

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

VOLUME I: HIGHLIGHTS AND EXECUTIVE SUMMARY

DECEMBER 2000



COMMUNITY EPIDEMIOLOGY WORK GROUP
National Institute on Drug Abuse

NATIONAL INSTITUTES OF HEALTH

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The National Institute on Drug Abuse (NIDA) acknowledges the contributions made by the members of the Community Epidemiology Work Group (CEWG) who voluntarily have invested their time and resources in preparing the reports presented at the meetings.

The data in Volume I (this volume) of this publication were extracted from 21 city drug abuse indicator trend presentations. The full edited text from those reports appears in Volume II. Volume II also contains the full edited text of reports on specialized topics.

This publication was developed by Rebecca Chalmers, Marcia Meth, and staff of Johnson,

Bassin & Shaw, Inc., under subcontract to CDM Group, Inc., contract number N01DA-65054, for the National Institute on Drug Abuse.

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For more information about the Community Epidemiology Work Group, and for some past publications, visit the CEWG home page through the NIDA Web site:

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National Institute on Drug Abuse
NIH Publication No. 01-4916

Printed April 2001

FOREWORD

The Community Epidemiology Work Group (CEWG) is a drug abuse surveillance network established by the National Institute on Drug Abuse (NIDA), National Institutes of Health (NIH) in 1976. It is composed of researchers from 21 sentinel areas of the United States who meet semiannually to present and discuss quantitative and qualitative data related to drug abuse. Through this program, the CEWG provides current descriptive and analytical information regarding the nature and patterns of drug abuse, emerging trends, characteristics of vulnerable populations, and social and health consequences.

The 49th meeting of the CEWG, held in San Francisco, California, on December 12–15, 2000, provided a forum for presentation and discussion of drug abuse data in the United States, Canada, and Mexico as well as in East Asia, with a focus on Malaysia and Thailand. This meeting also provided the opportunity for presentation of research findings on important topics of both national and international concern: risk behavior associated with HIV/AIDS, drug abuse treatment and HIV preventive interventions, and the cost-benefit relationship of potential HIV vaccines. In addition, the venue in San Francisco afforded the opportunity for presentation and discussion of drug-abuse-related issues of special concern to the local community. These included a summary retrospective on drug abuse in San Francisco from the 1960s until the present and advances in the neurobiology of addiction by Dr. David Smith, founder of the Haight-Ashbury Free Clinics; an

ethnographic perspective on homeless heroin injectors and crack smokers by Dr. Philippe Bourgois; conditions and circumstances that define a heroin overdose by Dr. Shieghla Murphy; drug abuse and sexual risk behavior in the Latino gay male community by Dr. Raphael Diaz; and medical consequences from soft tissue infections among IDUs by Dr. Dan Ciccarone. In addition, Dr. Alice Gleghorn moderated a panel consisting of Dr. Grant Colfax, Nathan Purkiss, and Emanuel Sferios on behavior, public policy, outreach, and intervention concerning club drugs at raves and circuit parties. Finally, Dr. Ed Bein, Dr. Darryl Inaba, and Kirsten Melbye provided a historical review and described current innovative approaches to treating heroin abusers in the bay area.

These wide-ranging research and other presentations pointed out unique and local aspects of drug abuse and social and health consequences that have confronted and continue to concern the city of San Francisco. They also served to capture the diversity and community-based nature of drug abuse: its emergence in the community, its imposition on the community, and its resolution by the community. They underscored, once again, the necessity of establishing effective networks of drug abuse surveillance at the local level in communities throughout the world.

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CONTENTS

	Page
FOREWORD	iii
LIST OF REPORTS IN VOLUME II	vi
INTRODUCTION	1
HIGHLIGHTS	
Drug Highlights	3
Regional Highlights	8
City Highlights	12
EXECUTIVE SUMMARY	
Cocaine and Crack	15
Heroin	31
Marijuana	48
Methamphetamine	60
“Ecstasy”	71
Gamma Hydroxybutyrate (GHB)	78
Hallucinogens	82
Abused Pharmaceuticals: Opiates	86
Abused Pharmaceuticals: Stimulants	90
Abused Pharmaceuticals: Depressants	91
Other Illicit Drugs and Abused Pharmaceuticals	94
Infectious Diseases Related to Drug Abuse	96

LIST OF REPORTS IN VOLUME II

CITY REPORTS

Atlanta: Metropolitan Atlanta Drug Abuse Trends

Claire E. Sterk and Katherine P. Theall

Baltimore: Drug Use in the Baltimore Metropolitan Area: Epidemiology and Trends

Leigh A. Henderson

Boston: Drug Use Trends in Greater Boston and Massachusetts

Thomas W. Clark, Elsa A. Elliott, and Stephen Soldz

Chicago: Patterns and Trends of Drug Abuse in Chicago

Wayne Wiebel, Steven Diaz, Susan Bailey, Kujtim Sadiku, and Lawrence Ouellet

Denver: Drug Use Trends in Denver and Colorado

Bruce Mendelson

Detroit: Drug Abuse Trends in Detroit/Wayne County, Michigan

Richard F. Calkins

Honolulu: Illicit Drug Use in Honolulu and the State of Hawaii

D. William Wood

Los Angeles: Drug Abuse Trends in Los Angeles County

Sharon M. Boles and Caitlin Beck

Miami: Drug Abuse in Miami and South Florida

James N. Hall, Joe Spillane, and Madeline Camejo

Minneapolis/St. Paul: Minneapolis/St. Paul Drug Abuse Trends

Carol L. Falkowski

Newark: Heroin as the Drug of Choice in Newark

Abate Mammo, Richard J. Schadl, and Anna Kline

New Orleans: Drug Abuse Indicators in New Orleans

Gail Thornton-Collins

New York City: Drug Use Trends in New York City

Blanche Frank and John Galea

Philadelphia: Drug Use in Philadelphia, Pennsylvania

Mark R Bencivengo and Samuel J. Cutler

Phoenix: Drug Abuse Trends in Phoenix and Arizona

Ilene L. Dode and Christy Dye

St. Louis: Drug Trends in St. Louis

Heidi Israel-Adams and James Topolski

San Diego: Indicators of Drug Abuse in San Diego County

Michael Ann Haight

San Francisco: Patterns and Trends of Drug Abuse in the San Francisco Bay Area

John A. Newmeyer

Seattle: Recent Drug Abuse Trends in Seattle-King County

T. Ron Jackson, Ellen Silverman, Arnold F. Wrede, L. David Murphy, Michael Hanrahan, Hanne Thiede, Holly Hagan, Richard Harruff, Kris Nyrop, Fiona Couper, Steve Freng, and Susan Kingston

Texas: Substance Abuse Trends in Texas

Jane C. Maxwell

Washington, DC: Patterns and Trends of Drug Abuse in Washington, DC

Marianna T. Toce, Alfred Pach, Felicia Gray Cerbone, Jerry Brown, and James C. Hendrickson

INTERNATIONAL REPORTS

Canada: The Canadian Community Epidemiological Network on Drug Use: Overview Report, 2000
Eric Single

Canada (Toronto): An Overview of Drug Use in Toronto, 2000
Joyce Bernstein

Mexico: Update of the Epidemiologic Surveillance System of Addictions (SISVEA) in Mexico
Roberto Tapia-Conyer, Patricia Cravioto, Pablo Kuri, Arturo Revuelta, Mario Cortes, and Blanca de la Rosa

East Asia: Subregional Development of Institutional Capacity for Demand Reduction Among High-Risk Groups
Marc Morival

Malaysia: A Study of Amphetamine-Type Substance Users in Penang, Malaysia: Preliminary Findings
Vis. Navaratnam, B. Vicknasingam, and Hilal Hj Othman

Thailand: The Amphetamine-Type Stimulants Epidemic in Thailand: A Case Study of the Treatment, Students, and Wage Laborer Populations
Vichai Poshyachinda, Usaneya Perngparn, and Vipa Danthamrongkul

RESEARCH REPORTS

Explaining Drug Preferences: Heroin, Crack, and Fortified Wine in a Social Network of Homeless African-American and White Injectors
Philippe Bourgois and Jeff Schonberg

Soft Tissue Infections among Users of Black Tar Heroin: A Cross-Methodological Examination
Dan Ciccarone, Philippe Bourgois, Edward Murphy, Alex Kral, Karen Seal, Jeff Moore, and Brian R. Edlin

Drug Use and Sexual Risk Among Hispanic Gay Men in Three U.S. Cities
Rafael Diaz

Substance Abuse Concerns in the San Francisco Area Rave/Club Drug Task Force Recommendations: Public Policy Implications
Ellen Komp

Initiating Mobile Methadone Services in San Francisco
Kirsten A. Melbye

What Exactly is a Heroin Overdose?
Sheigla Murphy

Cost Effectiveness of Potential HIV Vaccines
Douglas Owens, Donna Edwards, and Ross Shacter

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

INTRODUCTION TO VOLUME I

The 49th meeting of the Community Epidemiology Work Group (CEWG) was held December 12–15, 2000, in San Francisco, California. During this meeting, 21 CEWG representatives reported on current drug trends and patterns in U.S. cities. The following highlights and executive summary are based on these reports.

DATA SOURCES

To assess drug abuse patterns and trends, city- and State-specific data are gathered and compiled from a variety of health and other drug abuse indicator sources. Such sources include public health agencies, medical and treatment facilities, criminal justice and correctional offices, law enforcement agencies, surveys, and other sources unique to local areas, including:

- **Drug-related deaths** reported on death certificates by medical examiner (ME)/local coroner offices, by State public health agencies, or by the Drug Abuse Warning Network (DAWN) of the Substance Abuse and Mental Health Services Administration (SAMHSA)
- **Drug-related emergency department (ED) mentions** (estimated mentions and estimated rates per 100,000 population) reported by DAWN (Note: Mentions differ from episodes—each ED episode may involve one or more mentions of specific drugs.); and ED mentions reported by local poison control centers and hospitals

- **Primary substance of abuse** of clients at admission to treatment programs, as reported by drug abuse agencies
- **Arrestee urinalysis results** based on data collected by the Arrestee Drug Abuse Monitoring (ADAM) program of the National Institute of Justice
- **Seizure, price, purity, prescription/distribution, and arrest data** obtained from the Drug Enforcement Administration (DEA) and from State and local law enforcement agencies

Additionally, these quantitative data are enhanced with information obtained through field reports, focus groups, interviews, and other qualitative methodologies. Such observations are interspersed throughout executive summary discussions of indicator data; these excerpts and extracts may be set off in indented, bold italics.

A NOTE TO THE READER

The highlights and executive summary are organized by specific drug of abuse. Please note, however, that multiple-drug abuse is the normative pattern among a broad range of substance abusers. Furthermore, most indicators do not differentiate between cocaine

hydrochloride (HCl) and crack. Finally, local comparisons are limited, especially for the following indicators:

- **Mortality**—Definitions associated with drug deaths vary. Common reporting terms include “drug-related,” “drug-induced,”

“drug-involved,” and “drug detections”—these terms have different meanings in different areas of the country.

- **Treatment admissions**—Many variables affect treatment admission numbers, including program emphasis, slot capacity, data collection methods, and reporting periods. While most areas report citywide data, Colorado, Hawaii, and Texas report statewide data.
- **Arrests and seizures**—The number of arrests, seizures, and quantity of drugs confiscated often reflect enforcement policy rather than levels of abuse.

The following methods were applied to facilitate local area comparisons in the highlights and executive summary:

- Most ED data are based on data files run by SAMHSA in March 2000. These data reflect weighted estimates of the number of mentions based on a sample of hospital emergency departments.
- Long-term ED trend data cover 1994 through 1999. Short-term comparisons are based on data for 1998 versus 1999. Increases or decreases are noted only when they meet standards of precision at $p < 0.05$.
- Unless otherwise specified, all percentages for treatment program admissions are calculated based on admissions excluding alcohol-only but including alcohol-in-combination. Comparisons are generally for first half 1999 versus first half 2000, unless specified otherwise.

- Percentage-point increases or declines between reporting periods generally are noted only when they are 5 points.
- Row percentages in tables do not always add up to 100 percent, often because of rounding or large numbers in the “unknown” or “other” categories.
- Comparisons of ADAM arrestee urinalysis data are based on full-year figures for 1998 and 1999. More current data are not available.
- Heroin purity levels per milligram were obtained from the DEA Domestic Monitor Program, Intelligence Division, Domestic Unit. Comparisons are for full year 1999 versus the first quarter of 2000.
- Cumulative totals of acquired immunodeficiency syndrome (AIDS) cases for the total United States are based on the *HIV/AIDS Surveillance Report* 12(1):8,9,12, 2000, from the Centers for Disease Control and Prevention (CDC).

Local areas vary in their reporting periods. Many indicators reflect fiscal periods that may differ between local areas.

Some indicator data are unavailable in certain areas. The symbol “NR” in tables refers to data not reported.

In some 100-percent bar charts, the bars do not equal 100 percent for a variety of reasons, including the existence of categories such as “other,” “unknown,” or “not reported.”

Drug Highlights

Cocaine indicators continue to suggest declining or stable trends in most CEWG areas. Heroin indicators increased or remained stable, with younger age groups continuing to initiate intranasal use and some shifting to injecting. Marijuana indicators show mostly stabilizing trends after the upsurge in the 1990s. Methamphetamine indicators continue to decline in western CEWG sites, except for law enforcement indicators, which trended upwards in most CEWG areas. "Club drugs," especially "ecstasy" (MDMA), GHB and its precursors (GBL and 1,4 BD), and ketamine, continue to spread across the country. Ecstasy remains highly available, and its use continues to increase in many areas. The abuse of pharmaceuticals, especially in combination with other drugs, may be increasing in many CEWG areas.

COCAINE AND CRACK

Most cocaine indicators during this reporting period declined or remained stable, with exceptions in Denver, St. Louis, and Seattle, where some indicators resurged. Projected mortality data¹ showed mixed trends: increases were reported in five areas (Detroit, Minneapolis/St. Paul, Philadelphia, San Diego, and Seattle) and decreases in four (Honolulu, Miami, Phoenix, and St. Louis). Cocaine emergency department (ED) mentions² decreased in nine cities (significantly in six: Boston, Dallas, Newark, New Orleans, New York, and Washington, DC, and nonsignificantly in three); they increased in nine cities (significantly only in two: Denver and Phoenix, but nonsignificantly in seven). Cocaine is the primary drug of choice for treatment admissions³ in six CEWG sites, and, similar to ED trends, treatment admissions declined or remained stable in most areas. Positive arrestee urinalysis percentages⁴ among adult males were relatively stable, except for declines at two sites (Los Angeles and Philadelphia) and increases in Dallas and Laredo; the drug is now

surpassed by marijuana in all but six sites. By contrast, among female arrestees, cocaine remains the most commonly detected drug in all but one city (San Diego), and positive urinalysis trends for females are also mixed, with increases in three cities (Chicago, Dallas, and Minneapolis/St. Paul) and decreases in Houston, Laredo, Los Angeles, and Seattle. The 35-and-older cohort increased in most sites among ED mentions, while among cocaine treatment admissions, that age group showed mixed trends. Speedball injections (crack or cocaine hydrochloride [HCl] combined with heroin) continued in some cities, including Atlanta, Baltimore, Boston, Philadelphia, and St. Louis; freebasing cocaine may be increasing in Atlanta and Washington, DC. Cocaine price and purity are stable in most reporting areas, with the exception of HCl purity increases reported in New York City and San Diego and declines in Chicago and Seattle. Cocaine HCl availability seems to be increasing in Chicago, Dallas (where crack availability is also up), and Denver (where crack availability is down).

HEROIN

Heroin indicators continued to rise or remain stable at elevated levels. Mortality figures¹ increased or were stable: deaths increased in

six areas (Detroit, Honolulu, Minneapolis/St. Paul, Philadelphia, Phoenix, and San Diego) and remained stable in three. ED mentions²

increased in most cities, with five significant increases (in Denver, Miami, New Orleans, San Francisco, and St. Louis) and four non-significant increases. Only in Washington, DC, did ED mentions significantly decline. Heroin is the primary drug of abuse among treatment admissions³ in seven CEWG sites. Positive arrestee urinalysis levels⁴ among adult males remained relatively low (ranging from 3.4 to 20.1 percent positive) and stable in most cities, except for Washington, DC, where levels increased by 6 percentage points. Among females, opiate-positive levels increased substantially in two sites (Chicago and Phoenix) and declined in Detroit. Younger age groups continued to initiate heroin use in many cities; additionally, older age groups (35+) may be increasing in several cities. Intranasal use

remained the most mentioned starting mode of administration among new younger users, but progression to injecting is widely reported. Moreover, injecting increased in several northeastern cities, including Newark, New York City (especially among older users), and Philadelphia. Other drugs, including depressants, other opiates, and cocaine, continue to be used concomitantly or as heroin substitutes. Purity⁵ averages range from 16 percent in Dallas to 77 percent in Newark. Purity trends were mixed, with notable increases in six areas (Boston, Denver, Miami, Newark, Phoenix, and San Francisco), declines in five (Atlanta, Baltimore, Los Angeles, New Orleans, and St. Louis), and stable trends in remaining areas. The rise in heroin use could presage a rise in HIV/AIDS, hepatitis B, and hepatitis C.

MARIJUANA

Indicators were mixed, with many showing stability after the upsurge in the 1990s. Marijuana ED mentions² were mixed, with significant increases in three sites (Baltimore, Minneapolis/St. Paul, and Phoenix) and significant declines in three (Boston, New Orleans, and San Diego). Marijuana is the predominant drug problem among treatment admissions³ in three areas (Denver, Minneapolis/St. Paul, and Seattle). However, the proportion of marijuana admissions referred by the criminal justice system is very high in most reporting areas when compared with other drug clients. Among adult males, marijuana surpassed cocaine as the most commonly detected drug in arrestee urinalyses⁴ in the majority of CEWG cities. Positive findings continue to increase—sharply in three cities (Atlanta, Los Angeles, and Miami). Levels also increased or remained stable among female arrestees, except for one notable

decline in Seattle. Although marijuana use among adolescents remains prevalent in CEWG cities (as demonstrated by high marijuana-positive levels among juvenile arrestees), the ages of marijuana users are shifting from adolescents to young adults in several cities, including Atlanta, Miami, and Washington, DC. Blunts remain common, especially among youth, in many sites including Boston, Chicago, New York City, Philadelphia, and Washington, DC. Blunts or joints also continue as a delivery medium for other drugs: PCP in Chicago, Philadelphia, and Washington, DC; embalming fluid and PCP in Minneapolis/St. Paul and Texas; cocaine in Boston, Chicago, Philadelphia, and Washington, DC; and codeine cough syrup in Texas. Availability of high-quality, indoor-grown marijuana (“hydro”) continued to increase in many CEWG cities.

METHAMPHETAMINE

Methamphetamine remains concentrated in the West and, to a lesser extent, in some rural areas elsewhere. In the West, most indicators (except for law enforcement) continued showing the declines reported since 1998. Declining indicators may be due to reduced precursor availability and increased law enforcement attention. In nonwestern cities where methamphetamine use is low, methamphetamine users are predominantly students, clubgoers, or gay males who engage in multisubstance use. Methamphetamine ED mentions² declined significantly in

six cities (Atlanta, Dallas, Miami, New York, Phoenix, and San Diego) and increased significantly in three (Baltimore, St. Louis, and Seattle). Methamphetamine remains the foremost primary drug problem among treatment admissions³ in Honolulu and San Diego. Positive arrestee urinalysis levels⁴ among adult males remained relatively low and stable, except in San Diego, where they declined notably; percentages among females increased notably in Seattle and declined notably in Phoenix.

"ECSTASY"

Ecstasy (methylenedioxymethamphetamine, MDMA), used primarily at dance clubs, raves, and college scenes, continues to increase in nearly every CEWG city—an increase that continues to be driven by two factors: high availability due to large shipments from European countries, and the misconception that it is a relatively harmless drug. In 2000, deaths involving ecstasy were reported in six CEWG areas: Detroit, Minneapolis/St. Paul, Philadelphia, South Florida, Texas, and Washington State. Ecstasy ED mentions² across the United States increased significantly; ED rates per 100,000 population were highest in New Orleans and Miami (at 4.2 and 3.1, respectively). Poison control calls related to ecstasy are relatively high in reporting areas, and treatment

admissions are emerging. Ecstasy use seems to be spreading outside the club drug scene to include casual social settings, singles bars, mainstream dance clubs, house parties, or streets in several CEWG cities: Atlanta, Baltimore, Boston, Chicago, Denver, New York, and Seattle. The use of ecstasy in combination with other drugs is reportedly common. Additionally, substances entirely different from MDMA are used as adulterants in ecstasy pills. Ecstasy adulterants include **paramethoxyamphetamine (PMA)** (a substance responsible for several overdose deaths), other stimulants, dextromethorphan (DXM), and ketamine. Ecstasy is most often available in a logo-emblazoned pill form, but a powder form is also available in New York, Seattle, and Washington, DC.

GAMMA HYDROXYBUTYRATE (GHB)

Gamma hydroxybutyrate (GHB, a central nervous system depressant considered a club drug) and two of its precursors **gamma butyrolactone (GBL)** and **1,4 butanediol (1,4 BD)**, have been increasingly involved in poisonings, overdoses, drug rapes and other criminal behaviors, or fatalities in nearly all CEWG

cities and their surrounding suburban and rural areas. In 1999 and 2000, GHB-related deaths were reported in five CEWG areas: Minneapolis/St. Paul, Missouri, South Florida, Texas, and Washington State. Overdoses are more frequent with GHB than with other club drugs, especially when used in combination with

alcohol. GHB ED mentions² across the United States increased significantly; ED rates per 100,000 population were highest in San Francisco and New Orleans (at 8.6 and 6.3, respectively). GHB, most often found as a clear liquid, is manufactured in clandestine labs,

often mixed with beverages, and sold in nightclubs and raves. Its precursors, often sold as nutritional supplements, are obtainable over the Internet and sold in health food stores, gyms, and bars. Like other club drugs, GHB is often taken in combination with other drugs.

HALLUCINOGENS

Phencyclidine (PCP) ED mentions² were mixed. Positive arrestee urinalysis levels⁴ remained generally stable. PCP is sold in liquid form and continues to be combined with marijuana in Chicago, Philadelphia, St. Louis, and Washington, DC. In Minneapolis/St. Paul and Texas, marijuana joints are dipped in embalming fluid containing PCP. **Lysergic acid diethylamide (LSD, “acid”)** ED mentions² increased significantly in eight cities; no

significant declines were recorded. In several CEWG areas, LSD used in combination with other club drugs continues to be reported among youth. LSD typically appears as a liquid or on blotter paper, but in Washington, DC, a new “crystal” form has emerged. **Psilocybin mushrooms** (“shrooms”) are common among youth in Boston, Minneapolis/St. Paul, Seattle, and Texas. **Peyote** continues to be available in Phoenix.

ABUSED PHARMACEUTICALS

Licit opiates, such as **hydrocodone** (Vicodin, Hycodan, Lortab, Lorcet, and NORCO) and **oxycodone** (Percodan, Percocet, and OxyContin—a high-potency, time-released form of oxycodone), are increasingly available. Treatment and ethnographic sources in Atlanta, Baltimore, Boston, and Phoenix mentioned the emergence of OxyContin abuse, and deaths involving oxycodone have increased in Philadelphia. Youth reportedly abuse the stimulant **methylphenidate** (Ritalin) in four sites (Atlanta, Boston, Detroit, and Texas), typically by crushing the tablets and using them intranasally. Other licit stimulants reportedly abused include **dextroamphetamine** (Dexedrine), pills containing **ephedra**, and pills containing **ephedrine**. Use of the veterinary anesthetic **ketamine** (“K,” “Special K,” or “vitamin K”), available in the nightclub and rave scenes, continues to increase, especially among White

youth. It is most often sold as a powder, but it is available as a liquid in Chicago and New York City (where it is injected), a tablet in Philadelphia, and all three forms in Seattle. The use of benzodiazepines, such as **clonazepam** (Klonopin), **alprazolam** (Xanax), and **diazepam** (Valium), remains common in CEWG areas, especially in combination with other drugs, such as cocaine or heroin. **Flunitrazepam** (Rohypnol), a benzodiazepine illegal in the United States but legally prescribed in Mexico, is sometimes used as a club drug, and it has been associated with drug-assisted rape. Reports of its use have been declining in recent years, and its abuse is very low or nonexistent in most CEWG areas except Atlanta and Texas (especially along the Mexican border). Other licit drugs abused in CEWG cities include **carisoprodol** (Soma) in combination with opiates; products containing **dextromethorphan** (DXM)

among youth; inhalants, such as **nitrous oxide**, among clubgoers; **sildenafil citrate** (Viagra) used in combination with club drugs; **steroids**

among bodybuilders; and in New York, drugs used to treat HIV/AIDS.

¹Mortality trends are projections based on the first half or first three quarters of 2000 data versus 1999 and were available for cocaine- and heroin-related deaths in nine areas; changes are noted only when they are ≥ 5 percentage points.

²Emergency department (ED) mentions are for 20 CEWG cities in the Drug Abuse Warning Network (DAWN) of the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies (OAS); comparisons are for 1998 versus 1999; statistically significant equals $p < 0.05$; nonsignificant changes are noted only when they are ≥ 5 percentage points.

³Treatment admission figures were reported in 18 CEWG sites and are primary drug of abuse as a percentage of total admissions; comparisons are for the first half of 1999 versus the first half of 2000, unless otherwise specified.

⁴Arrestee urinalysis data are for 19 CEWG cities (including 4 in Texas) in the National Institute of Justice (NIJ) Arrestee Drug Abuse Monitoring (ADAM) program; comparisons are for 1998 versus 1999; changes are noted only when they are ≥ 5 percentage points.

⁵Heroin purity information is for 20 CEWG sites (including 2 in Texas) in the Drug Enforcement Administration (DEA) Domestic Monitor Program (DMP); comparisons are for the first quarter of 2000 versus 1999.

REGIONAL HIGHLIGHTS: THE NATION



EAST

Cocaine: #1 ED in most cities; #1 treatment drug in some cities; indicators ↓ or stable; speedballs continue

Heroin: #1 treatment and ED drug in some cities; most indicators ↑ or stable; most use high purity Colombian heroin intranasally; combinations common

Marijuana: ED mixed; other indicators ↑ or stable in most cities; blunts common; combinations common, especially PCP or cocaine; "hydro" ↑

Methamphetamine: Indicators at low levels, law enforcement indicators ↑ in some cities

Club drugs: Ecstasy, GHB/GBL, ketamine ↑; combinations common

Abused pharmaceuticals: OxyContin abuse emerging; diverted prescription drugs ↑; Ritalin, DXM abused by youth in some cities

WEST

Cocaine: #1 ED in most cities; indicators mixed

Heroin: #1 ED and treatment drug in some cities; most indicators ↑ or stable; most inject Mexican black tar

Marijuana: #1 treatment drug in some cities; most indicators ↓ or stable; PCP-laced joints in some cities

Methamphetamine: #1 treatment drug in some cities; indicators mixed

Club drugs: Ecstasy, GHB/GBL ↑; combinations common

Abused pharmaceuticals: Opiate mortality ↑ in some cities

CENTRAL

Cocaine: #1 ED; #1 treatment drug in most cities; indicators mixed

Heroin: Indicators ↑ in most cities

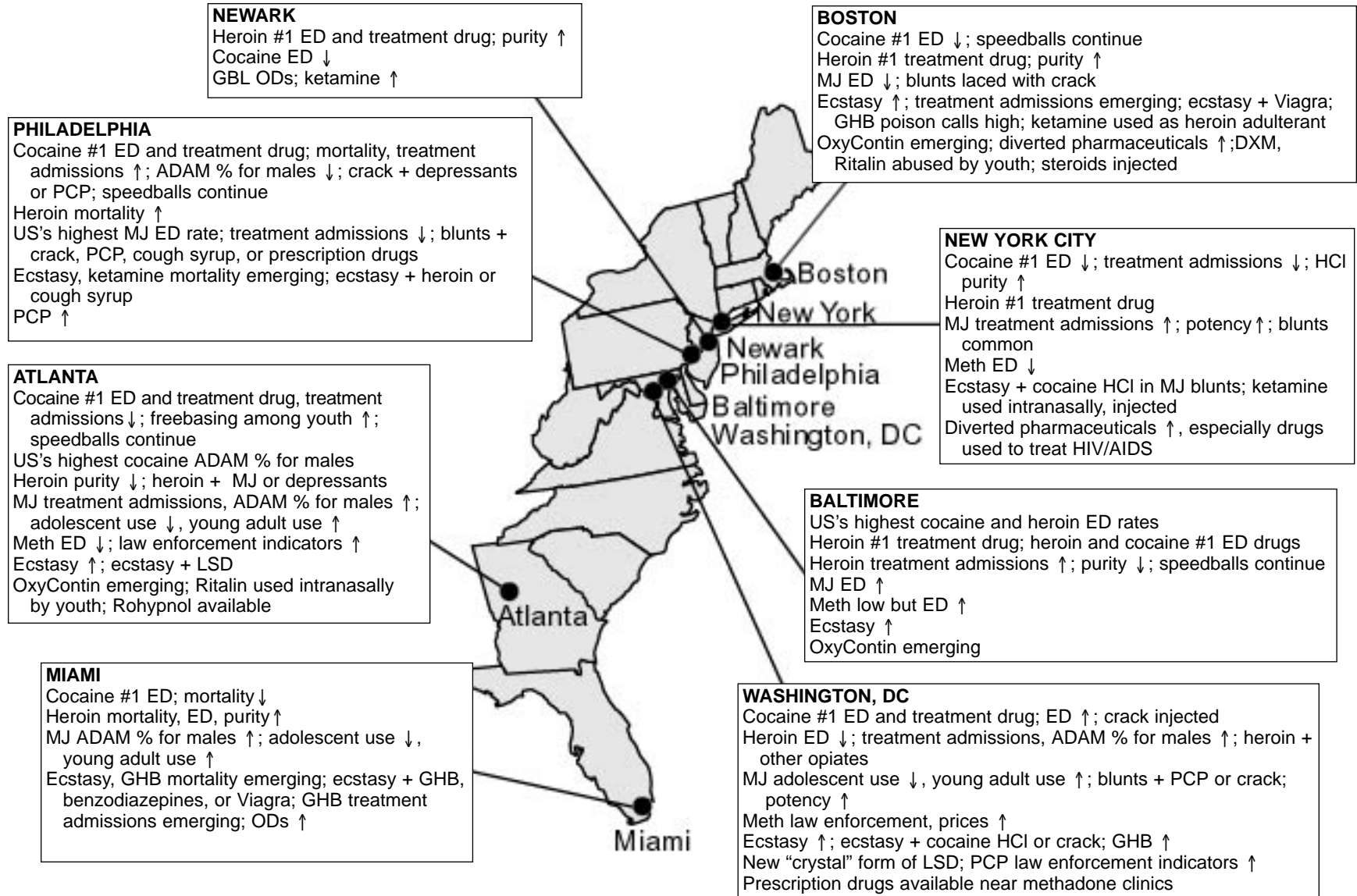
Marijuana: Indicators mostly stable; combined with PCP, embalming fluid, or crack in some cities

Methamphetamine: Indicators mostly stable

Club drugs: Ecstasy, GHB/GBL, ketamine ↑ in most cities

Abused pharmaceuticals: DXM, Ritalin abused by youth in some cities

REGIONAL HIGHLIGHTS: EAST



REGIONAL HIGHLIGHTS: CENTRAL

MINNEAPOLIS/ST. PAUL

US's lowest heroin and MJ ED
 Cocaine #1 ED; mortality, ADAM % for females ↑
 MJ #1 treatment drug; ED; MJ + PCP,
 embalming fluid
 Heroin mortality ↑; prices ↓
 Meth law enforcement indicators ↑
 Ecstasy, GHB mortality emerging; GHB ODs ↑
 DXM, Ritalin abused by youth

DETROIT

Cocaine #1 ED; mortality ↑
 Heroin mortality, purity ↑; ADAM % for females ↓
 US's highest MJ ADAM % for males
 Ecstasy, ketamine mortality emerging;
 ecstasy poison calls ↑; GHB poison calls ↓
 DXM, Ritalin abused by youth



CHICAGO

Cocaine #1 ED and treatment drug;
 purity ↓; HCl availability ↑
 US's highest cocaine ADAM % for
 females ↑, highest opiate % for
 males and females ↑
 MJ blunts laced with crack or PCP
 Ecstasy ↑

ST. LOUIS

Cocaine #1 ED and treatment drug;
 mortality ↓; speedballs continue
 Heroin ED, treatment admissions ↑;
 purity ↓
 MJ treatment admissions ↑; joints + PCP
 Meth low, but ED ↑
 Ketamine theft ↑

NEW ORLEANS

Cocaine #1 ED ↓
 Heroin #1 treatment drug; ED,
 treatment admissions, prices ↑; purity ↓
 MJ ED ↓

REGIONAL HIGHLIGHTS: WEST

SEATTLE
 Cocaine and heroin #1 ED; cocaine mortality ↑; ADAM % for females, HCl purity ↓
 Heroin treatment admissions ↑
 MJ #1 treatment drug; ADAM % for females ↓; MJ + PCP
 Meth ED, ADAM % for females, law enforcement indicators ↑
 Ecstasy ↑; ecstasy + LSD or GHB; GHB ODs ↑
 Opiate mortality ↑

DENVER
 Cocaine #1 ED ↑; HCl availability ↑, crack ↓
 MJ #1 treatment drug, but admissions ↓; poison calls ↑
 US's highest MJ ADAM % for females ↑
 Heroin ED, poison calls, purity ↑
 Meth poison calls ↑
 Ecstasy ↑; GHB poison calls ↑

SAN FRANCISCO
 Heroin #1 ED and treatment drug; ED, purity ↑
 US's highest meth ED rate

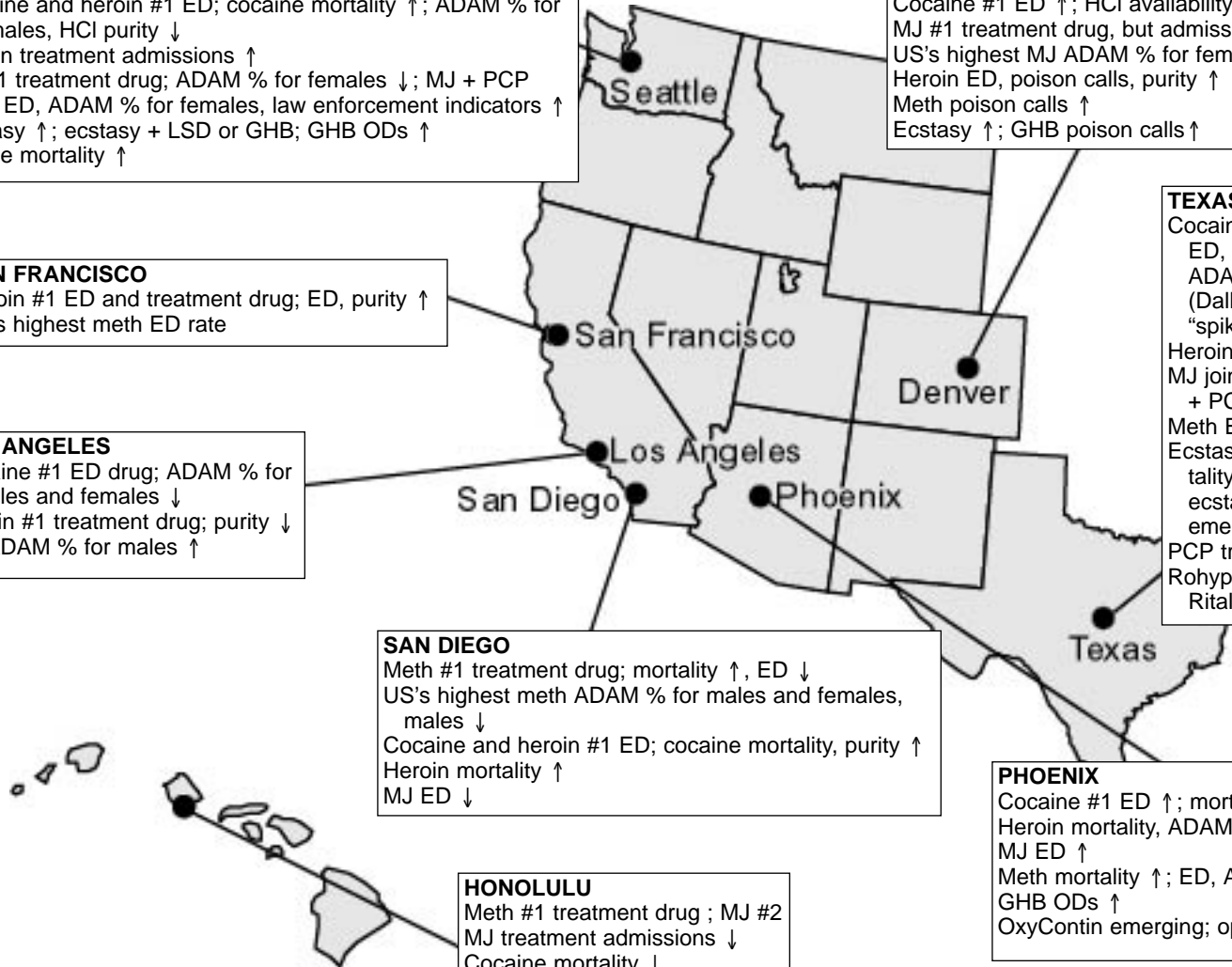
TEXAS
 Cocaine #1 ED and treatment drug; ED, treatment admissions ↓; ADAM % for males and females (Dallas) ↑, poison calls ↑; crack "spiked" with codeine (Austin)
 Heroin + depressants
 MJ joints dipped in embalming fluid + PCP or codeine cough syrup
 Meth ED ↓
 Ecstasy, GHB, and ketamine mortality emerging, poison calls ↑; ecstasy and GHB treatment emerging; ecstasy + heroin tablets
 PCP treatment admissions ↑
 Rohypnol treatment admissions ↑; Ritalin used intranasally by youth

LOS ANGELES
 Cocaine #1 ED drug; ADAM % for males and females ↓
 Heroin #1 treatment drug; purity ↓
 MJ ADAM % for males ↑

SAN DIEGO
 Meth #1 treatment drug; mortality ↑, ED ↓
 US's highest meth ADAM % for males and females, males ↓
 Cocaine and heroin #1 ED; cocaine mortality, purity ↑
 Heroin mortality ↑
 MJ ED ↓

PHOENIX
 Cocaine #1 ED ↑; mortality ↓
 Heroin mortality, ADAM % for females, purity ↑
 MJ ED ↑
 Meth mortality ↑; ED, ADAM % for females ↓
 GHB ODs ↑
 OxyContin emerging; opiate mortality ↑

HONOLULU
 Meth #1 treatment drug ; MJ #2
 MJ treatment admissions ↓
 Cocaine mortality ↓



CEWG CITY HIGHLIGHTS: KEY ABUSED DRUGS, DECEMBER 2000

12

AREA	COCAINE	HEROIN	MARIJUANA	OTHER DRUGS OF NOTE
Atlanta	ED rate 189; 52% of TXs; \$100/g, crack \$85–\$100/g; cocaine injected and freebased	ED rate 16; 4% of TXs; \$1.18/mg; 41% pure (↓); speedball use; combined with cocaine, mj, or depressants	ED rate 91; 21% of TXs; domestic \$120–\$240; sinsemilla \$160–\$250/oz	Methamphetamine ED rate 3 (↓), law enforcement indicators ↑; ecstasy ↑, combined with LSD; OxyContin ↑; Ritalin abused by youth; Rohypnol available
Baltimore	ED rate 296; 15% of TXs	ED rate 299; 51% of TXs; \$.35/mg; 18% pure (↓); speedball use	ED rate 72 (↑); 15% of TXs	Methamphetamine ED rate (↑); ecstasy ↑; OxyContin ↑
Boston	ED rate 96 (↓); 22% of TXs; \$50–\$90/g (40–90% pure), crack \$10–\$20/rock (30–40% pure); crack injected; marijuana laced with crack	ED rate 76; 70% of TXs; \$.62/mg; 66% pure (↑); speedball use	ED rate 53 (↓); 6% of TXs; commercial \$200–\$250/oz; sinsemilla \$200–\$300/oz; blunts laced with crack	Ecstasy ↑, TX mentions, combined with Viagra; GHB poison calls high; OxyContin ↑; Ritalin, DXM abused by youth; diverted pharmaceuticals ↑; ketamine used as heroin adulterant; steroids injected
Chicago	ED rate 225; 25% of TXs; \$50–\$100/g (39% pure), crack \$5–\$20/rock	ED rate 164; 16% of TXs; \$.70/mg; 23% pure	ED rate 77; <1% of TXs; blunts laced with PCP or crack	Ecstasy ↑
Denver	ED rate 87 (↑); 14% of TXs; \$80/g; crack \$10–\$20/rock	ED rate 41 (↑); 10% of TXs; \$.71/mg; 28% pure (↑)	ED rate 43; 28% of TXs; commercial \$50–\$100/oz; sinsemilla \$100/oz; BC bud \$500/oz	Methamphetamine ED rate 6, 9% of TXs; ecstasy ↑; GHB poison calls ↑
Detroit	302 deaths in first 3Q00; ED rate 178; crack \$5–\$50/rock	356 deaths in first 3Q00; ED rate 62; \$.64/mg; 52% pure	ED rate 95	2 ecstasy deaths in 1999, poison calls ↑; GHB poison calls ↓; Ritalin, DXM abused by youth; 4 ketamine deaths in first 3Q00; steroids available
Honolulu	11 deaths in 1H00; 12% of TXs; \$100–\$120/g (20–50% pure), crack \$5–\$15/dose	12 deaths in 1H00; 10% of TXs; \$200/g; 67% pure	28% of TXs; “low quality” \$250–\$500/oz; “high quality” \$400–\$800/oz	Methamphetamine 50% of TXs, remains #1 TX drug
Los Angeles	ED rate 79; 17% of TXs	ED rate 35; 46% of TXs; \$1.58/mg; 20% pure (↓)	ED rate 64; 7% of TXs; sinsemilla \$10–\$80/oz	Methamphetamine ED rate 11, 7% of TXs
Miami	26 deaths in first 3Q00; ED rate 210	50 deaths in first 3Q00; ED rate 48 (↑); \$1.03/mg; 23% pure (↑)	ED rate 67; commercial \$700–\$1,000/lb; hydroponic \$500+/oz	Methamphetamine ED rate (↓); 7 ecstasy deaths in first 3Q00, combined with GHB, benzodiazepines, Viagra; 3 GHB deaths in 2H99, ODs ↑, TX emerging
Minneapolis/St. Paul	46 deaths in first 3Q00; ED rate 34; 14% of TXs; \$100/g; crack \$20/rock	47 deaths in first 3Q00; ED rate 9; 3% of TXs; \$900/g	ED rate 26 (↑); 23% of TXs; \$165/oz; combined with PCP and embalming fluid	Methamphetamine ED rate 5, law enforcement indicators ↑; 5 ecstasy deaths in first 3Q00; 2 GHB deaths in 1999, ODs continue; Ritalin, DXM abused by youth
Newark	ED rate 172 (↓); 9% of TXs; crack \$5–\$50/bag	ED rate 260; 79% of TXs; \$.25/mg (↑); 78% pure (↑)	ED rate 29; 6% of TXs	GBL ODs; ketamine ↑
New Orleans	ED rate 176 (↓); 21% of TXs; \$80–\$150/g; crack \$5–\$25/rock	ED rate 55 (↑); 30% of TXs; \$1.64/mg; 25% pure (↓)	ED rate 86 (↓); 26% of TXs; commercial \$130–\$170/oz; sinsemilla \$350–\$450/oz	Dilaudid substituted for heroin

CEWG December 2000

New York City	ED rate 175 (↓); 29% of TXs; \$20–\$50/g, crack \$5–\$50/bag	ED rate 110; 44% of TXs; \$.27/mg; 60% pure	ED rate 41; 23% of TXs; commercial \$800–\$2,500/lb; blunt use	Methamphetamine rate (↓); ecstasy combined with cocaine HCl in marijuana blunts; depressants ↑; ketamine used intranasally, injected; diverted pharmaceuticals ↑, especially drugs used to treat HIV/AIDS
Philadelphia	146 deaths in 1H00; ED rate 260; 36% of TXs; crack \$5/rock; cocaine injected; crack combined with depressants, marijuana, PCP	151 deaths in 1H00; ED rate 87; 18% of TXs; \$.31/mg; 73% pure; speedball use	ED rate 114; 10% of TXs; blunt use; combined with PCP	Methamphetamine available but requires a connection to purchase; 3 ecstasy deaths in 1H00, combined with heroin and alcohol or cough syrup; PCP ↑; 3 ketamine deaths in 1H00
Phoenix	77 deaths in 1H00; ED rate 91 (↑); \$80–\$150/g; crack \$17.50–\$20/rock	79 deaths in 1H00; ED rate 43; \$.47/mg; 47% pure (↑)	ED rate 50 (↑); \$75–\$150/oz	Methamphetamine ED rate 17 (↓); GHB ODs; peyote available; OxyContin ↑; opiate deaths ↑
St. Louis	15 deaths in 1H00; ED rate 97; 35% of TXs; \$52–\$100/g (75% pure), crack \$20/rock (77% pure)	21 deaths in 1H00; ED rate 37 (↑); 14% of TXs; \$1.75/mg; 18% pure (↓); speedball use	ED rate 68; 28% of TXs; combined with PCP	Methamphetamine ED rate 4 (↑); ketamine theft ↑
San Diego	28 deaths in 1H00; ED rate 44; 11% of TXs; \$45–\$80/g (75–80% pure), crack \$10/0.1g	66 deaths in 1H00; ED rate 46; 13% of TXs; \$.46/mg; 52% pure	ED rate 38 (↓); 20% of TXs; commercial \$310/lb; “high-quality” \$1,200–\$2,000/lb	Methamphetamine ED rate 24 (↓), 37% of TXs
San Francisco	ED rate 120; 24% of TXs	ED rate 191 (↑); 54% of TXs; \$.30/mg; 25% pure (↑)	ED rate 29; \$2,500/lb	Methamphetamine ED rate 34, 13% of TXs
Seattle	62 deaths in first 3Q00; ED rate 130; 12% of TXs; \$30/g; crack \$20–\$40/rock	82 deaths in first 3Q00; ED rate 128; 17% of TXs; \$.62/mg; 18% pure	ED rate 42; 18% of TXs; domestic \$4,000–\$5,200/lb; combined with PCP	Methamphetamine ED rate 18 (↑), 6% of TXs, law enforcement indicators ↑; ecstasy ↑, combined with LSD, GHB; GHB ODs ↑; opiate deaths ↑
Texas	ED rate 86 (↓) in Dallas; 31% of TXs; \$50–\$125/g (80–98% pure), crack \$10–\$50/rock; crack “spiked” with codeine in Austin	13% of TXs; Dallas: ED rate 18; \$.59/mg; 16% pure; Houston: \$1.07/mg; 19% pure; combined with alprazolam	ED rate 48 in Dallas; 10% of TXs; sinsemilla \$50–\$100/oz in Dallas; combined with embalming fluid and PCP; joints dipped in codeine syrup	Methamphetamine ED rate 4 (↓) in Dallas, 5% of TXs; 2 ecstasy deaths in 1999, poison calls ↑, TX emerging, combined with heroin in tablets; 3 GHB deaths in 1999, poison calls ↑, TX emerging; PCP TXs ↑; Ritalin abused by youth; Rohypnol TXs ↑; 2 ketamine deaths in 1999, poison calls ↑
Washington, DC	ED rate 81 (↓); 44% of TXs; \$100–\$200/g (19–95% pure), crack \$100/g (30–81% pure); crack injected	ED rate 46 (↓); 42% of TXs; \$1.36/mg; 23% pure; combined with other opiates	ED rate 65; 14% of TXs; commercial \$600–\$1,300/lb; sinsemilla \$4,500/lb; hashish \$200/oz; blunt use; combined with PCP or crack	Ecstasy ↑, combined with cocaine HCl or crack; GHB ↑; new “crystal” form of LSD; PCP law enforcement indicators ↑; prescription drugs available near methadone clinics

ED = DAWN estimates of emergency department mentions per 100,000 population for each drug during 1999; arrows reflect significant shifts ($p < 0.05$) between 1998 and 1999.

TX = Treatment admissions, including alcohol-in-combination, but excluding alcohol-only, except in Texas, Minneapolis/St. Paul, and New Orleans (where alcohol-only is not excluded) and Boston, Hawaii, New York City, and San Francisco (where alcohol-in-combination is not included). Data are statewide for Colorado, Hawaii, and Texas. Reporting periods are first half 2000, except for the following: full year 1999 in Atlanta, second half 1999 in Baltimore, July 1999–June 2000 in Boston, FY 2000 in San Francisco, and the first three quarters of 2000 in Texas.

Purity = Heroin price and purity data provided by the Domestic Monitor Program for the first quarter of 2000; arrows reflect ≥ 5 -percentage-point shifts since full-year 1999; other drug price data provided by December 2000 CEWG city reports.

EXECUTIVE SUMMARY

COCAINE AND CRACK

Boston: "Cocaine indicators continue a decline that first became apparent in 1995, although it still ranks highest of any illicit drug in ED mentions and arrests."

MORTALITY DATA

Compared with 1999, projected 2000 cocaine deaths suggest mixed trends, with nearly equal numbers of increases and declines in the 9 CEWG areas where partial-2000 data were available.

Increases were reported in five areas:

- Detroit/Wayne County: Cocaine-positive toxicology reports are projected to increase 18 percent (totaling 342 in 1999 and 302 in the first 9 months of 2000).
- Minneapolis/St. Paul: Cocaine-related deaths in Hennepin County are projected to remain stable (43 in 1999 and 32 in the first three quarters of 2000), while cocaine-related deaths in Ramsey County are projected to increase (between 5 and 10 deaths in 1999 and 14 in the first three quarters of 2000).
- Philadelphia: Cocaine-related deaths, after declining between 1997 and 1999, are projected to increase 23 percent (238 in 1999 and 146 in the first half of 2000).
- San Diego County: After declining between 1998 and 1999, accidental cocaine overdose deaths are projected to increase 27 percent (44 in 1999 and 28 in the first half of 2000).
- Seattle/King County: Cocaine-caused deaths are projected to increase 9 percent (76 in 1999 and 62 in the first three quarters of 2000), continuing a general increase since 1997.
- Honolulu: Cocaine-positive toxicology screens in Oahu are projected to decline 8 percent (totaling 24 in 1999 and 11 in the first half of 2000), continuing a relatively stable trend since 1995.
- Miami: Cocaine-only induced deaths are projected to decline 19 percent (from 43 in 1999 to 26 in the first three quarters of 2000).
- Phoenix/Maricopa County: Cocaine-related deaths are projected to decline 28 percent (from the 1999 peak of 215 deaths to 77 in the first half of 2000).
- St. Louis County: Cocaine-related deaths are projected to decline 41 percent (from 51 in 1999 to 15 in the first half of 2000), continuing a general decline since 1993.

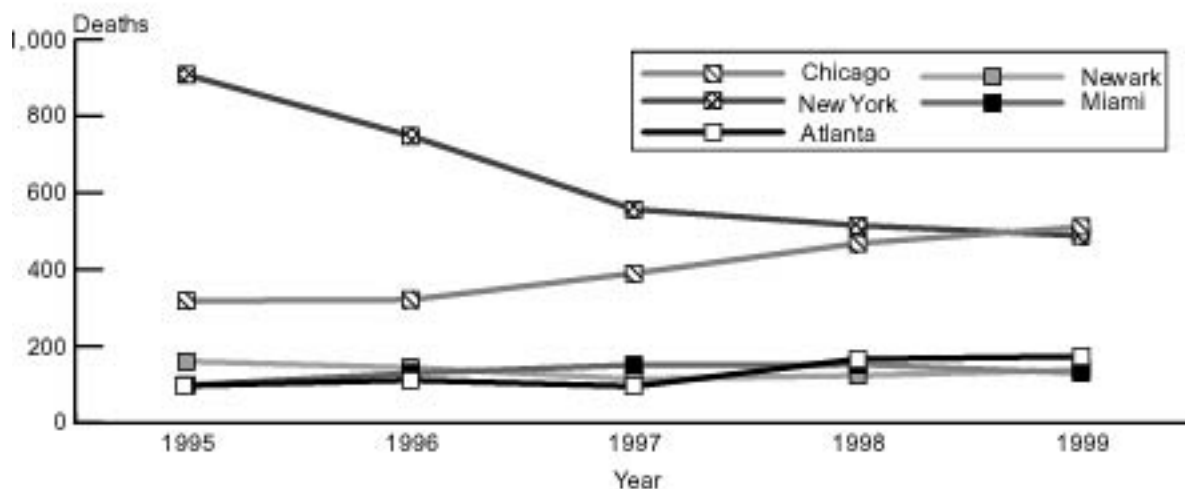
Mortality trends appear to be declining in four areas:

Longer term medical examiner (ME) data in cities where the majority of drug deaths involved cocaine also show mixed trends: cocaine-related deaths generally increased between 1995 and 1999 in Atlanta and Chicago, remained relatively stable in Miami and Newark, and declined in New York (exhibit 1).

EMERGENCY DEPARTMENT DATA

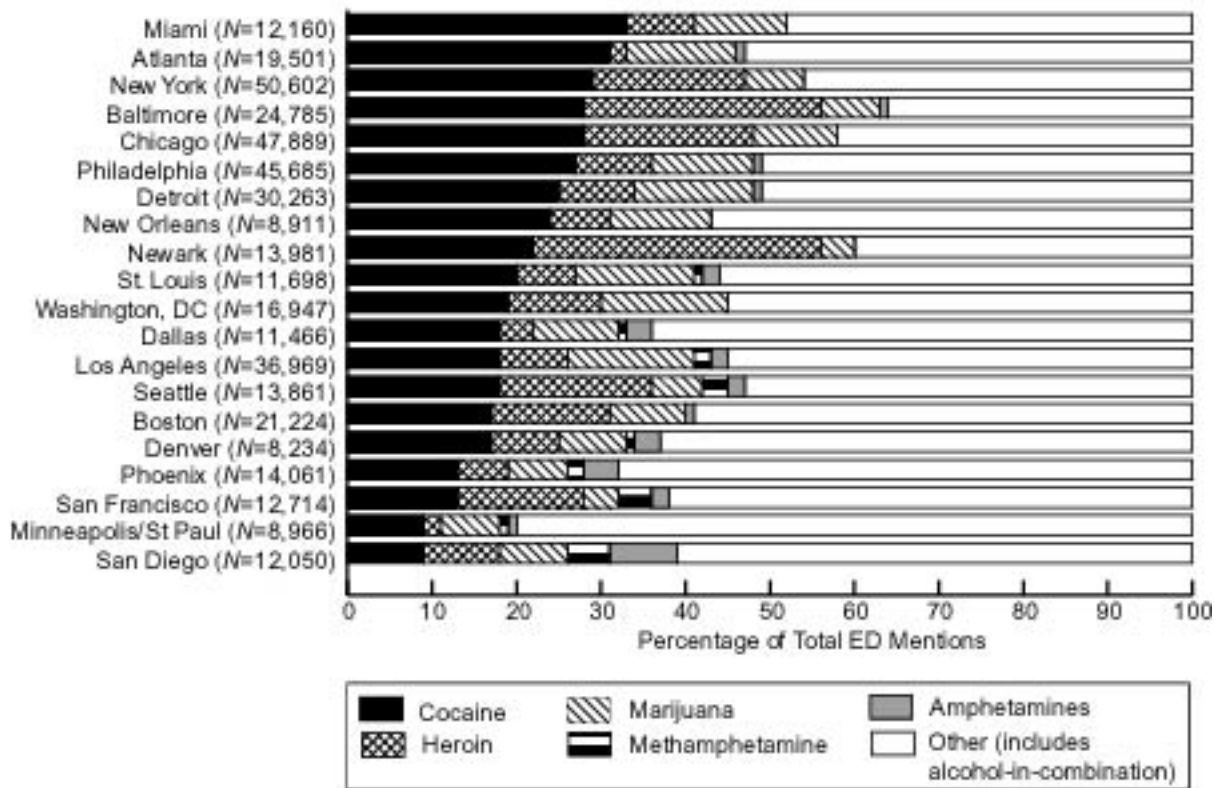
Cocaine (including crack) remains the most frequently mentioned drug in 15 of the 20 CEWG cities in the Drug Abuse Warning Network (DAWN), according to 1999 estimates, and it equals heroin as a proportion in Baltimore, San Diego, and Seattle (exhibit 2). It accounts for particularly high proportions (≥ 20 percent) of total emergency department (ED) drug mentions in 10 cities: Atlanta, Baltimore, Chicago, Detroit, Miami, New Orleans, New York,

Exhibit 1. Cocaine-related deaths in cities where the majority of drug deaths involved cocaine, 1995–99



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (July 2000 update)

Exhibit 2. Percentages of total ED mentions composed of cocaine, heroin, marijuana, methamphetamine, amphetamines, and "other" by metropolitan area, ranked by cocaine, 1999



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Newark, Philadelphia, and St. Louis. It is out-ranked by heroin in Newark and San Francisco.

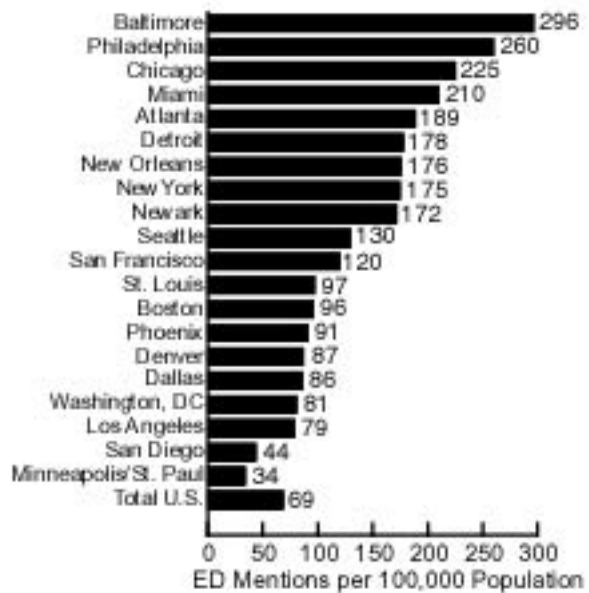
The Nation's highest rate of cocaine ED mentions per 100,000 population was reported in Baltimore (as it has been since 1992), followed by Philadelphia; the lowest rates were in Minneapolis/St. Paul and San Diego (exhibit 3).

Between 1998 and 1999, cocaine ED mentions increased significantly ($p < 0.05$) in two cities (Denver and Phoenix) (exhibit 4). By contrast, significant declines were noted in six cities: Boston, Dallas, Newark, New Orleans, New York, and Washington, DC. Moreover, in Newark and New York, cocaine ED mentions declined both in number and as a proportion of total ED mentions (by 3 and 4 percentage points, respectively). In the remaining sites, cocaine remained relatively stable as a proportion of total ED mentions.

Long-term ED trends have varied somewhat among the Nation's four highest ranking cities (exhibit 5). Baltimore's cocaine ED rate generally

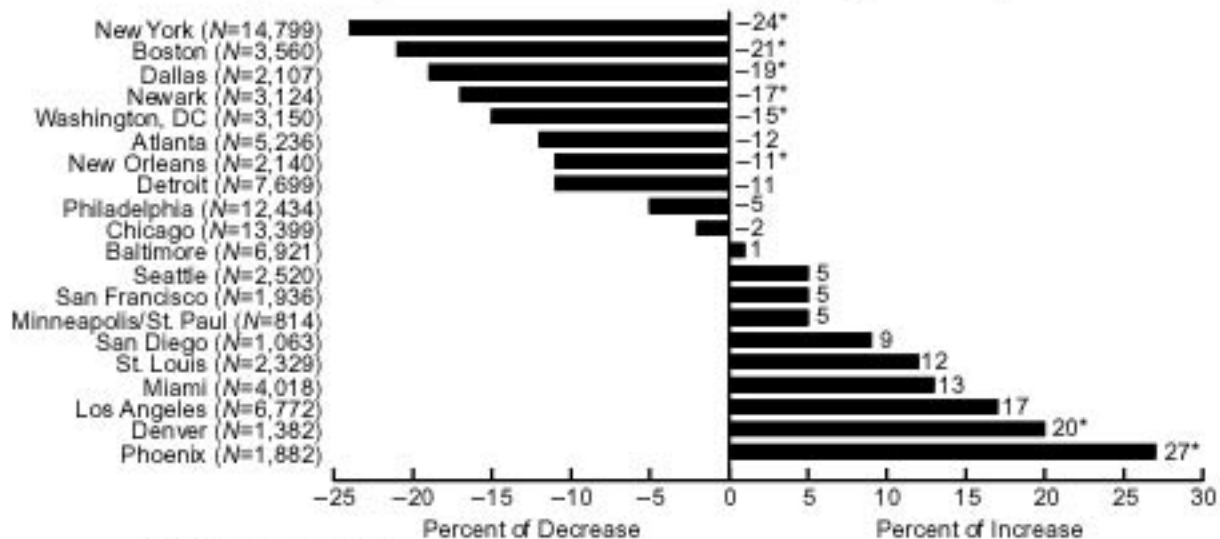
declined between 1995 and 1997, increased in 1998, and remained level in 1999. Conversely, after peaking in 1997, Chicago's rate declined steadily. Miami and Philadelphia's rates increased

Exhibit 3. Estimated rate of cocaine/crack ED mentions per 100,000 population by metropolitan area, 1999



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Exhibit 4. Percentage of change in cocaine/crack ED mentions by metropolitan area, 1998 versus 1999

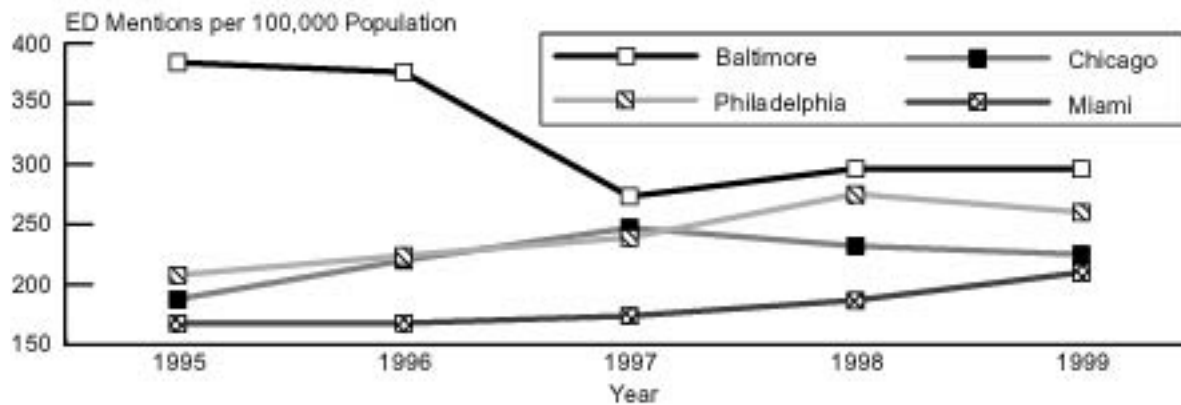


NOTE: (N) refers to 1999 mentions.

* $p < 0.05$

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Exhibit 5. Annual trends in cocaine/crack ED mentions per 100,000 population in four top-ranking cities, 1995–99



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

steadily since 1995, with a slight decline in Philadelphia's rate between 1998 and 1999.

TREATMENT DATA

Cocaine (including crack) as the primary drug of abuse accounts for the largest percentage of admissions in 6 of 18 reporting areas (exhibit 6). It also accounts for major proportions of admissions (>20 percent) in four other areas: Boston, New Orleans, New York City, and San Francisco. Heroin now dominates treatment proportions in seven areas, marijuana in three, and methamphetamine in two.

Similar to most ED indicators, treatment percentages for cocaine remained relatively stable (within 3 points) or declined in comparison with figures from the same reporting period 1 year earlier in 16 of the 17 sites where trend data were available. Philadelphia was the exception, with a 6-point increase. The largest declines were noted in Atlanta, New York City, and Texas (by 8, 4, and 4 points, respectively).

Long-term treatment admission data for cocaine show mostly declining or stable trends:

- Baltimore: The admission rate for cocaine has continued to decline since 1995.
- Boston: Only 12 percent of those in publicly funded treatment in fiscal year (FY) 2000 reported cocaine as their drug of choice, compared with 27 percent in FY 1994.
- Chicago: Since 1995, the number of cocaine admissions has remained relatively stable, ranging from 33,382 to 31,978.
- Colorado: The proportion of cocaine admissions declined considerably between 1994 and the first half of 2000 (from 39 percent of all drug admissions to 21 percent). The proportion of new cocaine users (those who enter treatment within 3 years of initial use) declined slightly between those same periods (from 17 to 15 percent).
- Honolulu: Cocaine admissions have been relatively stable since 1996.
- Newark: Cocaine admissions have been declining since 1992.
- New York City: After increasing between 1993 and 1998, cocaine admissions declined over the last 2 years to levels similar to those reported in 1994.
- Philadelphia: Cocaine admissions declined between 1994 and the first half of 2000.

Exhibit 6. Primary drugs of abuse as percentages of treatment admissions in reporting CEWG areas, first half 2000 (including alcohol-in-combination and excluding alcohol only)^a

Area	Cocaine	Heroin	Marijuana	Stimulants
Atlanta	52	4	21	2
Washington, DC	44	42	14	<1
Philadelphia	36	18	10	<1
St. Louis	35	14	28	3
Texas ^b	31	13	10	5
Chicago	25	16	16	<1
Newark	9	79	6	1
Boston ^c	22	70	8	NR
San Francisco ^d	24	54	NR	13
Baltimore	15	51	15	0
Los Angeles	17	46	7	9
New York City ^d	29	44	23	0
New Orleans ^b	21	30	26	<1
Colorado	14	10	28	9
Minneapolis/St. Paul ^b	14	3	23	3
Seattle	12	17	18	6
Hawaii ^d	12	10	28	50
San Diego	11	13	20	37

NOTE: The highlighted areas indicate the top-ranking primary drug of abuse in each area.

^aReporting periods are January–June 2000, except for the following: full year 1999 in Atlanta, July–December 1999 in Baltimore, July 1999–June 2000 in Boston, FY 2000 in San Francisco, and January–September 2000 in Texas.

^bAlcohol-only is not excluded.

^cDrugs other than cocaine, heroin, and marijuana are excluded.

^dAlcohol-in-combination is excluded.

SOURCE: Drug abuse treatment agencies

- Texas: Cocaine admissions dropped from 28 percent of all adult drug admissions in 1993 to 23 percent in 2000.

Long-term increases in cocaine treatment admissions were reported in two cities:

- Los Angeles: Between 1995 and the first half of 2000, cocaine admissions increased steadily (from 14 to 17 percent of all drug admissions).
- San Francisco: The number of cocaine admissions increased substantially between 1994 and FY 2000. As a proportion of total

admissions, cocaine's share increased more modestly (from 23 to 24 percent).

OTHER LOCAL DATA

Poison control data in various areas reflect stable or declining trends:

- Colorado: In 1999, calls concerning cocaine totaled 49, a stable number since 1995. However, since 1995 the proportion of cocaine calls among total illicit-drug-related calls has declined from 32 to 8 percent, driven mostly by recent increases in methamphetamine-, marijuana-, gamma hydroxybutyrate (GHB)-, and heroin-related calls.

- Massachusetts: In the second and third quarters of 2000, cocaine was mentioned in 15 percent of helpline calls in which drugs were specified, similar to levels during previous periods. By contrast, alcohol was mentioned in 44 percent and heroin in 24 percent of the calls.
- Texas: Confirmed exposures to cocaine totaled 357 in 1999 and 675 from January to August 2000.

Survey data for cocaine use show mixed trends:

- Massachusetts: The 1999 school survey showed a small, but statistically significant, increase in cocaine use among 9th–12th graders between 1996 and 1999 (from 6 to 8 percent lifetime use and from 2 to 3 percent current use).
- San Francisco: The proportion of high school students in San Francisco County who reported ever using cocaine dropped slightly from 6 to 5 percent between 1997 and 1999.
- Texas: The 2000 statewide school survey found that 9 percent of students had ever used cocaine hydrochloride (HCl), and 3 percent had used it in the past month. Use of crack was lower, with students reporting 3 percent lifetime and 1 percent past-month use. The levels of use in 2000 decreased very slightly from 1998 levels.

Additionally, the New York City Department of Health reports that in 1999, 626 females admitted using cocaine during pregnancy—an 80-percent decline from 3,168 in 1989.

DEMOGRAPHIC DATA

Age

Atlanta: *“Although the majority (at least 85 percent) of treatment clients in 1998 and*

1999 were older than 26, ethnographic data suggest that cocaine HCl, crack, or freebase cocaine HCl, in particular, may be increasingly common among younger age groups. Cocaine use among younger groups is corroborated by poison control data: 32 percent of first-half-2000 calls for cocaine were among persons younger than 26.”

Boston: *“According to focus groups with teens and interviews with youth treatment providers, cocaine use remains relatively rare among adolescents. Crack in particular has a bad reputation among teens, and its use is strongly stigmatized.”*

Philadelphia: *“The most recent focus groups reported an aging crack-using population, mostly in their twenties and thirties, with fewer new users.”*

Available mortality demographics generally reflect an aging cocaine-using population. In the first half of 2000, nearly all (83 percent) of cocaine-related decedents in San Diego were older than 35 years, and in FY 1999 in San Francisco, the median age of cocaine-related decedents was a record high of 40.6 years. Conversely, in Minneapolis/St. Paul (Hennepin County) in the first three quarters of 2000, the average age of decedents was 36.7, slightly younger than the decedents in 1999.

Age distributions among cocaine ED mentions continue to suggest an aging cohort of cocaine users. The 35+ group continues to account for the largest percentage of cocaine mentions in every CEWG city in DAWN (exhibit 7). Between 1998 and 1999, this oldest group’s representation increased by 5 or more percentage points in five cities (Boston, Chicago, Phoenix, San Diego, and Seattle); moreover, that group also increased significantly in number of mentions in three of those cities (Chicago, Phoenix, and San Diego). In the remaining cities, the proportion of the 35+ group remained relatively stable.

Exhibit 7. Age and gender distribution of cocaine ED mentions, by percentage, in reporting CEWG cities, 1999

City	(N)	35+	26–34	18–25	12–17	Males
Atlanta	(5,236)	56	32–	11	1	66
Baltimore	(6,921)	55	33	11	1–	61
Boston	(3,560)	49	34–	16	1–	58
Chicago	(13,399)	59+	31–	8	1–	62
Dallas	(2,107)	44	31–	20–	5	64
Denver	(1,382)	43+	32	21+	4	62
Detroit	(7,699)	69	24–	6	1	62
Los Angeles	(6,772)	56+	28	15	2	66
Miami	(4,018)	59	30	11	1–	68
Minneapolis/St. Paul	(814)	44	34	18	4	69
Newark	(3,124)	56–	35–	9–	1	63
New Orleans	(2,140)	54	27–	18	1–	72
New York	(14,799)	55–	36–	8–	0	72
Philadelphia	(12,434)	50	35	14	1	66
Phoenix	(1,882)	44+	31	21+	4	66
San Diego	(1,063)	59+	24	15	2+	61
St. Louis	(2,329)	58	30	11	1	62
San Francisco	(1,936)	62	25	11	2	66
Seattle	(2,520)	58	30	11	2	66
Washington, DC	(3,150)	59–	30–	9–	1	60

NOTE: “+” or “–” indicates significant increase or decrease ($p < 0.05$) in number (not percentage) of mentions since 1998.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Correspondingly, as they moved into the oldest age group, the 26–34-year-olds declined as a percentage of cocaine ED mentions in every city (except St. Louis, where it remained stable), accounting for only 24–36 percent of cocaine mentions among the 20 cities. Between 1998 and 1999, the largest declines (5–10 percentage points) were in New Orleans, Phoenix, and Washington, DC.

The young adult (18–25) group, which accounts for 6–22 percent of cocaine ED mentions in the 20 cities, remained relatively stable. Similarly, the juvenile (12–17) group remained relatively stable, accounting for 0–5 percent of cocaine mentions.

Like age distribution shifts, changes in the number of mentions suggest generally leveling or declining trends except for the 35+ group, which showed mixed trends. Mentions among the 35+ group increased in 11 cities (5 were significant: Chicago, Denver, Los Angeles, Phoenix, and San Diego) and decreased in 9 cities (3 were significant: Newark, New York, and Washington, DC) (exhibit 7). The 26–34 group showed mostly declining trends, with 9 significant declines; the young adult group showed mostly declines, with 5 significant declines and 2 significant increases; and the juvenile group showed mostly declines, with 5 significant declines and only one significant increase (in San Diego).

Exhibit 8. Cocaine ED rates per 100,000 population, by age and metropolitan area, 1999

City	35+	26–34	18–25	12–17
Atlanta	203	362	174	19
Baltimore	290	651	285	27
Boston	83	211	120	13
Chicago	243	472	166	24
Dallas	75	153	140	45
Denver	68	170	188	34
Detroit	222	303	101	9
Los Angeles	86	141	85	15
Miami	212	453	211	20
Minneapolis/ St. Paul	28	69	56	15
Newark	166	432	139	14
New Orleans	178	330	296	18
New York	168	428	129	7
Philadelphia	228	648	321	31
Phoenix	74	189	166	39
St. Louis	100	200	109	13
San Diego	50	73	41	12
San Francisco	124	191	130	27
Seattle	134	239	131	30
Washington, DC	88	160	62	11

NOTE: Highlighted areas indicate highest ranking age group in each city.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Cocaine ED rates per 100,000 population were highest among the 26–34 age group in all CEWG cities in DAWN except for Denver, where the 18–25 group was highest (exhibit 8).

Similar to mortality and ED data, treatment data continue to reflect an aging group of cocaine users (exhibit 9). The oldest (35+) group accounts for the largest percentages of primary cocaine admissions (ranging from 47 percent in Atlanta to 64 percent in San Diego) in all CEWG reporting areas. In all areas where trend data are available, the 26–34 group continues to transition into the oldest group: compared with the same period 1 year earlier,

the 26–34 group declined substantially (≥ 5 percentage points) in five cities (Baltimore, Newark, New York, Philadelphia, and San Diego), while the older group generally increased correspondingly.

The young adult (18–25) group accounts for smaller percentages than the two older groups (ranging from 6 percent in New York City to 13 percent in Colorado); trends within that group are relatively stable. Juveniles (≤ 17 years) account for 0–2 percent of cocaine admissions in CEWG reporting areas.

Among male juvenile arrestees, cocaine-positive urinalyses ranged from 3 percent positive in San Diego to 16 percent in Phoenix. Between 1998 and 1999, positive levels declined or remained stable in all CEWG sites included in ADAM juvenile testing (Denver, Los Angeles, Phoenix, San Antonio, and San Diego), with a substantial decline in Denver. According to the District of Columbia Pretrial Services Agency, cocaine-positive levels among juvenile arrestees have remained stable (at 7 percent positive) between 1999 and the first three quarters of 2000.

As in mortality, ED, and treatment data, the 35+ age group has higher cocaine-positive urinalysis levels than other age groups in all CEWG cities where ADAM tests adults.

Gender

Available mortality data show that males continue to account for the large majority of cocaine decedents: 81 percent in Minneapolis/St. Paul (Hennepin County), 88 percent in San Diego, 86 percent in San Francisco, and 82 percent in Seattle.

Similarly, males continue to outnumber females as a percentage of cocaine ED mentions in every CEWG city in DAWN (exhibit 7). The gender gap remains widest in New

Exhibit 9. Age distribution of primary cocaine treatment admissions, by percentage, in reporting CEWG areas^a

Area	35+	26–34	18–25	≤17	Males
Atlanta	47	40	12	1	61
Baltimore	57	33	9	1	58
Boston	NR	NR	NR	NR	59
Chicago	50	39	10	1	55
Colorado	51	33	13	2	59
Los Angeles	58	30	11	1	58
Minneapolis/ St. Paul	52	35	11	2	64
Newark	57	35	8	<1	52
New York City ^b	55	38	6		63
Philadelphia	52	37	10	1	58
St. Louis	57	36	7	<1	55
San Diego	64	25	9	2	59
Seattle	62	28	7	2	56
Texas	NR	NR	NR	NR	57

^aReporting periods are January–June 2000, except for the following: full year 1999 in Atlanta, July–December 1999 in Baltimore, July 1999–June 2000 in Boston, and January–September 2000 in Texas.

^bAge groups are 36+, 26–35, and ≤25.

SOURCE: Drug abuse treatment agencies

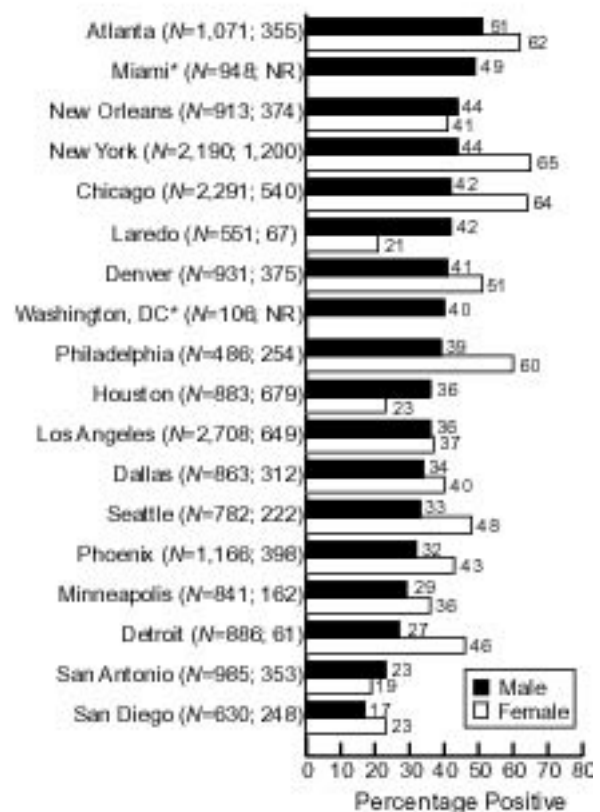
Orleans (72 percent male and 28 percent female); it is narrowest in Boston (58 percent male and 42 percent female). Between 1998 and 1999, gender distributions remained generally stable.

Males also outnumber females among cocaine treatment admissions in all reporting areas (exhibit 9). In areas where comparative data are available, gender gaps among treatment admissions are generally narrower than gender gaps among ED mentions. Gender trends among treatment admissions were mixed compared with the same period 1 year earlier: female representation increased substantially (≥5 percentage points) in two areas (Atlanta and Colorado, by 6 and 8 points, respectively) and remained relatively stable in the remaining areas.

In nearly every reporting area, the gender gap among treatment admissions was narrower for cocaine than for other drugs. By contrast, the gender gap was widest for marijuana.

Only in one indicator do females continue to predominate: according to 1999 ADAM data, female arrestees tested cocaine-positive at higher levels than males in every CEWG city, except for New Orleans and three Texas cities (exhibit 10). Atlanta had the highest level among males, while New York had the highest level among females.

Exhibit 10. Percentage positive for cocaine among adult male and female booked arrestees, 1999 (ranked by males)



*Females are not tested at these sites.

SOURCE: National Institute of Justice, Arrestee Drug Abuse Monitoring program, 1999 Annual Report

Race/Ethnicity

San Diego: *“These demographic [ED] data show some preliminary support for informant reports of increased cocaine use among Whites and more recreational use.”*

Texas: *“Analysis of treatment client data shows the increase in cocaine HCl and crack use among Hispanics.”*

According to available mortality data, Whites predominate as cocaine decedents in several CEWG areas, such as San Diego (at 60 percent) and Minneapolis/St. Paul (at 44 percent).

In contrast with mortality data, Blacks predominate among cocaine ED mentions in 12 of the CEWG cities in DAWN (ranging from 12 percent in Phoenix to 73 percent in Detroit), Whites predominate in 5 cities (ranging from 10 percent in Newark to 61 percent in Baltimore), and 3 cities have too many mentions in the “race unknown” category to be included in the count. The largest Hispanic representations continue to be reported in Los Angeles, New York, and Phoenix (at 23, 24, and 23 percent, respectively).

Between 1998 and 1999, most cities’ racial/ethnic distributions of cocaine ED mentions remained stable, although several did shift. For example, in San Diego the proportion of Blacks increased (by 5 percentage points), while Hispanics decreased in proportion (by 4 points). Blacks as a proportion declined substantially in Miami (by 5 points).

Among first-half-2000 primary cocaine treatment admissions, Blacks’ representation (ranging from 21 percent in Colorado to 84 percent in Philadelphia) was greater than that of other races/ethnicities in all but two reporting areas (Colorado and Texas, where Blacks and Whites were equally represented). Proportions of Whites among cocaine admissions ranged from 6 percent in Newark to 49

percent in Colorado; Hispanic representation ranged from <1 percent in Atlanta and St. Louis to 29 percent in Colorado.

In areas where comparative treatment data for 1 year earlier were available, racial/ethnic distributions shifted in several areas. Trends for Whites and Blacks as a proportion of cocaine admissions were mixed, while trends for Hispanics increased or remained stable: Whites increased by ≥ 3 points in three areas (Atlanta, Colorado, and St. Louis) and declined in three areas (Baltimore, New York City, and Philadelphia); Blacks increased in two areas (Baltimore and Philadelphia) and declined in four (Atlanta, Colorado, Los Angeles, and St. Louis); and Hispanics increased in three areas (Los Angeles, New York City, and San Diego) and declined in none.

USE PATTERNS

Denver: *“While smoking has declined among primary cocaine treatment admissions, intranasal use has been increasing steadily since 1994. This rise may be due to the increased availability of cocaine HCl...[which] may have brought about changes in cocaine user groups, and thus, in the population entering treatment.”*

St. Louis: *“Most cocaine users smoke crack cocaine, although some use cocaine HCl...Younger users smoke cocaine exclusively. Polydrug use is also evident in the treatment data. Increases in marijuana, heroin, and methamphetamine use suggest this trend will likely continue.”*

Route of Administration

New York City: *“Given the current high purity of cocaine HCl, crack users these days are more likely to be freebasing their own. One user stated, ‘You haven’t really smoked cocaine until you’ve freebased your own.’”*

LOCAL GEOGRAPHIC PATTERNS:

In most CEWG metropolitan areas, smoking crack remains an inner-city phenomenon, but using cocaine HCl intranasally occurs citywide and more often in suburban areas:

- *Boston: Smoking was the preferred route of administration for 70 percent of cocaine treatment admissions, indicating the continued preference for crack in the inner-city area. Police indicate that crack remains the predominant form of cocaine in the inner city, with cocaine HCl more common in nearby suburbs.*
- *Denver: Crack cocaine availability has been declining and is mostly limited to larger metropolitan areas in street-level amounts.*
- *Newark: Newark City residents may account for most of the recent decline in cocaine use. For example, the proportionate share of cocaine (including crack) admissions declined from 27 percent in 1992 to only 10 percent in the first half of 2000. Statewide, the decline in proportion was far less acute (from 31 percent in 1992 to 20 percent in 1998).*
- *St. Louis: Cocaine use varies by area: it is the primary drug of choice identified in inner-city treatment programs; alcohol, however, remains the primary drug in both the outlying rural areas and statewide. (Most of Missouri, outside of St. Louis and Kansas City, is rural.)*

Other patterns and trends of cocaine use related to location within a metropolitan area vary from city to city. In San Francisco, the big decline in cocaine indicators noted in the county in the early and mid-1990s may be partly the result of changing demographics: low-income Blacks have been priced out of their traditional neighborhoods, such as the Western Addition, or have lost their homes in recently demolished public housing projects. In Texas, students in schools near the Texas-Mexican border showed substantially higher levels of both cocaine HCl and crack use compared with students statewide; additionally, in Laredo, 42 percent of males and 24 percent of females tested cocaine-positive in 2000, underscoring the extent of the cocaine problem on the border. In San Diego, cocaine use reportedly increased in northern and eastern counties—current strongholds of methamphetamine use. Although the purported use has not yet affected indicators there to any discernible extent, it is a possible trend that warrants watching.

Texas: “The term ‘lag’ refers to the period from first consistent use of a drug to date of admission to treatment. Crack smokers and cocaine HCl inhalers average 8–9 years of lag time, but injectors average 13 years of lag time.”

Smoking, typically crack, remains the predominant route of administration, by far, among primary cocaine treatment admissions in every reporting area (ranging from 57 percent of cocaine admissions in Colorado to 94 percent in Washington, DC), followed by intranasal use and then injecting (except in

Seattle, where injecting is more common than intranasal use among cocaine admissions). Between the first halves of 1999 and 2000, the proportion of smokers among treatment admissions declined by ≥ 3 points in three areas: Chicago, Colorado (where intranasal users increased correspondingly), and San Diego. No other substantial changes in proportions of cocaine route of administration were reported.

Route of administration continues to vary by demographic characteristics of the treatment population:

SEVERAL REPORTS OF INCREASES IN COCAINE INJECTION WARRANT WATCHING:

Atlanta: "Although smoking remains the more common route of administration for cocaine according to all indicators, injection of freebase cocaine may be increasing in popularity."

Philadelphia: "Autumn 2000 focus groups estimated that 50 percent of cocaine HCl buys are for intranasal use, 30 percent for injecting, and 20 percent for injecting in a speedball."

Washington, DC: "Although smoking is the predominant route of administration among crack users, ethnographic reports have identified injection as a continuing means of crack ingestion among IDUs. While this phenomenon is seemingly fueled by decreases in the quality and availability of cocaine HCl, some IDUs report that they prefer those of injecting crack to those of injecting cocaine HCl. Yet, many IDUs prefer injecting cocaine HCl and dislike having to inject the vinegar commonly used to dissolve crack."

- Baltimore: Admissions who smoke crack include a substantial proportion of females (45 percent) and Blacks (62 percent). The average age at admission is 35 years, and 43 percent are entering treatment for the first time.
- Newark: Seventy-six percent of Black cocaine admissions are cocaine smokers, while only 21 percent are intranasal users. Among Whites and Hispanics, intranasal use and smoking are distributed more evenly.
- New York City: Compared with those who use cocaine intranasally, those who smoke crack are more likely to be female, Black, readmissions to treatment, and without income. They are similar in age and secondary drugs of abuse, mostly alcohol and marijuana. A recent, noteworthy trend is an

increase in Hispanics among admissions who use cocaine intranasally.

- Philadelphia: Smoking was reported by 75 percent of male and 82 percent of female admissions for cocaine (crack and HCl).
- Texas: Cocaine HCl admissions are younger than crack admissions (31 compared with 35 years) and more likely to be male and White. Admissions who use intranasally are the youngest, the most likely to be Hispanic, and the most likely to be employed.

Multisubstance Use

Boston: "Among primary cocaine and crack treatment clients, 68 percent used at least one other illicit drug in the month prior to treatment."

Available mortality data show high levels of heroin present in cocaine decedents, suggesting continued use of "speedballs" (combination of cocaine and heroin, usually by injecting cocaine HCl combined with heroin, and less commonly by injecting diluted crack cocaine combined with heroin). Cocaine-in-combination-with-heroin deaths outnumber cocaine-only deaths in several cities, including Newark (where 71 cocaine-related deaths occurred in 1999, in conjunction with heroin use) and Philadelphia (where cocaine alone was found in only 23 percent of all cocaine-positive toxicology reports in the first half of 2000, while cocaine plus heroin/morphine was present in 37 percent). In Phoenix between 1999 and 2000, cocaine-related deaths are projected to decline nearly 28 percent (based on first-half 2000 data), but cocaine/morphine deaths are projected to increase 35 percent.

Treatment data further suggest the overlap of cocaine and heroin use: among primary heroin users, cocaine was the most common secondary drug in all (11) reporting cities except for Los Angeles. The severity of cocaine as a secondary drug problem among heroin admissions

is underscored by the high percentages reported, ranging from 22 percent in Colorado to 55 percent in Philadelphia.

Qualitative reports of speedballing also continue in many CEWG areas. In Atlanta, some injecting drug users (IDUs) dissolve crack with various substances and inject it, either alone or in combination with heroin. This practice has been observed primarily among individuals who consider heroin to be their drug of choice, and also among those who smoke crack. Similarly, in Boston, some IDUs dissolve crack in vinegar or lemon juice, to be used most often in combination with heroin. Outreach workers there report that injectors choose crack when it is difficult to find high-quality cocaine HCl. In Baltimore, where the cocaine and heroin ED rates and patterns have been similar since 1995, the concurrent use of the two drugs may be common. In Philadelphia, speedball use is common according to recent focus groups. In St. Louis, “old-time” users continue to speedball; otherwise, cocaine injection is rare in that city.

Although heroin is often used concurrently with cocaine, alcohol is the most frequently reported secondary drug of abuse among primary cocaine treatment admissions in all reporting areas. Additionally, marijuana is commonly mentioned as the tertiary drug of abuse among primary cocaine admissions in CEWG areas. In Boston, participants in several focus groups mentioned inadvertent exposure to cocaine via marijuana joints or blunts laced with crack. At a South Florida hospital, 23 percent of 587 cocaine-related cases also involved marijuana.

In Philadelphia, crack users continue to report frequent use of 40-ounce bottles of malt liquor or other drugs, including alprazolam (Xanax), diazepam (Valium), or marijuana along with crack; less frequently, heroin or phencyclidine (PCP) is used with crack. In Austin, crack is

being “spiked” with codeine to enhance the narcotic effect of the drug.

LAW ENFORCEMENT DATA

Atlanta: “Cocaine remains a frequently encountered drug...although manpower continues to shift to other popular drugs.”

St. Louis: “Cocaine is no longer the drug problem driving the efforts of St. Louis law enforcement and treatment programs. Emphasis has shifted from cocaine to methamphetamine and heroin,...despite a recent upswing in cocaine indicators such as deaths and treatment admissions....”

Arrestee Urinalysis Data

Cocaine is the most frequently detected drug among adult male arrestees in six CEWG areas in the ADAM program: Atlanta, Los Angeles, Miami, New Orleans, New York, and Washington, DC, and, in the State of Texas, Laredo (exhibit 10). It is exceeded by marijuana in the other 11 cities. Among adult female arrestees, however, cocaine still ranks first in all cities, except for San Diego, where it is exceeded by both methamphetamine and marijuana.

Compared with 1998 levels, cocaine-positive levels among male adult arrestees in 1999 were relatively stable (within 4 points), except for increases in Dallas, Laredo, and Washington, DC (all by 5 points), and decreases in Los Angeles (by 7 points), Philadelphia (by 6 points), and San Antonio (by 5 points). Trends among females were mixed: levels increased (7–10 points) in Chicago, Dallas, and Minneapolis; they declined (8–14 points) in Houston, Laredo, Los Angeles, and Seattle; and they remained relatively stable elsewhere.

According to the District of Columbia Pretrial Services Agency, cocaine remains the most commonly detected drug among adult arrestees,

although cocaine-positive levels continue to decline. In the first three quarters of 2000, 32–35 percent of adult arrestees tested cocaine-positive, compared with 39 percent in 1999 and 43 percent in 1998.

Arrests and Seizures

Cocaine-related arrests in various areas show high levels of associated activity and stable or declining trends:

- **Boston:** Between 1999 and the first half of 2000, arrests for cocaine and its derivatives continued to drop (from 45 percent of drug-related arrests to 40 percent, well below the all-time high of 66 percent in 1992).
- **Chicago:** Of 55,000 drug arrests in 1999, 45 percent were for cocaine-related charges.
- **Honolulu:** The number of cocaine cases plummeted between 1996 and the first half of 2000 (from 1,318 to 128).
- **New Orleans:** Between the first halves of 1999 and 2000, possession-related arrests declined from 662 to 417, and distribution-related arrests declined from 1,032 to 701.
- **New York City:** Cocaine-related arrests declined 22 percent between 1995 and 1999, with more than 82 percent of cocaine-related arrests involving crack.
- **Washington, DC:** In the first half of 2000, cocaine-related charges figured prominently among total drug charges, with nearly 41 percent involving cocaine (a proportion less than marijuana [at 46 percent] and larger than heroin [at 11 percent]).

Conversely, in Newark, cocaine-related arrests may be increasing, with 3,608 arrests in 1998, 3,120 in 1999 through October, and 1,934 in the first quarter of 2000.

Cocaine seizures show mixed trends in reporting CEWG areas. In Atlanta, the amount of cocaine HCl seized increased between 1998 and 1999 (from 23,843 to 29,618 grams), whereas seizures of crack declined (from 2,488 to 1,210 grams). In Washington, DC, the amount of cocaine seized increased 49 percent between 1999 and 2000. Conversely, in Boston, the proportion of cocaine lab submissions declined steadily between 1994 and FY 2000 (with cocaine HCl submissions increasing slightly since 1995 and crack submissions decreasing markedly). Seizures of cocaine entering Washington State also decreased substantially between 1999 and October 1, 2000 (from 68,018 to 9,081 grams). In Minneapolis/St. Paul in 2000, seizures of cocaine in many jurisdictions were surpassed by seizures of methamphetamine.

Availability and Source

New York City: “The packaging of crack continues to change: small glassine bags and plastic wrap knotted at both ends are replacing plastic vials.”

Cocaine HCl and crack continue to be widely available in most CEWG areas. Cocaine HCl availability shows mixed trends, with increases in Boston and Dallas, declines in Washington, DC, and relatively stable trends in the remaining CEWG areas. Crack cocaine availability also shows mixed trends, with increases reported in Boston, Dallas, and Houston, declines reported in Denver, and relatively stable trends in the remaining areas.

Cocaine HCl and crack prices vary widely across the country, with cocaine HCl selling for as little as \$20–\$50 per gram in New York City, where it is packaged in tinfoil, glassine bags, and crisp dollar bills, to \$100–\$200 per gram in Washington, DC (exhibit 11). Crack cocaine

Exhibit 11. Cocaine hydrochloride prices and purity in reporting CEWG areas

Area	Purity (%)	Gram	Ounce	Kilogram
Atlanta	NR	\$100	\$1,000	\$23,000
Boston	40–90	\$50–\$90	\$650–\$1,400	\$24,000–\$32,000
Chicago	39 (2–25 g)	\$50–\$100	\$1,000	\$18,000–\$20,000
Denver	NR	\$80	\$800–\$1,200	\$18,000–\$22,000
Honolulu	20–50 (g) >90 (pound)	\$100–\$120	\$1,100–\$1,500	\$26,500–\$52,000
Minneapolis/ St. Paul	NR	\$100 \$250/“eightball” (1/8 oz)	\$700–\$1,200	\$24,000
New Orleans	NR	\$80–\$150	\$800–\$1,200	\$20,000–\$28,000
New York City	NR	\$20–\$50	\$650–\$1,000	\$20,000–\$28,000
Phoenix	NR	\$80	\$400–\$800	\$13,500–\$17,000
St. Louis	75	\$52–\$100 (large quantity) \$62–\$100 (street-level quantity)	NR	NR
San Diego	75–80 (oz–lb)	\$45–\$80 \$90–\$160/eightball (1/8 oz)	\$700	NR
Seattle	NR	\$10/dime bag (1/10 g) \$30	NR	NR
Texas	80–98	\$50–\$125	\$500–\$1,200	\$10,000–\$22,000
Washington, DC	19–95	\$100–\$200	\$1,050–\$1,200	\$22,000–\$25,000

SOURCE: CEWG city reports, December 2000

sells for \$5–\$100 per rock in reporting CEWG areas (exhibit 12). In New York City, “basuco,” a smokable, beige cocaine derivative, remains available in certain parts of the city, and is sold in \$10, \$20, and \$30 quantities.

Cocaine prices remained relatively stable in CEWG areas since the last reporting period, except in Washington, DC, where cocaine HCl ounce and kilogram prices declined. In Philadelphia and Washington, DC, cocaine HCl is commonly purchased in larger quantities and by affluent buyers, perhaps to reduce the number of buys and risk of buyer apprehension. Similarly, in Phoenix, where cocaine HCl is the most commonly sold form of cocaine, it is usually sold in kilogram and ½-kilogram pressed bricks. In Philadelphia, where crack is more commonly sold in colored packets than in packets with brand names or logos, “ready rock,” selling for

\$5, was approximately ¼ inch across and noticeably smaller in 2000 than in 1999.

Cocaine HCl purity ranges from 20–50 percent (gram quantities) in Honolulu to 80–90 percent in Texas. Purity trends were mixed, with increases in New York City and San Diego and declines in Chicago (where it is substantially lower than its 60–70 percent purity levels between 1990 and 1999) and Seattle. Crack purity remained relatively stable, except in Philadelphia, where it reportedly declined.

Trafficking and Distribution

In many areas, cocaine continues to be distributed by street gangs and criminal organizations, including Hispanic gangs in Seattle and Black gangs in Denver (despite declining crack use), with supplies coming from street gangs in Los Angeles and Chicago.

Exhibit 12. Crack prices and purity in reporting CEWG areas

Area	Price/Unit
Atlanta	\$85–\$100/g \$750–\$1,100/oz \$22,000–\$26,000/kg
Boston ^a	\$10–\$20/rock
Chicago	\$5, \$10, or \$20/rock \$500/oz
Denver	\$10–\$20/rock \$800–\$1,200/oz
Detroit	\$5–\$50/rock \$20/rock (most common)
Honolulu	\$5–\$15/dose \$20–\$100/rock \$100–\$250/g \$1,000–\$1,500/oz
Minneapolis/St. Paul	\$20/rock
Newark	\$5–\$50/bag
New Orleans	\$5–\$25/rock \$80–\$125/g \$800–\$1,200/oz \$20,000–\$28,000/kg
New York City	\$5, \$10, \$20, and \$50/bag \$19–\$35/g \$700/oz
Philadelphia	\$3/"trey" \$5/"ready rock"
Phoenix	\$17.50–\$20/rock \$450–\$650/oz \$7,500–\$8,500/1/2 kg
St. Louis ^b	\$20/rock \$300–\$400/g (\$250/g in rural areas)
San Diego	\$10/1/10 g
Seattle	\$20/rock (1/10–1/8 g) \$40/rock (1/5–1/4 g)
Texas	\$10–\$50/rock \$500–\$1,000/g \$15,000–\$25,000/kg
Washington, DC ^c	\$100/g \$1,000/oz \$2,100–\$2,200/"62" (62 g) \$24,000–\$27,000/kg

^aPurity 30–40 percent

^bGram purity 77 percent

^cPurity 30–81 percent

SOURCE: CEWG reports, December 2000

In New York City, cocaine HCl is sold by White, Black, and Hispanic males in their late twenties or younger, but crack is generally sold by Black and Hispanic males no older than their early twenties.

In Boston, cocaine and crack (as well as heroin) are often delivered to users' homes, with appointments made by cell phone and beeper. In Washington, DC, crack is entrenched in trafficking organizations that aggressively market their products through various activities, such as staining crack rocks with tea to imply manufacture with high-quality cocaine HCl and eliminating the sale of competing drugs of lesser market value. In most CEWG areas, cocaine is transported into the city as HCl and converted to crack locally, perhaps due to dealers' concerns over more severe penalties for crack than for cocaine HCl.

Detroit remains the source for cocaine destined for the Midwest; New York and Florida are considered primary sources for cocaine in the Washington, DC, area, with increases in trafficking among Mexican criminal organizations and low-level involvement among Jamaican organizations; Mexico is the source for many Western cities, with Mexican nationals reported as the primary traffickers in those areas. Colombians remain the primary suppliers for cocaine as reported in Detroit and Boston, with trafficking there via Puerto Rico, Jamaica, Florida, Texas, and New York City. Kilogram quantities are brought into New England in automobiles, with sophisticated electronic "hides" (hidden compartments) making detection difficult. According to sources in Colorado, vehicles are the primary means of transporting cocaine from the southwest border and southern California on interstate and local highways; however, sources in western Colorado indicate smugglers are now using various local airports for smuggling due to their minimal enforcement activity.

HEROIN

Washington, DC: *“Ethnographic data indicate that heroin is increasingly available in all quadrants of Washington, DC, as the range and diversity of individual heroin users broadens. Of particular interest, this qualitative information also suggests that heroin use appears to be on the upswing among young inner-city substance abusers. Furthermore, an abuse trend in the city mirrors an alarming pattern prevalent throughout the United States—the abuse of heroin by suburban youth.”*

MORTALITY DATA

St. Louis: *“Most heroin deaths involved older, experienced users and may have resulted from increased purity levels.”*

In the nine CEWG areas where 1999 versus partial-2000 trend data were available, heroin mortality figures suggest either increasing or stable trends:

In six reporting areas, heroin-related deaths appear to be increasing:

- Detroit: Opiate-positive toxicology levels are projected to increase by 24 percent (totaling 383 in 1999 and 356 in the first three quarters of 2000), continuing a steady upward trend since 1995.
- Miami: Heroin-induced deaths are projected to increase 16 percent (58 in 1999 and 50 in the first three quarters of 2000).
- Minneapolis/St. Paul: Opiate-related deaths are projected to increase 34 percent (totaling 47 in 1999 and 47 in the first three quarters of 2000), with an increase in Hennepin County and a decline in Ramsey County.
- Philadelphia: After declining between the 1997 peak and 1999, heroin/morphine-positive toxicology reports are projected to rebound 28 percent (236 in 1999 and 151 in the first half of 2000).
- Phoenix: Morphine-related deaths are projected to increase 49 percent (totaling 106 in 1999 and 79 in the first half of 2000), continuing a generally increasing trend since 1995.

- San Diego: Heroin-related accidental overdose deaths are projected to increase 9 percent (121 in 1999 and 66 in the first half of 2000).

In three areas, heroin-related deaths appear to be stable:

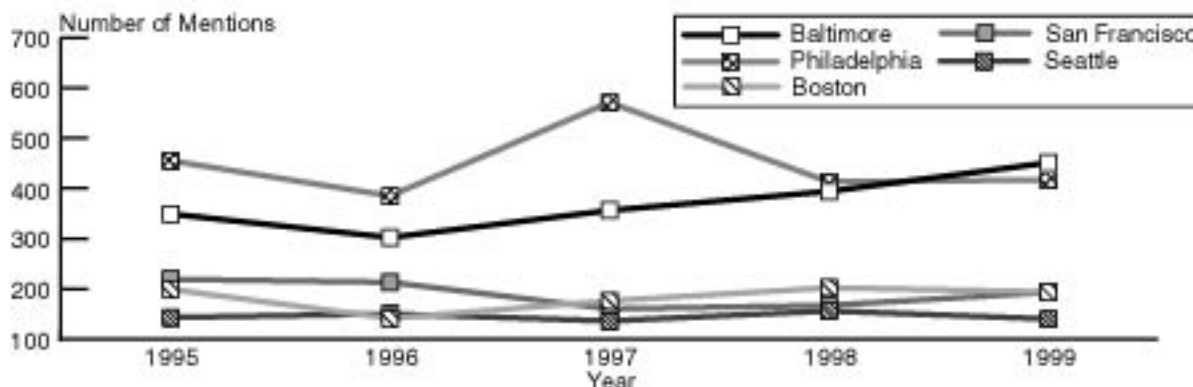
- Honolulu: After declining between 1995 and 1997, heroin-positive toxicology levels are projected to remain relatively stable (totaling 23 in 1999 and 12 in the first half of 2000).
- St. Louis: Heroin-related deaths are projected to remain relatively stable (44 in 1999 and 21 in the first half of 2000).
- Seattle: Heroin-caused deaths are projected to remain relatively stable (111 in 1999 and 82 in the first three quarters of 2000).

Long-term DAWN medical examiner (ME) data in the five cities with highest proportions of heroin deaths among total drug deaths show mixed trends, with general increases between 1995 and 1999 in Baltimore, relatively stable trends in Boston and Seattle (with upward “blips” in 1998), and declines in Philadelphia and San Francisco (exhibit 13).

EMERGENCY DEPARTMENT DATA

Boston: *“ED data and key informants indicate that heroin users remain at high risk for overdoses. Factors in overdoses seem to be high and variable purity, concomitant use of alcohol and other drugs, admixtures of toxic substances, and lowered tolerance following discharge from treatment.”*

Exhibit 13. Heroin-related deaths in selected cities, 1995-99



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (July 2000 update)

In 1999, heroin was the ED illicit drug most frequently mentioned in Newark and San Francisco (at 34 and 15 percent, respectively), and it equaled cocaine as the most frequent mention in Baltimore (28 percent each), San Diego (9 percent each), and Seattle (18 percent each) (exhibit 2). It also accounted for sizable percentages of ED mentions in Chicago (20 percent) and New York (18 percent).

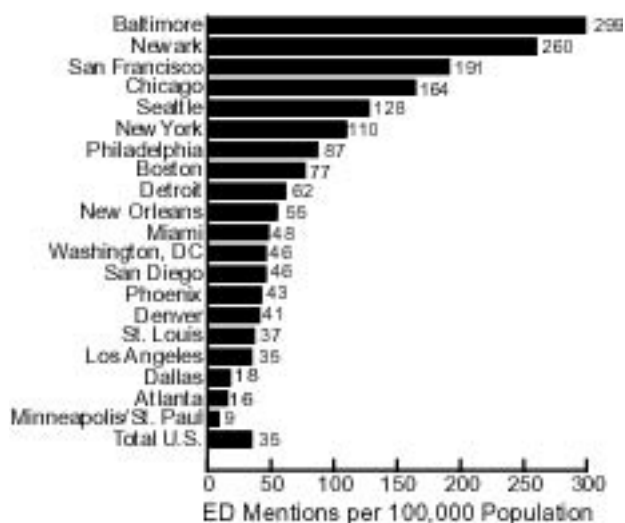
During that time period, Baltimore continued to have the highest rate of heroin mentions per 100,000 population of the 20 CEWG cities in DAWN, followed by Newark, San Francisco, and Chicago (exhibit 14). Minneapolis/St. Paul continued to have the lowest heroin rate (as it did for cocaine).

Between 1998 and 1999, heroin ED trends were mixed, with more increases than declines (exhibit 15). Mentions increased significantly in five cities (Miami, New Orleans, Denver, San Francisco, and St. Louis) and declined significantly only in Washington, DC. As a percentage of total ED mentions, heroin declined substantially (≥ 3 points) in three areas (Boston, New York, and Newark) and remained stable elsewhere during that same period.

Long-term trends show rates in the three top-ranking cities (Baltimore, Newark, and San

Francisco) as lower in 1999 than they were in 1995; in Chicago, however, rates increased steadily between the 2 years (exhibit 16).

Exhibit 14. Estimated rate of heroin/morphine ED mentions per 100,000 population by metropolitan area, 1999



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

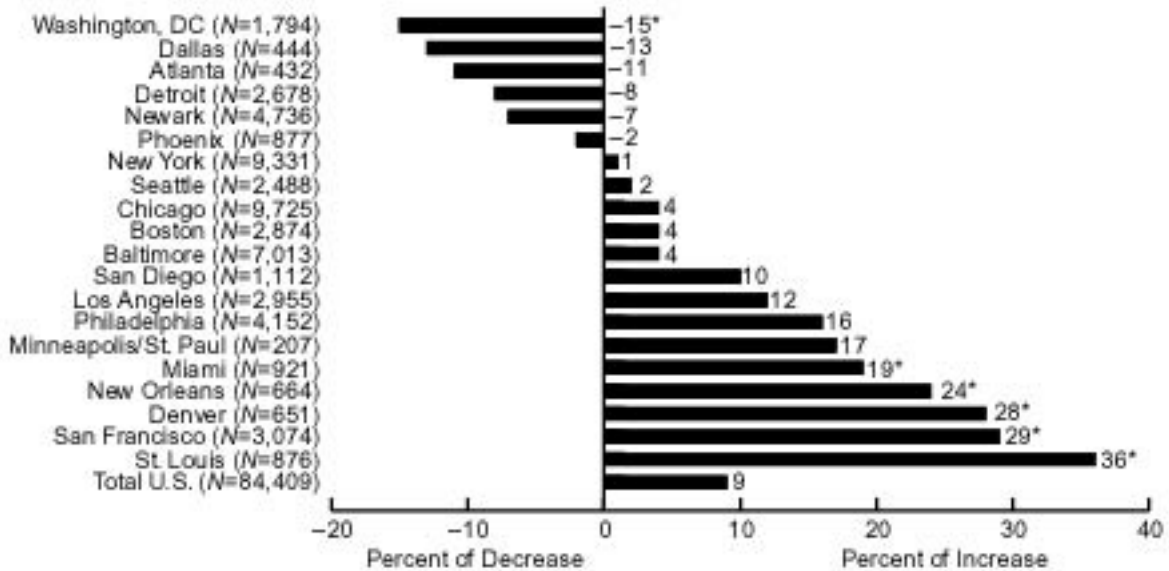
TREATMENT DATA

Boston: *“Even more than in previous periods, the impact of widely available, low-cost, and very pure heroin is reported by treatment providers, who continue to see more heroin users seeking services.”*

Heroin as the primary drug of abuse accounts for the largest percentage of admissions in 7 of 18 reporting CEWG areas (exhibit 6). Additionally, it accounts for large proportions of admissions (>15 percent) in Chicago, Philadelphia, Seattle, and Washington, DC (exhibit 17).

Heroin treatment percentage trends were mixed when compared with figures from the same reporting period 1 year earlier. Heroin proportions increased (3–16 points) in Baltimore, New Orleans, Seattle, and Washington, DC, declined in St. Louis (by 4 points), and

Exhibit 15. Percentage of change in heroin ED mentions by metropolitan area, 1998 versus 1999

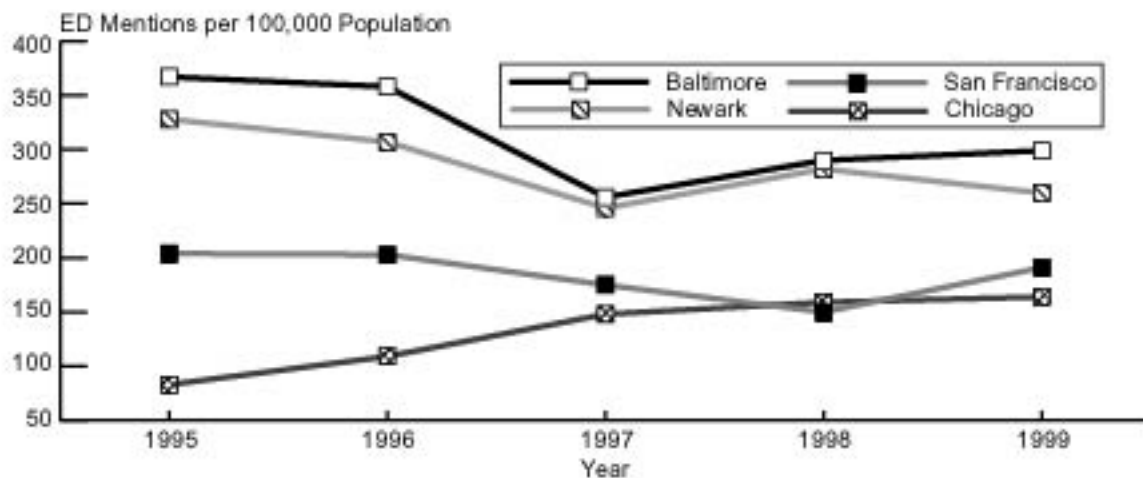


NOTE: (N) refers to 1999 mentions.

*p<0.05

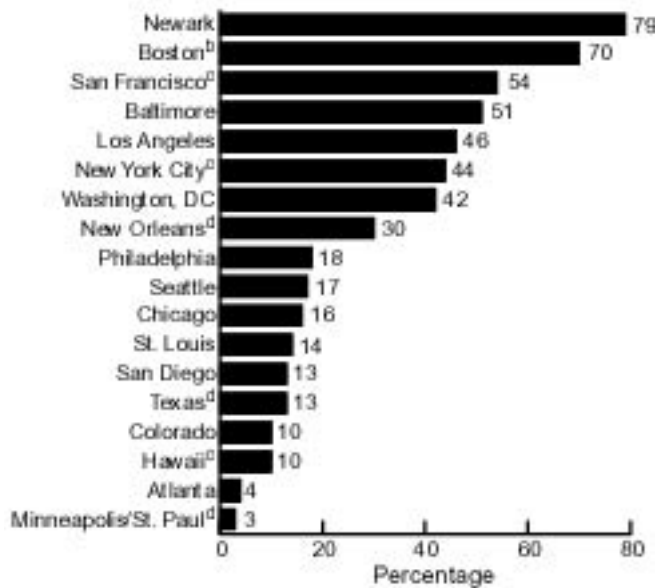
SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Exhibit 16. Annual trends in heroin ED mentions per 100,000 population in four top-ranking cities, 1995–99



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Exhibit 17. Heroin as a proportion of primary drugs of abuse among treatment admissions, first half 2000 (including alcohol-in-combination and excluding alcohol-only)^a



^aReporting periods are January–June 2000, except for the following: full year 1999 in Atlanta, July–December 1999 in Baltimore, July 1999–June 2000 in Boston, FY 2000 in San Francisco, and January–September 2000 in Texas.
^bExcludes drugs other than cocaine, heroin, and marijuana.
^cAlcohol-in-combination is not included.
^dAlcohol-only is not excluded.

SOURCE: Drug abuse treatment agencies

remained relatively stable (<3 percentage-point change) in the remaining areas.

Long-term treatment data show mostly increasing or stable trends:

- Chicago: Since a rise in 1996, the number and proportion of heroin admissions remained relatively stable between 1996 and fiscal year (FY) 2000.
- Colorado: Among all drug admissions, the proportion and number of heroin admissions have remained relatively stable from 1994 (14 percent) through the first half of 2000 (15 percent). Despite static totals, the proportion and number of new heroin users entering treatment has increased in recent

years (from 15 percent in 1995 to 17 percent in the first half of 2000).

- New York City: Between 1991 and 1999, primary heroin admissions have been gradually increasing (from 15,085 to 20,879—a 38-percent increase).
- St. Louis: From 1996 to the first half of 2000, treatment data showed a large increase in the number of heroin users (from 345 to 819).
- Texas: Between 1993 and the first quarter of 2000, the proportion of heroin admissions among total admissions increased (from 9 to 13 percent).

Conversely, in CEWG cities in California (Los Angeles, San Diego, and San Francisco), long-term trends for heroin admission showed declines. Between 1995 and the first half of 2000 in Los Angeles, heroin admissions declined from 57 to 46 percent. Between the first halves of 1994 and 2000, they declined 14 percent in San Diego. The number of primary heroin admissions in the San Francisco Bay area fluctuated narrowly between 1994 and FY 2000, but the proportion of heroin admissions among total admissions declined (from 64 to 54 percent). The number and proportion of heroin admissions also showed declines in Newark between 1995 and 1999 (from 4,511 to 3,744 admissions).

OTHER LOCAL DATA

Poison control data suggest increasing or stable trends:

- Colorado: Heroin-related poison calls, which had been steady from 1994 (21 calls) to 1998 (22 calls), increased to 36 calls in 1999.
- Massachusetts: In the second and third quarters of 2000, heroin was mentioned in 24 percent of helpline calls in which drugs were specified, similar to earlier periods.

TREATMENT DATA AND OTHER INDICATORS POINT TO AN EMERGING COHORT OF YOUNGER, MOSTLY SUBURBAN HEROIN USERS IN SEVERAL CEWG AREAS:

Atlanta: Although the majority of treatment admissions are among persons older than 26, the emergence of a younger cohort of heroin users continues to be supported by all indicators.

Baltimore: The new cohort of white suburban youth who reportedly began to emerge in the early 1990s is beginning to appear in the treatment system.

Boston: Needle exchange contacts in Boston proper report mostly traditional, older clients who have injected heroin for many years, while exchange contacts in Cambridge and Northampton (in western Massachusetts) continue to see more younger heroin injectors.

Boston: Treatment providers report seeing younger heroin users, many from fairly stable backgrounds, who began using heroin intranasally and recreationally. One program director described the recent increase in heroin addicts seeking treatment as “almost shocking,” and a clinician described it as “overwhelming.”

St. Louis: One hospital with a treatment program geared to young adults (<25 years) reported that as many as half of its admissions reported heroin use.

- Texas: Confirmed exposure calls involving heroin totaled 231 in 1999 and 184 from January through August 2000.

Local survey data for heroin use show mixed trends:

- Arizona: Between 1997 and 1999, lifetime narcotics use among elementary school students increased (from 2.2 to 3.1 percent), past-month use increased among junior high students (from 2.8 to 4.3 percent), and past-month use remained relatively stable among high school students (from 4.6 to 4.8 percent).
- Boston: School survey data from 1999 suggest that heroin use remains low among adolescents, with 3 percent of 7th–12th graders reporting lifetime use and 1 percent reporting current use.
- Chicago: Between 1995 and 1998, opioid toxicity remained stable (8 and 9 percent positive, respectively) among infants who were tested for controlled substances. In the first quarter of 1999, positive levels declined slightly to 6 percent.

- Texas: The proportion of secondary students reporting lifetime heroin use dropped from 2.4 percent in 1998 to 1.6 percent in 2000.

Additionally, in Seattle, among enrollees in two epidemiologic studies with large samples of injecting drug users (IDUs) (more than 4,400), the proportion of IDUs reporting heroin as their primary drug increased considerably between 1994 and 1999 (from 61 to 86 percent).

DEMOGRAPHIC DATA

Age

In CEWG areas reporting mortality demographics, heroin decedents were typically 35 or older. In San Diego, 78 percent of heroin overdose decedents in the first half of 2000 were 35 or older; in Texas, the average age of heroin-related decedents in 1999 was 38 years; and in Minneapolis (Hennepin County), in the first three quarters of 2000, the average age was 41.2 years.

Similar to mortality data, ED data showed that the 35+ group accounts for the largest proportion of heroin mentions in all CEWG areas in DAWN, ranging from 42 percent in New Orleans to 81 percent in Detroit (exhibit 18). The 26–34 group still accounts for substantial proportions (≥ 25 percent) in half of the 20 CEWG cities in DAWN, with proportions ranging from 13 percent in Detroit to 34 percent in Newark. The young adult group (18–25) accounts for a substantial proportion (≥ 20 percent) of heroin mentions in Dallas, New Orleans, Philadelphia, and St. Louis. Dallas also has a relatively high representation of adolescents (12–17 years) (at 4 percent of heroin mentions). While still a rarity, adolescent involvement in heroin ED mentions has

been a growing phenomenon: in 1994, they were reported in six cities, and in 1999, they were reported in nine cities.

Between 1998 and 1999, age distribution shifts among heroin ED mentions continued to suggest the transition of the 26–34 group into the oldest age bracket: the oldest group increased as a percentage of heroin ED mentions in all but three cities (it remained stable in Baltimore and declined in Minneapolis/St. Paul and St. Louis), while the 26–34 group declined in all but four cities (it increased in Baltimore, Denver, Minneapolis/St. Paul, and Philadelphia). Increases among the 35+ group were particularly marked (5–19 percentage points) in Atlanta, Detroit, Los Angeles,

Exhibit 18. Age and gender distribution of heroin ED mentions, by percentage, in CEWG cities, 1999

City	(N)	35+	26–34	18–25	12–17	Males
Atlanta	(432)	58	25–	16	0–	70
Baltimore	(7,013)	53	31	14	1	60
Boston	(2,874)	53	28	18	0	67
Chicago	(9,725)	57+	30	11	1+	59
Dallas	(444)	45	20	31	4	63
Denver	(651)	64+	21+	14	1	71
Detroit	(2,678)	81	13–	5–	...	65
Los Angeles	(2,955)	73+	19	8	1	72
Miami	(921)	58+	30	11+	0+	74
Minneapolis/St. Paul	(207)	54	27	19	0	69
Newark	(4,736)	55	34–	11	0	63
New Orleans	(664)	42+	19	38+	...	87
New York	(9,331)	71	20	8	0	78
Philadelphia	(4,152)	45	32	21	1	71
Phoenix	(877)	61+	27	11–	1	67
St. Louis	(876)	54+	21	23+	2	65
San Diego	(1,112)	67+	21	11–	2+	65
San Francisco	(3,074)	72+	18	10+	0	66
Seattle	(2,488)	62	26	12	0–	64
Washington, DC	(1,794)	75–	17	8	...	62

NOTE: “...” denotes does not meet standard of precision; “+” or “–” indicates significant increase or decrease ($p < 0.05$) in number (not percentage) of mentions since 1998.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Phoenix, and San Diego. Declines among the 26–34 group were particularly marked in Los Angeles (6 points), New Orleans (8 points), and Phoenix (16 points).

Trends were relatively stable among younger cohorts. The young adult group remained stable in most cities, except in Denver where proportions declined by 5 percentage points, and in New Orleans and St. Louis, where proportions increased by 8 points and 5 points, respectively. Adolescent proportions remained relatively stable in all cities.

Like the shifts in age distribution between 1998 and 1999, changes in the numbers of heroin mentions during that period also suggest that the 26–34 group has been transitioning into the 35+ group. The 35+ group increased significantly ($p < 0.05$) in nine cities and declined significantly only in Washington, DC, whereas the 26–34 group declined significantly in four cities and increased significantly only in Denver (exhibit 18). Trends among the young adult and adolescent groups were mixed.

Heroin ED rates per 100,000 population are highest among the 26–34 age group in 11 DAWN cities, highest among the 18–25 group in 5 cities, and highest among the 35+ group in 4 cities (exhibit 19).

Like mortality and ED data, treatment data show that the oldest (35+) group accounts for the highest percentage of admissions for primary heroin abuse in every reporting area (exhibit 20). The 26–34 group, however, is still well represented at 20 percent or more of heroin admissions in all reporting areas (ranging from 20 percent in Los Angeles to 39 percent in Atlanta). The 18–25 group accounts for substantial percentages (≥ 20 percent) in St. Louis and San Diego.

Age distribution shifts among heroin users in treatment show mixed trends. The 35+ group as a proportion of heroin admissions increased substantially (≥ 3 percentage points) in three areas (Los Angeles, Newark, and New York City), declined in two areas (Atlanta and St. Louis), and remained relatively stable elsewhere, while the 26–34 group declined in three areas (Newark, New York, and San Diego), increased in two (Atlanta and St. Louis), and remained relatively stable elsewhere. The 18–25 group remained relatively stable as a proportion, except for increases in St. Louis and San Diego and a decline in Atlanta. In South Florida

Exhibit 19. Heroin ED rates per 100,000 population, by age and metropolitan area, 1999

City	35+	26–34	18–25	<18
Atlanta	17	24	22	0
Baltimore	283	629	380	36
Boston	73	140	108	4
Chicago	170	332	163	22
Dallas	16	21	46	7
Denver	47	54	59	3
Detroit	91	58	29	...
Los Angeles	49	42	19	2
Miami	48	105	52	2
Minneapolis/ St. Paul	9	14	15	1
Newark	245	637	276	11
New Orleans	43	75	193	...
New York	137	152	81	3
Philadelphia	69	196	167	11
Phoenix	48	77	40	5
St. Louis	35	53	83	9
San Diego	60	67	31	8
San Francisco	227	219	178	7
Seattle	141	206	146	4
Washington, DC	64	47	30	...

NOTE: "..." denotes does not meet standard of precision; highlighted areas indicate highest ranking age group in each city.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

(Broward County), the proportion of 18–25-year-olds among heroin admissions doubled between 1998 and the first half of 2000 (from 10 to 20 percent), and the youngest group's proportion (<18 years) also increased dramatically, from 1 to 6 percent—the highest proportion recorded among heroin admissions younger than 18 in all reporting CEWG areas.

Gender

Males continue to predominate in heroin mortality figures in the areas where such data are available: San Diego (where males account for 90 percent of heroin overdose decedents), Minneapolis (Hennepin County) (where males account for 86 percent of heroin-related decedents), and South Florida.

Males also outnumber females among heroin ED mentions in all CEWG cities in DAWN (exhibit 18). The male-female gender gap remains widest in New Orleans (87 versus 13 percent) and remains narrowest in Chicago (59 versus 41 percent). Between 1998 and 1999, gender distributions remained relatively stable, except for an 11-point increase among females in Phoenix.

Supporting both mortality and ED data, males also outnumber females among heroin treatment admissions in all reporting areas (exhibit 20). In areas where comparative data are available, gender gaps among treatment admissions are generally narrower than gender gaps among ED mentions. Gender trends among treatment admissions were mixed compared with the same period 1 year earlier: female representation increased substantially (≥ 5 points) in Philadelphia, declined substantially in Newark and San Diego, and remained relatively stable elsewhere.

Females continue to appear more prominently in the arrestee population (indicated by ADAM data) than in other heroin-using populations:

Exhibit 20. Age distribution of primary heroin treatment admissions, by percentage, in reporting CEWG areas^a

Area	35+	26–34	18–25	≤17	Males
Atlanta	48	39	14	0	64
Baltimore	50	34	14	2	55
Boston	NR	NR	NR	NR	75
Chicago	49	35	16	1	55
Colorado	58	26	16	1	65
Los Angeles	74	20	6	<1	72
Minneapolis/ St. Paul	51	34	13	1	67
Newark	59	36	5	0	62
New York City ^b	62	31	7		73
Philadelphia	51	29	19	1	54
St. Louis	43	22	33	2	71
San Diego	51	22	25	1	68
Seattle	69	21	9	1	57
South Florida (Broward County)	48	27	19	6	NR
Texas	NR	NR	NR	NR	57

^aReporting periods are January–June 2000, except for the following: full year 1999 in Atlanta, July–December 1999 in Baltimore, July 1999–June 2000 in Boston, and January–September 2000 in Texas.

^bAge groups are 36+, 26–35, and ≤25.

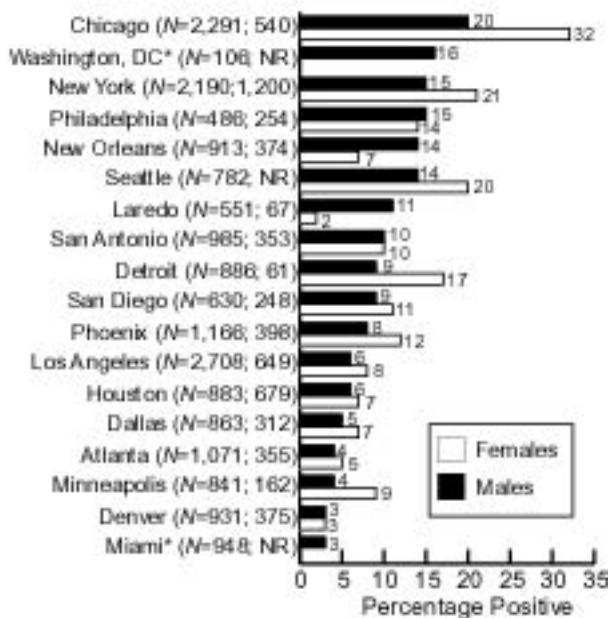
SOURCE: Drug abuse treatment agencies

female arrestees tested higher for opiates than males in 12 of the 16 CEWG cities where both males and females were tested in 1999 (exhibit 21). The gender disparity was most noticeable in Chicago, where females had the highest opiate-positive levels among the cities. New York and Seattle also had particularly high levels among females. Only in Denver, Laredo, New Orleans, and Philadelphia did females test positive at lower levels than males.

Race/Ethnicity

Whites predominate in heroin mortality figures in all CEWG areas where such data are available, including Minneapolis (Hennepin County) (at 61 percent), Philadelphia, San Diego (at 49 percent), South Florida, and

Exhibit 21. Percentage positive for opiates among male and female booked arrestees, 1999 (ranked by males)



*Females are not tested at these sites.

SOURCE: National Institute of Justice, Arrestee Drug Abuse Monitoring program, 1999 Annual Report

Texas. Hispanics are overrepresented among San Diego decedents (at 42 percent), as they are in most of that city’s heroin indicators.

Heroin ED racial demographics vary depending on geographic location. In 1999, Blacks were the largest racial/ethnic group among heroin mentions in eight CEWG cities (Atlanta, Baltimore, Chicago, Detroit, New Orleans, New

York, Newark, and Washington, DC), Whites were the largest in six cities (Boston, Dallas, Miami, Philadelphia, St. Louis, and San Diego), Hispanics in one city (Los Angeles), and five cities had too many mentions in the “unknown” category to be included in the count.

Between 1998 and 1999, several substantial shifts occurred in the racial/ethnic distributions among heroin ED mentions (exhibit 22). In St. Louis, Whites as a proportion of heroin mentions increased (by 10 points), while Blacks as a proportion declined correspondingly. Conversely, in Detroit and Philadelphia, Whites as a proportion declined (by 8 and 7 points, respectively), while Blacks as a proportion increased (by 6 and 5 points, respectively). Hispanics as a proportion remained relatively stable in CEWG cities, except in New York (where proportions declined) and Philadelphia (where they increased).

Like ED heroin demographics, racial/ethnic demographics among heroin treatment admissions vary from city to city. Among heroin admissions, Blacks’ representation (ranging from 8 percent in San Diego to 71 percent in Chicago) was greater than that of other races/ethnicities in five reporting areas (Baltimore, Chicago, Minneapolis/St. Paul, Newark, and St. Louis). Whites’ representation (ranging from 8 percent in Newark to 69 percent in Seattle) was greater than that of other

Exhibit 22. Recent shifts in racial/ethnic distributions among heroin ED mentions (1998 versus 1999) and primary heroin treatment admissions (first half 1999 versus first half 2000)

City	Treatment	ED
Atlanta	Whites ↑, Blacks ↓	Relatively stable
Chicago	Whites ↑, Blacks ↓	Relatively stable
St. Louis	Whites ↑, Blacks ↓	Whites ↑, Blacks ↓
Baltimore	Blacks ↑, Whites ↓	Relatively stable
Detroit	NR	Blacks ↑, Whites ↓
Philadelphia	Relatively stable	Blacks and Hispanics ↑, Whites ↓
New York	Hispanics ↑, Whites and Blacks ↓	Hispanics ↓

SOURCES: Drug abuse treatment agencies; Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

racess/ethnicities in six areas (Atlanta, Boston, Colorado, Philadelphia, San Diego, and Seattle). Hispanics' representation (ranging from 0 percent in Atlanta to 56 percent in Texas) was greater than that of other races/ethnicities in three areas (Los Angeles, New York City, and Texas).

LOCAL GEOGRAPHIC PATTERNS

Urban-versus-suburban patterns and trends of heroin use vary from city to city. In Newark, the proportion of heroin mentions among treatment admissions is larger in the city proper than in the Newark primary metropolitan statistical area (PMSA), but data show continuing and parallel increases in heroin admissions both in Newark City and areas outside the city. Similarly, in Baltimore, the rate of heroin admissions per 100,000 population was about five times as high in Baltimore City as in the suburban counties; however, just as heroin has historically dominated the Baltimore City treatment system, it surpassed alcohol as the primary drug in the suburban counties as well in 4 of 5 years between 1995 and 1999. Treatment data suggest that heroin users in Detroit/Wayne County are older than those statewide.

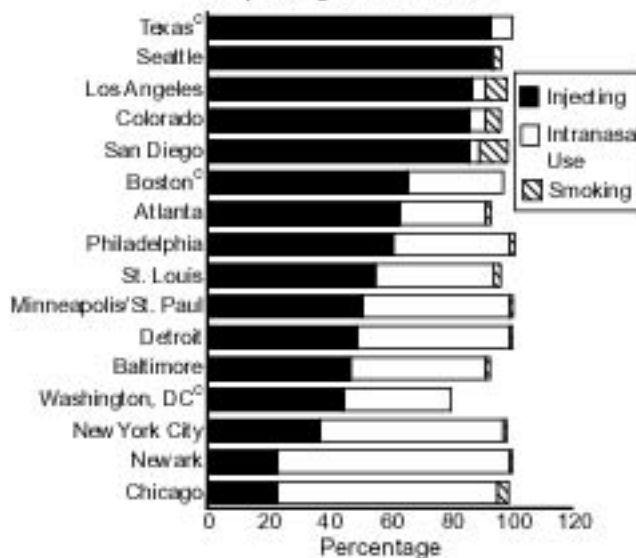
In several areas where comparative treatment data for 1 year earlier were available, racial/ethnic distributions among heroin admissions shifted (exhibit 22). In three cities (Atlanta, Chicago, and—similar to ED data—St. Louis), Whites' representation increased, while Blacks' representation declined. Conversely, in Baltimore, Whites' representation declined, while Blacks' representation increased. In New York City, both Whites' and Blacks' representations declined (by 5 and 4 points, respectively), while Hispanics' representation increased markedly (by 8 points). In Texas since 1996, the proportion of Hispanics entering treatment for a primary problem with heroin has been increasing.

USE PATTERNS

Route of Administration

Injecting remains the most common route of administration among heroin treatment admissions in the majority of cities, with the highest proportions in the West, where lower purity black tar heroin continues to predominate (exhibit 23). Intranasal use continues to predominate in Chicago, Detroit, Newark, and New York City, and it accounts for substantial proportions (>25 percent) in seven other eastern and midwestern cities: Atlanta, Baltimore, Boston, Minneapolis/St. Paul, Philadelphia, St. Louis, and Washington, DC. Smoking still accounts for relatively small percentages of heroin admissions. The highest proportions were reported western cities: San Diego (10 percent), Los Angeles (7 percent), and Denver (5 percent).

Exhibit 23. Route of administration^a among heroin treatment admissions, by percentage, in reporting CEWG areas^b



^aOther/multiple routes of administration also account for small percentages in some areas.
^bReporting periods are January–June 2000, except for the following: full year 1999 in Atlanta, July–December 1999 in Baltimore, July 1999–June 2000 in Boston, FY 2000 in Detroit, and January–September 2000 in Texas.
^cOnly two sources are reported.

SOURCE: Drug abuse treatment agencies

Compared with the same period 1 year earlier, injection generally remained stable as a percentage of heroin admissions, except in Philadelphia, where percentages increased by 4 points, and St. Louis and Washington, DC, where percentages declined by 14 points and 17 points, respectively. Intranasal use as a proportion of heroin admissions remained relatively stable, except for increases in Atlanta and St. Louis (by 13 and 12 points, respectively) and declines in Philadelphia (by 3 points).

Longer term trends show some more marked shifts in route of administration, especially in eastern cities and from injecting to intranasal use. For example, in Philadelphia, injecting has declined, while intranasal use has increased among heroin admissions since the mid-1990s. Disturbingly, in some eastern cities route of administration among admissions may be trending back from intranasal use toward injecting. In Newark, for example, intranasal use surpassed injecting in 1992; however,

INTRANASAL USE VERSUS INJECTING: A CLOSER LOOK

Self-perception among those who use heroin intranasally:

Atlanta: "Ethnographic data suggest that injection remains quite common among users of heroin; however, intranasal use and other routes of administration continue to increase and may be under-represented in traditional sources of data. Ethnographic reports also point to differences in the self-realization of use depending on the mode of administration: those injecting, for example, seem more likely to consider themselves heroin users than those who use it intranasally in social settings."

Boston: "One treatment provider reported that heroin clients seeking treatment for the first time were often prompted to do so by having injected, widely considered the mark of a true addict. Nevertheless, a substantial minority of admissions report for treatment having never injected."

From intranasal use to injecting:

Boston: "Due to high purity, intranasal use is the common and starting route of administration for new and younger users....Progression to injection is widely reported, due perhaps to the increased effect from a given amount of heroin and the need to buy fewer bags to support a habit."

"Lag time" to treatment among injectors versus intranasal users:

Texas: "While the number of individuals who use heroin intranasally is small, it is significant to note that their lag period from first use to seeking treatment is 7 years rather than 15 for injectors. This shorter lag period means that contrary to street rumors that "sniffing or inhaling is not addictive," those who use intranasally may need treatment much more quickly than needle users."

Motivations for using intranasally instead of injecting:

Although heroin injectors continue to account for the highest proportion of heroin admissions in the majority of CEWG areas, new heroin users often begin using the drug intranasally instead of injecting, and various reasons have been cited for this pattern: fear of needles, increased availability of high-purity heroin, wider acceptance of the drug in social circles because needles are not necessary, and the heavy toll of the AIDS epidemic among IDUs. In Miami and several other CEWG areas, these new intranasal heroin users are now appearing among those in trouble with that drug.

between 1995 and 1999, injection rebounded from 20 to 24 percent. Similarly in New York City, intranasal use may have peaked during the second half of 1998; since then, the proportion reporting intranasal use has been declining, while injecting has been increasing.

In western and midwestern cities, long-term route of administration trends for heroin admissions vary. In Colorado, heroin smoking and intranasal use have become more common, with only 3.5 percent of treatment admissions reporting smoking or using heroin intranasally in 1993, compared with 10 percent in the first half of 2000. Similarly, in Chicago, the proportion of admissions reporting intranasal use of heroin has risen dramatically between FYs 1998 and 2000 (from 60 to 72 percent). And in San Diego, the proportion of injectors among heroin admissions declined between 1994 and the first half of 2000 (from 95 to 86 percent).

Route of administration often varies demographically, as demonstrated by the following treatment data:

- Baltimore: Treatment data show that intranasal heroin users are more likely than injectors to be females (47 versus 40 percent) and less likely to be younger than 25 (13 versus 19 percent).
- Boston: Among heroin admissions in FY 2000, those who used the drug intranasally had a mean age at first use of 11.4 years, compared with 13.4 years for injectors.
- Colorado: In general, heroin intranasal users and injectors are more similar demographically than either group is to smokers. Heroin smokers are younger than injectors and intranasal users, more likely to be White, and more likely to be employed.
- New York City: Compared with heroin injectors, intranasal users are more likely to be Hispanic (55 versus 48 percent) and first

admissions to treatment (16 versus 11 percent). In contrast, primary heroin injectors are more likely than intranasal users to be White (32 versus 14 percent) and to have started use prior to age 20 (57 versus 41 percent).

- Texas: Heroin admissions who inject are more likely than intranasal users to be male (71 percent versus 64 percent), less likely to be Black, and more likely to be White or Hispanic. Their average age is higher than that of intranasal users (37 versus 29 years).

Multisubstance Use and Adulteration

Boston: "The level of multisubstance use among primary heroin admissions was the highest for any drug, with 87 percent reporting the use of at least one other illicit drug in the month prior to admission."

Mortality data continue to show high levels of heroin used in combination with cocaine and other drugs. In Philadelphia, heroin/morphine alone was identified in only 16 percent of heroin/morphine toxicology reports in the first half of 2000, compared with cocaine in addition to heroin in 36 percent. (In total, 48 percent of the heroin/morphine reports indicated the presence of other drugs.) In Phoenix, heroin-in-combination-with-cocaine deaths (37 in the first half of 2000) are projected to increase 35 percent from the 1999 level.

Among primary heroin treatment admissions, cocaine and alcohol remain the most common secondary and tertiary drugs of abuse, respectively, in nearly all reporting areas. Exceptions include marijuana as the most common secondary drug in Los Angeles, marijuana as the most common tertiary drug in Atlanta, and benzodiazepines as the most common tertiary drugs in Philadelphia.

According to ethnographic reports in Atlanta, alcohol, crack, cocaine HCl, and marijuana are among the most common drugs combined with

heroin, and some users there also use other depressants, such as flunitrazepam (Rohypnol), to increase or sustain the heroin high. In Boston, a clinician reported heroin clients testing positive for benzodiazepines even though clients claimed to use only heroin, suggesting that heroin may sometimes be cut with benzodiazepines. Heroin users continue to substitute other opiates (such as hydromorphone and codeine) for heroin in Washington, DC, where the pills are also used to ease withdrawal and to potentiate the strength of heroin.

LAW ENFORCEMENT DATA

Arrestee Urinalysis Data

Opiate-positive screens among arrestees remain low relative to those for cocaine and marijuana (exhibit 21). Adult males in eight CEWG cities in the ADAM program, spanning all regions of the country, had levels of 10 percent or higher in 1999: Chicago, New Orleans, New York, Philadelphia, Seattle, Washington, DC, and two Texas cities (Laredo and San Antonio). Likewise, adult females tested positive at 10 percent or higher in eight CEWG cities from diverse parts of the country: Chicago, Detroit, New York, Philadelphia, Phoenix, San Antonio, San Diego, and Seattle.

Between 1998 and 1999, opiate-positive levels remained generally stable among males (within 3 percentage points), with two exceptions: a 4-percentage-point decline in Philadelphia and a 6-point increase in Washington, DC. (However, the sample size in Washington, DC, declined considerably between the two reporting periods; furthermore, the District's more extensive Pretrial Services urinalyses show a 21-percent decline in the number of arrestees testing opiate-positive between the first halves of 1999 and 2000). Among females, slight increases (3–5 percentage points) were report-

ed in several cities: Chicago, Minneapolis, New Orleans, Phoenix, San Diego, and Seattle. (Note, however, that the sample sizes in Chicago and Seattle increased considerably between the two reporting periods.) Only in Detroit did opiate-positive levels decline notably (5 points) among females.

Arrests, Seizures, and Submissions

Boston: "State police continue to report consistently large seizures of heroin, often packed in compact, short latex 'fingers.'"

Heroin-related arrests in various cities show mostly stable trends:

- Honolulu: In the first half of 2000, 43 heroin cases were reported, similar to the numbers over the past 2 years.
- New Orleans: Between the first halves of 1999 and 2000, possession-related arrests (171 in the first half of 2000) and distribution-related arrests (102 in the first half of 2000) remained relatively stable.
- New York City: Heroin arrests peaked in 1989 (at 28,083), declined for a few years, and then peaked again in 1995. Between 1998 and 1999, arrests declined 12 percent (from 37,483 to 32,949 heroin arrests).
- San Francisco: Heroin-related offenses totaled 6,905 in the county in 1999, a number in the middle of the range (6,546–7,214 heroin-related offenses) from 1996 through 1999.
- Seattle: Heroin-related offenses have not shown a clear trend between 1991 and the first three quarters of 2000. This may be due to the fact that arrests and convictions are influenced by factors other than underlying use.
- Washington, DC: Heroin charges accounted for 14 percent of all drug arrests in 1999 and 11 percent in the first 4 months of 2000 (368 arrests).

By contrast, heroin-related arrests as a proportion of drug arrests in Boston remained relatively stable (22–24 percent) between 1995 and 1999, but increased markedly (to 30 percent) in the first half of 2000.

The numbers of heroin seizures and submissions show mixed trends in reporting CEWG areas, with four increases (in Arizona, Atlanta, Boston, and Minneapolis/St. Paul) and two declines (in Newark and Washington, DC). In Arizona, 102 pounds of black tar heroin were seized, doubling the previous record of 44 pounds confiscated in 1995. In Atlanta, seizures increased between 1998 and 1999 (from 22 to 7,271 grams). In Boston, heroin submissions increased between 1999 and the first half of 2000 (from 17 percent of all submissions to 20 percent—the highest percentage for heroin recorded in these CEWG reports). In St. Paul, almost as much heroin was seized in the first quarter of 2000 as in the full year of 1999. Conversely, in Newark, police reported 2,363 heroin seizures in the first 10 months of 1999, down from 3,372 in 1998. And in Washington, DC, seizures were down (from 939 in the first three quarters of 1999 to 771 in the first 10 months of 2000).

Availability and Source

Miami: “More heroin on the street, increased purity, and decreased prices have allowed for new routes of abuse (intranasal use and smoking) and for new users (those who ‘would never inject.’)”

Heroin is widely available in nearly all CEWG areas, and its availability is increasing or stable in all reporting areas.

In the first quarter of 2000, the DEA’s Domestic Monitor Program (DMP) undercover heroin buys showed South American white heroin (57 percent average purity) to be the

dominant source and type throughout the Northeast, Southeast, and Midwest (except in St. Louis, where Mexican heroin remains the only type available). Mexican heroin (29 percent average purity) still predominates in the West and Southwest (Texas). A limited number of Southwest Asian heroin samples (41 percent average purity) were available in Atlanta, Baltimore, Chicago, Detroit, Newark, and New York. Southeast Asian samples (38 percent average purity) were available in Atlanta, Chicago, and Detroit.

Several recent changes in heroin type and source within cities were reported in 2000. In several cities where South American heroin does not predominate, its availability increased: in Denver (where Mexican heroin predominates), heroin purported to be Colombian was encountered in the fourth quarter of FY 2000, and in Chicago (where heroin type varies), South American heroin became more available in 2000. It is therefore possible that increased purity levels may be recorded in those cities in 2001. Conversely, in South Florida (where South American heroin predominates), Mexican black tar heroin may be increasing. In Arizona (where Mexican black tar heroin predominates), traffickers are starting to smuggle Mexican white heroin, which is being dissolved in dark liquids such as whisky and carbonated beverages, across major ports of entry along the U.S.-Mexican border. In Minneapolis/St. Paul, high-purity heroin, most of it an off-white or tan-colored powder, became increasingly available in 2000, possibly contributing to the rising number of accidental overdose deaths.

Price

Boston: “Low heroin prices mean that users can afford relatively large habits (20–50 bags per day in some cases) on relatively small incomes.”

New York City: “Although \$10 bags remain the most common, occasionally \$5 bags are made available to attract business, to market a ‘new’ product, or as a sample of quality.”

Exhibit 24 lists price information reported at the local level. Heroin prices range from \$50–\$100 per gram in Phoenix to \$300–\$750 in New Orleans. Price changes at the local level were reported in only two cities: in Minneapolis/St. Paul, where prices fell dramatically from \$50 to \$10 per dose between 1999 and the first quarter of 2000, and in New Orleans, where prices increased.

First-quarter-2000 DMP data continue to show wide price variations across the country (exhibit 25). Between 1999 and the first quarter of 2000, prices per milligram pure declined in 9 of 20 CEWG cities where the DMP purchased heroin, increased in 6 cities, and remained stable in 5. Prices dropped sharply in Miami (by \$0.95) and St. Louis (by \$0.50) and increased sharply in Los Angeles (by \$1.18). Several declines continue long-term downward trends: in Dallas, prices declined steadily between 1996 and the first quarter of 2000 (from \$6.66 to \$.59 per milligram pure); in Detroit, prices declined steadily between 1995 and the first quarter of 2000 (from \$1.67 to \$.64); and in San Francisco, prices generally declined between 1994 and the first quarter of 2000 (from \$.95 to \$.30).

Purity

Atlanta: “Ethnographic researchers are getting mixed reports on heroin purity: some users report not having to even cook the heroin at all.”

According to first-quarter-2000 DMP data, street-level purity remains highest in the Northeast, although high purity levels (>50 percent) continue in some parts of the Midwest (in Detroit) and the West (in San Diego)

(exhibit 25). Newark surpassed Philadelphia as the city with highest average purity of all controlled heroin buys.

Purity increases (by 5–12 percentage points) between 1999 and the first quarter of 2000 were recorded in six cities: Boston, Denver, Miami, Newark, Phoenix, and San Francisco. By contrast, declines (by 5–19 percentage points) were recorded in five cities: Atlanta, Baltimore, Los Angeles, New Orleans, and St. Louis. Purity levels remained fairly stable (within 5 percentage points) in the remaining nine cities.

Long-term trends show more dramatic shifts. In Chicago, average purity more than doubled between 1991 and the first quarter of 2000 (from 10 to 23 percent); in Dallas, purity more than doubled between 1995 and the first quarter of 2000 (from 7 to 16 percent); in Detroit, it nearly tripled between 1991 and the first quarter of 2000 (from 18 to 52 percent); in Newark, it increased considerably between 1995 and the first quarter of 2000 (from 55 to 77 percent); and in St. Louis, purity doubled between 1994 and the first quarter of 2000 (from 9 to 18 percent).

Trafficking and Distribution

South Florida’s expanding heroin epidemic is linked to the active marketing of South American heroin from Colombia that has been moving into the area since the beginning of this decade. Trafficking throughout New England, mostly stemming from New York, is dominated by Dominican nationals, with smaller operations run by South and Central American, Nigerian, Asian, and local groups.

In New York, heroin distribution is more circumspect than it has ever been, with sales occurring in apartments, stores, and vacant buildings, and dealers starting to sell at 3:00 a.m. In contrast, in Washington, DC, heroin

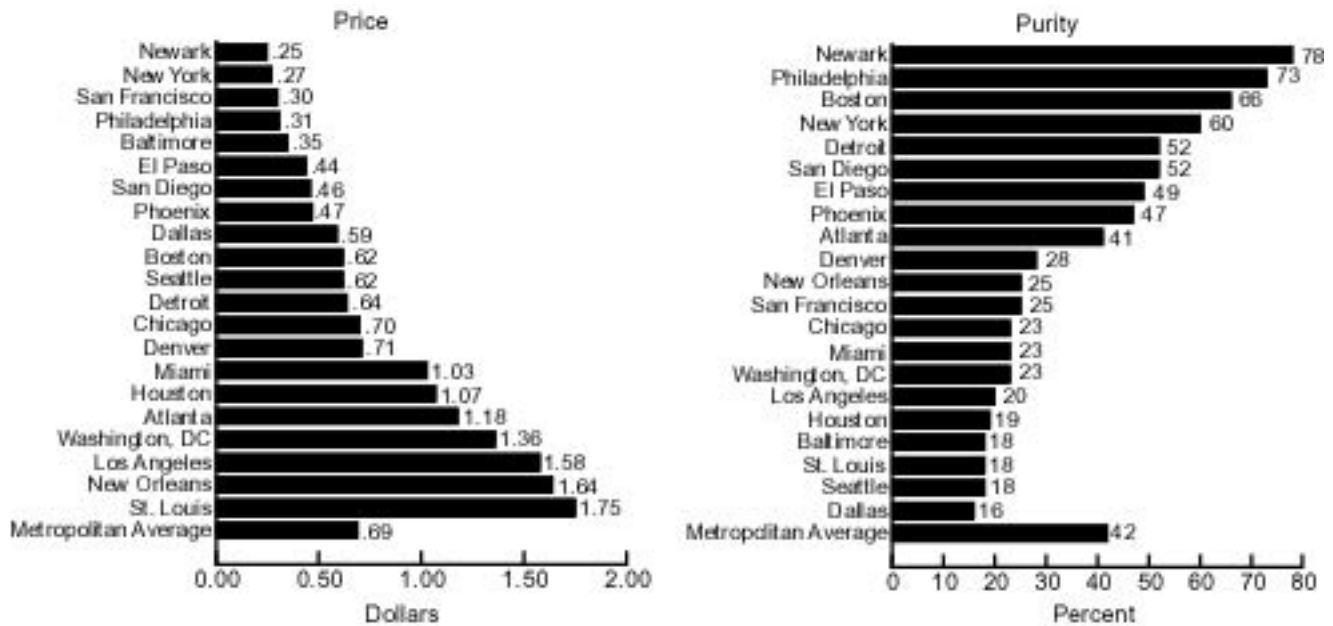
Exhibit 24. Heroin prices and purity in reporting CEWG areas

Area	Type/Source	Standard Street-Level Unit	Gram	Ounce	Kilogram
Boston	South American	\$20/bag	NR	\$3,100–\$5,000 (50%–90% pure)	\$100,000–\$120,000 (≥65% pure)
Chicago	Southeast Asian	NR	\$60–\$100	\$1,000–\$2,500	\$20,000
	Mexican brown		\$150	\$2,000	NR
	Mexican black tar		NR	\$1,400	NR
Denver	Mexican black tar	NR	\$100 (16%–18% pure)	NR	NR
	Mexican brown		NR	\$1,200–\$1,500 (74% pure)	NR
	South American		NR	\$2,500 (70%–80% pure)	NR
Detroit	South American	\$10–\$15/packet or bag	NR	NR	NR
Hawaii	Mexican black tar	NR	\$200 (67% pure)	\$3,000 (67% pure)	NR
Miami/ South Florida	South American	NR	\$150–\$200	NR	\$55,000–\$65,000 (≤80% pure)
Minneapolis/ St. Paul	off-white or tan powder (unknown source)	\$10/per dose (“paper”)	NR	\$900	NR
New Orleans	South American	NR	\$300–\$750	\$4,000–\$10,000	\$140,000–\$175,000 (per unit)
New York City	South American	\$5 and \$10/bag	NR	NR	\$70,000–\$90,000
Philadelphia	South American	\$10/bag (one dose) \$5 and \$20/bag	NR	NR	NR
Phoenix	Mexican black tar	\$20/80–100 mg (a “20” or a “BB”) \$20–\$30/1/4 gram paper	\$50–\$100 (45%–71% pure)	\$1,000–\$1,500 (“piece”) (45%–71% pure)	\$32,000–\$40,000 (45%–71% pure)
St. Louis	Mexican black tar or brown	\$40/1/10 gram (“bundle”)	\$250–\$600 (18% pure)	NR	NR
San Francisco	Mexican (type unspecified)	NR	NR	NR	\$18,000–\$80,000 (20%–60% pure)
Texas	Mexican black tar	\$10–\$20/capsule	\$150–\$300	\$1,000–\$5,000	\$50,000–\$175,000
	Mexican brown	\$10/cap	\$110–\$300	\$800–\$3,000	NR
	White (source unknown)	\$10/cap	\$100	NR	NR
	Colombian	NR	\$1,000	NR	NR
Washington, DC	NR	\$10 and \$20/bags (“joints”)	NR	NR	NR
	“Bone,” “raw” (uncut used intranasally)	\$30 and \$40/bag	\$120–\$130 (40%–94% pure)	NR	NR

SOURCE: CEWG city reports, December 2000

is typically sold in open air markets usually located within housing projects, or along main corridors leading into and out of the city.

Loosely organized “crews” control most of that city’s heroin street sales. Further up the east coast, heroin sales in Boston are often arranged



SOURCE: DEA Domestic Monitor Program, Intelligence Division, Domestic Unit

by beeper or cell phone, and the drug can be delivered door-to-door.

Similarly, in St. Louis, most business is handled by cellular phone, which has decreased the seller's need to have a house for users, thus reducing risk to the seller. In St. Louis, as in other smaller urban areas, heroin is sold by small distribution networks, as well as by many small entrepreneurs.

Denver: *"The availability of South American heroin may be due to a cooperative effort between Colombian and Mexican traffickers, with Mexican traffickers using Black distributors in an attempt to open the market."*

In the West, Mexican nationals control Denver's marketing. And in Phoenix, heroin dealers are also dealing in kilogram quantities of cocaine HCl and crack, referred to as "crack and black," meaning both crack and black tar heroin are being sold.

BRAND NAMES AS AN INDICATOR OF AVAILABILITY AND METHOD OF DISTRIBUTION :

Boston: "Fewer logos were reported on heroin packaging in 2000, perhaps to make tracing more difficult."

New York: "Sellers increasingly shy away from identifying their bags of heroin with a brand name, to avoid monitoring and possible arrest. Some dealers, however, do use colored bags to identify themselves as the source."

Philadelphia: "Autumn 2000 focus groups identified 31 of 34 packaging brand names that were mentioned by the spring 2000 groups. In addition, 33 new brands were named along with the return of an old brand."

Washington, DC: "Brand names, including 'smack down,' 'flavors,' 'top of the line,' 'sports zone,' 'revenge,' 'magic,' 'keep it real,' 'lynch mob,' and 'pleasure,' are numerous and tend to differ by city quadrants."

MARIJUANA

Chicago: “Qualitative indicators reflect a general upward trend in marijuana use throughout most of the 1990s. Some evidence from the latest indicators suggests that the escalation may be abating, and possibly beginning a downward trend, but this remains to be confirmed in subsequent reports.”

Washington, DC: “Recent media reports claim that marijuana now rivals crack as the drug of choice in the District. The generation now coming of age has chosen marijuana in hope of avoiding the problems experienced by their older siblings and parents, whose lives and neighborhoods were destroyed by crack use.”

EMERGENCY DEPARTMENT DATA

In 1999, ED data showed that marijuana continued to account for substantial proportions (≥ 10 percent) of total ED mentions in the following 10 cities: Atlanta, Chicago, Dallas, Detroit, Los Angeles, Miami, New Orleans, Philadelphia, St. Louis, and Washington, DC (exhibit 2). Philadelphia has the Nation’s highest estimated rate of marijuana ED mentions per 100,000 population, followed by Detroit, Atlanta, and New Orleans (exhibit 26).

Between 1998 and 1999, marijuana as a percentage of total ED mentions increased substantially (≥ 3 points) in two areas (Los Angeles and Washington, DC), decreased substantially in one area (Boston), and remained stable elsewhere. During the same time period, trends in the number of marijuana ED mentions were mixed, with 10 increases, 9 declines, and 1 stable trend (in Newark) (exhibit 27). Mentions increased significantly in three cities (Baltimore, Minneapolis/St. Paul, and Phoenix) and declined significantly in three cities (Boston, New Orleans, and San Diego).

Long-term trends in the four top-ranking cities (Atlanta, Detroit, New Orleans, and

Philadelphia) show that rates in Philadelphia and Atlanta increased overall between 1995 and 1999, while rates in Detroit and New Orleans fluctuated between 1995 and 1999, and in 1999 returned to 1995 rates (exhibit 28).

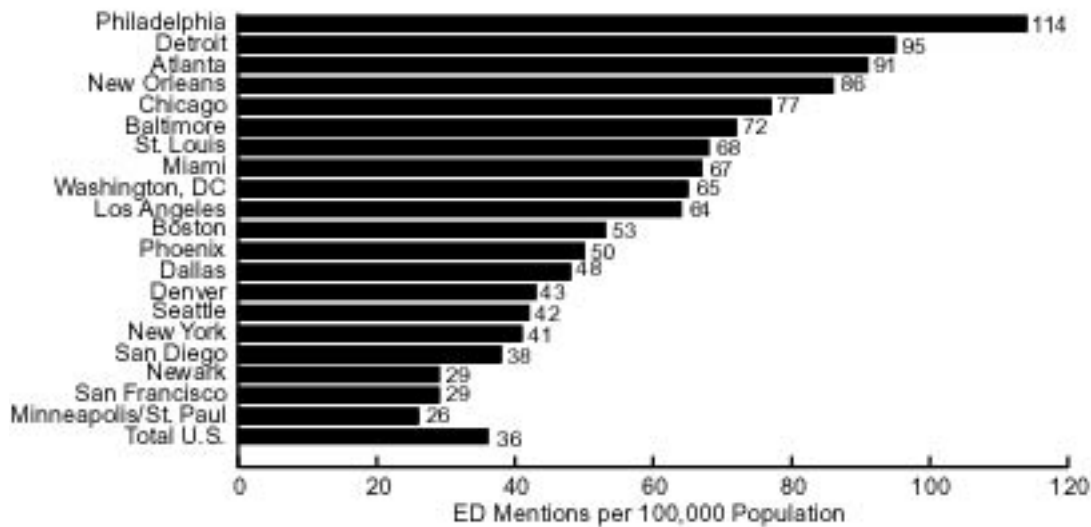
TREATMENT DATA

Baltimore: “Primary marijuana admissions were likely to be experiencing their first treatment episode (68 percent), and 23 percent reported daily marijuana use.”

Marijuana as the primary drug of abuse accounts for the largest percentage of treatment admissions in Colorado, Minneapolis/St. Paul, and Seattle (exhibits 6 and 29). Marijuana also accounts for substantial proportions of admissions (≥ 20 percent) in Atlanta, Hawaii, New Orleans, New York City, St. Louis, and San Diego.

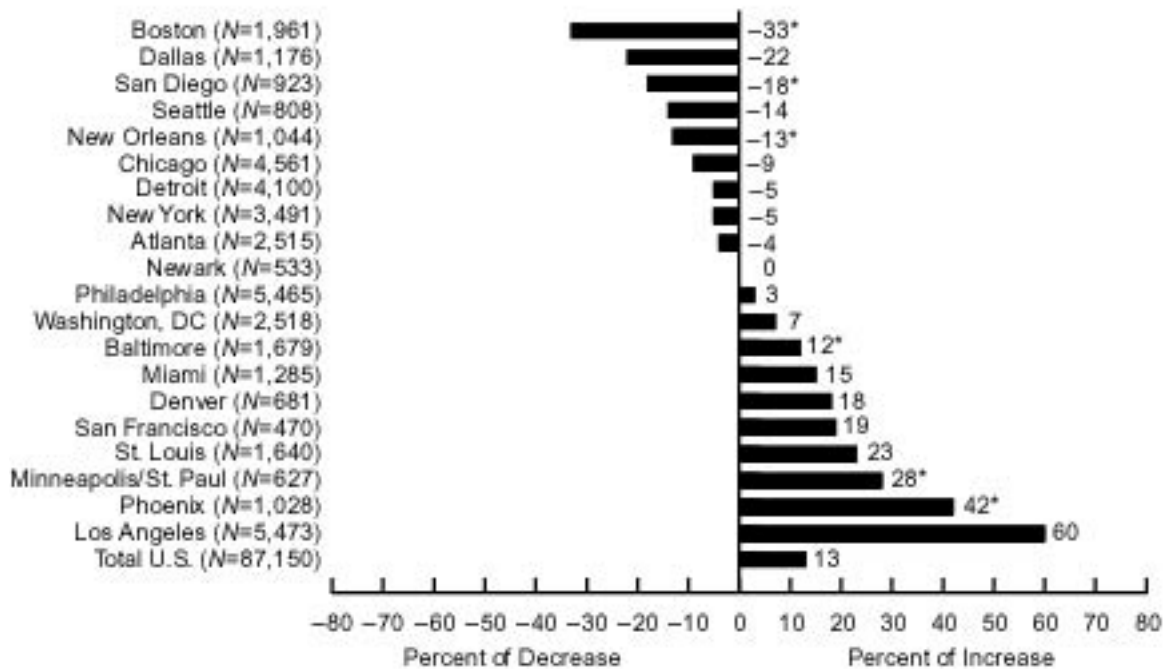
Marijuana treatment percentage trends were mixed when compared with figures from the same reporting period 1 year earlier. Marijuana proportions increased (5–6 points) in Atlanta, New York City, and St. Louis, declined (3–5 points) in Colorado, Hawaii, and Philadelphia, and remained relatively stable (< 3 percentage points) in the remaining areas.

Exhibit 26. Estimated rate of marijuana/hashish ED mentions per 100,000 population by metropolitan area, 1999



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Exhibit 27. Percentage of change in marijuana/hashish ED mentions by metropolitan area, 1998 versus 1999

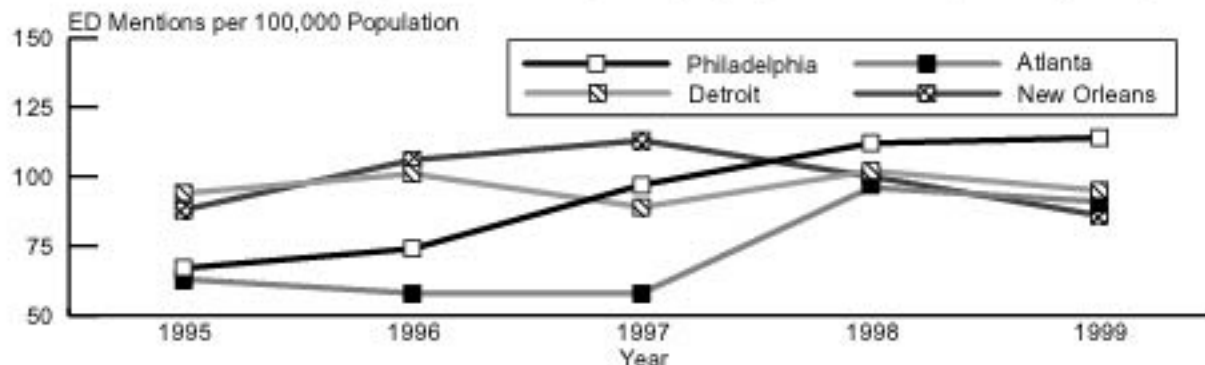


NOTE: (N) refers to 1999 mentions.

*p<0.05

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Exhibit 28. Annual trends in marijuana ED mentions per 100,000 population in four top-ranking cities, 1995–99

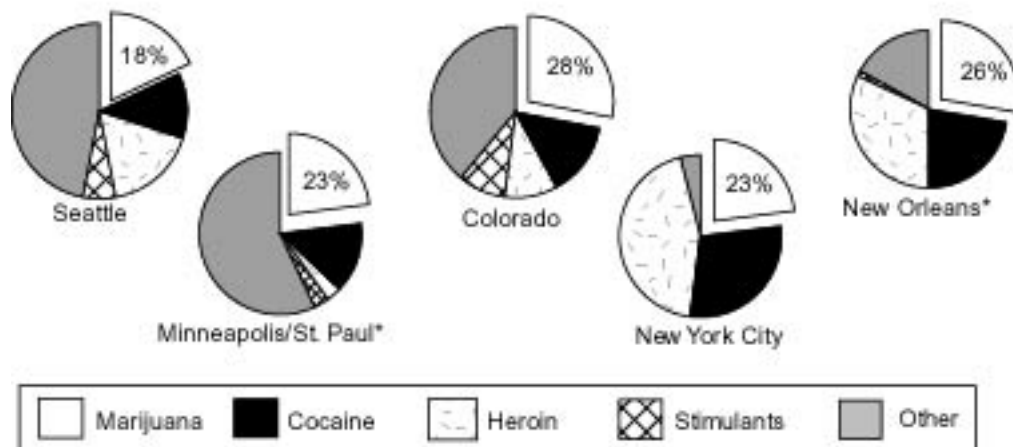


SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Long-term marijuana treatment admission trends are mixed:

- Baltimore: The rate per 100,000 population for marijuana admissions continued to decline from its peak in 1996.
- Colorado: The proportion of new marijuana users entering treatment increased from 1991 through 1994 (when it peaked at 37 percent), declined from 1994 through 1999 to 25 percent, and increased slightly to 26 percent in the first half of 2000.
- Hawaii: Primary marijuana treatment admissions in the first half of 2000 were the second highest in 10 years and triple the number in 1992.
- Newark: The proportion of primary marijuana treatment admissions among total drug admissions increased from 2 percent in 1992 to 5 percent in 1998 and stayed at 5 percent in 1999.
- New York City: Primary marijuana admissions increased dramatically between 1991 and 1999 (from 1,374 to 10,219).

Exhibit 29. Marijuana as a proportion of primary drugs of abuse among treatment admissions (excluding alcohol-only) in five CEWG areas, first half 2000



*Alcohol-only is included.

SOURCE: Drug abuse treatment agencies

Furthermore, the proportion of marijuana admissions among total drug admissions increased between 1991 and the first half of 2000 (from 5 to 23 percent).

- San Diego: Primary marijuana admissions increased 312 percent between the first halves of 1994 and 2000; however, between the first halves of 1999 and 2000, they increased only 7 percent.
- San Francisco: Between FYs 1992 and 1999, primary marijuana admissions increased steadily.
- Washington, DC: Only 12 percent of total drug admissions were for marijuana in 1997; this figure jumped to 18 percent in 1998 and declined in the first half of 2000.

A large proportion of marijuana treatment admissions in Baltimore (63 percent) represent referrals through the criminal justice system, and it is possible that the Maryland Drug Court instituted in 1994 is related to the recent, high number of marijuana treatment admissions. Similarly, in New York City, of first-half-2000 treatment admissions, 69 percent had some criminal justice status. In San Diego, the increase in marijuana admissions among the treatment population might be explained by the expanded treatment services for adolescents. In Colorado, increases in primary marijuana treatment admissions might be related to user accounts of increased drug potency.

OTHER LOCAL DATA

Local data sources around the country show mixed trends in marijuana use, with student surveys showing declines.

- Colorado: Marijuana poison calls were nearly nonexistent between 1994 and 1998, with only one or two per year. However, in 1999, marijuana-related calls totaled 47.

- Illinois: Among the 2,249 infants who tested positive for controlled substances in 1995, 4 percent tested marijuana-positive, compared with 7 percent in 1997, 8 percent in 1998, and 11 percent in the first quarter of 1999—evidence of a slow, continued upward trend.
- Massachusetts: In April through September 2000, marijuana was mentioned in 5 percent of helpline calls specifying particular drugs, level with prior periods.
- Massachusetts: School survey data show that after increasing from 1993 to 1996, marijuana use fell, particularly among those in grades six through eight.
- San Francisco: Reported lifetime marijuana use by public high school students declined slightly from 33 to 31 percent between 1997 and 1999. Such use among middle school students also fell during that time period (from 17 to 12 percent).
- Texas: In 2000, 32 percent of secondary students had ever tried marijuana, and 14 percent reported past-month use. These are declines from 1998, when 35 percent had ever used marijuana and 15 percent had used in the past month.

DEMOGRAPHIC DATA

Age

Boston: "Survey and focus group data indicate that marijuana use remains very common among youth, with the widespread perception that cannabis is less risky than drugs such as LSD, cocaine, or heroin."

Among marijuana ED mentions in 1999, all age groups are represented substantially (exhibit 30). The 18–25 group continues to account for the largest proportion of mentions in 10 cities; the 35+ group is largest in seven cities. The 12–17 group accounts for substantial proportions (≥ 20

Exhibit 30. Age and gender distribution of marijuana ED mentions, by percentage, in CEWG cities, 1999

City	(N)	35+	26–34	18–25	12–17	Males
Atlanta	(2,515)	36	29	28	7	67
Baltimore	(1,679)	25	24–	32	19–	66
Boston	(1,961)	25	24	33–	18–	65
Chicago	(4,561)	32	27	26	14	68
Dallas	(1,176)	21	24	36	19	65
Denver	(681)	24	22	30	24+	67
Detroit	(4,100)	39	28	25	8	65
Los Angeles	(5,473)	43	23	24	9+	66
Miami	(1,285)	36	28	27+	8	72
Minneapolis/St. Paul	(627)	21+	19	31	29	69
Newark	(533)	28+	22–	31+	19	68
New Orleans	(1,044)	33	26–	35	6–	75
New York	(3,491)	30	28	30	12	70
Philadelphia	(5,465)	29	28	29	14	66
Phoenix	(1,028)	26+	24+	33+	17+	64
St. Louis	(1,640)	33+	25	30+	13	62
San Diego	(923)	39	20–	27–	13–	67
San Francisco	(470)	30+	21	25	22	75
Seattle	(808)	26	26	30	17	69
Washington, DC	(2,518)	27	28	32	13	66

NOTE: “+” or “–” indicates significant increase or decrease (p<0.05) in number (not percentage) of mentions since 1998.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

percent) of mentions in three cities (Denver, Minneapolis/St. Paul, and San Francisco).

Between 1998 and 1999, percentages of ED mentions in the 35+ group increased substantially (5–9 percentage points) in Los Angeles, Newark, San Diego, and San Francisco and remained relatively stable elsewhere. Only in Newark did other age groups shift substantially: the 26–34 group declined (by 7 points), the 18–24 group increased (by 6 points), and the 12–17 group declined (by 7 points).

Marijuana ED rates per 100,000 population are highest among 18–25-year-olds in 18 of 20 CEWG cities in DAWN and are highest among 12–17-year-olds in 2 cities: Minneapolis/St. Paul and San Francisco (exhibit 31).

The 18–25 group accounts for the largest proportion of treatment admissions in four areas, the ≤17 group accounts for the largest proportion of marijuana admissions in six areas, and the 35+ group accounts for the largest proportion in Philadelphia (exhibit 32). In New York, the two youngest groups (≤25 and 26–35) account for 63 percent of the admissions.

Among cities where comparison data for 1 year earlier were available, age distribution shifts among marijuana treatment admissions showed mixed trends. The 35+ group increased in Newark (by 10 percentage points) and Philadelphia (by 5 points) and declined in Colorado (by 9 points), while the 26–34 group declined in Philadelphia (by 21 percentage points). The young adult group declined in

Exhibit 31. Marijuana/hashish ED rates per 100,000 population, by age and metropolitan area, 1999

City	35+	26–34	18–25	12–17
Atlanta	62	157	222	67
Baltimore	32	115	206	159
Boston	24	83	134	118
Chicago	45	140	175	117
Dallas	20	66	141	95
Denver	19	58	135	112
Detroit	67	187	227	73
Los Angeles	54	95	112	64
Miami	42	136	170	63
Minneapolis/ St. Paul	10	30	74	86
Newark	14	47	85	62
New Orleans	53	155	280	50
New York	22	78	111	56
Philadelphia	58	225	300	183
Phoenix	24	80	141	91
St. Louis	40	118	203	91
San Diego	29	54	64	61
San Francisco	15	40	72	98
Seattle	20	68	120	86
Washington, DC	32	109	176	102

NOTE: Highlighted areas indicate highest ranking age group in each city.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

St. Louis (by 6 percentage points), while the juvenile group increased in Colorado (by 6 percentage points), Philadelphia (by 14 points), and St. Louis (by 8 points), and declined (by 5–7 points) in Atlanta and Newark.

Additionally, in South Florida (Broward County), 80 percent of first-half-2000 marijuana admissions were age 25 or younger, and between the second half of 1999 and the first half of 2000, proportions declined nearly 50 percent for those younger than 18 and more than doubled for those age 18–26 years. In New York City, 39 percent of marijuana admissions were younger than 21 in the first half of

2000, compared with 46 percent who were younger than 21 in 1999. Similarly, in Washington, DC, the proportion of youth (17 and younger) declined from 24 percent of marijuana admissions in 1998 to only 2 percent in the first half of 2000, but the proportion of young adult marijuana admissions increased from 34 to 52 percent during that time period.

In five CEWG cities where ADAM test results were reported for male adults and juvenile arrestees—Denver, Los Angeles, Phoenix, San Antonio, and San Diego—the percentage of juveniles testing positive for marijuana in 1999 was substantially greater than the percentage of adults (exhibit 33).

Gender

Exhibit 32. Age distribution of primary marijuana treatment admissions, by percentage, in reporting CEWG areas^a

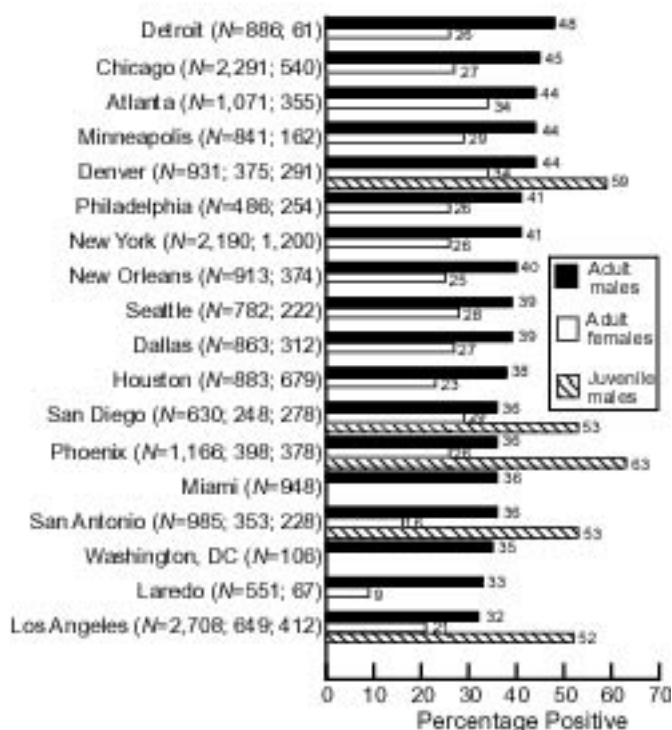
Area	35+	26–34	18–25	≤17	Males
Atlanta	17	27	47	8	73
Baltimore	8	12	33	46	84
Boston	NR	NR	NR	NR	73
Chicago	10	16	40	35	76
Colorado	18	15	32	35	74
Los Angeles	14	17	25	44	70
Minneapolis/ St. Paul	10	13	30	47	81
Newark	15	22	35	28	79
New York City ^b	12	25	63		80
Philadelphia	33	16	26	25	63
St. Louis	14	25	43	18	78
San Diego	9	8	16	68	78
Seattle	9	11	27	54	74
Texas	NR	NR	NR	NR	65

^aReporting periods are January–June 2000, except for the following: full year 1999 in Atlanta, July–December 1999 in Baltimore, July 1999–June 2000 in Boston, and January–September 2000 in Texas.

^bAge groups are 36+, 26–35, and ≤25.

SOURCE: Drug abuse treatment agencies

Exhibit 33. Percentage positive for marijuana among adult male, female, and juvenile male booked arrestees, 1999 (ranked by adult males)



NOTE: Female adults are not tested in Miami and Washington, DC; juvenile males are tested only in Denver, Los Angeles, Phoenix, San Antonio, and San Diego.

SOURCE: National Institute of Justice, Arrestee Drug Abuse Monitoring program, 1999 Annual Report

In all CEWG cities in DAWN, males consistently outnumber females in marijuana ED mentions, with males ranging from 62 percent in St. Louis to 75 percent in New Orleans and San Francisco (exhibit 30). Gender distributions remained relatively stable between 1998 and 1999. Only in Minneapolis/St. Paul did the percentage of males among marijuana ED mentions increase substantially (5 percentage points), and only in Newark did the percentage of females among marijuana ED mentions increase substantially (by 5 points).

Treatment admissions in the first half of 2000 were also more likely to involve males than

females (exhibit 32). In all 14 areas where data were available, males accounted for the vast majority of marijuana treatment admissions, ranging from 63 percent in Philadelphia to 84 percent in Baltimore. However, males declined as a proportion of marijuana admissions in eight areas (Atlanta, Boston, Chicago, Colorado, Los Angeles, Newark, Philadelphia, and St. Louis), and increased as a proportion in three (Baltimore, New York City, and San Diego).

According to 1999 ADAM data, adult males tested marijuana-positive at higher levels than adult females in all CEWG cities where both genders were tested (exhibit 33). Detroit had the highest level for males (48 percent), and Los Angeles had the lowest (32 percent). Among cities where adult females were tested, the highest percentages were in Atlanta and Denver (both at 34 percent), and the lowest was in Laredo (at 9 percent).

Race/Ethnicity

Marijuana ED racial demographics vary depending on geographic location. In 1999, Blacks were the largest racial/ethnic group among marijuana mentions in nine CEWG cities (Atlanta, Chicago, Detroit, Miami, Newark, New Orleans, New York, Philadelphia, and Washington, DC), Whites were the largest in six cities (Baltimore, Boston, Dallas, Minneapolis/St. Paul, St. Louis, and San Diego), and five cities had too many mentions in the “unknown” category to be included in the count. Hispanics accounted for a substantial number of mentions (≥ 15 percent) in four cities: Los Angeles, Newark, New York, and Phoenix.

Between 1998 and 1999, the percentage of Whites among marijuana ED mentions increased 14 percentage points in Newark and decreased 5 points in Dallas. Blacks as a percentage of marijuana mentions increased

(5–6 points) in Atlanta and Miami and declined in Newark (by 11 points). Hispanics as a proportion of marijuana mentions increased (7–25 percentage points) in five cities (Boston, Chicago, Newark, New York, and San Diego) and declined (7–21 points) in six cities (Dallas, Miami, Minneapolis/St. Paul, New Orleans, Philadelphia, and St. Louis).

Among marijuana treatment admissions in the first half of 2000, Whites accounted for the majority in eight areas (Atlanta, Baltimore, Chicago, Colorado, Minneapolis/St. Paul, San Diego, Seattle, and Texas), Blacks accounted for the majority in 5 cities (Boston, Newark, New York, Philadelphia, and St. Louis), and Hispanics accounted for the majority in Los Angeles.

In areas where comparison data from 1 year earlier were available, Whites as a proportion of marijuana treatment admissions increased considerably in Colorado (by 5 points) and Philadelphia (by 16 points). Correspondingly, in Philadelphia, Black representation declined by 19 points. In New York City, Hispanics as a proportion of marijuana admissions increased by 5 percentage points. Racial/ethnic distributions among treatment admissions remained relatively stable elsewhere.

USE PATTERNS

Honolulu: *“It is important to note that although marijuana may be listed as the primary drug at admission, many marijuana clients also use other substances.”*

Washington, DC: *“A cause for concern is that users are smoking more potent marijuana in large amounts and using methods developed to enhance the weaker marijuana that was formerly available.”*

Marijuana, seldom the sole drug that precipitates a trip to hospital emergency departments in

Minneapolis/St. Paul, is often used in combination with other drugs.

Of the 1,062 cases of drug abuse in the first half of 2000 at a Broward County hospital in South Florida, 30 percent involved marijuana, but only 16 percent involved marijuana only. (Cocaine/marijuana cases accounted for 13 percent of all drug cases, and marijuana was also found in combination with ecstasy or amphetamine in nine additional cases, and in combination with GHB in five additional cases.)

Similarly, among primary marijuana treatment admissions, alcohol and cocaine remain the most common secondary and tertiary drugs reported in CEWG areas. The severity of alcohol as a secondary drug of abuse is underscored by the high percentages reported, ranging from 23 percent in Atlanta to 79 percent in Minneapolis/St. Paul. Additionally, in Minneapolis/St. Paul, hallucinogens are reported as the tertiary drug of abuse by 25 percent of primary marijuana admissions.

The 1990s saw an increasing trend in marijuana use in many CEWG areas, one that closely corresponded with the rise in popularity of “blunt” smoking, especially common among youth. Blunt smokers cut cigars open using a razor, pour out the tobacco, and replace it with marijuana. In Philadelphia, blunts are referred to as “phillies” (after the most popular cigar brand used in making blunts) and “L’s,” and new street names include “blizzies,” “chocolate tide,” “dutchies,” and “stogies.” Regular blunt users in Philadelphia reportedly smoke about four blunts per day, and blunt smoking among females may be increasing there. Blunt smoking also remains common in other large urban centers, including Boston, Chicago, New York City, and Washington, DC.

When used in blunt form, marijuana can be more easily combined with other drugs. For

example, in Chicago, users often lace blunts with crack or phencyclidine (PCP). In New York City, the combination of hydroponically grown and commercial-grade marijuana (“Jekyll and Hyde”) is heated on tinfoil, placed in a blunt cigar, and smoked. In Washington, DC, especially among young users, marijuana is combined with PCP or with small rocks of crack cocaine in blunts. In Philadelphia, where autumn 2000 focus groups estimated that 50 percent of blunts are laced with another drug, the combination of marijuana and PCP is called “love boat” or “wet” (which is also a term for PCP itself), and according to users new to treatment, the use of PCP-laced blunts is increasing. “Turbos” (blunts laced with cocaine) also remain popular in Philadelphia, and users continue to use beer, alprazolam (Xanax), cough syrup, or oxycodone (Percocet) along with blunts in that city.

In Minneapolis/St. Paul, marijuana continues to be combined with embalming fluid and/or PCP, and marijuana cigarettes dipped in this mixture or dipped in PCP or formaldehyde alone are known as “amp,” “dipped joints,” “happy sticks,” “wet sticks,” or “wets.” Similarly, in Texas, 125 poison center calls from January through August 2000 included terms such as “amp,” formaldehyde, “fry,” or PCP.

LAW ENFORCEMENT DATA

St. Louis: *“It is difficult to track marijuana use with enforcement indicators because, considering the heroin, cocaine, and methamphetamine problems that have developed, marijuana is not law enforcement’s major concern. Limited resources require establishing enforcement priorities.... However, as a gateway drug to more serious drug abuse, marijuana is being seriously targeted by local prevention efforts.”*

Washington, DC: *“Marijuana users from Maryland and Virginia are increasingly com-*

ing to the city to buy marijuana because possession and distribution (regardless of amount) are only misdemeanors in the District.”

Arrestee Urinalysis Data

In 1999, marijuana was the most frequently detected drug among adult male arrestees in 11 CEWG ADAM cities (Chicago, Dallas, Denver, Detroit, Houston, Minneapolis, Philadelphia, Phoenix, San Antonio, San Diego, and Seattle). The findings in those 11 cities ranged from 36 percent of male arrestees testing positive in Phoenix, San Antonio, and San Diego, to 48 percent in Detroit (exhibit 33). Positive marijuana findings among female arrestees ranged from 9 percent in Laredo to 34 percent in Atlanta and Denver.

Comparing 1998 and 1999 figures, the percentage of adult male arrestees testing positive for marijuana increased substantially (≥ 5 points) in Atlanta (18 points), Miami (7 points), and Los Angeles (5 points). Laredo registered a substantial decrease (6 percentage points), as did San Antonio (5 points). Figures remained relatively stable for the rest of the cities in the ADAM program. Among adult female arrestees, substantial increases were recorded only in Chicago (7 percentage points) and Minneapolis (6 points), while a substantial decrease was recorded in Seattle (10 points). The female arrestee figures remained relatively stable in the rest of the cities.

In the seven CEWG cities where ADAM tests male juvenile arrestees, marijuana remained, by far, the number-one drug detected. Positive marijuana findings among male juveniles ranged from 52 percent in Los Angeles to 63 percent in Phoenix. Data for female juvenile arrestees in the four CEWG cities where ADAM tests this group also show that

marijuana is, by far, the number-one drug detected, with positive findings ranging from 24 percent in San Antonio to 41 percent in Denver and San Diego.

Washington, DC, Pretrial Services data show that in the first three quarters of 2000, about 62 percent of juvenile arrestees tested marijuana-positive, consistent with levels in 1997 and 1999. However, these figures represent a substantial increase over 1994, when only about half of juvenile arrestees tested marijuana-positive.

Arrests, Seizures, and Submissions

Recent trends in marijuana arrests are mixed in reporting CEWG cities, with three increases (in Honolulu, New York City, and Phoenix), one decline (in New Orleans), and two stable trends (in Boston and Washington, DC). In Honolulu, possession cases are steady at about 650 per year, although distribution cases have continued to increase. In spite of the decriminalization of possessing small amounts of marijuana, the New York Police Department continues to make a record number of marijuana-related arrests. Cannabis-involved arrests had reached a low of 4,762 in 1991 and then increased more than ninefold in 1999 to 43,122, 35 percent of which involved arrestees age 20 or younger. In Phoenix, arrests for marijuana possession rose from 6,178 in 1989 to 13,516 in 1999—a 119-percent increase. Conversely, marijuana-related arrests decreased between the first halves of 1999 and 2000 in New Orleans. In Boston, the proportion of marijuana arrests remained relatively stable at 28 percent of all drug-related arrests in 1999 and 27 percent in the first half of 2000. Most arrests there are for small quantities of marijuana and involve juveniles and young adults. And in Washington, DC, the number of adults charged with marijuana possession between the first halves of 1999 and 2000 remained relatively stable.

Recent trends for marijuana seizures, like those for marijuana-related arrests, were mixed in CEWG areas, with declines reported in two areas and an increase reported in Washington, DC. In Atlanta, seizures decreased between 1998 and 1999 (from 1,030 pounds to 569 pounds), and in Massachusetts, plant seizures declined due to rainy conditions affecting both flyovers and cultivation. In contrast, between 1998 and the first 10 months of 2000, marijuana seizures in Washington, DC, increased from 31 to 37 percent of all drug seizures. Furthermore, for the last several years, marijuana has been the second most commonly seized illicit drug (after cocaine) by law enforcement agencies in the District. Similarly, in Newark, marijuana seizures accounted for 25 percent of drug seizures in the first quarter of 2000 (compared with 30 percent for heroin and 45 percent for cocaine). Massachusetts State Police reported that seizures of hashish have risen recently.

Availability and Source

Marijuana is widely available in most reporting CEWG cities, with the exception of Seattle, where the marijuana available is primarily the lower grade, more commercial product. Since the last reporting period, potency of marijuana reportedly increased in several CEWG areas, including New York City and Washington, DC. In New York City, where marijuana availability and quality continue to increase due to new varieties and combinations, Canadian marijuana called “Quebec gold” is now in demand in certain parts of the city, but is also in short supply. Hydroponically grown marijuana (“hydro”) seems to be preferred by teenagers in New York City for its economy and quality—one hydro joint supposedly can satisfy at least two people. Additionally, a combination of a block of marijuana and hydro (Jekyll and Hyde) has been marketed lately. In Colorado, high-quality British Columbian marijuana (“BC bud”) has appeared recently.

Exhibit 34. Marijuana prices and purity in reporting CEWG areas, December 2000 reporting period

Area	Source/Quality	Price/Unit	
		Ounce	Pound
Atlanta	Domestic	\$120–\$240	\$1,200
	Sinsemilla	\$160–\$250	\$1,000–\$2,000
Boston	Commercial grade	\$200–\$250	\$900–\$1,500
	Sinsemilla	\$200–\$300	\$2,500–\$3,000
Denver	Commercial grade	\$50–\$100	\$500–\$1,200
	Sinsemilla	\$100	\$1,500–\$3,500
	British Columbian (“BC bud”)	\$500	\$4,000–\$5,000
Honolulu	Low quality	\$250–\$500	\$6,000–\$9,000
	High quality	\$400–\$800	(quality not specified)
Miami/South Florida	Commercial grade (“regs”)	NR	\$700–\$1,000
	Hydroponic (“crippy”)	≥\$500	\$1,600–\$3,700
Minneapolis/St. Paul	NR	\$165	\$1,350
New Orleans	Commercial grade	\$130–\$170	\$800–\$1,200
	Sinsemilla	\$350–\$450	\$2,500–\$4,000
New York City	Commercial grade	NR	\$800–\$2,500
Phoenix	NR	\$75–\$150	\$400–\$600
San Diego	Commercial grade (2–3 percent THC)	NR	\$310
	High quality (“buds”)	NR	\$1,200–\$2,000
San Francisco	NR (3–20 percent THC)	NR	\$2,500
Seattle	Domestic	NR	\$4,000–\$5,200
Texas	Dallas	Commercial grade	NR
		Sinsemilla	\$50–\$100
	Houston	Commercial grade	NR
		Sinsemilla	NR
Washington, DC	Commercial grade	NR	\$600–\$1,300
	Sinsemilla	NR	\$4,500
	Hashish	\$200	\$1,300

SOURCE: CEWG city reports, December 2000

Exhibit 34 presents available marijuana price data in the CEWG areas. Ounce prices for commercial grade marijuana range from \$50–\$100 in Denver to \$250–\$500 in Honolulu. In Minneapolis/St. Paul, individual marijuana joints cost \$5, and dipped joints cost more. In New York City, bags of marijuana are priced at \$10–\$50, hydro joints cost \$10 each, and blunts cost \$15 each. In Washington, DC, “dime bags” cost \$10–\$20, and some dealers are known for selling bags that are “over-stuffed” with marijuana. In Seattle, where main

venues for marijuana sales are known as “house” connections, sinsemilla (“bud”) sells for \$15–\$25 per gram, but only young students or street buyers purchase such small amounts.

Since the June 2000 reporting period, prices declined in three areas reporting such data: Seattle, Texas (where commercial grade marijuana declined to the lowest price ever recorded), and Washington, DC. By contrast, prices increased in New Orleans and remained relatively stable in 10 areas.

Cultivation and Trafficking

Boston: “High profit margins and relatively weak penalties are incentives to traffic in marijuana.”

Washington, DC: “Strong demand, high profit margins, and minimal repercussions have led to heightened marijuana trafficking and distribution in the District.”

Indoor marijuana production continues to increase in many CEWG areas. For example, while imported marijuana continues to move into South Florida, the source of marijuana has shifted from imported to domestic, approximately 30 percent of which is grown in sophisticated hydroponic operations. Similarly, in Atlanta, although imported marijuana remains common, local marijuana cultivation may have decreased the need for importation. In Washington, DC, marijuana is being cultivated locally and hydroponically in what are called “growing houses,” contributing to the increased potency of marijuana. And in St. Louis, indoor production is now the primary cultivation mode, making weather less of a factor; law enforcement officials now focus on indoor growing operations. In Seattle, locally grown marijuana is the variety of choice, but more

potent sinsemilla (grown indoors in British Columbia using hydroponic methods) generally passes through the area to destinations further south on the west coast.

Although indoor-grown, domestic marijuana is increasing in CEWG areas, Mexican-grown marijuana is still common. In Dallas (a transshipment point for marijuana destined for the Midwest, Northeast, and Southwest), most marijuana is imported from Mexico, with limited quantities of indoor-grown marijuana available. In Denver, the most abundant supply of marijuana is also Mexican-grown and is trafficked into the area by vehicles in shipments of varying quantities (from 2 to 500 pounds). Most marijuana in Boston seems to be shipped overland or via delivery services from Mexico through the Southwest, as well as from Jamaica and Colombia. In Washington, DC, marijuana is both hydroponically grown and imported into the region from the Southwest. In Detroit, Mexican marijuana remains increasingly dominant, although outdoor growing in Michigan, which may have declined in 1998 and 1999, was stable in 2000. In the Phoenix area, as many as 1,000 pounds of marijuana per day have been seized on an Indian reservation.

METHAMPHETAMINE

Boston: “Stimulant indicators remain very low in the Boston area, but reports continue to suggest that amphetamine and methamphetamine are available, if not widely used.”

Denver: “Information from the DEA and the Denver Police suggests that recent declines in methamphetamine indicators may reflect the substantially lower purity resulting from reduced precursor availability and from reduced supply due to extensive lab seizures.”

MORTALITY DATA

Methamphetamine-related deaths remained relatively few. In the seven CEWG areas where 1999 versus partial-2000 data were available, methamphetamine mortality figures suggest mixed trends:

- Honolulu: Methamphetamine-positive toxicology levels are projected to decline slightly (totaling 34 in all of 1999 to 15 in the first half of 2000).
- Minneapolis/St. Paul: Methamphetamine-related deaths are relatively low (totaling seven in calendar year 1999 and seven in the first three quarters of 2000).
- Philadelphia: Although relatively low, methamphetamine-related deaths may be increasing (totaling 12 in 1999 and 9 in the first half of 2000).
- Phoenix: Continuing a steady increase since 1996, methamphetamine-related deaths are projected to increase 23 percent (totaling 75 in all of 1999 and 46 in the first half of 2000).
- St. Louis: Methamphetamine-related deaths are low at four in 1999 and none in the first half of 2000.
- San Diego: After a slow, steady decline between 1997 and 1999, accidental overdose methamphetamine deaths are projected to increase 57 percent (totaling 37 in all of 1999 and 29 in the first half of 2000).

- Seattle: Methamphetamine-caused deaths are projected to remain stable (111 in 1999 and 82 in the first three quarters of 2000).

Earlier, between 1998 and 1999, methamphetamine ME mentions increased in western cities, according to DAWN: in Denver (from 3 to 9 mentions), Los Angeles (from 111 to 147), Phoenix (from 60 to 94), San Diego (from 84 to 88), San Francisco (from 45 to 58), and Seattle (from 4 to 30). Interestingly, methamphetamine ME mentions also increased substantially in New York during that time period (from 2 to 44 mentions).

EMERGENCY DEPARTMENT DATA

Methamphetamine accounted for 1–5 percent of total ED mentions in the western CEWG cities in DAWN (Denver, Los Angeles, Phoenix, San Diego, San Francisco, and Seattle), and it accounted for 1 percent of ED mentions in Dallas, Minneapolis/St. Paul, and St. Louis (exhibit 2). In all the other cities, the drug was involved in less than 1 percent of ED mentions.

Western cities also had the Nation’s highest ED rates per 100,000 population in 1999, with particularly high rates in San Francisco and San Diego (exhibit 35). Minneapolis/St. Paul was the only nonwestern area with a rate of at least 5 per 100,000 population.

Between 1998 and 1999, methamphetamine ED mentions declined significantly ($p < 0.05$) in six cities (Atlanta, Dallas, Miami, New York,

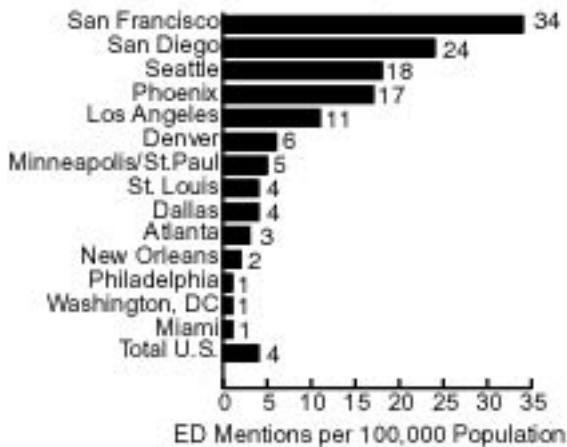
AREA FOR FURTHER RESEARCH: AMPHETAMINE, METHAMPHETAMINE, OR ECSTASY?

Baltimore: "Methamphetamine ED mentions are rarely reported; however, amphetamine ED rates have tripled from 2 per 100,000 population in 1992 to 6 in 1999. These are likely to represent ecstasy mentions."

Detroit: "Between 1996 and 1999, no methamphetamine ED mentions were reported in Detroit; however, amphetamine mentions increased from 27 in 1992 to 165 in 1999. It is believed that many of these cases may actually reflect methamphetamine use."

San Diego: "San Diego has historically combined methamphetamine and ED amphetamine mentions, which made sense in the late 1980s when amphetamine mentions totaled fewer than 25. However, the number of mentions has been increasing more rapidly for amphetamine than for methamphetamine. For the past four half-year periods, amphetamine mentions exceeded methamphetamine mentions. This finding has been discussed among local health practitioners, treatment providers, and other experts. It is not clear why there has been a switch, but the phenomenon is of great interest locally and may lead to focus group discussions."

Exhibit 35. Estimated rate of methamphetamine ED mentions per 100,000 population by metropolitan area, 1999



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Phoenix, and San Diego) and nonsignificantly in another five; they increased significantly in three cities (Baltimore, St. Louis, and Seattle) and nonsignificantly in two; and they remained stable in Boston and Minneapolis/St. Paul (exhibit 36).

The recent declines in ED mentions per 100,000 population in Phoenix, San Diego, and

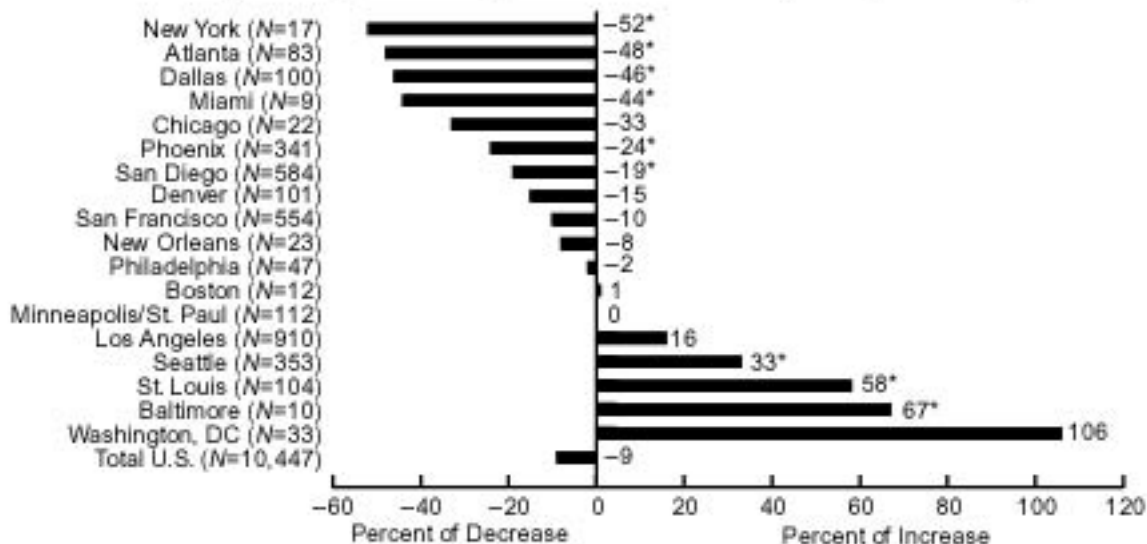
San Francisco continue a 5-year downward trend, except for a brief upturn in 1997 (exhibit 37). In Seattle, however, the 1999 rate is higher than it was in 1995.

TREATMENT DATA

Honolulu: "Methamphetamine treatment admissions remained extremely high during this reporting period, exceeding those for alcohol....This situation has so far outstripped the treatment system's capacity that even people who might want treatment would not be likely to receive it in a timely manner."

Stimulants (mostly involving methamphetamine) continued to account for the largest percentage of all treatment admissions in Hawaii and San Diego in the first half of 2000, and they accounted for noticeable proportions (5–13 percent) of admissions in the other western areas (exhibits 6 and 38). In other areas of the country, proportions remained relatively low. Between the first halves of 1999 and 2000, treatment proportions remained fairly stable in all CEWG areas where trend data were available.

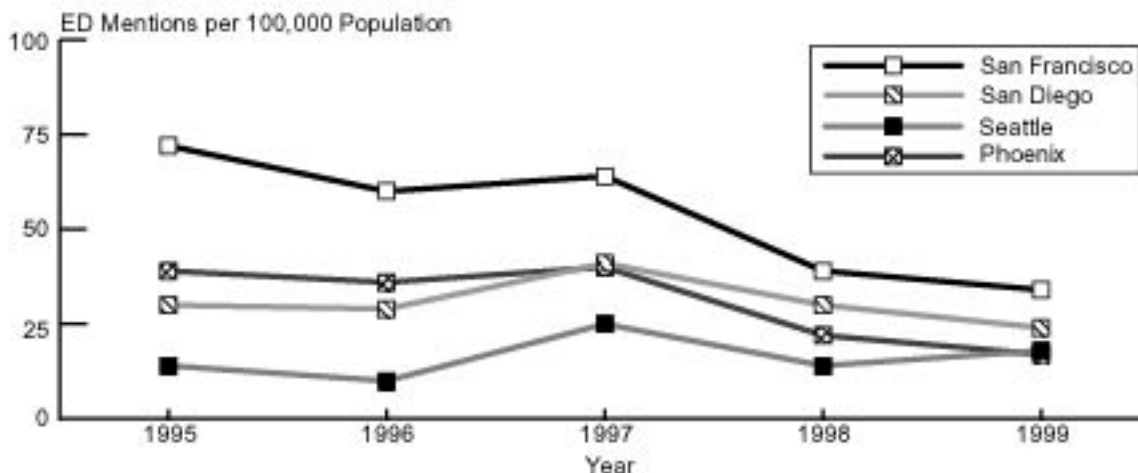
Exhibit 36. Percentage of change in methamphetamine ED mentions by metropolitan area, 1998 versus 1999



NOTE: (N) refers to 1999 mentions.
*p<0.05

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Exhibit 37. Annual trends in methamphetamine ED mentions per 100,000 population in four top-ranking cities, 1995-99



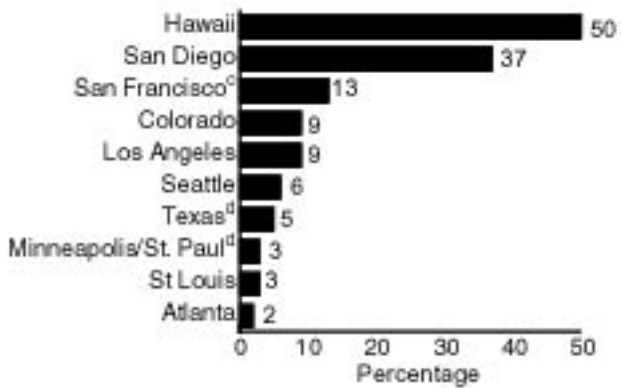
SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

POISON CONTROL DATA

Poison control trend data were available for two CEWG areas, Colorado and Detroit, both of which showed increases. In Colorado, amphetamine-related calls fluctuated between 1994 and

1998 (11-38 calls) and increased to an astounding 291 in 1999. Detroit poison centers reported 351 contacts involving amphetamine in 1998, 379 in 1999, and 380 in the first 10 months of 2000. In Texas, 130 cases mentioning amphetamines or methamphetamine were reported in the first three quarters of 2000.

Exhibit 38. Methamphetamine as a proportion of primary drugs of abuse among treatment admissions^a, first half 2000^b



^aTotal admissions number excludes alcohol-only but includes alcohol-in-combination.

^bReporting periods are first half 2000, except for the following: full year 1999 in Atlanta, FY 2000 in San Francisco, and January–September 2000 in Texas.

^cAlcohol-in-combination is not included.

^dAlcohol-only is not excluded.

SOURCE: Drug abuse treatment agencies

DEMOGRAPHIC DATA

Chicago: “Gay men have reported using the drug to enhance their sexual appetite, homeless youth to stave off hunger, and clubgoers to extend their stamina for recreational activities.”

Age

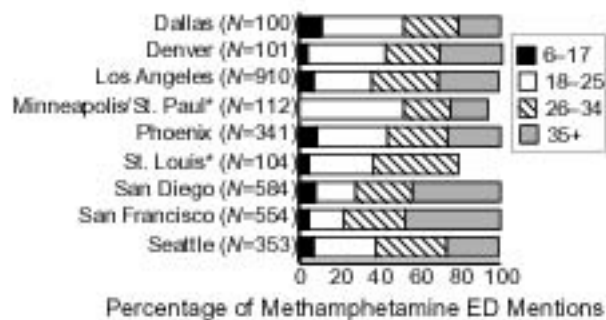
Of the methamphetamine-related decedents in the first half of 2000 in San Diego, 75 percent were 35 or older. In San Francisco, the median age in 1999 was 42 years.

Age distributions vary somewhat in the 9 CEWG cities in DAWN where methamphetamine was involved in 100 or more ED mentions during 1999: the modal age group was 18–25 years in four (Dallas, Denver, Minneapolis/St. Paul, and Phoenix), 26–34 years in three (Los Angeles, St. Louis, and Seattle), and 35+ years in two (San Diego and San Francisco) (exhibit 39). Between 1998 and 1999, the younger (18–25) group

increased substantially in Denver (8 points) and Minneapolis/St. Paul (15 percentage points), and the oldest (35+) group increased in Denver (9 points), Phoenix (8 points), and San Diego (5 points). By contrast, the middle (26–34) group declined substantially (9–12 percentage points) in three cities (Denver, Minneapolis/St. Paul, and Phoenix); they increased, however, in St. Louis (by 10 points).

Primary methamphetamine treatment clients tend to be in the two older-than-25 groups (exhibit 40). Minneapolis/St. Paul is the only reporting area where younger (age 18–25) clients account for the largest group. In areas where trend data were available for the first half of 1999 versus the first half of 2000, three substantial increases were noted: the 18–25 group in Los Angeles (5 percentage points), the 26–34 group in St. Louis (10 points—similar to that group’s increase among ED mentions), and the 35+ group in San Diego.

Exhibit 39. Age distribution of methamphetamine ED mentions in selected CEWG cities, 1999

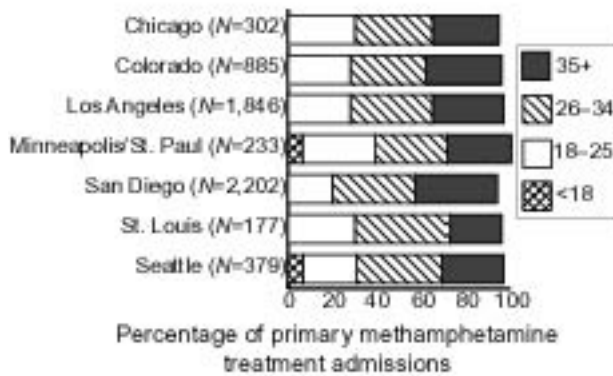


*Estimate for missing age group does not meet standard of precision.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

In nonwestern cities, where methamphetamine use is low, ethnographic sources report that methamphetamine users are students or clubgoers. For example, in Atlanta, although the majority of persons who entered treatment for stimulant use during 1999 were 26 or older, the popularity of stimulants among younger age

Exhibit 40. Age distribution of primary methamphetamine treatment admissions in selected CEWG areas, first half 2000



SOURCE: Drug abuse treatment agencies

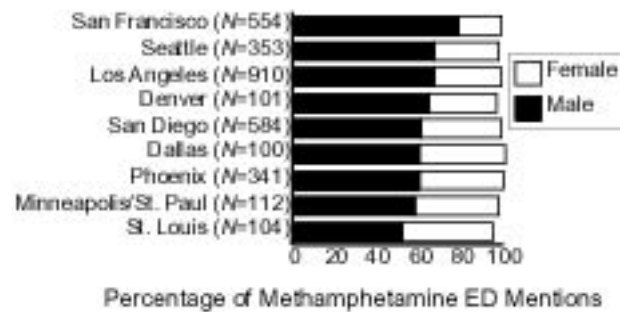
groups is indicated by poison control and ethnographic data. In New Orleans, street sources report increases in use among high school and college students. During the past 2 years in Chicago, White youth have used methamphetamine in areas on the North Side where young gay men, homeless youth, and clubgoers congregate; drug-using youth who travel to cities where methamphetamine use is common also reportedly use methamphetamine. Similarly, in Boston, users are generally students and young adults, especially those who frequent raves or have recently arrived from the west coast, where crystal methamphetamine (“ice”) is common. Biker gangs also remain among the traditional methamphetamine users in that city. And in St. Louis, methamphetamine has become more widespread among high school and college students who do not consider stimulants as dangerous as cocaine.

Gender

In San Diego, most (88 percent) of methamphetamine-related decedents in the first half of 2000 were males. Similarly, 90 percent of fiscal year (FY) 1999 methamphetamine-related decedents in San Francisco were males. And in Seattle, all methamphetamine-related decedents in the first three quarters of 2000 were males.

Similarly, males account for the majority of methamphetamine ED mentions in the 9 cities with a substantial number (>100) of mentions (exhibit 41). The gender gap is widest in San Francisco and narrowest in St. Louis. Between 1998 and 1999, females increased considerably as a proportion of ED mentions in Dallas (10 percentage points) and Phoenix (7 points), while males declined correspondingly; conversely, males increased in proportion in Denver (by 10 points) and Minneapolis/St. Paul (6 points), with corresponding declines for females.

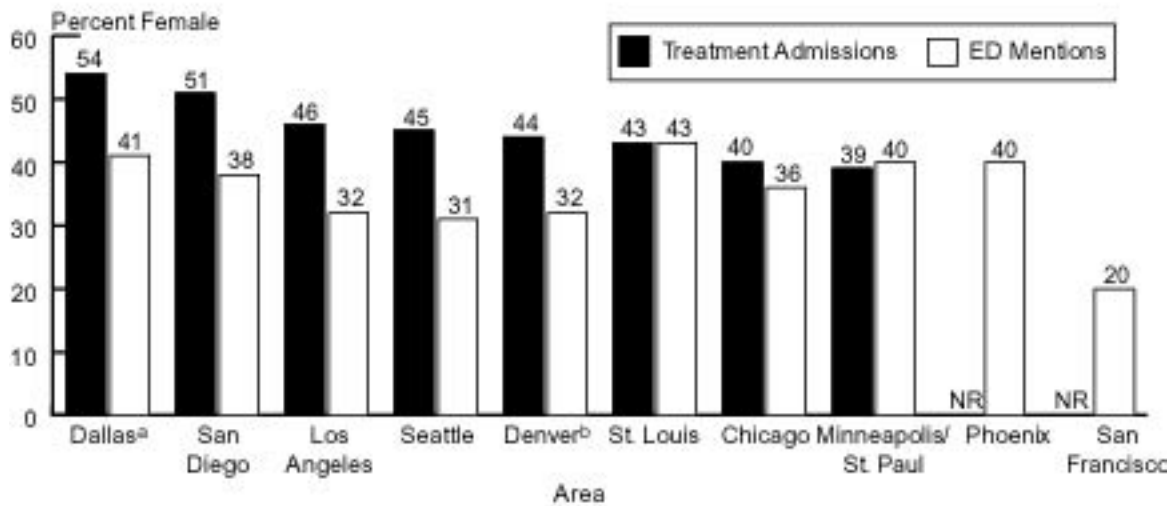
Exhibit 41. Gender distribution of methamphetamine ED mentions in selected CEWG cities, ranked by males, 1999



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Female representation is generally higher among stimulant treatment admissions than among methamphetamine decedents and ED mentions (exhibit 42). As a matter of fact, females outnumber males among stimulant admissions in San Diego and Texas. Gender distributions remained relatively stable in the areas where trend data were available for the first half of 1999 versus the first half of 2000. The largest shift was in Colorado, where females increased and males correspondingly declined (by 5 percentage points) as a proportion of stimulant admissions. More modest shifts (2–4 percentage points) were noted in Los Angeles, St. Louis, and San Diego, where males increased and females declined in proportion.

Exhibit 42. Female representation among primary stimulant treatment admissions (first half 2000) and among methamphetamine ED mentions (1999)



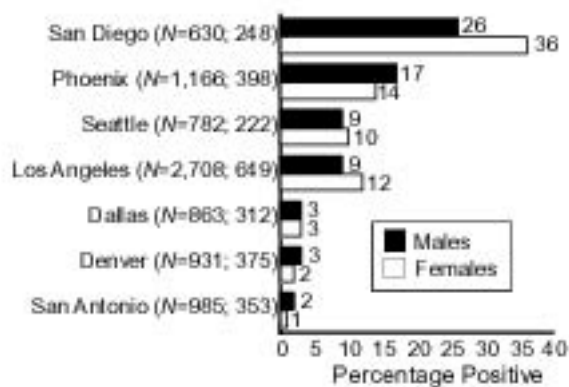
^aTreatment figure is for Texas for the first three quarters of 2000; ED figure is for Dallas.

^bTreatment figure is for Colorado; ED figure is for Denver.

SOURCE: Drug abuse treatment agencies; Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

More similar to treatment admissions than to mortality or ED data, female arrestees generally were as likely as their male counterparts to test methamphetamine-positive in nearly all ADAM sites (although arrestee samples were smaller for females than for males) (exhibit 43).

Exhibit 43. Percentage positive for methamphetamine among male and female booked arrestees in selected cities, 1999 (ranked by males)



SOURCE: National Institute of Justice, Arrestee Drug Abuse Monitoring Program (March 2000 files)

According to ethnographic data, gay males remain the predominant methamphetamine users in several CEWG cities, including Chicago, New York City, and San Francisco. Because gay men remain the predominant users in San Francisco, there are localized increases in the apparent prevalence of use in districts where they have been displacing Blacks of lower socioeconomic status.

Race/Ethnicity

Mortality and treatment data indicate that methamphetamine users are predominantly Whites. For example, among San Diego decedents in the first half of 2000, two-thirds were White, 3 percent were Black, and 30 percent were Hispanic. In the first half of 2000, Whites were the majority in all areas reporting race/ethnicity among methamphetamine treatment admissions, ranging from 59 percent in San Diego to 97 percent in St. Louis. However, White proportions declined between the first

halves of 1999 and 2000 in all reporting areas (except St. Louis, where the proportion of Whites remained stable). Hispanics held large proportions in Los Angeles (27 percent) and San Diego (25 percent—a 4-percentage-point increase since the first half of 1999). In Chicago, Blacks as a proportion of methamphetamine admissions doubled between the first halves of 1999 and 2000 (from 10 to 20 percent). All South Florida methamphetamine-related deaths (3) and ED cases (12) in 1999 were among Whites.

USE PATTERNS

Boston: “Key informants believed methamphetamine is used most likely as a club drug along with ecstasy, gamma hydroxybutyrate (GHB), and ketamine.”

Route of Administration

Methamphetamine route of administration varies across the country (exhibit 44). For example, among primary methamphetamine treatment admissions during the first half of 2000, smoking was the most common route in

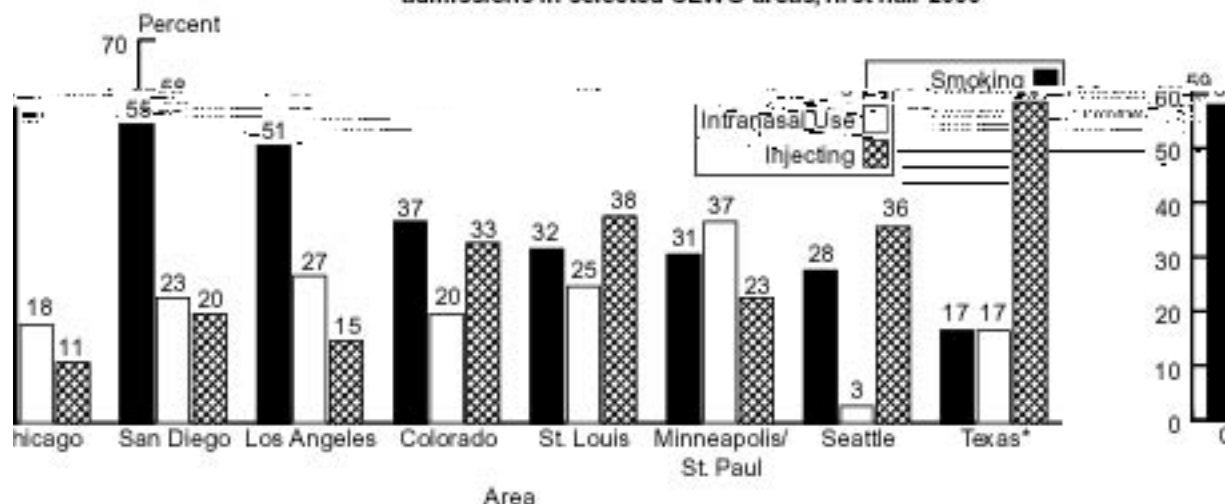
Chicago, Colorado, Los Angeles, and San Diego, while injecting predominated in St. Louis, Seattle, and Texas. Intranasal use, however, was the most common route in Minneapolis/St. Paul.

Compared with the same reporting period 1 year earlier, the percentage of primary methamphetamine admissions who were smokers increased in at least six areas (Chicago, Colorado, Los Angeles, St. Louis, San Diego, and Seattle), corresponding to declines in intranasal use in five of those areas (Chicago, Colorado, Los Angeles, St. Louis, and San Diego). Most of those changes were moderate (within 2–4 percentage points), except in Chicago and St. Louis, where the changes were more substantial (10–24 points). Injectors increased somewhat (2–3 points) among methamphetamine admissions in San Diego and St. Louis, declined considerably (5–7 points) in Chicago and Seattle, and remained relatively stable in Colorado and Los Angeles.

Multisubstance Abuse

Polydrug use among methamphetamine users is common in most areas. Of the three South

Exhibit 44. Route of administration among primary methamphetamine treatment admissions in selected CEWG areas, first half 2000



*Data are for the first three quarters of 2000.

IRCE: Drug abuse treatment agencies

*Data

SOI

Florida (Broward County) methamphetamine-related decedents in 1999, all involved multiple drugs, including benzodiazepines, cocaine, ecstasy, heroin, and gamma hydroxybutyrate (GHB). Similarly, of the eight methamphetamine-related deaths in Seattle in the first three quarters of 2000, all involved other substances. Furthermore, all methamphetamine-related ED cases at a South Florida hospital in the second half of 1999 involved other drugs, including cocaine, GHB, marijuana, opiates, and sildenafil citrate (Viagra). Among primary stimulant treatment admissions in all reporting CEWG areas, marijuana and alcohol were mentioned as the secondary and tertiary drugs of choice.

LAW ENFORCEMENT DATA

Minneapolis/St. Paul: *“The most pronounced change in narcotics law enforcement activity this year centered around the influx of methamphetamine into the State and the continued growth in the number of clandestine methamphetamine labs.”*

Seattle: *“While other methamphetamine indicators remain stable, law enforcement and clandestine lab response efforts are increasing substantially.”*

Arrestee Urinalysis Data

San Diego, by far, tops the list of CEWG cities in methamphetamine-positive urinalysis levels among adult ADAM arrestees (exhibit 43). Outside western ADAM sites, methamphetamine continues to appear only sporadically, but it has recently appeared in four nonwestern areas: Atlanta, Minneapolis, Philadelphia (only males tested), and Washington, DC (only males tested); positive levels in those cities, however have been small (3 percent).

Between 1998 and 1999, methamphetamine-positive levels among male adult arrestees remained relatively stable (< 3-percent-

point change), except in San Diego, where male arrestee levels declined by 7 points. By contrast, levels among female arrestees increased in San Diego (by 3 percentage points) and Seattle (by 4 points), but declined sharply in Phoenix (by 8 points).

According to arrestee urinalysis data from the first three quarters of 2000 in Hawaii, 36–40 percent of arrestees tested amphetamine-positive compared with 25–29 percent for marijuana, 13–19 percent for cocaine, and only 6–10 percent for opiates.

Arrests, Seizures, and Submissions

Methamphetamine-related arrests increased in most reporting CEWG areas. In Atlanta, they increased from 307 in 1997 to 521 in FY 2000, and methamphetamine-related investigations increased from 78 in FY 1996 to 185 in FY 2000. In Seattle/King County, prosecutions involving methamphetamine have been steadily increasing, with prosecuted felonies in the first three quarters of 2000 (71) increasing by 13 percent over the 1999 total. In 2000, methamphetamine seizures outpaced those for cocaine in the Minneapolis/St. Paul area. By contrast, in 2000, methamphetamine-related cases decreased to 373 in Honolulu, where cases have been decreasing since the peak in 1994.

The number of methamphetamine labs seized continues to increase in four CEWG reporting areas: Georgia, Michigan (from 14 in 1999 to 50 in 2000), Minnesota (from 22 in 1997 to 109 in 1999 to 119 in 2000), and Seattle (789 seized in calendar year 1999 and 1,050 in the first three quarters of 2000). Conversely, the number of labs seized by the Midwest Field Division of the DEA (in southwestern Missouri, Kansas, and Nebraska) has declined (from 454 in FY 1998 to 200 in 1999). This decrease occurred as funding shifted to local enforcement for cleanup of these labs.

Although no trend data are available, 377 labs were seized in the Phoenix area during FY 2000. In northeastern and southern CEWG areas, methamphetamine labs are sporadically seized. For example, four labs were seized in Ft. Lauderdale in 1999; a few small, clandestine labs have been identified in operation in Washington, DC; and several labs that are able to produce large quantities of methamphetamine have been discovered in cities surrounding the District.

Seizure data vary. Methamphetamine seizures remain infrequent in northeastern and southern CEWG areas; however, in the Washington, DC, area, the amount of methamphetamine seized among Mexicans with connections to Mexican drug traffickers increased in 2000.

Availability and Source

In most western areas of the United States, methamphetamine is readily available. In Hawaii, methamphetamine (“ice”) availability remains high; there it appears in two forms: “clear,” a clean, white form; and “wash,” a

brownish, less processed form. The DEA reports that methamphetamine is also readily available and in high demand throughout the Midwest, where it is sold in vials, plastic bags, and paper or foil wrappers. It is less available in the Northeast. For example, Philadelphia focus group members indicate that methamphetamine remains difficult to obtain, is not sold outdoors, and requires a connection. Likewise, in New York City, the drug is not sold in the street.

Methamphetamine prices vary in the reporting areas, depending on purity, availability, and quantity (exhibit 45). Since the last reporting period, prices have remained stable in reporting areas, except in Washington, DC, where prices nearly doubled. Similarly, since the last reporting period, purity levels have remained unchanged in reporting CEWG areas. In Phoenix, where the drug is usually packaged in clear plastic wrap, plastic zipper bags, or layers of plastic wrap covered with vapor rub compressed into a hard rock using a car jack, high-purity methamphetamine (96–98 percent)

BEYOND THE CITY LIMITS...

Boston: “The DEA continues to report user-level quantities of methamphetamine available in New England, mostly in Maine and New Hampshire, suggesting that methamphetamine markets are more likely to be found in rural areas. One nonoperational lab was recently seized in Maine.”

Chicago: “Methamphetamine use in Chicago remains low, but anecdotal reports from other areas of the State indicate that the use of this drug may be more common outside Chicago. Recently, the DEA shut down a methamphetamine lab in a small city in central Illinois.”

Detroit: “In FY 2000, 189 primary stimulant admissions were reported statewide; only six were in Detroit/Wayne County. Most live in large rural areas, with more admissions in western and southern counties.”

St. Louis: “While the number of methamphetamine treatment admissions was still relatively low (177 during the first half of 2000), in rural treatment programs methamphetamine was the drug of choice after alcohol.”

Washington, DC: “Although most methamphetamine indicators in the District remain low, DEA intelligence reports that the availability of the drug has ‘exploded’ in parts of Maryland and Virginia.”

Exhibit 45. Methamphetamine prices and purity in reporting CEWG areas, December 2000 reporting period

City	Purity (%)		Price		
			Gram	Ounce	Pound
Atlanta	NR		\$100	\$1,500	\$14,600
Boston	NR		\$70–\$200	\$800–\$1,900	\$8,000–\$24,000
Denver	NR		\$80–\$125	\$600–\$1,100	\$5,000–\$8,000
Honolulu	90–100	“wash”	\$600–\$900	\$3,000–\$5,000	NR
		“clear”	\$800–\$1,000		NR
Minneapolis/St. Paul	NR		\$90–\$100	\$600–\$900	\$10,000–\$12,000
Phoenix	Mexican	19–30	\$48–\$55 (type not specified)	NR	NR
	“glass”	96–98			
St. Louis	up to 100		NR	\$700–\$1,300	NR
San Diego	25–53		\$80	NR	NR
San Francisco	NR		NR	\$500–\$1,000	\$3,500–\$10,000
Texas (Houston)	domestic		NR	\$600–\$800	\$10,000–\$14,000
	Mexican		NR	\$450–\$900	\$5,000–\$8,000
Washington, DC	NR		\$150	\$2,400–\$2,800	\$23,000–\$30,000

SOURCE: CEWG city reports, December 2000

referred to as “glass” is available, as well as lower purity (19–30 percent) Mexican methamphetamine. In Washington, DC, high-quality forms of methamphetamine are called “hydro” (a powdered substance) and “glass”(crystalline shards or powder), and recently a pill form of methamphetamine reportedly sold for \$25. In Seattle, methamphetamine purity is increasingly inconsistent. A common methamphetamine cutting agent in Minneapolis/St. Paul is dimethyl sulfone, a substance used to treat arthritis in horses.

Manufacture, Distribution, and Trafficking

St. Louis: “Competition between locally manufactured methamphetamine and that imported from Mexico is predicted to affect both price and purity.”

Local methamphetamine labs in Texas generally use two types of manufacturing methods: (1) the “Nazi method,” which uses ephedrine or pseudoephedrine, lithium, and anhydrous

ammonia, or (2) the “cold method,” which uses ephedrine, red phosphorus, and iodine crystals. The most commonly diverted chemicals used in those methods are 60-milligram pseudoephedrine tablets such as “Xtreme Relief,” “Mini-Thins,” “Zolzina,” “Two-Way,” and “Ephedrine Release.”

In Seattle, the predominant manufacturing method still used in most rural counties is the red phosphorous cold method; however, in King and Pierce Counties, the quick-cooking “Nazi method” is most prevalent. This newer method allows for smaller and more mobile labs that are able to produce larger quantities of methamphetamine in a shorter time period. Similarly, the trend in methamphetamine manufacture in Arizona is for mobile labs, known as “box labs,” which are operated by independent “cooks.” The box labs are small labs in which all the chemicals and production supplies are stored in a box that can easily be transported in the trunk of a vehicle, making them difficult for law enforcement to locate

and dismantle. In the Denver area, where the ephedrine reduction method is the primary local manufacturing process, most labs are generally capable of manufacturing an ounce or less per “cook” and vary from being primitive to quite sophisticated.

Similar to labs in the West, methamphetamine labs in Minneapolis/St. Paul typically produce small amounts of the drug, are operated by people inexperienced in chemistry, and have been located in city apartments, rural mobile homes, farmhouses, garages, sheds, an ice fishing house, a tree house, and even a houseboat. Caustic and volatile raw ingredients produce dangerous, toxic wastes that pose serious environmental and safety dangers to the people and property in surrounding areas. Recently, a cold-cooking method of preparing methamphetamine was reported in South Florida. Seizures of ephedrine and pseudoephedrine are also

increasing in Michigan, with much coming from Canada.

Along with locally produced methamphetamine, most methamphetamine available in CEWG areas is Mexican in origin. For example, in Denver, most methamphetamine originates in Mexico or large-scale labs in California. Methamphetamine in Texas comes from California and Mexico, as well as from local “mom and pop labs.” Most methamphetamine in Minneapolis/St. Paul originates in Mexico and is transshipped via Arizona, California, or Texas. In St. Louis, Hispanic traffickers, rather than the old network of motorcycle gangs, are the predominant distributors in addition to individual entrepreneurs. In Washington, DC, most methamphetamine comes from Mexican trafficking. California-based Mexican sources use Hawaii’s cultural diversity to facilitate smuggling and distribution to and within the islands.

“ECSTASY”

Atlanta: “Ecstasy and other club drugs are not exactly new, nor are they suddenly appearing on the streets. Ethnographic reports suggest that they have just become more readily and easily available.”

Boston: “Data from poison control centers, the Drug Enforcement Administration (DEA), State Police, key informants, and prevalence surveys all continue to indicate that ecstasy use is not uncommon among teens and young adults in Boston and throughout Massachusetts.”

Chicago: “Ecstasy is the most commonly identified stimulant used in the Chicago area.”

Miami: “Numerous indicators point toward increased use of methylenedioxyamphetamine (MDMA) and other drugs and combinations also referred to as ecstasy.”

ADVERSE MEDICAL CONSEQUENCES

Mortality Data

According to CEWG city reports, ecstasy-related deaths are relatively rare but mostly increasing in reporting areas:

- Detroit/Wayne County: One ecstasy-related death was reported in 1998, two in 1999, and several in 2000 (confirmations are pending on some). Furthermore, a death caused by paramethoxyamphetamine (PMA), an ecstasy-like substance, occurred in June 2000 in neighboring Macomb County, and a bacterial meningitis case was identified in August 2000 in rural northern Michigan after an outdoor rave party, where attendees shared a pacifier dipped in liquid containing ecstasy.
- Minneapolis/St. Paul: Ecstasy contributed to five deaths in the first three quarters of 2000.
- Philadelphia: MDMA was present in three decedents during the second half of 1999—the first time ecstasy was present in any standard indicators in that city—and three during the first half of 2000.
- South Florida: Ecstasy has been linked to eight drug deaths in 1999 and five in the first three quarters of 2000. Seven deaths

attributed to PMA have been identified in Central Florida during summer 2000.

- Texas: Two deaths involved MDMA in 1999.
- Washington State: From January 1999 to October 2000, seven decedents tested MDMA-positive.

According to DAWN ME data, deaths across the United States involving methylenedioxy-methamphetamine (MDMA, “ecstasy”) and other club drugs, such as flunitrazepam (Rohypnol), gamma hydroxybutyrate (GHB), and ketamine, are relatively rare. During the 5-year period from 1994 to 1998, medical examiners participating in the DAWN program reported only 27 ecstasy-related deaths.

Emergency Department Data

According to DAWN ED data, ED visits for ecstasy are relatively rare, especially when compared with ED visits involving other major illicit drugs. Although ecstasy ED mentions were low, aggregate data showed that they increased significantly ($p < 0.05$) between 1994 and 1999, between 1997 and 1999, and between 1998 and 1999.

In 1999, of the 20 CEWG cities in DAWN, New Orleans had the highest rate of ecstasy ED mentions per 100,000 population (4.2),

followed by Miami (3.1), San Francisco (2.9), and Boston (2.3). Six cities have rates at less than 1 per 100,000 population: Denver, Detroit, Los Angeles, Minneapolis/St. Paul, St. Louis, and Washington, DC. According to a South Florida hospital, in the first half of 2000, 3 percent of all ED drug cases involved ecstasy.

Other Adverse Medical Consequences

The number of poison calls related to ecstasy was relatively large in most reporting CEWG areas:

- Boston: In the first three quarters of 2000, ecstasy was mentioned more frequently than any other illicit drug.
- Detroit: Ecstasy-related calls are increasing, from 10–15 contacts in 1998 to 31 in 1999 to approximately 31 in only the first 10 months of 2000.
- Miami: During June–October 2000, 32 calls (of 426 total calls) involved ecstasy.
- Minneapolis/St. Paul: From January through November 15, 2000, 42 calls regarding ecstasy were reported.
- Texas: The number of ecstasy-related poison cases increased from 35 in 1999 to 71 as of August 2000.

Conversely, in Colorado, few calls involving ecstasy (3–11 calls) were reported each year between 1994 and 1999.

Although ecstasy treatment admissions have not emerged in large numbers, in a few CEWG cities, mentions of ecstasy among treatment clients are increasing. For example, in Texas, among adults, admissions for a primary, secondary, or tertiary problem with ecstasy increased from 99 in 1999 to 113 in the first three quarters of 2000; among adolescents, admissions increased from 17 in 1999 to 41 in

USERS' MISCONCEPTIONS ABOUT ECSTASY:

Boston: "The rise in ecstasy use is being driven by an increase in availability...and by its reputation as a relatively benign, mood-enhancing substance."

Boston: "Thus far, treatment providers in contact with ecstasy users receive mostly positive reports about this drug, with few mentions of immediate downsides (although one clinician spoke of young clients feeling depressed the day after use). However, clinical data that heavy or prolonged MDMA use may produce significant neurological damage, with concomitant emotional disturbance, are accumulating. Given the growing prevalence of ecstasy use, promoting greater awareness of such risks seems warranted."

Washington, DC: "Users consider it [ecstasy] a safe and recreational drug, and DEA reports suggest that this perception may be leading individuals to abandon more addictive substances, such as heroin, for the supposedly safer ecstasy."

the first three quarters of 2000. In Boston, youth treatment providers continued to report mentions of ecstasy by their clients.

DEMOGRAPHIC DATA

In 1999, DAWN ED data corroborated the anecdotal reports that ecstasy and club drug users tend to be young: at least 80 percent of ecstasy ED mentions are among patients 25 and younger (compared with only 29 percent of ED drug cases overall). Similarly, according to first-half-2000 ED data from a South Florida hospital, 88 percent of cases involving ecstasy were among users younger than 30 (41 percent were in their teens, and 47 percent were in their twenties).

Other local data also corroborate that youth are the predominant ecstasy users. Of the adult treatment admissions with primary, secondary, or tertiary ecstasy problems in Texas in 2000, the average age was 24. In a recent survey among substance abuse recovery program clients in Seattle, 44 percent of youth (14–24 years) reported having ever used ecstasy and 30 percent reported past-6-month use ($N=71$). However, among older clients (25–50 years), 45 percent reported having ever used ecstasy, but fewer than 10 percent reported past-6-month use ($N=114$).

Finally, student and young adult surveys across the United States show high and mostly increasing ecstasy use. For example, between 1996 and 1999, lifetime use among Massachusetts high school students increased from 6 to 15 percent, and current use increased from 2 to 7 percent. In Miami between 1996 and 1999, past-year ecstasy use remained relatively stable among 10th graders (from 4.6 to 4.4 percent) but increased among 12th graders (from 4.6 to 5.6 percent). In Texas, between 1998 and 2000, ecstasy use among secondary students remained relatively stable, with lifetime use at 4.5 percent each year and past-month use at 1.9 percent in 1998 and 1.4 percent in 2000.

ECSTASY MORTALITY DATA IN ONE CEWG CITY REFLECT RACIAL/ETHNIC AND GENDER DIVERSITY AND POLYDRUG USE:

In Minneapolis/St. Paul, five ecstasy-related deaths were reported in the first three quarters of 2000: the drug overdose death of a 23-year-old White male using ecstasy, heroin, and alcohol; the accidental ecstasy overdose death of a 26-year-old Black male; the murder of a 24-year-old Black male in which acute alcohol and ecstasy use was noted as a significant contributing condition; the death of a 17-year-old White male; and the death of a 25-year-old White female who also used cocaine and opiates.

Corroborating anecdotal information that club drug users, including ecstasy users, are typically Whites, the majority of ecstasy ED mentions in DAWN involved White, non-Hispanic patients in approximate proportion to the general U.S. population. According to ED data from a South Florida hospital, 78 percent of first-half-2000 hospital cases involving ecstasy were among Whites.

Similarly, in 2000, among adult treatment admissions with primary, secondary, or tertiary ecstasy problems in Texas, 85 percent were Whites and 10 percent were Hispanics, 66 percent were males, 33 percent were referred by the criminal justice or legal system, and 24 percent were employed. Among adolescent admissions for ecstasy, 76 percent were males, 68 percent were Whites and 27 percent were Hispanics, and 73 percent were referred by the juvenile justice system.

Focus groups in Philadelphia described Whites of college age and typical clubgoers in their twenties as primary ecstasy users. In Washington, DC, ecstasy has become the drug of choice among White middle class young adults who use it at raves and dance and music clubs, but a diverse range of ecstasy users exists, including those older than 40, college students, and high school students. Similarly, in Atlanta, ethnographic data indicate ecstasy popularity among a wide variety of age groups.

USE PATTERNS

Settings and Context

In nearly every CEWG area, ecstasy is reportedly readily available at raves and other dance parties, as well as many nightclubs. For example, in Boston, ecstasy use at nightclubs, raves, and dances among young adults seems widespread. At St. Louis raves, which have become quite popular, ecstasy is widely available. In Phoenix,

BEYOND THE RAVE AND NIGHTCLUB SCENE:

Baltimore: "Ecstasy has been reported as an emerging drug in several Baltimore counties. It is said to be spreading from the rave or club scene to the general teen and young adult populations."

Seattle: "The use of ecstasy and other club drugs appears to be widespread not only in the dance and club scenes...."

ecstasy activity occurs at raves, bars, and nightclubs that cater to the college-age population. In Minneapolis/St. Paul, where raves were held nearly every weekend in 2000 in ballrooms, meeting halls, hockey arenas, or outdoors, the practice of wearing disposable respiration masks rubbed in menthol-based cold ointments is believed to heighten the effects of ecstasy, and pacifiers may be used to reduce teeth grinding. Ecstasy use is still uncommon in Newark; however, the rave phenomenon and ecstasy use are cited across the State, particularly in some college towns.

In several CEWG areas, ecstasy activity may be expanding outside the rave and nightclub scene. For example, in Atlanta, although its use at nightclubs and raves remains common, ecstasy appears to be as common as alcohol in certain casual social settings. In Boston, its use has moved outside the rave and dance scenes to include recreational use by younger adolescents in other settings. In Chicago, ecstasy use, once the purview of the rave scene, can be found in most mainstream dance clubs and many house parties. In the Denver area, ecstasy remains readily obtainable by individuals involved in the rave scene, but is also being sold in many singles bars. In Detroit, too,

ecstasy use may be expanding outside the rave scene. In New York, where ecstasy is sometimes sold on the streets, in the evenings and on weekends most dealing still takes place in nightclubs.

Multisubstance Abuse and Route of Administration

Miami: "Other consequences related to the glut of ecstasy include a rise in the abuse of benzodiazepines and other prescription drugs among adolescents. These drugs are being used to alleviate the stimulant effects of ecstasy in a practice called 'candy flipping.'"

Mortality data indicate common multisubstance use among ecstasy users. For example, in Washington State, during January 1999–October 2000, seven decedents tested MDMA-positive, and the majority of cases involved other drugs such as alcohol, cocaine, marijuana, methamphetamine, and phencyclidine (PCP). In Detroit, among ecstasy-related deaths in 2000, findings of multiple drugs were typical.

Similarly, according to 1999 DAWN ED data, more than 70 percent of ED episodes involving club drugs (ecstasy, flunitrazepam, GHB, ketamine, or lysergic acid diethylamide [LSD]) involved more than one drug. Alcohol was the most frequent substance mentioned in combination episodes involving ecstasy (in 47 percent of ecstasy episodes), followed by marijuana (in 28 percent of ecstasy episodes) and cocaine (in 18 percent). Additionally, 15 percent of GHB episodes involved ecstasy. According to South Florida first-half-2000 ED data, most ecstasy cases also involved another drug, including alcohol (in 59 percent of ecstasy cases), marijuana (in 34 percent), benzodiazepines (in 31 percent), GHB (in 28 percent), cocaine (in 19 percent), and LSD (in 9 percent).

In Atlanta, the use of ecstasy in combination with other club drugs appears increasingly common in the nightclub or rave scene. In Seattle, ecstasy is used in combination with other drugs such as LSD (“candy flippers”). Anecdotal reports in Boston indicate that sildenafil citrate (Viagra) is sometimes used in combination with ecstasy.

In Philadelphia, ecstasy is also reportedly combined with heroin and alcohol or cough syrup. Similarly, in Washington, DC, most ecstasy users follow a polydrug pattern of using ecstasy with (depending on availability) alcohol, cocaine hydrochloride (HCl), or more recently crack. In that city, users may also use ecstasy either in combination or sequentially with methamphetamine, LSD, and marijuana.

The most common route of ecstasy administration is oral ingestion via tablet or, less often, capsule form. However, a powder form was reported in Brooklyn, where it is reportedly smoked with cocaine HCl in a blunt. Intranasal use of powder ecstasy was also reported in Seattle and Washington, DC.

LAW ENFORCEMENT DATA

Atlanta: “According to the DEA, ecstasy cases dominate the manpower resources of the Atlanta Field Division.”

Ecstasy seizures are numerous and increasing in most reporting CEWG areas. In Boston, for example, ecstasy seizures continued to increase, and most of the tablets seized were relatively pure. In South Florida, 1 million tablets were seized during November 2000, and in the first half of 2000, ecstasy accounted for 144 of the 4,105 cases in which drug samples were analyzed—representing nearly 4 percent of all cases, more than the proportions for heroin, LSD, or GHB. In Minneapolis/St. Paul, ecstasy seizures increased substantially in

2000. Similarly, in Phoenix, between fiscal years (FYs) 1999 and 2000, ecstasy seizures increased from 3,300 to more than 131,000 dosage units. Recently, 8,000 pills were confiscated in the Washington, DC, area.

Brand Names, Logos, and Packaging

Ecstasy pills are often sold using brand names—ones that invoke successful business or wealth status are often used, as well as pop-culture icons—and names or logos are imprinted on them. Other faddish aspects of ecstasy sales include the frequent changing of pill or capsule colors. Brand names and logos differ according to geographic location, although several, such as “X-Files” and “Mitsubishi,” may traverse regions. For example, in Baltimore, brands included “superman,” “X-Files,” “Mitsubishi,” “Buddha,” and “white diamonds.” In New York, pills are often marked with “M&M,” “Pokemon,” or a blue star. In Washington, DC, names include “Smurfs,” “thumbs-up,” “Mitsubishi,” and “X-Files.” Some brand names may be intended to indicate ecstasy quality. For example, in Baltimore, some pills are believed to be two or three times more potent than others and are referred to as “double-stacked” or “triple-stacked.” In Washington, DC, an especially high-quality brand is called “molecule.” Pills are also in the form of a cross or diamond in the District.

Availability, Price, and Purity

Ecstasy is reportedly highly available in nearly every CEWG area, and availability is increasing in many. Quality and purity of ecstasy tablets vary. For example, in Miami, each 300-milligram ecstasy pill contains only about 75–125 milligrams of MDMA. In Phoenix, PMA, a substance responsible for some overdose deaths in other States, continues to show up in pills being sold as ecstasy, many of which are stamped with a three-diamond

Mitsubishi logo. Similarly, in Atlanta, PMA availability may be increasing. In Seattle, where ecstasy quality varies, tablets are often cut with other drugs such as caffeine, ephedrine, methylenedioxyamphetamine, (MDA), methylenedioxyethylamphetamine (MDEA), dextromethorphan (DXM), and PMA. Law enforcement officials in Minneapolis/St. Paul reported two chemically related compounds, dimethyltryptamine (DMT) and dipropyltryptamine (DPT), both sold as ecstasy, one in pill and one in powder form. In parts of Texas, heavily cut Mexican brown heroin is being pressed into tablets sold as ecstasy and called "H-bombs" or "heaven's gate." Ecstasy pills in Washington, DC, may contain amphetamine, ketamine, methadone, and lethal substances that are by-products of the MDMA manufacturing process. By contrast, in Boston, in recent analyses, no ecstasy tablets have contained PMA, DXM, or heroin (rumored to be a common additive to ecstasy).

Ecstasy is available at the retail level by the tablet or capsule for as little as \$5 in Atlanta and as much as \$40 in Atlanta, Chicago, and Phoenix (exhibit 46). Wholesale costs are much cheaper (\$2–\$13.50 per tablet), making ecstasy distribution potentially lucrative. Ecstasy may also be cheaper for those who know the distributors. Ecstasy prices have remained stable in most CEWG areas since the last reporting period.

Distribution and Trafficking

The rise in ecstasy use may be driven partly by an increase in its availability. Ecstasy reportedly originates in clandestine labs in Western Europe (especially Belgium and The Netherlands). Two modes of entry into the United States are reportedly through the U.S. Post Office and express courier services. A secondary source country for ecstasy destined for the

Exhibit 46. Methylenedioxyamphetamine (MDMA, ecstasy) prices in reporting CEWG areas, December 2000 reporting period

Area		Price/pill or dosage unit	
Atlanta		\$5–\$40	
Baltimore		\$25	
Boston		\$20–\$30	
Chicago		\$20–\$40 or \$12–\$15 for those with connections to suppliers or producers	
Denver		\$15–\$25	
Miami		wholesale	\$8
		retail	\$20–\$30
Minneapolis/ St. Paul		\$10–\$40	
New York City		\$20–\$25 or 3 for \$50	
Philadelphia		\$20–\$25	
Phoenix		wholesale	\$2–\$8
		retail	\$20–\$40
St. Louis		\$15–\$30	
Seattle		\$20–\$30 or \$15 if bought from friends	
Texas	Austin	wholesale	\$6–\$7
		retail	\$15–\$25
	Dallas	\$10–\$20	
	Houston	wholesale	\$7.50–\$10
retail		\$20–\$30	
Washington, DC		wholesale	\$13.50
		retail	\$20–\$30

SOURCE: CEWG city reports, December 2000

United States is Spain. Miami serves as the transshipment point for ecstasy trafficking between Europe and South America, and the first major ecstasy seizure (60 kilograms) in Brazil originated in Spain and transited through Miami. Mexico, as well as Miami, appears to be a diversionary route. In 2000, three people were arrested at Newark Airport for attempting to transport approximately 2,835 grams of ecstasy pills from Santo Domingo to Newark.

Russian-Eurasian and Israeli organized crime groups appear to be the key ecstasy operatives working in the Miami area. Similarly, distribution in Atlanta appears to be controlled by local drug traffickers with connections to Russian and Israeli organized crime members.

In Washington, DC, the same individuals who use ecstasy distribute it—typically White middle class and suburban youth. Distribution points in many CEWG areas include places where the drug is used: nightclubs, raves, after-hours clubs, and college campuses.

GAMMA HYDROXYBUTYRATE (GHB)

Atlanta: *“GHB is easily accessible at raves and is commonly used by both teenagers and young adults. The DEA continues to report that its use is associated with sexual assault.”*

San Francisco: *“Observers report that GHB use continues, but not with anything like the prevalence of ecstasy use.”*

ADVERSE MEDICAL CONSEQUENCES

Gamma hydroxybutyrate (GHB) and its precursors, gamma butyrolactone (GBL) and 1,4 butanediol (1,4 BD)—which convert into GHB once ingested—are considered club drugs and are central nervous system depressants that can produce drowsiness, increased heart rate, depressed respiration, visual distortions, seizures, coma, unconsciousness, and sometimes death.

Mortality Data

According to DAWN ME data, in the 5-year period from 1994 to 1998, participating medical examiners across the United States reported 12 GHB-related deaths—a relatively low number compared with deaths associated with other major illicit drugs. Additionally, GHB-related deaths have been reported in five CEWG areas: two in Minneapolis/St. Paul (in 1999), nine in Broward County (between 1996 and the first half of 2000), three in Miami-Dade County (since July 1999), three in Texas (in 1999), one in Washington State, and five in Missouri. Two near-deaths have been reported in St. Charles, Missouri, where GHB was used for drug rape.

Emergency Department Data

Chicago: *“Compared with other club drugs, overdose experiences are more frequent with GHB, especially when used in combination with alcohol. GHB is not tracked in most quantitative indicators, but use is perceived to be low in comparison to that of ecstasy.”*

South Florida: *“In virtually every GHB-related case, the reason for the ED visit was decreased responsiveness/coma usually lasting less than 3 hours.”*

According to DAWN, ED visits for GHB are relatively rare when compared with ED visits involving the major illicit drugs, but are higher than mentions involving other club drugs, such as methylenedioxymethamphetamine (MDMA, ecstasy), flunitrazepam (Rohypnol), or ketamine. Although GHB ED mentions are relatively low, aggregate data showed that they increased significantly ($p < 0.05$) between 1994 and 1999, between 1997 and 1999, and between 1998 and 1999—similar to ED trends for ecstasy. In 1999, of the 20 CEWG cities in DAWN, San Francisco had the highest rate of GHB ED mentions per 100,000 population (8.6), followed by New Orleans (6.3) and Dallas (6.0). Eight cities have rates at less than 1 per 100,000 population: Baltimore, Boston, New York, Newark, Philadelphia, Phoenix, St. Louis, and Washington, DC.

Additionally, GHB-related overdoses continued to be reported in many CEWG areas:

- Minneapolis/St. Paul: The major hospital trauma center in St. Paul has reported treating up to five GHB-related cases per week since September 1999.
- Newark: GBL recently attracted attention because of its link to 18 hospitalizations statewide and 2 overdoses by Princeton University students.
- Phoenix: Recently, the Phoenix Fire Department reported responding to several GHB overdoses.

- South Florida (Broward County): During the first half of 2000, a regional hospital treated 43 people with GHB (or GHB precursor) toxicity, compared with a total of 48 for all of 1999.
- Seattle: Local ED mentions in which GHB was the primary drug continued to increase. Furthermore, several sexual assault victims have presented to hospitals with symptoms similar to GHB overdose, but due to the drug's rapid elimination, only one sexual assault victim has tested GHB-positive to date.

Other Adverse Medical Consequences

As ED mentions and overdoses rise, poison center calls for GHB (including its precursors) continued to increase in reporting CEWG areas across the Nation:

- Boston: Calls concerning GHB continued, involving mostly adolescent and young adult males.
- Denver: Between 1994 and 1998, the poison control center reported only 1–6 calls regarding GHB. However, in 1999 the number of GHB calls jumped to 92.
- Minneapolis/St. Paul: From January through November 15, 2000, 68 calls were received involving GHB.
- Texas: In 1998, 100 confirmed exposures to GHB were reported, compared with 166 in 1999, and 138 in January–August 2000.

Conversely, in Detroit, poison calls declined: in 1999, 100 GHB cases were reported compared with 23 cases in the first 10 months of 2000. This decline in poison control contacts may be due to the hospital staff learning successful approaches to treat GHB-related emergency cases, thus eliminating their need to call poison centers for advice when these cases

occur. Note, however, that GBL cases increased, from six in 1999 to nine in the first 10 months of 2000.

Reports of GHB treatment clients or users suffering from withdrawal are emerging in a few CEWG areas. For example, in South Florida in 1999, three cases of GHB withdrawal were reported. In Texas, clients have appeared in treatment with primary, secondary, or tertiary problems with GHB (or its precursors): in 1999, 17 adults were admitted, and in the first three quarters of 2000, 7 were admitted; in the first three quarters of 2000, only one adolescent was admitted to treatment.

DEMOGRAPHIC DATA

San Diego: "There can be little doubt that these drugs are widely available in San Diego, but the evidence of who uses the drugs and where and how they are used will have to wait until ethnographic studies are conducted."

DAWN ED data in 1999 corroborated anecdotal reports that GHB and club drug users tend to be young: 59 percent of GHB ED mentions across the United States involved patients age 25 and younger (compared with 29 percent of ED drug cases overall). Similarly, according to first-half-2000 ED data in a South Florida hospital, the average age of a GHB patient was 26.6 years.

Other local data corroborate that young, White adults are the predominant GHB users. Of the adult treatment admissions with primary, secondary, or tertiary GHB problems in Texas in the first three quarters of 2000, the average age was 25. In 1999, both GHB decedents in Minneapolis/St. Paul were White males in their thirties, and the three GHB decedents in Texas were Whites (one male and two females) with an average age of 32. Although GHB users are

predominantly adolescents and young adults, the prevalence of use was relatively low according to the 1999 Massachusetts high school survey: only 5 percent of students in grades 9–12 reported lifetime use of GHB.

Even though anecdotal evidence indicates that White males are the predominant GHB users, all Texas treatment admissions with a primary, secondary, or tertiary GHB problem in the first three quarters of 2000 were White females. By contrast, of the GHB ED patients at a South Florida hospital in the first half of 2000, 74 percent were males and nearly all (86 percent) were Whites, and in a Seattle study of 42 GHB nonfatal overdoses, 80 percent involved males.

CONTEXT AND USE PATTERNS

Club drugs, including GHB and its precursors, are typically used at parties, raves, and nightclubs. For example, in the first half of 2000, the initial setting for 21 of 43 GHB-related ED visits to a South Florida hospital was a local bar/nightclub or the beach. GHB is used not only as a party drug in raves and nightclubs, but also in drug rapes and as an alleged muscle-stimulating growth hormone and aphrodisiac. For example, of 12 GHB-related driving-under-the-influence cases during January–October 2000 in Washington State, all of the drivers had either taken GHB recreationally or for bodybuilding purposes, and none had been involved in the rave or dance club scene.

According to aggregate 1999 DAWN ED data, GHB episodes typically involve other drugs, including alcohol (in 56 percent of GHB episodes), ecstasy (in 15 percent), and cocaine (in 6 percent). Similarly, in Miami, of the seven GHB deaths in which GHB was the proximate cause, all seven involved other substances, including alcohol, cocaine, marijuana, benzodiazepines, opiates, carisoprodol (Soma),

sertraline (Zoloft), and ecstasy, and alcohol was detected in 6 of 7 cases. In a Seattle study of 43 GHB nonfatal overdoses, 37 percent ingested GHB only, 35 percent combined GHB with alcohol, 23 percent with ecstasy, and 9 percent each with methamphetamine and cocaine. A common drug combination in these overdoses involved GHB, alcohol, and ecstasy.

LAW ENFORCEMENT DATA

Boston police reported occasional seizures, but noted that GHB is sometimes overlooked because it is a clear liquid often mistaken for water. In Minneapolis/St. Paul, three seizures of large amounts of GBL-containing products occurred in 2000: two in suburban areas and one in a university town. In Washington, DC, where GHB is becoming increasingly common at raves and nightclubs, a lab was discovered recently in a nearby Maryland county.

Availability and Source

Boston: “In press reports, GHB, often called ‘liquid ecstasy’ or ‘liquid X,’ is sometimes confused with ecstasy. Although both are so-called club drugs and are often used in the same settings, their effects are quite distinct, with GHB presenting higher risk for both overdose and dependence.”

GHB, known as “easy lay,” “G,” “gamma,” “G-caps,” “Georgia home boy,” “grievous bodily harm,” “liquid E,” “liquid X,” “vita-G,” and “water,” is reported to be increasingly available at nightclub and party settings in many CEWG areas. It is often manufactured in homes by “kitchen chemists” who use recipes and ingredients found on the Internet. In Houston, for example, GHB manufacturing is reportedly very prevalent. It appears most often in liquid form (although it has appeared as a white powder and in tablet and capsule form in Denver), is taken orally (most often in

combination with alcohol), and is usually sold in dosage units (bottle capfuls, teaspoons, swigs, and drops). Dose prices range widely, at \$5–\$40, and have remained relatively stable since the last reporting period (exhibit 47).

GBL and 1,4 BD, both precursors to GHB, can be found in nutritional supplements and industrial organic solvents, which can be purchased over the Internet or in bars or gyms in some CEWG areas. These products are sold under a variety of names, including Blue Nitro, Dream On, Gen-X, InnerG, Jolt, pine needle extract, ReActive, Renewtrient, Serenity, Thunder FX, and Verve. Product labels often refer to GBL as “2(3H) furanone dihydro” and to 1,4 BD as “tetramethylene glycol” or “butylene glycol.” Quarts of GBL or 1,4 BD are reportedly available commercially for \$75–\$125 in the Seattle area, and in Newark, GBL is sold in nightclubs by bartenders for \$100 per bottle.

Exhibit 47. Gamma hydroxybutyrate (GHB) prices in selected reporting CEWG areas, December 2000 reporting period

Area	Price/Quantity
Atlanta	\$10–\$20/dose
Chicago	\$5–\$10/bottle capful
Denver	\$5–\$10/dose (one bottle capful)
Phoenix	\$5–\$10/dose (1 teaspoon) \$425/25 pounds \$3,200/55-gallon drum (wholesale) \$4,300/55-gallon drum (retail)
St. Louis	\$5/capful \$40/ounce
Seattle	\$5–\$10/dose (1 teaspoon or 2.5 g)
Texas	\$15–\$20/ounce \$500/gallon

SOURCE: CEWG city reports, December 2000

HALLUCINOGENS

Atlanta: “Ethnographic data continued to suggest the use of lysergic acid diethylamide (LSD) with ecstasy, methamphetamine, and club drugs.”

Boston: “Despite the low treatment and ED indicators for hallucinogens, use of LSD, psilocybin mushrooms (“shrooms”), and mescaline among adolescents and young adults is not uncommon, as indicated by survey data and focus groups. In focus groups, LSD was in many cases the illicit drug most often mentioned after marijuana and pharmaceuticals.”

Philadelphia: “According to users new to treatment, the use of phencyclidine (PCP) as an additive to marijuana blunts, which started gaining popularity in 1994, is increasing.”

ADVERSE MEDICAL CONSEQUENCES

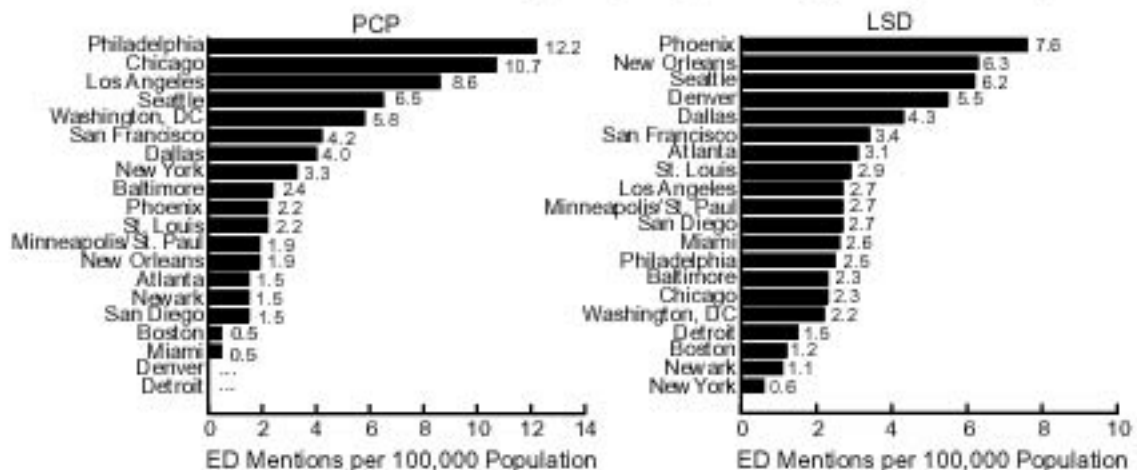
Philadelphia had the Nation’s highest estimated rate of phencyclidine (PCP) (“angel dust”) ED mentions per 100,000 population in 1999 (12.1), followed by Chicago (10.7) and Los Angeles (8.6) (exhibit 48). Between 1998 and 1999, PCP ED trends were mixed, with three significant ($p < 0.05$) increases (in Chicago, Minneapolis/St. Paul, and Newark) and two significant declines (in Miami and San Diego). Long-term PCP ED trends in most CEWG cities show that after peaks in 1995, the rate of mentions per 100,000 population generally declined.

Similar to PCP ED mentions, in 1999, lysergic acid diethylamide (LSD) (“acid”) ED mentions

were relatively few across the Nation, with the highest rate per 100,000 population at 7.6 in Phoenix, followed by 6.3 in New Orleans and 6.2 in Seattle. However, between 1998 and 1999, LSD mentions increased significantly ($p < 0.05$) in eight areas and declined significantly in none (exhibit 49).

The number of poison calls involving LSD remained low and stable in most reporting areas: between June and October 2000 in Miami, 11 such calls were reported; in the first 10 months of 2000 in Detroit, 14 calls were reported; and in the first 8 months of 2000 in Texas, 63 were reported. Additionally, during the same time period in Texas, 125 marijuana-related cases were reported mentioning the terms “PCP” or any of three names referring to

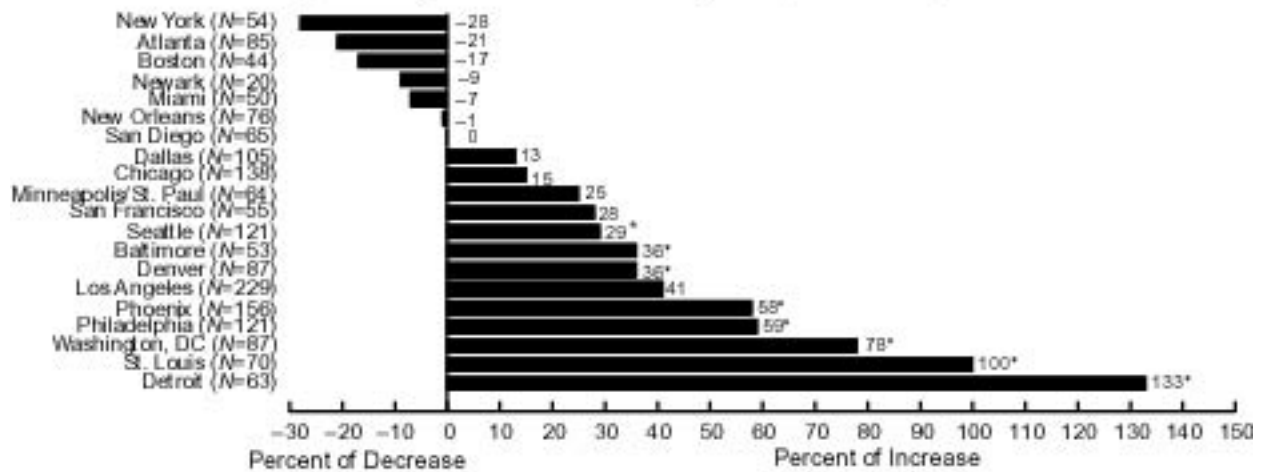
Exhibit 48. Rate of PCP and LSD ED mentions per 100,000 population by metropolitan area, 1999



NOTE: “...” denotes that estimate does not meet the standard of precision.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

Exhibit 49. Percentage of change in LSD ED mentions by metropolitan area, 1998 versus 1999



NOTE: (N) refers to 1999 LSD mentions.

*p<0.05

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

embalming fluid used in combination with marijuana: “formaldehyde,” “fry,” or “amp.” Also in Texas, 73 psilocybin mushroom-related cases were reported—a large increase compared with 13 psilocybin cases in all of 1999.

Treatment numbers and percentages involving primary hallucinogen use remain low and stable in most reporting CEWG areas, except in Texas, where PCP admissions (primary, secondary, or tertiary) increased between 1999 and the first three quarters of 2000 (from 50 to 144).

DEMOGRAPHIC DATA

PCP use seems to be concentrated among young males in most CEWG areas, and race/ethnicity varies by geographical location. In Texas, among recent poison cases involving PCP combined with marijuana, the average age was 22 years and most (87 percent) were males. Also in Texas, most (81 percent) of adult PCP treatment admissions were Black, most (71 percent) were male, and the average age was 24; among adolescent PCP treatment admissions, only 49 percent were Black, 29 percent were Hispanic, 22 percent were White,

and 89 percent were male. In Washington, DC, primarily young Black males and lower- to middle-class Whites who sometimes have ties to motorcycle gangs use PCP.

LSD and psilocybin mushrooms are used primarily by young Whites in most CEWG areas. For example, among South Florida LSD-related ED cases in the first half of 2000, most were younger than 30, male, and White. In Texas, among recent LSD- and psilocybin mushroom-related poison cases, the average ages were 21 and 20 years, respectively. In Detroit, most LSD use is limited to high school age suburban and rural youth. In Washington, DC, predominant LSD users are high school and college age individuals involved with raves and nightclubs in the Southeast quadrant. In Minneapolis/St. Paul, LSD, PCP, and psilocybin mushrooms are hallucinogens that are abused primarily by adolescents and young adults.

USE PATTERNS AND CONTEXTS

Philadelphia: “Users describe the effects of PCP as making you ‘crazy,’ ‘numb,’ ‘violent,’ and ‘hallucinate.’”

PCP is combined with marijuana or cigarettes in many CEWG areas, including Chicago, Minneapolis/St. Paul, Philadelphia, St. Louis, Texas, and Washington, DC. In Chicago, PCP is smoked in several forms: “mint leaf” or “love leaf” (a moist, loose, tobacco-like substance sprayed with PCP and wrapped in tinfoil), “sherm sticks” or “happy sticks” (cigarettes dipped in PCP), and PCP-laced marijuana blunts. In Minneapolis/St. Paul, marijuana continued to be combined with embalming fluid and/or PCP—a combination known as “wet sticks,” “wets,” “amp,” “happy sticks,” or simply “dipped joints.” Similarly, in Texas, poison cases involving PCP combined with marijuana continued. In Philadelphia, the combination of marijuana and PCP, frequently mixed in blunts, is called “love boat” or “wet” (also a term for PCP itself). In St. Louis, PCP has generally been used as a dip on marijuana joints. In Seattle, PCP (“angel dust,” “elephant,” “hog,” “dips,” “peace pill,” “Tic Tac,” “tranq,” “superkools,” sherms,” “fry,” and “amp”) appears as a clear, yellow liquid frequently added to cigarettes, marijuana, or mint leaves and smoked, and as white crystalline powder, tablet, or capsule forms that can be ingested orally, used intranasally, or administered intravenously. In Washington, DC, PCP is sold in both liquid form and mixed with parsley or marijuana.

LSD is a clear liquid usually abused orally and applied to small tablets (“microdots”), thin squares of gelatin (“window panes”), blotter paper (“blotter acid”), stickers, sugar cubes, candy, and beverages, or stored in small dropper bottles. In Detroit, LSD typically appears on paper cutouts of various designs. In Minneapolis/St. Paul, most LSD is sprayed onto absorbent blotter paper, which is divided into very small pieces that are placed under the tongue. In Seattle, where LSD is known as “panes,” “tabs,” “trips,” “cid,” “sandoz,” and “barrels,” LSD liquid in bottles appears to be common and is often given to friends in single

doses (a drop on their hands) for free. Users in Seattle consider the liquid lower in quality than the tablet or blotter paper form. In Austin, LSD is readily available in blotter paper and liquid forms. It also appears mostly in blotter paper form in Washington, DC; however, a new “crystal” LSD has been noted there.

In many CEWG areas, anecdotal reports of LSD and LSD combined with other drugs among clubgoers are increasing. In Atlanta, many are using LSD with methylenedioxy-methamphetamine (MDMA, “ecstasy”) or other club drugs. In Texas, along with ecstasy and other drugs with hallucinogenic properties, LSD is increasingly available to young adults in nightclubs. In South Florida among LSD ED patients, many reported combining the drug with ecstasy, marijuana, or cocaine.

LAW ENFORCEMENT DATA

Boston: “State police reported that seizures of these drugs [hallucinogens] typically increase around the time of large outdoor rock concerts.”

Washington, DC: “PCP seizures more than doubled between 1999 and the first 10 months of 2000 (from 39 seizures and 366 dosage units to 74 seizures and 8,644 dosage units).”

Arrestee Data

In 1999, PCP-positive urinalysis levels among ADAM adult male arrestees were highest (from 5 to 7 percent) in Dallas, Houston, Philadelphia, and Washington, DC. Levels increased only in Washington, DC (by 4 percentage points); they declined in Philadelphia (by 4 points). Females tested positive at lower levels: Houston had the highest level at 3 percent. According to Washington, DC, Pretrial Services toxicology data, PCP-positive levels have declined markedly during the past 10 years (from 17 percent in 1989 to

2 percent in 1998); however, recent data suggest a possible upturn to 9 percent in the first three quarters of 2000. Furthermore, PCP-positive levels for Washington, DC, juveniles revealed trends similar to those for adults: during the past several years positive levels have declined (from 18 percent in 1995 to 3 percent in 1998), with recent increases in the first three quarters of 2000 (to nearly 10 percent).

Availability and Source

Reports of PCP availability are sporadic. Although it is relatively rare in most of New England, it is available further south in New York City. In Philadelphia, where PCP started gaining popularity as an additive to blunts, it is easier to obtain than ever. In Texas, PCP availability has increased sharply and its use appears to be gang related. Although PCP is not as available as it was in the past in Washington, DC, it is obtainable in the Northeast quadrant of the city. Supply sources for the District reside in surrounding Maryland and Virginia suburbs, although suppliers continue to have connections to California-based manufacturers.

PCP prices depend on its form and geographic location (exhibit 50). In New York City, PCP is packaged in small plastic bags, sold for \$10 per bag, and sprayed on mint leaves. In Philadelphia, liquid PCP sold in small bottles is easier to obtain than ever, and large quantities (enough for four marijuana blunts) cost \$40. In Dallas, where liquid PCP purity levels average around 22 percent, it sells for as much as \$500 per ounce.

LSD is widely available in CEWG cities. Prices are relatively low (\$1–\$10 per dose), and purity is reportedly much lower than it was in the 1960s and 1970s (exhibit 51). In Michigan, where a lab with reported capacity to manufacture LSD (along with methamphetamine) was seized in 2000, most LSD is believed to originate in California. In St. Louis, where LSD has sporadically reappeared in local high schools

and rural areas, most LSD is thought to be imported from the Pacific coast.

Exhibit 50. PCP prices in reporting CEWG areas, December 2000 reporting period

Area	Price/Unit
Chicago	\$10, \$20/"mint leaf" \$20/dipped cigarette
Dallas	\$10/dose \$500/ounce
New York City	\$10/bag
Philadelphia	\$5/bottle
St. Louis	\$350/ounce
Seattle	\$4–\$15/tablet \$1–\$3/vial ≤ \$20/dipped cigarette
Washington, DC	\$350/ounce

SOURCE: CEWG city reports, December 2000

In Seattle, psilocybin mushrooms are available and common names include "shrooms," "magic mushrooms," "psilocybin cubes," and "liberty caps." In Minneapolis/St. Paul, psilocybin mushrooms cost \$150–\$200 per ounce. In Boston, ordinary dried mushrooms spiked with LSD are sometimes sold as containing psilocybin. In Phoenix, peyote appears to be readily available.

Exhibit 51. LSD prices in reporting CEWG areas, December 2000 reporting period

Area	Price/Dose	Other
Atlanta	\$4–\$10	\$1,000/1,000-dose blotter
Boston	\$5	\$300/100 doses
Chicago	\$5	NR
Honolulu	\$4–\$6	\$225–\$275/100-dose sheet (1 "page")
Minneapolis/ St. Paul	\$1–\$5	NR
Phoenix	\$4	NR
St. Louis	\$2–\$4	NR
Seattle	\$3–\$5	\$80/vial
Texas		
Dallas	\$1–\$10	NR
Fort Worth	\$6–\$10	NR
Washington, DC	\$3–\$5	NR

SOURCE: CEWG city reports, December 2000

ABUSED PHARMACEUTICALS: OPIATES

This drug group excludes heroin but includes opiates such as butorphanol tartrate (Stadol), codeine and its compounds, fentanyl, hydrocodone (Vicodin, Hycodan, Lortab, Lorcet, and NORCO), hydromorphone (Dilaudid), meperidine or pethidine (Demerol), methadone (Dolophine), morphine, nalbuphine (Nubain), oxycodone (Percodan, Percocet, and OxyContin—a newer, higher dose, time-release formulation), propoxyphene (Darvon and Darvocet), and tramadol (Ultram).

OXYCONTIN ABUSE EMERGING:

Atlanta: "Use of heroin and other opiates appears to be on the rise among many young (18–25), primarily suburban Atlanta residents. In particular, OxyContin use is on the rise, according to correspondence with local treatment centers and ethnographic fieldworkers. Individuals are injecting this long-acting, high-dose version of oxycodone and possibly using it intranasally as well."

Baltimore: "An ethnographic researcher reports that Oxycontin is reputed on the streets 'to bring the ol' heads to a nod for about 12 hours.' Street prices are usually \$25 per pill but can be as high as \$100."

Boston: "One clinician spoke of "oxy 40s" and "oxy 80s," high-dose versions of oxycodone (Percodan and Percocet) as the new prescription drug of choice among young clients."

Phoenix: "Treatment programs reported an increase in OxyContin abuse and addiction."

- In Philadelphia, propoxyphene-related deaths totaled 22 in 1999 and 21 in the first half 2000, oxycodone deaths totaled 17 in 1999 and 23 in the first half of 2000, and hydrocodone deaths totaled 13 in 1999 and 22 in the first half of 2000.
- Phoenix: Continuing the upward trend, opiate deaths (other than heroin and morphine) are projected to increase 58 percent (57 in 1999 and 45 in the first half of 2000).
- In Seattle/King County, drug-caused deaths involving opiates other than heroin are projected to increase 21 percent (totaling 34 in 1999 and 31 through the third quarter of 2000). Methadone was the opiate other than heroin most frequently reported by the medical examiner in both years.

Furthermore, in Detroit, between April and September 2000, 107 codeine-positive ME cases were reported—most in combination with several other drugs.

According to aggregate DAWN ME data, between 1998 and 1999, the prescription drugs with the largest increases in ME mentions were meperidine (59 percent increase) and oxycodone (53 percent increase).

In 1999, the percentage of mentions for opiates other than heroin among total ME mentions was high in several CEWG cities included in DAWN. For example, codeine mentions as a percentage of total ME mentions accounted for 37 percent in San Francisco, 24 percent in San Diego, and 23 percent in Philadelphia. The figures for methadone mentions were 14 percent in New Orleans, 13 percent in New York, and 10 percent in San Antonio, and those for propoxyphene mentions were 8 percent in New Orleans and 7 percent in Phoenix and San Antonio.

MORTALITY DATA

In three CEWG areas where 1999 versus partial-2000 trend data were available, mortality figures for opiates other than heroin and morphine are projected to increase:

Exhibit 52. Number of ME drug mentions, by drug, in selected CEWG cities, 1999

City	Codeine	Methadone	Propoxyphene	Oxycodone	Meperidine	Hydromorphone
Detroit	135	47	49	4	9	1
Los Angeles	259	81	57	7	29	8
New York	23	118	7	10	2	4
Philadelphia	188	42	50	42	6	8
Phoenix	110	44	37	33	18	1

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (July 2000 update)

In 1999, the number of codeine ME mentions was highest in Los Angeles, and codeine mentions were followed by methadone, propoxyphene, meperidine, hydromorphone, and oxycodone mentions in that city (exhibit 52). In most CEWG cities, however, oxycodone followed only codeine, methadone, and propoxyphene.

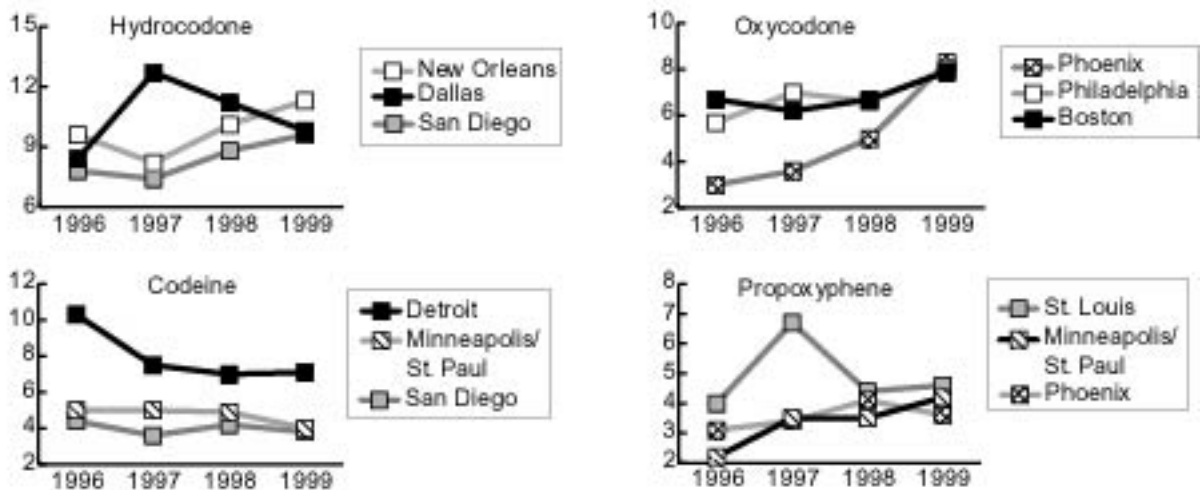
EMERGENCY DEPARTMENT AND POISON CONTROL DATA

Exhibit 53 lists the CEWG cities with the highest ED rates per 100,000 population in 1999 for selected opiates (codeine, hydrocodone,

oxycodone, and propoxyphene). Among the cities with the highest ED rates, four-year trends for hydrocodone, oxycodone, and propoxyphene show general increases between 1996 and 1999, while codeine rates generally declined.

More recent trends (1998 versus 1999) showed hydrocodone and oxycodone ED mentions increasing in most CEWG cities in DAWN. Hydrocodone mentions increased significantly ($p < 0.05$) in two cities (Phoenix and San Diego). Oxycodone mentions increased significantly in four (Baltimore, New Orleans, Phoenix, and San Diego) and declined only in two (San Francisco

Exhibit 53. Four-year trends of ED rates per 100,000 population for four selected opiates, by cities with highest rates, 1999



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1999 (March 2000 update)

and Washington, DC). Conversely, codeine and propoxyphene ED mentions showed mostly decreases, with five significant decreases for propoxyphene and four for codeine. Only two significant increases for codeine (in Atlanta and Newark) were reported.

In Massachusetts, prescription drugs (such as hydrocodone, oxycodone, and some benzodiazepines) were mentioned in 7 percent of all helpline calls in the first three quarters of 2000, with oxycodone mentioned most frequently. In Texas, among January–August 2000 calls, 16 involved intentional misuse or abuse of morphine; additionally, 21 confirmed exposures to methadone were reported during that period, compared with 24 in all of 1999.

TREATMENT DATA

Other opiates as primary drugs of abuse account for relatively small proportions of treatment admissions. For example, primary opiate admissions equal fewer than 1 percent of total admissions in Newark and 2.3 percent statewide. In Texas, primary opiate admissions totaled 3 percent of adult admissions in the first three quarters of 2000; of these, 33 used illegal methadone, and 671 used other opiates. In New Orleans, primary opiate admissions increased from 2 to 3 percent of total drug admissions between the first halves of 1999 and 2000.

DEMOGRAPHIC DATA

Among 1999 methadone-related decedents in Texas, 63 percent were male, 81 percent were White, 13 percent were Hispanic, 6 percent were Black, and the average age was 37.5 years. Similarly, among methadone poison callers in Texas, 66 percent were male, and the average age was 40. However, among morphine poison callers in Texas, only 31 percent

were male, and the average age was 34. More like morphine than methadone demographics, 62 percent of Texas opiate treatment admissions were female, 84 percent were White, and average education was 12.2 years—highest of any drug client. In New Orleans, however, White males continue to dominate opiate admissions, representing 57 percent in 2000.

USE PATTERNS

According to 1999 aggregate DAWN ED data, hydrocodone, propoxyphene, and oxycodone are among the 20 drugs most commonly mentioned in combination with marijuana. Since 1990, ED mentions increased for these drugs used in combination with marijuana: hydrocodone from 8 to 840 mentions (more than a thousandfold increase), propoxyphene from 9 to 653 (almost a 700-fold increase) and oxycodone from 12 to 453 (more than a 350-fold increase). Between 1990 and 1999, the increase of hydrocodone-in-combination-with-marijuana mentions was the largest for any drug combined with marijuana.

Availability and Source

The following opiates continue to be available on the street in CEWG areas:

- **Codeine**—In Texas, codeine cough syrup abuse continues to be reported, while in Chicago, the abuse of codeine in both syrup and pill forms (used primarily by heroin addicts to moderate withdrawal symptoms) has been declining over the past decade. In Detroit, the combination of hydrocodone or carisoprodol (Soma) with acetaminophen containing codeine is common, and in Houston, promethazine with codeine is commonly abused. Reported pill prices (for Tylenol 3s and 4s) are \$1–\$3 on Chicago’s South Side, where some dealers specialize in their sale, and \$1–\$2 in Washington, DC, where they are sold around methadone clinics.

- **Hydrocodone** (Vicodin, Hycodan, Lortab, Lorcet, and NORCO)—Hydrocodone’s street availability in New York City may be increasing. In New Orleans, along with oxycodone and propoxyphene, it remains the drug of choice among some users. In Massachusetts, pharmacy break-ins have increased recently, and police reported seizures of stolen hydrocodone (and oxycodone) on the streets. In Dallas, where it costs \$4–\$7 per tablet, and Houston, where it costs \$3–\$3.50 per tablet, it is one of the most commonly abused prescription drugs.
- **Hydromorphone** (Dilaudid)—The drug is the pharmaceutical opiate preferred by many Chicago injecting drug users (IDUs), but its availability has diminished there since 1987. Recent declines in hydromorphone-related arrests were noted in Washington, DC, where heroin users continue to substitute hydromorphone (or other pharmaceutical narcotics) for heroin. In St. Louis, hydromorphone use remains common among a small, chronic population of white addicts, and in Dallas and New Orleans, the drug remains widely abused. Street prices are reported in several cities: \$7 per milligram, \$15 per 2 milligrams, and \$25–\$35 per 4 milligrams on Chicago’s North Side; \$20–\$80 per tablet in Dallas; \$45–\$75 per 4-milligram pill in St. Louis; and \$20 per pill in Washington, DC.
- **Methadone** (Dolophine)—In San Francisco, methadone sales in “take-home doses” continued. Street prices include \$1 per milligram in Chicago and \$10 per tablet in Dallas.
- **Oxycodone** (Percocet, Percodan, and Oxy-Contin)—Oxycodone abuse remains common in Phoenix, and abuse by prescription is common in St. Louis. The recent Massachusetts pharmacy break-ins and police seizures mentioned above also involved stolen oxycodone. The drug is sold near methadone clinics for \$5 per pill in Washington, DC.
- **Other prescriptive opiates**—In Phoenix, **tramadol** (Ultram) and **nalbuphine** (Nubain) continued to be abused. In Houston, **butorphanol tartrate** (Stadol), in nasal spray and injectable forms, is one of the most commonly abused licit narcotic drugs.

ABUSED PHARMACEUTICALS: STIMULANTS

■ **Adderall**—A combination of four amphetamines (dextroamphetamine saccharate, amphetamine aspartate, dextroamphetamine sulfate, and amphetamine sulfate) and a drug prescribed for attention deficit hyperactivity disorder (ADHD), Adderall figures prominently in poison calls in Atlanta and Boston.

■ **Methylphenidate (Ritalin)**—The abuse among youth of methylphenidate, a pharmaceutical prescribed for ADHD, has been reported in many CEWG areas. In Atlanta, Boston, Detroit, and Texas, methylphenidate poison control cases were numerous in 2000. Student focus groups and treatment providers in Boston report that methylphenidate is readily obtainable because prescriptions are easily diverted for sale or personal use. Furthermore, according to the 1999 Massachusetts student survey, 10 percent of

7th–12th graders reported illicit, lifetime use of methylphenidate. In Detroit, where the drug is not widely available on the street, scattered reports of diversion and thefts of children’s prescriptions continue.

Methylphenidate tablets are often crushed and used intranasally, as reported in Boston and Minneapolis/St. Paul.

■ **Other stimulants—Dextroamphetamine** (Dexedrine, a pharmaceutical often prescribed for ADHD) and pills containing **ephedra** figure prominently in poison control calls in Atlanta. In the first three quarters of 2000 in Texas, 50 poison cases were reported in which Mini-Thins or Two-Way (over-the-counter pills containing **ephedrine**) were mentioned. Of the 50 cases, 30 were categorized as intentional misuse or abuse, among which 66 percent involved females, and the average age was 25 years.

ABUSED PHARMACEUTICALS: DEPRESSANTS

This section includes benzodiazepines, such as alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), and flunitrazepam (Rohypnol). It also includes ketamine, carisoprodol (Soma), and clonidine (Catapres).

Benzodiazepines

Benzodiazepines such as diazepam, clonazepam, and alprazolam are the most commonly abused pharmaceutical depressants in CEWG areas: they are the depressants most often identified in the ADAM program and in DAWN ED mentions. However, pharmaceutical depressant indicators remain relatively low. Overall, depressant treatment admissions account for only 1–8 percent of total admissions in reporting CEWG areas. Most benzodiazepine treatment admissions and decedents are White females.

Although diazepam has been considered the most commonly abused benzodiazepine for decades, it seems to be declining in many CEWG areas, while clonazepam and alprazolam abuse has increased. For example, between 1998 and 1999, diazepam ED mentions declined significantly ($p < 0.05$) in four CEWG areas (Baltimore, New Orleans, St. Louis, and Washington, DC), and increased significantly in two (San Diego and San Francisco). Other benzodiazepine ED mentions in most CEWG areas remained stable between 1998 and 1999. According to recent focus groups in Philadelphia, alprazolam has reportedly overtaken diazepam as the most “popular pill” on the street. In contrast, diazepam remains the most readily available and frequently used pharmaceutical depressant in Chicago. In New York City, a variety of psychoactive prescription drugs are increasingly available on the street, including alprazolam (“footballs”), clonazepam, and diazepam. In Boston, seizures of diverted prescription drugs have increased in the past year, connected with a rash of pharmacy

break-ins and out-of-State heists. Street prices for commonly diverted benzodiazepines in reporting areas are \$1–\$4 per 5- or 10-milligram tablet, depending on geographic location and whether they are generic or brand name.

Benzodiazepines are often combined with other drugs, and combinations often vary by geographic location. For example, among recent depressant-related (typically diazepam and alprazolam) poison calls in Atlanta, a large number involved combinations with heroin or cocaine as suicide attempts. According to treatment data in Detroit, pharmaceutical depressants are more likely to be secondary or tertiary rather than primary drugs of abuse. In Texas, alprazolam is often used to heighten or prolong the effects of heroin. In Philadelphia, prescription drugs (most commonly diazepam) are detected among decedents most frequently in combination with other drugs of the same type or in combination with cocaine, heroin, or alcohol. In South Florida, alprazolam and clonazepam are increasingly identified among adolescent and young adult ecstasy users.

Flunitrazepam (Rohypnol, “roofies,” “roach pills,” “Mexican Valium,” and “rope”), a benzodiazepine illegal in the United States but legally prescribed in Mexico, has been associated with drug-assisted rape and club drugs. Reports of its use have been declining since the legislation of recent years, and in most CEWG areas, its abuse is very low or nonexistent (except in Atlanta and Texas). For example, in Miami, alprazolam and clonazepam have replaced flunitrazepam among adolescents, according to poison control calls. In Texas, flunitrazepam treatment admissions and poison contacts have been increasing in recent years, especially among young Hispanics and in areas along the Mexican border. In Atlanta, it may be used in combination with heroin to increase or sustain the heroin high.

Ketamine (“K,” “Special K,” “Vitamin K”)

The veterinary anesthetic ketamine is a depressant with dissociative properties; its effects, known as being in the “k-hole,” have been described as similar to the effects of phenylcyclidine (PCP). Ketamine is considered a club drug due to its use in raves, nightclubs, and dance venues among White youth and often in combination with other club drugs. According to DAWN ME data, over the 5-year period from 1994 to 1998, 46 ketamine-related deaths were reported across the United States.

Furthermore, several ketamine-related deaths were reported recently in CEWG areas: in Detroit, the drug was found in 4 decedents (between April and September 2000); in Philadelphia, it was detected in 3 decedents (in the first half of 2000); in Texas, two deaths involved ketamine (in 1999); and in Washington State, three decedents tested ketamine-positive (between January and October 2000).

According to 1999 DAWN ED data, ketamine mentions were fewer than 1 per 100,000 population in all CEWG cities. Other local indicators for the drug were also relatively low: for example, in Texas, only 7 poison cases were reported in 1999 (but 22 were reported in the first three quarters of 2000). In Seattle, according to a recent survey in a substance abuse recovery program, 14 percent of patients (age 14–24) reported having ever used ketamine, and 6 percent reported past-6-month use. (Similar numbers were reported in patients age 25–50.)

In many reporting CEWG areas, ketamine is readily available: in Chicago, it is somewhat available at rave parties or in clubs frequented by younger adolescents; in Miami, its use is linked with ecstasy use; in Newark, ketamine is increasingly reported to be used at rave parties around college campuses; and throughout

Arizona, the drug is readily available. In Boston, ketamine use continues to be reported, but less frequently than use of ecstasy or gamma hydroxybutyrate (GHB); the drug has reportedly been used as a heroin adulterant and may have played a role in overdose deaths, and lifetime use among high school students in 1999 was 5 percent.

Ketamine is often sold as a powder for \$20 per dose in Atlanta, Chicago, and New York City; \$25 per “hit” in Denver; and \$20–\$25 per bag or “bump” and \$60–\$100 per vial in Washington, DC (where it is also available in cases of vials). In Philadelphia, it costs \$10 per tablet. It is also available as a liquid in Chicago and New York City (where it is injected). In Atlanta, the drug is diverted in liquid form, dried, distributed as a powder, and used intranasally in 5–10 minute intervals until the desired effect is achieved. In Seattle, where ketamine is known as “jet,” “super K,” and “cat Valium,” it may be added to a cigarette or marijuana and smoked, as well as injected intramuscularly, used intranasally, or taken orally.

Ketamine is typically obtained illicitly through veterinary burglaries, and these were recently reported in several CEWG cities, including Boston, Denver, St. Louis (where they are increasing), and Seattle. In Boston, where police reported a small rise in ketamine seizures recently (both in liquid and powder form), ketamine is also reported to be trafficked from China and the west coast. Although relatively small amounts appeared in Minneapolis/St. Paul crime labs, one recent case involved several gram packages of ketamine powder.

Carisoprodol (Soma)

Poison control cases for carisoprodol, a muscle relaxant, were reported in Detroit and Texas, and ME and ED mentions related to the drug were reported in South Florida. In Texas,

where 80 percent of 393 adverse reactions reported to poison control centers in the first half of 2000 involved intentional misuse or abuse, the drug is reportedly used to heighten and prolong the effects of heroin, and it sells for \$4 per tablet.

In Detroit, the drug is commonly combined with acetaminophen containing codeine.

In the first half of 2000, the eight ED visits in South Florida also involved other drugs,

including opiates, benzodiazepines, and cocaine. Furthermore, carisoprodol was mentioned in 10 South Florida ME cases in the first half of 2000 and was identified in 18 decedents.

Clonidine (Catapres)

Clonidine, an antihypertensive with depressant effects, is reportedly abused in New York City, where it is available on the street, and Washington, DC, where it is available around methadone clinics for \$1 per pill.

OTHER ILLICIT DRUGS AND ABUSED PHARMACEUTICALS

In addition to the substances discussed earlier, a wide variety of substances, both licit and illicit, are abused across the country:

- **Antidepressants**—In Detroit, 124 poison control calls involving amitriptyline (Elavil) and 147 for **trazodone** (Desyrel) were reported during the first 10 months of 2000. **Amitriptyline** is also increasingly available on the street in New York City, where it is referred to as “sticks.”
- **Dextromethorphan (DXM)**—Teens in some cities, such as Boston and Minneapolis/St. Paul, abuse over-the-counter cough preparations containing DXM (such as Robitussin) for their hallucinogenic properties (“robotripping”) and their ability to prolong and enhance the effects of other drugs. A white powder form of DXM was seized in Boston and is reportedly available packaged in clear, unmarked capsules for \$5 in Minneapolis/St. Paul. Also in Minneapolis/St. Paul, students reportedly prefer cough and cold tablets to liquid cough syrup (which when taken in large amounts can produce nausea); some students report taking up to 20 tablets at a time. Coricidin HPB, a nonprescription cold medicine that also contains DXM, is abused in Boston, where several poison control calls and school incidents related to its abuse were recently reported, and Detroit, where 23 poison control cases of its intentional abuse were reported in the first 10 months of 2000. Because cold medications often include acetaminophen and because DXM is usually bromated, the dangers of abuse include potentially fatal acetaminophen poisoning and bromism, which can produce confusion, lethargy, and toxic psychosis.
- **Inhalants**—Abuse of inhalants, especially **nitrous oxide** among clubgoers, continues to be reported in several CEWG areas. In Seattle, where nitrous oxide is known as

“hippie crack,” “laughing gas,” “N₂O,” and “nitrous,” the abuse of the drug is most common among younger adolescents, primarily because it is readily available and inexpensive. It is obtained from hospitals and purchased from retailers most commonly in the form of whipped cream charges, which are cracked into balloons for inhalation. In Seattle, nitrous oxide charges cost \$.50–\$1.50 per cartridge, and balloons are sold at parties for \$3–\$5. Similarly, in Chicago, nitrous oxide is a club drug, typically inhaled from balloons and used in combination with other drugs. Intermittent reports continue in Detroit regarding nitrous oxide, **propane**, and other inhalants. **Amyl nitrite** (“poppers”) is also an inhalant commonly used among clubgoers in Seattle. In Texas, 2 percent of adolescent treatment admissions were primary inhalant abusers in the first three quarters of 2000. According to the 2000 Texas secondary school survey, 20 percent of males reported having ever used inhalants compared with 18 percent of females; 24 percent of Hispanics, 18 percent of Whites, and 12 percent of Blacks reported having ever used inhalants.

- **Khat**—This plant’s active ingredients, cathinone and cathine, are controlled substances. It is used in East Africa and the Middle East for its stimulant effects. In Minneapolis/St. Paul, its use remains almost exclusively within East African refugee communities. About 12 cases have been prosecuted annually in a Minneapolis Drug Court since 1997.
- **Methcathinone**—“Cat” or “goob” is an easily manufactured stimulant identified in Michigan in 1990. Although several treatment admissions have been reported in the area each year since 1990 (nine in fiscal year [FY] 2000), no methcathinone labs have been seized there since 1994.

- **Opium**—Continuing a pattern that began more than 15 years ago, packages containing opium are shipped from Asia to Asian communities in Minneapolis/St. Paul. Submissions of opium in that city totaled 591 grams in 1999 and 539 grams from January through mid-November 2000.
- **Sildenafil citrate (Viagra)**—Recent police roadstops have resulted in seizures of sildenafil citrate in Boston, where anecdotal reports suggest the drug is used in combination with ecstasy. Similarly, in South Florida, ED data indicate the drug is used in combination with gamma hydroxybutyrate (GHB) or methamphetamine.
- **Steroids**—Needle exchange programs in areas surrounding Boston report that young male bodybuilders inject steroids intramuscularly. According to the Massachusetts high school survey, the lifetime use of steroids among students increased from 2 percent in 1996 to 4 percent in 1999. Law enforcement sources report continued steroid availability in commercial gyms and exercise clubs in Detroit, especially via smuggling from Canada.

AN INCREASING DEMAND FOR HIV MEDICATIONS?

New York City: "In the variety of drug dealing roles in the city, there is the 'noncontrol' person who deals in legal pills and medication. Most recently, these people have been focusing on medication for HIV disease. They often carry a color chart of medications showing the different brands and prices they will pay for them. Medication is then sold back to pharmacies, sometimes warehoused for future sales, and sometimes shipped to other countries in desperate need of these medications."

- **Drugs used to treat HIV/AIDS**—In New York City, several drugs used to treat HIV/AIDS are commonly diverted, including **dronabinol** (Marinol, an appetite stimulant containing tetrahydrocannabinol [THC]), **megestrol acetate** (Megace, an appetite stimulant), and **efavirenz** (Sustiva, an antiviral drug). Efavirenz may have psychoactive properties, and one New York City informant stated, "If you take a couple of Sustiva pills and drink a beer, you don't need to sniff a bag of dope." In South Florida, two suicide attempts involving the overdose of dronabinol were reported in the first half of 2000.

INFECTIOUS DISEASES RELATED TO DRUG ABUSE

Newark: *“The recent increase in heroin injection by young adults (those younger than 26) along with the sharp rise in heroin use has set a dangerous precedent for a rise in infectious diseases such as HIV/AIDS, hepatitis B, and hepatitis C.”*

HIV/AIDS MODE OF EXPOSURE

According to the Centers for Disease Control and Prevention (CDC), injecting drug use remains one of the most common modes of exposure among acquired immunodeficiency syndrome (AIDS) cases nationwide, second only to male-to-male sex. Through December 2000, injection-related cases accounted for 31 percent of the 745,103 cumulative adult and adolescent diagnoses for full-blown AIDS in the United States: 25 percent involved injecting drug use as the sole mode of exposure, and 6 percent involved the dual risk categories of injecting drug use and male-to-male sex (exhibit 54).

Newark and New York City continue to have the highest proportion of injecting drug use as the sole mode of exposure (56 and 46 percent, respectively) among reporting CEWG areas. Between the December 1999 and December 2000 reporting periods, the proportion of injecting drug use as mode of exposure for AIDS remained relatively stable or declined in CEWG areas, except Seattle, Texas, and Washington, DC, where proportions increased by 1–3 points. The proportions for dual exposure of injecting drug use and male-to-male sex were mixed: they increased in San Francisco and Seattle, and in the States of Illinois and Texas; they declined in Louisiana and Minnesota; and trends were stable elsewhere.

New AIDS cases in several CEWG areas revealed increasing proportions of injection-related cases. During May–October 2000, of the 408 new adult/adolescent AIDS cases reported in Massachusetts (a number well below the 712 cases in the last 6-month period), injecting drug users (IDUs) accounted for 44 percent—a

17-percentage-point increase from the prior 6-month period. Of the 8,351 new AIDS cases in Louisiana during May–October 2000, IDUs represented 24 percent, compared with only 18 percent of cumulative cases.

SEVERAL CEWG REPORTS POINT TO THE INCREASING IMPACT OF INJECTING DRUG USE ON THE SPREAD OF HIV/AIDS:

Boston: “Injecting drug use has been the greatest single factor in AIDS incidence in Massachusetts since 1993.”

Philadelphia: “Continuing a trend that began in 1994, IDUs represent the highest percentages of AIDS cases identified.”

Texas: “The proportion of AIDS cases related to injecting drug use is increasing (from 16 percent in 1987 to 28 percent though September 2000).”

Washington, DC: “The proportion of adult cases attributable to injecting drug use increased 10 percent between 1995 and 1999.”

HIV/AIDS DEMOGRAPHIC DATA

Non-Whites continue to account for a disproportionately high number of injection-related AIDS cases. For example, in New York City, Blacks account for 47 percent, Hispanics for 38 percent, and Whites for 14 percent of injection-related AIDS cases. Similarly, in Georgia, the percentage of injection-related cases among Blacks and Hispanics is disproportionately higher than that among Whites. In Los Angeles County, Whites account for 41 percent of the

injection-related cases, followed by Blacks at 33 percent, and Hispanics at 26 percent. Injection-related cases account for 40 percent of the Illinois cumulative cases among Blacks, 56 percent among Hispanics, but only 20 percent among Whites, suggesting the need for more street outreach and additional needle exchange sites targeted to non-White IDUs. Seattle is another example, with methadone treatment clients of Black or Native American background having significantly higher ($p < 0.05$) HIV prevalence compared with White clients (2.6, 4.2, and 1.5 percent, respectively).

Males continue to constitute the majority of heterosexual, injection-related AIDS cases in CEWG sites, including Los Angeles (84 percent) and New York City (75 percent). However, among female AIDS cases, the proportions related to injecting drug use are higher than among male cases. For example, in Georgia, as in previous semesters, injection-related AIDS cases account for 35 percent of female cases and only 23 percent of male cases, and in Arizona, only 26 percent of males with HIV are IDUs, compared with 41 percent of females with HIV.

In San Francisco, heterosexual IDU demography is like that of heroin users except for an overrepresentation of Blacks; the gay male IDU demography is similar to that of male methamphetamine users. Furthermore, the AIDS case

rate among gay/bisexual male IDUs has been increasing faster than that among heterosexual IDUs for several years. Similarly, a longitudinal study during 1994–97 in Seattle found that HIV seroprevalence among local men who have sex with men (MSM) who inject methamphetamine was 47 percent—the highest rate of infection of any risk group in the area.

INFECTIOUS DISEASES OTHER THAN HIV/AIDS RELATED TO DRUG ABUSE

- **Hepatitis B**—In the San Francisco area, reported cases have fluctuated in a narrow range over the past 5 years: 58 in 1996, 62 in 1997, 60 in 1999, and (if the level for the first 43 weeks of 2000 is maintained) 50 in 2000.
- **Hepatitis C**—Hepatitis C prevalence among IDUs in CEWG areas is high. For example, in Boston, high rates of hepatitis C (and HIV) have been reported among needle exchange clients. Similarly, in San Francisco, where hepatitis C is emerging as a far greater health concern for IDUs than hepatitis B, preliminary serosurveillance results for IDUs suggest an infection level in the 50–60 percent range, and although this level is ominously high, it appears to be substantially lower than that among IDUs from other U.S. metropolitan areas.

Exhibit 54. Acquired immunodeficiency syndrome among injecting drug users as reported by CEWG representatives, December 2000

Area	Cumulative Number of Cases (Reported through month/year for areas specified)				% IDU (sole mode of exposure)			% IDU and men/sex/men (dual mode of exposure)		
	December 98 CEWG Report	December 99 CEWG Report	December 00 CEWG Report	% Increase 99–00	December 98	December 99	December 00	December 98	December 99	December 00
Arizona ^a	5,944 (11/98)	6,756 (10/99)	7,288 (10/00)	7.8	10.0	10.0	NR	12.0	11.0	NR
Baltimore, MD	11,827 ^b (6/98)	13,009 (6/99)	13,904 (6/00)	6.8	NR	NR	NR	NR	NR	NR
Colorado	6,172 (3/98)	6,656 (9/99)	6,985 (10/00)	4.9	8.3	8.7	8.7	10.8	10.8	11.0
Georgia	19,324 ^b (6/98)	21,167 (9/99)	22,377 (9/00)	5.7	19.3	19.0	18.5	5.8	5.7	5.7
Honolulu, HI	1,576 ^b (6/98)	1,667 ^c (6/99)	1,766 ^d (6/00)	5.9	NR	NR	NR	NR	NR	NR
Illinois	20,679 (3/98)	22,696 (9/99)	24,743 (9/00)	9.0	26.0	27.0	22.0	5.0	5.0	7.0
Los Angeles County, CA ^a	38,067 (9/98)	40,281 (9/99)	41,669 (10/00)	3.4	7.0	6.0	NR	6.5	7.0	NR
Louisiana	10,708 ^b (6/98)	11,466 ^c (12/99)	12,185 ^d (10/00)	6.2	18.0	NR	18.0	10.0	9.0	8.0
Massachusetts ^a	13,448 (11/98)	14,788 (10/99)	15,908 (10/00)	7.6	35.0	35.0	35.0	4.0	4.0	4.0
Miami, FL	20,751 (9/98)	22,235 (10/99)	23,521 ^d (6/00)	5.7	18.0	17.0	NR	4.0	3.0	NR
Michigan	9,518 (7/98)	10,267 ^c (6/99)	10,817 (6/00)	5.3	24.0	NR	23.0	6.0	NR	6.0
Minnesota	3,201 (6/98)	3,477 (10/99)	3,717 (10/00)	6.9	8.0	8.0	8.0	7.0	7.0	6.0
Newark, NJ ^a	6,766 (9/98)	7,070 (6/99)	7,432 (6/00)	5.1	48.0	57.0	56.0	4.0	4.0	4.0
New York, NY ^a	103,248 (3/98)	110,395 (3/99)	116,316 (3/00)	5.3	47.0	47.0	46.0	NR	NR	NR
Philadelphia, PA ^a	10,753 (6/98)	11,822 (6/99)	12,933 (6/00)	9.3	35.5	35.9	36.4	6.1	6.0	5.8
St. Louis, MO	3,248 (5/98)	3,462 (5/99)	3,539 (9/99)	2.2	8.0	6.1	7.0	4.1	6.2	6.0
San Diego County, CA ^a	9,540 (11/98)	9,876 ^c (6/99)	10,558 (11/00)	6.9	8.0	NR	9.0	9.0	NR	9.0
San Francisco County, CA	25,693 (9/98)	26,398 (9/99)	27,194 (9/00)	3.0	6.6	6.6	7.0	10.7	12.0	13.0
Seattle, WA (King County)	5,584 (9/98)	5,799 (9/99)	5,968 (6/00)	2.9	8.0	7.0 ^e	8.0	9.0	10.0 ^e	11.0
Texas	46,542 ^b (6/98)	50,075 ^c (6/99)	52,667 ^d (6/00)	5.1	20.0	16.0	19.0	7.0	7.0	8.0
Washington, DC	10,828 (6/98)	11,312 (12/98)	12,154 (6/99)	7.4	32.0	28.0	31.0	4.0	NR	4.0
Total U.S.	665,357^b (6/98)	711,344^c (6/99)	745,103^{a,d} (6/00)	4.7	26.0^b	26.0^c	25.0^d	6.0^b	6.0^c	6.0

^aCalculated from adult and adolescent cases only

^bSOURCE: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report 10(1):6,12, 1998

^cSOURCE: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report 11(1):6,8, 1999

^dSOURCE: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report 12(1):8,9,12, 2000

^eProportions are based on 10/1/96–9/30/99 AIDS cases.