.

As reported in the last two *Pulse Checks*, treatment sources have less first-hand knowledge of club drug activity than their law enforcement and epidemiologic/ethnographic counterparts, indicating that club drug users have not entered treatment in large numbers. The amount of information received from *Pulse Check* sources remains much greater for ecstasy than for other club drugs.

Although these drugs are categorized as club drugs, the settings and contexts of their use continue to expand to settings other than nightclubs, raves, and college campuses, to include streets and in or around high schools. Moreover, *Pulse Check* sources continue to suggest that White non-Hispanics are no longer the exclusive sellers and users of the drugs, and reports that ecstasy is sold with heroin, crack, and powder cocaine continue. Finally, in this reporting period, adolescents have increased markedly as ecstasy sellers and users, according to sources in many *Pulse Check* cities.

Exhibit 1.
Where is ecstasy emerging across the 20 *Pulse Check* cities?



What club drugs are emerging in *Pulse Check* communities?

(Exhibit 1) Nearly identical to the last *Pulse Check*, ecstasy is reported as an emerging drug of abuse by 21 sources in 16 cities across the Nation, with no regional patterns evident. Other club drugs mentioned as emerging this reporting period include GHB in Los Angeles, DXM (sold as ecstasy) in Memphis, and ketamine in New Orleans. In only four cities (Columbia, [SC], Miami, St. Louis, and Seattle) are club drugs not reported as emerging, but in all of those cities, they were reported as emerging last reporting period, suggesting they are now established drugs of abuse in those communities.

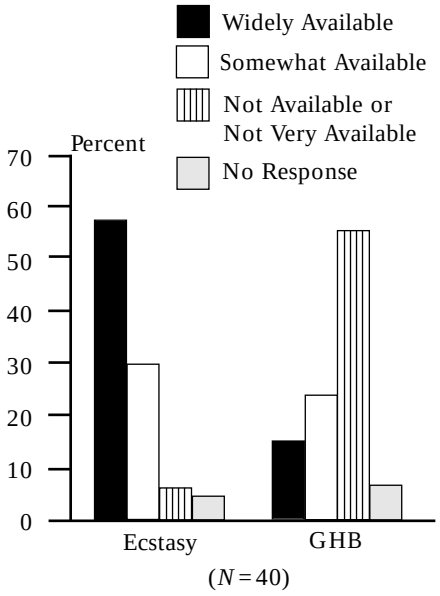
How available are club drugs in *Pulse Check* communities?

(Exhibits 2 and 3) Nearly identical to reports in the last two issues of *Pulse Check*, ecstasy (typically in pill form) is considered widely or somewhat available by nearly 90 percent of law enforcement and epidemiologic/ethnographic sources. Only three sources continue to report it as not very available: the law enforcement source in El Paso and the epidemiologic sources in Billings and New Orleans. Moreover, ecstasy availability has increased according to more than half of sources, with no regional patterns evident. Only the New Orleans epidemiologic source reports declines in availability.

GHB, typically in liquid form, is not nearly as available as ecstasy, with only 38 percent of sources reporting it as somewhat or widely available and 55 percent reporting it as not very or not available. As reported in the last two issues of *Pulse Check*, cities where

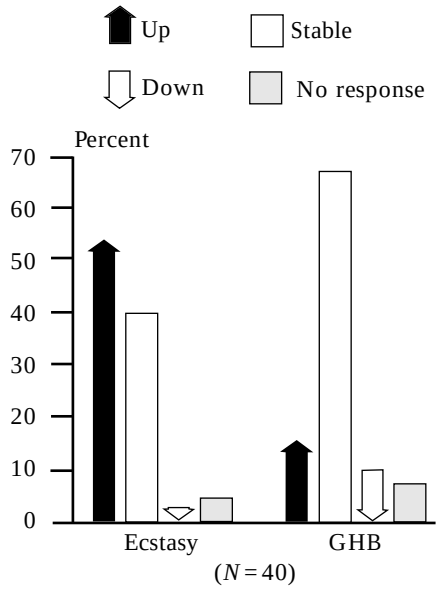
[+]*The following symbols appear throughout this chapter to indicate type of respondent: [L]Law enforcement respondent, [E]Epidemiologic/ethnographic respondent, [N]Non-methadone treatment respondent, and [M]Methadone treatment respondent.*

Exhibit 2.
How available are ecstasy and GHB across the 20 *Pulse Check* cities?



Sources: Law enforcement and epidemiologic/ethnographic respondents

Exhibit 3.
Has ecstasy or GHB availability changed across the 20 *Pulse Check* cities (spring 2001 vs fall 2001)?



Sources: Law enforcement and epidemiologic/ethnographic respondents

wide availability is reported are predominantly in the West or South: Denver, Los Angeles, Miami, New Orleans, and (in the Northeast) New York. In contrast with ecstasy availability trends, GHB availability remained stable, according to most (68 percent) sources. Increases are noted in Boston (probably due to increased law enforcement awareness of the drug), Los Angeles, Memphis, New Orleans, and Sioux Falls, and declines are reported mostly in midwestern cities (Chicago, Detroit, and St. Louis) and (in the South) Washington, DC.

Ketamine availability is increasing at low levels in Chicago and Columbia (SC) and at higher levels in Honolulu and New Orleans. It is declining in Philadelphia. Other club drugs available in *Pulse Check* cities include LSD, typically as a liquid or sprayed on blotter paper, which is somewhat available and increasing in Denver and Portland (ME). Rohypnol® is widely available in El Paso and Los Angeles at stable levels.

How are club drugs and their combinations referred to across the country? *(Exhibit 4)* Slang terms for ecstasy are similar across the Nation. It continues to be referred to as "X," "XTC," and "Adam," but "E" and "roll" are also used. The practice of taking ecstasy is often referred to as "rolling." Ecstasy continues to be referred to by its logo or the shape of the pill in many *Pulse Check* cities: for example, it is called "shamrock" in St. Louis and "four-leaf clover" in Columbia, SC, because pills may be clover shaped. New slang terms continue to be coined, indicating the continuing popularity of ecstasy.

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

ECSTASY: THE DRUG

What form is ecstasy in, and how is it labeled and packaged? *(Exhibit 5)* According to law enforcement and epidemiologic/ethnographic sources, the tablet form of ecstasy remains, by far, the most available, followed by powder and liquid forms. As reported in the last *Pulse Check*, ecstasy tablets are white or colored, round or sometimes shaped like diamonds or clovers, and many are pressed with designs and logos that change periodically. Designs on ecstasy tablets common across the country are similar to those reported in the last *Pulse Check* and include "E," "mitubishi," "nike," and various cartoon characters. Other designs and logos vary by city.

Overwhelmingly, law enforcement and epidemiologic/ethnographic respondents continue to agree that ecstasy tablets are sold as loose (or "naked") pills. Additionally, pills are often packaged in small plastic bags and in plastic prescription bottles. Packaging remains similar to that reported during the last reporting period, except in Seattle, where sellers do not sell individual, loose pills as often as before. Now, in that city, rather than buyers being in charge of how many tablets they want, the dealers increase their profits by only selling increments of 5 or 10 tablets per transaction. The Denver law enforcement source reports a similar new phenomenon.

Exhibit 4. How are club drugs and club drug combinations referred to across *Pulse Check* cities?

Drug or drug combination	Slang term	City
Ecstasy	The bean, beans	Denver, Memphis, and Miami
	Tabs	Memphis, New Orleans, and St. Louis
	Beads, ills, illy, pills	Denver
	Dice, **four-leaf clover,** smurfs	Columbia, SC
	Candy, shamrock	St. Louis
	Charity, double stacks, **lovers' special**	Memphis
	Hype	Washington, DC
	Love pill, sky	Portland, ME
	Sex drug	Billings
	Tachas	El Paso
The practice of taking ecstasy	Flipping	Boston
The use of more than one ecstasy tablet sequentially	Piggybacking	St. Louis
The use of three or more ecstasy tablets in combination	Stacking	St. Louis
Ecstasy (adulterated with amphetamine)	Speedies	Sioux Falls
Ecstasy (adulterated with mescaline)	Snackies	Sioux Falls
Ecstasy (adulterated with heroin or crack)	**Stacks**	Memphis
Ecstasy + heroin (dealer shaves a slice of ecstasy into a bag of heroin)	**Moonstone, on the ball**	New York
Ecstasy + LSD	Candy flip	Chicago, Los Angeles, and Philadelphia
	Trolling	Boston, Miami
Ecstasy + GHB, ketamine, or nitrous oxide	E sitting, Sitting E	St. Louis
Ecstasy, then GHB	Parachute down	Miami
Ecstasy + ketamine	Kitty flipping	Los Angeles
Ecstasy + methamphetamine	Hugs and kisses, super X	Miami
Ecstasy + powder cocaine	Bumping up	Miami
GHB	**Caps**, liquid G	Chicago
	Date rape drug	Billings
	Easy lay	Philadelphia
	Funk, holy water	Denver
	G juice	St. Louis
	Gamma	New Orleans
	Scoop	Miami
	Sleep	Portland, ME
	Water	Sioux Falls
Ketamine	Cat, thunder	Columbia, SC
	Kitty, in the K-hole	Denver
Rohypnol	Roche, roche2, roaches, cruzettas	El Paso
DXM	Triple C, CCC	Denver, Los Angeles
	Drex, dex	Washington, DC
	Skittles	Denver

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

What are street-level ecstasy prices across the country?

(Exhibit 6) The most commonly reported unit of ecstasy sold is one tablet (approximately 100–150 milligrams in Miami, 150–250 milligrams in Seattle, and 30 milligrams in Chicago), selling at $12–$38 in the Northeast, $5–$35 in the South, $20–$50 in the Midwest, and $10–$40 in the West. Since the last reporting period, prices have remained relatively stable. In several cities, including Honolulu and New York, ecstasy prices depend on where it is sold. For example, in Honolulu, it is $2–$3 cheaper per pill in high schools than on the street, and in New York, prices are higher in clubs than on the street. Moreover, in that city, clubgoers in Greenwich Village claim that because ecstasy costs are so high, people are reverting to using LSD.

What adulterants are added to ecstasy?

Ecstasy may be adulterated with a variety of other substances, most commonly hallucinogens, such as mescaline in Memphis and Sioux Falls, LSD in Denver, peyote in Columbia (SC), and PCP in Detroit. Stimulants, such as amphetamines in Sioux Falls, methamphetamine in Memphis, and paramethoxyamphetamine (PMA) in Detroit, are also reported as common adulterants. Additionally, heroin, crack, and powder cocaine are reportedly used as ecstasy adulterants in Memphis, and a variety of stimulants and hallucinogens are reportedly used in Seattle, where there are anecdotal reports of increases in the use of these adulterants.

ECSTASY: THE SELLERS

Who sells ecstasy?

Street-level ecstasy sellers continue to be independent, according to most (21 of 28) law enforcement and epidemiologic/

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

	City	Label
Northeast	Boston, MA	**Bulldogs, calvin klein, hearts, lightning bolts, mcdonald's, nike,** playboy**, tulips, yin and yang signs**
	Philadelphia, PA	Michelin, mitsubishi
	Portland, ME	E
South	Baltimore, MD	**XXX**
	Columbia, SC	Diamonds, elephants, mercedes, mickey mouse
	El Paso, TX	E (red tablets)
	Memphis, TN	Arrowheads, mercedes, **motorola**, teletubbies
	New Orleans, LA	Cartoon characters, **knight heads, nike, stars**
	Washington, DC	Animals, E, **igloos, mercedes,** pikachu
Midwest	Chicago, IL	Cartoon characters, **CK** (calvin klein) **mitsubishi, motorola**
	Detroit, MI	Butterflies, fish, mitsubishi
	St. Louis, MO	Mitsubishi, playboy, clovers
	Sioux Falls, SD	**Elephants**, mitsubishi, nike, sun faces
West	Denver, CO	Cartoon characters, **clovers**, stars
	Honolulu, HI	Happy faces, sunshines
	Los Angeles, CA	**Blue dolphins, doves, ferrari, green apples, smiley faces**

Sources: Law enforcement and epidemiologic/ethnographic respondents
Note: A logo in bold face indicates that it is newly reported this reporting period.

Exhibit 6.
How much does a pill (one dose) of ecstasy cost in 18 *Pulse Check* cities?*

	City	Price
Northeast	Boston, MA	$20–$25
	New York, NY	$12–$25 (in street) $25–$38 (in clubs)
	Philadelphia, PA	$20–$35
	Portland, ME	$25
South	Columbia, SC	$20–$35
	El Paso, TX	$5–$8
	Memphis, TN	$5–$30
	Miami, FL	$20–$35
	Washington, DC	$18–$35
Midwest	Chicago, IL	$20–$30
	Detroit, MI	$20–$40
	St. Louis, MO	$30
	Sioux Falls, SD	$30–$50
West	Billings, MT	$25
	Denver, CO	$10–$30
	Honolulu, HI	$20–$45
	Los Angeles, CA	$20–$40
	Seattle, WA	$20–$30

Sources: Law enforcement and epidemiologic/ethnographic respondents
**Sources in Baltimore and New Orleans did not provide this information.*

ethnographic respondents. Young adults (18–30 years) continue to be the predominant street-level ecstasy sellers, according to most (19 of 28) respondents. However, adolescents are the predominant sellers in El Paso, New Orleans, and Seattle, and young adults and adolescents are evenly split in Detroit, Memphis, St. Louis, and Sioux Falls. According to the law enforcement source in Denver, adolescents are selling single pills and often use the drug, but adults sell larger quantities of the drug and do not typically use it. *(A summary of ecstasy sales characteristics appears in exhibit 9 at the end of this section.)*

Are ecstasy sellers involved in other crimes? Most law enforcement and epidemiologic/ethnographic respondents report that street-level ecstasy sellers are not typically involved in other crimes or violence. However, the most common crime associated with ecstasy dealers is drug-assisted rape, as reported in eight *Pulse Check* cities: Columbia (SC), Denver, El Paso, Honolulu, Los Angeles, Memphis, New Orleans, and New York. According to the Memphis epidemiologist, crimes associated with ecstasy have become less violent and less gang related since the last reporting period.

Since the last ***Pulse Check***, reports of other drugs of abuse, including heroin and cocaine, sold by ecstasy dealers have continued:

- **Columbia, SC**[L]: Powder cocaine is sold with ecstasy.
- **Memphis, TN**[E]: Ecstasy dealers sell virtually any drug because "you can get anything if you can get ecstasy."
- **Miami, FL**[E]: Now people who sell marijuana, cocaine, and heroin on the street also sell ecstasy.
- **New York, NY**[L]: The trend toward polydrug sales (crack, powder cocaine, heroin, and ecstasy) continues, and "everyone wants to be involved in ecstasy sales" because they are lucrative.
- **Washington, DC**[L]: Crack cocaine dealers continue to be increasingly involved in ecstasy sales.

Where is ecstasy sold? The geographic locations of ecstasy sales are mostly suburbs, followed by central city areas, according to law enforcement and epidemiologic/ethnographic respondents. Ecstasy is mostly sold indoors, typically in raves and nightclubs or bars. Other frequently mentioned settings include college campuses, followed by in or around high schools, private residences, and private parties. Streets are mentioned as sales settings in 10 *Pulse Check* cities: Billings, Denver, El Paso, Honolulu, Los Angeles, Memphis, Miami, New York, Sioux Falls, and

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

Ecstasy seller populations continue to expand to include more high school age sellers:

- **Billings, MT**[L]: The drug is more commonly sold and used by high school and college students than before.
- **Los Angeles, CA**[L]: More adolescents are selling and using than before, and these sellers tend to be independent.
- **Miami, FL**[L]: Young adults are increasingly involved, especially via connections through high schools.
- **St. Louis, MO**[E]: As reported in the last *Pulse Check*, adolescents continue to be increasingly involved in sales, with an expansion from college age to high school age sellers. That expansion, however, may be starting to level off.

New seller groups continue to include various races and ethnicities:

- **Memphis, TN**[L]: More Blacks are selling the drug.
- **Miami, FL**[L]: Various ethnic groups are now involved in club drug (typically ecstasy) sales. Contacts at schools, nightclubs, and raves are making it possible for a wider variety of groups to become involved.
- **Washington, DC**[L]: Some ecstasy is being sold and bought in the Black community. Sellers there are Black and are often street (open-air market) dealers of crack cocaine.

Ecstasy sales settings have also continued to expand, especially to the streets:

- **Memphis, TN**[L,E]: The epidemiologic source states that ecstasy sales are moving out of the city: they are now equally likely to take place in central city and suburban areas. The law enforcement source agrees that sales are expanding to other areas of the city.
- **Miami, FL**[E]: Ecstasy sales used to be limited to raves, clubs, and private residences, but now people who sell marijuana, cocaine, and heroin also sell ecstasy, and this is occurring in the street.
- **New York, NY**[E]: Ecstasy sales on the street are emerging.
- **St. Louis, MO**[E]: Sales continue to expand, as reported in the last *Pulse Check*, from raves to schools and from the central city to the suburbs—but this reporting period the expansion is occurring at a slower rate.
- **Washington, DC**[L]: More ecstasy sales occur on the street since the last reporting period, most likely because crack cocaine dealers are now involved in ecstasy sales.

Washington, DC. According to the New York ethnographer, some dealers sell ecstasy from their houses because the drug sells so well "that they don't need to sell it in clubs."

What other drugs do ecstasy dealers sell? The most common other drugs sold are club drugs, including GHB, ketamine, and LSD. Marijuana is sold by ecstasy dealers in six cities (Billings, El Paso, Los Angeles, Miami, Philadelphia, and Sioux Falls), methamphetamine in three cities (Billings, Philadelphia, and Washington, DC), and other pills, typically benzodiazepines or opiates, in Memphis and Philadelphia.

ECSTASY: THE USERS

How has the number of novice ecstasy users in treatment changed? *(Exhibit 7)* According to 10 treatment respondents in 8 *Pulse Check* cities, the number of novice ecstasy users in treatment (defined as any drug treatment client who has recently begun using ecstasy) has increased since the last reporting period. However, the number declined according to the methadone treatment source in New Orleans. It is important to note that treatment clients who report using ecstasy tend to report it as their secondary substance of abuse, with marijuana or alcohol typically reported as the primary substance of abuse.

Who uses ecstasy? According to epidemiologic/ethnographic sources, ecstasy users tend to be young adults (18–30 years). However, according to non-methadone treatment sources, ecstasy users are often adolescents, as reported in Columbia (SC), Detroit, Los Angeles, and Miami. They are often evenly split between young adults and adolescents, as reported in Philadelphia and Sioux Falls. Ecstasy users tend to be evenly split between the genders, more so than with any other drug *(see exhibit 6 of the crack cocaine section)*. Whites predominate as ecstasy users in nearly all cities. The socioeconomic status of ecstasy users ranges from low in Baltimore to middle-high in Detroit, Denver, Honolulu, Memphis, St. Louis, and Sioux Falls. User residences are predominantly in the suburbs, followed by central city areas.

Where do users take ecstasy? As reported in the last *Pulse Check*, nearly all epidemiologic and treatment sources report that ecstasy is used predominantly in groups or among friends typically at raves, nightclubs or bars, and private parties. Other common use settings are similar to sales settings, including private residences, college campuses, and in or around high schools. Streets are reported as user settings in Denver, Memphis, Sioux Falls, and Washington, DC.

Exhibit 7.
Has the number of novice ecstasy users in treatment changed (spring 2001 vs fall 2001)?*

**Sources in Boston, Chicago, Columbia (SC), Denver, El Paso, Honolulu, Memphis, Miami, and New York did not provide this information. Billings has two non-methadone treatment sources.*

How and with what other drugs is ecstasy taken? Oral ingestion of an ecstasy tablet continues to be, by far, the most common route of administration. Alternate routes of administration include injecting tablets dissolved in water in Boston, Miami (where the practice is increasing), and St. Louis; anal insertion in Billings and Memphis; and crushing tablets and snorting them in El Paso and Sioux Falls.

Ecstasy is taken either in combination with or sequentially with a wide variety of other drugs, most commonly marijuana and other club drugs, including GHB, ketamine, LSD, DXM, and nitrous oxide. It is taken with powder cocaine or prescription pills in Miami; with heroin in St. Louis; and with methamphetamine in Denver. Additionally, since the last *Pulse Check*, other combinations have become more consistently reported,

How have ecstasy users and use patterns changed between between **spring** and fall 2001?

Similar to the expansion of adolescents (13–17 years) among seller groups, ecstasy use continues to be increasingly reported among adolescents, as reported in eight Pulse Check *cities:*

- In six cities where young adults (18–30 years) predominate, emerging users are adolescents: Baltimore, Billings, Boston, El Paso, Miami, and St. Louis.
- **Memphis, TN[E]**: Although the predominant user age is split between young adults and adolescents, emerging users are predominantly adolescents. Furthermore, those with high SES are increasingly using the drug.
- **Sioux Falls, SD[N]**: Ecstasy use increased, especially among adolescents. Typically, it is the secondary substance to alcohol, but that may be changing for younger users. Young novice users may start with ecstasy instead, and it is increasingly reported as their primary drug of abuse.

Similar to expanding seller groups, ecstasy use continues to expand to non-White and Hispanic populations, as reported in six Pulse Check *cities:*

- **Boston, MA[E]**: Although Whites continue to predominate, use is increasing among Black youth.
- **Los Angeles, CA[E]**: While Whites remain the predominant users, use is increasing among Blacks (especially those involved in the "hip-hop crowd") and among Asian/Pacific Islanders.
- **Miami, FL[E]**: Hispanics are the predominant user group, but Blacks are emerging users.
- **New York, NY[E]**: While young adult, middle socioeconomic Whites continue to be the predominant users, lower socioeconomic Black and Hispanic young adults continue to emerge as ecstasy users.
- **St. Louis, MO[N]**: While Whites predominate, Blacks are emerging as ecstasy users.
- **Washington, DC[E]**: The club scene has started moving into the Black community, but the numbers are still small.

Ecstasy use continues to expand to new settings (typically high schools and streets) in several cities:

- **Boston, MA[E]**: Ecstasy use is becoming more common as a drug of abuse in high schools.
- **Detroit, MI[N]**: Emerging user settings include high schools and public housing developments.
- **St. Louis, MO[E]**: Ecstasy activity in high schools is emerging.
- **Baltimore, MD[E]**: During the last reporting period ecstasy was used primarily in club settings, now adolescents access it in school and on the street.
- **Memphis, TN[E]**: Ecstasy is increasingly used in private. Additionally, street use, which was not mentioned during the last reporting period, has become more common during the current period.

Interestingly, as ecstasy use settings expand to include settings other than raves, in some cities, the number and popularity of raves may be declining:

- **Denver, CO[N]**: Raves may be phasing out, and club drug use is down, most likely because of high-profile deaths involving ecstasy.
- **Los Angeles, CA[E]**: Use and sales are spreading from raves to other places, such as private residences, college campuses, and nightclubs and bars. The most notable shift is from the rave culture into the "hip-hop" culture.
- **New Orleans, LA[E]**: Raves no longer take place in this city.

including ecstasy plus powder cocaine, crack, heroin, methamphetamine, PCP, prescription pills, or over-the-counter inhalers, according to the Memphis epidemiologic source. In Boston and Columbia, the sequential use of marijuana with ecstasy is increasing.

OTHER CLUB DRUGS: THE DRUGS *(Exhibit 8)*

GHB continues to be available most often as a liquid (typically clear), followed by a powder, as reported by law enforcement and epidemiologic/ethnographic sources. The drug continues to be packaged mostly in plastic bottles (mostly water or sports drink bottles) and distributed by the capful for $5–$20 per dose. Other packaging includes eyedropper bottles in Chicago and Los Angeles; glass vials in Boston, Philadelphia, and Washington, DC; and mouthwash bottles in Chicago, a new, very common packaging.

GBL and BDL (GHB precursors) are no longer available in many *Pulse Check* cities. However, as products containing these precursors become more controlled and removed from the shelves of health food stores and gyms, two new and related precursors are emerging: GHV (gamma hydroxyvalerate) and GVL (gamma valerolactone), as reported by the Los Angeles and Miami epidemiologic sources. The Los Angeles epidemiologic source states that these precursors have joined GBL and BDL as new GHB analogue products sold mostly over the Internet, at health food stores, at raves, and in nightclubs and bars. The products are known as "sublimiss," "midnight blue," and "tranquil G." Other than the emergence of GHV and GVL, GHB packaging and prices have remained stable since the last reporting period, as have packaging and prices for other club drugs.

Exhibit 8.
What are club drug prices?

City	Most Common Unit Sold	Price
GHB		
Boston, MA	Capful (GBL) (one dose)	$5
Chicago, IL	Shot or capful (one dose)	$5–$10
Denver, CO	Capful (one dose)	$5–$10
Los Angeles, CA	Shot or capful (one dose)	$5–$20
	16-ounce bottle	$65–$100
Memphis, TN	Capful (one dose)	$40
Miami, FL	Pill (one dose)	$10
New Orleans, LA	Shot (one dose)	$5–$20
New York, NY	1 gram (one dose)	$30
Philadelphia, PA	Vial (one dose)	$10–$20
Ketamine		
Boston, MA	Capful (one dose)	$5
	Bottle (1 ounce)	$50
Columbia, SC	Vial (1/2 ounce)	$125
Philadelphia, PA	Vial (one dose)	$10–$20
Washington, DC	Bag (1/8 gram)	$20
	Bag (150 milligrams)	$25
	Bag (3/8 gram)	$50
Rohypnol®		
El Paso, TX	Pill (one dose)	$10
Los Angeles, CA	Pill (one dose)	$6–$10
Philadelphia, PA	Pill (one dose)	$10
LSD		
Chicago, IL	Strip (one dose)	$5
Honolulu, HI	Hit (one dose)	$4–$6
Philadelphia, PA	Tab (one dose)	$3–$5
Seattle, WA	One dose	$5
Nitrous Oxide		
Philadelphia, PA	Balloon (one dose)	$5

Sources: Law enforcement and epidemiologic/ethnographic sources

CLUB DRUGS: THE SELLERS *(Exhibit 9)*

According to most law enforcement and epidemiologic/ethnographic sources, GHB, ketamine, and other club drugs seller and sales characteristics remain similar to those of ecstasy sellers with a few differences, as shown in exhibit 9. No changes in other club drug sales or seller characteristics are reported since the last *Pulse Check*.

CLUB DRUGS: THE USERS *(Exhibit 10)*

Regardless of the specific drug, club drug user characteristics are similar, with a few key differences noted in exhibit 10.

Exhibit 9.
What are the predominant characteristics of club drug sellers and sales?

Characteristics	Ecstasy	GHB and its precursors	Ketamine
Age	18–30 years	18–30 years	18–30 years
Organization	Independent	Independent	Independent
Likeliness to be involved with other crimes or violence	Not very likely, with the exception of drug-assisted rape	Somewhat likely, especially non-violent crimes and drug-assisted rape	Somewhat likely
Likeliness to use the drug	Somewhat or very likely	Somewhat likely	Somewhat likely
Indoors or outdoors	Indoors and outdoors	Indoors	Indoors
Most common settings	Raves, nightclubs/bars, college campuses, in or around high schools, private residences and parties, but vary widely	Nightclubs/bars, raves, the Internet, college campuses, health food stores	Nightclubs/bars, raves, and private parties
Most common other drugs sold with the drug	Other club drugs (GHB, ketamine, LSD), marijuana	Ecstasy, LSD	NR
Major changes since the last reporting period in seller group characteristics	Expanding to include more high school age sellers and other races/ethnicities	No major changes reported	No major changes reported
Major changes since the last reporting period in sales settings	Expanding to include the streets and in or around high schools	Health food stores are selling products containing new GHB precursors: GVL and GHV	No major changes reported

Sources: Law enforcement and epidemiologic/ethnographic respondents

Exhibit 10.
What are the predominant characteristics of club drug users and use?

Characteristics	Ecstasy	GHB and its precursors	Ketamine
Age	18–30 years, followed closely by 13–17 years	18–30 years	18–30 years
Gender	Both	Males, sometimes bodybuilders	Males
Race/ethnicity	Whites	Whites	Whites
Socioeconomic status	Middle, but varies widely	Middle	Middle
Residence	Suburbs	Suburbs	Suburbs
Indoors or outdoors	Indoors	Indoors	Indoors
Most common settings	Raves, nightclubs/bars, private parties and residences, college campuses, and high schools, but vary widely	Private residences and parties, nightclubs/bars, and raves	Private residences and parties, nightclubs/bars, and college campuses
Most common other drugs used with the drug	Marijuana, other club drugs (GHB, ketamine, DXM, LSD) but vary widely	Ecstasy	Marijuana
Major changes since the last reporting period in user characteristics	Expanding to include adolescents and other races/ethnicities	No major changes reported	No major changes reported
Major changes since the last reporting period in use settings	Expanding to include the streets; rave popularity may be declining in several cities.	No major changes reported	No major changes reported

Sources: Epidemiologic/ethnographic and treatment provider respondents

Since the last reporting period, club drug users and use patterns have changed in several *Pulse Check* cities:

- **Los Angeles, CA[E]:** While GHB users are predominantly young adults, emerging users include both young adults and older adults. Morever, because of Internet access, use is expanding to include not only use by those in the suburbs but also among those who reside in central city and rural areas.
- **Portland, ME[N]**: GHB use has increased, but the increase is not yet noted among treatment clients.
- **St. Louis, MO[E]**: Following a recent law enforcement crackdown on precursors and Internet sales, reports of GHB sales have declined. Sellers who had previously not realized the seriousness of their offense are now being more discreet.
- **Washington, DC[E]**: GHB use is declining because of its unsafe reputation.
- **Denver, CO[E]**: The proportion of treatment clients for DXM, particularly in over-the-counter cough medications, is now higher than that for GHB.
- **Seattle, WA[E]**: DXM in cough syrup form is sometimes swallowed by ecstasy users, as suggested by its recent detection in three decedents and by anecdotal information that it is a popular club drug.

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APPENDIX 1: METHODOLOGY

How were the sites selected?

(See map in the Introduction) A total of 20 sites were studied for this issue of *Pulse Check*. During 2000, we selected sites using Census Bureau regions and divisions with a goal of achieving geographic and demographic diversity. In addition, we made an effort to select sites in areas with special drug abuse problems of national concern. More specifically, we applied the following methodology in selecting sites.

We purposely selected the most populous States in the four census regions: New York in Region I (Northeast Region); Texas in Region II (South Region); Illinois in Region III (Midwest Region); and California in Region IV (West Region). In three of these States, we selected the most populous metropolitan areas: New York City, Chicago, and Los Angeles. In Texas, however, we selected El Paso—a known high trafficking area with particularly high levels of unemployment, population growth, and poverty—because of its proximity to the United States border with Mexico.

We included four rural States, one per census region. (Rural States are defined by the Census Bureau as those in which 50 percent or more of the State's population reside in census-designated rural areas.) The four rural sites selected are as follows:

- Region I (Northeast): Portland, ME—Of the three rural States in the Northeast Region (including New Hampshire and Vermont), Maine has the only Atlantic coastline and shares the longest border with Canada. It also includes an ONDCP-designated High Intensity Drug Trafficking Area (HIDTA). Portland is Maine's most populous metropolitan area.

- Region II (South): Columbia, SC—The three other rural States in the South census region are Kentucky, Mississippi, and West Virginia. However, South Carolina's location along a major drug trafficking corridor makes that State a strategic choice. Recent cocaine seizures in Columbia further highlight its strategic importance.

- Region III (Midwest): Sioux Falls, SD—Sioux Falls is the most populous metropolitan area within the Midwest Region's two rural States (North Dakota and South Dakota).

- Region IV (West): Billings, MT—Montana is the only census-designated rural State in the West Region, and Billings is its most populous metropolitan area.

The remaining 12 sites were selected to ensure that the entire list included at least 2 sites from each of the 9 Census Bureau divisions (East North Central, Mountain, Middle Atlantic, New England, Pacific, South Atlantic, South East Central, South West Central, and West North Central). Additional selection criteria included population density, representation of racial/ethnic minorities, and emphasis on high drug trafficking areas.

Applying these criteria resulted in the final selection of the following 20 *Pulse Check* sites:

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

How do the 20 sites vary demographically?

Appendix 2 highlights the demographic diversity of these 20 sites. For example, their population density per square kilometer ranges from a sparse 18.6 in Billings, MT, to a crowded 2,931.6 in New York City. Their unemployment rates range from a 1.7 low in Sioux Falls, SD, to a 9.4 high in El Paso, TX. The racial/ethnic breakdowns in the 20 sites further exemplify their diversity: White representation ranges from 30.9 percent in Honolulu, HI, to 97.8 percent in Portland, ME; Black representation ranges from 0.5 percent in Billings, MT, to 42.4 percent in Memphis, TN; and Hispanic representation ranges from less than 1 percent in Portland, ME, to 75.4 percent in El Paso, TX.

**Because of concerns about its unique problems involving heroin and cocaine, Baltimore, MD, was added as a Pulse Check site for the report covering the January–June 2001 period; Birmingham, AL, was dropped for the current (July–December 2001) issue in order to maintain balanced geographic representation.*

What other data are available at the 20 selected sites? Information from other national-level data sources will be useful for framing, comparing, corroborating, enhancing, or explaining the information obtained for *Pulse Check*. The following data sources are available in nearly every site: ONDCP's past *Pulse Check* reports; the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG); the Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Warning Network (DAWN); and the National Institute of Justice (NIJ) Arrestee Drug Abuse Monitoring (ADAM) program.

Who are the ***Pulse Check*** sources, and how were they selected? Consistent with previous issues, the information sources for *Pulse Check* were telephone discussions with 4 knowledgeable individuals in each of the 20 sites: 1 ethnographer or epidemiologist, 1 law enforcement official, and 2 treatment providers. Ethnographers and epidemiologists were recruited based on several possible criteria: past participation in the *Pulse Check* program; membership in NIDA's CEWG; research activities in local universities; or service in local community programs. We recruited law enforcement officials by contacting local police department narcotic units, Drug Enforcement Administration (DEA) local offices, and HIDTA directors. The vast majority of the 40 epidemiologists, ethnographers, and law enforcement sources who reported for this issue of *Pulse Check* were the same, or associated with the same agencies, as those who reported for the previous issue.

To identify treatment sources for the Mid-Year 2000 issue of *Pulse Check*, we randomly selected providers from the 1998 Uniform Facility Data Set (UFDS), a listing of Federal, State, local, and private facilities that offer drug abuse and alcoholism treatment services. For this purpose, we excluded facilities that reported more than 50 percent of their clientele as having a primary alcohol abuse problem, served a caseload of fewer than 100 clients, or provided only prevention or detox services. We then divided the remaining facilities into two groups—methadone and non-methadone treatment facilities—in order to capture two client populations whose demographic characteristics and use patterns often differ widely. We selected one from each of these two categories of programs for each of the 20 selected sites. Because Billings, MT, and Sioux Falls, SD, have no UFDS-listed methadone treatment facilities, we selected two non-methadone facilities in those sites.

Since the Mid-Year 2000 issue of *Pulse Check*, in order to preserve continuity, all actively available treatment sources have been retained. Additionally, to ensure regular reporting, any treatment provider who becomes unavailable to participate is being replaced via purposeful, rather than random, selection based on consultation with experts in the field. Altogether, we recruited 40 treatment sources: 18 methadone providers (1 from each *Pulse Check* site except for Billings and Sioux Falls, where methadone treatment is unavailable), and 22 non-methadone providers (1 from each *Pulse Check* site plus extra sources from Billings and Sioux Falls). Thus, a total of 80 sources have been identified and recruited, and for this *Pulse Check* issue we successfully obtained information from 75 of them: a response rate of 94 percent. Five participants were unavailable: the law enforcement source from Baltimore; the non-methadone treatment providers from Baltimore, Honolulu, and Memphis; and the methadone treatment provider from Memphis.

What kind of data were collected, and how? For each of the 75 responding sources, we conducted a single telephone discussion lasting about 1 hour. We asked sources to explore with us their perceptions of the change in the drug abuse situation between spring and fall 2001. We discussed a broad range topic areas with these individuals, as delineated in Appendix 5. Not surprisingly, ethnographic and epidemiologic sources seemed to be very knowledgeable about users and patterns of use; they were somewhat knowledgeable about drug availability; and they were less informed about sellers, distribution, and trafficking patterns. Treatment providers had a similar range of knowledge, but they generally focused on the specific populations targeted by their programs. Some providers, however, were able to provide a broader perspective about the communities extending beyond their individual programs. Among the three *Pulse Check* source types, law enforcement officials appeared to be most knowledgeable about drug availability, trafficking patterns, seller characteristics, sales practices, and other associated activities; they were not asked to discuss user groups and characteristics.

APPENDIX 2: POPULATION DEMOGRAPHICS IN THE 20 *PULSE CHECK* SITES

	Pulse Check Site	MSA Size* (S, M, L, X)	Race Percent[a] White	Black	American Indian Eskimo Aleut.	Asian and Pacific Islander	Percent Hispanic[a]	Violent Crime/ 100,000 Population[b]	Percent Persons Under18 Below Poverty Level[c]	Unemployment Rate	Population Density/ Square KM[a]	Percent Population Change[d]
Northeast	Boston, MA[1]	X	89.9	6.0	.2	3.9	5.7	505	15.2	3.1	353.3	3.8
	New York City, NY	X	61.3	28.9	.4	9.3	25.6	1,037	32.9	6.2	2,931.6	1.9
	Philadelphia, PA-NJ	L	76.5	20.1	.2	3.2	4.7	667	17.1	4.1	495.7	.6
	Portland, ME	S	97.8	.8	.3	2.6	2.0	730	16.6	4.0	368.7	4.6
South	Baltimore, MD	L	69.1	28.0	.3	.6	.8	581	19.4	3.1	110.9	8.9
	Columbia, SC	M	68.7	29.6	.2	1.5	2.1	868	19.2	2.5	136.8	13.8
	El Paso, TX	M	94.5	3.4	.5	1.5	75.4	668	38.6	9.4	267.5	18.6
	Memphis, TN	L	56.3	42.4	.2	1.2	1.3	1,081	21.4	3.6	141.9	9.7
	Miami, FL	L	77.6	20.4	.3	1.8	57.4	1,532	29.6	5.8	432.0	12.3
	New Orleans, LA	L	62.6	34.9	.3	2.2	5.2	918	26.4	4.4	148.2	1.6
	Washington, DC[2]	L	67.7	25.3	.3	6.7	7.6	537	12.8	2.6	281.1	12.2
Midwest	Chicago, IL	X	75.8	19.3	.2	4.6	14.8	NA	17.2	4.1	610.5	8.1
	Detroit, MI	L	74.9	22.6	.4	2.0	2.5	870	19.1	3.5	433.3	4.9
	Sioux Falls, SD	S	96.9	0.8	1.5	0.8	0.9	252	11.4	1.7	45.8	18.1
	St. Louis, MO-IL	L	80.8	17.6	.2	1.3	1.5	NA	16.4	3.7	155.2	3.1
West	Billings, MT	S	95.5	.5	3.3	.6	3.3	187	16.8	4.0	18.6	12.2
	Denver, CO	L	89.8	6.2	.8	3.1	14.9	385	13.4	2.4	203.2	21.9
	Honolulu, HI	M	30.9	3.6	.5	65.0	7.4	268	14.8	4.9	556.4	3.4
	Los Angeles, CA[3]	X	74.8	11.2	.6	13.4	44.4	1,027	30.5	5.9	887.3	5.3
	Seattle, WA[4]	L	84.7	4.7	1.3	9.3	4.3	419	11.7	3.4	203.7	14.8

**Small = <300,000 persons; Medium = 300,000–1 million persons; Large = 1 million–5 million persons; Extra Large = >5 million persons*

[1]Includes Worcester, Lawrence, Lowell, Brockton MA-NH

[2]Includes Washington, DC-MD-VA-WVA

[3]Includes Los Angeles-Long Beach

[4]Includes Seattle, Bellevue-Everett, WA

[a]1999

[b]1998

[c]1997

[d]1990–1999

Note: Shaded boxes indicate that selected city is in a rural State. SOURCE: 2001 County and City Extra: Annual Metro, City, and County Data Book, Tenth Edition. Eds: Gaquin, D.A., and Littman, M.S. Washington, DC: Bernan Press

APPENDIX 3: NATIONAL-LEVEL DATA SOURCES AVAILABLE IN THE 20 *PULSE CHECK* SITES

	Pulse Check Site	HIDTA[1] State	CEWG[2]	DAWN[3]	ADAM[4]
Northeast	Boston, MA	✓	✓	✓	
	New York, NY	✓	✓	✓	✓
	Philadelphia, PA		✓	✓	✓
	Portland, ME	✓			
South	Baltimore, MD	✓	✓	✓	
	Columbia, SC				
	El Paso, TX	✓	✓		
	Memphis, TN	✓			
	Miami, FL	✓	✓	✓	✓
	New Orleans, LA	✓	✓	✓	✓
	Washington, DC	✓	✓	✓	✓
Midwest	Chicago, IL	✓	✓	✓	✓
	Detroit, MI	✓	✓	✓	✓
	Sioux Falls, SD	✓			
	St. Louis, MO	✓	✓	✓	
West	Billings, MT				
	Denver, CO	✓	✓	✓	✓
	Los Angeles, CA	✓	✓	✓	✓
	Honolulu, HI	✓	✓		✓
	Seattle, WA	✓	✓	✓	✓

[1]High Intensity Drug Trafficking Area of the Drug Enforcement Administration (DEA)

[2]Community Epidemiology Work Group of the National Institute on Drug Abuse (NIDA)

[3]Drug Abuse Warning Network of the Substance Abuse and Mental Health Services Administration (SAMHSA)

[4]Arrestee Drug Abuse Monitoring program of the National Institute of Justice (NIJ)

Note: Shaded boxes indicate that selected citiy is in a rural State.

Pulse Check Site	Epidemiology/Ethnography	Law Enforcement
Baltimore, MD	**James Peterson** Johns Hopkins University School of Public Health	**Nonrespondent**
Billings, MT	**Ernesto Randolfi, Ph.D.** Montana State University at Billings Department of Health and Physical Education	**Scott Forshee** City/County Special Investigations Unit
Birmingham, AL	**Foster Cook** University of Alabama	**Sergeant T.E. Thrash** Birmingham Police Department Vice and Narcotics Division
Boston, MA	**George Arlos** Substance Abuse Treatment and Prevention Services	**Lieutenant Francis W. Armstrong, Jr.** Boston Police Department Drug Control Division
Chicago, IL	**Larry Ouellet, Ph.D.** University of Illinois at Chicago School of Public Health	Chicago Police Department Organized Crime Division, Narcotic and Gang Investigations Section
Columbia, SC	Department of Alcohol and Other Drug Abuse Services	**C.O. Clark** Columbia Police Department Organized Crime and Narcotics Unit
Denver, CO	**Bruce D. Mendelson, M.P.A.** State Treatment Needs Assessment Contract Colorado Department of Human Services Alcohol and Drug Abuse Division	**Curt Williams, B.S.** Denver Police Department Fugitive Location and Apprehension Group
Detroit, MI	**Richard F. Calkins** Michigan Department of Community Health Division of Substance Abuse Quality and Planning	Southeast Michigan HIDTA
El Paso, TX	**Tessa Hill, M.A.** Aliviane, Inc.	**Jeff Cole** El Paso Police Department, Narcotics Unit
Honolulu, HI	**D. William Wood, Ph.D., M.P.H.** University of Hawaii Department of Sociology	**Lieutenant Mike Moses** Narcotics, Vice Division Honolulu Police Department
Los Angeles, CA	**Richard Rawson, Ph.D.** University of California, Los Angeles Integrated Substance Abuse Programs (ISAP)	Criminal Intelligence Group Los Angeles Police Department
Memphis, TN	**Randolph Dupont, Ph.D.** Department of Psychiatry University of Tennessee	**Fred Romero** Memphis Police Department Vice Narcotics Unit
Miami, FL	**James N. Hall** Up Front Drug Information Center	**Prefers anonymity**
New Orleans, LA	**Gail Thornton-Collins** New Orleans Health Department	**Lieutenant Reginald Jacque**
New York, NY	**John A. Galea, M.A.** New York State Office of Alcoholism and Substance Abuse Services Street Studies Unit	Drug Enforcement Administration New York Division Unified Intelligence (S-13)
Philadelphia, PA	**Samuel J. Cutler** Philadelphia Behavioral Health System Coordinating Office for Drug and Alcohol Abuse Programs	**Ken Bergmann** Drug Enforcement Administration Philadelphia Field Division Divisional Intelligence Group
Portland, ME	**Nate Nickerson, R.N., M.S.N.** Public Health Division, Department of Health and Human Services City of Portland	**George Connick** Maine Drug Enforcement Agency
Seattle, WA	**Thomas R. Jackson, M.S.W.** Evergreen Treatment Services	**Steve Freng** High Intensity Drug Trafficking Area
Sioux Falls, SD	**Darcy Jensen** Prairie View Prevention Services	**Jerry Mundt** Sioux Falls Police Department Narcotics Division
St. Louis, MO	**James M. Topolski, Ph.D.** Missouri Institute of Mental Health	**Detective Leo Rice** St. Louis Police Department Narcotics Division
Washington, DC	**Alfred Pach, Ph.D., M.P.H.**	**Sergeant John Brennan** Washington, D.C. Police Department Major Narcotics

Pulse Check Site	Non-Methadone Treatment	Methadone Treatment
Baltimore, MD	**Nonrespondent**	**Cindy Shaw** IBR Reach
Billings , MT	**Mona Sumner** Rimrock Foundation **Kathy Woodward** South Central Mental Health Center Journey Recovery Program	**Illegal in the State of Montana**
Birmingham, AL	**Eleanor D. Powers** Program prefers anonymity	**Bill Garrett, M.P.H.** University of Alabama Birmingham Substance Abuse Program
Boston, MA	**Jim Sweeney** Gavin House	**Joanne Swindell** CAB Health and Recovery Services **Patrick Griswold** NCIA
Chicago, IL	**Del Larkin** Association House of Chicago	Cornell Interventions
Columbia, SD	**Bryan Fox** Palmetta Baptist Medical Center Outpatient Behavioral Health Services	**Jim Van Frank** Columbia Metro Treatment Center
Denver, CO	**Tim McCarthy** Arapahoe House	**Pamela J. Manuele, RN, BSN, ANPC, CCJS** Comprehensive Addiction Treatment Services
Detroit, MI	Renaissance West Community Health Services	**Octavius Sapp, C.A.C.** City of Detroit, Department of Human Services Drug Treatment Program
El Paso, TX	**Armando Salas** Aliviane Men's Residential Facility	**Julie Renteria, L.V.N.** El Paso Methadone Maintenance and Detox Treatment Center
Honolulu, HI	**Nonrespondent**	**Lisa Cook** Drug Addiction Services of Hawaii
Los Angeles, CA	**Mari Radzik, Ph.D.** Substance Abuse Treatment Program Division of Adolescent Medicine Children's Hospital of Los Angeles	**Wynnell Dominguez** West Los Angeles Treatment Program
Memphis, TN	**Nonrespondent**	**Nonrespondent**
Miami, FL	**Michael Miller, Ph.D.** The Village South, Inc. Addiction Treatment Center	**Prefers anonymity**
New Orleans, LA	**Eleanor Glapion** New Orleans Substance Abuse Clinic	**Prefers anonymity**
New York, NY	**Jean Scott** Pheonix House	Lower Eastside Service Center
Philadelphia, PA	**C. Joseph Schultz, M.Ed.** Northeast Treatment	**Peter A. Demaria, Jr., M.D., FASAM** Department of Psychiatry and Human Behavior Jefferson Medical College
Portland, ME	**Stephen Leary** Milestone Foundation, Inc.	**Douglas Smith** Discovery House Maine
Seattle, WA	**Ramona Graham**	**Victoria Evans** Therapeutic Health Services
Sioux Falls, SD	**Robin Erz, CCDCIII** Turning Point Alcohol and Drug Center Keystone Treatment Center	**Illegal in the State on South Dakota**
St. Louis, Missouri	**Mike Morrison** Bridgeway Counseling	**Cheryl Gardine** DART
Washington, D.C.	**James Shepard** Cataada House/Aftercare Program Greater Mt. Calvary	Umoja Treatment Center

APPENDIX 5: DISCUSSION AREAS BY SOURCE TYPE*

Topic	L	E	M	N
SPECIAL SECTION: THE IMPACT OF THE SEPTEMBER 11 TERRORIST ATTACTS ON DRUG MARKETS AND USE				
Since the terrorist attacks on September 11, what has been the reaction or change within your local drug markets and among chronic drug users?	✓	✓	✓	✓
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				
What is the most commonly abused drug in your community during the current reporting period? Second most commonly abused drug? What drug is related to the most serious consequences? Second most serious consequences? Is any new problem drug appearing in your community?	✓	✓	✓	✓
What was the most commonly abused drug in you community during the last reporting period? Second most commonly abused drug in your community? What drug was related to the most serious consequences last reporting period? Second most serious consequences?	✓	✓	✓	✓
THE DRUG**				
How available is the drug in your community (for each drug, asks about various forms)?	✓	✓		
How has availability changed?	✓	✓		
What are the most common and second most common units of sale and corresponding standard units of the drug?	✓	✓		
What is the purity range for the drug during the current reporting period? During the last reporting period?	✓	✓		
What is the price range during the current reporting period? During the last reporting period?	✓	✓		
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 why have they remained stable?	✓	✓		
What is the source for your price, purity, and adulterant information?	✓	✓		
What are the street names, and are any of these new this reporting period?	✓	✓	✓	✓
What types of packaging are used, and are any of these new this reporting period?	✓	✓		
Are labels or brand names used? If yes, please list and indicate if any are new this reporting period.	✓	✓		
Have street names, packaging, or label/brand names changed since the last reporting period?	✓	✓		
How is the drug locally manufactured, processed, or grown?	✓	✓		
Have there been any changes in the local manufacturing process since the last reporting period? If yes, please describe.	✓	✓		
THE SALE**				
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 types of other crimes are sellers involved?	✓	✓		
Have there been any changes in seller characteristics since the last reporting period? If yes, please describe.	✓	✓		
Are there any new sellers groups this reporting period? If yes, please describe.	✓	✓		
What is the geographical area where most street-level sales of the drug occur?	✓	✓		
Is the drug sold mostly indoors, outdoors, or evenly split between both?	✓	✓		
In what settings is the drug sold?	✓	✓		
How is the drug sold?	✓	✓		
Are other drugs sold by this type of dealer? If yes, please list the drugs.	✓	✓		
Have any of the drugs sold with this drug changed since the last reporting period? If yes, please describe.	✓	✓		
Have any of the drug scene characteristics changed since the last reporting period? If yes, please describe.	✓	✓		

Topic	L	E	M	N
THE USERS: Predominant characteristics**				
What is the predominant age range of the drug users, and has it changed since the last reporting period?		✓	✓	✓
What is the predominant gender, 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?		✓	✓	✓
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?		✓	✓	✓
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 most common frequency of use, and has it changed since the last reporting period?			✓	✓
What is the predominant employment status, and has it changed since the last reporting period?			✓	✓
THE USERS: New/emerging or novice 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.		✓		
How did the number of novice users in your program change since the last reporting period? If increased, repeat all questions under "the users: predominant characteristics" for the novice user group.			✓	✓
METHADONE DIVERSION/TREATMENT				
What is the availability of methadone treatment in your community?		✓		
How has treatment availability changed since the last reporting period?		✓		
What is the capacity of public methadone treatment? Private methadone treatment?		✓		
How has the capacity of public methadone treatment changed since the last reporting period? Private methadone treatment?		✓		
COMMUNITY CONTEXTS				
Have drug-related consequences (HIV/AIDS, hepatitis C, liver cirrhosis, drug-related automobile accidents, high-risk pregnancy, drug overdoses, alcohol DTs, tuberculosis, other) increased, decreased, or remained stable since the last reporting period? If changed, explain.			✓	✓
Do any potential barriers (limited slot capacity, lack of trained staff to treat comorbid clients, violent behavior among presenting clients, age restrictions, other) prevent your program from serving all individuals who seek treatment? If yes, explain.			✓	✓
TREATMENT BACKGROUND				
What is your program's maximum capacity?			✓	✓
What is your current enrollment?			✓	✓
Does your program's clientele reflect the population of your local community? If no, please describe.			✓	✓

[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, powder cocaine, methamphetamine, marijuana, ecstasy, GHB, OxyContin®, and any other drugs (specify) for each of the discussion areas.*

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