

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

**Proceedings of the Community
Epidemiology Work Group**

Highlights and Executive Summary

January 2009

NATIONAL INSTITUTE ON DRUG ABUSE



COMMUNITY EPIDEMIOLOGY WORK GROUP

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January 2009

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 information presented in this Executive Summary is primarily based on CEWG area

Update Briefs and meeting presentations prepared by CEWG representatives for the January 2009 CEWG meeting. 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 PROVIDES A synthesis of findings from reports presented and data prepared for the 65th semiannual meeting of the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG) held in San Francisco, California, on January 21–23, 2009. The CEWG is a network of researchers from sentinel sites throughout the United States. It meets semiannually to provide ongoing community-level public health surveillance of drug abuse through presentation and discussion of quantitative and qualitative data. CEWG representatives access multiple sources of existing data from their local areas to report on drug abuse patterns and consequences in their areas and to provide an alert to potentially emerging new issues. Local area data are supplemented, as possible, with data available from federally-supported projects, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Warning Network (DAWN), Drug Enforcement Administration (DEA) National Forensic Laboratory Information System (NFLIS), and the DEA Heroin Domestic Monitor Program (HDMP). This descriptive and analytic information is used to inform the health and scientific communities and the general public about the current nature and patterns of drug abuse, emerging trends, and consequences of drug abuse.

The CEWG convenes twice yearly, in January and June. For the June meetings, CEWG representatives prepare full reports on drug abuse patterns and trends in their areas. After the meeting, a Highlights and Executive Summary Report is produced, and the full CEWG area reports are included in a second volume. For the January report, the representatives present an abbreviated report to provide an update on data newly available since the prior June report and to identify significant issues which have emerged since the prior meeting. These abbreviated reports, or Update Briefs, are included in this Executive Summary Report, along with highlights from the

meeting and cross-site data compilations. A second volume is no longer produced for the January meetings.

For the January 2009 meeting, CEWG representatives were invited to provide an overview and update on drug abuse trends in their areas, with particular attention to issues pertaining to the abuse of heroin and prescription opiates. In addition, representatives from border States, Mexico, and Canada were invited to briefly address drug abuse issues along the United States northern and southern borders. After the area reports, breakout groups were formed to discuss key drug abuse indicators and to review meeting findings by region. Other highlights of the meeting included: a presentation by DEA representative Scott Rowan on heroin trafficking in the United States; a workshop on prescription drugs provided by Jan Scaglione, Pharm. D.; a session on geographic information system approaches to drug abuse research by Yonette Thomas, Ph.D., Ilene Anderson, Pharm. D., and Rudy Banerjee, Ph.D.; a report on the National Drug Intelligence Center Sentry Program by Susan Seese; and presentations on NIDA-supported research in the San Francisco area. The NIDA-supported research presentations related to: club drug use among Asian American youth and young adults, presented by Geoffrey Hunt, Ph.D.; prescription drug abuse, presented by Sheigla Murphy, Ph.D.; and heroin-related research and methamphetamine use among women, presented by Alexander Kral, Ph.D. and Jennifer Lorvick, M.P.H.

The present report includes the CEWG Update Briefs and International Reports, and highlights findings from the CEWG area reports and discussions.

Moirá P. O'Brien

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National Institute on Drug Abuse
National Institutes of Health
Department of Health and Human Services

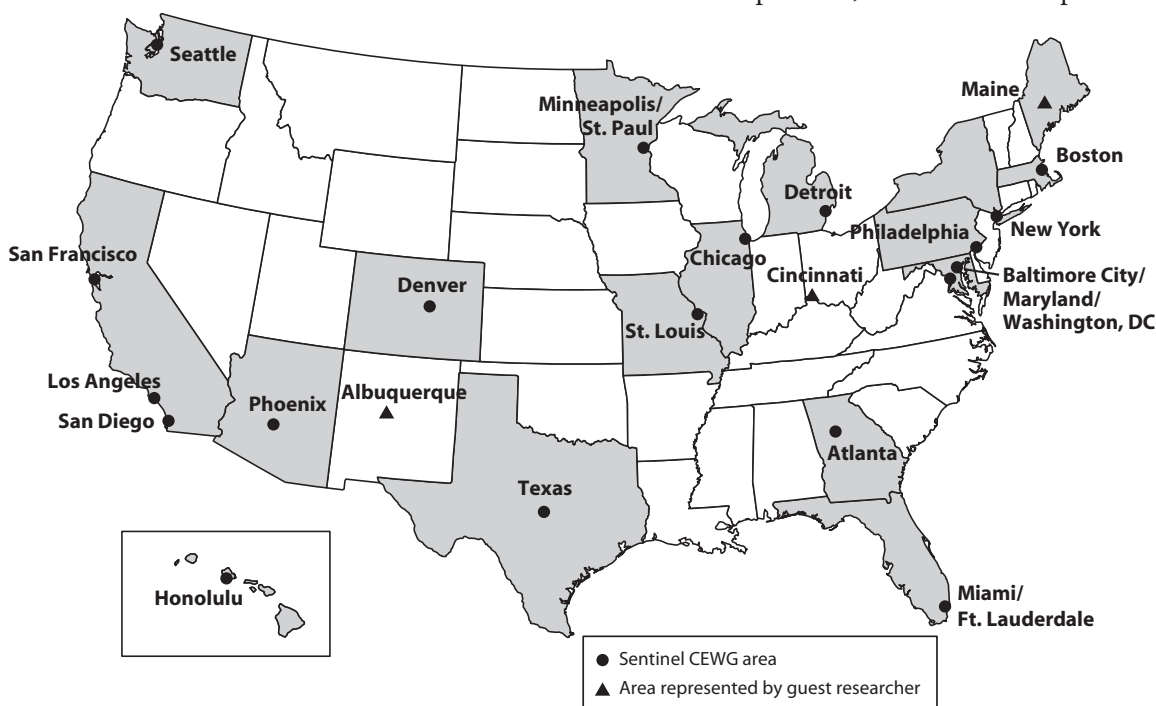
Section I. Introduction

THE 65TH SEMIANNUAL MEETING OF THE COMMUNITY Epidemiology Work Group (CEWG) was held on January 21–23, 2009, in San Francisco, California. During the meeting, researchers from 22 geographically dispersed areas in the United States reported on current trends and emerging issues in their areas. In addition to the information provided for 19 sentinel areas that have contributed to the network for many years, guest researchers from Albuquerque, Cincinnati, and Maine provided data from their respective areas, as did international representatives from Mexico and Canada. The following highlights and summary are based on these reports.

The CEWG Network

The CEWG is a unique epidemiology network that has functioned since 1976 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 hospital emergency departments, 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 CEWG areas on which presentations were made are depicted in the map below, with one area presentation



including data on Baltimore City, Maryland, and Washington, DC.

CEWG Meetings

The CEWG convenes semiannually; these meetings continue to be a major and distinguishing feature of the workgroup. CEWG representatives and guest researchers present information on drug abuse patterns and trends in their areas, and personnel from Federal agencies provide updates of data sets used by the CEWG. In addition, 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

At the semiannual meetings, CEWG representatives address issues identified in prior meetings and, subsequently, identify drug abuse issues for follow-up in the future.

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. 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 post-meeting communications.

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.

Types of data reviewed by CEWG representatives to derive drug abuse indicators include, but are not limited to, the following:

- Admissions to drug abuse treatment programs by primary substance of abuse or primary reason for treatment admission reported by clients at admission
- Drug-related emergency department (ED) reports of drugs mentioned in ED records in the Drug Abuse Warning Network (DAWN) *Live!* data system
- Seizure, average price, average purity, and related data obtained from the Drug Enforcement Agency (DEA) and from State and local law enforcement agencies
- Drug-related deaths reported by medical examiner (ME) or local coroner offices or State public health agencies
- Arrestee urinalysis results
- State and local random samples and other surveys, such as the Youth Risk Behavior Survey (YRBS) and the National Survey on Drug Use and Health

- Poison control center data
- Prescription drug monitoring programs

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 that a particular data source uses to characterize a drug, for example, cannabis versus marijuana, is replicated here.

Treatment data were derived from CEWG area reports. For this report, they represent data for 16 CEWG metropolitan areas and five States: Hawai'i, Maine, Maryland, Texas, and Colorado. Recent or complete treatment admissions data were not available for Albuquerque, Chicago, and Washington, DC. Treatment data for Maryland are included, along with data for Baltimore City, because the newly defined Baltimore City/Maryland/Washington, DC area currently encompasses all three locations. The reporting period is cited as the first half of 2008 (1H 2008), since all but two area representatives reported data for that time interval. Data for the first half of 2008 were not available for two areas—Miami and San Francisco—but fiscal year (FY) 2008 data were provided. Appendix table 1 shows overall treatment admissions data by drug and CEWG area for the current reporting period. Table 2 in section II and several tables in section IV (tables 3, 4, 7, 10, and 11) also display cross-area treatment admissions data as do several figures in section II (figures 3, 7, 9, and 10).

DAWN ED data were presented in some CEWG Update Briefs contained in this Executive Summary in figures 13 and 14 in section II, and in appendix tables 3.1 and 3.2. ED data were derived for the first 6 months of 2008 from the DAWN *Live!* restricted-access online query system, administered by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA). 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). All DAWN cases are reviewed for quality control, and based on this review, cases may be corrected or deleted. Therefore, the data presented are subject to change. DAWN includes a sample of EDs in participating areas, and data derived from DAWN *Live!* are unweighted and are not estimates for the reporting area. The completeness of data reported by particular EDs varies by month. DAWN *Live!* data were available for 11 of the 22 CEWG areas reporting for the January 2009 meeting. DAWN data are most often specific to areas defined as Metropolitan Statistical Areas (MSAs), but the geographical units covered for the 11 reporting CEWG areas are defined in appendix tables 3.1 and 3.2. Based on reporting preferences by the area representative from Miami/Ft. Lauderdale, data for the three-county Miami MSA are reported in terms of two divisions, creating two entries for that area in the tables and maps. These are the Miami/Dade County division and the Miami/Ft. Lauderdale division. This results in 12 areas appearing in appendix tables 3.1 and 3.2 and in associated maps, although 11 CEWG areas are represented. A full description of the DAWN system can be found at: <http://dawninfo.samhsa.gov>.

Forensic laboratory data for a total of 22 CEWG sites were available for the first half of 2008. Data for all CEWG metropolitan areas in the first half of 2008 were provided by the National Forensic Laboratory Information System (NFLIS), maintained by the DEA. NFLIS is a program in the DEA Office of Diversion Control which systematically and continuously collects results from drug analyses of items received from drug seizures by law enforcement authorities. Drug analyses are conducted by Federal (DEA) forensic laboratories and participating State and local forensic laboratories. As of October 2008, in addition to the DEA laboratories, the NFLIS system included 47 State systems, 95 local or municipal laboratories, and 1 territorial laboratory, representing a total of 278 individual laboratories. These laboratories handled over 88 percent of the Nation's nearly 1.2 million annual State and local drug analysis cases. Data are entered daily

based on seizure date and the county in which the seizure occurred. NFLIS provides detailed information on the prevalence and types of controlled substances secured in law enforcement operations, and assists in identifying emerging drug problems and changes in drug availability and in monitoring illicit drug use and trafficking, including the diversion of legally manufactured drugs into illegal markets. A list of participating and reporting State and local forensic laboratories is included in Appendix B of the Office of Diversion Control (2008) report, *National Forensic Laboratory Information System: Midyear Report 2008* (Washington, DC: U.S. Drug Enforcement Administration). Boston 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 calendar year (CY) 2007 for 22 CEWG areas is included as figure 12 in section II, while a number of tables and other figures in section II (table 1) and section IV (tables 8, 9, and 12, and figures 15, 16, 18, and 19), along with appendix tables 2.1–2.22, are provided to display the data on forensic laboratory drug items identified for the period across areas. CEWG area Update Briefs in section III of this report also include NFLIS data for CEWG areas.

Average price and purity data for heroin for CEWG metropolitan areas in CY 2007 (the most recent period available) came from the DEA report, *2007 Heroin Domestic Monitor Program (HDMP) Drug Intelligence Report*, published November 2008. This report is prepared by the Domestic Strategic Intelligence Unit of the Special Strategic Intelligence Section, and reflects analysis of program data to December 31, 2007. Data from this report are included for the following CEWG sites/areas: Atlanta, Boston, Chicago, Dallas, El Paso, Houston, San Antonio, Denver, Detroit, Los Angeles, Miami, New York City, Philadelphia, Phoenix, San Diego, San Francisco, Seattle, St. Louis, Baltimore City, and Washington, DC. Figure 6 in section II and tables 5 and 6 in section IV show data for average price and purity for CEWG areas.

DEA ARCOS (Automation of Reports and Consolidated Orders System) data were presented by CEWG area representatives in several CEWG area presentations and Update Briefs contained in section III. Figure 5 in section II displays ARCOS data presented at the January meeting by an area representative. ARCOS is an automated, comprehensive drug reporting system that monitors the flow of DEA-controlled substances from their point of manufacture through commercial distribution channels to point of sale or distribution at the dispensing/retail level. The following controlled substance transactions are tracked by ARCOS: all Schedule I and II materials (manufacturers and distributors); Schedule III narcotic and gamma hydroxybutyric acid (GHB) materials (manufacturers and distributors); and selected Schedule III and IV psychotropic drugs (manufacturers only).

Local drug-related mortality data from medical examiners/coroners (ME/Cs) or State public health agencies were reported for 15 CEWG areas: Albuquerque, Atlanta, Baltimore City, Cincinnati, Denver, Detroit, Honolulu, Maine, Miami, Philadelphia, Texas, San Diego, Seattle, St. Louis, and Washington, DC. These are described in the Update Briefs in section III and shown in figures 1 and 2 in section II of this report.

Other data cited in this report were local data accessed and analyzed by CEWG representatives. The sources included: 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; High Intensity Drug Trafficking Area (HIDTA) reports; poison control centers and help lines; prescription drug monitoring systems; local and State surveys; and key informants and ethnographers (figures 6 and 8, in section II report poison control calls data, while figure 11 displays hospital admissions data for CEWG areas).

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; therefore, 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. Percentage distributions based on total treatment admissions by drug, including primary alcohol admissions, were used for all cross-area comparisons. Data on demographic characteristics (gender, race/ethnicity, and age group) and route of administration of particular drugs were provided for some CEWG areas and reported in Update Briefs. The numbers of admissions for alcohol and other drugs in the first half of 2008 are presented for 21 reporting CEWG sites/areas in appendix table 1, with rankings documented in section II, table 2. As noted, two areas reported FY 2008 in those tables. Treatment data are not totally comparable across CEWG areas, and differences are noted insofar as possible. Treatment numbers are subject to change.

ED Drug Reports—Because the DAWN *Live!* reports represent unweighted numbers of ED visits from samples of EDs that may vary over time, they cannot be compared across CEWG areas or data collection years, and the data may change after cases are reviewed for quality control. Percentages are calculated based on two totals—major substances of abuse and for the subcategory, opiates/opioids. Completeness data provided in appendix table 3.1 for each reporting CEWG area show the percentages of sampled EDs that were included in the DAWN *Live!* data for the report period. Maps displaying unweighted DAWN *Live!* data have been constructed (section II, figures 13 and 14) to illustrate the proportions of unweighted drug reports in drug-related ED visits for particular substances within reporting areas. Readers are cautioned that these

percentages are calculated based on reports from EDs in the DAWN sample that submitted data for the reference period and are not final estimates for the areas.

Forensic Laboratory Drug Items Identified—NFLIS includes drug chemistry results from completed analyses only; drug evidence secured by law enforcement but not analyzed in laboratories is not included in the NFLIS database. State and local policies related to the enforcement and prosecution of specific drugs may affect drug evidence submissions to laboratories for analysis. Laboratory policies and procedures for handling drug evidence vary, and range from analysis of all evidence submitted to the laboratory to analysis of selected items only. Many laboratories do not analyze the evidence when a case was dismissed or if no defendant could be identified (see NFLIS 2008 Midyear Report cited earlier). Differences in local/State laboratory procedures and law enforcement practices across areas make 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 of the total number of drug items seized and 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 that performed the item identification, the first half of 2008 NFLIS data cannot be compared with pre-2007 data presented in prior CEWG reports. The nature of the reporting system is such that there may be a time lag between the time of seizure, the time of analysis of drug items, and the time of reporting to the NFLIS system. Therefore, differences in the number of drug items for a specified time period may occur when NFLIS is queried at different times, since data input is daily and cases may be held for different periods of time before analysis and reporting in

various areas and agencies. This results in reporting lags. Numbers of drug items presented in these reports are subject to change and may differ when drawn on different dates.

Deaths—Mortality data may represent the presence of a drug detected in a decedent or 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.

Arrest and Seizure Data—The numbers of arrests and quantities of drugs seized often reflect enforcement policy and resources, rather than level of abuse.

Local Area Comparisons

The following methods and considerations pertain to 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 may also differ depending on the data source. Care has been taken to delineate the definition of the geographic unit under study for each data source, whether a city, a single metropolitan county, an 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 western region in this report, rather than in the census-defined southern region, based on member recommendations concerning area comparability of drug patterns and similarity of population characteristics to other western areas.
- In section IV 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 primary alcohol admissions in the total on which percentages are based. However, all cross-area comparisons use only the latter measure.
- Nearly all treatment data in the cross-area comparison section of this report cover the first half of 2008, which is characterized as the current reporting period.
- All ED data are based on unweighted preliminary DAWN data for the first half of 2008 and cannot be compared across time or areas. The completeness data are provided in appendix table 3.1, along with data in appendix table 3.2 of drug mentions by drug for each reporting area. Completeness tables reflect the extent of completeness of coverage among sampled EDs over the period to provide the reader with a measure of sample participation and response rates.
- Some indicator data are unavailable for certain cities. Therefore, the symbol, “NR,” in tables refers to data not reported by the CEWG area representative.
- The population racial/ethnic composition differs across CEWG areas. Readers are directed to the individual CEWG Update Briefs in section III of this report for information regarding treatment patterns and trends pertaining to race/ethnicity, age, and gender.

Section II. Highlights and Summary of Key Findings and Emerging Drug Issues From the January 2009 CEWG Meeting

THE CORNERSTONE OF THE CEWG MEETING IS the CEWG area report. Area representatives provide 20-minute presentations summarizing the most recent data pertaining to illicit and abused drugs and noting changes since the prior meeting. These data are viewed as indicators of the drug problem in an area. Indicators reflect different aspects of the drug abuse situation in an area, such as prevalence of abuse of drugs (e.g., survey findings), consequences of drug abuse (e.g., drug-related ED reports, substance abuse treatment admissions, and drug-related deaths), and availability of abused substances or law enforcement engagement (e.g., drug seizures). Qualitative information from ethnographic studies or local key informants is also used to describe drug use patterns and trends, and may be particularly informative in the early identification of new issues or substances being misused or abused.

In presenting area reports, CEWG representatives are invited to use their professional judgment and knowledge of the local context to provide an overall characterization of the indicators for their areas, as possible, given available data; that is, to assess whether indicators appear to be stable, increasing, decreasing, or are mixed so that no consistent pattern is discernable. CEWG representatives may also provide an overall characterization of the level of the indicators as high, moderate, or low, or identify when particular drugs are considered to be the dominant drugs of abuse in an area. Some indicators are sensitive to recent changes in local policy or law enforcement focus; therefore representatives use their knowledge of the local context in describing and interpreting data available for their area.

Update Briefs reflecting the CEWG area presentations are included in section III of this report. Area Update Briefs document and summarize drug abuse trends and issues in specific CEWG areas, with an emphasis on information newly available since the June 2008 meeting area reports. The availability of data varies by area. Readers are directed to the Data Sources section of the Update Briefs in section III to determine which data sources were reviewed for particular areas.

Subsequent to the CEWG meeting, data available across a majority of CEWG areas, such as substance abuse treatment admissions and information from NFLIS, are reviewed. These data are presented in section IV of this report and in appendix tables 2.1–2.22. Highlights from these cross-area tabulations are also included in section II.

For the January 2009 CEWG meeting, CEWG representatives were invited to provide an overview and update on drug abuse trends in their areas, with particular attention to issues pertaining to the abuse of heroin and prescription opiates. Representatives from United States border States, Mexico, and Canada were also invited to briefly address drug abuse issues along the United States northern and southern borders. Following the January 2009 area presentations, CEWG representatives convened in small work groups organized by region to discuss local issues in the regional context and to facilitate the identification of issues and patterns within and across regions. Key findings and issues identified are highlighted in section II, with more detail provided in the Update Briefs in section III.

Findings in this report are summarized by type of substance, but it is important to note that polysubstance abuse continues to be a pervasive pattern across all CEWG areas.

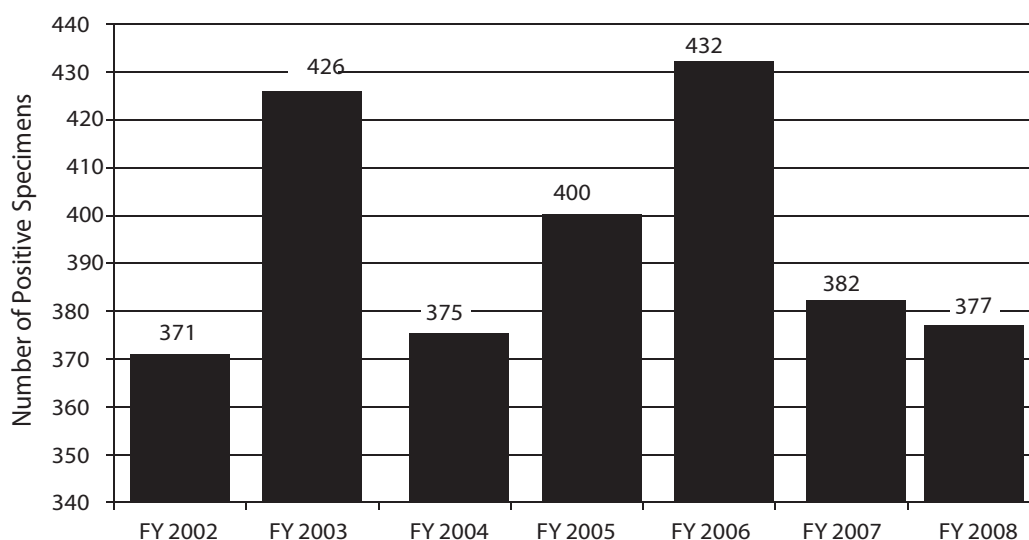
Cocaine/Crack

- Cocaine indicators remained high and stable in several areas of the northeastern and mid-western regions of the United States, including Chicago, St. Louis, Minneapolis/St. Paul, and Boston. However, cocaine abuse indicators were reported as mixed in New York City, and, based on several indicators, as falling slightly in Cincinnati, Philadelphia, Maine, and Detroit in the current 2008 reporting period.
- Stable or slightly downward trends were also reported in CEWG areas in the southern and western regions. Indicators suggesting decreasing trends in cocaine abuse include: treatment admissions in Miami, Atlanta, and Maryland; deaths, arrests, and treatment admissions

in Hawai'i (following a multi-year pattern); and all cocaine abuse indicators in Phoenix. The Atlanta CEWG area representative noted declines in the number of postmortem specimens testing positive for cocaine in FY 2007 and FY 2008 (figure 1). Treatment admissions for cocaine were slightly elevated in San Francisco and Colorado, but were unchanged and stable from previous reporting periods in San Diego and New Mexico.

- Selected findings from CEWG area reports illustrate how prominently cocaine figures in the indicator data in many areas across regions. Treatment admissions and deaths attributed to cocaine remained high in the Seattle area. Cocaine was the most common illicit drug identified in unweighted DAWN ED reports in Seattle. However, for the first time in the unweighted DAWN *Live!* data, prescription opiates ($n=2,138$) slightly exceeded cocaine ($n=2,132$) in ED reports in that area. The CEWG member from the Denver area

Figure 1. Number of Postmortem Specimens Testing Positive for Cocaine, Georgia: FY 2002–FY 2008



SOURCE: Georgia Bureau of Investigation, Medical Examiner's Office, as reported by Brian Dew at the January 2009 CEWG meeting

reported that cocaine deaths and unweighted DAWN ED reports continued to dominate drug abuse indicators, while treatment admissions decreased slightly. The cocaine poisoning death rate in Albuquerque was the highest of all drugs reported, while Miami/Dade County had the highest proportion of cocaine-related deaths, primary cocaine treatment admissions, and crime lab cases in Florida. However, both cocaine-related treatment admissions and cocaine-related deaths were reported as declining in the first half of 2008 in Florida and in Miami/Dade and Ft. Lauderdale/Broward Counties, reversing previously reported increases. These two South Florida counties nevertheless have the highest percentage of indicators of cocaine-related consequences in the State and across all CEWG reporting areas.

- Shifts in the race/ethnicity and gender of primary cocaine treatment admissions were reported in several CEWG areas. The Boston area representative reported an increase in female primary cocaine treatment admissions. Several area representatives noted that some treatment clients may be switching from methamphetamine to cocaine. Evidence of a shift to higher percentages of Hispanics and/or Whites among cocaine treatment admissions was reported by representatives from Texas, Atlanta, and Philadelphia. For example, the Atlanta area member reported that while a majority of cocaine treatment admissions were still African American, there continued to be an increase in White cocaine treatment admissions, and Hispanic treatment admissions more than doubled in the first half of 2008, compared with previous periods. The Philadelphia representative reported a decline in African-American cocaine treatment admissions, accompanied by increases in White admissions.
- Treatment admissions data for the first half of 2008 revealed that treatment admissions for primary cocaine/crack, as a percentage of total drug treatment admissions, including primary alcohol admissions, ranked first in frequency

in 2 of 21 reporting CEWG areas: Miami/Dade County and Philadelphia (table 2).

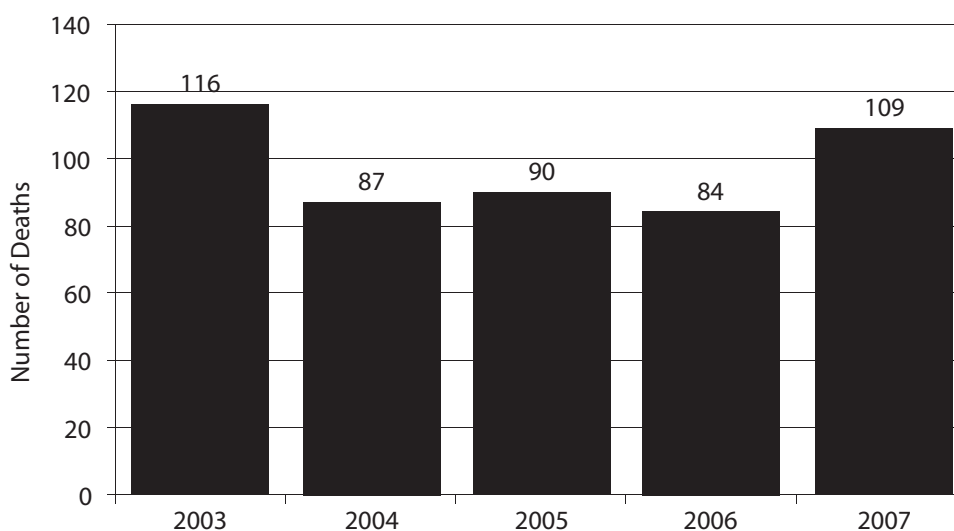
- Cocaine was the drug most frequently identified by forensic laboratories in 13 of 22 reporting CEWG areas. Based on forensic laboratory analysis of drug items identified in the first half of 2008, cocaine/crack ranked first in four of five areas in the southern region (Miami/Dade County, Baltimore City, Atlanta, and Washington, DC), two of three areas in the northeastern region (New York City and Philadelphia), and six of nine areas in the western region (Albuquerque, San Francisco, Seattle, Los Angeles, Denver, and Texas). Cocaine also ranked first in one of the five CEWG areas in the midwestern region, Minneapolis/St. Paul, in frequency of drug items identified (section II, table 1; appendix table 2).

Heroin

- Heroin abuse indicators increased in a number of areas after stability or slight declines for several prior reporting periods. However, the upward trend did not follow regional patterns. Heroin abuse indicators have increased in Miami/Dade County, Atlanta, St. Louis, Detroit, and the Minneapolis/St. Paul area.
- Heroin treatment admissions were reported as having increased in the current reporting period in Cincinnati, San Francisco, Detroit, San Diego, Phoenix, and Hawai'i (reversing a previous downward movement in heroin indicators in that State). Heroin treatment admissions for Los Angeles have been stable since 2005.
- Drug overdose deaths involving heroin (or much less often morphine), rose in San Diego in 2007, compared with 2006 (figure 2).
- Heroin indicators remained high and stable in: Boston; Chicago; Maryland; Washington, DC; New Mexico; Philadelphia; and New York City (although treatment admissions declined in the latter area in the first half of 2008).

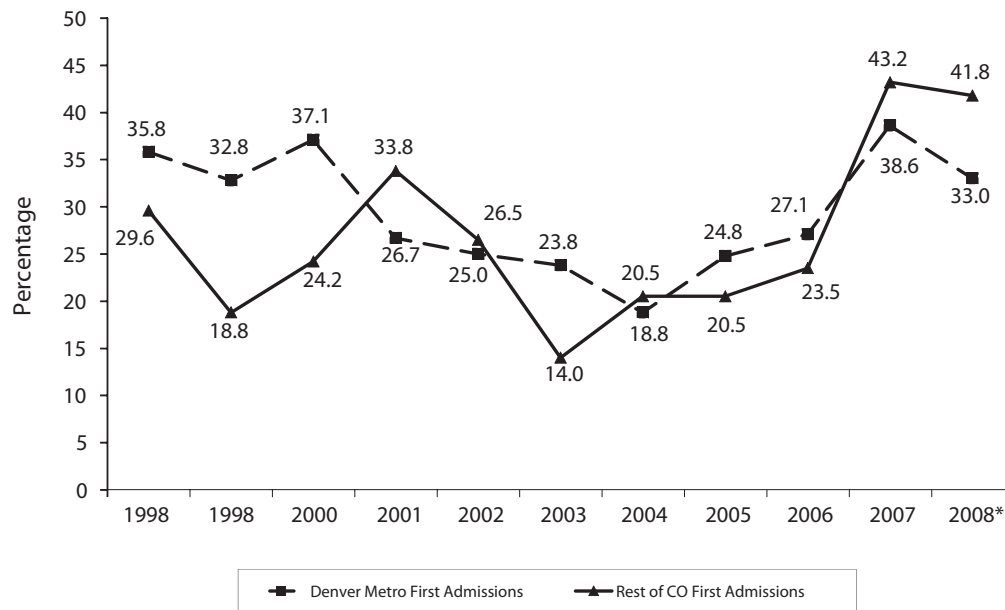
- A slight downward trend was noted in some reporting areas, including Seattle (where heroin mortality was at its lowest point in a decade), Denver, and Maine.
- The Texas representative reported that heroin indicators were low and stable, but the proportion of heroin treatment admissions who reported inhaling or sniffing has increased.
- The Denver CEWG area member observed that percentages of primary heroin treatment admissions who were first-time admissions (suggesting new users) in the Denver metropolitan area had increased from 27.1 percent in 2006 to 33.0 percent in 2008. This trend was mirrored in the rest of the State of Colorado, where the increase was from 23.5 percent in 2006 to 41.8 percent in 2008 (figure 3).
- The Texas representative reported that in Dallas arrests and overdoses related to “cheese heroin”, a mixture of Tylenol PM® and heroin (heroin combined with diphenhydramine and acetaminophen), were down, but treatment admissions of young heroin users were increasing.
- The New York City area member reported, based on information from the Street Studies Unit, that heroin users are crushing prescription pills into powder form and mixing them with heroin. The users are smoking this mixture in blunt cigars.
- Based on ethnographic reports, a potential increase in the availability of Mexican heroin of high quality was a concern expressed by area members from the southern region of the country, including Miami and Atlanta.
- Declining purity and increasing price of heroin—both South American (SA), which predominates in northeastern regional drug markets, and Mexican, which is the most common form of heroin used west of the Mississippi River—were noted by several CEWG areas representatives, including the Boston area member (figure 4).

Figure 2. Number of Drug Overdose Deaths Involving Heroin/Morphine, San Diego: 2003–2007



SOURCE: San Diego County Health and Human Services Agency Medical Examiner Database, as reported by Robin Pollini at the January 2009 CEWG meeting

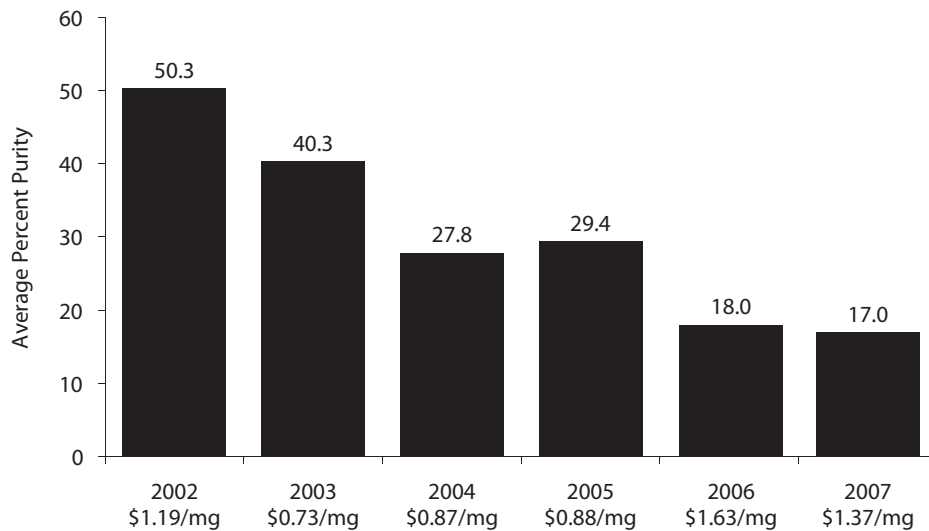
Figure 3. Percentages of Heroin Treatment Admissions Among First-Time Admissions, Denver Metropolitan Area Compared with the Rest of the State of Colorado: 1998–2008¹



¹2008 estimated based on partial year data.

SOURCE: Colorado Drug/Alcohol Coordinated Data System maintained by the Alcohol and Drug Abuse Division of the Colorado Department of Human Services, as reported by Bruce Mendelson at the January 2009 CEWG meeting

Figure 4. Average Percent Purity and Average Price¹ of Heroin, Greater Boston: 2002–2007



¹Price reflects cost of a 100-percent pure milligram. Boston samples are predominantly South American in origin and distributed in clear or colored glassine or wax packets. Past documented supplying sources have routed through New York City, Miami, and Houston.

SOURCE: HDMP, DEA; Graphics: Boston Public Health Commission Research Office, as reported by Daniel Dooley at the January 2009 CEWG meeting

- The Detroit CEWG representative reported an increase in heroin-related treatment admissions, and an increase in the percentage of White non-Hispanic clients among those admissions during the current reporting period.
- The Phoenix area member reported that although Arizona has been almost exclusively a black tar heroin area for decades, recent law enforcement seizures indicate that Phoenix may now serve as a feeder city for white heroin arriving from Mexico. Law enforcement sources indicate that the white heroin is being transported to wholesale distribution markets in the Midwest and Northeast. To date, white heroin has not been encountered by local wholesale or street level distributors based in the Phoenix area.
- Heroin primary treatment admissions, as a percentage of total admissions, including primary alcohol admissions, were particularly high in Baltimore City (approximately 55 percent), followed by Boston (approximately 48 percent) in the first half of 2008. In both Baltimore City and Boston, along with Detroit, heroin primary admissions ranked first as the most frequent substance abuse admissions in the reporting period (section II, table 2; section IV, table 4; appendix table 1).
- In 16 of 22 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in NFLIS forensic laboratories in the first half of 2008. Proportions were highest in Baltimore City and Maryland (approximately 22 and 20 percent, respectively). They were lowest in Texas and Atlanta, at approximately 2 percent of drug items identified (section IV, figure 16; appendix table 2). Heroin was not ranked first in drug items identified in forensic laboratories in any CEWG area (section II, table 1).
- According to the DEA's HDMP, in CY 2007, SA heroin continued to be the primary source of heroin east of the Mississippi River, as has been the case since the mid-1990s, while Mexican black tar and, to a lesser extent, Mexican brown

powder heroin dominated markets west of the Mississippi (section IV, figure 17). The HDMP also reported that in 2007, for the second straight year, no Southeast Asian heroin was purchased through the program in any areas. However, Southwest Asian heroin, although limited, was purchased in these CEWG areas: Atlanta, Baltimore, Chicago, Detroit, and Washington, DC. The number of samples of Southwest Asian heroin purchased rose from 12 in 2006 to 27 samples in 2007.

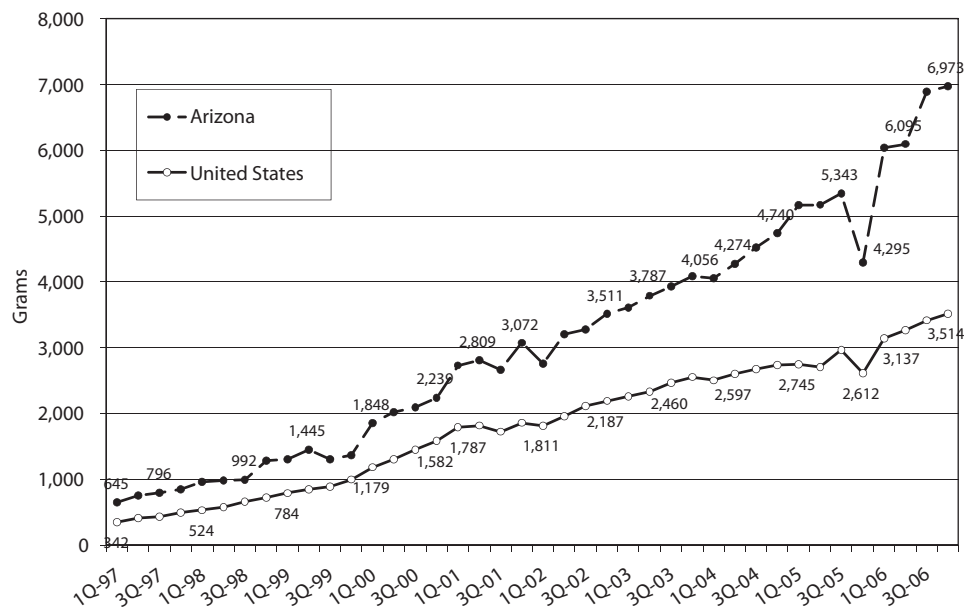
- From 2006 to 2007, average purity levels for SA heroin increased in 6 of 10 CEWG areas, in contrast to 2005–2006, when purity levels remained stable or declined in most areas. These six areas were Philadelphia, New York City, Detroit, Chicago, St. Louis, and Washington, DC (section IV, table 5).
- Over the 1-year period from 2006 to 2007, average prices for SA heroin fell in 6 of 10 CEWG areas (Atlanta, Chicago, St. Louis, Miami, Boston, and Washington, DC) and rose in 4 (Philadelphia, New York City, Baltimore City, and Detroit) (section IV, table 5).
- From 2006 to 2007, Mexican heroin average purity declined in five CEWG areas (San Diego, El Paso, San Antonio, Houston, and San Francisco). Average purity increased in four areas (Seattle, Phoenix, Denver, and Dallas), and remained constant in one area (Los Angeles). The average price was lower or the same in 2007, compared with 2006, in 7 of 10 reporting CEWG areas, namely Seattle, Phoenix, Denver, San Diego, Los Angeles, Dallas, and Houston, but was higher in El Paso, San Antonio, and San Francisco (section IV, table 6).

Other Opiates/Narcotic Analgesics

- In the first half of 2008, indicators for opiates other than heroin were reported for selected narcotic analgesics, including oxycodone, hydrocodone, methadone, fentanyl, and buprenorphine, by CEWG area members in Update Briefs and meeting presentations.

- Continuing increases in narcotic analgesic abuse indicators were reported in Miami, Chicago, Denver, Colorado, Phoenix, Los Angeles, Seattle, and New Mexico. In Chicago, for example, hydrocodone forensic laboratory drug items identified increased from 49 percent of all such drug items in 2007, to 58 percent in the first half of 2008.
- The Maine representative reported a continuing problem with prescription drugs, with indicators for oxycodone and methadone at high levels and increasing. Deaths in Maine from oxycodone were reported as increasing, while methadone-induced deaths were stable but still high. Law enforcement seizures for both oxycodone and methadone increased in the reporting period.
- In the current reporting period, Ft. Lauderdale/Broward County led the nation in the amount of oxycodone directly provided by dispensing practitioners, based on DEA ARCOS data.
- Retail sales of oxycodone, hydrocodone, morphine, and methadone have risen sharply in the Phoenix area, where sales of oxycodone, morphine, and methadone were higher than in the Nation as a whole. Trends in retail sales of oxycodone in Arizona and the United States from the first quarter of 1997 through the third quarter of 2006 are shown in figure 5.
- Death rates from narcotic analgesics, mainly attributed to accidental overdoses, increased in Albuquerque, and higher death rates were reported in New Mexico counties bordering Mexico than in nonborder counties, based on analyses by the area representative. In Maryland, narcotics were the most frequently identified drugs in drug abuse deaths in 2007.
- Abuse of opioid narcotics (oxycodone and hydrocodone) was noted by the Cincinnati area representative as an increasing drug issue in that area, while the Texas CEWG member also reported a continuing and increasing problem with hydrocodone.

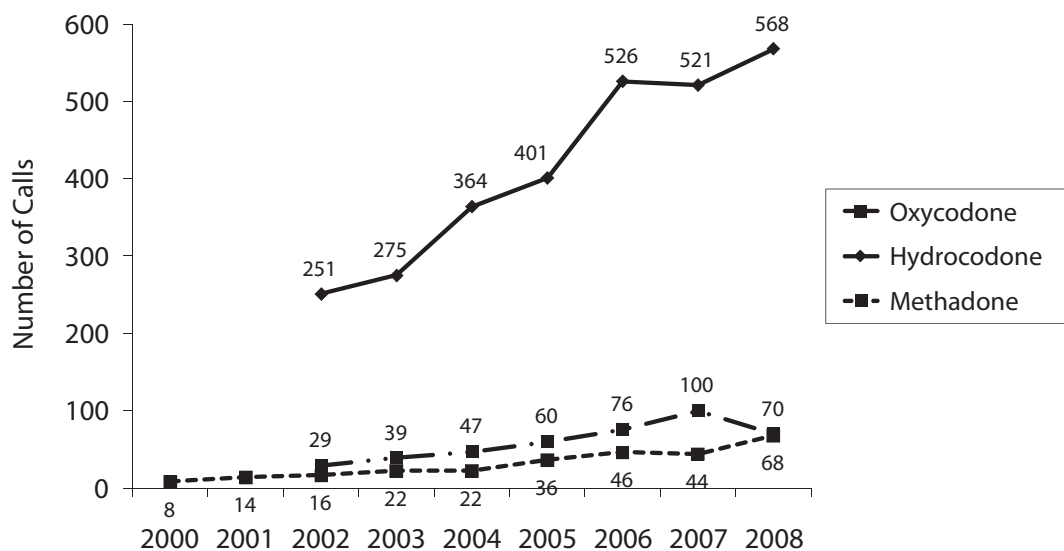
Figure 5. Oxycodone in Grams Distributed per 100,000 Population, Arizona and the United States, in Quarters of the Year: 1997–2006



SOURCE: DEA, ARCOS, as reported by James Cunningham at the January 2009 CEWG meeting

- In Detroit, hydrocodone poison control center calls have increased over the period from 2000 to 2008, with recent increases in numbers of human intentional exposure calls, from 526 in 2005, and 516 in 2006, to an estimated 568 in 2008. Oxycodone calls showed signs of declining in the 2007–2008 period, while methadone calls increased (figure 6).
- Indicators for prescription drug abuse in Atlanta were low and stable. Philadelphia and New York City had mixed and low indicators, but prescription drugs were widely available on their streets. Although still low in Los Angeles, indicators for prescription narcotics were reportedly increasing. Similarly, the Denver area member reported an increase in the use of “other opiates” since previous reporting periods.
- In Seattle, prescription-type opiates continued as the most commonly identified drug in fatal overdoses and unweighted DAWN ED reports. The San Francisco CEWG member reported an increase in proportions of hydrocodone and oxycodone in unweighted DAWN ED reports in the coastal counties of the reporting area, but no increase in the inland counties.
- Treatment admissions for prescription narcotic analgesics were reported as on the rise in the Minneapolis/St. Paul area.
- Indicators for prescription narcotic analgesics have stabilized in St. Louis after an increase in the previous reporting period. However, there is anecdotal concern about an increase in the use of prescription narcotics in rural areas around St. Louis. Indicators for other opiate abuses were down in Hawai'i and Detroit, and the Boston area member reported stable indicators.
- In several CEWG areas, including Seattle, Detroit, Denver, and Atlanta, ethnographic, community outreach and other data sources identified the combined use of prescription opioids, such as oxycodone and heroin, or the

Figure 6. Number of Poison Control Center Calls¹ on Human Intentional Use of Oxycodone, Hydrocodone, and Methadone, Detroit: 2000–2008 Annualized²



¹New codes were added mid-2001.

²Annualized for 2008 based on January through June 2008 data.

SOURCE: Eastern Michigan Poison Control Center, as reported by Cynthia Arfken at the January 2009 CEWG meeting

crossover or transition from one to the other. The importance of alcohol and other drug interactions were also emphasized by several CEWG members, including the Minneapolis/St. Paul representative.

- Several CEWG area representatives reported that methadone abuse indicators appeared to be leveling off (Cincinnati) or declining. For example, the Detroit, Hawai'i, and Miami members reported declining numbers of methadone-related deaths, compared with previous periods, and the Chicago member reported decreased numbers of drug items seized and identified as methadone.
- CEWG members from Maine, Boston, New York City, Philadelphia, Maryland/Washington, DC, Atlanta, Cincinnati, Chicago, Detroit, Texas, and Seattle mentioned buprenorphine in their area presentations or Update Briefs. The type of information reported varied by area.
- The representative from Maine reported that seizures of buprenorphine in Maine increased from 2007 to 2008 based on forensic testing of items seized. The CEWG member from Boston reported 148 mentions of buprenorphine in drug-related ED visits in 2006 in the Greater Boston DAWN reporting area, which includes the New England County Metropolitan area, based on weighted estimates from DAWN. During this same time period, there were more than 9,400 ED mentions of heroin in DAWN data for this area. Based on information from the New York State Office of Alcoholism and Substance Abuse Services Street Studies Unit, the New York City representative reported that Suboxone® has become available on the street and that 8-milligram pills can be obtained on the street for \$10 each. In Philadelphia, buprenorphine ranked 14th in seized items reported to NFLIS and represented 0.1 percent of total NFLIS items identified from January through June 2008.
- Retail distribution of buprenorphine in Washington, DC and Baltimore City increased from

2005 to 2006, based on ARCOS data presented by the Maryland/Washington, DC representative. The Atlanta representative reported that Suboxone® is available on the black market at \$15–\$20 per 8-milligram pill, according to information derived from ethnographic reports.

- Indicators for abuse of buprenorphine-containing pharmaceuticals increased in the past reporting period in Cincinnati (with a 61-percent increase in human exposure calls to poison control in 2008 over 2007). This was interpreted to suggest an increased diversion of the drug to the streets. Based on ethnographic observations from the University of Illinois at Chicago Community Outreach Intervention Projects, the Chicago area member reported that buprenorphine use is increasing among heroin users, who are using it to withdraw or better manage their addiction. According to the Detroit representative, participants in law enforcement focus groups discussing drug issues in Detroit reported that they were not hearing anything about buprenorphine on the street in Detroit.
- The representative from Texas reported low buprenorphine use based on the indicator data, and the area member from Seattle also reported that buprenorphine remained at low levels across the data sources. Of note, two overdose fatalities were positive for buprenorphine in the first half of 2008 in King County (the county in which Seattle is located), following the first such death identified in the area in the first half of 2007. In these cases, drug tests were positive for buprenorphine and other prescription-type drugs but not for illicit drugs.
- Treatment admissions for primary abuse of other opiates as a percentage of total admissions, including primary alcohol admissions, ranged from 1 to approximately 7 percent in 16 of 17 reporting CEWG areas. The outlier was Maine, where nearly 30 percent of primary treatment admissions were for other opiate problems (section IV, table 7; appendix table 1).

- Of total drug items identified in forensic laboratories in 22 CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in the first half of 2008. In Baltimore City, Philadelphia, Boston, Cincinnati, and Maryland, oxycodone ranked fourth in drug items identified, and it ranked fifth in Albuquerque and Seattle. Hydrocodone ranked fourth in Detroit and fifth in frequency of drug items identified in Atlanta, Cincinnati, Texas, and Phoenix (table 1; section IV, table 8).
- Based on NFLIS data, buprenorphine ranked fifth in identified drug items in Boston, Baltimore City, and Maryland in the first half of 2008 (table 1).
- Methadone ranked 6th in identified drug items from NFLIS data in New York City, 7th in Baltimore City, 8th in Maryland, 9th in Boston and San Francisco, and 10th in Philadelphia during the reporting period (table 1).

Benzodiazepines/Depressants

- Alprazolam and clonazepam continued to be the most frequently reported benzodiazepines in the indicator data in the current reporting period.
- The Maine representative reported high and increasing levels of benzodiazepine-related deaths and law enforcement seizures, while increased benzodiazepine abuse indicators were reported by the Cincinnati and Texas representatives, particularly alprazolam and clonazepam in Cincinnati and alprazolam in Texas. The Atlanta representative reported that death rates related to benzodiazepines continued to rise in the Atlanta area during the reporting period.
- Texas had the highest percentage of alprazolam drug items identified in forensic laboratories in the first half of 2008, at 4.2 percent, followed by Atlanta (3.7 percent), and Philadelphia (2.9 percent). Alprazolam ranked fourth in frequency among the top 10 drug items identified in four

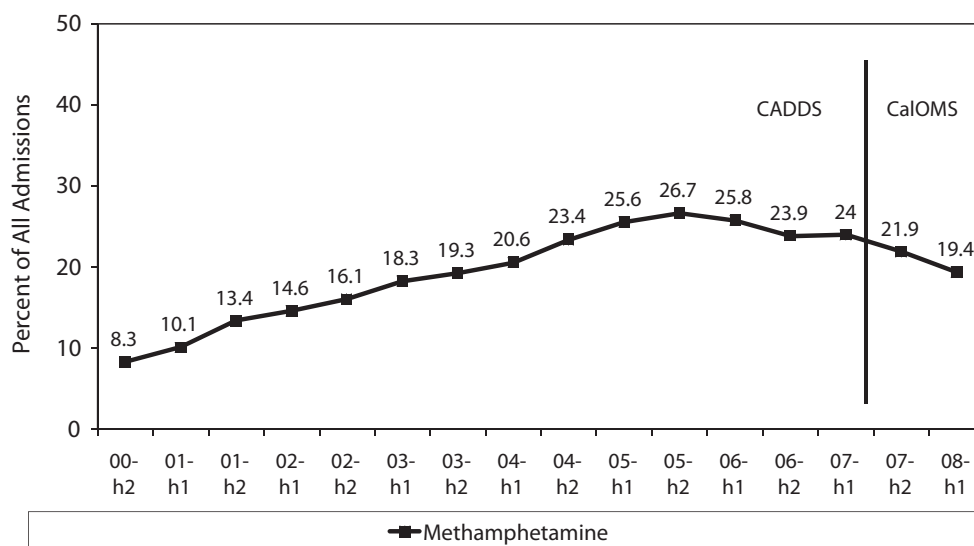
CEWG areas: Miami/Dade County, Atlanta, New York City, and Texas. It ranked fifth in Philadelphia (table 1; section IV, table 9).

- Drug items containing clonazepam accounted for 1.7 percent of all drug items in Boston, where clonazepam figured as the sixth most frequently identified drug in forensic laboratories in the first half of 2008 (table 1; section IV, table 9).
- Diazepam ranked 7th in Honolulu, 9th in Cincinnati and San Diego, and 10th in San Francisco among drug items identified in NFLIS forensic laboratories in the first half of 2008 (table 1).

Methamphetamine

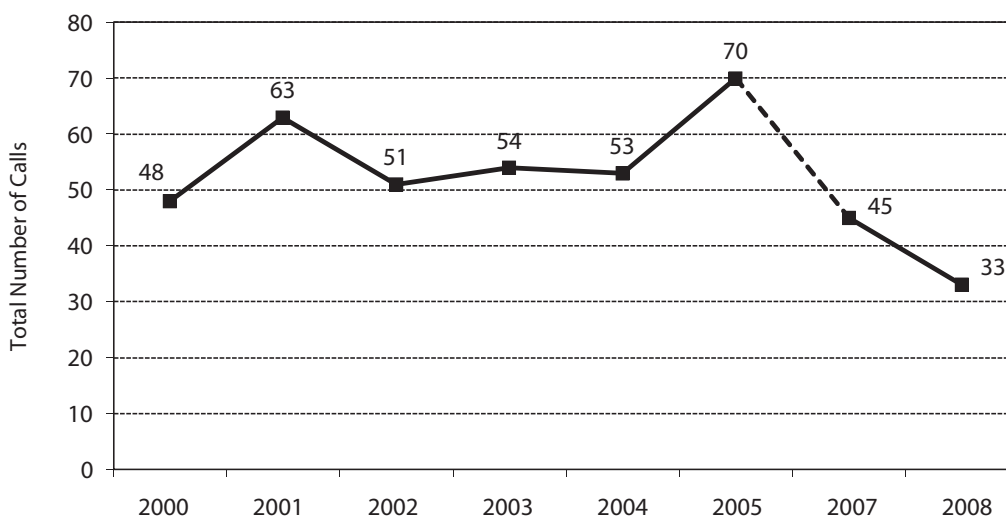
- During the first half of 2008, indicators of methamphetamine abuse declined overall across many CEWG areas, especially in the western and midwestern regions, continuing the downward trend that began in 2005–2007 for many of these areas.
- Methamphetamine indicators have begun or continued to decrease across nearly all of the CEWG areas where methamphetamine indicators have been highest, specifically in the western region. Nevertheless, methamphetamine indicators were still considered to be high relative to other drugs in most areas in the western region.
- Examples of declines are shown in figures 7 and 8 for Los Angeles. The proportions of primary methamphetamine treatment admissions peaked in the second half of 2005, at 26.7 percent of total admissions, and have dropped fairly steadily to 19.4 percent in the first half of 2008 (figure 7). Figure 8 shows declines in the numbers of poison control center calls for methamphetamine in Los Angeles, from 70 in 2005 to 33 in 2008, based on projections for the first 9 months of the year.
- Having reported declines in methamphetamine abuse indicators for the previous reporting

Figure 7. Primary Methamphetamine Treatment Admissions as a Percentage of Total Admissions, Los Angeles County: 2000–2008 in Half-Year Intervals¹



¹Half-year data are indicated and defined as follows: "h1"= first half (January-June); "h2"=second half (July-December).
 SOURCE: Los Angeles Alcohol and Drug Program Administration & California Alcohol and Drug Program, California Outcome Monitoring System (CalOMS), 2008 (06/h2-08/h1); CADDs (00/h2-06/h1) as reported by Mary-Lynn Brecht at the January 2009 CEWG meeting

Figure 8. Number of Calls to the Poison Control System Related to Mehtamphetamine, Los Angeles County: 2000–2008¹



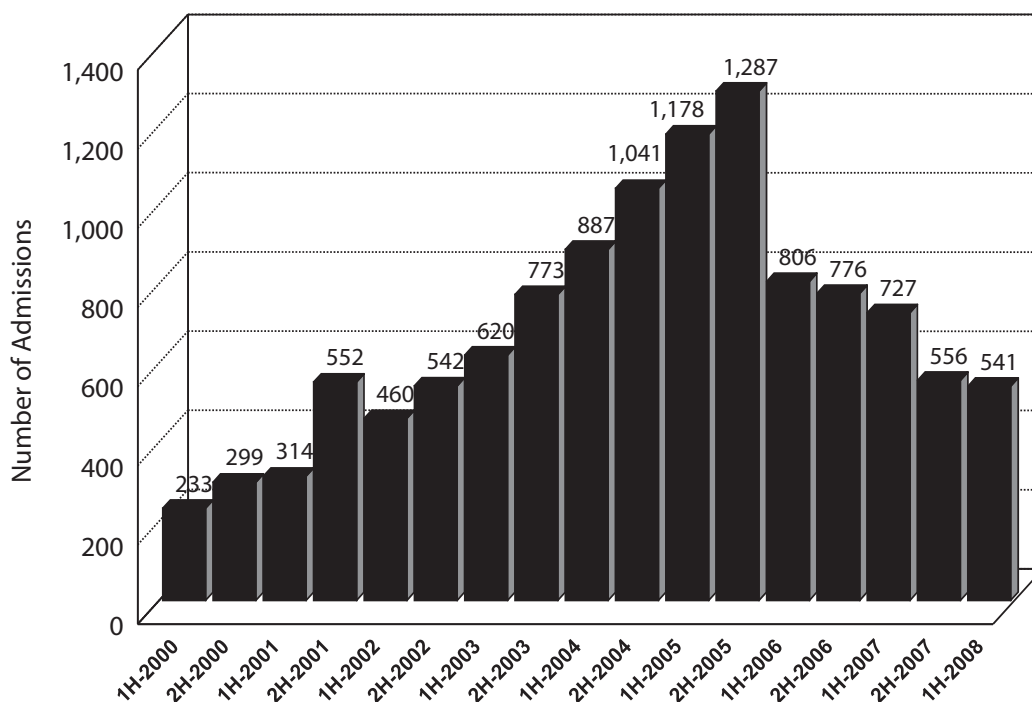
¹2008 is projected from January–September data; 2006 data not available for this report (numbers of illicit drug reports are approximately 9 percent of all drugs reported).
 SOURCE: California Poison Control System, as reported by Mary-Lynn Brecht at the January 2009 CEWG meeting

period (CY 2007), Hawai'i, Los Angeles, Colorado, San Diego, Phoenix/Maricopa County, and Texas continued to report declines in the first half of 2008. In Phoenix, the area representative reported that some anecdotal evidence may indicate that the methamphetamine supply is beginning to turn upward again. In addition, methamphetamine indicators were leveling off or declining slightly in Seattle, stable or declining in the Denver/Boulder area, and declining in San Francisco. Indicators (including overdose deaths, arrestee prevalence, treatment admissions, and drug items identified in forensic laboratories) were down in San Diego, after peaking in 2005. The CEWG representative reported that methamphetamine has become less available and of lower quality with increased prices since 2005 in San Diego County, based

on survey data. In Albuquerque, methamphetamine indicators were reported as stable and as increasing slightly in New Mexico.

- In the midwestern region, methamphetamine indicators were reported as decreasing in the Minneapolis/St. Paul reporting area (figure 9), as stable or decreasing in St. Louis, and as stable or mixed in other areas of the region. Methamphetamine indicators were low in Chicago and Cincinnati.
- Methamphetamine indicators were low across most northeastern and southern CEWG areas, including Baltimore City, Maryland, Detroit, Philadelphia, New York City, Boston, Maine, and Washington, DC. Atlanta reported a decline in indicators in the first half of 2008. Despite the fact that methamphetamine abuse indicators in

Figure 9. Methamphetamine-Related Treatment Admissions in the Minneapolis/St. Paul Metropolitan Area: 2000–2008 (in Half-Year Intervals)¹



¹Half-year data are indicated and defined as follows: "h1"= first half (January-June); "h2"=second half (July-December).

SOURCE: Drug and Alcohol Abuse Normative Evaluation System, Minnesota Department of Human Services, 2008, as reported by Carol Falkowski at the January 2009 CEWG meeting

Miami/Dade County were relatively low, methamphetamine-related deaths were found to be increasing in the current reporting period.

- While methamphetamine use was reportedly low and stable in many of these urban areas, it may be increasing in rural areas, as suggested by anecdotal reports from the St. Louis region and other reporting areas that include rural counties.
- The proportions of primary treatment admissions including primary alcohol admissions for methamphetamine abuse in 17 reporting CEWG areas were especially high in Hawai'i, San Diego, and Phoenix, at approximately 33, 32, and 25 percent, respectively. They were also relatively high in San Francisco and Los Angeles, at approximately 20 and 19 percent, respectively (appendix table 1; section IV, table 10).
- Methamphetamine ranked first in treatment admissions as a percentage of total admissions in San Diego, and ranked second in Hawai'i, Los Angeles, and Phoenix (table 2).
- Methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in Honolulu in the first half of 2008, and second in Atlanta, Phoenix, and San Diego (table 1). The largest proportions of methamphetamine items identified were reported in Honolulu (close to 43 percent), followed by Minneapolis/St. Paul (approximately 27 percent), Phoenix (approximately 23 percent), and San Diego and Albuquerque (approximately 20 percent each). On the other hand, less than 1–2 percent of drug items identified as containing methamphetamine were reported in most CEWG metropolitan areas east of the Mississippi, including Chicago, Philadelphia, New York City, Cincinnati, Miami, Detroit, Baltimore City, Boston, and Maryland (section IV, figure 18; appendix table 2).

Marijuana

- Most CEWG area members reported marijuana abuse indicators as high and stable with a few exceptions. The New York City representative reported increases in marijuana abuse indicators in the current reporting period. In New York City, treatment admissions for marijuana increased to the highest number ever reported, and more arrestees tested positive for marijuana and self-reported marijuana use than any other drug. Marijuana-related primary treatment admissions also increased in St. Louis, and an increase in marijuana indicators was reported for San Francisco and Los Angeles. The Denver area representative reported that marijuana continues as the primary drug of abuse in Colorado and the Denver/Boulder metropolitan area, based on treatment admissions, ED reports, law enforcement drug testing, and both adult and juvenile arrests. It is the most widely used drug in New Mexico, and is a primary drug of concern in Cincinnati, where marijuana continues to dominate all other illicit drugs in treatment admissions.
- In Washington, DC, a higher percentages of juvenile arrestees tested positive for marijuana than for any other drug, with the percentage of positive marijuana tests increasing from 49.8 percent in 2005 to 53.6 percent in the first 10 months of 2008.
- The Texas and New York City area members reported that blunt cigars continued to be used for smoking marijuana. The New York City representative reported that marijuana in a blunt cigar often serves as a base to which other drugs are added, and noted that heroin users are crushing prescription pills into powder form, mixing with heroin, and smoking this mixture in blunt cigars.
- Marijuana treatment admissions as a proportion of total admissions decreased in the Detroit/Wayne County area for the first time in this decade. Hawai'i and Maine were two CEWG reporting areas where marijuana abuse

indicators showed declines based on more than one data source. Marijuana indicators were mixed in Phoenix and Texas.

- Percentages of primary marijuana treatment admissions, including primary alcohol admissions, were highest in the first half of 2008 in Cincinnati (30.2 percent), followed by Miami/Dade County (26.9 percent), and Denver (24.3 percent). The lowest proportions of such admissions were in Boston (3.1 percent) (section IV, table 11; appendix table 1).
- Marijuana did not rank first as the primary drug problem in total drug admissions (including alcohol admissions) in any CEWG area; however, marijuana ranked second in 8 of 21 CEWG areas, covering all four regions. These areas include Miami/Dade, Philadelphia, Cincinnati, Minneapolis/St. Paul, St. Louis, Colorado, Denver, and Texas (table 2).
- Cannabis/marijuana ranked first in frequency in the proportion of drug items identified in forensic laboratories in the first half of 2008 in 8 of 22 CEWG areas. These areas are Boston, Chicago, Cincinnati, Detroit, St. Louis, Philadelphia, San Diego, and Maryland (table 1). The highest proportions of marijuana items identified were in Chicago, San Diego, and St. Louis, at approximately 56, 51, and 50 percent, respectively (section IV, figure 19; appendix table 2).

MDMA/Ecstasy and Club Drugs

- While low compared with other drug abuse indicators in all CEWG areas, MDMA (methylenedioxymethamphetamine, or ecstasy) indicators were reported as increasing in several CEWG areas, including Miami/Ft. Lauderdale, Texas, Chicago, St. Louis, Los Angeles, San Diego, and Hawai'i.
- MDMA indicators were reported as mixed in the midwestern region. Self-reported MDMA/ecstasy use by Chicago students had increased, and MDMA/ecstasy was reported as still popular with users from low-income African-American neighborhoods in that city based on ethnographic information. MDMA indicators were reported as low to moderate, however, in St. Louis and Cincinnati, and as stable in Detroit.
- In the western region, MDMA abuse indicators remained relatively low, but increases were noted by the representatives from Los Angeles and San Diego, with continued concern in Seattle. MDMA indicators in Texas were stable or increasing. The Seattle representative reported that law enforcement data indicate that BZP (1-benzylpiperazine) is available in Seattle and has been sold in tablet form as MDMA. There was a large seizure in 2008 at the Canadian border of approximately 200,000 BZP tablets, according to the Seattle CEWG representative, who reported that BZP is potentially widely distributed in the area since Washington State has been a distribution point for MDMA from Canada to the United States.
- Generally, MDMA indicators were low and stable or decreasing in the southern and northeastern CEWG areas; however, the Miami/Ft. Lauderdale area CEWG Work Group member reported that MDMA continues to be found in combination with methamphetamine in South Florida. The Atlanta area member reported a stabilization of MDMA use, after reporting an increase in 2007. The Miami CEWG member also reported a growing concern regarding "sparkle," which is reportedly a combination of MDMA and phencyclidine (PCP).
- MDMA was the third most frequently identified drug item in Atlanta, and it ranked fourth in Chicago, Minneapolis/St. Paul, and Honolulu in the first half of 2008 (table 1; section IV, table 13).
- **Club Drugs:** Neither **ketamine**, **GHB (gamma hydroxybutyrate)**, nor **LSD (lysergic acid diethylamide)** figured among the top 10 most frequently identified drug items in any CEWG area (table 1). However, the Seattle CEWG member reported that lysergic acid diethylamide (LSD)

is returning in popularity in that area, where psychedelic mushrooms continue to be used.

PCP (Phencyclidine)

- PCP persisted on the drug scene in several CEWG areas east of the Mississippi (St. Louis, Washington, DC, Philadelphia, New York City, Miami, and Chicago) and two in the West (Los Angeles and Texas).
- The Philadelphia area representative reported that urinalysis results from the Adult Probation and Parole Department testing program have shown a gradual increase in the proportion of adult probationers and parolees testing positive for PCP, from 8 percent in 2005 to 12 percent in CY 2008. PCP deaths decreased, and treatment admissions were stable in the first half of 2008 in Philadelphia, compared with 2007. However, female treatment admissions, as a proportion of total PCP treatment admissions, have increased, from 14 percent in 2005 to 29 percent in the first half of 2008.
- In Washington, DC, in the first 10 months of 2008, approximately 10 percent of arrestees tested positive for PCP, compared with approximately 9 percent each in 2006 and 2007, and 8 percent in 2005, based on data from the District of Columbia Pretrial Services Agency. The percentage of juveniles testing positive for PCP remained stable at approximately 3 percent, from 2005 through the first 10 months of 2008. The Los Angeles area, however, did not show an increase in PCP indicators during the reporting period.
- In Washington, DC, PCP ranked fourth as the most frequently identified drug item in forensic laboratories in the first half of 2008 (table 1).

- PCP was also among the top drug items identified in Philadelphia, where it ranked sixth, and New York City, where it ranked fifth.
- No PCP items were documented among the forensic laboratory data on drug items identified in eight CEWG areas (Albuquerque, Atlanta, Cincinnati, Denver, Detroit, Honolulu, Miami, and Minneapolis/St. Paul), and fewer than 30 such items were identified in seven areas (Baltimore City, Boston, Phoenix, San Diego, San Francisco, Seattle, and St. Louis). The areas reporting 30 or more PCP items were Chicago, Los Angeles, New York City, Philadelphia, Maryland, Texas, and Washington, DC. (section IV, table 12).
- PCP figured among the top 10 most frequently identified drug items in seven CEWG areas from NFLIS data for the first half of 2008. Besides Washington, DC, New York City, and Philadelphia, where PCP ranked 4th, 5th, and 6th, respectively, in NFLIS drug items identified in 1H 2008, PCP ranked 7th in Los Angeles, and 10th each in Maryland, Chicago, and Texas (table 1). As a percentage of all identified items, PCP items were highest in Washington, DC, at 5.6 percent, followed by Philadelphia, at 2.7 percent, and New York City, at 1.5 percent (section IV, table 13; appendix table 2).

Other Drugs and Drug Abuse Patterns/Issues

- **BZP (1-benzylpiperazine)¹:** Findings from the January 2009 CEWG meeting suggest that BZP may be emerging as a drug of concern. BZP is a synthetic stimulant, usually consumed orally, but sometimes smoked or snorted. BZP is illegal, has no accepted medical use in the United States, and has been controlled as a Schedule I substance since 2004 under the Controlled Substance Act. The representative from Seattle

¹More information on BZP can be found at: http://www.deadiversion.usdoj.gov/drugs_concern/bzp_tmp/bzp_tmp.htm.

noted the recent emergence of BZP in the Seattle area and Washington State, and referred to law enforcement reports that BZP is being sold in tablet form as MDMA. The CEWG representatives from two midwestern areas, Chicago and Detroit, also noted in their meeting presentations the appearance of BZP in the indicator data in the first half of 2008. A review of the NFLIS data revealed the emergence of BZP in most CEWG areas as follows:

- In the first half of 2008, BZP emerged among the top 25 identified drugs in NFLIS forensic laboratories in all 22 CEWG areas, with the exception of 6: Albuquerque, Atlanta, Cincinnati, Philadelphia, New York City, and San Diego. This contrasts with CY 2007 when none of the 22 CEWG areas, with the exception of Detroit, listed BZP-containing drug items among the top 25 drugs identified in forensic laboratories. In Detroit, 11 BZP items were identified in CY 2007, representing 0.1 percent of all drug items identified, while in the first half of 2008, 20 items, or 0.6 percent of drug items in the half-year period, were so identified (no data shown).
- Table 1 shows BZP rankings among the top 10 most frequently identified drug items in NFLIS data in the first half of 2008. BZP ranked 7th in Seattle and Chicago, 9th in Washington, DC and Miami/Dade County, and 10th in Honolulu and Detroit.
- **TFMPP or 1-(3-trifluoromethylphenyl)piperazine²** is a synthetic substance abused for its hallucinogenic effects. TFMPP is currently an uncontrolled substance. It has no accepted medical use in treatment in the United States. The CEWG area member from Atlanta reported an increase in items containing TFMPP in the first half of 2008, when 117 such drug items

were reported, compared with CY 2007, when 16 such items were reported (no data shown). This represents an increase from 0.1 to 1.7 percent of drug items identified in the respective periods. In the first half of 2008, TFMPP ranked eighth among drug items most frequently identified in Atlanta and seventh in Washington, DC (table 1).

• **Foxy or Foxy Methoxy (5-Methoxy-N, N-diisopropyltryptamine, or 5-MeO-DIPT)³**

is a synthetic substance abused for its hallucinogenic effects. It is usually consumed orally as powder, tablets, or capsules, but route of administration may include smoking or snorting. It is illegal in the United States and has been controlled since 2004 as a Schedule I substance under the Controlled Substance Act. Increasing from none in CY 2007 to 19 drug items identified in Denver NFLIS laboratories in the first half of 2008, the drug, usually known as Foxy or Foxy Methoxy, made up 0.5 percent of total drug items in Denver in this reporting period (no data shown). The majority of these drug items identified as Foxy (18 out of 19) were seized in suburban Arapahoe County, south of Denver County, in the Denver MSA. It ranked 10th among the most frequently identified drug items in Denver in the reporting period (table 1).

- **Salvia divinorum⁴** was reported in Texas as an emerging drug of concern. The Texas area member reported that it is difficult for poison control centers to identify the correct species because it resembles other species in the mint family. *Salvia divinorum* is a perennial herb native to Mexico. Its active ingredient, salvinin A, produces hallucinogenic effects when it is chewed or smoked. *Salvia divinorum* is not currently controlled under the Federal Controlled Substance Act, but several States (and several

²More information on TFMPP can be found in the Federal Register Notice 68 FR 52872.

³More information on 5-MeO-DIPT can be found at: http://www.deadiversion.usdoj.gov/drugs_concern/5meodipt.htm.

⁴More information on *Salvia divinorum* is available at: http://www.usdoj.gov/dea/drugs_concern/salvia_d/salvia_d.htm and at <http://www.drugabuse.gov/infacts/salvia.html>.

other countries) have placed regulatory controls on *Salvia divinorum* and/or salvinorin A.

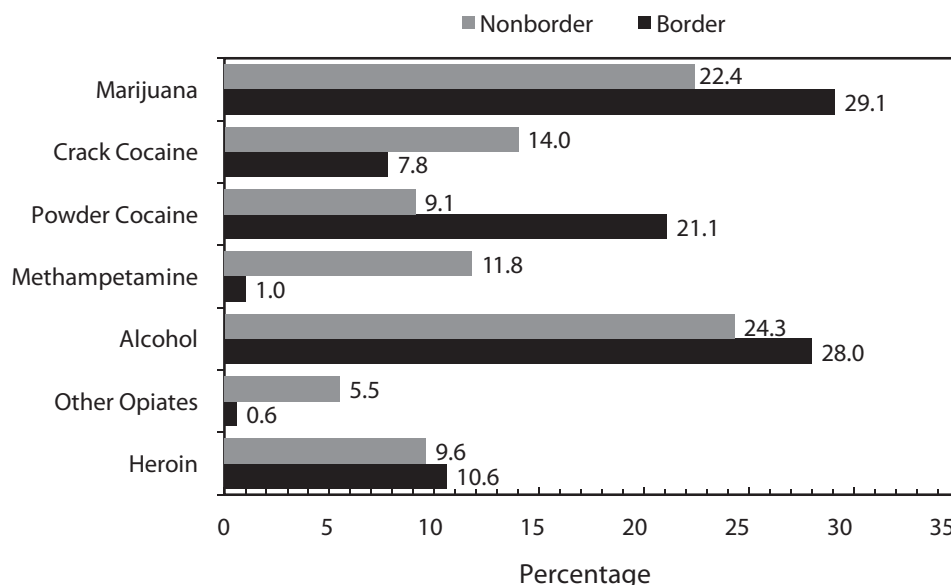
- **Carisoprodol (Soma®)**⁵ is a muscle relaxant and central nervous system depressant taken orally in tablet form. While it is currently not controlled on the Federal level and is available for therapeutic use by prescription, several States have scheduled Soma® as a controlled substance. Based on NFLIS data for 22 CEWG areas, drug items containing carisoprodol ranked 8th among all drug items identified in forensic laboratories in Texas and 10th in Atlanta, Los Angeles, and Phoenix in the first half of 2008 (table 1).
- The South Florida representative reported that the area is seeing an emergence of a new drug combination called “MTV,” which includes methamphetamine, the antiretroviral drug

tenofovir, and Viagra®. Use of the drug is called “PrEPing” (for pre-exposure prophylaxis), as reportedly people using it often forego condom use due to the inaccurate perception that it protects them from exposure to human immunodeficiency virus (HIV).

United States Border Drug Abuse Patterns and Issues

- Differences in drug abuse patterns and issues in border and nonborder areas of United States southern border States, and in northern border and nonborder areas of Mexico, were illustrated in the Texas, New Mexico, Phoenix, and Mexico reports.
- The Texas representative reported that a higher percentage of Texas border treatment clients in

Figure 10. Percentage of Treatment Admissions to Texas Department of Social and Health Services Treatment Facilities by Primary Substance Abuse Problem at Admission, Texas Border and Nonborder Areas: CY 2007



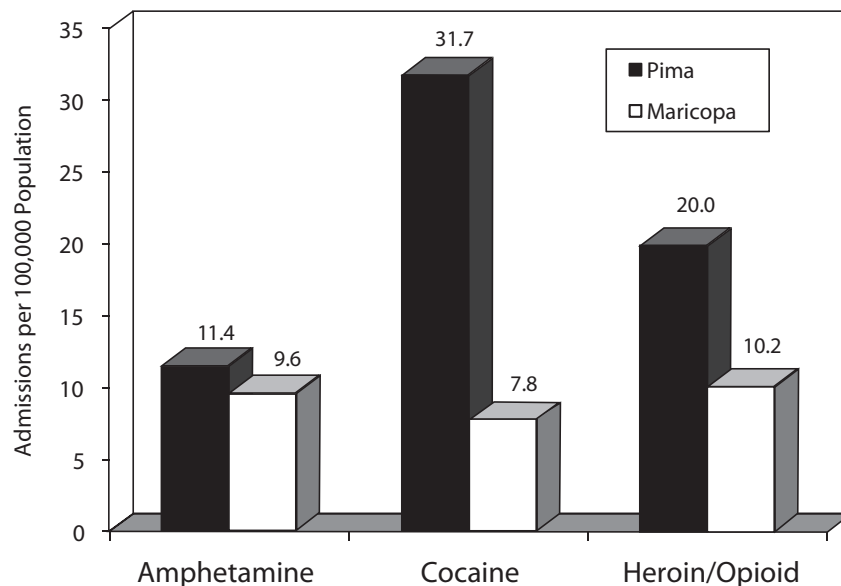
SOURCE: Texas Department of Social and Human Services data; analysis by Jane C. Maxwell as reported at the January 2009 CEWG meeting

⁵Information on carisoprodol and Soma® can be found at: http://www.deadiversion.usdoj.gov/drugs_concern/carisoprodol.htm.

2008 reported problems with marijuana, powder cocaine, alcohol, and heroin, while higher proportions of nonborder clients reported problems with crack/cocaine, methamphetamine, and other opiates (figure 10). The Texas representative also pointed out that treatment admissions exhibit regional variation from east to west along the Texas border, with cocaine the most commonly reported primary drug problem in the Lower Rio Grande Valley, marijuana in Laredo, and alcohol in El Paso.

- In New Mexico, 1,588 unintentional drug poisoning deaths were reported during 2003–2007, a death rate of 16.5 per 100,000 population. The New Mexico representative reported that compared with nonborder counties, border counties in New Mexico had significantly higher death rates per 100,000 from any illicit drug, any prescription drug, prescription opioids other than methadone, and antidepressants.
- The Phoenix area member presented a comparison of hospital admissions per 100,000 population in 2007 in Pima County, situated along the Mexico border, and Maricopa County, a non-border county in which Phoenix is located. The border county had higher hospital admissions rates for cocaine and heroin/opioids than the nonborder county (figure 11).
- The Phoenix representative also referred to marijuana and heroin trafficking and prescription drug smuggling north from Mexico into Arizona, arms trafficking south into Mexico, and violence in the Arizona–Mexico border area. It was reported that recent seizures in Phoenix indicate that some drug traffickers may be using the area as a distribution point for white heroin from Mexico destined for other areas of the United States.
- The representative from Mexico reported a different pattern of substance abuse in Mexican states bordering the United States, compared

Figure 11. Amphetamine, Cocaine, and Heroin/Opioid-Related Hospital Admissions per 100,000 Population, Pima and Maricopa Counties, Arizona: 2007



Source: The University of Arizona, Department of Family and Community Medicine, as reported by James Cunningham at the January 2009 CEWG meeting

with the rest of Mexico. While treatment admissions in the nonborder area were dominated by alcohol, the primary drugs of abuse in states along the U.S. border were heroin and methamphetamine.

- Reports from Seattle, Canada, and Detroit indicate that drug trafficking is of concern along the United States northern border as well as the southern border. The Seattle representative referred to law enforcement reports that MDMA is continuing to be manufactured in British Columbia, Canada, and shipped to the United States through Washington State. Marijuana grown in British Colombia is also brought into the United States over the border.
- The representative from Canada reported that marijuana continues to dominate the number of drug exhibits/items seized by police and border services and submitted to Health Canada for testing.
- The representative from Detroit reported that MDMA was being brought in across the United States–Canadian border and referred to inter-related patterns of gun and drug trafficking between Michigan and Canada using waterways and two bridges connecting the two countries. Both bridges are sites for drug seizures, especially ecstasy and marijuana, transported in cars and trucks.

Table 1. NFLIS Top 10 Drug Items Analyzed by CEWG Area and Rank (Based on Frequency): January–June (1H) 2008

CEWG Areas	Cocaine/Crack	Cannabis	Methamphetamine	Heroin	MDMA	Oxycodone	Hydrocodone	Alprazolam	Phencyclidine (PCP)	Clonazepam	Other Drugs
SOUTHERN REGION											
Atlanta	1 ¹	9	2	7	3	6	5	4	–	–	1-(3-Trifluoromethylphenyl) piperazine=8, Carisoprodol=10
Baltimore City	1	2	–	3	9	4	–	6	–	8	Buprenorphine=5, Methadone=7; 3,4-Methylenedioxy-amphetamine=10
Maryland	2	1	–	3	7	4	–	6	10	9	Buprenorphine=5, Methadone=8
Miami/Dade	1	2	8	3	5	7	10	4	–	–	Hallucinogens=6, 1-Benzylpiperazine=9
Washington, DC	1	2	5	3	6	8	–	–	4	–	1-(3-Trifluoromethylphenyl) piperazine=7, 1-Benzylpiperazine=9, Cathinone=10
NORTHEASTERN REGION											
Boston	2	1	–	3	–	4	8	7	–	6	Buprenorphine=5, Methadone=9, Amphetamine=10
New York City	1	2	9	3	–	7	8	4	5	10	Methadone=6
Philadelphia	1	2	–	3	–	4	8	5	6	9	Codeine=7, Methadone=10
MIDWESTERN REGION											
Chicago	2	1	5	3	4	–	6	9	10	–	1-Benzylpiperazine=7, Acetaminophen =8
Cincinnati	2	1	8	3	6	4	5	7	–	10	Diazepam =9
Detroit	2	1	7	3	5	8	4	6	–	–	Codeine=9, 1-Benzylpiperazine=10
Minneapolis/St. Paul	1	2	3	5	4	6	7	–	–	–	Amphetamine=8, Codeine=9, Dimethylsulfone=10
St. Louis	2	1	4	3	5	10	8	6	–	–	Pseudoephedrine=7, Acetaminophen=9
WESTERN REGION											
Albuquerque	1	2	3	4	6	5	7	–	–	–	Phosphorus, Red=8, Pseudoephedrine=9, Psilocin=10
Denver	1	2	3	4	5	6	7	8	–	–	Psilocin=9, 5-Methoxy-N,N-Diisopropyltryptamine=10
Honolulu	3	2	1	5	4	6	8	–	–	–	Diazepam=7, Testosterone=9, 1-Benzylpiperazine=10
Los Angeles	1	2	3	4	5	–	6	8	7	–	Codeine=9, Carisoprodol=10
Phoenix	3	1	2	4	7	6	5	9	–	–	Morphine=8, Carisoprodol=10
San Diego	3	1	2	4	5	7	6	8	–	–	Diazepam=9, Amphetamine=10
San Francisco	1	2	3	4	5	6	7	–	–	–	Morphine=8, Methadone=9, Diazepam=10
Seattle	1	2	3	4	6	5	8	9	–	10	1-Benzylpiperazine=7
Texas	1	2	3	6	7	–	5	4	10	9	Carisoprodol=8

¹In 2004, Georgia initiated a statewide administrative policy that when cannabis is seized by law enforcement officers, laboratory testing is not required. This results in artificially low numbers of such drug items identified in this CEWG area relative to other CEWG areas.

SOURCE: NFLIS, DEA (see appendix tables 2.1–2.22); data are subject to change and may differ according to the date on which they were queried

Table 2. Top-Ranked Primary Drugs as a Percentage of Total Treatment Admissions, Including Primary Alcohol Admissions, in 21 CEWG Areas¹, by Region and Ranking: 1H 2008²

CEWG Areas	Alcohol	Cocaine/ Crack	Marijuana/ Cannabis	Metham- phetamine	Heroin	Other Opiates	Other Drugs
SOUTHERN REGION							
Atlanta	1	2	3	4	6	5	7
Baltimore City	3	2	4	7	1	5	6
Maryland	1	4	3	7	2	5	6
Miami/Dade County ^{3,4}	3	1	2	6 ⁵	5 ⁶	— ⁶	4
NORTHEASTERN REGION							
Boston	2	3	5	7	1	4	5
Maine	1	5	3	7	4	2	6
New York City	1	4	3	7	2	6	5
Philadelphia	3	1	2	7	4	6	5
MIDWESTERN REGION							
Cincinnati	1	3	2	6 ⁷	4 ⁶	— ⁶	5
Detroit	2	3	4	7	1	5	6
Minneapolis/St. Paul	1	3	2	5	4	6	7
St. Louis	1	3	2	5	4	6	7
WESTERN REGION							
Colorado	1	4	2	3	5	6	7
Denver	1	3	2	4	5	6	7
Hawai'i	1	4	3	2	6	NR ⁸	5
Los Angeles	1	5	3	2	4	7	6
Phoenix	1	5	3	2	4	6	7
San Diego	2	5	4	1	3	6	7
San Francisco ³	1	2	5	4	3	NR	7
Seattle	1	2	3	5	4	6	7
Texas	1	3	2	5 ⁵	4	6	7

¹CEWG areas not included in the table due to lack of availability of treatment admissions data for the reporting period are Washington, DC in the southern region, Chicago in the midwestern region, and Albuquerque in the western region.

²All areas report 1H 2008 data with the exception of Miami/Dade County and San Francisco.

³Data are for FY 2008 (July 2007–June 2008).

⁴Miami/Dade County data include data for Miami/Dade County and for Monroe County (Florida Keys).

⁵Methamphetamine and amphetamine are grouped together.

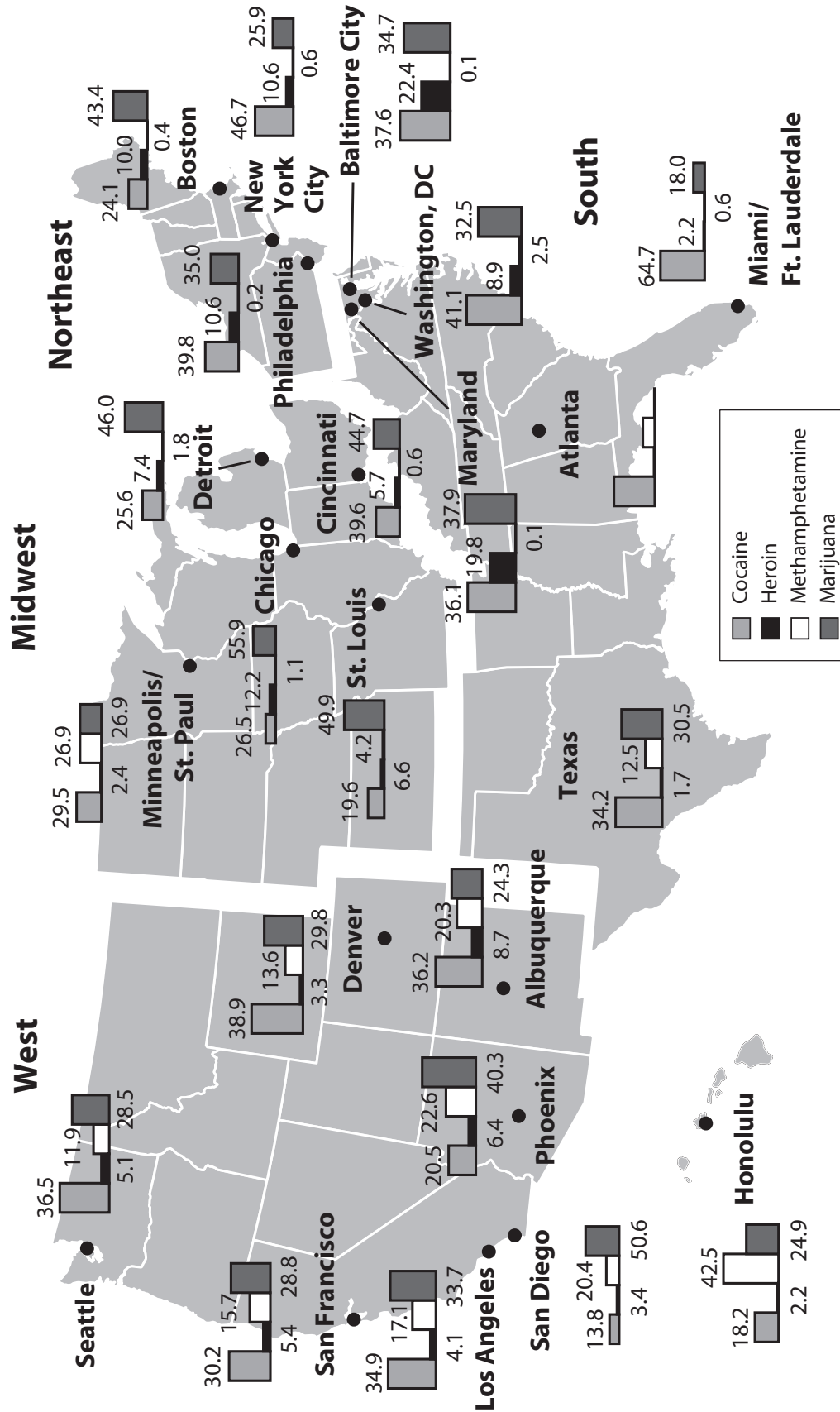
⁶Heroin and other opiates are grouped together; data are included in primary heroin treatment admissions counts and tables only.

⁷Methamphetamine, amphetamine, and MDMA are grouped together.

⁸NR=Not reported by the CEWG area representative.

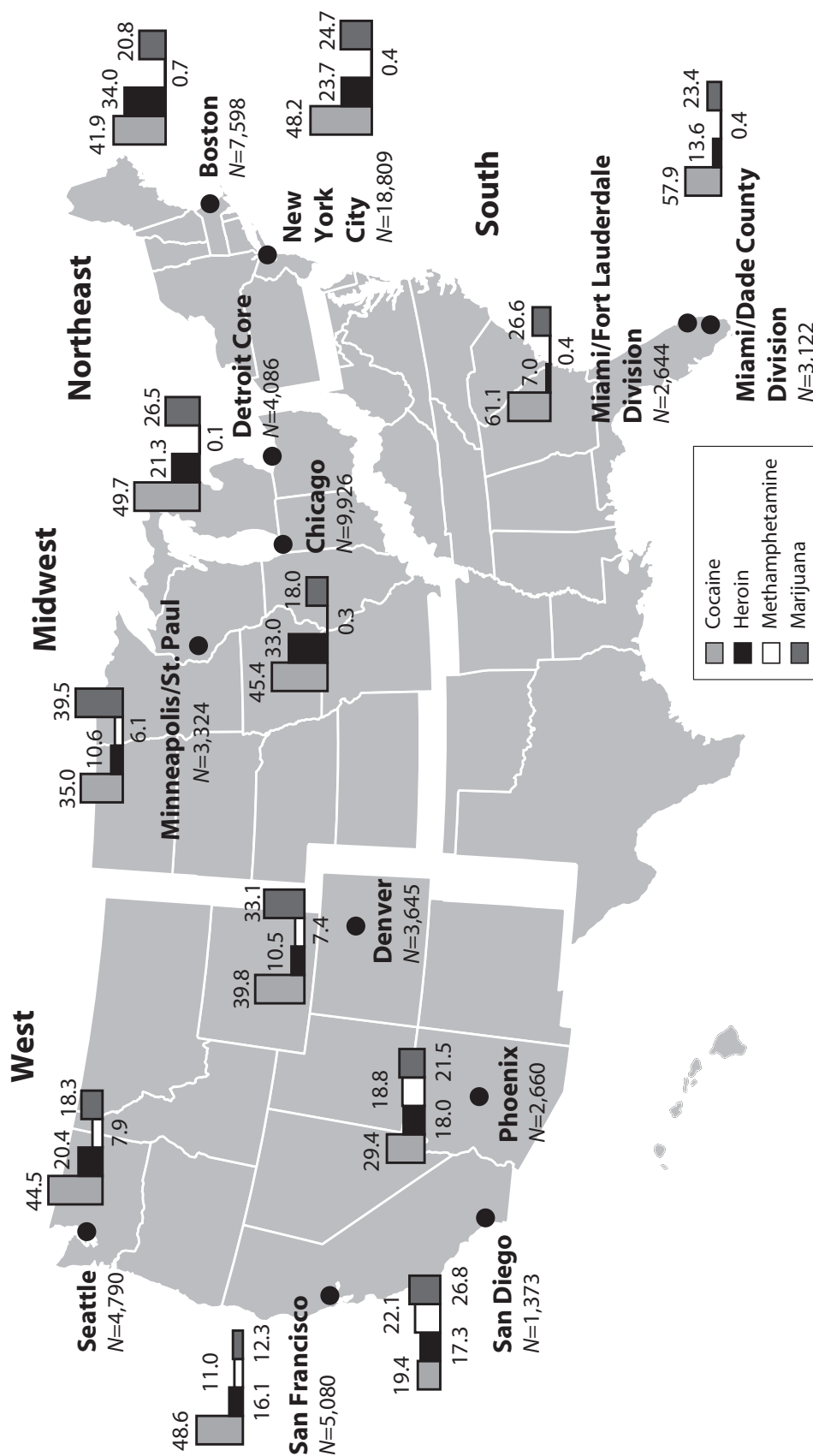
SOURCE: January 2009 State and local CEWG reports

Figure 12. Percentages of Cocaine, Heroin, Methamphetamine, and Marijuana Items Analyzed by Forensic Laboratories in 22 CEWG Areas in Four U.S. Regions, Each as a Percentage of Total Items Analyzed: 1H 2008¹



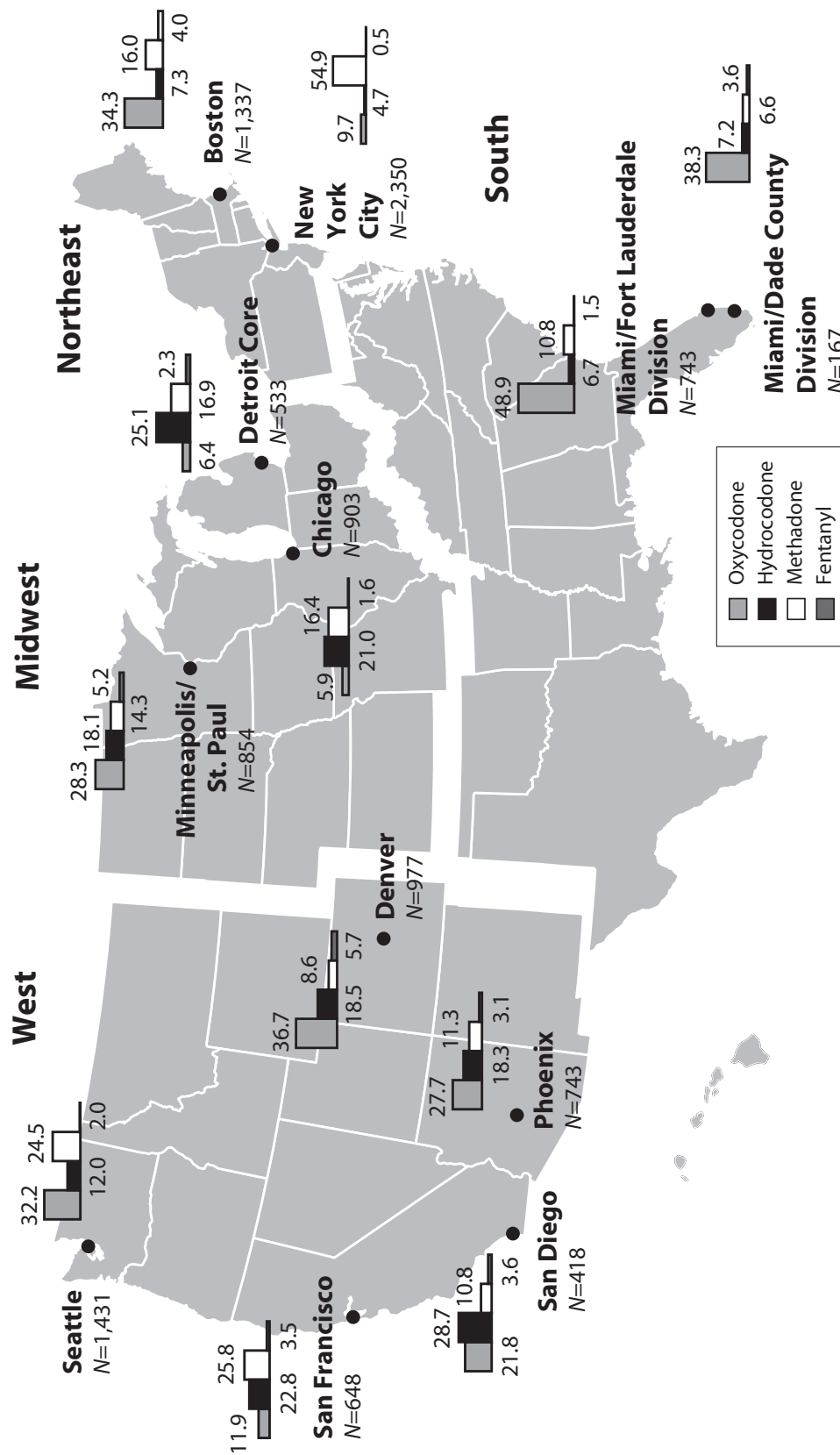
¹Data are for January–June 2008 (see appendix tables 2.1–2.22). Data are subject to change; data queried on different dates may reflect differences in the timing of data analysis and reporting. SOURCE: NFLIS, DEA; data received January 4, 2009

Figure 13. Unweighted Emergency Department (ED) Reports of Selected Major Substances of Abuse, Specifically Cocaine, Heroin, Methamphetamine, and Marijuana, as a Percentage of Total Drug Reports for Illicit Substances, Excluding Alcohol (Nonalcohol Illicit Drugs), for 12 CEWG Metropolitan Sites: January–June 2008¹



¹Percentages for selected major substances of abuse are calculated based on total nonalcohol illicit drug reports for such substances. All case types were selected in the data queries. These are unweighted reports of drugs based on a representative sample of non-Federal, short-term hospitals with 24-hour EDs in the United States.
SOURCE: Area-specific data obtained by request from DAWN, OAS, SAMHSA, December 22–23, 2008; data are subject to change

Figure 14. Unweighted Emergency Department (ED) Reports of Nonmedical Use of Selected Narcotic Analgesics, Including Oxycodone, Hydrocodone, Methadone, and Fentanyl, as a Percentage of Total Nonmedical Use Reports of Opiates/Opioids, in 12 CEWG Metropolitan Sites: January–June 2008



¹Percentages for nonmedical use of selected narcotic analgesics are calculated based on total drug reports for opiates/opioids, excluding heroin. Case types selected included "Nonmedical Use" categories, specifically, overmedication, malicious poisoning, and other. These are unweighted reports of drugs based on a representative sample of non-Federal, short-term hospitals with 24-hour EDs in the United States.

SOURCE: Area-specific data obtained by request from DAWN, OAS, SAMHSA, December 22-23, 2008; data are subject to change

Section III. CEWG Area Update Briefs and International Presentations—January 2009 CEWG Meeting

Introduction

The 64th semiannual meeting of the Community Epidemiology Work Group (CEWG) was held on January 21–23, 2009, in San Francisco, California. During this meeting the 21 CEWG area members reported on current drug trends and patterns in their areas based on data newly available since the June 2008 CEWG area report. Two international presentations were also given. The following Update Briefs and International Reports were provided by the speakers.

CEWG AREA UPDATE BRIEFS

Drug Abuse Patterns and Trends in Albuquerque and New Mexico—Update: January 2009

Nina Shah, M.S.

For inquiries concerning this report, please contact Nina Shah, M.S., Drug Epidemiologist, New Mexico Department of Health, 1190 St. Francis Drive, P.O. Box 26110, Santa Fe, NM 87502, Phone: 505-476-3607, Fax: 505-827-0013, E-mail: nina.shah@state.nm.us.

Overview of Findings: The unintentional prescription drug poisoning death rate in New Mexico increased 20 percent from 2006 to 2007, driven by an increase in prescription opioid poisoning, and now exceeds the illicit drug poisoning death rate. A special analysis found significantly higher death rates in counties that border Mexico for total unintentional drug poisoning, and also for deaths from any prescription drug,

prescription opioids other than methadone, and antidepressants, when compared with nonborder counties. State-funded treatment admissions for abuse of methamphetamine slightly increased from 2006 to 2007. In 2007, one-half of all admissions were for alcohol abuse. Cocaine/crack became the most common primary drug of abuse among treatment admissions, followed by heroin, methamphetamine, marijuana, and other opiates. During the 2007–2008 school year, a middle school and high school Youth Risk and Resiliency survey was administered in public schools. Inhalant use was reported most often among middle school students, while the prevalence of current marijuana use was highest among 10th graders, and lifetime cocaine and injection drug use prevalence was highest among 11th graders. In 2008, the most common items analyzed from the Albuquerque forensic lab data were cocaine, marijuana, methamphetamine, and heroin, respectively.

Updated Drug Abuse Trends and Emerging Patterns: Poisoning deaths caused by heroin remained stable (2006: $n=106$; 2007: $n=108$), and the proportion of treatment admissions for heroin also remained stable from 2006 to 2007. Excluding alcohol, heroin abuse accounted for the second most treatment admissions in 2007 ($n=678$). Admissions were predominantly male (61 percent) and Hispanic (60 percent), with 88 percent injecting the drug. A large proportion of these clients had been in treatment at least twice prior to the current admission (45 percent). Of items analyzed by Albuquerque area forensic labs in 2008, 10 percent were heroin items. In Las Cruces, the lower end price of wholesale Mexican

black tar heroin significantly decreased from December 2007 to June 2008 (from \$40,000 to \$19,000 per pound). The **cocaine** poisoning death rate remained steady from 2006 to 2007, but was highest of all drugs in 2007 (6.0 per 100,000). The proportion of cocaine treatment admissions (among all admissions) remained relatively stable from 2006 to 2007. Of 2007 treatment admissions for cocaine/crack abuse ($n=687$), 58 percent were male; 41 percent were Hispanic; and 53 percent reported smoking the drug. In 2007, the prevalence of lifetime cocaine use reported among students in grades 6–12 was highest among 11th graders, at 15.1 percent. In 2008, 37 percent of the items analyzed by Albuquerque forensic labs were cocaine items, the highest proportion of all substances. From June 2008 data, the price of powder cocaine was similar in Albuquerque and Las Cruces (\$500–\$700 per ounce). Retail crack prices in Albuquerque have been similar over the past year, at roughly \$20 per rock. The 2007 **methamphetamine** poisoning death rate remained relatively low, at approximately 30 percent that of heroin and cocaine (1.8 per 100,000), and unchanged since 2005. The methamphetamine death rate in the southeastern region of New Mexico was 80 percent higher than the rest of the State. The number of treatment admissions for methamphetamine increased from 2006 ($n=531$) to 2007 ($n=622$). Females represented one-half of the primary treatment admissions for methamphetamine in 2006, and Whites represented 59 percent. For most users (60 percent), smoking was the primary mode of administration, although this proportion has been slightly decreasing since 2005. A large proportion of these clients (44 percent) were referred through the criminal justice system. Methamphetamine items comprised 20 percent of items analyzed by Albuquerque forensic labs. Lab incidents have been decreasing over time; however, this should be monitored closely as methamphetamine from Mexico is in short supply and domestic production may increase in 2009. **Marijuana** remains the most widely used drug in New Mexico, and prices for the drug were extremely inexpensive in the border region.

Marijuana treatment admissions decreased slightly from 2006 ($n=635$, 6.0 percent) to 2007 ($n=599$, 5.6 percent), among all admissions. In 2007, these clients were youngest (median age of 27 years), compared with other clients; 75 percent were male and equal proportions were White and Hispanic (36 percent). The highest prevalence of current marijuana use among New Mexico students in grades 6–12 was found for 10th graders (26.2 percent). The second highest proportion of forensic lab items analyzed in 2008 was marijuana (21 percent). In 2007, 55 percent of all unintentional drug poisoning deaths in New Mexico were caused by **prescription opioids**, as medical and nonmedical use of these drugs continues to rise. *Methadone*-caused deaths were stable from 2006 to 2007. Poisoning death rates from *opioids other than methadone* increased roughly 20 percent, from 5.6 deaths per 100,000 in 2006 to 6.6 deaths per 100,000 in 2007. Prescription opioid abuse accounted for 241 treatment admissions in 2007; 57 percent were male and 49 percent were Hispanic. These clients had the shortest duration of use at admission, a median of 7.5 years, and roughly one-quarter of clients were referred to treatment by their health care provider. Poisoning deaths caused by *tranquilizers/muscle relaxants* (i.e., benzodiazepines) remained unchanged from 2006 to 2007 (4.5 per 100,000). The statewide poisoning death rate from *antidepressants* increased from 1.9 per 100,000 in 2006 to 2.8 per 100,000 in 2007. The highest death rate for this cause was found in the southeastern region of the State during 2005–2007. **New Mexico border patterns:** There were 1,588 unintentional drug poisoning deaths during 2003–2007 in New Mexico, producing a death rate of 16.5 per 100,000 persons. Compared with nonborder counties, United States–Mexico border counties had significantly higher death rates per 100,000 from: total drugs, at 21.8 percent (95-percent confidence interval, or CI:18.6,25.5), compared with 16.1 percent (CI:15.2,16.9); any prescription drug, at 12.1 percent (CI:9.7,14.9) versus 7.9 percent (CI:7.3,8.5); prescription opioids other than methadone, at 8.7 percent (CI:6.7,11.2), compared with 4.5

percent (CI:4.1,5.0); and antidepressants, at 3.5 percent (CI:2.3,5.2), compared with 1.7 percent (CI:1.4,2.0). Death rates from heroin, cocaine, methamphetamine, methadone, tranquilizers, and alcohol/drug combinations were similar. **HIV/AIDS Update:** The mode of exposure for living acquired immunodeficiency syndrome (AIDS) cases ($n=3,582$) has not changed over recent years, at approximately 21 percent from injection drug use (IDU) and men who have sex with men (MSM)/IDU. Surveillance of human immunodeficiency virus (HIV)/hepatitis C (HCV) co-infection among IDUs in 2008 ($n=321$ prevalent cases) characterized cases as largely male (80 percent); one-half were White and 35 percent were Hispanic. Roughly 40 percent of cases were age 30–39 at the time of diagnosis, but 80 percent of living cases are now 40 and older.

Data Sources: *Treatment data for calendar year (CY) 2007 were provided by the New Mexico State Behavioral Health Services Division, Human Services Department. These are State-funded treatment admissions only, including opiate replacement therapy. This report focuses on admissions during 2007, the most recent data available. New Mexico Treatment Episode Data Set for 2002–2007 was also accessed in order to compare previous year trends. School survey data was from the Centers for Disease Control and Prevention (CDC)-sponsored Youth Risk Behavior Survey conducted during 2007–2008. In addition, New Mexico administered a middle school survey alongside the high school survey. The data are reported as percentages with 95-percent confidence intervals and by gender for New Mexican students. Crime laboratory data for CY 2008 were provided by the Albuquerque Police Department who submit data to the National Forensic Laboratory Information System, Drug Enforcement Administration. Drug price data for June 2008 were from the National Drug Intelligence Center. Infectious disease data related to IDU was obtained from the State HIV and Hepatitis Epidemiology Surveillance Program, New Mexico Department of Health. Mode of exposure among living HIV/AIDS cases is reported and*

prevalent HIV/HCV co-infection among IDU cases is described. Death data for 2003–2007 were provided by the State-centralized New Mexico Office of the Medical Investigator. Unintentional drug poisoning death rates were described for New Mexico counties bordering Mexico compared with non-border counties (age-adjusted rates per 100,000). Drug-specific poisoning death rates were also calculated by demographics.

Drug Abuse Patterns and Trends in Atlanta—Update: January 2009

Brian J. Dew, Ph.D.

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Overview of Findings: Cocaine and marijuana remained the dominant drugs of abuse in the metropolitan Atlanta area in 2008.

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, and in National Forensic Laboratory Information System (NFLIS) drug seizure data. While the proportion of cocaine-related treatment admissions continued a 6-year decline (from 59 percent in 2000 to 24.6 percent in the first half of 2008), the proportion of primary treatment admissions reporting secondary cocaine use was 28.1 percent, a 51-percent increase from 2006, and stable from 2007. When primary and secondary cocaine treatment admissions are considered together, the proportion of cocaine admissions has decreased by 19 percent since 2000, a percentage substantially smaller than that reported among solely primary treatment admissions. Atlanta's cocaine users continue to be mainly African American, male, and older than 35. Although smaller in proportion compared

with Whites and African Americans, the number of cocaine-related primary treatment admissions for Hispanics more than doubled in the first half of 2008 (1.7 percent in 2007 to 3.5 percent in the first half of 2008). 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 6 years. Two drug surveillance organizations—the Drug Enforcement Administration (DEA) and the Atlanta High Intensity Drug Trafficking Area (HIDTA)—reported a decrease in cocaine supply for Atlanta in the first half of 2008. This reduced supply did impact the local cocaine market, whereas the wholesale, mid-level, and retail price of powder cocaine increased and purity levels decreased. Street-level ethnographic reports confirmed brief shortages of powder cocaine at the retail level in the first half of 2008. However, no changes in the price or purity levels of crack/cocaine were reported in Atlanta. Mexican drug trafficking organizations (DTOs) have strengthened control over the 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, 19 of 28 reported that crack/cocaine was most responsible for violent crimes in their jurisdictions, an increase from 2007. **Marijuana** remains the most commonly used substance in Atlanta. Ethnographic reports suggest that supply for marijuana is easily available and price levels for Mexican-grown marijuana have remained stable. However, the supply of “BC Bud” from British Columbia and hydroponic marijuana has increased, thereby driving retail prices down. Cuban-based DTOs have increased their efforts in distributing lower price marijuana in Atlanta. Local indoor cultivation of more potent hydroponic marijuana increased in the first half of 2008, and law enforcement officials cited an increased influence of Asian DTOs in its production and distribution. Street-level ethnographic reports suggested that retail dealers of marijuana also sell crack and powder cocaine, but not methamphetamine.

Several indicators, including statewide medical examiners postmortem occurrence, prison and public treatment admissions, and NFLIS drug seizure data, were down with regard to the use of **methamphetamine**. In the first half of 2008, methamphetamine-related treatment admissions decreased to 6.2 percent from 7.7 percent in 2007, dropping nearly 44 percent from the drug’s peak use in 2005. During the first half of 2008, women entering substance abuse treatment for methamphetamine outnumbered men (62 versus 38 percent), a consistent trend that contrasts with findings from other CEWG reporting cities. The proportion of methamphetamine-related primary treatment admissions smoking the drug stabilized in the first half of 2008 at close to 60 percent—consistent with the previous year when a leveling off was indicated after six consecutive increases in smoking-related primary methamphetamine-related admissions. Law enforcement officials noted a slight decline in the importation of Mexican “ice” in metropolitan Atlanta, while suggesting that local production of methamphetamine increased, especially in the more rural counties of the metropolitan Atlanta area. Although Whites were the most frequent users of methamphetamine, indicators suggested a growing level of methamphetamine use occurred among African Americans and Hispanics. Street-level ethnographic reports have found greater cross-over use of methamphetamine by non-White crack/cocaine users. **Heroin** indicators continued to show stable levels of use with the majority of users concentrated in Atlanta’s Bluff district. However, due to several high-profile heroin-related deaths in 2008, law enforcement increased its presence in this community, resulting in a greater number of arrests and drug seizures during the first half of 2008, as evidenced by a 168-percent increase in NFLIS’s drug identification and seizure data. Street-level ethnographic findings suggest that drug distribution may be moving outside the Bluff district and into the Downtown and Midtown sections of metropolitan Atlanta. Rates of injecting South American (SA) heroin have increased due to decreased purity levels and increases in

price. While the DEA's Heroin Domestic Monitor Program (HDMP) analyzed only samples of SA and Southwest Asian heroin, law enforcement officials and ethnographic street workers have reported greater amounts of Mexican brown powder heroin in Atlanta. The Georgia Medical Examiner's Office reports that prescription **benzodiazepines** were second only to cocaine in the number of statewide postmortem specimens that test positive for a particular drug. **Alprazolam** remained the most popular benzodiazepine in Atlanta, especially among White women and young adults (age 18–28), followed by **diazepam**. Multiple indicators show that **hydrocodone** was the most commonly abused **narcotic analgesic** in Atlanta, followed by **oxycodone**. In the first half of 2008, treatment admissions for hydrocodone-based products comprised 2.5 percent of admissions, an increase from 1.8 percent in 2007. Oxycodone-related treatment admissions were 1.0 percent of total treatment admissions in the first half of 2008, slightly down from 1.2 percent in 2007. Drug indicators suggested that the use of **MDMA** stabilized in the first half of 2008, after increasing in 2007. In Atlanta, Asian DTOs control the transportation of the drug from Canada and distribute at the wholesale level. White and African-American dealers typically distribute MDMA at the retail level. MDMA use in Atlanta was most popular among suburban White high school students and young adults and urban African-American high school students and adults (age 18–35). In the first half of 2008, the wholesale (\$3–\$9) and retail (\$20–\$25) prices per MDMA tablet remained stable.

Data Sources: *Treatment data* were provided by the Georgia Department of Human Resources. Coverage includes all direct providers of treatment services that received county or State program funds in the 28 counties that comprise metropolitan Atlanta. Data on all client admissions for drug and alcohol treatment—not just clients receiving treatment paid for using public funding sources—were included in the data set. This report presents admissions data from January through June 2008—the

most recent data available—and makes comparisons with the same calendar period from prior years. **Forensic laboratory data** were provided by NFLIS, DEA, for the first half of 2008. While these data are described, they can only be compared with 2007 results due to the establishment of new methodology methods. For purposes of comparison with the previous year, calendar year (CY) 2008 data were extrapolated. **Prison/jail admissions data** were provided by the Georgia Department of Corrections and included admissions through November 2008. For comparison purposes, CY 2008 data were extrapolated. **Ethnographic data** were available for identifying possible emerging trends. **Local drug threat assessments** were provided by the National Drug Intelligence Center. **Positive drug results for postmortem specimens** were provided by the Georgia Bureau of Investigation, Medical Examiner's Office. This data, which included fiscal year 2008 results were statewide. **Georgia Crisis and Access Line Call** data were provided by the Georgia Department of Human Resources. Coverage included 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 presented call data from July 2006 through November 2008. For comparison, data for the second half of 2008 were extrapolated.

Drug Abuse Patterns and Trends in Baltimore City, Maryland, and Washington, DC—Update: January 2009

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Overview of Findings: Throughout the Washington, DC, and Maryland region, cocaine, marijuana, and heroin continued to be the

primary drug problems from 2002–2008, but the misuse of prescription drugs appeared to be increasing in 2007. The Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) reported that cocaine and marijuana were the most frequently seized drugs in the region. The third most frequently found drug in the *Maryland* part of the HIDTA region was heroin, while in *DC* it was PCP. While other parts of the country have seen shifts in the use of methamphetamine, its use remained low throughout *Maryland* and *Washington, DC*, and was confined to isolated communities in the *DC* District. The percentage of adult and juvenile offenders in *Washington, DC* testing positive for amphetamines remained considerably lower than for other drugs and appeared to be decreasing in 2008.

Updated Drug Abuse Trends and Emerging Patterns: In *Washington, DC*, in 2007 and 2008, **cocaine/crack, marijuana, and heroin** continued to be the primary illicit drug problems. The use of phencyclidine (**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. In the first 10 months of 2008, 33.8 percent of adult arrestees tested positive for cocaine, and about 1 in 10 tested positive for opiates and/or PCP. In addition, more seized items tested positive for cocaine (41 percent) in the first 6 months of 2008 than for any other drug, as reported by the National Forensic Laboratory Information System (NFLIS). In 2006, overdose deaths were also more likely to be related to cocaine (66 percent) than to any other drug. During the first 10 months of 2008, juvenile arrestees were more likely to test positive for marijuana (53.6 percent) than for any other drug. The percentage of such juveniles testing positive for marijuana increased slightly (from 49.8 to 54.4 percent) during each of the prior 3 years and appeared to have leveled off in 2008. The percentages testing positive for cocaine (3.5

to 1.6 percent) decreased slightly, but the percentages testing positive for PCP (3.4 to 2.9 percent) remained about the same.

In *Maryland*, primary admissions to certified treatment programs increased by 1.5 percent from 2006 to 2007, and most frequently involved **alcohol, heroin, marijuana, crack, and other cocaine**. Cocaine and marijuana also accounted for nearly three-quarters of the positive items tested through NFLIS during the first 6 months of 2008. **Narcotics** (heroin, methadone, oxycodone, fentanyl, and other) were the most frequently identified drugs in drug abuse deaths in 2007, and more than one-half of these deaths occurred in Baltimore City. According to the Heroin Domestic Monitor Program (HDMP), the cost of heroin in Baltimore City was much lower than in *Washington, DC*, but from 2002–2006, the purity was slightly higher. In 2007, the purity was about the same.

Data Sources: *Drug seizure data* were provided by NFLIS and the Drug Enforcement Administration for the first half of 2008, and the *Washington/Baltimore HIDTA*. **Heroin cost data** were obtained from the HDMP, and **data on the retail distribution of selected prescription opioid medications** were obtained from the Automation of Reports and Consolidated Orders System Retail Drug Summaries. **Mortality data** were obtained from the Office of the Chief Medical Examiner, *Washington, DC*. **Data on substance abuse by youth** were adapted by the Center for Substance Abuse Research from the *Maryland State Department of Education's 2007 Maryland Adolescent Survey and the Youth Risk Behavior Survey*. **Adult and juvenile arrestee data** were adapted from information obtained from the *District of Columbia Pretrial Services Agency*. **Treatment admissions data** for Baltimore City were obtained from the *Alcohol and Drug Abuse Administration State of Maryland Automated Record Tracking system* and for *Washington, DC* from the *Treatment Episode Data Set*.

Drug Abuse Patterns and Trends in Greater Boston—Update: January 2009

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Overview of Findings: In Boston, heroin and cocaine remained heavily abused drugs during this reporting period. Heroin continued to dominate as the primary drug in treatment and was cited most often among calls to the substance abuse helpline. Cocaine continued to figure prominently among treatment admissions, drug arrests, and drug lab samples derived from drug arrests. Marijuana, other opiates including oxycodone, and benzodiazepines were present among the indicators at more moderate levels. Methamphetamine abuse remained at low levels overall.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine indicators remained mostly stable at very high levels. Close to one of every four treatment admissions (24 percent) reported past-month cocaine (including crack) use in fiscal year (FY) 2008. The proportion of admissions with past-month cocaine use has remained fairly stable, at between 23 and 26 percent, from FY 2001 to FY 2008. The proportion of female cocaine primary treatment admissions increased from 37 percent in FY 2007 to 45 percent in FY 2008. The proportion of cocaine calls to the helpline remained at 18 percent from 2007 to 2008; it has fluctuated between 18 and 22 percent over the 10-year period from 1999 to 2008. The proportion of Class B drug arrests (mainly cocaine) increased slightly from 43 percent in 2006 to 46 percent in 2007. Cocaine drug lab samples remained stable from 2006 to 2007, accounting for one-third of all samples each year. **Heroin** abuse indicators remained stable at extremely high levels in Boston. In FY 2008, one-half of all treatment admissions ($n=9,325$) cited

heroin as the primary drug of abuse. After having steadily increased from 35 percent in FY 1998 to 51 percent in FY 2007, the proportion of heroin treatment admissions remained fairly stable at 50 percent in FY 2008. After increasing over 9 years, the proportion of all admissions with past-month heroin use decreased from 48 percent in FY 2007 to 43 percent in FY 2008. The proportion of male **heroin and other opiates** treatment admissions decreased slightly from 75 percent in FY 2007 to 72 percent in FY 2008. Conversely, the proportion of female admissions increased slightly from 25 to 28 percent during the same period. Although accounting for a small proportion, the number of heroin and other opiate treatment admissions under age 19 more than doubled from 54 in FY 2007 to 121 in FY 2008, reaching the highest level for this age group in 11 years of reported data. Proportions of other age groups remained stable from FY 2007 to FY 2008, but from FY 1998, the proportion of admissions in the age group 19–29 increased by 40 percent (from 29 percent in FY 1998 to 40 percent in FY 2008) while the proportions of admissions age 30–39 and age 40–49 decreased by 25 and 19 percent, respectively. In FY 2008, two-thirds of the heroin and other opiates admissions were White. From FY 1998 to FY 2008, the proportion of White admissions increased by 38 percent, while the proportions of Black and Latino admissions decreased by 53 and 13 percent, respectively. From FY 2007 to FY 2008, the proportion of heroin and other opiates admissions with a criminal justice history decreased from 19 to 12 percent, while the proportion with a mental health services history increased from 16 to 23 percent. After reaching the highest level in 10 years in FY 2007, the proportion of past-year injection drug use among heroin and other opiates admissions remained stable at 71 percent in FY 2008. After peaking at 40 percent in 2003, the proportion of heroin calls to the substance abuse helpline has remained stable at between 32 and 34 percent from 2005 to 2008. Similarly, the levels of Class A drug arrests (mainly heroin) and heroin drug lab samples were stable from 2005 to 2007 at levels lower than

their peaks in 2000 and 2001. The Drug Enforcement Administration (DEA)'s most recent data (December 2008), revealed that a bag of heroin on the streets of Boston cost between \$3 and \$50, with an average purity level of between 20 and 30 percent. Indicators for **other opiates/opioids** were stable at moderate levels. The number of treatment admissions for other opiates increased from 110 in FY 1998 to 761 in FY 2002. Since then, the proportion of primary treatment admissions for other opiates has remained stable at between 3 and 4 percent from FY 2002 to FY 2008. Similarly, the proportion of other opiates helpline calls increased from 6 percent in 1999 to 18 percent in 2004, but has remained stable at between 16 and 17 percent from 2005 to 2008. The proportion of oxycodone drug lab samples remained stable for 6 years (2002 to 2007) at between 2 and 3 percent. **Marijuana** indicators were mixed at varied levels. The proportion of treatment admissions citing past-month marijuana use increased slightly to 9 percent in FY 2008, after steadily decreasing from 14 percent in FY 1998 to 7 percent in FY 2007. The proportion of female marijuana primary treatment admissions increased from 25 percent in FY 2007 to 35 percent in FY 2008. The proportion of admissions younger than 30 remained stable at 70 percent from FY 2007 to FY 2008. From 2007 to 2008, the proportion of marijuana helpline calls remained at 4 percent. Class D drug arrests (mainly marijuana) accounted for 35 percent of total drug arrests. The proportion has remained stable at between 33 and 37 percent from 2002 to 2007. The proportion of marijuana drug lab samples decreased from 40 percent 2006 to 35 percent in 2007. **Methamphetamine** abuse levels remained low in Boston, representing less than 1 percent of all treatment admissions. The number of primary admissions for methamphetamine totaled 59 admissions in FY 2008 and 29 admissions in FY 2007. Similarly, methamphetamine calls to the helpline ($n=22$) accounted for less than 1 percent of all calls in 2008. Methamphetamine drug lab samples totaled 26 in 2007 and 36 in 2006. **Benzodiazepine** abuse in Boston remained at moderate levels. Calls to the helpline

have been fairly stable in number (at between 130 and 188) but have increased in proportion (from 3 to 5 percent) between 2000 and 2008. **HIV/AIDS Update:** In 2006, there were 214 adult acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) cases who were injection drug users (IDUs), 3 percent who had sex with IDUs, and 29 percent who had an unknown/undetermined risk factor.

Data Sources: *State-funded substance abuse treatment admissions data for the Boston region comprising the cities of Boston, Brookline, Chelsea, Revere, and Winthrop (Community Health Network Area [CHNA] 19), for FYs 1998 through 2008 (July 1, 1997 through June 30, 2008) were provided by the Massachusetts Department of Public Health (DPH), Bureau of Substance Abuse Services. Helpline data provided information on drug mentions during calls received by the Massachusetts Substance Abuse Information and Education Helpline for the CHNA 19 region for 1999 through 2008. Drug arrest data for the city of Boston for 2002 through 2007 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 included those who identify themselves as Hispanic. A new Massachusetts law decriminalizing possession of less than an ounce of marijuana took effect January 1, 2009 and will impact future drug arrest indicators. Forensic laboratory data for the Boston region comprising the cities of the CHNA 19 for 1998 through 2007 were provided by the Massachusetts DPH 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/purity information was provided by the DEA's New England Field Division, December 2008. Adult AIDS and HIV data for 2006 were provided by the Massachusetts DPH AIDS Surveillance Program, October 1, 2008.*

Drug Abuse Patterns and Trends in Chicago—Update: January 2009

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Overview of Findings: Cocaine, heroin, and marijuana continued to be the major substances of abuse for Chicago and the surrounding metropolitan area in 2008. Major indicators suggest that levels of cocaine, heroin, and marijuana abuse were high and steady. There were few noteworthy changes that occurred for the reporting period. Drug Enforcement Administration (DEA) Heroin Domestic Monitor Program (HDMP) data indicated that heroin purity increased in 2007 after years of decline. According to the Youth Risk Behavior Survey, Illinois students' lifetime use of inhalants decreased significantly, from 14.5 percent (95-percent confidence interval or CI:12.0,17.4) in 1995 to 9.6 percent (CI:7.1,12.9) in 2007 ($p<.01$). In addition, there was a nearly significant increase in the percentage of students who reported being offered, sold, or given an illegal drug by someone on school property, which rose from 28.1 percent (CI:24.8,31.7) in 1995 to 32.9 percent in 2007 (CI:29.1,36.9) ($p=.06$). Among students in Chicago, there were notable, statistically significant increases between 2005 to 2007 in lifetime methamphetamine use, from 1.5 percent (CI:0.7,3.3) in 2005 to 4.7 percent (CI:2.9,7.5) in 2007, and lifetime ecstasy use, from 3.3 (CI:2.0,5.2) to 6.4 percent (CI:4.2,9.6) in that period. Lifetime marijuana use among Chicago students remained stable from 2005 to 2007, at 44.9 (CI:41.0,48.9) and 44.0 percent (CI:39.8,48.2), respectively, as did current marijuana use, at 22.5 percent (CI:19.4,26.) in 2005, and 21.7 percent (CI:18.1,25.7) in 2007.

Updated Drug Abuse Trends and Emerging Patterns:

Most indicators of drug use were collected for the calendar or fiscal year 2008 or, if not available, for 2007. Levels of **cocaine** abuse continued to be high and stable in 2008. Preliminary unweighted data accessed from Drug Abuse Warning Network (DAWN) *Live!* for the first half of calendar year (CY) 2008 showed that 32 percent of total emergency department (ED) reports for major substances of abuse (including alcohol) were cocaine related. Cocaine constituted 27 percent of all drug items identified by the National Forensic Laboratory Information System (NFLIS) in fiscal year (FY) 2008. Wholesale prices of powder cocaine reported by the National Drug Intelligence Center (NDIC) increased slightly, ranging from \$17,000–\$25,000 per kilogram. Ethnographic reports suggest that availability of powder cocaine remained moderate 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 the first half of CY 2008 show that 26 percent of total ED reports for major substances of abuse (including alcohol) were heroin related. The average purity of heroin as reported by the DEA increased from 14.7 percent in 2006 to 21.4 percent in 2007, while there was a decline in wholesale price of heroin, from \$45,000–\$80,000 per kilogram in 2006 to \$30,000–\$70,000 per kilogram in 2007. Major indicators of drug use suggest that **marijuana** abuse was high and stable in 2007. Preliminary unweighted data accessed from DAWN *Live!* for the first half of CY 2008 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 2008, consisting of 55 percent all drugs. Hydroponic marijuana continued to be available in Chicago, priced significantly higher than nonhydroponic marijuana. Average wholesale prices for hydroponic marijuana remained stable, but narrowed in range in 2007 to between \$2,700–\$3,000 per pound, while nonhydroponic marijuana increased significantly to prices

between \$700–\$3,000 per pound, according to the NDIC. Among **prescription drugs**, those most often cited in ethnographic reports as being used without prescription were Xanax®, Vicodin®, Klonopin®, clonidine, and methadone. **MDMA** was popular in low-income African-American neighborhoods. Primary users were in their teens and twenties, but use by middle-aged persons was often reported. Prices have declined to \$10 per tablet on the South Side and \$10–\$15 on the West Side. Nonprescription **buprenorphine (Suboxone®)** use was increasingly common among heroin users, who mainly used it to avoid withdrawal or to better manage their addiction. Injection and recreational use of Suboxone® was rare. **Drug injection** by young African Americans was rare. New injection drug users were likely to be White and to reside in suburban Chicago. **HIV/AIDS Update:** The prevalence and incidence of human immunodeficiency virus (HIV) infection among injection drug users (IDUs) has declined markedly, compared with the 1980s and 1990s. HIV prevalence among injecting and noninjecting drug users is converging in low-income Chicago neighborhoods.

Data Sources: *Treatment data* for the State of Illinois and Chicago for FYs 2000–2007 (July 1–June 30) were provided by the Illinois Division of Alcoholism and Substance Abuse. An update was not available. **ED data** were derived for the first half of CY 2008 from the DAWN Live! restricted-access online query system administered by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA). The DAWN Live! data are unweighted and are not estimates for the reporting area. These data cannot be compared with DAWN data from 2007 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. **Survey data on student and household populations** were derived from two sources. The 2007 Youth Risk Behavioral Surveillance System, prepared by the Centers for Disease Control and Prevention (CDC), provided drug use data representative of 9th through 12th grade students in public and private schools. Data on substance use and abuse for State of Illinois were provided by SAMHSA's National Survey on Drug Use and Health for 2005 and 2006. **Price and purity data** for heroin for 1991–2007 were provided by the DEA's HDMP. The Illinois State Police, Division of Forensic Science, provided **purity data** on drug samples for 2007. **Drug price data** are reported from the June 2007 and December 2007 reports of National Illicit Drug Prices by the NDIC. Data from NFLIS for FY 2008 were used to report on **drugs items identified in forensic laboratories after being 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, School of Public Health, University of Illinois at Chicago. **HIV prevalence data** for 2005–2008 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=3,220) in this ongoing study completed a computerized self-administered interview and were tested for HIV, syphilis, chlamydia, and gonorrhea. SATH-CAP data were compared with findings from earlier studies of IDUs sponsored by NIDA and the CDC. 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 2009

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Overview of Findings: The predominant drug issues in Cincinnati continue to involve both cocaine and marijuana as primary drugs of abuse. Crack/cocaine and powder cocaine indicators were noted to decrease in 2008, however, when compared with 2007 data. Indicators for marijuana in the Cincinnati region were reported at high but stable levels. Marijuana as a primary drug of choice accounted for 47 percent of treatment admissions, excluding alcohol, and it represented nearly 45 percent of identified drug items submitted for forensic analysis in the Cincinnati area. Indicators for heroin remained fairly stable, with some indicators increasing during 2008 from the previous year. The number of exposure cases reported to poison control involving heroin increased in 2008 over 2007. Methamphetamine indicators remained low in Cincinnati. The number of methamphetamine lab seizures continued to decrease through fiscal year (FY) 2008, compared with the previous year, and qualitative indicators showed methamphetamine to be more prevalent in rural areas compared with the city. MDMA availability and use were low to moderate in Cincinnati, with indicators picking up an increase during 2008, compared with 2007. Abuse of prescription drugs, specifically benzodiazepines and opioid narcotics, continued to be an increasing drug issue in Cincinnati. Abuse of buprenorphine-containing pharmaceuticals remained low in 2008, but indicators showed a rise in human exposure cases reported to poison control as well as increased number of drug

identification calls, which is often an early indicator of increased diversion to the streets.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine remained a predominant drug reported during admission to publicly-funded treatment programs. It accounted for 28 percent of primary admissions, excluding alcohol, during FY 2008. Cincinnati law enforcement removed nearly 7 kilograms of crack/cocaine from the region from January to September 2008, slightly less than the 8.3 kilograms removed during the same time period in 2007. The Regional Enforcement Narcotics Unit (RENU) removed a combined total of 120 kilograms of cocaine from the streets of Cincinnati in 2008. Overall the law enforcement seizures of cocaine during 2008 resulted in less cocaine availability to users, similar to the previous year. An increased amount of powder cocaine was also removed from the street during the first 9 months of 2008, compared with 2007. Although indicators for crack/cocaine remained high, they appeared to decrease in 2008, compared with 2007. The purity of both powder cocaine and crack/cocaine seized during 2008 was lower than reported purity data from 2007, with similar impurities recorded in analyzed samples. **Marijuana** continued to dominate all other reported illicit drugs as primary among treatment admissions, accounting for 47 percent of the admissions, excluding alcohol, during FY 2008. Marijuana availability and use remained high across the Cincinnati region in 2008, and indicators continued to level off. The number of marijuana seizures by Cincinnati law enforcement, including the RENU, increased during 2008, compared with 2007. Primary indicators for **heroin** showed the drug at a moderate level, with some indicators showing an increase for the Cincinnati region for 2008, compared with 2007. Treatment admissions for primary heroin use were not delineated from other opiate/opioid admissions for either 2007 or 2008, but the total number of admissions increased significantly for that category. The number of law enforcement seizures involving heroin also rose during 2008,

compared with 2007. Poison control data showed a 33-percent increase in reported human heroin exposure cases in 2008, compared with the previous year. Use of **methamphetamine** in Cincinnati remained low, with little indication of change noted during 2008. A decrease in the number of methamphetamine lab seizures, combined with decreased purity of submitted seizure samples, indicated less availability for use during 2008. Qualitative indicators continue to show higher methamphetamine numbers in rural populations than those in the city. Determination of rural access and use of methamphetamine would be useful for future monitoring of the drug. **MDMA** availability and use in Cincinnati during 2008 continued to be reported at a low to moderate level, with some qualitative indicators pointing to a slight increase. The number of reported human exposure cases increased by 13 percent in 2008 over the previous year. **Prescription narcotics** containing either oxycodone or hydrocodone remained the most desirable of the opioid products abused in Cincinnati. In addition, qualitative indicators point to relative high availability, with a slight increase in 2008 from 2007. Poison control data on oxycodone and hydrocodone showed relatively stable numbers of human exposure cases reported during 2008, compared with 2007. Abuse of methadone appeared to be leveling off, but a 39-percent increase in the number of morphine-related exposures was reported to poison control in 2008. The most desirable benzodiazepine abused continued to be alprazolam, according to both users and law enforcement. An increased number of human exposure cases involving alprazolam were reported to poison control from 2007 to 2008, and a similar increase in the number of clonazepam exposures were reported to poison control occurred in 2008. It remains unclear if clonazepam is being prescribed in higher numbers or more abuse is occurring, but this remains an area for observation in the future. **Emerging Patterns:** There was a 61-percent increase in the number of human exposures to poison control for buprenorphine-containing pharmaceuticals in 2008 over 2007, suggesting increased availability

and possible abuse of the drug. This remains an area to monitor in the future. A nearly 48-percent increase in drug identification calls was reported by poison control, suggesting an increase in diversion of the drug to the street in 2008 from the previous year.

Data Sources: *Medical examiner data* were obtained by the Hamilton County Coroner's Office for drug-related deaths for the years 2006 and 2007 for comparison with death data from January to June 2008. Data included results 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** came from focus group interviews conducted for the Ohio Substance Abuse Monitoring Project, funded by the Ohio Department of Alcohol and Drug Addiction Services through a grant to Wright State University. Focus groups are conducted in 6-month intervals. **Drug purity data** were provided by the Drug Enforcement Administration, Cincinnati Resident Office, for January to June 2008 and the years 2006–2007. **Treatment data** were provided by the Hamilton County Mental Health and Recovery Services Board for FYs 2006 through 2008. 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 except for years 2007 and 2008. 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 for calendar years 2006–2008. There are two call “types” with respect to poison control data. A call coming into the center involves either (1) a question or (2) an exposure 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 and the RENU for illicit drugs seized in Hamilton County. Forensic laboratory data were provided by the National Forensic Laboratory Information System for FY 2008. Additional qualitative and drug seizure data were provided by the Greater Warren County Drug Task Force. Methamphetamine clandestine lab data were provided by the Ohio Bureau of Criminal Identification and Investigation.

Drug Abuse Patterns and Trends in Colorado and the Denver/Boulder Metropolitan Area—Update: January 2009

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Overview of Findings: With mostly stable or increasing trends, marijuana continued to be a major drug of abuse in Colorado and the Denver/Boulder metropolitan area based on treatment admissions, hospital discharges, law enforcement drug testing, emergency department (ED) visits, and adult and juvenile arrests. Likewise, with mostly stable or increasing trends, cocaine continued to be at or near the top of Colorado and Denver/Boulder area indicators, including treatment admissions, hospital discharges, ED visits, drug-related mortality, poison center calls, and law enforcement drug testing. Conversely, among Colorado and Denver/Boulder area indicators, methamphetamine presented more of a mixed picture, with stable or downward

treatment admissions, declining lab seizures, and relatively small proportions of ED visits and drug-related mortality. Many heroin abuse indicators decreased over the last several years, while poison calls remained stable. However, it is likely that Denver heroin deaths are under-reported. Statewide and in the Denver/Boulder area, other opiates were a small but increasing percentage of treatment admissions, and were a substantial proportion of ED visits, and drug-related mortality. Beyond abuse of illicit drugs, alcohol remained Colorado’s most frequently abused substance and accounted 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 continued to be the primary drug of abuse statewide and in greater Denver. During the first half of 2008, it represented 37 percent of drug treatment admissions in Colorado, an increase from 34 percent during the first half of 2007. Marijuana accounted for 38 percent of Denver area admissions in the first half of 2008, an increase from 36 percent in the first half of 2007. In the first half of 2008, there were 1,200 unweighted marijuana Drug Abuse Warning Network (DAWN) ED reports in greater Denver, representing 25.5 percent of the reports (excluding alcohol) and ranking third behind cocaine and nonheroin opiates. Marijuana ranked second in 2007 Denver County hospital discharges ($N=1,050$; rate per 100,000=181), but both the number and rate of such discharges declined from the 2006 peak ($N=1,188$; rate per 100,000=207). Also, cannabis was the second most common drug submitted for testing by local law enforcement in the first half of 2008 (January–June) in Denver and Arapahoe Counties, and ranked first in Jefferson County. Federal drug seizures for marijuana across Colorado, after being relatively stable from 2003 (444.1 kilograms) to 2006 (656.8 kilograms), nearly doubled to 1,149.5 kilograms in 2007. Total adult and juvenile marijuana arrests in Denver (both sales and possession) decreased from 3,235 in 2000 to

2,110 in 2004, but then climbed steadily to 3,212 by 2007. **Methamphetamine**, which accounted for the next highest proportion of treatment admissions statewide (excluding alcohol), overtook cocaine admissions in the first half of 2003. Methamphetamine admissions continued to increase until the first half of 2006 (31 percent), remained stable through 2007, but then declined in the first half of 2008 (26 percent). In greater Denver, methamphetamine represented 22 percent of first half of 2006 admissions, increased to 23 percent in the first half of 2007, but then declined to just 19 percent in the first half of 2008. Greater Denver methamphetamine admissions were behind cocaine in all three of these time periods. Methamphetamine ED reports in greater Denver totaled 266 in the first half of 2008, accounting for just 6 percent of unweighted DAWN reports (excluding alcohol). While methamphetamine was not among the most common drugs found in Denver drug-related decedents, it still accounted for 7.1 percent of Denver drug-related mortality in 2005, 5.3 percent in 2006, and 6.3 percent in 2007. Methamphetamine was the third most common drug submitted for testing by local law enforcement in the first half of 2008 in Denver, Arapahoe, and Jefferson Counties. Federal drug seizures for methamphetamine across Colorado increased each year from 2003 (14.8 kilograms) to 2006 (50.3 kilograms), but then declined to only 8 kilograms in 2007. Likewise, methamphetamine lab seizures in Colorado have declined from 345 in 2003 to only 44 in 2007. **Cocaine** admissions (excluding alcohol) statewide declined slightly from 21 percent in both the first half of 2006 and 2007 to 20 percent in the first half of 2008. Similarly, Denver area cocaine admissions had increased from 23 percent in the first half of 2006 to 24 percent in the first half of 2007, but then decreased slightly to 22 percent in the first half of 2008. In the first half of 2008, there were 1,436 cocaine ED reports, which at 31 percent of greater Denver unweighted DAWN reports, was the highest number of reports among all drugs excluding alcohol. Likewise, excluding alcohol,

cocaine was the most common drug reported in substance abuse-related hospital discharges in 2007, a trend extending from calendar year (CY) 2000. Cocaine was also the most common drug found in Denver drug-related decedents in 2005 (48.2 percent), 2006 (50.3 percent), and 2007 (39.7 percent). Likewise, cocaine in combination with other drugs (i.e., morphine, codeine, alcohol, and heroin) was among the most common combinations found in Denver drug-related decedents in the 2005 to 2007 time period. Continuing the scenario of cocaine dominance in the greater Denver area, cocaine was the most common drug submitted for testing by local law enforcement in the first half of 2008 in Denver and Arapahoe Counties, and ranked second after cannabis in Jefferson County. Federal drug seizures for cocaine across Colorado, after decreasing from 65.5 to 36 kilograms from 2003 to 2004, increased substantially in 2005 (131.5 kilograms) and 2006 (135.1 kilograms), but declined sharply in 2007 (44.0 kilograms). In the first half of 2008, **heroin** ranked fourth in both statewide and greater Denver treatment admissions, representing 7 and 11 percent of admissions (excluding alcohol), respectively. Heroin accounted for 8 percent of unweighted DAWN reports in the first half of 2008 ($n=379$), ranking fourth behind cocaine, marijuana, and other opiates. Heroin was found in 11.2, 9.5, and 10.1 percent of Denver drug-related decedents in 2005, 2006, and 2007, respectively. However, it is likely that this percentage was much greater. The marker for heroin, the metabolite 6-monoacetylmorphine, needs to be present to confirm that heroin was related to the cause of death. However, this metabolite has a very short half-life and may be undetectable by the time blood toxicology is done as part of an autopsy. Morphine and codeine almost always are present when heroin is metabolized, but are also abused opiates. Thus, it is sometimes difficult to determine whether heroin was involved in a drug-related death. Often, an autopsy report will describe the circumstances surrounding a drug-related death including information such as

drug-use history (e.g., decedent had history of heroin abuse). While such information cannot be used to specify heroin as a cause of death in the absence of 6-monoacetylmorphine, it does indicate that heroin is the likely “parent drug.” The combination of heroin and cocaine (typically called a “speedball”) was found among 4.7, 5.3, and 2.6 percent of Denver drug-related decedents in 2005, 2006, and 2007, respectively. Again, it is likely that the combination of heroin with other drugs among Denver drug decedents was a much higher percentage than indicated for the same reason as described above. Heroin lagged far behind cocaine, cannabis, and methamphetamine among drugs submitted for testing by local law enforcement in the first half of 2008 in Denver, Arapahoe, and Jefferson Counties. Only small quantities of heroin were seized in Colorado, ranging from 2.5 to 4.6 kilograms from 2003 to 2007. **Other opiates** ranked fifth in both statewide and greater Denver treatment admissions (excluding alcohol), accounting for 6.7 and 6.2 percent of admissions, respectively, in the first half of 2008. Statewide, other opiate admissions accounted for 4.8 and 5.1 percent, respectively, during the first half of 2006 and 2007. In greater Denver, opiate admissions fluctuated from 5.1 percent in the second half of 2006, to 4.5 percent in the second half of 2007, to 6.2 percent in the first half of 2008. With 1,081 ED reports, other opiates (excluding alcohol) ranked third behind cocaine and marijuana, and represented 23 percent of the unweighted DAWN Live! reports. For the first half of 2008, oxycodone and hydrocodone accounted for approximately two-thirds of all unweighted narcotic analgesic ED visits. Other opiates were among the most common drugs found in Denver drug-related decedents from 2005 to 2007. Morphine was involved in 35.3, 37.9, and 22.8 percent of Denver drug-related deaths in 2005, 2006, and 2007, respectively. Codeine was involved in 21.2 percent of Denver drug-related deaths in 2005, 21.3 percent in 2006, and 9.5 percent in 2007. However, based on the prior discussion of the short half-life of the marker for heroin deaths (6-monoacetylmorphine)

and the fact that codeine and morphine are heroin metabolites, it is likely that a substantial proportion of morphine and codeine deaths are really heroin-related deaths. Oxycodone accounted for only 7.1 percent of Denver drug-related deaths in 2005, but increased to 20.1 percent by 2007. Likewise, oxycodone in combination with any other drug as a cause of Denver drug mortality was virtually nonexistent in 2005 and 2006, but increased to 10.1 percent of decedent drug combinations in 2007. Taken together, oxycodone, hydrocodone, morphine, codeine, and hydromorphone accounted for 2.8, 2.5, and 1.6 percent of drugs submitted for testing by local law enforcement in the first half of 2008 in Denver, Arapahoe, and Jefferson counties, respectively. Interestingly, Denver combined adult and juvenile arrests for sale and possession of opium have declined by 31 percent from 2000 to 2007, while those for synthetic narcotics increased by 88 percent during the same time period. **HIV/AIDS Update:** Cumulative acquired immunodeficiency syndrome (AIDS) data through September 2008 indicated decreasing cases related to injection drug use.

Data Sources: *Treatment data* were provided by the Colorado Department of Human Services, Division of Behavioral Health (DBH). *Data from client admissions to all DBH-licensed treatment providers from January–June 2008 were included in the data set.* **Unweighted ED DAWN Live! data** from the Office of Applied Studies, Substance Abuse and Mental Health Services Administration were available to report drug mentions in ED visits occurring from January–June 2008. 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 EDs in the sample totaling 17 (some hospitals have more than one ED). 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 8,

2008. Unweighted DAWN data are reported for the Denver area only. **Forensic laboratory data** were provided by the Denver Police Department Crime Lab (for CY 2008 through 08/31/2008) and the National Forensic Laboratory Information System, Drug Enforcement Administration, for the first half of CY 2008 (January–June). While the NFLIS data are described, they cannot be compared with earlier data to establish trends, as a new methodology renders them not comparable. **Hospital discharge data** were obtained from the Colorado Department of Public Health and Environment, and from the Colorado Hospital Association. These data represent CY 2007. **Death data** were obtained for CYs 2005 through 2007 from the Denver Office of the Medical Examiner. **Poison call data** were obtained from the Rocky Mountain Poison Control Center and represent CY 2007. **Information on drug seizure quantities** was obtained from the standard Drug Enforcement Administration report, State Facts: Colorado 2008. Data were for CY 2007. CY 2008 data is scheduled to be published in February 2009. **Drug price and purity data** came from the National Drug Intelligence Center's intelligence bulletin, "National Illicit Drug Prices," published in March 2008, and cover drug prices collected in June 2007. **Intelligence and qualitative data** were obtained from a questionnaire developed by the Denver Office of Drug Strategy and sent in September 2008 to law enforcement, treatment, research, public health, and street outreach agencies. **AIDS data** were obtained from the Colorado Department of Public Health and Environment (HIV/STD Surveillance Program Disease Control and Environmental Epidemiology).

Drug Abuse Patterns and Trends in Detroit, Wayne County, and Michigan—Update: January 2009

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Overview of Findings: Cocaine and heroin were the two major drugs of abuse in the Detroit/Wayne County area in 2008, and marijuana was widespread.

Updated Drug Trends and Emerging Patterns: Cocaine primary treatment admissions accounted for 24.1 percent of Detroit publicly-funded admissions in fiscal year (FY) 2008; 91.6 percent of these admissions were for crack cocaine. Of the crack cocaine admissions, 54 percent were male; 88.7 percent were African American; and 84.9 percent were older than 35. Of the powder cocaine admissions, 54.1 percent were male; 83 percent were African American; and 68.6 percent were older than 35. Cocaine accounted for 25.6 percent of Wayne County drug items identified by forensic laboratories in the National Forensic Laboratory Information System (NFLIS) in first half of 2008, a decrease from 34.4 percent in 2007. In the first half of 2008, the Wayne County Medical Examiner (ME) reported 138 deaths involving cocaine, the highest number for all drugs, but lower than the preceding year. In FY 2008, heroin primary treatment admissions represented 31.7 percent of the publicly-funded admissions; 61.5 percent were male (an increase of 4.8 percent from FY 2007); 84.3 percent were African American; and 90.4 percent were older than 35. White clients had a younger mean age and were more likely to inject heroin than African-American clients: 39.1 years versus 49.7 years, and 77 percent versus 37.1 percent. Heroin items analyzed by forensic laboratories accounted for 7.4 percent of the total drug items. For 2008 compared with 2007, the Wayne County ME reported an increase in the number of deaths with heroin detected—projected to be 182, compared with 167 in 2007. The Drug Enforcement Administration (DEA) through the Heroin Domestic Monitor Program (HDMP) reported an increase in purity and cost for both South American heroin and Southwest

Asian heroin. A focus group of law enforcement officials reported an increase in crime associated with heroin. Calls to the Poison Control Center about intentional use of heroin by humans increased in the first half of 2008, compared with 2007. There were declines in the number of deaths in which either **fantanyl**, **hydrocodone**, or **methadone** was detected in decedents. Treatment admissions for **marijuana** decreased in FY 2008, the first time this decade, and accounted for 14.2 percent of the publicly-funded admissions. Of these admissions, 71.8 percent were male; 91.2 percent were African American; and 38.7 percent were younger than 18. There was criminal justice involvement in 65.4 percent of the marijuana admissions. Marijuana represented 46.0 percent of the drug items reported by NFLIS in first half of 2008. Michigan voters approved a Medical Marijuana referendum in the 2008 election. The indicators for **methamphetamine** remained low. **Ecstasy** use was still troublesome, as evidenced by NFLIS, but was reported to be stable by law enforcement and ME reports. For treatment admissions, there was an increase of 25.6 percent in FY 2008, compared with FY2007, in the proportion of clients who were homeless. There was also an increase of 14.3 percent of the clients who were White.

Data Sources: *Forensic laboratory data* were provided by NFLIS. *Mortality data* came from the Wayne County ME. *Drug purity and cost data* were provided by the DEA's HDMP. *Drug-related crime data* came from a law enforcement officials' focus groups conducted by Cynthia L. Arfken, Ph.D. *Poison control data* came from calls made to the Michigan Poison Control Center in Detroit. *Treatment admissions data* were provided by the Bureau of Substance Abuse and Addiction Services, Division of Substance Abuse and Gambling Services, Michigan Department of Community Health.

Drug Abuse Patterns and Trends in Honolulu and the State of Hawai'i—Update: January 2009

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Overview of Findings: The previously reported trend in overall drug use has persisted, with most categories of drug use lower than in the June 2008 report (based on data from the last half of 2007). The cause of this reduction in apparent use is not totally clear. While the Honolulu Police Department claims it is the result of increased surveillance and interdiction, the Alcohol and Drug Abuse Division of the State Department of Health reports that it is due to their increased efforts in prevention at all levels. On the street, the sentiment is that "Sometimes it is up, sometimes it is down; now it is ok."

Updated Drug Abuse Trends and Emerging Patterns: In the first half of 2008, the Hawai'i economy continued to boom, with large construction projects throughout the islands. Almost total employment existed with an unemployment rate of less than 3 percent. Tourism was a little slower than in previous years but was still relatively strong from Asia and the mainland in spite of their economic changes. While few legislative 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**. Drug prices have remained stable for nearly 2 years, regardless of the size of seizures, number of arrests, or degree of apparent surveillance. The system of delivery has remained in place, with new dealers replacing those incarcerated for trafficking. Street reports continue to

suggest no shortages of drugs, just a need to know where to look and whom to ask. There has been a suggestion that use of crystal methamphetamine has modified, with former heavy users cutting down their intake due to health issues, and less dedicated users switching to less powerful stimulants. There are no confirmations of these reports, but in the next period information will be sought that focuses on the issue of use patterns. The four major drugs identified after seizure or capture and sent for analysis to laboratories participating in the National Forensic Laboratory Information System (NFLIS) had remained stable over the past 5 years, with methamphetamine identified most often. However, the proportion of methamphetamine analyses was importantly lower than in previous years, with cannabis and cocaine taking up the difference. Treatment admissions data in Hawai'i are based on self-reported primary drug information, and showed that during this period primary admissions for **cocaine** use continued their multi-year decline. The numbers of decedents with cocaine as part of the body toxicology also decreased from previous reporting periods. The Medical Examiner (ME) findings were confirmed by Honolulu Police data that also showed a downturn in cases. Cocaine was the third most frequently analyzed drug by NFLIS labs. **Heroin** admissions for treatment reversed their multi-year downturn and increased slightly, compared with the previous reporting period. Heroin deaths remained a problem for the ME lab because of an apparent spike in morphine use that has made the unambiguous identification of heroin as the drug in the toxicology report difficult to ascertain. Police cases for heroin use were up slightly, but remained within the normal variability of the numbers of cases from one period to another. Heroin has been minimal in the drug items identified by NFLIS. The number of decedents with **other opiates** as part of their toxicology analysis decreased, with hydrocodone, followed by oxycodone, as the primary drugs involved. **Methadone** deaths were also down from previous periods. Admissions for treatment with **marijuana** as the primary drug were down markedly during

this period, with no apparent explanation. The ME reports that the number of decedents with THC (tetrahydrocannabinol, the active ingredient in marijuana) in their toxicology screen was slightly down. Police, while not actively seeking cases, reported a slight increase. Cannabis, THC, or similar products were the second most identified drug category analyzed by NFLIS labs. Also, a sharp rise in **MDMA** was included in the "other drug" category. The State of Hawai'i does little analysis of its data on clients in treatment. Univariate statistics are available, but even bivariate data showing profiles of users of specific drugs are not routinely generated, and accessing those data by people who are not affiliated with the Alcohol and Drug Abuse Division is not permitted. No analysis of polydrug use is conducted, nor of recidivists in the treatment system. Differential analyses of those succeeding in treatment, compared with those that do not succeed, are also not completed, although 6-month post treatment data are collected.

Data Sources: *Data for this period were obtained from the following sources: Hawai'i High Intensity Drug Trafficking Area reports; Honolulu Police Department Narcotics and Vice Data sets; Hawai'i Office Drug Enforcement Administration Reports; State of Hawai'i Office of Narcotic Control; office of the 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; State of Hawai'i Department of Business, Economic Development and Tourism; and Hawai'i Drug Policy Forum Reports. Data were also collected from: NFLIS; private drug treatment facilities; Department of Psychiatry, University of Hawai'i; 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 2009

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Overview of Findings: Overall numbers of treatment admissions in January–June 2008 were similar to those of the corresponding reporting period in 2007 (27,944 and 26,657, respectively). Four primary substances each accounted for approximately one in five admissions: alcohol (20 percent), methamphetamine (19 percent), marijuana (19 percent), and heroin (19 percent). Methamphetamine admissions have decreased from 23 percent in calendar year (CY) 2007. Cocaine (35 percent), marijuana (34 percent), and methamphetamine (17 percent) accounted for the substantial majority of Los Angeles-based illicit drug items analyzed and recorded by the National Forensic Laboratory Information System (NFLIS) for January–June 2008. Results indicate a continuing trend of an increasing percentage for marijuana and decreases for cocaine and methamphetamine. While remaining very small percentages of NFLIS items, increases over 2007 levels were also seen for hydrocodone and oxycodone. Increases were also seen in these drugs for California Poison Control System (CPCS) reports. Benzodiazepines (29 percent) and narcotic analgesics (16 percent) were the most frequently reported classes of drugs in CPCS calls. The most recent California Healthy Kids survey results indicated a very slight increase in past 30-day inhalant use for the period ending in 2007 over 2006 levels, and stable trends for other major substances. Both street and wholesale prices for methamphetamine have remained stable in 2008, following earlier substantial increases over 2006–2007 prices. Wholesale prices for cocaine have increased, but

this has not yet impacted street prices. Prices for other drugs have remained stable.

Updated Drug Abuse Patterns and Emerging Patterns:

While continuing to account for a large proportion (19.4 percent) of alcohol and other drug (AOD) treatment admissions in Los Angeles County in January–June 2008, **methamphetamine** admissions have decreased from their 24 percent level of January–June 2007 and have fallen slightly below alcohol (20 percent). Hispanics represented a higher proportion of methamphetamine admissions (56 percent) than they did of admissions for other major substances. Approximately one-sixth of NFLIS-reported items tested in forensic labs contained methamphetamine, ranking it third among types of substances found (after cocaine and cannabis). This represents a decrease over 2007 levels. While only a small percentage (under 2 percent) of CPCS calls reported methamphetamine in January–September 2008, this was a decrease from 2005 and 2007 levels. By early 2008 the street price for methamphetamine had increased to \$240 per one-eighth ounce, nearly double that in 2006 and early 2007, but then has remained stable through September 2008. **Cocaine** accounted for 16 percent of Los Angeles County AOD treatment admissions in the first half of 2008, a majority (57 percent) of whom were African American. Of January–June 2008 NFLIS items, 35 percent contained cocaine (a larger percentage than for any other substance), a slight decrease from 2007. CPCS calls for cocaine poisoning were relatively stable since 2005 (at 3 percent for January–September 2008). The wholesale price of cocaine has continued its increase during 2008 (to \$18,500–\$23,000 per kilogram, 15–30 percent over 2007 prices), but street prices have not yet been affected. Treatment admissions for **MDMA** showed a slight increase over 2007 levels, but remained at a very low level (0.2 percent). CPCS reports for MDMA, while a small percentage of total reports (2 percent), also showed an increase for January–September 2008 over 2003–2007 levels. However, MDMA ranked fifth among drugs

identified in NFLIS forensic lab testing reports for Los Angeles County (2.3 percent of items, an increase in percentage over 2007 levels). Street and wholesale prices of MDMA have remained stable during 2008. **Benzodiazepines**, tranquilizers, and sedatives together accounted for a very small percentage (0.5 percent) of treatment admissions. Benzodiazepines accounted for the largest percentage of CPCS reports (29 percent), remaining stable from 2007. The category of “other” amphetamines and stimulants, which includes several **prescription drugs**, such as Adderall® and Ritalin®, accounted for 3 percent of treatment admissions. In January–June 2008, 19 percent of treatment admissions were for **heroin**, with a fairly stable trend since 2005. Heroin was identified in 4 percent of NFLIS items and represented less than 1 percent of drugs reported by CPCS. Prices remained stable. Approximately 2 percent of treatment admissions were for **other opioids/narcotics** excluding heroin. There appeared to be an increasing trend specifically for oxycodone admissions, but this drug still accounted for less than 1 percent of treatment admissions. Other opioids/narcotics accounted for 1.9 percent of NFLIS items, with hydrocodone as most prevalent (0.8 percent of total NFLIS items), and oxycodone accounting for 0.3 percent of NFLIS items, both showing increases over 2007 levels. Prescription narcotics accounted for 16 percent CPCS reports, an increase over 2007 levels. **Marijuana** was reported as the primary drug for 19 percent of Los Angeles County treatment admissions, a slight increase over 2007 levels. Over one-half (55 percent) of marijuana admissions were for adolescents younger than 18. Cannabis was identified in 34 percent of NFLIS items, an increase over 2007 levels. The California Health Kids survey showed stable levels in past 30-day use for secondary students. The street price for marijuana has remained stable. **HIV/AIDS Update:** The numbers of new acquired immunodeficiency syndrome (AIDS) cases reported during January–June 2008 were $n=864$ (preliminary count), a slight increase over the similar period in 2007. **Emerging Patterns:** Treatment admissions

for methamphetamine continued to decrease in the first half of 2008, and those for alcohol and marijuana increased slightly.

Data Sources: *Treatment data* were provided by Los Angeles County Department of Public Health, Alcohol and Drug Program Administration from CalOMS (California Outcome Monitoring System). CalOMS is a statewide client-based data collection and outcomes measurement system for 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 January–June 2008. Note that CalOMS was implemented in early 2006 (replacing the earlier CADDs system); data reported for periods prior to July 2006 may not be exactly comparable to more recent periods. **Forensic laboratory data** were provided by the NFLIS, Drug Enforcement Administration (DEA), for January–June 2008. **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’s June 2008 Drug Market Analysis report for Los Angeles County, 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 2008. The price estimates are based primarily on field reports, interviews with law enforcement agencies throughout the Los Angeles HIDTA, and post-seizure analysis. **AIDS and human immunodeficiency virus (HIV) data** (cumulative through June 2008 with most recent 6-month update for January–June 2008) were from the Los Angeles County Department of Health Services, HIV Epidemiology Program, HIV/AIDS Semi-annual Surveillance Summary, June 2008. **Youth drug use data** were from the California Healthy Kids Survey (provided by WestEd) from the most recent school

district data available through 2007. Youth Risk Behaviour Study data, also previously reported to CEWG in June 2008, were from online reports as of 06/04/2008. Poison Control System data were provided by the CPCS for 2007 and January–September 2008. Updates from other data sources were not available for this report.

Drug Abuse Patterns and Trends in Maine—Update: January 2009

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Overview of Findings: This report updates drug abuse indicators in Maine, arrests and seizures through calendar year 2008, and deaths and treatment admissions through the first half of the year. Several drug categories showed mixed or conflicting patterns. Most heroin indicators declined in 2008, continuing a multi-year trend, although seizures increased slightly. Cocaine abuse, which had been growing strongly through 2007, declined across most indicators, with the exception of a slight increase in cocaine powder primary admissions through June 2008. Decreases were seen for cocaine and crack arrests and seizures, as well as for primary cocaine powder admissions. The decreasing number of cocaine-induced deaths during the first 6 months of 2008 suggests a possible downturn for the year. Marijuana indicators continued to be moderately high, with arrests, seizures, and primary admission levels stable or in gradual decline for the last several years. Although the percentage of primary marijuana admissions decreased in the first half of 2008, the number of admissions increased. Abuse of prescription drugs, predominantly methadone, oxycodone, and benzodiazepines, continued at high and increasing levels; these drugs are

frequently used in combination with each other or with alcohol. The percentage of deaths caused by one or more prescription drugs in 2007 was 86 percent, rising to 95 percent in the first half of 2008, as the overall number of prescriptions written statewide for Schedule II, III, and IV drugs continued to rise. During the second half of 2007, primary admissions for prescription drugs began to exceed those for illicit drugs, a trend that continued into the first half of 2008. Among narcotic analgesics, seizures through 2008 for methadone and buprenorphine were higher, as well as primary treatment admissions for oxycodone and methadone through the first half of 2008. Methadone-induced deaths leveled off at 36 percent of drug deaths, and benzodiazepine-induced deaths rose to 26 percent through the first 6 months of the year. The proportion of arrests for pharmaceuticals increased from 21 to 29 percent through 2008, and pharmaceutical arrests dominated other drug categories, exceeding the percentage of cocaine arrests. Methamphetamine abuse indicators were mixed, and the numbers were still quite low. The majority of methamphetamine seizures were tablets containing caffeine, some containing MDMA as well. The numbers of MDMA seizures and arrests have increased but remain low in number. The proportion of MDMA treatment admissions fell sharply in 2007 to nearly zero, and has remained there through June 2008.

Updated Drug Trends and Emerging Patterns: Heroin abuse remained a serious problem but recent indicators have been stable or decreasing. Heroin/morphine caused 13 percent of January–June drug-induced deaths in 2008, compared with 16 percent in 2007, continuing to decline from a peak of 25 percent in 2005. Six percent of 2008 arrests were for heroin, down slightly from 7 percent in 2007. Heroin seizures rose slightly between 2007 and 2008, from 7 to 8 percent. Primary heroin/morphine admissions for the first half of 2008 were down to 13 percent, continuing a decline since the peak of 22 percent in the second half of 2005. Cocaine and prescription narcotics remained the two leading types of

substance abuse in Maine, excluding alcohol and tobacco. Cocaine/crack arrests have dominated the illicit drug activity of the Maine Drug Enforcement Agency in recent years, but the proportion of arrests has decreased substantially to 33 percent of arrests in 2008, down from 45 percent in 2007. Both crack and powder cocaine arrests have decreased. The percent of females arrested for cocaine/crack, which had increased from 23 percent in 2005 to 40 percent in 2007, declined slightly to 37 percent in 2008. Cocaine/crack also constituted the largest single category of samples tested in Maine's forensic laboratory, growing from 36 percent in 2003 to 50 percent in 2007; it decreased to 41 percent through 2008. Cocaine-induced deaths had risen sharply, from 4 percent in 2002 to a peak of 19 percent in 2006, but have declined to 18 percent in 2007 and 15 percent in the first half of 2008. Primary treatment admissions for crack and powder cocaine combined constituted 14 percent of primary admissions during the first half of 2008, with 3 percent for crack/cocaine and 10 percent for powder cocaine; this proportion has been essentially level since 2005. **Prescription narcotics** misuse and abuse remained high in early 2008 indicators, with mixed trend signals, contributing to 29 percent of arrests (up from 21 percent in 2007), 13 percent of forensic lab samples (down slightly from 15 percent in 2007), 69 percent of drug-induced deaths during the first half of 2008 (down slightly from 72 percent in 2007), and 53 percent of primary admissions, excluding alcohol, in the first half of 2008 (continuing a steady upward trend). Cocaine had been found frequently as a co-intoxicant cause of death with methadone, although cocaine involvement decreased in early 2008. Among pharmaceutical narcotics, methadone and oxycodone dominated deaths, arrests, seizures, and poison center exposure and information calls. The number of oxycodone-induced deaths, which had increased sharply in 2007, returned to 2006 levels in the first half of 2008. During the first half of 2008, methadone-induced deaths, which had peaked in 2004, appeared to have stabilized at the 2007 level. **Benzodiazepines** continued to play a persistent role

in 2008 drug abuse. Constituting approximately 4 percent of seizures (up from 3 percent in 2007), and 26 percent of drug-induced deaths (up from 24 percent in 2007), benzodiazepines were frequent co-intoxicants in narcotic deaths and often identified as secondary or tertiary problems on admission. **Methamphetamine** indicators were mixed, but numbers continued to be small. Seizures rose slightly, from 2 to 3 percent in 2008. Sixty-two percent of the methamphetamine samples were tablets, similar to 60 percent 2007; nearly all of those contained caffeine, although 12 percent of them also contained MDMA. Only one death was due to methamphetamine in the first half of 2008. Although primary methamphetamine admissions rose slightly in 2006–2007, the proportion remained under 1 percent in the first half of 2008. **MDMA** seizures are only 1 percent of tested seizures in 2008, and primary admissions for MDMA constituted only one-tenth of 1 percent in the first 6 months of 2008. **Marijuana** declined from 20 percent of arrests in both 2006 and 2007 to 16 percent in 2008. Seizures have declined from 11 percent of lab samples in both 2006 and 2007 to 8 percent in 2008. The percentage of primary marijuana admissions has been declining slightly since 2004, although the absolute number increased slightly during the first half of 2008. **HIV/AIDS Update:** Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) data were reported through 2007, and showed a slight decline in new diagnoses from previous years, from a recent peak of 58 in 2005, down to 52 in 2007. The proportion of new diagnoses that involve injection drug use has declined sharply from 14 percent in 2006 to only 2 percent in 2007. **Emerging issues** include continuing problems with the high volume of prescription drug abuse. Of particular note is the rising percentage of deaths in which benzodiazepines were mentioned as a cause, usually in combination with narcotics, and currently constituting more than one-quarter of the drug-induced deaths.

Data Sources: *Treatment admission data* were provided by the Maine State Office of Substance Abuse, and included all admissions for programs receiving State funding. This report includes admissions data from January–June 2008, excluding shelter and detoxification treatment; comparisons extend back to 2003. **Forensic laboratory data** were provided by the Maine State Health and Environmental Testing Laboratory, which identified drug items from test samples seized statewide. Data were provided for calendar year (CY) 2008 and compared with previous years back to 2003. **Arrest data** were provided by the Maine State Drug Enforcement Agency, which directs eight multi-jurisdictional task forces covering the State, generating approximately 60 percent of all Uniform Crime Report drug-related offenses statewide. Data were provided for CY 2008 and compared with previous years back to 2003. **Mortality data** were provided by the State of Maine Office of Chief Medical Examiner for all completed cases from 2000 through June 2008. That office investigates all drug-related cases statewide. In 2008 they changed to the National Medical Services Laboratory which does screening and quantification for additional substances. Toxicology is routinely done on all suspected drug cases. **Data regarding HIV/AIDS**, provided by the Maine Center for Disease Control, were updated through calendar year 2007.

Drug Abuse Patterns and Trends in South Florida: Miami/Dade and Broward Counties—Update: January 2009

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Overview of Findings: Cocaine remained entrenched as South Florida's major illicit drug problem, yet there were modest declines in deaths

and treatment admissions related to it during the first half of 2008, as compared with the previous 6 months. Increasing heroin consequences that began in Miami/Dade County during the second half of 2007 continued in the first half of 2008, when heroin deaths increased in Ft. Lauderdale/Broward County and other areas of Florida. Consequences for nonmedical use of prescription narcotic opioids stabilized at high levels in the first half of 2008. Broward County led the nation in the amount of oxycodone directly provided by dispensing practitioners. MDMA continued to be found in combination with methamphetamine, as both drugs have been detected in ecstasy tablets. Consequences related to benzodiazepines declined during the first half of 2008 in both Miami/Dade and Ft. Lauderdale/Broward Counties, but increased statewide.

Updated Drug Abuse Trends and Emerging Patterns: South Florida's two counties have the highest proportion of **cocaine**-related consequences among all CEWG reporting areas, with 60 percent of both illicit unweighted drug emergency department (ED) reports and crime lab cases during the first half of 2008. Cocaine-related deaths declined by 54 percent in Miami/Dade County, 48 percent in Ft. Lauderdale/Broward County, and 10 percent across the State between the last half of 2007 and the first half of 2008. These declines reverse rising numbers of cocaine-related deaths in the State since 2000 and in the two South Florida Counties since 2004. Polysubstance abuse was linked to 64 percent of the Ft. Lauderdale/Broward County cocaine-related deaths, 55 percent of those in Miami/Dade County, and 75 percent statewide during the first half of 2008. The 16 **heroin**-related deaths in Miami/Dade County during the first half of 2008 were the highest number in the State, yet represented a 16-percent decline from the previous 6 months. Heroin deaths in Ft. Lauderdale/Broward County increased from one to six (500 percent) during the same period, compared with a 34-percent increase across Florida. Heroin consequences have been declining since 2001

in Florida as prescription opioid abuse began to sharply escalate. Heroin indicators began increasing during the second half of 2007 in Miami/Dade County, and increased as well in the State and in Ft. Lauderdale/Broward County during the first 6 months of 2008. Ft. Lauderdale/Broward County and most of the State had higher numbers and per capita rates of **prescription opioid** nonmedical use and abuse than Miami/Dade County. Yet, consequences rose sharply in Miami/Dade during the second half of 2007 before declining there and in Ft. Lauderdale/Broward County during the first 6 months of 2008. Statewide, methadone deaths decreased by 17 percent, from 520 in the last half of 2007 to 432 in the first 6 months of 2008, while fentanyl deaths increased by 44 percent, from 89 to 128, over the same period. In the first half of 2008, among unweighted ED reports for five illicit drugs as well as prescription opioids and benzodiazepines, 17 percent were for narcotic opioids in Ft. Lauderdale/Broward County, compared with 5 percent in Miami/Dade County. During the first half of 2008, 29 percent of treatment admissions (excluding alcohol) among a sample of Ft. Lauderdale/Broward County adult clients were for a prescription narcotic as the primary drug of abuse, up from 22 percent of a similar sample in the first half of 2007, and from 15 percent during the first 6 months of 2006. Oxycodone was the most frequently cited prescription opioid observed in most abuse indicators. Indicators of **methamphetamine** abuse remained low. Less than 1 percent of unweighted ED reports (excluding alcohol) were methamphetamine related in both counties. However, those reports doubled in Miami/Dade County, from 31 to 63 between the second half of 2007 and the first half of 2008. Statewide, methamphetamine-related deaths increased by 27 percent, from 45 in the last half of 2007 to 57 in the first half of 2008. Methamphetamine continues to be detected in ecstasy tablets. Statewide, **MDMA**-related deaths decreased 45 percent, from 40 in the last half of 2007 to 22 in the first half of 2008. South Florida trends were stable for the two methylated amphetamines, MDMA and methamphetamine. Indicators of

marijuana consequences remained stable and high, ranking second to cocaine. Approximately one-fourth of unweighted ED reports for all non-alcohol illicit drugs were for marijuana in both counties. Marijuana was the primary drug cited by 84 percent of adolescent clients and 23 percent of adult clients in Miami/Dade County treatment programs (excluding primary alcohol admissions). Alprazolam was the most frequently cited **benzodiazepine** observed in most abuse indicators. Benzodiazepines accounted for 37 percent of drug-related deaths (excluding alcohol) and 17 percent of unweighted ED reports for five illicit drugs, as well as prescription opioids and benzodiazepines, in Ft. Lauderdale/Broward County during the first half of 2008. In Miami/Dade County, they accounted for 26 percent of drug-related deaths and 9 percent of unweighted ED reports. Benzodiazepine deaths declined sharply in both counties between the two most recent semi-annual reporting periods, while increasing 10 percent statewide. **Emerging Patterns:** The decline of cocaine indicators, perhaps related to lower purity of South American cocaine, and the increase of heroin consequences, linked to rising opiate addiction with nonmedical use of prescription narcotic analgesics, are the major changes between CEWG reporting periods. Patterns of cocaine trafficking, including purity of the drug sold in wholesale quantities, should be monitored for changes in its availability and consequences. Initiation of heroin use among nonmedical opioid users is a potential risk.

Data Sources: *Drug-related death data came from the Florida Medical Examiners Commission 2008 Interim Report on Drugs Identified In Deceased Persons by Florida Medical Examiners covering the first half of 2008. Unweighted ED Drug Alert Warning Network (DAWN) Live! data were from Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies, and were reported for the period January 2008 through June 2008 separately for the Miami/Dade and Ft. Lauderdale/Broward Divisions of DAWN Live! No comparisons with earlier time*

periods can be made. Weighted ED DAWN data were not available for this reporting period. **Treatment data** were provided by Broward Addiction Recovery Centers (BARC) of the Broward County Department of Human Services and came from nine adult programs operated by BARC in Broward County. The data from Miami/Dade County were provided by the South Florida Provider Coalition from all publicly-funded treatment programs in the county. These data were also reported to the State of Florida for inclusion in its Treatment Episode Data Sets submission to SAMHSA. **Forensic laboratory data** were provided by the National Forensic Laboratory Information System, Drug Enforcement Administration (DEA), for January–June 2008. **Prescription distribution data** were provided by the Automation of Reports and Consolidated Orders System, DEA, for January–June 2008.

Drug Abuse Patterns and Trends in Minneapolis/St. Paul—Update: January 2009

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Overview of Findings: Addiction treatment programs continued to treat more clients for alcoholism than any other drug disorder, and more metropolitan area hospital emergency department (ED) reports involved underage alcohol consumption than reports for any single illicit drug in the first half of 2008. Treatment admissions for methamphetamine continued to drop, while those for heroin were increasing. For the first time in several years cocaine seizures by law enforcement surpassed those for methamphetamine.

Updated Drug Abuse Trends and Emerging Patterns: Treatment admissions for **methamphetamine** continued to drop in 2008 in the

Twin Cities (Minneapolis/St. Paul) metropolitan area; this is the continuation of a decline that began in 2006. Methamphetamine admissions accounted for 5.5 percent of total metropolitan area treatment admissions in the first half of 2008, compared with 7.5 percent in the first half of 2007 and 12 percent in 2005 (the highest year). Of these, a shrinking proportion was adolescents. Clients under the age of 18 accounted for 1.3 percent of methamphetamine-related treatment admissions in the first half of 2008, compared with 4 percent in the first half of 2007, and a high of 17.8 percent in 2003. Smoking remained the most common route of methamphetamine administration (64.9 percent). Seizures of methamphetamine by law enforcement were slightly surpassed by those of **cocaine** in 2008. Cocaine accounted for 29.5 percent of seizures, and methamphetamine accounted for 26.9 percent in the first half of 2008. Most cocaine treatment admissions were for crack/cocaine, and most clients (69 percent) were age 35 or older. Treatment admissions for **heroin** have steadily and gradually increased since the turn of the century to 6.6 percent in the first half of 2008, as have admissions for opiates other than heroin—mostly **prescription narcotic analgesics** used for nonmedical purposes (5.3 percent.) Of those clients admitted to treatment for other opiates, almost one-half (45.2 percent) were women, and oral was the primary route of administration (75.8 percent). **Marijuana** treatment admissions accounted for 16.9 percent of total treatment admissions in 2008 (first half), and cocaine accounted for 11 percent. Most clients (68.8 percent) admitted to treatment for marijuana dependence were under age 25 in the first half of 2008. More than half (52.1 percent) of treatment admissions reported **alcohol** as the primary substance problem. Addiction treatment programs continued to treat more clients for alcoholism than any other drug disorder. Most alcohol admissions (60.3 percent) were age 35 or older. More metropolitan area hospital ED reports involved underage alcohol consumption than reports for any single illicit drug in the first half of 2008. The results of drug testing among

arrestees in Hennepin County were available for the first time in years, due to the renewed funding of the Arrestee Drug Abuse Monitoring (ADAM II) System by the White House Office of National Drug Control Policy. Of the 881 male arrestees tested in Hennepin County in 2007, 43.4 percent tested positive for marijuana; 28.5 percent tested positive for cocaine; 5.3 percent tested positive for opiates; and 5.1 percent tested positive for methamphetamine. Characteristics of the 31,696 people treated statewide in local detoxification treatment centers are also presented in this report. Most (89.4 percent) had alcohol as a presenting problem, followed by marijuana (30.6 percent), and cocaine (18.2 percent). One-half reported at least one lifetime DWI (driving while intoxicated) arrest, and one-quarter (26.2 percent) reported a non-DWI or drug arrest. The most common referral at discharge was to a peer support group (69.7 percent), followed by social services (23 percent), and no referral at all (21.8 percent).

Data Sources: *Treatment data* were provided by addition treatment programs in the five-county Twin Cities metropolitan area as reported on the Drug and Alcohol Abuse Normative Evaluation System of the Minnesota Department of Human Services (January–June 2008). **Forensic laboratory data** were derived from the National Forensic Laboratory Information System, Drug Enforcement Administration, for the first half of 2008 (January–June 2008). **Arrestee drug testing data** were provided by the ADAM II system for Hennepin County arrestees in 2007, as reported by the White House Office of National Drug Control Policy. **Hospital ED data** were derived from the Drug Abuse Warning Network (DAWN) Live! system administered by the Office of Applied Studies of the Substance Abuse and Mental Health Services Administration (January–June 2008).

Drug Abuse Patterns and Trends in New York City—Update: January 2009

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Overview of Findings: Cocaine remained a major problem in New York City, and cocaine indicators were mixed for this reporting period. New York City is the most significant heroin market in the country, but treatment admissions for heroin were down slightly since the last reporting period. Marijuana indicators were mixed but remained at a high level. Although prescription drug use remained low, compared with the use of other substances, many kinds of prescription drugs were available on the street. Marijuana continued 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 remained low, and there was little availability or selling activity. Indicators for MDMA and other club drugs remained low.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine indicators were mixed, but several showed signs of increase. Primary cocaine treatment admissions remained stable at 19 percent of all admissions, but more clients in treatment had a primary, secondary, or tertiary problem with cocaine than with any other drug. There were more Drug Abuse Warning Network (DAWN) Live! unweighted emergency department (ED) reports for cocaine, as well as more National Forensic Laboratory Information System (NFLIS) items for cocaine, than for any other drug. Street sources reported that cocaine was highly available. Almost one-third of

arrestees tested positive for cocaine, according to the Arrestee Drug Abuse Monitoring (ADAM) II system. This is the same level as the previous ADAM study (2003), but lower than 2000–2002 levels. **Heroin** remained a major problem in New York City, which is considered the most significant heroin market and distribution center in the country. More than one-quarter of all primary treatment admissions were for heroin, although the number of treatment admissions for the first half of the year was slightly lower than for the first half of last year. Among primary heroin treatment admissions, the percentage of injectors remained at 39 percent. Compared with 1991, primary heroin admissions are more likely to be older, male, and have no source of income. Other than cocaine, alcohol, and marijuana, there were more DAWN *Live!* unweighted ED reports for heroin than for any other drug. Eleven percent of NFLIS items identified were heroin. **Marijuana** indicators were mixed but remained at a high level. Marijuana primary treatment admissions increased to the highest number ever and represented almost one-quarter of all treatment admissions. More than one-quarter of NFLIS items analyzed were marijuana. There were more DAWN *Live!* unweighted reports for marijuana than for heroin. Only cocaine and alcohol had more unweighted ED reports than these two. More arrestees tested positive for marijuana and self-reported use than for any other drug. Marijuana continued 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 remained low. Treatment admissions, DAWN *Live!* unweighted ED reports, and NFLIS items involving the drug were all at very low levels. According to the New York State Office of Alcoholism and Substance Abuse Services (OASAS) Street Studies Unit (SSU), there was little methamphetamine availability or selling activity. **MDMA** indicators remained low. MDMA primary treatment admissions represented a very small number. **Prescription drug** use remained

low. Prescription drugs represented only a small fraction of primary admissions to treatment. Among the DAWN *Live!* unweighted ED reports, opiates/opioids accounted for 2,350 reports, and benzodiazepines totaled 1,052. Among the opiates/opioids, methadone reports accounted for the largest number (1,289). Compared with primary admissions for heroin, primary admissions for other opiates tended to be younger, White, female, have a source of income, and began using at an older age. Although prescription drugs represented 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. **HIV/AIDS Update:** Of the 102,404 New Yorkers living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) as of December 31, 2007, men having sex with men (MSM) and injection drug use history continued to be the two major transmission risk factors. In 2007 there were 3,787 new HIV diagnoses in New York City. Of new diagnoses, 73 percent were male; 50 percent were Black; and 40 percent were MSM. Furthermore, a new test to estimate HIV incidence showed that Blacks and Hispanics, men, people age 30 and over, and MSM were at highest risk for incident HIV infection.

Data Sources: *ED data were derived for the first 6 months of 2008 from the DAWN Live! restricted-access online query system administered by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA). Eligible hospitals in the New York Five Boroughs Division totaled 52; hospitals in the DAWN sample numbered 41, with the number of EDs in the sample totaling 62 (some hospitals have more than one ED). During this 6-month period, between 39 and 40 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 22–23, 2008, and January 10, 2009. 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 unweighted 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 are not estimates for the reporting area. These data cannot be compared with 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://dawn-info.samhsa.gov>. **Treatment admissions data** were provided by OASAS for 1991 through the first half of 2008 and included both State-funded and nonfunded admissions. Demographic data are for the first half of 2008. **Forensic laboratory testing data** for New York City were provided by the Drug Enforcement Agency's (DEA) NFLIS for the first half of 2008. The data include New York Police Department laboratory data for the five boroughs of New York City as well as data from New York State and DEA labs. **Arrestee data** were derived from the ADAM II 2007 Report, Office of National Drug Control Policy, and included weighted data from male arrestees in Manhattan, New York City. **Drug price, purity, and trafficking data** were provided by SSU reports. **AIDS/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, Vol. 3, No. 2, covering January 1, 2007–June 30, 2007.*

Drug Abuse Patterns and Trends in Philadelphia—Update: January 2009

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Overview of Findings: This report updates data on drug abuse indicators for Philadelphia since the last CEWG report for this area in June 2008. Much of the data is for the first 6 months of 2008, compared with prior periods from their respective data sources. One exception is that urinalysis data for adults on probation or parole was through December 31, 2008.

Updated Drug Abuse Trends and Emerging Patterns: The drugs/drug groups below are commented on in descending order of their impact. In the first half of 2008, **cocaine** abuse, particularly in the form of crack, continued to lead the consequence data with respect to treatment admissions (24.3 percent), deaths with the presence of drugs (33.7 percent), and laboratory tests performed by the National Forensic Laboratory Information System (NFLIS) (39.8 percent). Cocaine continued to be the second most frequently encountered substance in urine/drug screens performed by the Philadelphia Adult Probation and Parole Department (APPD) (29.7 percent). However, during this period, declines were noted in all indicators. Females comprised a low of 25 percent of treatment admissions in 2005, but their share has gradually increased to 31 percent by mid-2008. The percentage of Whites entering treatment for cocaine abuse increased from 15 percent of all cocaine admissions in 2004 to 30 percent in 2007 and the first half of 2008. In this time span, the proportion of African-American cocaine treatment admissions decreased from 79 to 66 percent. Proportions of clients entering treatment age 41 and older have been increasing since early 2006, while proportions of clients age 31–40 have decreased. Crack smoking continued as the dominant form of cocaine use; 83 percent of clients entering treatment in the first half of 2008 identified smoking as their preferred route of administration. Mortality data from the first half of 2008 revealed that cocaine was most commonly used in combination with alcohol, heroin, diphenhydramine, and/or oxycodone. In the first half of 2007, **marijuana** ranked second in treatment admissions (23.7 percent), second in the

NFLIS data (35 percent), and first in the APPD (45.8 percent). (It is not tested for in decedents.) Marijuana use was common by itself or in combination with cocaine, alcohol, and phencyclidine (PCP), among others. Treatment admission trends have been stable since 2001 with respect to gender (ranging from 78 to 82 percent male). The percentage of African Americans entering treatment increased from 68 to 75 percent from 2006 to mid-2008, while proportions of Asians/others declined to very low levels. The proportions by age group for treatment admissions have remained stable from early 2005 through mid-2008: with clients under age 21 constituting from 9 to 9.4 percent; age 21–30, from 44 to 46.2 percent; age 31–40, from 27 to 26.7 percent; and age 41 and over, from 19 to 17.7 percent. **Alcohol** in combination with other drugs declined from second rank to third in deaths with drugs detected (present in 21.6 percent of decedents in the first half of 2008). It was most commonly reported as used along with or after cocaine, heroin, and/or marijuana. Alcohol was also the second most frequently mentioned drug in treatment admissions data (remaining stable at 22.1 percent) and seventh in the APPD study (5.4 percent). The proportion of African Americans entering treatment has changed from 49 percent in 2002 to 70 percent in the first half of 2008. Concomitantly, percentages of Whites have decreased from 41 to 26 percent during this period. Deaths with the presence of alcohol in combination decreased from a high of 386 in 2006, to 264 in 2007, to 107 in the first half of 2008. The street-level purity of **heroin** declined from 2000 (73 percent) to 2004 (52 percent) and increased to 56.3 percent in 2007. The price per milligram pure has been fluctuating from \$0.71 in 2004, to \$0.58 in 2005, \$0.63 in 2006, and \$0.71 in 2007; however, the standard bag price remained \$10 and contained one “hit.” In the first half of 2008, heroin ranked fourth in treatment admissions (17.9 percent), moving from third to second in deaths with the presence of drugs (25.8 percent); it was third in the NFLIS data, and fifth in the APPD data (within the category “total opioids,” at 13.2 percent). At the beginning

of the period of declining heroin purity in 2001, Whites comprised 54 percent of treatment admissions and had increased to over 68 percent by mid-2008. Proportions of African Americans declined from 42 percent in 2001 to 23 percent by mid-2008. As the purity levels bottomed out, the 21–30 age group entered treatment in increasing proportions (from 22 percent in 2001 to 42 percent in 2005), and as the purity leveled off in 2006, so did this population entering treatment. Deaths with the presence of heroin closely matched the purity trends from 2001 through mid-2008, with the exception of the period of the fentanyl outbreak from spring 2006 to spring 2007. Heroin was most commonly reported as used in combination with cocaine, alprazolam, alcohol, and/or oxycodone. In the first half of 2008, 88 percent of females and 85 percent of males reported injection as their preferred route of administration. Within the **other opioids** category, use was characterized as at medium levels with mixed indicator results, depending on the drug. Codeine and oxycodone remained low in treatment admissions, but relatively high in the Philadelphia Medical Examiner’s (ME’s) toxicology reports. However, six “other opioids” were in the top 15 drugs in the NFLIS report for the first half of 2008—oxycodone (4th), codeine (7th), hydrocodone (8th), methadone (10th), buprenorphine (14th), and propoxyphene (15th). **Benzodiazepine use**, while lower than use of drugs discussed above, remained a drug used in combination with other drugs according to trend data. Indications of abuse appeared to be increasing in the first half of 2008. Benzodiazepines ranked third in the mortality data. Alprazolam is clearly the benzodiazepine of choice, ranking seventh in the ME’s toxicology reports and fifth in the NFLIS data. Alprazolam is most commonly used in combination with heroin and/or oxycodone. **PCP** is primarily smoked in combination with marijuana in blunts. Indicators reflect medium levels of use, and indicators were either stable or declined in the first half of 2008, with the exception of the APPD study, where 12 percent of the (positive) tests were positive for PCP in the full calendar year 2008. The most common

cause of death with the presence of PCP remained homicide. Among **antidepressants**, data were only available from the ME's Office. Relatively low levels of use have been detected, with the leading drugs being in the Selective Serotonin Reuptake Inhibitor category (citalopram, fluoxetine, sertraline, and paroxetine). Use of **methamphetamine** and other amphetamines remained at very low levels, and indicators were either stable or declining. There was only one treatment admission for methamphetamine in the first half of 2008. There were no deaths with the presence of **MDMA** in 2007, but five in the first half of 2008.

Data Sources: *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, ME's Office, included 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 APPD, which analyzed more than 61,000 samples in 2008 using a nine-panel screen. Heroin purity and price data were provided by Drug Enforcement Administration's, (DEA) Heroin Domestic Monitor Program, for 2007 and earlier periods. Forensic laboratory data came from NFLIS, DEA, for the first half of 2008. Because of changes in methodology, no comparisons with previous time periods can be made. Note: hospital emergency department (ED) data were not available because Philadelphia is not associated with the Drug Abuse Warning Network (DAWN) Live! hospital ED data collection system.*

Drug Abuse Patterns and Trends in the Phoenix Area—Update: January 2009

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Overview of Findings: This report updates data on drug abuse indicators for the Phoenix area (Maricopa County) since the last reporting period in June 2008. Much of the data covers the first half of 2008. Indicators for amphetamine/methamphetamine problems were down—amphetamine/methamphetamine-related hospital admissions declined, and methamphetamine treatment admissions declined. Indicators for cocaine problems were down—both cocaine-related hospital admissions and cocaine treatment admissions declined. Marijuana indicators were mixed. Heroin/opioid indicators were up—both primary heroin treatment admissions and heroin/opioid-related hospital admissions increased. Retail sales of oxycodone, hydrocodone, morphine, and methadone rose sharply from 2000–2006. Although Arizona has been almost exclusively a black tar heroin area for decades, recent seizures indicate that Phoenix may now serve as a feeder city for white heroin arriving from Mexico. White heroin, however, has not been encountered by street level distributors based in the Phoenix area.

Updated Drug Abuse Trends and Emerging Patterns: Amphetamine/methamphetamine-related hospital admissions dropped in the first half of 2008, and have been dropping since the beginning of 2007. Seizures of methamphetamine and clandestine methamphetamine labs increased in the second quarter of 2008. Of the items reported by the National Forensic Laboratory Information System (NFLIS), methamphetamine was the second most common drug identified after marijuana. The number of treatment admissions with methamphetamine as the primary drug decreased from 670 in the first half of 2007 to 513 in the first half of 2008. Methamphetamine constituted 25 percent of all treatment admissions reporting a primary drug, making it

the illicit drug most often reported by these admissions. **Cocaine** constituted 9 percent of treatment admissions reporting a primary drug. The number of cocaine treatment admissions decreased from 227 in the first half of 2007 to 183 in the first half of 2008. After rising steadily during 2005 and 2006, cocaine-related hospital admissions began declining in the first half of 2007, and continued declining through the first half of 2008. Cocaine seizures were lower in the second quarter of 2008 compared with the first quarter. Thirty-six **MDMA** items were reported by NFLIS during the first half of 2008, a small number when compared with that for methamphetamine items ($n=763$). **Marijuana** was the primary drug reported by 15 percent of the treatment admissions reporting a primary drug. Marijuana treatment admissions increased slightly, from 292 in the first half of 2007 to 309 in the first half of 2008. Marijuana seizures dropped slightly in the first quarter of 2008 and increased slightly in the second quarter of 2008. Much of the marijuana smuggled into Arizona comes through a remote “transportation corridor” west of Nogales, Mexico. This corridor runs through the Tohono O’odham Indian Reservation, which lies along the United States–Mexico border. It is estimated that traffickers transport as much as 20 tons of marijuana per week through this corridor. **Heroin** was the primary drug reported by 13 percent of the treatment admissions reporting a primary drug. Heroin admissions increased from 231 in the first half of 2007 to 257 in the first half of 2008. Hospital admissions related to heroin/opioids have been rising fairly steadily since 2000. Consistent with this, heroin/opioid-related admissions rose in the first half of 2008. Although Arizona has been almost exclusively a black tar heroin area for decades, recent seizures indicate that Phoenix may now serve as a feeder city for white heroin arriving from Mexico. The white heroin is being transported to midwestern and northeastern wholesale distribution markets; to date, white heroin has not been encountered by local wholesale or street level distributors based in the Phoenix area. According to the Automation of Reports and Consolidated Orders System

(ARCOS) operated by the Drug Enforcement Administration (DEA), Arizona’s per capita retail sales of **oxycodone**, **morphine**, and **methadone** are substantially greater than those of the Nation as a whole. **Hydrocodone** per capita sales in Arizona and the Nation were roughly comparable. **HIV/AIDS Update:** New data were unavailable to update rates reported at the June 2008 meeting. **Emerging Patterns Regarding Use:** Agwa de Bolivia Coca Leaf Liqueur reportedly had become popular in bars and clubs in the Phoenix area in 2008. It is also sold at a limited number of liquor stores. Advertisements indicate that it provides a “cocaine buzz” and is made from the leaves of the coca plant as well as ginseng, green tea, and a natural source of caffeine called guarana. The drink is 60-percent alcohol; however, many users state they get more of a “drug high” than a “liquor buzz.” The coca leaves used to manufacture it are the leaves from which cocaine alkaloids have been removed. The substance is made in Amsterdam and legally imported into the United States. **Emerging Patterns Regarding Smuggling:** There are reports of smugglers: (1) ramming U.S. Border Patrol vehicles and driving directly toward agents at high rates of speed in attempts to hit them; (2) intentionally causing accidents and incidents to distract law enforcement officers; (3) faking distress calls in order to lure agents into attack; and (4) now being more likely to shoot at officers in order to avoid apprehension.

Data Sources: *Treatment data* were provided by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services. **Hospital admissions (inpatient) data** were derived 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 ADHS. **Law enforcement data, including clandestine lab seizure data**, were from the DEA and the National Drug Intelligence Center. **Forensic drug analysis data** came from NFLIS, DEA. **Data on the retail distribution of selected prescription opioid medications** were obtained from ARCOS.

Drug Abuse Patterns and Trends in San Diego County—Update: January 2009

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Overview of Findings: Methamphetamine continued to be the drug of primary concern in San Diego County in the first half of 2008. However, most indicators of methamphetamine use and abuse have declined since the last reporting period. Of 7,616 primary drug treatment admissions between January and June 2008, 2,401 (36 percent) were for methamphetamine; this represents a 14-percent decrease in methamphetamine admissions compared with the first half of 2007. Positive urine tests for methamphetamine among arrestees declined between 2006 and 2007 among male (36 percent versus 24 percent), female (47 percent versus 44 percent) and juvenile (10 percent versus 8 percent) arrestees. Unweighted emergency department (ED) reports involving methamphetamine also declined as a proportion of all major substances of abuse reported from January–June 2007 to the same period in 2008 (19 percent compared with 13 percent). Only drug overdose deaths involving amphetamine (including methamphetamine) were up, from 88 in 2006 to 98 in 2007. In contrast to methamphetamine, heroin primary treatment admissions increased in January–June 2008, up by 21 percent from the first half of 2007. The number of overdose deaths involving heroin/morphine also increased, from 84 in 2006 to 109 in 2007. Indicators for marijuana and cocaine remained relatively unchanged from the prior reporting period.

Updated Drug Abuse Trends and Emerging Patterns: After peaking in 2005, methamphetamine use and abuse continued to decline. The proportion of male and juvenile arrestees

testing positive for methamphetamine was at an 8-year low; primary treatment admissions decreased in the first half of 2008 to a level not seen since 2004, and the proportion of unweighted ED reports attributed to methamphetamine has been declining since 2005. These declines coincide with an increase in price and decrease in availability of methamphetamine since 2005. The San Diego County Law Enforcement Coordination Center (LECC) has reported increases in the price of ounce and pound quantities of methamphetamine since 2005, with the latter quantity increasing from \$3,500–\$8,500 in 2005 to \$10,000–\$20,000 in 2008. Similarly, the proportion of San Diego County arrestees who said that methamphetamine was less available in the past year increased more than three-fold, from 13 percent in 2005 to 45 percent in 2007, and the proportion that said the price was higher increased from 29 percent in 2005 to 68 percent in 2007. Recent increases in **heroin** primary treatment admissions and overdose deaths warrant monitoring to determine if use of heroin and its adverse impacts on health are increasing. Indicators for **marijuana** and **cocaine/crack** remained relatively stable. There are some indications that **MDMA** use is increasing, but the overall number of primary and secondary treatment admissions and ED reports remained low.

Data Sources: *Arrestee data* were provided by the San Diego Association of Governments Substance Abuse Monitoring program, a regional continuation of the Federal Arrestee Drug Abuse Monitoring program that was discontinued in 2003. This report presents 2007 data for both adult ($n=764$) and juvenile ($n=173$) arrestees. **Drug price data** were from the San Diego LECC's "2008 Street Drug Price List," which reported on street-level drug buys conducted in San Diego County in 2007. **Forensic laboratory data** were from the National Forensic Laboratory Information System, Drug Enforcement Administration. There were 10,234 drug items analyzed by local forensic laboratories between January and June 2008. **Treatment data** were from the San Diego Department of Alcohol

and Drug Programs (tables produced by the California Department of Alcohol and Drug Programs) using the California Outcomes Measurement System (CalOMS). 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 to San Diego County for the period January–June 2008. Note that CalOMS was implemented in early 2006 (replacing the earlier CADDIS system); data reported for periods prior to July 2006 may not be comparable to more recent periods. Unweighted **ED data** for January–June 2008 came from the Drug Abuse Warning Network (DAWN) Live!, a restricted access on-line query system administered by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration. The completeness of data reported by participating EDs varied by month. The first half of 2008 data for San Diego represent reports of major substances of abuse ($n=2,281$), including illicit drugs and alcohol only reports for patients younger than 21. These data were accessed on January 15, 2009, and are subject to change due to corrections and/or deletions arising from quality control reviews. Data represent drug reports in drug-related ED visits and may exceed the number of ED visits due to patients reporting multiple drugs. A full description of the DAWN data system can be found at <http://dawninfo.samhsa.gov/>. **Mortality data** were obtained from the Emergency Medical Services Medical Examiner Database, which is maintained by the County of San Diego Health and Human Services Agency.

Drug Abuse Patterns and Trends in the San Francisco Bay Area—Update: January 2009

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Overview of Findings: The five-county San Francisco Bay area was hit hard by economic troubles in the last half of 2008. These troubles especially affected the two inland counties (Alameda and Contra Costa), where unemployment rose to 7.2 percent and housing values fell by as much as one-third. The three coastal counties (Marin, San Francisco, and San Mateo) suffered somewhat less, with unemployment at 5.7 percent and housing values down by approximately one-sixth. Recent trends for cocaine and methamphetamine were down for this reporting period, while those for marijuana and prescription painkillers were up. Heroin use was level or up after a long decline.

Updated Drug Abuse Trends and Emerging Patterns: Admissions for **cocaine** were up slightly. However, nearly half of 2008's emergency department (ED) reports of cocaine were older than 45, and the cost of crack/cocaine at the wholesale and retail level was notably higher. All indicators for **heroin** were down during the 2004 to 2007 time frame. However, between 2007 and 2008 admissions increased by 9 percent, and the proportion under age 25 among unweighted ED cases rose from 4 to 7 percent. The Heroin Domestic Monitor Program's (HDMP) local heroin samples for 2007 had the highest price and lowest purity since 2001. Over the most recent 3 years, three indicators for **methamphetamine**—the share of unweighted ED reports, the reported usage among San Francisco gay men (from ethnographic sources), and the price of the drug at the wholesale and retail levels—all suggest a sharp decline in usage. Unweighted ED data in 2008

reflect an aging population based on methamphetamine ED reports, with 28 percent over age 45. **Marijuana** treatment admissions were up by 15 percent between fiscal years (FYs) 2007 and 2008. There were significant recent increases in the proportions of **hydrocodone** and **oxycodone** among unweighted ED reports in the coastal counties but not the inland counties. Phencyclidine (**PCP**), gamma hydroxybutyrate (**GHB**), lysergic acid diethylamide (**LSD**), and **ketamine** indicators were minimal. **HIV/AIDS Update:** Acquired immunodeficiency syndrome (AIDS) annual caseload increase is at 2.3 percent among both heterosexual and gay/bisexual male injection drug users over the past reporting period.

Data Sources: *Treatment admissions data* were available for all five bay area counties for FYs 2007 and 2008. These data were compiled by the California Department of Alcohol and Drug Programs. **Unweighted ED Drug Abuse Warning Network (DAWN) Live! data** from Office of Applied Studies, Substance Abuse and Mental Health Services Administration were available to report drug mentions in ED visits for 2008, although data for the last few months of the year were incomplete. **Reports of arrests for drug law violations** were provided by the San Francisco Police Department for 2001–2006. **Price and purity data** came from the Drug Enforcement Administration, HDMP, and referenced heroin “buys” mostly made in San Francisco County. Data for 2007 were compared with those for 2001–2006. 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. **AIDS surveillance data** were provided by the San Francisco Department of Public Health and covered the period through September 30, 2008.

Drug Abuse Patterns and Trends in the Seattle/King County Area—Update: January 2009

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Overview of Findings: No major changes were evident in data available for the Seattle/King County area for the first half of 2008, compared with prior years, with small numbers and the short time frame precluding trend analyses. Drugs with substantial negative impacts on health and mortality included prescription-type opiates, cocaine, and heroin. Methamphetamine indicators have generally leveled off or declined slightly. Marijuana indoor growing operations are substantial in the Seattle area, and use is common. Alcohol and benzodiazepines continued to be frequently used in combination with other drugs, both among those entering treatment and among those dying from drug overdoses. MDMA is being manufactured in substantial quantities in the adjacent Canadian province of British Columbia and shipped through Washington. MDMA use appeared to continue at moderate levels among young adults in the area. BZP (1-benzylpiperazine) is has emerged as an MDMA-like drug, often sold as MDMA. There is persistent heroin use, mostly in the Seattle area, with increasing prescription opiate use widespread throughout King County. Mortality for heroin is at its lowest point in at least a decade, while prescription-type opiates remained the drugs most commonly identified in fatal overdoses.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine was the most common illicit drug identified in unweighted emergency department (ED) reports, with 2,132 reports, double

the level for heroin and five times the level for methamphetamine. Youth treatment admissions have remained fairly steady over the past decade, while adult admissions have increased by 50 percent. Treatment admissions for adults for cocaine as the primary drug increased over the past decade to 20 percent of admissions, while it remains uncommon, at 3 percent, as a primary drug for youth. Any use of cocaine reported at treatment entry (i.e., secondary or tertiary use) has, conversely, remained steady for adults, at approximately 50 percent, while for youth it has nearly doubled to 15 percent. Cocaine continues to be the second most common drug identified in drug-caused deaths. Most deaths with cocaine involved other drugs (88 percent), with prescription opiates present in 41 percent of deaths, followed by heroin and alcohol, each at 27 percent. Comparing the four regions of King County, the rate of cocaine mortality over the past 5 years is much higher in Seattle than the surrounding areas of the county. Local law enforcement evidence submitted for testing through NFLIS forensic laboratories was most frequently found to contain cocaine (574 positives), with more than one-third of all evidence testing positive for drugs. **Methamphetamine** use indicators appear to be leveling off or declining. Mortality levels have been steady the past 3 years, at approximately one-quarter of the rate of cocaine-involved deaths. Methamphetamine is much more likely to be the sole drug present in drug-caused deaths, compared with other substances, with 47 percent of the methamphetamine deaths in the past year involving no other substance. The methamphetamine-involved drug-caused death rate is much higher in Seattle than the surrounding regions, although deaths have occurred throughout the county. Drug Abuse Warning Network (DAWN) *Live!* unweighted ED reports for methamphetamine totaled 380 in the first half of 2008. Primary treatment admissions for methamphetamine among adults leveled off in 2005, at approximately 12 percent of admissions, with a slight decline proportionally in the first half of 2008. A similar pattern is evident for any use of methamphetamine,

with 18 percent of adults reporting any use of methamphetamine in the first half of 2008. Youth methamphetamine has dropped more precipitously, down to 5 percent reporting any use in the first half of 2008, compared with 11 percent in 2004. National Forensic Laboratory Information System (NFLIS) data indicate methamphetamine was detected in 187 local law enforcement cases, the third most common drug identified. Methamphetamine laboratories and dump sites in King County totaled 16 in the first half of 2008, down from a peak of 271 incidents in 2001. **Prescription-type opiates** continued to be the substance most commonly detected in drug-caused deaths, although they were at lower levels in several other indicator data sources. Of the 127 drug-caused deaths in the first half of 2008, 74 involved prescription-type opiates, a similar number and proportion to the prior 2 years. From July 2007 through June 2008, 85 percent of other opiate-involved deaths also involved at least one other drug; benzodiazepines were the most common other drug detected, at 27 percent. Almost one-half of other opiate-involved deaths were among women, and 71 percent were 41 or older. The rate of other opiate-involved deaths was similar throughout King County except for the eastern region, where the rate was approximately one-third the rate elsewhere. Buprenorphine remained at low but detectable levels across data sources. Of note, two overdoses were positive for buprenorphine in the first half of 2008; previously just one overdose, in the first half of 2007, was confirmed to involve buprenorphine. In all cases positive for buprenorphine, other prescription-type drugs were detected and illicit drugs were not. For the first time, prescription-type opiates were the most common drug type reported by area EDs participating in DAWN. There were 2,138 unweighted DAWN reports for prescription-type opiates among all case types. Even though the proportions of youth treatment admissions with prescription opiates as primary have increased, the absolute numbers are low, with 17 admissions (2 percent) in the first half of 2008. For adults, a total of 275 people entering treatment reported opioids

as primary; this represents 4 percent of admissions, similar to the previous 2 years. Fully one-half of prescription-type opiate treatment admissions were age 18–29, compared with 23 percent for heroin. **Heroin** unweighted ED reports for all case types totaled 979, approximately one-half the number of prescription opiate reports. Just 81 pieces of evidence submitted by local law enforcement tested positive for heroin, compared with 129 for prescription-type opiates. Treatment admissions for heroin totaled 795 for adults (13 percent) in the first half of 2008, similar to the level observed for the prior 2 years, but down from 2004 and 2005 when capacity was expanded. As a proportion of methadone maintenance treatment admissions, heroin has been declining, and prescription-type opiates as primary have increased. Youth admissions for heroin continued to be rare, less than 1 percent of youth admissions. The 23 percent of heroin primary admissions age 18–29 represented an increase compared with a decade ago. Cocaine is by far the most common secondary drug, with 52 percent reporting cocaine as secondary to their heroin use. For the year ending June 2008, the overall rate of heroin treatment admissions per 100,000 population in King County was 86, compared with 30 for prescription-type opiates. The rate was much higher in Seattle, at 150 per 100,000, and much lower in the eastern region of the county, at 20 per 100,000. There were a total of 55 heroin/opiate deaths in the year ending June 2008, the fewest recorded in at least a decade. Three-quarters of heroin-involved overdoses involved another drug, with cocaine detected in almost one-half of heroin drug-caused deaths. As with treatment admissions, heroin was concentrated in Seattle. The annual rate of heroin-involved drug-caused deaths per 100,000 population was 5.1, compared with 2.5 for the county as a whole. **Marijuana** unweighted ED reports totaled 875, slightly lower than those for heroin. Cannabis was the second most common drug identified in local law enforcement seizures, with 448 cases. Any use of marijuana was reported by 85 percent of youth and 44 percent of adults at entry to treatment although youth were much

more likely to report it as a primary drug of abuse. These proportions have held steady for adults, but represent a decline for youth. Marijuana is grown in indoor grow houses throughout the Seattle area. **MDMA** and other hallucinogenic drug use continued in the Seattle area. In the last year or so, **BZP** has emerged as an MDMA-like drug, often being sold in tablet form as MDMA. It is reported that both dealers and users may be unaware that the substance is BZP. While BZP has apparently been available at low levels in recent years, use has increased substantially and is seen throughout Washington State. In 2007 there were no drug items identified as containing BZP among law enforcement seizures in King County, compared with 29 in the first half of 2008; there was a single drug item identified as positive for BZP in neighboring Pierce County in 2007. At the same time, MDMA is reported to be somewhat less available. There were 51 drug items identified as positive for MDMA in the first half of 2008, compared with 249 in all of 2007. There was one drug overdose in the first half of 2008 involving MDMA, a level similar to that seen since the second half of 1999. Lysergic acid diethylamide (**LSD**) was reportedly returning in popularity, and psychedelic mushrooms continued to be used. There was one piece of law enforcement evidence positive for LSD in 2007 and five in the first half of 2008. For psilocin/psilocybin (i.e., psychedelic mushrooms), the numbers declined from 31 to 6 for the same periods. DAWN ED reports totaled 102 for MDMA, 36 for LSD, and 44 for miscellaneous hallucinogens (note that most ED cases do not undergo toxicology testing, and drug type is usually based on self-report). Law enforcement reports that MDMA is continuing to be manufactured in British Columbia, Canada.

Data Sources: *Drug trafficking data* were obtained from the Drug Enforcement Administration (DEA) Seattle Field Division Quarterly Trends in the Traffic Reports, redacted versions for January–June 2008. *Drug overdose data* were obtained from the King County Medical Examiner, Public Health—Seattle & King County for the

first half of 2008. **Data on drug items identified in forensic laboratories from drug samples submitted for analysis** were obtained from NFLIS, DEA, for January–June 2008. Drug testing results for law enforcement seizures in King County were reported by the county where the drug was seized. **Unweighted ED drug reports data** were obtained from DAWN Live!, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, for the first half 2008. Data were accessed December 22, 2008. Data completeness for the first half of 2008 (for 25 eligible EDs) was as follows: 11 to 12 of the EDs reported basically complete data (90 percent or greater) each month, and 13 to 15 reported no data. **Drug treatment data** were provided by Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, Treatment Report and Generation Tool from 1999–June 2008. 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–June 2008.

Drug Abuse Patterns and Trends in St. Louis—Update: January 2009

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Overview of Findings: Many of the indicators for the major substances of abuse have remained relatively stable or were mixed through the first half of 2008. Alcohol and all drug categories have shown some increase in treatment admissions, but deaths and arrests appear more stable. Anecdotal information indicates that heroin use and availability may have increased as well

as treatment admissions. While cocaine indicators have increased in treatment admissions data, death data for St. Louis City and County appear to have stabilized during both 6-month reporting periods (death data were reported for the second half of 2007 and the first half of 2008). Prescription narcotic analgesics were also reported to be available in the more rural areas of the St. Louis Metropolitan Statistical Area (MSA). Indicators for both cocaine and the opiates will need continued monitoring to determine if there have been changes in these markets or in the user populations. Methamphetamine indicators have been stable in the last 6 months.

Updated Drug Abuse Trends and Emerging Patterns: Alcohol was the primary drug of abuse for those entering publicly-funded treatment programs in Missouri. Treatment admissions increased from 2006 to 2007 and again in 2008, and alcohol was frequently indicated as a secondary drug of abuse. The Youth Risk Behavioral Surveillance System (YRBS) survey indicated no change in lifetime use of alcohol and cigarettes in 2007, compared with 2005. **Cocaine** indicators, in general, were stable over the past 12 months. YRBS current cocaine use indicators were stable in 2007, compared with 2005, while treatment admissions and deaths increased in the last 6 months of 2008. Cocaine continues to be St. Louis City's primary drug problem, and timelier multiple indicator data are needed to develop a better picture of the cocaine situation in the region. It is believed that Mexican-controlled distribution chains may be increasing in urban areas of St. Louis and possibly organizing networks that control distribution of multiple drugs. National Drug Intelligence Center (NDIC) reports showed an increase in street prices for crack/cocaine in 2007. The **heroin** market in the St. Louis Region has grown and become more complex over the past few reporting periods. From 2006 to 2007, treatment admissions increased by 11.2 percent, and increased another 44 percent in the first half of 2008. YRBS lifetime use was stable from 2005 to 2007, at 2.7 percent (95-percent Confidence

Interval, or CI:1.5,5.1) in 2005 and 2.3 percent (CI:1.6,3.4) in 2007. Two types of heroin were available—Mexican black tar coming to the region from the Southwest and more recently, South American (SA) heroin. Increased involvement of Mexican dealers has complicated the market. Heroin Domestic Monitor Program (HDMP) analyses in 2007 reflected this growing, competitive heroin market in the St. Louis area, with decreasing purity in black tar heroin and increasing purity in the SA heroin. South American and Mexican black tar were represented in the samples, with more white samples than black tar samples. Indicators for opiates have increased for both heroin and other opiates. This increase is consistent with reported availability for heroin and reports from rural law enforcement about increased usage. The available indicators for **other opiates** remained stable for this reporting period, after a significant increase in reports between 2006 and 2007 in the St. Louis area. While the actual number of admissions was relatively low, there is still reason for concern, as anecdotal information has indicated that abuse of narcotic analgesics has been on the rise in this region, along with concern about rural use of prescription narcotics. **Marijuana** was considered stable or possibly growing slightly in the region. While treatment admissions dropped 7.3 percent from 2006 to 2007, they rose again in the first half of 2008. However, these admissions may be in response to criminal justice demands. The percentage of current users in the YRBS shows no change since the 2005 survey. Cannabis was the most frequently cited substance identified in the 2007 and January–June 2008 National Forensic Laboratory Information System (NFLIS) reports for the St. Louis MSA. **Methamphetamine** indicators appeared to be decreasing in for the St. Louis region. Treatment admissions have risen by 30 percent since the second half of 2007. YRBS data suggest that lifetime methamphetamine use among students has decreased, from 6.4 percent (CI:4.4,9.1) in 2005 to 3.7 percent (CI:2.9,4.7) in 2007. While it is believed that the bulk of the available methamphetamine is being imported from Mexico, reports of “ice” from Mexico are

not well-substantiated. One indication that the methamphetamine problem is not disappearing is the large number of positive toxicology screens among the Department of Corrections population in 2007 and the anecdotal reports from rural health clinics about patients who are current or former methamphetamine users. The pseudoephedrine control legislation has led to more creative ways of networking for the local “cooks” to gain access to the chemicals needed to make methamphetamine. Further analysis and monitoring are needed. Interestingly, the eastern half of the State remained relatively active in clandestine laboratory operations; 108 clandestine laboratories were reported in a rural county of the MSA in the first half of 2008 (Jefferson County). However, clandestine laboratory incidents in the St. Louis MSA were down from 868 in 2005 to 503 in 2007. Statewide, 770 clandestine laboratories were reported in the first half of 2008. **Prescription drug** abuse has been growing, particularly in the rural areas. 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 continued use of **MDMA** in select populations. **HIV/AIDS Update:** Data available from the St. Louis City Health Department and the Missouri Department of Health and Senior Services for 2007 indicate that the risk factor of injection drug use does not play a major role in the transmission of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) in the St. Louis area. However, the men who have sex with men (MSM) population and heterosexual contact in minority populations are more prominent risk factors. The role of alcohol and other drug use among these populations is a key factor. **Emerging Patterns:** Indicators for many substances appeared to be stable. However, the number of cocaine-related deaths and the increase in a number of opiate abuse indicators are cause for concern and continued monitoring. 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 diverse and the drug becoming available to a wider range of users. It is reportedly available frequently in many rural areas, some over 100 miles from the urban St. Louis City, where traditionally the drug was purchased. Anecdotal reports of increases in prescription drug abuse have not been verified through multiple data sources.

Data Sources: Analysis of drug trends for the St. Louis region requires multiple data sources; a number of sources have been used for this report. Missouri Treatment Episode Data Set admissions for calendar years (CYs) 2006–2008 provided invaluable indicators for **treatment data**. Although the Missouri Division of Alcohol and Drug Abuse has made major changes in its management information system, the data provided gross indication of general trends. The Missouri Department of Corrections Probation, Parole and Inmate Toxicology Reports, fiscal years (FYs) 2003–2007, provided a rich source of information about a hard to reach population that is closely tied to the end user population and their drug issues in the state. The Missouri State highway Patrol and the Missouri Uniform Crime Report CYs 2006–2008 also provided limited information on the **drug use behaviors of offenders**. The January–June 2008 NFLIS reports for the St. Louis MSA provided **forensic information** and offered a unique view of drug trends on the county level for a variety of substances. The Missouri Department of Health and Senior Services **HIV/AIDS** data FY 2006–2007 and local St. Louis City Health Department provided measures of HIV, AIDS, and other data by risk factor that is helpful in understanding the role of injection drug use on health. YRBS survey data for Missouri for the years 2005 through 2007 gave a glimpse of general **youth trends** in current and lifetime use of some of the major substances. **Death data** from the St. Louis City and County Medical Examiner for CY 2007–2008 provided insight to

the extent that drug use results in death, along with basic demographic data helpful to understanding emerging trends. Ongoing reports of drug use price and purity from the Drug Enforcement Administration and NDIC are invaluable as well as the frequent formal written reports and anecdotal insight provided by the staff of these agencies.

Drug Abuse Patterns and Trends in Texas—Update: January 2009

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Overview of Findings: This report updates data on drug abuse indicators in Texas from calendar year 1998 through 2008.⁶ Heroin use was low and stable, but proportions of younger inhalers of Mexican brown powder were increasing. Cocaine indicators were at a high level but mixed, with increasing crack use among Whites and Hispanics; this is a growing problem on the United States–Mexico border. Marijuana use was mixed, and the role of blunts continued. Use of methadone pain pills and hydrocodone was high; use of oxycodone, fentanyl patches, and lozenges was low; buprenorphine use was also low. Alprazolam (Xanax®) was the most prevalent benzodiazepine and was the most popular prescription drug used by Texas secondary students for “feeling.” Methamphetamine indicators peaked in 2005. Increasing price and decreasing purity and supply have resulted in an increase in clandestine laboratories in the Dallas/Fort Worth area. Ecstasy indicators were mixed; it is no longer a drug just used

⁶Data described in this Update Brief are for CY 2008 (January–December), as of January 16, 2009 (data are subject to change). Texas treatment admissions data provided for the cross-area comparisons in section IV, tables 2–4, 7, 10, and 11 and appendix table 1 are for the first half of 2008 (January–June). They will therefore differ from data represented in this Update Brief.

by Whites at “raves”. Phencyclidine (PCP) use was increasing, and gamma hydroxybutyrate (GHB) numbers were low and mixed. Carisoprodol (Soma®) remained a problem, and there were increasing mentions of dextromethorphan (DXM) by young users. Of recent concern is *Salvia divinorum*, but it is difficult for poison centers to identify the correct species.

Updated Indicators and Emerging Patterns: **Alcohol** was the primary drug for which Texans enter treatment (27 percent of all admissions) in this reporting period, followed by cocaine (12 percent crack and 10 percent powder cocaine). **Cocaine** was a major problem on the border with Mexico. Indicators of cocaine use remained high but mixed, with increasing crack use among Whites and Hispanics. The proportion of Black crack admissions has dropped from 75 percent in 1993 to 47 percent in 2008, and the proportion of cocaine deaths who were Hispanic has increased from 22 percent in 1993 to 33 percent in 2007. **Heroin** indicators were low and level, but the proportion who were inhaling or sniffing heroin was growing (up from 1 percent in 1989 to 20 percent in 2008), with an increasing proportion of younger Hispanic inhalers of Mexican brown powder. Arrests and overdoses of “cheese heroin,” a mixture of Tylenol PM® and heroin (a combination of heroin, diphenhydramine, and acetaminophen), were down in Dallas, but treatment admissions of young heroin users were increasing statewide. **Hydrocodone** was a larger problem than **oxycodone** (359 deaths versus 63 deaths in 2007). Indicators of problems with **fentanyl** patches or lozenges were low; they fluctuate from year to year. **Methadone** indicators were increasing, and most adverse events were related to methadone pain pills rather than liquid methadone from narcotic treatment programs. **Codeine** cough syrup, “Lean,” continued to be abused. **Marijuana** indicators were mixed, with blunt cigars continuing to be used. The 2008 Texas secondary school survey reported that 8 percent of all students who reported ever having used marijuana used blunts most of the time

or always, as compared with 6 percent who used “joints” 6 percent who used pipes, and 4 percent who used “bongs.” In addition, marijuana is a far larger problem than alcohol for underage drivers who entered treatment as a result of a DUI (driving under the influence) (63 percent compared with 21 percent). **Methamphetamine** indicators peaked in 2005. The price of a pound of “ice” in Dallas has increased from \$4,500–\$19,000 in 2005 to \$13,000–\$20,000 in 2008. The purity of ice was lower, since it is being cut with methylsulfonylmethane (MSM). Abuse of **alprazolam** and **carisoprodol** was increasing. The 2008 Texas Secondary School reported 13 percent of students had used Xanax® for the experience or feeling, as compared with 6 percent who had used Vicodin®, and 5 percent who had used codeine for the same reason. Deaths involving a mention of carisoprodol and National Forensic Laboratory Information System (NFLIS) identification of drug items containing the drug continued to increase. Of the 208 carisoprodol deaths in Texas in 2007, all but 4 involved other substances. All indicators of **ecstasy** use were stable or increasing as the drug spread from the club scene to the street. The proportion of White ecstasy users entering treatment has dropped from 100 percent in 1989 to 39 percent in 2008. **PCP** treatment admission and toxicology laboratory indicators continued to rise. **Border patterns:** Drug use patterns on the border not only differ from California to Texas and from El Paso to the Lower Rio Grande border, but they also differ between border and nonborder areas in the State. The percentages of treatment admissions for methamphetamine were higher on both sides of the western end of the border, with heroin admissions higher in the middle border area, and cocaine admissions highest on both sides of the eastern end of the border. The 2008 Texas secondary school survey found border students were more likely to report lifetime use of tobacco, cocaine, crack, and Rohypnol®, while nonborder students reported higher levels of use of alcohol, any illicit drug, marijuana, Xanax®, methamphetamine, and ecstasy. Border students reported that it was very easy to obtain Rohypnol®,

crack, and powder cocaine, while nonborder students reported that it was very easy to obtain marijuana, tobacco, and alcohol. Border treatment clients were more likely to report problems with marijuana, powder cocaine, alcohol, and heroin, while nonborder clients had problems with crack, methamphetamine, and other opiates. Powder cocaine and marijuana admissions to border programs were higher as heroin admissions decreased, while in nonborder areas cocaine admissions were decreasing and marijuana admissions were increasing. Methamphetamine admissions into border programs never exceeded 1 percent, while methamphetamine admissions into nonborder programs peaked at 14 percent in 2005. Border admissions were more likely to inhale powder cocaine, while nonborder admissions were more likely to smoke crack. Both groups preferred to inject heroin and smoke methamphetamine. **Regional border patterns:** Patterns also differed from El Paso to Laredo to the Lower Valley. Alcohol was the primary drug for clients entering treatment in El Paso, followed by cocaine and marijuana; in Laredo marijuana was the primary drug, followed by cocaine and heroin; and in the Valley cocaine was the primary drug, followed by alcohol and marijuana. The different patterns of admission reflect historical funding practices in these areas as well as trafficking patterns. NFLIS reports that marijuana was the primary drug seized and identified in El Paso and Laredo, while cocaine was the primary drug identified in the Lower Valley. A 2002–2003 survey (Wallisch and Spence) found high perceptions of trafficking and availability of drugs, and the economic benefits of dealing as a factor in some areas.

Data Sources: *Poison control center data* were provided by the Texas Department of State Health Services from 1998 through 2008. *Treatment data* were provided by the Department of State Health Services from 1987 through 2008.

Death certificates were provided by the Texas Department of State Health Services from 1998 through 2007. Results of **toxicology** tests on items submitted to the Texas Department of Public Safety from 1998 through 2008 were downloaded from NFLIS.⁷ **Emergency department** admissions to hospitals in Houston were downloaded for 2004–2008. **Price, purity, and trafficking** information came from the 2008 Intelligence Reports from the Dallas, El Paso, and Houston Drug Enforcement Administration Field Divisions. The 2008 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. Additional information was retrieved from: Wallisch, L S and Spence, R T (2006), *Alcohol and Drug Use, Abuse and Dependence in Urban Areas and Colonias of the Texas–Mexico Border*, *Hispanic Journal of Behavioral Sciences*, 28, 286–307. The human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) information presented in the June 2008 report was not updated for this report.

INTERNATIONAL REPORTS: CANADA AND MEXICO

Trends in Drug Seizures: Health Canada's Drug Seizure Information— Update: January 2009

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⁷Texas NFLIS data for the first half of the year only are used in tables 1, 8, 9, 12, and 13, figures 15, 16, 18, and 19, and appendix table 2 of this report.

Canada, Phone: 613-948-8954, Fax: 613-948-7977, E-mail: robert_hanson@hc-sc.gc.ca.

Overview of Findings: Marijuana continued to dominate the drug scene in Canada during this reporting period, along with increases in exhibits seized by law enforcement of cocaine, MDMA, and prescription opioids. Methamphetamine showed a shift from the west of the country to the eastern portion of Canada, and heroin indicators were mixed (high in the western provinces and declining in several provinces).

Updated Drug Abuse Trends and Emerging Patterns: Data submitted to Health Canada's Drug Analysis Service (DAS) of Health Canada laboratories indicated that **marijuana** continued to dominate the number of exhibits seized by police and border services and submitted to Health Canada for testing. However, the number of exhibits overall in Canada has declined in the past 5 years. **Cocaine** was submitted to DAS less often than marijuana, but represents approximately 22 percent of all exhibits received since 2003. All provinces show a slight increase in the number of cocaine exhibits since 2002, with most originating in Ontario. The provinces of Quebec and Ontario had the highest growth in the number of **methamphetamine** exhibits in the past 4 years, while a decline has been noted in the number of methamphetamine exhibits coming from the western provinces. This may be an indication of the West-East trend in movement of this substance. All provinces have shown an increase in **MDMA** since 2000, with the largest increase found in Ontario and Quebec. For these analyses, methamphetamine samples included those that contain predominately methamphetamine, as well as those found in smaller concentrations in conjunction with other substances. There has been a dramatic increase in the number of samples found to contain other agents or adulterants when the primary substance is methamphetamine or MDMA, and the number of multiple agents or adulterants in a particular sample is also increasing. Most **heroin** submitted for testing had

been seized in British Columbia (approximately 80 percent), while other provinces showed a decline in the number of heroin exhibits (Ontario and Quebec) or relatively few exhibits (Prairie Provinces and Atlantic Canada). Heroin and cocaine exhibits have remained stable in terms of the number of other substances found in combination. There has been a steady increase in **prescription opioid** submissions (hydromorphone, morphine, codeine, oxycodone, methadone, and fentanyl) since 1988. This is most prominent in Ontario and Quebec.

Data Sources: Drug seizure data: In Canada, the Drug Analysis Service (DAS) of Health Canada is responsible for analyzing suspected controlled substances that are seized by Canadian police officers and custom agents for prosecutorial purposes. The tests confirm the identity and in some cases, the purity of the substances seized, and result in certificates of analysis that are used as evidence in Canadian courts. The results of these analyses are retained in a computerized national database, known as the Laboratory Information Management System (LIMS). The database holds results for over 1,793,790 analyses conducted from January 1988 to the present. In 2007 alone, over 127,700 substances were identified by DAS. Moreover, whenever a drug is seized in Canada, police and custom officials are required to disclose the information to Health Canada on the seizure and disposition of the case. It is the responsibility of Health Canada to authorize the destruction of the controlled drug or substance. This information has strategic value for intelligence purposes and it provides context in which drugs are seized in Canada and the outcomes of those seizures. This source of information, the Controlled Drugs and Substances Database (CDSD), complements the LIMS data. The two data sources are not without limitations. The LIMS data represents substances confirmed to contain a controlled substance but only represents those pending prosecution. The CDSD contains information on all seizures in Canada; however, it only specifies what is suspected at time of

seizure and is not based on analytical confirmation through the drug testing labs.

Drug Abuse Patterns and Trends in Mexico: Information from the National Epidemiological Surveillance System of Addictions (SISVEA)—Update: January 2009

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Overview of Findings: This report presents epidemiological surveillance information on legal and illegal substance use in Mexico for the first half of 2008. Most of the information comes from 790 treatment centers providing information to the National Epidemiological Surveillance System of Addictions (SISVEA). During this period, the number of treatment centers reporting to SISVEA increased by 26 percent. The majority of the new centers are located in Chihuahua in the northern region; Jalisco, Michoacan, Mexico City, Puebla, Estado de Mexico, and San Luis Potosí in central Mexico; and Tabasco and Guerrero in the south. The new centers are similar to the ones previously reporting in terms of the kind of population served, admission criteria, and provided services. Because of this, their inclusion is not expected to result in systematic changes in the trends observed. The main primary drugs reported remained much the same as in 2007, with slight decreases in the report of methamphetamine and cocaine as primary drugs, and a slight rise in heroin. At the national level, and for the central and southern regions, alcohol continued to be the main primary drug. However, for the northern region, heroin was the main primary drug in

2008, after being second after methamphetamine for the last 4 years. The report of tobacco as drug of onset increased, as a result of the emphasis made by SISVEA on considering it as a drug.

Updated Drug Abuse Trends and Emerging Patterns: The decrease in **methamphetamine** that began in 2006 continued in all regions of the country, with percentages of users now similar to those of 2002–2003. However, methamphetamine as the primary drug was still highly prevalent among users in treatment centers in the north, accounting for 21 percent of admissions. Twelve percent of all methamphetamine users were female. After a sustained increase in reports of **cocaine** as the primary drug of abuse during the last 3 years, a small decrease was seen in 2008 (although not enough to consider that a decreasing trend is under way). Cocaine as a primary drug was widespread in treatment centers all over the country, being the main primary drug in Tamaulipas, Quintana Roo, Nuevo León, Jalisco, Mexico City, and Coahuila. At the national level, 11 percent of those seeking care at treatment centers reported cocaine as their primary drug, while 8 percent reported crack. Eight percent of users were female. Two percent of users reported cocaine injection. After a downward trend since the beginning of the decade, the percentage of admissions to treatment centers reporting **heroin** as the primary drug increased slightly in 2008 (from 11 percent in 2007 to 12 percent in the past year). This tendency was more clear for the northern region. Six percent of heroin users seeking treatment were females. Use of **opiates** remained relatively low and stable. Thirteen percent of users were female. Sixty-nine percent of users reported injection of the drug. The use of **prescription drugs** (benzodiazepines, barbiturates, antihistamines, amphetamines, diet pills, and other prescription drugs) remained low and stable. Benzodiazepines were the most commonly used prescription drugs, and 23 percent of users were female. **Marijuana** as primary drug remained stable, reported in 9 percent of admissions nationwide. During 2008, 8 percent of marijuana users

were female. The use of inhalants also remained stable, and 13 percent of users were female. **Alcohol** continued as a primary drug of abuse. At the national level, alcohol was the main substance reported by forensic services, followed by cocaine in the central and southern regions, and heroin in the north. It was also the main substance identified at admission to emergency departments. Ten percent of alcohol users in treatment centers were females. **Northern border region patterns:** The northern border region, including the states of Baja California, Sonora, Chihuahua, Coahuila, Nuevo León, and Tamaulipas, showed a very different pattern of substance use when compared with the rest of the country. While 46 percent of admissions to treatment centers for the rest of the country in 2008 were due to alcohol, the primary drug at the border was heroin (29 percent of admissions), followed by methamphetamine (21 percent). Alcohol accounted for only 19 percent of admissions at the border. There were no differences in the age or gender distribution of admissions between the border and the rest of the country. By states, methamphetamine and

heroin were the more frequent primary drugs in Baja California and Sonora; heroin and cocaine were the main ones in Chihuahua; and cocaine and alcohol were the main drugs in Coahuila, Nuevo Leon, and Tamaulipas. The percentage of admissions to treatment centers reporting ever having used intravenous drugs has decreased constantly during the past 10 years, from 64 percent in 1998, down to 32 percent in 2007 and the first half of 2008.

Data Source: National Epidemiological Surveillance System of Addictions (SISVEA), 2008: *During the first half of 2008, 790 treatment centers contributed information to SISVEA. They were mostly nongovernmental, run by nonprofit organizations, and many of them follow a self-help approach based on Alcoholics Anonymous 12-step programs. Also during this period, 31 Juvenile Detention Centers and Forensic Services in 20 states reported to SISVEA. One hundred and sixteen emergency departments in 17 states conducted surveys of substance use in admissions. Information for this report came from 152 cities in all 32 states.*

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

Cocaine/Crack

- Treatment admissions data for the first half of 2008 revealed that treatment admissions for primary cocaine/crack, as a percentage of total drug treatment admissions, including primary alcohol admissions, ranked first in frequency in 2 of 21 reporting CEWG areas: Miami/Dade County and Philadelphia (section II, table 2).
- Cocaine was the drug most frequently identified by forensic laboratories in 13 of 22 reporting CEWG areas. Based on forensic laboratory analysis of drug items identified in the first half of 2008, cocaine/crack ranked first in four of five areas in the southern region (Miami/Dade County, Baltimore City, Atlanta, and Washington, DC), two of three areas in the northeastern region (New York City and Philadelphia), and six of nine areas in the western region (Albuquerque, San Francisco, Seattle, Los Angeles, Denver, and Texas). Cocaine also ranked first in one of the five CEWG areas in the midwestern region, Minneapolis/St. Paul, in frequency of drug items identified (section II, table 1; appendix table 2).

Treatment Admission Data on Cocaine/Crack

Table 3 presents the most recent data from 21 CEWG areas on primary cocaine treatment admissions as a proportion of total admissions, including those for alcohol (see also appendix table 1). In all but three cases, the reporting period covers January through June, 2008; therefore, it will be referred to as the first half of 2008 (1H 2008).

Miami/Dade County had the highest percentage (37.6 percent) of primary cocaine admissions, followed by Atlanta and Detroit (24.6 percent each), Philadelphia (24.3 percent), and Texas (23.0 percent). The lowest proportions of primary cocaine treatment admissions, including primary alcohol admissions, were observed for Hawai'i (4.4 percent), Maine (6.7 percent), and San Diego (6.9 percent).

Based on total treatment admissions for the first half of 2008 reporting period, including those for primary alcohol problems, cocaine ranked first in Miami/Dade County and Philadelphia, and ranked second in 4 of the 21 reporting CEWG areas: Atlanta, Baltimore City, San Francisco, and Seattle (section II, table 2).

Forensic Laboratory Data on Cocaine/Crack

In the first half of 2008, cocaine was the drug most frequently reported for 13 of the 22 CEWG areas shown on the map in section II, figure 12 and figure 15 below (see also section II, table 1). Cocaine items as a percentage of the total drug items reported in the NFLIS system were particularly high in the Miami/Dade MSA (64.7 percent) and Atlanta (58.9 percent). The lowest reported

Table 3. Primary Cocaine Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: FY 2008¹ and 1H 2008²

CEWG Areas	Primary Cocaine Admissions	Total Admissions with Primary Alcohol Admissions Excluded ³		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
FY 2008					
Miami/Dade County ⁴	2,074	4,068	51.0	5,509	37.6
San Francisco	6,380	21,324	29.9	29,462	21.7
1H 2008					
Atlanta	1,045	2,789	37.5	4,242	24.6
Baltimore City	1,511	8,267	18.3	9,729	15.5
Boston	642	5,780	11.1	8,722	7.4
Cincinnati	558	2,042	27.3	3,260	17.1
Colorado	1,648	8,286	19.9	13,953	11.8
Denver	852	3,860	22.1	6,094	14.0
Detroit	1,006	2,965	33.9	4,095	24.6
Hawai'i	193	2,814	6.9	4,431	4.4
Los Angeles	4,467	22,260	20.1	27,944	16.0
Maine	430	3,623	11.9	6,444	6.7
Maryland	4,776	22,510	21.2	34,379	13.9
Minneapolis/St. Paul	1,092	4,713	23.2	9,846	11.1
New York City	8,150	30,362	26.8	42,402	19.2
Philadelphia	1,802	5,785	31.1	7,422	24.3
Phoenix	188	1,352	13.9	2,028	9.3
San Diego	527	6,160	8.6	7,616	6.9
Seattle	1,303	4,522	28.8	7,067	18.4
St. Louis	1,235	4,129	29.9	6,248	19.8
Texas	10,338	33,212	31.1	44,983	23.0

¹Data are for fiscal year 2008: July 2007–June 2008.²Data are for the first half of 2008: January–June 2008.³Percentages of primary cocaine admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.⁴Miami/Dade County data include data for both Miami/Dade County and Monroe County (Florida Keys).

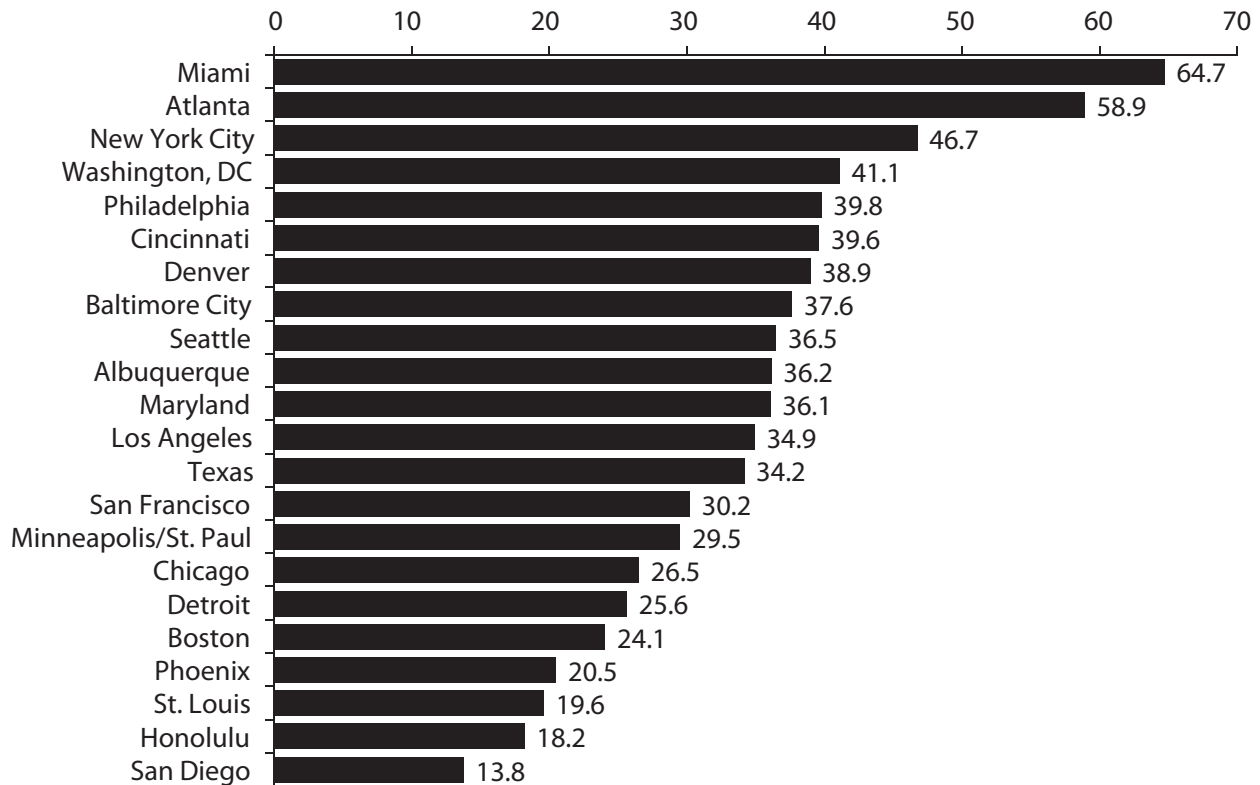
SOURCE: January 2009 State and local CEWG reports

frequencies of cocaine drug items among those identified in forensic laboratories were in Honolulu and San Diego, at 18.2 percent and 13.8 percent, respectively (figure 15; appendix table 2).

Based on rankings shown in section II, table 1, in four of the five southern region CEWG areas (Miami, Atlanta, Baltimore City, and Washington, DC), cocaine ranked as the most frequently identified drug in forensic laboratories in the first half of 2008. In two of the three CEWG areas in

the northeastern region, Philadelphia and New York City, cocaine ranked first among drug items identified. It was first in six of nine areas in the western region (Texas, Los Angeles, Seattle, Denver, Albuquerque, and San Francisco). Cocaine ranked first in one of the five areas in the mid-western region, Minneapolis/St. Paul, although it ranked second in drug items identified in 2007 in the other four areas in the Midwest, as well as in Boston and Maryland.

Figure 15. Cocaine Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: 1H 2008



SOURCE: NFLIS, DEA, received January 4, 2009; see appendix table 2

Heroin

- Heroin primary treatment admissions, as a percentage of total admissions, including primary alcohol admissions, were particularly high in Baltimore City (approximately 55 percent), followed by Boston (approximately 48 percent) in the first half of 2008 (appendix table 1; section II, table 2; table 4 below). In Boston, Baltimore City, and Detroit, heroin primary admissions ranked first as the most frequent substance abuse admissions in the reporting period (section II, table 2).
- In 16 of 22 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in NFLIS forensic laboratories in the first half of 2008. Proportions were highest in Baltimore City and Maryland (approximately 22 and 20 percent, respectively). They were lowest in Texas and Atlanta, at approximately 2 percent of drug items identified (figure 16; appendix table 2). Heroin was not ranked first in drug items seized in any CEWG area (section II, table 1).
- According to the DEA's HDMP, in CY 2007, South American (SA) heroin continued to be the primary source of heroin east of the Mississippi River, as has been the case since the mid-1990s, while Mexican black tar and, to a lesser extent, Mexican brown powder heroin dominated markets west of the Mississippi (figure 17).
- From 2006 to 2007, average purity levels for SA heroin increased in 6 of 10 CEWG areas (Philadelphia, New York City, Detroit, Chicago, St. Louis, and Washington, DC), in contrast to 2005–2006, when purity levels remained stable or declined in most areas (table 5).
- Over the 1-year period from 2006 to 2007, average prices for SA heroin fell in 6 of 10 CEWG areas (Atlanta, Miami, Boston, Chicago, St. Louis, and Washington, DC) and rose in 4 (Philadelphia, New York City, Baltimore, and Detroit). From 2006 to 2007, the highest unit increase was for Detroit (\$0.22), while the highest unit decrease was for Atlanta (\$0.45) (table 5).
- From 2006 to 2007, Mexican heroin average purity declined in five CEWG areas (San Diego, El Paso, San Antonio, Houston, and San Francisco). Average purity increased in four areas (Seattle, Phoenix, Denver, and Dallas), and remained constant in one area (Los Angeles). The average price was lower or the same in 2007, compared with 2006, in 7 of 10 reporting CEWG areas, namely Seattle, Phoenix, Denver, San Diego, Los Angeles, Dallas, and Houston. It was higher in El Paso, San Antonio, and San Francisco (table 6).

Treatment Admission Data on Heroin

In this reporting period (the first half of 2008) for 18 of 22 CEWG areas, primary heroin treatment admissions, as a proportion of total admissions for substance abuse treatment, including primary alcohol admissions, ranged from approximately 2 percent in Hawai'i to approximately 55 percent in Baltimore City. After Baltimore City, Boston had the highest proportion of heroin admissions, at 48.3 percent of all admissions (table 4). The lowest percentage of primary heroin admissions, after Hawai'i (2.3 percent), was in Miami/Dade County (3.6 percent).

When all admissions, including those for whom alcohol was the primary drug, are examined, heroin ranked first in Boston, Baltimore City, and Detroit, and second in New York City and Maryland (section II, table 2).

Forensic Laboratory Data on Heroin

In 16 of the 22 CEWG areas shown on the map in figure 12 (section II), heroin items accounted for less than 10 percent of the total drug items reported by NFLIS. The exceptions were New York City, Philadelphia, Chicago, Baltimore City, and Maryland. As a proportion of total drug items,

Table 4. Primary Heroin Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: FY 2008¹ and 1H 2008²

CEWG Areas	Primary Heroin Admissions	Total Admissions with Primary Alcohol Admissions Excluded ³		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
FY 2008					
Miami/Dade County ^{4,5}	200	4,068	4.9	5,509	3.6
San Francisco	5,974	21,324	28.0	29,462	20.3
1H 2008					
Atlanta	179	2,789	6.4	4,242	4.2
Baltimore City	5,317	8,267	64.3	9,729	54.7
Boston	4,215	5,780	72.9	8,722	48.3
Cincinnati ⁵	465	2,042	22.8	3,260	14.3
Colorado	638	8,286	7.7	13,953	4.6
Denver	428	3,860	11.1	6,094	7.0
Detroit	1,184	2,965	39.9	4,095	28.9
Hawai'i	100	2,814	3.6	4,431	2.3
Los Angeles	5,208	22,260	23.4	27,944	18.6
Maine	447	3,623	12.3	6,444	6.9
Maryland	8,889	22,510	39.4	34,379	25.9
Minneapolis/St. Paul	653	4,713	13.9	9,846	6.6
New York City	10,968	30,362	36.1	42,402	25.9
Philadelphia	1,327	5,785	22.9	7,422	17.9
Phoenix	257	1,352	19.0	2,028	12.7
San Diego	1,425	6,160	23.1	7,616	18.7
Seattle	802	4,522	17.7	7,067	11.3
St. Louis	1,088	4,129	26.4	6,248	17.4
Texas	4,680	33,212	14.1	44,983	10.4

¹Data are for fiscal year 2008: July 2007–June 2008.²Data are for the first half of 2008: January–June 2008.³Percentages of primary heroin admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.⁴Miami/Dade County data include data for Miami/Dade County and Monroe County (Florida Keys).⁵Heroin and other opiates are grouped together; data are reported in treatment admission tables under heroin only.

SOURCE: January 2009 State and local CEWG reports

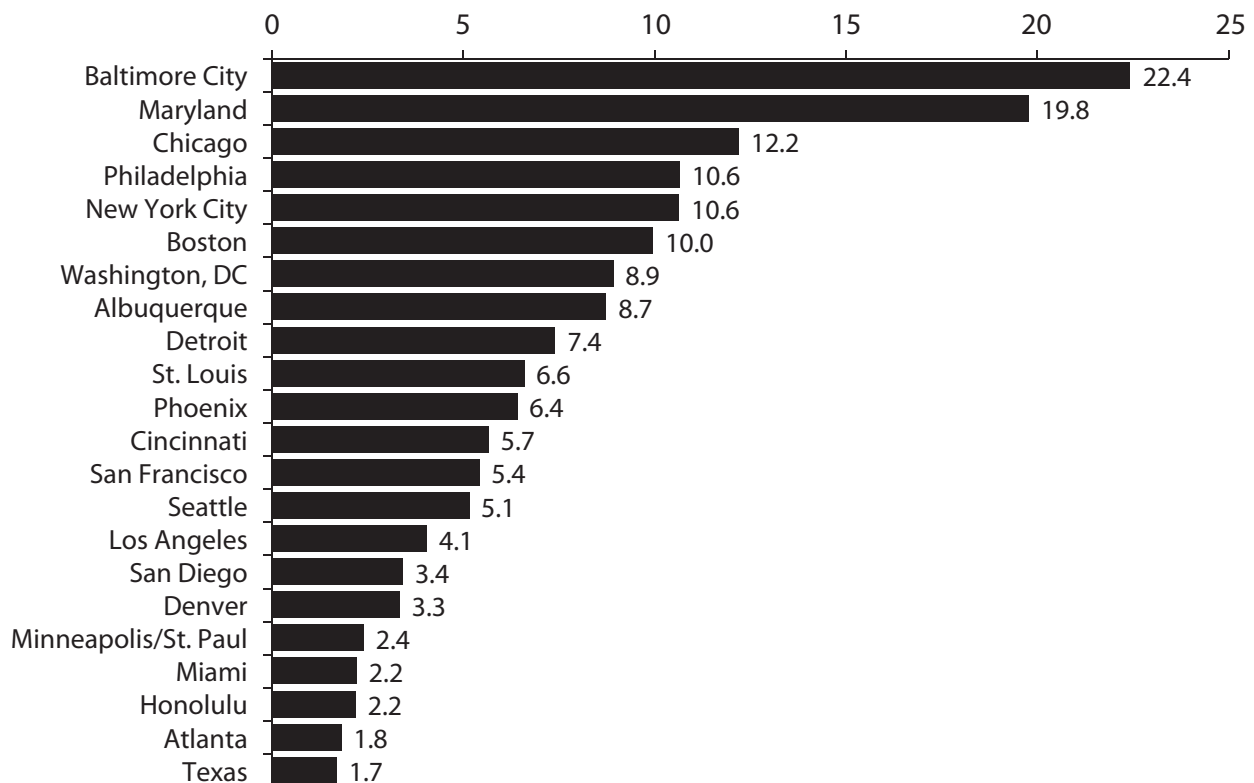
heroin items were highest in Baltimore City (22.4 percent) and Maryland (19.8 percent), compared with other CEWG areas. Heroin drug items identified were lowest in Texas (1.7 percent), followed by Atlanta (1.8 percent) (figure 16; appendix table 2).

Heroin was not ranked as the number one most frequently identified drug in any of the CEWG areas in the first half of 2008 (section II, table 1), and it appeared as no higher than third in the rankings of drug items identified in that reporting period. However, it ranked third in all areas within the northeastern, southern, and midwestern regions, with the exception of Atlanta (where it ranked seventh) and Minneapolis/St. Paul (where it ranked fifth) in the South and Midwest, respectively.

Heroin Domestic Monitor Program (HDMP) Price and Purity Data

The map below (figure 17) 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 HDMP for 2007. Data from the HDMP suggest that for CY 2007, SA heroin continued to be the primary source of heroin east of the Mississippi River, as has been the case since the mid-1990s. Mexican black tar and, to a lesser extent, Mexican brown powder heroin dominated markets west of the Mississippi. Data shown here are confined to SA and Mexican heroin, since the availability of Southwest Asian heroin was limited in the CEWG areas where it was reported—Atlanta, Baltimore

Figure 16. Heroin Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: 1H 2008



SOURCE: NFLIS, DEA, received January 4, 2009; see appendix table 2

City, Chicago, Detroit, and Washington, DC—and no Southeast Asian heroin was purchased in the HDMP program in 2006 or 2007.

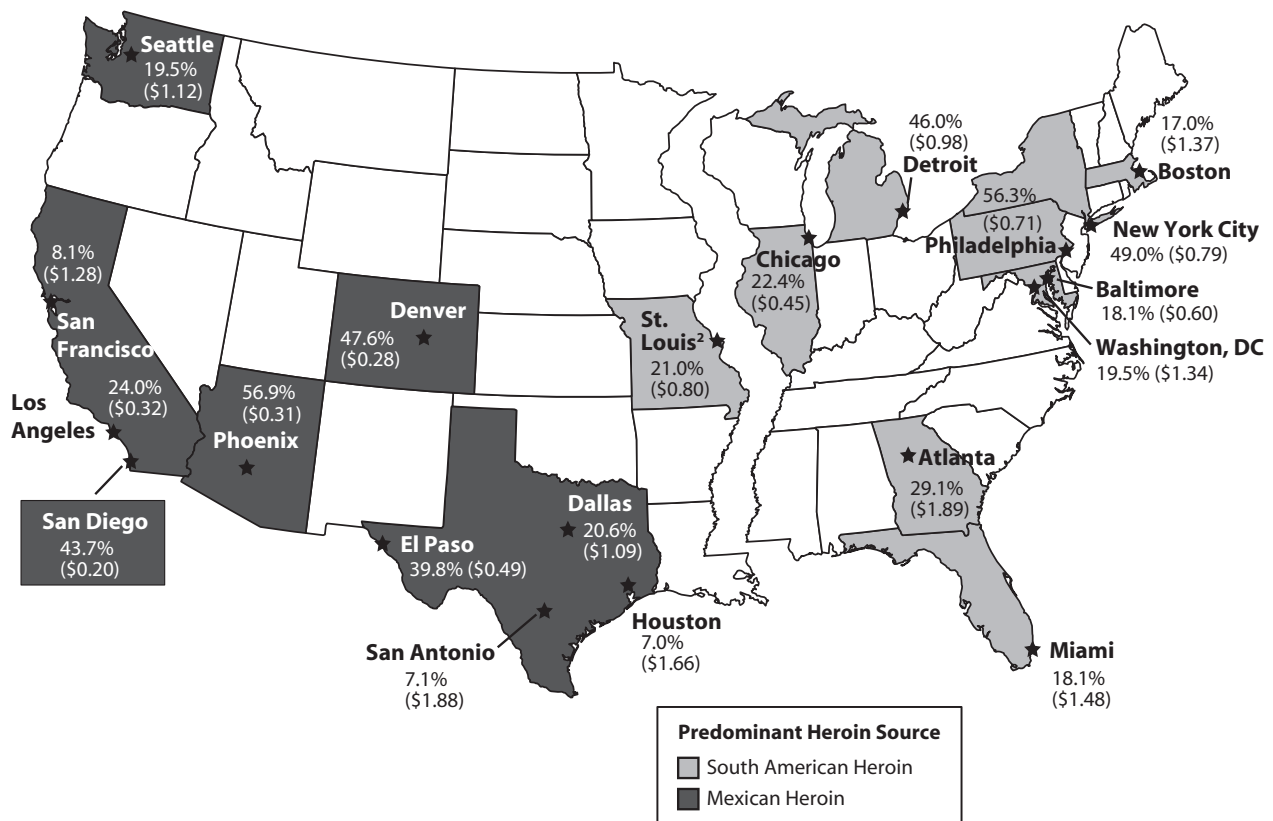
Table 5 reports average percent purity and average price per milligram pure of SA heroin in 10 CEWG cities for the period 2004–2007. From 2006 to 2007, average purity levels for SA heroin increased in 6 of 10 CEWG areas (Philadelphia, New York City, Detroit, Chicago, St. Louis, and Washington, DC), in contrast to 2005–2006, when purity levels remained stable or declined in most areas. Among the CEWG areas with declining

average purity, Baltimore and Atlanta represented the largest declines of between 10 and 13 percentage points (31.0 to 18.0 percent and 39.1 to 29.1 percent, respectively) during the period.

Over the 1-year period from 2006 to 2007, average prices for SA heroin fell in 6 of 10 CEWG areas (Atlanta, Miami, Boston, Chicago, St. Louis, and Washington, DC), and rose in 4 (Philadelphia, New York City, Baltimore, and Detroit) (table 5).

Data on results of purchases of Mexican black tar heroin are presented in table 6 for another 10

Figure 17. Heroin Domestic Monitor Program—Average Heroin Purity and Average Price Per Milligram Pure by Predominant Source in CEWG Areas:¹ 2007



¹Not included here are some types, e.g., Southeast and Southwest Asian heroin. Where both South American (SA) and Mexican heroin purchases were made, the more prevalent drug source identified is reported as predominant.

²In St. Louis, Mexican heroin was the predominant source in 2006, unlike 2005 and 2007 when SA heroin samples were more frequently identified. Therefore, while data are reported for St. Louis in tables for both forms of heroin, only SA heroin average price and purity data are presented on this map.

SOURCE: DEA, 2007 HDMP Drug Intelligence Report, published November 2008, page 7

CEWG areas, where this form of heroin predominates in the drug markets (figure 17). The highest purity levels were reported in 2007 in Phoenix and Denver (56.9 and 47.6 percent, respectively), and the lowest were reported in Houston and San Antonio (7.0 and 7.1 percent, respectively).

From 2006 to 2007, Mexican heroin average purity declined in five CEWG areas, namely San Diego, El Paso, San Antonio, Houston, and San Francisco. Average purity increased in four areas (Phoenix, Denver, Dallas, and Seattle), between 2.3 and 11.5 percentage points, and remained constant in one area (Los Angeles) (table 6).

The average price per milligram pure of Mexican black tar heroin ranged in 2007 from a low of \$0.20 in San Diego to a high of \$1.88 in San Antonio. The average price was lower or the same in 2007, compared with 2006, in 7 of 10 reporting CEWG areas (Seattle, Phoenix, Denver, San Diego, Los Angeles, Dallas, and Houston), but was higher in El Paso, San Antonio, and San Francisco. The prices approximately doubled over the 1-year period in San Antonio and San Francisco (table 6).

Table 5. Average Percent Purity and Average Price per Milligram Pure in Dollars of South American (SA) Heroin in 10 CEWG Areas, Ordered by Highest Average Purity in 2007: 2004–2007

CEWG Areas	2004 Avg. Purity	2004 Avg. Price	2005 Avg. Purity	2005 Avg. Price	2006 Avg. Purity	2006 Avg. Price	2007 Avg. Purity	2007 Avg. Price
Philadelphia	51.6	\$0.71	54.9	\$0.58	54.9	\$0.63	56.3	\$0.71
New York City	43.3	\$0.62	49.4	\$0.46	44.5	\$0.67	49.0	\$0.79
Detroit	38.9	\$0.86	46.6	\$0.76	41.4	\$0.76	46.0	\$0.98
Atlanta	40.9	\$2.30	39.3	\$2.04	39.1	\$2.34	29.1	\$1.89
Chicago	13.8	\$0.56	17.1	\$0.45	12.6	\$0.49	22.4	\$0.45
St. Louis ¹	NR ²	NR	28.3	\$1.00	17.6	\$1.22	21.0	\$0.80
Wash., DC	15.6	\$1.06	20.2	\$0.95	11.7	\$1.42	19.5	\$1.34
Miami	15.7	\$1.53	19.4	\$1.36	24.4	\$1.75	18.1	\$1.48
Baltimore	27.5 NR	\$0.50 NR	29.1	\$0.54	31.0	\$0.46	18.1	\$0.60
Boston	27.8	\$0.87	29.4	\$0.88	18.2	\$1.63	17.0	\$1.37

¹In 2005, SA rather than Mexican heroin emerged for the first time as the predominant form of heroin in St. Louis. However, in 2006, Mexican heroin reestablished itself as the predominant form. In 2007, SA heroin was again the predominant form purchased in St. Louis. Therefore, while data are reported for St. Louis in both SA heroin and Mexican heroin tables (tables 5 and 6), only St. Louis SA heroin purchases are discussed in the text.

²NR = Not reported by the CEWG area representative.

SOURCE: DEA, 2007 HDMP Drug Intelligence Report, published November 2008

Table 6. Average Percent Purity and Average Price per Milligram Pure in Dollars of Mexican Heroin in 11 CEWG Areas, Ordered by Highest Average Purity in 2007: 2004–2007

CEWG Areas	2004 Avg. Purity	2004 Avg. Price	2005 Avg. Purity	2005 Avg. Price	2006 Avg. Purity	2006 Avg. Price	2007 Avg. Purity	2007 Avg. Price
Phoenix	47.7	\$0.49	53.1	\$0.22	45.4	\$0.36	56.9	\$0.31
Denver	34.4	\$0.46	44.3	\$0.42	45.3	\$0.30	47.6	\$0.28
San Diego	49.7	\$0.20	55.9	\$0.15	48.6	\$0.37	43.7	\$0.20
El Paso	50.5	\$0.27	44.7	\$0.40	44.8	\$0.33	39.8	\$0.49
Los Angeles	31.4	\$0.23	31.1	\$0.33	24.7	\$0.33	24.0	\$0.32
Dallas	16.3	\$0.90	11.6	\$1.11	17.7	\$1.10	20.6	\$1.09
Seattle	10.4	\$1.18	10.8	\$1.23	10.9	\$1.48	19.5	\$1.12
San Francisco	11.1	\$0.98	12.3	\$0.89	9.7	\$0.69	8.1	\$1.28
San Antonio	6.4	\$2.24	11.2	\$0.56	17.4	\$0.79	7.1	\$1.88
Houston	24.8	\$0.44	23.7	\$1.14	18.1	\$1.90	7.0	\$1.66
St. Louis ¹	14.4	\$1.89	(15.9) ¹	(\$1.47)	19.5	\$0.99	(3.1)	(\$6.95)

¹Because South American heroin was the most dominant form of heroin reported in 2005 and 2007 in St. Louis, while Mexican heroin predominated in that area in 2006, Mexican heroin purchase data are presented in parentheses and are not discussed in the text.

SOURCE: DEA, 2007 HDMP Drug Intelligence Report, published November 2008

Other Opiates/Narcotic Analgesics

- Treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from 1 to approximately 7 percent in 16 of 17 reporting CEWG areas. The outlier was Maine, where nearly 30 percent of primary treatment admissions were for other opiate problems (table 7; appendix table 1).
- Of total drug items identified in forensic laboratories in 22 CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in the first half of 2008. In Baltimore City, Philadelphia, Boston, Cincinnati, and Maryland, oxycodone ranked fourth in drug items identified, and it ranked fifth in Albuquerque and Seattle. Hydrocodone ranked fourth in Detroit and fifth in frequency of drug items identified in Atlanta, Cincinnati, Texas, and Phoenix (section II, table 1; see also table 8).
- Buprenorphine ranked fifth in identified drugs in Boston, Baltimore City, and Maryland in the first half of 2008 (section II, table 1).
- Methadone ranked 6th in identified drugs in New York City, 7th in Baltimore City, 8th in Maryland, 9th in Boston and San Francisco, and 10th in Philadelphia during the reporting period (section II, table 1).

Treatment Admission Data on Other Opiates

In the first half of 2008, 17 CEWG areas provided data on treatment admissions for primary abuse of opiates other than heroin as a category separate from heroin. Including primary alcohol admissions, the other opiates admissions group accounted for 29.7 percent of the primary treatment admissions in Maine. This was followed distantly by Maryland and Minneapolis/St. Paul, where 7.2 and 5.3 percent, respectively, of total primary treatment admissions were for other opiates. At the low end, other opiates accounted for approximately 1 percent of total admissions in Philadelphia, New York City, and Detroit (table 7).

Forensic Laboratory Data on Other Opiates

Of the narcotic analgesic/opiate items identified by forensic laboratories across CEWG areas in the first half of 2008, oxycodone and hydrocodone were the two most frequently reported in most areas. However, they rarely accounted for more

than 2 percent of all drug items identified in any area (table 8; appendix table 2).

Oxycodone. Seattle reported the highest frequency of oxycodone items identified in forensic laboratories in the period (at 4.8 percent), followed by Boston (4.1 percent) and Philadelphia (3.0 percent) (table 8). Oxycodone ranked fourth in drug items identified in Boston, Philadelphia, Baltimore City, Cincinnati, and Maryland (section II, table 1). It ranked fifth in frequency of drug items identified in forensic laboratories in two other CEWG areas—Albuquerque and Seattle. Oxycodone ranked sixth in Minneapolis/St. Paul, Atlanta, Denver, Phoenix, Honolulu, and San Francisco (section II, table 1). In 6 of 22 CEWG areas, oxycodone represented less than 1 percent of the total drug items identified in the reporting period (table 8).

Hydrocodone. Hydrocodone ranked fourth in drug items identified in Detroit, and fifth in drug items identified in 4 of 22 areas, namely Atlanta, Cincinnati, Phoenix, and Texas (section II, table 1). Identified percentages ranged from

6.0 percent in Detroit and 3.8 percent in Texas to less than 1.0 percent in 10 of 22 areas reporting in the first half of 2008 (table 8).

Buprenorphine and Methadone. Boston was the only CEWG area with at least 1 percent of drug items identified containing buprenorphine, while New York City was the only area reporting a percentage of 1 or higher for methadone drug items (table 8). In Boston, 274 drug items containing buprenorphine were identified, constituting 1.8 percent of all drug items identified in

the first half of 2008. In New York City, 281 drug items containing methadone were identified in the period, representing 1.0 percent of all drug items identified (table 8).

According to CEWG area reports reflected in table 1 (section II), buprenorphine ranked fifth in identified drugs in Boston, Baltimore City, and Maryland in the first half of 2008. Methadone ranked 6th in identified drugs in New York City, 7th in Baltimore City, 8th in Maryland, 9th in Boston and San Francisco, and 10th in Philadelphia during this reporting period.

Table 7. Primary Other Opiates Treatment Admissions in 17 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: 1H 2008¹

CEWG Areas ²	Primary Other Opiate Admissions	Total Admissions with Primary Alcohol Admissions Excluded ³		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
1H 2008					
Atlanta	209	2,789	7.5	4,242	4.9
Baltimore City	291	8,267	3.5	9,729	3.0
Boston	346	5,780	6.0	8,722	4.0
Colorado	557	8,286	6.7	13,953	4.0
Denver	239	3,860	6.2	6,094	3.9
Detroit	58	2,965	2.0	4,095	1.4
Los Angeles	586	22,260	2.6	27,944	2.1
Maine	1,915	3,623	52.9	6,444	29.7
Maryland	2,473	22,510	11.0	34,379	7.2
Minneapolis/St. Paul	521	4,713	11.1	9,846	5.3
New York City	489	30,362	1.6	42,402	1.2
Philadelphia	71	5,785	1.2	7,422	1.0
Phoenix	51	1,352	3.8	2,028	2.5
San Diego	303	6,160	4.9	7,616	4.0
Seattle	292	4,522	6.5	7,067	4.1
St. Louis	118	4,129	2.9	6,248	1.9
Texas	2,638	33,212	7.9	44,983	5.9

¹Data are for the first half of 2008: January–June 2008.

²Miami/Dade County data for FY 2008 and Cincinnati data for 1H 2008 combine heroin and other opiates; data are included in the heroin treatment admissions tables.

³Percentages of primary other opiates admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.

SOURCE: January 2009 State and local CEWG reports

Table 8. Selected Narcotic Analgesic Items Reported by Forensic Laboratories in 22 CEWG Areas, by Number and Percentage of Total Items Identified¹: 1H 2008²

CEWG Areas	Oxycodone		Hydrocodone		Methadone		Fentanyl		Buprenorphine		Total Items
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	
Albuquerque	11	1.5	5	*	1	*	0	*	0	*	733
Atlanta	145	2.1	192	2.8	37	*	0	*	0	*	6,779
Baltimore City	274	1.0	50	*	107	*	0	*	265	*	28,288
Boston	609	4.1	119	*	92	*	4	*	274	1.8	14,921
Chicago	32	*	202	*	39	*	1	*	29	*	40,400
Cincinnati	143	2.0	106	1.5	21	*	2	*	0	*	7,011
Denver	62	1.5	42	1.0	5	*	0	*	1	*	4,252
Detroit	44	1.2	210	6.0	14	*	0	*	3	*	3,527
Honolulu	13	1.1	7	*	6	*	0	*	0	*	1,143
Los Angeles	80	*	358	1.2	34	*	0	*	7	*	29,567
Maryland	366	1.1	76	*	116	*	1	*	284	*	33,219
Miami	111	*	38	*	11	*	0	*	4	*	16,015
Minneapolis/ St. Paul	35	1.4	25	1.0	9	*	0	*	6	*	2,502
New York City	277	1.0	228	*	281	1.0	0	*	79	*	27,064
Philadelphia	484	3.0	104	*	50	*	9	*	18	*	16,057
Phoenix	37	1.1	40	1.2	5	*	0	*	5	*	3,372
San Diego	83	*	179	1.7	25	*	1	*	15	*	10,234
San Francisco	273	2.3	240	2.0	93	*	6	*	5	*	11,925
Seattle	75	4.8	25	1.6	7	*	0	*	6	*	1,573
St. Louis	94	1.0	122	1.3	18	*	2	*	13	*	9,605
Texas	176	*	1,814	3.8	128	*	10	*	21	*	47,868
Washington, DC	21	*	1	*	3	*	0	*	5	*	2,309

¹Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated by the symbol *.

²Data are for the first half of 2008: January–June 2008.

SOURCE: All data were received from NFLIS, DEA, January 4, 2009 (see appendix table 2); data are subject to change and may differ according to the date on which they were queried

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 or tertiary drugs of abuse among some treatment admissions.

Forensic Laboratory Data on Benzodiazepines

Three benzodiazepine-type items—alprazolam, clonazepam, and diazepam—were the most frequently reported benzodiazepines identified by

Table 9. Selected Benzodiazepine Items Reported by Forensic Laboratories in 22 CEWG Areas, by Number and Percentage of Total Items Identified¹: 1H 2008²

CEWG Area	Alprazolam		Clonazepam		Diazepam		Total Items
	#	(%)	#	(%)	#	(%)	
Albuquerque	1	*	1	*	3	*	733
Atlanta	249	3.7	33	*	29	*	6,779
Baltimore City	144	*	84	*	26	*	28,288
Boston	152	1.0	259	1.7	45	*	14,921
Chicago	92	*	22	*	27	*	40,400
Cincinnati	57	*	29	*	36	*	7,011
Denver	25	*	11	*	6	*	4,252
Detroit	67	1.9	7	*	15	*	3,527
Honolulu	1	*	2	*	7	*	1,143
Los Angeles	112	*	58	*	66	*	29,567
Maryland	179	*	96	*	39	*	33,219
Miami	293	1.8	15	*	10	*	16,015
Minneapolis/ St. Paul	8	*	7	*	5	*	2,502
New York City	517	1.9	138	*	41	*	27,064
Philadelphia	464	2.9	75	*	49	*	16,057
Phoenix	16	*	9	*	10	*	3,372
San Diego	81	*	34	*	49	*	10,234
San Francisco	40	*	53	*	70	*	11,925
Seattle	8	*	8	*	8	*	1,573
St. Louis	162	1.7	27	*	52	*	9,605
Texas	2,025	4.2	351	*	195	*	47,868
Washington, DC	5	*	4	*	0	*	2,309

¹Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated with the symbol *.

²Data are for the first half of 2008: January–June 2008.

SOURCE: All data were received from NFLIS, DEA, January 4, 2009 (see appendix table 2); data are subject to change and may differ according to the date on which they were queried

forensic laboratories in 22 CEWG areas in the first half of 2008 reporting period. Table 9 shows the numbers and percentages of drug items containing alprazolam, clonazepam, and diazepam in each of the reporting CEWG areas.

Alprazolam. In the 22 CEWG areas for which NFLIS data were reported for the first half of 2008, the highest percentages of alprazolam drug items identified were in Texas (4.2 percent), followed by Atlanta (3.7 percent), and Philadelphia (2.9 percent). Alprazolam drug items were reported at 1.0–1.9 percent in Boston, St. Louis, Miami, New York City, and Detroit, and at less than 1 percent in the remaining 14 reporting CEWG areas (table 9).

In section II, table 1, which shows the rankings of the most frequently reported drugs in NFLIS for the first half of 2008 data, alprazolam ranked fourth in frequency among the top 10 drug items identified in four CEWG areas: Miami/Dade County, Atlanta, New York City, and Texas. It ranked fifth in Philadelphia.

Clonazepam. Drug items containing clonazepam accounted for 1.7 percent of all drug items in Boston. Its presence was minimal in the 21 other CEWG areas (table 9). In Boston, clonazepam figured as the 6th most frequently identified drug in forensic laboratories in the first half of 2008; 8th in Baltimore City; 9th in Maryland, Philadelphia, and Texas; and 10th in New York City, Cincinnati, and Seattle (section II, table 1).

Diazepam. Drug items containing diazepam accounted for less than 1 percent of all drug items in each of the 22 CEWG areas (table 9). However, diazepam ranked 7th in Honolulu, 9th in Cincinnati and San Diego, and 10th in San Francisco among drug items identified in NFLIS forensic laboratories in the first half of 2008 (section II, table 1).

Methamphetamine

- The proportions of primary treatment admissions including primary alcohol admissions for methamphetamine abuse in 17 reporting CEWG areas were especially high in Hawai'i, San Diego, and Phoenix, at approximately 33, 32, and 25 percent, respectively. They were also relatively high in San Francisco and Los Angeles, at approximately 20 and 19 percent, respectively (table 10; appendix table 1).
- Methamphetamine ranked first in treatment admissions as a percentage of total admissions in San Diego, and ranked second in Hawai'i, Los Angeles, and Phoenix (section II, table 2).
- Methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in Honolulu in the first half of 2008, and second in Atlanta, Phoenix, and San Diego (section II, table 1). The largest proportions of methamphetamine items identified were reported in Honolulu (close to 43 percent), followed by Minneapolis/St. Paul (approximately 27 percent), Phoenix (approximately 23 percent), and San Diego and Albuquerque (approximately 20 percent each). On the other hand, less than 1–2 percent of drug items identified as containing methamphetamine were reported in most CEWG metropolitan areas east of the Mississippi, including Chicago, Philadelphia, New York City, Cincinnati, Miami, Detroit, Baltimore City, Boston, and Maryland (figure 18; appendix table 2).

Treatment Admission Data on Methamphetamine

Data on primary methamphetamine treatment admissions in the first half of 2008 reporting period were available for 17 CEWG areas (table 10). As a percentage of total treatment admissions, including primary alcohol admissions, Hawai'i had the highest proportion of methamphetamine admissions, at 32.6 percent, followed by San Diego, at 31.5 percent. In the same period, primary methamphetamine admissions accounted for approximately 19–25 percent of total primary admissions in Phoenix, San Francisco, and Los Angeles (table 10). Nine CEWG areas, all east of the Mississippi River, reported that either no admissions, very few admissions (Baltimore City, Cincinnati, Detroit, and Philadelphia), or less than 1 percent of admissions (Maryland, New York City, Boston, Maine, and Miami/Dade County) were for primary methamphetamine abuse (table 10). On the other hand, six areas—Minneapolis/St. Paul, Atlanta, Texas, Seattle, Denver, and Colorado—reported that between 5 and 16 percent of primary treatment

admissions were for methamphetamine abuse problems in this reporting period.

Forensic Laboratory Data on Methamphetamine

In the first half of 2008, forensic laboratory data for CEWG reporting areas (figure 18 and on the map in section II, figure 12) show that methamphetamine was the drug identified most frequently in Honolulu (42.5 percent of total drug items). Items containing methamphetamine were next most frequently identified among total drug items in Minneapolis/St. Paul (26.9 percent), Phoenix (22.6 percent), San Diego (20.4 percent), and Albuquerque (20.3 percent) (figure 18). In nine 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 (figure 18; appendix table 2).

Methamphetamine ranked first in drug items identified in Honolulu; second in Atlanta, Phoenix, and San Diego; and third in seven CEWG areas—Minneapolis/St. Paul, Albuquerque, Denver, Los Angeles, San Francisco, Seattle, and Texas in this reporting period (section II, table 1).

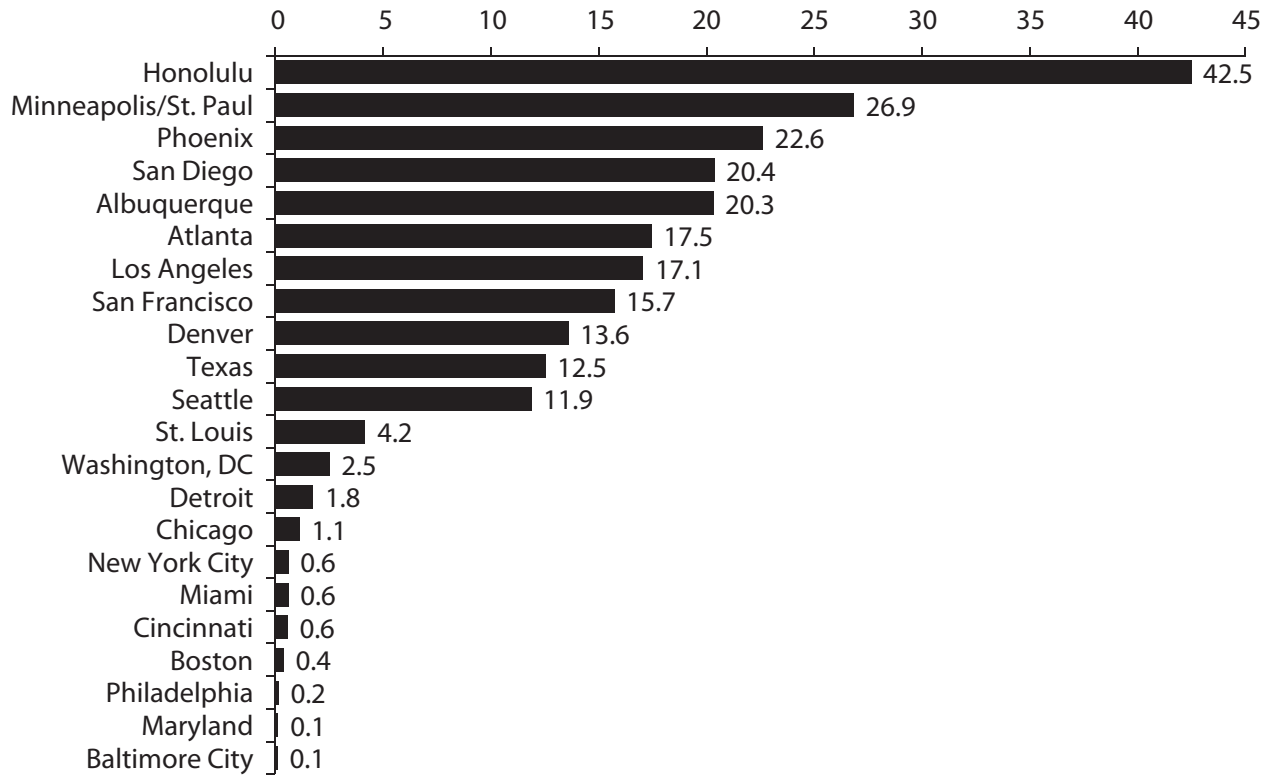
Table 10. Primary Methamphetamine Treatment Admissions in 17 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: FY 2008¹ and 1H 2008²

CEWG Areas	Primary Methamphetamine Admissions ³	Total Admissions with Primary Alcohol Admissions Excluded ⁴		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
FY 2008					
Miami/Dade County ^{5,6}	31	4,068	0.8	5,509	0.6
San Francisco	5,864	21,324	27.5	29,462	19.9
1H 2008					
Atlanta	263	2,789	9.4	4,242	6.2
Boston	41	5,780	0.7	8,722	0.5
Colorado	2,171	8,286	26.2	13,953	15.6
Denver	745	3,860	19.3	6,094	12.2
Hawai'i	1,446	2,814	51.4	4,431	32.6
Los Angeles	5,425	22,260	24.4	27,944	19.4
Maine	18	3,623	0.5	6,444	0.3
Maryland	29	22,510	0.1	34,379	0.1
Minneapolis/St. Paul	541	4,713	11.5	9,846	5.5
New York City	89	30,362	0.3	42,402	0.2
Phoenix	513	1,352	37.9	2,028	25.3
San Diego	2,401	6,160	39.0	7,616	31.5
Seattle	688	4,522	15.2	7,067	9.7
St. Louis	173	4,129	4.2	6,248	2.8
Texas ⁶	3,839	33,212	11.6	44,983	8.5

¹Data are for fiscal year 2008: July 2007–June 2008.²Data are for the first half of 2008: January–June 2008.³Data for four CEWG areas—Cincinnati, Detroit, Baltimore City, and Philadelphia—were excluded from this table based on very small numbers. Cincinnati reported six combined methamphetamine, amphetamine, and MDMA admissions; Baltimore City reported five; and Detroit and Philadelphia each reported one primary methamphetamine treatment admission in the period.⁴Percentages of primary methamphetamine admissions were obtained from admissions with primary alcohol admissions excluded for comparability with past data.⁵Miami/Dade County data include data for Miami/Dade County and Monroe County (Florida Keys).⁶Miami/Dade County and Texas reported combined methamphetamine and amphetamine admissions.

SOURCE: January 2009 State and local CEWG reports

Figure 18. Methamphetamine Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: 1H 2008



SOURCE: NFLIS, DEA, received January 4, 2009; see appendix table 2

Marijuana/Cannabis

- Percentages of primary marijuana treatment admissions, including primary alcohol admissions, were highest in the first half of 2008 in Cincinnati (30.2 percent), followed by Miami/Dade County (26.9 percent), and Denver (24.3 percent). The lowest proportions of such admissions were in Boston (3.1 percent) (table 11; appendix table 1).
- Marijuana did not rank first as the primary drug problem in total drug admissions (including alcohol admissions) in any CEWG area; however, marijuana ranked second in 8 of 21 CEWG areas, covering all four regions (section II, table 2).
- Cannabis/marijuana ranked first in frequency in the proportion of drug items identified in forensic laboratories in the first half of 2008 in 8 of 22 CEWG areas. These areas are Boston, Chicago, Cincinnati, Detroit, St. Louis, Phoenix, San Diego, and Maryland (table 1). The highest proportions of marijuana items identified were in Chicago, San Diego, and St. Louis, at approximately 56, 51, and 50 percent, respectively (figure 19; appendix table 2).

Treatment Admission Data on Marijuana

In the first half of 2008 reporting period, marijuana/cannabis did not rank as the most frequently reported drug by primary treatment admissions in any CEWG area, when primary alcohol admissions were included in the total (section II, table 2). However, marijuana ranked second among primary drugs of admission in Miami/Dade County, Philadelphia, Cincinnati, Minneapolis/St. Paul, St. Louis, Denver, and the States of Colorado and Texas (section II, table 2).

As shown in table 11, Cincinnati had the highest percentage of primary marijuana treatment admissions, including primary alcohol admissions, at 30.2 percent. In all, three other CEWG areas, besides Cincinnati, had percentages of marijuana treatment admissions close to one-quarter: Miami/Dade County (26.9 percent), Denver (24.3 percent), and Philadelphia (23.7 percent). The lowest proportions of marijuana treatment admissions was reported in Boston, at 3.1 percent.

Forensic Laboratory Data on Marijuana

Chicago had the highest percentage of marijuana identified by NFLIS laboratories in the first half of 2008 (55.9 percent), followed by San Diego (50.6 percent) (figure 19 and appendix table 2). The proportions of cannabis drug items identified in the other 20 CEWG areas were highest in St. Louis (49.9 percent), Detroit (46.0 percent), Cincinnati (44.7 percent), Boston (43.4 percent), and Phoenix (40.3 percent). The remaining CEWG sites had percentages ranging from 1.5 percent (Atlanta)⁸ to 37.9 percent (Maryland) for cannabis drug items identified (figure 19).

Cannabis ranked in either first or second place among drug items most frequently identified in all CEWG areas, with the exception of Atlanta, in the first half of 2008. Cannabis ranked in first place among identified drugs in 8 of 22 CEWG areas in the period: Maryland, Boston, Detroit, Chicago, St. Louis, Cincinnati, San Diego, and Phoenix. It was the second most frequently identified drug item in the first half of 2008 NFLIS data in another 13 CEWG areas (section II, table 1). This represents a change for Atlanta and Minneapolis/

⁸In 2004, Georgia initiated a statewide administrative policy that when cannabis is seized by law enforcement officers, laboratory testing is not required. This results in artificially low numbers of such drug items identified in this CEWG area relative to other CEWG areas.

St. Paul over the CY 2007 NFLIS rankings, in which cannabis occupied sixth and third place,

respectively, in terms of frequency of drug items identified in these areas.

Table 11. Primary Marijuana Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: FY 2008¹ and 1H 2008²

CEWG Areas	Primary Marijuana Admissions	Total Admissions with Primary Alcohol Admissions Excluded ³		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
FY 2008					
Miami/Dade County ⁴	1,484	4,068	36.5	5,509	26.9
San Francisco	3,106	21,324	14.6	29,462	10.5
1H 2008					
Atlanta	935	2,789	33.5	4,242	22.0
Baltimore City	1,054	8,267	12.7	9,729	10.8
Boston	268	5,780	4.6	8,722	3.1
Cincinnati	984	2,042	48.2	3,260	30.2
Colorado	3,041	8,286	36.7	13,953	21.8
Denver	1,482	3,860	38.4	6,094	24.3
Detroit	708	2,965	23.9	4,095	17.3
Hawai'i	918	2,814	32.6	4,431	20.7
Los Angeles	5,328	22,260	23.9	27,944	19.1
Maine	731	3,623	20.2	6,444	11.3
Maryland	5,678	22,510	25.2	34,379	16.5
Minneapolis/St. Paul	1,664	4,713	35.3	9,846	16.9
New York City	9,799	30,362	32.3	42,402	23.1
Philadelphia	1,757	5,785	30.4	7,422	23.7
Phoenix	309	1,352	22.8	2,028	15.2
San Diego	1,396	6,160	22.7	7,616	18.3
Seattle	1,160	4,522	25.7	7,067	16.4
St. Louis	1,434	4,129	34.7	6,248	23.0
Texas	10,376	33,212	31.2	44,983	23.1

¹Data are for fiscal year 2008: July 2007–June 2008.

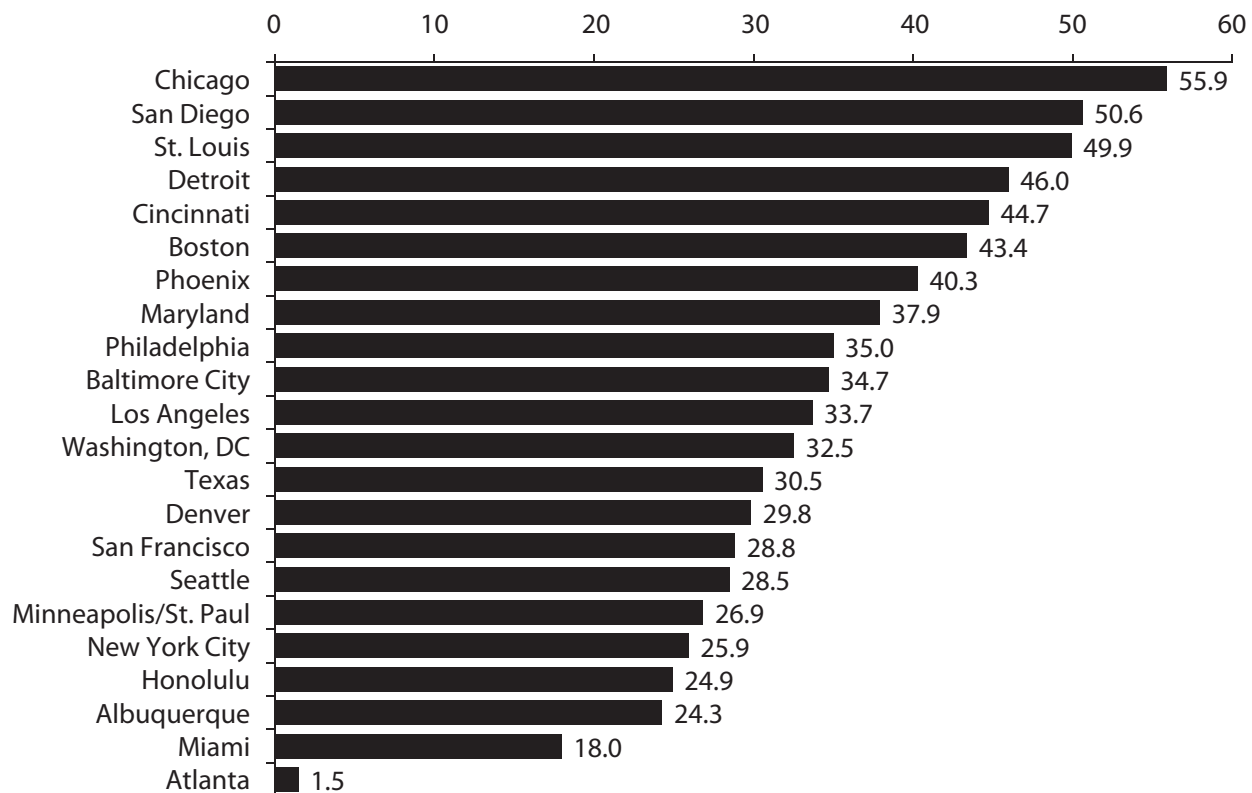
²Data are for the first half of 2008: January–June 2008.

³Percentages of primary marijuana admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.

⁴Miami/Dade County data include data for Miami/Dade County and Monroe County (Florida Keys).

SOURCE: January 2009 State and local CEWG reports

Figure 19. Marijuana Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: 1H 2008



SOURCE: NFLIS, DEA, received January 4, 2009; see appendix table 2

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

Treatment Admission Data on Club Drugs

The club drugs reported on in this section include MDMA (methylenedioxymethamphetamine, 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 low in those areas that do report on these drugs.

Forensic Laboratory Data on Club Drugs

MDMA. MDMA was the club drug most frequently reported among NFLIS data in the 22 CEWG areas depicted in table 12. As shown, MDMA equaled or exceeded 2 percent of all drug items in 11 areas. These include Atlanta and San Francisco, which had the highest percentage (3.8 percent each), followed by Detroit (3.7 percent), Minneapolis/St. Paul (3.6 percent), and Seattle (3.2 percent). Others in this group were St. Louis, Los Angeles, Honolulu, Denver, Washington, DC, and San Diego (table 12). As shown in section II, table 1, MDMA was the third most frequently identified drug item in Atlanta, and it ranked fourth in Chicago, Minneapolis/St. Paul, and Honolulu in the first half of 2008.

GHB. GHB items were reported among the forensic laboratory data in 10 CEWG areas: Boston, Chicago, Los Angeles, New York City, San Diego, San Francisco, Seattle, St. Louis, Texas, and Washington, DC. These items accounted for much less than 1 percent of all items in all reporting areas. GHB was not among the top 10 drugs reported from any CEWG area (table 13 and section II, table 1).

LSD. LSD was reported in the forensic laboratory data among drug items identified for 17 CEWG metropolitan areas. None, however, had 30 or more cases. LSD was not among the top 10 drugs reported for any CEWG reporting area, and no LSD items were reported from Albuquerque, Detroit, Honolulu, Phoenix, and Washington, DC (table 13 and section II, table 1).

Ketamine. Ketamine items were reported among drug items identified from all except 5 of 22 CEWG areas during the first half of 2008. While ketamine represented less than 1 percent of total drug items identified in any reporting area, four areas reported 30 cases or more: Texas, New York City, Los Angeles, and Atlanta (table 13). Ketamine did not figure among the top 10 most frequently identified drug items in any CEWG area (section II, table 1).

Phencyclidine (PCP)

Forensic Laboratory Data on PCP

No PCP items were documented among the forensic laboratory data on drug items identified in eight CEWG areas (Albuquerque, Atlanta, Cincinnati, Denver, Detroit, Honolulu, Miami, and Minneapolis/St. Paul), and fewer than 30 such items were identified in seven areas (Baltimore City, Boston, Phoenix, San Diego, San Francisco,

Seattle, and St. Louis). The areas reporting 30 or more PCP items were Chicago, Los Angeles, New York City, Philadelphia, Maryland, Texas, and Washington, DC. As a percentage of all identified items, PCP items were highest in Washington, DC, at 5.6 percent, followed by Philadelphia, at 2.7 percent, and New York City, at 1.5 percent (table 13; appendix table 2).

Table 12. Number of MDMA Items Identified and MDMA Items as a Percentage of Total Items Identified by Forensic Laboratories in 22 CEWG Areas¹: 1H 2008²

CEWG Area	MDMA Items	Total Items	Percentage of Total Items
Albuquerque	6	733	*
Atlanta	257	6,779	3.8
Baltimore City	70	28,288	*
Boston	58	14,921	*
Chicago	522	40,400	1.3
Cincinnati	58	7,011	*
Denver	91	4,252	2.1
Detroit	131	3,527	3.7
Honolulu	25	1,143	2.2
Los Angeles	683	29,567	2.3
Maryland	121	33,219	*
Miami	142	16,015	*
Minneapolis/St. Paul	90	2,502	3.6
New York City	135	27,064	*
Philadelphia	37	16,057	*
Phoenix	36	3,372	1.1
San Diego	207	10,234	2.0
San Francisco	455	11,925	3.8
Seattle	51	1,573	3.2
St. Louis	257	9,605	2.7
Texas	663	47,868	1.4
Washington, DC	48	2,309	2.1

¹Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated by the symbol *.

²Data are for the first half of 2008: January–June 2008.

SOURCE: All data were received from NFLIS, DEA, January 4, 2009 (see appendix table 2); data are subject to change and may differ according to the date on which they were queried

PCP ranked 4th in drug items identified in NFLIS data in the first half of 2008 in Washington, DC, 5th in New York City, 6th in Philadelphia,

7th in Los Angeles, and 10th each in Maryland, Chicago, and Texas (section II, table 1).

Table 13. GHB, Ketamine, LSD, and PCP Items Reported by Forensic Laboratories in 22 CEWG Areas, by Number and Percentage of Total Items Identified¹: 1H 2008²

CEWG Area	GHB		Ketamine		LSD		PCP		Total Items
	#	(%)	#	(%)	#	(%)	#	(%)	
Albuquerque	0	*	0	*	0	*	0	*	733
Atlanta	0	*	32	*	5	*	0	*	6,779
Baltimore City	0	*	1	*	1	*	16	*	28,288
Boston	8	*	13	*	6	*	10	*	14,921
Chicago	7	*	25	*	27	*	82	*	40,400
Cincinnati	0	*	1	*	3	*	0	*	7,011
Denver	0	*	3	*	9	*	0	*	4,252
Detroit	0	*	1	*	0	*	0	*	3,527
Honolulu	0	*	0	*	0	*	0	*	1,143
Los Angeles	18	*	37	*	5	*	236	*	29,567
Maryland	0	*	5	*	2	*	83	*	33,219
Miami	0	*	12	*	3	*	0	*	16,015
Minneapolis/ St. Paul	0	*	0	*	4	*	0	*	2,502
New York City	4	*	92	*	4	*	394	1.5	27,064
Philadelphia	0	*	0	*	3	*	428	2.7	16,057
Phoenix	0	*	2	*	0	*	12	*	3,372
San Diego	1	*	6	*	1	*	25	*	10,234
San Francisco	21	*	26	*	4	*	11	*	11,925
Seattle	2	*	0	*	5	*	7	*	1,573
St. Louis	1	*	6	*	6	*	17	*	9,605
Texas	45	*	77	*	19	*	199	*	47,868
Washington, DC	1	*	5	*	0	*	130	5.6	2,309

¹Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated by the symbol *.

²Data are for the first half of 2008: January–June 2008.

SOURCE: All data were received from NFLIS, DEA, January 4, 2009 (see appendix table 2); data are subject to change and may differ according to the date on which the data were queried

Other Drugs (BZP, TFMPP, Foxy Methoxy, Carisoprodol)

BZP (1-Benzylpiperazine). In the first half of 2008, BZP emerged among the top 25 identified drugs in NFLIS forensic laboratories in 16 of 22 CEWG areas. The six exceptions were: Albuquerque, Atlanta, Cincinnati, Philadelphia, New York City, and San Diego. This contrasts with CY 2007 when none of the 22 CEWG areas, with the exception of Detroit, listed BZP-containing drug items among the top 25 drugs identified in forensic laboratories. In Detroit, 11 BZP items were identified in CY 2007, representing 0.1 percent of all drug items identified, while in the first half of 2008, 20 items, or 0.6 percent of drug items in the half-year period, were so identified. In Seattle, for example, 1.8 percent ($n=29$) of drug items identified in the first half of 2008 contained BZP, compared with none in CY 2007. Section II, table 1 shows BZP rankings among the top 10 most frequently identified drug items in NFLIS data in the first half of 2008. BZP ranked 7th in Seattle and Chicago, 9th in Washington, DC and Miami/Dade County, and 10th in Honolulu and Detroit.

TFMPP or 1-(3-Trifluoromethylphenyl) Piperazine. The identification of this drug in top 25 NFLIS data for the first half of 2008 was localized to two areas—Atlanta and Washington, DC. Atlanta reported an increase in items containing TFMPP in the first half of 2008, compared with CY 2007, reporting 16 such drug items in CY 2007 and 117 in the first half of 2008. This represents an increase from 0.1 percent to 1.7 percent of drug items identified in the respective periods. In the first half of 2008 forensic laboratory data, TFMPP ranked seventh in Washington, DC and eighth in frequency among drug items identified in Atlanta (section II, table 1).

Foxy or Foxy Methoxy (5-Methoxy-N,N-Diisopropyltryptamine, or 5-MeO-DIPT). No Foxy Methoxy drug items were identified in any CEWG areas among the top 25 in CY 2007, with the exception of Seattle ($n=5$). In the first half of 2008, however, Denver ($n=91$) and Phoenix ($n=3$) both reported identification of this drug. Increasing from none in CY 2007, 19 drug items were identified in Denver in the first half of 2008, 18 of which this drug represented 0.5 percent of total drug items in that area. Eighteen of the 19 such drug items identified were identified in Arapahoe County, a suburban county south of Denver in the Denver MSA. This drug ranked 10th among the most frequently identified drug items in Denver in this reporting period (section II, table 1).

Carisoprodol. Drug items containing carisoprodol ranked eighth in Texas and tenth in Atlanta, Los Angeles, and Phoenix among the most frequently identified items in the first half of 2008 for 22 CEWG areas (section II, table 1). Reported among the top 25 most commonly identified drugs in both CY 2007 and the first half of 2008, carisoprodol items increased slightly over the two periods in Atlanta and Los Angeles. In Atlanta, carisoprodol-containing drug items represented 0.7 percent ($n=103$) of drug items identified in CY 2007 and 0.9 percent ($n=60$) in the first half of 2008, while they represented 0.2 percent ($n=123$) and 0.3 percent ($n=86$) in the respective periods in Los Angeles. Percentages were stable over the two reporting periods for Phoenix, San Diego, and Texas.

Appendix Tables

Appendix Table 1. Total Treatment Admissions by Primary Substance of Abuse, Including Primary Alcohol Admissions, and CEWG Area: FY 2008¹ and January–June 2008²

CEWG Areas	Number of Total Admissions							Total (N)
	Alcohol	Cocaine/ Crack ³	Heroin	Other Opiates	Marijuana	Metham- phetamine	Other Drugs	
FY 2008								
Miami/Dade County ⁴	1,441	2,074	200 ⁵	— ⁵	1,484	31 ⁶	279	5,509
San Francisco	8,138	6,380	5,974	NR ⁷	3,106	5,864	NR	29,462
1H 2008								
Atlanta	1,453	1,045	179	209	935	263	158	4,242
Baltimore City	1,462	1,511	5,317	291	1,054	5	89	9,729
Boston	2,942	642	4,215	346	268	41	268	8,722
Cincinnati	1,218	558	465 ⁵	— ⁵	984	6 ⁷	29	3,260
Colorado	5,667	1,648	638	557	3,041	2,171	231	13,953
Denver	2,234	852	428	239	1,482	745	114	6,094
Detroit	1,130	1,006	1,184	58	708	1	8	4,095
Hawai'i	1,617	193	100	NR ⁸	918	1,446	157	4,431
Los Angeles	5,684	4,467	5,208	586	5,328	5,425	1,246	27,944
Maine	2,821	430	447	1,915	731	18	82	6,444
Maryland	11,869	4,776	8,889	2,473	5,678	29	665	34,379
Minneapolis/ St. Paul	5,133	1,092	653	521	1,664	541	242	9,846
New York City	12,040 ⁹	8,150	10,968	489	9,799	89	867	42,402
Philadelphia	1,637	1,802	1,327	71	1,757	1	827	7,422
Phoenix	676	188	257	51	309	513	34	2,028
San Diego	1,456	527	1,425	303	1,396	2,401	108	7,616
Seattle	2,545	1,303	802	292	1,160	688	277	7,067
St. Louis	2,119	1,235	1,088	118	1,434	173	81	6,248
Texas ¹⁰	11,771	10,338	4,680	2,638	10,376	3,839 ⁶	1,341	44,983

¹Data are for fiscal year 2008: July 2007–June 2008.

²Data are for first half of 2008: January–June 2008.

³Cocaine values were broken down into crack or other cocaine for the following areas: Baltimore City (crack=1,305; cocaine=206); Boston (crack=368; cocaine=274); Colorado (crack=998; cocaine=650); Denver (crack=488; cocaine=364); Detroit (crack=931; cocaine=75); Maine (crack=104; cocaine=326); Maryland (crack=3,796; cocaine=980); Miami/Dade County (crack=1,400; cocaine=674); Minneapolis/St. Paul (crack=822; cocaine=270); New York City (crack=4,176; cocaine=3,974); Philadelphia (crack=1,498; cocaine=304); and Texas (crack=5,529; cocaine=4,809).

⁴Miami/Dade County data include data for Miami/Dade County and for Monroe County (Florida Keys).

⁵Heroin and other opiates are grouped together in data for Cincinnati and Miami/Dade County; data are reported in primary heroin treatment admissions tables only in this report.

⁶Methamphetamine and amphetamine are grouped together in Texas and Miami/Dade County treatment data.

⁷Methamphetamine, amphetamine, and MDMA are grouped together in Cincinnati treatment data.

⁸NR = Not reported by the CEWG area representative.

⁹Alcohol data for New York City are alcohol only=5,271, and alcohol plus other=6,769.

¹⁰Based on the first half of 2008, Texas treatment admissions data in this table and tables 2–4, 7, 10, and 11 differ from data reported in the Texas representatives' Update Brief, which covers CY 2008, as of January 16, 2009.

NOTES to APPENDIX TABLE 1:

In Hawai'i, the methamphetamine category includes "other stimulants." Baltimore City and Maryland data for other opiates include nonprescription methadone, oxycodone, and other opiates and synthetics. Los Angeles data for other opiates include oxycodone ($n=167$). Hawai'i data report total admissions of 4,503, of which 72 did not report using any drugs at admission for substance abuse treatment; the N of 4,431 includes cases in which a primary drug was reported. Phoenix data report total admissions of 3,807, of which 1,779 did not report using any drugs at admission for substance abuse treatment; the N of 2,028 includes cases in which a primary drug was reported. Treatment data were provided by CEWG representatives between December 2008 and February 2009. Treatment admissions data for New Mexico were received for CY 2007, and as such are not included in the cross-area treatment data presentations in section IV, which focus on the 2008 reporting period. However, the 2007 treatment data for New Mexico are discussed in the Albuquerque and New Mexico Update Brief in section III of this report.

SOURCE: January 2009 State and local CEWG reports

Appendix Tables 2.1–2.22. NFLIS Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items in Forensic Laboratories for 22 CEWG Areas: January–June 2008.

Appendix Table 2.1. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Albuquerque: 1H 2008¹

Drug	Number	Percent
Cocaine	265	36.2
Cannabis	178	24.3
Methamphetamine	149	20.3
Heroin	64	8.7
Oxycodone	11	1.5
3,4-Methylenedioxy-methamphetamine	6	0.8
Hydrocodone	5	0.7
Phosphorus, Red	5	0.7
Pseudoephedrine	5	0.7
Psilocin	5	0.7
Other	40	5.5
Total	733	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for counties in the Albuquerque MSA including Bernalillo, Sandoval, and Valencia. Bernalillo makes up 97.4 percent of total items seized.

2. "Noncontrolled Nonnarcotic Drug" represents one case and is included as "Other."

3. "Negative Results - Tested for Specific Drugs" represents 24 cases and is included as "Other."

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

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.2. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Atlanta: 1H 2008¹

Drug	Number	Percent
Cocaine	3,993	58.9
Methamphetamine	1,184	17.5
3,4-Methylenedioxy-methamphetamine	257	3.8
Alprazolam	249	3.7
Hydrocodone	192	2.8
Oxycodone	145	2.1
Heroin	123	1.8
1-(3-Trifluoromethylphenyl)-Piperazine	117	1.7
Cannabis	101	1.5
Carisoprodol	60	0.9
Other	358	5.3
Total	6,779	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for the 28-county Atlanta/Sandy Springs/Marietta GA MSA, including Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Newton, Paulding, Pickens, Rockdale, Pike, Spalding, and Walton Counties.

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

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.3. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Baltimore City: 1H 2008¹

Drug	Number	Percent
Cocaine	10,648	37.6
Cannabis	9,825	34.7
Heroin	6,342	22.4
Oxycodone	274	1.0
Buprenorphine	265	0.9
Alprazolam	144	0.5
Methadone	107	0.4
Clonazepam	84	0.3
3,4-Methylenedioxy-methamphetamine	70	0.2
3,4-Methylenedioxy-amphetamine	66	0.2
Other	463	1.6
Total	28,288	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for Baltimore City only.
2. "Noncontrolled Nonnarcotic Drug" represents one case and is included as "Other."
3. "Negative Results - Tested for Specific Drugs" represents 126 cases and is included as "Other."
4. "Some Other Substance" represents 10 cases and is included as "Other."
5. Percentages may not sum to total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.5. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Chicago: 1H 2008¹

Drug	Number	Percent
Cannabis	22,580	55.9
Cocaine	10,710	26.5
Heroin	4,923	12.2
3,4-Methylenedioxy-methamphetamine	522	1.3
Methamphetamine	455	1.1
Hydrocodone	202	0.5
1-Benzylpiperazine	137	0.3
Acetaminophen	100	0.2
Alprazolam	92	0.2
Phencyclidine	82	0.2
Other	597	1.5
Total	40,400	100.0

¹January 2008–June 2008.

NOTES:

1. Data include all counties in the Chicago/Naperville/Joliet II/IN/ WI MSA, including: Cook, DeKalb, DuPage, Grundy, Kane, McHenry, and Will Counties in IL; Jasper, Lake, Newton, and Porter Counties in IN; and Kenosha County in WI. Cook County represents 83.8 percent of total items seized.
2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.4. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Boston: 1H 2008¹

Drug	Number	Percent
Cannabis	6,474	43.4
Cocaine	3,591	24.1
Heroin	1,485	10.0
Oxycodone	609	4.1
Buprenorphine	274	1.8
Clonazepam	259	1.7
Alprazolam	152	1.0
Hydrocodone	119	0.8
Methadone	92	0.6
Amphetamine	83	0.6
Other	1,783	11.9
Total	14,921	100.0

¹January 2008–June 2008.

NOTES:

1. Data include all counties in the Boston MSA, specifically Essex, Middlesex, Norfolk, Plymouth, Rockingham, Strafford, and Suffolk Counties.
2. "Noncontrolled Nonnarcotic Drug" represents 136 cases and is included as "Other."
3. "Negative Results - Tested for Specific Drugs" represents 402 cases and is included as "Other."
4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.6. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Cincinnati: 1H 2008¹

Drug	Number	Percent
Cannabis	3,137	44.7
Cocaine	2,776	39.6
Heroin	397	5.7
Oxycodone	143	2.0
Hydrocodone	106	1.5
3,4-Methylenedioxy-methamphetamine	58	0.8
Alprazolam	57	0.8
Methamphetamine	40	0.6
Diazepam	36	0.5
Clonazepam	29	0.4
Other	232	3.3
Total	7,011	100.0

¹January 2008–June 2008.

NOTES:

1. Data include Hamilton County.
2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.7. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Denver: 1H 2008¹

Drug	Number	Percent
Cocaine	1,656	38.9
Cannabis	1,269	29.8
Methamphetamine	578	13.6
Heroin	142	3.3
3,4-Methylenedioxy-methamphetamine	91	2.1
Oxycodone	62	1.5
Hydrocodone	42	1.0
Alprazolam	25	0.6
Psilocin	25	0.6
5-Methoxy-N, N-Disopropyltryptamine	19	0.4
Other	343	8.1
Total	4,252	100.0

¹January 2008–June 2008.

NOTES:

1. Data include Denver, Arapahoe, and Jefferson Counties.
2. "Noncontrolled Nonnarcotic Drug" represents 215 cases and is included as "Other."
3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.9. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Honolulu: 1H 2008¹

Drug	Number	Percent
Methamphetamine	486	42.5
Cannabis	285	24.9
Cocaine	208	18.2
3,4-Methylenedioxy-methamphetamine	25	2.2
Heroin	25	2.2
Oxycodone	13	1.1
Diazepam	7	0.6
Hydrocodone	7	0.6
Testosterone	7	0.6
1-Benzylpiperazine	6	0.5
Other	80	7.0
Total	1,143	100.0

¹January 2008–June 2008.

NOTES:

1. Data include Honolulu County.
2. "Noncontrolled Nonnarcotic Drug" represents three cases and is included as "Other."
3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.8. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Detroit: 1H 2008¹

Drug	Number	Percent
Cannabis	1,622	46.0
Cocaine	904	25.6
Heroin	261	7.4
Hydrocodone	210	6.0
3,4-Methylenedioxy-methamphetamine	131	3.7
Alprazolam	67	1.9
Methamphetamine	62	1.8
Oxycodone	44	1.2
Codeine	26	0.7
1-Benzylpiperazine	20	0.6
Other	180	5.1
Total	3,527	100.0

¹January 2008–June 2008.

NOTES:

1. Data include Wayne County.
2. "No Controlled Drug Identified" represents 59 cases and is included as "Other."
3. "Noncontrolled Nonnarcotic Drug" represents two cases and is included as "Other."
4. Percentages may not sum to total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.10. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Los Angeles: 1H 2008¹

Drug	Number	Percent
Cocaine	10,326	34.9
Cannabis	9,959	33.7
Methamphetamine	5,047	17.1
Heroin	1,199	4.1
3,4-Methylenedioxy-methamphetamine	683	2.3
Hydrocodone	358	1.2
Phencyclidine	236	0.8
Alprazolam	112	0.4
Codeine	98	0.3
Carisoprodol	86	0.3
Other	1,463	4.9
Total	29,567	100.0

¹January 2008–June 2008.

NOTES:

1. Data include Los Angeles County.
2. "No Controlled Drug Identified" represents 133 cases and is included as "Other."
3. "Negative Results - Tested for Specific Drugs" represents 270 cases and is included as "Other."
4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.11. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maryland: 1H 2008¹

Drug	Number	Percent
Cannabis	12,595	37.9
Cocaine	11,983	36.1
Heroin	6,566	19.8
Oxycodone	366	1.1
Buprenorphine	284	0.9
Alprazolam	179	0.5
3,4-Methylenedioxy-methamphetamine	121	0.4
Methadone	116	0.3
Clonazepam	96	0.3
Phencyclidine	83	0.2
Other	830	2.5
Total	33,219	100.0

¹January 2008–June 2008.

NOTES:

1. Data include the State of Maryland.
2. "Noncontrolled Nonnarcotic Drug" represents one case and is included as "Other."
3. "Negative Results - Tested for Specific Drugs" represents 126 cases and is included as "Other."
4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.13. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Minneapolis/St. Paul: 1H 2008¹

Drug	Number	Percent
Cocaine	738	29.5
Cannabis	672	26.9
Methamphetamine	672	26.9
3,4-Methylenedioxy-methamphetamine	90	3.6
Heroin	60	2.4
Oxycodone	35	1.4
Hydrocodone	25	1.0
Amphetamine	18	0.7
Codeine	14	0.6
Dimethylsulfone	13	0.5
Other	165	6.6
Total	2,502	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for seven MN counties including Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington. Ramsey County represents 60.9 percent of total items seized.
2. "No Controlled Drug Identified" represents 7 cases and is included as "Other."
3. "Some Other Substance" represents one case and is included as "Other."
4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.12. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Miami MSA: 1H 2008¹

Drug	Number	Percent
Cocaine	10,363	64.7
Cannabis	2,878	18.0
Heroin	355	2.2
Alprazolam	293	1.8
3,4-Methylenedioxy-methamphetamine	142	0.9
Hallucinogen	111	0.7
Oxycodone	111	0.7
Methamphetamine	97	0.6
1-Benzylpiperazine	48	0.3
Hydrocodone	38	0.2
Other	1,579	9.9
Total	16,015	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for the Miami/Fort Lauderdale/Pompano Beach FL MSA and include Broward, Dade, and Palm Beach Counties, FL; 65.8 percent of items seized are for Dade County and 33.2 percent are for Broward County.
2. "Negative Results - Tested for Specific Drugs" represents 139 cases and is included as "Other."
3. "Unreported Scheduled Drug" represents 367 cases and is included as "Other."
4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.14. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, New York City: 1H 2008¹

Drug	Number	Percent
Cocaine	12,651	46.7
Cannabis	7,018	25.9
Heroin	2,877	10.6
Alprazolam	517	1.9
Phencyclidine	394	1.5
Methadone	281	1.0
Oxycodone	277	1.0
Hydrocodone	228	0.8
Methamphetamine	166	0.6
Clonazepam	138	0.5
Other	2,517	9.3
Total	27,064	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for five counties/areas including Bronx, Kings, Queens, New York, and Richmond.
2. 1,631 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 97.4 percent of the total.
4. "Noncontrolled Nonnarcotic Drug" represents 39 cases and is included as "Other."
5. Percentages may not sum to total due to rounding.

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix 2.15. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Philadelphia: 1H 2008¹

Drug	Number	Percent
Cocaine	6,387	39.8
Cannabis	5,619	35.0
Heroin	1,710	10.6
Oxycodone	484	3.0
Alprazolam	464	2.9
Phencyclidine	428	2.7
Codeine	130	0.8
Hydrocodone	104	0.6
Clonazepam	75	0.5
Methadone	50	0.3
Other	606	3.8
Total	16,057	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for Philadelphia County.

2. “Noncontrolled Nonnarcotic Drug” represents 119 cases and is included as “Other.”

3. “No Controlled Drug Identified” represents 247 cases and is included as “Other.”

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

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix 2.17. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Diego: 1H 2008¹

Drug	Number	Percent
Cannabis	5,179	50.6
Methamphetamine	2,085	20.4
Cocaine	1,411	13.8
Heroin	350	3.4
3,4-Methylenedioxy-methamphetamine	207	2.0
Hydrocodone	179	1.7
Oxycodone	83	0.8
Alprazolam	81	0.8
Diazepam	49	0.5
Amphetamine	45	0.4
Other	565	5.5
Total	10,234	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for San Diego County.

2. “Plant Material, Other” represents 110 cases and is included as “Other.”

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

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix 2.16. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Phoenix: 1H 2008¹

Drug	Number	Percent
Cannabis	1,359	40.3
Methamphetamine	763	22.6
Cocaine	691	20.5
Heroin	216	6.4
Hydrocodone	40	1.2
Oxycodone	37	1.1
3,4-Methylenedioxy-methamphetamine	36	1.1
Morphine	24	0.7
Alprazolam	16	0.5
Carisoprodol	16	0.5
Other	174	5.2
Total	3,372	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for Maricopa County.

2. “Noncontrolled Nonnarcotic Drug” represents nine cases and is included as “Other.”

3. “Negative Results - Tested for Specific Drugs” represents 28 cases and is included as “Other.”

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

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.18. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Francisco: 1H 2008¹

Drug	Number	Percent
Cocaine	3,602	30.2
Cannabis	3,438	28.8
Methamphetamine	1,876	15.7
Heroin	646	5.4
3,4-Methylenedioxy-methamphetamine	455	3.8
Oxycodone	273	2.3
Hydrocodone	240	2.0
Morphine	94	0.8
Methadone	93	0.8
Diazepam	70	0.6
Other	1,138	9.5
Total	11,925	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for the San Francisco/Fremont MSA, including Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties.

2. “Negative Results - Tested for Specific Drugs” represents 650 cases and is included as “Other.”

3. 57.3 percent of items were seized in San Francisco County, 24.5 percent in Contra Costa, 14.8 percent in San Mateo, 2.5 percent in Marin and 0.8 percent in Alameda.

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

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.19. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Seattle: 1H 2008¹

Drug	Number	Percent
Cocaine	574	36.5
Cannabis	448	28.5
Methamphetamine	187	11.9
Heroin	81	5.1
Oxycodone	75	4.8
3,4-Methylenedioxy-methamphetamine	51	3.2
1-Benzylpiperazine	29	1.8
Hydrocodone	25	1.6
Alprazolam	8	0.5
Clonazepam	8	0.5
Other	87	5.5
Total	1,573	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for King County.

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

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.21. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Texas: 1H 2008¹

Drug	Number	Percent
Cocaine	16,355	34.2
Cannabis	14,623	30.5
Methamphetamine	6,001	12.5
Alprazolam	2,025	4.2
Hydrocodone	1,814	3.8
Heroin	809	1.7
3,4-Methylenedioxy-methamphetamine	663	1.4
Carisoprodol	455	1.0
Clonazepam	351	0.7
Phencyclidine	199	0.4
Other	4,573	9.6
Total	47,868	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for the State of Texas.

2. "Noncontrolled Nonnarcotic Drug" represents 432 cases and is included as "Other."

3. "Negative Results - Tested for Specific Drugs" represents 768 cases and is included as "Other."

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

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.20. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, St. Louis: 1H 2008¹

Drug	Number	Percent
Cannabis	4,795	49.9
Cocaine	1,882	19.6
Heroin	633	6.6
Methamphetamine	401	4.2
3,4-Methylenedioxy-methamphetamine	257	2.7
Alprazolam	162	1.7
Pseudoephedrine	125	1.3
Hydrocodone	122	1.3
Acetaminophen	96	1.0
Oxycodone	94	1.0
Other	1,038	10.8
Total	9,605	100.0

¹January 2008–June 2008.

NOTES:

1. St. Louis MO/IL MSA counties include Bond, Calhoun, Clinton, Jersey, Macoupin, Madison, Monroe, and St. Claire Counties in IL, and Crawford, Franklin, Jefferson, Lincoln, St. Charles, St. Louis City, Warren, and Washington Counties in MO, for a total of 17 counties.

2. "Negative Results - Tested for Specific Drugs" represents 487 cases and is included as "Other."

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

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 2.22. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Washington, DC: 1H 2008¹

Drug	Number	Percent
Cocaine	949	41.1
Cannabis	751	32.5
Heroin	206	8.9
Phencyclidine	130	5.6
Methamphetamine	58	2.5
3,4-Methylenedioxy-methamphetamine	48	2.1
1-(3-Trifluoromethylphenyl)-Piperazine	25	1.1
Oxycodone	21	0.9
1-Benzylpiperazine	15	0.6
Cathinone	14	0.6
Other	92	4.0
Total	2,309	100.0

¹January 2008–June 2008.

NOTES:

1. Data are for the District of Columbia only.

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

SOURCE: NFLIS, DEA, January 4, 2009; data are subject to change

Appendix Table 3.1. DAWN ED Samples and Reporting Information, by CEWG Area¹: January–June 2008

CEWG Areas	Total EDs in DAWN Sample	Number of EDs Reporting per Month: Completeness of Data (%)		Number of EDs Not Reporting
		≥90%	<90%	
Boston	38	19–24	1–6	13–15
Chicago	79	25–29	5–9	44–47
Denver	17	7–9	1–4	6–8
Detroit Core	6	3	2	1
Miami/Dade County Division	19	8	1	10
Miami/Ft. Lauderdale Division	21	7–9	0–2	12
Minneapolis/St. Paul	26	7–11	1–4	14–15
New York City	62	30–36	4–9	22–23
Phoenix	28	7–9	4–6	14–17
San Diego	17	4–6	1–2	10–11
San Francisco	35	11–14	0–2	21–22
Seattle	25	11–12	0–2	12–13

¹Most of the DAWN spatial units here are metropolitan areas or MSAs, including San Francisco, for which both the San Francisco and Oakland divisions combined are reported. Non-MSA spatial units reported are: New York, which includes the Five Boroughs division; Detroit, which reports data for Detroit core only; and Miami, which includes the Miami/Dade County division and the Miami/Ft. Lauderdale division reported separately. In terms of the DAWN *Live!* classification system, the other spatial units are: Boston core plus Boston other; Chicago core plus Chicago other; and the Denver, Minneapolis, Phoenix, San Diego, and Seattle metropolitan areas.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 12/22–12/23, 2008

Appendix Table 3.2. Number of Cocaine, Heroin, Methamphetamine (MA), Marijuana (MJ), Methylenedioxymethamphetamine (MDMA), Phenycyclidine (PCP), and Lysergic Acid Diethylamide (LSD) ED Reports in 12 CEWG Areas (Unweighted¹): January–June 2008

CEWG Areas ²	Cocaine	Heroin	MA	MJ	MDMA	PCP	LSD ³
Boston	3,181	2,583	54	1,581	49	5 ⁴	13
Chicago	4,508	3,274	29	1,784	106	87	18
Denver	1,449	384	268	1,206	82	11	30
Detroit Core	2,029	871	6	1,082	64	–	7
Miami/Dade County Division	1,809	426	14	729	63	7	12
Miami/Ft. Lauderdale Division	1,615	185	11	702	57	1	7
Minneapolis/St. Paul	1,165	353	203	1,312	113	11	26
New York City–Five Boroughs	9,070	4,461	71	4,652	114	287	31
Phoenix	783	480	501	572	36	29	12
San Diego	267	237	304	368	40	11	6
San Francisco–San Francisco and Oakland Divisions	2,467	820	557	624	111	33	36
Seattle	2,132	979	380	876	103	58	36

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

²Most of the DAWN spatial units are metropolitan areas or MSAs, including San Francisco, for which both the San Francisco and Oakland divisions combined are reported. Non-MSA spatial units reported are: New York, which includes the Five Boroughs division; Detroit, which reports data for Detroit core only; and Miami, which includes the Miami/Dade County division and the Miami/Fort Lauderdale division reported separately. In terms of the DAWN *Live!* classification system, the other spatial units are: Boston core plus Boston other; Chicago core plus Chicago other; and the Denver, Minneapolis, Phoenix, San Diego, and Seattle metropolitan areas.

³The 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 at: <http://www.multum.com>.

⁴Unweighted data with small values, e.g., less than 30, should be interpreted with caution.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 12/22-12/23, 2008

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