

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

Proceedings of the Community
Epidemiology Work Group

Highlights and Executive Summary

January 2008

NATIONAL INSTITUTE ON DRUG ABUSE



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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
Division of Epidemiology, Services and Prevention Research
National Institute on Drug Abuse
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The National Institute on Drug Abuse (NIDA) acknowledges the contributions made by the representatives of the Community Epidemiology Work Group (CEWG) who prepare the reports presented at the meetings. Appreciation is extended also to other participating researchers, agency personnel from the host city of Philadelphia, and Federal officials who contributed information. This publication was prepared by Social Solutions International, Inc., with assistance from its subcontractor, MasiMax Resources, Inc., under contract number HHSN-2712007-000003C from the National Institute on Drug Abuse.

The information presented in this *Executive Summary* is from the *Update Briefs* and slide presentations prepared by CEWG representatives for

the CEWG meeting in Ft. Lauderdale, Florida; tape recordings from the meeting; and papers prepared by other presenters. Data/information from Federal sources supplemental to the meeting presentations and discussions have been included in this report to facilitate cross-area comparisons.

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Foreword

THIS EXECUTIVE SUMMARY IS A SYNTHESIS OF findings from data prepared by 20 CEWG representatives for the 63rd semiannual meeting of the Community Epidemiology Work Group (CEWG) held in Ft. Lauderdale, Florida, on January 23–25, 2008, under the sponsorship of the National Institute on Drug Abuse (NIDA). The focus of the meeting, stemming from emerging issues discussed at the June 2007 meeting, was on stimulant drugs, especially cocaine, methamphetamine, and MDMA, and the nonmedical use of prescription drugs, including narcotic analgesics and benzodiazepines. CEWG representatives were also asked to provide updates on data and issues pertaining to marijuana, heroin, and club drugs and to discuss emerging drug abuse trends and issues in their local areas.

At the opening of the meeting, Patricia Kramer, Circuit 17 Program Supervisor, Florida Department of Children and Families, Substance Abuse and Mental Health, provided participants an overview of the services provided to substance abusers in Broward County, Florida. Ms. Kramer also underscored the vital role that drug epidemiologists serve in enabling policymakers to be proactive rather than reactive to drug trends and patterns of abuse. For the January 2008 meeting, CEWG representatives prepared first half of 2007 calendar year and/or fiscal year 2007 data on patterns and trends in drug abuse in their areas, as available. The primary emphasis of the meeting was on pursuing, discussing, reviewing, and providing updates on drug abuse issues that emerged from the June 2007 deliberations, for which calendar year 2006 data were generally reported. Two international presentations described drug abuse trends and patterns in Canada and South Africa, respectively.

Through focused discussions at the CEWG meetings, participants reported on, shared insight about, and reviewed...

- What was learned about drugs patterns and trends and emerging drug problems from available data sources
- Issues related to data sources, including methodologies, strengths and limitations, and ways of assessing and reporting relevant findings

- What was learned from local sources of information, such as key informants
- The emerging questions and issues

The information from the CEWG network presented in this report includes an overview section featuring cross-area comparisons of drug abuse patterns and trends in 20 CEWG areas. The findings are taken from the CEWG representatives' papers and their slide presentations at the meeting and from Federal data sources (DEA; NFLIS; and SAMHSA, OAS, DAWN *Live!*). The Update Briefs from the CEWG members are presented in the second section of this report and provide the reader with a snapshot of the variations in local drug abuse patterns and trends in the CEWG areas and any emerging issues in drug abuse. Data and information supplemental to the meeting presentations and discussions have been included as appropriate.

The report presents data relevant to the abuse of cocaine/crack, heroin, opiates/narcotic analgesics (other than heroin), methamphetamine, marijuana, club drugs, phencyclidine (PCP), other hallucinogens, and benzodiazepines. Data sources include those from law enforcement, treatment, and medical care facilities; population-based surveys; and ethnographic studies. The information published after each CEWG meeting represents findings from CEWG area representatives across the Nation, which are supplemented by national data and by special presentations at each meeting. Publications are disseminated to drug abuse prevention and treatment agencies, public health officials, researchers, and policymakers. The information is intended to alert authorities at the local, State, regional, and national levels, and the general public to current conditions and potential problems so that appropriate and timely action can be taken. Researchers also use the information to develop research hypotheses that might explain social, behavioral, and biological issues related to drug abuse.

Moira P. O'Brien

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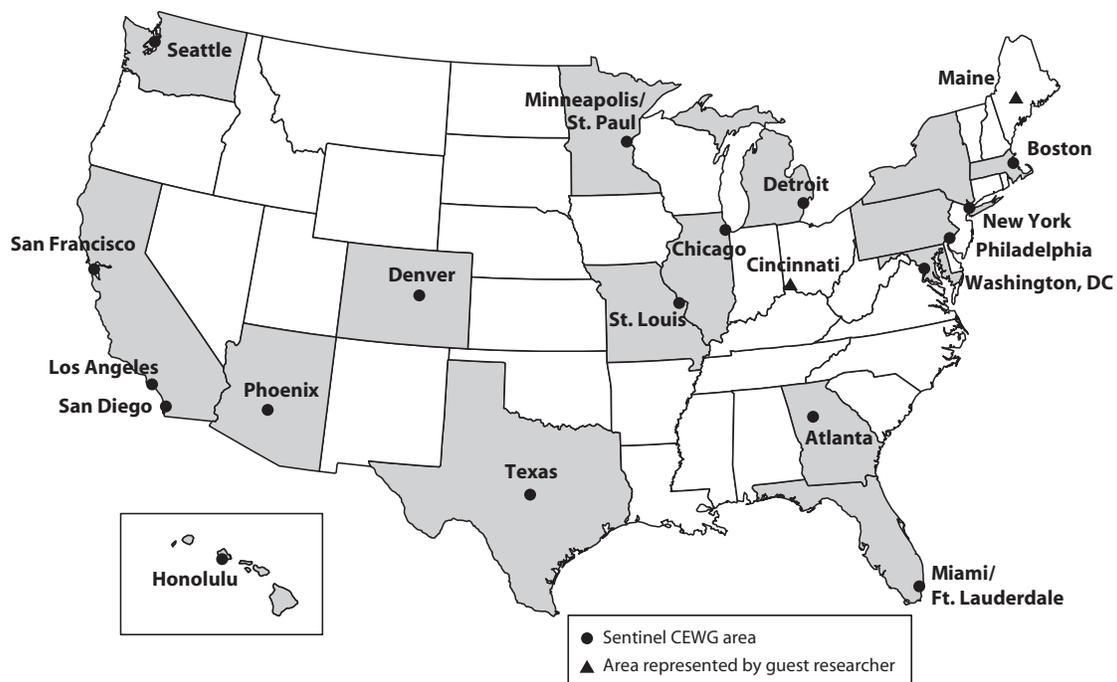
Section I. Introduction

THE 63RD SEMIANNUAL MEETING OF THE COMMUNITY Epidemiology Work Group (CEWG) was held on January 23–25, 2008, in Ft. Lauderdale, Florida. During the meeting, researchers from 20 geographically dispersed areas in the United States reported on current trends and emerging issues in their areas. In addition to the information provided by 18 sentinel areas that have contributed to the network for many years, guest researchers from Cincinnati and Maine provided data from their respective areas, as did international representatives from Canada and South Africa. The following highlights and summary are based on these reports.

The CEWG Network

The CEWG is a unique epidemiology network that has functioned for 32 years as a drug abuse surveillance system to identify and assess current and emerging drug abuse patterns, trends, and issues, using multiple sources of information. Each source provides information about the abuse of particular drugs, drug-using populations, and/

or different facets of the behaviors and outcomes related to drug abuse. The information obtained from each source is considered a *drug abuse indicator*. Typically, indicators do not provide estimates of the number (prevalence) of drug abusers at any given time or the rate at which drug-abusing populations may be increasing or decreasing in size. However, indicators do help to characterize drug abuse trends and different types of drug abusers (such as those who have been treated in emergency rooms, admitted to drug treatment programs, or died with drugs found in their bodies). Data on items submitted for forensic chemical analysis serve as indicators of availability of different substances and engagement of law enforcement at the local level, and data such as drug price and purity are indicators of availability, accessibility, and potency of specific drugs. Drug abuse indicators are examined over time to monitor the nature and extent of drug abuse and associated problems within and across geographic areas. The 20 participating areas are depicted in the map below.



The Functions of CEWG Meetings

The CEWG convenes semiannually. The semiannual meetings continue to be a major and distinguishing feature of the CEWG. CEWG representatives and guest researchers present information on drug abuse patterns and trends in their areas through formal presentations, using slides to present graphical data and maps. Personnel from Federal agencies provide updates of data sets used by the CEWG. Time is set aside for question-and-answer periods and discussion sessions. The meetings provide a foundation for continuity in the monitoring and surveillance of current and emerging drug problems and related health and social consequences.

Through the meetings, the CEWG accomplishes the following:

- Dissemination of the most up-to-date information on drug abuse patterns and trends in each CEWG area
- Identification of changing drug abuse patterns and trends within and across CEWG areas
- Planning for followup on identified problems and emerging drug abuse problems

Through ongoing research at State, city, and community levels; the semiannual meetings; and several exchange mechanisms including e-mail and conference calls, CEWG representatives maintain a multidimensional perspective from which to access, analyze, and interpret drug-related phenomena and change over time. At the semiannual meetings, CEWG representatives address issues identified in prior meetings and, subsequently, identify drug abuse issues for followup in the future.

Presentations by each CEWG representative include a compilation of quantitative drug abuse indicator data. Many representatives go beyond publicly accessible data and provide a unique local perspective obtained from qualitative research. Information is often obtained from local substance abuse treatment providers and administrators, personnel of other health-related agencies,

medical examiners, poison control centers, law enforcement officials, and drug abusers.

Time at each meeting is devoted to presentations by invited speakers. These special sessions typically focus on the following:

- Presentations by researchers in the CEWG host city
- Presentations by a panel of experts on a current or emerging drug problem identified in prior CEWG meetings
- Updates by Federal personnel on key data sets used by CEWG representatives
- Drug abuse patterns and trends in other countries

Identification of changing drug abuse patterns is part of the discussions at each CEWG meeting. Through this process, CEWG representatives can alert one another to the emergence of a potentially new drug of abuse that could spread from one area to another. The CEWG is uniquely positioned to bring crucial perspectives to bear on urgent drug abuse issues in a timely fashion and to illuminate their various facets within the local context through its semiannual meetings and postmeeting communications.

Planning for followup on issues and problems identified at a meeting is initiated during discussion sessions at meetings, with postmeeting planning continuing through e-mails and conference calls as needed. Postmeeting communications assist in formulating agenda items for a subsequent meeting, and they also raise new issues for exploration at the next meeting.

The agenda for the January 2008 meeting was patterned after previous CEWG meetings. Officials from the host city tendered an overview of the services provided to substance abusers in Broward County, Florida. A community coalition leader and officers from local and Federal enforcement agencies discussed drug trafficking and supply-side information in South Florida and the southeastern United States. Staff from the Drug Enforcement Administration (DEA) provided an

update on data sources for identifying emerging drugs of concern. Guest researchers from Canada and South Africa presented information on drug abuse patterns and trends in their countries.

At a special workshop session on reporting and presenting indicator data, a guest researcher from Indiana University–Purdue University Indianapolis outlined GIS/Mapping approaches; an official from the DEA provided guidance on the use of average drug price and purity data; and a guided discussion was held to identify conceptual and practical issues in accessing, compiling, and reporting drug abuse indicator data as well as measuring and attributing change over time. The workshop and discussions led to clarification of issues to be addressed at the next CEWG meeting.

Data Sources

To assess drug abuse patterns and trends, city- and State-specific data were compiled from a variety of health and other drug abuse indicator sources. Such sources include public health agencies; medical and treatment facilities; ethnographic research; key informant discussions; criminal justice, correctional, and other law enforcement agencies; surveys; and other sources unique to local areas.

Drug abuse indicators include but are not limited to the following:

- Primary substance of abuse or primary reason for treatment admission reported by clients at admission to drug abuse treatment programs
- Drug-related emergency department reports of drugs mentioned in emergency department records in the DAWN *Live!* data system
- Seizure, average price, average purity, and related data obtained from the DEA and from State and local law enforcement agencies
- Drug-related deaths reported by medical examiner (ME)/local coroner offices or State public health agencies
- Arrestee urinalysis results based on data collected by local criminal justice agencies

Because the annual January meetings occur before a full set of recent calendar year (CY) data is available from most surveillance and data collection systems, these reports rely upon data for the first half of the calendar year (here, 2007) and occasionally on fiscal year data (generally, but not always, from October of a year through September of the subsequent year). Efforts are underway to make the time period reporting more uniform and comparable across CEWG areas and meetings.

Primary sources of data used by the CEWG and presented in this *Executive Summary* are summarized below, along with some caveats related to their use and interpretation. The terminology which a particular data source uses to characterize a drug, for example, marijuana versus cannabis, is replicated here.

Treatment data are from CEWG area reports. For this report, they represent data for 13 CEWG metropolitan areas and 2 states, Texas and Hawai'i. Recent or complete treatment admissions data were not available for Broward County, Maine, and Washington, DC. Half-year calendar year data were not available for Cincinnati or Atlanta, although fiscal year (FY) 2007 data were provided. Data for FY 2006 were reported for San Francisco in the June 2007 *Highlights and Executive Summary* report. Table 1 shows overall treatment admissions data by drug and CEWG area, for which 2 CEWG areas provided FY 2007 data, as noted, and 13 provided data for the first half (H1) of Calendar Year (CY) 2007. Tables 2 and 3 also display cross-area treatment admissions data, along with several tables in Section IV.

Drug Abuse Warning Network (DAWN) emergency department (ED) data were presented in some CEWG Update Briefs, in Figures 17 and 18, and in *Appendix Table 3* as shown later. These represent first half (H1) calendar year 2007 unweighted drug reports or mentions. These are accessed through DAWN *Live!*, a restricted-access online data query system administered by the OAS. They are available for 11 of the 20 CEWG areas reporting for the January 2008 meeting. A full description of the DAWN system can be found at <<http://dawninfo.samhsa.gov>>.

Forensic laboratory data for a total of 19 CEWG areas were available for the 2007 Federal fiscal year, which extends from October 1, 2006, through September 20, 2007. Data for 18 CEWG metropolitan areas in FY 2007 were provided by the National Forensic Laboratory Information System (NFLIS), maintained by the DEA. Texas NFLIS forensic laboratory data for 2007, which is confined to data reported by the Texas Department of Public Safety, were accessed by the Texas CEWG area member to maintain consistency over time. All data are based on State and local forensic laboratory analyses of items identified from drug seizures by law enforcement authorities. Boston also reports forensic drug seizure data from the Massachusetts Department of Public Health Drug Analysis Laboratory to supplement NFLIS reports. A map displaying NFLIS data for FY 2007 for 19 CEWG areas is included as Figure 16, while a number of tables, including Table 1 and *Appendix Tables 2.1 through 2.19*, as well as several text tables, are provided to display the data on forensic laboratory drug items identified for the period across areas. CEWG Update Briefs also include NFLIS data for CEWG areas.

Average price and purity data for heroin for CEWG metropolitan areas in CY 2006 (the most recent period available) are from DEA's report, *2006 Heroin Domestic Monitor Program (DMP)*, published September 2007. **Cocaine/crack and methamphetamine price and purity data** for CY 2006 are from DEA's Office of Domestic Intelligence, Domestic Strategic Intelligence Unit report, *2005–2006 Price and Purity Data National Ranges in U.S. Dollars*, published October 4, 2007. Average price data come from the DEA's *Quarterly Trends in Trafficking Reports* and reflect average prices throughout the entire field divisions, not the specific cities. Average purity data were only available for the Nation through the DEA's System To Retrieve Information on Drug Evidence (STRIDE). Data are included for the following CEWG sites/areas: Atlanta, Boston, Chicago, Dallas, Denver, Detroit, Los Angeles, Miami, New York City, Philadelphia, Phoenix, San Diego, San Francisco, Seattle, St. Louis, and

Washington, DC. Some data were not reported by the DEA for Phoenix, Denver, and San Francisco.

Local drug-related mortality data from medical examiners/coroners (ME/Cs) were reported for the first half of 2007 for 14 CEWG areas, including Atlanta; Miami/Dade/Broward County, Florida; Maine; Texas; Denver; Detroit; Cincinnati; Honolulu; Minneapolis/St. Paul; St. Louis; San Diego; Seattle; and Philadelphia.

Other data cited in this report are local data accessed and analyzed by CEWG representatives. The sources include local law enforcement (e.g., data on drug arrests); local DEA offices; drug price data from the National Drug Intelligence Center (NDIC), U.S. Department of Justice (2007); High Intensity Drug Trafficking (HIDTA) reports; poison control centers and help lines; local and State surveys; and key informants and ethnographers.

A Note to the Reader—Caveats

Local comparisons are limited, or must be made with caution, for the following indicators:

Treatment Admissions—Many variables affect treatment admission numbers, including program emphasis, capacity, data collection methods, and reporting periods, so that changes in admissions bear a complex relationship to drug abuse prevalence. Treatment data on primary abuse of specific drugs in this report represent percentages of total admissions, both including and excluding primary alcohol admissions. However, to increase comparability with other data that are confined to illicit drug use (DEA, NFLIS) or which do not systematically include all alcohol-related reports or visits (SAMHSA, OAS, DAWN), percentage distributions based on total treatment admissions by drug excluding primary alcohol admissions are used for most cross-area comparisons to approximate illicit drug admissions. It should be noted that in Section II of this report, in the Update Briefs from CEWG areas, the percentages of treatment admissions for different drug groups may include primary alcohol admissions in the denominator, as do text and tables in the cross-area comparison section of this report. Data on demographic characteristics (gender,

race/ethnicity, age) and route of administration of particular drugs were provided for some CEWG areas. The numbers of admissions for alcohol and other drugs in the first half of 2007 time period are presented for the 15 CEWG areas in Tables 2 and 3 and *Appendix Table 1*. Treatment data are not totally comparable across CEWG areas, and differences are noted insofar as possible. Treatment numbers may be subject to change until a calendar year for the treatment data system is closed.

ED Drug Reports—Because the *DAWN Live!* reports represent unweighted numbers of ED visits, they cannot be compared across CEWG areas or across data collection years, and estimates may change after cases are reviewed for quality control. Percentages are calculated based on two totals: major substances of abuse and the subcategory opiates/opioids.

Forensic Laboratory Drug Items Identified—There are differences in local/State lab procedures and law enforcement practices across areas, making area comparisons inexact. Also, the data cannot be used for prevalence estimates, because they are not adjusted for population size. They are reported as the percentage that each drug represents in the total drug items identified by forensic laboratories in a CEWG area, and cases are assigned to a geographic area by the location of the seizure event, not the laboratory. Because the method of case assignment for the data provided by DEA to the CEWG has changed recently to assignment based on the geographic location from which items were submitted for identification rather than the location of the laboratory which performed the item identification, the NFLIS data cannot be compared with past years of data presented in prior CEWG reports.

Deaths—Mortality data typically represent the presence of a drug detected in a decedent rather than overdose deaths. The mortality data are not comparable across areas because of variations in methods and procedures used by ME/Cs. Drugs may cause a death, be detected in a death, or simply relate to a death in an unspecified way. Multiple drugs may be identified in a single case,

with each reported in a separate drug category. Definitions associated with drug deaths vary. Common reporting terms include “drug-related,” “drug-detected,” “drug-induced,” “drug-caused,” and “drug-involved.” These terms may have different meanings in different areas of the country, and their meaning may depend upon the local reporting standards and definitions. Cross-area tabulations of mortality drug abuse indicators are not included in this report, although a number of area Update Briefs utilize such data.

Arrest and Seizure Data—The number of arrests and quantities of drugs seized often reflect enforcement policy and resources rather than level of abuse. Only a few CEWG areas report these data at the present time due to concerns about validity as well as lack of availability.

The following methods were applied to facilitate local area comparisons:

- Local areas vary in their reporting periods. Some indicators reflect fiscal periods that may differ among local areas. In addition, the timelines of data vary, particularly for death and treatment indicators. Spatial units defining a CEWG area in different data sources may also differ. Care has been taken to delineate the definition of the geographic unit under study for each data source, whether it be a single metropolitan county, a Metropolitan Statistical Area (MSA), or some subset of counties in an MSA. In some instances, data were compiled by region defined by the U.S. census as northeastern, southern, midwestern, and western regions. Texas is included in the southern region in this report, but in future reports, it will be included in the western region based on member recommendations.
- In Section II of this report, percentages for treatment program admissions are calculated and presented in two ways: excluding primary alcohol admissions from the total on which the percentages are based, and including admissions in which alcohol was reported as the primary drug of abuse in the total on which percentages are based.

- Most treatment data in the cross-area comparison section of this report cover the first half of CY 2007.
- All ED data are based on unweighted preliminary DAWN data for the first half of 2007 and cannot be compared across time or areas. The completeness tables are provided in *Appendix Table 3.1*, along with data in *Appendix Table 3.2* for each reporting area of drug mentions by drug. The weighted data may be available for future meetings, enabling cross-area comparisons.
- In the future, current NFLIS data will be able to be compared with subsequent time periods. With the implementation of new case allocation methods for this FY 2007 data, no comparisons with past years are possible.
- Some indicator data are unavailable for certain cities. Therefore the symbol “NR” in tables refers to data not reported.
- The population racial/ethnic composition differs across CEWG areas. This fact should be considered when interpreting tables displaying demographic characteristics of treatment admissions. Where U.S. census categories are used, treatment admissions data are provided across CEWG areas. However, readers are directed to the individual CEWG area Update Briefs regarding treatment patterns and trends pertaining to race/ethnicity.

Section II. Highlights and Summary of Key Findings and Emerging Issues from the January 2008 CEWG Meeting

THIS SECTION HIGHLIGHTS AND SUMMARIZES key findings reported and issues identified at the January 2008 CEWG meeting, held January 23–25, 2008, in Ft. Lauderdale, Florida. Findings are reported by type of substance, but it is important to note that polysubstance use continues to be a pervasive pattern across all CEWG areas. Treatment admissions commonly report problems with more than one drug, and multiple drug use continues to be a major contributor to drug-related deaths.

Update Briefs summarizing drug abuse trends and issues in specific CEWG areas, with an emphasis on information newly available since the June 2007 meeting area reports, are included in a subsequent section (Section III) of this report.

The final section (Section IV) of the report summarizes and compares drug abuse indicator data commonly available across a majority of CEWG areas.

Cocaine

- CEWG members from the southern, northeastern, and midwestern regions reported increased seizures of cocaine in 2007, based on law enforcement sources. The impact on local availability, wholesale and retail prices, and purity of cocaine varied across areas. Several CEWG members suggested that adulterants could be filling the supply gap at the retail level. Chicago, Atlanta, and Miami-Dade/Broward County, Florida, referred to qualitative reports of decreases in perceived quality or purity of cocaine, while Cincinnati reported that average purity of cocaine decreased 14 percent in the first half of 2007, as compared with 2006.
- Cocaine was the drug most frequently identified by forensic laboratories in 10 of 19 CEWG areas in FY 2007. Cocaine ranked first in drug items identified in every area in the southern region (Miami; Atlanta; Washington, DC; and Texas) and in two of three areas in the northeastern region (New York City and Philadelphia). Cocaine ranked first in frequency of forensic drug items identified in one of five areas in the Midwestern region (Cincinnati) and in three of seven areas in the western region of the United States (Seattle, Los Angeles, and Denver).
- Treatment admission data for FY 2007 or the first half of CY 2007 reveal that treatment admissions for primary cocaine/crack, as a percentage of all treatment admissions, excluding primary alcohol admissions, ranked first in frequency in 6 of the 15 CEWG areas for which treatment data were reported: Texas, Atlanta, Philadelphia, Detroit, St. Louis, and Seattle.
- During discussion it was stressed that cocaine is often reported as a secondary or tertiary drug among treatment admissions and that cocaine is often used in conjunction with other substances. In Florida, polysubstance abuse was linked to 75 percent of cocaine-related deaths statewide during the first half of 2007, with cocaine-related deaths declining very slightly statewide (by 3 percent) between the last half of 2006 and the first half of 2007 (Figure 1). Cocaine-related deaths declined even more in Broward and Miami-Dade Counties (35 and

21 percent, respectively), reversing an upward trend since 2000 in the State and since 2004 in the two counties.

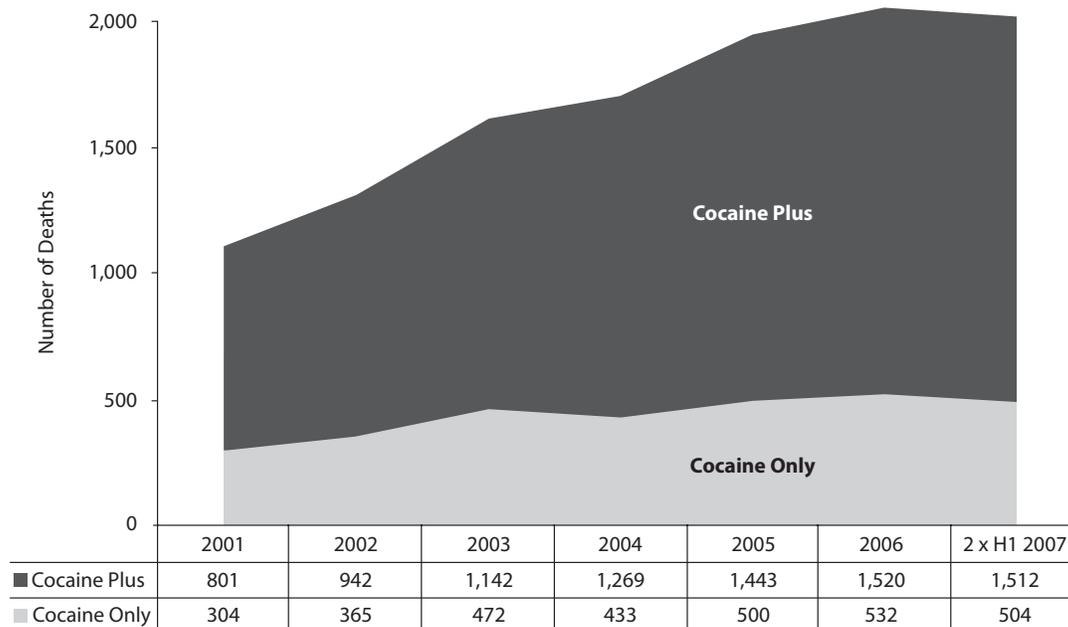
- Crack continued to be the predominant form used by cocaine abusers entering treatment, as indicated by the proportions of primary treatment admissions who reported smoking the drug as the primary route of administration in all of the 11 CEWG areas reporting on route of administration.
- Recent shifts in age and racial/ethnic characteristics of primary cocaine treatment admissions were observed in Philadelphia and Boston, where higher percentages of younger and White non-Hispanic treatment admissions and lower percentages of African-American non-Hispanic treatment admissions have been observed in recent reporting periods (Figures 2, 3, and 4).

- Miami-Dade/Broward County, Florida, reported increasing popularity of powder cocaine, in combination with alcohol, in the club scene. The possibility of a resurgence of use of powder cocaine was the subject of some discussion during the meeting and will be monitored in future reports.

Heroin

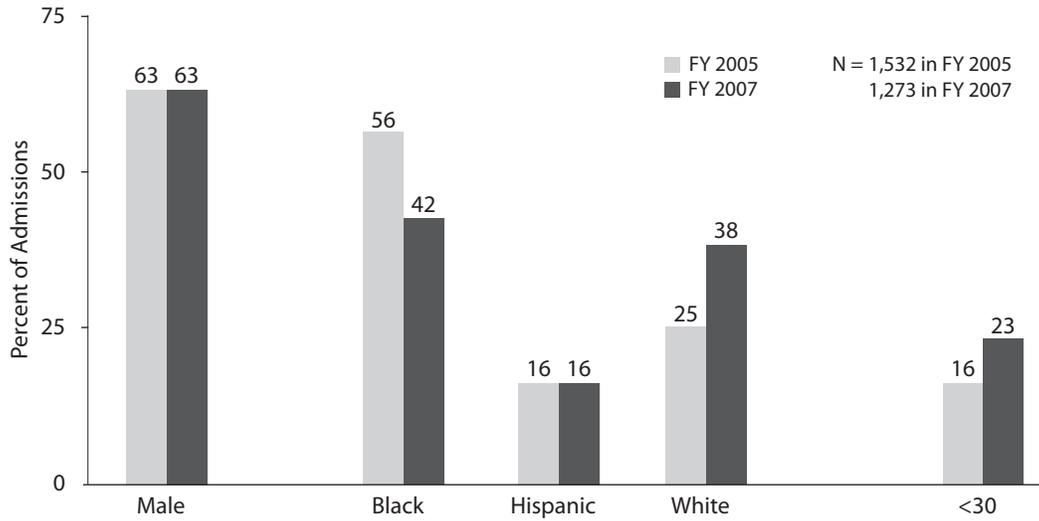
- Heroin ranked first as the primary drug reported in substance abuse treatment admissions, excluding primary alcohol admissions, in 2 of the 15 CEWG areas reporting treatment data. Both were located in the northeast region: New York City and Boston.
- Injection continued to be the most commonly reported route of heroin administration among primary treatment admissions in most of the 11

Figure 1. Polysubstance Use Among State of Florida Cocaine-Related Deaths: 2001 through H1 2007 (Annualized)



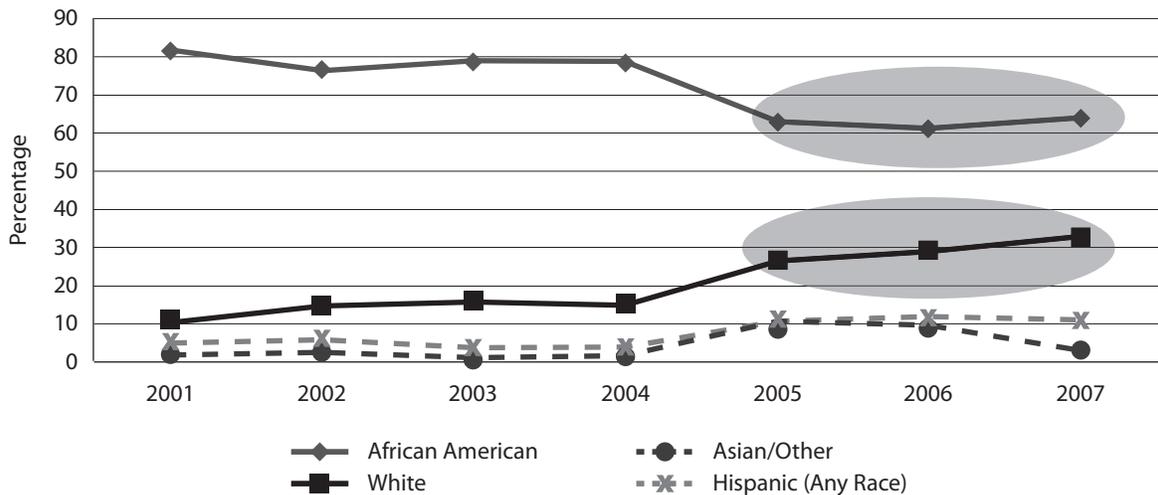
SOURCE: Florida Dept. of Law Enforcement, Florida Medical Examiners Commission Reports 2001–2007. Reported by James Hall, January 2008 CEWG meeting

Figure 2. Primary Drug Admissions for Cocaine by Gender, Race, and Age Group as a Percentage of Substance Abuse Treatment Admissions, Greater Boston: FY 2005, FY 2007



NOTE: Greater Boston includes Boston, Brookline, Chelsea, Revere, and Winthrop (CHNA 19).
SOURCE: Massachusetts Bureau of Substance Abuse Services, Massachusetts Department of Public Health (MIS, FY 2005, FY 2007). Graphics: Boston Public Health Commission Research Office. Reported by Daniel Dooley, January 2008 CEWG meeting

Figure 3. Primary Admissions for Cocaine as a Percentage of Total Treatment Admissions by Race/Ethnicity, Philadelphia: 2001–H1 2007



SOURCE: Behavioral Health Special Initiative (BHSI) Client Data System. Reported by Sam Cutler, January 2008 CEWG meeting

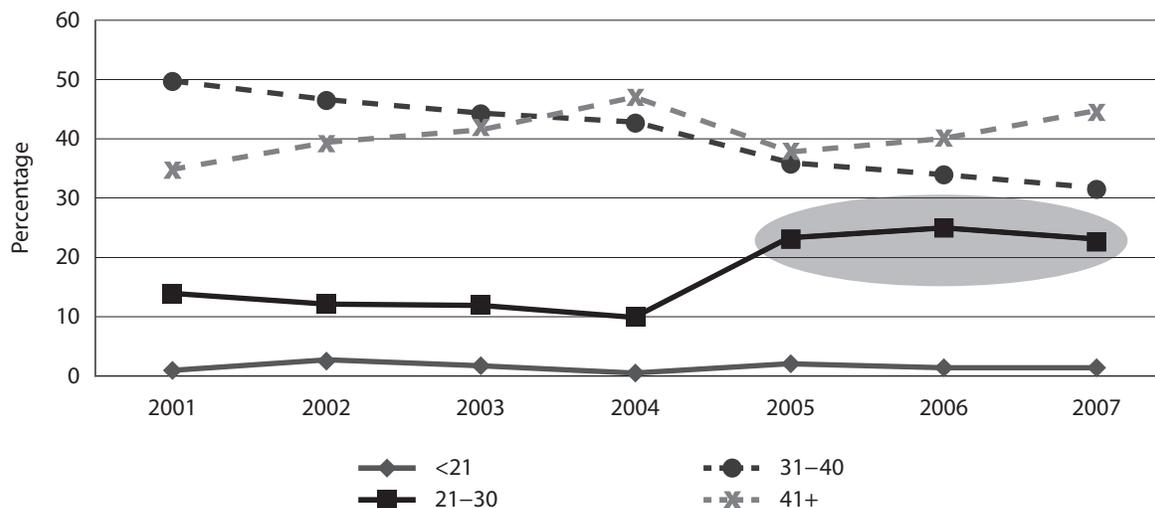
CEWG areas reporting on route of administration. In New York City and Detroit, however, the majority of treatment admissions reported inhalation as the route of administration. The proportion of primary heroin treatment admissions who reported inhalation is rising in Texas. The numbers and proportions of younger (younger than 30) and Hispanic heroin treatment admissions for whom inhalation is the major route of administration have also increased in Texas.

- Use of “cheese” heroin (a mixture of heroin, diphenhydramine, and acetaminophen as described by the Texas CEWG member) continues to be a problem in Dallas, but it was not reported in other CEWG areas.
- Average purity of heroin, based on DEA data, has fluctuated in recent years but has shown a downward trend in many CEWG areas through 2006, the most recent year for which data were available. The decrease in average purity has tended to be accompanied by an increase in average price per milligram pure. Price and

purity of heroin may influence the composition of street heroin, route of administration, health consequences, and seeking of illicitly obtained opioid medications.

- Poison control data for Cincinnati showed a 33-percent increase in reported human heroin exposure cases in 2007, with findings indicating distribution of adulterated heroin in the Cincinnati region between April and September 2007.
- The Atlanta representative reported that injection of South American heroin has increased due to decreased purity levels and increases in price. Boston has experienced a decline in average purity of South American heroin from 40 percent in 2003 to 18 percent in 2006, with concurrent increases in average price. The Boston area member reported that the proportion of past-year injection drug use among heroin and other opiates admissions reached the highest level in 10 years (83 percent in FY 2007). Average purity of South American heroin decreased in Chicago in 2006 to 12.6 percent, one of the lowest average purity levels in the eight CEWG

Figure 4. Primary Admissions for Cocaine as a Percentage of Total Treatment Admissions by Age Groups, Philadelphia: 2001–H1 2007



SOURCE: Behavioral Health Special Initiative (BHSI) Client Data System. Reported by Sam Cutler, January 2008 CEWG meeting

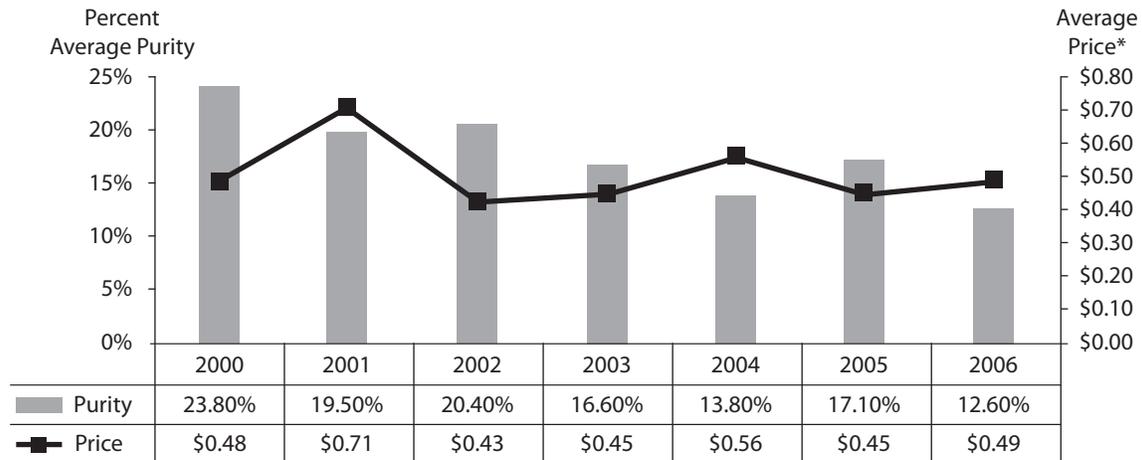
areas for which data on South American heroin were available (Figure 5).

- New York City reported an overall downward trend in the number of deaths involving heroin since 2002, although such deaths had increased slightly in 2006. In Florida, a downward trend in heroin-related deaths has been observed through the first half of 2007, while deaths related to three opioid medications (hydrocodone, oxycodone, and methadone) have increased substantially in recent years (Figure 6).
- Increased diversification of the heroin market was reported for Atlanta and St. Louis. In Atlanta, it was noted that law enforcement officials have reported greater amounts of Mexican brown powder heroin. The heroin market in St. Louis was described as increasingly complex due to the infusion of South American and Southwest Asian heroin in addition to Mexican black tar heroin.

Opiates Other Than Heroin

- In the first half of 2007, abuse indicators for other opiates were reported for selected narcotic analgesics, mainly oxycodone, hydrocodone, methadone, and fentanyl, by CEWG area members in Update Briefs and meeting presentations.
- Of total drug items identified in forensic laboratories in CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in FY 2007. In Philadelphia, Boston, and Cincinnati, oxycodone ranked fourth in drug items identified, and it ranked fifth in Phoenix and Minneapolis/St. Paul. Hydrocodone ranked fifth in frequency of drug items identified in Atlanta, Texas, San Diego, and Cincinnati.
- Treatment admissions for primary abuse of other opiates, as a percentage of total admissions (excluding primary alcohol admissions), ranged from less than 1 to 9 percent in 12 of 15 reporting CEWG areas. They were highest in Minneapolis/St. Paul.

Figure 5. South American Heroin Average Price and Purity Trends in Chicago: 2000–2006



*Price refers to "per milligram pure."

SOURCE: DEA, Domestic Monitoring Program. Reported by Lawrence Ouellet, January 2008 CEWG meeting

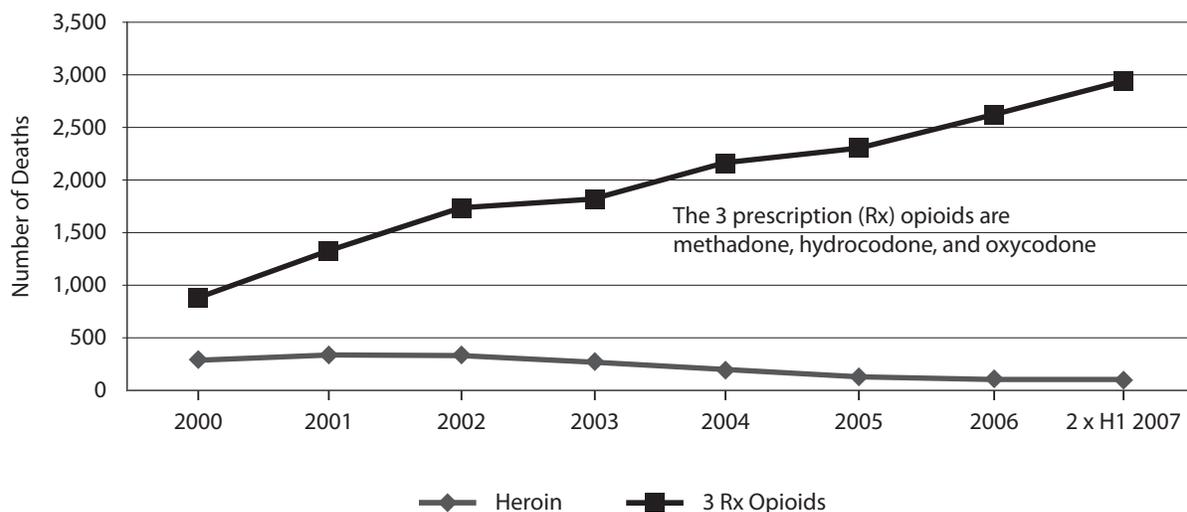
- For several CEWG areas, including Detroit, Denver, Honolulu, and Texas, representatives reported increases in deaths in which opioid drugs were detected in decedents. Deaths in which opioid drugs were detected continued to rise in Wayne County (Detroit report), especially those related to hydrocodone and methadone, while deaths in which fentanyl was detected fell substantially (Figure 7). The Texas representative reported increases in methadone indicators, including deaths (Figure 8), and noted that most of the increase in poison center calls has pertained to methadone pills, rather than liquid or diskettes.
- Diversion or indications of diversion of buprenorphine to street use were reported in Chicago, Cincinnati, and Maine. The Chicago representative reported nonprescribed buprenorphine use is increasingly common among heroin users, who mainly use it to avoid withdrawal or manage their addiction. The Cincinnati representative reported increased numbers of calls to poison control for tablet identification of buprenorphine-containing

pharmaceuticals, suggesting the possibility of diversion for nonmedical use. In Maine, street abuse reportedly increased, as indicated by seizure samples, information calls to poison control, and two cases in which buprenorphine, in combination with other drugs, was ruled as the cause of death. Buprenorphine was the sixth most commonly identified drug reported to NFLIS in Boston in FY 2007, with 380 buprenorphine items identified.

Benzodiazepines

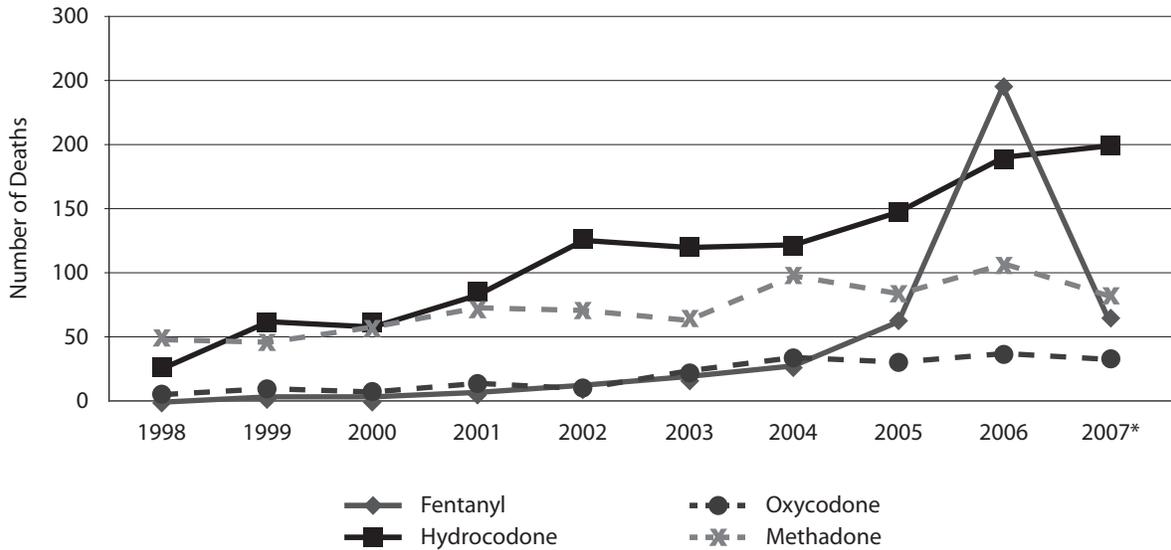
- Treatment and mortality data show that benzodiazepines were often used with other drugs. Deaths with the presence of benzodiazepines were reported in several areas, including Georgia, Philadelphia, South Florida, Seattle, and Texas. The Georgia Medical Examiner’s Office reports that benzodiazepines are second only to cocaine in the number of statewide specimens that test positive for a particular drug. In Philadelphia, benzodiazepines ranked fourth as a detected drug in mortality data.

Figure 6. Numbers of Heroin-Related and Three-Opioid-Related Deaths in Florida: 2000–2007 (Annualized)



SOURCE: Florida Medical Examiners Commission Reports 2000–2007. Reported by Jim Hall, January 2008 CEWG meeting

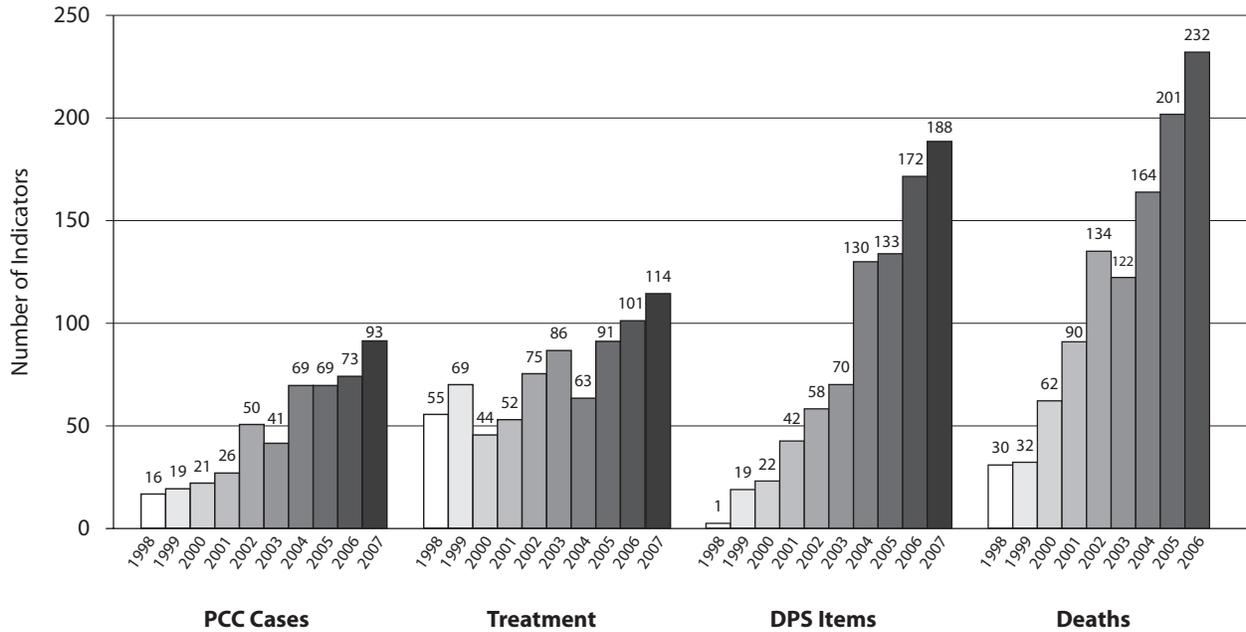
Figure 7. Number of Deaths with Selected Prescription Opioids Detected by Year—Wayne County, Michigan: 1998–2007* (Annualized)



*Annualized 2007 data from January–August reports.

SOURCE: Wayne County Medical Examiner’s Office. Reported by Cynthia Arfken, January 2008 CEWG meeting

Figure 8. Methadone Abuse Indicators in Texas: 1998–2007



NOTE: PCC=Poison Control Center; DPS=NFLIS forensic laboratory drug items.

SOURCE: Texas Department of Public Safety. Reported by Jane Maxwell, January 2008 CEWG meeting

- Alprazolam and clonazepam continued to be the most frequently reported benzodiazepines in the indicator data.
- In the 19 CEWG areas reporting to NFLIS in FY 2007, the highest percentages of alprazolam drug items were identified in Texas, with 6 percent of all items identified, followed by Atlanta and Philadelphia, with approximately 3 percent of all drugs identified. Alprazolam ranked fourth in frequency among the top 10 drug items identified in 3 CEWG areas, namely Texas, Atlanta, and New York City, while clonazepam was the fifth ranked drug identified in Boston.
- Alprazolam indicators were reported as having increased in Cincinnati, Texas, and Atlanta. There was a 45 percent increase in the number of clonazepam exposures reported to poison control in Cincinnati in 2007, a possible early indicator of increased abuse of clonazepam.

Carisoprodol

- The Texas representative reported that deaths involving a mention of carisoprodol and NFLIS laboratory exhibits identified as carisoprodol continue to increase.
- Carisoprodol appeared among the top 10 drugs most frequently identified by forensic laboratories in Texas, Phoenix, and Atlanta.

Methamphetamine

- The halt in the escalation of methamphetamine indicators noted at the June 2007 CEWG meeting has continued based on January 2008 CEWG area reports. Methamphetamine indicators were down or stable across most CEWG areas, although indicators were still considered to be high relative to other drugs in most areas in the western region.
- Methamphetamine ranked first in treatment admissions as a percentage of all treatment admissions in Los Angeles, San Diego, and Hawai'i, and additionally in Phoenix, when

primary alcohol admissions are excluded from total admissions. With the exception of Atlanta, methamphetamine indicators were low across most northeastern and southern CEWG areas.

- Methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in three areas in FY 2007: Honolulu (52 percent), San Francisco (37 percent), and Minneapolis/St. Paul (33 percent). On the other hand, less than 2 percent of drug items identified as containing methamphetamine were reported in CEWG metropolitan areas east of the Mississippi River, with the exception of Atlanta (23 percent).
- Several CEWG reports, including Los Angeles, Phoenix, Seattle, and Minneapolis/St. Paul, presented law enforcement data illustrating continuing decreases in seizures and incidents pertaining to methamphetamine laboratories (Figure 9).
- Price, purity, and availability of methamphetamine were the subject of discussion during the meeting. It was suggested that increases in wholesale prices of methamphetamine may reflect decreased availability and may impact the purity of methamphetamine available on the street (Figure 10). The importance of monitoring retail price, which most directly impacts consumers, and purity of methamphetamine was stressed.
- Decreases in proportions of arrestees testing positive for methamphetamine in San Diego and methamphetamine/amphetamine in Maricopa County (Phoenix report) were reported (Figures 11 and 12).

MDMA/Ecstasy

- June 2007 and January 2008 CEWG reports indicated that MDMA/ecstasy, which had been popular as a club drug in the late 1990s and peaked in popularity based on national survey data in 2001, may be re-emerging and appealing to a broader range of users.

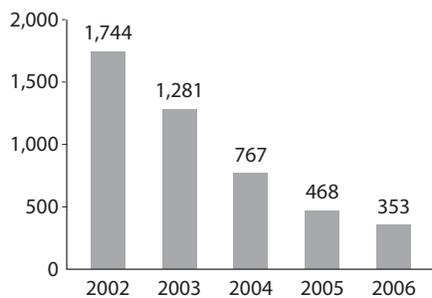
- While MDMA/ecstasy indicators were low compared with other drug abuse indicators in all CEWG areas, they were reported as increasing in many CEWG areas, including Miami-Dade/Broward County, Texas, Atlanta, Maine, Detroit, Chicago, St. Louis, Cincinnati, Minneapolis/St. Paul, Los Angeles, and San Diego. All Midwestern region CEWG areas reported indicators to have increased.
- MDMA exceeded 2 percent of all drug items identified in forensic laboratories and reported to NFLIS in FY 2007 in Atlanta; Seattle;

Minneapolis/St. Paul; Washington, DC; Detroit; and San Francisco. The highest percentage (approximately 6 percent) was reported in Atlanta and Seattle. MDMA was the third most frequently identified drug item in Atlanta and ranked fourth in Miami, Detroit, Chicago, Minneapolis/St. Paul, Seattle, and Honolulu.

- Increased seizures of MDMA in 2006 were reported for Denver (Figure 13). Broward County, Florida, experienced a large rise in MDMA crime laboratory cases from 2006 to 2007, following a steady decline since 2001 (Figure 14).

Figure 9. Methamphetamine Laboratory Incidents/Seizures, California and Los Angeles, HIDTA: 2002–2007

Methamphetamine Lab Incidents, California



CA #6 among states in meth lab seizures, 2006

*Powder Methamphetamine Lab Seizures in LA HIDTA**

	2002	2003	2004	2005	2006
Superlabs	57	55	27	10	2
Major Laboratories	74	43	43	8	5
Small-Scale Laboratories	476	372	7	94	71
All Laboratories	607	470	217	112	78

*LA County accounts for approximately 40% of LA HIDTA meth lab seizures
Meth-related cleanup costs running about \$34,000–\$36,000 per quarter in 2007.

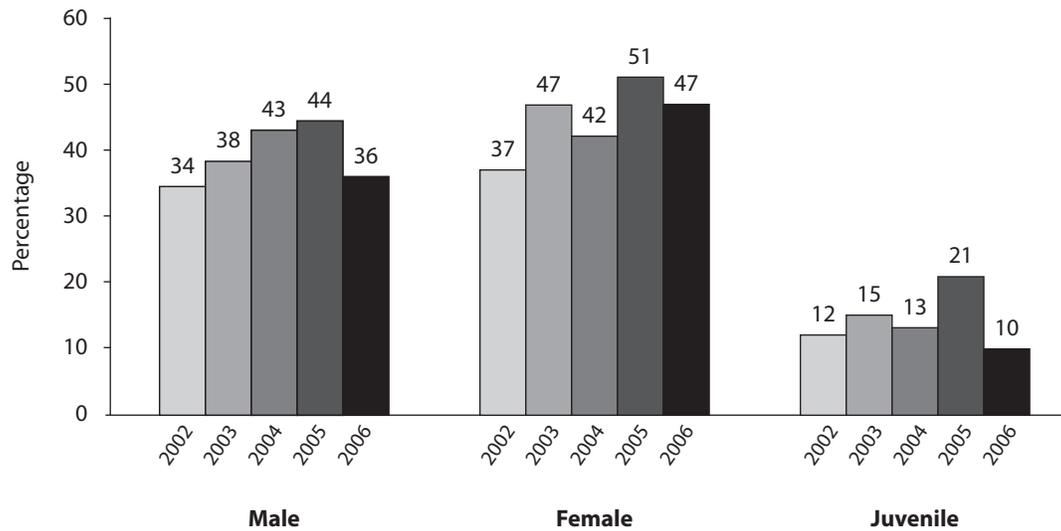
SOURCES: (1) Graph: DEA State Factsheets CA 2007 (data source: EPIC/CLSS) and (2) Table: NDIC/LA HIDTA report June 2007. Reported by Mary-Lynn Brecht, January 2008 CEWG meeting

Figure 10. Methamphetamine Prices, San Diego County: 2005–2007

	2005	2006	2007
¼ Gram	\$20	\$20–25	\$20–25
Gram	\$40–50	\$50–100	\$50–100
Ounce	\$550–900	\$600–1,000	\$750–1,000
Pound	\$3,500–8,500	\$6,000–10,000	\$9,000–12,500

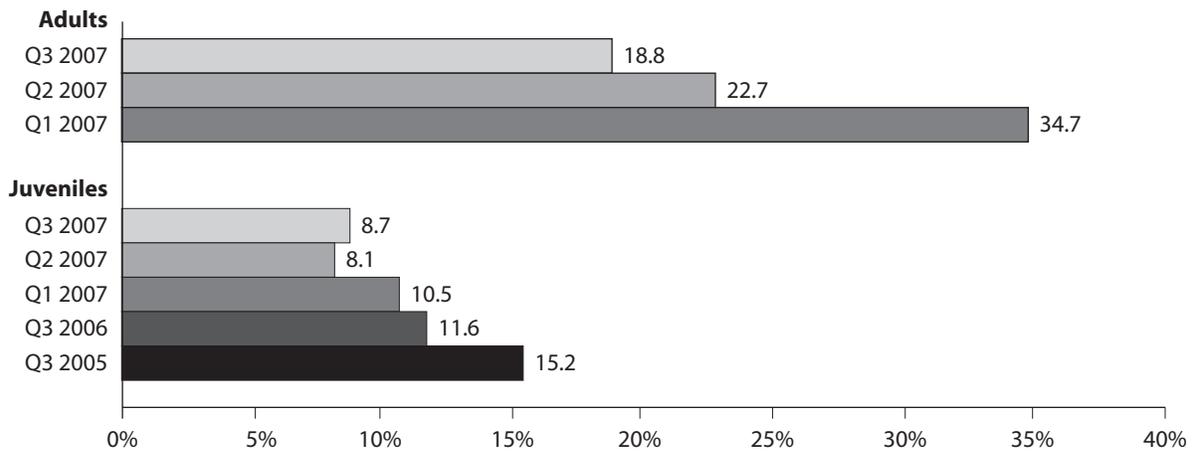
SOURCE: San Diego Law Enforcement Coordination Center. Reported by Robin Pollini, January 2008 CEWG meeting

Figure 11. Percentage of Arrestees Testing Positive for Methamphetamine by Gender and Among Juveniles, San Diego: 2002–2006



SOURCE: San Diego Association of Governments (SANDAG), Substance Abuse Monitoring Program. Reported by Robin Pollini, January 2008 CEWG meeting

Figure 12. Percentage of Maricopa County Arrestees Testing Positive for Amphetamine/ Methamphetamine: Q1–Q3 2007, Q3 2006, and Q3 2005



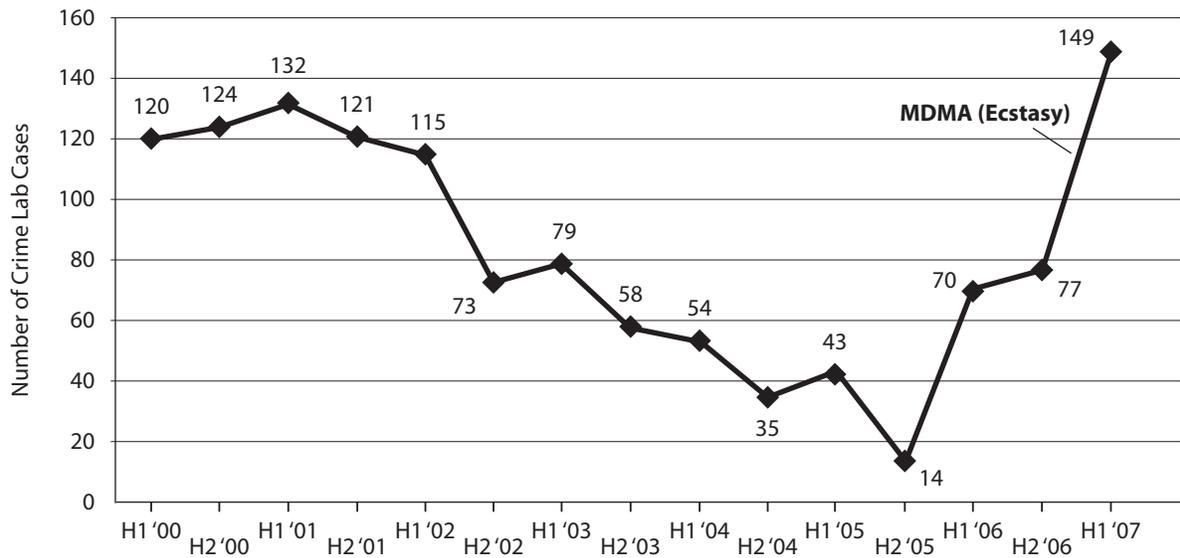
SOURCE: Treatment Assessment Screening Center (TASC). Reported by Jim Cunningham, January 2008 CEWG meeting

Figure 13. MDMA Seizures, Denver: 2004–2006



SOURCE: DEA State Facts 2007, Colorado. Reported by Tamara Hoxworth, January 2008 CEWG meeting

Figure 14. Crime Laboratory Cases Related to MDMA (Ecstasy), Broward County, Florida: First Half 2000–First Half 2007



SOURCE: Broward County's Sheriff's Office Crime Laboratory. Reported by Jim Hall, January 2008 CEWG meeting

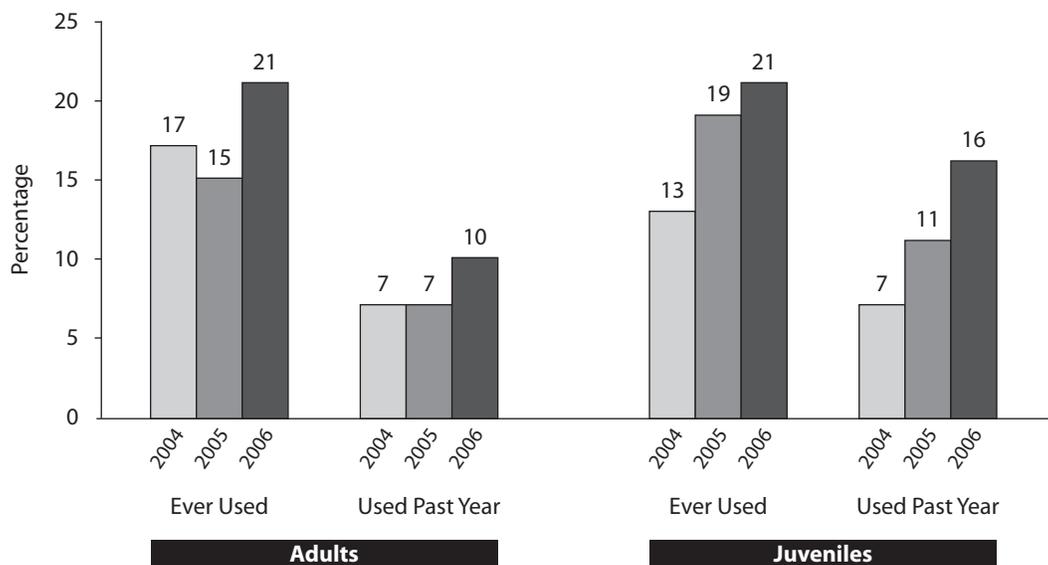
The Atlanta representative reported that supplies of MDMA are nearing 2001 levels based on law enforcement data. In Seattle, it was reported that law enforcement data indicate a substantial volume of MDMA has been moving across the Canadian border through Washington State, with final destinations throughout the United States.

- CEWG reports described a diversity of MDMA users. In Miami-Dade/Broward County, it was reported that MDMA/ecstasy is associated with the hip-hop club scene. The Chicago representative discussed MDMA/ecstasy use in low income, African-American neighborhoods. In urban Atlanta, MDMA/ecstasy is reportedly most popular among African-American youth and young adults, while in suburban Atlanta, it is most popular among White youth and young adults. The Texas representative highlighted the decreasing proportion of White treatment admissions in Texas reporting a problem with MDMA and the increasing proportion of minority treatment admissions. In New York City, MDMA/ecstasy use is most commonly

seen among area college students. An increase in past-year MDMA use among high school seniors from 2004 to 2007 was reported for Minneapolis/St. Paul, and data from the San Diego Substance Abuse Monitoring survey suggest that ecstasy use may be increasing among individuals involved in the criminal justice system (Figure 15).

- Several CEWG representatives reported that tablets sold as ecstasy or MDMA often contained other substances (especially methamphetamine). User knowledge of the drugs included in products sold as MDMA/ecstasy was reported to vary across area and demographic subgroups. Some users knowingly purchased adulterated MDMA/ecstasy, while other users purchased it unaware. Monitoring adulterants in MDMA/ecstasy, attempting to get better data on MDMA purity, and determining whether marketing for MDMA/ecstasy included products combining MDMA and methamphetamine were mentioned as priorities by several CEWG representatives.

Figure 15. Self-Reported Ecstasy Use Among Arrestees in San Diego: 2004–2006



SOURCE: San Diego Association of Governments (SANDAG), Substance Abuse Monitoring Program. Reported by Robin Pollini, January 2008 CEWG meeting

- An increase in violence associated with MDMA use was also reported, and discussion arose regarding the potential relationship between MDMA-related violence and MDMA/methamphetamine combinations.

Marijuana

- Most CEWG area members reported marijuana abuse indicators as high and stable.
- Cannabis ranked first in frequency in proportions of drug items identified in forensic laboratories in FY 2007 in 6 CEWG areas: St. Louis (57 percent), Chicago (54 percent), San Diego (48 percent), Boston (45 percent), Detroit (42 percent), and Phoenix (36 percent).
- In no area did marijuana rank first as the primary drug in total treatment admissions, although when primary alcohol admissions are excluded, marijuana ranked first in treatment admissions in Denver (37 percent), Cincinnati (36 percent), and Minneapolis/St. Paul (33 percent).
- The Seattle representative reported that indoor and outdoor cultivation of marijuana has increased in Washington State in recent years. In Atlanta, it was reported that local cultivation of more potent hydroponic marijuana increased in 2007 due to drought-like conditions in Atlanta and throughout Georgia.

Phencyclidine (PCP)

- PCP abuse indicators were stable in most areas during the period. Based on reporting from area members, PCP abuse indicators, although low relative to other drugs, showed slight increases

in Los Angeles and Texas, while they were reported as moderate and stable in Philadelphia and Washington, DC.

- In six CEWG areas, the number of drug items containing PCP identified in forensic laboratories exceeded 75. A few PCP items were reported in seven other CEWG areas. No PCP items were documented in the other CEWG areas. Thirty or more PCP items were identified in these seven CEWG areas: Washington, DC; Philadelphia; Miami; New York City; Los Angeles; Texas; and Chicago. As a percentage of all identified items, PCP items were highest in Washington, DC, at 4 percent, and Philadelphia, at 3 percent.

The following tables and figures provide a summary of some of the CEWG cross-area comparison results for this reporting period. These include the top 10 drug items identified by forensic laboratories, ranked by order of frequency, in the reporting CEWG areas (Table 1) and the top-ranked drugs based on treatment admissions data, both including and excluding primary alcohol admissions, for reporting CEWG areas (Tables 2 and 3). A map (Figure 16) displays NFLIS data on percentages of cocaine, heroin, methamphetamine, and marijuana items identified by forensic laboratories in 19 CEWG areas. Two additional maps are based on SAMHSA, OAS, DAWN *Live!* data for the 11 reporting CEWG areas. Figure 17 shows relative proportions of ED reports of major substances of abuse related to cocaine, heroin, marijuana, and methamphetamine. Selected narcotic analgesics as a proportion of all opiates/opioids reported in ED visits for the same areas are found in Figure 18. Data for these tables and maps are provided in *Appendix Tables 1–3*.

Table 1. NFLIS Top 10 Drug Items Analyzed by CEWG Area, Region and Rank (Based on Frequency): FY 2007

CEWG Areas	Cocaine/ Crack	Cannabis	Methamphetamine	Heroin	MDMA	Oxycodone	Hydrocodone	Alprazolam	Hallucinogens ¹	Clonazepam	Other
SOUTHERN REGION											
Miami/Dade Co.	1	2	8	3	4	7	9	5	6	10	
Texas	1	2	3	7	6		5	4		9	Carisoprodol=8, Diazepam=10
Atlanta	1	6	2	10	3	7	5	4			Methadone=8, Carisoprodol=9
Wash., DC	1	2	6	3	5	7			4		Methadone=8 (8 items), MDA=9 (7 items), and Buprenorphine=10 (6 items)
NORTHEASTERN REGION											
Philadelphia	1	2	10	3	8	4	7	5	6	9	
New York City	1	2		3	9	7	8	4	6		Methadone=5, MDA=10
Boston	2	1		3	9	4	8	7		5	Methadone=10, Buprenorphine=6
MIDWESTERN REGION											
Detroit	2	1	10	3	4	7	8	6			Dihydrocodeine=5, Codeine=9
Chicago	2	1	6	3	4		7	8	9		Clonidine=5, Acetaminophen=10
St. Louis	2	1	3	4	5	9	10	6			Acetaminophen=7, Pseudoephedrine=8
Cincinnati	1	2	10	3	6	4	5	7			Diazepam=8, Methadone=9
Minneapolis/ St. Paul	2	3	1	6	4	5	7		8		Acetaminophen=9, Codeine=10
WESTERN REGION											
Seattle	1	2	3	5	4	6	7		10	9	Methadone=8
Honolulu	3	2	1	5	4	9	8	10			Morphine=6, MDA=7
San Francisco	3	2	1	4	5				9		Dihydroxycodeinone=6, Ketamine=7, Methadone=8, Diazepam=10
Los Angeles	1	2	3	4	5		6	8	7		Diazepam=9, Codeine=10
San Diego	3	1	2	4	6	7	5	9		10	Diazepam=8
Phoenix	3	1	2	4	7	5	6	9			Carisoprodol=8, Morphine=10
Denver	1	2	3	4	5	8	7	9	6	10	

¹Hallucinogens are defined as hallucinogens in Miami; phencyclidine in Washington, DC; Los Angeles; New York City; Chicago; phencyclidine/PCP in Philadelphia and Seattle; and psilocin in Minneapolis/St. Paul, Denver, and San Francisco.

SOURCE: NFLIS, DEA (see Appendix Table 2)

Table 2. Top-Ranked Drugs Classified as Primary in Total Substance Abuse Treatment Admissions as a Percentage of Total Admissions, Including Primary Alcohol Admissions, by Region and Ranking in 15 CEWG Regions:¹ FY 2007 and H1 CY 2007²

CEWG Areas	Alcohol	Cocaine/ Crack	Marijuana/ Cannabis	Metham- phetamine	Heroin	Other Opiates	Other Drugs ⁴
SOUTHERN REGION							
Texas	1	2	3	5	4	NR ³	6
Atlanta	1	2	3	4	5	NR ³	–
NORTHEASTERN REGION							
Philadelphia	2	1	3	–	4	6	5
New York City	2	4	3	7	1	6	5
Boston	2	3	4	7	1	5	6
MIDWESTERN REGION							
Detroit	3	1	4	–	2	5	6
St. Louis	1	2	3	5	4	6	7
Cincinnati	1	3	2	–	5	NR ³	4
Minneapolis/St. Paul	1	3	2	4	5	6	7
WESTERN REGION							
Seattle	1	2	3	5	4	7	6
Los Angeles	2	5	3	1	4	6	7
San Diego	2	5	4	1	3	6	7
Phoenix	1	5	3	2	4	6	7
Denver	1	3	2	4	5	6	7
Hawai'i	2	4	3	1	7	5	6

¹CEWG areas not included in the table due to lack of availability of treatment admissions data for the first half of 2007 are Miami/South Florida and Washington, DC in the southern region, San Francisco in the western region, and Maine.

²FY 2007 data are October 2006–September 2007 in Atlanta and July 2006–June 2007 in Cincinnati.

³NR=Not reported; Texas and Cincinnati include other opiates with heroin, under which their totals are reported.

⁴Other drugs include benzodiazepines and hallucinogens as major categories.

Table 3. Top-Ranked Drugs Classified as Primary in Total Substance Abuse Treatment Admissions as a Percentage of Total Admissions, Excluding Primary Alcohol Admissions, by Region and Ranking in 15 CEWG Regions:¹ FY 2007 and H1 CY 2007²

CEWG Areas	Cocaine/ Crack	Marijuana/ Cannabis	Metham- phetamine	Heroin	Other Opiates	Other Drugs ⁴
SOUTHERN REGION						
Texas	1	2	4	3	NR ³	5
Atlanta	1	2	3	4	NR ³	–
NORTHEASTERN REGION						
Philadelphia	1	2	–	3	5	4
New York City	3	2	6	1	5	4
Boston	2	3	6	1	4	5
MIDWESTERN REGION						
Detroit	1	3	–	2	4	5
St. Louis	1	2	4	3	5	6
Cincinnati	2	1	–	4	NR ³	3
Minneapolis/St. Paul	2	1	3	4	5	6
WESTERN REGION						
Seattle	1	2	4	3	6	5
Los Angeles	4	2	1	3	5	6
San Diego	4	3	1	2	5	6
Phoenix	4	2	1	3	5	6
Denver	2	1	3	4	5	6
Hawai'i	3	2	1	6	4	5

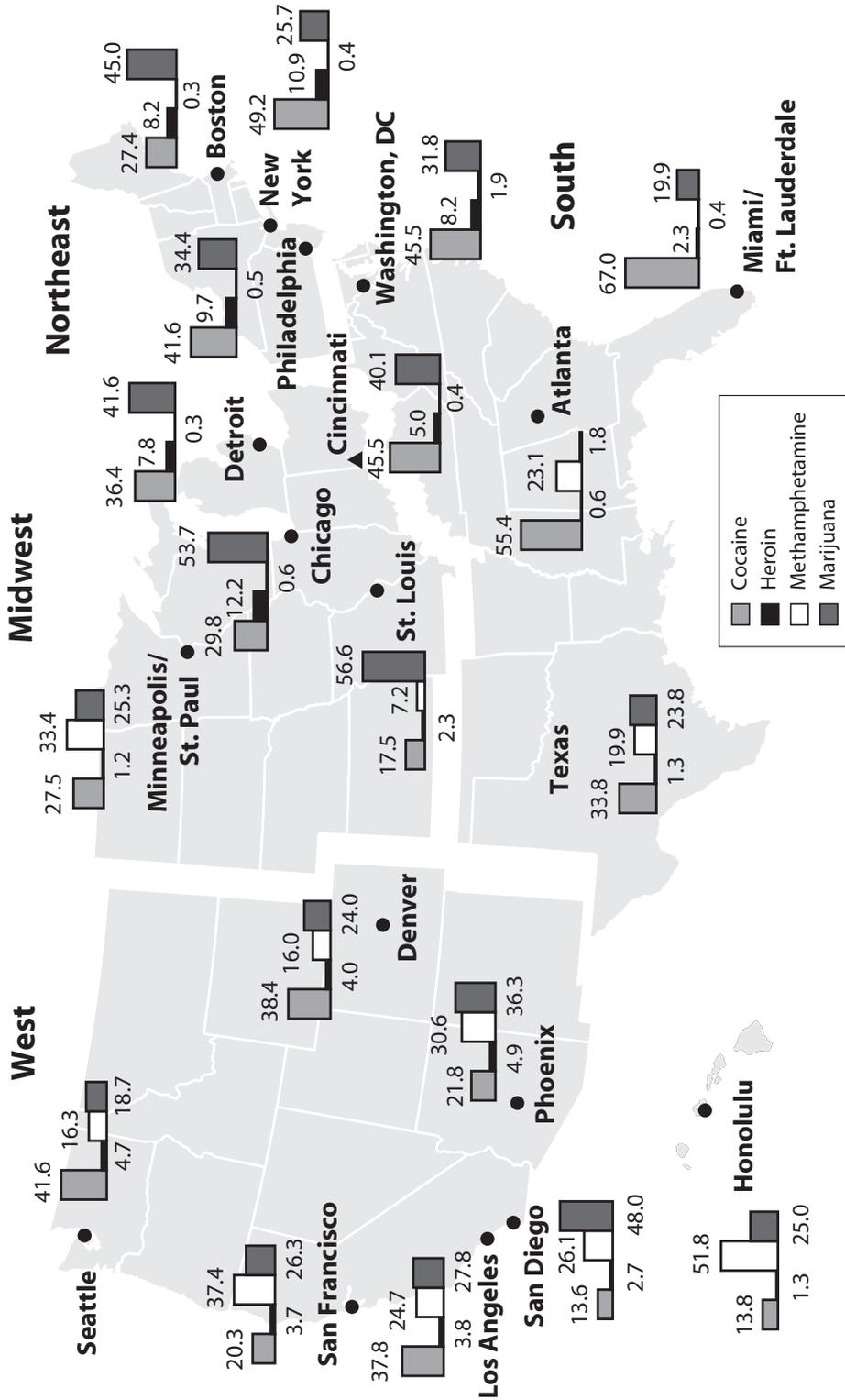
¹CEWG areas not included in the table due to lack of availability of treatment admissions data for the first half of 2007 are Miami/South Florida and Washington, DC in the southern region, San Francisco in the western region, and Maine.

²FY 2007 data are October 2006–September 2007 in Atlanta and July 2006–June 2007 in Cincinnati.

³NR=Not reported; Texas and Cincinnati include other opiates with heroin, under which their totals are reported.

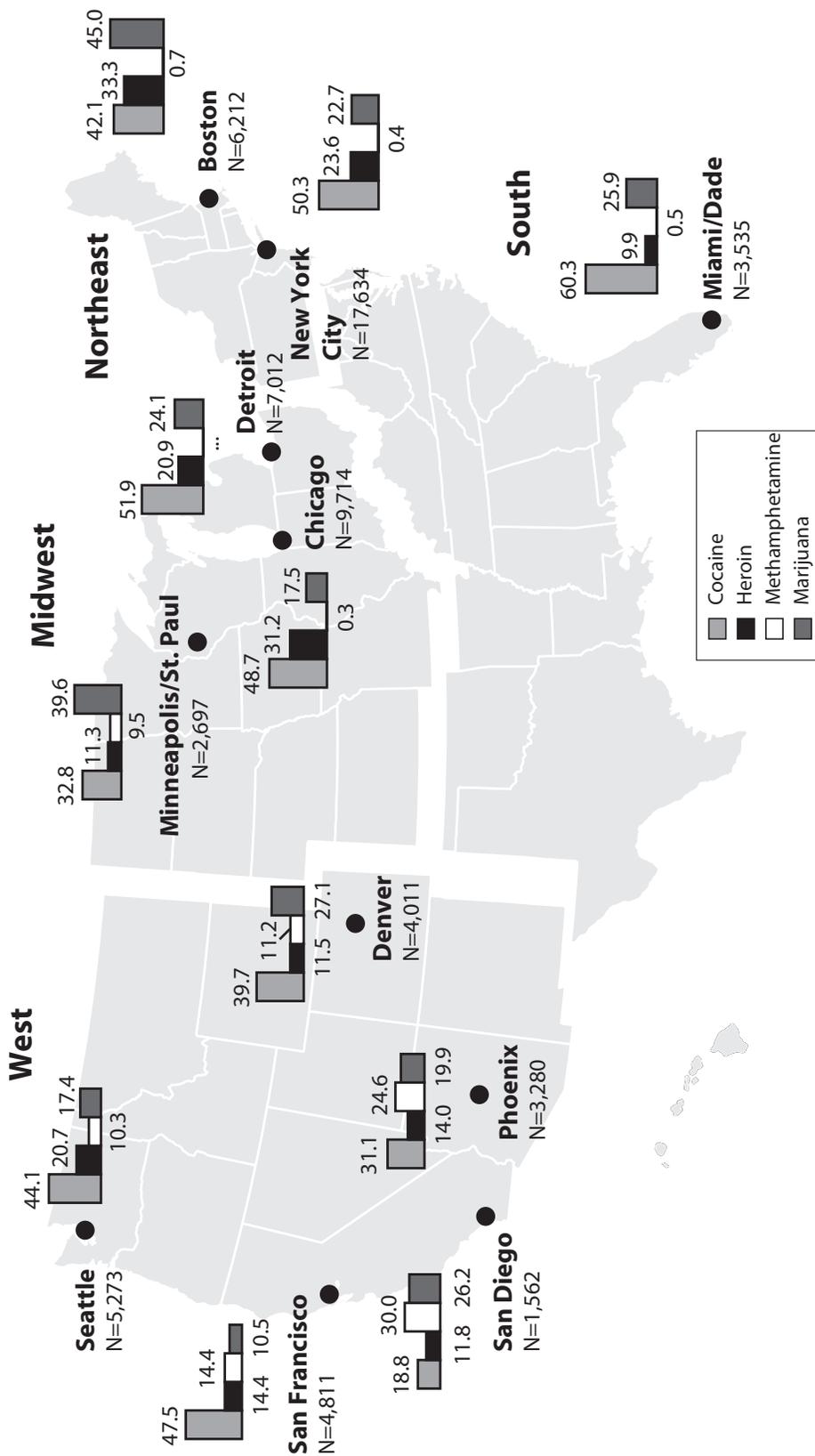
⁴Other drugs include benzodiazepines and hallucinogens as major categories.

Figure 16. Percentages of Cocaine, Heroin, Methamphetamine, and Marijuana Items Analyzed by Forensic Labs in 19 CEWG Areas in 4 U.S. Regions, Each as a Percentage of Total Items Analyzed: FY 2007¹



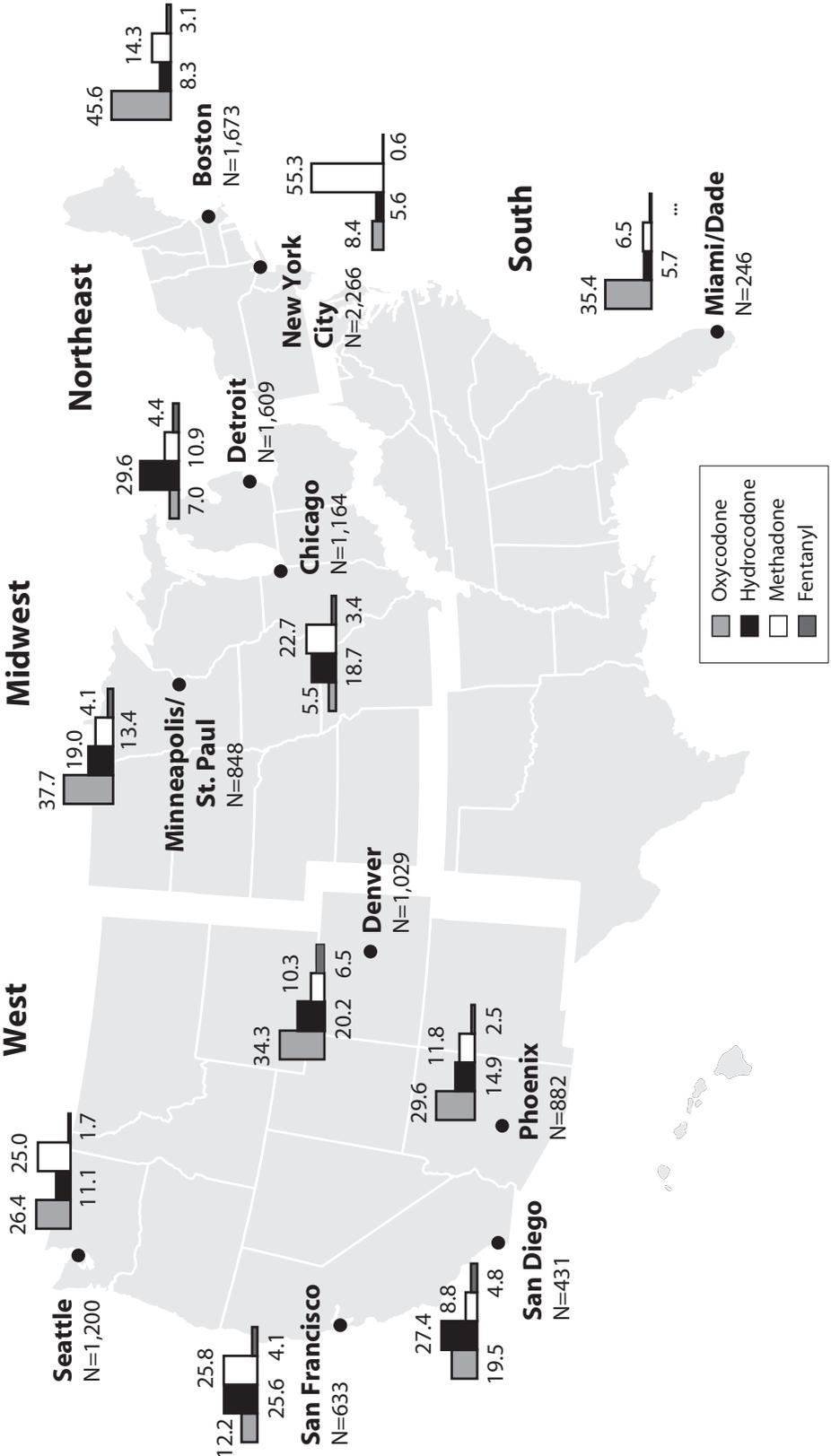
¹Data are for FY 2007, October 2006–September 2007. See Appendix Table 2. SOURCE: Texas data, provided by the Texas Department of Public Safety, were analyzed by the Texas CEWG representative; data for all other areas were provided by NFLUS, DEA

Figure 17. Unweighted ED Reports or Mentions of Cocaine, Heroin, Marijuana, and Methamphetamine as a Percentage of Total Drug Mentions for Major Substances of Abuse, Excluding Alcohol, for 11 CEWG Metropolitan Sites: January–June 2007¹



¹Percentages for selected major substances of abuse are calculated based on total drug reports for such substances, excluding those for alcohol among those under 21 or in combination with other drugs. These are unweighted reports of drugs based on a representative sample of non-Federal, short-term hospitals with 25-hour emergency departments (EDs) in the United States. Three dots (...) indicate that the number of cases is less than 10 (for methamphetamine drug items: Detroit, n=6; Miami/Dade, n=16; Chicago, n=28). SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 12/11/07. Data are subject to change

Figure 18. Unweighted ED Reports or Mentions of Selected Narcotic Analgesics, as a Percentage of Total Opiates/Opioids, Including Hydrocodone, Oxycodone, Methadone, and Fentanyl in 11 CEWG Metropolitan Sites: January–June 2007¹



¹Percentages for selected major substances of abuse are calculated based on total drug reports for such substances, excluding those for alcohol among those under 21 or in combination with other drugs. These are unweighted reports of drugs based on a representative sample of non-Federal, short-term hospitals with 25-hour emergency departments (EDs) in the United States. Three dots (...) indicate that the number of cases is less than 10 (for fentanyl drug items: Miami/Dade, n=6; other areas with n <30 are NYC, San Francisco, Seattle, San Diego, and Phoenix. SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 12/11/07. Data are subject to change

Section III. Update Briefs and International Presentations— January 2008 CEWG Meeting

Introduction

The 63rd semiannual meeting of the Community Epidemiology Work Group (CEWG) was held on January 23–25, 2008, in Ft. Lauderdale, Florida. During this meeting, the 20 CEWG area members reported on current drug trends and patterns in their areas. Two international presentations were also given. The following Update Briefs and Abstracts are based on these reports.

Drug Abuse Patterns and Trends in Atlanta, GA—Update: January 2008

Brian J. Dew, Ph.D.

For inquiries concerning this report, please contact Brian J. Dew, Ph.D., Associate Professor, Georgia State University, Department of Counseling and Psychological Services, P.O. Box 3980, Atlanta, GA 30302-3980, Phone: 404-413-8168, Email: <bdew@gsu.edu>.

Overview of Findings: Cocaine, marijuana, and methamphetamine remain the dominant drugs of abuse in the metropolitan Atlanta area.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine remains Atlanta's primary illicit drug concern. Cocaine was the most mentioned drug among treatment admissions and prison admissions, as well as in NFLIS's drug seizure data. While the proportion of cocaine-related treatment admissions continued a 6-year decline (from 59.0 percent in FY 2000 to 23.2 percent in FY 2007), the proportion of primary treatment admissions reporting secondary cocaine use was

29.2 percent, a 55-percent increase from the previous 2 years. When primary and secondary cocaine treatment admissions are considered together, the proportion of cocaine admissions has decreased 21 percent since 2000, a percentage significantly smaller than admissions reported solely for primary treatment admissions. Atlanta's cocaine users continue to be predominantly African-American, male, and older than 35. Nearly 8 out of 10 of all cocaine users who entered treatment preferred to smoke the drug, a proportion that has remained stable over the last 5 years. Drug surveillance organizations (NDIC and DEA) reported a decrease in cocaine supply for Atlanta in the first half of 2007. This reduced supply did impact the local cocaine market: the wholesale, midlevel, and retail prices of powder cocaine increased and purity levels decreased. However, no changes in the price or purity levels of crack cocaine were reported in Atlanta. Ethnographic reports indicate that the current cocaine supply has returned to pre-2007 levels. Mexican DTOs have strengthened control over cocaine transportation and wholesale distribution in Atlanta. Atlanta remains the leading cocaine staging and distribution hub for the East Coast (including Miami and New York City). Among law enforcement agencies in metropolitan Atlanta counties, 17 of 28 reported that crack cocaine was most responsible for violent crimes in their jurisdictions. In 2007, increased violence between cocaine dealers from Atlanta and dealers previously living in New Orleans who are establishing new markets in Atlanta was reported by law enforcement in Cobb and Gwinnett Counties. **Marijuana** remains the most commonly used substance in Atlanta. Ethnographic reports

suggest that marijuana is easily available, and price levels for Mexican-grown marijuana have remained stable. However, the supply of BC Bud and hydroponic marijuana has increased, thereby driving retail prices down. Cuban-based DTOs have increased their efforts in distributing lower priced marijuana in Atlanta. Local indoor cultivation of more potent hydroponic marijuana increased in 2007, due to drought-like conditions in Atlanta and throughout Georgia. Indicators are stable with regard to **methamphetamine**. In the first half of FY 2007, methamphetamine-related treatment admissions were similar to those in 2006 (8.1 and 8.0 percent, respectively). However, these proportions represented decreases from 2005, when the proportion of primary treatment admissions peaked at 11.4 percent. Women entering substance abuse treatment for methamphetamine outnumbered men (59 vs. 41 percent), a consistent trend that contrasts with findings from other CEWG reporting cities. The proportion of methamphetamine-related primary treatment admissions who smoke the drug remained near 60 percent, representing the first time in 6 years that this proportion had not increased. In 2007, local law enforcement officials, while indicating stabilized use of methamphetamine, reported that methamphetamine was the drug that most contributed to property crime in 15 of 18 jurisdictions. Nearly 90 percent of Atlanta's methamphetamine is "Ice" and is imported from Mexico. Although Whites were the most frequent users of methamphetamine, indicators suggest a growing level of methamphetamine use occurred among African-Americans. **Heroin** indicators continued to show decreasing levels of use, with the majority of users concentrated in Atlanta's Bluff district. Rates of injecting South American heroin have increased due to decreased purity levels and increases in prices. Law enforcement officials have reported greater amounts of Mexican brown powder heroin in Atlanta. The Georgia Medical Examiner's Office reports that prescription **benzodiazepines** are second only to cocaine in the number of statewide postmortem specimens that test positive for a particular drug. **Alprazolam**

remains the most popular benzodiazepine in Atlanta, especially among White women and young adults (age 18–28), followed by **diazepam**. Multiple indicators show that **hydrocodone** is the most commonly abused **narcotic analgesic** in Atlanta, followed by **oxycodone**. Drug indicators suggest that the use of **MDMA** has increased in the last 18 months, nearing use rates similar to 2001. In Atlanta, Asian DTOs control the transportation of the drug from Canada and distribute it at the wholesale level. Caucasian and African-American dealers typically distribute MDMA at the retail level. MDMA use in Atlanta is most popular among suburban, White, high school students and young adults and urban, African-American high school students and adults age 18–35. In 2007, the wholesale and retail costs per MDMA tablet remained stable at ranges of \$3–\$9 and \$20–\$25, respectively.

Data Sources: *Treatment data* were provided by the Georgia Department of Human Resources. Coverage includes all direct providers of treatment services that receive county or State program funds in the 28 counties that constitute metropolitan Atlanta. Data on all patient admissions for drug and alcohol treatment—not just patients receiving treatment paid by public funding sources—are included in the data set. This report presents admissions data from FY 2007, the most recent data available, and makes comparisons with the same calendar period from prior years. **Forensic laboratory data** were provided by the National Forensic Laboratory Information System (NFLIS), Drug Enforcement Administration (DEA), for fiscal year 2007 (October 2006 through September 2007). While these data are described, they cannot be compared with earlier data to establish trends, as a new methodology renders them noncomparable. **Prison/jail admissions data** are provided by the Georgia Department of Corrections and include admissions through November 10, 2007. For comparison purposes, CY 2007 data are extrapolated. **Drug price and purity data** are from the Domestic Monitor Program (DMP) report for 2006, compared with the report for 2005. **Ethnographic data** were available

for identifying possible emerging trends. **Local drug threat assessments** were provided by the National Drug Intelligence Center (NDIC). **Positive drug results for postmortem specimens** were provided by the Georgia Bureau of Investigation, Medical Examiner's Office. These data, which include FY 2007 and FY 2008 data through January 10, 2008, are statewide. FY 2008 data are extrapolated for comparisons to previous years. **Georgia Crisis and Access Line call data** were provided by the Georgia Department of Human Resources. Coverage includes all statewide telephone calls for Georgia's single-point-of-entry program, a required step toward seeking substance abuse treatment from a public facility. This report presents call data from July 2006 through December 2007.

Drug Abuse Patterns and Trends in Greater Boston—Update: January 2008

Daniel P. Dooley

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Overview of Findings: Heroin and cocaine continue to be the two most abused drugs in Boston. Cocaine tends to dominate in hospital emergency department settings and figures largely in drug arrest data and drug lab samples that are derived from drug arrests. Heroin dominates as the primary drug in treatment and the substance abuse helpline, which serves primarily as a treatment referral resource. During the past decade, Boston experienced unprecedented growth in other (nonheroin) opiate abuse, but the most recent indicators suggest that abuse is stabilizing at a moderate level. Among the other opiates, oxycodone is the predominant drug of abuse. Marijuana indicators suggest decreasing levels of abuse. This is most evident in a 9-year trend of decreasing past-month use among treatment admissions and decreasing numbers of class D (mostly marijuana) drug arrests. Methamphetamine is present

in Boston, but the available indicators suggest abuse remains at low levels overall.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine indicators are mostly stable overall at high levels. One of every four treatment admissions (25 percent) reported past-month cocaine (including crack) use in FY 2007. The proportion of admissions with past-month cocaine use has remained fairly stable from FY 2005. Demographically, increases in cocaine primary treatment admissions are seen within a young (age 19–29) cohort and a White cohort. The proportion of Black cocaine primary admissions has steadily decreased over 7 years. The proportion of cocaine calls to the helpline has fluctuated between 18 and 22 percent over 8 years from FY 2000 to FY 2007. The most recent helpline data reveal a very slight decrease from 22 percent in FY 2006 to 20 percent in FY 2007. The proportion of Class B drug arrests (mainly cocaine) has remained stable between 42 and 43 percent for 6 years from 2001 to 2006. Drug lab samples increased from 29 percent in 2005 to 33 percent in 2006. Data for the first half of 2007 suggest the proportion and number of cocaine samples are continuing to edge upward. Heroin abuse remains at high levels with mixed indicators in Boston. In FY 2007, more than one-half of all treatment admissions (51 percent) cited heroin as the primary drug. The proportion increased slightly from 50 percent in FY 2006 and 49 percent in FY 2005, but it has increased 46 percent from 35 percent in FY 1998. Demographically, increases in heroin and other opiate primary treatment admissions are seen within a young (age 19–29) cohort and a White cohort. The proportion of past-year injection drug use among heroin and **other opiates** admissions reached the highest level in 10 years (83 percent in FY 2007). The proportion of heroin calls to the substance abuse helpline decreased from 35 percent in FY 2006 to 32 percent in FY 2007. The levels of Class A drug arrests (mainly heroin) and heroin drug lab samples were stable from 2005 to 2006. According to the most recent DEA data (June 2007), a bag of heroin typically

costs between \$6 and \$20 on the streets of Boston. Indicators for other opiates are stable at moderate levels. The proportion of other opiates primary treatment admissions increased slightly over 2 years from FY 2005 (3 percent) to FY 2007 (4 percent). The proportion of other opiates helpline calls (18 percent in FY 2007) has remained fairly stable since FY 2004. The proportion of oxycodone drug lab samples remained stable for 5 years (2002 to 2006) at 2–3 percent. Recent **marijuana** indicators are mostly decreasing. Treatment admissions citing past-month marijuana use have steadily decreased from 14 percent in FY 1999 to 7 percent in FY 2007. The proportion of marijuana primary treatment admissions younger than 30 increased from 65 percent in FY 2006 to 70 percent in FY 2007. From FY 1999 to FY 2007, the proportion of marijuana helpline calls remained stable at between 5 and 6 percent. The proportion of Class D drug arrests (mainly marijuana) decreased from 37 percent in 2005 to 29 percent in 2006. The proportion of marijuana drug lab samples was unchanged from 2005 to 2006, but data from the first half of 2007 suggest the level of marijuana samples is decreasing. **Methamphetamine** abuse levels remain small overall in Boston, but anecdotal evidence suggests that specific subpopulations experience higher levels of abuse. The number of primary admissions for methamphetamine totaled 29 admissions in FY 2007, representing less than 1 percent of all treatment admissions. Similarly, methamphetamine calls to the helpline ($n=20$) accounted for less than 1 percent of all calls in FY 2007. Methamphetamine drug lab samples totaled 36 in 2006 and 13 in the first half of 2007. In 2006, there were 188 adult **HIV/AIDS** cases diagnosed in Boston. Primary transmission risk factors of these cases included 5 percent who were injection drug users (IDUs), 2 percent who had sex with IDUs, and 29 percent with an unknown/undetermined risk factor.

Data Sources: *State-funded substance abuse treatment admissions data* for a Boston region comprising the cities of Boston, Brookline, Chelsea, Revere, and Winthrop (Community Health

Network Area [CHNA] 19), for fiscal years that run July through June, for FY 1998 through FY 2007 (July 1, 1997, through June 30, 2007) were provided by the Massachusetts Department of Public Health (DPH), Bureau of Substance Abuse Services. **Helpline data** provide information on drug mentions during calls received by the Massachusetts Substance Abuse Information and Education Helpline for a Boston region comprising the cities of Boston, Brookline, Chelsea, Revere, and Winthrop (CHNA 19) for FY 1999 through FY 2007. **Drug arrests data** for the city of Boston for 1997 through 2006 were provided by the Boston Police Department, Drug Control Unit and Office of Research and Evaluation. For arrest data only, Black and White racial designations include those who identify themselves as Hispanic. **Forensic laboratory data** for a Boston region comprising the cities of Boston, Brookline, Chelsea, Revere, and Winthrop (CHNA 19) for 1998 through the first half of 2007 were provided by the Massachusetts Department of Public Health Drug Analysis Laboratory in Amherst, Massachusetts. These Boston-area drug sample counts differ from drug sample counts derived from the National Forensic Laboratory Information System and do not include samples analyzed at the Worcester County or State Police laboratories. **Drug price information** was provided by the National Drug Intelligence Center report entitled “National Illicit Drug Prices, June 2007.” **Adult acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) data** for 2006 were provided by the Massachusetts Department of Public Health AIDS Surveillance Program.

Drug Abuse Patterns and Trends in Chicago, IL—Update: January 2008

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Overview of Findings: This report updates data on drug abuse trends for Chicago, Illinois, since the last reporting period in June 2007. Most indicators of drug use were collected for the calendar year or fiscal year of 2007. Cocaine, heroin, and marijuana are still the major substances of abuse for Chicago and the surrounding metropolitan area. Major indicators suggest that levels of cocaine, heroin, and marijuana abuse are high and steady. There were few noteworthy changes that occurred for the reporting period. Arrests under the Controlled Substance Act decreased by 6 percent from 2005 to 2006 for Cook County, which includes the city of Chicago. Arrests under the Hypodermic Syringe/Needle Act were few and decreased by 32 percent from 2005 to 2006, perhaps reflecting legal changes that allow the possession of nonprescribed syringes.

Updated Drug Abuse Trends and Emerging Patterns: Levels of **cocaine** abuse continued to be high and stable in 2007. Preliminary unweighted data accessed from DAWN *Live!* for 2007 show that 35 percent of total ED reports for major substances of abuse (including alcohol) were cocaine-related. Cocaine constituted 30 percent of all drugs analyzed by the National Forensic Laboratory Information System (NFLIS) in FY 2007. Wholesale prices of powder cocaine reported by the National Drug Intelligence Center (NDIC) increased slightly, ranging from \$17,000 to \$23,000 per kilogram. Ethnographic reports suggest that availability of powder cocaine has decreased on the Chicago streets and that the quality of crack cocaine may have declined. **Heroin** levels of abuse were high and stable in 2007. Preliminary unweighted data accessed from DAWN *Live!* for 2007 show that 23 percent of total ED reports for major substances of abuse (including alcohol) were heroin-related. The average purity of heroin as reported by the Drug Enforcement Administration decreased from 17.1 percent in 2005 to 12.6 percent in 2006, while there was a \$0.04 increase to \$0.49 in average price per pure milligram. Major indicators of drug use suggest that **marijuana** abuse was high and stable in

2007. Preliminary unweighted data accessed from DAWN *Live!* for 2007 show that 13 percent of ED reports for major substances of abuse (including alcohol) were marijuana-related. Marijuana was the predominant drug item analyzed by NFLIS for FY 2007, representing 54 percent of all drugs. Hydroponic marijuana continues to be available in Chicago and is priced significantly higher than nonhydroponic marijuana. Average wholesale prices for hydroponic marijuana remained stable in 2007, ranging between \$2,000 and \$4,000 per pound, while nonhydroponic marijuana was priced between \$450 and \$700 per pound, according to NDIC. Among **prescription drugs**, those most often cited in ethnographic reports as being used without prescription are alprazolam, amitriptyline, hydrocodone, clonazepam, clonidine, and methadone. **MDMA** is popular in low-income, African-American neighborhoods. Primary users are in their teens and twenties, but use by middle-aged persons is often reported. Prices have declined to \$10 per tablet on the South Side and \$10–\$15 on the West Side. Nonprescribed **buprenorphine** use is increasingly common among heroin users, who mainly use it to avoid withdrawal or to better manage their addiction. Injection and recreational use of this drug are rare, according to qualitative monitoring of buprenorphine use. **Drug injection** by young African-Americans is rare. New injection drug users are likely to be White and to reside in suburban Chicago. The prevalence of **HIV** infection among injection drug users has declined markedly compared with the 1980s and 1990s.

Data Sources: *Treatment data for the State of Illinois and Chicago for FYs 2000–2006 (July 1–June 30) were provided by the Illinois Division of Alcoholism and Substance Abuse (DASA). An update was not available. Emergency department (ED) data were derived for CY 2007 from the Drug Abuse Warning Network (DAWN) Live! restricted-access online query system administered by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA). Eligible hospitals in the Chicago area*

totaled 88; hospitals in the DAWN sample numbered 77, with the number of EDs in the sample totaling 80. (Some hospitals have more than one ED.) During this 12-month period, between 28 and 35 EDs reported data each month. The completeness of data reported by participating EDs varied by month. The DAWN Live! data are unweighted and, thus, are not estimates for the reporting area. These data cannot be compared with DAWN data from 2002 and before, nor can these preliminary data be used for comparison with future data. **Criminal justice data** were available from the Illinois Criminal Justice Information Authority (ICJIA), which collects, maintains, and updates a variety of criminal justice data to support its research and evaluation efforts. ICJIA regularly publishes criminal justice research, evaluation reports, and statistical profiles. ICJIA's drug arrest data for 2005–2006 and the 2004 special report on methamphetamine trends in Illinois were reviewed. **Price and purity data** were provided by the Drug Enforcement Administration (DEA), Domestic Monitor Program (DMP), for heroin for 1991–2006. The Illinois State Police (ISP), Division of Forensic Science, provided purity data on drug samples for 2006. Drug price data are reported from the June 2007 and December 2007 reports of National Illicit Drug Prices by the NDIC. Data from the NFLIS for FY 2007 were used to report on drugs seized by law enforcement in Chicago. **Ethnographic data** on drug availability, prices, and purity are from observations and interviews conducted by the Community Outreach Intervention Projects (COIP), School of Public Health, University of Illinois at Chicago (UIC). **Buprenorphine data** are from a postmarketing surveillance project under a contract to CRS Associates issued by Reckitt Benckiser. Dr. Ouellet collected Chicago data described in this report. **HIV prevalence data** were derived from the ongoing NIDA-funded "Sexual Acquisition and Transmission of HIV—Cooperative Agreement Program" (SATH-CAP) study in Chicago (U01 DA017378). Respondent-driven sampling was used at multiple sites in Chicago to recruit men and women who use "hard" drugs (cocaine, heroin, methamphetamine, or any illicit injected drug), men who have sex with men regardless of drug use,

and sex partners linked to these groups. All participants (n=2715) in this ongoing study completed a computerized self-administered interview and were tested for human immunodeficiency virus (HIV), syphilis, chlamydia, and gonorrhea. Several of the sources traditionally used for this report have not been updated by their authors or were unavailable at the time this report was generated.

Drug Abuse Patterns and Trends in Cincinnati (Hamilton County)— Update: January 2008

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Overview of Findings: The predominant drug issues in Cincinnati continue to involve both cocaine/crack cocaine and marijuana as primary drugs of abuse. Crack cocaine indicators remain high, with some indication of decrease noted during the first half of 2007 compared with 2006 data. Wider acceptability of crack cocaine among users has led to increased numbers of young dealers to keep up with the high demand throughout the city and county. Indicators for marijuana in the Cincinnati region are consistently reported at high levels, with some indication of a slight increase during the first half of 2007 compared with 2006 data sources. Marijuana as a primary drug of choice accounted for nearly 36 percent of treatment admissions, excluding alcohol, and it represented more than 40 percent of submitted items for forensic analysis for the Cincinnati area. Indicators for heroin remained fairly stable, with some indicators showing a slight increase during 2007 from the previous year. The number of exposure cases reported to poison control involving heroin increased in 2007 over 2006, in part because of adulterated heroin distribution in the Cincinnati region. Methamphetamine indicators

remain low in Cincinnati, with an additional decrease noted during 2007 compared with 2006 data. The number of methamphetamine lab seizures continued to decrease through FY 2007 compared with the previous reporting period, and qualitative indicators show movement away from the city into more rural areas. MDMA availability and use remain low to moderate in Cincinnati, with indicators showing a slight increase during 2007 compared with 2006. Abuse of prescription drugs, specifically benzodiazepines and opioid narcotics, continues to be an increasing drug issue in Cincinnati. While human exposure cases to buprenorphine-containing pharmaceuticals remained stable from 2006 to 2007, indicators point to increased diversion to the streets of Cincinnati.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine/crack cocaine remains a primary drug reported during admission to publicly funded treatment programs, accounting for approximately 27 percent of individuals, excluding alcohol, during FY 2007. Cincinnati law enforcement removed more than 91 kilograms of crack cocaine from the region from January to November 2007, an 88-percent increase over the previous year (2006). During the first half of 2007, the larger-than-normal seizure of crack cocaine resulted in a brief period of low street availability. An increased amount of powdered cocaine was also removed from the street during the first 11 months of 2007 compared with 2006. Although indicators for cocaine/crack remain high, they appear to be stable to slightly decreasing for the first half of 2007 compared with 2006. On average, the purity of cocaine/crack decreased 14 percent during the first half of 2007 compared with 2006, and an increased number of impurities were recorded in analyzed samples. **Marijuana** dominates all other reported drugs as primary among treatment admissions, accounting for nearly 36 percent of the admissions, excluding alcohol, during FY 2007. While marijuana availability and use remain high across the Cincinnati region, indicators point to a leveling off at high

levels. The number of marijuana seizures by Cincinnati law enforcement doubled from January to November 2007 compared with 2006 and may have accounted for the slight increase in marijuana pricing that extended to the wholesale level of marketing. Indicators for **heroin** remained at a moderate level, with some indicators pointing to a slight increase for the Cincinnati region for 2007 compared with 2006. Treatment admissions for primary heroin use were not delineated from other opiate/opioid admissions, but the total number of admissions remained relatively stable for the category. The number of law enforcement seizures involving heroin rose slightly during 2007 compared with 2006. Poison control data showed a 33-percent increase in reported human heroin exposure cases in 2007, with resulting findings pointing to distribution of adulterated heroin in the Cincinnati region between April and September 2007. Use of **methamphetamine** in Cincinnati has remained low, with little indication of change noted during 2007. A decrease in the number of methamphetamine lab seizures, combined with increased pricing, indicated less availability for use during 2007. Qualitative indicators show movement away from the city to more rural areas. Determination of rural access and use of methamphetamine would be useful for future monitoring of the drug. **MDMA** availability and use in Cincinnati during 2007 remained at a low to moderate level, with some indication of a slight increase. The number of reported human exposure cases increased in 2007. Recent reports of “extreme” ecstasy distribution in the State of Ohio will need to be monitored going forward. **Prescription narcotics** containing either oxycodone or hydrocodone remain the most desirable of the opioid products abused in Cincinnati. In addition, qualitative indicators point to relatively high availability, with a slight increase in 2007 from 2006. Poison control data on oxycodone and hydrocodone showed increased numbers of human exposure cases reported during 2007 compared with 2006. Abuse of methadone appears to be leveling out. The most desirable benzodiazepine abused continues to be alprazolam, according to

both users and law enforcement. Increased numbers of human exposure cases involving alprazolam were also reported to poison control from 2006 to 2007. A 45-percent increase in the number of clonazepam exposures reported to poison control in 2007 will need to be monitored to determine if there may be an increase in clonazepam abuse. **Emerging Patterns:** Increased numbers of calls to poison control for tablet identification of buprenorphine-containing pharmaceuticals suggest the possibility of use for abuse purposes, although data are currently lacking to definitively determine this at this time. The paucity of exposure data available indicates a need for future monitoring for patterns that suggest emergence of an abuse trend due to increased diversion of buprenorphine.

Data Sources: *Medical examiner data* were obtained by the Hamilton County Coroner's Office for drug-related deaths for the year 2006 for comparison with death data from January to June 2007. Data included resulted from positive toxicology evidence of drug or alcohol use found in decedents. Cases recorded were classified as accidental, suicide, or homicide, and drug or alcohol findings were not necessarily recorded as cause of death. **Qualitative data** are from focus group interviews conducted for the Ohio Substance Abuse Monitoring (OSAM) Project, funded by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) through a grant to Wright State University (WSU). Focus groups are conducted in 6-month intervals. **Drug purity data** were provided by the Drug Enforcement Administration (DEA), Cincinnati Resident Office, for January to June 2007 and the year 2006. **Treatment data** were provided by the Hamilton County Mental Health and Recovery Services Board for FY 2006 and FY 2007. Data were provided for publicly funded treatment programs within Hamilton County only. Primary drug of use at admission was determined through billing data submitted by reporting agencies. Data methodology capture differed from previous reporting periods and does not provide for direct comparison to previous reports. Data were captured by group classification and

not necessarily by specific drug type or route of administration. Additional changes in reporting of admissions may result in lack of comparison from this report to the next. Poison control data were provided by the Cincinnati Drug and Poison Information Center (DPIC) for calendar years 2006 and 2007. There are two call "types" with respect to poison control data. A call coming into the center involves either (1) a question (or query) or (2) someone has been "exposed" to a product. Exposures are further broken down into subtypes: Intentional, Unintentional, Adverse Reaction, Other, or Unknown. Most of the exposures involve intentional abuse/misuse/suspected suicide, but all were captured in the data set. All exposure cases are for human cases only; animal cases were excluded, as were "confirmed" nonexposure cases. **Drug seizure data** were provided by the Cincinnati Police Department for illicit drugs seized in Hamilton County. **Forensic laboratory data** were provided by the National Forensic Laboratory Information System (NFLIS) for FY 2007. **Additional qualitative and drug seizure data** were provided by the Warren-Clinton County Drug Task Force. **Methamphetamine clandestine lab data** were provided by the Ohio Bureau of Criminal Identification & Investigation.

Drug Abuse Patterns and Trends in Colorado and the Denver/Boulder Metropolitan Area—Update: January 2008

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Overview of Findings: Excluding alcohol, marijuana abuse has continued to result in the highest number of treatment admissions annually since 1997. However, statewide marijuana treatment admissions declined from 43 percent

in 2001 to 34 percent in the first half of 2007, and in the Denver/Boulder metropolitan area (greater Denver), they declined from 40 percent in the first half of 2005 to 36 percent in the first half of 2007. In the first half of 2007, cocaine ranked third in statewide treatment admissions and second in Denver metropolitan treatment admissions. However, cocaine treatment admissions for both areas increased slightly over the past 2 years. Cocaine accounted for the highest number and proportion of illicit drug hospital discharges since 1996. Cocaine also accounted for the highest drug-related mortality rates from 1996 through 2002, but it was surpassed in 2003 by all opiates, including heroin, and in 2004 through 2006 by opiates other than heroin. Cocaine had the highest number of illicit drug-related calls to the Rocky Mountain Poison and Drug Center from 2001 through 2003 in the Denver area, but it was surpassed by methamphetamine in 2004 and 2005. However, in 2006, cocaine had significantly more poison calls than methamphetamine (129 vs. 29, respectively). Methamphetamine has exceeded cocaine in statewide treatment admissions since 2003, and it overtook Denver/Boulder treatment admissions during the first half of 2005 only. However, 2006 showed the first decline in several years for methamphetamine admissions and poison calls. Clandestine laboratory closures have decreased steadily since 2003, but the amount of methamphetamine seized increased through 2006, most likely because an estimated 80 percent of Colorado's methamphetamine comes from outside the State, predominantly Mexico. Many heroin abuse indicators decreased over the last several years, while poison calls remained stable. In 2003 through the first half of 2007, opiate-related drug misuse mortalities exceeded those that were cocaine-related. One demographic trend noted is a decline in the age of onset and age at first treatment for users of other opiates. Beyond abuse of illicit drugs, alcohol remained Colorado's most frequently abused substance and accounts for the most treatment admissions, ED reports, poison center calls, drug-related hospital discharges, and drug-related mortality.

Updated Drug Abuse Trends and Emerging Patterns: Excluding alcohol, **marijuana** continues to be the primary drug of use statewide and in greater Denver. During the first half of 2007, it represented 34 percent of drug treatment admissions statewide, a decline from 37 percent during the first half of 2005. Marijuana accounted for 36 percent of Denver-area admissions, a decline from 40 percent in the first half of 2005. There were 1,094 unweighted marijuana DAWN ED reports, representing 18 percent of the reports and ranking third behind cocaine and nonheroin opiates. It ranked second in 2006 hospital discharges and poison calls, both of which declined in recent years. **Methamphetamine**, which accounts for the next highest proportion of treatment admissions statewide (31 percent), overtook cocaine admissions in the first half of 2003. Methamphetamine admissions continued to increase until the first half of 2006, and they have remained stable through the first half of 2007. In greater Denver, methamphetamine represented only 23 percent of first half of 2007 admissions (behind cocaine at 24 percent), increasing from the same time periods in 2006 and 2005 (21 and 20 percent, respectively). Regionally, the largest increases in methamphetamine admissions occurred in persons from the northeast and northwest areas of the State. Methamphetamine ED reports totaled 453, accounting for 8 percent of unweighted DAWN reports. While quantities seized by law enforcement also increased for methamphetamine, other indicators (hospital discharges, deaths, poison calls, lab seizures, and use among high school youth) declined in CY 2006. **Cocaine** treatment admissions ranked third statewide (21 percent) and second in greater Denver (24 percent) in the first half of 2007. Statewide cocaine admissions have increased slightly from 20 percent in the first half of 2006 and 18 percent in the first half of 2005. Denver-area cocaine admissions also increased from 23 and 20 percent, respectively, since the first halves of 2006 and 2005. Quantities of cocaine seized by law enforcement in CY 2006 increased. Additionally, cocaine accounted for the highest proportion of unweighted DAWN

ED reports (1,624 reports, 27 percent) in the first half of 2007, as well as the highest proportion of poison calls in CY 2006 (an increase over previous data). Cocaine ranked first in 2006 hospital discharges, which remained stable, and second in 2006 deaths, which declined. Another decline was noted for reported cocaine use among high school youth in 2005. **Heroin** ranks fourth in both statewide and greater Denver treatment admissions, representing 7 and 10 percent of admissions, respectively. Heroin accounted for 8 percent of unweighted DAWN reports in the first half of 2007 ($n=467$), ranking fourth behind cocaine, other opiates, and marijuana. Overall, most indicators of heroin use have declined, although 2006 poison calls remained stable, and quantities seized by law enforcement in 2006 increased. In early 2007, the Rocky Mountain High Intensity Trafficking Program reported increased heroin purity levels and five heroin overdose deaths in Boulder. **Other opiates** rank fifth in both statewide and greater Denver treatment admissions, accounting for 5.2 and 4.6 percent of admissions, respectively, in the first half of 2007. Statewide, other opiate admissions rose slightly from 4.8 and 4.3 percent, respectively, during the first halves of 2006 and 2005. In greater Denver, opiate admissions fluctuated from 6.7 percent in the second half of 2005 to 5.6 percent in the second half of 2006 to 4.6 percent in the first half of 2007. With 1,191 ED reports, other opiates ranked second behind cocaine and represented 20 percent of the unweighted DAWN reports. Other opiates also accounted for the highest proportion of illicit drug use deaths (17 percent) in CY 2006, an increase, and ranked third behind cocaine and marijuana in CY 2006 hospital discharges (also an increase). Demographic trends noted were increases in the ages of initial treatment and onset for users of marijuana, cocaine, and methamphetamine. Conversely, the age of initial treatment in users of other opiates declined from 39 in the second half of 2001 to 34 in the first half of 2007 among statewide admissions and from 40 in the second half of 2002 to 34 in the first half of 2007 among Denver-area admissions. Age of onset for other

opiate users statewide also declined from 30.0 in the second half of 2001 to 25.0 in the second half of 2005, but it rose to 26.5 in the first half of 2007. Similarly, onset age in greater Denver declined from 30.5 in the second half of 2001 to 24.0 in the second half of 2005, but rose to 27.7 in the second half of 2006 and declined again to 25.8 in the first half of 2007. Although 2007 **HIV/AIDS** data are not yet available, data through 2006 indicate decreasing AIDS and HIV cases related to injection drug use.

Data Sources: *Treatment data were provided by the Colorado Department of Human Services, Alcohol and Drug Abuse Division (ADAD). Data from client admissions to all ADAD-licensed treatment providers from January through June 2007 are included in the data set. Unweighted emergency department (ED) DAWN Live! data from SAMHSA, OAS, are available to report drug mentions in ED visits occurring from January through June 2007. No comparisons with earlier time periods or discussions of trends can be done with unweighted data. Eligible hospitals in the Denver area totaled 15; hospitals in the DAWN sample numbered 15, with the number of emergency departments in the sample totaling 15. (Some hospitals have more than one emergency department.) During this 6-month period, nine EDs reported data each month. The completeness of data reported by participating EDs varied by month. Data in this report reflect cases that were received by DAWN as of December 10, 2007. Weighted ED DAWN data will be available in the spring of 2008 to compare 2006 with earlier years. Unweighted DAWN data are reported for the Denver area only. Forensic laboratory data were provided by the National Forensic Laboratory Information System (NFLIS), Drug Enforcement Administration (DEA), for FY 2007 (October 2006–September 2007). While these data are described, they cannot be compared with earlier data to establish trends, as a new methodology renders them noncomparable. Hospital discharge data were obtained from the Colorado Department of Public Health and Environment (CDPHE), which receives data from the Colorado*

Hospital Association. These data represent CY 2006. **Death data** were also obtained for CY 2006 from the CDPHE, which received them from the Colorado Association of Coroners. **Poison call data** were obtained from the Rocky Mountain Poison Control Center and represent CY 2006. **Colorado Youth Risk Behavior Survey data** were obtained from the CDPHE, which administers the survey every other year to 9th through 12th graders in a random sample of Colorado high schools. Data in this report represent CY 2005, because 2007 results are not yet available. **Information on drug seizure quantities** was obtained from the standard DEA report, *State Facts: Colorado 2007*. Data were for CY 2006. CY 2007 data should be published in February 2008. **Drug price and purity data** came from the National Drug Intelligence Center's (NDIC) intelligence bulletin, "National Illicit Drug Prices," published in September 2006, and cover drug prices collected in June 2006. **Intelligence data** were obtained from tasking reports prepared by NDIC's Rocky Mountain High Intensity Drug Trafficking program. The most recent report covered information collected in early 2007. **Anecdotal reports** of drug use on Denver inner city streets were obtained from phone calls made in January 2008 to outreach staff at Urban Peak (an agency serving homeless youth). Data for 2007 are not yet available for hospital discharges, deaths (which are not available for marijuana), poison calls, and Youth Risk Behavior Survey data (most recent YRBS data are 2005).

Drug Abuse Patterns and Trends in the Detroit Area—Update: January 2008

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Overview of Findings: This report updates data on drug abuse indicators for the CEWG Detroit area since the last reporting period in June 2007. Much of the data cover the last 6 months of FY 2007 compared with the first 6 months of FY

2007 from the same data source. During the second half of FY 2007, there were limited changes, with some increases in cocaine indicators. The big news, however, was the disappearance of fentanyl as a cause of death. The increase in cocaine is indicated by the increase in calls to poison control centers and deaths related or attributed to cocaine. The proportion of treatment admissions for heroin, cocaine, alcohol, and marijuana continued to converge due to the increasing proportion of admissions for marijuana. The emergency department visits also show stability in major drugs of abuse and prescription opioids. Prices and arrests by major drug of abuse did not show change.

Updated Drug Trends and Emerging Patterns: **Crack** is the major drug of abuse in Detroit, based upon treatment admissions, deaths, poison control center calls, emergency department mentions, items seized, and drug intelligence reports. **Powder cocaine** is less available and appears to be used by different demographic groups (i.e., Whites, Hispanics, and younger adults). **Heroin** is also a major drug of abuse in Detroit, with continued high purity and stable prices. Most items analyzed are South American, but Southwest Asian heroin is also found. Treatment admissions, arrests, and items seized are stable. **Marijuana** remained the third most frequently reported primary illegal substance for treatment admissions, but the proportion of marijuana admissions is increasing due to criminal justice referrals. Marijuana is also widely available according to drug intelligence. **Methamphetamine** is almost nonexistent as evidenced by treatment admissions, emergency department visits, office of medical examiners' report, calls to poison control centers, and drug intelligence. Drug intelligence also reports that **MDMA** is easy to obtain from traditional marijuana dealers, suggesting increased availability. People caught smuggling MDMA at the Canadian border are increasingly diversified, suggesting that there is a market for the drug. Deaths in which **opioids** were detected continued to rise in the current reporting period based on Office of Medical Examiners' data, especially

those related to hydrocodone and methadone. At the same time, however, deaths in which **fentanyl** was detected fell dramatically. The number of prescriptions filled for scheduled medications continued to increase through 2006. While no trends can be ascertained, two data sources—NFLIS and DAWN Live! emergency department data—reveal rank order and levels of drug indicators. NFLIS data for Wayne County show marijuana, cocaine, and heroin are the predominant items analyzed. The unweighted DAWN data for the periods January 2005 through June 2007 show cocaine, heroin, and marijuana ranking until recently, when marijuana surpassed heroin in number of potentially abuse-related drug mentions in emergency department visits. **Emerging issues** include the disappearance of illegally manufactured fentanyl in the Detroit area and the return to low levels of deaths with fentanyl detected in the decedents. **HIV/AIDS:** Based on data for the first 6 months of 2007, injection drug use continues to account for approximately 20 percent of people with HIV/AIDS. The number of individuals counted and their distribution by race and risk factors are virtually unchanged.

Data Sources: Specific data sources for which more recent data were available for use in this Update Brief were as follows. **Treatment admissions and demographic data** for FY 2007 (October 1, 2006–September 30, 2007) were provided by the Bureau of Substance Abuse and Addiction Services, Division of Substance Abuse and Gambling Services, Michigan Department of Community Health (MDCH), for the State and by county, as reported by State and federally funded programs. These data are for treatment paid by public money, excluding those covered by Department of Corrections. **Drug-attributed and related death data** for January–August 2007 were provided by the Wayne County Medical Examiner's Office. These data are based on toxicology screens performed by the ME Office on decedents brought to them for examination under circumstances that include deaths by suspicious cause, most injury deaths, deaths unattended by a physician or other person,

and clearly drug-related deaths. **Drug intelligence data** were received from the Drug Enforcement Administration (DEA), National Drug Intelligence Center (NDIC), and High Intensity Drug Trafficking Area (HIDTA) officials. **Drug price data** were provided by DEA's Domestic Monitor Program for 2006 compared with 2005 data. **Forensic laboratory data** are from the National Forensic Laboratory Information System (NFLIS), DEA, for FY 2007. Because of changes in geographic coverage, no comparisons with previous time periods can be made. **Unweighted emergency department (ED) drug mentions data** from the DAWN Live! system for the city of Detroit are reported for the period January 2005 through June 2007, although, again, no comparisons with earlier time periods can be made. Eligible hospitals in the Detroit core totaled 13; hospitals in the DAWN sample numbered 6, with the number of emergency departments in the sample totaling 6. During this time period, between four and six EDs reported data each month. The completeness of data reported by participating EDs varied by month. Data in this report reflect cases that were received by DAWN as of December 14, 2007. Note that the DAWN Live! data reported here refer to Detroit city only, while the data reported in Section II of this report refer to the Detroit metropolitan region. **Calls for intentional use by humans** between January and June 2007 were collected from the Eastern Michigan Poison Control Center. **Data on the number of prescriptions filled for scheduled medications** were provided for the period 2003 through 2006 by the Michigan Department of Community Health, Bureau of Health Professions, Michigan Automated Prescription System. **HIV/AIDS data** for the first half of 2007 were provided by the State Department of Health.

Drug Abuse Patterns and Trends in Honolulu and the State of Hawai'i—Update: January 2008

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Overview of Findings: Recent Changes: Moneys released last year for treatment and prevention services were received just before Christmas 2006. During the first half of 2007, the funds began to be used and were seen in the form of several new public service announcements, but few new treatment slots resulted. Instead, many of the existing programs increased their staffing ratios to provide better services to their existing numbers of clients. The efforts of the local HIDTA were seen in the form of several high-profile drug seizures on neighbor islands and the discovery of a 5-acre outdoor marijuana growing operation. The coordination of effort through HIDTA has been quite successful in improving the capacity of the narcotics divisions of local police departments for drug interdiction. The National Guard is also involved in these operations. The State economy continues to boom with many large construction projects throughout the islands. Almost total employment exists, with an unemployment rate of 2 percent. Tourism remains strong from Asia and the mainland in spite of their economic changes. The State Legislature was in session during this reporting period; there is little of importance to report. Few hearings focused on drug use in Hawai'i. Some minor legislative attempts were developed to refine laws passed last year regarding the committing of crimes under the influence of methamphetamine, but the session was essentially quiet on the topic of drugs in Hawai'i. Several reports were made by law enforcement agencies to the media indicating that the methamphetamine problem in the State was over. Indicators such as the number of pounds of methamphetamine seized, the amounts of money, and numbers of persons within the distribution networks for the drugs who were arrested were all presented as evidence that the problem was on the decline. The same agency reports of drug prices have shown no significant increase in the price of

methamphetamine, although the cost of cocaine has escalated during this time period.

Updated Drug Abuse Trends and Emerging Patterns: Because the time elapsed before persons seek and receive treatment is variable, treatment data are not viewed as particularly useful for monitoring current drug trends in the community. In Hawai'i, the treatment admissions data, based on the self-reported primary drug information, show that during this period, admissions for **cocaine** use continued their multiyear decline, but the numbers of decedents with cocaine as part of the body toxicology increased from previous reporting periods. The ME finding is similar to Honolulu Police data that also showed an upturn in cocaine cases. **Heroin** admissions for treatment also continued their multiyear downturn. Heroin deaths have been a problem for the ME lab for some time because of an apparent spike in use of morphine that has made the unambiguous identification of heroin as the drug in the toxicology report difficult to ascertain. Police cases for heroin use are up a little, but it is within the normal variability of the numbers of cases from one period to another. The number of decedents with **other opiates** as part of their toxicology analysis increased sharply, with hydrocodone followed by oxycodone as the primary drugs involved. **Methadone** deaths were also up slightly from previous periods. Admissions for treatment with **marijuana** as the primary drug were up considerably during this period, with no apparent explanation. The ME reports that the number of decedents with THC in their toxicology screen is stable. Police, while not actively seeking marijuana cases, report a slight increase in numbers of cases. Admissions to treatment with **methamphetamine** as a primary drug are down slightly from the previous period. However, upon examining 16 years of treatment data in the data set, the decline in numbers returns the total in methamphetamine treatment to the level the system was experiencing in 2002. The ME does not find a decline in methamphetamine-positive toxicologies, but rather a return to numbers of

positive toxicology reports that ends a 2-year decline in numbers. Police reports place the numbers of methamphetamine cases as the same as last year. The four major drugs seized or captured and sent for analysis in NFLIS-participating labs have remained stable over the past 5 years, with methamphetamine analyzed most often, followed by cannabis, THC, or similar products; cocaine; and then all other drugs.

Characteristics of Treatment Admissions:

The State of Hawai'i does little analysis of its data on those in treatment. Univariate statistics are available, but even bivariate data showing profiles of users of specific drugs are not routinely generated. Accessing those data by non-ADAD persons is extremely difficult. No analysis of polydrug use is conducted, nor are recidivists in the treatment system analyzed. Differential analysis of those succeeding in treatment compared to those that do not succeed (although 6-month posttreatment data are collected) are also not completed. Efforts will continue to be made, in the face of scarce resources, to increase the information value of treatment data and to enhance data from the police and the medical examiner with treatment data insofar as possible.

Data Sources: *Data for January–June 2007 were obtained from the following sources: Hawai'i High Intensity Drug Trafficking Area report; Honolulu Police Department Narcotics and Vice Data sets; Hawai'i Office Drug Enforcement Administration Reports; State of Hawai'i, Office of Narcotic Control; U.S. Attorney; State of Hawai'i, Department of Health, Alcohol and Drug Abuse Division and the Infectious Disease Branch, STD/AIDS statistics division; Attorney General's Office, Crime Data Statistics Office; City and County of Honolulu, Office of the Medical Examiner Data; State of Hawai'i, Department of Business, Economic Development and Tourism Data; Hawai'i Drug Policy Forum Reports; Mr. Michael Palazzo, doctoral student, School of Nursing, University of Hawai'i; Mr. Joseph Allen, doctoral student, Department of*

Sociology, University of Hawai'i. Data were also collected from the National Forensic Laboratory Information System, private drug treatment facilities, the University of Hawai'i, Department of Psychiatry, Queens Hospital, and the Hawai'i Health Information Corporation. All data pertain to adults within the State of Hawai'i.

Drug Abuse Patterns and Trends in Los Angeles County—Update: January 2008

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Overview of Findings: This report updates data on drug abuse indicators for CEWG area Los Angeles County since the last reporting period ended in June 2007. Overall numbers of treatment admissions remained stable for the second half of 2006 and the first half of 2007. Methamphetamine continued to dominate the local treatment system, with about one in four admissions (24 percent) reporting methamphetamine as the primary substance of abuse. Four other substances each accounted for slightly lower percentages of admissions: alcohol (19 percent), marijuana (18 percent), heroin (18 percent), and cocaine (16 percent). Seizures and laboratory incidents for methamphetamine have continued their decline. Wholesale prices for methamphetamine have increased substantially, but this has not yet been reflected in street price increases. Prices for other drugs have not changed dramatically. Increasing interdiction efforts are reported for marijuana. Cocaine (38 percent), marijuana (28 percent), and methamphetamine (25 percent) account for the substantial majority of Los Angeles-based illicit drug items analyzed and recorded by NFLIS for the October 2006 through September 2007 fiscal year.

Updated Drug Abuse Trends and Emerging Patterns: Methamphetamine (24 percent of admissions) continued to account for more alcohol and other drug treatment admissions in Los Angeles County than any other substance during the two most recently available 6-month periods (July–December 2006 and January–June 2007), based on the new CalOMS data system. Numbers of treatment admissions for the five major substances remained relatively stable (with differences of 2 percent or less across the past three 6-month periods). Note that for marijuana, a 2-percent increase was noted; however, additional experience with the CalOMS system is needed before evaluating such minor changes. Hispanics represented a higher proportion of methamphetamine admissions (55 percent) than admissions for other major substances. Drug and laboratory seizures for methamphetamine continue to decline from previous years; however, the Los Angeles HIDTA area (Los Angeles, Orange, Riverside, and San Bernardino Counties) still accounts for a major proportion of California’s methamphetamine lab seizures. The wholesale price of methamphetamine increased from \$8,000–\$12,000 per pound in 2006 to \$15,000 midway through 2007. This wholesale price increase, however, has not yet been reflected in street price increases. About one-fourth of NFLIS-reported items tested in forensic labs contained methamphetamine, ranking it third among types of substances found (after cocaine and cannabis). **Cocaine/crack** accounted for 16 percent of LA County AOD treatment admissions in January–June 2007, a majority of whom were Black (56 percent of cocaine/crack admissions were Black). If reported seizure rates for cocaine continue through the remainder of 2007, then they will be lower than for 2006. Street prices have remained stable for powder cocaine (at about \$80 per gram), but they have declined for crack (\$5–\$10 per rock vs. \$10–\$40 in 2006). Of FY 2007 NFLIS items, 38 percent contained cocaine (a larger percentage than for any other substance). Treatment admissions for **MDMA** remain at a negligible level (0.1 percent). However, MDMA ranks fifth among drugs identified

in NFLIS forensic lab testing reports for Los Angeles County (1.4 percent of items). While the street price of MDMA has remained stable, there has been a drop in the wholesale price (to \$2,500–\$3,000 per boat, less than half the 2006 prices). **Prescription drugs** (including benzodiazepines and tranquilizers, but excluding narcotic analgesics) accounted for a negligible percentage (less than 0.5 percent) of treatment admissions. About 18 percent of treatment admissions in January–June 2007 were for **heroin**. Heroin was identified in 4 percent of NFLIS items. Prices remained fairly stable. About 2.3 percent of treatment admissions and 1.6 percent of NFLIS items were for **other opiates** excluding heroin. Among NFLIS **narcotics**, hydrocodone was most prevalent (0.7 percent of total NFLIS items); oxycodone accounted for 0.2 percent of NFLIS items and 0.4 percent of treatment admissions. **Marijuana** was reported as the primary drug for 18 percent of Los Angeles County treatment admissions (equivalent to the fraction for heroin), a slight increase over the previous 6-month period. Nearly one-half (47 percent) of marijuana admissions were for adolescents younger than 18. Cannabis was identified in 28 percent of NFLIS items. The street price for marijuana has remained stable. **Emerging Patterns:** Some stability in treatment admissions for methamphetamine was seen during the past year, and a very slight increase was observed for marijuana. We hope to have additional indicators for the next update to show whether the apparent decrease in methamphetamine availability (fewer seizures) and higher wholesale prices will translate to decreases in its general use and related consequences. **HIV/AIDS:** Numbers of new AIDS cases diagnosed during January–June 2007 remained relatively stable ($n=712$ for preliminary counts).

Data Sources: *Treatment data were provided by Los Angeles County Department of Public Health, Alcohol and Drug Program Administration (ADPA) (tables produced by California Department of Alcohol and Drug Programs [ADP]) from CalOMS (California Outcome Monitoring System).*

*CalOMS is a statewide client-based data collection and outcomes measurement system for alcohol and other drug (AOD) prevention and treatment services. Submission of admission/discharge information for all clients is required of all counties and their subcontracted AOD providers, all direct contract providers receiving public AOD funding, and all private-pay licensed narcotic treatment providers. Data for the current report include admissions in Los Angeles County for periods July–December 2006 and January–June 2007. Note that CalOMS was implemented in early 2006 (replacing the earlier CADDSS system). Thus, data reported for periods prior to July 2006 may not be comparable to more recent periods. **Forensic laboratory data** were provided by the National Forensic Laboratory Information System (NFLIS), Drug Enforcement Administration (DEA), for fiscal year 2007 (October 2006–September 2007). While these data are described, their comparison with earlier data to establish trends may not be possible because of the new methodology. **Drug availability, price, and seizure data** were derived from reports from the Los Angeles High Intensity Drug Trafficking Area (HIDTA), the Los Angeles County Regional Criminal Information Clearinghouse (LA CLEAR), the National Drug Intelligence Center (NDIC) June 2007 National Illicit Drug Prices report, and the DEA. The prices included in this report reflect the best estimates of the analysts in the Research and Analysis Unit at LA CLEAR as available for the 3rd Quarter Report (October 2007). The price estimates are based primarily on field reports, interviews with law enforcement agencies throughout the Los Angeles HIDTA, and post-seizure analysis. **Acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) data** (cumulative through June 2007 with most recent 6-month update for January–June 2007) were provided by the Los Angeles County Department of Health Services, HIV Epidemiology Program, HIV/AIDS Semi-annual Surveillance Summary, July 2007. Updates from other data sources were not available for this report.*

Drug Abuse Patterns and Trends in Maine—Update: January 2008

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Overview of Findings: This report updates drug abuse indicators in Maine through calendar year (CY) 2007. Most heroin indicators (deaths, seizures, admissions) continued to decline in 2007; however, after falling every year 2003–2006, the proportion of heroin arrests by the Maine Drug Enforcement Agency rose from 3 to 7 percent in 2007. Cocaine abuse, already substantial, grew during 2007 beyond 2006 levels. Increases were seen for arrests, seizures, and admissions for both crack and cocaine. The estimate for 2007 deaths indicates a slight reduction. Marijuana indicators are moderately high, with arrests and primary admission levels remarkably stable since 2003, although seizures declined in 2007. Abuse of prescription drugs, predominantly methadone, oxycodone, and benzodiazepines, continues at high levels. The number of deaths, arrests, and seizures has remained relatively steady; however, the number of abuse-related calls to the poison center has risen sharply in the last 2 years. Methamphetamine abuse is now focused on pills, and indicators are declining, although the numbers are still quite low. Methamphetamine arrests and seizures went down in 2007; treatment percentages dropped in 2006 and 2007. MDMA seizures have increased, but the percent of treatment admissions declined in 2007. MDMA pills have been combined with methamphetamine in some samples.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine and narcotic analgesics remain the two leading types of substance abuse in Maine, excluding alcohol and tobacco. Cocaine/

crack arrests dominate activity of the Maine Drug Enforcement Agency, accounting for 45 percent of arrests and staying essentially level during 2006 and 2007. The proportion of females arrested for crack has increased from 23 percent in 2005 and 24 percent in 2006 to 40 percent in 2007, after remaining level in 2003–2005. Cocaine/crack also constitutes the largest single category of samples tested in Maine's forensic lab, growing from 36 percent in 2003 to 50 percent in 2007. Cocaine-induced deaths rose sharply from 4 percent in 2002 to 19 percent in 2006, but estimates for 2007 suggest a slight decrease. Primary treatment admissions have, however, increased slightly for cocaine and decreased slightly for crack between 2006 and 2007; combined they now represent 14 percent of admissions (4 percent crack and 10 percent cocaine). **Narcotic analgesics** misuse and abuse remain high and stable in 2007, contributing to 21 percent of arrests, 18 percent of forensic lab samples, and 46 percent of primary admissions. Cocaine cointoxication is commonly found with narcotic substance abuse, based on decedent toxicology and treatment admissions data. The supply of pharmaceutical narcotics has continued to rise in Maine, as is shown by the Prescription Monitoring Program data, growing 15 percent from 963,055 in FY 2005 to 1,109,881 prescriptions dispensed in FY 2007. Deaths caused by pharmaceutical narcotics constitute around 80 percent of drug-induced deaths. This indicator spiked in 2002 and has stayed high and level. Among narcotics, methadone and oxycodone dominate deaths, arrests, seizures, and poison center exposure and information calls. The estimated total of oxycodone deaths increased in 2007, while that for methadone stabilized. When the form of methadone is known in a drug-induced death, tablets outnumber liquid two to one in 2005 and 2006 cases. Prescriptions for buprenorphine have increased sharply since 2006, corresponding with an increase in street abuse as indicated in seizure samples, information calls to poison control, and two cases in which buprenorphine, in combination with other drugs, was ruled as the cause of death. **Benzodiazepines** continue to play a stable

and ubiquitous role in 2007, despite low numbers. Constituting about 3 percent of seizures and 12 percent of drug-induced deaths, benzodiazepines are frequent cointoxicants in narcotic deaths and identified as secondary or tertiary problems on admission. **Heroin** abuse continues as a serious problem, but recent indicators have been stable or decreasing. Heroin caused 19 percent of drug-induced deaths in 2006 and an estimated 14 percent in 2007, as well as 7 percent of 2007 arrests (up from 3 percent in 2006), 7 percent of 2007 seizures (down from 10 percent in 2006), and 15 percent of early 2007 primary admissions (down from 19 percent). **Methamphetamine** indicators are mixed, but numbers continue to be small. In 2007, only one lab was discovered, a "box" lab seized at the U.S.-Canada border. About 60 percent of methamphetamine samples tested are in pill form. The proportion of female arrestees has risen from 13 percent in 2006 to 29 percent in 2007. Although admissions declined slightly from 2006 to 2007, the proportion is less than 1 percent. **MDMA** seizures represent only 1 percent of samples, and admissions for MDMA constitute only 0.1 percent. Yet, the combination with methamphetamine in one-third of seized MDMA pills suggests the need to look at this combination in the future. **Marijuana** is stable at 20 percent of arrests in both 2006 and 2007 and 11 percent of lab samples in both years. Just over 20 percent of primary admissions are for marijuana, stable from 2006 to 2007. **Emerging issues** include continuing problems with the high volume of cocaine and prescription drug abuse. Of particular note, oxycodone deaths and poison center inquiries have increased in 2007. MDMA and methamphetamine abuse, although low in proportion, exhibit potential threats that bear monitoring. The trend of increasing female percentages for both cocaine and methamphetamine arrests will be analyzed further. **HIV/AIDS** data were not available to update previous years.

Data Sources: *Treatment admission data, provided by the Maine State Office of Substance Abuse, include all admissions for programs receiving*

State funding. This report includes admissions data from January to June 2007, excluding shelter and detoxification, and makes comparisons with prior calendar years. **Forensic laboratory data** were provided by the Maine State Health and Environmental Testing Laboratory, which tests all samples seized by the Maine Drug Enforcement Agency. Data were provided for CY 2007 and compared to previous years back to 2003. **Arrest data** were provided by the Maine State Drug Enforcement Agency, which directs eight multijurisdictional task forces covering the State, generating approximately 60 percent of all UCR drug-related offenses statewide. Data were provided for CY 2007 and compared with previous years back to 2003. **Poison center data** for CY 2007 and previous years were provided by the Northern New England Poison Center, which serves Maine, New Hampshire, and Vermont, and include data on calls for law enforcement information, substance abuse information, and calls regarding poisoning exposures. **Mortality data** were provided by the State of Maine Office of the Chief Medical Examiner for all completed cases through 2007. That office investigates all drug-related cases statewide. In 2007 and several previous years, they utilized Central Valley Toxicology for all toxicology testing, which is routinely done on all suspected drug cases. Data for 1997–2006 are complete, but data for 2007 await case completion by their office. Nearly all deaths for January to June were available. Based on algorithms developed in previous data years, estimates for 2007 used in this report were calculated for total drug deaths in several of the larger drug categories. **Prescription data** were provided by the State Prescription Monitoring Program administered by the Maine State Office of Substance Abuse. These included aggregate tables summarizing counts for all controlled substance prescriptions dispensed statewide.

Drug Abuse Patterns and Trends in South Florida—Update: January 2008

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Overview of Findings: Cocaine consequences dominate indicators among all abused drugs in Miami-Dade County and most drugs in Broward County (Ft. Lauderdale). Yet, the number of cocaine-related deaths declined in the first half of 2007, compared with the previous 6 months. Declines in heroin indicators have occurred as rising consequences for prescription narcotic analgesics have stabilized. MDMA-related deaths in both counties are now detected in combination with methamphetamine, because both drugs are found in ecstasy tablets. The number of consequences related to benzodiazepines is more than double in Broward County than the number in Miami-Dade County. South Florida has one of the highest per capita rates of AIDS cases in the Nation, at 64.6 cases per 100,000 people. Emerging trends include monitoring availability and purity of South American cocaine and the spread to new user groups of ecstasy containing methamphetamine and MDMA.

Updated Drug Abuse Patterns and Emerging Trends: South Florida has the highest proportion of unweighted cocaine-related ED DAWN reports and crime lab cases among all CEWG reporting areas. Cocaine represented 60 percent of illicit drug ED reports and two-thirds of crime lab cases during the first half of 2007 in both counties. Cocaine-related deaths declined 21 percent in Miami-Dade County, 35 percent in Broward County, and 3 percent across the State between the last half of 2006 and the first half of 2007. These declines reverse rising numbers of cocaine-related deaths for the State since 2000 and since 2004 in the two South Florida counties. Polysubstance abuse was linked to 80 percent of the Broward County cocaine-related deaths, 75 percent of those statewide, and 55 percent of those in Miami-Dade County during the first half of 2007. Availability of cocaine appears plentiful, while ethnographic sources suggest that

users report lower street purity and dealers complain about lower profits because of more adulterated, less pure cocaine coming into the United States. Some South American cocaine is now being sent to Europe via Western Africa, suggesting possible future declines in availability and purity of the drug in the United States. Cocaine is increasingly viewed as the major club drug, along with alcohol. Downward trends of heroin consequences continued in the first half of 2007 for Miami-Dade and Broward Counties as well as in the State, with a 53 percent decline in heroin-related deaths for Miami-Dade County since the last half of 2006, a 25 percent decline in Broward County, and a 13 percent decline statewide. Regarding **other opiates**, Broward County and most of the State have higher numbers and per capita rates of prescription narcotic nonmedical use and abuse than Miami-Dade County. Deaths related to this group of medications decreased 2 percent in Broward County between the second half of 2006 and the first half of 2007, totaling 118 in the most recent reporting period, or 43 percent of all drug-related deaths (excluding alcohol). In Miami-Dade County, the number of such deaths declined 45 percent over the same period (totaling 32). Among unweighted ED DAWN reports for the nonmedical use of a medication in the first half of 2007, 36 percent were for narcotic analgesics in Broward County, while 21 percent were in Miami-Dade County. During the first half of 2007, 22 percent of treatment admissions (excluding alcohol) among a sample of Broward County adult clients were for a prescription narcotic as the primary drug of abuse, up from 15 percent of a similar sample in the first half of 2006. NFLIS crime lab data do not capture all the narcotic analgesic items for Broward County, yet the Broward Sheriff's Office Crime Lab reports 549 such cases from July 2006 to June 2007, or 5 percent of all items tested. This compares with 124 items from the Miami-Dade County NFLIS report for October 2006 to September 2007, or less than 1 percent of all items analyzed. Indicators of methamphetamine abuse remain low; the drug represents about 1 percent or less of unweighted ED

DAWN reports in both counties. While NFLIS data report only 10 methamphetamine crime lab cases in Broward County for the period October 2006 to September 2007, the Broward Sheriff's Office reports 185 such cases from July 2006 to June 2007, with the number of cases doubling between the last half of 2006 and the first half of 2007. The rise in methamphetamine crime lab cases parallels the increase of MDMA Broward County crime lab items that nearly doubled from 77 in the second half of 2006 to 149 in the first half of 2007. The NFLIS reports 386 (or 2 percent of all items) MDMA cases in Miami-Dade County between October 2006 and September 2007. It is believed that the data reflect increasing numbers of ecstasy tablets that contain both MDMA and methamphetamine. Deaths involving the combination of these two drugs are observed mainly among young adult African-American males who died of gunshot wounds, reflecting the increasing use of ecstasy associated with the hip-hop club scene. More than one-fourth of unweighted ED DAWN reports for all nonalcohol illicit drugs in both counties are for marijuana. Indicators of marijuana consequences remain stable and high, ranking second to cocaine. Alprazolam is the most frequently cited benzodiazepine observed in most abuse indicators. Benzodiazepines accounted for 35 percent of all drug-related deaths (excluding alcohol) and 34 percent of unweighted ED DAWN reports for all nonmedical prescription drugs in Broward County during the first half of 2007. **Emerging Patterns:** Patterns of cocaine trafficking, including purity of the drug sold in wholesale quantities, should be monitored for changes in the drug's availability and possible shifts in measures of its consequences. Increases in MDMA consequences suggest rising availability of the drug, often containing methamphetamine, and more ecstasy use among Hispanics and African-Americans. **HIV/AIDS:** The number of new AIDS cases declined 30 percent in Miami-Dade County and 23 percent in Broward County from the first half of 2006 to the first half of 2007. Transmission categories remain unchanged between 2006 and 2007 for both counties and the State at 40 percent

for MSMs, 17 percent for IDUs, and 4 percent for MSMs who are also IDUs.

Data Sources: *Drug-related death data* are from the Florida Medical Examiners Commission 2007 Interim Report on Drugs Identified In Deceased Persons by Florida Medical Examiners covering the first half of 2007 and from the chief toxicologists for the Medical Examiner Division in Broward and the Miami-Dade County Medical Examiner's Department. **Unweighted emergency department (ED) DAWN Live! data** from SAMHSA, OAS, are reported for the period January 2007 through June 2007 separately for the Miami-Dade County and Ft. Lauderdale Divisions of DAWN Live! No comparisons with earlier time periods can be made. Weighted ED DAWN data are not currently available. Eligible hospitals in the Miami-Dade County area totaled 21; hospitals in the DAWN sample numbered 19, with the number of EDs in the sample totaling 19. (Some hospitals have more than one ED.) During this 6-month period, between eight and nine EDs reported data each month. The completeness of data reported by participating EDs varied by month. Eligible hospitals in the Ft. Lauderdale area totaled 27; hospitals in the DAWN sample totaled 22, with the number of EDs in the sample totaling 22. During this 6-month period, nine EDs reported data each month. The completeness of data reported by participating EDs varied by month. **Treatment data** were provided by Broward Addiction Recovery Center (BARC) of the Broward County Department of Human Services and are from nine adult programs operated by BARC in Broward County. There are a total of 19 addiction treatment programs in the county. The data from Miami-Dade County are provided by the South Florida Provider Coalition and are from all publicly funded residential adult treatment programs in the county and cover the two semiannual periods from July to December 2006 and January to June 2007. These data are also reported to the State of Florida for inclusion in its Treatment Episode Data Set (TEDS) submission to SAMHSA. **Forensic laboratory data** were provided by the National Forensic Laboratory Information System (NFLIS),

Drug Enforcement Administration (DEA), for fiscal year 2007 (October 2006 to September 2007). While these data are described, they cannot be compared with earlier data to establish trends, as a new methodology renders them noncomparable. Crime lab data were also provided by the Broward Sheriff's Office Crime Lab for the last half of 2006 and first half of 2007. Drug price and purity data are from the Domestic Monitor Program (DMP) report for 2006, compared to the report for 2005. Drug pricing data for South Florida were also derived from the National Drug Intelligence Center (NDIC), "National Illicit Drug Prices," June 2007. *Ethnographic data* are from Up Front Drug Information Hotline calls. **HIV/AIDS data** for January through June 2007 are from Broward, Miami-Dade, and Florida Departments of Health.

Drug Abuse Patterns and Trends in Minneapolis/St. Paul, Minnesota— Update: January 2008

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Overview of Findings: Methamphetamine indicators continued to decline during 2007, while heroin treatment admissions continued their steady increase since 2000. Marijuana and cocaine treatment admissions declined in the first half of 2007. Use of marijuana, MDMA, and LSD increased among area high school seniors, but reported cigarette use declined among area high school students. Alcohol remained the most widely abused substance in the area.

Updated Drug Abuse Trends and Emerging Patterns: Numerous indicators of methamphetamine abuse, particularly among adolescents, continued to decline in 2007 in the Twin Cities metropolitan area, reversing previous upward

trends. Seizures of methamphetamine by law enforcement, however, continued to outnumber seizures of any other illicit drug in 2007 (representing 34.7 percent of all seizures). Admissions to addiction treatment programs with methamphetamine as the primary substance problem accounted for 7.6 percent of metropolitan-area treatment admissions in 2007 (first half), compared with 8.0 percent in 2006 and 12.0 percent in 2005 (the highest peak year). An increasingly smaller proportion of methamphetamine admissions were adolescents. Patients younger than 18 accounted for 4.0 percent of methamphetamine-related treatment admissions in 2007 (first half), compared with a high of 17.8 percent of total methamphetamine-related admissions in 2003. Methamphetamine use by high school students in the metropolitan area also showed downward trends, according to new data from the Minnesota Student Survey. Among high school seniors, 2.2 percent reported methamphetamine use in 2007, compared with 4.8 percent in 2004 and 5.3 percent in 2001. In 2007, methamphetamine use (any use in the year prior to the survey) was reported by 1.5 percent of metropolitan 9th grade students, compared with 4.1 percent in 2004 and 4.3 percent in 2001. Similar declines were found statewide. Collectively, these findings suggest that the growth in methamphetamine abuse in the Twin Cities is slowing and possibly reversing itself due to continued pressures on the supply side and reduced interest on the demand side, particularly among young people. From 2004 to 2007, use of **marijuana**, **MDMA** (“ecstasy”), and **LSD** increased among metropolitan-area high school seniors. Marijuana use (any use in the past year) was reported by 33.0 percent of high school seniors in 2007, compared with 29.2 percent in 2004, reversing a slight downward trend since a rate of 35.0 percent in 1995. Declines were seen for grades 6 and 9, however. MDMA use (any use in the past year) rose from 4.3 percent in 2004 to 5.7 percent in 2007, and LSD use increased from 4.9 to 6.2 percent during the same period. Since 1998, **cigarette** use (any use in the past month) declined among metropolitan-area high school students,

and in 2007, cigarette use was reported by 21.5 percent of seniors, 9.0 percent of 9th graders, and 1.5 percent of 6th graders. Both **marijuana** and **cocaine** treatment admissions declined. In 2007 (first half), marijuana admissions accounted for 16.4 percent of total admissions, compared with 18.3 percent in 2006. Cocaine accounted for 11.6 percent in 2007 (first half), compared with 14.1 percent in 2006. Most cocaine admissions were for crack cocaine. Admissions for **heroin** have steadily and gradually increased since the turn of the century to 6.1 percent in 2007 (first half). Opiate-related deaths outnumbered those related to any other illicit drug. **Alcohol** remained the most widely abused substance. Treatment admissions for alcohol accounted for one-half of all admissions in 2007, up slightly from 2006 (48.3 percent). Sixty percent of alcohol-related treatment admissions were age 35 or older. Recent alcohol toxicity-involved deaths at numerous college campuses across the State raised public awareness of extreme college binge drinking, an ongoing issue with dangerous consequences. Current alcohol use was reported by 73.7 percent of students age 18–24 at the University of Minnesota Twin Cities campus in 2007, according to the 2007 College Health Survey Report by Boynton Health Service of the University of Minnesota Twin Cities. High-risk drinking (five or more drinks at one sitting in the past 2 weeks) was reported by 41.6 percent of students, with relatively stable trends since 2000. Alcohol consumption (any use in past year) was reported by 60.8 percent of metropolitan-area high school seniors in 2007, virtually unchanged from the 2004 survey (60.6 percent), but lower than the highest proportion (78.1 percent) in 1992. From 2004 to 2007, alcohol use declined among 6th graders from 10.9 to 8.8 percent and among 9th graders from 40.3 to 35.4 percent. Binge drinking rates (five or more drinks on one occasion in past two weeks) were also relatively stable among high school seniors (roughly 28.0 percent since 1998) and fell slightly among 9th graders to 11.5 percent in 2007 from 14.0 percent in 2004. In 2007 (through September), 68 alcohol-related deaths were reported in Hennepin County: 8 in which

acute alcohol poisoning was cited as the cause of death and 60 in which acute alcohol intoxication was reported as a significant contributing condition. By comparison, in the same period in 2007, there were 52 opiate-related deaths, 42 cocaine-related deaths, and 5 involving methamphetamine in Hennepin County.

Data Sources: *Treatment data* are from addiction treatment programs (residential, out-patient, extended care) in the five-county Twin Cities metropolitan area as reported on the Drug and Alcohol Abuse Normative Evaluation System (DAANES) of the Minnesota Department of Human Services (through June 2007). **Hospital emergency department data** are from the Drug Abuse Warning Network (DAWN) Live!, a newly revised system administered by the Office of Applied Studies of the Substance Abuse and Mental Health Services Administration. Data are for the period of January to June 2007. A patient may report the use of multiple drugs (up to six) and alcohol. Due to the 2003 redesign, these DAWN Live! data cannot be compared to earlier time periods. Eligible hospitals in the Minneapolis area totaled 28; hospitals in the DAWN sample numbered 26, with the number of emergency departments in the sample totaling 26. (Some hospitals have more than one emergency department.) During this 6-month period, between 9 and 10 EDs reported data each month. The completeness of data reported by participating EDs varied by month. Exhibits in this report reflect cases that were received by DAWN as of December 10, 2007. **Mortality data** are from the Hennepin County Medical Examiner and the Ramsey County Medical Examiner (through September 2007). 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. **Crime lab data** are from the National Forensic Laboratory Information System (NFLIS), sponsored by the U.S. Drug Enforcement

Administration. **Methamphetamine lab data** are from the U.S. Drug Enforcement Administration, National Clandestine Laboratory Database. **Secondary schools student survey data** are from the Minnesota Student Survey, which is administered statewide every 3 years to students in grades 6, 9, and 12 and asks questions about tobacco, alcohol, and other drug use. Results presented here are from students in the five-county metropolitan area. **College student survey data** are from 2007 College Health Survey Report, Boynton Health Service, University of Minnesota Twin Cities, 2007.

Drug Abuse Patterns and Trends in New York City—Update: January 2008

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Overview of Findings: Cocaine remains a major problem in New York City. Cocaine indicators are mixed for this reporting period, but several continue to show signs of increase. Although there are reports of cocaine shortages at the wholesale level, cocaine is still highly available at the retail level. New York City is the most significant heroin market in the country. After many years of purity levels of 60 percent or higher, purity dropped again this reporting period to 44.5 percent, the second lowest level in more than a decade. In addition, the price rose to \$0.67, an increase of \$0.21 since last year. Treatment admissions for heroin and heroin-involved deaths were up slightly since the last reporting period. Marijuana indicators are mixed but remain at a high level. Marijuana continues to be considered high quality and widely available. Treatment admissions for marijuana increased to the highest number ever. Marijuana in a blunt cigar often serves as the base to which other drugs are added.

Methamphetamine indicators in New York City remain low, and there is little availability or selling activity. The price is high and the quality is low. The drug is still primarily limited to the gay male community. Although prescription drug use remains low compared with the use of other substances, many kinds of prescription drugs are available on the street. Indicators for MDMA and other club drugs remain low. The use of MDMA has extended beyond the club scene to other areas of New York, including college campuses.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine indicators are mixed but several show signs of increase. Primary cocaine treatment admissions remained stable at 24 percent, but more clients in treatment had a primary, secondary, or tertiary problem with cocaine than with any other drug. There were more DAWN *Live!* reports for cocaine, as well as more NFLIS items for cocaine, than for any other drug. There was an increase in the number of cocaine-involved deaths, but there was stability in the number of births to women using cocaine. Street reports indicate that cocaine is highly available, but NDIC reports that there seems to be a shortage at the wholesale level. There are a variety of methods for using cocaine, including crack stems and blunts. **Heroin** remains a major problem in New York City, which is considered the most significant heroin market and distribution center in the country. An important change this reporting period was the decrease in heroin purity to 44.5 percent—the second lowest level in more than a decade—and the concomitant increase in price to \$0.67—an increase of \$0.21 since last year. More than 30 percent of primary treatment admissions were for heroin, and the number of treatment admissions for the first half of the year was slightly higher than for the first half of last year. Heroin-involved deaths were slightly higher than during the previous reporting period. Other than cocaine and alcohol, there were more DAWN *Live!* reports for heroin than for any other drug. Eleven percent of NFLIS items were for heroin. Most of the heroin in New York City is from

South America, and the prices for South American heroin did not change during this period. The wholesale price for Southeast Asian heroin, however, increased significantly between December 2006 and June 2007. **Marijuana** indicators are mixed but remain at a high level. Marijuana primary treatment admissions increased to the highest number ever and represent one-quarter of all treatment admissions. More than one-quarter of NFLIS items analyzed were for marijuana. There were almost as many DAWN *Live!* reports for marijuana as for heroin. Only cocaine and alcohol had more reports than these two drugs. Marijuana continues to be of good quality and available in a wide variety of colors and flavors. The price remained stable during this reporting period. There is much polydrug use, and marijuana in a blunt cigar often serves as the base to which other drugs are added. **Methamphetamine** indicators remain low. Treatment admissions, DAWN *Live!* reports, and NFLIS items involving the drug are all at very low levels. Admissions to treatment and DAWN *Live!* reports involving methamphetamine were overwhelmingly male. They also tended to be White and without criminal justice status. Methamphetamine's price remains high, and there was no significant change in this reporting period. According to the SSU, there is little methamphetamine availability or selling activity; the quality is poor and the price is high. The drug is still primarily limited to the gay male community. **MDMA** indicators remain low. MDMA primary treatment admissions represent a very small number, but only 15 percent of treatment admissions reporting an MDMA problem consider MDMA their primary drug. The number of DAWN *Live!* MDMA reports was extremely small. Most MDMA admissions and DAWN *Live!* reports are young and male. It should be noted that three-quarters of primary MDMA treatment admissions have a criminal justice status. Prices range between \$10 and \$25 per tablet, and there were no significant changes this period. According to the SSU, the use of MDMA has extended from the club scene to college campuses as well as a wide variety of neighborhoods. **Prescription**

drug use remains low. Prescription drugs represent only a small fraction of primary admissions to treatment who tend to be 35 and older and White, with more than 40 percent being female. Among the DAWN Live! reports, opiates/opioids accounted for 2,266 reports, and benzodiazepines accounted for 1,239. Among the opiates/opioids, methadone accounted for the largest number of reports (1,252). Although prescription drugs represent only a small number of NFLIS items analyzed, the specific drugs that accounted for more than 100 items each were alprazolam, methadone, oxycodone, hydrocodone, and clonazepam. School survey data show that other than alcohol, cigarettes, and marijuana, more students in New York State had used analgesics nonmedically than any other substance. **HIV/AIDS Update:** Of the 97,524 New Yorkers living with HIV or AIDS as of June 30, 2006, men having sex with men and injection drug use history continue to be the two major transmission risk factors. During this reporting period, injection drug users accounted for 21.6 percent of people living with HIV or AIDS, but they represented 37.6 percent of all deaths to persons with HIV/AIDS.

Data Sources: Emergency department (ED) data were derived for the first 6 months of 2007 from the DAWN Live! restricted-access online query system administered by the OAS, SAMHSA. Eligible hospitals in the New York-5 Boroughs Division totaled 52; hospitals in the DAWN sample numbered 42, with the number of emergency departments in the sample totaling 63. (Some hospitals have more than one emergency department.) During this 6-month period, between 37 and 39 EDs reported data each month. The completeness of data reported by participating EDs varied by month. Exhibits in this report reflect cases that were received by DAWN as of December 10, 2007, and January 16, 2008. All DAWN cases are reviewed for quality control. Based on this review, cases may be corrected or deleted. Therefore, the data presented are subject to change. Data derived from DAWN Live! represent drug reports in drug-related ED visits. Drug reports exceed the number of ED visits,

since a patient may report use of multiple drugs (up to six drugs and alcohol). The DAWN Live! data are unweighted and, thus, are not estimates for the reporting area. These data cannot be compared to DAWN data from 2002 and before, nor can preliminary data be used for comparison with future data. Only weighted DAWN data released by SAMHSA can be used for trend analysis. A full description of the DAWN system can be found at <http://dawninfo.samhsa.gov>. **Drug abuse-related death data** are from the New York City Department of Health and Mental Hygiene, Bureau of Vital Statistics. Data were made available for the period of 1995 through 2006 and cover the five counties constituting New York City. These data have been coded in accordance with the International Classification of Diseases (i.e., ICD-9 for years 1995–1998 and ICD-10 for years 1999–2006) and are defined as “Mental and Behavioral disorders due to use of cocaine/drug dependence” and “Mental and Behavioral disorders due to use of Opioids (including Heroin)/drug dependence.” The relevant codes used by the Bureau of Vital Statistics in compiling the totals for cocaine-related deaths were 304.2 for years 1995–1998 (ICD-9) and F14 for 1999–2006 (ICD-10). In compiling the totals for heroin-related deaths, the codes used were 304.0 (ICD-9) for years 1995–1998 and F11.2 (ICD-10) for years 1999–2006. **Treatment admissions data** were provided by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) for 1995 through the first half of 2007 and included both State-funded and nonfunded admissions. Demographic data are for the first half of 2007. **Forensic laboratory testing data** for New York City were provided by the Drug Enforcement Administration’s (DEA) National Forensic Laboratory Information System (NFLIS) for fiscal year (FY) 2007 (from October 1, 2006, through September 2007). The data include NYPD laboratory data for the five boroughs of New York City as well as data from New York State and DEA labs. **Drug price, purity, and trafficking data** were provided by the DEA’s Domestic Monitor Program (DMP) for heroin, 2006 Heroin Domestic Monitor Program: Drug Intelligence Report. These data are supplemented by information from

the National Illicit Drug Prices—June 2007, a National Drug Intelligence Center (NDIC) Intelligence Bulletin and Intelligence Bulletin: Changes in Drug Production, Trafficking, and Abuse, First Half-Year CY2007. Other data were provided by OASAS Street Studies Unit (SSU) reports. **School Survey data** were provided by the 2006 OASAS New York State School Survey. **Cocaine use during pregnancy data** were provided by the New York City Department of Health for 1995–2006. **Acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) data** were provided by the New York City Department of Health and Mental Hygiene, HIV Epidemiology and Field Services Program, including the HIV Epidemiology and Field Services Semiannual Report, covering January 1, 2006–June 30, 2006, released April 2007. **Hepatitis C data** were provided by the New York City Department of Health and Mental Hygiene, Bureau of Communicable Diseases for 2003–2006.

Drug Abuse Patterns and Trends in Philadelphia—Update: January 2008

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Overview of Findings: This report updates data on drug abuse indicators for Philadelphia, Pennsylvania, since the last CEWG report for this area in June 2007. Much of the data covers the first 6 months of 2007 compared with prior periods from their respective data sources.

Updated Drug Abuse Trends and Emerging Patterns: The most significant event during the first half of 2007 was the apparent ending of the lethal **fentanyl** outbreak that occurred from mid-April 2006 until early spring 2007. Clandestinely

manufactured fentanyl had been placed in packets that resembled heroin packets and were sold as heroin at the usual \$10 price per bag. While there were 248 deaths with the presence of fentanyl from mid-April through December 31, 2006, that were classified as adverse effect of drugs by the Medical Examiner (ME), there were 15 such deaths from January through March 2007 and only 1 such death from April 1, 2007, through June 30, 2007. The end of the fentanyl outbreak was evidenced by the sharp decline in total deaths with the presence of drugs in the first half of 2007. Still, it is projected that the total deaths in 2007 will exceed the annual total reached in preoutbreak 2005. While the average number of drugs per decedent was inflated by fentanyl in 2006 ($n=4.16$ drugs), in the first half of 2007 it was 3.77 drugs per decedent. This was close to the levels attained in 2004 ($n=3.75$) and 2005 ($n=3.69$). The drugs/drug groupings below are commented on in descending order of their impact. **Cocaine** abuse, particularly in the form of crack, continues to lead the consequence data with respect to treatment admissions, deaths with the presence of drugs, and laboratory tests performed by NFLIS. It was the second most frequently encountered substance in urine/drug screens performed by the APPD. Whites entering treatment for cocaine abuse increased from 15 percent of all cocaine admissions in 2004 to nearly 33 percent in the first half of 2007. In this time span, the proportion of African-American cocaine treatment admissions decreased from 79 to 64 percent. Clients entering treatment aged 41 and older have been increasing since early 2006, while clients aged 31–40 decreased. Cocaine in combination with alcohol continued to be the most common combination of drugs in decedents, as it has been since 2003. In the first half of 2007, **marijuana** ranked third in treatment admissions (21 percent), second in the NFLIS (34 percent), and first in the APPD. (It is not tested for in decedents.) Marijuana use is common by itself or in combination with cocaine, alcohol, and PCP, among others. Treatment admission trends have been stable since 2001 with respect to gender (ranging from 78 to 82

percent male) and race/ethnicity (58–69 percent African-American, 21–26 percent White, and 10–13 percent Hispanic), with the exception of an increase in Asians entering treatment (up from 2 percent to 11 percent) during this period. Admissions in the younger-than-21 age group decreased precipitously from 46 percent in 2003 to 7 percent by the first half of 2007, while the largest increase occurred among those age 21–30 (from 33 to 47 percent). **Alcohol** in combination with other drugs ranked second in mortality; alcohol was also the second most frequently mentioned drug in treatment admissions data and seventh in the APPD study. Alcohol and cocaine were the drugs of choice among clients age 46 and older who entered treatment for the first time in the fiscal year ending June 30, 2007. The street-level purity of **heroin** declined from 2000 (73 percent) to 2004 (52 percent) and stood at 55 percent in both 2005 and 2006. During the decline, users informed the authors that they sought to approximate the high by using increased amounts of heroin, adding other drugs to use in combination with heroin, and/or using synthetic opiates. In the first half of 2007, heroin ranked fourth in treatment admissions, third in deaths with the presence of drugs and NFLIS data, and fifth in the APPD data. The price per milligram pure has been fluctuating from \$0.71 in 2004, to \$0.58 in 2005, to \$0.63 in 2006; however, the standard bag price remained \$10 and contained one “hit.” Gender and race/ethnicity trends have been mostly stable. In the first half of 2007, however, treatment admissions increased among clients age 41 and older (from 24 to 29 percent), while the proportion of those age 21 to 30 among those entering treatment declined (from 44 to 40 percent). Use of **benzodiazepines**, while lower than use of drugs discussed above, remained fairly high as an adjunct drug according to trend data. Benzodiazepines ranked fourth in both the mortality and APPD data. Alprazolam is clearly the benzodiazepine of choice, itself ranking eighth in the ME’s toxicology reports and fifth in the NFLIS data. Within the category **other opiates**, use is characterized as at medium levels with mixed indicator results, depending on the drug.

Codeine, oxycodone, and hydrocodone remain low in treatment admissions but relatively high in the ME’s toxicology reports. The only drug in this group that is projected to show an increase for calendar year 2007 is propoxyphene, while the other drugs are either stable or declining. **PCP** is primarily smoked in combination with marijuana in blunts. Indicators reflect medium levels of use, and indicators are mostly stable. Among **antidepressants**, data are only available from the ME’s Office. Relatively low levels of use have been detected, with the leading drugs being in the tricyclics category (nortriptyline and amitriptyline) or within the SSRI category (citalopram, fluoxetine, and sertraline). Use of **methamphetamine** and other amphetamines remains at very low levels, and indicators are either stable or declining. There was only one treatment admission for methamphetamine in the fiscal year ending June 30, 2007. Deaths with the presence of methamphetamine or amphetamines are projected to decline in CY 2007; there were no deaths with the presence of **MDMA** in the first half of 2007.

Data Sources that were used for the above description include the following: **treatment admissions data** were provided by the Philadelphia Department of Behavioral Health and Mental Retardation Services, Behavioral Health Special Initiative, for the uninsured population only. **Data on deaths with the presence of drugs**, obtained from the City of Philadelphia Department of Public Health, Medical Examiner’s Office, include positive toxicology reports for people who died in Philadelphia from either an adverse reaction to drugs, overdose, homicide, suicide, or numerous other causes. **Criminal justice data** consists of the random urinalysis program of the Philadelphia Adult Probation and Parole Department (APPD), which analyzed more than 47,000 samples in 2007 using a 9-panel screen. **Heroin purity and price data** were provided by Drug Enforcement Administration (DEA), Domestic Monitor Program, for 2006 and earlier periods. **Forensic laboratory data** are from the National Forensic Laboratory Information System (NFLIS), DEA, for Federal FY 2007

(October 1, 2006, through September 30, 2007). Because of changes in methodology, no comparisons with previous time periods can be made. Note: Hospital emergency department data are not available because Philadelphia is not associated with the DAWN hospital emergency department data collection system.

Drug Abuse Patterns and Trends in the Phoenix Area—Update: January 2008

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Overview of Findings: This report updates data on drug abuse indicators for the Phoenix area (including Maricopa County) since the last reporting period in June 2007. Much of the data covers the first half or first three quarters of 2007. Indicators for amphetamine/methamphetamine were mixed. The percentage of positive tests for amphetamine/methamphetamine among arrestees in Maricopa County declined; methamphetamine/amphetamine-related hospital admissions were flat; and methamphetamine treatment admissions reporting methamphetamine as the primary drug increased. Indicators for cocaine were also mixed. The percentages of positive tests for cocaine among arrestees in Maricopa County were flat; the number of hospital admissions related to cocaine declined; and treatment admissions reporting cocaine as the primary drug increased slightly. All the indicators reported for heroin were essentially flat. An emerging issue is the growing number of hospital admissions that involve both amphetamine/methamphetamine and cocaine.

Updated Drug Trends and Emerging Patterns: Amphetamine/methamphetamine-related hospital admissions changed little in the

first half of 2007, and they have remained relatively flat since the first half of 2005. The percentage of Maricopa County Adult Diversion Arrestees testing positive for amphetamine/methamphetamine decreased sharply from 34.7 percent in the first quarter of 2007 to 18.8 percent in the third quarter of 2007. The percentage of Maricopa County Juvenile Arrestees testing positive for amphetamine/methamphetamine changed slightly, from 10.5 percent in the first quarter of 2007 to 8.7 percent in the third quarter of that year. After rising in the first and second quarters of 2007, methamphetamine arrests reported by the DEA Phoenix Division declined slightly in the third quarter of 2007. While 44 clandestine methamphetamine labs were seized in 2006, only 12 labs were seized in the first half of 2007. Of the items reported by NFLIS, methamphetamine was the second most common (marijuana was the most common). The number of treatment admissions with methamphetamine as the primary drug increased from 542 in the first half of 2006 to 670 in the first half of 2007. Methamphetamine constituted 30 percent of all treatment admissions reporting a primary drug, making it the illicit drug most often reported by these admissions. **Cocaine** constituted 10 percent of all treatment admissions reporting a primary drug. The number of cocaine treatment admissions increased slightly from 193 in the first half of 2006 to 227 in the first half of 2007. After rising steadily during 2005 and 2006, cocaine-related hospital admissions declined in the first half of 2007. The percentage of Adult Diversion Arrestees testing positive for cocaine was approximately 18–19 percent during each of the first three quarters of 2007. The percentage of Maricopa County Juvenile Arrestees testing positive for cocaine was approximately 10 percent during each of those three quarters. Fifty-four **MDMA** items were reported by NFLIS, a small number when compared with that for methamphetamine items ($n=2,881$). **Marijuana** was the primary drug reported by 13 percent of the treatment admissions reporting such a drug. Marijuana admissions increased from 249 in the first half of 2006 to 292 in the first half of 2007.

Marijuana seizures during the first three quarters of 2007 exceeded seizures during the first three quarters of 2006. The percentage of Adult Diversion Arrestees testing positive for marijuana increased from 21.9 percent in the first quarter of 2007 to 31.7 percent in the third quarter. In contrast, the percentage of Maricopa County Juvenile Arrestees testing positive for marijuana was approximately 76–79 percent during each of the first three quarters of 2007. **Heroin** was the primary drug reported by 10 percent of the treatment admissions reporting such a drug. During the second half of 2005 through the first half of 2007, heroin treatment admissions were relatively flat, staying within a range of about 210 to 230. The percentage of Adult Diversion Arrestees testing positive for heroin/opiates was approximately 16–19 percent during each of the first three quarters of 2007. The percentage of Maricopa County Juvenile Arrestees testing positive for heroin/opiates was approximately 2 percent during each of those three quarters. Hospital admissions related to heroin/opioids in the first half of 2007 were about the same as in the second half of 2006. Mexican black tar is the most common type of heroin used in Arizona. The average purity of heroin in the area has been relatively stable, ranging from 45 to 53 percent during 2003 through 2006. **Oxycodone** ($n=91$) and **hydrocodone** ($n=83$) were the fifth and sixth most common drugs, respectively, reported by NFLIS. New **HIV/AIDS** data were unavailable to update rates reported at the June meeting.

Data Sources: *Treatment data* are from the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS), Division of Clinical Recovery Services, Bureau of Grants Management, Training and Administration, Evaluation Unit for 2005 and 2006. **Hospital admissions (inpatient) data** are from analyses conducted by the University of Arizona, Department of Family and Community Medicine, using hospital discharge records from the Arizona Hospital Discharge Data System operated by the Arizona Department of Health Services. **Urine screening**

data are from the Treatment Assessment Screening Center, Inc. (TASC) headquartered in Phoenix, Arizona. **Law enforcement data, including clandestine lab seizure data**, are from the DEA and the DEA Phoenix Division, Intelligence Quarterly Trends Report, second quarter 2007. **Forensic drug analysis data** are from the National Forensic Laboratory Information System (NFLIS), DEA.

Drug Abuse Patterns and Trends in St. Louis—Update: January 2008

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Overview of Findings: Within the past year, the State of Missouri, Division of Alcohol and Drug Abuse, has implemented a new client information system. This change has resulted in fewer admissions for the first half of 2007 compared with the first half of 2006. Therefore, it is difficult to use admissions data to determine changes in drug abuse trends until more is known about the effects of the computer system on admissions statistics. The admissions data provide key indicators with a relatively short time lag between data input and access. For this reporting period, the first halves of 2007 and 2006 were compared using percentages of admissions instead of the more direct change in raw numbers.

Updated Drug Abuse Trends and Emerging Patterns: Overall, indicators for **cocaine** are stable. This is the St. Louis Region's primary drug problem, but indicators have remained stable for several reporting periods. NDIC has reported cocaine shortages in both Kansas City and in St. Louis. However, the Quest Diagnostics positivity rates for cocaine have increased 45.9 percent (Kansas City, KS) and 15.8 percent (St. Louis,

MO) from the second quarter of 2006 to the second quarter of 2007. It is believed that Mexican-controlled distribution chains may be increasing in urban areas of St. Louis and moving existing marketers to suburban and rural settings. Prices in general appeared to be down slightly from 2005 to 2006. However, NDIC reports 2007 street prices for crack to be increased. The Missouri Uniform Crime Report shows decreases for *Possession of Opium or Cocaine and their Derivatives* from 2006 to 2007. These decreases hold at the State (a decrease of 35.6 percent), St. Louis City (a decrease of 29.3 percent), and St. Louis County (a decrease of 36.7 percent) areas. Unfortunately, this measure combines opiates and stimulants, so it is difficult to determine with certainty how much this variable measures changes in cocaine use. **Heroin** is edging upwards. The heroin market in the St. Louis Region has grown and become more complex over the past few reporting periods. While treatment admissions were substantially down for all substances from the first half of 2006 to the first half of 2007, heroin admissions stayed almost the same, and heroin was the primary drug for a larger proportion of admissions. In previous years, Mexican black tar was the only type of heroin found in this area, entering from the Southwest. Now, South American and Southwest Asian heroin are found routinely. Increased involvement of Mexican dealers from the Southwest or via Chicago has complicated the market. Results from the National HIV Behavioral Surveillance Survey for Injection Drug Users in the St. Louis metropolitan statistical area indicated that 65 percent of those using heroin used powdered heroin. DMP analyses for 2006 reflect this growing, competitive heroin market in the St. Louis area. Southwest Asian, South American, and Mexican black tar were represented in the samples, with more white samples than black tar samples. Dropping prices have been the general trend since 2004. For example, the Mexican samples have dropped in price from \$1.89 per milligram pure in 2004 to \$0.99 per milligram pure in 2006, while purity has increased in these samples from 14.4 percent to 19.5 percent in this

period. **Other opiates** have been stable, but the abuse of prescription drugs and narcotic analgesics specifically has been on the rise in this region. **Marijuana** is stable, with some indicators decreasing. The Missouri Uniform Crime Report provides an excellent database for the analysis of county-level indicator data. One measure, possession of marijuana, shows that these arrests are down more than 18 percent statewide. However, this same indicator is up 65.4 percent in the city of St. Louis. This may reflect the recent success of the St. Louis Police Department in targeted efforts to reduce crime. Cannabis was the most frequently cited substance identified in the 2007 NFLIS report for the St. Louis metropolitan statistical area. However, St. Louis County data were missing from the report. **Methamphetamine** is stable, with some indicators decreasing. It is possible that the use of methamphetamine is decreasing in Missouri, but it is difficult to tell for several reasons. Overall, clandestine lab seizures have dropped considerably after enactment of pseudoephedrine-access legislation. However, there are many reports of increases in “ice” imported by Mexican-controlled organizations. While clandestine laboratory seizures provided a visible indicator of locally produced methamphetamine, the amount of imported methamphetamine is less easy to quantify in a consistent manner. The St. Louis area remains active in locally produced methamphetamine and has not seen the large increase of Mexican-produced “ice” that the other areas of the State have experienced. **Prescription drug** abuse has been growing. However, it has been difficult to access data to substantiate this trend. There have been multiple reports from key informants about increases in prescription drug use and in the use of **MDMA**. Overall, many drugs are stable, and with treatment data system changes it is difficult to determine significant changes that have occurred in the past 6 months. However, a synthesis of all data sources leads to the conclusion that the heroin problem in St. Louis is becoming larger and more complex, with the market becoming more competitive. Anecdotal reports of increases in prescription abuse

and MDMA have not been verified via multiple data sources. There are no new HIV/AIDS data to report since the June 2007 meeting.

Data Sources: *Treatment data* were provided by the Missouri Treatment Episode Data Set for admissions in the first halves of 2006 and 2007. *Criminal justice data* were accessed from the Missouri Uniform Crime Report for calendar years 2006 and 2007. *Drug lab submissions data* were provided by the National Forensic Laboratory Information System (NFLIS) 2007 report for the St. Louis metropolitan statistical area. *Drug overdose data* were obtained from St. Louis City and County medical examiner (ME) data for the first half of 2007. *Drug price and purity data* were obtained from the 2006 report of the Domestic Monitor Program (DMP) and the 2007 National Drug Intelligence Center (NDIC) report.

Drug Abuse Patterns and Trends in San Diego County, California— Update: January 2008

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Overview of Findings: San Diego County, California, is situated adjacent to the U.S.–Mexico border and serves as a principal distribution center for both methamphetamine and marijuana shipments from Mexico. Methamphetamine continues to be the drug of primary concern in San Diego.

Updated Drug Abuse Trends and Emerging Patterns: Almost one-half (46 percent) of all primary drug treatment admissions (excluding alcohol) between January and June 2007 were for **methamphetamine**, and methamphetamine was the most commonly cited illicit drug at ED visits reported to DAWN during the same period.

In addition, 47 percent of adult female arrestees, 36 percent of adult male arrestees, and 10 percent of juvenile arrestees surveyed as part of the county's Substance Abuse Monitoring program in 2006 tested positive for methamphetamine. An examination of recent trends in San Diego, however, suggests that methamphetamine use may be declining, perhaps as the result of reduced availability. Although the number of primary treatment admissions for methamphetamine in the first half of 2007 ($n=2,744$) was almost identical to that reported in the first half of 2006 ($n=2,733$), the proportion of adult female arrestees testing positive for methamphetamine in 2006 (47 percent) was down from 2005 (51 percent). The same was true for adult male arrestees (36 percent vs. 44 percent) and juvenile arrestees (10 percent vs. 21 percent). Arrestees in 2006 were also more likely to report that methamphetamine was less available (28 percent), its price was higher (51 percent), and demand for the drug was increasing (73 percent) than arrestees surveyed in 2005 (13 percent, 28 percent, and 65 percent, respectively). Further, in its 2007 report on street drug prices, the San Diego Law Enforcement Coordination Center stated that “ice” methamphetamine availability is decreasing in some parts of San Diego County. Methamphetamine prices appear to have risen and purities have decreased. Notably, these increases in price appear only at higher volumes (e.g., \$9,000–\$12,500 per ounce in 2007 vs. \$3,500–\$8,500 in 2005), while the street prices of lower quantities have remained relatively consistent since 2005 (e.g., one-quarter gram for \$20–\$25). All of these findings are consistent with the hypothesis of reduced methamphetamine availability in San Diego. The reasons for this reduction in availability warrants further investigation and analysis. Indicators regarding other illicit drugs in San Diego County at this time are mixed. **Heroin** indicators remain stable. Twenty percent of nonalcohol treatment admissions between January and June 2007 were for primary heroin use; 8 percent and 5 percent of male and female arrestees, respectively, tested positive for heroin/morphine in 2006; and 3 percent of NFLIS samples

tested heroin-positive in FY 2007. An upward trend in **marijuana** use among male arrestees was observed, with 40 percent testing positive in 2006, compared with 34 percent in 2005; however, other marijuana indicators did not display similar increases. In contrast, with regard to **cocaine**, the proportion of female arrestees testing positive increased from 15 percent in 2005 to 21 percent in 2006 but remained relatively stable among male and juvenile arrestees. There is also evidence of upward pressure on cocaine prices at lower volume units, with the price of one-quarter gram rising from \$20–\$40 in 2005 to \$50–\$100 in 2007. The last drug examined in this update is **ecstasy** (MDMA), for which indicator data are limited. Although there were no primary drug treatment admissions for ecstasy use, and only 37 secondary users were admitted for treatment, data from the Substance Abuse Monitoring survey suggest that ecstasy use may be increasing—at least among individuals involved in the criminal justice system. The number of adult arrestees who reported ever using ecstasy rose from 17 percent and 15 percent in 2004 and 2005, respectively, to 21 percent in 2006, and 10 percent reported using the drug in the past year. Similarly, the proportion of juveniles who reported ever using ecstasy increased from 13 percent in 2004 to 21 percent in 2006, and past-year use increased from 7 to 16 percent over the same time period. This suggests the need for ongoing surveillance of ecstasy use—particularly among juveniles—in San Diego County.

Data Sources: *Arrestee drug use data for 2002–2006 and arrestee drug opinion data for 2000–2006 were provided by the San Diego Association of Governments (SANDAG) Substance Abuse Monitoring (SAM) program. Emergency department drug mentions data were derived for the first 6 months of 2007 from the unweighted DAWN Live! restricted-access online query system administered by the OAS, SAMHSA. Eligible hospitals in the San Diego area totaled 17; hospitals in the DAWN sample numbered 17, with the number of emergency departments in the sample totaling*

17. (Some hospitals have more than one emergency department.) During this 6-month period, 7 EDs reported data each month. The completeness of data reported by participating EDs varied by month. Data were accessed December 12, 2007. Information on seized drug samples submitted for analysis were obtained from the National Forensic Laboratory Information System (NFLIS) for FY 2007. Drug price and purity data for 2005–2007 were provided by the San Diego Law Enforcement Coordination Center. Additional information was obtained from the National Drug Intelligence Center, National Drug Threat Assessment 2006.

Drug Abuse Patterns and Trends in the San Francisco Bay Area— Update: January 2008

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Overview of Findings: Indices of prosperity (unemployment, housing costs, and median income) have lately been more favorable for the three coastal counties (Marin, San Francisco, San Mateo) than for the two inland counties (Alameda, Contra Costa) of the five-county San Francisco Bay area. This augurs continued out-migration of substance abusers from the coastal counties. Indicators for cocaine suggest a decrease in the use of crack and a shift to the powder form of the drug. Recent trends for heroin are downward, as are some indicators for methamphetamine and MDMA. Marijuana indicators are level.

Updated Drug Abuse Trends and Emerging Patterns: Recent indicators for **cocaine**—the declining frequency of its presence in ME cases and the rising cost of “crack” at the wholesale and retail level—suggest a fall in usage. However, there are indications of a shift to the powder

(HCl) form of the drug: the wholesale and retail cost of this form has fallen, and the proportion of Whites among ME reports has risen. Recent trends for **heroin** are downward. San Francisco ME reports of the drug fell by two-thirds during the first half of this decade; treatment admissions have declined; and wholesale prices have increased. The median age of heroin ME cases is higher than ever. However, the “street” price of heroin is at its lowest point since 1999. Over the most recent 3 years, some indicators for **methamphetamine**—the reported usage among San Francisco gay men and the price of the drug at the wholesale and retail levels—suggest a decline in usage. **Marijuana** indicators are level, based on treatment admissions and arrest data. Among **other drugs**, MDMA treatment admissions are declining. **AIDS** incidence is decelerating among heterosexual IDUs, but it is accelerating among gay/bisexual male IDUs. Political events in California may result this year in a turn away from the practice of incarcerating people for possession or nonviolent trafficking of drugs.

Data Sources: *Treatment admissions data* were available for all five Bay area counties for 2000 through the first half of 2005. These data were compiled by the California Department of Alcohol and Drug Programs. In addition, admissions data for San Francisco County were provided by the San Francisco Department of Public Health (SFDPH) for fiscal years (FYs) 2002 through 2006, and also the first half of 2007. **Medical Examiner (ME) data on drug mentions** in decedents were provided by the San Francisco County Medical Examiner for that county for FYs 2000 through 2005. **Reports of arrests for drug law violations** were provided by the San Francisco Police Department for 2001 through 2006. **Price and purity data** came from the Drug Enforcement Administration, Domestic Monitor Program, and referenced heroin “buys” mostly made in San Francisco County. Data for 2006 were compared with those for 1994–2005. Data on trafficking in heroin and other drugs were available from the National Drug Intelligence Center and pertained to wholesale, midlevel, and retail

prices prevailing in San Francisco in early 2007. Acquired immunodeficiency syndrome (AIDS) surveillance data were provided by the SFDPH and covered the period through September 30, 2007. **Surveys of drug use by gay and bisexual men** in San Francisco were conducted by the SFDPH in 2006.

Drug Abuse Patterns and Trends in the Seattle-King County Area—Update: January 2008

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Overview of Findings: No major changes are evident in data available for the first half of 2007 compared with prior years, though small numbers preclude trend analyses. A summary of emergent issues and the relative impact of drugs of abuse indicate that prescription-type opiates, heroin, and cocaine continue to have substantial impact on morbidity and mortality. Buprenorphine, a prescription-type opiate used for pain and increasingly for opiate substitution drug treatment, was identified, for the first time, in a polydrug-caused death involving alcohol and several prescription sedative medications. It is important for patients and physicians to be mindful of the potential danger of combining buprenorphine with other central nervous system depressants. Methamphetamine indicators appear to be leveling off in recent years, with most negative health indicators at levels generally lower than for cocaine, heroin, and prescription-type opiates. Marijuana use and local growing

operations continue to be common. MDMA/ecstasy negative health indicators remain low, but law enforcement data indicate a substantial volume of MDMA moving across the Canadian border through Washington State, with final destinations throughout the United States.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine is the most common drug identified in ED reports, with the largest group of such ED reports aged 35–54. Treatment admissions for cocaine are predominately those in their forties, and there has been a notable increase in this age group compared with the first half of 1999 (the oldest comparable data). Cocaine-involved, drug-caused deaths were the second most common type of drug-caused death in the first half of 2007, similar to the prior 18 months. Many cocaine-involved deaths are in combination with heroin, and African-Americans are disproportionately represented in cocaine-involved, drug-caused deaths. Cocaine was the most common drug identified in testing of law enforcement evidence for King County in FY 2007, representing 42 percent of submissions ($n=1,673$), and it is present at somewhat lower levels in the surrounding counties. **Methamphetamine** use is more prevalent outside of the urban core of Seattle and is used throughout much of Washington State. Methamphetamine-positive drug seizures by local law enforcement are more prevalent in the surrounding counties, though they still constituted 16 percent ($n=658$) of tests in King County. Methamphetamine incidents, a combination of labs and dump sites, totaled 42 in King County for 2007, down from 63 the prior year. For Washington State, the number dropped to 237, down from 390. Newly available DMP data from the DEA indicate that there is enormous variability in the purity of methamphetamine, most of which is reported to be crystal/ice. From November 2006 to September 2007, the local DEA made 33 buys in 12 different cities throughout Washington, reporting an average purity of 59 percent and a range of 0–99 percent. Methamphetamine has held steady at about 16 percent of helpline

calls for adults in recent years, while the proportion of calls for youth has declined somewhat to approximately 13 percent. ED data indicate that methamphetamine is among the least common “major substances of abuse” with approximately 500 reports, compared with more than 2,000 for cocaine (King and Snohomish Counties). Methamphetamine reports in the ED are generally among a much younger population compared with cocaine, with the modal group of methamphetamine users being 25–29 years of age. The proportion of Caucasian treatment admissions for primary methamphetamine use has declined, whereas admissions appear to have increased among African-Americans, Asian/Pacific Islanders, and Hispanics. Methamphetamine-involved, drug-caused deaths totaled 10, similar to the level seen over the prior 4 years. Compared with other drug-caused deaths involving illegal drugs, methamphetamine fatality cases have the highest proportion of Caucasians and young people and are most likely to be single-drug cases. **Prescription-type opiates** continue to have substantial impact on morbidity and mortality. Trend data for the helpline, fatalities, and treatment admissions are all at or near highs for prescription-type opiates. Drug-caused deaths with prescription-type opiates remain the most common type of overdose death. A minority of drug-caused deaths involving opioids also involved an illegal drug (36 percent), and polydrug cases are the norm (91 percent). A polydrug-caused death occurred in the first half of 2007 in King County, in which alcohol, buprenorphine, and several prescription sedatives were detected. This is the first known case of a drug-caused death in which buprenorphine was detected. It must be noted that toxicological testing for buprenorphine is not routinely done and must be specifically requested. The patient was receiving buprenorphine for opiate addiction treatment. Testing of local law enforcement evidence indicates that the combined class of opioids represented 7 percent of tests conducted ($n=297$). The most common substances identified include oxycodone ($n=144$), hydrocodone ($n=72$), and methadone ($n=51$). Treatment admissions with

prescription-type opiates as primary drug totaled 248, representing 4 percent of all admissions in the first half of 2007, up from 46 admissions, or 1 percent, in the first half of 1999. Individuals in their twenties represented the largest age group in treatment with prescription-type opiates as a primary drug, representing 48 percent of cases in the first half of 2007, compared with 15 percent in the first half of 1999. From January to June 2007, just 12 percent of prescription-type opiate users reported any injection drug use in the month prior to treatment, with comparable data unavailable for 1999. ED reports for prescription-type opiates totaled 1,555, the third highest after cocaine and alcohol. **Heroin** ED reports for all case types totaled 1,089, approximately one-half the number of cocaine cases. More than one-half of ED reports for heroin were among those aged 35–54. Drug-caused deaths involving heroin/opiates have remained steady at lower levels for the past 6 years, with 39 deaths in the first half of 2007. Compared with primary heroin drug treatment admissions in the first half of 1999, those in the first half of 2007 were more likely to be in their twenties or older than 50, with the relative proportion of those in their thirties and forties declining. They were also more likely to report methamphetamine or prescription-type opiates as a secondary drug of abuse (6 and 10 percent, respectively, in 2007), although the most common secondary drug continued to be cocaine (49 percent in both time periods). Purity data from the DEA indicate that the average purity of street purchases in Seattle and Tacoma from December 2006 through July 2007 was 12 percent, similar to prior years. However, there was significant variability, with a median of 10 percent and a range from 0 to 62 percent purity. The use of unexpectedly high-purity heroin could result in overdoses. **Marijuana** ED reports totaled 918, slightly lower than those for heroin. Comparing treatment admissions from the first half of 1999 to the first half of 2007 reveals that the proportion who were Black increased by more than one-third. Admissions among those younger than 18 declined from 65 percent of marijuana admissions to 36 percent,

and the proportion of admittees who were currently on probation or parole increased slightly from 35 to 43 percent. Alcohol as a secondary drug declined, while cocaine and methamphetamine increased to 12 and 7 percent, respectively, in 2007. Marijuana from Mexico and Canada, as well as that grown locally, are all available in King County. There has been a large increase in indoor and outdoor grow operations in Washington in recent years. **MDMA and other hallucinogenic drug** use continue in the Seattle area. Helpline data for youth indicate that 6 percent of calls are regarding MDMA, a higher proportion than for adults. MDMA is relatively uncommon in area EDs, with only a few dozen reports in the first half of 2007. MDMA is rarely mentioned as a primary drug upon treatment entry. Fatalities involving MDMA are still uncommon, with two cases positive for MDMA in the first half of 2007. Testing of local law enforcement evidence indicates that MDMA is more common in Seattle-King County than the surrounding counties, but that it is still present in about 3 percent of tests in Snohomish and Pierce Counties. For evidence obtained in King County, there were 249 MDMA-positive tests (6 percent), with 31 tests positive for psilocin/psilocybin (i.e., psychedelic mushrooms) and 22 positive for PCP. There were also four positive tests for “foxy methoxy,” a research chemical, which has been present for several years in the Seattle area. LSD was detected once. Law enforcement reports that MDMA is now being manufactured in British Columbia, a shift from manufacturing in Northern Europe several years ago.

Data Sources: *Drug trafficking data* were obtained from the DEA Seattle Field Division Quarterly Trends in the Traffic Reports, redacted versions for January–June 2007. **Heroin price and purity data** were provided by the DEA Domestic Monitoring Program, Seattle Field Division for November 2006–September 2007. **Drug overdose data** were obtained from the King County Medical Examiner, Public Health—Seattle & King County for the first half of 2007. **Data on seized drug samples submitted for analysis** were obtained from the

*National Forensic Laboratory Information System (NFLIS), DEA, for FY 2007. Drug testing results for law enforcement seizures in King, Pierce, and Snohomish Counties were reported by the county where the drug was seized. **Emergency department drug reports data** were obtained from DAWN Live!, OAS, SAMHSA, for the first half 2007. Data were accessed December 10, 2007. Data completeness for the first half of 2007 was as follows: 9 to 10 of the EDs reported basically complete data (90 percent or greater) each month, and 14 to 15 reported no data out of 25 eligible EDs. **Drug treatment data** were provided by Washington State Department of Social and Health Services (DSHS), Division of Alcohol and Substance Abuse (DASA), Treatment and Report Generation Tool (TARGET) for the first halves of 1999 and 2007. Treatment modalities included outpatient, intensive inpatient, recovery house, long-term residential, and opiate substitution admissions. Department of Corrections and private-pay admissions are included. **Methamphetamine incident data** were provided by the Washington State Department of Ecology for 1990–October 2007. **Drug helpline data** for 2003–June 2007 were provided by the Washington Alcohol and Drug Helpline.*

Drug Abuse Patterns and Trends in Texas—Update: January 2008

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Overview of Findings: This report updates data on drug abuse indicators in Texas since the June 2007 report and reports on trends by calendar year from 1998 through 2006–2007. Important changes include decreases in methamphetamine indicators, with supplies down, price increasing, and purity decreasing. The expected influx

of Mexican methamphetamine to replace the locally produced product has not been as great as expected. The other notable trend is the increase in heroin inhalation by younger Hispanics. This trend was first noticed with the “cheese heroin” situation in Dallas, but further investigation has found that many of the users are not novices but are using other illicit drugs, and the increase in inhalation is being seen statewide.

Updated Drug Trends and Emerging Patterns: **Alcohol** is the primary drug for which Texans enter treatment (25 percent of all admissions), followed by cocaine (13 percent crack and 11 percent powder cocaine). **Cocaine** is a major problem on the border with Mexico. Indicators of cocaine use remain high and stable, with increasing crack use among Whites and Hispanics. The proportion of Black crack admissions has dropped from 75 percent in 1993 to 46 percent in 2007, and the proportion of cocaine deaths who were Hispanic has increased from 22 percent in 1993 to 28 percent in 2006. **Heroin** indicators are level, but the proportion who are inhaling or sniffing heroin is growing (up from 1 percent in 1989 to 20 percent in 2007), with an increasing proportion of younger Hispanic inhalers of Mexican brown powder. “Cheese heroin,” a mixture of Tylenol PM and heroin (heroin+diphenhydramine+acetaminophen), continues to be a problem in Dallas. A recent analysis of records from the medical examiner, however, has shown that only one death involved just “cheese” heroin; all the other cheese heroin deaths also involved cocaine, alprazolam, hydrocodone, etc. This shows that this is not a population of novice users but is an emerging problem among more experienced heroin users. **Hydrocodone** is a larger problem than **oxycodone** (374 deaths vs. 78 deaths in 2006); indicators of problems with **fentanyl** patches or lozenges are low and fluctuate from year to year. **Methadone** indicators are increasing, and most adverse events are related to methadone pain pills rather than liquid methadone from narcotic treatment programs. In 2006, there were 232 death certificates with a mention of

methadone; only 14 were clients in narcotic treatment programs. **Codeine** cough syrup, “lean,” continues to be abused. **Marijuana** indicators are mixed, with treatment admissions increasing. Treatment admissions referred from the criminal justice system are less impaired than those who enter treatment voluntarily. Some 79 percent are criminal justice admissions. Marijuana treatment admissions have increased from 11 percent of all admissions in 1989 to 23 percent in 2007, almost equal to alcohol and cocaine admissions. **Methamphetamine** indicators peaked in 2005 and have dropped because of the decreased number of laboratories in Texas, and the expected influx of Mexican methamphetamine has been limited by border security. Ice in Texas is more expensive; the price of a pound of Ice in Dallas has increased from \$4,500–\$19,000 in 2005 to \$10,900–\$19,000 in 2007. The purity of Ice is lower since it is being cut with methylsulfonylmethane (MSM). Fifty-three percent of persons entering methamphetamine treatment are Ice smokers. Abuse of **alprazolam** and **carisoprodol** is increasing. Alprazolam is widely available, and Mexico may be a source for this drug. The proportion of laboratory exhibits identified as alprazolam increased from 2.0 percent in 2000 to 6.4 percent in 2007, and 216 of the 1,912 drug deaths reported in 2006 specified alprazolam as one of the substances found in the bodies. Deaths involving a mention of carisoprodol and NFLIS exhibits of the drug continue to increase. Of the 146 carisoprodol deaths in Texas in 2006, all but 1 involved other substances. All indicators of **ecstasy** use are stable or increasing as the drug spreads from the club scene to the street. The proportion of White ecstasy users entering treatment has dropped from 100 percent in 1989 to 38 percent in 2007. PCP treatment admission and toxicology lab indicators continue to rise.

Data Sources: *Poison control center data were provided by the Texas Department of State Health Services from 1998 through 2007. Treatment data were provided by the Texas Department of State Health Services from 1987 through 2007. Death certificates were provided by the*

Texas Department of State Health Services from 1998 through 2006. Results of toxicology tests on items submitted to the Texas Department of Public Safety from 1998 through 2007 were downloaded from the National Forensic Laboratory Information System. Price, purity, and trafficking information came from the 4th Quarter 2007 Intelligence Reports from the Dallas, El Paso, and Houston DEA Field Divisions. Local drug trend information came from reports from HIV Outreach Units to the Texas Department of State Health Services. Information on use of “cheese” heroin came from interviews by the author with 25 clients in 3 drug treatment programs in Dallas and from information provided by members of the Cheese Heroin Task Force in Dallas. The HIV/AIDS information presented in the June 2007 report was not updated for this report. The 2007 treatment and NFLIS data reflect cases submitted as of the time they were downloaded by the author. Cases continue to be added to these two datasets and total numbers are subject to change.

Drug Abuse Patterns and Trends in Washington, DC—Update: January 2008

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Overview of Findings: In 2006 and 2007, cocaine/crack, marijuana, and heroin continued to be the primary illicit drug problems in Washington, DC. The use and availability of PCP continued to fluctuate, and cocaine remained one of the most serious drugs of abuse, as evidenced by the fact that more adult arrestees tested positive for cocaine than for any other drug. The number of decedents testing positive for drugs decreased 20 percent in 2006, from 631 cases in 2005 to 503

cases in 2006, although most deaths continued to result from natural causes and accidents. One hundred fourteen of the 2006 positive drug deaths were from drug overdoses. The most frequently found drugs were cocaine, morphine, and alcohol. Most overdose deaths were aged 41 to 50 and Black. From 2002 to 2006, all violent and property crimes except theft decreased in the District. In 2006, approximately 1 in 10 homicides and an estimated 6,011 property crimes were drug-related. In addition, there were an estimated 1,194 alcohol-related violent crimes. (Estimates are based on attributable fractions, not including homicides.¹) In contrast, the number of drug arrests (distribution, possession) increased during this time. Most of these arrests were related to possession of marijuana or cocaine/crack and involved adults, males, and Blacks.² Items submitted to NFLIS from DC were more likely to test positive for illicit street drugs (cocaine, heroin, PCP, and methamphetamine) than for prescription drugs (methadone, oxycodone, hydrocodone, and buprenorphine). Items from neighboring Virginia jurisdictions were more likely to test positive for the prescription drugs listed above than items from either DC or Maryland. However, items testing positive for these prescription drugs accounted for less than 2.5 percent of positive items in each of the three regions. Preliminary data from the 2007 Youth Risk Behavior Survey (YRBS) indicate that one in three senior high school youths reported past-month drinking, and one in five reported past-month marijuana use. Increases were also reported in lifetime use of ecstasy, heroin, and methamphetamine, ranging from 5 to 8 percent in 2007.

Updated Drug Abuse Trends and Emerging Patterns: In 2007, adult arrestees were more likely to test positive for **cocaine** than for

any other drug (37.5 percent in January through November), but this reflected a slight decrease from 2006 (41.0 percent). In addition, more seized items tested positive for cocaine (45 percent) in FY 2007 than for any other drug, as reported by the NFLIS. Overdose deaths were also more likely to be related to cocaine (66 percent) than to any other drug in the same year. The numbers of Whites and females arrested for cocaine/crack increased from 2002 to 2006. According to NFLIS data, 32 percent of items submitted for analysis tested positive for **marijuana**. Juvenile arrestees were more likely to test positive for marijuana (55 percent) than for any other drug. The percentages of juveniles testing marijuana-positive have increased slightly (from 51 to 55 percent) over the past 3 years, but the percentages testing positive for cocaine (3.5 to 2.9 percent) and PCP (3.4 to 2.6 percent) remained about the same. Between 2002 and 2006, the number of females arrested for marijuana increased. While other parts of the country have seen shifts in the use of **methamphetamine**, use remained low and confined to isolated communities in the District. DC Pretrial Services began testing for amphetamines in mid-2006 (August for adults, September for juveniles). The percentages of adults and juveniles testing positive for amphetamines were considerably lower than the percentages testing positive for other drugs, ranging from 1.2 to 4.2 percent and 0.5 to 4.0 percent, respectively. However, these percentages showed signs of increasing. Less than 2 percent of items submitted to NFLIS tested positive for methamphetamine or **prescription drugs**. Few drug arrests involved amphetamines; of the 27 amphetamine arrests in 2006, nearly all were adult, male, and Black.² New research conducted by the Crystal Meth Working Group, and described below, sheds new light on the use of methamphetamine in the lesbian/gay/

¹Attributable fraction percent estimates for alcohol-related violent crimes and drug-related property crimes were provided by the State Epidemiological Data System (SEDS) from *The Economic Costs of Alcohol and Drug Abuse in the United States—1992* at www.nida.nih.gov/economiccosts/index.html. Estimates of the percentage of crimes attributable to illicit drugs were derived primarily from self-reports of incarcerated offenders. The actual percentages attributable to alcohol or drugs may vary across geographic units or subpopulations.

²Approximately 60 percent of the general D.C. population is Black according to 2000 census data.

bisexual/transgender (LGBT) community. About 1 in 10 adult arrestees tested positive for **opiates** and **PCP** each in 2007. **HIV/AIDS:** The number of new HIV cases decreased steadily from 2002 through 2006 (from 687 to 403), and they were most likely to be male, Black, and aged 20 to 49.² The largest decrease by mode of transmission was in the proportion of cases attributed to injection drug use (61 percent). The number of new AIDS cases decreased 30 percent from 2002 to 2005 (from 975 to 679) then increased slightly in 2006 (to 700). New AIDS cases were most likely to be Black, male, and aged 30–49. The number of new AIDS cases attributed to injection drug use fluctuated during this time, with this becoming the most frequent mode of transmission in 2005. This number decreased 31 percent in 2006 from 228 to 158. Injection drug use accounted for more than one-third of the deaths and one in four of all living AIDS cases in 2006.

Special Study: In 2006, the Crystal Meth Working Group conducted a 14-question, self-administered survey with 1,109 participants at three LGBT events in DC. The data were analyzed by researchers at the Georgetown University Medical Center. More than one-half of the respondents were male (53 percent) and White (54 percent); two-thirds (69 percent) were aged 20–39; and 61 percent identified as gay or lesbian. Preliminary results indicate that nearly 1 in 10 (8 percent) reported using crystal methamphetamine at least once. Nearly all (93 percent) of the users were gay or bisexual; 69 percent were White males; 70 percent were aged 20–39; 23 percent were self-reported HIV-positive; and 67 percent used other illicit drugs (cocaine, crack, marijuana, ecstasy, and poppers). Reasons offered for using included the following: 49 percent liked the meth “high”; 30 percent wanted “more energy”; 28 percent wanted “hotter sex”; 25 percent wanted “more sex”; and 24 percent wanted to be “more sociable.” Two limitations noted by the researchers are that this study utilized convenience sampling and is not representative of the general DC

population and that the venue choices missed high-risk groups.

Data Sources: *Crime data* were provided by the Metropolitan Police Department (MPD), National Forensic Laboratory Information System (NFLIS), and Drug Enforcement Administration (DEA), Office of Diversion Control. Regarding crime data provided by the MPD, as part of Chief Cathy Lanier’s dedication to improving crime data tracking and analysis, in 2008 MPD upgraded key data systems. The data provided for the “District of Columbia: Community Profile” were disseminated prior to these upgrades and should not be compared with datasets released thereafter. Geocoded Analytical Services Application (ASAP) data are as of May 7, 2007. All statistics presented here are based on preliminary DC Index crime data. The data do not represent official statistics submitted to the FBI under the Uniform Crime Reporting program (UCR). All preliminary offenses are coded based on DC criminal code and not the FBI offense classifications. All statistics are subject to change due to a variety of reasons, such as a change in classification, the determination that certain offense reports were unfounded, or late reporting. It should be understood that any comparisons between MPD preliminary data as published here and the official crime statistics published by the FBI under the Uniform Crime Reporting Program (UCR) are inaccurate and misleading. All homicide data are verified through the Violent Crimes Branch (VCB), Geocoded Criminal Justice Information System (CJIS) data as of May 7, 2007. Totals are based solely on the top arrest charge, as one person may have been booked on more than one arrest charge, and it excludes arrests for which no address could be identified (between 1 and 3 percent of all arrests). **Mortality data** were obtained from the Office of the Chief Medical Examiner, Washington, DC, from the 2005 and 2006 annual reports. **Information on substance abuse by offenders** was provided by the DC Pretrial Services Agency. The agency regularly tests adult offenders for cocaine, opiates, PCP, and amphetamines and juvenile offenders for cocaine,

PCP, marijuana, and amphetamines. **Data on substance abuse by youth** was provided by the Washington, DC, Department of Health, Youth Risk Behavior Surveillance System (YRBS). **HIV/AIDS data** were provided by the District of Columbia HIV/AIDS Epidemiology Annual Report 2007, DC Department of Health. **Information on substance abuse in the LGBT community** was provided by the Crystal Meth Working Group. This information was provided by Kristen Degan, M.P.H., Michael Plankey, Ph.D., and David Schwartz, Ph.D. The survey was conducted in 2007 by the Crystal Meth Working Group, and preliminary findings were released in January 2008.

INTERNATIONAL PRESENTATIONS: CANADA AND SOUTH AFRICA

Current and Future Drug Surveillance in Canada: January 2008

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Overview of Findings: This report highlights drug surveillance systems and data sources in Canada and summarizes some of the most current data/information available on illicit drug use in the country. It is important to point out that in response to the 2001 Auditor General's Report, funding was made available in 2003 at the Federal level for knowledge generation, including alcohol and other drug monitoring. Under a newly elected government, Canada's National Anti-Drug Strategy was announced in 2007, which included continued support for surveillance activities. Prior to

2001, and dating back to the 1990s, government cutbacks limited the ability to pursue or sustain national initiatives.

Drug Use Trends and Emerging Patterns:

Acknowledging the absence of national data through the Canadian Community Epidemiology Network on Drug Use (CCENDU) (i.e., purchased and collated), highlights from public access data sources are provided below. *Prevalence*—According to the 2004 Canadian Addiction Survey, 44.5 percent of Canadians aged 15 and older reported using cannabis at least once in their lifetime; 14.1 percent reported using in the past 12 months. The rate of past-year use is higher for males (18.2 percent) than females (10.2 percent). Almost 30 percent of youth aged 15–17 reported past-12-month use of cannabis, and more than 47 percent of youth aged 18–19 reported use in the past 12 months. Excluding cannabis, the most commonly reported illicit drugs used in one's lifetime are hallucinogens (11.4 percent), cocaine (10.6 percent), speed (6.4 percent), and ecstasy (4.1 percent). Rates of past-year use are much lower: cocaine (1.9 percent), ecstasy (1.1 percent), speed (0.8 percent), and hallucinogens (0.7 percent). Rates for males tend to be about twice the rates for females. Highest rates are found for those in the 18–24 age range. *Treatment*—The most recent data available are the 2005–2006 Residential Care Facilities survey; however, data specific to addictions could not be publicly accessed. Furthermore, these data are inadequate for monitoring purposes. In 2005, a report undertaken by the Canadian Centre on Substance Abuse demonstrated the value of a national addictions treatment data collection and analysis system for Canada and outlined the steps required to achieve such a system. *Enforcement*—Data from the Uniform Crime Report, Adult Criminal Court Survey, and the Youth Court Survey were collected and reported on by CCENDU in the past. The most recent data are not publicly available. In its place, *The 2006 Drug Situation* report, published by the Royal Canadian Mounted Police (RCMP),

was accessed. **Marijuana** consumption continues to be high among communities across Canada. *Hashish and hashish oil* represent a limited market, with concentration in Ontario, Quebec, and the Atlantic Provinces. **Cocaine** remains readily available across the country, with crack prevalent among street drug-user populations. An emerging trend of lacing cocaine with methamphetamine has been identified in Ontario and British Columbia. The pattern of wide availability and stable use of **methylenedioxymethamphetamine (MDMA/ecstasy)** reported in 2005 was repeated in 2006. **Methamphetamine** availability continues to expand eastward. Traffickers continue their attempts to capture a wider user group by lacing other so-called “softer” drugs like ecstasy and marijuana with methamphetamine. **Heroin** consumption remains one of the lowest of all forms of drug use and is concentrated in major metropolitan areas (Vancouver and Toronto). *Opium* use is quite common in various segments of Middle Eastern communities (primarily older, middle-to-upper-class males), located primarily in Vancouver and Toronto. Demand and supply patterns for longstanding substances such as **lysergic acid diethylamide (LSD)**, **phencyclidine (PCP)**, and **psilocybin** changed dramatically over the last decade, yet remained stable in recent years. **Ketamine and gamma hydroxybutyrate (GHB)** gained popularity as new “club drugs” that were introduced alongside MDMA in the late 1990s and continue to have steady supply and demand patterns. *Mortality*—The most recent data available through CCENDU are the 2003 Vital Statistics Death Database. Given that they are dated, data are not presented here. *Morbidity*—The most recent data available through CCENDU are the 2001–2002 Hospital Morbidity Database and are not presented here. **HIV/AIDS/Hepatitis C**—Up to December 31, 2006, injection drug use accounted for 8 percent (1,536) of cumulative adult AIDS cases in Canada and 17 percent of cumulative adult positive HIV test reports. The proportion of positive HIV tests attributed to injection drug use decreased between 2001 (25 percent) and 2006 (19 percent). This differed,

however, for female and male adults. The proportions of females with HIV attributed to injection drug use were 31 percent in 2002, 26 percent in 2003, and 31 percent in 2006, whereas males steadily decreased from 22 percent in 2001 to 15 percent in 2006. The proportion of new HIV infections in 2005 among Aboriginal Canadians attributable to injection drug use was substantially higher (53 percent) compared with all Canadians (14 percent), and females make up a large part of the Aboriginal HIV epidemic. A baseline positive rate of hepatitis C antibodies of between 44 and 74 percent was found in a cohort of illicit opioid users through the “OPICAN” study in five Canadian cities.

Prescription drug monitoring—There is a serious absence of monitoring in Canada; however, as mentioned above, work is currently underway to begin monitoring with the development of the Canadian Alcohol and Other Drug Use Monitoring Survey. Highlights from the current literature show that Canada has one of the highest prescribed drug rates in the world. The population that abuses prescription drugs and their reasons for doing so vary widely. Those most at risk for abuse appear to include adolescents, older adults, women, and Aboriginal peoples. The abuse of oxycodone in Atlantic Canada (particularly Nova Scotia) is well-documented, and it appears the abuse of opioids is increasing. Women are more likely to be prescribed medication (e.g., benzodiazepines), and this may contribute to greater opportunity for abuse. Individuals who abuse prescription drugs are more likely to also use alcohol and illicit drugs. Medication abuse among the elderly is commonly associated with unintentional misuse, but there is also concern with over-prescribing again, particularly among women. There is also an increase in the general use of medication with technological advancements in society and, hence, the increased chance for abuse.

Data Sources: *The Canadian Community Epidemiology Network on Drug Abuse (CCENDU)*

was established in response to a 1995 feasibility study that identified the need for a Canada-wide surveillance system on substance use. Some local CCENDU sites across the country are still actively collecting data. However, there is national movement toward the establishment of an expanded and more comprehensive alcohol and other drug monitoring program. Consequently, up-to-date national- and provincial-level data that CCENDU had purchased and collated in the past are not currently available. At present, a pilot study of the alcohol and other drug monitoring project is underway in British Columbia. The data sources/indicators include general population and student surveys, addictions treatment reports, enforcement data, alcohol sales data, drug analysis, high-risk population and emergency department surveys, and mortality and morbidity data. Health Canada has supported this as a pilot project to help design a comprehensive nationwide alcohol and other drug monitoring system. With Federal support, in recent years Health Canada has been working toward the development of a national surveillance strategy, with four key activities to date. The first, as mentioned, is the pilot testing of an epidemiological monitoring system for alcohol and other drug use in British Columbia. Second, a National Surveillance Advisory Committee has been set up to help identify information needs and propose initiatives to address those needs. Third, attention has been focused on the development of a new, ongoing national survey (Canadian Alcohol and Other Drug Use Monitoring Survey) on the use of alcohol and drugs (including prescription drugs), to be collected monthly over an initial 5-year period. The survey is designed to be modular, with space to add new topics as they emerge. And fourth, collaborative work in initiatives focusing on specific populations (e.g., street youth) is being undertaken. Note: direct quotes are not indicated in this summary even though some wording mirrors that in the original source.

The South African Community Epidemiology Network on Drug Use (SACENDU): Summary of Latest Findings

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Background: The SACENDU³ Project is an alcohol and other drug (AOD) sentinel surveillance system now operational in eight provinces in South Africa: Western Cape (WC: Cape Town), KwaZulu-Natal (KZN: Durban, Pietermaritzburg), Eastern Cape (EC), Mpumalanga (MP), Gauteng (GT: Johannesburg, Pretoria), Free State (FS), Northern Cape (NC), and Northwest (NW). The last three provinces form part of what is termed the Central Region (CR) and provided data from the second half of 2006. The system, operational since 1996, monitors trends in AOD use and associated consequences on a 6-month basis from specialist AOD treatment programs. The surveillance system has been expanded to all provinces during 2007, with Limpopo collecting data from July 2007. This report will focus on data on treatment admissions from the 9,414 patients seen across the 72 centres/programmes in the first half of 2007.

Latest Key Findings by Substance of Abuse: Unless stated otherwise, the findings relate to the first half of 2007. **Alcohol** remains the dominant substance of abuse across all sites except WC. Between 44 percent (WC) and 70 percent (CR) of patients in treatment have alcohol as a primary or secondary drug of abuse. The proportion reporting it as a primary drug of abuse continued to decrease in MP (44 percent)

³SACENDU is funded by the Medical Research Council of South Africa and the South African National Departments of Health and Social Development.

and KZN (50 percent). Treatment admissions for alcohol-related problems in persons younger than 20 are generally less common, ranging between 4 percent (WC) and 26 percent (EC) of all patients in this age group. Across sites, between 27 percent (EC, CR) and 48 percent (MP) of patients attending specialist treatment centres had **cannabis** as their primary or secondary drug of abuse, compared with between 2 percent (CR) and 13 percent (WC, EC) for the cannabis/**Mandrax** (methaqualone) “white-pipe” combination. In the first half of 2007, treatment admissions for cannabis as a primary drug remained fairly stable in all sites when compared with the previous period. In all sites, except WC, cannabis is reported as primary substance of abuse by more than 50 percent of patients who are younger than 20. Treatment admissions for Mandrax remain low in all sites, having decreased significantly over the past 2 years in all sites. In the WC, Mandrax is now more commonly reported as a secondary drug of abuse (by 10 percent of all patients). Treatment admissions for **cocaine**-related problems have shown an increase over the past few reporting periods in GT and KZN, and they remain high in the EC. Between 10 percent (WC) and 25 percent (GT) of patients in treatment have cocaine as a primary or secondary drug of abuse. The proportion of patients reporting cocaine as a primary or as a secondary substance of abuse has decreased over time in the WC (possibly due to the increased availability of cheaper methamphetamine). Over time, there has been a large increase in treatment admissions for **heroin** as a primary drug of abuse in WC, GT, MP, and, more recently, in KZN. In these sites, between 12 percent (WC) and 32 percent (MP) of patients have heroin as a primary or secondary drug of abuse. Mostly heroin is smoked, but of patients with heroin as their primary drug of abuse in WC, GT, and MP, 8 percent, 35 percent, and 20 percent, respectively, report injection use. This reflects a decrease in all three provinces as compared with the second half of 2006. One patient in KZN reported injecting heroin. The proportion of heroin patients who are Black/African continues to increase in GT and MP. In MP,

52 percent of patients in treatment with heroin as a primary drug of abuse are Black/African (vs. 39 percent in GT). Furthermore, 68 percent of heroin patients in GT and 75 percent of heroin patients in MP younger than 20 were Black/African (also increasing). Treatment admissions related to use of “Sugars” (low quality heroin and cocaine mixed with cannabis) continue to increase among young, Indian males in South Durban. Treatment admissions for methylenedioxymethamphetamine (**ecstasy**), **lysergic acid diethylamide (LSD)**, or **methamphetamine** as primary drugs of abuse are low except in Cape Town. Across sites, only 2 to 4 percent of patients had ecstasy as a primary or secondary drug of abuse. Treatment admissions for methamphetamine remain high in Cape Town in the first half of 2007. About one-half (49 percent) of patients in WC now have methamphetamine as a primary or secondary drug of abuse ($n=1413$), with 60 percent reporting daily use. Methamphetamine (aka “Tik”) has now emerged as the main substance of abuse among both young and older patients in treatment in Cape Town. Among patients younger than 20, 70 percent have methamphetamine as a primary or secondary substance of abuse. Three-quarters (74 percent) of patients with methamphetamine as a primary drug of abuse were male, and 91 percent were coloured. Treatment admissions related to methamphetamine use as a primary or secondary drug remain low in EC ($n=17$), GT ($n=28$), CR ($n=6$), MP ($n=5$), and KZN ($n=0$). The abuse of **over-the-counter (OTC) and prescription medicines**, such as slimming tablets, analgesics, and benzodiazepines (e.g., diazepam and flunitrazepam) continues to be an issue across sites. Treatment admissions for these substances as a primary or secondary drug of abuse were between 2 percent (MP) and 8 percent (CR, GT). **Inhalant/solvent** use among young persons continues to be an issue across sites, especially in the NC, where 14 percent of patients reported inhalants as their primary substance of abuse. **Methcathinone** (“CAT”) use was noted in all sites, especially in GT, where 6 percent of patients ($n=198$) had CAT as a primary or secondary drug of abuse.

Use of **khat** was reported by four patients in the CR. **Polysubstance abuse** remains high, with between 22 percent (CR) and 48 percent (MP) of patients indicating more than one substance of abuse. **Other Key Findings:** The proportion of patients younger than 20 ranged from 19 percent (CR) to 28 percent (WC). In all sites, the proportion of Black/African patients in treatment is still substantially less than would be expected from the underlying population demographics, and the situation does not appear to be improving except among patients younger than 20 and in MP. Between 14 percent (MP, CR) and 27 percent (GT) of patients reported that they had been tested for HIV in the past 12 months, although some patients declined to answer this question, and these data have not yet been collected in the EC. **Selected implications for policy/practice**, including voluntary counseling and testing for

HIV (VCT), should be provided at drug treatment services; barriers to treatment for Black/Africans should be addressed; there should be better marketing of drug treatment services; and drug and HIV service providers should receive cross-training. Among **selected issues to monitor** are increases in methcathinone (“CAT”) use outside of GT; increases in cocaine use in GT and EC; use of methamphetamine and heroin together in Cape Town; and methamphetamine use among groups other than coloured in WC and possible increases in use in other sites. Finally, **selected topics for further research** are the extent of needle sharing among injecting drug users and the reasons for this; how many patients who report to drug treatment for the first time are “treatment ready”; and the long-term mental health impact of methamphetamine use and the role of duration of methamphetamine use.

Section IV. Across CEWG Areas: Treatment Admissions, Forensic Laboratory Analysis Data, and Average Drug Price and Purity Data

Cocaine/Crack

- Treatment admissions data for FY 2007 or H1 CY 2007 reveal that treatment admissions for primary cocaine/crack, as a percentage of drug treatment admissions excluding primary alcohol admissions, ranked first in frequency in six CEWG areas: Texas, Atlanta, Philadelphia, Detroit, St. Louis, and Seattle.
- Several CEWG representatives noted in their reports that cocaine is often identified as a secondary or tertiary drug among treatment admissions.
- Crack continued to be the predominant form used by cocaine abusers, as judged by the proportions of primary treatment admissions who smoked the drug (between 56 and 95 percent of cocaine/crack treatment admissions in eleven CEWG areas).
- Cocaine was the drug most frequently identified by forensic laboratories in 10 CEWG areas. Based on forensic laboratory analysis of drug items identified in FY 2007, cocaine/crack ranked first in every area in the southern region (Miami; Atlanta; Washington, DC; and Texas), in all but one area in the northeastern region (New York City and Philadelphia), in one of five areas in the midwestern region (Cincinnati), and in three of seven areas in the western region (Seattle, Los Angeles, and Denver).

Treatment Admission Data on Cocaine/Crack

Table 4 presents preliminary 2007 data from 15 CEWG areas on primary cocaine treatment admissions as a proportion of total admissions, including and excluding those for alcohol (see also *Appendix Table 1*). Detroit and Philadelphia had the highest percentages (29 percent and 26 percent, respectively) of primary cocaine admissions, followed by Texas and Atlanta (23 percent each), St. Louis (22.5 percent), and New York City (approximately 21 percent). Percentages of primary cocaine treatment admissions ranged

between approximately 16 and 18 percent in Denver, Los Angeles, Seattle, and Cincinnati. In the range of 4 to 8 percent of total admissions, the lowest proportions were observed for Hawai'i, San Diego, and Boston.

Route of Administration of Cocaine. Data from 11 CEWG areas indicate that cocaine treatment admissions in 2007 (preliminary data) were most likely to smoke the drug.⁴ Smoking was the most common mode of cocaine administration among primary cocaine treatment admissions in the 11 areas shown in Table 5 and Figure 19. The

⁴SAMHSA's Treatment Episode Data Set report (2003) notes that "Smoked cocaine primarily represents crack or rock cocaine, but can also include cocaine hydrochloride (powder cocaine) when it is free-based." TEDS uses smoked cocaine (crack).

Table 4. Primary Cocaine Treatment Admissions in 15 CEWG Areas as a Percentage of Total Admissions Including and Excluding Primary Alcohol Admissions: FY 2007 or H1 CY 2007

CEWG Areas	Primary Cocaine Admissions	Total Admissions with Primary Alcohol Admissions Excluded ¹		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta ²	2,419	5,558	43.5	10,447	23.2
Boston	840	7,038	11.9	10,705	7.8
Cincinnati ³	957	3,521	27.2	5,325	18.0
Denver	952	3,932	24.2	6,071	15.7
Detroit	1,231	3,152	39.1	4,219	29.2
Hawai'i	169	2,917	5.8	3,994	4.2
Los Angeles	4,281	21,716	19.7	26,657	16.1
Mpls./St. Paul	1,112	4,775	23.3	9,543	11.7
New York City	8,547	29,847	28.6	40,941	20.9
Philadelphia	2,020	5,951	33.9	7,691	26.3
Phoenix	227	1,534	14.8	2,261	10.0
San Diego	512	5,927	8.6	7,277	7.0
Seattle	879	3,067	28.7	5,019	17.5
St. Louis	1,195	3,448	34.7	5,342	22.5
Texas	10,478	33,644	31.1	44,710	23.4

¹Percentages of primary cocaine admissions are obtained from primary admissions excluding primary alcohol for comparability with past data.

²Data are for fiscal year 2007 (October 2006–September 2007).

³Data are for July 2006–June 2007; all other data are for the first half of CY 2007.

SOURCE: January 2008 CEWG reports

Table 5. Major Routes of Administration of Cocaine among Treatment Admissions in 11 CEWG Areas as a Percentage¹ of Primary Cocaine Treatment Admissions: FY 2007 or H1 CY 2007

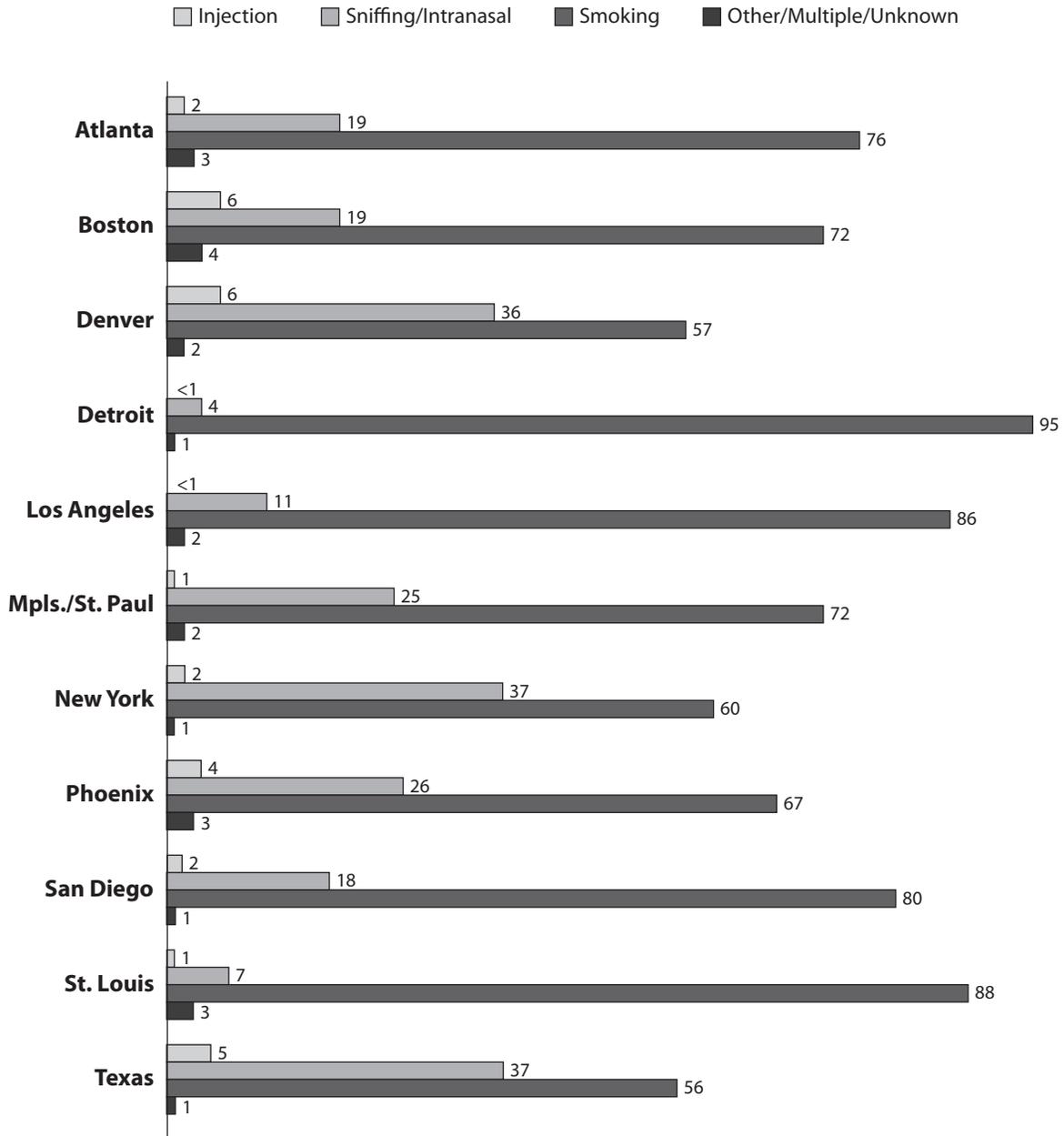
CEWG Areas	Smoked		Inhaled		Injected		Other/Unknown		Total N
	#	%	#	%	#	%	#	%	
Atlanta ²	1,843	76.2	459	19.0	40	1.7	77	3.1	2,419
Boston	605	72.0	157	18.7	47	5.6	31	3.7	840
Denver	539	56.6	345	36.2	53	5.6	15	1.6	952
Detroit	1,174	95.4	43	3.5	0	-	14	1.1	1,231
Los Angeles	3,694	86.3	459	10.7	24	0.6	104	2.4	4,281
Mpls./St. Paul	799	71.8	279	25.1	13	1.2	21	1.9	1,112
New York City	5,169	60.5	3,130	36.6	141	1.7	107	1.2	8,547
Phoenix	153	67.4	59	26	8	3.5	7	3.1	227
San Diego	408	79.6	91	17.8	8	1.6	5	1.0	512
St. Louis	1,053	88.1	89	7.4	17	1.4	36	3.0	1,195
Texas	5,860	55.9	3,915	37.4	554	5.3	149	1.4	10,478

¹Percentages may not sum to 100 due to rounding.

²Atlanta reports FY 2007 (October 2006–September 2007) data; all others report first half of CY 2007 data.

SOURCE: January 2008 CEWG reports

Figure 19. Major Routes of Administration of Cocaine among Treatment Admissions in 11 CEWG Areas as a Percentage¹ of Primary Cocaine Treatment Admissions: FY 2007 or First Half of CY 2007²



¹Percentages rounded to nearest integer.

²Atlanta reports FY 2007 data; all others report first half of CY 2007 data.

SOURCE: January 2008 CEWG reports

range is from approximately 56 percent in Texas to 95 percent in Detroit. The highest percentages of smoking cocaine were reported for Detroit, St. Louis, and Los Angeles.

Inhaling or sniffing cocaine was the major route of administration in approximately 36 to 37 percent of cocaine admissions in Texas, New York City, and Denver and in 25 to 26 percent in Minneapolis/St. Paul and Phoenix. The lowest proportions reporting inhaling or sniffing cocaine as the major administration route, were in Detroit (3.5 percent), St. Louis (7 percent), and Los Angeles (11 percent). Across the CEWG areas reporting data on mode of administration of cocaine, the

proportions of cocaine admissions who reported injecting the drug as the major route tended to be low, with the highest proportions being in Denver and Boston (5.6 percent each) and Texas (5.3 percent).

Gender of Cocaine/Crack Admissions.

Across all 14 reporting CEWG areas in H1 2007, primary cocaine admissions were more likely to be male than female (Table 6). The highest proportions of male cocaine admissions were in Philadelphia (73 percent) and New York City (69 percent), while the lowest percentages were in Texas (51 percent) and Atlanta (52 percent).

Table 6. Demographic Characteristics of Primary Cocaine Treatment Admissions in 14 CEWG Areas as a Percentage¹: FY 2007 or H1 CY 2007²

CEWG Areas	Gender		Race/Ethnicity ³			Age Group	
	Male	Female	White Non-Hispanic	Afr.-Amer. Non-Hispanic	Hispanic	Under 25	35–36 or Older
Atlanta	52	48	28	66	2	NR	NR
Boston	60	40	37	43	16	14	65
Cincinnati	58	42	42	58	NR ⁴	11	69
Denver	60	40	41	22	32	16	57
Detroit	56	44	8	91	1	4	83
Los Angeles	64	36	16	56	24	8	75
Mpls./St. Paul	62	38	46	44	3	16	62
New York City	69	31	15	58	24	7	77
Philadelphia	73	27	29	60	10	11	62
Phoenix	64	36	42	32	24	14	65
San Diego	67	33	26	55	12	14	69 ⁵
Seattle	61	39	*	*	*	10	58 ⁶
St. Louis	59	41	28	70	1	6	76
Texas	51	49	34	32	32	21	49

¹Percentages rounded to the nearest integer.

²Atlanta reports FY 2007 (October 2006–September 2007) data, while Cincinnati reports FY 2007 (July 2006–June 2007) data. All other areas report H1 CY 2007 data.

³CEWG areas differ in the racial/ethnic composition of the general population, which should be taken into account when interpreting these data. Some areas (Philadelphia, Boston, St. Louis) allow more than one race/ethnicity to be coded per case.

⁴NR=Not reported by the CEWG representative.

⁵Represents admissions age 36 or older (San Diego only).

⁶Data from Seattle are for ages 30–39 and 40 and older.

*Seattle reports using noncensus categories: 36 percent White, 44 percent African-American, and 5 percent Hispanic.

SOURCE: January 2008 CEWG reports

Race/Ethnicity of Cocaine/Crack Admissions. Racial/ethnic distributions of cocaine admissions should be interpreted in light of the facts that CEWG areas differ in the racial/ethnic composition of the general population; census categories are not always used in reporting the data; and three areas allow reporting of multiple race/ethnicity categories for one case (so that race/ethnicity counts total more than total cocaine admissions). As shown in Table 6, White non-Hispanics represented less than one-half of cocaine treatment admissions in all 14 areas reporting preliminary 2007 data. The highest percentages of White non-Hispanic cocaine admissions were reported in Minneapolis/St. Paul (46 percent), followed by Cincinnati and Phoenix (42 percent each), and Denver (41 percent). The lowest percentages were in Detroit (8 percent), New York City (15 percent), and Los Angeles (16 percent). African-American non-Hispanics represented 22 to 91 percent of cocaine treatment admissions in the 14 reporting areas. Denver cocaine admissions had the lowest representation from this racial/ethnic group, while Detroit had the highest. Also relatively high were St. Louis, at 70 percent, and Atlanta, at 66 percent, for cocaine treatment admissions classified as African-American non-Hispanic. Finally, Hispanics represented from 1 percent (Detroit and St. Louis) to 32 percent (Texas and Denver) of primary cocaine treatment admissions. Three CEWG areas, Los Angeles, New York City, and Phoenix, reported the percentage of Hispanics at approximately one-quarter of cocaine treatment admissions.

Age of Cocaine/Crack Admissions. In 13 of 14 reporting CEWG areas in H1 2007, more than one-half of the primary cocaine treatment admissions were aged 35–36 or older (or 40 and

older in Seattle), with the largest proportions reported in Detroit (83 percent), followed by New York City (77 percent), St. Louis (76 percent), and Los Angeles (75 percent) (Table 6). In Texas, Denver, and Seattle, proportions of older cocaine admissions were lowest at 49, 57, and 58 percent, respectively. The highest percentages of cocaine treatment admissions younger than 25 were in Texas (21 percent) and Minneapolis/St. Paul and Denver (16 percent each).

Forensic Laboratory Data on Cocaine/Crack

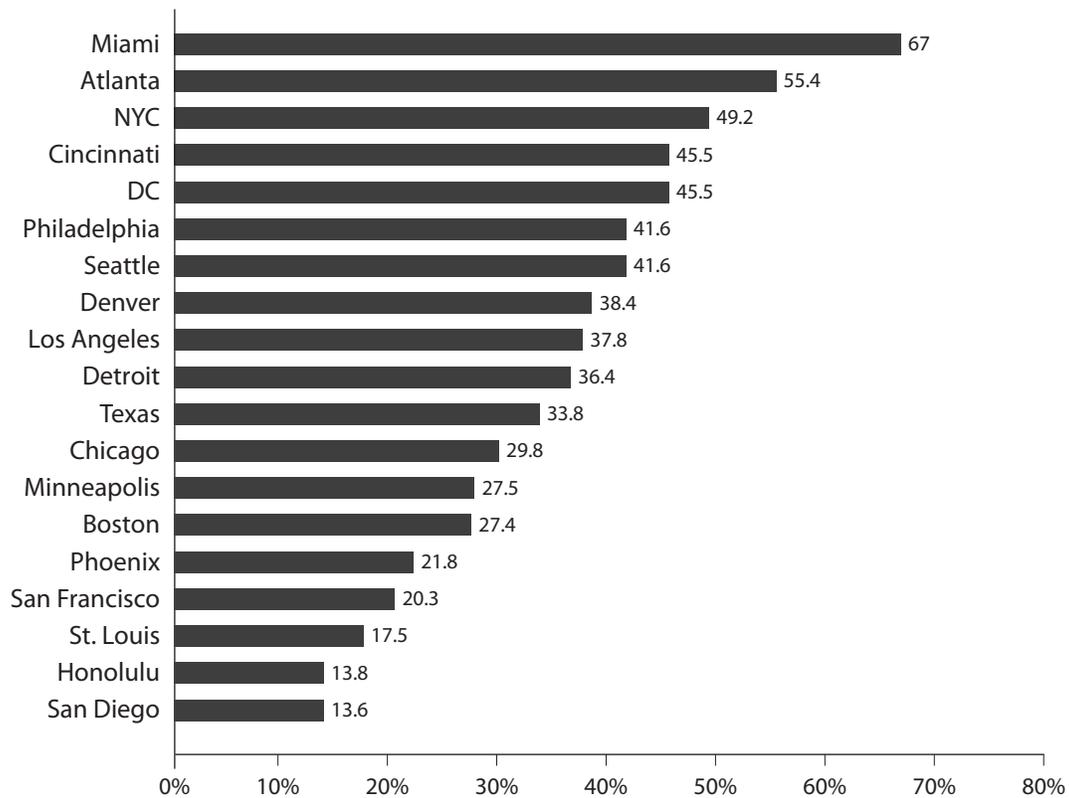
In FY 2007, cocaine was the drug most frequently reported for 10 of the 19 CEWG areas shown on the map in Figure 16. Cocaine items as a percentage of the total drug items reported in the NFLIS system were particularly high in Miami-Dade (67 percent) and Atlanta (approximately 55 percent) (see Figure 20).

Based on rankings shown in Table 1, in all four of the southern region CEWG areas (Miami, Texas, Atlanta, and Washington, DC), cocaine ranked as the most frequently identified drug in forensic laboratories in FY 2007. In two of the three CEWG areas in the northeast region, Philadelphia and New York City, cocaine ranked first among drug items identified, as in one of five areas in the midwestern region (Cincinnati) and three of seven areas in the western region (Los Angeles, Seattle, and Denver).

DEA Price Data on Cocaine

Across 12 CEWG areas in 2006, the lowest minimum street prices per gram of powder cocaine were in Miami (\$13–\$110) (Table 7).

Figure 20. Cocaine Items Identified as a Percentage of Total NFLIS Drug Items, 19 CEWG Areas: FY 2007



SOURCE: NFLIS, DEA; FY 2007=October 2006–September 2007
See Appendix Table 2.

Table 7. Powder Cocaine Retail (Street) Price in 12 CEWG Areas, Ordered by Lowest Minimum Price: 2006

CEWG Areas	Price per Gram
Miami	\$13 – \$110
San Francisco	\$20 – \$67
Washington, DC	\$20 – \$200
Los Angeles	\$20 – \$350
Boston	\$24 – \$100
New York City	\$25 – \$150
St. Louis	\$25 – \$200
Dallas	\$50 – \$100
Chicago	\$50 – \$150
Detroit	\$50 – \$150
Atlanta	\$50 – \$170
Philadelphia	\$70 – \$125

SOURCE: DEA, Office of Domestic Intelligence, Domestic Strategic Intelligence Unit report 2005–2006 Price and Purity Data National Ranges in U.S. Dollars, published October 4, 2007

Heroin

- Heroin primary treatment admissions, as a percentage of total admissions (excluding primary alcohol admissions), were particularly high in Boston (approximately 74 percent), followed by New York City (38 percent) and Detroit (36 percent).
- Injection continued to be the most frequently reported route of heroin administration among primary heroin admissions in most (9 of 11) CEWG areas, particularly areas west of the Mississippi River, where black tar heroin is the most available form of the drug. In New York City and Detroit, the majority of heroin treatment admissions reported inhalation as the major mode of administration in this time period.
- In 16 of 19 CEWG areas, heroin items accounted for less than 9 percent of total drug items identified in forensic laboratories in FY 2007 by NFLIS or local/State laboratories; proportions were highest in Chicago and New York City (12 and 11 percent, respectively).
- Average purity of South American white powder heroin increased in 2006, as in 2005, in one CEWG area (Miami), declined in five in 2006 from 2005 levels, and remained stable in two areas across 8 CEWG areas reporting data for both years. The average purity of Mexican black tar heroin varied across the 10 CEWG areas reporting data for both 2005 and 2006, increasing in 3 areas, decreasing in 5 areas, and remaining stable in 2 areas. DEA average price and purity data continue to show predominance of South American heroin in areas east of the Mississippi River and of Mexican heroin west of the Mississippi. The average price of heroin varied inversely with average purity; Boston and Washington, DC, showed the sharpest declines in average purity levels from 2005 to 2006.

Treatment Admission Data on Heroin

In the first half of 2007, primary heroin treatment admissions, as a proportion of total admissions for substance abuse treatment, ranged from approximately 2 percent in Hawai'i to 49 percent in Boston. After Boston, New York City and Detroit had the highest proportions of heroin admissions, at approximately 27 percent of all admissions in H1 2007 (Table 8). After Hawai'i, the lowest percentages of primary heroin admissions of total admissions were in Atlanta (4 percent) and in Denver and Minneapolis/St. Paul (6 percent each).

When all admissions, including those for whom alcohol was the primary drug, are examined (Table 2), heroin ranked first in Boston and New York City and second in Detroit. When treatment admissions excluding primary alcohol admissions are examined (Table 3), the same two areas rank first, but San Diego is added to Detroit among the areas ranking second in heroin treatment admissions.

Primary heroin admissions, excluding primary alcohol admissions, ranged from 3 percent to 74 percent (Table 8). As with total admissions, Boston, New York City, and Detroit led the CEWG areas in percentages of heroin admissions, excluding primary alcohol admissions, in H1 2007.

Boston reported by far the highest percentage of heroin admissions in the reporting period at close to three-quarters of all admissions, excluding primary alcohol admissions. New York City had the second highest proportion of such heroin admissions (38 percent), followed by Detroit (36 percent). Primary heroin admissions excluding primary alcohol admissions represented approximately one-fourth of such admissions in Philadelphia and St. Louis. In Los Angeles and San Diego, where methamphetamine is the dominant drug, primary heroin admissions, excluding alcohol admissions were at similar levels—at around 23 percent and close to 20 percent, respectively. Hawai'i reported the lowest proportion of primary

heroin admissions (approximately 3 percent of primary treatment admissions excluding primary alcohol admissions).

Route of Administration of Heroin. Injection was the most frequently reported mode of heroin administration by primary heroin admissions in all but 2 of the 11 CEWG areas reporting (Detroit and New York City) (Table 9 and Figure 21). Proportions of heroin admissions injecting ranged from a low of 38 percent in New York City to a high of 84 percent in Los Angeles. Boston and San Diego followed Los Angeles very closely in the percentage of injection heroin treatment

admissions, at 83 percent and 82 percent, respectively. Denver reported 77 percent and Phoenix reported 76 percent for injection heroin treatment admissions in H1 2007. The lowest proportions of injection heroin treatment admissions were in New York City and Detroit.

Inhalation or intranasal use was the most frequent mode of heroin administration reported by heroin admissions in New York City, at 60 percent, and Detroit, at 58 percent, followed distantly by St. Louis, at 41 percent. This mode was relatively rarely reported among treatment admissions in Los Angeles, San Diego, and Phoenix (5 percent, 5 percent, and 7 percent, respectively).

Table 8. Primary Heroin Treatment Admissions in 15 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: FY 2007 and H1 CY 2007¹

CEWG Areas	Primary Heroin Admissions	Total Admissions with Primary Alcohol Admissions Excluded ¹		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta ²	385	5,558	6.9	10,447	3.7
Boston	5,220	7,038	74.2	10,705	48.8
Cincinnati ^{3,4}	586	3,521	16.6	5,325	11.0
Denver	391	3,932	9.9	6,071	6.4
Detroit	1,141	3,152	36.2	4,219	27.0
Hawai'i	82	2,917	2.8	3,994	2.1
Los Angeles	4,908	21,716	22.6	26,657	18.4
Mpls./St. Paul	587	4,775	12.3	9,543	6.2
New York City	11,264	29,847	37.7	40,941	27.5
Philadelphia	1,442	5,951	24.2	7,691	18.7
Phoenix	231	1,534	15.1	2,261	10.2
San Diego	1,174	5,927	19.8	7,277	16.1
Seattle	577	3,067	18.8	5,019	11.5
St. Louis	819	3,448	23.8	5,342	15.3
Texas ⁴	6,261	33,644	18.6	44,710	14.0

¹Percentages of primary heroin admissions are obtained from admissions excluding primary alcohol admissions for comparability with past data.

²Data are for fiscal year 2007 (October 2006–September 2007).

³Data are for July 2006–June 2007.

⁴Other opiates are combined with heroin in classifying primary drug treatment admissions for Texas and Cincinnati.

SOURCE: January 2008 CEWG reports

Phoenix, San Diego, and Denver reported the highest proportions of heroin treatment admissions whose major mode of administration was smoking, at 13 percent, 12 percent, and 11 percent, respectively. Smoking represented 2 percent or less of the heroin modes of administration in 6 of 11 CEWG areas reporting.

Gender of Heroin Admissions. There were proportionally more male than female heroin admissions in 13 of 14 CEWG areas represented in Table 10. The largest proportions of male heroin admissions were in New York City (77 percent), Philadelphia (75 percent), and Boston and Los Angeles (74 percent each), while the largest proportions of females were in Cincinnati (54 percent), followed by St. Louis and Detroit (46 percent and 45 percent, respectively) (Table 10). It should be noted that heroin is reported with other opiates in Cincinnati treatment admissions data.

Race/Ethnicity of Heroin Admissions.

Racial/ethnic distributions of heroin admissions should be interpreted in light of the facts that CEWG areas differ in the racial/ethnic composition of the general population; census categories are not always used in reporting the data; and three areas allow reporting of multiple race/ethnicity categories for one case (so that race/ethnicity counts total more than total heroin admissions). More than one-half of heroin admissions were White non-Hispanic in 9 of the 14 CEWG sites reporting in H1 2007 (Table 10). The highest percentages of African-American non-Hispanic heroin admissions were in Detroit (89), followed by Atlanta (51) and St. Louis (47), consistent with racial/ethnic distributions in those areas. African-American non-Hispanics were least represented among heroin treatment admissions in San Diego (4 percent) and Phoenix (5 percent), while Hispanics figured less

Table 9. Major Routes of Administration of Heroin Among Treatment Admissions in 11 CEWG Areas as a Percentage¹ of Primary Heroin Treatment Admissions: FY 2007 and H1 CY 2007

CEWG Areas ²	Smoked		Inhaled		Injected		Other/Unknown		Total N
	#	%	#	%	#	%	#	%	
Atlanta ³	9	2	45	25	261	68	20	5	385
Boston	32	<1	769	15	4,304	83	115	2	5,220
Denver	43	11	42	11	302	77	4	1	391
Detroit	8	<1	657	58	472	41	4	<1	1,141
Los Angeles	453	9	255	5	4,416	84	84	2	4,908
Mpls./St. Paul	28	5	167	29	381	66	0	0	576 ⁴
New York City	58	<1	6,768	60	4,322	38	116	1	11,264
Phoenix	30	13	17	7	176	76	8	3	231
San Diego	146	12	59	5	959	82	10	<1	1,174
St. Louis	17	2	333	41	962	56	7	<1	819
Texas ⁵	71	1	856	14	3,344	53	1,990 ⁶	32	6,261

¹Percentages may not sum to 100% due to rounding.

²Data were not reported for Cincinnati, Philadelphia, and Seattle.

³Atlanta reports FY 2007 (October 2006–September 2007) data; all others report first half of CY 2007 data.

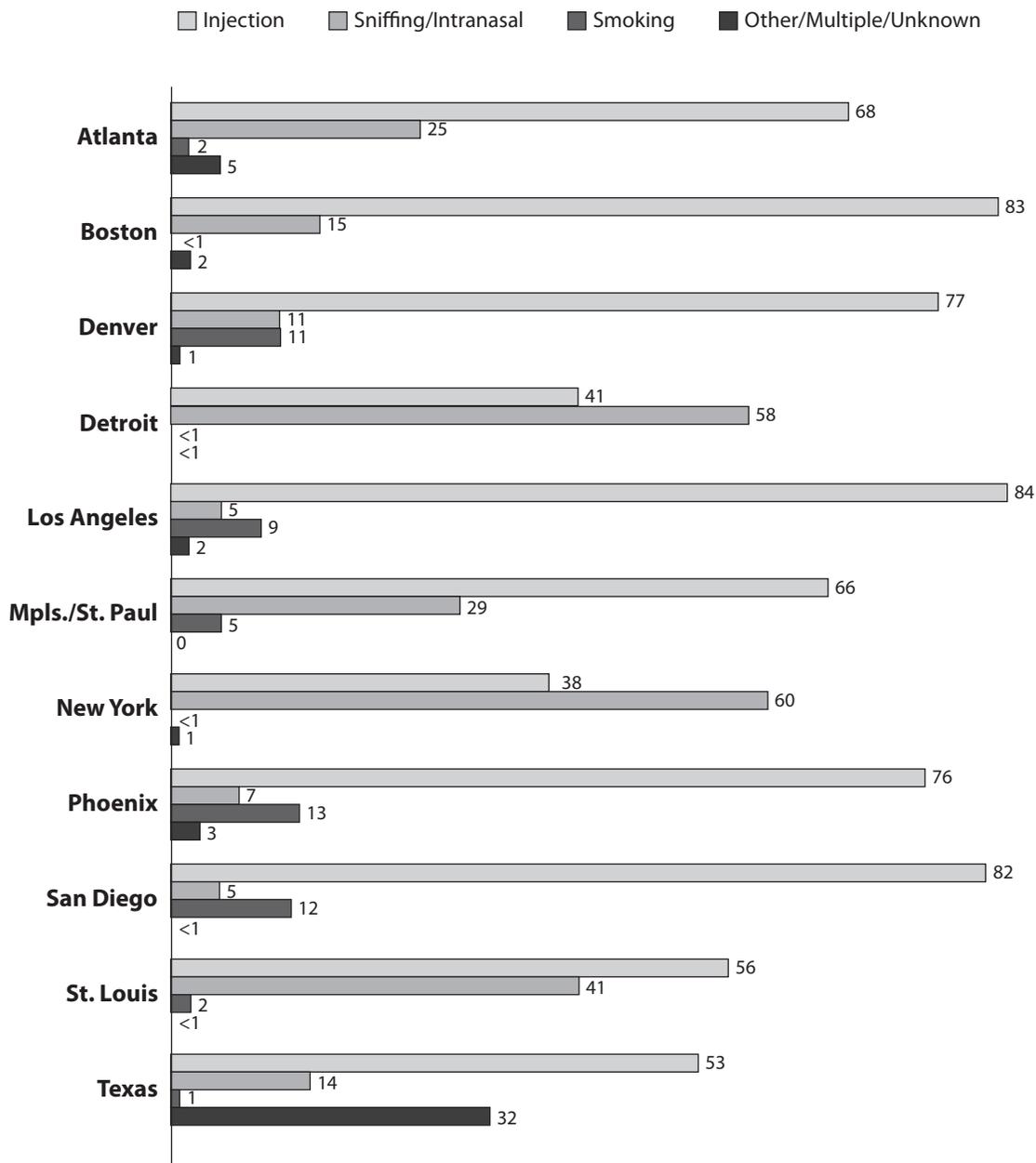
⁴Minneapolis/St. Paul's total is 576, not 587, due to missing data

⁵Other opiates are combined with heroin in classifying primary drug treatment admissions for Texas.

⁶In the "Other/Unknown" category, 1,984 cases of "oral" mode of administration are included.

SOURCE: January 2008 CEWG reports

Figure 21. Major Routes of Administration of Heroin Among Treatment Admissions in 11 CEWG Areas as a Percentage of Primary Heroin Treatment Admissions¹: FY 2007 or First Half of CY 2007²



¹Percentages rounded to the nearest integer.

²Atlanta reports FY 2007 data; all other areas report half-year CY 2007 data.

SOURCE: January 2008 CEWG reports

prominently in heroin admissions in Detroit, St. Louis, and Cincinnati at 1 percent or less. On the other hand, Hispanics represented approximately equal proportions of heroin treatment admissions in New York City and Los Angeles, at nearly one-half each (47–48 percent of admissions, not including primary alcohol admissions). Texas and San Diego also had moderately high percentages of Hispanic heroin treatment admissions excluding primary alcohol admissions (39 percent and 38 percent, respectively). As in Cincinnati, heroin is reported with other opiates in Texas treatment admissions data.

Age of Heroin Admissions. In 8 of 14 reporting CEWG areas, more than one-half of the primary heroin admissions in H1 2007 were 35–36 or older, with the highest proportion in Detroit (91 percent). In St. Louis, 29 percent of heroin treatment admissions were younger than 25, while in Cincinnati, 28 percent were in this younger age group (Table 10). As noted, Cincinnati’s treatment admissions data combine heroin with other opiates.

Table 10. Demographic Characteristics of Primary Heroin Treatment Admissions in 14 CEWG Areas as a Percentage¹: FY 2007 or First Half of CY 2007

CEWG Areas ²	Gender		Race/Ethnicity ³			Age Group	
	Male	Female	White Non-Hispanic	African.-Amer. Non-Hispanic	Hispanic	Under 25	35–36 or Older
Atlanta	66	34	43	51	2	NR ⁴	NR
Boston	74	26	67	12	18	24	41
Cincinnati ⁷	46	54	86	14	-	28	34
Denver	68	32	64	7	25	18	56
Detroit	55	45	10	89	<1	2	91
Los Angeles	74	26	38	10	47	9	73
Mpls./St. Paul	69	31	65	28	3	23	51
New York City	77	23	20	28	48	5	79
Philadelphia	75	25	58	22	12	24	41
Phoenix	70	30	61	5	31	20	62
San Diego ⁵	72	28	51	4	38	16	52
Seattle	61	39	*	*	*	12	53 ⁶
St. Louis	54	46	49	47	1	29	32
Texas ⁷	57	43	52	9	39	26	43

¹Percentages are rounded to the nearest integer.

²Boston, Philadelphia, and St. Louis reported more race/ethnicity admissions than total primary heroin admissions because a case can be classified in more than one race/ethnicity category. Detroit reported four fewer race/ethnicity cases than total primary heroin cases.

³The racial/ethnic population distribution varies across CEWG areas.

⁴NR=Not reported by the CEWG representative.

⁵San Diego reports age categories as 26–35 and 36 and older.

⁶Data from Seattle are for age 26–39 and 40 and older.

⁷Other opiates are combined with heroin in classifying primary drug treatment admissions for Texas and Cincinnati.

*Seattle reports using noncensus categories with 65 percent White, 18 percent African-American, and 4 percent Hispanic.

SOURCE: January 2008 CEWG reports

Forensic Laboratory Data on Heroin

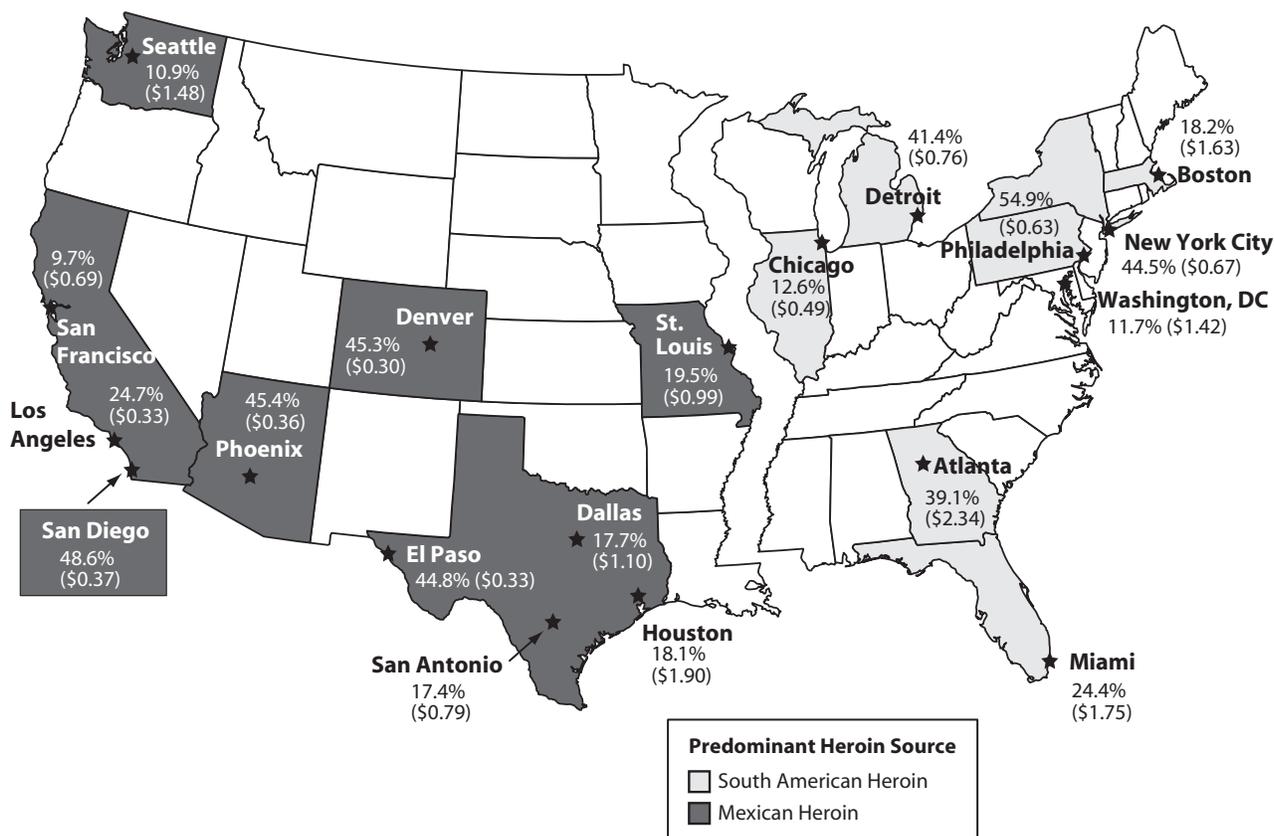
In 16 of the 19 CEWG areas shown earlier in the map in Figure 16, heroin items accounted for less than 9 percent of the total drug items reported by NFLIS. As a proportion of total drug items, heroin items were higher in Chicago (12.2 percent), New York City (10.9 percent), and Philadelphia (9.7 percent) than in other CEWG areas. In Washington, DC; Boston; and Detroit, heroin items accounted for approximately 8 percent of all drug items identified, while heroin items represented between 4 and 5 percent of all drug items in Denver, Seattle, Phoenix, and Cincinnati (see *Appendix Table 2*).

Heroin was not ranked as the number one most frequently identified drug in any of the CEWG areas in FY 2007 (Table 1).

Domestic Monitoring Program Price and Purity Data on Heroin

The map below (Figure 22) depicts the most recent data on the average price per milligram pure and the average percentage of heroin purity across CEWG areas, as reported by the DEA's Domestic Monitor Program for 2006. The data continue to illustrate the predominance of South American heroin in areas east of the Mississippi River and the predominance of Mexican heroin in areas

Figure 22. Domestic Monitor Program—Average Heroin Purity, Price, and Predominant Source in CEWG Areas:¹ 2006



¹Not included here are some types, e.g., Southeast and Southwest Asian heroin.
SOURCE: DMP, DEA

west of the Mississippi. In 2005, South American rather than Mexican heroin emerged for the first time as the predominant form of heroin in St. Louis. However, in 2006, Mexican heroin re-established itself as the predominant form.

Trend data on the average purity of South American heroin per milligram pure are shown in Table 11 for eight CEWG areas. Across the 4 years shown, the average purity per milligram pure was at peak levels in 2003 for the majority of CEWG areas presented in this table (six CEWG areas: Philadelphia, New York City, Detroit, Atlanta, Miami, and Boston).

Across the eight CEWG areas where 2003–2006 data were reported, the average price per milligram pure for South American heroin tended to be inversely related to the average purity of the drug. This occurred, for example, in Atlanta and Boston, where average purity levels were high and average prices low in 2003, as compared with 2006, when average purity was lower and average prices higher.

From 2005 to 2006, average purity levels for South American heroin remained stable or declined in most areas. Miami was the one

exception; there, average purity levels increased from 19.4 percent in 2005 to 24.4 percent in 2006 (Table 11). Among those areas with declining average purity, Boston and Washington, DC, represented the sharpest declines (29.4 to 18.2 and 20.2 to 11.7 percent, respectively).

Similar data on Mexican black tar heroin are presented in Table 12 for another 11 CEWG areas. The data illustrate a different pattern than that reported for South American heroin over the 4-year period. For Mexican black tar, average purity levels per milligram pure rose or remained relatively unchanged from 2003 to 2006 in 8 of the 11 CEWG areas. Decreases in average purity over the time period were considerable (greater than or equal to 5 percentage points) in Los Angeles (29.7 to 24.7 percent) and Houston (28.2 to 18.1 percent), with a slight decrease in San Francisco (11.1 to 9.7 percent)

The increase in average purity of Mexican black tar heroin was particularly striking in Denver, up 27 percentage points. Average purity levels in Denver increased 15 percentage points from 2003 to 2004 and another 10 percentage points

Table 11. Average Percent Purity and Average Price in Dollars of South American Heroin in 8 CEWG Areas, Ordered by Highest Purity in 2006: 2003–2006

CEWG Areas	2003 Avg. Purity ¹	2003 Avg. Price	2004 Avg. Purity	2004 Avg. Price	2005 Avg. Purity	2005 Avg. Price	2006 Avg. Purity	2006 Avg. Price
Philadelphia	59.6	\$.60	51.6	\$.71	54.9	\$.58	54.9	\$.63
New York City	53.5	\$.48	43.3	\$.62	49.4	\$.46	44.5	\$.67
Detroit	47.9	\$.80	38.9	\$.86	46.6	\$.76	41.4	\$.76
Atlanta	56.8	\$1.29	40.9	\$2.30	39.3	\$2.04	39.1	\$2.34
Miami	25.8	\$.90	15.7	\$1.53	19.4	\$1.36	24.4	\$1.75
Boston	40.3	\$.73	27.8	\$.87	29.4	\$.88	18.2	\$1.63
Chicago	16.6	\$.45	13.8	\$.56	17.1	\$.45	12.6	\$.49
Wash., DC	20.0	\$.73	15.6	\$1.06	20.2	\$.95	11.7	\$1.42

¹The “peak year,” based on the 4-year period, was 2003 (6 areas).

SOURCE: DEA, 2006 Heroin Domestic Monitor Program (DMP), published September 2007

from 2004 to 2005, before stabilizing in the most recent period, 2005 to 2006.

The average price per milligram pure of Mexican black tar heroin tended to be lower in areas where average purity of the drug was higher, as was the pattern with South American heroin.

One dramatic example of the inverse relationship of average price and average purity was seen in Houston, where average price per milligram pure increased 322 percent from 2003 to 2006, while purity levels fell from 28.2 to 18.1 percent (Table 12).

Table 12. Average Percent Purity and Average Price of Mexican Heroin per Milligram Pure in 11 CEWG Areas, Ordered by Highest Average Purity in 2006: 2003–2006

CEWG Areas	2003 Avg. Purity	2003 Avg. Price	2004 Avg. Purity	2004 Avg. Price	2005 Avg. Purity	2005 Avg. Price	2006 Avg. Purity	2006 Avg. Price
San Diego	44.9	\$0.25	49.7	\$0.20	55.9	\$0.15	48.6	\$0.37
Phoenix	45.3	\$0.42	47.7	\$0.49	53.1	\$0.22	45.4	\$0.36
Denver	18.7	\$0.81	34.4	\$0.46	44.3	\$0.42	45.3	\$0.30
El Paso	44.7	\$0.40	50.5	\$0.27	44.7	\$0.40	44.8	\$0.33
Los Angeles	29.7	\$0.34	31.4	\$0.23	31.1	\$0.33	24.7	\$0.33
Houston	28.2	\$0.45	24.8	\$0.44	23.7	\$1.14	18.1	\$1.90
St. Louis	14.0	\$1.54	14.4	\$1.89	NR ¹	NR	19.5	\$0.99
Dallas	13.3	\$0.98	16.3	\$0.90	11.6	\$1.11	17.7	\$1.10
San Antonio	8.2	\$1.97	6.4	\$2.24	11.2	\$0.56	17.4	\$0.79
Seattle	10.4	\$1.18	10.4	\$1.18	10.8	\$1.23	10.9	\$1.48
San Francisco	11.1	\$0.98	11.1	\$0.98	12.3	\$0.89	9.7	\$0.69

¹NR=Not reported because South American heroin was the most dominant form of heroin reported in 2005 in St. Louis.
 SOURCE: DEA, 2006 Heroin Domestic Monitor Program (DMP), published September 2007

Other Opiates/Narcotic Analgesics

- Treatment admissions for primary abuse of other opiates, as a percentage of total admissions excluding primary alcohol admissions, ranged from less than 1 to approximately 9 percent in 12 reporting CEWG areas; they were highest in Minneapolis/St. Paul.
- Of total drug items identified in forensic laboratories in CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in FY 2007. In Philadelphia, Boston, and Cincinnati, oxycodone ranked fourth in drug items identified, and it ranked fifth in Phoenix and Minneapolis. Hydrocodone ranked fifth in frequency of drug items identified in Atlanta, Texas, San Diego, and Cincinnati.
- Methadone ranked fifth in drug items identified in forensic laboratories in New York City; eighth in Atlanta, San Francisco, Seattle, and Washington, DC; ninth in Cincinnati; and tenth in Boston.
- Buprenorphine ranked sixth in drug items identified in Boston, and both methadone and buprenorphine were among the top 10 drug items in Washington, DC, although numbers are small.

Treatment Admission Data on Other Opiates

In the FY 2007 and H1 2007 reporting periods, 12 CEWG areas provided data on treatment admissions for primary abuse of opiates other than heroin (2 more areas, Cincinnati and Texas, provided combined heroin and other opiates data, which is reported in the heroin section above). When primary alcohol admissions are included among total admissions, alcohol's dominance as the most frequent drug of abuse in 8 of 12 reporting areas diminishes the impact of other opiates on total admission percentages. These range from 0.5 percent in Philadelphia to nearly 5.0 percent in Minneapolis/St. Paul (Table 13).

Excluding primary alcohol admissions, the other opiates admissions group accounted for more than 9 percent of the primary treatment admissions in Minneapolis/St. Paul and for less than 1 percent of such drug admissions in Philadelphia (Table 13). Between these two extremes, the representation of primary admissions for other opiates accounted for between 4 and 5 percent of drug admissions (excluding primary alcohol admissions) in five CEWG areas (Boston, Seattle, San Diego, Denver, and Phoenix) and for around 2 to 3 percent of such admissions in another four CEWG areas (Detroit, Hawai'i, Los

Angeles, and St. Louis) (Table 13). The Seattle area reports much higher percentages of treatment opiates primary among private payment treatment admissions.

Gender of Other Opiate Admissions.

Females were more prominent in this admission group than in any other drug admission group in 9 of 11 reporting CEWG areas. Males predominated in all but two areas, Detroit and Phoenix, where percentages of females were 62 and 53 percent, respectively (Table 14). However, the gender differences were relatively small in all other areas, except New York City and Boston, where 87 and 63 percent of other opiate admissions, respectively, were male. Philadelphia had less than 50 other opiate treatment admissions in the first half of 2007. Females predominated among these admissions, at 74 percent, but it must be noted that these demographic patterns are based on low numbers.

Race/Ethnicity of Other Opiate Admissions. Racial/ethnic distributions of other opiate admissions should be interpreted in light of the facts that CEWG areas differ in the racial/ethnic composition of the general population; census categories are not always used in reporting the

data; and three areas allow reporting of multiple race/ethnicity categories for one case (so that race/ethnicity counts total more than total other opiate admissions). In the first half of 2007, the majority of other opiate admissions in CEWG areas were White non-Hispanic. The exceptions were Detroit, where a majority (65 percent) of other opiate treatment admissions were African-American non-Hispanic, and Los Angeles, where a relatively high percentage was Hispanic (21 percent). The proportions of White non-Hispanic other opiate admissions ranged from 24 percent (Detroit) to 89 percent (Boston).

Besides Detroit, the highest percentages of African-American non-Hispanics were reported among other opiate admissions in St. Louis (20 percent). Philadelphia reported 24 percent based on small numbers of admissions. Besides Los

Angeles, the highest proportions of Hispanics were reported among other opiate admissions in New York City, San Diego, Phoenix, and Denver, at 12 percent (Table 14). (Philadelphia reported 15 percent Hispanics in this primary drug admissions category with small numbers.)

Age of Other Opiate Admissions. In Detroit, Los Angeles, New York City, Minneapolis/St. Paul, St. Louis, and Denver, a majority of the primary other opiate admissions were aged 35 or older (51–73 percent), led by Detroit. The age group younger than 25 was more highly represented among other opiate admissions in Seattle (37 percent) and Phoenix and Boston (28 percent each). Philadelphia also had higher percentages (36 percent) of younger other opiate admissions, despite small numbers ($n=39$) (Table 14).

Table 13. Treatment Admissions for Primary Other Opiate Abuse in 12 CEWG Areas¹ as a Percentage of Total Admissions Including and Excluding Primary Alcohol Admissions: FY 2007 or H1 CY 2007 (January–June 2007)

CEWG Areas	Primary Other Opiate Admissions	Total Admissions with Primary Alcohol Admissions Excluded ²		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Boston	364	7,038	5.2	10,705	3.4
Denver	179	3,932	4.6	6,071	2.9
Detroit	55	3,152	1.7	4,219	1.3
Hawai'i	97	2,917	3.3	3,994	2.4
Los Angeles	621	21,716	2.9	26,657	2.3
Mpls./St. Paul	443	4,775	9.3	9,543	4.6
New York City	368	29,847	1.2	40,941	0.9
Philadelphia	39	5,951	0.7	7,691	0.5
Phoenix	65	1,534	4.2	2,261	2.9
San Diego	276	5,927	4.7	7,277	3.8
Seattle	157	3,067	5.1	5,019	3.1
St. Louis	83	3,448	2.4	5,342	1.6

¹Atlanta did not report primary other opiates treatment admission data for fiscal year 2007 (October 2006–September 2007). Other opiates, which were combined with heroin for Texas and Cincinnati, are reported for these sites in the heroin section of this report.

²Percentages of other opiate admissions are obtained from admissions excluding primary alcohol admissions for comparability with past data.

SOURCE: January 2008 CEWG reports

Forensic Laboratory Data on Other Opiates

Of the narcotic analgesic/opiate items identified by forensic laboratories across CEWG areas in FY 2007, oxycodone and hydrocodone were the two most frequently reported in most areas. However, they generally accounted for approximately 1 percent or less of all drug items reported in each area (Table 15 and Appendix Table 2).

Oxycodone ranked fourth in drug items identified in Boston (4.0 percent), Philadelphia (3.0 percent), and Cincinnati (2.2 percent), after heroin (Table 1). It ranked fifth in frequency of drug items identified in forensic laboratories in Minneapolis/St. Paul and Phoenix (although

representing 1.4 and 1.0 percent of drug items, respectively, in those areas).

Oxycodone ranked sixth in frequency of drugs identified by NFLIS in FY 2007 in Seattle, high relative to other sites, at 3.6 percent of drug items identified. In Texas, hydrocodone ranked fifth (before MDMA and heroin and after methamphetamine and alprazolam) among drugs identified in NFLIS FY 2007 data, with 4.1 percent of drug items found to contain hydrocodone. In four other areas, relatively high percentages of hydrocodone items were identified, namely Atlanta, at 2.7 percent; Seattle, at 1.8 percent; San Diego, at 1.5 percent; and Cincinnati, at 1.4 percent (Table 15).

Table 14. Demographic Characteristics of Primary Treatment Admissions for Opiates Other than Heroin in 11 CEWG Areas, by Percent¹: FY 2007²

CEWG Areas	Gender		Race/Ethnicity ³			Age Group	
	Male	Female	White Non-Hispanic	African.-Amer. Non-Hispanic	Hispanic	Under 25	35-36 or Older
Boston	63	37	89	6	4	28	44
Denver	57	43	83	3	12	12	51
Detroit	38	62	24	65	9	7	73
Los Angeles	60	40	62	9	21	13	65
Mpls./St. Paul	53	47	84	4	3	22	54
New York City	87	13	74	11	12	20	59
Philadelphia	74	26	57	24	15	36	33
Phoenix	47	53	82	3	12	28	40
San Diego ⁴	58	42	80	4	12	25	45 ⁴
Seattle ⁵	57	43	*	*	*	37	24 ⁵
St. Louis	58	42	67	20	9	18	51

¹Percentages are rounded to the nearest integer.

²All areas report H1 CY 2007 data.

³CEWG areas differ in the racial/ethnic composition of the general population, which should be taken into account when interpreting these data. Some areas (Philadelphia, Boston, St. Louis) allow more than one race/ethnicity to be coded per case.

⁴Represents admissions age 36 or older (San Diego only).

⁵Data from Seattle are for age 30-39 and 40 and older.

*Seattle reports race in noncensus categories; these are 74 percent White, 8 percent African-American, and 3 percent Hispanic.

SOURCE: January 2008 CEWG reports

Table 15. Number and Percentage of Selected Narcotic Analgesic Items Reported by Forensic Laboratories in 19 CEWG Areas to Total Items Identified: FY 2007¹

CEWG Areas	Oxycodone Number (%)	Hydrocodone Number (%)	Methadone Number (%)	Fentanyl Number (%)	Buprenorphine Number (%)	Total Items
Atlanta	243 (1.7)	381 (2.7)	100*	0 (-)	0 (-)	14,317
Boston	992 (4.0)	220*	151*	36*	380 (1.5)	24,934
Chicago	57*	255*	88*	9*	31*	82,010
Cincinnati	315 (2.2)	211 (1.4)	64*	0 (-)	0 (-)	14,618
Denver	71 (1.0)	87 (1.2)	8*	0 (-)	2*	7,132
Detroit	62*	37*	6*	21*	5*	7,391
Honolulu	11*	12*	9*	0 (-)	0 (-)	3,213
Los Angeles	93*	413*	57*	5*	14*	59,768
Miami	116*	49*	16*	0 (-)	1*	30,014
Mpls./St. Paul	65 (1.4)	49 (1.1)	12*	1*	2*	4,600
New York City	415*	359*	566 (1.1)	17*	50*	51,356
Philadelphia	782 (3.0)	195*	149*	148*	43*	25,949
Phoenix	91 (1.0)	83*	15*	3*	6*	9,412
San Diego	130*	298 (1.5)	33*	7*	12*	20,382
San Francisco	52*	53*	57*	0 (-)	0 (-)	10,695
Seattle	144 (3.6)	72 (1.8)	51 (1.3)	0 (-)	8*	4,026
St. Louis	106 (1.0)	100 (1.0)	14*	16*	10*	10,522
Wash., DC	40 (1.2)	4*	8*	1*	6*	3,251
Texas	216*	2,323 (4.1)	171*	NR ²	NR	56,537

¹ FY 2007 is October 2006–September 2007.

²NR = Not reported.

*Only percentages of 1.0 or higher are reported in this table.

NOTE: All data were requested from NFLIS between 12/10/07 and 12/13/07. See *Appendix Table 2*.

SOURCE: Texas NFLIS data were provided by the Texas Department of Public Safety, accessed by the Texas area member; data for the other areas were provided by NFLIS, DEA

Benzodiazepines/Depressants

Treatment Admission Data on Benzodiazepines

In most CEWG area treatment data systems, benzodiazepines are included with other depressants, barbiturates, and sedative/hypnotics; these admissions continued to account for small proportions of total treatment admissions. However, some CEWG areas note that benzodiazepines or

sedative/hypnotics are secondary drugs of abuse among some treatment admissions.

Forensic Laboratory Data on Benzodiazepines

In FY 2007, 3 benzodiazepine-type items were the most frequently reported benzodiazepines identified by forensic laboratories in 19 CEWG areas. Table 16 shows the numbers and percentages of

Table 16. Number and Percentage of Selected Benzodiazepine Items Reported by Forensic Laboratories in 19 CEWG Areas to Total Items Identified: FY 2007¹

CEWG Areas	Alprazolam	Percent of Total	Clonazepam	Percent of Total	Diazepam	Percent of Total	Total Items
Atlanta	436	3.0	66	*	47	*	14,317
Boston	242	1.0	473	1.9	120	*	24,934
Chicago	136	*	37	*	44	*	82,010
Cincinnati	131	*	55	*	73	*	14,618
Denver	25	*	25	*	24	*	7,132
Detroit	90	1.2	14	*	19	*	7,391
Honolulu	10	*	4	*	9	*	3,213
Los Angeles	146	*	116	*	117	*	59,768
Miami	380	1.3	29	*	27	*	30,014
Mpls./St. Paul	15	*	13	*	14	*	4,600
New York City	732	1.4	234	*	77	*	51,356
Philadelphia	758	2.9	121	*	86	*	25,949
Phoenix	40	*	32	*	18	*	9,412
San Diego	80	*	78	*	93	*	20,382
San Francisco	17	*	36	*	55	*	10,695
Seattle	17	*	23	*	21	*	4,026
St. Louis	198	1.9	35	*	43	*	10,522
Wash., DC	5	*	1	*	1	*	3,251
Texas	3,497	6.2	470	*	344	*	56,537

¹ FY 2007 is October 2006–September 2007.

*Only percentages of 1.0 or higher are reported in this table.

NOTE: All data were requested from NFLIS between 12/10/07 and 12/13/07. See *Appendix Table 2*.

SOURCE: Texas NFLIS data were provided by the Texas Department of Public Safety, accessed by the Texas area member; data for the other areas were provided by NFLIS, DEA

drug items containing alprazolam, clonazepam, and diazepam in each of the 19 CEWG areas.

Alprazolam. In the 19 CEWG areas for which NFLIS data were reported for FY 2007, the highest percentages of alprazolam drug items identified were in Texas (6 percent), Atlanta and Philadelphia (approximately 3 percent each), and St. Louis, with approximately 2 percent. Alprazolam drug items were reported at approximately 1 percent in New York City, Miami, Detroit, and Boston, and they totaled less than 1 percent in the remaining CEWG metropolitan areas (Table 16).

In Table 1, which shows the rankings of the most frequently reported drugs in NFLIS FY 2007 data, alprazolam ranked fourth in frequency among the top 10 drug items identified in 3 CEWG areas: Texas, Atlanta, and New York City.

At the same time, clonazepam figured as the fifth-ranked drug identified in Boston.

Clonazepam. Drug items containing clonazepam accounted for approximately 2 percent of all drug items in Boston and nearly 1 percent in Texas. Its presence was minimal in all other CEWG areas (Table 16).

Diazepam. Drug items containing diazepam accounted for less than 1 percent of all drug items in each of the 19 CEWG areas (Table 16). However, diazepam ranked eighth in San Diego and Cincinnati, ninth in Los Angeles, and tenth in Texas and San Francisco among drug items identified in NFLIS forensic laboratories in FY 2007 (Table 1).

Methamphetamine

- The proportions of primary treatment admissions (excluding primary alcohol admissions) for methamphetamine abuse in 15 reporting CEWG areas were especially high in Hawai'i, San Diego, and Phoenix, at 53, 46, and 44 percent, respectively. They were also relatively high in Los Angeles (30 percent) and Denver (23 percent).
- Methamphetamine ranked first in treatment admissions as a percentage of all treatment admissions (including primary alcohol admissions) in three areas: Hawai'i, Los Angeles, and San Diego. The rank of first applied to an additional area, Phoenix, when treatment admissions excluding primary alcohol admissions were considered.
- Methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in three areas—Honolulu, San Francisco, and Minneapolis/St. Paul—in FY 2007. The largest proportions of methamphetamine items identified by forensic laboratories were reported in Honolulu (52 percent), followed by San Francisco and Minneapolis/St. Paul (37 and 33 percent, respectively). Conversely, less than 1 to 2 percent of drug items identified as containing methamphetamine were reported in most CEWG metropolitan areas east of the Mississippi River, including Washington, DC; Chicago; Philadelphia; New York City; Cincinnati; Miami; Detroit; and Boston.

Treatment Admission Data on Methamphetamine

Specific data on primary methamphetamine treatment admissions in the first half of 2007 were reported for 15 CEWG areas. As a percentage of total treatment admissions, including primary alcohol admissions, Hawai'i and San Diego had the highest proportions of methamphetamine admissions, at 38–39 percent, followed by Phoenix (30 percent), and Los Angeles (24 percent) (Table 17).

When primary alcohol admissions are excluded, five CEWG areas, all east of the Mississippi River, reported that either no admissions (Cincinnati, Detroit, and Philadelphia) or less than 1 percent (Boston and New York City) were for primary methamphetamine abuse (Table 17).

In the first half of 2007, more than one-half of treatment admissions excluding primary alcohol admissions in Hawai'i (53 percent) were for primary methamphetamine abuse. In the same period, primary methamphetamine admissions accounted for approximately 46 and 44 percent of primary admissions excluding primary alcohol admissions in San Diego and Phoenix, respectively,

approximately 30 percent in Los Angeles, and 23 percent in Denver. St. Louis, Boston, and New York City reported the lowest percentages of such admissions (Table 17).

Route of Administration of Methamphetamine. In the 10 CEWG areas represented in Table 18, smoking was the most common mode of administering methamphetamine among primary methamphetamine admissions. Smoking was reported at levels ranging from approximately 55–56 percent in New York City, Texas, and St. Louis to 81 percent in Phoenix. Texas and St. Louis had the largest proportions of methamphetamine admissions who injected the drug (approximately 31 percent and 25 percent, respectively), while the highest percentage reporting inhalation as the major administration mode for methamphetamine was in New York City, at 17 percent, followed by Denver, at approximately 16 percent (Table 17).

Gender of Methamphetamine Admissions. In 11 CEWG areas reporting on the gender of primary methamphetamine admissions,

females predominated in Atlanta (61 percent), while the gender split was nearly equal in Phoenix. The largest proportions of male methamphetamine admissions were in New York City, at 87 percent, and Boston, at 85 percent. In eight other metropolitan CEWG areas reporting gender data, females represented between 13 and 43 percent of the primary methamphetamine admissions, with Texas reporting that 56 percent of methamphetamine admissions in H1 2007 were female (Table 19).

Race/Ethnicity of Methamphetamine Admissions. Racial/ethnic distributions of methamphetamine admissions should be interpreted in light of the facts that CEWG areas differ in the racial/ethnic composition of the general population; census categories are not always used in reporting the data; and three areas allow reporting of multiple race/ethnicity categories for one case (so that race/ethnicity counts total more than total methamphetamine admissions). The racial/ethnic distribution of primary methamphetamine

Table 17. Primary Methamphetamine Treatment Admissions in 15 CEWG Areas as a Percentage of Total Admissions Including and Excluding Primary Alcohol Admissions: FY 2007 and H1 CY 2007 (January–June 2007)

CEWG Areas	Primary Methamphetamine Admissions	Total Admissions with Primary Alcohol Admissions Excluded ¹		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta ²	854	5,558	15.4	10,447	8.2
Boston	55	7,038	0.8	10,705	0.5
Cincinnati ^{3,4}	–	3,521	–	5,325	–
Denver	898	3,932	22.8	6,071	14.8
Detroit ⁴	–	3,152	–	4,219	–
Hawai'i	1,546	2,917	53.0	3,994	38.7
Los Angeles	6,410	21,716	29.5	26,657	24.0
Mpls./St. Paul	727	4,775	15.2	9,543	7.6
New York City	117	29,847	0.4	40,941	0.3
Philadelphia ⁴	–	5,951	–	7,691	–
Phoenix	670	1,534	43.7	2,261	29.6
San Diego	2,744	5,927	46.3	7,277	37.7
Seattle	503	3,067	16.4	5,019	10
St. Louis	151	3,448	4.4	5,342	2.8
Texas ⁵	5,380	33,644	16.0	44,710	12.0

¹Percentages of primary methamphetamine admissions are obtained from admissions, excluding primary alcohol admissions, for comparability with past data.

²Data are for fiscal year 2007 (October 2006–September 2007).

³Data are for July 2006–June 2007.

⁴Cincinnati, Detroit, and Philadelphia report no primary methamphetamine treatment admissions and minimal primary amphetamine admissions.

⁵Texas does not separate methamphetamine from amphetamine when classifying primary drug in treatment admissions.

SOURCE: January 2008 CEWG reports

treatment admissions in 10 CEWG metropolitan areas reporting for H1 2007 showed that nearly all (99 percent) of the methamphetamine treatment admissions in St. Louis were White non-Hispanic, as were between 82 and 87 percent in Minneapolis/St. Paul, Texas, Atlanta, and Boston (Table 19). At the low end of the distribution, a little more than one-third of methamphetamine admissions were White non-Hispanic in Los Angeles, and a little more than one-half of such admissions were White non-Hispanic in San Diego (52 percent).

While African-American non-Hispanics accounted for only a small percentage of primary methamphetamine admissions in reporting CEWG areas (zero to 10 percent), the largest percentage of African-American non-Hispanic methamphetamine treatment admissions was in New York City (10 percent). The highest proportions of Hispanic methamphetamine treatment admissions were reported in Los Angeles (55 percent) and San Diego (32 percent), followed by

Denver and New York City (15 and 14 percent, respectively). Proportions of African-American methamphetamine admissions were lowest in Minneapolis/St. Paul, while proportions of Hispanics among primary methamphetamine treatment admissions were lowest in St. Louis, Atlanta, and Minneapolis/St. Paul (Table 19).

Age of Methamphetamine Admissions.

In the 10 CEWG areas for which age of methamphetamine admissions was reported, the majority of methamphetamine admissions were 35 years of age or older in Boston and New York City (65 percent and 57 percent, respectively). Minneapolis/St. Paul had the highest proportions of methamphetamine admissions younger than 25 (37 percent), followed by Los Angeles, at 32 percent, and Seattle, at 31 percent. Texas, Phoenix, Denver, and San Diego reported that between 20 and 29 percent of methamphetamine admissions were younger than 25, while Boston, New York

Table 18. Major Routes of Administration of Methamphetamine Among Treatment Admissions in 10 CEWG Areas as a Percentage¹ of Primary Methamphetamine Treatment Admissions: FY 2007 or H1 CY 2007²

CEWG Areas	Smoked		Inhaled/Snorted		Injected		Other/Unknown		Total N
	#	%	#	%	#	%	#	%	
Atlanta	516	60.4	126	14.8	101	11.8	111	13.1	854
Boston	34	61.8	2	3.6	11	20	8	14.5	55
Denver	556	61.9	142	15.8	173	19.3	27	3.0	898
Los Angeles	4,876	76.1	971	15.1	380	5.9	183	2.9	6,410
Mpls./St. Paul	516	73.1	84	11.9	78	11	28	4.0	706
New York City	64	54.7	20	17.1	23	19.7	10	8.5	117
Phoenix	544	81.2	50	7.5	57	8.5	19	2.8	670
San Diego	2,024	73.8	290	10.6	382	13.9	48	1.7	2,744
St. Louis	85	56.3	23	15.2	38	25.2	5	3.3	151
Texas ³	2,945	54.7	493	9.2	1,687	31.3	255 ⁴	4.6	5,380

¹Percentages may not sum to 100 due to rounding.

²Atlanta reports FY 2007 (October 2006–September 2007) data; all others report H1 CY 2007 data.

³Includes amphetamine as well as methamphetamine.

⁴Some 248 "oral" administration for Texas were classified as "Other."

SOURCE: January 2008 CEWG reports

City, and St. Louis had relatively low percentages of young methamphetamine treatment admissions (less than 15 percent each younger than 25) (Table 19).

Forensic Laboratory Data on Methamphetamine

In the FY 2007 forensic laboratory data for CEWG areas, shown earlier in Figure 16, methamphetamine was the drug identified most frequently in Honolulu (approximately 52 percent of total drug items) and San Francisco (37 percent). Items containing methamphetamine were next most frequently identified among total drug

items in Minneapolis/St. Paul (33 percent) and Phoenix (around 31 percent). Methamphetamine items were nearly equal as a proportion of drug items identified in Los Angeles and San Diego, at approximately 25–26 percent (Figure 23). In eight of the CEWG reporting areas, less than 2 percent of the total drug items contained methamphetamine; all were in areas east of the Mississippi River (*Appendix Table 2*).

Methamphetamine ranked first in drug items seized in Minneapolis/St. Paul, Honolulu, and San Francisco in the first half of 2007 (Table 1). Drug items containing methamphetamine ranked second in frequency of identification in forensic laboratories in Atlanta, San Diego, and Phoenix.

Table 19. Demographic Characteristics of Primary Methamphetamine Treatment Admissions in 11 CEWG Areas by Percent¹: FY 2007 or First Half of CY 2007²

CEWG Areas	Gender		Race/Ethnicity ³			Age Group	
	Male	Female	White Non-Hispanic	African-Amer. Non-Hispanic	Hispanic	Under 25	35–36 or Older
Atlanta	39	61	84	2	<1	NR ⁴	NR
Boston	85	15	82	4	11	11	65
Denver	57	43	80	2	15	26	38
Los Angeles	60	40	35	4	55	32	33
Mpls./St. Paul	61	39	87	1	4	37	29
New York City	87	13	68	10	14	13	57
Phoenix	47	53	69	3	22	28	34
San Diego	58	42	52	6	32	21	48 ⁵
Seattle ⁶	57	43	*	*	*	31	22 ⁶
St. Louis	58	42	99	0	0	14	46
Texas ⁷	44	56	85	2	12	29	34

¹Percentages rounded to the nearest integer.

²Atlanta reports FY 2007 (October 2006–September 2007) data; all other areas report H1 CY 2007 data.

³CEWG areas differ in the racial/ethnic composition of the general population, which should be taken into account when interpreting these data. Some areas (Philadelphia, Boston, St. Louis) allow more than one race/ethnicity to be coded per case.

⁴NR=Not reported by the CEWG representative.

⁵Represents admissions age 36 or older.

⁶Data from Seattle are for age 30–39, and 40 and older.

⁷Includes amphetamine as well as methamphetamine.

*Seattle does not use census categories to report race/ethnicity; the percentages are 76 percent White, 3 percent African-American, and 5 percent Hispanic.

SOURCE: January 2008 CEWG reports

DEA Average Price Data on Methamphetamine

Across 12 CEWG areas in 2006, the average street price per gram of powder methamphetamine was

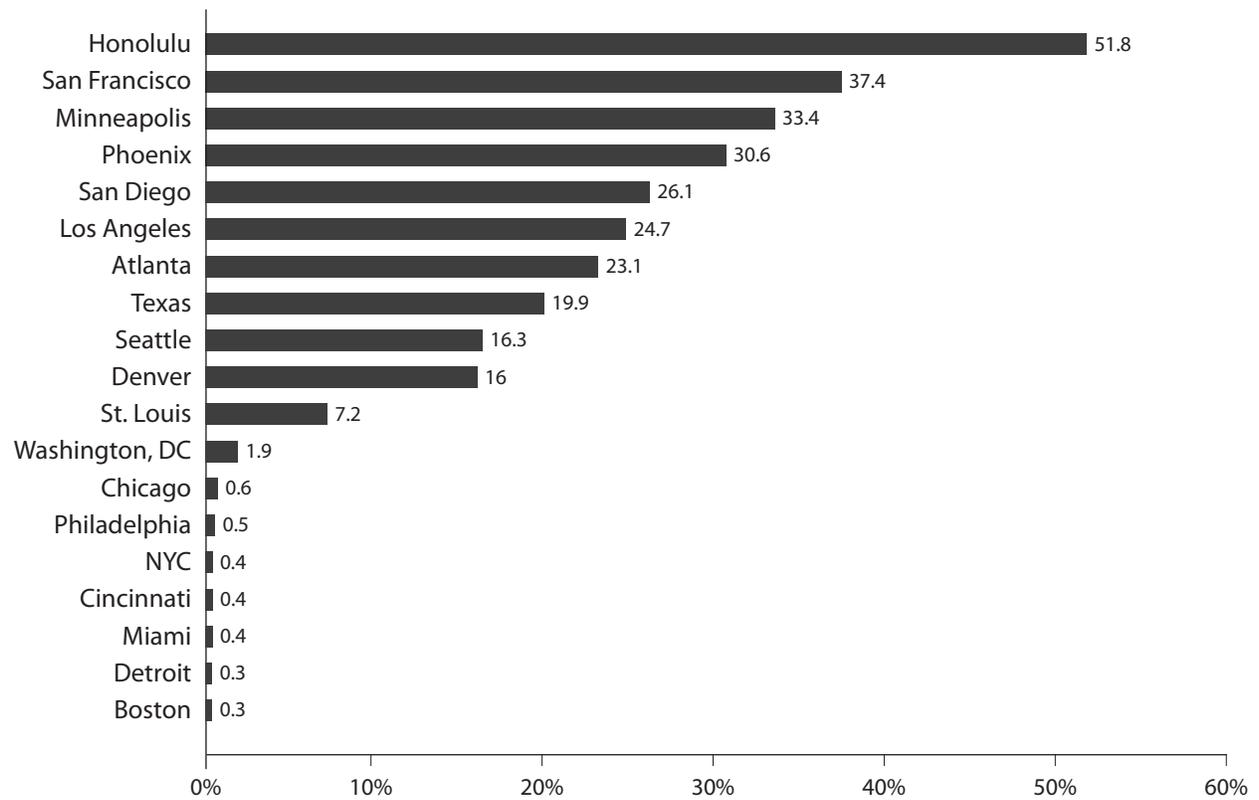
lowest in Miami (\$15–\$150) and Chicago (\$15–\$200). The highest minimum prices per gram were in Boston (\$100–\$200) and Detroit (\$100–\$175) (Table 20).

Table 20. Powder Methamphetamine Retail (Street) Average Price in 12 CEWG Areas, Ordered by Lowest Minimum Price: 2006

CEWG Areas	Average Price per Gram
Miami	\$15–\$150
Chicago	\$15–\$200
Philadelphia	\$20–\$200
Phoenix	\$25–\$100
Atlanta	\$30–\$200
Los Angeles	\$35–\$120
Washington, DC	\$40–\$150
St. Louis	\$50–\$250
Dallas	\$70–\$100
New York City	\$80–\$250
Detroit	\$100–\$175
Boston	\$100–\$200

SOURCE: DEA, Office of Domestic Intelligence, Domestic Strategic Intelligence Unit report *2005–2006 Price and Purity Data National Ranges in U.S. Dollars*, published October 4, 2007

Figure 23. Methamphetamine Items Identified as a Percentage of Total NFLIS Drug Items, 19 CEWG Areas: FY 2007



SOURCE: NFLIS, DEA; FY 2007=October 2006–September 2007
See Appendix Table 2.

Marijuana

- Percentages of primary marijuana treatment admissions exceeded those for other nonalcohol drug admissions groups in Denver (36.5 percent), Cincinnati (36 percent), and Atlanta (34 percent). The lowest proportion of such admissions was in Boston (6 percent).
- In no CEWG area did marijuana rank first as the primary drug in total drug admissions (including alcohol admissions); however, when only treatment admissions excluding primary alcohol admissions are considered, marijuana ranked first in H1 CY 2007 in three areas: Cincinnati, Minneapolis/St. Paul, and Denver.
- Cannabis also ranked first in frequency in proportions of drug items identified in forensic laboratories in FY 2007 in six CEWG areas—St. Louis (57 percent), Chicago (54 percent), San Diego (48 percent), Boston (45 percent), Detroit (42 percent), and Phoenix (36 percent).

Treatment Admission Data on Marijuana

In the first half of 2007, marijuana ranked in second place to alcohol as the most frequently reported drug by primary treatment admissions in Cincinnati, Denver, and Texas (Table 2). It accounted for 23–24 percent of total admissions, including primary alcohol admissions, in those CEWG areas (Table 21).

As shown in Table 21, Denver and Cincinnati had the highest percentages of primary marijuana treatment admissions excluding primary alcohol admissions. In all, six CEWG areas had percentages of marijuana treatment admissions close to one-third or slightly higher: Denver (36.5 percent), Cincinnati (35.9 percent), Atlanta (34.2 percent), Minneapolis/St. Paul (32.7 percent), St. Louis (32.5 percent), and Hawai'i (32.1 percent). The lowest proportion of marijuana treatment admissions was reported in Boston, at approximately 6 percent.

Gender of Marijuana Admissions. In 14 CEWG areas reporting on the gender of primary marijuana admissions in H1 2007, males predominated in all areas (Table 22). The proportion of males ranged from a high of 82 percent of marijuana admissions in Philadelphia to a low of 65 percent in Phoenix. Atlanta, at 32 percent, had the largest percentage of female marijuana admissions, after Phoenix (35 percent).

Race/Ethnicity of Marijuana Admissions. Racial/ethnic distributions of marijuana admissions should be interpreted in light of the facts that CEWG areas differ in the racial/ethnic composition of the general population; census categories are not always used in reporting the data; and three areas allow reporting of multiple race/ethnicity categories for one case (so that race/ethnicity counts total more than total marijuana admissions). The proportions of marijuana treatment admissions who reported White non-Hispanic race/ethnicity ranged from 4 percent in Detroit and 7 percent in New York City to 61 percent in Minneapolis/St. Paul and 53 percent in Phoenix. The highest percentage of African-American non-Hispanic marijuana admissions was in Detroit (94 percent), followed by Philadelphia and Cincinnati, each at around two-thirds. San Diego, Phoenix, and Denver had the lowest percentages of African-American non-Hispanic marijuana admissions in H1 2007. Hispanics predominated among marijuana treatment admissions in Los Angeles, at 51 percent, and they represented 42 percent of that group in both San Diego and Texas (Table 22).

Age of Marijuana Admissions. Primary marijuana treatment admissions tended to be younger than other treatment admission groups in H1 2007 (Table 22). Close to one-half of marijuana treatment admissions (47 percent) were

younger than 18 in Los Angeles; 42 percent were in that age group in both Cincinnati and Seattle. This younger group (younger than 18) accounted for the highest proportions of marijuana treatment admissions in San Diego, Seattle, Denver, Detroit, Cincinnati, and Los Angeles. Minneapolis/St. Paul had the same proportions in both the younger-than-18 and the 18–25-year age groups, with no clear majority among marijuana admissions.

Across 13 of the 14 reporting CEWG areas for which age distributions were reported, the majority of primary marijuana admissions were age 25 or younger, ranging from 33 percent in Philadelphia, to 50 percent in New York City and Phoenix,

to 72–73 percent in Seattle, Texas, and Los Angeles. In Phoenix, Boston, New York City, Texas, and St. Louis, marijuana admissions were more likely to be aged 18–25 than in other age groups (50, 48, 39, 37, and 30 percent, respectively). In Minneapolis/St. Paul, marijuana admissions were equally represented at 35 percent each in two age categories: 17 and younger and 18–25 (Table 22).

Forensic Laboratory Data on Marijuana

Cannabis was the drug item most frequently reported in FY 2007 by NFLIS for St. Louis (56.6 percent) and Chicago (53.7 percent) (Table 1 and *Appendix Table 2*). The proportions of cannabis

Table 21. Primary Marijuana Treatment Admissions in 15 CEWG Areas as a Percentage of Total Admissions Including and Excluding Primary Alcohol Admissions: FY 2007 and H1 CY 2007 (January–June 2007)

CEWG Areas	Primary Marijuana Admissions	Total Admissions with Primary Alcohol Admissions Excluded ¹		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta ²	1,900	5,558	34.2	10,447	18.2
Boston	415	7,038	5.9	10,705	3.9
Cincinnati ³	1,264	3,521	35.9	5,325	23.7
Denver	1,434	3,932	36.5	6,071	23.6
Detroit	715	3,152	22.7	4,219	16.9
Hawai'i	935	2,917	32.1	3,994	23.4
Los Angeles	4,913	21,716	22.6	26,657	18.4
Mpls./St. Paul	1,562	4,775	32.7	9,543	16.4
New York City	8,725	29,847	29.2	40,941	21.3
Philadelphia	1,646	5,951	27.7	7,691	21.4
Phoenix	292	1,534	19.0	2,261	12.9
San Diego	1,159	5,927	19.6	7,277	15.9
Seattle	787	3,067	25.7	5,019	15.7
St. Louis	1,122	3,448	32.5	5,342	21.0
Texas	10,289	33,644	30.6	44,710	23.0

¹Percentages of primary marijuana admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.

²Data are for FY 2007 (October 2006–September 2007).

³Data are for July 2006–June 2007.

SOURCE: January 2008 CEWG reports

drug items identified in the other 17 CEWG areas were highest in San Diego, Boston, Detroit, and Cincinnati—ranging from approximately 40 to 48 percent of drug items. Phoenix, Philadelphia, and Washington, DC, reported between 32 and 36 percent of drug items identified contained cannabis in FY 2007. The remaining CEWG sites had percentages ranging from approximately 2 percent (Atlanta) to 28 percent (Los Angeles) for cannabis drug items identified.

Cannabis was the most frequently identified drug in Boston, Detroit, Chicago, St. Louis, San Diego, and Phoenix. It was the second most frequently identified drug item in FY 2007 NFLIS data for Miami/Dade County; Texas; Washington, DC; Philadelphia; New York City; Cincinnati; Seattle; Honolulu; San Francisco; Los Angeles; and Denver (see Table 1).

Table 22. Demographic Characteristics of Primary Marijuana Treatment Admissions in 14 CEWG Areas, as a Percentage¹: FY 2007 or H1 CY 2007²

CEWG Areas	Gender		Race/Ethnicity ³			Age Group			
	Male	Female	White Non-Hispanic	Afr.-Amer. Non-Hispanic	Hispanic	≤ 17	18–25	26–34/35	35–36 or Older
Atlanta	68	32	35	48	2	NR ⁴	NR	NR	NR
Boston	78	22	26	45	25	5	48	27	20
Cincinnati	72	28	34	65	–	42	28	18	12
Denver	77	23	42	21	33	36	32	18	14
Detroit	72	28	4	94	1	37	24	22	17
Los Angeles	70	30	13	31	51	47	26	14	13
Mpls./St. Paul	77	23	61	25	4	35	35	17	13
New York City	79	21	7	58	29	11	39	29	21
Philadelphia	82	18	21	66	10	1	32	33	33
Phoenix	65	35	53	19	23	0	50	28	22
San Diego	74	26	32	17	42	40	30	18	13 ⁵
Seattle	74	26	*	*	*	42	30	19 ⁶	9 ⁶
St. Louis	77	23	40	56	1	28	30	26	17
Texas	71	29	31	26	42	35	37	19	10

¹Percentages rounded to the nearest integer.

²Atlanta reports FY 2007 (October 2006–September 2007) data, while Cincinnati reports FY 2007 (July 2007–June 2008) data. All other areas report H1 CY 2007 data.

³CEWG areas differ in the racial/ethnic composition of the general population, which should be taken into account when interpreting these data. Some areas (Philadelphia, Boston, St. Louis) allow more than one race/ethnicity to be coded per case.

⁴NR=Not reported by the CEWG representative.

⁵Represents admissions age 36 or older.

⁶Data from Seattle are for age 30–39 (32 percent) and 40 and older (58 percent).

*Seattle does not use census categories for race/ethnicity; their percentages are 41 percent White, 26 percent African-American, and 12 percent Hispanic.

SOURCE: January 2008 CEWG reports

Club Drugs (MDMA, GHB/GBL, LSD, Ketamine)

Treatment Admission Data on Club Drugs

The club drugs in this section include MDMA (methylenedioxyamphetamine, or ecstasy), GHB (gamma hydroxybutyrate), GBL (gamma butyrolactone), LSD (lysergic acid diethylamide), and ketamine. Admissions for primary treatment of club drugs or MDMA are not captured in all

treatment data systems, but they appear below in those that do.

Forensic Laboratory Data on Club Drugs

MDMA. MDMA was the club drug most frequently reported in the 19 CEWG areas depicted in Table 23. As shown, MDMA exceeded 2 percent of all drug items in Atlanta; Seattle; Minneapolis/St. Paul; Washington, DC; Detroit; and San

Table 23. Number of MDMA Items Identified and MDMA Items as a Percentage of Total Items Identified by Forensic Laboratories in 19 CEWG Areas: FY 2007¹

CEWG Areas	MDMA Items	Total Items	Percentage of Total Items
Atlanta	902	14,317	6.3
Seattle	249	4,026	6.2
Mpls./St. Paul	184	4,600	4.0
Wash., DC	123	3,251	3.8
Detroit	247	7,391	3.3
San Francisco	325	10,695	3.0
St. Louis	215	10,522	2.0
Honolulu	57	3,213	1.8
Denver	123	7,123	1.7
Los Angeles	830	59,768	1.4
Cincinnati	198	14,618	1.4
Miami	398	30,014	1.3
Chicago	943	82,010	1.2
San Diego	223	20,382	1.1
Boston	208	24,934	0.8
New York City	315	51,356	0.6
Phoenix	54	9,412	0.6
Philadelphia	142	25,949	0.6
Texas	1,084	56,537	1.9

¹FY 2007 data are reported covering the period from October 2006 through September 2007. SOURCE: Texas NFLIS data were provided by the Texas Department of Public Safety and were accessed by the Texas CEWG representative; data for all other areas were provided by NFLIS, DEA

Francisco, with the highest percentage (6.3) being in Atlanta, followed by Seattle (6.2).

As shown in Table 1, MDMA was the third most frequently identified drug item in Atlanta, and it ranked fourth in Miami/Dade County, Detroit, Chicago, Minneapolis/St. Paul, Seattle, and Honolulu.

Ketamine. Ketamine items were reported from all areas except 1, although 12 areas reported cases numbering fewer than 30. Among the 6 sites for which 30 cases or more were identified (Atlanta, Chicago, Los Angeles, New York City, Texas, and San Francisco), ketamine accounted for the highest percentage of club drug items identified in San Francisco (0.7 percent). However,

ketamine represented less than 1 percent of the total drug items in all reporting CEWG areas (including Texas).

LSD. LSD was reported in 13 CEWG metropolitan areas. None, however, had 30 or more cases. LSD was not among the top 25 drugs reported from Texas, and no LSD items were reported from Detroit, Honolulu, Philadelphia, Phoenix, and Washington, DC.

GHB. GHB items represented 1.9 percent of club drugs identified in forensic laboratories in FY 2007. These items accounted for much less than 1 percent of all items in 10 CEWG areas in FY 2007.

Phencyclidine (PCP)

Forensic Laboratory Data on PCP

Regarding NFLIS data, no PCP items were documented in 5 CEWG areas, and fewer than 30 such items were identified in 7 areas. The areas reporting 30 or more PCP items were Washington, DC; Philadelphia; Miami; New York City; Los Angeles; Texas; and Chicago. As a percentage of all identified items, PCP items were highest in Washington, DC, at 4 percent, and Philadelphia, at 3 percent. In Miami and New York City, percentages

approached 1 percent, while in Los Angeles, Texas, and Chicago, they were less than 1 percent.

Other Hallucinogens: A total of 734 psilocin and psilocybin drug items were reported in 18 CEWG areas. In 11 areas, 30 or more such items were reported. Denver had the highest percentage of such reports at 1.3 percent ($n=91$) (no data shown).

Appendix Tables

Appendix Table 1. Total Admissions, by Primary Substance of Abuse Including Primary Alcohol Admissions and CEWG Area: FY 2007 and First Half of CY 2007

CEWG Areas	Number of Total Admissions							Total (N)
	Alcohol	Cocaine/ Crack	Heroin	Other Opiates	Marijuana	Metham- phetamine	Other Drugs	
FY 2007								
Atlanta	4,889	2,419	385	NR ¹	1,900	854	–	10,447
Cincinnati ²	1,804	957	586 ²	NR	1,264	– ³	714	5,325
First Half of CY 2007								
Boston	3,667	840	5,220	364	415	55	144	10,705
Denver	2,139	952	391	179	1,434	898	78	6,071
Detroit	1,067	1,231	1,141	55	715	– ³	10	4,219
Hawai'i ⁴	1,077	169	82	97	935	1,546	88	3,994
Los Angeles	4,941	4,281	4,908	621	4,913	6,410	583	26,657
Mpls./St. Paul	4,768	1,112	587	443	1,562	727	344	9,543
New York City	11,094	8,547	11,264	368	8,725	117	826	40,941
Philadelphia	1,740	2,020	1,442	39	1,646	– ³	804	7,691
Phoenix ⁵	727	227	231	65	292	670	49	2,261 ⁵
San Diego	1,350	512	1,174	276	1,159	2,744	62	7,277
Seattle	1,952	879	577	157	787	503	164	5,019
St. Louis	1,894	1,195	819	83	1,122	151	78	5,342
Texas ²	11,066	10,478	6,261 ²	NR	10,289	5,380 ³	1,236	44,710

¹ NR=Not Reported.

²Heroin is combined with other opiates under the category, "opiates", by Texas and Cincinnati; their data are reported under "heroin" in this and other treatment admissions data tables.

³Texas data combines methamphetamine under "Amphetamine." Cincinnati ($n=14$), Detroit ($n=2$), and Philadelphia ($n=29$) report no methamphetamine, only amphetamine.

⁴Hawai'i data report total admissions of 4,069, of which 75 did not report using any drugs at admission for substance abuse treatment; the N of 3,994 includes cases where a primary drug was reported.

⁵Phoenix data report total admissions of 5,857, of which 3,596 did not report using any drugs at admission for substance abuse treatment; the N of 2,261 includes cases where a primary drug was reported.

SOURCE: January 2008 State and local reports

Appendix Table 2.1. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Atlanta: FY 2007¹

Drug	Number	Percentage
Cocaine	7,928	55.4%
Methamphetamine	3,304	23.1%
MDMA	902	6.3%
Alprazolam	436	3.0%
Hydrocodone	381	2.7%
Cannabis	264	1.8%
Oxycodone	243	1.7%
Methadone	100	0.7%
Carisoprodol	96	0.7%
Heroin	87	0.6%
Other ²	576	4.0%
Total	14,317	100.0%

¹October 2006–September 2007.

²All other analyzed items; n=35.

NOTES:

1. Data are for 13 of the 28 counties in the Atlanta-Sandy Springs-Marietta, GA MSA including Barrow, Bartow, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Forsyth, Fulton, Gwinnett, Spalding, and Walton. DeKalb represents 97.8% of items seized.

2. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.3. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Chicago: FY 2007¹

Drug	Number	Percentage
Cannabis	44,020	53.7%
Cocaine	24,447	29.8%
Heroin	10,015	12.2%
MDMA	943	1.1%
Clonidine	611	0.7%
Methamphetamine	459	0.6%
Hydrocodone	255	0.3%
Alprazolam	136	0.2%
Phencyclidine	115	0.1%
Acetaminophen	101	0.1%
Other ²	908	1.1%
Total	82,010	100.0%

¹October 2006–September 2007.

²All other analyzed items; n=80.

NOTES:

1. Data include all counties in the Chicago-Naperville-Joliet, IL-IN-WI MSA including Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry, and Will Counties in IL; Jasper, Lake, Newton, and Porter in IN; and Kenosha in WI. Cook County represents 88.1% of total items seized.

2. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.2. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Boston: FY 2007¹

Drug	Number	Percentage
Cannabis	11,208	45.0%
Cocaine	6,837	27.4%
Heroin	2,051	8.2%
Oxycodone	992	4.0%
Clonazepam	473	1.9%
Buprenorphine	380	1.5%
Alprazolam	242	1.0%
Hydrocodone	220	0.9%
MDMA	208	0.8%
Methadone	151	0.6%
Other ²	2,172	8.7%
Total	24,934	100.0%

¹October 2006–September 2007.

²All other analyzed items; n=131.

NOTES:

1. Data are for all counties in the MSA—Essex, Middlesex, Norfolk, Plymouth, and Suffolk, MA, and Rockingham and Strafford, NH.

2. Items seized include 38.4% in Suffolk, 27.5% in Middlesex, 15.2% in Essex, 12.4% in Plymouth, and 9.8% in Norfolk, with only 31 items seized in the two NH counties in the MSA.

3. “Noncontrolled Nonnarcotic” drugs represent 803 cases or 3.2% of the total and are included as “Other.”

4. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.4. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Cincinnati: FY 2007¹

Drug	Number	Percentage
Cocaine	6,648	45.5%
Cannabis	5,860	40.1%
Heroin	732	5.0%
Oxycodone	315	2.2%
Hydrocodone	211	1.4%
MDMA	198	1.4%
Alprazolam	131	0.9%
Diazepam	73	0.5%
Methadone	64	0.4%
Methamphetamine	60	0.4%
Other ²	326	2.2%
Total	14,618	100.0%

¹October 2006–September 2007.

²All other analyzed items; n=30.

NOTES:

1. Data are for Hamilton County, OH only, which total 77.9% of items seized in the Cincinnati-Middletown, OH-KY-IN MSA consisting of 15 counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.5. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Denver: FY 2007¹

Drug	Number	Percent
Cocaine	2,739	38.4%
Cannabis	1,710	24.0%
Methamphetamine	1,139	16.0%
Heroin	285	4.0%
MDMA	123	1.7%
Psilocin	91	1.3%
Hydrocodone	87	1.2%
Oxycodone	71	1.0%
Alprazolam	25	0.4%
Clonazepam	25	0.4%
Other ²	837	11.7%
Total	7,132	100.0%

¹ October 2006–September 2007.² All other analyzed items; *n*=62.

NOTES:

1. The Denver-Aurora, CO MSA includes 9 counties of which only three are included here—Arapahoe, Denver, and Jefferson, CO; of the 3 represented, Denver accounts for 69.5% of items seized.

2. 624 “Noncontrolled Nonnarcotic” drug items were reported by NFLIS (8.7% of the total) and were included under “Other.”

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.7. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Honolulu: FY 2007¹

Drug	Number	Percentage
Methamphetamine	1,663	51.8%
Cannabis	804	25.0%
Cocaine	445	13.8%
MDMA	57	1.8%
Heroin	42	1.3%
Morphine	20	0.6%
MDA	18	0.6%
Hydrocodone	12	0.4%
Oxycodone	11	0.3%
Alprazolam	10	0.3%
Other ²	131	4.1%
Total	3,213	100.0%

¹ October 2006–September 2007.² All other analyzed items; *n*=40.

NOTES:

1. Data are for Honolulu, HI.

2. Eighteen cases of “Noncontrolled Nonnarcotic” drug items, so classified by NFLIS, are included under “Other,” they represent 0.6% of the total.

3. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.6. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Detroit: FY 2007¹

Drug	Number	Percentage
Cannabis	3,077	41.6%
Cocaine	2,692	36.4%
Heroin	575	7.8%
MDMA	247	3.3%
Dihydrocodeine	152	2.1%
Alprazolam	90	1.2%
Oxycodone	62	0.8%
Hydrocodone	37	0.5%
Codeine	23	0.3%
Methamphetamine	22	0.3%
Other ²	414	5.6%
Total	7,391	100.0%

¹ October 2006–September 2007.² All other analyzed items; *n*=50.

NOTES:

1. Data are for Wayne County only, which accounts for 71.6% of items analyzed in the 6-county Detroit-Warren-Livonia, MI MSA.

2. Only named drugs are included in the top 10 ranking; “Noncontrolled Nonnarcotic” drugs number 179 or 2.4% for Wayne County and are included under “Other.”

3. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.8. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Los Angeles: FY 2007¹

Drug	Number	Percent
Cocaine	22,582	37.8%
Cannabis	16,610	27.8%
Methamphetamine	14,790	24.7%
Heroin	2,263	3.8%
MDMA	830	1.4%
Hydrocodone	413	0.7%
Phencyclidine	404	0.7%
Alprazolam	146	0.2%
Diazepam	117	0.2%
Codeine	117	0.2%
Other ²	1,496	2.5%
Total	59,768	100.0%

¹ October 2006–September 2007.² All other analyzed items; *n*=137.

NOTES:

1. Data are for LA County only, which accounts for 92.9% of the items seized in the 2-county MSA.

2. MSA is Los Angeles-Long Beach-Santa Ana, CA.

3. “Noncontrolled Nonnarcotic” drug items, classified as such by NFLIS, total 196 or 0.3% and are reported under “Other.”

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.9. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Miami MSA: FY 2007¹

Drug	Number	Percentage
Cocaine	20,115	67.0%
Cannabis	5,960	19.9%
Heroin	688	2.3%
MDMA	398	1.3%
Alprazolam	380	1.3%
Hallucinogens	286	1.0%
Oxycodone	116	0.4%
Methamphetamine	109	0.4%
Hydrocodone	49	0.2%
Clonazepam	29	0.1%
Other ²	1,884	6.3%
Total	30,014	100.0%

¹ October 2006–September 2007.

² All other analyzed items; n=79.

NOTES:

1. Data are for the Miami-Fort Lauderdale-Pompano Beach, FL MSA and include Broward, Dade, and Palm Beach Counties, FL; 67.4% of items seized are for Dade County and 32% for Broward.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.11. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, New York City: FY 2007¹

Drug	Number	Percentage
Cocaine	25,285	49.2%
Cannabis	13,186	25.7%
Heroin	5,574	10.9%
Alprazolam	732	1.4%
Methadone	566	1.1%
Phencyclidine	452	0.9%
Oxycodone	415	0.8%
Hydrocodone	359	0.7%
MDMA	315	0.6%
MDA	273	0.5%
Other ²	4,199	8.2%
Total	51,356	100.0%

¹ October 2006–September 2007.

² All other analyzed items; n=79.

NOTES:

1. The geographical unit includes five counties in the MSA : Bronx, Kings, Queens, NY and NYPD, Richmond.

2. The 2,856 analyzed items included in the total are reported by NFLIS as “No Drug Found.” These are included under “Other”; all are reported by NYPD labs.

3. Items seized and analyzed by the NYPD represent 97.7% of the total.

4. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.10. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Minneapolis/St. Paul: FY 2007¹

Drug	Number	Percentage
Methamphetamine	1,535	33.4%
Cocaine	1,263	27.5%
Cannabis	1,165	25.3%
MDMA	184	4.0%
Oxycodone	65	1.4%
Heroin	54	1.2%
Hydrocodone	49	1.1%
Psilocin	27	0.6%
Acetaminophen	26	0.6%
Codeine	24	0.5%
Other ²	208	4.5%
Total	4,600	100.0%

¹ October 2006–September 2007.

² All other analyzed items; n=50.

NOTES:

1. Data are for 7 MN counties including Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington in the 13-county Minneapolis-St. Paul-Bloomington, MN-WI MSA. These seven counties account for 87% of seized items in the MSA.

2. Thirty-four items were reported by NFLIS as “Noncontrolled Nonnarcotic” drugs or 0.8% of the total; these were included under “Other.”

3. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.12. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Philadelphia: FY 2007¹

Drug	Number	Percentage
Cocaine	10,794	41.6%
Cannabis	8,939	34.4%
Heroin	2,506	9.7%
Oxycodone	782	3.0%
Alprazolam	758	2.9%
Phencyclidine/PCP	751	2.9%
Hydrocodone	195	0.8%
MDMA	142	0.5%
Clonazepam	121	0.5%
Methamphetamine	117	0.5%
Other ²	844	3.3%
Total	25,949	100.0%

¹ October 2006–September 2007.

² All other analyzed items; n=52.

NOTES:

1. Of items seized in the MSA, 66.8% were reported for Philadelphia County.

2. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.13. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Phoenix: FY 2007¹

Drug	Number	Percent
Cannabis	3,417	36.3%
Methamphetamine	2,881	30.6%
Cocaine	2,048	21.8%
Heroin	460	4.9%
Oxycodone	91	1.0%
Hydrocodone	83	0.9%
MDMA	54	0.6%
Carisoprodol	52	0.6%
Alprazolam	40	0.4%
Morphine	33	0.4%
Other ²	253	2.7%
Total	9,412	100.0%

¹October 2006–September 2007.²All other analyzed items; n=47.

NOTES:

1. Data represent only Maricopa County in the two-county Phoenix-Mesa-Scottsdale, AZ MSA.
2. "Noncontrolled Nonnarcotic" drugs number 29 as reported by NFLIS and are included under "Other."
3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.15. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Francisco: FY 2007¹

Drug	Number	Percentage
Methamphetamine	3,999	37.4%
Cannabis	2,811	26.3%
Cocaine	2,174	20.3%
Heroin	395	3.7%
MDMA	325	3.0%
Dihydrocodeinone	144	1.3%
Ketamine	79	0.7%
Methadone	57	0.5%
Psilocin	56	0.5%
Diazepam	55	0.5%
Other ²	600	5.6%
Total	10,695	100.0%

¹October 2006–September 2007.²All other analyzed items; n=55

NOTES:

1. The geographical unit is the San Francisco-Oakland-Fremont MSA, including Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties.
2. Total includes 14 cases for Marin County where "Result Not Reported"; these are included under "Other."
3. "Some Other Substance" (n=70) was excluded from the list of top 10 named drugs and included under "Other."
4. 61.1% of items were seized in Contra Costa County, 26.2% in San Mateo, 8.2% in Marin, 2.4% in San Francisco, and 2.1% in Alameda.
5. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.14. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Diego: FY 2007¹

Drug	Number	Percentage
Cannabis	9,783	48.0%
Methamphetamine	5,321	26.1%
Cocaine	2,775	13.6%
Heroin	559	2.7%
Hydrocodone	298	1.5%
MDMA	223	1.1%
Oxycodone	130	0.6%
Diazepam	93	0.5%
Alprazolam	80	0.4%
Clonazepam	78	0.4%
Other ²	1,042	5.1%
Total	20,382	100.0%

¹October 2006–September 2007.²All other analyzed items; n=102.

NOTES:

1. Data are for San Diego County, which constitutes the San Diego-Carlsbad-San Marcos, CA MSA.
2. "Noncontrolled Nonnarcotic" drug items number 167 or 0.8% of the total and "Plant Material, Other" is reported by NFLIS at 159 or 0.8%. These categories are included under "Other."
3. Five cases were classified as "Results Not Reported" and were included in the total of 20,382.
4. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.16. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Seattle: FY 2007¹

Drug	Number	Percentage
Cocaine	1,673	41.6%
Cannabis	754	18.7%
Methamphetamine	658	16.3%
MDMA	249	6.2%
Heroin	189	4.7%
Oxycodone	144	3.6%
Hydrocodone	72	1.8%
Methadone	51	1.3%
Clonazepam	23	0.6%
Phencyclidine/PCP	22	0.5%
Other ²	191	4.7%
Total	4,026	100.0%

¹October 2006–September 2007.²All other analyzed items; n=39.

NOTES:

1. Data are for King County only in the 3-county Seattle-Tacoma-Bellevue MSA.
2. King County represents 58.2% of total items seized and analyzed in the MSA.
3. One case of "Noncontrolled Nonnarcotic" drugs is reported by NFLIS and included under "Other."
4. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.17. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, St. Louis: FY 2007¹

Drug	Number	Percentage
Cannabis	5,954	56.6%
Cocaine	1,842	17.5%
Methamphetamine	754	7.2%
Heroin	240	2.3%
MDMA	213	2.0%
Alprazolam	198	1.9%
Acetaminophen	186	1.8%
Pseudoephedrine	168	1.6%
Oxycodone	106	1.0%
Hydrocodone	100	1.0%
Other ²	761	7.2%
Total	10,522	100.0%

¹ October 2006–September 2007.

² All other analyzed items; n=98.

1. St. Louis, MO-IL MSA counties include Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, and St. Clair, IL; and Crawford, Franklin, Jefferson, Lincoln, St. Charles, St. Louis City, Warren, and Washington, MO, a total of 16 counties.

2. “Noncontrolled Nonnarcotic” drugs, classified as such by NFLIS, equal 114 or 1.1% of the total and are reported under “Other.”

3. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, January 24, 2008

Appendix Table 2.18. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Texas: FY 2007¹

Drug	Number	Percentage
Cocaine	19,097	33.8%
Cannabis	13,430	23.8%
Methamphetamine	11,247	19.9%
Alprazolam	3,497	6.2%
Hydrocodone	2,323	4.1%
MDMA	1,084	1.9%
Heroin	734	1.3%
Carisoprodol	583	1.0%
Clonazepam	470	0.8%
Diazepam	344	0.6%
Other ²	3,728	6.6%
Total	56,537	100.0%

¹ October 2006–September 2007

² All other analyzed items; n=unknown

NOTES:

1. Data are for the State of Texas.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 2.19. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Washington, DC: FY 2007¹

Drug	Number	Percentage
Cocaine	1,479	45.5%
Cannabis	1,034	31.8%
Heroin	268	8.2%
Phencyclidine	143	4.4%
MDMA	123	3.8%
Methamphetamine	61	1.9%
Oxycodone	40	1.2%
Methadone	8	0.2%
MDA	7	0.2%
Buprenorphine	6	0.2%
Other ²	82	2.5%
Total	3,251	100.0%

¹ October 2006–September 2007.

² All other analyzed items; n=39.

NOTES:

1. Data are for the District of Columbia only out of the 22 counties constituting the Washington-Arlington-Alexandria DC-VA-MD MSA ; DC items represent 19% of the MSA total.

2. A total of 5 items were reported as “Noncontrolled Nonnarcotic” drugs by NFLIS and are included under “Other.”

3. Percentages may not add to the total due to rounding.

SOURCE: NFLIS, DEA, November 5, 2007

Appendix Table 3.1. DAWN ED Samples and Reporting Information, by CEWG Area: January–June 2007

CEWG Areas	Total EDs in DAWN Sample	Number of EDs Reporting per Month: Completeness of Data (%)		Number of EDs Not Reporting
		≥90%	<90%	
Boston	37	18–22	2–4	12–16
Chicago	80	26–29	4–6	46–48
Denver	15	8–9	0–1	6
Detroit	31	14–18	1–5	12–14
Miami-Dade	19	6–9	0–3	10–11
Mpls./St. Paul	26	9–10	0–1	15–16
New York City	63	29–34	5–9	24–26
Phoenix	28	10–12	2–4	14
San Diego	17	5–7	0–2	10
San Francisco	35	14–15	0–1	20
Seattle	25	9–10	0–1	14–15

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 12/10–12/13, 2007

Appendix Table 3.2. Number of Cocaine, Heroin, Methamphetamine (MA), Marijuana (MJ), Methylendioxyamphetamine (MDMA), Phencyclidine (PCP), and Lysergic Acid Diethylamide (LSD) ED Reports in 11 CEWG Areas (Unweighted¹): January–June 2007

CEWG Areas	Cocaine	Heroin	MA	MJ	MDMA	PCP	LSD
Boston	2,614	2,066	41	1,301	48	6	16
Chicago	4,726	3,035	28	1,703	53	53	7
Denver	1,592	461	451	1,088	79	9	26
Detroit	3,640	1,464	6	1,688	73	11	6
Miami-Dade	2,133	350	16	915	49	5	24
Mpls./St. Paul	884	306	255	1,068	71	11	13
New York City	8,866	4,167	70	3,996	118	265	22
Phoenix	1,020	458	808	654	23	21	8
San Diego	293	185	468	409	29	13	9
San Francisco	2,286	692	695	505	85	36	26
Seattle	2,326	1,089	543	918	71	55	19

¹All DAWN cases are reviewed for quality control and, based on review, may be corrected or deleted. Therefore, these data are subject to change.

NOTES:

1. The classification of drugs used in DAWN is derived from the Multum *Lexicon*, © 2005, Multum Information Services, Inc. The classification was modified to meet DAWN's unique requirements (2006). The Multum Licensing Agreement governing use of the Lexicon can be found on the Internet at <http://www.multum.com>.

2. Unweighted data with values less than 30, while not suppressed, are not reported in the text, as they may be unstable and should be interpreted with caution.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 12/10–12/13, 2007

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NATIONAL INSTITUTES OF HEALTH

NIDA NATIONAL INSTITUTE
ON DRUG ABUSE

NIH Publication No. 09-6420

November 2008