



EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

Proceedings of the Community
Epidemiology Work Group

Highlights and Executive Summary

January 2011

NATIONAL INSTITUTE ON DRUG ABUSE



COMMUNITY EPIDEMIOLOGY WORK GROUP

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

Proceedings of the Community
Epidemiology Work Group

Highlights and Executive Summary

January 2011

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH

Division of Epidemiology, Services and Prevention Research
National Institute on Drug Abuse
6001 Executive Boulevard
Bethesda, Maryland 20892

The National Institute on Drug Abuse (NIDA) acknowledges the contributions made by the representatives of the Community Epidemiology Work Group (CEWG), who prepare the reports presented at the semiannual meetings. Appreciation is extended also to other participating researchers and Federal officials who contributed information. This publication was prepared by Social Solutions International, Inc., under contract number HHSN-2712007-000003C from NIDA.

The information presented in this Executive Summary is primarily based on CEWG area reports and meeting presentations prepared by CEWG representatives for the January 2011

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.

All material in this report is in the public domain and may be reproduced or copied without permission from the Institute or the authors. Citation of the source is appreciated. The U.S. Government does not endorse or favor any specific commercial product. Trade or proprietary names appearing in this publication are used only because they are considered essential in the context of the studies reported herein.

For more information about the Community Epidemiology Work Group and other research-based publications and information on drug abuse and addiction, visit NIDA's Web site at <<http://www.drugabuse.gov>>.

This report (available in limited supply) can be obtained by contacting the NIDA DrugPubs Research Dissemination Center

***by phone: 877-NIDA-NIH (877-643-2644)
240-645-0228 (TTY/TDD)***

by fax: 240-645-0227

by email: drugpubs@nida.nih.gov

Contents

Foreword	vi
Section I. Introduction	1
Section II. Highlights and Summary of Key Findings and Emerging Drug Issues From the January 2011 CEWG Meeting	8
Section III. CEWG Area Update Briefs and International Reports—January 2011 CEWG Meeting	58
 CEWG AREA UPDATE BRIEFS	
Drug Abuse Patterns and Trends in Albuquerque and New Mexico—Update: January 2011 <i>Nina Shah, M.S.</i>	58
Drug Abuse Patterns and Trends in Atlanta—Update: January 2011 <i>Lara DePadilla, Ph.D., and Mary Wolfe, B.S.</i>	61
Drug Abuse Patterns and Trends in Baltimore City, Maryland, and Washington, DC— Update: January 2011 <i>Erin Artigiani, M.A., Maribeth Rezey, M.A., Margaret Hsu, M.H.S., and Eric D. Wish, Ph.D.</i>	63
Drug Abuse Patterns and Trends in Greater Boston—Update: January 2011 <i>Daniel P. Dooley</i>	64
Drug Abuse Patterns and Trends in Chicago—Update: January 2011 <i>Lawrence Ouellet, Ph.D.</i>	66
Drug Abuse Patterns and Trends in Cincinnati (Hamilton County)—Update: January 2011 <i>Jan Scaglione, Pharm.D., M.T., DABAT</i>	66
Drug Abuse Patterns and Trends in Colorado and the Denver/Boulder Metropolitan Area— Update: January 2011 <i>Kristen Dixon, M.A., L.P.C.</i>	70
Drug Abuse Patterns and Trends in Detroit, Wayne County, and Michigan— Update: January 2011 <i>Cynthia L. Arfken, Ph.D.</i>	73
Drug Abuse Patterns and Trends in Honolulu and Hawaii—Update: January 2011 <i>D. William Wood, M.P.H., Ph.D.</i>	75
Drug Abuse Patterns and Trends in Los Angeles County—Update: January 2011 <i>Mary-Lynn Brecht, Ph.D.</i>	77

Drug Abuse Patterns and Trends in Maine—Update: January 2011 <i>Marcella Sorg, Ph.D., R.N., D-ABFA</i>	79
Drug Abuse Patterns and Trends in Miami-Dade and Broward Counties, Florida— Update: January 2011 <i>James N. Hall</i>	81
Drug Abuse Patterns and Trends in Minneapolis and St. Paul, Minnesota—Update: January 2011 <i>Carol L. Falkowski</i>	83
Drug Abuse Patterns and Trends in New York City—Update: January 2011 <i>Rozanne Marel, Ph.D.</i>	87
Drug Abuse Patterns and Trends in Philadelphia—Update: January 2011 <i>Samuel J. Cutler</i>	88
Drug Abuse Patterns and Trends in the Phoenix Area and Arizona—Update: January 2011 <i>James K. Cunningham, Ph.D.</i>	91
Drug Abuse Patterns and Trends in St. Louis, Missouri—Update: January 2011 <i>Christopher Long, Ph.D., and Heidi Israel, Ph.D., R.N., F.N.P., L.C.S.W.</i>	92
Drug Abuse Patterns and Trends in San Diego County—Update: January 2011 <i>Robin A. Pollini, Ph.D., M.P.H.</i>	94
Drug Abuse Patterns and Trends in the San Francisco Bay Area—Update: January 2011 <i>John A. Newmeyer, Ph.D., and Alice Gleghorn, Ph.D.</i>	96
Drug Abuse Patterns and Trends in Seattle, Washington—Update: January 2011 <i>Caleb Banta-Green, T. Ron Jackson, Pat Knox, Steve Freng, Michael Hanrahan, David H. Albert, John Ohta, Ann Forbes, Robyn Smith, Steve Reid, Mary Taylor, and Richard Harruff</i>	97
Drug Abuse Patterns and Trends in Texas—Update: January 2011 <i>Jane C. Maxwell, Ph.D.</i>	98
INTERNATIONAL REPORTS	
Main and New Drug Trends in the European Union: EMCDDA 2010 Report <i>Julian Vicente, Roumen Sedefov, Ana Gallego, and Paul Griffiths</i>	99
The Drug Situation in Canada—Health Canada’s Update: January 2011 <i>Judy Snider, M.Sc.</i>	100
The Australian Drug Market: Findings From the Ecstasy and Related Drugs Reporting System <i>Natasha Sindicich, M.Psych (Forensic)</i>	102
Monitoring Systems and the Situation of Substance Abuse and HIV Related to Drug Use in Thailand <i>Usaneya Perngpam, Ph.D., and Chitlada Areesantichai, Ph.D.</i>	103
Community Epidemiology of Illegal Drug Use in Jamaica: The Last 24 Months <i>Ellen Campbell Grizzle, B.Pharm., Ph.D., R.Ph.</i>	104

Section IV. Across CEWG Areas: Treatment Admissions, Forensic Laboratory Analysis Data, and Average Price and Purity Data	106
Cocaine/Crack	106
Heroin	109
Opiates/Opioids Other Than Heroin (Narcotic Analgesics)	115
Benzodiazepines/Depressants	119
Methamphetamine	122
Marijuana/Cannabis	125
Club Drugs (MDMA, GHB, LSD, and Ketamine)	128
PCP	131
Other Drugs	132
Appendix Tables.	133
Appendix Table 1. Total Treatment Admissions by Primary Substance of Abuse, Including Primary Alcohol Admissions, for 21 CEWG Areas: Fiscal Year 2010 and January–June 2010	133
Appendix Tables 2.1–2.23. NFLIS Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items in Forensic Laboratories for 23 CEWG Areas: January–June 2010	135
Participant List	141

Foreword

THIS EXECUTIVE SUMMARY PROVIDES A SYNTHESIS OF findings from reports presented and data prepared for the 69th semiannual meeting of the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG) held in Scottsdale, Arizona, on January 19–21, 2011. 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 that have emerged since the prior meeting. These abbreviated reports, or Update Briefs, are included in this Executive Summary, along with highlights from the meeting and cross-site data compilations.

The majority of the January 2011 meeting was devoted to the CEWG area reports and presentations. CEWG area representatives presented data on recent drug abuse patterns and trends. Presentations on drug abuse patterns and issues were also provided by guest researchers from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, Portugal; Canada; Australia; Thailand; and Jamaica. Other highlights of the meeting included an update on SAMHSA activities from Nicholas Reuter, M.P.H., from SAMHSA's Center for Substance Abuse Treatment; a presentation on dextromethorphan and the abuse of over-the-counter cough products by Corrine Moody from the Food and Drug Administration; and presentations by DEA representatives, Cassandra Prioleau, Ph.D., and Artisha Polk, M.P.H., on NFLIS and emerging drugs of concern and drug scheduling issues, John Swartz on trends in drug trafficking, and Angela Walker on changes in methamphetamine production and quality. Rudy Banerjee, Ph.D., a GIS expert, presented on the use of mapping for displaying and interpreting trends over time in weighted DAWN data. A panel session on substance abuse in American Indian communities included the following presentations: "American Indian Populations: Drug Use, Disorder, and Chronic Stress," by Jan Beals, Ph.D., from the Centers for American Indian and Alaska Native Health at the University of Colorado; and "Substance Abuse Treatment in Arizona," by Yvonne Fortier, M.A., from Native American Connections in Phoenix, Arizona.

This Highlights and Executive Summary Report for the January 2011 CEWG meeting includes the CEWG Update Briefs and International Reports and highlights findings from the CEWG area reports and discussions.

Moira P. O'Brien

Division of Epidemiology, Services and
Prevention Research
National Institute on Drug Abuse
National Institutes of Health
Department of Health and Human Services

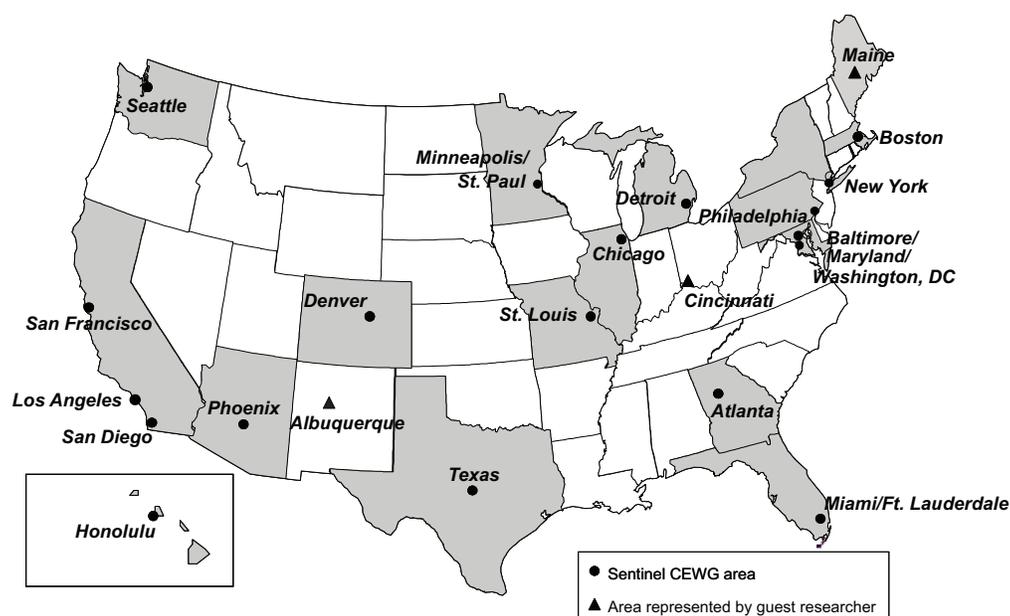
Section I. Introduction

THE 69TH SEMI-ANNUAL MEETING OF THE COMMUNITY Epidemiology Work Group (CEWG) was held on January 19–21, 2011, in Scottsdale, Arizona. During the meeting, CEWG area representatives from 21 geographically dispersed areas in the United States reported on current trends and emerging issues in their areas. In addition to the information provided for 18 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 Europe, Canada, Australia, Thailand, and Jamaica.

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 for which presentations were made at the January 2011 meeting are depicted in the map below, with one area presentation including data on Baltimore, Maryland, and



Washington, DC. A second area presentation for South Florida included data on two Miami metropolitan statistical area (MSA) counties.

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.

In addition to CEWG area presentations, time at each meeting is devoted to presentations by invited speakers. These sessions typically focus on the following:

- Presentations by researchers in the CEWG host city
- 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.

Availability of data varies by area, so reporting varies by area. Examples of types of data reviewed by CEWG representatives to derive drug indicators include 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-involved emergency department (ED) reports of drugs mentioned in ED visits reported by the Drug Abuse Warning Network (DAWN)
- Seizure, average price, average purity, and related data obtained from the Drug Enforcement Administration (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 and other toxicology data
- Surveys of drug use
- Poison control center data

Sources of data used by several or most of the CEWG area representatives and presented in this Highlights and Executive Summary Report 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 17 CEWG metropolitan areas and 5 States: Colorado, Hawaii, Maine, New Mexico, and Maryland. Recent or complete treatment admissions data were not available for Chicago, New Mexico, Texas, or Washington, DC. Data for several States are included with metropolitan data for comparison, including data for Colorado with Denver, Hawaii with Honolulu, and Florida with Miami-Dade County and Broward County. The latter two counties in South Florida are part of the Miami MSA. The reporting period is cited as the first half (1H) of calendar year (CY) 2010 (January–June 2010) for all areas except San Francisco, which reported data for fiscal year (FY) 2010 (July 2009–June 2010). 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, 4, 8, 12, 16, 18, and 20).

DAWN ED¹ weighted estimates for 12 CEWG areas for 2004 through 2009 were accessed on the DAWN Web site (<https://dawninfo.samhsa.gov/default.asp>) maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). The data represent drug reports for drug-involved visits for illicit drugs (derived from the category of “major substances of abuse,” excluding alcohol) and the nonmedical use of selected pharmaceutical drugs. Nonmedical use of pharmaceuticals is use that involves taking

a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs, especially illegal drugs or alcohol. Since drug reports exceed the number of ED visits because a patient may report use of multiple drugs (up to six drugs plus alcohol), summing of drugs across categories is not recommended. A description of the DAWN system can be found at <https://dawninfo.samhsa.gov/default.asp>. Several CEWG Update Briefs in section III include DAWN data: Boston, Chicago, Denver, Detroit, Miami-Dade County², Minneapolis/St. Paul, New York City, Phoenix, and San Francisco. Weighted DAWN data for 2004–2009 are reported in section II, figures 7, 14, 15, and 22.

Forensic laboratory data for a total of 23 CEWG sites were available for the first half of 2010. Data for all CEWG metropolitan areas in the first half of 2010 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 that 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 December 2010, in addition to the DEA laboratories, the NFLIS system included 48 State systems, 94 local or municipal laboratories/

¹DAWN uses a national sample of non-Federal, short-stay, general surgical and medical hospitals in the United States that operate 24-hour EDs. The American Hospital Association (AHA) Annual Survey is the source of the sample. ED medical records are reviewed retrospectively for recent drug use. Visits related to most types of drug use or abuse cases are identified and documented. Drug cases encompass three visit categories: those related to illegal or illicit drugs; non-medical use of prescription, over-the-counter, or other pharmaceutical drugs; and alcohol among patients younger than the legal drinking age of 21, and patients of all ages when used in combination with other drugs.

²Weighted DAWN data for Miami MSA/Broward County are available for 2008 and 2009 only, resulting in the lack of ability to compare across the span of 6 years as for the other 12 areas. Nevertheless, weighted DAWN data for the Broward County (Ft. Lauderdale) area were reported as appropriate at the January 2011 CEWG meeting by the Miami/South Florida area representative.

laboratory systems, and 1 territorial laboratory, representing a total of 283 individual laboratories. These laboratories handled more than 89 percent of the Nation's estimated 1.1 million annual State and local drug analysis distinct cases (estimated as of 2009). 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 U.S. Drug Enforcement Administration, Office of Diversion Control report, *National Forensic Laboratory Information System: Year 2009 Annual Report* (Washington, DC: U.S. Drug Enforcement Administration)³. In most cases, data are for MSAs, rather than single metropolitan counties, but the exact geographic areas covered in this report are defined in appendix table 2. A map displaying NFLIS data for the first half of 2010 for 23 CEWG areas is included as figure 23 in section II, while a number of other figures and tables in section II (table 1; figure 21) and section IV (figures 24, 25, 27, and 28, and tables 8, 9, 12, and 13), along with appendix tables 2.1–2.23, are provided to display the data on forensic laboratory drug items identified for the period across areas. Update Briefs in section III of this report also include NFLIS data for CEWG areas.

Average price and purity data for heroin for 21 CEWG metropolitan areas in CY 2009 (the most recent period available) came from the DEA report, *2009 Heroin Domestic Monitor Program (HDMP) Drug Intelligence Report*, published November 2010 (DEA-NCW-RPT-013-10). 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, 2009. Drug price and purity data

from this report or from local DEA Field Divisions are included in Update Briefs for the following CEWG sites/areas: Atlanta; Baltimore/Maryland/Washington, DC; Boston; Chicago; Cincinnati; Denver; New York City; Philadelphia; St. Louis; San Francisco; Seattle; and Texas. In section IV, figure 26 and tables 5 and 6 show data for average price and purity for CEWG areas.

Drug prices and trafficking trends also came from the National Drug Intelligence Center (NDIC)'s report, *National Illicit Drug Prices—Mid Year 2009*. Data from this report are included in the Chicago Update Brief. The Albuquerque Update Brief includes data from NDIC Field Intelligence through December 2009.

DEA ARCOS (Automation of Reports and Consolidated Orders System) data were presented in the Baltimore/Maryland/Washington, DC, area Update Brief by the CEWG 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/hydroxybutyrate (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 16 CEWG areas: Albuquerque; the Baltimore/Maryland/Washington, DC, area; Boston; Cincinnati; Denver; Detroit; Honolulu; Los Angeles; Maine; Miami-Dade and Broward Counties in the Miami MSA in South Florida; Minneapolis/St. Paul; Philadelphia; St. Louis; San Diego; Seattle; and Texas. These are described in Update Briefs in section III and shown in figures 1, 2, 5, 9, and 10 in section II of this report.

³This can be found at http://www.deadiversion.usdoj.gov/nflis/2009annual_rpt.pdf.

Other data cited in this report were local data accessed and analyzed by CEWG representatives. The sources included the Centers for Disease Control and Prevention (CDC)'s Youth Risk Behavior Surveillance System (YRBSS) and Youth Risk Behavior Survey (YRBS); local law enforcement (e.g., data on drug arrests); local DEA offices (DEA field reports); High Intensity Drug Trafficking Area (HIDTA) reports; arrestee drug information from the Arrestee Drug Abuse Monitoring (ADAM) II system and from local and State corrections departments and facilities; poison control centers and help lines; prescription drug monitoring systems; local and State surveys; hospital admissions and discharge data; key informants and ethnographers; and human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) data from local and State health departments (figure 11 reports helpline call data; figure 13 contains arrestee urinalysis data; figure 19 shows data on drug-related arrests; figure 17 uses school survey data; figure 1 displays hospital admissions data; and figure 6 shows poison control center data).

A Note to the Reader—Caveats

Terminology and Geographic Coverage—

The CEWG representatives use existing data, which are subject to the definitions and geographic coverage of the source data. Representatives generally use the terminology as it is used in the data source. For example, many treatment systems use the phrase “other opiates” for classifying opiates⁴ or opioids⁵ other than heroin as the primary problem at admission. The term “other opiates” is therefore retained in this summary report, and the terms “other opiates” and “opioids” may be used in a single area report. Similarly, the term “prescription-type opioid” is used by some representatives to distinguish synthetic or semisynthetic opioids,

such as oxycodone and hydrocodone, from heroin. The geographic coverage of data sources may vary within a CEWG area report. Readers are directed to the Data Sources paragraph in the CEWG area Update Briefs in section III for a more complete description of data sources used in specific areas. In this summary report, in most cases, the general name of the CEWG area will be used for data sources. For the treatment admissions and NFLIS data, the specific geographic coverage will be noted in footnotes. For example, appendix table 1 presents the treatment admissions data for each area, and footnotes specify the geographical coverage; appendix table 2 presents local area NFLIS data with notes on spatial composition.

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 2010 are presented for 21 reporting CEWG sites/areas in appendix table 1, with rankings documented in section II, table 2. Treatment data are not totally comparable across CEWG areas, and differences are noted insofar as possible. Treatment numbers are subject to change. Most of the CEWG area representatives report Treatment

⁴Opiate is defined as “any preparation or derivative of opium” by *Stedman’s Medical Dictionary – 28th Edition*, Lippincott Williams and Wilkins, Baltimore, MD: c. 2006.

⁵Opioid is defined as “Originally a term denoting synthetic narcotics resembling opiates but increasingly used to refer to both opiates and synthetic narcotics” by *Stedman’s Medical Dictionary – 28th Edition*, Lippincott Williams and Wilkins, Baltimore, MD: c. 2006.

Episode Data Set (TEDS)⁶ data accessed from local treatment programs or States, and these data are included in cross-area comparison tables in this report (table 2; section IV, tables 3, 4, 7, 10, and 11, and appendix table 1).

ED Drug Reports—For this meeting report, weighted estimate data were accessed at the DAWN Web site (<https://dawninfo.samhsa.gov/default.asp>). These data were used in area Update Briefs by CEWG area representatives for 10 of the 12 metropolitan areas for whom such data were available for 2004–2009 in the DAWN system: Boston; Chicago; Denver; Detroit; Miami-Dade County; Miami MSA/Ft. Lauderdale; Minneapolis/St. Paul; New York City; Phoenix; and San Francisco. Weighted DAWN data for Miami MSA/Ft. Lauderdale were only available for 2008 and 2009 as of the January 2011 meeting. When comparisons are made across time periods with a CEWG area, this caveat is needed: statements about drug-involved ED weighted rates in CEWG areas being higher or lower in 1 year than another year are only made when their respective *t*-test *p*-values are significant at the .05 level or below. Otherwise, no difference is reported.⁷

Forensic Laboratory Drug Items Identified—NFLIS data include 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 they range from analysis of all evidence submitted to the laboratory to analysis of selected items only. Many laboratories did not analyze the evidence when a case was dismissed or if no defendant could be identified (see NFLIS Year 2009 Annual Report cited earlier). Differences in local/State laboratory procedures and law enforcement practices across areas make cross-area comparisons inexact. Also, the data cannot be used for prevalence estimates, because they are not adjusted for population size. NFLIS data are reported as counts and as the percentage that each drug represents of the total number of drug items seized and identified by forensic laboratories in a CEWG area. 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, NFLIS data for 2007 to the first half of 2010 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

⁶TEDS is an administrative data system providing descriptive information about the national flow of admissions to specialty providers of substance abuse treatment, conducted by CBHSQ, SAMHSA.

⁷Estimates of ED visits associated with misuse and abuse of drugs are derived by applying sampling weights to data from a stratified probability sample of hospitals. The estimates obtained are of drug-involved visits. A single ED visit may involve multiple drugs, which are counted separately. When ED visits involve multiple drugs, such visits appear multiple times in a table. Therefore, summing ED visits as reported in these tables will produce incorrect and inflated counts of ED visits. Combining estimates for categories of drugs is subject to a similar limitation. Multiple drugs may be involved in a single visit, so categories are not mutually exclusive and will not sum to 100 percent when percentages are calculated. Because multiple substances may be recorded for each DAWN case, caution is necessary in interpreting the relationship between a particular drug and the number of associated visits. It is important to note that a drug-involved ED visit is any ED visit related to recent drug use. This is the new definition of a DAWN case as of 01/01/03. One or more drugs have to be implicated only in the visit; they do not necessarily have to have precipitated or caused the visit. These are visits, not patients, such that they are duplicated numbers to an unknown extent rather than being unique numbers. See: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *Drug Abuse Warning Network, 2007: National Estimates of Drug-Related Emergency Department Visits*. Rockville, MD, 2010. Available at: <http://dawninfo.samhsa.gov/pubs/>.

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. Numbers of drug items presented in these reports are subject to change and may differ when drawn on different dates. Not all forensic laboratories report on substances that are not controlled, rendering some comparisons of such drugs inaccurate. Only the top 50 drug items identified in an area were retrieved by NFLIS for each CEWG area, resulting in a possible underestimation of less common, but emergent drugs.

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 may 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 January through June of 2010, which is characterized as the current reporting period. However, San Francisco reported FY 2010 data (July 2009–June 2010).
- 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 racial/ethnic population compositions differ across CEWG areas. Readers are directed to the individual CEWG area Update Briefs in section III of this report for information regarding treatment patterns and trends pertaining to race/ethnicity, age, and gender, if discussed.

Section II. Highlights and Summary of Key Findings and Emerging Drug Issues From the January 2011 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-involved 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 this 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. Consequently, the representatives 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.

Contained in this volume for each CEWG area represented at the meeting are Update Briefs, which document and summarize drug abuse trends and issues in specific CEWG areas, with an emphasis on information newly available since the January and June 2010 meeting reports. The availability of data varies by area. Readers are directed to the Data Sources section of the Update Briefs in section III of this report 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 and HDMP, are reviewed. These data are presented in section IV of this report and in appendix tables 2.1–2.23. Highlights from these cross-area tabulations are also included in section IV.

For the January 2011 CEWG meeting, CEWG representatives were invited to provide an overview and update on drug abuse trends in their areas for the first half of the most recent calendar year (January–June 2010). Key findings and issues identified at the CEWG meeting 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 remained a major drug of concern in CEWG areas in all regions of the country—the West, South, Midwest, and Northeast—but the

decline in indicators reported by area representatives at recent CEWG meetings continued. Seventeen area representatives (all with the exception of four) reported decreasing but elevated indicators. Cocaine indicators were high and mixed (some increasing and some decreasing) in the Baltimore/Maryland/Washington, DC, area in the southern region, Detroit in the midwestern region, and Maine in the northeastern region. In the West, the area representative from Albuquerque reported high indicators for cocaine, with some stable and some declining.

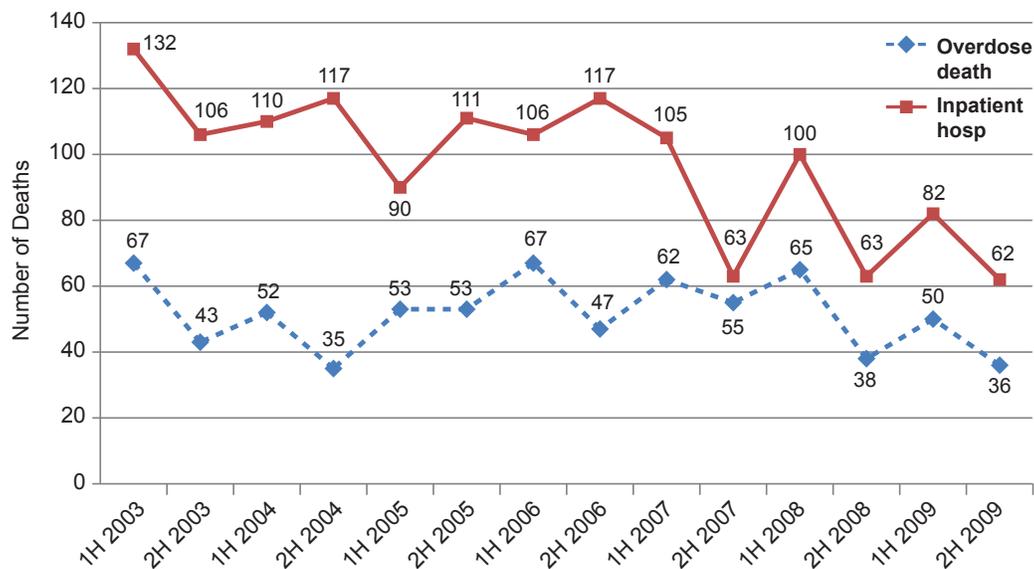
Western Region CEWG Areas:

- **Phoenix Report.** The area representative from Phoenix reported that a decline in the number of cocaine-related hospital admissions in Maricopa County that began in 2007 continued into the first half of 2010, from 1,598 admissions in the first half of 2007 to 884 admissions in the first half of 2010. Similarly, the number of cocaine-related hospital admissions declined in Pima County

(Tucson), from 1,577 in the first half of 2007 to 883 in the first half of 2010. These admissions also declined in the rural Arizona counties, from 104 in the first half of 2007 to 56 in the first half of 2010.

- **Albuquerque/New Mexico Report.** Despite overall stability, several cocaine indicators were declining in New Mexico, according to that area representative. These included the number of inpatient hospitalizations, showing a slight decline in 2009 from 2008, and overdose deaths caused by cocaine, declining by 16 percent from 2008 to 2009 (figure 1). While the 22.4 percent of items analyzed and identified as containing cocaine by Albuquerque forensic laboratories in the first half of 2010 represented the highest proportion of all substances analyzed, this was a decrease from the 34.5 percent of drug items identified as cocaine in 2008.
- **Texas Report.** All cocaine indicators in Texas were in decline, according to the area

Figure 1. Number of Overdose Deaths Related to Cocaine and Hospitalizations with the Primary Diagnosis of Cocaine: Albuquerque, New Mexico: 2003–2009



SOURCE: The Office of the Medical Investigator; New Mexico Health Policy Commission, as reported by Nina Shah at the January 2011 CEWG meeting

representative. From 2009 to the first half of 2010, calls to poison control centers decreased from 792 to 753; primary cocaine treatment admissions as a portion of all admissions dropped from 17.9 to 14.1 percent; and the percentage of samples analyzed and identified as containing cocaine by the Texas Department of Public Safety laboratories decreased from 29.3 to 25.0 percent.

- **San Diego Report.** In San Diego, the prevalence of cocaine-positive test results among arrestees declined from 2007 to 2009 for all arrestees—adult males and females, as well as juveniles. Primary cocaine treatment admissions decreased to 350 in the first half of 2010 (5 percent of all admissions), from 527 in the first half of 2008 (7 percent of all admissions). Drug items identified as containing cocaine also decreased in the San Diego area; 9 percent of drug items seized and analyzed in the first half of 2010 contained cocaine, compared with 13 percent in 2008.
- **Los Angeles Report.** Cocaine accounted for 10 percent of alcohol and drug treatment admissions in Los Angeles County in the first half of 2010, a decline from 13 percent in 2009. Drug items seized and identified in forensic laboratories as containing cocaine also declined in the Los Angeles area, from 27 percent of all items in 2009 to 22 percent in the first half of 2010. Cocaine was present in 14 percent of coroner toxicology cases, a decrease from 2009 levels.
- **San Francisco Report.** The area representative from San Francisco also reported a decrease in primary cocaine treatment admissions in the five-county bay area from FY 2009 to FY 2010. However, new admissions for cocaine exceeded heroin admissions in both FY 2009 and FY 2010, ending the long dominance of heroin in this indicator. Despite the high proportions of admissions, 21 percent of all drugs seized and analyzed by forensic laboratories in the San Francisco area contained cocaine in 2010, a decrease from 25 percent in 2009.
- **Denver/Colorado, Honolulu/Hawaii, and Seattle Reports.** Elsewhere in the West—in Denver and Honolulu—cocaine indicators also continued to decline. The CEWG area representative from Denver reported that primary cocaine treatment admissions decreased from 24 percent in the first half of 2007 and 22 percent in the first half of 2008 to a 10-year low of 16 percent in the first half of 2010. In addition, estimated cocaine-involved DAWN ED visit rates decreased significantly by 34 percent for the Denver metropolitan area, from 168.5 per 100,000 population in 2008 to 109.6 per 100,000 in 2009. The Honolulu area representative reported that in the first half of 2010 primary cocaine treatment admissions continued their multiyear decline to the lowest level in 5 years (a decrease from 326 in 2009 to 78 in the first half of 2010). The Honolulu police department reported the lowest number of cocaine-related arrests in 5 years (51 in the first half of 2010, down from a peak of 305 in 2006); and the Honolulu Medical Examiner also reported the lowest number of deaths in the past 5 years in which cocaine was revealed in the toxicological screens of decedents. While cocaine persisted as a major drug of abuse in Seattle, as reported by the area representative, all cocaine indicators remained level in the first half of 2010, compared with 2009.

Southern Region CEWG Areas:

In the CEWG areas in the southern region, cocaine continued as a persistent problem, according to area representatives, but indicators were primarily declining in the first half of 2010, compared with 2009.

- **Miami MSA/South Florida Report.** In the Miami MSA/South Florida area, numbers of cocaine-related deaths declined sharply in Miami-Dade County between 2007 and 2009, from 281, to 201, and to 155. The decline continued to an estimated 82 for 2010 (based on annualization of the 41 deaths in the first half of 2010) (figure 2).

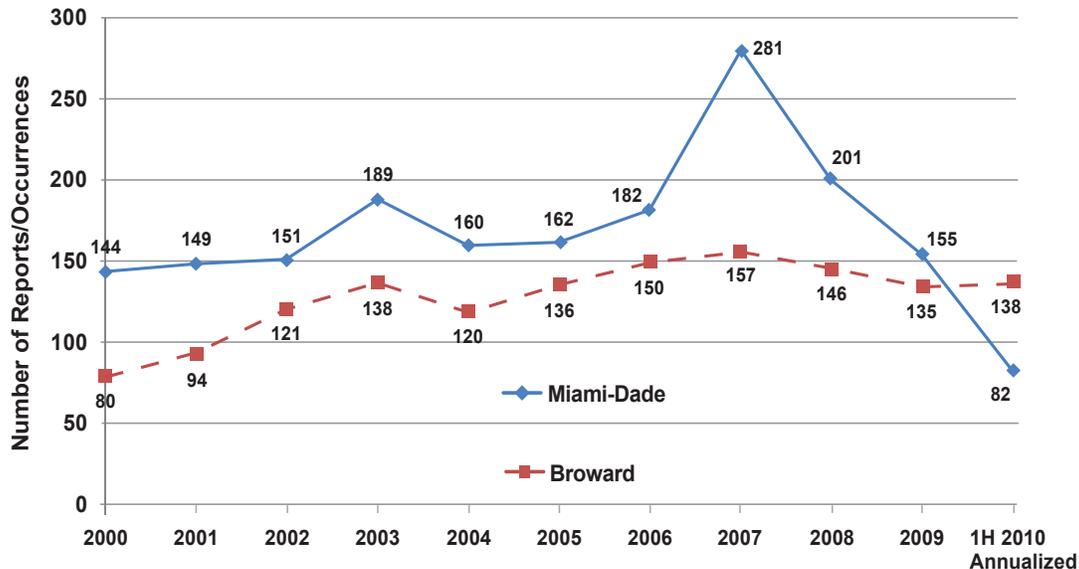
- Atlanta Report.** Cocaine remained a dominant drug of abuse in the metropolitan Atlanta area, according to the area representative, but several cocaine indicators showed continuing declines in the first half of 2010, compared with 2008 and 2009 data. For example, primary treatment admissions for cocaine constituted 17.7 percent of all admissions in the first half of 2010, compared with 19.8 percent in 2009, and 22.8 percent in 2008⁸.
- Baltimore/Maryland/Washington, DC, Report.** In Washington, DC, cocaine continued to be one of the most serious drugs of abuse, as reported by the area representative. Overdose deaths in Washington, DC, were more likely to involve cocaine in 2008 (60 percent) than any other drug. Cocaine was also more likely than other drugs to be identified in toxicology screens of

adult arrestees (however, the percentage of adult arrestees testing positive for cocaine continued to decrease—from 33 percent in 2008 and 28.7 percent in 2009 to 26.4 percent in 2010 [January–November]). In Maryland, drug intoxication deaths attributed to cocaine appeared to be decreasing, from 159 in 2009 to an estimated 138 in 2010 (annualized from 69 in the first half of the year).

Midwestern Region CEWG Areas:

Cocaine indicators continued to be reported as high in Chicago, Detroit, and the Minneapolis/St. Paul area, and they were also reported to be high in Cincinnati and St. Louis. However, indicators were seen as trending down in all CEWG areas in the Midwest except Detroit, where they were mixed but mostly declining.

Figure 2. Number of Cocaine Reports¹ Detected Among Decedents in Miami-Dade and Broward Counties in South Florida: CY 2000–Estimated CY 2010²



¹Number of reports of cocaine-related deaths included cases in which cocaine is “present” and where cocaine is determined to be the “cause of death.”

²CY 2010 data are estimates based on annualized counts for 1H 2010

SOURCE: Florida Medical Examiners Commission Interim Report 2010, as reported by James Hall at the January 2011 CEWG meeting

⁸Primary treatment admissions percentages for individual drugs included in the Update Brief for Atlanta and referenced in section II differ from those shown in cross-area tables in section IV because total admissions exclude “alcohol only” admissions in the former.

- **Detroit Report.** Cocaine as the primary drug of abuse accounted for 18.9 percent of all substance abuse treatment admissions in Detroit in FY 2010⁹, continuing its decade-long decline from a high of 33.8 percent in FY 2000. According to the area representative, these proportions appeared to be stabilizing (cocaine admissions were at 19 percent in FY 2009). Calls to the Poison Control Center at the Children's Hospital of Michigan were also stable in the first half of 2010. However, the DAWN weighted cocaine-involved DAWN ED visit rate in the five-county Detroit area showed a significant decline of 5 percent from 2008 to 2009.
- **Chicago Report.** The area representative from Chicago reported a continuing decline in cocaine as a percentage of all drug items analyzed in forensic laboratories, at 20.1 percent in the first half of 2010, compared with 22.2 percent in 2009, and 25.5 percent in 2008. However, the percentage of high school students in Chicago reporting ever using cocaine in the 2009 YRBS (at 6.7 percent) was the highest since 2003.
- **Minneapolis/St. Paul Report.** The decline in cocaine-related treatment admissions reported by the Minneapolis/St. Paul area representative at previous CEWG meetings continued into the first half of 2010. In Minneapolis/St. Paul, cocaine was the primary substance abuse problem for 5.8 percent of total treatment admissions in the first half of 2010, compared with 6.4 percent in 2009, 9.9 percent in 2008, 11.6 percent in 2007, and 14.1 percent in 2006. The percentage of male arrestees testing positive for cocaine also declined in that area, from 27.5 percent in 2007 and 22.5 percent in 2008 to 18.7 percent in 2009.
- **St. Louis and Cincinnati Reports.** Cocaine-related treatment admissions also continued to decline in the St. Louis area—from 1,235 in the first half of 2008, to 825 in the first half of 2009, to 788 in the first half of 2010. In Cincinnati,

where all cocaine indicators were declining, according to the area representative, 26 percent fewer calls were recorded by the Cincinnati Drug and Poison Information Center for cocaine in 2010 than in 2009.

Northeastern Region CEWG Areas:

Cocaine indicators continued to be high in the Northeast, although they were mostly declining in all four CEWG areas there—New York City, Boston, Philadelphia, and Maine.

- **New York City Report.** Although cocaine remained a major problem in New York City, as reported by the CEWG representative from that area, all indicators decreased there in this reporting period, compared with 2009. Cocaine-related treatment admissions declined to the lowest level in more than two decades; they showed recent declines from 21 percent of total substance abuse admissions in the first half of 2004 to 16 percent in the first half of 2010 (figure 3). Weighted DAWN ED visit rates involving cocaine showed a significant decrease of 18 percent from 2008 to 2009.
- **Boston Report.** In Boston, most cocaine indicators were decreasing but remained at very high levels when compared with other drugs. Cocaine figured prominently among drug-related deaths, drug arrests, and drug laboratory samples seized in drug arrests in 2009 and the first half of 2010. The rate of estimated cocaine-involved DAWN ED visits, however, decreased a significant 12 percent from 2008 to 2009.
- **Maine Report.** While cocaine-related deaths and treatment admissions remained stable in Maine in the first half of 2010, cocaine arrests (as a proportion of all arrests) and the percentage of cocaine items seized and analyzed in forensic laboratories declined compared with 2009. Cocaine/crack arrests dominated the illicit drug arrests of the Maine Drug Enforcement Agency

⁹Note that the Detroit area representative reported treatment data by fiscal year in the Detroit Update Brief, which is included in section III; however, calendar year data for the first half of 2010 are reported for Detroit in cross-area treatment tables contained in this *Highlights and Executive Summary* report.

during the mid-2000s, but the proportion of arrests had decreased substantially to 21 percent in January–October of 2010, from 36 percent in 2008 and 26 percent in 2009.

- **Philadelphia Report.** Cocaine indicators declined in Philadelphia in the first half of 2010 for treatment admissions, decedents, and urinalysis screens performed by the Philadelphia Adult Probation and Parole Department. The number of decedents in which cocaine was detected declined there from 311 in 2009 to 118 in the first half of 2010. Among probationers and parolees, cocaine-positive screens declined from 41.5 percent in 2001 to 16.2 percent by the first half of 2010.

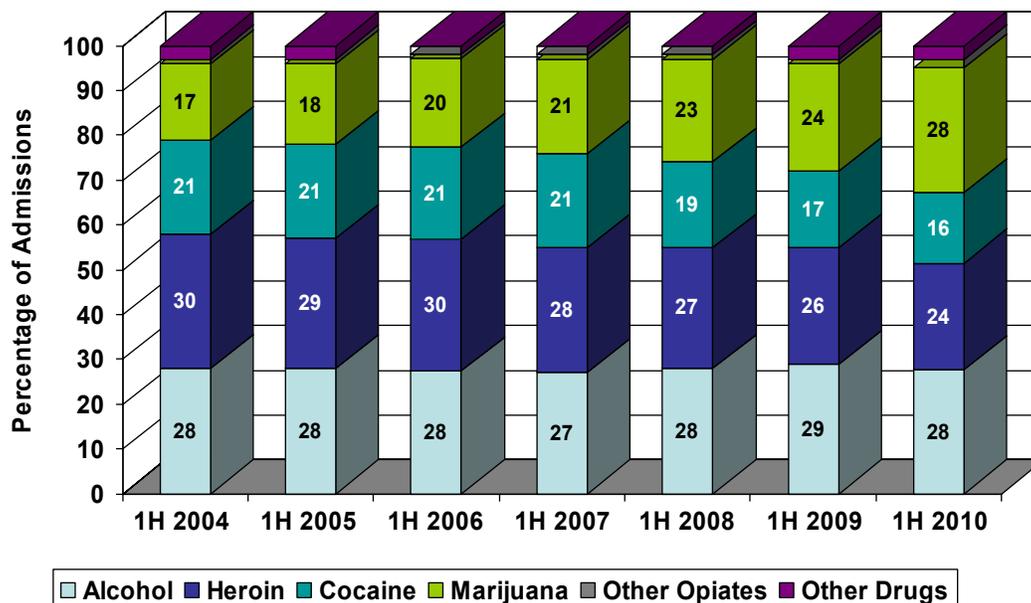
Other Highlights:

- The reports by CEWG area representatives on cocaine contaminated with adulterants, particularly levamisole¹⁰, which emerged in presentations at

the 2009 and 2010 CEWG meetings, continued at the January 2011 meeting. Seven out of 21 area representatives reported on levamisole presence in items containing cocaine in the first half of 2010.

- **Miami MSA/South Florida, Philadelphia, Minneapolis/St. Paul, and Cincinnati Reports.** Levamisole was detected as an adulterant in all cocaine-related deaths in Miami-Dade County in the first half of 2010. The Philadelphia area representative reported that levamisole was detected in 55 of the 68 cocaine-positive drug intoxication decedents in that city. According to a study conducted by the Minnesota Bureau of Criminal Apprehension from June 16 to August 31, 2010, 47.6 percent of cocaine samples tested contained levamisole. In Cincinnati, 78 percent of the

Figure 3. Percentage of Treatment Admissions by Primary Problem Substance for Selected Illicit Drugs, New York City: 1H 2004 to 1H 2010



SOURCE: New York State Office of Alcoholism and Substance Abuse Services (OASAS), as reported by Rozanne Marel at the January 2011 CEWG meeting

¹⁰Levamisole, used in veterinary medicine as an antiparasitic drug, is no longer an approved drug for use in humans, although it was previously approved as a cancer medication. Negative effects from levamisole include agranulocytosis, a relatively uncommon condition in the United States, and severe neutropenia.

cocaine items seized and analyzed in forensic laboratories in the NFLIS system in the first half of 2010 revealed levamisole impurities (21 out of 27 samples).

- **Denver, Maine, and Detroit Reports.** In Denver and Maine, however, the detection of levamisole in cocaine samples declined in this reporting period. In Maine, the proportion of cocaine drug samples in forensic laboratories testing positive for levamisole decreased to 32 percent (103 cases) in 2010, down from 38 percent (139 cases) in 2009. In Detroit, levamisole was detected in 78 decedents in the first half of 2010 (a possible decline when annualized at 156 cases, compared with 176 cases for 2009).
- **Albuquerque/New Mexico, Los Angeles, and Philadelphia Reports.** Shifts in ethnicity and gender of cocaine-related treatment admissions were reported by the Albuquerque and Los Angeles area representatives. Treatment data from New Mexico indicated a large increase in the proportion of Hispanics among primary cocaine treatment admissions, from 34 percent in 2008 to 48 percent in 2009. In Los Angeles, African-Americans represented an increasing majority of cocaine treatment admissions, at approximately 63 percent of cocaine admissions in the first half of 2010, compared with 61 percent in the first half of 2009 and 56 percent in the second half of 2004. A notable gender shift in cocaine treatment admissions in Philadelphia was reported by that area representative, with the percentage of female admissions with primary cocaine problems declining from 41.0 percent in 2001 to 28.8 percent in the first half of 2010.
- **Albuquerque/New Mexico, Chicago, Atlanta, Denver/Colorado, Detroit, New York City, and Philadelphia Reports.** While area representatives from Albuquerque and Chicago reported relatively high self-reported cocaine use by youth in their areas (the prevalence of cocaine use among high school students in New Mexico was the highest in the Nation), area representatives from Atlanta,

Denver, Detroit, New York City, and Philadelphia reported an aging cohort of primary cocaine treatment admissions. For example, the percentage of primary cocaine clients entering treatment who were 40 and older increased in Philadelphia. In the first half of 2010, in Philadelphia, 49.3 percent of primary treatment admissions for cocaine were age 40 and older, compared with 44.7 percent in 2008 and 48.6 percent in 2009.

- Treatment admissions data for this 2010 reporting period revealed that primary cocaine treatment admissions, including primary alcohol admissions, did not rank first in frequency in any CEWG area, but they ranked second in 1 of the 21 reporting CEWG areas, San Francisco (table 2).
- Cocaine was the drug most frequently identified by forensic laboratories in 8 of 23 reporting CEWG areas—Albuquerque, Atlanta, Denver, Maine, Miami, New York City, Seattle, and Washington, DC—in the first half of 2010 (table 1 and figure 23). Based on forensic laboratory analysis of drug items identified in the first half of 2010, cocaine/crack ranked first in three of the five areas in the southern region (Atlanta, Miami, and Washington, DC); two of the four CEWG areas in the northeastern region (Maine and New York City); and three of nine areas in the western region (Albuquerque, Denver, and Seattle). In none of the CEWG areas in the midwestern region did cocaine rank first. However, it ranked second in frequency of drug items identified in three of the five areas in the midwestern region (Chicago, Cincinnati, and Detroit) (table 1; appendix table 2).

Heroin

Heroin indicators remained high in several CEWG areas in the Midwest and Northeast regions of the country. The increase in heroin indicators, documented in recent CEWG meeting reports, was reported as moderating during this reporting period, with fewer area representatives reporting increases for the first half of 2010, compared with 2009.

Western Region CEWG Areas:

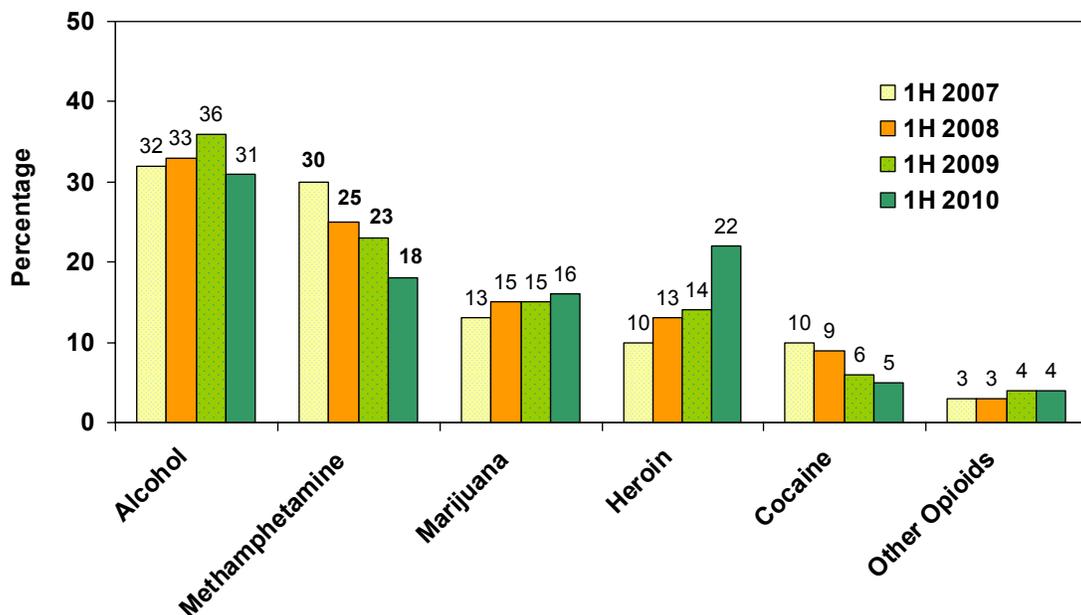
Representatives from most areas in the West reported stable or mixed heroin indicators, with the exception of those from Denver and Los Angeles, who reported possible increases in heroin indicators. Representatives from Honolulu and San Francisco reported continuing declines.

- **Phoenix Report.** In Phoenix, heroin indicators were mixed. Primary heroin treatment admissions increased, with heroin replacing methamphetamine as the most common illicit primary drug reported by treatment clients (22 percent in the first half of 2010, compared with 14 percent in the first half of 2009) (figure 4). The number of NFLIS drug items identified in forensic laboratories as containing heroin increased from 216 in the first half of 2008 to 329 in the first half of 2010. However, heroin-involved estimated ED visits were stable from 2008 (2,712) to 2009 (2,662).
- **San Diego Report.** Indicators were also mixed in the San Diego area, but an increase

was reported in forensic laboratory items testing positive for heroin, from 3.7 percent in 2009 to 4.9 percent in the first half of 2010.

- **Albuquerque/New Mexico Report.** Heroin indicators were high and stable or decreasing in Albuquerque, according to the area representative. Heroin overdose death rates per 100,000 decreased there, from 12.0 in 2008 to 8.5 in 2009. However, the percentage of heroin-related decedents who were 21 and younger increased significantly, from 1.9 percent in 2007 to 8 percent in 2008 and 12 percent in 2009 (figure 5).
- **Los Angeles Report.** Heroin indicators continued the slight upward trend in Los Angeles reported by the area representative at the June 2010 CEWG meeting. Treatment admissions, drug items seized and identified as containing heroin in forensic laboratories, and coroner toxicology cases all experienced slight increases over 2009 numbers in the first half of 2010 in Los Angeles.

Figure 4. Percentage of Treatment Episodes by Primary Drug for Methamphetamine and Selected Other Drugs, Maricopa County (Phoenix): 1H 2007–1H 2010



SOURCE: Arizona Department of Health Services, as reported by James Cunningham at the January 2011 CEWG meeting

- **Denver/Colorado Report.** In Denver, primary treatment admissions for heroin increased slightly to 548 (annualized as 1,090) in the first half of 2010, compared with 960 for CY 2009. Although heroin was not among the most common drugs found in Colorado death mentions, it increased slightly in State deaths in 2009 to 1.4 per 100,000, from a stable rate of 0.9 from 2005 to 2008.
- **Seattle and Texas Reports.** In Seattle, heroin-related treatment admissions have been stable since 2006, and overdose deaths have declined in that same time period, according to the area representative. The Texas area representative also reported stable heroin indicators for the first half of 2010.
- **Honolulu/Hawaii Report.** In Hawaii, treatment admissions for heroin continued to decline to the lowest number in 5 years, down from 170 in 2009 to 66 in the first half of 2010; arrests

for heroin in Honolulu also reached their lowest point in 5 years.

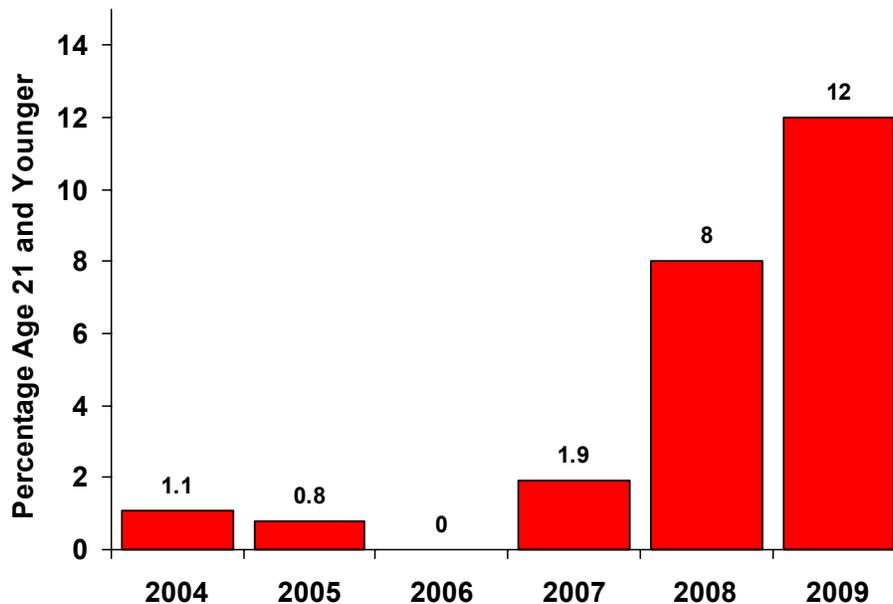
- **San Francisco Report.** All indicators for heroin—treatment admissions, drug items analyzed by forensic laboratories, estimated heroin-involved DAWN ED visits, and price and purity data—declined in San Francisco, according to the area representative. For example, new treatment admissions for heroin in San Francisco County declined from 3,067 in FY 2009 to 2,521 admissions in FY 2010.

Southern Region CEWG Areas:

Heroin indicators in the southern region of the country were reported as mostly stable in the first half of 2010.

- **Atlanta and Miami MSA/South Florida Reports.** Heroin indicators remained low relative to other drugs in Atlanta and South Florida. Indicators in Atlanta, however, showed a

Figure 5. Percentage of Heroin Overdose Decedents Age 21 and Younger, New Mexico: 2004–2009¹



¹The N's for this table are 2004, 89; 2005, 125; 2006, 106; 2007, 108; 2008, 150; and 2009, 118.

SOURCE: New Mexico Medical Examiners Data, as reported by Nina Shah at the January 2011 CEWG meeting

possible increase, according to the CEWG area representative. For example, treatment admissions for heroin, which were concentrated in the urban Atlanta area, constituted 5.7 percent of all admissions in the first half of 2010, compared with 4.9 percent in 2009. Heroin indicators (including deaths, ED reports, primary treatment admissions, and crime laboratory data) were reported as low and mostly stable in South Florida. Numbers of heroin-related deaths in the Miami-Dade County area, however, decreased from 33 in 2008, to 26 in 2009, to 5 in the first half of 2010.

- **Baltimore/Maryland/Washington, DC, Report.** Heroin indicators in the Baltimore/Maryland/Washington, DC, area were high and mixed in the first half of 2010, after increasing in 2009, yet heroin continued to be a major drug of concern in the area, particularly in Baltimore, according to the area representative. For instance, the percentage of drug items seized and identified as

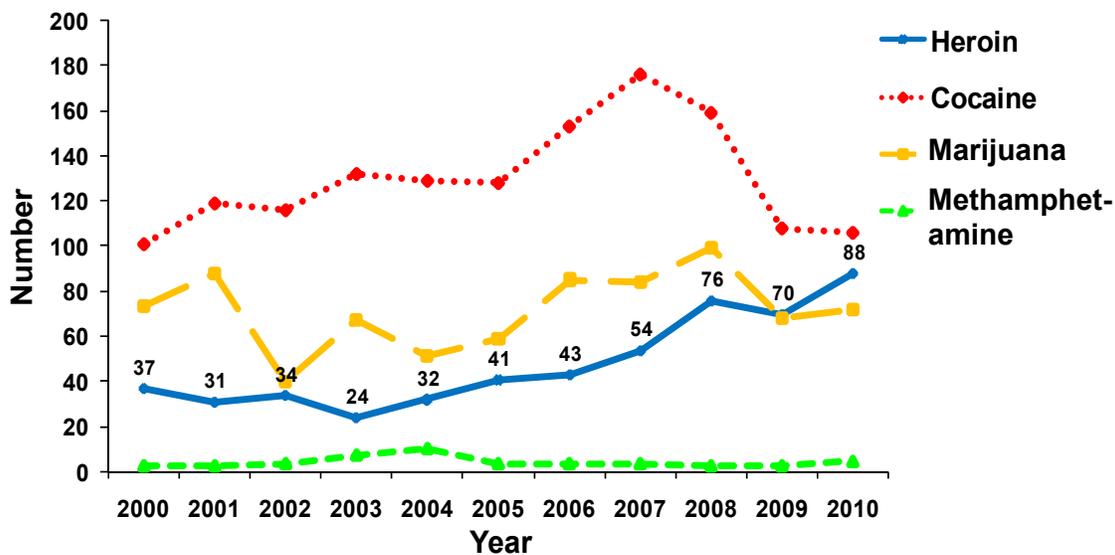
containing heroin in Maryland forensic laboratories was 17.9 percent of all items, compared with 7.1 percent for the Nation.

Midwestern Region CEWG Areas:

Heroin also continued as a major drug of concern in all CEWG areas in the Midwest.

- **Detroit Report.** Heroin indicators in Detroit were high and stable, according to the area representative. The weighted heroin-involved ED visit rate in the five-county Detroit area showed a significant increase from 2008 to 2009. Calls to the Poison Control Center at the Children's Hospital of Michigan about intentional use of heroin increased to an annualized estimate of 88 calls for 2010, compared with 70 calls in 2009 (figure 6). In the first half of 2010, however, the Wayne County Medical Examiner reported an annualized 170 deaths involving heroin, an estimate that represents a large decline from 245 deaths in 2009.

Figure 6. Number of Poison Control Center Calls on Human Intentional Use of Heroin and Selected Other Illicit Drugs, Eastern Michigan: CYs 2000–Estimated CY 2010¹



¹January–June 2010 data are annualized.

SOURCE: Michigan Poison Control Center, Children's Hospital of Michigan, as reported by Cynthia Arfken at the January 2011 CEWG meeting

- **Chicago Report.** Similarly, the Chicago area representative reported that heroin indicator levels were high and stable based on estimated ED visits, YRBS data for 2009, and NFLIS data for the first half of 2010.
- **Minneapolis/St. Paul Report.** While primary heroin treatment admissions fell slightly in the first half of 2010 in the Minneapolis/St. Paul area (from 8.0 percent in 2008 to 6.7 percent in the first half of 2010), the area representative reported that most indicators for heroin continued their upward trend and remained at heightened levels.
- **St. Louis Report.** In St. Louis, heroin indicators remained high and continued the recent upward trend as reported by the area representative. Anecdotal information from DEA and NDIC staff, as well as street reports from users, indicated that heroin use and availability increased in the first half of 2010. In addition, primary heroin treatment admissions increased by 20.0 percent from the first half of 2008 to the first half of 2010, exceeding admissions for marijuana as they did in 2009. Items identified as containing heroin constituted 13.7 percent of the drug items analyzed by forensic laboratories in the St. Louis area in the first half of 2010, compared with 11.6 percent of all items in 2009, continuing the increase over the past 2 years.
- **Cincinnati Report.** The Cincinnati area representative reported that heroin indicators remained at a moderate level in Cincinnati, with mixed indicators when compared with 2009. Treatment admissions for primary heroin and opiate/opioid abuse (which are combined in the Cincinnati area) remained relatively high, but data from the Cincinnati Drug and Poison Information Center showed a 25-percent decrease in reported human heroin exposure cases in 2010 (80 cases reported, compared with 106 in 2009). The area representative reported anecdotal information that some users were switching from cocaine to heroin because of the poor quality of available cocaine.

Northeastern Region CEWG Areas:

In the Northeast, area representatives continued to report relatively high levels of heroin indicators in New York City, Boston, and Philadelphia, although they were observed to be trending down in both New York City and Philadelphia. Heroin indicators in Maine continued at moderate levels, as was the case in 2009.

- **New York City Report.** Heroin remained a major problem in New York City, according to the CEWG area representative. Almost one-quarter of all primary treatment admissions there were for heroin, although the number of primary heroin treatment admissions declined to the lowest level since 1996 (admissions for heroin totaled 9,975 in the first half of 2010, compared with 11,242 in the second half of 2009). Estimated DAWN ED visits involving heroin decreased significantly (by 24 percent) from 2007 to 2009 and (by 20 percent) from 2008 to 2009 in New York City (figure 7)
- **Boston Report.** In Boston, heroin continued, along with cocaine, as a dominant drug of abuse, according to the area representative, although after years of increasing, indicators were reported as stable in the first half of 2010. Heroin was dominant as the primary drug in Boston area estimated DAWN ED visits in 2009. At a rate of 251 per 100,000 population in 2009, the Boston ED visit rate involving heroin was stable from the rate of 259 in 2008. Fifty-one percent of all treatment admissions were for heroin in FY 2010, the same percentage as in FY 2009. Heroin was cited most often among calls to the substance abuse helpline in Boston. Such calls remained stable from 2008 to 2010 at approximately 32 percent of all calls.
- **Maine Report.** Heroin remained a serious problem in Maine, but most indicators were stable or decreasing in the first half of 2010, according to the area representative. The number of arrests for heroin remained stable in 2010, but heroin/morphine-induced deaths were down (from 12 percent of drug-induced deaths

in 2008 to 7 percent in 2009 and an estimated 6 percent for 2010). Maine primary heroin treatment admissions declined from 16 percent of all admissions in the second half of 2009 to 12 percent in the first half of 2010.

- **Philadelphia Report.** In the first half of 2010, heroin indicators were mixed in Philadelphia, according to the area representative. Primary heroin treatment admissions as a percentage of all admissions increased (from 13.4 percent in 2009 to 15.1 percent in the first half of 2010), while deaths with the presence of heroin were reported by the Philadelphia area representative as declining in the first half of 2010.

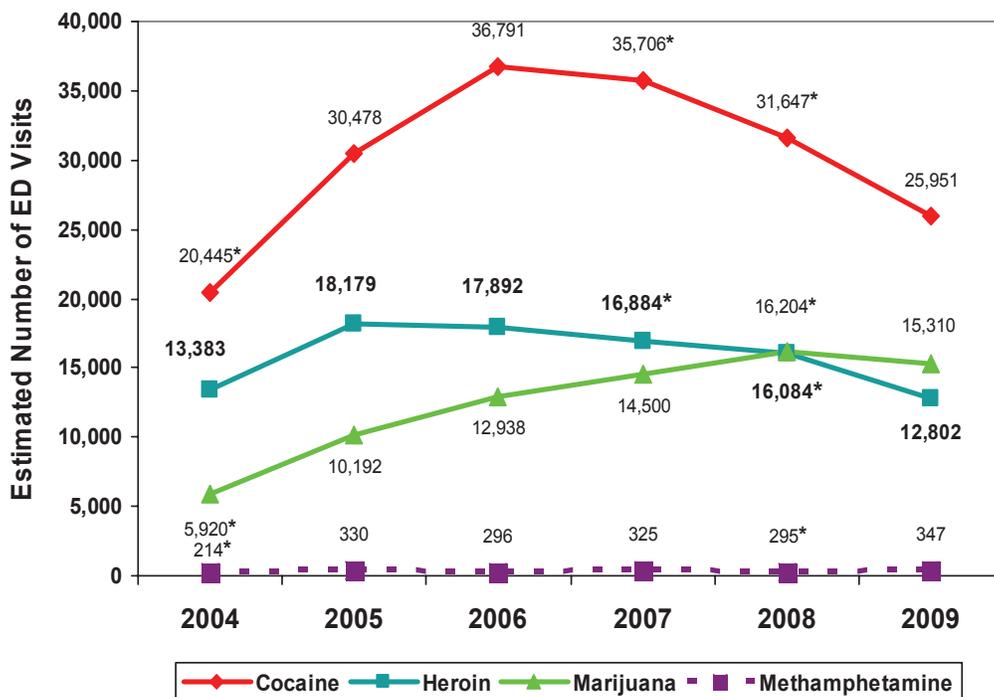
Other Highlights:

- **Seattle and St. Louis Reports.** A concern about heroin use in suburban and rural areas,

voiced by several area representatives at previous meetings, continued in this reporting period. The Seattle area representative reported continuing anecdotal information about heroin use in smaller cities and towns throughout the State of Washington. The area representative from St. Louis noted a continuing trend there of increasing deaths related to heroin in rural counties surrounding St. Louis, as well as younger heroin deaths.

- **Albuquerque/New Mexico and Texas Reports.** In New Mexico, heroin use as reported in youth survey data remained stable from 2008 to 2009. However, primary heroin treatment admissions were considerably younger in 2009 than in previous years (with a median age of 33.2 years), according to the area representative from Albuquerque. Similarly, an increase in Texas statewide treatment admissions for clients

Figure 7. Estimated Number of Drug-Related ED Visits for Heroin and Selected Other Illicit Drugs, by Drug Category, New York City: 2004–2009¹



¹Statistically significant changes are indicated by the symbol “*”, where the visits for a year are significantly different from visits for 2009. No significance testing of data for 2005 or 2006, compared with 2009, was available from CBHSQ.

SOURCE: Weighted DAWN, 2009, CBHSQ, SAMHSA, as reported by Rozanne Marel at the January 2011 CEWG meeting

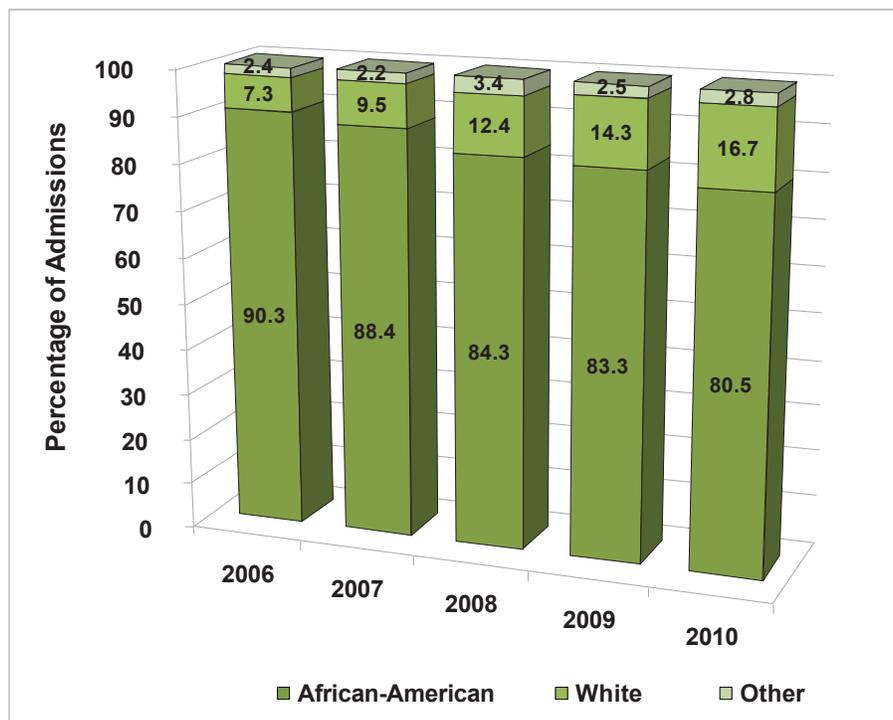
in their twenties was a concern in the first half of 2010, as reported by the area representative.

- **Detroit Report.** In Detroit, the proportion of heroin-related treatment admissions increased among Whites from FY 2006 to FY 2010, rising from 7.3 to 16.7 percent, while concomitant declines in African-American treatment admissions over the period were observed (figure 8).
- Heroin primary treatment admissions, as a percentage of total admissions, including primary alcohol admissions, were particularly high in Baltimore (approximately 54 percent) and Boston (approximately 51 percent) in the first half of 2010 (section IV, table 4). In Baltimore and Boston, heroin was the substance most frequently reported as the primary problem at treatment admission in the reporting period (table 2; appendix table 1). This represents a substantial change

in the heroin rankings, since three additional areas—Chicago, Detroit, and San Francisco—reported heroin as the most frequently abused drug among primary treatment admissions in 2009. Among Maryland, Detroit, St. Louis, and Phoenix substance abuse treatment admissions in the first half of 2010, heroin ranked in second place.

- In 10 of 23 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in NFLIS forensic laboratories in the first half of 2010. Proportions were highest in Baltimore and Maryland (approximately 24 and 18 percent, respectively). They were lowest in Honolulu and Atlanta, at 1.2 and 2.4 percent, respectively, of drug items identified (figure 23; appendix table 2). Heroin was not ranked first in drug items seized in any CEWG area, although it was ranked second in one area—St. Louis (table 1).

Figure 8. Percentage of Treatment Admissions With Heroin as the Primary Drug of Abuse by Race/Ethnicity, City of Detroit: FY 2006–FY 2010



SOURCE: Michigan Department of Community Health, as reported by Cynthia Arfken at the January 2011 CEWG meeting

- Data from the HDMP suggest that for CY 2009, South American heroin continued to be the primary type 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.
 - Average purity levels for South American heroin increased in 5 of 10 CEWG areas (Atlanta, Chicago, Detroit, St. Louis, and Washington, DC) from 2008 to 2009. They declined in five other areas—Baltimore, Boston, Miami, New York City, and Philadelphia. Average prices for South American heroin fell in 5 of 10 CEWG areas (Atlanta, Boston, Miami, St. Louis, and Washington, DC). They remained stable in one area (Chicago), and they rose in four areas (Baltimore, Detroit, New York City, and Philadelphia) (section IV, table 5).
 - From 2008 to 2009, Mexican heroin average purity declined in 9 of 11 CEWG areas, namely Denver, El Paso, Houston, Los Angeles, Minneapolis, Phoenix, San Diego, San Francisco, and Seattle, while average purity increased in Dallas and San Antonio. The average price for Mexican heroin was lower in 2009, compared with 2008, in 4 of 11 CEWG reporting areas (Dallas, Los Angeles, Minneapolis, and San Antonio), and it was higher in 7 areas (Denver, El Paso, Houston, Phoenix, San Diego, San Francisco, and Seattle) (section IV, table 6).

Opiates/Opioids Other than Heroin (Narcotic Analgesics)

The increase in indicators for opiates/opioids other than heroin (including narcotic analgesics) reported by CEWG area representatives in recent reporting periods persisted into the first half of 2010. Representatives from all CEWG areas reported stable, mixed, or increasing indicators; no area reported a decrease from previous reports. The primary prescription opioids appearing in indicator data across all regions continued

to be oxycodone and hydrocodone, although methadone was still reported as a problem in some CEWG areas, namely Phoenix, Seattle, San Francisco, Boston, Maine, and New York City. Nonmedical use of buprenorphine continued to be reported by area representatives from Chicago, Cincinnati, Detroit, Boston, Maine, and the Baltimore/Maryland/Washington, DC, areas.

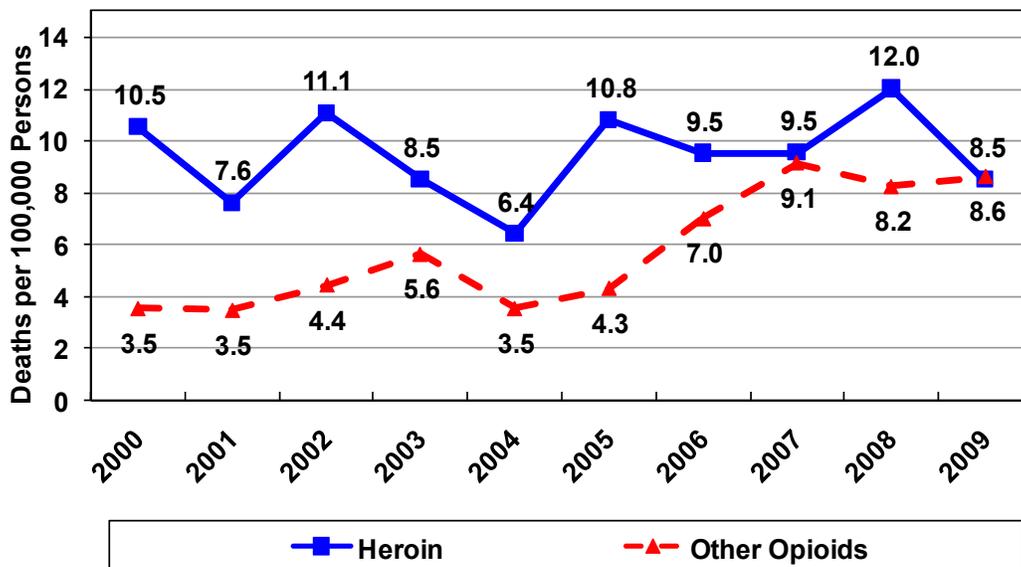
Western Region CEWG Areas:

All CEWG areas in the West reported stable or increasing indicators for narcotic analgesics. Increased indicators were reported by area representatives from Phoenix, Albuquerque, Texas, Denver, and Seattle. In San Francisco, indicators remained low but were showing possible slight increases, according to the area representative. Indicators in Los Angeles were reported as mixed but mostly up, and those in San Diego and Honolulu were reported as low and stable.

- **Phoenix Report.** In Phoenix, estimated DAWN ED visits involving nonmedical use of pharmaceutical opioids increased significantly, from 4,412 visits in 2008 to 5,883 in 2009. DAWN ED visits involving oxycodone, hydrocodone, and morphine showed statistically significant increases in 2009 over 2007.
- **Albuquerque/New Mexico Report.** Figure 9 illustrates an increase in “other opioid” overdose deaths in Albuquerque since 2004. With regard to specific opioids, while methadone and hydrocodone overdose death rates decreased from 2008 to 2009, there was a 28-percent increase in the overdose death rate from oxycodone. Oxycodone was the third leading cause of overdose death in 2009, behind heroin and cocaine. The number of hospitalizations with a primary diagnosis related to heroin and synthetic opiates increased from 341 in the first half of 2008 to 455 in the second half of 2009 in the State of New Mexico. The Albuquerque Drug Enforcement Administration cited controlled prescription drugs as the primary drug threat in the area in the first half of 2010.

- Texas Report.** In Texas, where the area representative reported increasing indicators for other opiates, hydrocodone indicators (deaths, calls to poison control, and drug items analyzed in forensic laboratories) exceeded oxycodone indicators. The “Houston Cocktail” (also called “The Holy Trinity”), a combination of hydrocodone, alprazolam, and carisoprodol, continued to be popular, according to the area representative.
- Denver/Colorado Report.** Denver area treatment admissions for other opioids have been gradually increasing since 2007 (when they constituted 5 percent of all admissions); they rose to 8 percent in the first half of 2009, and 9 percent in the first half of 2010. Other opioids were the most common drugs found in Colorado drug-related deaths from 2005 to 2009 (figure 10).
- Seattle Report.** The Seattle area representative reported that drug-caused deaths involving pharmaceutical opioids remained elevated. They remained the most common type of overdose
- death in the first half of 2010, representing 53 percent of such deaths in that area. The number and proportion of primary pharmaceutical opioid treatment admissions in the Seattle area also increased continuously from 2003 to the first half of 2010, although they remained less frequent than admissions for other major drugs of abuse.
- Los Angeles Report.** In Los Angeles, where indicators for other opiates were reported as mixed, treatment admissions for oxycodone as the primary drug of abuse increased from 184 in the second half of 2009 to 279 in the first half of 2010. Reports of opiates/opioids (other than heroin/morphine) also increased among coroner toxicology cases, from 808 cases in 2009 to 850 projected in 2010 (based on actual January to November data).
- San Diego Report.** Primary treatment admissions for narcotic analgesics in San Diego remained low and stable at 4 percent of all primary treatment admissions in that area.

Figure 9. Unintentional Drug-Specific Overdose Death Rates¹ for Other Opioid-Related Deaths, Compared With Heroin Deaths, Albuquerque, New Mexico: 2000–2009



¹Rates are age-adjusted to the 2000 U.S. Standard Population.

SOURCE: The New Mexico Office of the Medical Investigator, as reported by Nina Shah at the January 2011 CEWG meeting

Southern Region CEWG Areas:

In CEWG areas in the southern region of the country, indicators for opiates other than heroin and narcotic analgesics continued to be high and increasing.

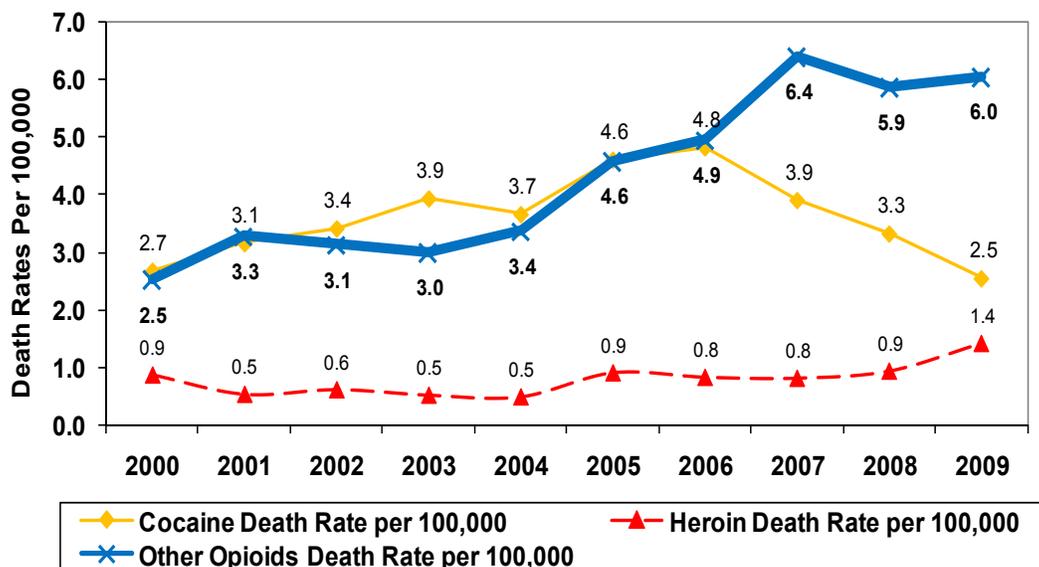
• Miami MSA/South Florida Report.

According to the area representative, most heroin-related deaths in South Florida also involved opioids, based on an analysis of Florida Medical Examiners Commission data by the Center for the Study and Prevention of Substance Abuse at Nova Southeastern University. This study found that in 59 percent of all heroin deaths in Florida during 2009, at least one prescription opioid was also detected at the time of death. Oxycodone continued as the most frequently reported opioid involved in nonmedical use in the South Florida area, according to the area representative, in the first half of 2010. Prescription opioid indicators remained stable at very high levels. There were increasing reports of injection drug use among nonmedical users of prescription opioids in the

first half of 2010 in Broward County, according to anecdotal information reported by the Broward County Public Defender's Office and the Broward County Drug Court staff.

- **Atlanta Report.** In Atlanta, indicators for both oxycodone and hydrocodone were reported as showing recent increases. Oxycodone-related treatment admissions increased in the first half of 2010 to 3.7 percent of all admissions, compared with 2.4 percent in 2009. Forensic laboratories in the Atlanta area reported an increase in the number of drugs seized and identified as containing either oxycodone or hydrocodone in the first half of 2010. The number of analyzed drug items identified as containing oxycodone increased from 339 in 2008, to 524 in 2009, to an annualized estimate of 764 in 2010 (based on 382 items identified in the first half of 2010). Similarly, the number of analyzed drug items identified as containing hydrocodone increased from 400 in 2008, to 515 in 2009, to an annualized estimate of 584 in 2010 (based on 292 items in the first half of 2010).

Figure 10. Other Opioids and Selected Other Drug-Related Death Rates (per 100,000 Population), Colorado: 2000–2009



SOURCE: Health Statistics Section, Colorado Department of Public Health and Environment, as reported by Kristen Dixon at the January 2011 CEWG meeting

- **Baltimore/Maryland/Washington, DC, Report.** Numbers of primary treatment admissions for other opiates were also on the rise in the Baltimore/Maryland/Washington, DC, area. For example, in Maryland, primary treatment admissions for other opiates continued their steady increase since 2006; they totaled 5,476 admissions in 2009 and 3,363 in the first half of 2010.

Midwestern Region CEWG Areas:

In the Midwest, indicators for opiates other than heroin were reported as stable in Detroit and increasing in Chicago, Cincinnati, Minneapolis/St. Paul, and St. Louis.

- **Detroit Report.** The area representative from Detroit reported that other opiates were more of a problem in the rest of the State than in the city of Detroit based on multiple indicators. The Detroit area representative also reported evidence that the Holy Trinity combination (hydrocodone, alprazolam, and clonazepam) that appeared in Texas also showed up in 57 cases reported to Poison Control Center at Children's Hospital of Michigan in the first half of 2010. The area representatives from Texas and Detroit reported this combination in their areas in 2009 also.
- **Minneapolis/St. Paul Report.** Primary treatment admissions for other opiates have increased steadily in the Minneapolis/St. Paul area since 2000, and they totaled 8.7 percent of total primary admissions (including alcohol) in the first half of 2010 (compared with 8.3 percent in 2009).
- **St. Louis Report.** Similarly, an increase in primary treatment admissions for other opiates was observed in the St. Louis reporting area, where such admissions increased to 205 in the first half of 2010, compared with 157 in the first half of 2009. Anecdotal information there, reported by the area representative, indicated a rise in the abuse of narcotic analgesics, particularly oxycodone, in the eastern region of the State, with a growing problem with prescription drug abuse in the rural areas surrounding the city of St. Louis.
- **Cincinnati Report.** In Cincinnati, where oxycodone and hydrocodone continued to be the most prevalent of the opioid pharmaceutical products reported as abused, the number of both of these drug items submitted for forensic analysis in the first half of 2010 exceeded those submitted for all of 2009.

Northeastern Region CEWG Areas:

Indicators for opiates other than heroin varied across the CEWG areas in the Northeast, from low but rising in New York City, to moderate and stable or increasing in Boston, to moderate and mixed in Philadelphia, and to high and increasing in the State of Maine, as reported by area representatives.

- **New York City Report.** Although prescription drug indicators remained relatively low in New York City, compared with other substances, many kinds of prescription drugs were available on the street and gaining in popularity, according to street study reports. Treatment admissions for other opiates remained low, but they increased in the first half of 2010 from 2009. Weighted DAWN ED visit data showed a 123-percent significant increase in visits involving nonmedical use of opiates/opioids in 2009 compared with 2004. Within that category, oxycodone, methadone, and hydrocodone all increased significantly in 2009 over 2004 levels, by 262 percent, 92 percent, and 49 percent, respectively.
- **Boston Report.** In Boston, primary treatment admissions for other opioids remained stable from previous reporting periods, at 4 percent of all admissions, but the number of admissions in FY 2010 ($n=862$) was the highest recorded in the past 10 years. The proportion of other opioid helpline calls climbed from 15 percent in FY 2008 to 19 percent in FY 2009, and to 22 percent in FY 2010 (figure 11). In addition, weighted DAWN estimates of opiate/opioid-involved ED visits increased significantly in the Boston area, by 6 percent from 2008 to 2009 and by 17 percent from 2007 to 2009.

- **Maine Report.** According to the Maine representative, prescription opioid indicators remained high in that State in 2010. Pharmaceutical-related arrests rose from 21 percent of all drug-related arrests in 2007 to 38 percent in 2010 (partial data are for January–October 2010). The percentage of treatment admissions for prescription opioids increased to 57 percent of all primary admissions (excluding primary alcohol admissions) in the State of Maine in the first half of 2010 (figure 12).
- **Philadelphia Report.** Numbers of primary treatment admissions for oxycodone increased in Philadelphia, from 10 admissions in 2007 to 410 in the first half of 2010, while other indicators there for prescription opioids remained stable from previous reporting periods.

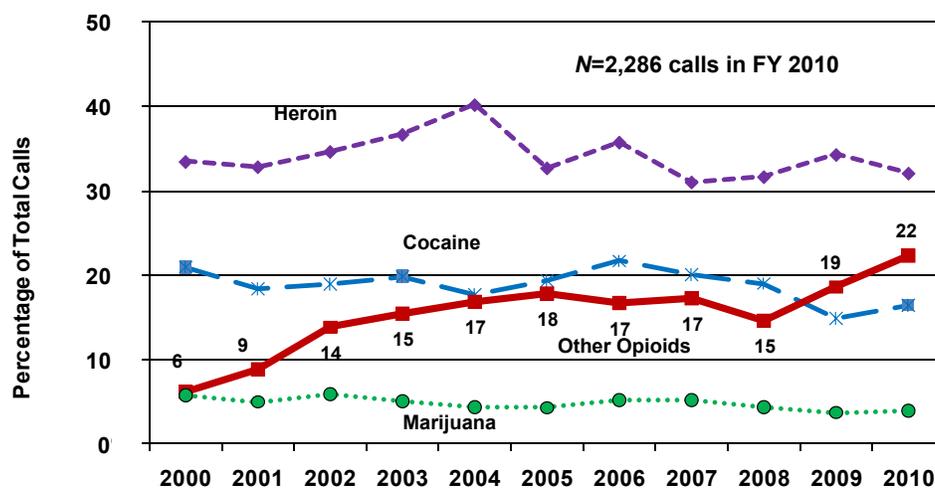
Other Highlights:

- **Buprenorphine** indicators were reported as increasing in several CEWG areas in the first half of 2010. Of the eight CEWG areas for which area representatives reported data on buprenorphine,

increased indicators were noted for the first half of 2010 in six areas, namely Boston, Maine, Baltimore and Maryland, Chicago, Cincinnati, and Detroit.

- **Baltimore/Maryland/Washington, DC, Report.** Drug items testing positive for buprenorphine in forensic laboratories increased in the State of Maryland. In the first half of 2010, 463 items were identified as containing buprenorphine, compared with 368 items in the first half of 2009. According to the area representative, probationers/parolees interviewed as participants in a pilot study designed to collect information about the use of buprenorphine in neighborhoods across the city of Baltimore reported on buprenorphine patterns. They stated that buprenorphine was easily available in Baltimore neighborhoods and is purchased on the street to self-medicate.
- **Detroit, Chicago, and Cincinnati Reports.** In the Midwest, buprenorphine was reported as a pharmaceutical opioid

Figure 11. Percentage of Helpline Drug Mentions Involving Other Opioids and Selected Other Illicit Drugs, Greater Boston: FY 2000–FY 2010¹



¹FY 2010 runs from July 1, 2009, through June 30, 2010. Greater Boston includes Boston, Brookline, Chelsea, Revere, and Winthrop (CHNA 19).

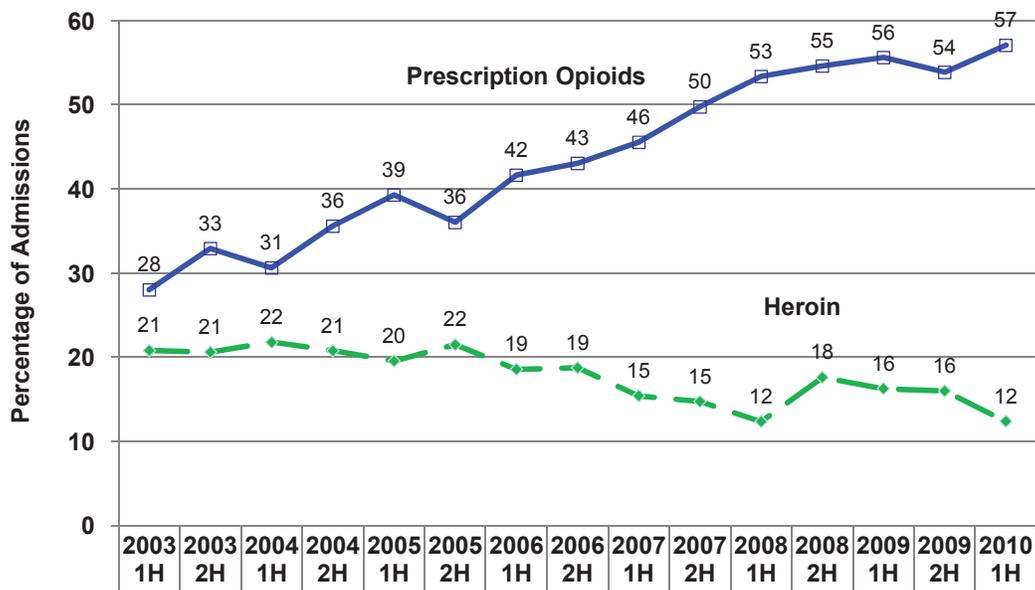
SOURCE: Massachusetts Substance Abuse Information and Education Helpline, as reported by Daniel P. Dooley at the January 2011 CEWG meeting

drug of concern by Detroit, Chicago, and Cincinnati area representatives. In the first half of 2010, buprenorphine appeared for the first time in the top 10 drugs detected in forensic laboratories among items seized in Detroit. It also continued to climb the NFLIS rankings in Chicago, where buprenorphine was second in the first half of 2010 among the top four opioids identified in forensic laboratories, behind hydrocodone and ahead of methadone and oxycodone (in 2009, buprenorphine was third behind hydrocodone and methadone). The area representative reported continuing ongoing use of the drug in the Chicago area to avoid withdrawal or to better manage an addiction to heroin. In Cincinnati, calls to poison control involving buprenorphine-containing pharmaceuticals continued to increase, with a 60-percent increase in human exposure calls from 2009 to 2010, and with some increase in cases suspected as intentional abuse of the drug. In addition, the number of drug items

submitted for forensic analysis that contained buprenorphine increased by nearly 116 percent in the first half of 2010 from the previous year.

- o **Boston and Maine Reports.** In the Northeast, the Boston area representative reported a statistically significant 39-percent increase in estimated buprenorphine-involved DAWN ED visit rates from 2008 to 2009. Buprenorphine diversion was identified as an emergent problem in Maine in 2010, according to the area representative. Figure 13 shows the percentage of buprenorphine among other selected opioids that was identified in impaired drivers' urinalysis results. Buprenorphine-positive test results rose from approximately 2 percent in 2006–2008, to approximately 7 percent in 2010. Poison center calls to the Northern New England Poison Center for medication identification showed an increase in buprenorphine identifications from 57 in 2005, to 154 in 2009, and to 334 in 2010.

Figure 12. Percentage of Primary Treatment Admissions with Primary Substance Abuse Problems With Heroin and Prescription Opioids (Narcotic Analgesics), Maine: 1H 2003–1H 2010



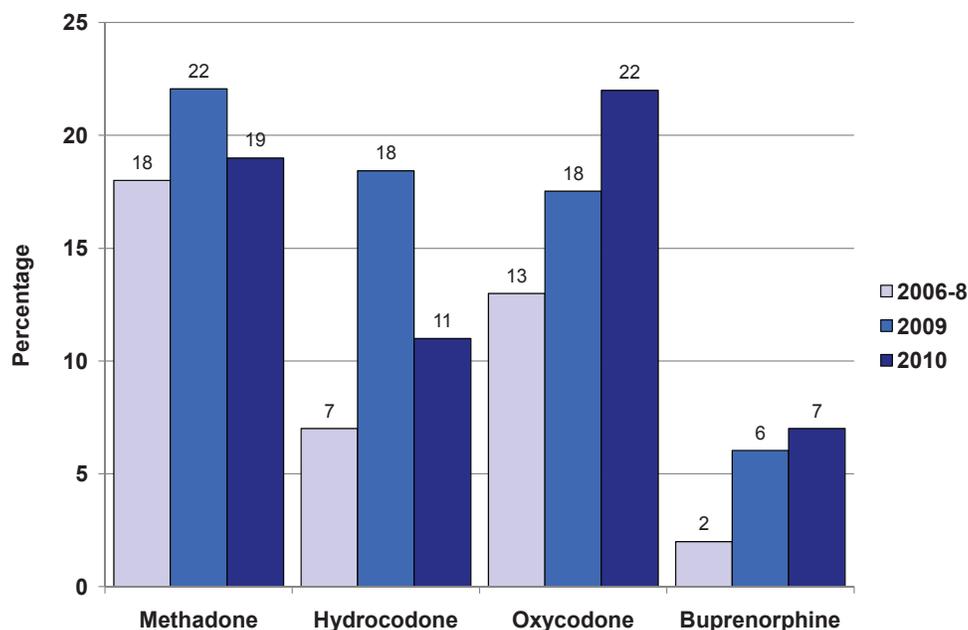
SOURCE: Maine Office of Substance Abuse, as reported by Marcella Sorg at the January 2011 CEWG meeting

- Qualitative reports in some CEWG areas of the abuse of **codeine** continued into the first half of 2010.
 - The Texas area representative reported anecdotal evidence suggesting the popularity of dipping joints in promethazine with codeine cough syrup, as well as drinking “Syrup” (soft drinks laced with codeine cough syrup).
- **Methadone** continued to appear in drug abuse indicators across the CEWG areas, with several areas reporting increases in indicators.
 - **Seattle Report.** According to the area representative, methadone-related deaths continued to be a concern in Seattle, where the most common pharmaceutical opioids involved in deaths in that area were methadone and oxycodone.
 - **Maine Report.** The Maine area representative reported similar findings. Narcotic

analgesics caused 74 percent of overdose deaths in the first half of 2010 in Maine, with the most frequently identified drugs being methadone and oxycodone, as in 2008 and 2009.

- **San Francisco Report.** Although the percentages remained very low compared with the proportions of other admissions, treatment admissions for clients enrolled in methadone maintenance programs in San Francisco increased from FY 2008 (0.3 percent) to FY 2009 (0.6 percent).
- **Detroit, Boston, and New York City Reports.** The area representatives from Detroit, Boston, and New York City reported increases in estimated methadone-involved ED visits in 2009, compared with 2008, in Detroit and Boston and from 2004 to 2009 and 2007 to 2009 in New York City.

Figure 13. Percentage of Selected Opioids Identified in Urinalyses of Impaired Drivers, Maine: 2006–2008 Through 2010



SOURCE: Maine Health and Environmental Testing Laboratory, as reported by Marcella Sorg at the January 2011 CEWG meeting

- Methadone-related indicators, however, decreased in some areas.
 - **Albuquerque/New Mexico and Cincinnati Reports.** Deaths related to methadone decreased in Albuquerque (where the death rate for methadone declined from 4.1 per 100,000 persons in 2008 to 1.9 in 2009), and methadone-related calls to the Cincinnati Drug and Poison Information Center decreased from 64 in CY 2009 to 48 in CY 2010.
- **Fentanyl** continued to show up in indicators in several CEWG areas, but numbers were still small and generally decreasing.
 - **St. Louis, Cincinnati, Detroit, and Minneapolis/St. Paul Reports.** Fentanyl did, however, emerge in death data in St. Louis County, as well as surrounding counties, according to the St. Louis area representative. It also continued to appear in death data and poison control call data in the Cincinnati area, and area representatives from Detroit and Minneapolis/St. Paul reported increases in estimated fentanyl-involved ED visits from 2008 to 2009.
- **Tramadol**, an opioid analgesic used to treat pain, surfaced as a drug of concern in the Midwest.
 - **Detroit and Minneapolis/St. Paul Reports.** Tramadol was reported as a drug of concern in two CEWG areas in the Midwest, Detroit and Minneapolis/St. Paul. In Detroit, significant increases in estimated DAWN ED visits involving nonmedical use of tramadol occurred in 2009.

Additional Highlights:

- In the first half of 2010, treatment admissions for primary abuse of **opiates other than heroin** as a percentage of total admissions, including primary alcohol admissions, ranged from approximately 2 to approximately 11 percent in 16 of 18 reporting CEWG areas. The outlier was Maine, where nearly 32 percent of primary treatment admissions were for other opiate problems (section IV,

table 7; appendix table 1). While none of the 18 CEWG reporting areas ranked other opiates as being first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions, other opiates ranked second in Maine, and third in Broward County and Minneapolis/St. Paul (table 2).

- Of total drug items identified in forensic laboratories in 23 CEWG areas, **oxycodone and hydrocodone** often appeared in the top 10 ranked drug items in terms of frequency in the first half of 2010. In Atlanta and Maine, oxycodone ranked third among drug items identified, and it ranked fourth in five other CEWG areas—Boston, Cincinnati, Miami, Maryland, and Philadelphia (table 1). Hydrocodone ranked fourth among drug items identified in Atlanta and Detroit (table 1; section IV, table 8).
- **Buprenorphine** ranked 4th in identified NFLIS drug items in Baltimore; 5th in Boston, Maine, and Maryland; 7th in Seattle; 8th in Detroit and Washington, DC; 9th in New York City and San Diego; and 10th in Albuquerque and Philadelphia in the first half of 2010 (table 1; section IV, table 8).
- **Methadone** ranked in the top 10 identified drugs in New York City (7th); San Francisco (8th); and Baltimore, Maine, and Maryland (10th each) during this reporting period (table 1; section IV, table 8).

Benzodiazepines/Depressants

Indicators for benzodiazepines across all CEWG regions continued to be stable, mixed, or increasing during the first half of 2010 for the 15 out of 21 CEWG areas that reported on them. Alprazolam continued to be the most frequently identified benzodiazepine in the NFLIS data reported in this period.

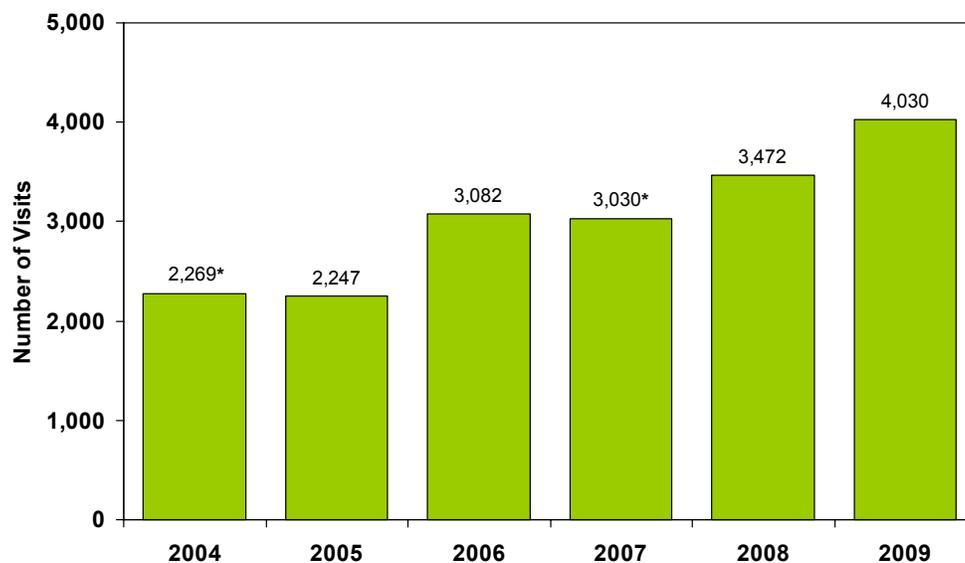
Western Region CEWG Areas:

- **Phoenix Report.** In the CEWG areas in the western region, estimated benzodiazepine-involved ED visits increased in 2009, compared

with 2004 and 2007, in Phoenix (figure 14). In Albuquerque, overdose deaths and inpatient hospitalizations for the broad class of sedative/tranquilizers (including alprazolam) increased from 2008 to 2009.

- **Los Angeles Report.** Los Angeles indicators for benzodiazepines were reported as mixed. While benzodiazepines, tranquilizers, and sedatives together accounted for a very small percentage (0.5 percent) of all treatment admissions in Los Angeles, they increased slightly in numbers from 72 in the second half of 2009 to 80 in the first half of 2010. These types of drugs were present in 12 percent of Los Angeles coroner toxicology cases, which was a decrease from 16 percent in 2009.
- **Denver/Colorado Report.** The Denver area representative reported very small numbers of treatment admissions for the primary abuse of benzodiazepines, and the few benzodiazepine indicators were relatively stable.
- **Seattle Report.** In Seattle, benzodiazepines were present in 22 percent of drug-caused deaths, and they were almost always detected in combination with other drugs.
- **Miami MSA/South Florida Report.** Benzodiazepine indicators in the Miami MSA/South Florida area remained at relatively high levels, but they were observed to have stabilized in the first half of 2010. Benzodiazepine-related deaths decreased in the first half of 2010 from the second half of 2009 (down by 18 percent in Miami-Dade County and by 38 percent in Broward County). Estimated DAWN ED visits involving benzodiazepines increased in 2009 over 2008 in Broward County.
- **Atlanta Report.** Elsewhere in the South, indicators for alprazolam remained stable in Atlanta. Alprazolam accounted for 1.2 percent of primary treatment admissions in Atlanta in 2009, compared with 1.4 percent in the first half of 2010. Alprazolam-containing drug items analyzed in forensic laboratories were also stable in Atlanta,

Figure 14. Number of Estimated DAWN ED Visits Involving Benzodiazepines, Phoenix: 2004–2009¹



¹Statistically significant differences in estimated visits are indicated by the use of the symbol, “*”, next to the count for each year that differs significantly from 2009. No significance testing of data for 2005 or 2006, compared with 2009, was available from CBHSQ. SOURCE: Weighted DAWN, 2009, CBHSQ, SAMHSA, as reported by James Cunningham at the January 2011 CEWG meeting

with 582 estimated drug items in 2010 (based on annualizing 291 cases in the first half of 2010), compared with 583 in 2009.

Midwestern Region CEWG Areas:

Increases in benzodiazepine-related indicators were reported in some areas of the Midwest.

- **Detroit Report.** In Detroit, weighted DAWN alprazolam-involved visits and clonazepam-involved visits increased significantly for females from 2008 to 2009 (41 and 61 percent, respectively). Clonazepam-involved weighted DAWN visits also increased significantly for males from 2008 to 2009 (33 percent).
- **Chicago Report.** Weighted benzodiazepine-involved DAWN ED visit rates showed a statistically significant increase in Chicago in 2009 compared with 2004.
- **St. Louis Report.** The St. Louis area representative reported that primary treatment admissions for benzodiazepines in that area increased by two-thirds from the first half of 2008 ($n=25$) to the first half of 2009 ($n=42$) and to the first half of 2010 ($n=31$).
- **Cincinnati Report.** In Cincinnati, human exposure cases involving alprazolam and clonazepam reported to the Cincinnati Drug and Poison Information Center remained relatively stable during 2010, compared with 2009, although they continued at a high level.

Northeastern Region CEWG Areas:

- **New York City Report.** In the Northeast, the area representative from New York City reported a 63-percent statistically significant increase in weighted DAWN ED visit rates involving benzodiazepines as a category from 2004 to 2009. Within that category, alprazolam visit rates increased by 79 percent over the 6-year period.
- **Maine Report.** Benzodiazepines continued to play a substantial role in Maine drug problems in 2010, according to the area representative. Benzodiazepines caused 31 percent of drug-induced

deaths in Maine (up from 12 percent in 2000), usually as co-intoxicants in narcotic deaths. Impaired driver urinalyses in 2010 included 40 percent positive for one or more benzodiazepine—17 percent were for alprazolam, and 5 percent were for clonazepam. Primary treatment admissions for benzodiazepines were estimated to increase slightly in Maine in 2010, with 99 admissions in 2009 and 102 admissions in 2010 (annualized from 51 in the first half of 2010).

- **Philadelphia Report.** While the use of benzodiazepines in Philadelphia was lower than use of marijuana, alcohol, cocaine, or heroin, it continued to be common in conjunction with other drugs, according to the area representative. Alprazolam was the most widely used benzodiazepine in Philadelphia, ranking third among all deaths in Medical Examiner toxicology reports when the cause of death was drug intoxication.
- **Boston Report.** All indicators were reported as remaining stable at a moderate level in Boston for benzodiazepines in FY 2010.

Other Highlights:

- Texas and Atlanta had the highest percentages of alprazolam drug items identified in forensic laboratories in the first half of 2010, at 5.7 and 4.9 percent, respectively (section IV, table 9). Alprazolam ranked third in frequency among the top 10 drug items identified in forensic laboratories in Miami; fourth in New York City and Texas; fifth in Atlanta, Detroit, Philadelphia, and St. Louis; and sixth in Baltimore, Cincinnati, Maryland, and Phoenix (table 1).
- Drug items containing clonazepam accounted for 2.6 percent of all drug items in Boston, where clonazepam was the sixth most frequently identified drug in forensic laboratories in the first half of 2010 (table 1; section IV, table 9).
- Diazepam ranked 10th in Miami, San Diego, and San Francisco among drug items identified in NFLIS forensic laboratories in the first half of 2010 (table 1).

Methamphetamine

Methamphetamine indicators continued to be more prominent in the West than in any other region of the country. While many area representatives in the western region of the country had reported declining indicators for methamphetamine in 2008 and 2009, including Denver, Phoenix, San Diego, and San Francisco, some indicators appeared to be stabilizing or increasing in the first half of 2010 in these areas.

Western Region CEWG Areas:

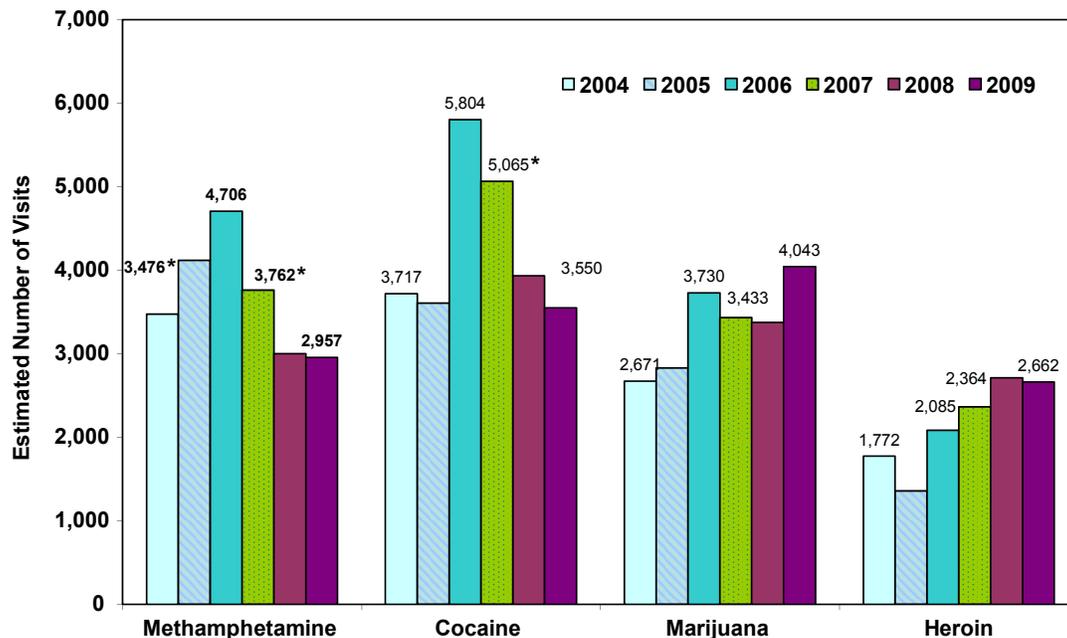
Six CEWG area representatives in the West—Albuquerque, Denver, Honolulu, Los Angeles, Phoenix, and San Francisco—reported stable and mixed indicators for methamphetamine. In three areas—Texas, San Diego, and Seattle—indicators were seen as increasing or stabilizing.

- **Phoenix Report.** Methamphetamine was still a prominent drug in Phoenix, and most

indicators there were flat or slightly increasing, as reported by the area representative. Consistent with this, estimated numbers of DAWN ED visits involving methamphetamine changed little from 2008 to 2009 (figure 15). Seizures of clandestine methamphetamine laboratories remained low, with only 9 seized in the first half of 2010, compared with 29 in 2009.

- **Albuquerque/New Mexico Report.** In Albuquerque, where indicators were reported as mixed, methamphetamine as a drug threat was considered to be moderate to high in 2010, according to the area representative. Most methamphetamine in New Mexico came from Mexico through California and Arizona, but local production was reported by the area representative as being popular in Albuquerque.
- **Los Angeles Report.** Methamphetamine indicators continued to be relatively high in Los Angeles. According to the area representative,

Figure 15. Estimated Number of DAWN ED Visits Involving Methamphetamine¹ and Other Major Illicit Drugs, Phoenix: 2004–2009



¹Statistically significant differences in estimated visits are indicated by the use of the symbol, “*”, next to the count for each year that differs significantly from 2009. Significance testing was not available from CBHSQ for 2005 or 2006 data, compared with 2009 data. SOURCE: Weighted DAWN, 2009, CBHSQ, SAMHSA, as reported by James Cunningham at the January 2011 CEWG meeting

methamphetamine remained the primary drug of concern for law enforcement agencies in the Los Angeles County region. However, indicators for methamphetamine were mixed for this reporting period. For example, in Los Angeles, while the number of primary treatment admissions for methamphetamine declined somewhat in the first half of 2010 over 2009, the number of drug items seized and identified in forensic laboratories as containing methamphetamine increased. Coroner toxicology cases testing positive for methamphetamine (representing 14 percent of positive tests) also increased in 2010 (402 cases) over 2008 levels (359 cases).

- **San Francisco Report.** Following a decline that began in 2006 and continued into the 2009 reporting period, indicators for methamphetamine were reported as stable and mixed in the San Francisco area. Primary methamphetamine admissions were stable (in San Francisco County) or down (in counties surrounding San Francisco), but drug items seized and identified as containing methamphetamine in forensic laboratories increased (from 17.3 percent in 2008 to 24.7 percent in the first half of 2010). Weighted methamphetamine-involved DAWN ED visits for the five-county San Francisco area were also up by 9 percent from 2007 to 2009.
- **Denver/Colorado Report.** In Colorado, methamphetamine remained one of the top five drugs of concern, according to the area representative, and indicators there were seen as mixed. Primary treatment admissions for methamphetamine declined in the Denver metropolitan area to 18 percent of all admissions in the first half of 2010, from a high of 23 percent in the first half of 2007. The proportions of drug items seized and analyzed in forensic laboratories that contained methamphetamine remained relatively stable in Denver in the first half of 2010, at 15 percent of all drug items, compared with 13 percent in 2009 (ranking third amount all drug items in both reporting periods). The area representative reported high methamphetamine purity levels in the Denver area, where much of the drug is supplied by Mexican drug trafficking organizations.
- **Honolulu/Hawaii Report.** The increases in methamphetamine indicators reported by the Honolulu area representative in 2009 were seen as having stabilized during this 2010 reporting period. Treatment admissions in the State of Hawaii, when annualized for 2010, were projected to return to 2008 levels. Deaths on the island of Oahu in which methamphetamine was detected in toxicology screens were relatively stable at an annualized estimate of approximately 76 for 2010 (based on 38 cases in the first half of 2010), compared with 73 such deaths in 2009. Methamphetamine-related arrests in Honolulu, however, had risen, from 337 in 2009 to a 2010 estimate of approximately 480 (based on annualization of the 242 reported arrests reported in the first half of 2010).
- **Texas Report.** Methamphetamine indicators in Texas were starting to increase in the first half of 2010, according to the area representative, reversing a downward trend that began in 2006.
- **San Diego Report.** Similarly, methamphetamine indicators in the San Diego area were reported as showing some increases, reversing a decline that began there in 2005. The prevalence of test-positives for methamphetamine among female arrestee urinalysis results was 38 percent in 2009, compared with 31 percent in 2008. Among male arrestees, it was 22 percent in 2009, compared with 20 percent in 2008. Proportions of primary treatment admissions for methamphetamine were relatively stable in the first half of 2010, at 29 percent of all admissions (figure 16). Percentages of drug items identified as containing methamphetamine from State and local drug seizures analyzed in forensic laboratories were also stable in the first half of 2010, at 19.8 percent (compared with 20.2 percent in CY 2009 and 20.0 percent in CY 2008).
- **Seattle Report.** Methamphetamine indicators that had been mostly stable in previous reporting periods in Seattle were showing increases from the area representative's perspective.

While treatment admissions for primary methamphetamine remained stable, statewide death and motor vehicular data showed increased indicators. In Washington State, the presence of methamphetamine identified in the toxicology of decedents increased from 221 to 236 deaths for the 12-month FY periods ending in June 2009 and June 2010 respectively. Over this same time period, DUIs (Driving Under the Influence) in which methamphetamine was detected increased substantially, from 387 to 499 cases.

Southern Region CEWG Areas:

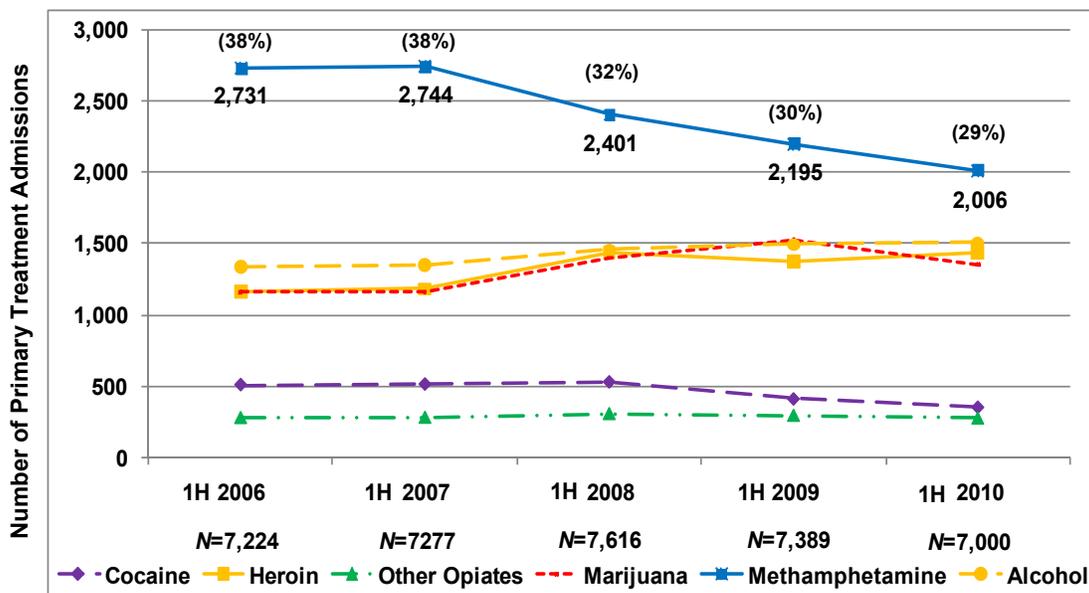
All CEWG areas in the southern region of the United States continued to report low indicators for methamphetamine.

- **Atlanta Report.** In Atlanta, methamphetamine remained at stable levels during the first half of 2010. However, drugs seized and identified by forensic laboratories as containing

methamphetamine showed an increase in Atlanta in the first half of 2010. This continues a trend that began in 2009. Proportions of treatment admissions for primary methamphetamine in the Atlanta area have been stable at approximately 6 percent since 2008 and were relatively evenly geographically distributed across the metropolitan area.

- **Miami MSA/South Florida Report.** Consequences indicators for methamphetamine remained very low in the Miami/South Florida area; however, the number of methamphetamine-related deaths increased by 25 percent statewide, from 39 in the last half of 2009 to 49 in the first half of 2010.
- **Baltimore/Maryland/Washington, DC, Report.** Methamphetamine indicators also remained relatively low in both Maryland and Washington, DC, and were reported by the area representative as confined to isolated communities.

Figure 16. Number (and Percentage) of Primary Methamphetamine Treatment Admissions, Compared With Selected Other Primary Drug Admissions, San Diego: January–June (1H), 2006–2010



SOURCE: California Outcomes Measurement System (CalOMS)/California Alcohol and Drug Data System (CADDs), as reported by Robin Pollini at the January 2011 CEWG meeting

Midwestern Region CEWG Areas:

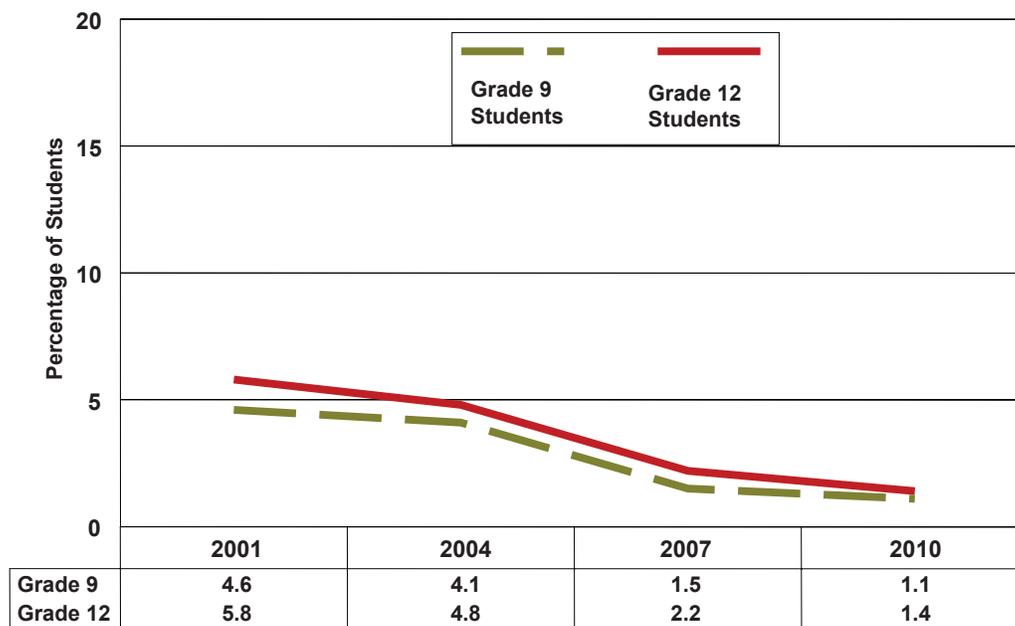
Methamphetamine indicators were also relatively low in the Midwest, although the drug continued to be an important one to monitor in that region, according to area representatives.

- **St. Louis Report.** In the St. Louis area, methamphetamine remained a drug of concern in rural areas according to the area representative. While the bulk of the available methamphetamine in the area was believed to have been imported from Mexico, clandestine methamphetamine laboratories continued to be numerous. Based on anecdotal evidence, local “cooks” continued to develop creative ways of networking to gain access to the chemicals needed to make methamphetamine. St. Louis continued to rank first in the country in the number of small clandestine methamphetamine laboratories.
- **Cincinnati Report.** Use of methamphetamine in Cincinnati remained low in the first half of

2010 relative to other drugs, but cases of human exposure called into the Cincinnati Drug and Poison Information Center increased by 67 percent, and the number of clandestine laboratory seizures increased in the first half of 2010 over comparable 2008 and 2009 levels.

- **Minneapolis/St. Paul Report.** The area representative from Minneapolis/St. Paul reported continuing downward trends for methamphetamine indicators in the Twin Cities area. Estimated numbers of methamphetamine-involved ED visits in Minneapolis decreased significantly from 1,741 in 2004 to 970 in 2009. Past-year use of methamphetamine reported by Minnesota 12th graders also declined, from 5.8 percent in 2001 to 1.4 percent in 2010 (figure 17). In the first half of 2010, proportions of primary methamphetamine treatment admissions represented 6.3 percent of all admissions in the Minneapolis metropolitan area, compared with 6.0 percent in 2009 (down from approximately 12 percent in 2005).

Figure 17. Self-Reported Past-Year Methamphetamine Use Prevalence Among Minnesota Students: 2001–2010



SOURCE: Minnesota Student Survey, 2010, as reported by Carol Farkowski at the January 2011 CEWG meeting

- **Detroit Report.** All indicators for methamphetamine remained relatively low in Detroit. Based on information from a law enforcement focus group conducted by the area representative, methamphetamine was considered more of a problem in the western side of the State than in the urban Detroit area.
- **Chicago Report.** Similarly, methamphetamine-related treatment admissions were reported as more common in the “downstate” region of Illinois than in urban Chicago.

Northeastern Region CEWG Areas:

All CEWG area representatives in the four Northeast areas—New York City, Boston, Maine, and Philadelphia—continued to report methamphetamine indicators as low in the first half of 2010.

- **New York City Report.** In New York City, proportions of primary methamphetamine treatment admissions and drug items analyzed by NFLIS as containing methamphetamine remained at very low levels. According to street reports, there was very little methamphetamine street selling activity in the city, although the drug was still available to users. Estimated DAWN ED visits involving methamphetamine, however, showed a significant increase (63 percent) from 2004 to 2009 in the five boroughs of New York.
- **Boston and Philadelphia Reports.** Similar relatively low indicator levels were reported for the Boston and Philadelphia areas. In Boston, methamphetamine represented less than 1 percent of all estimated ED visits, treatment admissions, helpline calls, and drug laboratory samples analyzed in 2009 and in the first half of 2010.
- **Maine Report.** The area representative from Maine also continued to report very small numbers for methamphetamine indicators, along with a mixed picture of change, based on primary treatment admissions, arrests, and drug items containing methamphetamine identified in forensic laboratories. There was a very slight increase in methamphetamine arrests, from 3 percent in 2009 to 4 percent in 2010, with most arrests occurring near the Canadian border. The number of primary methamphetamine treatment admissions remained low and stable, with an estimated 36 admissions in 2010 (annualized from 18 in the first half of 2010), compared with 33 in 2009. A majority (54 percent) of the methamphetamine forensic samples identified were tablets, similar to 2009, according to the area representative.

Other Highlights:

- Because methamphetamine is synthetic and must be manufactured, several methods to produce it are used. The popularity of certain production methods depends, among other factors, on the availability of precursors in a specific area. The P2P (phenyl-2-propanone) production method has become more common recently because pseudoephedrine is no longer available in Mexico and is only available in small quantities in the United States. The P2P precursors have been controlled in the United States since the early 1980s, but the ingredients are available in Mexico. Most of the methamphetamine samples currently examined in DEA laboratories are made with the P2P process.
 - **Texas Report.** The Texas area representative reported that most of the methamphetamine in that State came from Mexico, where it was made using a refined P2P process. This process can produce methamphetamine that is nearly as potent as the d-methamphetamine made with pseudoephedrine.
- Prices for methamphetamine were down in several areas in the western region, including Phoenix, Los Angeles, Albuquerque, and San Diego.
 - **Los Angeles Report.** In Los Angeles, for example, the wholesale price of crystal methamphetamine was \$14,000 per pound in the fourth quarter of 2009, compared with \$9,000–\$13,000 per pound in the third quarter of 2010.
 - **Albuquerque/New Mexico Report.** In Albuquerque, the wholesale price of

Mexican “ice” decreased from \$26,000–\$28,000 per kilogram in December 2008 to \$18,000–\$20,000 per kilogram in June 2009.

- o **San Diego Report.** Finally, in San Diego, the price per pound was \$9,000–\$12,000 in 2009, compared with \$10,000–\$20,000 in 2007.

Additional Highlights:

- The proportions of primary treatment admissions, including primary alcohol admissions, for methamphetamine in 18 reporting CEWG areas in this 2010 reporting period were especially high in Hawaii and San Diego, at approximately 36 and 29 percent, respectively. They were also relatively high in Phoenix and San Francisco, at approximately 18 and 16 percent, respectively (section IV, table 10; appendix table 1). Methamphetamine ranked first in treatment admissions as a percentage of total admissions in Hawaii and San Diego; third in Colorado, Denver, Phoenix, and San Francisco; fourth in Los Angeles; and fifth in Atlanta, Minneapolis/St. Paul, St. Louis, and Seattle (table 2).
- In the first half of 2010, methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in Honolulu and Minneapolis/St. Paul; second in Atlanta, Phoenix, San Diego, and San Francisco; and third in four CEWG areas—Albuquerque, Denver, Los Angeles, and Texas (table 1). The largest proportions of methamphetamine items identified were reported in Honolulu (close to 45 percent), followed distantly by San Francisco (approximately 25 percent), and Atlanta and Minneapolis/St. Paul (approximately 24 percent each). In contrast, less than 1 percent of drug items identified as containing methamphetamine were reported in nine CEWG metropolitan areas east of the Mississippi: Baltimore, Boston, Chicago, Cincinnati, Detroit, Maryland, Miami, New York City, and Philadelphia (figure 23; appendix table 2).

Marijuana/Cannabis

All 21 CEWG areas continued to report high levels for marijuana indicators in the first half of 2010 as in previous periods, and marijuana continued to be reported as widely available across all areas. The Boston area representative reported some moderation in marijuana arrests and forensic laboratory data, which was attributed to a 2009 change in Massachusetts marijuana laws that affected arrests and drug seizure activity. Most area representatives reported increasing, stable, or mixed indicators, but the area representative from Philadelphia reported that indicators there could be decreasing slightly.

Western Region CEWG Areas:

Marijuana remained a major drug of abuse in the western CEWG areas. All nine CEWG area representatives in the West reported continuing high marijuana indicators, which were described as stable, increasing, or mixed. Marijuana indicators were high and stable or mixed in Albuquerque, Hawaii, Los Angeles, San Diego, San Francisco, Seattle, and Texas. They were high and increasing in Denver, and they were mostly increasing in Phoenix, as reported by the area representatives.

- **Denver/Colorado Report.** Excluding alcohol, marijuana continued to be the most common primary drug of abuse among treatment admissions both statewide in Colorado and in the greater Denver area, and the supply and demand for marijuana continued to be very high, according to the area representative. Marijuana represented the highest percentage of treatment admissions (excluding alcohol) in the State (at 39 percent) and in the Denver area (at 41 percent) in the first half of 2010. Marijuana ranked first in 2009 in Colorado drug-related hospital discharges, with both the number and rate increasing over 2008 (4,451 marijuana-related discharges in 2009, compared with 4,256 in 2008). Marijuana/cannabis continued to rank second, behind cocaine, in proportion of drugs seized and identified in forensic laboratories in Denver in the first half of 2010, increasing slightly from 26.4 percent of all drugs in 2009 to 27.1 percent in the first half of 2010.

- **Phoenix Report.** The Phoenix area representative reported that primary marijuana treatment admissions in Maricopa County remained stable in the first half of 2010, at 16 percent of all admissions (they accounted for 15 percent in the first half of 2009). Other marijuana indicators, however, were increasing. Marijuana-related hospital admissions in Maricopa County continued an upward trend that began in 2007, rising from 1,833 admissions in the second half of 2009 to 2,103 admissions in the first half of 2010. Drug items seized and identified in Phoenix area forensic laboratories as containing marijuana/cannabis increased sharply in the first half of 2010, to 1,703 items, from 1,076 items in the first half of 2009.

- **Honolulu/Hawaii Report.** The Honolulu representative reported a mixed picture for marijuana in this reporting period, although most indicators were increasing. In Honolulu, numbers of treatment admissions for marijuana appeared to be decreasing. Primary treatment admissions for marijuana in the State of Hawaii numbered 2,358 in 2009, with an estimated approximate number of 1,800 marijuana admissions for 2010 (annualized from 902 reported cases for the first half of the year). However, the number of decedents who tested positive for marijuana in their toxicology screens appeared to be increasing on Oahu; there were 49 such deaths in 2009, compared with 27 in the first half of 2010 (annualized to 54). Similarly, police cases involving marijuana in Honolulu appeared to be increasing in the first half of 2010 (at 102—annualized to 201—compared with 178 in 2009).

According to the area representatives, marijuana indicators in the first half of 2010 were high relative to other drugs and stable in Albuquerque, Seattle, and Texas, and they were reported by CEWG area representatives as high and mixed in Los Angeles, San Francisco, and San Diego.

- **Los Angeles Report.** In Los Angeles, the proportion of drug items seized and identified as containing marijuana/cannabis in NFLIS data showed that the increase that began in 2007

continued, increasing from 37.9 percent of all items in 2009 to 40.1 percent in the first half of 2010. Primary marijuana treatment admissions also continued to increase, as they have since 2006. At 24.3 percent of all admissions in the first half of 2010 (a slight increase over 23 percent in the first half of 2009), marijuana admissions exceeded admissions for all other drugs, including alcohol in the first half of 2010. Figure 18 shows the increasing proportions of marijuana treatment admissions for both primary marijuana problems and primary or secondary marijuana problems in Los Angeles from 2000 to 2009. Conversely, the number of coroner toxicology cases with marijuana detected in Los Angeles was projected by the area representative to decrease in 2010 to 353 cases, from 401 cases in 2009.

- **San Francisco Report.** In San Francisco, primary treatment admissions for marijuana in the five-county bay area were stable from 2007 to this reporting period (FY 2010) at approximately 10 percent of all admissions. Marijuana-involved DAWN ED visits and visit rates increased for the bay area in 2009, by 32 percent from 2007 and by 76 percent from 2004. The proportion of items seized and identified as marijuana/cannabis in forensic laboratories in the San Francisco area, however, declined, from approximately 32 percent in 2008 to approximately 26 percent in the first half of 2010.

- **San Diego Report.** The San Diego area representative also reported mixed marijuana indicators, but the changes observed were generally slight. Primary marijuana treatment admissions in San Diego County dropped somewhat in the first half of 2010 (to 19 percent from 21 percent in 2009), reversing the previous increasing trend each year from 2007 to 2009. Similarly, drug items seized and identified in forensic laboratories in the NFLIS system as containing marijuana/cannabis showed a small decrease in this reporting period, from 51.7 percent of all items identified in 2009 to 48.2 percent in the first half of 2010. The prevalence of marijuana-positive

urinalysis results among all arrestees—male and female adults and juveniles—increased, however, in 2009 data. After reaching a 9-year low of 26 percent in 2008, marijuana test-positive prevalence among female arrestees rose in 2009 to 28 percent; the prevalence for males was 36 percent in 2008 and 37 percent in 2009. The largest shift was in marijuana test-positive prevalence among juvenile arrestees, which jumped from 44 percent in 2008 to 51 percent in 2009.

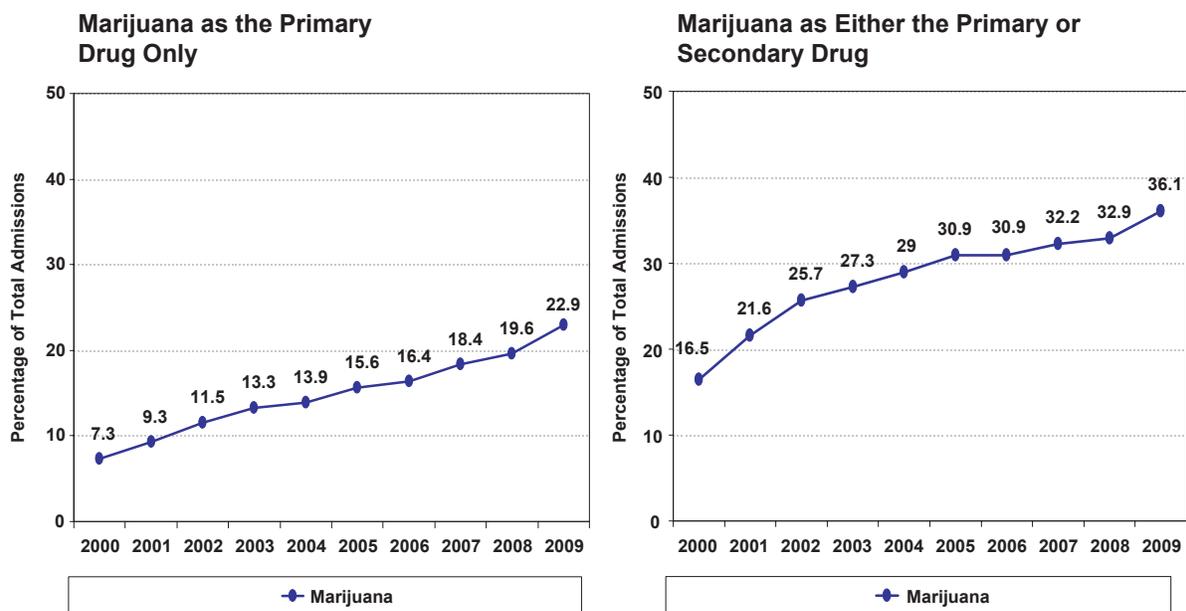
- Albuquerque/New Mexico and Los Angeles Reports.** Marijuana prices were increasing in some areas in the West, including Albuquerque and Los Angeles, according to the area representatives. The greatest increase occurred in Los Angeles, where the wholesale price for domestic marijuana approximately doubled from the fourth quarter of 2009 (\$750 per pound) to the third quarter of 2010 (\$1,300–\$1,800 per pound).

Southern Region CEWG Areas:

According to the CEWG area representatives, marijuana indicators continued to be relatively high in all three CEWG areas in the South. While they were reported as increasing in Atlanta and the Baltimore/Maryland/Washington, DC, area, they were seen as stable in the Miami/South Florida area in the first half of 2010.

- Atlanta Report.** Marijuana continued as the most commonly used illicit substance in Atlanta, based on primary treatment admissions. Primary marijuana treatment admissions in the first half of 2010, marijuana test-positive urinalysis results among male arrestees in 2009, and crisis line calls related to marijuana in the first quarter of 2010 all showed increases over previous reporting periods. Treatment admissions for marijuana for the 28-county Atlanta MSA constituted 25.8 percent of all admissions in the first half of 2010, representing a slight increase over the 23.3

Figure 18. Treatment Admissions for Marijuana as the Primary Drug of Abuse Only or as Either the Primary or Secondary Drug of Abuse, Los Angeles: 2000–2009



SOURCE: Los Angeles Alcohol and Drug Program Administration (LAADPA)/California Alcohol And Drug Program (CAADP); California Alcohol and Drug Data System (CADDs) for 2000–2005, and California Outcome Monitoring System (CalOMS) for 2006–2009; California Department of Finance, as reported by Mary-Lynn Brecht at the January 2011 CEWG meeting

percent of all admissions in 2009. Among male arrestees in Fulton County, the percentage testing positive for marijuana increased from 39.2 percent in 2008 to 44.9 percent in 2009. There was also an increase in the percentage of male arrestees in the city of Atlanta reporting any treatment for marijuana (27.1 percent in 2009, compared with 23.2 percent in 2008). Finally, calls to the statewide Georgia crisis line for marijuana in the first quarter of 2010 continued to rise; marijuana was the most reported illicit drug among calls, according to the area representative.

- **Baltimore/Maryland/Washington, DC, Report.** In Maryland, primary marijuana treatment admissions and NFLIS drug items testing positive for marijuana/cannabis in forensic laboratories were increasing. There were an estimated number of approximately 12,000 primary treatment admissions in 2010 in Maryland (based on annualization of the figure of 5,943 such admissions for the first half of 2010). This compares with 10,911 admissions for marijuana in Maryland in 2009. The proportions of items containing marijuana/cannabis that were seized and analyzed in Maryland forensic laboratories increased slightly to 47.0 percent of all items, from 42.7 percent in 2009.
- **Miami MSA/South Florida Report.** Although marijuana levels were reported as remaining high in the Miami MSA/South Florida CEWG area, most indicators appeared to be stabilizing in the first half of 2010, according to the area representative.

Midwestern Region CEWG Areas:

All CEWG areas located in the Midwest continued to report high and stable or increasing marijuana indicators.

- **Detroit Report.** The Detroit area representative reported that marijuana was widespread there, with high and stable and some possibly increasing indicators. In Detroit, primary treatment admissions for marijuana increased to their highest proportion ever reported in FY 2010,

accounting for 17.3 percent of all admissions in that year, compared with 14.6 percent in FY 2009. The weighted DAWN ED visit rate involving marijuana in the five-county Detroit area showed a significant increase from 2008 to 2009 for the total population.

- **Minneapolis/St. Paul Report.** Similarly, marijuana indicators in Minneapolis/St. Paul were high and stable with some possible increases in the first half of 2010, according to the area representative. In the Twin Cities area, the proportion of treatment admissions with marijuana as the primary substance of abuse was higher than for any other substance except alcohol. Such admissions constituted 19.3 percent of total admissions in the first half of 2010, compared with 18.1 percent in 2009. In 2009, 46.9 percent of male arrestees in Hennepin County tested positive for marijuana, close to the 47.8 percent in 2008, but an increase over 42.7 percent in 2007.

Area representatives from Cincinnati, St. Louis, and Chicago reported high and stable indicators for marijuana in the first half of 2010.

- **Cincinnati Report.** While marijuana availability and use remained high across the Cincinnati area, some indicators pointed to a leveling off. However, marijuana continued to dominate all other reported drugs (excluding alcohol) as the most frequently reported primary drug of abuse among treatment admissions in Cincinnati. Marijuana accounted for 28.9 percent of Cincinnati admissions during the first half of 2010—stable since the 28.0 percent reported in 2009.
- **St. Louis Report.** In St. Louis, primary treatment admissions for marijuana, which showed increases from 2007 to 2008 (from 20.3 to 23.7 percent), and then decreased slightly in 2009 (to 21.3 percent), remained stable in the first half of 2010, at 22.5 percent of all admissions.
- **Chicago Report.** In Chicago, marijuana/cannabis continued to be the most frequently identified drug among drug items seized and analyzed in forensic laboratories (at 59 percent of all items, compared with 58 percent in 2008 and 2009).

Northeastern Region CEWG Areas:

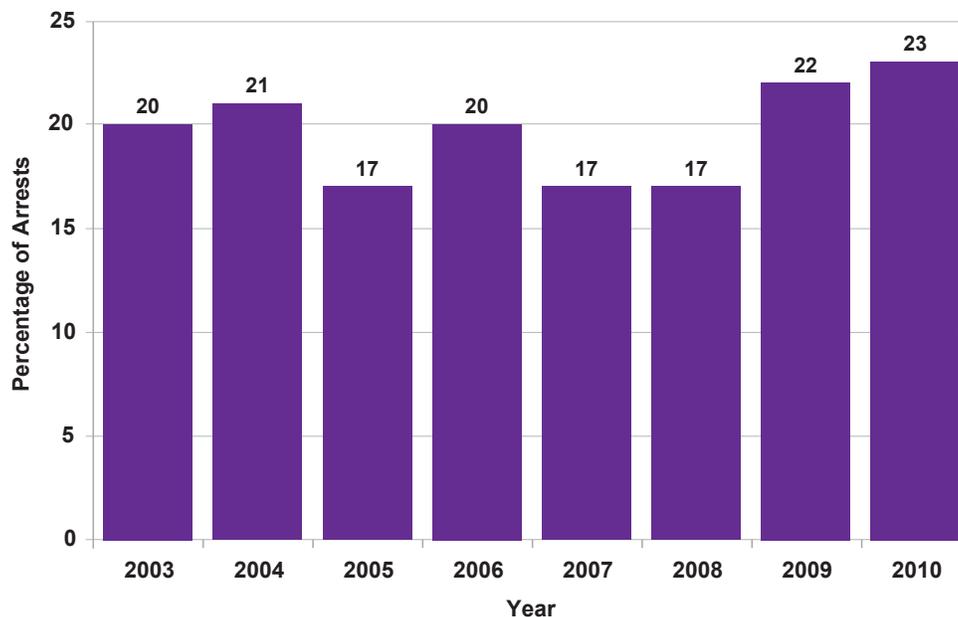
Marijuana indicators in three CEWG areas located in the Northeast remained relatively high (New York City, Maine, and Philadelphia), while moderate levels were reported as persisting in Boston, according to the area representatives.

- **New York City Report.** In New York City, marijuana primary treatment admissions continued to increase, reaching the highest level ever reported at 28 percent of all treatment admissions. More clients in treatment had a primary, secondary, or tertiary problem with marijuana than with any other drug. According to street reports, marijuana continued to be of good quality and widely available in the city.
- **Maine Report.** The Maine area representative reported continuing high levels and mixed indicators for marijuana. There was an increase in the percentage of arrests for marijuana from 2008 to 2010 through December (figure 19), and the proportion of drug items seized and identified in forensic laboratories as containing marijuana/

cannabis rose from 7 percent of all items in 2009 to 10 percent in 2010. Conversely, the proportion of urinalysis tests of impaired drivers in Maine that were positive for cannabinoids decreased to 22 percent in 2010 from 30 percent in 2006–2008.

- **Philadelphia Report.** High levels of marijuana indicators continued to be reported by the Philadelphia area representative. Marijuana ranked first in proportions of primary treatment admissions (22.8 percent of all admissions); first in number of drug items analyzed in forensic laboratories (38.1 percent of samples seized and identified); and first in the Philadelphia Adult Probation and Parole Department (APPD) study, with 53.4 percent of all drug-positive urine drug screens positive for marijuana. The area representative reported, however, that some indicators—primary treatment admissions and APPD screens—may have decreased slightly in the first half of 2010 from 2009.
- **Boston Report.** In Boston, the effects of a change in 2009 in the Massachusetts marijuana possession law that decriminalized possession

Figure 19. Percentage of Drug-Related Arrests for Marijuana, Maine: 2003–2010



SOURCE: Maine Drug Enforcement Agency, as reported by Marcella Sorg at the January 2011 CEWG Meeting and revised March 2012

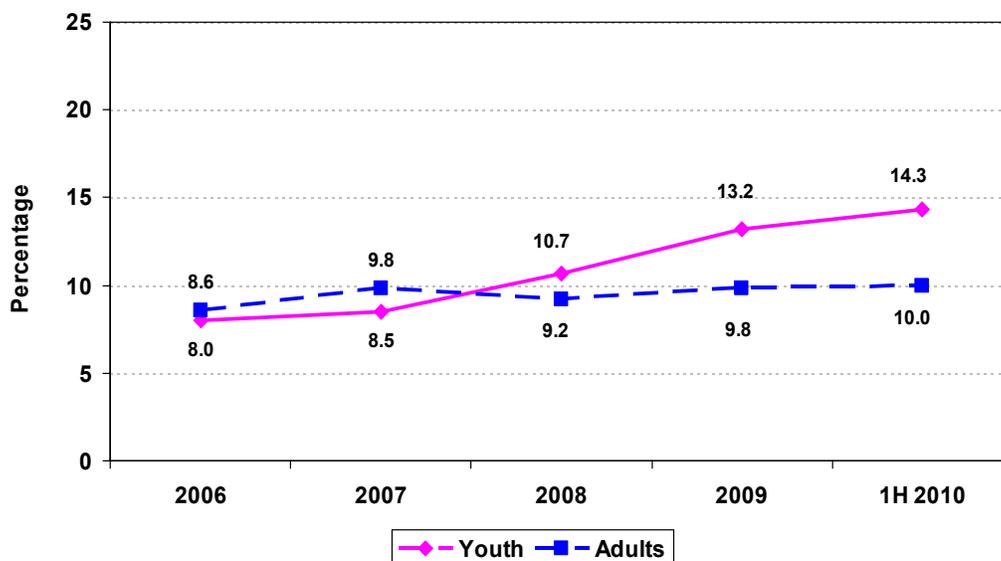
of an ounce or less of the drug continued to be observed in the first half of 2010. The proportion of marijuana/cannabis drug items seized and identified in NFLIS forensic laboratories declined from 43 percent in 2008, to 24 percent in 2009, and to 26 percent in the first half of 2010. Marijuana drug arrests also decreased in Boston. Treatment and other indicators not directly affected by the new legislation were stable at moderate levels there. The proportion of marijuana treatment admissions has remained stable between 4 and 5 percent for 10 years, from FY 2001 to FY 2010. The proportion of marijuana helpline calls also remained stable at 4 percent from FY 2008 to FY 2010.

Other Highlights:

- Several CEWG representatives reported high and increasing marijuana indicators for youth in their areas. Younger treatment admissions for marijuana than for other drugs were noted in several CEWG areas by the area representatives.

- **New Mexico Report.** New Mexico high school students reported the highest prevalence use rates during the 2009–2010 school year among students nationally for current marijuana use (at 28 percent) and initiating use before age 13 (18.4 percent).
- **Seattle Report.** In Seattle, marijuana has represented the majority of primary treatment admissions for youth since 1999. In the first half of 2010, 65 percent of youth treatment admissions reported marijuana as the primary drug, up from approximately 60 percent in 2008.
- **Los Angeles Report.** In Los Angeles, marijuana was reported as the primary substance of abuse by 24 percent of all treatment admissions in the first half of 2010, with more than one-half (59 percent) of those marijuana admissions among adolescents younger than 18, a larger percentage for this age group than in 2009 (54 percent). Figure 20 shows the relative stability of

Figure 20. Percentage of Primary Treatment Admissions for Marijuana as the Primary Substance of Abuse, Los Angeles, Youth Versus Adults¹: 2006–1H 2010



¹Percentages of treatment admissions among youth with marijuana as the primary drug of abuse are for those younger than 18, while adult admissions are for those age 18 and older.

SOURCE: Los Angeles Alcohol and Drug Program Administration (LAADPA)/California Alcohol And Drug Program (CAADP); California Alcohol and Drug Data System (CADDSS); and California Outcome Monitoring System (CalOMS); California Department of Finance, as reported by Mary-Lynn Brecht at the January 2011 CEWG meeting

proportions of primary treatment admissions for marijuana among adults 18 and older (rising slightly from 8.6 percent in 2006 to 10 percent in 2009), compared with greater increases among youth younger than 18 (from 8.0 percent in 2006 to 14.3 percent in the first half of 2010).

- **Baltimore/Maryland/Washington, DC, Report.** Youth treatment clients in Maryland were more likely to mention marijuana than any other drug as the primary drug, according to the area representative. In Washington, DC, the proportion of juvenile arrestees testing positive for marijuana increased slightly during this reporting period, from 52.2 percent in 2009 to 54.7 percent in 2010 (January–November).
- **Miami MSA/South Florida Report.** The area representative from South Florida reported that the 2010 Florida Youth Substance Abuse Survey showed increases in prevalence of past-30-day marijuana use among middle and high school students statewide, as well as in Miami-Dade and Broward Counties.
- **Minneapolis/St. Paul Report.** In the Minneapolis/St. Paul CEWG area, in the first half of 2010, 68.3 percent of the clients admitted to treatment with marijuana as the primary problem were younger than 26 (31.3 percent were younger than 17). Past-year marijuana use by Minnesota 12th graders increased from 21.8 percent in 1992 to 30.6 percent in 2010.
- **Texas Report.** Smoking marijuana in blunt cigars (“blunts”) continued to be a popular mode for young marijuana users, according to the area representative from Texas. Nine percent of Texas secondary students used marijuana in blunts “most of the time or always” in 2010, compared with 8 percent who used pipes, 7 percent who used joints, and 6 percent who used bong.

- Percentages of primary marijuana treatment admissions, including primary alcohol admissions, were highest in the first half of 2010 in Miami MSA/Dade County (38.7 percent), followed by Miami MSA/Broward County (34.0 percent), Cincinnati (28.9 percent), and New York City (27.7 percent). The lowest proportions of such admissions were in Boston (4.1 percent) (section IV, table 11; appendix table 1).
- Marijuana ranked first as the primary drug problem among total drug admissions, including alcohol admissions, in 4 of 23 CEWG reporting areas: Miami MSA/Broward County, Miami MSA/Dade County, Philadelphia, and Los Angeles. Marijuana ranked second among primary drugs of admission in seven additional areas: Atlanta, Cincinnati, Colorado, Denver, Minneapolis/St. Paul, New York City, and Seattle (table 2).
- Marijuana/cannabis ranked in either first or second place in frequency in the proportion of drug items identified in forensic laboratories in the first half of 2010 in all CEWG areas, with the exception of Atlanta, where it ranked seventh. Marijuana/cannabis ranked in first place among identified drugs in 13 of 23 CEWG areas in this reporting period: Baltimore, Boston, Chicago, Cincinnati, Detroit, Los Angeles, Maryland, Philadelphia, Phoenix, St. Louis, San Diego, San Francisco, and Texas. It ranked second in the remaining nine CEWG areas (table 1). The highest proportions of marijuana items identified in the NFLIS system were in Chicago, Detroit, and St. Louis, at approximately 59, 51, and 50 percent, respectively (figure 23; appendix table 2).

MDMA/Ecstasy and Other Club Drugs, Including MDA, GHB, LSD, and Ketamine

MDMA (3,4-methylenedioxymethamphetamine)

MDMA indicators continued to be low across all regions of the country when compared with most other drug indicators. However, MDMA remained a persistent problem in several CEWG areas, as reported by area representatives in

Update Briefs and slide presentations in 10 of the 21 CEWG reporting areas. A slight upward trend in indicators was reported in the first half of 2010 in six areas in the West (Albuquerque, Los Angeles, Phoenix, San Diego, Hawaii, and Texas); three areas in the Midwest (Chicago, Minneapolis/St. Paul, and St. Louis); and one CEWG area in the Northeast (New York City). The area representatives from Phoenix and Los Angeles cited MDMA as a substance to monitor in future reporting periods. Declines in MDMA indicators were noted by three area representatives—from Denver, Atlanta, and Miami/South Florida.

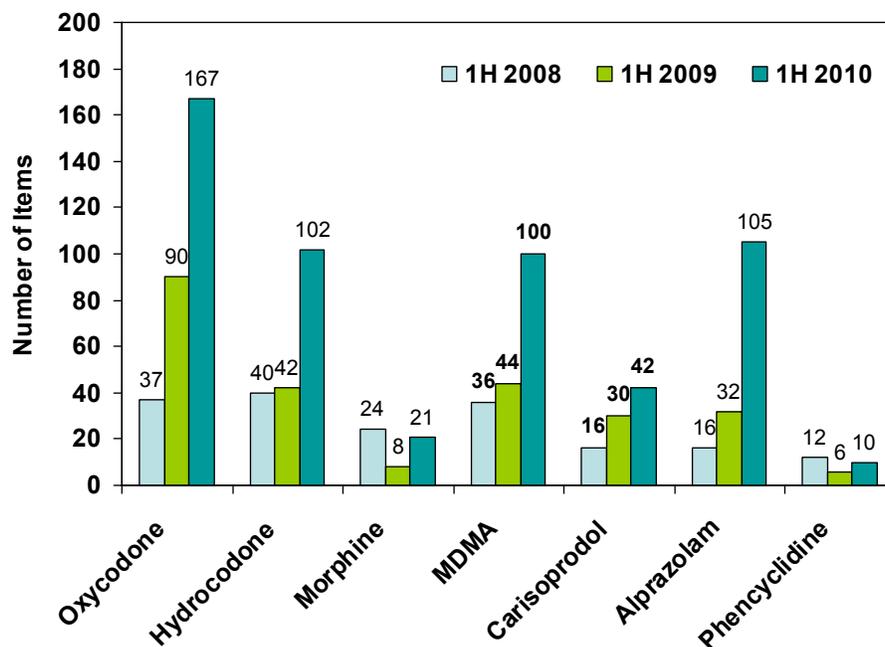
Western Region CEWG Areas:

MDMA persisted as a problem reported by area representatives in the western region of the country. Area representatives from Albuquerque/New Mexico, Phoenix, Los Angeles, San Diego, San Francisco, Hawaii, and Texas reported relatively low but increasing MDMA indicators.

Drug items seized and identified as containing MDMA in NFLIS forensic laboratories increased in Albuquerque, Phoenix, Los Angeles, and San Diego.

- **Albuquerque/New Mexico Report.** The percentage of MDMA items in Albuquerque increased slightly, from 0.9 percent of all identified items in 2008 to 1.5 percent in the first half of 2010.
- **Phoenix Report.** In Phoenix, the number of MDMA items increased from 36 in the first half of 2008, to 44 in the first half of 2009, and to 100 in the first half of 2010 (figure 21).
- **Los Angeles Report.** The percentage of MDMA items analyzed in Los Angeles increased in the first half of 2010 to 4.7 percent of all items, up from 2.8 percent in 2009.
- **San Diego Report.** Similarly, drug items seized and identified as containing MDMA/ecstasy in forensic laboratories in the San Diego

Figure 21. Number of NFLIS Drug Items Identified in Forensic Laboratories as Containing MDMA and Selected Other Drugs, Maricopa County (Phoenix): 1H 2008–1H 2010



SOURCE: NFLIS, DEA, retrieved on December 16, 2010, as reported by James Cunningham at the January 2011 CEWG meeting

area increased slightly in the first half of 2010 to 2.2 percent of all items analyzed, up from 1.9 percent in 2009.

- **Honolulu/Hawaii Report.** The Honolulu/Hawaii area representative noted that items identified as MDMA in forensic laboratories in the first half of 2010 represented approximately twice the number of samples analyzed as in previous reporting periods.
- **Phoenix and San Francisco Reports.** The Phoenix area representative reported a large increase in estimated MDMA-involved DAWN ED visits, from 94 in 2007 to 361 in 2009 (the highest number reported in 4 years). In San Francisco, the area representative reported that estimated MDMA-involved ED visits were 188 in 2007 and 369 in 2009 (a 96-percent increase from 2007 to 2009).
- **Los Angeles Report.** In Los Angeles, primary treatment admissions for MDMA nearly doubled in the first half of 2010 from 2009, but they still remained at a low level, at 0.5 percent of all admissions.

Southern Region CEWG Areas:

- **Atlanta and Miami MSA/South Florida Reports.** In the South, the area representatives from Atlanta and Miami/South Florida reported low MDMA indicators that continued to decrease. Primary treatment admissions for MDMA declined from 0.2 percent of all admissions in Atlanta in 2009 to 0.1 percent in the first half of 2010. In Miami-Dade County, the rate of weighted DAWN ED visits involving MDMA decreased from 11.9 per 100,000 population in 2008 to 7.7 per 100,000 in 2009. The estimated DAWN ED rate remained stable, however, in Broward County, at 7.3 per 100,000 in 2008 and 8.3 per 100,000 in 2009.

Midwestern Region CEWG Areas:

All five area representatives in the Midwest reported a continuing presence of MDMA indicators.

- **Chicago Report.** In Chicago, where MDMA was reported by the area representative as remaining popular in low income African-American neighborhoods, drug items seized and identified as containing MDMA increased to 1.9 percent of all NFLIS items in the first half of 2010, compared with 1.6 percent in 2009 and 1.0 percent in 2008.
- **Minneapolis/St. Paul Report.** In the Minneapolis/St. Paul Twin Cities area, numbers of estimated MDMA-involved DAWN ED visits increased from 204 in 2004 to 475 in 2009.
- **Cincinnati Report.** The area representative from Cincinnati reported low to moderate levels of MDMA, with indicators increasing slightly. MDMA-related calls to the Cincinnati Drug and Poison Information Center increased from 17 in 2009 to 20 in 2010.

Northeastern Region CEWG Areas:

- **New York City Report.** MDMA indicators were reported by the area representative as increasing in New York City in the first half of 2010. NFLIS items seized and identified as containing MDMA increased in number and ranking, rising from 11th place in 2008 to 6th in the first half of 2010. Additionally, there was a statistically significant 43-percent increase in estimated MDMA-involved ED visits in the five boroughs of New York City from 2008 to 2009 (figure 22).
- **Maine Report.** MDMA-related drug arrests by the Maine Drug Enforcement Agency increased from 1 percent of all arrests in 2009 to 3 percent in 2010.

Other Highlights:

- **New Mexico and St. Louis Reports.** An increase in ecstasy use by youth was reported in New Mexico and St. Louis based on the YRBS and the Missouri School Survey. In New Mexico, the YRBS estimate for current ecstasy use increased significantly among high school students, from 5.1 percent in 2007 to 8 percent in 2009 (New Mexico ranked first among all States in the 2009 YRBS data).

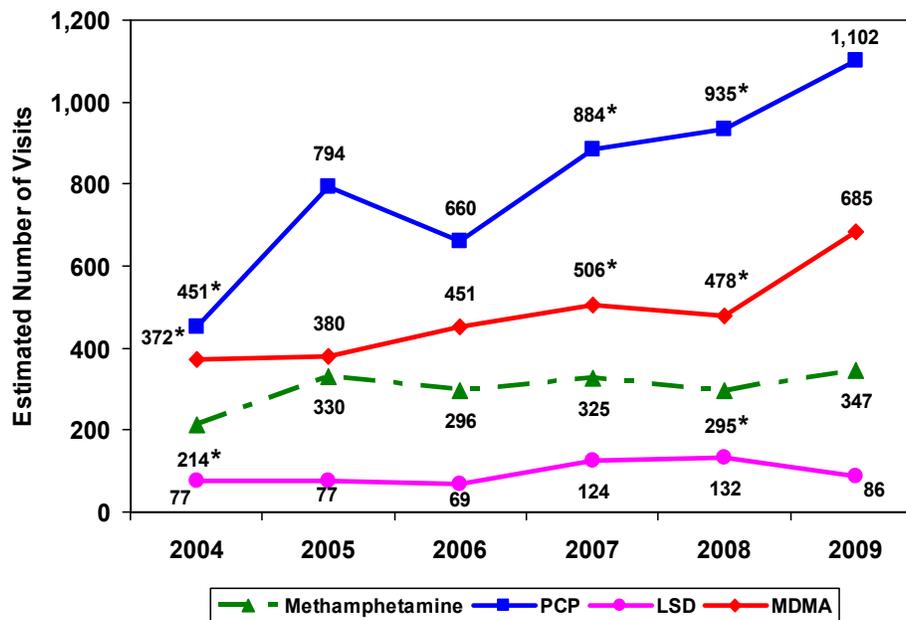
- MDMA was the fourth most frequently identified NFLIS drug item in Chicago, Minneapolis/St. Paul, Honolulu, and San Francisco in the first half of 2010 (table 1; section IV, table 12). It ranked fifth in proportion of drug items identified in forensic laboratories in Denver and Los Angeles. MDMA represented 5.9, 4.8, 4.8, 4.7, and 4.0 percent of total drug items identified in forensic laboratories in the first half of 2010 in Minneapolis/St. Paul, Denver, San Francisco, Los Angeles, and Seattle, respectively (section IV, table 12).

Other Club Drugs, Including MDA, GHB, LSD, and Ketamine

Other Club Drugs (including MDA [3,4-methylenedioxyamphetamine], GHB [gamma hydroxybutyrate], and ketamine) appeared relatively infrequently in indicator data for all areas. However, LSD (lysergic acid diethylamide) remained a drug of concern to CEWG representatives.

- **MDA** was reported among forensic items identified in 9 of 23 areas: Atlanta, Baltimore, Denver, Honolulu, Maryland, New York City, Philadelphia, San Francisco, and Texas (section IV, table 13). Like ketamine, GHB, and LSD, MDA did not figure among the top 10 most frequently identified drug items by NFLIS in any CEWG area in the first half of 2010 (table 1).
- **GHB** drug items were not among the top 10 drug items identified by NFLIS for any CEWG area in the first half of 2010, although 11 of 23 areas reported 1 or more such items, including Albuquerque, Atlanta, Chicago, Los Angeles, Miami, New York City, St. Louis, San Diego, San Francisco, Seattle, and Washington, DC (section IV, table 13).
- **Ketamine** was among the drug items identified in the NFLIS system in the first half of 2010 in 19 of 23 areas, with exceptions being Cincinnati, Minneapolis/St. Paul, Texas, and Washington, DC. Ketamine did not appear among the top 10

Figure 22. Estimated Number of DAWN ED Visits Involving MDMA, PCP, LSD, and Methamphetamine, New York City: 2004–2009¹



¹Statistically significant differences in estimated visits are indicated by the use of the symbol, “*”, next to the count for each year that differs significantly from 2009. No significance testing of data for 2005 or 2006, compared with 2009, was available from CBHSQ. SOURCE: Weighted DAWN, 2009, CBHSQ, SAMHSA, as reported by Rozanne Marel at the January 2011 CEWG meeting

ranked drug items in any CEWG area (section IV, table 13).

- In the first half of 2010, **LSD** was among identified drug items in 14 of 23 CEWG areas: Atlanta, Chicago, Cincinnati, Denver, Detroit, Los Angeles, Maine, Maryland, New York City, Philadelphia, Phoenix, St. Louis, San Diego, and San Francisco, although it made up 1 percent or less of all drug items identified in those areas (section IV, table 13).

PCP

PCP (phencyclidine) remained a drug of concern in the Baltimore/Maryland/Washington, DC, area, New York City, and Philadelphia, and it persisted on the drug scene in several other CEWG areas and across all CEWG regions, including San Francisco, Los Angeles, Chicago, and St. Louis, as reported by those CEWG area representatives.

Western Region CEWG Areas:

- PCP continued to be detected in drugs analyzed in forensic laboratories in the first half of 2010 in all CEWG areas in the West, with the exception of Denver and Honolulu. However, indicators remained very low (less than 1 percent).

Southern Region CEWG Areas:

- **Baltimore/Maryland/Washington, DC, Report.** The area representative reported elevated indicators for PCP in comparison to many other regions. Primary treatment admissions for PCP in Maryland were reported as increasing in the first half of 2010, while the percentage of adult arrestees testing positive for PCP increased slightly in Washington, DC, from 8.9 percent in 2009 to 9.8 percent in 2010 (through November). In comparison, analyzed drug items testing positive for PCP remained low in Baltimore and Maryland (less than 1.0 percent) and relatively stable in Washington, DC (5.8 percent).

Midwestern Region CEWG Areas:

- **St. Louis Report.** The representative from the St. Louis area reported a continuing although low

presence of PCP in urban areas, where it was said to be an indigenous drug in Kansas City and St. Louis.

Northeastern Region CEWG Areas:

- **New York City Report.** The New York City area representative reported a significant 18-percent increase in the estimated number of PCP-involved DAWN ED visits in the city from 2008 to 2009.
- **Philadelphia Report.** In Philadelphia, where the area representative reported continuing moderate PCP levels, the most common route of administration of the drug continued to be smoking in combination with marijuana in “blunts” (blunt cigars). Some indicators in Philadelphia, namely treatment admissions and positive toxicology detection in decedents, were reported as increasing in the first half of 2010, according to the area representative. PCP represented 4.6 percent of all Philadelphia treatment admissions, compared with 3.9 percent in 2009. PCP was detected in 7.3 percent of decedents, compared with 5 percent in 2009.
- In Washington, DC, PCP was fourth among the top drug items identified in forensic laboratories in the first half of 2010. PCP ranked sixth in drug items identified in that period in Philadelphia, seventh in Maryland and Los Angeles, eighth in New York City, and ninth in Chicago (table 1).
- Washington, DC, and Philadelphia reported the highest percentages of PCP drug items identified in the first half of 2009 in NFLIS data, at 5.8 and 2.1 percent of drug items identified, respectively (section IV, table 13).

Other Drugs (Including BZP, TFMPP, Carisoprodol, Levamisole, Salvia Divinorum, Psilocin/Psilocybin, Quetiapine, Cathinone/Cathine, Gabapentin, and Foxy Methoxy)

Polysubstance abuse, noted in previous CEWG reporting periods, persisted across all CEWG areas, and high levels of alcohol abuse continued to be noted for several CEWG areas.

BZP (1-Benzylpiperazine)

BZP, a synthetic stimulant that is illegal and has no accepted medical use in the United States, continued to be reported by area representatives as an emerging drug of concern in several CEWG areas across all CEWG regions. BZP was permanently controlled in 2004 as a Schedule I substance under the Controlled Substances Act, and it is one of the DEA's emerging drugs of interest.

Several CEWG area representatives reported stable or increasing BZP indicators in the first half of 2010, including Seattle and Texas in the West; Miami in the South; Detroit and Chicago in the Midwest; and New York City in the East.

- BZP continued to be detected in tablets sold as MDMA, as reported by area representatives from Denver and Miami, where 65 percent of crime laboratory samples alleged to be ecstasy were identified as BZP.
- In the first half of 2010, BZP appeared among the identified drugs in NFLIS forensic laboratories in all 23 CEWG areas (section IV, table 13). BZP ranked among the top 10 most frequently identified drug items in NFLIS data in the first half of 2010 in 7 of 23 CEWG areas. BZP ranked 5th in Chicago and Washington, DC; 8th in Maine; 9th in Denver; and 10th in Detroit, Minneapolis/St. Paul (tied with psilocin), St. Louis, and Texas.

TFMPP or 1-(3-trifluoromethylphenyl) piperazine

TFMPP¹¹ is a synthetic substance with no accepted medical use in the United States that is used for its hallucinogenic effects. Often taken in combination with BZP as a substitute for MDMA, TFMPP is currently not a DEA-controlled substance. It is, however, causing growing concern among representatives in several CEWG areas, including

Atlanta and Texas. Because it is not a controlled substance, it may frequently not be reported or tested for in forensic laboratories, a dynamic which would influence indicator data. It is also one of the DEA's emerging drugs of interest.

- According to NFLIS data for the first half of 2010, TFMPP ranked ninth among drug items identified in forensic laboratories in Atlanta, where 76 such drug items were identified (table 1). TFMPP drug items constituted 1.3 percent of Atlanta's drug items in the first half of 2010 (section IV, table 13, footnote 1, appendix table 2).

Carisoprodol (Soma®)

Carisoprodol is a muscle relaxant and central nervous system depressant that is available by prescription as Soma®¹². It is not controlled on the Federal level (although scheduling action under the Controlled Substances Act by the DEA is pending), but several States have scheduled Soma® as a controlled substance.

- **Texas Report.** Carisoprodol continued as a popular drug in the illicit drug market in Texas, according to the area representative. It is part of the combination with hydrocodone and alprazolam that is known as the "Houston Cocktail" or "Holy Trinity."
- **Phoenix Report.** Figure 21 shows increases in numbers of carisoprodol items among NFLIS drug items identified in Phoenix forensic laboratories in the first half of 2010 ($n=42$) compared with the first halves of 2008 ($n=16$) and 2009 ($n=30$), although numbers were relatively very low.
- NFLIS data for the first half of 2010 show that carisoprodol was identified among drug items analyzed in area forensic laboratories in 14 of 23 CEWG reporting areas: Albuquerque, Atlanta, Cincinnati, Detroit, Honolulu, Los Angeles,

¹¹More information on TFMPP can be found in the Federal Register Notice 68 FR 52872.

¹²More information about carisoprodol and Soma® can be found at <http://www.nlm.nih.gov/medlineplus/druginformation.html>.

Maine, Miami, Phoenix, St. Louis, San Diego, San Francisco, Seattle, and Texas (section IV, table 13). In the first half of 2010, drug items containing carisoprodol ranked seventh in Texas and ninth in Honolulu and Phoenix among the top 10 most frequently identified NFLIS drug items in the period (table 1).

Levamisole

- Several CEWG area representatives continued to report increased use of levamisole, a veterinary drug used to control parasites in livestock, as a cutting agent used with cocaine. Not available for human use in the United States, use of levamisole can lead to an autoimmune disorder, agranulocytosis (or neutropenia), characterized by a marked decrease in white blood cells. Seven area representatives—from Denver, Miami, Cincinnati, Detroit, Minneapolis/St. Paul, Maine, and Philadelphia—reported on levamisole as an adulterant in cocaine being present in indicators in the first half of 2010 (see section on cocaine).

Salvia Divinorum

- *Salvia divinorum*¹³ is a perennial herb that produces short-acting hallucinogenic effects when chewed, smoked, or brewed in tea. It is available on the Internet and is favored by adolescents. Some States control it as a Schedule I drug. It is not currently federally controlled, but it is one of the DEA's emerging drugs of interest. Because it is difficult for poison control centers to identify, its use is often difficult to detect and monitor.
- **Texas Report.** The only CEWG area representative reporting on *Salvia* in this reporting period was the Texas representative, who reported 13 *Salvia* calls to the Texas Poison Centers in 2010 (an increase from the 7 in 2009, but a sizeable decrease since the 73 reported in 2008).

Psilocin/Psilocybin

- Psilocin (also called psilocin/psilocybin and psilocybine) is a hallucinogen that ranked 8th in Denver, 9th in Albuquerque and Los Angeles, and 10th in Minneapolis/St. Paul (tied with BZP) in the NFLIS data for the January–June 2010 reporting period (table 1). Psilocin/psilocybin was reported among drug items in forensic laboratories in 21 of 23 CEWG areas in the first half of 2010, with no cases reported for Baltimore or Honolulu (section IV, table 13).

Quetiapine

- Quetiapine and quetiapine fumarate, antipsychotic drugs marketed as Seroquel®¹⁴, were among drug items identified in Boston NFLIS data in the first half of 2010. There were 76 such items identified, ranking 13th in the NFLIS data. These drugs were also reported in Texas data, ranking in 16th place there, with 149 items. Los Angeles data showed 38 drug items identified as containing quetiapine, constituting 0.2 percent of all items seized and identified in Los Angeles County in the first half of 2010. Ten or fewer items containing quetiapine or quetiapine fumarate were identified in this reporting period in Cincinnati, Honolulu, Minneapolis/St. Paul, Phoenix, and San Diego.
- In no CEWG areas did quetiapine appear among the top 10 drug items identified in forensic laboratories in the first half of 2010 (table 1).

Khat (Cathinone, Cathine)

- Khat¹⁵ is a plant indigenous to East Africa and the Arabian Peninsula and is used for its stimulant effects in East Africa and the Middle East. It has maintained a hidden presence within the Somali immigrant community in the Minneapolis/St. Paul area, according to the area representative. Its active ingredients, cathinone and cathine, are

¹³More information about *Salvia divinorum* can be found at: <http://www.nlm.nih.gov/medlineplus/medlineplus.html>.

¹⁴More information about quetiapine and Seroquel® can be found at: <http://www.nlm.nih.gov/medlineplus/druginformation.html>.

¹⁵More information about Khat and cathinone can be found at: <http://www.nida.nih.gov/Infofacts/khat.html>.

controlled substances in the United States. Cathinone, a Schedule I drug, is present only in the fresh leaves of the flowering plant and converts to the considerably less potent cathine in approximately 48 hours. Users chew the leaves, smoke it, or brew it in tea.

- Cathinone was found at very low levels in NFLIS data for the first half of 2010 in 11 of 23 reporting areas: Minneapolis ($n=39$), New York City ($n=30$), Denver ($n=11$), Chicago and Cincinnati ($n=4$ each), Seattle ($n=2$), and Detroit, Honolulu, Maine, San Francisco, and Washington, DC ($n=1$ each) (section IV, table 13, footnote 1).

Gabapentin

- Gabapentin¹⁶, sold under the brand names Neurontin® and Gabarone®, appeared for the first time in the top 10 identified NFLIS drugs in any CEWG area in the first half of 2010, ranking eighth in Boston. The drug, a central nervous system depressant, is not a scheduled drug under the Federal Controlled Substances Act. Although rarely encountered as a diverted pharmaceutical, law enforcement sources report that the drug is increasingly being abused (<http://www.justice.gov/dea/programs/forensicsci/microgram/mg0904/mg0904.pdf>).
- Gabapentin was identified in 109 samples in the NFLIS system in the first half of 2010 in Boston, in 8 samples in Los Angeles, 5 in Minneapolis/St. Paul, 4 in Phoenix, and 1 each in Honolulu and Maine. It ranked ninth among the most frequently identified drug items in the first half of 2010 in Boston, but it was not found within the top 10 drug items in any other CEWG area (table 1).

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

- Foxy Methoxy¹⁷ is a synthetic substance abused for its hallucinogenic effects. It is illegal in the

United States and is controlled as a Schedule I substance under the Controlled Substances Act. Foxy Methoxy was not detected in any indicator data for CEWG areas in the first half of 2010, and for the third reporting period it was not mentioned as a drug of concern in any CEWG area.

Spotlight on Spice and Synthetic Cannabinoids, Mephedrone, and “Bath Salts”

Spice and Synthetic Cannabinoids

- “Spice”¹⁸ is used to describe a diverse family of herbal mixtures marketed under many names, including K2, fake marijuana, Yucatan Fire, Skunk, Moon Rocks, and others. These products contain dried, shredded plant material and, presumably, chemical additives that are responsible for their psychoactive (mind-altering) effects. While Spice products are labeled “not for human consumption,” they are marketed to people who are interested in herbal alternatives to marijuana (cannabis). While Spice products do contain dried plant material, chemical analyses of seized Spice mixtures have revealed the presence of synthetic cannabinoid compounds that bind to the same cannabinoid receptors in the body as THC (delta-9-tetrahydrocannabinol), the primary psychoactive component of marijuana. Some of these compounds, however, bind more strongly to the receptors, which could lead to a much more powerful and unpredictable effect. Notably, these compounds have not been fully characterized for their effects and importantly, their toxicity in humans. Because the chemical composition of the various products sold as Spice is unknown, it is likely that some varieties also contain substances with dramatically different effects than those expected by the user. “Spice” and synthetic cannabinoids were noted as emerging drugs of concern at the June 2009 and June 2010 CEWG meetings, and concern about these “designer

¹⁶More information on gabapentin can be found at: <http://www.nlm.nih.gov/medlineplus/druginformation.html>.

¹⁷More information on 5-MeO-DIPT can be found at: http://www.deadiversion.usdoj.gov/drugs_concern/5meodipt.htm.

¹⁸More information about Spice can be found at: <http://www.nida.nih.gov/Infofacts/Spice.html>.

cannabinoids” continued in several CEWG areas during this reporting period. Because the consumption of synthetic cannabinoids for their psychoactive properties can lead to emergency room visits and calls to poison control centers, the DEA placed five synthetic cannabinoids under temporary scheduling, for possible control under the Controlled Substances Act in January 2011¹⁹. These substances are the following:

- 1-pentyl-3-(1-naphthyl)indole (**JWH-018**);
 - 1-butyl-3-(1-naphthoyl)indole (**JWH-073**);
 - 1-[2-(-morpholinyl)ethyl]3-(1-naphthoyl)indole (**JWH-200**);
 - 5-(1,1-dimethylheptyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (**CP-47,497**); and
 - 5-(1,1-dimethyloctyl)-2-[(1R,3S)-3-hydroxycyclohexyl]-phenol (cannabicyclohexanol: **CP-47,497 C8** homologue).
- Four CEWG area representatives in the West reported evidence of synthetic cannabinoids in their areas (three, Albuquerque, Phoenix, and Denver, from anecdotal or qualitative sources, and one, Texas, from poison control center calls). Three representatives in the Midwest (Minneapolis/St. Paul, Detroit, and St. Louis) and one in the South (Miami/South Florida) also reported on synthetic cannabinoids.

Western Region CEWG Areas:

- **Albuquerque/New Mexico Report.** In Albuquerque, qualitative information from law enforcement and sentinel surveillance indicated that JWH-018 was available, according to the area representative.
- **Phoenix Report.** Elsewhere in the western region, Spice was reported by the Phoenix area representative. Spice has received media attention in that area in this reporting period.

- **Denver/Colorado Report.** The Denver area representative reported that while synthetic cannabinoids (Spice, K2, and “Black Mamba”) have been a growing concern in the Denver metropolitan area, there are few indicators that have the ability to isolate and capture the data.
- **Texas Report.** The Texas area representative reported the continuing presence in the State of marijuana homologs, with calls to Texas Poison Centers related to exposure to them increasing.

Midwestern Region CEWG Areas:

- **Minneapolis/St. Paul Report.** In the Midwest, the Minneapolis/St. Paul area representative reported a continuing synthetic marijuana presence in the Twin Cities. The use of products such as Spice and K2 by youth created rising public concern throughout Minnesota in 2010, according to the area representative. In Minneapolis/St. Paul, the Hennepin Regional Poison Center documented 76 synthetic marijuana exposures in 2010.
- **Detroit Report.** Similarly, the Detroit area representative reported on calls to the Poison Control Center at Children’s Hospital of Michigan for exposure to K2 and similar smoked herbal products; 37 such cases were reported in the first half of 2010.
- **St. Louis Report.** The St. Louis area representative reported that herbal preparations such as K2 were the focus of many news stories in that area the first half of 2010.

Southern Region CEWG Areas:

- **Miami MSA/South Florida Report.** In the South, the area representative from Miami/South Florida reported that synthetic cannabinoids continued to be an emerging issue of concern there, where they were widely available in retail outlets.

¹⁹Notice of temporary scheduling can be found at: <http://www.justice.gov/dea/programs/forensicsci/microgram/mg2011/mg0111.pdf>.

Mephedrone

- Mephedrone²⁰ (4-methylmethcathinone) is a synthetic cathinone that has been popular in Europe. It is currently being monitored by the European Union's European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), as reported at the June 2010 and January 2011 CEWG meetings. Mephedrone is another example of the increasing popularity of newly emerging "designer drugs" that are marketed on the Internet and perceived by users as "legal highs."
- Concerns about mephedrone that were reported by area representatives at the June 2010 CEWG meeting continued into this reporting period. Three area representatives, from Texas, Miami, and St. Louis, reported mephedrone as a new drug showing up in qualitative data and anecdotal information. Mephedrone has been identified in Texas key informant interviews and toxicology laboratory and poison control data in Texas, although the mentions have been low, according to the area representative. Mephedrone is one of the DEA's emerging drugs of interest.

"Bath Salts"

- Synthetic stimulants marketed as "bath salts"²¹ have recently appeared in some CEWG areas, and they were reported as emerging drugs of concern in the first half of 2010 in the Minneapolis/St. Paul and St. Louis areas. Marketed and sold as legal substances under names such as "Ivory Wave," "Purple Wave," or "Vanilla Sky," they may cause serious medical reactions (such as chest pain, increased heart rate, hallucinations, extreme paranoia, and delusions) when ingested. An increase in calls to poison control centers across the country related to these substances in 2010 prompted the Office of National Drug Control Policy to release a statement of concern on February 1, 2011²².

HIV/AIDS Related to Drug Abuse

The CEWG continues to monitor trends in injection drug use as important for understanding the consequences of drug use, including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). Ten out of 21 area representatives reported HIV/AIDS data at the January 2011 meeting. Area representatives reported at this meeting that transmission of or exposure to HIV and AIDS through injection drug use had decreased in New York City and Seattle; remained stable in New Mexico, Colorado, and Atlanta; and increased in San Francisco and also very slightly in Detroit.

- **New York City Report.** The proportion of new HIV cases diagnosed in New York City in which reported exposure was from injection drug use declined from 6.7 percent in the first half of 2008 to 4.6 percent in the first half of 2009.
- **Seattle Report.** The Seattle area representative reported a similar decrease. The proportion of King County residents diagnosed with HIV who were exposed through injection drug use declined from 7 percent in 2001 to 4 percent 2009.
- **Albuquerque/New Mexico Report.** The proportion of people in New Mexico living with HIV/AIDS with injection drug use as a mode of exposure has not changed since 2006, according to the area representative. As of December 2010, 9 percent were injection drug users, and 10 percent were men who have sex with men (MSM) and also injection drug users.
- **Denver/Colorado Report.** Similarly, cumulative AIDS data in Colorado through September 2010 indicated that cases related to injection drug use remained stable statewide at 9 percent.

²⁰More information on mephedrone can be found at: http://www.deadiversion.usdoj.gov/drugs_concern/mephedrone.htm.

²¹More information about substances sold as "bath salts" can be found at: http://www.nlm.nih.gov/medlineplus/news/fullstory_108485.html.

²²The statement is available at: <http://www.whitehousedrugpolicy.gov/news/press11/020111.html>.

- **Atlanta Report.** In Atlanta, the proportion of cumulative AIDS cases attributed to injection drug use or MSM and injection drug use remained at 15 percent in the first half of 2010.
- **San Francisco Report.** In San Francisco, cumulative AIDS reports in San Francisco County increased by 7.6 percent among heterosexual injection drug users in the 6-year time period from December 2004 to September 2010 (this group constituted 7 percent of the total caseload); reports for MSM injection drug users increased in the same 6 years by 12.5 percent.
- **Detroit Report.** The Detroit area representative reported a slight increase in exposure through injection drug use in new HIV cases. As of October 2010, 7 percent of the people newly diagnosed with HIV infection reported injection drug use as a risk behavior, either alone or combined with other high-risk sexual behaviors, compared with 5 percent in 2010.

International Drug Abuse Patterns and Issues

Europe

- Drug abuse trends in Europe were presented to the CEWG by a representative from the EMCDDA, the agency that collects drug-related information for 30 countries—27 European Union member States, along with Croatia, Turkey, and Norway.
- Cannabis remained the most popular illicit drug across Europe. Overall, cannabis trends were reported as stable or declining, although each country showed a somewhat different pattern. The EMCDDA representative reported a 7-percent last-year prevalence and 4-percent last-month prevalence in Europe. Estimates show that up to 3 million young Europeans could be using cannabis on a daily basis.
- Cocaine remained popular, with relatively high prevalence rates, in the United Kingdom, Spain, Ireland, Italy, and Denmark. However, cocaine use prevalence in these countries has stabilized in recent years. Last-year prevalence of cocaine use across Europe was 1.3 percent, representing 4 million Europeans, with 3 million between ages 15 and 34.
- Heroin prevalence estimates remained relatively stable in Europe, but some indicators (drugs seized and identified as containing heroin, deaths, and treatment admissions) in the European Union and the EMCDDA showed moderate increases. Indicators continued to point to an aging population of heroin users.
- Amphetamines and ecstasy remained popular in several European countries (Nordic and central European countries), according to the EMCDDA representative, but there was an overall stabilization of use prevalence. In some countries, however, methamphetamine may be displacing amphetamine among established problem drug users, specifically the Czech Republic and Slovakia.
- The EMCDDA representative reported on the continuing work of the European Union's Early Warning System (EWS). The EWS provides a system for rapid exchange of information on new psychoactive substances that may pose public health or social threats. Work of the EWS has focused over the past few years on identifying newly emerging synthetic cannabinoids (including Spice), synthetic cathinones (including mephedrone), and other "legal highs" marketed and sold over the Internet (see Emerging Drugs section).

Canada

- According to the representative from Health Canada, cannabis continued to be the dominant illicit drug in Canada, with the highest levels of self-reported past-year use, as well as the highest number of exhibits analyzed in laboratories. Survey results from the Canadian Alcohol and Drugs Use Monitoring Survey (CADUMS) showed that cannabis use remained stable in 2009, compared with 2008. The number of cannabis exhibits analyzed in laboratories has remained stable since 2005.

- Cocaine exhibits continued to be the second most frequently analyzed and identified drug exhibits in Canada; however, fewer cocaine exhibits were analyzed in 2008 and 2009 than in previous years. The Health Canada representative noted a slight increase across the country in methamphetamine exhibits seized and analyzed, as well as an increase in prescription opioid exhibits identified in 2009. However, a significant decrease was reported in the number of Canadians age 15 and older who indicated past-year use of a psychoactive pharmaceutical drug (i.e., opioid pain reliever, stimulant, sedative, or tranquilizer) in the CADUMS, from 28 percent in 2008 to 25 percent in 2009.

Australia

- A representative from the national Drug and Alcohol Research Centre at the University of New South Wales in Sydney, Australia, reported to the CEWG on the Australian drug monitoring system, the Ecstasy and Related Drugs Reporting System (EDRS), and the primary drugs of concern in Australia—reported as ecstasy/MDMA and cocaine.
- Results of the EDRS in 2010 indicated that although ecstasy remained the drug of preference among participants in the EDRS survey of regular ecstasy users across Australia, some ecstasy indicators (percentage of survey participants who stated they were weekly ecstasy users; percentage stating that ecstasy was their drug of choice; and availability and purity of the drug) decreased in 2010 over 2009 levels. In 2010, 23 percent of the survey participants stated they used ecstasy weekly, a decline from 30 percent in 2009. Thirty-eight percent of the survey participants in 2010 reported that ecstasy was their drug of choice, compared with 42 percent in 2009. A significant increase was observed in the number of participants reporting that ecstasy was becoming difficult to obtain in 2010 (26 percent, compared with 12 percent in 2009). Also, a significant number of participants reported low drug purity (56 percent in 2010, compared with 24 percent in 2009).
- In contrast, cocaine preference has increased over time (13 percent of the national survey sample in 2010 reported cocaine as their preferred drug, compared with 8 percent in 2009). Its use was noted across all jurisdictions in Australia in 2010, whereas it was previously localized in the two largest cities, Sydney and Melbourne. In addition, the majority of survey participants in 2010 reported that cocaine was considered “easy to very easy” to obtain, in contrast to previous years when it was considered “very difficult.”

Thailand

- A representative from the WHO Collaborating Centre for Research and Training in Drug Dependence in Bangkok, Thailand, reported to the CEWG on substance abuse and monitoring systems in Thailand. According to the representative, the War on Drugs operation in Thailand, implemented in 2003, changed the monitoring system and influenced levels and patterns of drug indicators. The numbers of clients in treatment increased, and the number of drug offenders decreased with the new government policy, which for the first time regarded people dependent on drugs as patients, not criminals, and used treatment as a tool for recovery rather than prosecution.
- Many types of illicit substance abuse have been reported in Thailand. The most common indigenous natural products are cannabis/ganja and opium. While the country has experienced a heroin problem for 5 decades, heroin use has decreased since the legal control of the opium franchise in 1960, according to the Thailand representative. During the past 10 years, the number of heroin clients in treatment decreased about 106-fold.
- Illicit amphetamine (in tablet form) appeared along with heroin in the early 1960s in Thailand. Methamphetamine abuse evolved into a major epidemic in 1996, and methamphetamine continued as a major drug of concern in 2010. An increase in injection among methamphetamine users, as well as other drug users (such as heroin

users), has led in recent years to an increase in Thailand in HIV infection attributed to injection drug use. The percentage of HIV infection attributed to injection drug use reached its highest point in 2009 since 1997, at 52 percent, doubling from 26 percent in 2007.

Jamaica

- From the Caribbean, a representative from the National Council on Drug Abuse in Jamaica reported on illegal drug use trends in Jamaica. Among illegal drugs, cannabis/ganga use is predominant in Jamaica. As an endemic drug, many users in the country do not think of it as a drug,

but rather as a medicine or spiritual vehicle, according to the Jamaican representative. Levels of cannabis use, however, were reported as stable. Similarly, cocaine use was also seen as having stabilized in Jamaica. Increases in use of heroin were reported, and prescription drug use was described as an emerging problem of concern. In addition, in 2009, a large seizure (2,785 tablets) of MDMA/ecstasy was reported by Jamaican law enforcement officials. Qualitative reports indicated that some workers in Jamaica's commercial sex trade were transitioning from cocaine to ecstasy use.

Table 1. NFLIS Top 10 Drug Items Analyzed by CEWG Area and Rank (Based on Frequency) for 23 CEWG Areas: January–June 2010

CEWG Areas	Cocaine/ Crack	Heroin	Oxy- codone	Hydro- codone	Alprazolam	Clonaz- epam	Metham- phetamine	Cannabis/ THC	MDMA	Phency- lidine (PCP)	Other Drugs
SOUTHERN REGION											
Atlanta	1	6	3	4	5	--	2	7	8	--	1-(3-Trifluoromethylphenyl)piperazine=9; Amphetamine=10
Baltimore	2	3	5	--	6	7	--	1	8	--	Buprenorphine=4; Caffeine=9; Methadone=10
Maryland	2	3	4	--	6	8	--	1	9	7	Buprenorphine=5; Methadone=10
Miami	1	5	4	8	3	--	9	2	6	--	Hallucinogen (Nonspecified)=7; Diazepam=10
Washington, DC	1	3	10	--	--	--	7	2	6	4	1-Benzylpiperazine=5; Buprenorphine=8; Caffeine=9
NORTHEASTERN REGION											
Boston	2	3	4	--	7	6	--	1	--	--	Buprenorphine=5; Amphetamine=8; Gabapentin=9; Clonidine=10
Maine	1	4	3	7	--	--	6	2	9	--	Buprenorphine=5; 1-Benzylpiperazine=8; Methadone=10
New York City	1	3	5	10	4	--	--	2	6	8	Methadone=7; Buprenorphine=9
Philadelphia	2	3	4	9	5	7	--	1	--	6	Codeine=8; Buprenorphine=10
MIDWESTERN REGION											
Chicago	2	3	--	6	8	--	7	1	4	9	1-Benzylpiperazine=5; Acetaminophen=10
Cincinnati	2	3	4	5	6	8	7	1	10	--	Amphetamine=9
Detroit	2	3	7	4	5	--	--	1	6	--	Buprenorphine=8; Codeine=9; 1-Benzylpiperazine=10
Minneapolis/ St. Paul	3	5	6	--	--	--	1	2	4	--	Amphetamine=7; Cathinone=8; Acetylcodeine=9; Psilocybin/Psilocyn=10; 1-Benzylpiperazine=10 (tie)
St. Louis	3	2	7	6	5	--	4	1	8	--	Pseudoephedrine=9; 1-Benzylpiperazine=10
WESTERN REGION											
Albuquerque	1	4	5	8	--	--	3	2	6	--	Amphetamine=7; Psilocin=9; Buprenorphine=10
Denver	1	4	6	7	10	--	3	2	5	--	Psilocin=8; 1-Benzylpiperazine=9
Honolulu	3	5	7	6	8	--	1	2	4	--	Carisoprodol=9; Acetaminophen=10
Los Angeles	2	4	10	6	8	--	3	1	5	7	Psilocin=9
Phoenix	3	4	5	7	6	10	2	1	8	--	Carisoprodol=9
San Diego	3	4	7	5	8	--	2	1	6	--	Buprenorphine=9; Diazepam=10
San Francisco	3	5	7	6	--	--	2	1	4	--	Methadone=8; Morphine=9; Diazepam=10
Seattle	1	3	5	8	9	--	4	2	6	--	Buprenorphine=7; Amphetamine=10
Texas	2	6	--	5	4	9	3	1	8	--	Carisoprodol=7; 1-Benzylpiperazine=10

SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010; see appendix tables 2.1–2.23; 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: FY 2010 and 1H 2010 (the First Half of 2010)²

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

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

²Data are for January–June 2010 for all areas with the exception of San Francisco where data are for FY 2010.

³Data for Atlanta include data for the 28-county Atlanta Metropolitan Statistical Area. Boston data include data for the cities of Boston, Brookline, Revere, Chelsea, and Winthrop. Data for New York City are for the five boroughs of New York. Cincinnati data are for Hamilton County, while Minneapolis/St. Paul data pertain to metropolitan counties: Anoka, Dakota, Hennepin, Ramsey, and Washington. Data for St. Louis include data for the City of St. Louis and the County of St. Louis, as well as Jefferson, Franklin, Lincoln, St. Charles, and Warren Counties. Denver data are for the Denver/Boulder area. Data for Los Angeles cover Los Angeles County; data for Phoenix are for Maricopa County; for San Diego, San Diego County; for San Francisco, San Francisco County; and for Seattle, King County.

⁴Heroin and other opiates are grouped together for Cincinnati and San Francisco and are reported for heroin only.

⁵Methamphetamine, amphetamine, and MDMA are grouped together for Cincinnati.

⁶NR=Not reported by the CEWG area representative.

SOURCE: January 2011 State and local CEWG reports

Figure 23. Percentages of Cocaine, Heroin, Methamphetamine, and Cannabis/Marijuana Items Analyzed by Forensic Laboratories in 23 CEWG Areas in 4 U.S. Regions, Each as a Percentage of Total Items Analyzed: 1H 2010¹



¹Data are for January–June 2010; see appendix tables 2.1–2.23. 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 for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010

Section III. Update Briefs and International Reports: January 2011 CEWG Meeting

Introduction

The 69th semiannual meeting of the Community Epidemiology Work Group (CEWG) was held on January 19–21, 2011, in Scottsdale, Arizona. During this meeting 21 CEWG area members reported on current drug trends and patterns in their areas, based on data newly available since the June 2010 CEWG area report. Five 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 for Albuquerque and New Mexico—Update: January 2011

Nina Shah, M.S.

For inquiries regarding 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: Marijuana indicators were high and stable, with particularly high rates of use among students. Although synthetic marijuana has not been detected in large surveillance datasets, law enforcement reported that the substance was available in New Mexico. Survey estimates show a significant increase in ecstasy/MDMA abuse among New Mexico high school students. Cocaine indicators were high, but stable or decreasing. Cocaine overdose death and inpatient hospitalizations decreased from 2008

to 2009. The prevalence of cocaine use among New Mexico high school students remained stable during the 2009–2010 school year, ranking highest among Youth Risk Behavior Survey (YRBS) States. Cocaine was the most common item analyzed by Albuquerque forensic laboratories during the first half of 2010. Methamphetamine indicators were mixed as overdose deaths slightly increased from 2008 to 2009, prevalence of use among students decreased from 2007 to 2009, and hospitalizations remained stable from 2008 to 2009. There were slightly more methamphetamine laboratory incidents in the Albuquerque area during 2010 than in 2009. Heroin indicators were high, but stable or decreasing. Although heroin overdose deaths decreased in 2009, a notable trend emerged in that younger heroin users were dying of overdose. No increase in heroin use was found among high school students (4 percent in 2007 and 3 percent in 2009), but the issue has emerged as a serious community concern. Prescription drug indicators have worsened for the most part. Even though methadone and hydrocodone overdose death rates decreased from 2008 to 2009, the overdose death rate from oxycodone increased 28 percent during that period. Oxycodone was the third leading cause of overdose death in 2009, behind heroin and cocaine. Preliminary treatment data showed that admissions for abuse of other opiates and synthetics increased, and reports of painkiller abuse among high school students increased from 12 percent in 2007 to 14 percent in 2009. Overdose deaths and inpatient hospitalizations from the broad class of sedative/tranquilizers (e.g., alprazolam) also increased from 2008 to 2009. The Albuquerque Drug Enforcement Administration (DEA) cited controlled prescription drugs as the primary drug threat in the first half of 2010.

Updated Drug Abuse Patterns and Emerging Patterns: During the 2009–2010 school year, high school students in New Mexico reported the highest prevalence rates among students nationally of current **marijuana** use (28 percent) and initiating use before age 13 (18.4 percent). The proportion of State-funded treatment admissions for marijuana, among all admissions, was unchanged. In 2009, these clients were youngest (median age: 27 years) compared with other clients in treatment, as 59 percent were in treatment for the first time. Seventy-eight percent were male, 38 percent were White, and 33 percent were Hispanic. Of items analyzed by Albuquerque area forensic laboratories in the first half of 2010, 21 percent were marijuana, the second highest proportion of items analyzed. Synthetic marijuana (i.e., JWH-018) has not been reported in forensic laboratory data, although qualitative information indicated that the substance was available. The estimate for current **ecstasy** use increased significantly among high school students, from 5.1 percent in 2007 to 8 percent in 2009, ranking first among States in the 2009 YRBS. Overdose deaths caused by **cocaine** decreased 16 percent from 2008 to 2009, and inpatient hospitalizations were relatively stable ($n=163$ in 2008 and $n=144$ in 2009). Youth use prevalence remained stable (5.4 percent in 2007 and 5.6 percent in 2009), ranking highest in the Nation for lifetime and current cocaine use in the 2009–2010 school year. The proportion of primary cocaine/crack treatment admissions decreased, from 7.6 percent in 2008 to 4.4 percent in 2009 among all admissions. Forty percent smoked the drug (crack users). Almost one-half of crack admissions were female, 43 percent were Hispanic, 24 percent were White, and 14 percent were Black. They were the oldest of all clients, with a median age of 39.8 years. Admissions that used cocaine through oral (14 percent), inhalation (68 percent), and injection (17 percent) routes were 63 percent male, 48 percent Hispanic, 22 percent White, and 7 percent Black. In 2009, a greater proportion (52 percent) of admissions reported a secondary drug (largely alcohol and marijuana) than during 2006–2008 (32–42). In the first half of

2010, 22 percent of items analyzed by Albuquerque forensic laboratories were cocaine, the highest proportion of all substances. The high-end wholesale price of powder cocaine decreased in Albuquerque (from \$28,000 per kilogram to \$24,000 per kilogram) but remained stable in Las Cruces (\$16,000 per kilogram) from December 2008 to June 2009. The **methamphetamine** overdose death rate remained low, increasing slightly from 2008 (1.1 per 100,000) to 2009 (1.7 per 100,000), with the highest overdose death and hospitalization rates persisting in southeastern New Mexico. Statewide, amphetamine hospitalizations remained stable since early 2008, and current methamphetamine use among high school students decreased slightly from 2007 (4.4 percent) to 2009 (3.9 percent). The number of treatment admissions for methamphetamine decreased from 2008 ($n=598$; 5.2 percent) to 2009 ($n=426$; 4.6 percent). Almost one-half of methamphetamine admissions were female, and one-half were White. Clients were slightly older than in prior years, with a median age of 32.8 years in 2009, compared with a median age of 30–31 during 2006–2008. For most treatment admissions (61 percent), smoking was the primary route of administration, and a large proportion of clients were referred through the criminal justice system (45 percent). Methamphetamine items constituted 20 percent of items analyzed by Albuquerque forensic laboratories in the first half of 2010. The number of laboratory incidents in Albuquerque was slightly higher in 2010 than 2009. In Albuquerque, the wholesale price of Mexican “ice” decreased from \$26,000–\$28,000 per kilogram in December 2008 to \$18,000–\$20,000 per kilogram in June 2009. National Drug Intelligence Center (NDIC) information indicated this latter price range persisted through the first half of 2010. The methamphetamine drug threat was considered low to moderate. **Heroin** indicators were high and stable or decreasing. The heroin overdose death rate decreased from 2008 to 2009. Of note, people age 21 and younger represented less than 2 percent of people who died from a heroin overdose since 2004. That percentage significantly increased to 8 percent in 2008 and 12

percent in 2009. No increase in use was found in youth survey data (3.9 percent in 2007 and 3.2 percent in 2009). The proportion of heroin treatment admissions among all admissions remained stable from 2008 to 2009, at 6.4 and 6.7 percent, respectively. Heroin treatment admissions were mostly male (62 percent) and Hispanic (63 percent). In 2009, heroin admissions were considerably younger than in prior years (median age: 33.2 years). Eighty percent reported injecting the drug in 2009, and the proportion reporting smoking the drug increased from 11 percent in 2008 to 14 percent in 2009. Of items analyzed by Albuquerque area forensic laboratories in the first half of 2010, 12.5 percent were heroin items. In Las Cruces, the wholesale price of Mexican black tar heroin decreased from December 2008 to June 2009 (from \$18,000–\$20,000 per pound to \$12,000–\$15,000 per pound). The wholesale price in Albuquerque was stable. The New Mexico Prescription Drug Monitoring Program revealed that 44 percent of New Mexicans age 10 and older were prescribed a controlled substance during a recent 27-month time period, underscoring the prevalence of these drugs. Although the total **prescription opioid** overdose death rate decreased statewide from 2008 (9.1 per 100,000) to 2009 (8.4 per 100,000), *oxycodone*-related indicators increased. Oxycodone overdose deaths increased from 2.9 per 100,000 in 2008 to 3.7 per 100,000 in 2009; it was the third leading cause of overdose death in 2009, behind heroin and cocaine; and it was the fifth most common drug analyzed by Albuquerque forensic laboratories in the first half of 2010. *Methadone* overdose deaths declined to the lowest level since 2002, and they were most common among Albuquerque residents compared with the rest of the State (rate ratio=1.85). Multidrug methadone overdose deaths during 2005–2009 were more often in combination with other prescription drugs than illicit drugs, as was the case during 1998–2002. Hospitalizations with a primary diagnosis of heroin and synthetic opiates increased from 341 in the first half of 2008 to 455 in the second half of 2009, likely driven by morbidity related to prescription opioids as opposed to heroin. Treatment

admissions for other opiate and synthetic abuse increased, from 2.5 percent of admissions in 2008 to 3.7 in 2009. There was a growing proportion of Hispanics among these admissions (42 percent in 2008 and 52 percent in 2009), and the median age has gradually decreased (35.0 in 2007, 34.0 in 2008, and 32.4 in 2009). No apparent change in route of administration was detected. Controlled prescription drugs were cited by the Albuquerque DEA as the primary drug threat in the first half of 2010. **Sedative and tranquilizer** (i.e., benzodiazepines) indicators increased. The overdose death rate increased 30 percent from 2008 to 2009, and the number of overdose deaths caused by *alprazolam*, the fourth leading cause of drug overdose deaths in 2009, increased from less than 10 prior to 2004 to 56 in 2009. The number of hospitalizations with a primary diagnosis in the broad category of sedative/hypnotic, barbiturate, tranquilizer, and benzodiazepines increased by 17 percent from 2008 to 2009. The statewide overdose death rate caused by **anti-depressants** also increased, from 3.0 per 100,000 in 2008 to 4.2 per 100,000 in 2009. The mode of exposure for living injection drug users (IDUs) with human immunodeficiency virus/acquired immunodeficiency syndrome (**HIV/AIDS**) ($n=3,304$) has not changed in recent years; roughly 19 percent were IDUs and men who have sex with men (MSM)/IDUs. As of December 2010, these cases with HIV/hepatitis C (HCV) co-infection were largely male (80 percent); 48 percent were White; and 37 percent were Hispanic. Forty-six percent were age 30–39 at diagnosis, but 42 percent of living cases were 50 or older.

Data Sources: *Treatment data were provided by the State Behavioral Health Services Division, Human Services Department. The State behavioral health system contract transition in mid-2009 impacted the second half of 2009 Treatment Episode Data Set (TEDS). Data collection issues are under investigation. Therefore, 2009 data were the most recent, but were considered preliminary. These are State-funded treatment admissions only, including opiate replacement therapy. New Mexico TEDS for 2006–2008 was*

also accessed in order to compare previous year trends. **School survey data** were from the Centers for Disease Control and Prevention (CDC)-sponsored YRBS conducted during the 2009–2010 school year. In addition, New Mexico administered a middle school survey. The data are reported as percentages with 95 percent confidence intervals. **Hospitalization inpatient discharges** for 2003–2009 were obtained from the New Mexico Health Policy Commission. **Crime laboratory data** for the first half of 2010 were provided by the National Forensic Laboratory Information System (NFLIS), DEA. **Drug price data** for June 2009 were from the NDIC. NDIC Field Intelligence provided preliminary pricing information for Albuquerque through December 2009. **Infectious disease data related to drug use** was obtained from the State HIV and Hepatitis Epidemiology Surveillance Program, New Mexico Department of Health. Mode of exposure among living HIV-infected/AIDS IDUs is reported, and prevalent HIV/HCV co-infection cases are described. **Unintentional drug overdose death data** for 2003–2009 were provided by the State-centralized New Mexico Office of the Medical Investigator. Rates are age-adjusted rates and expressed per 100,000. Drug-specific overdose death rates were also calculated.

Drug Abuse Patterns and Trends in Atlanta, GA—Update: January 2011

Lara DePadilla, Ph.D., and Mary Wolfe, B.S.

For inquiries concerning this report, please contact Lara DePadilla, Ph.D., Research Assistant Professor, Department of Behavioral Sciences and Health Education, Rollins School of Public Health, Emory University, Floor 5, 1518 Clifton Road, Atlanta, GA 30322, Phone: 404–358–5037, Fax: 404–727–1369, E-mail: ldepadi@emory.edu.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine and marijuana remained the dominant drugs of abuse in the metropolitan Atlanta area. **Cocaine** was the drug most mentioned in National Forensic Laboratory

Information System (NFLIS) drug items seized and analyzed for the 28 metropolitan area counties during the first half of 2010. Treatment admissions data indicated that cocaine was the primary substance in 17.7 percent of admissions in the first half of 2010. This represents a decrease from 19.8 percent in 2009 and 22.8 percent in 2008. Cocaine mentions as a secondary drug of choice among primary heroin treatment admissions increased from 15.0 percent in 2009 to 20.6 percent in the first half of 2010, but they remained below the 27.2 percent reported in 2008. Cocaine use, including the use of powdered cocaine and crack cocaine, among treatment admissions in the first half of 2010 in Atlanta continued to be predominantly among African-Americans. The ratio of African-Americans to all other races was 2.67:1. This disparity was similar for crack cocaine and powder cocaine. Equal numbers of males and females reported cocaine as their primary reason for admission. However, gender comparisons between the two routes of cocaine use showed that more males reported using powder cocaine and slightly more females reported using crack cocaine. Seventy-one percent of clients in public treatment for cocaine were older than 35. More than 70 percent of crack cocaine clients were older than 35, while roughly 60 percent of powder cocaine clients were older than 35. More than 80 percent of crack cocaine clients in treatment reported smoking the drug, while the main routes of administration for powder cocaine were smoking and snorting, with snorting being slightly more popular. Calls to the Georgia Crisis and Access line involving cocaine were stable. Among the five major counties closest to the center of the city (Fulton, DeKalb, Cobb, Gwinnett, and Clayton), Fulton, Cobb, and Gwinnett experienced decreases in prison arrests for the possession of cocaine. Those in Clayton County slightly increased, and those in DeKalb County remained stable. Based on treatment data, cocaine use was largely found closer to the city of Atlanta, with 82.6 percent of the treatment admissions in the 28-county metropolitan statistical area reported in the surrounding five counties. Among male arrestees in 2008 in Fulton County, the percentage

testing positive for cocaine decreased, from 39.8 percent in 2008 to 36.3 percent in 2009. In the same population, self-reports of ever receiving treatment for crack cocaine increased, from 47.4 percent in 2008 to 59.6 percent in 2009, while self-reports of ever receiving treatment for powder cocaine increased only 1 percentage point, to 43.2 percent, during that time period. **Marijuana** remained the most commonly used substance in Atlanta, having surpassed cocaine use reported in public treatment data in 2009. The percentage of treatment admissions in the first half of 2010 was 25.8 percent, representing a slight increase from 2009. Marijuana was the secondary drug in 20.6 percent of cocaine and 25 percent of methamphetamine treatment admissions. Marijuana appeared to be more spread across urban and nonurban counties than cocaine, with 69.6 percent of primary marijuana treatment admissions in the five counties closest to the city. Roughly 70 percent of admissions for marijuana were male, and nearly 60 percent were African-American. The most represented age group was the 18–25 group, constituting more than 35 percent of marijuana primary treatment admissions. There was a slight decrease in admissions for clients younger than 18. Among male arrestees in 2008 in Fulton County, the percentage testing positive for marijuana increased slightly, from 39.2 percent in 2008 to 44.9 percent in 2009. There also was a slight increase in the percentage of male arrestees self-reporting any treatment for marijuana, from 23.2 percent in 2008 to 27.1 percent in 2009. Crisis line calls from the first quarter of 2010 indicated that calls for marijuana continued to rise. Marijuana was the most reported illicit drug among calls. **Methamphetamine** use varied across indicators. Treatment admissions for methamphetamine have been stable at approximately 6 percent since 2008. During the first half of 2010, female methamphetamine treatment admissions outnumbered those among males at a ratio of 1.78:1. Consistent with previous years, smoking was the primary route of administration. Whites remained the most frequent users of methamphetamine at a ratio of 13.06 compared with other races. Percentages of public treatment admissions

were approximately 30 percent across three age groups: 18–25, 26–34, and 35 and older. NFLIS showed an increase in drug items seized and identified as methamphetamine in the first half of 2010, continuing a trend that began in 2009. In the first half of 2010, 43 percent of treatment admissions were in the counties closest to the city, compared with only 30 percent of treatment admissions during the same period in 2009. This indicates that while methamphetamine use is lower than that of other drugs it may be becoming more distributed across the metropolitan area. Among male arrestees in 2008 in Fulton County, less than 1 percent tested positive. In the same population, self-reports of ever receiving treatment for methamphetamine decreased, from 59.2 percent in 2008 to 39.2 percent in 2009. **Heroin** indicators showed a possible increase in use in the Atlanta area. The percentage of primary treatment admissions in the first half of 2010 was 5.7 percent, compared with 4.9 percent in 2009. Admissions were concentrated in the urban counties (80 percent), similar to previous years. Among male arrestees in Fulton County, self-reports of ever receiving treatment for heroin use increased, from 47.5 percent in 2008 to 84.4 percent in 2009. Purity levels of Southwest Asian (SWA) heroin decreased, while purity levels for South American (SA) heroin increased slightly between 2008 and 2009. The price per milligram pure of SWA heroin decreased from 2008 to 2009 from \$1.49 to \$0.69, while the price of SA heroin decreased from \$1.31 to \$0.80 during the same period. **Alprazolam** levels remained consistent for treatment admissions at 1.4 percent in 2008, compared with 1.2 percent in 2009. NFLIS data also indicated consistency across years for alprazolam, with 291 seizures in the first half 2010, compared with 583 for the entire year of 2009. Indicators of **oxycodone** continued to show an increase in the Atlanta area. Oxycodone treatment admissions in the first half of 2010 constituted 3.7 percent of primary admissions, compared with 2.4 percent in 2009. NFLIS data showed a steady increase, from 230 seizures in the first half of 2009 of items seized and identified as oxycodone to 382 in the same period in 2010. This pattern was similar

for **hydrocodone**, with NFLIS data showing 292 items in the first half of 2010, compared with 201 seizures in the first half of 2009. It is of note that three of the top five drugs seized and identified in forensic laboratories were prescription medications. Drug indicators (treatment admissions and drugs seized and identified by NFLIS) suggested that **MDMA** (methylenedioxymethamphetamine) decreased slightly in the first half of 2010, continuing a trend from 2009.

Data Sources: *Treatment data* were provided by the Georgia Department of Human Resources. Coverage includes all direct providers of treatment services that receive county or State program funds in the 28 counties that constitute metropolitan Atlanta. Data on all client admissions for drug and alcohol treatment—not just clients receiving treatment paid for using public funding sources—are included in the data set. This report presents admissions data from January through June 2010—the most recent data available—and makes comparisons with percentages from prior years. Percentages of treatment admissions are calculated from total admissions excluding admissions for alcohol only as the primary substance of abuse. **Forensic laboratory data** were provided by NFLIS, Drug Enforcement Administration, for the first half of 2010. 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, half-year 2010 data are extrapolated. Cannabis seizures may not be accurate due to changes in field testing practices. In 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 the CEWG area relative to other CEWG areas. **Prison/jail admissions data** were provided by the Georgia Department of Corrections and include the calendar year 2010. **Georgia Crisis and Access Line Call** data were provided by the Georgia Department of Human Resources. Coverage

includes all statewide telephone calls for Georgia's single point of entry program, a required step toward seeking substance abuse treatment from a public facility. This report presents call data from July 2006 through June 2010. Arrestee data were provided by the Arrestee Drug Abuse Monitoring program and cover male arrestees in the city of Atlanta/Fulton County, Georgia. There were two facilities in the sample. **Heroin price and purity** data were provided by the Heroin Domestic Monitoring Program.

Drug Abuse Patterns and Trends in Baltimore City, Maryland, and Washington, DC—Update: January 2011

Erin Artigiani, M.A., Maribeth Rezey, M.A., Margaret Hsu, M.H.S., and Eric Wish, Ph.D.

For inquiries concerning this report, please contact Erin Artigiani, M.A., Deputy Director for Policy, Center for Substance Abuse Research, University of Maryland, Suite 501, 4321 Hartwick Road, College Park, MD 20740, Phone: 301-405-9794, Fax: 301-403-8342, E-mail: erin@cesar.umd.edu.

Overview of Findings: Throughout the Washington, DC, and Maryland region, cocaine, marijuana, and heroin continued to be the primary drug problems in the first half of 2010. In general, indicators for marijuana and other opiates were increasing across the region, while indicators for cocaine and heroin were more mixed. The Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) reported that cocaine and marijuana were the most frequent drugs seized and identified 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 (phencyclidine). 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.

Updated Drug Abuse Trends and Emerging Patterns: In *Washington, DC*, in 2010, **cocaine/crack, marijuana, and heroin** continued to be the primary illicit drug problems. Cocaine remained one of the most serious drugs of abuse, as evidenced by the fact that more adult arrestees and more items seized tested positive for cocaine than for any other drug. However, the percentage of adult arrestees testing positive for cocaine continued to decrease. In comparison, the percentage testing positive for opiates remained about the same, and the percentage testing positive for PCP increased slightly. In the first 9 months of 2010, 27 percent of adult arrestees tested positive for cocaine, and approximately 9–10 percent tested positive for opiates and/or PCP. In addition, more seized items tested positive for cocaine (37.5 percent) in the first 6 months of 2010 than for any other drug, as reported by the National Forensic Laboratory Information System (NFLIS). Overdose deaths increased, from 90 in 2007 to 105 in 2008. They were also more likely to be related to cocaine (60 percent) than to any other drug. During the first 9 months of 2010, juvenile arrestees were more likely to test positive for marijuana (55.8 percent) than for any other drug, and the percentage appeared to be increasing. The percentage testing positive for cocaine decreased in 2009 and remained about the same in the first 9 months of 2010. The percentage of adult and juvenile offenders in *Washington, DC*, testing positive for amphetamines remained considerably lower than for other drugs and decreased in 2010. In *Maryland*, there were 60,404 primary admissions to certified treatment programs in 2009. This appeared to be increasing in the first half of 2010. Admissions most frequently involved alcohol, heroin, marijuana, crack, and other cocaine. Cocaine and marijuana accounted for more than three-quarters of the positive drug items tested through NFLIS during the first 6 months of 2010. Approximately one in five items tested were positive for heroin, and nearly all of these items (87 percent) were from Baltimore City. The number of drug intoxication deaths in Maryland increased from 721 in 2008 to 760 in 2009, but appeared to be decreasing

in the first half of 2010. **Narcotics** (heroin, methadone, oxycodone, fentanyl, and other) were the most frequently identified drugs in drug intoxication deaths in the first half of 2010. Approximately one in four of the drug intoxication deaths occurred in Baltimore City.

Data Sources: *Drug seizure data* were provided by NFLIS, the Drug Enforcement Administration, and the Washington/Baltimore HIDTA. *Heroin cost data* were obtained from the Heroin Domestic Monitoring Program, 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, and the Maryland office of the Chief Medical Examiner. *Adult and juvenile arrestee data* were adapted from information obtained from the District of Columbia Pretrial Services Agency. *Treatment admissions data* for Maryland and 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 2011

Daniel P. Dooley

For inquiries concerning this report, please contact Daniel P. Dooley, Senior Researcher, Boston Public Health Commission, 1010 Massachusetts Avenue, Boston, MA 02118. Phone: 617-534-2360, Fax: 857-288-2212, E-mail: ddooley@bphc.org.

Overview of Findings: Cocaine and heroin continued as the dominant drugs of abuse in Boston during this reporting period. Cocaine figured prominently among drug-related deaths, drug arrests, and drug laboratory samples derived from drug arrests. Heroin dominated as the primary drug in emergency department (ED) visits and

substance treatment admissions and was cited most often among calls to the substance abuse helpline. Marijuana, other opiates/synthetics (including oxycodone), and benzodiazepines remained present at more moderate levels. Methamphetamine and other “club drugs” remained at relatively low levels overall.

Updated Drug Abuse Trends and Emerging Patterns: In Boston, **cocaine** indicators were mainly decreasing but remained at very high levels when compared with other drugs. Cocaine figured in 35 percent of all drug-related deaths in 2008. Cocaine was the second most prominent drug among identified drugs in ED visits. The rate of estimated cocaine-involved ED visits had a significant 12-percent decrease from 2008 to 2009. The proportion of primary cocaine treatment admissions also decreased, from 9 percent in fiscal year (FY) 2007 to 6 percent in FY 2010. The proportion of cocaine calls to the helpline remained fairly stable, at 15 percent in FY 2009 and 16 percent in FY 2010. After adjusting for the impact of a major change in 2009 in Massachusetts law that effectively decriminalized possession of small amounts of marijuana, the nonmarijuana proportion of Class B drug arrests (mainly cocaine) decreased, from 70 percent in 2007 to 63 percent in 2009. Similarly, the adjusted (nonmarijuana) proportion of cocaine drug laboratory samples decreased, from 40 percent in 2007, to 38 percent in 2008, and to 36 percent in the first half of 2010. The most recent **heroin** abuse indicators were mostly stable at extremely high levels in Boston. Heroin and/or other opioids figured in 57 percent of Boston drug-related deaths in 2008. Heroin was the most prominent drug among drugs identified during ED visits. The rate of estimated heroin-involved ED visits was stable from 2008 to 2009. The proportion of primary heroin treatment admissions increased, from 46 percent in FY 2006 to 51 percent in both FY 2009 and FY 2010. The proportion of heroin calls to the substance abuse helpline increased slightly, from 32 percent in FY 2008 to 34 percent in FY 2009, and then decreased back to 32 percent in FY 2010.

The adjusted (nonmarijuana) level of Class A drug arrests (mainly heroin) was stable at 28 percent from 2008 to 2009. The adjusted proportion of heroin drug laboratory samples was stable at approximately 21 percent in 2009 and in the first half of 2010. The most recent Drug Enforcement Administration (DEA) data indicated that street-level heroin in Boston cost \$5–\$80 per bag and \$40–\$120 per gram, with an average purity level at 17 percent. The price per milligram pure increased from \$1.37 in 2007 to \$1.62 in 2008. Indicators for **other opiates/opioids** were stable or increasing at moderate levels. The rate of estimated ED visits involving nonmedical use of opiates/opioids increased significantly by 17 percent from 2007 to 2009. The proportion of other opioid primary treatment admissions was stable from FY 2009 to FY 2010 at 4 percent. The number of other opioid primary treatment admissions in FY 2010 ($n=862$) was the highest recorded in more than 10 years. The proportion of other opioid helpline calls increased, from 15 percent in FY 2008 to 19 percent in FY 2009, and to 22 percent in FY 2010. The proportion of oxycodone adjusted (nonmarijuana) drug laboratory samples increased, from 8 percent in 2008, to 9 percent in 2009, and to 11 percent in the first half of 2010. Except for the indicators directly affected by the major change in the marijuana possession law, **marijuana** indicators were stable at varied levels. The rate of estimated marijuana ED visits was stable from 2008 to 2009. The proportion of marijuana treatment admissions has remained stable, between 4 and 5 percent, for 10 years, from FY 2001 to FY 2010. The proportion of marijuana helpline calls remained at 4 percent from FY 2008 to FY 2010. As a result of the new marijuana law in 2009, the proportion of Class D drug arrests (mainly marijuana) decreased from 35 percent in 2008 to 21 percent in 2009. Similarly, the proportion of marijuana drug laboratory samples decreased, from 43 percent in 2008, to 24 percent in 2009, and to 26 percent in the first half of 2010. **Methamphetamine** abuse levels remained low in Boston, representing less than 1 percent of all estimated ED visits, treatment admissions, helpline calls, and drug laboratory samples. The number of

primary admissions for methamphetamine totaled 69 in FY 2009 and 35 in FY 2010. The number of methamphetamine calls to the helpline from FY 2000 to FY 2010 totaled fewer than 25 for each year. Methamphetamine drug laboratory samples totaled 69 in 2008, 66 in 2009, and 22 in the first half of 2010. Indicators for **benzodiazepine** abuse in Boston were mostly stable at moderate levels. The rate of estimated ED visits involving nonmedical use of benzodiazepines was stable from 2007 to 2009. Klonopin® (clonazepam) was identified in more than one-half of the ED visits with an identified benzodiazepine in 2009. In FY 2010, the proportion of benzodiazepine primary treatment admissions reached 1 percent of the total; 10 percent (up from 6 percent in FY 2002) of treatment admissions cited benzodiazepines as primary, secondary, or tertiary drugs. The proportion of benzodiazepine calls to the helpline remained between 4 and 6 percent from FY 2005 to FY 2010. Clonazepam and alprazolam ranked sixth and seventh among NFLIS drug laboratory samples in the first half of 2010.

Data Sources: *Drug-related deaths* data for the city of Boston were provided by the Massachusetts Department of Public Health Vital Records. *ED drug visit estimates* for 2004–2009 for a seven-county Boston metropolitan area composed of five Massachusetts counties, including Essex, Middlesex, Norfolk, Plymouth, Suffolk, and two New Hampshire counties, including Rockingham and Strafford, were provided by the Drug Abuse Warning Network, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. **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 2001 through 2010 (July 1, 2000, through June 30, 2010) were provided by the Massachusetts Department of Public Health, 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 a Boston region comprising the cities of Boston, Brookline, Chelsea, Revere, and Winthrop (CHNA 19) for FYs 2000 through 2010. **Drug arrest data** for the city of Boston for 2002 through 2009 were provided by the Boston Police Department, Drug Control Unit and Office of Research and Evaluation. A 2009 Massachusetts law decriminalizing possession of less than an ounce of marijuana took effect January 1, 2009, and has impacted drug arrest indicators. **Forensic laboratory data** for the Boston Metropolitan Statistical Area for 2008, 2009, and the first half of 2010 were provided by the DEA's National Forensic Laboratory Information System, Data Query System, December 16, 2010. **Drug price and purity information** was provided by the DEA New England Field Division, May 2010.

Drug Abuse Patterns and Trends in Chicago—Update: January 2011

Lawrence Ouellet, Ph.D.

For inquiries concerning this report, please contact Lawrence Ouellet, Ph.D., Research Professor, Division of Epidemiology and Biostatistics, School of Public Health, University of Illinois at Chicago, MC-923, 1603 West Taylor Street, Chicago, IL 60612-0145, Phone: 312-355-0145, Fax: 312-996-1450, E-mail: ljo@uic.edu.

Overview of Findings: Cocaine, heroin, and marijuana continued to be the major substances of abuse for Chicago and the surrounding metropolitan area in 2009 and 2010. Major indicators suggested that levels of cocaine, heroin, and marijuana abuse were high and steady, while some indicators suggested cocaine use was declining. Drug Enforcement Administration (DEA) Heroin Domestic Monitor Program (HDMP) data indicated that heroin purity increased again in 2009 to the highest level of this decade. Among Chicago high school students sampled by the Youth Risk Behavior Survey, the proportions reporting ever using cocaine (6.7 percent) or heroin (4.7 percent) were the highest measured by the survey to date. Students' lifetime use of marijuana and methamphetamine

declined in 2009, compared with 2007, while life-time use of 3,4-methylenedioxymethamphetamine (MDMA) and inhalants was stable.

Updated Drug Abuse Trends and Emerging Patterns: Levels of **cocaine** abuse continued to be high and stable, but they may be declining. Weighted estimates from the Drug Abuse Warning Network (DAWN) for calendar year (CY) 2009 showed that 40 percent of total estimated emergency department (ED) visits for major substances of abuse were cocaine related. Cocaine declined to 20 percent of all drug items identified by the National Forensic Laboratory Information System (NFLIS) in mid-2010, second to marijuana. Wholesale prices for a kilogram of powder cocaine in Chicago reported by the National Drug Intelligence Center (NDIC) narrowed in range and may have declined slightly at \$22,000–\$26,000 in June 2009. The NDIC reported significantly lower prices for a gram of cocaine (\$50–\$75) in mid-2009 compared with year-end 2008. Ethnographic reports suggested that powder cocaine was in low demand on the street and its quality had declined. Crack cocaine remained highly available, and its quality was reported between moderate to excellent. **Heroin** levels of abuse were high and stable. Weighted estimates accessed from DAWN for CY 2009 showed that 36 percent of total ED reports for major substances of abuse were heroin related. Heroin ranked third and constituted 14 percent of drug items identified by NFLIS in mid-2010. The average purity of heroin as reported by the DEA increased from 22.4 percent in 2007, to 23.8 percent in 2008, and to 26.6 percent in 2009, the highest level since 1999. The price per milligram pure remained low and unchanged at \$0.37. The NDIC reported that the mid-level cost of an ounce of Mexican brown powder heroin in mid-2009 (\$800–\$1,000) represented a substantial decline compared with 2008. Major indicators of drug use suggested that **marijuana** abuse was high and stable in 2009. Weighted estimates from DAWN for CY 2009 showed that 22 percent of ED reports for major substances of abuse were marijuana related, which was an increase from CY

2008. Marijuana was the predominant drug item analyzed by NFLIS for mid-2010, representing 59 percent all drug samples. High-quality marijuana (e.g., hydroponic and BC Bud) continued to be available in Chicago and was priced significantly higher than commercial-grade marijuana. Average wholesale prices for high-end marijuana varied but were within the typical range at \$4,000 per pound, while commercial grade Mexican marijuana sold for around \$1,400 per pound, according to the NDIC. The NDIC reported significant increases in the cost of a gram of high-quality and commercial grade marijuana in mid-2009, compared with year-end 2008. Among **prescription drugs**, those most often cited in ethnographic reports as being used without prescription were Xanax®, Vicodin®, Klonopin®, clonidine, and methadone. **MDMA** remained popular in low-income African-American neighborhoods, and weighted DAWN estimates suggested that between 2004 and 2008 use of MDMA grew among African-Americans but not among non-Hispanic Whites. In 2009, African-Americans again led DAWN estimates of MDMA visits, but the difference compared with Whites narrowed. Primary users were in their teens and twenties. Prices generally ranged between \$10 and \$20 per tablet on the South Side and West Side. **Buprenorphine** was the fourth most commonly seized prescription drug identified by NFLIS in mid-2010, ahead of methadone, which ranked fifth. Suboxone® is the most commonly reported form of buprenorphine, and its use without a prescription is typically to avoid withdrawal or to better manage an addiction to heroin. **Drug injection** by young African-Americans continued to be rare. New injection drug users (IDUs) were likely to be White and to reside in suburban Chicago. **HIV/AIDS Update:** The Chicago Department of Public Health reported a cumulative total of 32,275 known cases of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in Chicago. The rate of persons living with HIV was about 2.8 times greater in Chicago, compared with the United States. The prevalence and incidence of HIV infection in IDUs have declined markedly, compared with the 1980s and 1990s.

The proportion of new HIV infections with injection drug use as a risk factor fell to a new low in 2008, at 16.8 percent. In that year, African-Americans represented about 35 percent of the population of Chicago but 80 percent of new HIV infections attributed solely to injection drug use. Injection-related HIV diagnoses in 2008 were most often found in persons who were at least 50, followed by persons age 40–49. HIV prevalence among injecting and noninjecting “hard” drug users was converging in low-income Chicago neighborhoods.

Data Sources: *ED visit data* were derived for CY 2009 from the DAWN online query system administered by the Center for Behavioral Health and Statistics and Quality, Substance Abuse and Mental Health Services Administration. The DAWN data are weighted and are estimates for the reporting area. The 2009 YRBS, prepared by the Centers for Disease Control and Prevention (CDC), provided **student drug use data** representative of students in grades 9 through 12 in Chicago public schools. **Price and purity data** for heroin for 1991–2009 were provided by the DEA’s HDMP. **Drug price data** for 2009 came from the “National Illicit Drug Prices” by the NDIC. Data from NFLIS for the first half of 2010 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 2005–2009 were derived from the NIDA-funded “Sexual Acquisition and Transmission of HIV—Cooperative Agreement Program” (SATH-CAP) study in Chicago (U01 DA017378).

Drug Abuse Patterns and Trends in Cincinnati (Hamilton County)—Update: January 2011

Jan Scaglione, Pharm.D., M.T., DABAT

For inquiries concerning this report, please contact Jan Scaglione, Pharm.D., M.T., DABAT,

Clinical Toxicologist, Cincinnati Children’s Hospital Medical Center; Cincinnati Drug and Poison Information Center; ML-9004, 3333 Burnet Ave., Cincinnati, Ohio 45229, Phone: 513–636–5060, Fax: 513–636–5072, E-mail: jan.scaglione@cchmc.org

Overview of Findings: The predominant drug issues in Cincinnati continued to involve both cocaine/crack cocaine and marijuana as primary drugs of abuse. Cocaine indicators decreased somewhat from a relatively high to moderate level for the first half of 2010, compared with 2009 data. Indicators for marijuana in the Cincinnati region were consistently reported at high levels, with a leveling off seen during the first half of 2010, compared with 2009 data sources. Marijuana as a primary drug of abuse accounted for 28.9 percent of all treatment admissions, and it represented 39.5 percent of items submitted for forensic analysis for the Cincinnati area. Indicators for heroin were at a moderate level, with a rise in some indicators during 2010 from the previous year. The number of items submitted for forensic analysis involving heroin increased by nearly 15 percent in the first half of 2010, compared with 2009 data. Methamphetamine indicators continued to be low relative to other drugs in Cincinnati, with some increase in indicators. MDMA (3,4-methylenedioxymethamphetamine) indicators remained low to moderate in Cincinnati, with a slight increase noted during 2010. Abuse of prescription drugs, specifically benzodiazepines and opioid narcotics, continued to be an increasing drug issue in Cincinnati. Calls to poison control involving buprenorphine-containing pharmaceuticals increased 60 percent from 2009 to 2010, with some increase in cases suspected as intentional abuse of the drug.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine/crack cocaine as a primary drug of abuse reported during admission to treatment programs accounted for 17 percent of admissions, excluding alcohol, during the first half of 2010. The Cincinnati Regional Narcotics Unit (RENU) removed a combined total of

more than 11,000 grams of cocaine/crack cocaine during 2010. Indicators for cocaine/crack dropped to moderate levels during the first half of 2010. There were 26 percent fewer calls recorded by poison control in 2010, compared with 2009. Cocaine and crack cocaine seizures submitted to the Drug Enforcement Administration (DEA) laboratory for analysis in the first half of 2010 revealed tetramisole (levamisole) impurities in 78 percent of the analyzed samples. **Marijuana** dominated all other reported drugs as primary among treatment admissions, accounting for nearly 42.3 percent of admissions, excluding alcohol, during the first half of 2010. While marijuana availability and use remained high across the Cincinnati region, indicators pointed to a leveling off at a high level. **Heroin** remained at a moderate level, with mixed indicators for the Cincinnati region for the first half of 2010, compared with 2009. Treatment admissions for primary heroin abuse were not delineated from other opiate/opioid admissions, but the number of overall heroin and opioid admissions accounted for 30.5 percent of total admissions, excluding alcohol. The number of items submitted in the first half of 2010 for forensic analysis and identified as heroin increased to 12.5 percent, from 10.9 percent the previous year. Purity levels dropped, and poison control data showed a 25-percent decrease in reported human heroin exposure cases in 2010. Use of **methamphetamine** in Cincinnati remained low, but exposure cases called to poison control increased by 67 percent, and the number of methamphetamine laboratory busts increased over 2008 levels. **MDMA** availability and use in Cincinnati during 2010 remained at a low to moderate level, with a nearly 18-percent increase in calls recorded by poison control over the previous year. **Prescription narcotics** containing either oxycodone or hydrocodone remained the most prevalent of the opioid products abused in Cincinnati. An increase in the number of items submitted for forensic analysis in the first half of 2010 exceeded those submitted for the entire 2009 year. Abuse of methadone appeared to be decreasing in 2010, compared with the previous year. The most frequent benzodiazepine abused continued

to be alprazolam, according to both users and law enforcement. Human exposure cases involving alprazolam and clonazepam reported to poison control remained relatively stable during 2010, compared with 2009. **Emerging Patterns:** Indicators for buprenorphine abuse, using poison control data, continued to show growing numbers of both human exposure calls as well as drug identification calls. The total number of human exposure calls rose by 60 percent in 2010 over the previous year. Drug identification calls to poison control are often used as indicators of pharmaceutical diversion. The number of items submitted for forensic analysis for buprenorphine increased nearly 116 percent in the first half of 2010 from the previous year.

Data Sources: *Medical Examiner data were obtained by the Hamilton County Coroner's Office for drug-related deaths for the first half of 2010, for comparison with death data from 2006–2009. Data resulted from positive toxicology evidence of drug or alcohol use found in decedents. Cases were classified as accidental, suicide, or homicide. 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. Drug purity data were provided by the DEA, Cincinnati Resident Office, for January to December 2010. Treatment data were provided by the Hamilton County Mental Health and Recovery Services Board for fiscal years 2006 to 2009, and the first half of calendar year (CY) 2010. 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 were captured by group classification and not necessarily by specific drug type or route of administration. Poison control data were provided by the Cincinnati Drug and Poison Information Center for CYs 2006 through 2010. There are two call "types" recorded—either drug information, or actual human exposure to a product. Most exposures involved 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 RENU for CYs 2006–2010. Forensic laboratory data were provided by the National Forensic Laboratory Information System, DEA, for the first half of 2010. Additional drug seizure data were provided by the Warren County Drug Task Force. Methamphetamine clandestine laboratory data were provided by the Ohio Bureau of Criminal Identification & Investigation.

Drug Abuse Patterns and Trends in Colorado and the Denver/Boulder Metropolitan Area—Update: January 2011

Kristen Dixon, M.A., L.P.C.

For inquiries concerning this report, please contact Kristen Dixon, M.A., L.P.C., Evaluation Researcher, Division of Behavioral Health, State of Colorado, 3824 West Princeton Circle, Denver, CO 80236, Phone: 303–866–7407, Fax: 303–866–7428, E-mail: kristen.dixon@state.co.us.

Overview of Findings: Ranked the highest in relation to other drugs and with most indicators trending upward, marijuana continued to be a major drug of abuse in Colorado and the Denver/Boulder metropolitan area, based on data on treatment admissions, hospital discharges, law enforcement drug testing, and estimated emergency department (ED) visits. Cocaine continued to rank in the top three of Colorado and Denver/Boulder area indicators, including treatment admissions, hospital discharges, estimated ED visits, drug-related mortality, poison control center calls, and law enforcement drug testing. However, the cocaine indicators reflected mostly downward trends. Among Colorado and Denver/Boulder area indicators, methamphetamine was stable with mixed trends, based on a large proportion of treatment admissions, a decrease in methamphetamine-involved ED visits in 2009 from 2007, and relatively small proportions

of hospital discharges and death mentions. Heroin abuse indicators, although being relatively low in proportionate share compared with other drugs, remained mostly stable with some slight increases, based on treatment admission and mortality data. Statewide and in the Denver/Boulder area, opioids (other than heroin) were a small but increasing percentage of treatment admissions. Other opioids also represented a substantial proportion of estimated ED visits, hospital discharges, and drug-related mortality. Beyond abuse of illicit drugs, alcohol remained Colorado’s most frequently abused substance and accounted for the most treatment admissions, estimated ED visits, 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 the greater Denver area. During the first half of 2010, admissions for marijuana represented 39 percent of total drug treatment admissions in Colorado and accounted for 41 percent of Denver area admissions. There was more than a 200-percent statistically significant increase in the Denver metropolitan area weighted marijuana-involved Drug Abuse Warning Network (DAWN) ED visit rate from 2004 (50.5) to 2008 (151.7); the rate in 2009 decreased to 124.1 (a statistically significant 17-percent decrease). However, marijuana continued to rank first (excluding alcohol) in Denver ED visit rates. Marijuana ranked first (excluding alcohol) in 2009 Colorado drug-related hospital discharges ($N=4,451$; rate per 100,000=88); both the number and rate of discharges increased from 2008 ($N=4,256$; rate per 100,000=85). Also, marijuana/cannabis was the second most common drug seized and identified by forensic laboratories in the first half of 2010 in Arapahoe, Denver, and Jefferson Counties, based on National Forensic Laboratory Information System (NFLIS) data. Federal drug seizures for marijuana across Colorado, after being relatively stable from 2003 (444.1 kilograms) to 2006 (656.8 kilograms), increased to 24,089.2 kilograms in 2008.

These are the most recent data available. There were several large-scale outdoor marijuana grow operations in Colorado National Forests as well as sophisticated indoor grow operations seized by the Drug Enforcement Administration (DEA). As of January 2009, Denver had more medical marijuana dispensaries per capita than any other city in the United States and has been named “America’s Cannabis Capital” by the National Organization for the Reform of Marijuana Laws. The supply and demand for marijuana were both very high. Denver-area substance use treatment providers have reported an overall climate in which marijuana is much more accessible and less stigmatized. The large influx of medical marijuana care centers may be contributing to the quality, increased availability, and increased use of marijuana. The implications of medical marijuana and its impact on substance use disorder treatment will need continued monitoring. **Methamphetamine**, which accounted for the next highest proportion of treatment admissions statewide (excluding alcohol), overtook cocaine admissions in the first half of 2003; they continued to increase and peaked during the second half of 2005 (at 33 percent). Primary methamphetamine admissions decreased slightly to 31 percent during the first half of 2006 and remained fairly stable (between 24 and 27 percent) from 2008 through 2009. In the first half of 2010, methamphetamine admissions represented 25 percent of all statewide treatment admissions. In greater Denver, methamphetamine reached a high proportion of 23 percent in the first half of 2007, but such admissions have since declined to 18 percent in the first half of 2010. The weighted methamphetamine DAWN ED visit rate per 100,000 for the Denver metropolitan area was 33.9 in 2009, compared with 35.6 in 2008. Methamphetamine could not be identified separately, but rather was included in the stimulants category in Colorado drug-related hospital discharge data. Excluding alcohol, stimulants ranked fourth (behind marijuana, opioids, and cocaine) in 2009 Colorado drug-related hospital discharges ($N=1,577$; rate per 100,000=31); both the number and rate of discharges increased from 2008

($N=1,431$; rate per 100,000=29). Stimulants (mostly methamphetamine) were the fourth most common drug (excluding alcohol) in Colorado death mentions in 2009, at a rate of 1.1 per 100,000 for the State. Methamphetamine was the third most common drug seized and identified by forensic laboratories in the first half of 2010 in Arapahoe, Denver, and Jefferson Counties, based on NFLIS data. Federal drug seizures for methamphetamine across Colorado increased each year from 2003 (14.8 kilograms) to 2006 (50.3 kilograms). In 2007, Federal drug seizures for methamphetamine sharply declined (totaling 8 kilograms), but they increased in 2008 (26.4 kilograms). Likewise, methamphetamine laboratory seizures in Colorado declined from 345 in 2003 to 33 in 2008. These are the most recent data available to date. **Cocaine** admissions (excluding alcohol) statewide remained mostly stable (between 18 and 22 percent) from 2002 through 2008 and declined to 16 percent in the first half of 2009; they then reached a 10-year low of 14 percent in the first half of 2010. Denver-area primary cocaine admissions decreased from 24 percent in the first half of 2007, to 22 percent in the first half of 2008, to a 10-year low of 16 percent in the first half of 2010. The weighted cocaine-involved ED visit rate per 100,000 for the Denver metropolitan area decreased, from 168.5 in 2008 to 109.6 in 2009, which represents a statistically significant decrease of 34 percent. Excluding alcohol, cocaine ranked third (behind marijuana and opioids) in 2009 Colorado substance abuse-related hospital discharges ($N=3,264$; rate per 100,000=64), but both the number and rate of discharges decreased from 2008 ($N=3,533$; rate per 100,000=71). Cocaine was the second most common drug (excluding alcohol and behind other opioids) in Colorado death mentions in 2009, at a rate of 2.5 per 100,000 for the State; this was down from a 3.3 rate in 2008. Cocaine was the most common drug submitted for testing by law enforcement in the first half of 2010 in Arapahoe, Denver, and Jefferson Counties, based on NFLIS data. 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). Federal drug seizures for cocaine increased slightly in 2008 (to 52.6 kilograms). These are the most recent data available. In the first half of 2010, **heroin** ranked fourth in both statewide and greater Denver treatment admissions, representing 10 and 13 percent of admissions (excluding alcohol), respectively. The weighted heroin-involved ED visit rate per 100,000 for the Denver metropolitan area was 51.7 in 2009, compared with 52.8 in 2008. Although heroin was not among the most common drugs found in Colorado death mentions, it remained fairly stable from 2005 to 2008, at a rate of 0.9 per 100,000; heroin death mentions increased slightly to a rate of 1.4 in 2009. Heroin lagged far behind cocaine, marijuana/cannabis, and methamphetamine among drugs submitted for testing by law enforcement in the first half of 2010 in Arapahoe, Denver, and Jefferson Counties based on NFLIS data. The DEA reported that all Denver heroin samples purchased through the 2009 Heroin Domestic Monitor Program (HDMP) were Mexican heroin, which is similar to previous years. The average heroin purity decreased, from 47.8 percent in 2008 to 40.7 percent in 2009, while the price of Mexican heroin increased from \$0.24 to \$0.37 per milligram pure in 2009. **Other opioids** (i.e., prescription opioids, narcotic analgesics) ranked fifth in both statewide and greater Denver treatment admissions (excluding alcohol), accounting for 10 and 9 percent of admissions, respectively, in the first half of 2010. Statewide, other opioid admissions have gradually been on the rise from the first half of 2007 (5 percent) to the first half of 2008 (7 percent) to the first half of 2009 (9 percent). Similarly, in the greater Denver area, primary opioid admissions climbed from 5 percent in the first half of 2007, to 6 percent in the first half of 2008, to 8 percent in the first half of 2009. The Denver metropolitan weighted ED visit rate per 100,000 for narcotic analgesics remained stable from 2008 (104.6) to 2009 (104.4). Excluding alcohol, opioids ranked second in 2009 Colorado substance abuse-related hospital discharges ($N=4,210$; rate per 100,000=83); both the number and rate of discharges increased from 2008

($N=3,890$; rate per 100,000=78). Other opioids were the most common type of drug (excluding alcohol) in Colorado death mentions in 2009, at a rate of 6.0 per 100,000 for the State, which remained fairly stable from 5.9 per 100,000 in 2008. Other opioids were the most common drugs found in Colorado drug-related deaths from 2005 to 2009. Oxycodone (2.2 percent) and hydrocodone (1.2 percent) were in the top 10 drugs analyzed in the first half of 2010 in Arapahoe, Denver, and Jefferson Counties, based on NFLIS data. **Benzodiazepines** (“benzos,” barbiturates, clonazepam, other sedatives, and tranquilizers) represented 1 percent of State treatment admissions in the first half of 2010. The rate of weighted benzodiazepine-involved DAWN ED visit rates in the Denver metropolitan area was 69.8 in 2009, compared with 72.0 in 2008. **MDMA** (3,4-methylenedioxy-methamphetamine) accounted for only 0.3 percent of State treatment admissions (excluding alcohol) in the first half of 2010. There were 295 weighted MDMA-involved DAWN ED visits in the Denver metropolitan area in 2009, compared with 354 in 2008. The DEA states that Canada is the source for most MDMA encountered in Colorado. Other local law enforcement and intelligence agencies also reported increased availability and distribution by Asian traffickers. The purity of MDMA seizures declined over recent years to approximately 50 percent pure. **BZP** (1-benzylpiperazine) was not identified by any of the most common drug indicators, but has typically been combined with MDMA and TFMPP (1-3-(trifluoromethylphenyl)piperazine). BZP was recently made a Schedule 1 controlled substance, which may have caused the decrease in exhibits as reported by the Denver Crime Laboratory. Synthetic **cannabinoids** (Spice, K2, and Black Mamba) have been a recent growing concern; however, there are few indicators that have the ability to isolate and capture the data, making it difficult to determine actual usage levels. **HIV/AIDS Update:** Cumulative acquired immunodeficiency syndrome (AIDS) data through September 2010 indicated cases related to injection drug use remained stable.

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 2010 were included in the data set. **Unweighted ED DAWN Live!** data from the Center for Behavioral Health Statistics and Quality (CBHSQ) Substance Abuse and Mental Health Services Administration (SAMHSA) provided drug reports in ED visits occurring for January–June 2010. No comparisons with earlier time periods or discussions of trends can be done with unweighted data. Data in this report reflect cases that were received by DAWN as of January 4, 2011. Unweighted DAWN data are reported for the Denver area only. **Weighted DAWN ED visit data** from the CBHSQ, SAMHSA were available to report drugs involved in ED visits occurring in 2004–2009 (output produced 10/5/2010). Rates per 100,000 were based on U.S. Census, County-Level Population Estimates (CPOP file). **Forensic laboratory data** were provided by NFLIS, DEA, for the first half of calendar year (CY) 2010 (January–June) for Denver, Jefferson, and Arapahoe Counties. 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 2009. **Mortality data** were obtained from the Colorado Department of Public Health and Environment and represent CY 2009. **Poison and drug control center call data** were obtained from the Rocky Mountain Poison and Drug Center. **Information on drug seizure quantities** was obtained from the standard DEA report, *State Facts: Colorado 2008*. **Heroin drug price and purity data** came from the DEA's 2009 HDMP report published in November 2010. **Intelligence and qualitative data** were obtained from a questionnaire developed by the Denver Office of Drug Strategy and sent in September 2010 to law enforcement, treatment, research, public health, and street outreach agencies, as well as from the

Proceedings of the Denver Epidemiology Work Group. Intelligence data and information were also obtained from the National Drug Intelligence Center, U.S. Department of Justice, High Intensity Drug Trafficking Area Program, Office of National Drug Control Policy, Rocky Mountain Region. **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 2011

Cynthia L. Arfken, Ph.D.

For inquiries concerning this report, please contact Cynthia L. Arfken, Ph.D., Associate Professor, Wayne State University, 2761 East Jefferson Avenue, Detroit, MI 48207, Phone: 313–993–3490, Fax: 313–577–5062, E-mail: carfken@med.wayne.edu.

Overview of Findings: Heroin and cocaine were the two major drugs of abuse in the Detroit/Wayne County area in the first half of 2010, and marijuana was widespread. Cocaine treatment admissions declined as a proportion of total admissions, and crack cocaine continued to be the dominant form of cocaine found in the city of Detroit. Treatment admissions declined for heroin but remained at a high level. The most striking trend for heroin admissions was the continued influx of young and White treatment clients, similar to that occurring in the rest of Michigan. Data for 2009 showed an increase in estimated emergency department (ED) heroin-involved visits, compared with 2008. In 2009, both price and purity increased for South American heroin. In the first half of 2010, deaths with heroin declined from 2009. This decline may be influenced by the initiation of an overdose intervention in the county. Treatment admissions for marijuana as the primary drug of abuse increased to their highest proportion ever. The percent of treatment admissions who were homeless continued to drop in fiscal year (FY)

2010 to 21 percent from a high of 28.7 percent in FY 2008. However, 40 percent of the admissions for cocaine were homeless. Levamisole continued to be detected in cocaine at the Medical Examiner's (ME) office. Calls to the Poison Control Center for intentional human consumption of cocaine and ecstasy declined; calls for heroin increased. BZP (1-benzylpiperazine) climbed in ranking of volume of specific drugs detected among items seized. For the first time, buprenorphine appeared in the ranking of the top 10 drugs detected among items seized and identified in forensic laboratories.

Updated Drug Trends and Emerging Patterns: Treatment admissions with **cocaine** as the primary drug accounted for 18.9 percent of Detroit publicly funded admissions in FY 2010²³, continuing cocaine's decline from its decade-long height of 33.8 percent in FY 2000; 91 percent of these admissions were for crack cocaine. The decline, however, might have been stabilizing as admissions with cocaine as the primary drug accounted for 19.0 percent of Detroit publicly funded admissions in FY 2009. The proportion of publicly funded admissions in the rest of the State with cocaine as the primary drug was much lower (8.2 percent). Of the cocaine admissions, 58.6 percent were male; 90.3 percent were African-American; and 86.3 percent were older than 35. The percentage of admissions older than 35 in Detroit was higher than in the rest of Michigan (66.0 percent). The Detroit cocaine treatment admissions had a high rate of homelessness (40 percent) compared with all admissions (21 percent). In the first half of 2010, the Wayne County ME reported 121 deaths involving cocaine, the highest number for all drugs, but this number was lower than the 280 deaths with cocaine in 2009 when annualized for 2010. Levamisole continued to be detected in many decedents (78 in first half of 2010, compared with 176 for all of 2009). The number of calls to the Poison Control Center for intentional human

consumption appeared to stabilize, from 108 in 2009 to an annualized count of 106 in 2010. The weighted ED cocaine rate per 100,000 population in the five-county Detroit area showed a significant decline from 2008 to 2009 for total population, and for both genders. A focus group of law enforcement officials reported little change in cocaine trends during the first 6 months of 2010. Cocaine continued to rank second in volume of drug items seized in Wayne County, according to the National Forensic Laboratory Information System (NFLIS). In FY 2010, primary treatment admissions with **heroin** as the primary drug declined to 30.9 percent of publicly funded admissions, from 36 percent in FY 2009. This decline brought the percentage of admissions with heroin as the primary drug back to the level of FY 2007. The proportion of publicly funded admissions in the rest of the State with heroin as the primary drug was much lower (13.8 percent). Of the Detroit heroin admissions, 61.8 percent were male, 80.5 percent were African-American, and 85.7 percent were older than 35. The percentage of admissions older than 35 in Detroit was higher than in the rest of Michigan (28.2 percent). In FY 2009, 83.2 percent of Detroit admissions for heroin were African-American, and 90.5 percent were older than 35. In FY 2010, similar to FY 2009, White heroin treatment clients continued to have a younger mean age and were more likely to inject heroin than African-American heroin treatment clients: 36.1 versus 50.6 years and 73.3 versus 33.6 percent, respectively. In the first half of 2010, the Wayne County ME reported an annualized 170 deaths involving heroin, a decrease from 245 in 2009. An overdose prevention program was implemented in 2010 and may have contributed to the decline. Calls to the Poison Control Center about intentional use of heroin by humans increased at an annualized rate for 2010 (88), compared with 70 calls in 2009. The weighted ED heroin rate per 100,000 population in the five-county Detroit area showed a significant

²³The Detroit area representative reported treatment data by calendar year data for the first half of 2010 in the cross-area treatment tables contained in this Highlights and Executive Summary report. However, fiscal year data are reported in this Update Brief.

increase from 2008 to 2009 for total population and for females. Heroin continued to rank third in NFLIS findings for Wayne County. Price and purity data for 2009 showed an increase in mean purity levels and in price. Treatment admissions with **marijuana** as the primary drug increased in FY 2010 to the highest proportion ever, at 17.3 percent of all admissions, compared with 14.6 percent in FY 2009. Of these admissions, the percentage of males was 67.2 percent; 91.1 percent were African-American; and the proportion younger than 18 was 28.9 percent. The percentage of publicly funded admissions in the rest of the State with marijuana as the primary drug was similar (14.9 percent). There was criminal justice involvement in 60.7 percent of the marijuana admissions in FY 2010, compared with 31.3 percent for all admissions. The weighted ED marijuana rate per 100,000 population in the five-county Detroit area showed a significant increase from 2008 to 2009 for total population and for females. Marijuana continued to rank first in NFLIS analyses for Wayne County. A focus group of law enforcement officials reported not yet seeing the impact of the Medical Marijuana Act of 2008. The indicators for **methamphetamine** remained low. It was not in the top 10 drugs in volume of drug items seized and identified in Wayne County according to NFLIS. **Ecstasy** use was still evident in ED and ME reports, but the number of calls to the Poison Control Center continued to decline from the peak in 2004. **MDMA** (3,4-methylenedioxymethamphetamine) ranked sixth in NFLIS data for Wayne County. **Buprenorphine** ranked eighth in NFLIS analyses for Wayne County, and ED visits increased significantly from 152 in 2008 to 327 in 2009. People with newly diagnosed human immunodeficiency virus (**HIV**) infection continued to be disproportionately living in the five-county area of Detroit (68 versus 42.4 percent of the total population for Michigan), African-American (60 versus 14.3 percent of the total population for Michigan), and male (82 percent). Seven percent of the people newly diagnosed with HIV infection reported injection drug use, either alone or combined with other high-risk sexual behavior, as a risk behavior.

In 2009, 65 percent of people with newly diagnosed HIV infection were African-American, 80 percent were male, and 5 percent reported injection drug use.

Data Sources: *Mortality data* came from the Wayne County ME for January–June 2010. *Drug-related crime data* came from a law enforcement officials' focus group conducted by Cynthia L. Arfken, Ph.D. *Poison control data* came from calls made to the Poison Control Center at Children's Hospital of Michigan for January–June 2010. *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 for Fiscal Year 2010. *ED data* came from the Drug Abuse Warning Network, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. *Forensic laboratory data* were provided by NFLIS. *HIV data* came from Michigan Department of Community Health for January–October 2010.

Drug Abuse Patterns and Trends in Honolulu and Hawaii—Update: January 2011

D. William Wood, M.P.H., Ph.D.

For inquiries concerning this report, please contact D. William Wood, M.P.H., Ph.D., Professor and Chair, Department of Sociology, University of Hawaii at Manoa, Room 247, Saunders Hall, 2424 Maile Way, Honolulu, HI 96822, Phone: 808-956-7693, Fax: 808-956-3707, E-mail: dwwood@hawaii.edu.

Overview of Findings: The previously reported trends in overall drug use continued, with most categories of drug use lower in indicators than in the June 2010 report (based on data from the last half of 2009). The cause of this decrease is not totally clear. The street wisdom remained the same as always, “Sometimes it is up, sometimes it is down; now it is okay.”

Updated Drug Abuse Trends and Emerging Patterns: In the first half of 2010, the Hawaii economy continued to feel the effects of the recession on the mainland and elsewhere. Large construction projects continued to grind to a halt or took a hiatus. Reports on closures and layoffs at local businesses remained common. Concerns continued about balancing the budget in light of several pessimistic reports on revenue forecasts from the State's Council on Economic Revenues, and news reports from the mainland indicating the depth of the recession taking place contributed to a mood of pessimism and worry. For the first time in decades, higher unemployment was present in all sectors of the economy in Hawaii, with the overall unemployment rate above 7 percent. Tourism continued to decline as Asia and the mainland continued to feel the effects of their own economic changes; people responded by tightening their collective belts and eliminating extras such as business meetings and vacations in Hawaii. The legislature was busy preparing for the November elections with the Governor and Lt. Governor's race a major highlight. The primary focus of the legislature was to balance the budget and still pay for expensive labor contracts for teachers, civil servants, the university, and other State-employed labor, while avoiding raising taxes. As a result, no legislation of any consequence for substance abuse, crime, and health were passed. Drug prices have remained relatively stable for more than 2 years, regardless of the size of seizures, number of arrests, or degree of apparent surveillance. The systems of delivery remained in place, and new dealers replaced those incarcerated for trafficking. Street reports continued to suggest no shortages of drugs, just a need to know where to look and who to ask. Street reports indicated that methamphetamine and cocaine were readily available, but prices were quite high given the state of the economy. However, as has been seen before in Honolulu, drug prices seem to be relatively inelastic and do not fluctuate much. While confirmation of these suggestions is not easy, the comments are the result of several independent interviews. The four major drugs identified after seizure or capture and

sent for analysis to laboratories participating in the National Forensic Laboratory Information System (NFLIS) shifted, with methamphetamine declining, cocaine rising, cannabis rising, and heroin declining. Previous reports of MDMA persisted and were double those of 2009. Methamphetamine was still identified most often, followed by cannabis and cocaine, with MDMA fourth.

Treatment admissions data in Hawaii are based on self-reported primary drug information. Honolulu Police Department data are either cases or arrests; this report uses cases. Data related to the Medical Examiner (ME) office represent all decedents dying without an immediately apparent cause of death; dying when violence was involved, including traffic accidents; or dying unattended. The ME office is only located in Honolulu. During this period, primary admissions for **cocaine** use continued their multiyear decline. Honolulu Police data demonstrated the decline in reporting the lowest number of cocaine cases in 5 years. The ME office also provided data demonstrating the lowest number of deaths in which cocaine was revealed in the toxicological screen performed. Cocaine remained as the third most frequently analyzed drug by NFLIS laboratories. **Heroin** admissions for treatment were the lowest in 5 years. Police arrests for heroin use decreased as well, again the lowest in 5 years. However, ME data showed an increase in the toxicological screens of decedents. Heroin has been minimal in the drug items identified by NFLIS. Primary **marijuana** treatment admissions were relatively stable in the first half of 2010 (at 920 admissions), compared with the first half of 2009 (with 1,281). Police cases increased during this period, and the numbers of decedents with THC (tetrahydrocannabinol), a metabolite of cannabis, in their blood were also up. Cannabis (including THC or similar products) was the second most identified drug category analyzed by NFLIS laboratories. **MDMA** appeared to have a regular place in the top five substances identified through NFLIS.

Data Sources: *Data for this period were obtained from the following sources: Hawaii High*

Intensity Drug Trafficking Area reports; Honolulu Police Department Narcotics and Vice Data sets; Hawaii Office Drug Enforcement Administration Reports; State of Hawaii Office of Narcotic Control; Office of the U.S. Attorney; State of Hawaii, 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, ME Office; State of Hawaii Department of Business, Economic Development, and Tourism; and Hawaii Drug Policy Forum Reports. Data were also collected from NFLIS; private drug treatment facilities; Department of Psychiatry, University of Hawaii; Queens Hospital; and the Hawaii Health Information Corporation. All data pertain to adults within the State of Hawaii. The State of Hawaii 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. Although 6-month post-treatment data are collected, differential analyses of those succeeding in treatment compared with those that do not succeed are not completed.

Drug Abuse Patterns and Trends in Los Angeles County—Update: January 2011

Mary-Lynn Brecht, Ph.D.

For inquiries concerning this report, please contact Mary-Lynn Brecht, Ph.D., Research Statistician, Integrated Substance Abuse Programs, University of California, Los Angeles, Suite 200, 1640 South Sepulveda Boulevard, Los Angeles, CA 90025, Phone: 310-267-5275, Fax: 310-473-7885, E-mail: lbrecht@ucla.edu.

Overview of Findings: This report updates data on drug abuse indicators for the Los Angeles County CEWG area since the last reporting period.

The overall number of treatment admissions in January–June 2010 was about 6 percent lower than that of the corresponding period in 2009 (23,870 and 25,346, respectively). The four primary substances accounting for the largest percentages of primary admissions were marijuana (24 percent), alcohol (23 percent), heroin (20), and methamphetamine (15 percent). These percentages continued the slight upward trends for marijuana and heroin and the downward trend for methamphetamine. Marijuana (40 percent), cocaine (22 percent), and methamphetamine (19 percent) accounted for a majority of Los Angeles-based illicit drug items seized and identified by the National Forensic Laboratory System (NFLIS) for January–June 2010; results indicated a continuing upward trend for marijuana and a decrease for cocaine; the percentage for methamphetamine increased over 2009, reversing a downward trend from 2005. Reports of opiates/opioids (other than heroin/morphine), methamphetamine, and antidepressants increased among coroner toxicology cases. Wholesale prices for methamphetamine continued a decline from previous periods. Some increase was seen for cocaine and domestic or Mexican marijuana over 2009 prices; however, these changes were not reflected in retail street price changes.

Updated Drug Abuse Patterns and Emerging Trends: For January–June 2010, the percentage of alcohol and other drug (AOD) primary treatment admissions for **methamphetamine** declined somewhat over calendar year (CY) 2009 levels. Hispanics (56 percent) and females (48 percent) continued to represent higher proportions of methamphetamine admissions than they did of admissions for other major substances. Approximately one in five of NFLIS-reported items identified in forensic laboratories contained methamphetamine, ranking it third among types of substances analyzed (after cocaine and marijuana/cannabis), an increase over 2009. Third quarter wholesale prices for methamphetamine showed a continuing decline from 2008–2009 levels. Methamphetamine remained the primary drug of concern to law enforcement agencies in

the Los Angeles County region. Coroner toxicology cases testing positive for methamphetamine (14 percent) increased in 2010 over 2008–2009 levels, with levels similar to those of heroin and cocaine. **Cocaine** accounted for 10 percent of Los Angeles County AOD treatment admissions in the first half of 2010, a decline over CY 2009 (13 percent). African-Americans represented an increasing majority of cocaine treatment admissions, at 63 percent of cocaine admissions, up from 61 percent during the first half of 2009 and 56 percent in 2007. Of January–June 2010 NFLIS items, 22 percent contained cocaine, a decrease from 2009 (when cocaine accounted for 27 percent of all items). Cocaine was present in 14 percent of coroner toxicology cases, a decrease from 2009 levels. The wholesale price of cocaine increased by mid-2010 over 2009 levels. Treatment admissions for **MDMA** (3,4-methylenedioxymethamphetamine) nearly doubled over the same period in 2009 but remained at a very low level (0.5 percent). MDMA remained at a ranking of fifth among drugs identified by NFLIS for Los Angeles County, while representing a higher percentage for January–June 2010 (4.7 percent of items) than for 2009 (2.8 percent). **Benzodiazepines, tranquilizers, and sedatives** together accounted for a very small percentage (0.5 percent) of total primary treatment admissions. These types of drugs were present in 12 percent of coroner toxicology cases, a decrease from 2009 levels. The category of “other” amphetamines and stimulants, which includes several **prescription drugs**, such as Adderall® and Ritalin®, accounted for 1.3 percent of treatment admissions. In January–June 2010, 20 percent of primary treatment admissions were for **heroin**, a slight increase over 2009 levels (18 percent). Heroin was identified in 6 percent of NFLIS items. Heroin/morphine was present in 16 percent of coroner toxicology cases in 2010, a decrease from 20 percent in 2009 but an increase in numbers of cases over 2009 numbers. Approximately 3 percent of primary treatment admissions were for **other opioids/narcotics excluding heroin**, a slight increase over 2009 levels. Hydrocodone, oxycodone, and codeine together accounted for

2.0 percent of NFLIS items, a slight decrease from 2009 levels (2.5 percent). Los Angeles County Coroner toxicology cases showed that other opioids/narcotics were present in 29 percent of cases in 2010 (January–November 2010). **Marijuana** was reported as the primary drug for 24 percent of Los Angeles County treatment admissions. More than one-half (59 percent) of marijuana admissions were for adolescents younger than 18, a larger percentage for this age group than in 2009 (54 percent). Marijuana/cannabis was identified in 40 percent of NFLIS items, continuing an increasing trend. THC (tetrahydrocannabinol), a metabolite of cannabis, was identified in 12 percent of coroner toxicology cases, a decrease from 2009 levels. **Emerging Patterns:** A slight increase was consistent across indicators for heroin and MDMA, but indicator trends were mixed for other substances.

Data Sources: *Treatment data* were provided by Los Angeles County Department of Public Health, Alcohol and Drug Program Administration (tables produced by California Department of Alcohol and Drug Programs [ADP]) from CalOMS (California Outcome Monitoring System). CalOMS is a statewide client-based data collection and outcomes measurement system for 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 this report include admissions in Los Angeles County for January–June 2010. **Forensic laboratory data** were provided by NFLIS, Drug Enforcement Administration, for January–June 2010. **Drug price data** were derived from reports from the Los Angeles County Regional Criminal Information Clearinghouse (LA CLEAR) (provided by R. Lovio). 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 “Third Quarter Report 2010,” based primarily on field reports, interviews with law enforcement agencies throughout the Los Angeles High

*Intensity Drug Trafficking Area (LA-HIDTA), and post-seizure analysis. **Drug threat** data were from the “U.S. Department of Justice LA-HIDTA 2010 Drug Market Analysis.” **Mortality data** for January–November 2010 were from the Los Angeles County Department of the Coroner (provided by O. Brown) and indicate positive drug results from toxicology cases (not necessarily specific causes of death).*

Drug Abuse Patterns and Trends in Maine—Update: January 2011

Marcella H. Sorg, Ph.D., R.N., D-ABFA

For inquiries concerning this report, please contact Marcella H. Sorg, Ph.D., R.N., D-ABFA, Research Associate Professor, Margaret Chase Smith Policy Center, University of Maine, Building 4, 5784 York Complex, Orono, ME 04469, Phone: 207–581–2596 Fax: 207–581–1266, E-mail: Marcella.sorg@umit.maine.edu.

Overview of Findings: This report updates drug abuse indicators in Maine to 2010. During the last decade illicit drug abuse has been dwarfed by a growing problem with pharmaceuticals; this continued in 2010. Heroin and cocaine indicators have declined, continuing a multiyear trend. Marijuana indicators showed a slight increase in the percent of arrests, seizures, and admissions, but fewer impaired drivers. Abuse of narcotic analgesics continued as the most salient of Maine drug abuse problems in 2010, causing 74 percent of overdose deaths alone or in combination with other drugs or alcohol; 38 percent of arrests; 19 percent of law enforcement seizures; 59 percent of impaired driver urinalyses; and 57 percent of primary treatment admissions, excluding alcohol. Buprenorphine diversion has been identified as an emergent problem.

Updated Drug Trends and Emerging Patterns: Heroin abuse remained a serious problem, but most indicators were stable or decreasing. Heroin/morphine deaths declined to only 6 percent in early 2010. Arrests for heroin, which peaked in

2007, declined to 5 percent in 2010. The number of arrests, however, remained stable. Heroin law enforcement seizures dropped to 9 percent of samples analyzed in 2010. Primary heroin/morphine admissions for the first half of 2010 constituted 12 percent of all admissions, excluding alcohol, down from a 22-percent peak in 2005. **Cocaine** indicators in 2010 were stable or decreasing. Deaths from cocaine in the first half of 2010 constituted 7 percent of all drug-induced deaths, stable since 2008. Cocaine/crack arrests dominated the illicit drug arrests of the Maine Drug Enforcement Agency (MDEA) during the mid-2000s, but the proportion of arrests decreased substantially to 22 percent in 2010. Although cocaine was the largest single category of samples tested in Maine’s forensic laboratory, it declined to 40 percent of all samples analyzed in the first half of 2010. Primary treatment admissions for crack and cocaine combined had been at a 14-percent plateau from 2005 to 2007, but declined gradually to 6 percent during the first half of 2010, 2 percent for crack and 4 percent for powder cocaine. Thirty-two percent of cocaine samples tested positive for levamisole and 3 percent for diltiazem, down from 38 and 11 percent, respectively, in 2009. **Marijuana** indicators remained moderately high, but mixed. Arrests had declined to 17 percent in 2008, but increased to 23 percent in 2010. Drug samples seized and identified as marijuana increased slightly, from 7 percent in 2009 to 10 percent in 2010. Since 2007, marijuana admissions have been at a plateau of about 18–20 percent. Urine tests of impaired drivers in 2010 decreased to 22 percent positive for cannabinoids, down from 30 percent in 2006–2008. **Prescription narcotics** misuse and abuse remained high in 2010 indicators, with seizures and admissions continuing to increase. Pharmaceutical narcotics caused 74 percent of overdose deaths in the first half of 2010; methadone and oxycodone continued to dominate frequencies. Deaths due to long-acting pharmaceutical morphine increased, totaling more than 50 percent of heroin/morphine-caused deaths. Nonlaw-enforcement medication identifications of pharmaceutical morphine by the poison control center doubled from 2005 to 2010.

Pharmaceutical narcotics arrests increased from 21 percent in 2007 to 38 percent in 2010. Seizure samples analyzed and identified as narcotic analgesics also increased to 19 percent in 2010, up from 12 percent in 2008. About one-half of the morphine samples were tablets. A total of 59 percent of impaired drivers tested positive for pharmaceutical narcotics in 2010. Some 24 percent were positive for oxycodone, an increase from previous years, and 18 percent were positive for methadone, a decrease from 2009. Twenty-eight percent tested positive for at least one opioid in combination with at least one benzodiazepine. In early 2010, admissions for pharmaceutical narcotics increased to 57 percent of admissions, excluding alcohol. Buprenorphine caused three deaths in 2008 and two during 2009 but none in early 2010. Four percent of law enforcement seizures tested in 2010, and 7 percent of impaired driver urinalyses in 2010, contained buprenorphine, up slightly from 2009. Nonlaw-enforcement poison center calls for medication identification showed an increase in buprenorphine identifications, from 57 in 2005 to 334 in 2010. **Benzodiazepines** continued to play a substantial role in Maine drug problems in 2010. Although involved in only 3 percent of seizures analyzed and 2 percent of arrests, benzodiazepines caused 31 percent of drug-induced deaths (an increase from 12 percent in 2000), usually as co-intoxicants in narcotic deaths. Impaired driver urinalyses in 2010 included 40 percent positive for one or more benzodiazepines, including 17 percent for alprazolam and 5 percent for clonazepam. **Methamphetamine** indicators were mixed but with very small numbers. Methamphetamine represented 4 percent of 2010 arrests, up slightly from 3 percent in 2009. Most arrests were near the Canadian border. There were five confirmed clandestine methamphetamine laboratories in 2010; in 2009 there was only one. Most (54 percent) of the methamphetamine forensic laboratory samples were tablets, similar to 2009. Nearly all of the tablets (91 percent) contained no other drugs; 9 percent had caffeine. This was a change from 2009, when most samples contained caffeine and a substantial minority had other substances, such as

TFMPP (1-3-(trifluoromethylphenyl)piperazine), BZP (1-benzylpiperazine), procaine, and diphenhydramine. There were no deaths due to methamphetamine in the first half of 2010. Primary methamphetamine admissions remained well under 1 percent in the first half of 2010. **MDMA** indicators were mixed but with small numbers. MDMA arrests in 2010 represented 3 percent of all arrests, up from 1 percent in 2009. Four percent of drug samples analyzed in 2010 were MDMA, up slightly from 3 percent in 2009. Primary admissions for MDMA constituted only one-tenth of 1 percent in the first 6 months of 2010. **Emerging issues** included continuing problems with the high volume of prescription drug abuse, including more deaths due to long-acting pharmaceutical morphine, as well as rising indicators for buprenorphine diversion. Benzodiazepine deaths continued at very high levels, constituting approximately one-third of the drug-induced deaths. Samples of seized methamphetamine pills have changed in the past year, with most containing methamphetamine alone. MDMA arrests have tripled, although the number of arrests was small.

Data Sources: *Data sources updated in this report include the following sources. **Treatment admission data** for January–June 2010 were provided by the Maine State Office of Substance Abuse, including all admissions for programs receiving State funding. This report updates admissions, excluding those for shelter and detoxification; comparisons extend back to 2003. **Forensic laboratory data** through calendar year 2010 were provided by the Maine State Health and Environmental Testing Laboratory, which tests samples seized statewide and reports these results to the National Forensic Laboratory Information System. Data for 2010 were compared with previous years back to 2003. The Health and Environmental Testing Laboratory has also provided **urine test data for impaired drivers** through calendar year 2010; these were compared with data from 2006 to 2009. **Arrest data** through calendar year 2010 were provided by the MDEA, which directs eight multijurisdictional task forces covering the*

State, generating approximately 60 percent of all Uniform Crime Report (UCR) drug-related offenses statewide. Data were refined this year for the period 2006–2010 to focus only on arrests by the MDEA, excluding arrests by other agencies to which MDEA provided assistance, and excluding arrests for nondrug offenses. Data for 2010 were compared with previous years back to 2003. **Mortality data**, updated through June 2010, were provided by the Office of Chief Medical Examiner, with comparisons back to 1997. That office investigates all suspected overdose cases statewide, including complete forensic testing (screening and quantification) for a broad panel of abused and therapeutic drugs. **Poison control center calls** to the Northern New England Poison Center were updated through 2010, focusing in this analysis on nonlaw-enforcement medication identification calls since 2005.

Drug Abuse Patterns and Trends in Miami-Dade and Broward Counties, Florida—Update: January 2011

James N. Hall

For inquiries regarding this report, please contact James N. Hall, Director, Center for the Study and Prevention of Substance Abuse, Nova Southeastern University, c/o Up Front, Inc., 13287 S.W. 124th Street, Miami, FL 33186, Phone: 786–242–8222, Fax: 786–242–8759, E-mail: upfrontin@aol.com.

Overview of Findings: Cocaine consequences continued to decline in Florida during the first half of 2010 and particularly in Miami-Dade County. Heroin indicators declined over the past decade and sharply in the past year, as consequences related to the nonmedical use of prescription opioids have increased. Oxycodone deaths and other consequences continued to increase across Florida, as delays have occurred in implementing a Prescription Drug Monitoring Program and other legislation aimed at regulating rampant “rogue pain clinics.” Benzodiazepine consequences remained at high levels but stabilized in the first half of 2010. Adolescent marijuana use continued to increase as

perceived risks about it were softening, according to 2010 State and local school surveys. Widespread availability of synthetic cannabinoids was reported in retail outlets. Local alleged “ecstasy” pills often contained BZP (1-benzylpiperazine); MDMA was also reported by South Florida crime laboratories. Emerging issues included the role of street-level purity and retail price in the decline of cocaine consequences; increasing reports of injection drug use among nonmedical users of prescription opioids; and retail sales of unregulated synthetic cannabinoids and hallucinogens/stimulants.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine-related deaths

declined sharply in Miami-Dade County while stabilizing in Broward County between the last half of 2009 and the first half of 2010. Most of these deaths involved more than one drug, therefore the higher rate of prescription drug deaths in Broward may contribute to more cases of cocaine detected among decedents there. Cocaine still accounted for the highest number of estimated emergency department (ED) visits, as compared with all other substances in the Drug Abuse Warning Network (DAWN) weighted ED estimates for 2009 in the two South Florida DAWN divisions; however, this was a significant decline from the number of estimated cocaine-involved visits in 2008 in both divisions. Cocaine crime laboratory reports declined to 57 percent of all cases in the first half of 2010, compared with 67 percent of cases in 2007. Primary treatment admissions for cocaine declined from 23 percent of 1999 admissions (including alcohol) for the State of Florida to 14 percent in 2009. Levamisole was detected as an adulterant in all Miami-Dade County cocaine deaths in 2010. Deaths in which **heroin** was detected decreased statewide and in Miami-Dade County during the first half of 2010 and remained stable in Broward County. Heroin-related deaths have declined statewide since 2000, while deaths linked to **prescription opioids** escalated. Based on an analysis of Florida Medical Examiners Commission data by Nova Southeastern University, in 59 percent of all heroin deaths in Florida during 2009, at least one

prescription opioid was also detected at the time of death. There were increasing reports of injection drug use among nonmedical users of prescription opioids. Miami-Dade County continued to report the lowest per capita rates of nonmedical prescription opioid deaths in the State. There were 65 occurrences of an opioid identified among deceased persons in Miami-Dade County during the first half of 2010, with 175 such reports in Broward County and 148 in Palm Beach County. Consequences of **methamphetamine** abuse remained very low; however, deaths related to it increased 25 percent statewide, from 39 in the last half of 2009 to 49 in the first half of 2010. BZP (1-benzylpiperazine) continued to be detected in most alleged ecstasy tablets in Broward County. However, testing is not done for TFMPP (3-(trifluoromethylphenyl)piperazine), which is frequently found in combination with BZP elsewhere. Statewide, **MDMA**-related deaths increased slightly, from 19 in the last half of 2009 to 22 in the first half of 2010. The per capita rate of MDMA (“ecstasy”) weighted DAWN ED visit estimates decreased significantly from 11.9 per 100,000 in 2008 to 7.7 in 2009 for Miami-Dade County, while remaining stable at 7.3 per 100,000 in 2008 and 8.3 in 2009 for Broward and Palm Beach Counties, respectively. Indicators of **marijuana** consequences remained stable and high, accounting for 3,378 estimated marijuana-involved ED visits in Miami-Dade County in 2009 and 2,870 estimated visits for Broward and Palm Beach Counties. The 2010 Florida Youth Substance Abuse Survey reported increases in prevalence of past-30-day marijuana use among middle and high school students statewide as well as in Miami-Dade and Broward Counties. At the same time, fewer students reported perceived harm and wrongfulness in using marijuana, and measures of its social acceptance increased. Synthetic cannabinoids were widely available and used mostly by those subject to frequent drug testing. Alprazolam continued as the most often cited **benzodiazepine** observed in most abuse indicators. There were 55 occurrences of either alprazolam or diazepam identified among deceased persons in Miami-Dade County during the first half of 2010 and 136

such reports in Broward County—decreases of 18 percent in Miami-Dade County and 38 percent in Broward County over the numbers for the second half of 2009. The 2,900 estimated DAWN ED visits for nonmedical benzodiazepine misuse during 2009 in Broward and Palm Beach Counties represented a significant 28-percent increase over the total estimates for 2008, while the 1,587 estimated visits during 2009 in Miami-Dade County were stable from the 1,524 visits in 2008. **Emerging Patterns:** The continued decline of cocaine consequences locally and nationally appeared to be related to lower purity and rising street prices per gram of pure cocaine. The nonmedical use of prescription opioids has created an increase in injection drug use among people in their twenties who are often naive about the risk of infected syringes. Most drug deaths are preventable, with multiple missed intervention opportunities. The introduction of synthetic cannabinoids in the region has created a distribution network of retail merchants who are poised to offer new unregulated drugs as their current products are scheduled and made illegal.

Data Sources: *Drug-related death data came from the Florida Medical Examiners Commission 2010 Interim Report on Drugs Identified in Deceased Persons by Florida Medical Examiners, covering the first half of 2010 from the Florida Department of Law Enforcement. Weighted DAWN ED estimates for 2009 from the Center for Behavioral Health Statistics and Quality (CBHSQ), Substance Abuse and Mental Health Services Administration (SAMHSA), are reported separately for the Miami-Dade and Ft. Lauderdale (Broward and Palm Beach Counties) divisions. A comparison of treatment data by primary drug from 1999 and 2009 are from the Treatment Episode Data Set from SAMHSA’s CBHSQ, as reported by the Florida Department of Children and Families for all publicly funded adult and youth treatment programs. Forensic laboratory data were provided by the National Forensic Laboratory Information System, Drug Enforcement Administration, for January–June 2010. School*

survey data were provided by the 2010 Florida Youth Substance Abuse Survey from the Florida Department of Children and Families. **Heroin and opioid user information, including injection drug use trends**, came from an analysis of Florida Medical Examiners Commission data by the Center for the Study and Prevention of Substance Abuse at Nova Southeastern University and anecdotal information reported by the Broward County Public Defender's Office and staff for the Broward County Drug Court.

Drug Abuse Patterns and Trends in Minneapolis and St. Paul, Minnesota—Update: January 2011

Carol Falkowski

For inquiries regarding this report, please contact Carol Falkowski, Drug Abuse Strategy Officer, Minnesota Department of Human Services, 444 Lafayette Rd., St. Paul, MN 55101, Phone: 651-431-2457, Fax: 651-431-7449, E-mail: carol.falkowski@state.mn.us.

Overview of Findings: This report is produced twice annually for participation in the Community Epidemiology Work Group of the National Institute on Drug Abuse, an epidemiological surveillance network of researchers from 21 U.S. metropolitan areas. The Minneapolis/St. Paul (“Twin Cities”) metropolitan area includes Minnesota’s largest city, Minneapolis (Hennepin County), the capital city of St. Paul (Ramsey County), and the surrounding counties of Anoka, Dakota, and Washington. Population estimates from 2009 for each of these counties are as follows: Anoka, 335,308; Dakota, 400,675; Hennepin, 1,168,983; Ramsey, 517,748; and Washington, 236,517, according to the Minnesota Department of Administration Office of Geographic and Demographic Analysis, Office of the State Demographer. This totals 2,659,631 people, which is equal to one-half of the Minnesota State population. In the five-county metropolitan area, 84 percent of the population is White. African-Americans constitute the largest minority group in Hennepin County, while Asians

are the largest minority group in Ramsey, Anoka, Dakota, and Washington Counties. Most indicators regarding heroin and other opiate abuse remained at heightened levels in the Twin Cities in 2010, while the indicators related to the abuse of cocaine continued to decline. Heroin accounted for 3.3 percent of treatment admissions in 2000, compared with 6.7 percent in the first half of 2010. Other opiates accounted for 1.4 percent of treatment admissions in 2000 and 8.7 percent in the first half of 2010. Cocaine-related admissions accounted for 14.4 percent of treatment admissions in 2005, but they accounted for only 5.8 percent in the first half of 2010. In Hennepin County, cocaine-related deaths declined in 2009, as did estimated emergency department (ED) cocaine-involved visits and the drug’s use among adult male arrestees. The 2010 Minnesota Student Survey found continuing declines in the use of cocaine, alcohol, methamphetamine, and tobacco among Minnesota public school students. The use of synthetic marijuana products, also known as “fake pot,” resulted in 76 reports to the Hennepin Regional Poison Center in 2010, and their use was banned in some Minnesota communities.

Updated Drug Abuse Trends and Emerging Patterns: The decline in cocaine-related treatment admissions continued into the first half of 2010. Cocaine was the primary substance problem for 5.8 percent of total treatment admissions in the first half of 2010, compared with 6.4 percent of total treatment admissions in 2009, 9.9 percent in 2008, 11.6 percent in 2007, and 14.1 percent in 2006. Most cocaine admissions were for crack cocaine; 73.7 percent of clients were age 35 or older; and one-half (50.1 percent) were African-American. Cocaine-related deaths fell in Hennepin County from 21 in 2008 to 10 in 2009. In Ramsey County, there were 10 cocaine-related deaths in 2008 and 11 in 2009. Cocaine use among arrestees also declined. In 2009, 18.7 percent of male arrestees in Hennepin County tested positive for cocaine, compared with 22.5 percent in 2008 and 27.5 percent in 2007. Cocaine accounted for 22.5 percent of items seized by law enforcement and identified

by the National Forensic Laboratory Information System (NFLIS) in the first half of 2010 in the Twin Cities, compared with 21.6 percent nationally. In 2009, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a nationwide alert about cocaine that had been adulterated with **levamisole**, a veterinary anti-parasitic drug approved for use in cattle, sheep, and swine but not approved for human use. Humans who ingest cocaine mixed with levamisole can experience reduced white blood cells and suppressed immune function that impairs the body's ability to fight off even minor infection. Between March and May 2010, the Minnesota Poison Control System identified three confirmed and two suspected cases of neutropenia associated with levamisole and recent cocaine. Two additional exposures were reported since July 2010. To help determine the extent to which cocaine in Minnesota was contaminated with levamisole, the Minnesota Bureau of Criminal Apprehension laboratory tested 198 cocaine samples between June 16 and August 31, 2010, and found that 47.9 percent of them contained levamisole. Cocaine samples with levamisole have increased nationwide since 2002. According to the U.S. Drug Enforcement Administration (DEA), 70 percent of cocaine samples analyzed nationwide in July 2009 contained levamisole. Drug Abuse Warning Network (DAWN) estimated cocaine-involved ED visits in the Twin Cities fell significantly from 5,390 in 2008 to 3,843 in 2009. Past-year cocaine use was reported by 4.7 percent of Minnesota 12th graders in 2010, compared with 2.9 percent reported by 12th graders nationally. Treatment admissions for both **heroin and other opiates** steadily increased in the Twin Cities since the turn of the century. In 2000, heroin accounted for 3.3 percent of total treatment admissions, and other opiates accounted for 1.4 percent. However, in this reporting period (January–June 2010), heroin-related admissions fell slightly and accounted for 6.7 percent of treatment admissions, compared with 8 percent in 2009. Treatment admissions involving other opiates continued an upward trend and accounted for 8.7 percent of total admissions in the first half of

2010, compared with 8.3 percent in 2009. For the most part, these admissions involved the nonmedical use of prescription pain medications. Of those clients admitted to treatment for other opiates, almost one-half (46.5 percent) were female, and oral was the primary route of administration (70 percent). From 2008 to 2009, opiate-related deaths rose from 31 to 36 in Ramsey County and declined from 84 to 77 in Hennepin County. In 2009, 5.8 percent of male arrestees in Hennepin County tested positive for opiates, compared with 6.1 percent in 2008 and 4.7 percent in 2007. Heroin accounted for 3.2 percent of items seized and identified by NFLIS in the first half of 2010 in the Twin Cities, compared with 7.1 percent of all seizures nationally. Both oxycodone and hydrocodone represented a larger percentage of law enforcement drug seizures nationally than in Minnesota. There were 1,651 estimated heroin-involved ED visits in the Twin Cities in 2008, compared with 1,855 in 2009. Overall, the total number of episodes involving the nonmedical use of narcotic analgesics in the Twin Cities EDs increased significantly from 1,723 in 2004 to 3,168 in 2009. From 2003 to 2009, fentanyl-involved episodes rose significantly from 94 to 184; hydromorphone increased significantly from 123 estimated visits in 2007 to 228 in 2009; and estimated oxycodone-involved visits increased significantly from 601 in 2004 to 1,383 in 2009. Hydrocodone-involved ED visits did not increase or decrease significantly. Tramadol is a prescription medication used to treat moderate pain. It is not federally scheduled in the United States, and it is sometimes sold at online pharmacies. According DAWN, there were 63 estimated tramadol-involved ED visits in the Twin Cities in 2005, compared with 164 in 2009 (this is not, however, a statistically significant increase). The Minnesota Board of Pharmacy maintains a program to help identify individuals who inappropriately obtain excessive amounts of controlled substances from multiple prescribers and pharmacies. The Minnesota Prescription Monitoring Program (PMP) has collected data (through 11/29/2010) on more than 5.6 million controlled substance prescriptions. Pharmacies licensed and

located in Minnesota must report to the PMP all schedule II, III, and IV controlled substance prescriptions that they dispense. Past-year use of heroin was reported by 1.4 percent of Minnesota 12th graders in 2010, compared with 0.9 percent nationally. Past-year use of prescription pain killers was reported by 6.3 percent of Minnesota 12th graders in 2010, compared with 8.7 percent of 12th graders nationally who reported the use of narcotics other than heroin. Treatment admissions with **marijuana** as the primary substance problem accounted for 19.3 percent of total admissions in the Twin Cities in the first half of 2010, compared with 18.1 percent in 2009. Most clients (68.3 percent) admitted to treatment with marijuana as the primary substance problem were younger than 26. In 2009, 46.9 percent of male arrestees in Hennepin County tested positive for marijuana, compared with 42.7 percent in 2007. Marijuana accounted for 22.8 percent of items seized by law enforcement and identified by NFLIS in the first half of 2010 in the Twin Cities, compared with 36.9 percent nationally. There were 4,302 estimated marijuana-involved ED visits in the Twin Cities in 2006, compared with 5,596 in 2009. Past-year use of marijuana by Minnesota 12th graders increased from 21.8 percent in 1992 to 30.6 percent in 2010, but it was still less than the percentage reported nationally in 2010 (34.8 percent). The use of **synthetic marijuana** by youth created rising public concern throughout Minnesota in 2010. Known as K2 or Spice and other names, these new herbal mixtures are sold as incense, but when smoked, mimic the effects of actual marijuana. K2 is sold online and in “head-shops,” under numerous other names such as “Smoke XXXX,” “Stairway to Heaven,” “Karma Kind,” or “California Dreams.” Sold in small zip-lock plastic bags with handmade packaging, these new synthetic marijuana mixtures are seen as a legal alternative to marijuana. They are loose mixtures of herbs allegedly sprayed with synthetic cannabinoids, the active ingredients in marijuana. The DEA, using its emergency scheduling authority, initiated action in November 2010 to temporarily control five chemicals that are used to make “fake pot” products—JWH-018, JWH-073,

JWH-200, CP-47,497, and cannabicyclohexanol. Several States and college towns in Minnesota, including Duluth, have already banned the sale and possession of these mixtures. Movements are underway in Minnesota to ban these products statewide as well, with pending action by the State Board of Pharmacy and a Minnesota legislator who intends to introduce a bill banning them statewide. Since the DEA action, several retail outlets that sell synthetic marijuana products in Minnesota are contending in pending litigation that the recent DEA emergency scheduling will have a significant detrimental economic impact on their businesses. One Minneapolis store, for example, reported that 70 percent of its sales from January through October 2010 were synthetic marijuana, accounting for over \$609,000 in gross profits. The retailers claim that the DEA action is both unconstitutional and illegal. Reports from metropolitan area school-based counselors indicate growing abuse of these mixtures and several incidents in which use produced highly combative and aggressive behavior, vomiting, seizures, and one case of extreme hair loss by an adolescent who was using 3 grams per day. The Hennepin Regional Poison Center documented 76 synthetic THC (tetrahydrocannabinol, a metabolite of cannabis) exposures in 2010. Primary treatment admissions for **methamphetamine** increased slightly in the first half of 2010 to 6.3 percent of admissions, compared with 6 percent in 2009 and 12 percent in 2005, the highest year. Among these admissions, more than one-third (36.1 percent) were female, 80.4 percent were White, and 78.5 were age 26 or older. In 2009, 3.6 percent of adult male arrestees in Hennepin County tested positive for methamphetamine, compared with 3.2 percent in 2007. Seizures of methamphetamine by law enforcement in the Twin Cities accounted for 24.1 percent of items seized and identified by NFLIS in the first half of 2010, compared with only 10.5 percent of seizures nationally. Estimated ED visits involving methamphetamine in the Twin Cities decreased significantly from 1,741 in 2004 to 970 in 2009. Past-year use of methamphetamine by Minnesota 12th graders declined from 5.8 percent in 2001 to

1.4 percent in 2010, but it still exceeded the 1.0 percent among 12th graders reported nationally in 2010. **MDMA** (3, 4-methylenedioxyamphetamine), known as ecstasy, “X,” or “e,” accounted for 5.9 percent of drug items seized and analyzed in the first half of 2010 in the Twin Cities, according to NFLIS, compared with 1.6 percent nationally. Estimated hospital ED visits involving MDMA in the Twin Cities increased significantly from 204 in 2004 to 475 in 2009. MDMA sold for \$20 per pill. The use of certain **bath salts** by adolescents to get high was infrequently and sporadically reported in the Twin Cities in 2010. Sold as Cloud 9, Ivory Wave, and Vanilla Sky, the bath salts are injected, smoked, or snorted for the psychoactive effects. Some include MPVD (methylenedioxypropylvalerone), a compound that produces effects similar to stimulants or MDMA. The Hennepin Regional Poison Center documented six exposures to bath salts in 2010. **Kratom** is a natural, legal product sold in various forms, and it is used by chewing, swallowing in pellets, or brewing in tea to produce its mood-altering effects. Kratom comes from the leaves of a large tree that is native to Southeast Asia. One Web site specializing in the sale of kratom claims its use can reduce loneliness, stress, and fatigue. The Hennepin Regional Poison Center documented two exposures to kratom in 2010. **Salvia divinorum** (a plant) and salvinorin A produce short-acting hallucinogenic effects when chewed, smoked, or brewed in tea. These are most often used by adolescents and young adults. Effective August 1, 2010, the sale or possession of these in Minnesota became punishable as a gross misdemeanor. Estimated hospital ED visits involving **inhalants** in the Twin Cities declined significantly, from 181 in 2004 to 92 in 2009. In the first half of 2010, more than one-half (51.2 percent) of admissions to addiction treatment programs in the Twin Cities were for **alcohol**. In Minnesota, the percentage of students reporting alcohol use declined continuously since 1992, from 79.9 percent of 12th graders in 1992 to 55.3 percent in 2010. The percentage of Minnesota 12th graders reporting alcohol use was also less than the percentage of 12th graders

reporting nationally (65.2 percent). The use of **cigarettes** among youth also declined markedly in Minnesota. In 1998, at the height of youth smoking in Minnesota, 41.9 percent of 12th graders reported cigarette smoking in the past 30 days. In 2010, it was 19.2 percent of 12th graders. Smoking rates of Minnesota 12th graders exceeded those of 12th graders nationally until 2010.

Data Sources: *Treatment data on characteristics of clients receiving addiction treatment services in the five-county Twin Cities metropolitan area are reported on the Drug and Alcohol Abuse Normative Evaluation System of the Minnesota Department of Human Services (January–June 2010). Data on the number of people in treatment per 100,000 population by State are from the National Survey of Substance Abuse Treatment Services data from the 2009 SAMHSA survey, 2010. Medical Examiner data on accidental drug-involved deaths are reported by the Hennepin County Medical Examiner and the Ramsey County Medical Examiner (through December 2009). Data on drug use among arrestees are from the Arrestee Drug Abuse Monitoring program in Hennepin County (through December 2009), White House Office of National Drug Control Policy, Washington, DC. Crime laboratory data are from NFLIS, DEA, U.S. Department of Justice, on drugs seized by law enforcement from January through June, 2010, nationally and in the seven-county Twin Cities metropolitan area. Poison control data on drug exposures (January–December 2010) are from the Hennepin Regional Poison Center located in Minneapolis, as reported on the American Association of Poison Control Centers, National Poison Data System. ED visit data are weighted estimates derived from DAWN from 2004 to 2009, administered by the Center for Behavioral Health Statistics and Quality, SAMHSA, 2010. Student survey data on substance use by Minnesota public school students in grades 6, 9, and 12, are from the Minnesota Student Survey, 1992–2010 survey results. Data on substance use by a national sample of 12th graders are from the annual Monitoring the Future Survey,*

University of Michigan, from the 1992–2010 surveys, accessed online on 12/14/2010.

Drug Abuse Patterns and Trends in New York City—Update: January 2011

Rozanne Marel, Ph.D.

For inquiries concerning this report, please contact Rozanne Marel, Ph.D., Assistant Chief of Epidemiology, New York State Office of Alcoholism and Substance Abuse Services, 501 Seventh Avenue, 8th Floor, New York, NY 10018, Phone: 646–728–4605, Fax: 646–728–4685, E-mail: rozannemarel@oasas.state.ny.us.

Overview of Findings: Cocaine remained a major problem in New York City, but cocaine indicators decreased for this reporting period. New York City is considered the most significant heroin market and distribution center in the country, although many New York City heroin indicators decreased. Marijuana indicators were at a high level, and most continued to increase. Marijuana continued to be considered high quality and widely available. Treatment admissions for marijuana increased to the highest number ever. Drug Abuse Warning Network (DAWN) data, however, may signal the beginning of a decrease in marijuana. Although prescription drug use remained low compared with the use of other substances, many kinds of prescription drugs were available on the street. In particular, prescription opiates/opioids showed dramatic increases. Most methamphetamine indicators in New York City remained low, and there was little street selling activity. DAWN data, however, indicated that estimated emergency department (ED) visits for methamphetamine increased significantly from 2008 to 2009. While most indicators for club drugs remained low, some indicators for MDMA (3,4-methylenedioxymethamphetamine) exhibited recent increases.

Updated Drug Abuse Trends and Emerging Patterns: Cocaine indicators continued to decrease in this reporting period. Primary cocaine treatment admissions decreased, but many

clients in treatment had a primary, secondary, or tertiary problem with cocaine. DAWN weighted data showed a significant increase in estimated cocaine-involved visits between 2004 and 2009, but there was a significant decrease between 2007 compared with 2009 and 2008 compared with 2009. There were more National Forensic Laboratory Information System (NFLIS) items seized and identified as cocaine than for any other drug. Street reports were that cocaine was highly available but that crack continued to be of lower quality. **Heroin** remained a major problem in New York City. Almost one-quarter of all primary treatment admissions were for heroin, although the number of treatment admissions declined to the lowest number since 1996. Among primary heroin treatment admissions, the percentage of injectors rose slightly to 41 percent, continuing the increase noted last reporting period. While there were no significant changes for heroin in the DAWN weighted data for 2004 to 2009, there were significant decreases for 2007 compared with 2009 and 2008 compared with 2009. Thirteen percent of NFLIS items seized and identified were heroin. The average purity decreased this period, and the price per milligram pure increased. **Marijuana** indicators remained at a high level. Marijuana primary treatment admissions increased to the highest number ever and represented 28 percent of all treatment admissions. More clients in treatment had a primary, secondary, or tertiary problem with marijuana than with any other drug. One-third of NFLIS items seized and identified were marijuana. DAWN weighted ED estimates showed that marijuana-involved visits increased significantly between 2004 and 2009. It should be noted, however, that estimated DAWN ED visits for marijuana decreased significantly from 2008 to 2009. Marijuana continued to be of good quality and widely available. **Methamphetamine** indicators for the most part remained low. Treatment admissions and NFLIS items involving the drug were all at very low levels, although DAWN ED data showed recent increases. According to the New York State Office of Alcoholism and Substance Abuse Services (OASAS) Street Studies Unit

(SSU), there was little methamphetamine street selling activity, although the drug was available to users. **MDMA** indicators were increasing. NFLIS data on drugs seized and identified may indicate increases in MDMA use, as it continued to rank 6th among all drugs in the first half of 2010, compared with 11th in 2008. DAWN ED data found a significant increase in MDMA-involved visits for all comparison years. **Prescription drug** indicators were mixed. Although most indicators remained low, there continued to be street study reports that pills were available and gaining in popularity. Treatment admissions for other opiates remained low but have increased. DAWN weighted ED visit data showed significant increases in prescription drug-involved visits for opiates/opioids from 2004 to 2009 (specifically methadone, oxycodone, and hydrocodone) and for benzodiazepines from 2004 to 2009 (specifically alprazolam). 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, oxycodone, methadone, buprenorphine, hydrocodone, and clonazepam. **Other drugs:** DAWN **PCP** (phencyclidine)-involved ED visits increased significantly for all comparison years. **BZP** (1-benzylpiperazine) moved from 32nd on the list of NFLIS items seized and identified to 13th—from 4 items analyzed in the first half of 2008 to 155 items in the first half of 2010. **HIV/AIDS Update:** Of the 107,177 New Yorkers living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) as of June 30, 2009, men having sex with men and injection drug use history continued to be the two major transmission risk factors. The proportion of new HIV diagnoses among injection drug users fell, from 6.7 percent in the first half of 2008 to 4.6 percent in the first half of 2009. People living with HIV/AIDS (PLWHA) were aging. Between 2004 and 2008, the numbers of PLWHA age 50 and older increased by 45 percent in males and by 58 percent in females.

Data Sources: *Weighted ED data are based on a representative sample of hospitals in*

the five boroughs of New York City, DAWN, 2009: Selected Tables of National Estimates of Drug-Related Emergency Department Visits, Center for Behavioral Health Statistics and Quality, SAMHSA, 2010. A full description of the DAWN system can be found at <http://dawninfo.samhsa.gov>. Treatment admissions data were provided by OASAS for 1991 through the first half of 2010 and included both State-funded and nonfunded admissions. Demographic data were for the first half of 2010. Forensic laboratory testing data for New York City were provided by the Drug Enforcement Administration's (DEA) NFLIS for the first half of 2010. 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 laboratories. Drug price, purity, and trafficking data were provided by the DEA Domestic Monitor Program, "The DEA—New York Field Division, Intelligence Bulletin: Heroin Domestic Monitor Program FY 2010—Preliminary Results, November 2010," "DEA-NYFD, New York Area Drug Prices, January–June 2010;" and OASAS SSU reports. AIDS and 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. 5, No. 1" covering January 1, 2009–June 30, 2009.

Drug Abuse Patterns and Trends in Philadelphia—Update: January 2011

Samuel J. Cutler

For inquiries concerning this report, please contact Samuel J. Cutler, Drug and Alcohol Abuse Program Manager, Department of Behavioral Health and Intellectual disAbility Services, Office of Addiction Services, City of Philadelphia, Suite 800, 1101 Market Street, Philadelphia, Pennsylvania 19107-2908, Phone: 215-685-5414, Fax: 215-685-4977, E-mail: sam.cutler@phila.gov.

Overview of Findings: This report updates data on drug abuse indicators for Philadelphia since the last CEWG report for this area in June

2010. Unless otherwise noted, data are for the first 6 months of 2010, compared with prior periods from their respective data sources.

Updated Drug Abuse Trends and Emerging Patterns: The drugs/drug groups below are commented on in descending order of their impact. High levels of the use of **marijuana** continued. Marijuana ranked first in primary treatment admissions (22.8 percent), first in National Forensic Laboratory Information System (NFLIS) laboratory testing data (38.1 percent of samples seized and identified), and first in the Philadelphia Adult Probation and Parole Department (APPD) study data (first tests of people placed on probation/parole status), accounting for 53.4 percent of all drug-positive urine drug screens. Treatment admissions data identified marijuana as the second most common secondary drug of abuse, and it was most frequently used in combination with cocaine and PCP (phencyclidine). **Alcohol** was the second most frequently mentioned drug in treatment admissions data, constituting 21.3 percent of all admissions in the first half of 2010. Deaths with the presence of alcohol in combination numbered 323 in 2005, declined to 227 in 2009, and were projected to total 222 in 2010. Alcohol was detected in 24.4 percent of drug-positive decedents in the first half of 2010. People in treatment most commonly reported alcohol use in combination with cocaine or marijuana, and mortality data showed alcohol most frequently detected along with benzodiazepines and/or prescription opioids. Indicator data for **cocaine** abuse have been declining in the areas of treatment, mortality, and APPD urinalysis. Cocaine treatment admissions, which ranked third, constituted 29.3 percent in 2002 but declined to 19 percent in both calendar year 2009 and the first half of 2010. There has been a notable shift in cocaine treatment admissions by gender, with females representing 41 percent in 2001 but only 28.8 percent in mid-2010. Additionally, the treatment-seeking population for cocaine has shifted to an older cohort during the past 4½ years, with 49.3 percent of treatment admissions being older than 40 in the first half of

2010. Detections of cocaine in decedents declined from 389 in 2007, to 338 in 2008, and to 311 in 2009; there were 118 such detections in the first half of 2010. NFLIS samples seized and identified as cocaine declined from 40.8 percent in 2007 to 33.5 percent in 2009, and totaled 34.1 percent in the first half of 2010. Among probationers and parolees (APPD data), cocaine-positive screens declined from 41.5 percent in 2001 to 16.2 percent by mid-2010. Clients in treatment most commonly reported cocaine use in combination with heroin or marijuana, and mortality data showed cocaine most frequently detected along with benzodiazepines and/or prescription opioids. The street-level purity of **heroin** declined from 2000 (73 percent) to 2004 (52 percent), was either 55 or 56 percent from 2005 through 2008, and was 50 percent in 2009. The price per milligram pure fluctuated from \$0.71 in 2004, to \$0.58 in 2005, \$0.63 in 2006, \$0.71 in 2007, and \$0.60 in 2008, but it increased to \$1.56 in 2009. However, the standard bag price remained \$10 and contained one “hit.” In the first half of 2010, indicators for heroin declined in the treatment, mortality, and APPD measures. Heroin continued to rank fourth in treatment admissions, at 15.1 percent (declining from more than 17 percent in 2008), third in deaths with the presence of drugs, at 19.8 percent (having ranked second in 2008), and third in NFLIS data for the first half of 2010 (11.9 percent). At the beginning of the period of declining heroin purity (2001), Whites constituted 54 percent of treatment admissions; this proportion had increased to more than 68 percent by 2006. In mid-2010, Whites accounted for 66.3 percent of treatment admissions for heroin. Proportions of African-Americans declined from 42.0 percent in 2001, to 22 percent in 2006, and stood at 26.5 percent by the first half of 2010. As the purity levels bottomed out, the 21–30 age group entered treatment in increasing proportions (from 22.0 percent in 2001 to 42.0 percent in 2005). Similarly, as the purity leveled off, the proportion of this population among treatment admissions leveled off as well, totaling 41.4 percent in 2009, but declining to 35.7 percent in mid-2010. Deaths with the presence of heroin closely matched the purity

trends from 2001 through 2009, with the exception of the period of the fentanyl outbreak from spring 2006 to spring 2007; based on mid-year 2010 data, a small decline in deaths with the presence of heroin was projected. People in treatment most commonly reported heroin use in combination with cocaine, and mortality data showed heroin most frequently detected along with benzodiazepines and/or cocaine. The nonmedical use of (prescription) **other opioids** has been in the background of the drug scene since the late 1990s until consequence data began increasing more recently, especially with respect to treatment admissions. Primary treatment admissions for oxycodone products increased from 10 clients in 2007, to 80 in 2008, to 387 in 2009, and to 410 in the first half of 2010. Secondary mentions of oxycodone increased similarly during these time periods. Among drug-positive decedents in the first half of 2010 whose cause of death was drug intoxication, oxycodone was the fourth most frequently detected drug, behind cocaine, heroin, and alprazolam. Four pharmaceutically produced opioids were in the top 10 drugs in the NFLIS report for the first half of 2010—oxycodone (4th), codeine (8th), hydrocodone (9th), and buprenorphine (10th). **Benzodiazepine** use, while lower than use of marijuana, alcohol, cocaine, or heroin, continued to be common in conjunction with other drugs, according to trend data and focus group participants. Based on treatment admissions data for the first half of 2010, there could be an 8-percent increase over 2009. Alprazolam was clearly the most widely used benzodiazepine, ranking third in the Medical Examiner (ME) toxicology reports when the cause of death was drug intoxication. In the NFLIS data, 3 benzodiazepines appeared in the top 12: alprazolam (5th), clonazepam (7th), and diazepam (12th). At mid-2010, the mortality data revealed that benzodiazepines were frequently detected among decedents who also tested positive for cocaine, alcohol, heroin, other opioids, PCP, or antidepressants. **PCP** (phencyclidine) continued to be primarily used by being smoked in combination with marijuana

in “blunts.” Indicators reflected medium levels of use, compared with other drugs, and were projected to increase with respect to primary treatment admissions and detections in decedents. There was stability in the PCP NFLIS rank (sixth) and APPD urinalysis results (9.1 percent of all positives). Characteristics of people who entered treatment for PCP included male (79.9 percent); African-American (68.2 percent); age 21–30 (57.1 percent); and age 31–40 (29.5 percent). Regarding **antidepressants**, 26.6 percent of all drug-positive decedents tested positive in the first half of 2010, compared with 32.0 percent in 2009. Use of **methamphetamine and other amphetamines** remained at very low levels. There were 24 treatment admissions for methamphetamine and 7 for other amphetamines in the first half of 2010. Mortality data for these drugs were also low; in the first half of 2010, there were a total of 11 detections of methamphetamine, amphetamine, MDMA (3,4-methylenedioxy-methamphetamine), or MDA (3,4-methylenedioxyamphetamine) among the 8 cases.

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 were obtained from the City of Philadelphia Department of Public Health, ME’s Office. Criminal justice data consist of the urinalysis program of the APPD, which analyzed samples for the first-time testing (only) of individuals on probation or parole. Heroin purity and price data were provided by Drug Enforcement Administration’s (DEA) Heroin Domestic Monitor Program for 2009 and earlier periods. Forensic laboratory data came from NFLIS, DEA, for the first half of 2010. Note: Emergency department (ED) data were not available because Philadelphia is not associated with the Drug Abuse Warning Network ED data collection system.*

Drug Abuse Patterns and Trends in the Phoenix Area and Arizona—Update: January 2011

James K. Cunningham, Ph.D.

For inquiries concerning this report, please contact James K. Cunningham, Ph.D., Social Epidemiologist, Department of Family and Community Medicine, The University of Arizona, 1450 North Cherry Avenue, Tucson, AZ 85719, Phone: 520-615-5080, Fax: 520-577-1864, E-mail: jkcnin@email.arizona.edu.

Overview of Findings: This report updates data on drug abuse indicators for the Phoenix area (Maricopa County) since the last reporting period in June 2010. After rising slightly in the second half of 2009, amphetamine/methamphetamine-related hospital admissions were flat in the first half of 2010. Methamphetamine treatment admissions declined as a percentage of total admissions. Cocaine-related hospital admissions and primary cocaine treatment admissions (as a percentage of total treatment episodes) declined in the first half of 2010. Marijuana-related hospital admissions rose in the first half of 2010, although marijuana treatment episodes (as a percentage of total episodes) were relatively flat. Heroin treatment episodes increased as a percentage of total treatment episodes. Drug Abuse Warning Network (DAWN) estimated emergency department (ED) heroin-involved visits were flat in 2009. In contrast, some opioids (oxycodone, hydrocodone, and morphine), along with benzodiazepine-involved visits, increased significantly from 2007 to 2009. Prices for ephedrine/pseudoephedrine-based methamphetamine declined in the first half of 2010. Prices for P2P methamphetamine (made with phenyl-2-propanone) were lower than those for ephedrine/pseudoephedrine-based methamphetamine.

Updated Drug Abuse Trends and Emerging Patterns: Of all treatment episodes that indicated a primary drug of abuse in the first half of 2010, 18 percent reported **methamphetamine**, making it the second most common

illicit drug reported, behind heroin. (**Alcohol** was the most common drug reported, at 31 percent.) The percentage of all treatment admissions with methamphetamine as the primary drug decreased slightly in the first half of 2010. Items seized and identified by the National Forensic Laboratory Information System (NFLIS) as containing methamphetamine increased in the first half of 2010. Seizures of clandestine methamphetamine laboratories remained low; 29 were seized in 2009; 9 were seized in the first half of 2010. After rising slightly in the second half of 2009, amphetamine/methamphetamine-related hospital admissions were flat in the first half of 2010. **Cocaine** was reported by 5 percent of treatment admissions reporting a primary drug in the first half of 2010. After increasing during 2005 and 2006, cocaine-related hospital admissions began to decline in the first half of 2007 and continued to decline through the first half of 2010. Cocaine items seized and identified by NFLIS decreased in the first half of 2010, compared with the first half of 2009. There were approximately 361 estimated ED visits involving **MDMA** (3,4-methylenedioxymethamphetamine) in 2009, the highest number in 5 years and a significant increase from the 94 visits in 2007, but the total was still small when compared with methamphetamine-involved ED visits in 2009 ($n=2,957$). The number of items seized and identified by NFLIS as containing MDMA increased in the first half of 2010 compared with the first half of 2009. During the first half of 2010, **marijuana** was reported by 16 percent of all treatment admissions reporting a primary drug, about the same as in the first half of 2009. In contrast, marijuana/cannabis-related hospital admissions rose in the first half of 2010, continuing an upward trend that began in 2007. Estimated ED visits involving marijuana were stable from 2008 (3,374 visits) to 2009 (4,043 visits). Marijuana items seized and identified by NFLIS increased sharply in the first half of 2010. Of all treatment episodes that indicated a primary drug of abuse in the first half of 2010, 22 percent reported **heroin**, making it the most common illicit drug so reported. For the previous several years, methamphetamine had that ranking.

Heroin-involved estimated ED visits were stable from 2008 to 2009, with 2,712 and 2,662 visits, respectively. The number of heroin/opioid-related hospital admissions with skin abscesses (a problem often arising from needle use) decreased in the first half of 2010. Estimated ED visits involving **oxycodone, hydrocodone, morphine, and benzodiazepines** all increased significantly from 2007 to 2009. **HIV/AIDS:** New data on human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) related to drug abuse were unavailable to update rates reported at the June 2010 CEWG meeting. **Emerging Patterns Regarding Use:** Significant increases in MDMA-involved ED visits and in NFLIS MDMA items (as noted above) suggest that the drug may be an emerging problem in the Phoenix area.

Data Sources: *Treatment data came from the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services. Hospital admissions (inpatient) data came 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 ADHS. Estimated ED visits came from DAWN, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Law enforcement data, including clandestine laboratory seizure data, were from the Drug Enforcement Administration (DEA). Forensic drug analysis data were from NFLIS, DEA.*

Drug Abuse Patterns and Trends in St. Louis, Missouri—Update: January 2011

Christopher Long, Ph.D., and Heidi Israel Ph.D., R.N., F.N.P., L.C.S.W.

For inquiries concerning this report, please contact Christopher Long, Ph.D., Department of Toxicology, Saint Louis University School of Medicine, St. Louis, MO 63139, Phone: (314) 522-3262, ext. 6517, E-mail: longc@slu.edu.

Overview of Findings: During the first 6 months of 2010, heroin indicators in the St. Louis metropolitan area remained high. Anecdotal information indicated that heroin use and availability had increased as had treatment admissions. Many of the indicators for the other major substances of abuse remained relatively stable or were trending downwards in the first half of 2010. Other drug categories have shown some decrease in treatment admissions, deaths, and arrests. Cocaine indicators decreased in treatment admissions and cocaine-related deaths for St. Louis City and County during three 6-month reporting periods (death data are for the first half of 2008–2010). Alcohol indicators for treatment and arrests remained stable. Amphetamine remained entrenched in the county and outlying counties at a lower but observable level. Newer combinations such as “Ivory Tide,” an amphetamine-based product, were of interest. Prescription narcotic analgesics were reported to be available in the more rural areas of the St. Louis metropolitan statistical area (MSA), and herbal preparations such as K2 have been the focus of many news stories. The poor economy has resulted in reduced State and local budgets, which may have an impact on several indicators of drug use.

Updated Drug Abuse Trends and Emerging Patterns: **Alcohol** remained the primary drug of abuse for clients entering publicly funded treatment programs in Missouri. Treatment admissions showed increases through 2008 but had decreased through the first half 2010, possibly due to capping of available treatment slots. Alcohol was frequently indicated as a secondary drug of abuse. The 2008 Missouri School Survey showed only a slight increase in past-30-day use among 6th and 12th graders from 2006 levels. Alcohol was frequently identified among positive screens among probationers and parolees and those incarcerated. **Cocaine** indicators decreased from the first half of 2010 except for deaths in urban St. Louis. Treatment admissions decreased almost one-third, from 1,235 in the first 6 months of 2008, to 825 in the first 6 months of 2009, and to 788 in the first half 2010. Cocaine in the St. Louis region

was the third most identified drug in the National Forensic Laboratory Information System (NFLIS) but represented only 12.6 percent of items, down from 15.1 percent of items in the first half of 2009. While identified as a major drug problem in the St. Louis area, recent concern about heroin abuse has taken attention from cocaine. Law enforcement officials reported a decrease in cocaine availability, which has resulted in an increase in prices and decreases in purity. No change in past-30-day cocaine use (2.4 percent) was noted between the 2006 and 2008 Missouri School Surveys. The **heroin** market in the St. Louis region has grown and become more complex over the past few reporting periods. From the first half of 2008 to the first half of 2010, treatment admissions increased by 20 percent and rival total admissions for marijuana abuse in the area. Two types of heroin were available—Mexican white heroin was primarily available with some black tar also reported. Increased involvement of Mexican dealers has complicated the market. Heroin Domestic Monitor Program analyses in 2008 reflected this growing, competitive heroin market in the St. Louis area, with decreasing purity in black tar heroin and increasing purity in white heroin. Deaths have increased in the city, county, and rural areas, with most of the surrounding rural counties reporting younger heroin deaths and increases for both heroin and other opiates. This increase was consistent with reported availability for heroin and reports from rural law enforcement about increased usage. Heroin represented 13.7 percent of identified drugs in the first half of 2010 NFLIS data, a continuing increase over the past 2 years. The available indicators for **other opiates** increased during this reporting period. While the actual number of admissions was relatively low (205 in first half of 2010, up from 157 in the first half of 2009), there was still reason for concern, as anecdotal information indicated that abuse of narcotic analgesics has been on the rise in this region. An example is that fentanyl appeared in death data in St. Louis County and in surrounding Jefferson, St. Charles, and Franklin Counties. Prescription narcotics were believed to be prevalent in some of the rural areas surrounding the central city.

Marijuana treatment admissions decreased 13.3 percent from the first half of 2008 to the first half of 2009, but appeared to be slightly up in the first half of 2010. Marijuana/cannabis was the most frequently cited substance identified in the first half of 2008–2010 NFLIS reports for the St. Louis MSA. Also, a slight increase (7.2 compared with 7.8 percent) in past-30-day marijuana use was noted in the Missouri School Survey from 2006 to 2008. **Methamphetamine** indicators appeared to be mixed. Treatment admissions decreased in the St. Louis region from the first half of 2008 (173) to the first half of 2009 (141) but increased again in the first half of 2010 (210). While clandestine methamphetamine laboratory seizures remained stable, and there was strong support in many areas to control all amphetamine precursors, it is believed that the bulk of the available methamphetamine was being imported from Mexico. More creative ways of networking for the local “cooks” to gain access to the chemicals needed to make methamphetamine continued to emerge. Interestingly, the eastern half of the State remained relatively active in clandestine laboratory operations. Statewide, 1,453 clandestine laboratories were reported as of the last week of 2009, compared with 1,487 in 2008. There was little change in past-30-day methamphetamine use (2.8 versus 2.7 percent) noted in the Missouri School Survey. The most recent addition to amphetamine-based products is Ivory Tide, which was responsible for some deaths in local emergency rooms and is actively being monitored by a local toxicology task force. **Prescription drug** abuse has been growing, particularly in the rural areas. However, it has been difficult to access data to substantiate this trend, although treatment admissions for benzodiazepines increased by two-thirds from the first half of 2008 ($n=25$) to the first half of 2009 ($n=42$). They totaled 31 in the first half of 2010. There have been multiple reports from key informants about increases in prescription drug use and in the continued use of **MDMA** (3,4-methylenedioxy-methamphetamine) in select populations. In the Missouri School Survey, past-30-day use of MDMA was reported by 2.2 percent of students in 2006 and 2.5 percent in 2008. The

National Monitoring of Adolescent Prescription Stimulant Study (NMAPSS) project documented lifetime use of MDMA among youth age 16–18 at 11 percent (males) and 13 percent (females). One death in the indicator data had both amphetamine and MDMA present. **HIV/AIDS Update:** Data available from the St. Louis City Health Department and the Missouri Department of Health and Senior Services for 2001–2009 indicated that the risk factor of injection drug use did not play a major role in the transmission of human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) in the St. Louis area. However, men having sex with men and heterosexual contact in minority populations were more prominent risk factors. The role of alcohol and other drug use among these populations was a key factor. **Emerging Patterns:** Indicators for many substances appeared to be stable or even decreasing. However, the increase in a number of opiate abuse indicators remained cause for concern and continued monitoring. New drugs such as Ivory Tide will be followed by poison control and toxicologists. A synthesis of all data sources leads to the conclusion that the heroin problem in St. Louis was leveling off at a high level of availability, which makes prevention and intervention more complex. The market has become more diverse, and potent drugs have become more available to a wider range of users, including those living in rural areas, with fewer resources to intervene.

Data Sources: *Analysis of drug trends for the St. Louis region requires multiple data sources; a number of sources were used for this report. Missouri Treatment Episode Data Set admissions for the first 6 months of CYs 2008–2010 provided invaluable indicators for **treatment data**. The January–June 2010 NFLIS reports for the St. Louis MSA provided **forensic information** and offered a unique view of drug trends for a variety of substances. The Missouri Department of Health and Senior Services **HIV/AIDS** data FY 2006–2009 and the 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. Missouri School Survey data for 2006–2008 gave a glimpse of general **youth trends** in current and lifetime use of some of the major substances. Data from the National Monitoring of Adolescent Prescription Stimulant Study (NMAPSS) and the Prescription Drug Use, Misuse, and Depression Study conducted by the Washington University Epidemiology and Prevention Research Program were used to address an important knowledge gap on adolescent drug trends in our area. **Death data** from the St. Louis City and County Medical Examiner for the first 6 months of CYs 2008–2010 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 the National Drug Intelligence Center are invaluable, as are the frequent formal written reports and anecdotal insight provided by the staff of these agencies.*

Drug Abuse Patterns and Trends in San Diego County—Update: January 2011

Robin A. Pollini, Ph.D., M.P.H.

For inquiries concerning this report please contact Robin Pollini, Ph.D., M.P.H., Assistant Professor, School of Medicine, University of California San Diego, mail code 0507, 9500 Gilman Drive, La Jolla, CA 92093, Phone: 858–534–0710, Fax: 858–534–7566, E-mail: rpollini@ucsd.edu.

Overview of Findings: After several years of decline, methamphetamine indicators in San Diego County suggest price stabilization with increases in use/abuse in some subpopulations in the first half of 2010. Cocaine indicators declined between 2007 and 2010, in some cases reaching record lows. Marijuana and heroin indicators were mixed, while MDMA (3,4-methylenedioxymethamphetamine)/ecstasy indicators remained low with incremental increases. Drug treatment admissions data suggested abuse of narcotic analgesics was stable.

Updated Drug Abuse Trends and Emerging Patterns: Indicators of methamphetamine use/abuse had been decreasing since peaking in 2005; however, in 2009 prevalence of **methamphetamine** use increased among adult arrestees. Prevalence among female arrestees was 38 percent in 2009, compared with 31 percent in 2008, and among males it was 22 percent in 2009 and 20 percent in 2008. Remaining indicators were mixed. In contrast to adult arrestees, methamphetamine prevalence among juvenile arrestees decreased from 10 percent in 2008 to 6 percent in 2009. Primary substance abuse treatment admissions for methamphetamine were stable, accounting for 29 percent ($n=2,006$) of all admissions in the first half of 2010, compared with 30 percent ($n=2,195$) in the first half of 2009. Meanwhile, street prices of methamphetamine remained relatively steady for smaller quantities from 2007 to 2009, while they decreased for larger quantity purchases. Regarding the latter, price per pound was \$9,000–\$12,000 in 2009, compared with \$10,000–\$20,000 in 2007. Interviews conducted with adult arrestees who used methamphetamine also suggested prices were stabilizing, with 67 percent perceiving higher prices over the past year, compared with a peak of 76 percent in 2008. **Cocaine/crack** indicators continued to show reductions in use and abuse. Prevalence of use among male, female, and juvenile arrestees in 2009 was 7, 11, and 1 percent, respectively, compared with 11, 16, and 3 percent, respectively, in 2007. Primary cocaine treatment admissions decreased to 350 in the first half of 2010, from 527 in the first half of 2008; the former represented 5 percent of all treatment admissions, compared with 7 percent in 2008. Further, 9 percent of drug seizures in the first half of 2010 tested positive for cocaine, compared with 13 percent in calendar year 2008. **Marijuana** indicators were mixed; primary treatment admissions decreased slightly from 21 percent of total treatment admissions in the first half of 2009 to 19 percent in the first half of 2010. In contrast, after recording a 9-year low in prevalence in 2008, 28 percent of female arrestees tested positive for marijuana in 2009, compared with 26 percent in the previous

year. Prevalence among male arrestees was also up slightly (37 percent in 2009 versus 36 percent in 2008), and juvenile prevalence increased from 44 to 51 percent. **Heroin** indicators were also mixed. Primary heroin treatment admissions increased 1 percentage point, from 19 percent in the first half of 2009 to 20 percent in the first half of 2010, and laboratory items testing positive for heroin increased from 3.7 percent in 2009 to 4.9 percent in the first half of 2010. However, other indicators remained stable. Treatment admissions for narcotic analgesics remained low and stable at 4 percent of primary treatment admissions, and **MDMA/ecstasy** indicators were low but continued to inch upward.

Data Sources: *Arrestee data* were from 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 2009 data for both adult ($n=766$) and juvenile ($n=154$) arrestees. **Forensic laboratory data** were from the National Forensic Laboratory Information System, Drug Enforcement Administration. There were 10,675 drug items analyzed by local forensic laboratories between January and June 2010. **Treatment data** came from the San Diego Department of Alcohol and Drug Programs (ADP) (tables produced by the California Department of ADP) 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 this report include admissions to San Diego County for the period January–June 2010. Note that CalOMS was implemented in early 2006, replacing the earlier California Alcohol and Drug Data System (CADDSS) system. Therefore, data reported for periods prior to July 2006 may not be comparable to more recent periods. **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 2011

John A. Newmeyer, Ph.D., and Alice Gleghorn, Ph.D.

For inquiries concerning this report, please contact Alice Gleghorn, Ph.D., County Alcohol and Drug Administrator, Community Behavioral Health Services, San Francisco Department of Public Health, Room 450, 1380 Howard Street, San Francisco, CA 94103, Phone: 415–255–3722, Fax: 415–255–3529, Email: alice.a.gleghorn@sfdph.org.

Overview of Findings: After a prolonged recession, economic conditions improved in the San Francisco Bay area during the second half of 2010. Cocaine indicators were generally down. Heroin indicators were consistently down. Methamphetamine indicators were mixed after a long decline. Little change was seen in marijuana usage in this reporting period. “Club drugs” were not a serious concern, except possibly for MDMA (3,4-methylenedioxymethamphetamine) which experienced a significant increase in 2009 in Drug Abuse Warning System (DAWN) estimated emergency department (ED) visits from 2004 and 2007.

Updated Drug Abuse Trends and Emerging Patterns: Treatment admissions for **cocaine** declined from fiscal years (FYs) 2009 to 2010, but weighted DAWN ED estimated cocaine-involved visits were stable from 2008 to 2009. Among local drug seizures, cocaine constituted only 21 percent in 2010, down from 25 percent in 2009. **Heroin** treatment admissions declined steadily from FY 2008 to FY 2010. Similarly, heroin constituted a smaller proportion of drug seizures in the bay area. The average price of street samples rose from 2008 to 2009, while the purity

declined. Indicators of **methamphetamine** use were mixed, with admissions stable or down and estimated methamphetamine-involved ED visits showing a significant increase from 2007 to 2009. Youth (younger than 21) estimated methamphetamine-involved ED visits decreased 46 percent from 2008 to 2009. **Marijuana** indicators were mixed, with significant increases in estimated ED visits from 2007 to 2009, the proportion of local drug seizures down, and treatment admissions steady. Estimated **hydrocodone**-involved ED visits were low and stable. Although also low, estimated **oxycodone**-involved ED visits increased significantly by 43 percent from 2008 to 2009. Estimated ED visits involving **MDMA** increased significantly from 188 visits in 2007 to 369 visits in 2009, while estimated **PCP** (phencyclidine)-involved visits were stable from 2008 (88 visits) to 2009 (111 visits). **HIV/AIDS Update:** Acquired immunodeficiency syndrome (AIDS) cumulative reports in San Francisco County increased by 7.6 percent among heterosexual injection drug users (IDUs), and by 12.5 percent among gay/bisexual male IDUs, in the 6 years to September 2010. The former group still constituted only 7 percent of the total San Francisco caseload.

Data Sources: *Treatment admissions data were available for all five San Francisco Bay area counties for FYs 2007 through 2010 and were provided by the California Department of Alcohol and Drug Programs. Admissions data for FYs 2008, 2009, and 2010 were provided for San Francisco by that county’s Community Substance Abuse Programs. Weighted ED DAWN visit data from the Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, were available from 2005 through 2009 for the three counties of the west bay area (San Francisco, San Mateo, and Marin). Price and purity data came from the Drug Enforcement Administration, Heroin Domestic Monitor Program, and referenced heroin “buys” mostly made in San Francisco County. Data for 2009 were compared with those for 2001–2008. Reports of drugs seized and identified were provided by the*

National Forensic Laboratory Information System for 2008, 2009, and the first half of 2010. AIDS surveillance data were provided by the San Francisco Department of Public Health and covered the period through September 30, 2010.

Drug Abuse Patterns and Trends in Seattle, Washington—Update: January 2011

Caleb Banta-Green, T. Ron Jackson, Pat Knox, Steve Freng, Michael Hanrahan, David H. Albert, John Ohta, Ann Forbes, Robyn Smith, Steve Reid, Mary Taylor, and Richard Harruff

For inquiries concerning this report, please contact Caleb Banta-Green, M.P.H., M.S.W., Ph.D., Research Scientist, Alcohol and Drug Abuse Institute, University of Washington, Suite 120, 1107 N.E. 45th Street, Seattle, WA 98105, Phone: 206-685-3919, Fax: 206-543-5473, E-mail: calebbg@u.washington.edu.

Overview of Findings: Overall, the 6 months worth of data reported on for the first half of 2010 were inadequate for trend analyses. Cocaine, marijuana, heroin, pharmaceutical opioids, and methamphetamine all persisted as major drugs of abuse. A range of other drugs were used at lower levels.

Updated Drug Abuse Trends and Emerging Patterns: The number and types of drugs involved in drug-caused deaths remained fairly steady from 2008 to the first half of 2010 overall. **Cocaine** was the most common illegal drug, identified in 24 of 116 drug-caused deaths; however, it was identified in fewer deaths than were pharmaceutical opioids, alcohol, and benzodiazepines. For adults, treatment admissions overall have increased 55 percent since 1999. Admissions for cocaine peaked in 2008 and declined in 2009 and further declined in the first half of 2010, likely related to policy changes that increased the amount of cocaine needed for prosecution. Arrests for cocaine possession appeared to have declined

as a result. **Heroin** treatment admissions have been steady since 2006, while overdose deaths have declined over this same period. Heroin purity appeared to be the lowest it has been since at least 1992, with a median purity of just 2 percent in the first quarter of 2010. Drug-caused deaths involving **pharmaceutical opioids** continued to be the most common type of overdose in the first half of 2010 and represented 53 percent of overdose deaths. The most common pharmaceutical opioids continued to be methadone and oxycodone. The number and proportion of pharmaceutical opioid treatment admissions increased continuously from 2003 to the first half of 2010, although they remained somewhat less common than admissions for the other major drugs of abuse. **Benzodiazepines** were present in 22 percent of drug-caused deaths and were almost always detected in combination with other drugs. The number of drug treatment admissions for youth has remained steady overall since 1999, with **marijuana** continuing to represent the majority of admissions (alcohol was second). The number and proportion of marijuana primary drug treatment admissions for adults were up substantially since 1999 and appeared to level off in the first half of 2010. Reasons for this increase were not clear. **Methamphetamine** treatment admissions have held fairly steady since 2005. Statewide data for methamphetamine indicated its presence in deaths for samples tested by State forensic laboratories, all causes and manners, increased from 221 to 236 for the 12-month periods ending in June 2009 and June 2010 respectively. Over this same period, DUIs (Driving Under the Influence) in which methamphetamine was detected increased substantially to 499, and the number of total clandestine laboratories remained steady at a low level, with 31. **Other drugs** are most likely to be identified by chemical testing of law enforcement seizures, and the overall number of pieces of evidence has declined substantially since 2007. Substances that continued to be occasionally detected in the first half of 2010 included **MDMA** (3,4-methylenedioxymethamphetamine) ($n=34$), **BZP** (1-benzylpiperazine) ($n=7$), and **PCP** (phencyclidine) ($n=9$).

Data Sources: *Drug overdose data* were obtained from the King County Medical Examiner; Public Health—Seattle & King County for the first half of 2010. *Data on seized drug samples submitted for analysis* were obtained from the National Forensic Laboratory Information System, Drug Enforcement Administration (DEA), for January–June 2010. Drug testing results for law enforcement seizures in King County were reported by the county where the drug was seized. **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 through June 2010. Treatment modalities included outpatient, intensive inpatient, recovery house, long-term residential, and opiate substitution admissions. Department of Corrections and private-pay admissions were included. **Methamphetamine incident, DUI, and fatality data** were provided by the Washington State Patrol Forensic Laboratory Services Bureau. **Heroin purity data** were provided by the DEA based on their Domestic Monitoring Program and include heroin obtained in the larger Seattle area.

Drug Abuse Patterns and Trends in Texas—Update: January 2011

Jane C. Maxwell, Ph.D.

For inquiries concerning this report, please contact Jane C. Maxwell, Ph.D., Senior Research Scientist, Addiction Research Institute, Center for Social and Behavioral Research, The University of Texas at Austin, Suite 335, 1717 West 6th Street, Austin, TX 78703, Phone: 512–232–0610, Fax: 512–232–0617, E-mail: jcmaxwell@mail.utexas.edu.

Updated Drug Abuse Trends and Emerging Patterns: Drug supply indicators across the State of Texas in the first half of 2010 differed in Dallas, El Paso, and Houston just as they differ among States. Statewide, the **heroin** situation remained level, but the increasing admissions among clients in their twenties were a concern.

Indicators for **other opiates** were increasing. The “Houston Cocktail” (a combination of hydrocodone, alprazolam, and carisoprodol) remained popular, as did drinking “Syrup” (soft drinks laced with codeine cough syrup). **Cocaine** indicators were down. **Marijuana** indicators were high and level, with use of “blunts” continuing to be a factor in the increased use of the drug. Calls to poison centers for exposure to marijuana homologs continued to increase. **Methamphetamine** indicators were increasing, with users divided as to the purity of the drug. Most of the methamphetamine was made in Mexico using the P2P (phenyl-2-propanone) process, which can produce methamphetamine that is nearly as potent as the d-methamphetamine made with pseudoephedrine. Methamphetamine users reported multiple routes of administration (based on the route immediately available), combined their methamphetamine with other drugs, and had specific impressions as to the benefits and risks of using the drug. **Ecstasy** indicators were level or increasing, and **BZP** (1-benzylpiperazine) and **TFMPP** (3-(trifluoromethylphenyl)piperazine) levels were increasing. **Mephedrone** has been identified in Texas interviews and toxicology laboratory and poison control data, although the mentions have been low. **Alcohol** use by underage drinkers in Texas exceeded national levels. The increasing use of alcohol in combination with drugs warrants inclusion of alcohol as one of the drugs routinely reported by CEWG members. Drugged driving indicators in Texas were about equal to or exceeded drunken driving indicators.

Data Sources: *Data sources included Texas Treatment Episode Data Set data for 1987 through the first half of 2010; Texas poison control calls through 2010; National Forensic Laboratory Information System data for Texas Department of Public Safety laboratories through the first half of 2010; Texas death data through 2009; intelligence reports from DEA Field Divisions through the first half of 2010; Texas school survey data through 2010; and Youth Risk Behavior Survey data for 2009.*

INTERNATIONAL REPORTS: EUROPE, CANADA, AUSTRALIA, THAILAND, and JAMAICA

Main and New Drug Trends in the European Union: EMCDDA 2010 Report

*Julian Vicente, Roumen Sedefov,
Ana Gallego, and Paul Griffiths on
Behalf of the EMCDDA Team*

For inquiries concerning this report please contact Julian Vicente, M.D., M.P.H., Head of Unit on Patterns, Consequences, and Data Management, European Monitoring Centre for Drugs and Drug Addiction, Cais do Sodré, Lisbon, Portugal 1249-289, Phone: 351-211-210-223, Fax: 351-213-584-441, E-mail: julian.vicente@emcdda.europa.eu.

Cannabis remained the most popular illicit drug used in Europe, estimated at an average of 7 percent last-year prevalence (LYP) and 4 percent last-month prevalence (LMP) based on survey data for 2009. There were large differences between countries, with a factor of 30 times between the highest and lowest national prevalence. Overall, the trends in consumption showed stable or declining trends, although with different national patterns. In most European Union (EU) countries, **stimulants** were the second most common illegal drug, though the pattern was complex. In the United Kingdom, Spain, Ireland, Italy, and Denmark, cocaine was the most popular stimulant, whereas in other countries amphetamines or ecstasy were more popular. **Cocaine** use increased markedly from 1995 in some of the mentioned countries, but in recent years it has stabilized. Some Nordic and central European countries presented a traditional pattern of problem amphetamine use (usually by injection) and, to a lesser extent, methamphetamine use, also by injection. In some cases, methamphetamine may have been displacing amphetamine among established problem drug users. **Heroin** use continued to account for the greatest share of recorded morbidity and mortality related to drug use in the EU; it was estimated that

there were between 1.2 and 1.5 million chronic opiate users. These prevalence estimations have remained relatively stable in recent years, although the number of new users (incidence) appeared to have decreased in many western countries since peaks in the 1980s or 1990s. Although there were some moderate increases in different heroin indicators (drug seizures, deaths, and treatment admissions), they are difficult to interpret (with factors such as an aging population or increased service availability).

Parallel to identification and tracking of more classical drug trends, the EMCDDA is also part of the Early Warning System (EWS), a legal mechanism established by an EU Council Decision for rapid exchange of information on new psychoactive substances that may pose public health and social threats. The EWS also provides for an assessment of the risks associated with these new substances. One of the main challenges to current approaches to monitoring and responding to new psychoactive substances is the appearance of a large number of unregulated synthetic psychoactive compounds. These are marketed on the Internet as “legal highs” or “not for human consumption” and are specifically designed to mimic the effects of known (established) drugs, in order to circumvent existing drug controls. An example was the Spice phenomenon (smokable herbal products laced with **synthetic cannabinoids** and advertised as incense products). More than 20 new synthetic cannabinoids have been reported through the EWS since 2008. Also, the EWS is currently monitoring more than 30 **synthetic cathinones**. Towards the end of 2009, increased evidence of the use and availability of one of these cathinones, mephedrone, prompted the EMCDDA to scientifically assess the health and social risks of the drug, which was submitted to control measures at the European level.

References:

EMCDDA 2010. Annual report 2010, the state of the drugs problem in Europe. Publications Office of the European Union, Luxembourg.

EMCDDA, 2010. Risk assessment of new psychoactive substances: operating guidelines. Publications Office of the European Union, Luxembourg.

Sedefov R, Gallegos A, King LA, et al. Understanding the 'Spice' phenomenon. Thematic papers, European Monitoring Centre for Drugs and Drug Addiction, 2009.

EMCDDA, 2010. Report of the risk-assessment report of 4-methylmethcathinone (mephedrone) in the framework of the Council decision on new psychoactive substances. Publications Office of the European Union, Luxembourg. In press.

Further Information:

EMCDDA general Web site: <http://www.emcdda.europa.eu/>

EMCDDA Statistical Bulletin: <http://www.emcdda.europa.eu/stats10>

EMCDDA Web page on "Action on new drugs": <http://www.emcdda.europa.eu/drug-situation/new-drugs>

The Drug Situation in Canada— Health Canada's Update: January 2011

Judy Snider, M.Sc.

For inquiries concerning this report please Judy Snider, M.Sc., Manager of Surveillance, Office of Research and Surveillance, Controlled Substances and Tobacco Directorate, Healthy Environments and Consumer Safety Branch, Health Canada, Room D677, A.L. 3506C, 123 Slater Street, Ottawa, ON K1A 0K9, Canada, Phone: 613-952-2514, Fax: 613-952-5188, E-mail: judy.snider@hc-sc.gc.ca

Overview of Findings: Cannabis continued to be the dominant illicit drug in Canada, both from self-reported past-year use and from laboratory analysis of exhibits from seized substances. Among the general population age 15 and older, approximately 1 percent reported past-year use of cocaine/crack cocaine. A similar proportion reported using other illicit drugs, including speed,

hallucinogens (including *Salvia divinorum*), and ecstasy in the past year. The number of exhibits analyzed for seizures of methamphetamine and prescription opioids appeared to have increased over the past year's reporting period.

Updated Drug Abuse Trends and Emerging Patterns:

Results from the Canadian Alcohol and Drugs Use Monitoring Survey (CAD-UMS) 2009 indicated that 11 percent of Canadians age 15 and older reported past-year **cannabis** use. There was no change in the reported prevalence of past-year cannabis use compared with 2008, and there was a decrease from the 14 percent measured in the 2004 Canadian Addiction Survey. Self-reported past-year use of other illicit drugs (e.g., **cocaine/crack cocaine, speed, hallucinogens, and ecstasy**) was around 1 percent for each of the substances in 2009. Since 2008, there has been a decrease in past-year use of hallucinogens, including **Salvia**, from 2 to 1 percent. A decrease was also noted in the reported past-year use of at least one of five illicit drugs (cocaine, hallucinogens [including *Salvia*], ecstasy, speed, and heroin) between 2008 (3.9 percent) and 2009 (2.1 percent). Among Canadian youth age 15–24, there was a decrease in reported past-year cannabis use from 37 percent in 2004 to 26 percent in 2009; however, no significant change was seen between 2008 and 2009. A decrease was also noted in the prevalence of use of at least one of five illicit drugs (cocaine, hallucinogens [including *Salvia*], ecstasy, speed, and heroin) from 15 percent in 2008 to 6 percent in 2009. In 2009, 25 percent of Canadians age 15 and older indicated that they had used (including for medical use) a psychoactive **pharmaceutical drug** (i.e., **opioid pain reliever, stimulant, sedative, or tranquilizer**) in the past year, a significant decrease since 2008 (28 percent). Among these users, approximately 2 percent reported that they used such a drug to get high (this represents less than 1 percent of the Canadian population). *Results from Health Canada's Drug Analysis Service (DAS) Laboratory Information Management System (LIMS)* indicated that the vast majority of exhibits analyzed from substances seized by police and border services

were **cannabis**, followed by **cocaine** (cocaine and crack cocaine). The number of cannabis exhibits analyzed each year has remained fairly stable since 2005. After year-over-year increases in cocaine exhibits analyzed from 2003 to 2007, fewer cocaine exhibits were analyzed in 2008 and 2009. With the exception of Quebec, all regions in Canada showed a slight increase in the number of cocaine exhibits since the mid-1990s. Overall, Ontario had the highest number of cocaine exhibits. Until 2004, all regions, except the Atlantic region and the Territories (north of 60°), which have a small number of exhibits, had a similar volume of exhibits of **methamphetamine**. Since that time, the number of exhibits in Ontario increased until 2008, and then they subsequently decreased in 2009. The number of methamphetamine exhibits in Quebec continued to grow at a steady rate. Since the mid-2000s, there has appeared to be a decline in the number of methamphetamine exhibits analyzed in the western part of the country (Prairies and British Columbia). All regions except the Territories (north of 60°) have shown an increase in **MDMA** since the late 1990s. Quebec has the highest number of MDMA exhibits of any region in the country, due to a substantial decrease in the number of exhibits in Ontario over the last 2 years (30 percent) and a steady growth in the number of exhibits in this province. A decrease in the number of exhibits was also noted in British Columbia. Most **heroin** exhibits submitted for testing have been seized in British Columbia. Regardless of the region, heroin exhibits peaked in 1999 and decreased in the early 2000s. There has been a rebound in the number of heroin exhibits being analyzed in British Columbia (2004–2008) and Ontario (2006). Since 2000, there has been a six-fold increase in the number of **prescription opioid** exhibits analyzed (e.g., hydromorphone, morphine, codeine, oxycodone, methadone, and fentanyl) in Ontario. All other regions have shown less marked increases. A comparison between suspected substances, as identified by police services, and the results of the laboratory analysis of exhibits found that in 2009, 98 percent of the substances seized and suspected to be cannabis were in fact cannabis; this has not changed over the last 5 years (period

of analysis). Similar patterns were seen for cocaine (90 percent of cocaine exhibits were determined to be cocaine) and for heroin exhibits (80 percent in 2005 to 79 percent in 2009). Over the past 5 years, there has been a decrease in the percentage of suspected methamphetamine exhibits that contain this substance (82 percent in 2005 to 70 percent in 2009); the same is true for MDMA exhibits (50 percent in 2005 to 40 percent in 2009). Ongoing monitoring of emerging substances including **BZP** (1-benzylpiperazine) and **TFMPP** (1-(3-trifluoromethylphenyl)piperazine) has been undertaken. Data from the LIMS is used to examine changes in the number of seizure exhibits analyzed over time, while questions on the use of these substances will be added to the CADUMS for 2011 to estimate use in the general population. It should be noted, however, that BZP and TFMPP are not controlled under the Controlled Drugs and Substances Act in Canada, and so the seizure data must be interpreted with caution.

Data Sources: Survey data: *In April 2008, Health Canada implemented the first ongoing survey on alcohol and illicit drug use in Canada, the CADUMS. Prior to the launch of this survey, the monitoring of alcohol, illicit drugs, and other substances had been based on occasional surveys, such as the Canadian Addictions Survey (2004). The availability of ongoing surveillance data will help to provide current information, monitor trends over time, and reduce some of the potential biases, including seasonal biases that can be particularly strong for alcohol and possibly drug use. CADUMS is an ongoing general population telephone-based survey of Canadians age 15 and older. The data are analyzed on an annual basis; the CADUMS data used for this report are from 2009 and 2008. Residents from all Provinces are included, but those in the Territories are not. The main objectives to be addressed by the core set of questions on an ongoing basis in the survey are twofold: to determine the prevalence and frequency of alcohol, cannabis, and other substance use in the Canadian population age 15 and older and to measure the extent of harms that*

are associated with the use of alcohol and other drug use. Data limitations include the potential underreporting of drug use. **Drug seizure data:** In Canada, the DAS of Health Canada is responsible for analyzing suspected controlled substances that are seized by Canadian police officers and border services for prosecutorial purposes. The tests confirm the identity 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 LIMS. The database holds results for more than 2 million records representing 1,838,818 exhibits analysed from January 1988 to the present. In 2009 alone, almost 100,000 exhibits were analyzed by DAS. Seizure data are affected by the extent, focus, and effectiveness of interception/detection activities by police and border services (e.g., a targeted crackdown on methamphetamine will increase the number of arrests, but does not necessarily indicate increased presence or use of that drug). Also in Canada, laboratory analyses of seized drugs are only carried out for cases going to court for which there is a “not guilty” plea (i.e., incomplete set of data, representativeness needs to be established).

The Australian Drug Market: Findings From the Ecstasy and Related Drugs Reporting System

Natasha Sindicich, M.Psych (Forensic)

For inquiries concerning this report please contact Natasha Sindicich, M. Psych (Forensic), National Drug and Alcohol Research Centre, University of New South Wales, SYDNEY NSW 2052, Australia, Phone: 612 9385 0191, Fax: 612 9385 0222, E-mail: n.sindicich@unsw.edu.au.

Abstract: The Ecstasy and Related Drugs Reporting System (EDRS) is currently the most comprehensive and detailed Australian monitoring system of the ecstasy and related drug (ERD) markets. The EDRS monitors the price, purity, and availability of “ecstasy” (MDMA, or 3,4-methylenedioxymethamphetamine) and other related drugs, such as methamphetamine, cocaine, GHB

(gamma hydroxybutyrate), and LSD (lysergic acid diethylamide). It also examines trends in the use and harms associated with these drugs. The EDRS has been monitoring the Australian ERD markets nationally since 2003.

Method: Data collection includes surveys with regular ecstasy users (REU) recruited through means of street press magazines/flyers or word-of-mouth; surveys with key experts (professionals who have regular contact with REU through their work, e.g., treatment staff, law enforcement, and nightclub owners and DJ’s); and the analysis of existing indicator data and sources that contain information on ecstasy and other drugs (e.g., ambulance attendance data and hospital emergency room data). This presentation is focused on the REU survey component of the 2010 national EDRS. REU were recruited as they are considered a sentinel (although not representative) group able to provide information on trends in ERD use and related harms. In 2010, 693 participants were recruited from the capital cities of all Australian States and Territories.

Results: The main results from the 2010 EDRS indicated that while ecstasy remained the drug of preference for the majority of participants (38 percent), this figure has been decreasing over time (from 53 percent in 2003). In contrast, cocaine (nominated by 13 percent of the national sample) and alcohol (nominated by 12 percent) have increased in preference over time. Data from the EDRS suggested a decrease in ecstasy availability and purity, with significantly more participants reporting ecstasy to be difficult to very difficult (26 percent in 2010 versus 12 percent in 2009; $p < 0.05$) to obtain. Additionally, significantly more participants have reported ecstasy to be currently of low purity (24 percent in 2009 versus 56 percent in 2010; $p < 0.05$). Increasing cocaine use was observed across the majority of jurisdictions (48 percent in 2010, up from 39 percent in 2009, $p < 0.05$), whereas use had previously been localized to Sydney and Melbourne (the two largest east coast cities). In 2010, the majority of REU

reported that cocaine was considered “easy to very easy” to obtain, whereas in previous years it had been considered “very difficult.”

Conclusions: The drug preference findings and market characteristic reports of REU supported the greater global market indicators of MDMA and cocaine. Australian border detections of MDMA were at the lowest number and weight reported in the last decade (Australian Crime Commission, 2010). This reduction in MDMA has been hypothesized to be linked to an increase in seizures of MDMA precursors and the destruction of large stockpiles in Southeast Asia (Australian Crime Commission, 2010). Domestic indicators of an increase in cocaine availability included increases in provider arrests and larger commercial quantities, which continued to be detected at the Australian border. Given the decrease in availability and purity of the Australian MDMA market, the question is apparent of what (other) drugs this demographic sample was using. The findings would suggest a slight increase in cocaine use. As well, there has been a surfacing of “emerging psychoactive substances” (EPS), including drug classes such as psychedelic phenethylamines (e.g., 2C-B, Mescaline); psychedelic tryptamines (DMT, dimethyltryptamine); and stimulant emerging psychoactive substances, such as mephedrone and BZP (1-benzylpiperazine). While only a small proportion of the REU sample in 2010 reported using EPS, reports of availability of certain substances appeared to be increasing. Given the little pharmacological information on the acute and long-term effects of these substances, this is an issue that will require further closer monitoring in the future.

Monitoring Systems and the Situation of Substance Abuse and HIV Related to Drug Use in Thailand

*Usaneyya Perngparn, Ph.D., and
Chitlada Areesantichai, Ph.D.*

*For inquiries concerning this report, please contact
Usaneyya Perngparn, Ph.D., Assistant Dean, College of Public Health Sciences, Drug Dependence*

Research Centre, WHO Collaborating Centre for Research and Training in Drug Dependence, Chulalongkorn University, Bangkok 10330, Thailand, Phone: 662 218-8200, E-mail: usaneyya.p@chula.ac.th.

Since historic times, Thailand has been periodically adversely affected by substance abuse. The country has gradually developed a substance abuse information system to monitor the situation and trends of change. The system is comprised of three sets of information and statistics derived from the record systems currently operated by various government agencies, population surveys, and substance abuse information systems. The “War on Drugs” operation in 2003 changed the treatment system. The new government policy regarded people dependent on drugs as patients, not criminals, by using treatment as a tool for recovery instead of prosecution. This has affected the monitoring systems—both the record systems and substance abuse information systems—in terms of increasing the compulsory treatment population and reducing the number of drug offenders. The national human immunodeficiency virus (HIV) surveillance system was developed in 1989 to monitor the risk population, including intravenous drug users (IVDUs).

Thailand has dealt with many types of illicit substance use. The common indigenous natural products are ganja (*Cannabis sativa*) and opium. The first heroin epidemic emerged suddenly following the resumption of legal control of the opium franchise in 1960. Since then, the country has faced a heroin problem for more than 5 decades. The preferred route of administration for the majority of heroin users (more than 80 percent) has been injection. During the last 10 years, however, the number of heroin patients has decreased about 160-fold, and less than 30 percent of new cases reported injecting.

Illicit amphetamines (in tablet form) and heroin appeared simultaneously in the early 1960s. The abuse pattern focused on enhancement of occupational performance. The sniffing of volatile substances (benzene, lacquer, and glue) first appeared in the late 1970s. In the late 1990s,

the abuse of a new set of substances—ecstasy, ketamine, ice (*crystalline methamphetamine*), cocaine, and hashish—appeared. Finally, during recent years the abuse of prescription drugs, and cough mixtures in particular, has become evident.

Methamphetamine abuse evolved into a major epidemic in 1996 and continues to the present. Even though treatment data reported that 80–90 percent reported inhalation or oral administration among methamphetamine users, some research studies have found injecting as well. Besides the sexual stimulation of methamphetamine, some research reported the relationship between methamphetamine use and sexually transmitted infections. It is suggested that the noninjecting substance abusers are vulnerable to HIV infection because sexual intercourse is a likely mode of contracting HIV infection.

The available information is considerably substantial and adequate for synthesizing the national substance abuse scenario. However, information specific to drug use and public health aspects are very limited. Only the national HIV sentinel surveillance system has reported that the HIV seroprevalence of the heroin users who injected heroin intravenously was quite high (40–52 percent). In 2010, a harm reduction program was approved, but the main focus is on the IVDUs. Although there are many monitoring systems, the situation of substance abuse has not satisfactorily subsided. Therefore, a proactive approach to prevention and control of abuse and health impact, especially HIV related to substance abuse, should be thoroughly considered.

Community Epidemiology of Illegal Drug Use in Jamaica: The Last 24 Months

Ellen Campbell Grizzle, B.Pharm., Ph.D., R.Ph.

For inquiries concerning this report, please contact Ellen Campbell Grizzle, B. Pharm., Ph.D., R.Ph., Director, Information and Research, National

Council on Drug Abuse; Adjunct Associate Professor Pharmacy, University of Technology, 2-6 Melmac Avenue, Kingston 5, Jamaica, Phone: 876-926-9002-4, Fax: 876-960-1820, E-mail: ncda@cwjamaica.com.

This paper presents data related to trends for illegal drug use in Jamaica. Additionally, findings from a recent project (2010) related to human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and substance abuse among the homeless population in Kingston are presented. Jamaica is the third largest Caribbean island, with a population of 3 million residents. The country is situated at a crossroads of major sea trade routes in the Caribbean Sea. This location makes it a convenient port for the transshipment route between the United States and Europe. The estimated residual impact of transshipment on Caribbean demand is the 3.7 percent of the region's adult population who consume illegal drugs; this "... is slightly lower than the global average of 4.2 percent"²⁴. Findings from national surveys and surveillance systems reveal use of various forms of "transshipped drugs." Additionally, marijuana (*ganja*, *Cannabis Sativa*) use is endemic to Jamaica.

In the period under review, treatment sought for crack cocaine use represented 1.4 percent of all persons in residential care (National Council on Drug Abuse [NCDA]/EPI-SIDUC summary). Data revealed a plateau effect for crack cocaine use at less than 0.1 percent among the population tracked in studies from 1987 to 2006. In 2009, no persons sought treatment for seasoned "spliff" use (combination of *ganja* and crack cocaine). This compared with 51 percent of the persons who sought care for marijuana abuse.

The NCDA has instituted a special monitoring and assistance program for deported persons from the United States, Canada, and the United Kingdom. This surveillance system is still in its infancy. However, two incidents of injectable heroin use by

²⁴Platzer, M., Mirella, F. & Nestares, C. R. (2004) Illicit Drug Markets in the Caribbean. In A. Klein, M. Day, A. Harriott. (Eds.), *Caribbean drugs: from criminalization to harm reduction* (pp. 189–223). Kingston, Jamaica: Ian Randle.

deportees from the United States were reported in 2010. National use of heroin is estimated to be less than 0.01 percent.

In 2009, 2,785 MDMA (3,4-methylenedioxy-methamphetamine or ecstasy) tablets were seized. Reports from the commercial sex trade indicated that some workers may have been transitioning from crack cocaine use to ecstasy.

Nonmedicinal use of pharmaceuticals was an emerging problem. The pharmacy community has detected “drug boosting efforts” related to

alprazolam, trihexipendyl, diphenhydramine, clomipramine, and cyproheptadine.

Data from the Ministry of Health/NCDA Street people project (2010) showed a trend for higher prevalence among polysubstance abusers.

Major concerns are the lowering age of initiation for drug use, the narrowing of the gender gap for drug use, and emerging concoctions related to marijuana use (“Hot Grabba-pickled” marijuana; “Hot Blem-pickled” marijuana and tobacco; and Lizard’s tail).

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

Cocaine/Crack

- Treatment admissions data for the first half of 2010 revealed that primary cocaine treatment admissions placed within the top six rankings in all reporting CEWG areas as a percentage of total treatment admissions, including primary alcohol admissions. While cocaine did not rank first in frequency in any CEWG areas in treatment admissions, it ranked second in 1 of the 21 reporting CEWG areas, San Francisco (section II, table 2).
- Three areas—Miami-Dade County, San Francisco, and Philadelphia (at approximately 19 percent each)—had the highest percentages of primary cocaine admissions, as a proportion of total admissions, in the first half of 2010, followed closely by Detroit (at 18 percent). The lowest proportions of primary cocaine treatment admissions in that period were observed for Hawaii (2.0 percent) and Maine (3.2 percent) (table 3).
- Cocaine appeared in the top 10 most frequently identified drug items in NFLIS forensic laboratories in all 23 CEWG areas reporting NFLIS data and ranked no lower than third place in each in the first half of 2010. Cocaine ranked first in eight CEWG areas: in three of the five areas in the southern region (Atlanta, Miami, and Washington, DC); two of the four CEWG areas in the northeastern region (Maine and New York City); and three of nine areas in the western region (Albuquerque, Denver, and Seattle). In none of the CEWG areas in the midwestern region did cocaine rank first. However, it ranked second in three of the five areas in the midwestern region (Chicago, Cincinnati, and Detroit) in frequency of drug items identified (section II, table 1 and figure 23; appendix table 2).

Treatment Admissions Data on Cocaine/Crack

Table 3 presents the most recent data from 21 CEWG areas reporting on primary cocaine treatment admissions as a proportion of total admissions, including those for alcohol (see also appendix table 1). In 20 areas, the reporting period covers the first half of 2010 (January through June). In one area, San Francisco, the reporting period is fiscal year (FY) 2010, July 2009 through June 2010.

Miami-Dade County, San Francisco, and Philadelphia (at approximately 19 percent each) had the highest percentages of primary cocaine admissions, as a proportion of total admissions, in the 2010 reporting period, followed closely by Detroit (at 18 percent). The lowest proportions of primary cocaine treatment admissions, including primary alcohol admissions, were observed for Hawaii (2.0 percent) and Maine (3.2 percent) (table 3).

Based on treatment admissions for the first half of 2010 period, including those for primary

Table 3. Primary Cocaine Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions¹: FY 2010² and 1H 2010³

CEWG Areas	Primary Cocaine Admissions	Total Admissions with Primary Alcohol Admissions Excluded ⁴		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
FY 2010					
San Francisco	5,377	18,871	28.5	27,963	19.2
1H 2010					
Atlanta	640	2,483	25.8	4,655	13.7
Baltimore City	1,000	7,328	13.6	8,790	11.4
Boston	499	6,368	7.8	9,549	5.2
Cincinnati	351	2,057	17.1	3,015	11.6
Colorado	1,254	8,844	14.2	15,442	8.1
Denver	664	4,106	16.2	6,677	9.9
Detroit	693	2,663	26.0	3,849	18.0
Hawaii	78	2,665	2.9	3,868	2.0
Los Angeles	2,414	18,385	13.1	23,870	10.1
Maine	228	3,947	5.8	7,139	3.2
Maryland	2,993	21,428	14.0	31,206	9.6
Miami MSA/Broward County	253	2,056	12.3	2,658	9.5
Miami MSA/Miami-Dade County	470	1,745	26.9	2,415	19.5
Minneapolis/St. Paul	593	5,036	11.8	10,315	5.7
New York City	6,453	29,873	21.6	41,432	15.6
Philadelphia	1,440	5,975	24.1	7,593	19.0
Phoenix ⁵	170	2,547	6.7	3,677	4.6
St. Louis	876	4,838	18.1	7,332	11.9
San Diego	350	5,497	6.4	7,000	5.0
Seattle	826	4,443	18.6	7,080	11.7

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for fiscal year 2010: July 2009–June 2010.

³Data are for the first half of calendar year 2010 (1H 2010): January–June 2010.

⁴For comparability with past data, percentages of primary cocaine admissions are obtained from admissions with primary alcohol admissions excluded.

⁵Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: January 2011 State and local CEWG reports

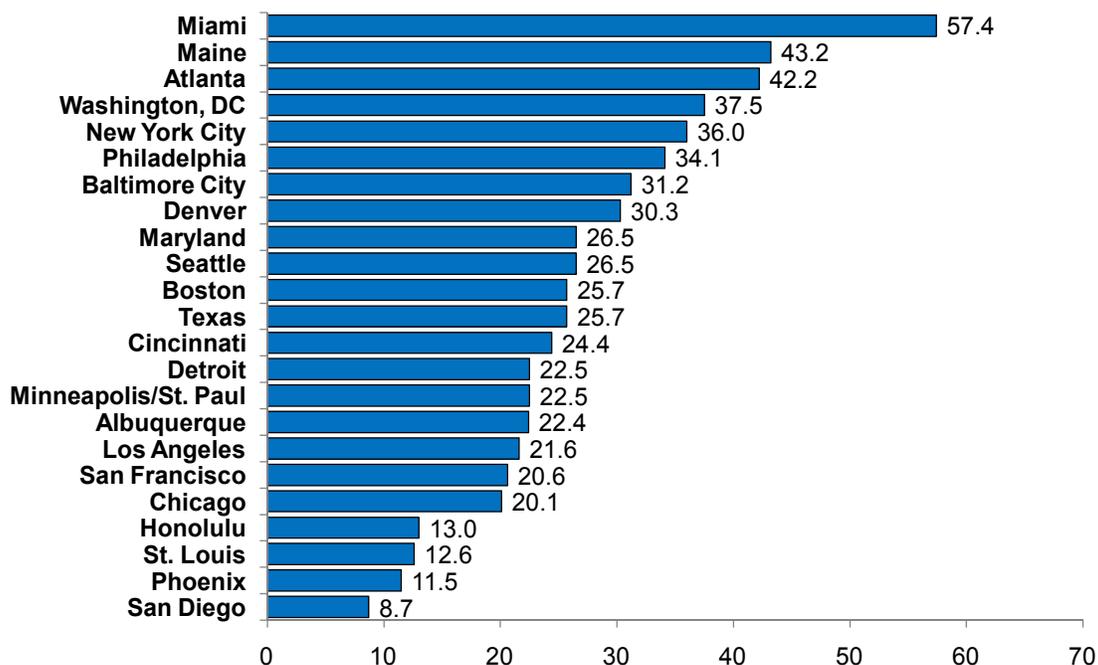
alcohol problems, cocaine appeared in the top 6 rankings for all 21 CEWG areas. While cocaine did not rank first among any CEWG area, it ranked second in 1 of the 21 reporting CEWG areas, San Francisco (section II, table 2). Cocaine ranked third in Atlanta, Miami-Dade County, Boston, Philadelphia, and Seattle (section II, table 2).

Forensic Laboratory Data on Cocaine/Crack

Based on rankings shown in section II, table 1, in all 23 reporting CEWG areas, cocaine ranked no lower than third in drug items identified in the NFLIS system for the first half of 2010. In 8 of the 23 areas, cocaine ranked as the most frequently identified drug in forensic laboratories. These were three of the five southern region CEWG areas (Atlanta, Miami, and Washington, DC); two of the four CEWG areas in the northeastern region (Maine and New York City); and

three of nine areas in the western region (Albuquerque, Denver, and Seattle). Cocaine did not rank first among drug items identified in any of the CEWG areas in the midwestern region. However, it ranked second in three of the five areas in the Midwest (Chicago, Cincinnati, and Detroit), along with another six CEWG areas. The other areas in which cocaine ranked second in identified drug items in the 2010 reporting period were Baltimore and Maryland; Boston and Philadelphia; and Los Angeles and Texas in the southern, northeastern, and western regions, respectively (section II, table 1 and figure 23; appendix table 2). Cocaine items as a percentage of the total drug items reported in the NFLIS system were highest in Miami (57.4 percent), followed by Maine (43.2 percent) and Atlanta (42.2 percent). The lowest reported frequencies of cocaine drug items among those identified in forensic laboratories were in San Diego, at 8.7 percent (figure 24; appendix table 2).

Figure 24. Cocaine Items Identified as a Percentage of Total NFLIS Drug Items, 23 CEWG Areas: 1H 2010¹



¹Data are for January–June 2010; see appendix tables 2.1–2.23. Data are subject to change; data queried on different dates may reflect differences in the time of data analysis and reporting.
SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010

Heroin

- Heroin primary treatment admissions, as a percentage of total admissions including primary alcohol admissions, were particularly high in Baltimore (approximately 54 percent) and Boston (approximately 51 percent) in the first half of 2010 (table 4). In none of the 21 CEWG areas reporting did heroin rank below sixth place in treatment admissions in the reporting period. In 2 of 21 CEWG areas—Baltimore and Boston—heroin was the substance most frequently reported as the primary problem at treatment admission. Heroin ranked second in treatment admissions in Detroit, Maryland, Phoenix, and St. Louis (section II, table 2; appendix table 1).
- Heroin ranked in the top 10 most frequently identified drug items in the NFLIS system in the first half of 2010 in all 23 CEWG areas, placing no less than sixth in any area. In 10 of 23 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in forensic laboratories in the first half of 2010. Proportions were highest in Baltimore and Maryland (approximately 24 and 18 percent, respectively). They were lowest in Honolulu, at less than 2 percent of drug items identified in the reporting period (figure 25; appendix table 2). Heroin was not ranked first in drug items seized and analyzed in any CEWG area, although it ranked second in one area—St. Louis (section II, table 1).
- Data from the HDMP suggest that for CY 2009, South American (SA) heroin continued to be the primary type 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. Average purity levels for SA heroin increased in 5 of 10 CEWG areas (Atlanta, Chicago, Detroit, St. Louis, and Washington, DC) from 2008 to 2009; they declined in 5 other areas—Baltimore, Boston, Miami, New York City, and Philadelphia. Average prices for SA heroin fell in 5 of 10 CEWG areas (Atlanta, Boston, Miami, St. Louis and Washington, DC), remained the same in 1 (Chicago), and rose in 4 (Baltimore, Detroit, New York City, and Philadelphia) (table 5). From 2008 to 2009, Mexican heroin average purity declined in 9 of 11 CEWG areas, namely Denver, El Paso, Houston, Los Angeles, Minneapolis, Phoenix, San Diego, San Francisco, and Seattle, while average purity increased slightly in 2 areas (Dallas and San Antonio) (table 6). The average price of Mexican heroin was lower in 2009, compared with 2008, in 4 of 11 CEWG reporting areas (Dallas, Los Angeles, Minneapolis, and San Antonio), and it was higher in 7 areas (Denver, El Paso, Houston, Phoenix, San Diego, San Francisco, and Seattle) (table 6).

Treatment Admissions Data on Heroin

In this reporting period (the first half of 2010) for 18 of 21 CEWG areas, primary heroin treatment admissions as a proportion of total admissions for substance abuse treatment, including primary alcohol admissions, ranged from approximately 2 to 54 percent. After Baltimore at 53.7 percent,

Boston had the highest proportion of heroin admissions, at 51.1 percent of all admissions (table 4). The lowest percentage of primary heroin admissions, after Hawaii (1.7 percent), was in Broward County in South Florida (3.3 percent). When all admissions, including those for whom alcohol was the primary drug, are examined, heroin occupied no lower than sixth place in the rankings for the first half of 2010 reporting period (section II, table

Table 4. Primary Heroin Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions¹: FY 2010² and 1H 2010³

CEWG Areas	Primary Heroin Admissions	Total Admissions with Primary Alcohol Admissions Excluded ⁴		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
FY 2010					
San Francisco ⁵	4,483	18,871	23.8	27,963	16.0
1H 2010³					
Atlanta	208	2,483	8.4	4,655	4.5
Baltimore	4,722	7,328	64.4	8,790	53.7
Boston	4,881	6,368	76.6	9,549	51.1
Cincinnati ⁵	628	2,057	30.5	3,015	20.8
Colorado	865	8,844	9.8	15,442	5.6
Denver	548	4,106	13.3	6,677	8.2
Detroit	1,171	2,663	44.0	3,849	30.4
Hawaii	66	2,665	2.5	3,868	1.7
Los Angeles	4,849	18,385	26.4	23,870	20.3
Maine	489	3,947	12.4	7,139	6.8
Maryland	8,374	21,428	39.1	31,206	26.8
Miami MSA/Broward County	89	2,056	4.3	2,658	3.3
Miami MSA/Miami-Dade County	97	1,745	5.6	2,415	4.0
Minneapolis/St. Paul	694	5,036	13.8	10,315	6.7
New York City	9,975	29,873	33.4	41,432	24.1
Philadelphia	1,148	5,975	19.2	7,593	15.1
Phoenix ⁶	816	2,547	32.0	3,677	22.2
St. Louis	1,799	4,838	37.2	7,332	24.5
San Diego	1,431	5,497	26.0	7,000	20.4
Seattle	819	4,443	18.4	7,080	11.6

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for FY 2010: July 2009–June 2010.

³Data are for the first half of calendar year 2010 (1H 2010): January–June 2010.

⁴For comparability with past data, percentages of primary heroin admissions are obtained from admissions with primary alcohol admissions excluded.

⁵Heroin and other opiates are grouped together for Cincinnati and San Francisco and are reported in this Heroin table only.

⁶Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: January 2011 State and local CEWG reports

2). Heroin ranked first in 2 of 21 CEWG areas—Baltimore and Boston. Heroin ranked second in Detroit, Maryland, Phoenix, and St. Louis, and third in Cincinnati, Los Angeles, New York City, and San Diego (section II, table 2).

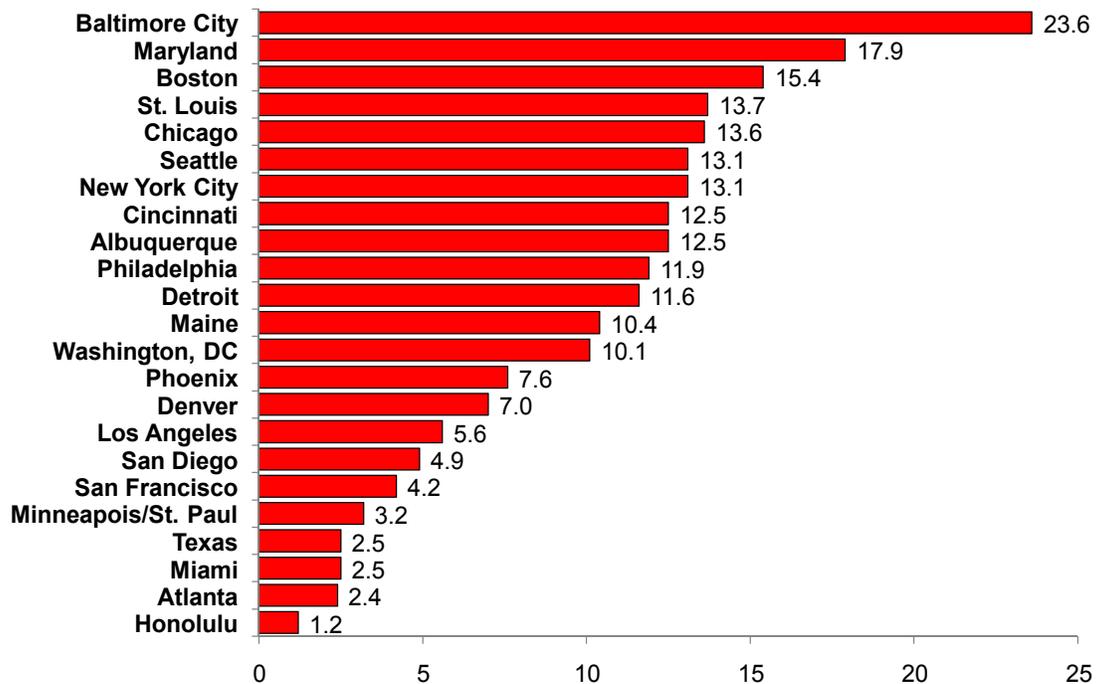
Forensic Laboratory Data on Heroin

In 10 of the 23 CEWG areas shown on the map in figure 23 (section II) and in figure 25 below, heroin items accounted for less than 10 percent of the total drug items reported by NFLIS. The exceptions were Albuquerque, Baltimore City, Boston, Chicago, Cincinnati, Detroit, Maine, Maryland, New York City, Philadelphia, St. Louis, Seattle, and Washington, DC. As a proportion of total drug items, heroin items were highest in Baltimore (23.6 percent) and Maryland (17.9 percent), compared with other CEWG areas. Heroin drug

items identified were lowest in Honolulu, at 1.2 percent (figure 25; appendix table 2).

Heroin placed within the top 10 most frequently identified drug items seized and analyzed in forensic laboratories in all 23 CEWG areas in the first half of 2010, and it ranked no lower than sixth in any area. However, heroin was not ranked as the number one most frequently identified drug in any of the CEWG areas in the first half of 2010, and it appeared as second in the rankings of drug items identified in that reporting period in only one area, St. Louis. Heroin ranked third in 10 of 23 reporting areas: in 3 of 5 areas in the South (Baltimore, Maryland, and Washington, DC); in 3 of 4 northeastern areas (Boston, New York City, and Philadelphia); in 3 of 5 midwestern areas (Chicago, Cincinnati, and Detroit); and in 1 of the 8 areas in the western region (Seattle) (section II, table 1).

Figure 25. Heroin Items Identified as a Percentage of Total NFLIS Drug Items, 23 CEWG Areas: 1H 2010¹



¹Data are for January–June 2010; see appendix tables 2.1–2.23. Data are subject to change; data queried on different dates may reflect differences in the time of data analysis and reporting.

SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010

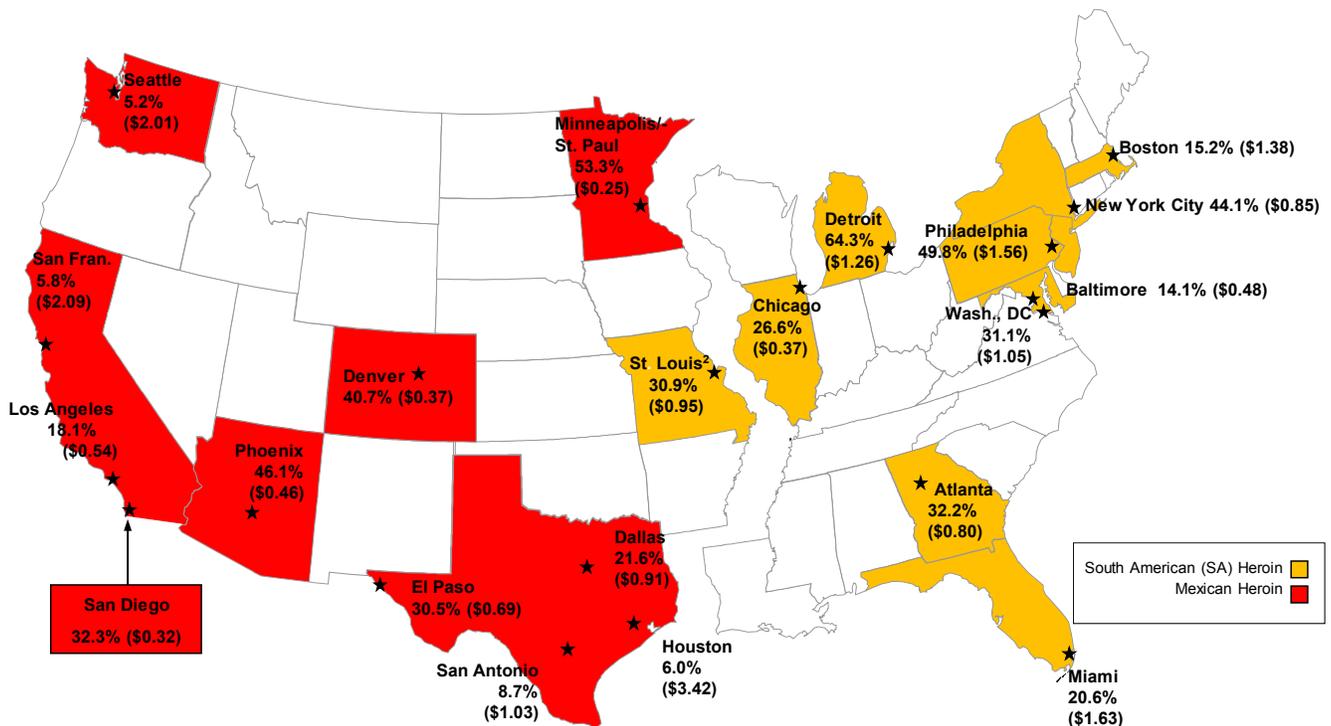
Heroin Domestic Monitor Program (HDMP) Price and Purity Data

Figure 26 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 2009. Data from the HDMP suggest that for CY 2009, South American heroin continued to be the primary type 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 South American and Mexican heroin, since the availability of Southwest Asian heroin was limited in the CEWG areas where it was reported—Atlanta, Baltimore, Detroit, Los Angeles, New York City, and Washington, DC²⁵—and no Southeast Asian heroin was purchased in the HDMP program in 2009, as in the previous 3 years.

Table 5 shows average percent purity and average price per milligram pure of SA heroin in 10 CEWG cities for the period 2006–2009. In 2009, average purity levels for SA heroin ranged from 14.1 percent in Baltimore to 64.3 percent in

Figure 26. Heroin Domestic Monitor Program—Average Heroin Purity and Average Price Per Milligram Pure by Predominant Source in CEWG Areas¹: 2009



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 2005–2009, when SA heroin samples were more frequently identified. Therefore, only SA heroin average price and purity data are presented on this map.

SOURCE: DEA, 2009 HDMP Drug Intelligence Report, published November, 2010, p. 6

²⁵In seven CEWG areas, Southwest Asian (SW) heroin was sampled in the 2009 HDMP. These include Atlanta (n=1), Baltimore (n=9), Detroit (n=1), New York City (n=1), and Washington, DC (n=14) in the East, and Los Angeles (n=1) in the West. Average purity was reported at 24.9 percent, 9.1 percent, 38.3 percent, 8.9 percent, 13.9 percent, and 71.0 percent, respectively, while average prices per milligram pure were \$0.69, \$0.70, \$0.39, \$2.50, \$2.97, and \$0.04, respectively.

Detroit. From 2008 to 2009, these levels increased in 5 of 10 CEWG areas (Atlanta, Chicago, Detroit, St. Louis, and Washington, DC), in contrast to 5 other areas—Baltimore, Boston, Miami, New York City, and Philadelphia—where heroin average purity declined. Among the five CEWG areas with declining average purity, three—Baltimore, Miami, and Philadelphia—had the largest declines of between approximately 5 and 6 percentage points during the 1-year period. Areas with the largest increases in average purity of seized heroin samples were Detroit (19.0 percentage points), St. Louis (14.3 percentage points), and Washington, DC (with a 13.0-percentage-point increase) from 2008 to 2009.

Over the 1-year period from 2008 to 2009, average prices for SA heroin fell in 5 of 10 CEWG

areas (Atlanta, Boston, Miami, St. Louis, and Washington, DC), rose in 4 (Baltimore, Detroit, New York City, and Philadelphia), and remained the same in 1 area (Chicago) (table 5). Average 2009 heroin prices ranged from a low of \$0.37 in Chicago to a high of \$1.63 in Miami. The largest price increase for 2009 was in Philadelphia, at an average of \$0.96 per milligram pure, followed by Detroit, at \$0.70.

Data on results of purchases of Mexican black tar heroin are presented in table 6 for another 11 CEWG areas, where this form of heroin predominated in the drug markets (figure 26). The highest purity levels were reported in 2009 in Minneapolis and Phoenix (53.3 and 46.1 percent, respectively), and the lowest purity levels were reported in San Francisco and Seattle, at 5.8 and 5.2 percent, respectively.

Table 5. Average Percent Purity and Average Price per Milligram Pure of South American (SA) Heroin in 10 CEWG Areas: 2006–2009

CEWG Areas	2006 Avg. Purity (%)	2006 Avg. Price (\$)	2007 Avg. Purity (%)	2007 Avg. Price (\$)	2008 Avg. Purity (%)	2008 Avg. Price (\$)	2009 ¹ Avg. Purity (%)	2009 ¹ Avg. Price (\$)
Atlanta	39.1	\$2.34	29.1	\$1.89	31.1	\$1.31	32.2	\$0.80
Baltimore	31.0	\$0.46	18.1	\$0.60	18.9	\$0.42	14.1	\$0.48
Boston	18.2	\$1.63	17.0	\$1.37	17.0	\$1.62	15.2	\$1.38
Chicago	12.6	\$0.49	22.4	\$0.45	23.8	\$0.37	26.6	\$0.37
Detroit	41.4	\$0.76	46.0	\$0.98	45.3	\$0.56	64.3	\$1.26
Miami	24.4	\$1.75	18.1	\$1.48	26.1	\$1.75	20.6	\$1.63
New York City	44.5	\$0.67	49.0	\$0.79	47.1	\$0.66	44.1	\$0.85
Philadelphia	54.9	\$0.63	56.3	\$0.71	55.4	\$0.60	49.8	\$1.56
St. Louis ²	17.6	\$1.22	21.0	\$0.80	16.6	\$1.32	30.9	\$0.95
Wash., DC	11.7	\$1.42	19.5	\$1.34	18.1	\$1.45	31.1	\$1.05

¹The following number of samples form the basis for 2009 averages: Atlanta, 26; Baltimore, 23; Boston, 26; Chicago, 18; Detroit, 20; Miami, 20; New York City, 37; Philadelphia, 26; St. Louis, 17; and Washington, DC, 10.

²In 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, 2008, and 2009, 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 in the HDMP report for 2009 (table 6), only St. Louis SA heroin purchases are discussed in the text of this report and are shown in this table and in figure 26.

SOURCE: DEA, 2009 HDMP Drug Intelligence Report, published November 2010; see also figure 26

From 2008 to 2009, Mexican heroin average purity declined in 9 of 11 CEWG areas (compared with 7 of 11 in 2008 versus 2007), namely Denver, El Paso, Houston, Los Angeles, Minneapolis, Phoenix, San Diego, San Francisco, and Seattle, with the largest declines in Phoenix (14.4 percentage points) and El Paso (10.6 percentage points). Average purity increased in two areas in Texas (Dallas and San Antonio) (table 6).

The average price per milligram pure of Mexican black tar heroin ranged in 2009 from a low of \$0.25 in Minneapolis to a high of \$3.42 in

Houston. The average price was lower in 2009, compared with 2008, in 4 of 11 reporting CEWG reporting areas (Dallas, Los Angeles, Minneapolis, and San Antonio), and it was higher in 7 areas (Denver, El Paso, Houston, Phoenix, San Diego, San Francisco, and Seattle). The largest increase of \$1.02 per milligram pure was seen in San Francisco, with average prices approximately doubling over the 1-year period, from \$1.07 to \$2.09. In Seattle, average prices increased by an average of \$0.54 in the 1-year period (table 6).

Table 6. Average Percent Purity and Average Price of Mexican Heroin per Milligram Pure in 11 CEWG Areas¹: 2006–2009

CEWG Areas ¹	2006 Avg. Purity (%)	2006 Avg. Price (\$)	2007 Avg. Purity (%)	2007 Avg. Price (\$)	2008 Avg. Purity (%)	2008 Avg. Price (\$)	2009 ² Avg. Purity (%)	2009 ² Avg. Price (\$)
Dallas	17.7	\$1.10	20.6	\$1.09	13.5	\$0.93	21.6	\$0.91
Denver	45.3	\$0.30	47.6	\$0.28	47.8	\$0.24	40.7	\$0.37
El Paso	44.8	\$0.33	39.8	\$0.49	41.1	\$0.61	30.5	\$0.69
Houston	18.1	\$1.90	7.0	\$1.66	6.2	\$3.05	6.0	\$3.42
Los Angeles	24.7	\$0.33	24.0	\$0.32	21.0	\$0.84	18.1	\$0.54
Minneapolis	52.4	\$0.27	59.9	\$0.29	54.7	\$0.26	53.3	\$0.25
Phoenix	45.4	\$0.36	56.9	\$0.31	60.5	\$0.29	46.1	\$0.46
San Antonio	17.4	\$0.79	7.1	\$1.88	7.6	\$1.42	8.7	\$1.03
San Diego	48.6	\$0.37	43.7	\$0.20	39.6	\$0.27	32.3	\$0.32
San Francisco	9.7	\$0.69	8.1	\$1.28	7.8	\$1.07	5.8	\$2.09
Seattle	10.9	\$1.48	19.5	\$1.12	9.4	\$1.47	5.2	\$2.01

¹South American heroin was the most dominant form of heroin reported in 2005, 2007, 2008, and 2009 in St. Louis, while Mexican heroin predominated in that area in 2006. Therefore, Mexican heroin purchase data are not included in this table and are not discussed in the text. St. Louis respective purity and price data are as follows: 15.9 percent and \$1.47 in 2005; 19.5 percent and \$0.99 in 2006; 3.1 percent and \$6.95 in 2007; 3.6 percent and \$4.87 in 2008; and 40.0 percent and \$2.00 in 2009.

²The following number of samples form the basis for 2009 averages: Dallas, 34; Denver, 32; El Paso, 10; Houston, 27; Los Angeles, 36; Minneapolis, 4; Phoenix, 41; San Antonio, 17; San Diego, 36; San Francisco, 27; and Seattle, 29. St. Louis' data were based on 5 samples of Mexican heroin, with 17 samples of South American heroin. One sample of Southwest Asian heroin was reported for Los Angeles, at 71.0 percent pure and an average price of \$0.04.

SOURCE: DEA, 2009 HDMP Drug Intelligence Report, published November 2010; see also figure 26

Opiates/Opioids Other Than Heroin (Narcotic Analgesics)

- In the first half of 2010, treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from approximately 2 to approximately 20 percent in 17 of 18 reporting CEWG areas. The outlier was Maine, where nearly 32 percent of primary treatment admissions were for other opiate problems (table 7; appendix table 1).
- Other opiates/opioids ranked no lower than seventh in treatment admissions in the first half of 2010 reporting period. While in none of the 18 CEWG areas reporting treatment data did other opiates rank first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions, they ranked second in Maine, and third in Broward County in South Florida and in Minneapolis/St. Paul (section II, table 2).
- Of total drug items identified in forensic laboratories in 23 CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in the first half of 2010. In 21 of 23 CEWG areas, oxycodone ranked in the top 10 drug items identified in the NFLIS system; the exceptions were Chicago and Texas. In Atlanta and Maine, oxycodone ranked third in drug items identified in the NFLIS system, and it ranked fourth in five other CEWG areas—Boston, Cincinnati, Maryland, Miami, and Philadelphia (section II, table 1). Hydrocodone ranked fourth in drug items identified in Atlanta and Detroit, and fifth in Cincinnati, San Diego, and Texas. Hydrocodone was among the top 10 ranked NFLIS drug items identified in 18 of 23 CEWG areas; the exceptions were Baltimore, Boston, Maryland, Minneapolis/St. Paul, and Washington, DC (section II, table 1; table 8).
- Buprenorphine ranked in the top 10 drug items identified in the NFLIS system in 11 of 23 reporting CEWG areas. It ranked 4th in identified NFLIS drug items in Baltimore; 5th in Boston, Maine, and Maryland; 7th in Seattle; 8th in Detroit and Washington, DC; 9th in New York City and San Diego; and 10th in Albuquerque and Philadelphia in the first half of 2010 (section II, table 1; table 8).
- Methadone ranked in the top 10 identified drugs in 5 of 23 reporting CEWG areas—New York City (7th); San Francisco (8th); and Baltimore, Maine, and Maryland (10th each) during this reporting period (section II, table 1; table 8).

Treatment Admissions Data on Opiates/Opioids

In this 2010 reporting period (the first half of 2010), 18 CEWG areas provided data on treatment admissions for primary abuse of opiates other than heroin as a category separate from heroin. Treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from approximately 2 to 11 percent in 16 of the 18 reporting CEWG areas. Including primary alcohol admissions, the other opiates admissions

group accounted for a high of 31.6 percent of the primary treatment admissions in Maine. This was followed distantly by Broward County in South Florida, where 20.2 percent of total primary treatment admissions were for other opiates. At the low end, other opiates accounted for approximately 2 percent of total admissions in Detroit and New York City (table 7).

While other opiates were ranked among the top 7 substances reported by CEWG areas in treatment admissions in the first half of 2010, none of the 21 CEWG areas ranked other opiates as being

Table 7. Primary Other Opiate Treatment Admissions in 18 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions¹: 1H 2010²

CEWG Areas ³	Primary Other Opiates Admissions	Total Admissions with Primary Alcohol Admissions Excluded ⁴		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta	325	2,483	13.1	4,655	7.0
Baltimore	291	7,328	4.0	8,790	3.3
Boston	446	6,368	7.0	9,549	4.7
Colorado	847	8,844	9.6	15,442	5.5
Denver	373	4,106	9.1	6,677	5.6
Detroit	81	2,663	3.0	3,849	2.1
Los Angeles	722	18,385	3.9	23,870	3.0
Maine	2253	3,947	57.1	7,139	31.6
Maryland	3363	21,428	15.7	31,206	10.8
Miami MSA/Broward County	537	2,056	26.1	2,658	20.2
Miami MSA/Miami-Dade County	115	1,745	6.6	2,415	4.8
Minneapolis/St. Paul	898	5,036	17.8	10,315	8.7
New York City	839	29,873	2.8	41,432	2.0
Philadelphia	537	5,975	9.0	7,593	7.1
Phoenix ⁵	146	2,547	5.7	3,677	4.0
St. Louis	205	4,838	4.2	7,332	2.8
San Diego	270	5,497	4.9	7,000	3.9
Seattle	501	4,443	11.3	7,080	7.1

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for the first half of calendar year 2010 (1H 2010): January–June 2010.

³Heroin and Other Opiates are grouped together for Cincinnati and San Francisco and are reported in the Heroin table only. Data for this table were not reported for Hawaii. For further information see appendix table 1.

⁴Percentages of primary other opiates admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.

⁵Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: January 2011 State and local CEWG reports

first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions. In Maine, other opiates ranked second; they ranked third in Minneapolis/St. Paul and Broward County in South Florida (section II, table 2).

Forensic Laboratory Data on Opiates/Opioids (Narcotic Analgesics)

Of the narcotic analgesic/opiate items identified by forensic laboratories across CEWG areas in the first half of 2010, oxycodone and hydrocodone were the two most frequently reported in most areas. However, they rarely accounted for more than 10 percent of all drug items identified in any area (table 8; appendix table 2).

Oxycodone. Maine reported the highest frequency of oxycodone items identified in forensic laboratories in the period (at 10.6 percent), followed by Seattle and Cincinnati (8.6 percent each) and Boston (8.1 percent) (table 8). Oxycodone ranked within the top 10 most frequently identified NFLIS drug items in 21 of 23 CEWG areas, with the exception of Chicago and Texas. It ranked third in drug items identified in Atlanta and Maine. It placed fourth in rankings of drug items identified in forensic laboratories in five other CEWG areas—Boston, Cincinnati, Maryland, Miami, and Philadelphia (section II, table 1). In 5 of 23 CEWG areas, oxycodone represented less than 1 percent of the total drug items identified in forensic laboratories in the reporting period. These areas were Chicago, Honolulu, Los Angeles, Texas, and Washington, DC (table 8).

Hydrocodone. Hydrocodone ranked fourth in drug items identified in Atlanta and Detroit, and fifth in Cincinnati, San Diego, and Texas (section

II, table 1). It placed among the top 10 most frequently identified drug items in all but 5 CEWG areas—Baltimore, Boston, Maryland, Minneapolis/St. Paul, and Washington, DC (section II, table 1). Identified percentages of drug items containing hydrocodone ranged from a high of approximately 5 percent in Atlanta and Texas to less than 1.0 percent in 10 of 23 areas reporting in the first half of 2010 (table 8). Eleven other areas had between 1.0 percent (Honolulu) and 4.0 percent (Detroit) of NFLIS hydrocodone items.

Buprenorphine. Baltimore, Boston, Maine, Maryland, New York City, and Seattle were the only CEWG areas with at least 1 percent of drug items identified containing buprenorphine. Percentages were 1.9, 3.3, 3.8, 1.7, 1.1, and 2.0, respectively. The highest percentages of buprenorphine identified were in Maine and Boston, at 3.8 and 3.3 percent of total drug items identified, respectively (table 8). According to CEWG area reports reflected in section II, table 1, buprenorphine ranked 4th among identified drugs in Baltimore; 5th in Boston, Maine, and Maryland; 7th in Seattle; 8th in Washington, DC, and Detroit; 9th in New York City and San Diego; and 10th in Albuquerque and Philadelphia, in the first half of 2010.

Methadone. Atlanta, Maine, New York City, and San Francisco were the only areas reporting a percentage of 1 or higher for methadone drug items, at 1.1, 1.5, 1.3, and 1.0 percent, respectively (table 8). Methadone ranked in the top 10 NFLIS drug items identified in 5 of 23 areas. It ranked 7th among identified drugs in New York City; 8th in San Francisco; and 10th in Baltimore, Maine, and Maryland during this reporting period (section II, table 1).

Table 8. Selected Narcotic Analgesic Items Identified by Forensic Laboratories in 23 CEWG Areas, by Number and Percentage of Total Items Identified¹: 1H 2010²

CEWG Area	Oxycodone		Hydrocodone		Methadone		Fentanyl		Buprenorphine		Total Items, All Drugs
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	
Albuquerque	44	3.7	11	*	5	*	1	*	6	*	1,172
Atlanta	382	6.4	292	4.9	63	1.1	—	—	20	*	5,941
Baltimore	183	1.0	15	*	41	*	—	—	332	1.9	17,507
Boston	976	8.1	93	*	69	*	—	—	401	3.3	12,096
Chicago	44	*	269	*	69	*	—	—	92	*	43,182
Cincinnati	637	8.6	225	3.0	43	*	6	*	52	*	7,403
Denver	85	2.2	47	1.2	8	*	2	*	3	*	3,863
Detroit	63	1.2	205	4.0	11	*	3	*	23	*	5,176
Honolulu	6	*	8	1.0	2	*	—	—	1	*	828
Los Angeles	81	*	315	1.4	31	*	—	—	8	*	23,073
Maine	42	10.6	8	2.0	6	1.5	—	—	15	3.8	396
Maryland	534	2.0	50	*	73	*	—	—	463	1.7	26,459
Miami	411	3.4	70	*	24	*	—	—	10	*	12,114
Minneapolis/ St. Paul	58	2.0	28	*	15	*	—	—	8	*	2,973
New York City	672	2.5	212	*	354	1.3	5	*	290	1.1	27,016
Philadelphia	646	3.7	82	*	55	*	4	*	75	*	17,452
Phoenix	167	3.8	102	2.3	7	*	—	—	24	*	4,353
St. Louis	142	1.6	176	2.0	16	*	—	—	59	*	8,793
San Diego	184	1.7	277	2.6	40	*	—	—	70	*	10,675
San Francisco	180	2.3	263	3.3	81	1.0	3	*	13	*	7,900
Seattle	72	8.6	14	1.7	6	*	4	*	17	2.0	840
Texas	211	*	2,397	5.0	147	*	—	—	60	*	48,363
Washington, DC	12	*	1	*	5	*	1	*	15	*	1,955

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 January–June 2010.

SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010; see appendix table 2.1–2.23; data are subject to change and may differ according to the date on which they were queried

Benzodiazepines/Depressants

- Texas and Atlanta had the highest percentages of alprazolam drug items identified in forensic laboratories in the first half of 2010, at 5.7 and 4.9 percent, respectively (table 9). Alprazolam ranked third in frequency among the top 10 drug items identified in forensic laboratories in Miami; fourth in New York City and Texas; and fifth in Atlanta, Detroit, Philadelphia, and St. Louis (section II, table 1).
- Drug items containing clonazepam accounted for 2.6 percent of all drug items in Boston. Proportions did not reach 1 percent in any other CEWG area (table 9). In Boston, clonazepam figured as the sixth most frequently identified drug in forensic laboratories in the first half of 2010. It also ranked in the top 10 drug items in 6 other areas—Baltimore, Cincinnati, Maryland, Philadelphia, Phoenix, and Texas, all between 7th and 10th place (section II, table 1).
- Diazepam ranked 10th in Miami, San Diego, and San Francisco among drug items identified in NFLIS forensic laboratories in the first half of 2010, representing less than 1 percent of cases in all CEWG areas (section II, table 1; table 9).

Treatment Admissions 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 noted that benzodiazepines or sedative/hypnotics were 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 forensic laboratories in 23 CEWG areas in the first half of 2010 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 23 CEWG areas for which NFLIS data were reported for the first half of 2010, the highest percentages of alprazolam drug items identified were in Texas (5.7 percent)

and Atlanta (4.9 percent), followed by Philadelphia (3.5 percent), Miami (3.4 percent), and New York City (3.2 percent). Alprazolam drug items were reported at 1.0–2.5 percent in 8 CEWG areas (Boston, Cincinnati, Detroit, Maine, Phoenix, St. Louis, San Diego, and Seattle), and at less than 1 percent in the remaining 10 reporting CEWG areas (table 9). As shown in section II, table 1, alprazolam ranked among the top 10 NFLIS drug items in all but 5 CEWG areas (Albuquerque, Maine, Minneapolis, San Francisco, and Washington, DC). It ranked third in frequency among the top 10 drug items identified in the first half of 2010 in Miami; fourth in New York City and Texas; and fifth in 4 CEWG areas, Atlanta, Detroit, Philadelphia, and St. Louis. Alprazolam ranked 6th among NFLIS items seized and identified in 4 CEWG areas (Baltimore, Cincinnati, Maryland, and Phoenix); 7th in Boston; 8th in Chicago, Honolulu, Los Angeles, and San Diego; 9th in Seattle; and 10th in Denver (section II, table 1).

Clonazepam. Drug items containing clonazepam accounted for 2.6 percent of all drug items in Boston. The drug's presence was minimal, at less than 1 percent, in the 22 other CEWG areas (table 9). Clonazepam was included among the 10

Table 9. Number of Selected Benzodiazepine Items Identified by Forensic Laboratories in 23 CEWG Areas, by Number and Percentage of Total Items Identified¹: 1H 2010²

CEWG Area	Alprazolam		Clonazepam		Diazepam		Total Items
	#	(%)	#	(%)	#	(%)	
Albuquerque	5	*	4	*	1	*	1,172
Atlanta	291	4.9	42	*	39	*	5,941
Baltimore	104	*	73	*	9	*	17,507
Boston	242	2.0	309	2.6	56	*	12,096
Chicago	192	*	51	*	22	*	43,182
Cincinnati	143	1.9	62	*	38	*	7,403
Denver	26	*	21	*	14	*	3,863
Detroit	127	2.5	8	*	13	*	5,176
Honolulu	4	*	1	*	1	*	828
Los Angeles	123	*	32	*	54	*	23,073
Maine	4	1.0	1	*	—	—	396
Maryland	245	*	114	*	45	*	26,459
Miami	415	3.4	18	*	34	*	12,114
Minneapolis/St. Paul	20	*	12	*	13	*	2,973
New York City	858	3.2	199	*	36	*	27,016
Philadelphia	609	3.5	127	*	51	*	17,452
Phoenix	105	2.4	37	*	19	*	4,353
St. Louis	181	2.1	43	*	29	*	8,793
San Diego	142	1.3	45	*	63	*	10,675
San Francisco	38	*	49	*	56	*	7,900
Seattle	12	1.4	7	*	5	*	840
Texas	2,748	5.7	408	*	209	*	48,363
Washington, DC	4	*	3	*	3	*	1,955

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 January–June 2010.

SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010; see appendix table 2.1–2.23; data are subject to change and may differ according to the date on which they were queried

most frequently identified drug items in 7 of the 23 CEWG reporting areas. In Boston, clonazepam ranked as the sixth most frequently identified drug in forensic laboratories in the first half of 2010. It ranked 7th in Baltimore and Philadelphia; 8th in Maryland and Cincinnati; 9th in Texas; and 10th in Phoenix (section II, table 1).

Diazepam. Drug items containing diazepam accounted for less than 1 percent of all drug items in each of the 23 CEWG areas (table 9). However, diazepam was still found among the top 10 drug items identified in NFLIS forensic laboratories in the first half of 2010 in 3 CEWG areas. Diazepam ranked 10th in Miami, San Diego, and San Francisco (section II, table 1).

Methamphetamine

- The proportions of primary treatment admissions, including primary alcohol admissions, for methamphetamine abuse in 18 reporting CEWG areas were especially high in Hawaii and San Diego, at approximately 36 and 29 percent, respectively. They were also relatively high in Phoenix, at approximately 18 percent (table 10; appendix table 1).
- Methamphetamine ranked first in treatment admissions as a percentage of total admissions in Hawaii and San Diego; third in Colorado, Denver, Phoenix, and San Francisco; fourth in Los Angeles; and fifth in Atlanta, Minneapolis/St. Paul, St. Louis, and Seattle. It ranked among the top 10 drugs in treatment admissions for all CEWG areas, ranking no lower than 7th in any area (section II, table 2).
- In the first half of 2010, methamphetamine appeared among the top 10 NFLIS drug items identified in 17 of 23 CEWG areas (the exceptions were Baltimore and Maryland in the South; Boston, New York City, and Philadelphia in the Northeast; and Detroit in the Midwest). Methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in Honolulu and Minneapolis/St. Paul and second in Atlanta, Phoenix, San Diego, and San Francisco. In the first half of 2010, methamphetamine ranked third in four CEWG areas—Albuquerque, Denver, Los Angeles, and Texas (section II, table 1). The largest proportions of methamphetamine items identified were reported in Honolulu (close to 45 percent), followed by Atlanta, Minneapolis, and San Francisco (approximately 24–25 percent). In contrast, less than 1 percent of drug items identified as containing methamphetamine were reported in nine CEWG metropolitan areas east of the Mississippi, including Baltimore, Boston, Chicago, Cincinnati, Detroit, Maryland, Miami, New York City, and Philadelphia (figure 27; appendix table 2).

Treatment Admissions Data on Methamphetamine

Data on primary methamphetamine treatment admissions in the first half of 2010 reporting period were available and reported for 18 CEWG areas (table 10)²⁶. As a percentage of total treatment admissions, including primary alcohol admissions, Hawaii had the highest proportion of methamphetamine admissions, at 36.3 percent, followed by San Diego, at 28.7 percent, and more distantly by Phoenix, at 18.1 percent. In the same period, primary methamphetamine admissions accounted for approximately 11–16 percent of total primary admissions in San Francisco (16.2 percent), Los Angeles (15.4 percent), Colorado (14.0 percent), and Denver (11.1 percent). Seven CEWG areas,

all on the east coast, including Boston, Maine, Miami-Dade and Broward Counties, New York City, and Philadelphia, reported that less than 1 percent of admissions were for primary methamphetamine abuse. Four areas—Atlanta, Minneapolis/St. Paul, St. Louis, and Seattle—reported that between approximately 2 and 9 percent of primary treatment admissions were for methamphetamine abuse problems in this reporting period (table 10).

Based on rankings of primary drugs as a percentage of total treatment admissions, including primary alcohol admissions, in 23 CEWG areas, methamphetamine ranked first in San Diego and Hawaii; third in Colorado, Denver, Phoenix, and San Francisco; fourth in Los Angeles; and fifth in Atlanta, Minneapolis/St. Paul, St. Louis, and Seattle (section II, table 2).

²⁶Data for three areas, Baltimore, Cincinnati, and Detroit, were excluded due to small numbers (table 10).

Table 10. Primary Methamphetamine Treatment Admissions in 18 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions¹: FY 2010² and 1H 2010³

CEWG Areas ⁴	Primary Methamphetamine Admissions	Total Admissions with Primary Alcohol Admissions Excluded ⁵		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
FY 2010					
San Francisco	4,531	18,871	24.0	27,963	16.2
1H 2010					
Atlanta	225	2,483	9.1	4,655	4.8
Boston	22	6,368	0.3	9,549	0.2
Colorado	2,167	8,844	24.5	15,442	14.0
Denver	741	4,106	18.0	6,677	11.1
Hawaii ⁶	1,405	2,665	52.7	3,868	36.3
Los Angeles	3,667	18,385	19.9	23,870	15.4
Maine	18	3,947	0.5	7,139	0.3
Maryland	19	21,428	0.1	31,206	0.1
Miami MSA/ Broward County	20	2,056	1.0	2,658	0.8
Miami MSA/ Miami-Dade County	16	1,745	0.9	2,415	0.7
Minneapolis/St. Paul	648	5,036	12.9	10,315	6.3
New York City	116	29,873	0.4	41,432	0.3
Philadelphia	24	5,975	0.4	7,593	0.3
Phoenix ⁷	667	2,547	26.2	3,677	18.1
St. Louis	210	4,838	4.3	7,332	2.9
San Diego	2,006	5,497	36.5	7,000	28.7
Seattle	634	4,443	14.3	7,080	9.0

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for fiscal year 2010: July 2009–June 2010.

³Data are for the first half of calendar year 2010 (1H 2010): January–June 2010.

⁴Data for three CEWG areas—Baltimore ($n=5$), Cincinnati ($n=7$), and Detroit ($n=1$)—were excluded from this table due to small numbers (fewer than 15 total primary methamphetamine treatment admissions for the half year). For further information, see appendix table 1.

⁵Percentages of primary methamphetamine admissions were obtained from admissions with primary alcohol admissions excluded for comparability with past data.

⁶Hawaii reported combined methamphetamine and stimulants admissions.

⁷Treatment data for Phoenix do not include admissions younger than age 18.

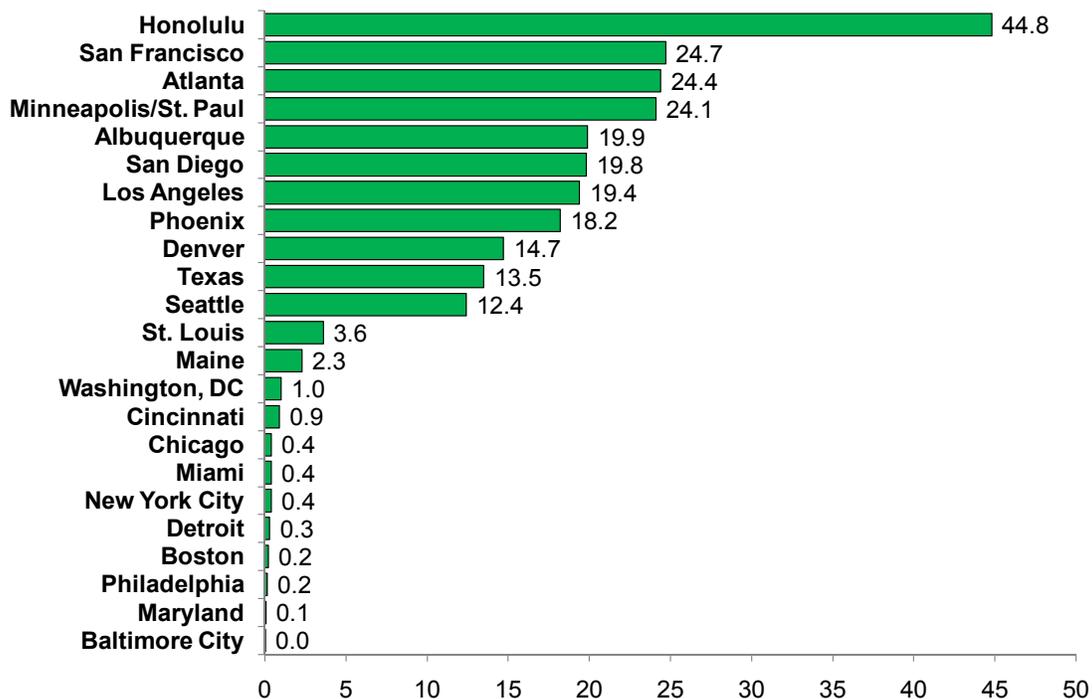
SOURCE: January 2011 State and local CEWG reports

Forensic Laboratory Data on Methamphetamine

In the first half of 2010, forensic laboratory data for CEWG reporting areas (figure 27; section II, figure 23) show that methamphetamine was the drug identified most frequently in Honolulu (44.8 percent of total drug items). Items containing methamphetamine were next most frequently identified among total drug items in San Francisco, Atlanta, and Minneapolis/St. Paul, at respective percentages of 24.7, 24.4, and 24.1. In 9 of the 23 CEWG reporting areas, less than 1 percent of the total drug items contained methamphetamine; all were in areas east of the Mississippi River (figure 27; section II, figure 23; appendix table 2).

Methamphetamine appeared among the top 10 drug items identified in the NFLIS system in the first half of 2010 in 17 of 23 CEWG areas (the exceptions being Baltimore and Maryland in the South; Boston, New York City, and Philadelphia in the Northeast; and Detroit in the Midwest). In all CEWG areas in the West, methamphetamine was ranked among the top 10 NFLIS drug items. Methamphetamine ranked first in drug items identified in Honolulu and Minneapolis/St. Paul; second in Atlanta, Phoenix, San Diego, and San Francisco; and third in four CEWG areas—Albuquerque, Denver, Los Angeles, and Texas—in this reporting period (section II, table 1).

Figure 27. Methamphetamine Items Identified as a Percentage of Total NFLIS Drug Items, 23 CEWG Areas: 1H 2010¹



¹Data are for January–June 2010; see appendix tables 2.1–2.23. Data are subject to change; data queried on different dates may reflect differences in the time of data analysis and reporting.

SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010

Marijuana/Cannabis

- Percentages of primary marijuana treatment admissions, including primary alcohol admissions, were highest in the first half of 2010 in Miami-Dade County (38.7 percent), followed by Broward County in South Florida (34.0 percent), Cincinnati (28.9 percent), and New York City (27.7 percent). The lowest proportions of such admissions were in Boston (4.1 percent) (table 11; appendix table 1).
- Marijuana ranked in no less than fifth place as the primary drug problem in total drug admissions, including alcohol admissions, in any of the 21 CEWG areas reporting. In 4 of 21 CEWG reporting areas (Broward County and Miami-Dade County in South Florida, Philadelphia, and Los Angeles), marijuana ranked first. Marijuana ranked second among primary drugs of admission in seven additional areas: Atlanta, Cincinnati, Colorado, Denver, Minneapolis/St. Paul, New York City, and Seattle (section II, table 2).
- Marijuana/cannabis ranked in either first or second place in frequency in the proportion of drug items identified in forensic laboratories in the first half of 2010 in 22 of 23 CEWG areas. The exception was Atlanta, where it ranked seventh. Marijuana/cannabis ranked in first place among identified drugs in 13 of 23 CEWG areas in this reporting period: Baltimore, Boston, Chicago, Cincinnati, Detroit, Los Angeles, Maryland, Philadelphia, Phoenix, St. Louis, San Diego, San Francisco, and Texas. It ranked second in the remaining nine areas (section II, table 1). The highest proportions of marijuana items identified in the NFLIS system were in Chicago, Detroit, and St. Louis, at approximately 59, 51, and 50 percent, respectively (figure 28; appendix table 2).

Treatment Admissions Data on Marijuana

In the first half of 2010 reporting period, marijuana ranked among the top 5 primary drugs of abuse in treatment admissions in the 21 CEWG areas reporting treatment data. Marijuana was the most frequently reported drug among primary treatment admissions in 4 of 21 CEWG areas; these were Miami-Dade and Broward Counties in South Florida, Los Angeles, and Philadelphia. Marijuana ranked second among primary drugs of admission in seven other areas: Atlanta, Cincinnati, Colorado, Denver, Minneapolis/St. Paul, New York City, and Seattle (section II, table 2).

As shown in table 11, Miami-Dade and Broward Counties in the Miami MSA in South Florida had the highest percentages of primary marijuana treatment admissions, including primary alcohol admissions, at approximately 39

and 34 percent, respectively. Two CEWG areas had percentages of marijuana treatment admissions at approximately 28–29 percent—Cincinnati and New York City. The lowest proportion of marijuana treatment admissions was reported in Boston, at 4.1 percent (table 11).

Forensic Laboratory Data on Marijuana/Cannabis

Chicago had the highest percentage of marijuana/cannabis drug items identified by NFLIS laboratories in the first half of 2010 (59.2 percent), followed by Detroit and St. Louis (50.7 and 50.0 percent, respectively) (figure 28; section II, figure 23; appendix table 2). The proportions of marijuana/cannabis drug items identified in the other 20 CEWG areas were highest in San Diego (48.2 percent) and Maryland (47.0 percent). Atlanta

Table 11. Primary Marijuana Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions¹: FY 2010² and 1H 2010³

CEWG Areas	Primary Marijuana Admissions	Total Admissions with Primary Alcohol Admissions Excluded ⁴		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
FY 2009					
San Francisco	2,778	18,871	14.7	27,963	9.9
1H 2010					
Atlanta	908	2,483	36.6	4,655	19.5
Baltimore	1,228	7,328	16.8	8,790	14.0
Boston	393	6,368	6.2	9,549	4.1
Cincinnati	870	2,057	42.3	3,015	28.9
Colorado	3,482	8,844	39.4	15,442	22.5
Denver	1,670	4,106	40.7	6,677	25.0
Detroit	713	2,663	26.8	3,849	18.5
Hawaii	902	2,665	33.8	3,868	23.3
Los Angeles	5,795	18,385	31.5	23,870	24.3
Maine	640	3,947	16.2	7,139	9.0
Maryland	5,943	21,428	27.7	31,206	19.0
Miami MSA/Broward County	904	2,056	44.0	2,658	34.0
Miami MSA/Miami-Dade County	935	1,745	53.6	2,415	38.7
Minneapolis/St. Paul	1,991	5,036	39.5	10,315	19.3
New York City	11,459	29,873	38.4	41,432	27.7
Philadelphia	1,733	5,975	29.0	7,593	22.8
Phoenix ⁵	574	2,547	22.5	3,677	15.6
St. Louis	1,652	4,838	34.1	7,332	22.5
San Diego	1,351	5,497	24.6	7,000	19.3
Seattle	1,352	4,443	30.4	7,080	19.1

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for the fiscal year 2010: July 2009–June 2010.

³Data are for the first half of the calendar year 2010 (1H 2010): January–June 2010.

⁴Percentages of primary marijuana admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.

⁵Treatment data for Phoenix do not include admissions younger than age 18.

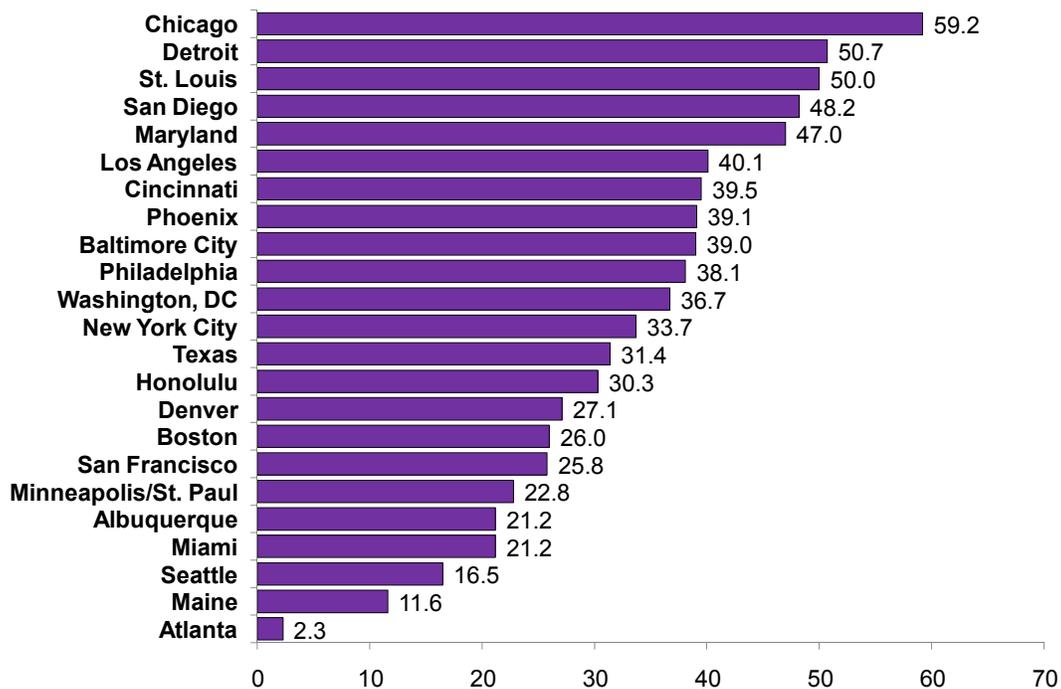
SOURCE: January 2011 State and local CEWG reports

represented the outlier, at 2.3 percent²⁷, while the remaining CEWG areas had percentages ranging from 11.6 percent in Maine to 40.1 percent in Los Angeles for marijuana/cannabis drug items identified (figure 28).

In the first half of 2010, marijuana/cannabis ranked in either first or second place among drug items most frequently identified in all CEWG areas, with the exception of Atlanta, where it ranked seventh. Marijuana/cannabis ranked in

first place among identified drugs in 13 of 23 CEWG areas in the period: Baltimore, Boston, Chicago, Cincinnati, Detroit, Los Angeles, Maryland, Philadelphia, Phoenix, St. Louis, San Diego, San Francisco, and Texas. It was the second most frequently identified drug item in the first half of 2010 NFLIS data in another nine CEWG areas—Albuquerque, Denver, Honolulu, Maine, Miami, Minneapolis/St. Paul, New York City, Seattle, and Washington, DC (section II, table 1).

Figure 28. Marijuana/Cannabis Items Identified as a Percentage of Total NFLIS Drug Items, 23 CEWG Areas: 1H 2010¹



¹Data are for January–June 2010; see appendix tables 2.1–2.23. Data are subject to change; data queried on different dates may reflect differences in the time of data analysis and reporting.

SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010

²⁷In 2004, Georgia initiated a statewide administrative policy that laboratory testing is not required when marijuana/cannabis is seized by law enforcement officers. This results in artificially low numbers of such drug items identified in this CEWG area relative to other CEWG areas.

Club Drugs (MDMA, MDA, GHB, LSD, and Ketamine)

Treatment Admissions Data on Club Drugs

The club drugs reported on in this section include MDMA (or ecstasy), MDA, GHB, LSD, and ketamine. Admissions for primary treatment of club drugs or MDMA are not captured in all treatment data systems, but they appeared low in those areas that do report on these drugs.

Forensic Laboratory Data on Club Drugs

MDMA. MDMA (3,4-methylenedioxymethamphetamine) was the club drug most frequently reported among NFLIS data in the 23 CEWG areas depicted in table 12. As shown, MDMA equaled or exceeded 2 percent of all drug items in 10 areas. These were Denver (4.8 percent), Honolulu (3.0 percent), Los Angeles (4.7 percent), Miami (2.0 percent), Minneapolis/St. Paul (5.9 percent), New York City (2.1 percent), Phoenix (2.3 percent), San Diego (2.2 percent), San Francisco (4.8 percent), and Seattle (4.0 percent). Minneapolis/St. Paul had the highest percentage at 5.9 percent, followed by Denver and San Francisco, at 4.8 percent each, and Los Angeles at 4.7 percent (table 12). As shown in section II, table 1, MDMA was included among the top 10 drug items identified by the NFLIS system in the first half of 2010 in all but 2 CEWG areas—Boston and Philadelphia. MDMA was the fourth most frequently identified drug item in Chicago, Honolulu, Minneapolis/St. Paul, and San Francisco in the first half of 2010. It ranked fifth in Denver and Los Angeles (section II, table 1).

MDA. MDA (3,4-methylenedioxyamphetamine) was reported among drug items identified in 9 of 23 areas: Atlanta, Baltimore, Denver, Honolulu, Maryland, New York City, Philadelphia, San

Francisco, and Texas. The range in numbers was from 1 to 81 (Texas) (table 13). However, MDA was not reported among the top 10 most frequently identified drug items in any CEWG area in the first half of 2010 (section II, table 1).

GHB. GHB (gamma hydroxybutyrate) drug items were not among the top 10 drug items identified for any CEWG area in the first half of 2010, although 11 of 23 areas reported 1 or more such drug items, including Albuquerque, Atlanta, Chicago, Los Angeles, Miami, New York City, St. Louis, San Diego, San Francisco, Seattle, and Washington, DC. GHB drug items numbered from 1 to 19 (Los Angeles) (table 13).

LSD. LSD (lysergic acid diethylamide) was not among the top 10 drugs reported in the NFLIS system for any CEWG reporting area (section II, table 1), but it appeared as one of the drug items identified in forensic laboratory data in 14 of 23 CEWG reporting areas: Atlanta, Chicago, Cincinnati, Denver, Detroit, Los Angeles, Maine, Maryland, New York City, Philadelphia, Phoenix, St. Louis, San Diego, and San Francisco. Numbers of such drug items ranged from 1 to 22 (in Chicago) (table 13).

Ketamine. Ketamine was among the drug items identified in the NFLIS system in the first half of 2010 in all but 4 of 23 reporting CEWG areas, with exceptions being Cincinnati, Minneapolis/St. Paul, Texas, and Washington, DC (table 13). The range of identified items was from 1 to 175, and only 4 areas reported identification of 15 or more ketamine-containing drug items in the half year period: New York City ($n=175$), Los Angeles ($n=30$), San Francisco ($n=25$), and Miami ($n=15$) (table 13). Ketamine did not appear among the top 10 most frequently identified drug items in any CEWG area (section II, table 1).

Table 12. Number of MDMA Items Identified and MDMA Items as a Percentage of Total Items Identified by Forensic Laboratories in 23 CEWG Areas: 1H 2010¹

CEWG Area	MDMA Items	Total Items Identified	Percentage of Total Items Identified
Albuquerque	18	1,172	1.5
Atlanta	115	5,941	1.9
Baltimore	59	17,507	0.3
Boston	70	12,096	0.6
Chicago	828	43,182	1.9
Cincinnati	54	7,403	0.7
Denver	184	3,863	4.8
Detroit	72	5,176	1.4
Honolulu	25	828	3.0
Los Angeles	1,076	23,073	4.7
Maine	6	396	1.5
Maryland	91	26,459	0.3
Miami	243	12,114	2.0
Minneapolis/St. Paul	176	2,973	5.9
New York City	577	27,016	2.1
Philadelphia	30	17,452	0.2
Phoenix	100	4,353	2.3
St. Louis	127	8,793	1.4
San Diego	235	10,675	2.2
San Francisco	380	7,900	4.8
Seattle	34	840	4.0
Texas	589	48,363	1.2
Washington, DC	26	1,955	1.3

¹Data are for January–June 2010.

SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010; see appendix table 2.1–2.23; data are subject to change and may differ according to the date on which they were queried

Table 13. Number of MDA, GHB, Ketamine, LSD, PCP, and Other Drug Items¹ Identified by Forensic Laboratories, in 23 CEWG Areas: 1H 2010²

CEWG AREAS	MDA	GHB ³	PCP	LSD	Psilocin ⁴	Ketamine	BZP	Cariso- prodol	Total, All Drug Items
Albuquerque	—	1	3	—	10	5	3	3	1,172
Atlanta	1	2	—	5	13	1	43	58	5,941
Baltimore	1	—	1	—	—	2	21	—	17,507
Boston	—	—	—	—	24	8	17	—	12,096
Chicago	—	5	125	22	70	7	379	—	43,182
Cincinnati	—	—	1	4	14	—	49	20	7,403
Denver	3	—	—	2	38	4	30	—	3,863
Detroit	—	—	—	1	3	1	21	4	5,176
Honolulu	1	—	—	—	—	2	2	4	828
Los Angeles	—	19	214	10	92	30	8	68	23,073
Maine	—	—	—	2	3	4	7	1	396
Maryland	2	—	140	2	6	6	37	—	26,459
Miami	—	8	— ⁵	—	6	15	23	27	12,114
Minneapolis/ St. Paul	—	—	5	—	33	—	33	—	2,973
New York City	7	7	350	7	18	175	155	—	27,016
Philadelphia	3	—	366	2	3	3	3	—	17,452
Phoenix	—	—	10	4	10	3	4	42	4,353
St. Louis	—	4	8	9	16	2	80	4	8,793
San Diego	—	15	30	8	39	4	5	3	10,675
San Francisco	2	9	4	6	35	25	3	14	7,900
Seattle	—	1	9	—	10	4	7	1	840
Texas	81	—	207	—	108	—	389	771	48,363
Washington, DC	—	3	113	—	1	—	36	—	1,955

¹**TFMPP** was found in 76 drug items identified in Atlanta; 36 in Chicago; 2 in Phoenix and Washington, DC; and 1 in Albuquerque, Honolulu, and Miami. **Quetiapine** and/or quetiapine fumarate were found in 149 items in Texas; 76 in Boston; 38 in Los Angeles; 10 in Cincinnati; 9 in Minneapolis/St. Paul; 7 in Phoenix; 3 in San Diego; and 2 in Honolulu. **Gabapentin** was found in 109 items in Boston; 8 in Los Angeles; 5 in Minneapolis/St. Paul; 4 in Phoenix; and 1 in Honolulu and Maine. **Cathinone** and/or cathine were found in 39 items in Minneapolis/St. Paul; 30 in New York City; 11 in Denver; 4 in Chicago and Cincinnati; 2 in Seattle; and 1 in Detroit, Honolulu, Maine, San Francisco, and Washington, DC. **Tramadol** was found in 116 items in Texas, 20 in Los Angeles, 18 in Cincinnati, 6 in Phoenix, 5 in Minneapolis/St. Paul, 3 in Denver, and 1 in Atlanta and Maine. **Mephedrone** was found in one item in Maine. The drug **mCPP** was found in 24 items in Atlanta. The **synthetic cannabinoid JWH-018** was found in four items in St. Louis; three in San Diego; and one in Honolulu.

²Data are for January–June 2010.

³GHB and its two precursors, GBL and 1,4-BD, are grouped together in this table under “GHB.”

⁴Psilocybine, psilocybin, psilocin and psilocin are grouped together in this table under the category, “Psilocin.”

⁵Miami does not report PCP as a separate category, reporting 167 “hallucinogens” identified in 1H 2010.

SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010; see appendix table 2.1–2.23; data are subject to change and may differ according to the date on which they were queried

PCP

Forensic Laboratory Data on PCP

PCP placed among the top 10 most frequently identified drug items in forensic laboratories in 6 CEWG areas from NFLIS data for the first half of 2010. In Washington, DC, PCP ranked fourth as the most frequently identified drug item in forensic laboratories in the current reporting period. PCP was also among the top drug items identified in Philadelphia, where it ranked sixth, and Los Angeles and Maryland, where it ranked seventh. In the first half of 2010, PCP ranked eighth in New York City and ninth in Chicago (section II, table 1).

No PCP items were identified in forensic laboratory data in seven CEWG areas: Atlanta, Boston,

Denver, Detroit, Honolulu, Maine, and Miami²⁸ (table 13; appendix table 2). Fewer than 15 such items were identified in 8 areas (Albuquerque, Baltimore, Cincinnati, Minneapolis/St. Paul, Phoenix, St. Louis, San Francisco, and Seattle). The areas reporting 15 or more PCP items in the half-year period were Chicago, Los Angeles, Maryland, New York City, Philadelphia, San Diego, Texas, and Washington, DC. The range in these areas was from 30 in San Diego to 366 in Philadelphia. As a percentage of all identified items, PCP items were highest in Washington, DC, at 5.8 percent, followed by Philadelphia, at 2.1 percent (table 13).

²⁸Although Miami reports hallucinogens as a category, PCP is not uniquely identified; hallucinogens ranked seventh in Miami drug items identified in this reporting period.

Other Drugs

BZP. In the first half of 2010, BZP (1-benzylpiperazine) appeared among the identified drugs in NFLIS forensic laboratories in all 23 CEWG areas (table 13). Numbers of drug items containing BZP ranged from 2 in Honolulu to 389 in Texas (table 13). BZP ranked among the top 10 most frequently identified drug items in NFLIS data in the first half of 2010 in 8 of 23 CEWG areas. BZP ranked 5th in Chicago and Washington, DC; 8th in Maine; 9th in Denver; and 10th in Detroit, Minneapolis/St. Paul (where it was tied with psilocin for 10th place), St. Louis, and Texas (section II, table 1).

TFMPP. The identification of TFMPP (3-(trifluoromethylphenyl)piperazine) in NFLIS data for the first half of 2010 was localized in NFLIS reporting to seven areas—Atlanta ($n=76$), Chicago ($n=36$), Phoenix and Washington, DC ($n=2$ each), and Albuquerque, Honolulu, and Miami ($n=1$ each). In the first half of 2010 NFLIS forensic laboratory data, TFMPP ranked ninth in frequency among drug items identified in Atlanta, representing 1.3 percent of total drug items there (section II, table 1; table 13, footnote 1).

Carisoprodol. Carisoprodol was identified in 14 of 23 reporting areas in the first half of 2010. These areas were Albuquerque, Atlanta, Cincinnati, Detroit, Honolulu, Los Angeles, Maine, Miami, Phoenix, St. Louis, San Diego, San Francisco, Seattle, and Texas. Carisoprodol-identified drug items ranged in these areas from 1 (Maine and Seattle) to 771 cases in Texas. In four CEWG areas, 1 percent or more items containing carisoprodol were identified—Atlanta, Los Angeles, Phoenix, and Texas, representing 1.0, 0.3, 1.0, and 1.6 percent of all drug items, respectively (table 13). In the first half of 2010, drug items containing carisoprodol ranked seventh in Texas and ninth in Honolulu and Phoenix among the most frequently identified items from CEWG areas (section II, table 1).

Psilocin. The hallucinogen psilocin (also called psilocin/psilocybin and psilocybine) ranked in the top 10 most frequently identified drug items in the first half of 2010 in 4 of 23 CEWG areas. It ranked 8th in Denver; 9th in Albuquerque and Los Angeles; and 10th in Minneapolis/St. Paul (where it was tied with BZP) in the NFLIS data for the current reporting period (section II, table 1). Psilocin/psilocybin was reported among drug items in forensic laboratories in all but 2 of 23 CEWG areas (Baltimore and Honolulu), with a range of 1 (Washington, DC) to 108 (Texas), in the first half of 2010. The highest percentage of psilocin was found in Minneapolis/St. Paul, Seattle, and Denver (1.1, 1.2, and 1.0 percent, respectively) (table 13).

Quetiapine. Quetiapine was identified in 8 of 23 CEWG areas in the first half of 2010. These were Boston, Cincinnati, Honolulu, Los Angeles, Minneapolis/St. Paul, Phoenix, San Diego, and Texas. Numbers ranged from 2 to 149 (Texas), with the highest percentage of drug items identified containing quetiapine in Boston, at 0.6 percent (in all areas, quetiapine percentages were well below 1 percent) (table 13, footnote 1).

Cathinone/Cathine. Cathinone/cathine was identified in NFLIS drug items in 11 of 23 areas: Chicago, Cincinnati, Denver, Detroit, Honolulu, Maine, Minneapolis/St. Paul, New York City, San Francisco, Seattle, and Washington, DC, with a range from 1 to 39. Cathinone/cathine drug items ranked eighth in Minneapolis, representing 1.3 percent of total drug items identified there in the first half of 2010 (section II, table 1).

Foxy or Foxy Methoxy. Foxy Methoxy (5-methoxy-N,N-diisopropyltryptamine) drug items were not identified in forensic laboratories in any CEWG area in the first half of 2010 based on the NFLIS system (table 13, footnote 1).

Appendix Tables

Appendix Table 1. Total Treatment Admissions by Primary Substance of Abuse, Including Primary Alcohol Admissions, by CEWG Area: FY 2010¹ and 1H 2010²

CEWG Areas	Number of Total Admissions							Total (N) ⁴
	Alcohol	Cocaine/ Crack ³	Heroin	Other Opiates	Meth- amphet- amine	Marijuana	Other Drugs/ Unknown	
FY 2010								
San Francisco	9,092	5,377	4,483 ⁵	-- ⁵	4,531	2,778	1,702	27,963
1H 2010								
Atlanta	2,172 ⁶	640	208	325	225	908	177	4,655
Baltimore	1,462	1,000	4,722	291	5	1,228	82	8,790
Boston	3,181	499	4,881	446	22	393	127 ⁷	9,549
Cincinnati	958	351	628 ⁵	-- ⁵	7 ⁸	870	201	3,015
Colorado	6,598	1,254	865	847	2,167	3,482	229	15,442
Denver	2,571	664	548	373	741	1,670	110	6,677
Detroit	1,186	693	1,171	81	1	713	4	3,849
Hawaii	1,203 ⁶	78	66	NR ⁹	1,405 ⁸	902	214	3,868
Los Angeles	5,485	2,414	4,849	722	3,667	5,795	938	23,870
Maine	3,192 ⁶	228	489	2,253	18	640	319	7,139
Maryland	9,778	2,993	8,374	3,363	19	5,943	736	31,206
Miami MSA/Ft. Lauderdale Broward County	602	253	89	537	20	904	253	2,658
Miami MSA/Miami-Dade County	670	470	97	115	16	935	112	2,415
Minneapolis/St. Paul	5,279	593	694	898	648	1,991	212	10,315
New York City	11,559	6,453	9,975	839	116	11,459	1,031	41,432
Philadelphia	1,618	1,440	1,148	537	24	1,733	1,093	7,593
Phoenix ¹⁰	1,130	170	816	146	667	574	174	3,677
St. Louis	2,494	876	1,799	205	210	1,652	96	7,332
San Diego	1,503	350	1,431	270	2,006	1,351	89	7,000
Seattle	2,637	826	819	501	634	1,352	311	7,080

¹Data are for fiscal year 2010: July 2009–June 2010.

²Data are for the first half of calendar year 2010 (1H 2010): January–June 2010.

³Cocaine values were broken down into crack or powder/other cocaine for the following areas: Atlanta (crack=438; powder or other cocaine=202); Baltimore (crack=871; powder or other cocaine=129); Boston (crack=280; powder or other cocaine=219); Detroit (crack=628; powder or other cocaine=65); Maryland (crack=2,447; powder or other cocaine=546); Broward County (crack=227; powder or other cocaine=26); Miami-Dade County (crack=302; powder or other cocaine=168); Minneapolis/St. Paul (crack=463; powder or other cocaine=130); New York City (crack=3,890; powder or other cocaine=2,563); Phoenix (crack=118; powder or other cocaine=52); and St. Louis (crack=788; powder or other cocaine=88). No breakdowns by type of cocaine were available for Cincinnati, Colorado, Denver, Hawaii, Los Angeles, Maine, Philadelphia, San Diego, San Francisco, and Seattle.

⁴These *N*'s are used in all percentage calculations involving total treatment admissions data for each area. Treatment data contain unknown primary admissions in Atlanta (*n*=2), Hawaii (*n*=65), Broward County (*n*=179), Miami-Dade County (*n*=52), Minneapolis/St. Paul (*n*=34), New York City (*n*=289), Philadelphia (*n*=1), and Seattle (*n*=36). Because these cases may be classified as to route of administration and demographic characteristics, they are included in the numbers for these areas and are included with "Other Drugs/Unknown" in this table. Total admissions data for all other areas exclude unknowns.

⁵Heroin and other opiates are grouped together in Cincinnati and San Francisco treatment data.

⁶Alcohol data for Atlanta are alcohol only=1,032 and alcohol in combination with other drugs=1,140. Alcohol only and alcohol in combination are grouped together in Maine treatment data. Hawaii reported data for alcohol in combination, but excluded alcohol only.

⁷Unknowns (*n*=182) are excluded from the "Other Drugs/Unknown" category for Boston and from the total for all drugs in that area. In past reports, this "Other Drug/Unknown" category has included unknowns. This fact makes these numbers noncomparable with data reported in reports before June 2010 for Boston.

⁸Methamphetamine, amphetamine, and MDMA are grouped together in Cincinnati treatment data. Methamphetamine and stimulants are grouped together in Hawaii treatment data.

⁹NR=Not reported by the CEWG area representative.

¹⁰Phoenix data report total admissions of 5,378, of which 1,701 did not report using any drugs at admission for substance abuse treatment; the *N* of 3,677 includes only cases in which a primary drug was reported. Treatment data for Phoenix do not include admissions younger than age 18.

SOURCE: January 2011 State and local CEWG reports

Additional NOTES on treatment data coverage:

Treatment data coverage for CEWG areas for the first half of 2010 includes the following areas and programs. San Francisco data include admissions for the five bay area counties (Alameda, Contra Costa, Marin, San Francisco, and San Mateo) for all ages to all publicly funded programs. Atlanta data cover the 28-county MSA and include public treatment admissions of all ages. Baltimore data cover admissions to publicly funded programs, including methadone maintenance (MM) programs, in the city of Baltimore. Boston data cover admissions to any program receiving any level of public support in five cities (Boston, Brookline, Chelsea, Revere, and Winthrop) in the metropolitan Boston area. Cincinnati data cover admissions to publicly funded treatment programs in Hamilton County, including MM programs. Colorado data include admissions of all ages statewide to all Colorado alcohol and drug treatment agencies licensed by the State and cover MM programs. Denver data cover the Denver/Boulder area and include admissions for all ages to alcohol and drug treatment agencies licensed by the State, including MM programs. Detroit data cover admissions to publicly supported programs (block grants and Medicaid funding) only in the city of Detroit and include MM programs. Hawaii data cover the State of Hawaii. Los Angeles data come from Los Angeles County treatment providers with public support and include MM programs. Maine data are for the State of Maine publicly supported programs only and include MM admissions. Maryland data cover admissions to publicly funded providers in the State of Maryland and include MM programs. Broward and Miami-Dade County data include all publicly funded treatment admissions of all ages including methadone maintenance clients; Minneapolis/St. Paul data cover the five counties of Anoka, Dakota, Hennepin, Ramsey, and Washington in the Twin Cities metropolitan area and include all treatment admissions to licensed providers regardless of funding source. New York City data are for the five boroughs of New York and cover both publicly funded and nonfunded treatment admissions. Philadelphia data are for the city and county (which are the same) and include publicly supported treatment admissions only; some programs provide medication assisted treatment. Phoenix data are for Maricopa County and cover adult (age 18 and older) publicly supported substance abuse treatment admissions only. St. Louis data cover the eastern region of Missouri, including St. Louis City and County, and five other counties—Jefferson, Franklin, Lincoln, St. Charles, and Warren—and cover admissions to publicly supported programs. San Diego data are for San Diego County and cover all public providers and subcontractors, as well as private narcotics treatment providers, and include MM programs. Seattle data are for King County and include admissions of all ages to public pay, private pay MM programs, and Department of Corrections programs.

Appendix Tables 2.1–2.23. NFLIS Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items in Forensic Laboratories for 23 CEWG Areas: January–June 2010

Appendix Table 2.1. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Albuquerque: 1H 2010¹

Drug	Number	Percentage
Cocaine	263	22.4
Cannabis/Marijuana	248	21.2
Methamphetamine	233	19.9
Heroin	146	12.5
Oxycodone	44	3.7
3,4-Methylenedioxy-methamphetamine	18	1.5
Amphetamine	15	1.3
Hydrocodone	11	0.9
Psilocin	10	0.9
Buprenorphine	6	0.5
Other ²	178	15.2
Total	1,172	100.0

¹January 2010–June 2010.

²All other analyzed items.

NOTES:

1. Data are for all counties in the Albuquerque MSA: Bernalillo, Sandoval, Torrance, and Valencia Counties.
 2. "Noncontrolled Nonnarcotic Drug" represents 77 cases and are included under "Other."
 3. "Unreported Prescription Drug" represents eight cases and are included under "Other."
 4. Percentages may not sum to the total due to rounding.
- SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.3. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Baltimore City: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	6,836	39.0
Cocaine	5,470	31.2
Heroin	4,134	23.6
Buprenorphine	332	1.9
Oxycodone	183	1.0
Alprazolam	104	0.6
Clonazepam	73	0.4
3,4-Methylenedioxy-methamphetamine	59	0.3
Caffeine	58	0.3
Methadone	41	0.2
Other ²	277	1.6
Total	17,507	100.0

¹January 2010–June 2010.

²All other analyzed items.

NOTES:

1. Data are for Baltimore City only.
 2. The drug item counts exclude the Maryland State Laboratory System data.
 3. Percentages may not sum to total due to rounding.
- SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.2. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Atlanta: 1H 2010¹

Drug	Number	Percentage
Cocaine	2,509	42.2
Methamphetamine	1,450	24.4
Oxycodone	382	6.4
Hydrocodone	292	4.9
Alprazolam	291	4.9
Heroin	145	2.4
Cannabis/Marijuana	134	2.3
3,4-Methylenedioxy-methamphetamine	115	1.9
1-(3-Trifluoromethyl-phenyl)Piperazine	76	1.3
Amphetamine	71	1.2
Other ²	476	8.0
Total	5,941	100.0

¹January 2010–June 2010.

²All other analyzed items.

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, Meriwe her, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton Counties.
 2. Percentages may not sum to the total due to rounding.
- SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.4. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Boston: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	3,140	26.0
Cocaine	3,108	25.7
Heroin	1,863	15.4
Oxycodone	976	8.1
Buprenorphine	401	3.3
Clonazepam	309	2.6
Alprazolam	242	2.0
Amphetamine	133	1.1
Gabapentin	109	0.9
Clonidine	103	0.9
Other ²	1,712	14.2
Total	12,096	100.0

¹January 2010–June 2010.

²All other analyzed items.

NOTES:

1. Data include all counties in the Boston MSA: Essex, Middlesex, Norfolk, Plymouth, Rockingham, Strafford, and Suffolk Counties.
 2. "Noncontrolled Nonnarcotic Drug" represents 145 cases and are included under "Other."
 3. Percentages may not sum to total due to rounding.
- SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.5. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Chicago: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	25,581	59.2
Cocaine	8,684	20.1
Heroin	5,894	13.6
3,4-Methylenedioxy-methamphetamine	828	1.9
1-Benzylpiperazine	379	0.9
Hydrocodone	269	0.6
Methamphetamine	194	0.4
Alprazolam	192	0.4
Phencyclidine	125	0.3
Acetaminophen	106	0.2
Other ²	930	2.2
Total	43,182	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data include all counties in the Chicago/Naperville/Joliet II/IN/WI MSA: Cook, DeKalb, DuPage, Grundy, Kane, McHenry, and Will Counties in IL; Jasper, Lake, Newton, and Porter Counties in IN; and Kenosha County in WI.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.6. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Cincinnati: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	2,925	39.5
Cocaine	1,804	24.4
Heroin	927	12.5
Oxycodone	637	8.6
Hydrocodone	225	3.0
Alprazolam	143	1.9
Methamphetamine	68	0.9
Clonazepam	62	0.8
Amphetamine	55	0.7
3,4-Methylenedioxy-methamphetamine	54	0.7
Other ²	503	6.8
Total	7,403	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data include Hamilton County.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.7. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Denver: 1H 2010¹

Drug	Number	Percentage
Cocaine	1,169	30.3
Cannabis/Marijuana	1,047	27.1
Methamphetamine	567	14.7
Heroin	271	7.0
3,4-Methylenedioxy-methamphetamine	184	4.8
Oxycodone	85	2.2
Hydrocodone	47	1.2
Psilocin	33	0.9
1-Benzylpiperazine	30	0.8
Alprazolam	26	0.7
Other ²	404	10.5
Total	3,863	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data include Denver, Arapahoe, and Jefferson Counties.

2. "Noncontrolled Nonnarcotic Drug" represents 198 cases and are included under "Other."

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.8. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Detroit: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	2,625	50.7
Cocaine	1,163	22.5
Heroin	602	11.6
Hydrocodone	205	4.0
Alprazolam	127	2.5
3,4-Methylenedioxy-methamphetamine	72	1.4
Oxycodone	63	1.2
Buprenorphine	23	0.4
Codeine	22	0.4
1-Benzylpiperazine	21	0.4
Other ²	253	4.9
Total	5,176	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data include Wayne County.

2. "Noncontrolled Nonnarcotic Drug" represents 153 cases and are included under "Other."

3. Drug item counts for the Detroit Police Department are included in the Wayne County data.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.9. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Honolulu: 1H 2010¹

Drug	Number	Percentage
Methamphetamine	371	44.8
Cannabis/Marijuana	251	30.3
Cocaine	108	13.0
3,4-Methylenedioxy-methamphetamine	25	3.0
Heroin	10	1.2
Hydrocodone	8	1.0
Oxycodone	6	0.7
Alprazolam	4	0.5
Carisoprodol	4	0.5
Acetaminophen	3	0.4
Other ²	38	4.6
Total	828	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data include Honolulu County.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.10. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Los Angeles: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	9,253	40.1
Cocaine	4,994	21.6
Methamphetamine	4,478	19.4
Heroin	1,287	5.6
3,4-Methylenedioxy-methamphetamine	1,076	4.7
Hydrocodone	315	1.4
Phencyclidine	214	0.9
Alprazolam	123	0.5
Psilocin	92	0.4
Oxycodone	81	0.4
Other ²	1,160	5.0
Total	23,073	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data include Los Angeles County.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.11. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maine: 1H 2010¹

Drug	Number	Percentage
Cocaine	171	43.2
Cannabis/Marijuana	46	11.6
Oxycodone	42	10.6
Heroin	41	10.4
Buprenorphine	15	3.8
Methamphetamine	9	2.3
Hydrocodone	8	2.0
1-Benzylpiperazine	7	1.8
3,4-Methylenedioxy-methamphetamine	6	1.5
Methadone	6	1.5
Other ²	45	11.4
Total	396	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data include the State of Maine.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.12. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maryland: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	12,432	47.0
Cocaine	7,007	26.5
Heroin	4,745	17.9
Oxycodone	534	2.0
Buprenorphine	463	1.7
Alprazolam	245	0.9
Phencyclidine	140	0.5
Clonazepam	114	0.4
3,4-Methylenedioxy-methamphetamine	91	0.3
Methadone	73	0.3
Other ²	615	2.3
Total	26,459	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data are for the State of Maryland.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.13. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Miami: 1H 2010¹

Drug	Number	Percentage
Cocaine	6,958	57.4
Cannabis/Marijuana	2,564	21.2
Alprazolam	415	3.4
Oxycodone	411	3.4
Heroin	301	2.5
3,4-Methylenedioxy-methamphetamine	243	2.0
Hallucinogen	167	1.4
Hydrocodone	70	0.6
Methamphetamine	53	0.4
Diazepam	34	0.3
Other ²	898	7.4
Total	12,114	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data include the Miami/Fort Lauderdale/Pompano Beach MSA: Miami-Dade, Broward, and Palm Beach Counties.

2. "Controlled Substance (Unspecified)" represents 464 cases and are included under "Other."

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.14. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Minneapolis/St. Paul: 1H 2010¹

Drug	Number	Percentage
Methamphetamine	716	24.1
Cannabis/Marijuana	679	22.8
Cocaine	670	22.5
3,4-Methylenedioxy-methamphetamine	176	5.9
Heroin	96	3.2
Oxycodone	58	2.0
Acetaminophen	44	1.5
Cathinone	39	1.3
Acetylcodeine	35	1.2
1-Benzylpiperazine	33	1.1
Psilocin ²	33	1.1
Other ³	394	13.3
Total	2,973	100.0

¹January 2010–June 2010.²1-Benzylpiperazine and Psilocin are tied for 10th place.³All other analyzed items.

NOTES:

1. Data include seven counties in Minnesota: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.15. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, New York City: 1H 2010¹

Drug	Number	Percentage
Cocaine	9,717	36.0
Cannabis/Marijuana	9,105	33.7
Heroin	3,534	13.1
Alprazolam	858	3.2
Oxycodone	672	2.5
3,4-Methylenedioxy-methamphetamine	577	2.1
Methadone	354	1.3
Phencyclidine	350	1.3
Buprenorphine	290	1.1
Hydrocodone	212	0.8
Other ²	1,347	5.0
Total	27,016	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data include the New York City Police Department and five New York City boroughs: Bronx, Kings, Queens, New York, and Richmond.

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

SOURCE: NFLIS, DEA, December 20, 2010; data are subject to change

Appendix Table 2.16. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Philadelphia: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	6,647	38.1
Cocaine	5,958	34.1
Heroin	2,075	11.9
Oxycodone	646	3.7
Alprazolam	609	3.5
Phencyclidine	366	2.1
Clonazepam	127	0.7
Codeine	117	0.7
Hydrocodone	82	0.5
Buprenorphine	75	0.4
Other ²	750	4.3
Total	17,452	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data are for Philadelphia County.

2. "Noncontrolled Nonnarcotic Drug" represents 433 cases and are included under "Other."

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.17. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Phoenix: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	1,703	39.1
Methamphetamine	792	18.2
Cocaine	502	11.5
Heroin	329	7.6
Oxycodone	167	3.8
Alprazolam		
Methylenedioxy-methamphetamine	105	2.4
Hydrocodone	102	2.3
3,4-Methylenedioxy-methamphetamine	100	2.3
Carisoprodol	42	1.0
Clonazepam	37	0.8
Other ²	474	10.9
Total	4,353	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data are for Maricopa County.

2. "Unreported Prescription Drug" represents 101 cases and are included under "Other."

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.18. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, St. Louis: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	4,398	50.0
Heroin	1,203	13.7
Cocaine	1,108	12.6
Methamphetamine	319	3.6
Alprazolam	181	2.1
Hydrocodone	176	2.0
Oxycodone	142	1.6
3,4-Methylenedioxy-methamphetamine	127	1.4
Pseudoephedrine	90	1.0
1-Benzylpiperazine	80	0.9
Other ²	969	11.0
Total	8,793	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data are for St. Louis City and 16 counties: St. Louis, St. Charles, St. Francis, Jefferson, Franklin, Lincoln, Warren, and Washington in Missouri; and Madison, St. Clair, Macoupin, Clinton, Monroe, Jersey, Bond, and Calhoun in Illinois.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.19. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Diego: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	5,142	48.2
Methamphetamine	2,115	19.8
Cocaine	929	8.7
Heroin	519	4.9
Hydrocodone	277	2.6
3,4-Methylenedioxy-methamphetamine	235	2.2
Oxycodone	184	1.7
Alprazolam	142	1.3
Buprenorphine	70	0.7
Diazepam	63	0.6
Other ²	999	9.4
Total	10,675	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data are for San Diego only.

2. "Plant Material, Other" represents 395 cases and are included under "Other."

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.20. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Francisco: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	2,042	25.8
Methamphetamine	1,954	24.7
Cocaine	1,626	20.6
3,4-Methylenedioxy-methamphetamine	380	4.8
Heroin	329	4.2
Hydrocodone	263	3.3
Oxycodone	180	2.3
Methadone	81	1.0
Morphine	64	0.8
Diazepam	56	0.7
Other ²	925	11.7
Total	7,900	100.0

¹January 2010–June 2010; San Francisco Police data January–March 2010.²All other analyzed items.

NOTES:

1. Data are for five counties in the San Francisco/Fremont MSA: Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties.

2. "Unknown" represents 481 cases and are included under "Other."

3. "Controlled Substance" represents 76 cases and are included under "Other."

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.21. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Seattle: 1H 2010¹

Drug	Number	Percentage
Cocaine	223	26.5
Cannabis/Marijuana	139	16.5
Heroin	110	13.1
Methamphetamine	104	12.4
Oxycodone	72	8.6
3,4-Methylenedioxy-methamphetamine	34	4.0
Buprenorphine	17	2.0
Hydrocodone	14	1.7
Alprazolam	12	1.4
Amphetamine	10	1.2
Other ²	105	12.5
Total	840	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data are King County.

2. "Unknown" represents 18 cases and are included under "Other."

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.22. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Texas: 1H 2010¹

Drug	Number	Percentage
Cannabis/Marijuana	15,165	31.4
Cocaine	12,447	25.7
Methamphetamine	6,535	13.5
Alprazolam	2,748	5.7
Hydrocodone	2,397	5.0
Heroin	1,225	2.5
Carisoprodol	771	1.6
3,4-Methylenedioxy-methamphetamine	589	1.2
Clonazepam	408	0.8
1-Benzylpiperazine	389	0.8
Other ²	5,689	11.8
Total	48,363	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data are for the State of Texas.

2. The Fort Worth Police Department Laboratory did not report drug exhibits to NFLIS during this time period.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Appendix Table 2.23. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Washington, DC: 1H 2010¹

Drug	Number	Percentage
Cocaine	733	37.5
Cannabis/Marijuana	718	36.7
Heroin	198	10.1
Phencyclidine	113	5.8
1-Benzylpiperazine	36	1.8
3,4-Methylenedioxy-methamphetamine	26	1.3
Methamphetamine	20	1.0
Buprenorphine	15	0.8
Caffeine	14	0.7
Oxycodone	12	0.6
Other ²	70	3.6
Total	1,955	100.0

¹January 2010–June 2010.²All other analyzed items.

NOTES:

1. Data are for the District of Columbia.

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

SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

Participant List

National Institute on Drug Abuse Community Epidemiology Work Group Meeting *DoubleTree Paradise Valley Resort Scottsdale, Arizona January 19–21, 2011*

Chitlada Areesantichai, Ph.D.

Lecturer and Researcher
College of Public Health Sciences
Chulalongkorn University
Chulalongkorn Soi 62, Phyathai Road
Bangkok 10330, Thailand
Phone: 662 218–8200
Fax: 662 255–2177
E-mail: chitlada.a@chula.ac.th

Cynthia L. Arfken, Ph.D.

Associate Professor
Wayne State University
2761 East Jefferson Avenue
Detroit, MI 48207
Phone: 313–993–3490
Fax: 313–577–5062
E-mail: carfken@med.wayne.edu

Erin Artigiani, M.A.

Deputy Director for Policy
Center for Substance Abuse Research
University of Maryland
Suite 501
4321 Hartwick Road
College Park, MD 20740
Phone: 301–405–9794
Fax: 301–403–8342
E-mail: erin@cesar.umd.edu

Aniruddha Banerjee, Ph.D., M.S.U.R.P.

Assistant Professor
and Director of Graduate Studies
Indiana University Purdue University
207D Cavanaugh Hall
425 University Boulevard
Indianapolis, IN 46202
Phone: 317–274–3281
Fax: 317–278–5220
E-mail: rbanerje@iupui.edu

Caleb Banta-Green, M.P.H., M.S.W., Ph.D.

Research Scientist
Alcohol and Drug Abuse Institute
University of Washington
Suite 120
1107 N.E. 45th Street
Seattle, WA 98105
Phone: 206–685–3919
Fax: 206–543–5473
E-mail: calebbg@u.washington.edu

Janette Beals, Ph.D.

Director of Research
Centers for American Indian and Alaska
Native Health
Anschutz Medical Campus
Room 333
13055 E. 17th Avenue
University of Colorado, Denver
Aurora, CO 80045
Phone: 303–724–1453
Fax: 303–724–1474
E-mail: jan.beals@ucdenver.edu

Mary-Lynn Brecht, Ph.D.

Research Statistician
 Integrated Substance Abuse Programs
 University of California, Los Angeles
 Suite 200
 1640 South Sepulveda Boulevard
 Los Angeles, CA 90025
 Phone: 310-267-5275
 Fax: 310-473-7885
 E-mail: lbrecht@ucla.edu

M. Fe Caces, Ph.D.

Statistician/Demographer
 Office of National Drug Control Policy
 Executive Office of the President
 750 17th Street, N.W.
 Washington, DC 20503
 Phone: 202-395-3173
 Fax: 202-395-6562
 E-mail: mcaces@ondcp.eop.gov

Karyn Bjornstad Collins, M.P.A.

CEWG Technical Editor
 Social Solutions International, Inc.
 441 Keith Avenue
 Missoula, MT 59801
 Phone: 406-370-9931
 E-mail: kcollins@socialsolutions.biz

Raymond B. Craib II

Chief, Domestic Indicators Program
 Drug Enforcement Administration
 U.S. Department of Justice
 8701 Morrisette Drive
 Springfield, VA 22152
 Phone: 202-307-4886
 E-mail: raymond.b.craib@usdoj.gov

James K. Cunningham, Ph.D.

Social Epidemiologist
 Department of Family and Community
 Medicine
 The University of Arizona
 1450 North Cherry Avenue
 Tucson, AZ 85719
 Phone: 520-615-5080
 Fax: 520-577-1864
 E-mail: jkcunnin@email.arizona.edu

Samuel J. Cutler

Drug and Alcohol Abuse Program Manager
 Office of Addiction Services
 Department of Behavioral Health &
 Intellectual disAbility Services (DBH/IDS)
 City of Philadelphia
 Suite 800
 1101 Market Street
 Philadelphia, PA 19107-2908
 Phone: 215-685-5414
 Fax: 215-685-4977
 E-mail: sam.cutler@phila.gov

Lara DePadilla, Ph.D.

Research Assistant Professor
 Department of Behavioral Sciences and Health
 Education
 Rollins School of Public Health
 Emory University
 Floor 5
 1518 Clifton Road
 Atlanta, GA 30322
 Phone: 404-358-5037
 Fax: 404-727-1369
 E-mail: ldepadi@emory.edu

Kristen A. Dixon, M.A., L.P.C.

Evaluation Researcher
 Division of Behavioral Health
 State of Colorado
 3824 West Princeton Circle
 Denver, CO 80236
 Phone: 303-866-7407
 Fax: 303-866-7428
 E-mail: kristen.dixon@state.co.us

Daniel P. Dooley

Senior Researcher
Boston Public Health Commission
1010 Massachusetts Avenue
Boston, MA 02118
Phone: 617-534-2360
Fax: 857-288-2129
E-mail: ddooley@bphc.org

Carol L. Falkowski

Drug Abuse Strategy Officer
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55101
Phone: 651-431-2457
Fax: 651-431-7449
E-mail: carol.falkowski@state.mn.us

Jillian Flight

Research Analyst
Office of Drug and Alcohol Research and
Surveillance
Controlled Substances and Tobacco
Directorate
Department of Health Canada
Sixth Floor, PL 3506D
123 Slater Street
Ottawa, Ontario K1A 0K9
Phone: 613-946-6755
Fax: 613-952-5188
E-mail: jillian.flight@hc-sc.gc.ca

Yvonne Fortier, M.A.

Director, Clinical Services
Native American Connections
Suites 100 or 600
4520 N. Central Avenue
Phoenix, AZ 85012
Phone: 602-820-6094
E-mail: y.fortier@nativeconnections.org

Alice A. Gleghorn, Ph.D.

County Alcohol and Drug Administrator
Community Behavioral Health Services
San Francisco Department of Public Health
Room 450
1380 Howard Street
San Francisco, CA 94103
Phone: 415-255-3722
Fax: 415-255-3529
E-mail: alice.gleghorn@sfdph.org

Ellen Grizzle, B.Pharm, Ph.D., R.Ph.

Director
Information and Research
National Council on Drug Abuse
2-6 Melmac Avenue
Kingston 5, Jamaica
Phone: 876-926-9002-4
Fax: 876-960-1820
E-mail: ncda@cwjamaica.com

James N. Hall

Director
Center for the Study and Prevention of
Substance Abuse
Nova Southeastern University
c/o Up Front, Inc.
13287 S.W. 124th Street
Miami, FL 33186
Phone: 786-242-8222
Fax: 786-242-8759
E-mail: upfrontin@aol.com

Heidi Israel, Ph.D., R.N., F.N.P., L.C.S.W.

Assistant Professor
Department of Orthopaedic Surgery
St. Louis University
School of Medicine
3625 Vista, FDT-7N
St. Louis, MO 63110
Phone: 314-577-8851
Fax: 314-268-5121
E-mail: israelha@slu.edu

Charles M. Katz, Ph.D.

Watts Family Director
and Associate Professor
Center for Violence Prevention
and Community Safety
Arizona State University
Suite 200
500 N. Third Street,
Phoenix, AZ 85004-2135
Phone: 602-496-1471
Fax: 602-496-1494
E-mail: ckatz@asu.edu

Emma Kibisu

Grants Evaluator
Arizona Department of Health Services
150 N. Eighteenth Street
Phoenix, AZ 85007
Phone: 602-364-4643
E-mail: kibisue@azdhs.gov

Melissa Lee

Special Agent
DEA Phoenix Field Division
U.S. Department of Justice
Suite 301
3010 North Second Street
Phoenix, AZ 85012
Phone: 602-664-5743
Fax: 602-664-5627
E-mail: melissa.a.lee@usdoj.gov

Marsha Lopez, Ph.D.

Acting Branch Chief
Epidemiology Research Branch
Division of Epidemiology, Services and
Prevention Research
Room 5185
6001 Executive Boulevard
Bethesda, MD 20892
E-mail: lopezmar@nida.nih.gov

Rozanne Marel, Ph.D.

Assistant Chief of Epidemiology
New York State Office of Alcoholism and
Substance Abuse Services
8th Floor
501 Seventh Avenue
New York, NY 10018
Phone: 646-728-4605
Fax: 646-728-4685
E-mail: rozannemarel@oasas.state.ny.us

Jane C. Maxwell, Ph.D.

Senior Research Scientist
Addiction Research Institute
Center for Social and Behavioral Research
The University of Texas, Austin
Suite 335
1717 West 6th Street
Austin, TX 78703
Phone: 512-232-0610
Fax: 512-232-0617
E-mail: jcmaxwell@mail.utexas.edu

Corinne P. Moody

Science Policy Analyst
Food and Drug Administration
Building 51, Room 5144
10903 New Hampshire Avenue
Silver Spring, MD 20993
Phone: 301-796-3152
Fax: 301-847-8736
E-mail: corinne.moody@fda.hhs.gov

John Newmeyer, Ph.D.

Epidemiologist
HIV Prevention Planning Council
2004 Gough Street
San Francisco, CA 94109
Phone: 415-441-1158
E-mail: jnewmeyer@aol.com

Clayton Norman

Reporter, Tombstone Epitaph
 Graduate Student
 University of Arizona
 1650 E. Linden Street
 Tucson, AZ
 Phone: 936-553-2434
 E-mail: claytonrnorman@gmail.com

Moira P. O'Brien, M.Phil.

Health Scientist Administrator
 Epidemiology Research Branch
 Division of Epidemiology, Services and
 Prevention Research
 National Institute on Drug Abuse
 National Institutes of Health
 Room 5153, MSC-9589
 6001 Executive Boulevard
 Bethesda, MD 20892
 Phone: 301-402-1881
 Fax: 301-443-2636
 E-mail: mobrien@nida.nih.gov

Lawrence Ouellet, Ph.D.

Research Professor
 Division of Epidemiology and Biostatistics
 School of Public Health
 University of Illinois, Chicago
 Mailcode 923
 1603 West Taylor Street
 Chicago, IL 60612
 Phone: 312-355-0145
 Fax: 312-996-1450
 E-mail: ljo@uic.edu

Usaneya Perngparn, Ph.D.

Assistant Dean
 College of Public Health Sciences
 Chulalongkorn University
 Bangkok 10330, Thailand
 Phone: 662 218-8200
 E-mail: usaneya.p@chula.ac.th

Artisha R. Polk, M.P.H.

Mathematical Statistician
 Office of Diversion Control/ODE
 Drug Enforcement Administration
 U.S. Department of Justice
 8701 Morrisette Drive
 Springfield, VA 22152
 Phone: 202-307-7180
 Fax: 202-353-1263
 E-mail: artisha.r.polk@usdoj.gov

Robin Pollini, Ph.D., M.P.H.

Assistant Professor
 University of California, San Diego
 Mail Code 0507
 9500 Gilman Drive
 La Jolla, CA 92093
 Phone: 858-534-0710
 Fax: 858-534-7566
 E-mail: rpollini@ucsd.edu

Cassandra Prioleau, Ph.D.

Drug Science Specialist
 Drug Enforcement Administration
 U.S. Department of Justice
 8701 Morrisette Drive
 Springfield, VA 22152
 Phone: 202-307-7254
 Fax: 202-353-1263
 E-mail: cassandra.prioleau@usdoj.gov

Sandra Putnam, M.Sc., Ph.D.

Project Director, CEWG
 Social Solutions International, Inc.
 1541 Stewartstown Road
 Morgantown, WV 26505
 Phone: 304-292-5148
 Fax: 304-292-5149
 E-mail: sputnam@socialsolutions.biz

Nicholas Reuter, M.P.H.

Senior Public Health Advisor
 Substance Abuse and Mental Health
 Services Administration
 U.S. Department of Health and Human
 Services
 Room 2-1063
 One Choke Cherry Road
 Rockville, MD 20850
 Phone: 240-276-2716
 Fax: 240-276-1040
 E-mail: Nicholas.Reuter@samhsa.hhs.gov

**Jan Scaglione, M.T., Pharm.D.,
DABAT**

Clinical Toxicologist
 Cincinnati Drug and Poison Information
 Center
 Cincinnati Children's Hospital Medical Center
 ML-9004
 3333 Burnet Avenue
 Cincinnati, OH 45229
 Phone: 513-636-5060
 Fax: 513-636-5072
 E-mail: jan.scaglione@cchmc.org

Nina Shah, M.S.

Drug Epidemiologist
 New Mexico Department of Health
 P.O. Box 26110
 1190 St. Francis Drive
 Santa Fe, NM 87502
 Phone: 505-476-3607
 Fax: 505-827-0013
 E-mail: nina.shah@state.nm.us

Susan A. Seese, Ph.D., M.B.A.

Senior Intelligence Analyst/SENTRY
 Program Manager
 National Drug Intelligence Center
 U.S. Department of Justice
 Fifth Floor
 319 Washington Street
 Johnstown, PA 15901
 Phone: 814-532-4093
 Fax: 814-532-5858
 E-mail: susan.seese@usdoj.gov

Natasha Sindicich, M.Psych (Forensic)

National Drug and Alcohol Research Centre
 University of New South Wales
 SYDNEY NSW 2052
 Australia
 Phone: 612 9385 0191
 Fax: 612 9385 0222
 E-mail: n.sindicich@unsw.edu.au

Marcella H. Sorg, Ph.D., R.N., D-ABFA

Research Associate Professor
 Margaret Chase Smith Policy Center
 University of Maine
 Building 4
 5784 York Complex
 Orono, ME 04469
 Phone: 207-581-2596
 Fax: 207-581-1266
 E-mail: marcella.sorg@umit.maine.edu

John S. Swartz

Senior Intelligence Specialist
 U.S. Drug Enforcement Administration
 U.S. Department of Justice
 700 Army Navy Drive
 Arlington, VA 22202
 Phone: 202-307-4453
 E-mail: john.s.swartz@usdoj.gov

Julian Vicente, M.D., M.P.H.

Head of Unit on Patterns, Consequences,
 and Data Management
 European Monitoring Centre
 for Drug and Drug Addiction
 Cais do Sodré
 Lisbon, Portugal 1249-289
 Phone: 351-211-210-223
 Fax: 351-213-584-441
 E-mail: julian.vicente@emcdda.europa.eu

Angela Walker

Senior Forensic Chemist
DEA South Central Laboratory
U.S. Drug Enforcement Administration
U.S. Department of Justice
10150 East Technology Boulevard
Dallas, TX 75220
Phone: 972-559-7900
Fax: 972-559-7999
E-mail: angela.z.walker@usdoj.gov

Jerry Walker

Associate Laboratory Director
DEA South Central Laboratory
U.S. Drug Enforcement Administration
U.S. Department of Justice
10150 East Technology Boulevard
Dallas, TX 75235
Phone: 972-559-7900
Fax: 972-559-7999
E-mail: jerry.a.walker@usdoj.gov

D. William Wood, M.P.H., Ph.D.

Professor and Chair
Department of Sociology
University of Hawaii at Manoa
Room 247
2424 Maile Way
Honolulu, HI 96822
Phone: 808-956-7693
Fax: 808-956-3707
E-mail: dwwood@hawaii.edu

Meeting Coordinator

Patricia Evans

Conference Manager
Knowledge Translation and Strategic
Communication Division
RTI International
Suite 902
6110 Executive Boulevard
Rockville, MD 20852
Phone: 301-816-4612
Fax: 301-230-4647
E-mail: pevans@rti.org

**U.S. Department of
Health and Human Services**

NATIONAL INSTITUTES OF HEALTH

NIDA NATIONAL INSTITUTE
ON DRUG ABUSE

September 2011