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ABSTRACT

This Pulse Check is a report of national trends in illicit drug abuse and drug markets in the United States. The report draws on conversations with ethnographers and epidemiologists working in the drug field, law enforcement agents, and drug treatment providers across the United States. Information from each of these sources is summarized in narrative form broken down by drug type and presented in detailed tables at the end of the report. The four groupings of drugs are heroin, cocaine, marijuana, and emerging drugs. Results show that the market for heroin and cocaine remains fairly stable. Marijuana continues to be popular among young people and is frequently used with alcohol, hallucinogens, cocaine, or methamphetamines. Among the emerging drugs, methamphetamine continues to be a problem in the West and parts of the South, its low price making it an easily accessible drug. "Club drugs," such as Lysergic Acid Diethylamide (LSD) and Ketamine, are part of the drug scene in most areas, with many young people using a combination of these substances. (RJM)

Office of National Drug Control Policy

PULSE CHECK

National Trends in Drug Abuse

Executive Office of the President
Office of National Drug Control Policy
Barry R. McCaffrey, *Director*

Summer 1997

OFFICE OF NATIONAL DRUG CONTROL POLICY

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Highlights

The *Pulse Check* is a report of national trends in illicit drug abuse and drug markets issued by the Office of National Drug Control Policy. The *Pulse Check* draws on conversations with ethnographers and epidemiologists working in the drug field, law enforcement agents, and drug treatment providers across the country. Below are highlights of this issue of the *Pulse Check*:

Heroin

- Sources in most areas report that the market for heroin is up or stable, although some report that its rate of growth seems to be slowing. Availability of heroin is high, though purity varies from region to region. Street level purchases are generally in 1/8th to 1/10th gram units that cost between $10 and $25.

- Most heroin users are the traditional group of older, long-term addicts. However, many sources (Bridgeport, New York, Denver, Chicago, Trenton San Antonio, San Diego, and Newark) report an increasing number of young users. These young users are primarily from inner city areas, and they may be using heroin because they feel it is more manageable than crack.

- "Double-breasted dealing" -- dealing both heroin and cocaine -- continues in many areas. In some, it is conducted by organized "crews" of young distributors who deliver relatively small purchase amounts to both inner city and suburban buyers. These crews of distributors have developed more efficient routes of distribution than heroin dealers of the past, and they often use beepers to communicate.

- Sources report that more users are injecting, rather than inhaling heroin, even in areas where high purity heroin is available. This could show that users have become habituated through inhalation, and have switched to injection, which is more efficient. Alternatively, it could mean that more users start out injecting when they initiate use. Sources note that users are less scared that injection drug use will lead to HIV infection.

Cocaine

- The market for cocaine is generally stable, though some sources say that cocaine powder availability is low, while the availability of crack is stable everywhere. Prices range from $50-$150/gram for cocaine powder and from $3-$40/rock or vial of crack. Purity is described as "good" to "fair" at the street level.

- The popularity of both forms of the drug is down, particularly among young users who disdain crack as a "ghetto drug" or find it unmanageable.

- Innovative methods of cocaine use have been reported by several sources. Some users have started to combine cocaine powder or crack with heroin in a "speedball"; some have started to cook their own crack from cocaine powder; and some dissolve crack into a liquid to inject it.

- Only sources in Birmingham report that cocaine use is rising. While previously it had only been popular in the inner city areas, it is now more popular in the suburbs.

- Treatment providers in all areas except the West and Southwest continue to report that cocaine is the most commonly cited drug of abuse among their clients. The majority of cocaine treatment clients smoke crack and are likely to be older, poly-drug users.

Marijuana

- Several varieties of marijuana are available in most areas, and prices are within reach of teens and young adults. Marijuana continues to be highly popular with a wide variety of users, particularly young users.

- Marijuana is typically used with alcohol, hallucinogens, cocaine, or sometimes methamphetamine. In Miami, marijuana and cocaine are rolled into cigarettes called "lace," and in Texas and San Diego, it is combined with crack and called a "primo."

- The percentage of clients entering treatment with marijuana as the primary drug of abuse rose slightly. Marijuana treatment clients are predominantly white, and a quarter to a third of them is less than 20 years of age. The majority of marijuana treatment clients have problems with alcohol abuse, but have had no prior treatment experience.

Emerging Drugs

- Methamphetamine continues to be a problem in the West and parts of the South. With lowered prices, methamphetamine may be a substitute for cocaine, but it also has a strong independent following. It is the primary problem of clients entering treatment in many areas of the Southwest and West.

- "Club drugs" (e.g., MDMA, Ketamine, GHB, LSD, and illegally used prescription drugs) are part of the drug scene in most areas. While the mix of club drugs varies between regions, "cafeteria use" -- the use of a number of hallucinogenic and sedative/hypnotic club drugs -- is reported almost everywhere. Many treatment providers report that teens and young adults enter treatment with a number of these drugs and alcohol, rather than a single drug, as their primary problem.

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Introduction

The *Pulse Check* is a quick turnaround report of national trends in illicit drug abuse and drug markets issued periodically[1] by the Office of National Drug Control Policy. Since its inception in 1992, the goal of each *Pulse Check* has been to capture the most current information about drug abuse and drug markets. The *Pulse Check* draws on conversations with ethnographers and epidemiologists working in the drug field, law enforcement agents, and drug treatment providers across the country. Approximately seventy-five people are called for each report.

Pulse Check is not a population-based survey and should not be considered a substitute for population based, long-term research. Rather, it is designed to provide timely information to policy makers and researchers about changes and trends in the drug scene as they develop. The information in this issue is drawn from a round of calls made in November of 1996. Information from each source is summarized in narrative form by drug, and presented in detailed tables at the end of the report.

This *Pulse Check* also includes a special report on the methamphetamine market. This report was produced in December 1996 and released for limited distribution in January 1997. Unlike the regular *Pulse Check*, this report examines six States in the West and Southwest that have been hit particularly hard by the problems associated with methamphetamine abuse and trafficking. The special methamphetamine report can be found in Appendix A.

The *Pulse Check* is produced by Dr. Dana Hunt and the staff of Abt Associates under contract to the Office of National Drug Control Policy. Information is obtained through lengthy conversations with drug ethnographers and epidemiologists, law enforcement agents, and drug treatment providers across the country. The first two sources are selected to represent various areas of the country and are generally the same reporters for each round of calls. The treatment providers are drawn randomly each time from a national directory of treatment programs to represent both small and large programs across the country. A description of the methodology used to conduct the *Pulse Check* and a list of ethnographic sources can be found in Appendix B.

[1] Between 1992 and 1996, the *Pulse Check* was published quarterly; it is currently conducted twice each year.

Description of Sources

Eleven ethnographers, epidemiologists, and other ethnographic sources were contacted for this issue of the *Pulse Check*. All *Pulse Check* sources speak about their impressions of changes and trends in the use and the markets for heroin, cocaine, marijuana, and emerging drugs. In this issue, ethnographic and epidemiologic sources reported from the following areas: Austin, Texas; Bridgeport, Connecticut; Chicago, Illinois; Denver, Colorado; Miami, Florida; Newark, Delaware; New York, New York (2 reporters); San Antonio/El Paso, Texas; San Diego, California; and Trenton/Newark, New Jersey. Appendix B describes topics raised in conversations with *Pulse Check* sources and a complete list of ethnographic sources contacted for this issue.

Law enforcement sources in six cities were contacted for this issue of the *Pulse Check*: Birmingham, Alabama; Boston, Massachusetts; Eugene, Oregon; Miami, Florida; New York, New York; and Seattle, Washington. For safety reasons, the names of law enforcement sources cannot be published. All sources reported from the Police Departments in their respective cities. Appendix B describes the topics raised in conversations with law enforcement sources.

For this *Pulse Check*, 61 drug abuse treatment providers were contacted. These providers work in both small and large treatment programs, and are selected to represent all regions of the country. Unlike ethnographic and law enforcement sources, which are generally the same for each round of calls, treatment providers are drawn randomly from a national database of providers. Appendix B describes how treatment providers are selected and the types of information they provide.

Trends in Drug Use: Spring–Fall 1996

Part I: HEROIN

Most sources contacted for this *Pulse Check* report that the market for heroin is stable or growing. The majority of heroin abusers are within the traditional, older cohort of long-term users, and some former addicts have begun using again since high purity, low price heroin is available. However, some areas report that there are more new, young heroin users. These new users include college students and suburban kids, but the majority are inner city youth. Sources also report that double breasted dealing -- selling both heroin and cocaine -- continues in many areas. While heroin use is rising in many areas, both by long-term users and new users, treatment providers have not noticed a marked increase in heroin abusers seeking treatment.

Ethnographers and Epidemiologic Sources

Heroin use continues to be common in almost all of the areas contacted, and eight of the eleven sources contacted report an increase in young heroin users. These users may be college or suburban kids (as in Denver, Trenton, and Newark), or low-income inner city youth (as in Chicago, New York, Bridgeport, and Newark). In Denver, sources report "cafeteria use" of drugs on local campuses where students try a number of drugs, such as LSD, MDMA, cocaine, marijuana, and Ketamine, as well as heroin. In New York, heroin use is reportedly popular with middle class teens and young adults who are part of a "club scene" and experiment with a variety of drugs.

The bulk of the new, young users they see are "street kids," that is, they are from inner city areas, are sometimes runaways, and are often minority teens (as in Chicago and Denver). Typically, they feel that heroin use can be better "controlled" or that their behavior under its influence is less volatile than it would be if they were using crack. Some are former crack users, while others have never used crack.

While there has been an increase in new, young users, heroin users are primarily adults, many of whom are former long-term users tempted back into use by the lower price, higher purity heroin now available. In Miami, where heroin use is relatively uncommon but increasing gradually, sources report that "more of the old-time shooters are at least trying to get a taste of heroin again" as availability increases.

In sections of Manhattan, large, stable cohorts of users in their 30s and 40s continue to use heroin with little change in their long-established routines. Greater availability of better quality heroin may simply prompt them to "add a bag or two if they hear of good stuff somewhere" to their typical consumption, but it does not significantly escalate their use.

As described in the last several *Pulse Checks*, snorting heroin is most common in areas of the country where high purity heroin (generally white heroin from Colombia or Southeast Asia) is available. These areas include the Northeast, the Mid-Atlantic region, and the Northwest. In contrast, in areas such as the Texas border and the West where lower purity Mexican brown and black tar heroin dominate the market, users are more likely to inject.

Contrary to the myth that snorting alone does not lead to addiction, many users establish addiction this way. After becoming habituated, these users switch to injection, which is a more efficient route of administration. Chicago, Newark and New York sources report a shift toward injection among heroin snorters, even in areas where high purity heroin is available. This could show that more users are becoming habituated, or that more users start out injecting when they initiate heroin use.

In these areas where there has been a shift toward injection, there appears to be less fear of HIV than there was a year or two ago. The Newark source states that most young users snort heroin, but more and more are trying it intravenously, and comments that "the idea of sharing needles and AIDS simply doesn't seem to bother them." This could indicate that new young users are not responding to public health messages about the risks of needle sharing. Alternatively, it could show that when heroin inhalers switch to injection, or switch back and forth between inhaling and injecting, they choose to ignore the extra risks associated with needle use. This trend has been reported in previous *Pulse Checks* in several areas, including Bridgeport, San Francisco, and Chicago.

Miami sources report that some heroin users, primarily those that experiment with a variety of drugs, are "skin-popping" heroin. Skin-popping -- injecting a drug under the skin or into soft tissue rather than directly into the bloodstream -- has long been associated with the early stages of injection drug use. Miami sources report that skin-popping is common among white, upper middle class, young adults in the Miami beach club scene.

In places as diverse as New York, Denver and the Texas border, sources report that dealers, primarily those who previously dealt only cocaine or crack, are now "double breasting," that is, selling both heroin and cocaine. As described in the last *Pulse Check*, heroin and cocaine markets have traditionally been distinct, with different dealers selling each drug. For example, the traditional heroin market consists of older users, selling to networks of friends and acquaintances.

In contrast, the new "crews," who in some cases are double breasting, consist primarily of young, entrepreneurial *non-users* who have developed more efficient distribution networks. One New York ethnographer reports a noticeable increase in the number of organized crews selling both heroin and cocaine on the street. The two drugs are sold in similar packages using similar bag markings, indicating a common supplier. He describes the crews as more efficient and better organized than traditional heroin distributors have ever been. Further, most crew members are *not* users themselves. These crews may be organized and supported as part of the marketing

strategies of mid-level distributors. Notably, these young crews usually distribute Colombian heroin.

With crack use declining in many of the areas that report double-breasted dealing, new drug distribution networks, that may be made up of second generation dealers, have emerged. Sources in New York, Bridgeport, San Diego, and Newark note that heroin dealers are more frequently using beepers or pagers to conduct sales. This practice coincides with a decrease in open air or public street sales of heroin in favor of indoor sales or "home deliveries" reported in New York, Bridgeport and San Diego. While large sales of heroin and cocaine have always been delivered, small amounts of heroin have traditionally been sold on the street and/or through acquaintances. However, current beeper sales can involve fairly small quantities of heroin and cocaine distributed to a wide range of customers, not just wealthier customers who pay much more than the street price. For example, beeper sales are common in areas where heroin is part of the after hours club scene (e.g., Bridgeport and New York). This pattern of distribution -- a network of street sellers, using beepers to communicate and make delivery sales -- is reminiscent of the methods that crews of crack entrepreneurs developed in the 1980s.

Heroin is also available to young users from street dealers in traditional "copping areas" -- public areas where drugs are sold frequently -- and from other young users in the community or in school. The Trenton/Newark source points out that unlike crack suppliers, who typically do not use, these suppliers are most often older students or recent graduates who *are* users. This distinguishes these young dealers from the more organized heroin crews described above. They are familiar faces among the students and can establish themselves unobtrusively as suppliers for a number of other students.

The Trenton/Newark source points out that in his area, the two markets are still fairly separated: heroin users sell heroin and cocaine distributors sell cocaine powder and crack. If joint sales occur, it is more likely to be serendipitous than part of a marketing plan. This is more typical of the old style heroin markets.

Ethnographers in Bridgeport, Chicago, and New York report that the drug trade has become more violent in their areas. For example, while many cities are reporting a decrease in violent crime, Bridgeport reported a higher homicide rate in mid-1996 than was reported for the entire previous year. In one two-week period in September, the city suffered ten drug-related homicides, reportedly related to the heroin trade. Similarly, in Chicago and New York, competition for the lucrative drug market is fierce, as many different groups as well as "independents" vie for customers and territory.

White heroin from both Southeast Asia and Colombia dominates the Northeast markets, while Mexican brown and black tar heroin is more prevalent in the West and South. Chicago, whose market had traditionally been dominated by Mexican brown and black tar heroin, has witnessed more white heroin in some parts of the city. Sources report that white heroin has been moving westwards for about a year. Miami sources also report that there is more white heroin on

the street. Since Miami is an important transshipment point, this heroin is probably the residual from larger shipments that have moved through the city on the way to other places.

In New York, one source notes that there are more "independent" dealers who are not connected to an established heroin selling network, but are typically associated with high purity heroin. These dealers are reportedly double-breasting, and are believed to be using odd adulterants (e.g., Dramamine, acetaminophen, scopolamine) to cut the drugs they sell. The increase in independent dealers, and more new dealers in general has led to more variety in purity at the street level, even within the same area. For example, a $10 bag that is 2-5 percent pure in one part of the city may be 25 percent pure in another part. These independent dealers could be former cocaine dealers who have developed relationships with mid-level distributors, and are trying their hand in dealing the high purity heroin that has recently emerged.

Prices remain fairly stable, though the purity of heroin sold on the street varies considerably. Street level purchases are generally in 1/8th-1/10th gram units that cost between $10 and $20. Units are sold as small bags, balloons, folded paper/foil or in a small capsule.

Law Enforcement Sources

Police sources in most of the areas surveyed report that heroin use is up or stable in their area. Only sources in Birmingham report that heroin is not widely available, and its use is relatively rare. Miami police describe use as stable, though its prevalence is still quite low compared to other drugs; they note, however, that several teenagers in the Orlando area recently overdosed on what appeared to be heroin. Most police sources report that the majority of users are still older, long-term addicts, though the appearance of the younger users described by ethnographic sources is also reported by police sources in New York, Miami and Boston.

Many police sources report that heroin users in their areas prefer to inject. Two areas (New York and Boston) report that snorting also is popular; this is consistent with the appearance of new, young users in these areas. Police sources report that cocaine and methamphetamine are also popular among heroin users.

In the Northwest, mid-level sales, particularly of larger quantities, are dominated by Mexican nationals. In the East and South, these mid-level dealers vary widely; they may be South American, Middle Eastern, Nigerian, or Russian. In Miami, Seattle, New York and Boston, police also note that more street level dealers are double-breasting (handling both heroin and cocaine).

Prices for heroin remain stable in most places ($10–$25/bag), though the purity or quality can vary considerably within an area. In Miami, purity can run from as high as 95 percent for large quantities seized in transport to lows of 2-5 percent on the street.

Treatment Providers Report

In the Northeast, Mid-Atlantic and the South, approximately 19 percent of people who enter treatment cite heroin as their primary drug of abuse. In the Midwest, South, and Southwest, this figure is about 10 percent. Though this proportion of people rose slightly in the West and Midwest, and fell slightly in the Northeast and the South, these changes did not represent a great increase or decrease for most of the 61 programs reporting in this *Pulse Check.*

Most heroin users entering treatment inject the drug, with the exception of the Northeast, where more clients inhale. One treatment provider in the Northeast points out that while the majority of heroin clients usually snort, many of these same clients also inject, especially when they are unable to find high purity heroin, or when they want to speedball with cocaine powder. Cocaine is commonly mentioned as a secondary drug of abuse (by 33-92 percent of clients in all regions) as is alcohol (by 60-92 percent of clients in all regions).

Heroin users seeking treatment in all regions tend to be older (i.e., over 30), though sources in the Northeast and Mid-Atlantic region report higher percentages of clients under twenty years old. In all areas contacted, the majority of heroin treatment clients are white, except in the Midwest where just over half of the clients are African American. Over 75 percent of the clients have been in treatment before, and there continues to be a 70/30 split between men and women.

Part II: COCAINE

In this *Pulse Check*, sources report that the market for cocaine is generally stable, and in some areas it is declining. In particular, the demand for both cocaine and crack has declined, cocaine availability is down, while the availability of crack is stable. Cocaine users continue to be a diverse group, primarily people in their 30s and 40s who have been using for several years. However, there have been reports of rising cocaine use in specific communities, such as the Birmingham suburbs; the Hispanic community near the Texas border; and young people in the New York/New Jersey area. Treatment providers in most areas report that cocaine and crack are still the most commonly cited drugs of abuse among their clients.

Ethnographers and Epidemiologic Sources

Sources report broad shifts in the population of cocaine powder and crack users in particular areas. For example, young inner city users are starting to disdain crack as a "ghetto drug"; Miami sources describe crack use as "unfashionable" among youth, particularly with African Americans in inner city areas, and often those who continue to use crack try to hide it from their peers. In contrast, crack has recently made inroads into the Hispanic community along the Texas border; formerly, it had only been popular in the African American community in that area. In addition, the New York/New Jersey area has seen an increase in young crack

users for the first time in over a year.

However, the market for both cocaine powder and crack cocaine is generally stable; and cocaine is still a commonly used drug in most. Prices range from $50-$150/gram for cocaine powder and from $3-$40/rock or vial of crack. Purity is described as "good" to "fair" at the street level, though there is considerable variation in most areas.

Cocaine users are a diverse group of all ages and ethnicities and both sexes. In most areas, crack is marketed to people in their 30s and 40s who have been using the drug for several years. Cocaine powder, though less common than crack, is marketed to a diverse group -- primarily adults, of all ethnicities and socioeconomic groups. It is mentioned as a "club drug" in New York, Miami, and San Diego, but is not as prominent in the club environment as methamphetamine, MDMA, marijuana, and some hallucinogens.

Sources in Chicago report that some users are dissolving crack cocaine in lemon juice or vinegar and injecting it intravenously. This practice may have started as an innovation -- a new method to administer cocaine -- or as an adjustment to the decreased availability of cocaine powder, since it is cheaper to dissolve and inject crack than to purchase enough cocaine powder to create the same effect. While this practice reportedly produces a more intense rush than smoking the same amount of crack, the dilutants can produce serious abscesses and pain if the user misses the vein and injects into muscle tissue.

Cocaine powder, when available, is often used by heroin addicts to "speedball" -- combine cocaine with heroin -- to enhance or extend the effect of heroin. This entails injecting or snorting heroin, then smoking crack immediately. Several ethnographers note that as cocaine powder became harder to purchase during the summer, some heroin users began to speedball with crack. This overlap in heroin/cocaine/crack users may be related to the increase in double-breasted dealing described in the section on heroin. Similarly, heroin may be used by crack addicts to dampen the overly agitated effect produced by extended crack use. In both cases, the second drug is used to supplement rather than substitute the primary drug.

New York and Bridgeport ethnographers describe large pieces of crack called "slabs" being sold at the street level in their areas. The slab is a piece of crack about the size and shape of a stick of chewing gum, sometimes scored to form pieces. The slab is sold in the same containers (e.g., vials, bags) as individual rocks or pieces but, due to its size, costs more. This unit is smaller than what was described last year in the *Pulse Check* as the "cookie," a larger piece or sheet of crack sometimes bought for the purposes of resale.

In New York and San Diego, sources report that many crack users look for powder to make their own crack because processed crack is seen as "a bad buy" (i.e., poor quality or made up primarily of adulterants). This is largely due to the perception that dealers are cheating crack users by using very little powder in the cooking process.

Law Enforcement Sources

Police sources in most areas report that cocaine use remains stable. Boston police report fewer crack users, but maintain that crack is still a serious problem in that area. Three police sources (Seattle, Miami, and New York) report double-breasting dealing in their areas. Prices of cocaine are low ($30-$70/gram), and purity varies considerably.

Birmingham police are the only source that reports rising cocaine use in this *Pulse Check*. Crack has become more popular in the inner city; even in the suburbs, which have long been a powder market, police note an increase in the sale and use of crack. Consequently, prices are high; a piece of crack can run from $40 to $50. Police report that this increase in price may reflect the increase in the "yuppie" crack market of casual, middle-class users. Dealers have followed their new clientele into suburban areas, resulting in fewer open air cocaine markets in the inner city.

Treatment Providers

Treatment providers in all areas except the West and Southwest continue to report that cocaine is the most common illegal drug problem of clients seeking substance abuse treatment. While there have been slight decreases in the percentage of treatment admissions with cocaine as the primary drug problem, in general, admissions for cocaine treatment changed little in recent months. The majority of cocaine treatment clients smoke crack and use a variety of other substances. In all regions, alcohol is mentioned as a problem drug by a majority of clients (79-93 percent), as is marijuana (53-80 percent). Heroin, amphetamines, and tranquilizers are also commonly cited as secondary drugs of abuse.

The majority of cocaine treatment clients are white, except in the Midwest, where there is a fairly even proportion of whites and African-Americans. About two-thirds of the clients in all areas are male, and just over half have had prior treatment.

As in the last *Pulse Check*, several treatment providers commented on the "aging" of the crack user population; that is, the hardcore crack user is more likely to be an older user, who also consumes marijuana, alcohol and other drugs, than a teen or young adult. Just 3 to 11 percent of cocaine clients in all areas are below 20 years old. While sources report that there appear to be more young cocaine users seeking treatment in the Northwest, unlike the younger heroin clients, these young cocaine users are more likely to be new to treatment.

Part III: MARIJUANA

The market for marijuana appears to be thriving in the areas surveyed in this *Pulse Check*. Marijuana users are a diverse group, and the drug is highly popular in a variety of social settings. Most sources report that many types of marijuana, both foreign and domestic, can be purchased

in their areas, and many users combine marijuana with other drugs such as alcohol, cocaine, or methamphetamine. Sellers are also a diverse group, reflecting the diversity of users. Treatment providers report that clients who cite marijuana as their primary illicit drug of abuse typically also have problems with alcohol.

Ethnographers and Epidemiologic Sources

Marijuana appears to be plentiful in all areas -- eight of the eleven areas contacted report that use is up, and the remaining three report that the market is stable. Marijuana attracts a wide variety of users, of all ages and ethnicities, and its popularity is growing among young (i.e., under 25) users. It is described as a "background drug" by several sources.

Marijuana is usually combined with alcohol, hallucinogens, cocaine, or methamphetamine. In Miami, users roll marijuana and cocaine into a cigarette called "lace" and in Texas and San Diego, it is combined with crack and called a "primo." In Chicago, marijuana is blended with PCP and crack cocaine into cigarettes called "ozones" that are sold for $15. Sources in San Antonio report that along with marijuana, there has been an increase in white, middle class high school kids using club drugs, including Rohypnol.

Sources of marijuana are both foreign and domestic. Mexico is the most commonly named foreign source, but in areas such as New York, marijuana and hashish from all over the world can be purchased. One New York ethnographer notes that marijuana often has a distinct brand name or place of origin that identifies its type and purported quality. Some marijuana dealers also sell hallucinogens, including LSD, psilocybin, MDMA, and Ketamine, and a variety of pills such as tranquilizers, sedatives, and hypnotics.

Marijuana prices vary widely, and this indicates that there are many different types available. In most areas, Mexican marijuana or poor quality domestic marijuana sells for $10-$15 a bag, which yields 2-4 cigarettes. Exotic varieties or sinsemilia can sell for as high as $200-$1,000/ounce. Similarly, the potency (THC content) and purity (amount of unusable herbage mixed in) varies considerably by type.

Large cigar-like marijuana cigarettes, often called "blunts," remain a staple in most areas. In addition, smoking paraphernalia such as pipes and large water cooled "bongs" continue to appear in many areas, indicating a renewed interest in the drug. While such paraphernalia is illegal in many states, it can be marketed as tobacco supplies or simply sold discretely in small bodegas or convenience stores.

Many sources report that there are a wide variety of sellers, while others report that particular groups dominate the market. In Bridgeport, Jamaicans sell larger quantities of the drug, while in San Antonio, Mexicans and African Americans dominate the trade. In New York, dealers are frequently young people who sell in public parks, near schools and in or around clubs

frequented by teens and young adults. One New York ethnographer notes an increase in marijuana sales around schools or school activities such as sports events, where students or former students who are currently dealing blend into the atmosphere easily.

Law Enforcement Sources

All police sources contacted report that marijuana use is stable or rising in their areas. As with the ethnographers' reports, police describe the user population as diverse, reflecting all ages and ethnicities, though marijuana is particularly popular with the young. Sellers match the demographics of their customers; thus, they too are a diverse group. Miami police report more hydroponically grown domestic marijuana in their area, though the bulk of the marijuana in the area is grown in Mexico or South America.

Street level sales are primarily in one gram bags costing $5 to $10 for ordinary varieties of marijuana, but more exotic varieties (e.g., sinsemilia, Thai, Middle Eastern, Jamaican) can cost up to $500/ounce. The purity of the marijuana is generally related to the price it commands. A police source in New York, however, commented that by labeling it with a foreign name, dealers in the area are able to obtain higher prices for fairly low-quality, domestic marijuana.

Treatment Providers

The percentage of clients entering treatment with marijuana as their primary drug of abuse rose slightly in this round of calls, though most programs report that this represents no visible change in the overall client mix of reported drug problems. About one-quarter to one-third of marijuana treatment clients are under 20 years old, and they are predominantly white. The majority also has problems with alcohol abuse, but has no prior treatment experience.

Part IV: EMERGING DRUGS

Sources contacted for this *Pulse Check* report that methamphetamine is increasingly popular in many areas. In addition, they cite that cafeteria use, that is, simultaneous use of a variety of sedatives, tranquilizers, and traditional and non-traditional drugs of abuse, is prevalent in their areas, particularly among young people.

Methamphetamine is a continuing presence in the West, the Southwest border, and parts of the Midwest, while little or no methamphetamine is reported in the Northeast. It has a large following among young white blue collar workers and laborers as well as among college students. In areas of the West, it is also becoming more popular among the Hispanic population. In Denver, where availability is high, methamphetamine is popular with a wide variety of users, particularly young runaways in Denver and Boulder. The Denver source also notes that there is less "bathtub crank" or poor quality methamphetamine made by individual entrepreneurs in the local market, while there is more high quality crystalline methamphetamine.

The special report on methamphetamine in this issue of the *Pulse Check* describes the problems associated with methamphetamine use in greater detail.

Club drugs. "Cafeteria use" -- the use of a number of hallucinogenic and sedative/hypnotic "club drugs" -- is reported by sources all over the country (i.e., Bridgeport, San Diego, Miami, New York, Austin, and Newark) The club drug mix varies slightly from area to area, but generally includes such drugs as marijuana, Ketamine, LSD, MDMA, Nexus and GHB. In some areas it includes steroids or herbal mixtures such as "power drinks" found in health food stores. In the West and South it typically also includes methamphetamine and prescription drugs (e.g., Clonapin, Ritalin, Lexotan, Rohypnol, Prozac) that come across the Mexican border illegally. Three sources (San Antonio, Miami and Austin) report that Rohypnol is an emerging drug in their areas. Rohypnol has only been reported in areas that are close to the Southwest border.

As the name implies, club drugs are popular with young adults and teenagers who are part of a club scene, and want to take the drugs to gain increased stamina for late night dancing or partying. Many of these young users experiment with a variety of club drugs in different combinations. Club drugs are increasingly mentioned as problematic for treatment programs. Many treatment providers report that teens and young adults enter treatment with a number of these drugs and alcohol, rather than a single drug, as their primary problem.

Previous *Pulse Checks* have reported that middle class high school kids are searching for naturally occurring hallucinogens that are supposed to produce a dream-like state, and this finding is supported by the increased use of some specific club drugs. In Delaware, sources report a wide range of hallucinogens as part of the array of drugs used by young adults, with mushrooms (psilocybin) as particularly popular. In addition, sources in Bridgeport cite mescaline as an emerging drug in that area.

CONCLUSIONS

This issue of the *Pulse Check* finds that the markets for heroin and marijuana are growing, while the market for cocaine is stable. These findings are generally corroborated by all sources in different regions of the country.

According to *Pulse Check* sources, youth drug use is rising. Not only are more young people using heroin and marijuana, cafeteria use of a variety of sedatives and hypnotics is increasingly popular. While the majority of heroin and crack users are a stable, older cohort of long-term users, the continued increase in youth drug use paints a troublesome picture. These findings are consistent with the results of population-based survey research, such as NIDA's *National Household Survey of Drug Abuse*, and University of Michigan's *Monitoring the Future* Study.

This *Pulse Check* also reveals an increase in poly-drug use, and innovative methods of drug use. For example, combining heroin and cocaine powder or crack (speedballing) was reported in several areas, as was cafeteria use. Innovations, such as cooking crack from cocaine powder, or dissolving crack to inject it intravenously, also indicate that users are searching for more creative ways to use drugs.

Treatment providers reported that the majority of their clients enter treatment with cocaine as the primary drug of abuse, while in the West and Southwest, methamphetamine is the most widely cited primary drug of abuse. In the Northeast, Mid-Atlantic and the South, approximately 19 percent of people who enter treatment cite heroin as their primary drug of abuse. In the Midwest, South, and Southwest, this figure is about 10 percent. This indicates that while heroin use is rising, there has not yet been a wide scale entry of heroin abusers into treatment facilities. However, treatment providers do report an increase in the number of young clients who enter treatment with a number of club drugs and alcohol as their problem drug problem.

Sources also reported that methods used to deal heroin and cocaine are becoming more sophisticated. First, there has been an increase in double-breasted dealing. Second, there are more organized, entrepreneurial crews of young dealers who use more efficient distribution methods. Like the well-organized crack dealers of the 1980s, these crews often use beepers to communicate with their clients and they are willing to deliver relatively small purchase amounts to suburban areas. These new crews may in fact be "second generation" crews, that is, they are somehow acquainted with members of the crack crews of the 1980s, and have picked up their methods to deal heroin and cocaine in the 1990s. Since the cocaine market has stabilized, dealers may be looking for innovative ways to reach potential heroin users.

Tables
Fall 1996

Table 1
Ethnographers and Epidemiologists Report on Heroin

	City			
	Bridgeport, CN	**San Antonio/ El Paso, TX**	**San Diego, CA**	**New York, NY**
Use	up	up	stable	stable
Who's Using/ Change in Users	traditional older users and teens/ young adults; more teen users, more female users	Hispanics, gang members, older users; more women, more young users	males, 25-50 years old; more Hispanic users, more young users	traditional older users; more young users, more middle class users
Method of Use	snorting injecting	snorting injecting	injecting snorting	snorting injecting
Drugs in Combination	alcohol; cocaine; crack	cocaine		cocaine
Who's Selling	Young dealers, some selling through beepers.	Both young dealers and older, established dealers	Hispanic males	Crews selling both heroin and cocaine, beeper sales
Purchase Amount/Purity	$10/bag; high purity	$10/bag, $70-1/16 oz.; variable purity	$140 - $200/gram; 40% - 60% purity	$10/bag
Other/Comments	Some sales are through beepers, and deliveries are made to clubs, houses, and suburban areas. Many young users and sellers.		Methamphetamine is the number one problem.	Young users seem to think heroin is controllable compared to crack, and it is part of a battery of drugs used to "party." Better organized street sales.

Table 1 (cont'd.)
Ethnographers and Epidemiologists Report on Heroin

	City			
	Denver, CO	**Miami, FL**	**Chicago, IL**	**Trenton/Newark, NJ**
Use	up	up	up	up
Who's Using/ Change in Users	young, some homeless, some college users; more use among people under 25	older users returning to use, middle class club goers	traditional older users plus young users (teens and 20s); more young users	25-40 years old, some increase in young users; more non-urban users
Method of Use	injecting	skin popping injecting	snorting injecting	snorting injecting
Drugs in Combination	cocaine crack			alcohol
Who's Selling	Mexican nationals and Hondurans at street level		Hispanic dealers for brown heroin; Nigerians for white heroin.	Older teens/young adults
Purchase Amount/Purity	$20/balloon; $30-$35 for 1/4 gram; 3% -15% purity	$10/bag $20/bag; 5% - 20% purity	high purity	$15/bag; good purity
Other/Comments	As compared to the past, more street dealers have both heroin and cocaine, though heroin is still easier to get. Methamphetamine available through white street level dealers.	More old-time shooters are getting a taste for heroin again. It is also being skin-popped in after hours clubs by white upper middle-class adult users.	Users are reporting difficulty getting into treatment and are fearful of medical cuts further limiting their options.	

Table 1 (cont'd.)
Ethnographers and Epidemiologists Report on Heroin

	City		
	New York	**Austin, TX**	**Newark, DE**
Use	up	up (slightly)	up
Who's Using/ Change in Users	more young users	older users (30+), primarily Hispanic;	traditional older users and many teen users; more young users
Method of Use	injecting snorting smoking	injection	snorting injecting
Drugs in Combination	crack cocaine		cocaine
Who's Selling	more independent sellers evident		
Purchase Amount/Purity	$10/bag $100/bundle; declining purity	Black Tar: $2,300 - $6,000/oz.	Purity is good
Other/Comments	There are many more independent sellers who are cutting heroin with odd adulterants i.e., Dramamine, aspirin.	Increasing problems with illicit prescription drugs from Mexico. Also, increase in ER mentions for GHB, including one overdose death.	Heroin use was down a little over the summer, but is gradually rising again, particularly among young (teen) users. It is easily accessible to teens.

Table 2
Law Enforcement Report on Heroin

	City		
	Birmingham, AL P.D.	**Seattle, WA P.D.**	**New York, NY P.D.**
Use	low	up	up
Who's Using/ Change in Users	very few users in area		old users and new young users; more young users
Method of Use		injection	snorting injecting
Drugs in Combination			cocaine
Who's Selling		Mexican traffickers handling all drugs	
Purchase Amount/Purity		$10 - $15/bag (Black Tar); 10% - 70% purity	$10/bag; variable purity
Other/Comments		This area is being "inundated by meth." from Mexico.	

Table 2 (cont'd.)
Law Enforcement Report on Heroin

	City		
	Miami, FL P.D.	**Eugene, OR P.D.**	**Boston, MA P.D.**
Use	stable	stable	up
Who's Using/ Change in Users	primarily older users, but young users increasing; more younger users	older users, white males	wide variety of users, young users
Method of Use	injecting	injecting	snorting injecting
Drugs in Combination	cocaine	methamphetamines	cocaine
Who's Selling	More sales of heroin by crack dealers	Mexican Nationals, local street dealers	Middle Eastern and South American source sellers
Purchase Amount/Purity	$125K/kilo for Colombian; high purity in large quantities	$15/bag $60 - 1/2 gram; variable purity	$10/bag; high purity
Other/Comments			Sellers of both heroin and cocaine evident on the street.

Table 3
Treatment Providers Report on Heroin Use Patterns

	Region			
	I: Northeast N = 13	**II: Mid-Atlantic & South N = 15**	**III: Mid-West N = 13**	**IV: West/ Southwest N = 12**
% clients with drug listed as primary drug of abuse	19	19	10	10
Change over last year				
increase	42%	40%	23%	17%
no change	50%	53%	69%	83%
decrease	8%	7%	8%	0%
% clients injecting	44	78	57	87
% clients inhaling/smoking	56	22	43	13
Other Drugs Abused (% clients who mention)				
cocaine	92%	53%	38%	33%
marijuana	15%	33%	38%	42%
alcohol	92%	60%	77%	67%
tranquilizers	15%	40%	15%	8%
amphetamines	8%	7%	0%	42%
other	8%	40%	23%	42%

Region I: Connecticut, Maine, Massachusetts, New York, New Jersey, Rhode Island, New Hampshire, Vermont, Pennsylvania

Region II: Alabama, Florida, Georgia, Kentucky, Mississippi, Texas, North and South Carolina, Tennessee, Arkansas, Louisiana, Oklahoma, Maryland, Delaware, Virginia, West Virginia, Washington, D.C.

Region III: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, Nebraska, North and South Dakota

Region IV: Colorado, Montana, Utah, Wyoming, Nevada, Arizona, California, Idaho, New Mexico, Washington, Oregon

Table 3 (cont'd.)
Treatment Providers Report on Heroin Use Patterns

	Region			
	I: Northeast N = 13	**II: Mid-Atlantic & South** N = 15	**III: Mid-West** N = 13	**IV: West/ Southwest** N = 13
Average by Age				
under 20	7%	7%	5%	2%
21-30	32%	22%	24%	25%
31+	61%	71 %	71%	73%
Average by Race/Ethnicity				
African-American	38%	38%	52%	12%
White	41%	57%	41%	60%
Hispanic & Other	21%	5%	7%	28%
Average by Sex				
Male	69%	69%	75%	73%
Female	31%	31%	25%	27%
Prior Treatment				
Yes	73%	69%	76%	81%
No	27%	31%	24%	19%

Region I: Connecticut, Maine, Massachusetts, New York, New Jersey, Rhode Island, New Hampshire, Vermont, Pennsylvania

Region II: Alabama, Florida, Georgia, Kentucky, Mississippi, Texas, North and South Carolina, Tennessee, Arkansas, Louisiana, Oklahoma, Maryland, Delaware, Virginia, West Virginia, Washington, D.C.

Region III: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, Nebraska, North and South Dakota

Region IV: Colorado, Montana, Utah, Wyoming, Nevada, Arizona, California, Idaho, New Mexico, Washington, Oregon

Table 4
Ethnographers and Epidemiologists Report on Cocaine/Crack

	City			
	Bridgeport, CN	**San Antonio/ El Paso, TX**	**San Diego, CA**	**New York, NY**
Use	stable	stable	stable	stable
Who's Using/ Change in Users	wide range of users	primarily African Americans, some Hispanics; more Hispanic users	African Americans (crack) 18-35 yrs. old, all groups (HCl)	
Method of Use	smoking snorting	smoking injecting	smoking snorting	smoking
Drugs In Combination	heroin	marijuana heroin	PCP heroin	heroin
Who's Selling	HCl sold with beepers, crack sold on street	More dealers of both heroin and cocaine.	African Americans & Hispanics; beeper sales	Young crews selling heroin also
Purchase Amount/Purity	$5, $10 bag; good purity	$20, $30/bag (HCl) $10, $20, $30/unit (crack)	$80-$100/gram $10 - 1/10 gr. (crack); 20% - 50% purity	$10, $20, $50/bag; $5/vial; purity fair
Other/Comments	There has been a noticeable trend among crack users to add heroin (snorted) to their use. Crack is also now sold as "slabs" or strips of crack in a plastic bag.	There are two major distributors: one uses young dealers to distribute, the other prefers older, experienced dealers.	A lot of users know how to make their own crack, so they buy powder. Vials have given way to tiny ziplock bags, so the product is more visible.	

Table 4 (cont'd.)
Ethnographers and Epidemiologists Report on Cocaine/Crack

	City			
	Denver, CO	**Miami, FL**	**Chicago, IL**	**Trenton/Newark, NJ**
Use	stable	stable	stable	stable
Who's Using/ Change in Users	wide range of ages; African Americans (crack)	Hispanics; decline in young adult use	wide range of users	20-30 yrs. old, all ethnicities; some more young users
Method of Use	injecting smoking	smoking	injecting smoking	
Drugs in Combination	heroin	marijuana alcohol	heroin marijuana	alcohol
Who's Selling	More sellers of heroin & cocaine together	Sellers match the communities they work	Gangs	Non-users primarily selling only cocaine.
Purchase Amount/Purity	$5 - $10/vial	$10, $20/bag $50-$75/gram	$50-$150/gram $3-$20/rock; purity "good"	$10 for 1/10 gram, $60-70/mg variable purity
Other/Comments	Methamphetamine is at highest level of availability in years. Most users are white, young, and equally likely to be male or female.		Hard to find HCl on the street, but crack is available. An "ozone" is a marijuana cigarette with PCP and crack in it that sells for $15.	

Table 4 (cont'd.)
Ethnographers and Epidemiologists Report on Cocaine/Crack

	City		
	New York, NY	**Austin, TX**	**Newark, DE**
Use	stable at high level	stable	stable
Who's Using/ Change in Users	wide range of users, including women & teens; more teens	African American & Hispanic, male & female; more Hispanics	more young users
Method of Use		smoking injecting inhaling	
Drugs in Combination			heroin marijuana
Who's Selling	Young sellers who match community.		Sellers often from larger cities & come into area with supply.
Purchase Amount/Purity	$10-$20/vial $40-$50/gram; purity is "good"	$600-$1,200/oz. $20-$100/gram $10-$40/rock variable purity	Purity is "fair"
Other/Comments	"Slabs" of crack available, increase in number of brand names or bag markings.	Cocaine continues as #1 drug among treatment admissions, though the proportion has dropped slightly. Crack users are older than HCl injectors or snorters.	

Table 5
Law Enforcement Report on Cocaine/Crack

	City		
	Birmingham, AL P.D.	**Seattle, WA P.D.**	**New York, NY P.D.**
Use	up		stable
Who's Using/ Change in Users	inner city crack users; suburban HCl users; some casual middle-class crack users	African American and Hispanic users	variety of users
Method	smoking	inhaling smoking	smoking injecting
Drugs in Combination	marijuana alcohol		heroin
Who's Selling	Fewer open markets; some move to suburban areas.	Crack dealers also selling heroin.	More sales of both heroin and crack by same dealer.
Purchase Amount/Purity	$40 - $50/rock	$30 - $50/gram $10 - $20/rock; 15% - 92% purity (HCl) 30% - 75% purity (crack)	$3 - $10/vial $50 - $70/gram; variable purity
Other/Comments	Increase in crack prices. "Yuppie" crack users in suburbs also reported.	Some Mexican dealers sell heroin cocaine, marijuana and methamphetamine.	

Table 5 (cont'd.)
Law Enforcement Report on Cocaine/Crack

	City		
	Miami, FL P.D.	**Eugene, OR P.D.**	**Boston, MA P.D.**
Use	stable	stable	stable
Who's Using/ Change in Users	No change in users		somewhat fewer crack users
Method of Use	snorting smoking	smoking injecting	
Drugs in Combination		marijuana	
Who's Selling	Crack dealers also selling heroin.	Mexican Nationals.	Dominican and Colombians.
Purchase Amount/Purity	$10 for 1/10 gram $50/gram; high purity	$15, $20 for 1/4 gram; variable purity	$800/oz.
Other/Comments		Methamphetamine is up and often substitutes for the more expensive, less available cocaine.	Crack is somewhat less popular than before.

Table 6
Treatment Providers Report on Cocaine/Crack Use Patterns

	Region			
	I: Northeast N = 15	II: Mid-Atlantic & South N = 17	III: Mid-West N = 15	IV: West/ Southwest N = 14
% clients with drug listed as primary drug of abuse	45	32	34	21
Change over last year				
increase	8%	29%	7%	29%
no change	77%	71%	73%	71%
decrease	15%	0%	19%	0%
% clients injecting	15	9	23	27
% clients inhaling/smoking	85	91	77	73
Other Drugs Abused (% clients who mention)				
heroin	47%	0%	20%	14%
marijuana	53%	59%	80%	57%
alcohol	93%	82%	80%	79%
tranquilizers	7%	12%	7%	7%
amphetamines	0%	12%	33%	21%
other	0%	6%	7%	14%

Region I: Connecticut, Maine, Massachusetts, New York, New Jersey, Rhode Island, New Hampshire, Vermont, Pennsylvania

Region II: Alabama, Florida, Georgia, Kentucky, Mississippi, Texas, North and South Carolina, Tennessee, Arkansas, Louisiana, Oklahoma, Maryland, Delaware, Virginia, West Virginia, Washington, D.C.

Region III: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, Nebraska, North and South Dakota

Region IV: Colorado, Montana, Utah, Wyoming, Nevada, Arizona, California, Idaho, New Mexico, Washington, Oregon

Table 6 (cont'd.)
Treatment Providers Report on Cocaine/Crack Use Patterns

	Region			
	I: Northeast N = 15	**II: Mid-Atlantic & South N = 17**	**III: Mid-West N = 15**	**IV: West/ Southwest N = 14**
Average by Age				
under 20	11%	10%	7%	3%
21-30	33%	44%	36%	46%
31+	56%	46%	57%	51%
Average by Race/Ethnicity				
African-American	39%	42%	47%	17%
White	48%	53%	46%	65%
Hispanic & Other	13%	5%	7%	18%
Average by Sex				
Male	64%	62%	69%	68%
Female	36%	38%	31%	32%
Prior Treatment				
Yes	65%	51%	56%	53%
No	35%	49%	44%	47%

Region I: Connecticut, Maine, Massachusetts, New York, New Jersey, Rhode Island, New Hampshire, Vermont, Pennsylvania

Region II: Alabama, Florida, Georgia, Kentucky, Mississippi, Texas, North and South Carolina, Tennessee, Arkansas, Louisiana, Oklahoma, Maryland, Delaware, Virginia, West Virginia, Washington, D.C.

Region III: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, Nebraska, North and South Dakota

Region IV: Colorado, Montana, Utah, Wyoming, Nevada, Arizona, California, Idaho, New Mexico, Washington, Oregon

Table 7
Ethnographers and Epidemiologists Report on Marijuana

	City			
	Bridgeport, CN	**San Antonio/ El Paso, TX**	**San Diego, CA**	**New York, NY**
Use	stable	stable	up	up
Who's Using/ Change in Users	all ages, all ethnicities; more teens	wide variety of users;	all ethnicities; 18-35 yrs. old; more young users	wide variety of users; more young users
Drugs in Combination		cocaine	cocaine	LSD heroin alcohol
Who's Selling	Wide variety of sellers; Jamaicans sell larger amounts.	Mexican Nationals	African Americans and Hispanics	Sellers generally see only marijuana and hallucinogens, and many have brand identities
Purchase Amount/Purity	$10/bag	$10, $15, $25 per bag	$50-100/oz. (regular); $200-$400/oz. (sinsemilia) ; 8% -16% THC for sinsemilia	variable purity
Other/Comments		There is some evidence in the last 6 months of more white high school kids using Rohypnol. Also sees combinations with crack in "primos."		Marijuana is sold by persons who may also sell pills or hallucinogens. They have developed brand names related to the origin of the marijuana.

Table 7 (cont'd.)
Ethnographers and Epidemiologists Report on Marijuana

	City			
	Denver, CO	**Miami, FL**	**Chicago, IL**	**Trenton/Newark, NJ**
Use	stable	up		up
Who's Using/ Change in Users	wide variety of users	all classes, all ethnicities	diverse group of users	wide variety of users, primarily urban; more young users
Drugs in Combination	alcohol methamphetamine	cocaine		alcohol
Who's Selling				
Purchase Amount/Purity	$425/oz.	$40-50 - 1/8 oz. $250-260/oz.; 8% - 14% THC	$60-200/oz.; variable purity	$19/bag
Other/Comments		Marijuana mixed with cocaine is rolled into a cigarette and called "lace."		

Table 7 (cont'd.)
Ethnographers and Epidemiologists Report on Marijuana

	City		
	New York, NY	**Austin, TX**	**Newark, DE**
Use	up	up	up
Who's Using/ Change in Users	young users under 25; more teens	young, male, all ethnicities; more young users	young users under 25
Drugs in Combination			cocaine
Who's Selling	Young sellers, around schools, public parks		Wide variety of sellers
Purchase Amount/Purity	$5, $10/bag $100-800/oz.	$40-100/oz.	Purity is very poor
Other/Comments	PCP-laced marijuana sells for $15/bag. Many teens smoking "woolies" (fat marijuana cigarettes mixed with PCP or crack)		

Table 8
Law Enforcement Report on Marijuana

	City		
	Birmingham, AL P.D.	**Seattle, WA P.D.**	**New York P.D.**
Use	stable	up	stable
Who's Using Change in Users	white, often rural or suburban users	wide range of users	"everyone"
Drugs in Combination	alcohol	alcohol cocaine	alcohol cocaine
Who's Selling	Sellers operate in suburban/rural areas where customers are.	Mexican traffickers.	Sellers match community they sell to.
Purchase Amount/ Purity	$100/oz.	$200 - $300/oz.; variable purity	$10/bag $100 - $500/oz.; variable purity
Other/Comments			Wide variety in quality and price.

Table 8 (cont'd.)
Law Enforcement Report on Marijuana

	City		
	Miami, FL P.D.	**Eugene, OR P.D.**	**Boston, MA P.D.**
Use	stable	stable	stable
Who's Using Change in Users	wide range of users; none	wide variety of users; none	none
Drugs in Combination		methamphetamine	crack MDMA
Who's Selling	More hydroponic growing sites.	Sellers look like their customers.	Wide variety of sellers.
Purchase Amount/ Purity	$5, $10/bag $2,500/lb for "exotics;" highly variable purity	$15/gram for local $10/gram for Mexican; purity varies by type	$10/gram; variable purity
Other/Comments			Smaller sales units continue to be available almost everywhere.

Table 9
Treatment Providers Report on Marijuana Use Patterns

	Region			
	I: Northeast N = 13	**II: Mid-Atlantic & South** N = 15	**III: Mid-West** N = 13	**IV: West/ Southwest** N = 12
% clients with drug listed as primary drug of abuse	17	16	20	28
Change over last year				
increase	27%	36%	0%	15%
no change	46%	64%	92%	77%
decrease	27%	0%	8%	8%
% clients injecting	NA	NA	NA	NA
% clients inhaling/smoking	NA	NA	NA	NA
Other Drugs Abused (% clients who mention)				
cocaine	36%	36%	8%	8%
alcohol	91%	93%	92%	85%
tranquilizers	0%	7%	0%	0%
hallucinogens	0%	21%	15%	15%
amphetamines	0%	0%	0%	38%
other	0%	14%	0%	23%

Region I: Connecticut, Maine, Massachusetts, New York, New Jersey, Rhode Island, New Hampshire, Vermont, Pennsylvania

Region II: Alabama, Florida, Georgia, Kentucky, Mississippi, Texas, North and South Carolina, Tennessee, Arkansas, Louisiana, Oklahoma, Maryland, Delaware, Virginia, West Virginia, Washington, D.C.

Region III: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, Nebraska, North and South Dakota

Region IV: Colorado, Montana, Utah, Wyoming, Nevada, Arizona, California, Idaho, New Mexico, Washington, Oregon

Table 9 (cont'd.)
Treatment Providers Report on Marijuana Use Patterns

	Region			
	I: Northeast N = 13	II: Mid-Atlantic & South N = 15	III: Mid-West N = 13	IV: West/ Southwest N = 12
Average by Age				
under 20	26%	21%	22%	29%
21-30	42%	40%	37%	38%
31+	32%	39%	41%	33%
Average by Race/Ethnicity				
African-American	27%	25%	31%	14%
White	62%	68%	65%	56%
Hispanic & Other	11%	7%	4%	30%
Average by Sex				
Male	69%	71%	74%	68%
Female	31%	29%	26%	32%
Prior Treatment				
Yes	20%	31%	35%	34%
No	80%	69%	65%	66%

Region I: Connecticut, Maine, Massachusetts, New York, New Jersey, Rhode Island, New Hampshire, Vermont, Pennsylvania

Region II: Alabama, Florida, Georgia, Kentucky, Mississippi, Texas, North and South Carolina, Tennessee, Arkansas, Louisiana, Oklahoma, Maryland, Delaware, Virginia, West Virginia, Washington, D.C.

Region III: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, Nebraska, North and South Dakota

Region IV: Colorado, Montana, Utah, Wyoming, Nevada, Arizona, California, Idaho, New Mexico, Washington, Oregon

Table 10
Ethnographers and Epidemiologists Report on Emerging Drugs

City	Emerging Drugs
Bridgeport, CN	mescaline, LSD
San Antonio/El Paso, TX	Rohypnol
San Diego, CA	MDMA, Nexus, Ketamine
New York, NY	MDMA, Ketamine, Rohypnol, GHB
Denver, CO	Ritalin
Miami, FL	MDMA, Ketamine, Rohypnol
Chicago, IL	Ritalin
Trenton/Newark, NJ	
Austin, TX	ephedrine, pseudoephedrine, illegally used prescription drugs, GHB, Rohypnol
Newark, DE	Ritalin, Prozac, psilocybin, LSD, Ketamine

Table 11
Law Enforcement Report on Emerging Drugs

City	Emerging Drugs
Birmingham, AL	MDMA
Seattle, WA	methamphetamines, Rohypnol
New York, NY	
Miami, FL	Rohypnol
Eugene, OR	
Boston, MA	

Appendix A

OFFICE OF NATIONAL DRUG CONTROL POLICY

PULSE CHECK: Special Report

Methamphetamine Trends in Five Western States and Hawaii

Executive Office of the President
Office of National Drug Control Policy
Barry R. McCaffrey, *Director*

Office of Programs, Budget, Research, and Evaluation
For Distribution Summer 1997

Introduction

Methamphetamine, a powerful central nervous system stimulant, has been part of the drug culture for many years. It was developed early in this century from its parent drug amphetamine and was originally used in nasal decongestants, bronchial inhalers, and in the treatment of narcolepsy and obesity. Legally produced by pharmaceutical houses, amphetamine and methamphetamine were widely available in the 1950s and '60s through prescriptions as well as from a booming black market. The Food and Drug Administration estimated in 1962 that over 8 billion tablets were legally produced each year with as much as half of that production going to unauthorized users.[1] In the 1970s methamphetamine became a Schedule II drug; that is, a drug with little medical use and a high potential for abuse.

Almost from their first appearance, amphetamine and methamphetamine were abused. Valued for the ability to keep a user awake for long periods of time and producing a false sense of energy and enhanced physical and mental performance, these drugs were used in the 1950s and early 1960s among groups such as students, long distance truckers, and sports figures. In addition to the tablet form, in the late 1960s methamphetamine in crystal or liquid form suitable for injection became popular and the terms "crystal," "speed" and "speed freak" became part of the drug vernacular.

Increased Federal regulation of these drugs produced important changes in their availability, and the 1970s saw a marked decline in their use. Often, what was sold on the street as methamphetamine was actually another stimulant like caffeine or ephedrine. Illegal dealers began to rely on domestic illegal laboratories to manufacture supplies for distribution. Highly dangerous, both because of the highly volatile chemicals used in the manufacturing process and the high potential for explosions and fire, methamphetamine production and distribution in the 1970s came to be dominated by outlaw motorcycle gangs operating out of mobile clandestine operations in the California and the Pacific Northwest. Methamphetamine use declined nationwide throughout the 1970s, concentrated in a few cities or regions. However, beginning in the late 1980s it appeared to be spreading from these isolated areas to other new markets and gaining popularity among a larger number of users.

Methamphetamine is a unique drug. In its conventional form, it can be snorted, injected or even eaten. It can also be processed into a potent smokeable form known as "ice," which, starting in Hawaii, gained popularity in recent years in other areas. Methamphetamine is both domestically produced and imported into the U.S. in already processed form. Once dominated by local producers in remote areas of California and the Northwest, the market now includes both locals and, increasingly, Mexican sources providing finished product to stateside distributors. For the local producers the processing required to make methamphetamine from precursor substances is not only easier than it once was, but also more accessible. There are literally thousands of recipes and discussions concerning how to make batches of methamphetamine on the Internet. These entries range from fairly simplistic recipes to highly technical and detailed instructions written by experts.

[1] For a complete discussion of the history of amphetamine use see Grinspoon and Hedblom *The Speed Culture: Amphetamine Use and Abuse in America*, Cambridge MA., Harvard University Press, 1975.

Sources for this Report

Since its first publication in 1992, the *Pulse Check* has reported the rise in methamphetamine use in the West and Southwest and the increasing mention of its use in other parts of the country. This special edition of the ONDCP *Pulse Check* looks at methamphetamine use in six States—New Mexico, Arizona, California, Washington, Oregon and Hawaii—those States which appear to be the hardest hit by the reappearance of methamphetamine.

For this report, a random sample of treatment providers from the National Drug Abuse Treatment Unit Survey was taken, and a brief telephone interview with them conducted during the third and fourth weeks of December 1996. A total of 115 treatment providers were interviewed. The geographic distribution of those providers is illustrated in Figure 1. In addition; drug ethnographers, researchers and law enforcement officials in each State were interviewed. These sources are listed in the Appendix. The interview covers topics such as: who is using the drug; how is it used; what other drugs dominate the area; the price of methamphetamine; how is the drug manufactured and sold.

Each State has a unique experience with the re-emergence of methamphetamine. In the sections which follow, we summarize the results of the study by State.

Methamphetamine in Selected States

CALIFORNIA

For many years methamphetamine abuse was highly localized in specific areas of California, notably San Francisco and San Diego County. In 1990 reports to the Community Epidemiology Work Group, methamphetamine was the most commonly abused drug in the population of persons entering treatment in San Diego. According to the San Diego researcher, in 1996, 45 percent of treatment admissions were due to methamphetamine. In addition, in 1995 arrestees in San Diego represented proportionately more methamphetamine users than at any other Drug Use Forecasting (DUF) site. In San Francisco over the past five years, methamphetamine has been consistently the third most commonly abused drug of clients admitted to treatment (behind heroin and cocaine) in the five counties that make up San Francisco; much of the abuse in the past was concentrated among the male gay community. Increases in other areas and among a wider spectrum of users has continued to the present. For example, Los Angeles, not associated with methamphetamine abuse in the past, currently reports that methamphetamine ranks second after cocaine as the primary drug of abuse at admission to treatment and is second nationwide in the number of emergency room mentions related to methamphetamine.

Methamphetamine use in California is still concentrated in some areas, though surveys of treatment providers show a far wider dispersion of the drug's reach than ever before. The mode of ingestion (snorting and smoking versus injection) and the level of involvement of non-local manufacturers and distributors also differs significantly from the northern to the southern parts of the State.

The prevalence of methamphetamine reported by all California sources reached for this report is consistent with recent DAWN data which places San Diego, San Francisco, and Los Angeles in the top five cities nationwide in emergency room mentions for methamphetamine in 1995. These three cities also lead the nation in the number of medical examiner reports (deaths) related to methamphetamine. There are interesting differences in route of administration reflected in DAWN data between these cities.[2] In San Francisco almost two-thirds of the methamphetamine mentions involve injection, whereas in the other two cities only 10-12 percent of mentions involve injection.

Ethnographic and epidemiologic sources in Los Angeles, San Diego and San Francisco substantiate the DAWN reports. In San Francisco, ethnographic sources report that methamphetamine, while once most popular in the gay community, is now increasingly used by blue collar workers, young professionals, and college students. Putting methamphetamine into coffee in what is termed "biker's coffee" is reported as popular among young professionals interested in the drug's energizing and appetite suppressant effects, but not interested in snorting or injecting the drug. There are reports that in some segments of the gay community use of methamphetamine is related to "marathon sex," often unprotected, where the drug allows the user to stay awake for long stretches of time. As the DAWN data indicate, in this area it is often injected, doubling the risk of transmission of blood borne viruses and sexually transmitted diseases.

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[2] These data should be interpreted with caution as they have problems due to large numbers of unspecified answers.

With the wider variety of users now evident, there is also a wider variety of sellers and distributors. While supplies had previously been part of a "close distribution network" when motorcycle clubs dominated production, there are now different kinds of distributors targeting each of the user populations (college students, young professionals, blue collar workers, and the gay and club communities).

In Southern California, methamphetamine continues to be the number one or two drug problem. DUF data indicate that after a slight drop in the number of arrestees testing positive for methamphetamine in San Diego in 1995, use rose again in 1996, particularly among women and juveniles. In August 1996, 41 percent of women arrested tested positive for methamphetamine. In September 1995, 5 percent of juvenile male arrestees tested positive for methamphetamine. By September 1996 that number had more than doubled to 13 percent. There is also increasing use among Hispanics in this area.

Methamphetamine in the San Diego area comes from two sources: some "Mom and Pop" operations out in rural areas of the county and, more commonly, from Mexican nationals bringing already manufactured methamphetamine across the border. The drug is typically sold in 1/4 gram ($20-25), gram ($50-75) and 1/8 ounce ($140-180) units though larger amounts are available. In this area, sources estimate that less than 10 percent of users inject, most preferring snorting or smoking the drug.

Methamphetamine appears to be second only to crack cocaine in popularity in the Los Angeles area. As in San Diego, there is a growing use among Hispanics, though the majority of users are white males. Methamphetamine is available from individual, local manufacturers in inland areas like Riverside, but the market is increasingly dominated by established Mexican Nationals with more efficient, well-organized distribution routes. In Los Angeles, methamphetamine is most often smoked or snorted rather than injected.

Treatment providers from across the State uniformly report that methamphetamine is one of their most serious problems. Treatment admissions in 1995 for methamphetamine abuse San Francisco, for example, were double the 1992 level. In our survey of providers, 57 percent of programs report that it is continuing to rise in their area; 25 percent feel that it has stabilized and 7 percent report it declining. While methamphetamine is a commonly reported drug, it may not be the primary drug problem which brings their clients to treatment. 39 percent of programs report alcohol as the most common problem among clients at entry into treatment, followed by opiates (18%), methamphetamine (18%), cocaine (14%) and marijuana (11%). However, on average 38 percent of treatment admissions are abusers of methamphetamine. Some programs, like one Northern California adolescent program, report far higher figures: 50 percent of the adolescent clients enter with methamphetamine as their primary drug of abuse and 80 percent report that they regularly use it.

Who is using methamphetamine? There are two basic profiles of users reported by treatment providers:

1) students, both high school and college age, males and females, and

2) white, blue collar workers or unemployed persons in their twenties.

Several providers in Southern California also mention an increase in the number of Hispanic methamphetamine users, though whites still appear to dominate this user group. They are also likely to be users of alcohol and marijuana along with methamphetamine rather than users of drugs like heroin. For example, two methadone programs reported that less than 10 percent of their clients enter treatment reporting that they use methamphetamine. In contrast, programs where alcohol or marijuana are the primary drugs of abuse at entry report that as many as 70-80 percent of their clients also use methamphetamine. 61 percent of treatment providers also felt that there was some substitution of methamphetamine for the less accessible and more expensive cocaine, but many also noted that methamphetamine has a clear following of its own.

What prompts methamphetamine users to enter treatment? Methamphetamine can cause a variety of mental, physical, and social problems which may prompt entry into treatment. Though it is not as expensive as heroin or cocaine, its cost might also produce financial problems for users and prompt them to seek help. Because so many clients in treatment for methamphetamine abuse are also unemployed, one might assume that it could eventually produce difficulties on the job. It is interesting to note, however, that the most commonly reported reason methamphetamine clients enter treatment is trouble with the law. 46 percent of programs report that legal problems are the most common reasons for entry; 29 percent report mental or emotional problems most common and 14 percent report problems on the job or at school.

Several providers also describe methamphetamine abusers as "the hardest to treat." They are often overly excitable and "extremely resistant to any form of intervention once the acute effects of meth use have gone away," e.g., malnourishment, depression, chronic sleeplessness, headaches.

WASHINGTON STATE

For the information concerning methamphetamine in Washington State, two law enforcement officials, a drug researcher at the University of Washington, and a random sample of 16 treatment providers around the State were interviewed.

In addition, we reviewed 1995 DAWN data, available only for Seattle. DAWN data indicate a 7 percent increase from 1994-1995 in the number of medical examiner mentions for Seattle, about 4 percent of all ME deaths reported for 1995. Of the 10,729 ER mentions for Seattle in 1995, approximately 3 percent involved methamphetamine.

All sources describe a rising trend in methamphetamine availability and use, though problems with heroin and cocaine are still dominant in the urban areas of the State. Epidemiologic data indicate that there has been a 252 percent increase in the number of treatment admissions with methamphetamine as the primary drug of abuse between 1992 and 1995. The overwhelming majority of methamphetamine admissions are of whites (almost 90%); 40 percent are in their late twenties and early thirties and 37 percent are injecting the drug.

Epidemiologic sources point out that while the majority of users continues to be rural bikers and blue collar workers, there are also a number of other groups now using. For example, it is reported that the drug is becoming increasingly popular among street youth, among Native American populations and among Hispanic immigrants. This source describes this as a diffusion from rural to urban, from gay populations to heterosexuals and from white to minorities.

Sellers and manufacturers in Washington State, including both local residents and Mexican Nationals, are reported to be increasing in number. One Seattle law enforcement source describes the increase in distribution and use as "remarkable in the last 18 months." The increase in the number of prosecutions from seven in 1991 to 52 in 1995 indicate the growth in the sheer number of dealers. Labs are reported as springing up in a variety of places: hotels, motels, backrooms of other facilities. DEA sources report that, as in California, Mexican meth dealers are using the same routes and distributors for meth as they use or have used for heroin and cocaine. This source also reports the practice of "eating" meth; that is, putting it on paper or food and chewing it, though injecting and snorting are the most common modes of ingestion.

Among **treatment providers** interviewed around the State, 94 percent reported that methamphetamine use is increasing in their area. The remaining 6 percent report that it has stabilized. Though no programs reported that methamphetamine use was the primary drug of abuse for most of their clients at treatment entry, on average, approximately 30 percent of those in treatment use the drug. As is reported in California, the most common reason cited for meth using clients to seek treatment is trouble with the law (50%), followed by mental and family problems.

There is a wider variety of methods of using methamphetamine in the Washington area than in some of the other States. Providers report that clients are equally likely to smoke, inject, or snort it. 81 percent of Washington treatment providers also reported that methamphetamine is substituting for the more expensive and far less accessible cocaine. Almost 70 percent reported that use is up because methamphetamine is cheap and/or readily available throughout the State. Methamphetamine, like marijuana, is considered a "local" or "homemade" drug.

Who is using meth in Washington State? The typical user is described as white, high school educated, in his or her twenties and thirties, and a blue collar or service worker. Several providers stress that this is not someone who also uses heroin and cocaine. Two directors of Seattle programs which serve heroin users state that less than 5 percent of their clients use methamphetamine. Most often the companion drugs used by methamphetamine users are alcohol and marijuana. As one provider comments, "It is the alcohol that brings them in here. Once in treatment, we see the problems with speed, pot, and hallucinogens."

OREGON

All sources describe methamphetamine as a "continuing problem" in Oregon. Methamphetamine has been part of the drug scene there since the 1960s—a part that did not disappear completely as it did in many other areas of the country. Oregon has also been one of the States with steady activity in the production of methamphetamine and distribution to other areas of the West. Whereas other States may report only a handful of laboratory busts or supply seizures over the last twenty years, Oregon law enforcement reports consistent activity surrounding the drug.

DAWN data from medical examiners in Portland indicates a decline in deaths due to methamphetamine from 1994-1995. Similarly, data gathered from police sources in Eugene, regional DEA agents and treatment providers indicates that, while there may be some stabilization, methamphetamine use is still a major drug problem in the State.

Law enforcement sources report that methamphetamine continues to plague the area. July of

1995 brought one of the largest laboratory busts in an area of rural Oregon where manufacturers were producing as much as 100 pounds of methamphetamine per batch. This bust led to related police action involving distributors across the Canadian border. While a portion of the drug is still produced locally, police sources report that currently the bulk of the supply now comes from California and Mexico. Production of methamphetamine is described as having "always been around" in rural Oregon. However, it is now no longer just a local operation managed by a handful of producers in small labs.

Treatment providers throughout the State describe methamphetamine as a problem. 47 percent of those interviewed reported that methamphetamine is the primary drug of abuse of their clients, followed by 40 percent reporting alcohol and 13 percent reporting marijuana as the primary problem. A average of 52 percent of clients across all programs use methamphetamine. In one small rural Oregon town, the treatment director commented that these are areas where "people don't use cocaine—wouldn't think of it—but speed is widely accepted, particularly among 18-25 year olds." Another program which dealt only with adolescents reports that only 10 percent come into treatment with meth as the primary problem (that is usually alcohol or marijuana), but 70-80 percent use it. Many providers also commented on its availability due to "homemade" sources. 80 percent of providers reported the prevalence of meth in their area as due primarily to its low cost and/or wide availability.

Who is using meth in Oregon? The typical Oregon user is quite similar to that reported in other States: white, often male, a blue collar worker now unemployed, in his/her twenties and early thirties. Adolescent programs also report methamphetamine use among students, sometimes as young as ninth graders. The most common reason for treatment entry is legal troubles. The most common method of ingestion in this area is snorting, followed by injecting and, to a far lesser degree, smoking.

ARIZONA

Like Southern California, Arizona has reported problems with methamphetamine use and trafficking for several years. Sitting at the southwest border, Arizona has been struggling with the traffic in what one source described as "first the makings for the cake (chemicals) and now the cake itself (processed methamphetamine)" for many years.

DAWN data indicate that Phoenix ranks third nationwide in the number of methamphetamine ER mentions in 1995 with 732 mentions, about 10 percent of all Phoenix ER mentions, though this number has been decreasing over the last few years. Medical examiner data from Phoenix is also somewhat encouraging, indicating a substantial decline (29%) in the number of deaths attributable to methamphetamine. Approximately 42 percent of these mentions involve smoking of the drug, the most common method reported in the State by all sources.

Ethnographic sources report that methamphetamine in both urban and rural areas is a widely prevalent, and may be increasingly popular among young users where "it has not received the attention cocaine has; does not have the 'mystique' cocaine has." Users tend to be either White, rural blue collar workers who have used the drug for many years or urban cocaine users who are switching to methamphetamine. The latter users are described as people who can not get cocaine and/or those who burn out on the drug and "need the stronger, longer lasting and cheaper high meth can provide." The problem noted by this source is that users burn out even faster often developing even higher levels of paranoia or other dysfunctional behavior than they experience with cocaine.

Law enforcement sources in Phoenix report that methamphetamine continues as the "drug of choice" in Arizona, the number one street trafficking drug problem. Though this source describes adult use as stabilizing somewhat, like the ethnographic source, he feels that adolescent use appears to be increasing as adolescents "feel more confident of its safety," perceiving it safer than cocaine. These users are more likely to snort the drug, though some are injecting.

Street level trade in methamphetamine is brisk in Phoenix. Prices range from $20–$25 for a 1/4 gram unit to $160-$180 for 1/8 ounce. Sellers tend to be U.S. citizens selling their own local product or Mexican nationals selling methamphetamine produced across the border. Many local labs continue to spring up in the area and it is estimated that police uncover one or even two a week.

Of the 24 Arizona **treatment providers** interviewed, 71 percent felt that methamphetamine use was up in their area, overwhelmingly (72%) because it is cheap and/or available. While alcohol (46%) and cocaine (17%) are the primary drugs of abuse at entry in most programs, methamphetamine (13%) ranks third. In addition, these programs report an average of 40 percent of their clientele using methamphetamine at entry. Smoking and snorting the drug are most common routes of administration.

As in other States, providers in Arizona report troubles with the law (63%) as the most common catalyst to treatment entry, followed by family problems (21%) and financial problems (8%). Most of the clients they see who are abusing methamphetamine are young (twenties) and either unemployed or employed in a blue collar occupation. While the typical user is still currently white, several providers noted the increase in methamphetamine abuse among young Hispanics and Native American populations. Urban areas like Phoenix and Tucson also reported the popularity of methamphetamine among the gay population due its image as an enhancer of sexual stamina.

NEW MEXICO

Law enforcement sources in New Mexico report that methamphetamine is readily available in that State, both from heavy trafficking across the border and from the local operations which spring up, particularly in rural or remote areas. Though there are many "match book" or "do-it-yourself" operations in the area, the bulk of the supplies to New Mexico come from the larger and more efficient Mexican based producers. The number of seizures of methamphetamine has increased dramatically since the early 1990s, including an almost 700 pound seizure in New Mexico in 1994.

The demand is both the traditional older "biker" users as well as former cocaine and crack users switching to the cheaper, longer lasting high. When cocaine is available, it is preferred by many of these users. This source reports that in fact, many users buy methamphetamine marketed as cocaine.

Half of the 16 **treatment providers interviewed** report that methamphetamine use has increased in the past year, while 44 percent report that it has stabilized in their areas. Three-fourths of the programs report that the primary drug of abuse at entry for most of their clients is alcohol, followed by opiates (13%). No program reported that the majority of their clients report methamphetamine as the primary drug problem, and the average proportion of clients using meth at entry is 27 percent.

Several providers report that the stabilization in use is due to crackdowns on local labs in their area as well as a rise in the popularity of heroin in the State. Methamphetamine is described as widely

available, however. As one provider commented, "They think they won't become addicted and it is cheaper than anything but pot." Programs in remote or very rural areas of the State often report users who value the drug for its ability to keep them working on farms or in oil fields for long periods of time allowing them to accumulate extra or overtime pay. Too often, that pay is spent on the common companion or primary drug problem, alcohol.

The typical users in New Mexico are white, unemployed, and in their twenties. They are as likely to snort the drug as they are to inject it. As in the other States, the most common reason for seeking treatment among meth abusers is trouble with the law. One provider describes a male client who abuses alcohol and methamphetamine and routinely gets into brawls as a result. The aggression produced by inebriation, heightened by the paranoia and sense of physical prowess produced by methamphetamine, combine to make him a regular with the local authorities. Methamphetamine also, however, makes him a difficult arrestee to manage in small facilities.

HAWAII

Sources in Hawaii report the greatest prevalence of methamphetamine use and the widest range in types of users of all the States surveyed. Most often in the smokeable crystalline form called "ice" in the mainland but a number of other names in Hawaii, methamphetamine is reported among whites, Asians, males and females, students, blue collar workers, and professionals. It is smoked in expensive glass pipes, mixed with tobacco, or even in pipes made from soda cans.

Drug research sources in Honolulu report that while methamphetamine has wide appeal in that area, it is also associated with violent episodes and difficulty in successful treatment. In a study in the early 1990s, 40 percent of prisoners admitted to local facilities had used methamphetamine. Sources of the drug are both local and from other areas in the Pacific, though the drug is distributed and readily available through local dealers of other drugs like cocaine and heroin.

69 percent of **treatment providers** interviewed felt that methamphetamine use had increased over the past year and 25 percent felt it was stabilizing. It is the primary drug of abuse at entry for 38 percent of programs interviewed, second only to alcohol (44%) and followed by marijuana (19%). An average of 55 percent of the clients at entry use methamphetamine, and, as in other States, it is trouble with the law which prompts them to seek treatment most of the time (44%). Several providers receive clients through employee assistance programs which refer employees who have exhibited inappropriate or aggressive behavior on the job or chronic absenteeism.

The typical user profile is harder to draw for Hawaii. While many programs report that users are young (teens and twenties), there is a range of jobs, ethnicities, and education levels reported. No program reports that clients inject; users either smoke methamphetamine (81%) or inhale it (25%). A commonly reported problem in treating these clients is that they "rarely admit to methamphetamine abuse. They will tell you about "huffing" (inhalant abuse) if they are kids or about alcohol if they are adults, but fail to mention the meth until you ask them." Methamphetamine users do, however, need extended treatment, according to several treatment providers, particularly if they have been smoking for a year or more.

SUMMARY

Methamphetamine abuse is a continuing problem in these Western states and in Hawaii. While the drug has been used in these States for many years by a small number of users, it has gradually become the drug of choice and primary drug of abuse at entry to treatment in many areas, even overtaking the more common drug problems of heroin and cocaine in treatment populations. Even in areas where alcohol is cited as the most common treatment problem, methamphetamine is often the companion drug, along with marijuana, in anywhere from 25 to 80 percent of the cases.

Methamphetamine is a drug with particular appeal to students and to blue collar workers, using it for recreation, to increase job or school performance, or simply to stay energized for long periods of time. It is cheaper and more accessible than cocaine and appears not to have the same stigma associated with it. As one ethnographer comments, "These users are too young to remember the 'Speed Kills' campaigns of the late 60s and early 70s, and seem to think it is pretty harmless." It can be injected, snorted, smoked or even eaten, making it more versatile drug to administer. However, it is also a drug which has high burnout potential. Treatment providers in all States report users enter treatment more rapidly with methamphetamine than with either heroin or cocaine.

One particularly interesting finding from these surveys is the uniformity of response in terms of why users decide to enter treatment. Over 50 percent of providers in each State cited legal problems as the catalyst for most of their methamphetamine clients' entry into treatment. These legal problems are described as aggressive behaviors like fighting or bizarre or inappropriate behaviors which prompt others to call the police. Police sources also note that arrestees under the influence of methamphetamine are some of the most difficult to manage due to high levels of hostility, paranoia and agitation.

This report also finds that methamphetamine is readily available in these six States. It is both locally manufactured by small producers operating in a variety of places and using recipes widely circulated in the drug culture and, increasingly (on the U.S. mainland), manufactured and distributed by Mexican nationals through local networks already established in the distribution of other drugs. This more efficient routing may be in part responsible for its increased popularity in many areas.

CITIES REPRESENTED IN SAMPLE OF TREATMENT PROVIDERS

Washington

Kirkland
Seattle
Wenatchee
Spokane
Yakima
Everett
Longview
Pasco
Tacoma

Arizona

Phoenix
Tempe
Tucson
Holbrook
Kingman
Chinle
Chandler

New Mexico

Albuquerque
Carlsbad
Alamogordo
Hobbs
Santa Fe

Hawaii

Honolulu
Kailua
Wahiawa
Waianae
Lihue
Pearl Harbor
Ewa Beach
Makawao
Wailuku

Oregon

John Day
Eugene
Medford
Portland
Pendleton
Albany
Salem
Hillsboro

California

Desert Hot Springs
Fresno
San Francisco
Los Angeles
Hawaiian Gardens
Berkeley
Chico
Hayward
Bakers Field
Modesta
Sacramento
Redwood City
Culver City
Bellevue
Canoga Park
San Mateo
Compton
Cypress
Long Beach
Chula Vista
Inglewood
Costa Mesa
Sonora

ETHNOGRAPHIC/DRUG RESEARCH SOURCES

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Appendix B

Pulse Check Methodology

Since its first publication in 1992, the *Pulse Check* has provided the most current intelligence about drug markets and patterns of drug abuse nation-wide. The *Pulse Check* draws on discussions with ethnographers and epidemiologists working in the drug field, law enforcement agents, and drug treatment providers across the country. Approximately seventy-five people are called for each report.

Ethnographers, Epidemiologists, and other Ethnographic Sources

Ethnography is a mode of research that analyzes the behavior of groups in the natural settings in which these behaviors occur. Ethnographers use field observations and interviews to gather data. Ethnography is *not* undercover work. Rather, the ethnographer, who is fully revealed as a social science researcher, enters the drug user's world to record and describe it "on its own terms," that is, without predetermined ideas.

Epidemiologists are also consulted for the *Pulse Check*. Epidemiologists study the origins, spread, and control of diseases, in a general public health paradigm. In the field of substance abuse, they track changes in patterns of drug use, including the incidence and prevalence of the use of specific drugs, characteristics of users, and emerging trends. Many epidemiologists who report for the *Pulse Check* are members of the National Institute on Drug Abuse (NIDA) Community Epidemiology Working Group (CEWG).

Other ethnographers, such as sociologists and psychologists who use ethnographic research techniques, also are included as sources for the *Pulse Check*.

The ethnographic sources contacted by *Pulse Check* include some of the best known drug researchers in the country. In some cases, they are trained ethnographers; in other cases, they are epidemiologists with access to ethnographic information; a few are social researchers working in a field site collecting ethnographic data. Reporters are generally the same for each round of calls.

The following twelve ethnographers, epidemiologists, and other ethnographic sources from urban areas were contacted for this issue of *Pulse Check*:

Austin, TX: Jane Maxwell, M.A. Director of Needs Assessment Department, Texas Commission on Alcohol and Drug Abuse.

Bridgeport, CN: Garry Geter. Addictions Counselor, Connecticut Department of Health.

Chicago, IL: Wayne Weibel, Ph.D. Associate Professor of Epidemiology and Director of

Community Outreach Intervention Projects, University of Illinois School of Public Health.

Denver, CO: Stephen Koester, Ph.D. Professor, University of Colorado School of Medicine.

Miami, FL: Bryan Page, Ph.D. Professor of Anthropology and Psychiatry and Deputy Director, Center for the Biopsychosocial Study of AIDS, University of Miami.

Newark, DE: Mario Pazzaglini, Ph.D. Private Consultant to State of Delaware and several drug treatment facilities. Formerly with the State of Delaware, Bureau of Alcoholism and Drug Abuse and the University of Delaware.

New York, NY: Doug Goldsmith, M.A. Ethnographer, NDRI (a non-profit drug research company).

New York, NY: John Galea, M.A. Chief of Ethnography, New York State Office of Alcoholism and Substance Abuse Services. Former Commanding Officer of the New York City Police Department Youth Gang Intelligence Unit.

San Antonio/El Paso, TX: Reyes Ramos, Ph.D. Professor of Health Sciences, University of Texas.

San Diego, CA: Susan Pennell, M.A. Director, Criminal Justice Research Division, San Diego Association of Governments.

Trenton/Newark, NJ: John French, M.A. Chief Epidemiologist, New Jersey Department of Public Health.

Police Sources

Police sources are drawn from the Abt staff's existing contacts within law enforcement and from contacts developed through the recommendations of law enforcement agencies. These sources are typically officers working on special squads, narcotics task forces, and DEA agents.

This issue of *Pulse Check* reached police sources in six cities. Reporters are generally the same for each round of calls; however, when police contacts must change as officers take on new positions, replacements are typically made on the recommendation of the officer who had been the *Pulse Check* reporter.

Treatment Providers

The sample of treatment providers is derived from the National Facility Register, a directory of treatment programs compiled by the Substance Abuse and Mental Health Administration, from which this sample from the Uniform Facility Data Set (formerly the

National Drug Abuse Treatment Unit Survey) is drawn within the U.S. Department of Health and Human Services. The listings are divided into four regions that have a similar number of treatment programs and are treated equally for sampling. The states in each region are listed below.

- ***Region I:*** Connecticut, Maine, Massachusetts, New York, New Jersey, Rhode Island, New Hampshire, Vermont, Pennsylvania

- ***Region II:*** Alabama, Florida, Georgia, Kentucky, Mississippi, Texas, North Carolina, South Carolina, Tennessee, Arkansas, Louisiana, Oklahoma, Maryland, Delaware, Virginia, Washington, D.C., West Virginia

- ***Region III:*** Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, Nebraska, North Dakota, South Dakota

- ***Region IV:*** Colorado, Montana, Utah, Wyoming, Nevada, Arizona, California, Idaho, New Mexico, Washington, Oregon

This *Pulse Check* incorporates the comments of 61 treatment providers. From each of the four regions listed above, 20 large (over 100 clients) programs and 20 small (under 100 clients) programs were identified, 10 to 15 of each type were contacted, and the remaining 5 served as replacements. The samples are stratified to include equal numbers of large and small programs.

Topics of Discussion

Below is a sample of topics that are raised with *Pulse Check* reporters.

ETHNOGRAPHERS, EPIDEMIOLOGISTS, AND LAW ENFORCEMENT SOURCES

- Level of illicit drug use in the community. Changes in the use of drugs over the last six months.

- Age, ethnicity, and sex of users in your area.

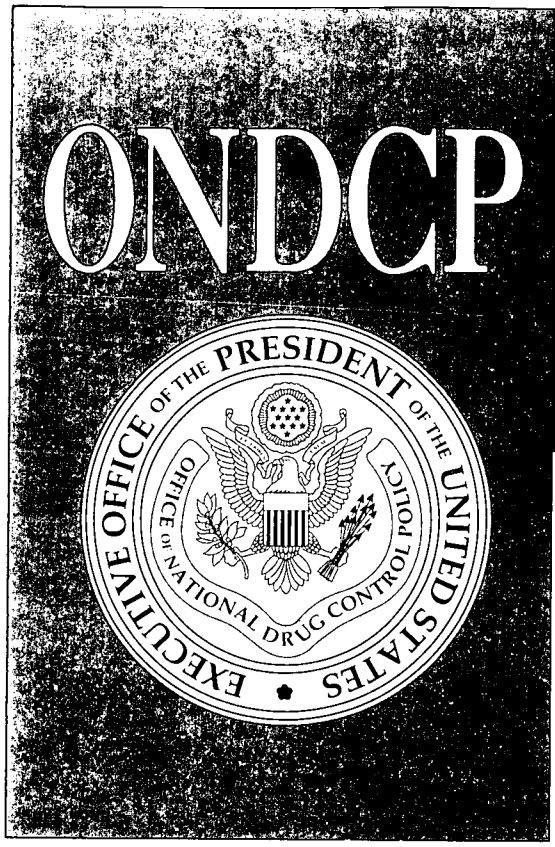
- Frequency of use, prevailing routes of administration. Changes over the last six months.

- Who is selling. Changes in this group over the last six months. Other drugs sold by this group.

- Current prices. Changes in prices over the last six months. Typical units of purchase.

TREATMENT PROVIDERS

- Proportion of population reporting heroin/cocaine/marijuana/alcohol as the primary drug of abuse.
- Proportion of population that is injecting versus inhaling/smoking the drug. Changes in this proportion over the last six months.
- Other drugs used.
- Characteristics (age, ethnicity, and sex) of clients.
- Proportion of population that has had prior treatment.



The ONDCP Drugs & Crime Clearinghouse

1-800-666-3332

email: askncjrs@aspensys.com
fax: 301-251-5212

P.O. Box 6000
Rockville, MD 20849-6000

The ONDCP Drugs & Crime Clearinghouse –

- operates a toll-free 800 number staffed by drugs and crime information specialists
- distributes Office of National Drug Control Policy and Department of Justice publications about drugs and crime
- answers requests for specific drug-related data
- performs customized bibliographic searches
- advises requesters on data availability and of other information resources that may meet their needs
- maintains a public reading room

Affiliated with the National Criminal Justice Reference Service

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