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ABSTRACT

The consequences of cocaine abuse and addiction remained apparent in the Minneapolis/St. Paul metropolitan area throughout 2003, as overdose deaths increased from 34 to 44 in Hennepin County. Heroin-related indicators continued at heightened levels. Opiate-related deaths outnumbered those for cocaine in both Hennepin and Ramsey County, a situation fueled by high-purity, low-cost heroin and the continuing abuse of prescription narcotic analgesics.

Methamphetamine abuse took hold among a younger population in 2003. Most high school-based drug counselors reported the rapidly rising abuse of methamphetamine, particularly among girls attracted by the promise of heightened energy and significant, rapid weight loss.

The most notable new trends in hallucinogen abuse among adolescents and young adults were the use of Salvia Divinorum, an unregulated type of sage plant sold on the Internet and in “head shops” as incense, and over-the-counter cough and cold products that contain dextromethorphan.

INTRODUCTION

This report is produced twice annually for participation in the Community Epidemiology Work Group of the National Institute on Drug Abuse, an epidemiological surveillance network comprised of researchers from 21 U.S. areas who monitor emerging patterns and trends in drug abuse. It is compiled using the most recent available data and information from multiple sources.

AREA DESCRIPTION

The Minneapolis/St. Paul metropolitan area includes the city of Minneapolis (Hennepin County), the capital city of St. Paul (Ramsey County), and the surrounding counties of Anoka, Dakota, and Washington. According to the 2000 census, the population of the metropolitan area is 2,482,353, roughly one-half of the Minnesota State population. More than one-half (56 percent) of the Ramsey County population lives in the city of St. Paul, and one-third (34.2 percent) of the Hennepin County population lives in the city of Minneapolis. The remainder of the State is less densely populated and rural in character. To the north, Minnesota shares an international border with Canada, and to the west borders North Dakota and South Dakota, two of the country’s most sparsely populated States. Illicit drugs are sold and distributed within Minnesota by Mexican drug trafficking organizations, street gangs, independent entrepreneurs, and other criminal groups.

In the five-county metropolitan area, 84 percent of the population is White. African-Americans constitute the largest minority group in Hennepin County, while Asians are the largest minority group in Ramsey, Anoka, Dakota, and Washington Counties. The total State population increased 9 percent from 1990 to 1998, while the minority population increased 45 percent. The size of the Hmong population was recently estimated at 66,000, making the Twin Cities home to the largest Hmong population of any U.S. city.

DATA SOURCES

Data for this report were drawn from the following sources:

- Mortality data on drug-related deaths are from the Hennepin County Medical Examiner and the Ramsey County Medical Examiner (through March 2004). Hennepin County cases include those in which drug toxicity was the immediate cause of death and those in which the recent use of a drug was listed as a significant condition contributing to the death. Ramsey County cases include those in which drug toxicity was the immediate cause of death and those in which drugs were present at the time of death.

- Hospital emergency department (ED) data on drug mentions are from the Drug Abuse Warning Network (DAWN), Office of
Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA). These are weighted estimates of all drug abuse-related ED mentions in non-Federal, short-term general hospitals in the Minneapolis/St. Paul Standard Metropolitan Statistical Area, and a single drug abuse-related ED episode can involve the “mention” of up to four drugs and alcohol-used-in-combination. Data run through 2002 and will not be available in 2003 due to a major system redesign.

- **Addiction treatment data** are from addiction treatment programs (residential, outpatient, extended care) in the five-county metropolitan area as reported on the Drug and Alcohol Abuse Normative Evaluation System (DAANES) of the Minnesota Department of Human Services from 1993 through 2003.

- **Poison center data** are from the Hennepin Regional Poison Center, Toxic Exposure Surveillance System (TESS).

- **Drug testing data** on drug abuse among adult males arrested in Hennepin County are from the Arrestee Drug Abuse Monitoring (ADAM) program of the National Institute of Justice, U.S. Department of Justice, which was terminated nationwide in early 2004. The Council on Crime and Justice administered ADAM in Minneapolis, and interviewed a sample of 677 adult male arrestees in 2003.

- **Law enforcement data** and information are from various county, city, State and Federal agencies.

- **Crime lab data** on seizures and purity level are from the Minneapolis Department of Health and Family Support, the Minnesota Bureau of Criminal Apprehension through 2003.

- **Acquired immunodeficiency syndrome (AIDS) data** for 2003 are from the Minnesota Department of Health.

- Additional information is from interviews with program staff of treatment programs, poison control specialists, narcotics agents, and school-based drug and alcohol specialists conducted in May 2004.

**DRUG ABUSE PATTERNS AND TRENDS**

**COCAINE**

Accidental overdose deaths involving cocaine increased from 2002 to 2003 in Hennepin County (from 34 to 44), and remained stable in Ramsey County, as shown in exhibit 1. The emergency department data reflected upward trends (see exhibit 2), although the most recent year for which data were available was 2002.

Admissions to addiction treatment programs with cocaine as the primary substance problem declined very slightly in recent years (see exhibit 3). In 2003, for example, 13.3 percent of treatment admissions reported cocaine as the primary substance problem, compared with 14.8 percent in 1998. Most admissions in 2003 were for crack cocaine, one-third were women, and 48.8 percent were African American. The average age of first crack use was 25.6 years. More than 4 out of 5 patients (81.3 percent) had prior treatment episodes. See exhibit 4.

Most (88 percent) patients receiving treatment for cocaine were age 25 or older (exhibit 4), with 63.7 percent over age 35. Indeed among patients age 35 and older, 19.9 percent reported cocaine as the primary substance problem (exhibit 6). Very few young people in treatment reported cocaine as the primary substance problem (exhibit 5).

Among males arrested in Minneapolis in 2003, 28.4 percent tested positive for cocaine, compared with 30.8 percent in 2002 (see exhibit 7). Nationwide, the presence of cocaine
among adult male arrestees ranged from a high of 50.6 percent in Chicago and 49.8 percent in Atlanta, to a low of 2.6 percent in Woodbury, Iowa, near Sioux City. See exhibit 8. The median across all cities was 30.1 percent.

Gangs continued to play a considerable role in the street-level, retail distribution of crack cocaine. Cocaine prices varied, but the drug generally sold for $100 per gram, $200 per “eighthball” (1/8 ounce), $700–$800 per ounce, and up to $22,000 per kilogram. The price of a rock of crack was $10–$20

HEROIN

Heroin-related indicators continued at heightened levels in 2003. Opiate-related deaths, mostly accidental heroin overdoses, outnumbered cocaine-related deaths in 2003, but declined slightly in Hennepin County from 59 to 50 and in Ramsey County went from 18 to 19. Hospital ED mentions of heroin nearly doubled from 2000 to 2002 (exhibit 2).

As with cocaine, patients in treatment for heroin tended to be older, with 77.7 percent over age 25, and 54.7 percent over age 35. Four percent of patients over age 25 reported heroin as the primary substance problem.

Among patients receiving treatment for heroin addiction, Whites accounted for 51.8 percent and African Americans 42.9 percent. Just over one quarter (27.1 percent) were women. The most common route of administration was injection (53.6 percent), followed by sniffing (41.9 percent), and smoking, also known as “foiling” (4.5 percent). The average age of first heroin use was 22.4 years. Most (86.8 percent) reported prior treatment episodes.

Five methadone maintenance programs served roughly 1,500 clients in the metropolitan area. While patients who were newly enrolled in some of these programs may be reflected in the treatment data, the private for-profit programs do not report to the Drug and Alcohol Abuse Normative Evaluation System.

Among adult males arrested in Minneapolis in 2003, 5.8 percent tested positive for opiates, up slightly from 5.1 percent in 2002. Nationwide, the presence of opiates among adult male arrestees ranged from a high of 28.4 in Rio Arriba, New Mexico and 24.9 percent in Chicago, to a low of 1.6 percent in Woodbury, Iowa. See exhibit 9. The median across all cities was 5.8 percent.

Heroin seized by law enforcement officers included white, off-white, or tan powder, in addition to dark-colored Mexican “black tar” heroin. Four Nigerians were apprehended in April at the Minneapolis/St. Paul International Airport on a flight from Amsterdam carrying suitcases filled with 25 pounds of heroin valued at $25 million. Retail and mid-level heroin prices remained at record low levels, at $20-$40 per dosage unit or “paper,” $300–$400 per gram, and $900–$2,000 per ounce. Purity levels were variable in 2003, with fewer samples of extremely high potency than in 2002.

OTHER OPIATES/NARCOTICS

Prescription narcotic analgesics, used medically in the treatment of pain, are increasingly used nonmedically as drugs of abuse for the heroin-like high they produce. In 2002, there were 1,040 hospital ED mentions involving the nonmedical use of narcotic analgesics, compared with 953 in 2001 and only 461 in 1996 (exhibit 2). The rate of narcotic analgesics/combinations mentions per 100,000 population rose significantly from 27 in 2000 to 40 in 2002. Of particular concern within this category were drugs containing oxycodone—Percodan, Percocet (oxycodone combined with aspirin or acetaminophen) and the long-acting OxyContin. Law enforcement seizures of oxycodone increased as well.

One local middle school reported several incidents of students bringing handfuls of prescription medications, including narcotic analgesics and benzodiazepines, to school to share with friends.
An estimated 2–5 percent of the Minnesota’s Hmong immigrant population regularly smokes opium. Packages concealing opium continued to be shipped from Asia to residents of the Twin Cities.

**MARIJUANA**

*Marijuana* indicators continued upward trends that began in the early 1990s (exhibit 2). In 2002, however, marijuana ED mentions stabilized, after rising from almost 600 to 1,200 from 1999 to 2001. When found as the sole drug in a hospital ED situation, patients typically present with symptoms of a panic or anxiety attack.

As in past years, marijuana precipitated more admissions into addiction treatment programs than any other illicit drug in the Twin Cities in 2003. Overall, one out of five (22.8 percent) people entering addiction treatment programs reported marijuana as the primary substance problem, compared with only 8 percent in 1991. Most (77.3 percent) were males, and 68.3 percent were White. For many, it was the first treatment experience (44.2 percent), which can reflect a relatively short abuse history. The average age of first marijuana use was 13.7 years.

Marijuana was overwhelmingly the primary drug among adolescents and young adults in treatment. Among treatment admissions under age 18, a whopping 73.2 percent reported marijuana as the primary substance problem, and among youth age 18 – 25, 34.8 percent (exhibit 5). In contrast, among patients age 26 to 34, 14.6 percent reported marijuana as the primary substance problem, and among patients 35 and older, only 4.5 percent. (exhibit 6).

In 2003 in Minneapolis, 48.3 percent of adult male arrestees tested positive for marijuana. Nationwide, it ranged from a high of 54.9 percent in Oklahoma City, to a low of 30.9 percent in Honolulu and 31.9 percent in Salt Lake City. See exhibit 10. The median across all cities was 44.1 percent.

Marijuana, readily available according to multiple sources, sold for $5 per joint, and could be purchased by any metropolitan area middle school student. Standard, commercial grade marijuana sold for $50 per quarter ounce, $150–$175 per ounce, and $600–$900 per pound. Higher potency “BC Bud” from British Columbia was increasingly available and sold for $100 per quarter ounce and up to $600 per ounce.

Marijuana joints that are dipped in formaldehyde, which is often mixed with phencyclidine (PCP), are known as “wets,” “wet sticks,” “water,” or “wet daddies.” Marijuana joints containing crack cocaine are known as “primos.”

**METHAMPHETAMINE AND OTHER STIMULANTS**

In addition to cocaine, *methamphetamine*, also known as “meth,” “crystal,” or “crank,” and amphetamine, known as “speed” or “crank,” are major stimulants of abuse. Prolonged abuse can rapidly result in addiction, accompanied by long periods of sleep and food deprivation, and pronounced paranoid delusions.

From 2002 to 2003 accidental deaths related to methamphetamine abuse grew from 3 to 10 in Ramsey County and from 11 to 15 in Hennepin County (exhibit 1). ED episodes involving methamphetamine increased steadily over the past few years (exhibit 2).

The growth of clandestine, makeshift meth labs in the state increased, with 301 dismantled with the assistance of the Drug Enforcement Administration in 2003, compared with 272 in 2002. Roughly two-thirds were in non-urban areas. The bulk of methamphetamine consumed in the state is still imported from Mexico, however.

Patients addicted to methamphetamine now account for 7.5 percent of total treatment admissions, compared with 2.9 percent in 1998, and less than one percent in 1991. Women accounted for 38.4 percent, the highest
percentage within any drug category. Almost all were White (92.6 percent), and the average age of first use was 19.8 years. Two-thirds had prior treatment episodes.

Methamphetamine abuse took hold among a younger population in 2003. Almost all on-site, school-based drug abuse counselors reported growing problems related to methamphetamine abuse by students attending metropolitan area high schools. Smoking was the most common route of first methamphetamine use, and some moved on to injection. The appetite suppressant effects, in particular, attracted young girls. Some adolescent girls entering treatment had no prior drug or alcohol abuse history other than methamphetamine, which they initially tried due to the promise of significant and rapid weight loss.

Over half (53.6 percent) of those receiving treatment for methamphetamine were age 25 or less, and a record high 17.8 percent were under age 18 (exhibit 4). Among patients under age 18 in 2003, 8.8 percent reported primary methamphetamine, and among those age 18 to 25, 13.6 percent reported methamphetamine as the primary substance problem (exhibit 5), the highest of any age group. In contrast only 3.6 percent of patients age 35 and above reported methamphetamines as the primary substance problem. Among treatment admissions, smoking was the most common route of administration (53.6 percent), followed by sniffing (26.5 percent) and injection (13.8 percent).

Adolescent users described the open scabs and unsightly skin lesions due to the abuse of methamphetamine as “lithium scabs,” and better grade methamphetamine as “lithium,” ranking in quality somewhere in between basic “crank” and top grade “ice” or “glass.” Some youth also noted that they could spot exceptionally good methamphetamine “if it makes you cough blood.” The use of light bulbs as pipes for smoking methamphetamine was commonplace, especially among youth. The presence of methamphetamine among arrestees in Minneapolis remained low, having gradually increased in recent years. In 2003, 3.3 percent of adult male arrestees in Minneapolis tested positive for methamphetamine, compared with 0.8 percent in 1998. The two ADAM cities in neighboring Iowa had rates many times greater than in Minneapolis: Des Moines (27.9 percent) and Woodbury (14.3 percent). Nationwide the cities with the highest rate of methamphetamine-positive arrestees were Honolulu with 40.3 percent, followed by Phoenix (38.3 percent), and Sacramento (37.6 percent). At the other end of the spectrum, less than one percent of arrestees tested positive for methamphetamine in Albany, Anchorage, Boston, Charlotte, Cleveland, Miami, New York City, Philadelphia, and Washington D.C. See exhibit 11. The median across all cities was 4.7 percent.

Seizures of methamphetamine by law enforcement continued upward trends. Cases handled by the state crime lab, for example, grew from 289 in 1996 to 2,160 in 2003. Minneapolis data indicate increased purity levels of methamphetamine as well, with an average weight-based purity of 13.8 percent in 2001, compared with 26.9 percent in 2003, and 40.7 percent in 2004 (first quarter). It comes in the form of crystals, powder, or chunks that are white, off-white, tan, orange, reddish, greenish or light purple-colored.

Methamphetamine prices were $90 to $100 per gram; $200 for a “teener,” (1/16 ounce); $240 - $280 for an “8-ball” (1/8 ounce); $600 to $800 per ounce; and up to $14,000 per pound. “Glass,” or “ice,” the high purity form that is smoked, typically sold for twice as much.

The abuse of methylenedioxymethamphetamine (MDMA), known as “ecstasy,” “X,” or “e,” by young people continued, and contributed to the death of a 21 year-old African American male in Hennepin County in 2003. MDMA hospital ED mentions increased from 16 in 1999 to 77 in both 2001 and 2002. Effects include tactile sensitivity, hallucinations and at high doses,
nausea, jaw clenching, hyperthermia, and muscle tension. The Hennepin Regional Poison Center received 9 exposure-related calls in 2004 and 6 calls seeking information (through May 27).

Crime labs continued to confirm that some pills sold as “ecstasy” actually contained no MDMA, but rather a combination of other drugs, such as methamphetamine, ketamine, caffeine, N,N-Diisopropyl-5-methoxy--tryptamine, (known as “5-MeO-DIPT” and “Foxy Methoxy”) or methylenedioxyamphetamine (MDA), a chemical similar in effect to MDMA.

*Khat*, a plant that is chewed or brewed in tea for its stimulant effects in East Africa and the Middle East, remained within the Somali refugee community in the Twin Cities and Rochester, Minnesota. Its active ingredients, cathinone and cathamine, are controlled substances in the U.S.

*Methylphenidate* (Ritalin), a prescription drug used in the treatment of attention deficit hyperactive disorder, is also used nonmedically as a drug of abuse to increase alertness and suppress appetite, by some adolescents and young adults. The pills are crushed and snorted or ingested orally. They sold for $5/pill or were simply shared with fellow middle school or high school students at no cost, and sometimes known as “hyper pills.”

### Hallucinogens

The most notable new trends in hallucinogen abuse are the increasingly prevalent abuse of Salvia Divinorum (by young adults and some high school-aged teens), and over-the-counter cough and cold products that contain dextromethorphan.

A type of sage plant, *Salvia Divinorum*, also known as diviner’s sage, can be smoked or chewed or brewed in tea. Some high school students consume it at school by placing the leaves in their lunchtime beverages. Its abuse has been reported at the University of Minnesota and some metropolitan area high schools in recent months. When ingested its effects include intense but short-lived hallucinations, out-of-body experiences, sensations of time travel or merging with inanimate objects, short-term memory loss, and unconsciousness. Unlike most other hallucinogens, the effects of Salvia Divinorum last for an hour or less. Not presently a controlled substance, it is being sold off the Internet, and also in local “head shops” in very small, plastic, zip lock bags. At one Minneapolis store customers who purchase it are asked to sign a written form stating that it will be used only as incense. The Hennepin Regional Poison Center received 1 call about an exposure in 2003 and 2 calls seeking information this year (through May 27). It has also appeared in Rochester, Minnesota.

Products that contain *dextromethorphan*, a cough suppressant common in most over-the-counter cough syrups, are ingested by adolescents in doses many times in excess of the recommended amount for the long-acting, hallucinogenic effects. Dextromethorphan (also known as “DXM”) is also the active ingredient in some over-the-counter cold preparations in pill form, such as Coricidin HBP Cough and Cold, (known as “Triple Cs”). People intoxicated on dextromethorphan experience profound hallucinations and altered time perception, slurred speech, sweating, uncoordinated movements, and high blood pressure. Recent growth in the abuse of these products by younger teenagers prompted many pharmacies, discount stores, and grocery stores to place these products behind the counter to prevent shoplifting. Being under the influence of these products is known as “Robo-tripping” or “Skittle-ing.”

*LSD* (lysergic acid diethylamide, or “acid”) is a strong, synthetically produced hallucinogen, typically sold as saturated, tiny pieces of paper known as “blotter acid,” for $5–$10 per dosage unit. Hospital ED episodes of LSD declined significantly from 58 in 2000 to 13 in 2002, perhaps due to the growing popularity of
MDMA and other substances which also produce hallucinogenic effects.

*Ketamine,* also known as “Special K,” “Vitamin K,” or “cat-killer,” a veterinary anesthetic, first appeared as a drug of abuse among young people in Minnesota in 1997, but rarely appears in ED data; three ED mentions of ketamine in 2001 and none in 2002. It is snorted, injected, or put into capsules or pills. People under the influence of ketamine are said to be in the “K-hole,” a stunned state of profoundly suspended animation.

Several law enforcement agencies reported incidents involving alpha-methyltryptamine (*AMT*), also known as “Amtrack” or “Amthrax,” a white granular powder purchased over the Internet that produces hallucinations and extremely agitated, aggressive behavior. Also in 2003 some clear capsules filled with white powder that lab analysis identified as N,N-Diisopropyl-5-methoxytryptamine, known as “5-MeO-DIPT” and “Foxy Methoxy,” were seized by law enforcement.

**Phencyclidine (PCP),** a dissociative anesthetic, is most often used in combination with marijuana, but can also be injected or snorted. ED mentions of PCP increased from 24 in 2001 to 85 in 2002. Two young African-American males (ages 18 and 19) died in 2003 in Hennepin County with recent PCP use reported as a significant contributing condition. Marijuana joints dipped in formaldehyde that is often mixed with PCP, are known as “wets,” “amp,” “wet sticks,” or “wet daddies,” and are easily distinguished by their strong, pungent, unpleasant chemical odor. The effects are much more stimulant-like than those of marijuana alone.

**SEDATIVE/HYPNOTICS**

*Gamma hydroxybutyrate (GHB)*, known as "G," “Gamma,” “Liquid E,” or “Liquid X,” is a concentrated liquid abused for its stupor-like, depressant effects, and a predatory knock-out, drug-induced rape drug which sells for $10 by the capful. GHB hospital emergencies declined significantly from a high of 93 in 2000 to 34 in 2002.

**OTHER DRUGS**

**Alcohol** remained the most widely used mood-altering substance. Overall, half of all admissions to addiction treatment programs were attributable to alcohol (exhibit 3). Among this group, 27.8 percent were women, 78.8 percent were White, and 70.9 percent had prior treatment experience. The average age of first intoxication was 15.6 years.

More than 80 percent of alcohol-related treatment admissions were age 26 and older, with 62 percent age 35 or above. Among patients under age 18, only 12.5 percent reported alcohol as the primary substance of abuse. In contrast for patients age 26–34, 50.8 percent reported alcohol as the primary substance problem, and among patients age 35 and older, 66 percent (exhibits 5 and 6).

Daily tobacco use remained widespread among patients in addiction treatment programs (exhibit 3). Adolescents who smoke tobacco are many times more likely to use alcohol and other drugs than adolescents who do not use tobacco.

**RELATED DISEASES**

Most AIDS cases in Minnesota were in the Minneapolis/St. Paul area. Of the 1,642 people living with AIDS in Minnesota in 2003, the exposure categories were as follows: men who have sex with men (54 percent); injection drug use (8 percent); men who have sex with men and injection drug use (5 percent); heterosexual contact (12 percent); perinatal/other (2 percent); unspecified (8 percent); and no interview (11 percent).

The level of *Hepatitis C* virus (HCV), a blood-borne liver disease, among injection drug abusers remained high, with estimated rates as high as 90 percent among patients in methadone treatment programs.
Drug-related Deaths in Hennepin County and Ramsey County 2000 - 2003

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<td>10</td>
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SOURCE: Hennepin County Medical Examiner and Ramsey County Medical Examiner. Hennepin County figures include cases where drug toxicity was the immediate cause of death and those in which recent drug use was listed as a significant condition contributing to the death. Ramsey County cases include those in which drug toxicity was the immediate cause of death and those in which drugs were present in the decedent at the time of death.
Hospital ED Mentions of Selected Drug Categories
Minneapolis/St. Paul Metropolitan Area 1998 - 2002

Admissions to Addiction Treatment Programs by Primary Substance Problem:
Minneapolis/St. Paul Metropolitan Area 1993 - 2003

Thousands

### Characteristics of Persons Admitted to Addiction Treatment Programs by Primary Substance Problem: Minneapolis/St. Paul Metropolitan Area 2003

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<tr>
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<th>Total Admissions = 18,614</th>
<th>ALCOHOL = 9,199 (49.4%)</th>
<th>MARIJUANA = 4,235 (22.8%)</th>
<th>COCAINE = 2,474 (13.3%)</th>
<th>METHAMPHETAMINE = 1,393 (7.5%)</th>
<th>HEROIN = 627 (3.4%)</th>
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<td></td>
<td></td>
</tr>
<tr>
<td>% marijuana</td>
<td>56.3</td>
<td>alcohol - 72.1</td>
<td>alcohol - 56.2</td>
<td>marijuana - 51.2</td>
<td>cocaine - 38.1</td>
<td></td>
</tr>
<tr>
<td>% cocaine</td>
<td>29.9</td>
<td>cocaine - 10.7</td>
<td>marijuana - 26.8</td>
<td>alcohol - 30.3</td>
<td>alcohol - 29.5</td>
<td></td>
</tr>
<tr>
<td>% alcohol</td>
<td>32.3</td>
<td>marijuana</td>
<td>alcohol</td>
<td>alcohol &amp; marijuana</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TERTIARY DRUG</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% cocaine</td>
<td>35.3</td>
<td>32.3</td>
<td>43.3</td>
<td>45.4</td>
<td>31.1</td>
<td></td>
</tr>
<tr>
<td>% 1st Treatment Episode</td>
<td>29.1</td>
<td>44.2</td>
<td>18.7</td>
<td>33.8</td>
<td>13.2</td>
<td></td>
</tr>
<tr>
<td>Age of 1st Use</td>
<td>(average in years)</td>
<td>15.6</td>
<td>13.7</td>
<td>25.6</td>
<td>19.8</td>
<td>22.4</td>
</tr>
<tr>
<td>% Daily Nicotine Use</td>
<td>59.9</td>
<td>62</td>
<td>65.3</td>
<td>74.3</td>
<td>73.8</td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** Drug and Alcohol Abuse Normative Evaluation System (DAANES), Minnesota Department of Human Services, 2004.
### Treatment Admissions by Primary Substance Problem by Age Group: Minneapolis/St. Paul Metropolitan Area 2003

#### Age 17 and Under

- **MJ 73.2%**
- **Alcohol 12.5%**
- **Cocaine 1.7%**
- **Heroin 2.9%**
- **Meth 8.8%**
- **All other 0.9%**

#### Age 18 - 25

- **MJ 34.8%**
- **Alcohol 37.4%**
- **Cocaine 6.5%**
- **Heroin 3.3%**
- **Meth 13.6%**
- **All other 4.4%**

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**SOURCE:** Drug and Alcohol Abuse Normative Evaluation System (DAANES), Minnesota Department of Human Services, 2004.
Treatment Admissions by Primary Substance Problem by Age Group: Minneapolis/St. Paul Metropolitan Area 2003

Adult Male Arrestees Testing Positive for Drugs:
Minneapolis 1998 - 2003

% testing positive

SOURCE: National Institute of Justice, Arrestee Drug Abuse Monitoring (ADAM) Program, 2004. 2003 data are based on the results of urinalysis obtained from 677 adult male arrestees, with a mean age of 31.5 years.
Adult Male Arrestees Testing Positive for COCAINE -- 2003

Adult Male Arrestees Testing Positive for OPIATES -- 2003

Rio Arriba, NM: 28.4%
Chicago: 24.9%
Boston: 17.3%
New York City: 15%
Portland, OR: 15%
New Orleans: 14%
Philadelphia: 11.5%
Albuquerque: 11.2%
Washington DC: 9.8%
San Antonio: 9.1%
Spokane: 8.4%
Birmingham: 8.3%
Salt Lake City: 7.7%
Anchorage: 7.4%
Dallas: 6.9%
Sacramento: 6.9%
Denver: 6.8%
Seattle: 6.8%
Las Vegas: 6.4%
MINNEAPOLIS: 5.8%
Houston: 5.7%
Cleveland: 5.4%
Indianapolis: 5.1%
San Diego: 5.1%
Omaha: 5%
Tulsa: 5%
Honolulu: 4.6%
Phoenix: 4.4%
Albany: 4.3%
Tucson: 4.2%
Tampa: 3.8%
San Jose: 3.1%
Atlanta: 3%
Oklahoma City: 3%
Des Moines: 2.8%
Miami: 2.5%
Charlotte: 2%
Los Angeles: 2%
Woodbury, IA: 1.6%

Adult Male Arrestees Testing Positive for MARIJUANA -- 2003

Adult Male Arrestees Testing Positive for METHAMPHETAMINE -- 2003

- Honolulu: 40.3%
- Phoenix: 38.3%
- Sacramento: 37.6%
- San Jose: 36.9%
- San Diego: 36.2%
- Spokane: 32.1%
- Los Angeles: 28.7%
- Las Vegas: 28.6%
- Des Moines: 27.9%
- Salt Lake City: 25.6%
- Portland, OR: 25.4%
- Omaha: 21.4%
- Tulsa: 17.4%
- Tucson: 16%
- Woodbury, IA: 14.3%
- Oklahoma City: 12.3%
- Seattle: 12.1%
- Albuquerque: 10.1%
- Dallas: 5.8%
- Denver: 4.7%
- San Antonio: 3.5%
- Rio Arriba, NM: 3.3%
- New Orleans: 2.8%
- Houston: 2.6%
- Atlanta: 2.1%
- Indianapolis: 2%
- Tampa: 1.9%
- Chicago: 1.6%
- Birmingham: 1.4%
- Anchorage: 1.2%
- Washington DC: 0.7%
- Charlotte: 0.7%
- Philadelphia: 0.6%
- Miami: 0.6%
- Cleveland: 0.4%
- Albany: 0.3%
- Boston: 0.3%
- New York City: 0.3%