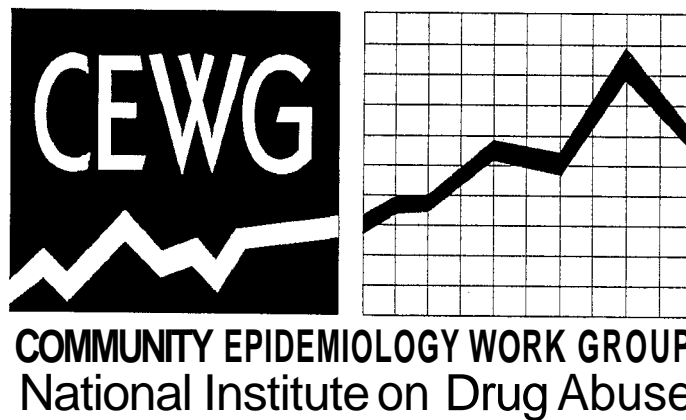


EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

VOLUME I:
HIGHLIGHTS AND
EXECUTIVE SUMMARY

DECEMBER 1999



NATIONAL INSTITUTES OF HEALTH

Division of Epidemiology, Services and Prevention Research
National Institute on Drug Abuse
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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 20 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.

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FOREWORD

The Community Epidemiology Work Group (CEWG) is a network of researchers from major metropolitan areas of the United States and from selected foreign countries. The primary mission of the CEWG is to provide ongoing community-level surveillance of drug abuse through collection and analysis of quantitative and qualitative research data. During biannual meetings, CEWG participants present and discuss the most current epidemiologic information concerning the nature and patterns of drug abuse, emerging trends, characteristics of vulnerable populations, and social and health consequences of drug abuse in the United States.

The 47th meeting of the CEWG was held in Los Angeles, California, on December 14–17, 1999, and provided an assessment of drug abuse in 20 metropolitan areas of the United States. Presentations also were made on current and emerging patterns and trends of drug abuse in Mexico and in Asia and the Pacific, specifically in China, Japan, and in American Samoa, the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Guam, Palau, and Papua New Guinea. In addition, special presentations were made on the use of epidemiologic data to improve drug abuse treatment and on current trends in HIV/AIDS and other infectious diseases among injecting drug users.

The venue also provided the opportunity to be informed about the Employee Assistance Programs within law enforcement agencies in Los Angeles through presentations by Officer Bud Nowell of the Los Angeles Police Academy and Sergeant Ray Terhorst

of the Los Angeles County Sheriffs Office who also is President of Badge 2 Badge, a program to assist Officers with substance abuse problems. In addition, Dr. Gregory Austin of WestEd presented findings from recent Los Angeles and California statewide student surveys.

These differing presentations underscore the wide impact of drug abuse on society. They also serve to point out the international scope of drug abuse and the regional relationships of substance abuse problems. Many of the problems facing countries of North America have emerged as serious problems in Asia and the Pacific. Abuse of marijuana and inhalants, especially by youth, appears to be a worldwide problem. Indicators of heroin abuse appear to be increasing in various parts of the world, including the United States. And the problem of methamphetamine, which had been increasing in the United States during recent years, is also becoming more prevalent in countries of Asia and in the Island Nations of the Pacific.

The data presented at this meeting demonstrate, once again, the value of an effective and efficient national system for drug abuse surveillance. They highlight the need to link epidemiologic information to preventive intervention, treatment, and other public health actions and research decisions.

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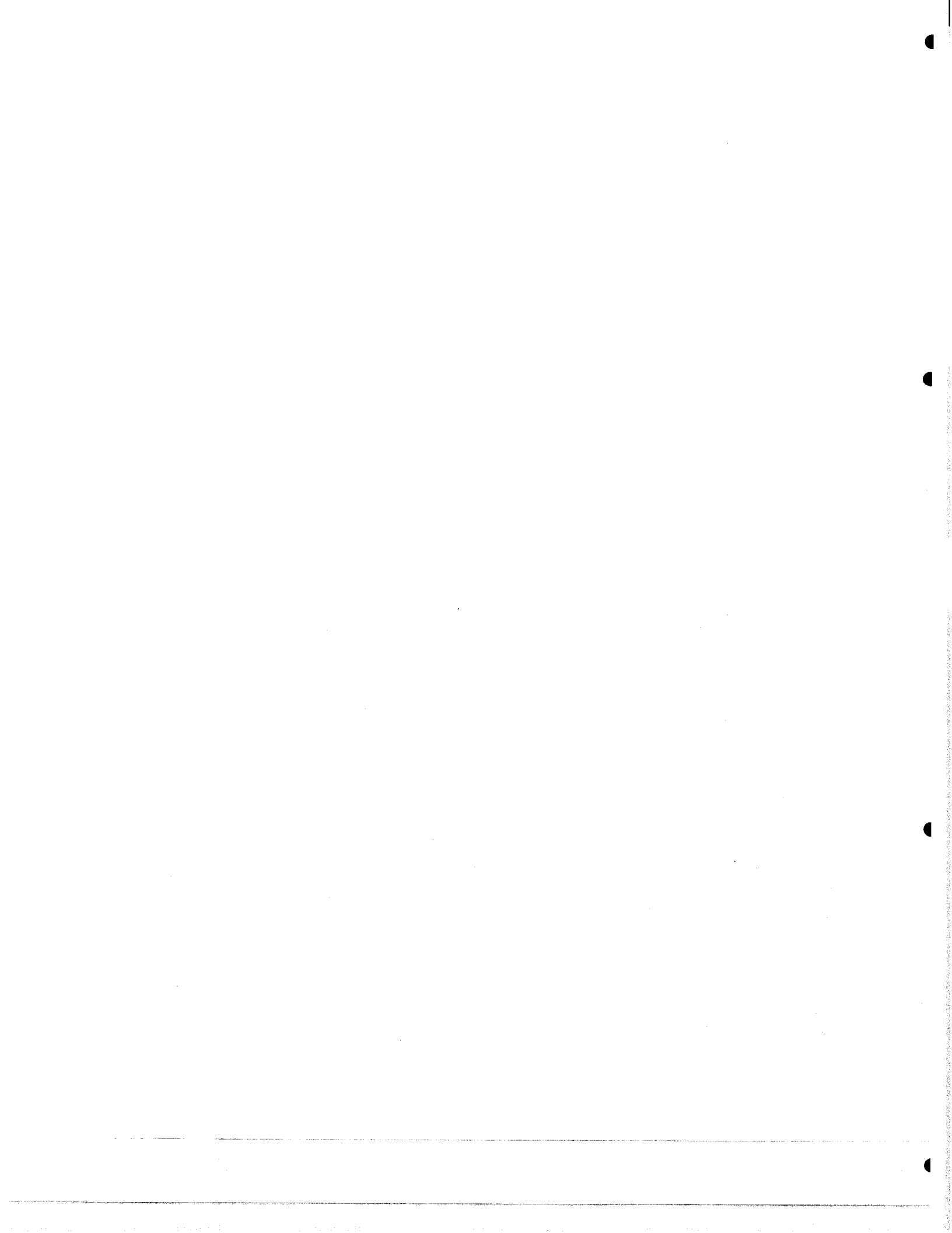
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EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

INTRODUCTION TO VOLUME I

The 47th meeting of the Community Epidemiology Work Group (CEWG) was held December 14–17, 1999, in Los Angeles, California. During this meeting, 20 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, or by State public health agencies
- **Drug-related emergency department (ED) mentions** (estimated mentions and estimated rates per 100,000 population) reported by the Drug Abuse Warning Network (DAWN) of the Substance Abuse and Mental Health Services Administration (SAMHSA) (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

- **Primary substance of abuse** of clients at admission to treatment programs, as reported by State drug abuse agencies
- **Arrestee urinalysis results** based on data collected by the Arrestee Drug Abuse Monitoring (ADAM) System 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 are set off in indented, bold italics.

A NOTE TO THE READER

The highlights, executive summary, and 20 U.S. city report summaries 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 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, Hawaii and Texas report statewide data.
- Arrest/seizure data — 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 July 1999. These data reflect weighted estimates of the number of mentions based on a sample of hospital emergency departments.
- Long-term ED trend data cover 1991–98. Short-term comparisons are based on either full-year data for 1997 versus 1998 or full-year data for 1996 versus 1998. 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-1998 versus first-half-1999 data, unless otherwise specified.

- Percentage-point increases or declines between reporting periods are generally 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-1998 and first-half-1999 figures.
- Heroin purity levels per milligram were obtained from the DEA Domestic Monitor Program, Intelligence Division, Domestic Unit. Comparisons are for full-year-1998 versus first-half-1999 figures.
- Cumulative totals of acquired immunodeficiency syndrome (AIDS) cases for the total United States are based on the *HIV/AIDS Surveillance Report* 11(1):6,8,1999, 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. In addition, the timeliness of data varies, particularly for mortality indicators.

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

DRUG HIGHLIGHTS

Following several reporting periods of stable or declining trends, some cocaine abuse indicators show rebounds in a number of cities; increases among younger age groups in some indicators warrant watching. Other indicators, however, continue to suggest declining or stable trends. Heroin indicators are mixed. Younger populations continue to initiate heroin use in several cities, and some are shifting from snorting to injecting. Marijuana indicators suggest generally increasing or leveling trends in most cities; in some cities, however, there are signs that prevention efforts targeted at youth may be paying off. Declines in methamphetamine consequences are reported in most cities, especially as reflected in emergency department (ED) data. "Club drugs," especially GHB, GBL, and MDMA, continue to spread across the country.

COCAINE AND CRACK

Following several reporting periods of stable or declining cocaine trends, mortality, ED, and female arrestee urinalysis indicators suggest slight increases in many cities. Mortality figures¹ increased in three cities (Philadelphia, Phoenix, and Seattle) and declined or remained stable in four (Honolulu, Miami, Minneapolis/St. Paul, and San Diego). Cocaine ED mentions² increased significantly in five cities (Dallas, Los Angeles, Philadelphia, Phoenix, and Washington, DC), with the largest increase in Dallas. Nonsignificant ED increases were reported in the majority of the other cities; no significant declines were noted. Disturbingly, cocaine ED mentions per 100,000 population in the 12–17 age group increased sharply in four cities (Baltimore, Boston, Dallas, and Denver). By contrast, treatment admission figures³

show generally declining or stable trends. Generally declining or stable trends were also found in cocaine-positive urinalysis percentages⁴ among adult male arrestees, except in Miami and Washington, DC, where levels increased; the drug is now surpassed by marijuana in all but six cities. By contrast, among female arrestees, cocaine is still the most commonly detected drug in all but one city (San Diego); levels increased in six cities (Dallas, Detroit, Minneapolis, Philadelphia, Phoenix, and San Diego) and declined in two (Houston and Los Angeles). Crack injection continues to be reported in some cities, including Boston, New York, and Washington, DC. Increased availability of cocaine hydrochloride (HCl) is reported in some cities, including Boston, Dallas, Denver, Philadelphia, and Phoenix.

HEROIN

Heroin indicators show mixed trends. Mortality figures¹ declined slightly in five cities (Honolulu, Minneapolis/St. Paul, Philadelphia, San Diego, and Seattle) and increased only in Phoenix. Heroin ED mentions² declined significantly in only one city (San Francisco) and increased significantly in four (Miami, Newark, New Orleans, and Washington, DC). Heroin is the top primary drug treatment problem³ in 6 of 18 reporting sites (Baltimore, Boston, Los Angeles, Newark, New York City, and San Francisco). Males outnumber females in most indicators, except for arrestee urinalysis data⁴, with females testing higher for opiates than

males in 10 of 16 cities where females are tested. Among adult males, opiate-positive levels remained relatively low and stable in most cities, excluding Washington, DC, where levels increased. Among adult females, opiate-positive levels declined notably in two cities (Chicago and Detroit) and increased in four (Minneapolis, New Orleans, Phoenix, and Seattle). Heroin purities⁵ declined in eight cities, particularly in Denver and Houston, and increased in five (Atlanta, Los Angeles, Newark, New Orleans, and Philadelphia). Younger populations are increasingly initiating heroin use in many CEWG cities, including

Atlanta, Baltimore (especially among suburbanites), Boston (where ethnographic sources report high school students snorting heroin, and treatment providers report increased injection among teens), Chicago, Denver (where ethnographic sources report college students increasingly using heroin and street youth switching from methamphetamine to heroin), Philadelphia (where focus groups report new teen users), St. Louis, San Diego, San Francisco, and Seattle (where young injectors are increasing). The proportion of treatment clients who snort is increasing in Atlanta, Baltimore, Chicago, Denver, New York City, and Philadelphia; conversely, injecting is increasing in Minneapolis/St. Paul, Newark, St. Louis, and Seattle (among younger users). In Boston and

Miami, new and younger users are reportedly progressing from snorting to injecting. While smoking remains comparatively rare, it is more common in the West than in other regions, with an especially sharp recent increase among San Diego treatment clients.

Heroin/cocaine (“speedball”) combinations are reported in Baltimore, Boston, Chicago (where reports of the combination, nicknamed “John Belushi,” have increased), New York City, Philadelphia, St. Louis, San Francisco, and Seattle. Heroin is also combined with pharmaceutical depressants (in Chicago and Seattle) and with **methylenedioxymethamphetamine (MDMA)** in Texas.

MARIJUANA

Marijuana ED mentions¹ increased significantly in 3 cities (Dallas, Philadelphia, and San Diego) and nonsignificantly in 10 others; they remained level in 4 cities; and they declined significantly in only 1 city (New Orleans) and nonsignificantly in 2 cities. However, the proportion of 12–17-year-olds among marijuana ED mentions declined considerably in several cities—perhaps reflecting prevention efforts in those areas. Marijuana is the top primary drug treatment problem³ in four cities (Denver, Minneapolis/St. Paul, New Orleans, and Seattle). Treatment percentages increased (4–9 percentage points) in three cities (Atlanta, Denver, and San Diego) and declined in two (Chicago and New Orleans). Among adult male arrestees⁴, marijuana has now surpassed cocaine as the most commonly detected drug in the majority of CEWG cities; positive findings increased sharply in four cities (Atlanta, Los Angeles, Miami, and Washington, DC) and remained relatively stable elsewhere. Levels also remained relatively stable among female arrestees, except for increases in four cities (Chicago, Denver, Minneapolis, and New Orleans) and a decline in Seattle. Juvenile arrestee levels also remained relatively stable, but

they exceeded adult marijuana-positive levels at all four sites where juveniles were tested. In some cities, such as Denver, increased potency resulting from genetic plant manipulation may have contributed to increased consequences, especially among older users who had smoked marijuana in their teens and have recently resumed use. Marijuana is increasingly a delivery medium for other psychoactive drugs. For example, in Chicago, blunts are often laced with either crack or PCP (“3750s”). Marijuana/crack combinations are also reported in Boston, Minneapolis/St. Paul (“fireweed”), and parts of Texas; and marijuana/PCP combinations are also reported in Minneapolis/St. Paul (“happy stick”), New York City, Philadelphia (“loveboat” or “wet”), and St. Louis. In Philadelphia, blunts are also laced with cocaine HCl (“turbo”). Marijuana/embalming fluid combinations are reported in Minneapolis/St. Paul (“wets” or “amp”), New York City (“duck foot,” which also includes the pesticide DDT), and parts of Texas (where this combination also includes PCP). In Texas, joints are also dipped in codeine cough syrup.

STIMULANTS

Methamphetamine (“crystal meth,” “ice”) remains concentrated in the West and, to a lesser extent, in some rural areas elsewhere. In the West, some recent indicators suggest declines, possibly related to national and community prevention programs, stricter precursor laws, increased clandestine lab seizures, and declining methamphetamine potency. In the East, indicators remain low, but ethnographic and law enforcement evidence indicates a slight increase in availability, especially in rural areas and among whites. Methamphetamine-related deaths] declined in two cities (Minneapolis/St. Paul and San Diego) and increased in four (Honolulu, Philadelphia, Phoenix, and Seattle). Methamphetamine ED mentions’ declined significantly in six cities, all in the West (Denver, Los Angeles, Phoenix, San Diego, San Francisco, and Seattle), and increased significantly in Dallas and Miami. Methamphetamine remains the top primary drug problem among treatment admissions in Honolulu and San Diego³; in San Diego, however, many methamphetamine indicators have declined. Methamphetamine-positive percentages among adult arrestees⁴ remained relatively stable, except for increases among males in two cities (San Diego and Seattle) and a decline among females in Phoenix. Methamphetamine users are heterogeneous, consisting of many small subgroups, as suggested by ethnographic data in Atlanta, where methamphetamine indicators appeared for the first time among arrestees. Increases in lab seizures were reported in five areas: Atlanta, Minneapolis/St. Paul, Phoenix, Seattle, and parts of Texas.

Methylenedioxymethamphetamine (MDMA) (“ecstasy,” “XTC,” “E,” “Florida dove,” “Mitsubishi,” “red devils,” “white dove,” “green Adidas,” and “purple Adidas”), used primarily as a club drug at raves, dance clubs, and college scenes, seems to be increasing in Boston, Miami, New Orleans, New York City, and parts of Texas; it is also reportedly available in Atlanta, Chicago, Minneapolis/St. Paul, Phoenix, St. Louis, Seattle, Washington, DC, and parts of New Jersey. In Boston, it is reportedly spreading outside the club scene. In Minneapolis/St. Paul, respirator masks rubbed with menthol-based cold ointments are worn after taking MDMA, a practice believed to heighten the drug’s effect. MDMA is combined with LSD in some areas, including Miami (“rolling and trolling”), Washington, DC (in a pill form called “nexus”), and parts of Texas. It is also combined with cocaine in Miami (“rolls”) and with heroin in Texas. In Atlanta, the content of what is sold as **MDMA** may vary widely. In Chicago, homemade MDMA is sold as “wigits.” Methylphenidate is abused by young adults in Minneapolis/St. Paul and in middle- and upper-class communities in Boston; African-Americans in Chicago sometimes inject methylphenidate (“west coast”) with heroin or with heroin plus cocaine. White injecting drug users (IDUs) in Chicago inject phenmetrazine (Preludin). Khat, a flowering shrub imported from east Africa and the Middle East, is reportedly used by small enclaves of immigrants in Boston and Minneapolis/St. Paul.

DEPRESSANTS

Problems associated with rave and club drugs have risen dramatically in 1999. Gamma-hydroxybutyrate (GHB, a central nervous system depressant) and two of its precursors, gamma-butyrolactone (GBL) and 1,4-butanediol (1,4-BDL, also called tetramethylene), have been

increasingly involved in fatalities, poisonings, overdoses, drug rapes, and other criminal behaviors in nearly every CEWG city and their surrounding suburban and rural areas. These products, obtainable over the Internet and sometimes still sold in health food stores, are also

available at gyms, nightclubs, raves, gay male party venues, college campuses, or on the street. Commonly mixed with alcohol, they have a short action duration, and are not easily detected on routine hospital toxicology screens. GBL is available in commercial products such as Blue Nitro, RenewTrient, and Revivarent G, while 1,4-butanediol is sold in products such as Enliven, Weight Belt Cleaner, and Revitalize Plus. New esters and analogs continue to appear as Federal and State laws prohibit the sale of these drugs. The anesthetic ketamine ("Special K" or "vitamin K"), also common in the club, rave, and party scene, is reported in numerous cities, including Baltimore (predominantly among suburban, white, middle- and upper-class youth), Boston (injected by some white, middle-class youth; as a heroin adulterant; and in some overdose deaths), Minneapolis/St. Paul (in crime lab submissions), New York (on the street; either snorted or injected; and sometimes mistaken for cocaine HCl), Newark, and Phoenix.

Recent deaths in Seattle have involved concomitant injection of heroin and a depressant, typically diazepam. Diazepam ED mentions' have declined significantly in several cities, while alprazolam

(Xanax, or "sticks") mentions² have increased significantly. Those two drugs are frequently reported by crack users in Philadelphia. In New York, diazepam now follows alprazolam as the leading psychoactive prescription drug; in Chicago, however, diazepam remains the most readily available and frequently used pharmaceutical depressant. Clonazepam (Klonopin or Rivotril) and alprazolam use, in various combinations and with alcohol, has recently increased in Boston, where diverted prescription drug seizures have increased sharply after a recent rash of pharmacy break-ins. Those two drugs have replaced flunitrazepam (Rohypnol) among adolescents in Miami; similarly, in parts of Texas, clonazepam continues to replace flunitrazepam, especially in combination with beer. Flunitrazepam remains a treatment problem in Texas, particularly among young Hispanic males along the border, and it has been involved in numerous poison control calls. Seizures of that drug have increased during the past year in New Orleans, where it remains common among white, upper-class high school and college students. It is also widely available in Atlanta. Amitriptyline (Elavil) use has reportedly increased among heroin users in Chicago.

HALLUCINOGENS

Despite relatively low numbers in traditional data sources, qualitative data suggest that hallucinogens are common among adolescents and young adults. Emergency department mentions' declined significantly in several cities, for both phencyclidine (PCP) (in Baltimore, New Orleans, and San Francisco) and lysergic acid diethylamide (LSD) (in Denver, Detroit, Miami, Minneapolis/St. Paul, New York, San Francisco, and Washington, DC); however, LSD mentions increased significantly in Dallas and New Orleans. Among adult male arrestees⁴, PCP-positive findings remained generally stable, except for a slight increase in Dallas, a marked upturn in Washington, DC (following a decade of marked decline), and a

slight decline in Philadelphia. The recent increases in Dallas PCP indicators may reflect the use of marijuana cigarettes dipped in embalming fluid containing PCP. PCP continues to be often smoked with marijuana in Chicago ("wicky stick" or "donk"), New York, and St. Louis. Some medical emergencies in south Florida have involved LSD abused with "rolls" (MDMA and cocaine). In parts of Texas, LSD is sometimes mixed with other drugs such as MDMA and diazepam, and it is sometimes sold with methamphetamine. LSD in Dallas is becoming more available in the young adult nightclub scene. In Seattle, LSD and mushrooms turn up frequently at local concerts or raves. Psilocybin mushrooms

("shrooms") and mescaline are common among adolescents and young adults in Boston. Mushroom availability is also reported in Minneapolis/St. Paul. In New York, the term "eaters" refers to teenagers and young adults who

use locally grown mushrooms, which are sometimes dipped in or treated with PCP, LSD, or methamphetamine. Peyote is readily available in Phoenix.

OTHER DRUGS

Among opiate ED mentions², oxycodone and hydrocodone increased significantly in several CEWG cities, while codeine and propoxyphene showed several significant declines. Five opiates are reported most frequently as diverted or abused: hydrocodone (in Boston, New Orleans, New York City, San Francisco, and parts of Texas); oxycodone (in Boston, New Orleans, New York City, Phoenix, St. Louis, Washington, DC, and parts of Texas); codeine and its products (in Chicago, primarily by heroin addicts; Houston, sometimes with marijuana; New York City; Phoenix; and Washington, DC); propoxyphene (in Chicago, New Orleans, and New York City); and hydromorphone (in Atlanta, Chicago, Dallas, Honolulu, Minneapolis/St. Paul, St. Louis, and Washington, DC). Hydromorphone is sometimes used as a heroin substitute by IDUs. Propoxyphene availability has recently declined in Chicago. Opium seizures continue in Minneapolis/St. Paul and Seattle.

Two anticholinergic plants, "devil's trumpet" and "angel's trumpet," have resulted in some medical emergencies among teenagers in south Florida. A substance called "red rock opium," "red run," and "red stuff," is smoked in Baltimore in combination with marijuana. It contains dracorhodin, a compound in the plant *daemonorops draco* ("dragon's blood"). Jimson weed has been involved in a recent death and in poison center calls in Phoenix. Cough medicines with dextromethorphan (DXM) are commonly abused by teens in some cities, including Boston and Minneapolis/St. Paul ("robo tipping"). Inhalant-related deaths continue to be reported in Phoenix and parts of Texas. "Huffing" of toluene and other solvents continues among Philadelphia youth. Needle exchange personnel in areas surrounding Boston report steroid injection among young male bodybuilders. Sildenafil citrate (Viagra) has been involved in seizures of diverted prescription drugs in Boston.

¹Mortality figures are for 1998 versus 1999 projections (based on first-half-year 1999 data) and were available in seven reporting areas.

²Emergency department mentions are for 20 CEWG cities in the Drug Abuse Warning Network (DAWN) of SAMHSA's Office of Applied Studies; comparisons are for 1997 versus 1998 estimates, except for age group comparisons, which are for 1996 versus 1998; changes are noted only when statistically significant at $p < 0.05$

³Treatment admission figures are primary drug of abuse as a percentage of total admissions; total admissions exclude alcohol-only but include alcohol-in-combination. Comparisons generally are for the first half of 1998 versus the first half of 1999.

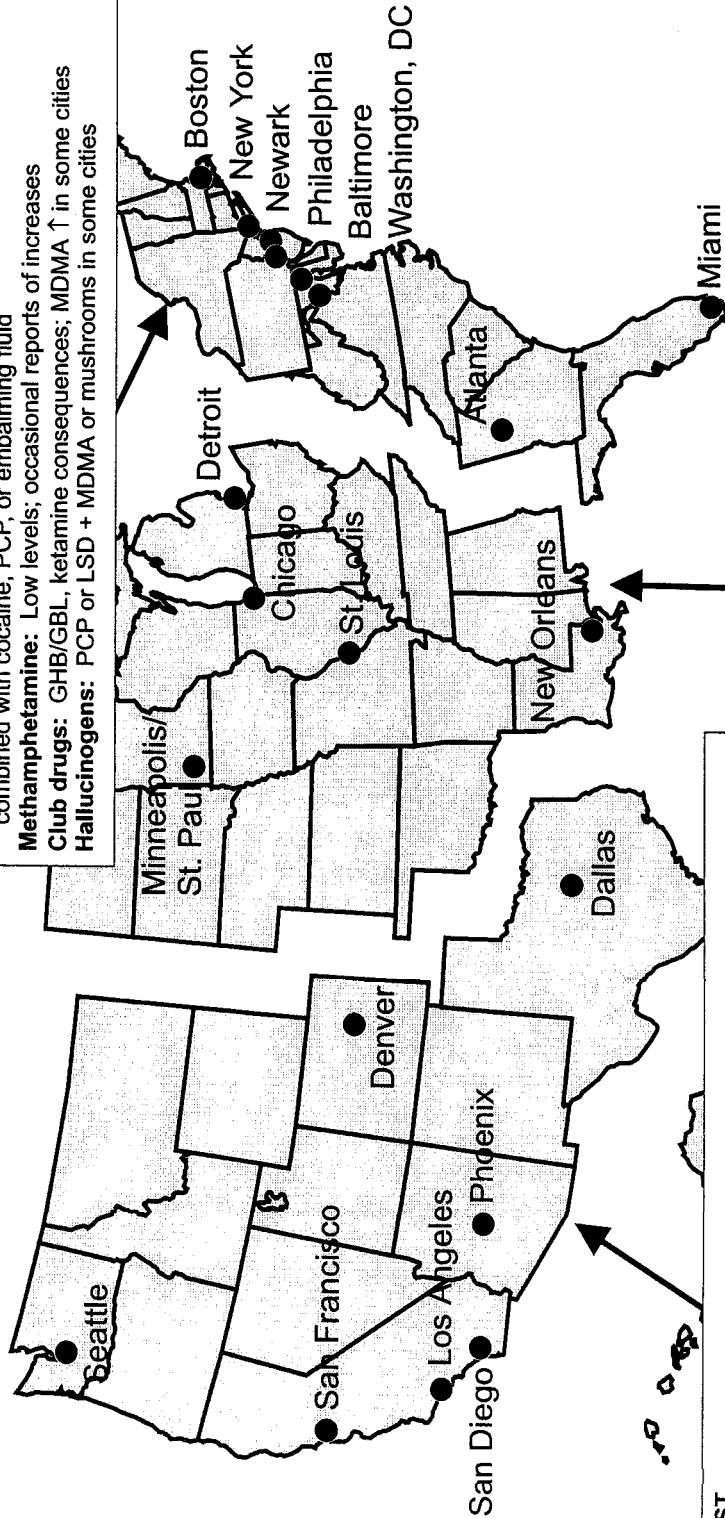
⁴Arrestee urinalysis data are for the 18 CEWG cities in the National Institute of Justice's Arrestee Drug Abuse Monitoring (ADAM) program; comparisons are for 1998 versus first-half-1999; first-half-1999 data are preliminary; changes are noted only when they are ≥ 5 percentage points.

⁵Heroin price and purity information are for 19 CEWG cities in the Drug Enforcement Administration (DEA) Domestic Monitor Program (DMP); comparisons are for 1998 versus the first half of 1999; shifts ≥ 3 percentage points are noted.

REGIONAL HIGHLIGHTS: THE NATION

EAST

Cocaine: #1 ED in most cities; #1 treatment drug in some cities; ED ↑ or stable; treatment admissions ↓ or stable; HCl availability ↑ in some cities
Heroin: #1 treatment and ED drug in some cities; ED ↑ or stable; treatment admissions ↓ or stable; many snorters, but injecting ↑ in several cities; younger users ↑; high-purity Colombian heroin
Marijuana: ADAM % for males ↑ or stable; other indicators generally stable; combined with cocaine, PCP, or embalming fluid
Methamphetamine: Low levels; occasional reports of increases
Club drugs: GHB/GBL, ketamine consequences; MDMA ↑ in some cities
Hallucinogens: PCP or LSD + MDMA or mushrooms in some cities



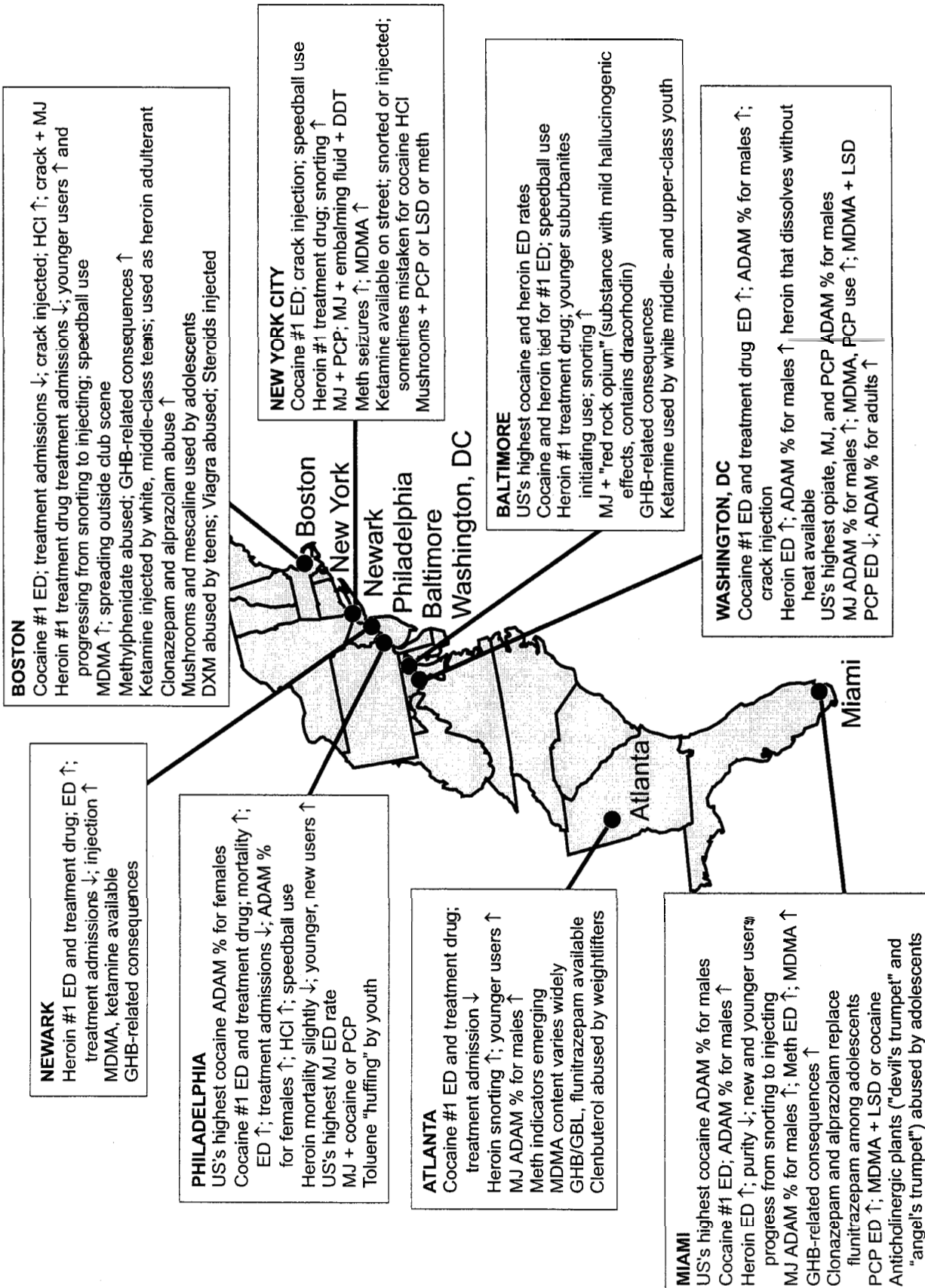
WEST

Cocaine: #1 ED in many cities; ED ↑ or stable; treatment admissions stable; HCl ↑ in some cities
Heroin: #1 ED and treatment drug in some cities; indicators generally stable; younger users ↑ in many cities; purity ↓ in some cities; most inject Mexican black tar
Marijuana: #1 treatment drug in some cities; indicators slightly ↑ or stable
Methamphetamine: #1 treatment drug in some cities; most indicators ↓; purity ↓; ED ↓ in most cities, but still Nation's highest
Club drugs: GHB/GBL consequences; MDMA, ketamine in some cities

CENTRAL

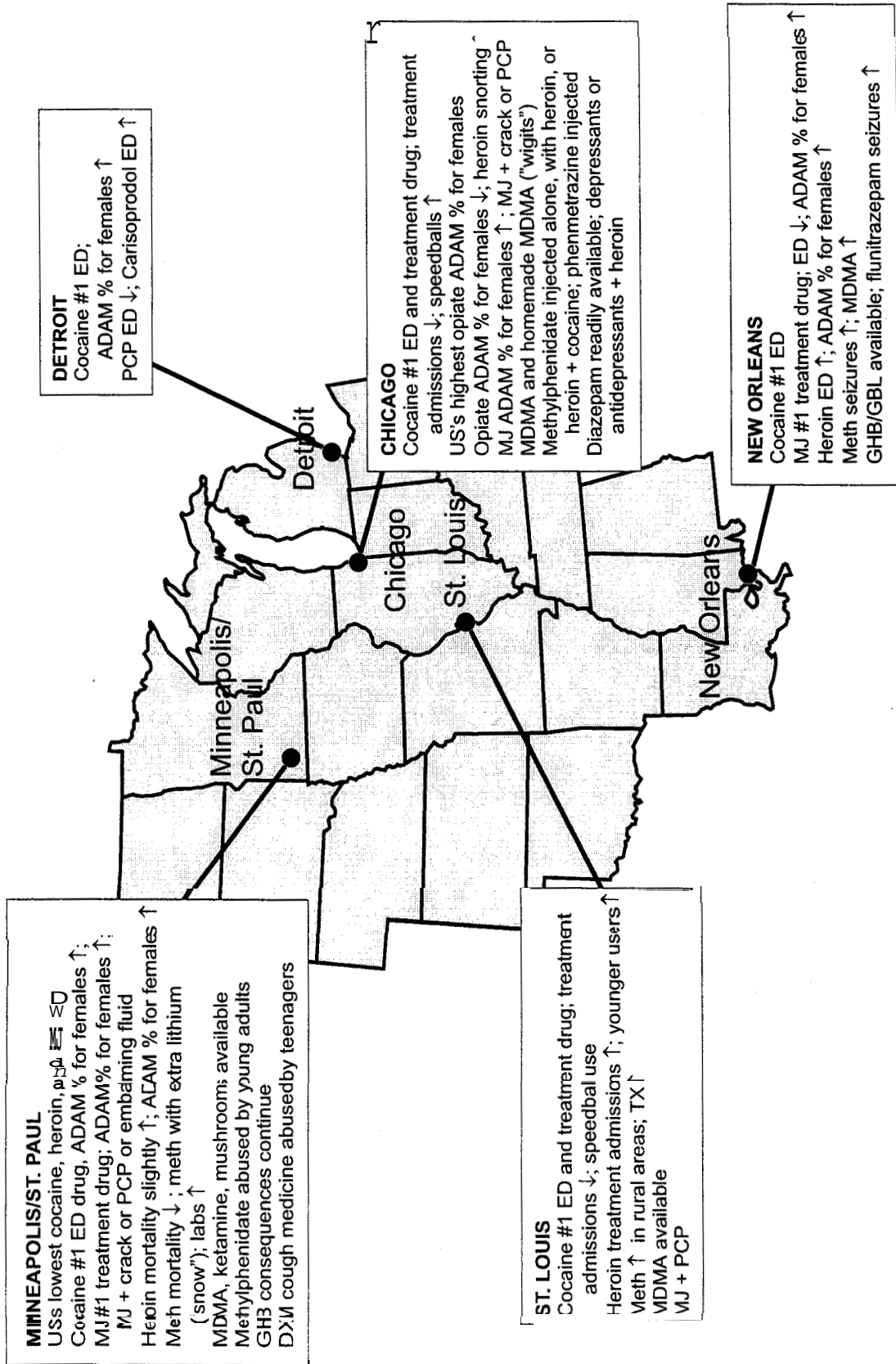
Cocaine: #1 ED; #1 treatment drug in some cities; ADAM % for females ↑ or stable; other indicators stable
Heroin: Indicators slightly ↑ or stable
Marijuana: #1 treatment drug in some cities; ADAM % for females ↑ or stable; other indicators stable; combined with PCP, crack, or embalming fluid
Methamphetamine: Increasing in some rural areas
Club drugs: MDMA, GHB/GBL generally available or ↑; ketamine, hallucinogens available

REGIONAL HIGHLIGHTS: EAST

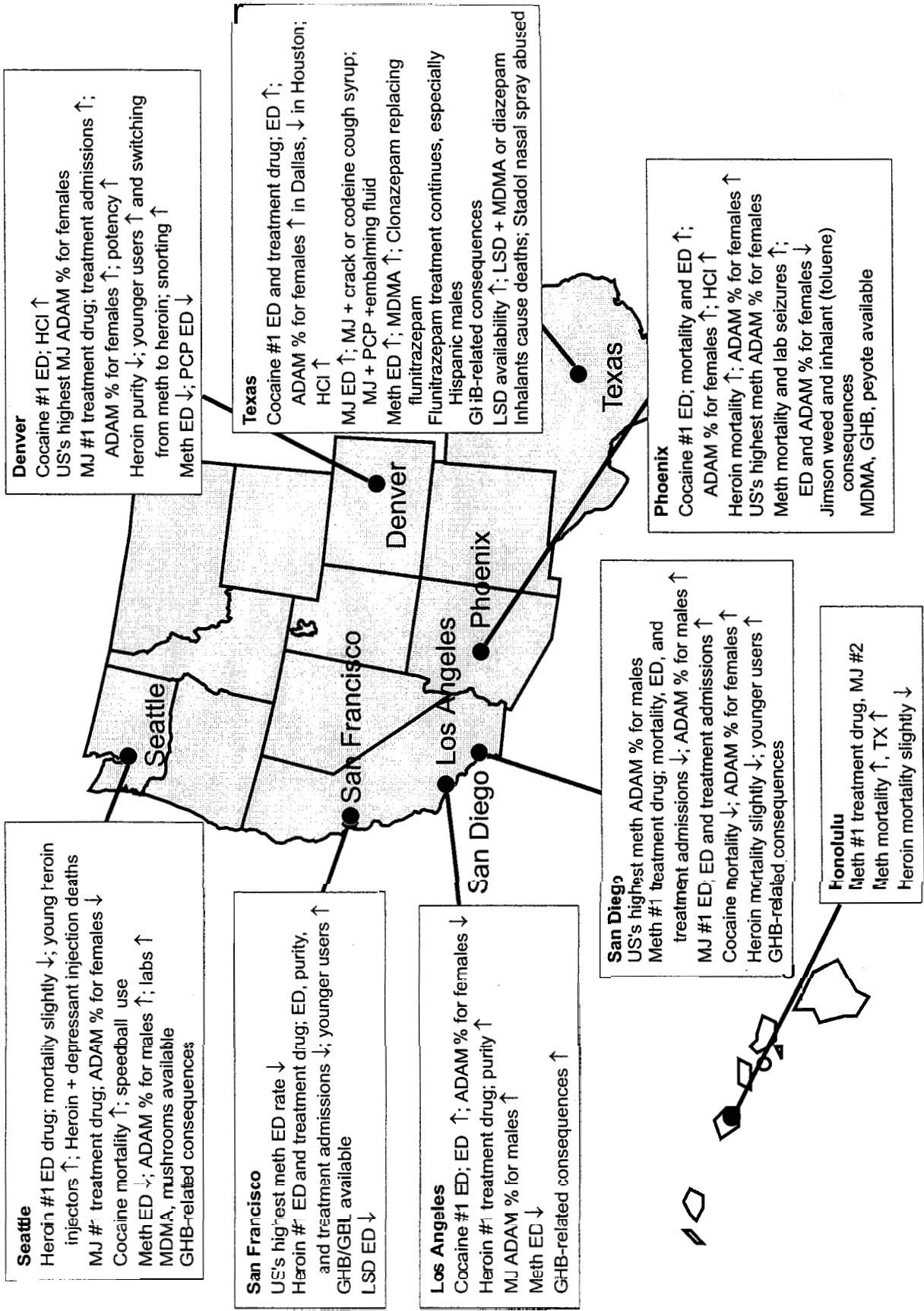


SOURCE: National Institute on Drug Abuse, December 1999

REGIONAL HIGHLIGHTS: CENTRAL



REGIONAL HIGHLIGHTS: WEST



SOURCE: National Institute on Drug Abuse, December 1999

CEWG CITY HIGHLIGHTS: KEY ABUSED DRUGS, DECEMBER 1999

AREA	COCAINE		HEROIN		MARIJUANA		OTHER DRUGS OF NOTE	
	ED rate \$100/g crack	% of TXs	ED rate \$100/g crack	% of TXs	ED rate \$100/g crack	% of TXs	ED rate \$100/g crack	% of TXs
Atlanta	ED rate 217.6; 52% of TXs; \$100/g (72% pure); crack \$10-\$20/rock	ED rate 17.6; 4% of TXs; \$.85/mg (1); 62% pure (1); speedball use	ED rate 95.8; 20% of TXs; sinsemilla \$160-\$250/oz; domestic \$120-\$240/oz	Methamphetamine ED rate 5.9, seizures 1; MDMA, GHB, flunitrazepam available; GHB ODS; clenbuterol abused by weightlifters				
Baltimore	ED rate 296.3; 15% of TXs	ED rate 290; 46% of TXs; \$.35/mg (1); 20% pure (1)	ED rate 64.5; 16% of TXs	10 GHB ODS in 1Q99; ketamine available; "red rock opium" (daemonorops draco plant) combined with marijuana				
Boston	ED rate 122.5; 13% of TXs; \$80-\$100/g (50% pure); crack \$10-\$20/vial (60-80% pure); crack injected	ED rate 74.6; 37% of TXs; \$1.31/mg (1); 64% pure; ketamine used as heroin adulterant; speedball use	ED rate 78.7; 4% of TXs; commercial \$75-\$300/oz; sinsemilla \$200-\$500/oz; combined with crack	Methamphetamine seizures 1; MDMA 1; methylphenidate, khat, psilocybin mushrooms, mescaline available; GHB consequences 1; ketamine injected; clonazepam ED rate 19.5 (1); benzodiazepines combined with heroin; DXM, Viagra abused; steroids injected				
Chicago	ED rate 231.7; 27% of TXs; \$75-\$100/g (61% pure); crack \$5-\$20/rock	ED rate 159; 15% of TXs; \$.47/mg (1); 26% pure; combined with cocaine, depressants, amitriptyline	ED rate 85; 14% of TXs; \$100-\$200/oz; blunts laced with crack, PCP	MDMA available; phenmetrazine, methylphenidate injected by youth; methylphenidate combined with heroin or heroin + cocaine				
Denver	ED rate 73.2; 16% of TXs; \$80-\$125/g; crack \$10-\$20/rock	ED rate 32.3; 10% of TXs; \$1.06/mg (1); 19% pure (1)	ED rate 36.7; 31% of TXs; \$800-\$1,200/lb	Methamphetamine ED rate 7.6 (1), 7% of TXs, purity 1; GHB available				
Detroit	74 deaths in 1Q99; ED rate 201.7	95 deaths in 1Q99; ED rate 67.9; \$1.26/mg (1); 45% pure	ED rate 101.5	Clonazepam ED rate (1); carisoprodol ED rate (1)				
Honolulu	15 deaths in 1H99; 7% of TXs; \$100-\$120/g (20-50% pure); crack \$5-\$15/dose	8 deaths in 1H99; 10% of TXs; \$150-\$250/g	21% of TXs; "low quality" \$250-\$500/oz; "high quality" \$400-\$800/oz	Methamphetamine deaths 1, 27% of TXs 1, remains #1 TX drug				
Los Angeles	ED rate 68.4 (1); 18% of TXs; \$80/g (80% pure)	ED rate 31.1; 47% of TXs; \$.38/mg (1); 33% pure (1)	ED rate 40.5; 6% of TXs; sinsemilla \$10-\$80/oz	Methamphetamine ED rate 9.3 (1), 7% of TXs, purity 1; GHB deaths, poison cases 1				
Miami	25 deaths in first 3Q99; ED rate 187.3; 43% of TXs; \$40-\$60/g (50% pure); crack \$5-\$20/bag or vial	ED rate 40.7 (1); \$4.19/mg (1); 11% pure (1)	ED rate 58.9; 30% of TXs; commercial \$800-\$1,000/lb; hydroponic \$600+/oz	Methamphetamine ED rate (1); MDMA 1, combined with LSD, cocaine; GHB deaths and withdrawal cases, ODS 1; ketamine available; other benzodiazepines replacing flunitrazepam; depressants combined with stimulants ("rollers"); anticholinergic plants abused				
Minneapolis/St. Paul	17 deaths in 1H99; ED rate 32.6; 14% of TXs; \$100/g; crack \$20/rock	17 deaths in 1H99; ED rate 7.5; 2% of TXs; \$250/g (1)	ED rate 20.7; 23% of TXs; \$250/oz; combined with crack, PCP, embalming fluid	Methamphetamine seizures 1; MDMA, methylphenidate, khat, ketamine, psilocybin mushrooms available; GHB deaths, seizures, ODS; DXM abused				
Newark	ED rate 208; 9% of TXs; 50-60% pure; crack \$3-\$20/vial	ED rate 282.4 (1); 66% of TXs; \$.43/mg (1); 67% pure (1)	ED rate 29.6; 2% of TXs	MDMA available; GBL suspected of causing 18 medical emergencies; alprazolam ED rate 12.9 (1); benzodiazepines 6% of TXs				

New Orleans	ED rate 199.3; 22% of TXs; \$80-\$150/g; crack \$5-\$25/rock	ED rate 44.4 (1); 14% of TXs; \$2.26/mg (1); 36% pure (1)	ED rate 99.5 (1); 26% of TXs; \$25-\$160/oz	Naluphine available; methamphetamine seizures 1; MDMA 1; GHB 1; flunitrazepam abused by youth, seizures 1
New York City	ED rate 233.4; 33% of TXs; crack \$2-\$10/vial; crack injected	ED rate 110.4; 43% of TXs; \$6.1/mg (1); 65% pure; speedball use	ED rate 44; 19% of TXs; \$300-\$2,500/lb; combined with PCP and with embalming fluid + DDT (pesticide)	Codeine abused; MDMA 1; ketamine snorted, injected; psilocybin mushrooms dipped in PCP, LSD, methamphetamine
Philadelphia	130 deaths in 1H99; ED rate 275.4 (1); 47% of TXs; crack \$3-\$5 rock; crack combined with depressants, PCP	119 deaths in 1H99; ED rate 75.7; 27% of TXs; \$30/mg; 75% pure (1); speedball use	ED rate 112.1 (1); 20% of TXs; combined with cocaine HCl, PCP	Methamphetamine available but requires a connection to purchase; alprazolam ED rate 21.4; inhalants abused
Phoenix	89 deaths in 1H99; ED rate 72.8 (1); \$500-\$800/oz (21-90% pure); crack \$20/rock	60 deaths in 1H99; ED rate 43.7; \$37/mg; 32% pure	ED rate 35.6; \$75-\$150/oz	Methamphetamine ED rate 21.8 (1), seizures 1; MDMA, GHB, peyote available; alprazolam ED rate (1); jimson weed-related consequences; toluene deaths in 1H99
St. Louis	ED rate 87.1; 36% of TXs; \$52-\$100/g (65-90% pure); crack \$25/rock	ED rate 27.1; 18% of TXs; \$2.26/mg (1); 20% pure (1); speedball use	ED rate 56.2; 23% of TXs; combined with PCP	Methamphetamine TXs 1; MDMA available
San Diego	About 20 deaths in 1H99; ED rate 40.7; 12% of TXs; crack \$10/0.1g	60 deaths in 1H99; ED rate 42.2; 12% of TXs; \$22/mg (1); 56% pure	ED rate 47.3 (1); 8% of TXs; commercial \$50-\$75/oz; sinsemilla \$200-\$400/oz	Methamphetamine deaths 1, ED rate 30.2 (1), 38% of TXs; GHB deaths; alprazolam ED rate (1)
San Francisco	ED rate 115.6; 24% of TXs; crack \$50/g	ED rate 149.7 (1); 43% of TXs; \$48/mg (1); 22% pure (1); speedball use	ED rate 24.7; \$2,800/lb	Methamphetamine ED rate 38.7 (1), 13% of TXs, purity 1; GHB available
Seattle	63 deaths through 9/13/99; ED rate 124.6; 23% of TXs; \$30/g; crack \$20-\$40/g	61 deaths in 1H99, including heroin + depressant deaths; ED rate 126.7; 28% of TXs; \$1.02/mg (1); 16% pure (1); speedball use	ED rate 48.6; 35% of TXs; sinsemilla \$325-\$400/oz	Methamphetamine ED rate 13.8 (1), 10% of TXs, seizures 1, purity 1; MDMA, psilocybin mushrooms available; 3-4 GHB criminal incidents per month; diazepam + heroin involved in deaths
Texas	ED rate 106 (1) in Dallas; 39% of TXs; \$50-\$275/g; crack \$10-\$20/rock	15% of TXs; Dallas: ED rate 21; \$1.25/mg (1); 12% pure; Houston: \$1.29/mg (1); 17% pure (1)	ED rate 62 in Dallas (1); 21% of TXs; \$35-\$60/oz; combined with crack, embalming fluid and PCP, dipped in codeine syrup	Methamphetamine ED rate 7.6 (1), seizures 1; MDMA 1, combined with LSD, heroin; GHB poison cases 1; flunitrazepam TXs 1; codeine syrup abuse 1; inhalant deaths; Stadol nasal spray abused; LSD + diazepam
Washington, DC	ED rate 97 (1); 46% of TXs; \$100-\$200/g (19-95% pure); crack \$100/g (30-81% pure) crack injected	ED rate 21.7 (1); 38% of TXs; \$1.22/mg (1); 19% pure (1); "bag delight" dissolves without heat	ED rate 61.6; 16% of TXs; Mexican or Jamaican \$80-\$300/oz; sinsemilla \$150-\$500/oz	Codeine and methadone available near methadone clinics; MDMA available, combined with LSD ("nexus")

ED = DAWN estimates of emergency department mentions per 100,000 population for each drug during 1998; arrows reflect rate shifts (p<0.05) between 1997 and 1998.

TX = Treatment admissions, including alcohol-in-combination, but excluding alcohol-only, except in Boston, Hawaii, Minneapolis/St. Paul, and New Orleans. Data are statewide for Hawaii and Texas. Reporting periods are January-June 1999, except for the following: January-June 1998 in Baltimore; July 1998-March 1999 in Boston; July-September 1999 in Los Angeles; full calendar year 1998 in Chicago; and FY 1999 in San Francisco.

Purity = Heroin price and purity data provided by the Domestic Monitor Program for first-half 1999 (except for Denver and New Orleans, which are for second-quarter 1999); arrows reflect >3-percentage-point shifts since full-year 1998; other drug price data provided by December 1999 CEWG city reports.



EXECUTIVE SUMMARY

COCAINE AND CRACK

Boston: "According to focus groups with teens and youth treatment providers, cocaine use remains relatively rare among school-aged adolescents.... However, inadvertent exposure to cocaine via marijuana joints or blunts laced with crack was mentioned by participants in several focus groups."

MORTALITY DATA

Partial-1999 cocaine-related mortality data were available in seven cities. Compared with 1998 data, projections suggest increases in three cities and declines or stable trends in four. The increases were reported in the following cities:

- Philadelphia: After declining 14 percent between 1997 and 1998 (from 284 to 245), cocaine-positive toxicology reports appear to be rebounding slightly in 1999 (130 in the first half).
- Phoenix: Cocaine-related deaths increased by more than 300 percent between 1997 and 1998 (from 21 to 87), and the dramatic increase continues into 1999—the half-year figure (89) has already surpassed the previous year's total. Cocaine has also increased as a percent of total drug-related deaths during those three periods (10, 21, and 28 percent, respectively).
- Seattle: Except for a decline in 1997, cocaine-related deaths have been increasing for several consecutive years. The increase was slight between 1997 and 1998 (from 66 to 69) but appears to be sharper in 1999 (63 through September 13).

Mortality trends appear stable or declining in the following cities:

- Honolulu: After increasing 26 percent between 1997 and 1998 (from 23 to 29), cocaine toxicology cases appear to be stable in 1999 (15 in the first half).
- Miami: Cocaine-induced deaths declined slightly between 1997 and 1998 (from 42 to 39) and appear relatively stable in 1999 (25 in the first 9 months, compared with 24 for the same period a year earlier).
- Minneapolis/St. Paul: Cocaine-related deaths declined 24 percent between 1997 and 1998 (from 58 to 44) and appear to be declining again in 1999 (17 in the first half).
- San Diego: Cocaine-related accidental overdose deaths declined 14 percent between 1997 and 1998 (from 63 to 54) and appear to be declining again in 1999 (40 projected, based on first-half-year data).

Earlier data show four increases between 1997 and 1998:

- Colorado: Continuing a steady 6-year climb, cocaine deaths increased 18 percent (from 92 to 109), reaching a record high.

Executive Summary: Cocaine

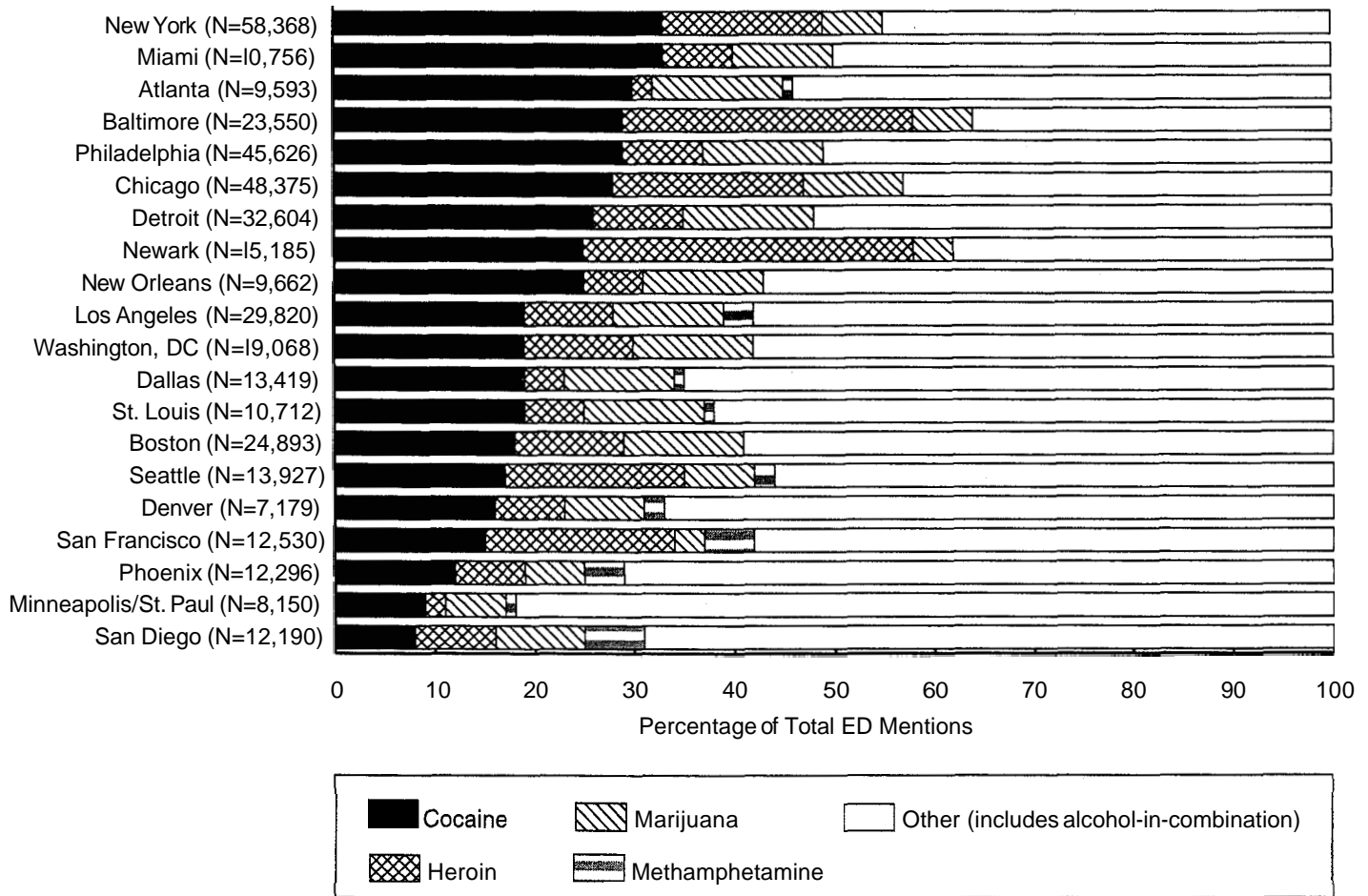
- St. Louis: After declining from a 1996 peak (of 93), cocaine-related deaths increased, but only slightly (from 43 to 47).
- San Francisco (fiscal year data): Medical examiner (ME) cocaine mentions increased 22 percent (from 83 to 101) but remained below the 1996 peak (of 111).
- Texas: Cocaine mentions increased 11 percent to a record high (from 338 to

374)—the third consecutive increase since a 1995 low (of 189).

EMERGENCY DEPARTMENT DATA

Cocaine (including crack) remains the most frequent illicit drug mention in 15 of the 20 CEWG cities in the Drug Abuse Warning Network, according to 1998 estimates, and is equal to heroin as a proportion in Baltimore (exhibit 1). It accounts for

Exhibit 1. Percentages of total ED mentions composed of cocaine, heroin, marijuana, methamphetamine, and "other" by metropolitan area, ranked by cocaine, 1998



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

particularly high proportions (>20 percent) of total emergency department (ED) drug mentions (including alcohol-in-combination) in nine cities (Atlanta, Baltimore, Chicago, Detroit, Miami, New Orleans, New York, Newark, and Philadelphia). It is outranked by heroin, however, in three cities (Newark, San Francisco, and Seattle); and in San Diego it nearly equals marijuana and heroin in frequency of mention.

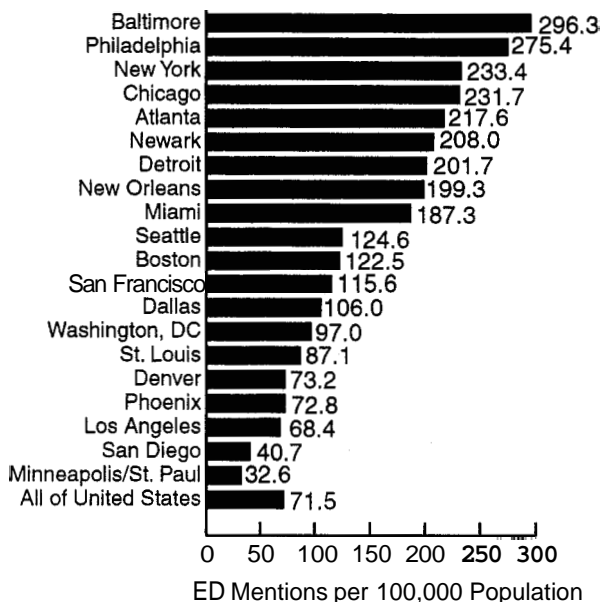
The Nation's highest rate of cocaine ED mentions per 100,000 population was reported in Baltimore (as it has been since 1992), followed by Philadelphia; the lowest rate, again, was in Minneapolis/St. Paul (exhibit 2).

Between 1997 and 1998, cocaine ED mentions increased significantly (>10

percent, $p < 0.05$) in five cities (Dallas, Los Angeles, Philadelphia, Phoenix, and Washington, DC), with the largest shift a 45-percent increase in Dallas (exhibit 3). Additionally, nonsignificant increases were reported in the majority of the other cities; no significant declines were noted. Correspondingly, over that same time period, cocaine increased slightly (3–5 percentage points) as a proportion of total ED mentions in six cities: Atlanta, Boston, Dallas, Los Angeles, Philadelphia, and St. Louis. Thus, cocaine increased both in number and proportion in three cities: Dallas, Los Angeles, and Philadelphia.

Long-term trends have varied somewhat among the Nation's four top-ranking cities (exhibit 4). Baltimore's current rate—despite its top-ranking national status, and despite the recent slight increase—is still well below that city's 1994 peak. Philadelphia's latest increase, however, has brought that city's cocaine ED rate to a record level, continuing a 4-year climb. The current leveling in Chicago follows a generally increasing trend since 1991. In New York, however, rates have been fairly stable throughout the 1990s, with minor fluctuations.

Exhibit 2. Estimated rate of cocaine/crack ED mentions per 100,000 population by metropolitan area, 1998



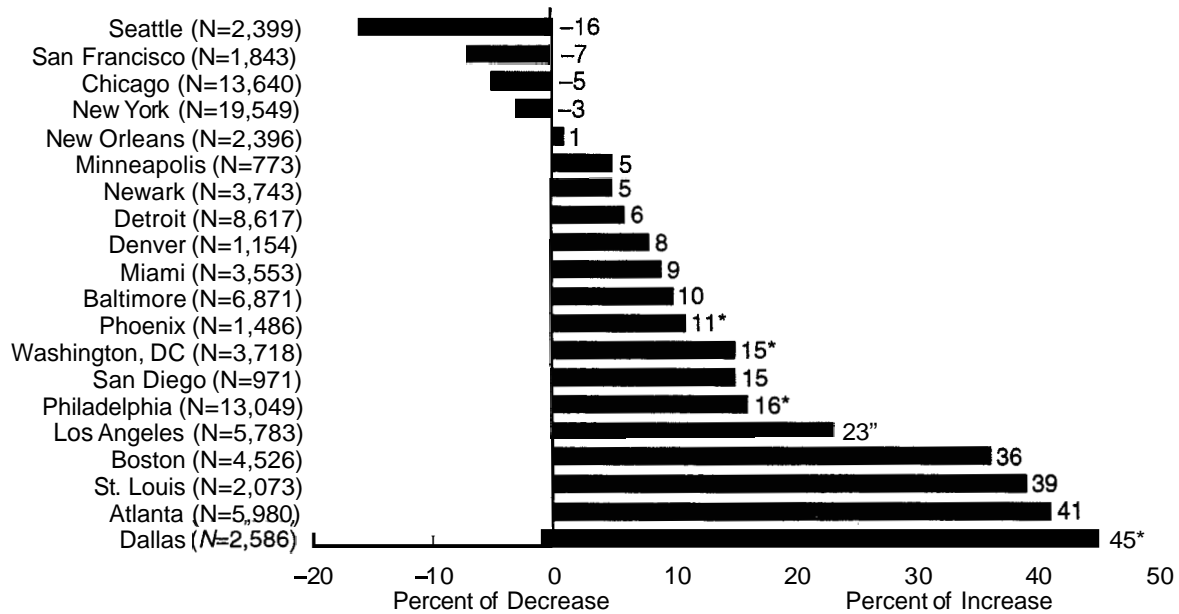
SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

TREATMENT DATA

BEYOND THE CITY LIMITS...

St. Louis: "Cocaine...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. --

Exhibit 3. Percentage of change in cocaine/crack ED mentions by metropolitan area, 1997 versus 1998

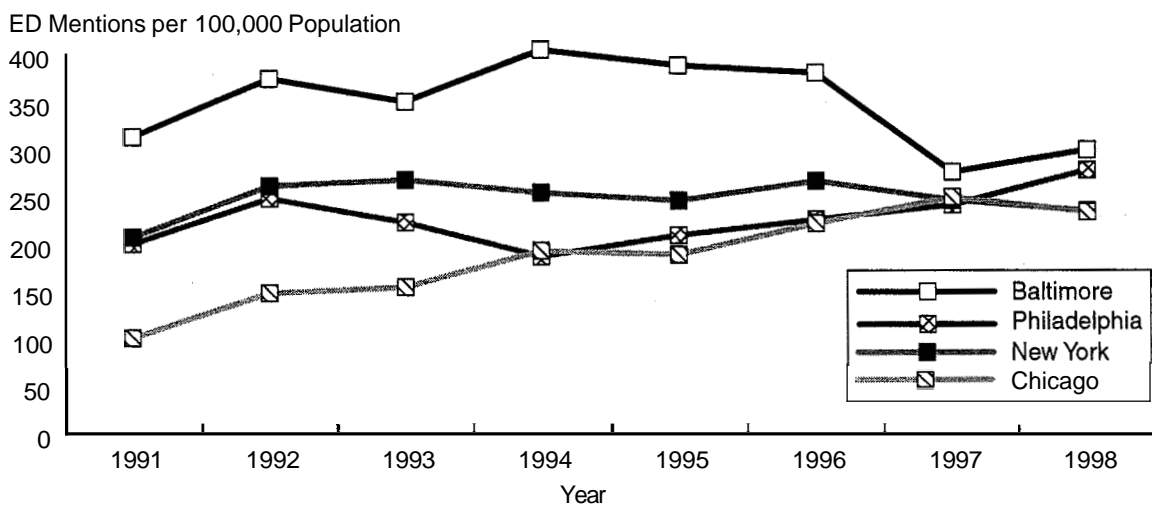


NOTE: (N) refers to 1998 mentions

*p<0.05

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

Exhibit 4. Annual trends in cocaine/crack ED mentions per 100,000 population in four top-ranking cities, 1991-98



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

Cocaine (including crack) as a primary drug of abuse accounts for the largest percentage of admissions (excluding alcohol-only but including alcohol-in-combination) in 6 of 18 reporting areas: Atlanta, Chicago, Philadelphia, St. Louis, Texas, and Washington, DC (exhibit 5). It also accounts for major proportions of admissions (>20 percent) in New Orleans, New York City, San Fran-

cisco, and Seattle. Heroin now dominates treatment proportions in six areas, marijuana in four, and methamphetamine in two.

Contrary to most ED indicators, treatment percentages for cocaine remained generally stable or declined in all areas where trend data were available, in comparison with

Exhibit 5. Primary drugs of abuse as percentages of treatment admissions^a in reporting CEWG areas, first half 1999^b

Area	Cocaine	Heroin	Marijuana	Stimulants
Atlanta	52	4	20	2
Philadelphia ^c	47	27	20	<1
Washington, DC	46	38	16	<1
Texas	39	15	21	4
St. Louis	36	18	23	2
Chicago	27	15	14	<1
Newark	9	66	2	<1
Los Angeles	18	47	6	7
Baltimore	15	46	16	<1
New York City	33	43	19	<1
San Francisco	24	43	NR	13
Boston ^d	13	37	4	NR
Seattle	23	28	35	10
Denver	16	10	31	7
New Orleans ^d	22	14	26	<1
Minneapolis/St. Paul ^d	14	2	23	2
San Diego	12	12	18	38
Hawaii ^d	7	10	21	27

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

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

^bReporting periods are January-June 1999, except for the following: January-June 1998 in Baltimore; July 1998-March 1999 in Boston; July-September 1999 in Los Angeles; full calendar year 1998 in Chicago; and FY 1999 in San Francisco.

^cData are preliminary.

^dAlcohol-only is not excluded.

SOURCE: State drug abuse treatment agencies

figures from the same reporting period 1 year earlier. The largest declines were noted in Atlanta, Chicago, Philadelphia, and St. Louis. Longer term comparisons show some more notable declines. In Boston, for example, admissions for primary cocaine abuse declined from 27 percent in 1994 to 13 percent in the first half of 1999. Similarly, in Denver, the cocaine percentage (excluding both alcohol-only and alcohol-in-combination) declined from 41 percent in 1993 to 22 percent in the first half of 1999. And, in Newark, cocaine admissions declined from 33 percent in 1992 to 9 percent in the first half of 1999.

While treatment data were not available for Miami or Florida, a south Florida provider reports stable trends for primary cocaine hydrochloride (HCl) admissions but a dramatic decline in primary crack admissions between the first halves of 1998 and 1999. Similarly, a Phoenix provider reports stable cocaine trends.

OTHER LOCAL DATA

Local data sources around the country underscore the severity of the cocaine problem, despite some indications of leveling or declining trends:

- South Florida: Among the 2,962 toxicology screens performed at a Broward County hospital during the first half of 1999, 26 percent were positive for cocaine.
- Denver area: Poison control calls declined between 1994 and 1995 (from 71

to 49) and have remained at about that level through 1998.

- Chicago: Among infants who tested drug positive, the proportion of cocaine findings declined between 1996 and 1998 (from 64 to 57 percent).
- Massachusetts: Cocaine was mentioned in 17 percent of helpline calls between May and September 1999, level with the prior 5-month period.
- Massachusetts: In 1998, lifetime cocaine or crack use was reported by 21 percent of juvenile offenders (±17 years), compared with just 5 percent for heroin.

WHY DO TREATMENT INDICATORS GENERALLY SHOW DECLINES, WHILE SOME OTHER INDICATORS SHOW INCREASES?

POSSIBLE EXPLANATIONS...

Texas: "This decrease could reflect shifts in funding among treatment programs with different target groups, especially heroin users, or it could indicate an upsurge in cocaine use among new users not yet in need of treatment. --

Newark: "Some of the decline may be attributed to the effect of managed care on admissions to hospital-based detoxification programs. --

NOTE: In comparing indicators, another factor should be considered: treatment data are generally available about 6 months before the ED data.

DEMOGRAPHIC DATA

BEYOND THE CITY LIMITS...

Atlanta: "The emergence of cocaine HCl as well as crack cocaine outside the inner city is also confirmed by ethnographic data. These new users are less likely to be adolescents, but encompass young adults who use cocaine for recreational purposes as well as professionals who use it to enhance their job performance. Typically, the crack used is not in rock form; rather, these users smoke freebase cocaine."

Age

Available mortality demographics continue to reflect an older cocaine-using population. For example, the average age of cocaine decedents was 39 in Miami (although the range was 17–63), 38.9 in Minneapolis/St. Paul, and 36.9 in Texas (an increasing trend). More than half (55 percent) of San Diego's cocaine decedents were age 35 or older. And, in San Francisco, median age was 40, a record high for recent years.

Philadelphia: "The recent [focus] groups also reported an aging crack-using population with fewer new users."

Likewise, age distributions among cocaine ED mentions generally suggest an aging cohort of cocaine users; however, rate increases among youth in four cities bear watching. The 35+ group now accounts for the largest percentage of cocaine mentions in every CEWG city in DAWN; moreover, it accounts for 50 percent or more in all but 6 of those 20 cities (Boston, Dallas, Denver,

Minneapolis/St. Paul, Philadelphia, and Phoenix) (exhibit 6). Between 1996 and 1998, that older group's representation increased by 5 or more percentage points in 13 cities (Boston, Chicago, Denver, Detroit, Los Angeles, Miami, Minneapolis/St. Paul, New Orleans, Newark, Phoenix, St. Louis, Seattle, and Washington, DC).

Correspondingly, as they moved into the older age group, the 26–34 group declined as a percentage of cocaine ED mentions in nearly every city, accounting for only 27–39 percent of cocaine mentions among the 20 cities. The largest declines (≥ 5 percentage points) were recorded in 12 cities (Boston, Dallas, Denver, Detroit, Los Angeles, Miami, New Orleans, Newark, Philadelphia, St. Louis, San Francisco, and Washington, DC).

The young adult (18–25) group, which accounts for 7–22 percent of cocaine ED mentions in the various cities, remained relatively stable in proportion, with a few exceptions: a 6-point increase in San Diego, and 5-percentage-point declines in both Philadelphia and Seattle. Similarly, the juvenile (12–17) group remained relatively stable between 1996 and 1998, generally accounting for 1–3 percent of cocaine mentions in all the cities except Dallas (6 percent) and Phoenix (5 percent).

Despite the juvenile group's stable proportions, their rates (cocaine ED mentions per 100,000 population) increased disturbingly between 1996 and 1998 in four cities: Baltimore, Boston, Dallas, and Denver (exhibit 7). In Baltimore, moreover, the increase is even more dramatic because it was accompanied by rate declines for the

Exhibit 6. Age distribution of cocaine ED mentions, by percentage, in reporting CEWG cities, 1998

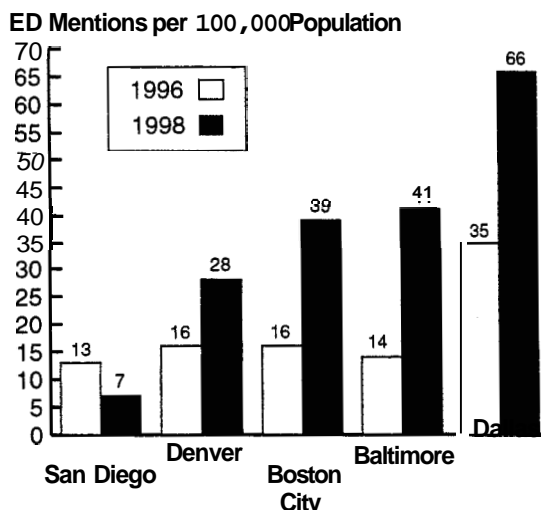
Area	12-17	18-25	26-34	35+
Atlanta	2	11	34	53
Baltimore	1	11	35	53
Boston	3	16	38	44
Chicago	1	11	35	53
Dallas	6	22	33	39
Denver	3	19	33	44
Detroit	<1	7	27	65
Los Angeles	2	15	31	52
Miami	1	11	30	56
Minneapolis/ St. Paul	3	17	35	45
Newark	1	10	36	54
New Orleans	2	17	31	50
New York City	<1	8	39	52
Philadelphia	1	15	35	48
Phoenix	5	22	36	37
St. Louis	...	11	29	58
San Diego	2	18	27	54
San Francisco	2	10	27	60
Seattle	2	13	33	52
Washington, DC	1	9	35	55

NOTE: Bolded areas reflect percentages that have increased by ≥5 points since 1996.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

three older age groups. In Boston and Denver, the older age groups did increase in rate; however, those increases were minor compared with the increase among juveniles. Only in Dallas did all four age groups show sharp rate increases. The sharpest rate decline in the 12-17 group took place in San Diego, where the 18-25 group correspondingly increased.

Exhibit 7. Cocaine emergency department mentions per 100,000 population for the 12-17 age group in selected cities, 1996 versus 1998



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

Treatment data also continue to reflect a generally aging group of cocaine users (exhibit 8). The oldest (35+) group accounts for the largest percentages of primary cocaine admissions (ranging from 45 percent in Texas to 63 percent in Washington, DC) in all but one reporting area: Newark, where that oldest group trails the middle (26-34) group by just 1 percentage point. In several areas where trend data were available, the middle group still seems to be transitioning into the oldest group: compared with the same period 1 year earlier, the middle group declined substantially (≥4 percentage points) in four areas — Chicago, Minneapolis/St. Paul, New York City, and Texas — while the oldest group increased correspondingly. The younger (18-25) group accounts for much smaller percentages than the two older groups (ranging from 5 percent in Washington, DC, to 16 percent in Texas). The youngest (≤17) group generally accounts for 1 percent or less of primary cocaine admissions, with a few exceptions: Baltimore

Exhibit 8. Age distribution of primary cocaine treatment admissions, by percentage, in reporting CEWG areas^a

Area	≤17	18-25	26-34	35+
Atlanta	1	12	41	47
Baltimore	4	9	41	46
Chicago	1	11	35	53
Denver	1	12	35	52
Los Angeles	1	10	32	57
Minneapolis/ St. Paul	2	9	37	52
Newark	NR	8	46	45
New York City ^b	0	6	43	51
St. Louis	<1	7	40	53
San Diego	1	10	31	58
San Francisco	NR	NR	NR	54
Texas	3	16	36	45
Washington, DC	<1	5	33	63

NOTE: Bolded areas reflect percentages that have increased by ≥5 points since the reporting period 1 year earlier.

^aReporting periods are January–June 1999, except for the following: January–June 1998 in Baltimore; July 1998–March 1999 in Boston; July–September 1999 in Los Angeles; full calendar year 1998 in Chicago; and FY 1999 in San Francisco.

^bAge groups reported are <17, 17–25, 26–35, and 36+.

SOURCE: State drug abuse treatment agencies

(4 percent), Texas (3 percent), and Minneapolis/St. Paul (2 percent).

Available juvenile arrestee urinalysis data show level or declining trends. In Denver, cocaine-positive findings in that population declined considerably between 1998 and the first half of 1999 (from 13 to 7 percent). Levels remained relatively stable in the other three cities where **ADAM** tested juveniles: Phoenix (16 percent); San Antonio (10

percent); and San Diego (5 percent). Similarly, in Washington, DC, Pretrial Services Agency urinalyses show relatively stable cocaine-positive levels among juvenile arrestees (8 percent in 1998 and 7 percent in the first 10 months of 1999).

Gender

Males continue to account for the large majority of cocaine deaths in all areas where mortality demographics were available: 90 percent in San Diego, **88** percent in Minneapolis/St. Paul, 74 percent in Seattle, 70 percent in San Francisco, and 60 percent in Miami.

Males also continue to outnumber females as a percentage of cocaine ED mentions in every CEWG city in DAWN. The gender gap remains widest in New Orleans and New York (72 versus 28 percent); it is narrowest in Boston and Washington, DC (**57** versus 43 percent). Between 1997 and 1998, gender distributions remained generally stable. The largest shifts were some slight increases (3–4 percentage points) for females in Los Angeles, Newark, and San Diego, and a slight decline (3 points) for females in Seattle.

Similarly, among cocaine admissions, males outnumber females in all reporting areas except Newark (where females account for 55 percent) and Chicago (where males and females are evenly divided). Following Newark and Chicago, the narrowest gender gap occurred in Philadelphia (52 percent versus 49 percent); the widest gap was reported in Minneapolis/St. Paul (68 percent versus **32** percent). Since the same period 1 year earlier, female representation increased markedly (5–7 percentage points) in three cities where trend data were available

(Newark, Philadelphia, and San Francisco) and declined in one (Denver).

In nearly every reporting area, women in treatment had a higher representation for cocaine than for other drugs. Men, by contrast, were more highly represented for marijuana than for other drugs.

Only in one indicator do women predominate: according to preliminary first-half-1999 ADAM data, female arrestees tested cocaine-positive at higher levels than males in nearly every CEWG city (exhibit 9). The only exceptions occurred in New Orleans and in two Texas cities (Houston and San Antonio), where percentages were higher for males than for females. Miami had the highest cocaine-positive level among males, while Philadelphia had the highest level among females.

Atlanta: "An ethnographic study to further explore this gender gap revealed a complex series of issues that might provide explanations, such as the following: women are easier to arrest; female prostitution is a highly visible crime; and women are less likely to report to emergency departments and drug treatment centers."

Race/Ethnicity

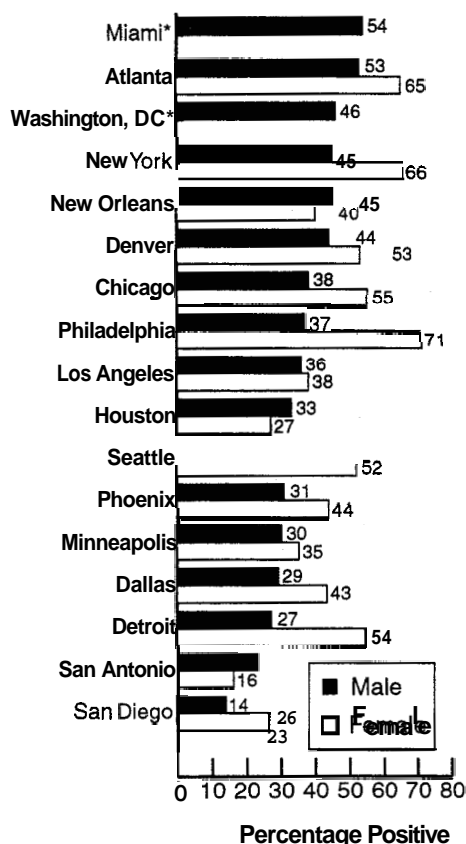
Whites generally predominate in available cocaine mortality data. They account for 70 percent of the cocaine decedents in San Diego, 60 percent in Miami, and 48 percent in Texas. In Minneapolis/St. Paul, however, 53 percent of cocaine decedents are African-American.

African-Americans predominate among cocaine ED mentions in 12 of the 20 CEWG

cities in DAWN, whites predominate in 5, and 3 cities have too many mentions in the "race unknown" category to be included in the count. The largest Hispanic representation occurs in Los Angeles, New York, and Phoenix (24–27 percent).

Between 1997 and 1998, San Diego's racial/ethnic distribution of cocaine ED mentions shifted dramatically, with a 13-percentage-point increase for whites and an 8-point decline for African-Americans. A

Exhibit 9. Percentage positive for cocaine among adult male and female booked arrestees, first half 1999 (ranked by males)



*Females not tested at these sites,

SOURCE: National Institute of Justice, Arrestee Drug Abuse Monitoring program, November 1999 files, preliminary data

similar but less dramatic trend ($\pm 2-4$ percentage points) was reported in five other cities: Baltimore, Chicago, Miami, New Orleans, and St. Louis. The reverse trend ($\pm 3-6$ points) was reported in Los Angeles and Philadelphia, where white representation declined while African-American representation increased. Hispanic representation declined slightly (3-4 percentage points) in Los Angeles and Phoenix, increased (4 points) in New York, and remained relatively stable elsewhere.

Among primary cocaine treatment admissions, African-Americans account for the majority in nearly every reporting area, and they are the modal group in Texas (40 percent). The only exception is Denver, where whites predominate (45 percent). In the majority of reporting areas, however, African-American representation has declined slightly (1-3 percentage points) since the same period 1 year earlier; and it has declined more markedly (4-7 points) in Atlanta, Baltimore, and Denver. Correspondingly, whites have increased markedly as a percentage of primary cocaine treatment admissions in Atlanta and Baltimore, while Hispanic representation has increased considerably in Denver and San Diego. The largest Hispanic representation is reported in Denver (27 percent), Texas (19 percent), New York City (18 percent), and Los Angeles (18 percent).

In some areas, these recent shifts are part of a long-term trend: in Texas, for example, the percentages of Hispanics and whites among treatment admissions, both for cocaine HCl and crack, have been increasing since 1987, while the percentage of African-Americans has been declining.

African-Americans are overrepresented at a south Florida treatment facility; but there, too, crack abusers who are African-American have been declining while whites and Hispanics have been increasing.

USE PATTERNS

Route of Administration

Atlanta: "At some crack houses, users can 'borrow' a pipe that is already loaded with a rock for \$6. They have to leave the crack pipe at the house, and typically the pipes are stored in one big box, which, in turn, leads to sharing crack pipes. ..

Philadelphia: "Focus group participants estimated that 60 percent of cocaine HCl buys are for inhaling, 25 percent are for injecting in a 'speedball,' and 75 percent are for injecting straight. ..

Smoking, typically crack, remains the predominant route of administration, by far, among primary cocaine treatment admissions in every reporting area. However, since the same period 1 year earlier, smoking declined markedly (4-6 percentage points) in four cities (Denver, Newark, Philadelphia, and San Diego) and to a lesser extent (2 points each) in three others (Minneapolis/St. Paul, New York City, and St. Louis); intranasal use showed corresponding increases, possibly due to increased availability of cocaine HCl in some areas. The highest levels for intranasal use were reported in Newark (35 percent), New York City (28 percent), and Denver (24 percent). Injecting accounted for 4 percent or less of cocaine admissions in all areas except Denver (14 percent), Texas (12 percent), and Baltimore (8 percent). The Denver percentage for injecting represents a

3-point increase over the figure reported 1 year earlier.

Boston: *“Needle exchange workers...continue to see some injecting drug users (IDUs) dissolving crack cocaine in vinegar or lemon juice, to be used most often in combination with heroin (speedballing). Primary cocaine injectors, who constitute a small minority of IDUs, tend to use cocaine HCl.”*

Crack injection continues to be reported in some cities, including Boston, New York, and Washington, DC. In New York, like in Boston, injectors use lemon juice or vinegar to dissolve the crack. Since this mixture has been causing serious skin infections, some needle exchange programs in that city have been distributing kits of boric acid and vitamin C to treat the problem. In Washington, DC, where injection is becoming a common method of crack administration, injectors similarly use vinegar as a diluent, and they often shoot the drug in tandem with heroin (as a speedball).

Route of administration varies by social and demographic characteristics of the treatment population. For example, in Newark, smoking was reported by 76 percent of African-American cocaine admissions, 42 percent of whites, and 42 percent of Hispanics. In Philadelphia, smoking was reported by 76 percent of male cocaine admissions and 87 percent of females. And, in New York, crack smokers, compared with cocaine inhalers or snorters, were more likely to be female (44 percent versus 28 percent) and African-American (72 percent versus 44 percent). In Texas, cocaine HCl abusers were younger than crack abusers (31 years compared with 35), and more likely to be male and white.

Multisubstance Use

Heroin was present in 39 percent of Philadelphia’s first-half-1999 cocaine-positive mortality cases. It was involved in 71 percent of Seattle’s cocaine deaths, and 70 percent of those deaths involved injecting of both the cocaine and heroin, suggesting the possibility of speedball injection.

EXPLANATION FOR A SIMILARITY?

Baltimore: “The similarity in the cocaine and heroin ED rates and patterns are probably attributable to the concurrent use of the two drugs.”

Speedballing was reported in several other cities besides Baltimore and Seattle: Boston; Chicago; New York City, where dealers in some areas sell a “piggyback” combination that includes a \$10 bag of crack attached to a \$10 bag of heroin; Philadelphia; St. Louis, where old-time IDUs continue to mix HCl and heroin together; and San Francisco, where speedballs (heroin and cocaine sold together for combination use) have become cheaper and more widely available.

Treatment data further suggest the overlap of cocaine and heroin use: among primary heroin users, cocaine was the most common secondary drug in every area where such treatment data were available, except Texas (where alcohol was the most common secondary drug and cocaine was the most common tertiary drug). The severity of cocaine as a secondary drug problem among heroin admissions is underscored by the relatively high percentages reported: Washington, DC (57 percent), Baltimore (52

percent), Newark (40 percent), New York City (37 percent), San Diego (37 percent), Atlanta (32 percent), Los Angeles (31 percent), Denver (23 percent), and St. Louis (19 percent).

Among primary cocaine treatment admissions, however, alcohol and marijuana generally remained the most frequently reported secondary or tertiary drugs of abuse. Some exceptions include Denver, Newark, and San Diego, where alcohol was most common, both as a secondary and tertiary drug; and Texas, where opiates and alcohol, respectively, were the most common secondary and tertiary drugs.

In Philadelphia, cocaine HCl continues to be used with marijuana in a blunt known as a "turbo." Crack in that city continues to be used frequently with malt liquor, alprazolam (Xanax), diazepam, or marijuana, and less frequently with heroin or phencyclidine (PCP).

LAW ENFORCEMENT DATA

Arrestee Data

Cocaine is the most frequently detected drug among adult male arrestees in only 5 of the 17 CEWG cities in the **ADAM** program: Atlanta, Los Angeles, Miami, New Orleans, and New York. It is exceeded by marijuana in the other 12 cities (Chicago, Dallas, Denver, Detroit, Houston, Minneapolis, Philadelphia, Phoenix, San Antonio, San Diego, Seattle, and Washington, DC). Among adult female arrestees, however, cocaine still ranks first in all cities, except for San Diego (where it is exceeded by both marijuana and methamphetamine).

Compared with full-year 1998 levels, cocaine-positive levels among male adult arrestees remained generally stable (<4 percentage points \pm) in the first half of 1999, with some exceptions: levels increased in Miami (7 percentage points) and Washington, DC (13 points); and they declined in Chicago (7 percentage points), Los Angeles (6 points), Philadelphia (8 points), and San Diego (5 points). Among females, however, levels were more volatile: percentages increased markedly (≥ 5 percentage points) in six cities (Dallas, Detroit, Minneapolis, Philadelphia, Phoenix, and San Diego) and declined in two (Houston and Los Angeles). The largest increases were recorded in Dallas (13 percentage points) and Philadelphia (10 points); Houston had the largest decline (10 points).

Boston: "Police contacts report that cocaine is still the number-one street drug, despite the long-term drop in arrests."

Other arrest data generally show level or declining trends:

- Boston: Cocaine arrests stayed level between 1997 and 1998 (at 48 percent of all drug arrests) but well below the 1992 peak (of 66 percent).
- Newark: Cocaine arrests had averaged 4,500 per year between 1991 and 1996, but then declined to 3,608 in 1998 and 3,120 in 1999 through October—still outnumbering heroin arrests.
- New York City: Cocaine arrests in declined 13 percent between 1995 and 1998 (to 35,577).

- Honolulu: Cocaine cases declined between 1997 and 1998 (from 1,045 to 874) and again appeared to be declining slightly in 1999 (408 in the first half).

In Phoenix, however, after declining between 1996 and 1997, opiate/cocaine arrests for manufacturing/sales rebounded in 1998 (to 1,776, or 33 percent of all manufacturing/sales arrests)—but still well below their 1989 peak.

Market Data

Boston: "Most anecdotal reports indicate that cocaine is still heavily trafficked on Boston streets, with increases in the availability of cocaine HCl. "

Washington, DC: "Ethnographic reports indicate that this form of cocaine [HCl] can be found only in particular neighborhoods of Northwest and Southeast DC. ...crack is much more widely available, being found in every neighborhood in the District. "

Increased availability of cocaine HCl is reported in some cities, including Boston, Dallas, Denver, Philadelphia, and Phoenix. In Boston, crack remains the predominant form of cocaine, despite the increased availability of HCl. Crack also remains available in New York City, but at lower levels than in the late 1980s and early 1990s. Cocaine, predominantly crack, is the most frequently encountered drug in Atlanta, where it is usually transported in HCl form and converted for sale as crack by the sellers. Similarly, in St. Louis, most cocaine arrives as HCl and is processed locally into crack. Ready availability of cocaine is also reported in south Florida and Texas.

INCREASING HCl: POSSIBLE EXPLANATIONS...

Boston: "The increase in cocaine HCl availability reported by the DEA and the Department of Public Health drug lab, and the continuing decline of crack in lab submissions may reflect the relatively harsh Federal penalties associated with crack possession and distribution. They may also reflect the stigma of crack use as the drug has taken its toll on long-term users. "

INCREASING HCl: POSSIBLE EFFECTS...

Denver: "...the increased availability of cocaine HCl may be bringing about changes in the cocaine user groups, and thus, in the population entering treatment. "

BEYOND THE CITY LIMITS...

Boston: "Crack remains the predominant form of cocaine in the inner city, with cocaine HCl more popular in nearby suburbs. "

St. Louis: "Crack prices in outlying [rural] areas are stable at \$100 per gram. "

Cocaine HCl and crack prices vary widely across the country (exhibits 10 and 11). In several cities, HCl prices declined recently at some purchase quantities, but crack prices were stable. In Boston, for example, kilogram prices declined, while crack prices remained unchanged. Similarly, in San Diego, the pound price range declined at the low

Exhibit 10. Cocaine hydrochloride prices in reporting CEWG areas

Area	Gram	Ounce	Kilogram
Atlanta	\$100	\$1,000	\$23,000
Boston ^a	\$80-\$100	\$700-\$1,500	\$19,000-\$27,000
Chicago ^b	\$75-\$100	\$650-\$2,200	\$19,000-\$20,000
Denver	\$100-\$125	\$900-\$1,200	NR
Honolulu ^c	\$100-\$120	\$1,100-\$1,500	\$26,500-\$52,000
Los Angeles ^d	\$80	\$600-\$700	\$14,000-\$16,000
Miami ^e	\$40-\$60	\$600-\$700	\$15,000-\$20,000
Minneapolis/St. Paul	\$100	\$850	\$22,000
Newark ^f	NR	NR	NR
New Orleans	\$80-\$150	\$800-\$1,200	\$18,000-\$25,000
New York City	NR	NR	\$25,000-\$30,000
Phoenix ^g	NR	\$500-\$800	\$15,000-\$18,000
St. Louis ^h	\$52-\$100	NR	NR
Seattle	\$30	NR	NR
Texas	\$50-\$275	\$500-\$1,200	\$14,000-\$22,000
Washington, DC ⁱ	\$100-\$200	\$1,050-\$1,200	\$30,000

^aGram purity 50 percent, ounce purity 80 percent, kilogram purity ≥90 percent

^bPurity 61 percent (samples of 2-25 grams)

^cGram purity 20-50 percent, >90 percent pound purity

^dGram purity 80 percent

^ePurity 50 percent

^fPurity 50-60 percent

^gpurity 21-90 percent

^hGram purity 65-90 percent

ⁱPurity 19-95 percent

SOURCE: CEWG city reports, December 1999

end (to \$4,000-\$12,000, with street purity stable at 20-40 percent), but crack prices remained stable. Ounce and kilogram prices dropped in Minneapolis/St. Paul, but gram prices remained stable. Prices in Texas were dropping since 1987 but have remained fairly stable more recently. Stable prices are reported in several other cities: New York City (kilogram level), Newark, New Orleans (both HCl and crack, for the past 3 years), Phoenix, and Seattle.

Atlanta: "Ethnographic information indicates that the price for a rock

fluctuates, and crack is still available for as little as \$5, or sometimes even \$3."

Philadelphia: "During focus group sessions, former drug users new to formal treatment said they perceived crack to be less potent in autumn 1999 than it had been since 1996."

Seattle: "Reports from users indicate that purity has declined compared with a year ago. "

Washington, DC: "Users say the quality is 'up and down. '"

Exhibit 11. Crack prices and purity in reporting CEWG areas

Area	Price/Unit
Atlanta	\$10-\$20/rock \$85-\$100/g \$750-\$1,100/oz \$22,000-\$26,000/kg
Boston ^a	\$10-\$20/vial
Chicago	\$5-\$20/rock
Denver	\$10-\$20/rock
Honolulu	\$5-\$15/dose \$20-\$100/rock \$100-\$150/g \$1,000-\$1,500/oz
Miami	\$5-\$20/bagor vial
Minneapolis/ St. Paul	\$20/rock
Newark	\$3-\$20/vial
New Orleans	\$5-\$25/rock
New York City	\$2-\$10/vial
Philadelphia	\$3-\$5/rock
Phoenix	\$20/rock \$500-\$700/oz
St. Louis	\$25/rock \$40-\$100/g
San Diego	\$10/0.1 g
San Francisco	\$50/g
Seattle	\$20-\$40/rock
Texas	\$10-\$20/rock \$500-\$1,100/oz
Washington, DC ^b	\$3-\$4/rock \$100/g \$24,000-\$27,000/kg

^aPurity 60-80 percent

^bGram purity 30-81 percent

SOURCE: CEWG city reports, December 1999

A few price increases are reported. In Denver, for example, the gram price increased since the last report; but there, too, crack prices remained stable. In Miami, according to the DEA, the kilogram price temporarily

increased by \$2,000 for several days, possibly because of a purposely induced shortage. And, in Washington, DC, since the previous half-year period, gram prices for both cocaine HCl and crack increased somewhat, as did crack kilogram prices.

Seizures, Trafficking, and Distribution

Seizure and submission data still indicate a high level of cocaine activity around the country. In Boston, cocaine HCl submissions have been increasing; crack submissions, however, have been declining. Cocaine is still the most common substance analyzed by crime labs in south Florida. In Minneapolis, the amount seized increased sharply between 1998 and the first three quarters of 1999, as did the number of submissions to the State crime lab. Crack seizures have also increased in New Orleans and its surrounding parishes. Cocaine continues to account for approximately 43 percent of all drug seizures in Washington, DC (15.4 kilograms in the first 9 months of 1999). While seizures of cocaine coming into Washington State decreased slightly between 1998 and 1999, amounts were still higher than in previous years.

BEYOND THE CITY LIMITS...

Chicago: "...the amount of cocaine seized in other areas of the State, especially in rural counties, has increased greatly."

Control of New York City's major crack markets is divided among small trafficking groups, with independent operators able to distribute only in certain areas.

New York: "The Street Studies Unit (SSU) continues to report less visible drug activity in public places. The big 'drug supermarkets,' where sellers operated openly and with impunity, are a thing of the past."

The open-air crack markets that still exist in New York City are smaller and less volatile than in the past. The crack dealers who continue to deal outdoors do so in areas with as much cover as possible, such as passageways in housing projects, the sides of buildings, parks, and playgrounds. Cocaine HCl is generally available through house connections and in nightclubs and bars.

New York City remains a primary source area for Atlanta, as do Florida and Texas.

Cocaine in the Boston area is also trafficked from New York, as well as from Houston, the Southwest border, Puerto Rico, and Miami. Boston's trafficking continues to be dominated by Colombian, Dominican, and Puerto Rican groups.

Gang involvement remains a key feature of cocaine distribution and sales in several cities, including Minneapolis/St. Paul and Seattle.

HEROIN

Boston: "Heroin has established itself as a cheap, pure, easily found alternative to cocaine."

Chicago: "New sociodemographic groups (namely white suburbanites) are visible in heroin-related ED mentions and in prospective surveys of younger IDUs; and prices per milligram of heroin are at their lowest in a decade."

Miami: "The new South American heroin source, increased purity, and decreased price have allowed for new routes of abuse (snorting, smoking) and for new users (those who 'would never inject')."

San Francisco: "Ethnographic observers report that heroin is abundant, cheap, and high quality. Young people (ages 18-25) appear to be using it more. Comments along the lines of 'I first shot up in San Francisco-never before' are often heard."

MORTALITY DATA

Phoenix: "An ME staff member reported several morphine-related deaths among users from the 'traditional/professional' community. They died with the needle still in their arms."

Denver: "An ethnographic report finds that some street youth who initially injected methamphetamine have shifted to heroin injection."

St. Louis: "Most heroin deaths involved older, experienced users and may have resulted from the reported increased purity levels."

Partial-1999 heroin-related mortality data were available in six cities. Compared with 1998 data, projections suggest declines in five cities and an increase in one.

Declines were reported in the following cities:

- Honolulu: First-half-1999 heroin toxicology cases (8) seemed to continue the 1995-98 decline (from 40 to 20).

- Minneapolis/St. Paul: After increasing between 1997 and 1998 (from 33 to 38), opiate-related deaths appeared to be declining slightly in the first half of 1999, when 17 cases were reported. This time period was the first during which the number of opiate- and cocaine-related deaths were equal.
- Philadelphia: Heroin/morphine toxicology reports declined 23 percent between 1997 and 1998 (from 353 to 271) and appeared to decline again in 1999 (119 cases in the first half).
- San Diego: Accidental overdose deaths involving heroin seemed to continue the 1997-98 decline (from 161 to 138) in 1999 (119 projected, based on first-half-year data).
- Seattle: After reaching an all-time high in 1998 (143 deaths), heroin/morphine-caused deaths appeared to decrease in 1999 (61 in the first half).

An increase was reported in Phoenix, where morphine-related deaths (which had been increasing since 1991) continued the upward

trend. A 33-percent increase in deaths between 1998 and 1999 is projected (based on 60 deaths in the first half).

Earlier 1997–98 data show four increases:

- Colorado: Narcotic-related deaths increased (from 98 to 135), continuing a 2-year trend. The 1998 opiate death total was the highest ever recorded in the State.
- Miami-Dade County: The number of heroin-induced deaths increased 30 percent (from 47 to 61).
- San Francisco (FY data): Heroin-caused deaths increased 21 percent (from 107 to 130).
- Texas: Heroin/narcotic overdose deaths increased 12 percent (from 333 to 374).

In the first 9 months of 1998, 270 narcotics-caused deaths were reported in the Baltimore metropolitan area. No comparison data were available.

EMERGENCY DEPARTMENT AND POISON CENTER DATA

Boston: *“Heroin users remain at high risk for overdoses. From March through May 1999, an emergency department reported 179 heroin-related overdoses.*

St. Louis: *“While heroin users have a variety of medical consequences and need detoxification services, these individuals do not seek services from the traditional medical model unless faced with life-threatening situations.”*

In 1998, heroin remained the number-one ED drug mentioned in Newark, San Francisco, and Seattle (exhibit 1). In Baltimore, the proportion of heroin ED mentions equaled that of cocaine. Four other CEWG cities (mostly eastern) also had relatively large proportions (11–19 percent) of heroin ED total mentions: Boston, Chicago, New York, and Washington, DC.

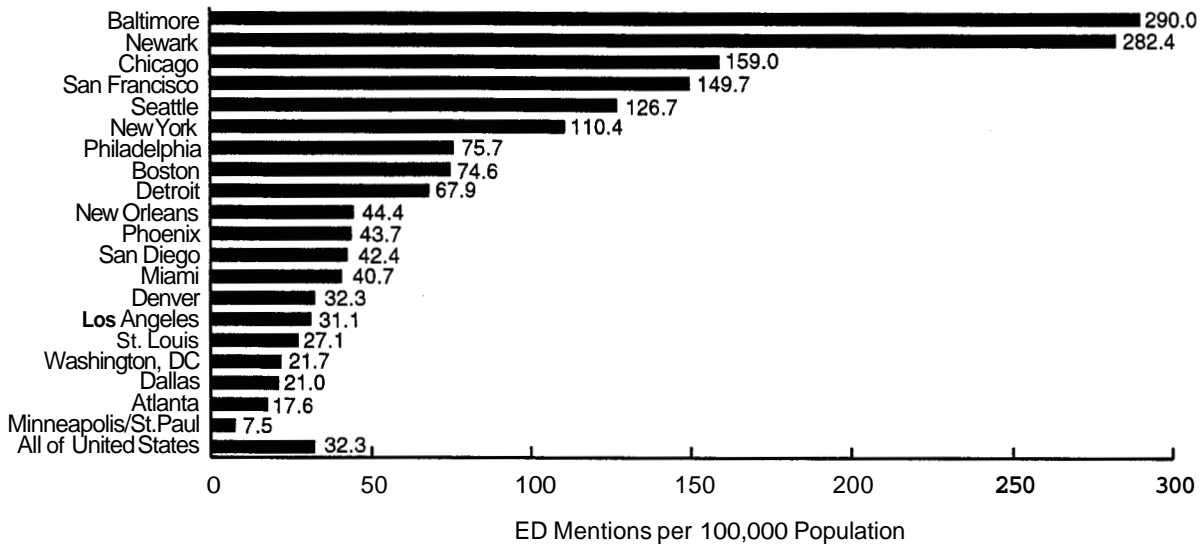
During that time period, Baltimore continued to have the Nation’s highest rate of heroin ED mentions per 100,000 population (290.0); Newark followed closely with 282.4 (exhibit 12). Minneapolis/St. Paul once again had the lowest heroin rate.

Rates are higher than they were 7 years earlier in four out of five top-ranking cities (exhibit 13). In Chicago, Newark, and Seattle, the rates have more than doubled since 1991; only in San Francisco, where rates have declined since 1993, is the rate lower.

Between 1997 and 1998, heroin ED trends were mixed: mentions increased in 14 cities and decreased in 6 (exhibit 14). Increases (ranging from 16 to 29 percent) were significant ($p < 0.05$) in Miami, Newark, New Orleans, and Washington, DC. They were nonsignificant but substantial in St. Louis (where they have increased steadily since 1993) and Atlanta. Only in San Francisco did rates decrease significantly (13 percent); in Seattle, after the 1997 peak, they decreased notably but not significantly (17 percent).

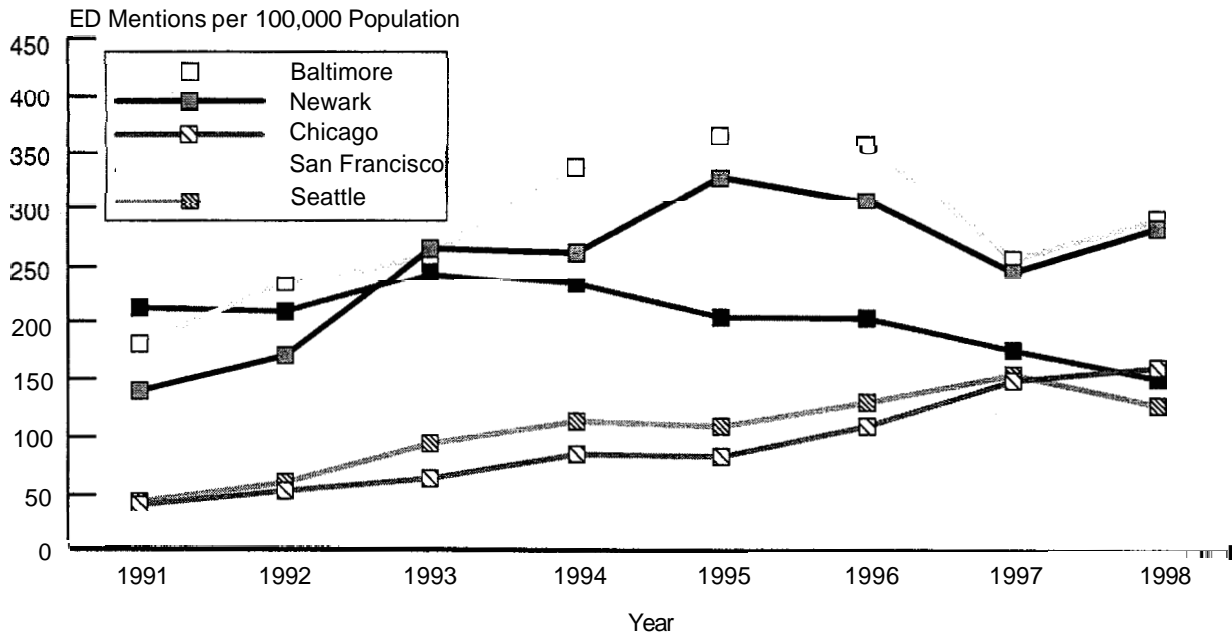
Heroin as a percentage of total ED mentions remained relatively stable, except in Newark, where it continued to increase (4 percentage

Exhibit 12. Estimated rate of heroin/morphine ED mentions per 100,000 population by metropolitan area, 1998



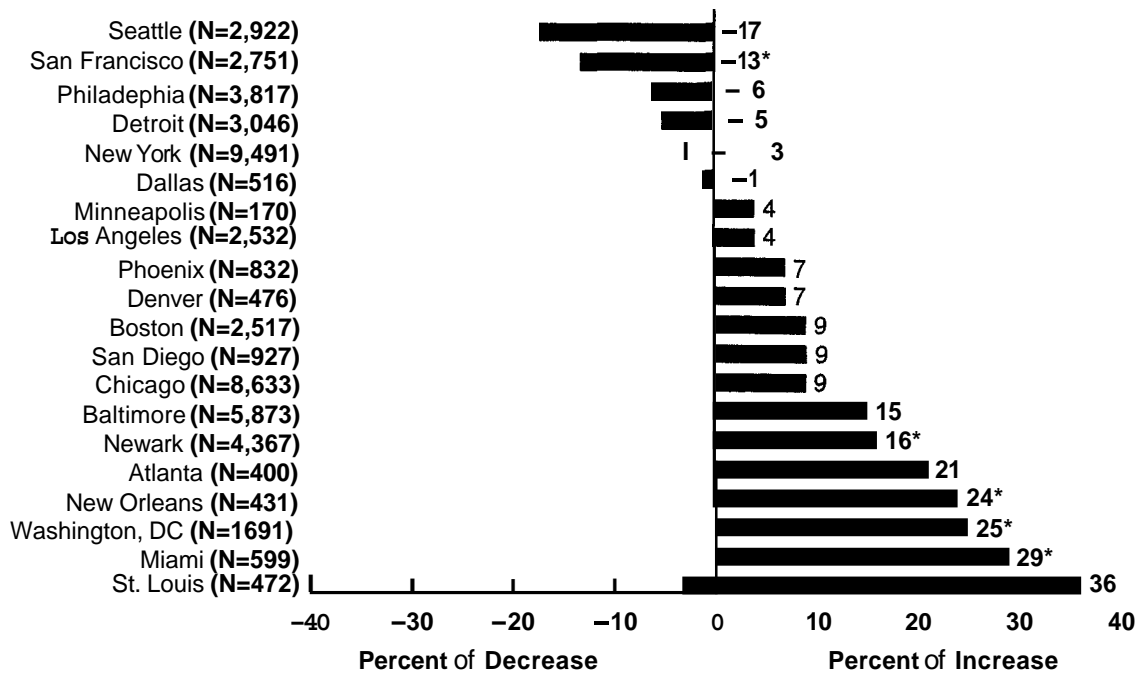
SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

Exhibit 13. 7-Year trends in heroin ED mentions per 100,000 population in the five cities with the highest mentions, 1991–98



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

Exhibit 14. Percentage of change in heroin ED mentions by metropolitan area, 1997 versus 1998



NOTE: (N) refers to 1998 heroin mentions.

*p<0.05

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

points between 1997 and 1998). Thus, both heroin proportions and numbers increased in Newark.

The proportion of poison center calls regarding heroin in various parts of the country remained relatively stable:

- Colorado: The proportion of heroin-related calls was 21 percent in 1994 and 22 percent in 1998.
- Georgia: Opioid-related calls (1,719) accounted for only 2 percent of toxic exposure calls in 1998.

- Massachusetts: The proportion of heroin-related substance abuse calls was 21 percent in January–April 1999, compared with 23 percent in May–September 1999.

TREATMENT DATA

Boston: "Heroin users leaving treatment are particularly at risk due to their lowered tolerance for the drug. . .

St. Louis: "Rapid detoxification, using naltrexone, is a new treatment option at private hospitals. Sources from this program state that calls regarding the treatment have increased in the last year. . .

BEYOND THE CITY LIMITS...

Baltimore: "While heroin has historically dominated the Baltimore City treatment system, in 3 of the 4 years from 1995 through 1998, it was the dominant primary drug in the suburban counties as well. "

Newark: "Treatment data show continuing [and parallel] increases in the use of heroin in both the city and areas outside the city.

In the first half of 1999, heroin remained the number-one primary treatment drug in six CEWG cities: Baltimore, Boston, Los Angeles, Newark, New York City, and San Francisco (exhibits 5 and 15). As a proportion of treatment admissions, it also accounted for a high percentage in Philadelphia, Seattle, and Washington, DC.

Between the first halves of 1998 and 1999, heroin as a proportion of treatment admissions decreased notably in three cities: Boston, Newark, and San Francisco (by 9, 12, and 13 percentage points, respectively). By contrast, in St. Louis, heroin increased 6 points to 18 percent of treatment admissions.

Though heroin remained stable as a primary drug among Denver admissions, the proportion of new heroin users entering treatment increased between 1995 and 1998 (from 15 to 20 percent). However, a slight decline occurred during the first half of 1999 (to 17 percent).

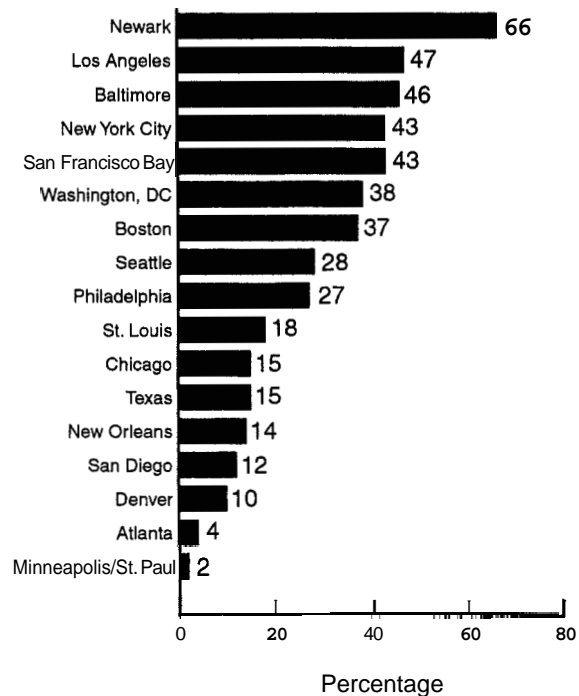
OTHER LOCAL DATA

A study of Seattle area drug injectors suggests that heroin use increased in 1998,

particularly among younger injectors. The proportion of new study recruits reporting heroin as their primary injection drug increased from 61 percent in 1994 to 86 percent in 1999. Among injectors younger than 20, the proportion reporting heroin increased from 78 to 100 percent in 1998.

Among Chicago infants tested for controlled substances, opioid toxicity remained stable between 1997 and 1998 (9 percent positive).

Exhibit 15. Heroin as a proportion of primary drugs of abuse among treatment admissions^a, first half 1999b



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

^bReporting periods are January-June 1999, except for the following: January-June 1998 in Baltimore; July 1998-March 1999 in Boston; July-September 1999 in Los Angeles; full calendar year 1998 in Chicago; and FY 1999 in San Francisco.

^cAlcohol-only is not excluded.

SOURCE: State drug abuse treatment agencies

School survey data in various parts of the United States show relatively low levels of heroin use by youth:

- Chicago: Surveys conducted every 2 years indicate that heroin use is relatively rare among students: about 1.5 percent reported past-year use in 1997.
- Massachusetts: 1996–97 data show that heroin and other opiate use remains low among adolescents and that students perceive it as involving substantial risks.

USE PATTERNS

Route of Administration

BEYOND THE CITY LIMITS...

Chicago: "The high enrollment of suburban youth in...[a recently initiated prospective study of younger injectors in Chicago and its surrounding suburbs], coupled with increasing heroin ED admissions outside central city borders, indicate that heroin use, specifically by injection, is no longer primarily an urban or inner-city phenomenon. "

Chicago: "Brown and black tar heroin are typically sought only by those who inject, although reports indicate that some users dissolve black tar heroin and drip the solution into their nostrils. "

Newark: "The substitution of snorting for injection among heroin users is believed to have resulted from improved heroin purity and the heavy toll of AIDS among IDUs."

St. Louis: "Younger users report a fear of needles as the reason for alternative methods of administration; the increased availability of consistent, higher purity heroin has led to a wider acceptance of the drug because needle administration is not necessary."

Injecting remains the most common mode of administration among treatment admissions in the majority of reporting CEWG cities, with the highest percentages reported in the West, where lower purity black tar heroin still predominates (exhibit 16).

Atlanta: "Heroin use remains comparatively low, although intranasal administration is becoming more prevalent, especially among younger users. "

Miami: "New users, intranasal heroin snorters, are now those who most frequently appear to be in trouble with that drug. "

Texas: "While the number of individuals who inhale heroin is small, it is significant to note that their lag period in seeking treatment is 8 years rather than 14 for injectors. This shorter lag period suggests that contrary to street rumors that 'sniffing or inhaling is not addictive,' inhalers will need treatment much more quickly than needle users. "

Snorting remains the most common route of administration for heroin in three cities: Chicago, where heroin snorting admissions rose 90 percent between FYs 1993 and 1997; Newark, where, conversely, heroin injection continues to show an upward trend in recent years, especially among Hispanics and African-Americans; and New York City, where the upward trend in snorting continues. Notable increases in the proportion of treatment clients who snort heroin between

the first halves of 1998 and 1999 were recorded in Atlanta (from 15 to 29 percent). The percentage of treatment clients who snort also continues to rise in Philadelphia (from 29 to 39 percent between the first halves of 1996 and 1999) and in Denver, where a small but steady upward trend of both snorters and smokers continues. In Baltimore, the increase in heroin treatment admissions between the two halves of 1998 was driven primarily by an increase in clients snorting in both the city and suburban counties.

FROM SNORTING TO INJECTING?

Boston: "Due to high heroin purity, snorting is the common starting route of administration for new and younger users. However, progression to injection is widely reported due to the increased effect from a given amount of heroin and the need to buy fewer bags to support one's habit. "

In St. Louis, the proportion of snorting declined while injecting increased (from 62 to 69 percent). Likewise, in Minneapolis/St. Paul, injecting increased slightly (from 53 to 59 percent between 1997 and the first half of 1999), while snorting decreased.

Denver: "Reports suggest that smoking heroin enables users [especially younger users] to avoid the stigma and health risks associated with injecting. "

In all reporting CEWG cities, the proportion of treatment clients who smoke heroin

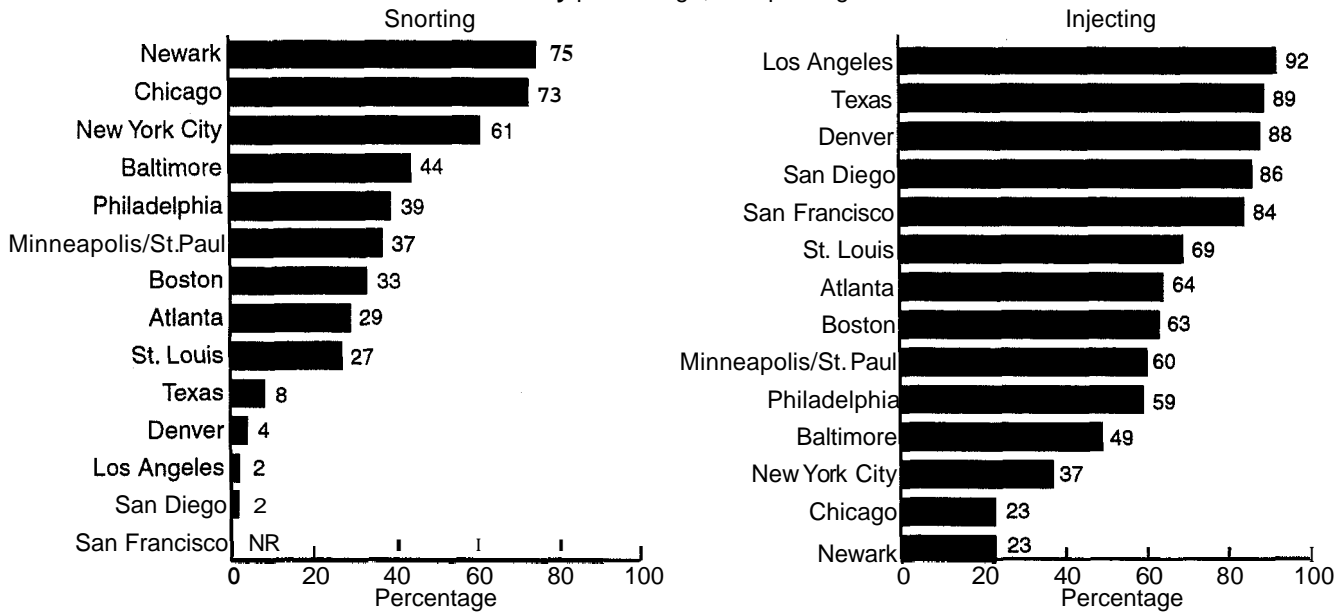
remains low—0–3 percent in eastern and midwestern cities and 4–10 percent in western cities. In San Diego, the proportion of heroin treatment clients who smoke doubled between the first halves of 1998 and 1999 (from 5 to 10 percent).

Route of administration often varies demographically. In CEWG areas reporting on age and route of administration among treatment admissions, injectors tend to be older than snorters. In Texas, for example, where 93 percent of heroin clients inject, the average age of heroin injectors was 5 years older than those who snort (36 and 31 years, respectively). In Baltimore, the average age of admission was 34 for injectors and 31 for snorters. In New York City, those who inject are more likely to be older than those who snort.

Based on geographic location, route of administration also tends to follow certain patterns along racial/ethnic lines. For example, in Baltimore, Texas, and Newark, African-Americans are more likely than other groups to snort, while in New York City, those who snort are more likely to be Hispanic. A higher percentage of whites and Hispanics inject rather than snort in Texas; in New York City, heroin injectors are more likely than snorters to be white.

In both Baltimore and Texas, females are more likely to snort than inject, and the proportions of males and females who snort are almost equal.

Exhibit 16. Snorting versus injecting^a among heroin admissions, by percentage, in reporting CEWG areas^b



^aSmoking and "other" routes of administration also account for small percentages in some areas.

^bReporting periods are January-June 1999, except for the following: January-June 1998 in Baltimore; July 1998-March 1999 in Boston; full calendar year 1998 in Chicago; July-September 1999 in Los Angeles; and FY 1999 in San Francisco.

SOURCE: State drug abuse treatment agencies

Multisubstance Use

Boston: "Focus group participants and treatment providers suggest that toxic additives to heroin (including scopolamine and ketamine) and the co-occurring use of benzodiazepines, synthetic opiates, cocaine, and alcohol may increase the risk of heroin overdose."

Chicago: "Recent field reports, especially from the South Side, indicated an increased use of heroin/cocaine combinations (speedball), now nicknamed 'John Belushi,' and of clonidine (Catapres) or amitriptyline (Elavil) immediately after injecting heroin (or methadone)."

In Seattle, through mid-September 1999, multiple drugs were present in more than 80 percent of the heroin-related deaths, with cocaine as the most common other drug, suggesting speedball use. High proportions of cocaine detected in heroin-related deaths were also reported in Philadelphia during the first half of 1999, when it was detected in 43 percent of heroin-positive decedents. In Minneapolis/St. Paul during the same time period, 3 of 17 heroin-related deaths in the first half of 1999 also involved methadone. In Seattle, deaths caused by the combination of depressants (usually diazepam) and heroin, first noted in 1998, continued in 1999.

New York City: "Treatment programs testing new admissions for heroin are sometimes finding drugs other than heroin. One program reports that several recent admissions tested positive for methadone and zidovudine (AZT) (Retrovere). The newly admitted patients were surprised by the findings because they were certain they were using heroin."

In all CEWG areas reporting on polydrug mentions among heroin treatment admissions in the first half of 1999, cocaine is the secondary drug most mentioned, except in Boston and Texas, where alcohol is the most mentioned secondary drug. Alcohol is the most common tertiary drug among heroin admissions in all reporting CEWG areas except Atlanta and Minneapolis/St. Paul, where marijuana is the most common tertiary drug. The rate of polysubstance use among primary heroin users in Boston was the highest for any primary drug, with 88 percent reporting the use of at least one other illicit drug in the month prior to admission. In Texas, 35 percent of primary cocaine admissions in the first half of 1999 reported opiates as their secondary drug.

In Baltimore, Boston, Chicago, New York City, Philadelphia, St. Louis, San Francisco, and Seattle, IDUs reportedly continue to inject heroin and cocaine (speedballs). In Chicago, pharmaceutical depressants are frequently combined with heroin. In Texas, **methylenedioxymethamphetamine (MDMA)** combined with heroin was reported.

DEMOGRAPHIC DATA

Denver: "Anecdotal information from local researchers corroborates treatment analyses, with reports suggest-

ing an increased number of college students are using heroin. "

*Philadelphia: "For the seventh consecutive half-year, focus group participants reported that new users entering the prevalence pool are likely to be in their teens and male or female in even proportions, and **1998-99** groups reported they are likely to be white, African-American, or Hispanic in even proportions. "*

Age

*Boston: "Most focus groups among adolescents revealed relatively low awareness and use of heroin compared with marijuana, diverted prescription medications, **LSD**, or MDMA. However, anecdotal reports suggest that heroin snorting has increased among high school youth. "*

In CEWG areas reporting mortality demographics, heroin decedents were most often in their late thirties or forties. In Philadelphia, the 25-and-younger age group was involved in 11 percent of heroin/morphine detections in the first half of 1999, a decline from 23 percent during the previous half-year. In Texas, where heroin overdose deaths have increased annually, the average age of decedents dropped from nearly 40 in 1997 to 37 in 1998.

The 35+ age group still accounts for the highest percentage of heroin ED mentions in all cities, except in Phoenix where the 26-34 group (at 43 percent) is slightly larger than the 35+ age group (exhibit 17). High percentages (>30 percent) are also recorded for the 26-34 group in six other cities (Baltimore, Boston, Chicago, Miami, Newark, and Philadelphia). In three cities, the 18-25 group accounts for >20 percent (Dallas,

New Orleans, and Philadelphia). The 12–17 age group still accounts for ≤ 1 percent in all cities, except in Dallas, New Orleans, Philadelphia, and St. Louis, where that age group accounts for at least 2 percent of heroin mentions. Heroin ED mentions in that youngest group are a relatively new phenomenon, but they were recorded in more than half the CEWG cities in 1998.

Heroin ED age distributions from 1991 through 1998 show generally steady declines in the 26–34 age group—possibly as that group has been transitioning into the next age bracket. Also apparent is the emergence of a younger cohort (18–25) in many cities.

Increases in both number and proportion of heroin ED mentions involving those younger than 26 suggest that heroin consequences among this group are growing. Between 1996 and 1998, heroin ED mentions among the youngest age group (12–17 years) increased significantly ($p < 0.05$) in three cities (Baltimore, Chicago, and Seattle); they did not decline significantly in any city. During that same time period, heroin mentions among the 18–25 group increased significantly ($p < 0.05$) in 10 cities (Atlanta, Baltimore, Dallas, Denver, Miami, Minneapolis/St. Paul, New Orleans, Philadelphia, Phoenix, and San Diego), and the proportion of that group among ED mentions increased by 5 points in 4 cities. Conversely, significant declines in heroin mentions among that age group were noted in two cities (Los Angeles and San Francisco).

Heroin ED trends among the 26–34 age group were mixed: mentions increased significantly in Dallas, Miami, and New Orleans; they declined significantly in New York and San Francisco. During that same

period, heroin mentions among the 35+ age group declined significantly in only one city (San Francisco) and increased significantly in seven (Dallas, Denver, Miami, Minneapolis/St. Paul, New Orleans, Phoenix, and Washington, DC).

Atlanta: *"Treatment admission data confirm ethnographic evidence of an emerging younger cohort of heroin users, many of whom are snorting the drug. In addition, a number of 'old dope fiends' resumed their habit when they got their hands on high-quality heroin."*

Boston: *"Treatment providers reported increases among heroin injectors in their late teens, and statewide data show that from FY 7992 to the first three quarters of 1999, primary heroin users rose from 4 percent of all adolescent admissions to 13 percent."*

Similar to heroin ED mentions, in most reporting areas, the largest percentage of heroin primary treatment clients in the first half of 1999 was 35 years or older, except in Boston, where the 26–34 age group was largest (exhibit 18). Large proportions (33–42 percent) of the 26–34 group were noted in seven cities. The 18–25 group remains the smallest group (next to the 17-and-younger group, which ranges from 0 to 3 percent) in most CEWG areas, with proportions among heroin admissions ranging from 2 percent in Washington, DC, to 28 percent in Boston.

Between the first halves of 1998 and 1999, the 18–25 group among heroin treatment admissions increased notably (≥ 5 percentage points) in Minneapolis/St. Paul and San Diego. Proportions for this age group did not decline in any cities, suggesting that this young cohort may be increasing. The 26–34 group increased notably in Atlanta (by 18

percentage points). The 35+ age group seeking heroin treatment remained relatively

stable in proportion, with an increase noted in Boston and a decline in Atlanta.

Exhibit 17. Age distribution of total heroin ED mentions, by percentage, in reporting CEWG areas, 1998

Area	12-17	18-25	26-34	35+
Atlanta	...	16	29	53
Baltimore	1	14	*31	53
Boston	<1	17	*31	51
Chicago	1	13	33	53
Dallas	3	33	21	43
Denver	...	19	20	61
Detroit	1	8	17	74
Los Angeles	<1	7	25	67
Miami	...	10	33	56
Minneapolis/ St. Paul	...	16	"25	58
Newark	<1	*12	"36	51
New Orleans	2	30	27	*41
New York City	<1	7	22	70
Philadelphia	2	23	31	*43
Phoenix	...	14	43	*42
St. Louis	2	18	24	*57
San Diego	...	14	23	*62
San Francisco	...	10	21	68
Seattle	1	12	27	60
Washington, DC	<1	74

NOTES: "...” denotes estimate does not meet standard of precision or is less than 10 percent. Bolded areas reflect percentages that have increased by ≥5 percentage points since 1996.

* Percentage has declined by ≥5 percentage points since 1996.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

Exhibit 18. Age distribution of primary heroin treatment admissions, by percentage, in reporting CEWG areas^a

Area	18-25	26-34	35+
Atlanta	14	38	^b 49
Baltimore	18	35	44
Boston ^c	28	42	29
Denver	15	24	60
Chicago	12	36	51
Los Angeles	6	20	74
Minneapolis/ St. Paul	19	33	47
Newark	7	39	54
New York City ^d	7	34	59
St. Louis	23	18	58
San Diego	24	23	52
San Francisco ^e	NR	NR	67
Texas	21	24	53
Washington, DC	2	11	86

NOTE: Bolded areas reflect percentages that have increased by ≥5 percentage points since the previous reporting period.

^aReporting periods are January–June 1999, except for the following: January–June 1998 in Baltimore; July 1998–March 1999 in Boston; full calendar year 1998 in Chicago; July–September 1999 in Los Angeles; and FY 1999 in San Francisco.

^bPercentage has declined by ≥5 points since the previous reporting period.

^cAge categories are 19–29, 30–39, and 40+.

^dAge categories are <26, 26–35, and 36+.

^eAge categories are 36+.

SOURCE: State drug abuse treatment agencies

BEYOND THE CITY LIMITS...

Baltimore: "Both indicators and anecdotal evidence point to a substantial and growing heroin problem among youth, particularly in the suburban counties surrounding Baltimore City."

Boston: "Needle exchange contacts in Boston proper report mostly traditional, older clients who have injected heroin for many years, while exchanges in Cambridge and Northampton (in western Massachusetts) have seen an increase in younger heroin injectors. Interviews with some of these injectors suggest that early onset of heroin use, sometimes in the midteens, is not uncommon."

Chicago: "A recently initiated prospective study of younger injectors in Chicago and its surrounding suburbs identified 715 drug injectors age 18-30. Among these, heroin use is nearly universal (99 percent). ...nearly 40 percent of the sample report a suburban residence, and suburban injectors are significantly more likely than urban respondents to be younger than 25."

In San Diego, anecdotal reports of adolescent heroin use continue to surface, particularly in the north county area, but use was not reflected in the data sets reported. In Boston, only 5 percent of the juveniles committed to the Department of Youth Services programs in 1998 reported lifetime heroin use, compared with 21 percent for cocaine.

Gender

Males predominate in heroin mortality figures in all areas where such data are available: Miami (91 percent of heroin-induced deaths in 1998); Minneapolis/St.

Paul (94 percent of opiate-related deaths in the first half of 1999); San Diego (92 percent of accidental heroin overdose deaths in the first half of 1999); San Francisco (76 percent of heroin-caused deaths in FY 1998); and Texas (80 percent of heroin overdose mentions in 1998).

Males also outnumber females as a percentage of heroin ED mentions in all the CEWG cities in DAWN, although the gender gap seems to be narrowing. The male-female gender gap remains widest in New Orleans (83 versus 17 percent, although it seems to be narrowing) and remains narrowest in Chicago (58 versus 42 percent, where it continues to narrow).

Between 1997 and 1998, heroin mentions among females increased significantly ($p < 0.05$) in seven cities; furthermore, the proportion of females among heroin mentions increased notably (>2 percentage points) in five cities. The greatest increases in the proportion of females among heroin admissions occurred in Dallas and San Diego (by 6 and 12 percentage points, respectively). By contrast, the percentage of females among heroin mentions declined notably in only two cities, and heroin mentions among females declined significantly only in San Francisco.

Similarly, among treatment admissions, males outnumber females in every CEWG reporting area. Women had the largest representation in Phoenix, Chicago, Baltimore, and Newark (46, 45, 44, and 44 percent of heroin admissions, respectively) and the smallest representation in New Orleans (18 percent). Unlike gender distribution for ED mentions between 1997 and 1998 (when the proportion of females generally increased or

remained stable), females declined among heroin treatment admissions in almost every reporting area. The largest declines were in New Orleans, St. Louis, and Philadelphia (by 13, 10, and 8 percentage points, respectively).

FEMALE ARRESTEES TEST OPIATE-POSITIVE AT HIGHER RATES THAN MALES: A POSSIBLE EXPLANATION...

Females might have higher opiate-positive levels than males because they are more likely to be arrested on drug and prostitution charges, categories that historically are likely to be drug-positive.

Women continue to appear more prominently in the **ADAM** data than in other indicators: female arrestees tested higher for opiates than males in 10 of the 16 cities where female arrestees are tested (exhibit 19). Chicago had the highest proportion of female arrestees testing opiate-positive (22 percent), followed by San Diego and Seattle (21 percent each). The gender gap was largest in Minneapolis.

Race/Ethnicity

Whites predominate in heroin mortality figures in all areas where such data are available, although African-Americans and Hispanics are overrepresented. In Texas in 1998, 55 percent of persons dying from heroin use were white (a proportion that has been increasing over the years); 32 percent were Hispanic; and 12 percent were African-American. Whites were also the majority in San Diego (72 percent of accidental heroin overdose deaths in the first half of 1999); Hispanics totaled 24 percent. In Miami, whites constituted 71 percent of heroin-

induced deaths in 1998; African-Americans and Hispanics accounted for 15 percent each. In Minneapolis/St. Paul, whites and African-Americans constituted almost equal proportions of opiate-related deaths in the first half of 1999 (53 and 47 percent, respectively).

African-Americans, as a proportion of heroin ED mentions, were overrepresented in many CEWG areas in 1998. African-Americans were the largest ethnic/racial group in nine cities (Atlanta, Baltimore, Chicago, Detroit, Newark, New Orleans, New York, St. Louis, and Washington, DC); whites predominated in eight cities (Boston, Dallas, Denver, Miami, Minneapolis/St. Paul, Philadelphia, Phoenix, and San Diego); and Hispanics were the largest group in Los Angeles.

Heroin ED mentions involving Hispanics seems to be increasing in several cities: significant increases ($p < 0.05$) were noted in four cities (Boston, Denver, New York, and Washington, DC); however, mentions declined significantly in Seattle. Heroin ED mentions involving whites also increased significantly between 1997 and 1998 in six cities (Boston, Chicago, Dallas, Denver, Miami, and San Diego) and declined significantly in none. Heroin ED mentions involving African-Americans increased significantly in five cities (Atlanta, Denver, Miami, New Orleans, and Washington, DC) and declined significantly in Phoenix.

Among treatment admissions, whites predominate, but African-Americans and Hispanics are often overrepresented. In the last reporting period, whites constituted the highest proportion of heroin treatment admissions in seven areas reporting treatment demographics (Atlanta, Boston,

Denver, Minneapolis/St. Paul, Phoenix, San Diego, and San Francisco); African-hericans predominated in five areas (Baltimore, Chicago, Newark, St. Louis, and Washington, DC); and Hispanics were the predominate group in three (Los Angeles, New York City, and Texas).

Between the first halves of 1998 and 1999, African-Americans as a proportion of heroin treatment admissions declined in eight reporting areas (Atlanta, Baltimore, Chicago, Los Angeles, Minneapolis/St. Paul, Newark, San Diego, and Washington, DC); conversely, they increased in three (Denver, St. Louis, and San Francisco). Whites as a proportion of heroin treatment admissions increased in five areas (Atlanta, Baltimore, Chicago, Denver, and Minneapolis/St. Paul) and declined in three (St. Louis, San Francisco, and Texas). Hispanics increased in five areas (Denver, Los Angeles, New York City, San Diego, and San Francisco) and declined in Minneapolis/St. Paul.

LAW ENFORCEMENT DATA

Arrestee Data

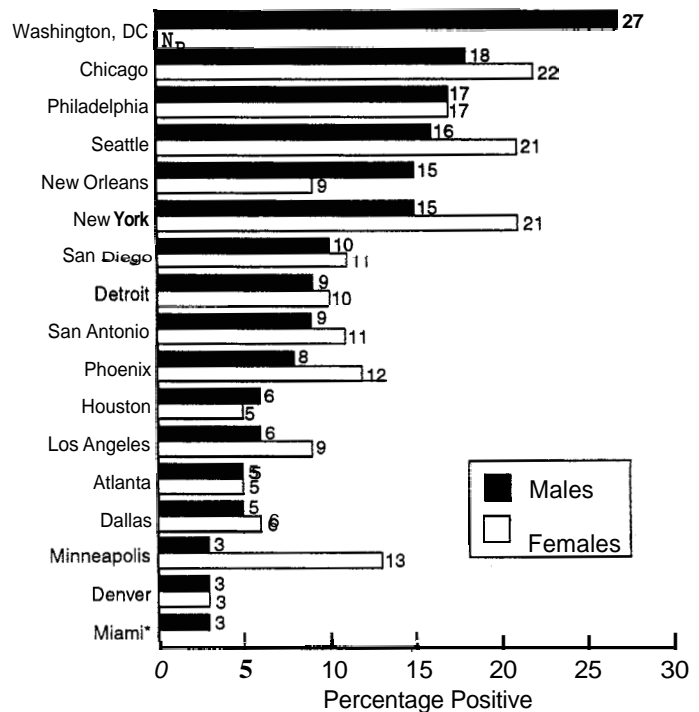
Los Angeles: "Heroin use by juvenile male arrestees, while still less than 1 percent, is persistent; increased purity may account for this persistence, allowing the drug to be snorted instead of injected. "

Opiate-positive screens among male arrestees remain low relative to those for cocaine and marijuana. Among adult males, seven CEWG cities in the **ADAM** program, spanning all regions of the country, had levels of 10 percent or higher in the first half of 1999: Chicago, New Orleans, New York City, Philadelphia, San Diego, Seattle, and

Washington, DC (exhibit 19). Opiate-positive levels in this population remained relatively stable between 1998 and the first half of 1999. Washington, DC, was an exception: levels there increased during that period from less than 10 percent to 27 percent, although first-half-1999 sample size was relatively small (N=37). According to the District of Columbia Pretrial Services Agency, opiate-positive levels for adult arrestees remained stable between 1998 and the first 10 months of 1999 (11 and 13 percent, respectively).

Among female arrestees, opiate-positive screens remain low relative to those for cocaine; however, in many CEWG sites in

Exhibit 19. Percentage positive for opiates among male and female booked arrestees, first half 1999 (ranked by males)



*Females are not tested at this site.

SOURCE: National Institute of Justice, November 1999 files, preliminary data

the **ADAM** program, they almost equal marijuana-positive levels. In the first half of 1999 among adult females, eight cities had opiate-positive levels higher than 10 percent: Chicago, Minneapolis, New York, Phoenix, Philadelphia, San Antonio, San Diego, and Seattle. Between 1998 and the first half of 1999, levels among females increased notably in four CEWG sites (Minneapolis, New Orleans, Phoenix, and Seattle) and declined notably in two (Chicago and Detroit).

Different types of law enforcement indicators show increases in various cities:

- Boston: Heroin arrests accounted for 23 percent of all drug arrests in 1998—level with the previous year, but substantially higher than the all-time low of 13 percent in 1992.
- New York: Numbers and trends in heroin arrests are similar to those involving cocaine: They peaked in 1995, declined slightly (7 percent) in 1997, but increased 6 percent in 1998, surpassing the number of cocaine arrests that year.
- San Francisco: Heroin-related arrests increased 10 percent between 1997 and 1998 (to 7,214—the highest number in the past 6 years).
- Seattle: Heroin-related convictions have continued to increase since 1996; the highest number of heroin convictions ever is projected for 1999.

Heroin cases reported by Honolulu police remained stable between the first halves of 1998 and 1999.

Availability

BEYOND THE CITY LIMITS...

Baltimore: "The city's open-air drug markets seem to be the source of much of the heroin used in suburban counties. "

Chicago: "Younger IDUs use white heroin most often, as it tends to be what they started out using. Brown is more popular among some older addicts, who perceive it to have higher purity. "

St. Louis: "The DEA's Domestic Monitor Program (DMP) purchased equal quantities of heroin on both the north and south sides of the city, indicating wider market availability."

Washington, DC: "Ethnographic data continue to show that, although police activity intermittently makes heroin procurement difficult, a steady supply is available in many sections of the District of Columbia. "

Washington, DC: "Users have recently reported using a variant called 'bag delight' from New York City, which purportedly does not need to be heated in order to dissolve."

Different types of heroin are available in the United States (exhibit 20). High-quality white or yellow heroin from Colombia, South America (SA) dominates the east coast market and has spread to cities in the central U.S. region. Lower quality Mexican black tar and brown heroin predominate in the U.S. West and Southwest but are also available in the Midwest and have recently increased in purity. Southeast Asian (SEA) and Southwest Asian (SWA) heroin availability declined in recent years, but these varieties are still reported in some cities.

For example, in Boston, small amounts of SWA and SEA are available, although most heroin is SA; in Atlanta, most comes from SA followed by SEA; and in New Orleans, SA (yellow and white), SEA (white), and Mexican (brown and black tar) heroin are available. Various types of heroin, including brown and black tar, are also available in Chicago, but white heroin is the most available and common for injectors and snorters alike.

Most heroin available in St. Louis is Mexican dark brown or black tar and is of consistent quality. Likewise in Hawaii, where high purity black tar (67 percent pure) is readily available in all areas of the State. China white is uncommon there, but present.

Seizures and Submissions

Information on heroin seizures and submissions in reporting CEWG areas is mixed:

- Boston: Heroin submissions declined from a relatively high 17 percent of all drug samples analyzed in 1998 to 15 percent during the first half of 1999.
- Miami: More than 80 heroin seizures were reported in the first half of 1999.
- Newark: Heroin seizures appear to be decreasing, based on comparisons between the first 10 months of 1998 and 1999 (3,372 and 2,362 seizures, respectively).
- Washington, DC: Seizures appear to be increasing from the 1997 and 1998 levels, based on numbers from the first 9 months

of 1999 (714 seizures). Heroin seizures in the first quarter of 1999 represented 12 percent of total drug seizures.

Price

Washington, DC: *"In a neighborhood in lower Northwest DC, 'bone,' a putatively uncut heroin used primarily for snorting, is sold in \$20, \$50, and \$70 bags. --*

Exhibit 20 lists price information reported at the local level. The prices reflect stable or declining trends in most reporting cities, except in Atlanta, where gram prices doubled since the last reporting period. Heroin prices appear to be declining in seven CEWG reporting areas: Denver (gram prices declined at the lower level by one-half), Honolulu (gram prices declined at the upper level), Los Angeles (gram prices declined), Minneapolis/St. Paul (gram and ounce prices were high but declined by one-half), south Florida (kilogram prices declined at the upper level), Texas (the highest ounce and lowest kilogram prices for black tar declined), and Washington, DC (upper-level gram prices declined).

Heroin street prices range from \$6 to \$20 per bag (in Boston, Chicago, New York City, Philadelphia, south Florida, and Washington, DC), per capsule (in St. Louis and Texas), and per "bundle," foil-packaged 1/10 gram one-hits, (in St. Louis). A much higher price per dosage unit (\$50) was reported in Minneapolis/St. Paul, perhaps because high-purity heroin is only sporadically available. In New York City and Washington, DC, dealers sometimes offer promotions, such as three bags for the price of two or even one.

Executive Summary: Heroin

Based on preliminary data at the national level, the DMP reported more increases than declines. Prices per milligram pure increased in 10 cities between 1998 and the first half of 1999 (Boston; Dallas; Denver; Houston, notably by \$1.14; Miami, notably by \$2.56; Newark; New York; San Francisco; St.

Louis; and Washington, DC), declined in 6 cities (Baltimore, Chicago, Detroit, Los Angeles, New Orleans, and Seattle), and remained relatively stable in 4. First-half-1999 DMP prices continued to show wide variations across the country (exhibit 21).

Exhibit 20. Heroin prices in reporting CEWG areas

Area	Type/Source ^a	Gram Price	Ounce Price	Kilogram Price
Atlanta	SA, SEA	\$300	\$6,000	\$106,000
Baltimore	SA	NR	NR	NR
Boston	SA	NR	\$2,500-\$3,100	NR
Chicago	SEA, SA, SWA, Mexican	\$100-\$175	\$800-\$2,000	NR
Denver	black tar	\$60-\$120	\$1,800-\$3,500	NR
Honolulu	black tar, China white	\$150-\$200	\$3,000	NR
Los Angeles	black tar	\$60-\$80	^b \$500-\$800	\$18,000-\$22,000
Minneapolis/St.Paul	NR	\$250	\$2,000	NR
New Orleans	SA (yellow, white), SEA, Mexican brown, black tar	\$300-\$600	\$4,000-\$9,000	\$130,000-\$160,000 (per unit)
New York City	SA	NR	NR	\$75,000-\$100,000
Philadelphia	NR	\$100	NR	NR
Phoenix	black tar, SA	NR	NR	NR
St. Louis	black tar, Mexican brown	\$250-\$600	NR	NR
San Francisco	Mexican	NR	NR	NR
South Florida	SA	\$100-\$200	NR	\$85,000-\$125,000
Texas	black tar	\$120-\$300	\$700-\$5,000	\$62,000-\$175,000
	Mexican brown	NR	\$900-\$3,500	NR
	SEA	NR	\$3,500-\$5,500	\$150,000-\$175,000
	SWA	NR	NR	\$85,000
	SA	\$1,000	NR	
Washington, DC	SA	NR	NR	NR

^aSA denotes South American; SEA, Southeast Asian; and SWA, Southwest Asian.

^b"pedazo" (a Mexican ounce)

SOURCE: CEWG city reports, December 1999

Purity

BEYOND THE CITY LIMITS...

Atlanta: "According to ethnographic information, heroin purity varies drastically depending on geographic location. Purity levels are dropping in a number of inner-city neighborhoods with a long history of heroin use, and purity in newer areas is higher. The highest levels were mentioned by young, new, female heroin users residing in suburban areas."

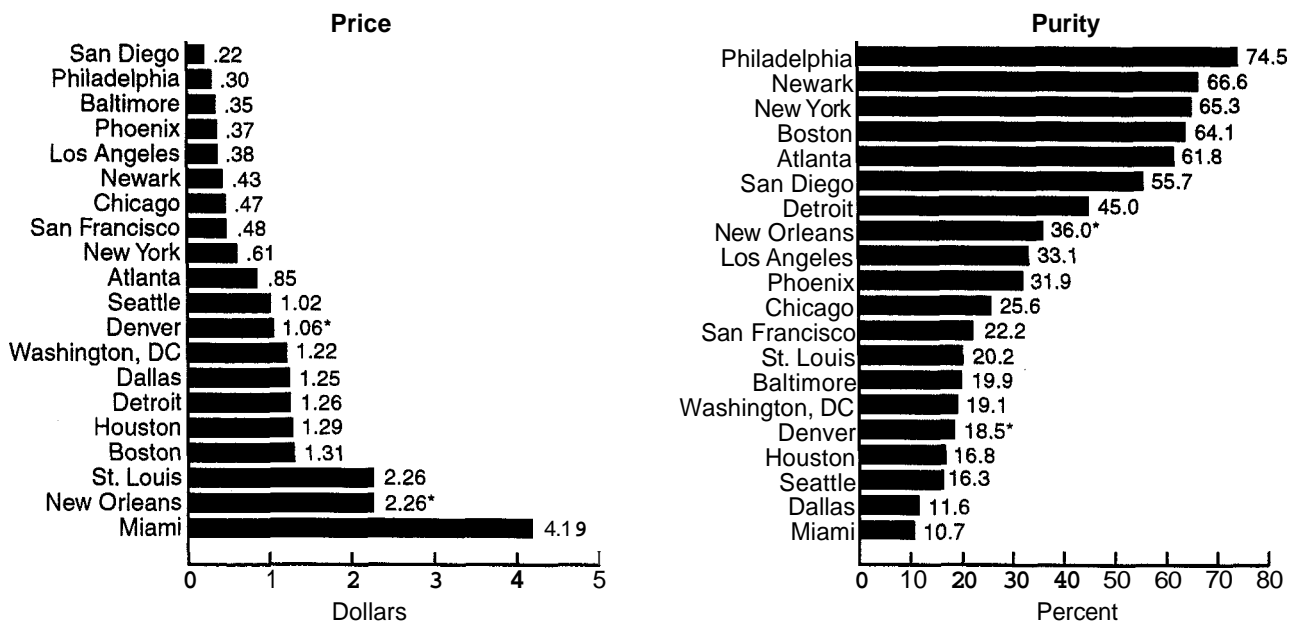
According to the **DMP**, street-level purity remained highest in the Northeast (exhibit 21). The highest average purity of all controlled heroin buys recorded in the first half of 1999 was in Philadelphia, where purity increased 4.5 percentage points since 1998. During the same time period, purity in-

creased notably (4–6 percentage points) in four other cities (Atlanta, Los Angeles, Newark, and New Orleans), and declined by at least 3 percentage points in eight cities (Baltimore, Denver, Houston, Miami, San Francisco, Seattle, St. Louis, and Washington, DC), with particularly steep declines in Denver and Houston (21 and 18 percentage points, respectively). Purity levels remained relatively steady in all other cities.

Trafficking and Distribution

Increases in trafficking have been reported in several CEWG reporting areas, including an increase in Colombian heroin transshipped thorough Texas to the northeastern United States. Law enforcement officials in New Orleans have also noted an increase in heroin trafficking.

Exhibit 21. Average heroin price and purity per milligram in CEWG cities, first half 1999



*Second-quarter-1999 data only

SOURCE: DEA Domestic Monitor Program, Intelligence Division, Domestic Unit, unpublished data for first half 1999

South Florida's heroin epidemic is linked to the active marketing of Colombian heroin that has been moving into south Florida since the beginning of this decade.

In New York City, heroin continues to be supplied by multiethnic organizations including Algerians, Chinese, Colombians, Dominicans, Lebanese, Nigerians, Pakistanis, Russians, and Sicilians. Heroin is readily available throughout New England, due to its transportation from New York. Dominican nationals dominate heroin trafficking in Boston, although smaller operations run by South and Central Americans, Nigerians, Asians, and local groups do exist.

Colombian traffickers have reportedly established heroin labs in Mexico where they are producing refined white heroin.

Boston: "The increase in purity variability in the city may result in part from poor batch mixing done in New England by marginally trained workers who receive bulk heroin from New York. In earlier years, heroin was batched in small quantities by New York professionals prior to shipment. A local police contact speculated that local dealers would probably tighten the monitoring of batching, because they do not want to lose customers to overdoses."

New York City: "Street dealers tend to be young, in their late teens and early twenties, while buyers appear to be veteran users in their thirties or older."

In many cities, including St. Louis and Boston, current heroin business is handled by cellular phone. Some Boston police workers credit the cellular phone and beeper industry with helping to reduce drug-related crime—buys arranged by beeper are usually consummated off the street, in stores, malls, homes, and cars, making turf wars and drug-related street violence infrequent.

In St. Louis, most heroin distribution is handled by large networks, although some independent entrepreneurs are also involved.

*Philadelphia: "Autumn 1999 focus groups identified **as** still available **28** of the **34** brand names on retail-level heroin packaging that were noted by spring 1999 groups, and **23** new brands were mentioned by the fall 1999 groups."*

*Washington, DC: "A large array of brand names along with the fairly high grade of heroin suggests a considerable amount of competition among dealers in the open-air markets and no shortage of supplies.... The variety of brand names for sale includes 'keep it cool,' 'let's do it again,' 'blue steel,' 'me man,' '**G 13**,' 'silk,' and 'lynch mob.' Many of these heroin brands are considered reasonably high quality."*

In Philadelphia, as in Washington, DC, dealers use brand names to maintain buyer affiliation and to indicate consistent potency of a specific brand of heroin. In Phoenix, heroin dealers are also dealing in kilogram quantities of cocaine, and referring to the joint sale of "crack and black."

OPIATES OTHER THAN HEROIN

Phoenix: 'A 300-percent increase in arrests for the possession of synthetic narcotics was reported between 1989 and 1998.'

MORTALITY AND EMERGENCY DEPARTMENT DATA

Methadone continued to be the opiate other than heroin most frequently reported by the ME in Seattle, with methadone-related deaths increasing from 17 in 1998 to 15 in the first three quarters of 1999. Five fentanyl-related deaths were reported in Seattle in 1998 and two in the three quarters of 1999. Propoxyphene (Darvon and Darvocet)-related deaths continued to increase in Phoenix and San Diego; they peaked in 1997 in Philadelphia. Hydrocodone (Vicodin, Hycodan, Lortab, and NORCO)-related deaths also seem to be increasing in Phoenix, San Diego, and Philadelphia, where deaths rose from 6 in 1994 to 15 in 1998. Also in Philadelphia, oxycodone (Percodan and Percocet)-related deaths increased between 1994 and 1998 (from 4 to 29).

Exhibit 22 lists the CEWG cities with the highest ED rates per 100,000 population in 1998 for selected opiates: codeine, propoxyphene, oxycodone, and hydrocodone. Between 1997 and 1998, codeine ED mentions declined significantly ($p < 0.05$) in seven CEWG areas (Atlanta, Boston, Chicago, Phoenix, St. Louis, San Francisco, and Seattle) and increased only in New Orleans. During that same period, propoxyphene mentions declined significantly in four cities (Dallas, New York, Philadelphia, and St. Louis) and increased significantly only in San Diego.

Between 1997 and 1998, oxycodone and hydrocodone mentions rose in many CEWG areas: oxycodone mentions increased

significantly ($p < 0.05$) in five cities (Denver, Minneapolis/St. Paul, Phoenix, San Diego, and San Francisco); hydrocodone mentions increased significantly in three (Chicago, Phoenix, and San Diego). No significant declines for these two drugs were recorded.

TREATMENT DATA

Other opiates as primary drugs of abuse account for relatively small proportions of treatment admissions. These proportions have remained stable for most reporting CEWG areas at ≤ 3 percent of total drug treatment admissions.

DEMOGRAPHIC DATA

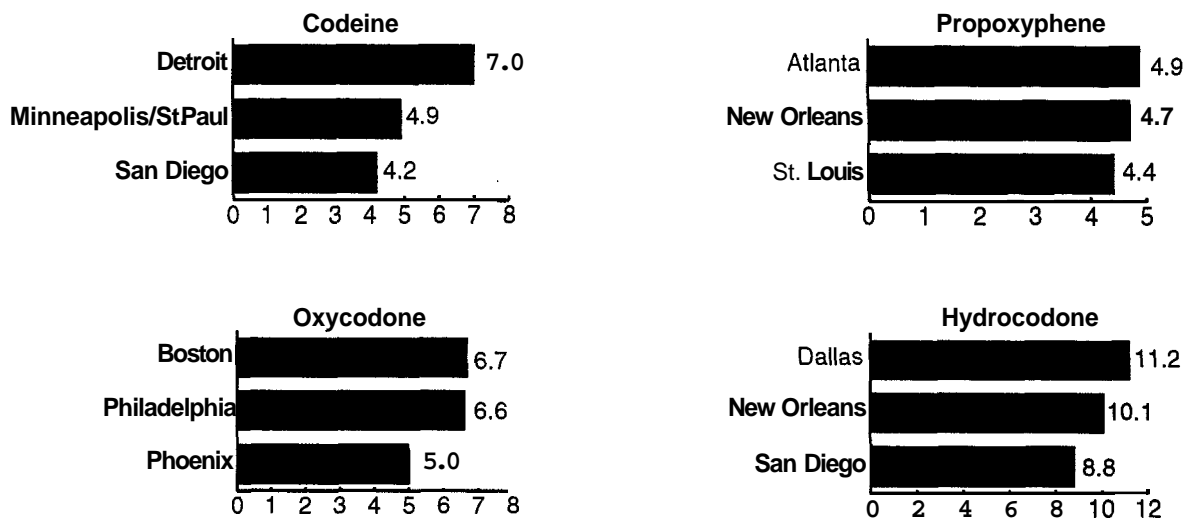
During the first three quarters of 1999, nearly half of Seattle's other-opiate decedents were female (48 percent), most were white (91 percent), and the mean age was 42 years. First-half-year-1999 treatment admissions for other opiates in New Orleans were most likely to involve white males (82 percent); African-American males as a proportion increased since the last reporting period, while white females declined. Primary other-opiate admissions in Texas were more likely to be older than 40, white, and female.

MARKET DATA AND USE PATTERNS

Codeine

Although ED data have recently declined in many CEWG cities, codeine and codeine products are still reported as commonly

Exhibit 22. Cities with the highest rates of ED mentions per 100,000 population for four selected opiates, 1998



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

diverted pharmaceutical opiates in many areas, including New York City, Phoenix, and Texas. In Chicago, where codeine is used primarily among heroin addicts to moderate withdrawal symptoms, the abuse of codeine in pill and syrup form has been relatively stable over the decade. On the South Side, some dealers specialize in their sale and pills cost \$1–\$3. Codeine cough syrup abuse is increasing in the Houston area among youth who use it as a primary drug and among adult polydrug users. Also in Houston, the practice of dipping marijuana joints in codeine cough syrup continues. In Washington, DC, codeine combinations in pill form (Tylenol 3s and 4s) can be purchased near methadone clinics for \$2 each.

Hydromorphone (Dilaudid)

Hydromorphone is reportedly available in Atlanta, Chicago, Honolulu, Minneapolis/St. Paul, St. Louis, Texas (especially in the Dallas area), and Washington, DC. In

Minneapolis/St. Paul and Washington, DC, heroin users continue to use it as a heroin substitute. In St. Louis, the drug is common among a small, chronic population of white addicts. The drug is preferred by many Chicago IDUs, but its use has diminished considerably there since 1987 due to decreased street availability.

Street prices are reported in several cities: \$25–\$35 for 4 milligrams and \$7 for 1 milligram on Chicago's North Side; \$40–\$80 per capsule in Honolulu; \$25–\$35 per tablet in Phoenix; \$40–\$70 per 4-milligram pill in St. Louis; and \$20 per pill in lower northwest Washington, DC.

Opium

U.S. Customs seized nearly 53,500 grams of raw opium in 1998 at the Seattle-Tacoma International Airport in mail parcels destined for Alaska. Another 13,273 grams were seized in the first three quarters of 1999 from other ports-of-entry in mail parcels destined

for Washington State. Although in the early 1990s U.S. Customs routinely seized raw opium destined for the Pacific Northwest, only one or two such cases per year were reported from 1994 through 1997 (531 grams over the period). Continuing a pattern that began in the 1980s, packages containing opium were shipped from Southeast Asia to destinations within Southeast Asian communities in the Minneapolis/St. Paul area. In one recent St. Paul case, law enforcement recovered more than 1,000 grams of opium.

Other Abused Opiates

- **Butorphanol tartrate** (Stadol)—This opioid analgesic in nasal spray form is one of the most commonly abused prescription drugs in Texas.
- **Hydrocodone** (Vicodin, Hycodan, Lortab, and NORCO)—Hydrocodone is reported to be one of the most commonly diverted pharmaceutical opiates in several areas, including Boston, New York, New Orleans, and parts of Texas. Despite low indicators in New Orleans, hydrocodone abuse and fraudulent prescriptions are up, according to law enforcement sources. *An* ethnographer reported that it is also a common prescriptive drug of abuse in San Francisco,
- **Methadone** (Dolophine)—Methadone pills are sold near methadone clinics in Washington, DC, for \$10 per pill. They are also available in Chicago for \$1 per milligram and in New York City for \$5 per pill.
- **Nalbuphine** (Nubain)—Nalbuphine is reported to be widely abused in the New Orleans nightclub scene by white male and female, middle- to upper-class college students and by strippers. It is available in liquid form and is often injected.
- **Oxycodone** (Percodan and Percocet)—Oxycodone is one of the most commonly diverted pharmaceutical opiates in several cities, including Boston, New Orleans, Phoenix, and St. Louis. It is also available in Texas, in New York City for \$5–\$8 per pill, and near methadone clinics in Northwest Washington, DC, for \$5 per pill.
- **Propoxyphene** (Darvon and Darvocet)—Propoxyphene and its combinations are some of the most frequently abused and diverted pharmaceutical opiates in Chicago, New Orleans, and New York City, although according to ethnographic reports, availability has decreased recently in Chicago. In New York City, it sells for \$1–\$2 per pill.

MARIJUANA

Boston: "Surveys and focus groups indicate that its use among adolescents is common, approaching that of cigarettes among older students. Cannabis is perceived by youth and those in treatment as less harmful and more 'natural' than drugs such as cocaine, heroin, or LSD."

Chicago: "Field observations on the behaviors of blunt smokers have noted that some youth exhibit a lack of control over their marijuana use and express sentiments about 'kicking the habit' that are more typically associated with heroin and cocaine dependence."

Miami: "Both marijuana prices and potencies have increased over the decade, with both factors directed at an older market as prevention efforts focus on youth."

San Diego: "These statistics showcase the integrated efforts of public health and criminal justice agencies and underscore the Board of Supervisors' commitment to treatment on demand for adolescents."

EMERGENCY DEPARTMENT DATA

In 1998, marijuana accounted for substantial (≥ 10 percent) proportions of total ED mentions in 11 cities (Atlanta, Boston, Chicago, Dallas, Detroit, Los Angeles, Miami, New Orleans, Philadelphia, St. Louis, and Washington, DC) (exhibit 1). At 9 percent of San Diego's ED mentions, marijuana slightly outranked cocaine and heroin (at 8 percent each) as the leading illicit drug mention.

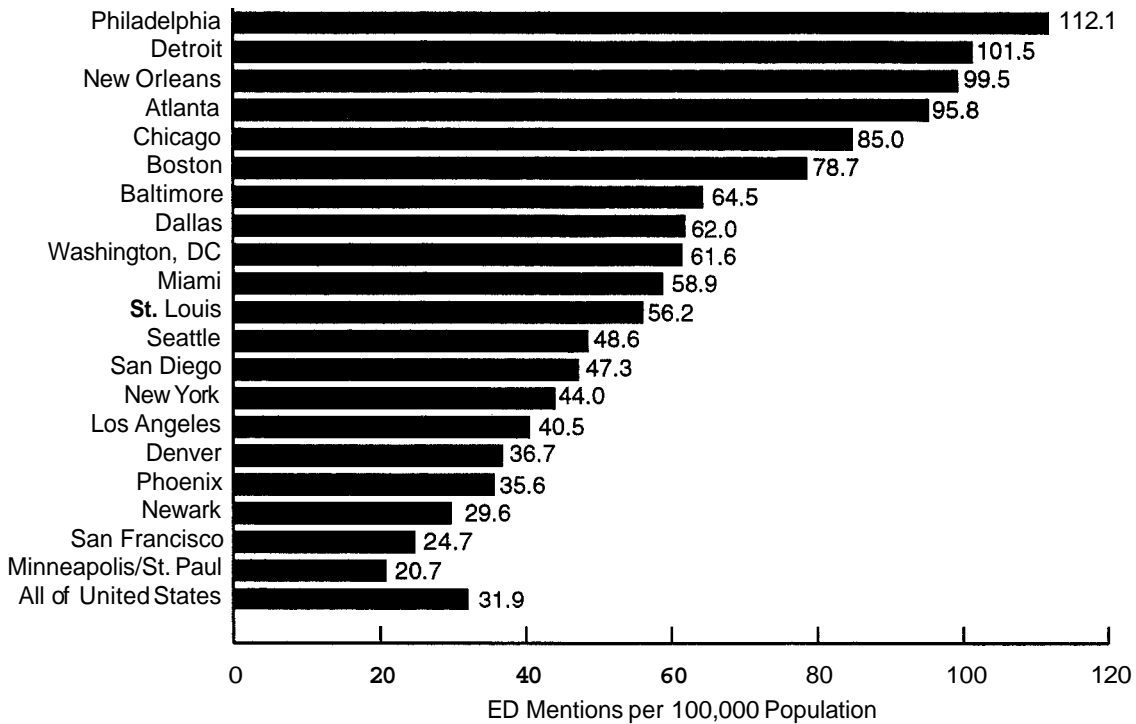
Philadelphia has the Nation's highest estimated rate of marijuana ED mentions per 100,000 population, followed by Detroit, New Orleans, and Atlanta (exhibit 23). Rates in those four cities, as elsewhere, have been escalating throughout the 1990s (exhibit 24). In Philadelphia, for example, the 1998 rate is about seven times the 1991 rate.

More recently, between 1997 and 1998, marijuana ED mentions increased signi-

ficantly (>10 percent, $p < 0.05$) in three cities (Dallas, Philadelphia, and San Diego) and nonsignificantly in the majority of the other CEWG cities in DAWN (exhibit 25). The increase in Dallas was particularly sharp. Declines (>10 percent) were reported in three cities, but only in New Orleans did mentions decline significantly.

In many cities, reason-for-ED-contact data differ for marijuana versus other drugs. In New York, for example, patients involved in marijuana episodes cited chronic effects and unexpected reaction almost equally as the foremost reasons for contact; by contrast, for other ED episodes, patients mainly reported seeking detoxification, followed by chronic effects—unexpected reaction ranked a distant fourth. In San Diego, unexpected reaction has been declining over time, while chronic effects as a reason for contact has been increasing for marijuana mentions.

Exhibit 23. Estimated rate of marijuana/hashish ED mentions per 100,000 population by metropolitan area, 1998



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

TREATMENT DATA

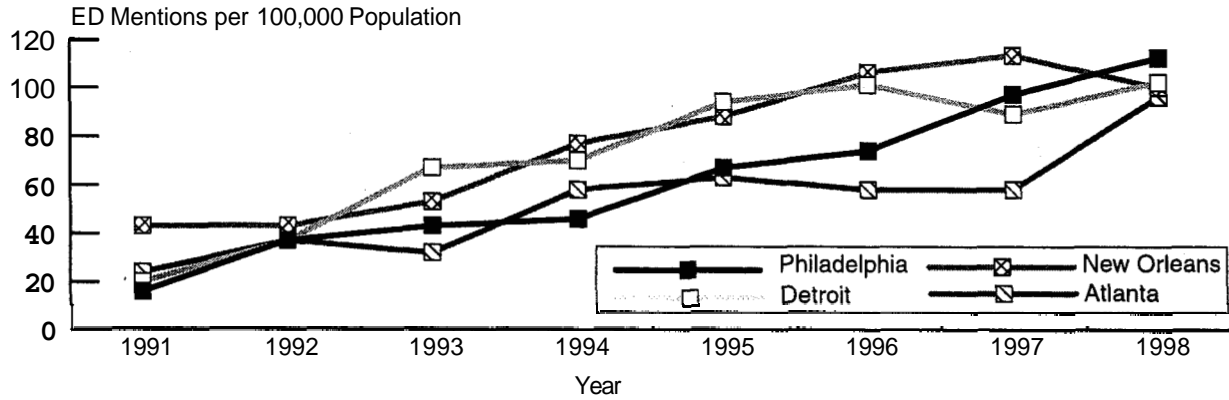
BEYOND THE CITY LIMITS...

Baltimore: "The proportion of marijuana treatment admissions was higher in the suburban counties than in Baltimore City...."

Primary marijuana abuse accounts for the top percentage of total admissions in Seattle and Denver (excluding alcohol-only) and in New Orleans and Minneapolis/St. Paul (including alcohol-only) (exhibits 5 and 26). It also accounts for substantial proportions of admissions (≥ 20 percent) in Atlanta, Hawaii, Philadelphia, St. Louis, and Texas.

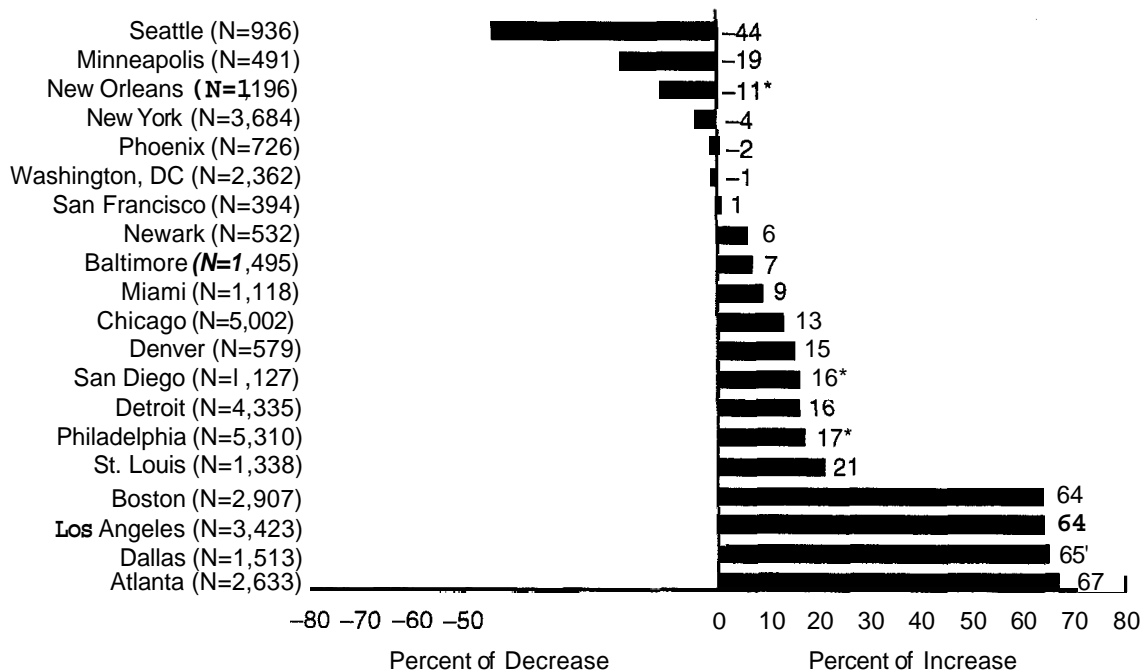
Among areas where comparison data were available between the first halves of 1998 and 1999, marijuana increased considerably as a percentage of treatment admissions in at least three cities: Atlanta (from 16 to 20 percent), Denver (from 22 to 31 percent), and San Diego (from 13 to 18 percent). Percentages declined considerably, however, in Chicago (from 18 to 14 percent) and New Orleans (from 30 to 26 percent), but the 1999 New Orleans level represented a return to the 1997 level. In a local Miami treatment facility, primary marijuana abusers increased from 37 to 43 percent of admissions between the first halves of 1998 and 1999.

Exhibit 24. Annual trends in marijuana/hashish ED mentions per 100,000 population in four top-ranking cities, 1991-98



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

Exhibit 25. Percentage of change in marijuana/hashish ED mentions by metropolitan area, 1997 versus 1998



NOTE: (N) refers to 1998 mentions.

*p<0.05

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

EXPLANATION FOR AN INCREASE?

San Diego: "Increases are largely attributable to expansion of county-funded treatment slots for adolescents."

Despite the recent increase in Denver, a leveling may be on the horizon: the proportion of new users entering treatment for marijuana use increased from 1991 through 1994, when it peaked at 37 percent; however, this proportion has steadily declined since then to only 22 percent in the first half of 1999.

Longer term data reveal escalating or leveling trends throughout the 1990s. In Baltimore, for example, the marijuana admission percentage increased steadily from 1992 through 1996, then remained relatively stable through the first half of 1998. In New York City, primary marijuana admissions

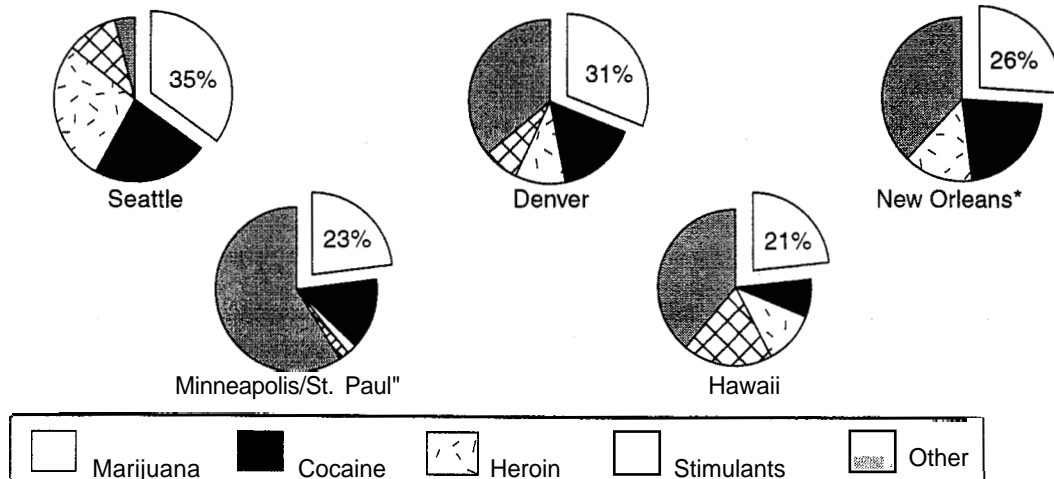
increased from 5 percent of all admissions in 1991 to 19 percent in the first half of 1999.

OTHER LOCAL DATA

Local data sources around the country are mixed, some showing declines, others stabilization, and still others increases. Some sources show small numbers, while large numbers in other areas underscore the magnitude of the marijuana problem:

- Boston: Between May and September 1999, marijuana was mentioned in 5 percent of all calls to the substance abuse hotline—level with the prior 5-month period.
- Denver: Interestingly, marijuana calls to the Rocky Mountain Poison and Drug Center are nearly nonexistent (only one or two per year from 1994 to 1998).

Exhibit 26. Marijuana as a proportion of primary drugs of abuse among treatment admissions (excluding alcohol-only) in five CEWG areas, January–June 1999



*Alcohol-only is not excluded.

SOURCE: State drug abuse treatment agencies

- New Jersey: In spring 1999, 7 percent of middle school students reported using marijuana in the past 30 days—down from 8 percent in 1995. The Newark middle school survey of 1999 showed a similar drug use pattern as the State data.
- Chicago: Among infants (N=1,650) testing drug-positive, the percentage testing marijuana-positive has been gradually increasing: 4 percent in 1995, 5 percent in 1996, 7 percent in 1997, and 8 percent (n=131) in 1998.
- South Florida: Among the 2,962 toxicology screens performed at a Broward County hospital during the first half of 1999, 15 percent were positive for cannabinoids. Among those patients, average age was 31.1, but 13 percent were teenagers and 47 percent were younger than 30.

USE PATTERNS

Alcohol is the most common secondary drug of abuse among primary marijuana treatment admissions in the majority of areas reporting such data (Atlanta, Baltimore, Denver, Los Angeles, Minneapolis/St. Paul, New York City, St. Louis, San Diego, and Texas).

Cocaine, by far, is the most common tertiary drug (as reported in Atlanta, Baltimore, Denver, Los Angeles, Minneapolis/St. Paul, New York City, St. Louis, and Texas). Some cities, however, are exceptions to this general pattern: in Newark, cocaine is the most common secondary drug, while alcohol is most common as a tertiary drug; in Washington, DC, cocaine is the most common secondary drug; and in San Diego, alcohol is the most common tertiary drug.

BEYOND THE CITY LIMITS...

Baltimore: "Some 10 percent of county admissions used other substances, primarily hallucinogens and inhalants, compared with 7 percent of city admissions. "

Marijuana itself is also commonly reported as a secondary drug, particularly among primary stimulant abusers (as reported in Atlanta, Baltimore, Denver, Los Angeles, Minneapolis/St. Paul, St. Louis, and San Diego). It is also a common tertiary drug among primary cocaine admissions (as in Atlanta, Baltimore, Los Angeles, Minneapolis/St. Paul, New York City, St. Louis, and Washington, DC). Less often, it is reported as a tertiary drug by heroin admissions (as in Atlanta and Minneapolis/St. Paul).

Boston: "Survey and focus group data indicate that...marijuana, often in the form of a blunt (hollowed-out cigar), is the drug of choice among young, inner-city crack sellers who would never use crack themselves. "

Philadelphia: "For the last three half-years, focus group participants estimated the percentages of blunts that are smoked unlaced at 50, 60, and 60 percent. The autumn 1998 and spring 1999 groups estimated that about 20 percent of blunts are laced with PCP (called 'loveboat' or 'wet'), while the autumn 1999 groups estimated a 10-percent level. The remaining blunts are laced with cocaine (called 'turbo'). "

St. Louis: "This increase in marijuana use, which is viewed by young adults as acceptable, is particularly in combination with alcohol."

Blunt usage continues to be reported in several cities, including Boston, Chicago, and Philadelphia (“Phillies” or “L”). Blunts have not yet appeared, however, in Honolulu. Marijuana is increasingly used as a delivery medium for other psychoactive drugs. For example, in Chicago, blunts are often laced with either crack or PCP (“3750s”). Marijuana/crack combinations are also reported in Boston, Minneapolis/St. Paul (“fireweed”), and parts of Texas; and marijuana/PCP combinations are also reported in Minneapolis/St. Paul (“happy stick”), Philadelphia (“loveboat” or “wet”), New York City, and St. Louis. In Philadelphia, blunts are also laced with cocaine HCl (“turbo”). The marijuana/cocaine combination is also reported in St. Louis, where treatment admissions also combine marijuana with methamphetamine. Marijuana/embalming fluid combinations are reported in Minneapolis/St. Paul (“wets” or “amp”), New York City (“duck foot,” which also includes the pesticide DDT), and parts of Texas (where this combination also includes PCP). In Texas, joints are also dipped in codeine cough syrup.

DEMOGRAPHIC DATA

Indicator data show signs of possible stabilization in the number of youth initiating marijuana use in several cities, suggesting that youth-targeted prevention and treatment efforts might be paying off. In some cities, however, increasing numbers suggest that much work remains to be done.

Among marijuana ED mentions in 1998, all age groups are represented fairly substantially (exhibit 27). However, two of the four

age groups predominate, by relatively narrow margins: young adults (age 18–25) account for the largest proportion of mentions in 11 of the cities; and the oldest group (age 35+) is largest in 8 cities. Only in Newark does the middle (26–34) group predominate.

The youngest (12–17) group, while still substantially represented (≥ 10 percent of

ARE YOUTH-TARGETED PREVENTION EFFORTS PAYING OFF?

Between 1996 and 1998, the proportion of 12–17-year-olds among marijuana ED mentions declined considerably in Dallas, Denver, Los Angeles, Phoenix, San Diego, and Washington, DC—perhaps reflecting the success of prevention efforts in those areas.

Miami: “Both marijuana prices and potencies have increased over the decade, with both factors directed at an older market as prevention efforts focus on youth. . .

San Diego: “...unlike primary cocaine, heroin, stimulant, or alcohol users, the marijuana user in treatment did not have a long history of use. Almost half (46 percent) were admitted to treatment within the first 3 years of use. These statistics showcase the integrated efforts of public health and criminal justice agencies and underscore the Board of Supervisors’ commitment to treatment on demand for adolescents. The board’s desire to get adolescents into treatment rapidly led to the Treatment on Demand and Delinquency Court initiatives. . .

marijuana ED mentions in 17 of the 20 cities), declined considerably in proportion between 1996 and 1998 (≥ 5 percentage points) in 6 cities (Dallas, Denver, Los Angeles, Phoenix, San Diego, and Washington, DC). Percentage increases (>5 points), however, were recorded for youth in two cities: Newark and San Francisco.

Nevertheless, it was the oldest (35+) group that showed the most widespread increases: their representation increased somewhat (2–15 percentage points) in 15 of the 20 CEWG cities in DAWN, with 7 of those increases fairly substantial (≥ 5 points in Denver, Los Angeles, Miami, Phoenix, San Diego, Seattle, and Washington, DC). Many of those increases correspond to slight declines in the 26–34 group, suggesting an aging older cohort, distinct from the cohort of young adults. San Francisco was the only city where the 35+ group declined substantially (6 percentage points).

Younger users are more represented in treatment data than in ED figures (exhibit 28). The youngest age group (≤ 17) accounted for the highest percentages among admissions for primary marijuana use in at least 8 of the 14 areas where data were available (Baltimore, Chicago, Los Angeles, Minneapolis/St. Paul, Newark, San Diego, Seattle, and Texas); young adults (18–25) predominated in 4 of the areas (Atlanta, New York City, St. Louis, and Washington, DC); and the oldest group (35+) was modal in Denver—but only by 1 percentage point more than the two youngest groups, which accounted for 27 percent each of that city’s marijuana admissions.

Exhibit 27. Age distribution of marijuana ED mentions, by percentage, in reporting CEWG cities, 1998

Area	12–17	18–25	26–34	35+
Atlanta	11	26	31	32
Baltimore	19	30	26	25
Boston	18	31	27	24
Chicago	15	27	28	29
Dallas	19	33	25	23
Denver	22	31	23	24
Detroit	7	26	29	38
Los Angeles	10	27	25	38
Miami	8	25	28	38
Minneapolis/ St. Paul	31	32	20	16
Newark	26	25	29	20
New Orleans	10	33	25	32
New York City	10	26	30	34
Philadelphia	14	30	27	28
Portland	16	37	20	26
St. Louis	---	26	27	31
San Diego	16	29	24	30
San Francisco	26	28	22	23
Seattle	13	34	24	29
Washington, DC	14	33	27	26

NOTE: Bolded areas reflect percentages that have increased by ≥ 5 points since 1996.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

A few notable shifts (25 percentage points \pm) in treatment age distributions were reported since the same reporting period 1 year earlier: the youngest (≤ 17) group declined as a percentage of marijuana admissions in three cities (Atlanta, Denver, and Washington, DC) and increased in only

Exhibit 28. Age distribution of primary marijuana admissions, by percentage, in reporting CEWG areas, January–June 1999a

Area	≤17	18–25	26–34	35+
Atlanta	^b 9	45	28	18
Baltimore	50	32	11	8
Chicago	41	35	16	8
Denver	^b 27	^b 27	18	28
Los Angeles	40	27	17	16
Minneapolis/ St. Paul	52	26	12	10
Newark	40	^b 32	21	6
New York City ^c	16	48	24	13
St. Louis	10	49	27	14
San Diego	68	^b 13	10	8
San Francisco	"majority"		NR	NR
Seattle	53	NR	NR	NR
Texas	52	25	13	9
Washington, DC	^b 7	48	30	16

NOTE: Bolded areas reflect percentages that have increased by ≥5 points since the reporting period 1 year earlier.

^aReporting periods are January–June 1999, except for the following: January–June 1998 in Baltimore; July 1998–March 1999 in Boston; July–September 1999 in Los Angeles; full calendar year 1998 in Chicago; and FY 1999 in San Francisco.

^bPercentage declined 5 points since the reporting period 1 year earlier.

^cAge groups reported are <17, 17–25, 26–35, and 36+.

SOURCE: State drug abuse treatment agencies

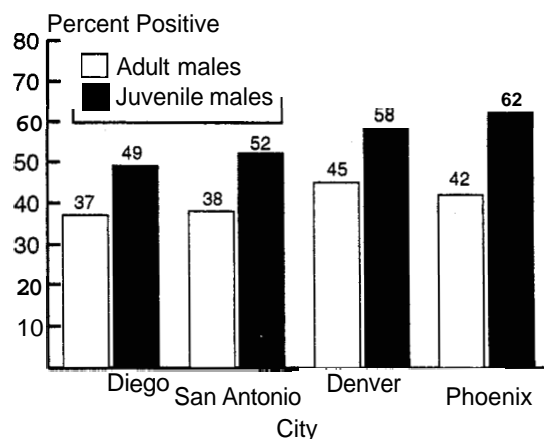
one (San Diego); the young adult (18–25) group similarly declined in three cities (Denver, Newark, and San Diego) and increased in two (Atlanta and Washington,

DC); the 26–34 group remained relatively stable, except for an increase in Newark; and the oldest (35+) group also remained relatively stable, except for an increase in Denver.

In all four cities where **ADAM** tested juvenile arrestees—Denver, Phoenix, San Antonio, and San Diego—the percentage testing positive for marijuana in the first half of 1999 was substantially greater (11–20 percentage points) than in the adult population (exhibit 29). Washington, DC, juvenile arrestees tested at an even higher level (64 percent) than their **ADAM** counterparts, according to local urinalysis data. Positive findings among juveniles in all five cities remained relatively stable compared with 1998 levels.

More than one-third (35 percent) of New York City's 42,030 cannabis-involved arrests in 1998 involved 16–20-year-olds. A review of juvenile arrests in San Diego for 1990 through 1998 shows a 43-percent decline in felony arrests but a 258-percent increase in misdemeanor arrests for marijuana.

Exhibit 29. Percentage positive for marijuana among adult and juvenile male booked arrestees, first half 1999



SOURCE: National Institute of Justice, Arrestee Drug Abuse Monitoring program, November 1999 files, preliminary data

Gender

In all CEWG cities in DAWN, males consistently outnumber females, accounting for 60 percent or more of total marijuana ED mentions. Boston continues to have the highest representation of females (39 percent), while San Francisco has the lowest (19 percent). Between 1997 and 1998, females increased slightly (3-4 points) as a percentage of marijuana ED mentions in eight cities (Baltimore, Detroit, Minneapolis/St. Paul, New York, Phoenix, San Diego, Seattle, and Washington, DC) and declined (3-7 points) in three (Newark, St. Louis, and San Francisco).

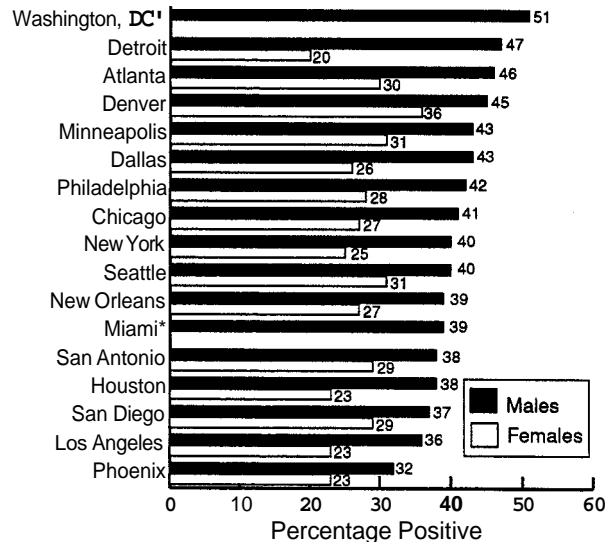
Males also account for the vast majority of treatment admissions for primary marijuana use: in all 15 areas where data were available, females accounted for only 29 percent or less of marijuana admissions. The gender gap was widest in Washington, DC (where 14 percent were female) and narrowest in San Francisco (where 29 percent were female). Since the same reporting period 1 year earlier, the percentage who were female increased notably in Atlanta (from 21 to 28 percent) and Newark (from 15 to 20 percent) and declined in Denver (from 29 to 22 percent).

In the first half of 1999, male arrestees tested marijuana-positive at higher levels than their female counterparts in every CEWG city in the ADAM program (exhibit 30). Washington, DC, had the highest percentage of males testing positive, and Phoenix had the lowest. Among cities where females were tested, the highest positive level was in Denver and the lowest in Detroit.

Race/Ethnicity

Among 1998 marijuana ED mentions, whites and African-Americans each predominated in half of the 18 CEWG cities where sufficient data were collected to warrant analysis. African-Americans accounted for the majority in seven cities (Atlanta, Detroit, Newark, New Orleans, New York, Philadelphia, and Washington, DC) and were the modal group in two (Chicago and Los Angeles). In the remaining cities, whites were the majority group in five (Baltimore, Boston, Dallas, Minneapolis/St. Paul, and San Diego) and the modal group in four (Denver, Miami, Phoenix, and San Francisco). Hispanics constituted considerable proportions (220 percent) in four cities (Denver, Los Angeles, New York, and Phoenix).

Exhibit 30. Percentage positive for marijuana among male and female booked arrestees, first half 1999 (ranked by males)



*Females are not tested at these sites.

SOURCE: National Institute of Justice, November 1999 files, preliminary data

Between 1997 and 1998, white representation among marijuana ED mentions increased substantially in four cities: Dallas (from 50 to 56 percent), New Orleans (from 38 to 43 percent), San Diego (from 53 to 65 percent), and San Francisco (from 36 to 44 percent). Conversely, percentages for whites declined in another four cities: Los Angeles (from 33 to 23 percent), Philadelphia (from 45 to 40 percent), Phoenix (from 58 to 49 percent), and Washington, DC (from 29 to 23 percent). Correspondingly, for African-Americans, percentages increased notably in four cities: Atlanta (from 41 to 51 percent), Los Angeles (from 34 to 49 percent), Philadelphia (from 47 to 53 percent), and Washington, DC (from 50 to 58 percent). And, by contrast, African-American representation declined in three: Chicago (from 50 to 42 percent), Detroit (from 71 to 64 percent), and New Orleans (from 61 to 55 percent). Hispanic representation remained relatively stable in most areas: the largest shifts were a decline in Los Angeles (from 28 to 23 percent) and an increase in Denver (from 16 to 20 percent).

As is the case with ED mentions, no one racial/ethnic group predominates in treatment admission figures. Whites account for the majority in Atlanta, Baltimore, Chicago, Denver, Minneapolis/St. Paul, and Seattle; and they are the modal group in San Diego, San Francisco, and Texas. African-Americans account for the majority in Newark, New York City, St. Louis, and Washington, DC, and they are the modal group in Boston. Hispanics are the modal group in Los Angeles, and they account for substantial proportions (>20 percent) in Boston, Denver, Newark, New York City, San Diego, San Francisco, and Texas. In many cities, such as Baltimore, the racial

breakdown of the marijuana admissions approaches that of the underlying population; in other cities, such as San Diego, African-Americans and Hispanics are reportedly overrepresented.

Philadelphia: "[Focus group participants/ reported that Asians entered the blunt scene in late 1997 and now constitute an estimated 5-10 percent of blunt smokers."

Since the same reporting period 1 year earlier, racial/ethnic marijuana treatment distributions remained relatively stable, with a few exceptions: Hispanic representation increased in Denver (from 32 to 39 percent) and San Diego (from 28 to 33 percent), while whites declined in San Diego (from 48 to 39 percent).

Racial distribution of felony marijuana convictions in Seattle more closely parallels population statistics than does the racial distribution of heroin convictions. In San Francisco, Mexican nationals were involved in about 75 percent of arrests during a major seizure of marijuana plants.

LAW ENFORCEMENT DATA

Arrestee Data

In the first half of 1999, marijuana was the most frequently detected drug among adult male arrestees in 11 of the 18 CEWG cities in the **ADAM** program (Chicago, Dallas, Denver, Detroit, Houston, Minneapolis, Philadelphia, Phoenix, San Antonio, Seattle, and Washington, DC), and it equaled cocaine in Los Angeles. These findings ranged from a low of 32 percent of male arrestees testing positive in Phoenix to a 51-percent high in

Washington, DC (exhibit 30). Among females, positive findings ranged from 15 percent in San Antonio to 36 percent in Denver. San Diego was the only city where marijuana was the most frequently detected drug among females (at 29 percent).

Compared with 1998 levels, percentages of males testing marijuana-positive in the first half of 1999 increased substantially in four cities: Atlanta (20 percentage points), Los Angeles (9 points), Miami (10 points), and Washington, DC (13 points). Levels remained relatively stable elsewhere, with no notable declines reported. Similarly, among female arrestees, positive findings increased in four cities: Chicago (7 percentage points), Denver (6 points), Minneapolis (8 points), and New Orleans (5 points). Only in Seattle did marijuana-positive levels decline substantially among females (7 percentage points).

Despite the decriminalization of possessing small amounts of marijuana in New York City, cannabis-involved arrests increased almost ninefold between 1991 and 1998, with a 53-percent increase between 1997 and 1998 (to a record number). In Boston, the proportion of arrests for marijuana—mostly for small quantities and involving juveniles and young adults—rose from 21 percent of all drug arrests in 1996 to 26 percent in 1997, but then stayed level in 1998. Marijuana possession arrests more than doubled in Phoenix between 1989 and 1998 and, as a percentage of total arrests, increased from 51 to 58 percent. In San Francisco, marijuana-related arrests have varied between 2,000 and 2,400 per year since 1993, with no particular upward or downward trend. And, in Washington, DC, arrests for sale or possession declined slightly between 1997 and 1998,

Market Data

Denver: *"Users report that the manipulation of plant genetics is a contributing factor to recent increases in potency. They describe powerful narcotic-like effects from smoking small quantities of marijuana.."*

New York City: *"The Street Studies Unit (SSU) reports that marijuana remains the most sought-after illegal substance in the metropolitan area, and it continues to grow in popularity and availability.."*

Seattle: *"The availability of very high-grade Canadian marijuana ("BC bud") is in dispute among users on the street: some report that it is widely available, but most say it is not."*

Marijuana is readily available in most parts of the country. For example, in Atlanta, where tetrahydrocannabinol (THC) levels increased from 3.3 percent to 11.37 percent between 1984 and 1999, the DEA reports marijuana as the most prevalent drug of abuse. The drug is also readily available in south Florida, where average THC levels since the 1980s have increased from 1.8 percent to 4.6 percent and, for sinsemilla, from 6 percent to 12–20 percent. Availability is also constant in Denver, despite seasonal fluctuations in the quality of marijuana produced by local cultivators. The abundance and popularity of marijuana across Chicago has led to an increased array of varieties and prices in that city.

Exhibit 31 presents available marijuana price data in CEWG areas. These prices reflect stable levels in many cities, including Boston (since the previous 6-month period), Denver (pound prices), Miami, New Orleans (for the past 2 years), and San Diego (where purity is

also stable). Prices have risen slightly in Phoenix due to the arrival of fresh crops from Mexico. By contrast, Seattle marijuana prices have followed the downward trend seen for both heroin and cocaine prices, but have not been nearly as pronounced. Washington, DC, pound prices declined for Mexican and Jamaican marijuana but increased for sinsemilla. Prices in Texas fluctuate depending on quality, quantity, demand, and availability.

Seizures

About 240,000 plants were seized in the San Francisco area in 1998, nearly two-thirds of which were being grown on National Forest lands. Multipound to multiton seizures are commonplace in Texas. In Seattle, cannabis seizures increased sharply between 1997 and 1998, but then declined in 1999 (through October), both in number and average weight (to 431 seizures averaging 5.6 pounds, compared with 853 seizures averaging 34 pounds in 1998). In Boston, marijuana submissions for lab analysis rose steadily from 1992 through 1998, but have stayed level in the first half of 1999 at 35 percent of all drugs analyzed—highest for any drug, above that for cocaine (32 percent) and heroin (15 percent). In Washington, DC, seizures increased between 1998 and 1999 (to 1,966 seizures, totaling more than 76 kilograms during the first 9 months),

Cultivation and Trafficking

Boston: *“Goodprofit margins and relatively weak penalties are incentives to traffic in marijuana, according to police contacts. --*

New York City: *“Even in the past several months, there has been a*

noticeable increase in the number of bodegas, candy stores, and health food stores selling marijuana.--

The size of local growing operations has increased in Massachusetts, but most cannabis in Boston is shipped from States such as Arizona, California, and Texas, as well as from Jamaica and Colombia. Mexico remains a primary supplier for Atlanta, with foreign sources transporting marijuana through interstate highways along with shipments of cocaine and methamphetamine; however, local Georgia counties are also a source for domestic grade marijuana. Similarly, in south Florida, marijuana is both imported and domestically grown (often hydroponically in sophisticated fully automatic indoor operations).

Similar reports emanate from western cities: Denver’s marijuana is both locally grown and imported from other States and Mexico, and Seattle’s most commonly found marijuana continues to be either high-grade locally grown (indoor) sinsemilla or indica or a low-grade commercially grown product from the southwestern United States or Mexico.

In the Midwest, indoor production is the primary growing method in the St. Louis area, with much of the Missouri-grown marijuana shipped out of State.

Distribution patterns vary from city to city. In Washington, DC, for example, street sales take place throughout the city, particularly in and around open-air drug markets. By contrast, in Seattle, marijuana is not readily available as a street drug (unlike most other illicit drugs in the area); rather, the main venues for sale (especially for higher grades) are known as “house connections” or select coffeehouses and bars.

Exhibit 31. Marijuana prices and purity in reporting CEWG cities,
December 1999 reporting period

City	Source/Quality	Price/Unit	
		Ounce	Pound
Atlanta	Sinsemilla Domestic	\$160-\$250	\$1,000-\$2,000
		\$120-\$240	\$1,200
Boston	Commercial grade Sinsemilla	\$75-\$300	\$1,000-\$3,000
		\$200-\$500	\$1,000-\$3,000
Chicago	type unspecified	\$100-\$200	\$1,000-\$4,000
	Sinsemilla	NR	\$2,500-\$4,000
	Colombian	NR	\$1,800-\$2,000
	Mexican	NR	\$ 900-\$ 1,200
Denver	Commercial grade Sinsemilla	NR	\$800-\$1,200
			\$1,500-\$3,200
Honolulu	"Low quality" (type unspecified)	\$250-\$500	NR
		NR	\$6,000-\$9,000
	"High quality"	\$400-\$800	NR
Los Angeles	Sinsemilla (25-30% THC)	\$ IO-\$80	\$300-\$6,000
Miami	Commercial grade ("regs") Hydroponic ("crippy")	NR	\$800-\$1,000
		\$600+	\$2,000-\$4,000
Minneapolis/ St. Paul	NR	\$250	\$800-\$850
New Orleans ^a	NR	\$25-\$160	\$750-\$1,000
New York City	NR	NR	\$300-\$2,400
	"Good-quality commercial"		\$2,000-\$4,000
Phoenix	NR	\$75-\$150	\$500-\$750
San Diego	Commercial grade Sinsemilla (8-16% THC)	\$50-\$75	\$400-\$600
		\$200-\$400	NR
San Francisco	NR	NR	\$2,800
Seattle ^b	Sinsemilla	\$325-\$400	\$4,000-\$5,200
Texas South North	NR	\$35-\$60	\$500-\$850
			\$400-\$700
Washington, DC	Mexican or Jamaican Sinsemilla	\$80-\$300	\$600-\$1,300
		\$150-\$500	\$4,500

^a\$2,000/kilogram

^b\$6,000-\$8,000/kilogram

SOURCE: CEWG city reports, December 1999

STIMULANTS

Boston: "For reasons most likely related to the entrenched tradition of cocaine and heroin trafficking, as well as a lack of local manufacture, methamphetamine has not become a significant factor in the street drug scene....Methylenedioxymethamphetamine (MDMA), gamma-hydroxybutyrate, ketamine, and crystal methamphetamine continue to be reported in the club and rave scenes. MDMA in particular has rapidly increased in popularity among youth."

Denver: "The substantial decrease in the quality and potency of methamphetamine may be diminishing drug-related consequences and subsequent treatment and ED admissions. Also, users could be switching to increasingly available and high-quality cocaine."

Minneapolis/St. Paul: "Despite significant statewide increases in law enforcement indicators, availability, and clandestine methamphetamine labs, other indicators declined in the metropolitan area."

San Francisco: "Ethnographic observers note less use of speed, especially among young people who now appear to prefer heroin. Use remains concentrated among gay men and (to a lesser extent) lesbians... To summarize, admissions and arrests are up, deaths and ED mentions are down, and ethnographic observers believe there is less use."

MORTALITY DATA

Methamphetamine-related deaths remain relatively few.

Using 1998 and partial-1999 data, stimulant mortality projections suggest declines in two of six CEWG areas where data were available:

- Minneapolis/St. Paul: Methamphetamine-related deaths appear to be declining (from eight to two).
- San Diego: After an all-time high in 1997, methamphetamine-related overdose deaths seem to be declining for the second year in a row, from 52 in 1998 to a projected 26 in 1999 (based on first-half-year data), the lowest level since 1992.

By contrast, methamphetamine toxicology reports have increased in Philadelphia,

totaling six in 1998 and nine in the first half of 1999. Similarly, stimulant mortality figures are on a projected course to increase in three other cities during that time period (based on 1998 versus partial-1999 data):

- Honolulu: Methamphetamine-related deaths totaled 27 in 1998 and 17 in the first half of 1999.
- Phoenix: Methamphetamine-related deaths totaled 51 in 1998 and 36 in the first half of 1999.
- Seattle: Amphetamine/methamphetamine toxicology reports totaled three in 1998 and nine through the third quarter of 1999.

Earlier 1997-98 data showed stable or upward trends:

- Colorado: Amphetamine-related deaths remained stable (five in each year).

- San Francisco County: Amphetamine-caused deaths increased 23 percent (from 22 in FY 1997 to 27 in FY 1998), but are still well below the 1995 peak (40 deaths),
- Texas: Methamphetamine/amphetamine-related deaths increased 18 percent (from 17 to 20).

EMERGENCY DEPARTMENT AND POISON CENTER DATA

Boston: "Although MDMA has not shown up in treatment or ED indicators, other sources suggest a rapid increase in its use, especially among high school youth. --

The highest proportions of methamphetamine per total ED mentions in 1998 were in western U.S. cities: Los Angeles, Phoenix, San Diego, and San Francisco (3, 4, 6, and 5 percent, respectively) (exhibit 1). These percentages remained relatively stable or declined slightly from 1997 proportions.

In 1998, among CEWG cities in DAWN, Phoenix, San Diego, and San Francisco had not only the highest methamphetamine-per-total-ED-mention proportions, but also the highest methamphetamine ED rates per 100,000 population (exhibit 32).

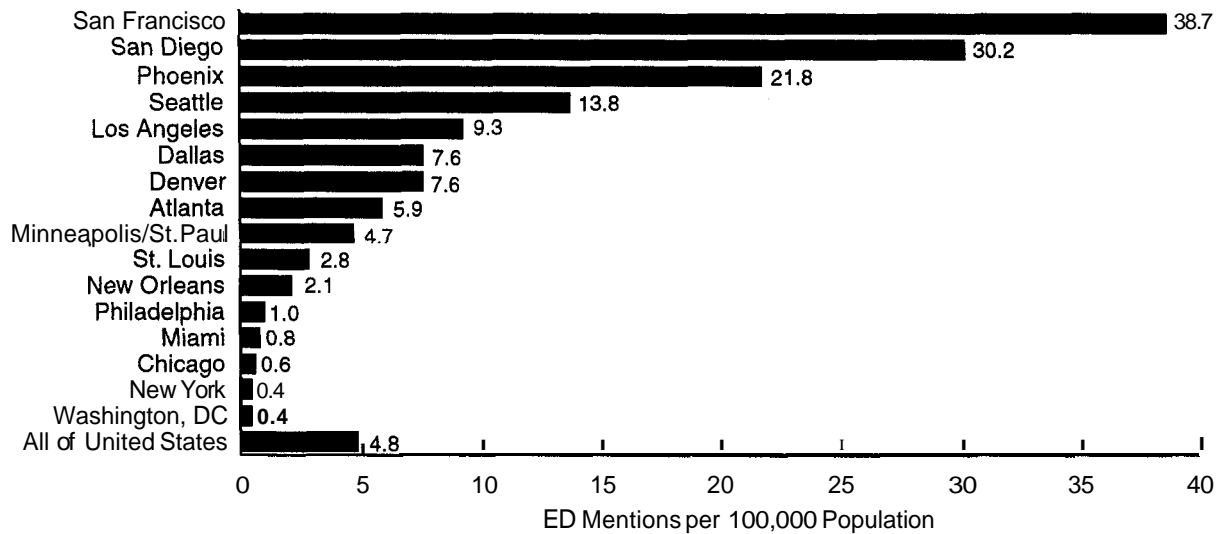
Four other western cities followed: Dallas, Denver, Los Angeles, and Seattle. Atlanta had the highest methamphetamine ED rate among eastern cities (5.9); Minneapolis/St. Paul had the highest among central cities (4.7). New York and Washington, DC, had the lowest rates.

Between 1997 and 1998, methamphetamine ED mentions declined significantly ($p < 0.05$) in six western cities: Denver, Los Angeles, Phoenix, San Diego, San Francisco, and Seattle; mentions declined nonsignificantly but notably (> 20 percent) in Atlanta, Minneapolis/St. Paul, and Philadelphia (exhibit 33). Conversely, methamphetamine rates increased significantly in two cities (Dallas and Miami), and nonsignificantly in two cities (Chicago and New York).

Recent declines in western areas follow generally downward trends (exhibit 34). However, since 1991, methamphetamine ED rates increased in Los Angeles, Phoenix, San Diego, and Seattle; they declined in San Francisco. In these cities, methamphetamine ED rates peaked in 1993 or 1994, except in Seattle, where rates peaked in 1997. The most recent rates represent an 8-year low for San Francisco, a 7-year low for Los Angeles, and a 5-year low for Phoenix.

In Colorado, amphetamine-related poison calls fluctuated between 1994 and 1997 (ranging from 16 to 38 calls), but in 1998, such calls dropped to 11; MDMA-related calls totaled 5 in 1998, a slight decline from 7 calls in both 1996 and 1997. In Boston, MDMA poison calls are increasing, and prescriptive amphetamines (Adderall) and methylphenidate (Ritalin) have figured prominently in calls. Also in Boston, poison centers reported two calls related to khat, a leafy plant used for its stimulant properties.

Exhibit 32. Estimated rate of methamphetamine ED mentions per 100,000 population by metropolitan area, 1998



SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

TREATMENT DATA

Chicago: *“Youth treatment providers reported more [MDMA] use among their clients.”*

Honolulu: *“This situation [extremely high methamphetamine treatment admissions] 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 continued to account for the largest percentage of all treatment admissions in Hawaii and San Diego (exhibit 5). Although the proportion of stimulant admissions in western U.S. cities generally increased this decade, between the first halves of 1998 and 1999, all reporting western cities showed declines in stimulant admission proportions. San Diego showed

the largest decline (8 percentage points). Stimulant admission proportions remained low and stable in other areas of the country (exhibit 35).

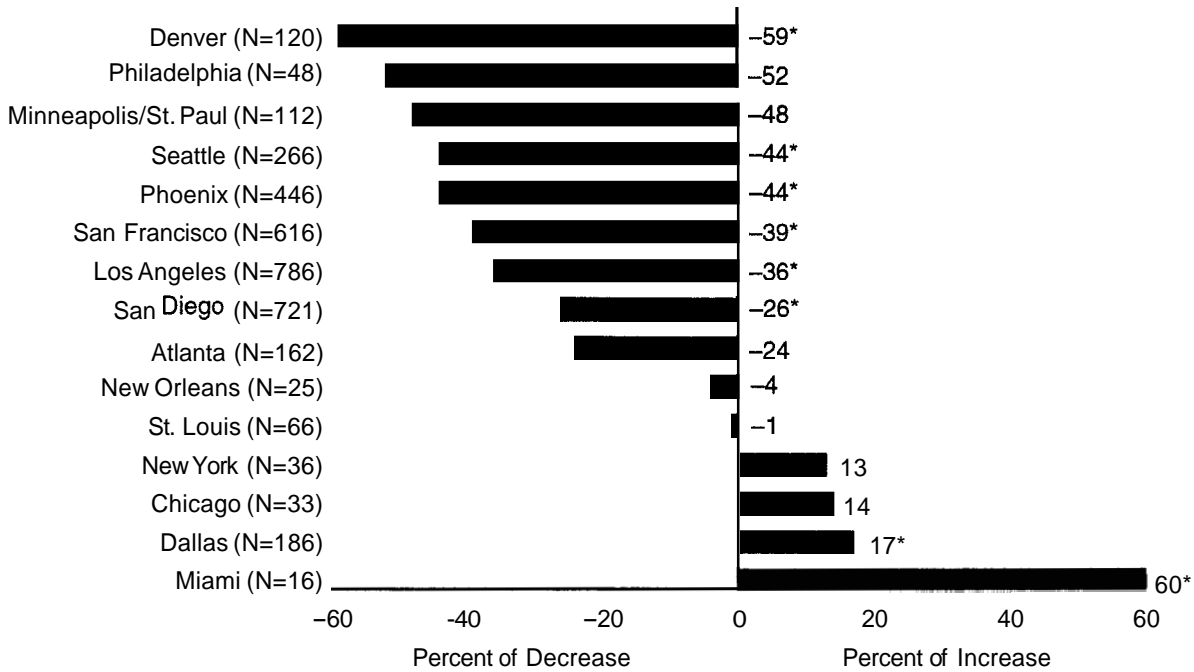
In addition to declining in proportions, stimulant admissions declined in number in

BEYOND THE CITY LIMITS...

St. Louis: *“In rural areas, methamphetamine is appearing in treatment data.... While the numbers are still relatively low in rural programs, methamphetamine is the drug of choice after alcohol.”*

Seattle: *“[Statewide treatment] data suggest that methamphetamine clearly has continued to be a problem in rural eastern and southern Washington and Puget Sound outside of Seattle and King County.”*

Exhibit 33. Percentage of change in methamphetamine ED mentions by metropolitan area, 1997 versus 1998

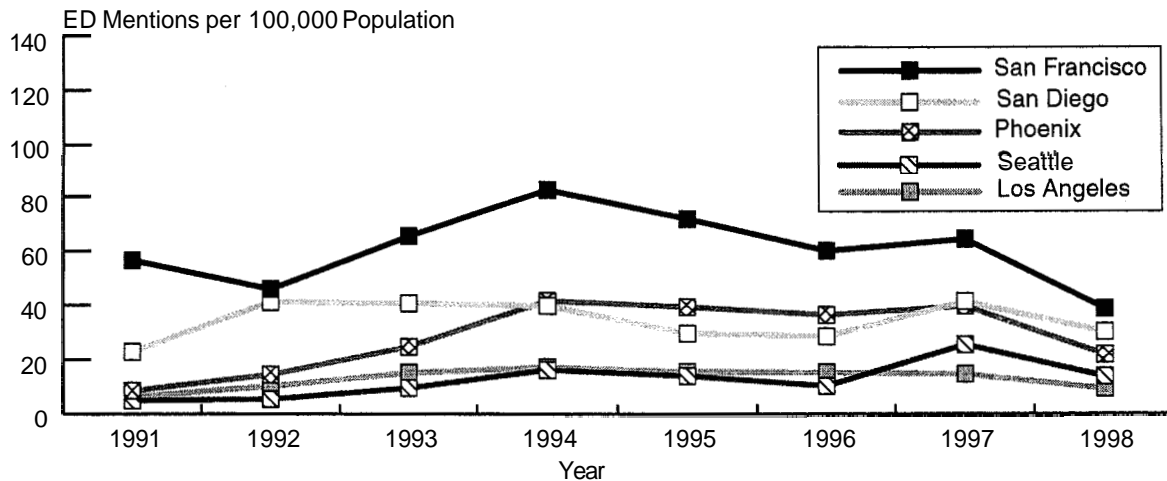


NOTE: (N) refers to 1998 mentions.

*p<0.05

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

Exhibit 34. 7-year trends in methamphetamine ED mentions per 100,000 population in the five cities with the highest mentions, 1991-98



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

several areas: Minneapolis/St. Paul (between the first halves of 1998 and 1999, from 358 to 175 clients); San Diego (between 1998 and 1999, from 4,413 to an estimated 4,024); Texas (between the first halves of 1998 and 1999, from 964 to 772); and Denver (between first halves 1998 and 1999, from 1,101 to 765).

Conversely, although the proportion of stimulant treatment admissions declined by 1 percentage point in San Francisco between FYs 1997 and 1998, the total number

increased 19 percent during that same time period. In St. Louis, stimulant admissions increased between the first halves of 1998 and 1999 (from 90 to 114). Stimulant treatment admissions in Hawaii remained high in the first half of 1999 (889), increasing 22 percent since the first half of 1998. In Denver, the proportion of new stimulant treatment admissions declined from a 1997 peak (from 31 to 17 percent) in the first half of 1999. Chicago's few treatment admissions for primary stimulant dependence have historically been abusers of over-the-counter preparations containing caffeine, ephedrine, or phenylpropanolamine.

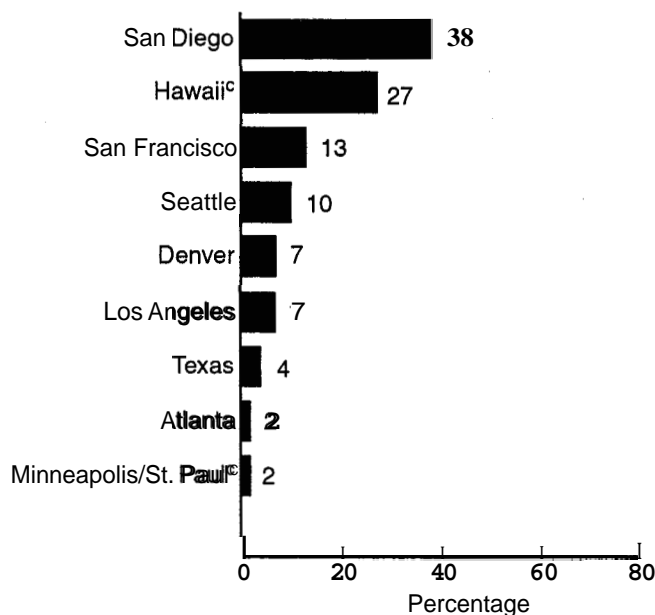
EXPLANATIONS FOR LOW METHAMPHETAMINE INDICATOR NUMBERS...

Minneapolis/St. Paul: "Methamphetamine can produce addiction; very long, extended periods of sleep and food deprivations; marked visual and auditory distortions; and in some cases, paranoid delusions. For these reasons, methamphetamine addicts sometimes initially appear for treatment at mental health centers or psychiatric units instead of substance abuse treatment centers. "

Washington, DC: "Although regular use [of methamphetamine] appears to have deleterious consequences, intermittent use of methamphetamine/speed may delay the psychophysiological impairment it produces, reducing the number of cases that appear in the problem indicator data. "

Washington, DC: "In the 1999 [ADAM] toxicology reports, none of those arrested had treatment for their use of methamphetamine. The low rates in various indicators suggest an incipient drug abuse problem, experimental or intermittent use, and possibly a lack of (or a perceived lack of) appropriate treatment for this drug. "

Exhibit 35. Stimulants as a proportion of primary drugs of abuse among treatment admissions^a, first half 1999^b



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

^bReporting periods are January–June 1999, except for the following: July–September 1999 in Los Angeles and FY 1999 in San Francisco.

^cAlcohol-only is not excluded.

SOURCE: State drug abuse treatment agencies

USE PATTERNS

Boston: "MDMA seems to be expanding outside the rave, dance, and club scenes to include recreational use by younger adolescents in other social contexts. "

Minneapolis/St. Paul: "At rave parties, wearing disposable respiration masks rubbed in menthol-based cold ointments was believed to heighten the effects of MDMA. "

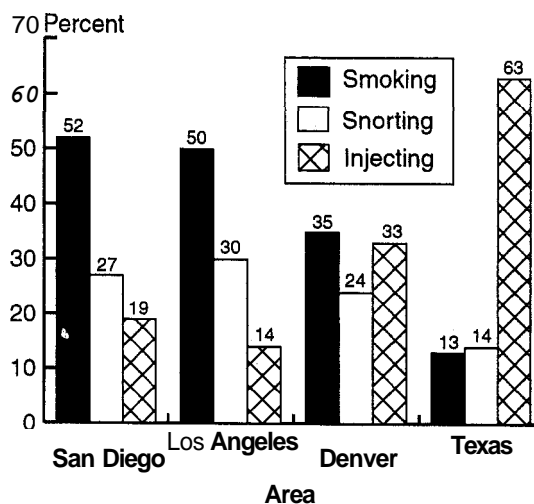
Route of Administration

Honolulu: "[Methamphetamine smoking in Hawaii] may be related to the fact that this State has had an ongoing marijuana culture for decades. The tradition of smoking 'dope' and the recent emphasis on keeping away from needles because of AIDS are the most probable reasons for this form of ingestion."

Minneapolis/St. Paul: "An anecdotal report indicated that some young adults crunch and smoke tablets of a popular ephedrine-based, over-the-counter decongestant often used in manufacturing methamphetamine. "

Route of administration for methamphetamine varies across the country. Smoking is the most common route among treatment admissions in five of nine CEWG areas reporting such data, and it continues to increase in those areas (Baltimore, Denver, Honolulu, Los Angeles, and San Diego) (exhibit 36). During the most recent reporting period in Denver, smoking surpassed injecting among stimulant admissions for the first time. In Hawaii, methamphetamine smokers rarely shift from smoking to injecting. Injecting is the most common route among primary stimulant treatment

Exhibit 36. Route of administration among primary stimulant/methamphetamine admissions in selected western CEWG areas during the most recent reporting period*



*Reporting periods are January–June 1999, except in Los Angeles (July–September 1999).

SOURCE: State drug abuse treatment agencies

admissions in three CEWG reporting areas: Atlanta, where injecting is increasing and snorting has declined; Seattle; and Texas, where injecting is particularly common, accounting for 63 percent of stimulant admissions. Snorting predominates in Minneapolis/St. Paul and St. Louis, where for the first time it surpasses injecting among stimulant admissions.

NIDA's Puget Sound Methamphetamine Study, conducted in Seattle, found that the majority of 65 methamphetamine users interviewed were IDUs, followed by snorters. Among stimulant treatment clients in Texas, injectors are, on average, 2 years older than those who smoke or inhale (31 years).

In Chicago, white IDUs on the North Side inject phenmetrazine (Preludin), while African-American stimulant users prefer

methylphenidate (Ritalin) ("west coast"), sometimes injecting it with heroin or heroin and cocaine.

Multisubstance Abuse

Washington, DC: "Methamphetamine/speed users may use it intermittently or on a more continuous basis, commonly with other drugs (cocaine HCl, marijuana, MDMA) and often to enhance occupational and recreational performance. --

In Seattle, of the nine methamphetamine-related deaths in 1999, six involved other drugs. Among primary stimulant admissions in reporting CEWG areas, marijuana and alcohol were mentioned as secondary and tertiary drugs of choice, except in Texas, where cocaine was the most common secondary drug. In San Diego, among alcohol-in-combination primary treatment admissions, methamphetamine was the most common secondary drug. In Atlanta, unlike admissions for other drugs, nearly one-half of methamphetamine treatment admissions reported no secondary drug.

Interviews with 65 methamphetamine-using women and heterosexual men in the Seattle/King County and Puget Sound areas found an increased use of multiple substances, including heroin, possibly related to a reported decline in methamphetamine purity. In New York City, mushrooms were reportedly dipped in or treated with methamphetamine (or PCP or LSD).

Washington, DC: "Ethnographic information indicates that MDMA is predominantly used by adults younger than 30 who attend dance and music clubs and raves and are involved in

polydrug use (including marijuana, methamphetamine, and LSD)."

Continued MDMA use and new MDMA combinations were reported in many CEWG areas. In Miami, the practice of "rolling and trolling" (combining MDMA with LSD) continues to be common among youth. MDMA is also mixed with LSD in Texas and Washington, DC, where the product is sold in a tablet form known as "nexus." In Miami, ED patients report the use of "rolls," combinations of MDMA and cocaine. In Texas, MDMA is mixed with heroin, and in Chicago, heroin is mixed with methylphenidate instead of cocaine as a speedball or with both for increased effect. In Miami, diverted pharmaceutical drug abuse seems to be increasing, perhaps associated with concomitant stimulant and depressant use ("rollers").

DEMOGRAPHIC DATA

New York City: "Given the high cost, MDMA is generally used by the more affluent. --

Washington, DC: "Ethnographic reports indicate that methamphetamine/speed is used by young heterosexual adults (often younger than 30) primarily at dance and music venues, and by gay men, who may use it at these locations or in sexual engagements. In addition, methamphetamine is used by older heterosexual groups and motorcycle clubs in the DC/Virginia area. --

Age

Boston: "Key informants and focus group participants thought that [methamphetamine] users are generally

students and young adults, especially those who frequent raves or those recently arrived from the west coast, where 'crystalmeth' or 'ice' is popular. ..

Minneapolis/St. Paul: "Methylphenidate remained a drug of abuse primarily among adolescents and young adults. ..

New Orleans: "MDMA continues to be popular among college students and is readily available at nightclubs. ..

St. Louis: "Speed and its derivatives have become more widespread among high school and college students who do not consider these drugs as dangerous as cocaine. Since it is so inexpensive and easy to produce, it is possible that it will be around for a long time. ..

In FY 1999 in San Francisco, the median age for methamphetamine-related deaths was 35; in Seattle, during the same period, the decedents' ages ranged from 24 to 54. In cities where methamphetamine ED demographics were available, percentages among the three oldest age groups (18–25, 26–34, and 35+) were distributed relatively evenly in 1998, with less than 12 percentage-point differences between these age groups, except in San Francisco (where the 35+ age group constituted 46 percent of methamphetamine ED mentions), Denver, and Phoenix (both with large majorities of mentions constituted by the 26–34 group).

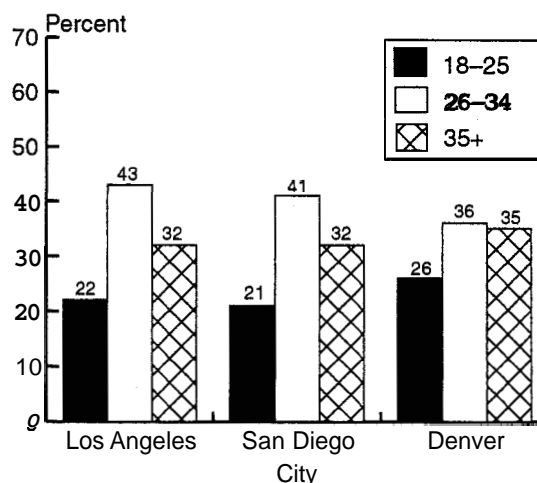
Between 1997 and 1998, the 35+ age group as a proportion of methamphetamine ED mentions increased notably (≥ 5 percentage points) in five cities: Atlanta, Dallas, Los Angeles, San Diego, and San Francisco. The 26–34 group declined notably (≥ 5 points) in two cities (Atlanta and San Francisco) and

increased in Denver. The 18–25 group declined notably (≥ 5 points) in three cities: Dallas, Denver, and Los Angeles.

Treatment clients older than 25 constitute the majority (63–75 percent) of stimulant treatment admissions in all reporting CEWG areas (Atlanta, Baltimore, Denver, Los Angeles, Minneapolis/St. Paul, St. Louis, San Diego, Seattle, and Texas, where the average age of clients continues to increase) (exhibit 37). The 18–25 age group constitutes large proportions (25–33 percent) of stimulant treatment admissions in Denver, Minneapolis/St. Paul, St. Louis, and Texas; the ≤ 17 group accounts for more than 5 percent in four areas: Baltimore, Los Angeles, San Diego, and Texas.

Between 1998 and the first half of 1999, a dramatic age shift in stimulant treatment clients was recorded in Denver: the proportion of clients younger than 26 declined

Exhibit 37. Age distribution of primary stimulant/methamphetamine admissions in selected CEWG areas during the most recent reporting period*



*Reporting periods are January–June 1999, except in Los Angeles (July–September 1999).

SOURCE: State drug abuse treatment agencies

(from 38 to 29 percent), while proportions for 35–55-year-olds increased (from 27 to 34 percent).

Gender

Seattle: *"[Among women in NIDA's Puget Sound Methamphetamine Study], the most frequently cited reason for using methamphetamine had to do with its 'socially empowering' effects. Women reported liking the greatly enhanced confidence and the social disinhibition that they associated with methamphetamine use. Some also reported using the drug initially to control weight. Among males, sexual enhancement was mentioned frequently as a reason for use, although many reported using the drug to facilitate work. ...*

In 1999, males accounted for 78 percent of methamphetamine-related deaths in Seattle, and 81 percent in San Diego. Among 1998 ED methamphetamine mentions, males outnumbered females in all CEWG areas where that information was available. The gender gaps were particularly wide (≥ 70 percent males) in Atlanta, where males have increased from 64 to 74 percent since 1997; Los Angeles; Philadelphia, where males have increased by 5 points since 1998; and San Francisco. The gaps were narrow in Denver, where males have declined from 65 to 55 points since 1997, and Minneapolis/St. Paul (52 percent males). The gender gap is also narrowing in San Diego, where females have increased by 5 percentage points since 1998.

Among stimulant treatment admissions, males and females were distributed relatively evenly (≤ 10 percentage-point difference) in reporting CEWG cities, except in Atlanta (85 percent males), Denver (61 percent males), and Minneapolis/St. Paul (65 percent males)

(exhibit 38). Los Angeles had the narrowest gender gap (51 percent males).

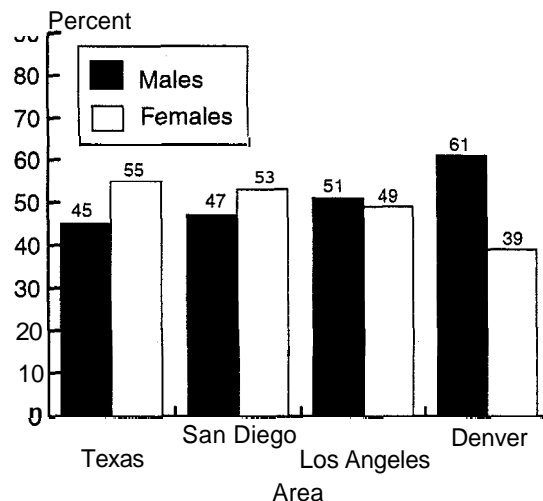
Female arrestees generally were as likely as their male counterparts to test positive for methamphetamine in almost all **ADAM** sites (though the samples of female arrestees were small in all sites).

Race/Ethnicity

Mortality, ED, and treatment data indicated that methamphetamine users are predominantly white. In San Diego, 77 percent of methamphetamine-related deaths involved whites in FY 1998.

In DAWN areas where ED race/ethnicity data were reliable (10 areas), whites constituted the majority (56–100 percent) of methamphetamine mentions in 1998.

Exhibit 38. Gender of primary stimulant/methamphetamine admissions in selected CEWG areas during the most recent reporting period*



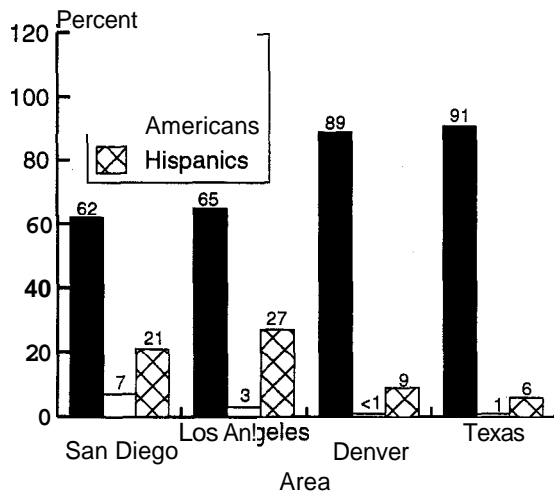
*Reporting periods are January–June 1999, except in Los Angeles (July–September 1999).

SOURCE: State drug abuse treatment agencies

Hispanics accounted for a particularly high percentage of ED mentions in Los Angeles (32 percent) and for considerable percentages in Denver, Phoenix, and San Diego. African-Americans accounted for 17 percent in Atlanta and 12 percent in Phoenix.

Whites also were the majority group in all areas reporting treatment data, ranging from 62 percent in San Diego to 98 percent in Atlanta (exhibit 39). Hispanics held large proportions in Los Angeles (27 percent) and San Diego (21 percent). In San Diego, Asians made up 7 percent of methamphetamine treatment admissions. In some cities, such as San Diego, the racial/ethnic breakdown for methamphetamine admissions, unlike that for other drug admissions, closely resembles the general population demographics. In Seattle, ethnic minority representation was disproportionately low; whites in that city constituted 90 percent of treatment admissions for methamphetamine.

Exhibit 39. Race/ethnicity of primary stimulant/methamphetamine admissions in selected CEWG areas during the most recent reporting period*



*Reporting periods are January-June 1999, except in Los Angeles (July-September 1999).

SOURCE: State drug abuse treatment agencies

In Texas, during the past 14 years, whites have been increasing among treatment admissions, while African-Americans have been declining. Also, in Denver, whites as a percentage of treatment admissions increased slightly between 1998 and the first half of 1999 (to 89 percent). Conversely, in New Orleans, whites as a percentage of admissions declined between 1998 and the first half of 1999.

LAW ENFORCEMENT DATA

Minneapolis/St. Paul: "Federal, State, and local law enforcement agencies reported major growth in methamphetamine-related activity and, in the course of investigations, reported encountering increasing quantities of the drug. --

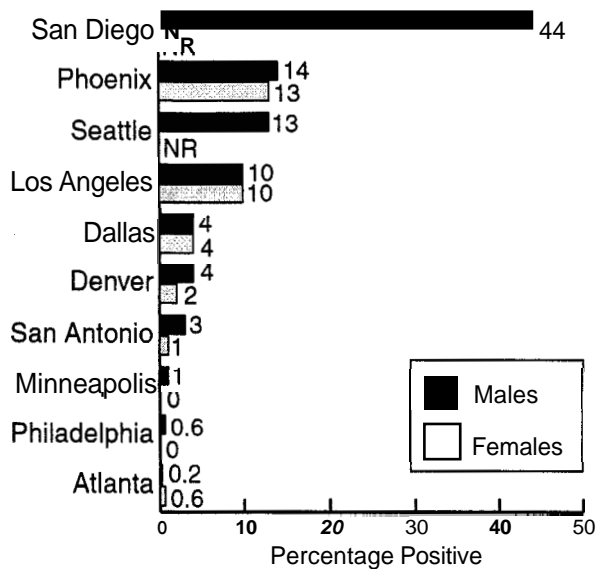
Arrestee Data

San Diego, by far, tops the list of CEWG cities in methamphetamine-positive levels among adult male **ADAM** arrestees (exhibit 40). Outside western **ADAM** sites, methamphetamine continues to appear only sporadically; but it has recently appeared in three non-western areas (Atlanta, Minneapolis, and Philadelphia); positive levels there, however, have been small (11 percent).

BEYOND THE CITY LIMITS...

Seattle: "Male arrestees in King County jails outside downtown Seattle had higher [methamphetamine-positive/ rates] than arrestees in Seattle/ in the second quarter of 1999.."

Exhibit 40. Percentage positive for methamphetamine among male and female booked arrestees in selected cities, first half 1999 (ranked by males)



SOURCE: National Institute of Justice, first-half 1999 preliminary data (November 1999 update)

Between 1998 and the first half of 1999, methamphetamine-positive percentages among adult male arrestees remained relatively stable. Substantial increases were recorded in only two cities: San Diego (11 percentage points) and Seattle (7 points). During the same time period, percentages among female arrestees declined substantially in Phoenix (9 points) and remained relatively stable elsewhere.

In San Diego, among drug-positive misdemeanor arrestees, 69 percent tested positive for methamphetamine in 1997 and 62 percent in 1998; among arrestees who were low-level users and relatively new to the criminal justice system, data were consistent from 1995 through the first half of 1999: methamphetamine was the primary drug involved in two-thirds of the arrests. Honolulu police cases involving methamphetamine increased from 253 to 298 between second semester 1998 and first semester 1999. In the St. Paul

area, methamphetamine arrests increased between 1996 and 1998 (from 23 to 103) but fell (to 31) in the first three quarters of 1999.

Methamphetamine Market Data

Atlanta: "Ethnographic sources found that those who smoke methamphetamine often refer to it as 'ice'; however, it is not the same substance as in Hawaii. Rather, the term is used to refer to crystal methamphetamine. --

Honolulu: "The drug...is a clear or cloudy crystalline substance, is usually smoked, and has potency lasting from 8 to 36 hours.... In the 1990s, the reputation of ice has been that of a 'cheap and long high,' an energy booster, and a sex enhancer, but at the same time it has also developed a reputation in Hawaii as a 'recipe for violence,' a 'crazy drug,' and a drug of instant addiction."

Philadelphia: "Focus group members indicated that methamphetamine is available. It is still difficult to obtain, is sold indoors, and requires a connection. --

In Hawaii, where availability of methamphetamine (called "ice," "glass," "shabu," or "batu") is high, it appears in two forms: "clear," a clean, white form; and "wash," a brownish, less processed form.' In Minneapolis/St. Paul, a variety of methamphetamine known as "snow" is available, allegedly containing extra lithium and producing hallucinations. Ethnographic data in Washington, DC, indicate the availability of a range of increasingly refined methamphetamine, differentiated by strength and purity, called "peanut butter," "bathtub speed," "crystal," "hydro," "glass," and "ice." In New York City, where methamphetamine indicators are low, the drug is

available in dance clubs and among gay males and is rarely sold on the street.

Seattle: "Interviewees reported a recent decline in the quality of street methamphetamine, although prices are stable. .."

Methamphetamine prices vary in the reporting areas, depending on purity, availability, and quantity (exhibit 41). Since the last reporting period, prices have remained relatively steady in CEWG reporting areas, except in Hawaii and the nonmetropolitan areas of Minneapolis/St. Paul (prices rose in both places); New Orleans, where prices increased at the ounce and pound levels; and Texas, where prices have decreased since 1994. Methamphetamine purity declined in at least four CEWG areas (Denver, to as low as 10–20 percent; Los Angeles; San Francisco; and Seattle).

Market Data for Stimulants Other Than Methamphetamine

Atlanta: "Ethnographic findings show that many MDMA users have no idea of the content of what they are taking. They refer to a combined high of an upper and a downer, and some complain because sometimes the drugs they buy are 'unbalanced,' causing a shift too much in one or the other direction. .."

Miami: "Rave activity has increased with widescale drug sales, mostly of MDMA, GHB, cocaine, and ketamine. .."

Washington, DC: "The Washington DEA office reports that high-quality MDMA, known as 'Florida dove' or 'doves,' is available in the District. .."

...other brand names of pills, known as 'red devils,' 'green Adidas,' and 'purple Adidas,' are available: the Adidas athletic shoe logo appears on the latter two. .."

MDMA availability is increasing in many CEWG areas and surrounding locations. Prices per dosage are relatively high and purity varies, depending on geographical location. On the North Side of Chicago, MDMA is sold for \$25–\$30 per capsule, a price that has remained stable in recent years; home-made MDMA ("wigit") sells for \$15–\$20 per capsule. In New Orleans, where MDMA is sold in tablet form and embossed with logos such as doves, cupid's arrows, and smiley faces, it sells for \$6–\$32 per dosage unit. In New York City, MDMA sells for \$25–\$30 per retail dosage unit (one pill) but only \$2 per wholesale dosage unit, making the distribution of MDMA somewhat lucrative. In Phoenix, the DEA has purchased 13 tablets of MDMA ("Mitsubishi") and 50 doses of LSD for \$100. MDMA costs \$5–\$25 per dosage in Atlanta, \$20–\$25 in Dallas, \$15–\$80 in Houston, and \$25 per tablet in Washington, DC, where recent ethnographic sources report high-quality MDMA.

BEYOND THE CITY LIMITS...

Newark: "MDMA and the rave phenomenon are still unknown in Newark and other inner cities; however, MDMA is more available across the State, particularly in college towns. Recently, Princeton students reported that the drug has become trendy on campus and is usually distributed by students for about \$30 per pill. .."

**Exhibit 41. Methamphetamine prices and purity in reporting CEWG areas,
December 1999 reporting period**

Area	Purity (%)		Price		
			Gram	Ounce	Pound
Atlanta	35		\$100	\$1,500	\$14,600
Boston	NR		\$70-\$200	\$800-\$1,900	\$10,000-\$24,000
Denver	10-20		\$90-\$125	\$800-\$1,500	\$5,500-\$10,000
Hawaii (Oahu)	90-100	"wash"	\$200-\$300	\$3,500-\$5,000	\$40,000
		"clear"	\$800-\$1,000	NR	\$240,000-\$250,000
Los Angeles	15-20		^a \$100-\$120	^b \$500-\$700	\$5,000-\$6,000
Minneapolis/St. Paul	NR		\$100	\$900	\$10,000-\$12,000
New Orleans	NR		\$100-\$150	\$1,400-\$1,600	\$20,000
New York City	NR		\$200	\$1,750	\$20,000
Phoenix	10-30		\$60	NR	^c \$7,500
St. Louis	up to 100		\$37-\$100	\$800-\$1,600	NR
San Diego	20		\$450-\$750	NR	NR
Seattle	NR		^d \$20-\$30	NR	NR
Texas	NR		\$100-\$125	\$500-\$1,400	\$4,400-\$13,000
Washington, DC	1-84		\$100	\$1,200	\$14,800-\$18,000

a1/16 ounce ("teener")

b1/8 ounce ("eightball")

^ckilogram

^d1/4 gram

SOURCE: CEWG city reports, December 1999

In Chicago, over-the-counter preparations containing caffeine, ephedrine, or phenylpropanolamine, sell for \$1-\$2 each. Methylphenidate, purchased because of its psychoactive effects and low price, is available on the South Side for \$3-\$4 per pill and \$2-\$2.50 per pill if purchased in quantities of at least five pills. Methylphenidate also continues to be available and is popular among adolescents and young adults in Minneapolis/St. Paul. Phenmetrazine, usually sold on Chicago's North Side, has been available only in limited amounts during the past few years. Methylenedioxyamphetamine (MDA) availability has been noted in St. Louis, and benzphetamine (Didrex) remains available. Diet pills are being diverted for sale in New York.

Boston: "Methylphenidate has been reported by student groups and treatment providers as readily obtainable, especially in middle- and upper-class communities. Prescriptions are easily diverted for sale or personal use. ..

Khat (a flowering shrub imported via air from east Africa and the Middle East) is smoked, chewed, or made into tea because of the stimulant properties of cathinone, its primary ingredient. It has been reported in Boston and Minneapolis/St. Paul. In both cities, its use seems restricted to small enclaves of recent immigrants. Since its potency declines sharply after 48 hours, wide distribution is unlikely.

Methamphetamine Manufacture, Seizures, Trafficking, and Distribution

Atlanta: "Recently, two labs were closed within the city [which is].... interesting because ethnographers found that most users reside outside the city limits. --

Minneapolis/St. Paul: "In July, one methamphetamine lab was discovered in a fourplex on the north side of Minneapolis after the mishandling of anhydrous ammonia containers caused a major explosion. Six law enforcement officers were treated for burn and inhalation injuries. In October, another methamphetamine lab was discovered in a high-traffic neighborhood in a trendy, upscale part of south Minneapolis. Three pounds of methamphetamine were recovered, the largest amount of 'finished product' found at a lab in Minnesota to date. --

Phoenix: "[Methamphetamine] labs typically are portable, makeshift, and operated by nonchemists, all of which contribute to unsafe and unhealthy conditions. --

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 are pseudoephedrine tablets (including Xtreme Relief, Mini-Thins, Zolzina, and Ephedrine Release).

Due to recently mandated State precursor laws, methamphetamine precursors (mostly ephedrine and pseudoephedrine) are be-

DECREASES IN METHAMPHETAMINE INDICATORS: POSSIBLE REASONS...

- *State precursor laws:*
 - *Help to decrease precursor availability and increase precursor price*
 - *Cause available methamphetamine to be lower in purity than in earlier reporting periods, possibly resulting in fewer methamphetamine consequences*
- *Law enforcement crackdowns and seizures of clandestine labs:*
 - *Help diminish the methamphetamine supply*
- *National and community prevention programs*

coming increasingly expensive and difficult to obtain in many CEWG areas, and many methamphetamine manufacturers ("speed cooks") are using alternate cooking methods, precursors, and cutting agents. New production methods to accommodate hard-to-obtain precursors have been reported: (1) the use of diet pill extracts, such as phenylpropanolamine, to make amphetamine instead of methamphetamine, (2) the combination of ephedrine and phenylpropanolamine, with a mixture of amphetamine and methamphetamine as an end-product (verified by recent drug seizures in Denver), (3) the combination of dimethyl sulfone and 2-phenethylamine to simulate methamphetamine, and (4) the use of ephedra (an organic herb used in "herbal ecstasy" and taken to relieve respiratory ailments) as a precursor. These alternate manufacturing methods have caused the resulting methamphetamine

product to be less potent. Methamphetamine cutting agents, which also decrease purity, include dimethyl sulfone and 2-phenethylamine.

Although large retail sales and even larger wholesale quantities of pseudoephedrine continue to be a problem in Texas, methamphetamine labs using pseudoephedrine are increasing dramatically. Other methamphetamine precursors are difficult to obtain in Texas (again, due to State precursor laws). As a result, lab operators often travel to Oklahoma and Louisiana to obtain the chemicals needed.

BEYOND THE CITY LIMITS

St. Louis: "The Midwest divisions of the DEA have decreased the cleanup of clandestine methamphetamine labs. In FY 1999, 307 clandestine "box" labs were identified in southwestern Missouri, Kansas, and Nebraska. This decrease occurred as funding shifted to local enforcement for cleanup of these labs. Methamphetamine has become the major focus for this branch of law enforcement."

Increases in methamphetamine labs were reported in 5 CEWG areas: Atlanta; Minneapolis/St. Paul (between 1997 and 1999, the number of dismantled labs quadrupled to 97; two-thirds of the labs were located outside the county metropolitan area); Phoenix (420 lab seizures through the third quarter of 1999); Seattle (279 labs through third quarter 1999, more than double all seized in 1998; all were located outside of King County); and Texas.

In Chicago, street-level seizures of methamphetamine remained relatively stable from

1997 to 1998, at 20 seizures per quarter-year. In Hawaii, 80 pounds of methamphetamine were seized in 1998 and 60 pounds were seized as of September 1999. In Minneapolis/St. Paul, law enforcement sources reported encountering increasing quantities of methamphetamine and an increasing number of submissions: 1,411 grams of methamphetamine seized in 1996 compared with 4,487 grams in the first half of 1999; and 404 submissions to the State crime labs in 1996 compared with 614 in the first half of 1999.

AN ANTICIPATED SHIFT...

Atlanta: "Although the current methamphetamine market in Atlanta is controlled by Mexican trafficking groups, as local labs increase, this control is likely to shift."

Law enforcement agencies report increases in methamphetamine trafficking in many CEWG areas, including Atlanta, New Orleans, and San Antonio. Although methamphetamine is sometimes manufactured in local labs, much of the methamphetamine in the United States continues to come from Mexico, with a recent shift in importation from California to a more eastern part of the U.S.-Mexican border.

Methamphetamine in Atlanta, Boston, Minneapolis/St. Paul, New Orleans, New York City, and St. Louis is mostly Mexican-made and arrives via California and the southwestern States. Likewise, in St. Louis and New Orleans, Hispanic traffickers whose supplies originate in Mexico and California dominate distribution networks, rather than the earlier networks of motorcycle gangs. Sources in New York also cite Filipino drug

traffickers, who send multikilogram quantities of methamphetamine by air.

MDMA Seizures, Distribution, and Trafficking

MDMA seizures increased in several CEWG areas, including Boston; Minneapolis/St. Paul, where a single case in 1999 involved 2,200 doses; New Orleans (from 21 to 401 dosage units during the past 2 years); and New York City (from 7 seizures in 1997 to 79 in the first several months of 1999).

According to the DEA and local law enforcement sources, MDMA trafficking has increased in many eastern CEWG areas: Boston, where it is transported from Europe via New York; Miami, where supplies reportedly come from Belgium and the Netherlands; New York City, where supplies are imported from Belgium, the Netherlands, and Luxembourg; and Washington, DC.

INCREASES IN MDMA INDICATORS: POSSIBLE REASONS...

Boston: "The DEA, State Police, Department of Public Health drug lab, and the Massachusetts poison center reported increases in arrests, seizures, submissions, and calls related to MDMA trafficking and use.... The rise in MDMA use may be driven by an increase in availability, primarily from Europe via New York (according to the DEA) and by its reputation as a benign, mood-enhancing substance."

DEPRESSANTS

Minneapolis/St. Paul: "Ketamine ("Special K"), an injectable medication primarily used by veterinarians, first appeared as a drug of abuse in Minnesota in 1997 among adolescents and young adults. Since then relatively small amounts of ketamine have appeared in local crime labs. "

*San Francisco: "The most often mentioned 'club drug' lately, at least among gay men, has been **GHB** as well as its precursor, gamma-butyrolactone (GBL) or 'Blue Nitro. '"*

Texas: "Depressants continue to be a problem because of their availability in Mexico, with clonazepam (Klonopin) being substituted for flunitrazepam (Rohypnol). Mentions of depressants are up in Dallas ED mentions; flunitrazepam treatment admissions are increasing, especially in programs along the border."

This "depressant" section includes four groups of drugs: (1) nonbarbiturate sedatives, anesthetics, and muscle relaxers; (2) benzodiazepines; (3) antidepressants or selective serotonin reuptake inhibitors (SSRIs); and (4) barbiturates. Nonbarbiturate sedatives include gamma-hydroxybutyrate (GHB) and its precursors, gamma-butyrolactone (GBL) and 1,4-butanediol. Ketamine (Special K) is an anesthetic commonly used by veterinarians. Carisoprodol (Soma) is a muscle relaxant. Examples of benzodiazepines include alprazolam (Xanax), clonazepam (Klonopin or Rivotril), diazepam, flunitrazepam (Rohypnol), oxazepam (Serax), temazepam (Restoril), and triazolam (Halcion). SSRIs include amitriptyline (Elavil), fluoxetine (Prozac), and sertraline (Zolofi). Barbiturates include phenobarbital and secobarbital (Seconal).

MORTALITY DATA

Boston: "Ketamine has... been used as an adulterant in heroin, and may have played a role in some overdose deaths. "

Los Angeles: "In the past few months, at least two cases of multiple

deaths were directly attributed to attendance at a rave and to drug use. Although one of these incidents was a car crash, drugs were found in the car and in the toxicology screens. "

GHB/GHB precursor-related deaths remain few, but they are beginning to appear in many CEWG areas. In the first half of 1999, two GHB/GHB precursor accidental overdose deaths were recorded in San Diego, doubling GHB-related deaths in 1998. In the Miami area, at least six GHB-related fatalities have occurred since 1997, most of which also involved alcohol. In Minneapolis/St. Paul, one death due to GHB toxicity was recorded in 1999.

In Seattle, deaths involving depressants declined between the first halves of 1998 and 1999 (from **25** to 13); benzodiazepines were reported in 60 percent of the 1999 depressant deaths. Antidepressant deaths in Seattle also declined (from 24 to 11). In Philadelphia, most depressant and antidepressant deaths involved other drugs, and trends between the first halves of 1998 and 1999 differed according to drug: increases were reported for deaths involving sertraline, diazepam, and temazepam; declines were reported for fluoxetine- and alprazolam-

related deaths; and oxazepam deaths remained stable. In Seattle, depressant-related deaths involving concomitant injections of heroin and depressants (typically diazepam), first noted in 1998, continued in 1999 (four cases reported, totaling 27 percent of depressant-related deaths).

EMERGENCY DEPARTMENT AND OVERDOSE DATA

Atlanta: *"Reports of overdoses from a combination of GHB and alcohol among gay men suggest that the drug continues to be available and popular in certain settings."*

Boston: *"Heavy GHB use has been reported in some Boston clubs, sometimes associated with overdoses requiring ED treatment."*

South Florida: *"Eleven of the 26 ED patients [with GHB toxicity in the first half of 1999] were completely comatose, 3 experienced respiratory failure requiring endotracheal intubation, ... and 9 were combative at some point during their visit."*

GHB produces drowsiness, increased heart rate, depressed respiration, visual distortions, seizures, coma, unconsciousness, and sometimes even death. ED overdoses related to GHB or its precursors are beginning to occur in several CEWG areas. A south Florida emergency department treated 26 youth with GHB/GHB precursor toxicity during the first half of 1999, an increase from 18 cases in the second half of 1998, and 6 during the first half of 1998. GHB/GBL was responsible for 10 overdoses in the first 3 months of 1999 in Baltimore. In Newark recently, a **GHB** precursor (GBL) was suspected of sending 18 people to hospitals, and 2 GBL-related

overdoses were reported among Princeton students. In Minneapolis/St. Paul emergency departments, one to five GHB-related overdoses are treated per month. Seattle ED staff continue to report anecdotal accounts of three to four incidents per month of incapacitation, induced intoxication, and rape and other criminal behaviors.

Benzodiazepines generally continue to play a relatively small role in ED data. According to 1998 DAWN data, alprazolam had the highest ED rate per 100,000 population of the depressant category in 8 out of 20 CEWG cities; diazepam and clonazepam each held the highest rates in 5 cities. Among CEWG cities, Philadelphia had the highest alprazolam ED rate per 100,000 population (21.4), followed by Atlanta (13.5) and Newark (12.9). Between 1997 and 1998, alprazolam mentions increased significantly ($p < 0.05$) in four cities: Dallas, Newark, Phoenix, and San Diego. Conversely, during the same time period, diazepam mentions declined significantly ($p < 0.05$) in four cities: Chicago, Detroit, Phoenix, and San Francisco; in 1998, diazepam rates ranged from 2.7 in Minneapolis/St. Paul to 11.0 in Phoenix. Clonazepam rates ranged from 2.1 in New Orleans to 19.5 in Boston; they increased significantly ($p < 0.05$) in Baltimore and San Diego and declined significantly in four CEWG areas (Boston, Detroit, Miami, and San Francisco).

EXPLANATION FOR AN INCREASE?

Texas: *"Through 1997, the Dallas ED rate for clonazepam increased; this may have been related to the initial popularity of flunitrazepam and then the increasing use of clonazepam, legally imported from Mexico, to replace flunitrazepam."*

In 1998, antidepressants (amitriptyline and fluoxetine) continued to show relatively low ED rates (ranging from 0.9 to 6.3) in CEWG cities. Amitriptyline ED mentions declined significantly ($p < 0.05$) in five cities: Chicago, Minneapolis/St. Paul, Philadelphia, Phoenix, and Seattle; fluoxetine rates declined significantly in six cities: Denver, Miami, Phoenix, St. Louis, San Francisco, and Seattle. Carisoprodol was the depressant with the highest ED rate in New Orleans (11.3), and its rate equaled the diazepam rate in Phoenix (11.0). Carisoprodol ED mentions increased significantly in three cities: Baltimore, Detroit, and San Diego.

POISON CONTROL DATA

Boston: "Massachusetts Poison Control reported a surge of calls involving GHB...many involving youth."

Poison control centers in many CEWG areas reported that calls regarding GHB or its analogs increased in 1998 and in 1999:

- Boston: Calls related to GHB/GHB precursors totaled **23** percent of **213** recent calls, a percentage higher than that for LSD and psilocybin mushrooms combined, amphetamines, and MDMA.
- Los Angeles County: During the first 8 months of 1999, **55** GHB-related calls were made from Los Angeles County compared with 45 calls in all of 1998.
- Texas: In 1998, 167 GHB/GHB precursor poison control calls were reported.

Conversely, in 1998, GHB-related calls to the Colorado poison center dropped from the 1997 peak (from 6 to 1).

Flunitrazepam calls in Colorado more than doubled between 1997 and 1998 (from 8 to **22** calls). In 1998, 237 calls were made to Texas poison centers regarding flunitrazepam. During the same time period, prescription drugs (including diazepam and clonazepam) were mentioned in 5 percent of all calls to Massachusetts' substance abuse hotlines.

TREATMENT DATA

Miami: "A 27-year-old woman required a 7-day intensive care unit admission to treat her GHB withdrawal."

St. Louis: "Private treatment programs often care for benzodiazepine, antidepressant, and alcohol abusers. Day hospital programs and 3-day detoxification have become the treatments of choice."

Primary depressant treatment admissions remain low in most CEWG areas. For example, in New York City and Texas, only 1 percent of the adults entering treatment have a primary problem with depressants. However, benzodiazepines are the fourth most abused drugs next to heroin, cocaine, and marijuana in New Jersey, where since 1991, benzodiazepines have been mentioned by an average of 6 percent of treatment admissions with only minor year-to-year fluctuations. In Texas, especially along the U.S.-Mexico border, flunitrazepam treatment admissions are increasing: 159 youth were

admitted to treatment with a primary, secondary, or tertiary problem with flunitrazepam in 1998, and 174 were admitted in the first 9 months of 1999. In addition, 184 adults were admitted into Texas treatment programs during this period with a primary, secondary, or tertiary flunitrazepam problem.

DEMOGRAPHIC DATA

Miami: *"Local indicators continue to reveal significant GHB abuse and a shift to younger users."*

New Orleans: *"Flunitrazepam continues to be popular among white, upper-class high school and college students, perhaps due to its low cost and the perception that it is safe...."*

Club drugs, including GHB/GHB precursors and ketamine, are easily obtainable in most CEWG areas and are used in clubs, raves, and concerts mostly by white adolescents and young adults. For example, in a south Florida hospital during the first half of 1999, GHB toxicity patients were age 18–33, the majority were male and white, and the location of the incident requiring the ED visit was a local bar/nightclub in 65 percent of the cases. In Texas, GHB poison control cases generally involved persons in their twenties and older, while flunitrazepam-related poison calls involved persons primarily in their teens. In Baltimore, ketamine users are reportedly white youth from middle- and upper-class backgrounds. Similarly in Boston, needle exchange personnel reported that some younger, white, middle-class clients inject ketamine.

Boston: *"Adolescent treatment providers and youth focus groups indicated that prescription drugs*

[including alprazolam and clonazepam] are commonly available."

In Miami, alprazolam and clonazepam have replaced flunitrazepam among adolescents. Similarly, in Texas, clonazepam is being used by juveniles in combination with beer just as flunitrazepam had been used.

USE PATTERNS AND CONTEXTS

BEYOND THE CITY LIMITS...

Phoenix: *"The Bureau of Land Management and Maricopa County Sheriff's Office reported significant GHB use at rave parties that are held in the rural areas of the counties."*

Club drugs, including GHB and its precursors (GBL and 1,4-butanediol), ketamine, and flunitrazepam (and some stimulants and hallucinogens), are usually taken at parties, raves, and clubs. GHB has appeared in indicators in 13 of 20 CEWG areas, and increases in GHB indicators were reported in 8 of these areas (Baltimore, Los Angeles, Miami, Minneapolis/St. Paul, Newark, New Orleans, Phoenix, and San Diego).

Ketamine has appeared in indicators in six areas and its use appears to be increasing since the last reporting period in Newark. Ketamine is injected intramuscularly in Boston, although it is more often converted to a powder and snorted; it is often used as an alternate for or in addition to heroin. In New York City, ketamine is either snorted or injected, and it is sometimes mistaken for cocaine HCl.

Boston: "Indiscriminate use of these drugs [prescription drugs such as alprazolam and clonazepam] in various combinations and with alcohol seems to have increased recently, according to a treatment provider contact... [those drugs] were mentioned by adult focus group participants and treatment providers as common ancillary or substitute drugs for heroin, the use of which might contribute to risk of overdosing. They are also reportedly used to potentiate the effects of methadone."

"Rollers," the combination of stimulants and depressants, remain common among Miami youth. Several ethnographic sources indicated that some heroin users in Chicago are taking pharmaceutical depressants, referred to as "beans," to potentiate the effect of opiates, and field reports from Chicago's South Side indicate an increase in amitriptyline taken immediately after heroin to increase its effect. In Philadelphia, crack cocaine users continue to report the frequent use of alprazolam and diazepam.

LAW ENFORCEMENT DATA

Minneapolis/St. Paul: "Flunitrazepam... was suspected but not proved to be involved in a recent rape case at a fraternity house on the Minneapolis campus of the University of Minnesota."

Arrest Data

Minneapolis/St. Paul: "A 42-year-old man pleaded guilty to putting a sleeping pill into the beverage of a woman without her knowledge with the intent of having sex with her. He was believed to be the first person in the country to be prosecuted under the Federal Drug Induced Date Rape

Prevention and Punishment Act....the drug involved was zolpidem tartrate (Ambien)...."

Depressant-positive levels among arrestees remain relatively low in the two CEWG areas where data are available: Of adult male arrestees in Seattle, 4 percent tested positive for depressants between July 1998 and June 1999. In Texas, benzodiazepines were the depressant drugs most often identified by **ADAM** in the first three quarters of 1999 (with positive findings ranging from 2 to 9 percent).

Market Data

Atlanta: "GHB is available in some gyms and is reputed to be widely accessible at gay male party venues.... DEA sources report that the most common manufactured depressants available in Atlanta include GHB and flunitrazepam..."

Boston: "One treatment provider for youth reported clients mentioning 'Enliven,' a liquid supplement sold until recently via the World Wide Web, and apparently designed to approximate the effects of GHB..."

South Florida: "The availability of GBL in local commercial products, such as Blue Nitro and Renew Trient, in local nutrition stores further fuels GHB overdoses in south Florida."

New Orleans: "The New Orleans Police Department reports a dramatic increase in GHB availability in both liquid and powder forms. GHB is prevalent in bars and lounges in the French Quarter area of the city."

In many CEWG cities, GHB, known as "Georgia home boy," "grievous bodily harm," "gamma," "G," "liquid E," "liquid

X,” “scoop,” and “somatomax,” seems to be increasingly sold at parties. GHB is often manufactured in homes by “kitchen chemists” who use recipes and ingredients found on the Internet. It is often in liquid or powder form and is usually sold in doses (capfuls or thimblefuls) (exhibit 42)

Exhibit 42. 1999 depressant prices

Drug	City	Price/Unit
GHB	Atlanta	\$10-\$25/dose
	Miami	\$5/capful
ketamine	New York City	\$20/dose
alprazolam clonazepam	Atlanta	\$3-\$5/pill
	Seattle	\$1-\$4/pill
diazepam	Chicago	\$1-\$4/pill
	Dallas	\$1-\$3/pill
	Seattle	\$1-\$4/pill
flunitrazepam	Atlanta	\$5-\$10/pill
	New Orleans	\$5-\$10/pill

SOURCE: CEWG city reports, December 1999

BEYOND THE CITY LIMITS...

Baltimore: “A small but stable market for ketamine is reported in the suburban counties.... ketamine is usually taken in social venues such as clubs, raves, and parties. --

GBL and 1,4-butanediol, both precursors to GHB, are easy to purchase on the Internet. They are sold as sleep aids, muscle builders, and sexual enhancers. They are distributed in most U.S. cities in health food stores, tanning salons, head shops, and gyms. GBL is sold in powder and liquid formulations and is often referred to as “goop.” Its brand names include Blue Nitro, Fire Water,

Furomax, GH Release, GH Revitalizer, Gamma-G, Insom X, Invigorate, Remforce, RenewTrient, Revivarant, Revivarant G, and X-Depress. Four to five capsules of GBL supposedly produce 2 grams of GHB in the body. Like GBL, 1,4-butanediol absorbs quickly, metabolizes into GHB, and causes the same responses as GHB in the body. Products containing 1,4-butanediol include Dormir, Enliven, GHRE, Neuro Mod, NRG3, Promusol, Rejuv@Nite, Revitalize Plus, Thunder Nectar, Serenity, SomatoPro, Weight Belt Cleaner, and White Magic. While some of those products list 1,4-butanediol (also listed as tetramethylene glycol or 2(3H-)furanone di-hydro), others, such as Thunder Nectar, have no label.

Boston: “Diverted prescription medications, including drugs such as alprazolam, clonazepam, and oxycodone, are widely available. --

New York City: “According to the DEA, the major pharmaceuticals on the streets are the benzodiazepines and hydrocodone. --

Diazepam and alprazolam, the most frequently encountered benzodiazepines, are easily obtainable in almost all CEWG areas, with reported prices in the \$1-\$5 range. In Chicago, diazepam is the most readily available and frequently used pharmaceutical depressant and is a common component in a variety of multidrug ingestion patterns. Depressants continue to be a problem in Texas because of their availability in Mexico, with clonazepam being substituted for flunitrazepam. In Honolulu, barbiturate prices have remained stable at \$3-\$20 per pill.

Manufacture, Seizures, and Trafficking

One seizure of GHB was reported in the Minneapolis/St. Paul area in 1999, and in New Orleans seizures of flunitrazepam, which continues to be smuggled into the

United States from Mexico, reportedly increased in 1999. The Massachusetts Police drug lab reported that seizures of diverted prescription drugs have increased dramatically in recent months, connected with a rash of pharmacy break-ins in Massachusetts.

HALLUCINOGENS

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."

Chicago: "Ethnographic reports suggest some increased phencyclidine (PCP) use in Chicago."

EMERGENCY DEPARTMENT AND POISON CONTROL DATA

Philadelphia, by far, had the Nation's highest estimated rate of phencyclidine (PCP) ED mentions per 100,000 population in 1998, followed by Los Angeles and Seattle (exhibit 43). Between 1997 and 1998, PCP-related mentions declined significantly ($p < 0.05$) in San Francisco (45 percent), New Orleans (38 percent), and Baltimore (37 percent). No significant increases were reported,

Boston: "In focus groups, lysergic acid diethylamide (LSD) or 'acid' was in many cases the illicit drug most often mentioned after marijuana and pharmaceuticals."

LSD ED mentions are relatively few across the Nation, with the highest 1998 estimated rate per 100,000 population (6.4) recorded in New Orleans, followed by Seattle and Phoenix (exhibit 43). Moreover, between 1997 and 1998, LSD mentions declined significantly ($p < 0.05$) in 7 of the 20 CEWG cities in **DAWN**: Detroit (64 percent), New York (46 percent), Washington, DC (46 percent), San Francisco (41 percent), Minneapolis/St. Paul (35 percent), Denver (23 percent), and Miami (14 percent). The only significant increases were reported in New Orleans (22 percent) and Dallas (21 percent).

LSD and psilocybin were involved in 15 percent of recent poison control calls

($n=213$) in Boston—a percentage equal to that for MDMA (ecstasy) but below that for amphetamine (16 percent) and GHB and its precursor, GBL (23 percent).

TREATMENT DATA

Treatment numbers and percentages involving primary hallucinogen use generally remain low and stable. Two slight increases were reported. In New Orleans, between the first halves of 1998 and 1999, primary PCP admissions increased from 3 percent ($n=10$) to 6 percent ($n=188$) of treatment admissions; other hallucinogens, however, continued to account for less than 1 percent of admissions. And in Chicago, LSD treatment admissions declined between FYs 1996 and 1997 (from 550 to 131) but rebounded in FY 1998 (to 455—a 247-percent increase).

DEMOGRAPHIC DATA

New Orleans: "High school students are beginning to experiment with these drugs [LSD and PCP] again."

Seattle: "Hallucinogenic drugs such as LSD and psilocybin mushrooms continue to appear in area reports involving primarily younger users. The drugs turn up frequently at local concerts or raves."

Texas: "In Lubbock, Beaumont, and Tyler, LSD is used by college and high

school students. In Dallas, LSD is becoming more available in the young adult nightclub scene..

New York City: "According to the Street Studies Unit (SSU), mushrooms or 'shrooms' have become more popular among teenagers and young adults.... the term applied to mushroom users is 'eaters,' and the question is openly posed, 'Do you want to eat?' Since few adults understand the jargon, young users take special pleasure in the new meaning....."

According to field and indicator data, hallucinogen users tend to be adolescents or young adults, they are more likely to be male than female, and racial/ethnic predominance varies from city to city. In Phoenix, for example, all four PCP-related homicides in the first half of 1999 involved young, African-American males age **20-24**. Among New

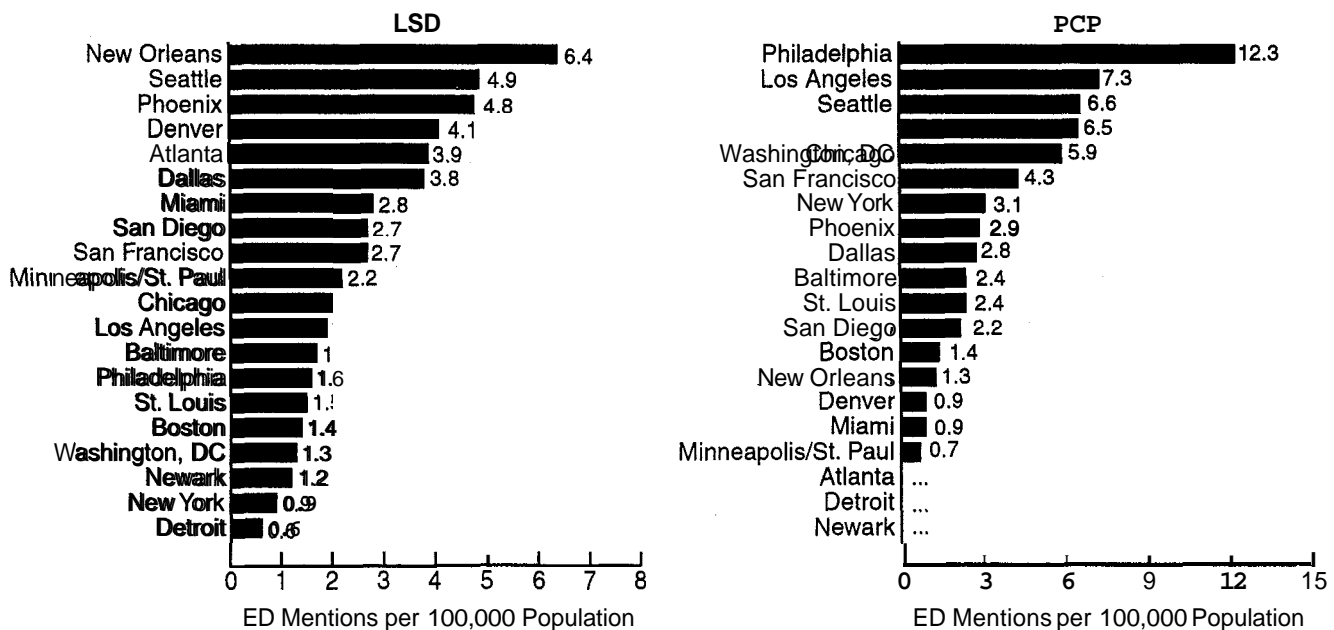
Orleans PCP treatment admissions, **45** percent were white males, 33 percent were white females, and **22** percent were African-American males. In a south Florida hospital, all six ED cases of LSD intoxication involved young white people: four males and two females.

Local urinalysis data in Washington, DC, show some recent changes in juvenile arrestee PCP-positive findings: after declining sharply between 1995 and 1998 (from **18** percent to **3** percent), levels increased somewhat in the first 10 months of 1999 (to **7** percent).

USE PATTERNS

In Chicago, PCP is smoked and sold in three forms: "mint leaf " or "love leaf" (a moist,

Exhibit 43. Rate of LSD and PCP ED mentions per 100,000 population by city, 1998



NOTE: "..." denotes that estimate does not meet the standard of precision or is less than 10.

SOURCE: Office of Applied Studies, SAMHSA, Drug Abuse Warning Network, 1998 (July 1999 update)

loose, tobacco-like substance sprayed with PCP and wrapped in tinfoil); "sherm sticks" or "happy sticks" (cigarettes dipped in PCP); and "wicky stick" or "donk" (PCP mixed with marijuana). Similarly, in New York City, PCP is sold in two forms: as a powder sprinkled on green mint leaves or marijuana, or in liquid form in a small shaker bottle. In St. Louis, PCP is generally used as a dip on marijuana joints. And in Texas, marijuana cigarettes are sometimes dipped in embalming fluid containing PCP. In New York City, mushrooms are dipped in or treated with PCP, LSD, or methamphetamine.

Emergency department data from a south Florida hospital reveal several LSD-drug combinations: among six LSD-intoxicated patients in the first half of 1999, all tested marijuana-positive; two were also positive for cocaine; one was also positive for amphetamines; and two claimed to have also abused MDMA or "rolls" (a combination of MDMA and cocaine). "Rolling and trolling" (LSD combined with MDMA) remains common among youth in that area. The LSD-MDMA combination is also reported in Texas, where some LSD has also been found mixed with other drugs, such as diazepam. LSD is linked to methamphetamine in Texas, but the link is related to distribution rather than combined consumption: it is sold there by Mexican nationals who also distribute methamphetamine.

LAW ENFORCEMENT DATA

Arrestee Data

During the first half of 1999, Washington, DC, by far, had the highest PCP-positive urinalysis level among **ADAM** adult male arrestees (19 percent); Philadelphia followed

(at 7 percent). Females tested positive at much lower levels with the highest at 2 percent in Houston and Los Angeles. Los Angeles also had the highest level for juvenile males (1 percent).

The Washington, DC, PCP-positive level for adult males represents a dramatic 17-percentage-point increase compared with levels in 1998. Pretrial Services urinalysis data in that city also suggest a possible upturn in 1999 after a marked decline during the past 10 years. The only other notable ADAM shifts for adult males between the two reporting periods were reported in Dallas (a 2-percentage-point increase) and Philadelphia (a 3-point decline). Findings remained relatively stable among adult females and juvenile males.

Market Data

BEYOND THE CITY LIMITS....

Chicago: "LSD hits...are available in both the city and most suburbs. .."

St. Louis: "LSD has sporadically reappeared in local high schools and rural areas. .."

LSD availability is reported in the majority of cities and often in the suburbs and surrounding rural areas. In Phoenix, it is sometimes referred to as "the mad hatter." Reports of PCP availability are more sporadic. The drug is rare in most of New England, according to the DEA, but it is available a little further south, in New York City. Moving down the eastern seaboard, seizure data suggest declining availability in Washington, DC: PCP seizures there declined between 1997 and 1998 (from 68 to

44) and appear to be declining further in 1999 (29 during the first 9 months). In some inner cities, such as St. Louis, PCP is available in limited quantities. Psilocybin mushroom availability is reported in Boston, New York City (where they are grown locally), and Minneapolis/St. Paul. Mescaline availability is reported in Boston, and peyote availability is reported in Phoenix.

New York City: "According to the SSU, PCP ('angel dust') continues to be available in the city."

Exhibit 44. PCP prices in reporting CEWG areas, December 1999 reporting period

Area	Price/Unit	
	Ounce	Other
Boston	\$500-\$1,200	\$50/1-1.5 g
Chicago	NR	\$10-\$20/ "mint leaf" \$30/dipped cigarette \$20/mixed marijuana joint
New York City	NR	\$10,\$20/ bag \$20/bottle
Washington, DC	\$350	NR

SOURCE: CEWG city reports, December 1999

Reported prices for PCP and LSD vary somewhat across the country (exhibits 44 and 45). Stable prices are reported for PCP in Washington, DC, and for LSD in Boston and New Orleans. LSD in New York City is less potent than it was in the 1960s and 1970s. Reported mushroom prices include \$10-\$50 in New York City for large "treated" mushrooms (sometimes used by groups) and \$150-\$200 per ounce in Minneapolis/St. Paul.

Exhibit 45. LSD prices in reporting CEWG areas, December 1999 reporting period

Area	Price/Unit	
	Dose	100-dose sheet
Atlanta	\$4-\$6	NR
Boston	\$5	\$200
Chicago	\$5	NR
Honolulu	\$4-\$6	\$225-\$275
Minneapolis/ St. Paul	\$1-\$5	NR
New Orleans	\$1.50-\$8	\$200-\$400
New York City	\$0.50	NR
Phoenix	\$5	NR
St. Louis	\$2-\$4	NR
Texas	\$2-\$10	NR
Washington, DC	\$5	NR

SOURCE: CEWG city reports, December 1999

OTHER DRUGS

- **Dracorhodin:** A substance with mild hallucinogenic effects, called “red rock opium,” “red run,” and “red stuff,” is smoked in Baltimore in combination with marijuana. It contains dracorhodin, a compound found in the plant *daemonecrops draco* (“dragon’s blood”), used in varnishes and stains, as an herbal medicine, and to make incense.
- **Anticholinergic plants:** Teenagers in south Florida occasionally abuse two local anticholinergic plants, “devil’s trumpet” and “angel’s trumpet,” by various routes (orally or via smoking), for their hallucinogenic properties. The plants’ toxic effects led to at least three medical emergencies involving teenage boys during March 1999.
- **Jimson weed** has been involved in one recent death and several poison center calls per month in Phoenix.
- **Dextromethorphan (DXM):** Teens in some cities, such as Boston and Minneapolis/St. Paul, commonly abuse over-the-counter cough preparations containing dextromethorphan (“robo tripping”) for their hallucinogenic properties, their numbing effects, and their ability to prolong and enhance the effects of other drugs.
- **Inhalants:** Toluene was involved in three of four inhalant deaths in Phoenix in the first half of 1999. The decedents were demographically diverse: a 16-year-old white female, a 29-year-old Native American, an 18-year-old male, and a 55-year-old male. In Texas, inhalants were mentioned in 144 deaths between 1998 and 1999. They included chlorinated hydrocarbons (such as Scotchguard, Liquid Paper, or carburetor cleaner), freon, toluene, and nitrous oxide. The majority of those decedents were male (92 percent) and white (81 percent), and the average age was 25.6; however, age, ethnicity, socioeconomic status, and school/employment status varied widely according to type of inhalant. Also in Texas, inhalant abusers constituted 2 percent of admissions to adolescent treatment programs in 1999. Those youth tended to be Hispanic males involved in gangs.

Philadelphia: “Focus groups held in spring 1999 continued to identify the use of toluene and other solvents in certain areas of Philadelphia. The practice is referred to as ‘huffing,’ and the predominant users are white males in their preteens or early teens.”
- **Steroids:** Needle exchange personnel in areas surrounding Boston report that young male bodybuilders inject steroids intramuscularly. In Atlanta, law enforcement sources note the potential for abuse of the anabolic steroid **clenbuterol** (Spiropent) by weightlifters.
- **Sildenafil citrate (Viagra):** Recent police road stops in Boston have resulted in seizures of sildenafil citrate. Anecdotal reports suggest increased illicit availability.

INFECTIOUS DISEASES RELATED TO DRUG ABUSE

Newark: "The rise in injecting drug [mostly heroin] use poses a major health challenge because of its implications for the spread of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and hepatitis C among drug users. ..

San Francisco: "It appears that the rapid increase in methamphetamine use (primarily by injection) among gay men in the early 1990s has led...to a corresponding increase in AIDS cases, ..

AIDS Mode of Exposure

Texas: "[According to a 1999 HIV prevention counseling and partner elicitation data collection system], the most significant drug use factors for testing HIV positive for males are selling sex, using cocaine and then having sex, and using inhalants and having sex; for whites, significant factors are using inhalants and having sex; and for African-Americans, the most significant factors are using cocaine and having sex, being an injecting drug user (IDU), and sharing injecting equipment. ..

According to the Centers for Disease Control and Prevention (CDC), one of the most common modes of exposure among AIDS cases nationwide continues to be injecting drug use, second only to male-to-male sex. Through December 1999, injection-related AIDS cases accounted for 32 percent of cumulative adult and adolescent diagnoses: 26 percent involved injecting drug use as the sole mode of exposure; 6 percent involved the dual risk categories of injecting drug use and male-to-male sex (exhibit 46).

Newark and New York City continue to have the highest levels of injecting drug use as the sole mode of exposure among reporting CEWG areas (57 and 47 percent, respectively). Between 1998 and 1999, injecting drug use levels as mode of exposure for AIDS remained relatively stable or declined, except in Illinois and Newark, where proportions of IDUs increased (1 and 9 percentage points,

respectively). The proportions of dual exposure of injecting drug use and male-to-male sex remained relatively stable except for increases in St. Louis, San Francisco, and Seattle.

Local studies in Seattle-area drug treatment agencies indicate an HIV seroprevalence of 1-4 percent among heroin and cocaine injectors, but 47 percent among gay and bisexual males who inject methamphetamine. A survey of IDUs recently booked in the King County jail in Seattle found that among HIV-positive arrestees, 87 percent reported injecting heroin, 69 percent speedballs, 65 percent cocaine, and 25 percent amphetamines; frequency of sharing drug use equipment was high.

AIDS Demographic Data

Nonwhites continue to account for a disproportionately high number of injection-related AIDS cases. For example, in Georgia the rate of injection-related AIDS cases among African-Americans is 15 times the rate for whites; in New York City, 47 percent of heterosexual IDUs with AIDS are African-American, and 38 percent are Hispanic; and in Seattle, methadone patients of African-American or Native American backgrounds have higher HIV prevalence compared with white clients (2.5, 4.2, and 1.5 percent, respectively). Among cumulative AIDS cases in Washington, DC, only 3 percent of white

males with AIDS but about 30 percent of African-American males report injecting drug use as their primary exposure mode. In San Francisco, heterosexual IDUs with AIDS are mostly black males, similar to the heroin user population; gay and bisexual male IDUs are mostly white males, similar to methamphetamine users.

The proportion of IDUs is higher among females with AIDS than among males with AIDS in all reporting CEWG areas: Texas, 40 percent of females with AIDS are IDUs, while the level for their male counterparts is 21 percent (including both singular and dual modes of exposure). Similarly in Los Angeles, 26 percent of females with AIDS are IDUs, but only 13 percent of males are IDUs (including both singular and dual modes of exposure). In Georgia, 31 percent of females with AIDS are IDUs compared with 23 percent of males with AIDS. In Washington, DC, more than half of the females with AIDS reported injecting drug use as their exposure mode, compared with 22 percent of males with AIDS. In New York City, female IDUs with AIDS are younger than their male counterparts: 66 percent of the females are 39 or younger, compared with 55 percent of the males.

Infectious Diseases Other Than AIDS Among IDUs

- **Hepatitis B**—The reported cases of hepatitis B in San Francisco between 1995 and 1999 increased slightly, but IDUs constituted less than half the cases. Hepatitis C seems to be emerging as a far greater health concern for IDUs than hepatitis B.

Hepatitis C—Between 1994 and 1998, hepatitis C cases reported to the Los Angeles Health Department nearly tripled (from 1,254 to 3,670 cases), and it is likely that a substantial number of the new cases are related to drug use. According to recent studies of hepatitis C among older IDUs in Baltimore, more than 90 percent had the hepatitis C virus. A Baltimore-based study of hepatitis C rates among young IDUs in several cities found high hepatitis C-positive levels in Baltimore, New York City, Chicago, New Orleans, and Los Angeles (58, 50, 33, 28, and 23 percent, respectively). Preliminary HIV serosurveillance results of San Francisco-area IDUs suggest an infection rate in the 50–60 percent range.

- **Skin infections**—In New York City, injecting crack cocaine dissolved with lemon juice or vinegar has been causing serious skin infections; some needle exchange programs have been distributing kits of boric acid and vitamin C to treat the problem. An increase in abscesses secondary to heroin injection is reported in San Francisco.
- **Syphilis**—In Colorado, four early latent syphilis cases have been reported in the most recent 8-week time period (fall 1999); two of these cases have been linked to sex-for-crack cocaine practices, with more than 20 at-risk individuals identified by outreach workers.

Exhibit 46. Acquired immunodeficiency syndrome among injecting drug users as reported by CEWG representatives, December 1999

Area	Cumulative Number of Cases (Reported through month/year for areas specified)				% Increase 98-99	% IDU (sole mode of exposure)			% IDU and men/sex/ men (dual mode of exposure)		
	Dec 97 CEWG	Dec 98 CEWG	Dec 99 CEWG	Dec 99 CEWG		Dec 97	Dec 98	Dec 99	Dec 97	Dec 98	Dec 99
	Arizona ^a	5,259 (10/97)	5,944 (11/98)	6,756 (10/99)		6,756 (10/99)	13.7	9.0	10.0	10.0	12.0
Baltimore, MD	10,679 (6/97)	^c 11,827 (6/98)	13,009 (6/99)	13,009 (6/99)	10.0	NR	NR	NR	NR	NR	
Colorado	6,019 (9/97)	6,172 (3/98)	6,656 (9/99)	6,656 (9/99)	7.8	8.2	8.3	8.7	10.7	10.8	
Georgia	^b 17,985 (6/97)	^c 19,324 (6/98)	21,167 (9/99)	21,167 (9/99)	9.5	19.0	19.3	19.0	6.0	5.7	
Honolulu, HI	^b 1,479 (6/97)	^c 1,576 (6/98)	^d 1,667 (6/99)	^d 1,667 (6/99)	5.8	NR	NR	NR	NR	NR	
Illinois	19,956 (9/97)	20,679 (3/98)	22,696 (9/99)	22,696 (9/99)	9.8	26.0	26.0	27.0	5.0	5.0	
Los Angeles County ^a , CA	36,315 (9/97)	38,067 (9/98)	40,281 (9/99)	40,281 (9/99)	5.8	5.0	7.0	6.0	7.0	7.0	
Louisiana	^a 9,843 (11/97)	^c 10,708 (6/98)	^d 11,584 (6/99)	^d 11,584 (6/99)	8.2	16.0	18.0	NR	9.0	NR	
Massachusetts ^a	12,750 (10/97)	13,448 (11/98)	14,788 (10/99)	14,788 (10/99)	10.0	34.0	35.0	35.0	4.0	4.0	
Miami-Dade County, FL ^a	19,382 (11/97)	20,751 (9/98)	22,235 (10/99)	22,235 (10/99)	7.2	19.0	18.0	17.0	3.7	3.0	
Michigan	^b 8,770 (6/97)	9,518 (7/98)	^d 10,267 (6/99)	^d 10,267 (6/99)	7.9	NR	24.0	NR	NR	NR	
Minnesota	3,040 (6/97)	3,201 (6/98)	3,477 (10/99)	3,477 (10/99)	8.6	8.0	8.0	8.0	7.0	7.0	
Newark, NJ ^a	6,328 (6/97)	6,766 (9/98)	7,070 (6/99)	7,070 (6/99)	4.5	58.0	48.0	57.0	4.0	4.0	
New York, NY ^a	94,524 (3/97)	103,248 (3/98)	110,395 (3/99)	110,395 (3/99)	6.9	45.0	45.0	47.0	3.0	NR	
Philadelphia, PA ^a	9,725 (6/97)	10,753 (6/98)	11,822 (6/99)	11,822 (6/99)	9.9	34.7	35.5	35.9	6.3	6.0	
St. Louis, MO	3,054 (6/97)	3,248 (5/98)	3,462 (5/99)	3,462 (5/99)	6.6	6.0	8.0	6.1	6.3	6.2	
San Diego County ^a , CA	8,997 (11/97)	9,540 (11/98)	^d 9,876 (6/99)	^d 9,876 (6/99)	3.5	8.0	8.0	NR	8.0	NR	
San Francisco County, CA	24,682 (9/97)	25,693 (9/98)	26,398 (9/99)	26,398 (9/99)	2.7	6.5	6.6	6.6	9.7	12.0	
Seattle, WA (King County)	5,327 (9/97)	5,584 (9/98)	5,799 (9/99)	5,799 (9/99)	3.9	5.0	8.0	^e 7.0	10.0	^e 10.0	
Texas	^b 42,185 (6/97)	^c 46,542 (6/98)	NR (9/99)	NR (9/99)	NR	17.0	20.0	^a 16.0	6.0	^a 7.0	
Washington, DC	9,865 (6/97)	10,828 (6/98)	^d 11,312 (12/98)	^d 11,312 (12/98)	4.5	27.0	32.0	28.0	5.0	NR	
Total U.S.	^b612,078 (6/97)	665,357 (6/98)	^d711,344 (6/99)	^d711,344 (6/99)	6.9	^b26.0	^c26.0	^{a, d}26.0	^b6.0	^{a, d}6.0	

^a Calculated from adult and adolescent cases only

^b SOURCE: Centers for Disease Control and Prevention, HIV/AIDS Surveillance Report 9(1):5,16, 1997

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

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

^e Proportions based on 10/1/96-9/30/99 AIDS cases.

