



Office of National
Drug Control Policy

PULSE CHECK
National Trends in Drug Abuse

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

Summer 1997

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Office of National Drug Control Policy

PULSE CHECK: Special Edition

Methamphetamine Trends in Five Western States and Hawaii

**Executive Office of the President
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January 1997

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Foreword

The *Pulse Check*, published by the Office of National Drug Control Policy (ONDCP), is a series of regular reports on drug use across the nation. Its name captures its purpose: to provide a quick sense of what is happening with regard to drug abuse and drug markets across the country. In the four years the *Pulse Check* has been conducted, it has provided valuable descriptions of the drug scene that inform researchers and policy makers in a timely manner. However, *Pulse Check* is not a population-based survey and should not be considered a substitute for such surveys.

The *Pulse Check* is conducted periodically¹ by Dr. Dana Hunt of Abt Associates. Data are collected through telephone conversations with 15-20 drug ethnographers and epidemiologists, 10-20 law enforcement agents, and 40-50 drug treatment providers all over the country. The ethnographic and law enforcement sources are chosen to represent various areas of the country, and are generally the same for each round of calls. Treatment providers are drawn randomly from a national listing of small and large treatment programs. Thus, the *Pulse Check* provides a blend of information and perspectives on the state of drug abuse in America.

One important element of the *Pulse Check* program is the additional capability it provides to perform quick turnaround, special studies of emerging problems, special populations, or certain geographical areas. The current situation surrounding methamphetamine trafficking and use is of considerable concern for policy makers at all levels, so is an appropriate topic for a special edition of the *Pulse Check*. Unlike the regular *Pulse Check*, this special edition focuses only on six States and on the problems associated with methamphetamine abuse.

¹Since 1992 *Pulse Check* has been conducted on a quarterly basis; however starting with this edition, it will be conducted bi-annually.

Introduction

Methamphetamine, a powerful central nervous system stimulant, has been part of the drug culture for many years. It was developed early in this century from its parent drug amphetamine and was originally used in nasal decongestants, bronchial inhalers, and in the treatment of narcolepsy and obesity. Legally produced by pharmaceutical houses, amphetamine and methamphetamine were widely available in the 1950s and '60s through prescriptions as well as from a booming black market. The Food and Drug Administration estimated in 1962 that over 8 billion tablets were legally produced each year with as much as half of that production going to unauthorized users.² In the 1970s methamphetamine became a Schedule II drug; that is, a drug with little medical use and a high potential for abuse.

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

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

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

² For a complete discussion of the history of amphetamine use see Grinspoon and Hedblom *The Speed Culture: Amphetamine Use and Abuse in America*, Cambridge MA., Harvard University Press, 1975.

Sources for this Report

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

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

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

Methamphetamine in Selected States

CALIFORNIA

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

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

The prevalence of methamphetamine reported by all California sources reached for this report is consistent with recent DAWN data which places San Diego, San Francisco, and Los Angeles in the top five cities nationwide in emergency room mentions for methamphetamine in 1995. These three cities also lead the nation in the number of medical examiner reports (deaths) related to methamphetamine. There are interesting differences in route of administration reflected in DAWN data between these cities.³ In San Francisco almost two-thirds of the methamphetamine mentions involve injection, whereas in the other two cities only 10-12 percent of mentions involve injection.

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

³ These data should be interpreted with caution as they have problems due to large numbers of unspecified answers.

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

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

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

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

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

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

- 1) students, both high school and college age, males and females, and
- 2) white, blue collar workers or unemployed persons in their twenties.

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

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

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

WASHINGTON STATE

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

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

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

Epidemiologic sources point out that while the majority of users continues to be rural bikers and blue collar workers, there are also a number of other groups now using. For example, it is reported that the drug is becoming increasingly popular among street youth, among Native American populations and among Hispanic

immigrants. This source describes this as a diffusion from rural to urban, from gay populations to heterosexuals and from white to minorities.

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

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

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

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

OREGON

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

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

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

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

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

ARIZONA

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

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

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

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

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

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

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

NEW MEXICO

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

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

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

Several providers report that the stabilization in use is due to crackdowns on local labs in their area as well as a rise in the popularity of heroin in the State. Methamphetamine is described as widely available, however. As one provider commented, "They think they won't become addicted and it is cheaper than anything but pot." Programs in remote or very rural areas of the State often report users who value the drug for its ability to keep them working on farms or in oil fields for long periods of time allowing them to accumulate extra or overtime pay. Too often, that pay is spent on the common companion or primary drug problem, alcohol.

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

HAWAII

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

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

69 percent of treatment providers interviewed felt that methamphetamine use had increased over the past year and 25 percent felt it was stabilizing. It is the primary drug of abuse at entry for 38 percent of programs interviewed, second only to alcohol (44%) and followed by marijuana (19%). An average of 55

percent of the clients at entry use methamphetamine, and, as in other States, it is trouble with the law which prompts them to seek treatment most of the time (44%). Several providers receive clients through employee assistance programs which refer employees who have exhibited inappropriate or aggressive behavior on the job or chronic absenteeism.

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

SUMMARY

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

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

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

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

CITIES REPRESENTED IN SAMPLE OF TREATMENT PROVIDERS

Washington

Kirkland
Seattle
Wenatchee
Spokane
Yakima
Everett
Longview
Pasco
Tacoma

Arizona

Phoenix
Tempe
Tucson
Holbrook
Kingman
Chino
Chandler

New Mexico

Albuquerque
Carlsbad
Alamogordo
Hobbs
Santa Fe

Hawaii

Honolulu
Kailua
Wahiawa
Waianae
Lihue
Pearl Harbor
Ewa Beach
Makawao
Wailuku

Oregon

John Day
Eugene
Medford
Portland
Pendleton
Albany
Salem
Hillsboro

California

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

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

Methamphetamine in Selected States

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

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

The prevalence of methamphetamine reported by all California sources reached for this report is consistent with recent DAWN data which places San Diego, San Francisco, and Los Angeles in the top five cities nationwide in emergency room mentions for methamphetamine in 1995. These three cities also lead the nation in the number of medical examiner reports (deaths) related to methamphetamine. There are interesting differences in route of administration reflected in DAWN data between these cities.³ In San Francisco almost two-thirds of the methamphetamine mentions involve injection, whereas in the other two cities only 10-12 percent of mentions involve injection.

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

³ These data should be interpreted with caution as they have problems due to large numbers of unspecified answers.

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

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

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

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

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

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

- 1) students, both high school and college age, males and females, and
- 2) white, blue collar workers or unemployed persons in their twenties.

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

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

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

WASHINGTON STATE

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

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

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

Epidemiologic sources point out that while the majority of users continues to be rural bikers and blue collar workers, there are also a number of other groups now using. For example, it is reported that the drug is becoming increasingly popular among street youth, among Native American populations and among Hispanic

immigrants. This source describes this as a diffusion from rural to urban, from gay populations to heterosexuals and from white to minorities.

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

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

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

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

OREGON

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

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

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

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

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

ARIZONA

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

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

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

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

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

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

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

NEW MEXICO

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

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

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

Several providers report that the stabilization in use is due to crackdowns on local labs in their area as well as a rise in the popularity of heroin in the State. Methamphetamine is described as widely available, however. As one provider commented, "They think they won't become addicted and it is cheaper than anything but pot." Programs in remote or very rural areas of the State often report users who value the drug for its ability to keep them working on farms or in oil fields for long periods of time allowing them to accumulate extra or overtime pay. Too often, that pay is spent on the common companion or primary drug problem, alcohol.

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

HAWAII

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

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

69 percent of treatment providers interviewed felt that methamphetamine use had increased over the past year and 25 percent felt it was stabilizing. It is the primary drug of abuse at entry for 38 percent of programs interviewed, second only to alcohol (44%) and followed by marijuana (19%). An average of 55

percent of the clients at entry use methamphetamine, and, as in other States, it is trouble with the law which prompts them to seek treatment most of the time (44%). Several providers receive clients through employee assistance programs which refer employees who have exhibited inappropriate or aggressive behavior on the job or chronic absenteeism.

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

SUMMARY

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

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

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

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

CITIES REPRESENTED IN SAMPLE OF TREATMENT PROVIDERS

Washington

Kirkland
Seattle
Wenatchee
Spokane
Yakima
Everett
Longview
Pasco
Tacoma

Arizona

Phoenix
Tempe
Tucson
Holbrook
Kingman
Chino
Chandler

New Mexico

Albuquerque
Carlsbad
Alamogordo
Hobbs
Santa Fe

Hawaii

Honolulu
Kailua
Wahiawa
Waianae
Lihue
Pearl Harbor
Ewa Beach
Makawao
Wailuku

Oregon

John Day
Eugene
Medford
Portland
Pendleton
Albany
Salem
Hillsboro

California

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

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Pulse Check
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WINTER 1997

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