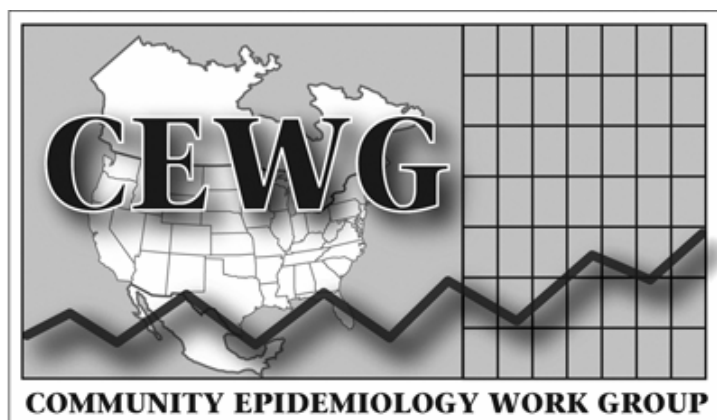


# NATIONAL INSTITUTE ON DRUG ABUSE



## EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

### Advance Report and Highlights/Executive Summary: Abuse of Stimulants and Other Drugs

Proceedings of the Community  
Epidemiology Work Group

January 2005

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This publication is based primarily on papers presented and data reported by CEWG representatives from 21 areas at the January 2005 CEWG meeting and presentations by an expert panel on abuse of methamphetamine. The text from the CEWG research papers appears in the

*Proceedings (Volume II)*, which also contains papers presented by the Panel on Methamphetamine Abuse and researchers from Mexico's Epidemiologic Surveillance System of Addictions.

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

*Volume II Proceedings* (available in limited supply) can be obtained by contacting the National Clearinghouse for Alcohol and Drug Information

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## FOREWORD

This report is a synthesis of findings presented at the 57th semiannual meeting of the Community Epidemiology Work Group (CEWG) held in Long Beach, California, on January 26–28, 2005, under the sponsorship of the National Institute on Drug Abuse, National Institutes of Health.

Representing 21 sentinel areas in the United States, CEWG members presented reports, citing the most current data on drug abuse patterns, trends, and emerging drug problems in their areas, with a focus on abuse of stimulants, especially cocaine/crack and methamphetamine/amphetamines. A highlight of the meeting was a series of presentations by NIDA-supported researchers in a panel on methamphetamine abuse.

The areas represented in the CEWG are Atlanta, Baltimore, Boston, Chicago, Denver, Detroit, Honolulu, Los Angeles, Miami/Ft. Lauderdale, Minneapolis/St. Paul, New Orleans, New York City, Newark, Philadelphia, Phoenix, St. Louis, San Diego, San Francisco, Seattle, Texas, and Washington, DC. To enhance nonurban representation in the CEWG, information was provided by a guest researcher from Maine.

Findings from the CEWG network are supplemented by national data and by special presenta-

tions at each meeting. Publications are disseminated to drug abuse prevention and treatment agencies, public health officials, researchers, and policymakers. The information is intended to alert authorities at the local, State, regional, and national levels, and the general public, to current conditions and potential problems so that appropriate and timely action can be taken. Researchers also use the information to develop research hypotheses that might explain social, behavioral, and biological issues related to drug abuse.

In addition to presentations by the 21 CEWG representatives and members of the Panel on Methamphetamine Abuse, the meeting included the following:

- A workshop on the new DAWN *Live!* system
- A panel on Exploring the Potential of the Internet as a Tool for Monitoring Drug Abuse Trends
- The status of and most recent data produced by the Canadian Community Epidemiology Network on Drug Use and Mexico's Epidemiologic Surveillance System of Addictions

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# ABUSE OF STIMULANTS AND OTHER DRUGS: INTRODUCTION TO THE CEWG REPORT

Moira P. O'Brien, NIDA

During recent CEWG meetings, concern has been raised regarding the serious threat posed by central nervous system (CNS) stimulants, particularly methamphetamine and crack cocaine. Indicators of methamphetamine abuse have persisted at high levels in western CEWG areas including Honolulu, San Diego, Seattle, San Francisco, and Los Angeles. Primary methamphetamine abuse now accounts for 59 percent of treatment admissions for substance abuse, excluding alcohol, in Hawaii, 51 percent in San Diego, and 38 percent in the State of Arizona. In the Midwest, primary methamphetamine treatment admissions (excluding alcohol) nearly doubled from 4.5 percent in 2001 to 8.2 percent in the first half of 2004 in St. Louis. Primary methamphetamine treatment admissions (excluding alcohol) increased in Minneapolis/St. Paul from 10.6 percent to 18.7 percent during this same time period. Methamphetamine has been recognized as a problem in rural areas in the West and Midwest for several years. Recent drug abuse indicators show that methamphetamine is increasing as a problem in urban areas as well.

Methamphetamine treatment admissions in eastern CEWG areas remain low at less than 1 percent of total substance abuse treatment admissions, with the exception of Atlanta, where primary methamphetamine admissions represented nearly 11 percent of the illicit drug treatment admissions in the first half of 2004. There are increased reports of clandestine lab seizures in more rural areas of eastern CEWG States, including Georgia, New York, and Maryland. Reports of the popularity of methamphetamine in some club contexts and within specific groups of users underscore the potential threat of spread and need for vigilance in monitoring methamphetamine in areas where most indicators are still low.

While the CEWG has been monitoring the recent expansion of methamphetamine abuse, it has also been reported that cocaine, another central nervous system stimulant, persists as a major abused drug. Cocaine abuse indicators, including treatment admissions, remain at high levels in many CEWG areas. For example, in St. Louis and Atlanta, two cities where methamphetamine treatment admissions have been increasing, primary

cocaine treatment admissions represented 53 percent of total admissions (excluding alcohol) in the first half of 2004. Primary cocaine use represented 30 percent or more of treatment admissions (excluding alcohol) in Detroit, Miami, New Orleans, Philadelphia, and Washington, DC. In 11 of 14 CEWG metropolitan areas that included route of administration data, smoking the drug (crack) represented 70 percent or more of the primary cocaine treatment admissions.

Stimulant abuse poses an enormous challenge to the treatment system, policymakers, prevention program planners, child welfare services, environmental protection, and law enforcement. Abuse of these stimulants has many negative effects on the well-being and behaviors of users, impacts families and communities, and strains resources.

Concern regarding the abuse of stimulant drugs prompted the decision to focus the CEWG January 2005 meeting presentations on this class of substances. CEWG representatives were asked to report, as usual, on the full range of abused substances but to devote most of the meeting presentation to data pertaining to the abuse of stimulant drugs. The major findings are presented in this report. Full CEWG metropolitan area reports will appear in the January 2005 *CEWG Proceedings*.

Because methamphetamine and cocaine were the two stimulant substances most prominently represented in the various CEWG area reports, a substantial portion of this report is devoted to these two stimulant-type drugs. Where possible, data on these two drugs are organized systematically to facilitate comparison within and across CEWG areas. Also, a paper from colleagues in Mexico provides a comparative perspective on the problems of cocaine and methamphetamine abuse in Mexico.

Since June 2003, CEWG meetings have included a panel examining a particular emerging/current trend in greater depth than is possible through the CEWG area reports. This approach has drawn on NIDA-supported research to complement the findings presented by CEWG representatives. Because of the heightened concern regarding

methamphetamine abuse, a panel was planned for the January 2005 meeting to examine what research is revealing about the natural history of methamphetamine abuse, long-term consequences, effects of prenatal exposure, and issues associated with the treatment of methamphetamine abuse. Summaries of the research panel presentations are included in this report.

The Drug Abuse Warning Network (DAWN) has been an important source of data for the CEWG since its inception. Major changes were instituted in DAWN at the beginning of 2003. These changes are a result of a redesign that altered virtually every feature of DAWN except its name. As a result of the redesign, new DAWN data cannot be compared with data from prior years. Interim national estimates of drug-related emergency department visits from the new DAWN for 2003 have been published and are available on the SAMHSA Web site (<<http://DAWNinfo.samhsa.gov>>). There

are, however, no metropolitan area estimates available for 2003 or 2004.

The new DAWN ED system includes real-time surveillance capability through *DAWN Live!*, an online query system. Access to *DAWN Live!* is limited to authorized users. Data in *DAWN Live!* are raw and unweighted reports of individual cases from participating hospitals, not population-based estimates as have been presented in previous CEWG reports. CEWG area representatives have been granted access to *DAWN Live!* and have been trained in its use. A session during the January 2005 meeting was devoted to a discussion of the potential for meaningfully incorporating data from this real-time, raw data into the CEWG. A brief description of the new DAWN ED system and *DAWN Live!* are included in *Appendix B*, and selected raw and unweighted data extracted from *DAWN Live!* are presented for each CEWG metropolitan area.



# THE CEWG NETWORK: ROLES, FUNCTIONS, AND DATA SOURCES

## Roles of the CEWG

The CEWG is a unique epidemiologic network that is designed to inform drug abuse prevention and treatment agencies, public health officials, policy-

makers, and the general public about current and emerging drug abuse patterns. The 21 geographic areas represented in the CEWG are shown in the map below.



## The Functions of CEWG Meetings

The CEWG convenes semiannually. Ongoing communication between meetings is maintained through e-mail, conference calls, and mailings.

The interactive semiannual meetings are a major and distinguishing feature of the CEWG and provide a foundation for continuity in monitoring and surveillance of current and emerging drug problems and related health and social consequences. Through the meetings, the CEWG accomplishes the following:

- ◆ Dissemination of the most up-to-date information on drug abuse patterns and trends in each CEWG area
- ◆ Identification of changing drug abuse patterns and trends within and across CEWG areas

- ◆ Planning for followup on identified problems and emerging drug abuse problems

**Presentations** by each CEWG member include a compilation of quantitative drug abuse indicator data. Members go beyond publicly accessible data and provide a unique local perspective obtained from both public records and qualitative research. Information is most often obtained from local substance abuse treatment providers and administrators, personnel of other health-related agencies, law enforcement officials, and drug abusers.

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

- ◆ Presentations by a panel of experts on a current or emerging drug problem identified in the previous CEWG meeting
- ◆ Updates by Federal personnel on key data sets used by CEWG members

- ◆ Drug abuse patterns and trends in other countries, such as Canada and Mexico

**Identification of changing drug abuse patterns** is part of the interactive discussions at each CEWG meeting. Through this process, members can alert one another to the emergence of a potentially new drug of abuse that could spread from one area to another. The CEWG has pioneered in identifying the emergence of several drug epidemics, such as those involving abuse of methaqualone (1979), crack (1983), methamphetamine (1983), and “blunts” (1993). The CEWG, with its semiannual meetings, is uniquely positioned to bring crucial perspectives to bear on urgent drug abuse issues in a timely fashion and to illuminate its various facets within the local context.

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

**Emerging/Current Trend** is an approach followed at CEWG meetings since June 2003; this is a direct product of the planning at the prior meeting and the subsequent followup activities. The Emerging/Current Trend at the January 2005 meeting was, as noted earlier, the panel on methamphetamine abuse. In June 2003, a special panel was convened on Methadone-Associated Mortality, and, in December 2003, a PCP Abuse Panel addressed the issue of phencyclidine abuse as a localized emerging trend. In June 2004, a special panel addressed the abuse of prescription drugs.

The Emerging/Current Trend approach draws upon the following:

- ◆ CEWG members’ knowledge of local drug abuse patterns and trends
- ◆ Small exploratory studies
- ◆ Presentations of pertinent information from federally supported data sources
- ◆ Presentations by other speakers knowledgeable in the selected topic area

At the June 2004 meeting, CEWG members discussed the issue of stimulant abuse. This issue was an integral part of the January 2005 CEWG meeting, and it constitutes major sections of this report.

## CEWG Data Sources

Major indicators and primary quantitative data sources used by CEWG members and cited in this report include those shown below.

**Forensic drug laboratory testing data** are from the National Forensic Laboratory Information System (NFLIS) and represent fiscal year (FY) 2004 (October 2003–September 2004). Sponsored by the Drug Enforcement Administration (DEA), NFLIS accumulates drug analysis results from State and local forensic labs. As of July 2004, 41 State systems and 82 local or municipal laboratory systems had joined the NFLIS, and efforts are underway to recruit all State and local laboratories and to integrate Federal laboratories into the system. Labs in 18 CEWG cities participated in NFLIS (the exceptions are Phoenix and San Francisco); also, the Texas Department of Public Safety submitted data from 13 Texas sites to NFLIS. Comparisons across CEWG areas are subject to distortion for several reasons. First, the data are not adjusted for population size. Also, there are variations within and across areas that can result in differences in drug seizures and analyses (e.g., police priorities, types of arrests from which drug specimens are taken, and other criminal justice procedures), and there are some variations in forensic laboratory procedures.

**Substance abuse treatment admissions data** for 2000–2004 were extracted from State treatment databases (18 CEWG areas); the Treatment Episode Data Set (TEDS), maintained by OAS, SAMHSA (Washington, DC); and samples from two programs in Broward County, Florida. Arizona, Colorado, Hawaii, Illinois, and Texas representatives report statewide treatment admissions data. Data from 9 CEWG areas represent a calendar year (CY), while data from 12 represent a fiscal year. Twelve areas reported treatment data for the first half of 2004 (Atlanta, Baltimore, Hawaii, Los Angeles, Miami, Minneapolis/St. Paul, New York, Newark, Philadelphia, St. Louis, Seattle, and Texas). Seven areas presented full CY or FY 2004 data (Arizona, Boston, Colorado, Detroit, New Orleans, San Diego, and San Francisco). Illinois and

Washington, DC, reported data for 2003. The findings represent percentages of admissions for primary drugs of abuse; the denominators exclude alcohol admissions. *Appendix A* presents information on treatment admissions in each CEWG area in the most recent reporting period.

**Drug-related mortality data** from four CEWG areas were obtained from local medical examiners: Honolulu (all of 2004), Miami, Philadelphia, and Seattle (first half of 2004). These data are not totally comparable across the four areas. Local drug-related mortality trends across eight CEWG areas for 2000–2003, and DAWN mortality data for 1999–2002, are published in the June 2004 *Volume I Proceedings*.

**Drug seizure, trafficking, price, and purity data** are extracted from DEA sources (e.g., the El Paso Intelligence Center [EPIC] National Clandestine Laboratory Seizure Database) and CEWG reports. CEWG members also report data from the National Drug Intelligence Center (NDIC), DEA, and their areas' High Intensity Drug Trafficking Area (HIDTA) reports produced by the Office of National Drug Control Policy.

In addition, DAWN emergency room data for 2004 are presented in *Appendix B*, together with a brief description of the system.

# Key Findings

- ◆ **Cocaine** continued to be, by far, the most widely abused illicit stimulant drug in CEWG areas in 2003–2004. Cocaine abuse indicators remained high in 19 of the 21 CEWG areas. The exceptions were Honolulu and San Diego, where cocaine indicators are low but methamphetamine indicators continue at high levels. The magnitude of the cocaine/crack problem is not always apparent from data on the primary drug of abuse. In many CEWG areas, cocaine/crack is often reported as a secondary drug, especially by primary heroin addicts entering treatment.
  
- ◆ The extent of **methamphetamine** abuse varies greatly by CEWG area, but CEWG reports indicate that methamphetamine is available in all CEWG areas, and patterns in several areas appear to be in transition:
  - Methamphetamine abuse indicators through 2003–2004 continued to be high in Honolulu, San Diego, Los Angeles, San Francisco, and Seattle.
  
  - Indicators of methamphetamine abuse increased in several CEWG areas through 2003–2004, including Atlanta, Colorado, Los Angeles, Minneapolis/St. Paul, and Phoenix.
  
  - Indicators of methamphetamine abuse varied in Texas, where it was more of a problem in the northern area of the State.
  
  - Recent data from Atlanta and Minneapolis/St. Paul suggest that these two areas are experiencing substantial increases in methamphetamine abuse. In Minneapolis/St. Paul, 61 percent of items tested in forensic labs in FY 2004 were methamphetamine, and treatment admissions for methamphetamine increased from 10.6 to 18.7 percent of treatment admissions (excluding alcohol) from 2001 to 2004. Atlanta appears to be emerging as a major distribution center for methamphetamine for nearby States, and indicators of abuse of methamphetamine have raised concern about this drug in rural Georgia, metropolitan Atlanta, and in suburban communities neighboring Atlanta.
  
  - Eastern CEWG areas other than Atlanta continue to report very low indicators of methamphetamine abuse, but some eastern area CEWG representatives reported recent increases in methamphetamine labs in state and, although the numbers remain small, increases were observed in methamphetamine treatment admissions in some CEWG metropolitan and outlying nonmetropolitan areas.



- Eastern CEWG areas—New York, Philadelphia, Washington, DC, and Miami—were among the metropolitan areas reporting use of methamphetamine within networks of gay males, including those who frequent clubs. The clear availability of methamphetamine in these metropolitan areas warrants vigilance in monitoring indicators to track whether methamphetamine diffuses to a broader population of users or becomes popular in a wider range of club contexts.
  
- ◆ **Methylenedioxymethamphetamine** (MDMA or ecstasy) abuse indicators decreased in four CEWG metropolitan areas (Boston, Miami, Seattle, and St. Louis), and school surveys showed ecstasy use decreasing among students in two States (Minnesota and Texas). Most CEWG members reported that MDMA was still used primarily by White youth and young adults, but there were reports from three areas (Chicago, New York City, and Texas) that abuse of this drug was increasing in or spreading to minority communities.
  
- ◆ **Heroin** indicators increased in 1 area, were stable or mixed (some up and some down) in 15 areas, and decreased in 5. However, heroin indicators (especially heroin treatment admissions) remained very high in nine areas.
  
- ◆ **Marijuana** abuse indicators continued at high levels in all CEWG areas. The drug was widely available, and indicators were particularly high among youth and young adult populations.
  
- ◆ **Prescription drug abuse** differed by geographic area, population group, and type of drug. More than 35 percent of the 7,319 opiate/opioid items identified by forensic labs in FY 2004 were hydrocodone, 23 percent were oxycodone, 19 percent were methadone, and the remainder were mostly codeine and morphine. Forensic labs also identified 6,604 benzodiazepine-type items analyzed across CEWG areas. Nearly two-thirds (63.8 percent) of the items were alprazolam, 18.2 percent were clonazepam items, 14.7 percent were diazepam, and 3.3 percent were lorazepam items.

# STIMULANT ABUSE PATTERNS AND TRENDS

## Stimulant Abuse: An Overview

As noted in the *Introduction*, CEWG area representatives were asked to devote special attention to data on the abuse of stimulants. This class of drugs enhances brain activity and causes increases in alertness, attention, and energy. Among these drugs that increase central nervous system (CNS) activity are cocaine, methamphetamine, amphetamines, and methylphenidate (Ritalin). MDMA (ecstasy) also stimulates the CNS, but it may be classified as a hallucinogen. CEWG monitoring of drug abuse trends shows that cocaine and methamphetamine are the most commonly abused stimulants.

documented by large-scale surveys. Prevalence estimates for metropolitan areas are less commonly available than those for the Nation overall. A brief review of recent estimates of the prevalence of the use of stimulants from three federally funded surveys follows.

**NSDUH.** The 2003 National Survey on Drug Use and Health, supported by SAMHSA, estimated that 2.3 million Americans age 12 and older were current cocaine users (i.e., had used the drug in the past 30 days); 601,000 were current crack users. Also, 1.3 million persons were current methamphetamine users.

Exhibit 1 shows the prevalence of past-year use of different stimulants by age group.

## Prevalence of Abuse of Stimulants

National-level estimates of the prevalence of the use and abuse of different stimulants are

**Exhibit 1. Past-Year Use of Stimulant Drugs Among Americans, by Age Group and Percent: 2003**

Drug	Age Category		
	12–17	18–25	26 and Older
Cocaine	1.8	6.6	1.9
Crack	0.4	0.9	0.6
Stimulants (Prescription-Type)	2.3	3.5	0.6
Methamphetamine	0.7 <sup>1</sup>	1.6	0.4
Ecstasy	1.3 <sup>2</sup>	3.7 <sup>2</sup>	0.3

<sup>1</sup>Difference between 2002 estimate and 2003 estimate is statistically significant at the 0.05 level.

<sup>2</sup>Difference between 2002 estimate and 2003 estimate is statistically significant at the 0.01 level.

SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003

The 2003 NSDUH reported a significant decrease in past-year use of ecstasy in the 12–17 and 18–25 age groups from 2002 and 2003. Over the same time period, there was a significant decline in past-year use of methamphetamine in the 12–17 age group. Use of other stimulant drugs shown in exhibit 1 did not change significantly from 2002 to 2003.

surveys include the Monitoring the Future (MTF) study, which provides national-level data, and the Youth Risk Behavior Survey (YRBS), which provides local data.

**MTF.** The Monitoring the Future study, supported through a NIDA grant, tracks drug use in students in grades 8, 10, and 12 annually. Data from the 2004 MTF study on past-year use of stimulants are shown in exhibit 2 below.

Surveys of school students provide information on stimulant use among youth. Federally supported

**Exhibit 2. Past-Year Use of Stimulant Drugs Among School Students Nationally, By Grade Level and Percent: 2004**

Drug	Age Category		
	8th Grade	10th Grade	12th Grade
Cocaine	2.0	3.7	5.3
Crack	1.3	1.7	2.3
Amphetamine	4.9	8.5	10.0
Methamphetamine	1.5 <sup>1</sup>	3.0	3.4
Ritalin	2.5	3.4	5.1
MDMA (Ecstasy)	1.7	2.4	4.0

<sup>1</sup>Level of significance of difference between the two most recent classes is 0.1

SOURCE: MTF (University of Michigan and NIDA)

In 2004, levels of cocaine and Ritalin use in the MTF data remained unchanged from 2003. While there was no significant decline in past-year use of ecstasy among students at any grade level surveyed in 2004, there was a significant decline in past-year use of this drug in all three grades from 2002 to 2003; this followed a 20-percent decline in students' use of ecstasy from 2001 to 2002. The 2004 data show a significant decline from 2003 in methamphetamine use among the youngest students surveyed; however, use among students in grades 10 and 12 remained unchanged from 2003. A troublesome finding in the 2004 survey was that 1 in 10 12th graders reported nonmedical use of amphetamines.

National-level estimates of drug use may mask substantial variations in local areas. The most recent **YRBS** data from the Centers for Disease Control and Prevention reveal such variations in the abuse of cocaine, methamphetamine, and ecstasy across CEWG areas where surveys were conducted. The weighted 2003 data showing the percentages of students in grades 9–12 who ever used (lifetime use) these three drugs are shown in exhibit 3 for 13 CEWG areas, together with confidence intervals (CIs) by drug and area.

**Exhibit 3. Lifetime Use of Cocaine, Methamphetamine, and Ecstasy Among Students in Grades 9–12 in 13 CEWG Areas,<sup>1</sup> by Percent: 2003**

City	Cocaine		Methamphetamine		Ecstasy	
	Percent	CI <sup>2</sup> (±)	Percent	CI (±)	Percent	CI (±)
Boston PS	3.3	1.1	3.6	1.4	6.2	1.7
Broward Co., FL PS	5.9	1.4	4.5	1.1	7.8	1.6
Chicago PS	5.6	1.6	3.7	1.7	5.3	1.9
Dallas ISD	11.9	1.8	5.2	1.2	NA <sup>3</sup>	–
DeKalb Co., GA PS	3.4	1.2	2.9	0.8	4.7	1.3
Detroit PS	2.3	0.8	2.6	1.0	NA	–
Los Angeles USD	9.9	2.2	8.0	1.7	4.7	2.0
Miami-Dade Co., FL PS	6.3	1.1	3.8	1.0	8.2	1.6
New Orleans PS	3.4	1.3	5.8	1.8	7.2	1.9
New York City PS	3.5	0.6	2.4	0.5	5.0	0.8
Philadelphia SD	2.9	0.9	2.0	0.9	4.9	1.5
San Diego USD	7.7	1.7	7.6	1.5	9.0	1.6
Wash., DC PS	6.2	1.5	5.7	1.5	8.8	2.0

<sup>1</sup>PS=Public school; SD=school district; ISD=independent school district; USD=unified school district.

<sup>2</sup>At the 95 percent confidence level.

<sup>3</sup>NA=Not available.

SOURCE: YRBS, CDC

As shown in exhibit 3, estimates of lifetime use of cocaine ranged from a low of 2.3 percent of the Detroit students to 11.9 percent of the students in Dallas. Lifetime use of methamphetamine varied from 2 percent among high schools students in Philadelphia to 8 percent among those in Los Angeles. Data reported on ecstasy from 11 CEWG areas also show variation, with a low of 4.7 percent in the Atlanta area (DeKalb County) to a high of 9.0 percent in San Diego.

## Cocaine/Crack and Methamphetamine

Although both cocaine and methamphetamine are psychostimulants, there are differences between the drugs, including the following:

<b>Cocaine</b>	<b>Methamphetamine</b>
➤ Plant-derived	➤ Manmade
➤ Smoking produces a high that lasts 20–30 minutes	➤ Smoking produces a high that lasts 8–24 hours
➤ Fifty percent of the drug is removed from the body in 1 hour	➤ Fifty percent of the drug is removed from the body in 12 hours
➤ Used as a local anesthetic in some surgical procedures	➤ Limited medical use

Both cocaine and methamphetamine produce a number of negative effects.

**Cocaine**, a powerfully addictive drug, is snorted, sniffed, injected, or smoked. Cocaine usually makes the user feel euphoric and energetic. Common health effects include heart attacks, respiratory failure, strokes, and seizures. Taken in large amounts, cocaine can cause bizarre behavior and violent behavior. Sudden death occurs upon first use of cocaine or shortly thereafter in rare cases.

Physical effects of cocaine use include constricted blood vessels, dilated pupils, and increased body temperature, heart rate, and blood pressure. Immediate euphoric effects of cocaine use include hyperstimulation, reduced fatigue, and mental clarity. The duration of the immediate euphoric effects of cocaine use depends on the route of administration.

Some cocaine users report feelings of restlessness, irritability, and anxiety. A tolerance to the “high” may develop. Many abusers report seeking but failing to achieve as much pleasure as they did from their first use of cocaine. Some users increase their dosage levels to intensify and prolong the euphoric effects.

**Methamphetamine**, also an addictive stimulant, has a high potential for abuse and addiction. Central nervous system actions that result from even small amounts of methamphetamine include decreases in appetite and increases in wakefulness, physical activity and respiration, hypothermia, and euphoria. Other CNS effects include irritability, confusion, anxiety, insomnia, tremors, convulsions, paranoia, and aggressiveness. Hypothermia and convulsions can lead to death.

Methamphetamine causes increases in heart rate and blood pressure that can cause irreversible damage to blood vessels in the brain, leading to strokes. Other physical effects of methamphetamine use include respiratory problems, irregular heartbeat, and extreme anorexia. Use can result in cardiovascular collapse and death.

More detailed information on the physical effects of these drugs, as well as other stimulant drugs, is available from the following NIDA publications/ Web sites:

- ◆ *NIDA Notes*, NIDA-Supported Scientists Identify Receptor Associated with Cocaine Abuse (NIH Publication Number 95-3478, 1995)
- ◆ *Research Report Series*, Methamphetamine Abuse and Addiction (NIH Publication No. 02-4210, reprinted January 2002)
- ◆ *NIDA Notes*, Methamphetamine Linked to Impaired Cognitive and Motor Skills Despite Recovery of Dopamine Transporters (NIH Publication Number 02-3478, April 2002)
- ◆ <http://www.drugabuse.gov/ResearchReports/Cocaine/Cocaine.html>
- ◆ <http://www.drugabuse.gov/ResearchReports/Methamphetamine.html>

The National Drug Intelligence Center, DEA, *National Drug Threat Assessment 2004*, documents notable differences in the ways cocaine and



methamphetamine products are manufactured and distributed. Most cocaine in the United States comes from Colombia, Peru, and Bolivia; it continues to be smuggled into the country overland from Mexico and by air and maritime via the Caribbean. Mexican criminal groups control the wholesale distribution; a wide range of different types of dealers distribute powder cocaine at the local retail level, often African-Americans or Hispanics. The conversion to crack most often occurs at the local level; the producers are usually African-American and Hispanic street gangs whose members also distribute the drug in all areas of the Nation (NDIC 2004).

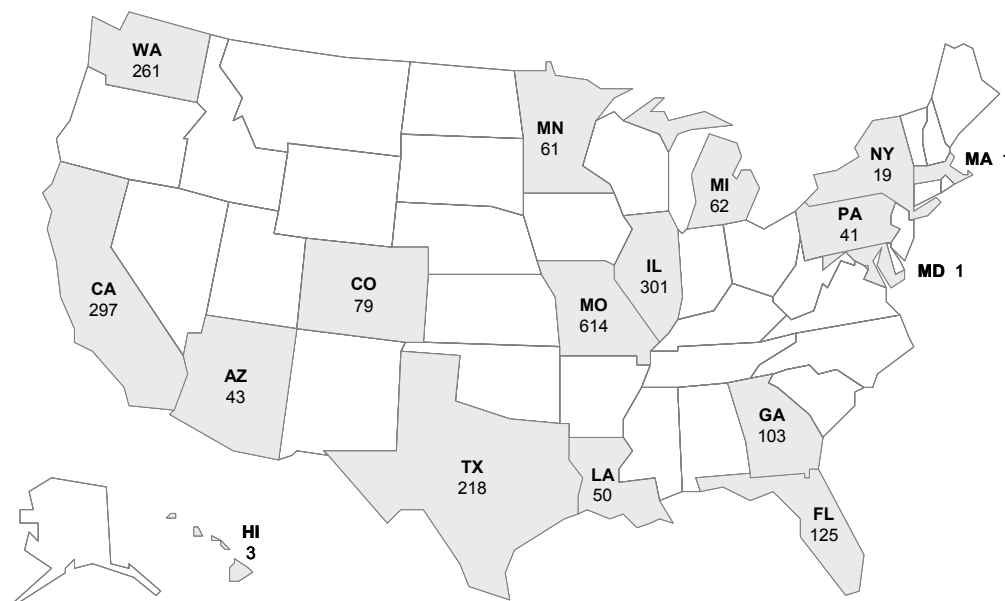
Methamphetamine comes from two major sources described below.

- ◆ The “**super labs**” are located in Mexico and California, and, increasingly, in other States. These labs are capable of producing 10–20 or more pounds per “cooking cycle.” Data generated by the National Clandestine Laboratory Seizure Database, El Paso Intelligence Center, show that 132 super labs were seized in 2003 (Logsdon 2005). These super labs had the capacity to produce 10–20+ pounds per cooking cycle, with 69 of these labs capable of producing more than 20 pounds. Of the 132 labs, 127 were located in California, 2 in Illinois, and 1 each in Missouri, Oregon, and Tennessee. The relatively pure form of methampheta-

mine produced by super labs accounts for most of the methamphetamine used in the United States (Hutchinson 2002), estimated at 80 percent (Houston 2005). Methamphetamine from the super labs is controlled and distributed primarily by Mexican drug trafficking organizations (DTOs) (NDIC 2004). Like the small clandestine laboratories, these super labs may be moving from more rural areas into the suburbs, as in Atlanta, where one was discovered in a suburban home in an otherwise “serene neighborhood” (Copeland 2005).

- ◆ The small **clandestine “mom and pop” laboratories** are located in many States across the Nation. These small labs use many recipes/ingredients and generally manufacture a relatively low grade of methamphetamine (NDIC 2004). Many are located in rural areas in various parts of the Nation; however, there are increasing reports of cooking methamphetamine in urban and suburban areas. There are reports of hotel rooms and apartments in Texas cities being used as methamphetamine labs (Agee 2004), of small labs operating in the Bronx, New York City, and of small labs in the more suburban areas of Nassau and Suffolk Counties in New York State (Schumer 2004). In 2004, EPIC reported seizures of 5,471 clandestine laboratories in 45 States; 2,279 (42 percent) were in 17 CEWG States (see exhibit 4).

**Exhibit 4. Number of Methamphetamine Laboratory Seizures in 17 CEWG States: 2004**



SOURCE: EPIC, DEA

The large-scale **Treatment Episode Data Set** (TEDS), maintained by OAS, SAMHSA, documents the high level of treatment demand for cocaine/crack abuse and the growing demand on State treatment systems associated with the escalating abuse of amphetamines (a category that includes methamphetamine). Data from the 2003 TEDS system on cocaine and amphetamines are shown in exhibit 5; the percentages exclude alcohol

admissions. Across 19 CEWG States (including the guest States of Maine and Ohio) and the District of Columbia, smoked cocaine (crack) accounted for the largest proportion of primary cocaine admissions in all but 2 States (Maine and Minnesota). Hawaii (56 percent) and California (39 percent) reported the highest proportions of amphetamine admissions, followed by Washington (27 percent), Colorado (24 percent), and Minnesota (21 percent).

**Exhibit 5. Percentages<sup>1</sup> of Primary Crack, Other Cocaine, and Amphetamine Treatment Admissions (Excluding Alcohol) in CEWG States<sup>2</sup>: 2003**

State	Smoked Cocaine (Crack)	Other Cocaine	Amphetamine <sup>3</sup>
California	12	3	39
Colorado	13	8	24
District of Columbia	23	12	.03
Florida	23	8	2
Georgia	27	11	13
Hawaii	6	1	56
Louisiana	34	7	4
Maine	5	6	1
Maryland	14	6	.03
Massachusetts	5	3	.03
Michigan	28	6	2
Minnesota	<.01	21	21
Missouri	27	4	16
New Jersey	9	5	.03
New York	20	9	.05
Ohio	24	4	.08
Pennsylvania	20	7	.07
Texas	24	12	12
Washington	12	4	27

<sup>1</sup>Percentages rounded.

<sup>2</sup>Excludes Arizona because of the high “unknown/other” cases (58 percent); includes the “guest” States of Maine and Ohio.

<sup>3</sup>Includes methamphetamine.

SOURCE: TEDS, OAS, SAMHSA

More detailed information on stimulant abuse in CEWG areas is presented in the next section, followed by recent data on cocaine and methamphetamine abuse in Mexico. This section con-

cludes with findings from methamphetamine studies presented by a panel of NIDA-supported researchers. *References* for this Overview are provided at the conclusion of this report.

## Stimulant Abuse: Issues and Findings from the CEWG

### Cocaine/Crack and Methamphetamine/Amphetamines

**Cocaine/crack and methamphetamine/amphetamines continue to be the most widely abused stimulants in CEWG areas. However, there are differences in the abuse of these drugs across CEWG areas, and differences in the populations that abuse them within and across CEWG areas.**

**High levels of cocaine/crack abuse were reported in the following CEWG areas...**

**Boston:** Cocaine/crack abuse indicators were stable at high levels, although the proportion of cocaine abusers admitted to treatment in 2004 continued to decline.—**Daniel Dooley**

**Miami/South Florida:** In 2003–2004, cocaine abuse remained stable at high levels, accounting for one-half or more of the drug-related deaths, medical emergencies, and drug treatment admissions.—**James Hall**

**Minneapolis/St. Paul:** In the Minneapolis/St. Paul metropolitan area, cocaine abuse indicators were stable in 2003, although the proportion of primary cocaine treatment admissions decreased slightly.—**Carol Falkowski**

**Seattle:** Cocaine continues to be a major drug of abuse in Seattle, with high levels of mortality.—**Caleb Banta-Green**

**Washington, DC:** Cocaine, particularly in the form of crack, remains the most serious drug of abuse in the District, accounting for more deaths, arrests, and emergency department cases than any other drug.—**Erin Artigiani**

**The magnitude of the cocaine/crack problem is not always apparent from primary indicator data. In many CEWG areas, cocaine/crack is often reported as a secondary drug, especially by primary heroin addicts entering treatment. Secondary cocaine abuse was reported in the following areas:**

**Baltimore:** Cocaine was reported as a secondary substance by 37 percent of treatment admissions in the first half of 2004, meaning that 51 percent of treatment admissions reported cocaine abuse as a primary or secondary problem.—**Leigh Henderson**

**Chicago:** Cocaine is commonly used by heroin abusers in Chicago. In an ongoing NIDA-funded study of non-injecting heroin users, age 16 to 30, 70 percent reported having used cocaine and 33 percent reported having used cocaine in the past 6 months. Crack cocaine use was reported by 68 percent of the study subjects, and 53 percent had used crack in the past 6 months. In the Family Process Study of young injection users (age 18–25), 86 percent had used powder cocaine, and 51 percent used in the past 12 months.—**Dita Broz**

**Detroit:** Cocaine was more likely than any other illicit drug to be reported as a secondary drug of abuse by clients being admitted to treatment. Twenty-six percent of treatment admissions in FY 2004 identified cocaine as their secondary drug of abuse.—**Carol Boyd**

**Minneapolis/St. Paul:** Relatively high percentages of primary heroin (38 percent), alcohol (30 percent), and marijuana (11 percent) treatment admissions in the first half of 2004 reported cocaine as their secondary or tertiary drug.—**Carol Falkowski**

**New York:** In the first half of 2004, 35 percent of the primary heroin abuse treatment admissions in city programs reportedly used cocaine as their secondary drug.—**Rozanne Marel**

**Several CEWG reports highlighted differences in the race/ethnicity representation in indicators pertaining to cocaine.**

**Atlanta:** *In the first 6 months of 2004, approximately three-quarters of the primary cocaine treatment admissions were African-American.—Brian Dew*

**New York:** *Normally, individuals who sell cocaine in the city do not sell other drugs. Street-level sales of cocaine for personal use are typically made in African-American and Hispanic low income neighborhoods.—Rozanne Marel*

**San Diego:** *Of the 2004 primary cocaine/crack treatment admissions to San Diego County facilities, 62 percent were African-American, a population group that represents only about 5 percent of the county population.—Michael Ann Haight*

**Seattle:** *African-Americans are involved in cocaine-related deaths at disproportionately high levels... 20 percent over a 7½-year period, although they represent only 5 percent of the King County population.—Caleb Banta-Green*

**Areas in which methamphetamine indicators remained high are...**

**Honolulu:** *Methamphetamine indicators were mixed (some up and some down) but very high. The numbers of methamphetamine-related deaths were higher in 2004, methamphetamine abuse treatment admissions were down a little [first half of 2004], and police cases were slightly lower in 2004.—D. William Wood*

**San Diego:** *Methamphetamine abuse indicators remained at high levels in 2004 after another peak in 2002. In 2004, primary methamphetamine treatment admissions represented about 54 percent of all illicit drug admissions in San Diego County, compared with nearly 53 percent in 2003. Treatment admissions peaked in 2002, when 6,365 clients were admitted to treatment for primary methamphetamine abuse. This compared to 6,303 methamphetamine admissions in 2003 and an estimated 6,376 in 2004.—Michael Ann Haight*

**San Francisco:** *Methamphetamine abuse indicators in the bay area remained relatively high. In the three-county bay area, medical examiner death mentions involving methamphetamine decreased in recent years. The proportion of amphetamine/methamphetamine admissions to treatment programs in San Francisco has remained relatively stable in the past 3 years; there was a slight increase from FY 2003 to 2004.—John Newmeyer*

**Seattle:** *Methamphetamine indicators appear to be plateauing. The proportion of King County treatment admissions involving methamphetamine increased slightly in the first half of 2004 to nearly 15 percent of illicit drug admissions. Deaths involving amphetamine/methamphetamine appear to have leveled off.—Caleb Banta-Green*

**Areas in which methamphetamine indicators increased include the following...**

**Atlanta:** *Methamphetamine abuse has recently emerged as a growing problem in Atlanta. During the 1-year period from October 2003 through September 2004, 27.2 percent of the items analyzed by forensic laboratories (NFLIS) in Atlanta contained methamphetamine. This was an increase over FY 2003 when 20.5 percent of the items tested positive for methamphetamine. Methamphetamine abuse treatment admissions also increased from 6.7 percent of illicit drug admissions in 2002, to 6.9 percent in 2003, to 10.6 percent in the first 6 months of 2004.—Brian Dew*

**Baltimore:** *Stimulants other than cocaine were rarely mentioned as the primary substance of abuse by treatment admissions. Nevertheless, the numbers, although small, increased from 42 admissions in 2000 to 73 in 2003; there were 41 admissions for the first half of 2004. The majority (63 percent) of the first-half 2004 admissions were for methamphetamine, and 29 percent were for amphetamine. Treatment admissions for stimulants increased from 2.0 per 100,000 in 2000 to 3.4 per 100,000 in 2003. Projections for 2004 suggest that the rate may reach 5.2 per 100,000 in 2004.—Leigh Henderson*

**Colorado:** Methamphetamine indicators have increased over the past few years. Treatment providers report that methamphetamine is the most popular drug of abuse and is frequently used in combination with alcohol, marijuana, and cocaine.—**Nancy Brace**

**Los Angeles:** The number and proportion of primary methamphetamine treatment admissions (excluding alcohol admissions) increased steadily over the past 4 years, from 10.0 percent in 2000 to 25.3 percent in the first half of 2004.—**Beth Finnerty**

**Minneapolis/St. Paul:** In 2004 (through June), patients addicted to methamphetamine accounted for an unprecedented 18.7 percent of treatment admissions (excluding alcohol admissions), compared with 14.8 percent in 2003, and only 6.6 percent in 2000. Since the beginning of 2004, most onsite, high school-based drug abuse counselors reported growing problems related to methamphetamine abuse by students.—**Carol Falkowski**

**New York:** Although the numbers remain small, methamphetamine indicators are showing an increase. Both New York City and Upstate areas have seen an increase in treatment admissions.—**Rozanne Marel**

**Phoenix:** Methamphetamine indicators have been increasing in Phoenix and the State. 'Ice' now dominates street sales, with purity levels ranging from 71 to 98 percent.—**Ilene Dode**

**Texas:** There were 144 calls to Texas poison control centers involving misuse or abuse of methamphetamine in 1998, 183 in 1999, 264 in 2000, 321 in 2001, 382 in 2002, 389 in 2003, and 109 in the first half of 2004. Of these 2004 calls, there were 38 mentions of 'ice' or 'crystal.' There were also 100 calls involving abuse or misuse of amphetamine pills, phentermine, or Adderall.—**Jane Maxwell**

**Several CEWG members compared methamphetamine indicators in CEWG metropolitan areas with nonmetropolitan areas within the State. While methamphetamine continues to be more prevalent in rural areas, there are clear indications of the availability and abuse of methamphetamine in some suburban and urban areas as well.**

**Arizona:** In Arizona during fiscal year 2002, methamphetamine accounted for nearly 21.4 percent of illicit drug treatment admissions, compared with more than 37.5 percent in 2004. Little variation existed between urban and rural areas.—**Ilene Dode**

**Atlanta:** Methamphetamine is an increasing threat in the suburban areas because of the drug's low price and ease of availability; as a consequence, it is replacing some traditional drugs as a less expensive, more potent alternative. Law enforcement officials report that methamphetamine has emerged as the primary drug threat in suburban communities neighboring Fulton and DeKalb Counties. Treatment data for the first 6 months of 2004 (excluding alcohol admissions), show that 10.6 percent of the publicly supported treatment admittees in metropolitan Atlanta reported methamphetamine as the primary drug of choice (compared with 6.7 and 6.9 percent in 2002 and 2003, respectively). In contrast, the proportion of primary methamphetamine admissions (excluding alcohol admissions) in nonmetropolitan Atlanta in 2003 was approximately 16 percent, the highest percentage ever reported; the nonmetropolitan admissions were more likely than metropolitan Atlanta admissions to smoke (53 vs. 45 percent) or inject (15 vs. 13 percent) methamphetamine.—**Brian Dew**

**Chicago:** While methamphetamine arrests increased across all regions of the State from 1997 (3 arrests) to 2003 (1,112 arrests), rural task force units experienced the greatest increase in such arrests (from zero to 514 arrests), followed by mixed urban/rural units (from 3 to 373 arrests), and mostly urban units (from zero to 225 arrests).—**Dita Broz**

**Colorado:** Treatment data in the first half of 2004 show that primary methamphetamine admissions were from both urban (61 percent) and rural (39 percent) areas of Colorado. Treatment providers stated they are seeing an increase in methamphetamine use in both rural and urban areas, and an increase in the social and community problems related to this use.—**Nancy Brace**

**New Orleans:** The DEA New Orleans Field Division reports that methamphetamine may be gaining popularity in some small towns and communities in the State. An increase in small clandestine methamphetamine labs in some rural areas has been reported. Across 9 Louisiana parishes, those with the highest numbers and percentages of primary methamphetamine admissions (excluding alcohol admissions) in 2004 included more rural parishes: Rapides (n=77, 4.3 percent), Ouachita (n=11, 3.2 percent), Bossier (n=14, 3.0 percent), and Calcasieu (n=24, 1.8 percent). Rapides Parish is located near the Texas border, through which most of the methamphetamine in Louisiana was transported. —**Gail Thornton-Collins**

**St. Louis:** St. Louis County law enforcement personnel continue to devote many resources to methamphetamine, and these labs in rural areas continued to be a problem. Methamphetamine is imported into St. Louis from Mexico or produced locally in the rural areas of the county and State... Thefts of anhydrous ammonia continued to be identified as an issue in rural areas. Methamphetamine, along with alcohol, remained a primary drug of abuse in both the outlying rural areas and statewide (most of Missouri, outside of St. Louis and Kansas City, is rural). Methamphetamine continued to be identified as a huge problem in rural communities. While the number of methamphetamine treatment admissions was still relatively low in St. Louis, in rural treatment programs, methamphetamine was the drug of choice after alcohol.—**Heidi Israel**

**Seattle:** NFLIS data indicate that methamphetamine is found in law enforcement seizures at a much lower level in the Seattle area compared with the rest of the State.—**Caleb Banta-Green**

**Washington, DC, Outlying Areas:** Outside the metropolitan Washington, DC, area, there are reports of methamphetamine use. Although extremely low, methamphetamine use is more prevalent in the rural western, eastern, and southern parts than in other parts of Maryland. From January 2003 to May 2004, law enforcement

officials report that there were eight methamphetamine labs seized in Maryland: three in Charles County, two in Garrett County, and one each in Cecil, Prince George's, and Washington Counties. In nearby Virginia areas, the Washington Post reported that nearly all of the methamphetamine seized in Virginia in 2004 was found in the Shenandoah Valley and that methamphetamine is the primary drug seized along the north-south corridor between Winchester and Harrisonburg. A special report on methamphetamine from the Washington/Baltimore HIDTA explains this trend further. The cities of Harrisonburg and Strasburg, in particular, are highlighted by law enforcement as having a substantial methamphetamine presence. According to law enforcement, the primary users in these areas are rural, White, working-class adults, while the sellers are primarily Latino.—**Erin Artigiani**

**The popularity of methamphetamine use among men who have sex with men (MSM) was reported in several CEWG areas, raising concern that the combination of methamphetamine use and associated sexual behaviors may increase risk for HIV transmission.**

**Chicago:** Ethnographic data suggest that methamphetamine availability has increased substantially since June 2001 among at least some networks of gay White men on the North Side who may use the drug to enhance sexual experiences.—**Dita Broz**

**New York City:** According to the Street Studies Unit, numerous sources in the gay community are concerned that the use of methamphetamine is spreading among young gay males that frequent clubs, and that the drug facilitates the spread of HIV. A number of gay male users have reported experiencing crystal methamphetamine binges during which they have engaged in unsafe sexual activity.—**Rozanne Marel**

**Philadelphia:** Key informants, for the first time, indicated a growing popularity of methamphetamine among men who have sex with men.—**Samuel Cutler**

**San Francisco:** Gay males remain a very prominent portion of the 'speed'-user population.—**John Newmeyer**

**Seattle:** *HIV among injection drug users (IDUs) is generally low, with the exception of methamphetamine-injecting MSM. In 2004, Public Health-Seattle & King County undertook a comprehensive review of local behavioral research studies and HIV/STD testing and reporting data to: 1) determine the current prevalence of methamphetamine use among MSM, 2) identify associations between MSM methamphetamine use and HIV, and 3) assess findings specific to methamphetamine injection. The study showed that roughly 1 out of 10 MSM has used methamphetamine at least once in the past year; recent use of methamphetamine may be up to two times higher (20 percent) among MSM younger than 30 than among older MSM; methamphetamine use is up to three times higher (about 30 percent) in MSM with HIV; and methamphetamine use is more prevalent among White MSM than MSM of color. Only about 2 percent (n=660–990) of all MSM had injected methamphetamine at least once in the past year, and injectors represent an estimated 11 percent of current MSM methamphetamine users. The risk profile of MSM is distinct from other injecting populations in terms of HIV prevalence, with nearly 30 percent HIV-infected among MSM amphetamine injectors, 10 percent in MSM heroin injectors, and 2 percent in non-MSM male heroin injectors. Public Health believes that the high HIV prevalence in MSM amphetamine injectors is probably related to sexual transmission rather than transmission via sharing of syringes or other drug injection equipment. (Note that ‘amphetamine’ was the term used in some data collection, but it is believed that the findings related directly to methamphetamine specifically.)—Caleb Banta-Green*

**Texas:** *Use of ‘crystal’ by young men having sex with men is increasing in Corpus Christi and surrounding counties.—Jane Maxwell*

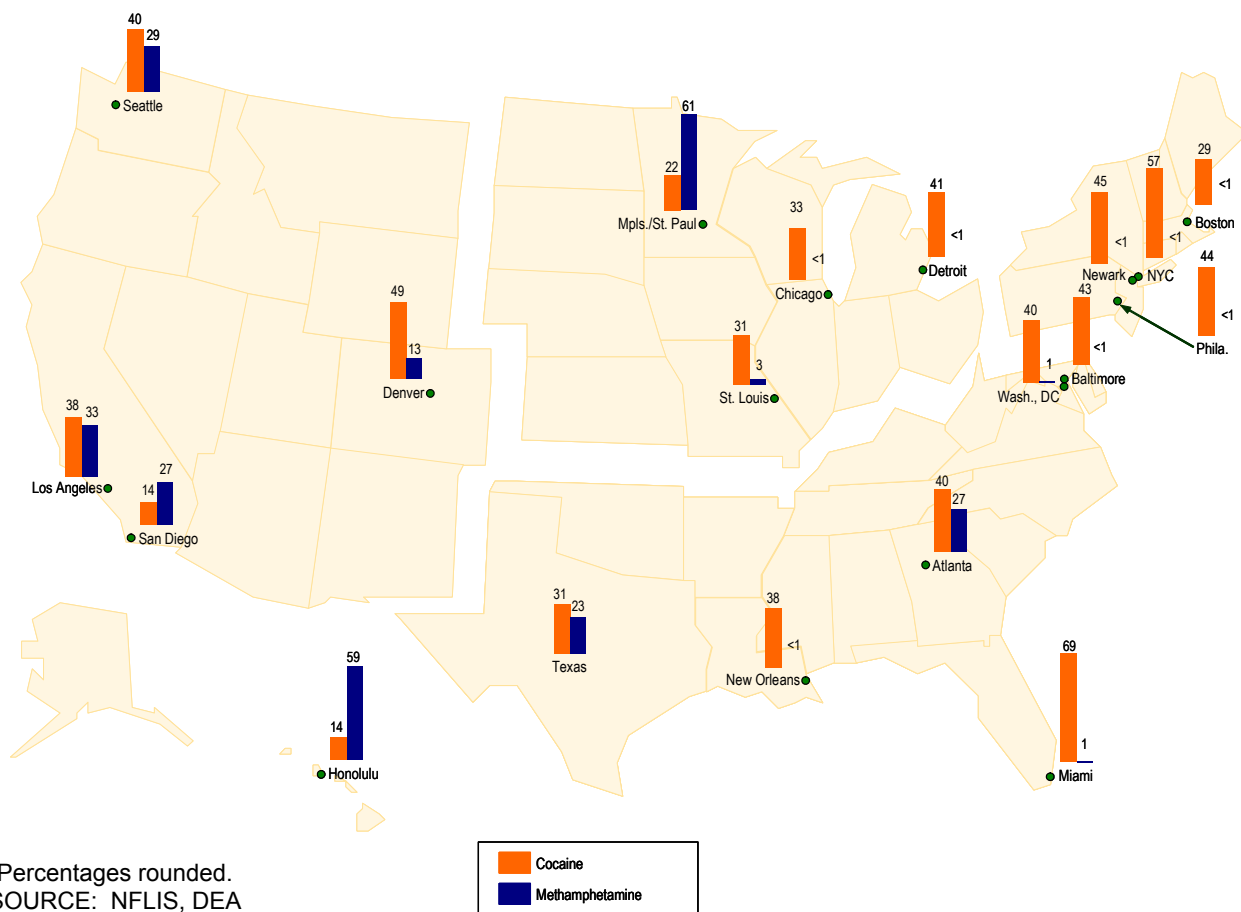
**Washington, DC:** *The Washington/Baltimore HIDTA reports that methamphetamine use is established in the homosexual community.—Erin Artigiani*

## Patterns and Trends in Cocaine/Crack and Methamphetamine/Amphetamine Abuse Across CEWG Areas

### ***NFLIS Data on Cocaine and Methamphetamine/Amphetamines***

Exhibit 1 depicts the percentages of cocaine and methamphetamine (MA) items analyzed and reported by forensic laboratories in 18 participating CEWG cities and the 13 combined Texas sites. While data cannot be compared across CEWG areas, the NFLIS geographic patterns show that the percentages of cocaine were “high” and those for MA were “low” in most eastern and midwestern areas, and those for MA were “high” in Honolulu, Los Angeles, and San Diego. Most striking in the NFLIS FY 2004 data are the high proportions of MA items reported in Minneapolis/St. Paul (61 percent) and Atlanta (27 percent), and the relatively low proportion in Denver (13 percent).

**Exhibit 1. Percentages<sup>1</sup> of Cocaine and Methamphetamine Items Analyzed by Forensic Laboratories in 19 CEWG Areas: FY 2004**



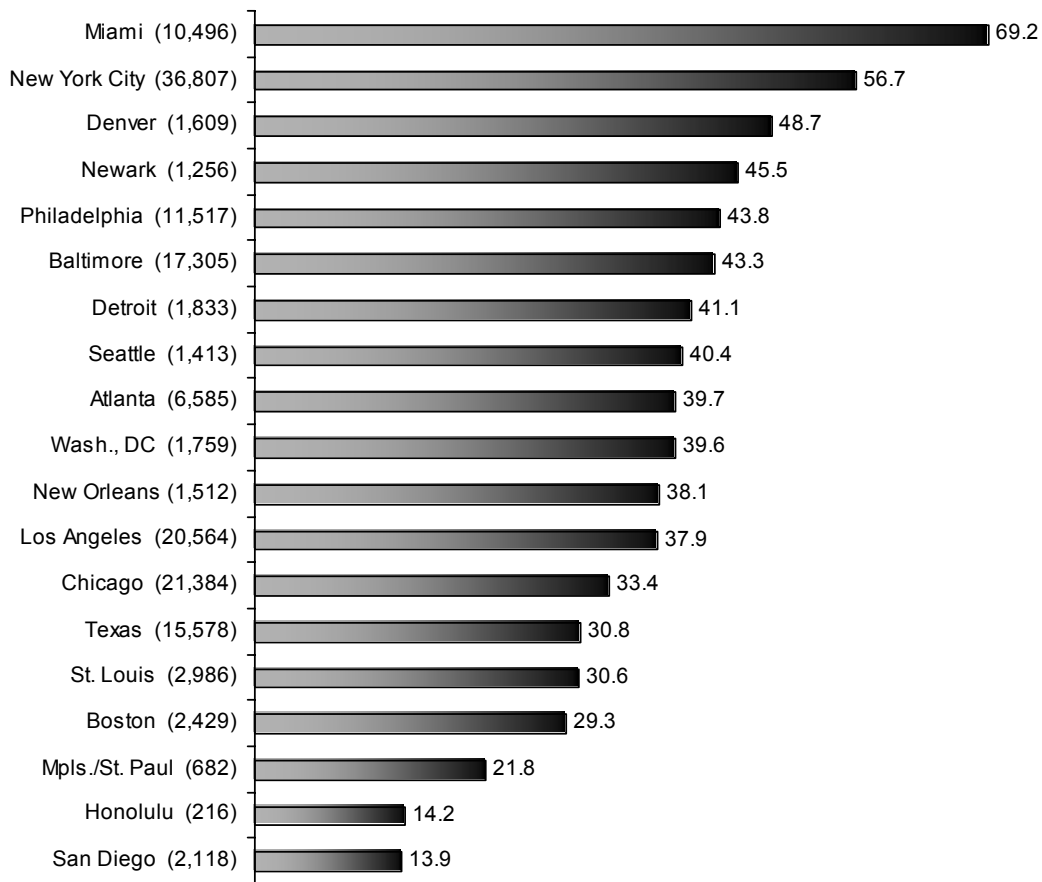
<sup>1</sup>Percentages rounded.  
SOURCE: NFLIS, DEA

**Cocaine.** Of the 19 areas depicted in exhibit 2, cocaine accounted for more than 40 percent of all drug items analyzed in FY 2004, with Miami

(69.2 percent) and New York City (56.7 percent) reporting very high proportions of cocaine items.



**Exhibit 2. Number of Cocaine Items Analyzed by Forensic Laboratories, Ordered by Percentage of Total Items in 19 CEWG Areas: FY 2004**

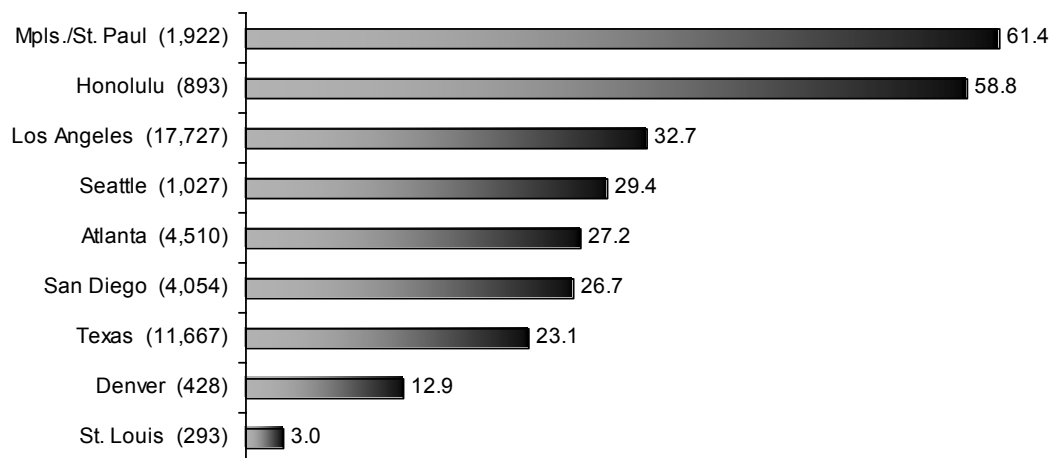


SOURCE: NFLIS, DEA

**Methamphetamine and amphetamines.** As shown in exhibit 3, methamphetamine accounted for large proportions of drug items analyzed in Minneapolis/St. Paul (61.4 percent) and Honolulu (58.8 percent) in FY 2004. In three west coast areas,

methamphetamine accounted for approximately 27 to 33 percent of the NFLIS items reported in FY 2004. More than one-quarter of the items analyzed in Atlanta were methamphetamine, as were 23 percent of those reported from 13 sites in Texas.

**Exhibit 3. Number of Methamphetamine Items Analyzed by Forensic Laboratories, Ordered by Percentage of Total Items in 9 CEWG Areas: FY 2004**



SOURCE: NFLIS, DEA

Not shown are eight CEWG areas where 1 percent or less of the items analyzed were methamphetamine. No methamphetamine items were reported from laboratories in Boston and Detroit.

Pseudoephedrine, used in the manufacture of methamphetamine, was reported by forensic labs in 5 CEWG areas: Newark ( $n=2$ , 0.07 percent), Minneapolis/St. Paul (4, 0.01 percent), Los Angeles (15, 0.03 percent), St. Louis (220, 2.25 percent), and Texas (540, 1.07 percent across 13 sites).

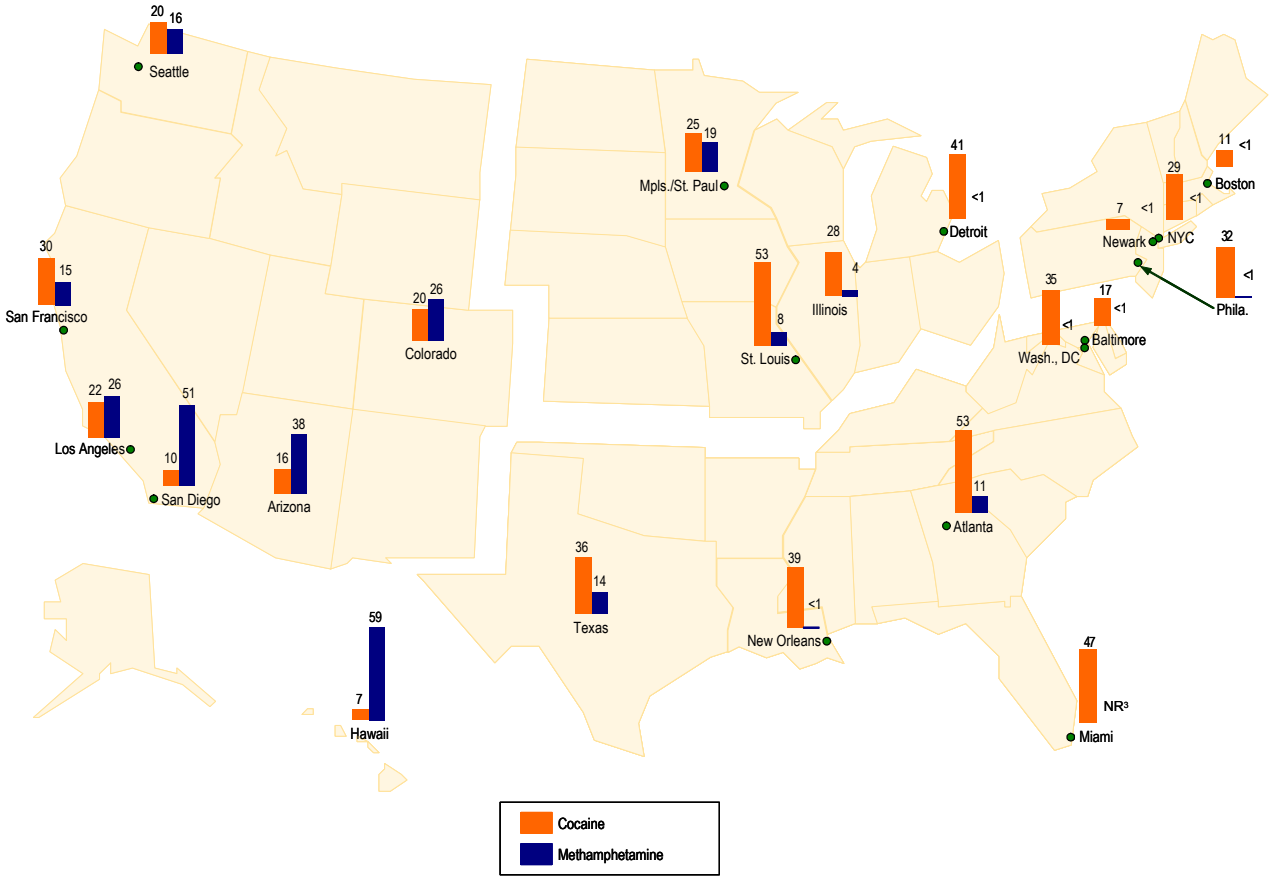
In FY 2004, small numbers of **amphetamine** items were reported by forensic labs in 14 CEWG areas, ranging from 2 in both Honolulu and New Orleans to 368 in the 13 Texas sites. In all cases,

amphetamine items accounted for less than 1 percent of all items analyzed.

***Treatment Data on Cocaine/Crack and Methamphetamine/Amphetamines***

Exhibit 4 on the following page depicts the percentages of primary cocaine and methamphetamine/amphetamine treatment admissions (excluding alcohol admissions) in CEWG areas in 2003–2004.

**Exhibit 4. Percentages<sup>1</sup> of Primary Cocaine and Methamphetamine/Amphetamine Treatment Admissions (Excluding Alcohol) in CEWG Areas: 2003–2004<sup>2</sup>**



<sup>1</sup>Percentages are rounded.

<sup>2</sup>Represents either calendar or fiscal year data for the first half of 2004 (n=12), all of 2004 (7), or 2003 (2); see *Data Sources*.

NR=Not reported; represents a sample of two Broward County programs.

SOURCE: January 2005 State and local reports

**Cocaine.** As can be seen in exhibit 5, high percentages of the primary cocaine abusers entering treatment in 2003–2004 were crack users (smoked the drug). The highest proportions were in Detroit and St. Louis (90 and 93 percent,

respectively), followed by Los Angeles and Hawaii (86 percent each). Trend data on admissions for primary cocaine abuse in CEWG areas from 2001 to 2004 are also depicted in exhibit 5.

**Exhibit 5. Primary Cocaine Treatment Admissions (Excluding Alcohol) by CEWG Area and Percent: 2001–2004<sup>1</sup>**

CEWG Area/State	Year				Percent Crack 2003–2004 <sup>2</sup>
	2001	2002	2003	2004	
Atlanta	68.1	60.8	57.6	53.2	75.2
Baltimore	15.1	15.7	15.5	16.9	79.1
Boston	16.0	15.0	12.7	11.3	60.0
Detroit	38.7	38.6	38.5	35.6	89.8
Los Angeles	22.9	23.3	23.0	22.3	86.4
Miami (sample)	NR <sup>3</sup>	45.3	32.0	47.3	NR
Mpls./St. Paul	26.6	27.2	26.3	24.7	81.9
New Orleans	40.0	42.7	43.1	38.9	NR
New York	29.3	28.5	28.9	29.1	60.9
Newark	7.0	6.8	6.6	7.4	78.4
Philadelphia	39.6	40.3	36.4	31.9	79.6
St. Louis	44.3	41.9	40.2	52.9	93.0
San Diego	12.1	10.2	9.6	10.4	82.0
San Francisco	24.1	24.0	25.9	29.7	85.0
Seattle	21.9	19.8	22.6	20.0	NR
Wash., DC	41.4	41.9	34.9	NR	66.2
Arizona	19.0	16.7	16.2	16.1	NR
Colorado	18.8	20.3	19.3	20.4	63.0
Hawaii	8.0	8.5	6.3	6.6	85.7
Illinois	31.6	30.0	28.0	NR	85.0
Texas	38.9	38.7	38.2	36.3	69.5

<sup>1</sup>Represents either calendar or fiscal year data for the first half of 2004 (n=12), all of 2004 (7), or 2003 (2); see *Data Sources*.

<sup>2</sup>Represents the percentage of primary cocaine admissions who reported smoking the drug.

<sup>3</sup>NR=Not reported.

SOURCES: CEWG June 2004 reports on State and local data

Excluding the Miami sample, which is not comparable across years, the proportions of primary cocaine abusers remained relatively stable, with the exception of St. Louis where cocaine admissions peaked to nearly 53 percent of illicit drug admissions in the first half of 2004.

**Methamphetamine and amphetamines.** Treatment programs in CEWG areas do not always classify and/or report methamphetamine and amphetamines in the same way. The three exhibits below present the data for 12 CEWG areas where primary

methamphetamine and/or amphetamine admissions exceeded 1 percent of illicit drug admissions in 2001–2004.

Exhibit 6a shows the proportions of primary methamphetamine treatment admissions (excluding alcohol admissions) in nine CEWG areas from 2001 to 2004 reporting periods. As shown, the proportions of primary MA admissions remained relatively stable in San Diego and Seattle but increased in the other seven areas, with the increase between 2001 and 2004 being greatest in Arizona (nearly 18 percentage points).

**Exhibit 6a. Primary Methamphetamine Treatment Admissions (Excluding Alcohol) in 9 CEWG Areas, by Percent: 2001–2004<sup>1</sup>**

CEWG Area	2001	2002	2003	2004	Percentage-Point Change: 2001–2004
Atlanta	2.5	6.7	6.9	10.6	8.1
Los Angeles	14.3	18.5	23.0	25.3	3.7
Mpls./St. Paul	10.6	11.1	14.8	18.7	8.1
St. Louis	4.5	5.5	5.9	8.2	3.7
San Diego	47.3	49.7	52.8	50.6	3.3
Seattle	14.7	14.9	13.1	14.8	0.1
Arizona	19.9	21.4	24.1	37.5	17.6
Colorado	16.5	19.2	23.3	25.7	9.2
Hawaii	49.0	52.1	56.3	58.6	9.6

<sup>1</sup>Represents either fiscal or calendar year data; Arizona and Colorado represent full year FY 2004 data; San Diego represents annualized full year CY 2004 data; all others represent the first half of 2004.

SOURCE: January 2005 local and State CEWG reports

Exhibit 6b shows trend data for three CEWG areas where primary methamphetamine treatment

admissions are included in the category of “Amphetamines” and/or “Stimulants.”

**Exhibit 6b. Primary Stimulant<sup>1</sup> Treatment Admissions (Excluding Alcohol) in 3 CEWG Areas, by Percent: 2001–2004<sup>2</sup>**

CEWG Area	2001	2002	2003	2004
Illinois <sup>2</sup>	3.8	3.7	3.7	NR
San Francisco	12.1	12.0	13.6	14.5
Texas	9.5	10.1	12.1	13.6

<sup>1</sup>Represents either fiscal or calendar year data; San Francisco represents full year FY 2004 data; Texas represents the first half of 2004.

<sup>2</sup>Variously categorized by site as “Stimulants” or “Methamphetamine/Amphetamines”; data were not reported (NR) in 2004 for Illinois.

SOURCE: January 2005 local and State CEWG reports

Exhibit 6c presents the trends from eight CEWG members who reported primary amphetamine admissions as well as primary methamphetamine data from 2001 to 2003 or 2004. As shown, the

proportions of primary amphetamine admissions (excluding alcohol admissions) were quite low, ranging from zero to 1.1 percent.

**Exhibit 6c. Primary Amphetamine Treatment Admissions (Excluding Alcohol) in 8 CEWG Areas, by Percent: 2001–2004<sup>1</sup>**

<b>CEWG Area</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Los Angeles	0.70	0.50	0.60	0.60
St. Louis	0.02	0.02	0.02	0.03
San Diego	0.60	0.60	0.50	NR <sup>2</sup>
Seattle	1.40	0.90	0.60	1.1
Arizona	1.80	1.90	0.70	NR
Colorado	0.90	1.00	0.70	0.40
Hawaii	NR	NR	0.40	0.00

<sup>1</sup>Represents either fiscal or calendar year data; San Diego (annualized) Arizona, and Colorado represent full year FY 2004 data; all others represent the first half of 2004.

<sup>2</sup>NR=Not reported.

SOURCE: January 2005 local and State CEWG reports

***Methamphetamine  
Clandestine Lab Incidents  
and Super Laboratory  
Seizures***

***Clandestine labs.*** As shown in exhibit 7, the numbers of clandestine methamphetamine laboratory incidents reported to the National Clandestine Laboratory Seizure Database decreased in California and Arizona from 1999 to 2004, as reported by EPIC, DEA. They also decreased in Washington State from 2001 to 2004. During this same period, methamphetamine lab incidents increased in midwestern States (Illinois, Michigan, Missouri, and Ohio) and in Pennsylvania. Surprisingly, in 2004, more lab

incidents were reported in Missouri (2,707) and Illinois (926) than in California (673). In 2003, methamphetamine lab incidents reached new highs in Georgia (250), Minnesota (309), Missouri (2,885), and Texas (677). There were only seven methamphetamine lab incidents reported in Hawaii in 2004.

Note that there are limitations to clandestine methamphetamine lab incident data. For example, the numbers of methamphetamine lab incidents reported in a given year depend largely on the resources available and committed by State and local law enforcement agencies in that year. Most of the methamphetamine that has been available in the Nation for the past 10 years or more has been produced in “super labs.”

**Exhibit 7. Number of Methamphetamine Clandestine Lab Incidents,<sup>1</sup> by State: 1999–2004**

<b>State</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Arizona	380	384	312	253	140	95
California	2,579	2,198	1,883	1,743	1,287	673
Colorado	104	142	240	450	352	223
Florida	23	15	35	157	240	277
Georgia	27	54	59	127	250	233
Hawaii	8	5	3	10	3	7
Illinois	124	127	319	552	751	926
Louisiana	8	15	16	133	94	113
Massachusetts	0	0	1	0	1	0
Maine	0	0	1	0	1	1
Maryland	1	2	0	1	2	1
Michigan	10	21	122	225	267	282
Minnesota	100	123	154	250	309	165
Missouri	439	889	2,180	2,767	2,885	2,707
New York	1	2	8	26	18	28
Ohio	14	29	89	97	124	211
Pennsylvania	1	8	17	30	62	106
Texas	177	429	619	547	677	434
Washington	599	944	1,480	1,443	1,011	743
<b>Totals</b>	<b>4,156</b>	<b>4,498</b>	<b>5,358</b>	<b>6,044</b>	<b>5,589</b>	<b>4,518</b>

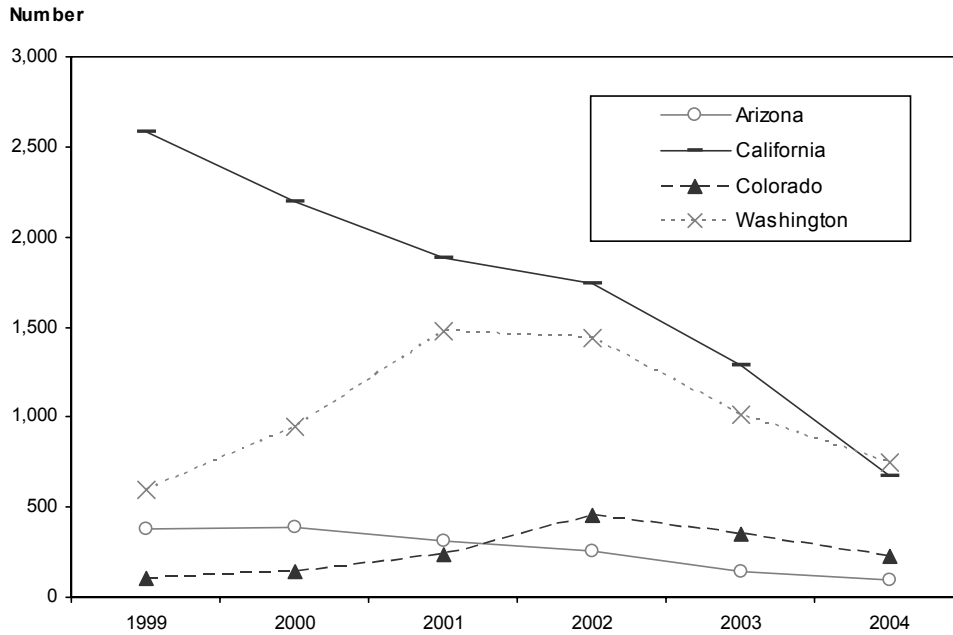
<sup>1</sup>Includes labs, dumpsites, chemicals/glass/equipment.

SOURCE: EPIC, National Clandestine Laboratory Seizure Database, EPIC, DEA

States where methamphetamine clandestine lab seizures have been trending downward are

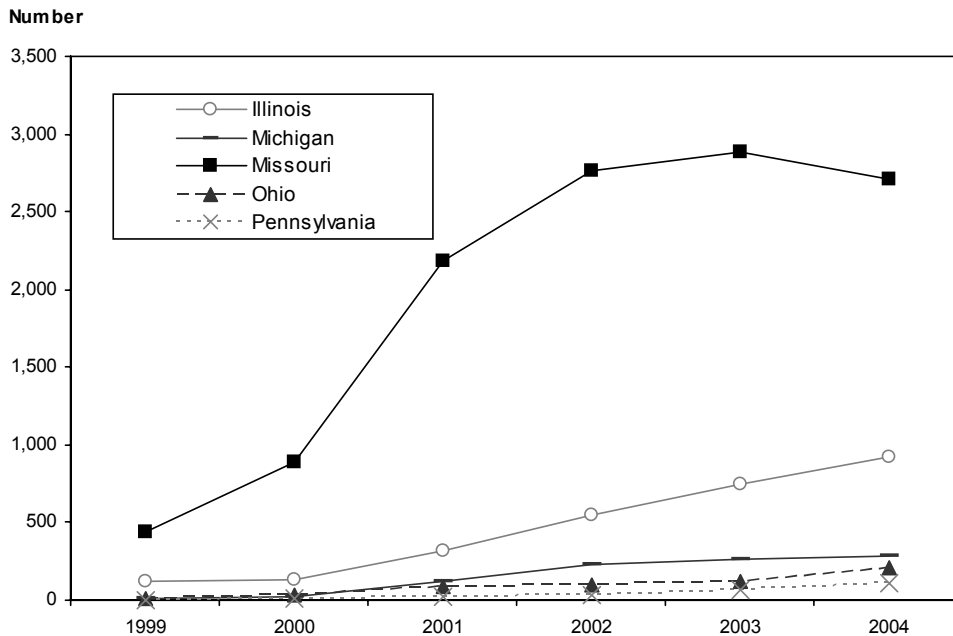
depicted in exhibit 8a. States where the seizures have been trending upward are shown in exhibit 8b.

**Exhibit 8a. States in Which the Numbers of Methamphetamine Clandestine Lab Incidents Have Trended Downward: 1999–2004**



SOURCE: National Clandestine Laboratory Seizure Database, EPIC, DEA

**Exhibit 8b. States in Which the Numbers of Methamphetamine Clandestine Lab Incidents Have Trended Upward: 1999–2004**



SOURCE: National Clandestine Laboratory Seizure Database, EPIC, DEA

**Super labs.** Most of the methamphetamine super labs seized in 2003 and the first half of 2004 were in California (127 and 21, respectively) (see exhibit

9a). In comparison, only six labs were seized in all of the other States combined in 2003 and eight in the first half of 2004 (see exhibit 9b).



**Exhibit 9a. Number of Super Lab Seizures by Area: 2003**

State	Production Levels in Pounds		Total
	10–20	Over 20	
California	58	69	127
Illinois	2	–	2
Missouri	1	–	1
Oregon	1	–	1
Tennessee	1	–	1
<b>Total</b>	<b>63</b>	<b>69</b>	<b>132</b>

SOURCE: National Clandestine Laboratory Seizure Database, EPIC, DEA

**Exhibit 9b. Number of Super Lab Seizures by Area: January–June 2004**

State	Production Levels in Pounds		Total
	10–20	Over 20	
California	12	9	21
Oregon	2	1	3
South Carolina	–	1	1
Texas	2	–	2
Washington	1	–	1
Wisconsin	1	–	1
<b>Total</b>	<b>18</b>	<b>11</b>	<b>29</b>

SOURCE: National Clandestine Laboratory Seizure Database, EPIC, DEA

### **Prices of Cocaine/Crack and Methamphetamine**

**Cocaine/Crack.** The price of powder cocaine varies across CEWG areas. The upper limits for a gram are typically \$100–\$125, but a gram may cost as little as \$9 in Newark to \$40 in San Francisco. A “rock” of crack is relatively inexpensive in Atlanta, New York, and Philadelphia, ranging between \$3 and \$7 in the lower price range. A more typical price is \$10 or \$20 per rock. Excerpts from the CEWG reports detail the variations in prices of different quantities of powder cocaine and crack, with some providing information on purity levels.

**Atlanta:** According to HIDTA and NDIC, prices remain relatively stable in Atlanta. Powdered cocaine typically sells for \$75–\$100 per gram. Crack rocks sell for as little as \$3.—**Brian Dew**

**Baltimore:** Prices for powdered cocaine for the second half of 2004 were reported as \$20,000–\$32,000 per kilogram at the wholesale level; \$600–\$1,200 per ounce at midlevel; and \$40–\$200 per gram at the retail level. Prices for crack cocaine were reported as \$20,000–\$26,000 per kilogram at the wholesale level; \$600–\$1,200 per ounce at midlevel; and \$40–\$200 per gram at the retail level. For powder cocaine, the price range at the wholesale kilogram level was unchanged from the second half of 2003, while the lower limit for an ounce was higher and the lower limit for a retail-level gram was lower.—**Leigh Henderson**

**Boston:** The DEA reports that street cocaine costs \$50–\$90 per gram in Boston. A rock of crack costs \$10–\$20. Cocaine purity has been decreasing, but availability is ‘steady’ throughout Massachusetts, ‘especially in inner cities.’—**Daniel Dooley**

**Chicago:** Ounce prices for powder cocaine were reported by street sources to be between \$400 and \$800, depending on the drug’s quality and the

buyer's relationship to the seller. Gram prices for powder and rock cocaine ranged from \$50 to \$150, with most reports around \$75. Ounce prices of crack cocaine ranged from \$900 to \$1,600.—**Dita Broz**

**Denver:** In the third quarter of Federal fiscal year 2003 and in the second quarter of 2004, powder cocaine sold for \$16,000–\$19,000 per kilogram and \$700–\$1,000 per ounce in the Denver metropolitan area. Crack cocaine prices have remained relatively stable at \$650–\$1,000 per ounce, while 'rock' prices on the street are \$20–\$50 in Denver. Prices are slightly higher outside of the Denver metropolitan area. Overall, Colorado has seen a decrease in the wholesale price of powder cocaine because these users have switched to methamphetamine.—**Nancy Brace**

**Detroit:** In 2004, cocaine generally sold for \$100 per gram, \$20 per rock, \$750–\$1,500 per ounce, and \$17,000–\$26,000 per kilogram.—**Carol Boyd**

**Honolulu:** According to the Honolulu Police Department, cocaine prices have remained relatively stable over the past several years. A quarter gram of crack currently sells for \$25–\$30, and the same amount of cocaine powder costs \$25–\$35.—**D. William Wood**

**Los Angeles:** Los Angeles remains one of the primary markets for cocaine (in addition to Houston, Chicago, New York, Atlanta, and Miami). Current midlevel prices of crack cocaine remained level at \$500–\$1,200 per ounce, as did the retail price range (\$10–\$40 per rock). The current wholesale price for 1 kilogram of powder cocaine ranges from \$14,000 to \$17,000, which is identical to the wholesale price cited in the past few CEWG reports. The current midlevel and retail prices of powder cocaine remained stable as well, at \$500–\$600 per ounce and \$80 per gram. The purity of powder cocaine is approximately 78 percent, similar to the purity cited in the last few CEWG reports.—**Beth Finnerty**

**Miami:** According to the National Drug Intelligence Center, in South Florida powder cocaine sells for \$18,000–\$26,000 per kilogram wholesale, \$700–\$800 per ounce, and \$40–\$110 per gram retail. Crack cocaine sells for \$700–\$800 per ounce, \$100 per gram, and \$10–\$20 per 'rock' in South Florida.—**James Hall**

**Minneapolis:** Cocaine generally sold for \$100 per gram, \$200 per 'eight-ball' (one-eighth ounce), \$700–\$800 per ounce, and \$22,000 per kilogram. The price of a rock of crack was \$15–\$25. Upward variations in price were attributed to higher purity products.—**Carol Falkowski**

**New Orleans:** Cocaine hydrochloride (HCl) is commonly sold in quarter, half, and 1 ounce quantities. Prices range from \$800 to \$1,600 per ounce and approximately \$18,000 to \$21,000 per kilogram. When cut/mixed with adulterants and less potent, cocaine HCl can be bought at low prices at the street level. Crack has been available at \$10–\$20 per rock and can be purchased on the street for \$650–\$950 per ounce.—**Gail Thornton-Collins**

**New York:** Cocaine prices can fluctuate because of sellers varying the purity of the product and offering several different size packages. Typically, cocaine is sold in \$20, \$30, and \$50 packages. The most common price on the street is the \$20 packet, which contains approximately 0.25 ounces of cocaine powder. While most users interviewed reported that the quality of the cocaine currently available remains high, they also indicate that a number of sellers are attempting to extend their product by adulterating it with mannitol, baking soda, or Diamond Crystal salt. Field researchers report that street-level crack in New York City continues to be sold in \$5 and \$10 packages. The most common price/package combination is the \$10 packet. Two years ago, there was a substantial decline in the number of selling locations offering crack in \$5 amounts. During that period, there was an attempt to make the \$20 (2-milligram) package the industry standard. The larger package would have reduced the number of total sales for a seller in a day and would have limited his exposure to arrest. The DEA reports that prices for cocaine powder for July to December 2003 were \$22,000–\$26,000 per kilogram and \$800–\$1,600 per ounce; crack sells for about \$28,000–\$30,000 per kilogram, \$800–\$1,600 per ounce, \$27–\$45 per gram, and \$7–\$10 per rock.—**Rozanne Marel**

**Newark:** Between July and December 2004, the retail price for powder cocaine in Newark was \$9–\$100 per gram; crack sold for \$20–\$100 per gram.—**Allison Gertel-Rosenberg**

**Philadelphia:** The predominant form of crack sold in Philadelphia is the 'rock,' which costs \$5. The \$5 rock ranged in size from 6 to 9 millimeters from 1996 until 2002. Since then, the size of the

\$5 rock was reduced to 5–6 millimeters. Treys (\$3 rocks) ranged in size from 3 to 5 millimeters since 1996, but they were reduced to 3 to 4 millimeters from the latter half of 2002 through the autumn of 2004. Shapes of crack range from circular, to bumpy-circular, to pieces cut into the shape of a parallelogram. Powder cocaine is not as readily available in small (\$5) quantities, but \$10 and especially \$20 bags are quite common. According to the National Drug Intelligence Center, the retail/street-level price per ounce of crack ranged from \$3 to \$20 per rock and from \$28 to \$125 per gram of powder cocaine in the first half of 2004. —**Samuel Cutler**

**Phoenix:** In Phoenix, the price of an ounce of cocaine dropped from \$500–\$800 to \$450–\$650. The price for a kilogram dipped slightly from \$15,000–\$16,500 to \$13,000–\$15,000. Crack cocaine continues to be readily available in the Phoenix metropolitan area. A rock continues to sell for \$20. The National Drug Intelligence Center reported a wholesale price of \$7,500 for a pound.—**Ilene Dode**

**St. Louis:** Cocaine is used and most available in the urban areas. Powder cocaine grams sold for \$100–\$125; purity averaged 70 percent. Crack prices remain at \$20 per rock on the street corner. —**Heidi Israel**

**San Francisco:** According to the NDIC, local prices for powder cocaine in 2004 were \$16,000–\$21,000 per kilogram, \$530–\$800 per ounce, and as low as \$10 per quarter gram. Crack prices were around \$600 per ounce and \$20–\$50 per ‘rock.’ These prices were up slightly from 2002. —**John Newmeyer**

**Texas:** A gram of powder cocaine costs \$50–\$80 in Dallas, \$50–\$60 in El Paso, and \$100 in Amarillo and Lubbock. Cocaine is less expensive at the border. An ounce in Laredo costs \$400–\$500, \$500–\$600 in El Paso, \$400–\$650 in Houston, \$650–\$950 in Dallas, \$600 in Alpine, \$700–\$900 in Midland, \$400–\$600 in McAllen, \$500–\$700 in San Antonio, \$500–\$600 in Austin, \$500–\$900 in Waco, \$650–\$850 in Amarillo, \$500–\$850 in Lubbock, \$300–\$750 in Tyler, and \$600–\$750 in Fort Worth. Across the State, a rock of crack costs between \$10 and \$50, with \$10–\$20 being the most common price. An ounce of crack cocaine costs \$325–\$450 in Houston, \$500 in Galveston, \$500–\$600 in Austin, \$500–\$700 in Waco, \$700–\$1,100 in Dallas, \$450–\$550 in Tyler, \$500–\$800 in Beaumont, \$450–\$850 in Amarillo and Lubbock, \$400–\$600 in San Antonio, \$830 in

El Paso, \$700–\$900 in Midland, \$500 in McAllen, and \$650–\$750 in Fort Worth.—**Jane Maxwell**

**Washington, DC:** The National Drug Intelligence Center reported that powder cocaine sold for \$27,500 to \$28,000 per kilogram and \$60 to \$100 per gram during the first 6 months of 2004. Crack sold for slightly more: \$28,000 to \$34,000 per kilogram and \$80 to \$100 per gram. —**Erin Artigiani**

**Methamphetamine.** Fourteen CEWG members reported prices for methamphetamine in their areas. Prices varied across areas, as detailed in the quotes below. Crystal methamphetamine (ice) was the most expensive form, but prices also varied by purity and availability, as in Hawaii. Typically, a gram of methamphetamine sold for between \$70 and \$125 per gram, although a gram might be purchased for as little as \$20 in Newark.

**Atlanta:** According to the DEA and HIDTA, methamphetamine popularity continues to rise, in part because of its low price and availability. In July of 2004, methamphetamine typically sold for \$110 per gram, \$1,316 per ounce, and \$8,250 per pound.—**Brian Dew**

**Boston:** The DEA’s most recent data show that methamphetamine costs \$250 per gram and is available ‘in limited (user-level) quantities’ in New England.—**Daniel Dooley**

**Chicago:** Methamphetamine prices have not changed since June 2003, when it was reported that bags of methamphetamine sold for \$20. Most drug users reported that the drug remained difficult to obtain.—**Dita Broz**

**Denver:** A cocaine and methamphetamine trafficking organization has been transporting drugs from Phoenix to Denver. Methamphetamine from this organization has purity levels of 95 percent. An organization on the western slope employs a number of drivers who transport anywhere from 2 to 10 pounds from Sinaloa, Mexico, or California. It can be obtained for \$500–\$1,500 per ounce, \$5,500–\$5,600 per one-half pound, and \$13,500 per pound in the Denver area. In southern Colorado, prices are \$600 per ounce and \$13,000 per pound. On the western slope, it sells for \$1,000–\$1,200 per ounce. Purity ranges from 11 to 92 percent. In Denver, ‘ice,’ a smokable form of methamphetamine that looks like rock candy or rock salt, is nearly 100 percent pure and widely available. Street prices for methamphetamine in

Denver are relatively stable at \$80–\$125 per gram.—**Nancy Brace**

**Detroit:** Methamphetamine prices are relatively high in Detroit and can be contrasted to the price of cocaine, which is much lower. In 2004, methamphetamine generally sold for \$175 per gram and \$1,200 per ounce.—**Carol Boyd**

**Honolulu:** Methamphetamine remains the drug of choice in the island chain. Analysis of confiscated methamphetamine reveals that the product is still a high-quality d-methamphetamine hydrochloride in the 90–100-percent purity range, which makes it ideal for smoking, the route of administration of choice. Crystal methamphetamine prices remained stable in 2004. The drug is sold in the islands as ‘clear’ (a clear, white form) or ‘wash’ (a brownish, less processed form). Prices for ice vary widely according to these two categories and availability, as illustrated by prices on O’ahu: \$50 (wash) or \$75 (clear) per 0.25 gram; \$200–\$300 (wash) or \$600–\$900 (clear) per gram; \$450–\$600 (wash) or \$1,000–\$2,000 (clear) per one-quarter ounce; \$2,200–\$3,000 (wash) per ounce.—**D. William Wood**

**Los Angeles:** The wholesale price per pound of methamphetamine ranged from \$5,000 to \$7,000, which is similar to the range reported in June 2004, but higher than the wholesale price reported in 2002–2003 (\$3,700 to \$5,000). The midlevel and retail prices are \$450–\$550 per ounce, \$20 per one-quarter gram, \$40–\$100 per gram, \$60 per one-sixteenth ounce (‘teener’), and \$100–\$120 per one-eighth ounce. According to one intelligence source, the purity of finished methamphetamine available in the Los Angeles area remains at approximately 30–35 percent. Crystal methamphetamine has a wholesale price of \$8,000–\$11,000 per pound in Los Angeles. The midlevel price for an ounce of crystal methamphetamine is \$600–\$800. A double case of pseudoephedrine (60-milligram tablets/17,000 tablets per case) sells for \$3,250–\$4,000.—**Beth Finnerty**

**Miami:** In South Florida, methamphetamine sells for some of the highest prices in the Nation—\$15,000 to \$20,000 per pound and \$900 to \$1,200

per ounce. Higher potency crystal methamphetamine sells for \$1,800 to \$2,000 per ounce and \$50 per one-quarter gram.—**James Hall**

**Minneapolis:** Methamphetamine prices were as low as \$70 per gram, \$600 per ounce, and \$6,000 per pound. ‘Glass,’ or ‘ice,’ the high-purity form that is smoked, typically costs twice as much.—**Carol Falkowski**

**New Orleans:** Prices for methamphetamine increased in the second half of 2003 and averaged \$100 per gram, \$1,400–\$1,600 per ounce, and \$20,000 per pound.—**Gail Thornton-Collins**

**Newark:** Methamphetamine previously sold for \$8,500 to \$20,000 per kilogram and \$800 to \$1,000 per ounce. Between July and December 2004, methamphetamine sold for between \$15,000 and \$25,000 per kilogram and \$800 to \$1,500 per ounce. On the retail level, methamphetamine sold for between \$20 and \$180 per gram.—**Allison Gertel-Rosenberg**

**St. Louis:** Methamphetamine sold for \$700–\$1,300 per ounce in St. Louis and for as little as \$100–\$120 per gram in some areas, a slight increase in price over the past year.—**Heidi Israel**

**San Francisco:** According to the NDIC, in 2004 pounds of crystal methamphetamine sold in the \$10,000–\$13,000 range, ounces in the \$600–\$1,500 range, and grams in the \$80–\$100 range.—**John Newmeyer**

**Texas:** The price for a pound of methamphetamine was \$8,000 in Houston 6 months ago; now it is \$7,000, and in Laredo, it has dropped from \$4,500–\$5,500 to \$2,500. An ounce of domestic methamphetamine sells for \$600–\$800 in Dallas (it was \$700–\$1,000 6 months ago), while an ounce of Mexican sells for \$400. The price of ice has dropped even more, from \$13,000–\$17,000 down to \$8,000–\$12,000 in Houston. It now costs \$8,500–\$16,000 in Dallas.—**Jane Maxwell**

**Washington, DC:** The NDIC reported that methamphetamine sold for \$4,800 per one-half pound and 8-balls sold for \$400 during the first 6 months of 2004.—**Erin Artigiani**

## MDMA (Ecstasy)

**Methylenedioxymethamphetamine (MDMA or ecstasy) abuse indicators tended to be low across CEWG areas. Indicators decreased in six CEWG areas, and school surveys in 2004 showed MDMA use among students decreasing in two additional areas (Minnesota and Texas). Two other school surveys (Florida and New Orleans), conducted in 2003, showed MDMA use at relatively high levels. Indicators increased in minority populations in four areas, and remained stable in three (Atlanta, Denver, and Phoenix). There was insufficient MDMA indicator data to draw any conclusions regarding changes in MDMA patterns or trends in eight areas (Baltimore, Detroit, Honolulu, Los Angeles, Newark, New Orleans, San Diego, and San Francisco).**

### Areas in which MDMA abuse indicators decreased included...

**Boston:** MDMA indicators are at relatively low levels, with some decreasing. The number of items identified as MDMA by police forensic labs peaked at 106 in 2000 and dropped in 2003 to 56 (less than 1 percent of the 9,219 samples analyzed). The number of Helpline MDMA calls decreased 44 percent from FY 2000 to FY 2004.—**Daniel Dooley**

**Miami:** MDMA's popularity appears to be declining in Miami, Dade County, and the State of Florida. Indicators suggest that MDMA abuse in Miami and Dade County peaked in 2001. In the State, there were 12 MDMA-related and 13 MDA-related deaths reported in the first half of 2004, compared with 23 MDMA-related deaths and 12 MDA-related deaths in the first half of 2003.—**James Hall**

**Minnesota:** MDMA abuse declined markedly among metropolitan students in 2004, according to Minnesota Student Survey findings. It was reported that 4.5 percent of high school seniors had used MDMA in the past year, compared with 9.1 percent in 2001.—**Carol Falkowski**

**St. Louis:** While MDMA remained available at dance parties and was relatively inexpensive (\$20 to \$30 per tablet), the popularity of the drug seems to be declining. Public treatment programs reported no admissions of MDMA abusers in FY 2003. It was also reported that MDMA was involved in less than 10 percent of the drug abuse histories of polydrug abusers admitted to private treatment programs.—**Heidi Israel**

**Texas:** Between 1990 and 2004, the proportion of White treatment admissions decreased from 88 to 57 percent. The proportion of African-Americans increased from 4 to 21 percent, while that for Hispanics decreased from 89 to 21 percent.—**Jane Maxwell**

**School surveys conducted in 2003 in New Orleans and Florida showed that relatively high percentages of students in secondary schools had used ecstasy.**

**Florida/South Florida:** In 2003, any lifetime ecstasy use was reported in results of the CDC Youth Risk Behavior Survey by 7.8 percent of high school students in Broward County and by 8.2 percent of high school students in Miami-Dade County. In Palm Beach County, 12.1 percent of high school students reported lifetime ecstasy use in the same survey. The rate for high school students in Florida was 9.9 percent.—**James Hall**

**New Orleans:** A secondary school survey conducted in 2003 showed that 7.2 percent of the students had used ecstasy in their lifetime, higher than the percentages reporting lifetime use of methamphetamine, heroin, or cocaine/crack.—**Gail Thornton-Collins**

**There were reports that MDMA abuse was spreading to or increasing in minority communities.**

**Chicago:** MDMA continues to be the most prominently identified club drug in Chicago, and its use appears to have increased among African-Americans. There have been increasing reports of MDMA use among low-income African-Americans in their twenties and thirties who have been involved in the club scene. Sixteen of the 23 MDMA abusers admitted to treatment in FY 2003 were African-Americans.—**Dita Broz**

**New York City:** Ecstasy is beginning to be available to a limited extent in communities of

*color. The appeal of this drug may be expanding across racial, ethnic, and social boundaries.—*  
**Rozanne Marel**

**St. Louis:** *Ecstasy has spread outside the White club scene and into Hispanic and African-American communities, as evidenced by the declining proportion of White clients reporting ecstasy abuse. In the first half of 2004, 289 clients admitted to treatment reported ecstasy as their primary, secondary, or tertiary drug of abuse.—*  
**Heidi Israel**

**Texas:** *MDMA use is spreading among African-Americans and among older drug users.—*  
**Jane Maxwell**

**Most CEWG members reported that MDMA was still used primarily by youth and young adults.**

**Chicago:** *Along with other club drugs, ecstasy continues to be used predominantly by White youth.—*  
**Dita Broz**

**New Orleans:** *Youth in New Orleans continue to be lured to these drugs because they are considered 'hip' and the belief that club drugs are safe.—*  
**Gail Thornton-Collins**

**Los Angeles:** *Between January 2003 and June 2004, about 64 percent of the callers to the California Poison Control System who were exposed to ecstasy were between the ages of 13 and 25.—*  
**Beth Finnerty**

**Philadelphia:** *MDMA is reportedly used in combination with marijuana and LSD by club goers ranging in age from the teens to young adults in their early twenties.—*  
**Samuel Cutler**

**It was reported in three CEWG areas that MDMA traffickers, distributors, or dealers were White and young.**

**Atlanta:** *The DEA reports that most MDMA dealers are White middle and upper class high school and college students between the ages of 18 and 25.—*  
**Brian Dew**

**Colorado:** *MDMA is readily obtainable at raves, nightclubs, strip clubs, or private parties. The traffickers are typically White and in their twenties or early thirties.—*  
**Nancy Brace**

**Washington, DC:** *MDMA is still most frequently used and distributed by teens and young adults at raves and nightclubs.—*  
**Erin Artigiani**

Beth Finnerty, CEWG representative for **Los Angeles**, described the difficulty in assessing MDMA abuse patterns and trends because of small numbers of MDMA users represented in traditional drug abuse data sources:

*Comprehensive indicator data relating to the use and abuse of MDMA and other club drugs are still lacking for Los Angeles County. Therefore, it is difficult to accurately assess and describe patterns of use.*

## MDMA Abuse Patterns and Trends

### **NFLIS Data on MDMA/MDA**

In FY 2004, 2,877 MDMA and MDA (methylenedioxyamphetamine) items were reported by forensic laboratories in 19 CEWG areas. Most (2,347, 87 percent) were MDMA.

In Atlanta, Los Angeles, and Washington, DC, MDMA/MDA items accounted for 2 percent of all items reported. In Denver, Detroit, Miami, New York City, San Diego, Seattle, and Texas, MDMA/MDA items accounted for between 1.0 and 1.5 percent of the items analyzed. In the other nine CEWG areas, less than 1 percent of the items reported were MDMA/MDA.

### **Prices of MDMA**

The retail cost for MDMA was relatively high in CEWG areas, generally in the \$20 to \$30 per tablet range. At the wholesale level, however, tablets were much cheaper, selling for \$13 in New York City, \$12 in Los Angeles, and \$8 in Florida. Bulk prices in Atlanta ranged from \$5 to \$10 per tablet. Those who had connections to suppliers in Chicago could purchase MDMA tablets for \$12–\$15 each. In Texas, the cost of MDMA tablets varied by area, ranging from \$20–\$30 in McAllen to a low price of \$4.75 in Houston.

**Atlanta:** The drug retails at \$25–\$30 per tablet, according to a July 2003 report by the NDIC, although ethnographic data indicate that many users buy ecstasy in bulk. Users report that bulk ecstasy rates are \$5–\$10 per pill.—**Brian Dew**

**Baltimore:** The wholesale price for MDMA in the second half of 2004 was reported as \$10–\$15 per tablet, unchanged from the second half of 2003.—**Leigh Henderson**

**Boston:** The most recent DEA data show that one MDMA tablet costs between \$20 and \$25 retail. Distributed at clubs and on college campuses, MDMA has remained widely available 'in spite of law enforcement seizures.'—**Daniel Dooley**

**Chicago:** Ecstasy continued to be sold in pill or capsule form, and the price range remained unchanged from December 2002: \$20–\$40 per pill. Individuals with connections to suppliers or producers reported prices as low as \$12–\$15 per pill. These prices parallel the 2003 NDIC report: wholesale prices ranged between \$10 and \$12 per tablet and the retail price was \$25–\$35 per dosage unit.—**Dita Broz**

**Denver:** The DEA reports one MDMA tablet or capsule costs \$15 to \$25, with larger quantities selling for \$8 to \$16 per tablet.—**Nancy Brace**

**Los Angeles:** With the exception of GHB [gamma hydroxybutyrate], wholesale and retail prices for club drugs remained stable since the June 2004 report. In multiple quantities, MDMA has a wholesale price of \$12 per pill or capsule. At the retail level, ecstasy usually sells for \$20–\$40 per pill. A standard dose of ecstasy is 60–150 milligrams, which is equivalent to 1 or 2 pills. In Los Angeles, ecstasy 'boats' continue to be mentioned. A boat contains 1,000 MDMA pills and sells for \$8,000.—**Beth Finnerty**

**Miami:** Ecstasy pills generally contain 75–125 milligrams of MDMA, although pills are often

adulterated and may contain other drugs being sold as 'ecstasy.' Wholesale prices are approximately \$8 per pill for 100 units, but retail prices in clubs and raves are \$10–\$50.—**James Hall**

**New Orleans:** The retail cost of MDMA in the last half of 2003 was \$15–\$20 per tablet.—**Gail Thornton-Collins**

**New York:** MDMA is available in tablet, capsule, and powdered form. A dose sells for about \$13 wholesale and \$30 retail.—**Rozanne Marel**

**Newark:** Between July and December 2004, MDMA sold for between \$20 and \$30 a tablet.—**Allison Gertel-Rosenberg**

**Philadelphia:** According to the National Drug Intelligence Center, the retail/street level price per MDMA tablet ranged from \$9 to \$35 in the first half of 2004.—**Samuel Cutler**

**St. Louis:** MDMA remained available at dance parties and cost \$20–\$30 per tablet.—**Heidi Israel**

**San Francisco:** The NDIC reports that in 2004 street prices of methylenedioxymethamphetamine (MDMA or 'X') were in the range of \$15–\$40 per 'tab.'—**John Newmeyer**

**Texas:** Single dosage units of ecstasy sell for \$6–\$20 in Dallas, \$5–\$12.50 in Fort Worth, \$12–\$25 in Tyler, \$4.75–\$25 in Houston, \$20–\$30 in McAllen, \$20 in Laredo, and \$11–\$20 in San Antonio. Multiple dosage units (1,000 tablets) sell for \$5,000–\$8,000 in Houston.—**Jane Maxwell**

**Washington, DC:** MDMA is the most readily available and frequently abused 'club drug,' selling for \$18 to \$25 per tablet in the fourth quarter of 2002, according to the DEA Washington Division. The Washington/Baltimore HIDTA estimated a slightly lower range for the cost per dosage unit: \$10 to \$20.—**Erin Artigiani**

# Cocaine and Methamphetamine Abuse in Mexico

*Roberto Tapia-Conyer, Ph.D., Patricia Cravioto, Ph.D., Pablo Kuri, M.D., M.Sc., and Fernando Galvan, M.Sc.*

U.S.-Mexico border areas where cost of the drug is relatively low; cocaine, which varies in price across areas of Mexico, is more likely to be abused by persons in nonborder areas.

These findings are from Mexico's Epidemiologic Surveillance System of Addictions (SISVEA), which currently operates in 31 States and 53 cities in Mexico. NGC data on the northern border are for the first half of 2004 and represent 16 cities on or near the border with the United States.

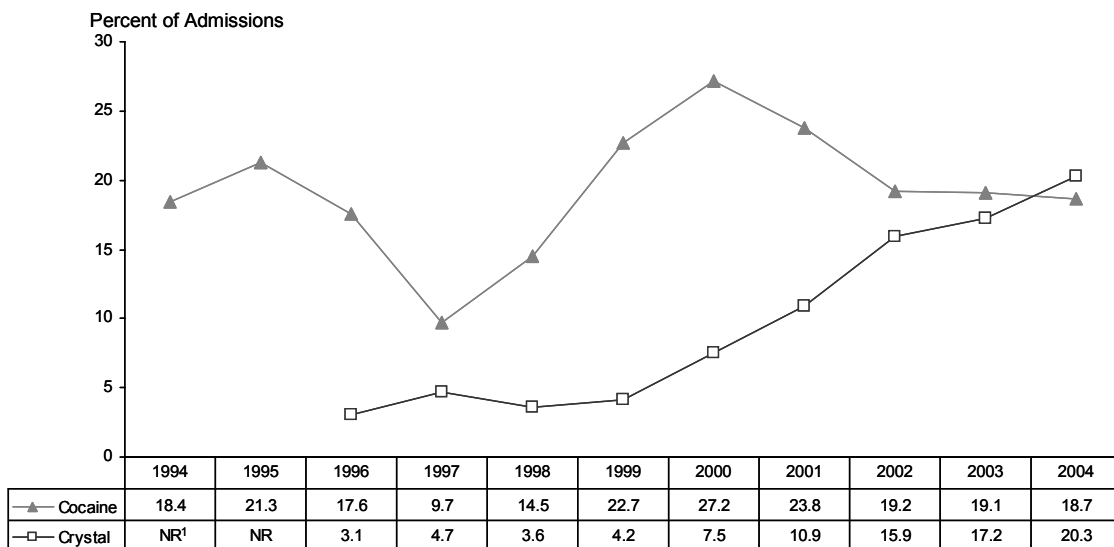
Trend data from nongovernment treatment centers (NGCs), juvenile detention centers, and qualitative research on cocaine and crystal methamphetamine in Mexico show...

## Treatment Data

- ◆ Crystal as a primary drug of abuse among NGC patients in Mexico more than tripled since 1996, while primary abuse of cocaine among patients peaked in 2000 and returned to 1994 levels in the first half of 2004.
- ◆ Approximately 20 percent of NGC patients reported crystal as their primary drug in the first half of 2004; nearly 19 percent reported cocaine as their primary drug.
- ◆ Levels of crystal abuse among NGC patients and juvenile arrestees are high in the western

Trend data presented in exhibit 1 show that cocaine as the primary drug of abuse among NGC patients nationally peaked in 2000 at slightly more than 27 percent of all patients in these programs. The proportions of patients treated for primary crystal methamphetamine abuse on the other hand has risen steadily from 1999 (4.2 percent) to the first half of 2004 (20.3 percent). Note that by 2004, the proportion of primary crystal patients slightly exceeded the proportion of primary cocaine patients.

**Exhibit 1. Percentages of NGC Patients in Mexico Treated for Primary Cocaine and Crystal Abuse: 1994–June 2004**



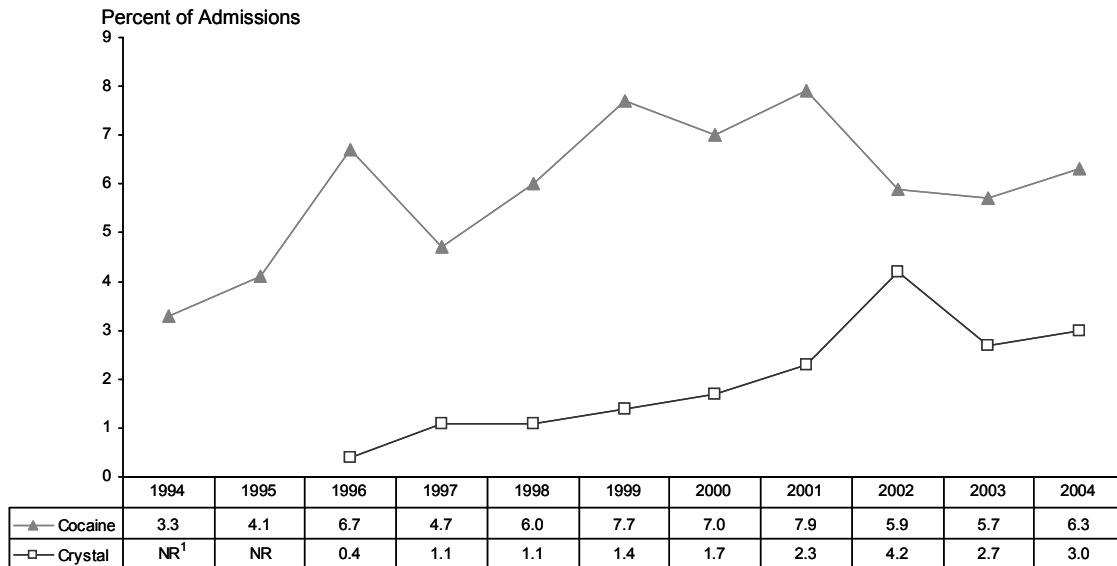
<sup>1</sup>NR=Not reported.  
SOURCE: SISVEA—Nongovernment treatment centers



Smaller proportions of NGC patients nationally reported cocaine or crystal as their first drug of use (see exhibit 2). However, cocaine was twice

as likely as crystal to be reported as a first drug of use among NGC patients in the first half of 2004.

**Exhibit 2. Percentages of NGC Patients in Mexico Reporting Cocaine and Crystal as Their First Drug of Use: 1994–June 2004**



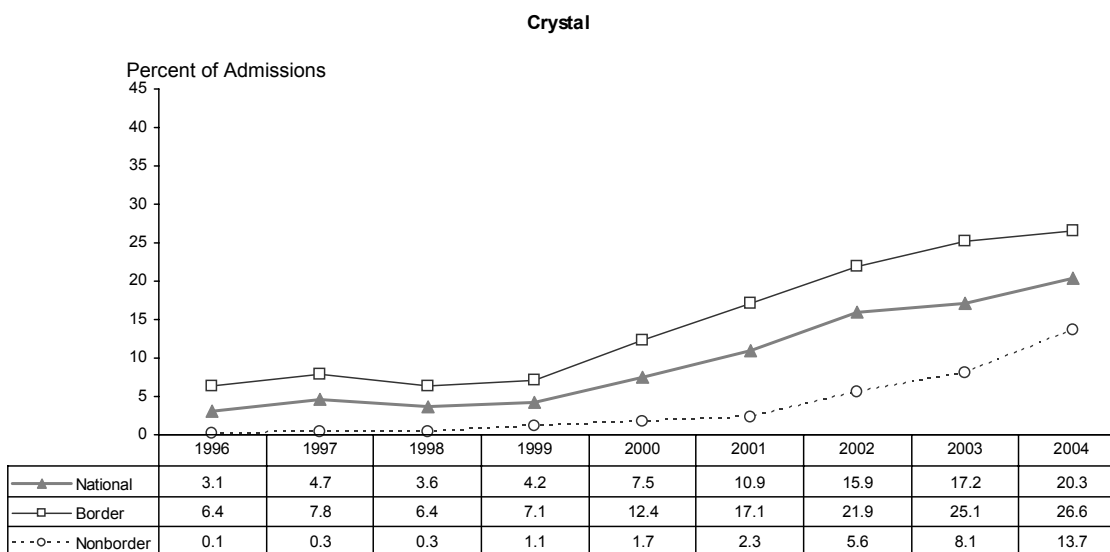
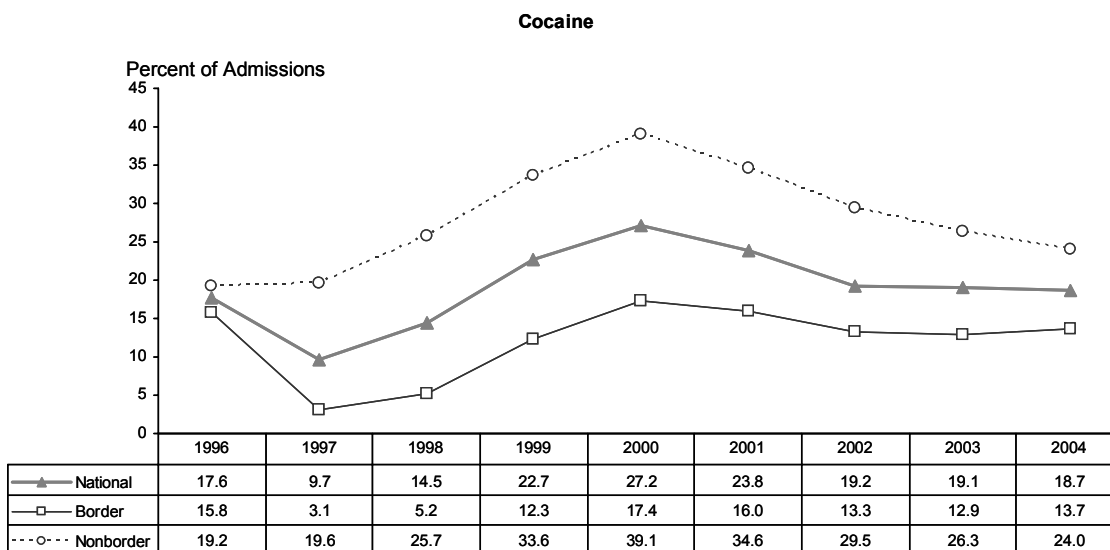
<sup>1</sup>NR=Not reported.

SOURCE: SISVEA—Nongovernment treatment centers

Other national data show that large proportions of patients reported using cocaine and crystal, though not necessarily as their first drug of choice. The proportions fluctuated for cocaine, ranging between 35.4 percent of the patients in 1994 to 54.9 percent in 1999, and falling to 44.9 percent in the first half of 2004. Trends for crystal use climbed steadily from 7.1 percent in 1996 to a peak of 28.2 percent in the first 6 months of 2004.

The 2004 data show that trends in cocaine and crystal abuse among NGC patients varied by region. Compared to the national figures, the proportions of primary cocaine abusers were lowest in border regions, while those for crystal were highest in border regions, as shown in exhibit 3.

**Exhibit 3. Trends in Primary Cocaine and Crystal NGC Admissions in Mexico, by Region and Percent: 1996–June 2004**

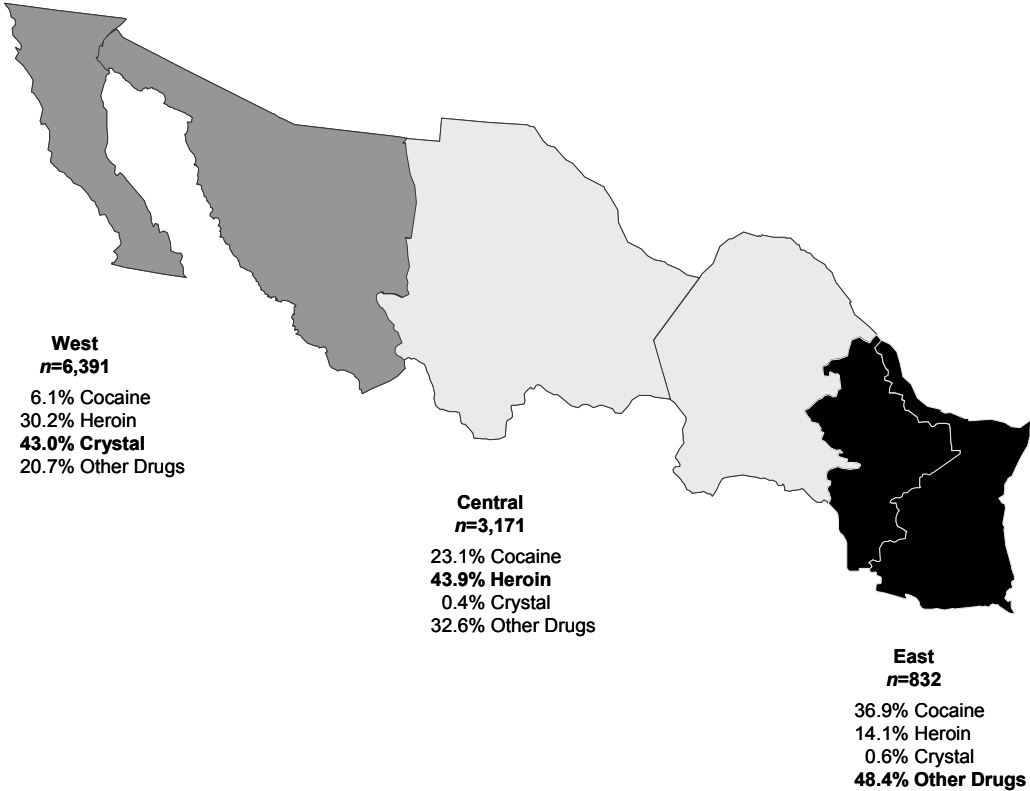


SOURCE: SISVEA—Nongovernment treatment centers

Further breakdowns of the 2004 NGC data for the northern border areas show that crystal dominated on the western side of the border, while cocaine

and heroin dominated in the central part and cocaine admissions were particularly high in the eastern area (see exhibit 4).

**Exhibit 4. Primary NGC Treatment Admissions in Mexico, by Border Area Regions and Percent: January–June 2004**



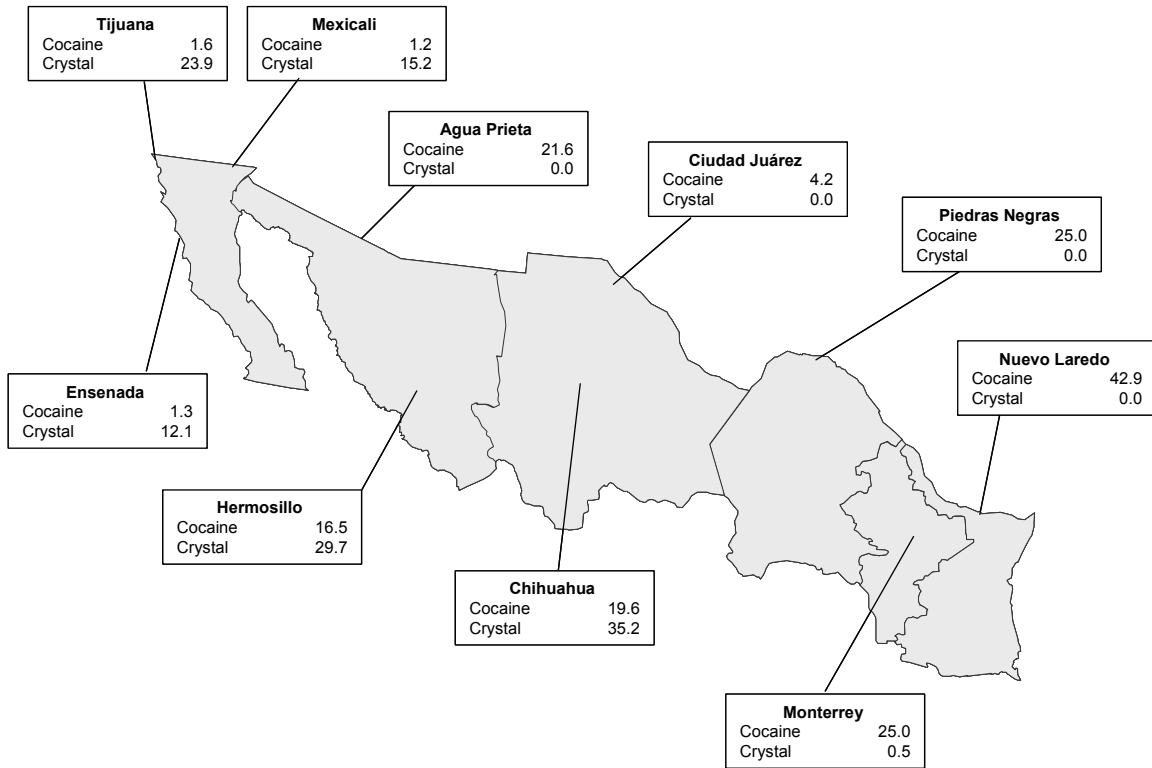
SOURCE: SISVEA—Nongovernment treatment centers

### Juvenile Arrestee Data

Data reported by Juvenile Detention Centers for the first half of 2004 follow the pattern reported by NGCs, that is, higher levels of crystal use in

western areas of Mexico and higher levels of cocaine use in central and eastern areas (see *exhibit 5*).

**Exhibit 5. Cocaine and Crystal Use Among Juvenile Arrestees in Mexican Cities, by Percent: January–June 2004**



SOURCE: SISVEA—Juvenile Detention Centers

## Emerging/Current Trend: Panel on Methamphetamine Abuse

A panel of researchers presented findings from four NIDA-supported methamphetamine (MA) studies...

- ◆ A natural history study designed to assess the treatment problems and needs of MA clients
- ◆ A comparison study of infants exposed and not exposed to MA
- ◆ A comparison study on the effectiveness of three short-term treatment interventions for male gay and bisexual MA abusers
- ◆ A study on the usefulness of brain imaging in predicting relapse among MA-dependent males

Summaries of these four studies are presented below.

### Natural History of Methamphetamine (MA) Abuse and Long-Term Consequences

*Mary-Lynn Brecht, Ph.D.*

#### **Major Findings**

Major findings from a natural history study of 350 methamphetamine abusers admitted to publicly funded drug abuse treatment programs in Los Angeles County include the following:

- ◆ All had used alcohol, marijuana, and/or tobacco, with 95 percent initiating use of one or more of these substances prior to first use of MA. Ninety-seven percent had also used at least one other drug, initiated prior to first use of MA for 65 percent.
- ◆ The average age of first use of methamphetamine was 19.
- ◆ More than one-half (51 percent) of the respondents reported prolonged use of MA (at least 20 days per month for at least 36 months since the age of 14).
- ◆ Health problems reported by a majority of the users included weight loss (84 percent), sleeplessness (78 percent), paranoia (67 percent), hallucinations (61 percent), violent behavior (56 percent), and dental problems (55 percent).
- ◆ Prolonged MA use (more than 36 months) was associated with current health problems and lower self-reported health status.
- ◆ Pregnancy and fetal loss rates were higher than national figures; 406 children were born to the 153 women in the sample. One-third of these women reported having children with disabilities; 75 percent had children who had lived with someone else during at least some period of the child's life.
- ◆ Four of every 10 respondents reported continuous MA abstinence for at least 12 months after treatment discharge. Approximately 2 in 10 were still MA abstinent 48 months after discharge from treatment.
- ◆ Nearly one-half (46 percent) of the respondents completed treatment. The average time in treatment was 3.7 months. Respondents with longer times in treatment were more likely to maintain abstinence 24 and 48 months after treatment.
- ◆ Time-to-relapse outcomes were worse for respondents who sold MA and respondents who experienced parental divorce during childhood.

#### **Background and Study Description**

From 1992 to 2002, there was a fivefold increase in the number of methamphetamine treatment admissions in California—from 5 to 27 percent of all treatment admissions to outpatient and residential programs. To better understand the impact of MA use on the treatment system, a

NIDA-funded study [RO1DA11020] was undertaken by the University of California Los Angeles Integrated Substance Abuse Programs (ISAP) to study the patterns of MA use and the consequences of MA use on health, risk behaviors, and treatment outcomes.

The ISAP study sample was randomly selected from adults admitted to Los Angeles County-funded outpatient and residential programs from 1995 to 1997 (most were admitted in 1996). The sample was stratified by gender, ethnicity, and modality. Of the sample selected...

- ◆ Seventy-six percent were located for followup.
- ◆ Three-quarters of those located participated in study interviews conducted in 1999–2000 ( $n=365$ ); 282 participated in a second interview in 2001–2003.
- ◆ Complete data were available for analysis of the first interview on 350 study subjects.

## Conclusions

The major findings, as summarized above, are evidence of the impact of MA abuse on users and the treatment system.

Given the increase in MA treatment admissions, the health problems of users, special needs (e.g., of children born to MA abusers), and the long-term treatment outcomes, there is a need to implement and evaluate specialized treatment approaches for this population.

Because of the health problems associated with long-term MA use, early interventions could decrease the high medical and social costs of MA use.

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## Prenatal Exposure to Methamphetamine and Child Development

*Barry Lester, Ph.D.,<sup>1</sup> Linda LaGasse, Ph.D.,<sup>1</sup> Lynne M. Smith, M.D.,<sup>2</sup> Chris Derauf, M.D.,<sup>3</sup> Penny Grant, M.D.,<sup>4</sup> Rizwan Shah, M.D.,<sup>5</sup> Amelia Arria, Ph.D.,<sup>6&7</sup> Marilyn Huestis, Ph.D.,<sup>8</sup> Jing Liu, Ph.D.<sup>1</sup>*

Preliminary findings on infants exposed prenatally to methamphetamine (MA) and nonexposed infants suggest...

- ◆ Prenatal exposure to MA is associated with an increase in SGA (small for gestational size).
- ◆ Neurobehavioral deficits at birth were identified in NNNS (Neonatal Intensive Care Unit Network Neurobehavioral Scale) neurobehavior, including dose response relationships and acoustical analysis of the infant's cry.

These preliminary findings are from the IDEAL (Infant Development, Environment, and Lifestyle) clinical network study supported by NIDA (RO1DA01498-01). The final sample will be comprised of 204 exposed and 208 nonexposed infants and their caretakers.

## Study Sample and Methods

The sample for these preliminary findings is based on infants who were exposed to MA prenatally and

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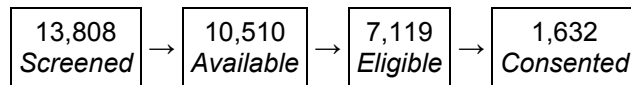
<sup>6</sup>Johns Hopkins University, School of Public Health, Baltimore, MD.

<sup>7</sup>Center for Substance Abuse Research (CESAR), University of Maryland, College Park, MD.

<sup>8</sup>The National Institute on Drug Abuse, the National Institutes of Health, Bethesda, MD.

infants who were not exposed to MA. Exposure was determined through mothers' self-reports and/or GC/MS (Gas Chromatography/Mass Spectroscopy) confirmation of MA in meconium. Subjects in both groups were ineligible for the study if the mothers used lysergic acid diethylamide (LSD), phencyclidine (PCP), opiates, or cocaine only during pregnancy. Other maternal exclusion criteria were non-English speaking, mental confusion or psychotic symptoms, low cognitive function, and being younger than 18. Infant exclusion criteria were multiple gestation, congenital anomalies or chromosomal abnormalities, unlikely to survive, and overt TORCH (Toxoplasmosis, Other Agents, Rubella, Cytomegalovirus, Herpes Simplex) infections. Mothers who used alcohol, tobacco, or marijuana during pregnancy were included in both the exposed or nonexposed groups.

The subjects were recruited from seven hospitals at four clinical research sites (Tulsa, OK; Des Moines, IA; Los Angeles, CA; and Honolulu, HI) from September 1, 2002, through August 31, 2003. The figures below show the number of mothers who were screened and ineligible and the final number of eligibles who consented to participating in the study:



Subjects with MA exposure and matched comparisons were enrolled in the followup phase (84 exposed and 92 comparison). In the comparison group, mothers denied MA use and the infants had a negative meconium screen. The comparison group was matched to the exposed group by race, infants' birthweight, type of medical insurance, and maternal education.

Data were collected soon after the infants' birth and at a 1-month followup. Mothers were interviewed at both time points for demographic information, drug use during pregnancy, and psychological characteristics. SGA was determined from physical growth parameters from hospital medical charts. The NNNS was used to test infant neurobehavior at birth. The NNNS includes measures of arousal, stress and abstinence signs, self-regulation, and quality of movement. Statistical analyses on NNNS scores included comparison between groups, trimester effects of MA use, and dose response relationships between the amphetamine metabolite in meconium and newborn neurobehavior. Following the NNNS exam, the infant's cry was elicited and

tape-recorded for subsequent computer acoustical analysis. The SASSI (Substance Abuse Subtle Screening Inventory) was used to determine substance dependence disorder in the mothers at 1 month.

## Findings

Based on self-reports of 1,632 eligible mothers who consented to participation, it was found that 6 percent used MA during pregnancy. Findings from this recruitment sample showed that MA-exposed infants were significantly more likely than their comparison counterparts to have lower birthweight and were more likely to be SGA. However, only the SGA effect remained, with adjustment for covariates.

Findings below are based on the initial followup sample of 84 subjects in the methamphetamine group and 92 subjects in the comparison group. MA use was higher in the first trimester (3 days a week) than in the second or third trimesters (2 days a week). Maternal use of alcohol, marijuana, and tobacco was higher in the MA group than in the comparison group (e.g., 79 percent of the MA mothers used tobacco, compared with 26 percent of the comparison group). Most mothers in the MA group had more than one prenatal care visit (89 percent), while almost all (99 percent) in the comparison group had more than one visit. However, the number of visits was somewhat lower in the MA group (11 vs. 14 in the comparison group), and the first prenatal visit took place later in the pregnancy in the exposed group (exposed 15 weeks vs. comparison 9 weeks gestational age).

At hospital discharge, 26 percent of the MA infants were not placed with their biological mothers, compared with 2 percent of the nonexposed infants. Child protection service (CPS) referrals were also higher (51 vs. 6 percent), as was CPS supervision at discharge (48 vs. 3 percent). On the SASSI, 74 percent of mothers in the MA group had a substance use disorder, compared with 11 percent in the comparison group. This effect remained after adjustment for covariates. Among infants, NNNS arousal scores were significantly lower and stress abstinence scores (with covariates) were higher in MA-exposed infants. The amount of MA use during the first and third trimester was related to more stress/abstinence signs; MA use during the third trimester was also related to a poorer quality of movement. There

were dose response relationships between the amount of MA metabolite in the infant's meconium and quality of movement, stress/abstinence signs, and regulation scores. Acoustic cry analysis showed that with covariates, more MA-exposed infants cried to the first stimulus, they had more dysphonation (turbulence), changes in voice pitch, variability in amplitude (loudness), and changes in voicing patterns than infants in the comparison group. There were no differences in maternal or newborn infant medical factors between the two groups.

## Conclusions

According to the 1999 National Survey on Drug Use and Health, MA was the only substance with the same percentage of use by pregnant and non-pregnant women. In the 2002 Treatment Episode Data Set, it was found that 21 percent of those pregnant reported use of MA, in contrast to 13 percent of the non-pregnant women. Few studies have been conducted on the in utero effects of MA. These studies do suggest birth abnormalities (e.g., placental abruption, premature delivery, fetal growth retardation) and later learning disabilities, aggressive behavior, and increased rates of attention deficit disorder. However, these findings on humans have been based on small sample sizes and lack of controls for confounding variables (including use of other drugs), lack of a control group, and examiners not being blinded to exposure status. The IDEAL study has been undertaken to provide greater knowledge of the effects of MA use during pregnancy on infants. The preliminary findings reported here found an increase in SGA, and neurobehavioral and cry deficits in MA-exposed infants. It is possible that this is "déjà vu," reminiscent of the effects of cocaine use on human development. The findings point to the following needs:

- ◆ There is a need for well-designed studies to determine the effects of MA on child outcome.
- ◆ There is a need for caution in not overinterpreting findings that can lead to unwarranted stigmatizing of drug-exposed infants and their families.
- ◆ There is a need for effective intervention programs that meet the special needs of female MA users and their children to reduce potential MA-related deficits.

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## Evidence-Based Approaches for Addressing Methamphetamine Use Among Gay Urban Males

Cathy J. Reback, Ph.D.

Findings from a NIDA-supported study [Grant No. RO1 DA 11031] of 162 gay and bisexual men enrolled in outpatient treatment for methamphetamine abuse or dependence included the following:

- ◆ Drug abuse treatment interventions were found to be effective in reducing methamphetamine use and human immunodeficiency virus (HIV) risk behaviors of methamphetamine abusers...
  - At baseline, the mean number of sexual partners in the prior 30 days was 8.6, compared with 2.9 at 52-week followup.
  - Participants demonstrated a threefold decrease in methamphetamine use (verified by urinalysis) and unprotected anal intercourse at 1-year followup.

- ◆ Combined contingency management (CM) and cognitive behavioral therapy (CBT) produced maximal short-term reductions in drug use and moderate effects on high-risk sex behaviors.
- ◆ Gay-specific CBT produced maximal short-term high-risk sex reduction and moderate drug use reduction.

### Study Methods

**Sample.** The study sample consisted of 162 self-reported gay or bisexual men who were enrolled in a Hollywood, California, outpatient treatment program for methamphetamine abuse. All men met the DSM-IV criteria for methamphetamine abuse or dependence. The participants were recruited for treatment through advertisements at gay venues and in the gay media, as well as through agency referrals. Men who responded were scheduled for an intake interview, completed an admission form, and began the informed consent process (approved by the Friends Research Institute West Coast Institutional Review Board).

Participants ranged in age from 19 to 57, with an average age of 37. Most were White (80.2 percent) and highly educated (mean years of schooling=14.7). On average, respondents reported a lifetime use of methamphetamine of 8.3 years. Nearly 38.0 percent reported a history of injection drug use, and 60.5 percent were HIV-infected.

**Interventions.** Following screening, participants were randomly assigned to one of four treatment conditions: contingency management (CM), cognitive behavioral therapy (CBT), CM + CBT, and gay-specific CBT (GCBT). The first three interventions targeted only drug use, and no instructions were given regarding sexual risk behaviors. The GCBT integrated the standard CBT with referents to cultural norms and values of an urban gay lifestyle and an emphasis on HIV-related issues. Treatment was scheduled for a 16-week duration. Groups met for 90 minutes, three evenings each week. Nearly 59 percent of the sample completed the 16-week intervention to which they were assigned.

**Data Collection.** Quantitative data were obtained from all participants at baseline, at 16 weeks, at 6

months, and at 1 year following treatment initiation. In addition to the Admission Form that collected demographic, substance use, treatment history, sexual behavior, and medical and psychiatric background data at baseline, two other instruments were used: the Substance Use Inventory and the Behavior Questionnaire—Amphetamine. Urinalysis was used to verify self-reported drug use. Qualitative interviews were conducted with 34 of the participants at baseline, 16 weeks, and 1 year.

### Study Findings

At baseline, 85.2 percent of the men responded that methamphetamine (i.e., “crystal”) use and sex were integrally connected, and “always” or “often” go together. Nearly 76 percent reported engaging

in sex in the prior 30 days while high on methamphetamine. On average, these men had 8.6 unique sexual partners during that 30-day period. Sex was considered “compulsive” by 69.1 percent of the participants.

By 1-year followup, the mean number of sexual partners was significantly lower (2.9,  $p < .001$ ). There was a regained sense of control over sexual choices. Significantly fewer respondents reported engaging in sexual behaviors, including oral sex, unprotected receptive anal intercourse, and any “public sex.” Significantly more participants were engaging in protected anal intercourse practices, thus decreasing risk for HIV/AIDS. Respondents also reported a greater willingness to disclose their HIV status.

Outcomes by type of intervention are summarized in the exhibit below.

### Outcomes by Treatment Condition

Measure	CM <i>n</i> =42	CBT <i>n</i> =40	CM+CBT <i>n</i> =40	GCBT <i>n</i> =40
Percent completers <sup>1</sup>	59%	40%	74%	62%
Consecutive negative urines—in weeks <sup>1</sup>	5.2	2.1	7.2	3.5
Retention in treatment—in weeks <sup>1</sup>	12.0	8.8	13.4	11.3
Unprotected receptive anal intercourse at termination—times in 30 days <sup>2</sup>	1.1 (3.1)	2.0 (5.5)	2.2 (4.0)	0.5 (1.9)

<sup>1</sup> $p < .01$   
<sup>2</sup> $p < .001$

### Conclusions

The study findings demonstrate that drug treatment for methamphetamine abuse can be effective in modifying high-risk sexual behaviors. The followup findings indicate that the behavior changes can be sustained for more than 1 year. Intervention focused specifically on methamphetamine abuse resulted in maximal short-term reduc-

tions in drug use and moderate effects on high-risk sexual behaviors, while the gay-specific intervention resulted in maximal short-term reductions in high-risk sexual behaviors and a moderate reduction in drug use.

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## Predicting Relapse in Methamphetamine-Dependent Individuals

Martin P. Paulus, M.D.

Findings from a study of the use and effectiveness of Functional Magnetic Resonance Imaging (fMRI) in predicting relapse in methamphetamine (MA) dependent individuals show that...

- ◆ fMRI imaging results can be used to predict whether and when relapse may occur; findings show that fMRI correctly predicted the following:
  - 17 of 18 relapses
  - 20 of 22 nonrelapses
- ◆ In relapse, there is less activation in insular cortex structures that are critical for decisionmaking; the poor decisionmaking “sets the stage” for relapse.

This study, designed to examine the neurobiology of decisionmaking dysfunction in stimulant-dependent subjects and the efficacy of using fMRI as a tool to predict relapse, was supported by NIDA [DA 013186 and DA 016663] and conducted by the University of California San Diego and the San Diego Veterans Affairs Health Care System.

### **Study Sample and Methods**

The initial sample included 46 males who were diagnosed as MA-dependent using the Structured Clinical Interview for DSM IV diagnosis; 6 were lost for followup, which was conducted in a median of 370 days. All subjects had been sober for a median of 25 days at baseline. All subjects were drawn from the San Diego Veterans Affairs Health Care System Alcohol and Drug Treatment Program under the leadership of Dr. Marc Schuckitt.

Of the 40 subjects included in the final analyses, 22 were “nonrelapsers” and 18 were “relapsers.” Some characteristics of the two groups are shown in the exhibit below.

### **Characteristics of the Study Samples**

Characteristic	Nonrelapsers	Relapsers
Average Age	40.3	41.9
Percent White	73.0	67.0
Percent Divorced/Separated/ Never Married <sup>1</sup>	95.0	89.0
Average Years of Education	12.9	13.5
Average Years of MA Use <sup>2</sup>	14.9	17.3

<sup>1</sup>Most in this category were either divorced or separated.

<sup>2</sup>At baseline, 5 nonrelapsers and 7 relapsers were currently abusing alcohol/marijuana; at followup, the respective numbers were 1 and 2, and 1 nonrelapse subject was also abusing cocaine.

The fMRI was used to determine changes in blood oxygenation and identify brain areas involved in the behavioral tasks. The Assessment Protocol at baseline included the following:

- ◆ **The two-choice prediction task** is used to determine the response characteristics in decisionmaking situations that have an uncertain outcome (for a detailed description, see Paulus 1997). Briefly, on a computer screen a house is presented with a person to the left and right. The subject is told that the task is to predict whether a car will come by on the left or right side to pick up the person on the computer screen. The subject has to make a decision (pressing the left or right button) and is shown the car *after* pressing the button for 300 milliseconds. If the selected response is “correct” (i.e., reinforced), the person on the selected side crosses over to the car; otherwise the person moves halfway across the screen and then returns to the center of the screen. The reinforcement schedule is determined apriori, such that 50 percent of the responses will be reinforced, as if they were “correct” predictions.
- ◆ **The two-choice response task** is one in which the subject is told that the task is to press the button on the same side that the car is shown on the screen (i.e., left or right). The duration of each trial depends on the time between presentation of the initial situation and the selection of the response. Therefore, the number of trials per experimental block depends on the subject’s average latency to select a response during a trial block.

- ◆ The key difference between these two tasks is that during the two-choice prediction task, the subject does not know the correct response in advance, and the only information provided that may guide the selection of the current response is the sequence of previous responses and outcomes. In comparison, during the two-choice response task, the subject knows the correct answer before selecting a response, and the current button press does not depend on the previous responses.
- ◆ **Diagnostic**—SCID (Structured Clinical Interview for DSM IV Diagnoses), used to obtain DSM IV diagnoses.
- ◆ **Symptoms**—BPRS/HDRS (Brief Psychiatric Rating Scale and Hamilton Depression Rating Scale), used to assess general psychiatric and depressive symptoms, and the YMRS (Young Mania Rating Scale), used to assess manic symptoms.
- ◆ **Decisionmaking:** See above.
- ◆ **A MRI**—Block design using the Two-Choice Prediction Task versus the Two-Choice Response Task. Briefly, both tasks were presented for 30 seconds each and were repeated five times.

## **Findings**

The fMRI correctly predicted 17 of 18 relapses and 20 of 22 nonrelapses, with a high level of sensitivity (94.4 percent) and specificity (86.4 percent).

Relapse was predictable by less activation in brain structures that are critical to decisionmaking; these were shown to be in the insular cortex, particularly the anterior insula, the inferior parietal lobule, and the dorsolateral prefrontal cortex. It also appears that poor assessment of the decisionmaking situation and subsequent reliance on habitual behavior involves processes in the inferior parietal lobule.

## **Conclusions**

This study has shown that brain patterns can be used to predict whether and when relapse may occur. Questions that need to be more fully addressed in future research are...

- ◆ What are the specific cognitive processes involved in relapse?
- ◆ Do interventions have an impact on relapse?
- ◆ Do such findings apply to other addictions?

## **Reference**

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## ABUSE OF OTHER ILLICIT DRUGS (HEROIN, MARIJUANA, PCP, DXM)

**Heroin and marijuana are among the most widely abused illicit drugs in CEWG areas. Data on phencyclidine (PCP) were reviewed as a followup to the concern that led to the studies reported on in the PCP Panel at the December 2003 CEWG meeting. CEWG reports were reviewed to extract recent information on dextromethorphan (DXM).**

### Heroin

**In 2003–2004, heroin abuse indicators were stable or mixed (some up and some down) in 15 CEWG areas, but high in Midwest and Northeast areas. Heroin indicators decreased in five areas (Denver, Honolulu, San Diego, San Francisco, and Seattle) located in the western half of the Nation, and increased only in Washington, DC.**

**Heroin abuse has been a major problem for some time in Washington, DC, one area that reported increases in heroin indicators:**

*The number of heroin abusers in the District continued to increase in 2003, with current estimates of 14,000 to 18,000 heroin addicts/abusers according to the Washington/Baltimore HIDTA. In 2003, heroin was the primary substance of abuse for 41.9 percent of all treatment admissions, a steady increase from the year 2000 (35.2 percent).—Erin Artigiani*

**Heroin indicators were stable, but at very high levels in CEWG areas in the Midwest (Chicago and Detroit) and Northeast.**

Heroin indicators continued at high levels in **Baltimore**. In Baltimore City, more than one-half (59.8 percent) of the treatment admissions (excluding alcohol) in the first half of 2004 were

primary heroin abusers. In addition, more than one-quarter (26.8 percent) of the items analyzed by police forensic labs tested positive for heroin.

After years of continued growth, indicators show that heroin abuse stabilized at high levels in **Boston**. Heroin continued to be one of Boston's most abused drugs. Heroin/morphine was indicated most often among drug abuse deaths, emergency department data, and treatment admissions. In FY 2004, 73 percent of treatment admissions (excluding alcohol) reported heroin as their primary drug of abuse. There were 716 overdose calls to the Boston Emergency Medical Services (BEMS).

In **Chicago** and the State of Illinois, heroin indicators continued at high levels in 2003 and 2004. In FY 2003, 34,615 primary heroin abusers were treated in Illinois, an increase of 58 percent from FY 2002. The proportion of primary heroin abusers who snorted the drug increased from 70 percent in FY 2002 to 73 percent in FY 2003. African-American admissions were more likely than Whites or Hispanics to choose sniffing as the primary means of administering the drug.

Based on limited data, heroin indicators remained relatively stable in **Detroit/Wayne County**. Heroin was the primary drug for 46 percent of treatment admissions (excluding alcohol) in FY 2004 (October 2003–September 2004). Only 3.1 percent reported heroin as a secondary drug. A relatively small proportion (12.8 percent) of the items analyzed by police forensic labs in FY 2004 contained heroin. In comparison, 41.1 percent of the items tested positive for cocaine and 45.3 percent were positive for cannabis.

Heroin abuse indicators remained stable in **New York City**. Heroin continued to remain widely available, although the purity levels decreased from 61.4 percent in 2002 to 53.5 percent in 2003. In the first half of 2004, primary heroin admissions remained at about 42 percent of New York City's treatment admissions (excluding alcohol). Heroin injection increased from 32 percent of heroin admissions in 1998 to 36 percent in the first half of 2004.

Heroin indicators remained high in **Newark City** and the State of New Jersey. In the first half of 2004, heroin accounted for 82.6 percent of primary treatment admissions (excluding alcohol) in Newark City. Primary heroin admissions predominated across the State, accounting for 60.8 percent of all admissions for drugs other than alcohol. Statewide, 54.6 percent of primary heroin admissions were White, compared with 39.2 percent African-American and 17.3 percent Hispanic. Heroin accounted for 34.7 percent of the items analyzed by police forensic labs (NFLIS) between October 2003 and September 2004.

In **Philadelphia**, heroin indicators remained high. In the first half of 2004, more individuals entered treatment for primary heroin abuse than for any other drug. Male (36.4 percent) and female (19.3 percent) heroin admissions were more likely to inject the drug than to use other routes of administration (e.g., intranasal, swallow, or smoke). In Philadelphia, heroin was detected by local medical examiners in 27 percent of all decedents with drug-positive toxicology reports in the first half of 2004, compared with 25 percent in 2003.

#### **Heroin abuse indicators decreased in CEWG areas on the west coast and Hawaii.**

In 2003–2004, heroin indicators decreased in **Denver** and the State of Colorado. In 2004, only 8.5 percent of the State treatment admissions reported heroin as their primary drug of abuse, compared with 14.7 percent in 2001. In 2004, 69 percent of heroin and other opiate users were White, 19 percent were Hispanic, and 8 percent were African-American. The predominant users of heroin were older White males living in the lower downtown Denver area. However, new suburban abusers were emerging.

Only seven opiate-detected deaths were confirmed by the **Honolulu** medical examiner in 2004. Heroin treatment admissions continued a decline that began in 1998 when record levels were recorded. Excluding alcohol admissions, only 2.8 percent of Hawaii treatment admissions

reported heroin as their primary drug of abuse in the first half of 2004.

In **San Francisco**, heroin indicators consistently point to a decline in heroin abuse from the peak in 1999. In 2001, heroin constituted 54 percent of treatment admissions (excluding alcohol), a smaller percentage than in prior years; this proportion declined to 43 percent in FY 2004. Injection (80 percent) remained, by far, the predominant route of administration. Arrests for heroin-related offenses in 2004 were about 55 percent below the 2002 level.

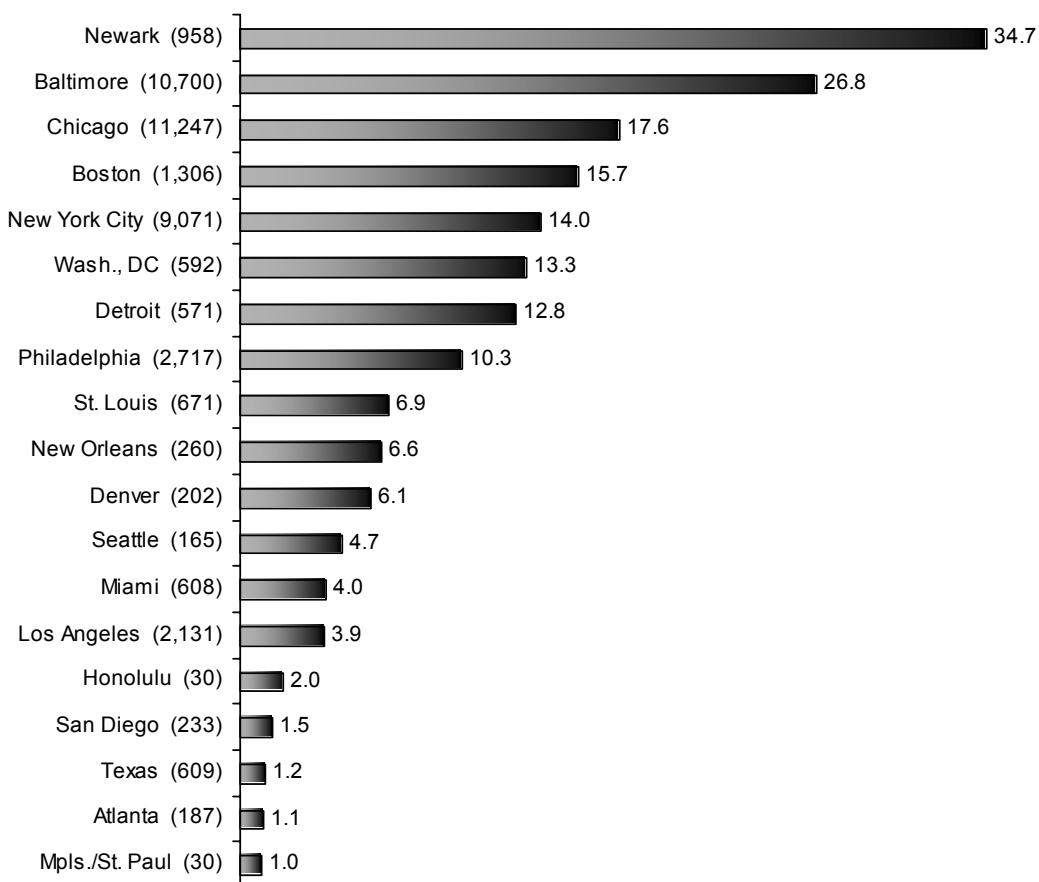
In **San Diego**, only 1.5 percent of the items tested by police forensic labs were found to contain heroin. In 2004, there were 1,310 primary heroin treatment admissions (10.4 percent of illicit drug admissions), the lowest number in more than 9 years. By comparison, there were 6,376 primary methamphetamine admissions in 2004.

In **Seattle**, the proportion of deaths involving heroin in the first half of 2004 were lower than at any time in the prior 7 years. The proportion of heroin treatment admissions involving **any** use of heroin among youth and adults declined from 26 to 20 percent from 1999 to June 2004. Nearly 5 percent of police forensic laboratory (NFLIS) items tested positive for heroin.

## Patterns and Trends in Heroin Abuse Across CEWG Areas

### ***NFLIS Data on Heroin***

The proportions of heroin items analyzed in FY 2004 varied across the 19 CEWG areas (see *exhibit 1*). Heroin accounted for nearly 35 percent of the items reported by Newark laboratories and for nearly 27 percent of those reported in Baltimore. In 11 CEWG areas, heroin accounted for less than 7 percent of all items analyzed.

**Exhibit 1. Number of Heroin Items Analyzed by Forensic Laboratories, Ordered by Percentage of Total Items in 19 CEWG Areas: FY 2004**

SOURCE: NFLIS, DEA

### ***Treatment Data on Heroin***

Excluding Miami, where trends are not comparable, the proportions of heroin treatment admissions were relatively stable in 14 CEWG areas in 2003–2004. Between 2001 and the most recent reporting periods, primary heroin admissions

remained relatively stable, changing less than 3 percentage points in 13 areas; increases of more than 3 percentage points occurred in Arizona and Washington, DC, (each approximately 4 percentage points), while decreases of more than 3 percentage points occurred in Colorado (6 percentage points) and Los Angeles and San Francisco (16 and 12 percentage points, respectively).

**Exhibit 2. Primary Heroin Treatment Admissions (Excluding Alcohol) by CEWG Area and Percent: 2001–2004<sup>1</sup>**

CEWG Area/State	2001	2002	2003	2004
Atlanta	8.6	5.2	8.5	7.6
Baltimore	60.4	62.0	61.5	59.8
Boston	74.1	72.6	73.4	74.2
Detroit	46.9	42.7	43.1	46.0
Los Angeles	46.3	37.4	31.1	30.1
Miami (sample)	NR <sup>2</sup>	9.0	4.1	13.0
Mpls./St. Paul	6.4	7.1	6.7	5.6
New Orleans	18.3	14.6	13.4	13.6
New York	43.2	41.1	42.3	42.1
Newark	85.9	85.8	85.4	82.6
Philadelphia	33.9	29.6	31.4	36.0
St. Louis	15.0	13.7	11.7	18.4
San Diego	12.3	11.7	10.9	10.4
San Francisco	54.4	47.4	35.6	42.8
Seattle	23.7	26.6	25.1	27.0
Washington, DC	47.0	46.9	51.2	NR
Arizona	15.4	14.0	11.7	19.6
Colorado	14.7	13.5	14.0	8.5
Hawaii	5.1	4.7	3.6	2.8
Illinois	24.7	23.4	28.6	NR
Texas	16.4	15.9	13.6	13.7

<sup>1</sup>Represents either CY or FY data for the first half of 2004 (n=12), all of 2004 (7), or 2003 (2); see *Data Sources*.

<sup>2</sup>NR=Not reported; note that the Miami samples are not comparable by year.

SOURCE: CEWG January 2005 reports on State and local data

### **Prices of Heroin**

Recent prices for heroin were reported for 17 CEWG metropolitan areas and several cities in Texas. Typically, a “bag” costs between \$10 and \$20, although the price may be higher in Minneapolis/St. Paul (\$20–\$25). In most areas, a gram of heroin can be purchased for as little as \$90–\$100, however, the range varied from as low as \$25 to as high as \$320 in Newark. In Atlanta, a gram of heroin costs \$462.

**Atlanta:** *The DEA reported a local purity range from 52 to 65 percent. According to the Office of National Drug Control Policy, in the first half of 2003 heroin sold for \$10–\$20 per bag, \$462 per gram, \$6,160 per ounce, and \$112,000 per kilogram in Atlanta.—Brian Dew*

**Baltimore:** *Prices for heroin for the second half of 2004 were reported as \$70,000–\$125,000 per kilogram at the wholesale level; \$2,000–\$3,250 per ounce at mid-level; and \$90–\$165 per gram or \$10–\$20 per bag at the retail level. Lower limits*

*reported for the kilogram, ounce, and gram level were higher than reported for the second half of 2003, but the retail-level bag price was unchanged.—Leigh Henderson*

**Boston:** *The DEA reports that in Boston, street heroin costs \$6–\$20 per bag, with an average purity of 40 percent and is ‘readily available’ throughout the New England area.—Daniel Dooley*

**Chicago:** *Heroin prices have not changed since the CEWG June 2003 report. On the street, heroin is commonly sold in \$10 and \$20 units (bags), though bags for as little as \$5 were available.—Dita Broz*

**Denver:** *One ounce of Mexican heroin at 40 percent purity costs \$1,000–\$3,000. One gram of heroin that is 8–64 percent pure costs \$100–\$150. Costs in Denver are slightly lower than in the rest of the State. It can be obtained in Denver for \$440 per quarter ounce. Purity is approximately 53 percent in the Denver area.—Nancy Brace*



**Detroit:** Heroin prices remain stable in Detroit. On the street, heroin typically sells for \$10 (a unit) and wholesale for \$65,000 to \$80,000 per kilogram.—**Carol Boyd**

**Honolulu:** According to the Honolulu Police Department, heroin prices remain stable in Honolulu, costing \$50 per one-quarter gram, \$200–\$300 per gram, and \$2,500–\$3,500 per ounce. Black tar heroin monopolizes the heroin market in Honolulu.—**D. William Wood**

**Los Angeles:** Mexican black tar heroin remains the predominant type of heroin used by Los Angeles County users. According to LA CLEAR, the wholesale price per kilogram of Mexican black tar heroin is approximately \$20,000 (the same price as in the last few CEWG reports). The current midlevel and retail prices are \$500–\$800 per 'pedazo' (Mexican ounce) and \$90–\$100 per gram, which are stable since the last report. A regular ounce is 28.5 grams, whereas a pedazo is 25.0 grams.—**Beth Finnerty**

**Miami:** The wholesale and retail prices of heroin have declined locally over the past year with the diversification of opioid abuse, which includes oxycodone, methadone, hydrocodone, heroin, and other opioids. Colombian heroin is widely available in South Florida, as described by law enforcement officials and epidemiologists/ethnographers. According to NDIC, 1 kilogram of heroin sells for \$45,000 to \$65,000 in the region, for \$2,500 per ounce, and retail prices are roughly \$100–\$150 per gram. The top price for heroin has dropped 19 percent at the kilogram level and 25 percent at the gram level in the past 12 months. The most common street unit of heroin is a bag (roughly 20 percent purity) weighing about one-tenth of a gram that sells for \$10.—**James Hall**

**Minneapolis:** Retail heroin prices remained at low levels, with \$20–\$40 per dosage unit or 'paper,' and \$150–\$200 per gram.—**Carol Falkowski**

**New Orleans:** Heroin is most commonly sold on the streets of New Orleans in 'bags' or 'papers.' Mixtures containing 0.3 to 0.5 grams are wrapped in small foil packages, which are placed in plastic sandwich bags for multiple sales. Bags or papers are sold for \$20–\$25 each at the retail level, but it is possible to buy a bundle (25 bags) for about \$300. In 2003, the Domestic Monitor Program (DMP) heroin street buys in New Orleans were of

South American origin. The purity of the heroin averaged 31.8 percent.—**Gail Thornton-Collins**

**New York:** DMP findings for 2003 show an average heroin purity of 53.5 percent, down from 61.4 percent in 2002. The associated price is \$0.48 per milligram pure, an increase from \$0.36 per milligram pure in 2002. According to the DEA, prices for January to June 2004 were \$60,000–\$70,000 per kilogram for South American heroin and \$60,000–\$90,000 for Southwest Asian heroin. Heroin demonstrates far less price variation than other drugs sold on the streets of New York, and over the last 6 months, heroin prices have been described as stable. The street seller usually sells one-size packet. The predominant price for street bought heroin is \$10 per packet, and each packet contains approximately 0.10 milligrams of powder. Recently, the \$5 bag (0.5 milligrams) appeared to be undergoing a limited resurgence. Last year, \$5 bags were only found in North Manhattan, but now \$5 bags are also being reported in other parts of the city. This appears to be an attempt to make the price of heroin more affordable and may be a consequence of increased competition among street sellers. There are some local sellers that are selling their product at slightly higher prices. For example, a street seller operating in downtown Brooklyn sold his product for \$13 dollars, claiming that his higher price reflected the better quality of his product. Out-of-town user/sellers usually resell part of their supply of \$10 packet for \$15 in their hometown.—**Rozanne Marel**

**Newark:** The price per gram of heroin between July and December 2004 was \$25–\$320.—**Allison Gertel-Rosenberg**

**Philadelphia:** Key informants continued to report that the \$10 bag of heroin remained the standard unit of purchase. The \$10 bag usually yields one hit; \$5 and \$20 bags reportedly remain available. According to the National Drug Intelligence Center, the retail/street-level price of heroin was \$10–\$20 per bag, \$180–\$250 per bundle, and \$65–\$300 per gram in the first half of 2004.—**Samuel Cutler**

**St. Louis:** Most heroin is purchased in aluminum foil or the number-5 gel capsule (one-tenth-gram packages of heroin in plastic wrap and aluminum foil) for \$10.—**Heidi Israel**

**San Francisco:** Prices of Mexican black tar heroin ranged from \$9,200 to \$30,000 per kilogram and from \$230 to \$850 per ounce in 2004. Gram prices ranged from \$50 to \$75. In

2002, prices ranged from \$16,000 to \$30,000 per kilogram, \$450 to \$850 per ounce, and around \$60 per gram.—**John Newmeyer**

**Seattle:** Data for King County from the Northwest HIDTA for 2003 showed the following prices for Mexican black tar heroin: \$30–\$150 per gram, \$400–\$900 per ounce, \$8,000–\$10,000 per pound, and \$16,000–\$25,000 per kilogram.

—**Caleb Banta-Green**

**Texas:** Depending on the location, black tar heroin sells on the street for \$10–\$20 a capsule, \$100–\$350 per gram, \$800–\$4,500 per ounce, and \$35,000–\$50,000 per kilogram. An ounce costs \$800–\$2,000 in Dallas, \$1,200–\$1,700 in Fort Worth, \$1,000–\$1,500 in El Paso, \$2,100–\$2,200 in Alpine, \$3,500–\$4,000 in Midland, and \$3,500–\$4,500 in Lubbock. An ounce costs \$1,200–\$1,500 in Houston, \$1,300 in Laredo, \$400–\$1,500 in McAllen, \$1,400–\$1,600 in Austin, and \$1,600–\$2,800 in San Antonio. Mexican brown heroin, which is black tar that has been cut with lactose or another substance and then turned into a powder to inject or snort, costs \$10 per cap and \$50–\$350 per gram. An ounce costs \$500–\$600 in San Antonio, \$1,100 in McAllen, \$800–\$1,600 in Dallas, and \$2,200–\$3,000 in Lubbock. Colombian heroin sells for \$10 per cap, \$2,000 per ounce, and \$70,000 per kilogram in Dallas. Asian heroin costs \$200–\$350 per gram, \$2,000–\$4,000 per ounce, and \$70,000 per kilogram in Dallas.

—**Jane Maxwell**

**Washington, DC:** The Metropolitan Police Department describes crack as a weekend drug, but heroin as having a more steady ongoing market. The NDIC reported that heroin sold for \$74,000 to \$110,000 per kilogram and \$100 to \$110 per gram during the first 6 months of 2004.

—**Erin Artigiani**

## Marijuana

Marijuana abuse indicators continued at high levels in CEWG areas, increasing slightly in some and decreasing slightly in others. In 2004, marijuana continued to be readily available and inexpensive in all CEWG areas. It was reported in most areas that marijuana abuse indicators were particularly high among youth and young adult populations, although some decline in marijuana use among youth was reported in two areas.

In some CEWG areas, marijuana was reportedly the most commonly abused illicit drug...

**Atlanta:** Ethnographic sources consistently confirm that marijuana is the most commonly abused drug in Atlanta. Most epidemiological indicators show an upward trend in marijuana use, particularly among individuals younger than 17.

—**Brian Dew**

**Chicago:** Marijuana continues to be the most widely available and used illicit drug in Chicago and Illinois.—**Dita Broz**

**Detroit:** Marijuana remains the most popular illicit drug in Detroit. More than one-fifth of DAWN emergency department reports for illicit drugs in the first half of 2004 were for marijuana, and nearly 20 percent of treatment admissions in FY 2004 reported marijuana as the primary or secondary reason for treatment.—**Carol Boyd**

**Miami:** Marijuana is abused by more people, and particularly among youth, than any other illicit drug. Consequences of marijuana abuse continue even as rates of use declined among youth.

—**James Hall**

**Marijuana abuse indicators continued to rise in...**

**Minneapolis/St. Paul:** *Marijuana indicators continued upward, a trend that began over a decade ago. Marijuana-related treatment admissions outnumbered those for any other illicit drug. However, the Minnesota Student Survey showed a decline in marijuana past-year use among high school seniors, from 33.9 percent in 2001 to 30.2 percent in 2004.*—**Carol Falkowski**

**Newark:** *Marijuana indicators were slightly higher in Newark. As a proportion of illicit drug treatment admissions, marijuana accounted for 7.9 percent in Newark City and 11.3 percent in Newark PMSA in the first half of 2004, both approximately 1 percentage point higher than in 2003.*—**Allison Gertel-Rosenberg**

**Marijuana abuse indicators were reportedly stable but at high levels in...**

**Boston:** *The most recent marijuana indicators for greater Boston are relatively stable at high levels.*—**Daniel Dooley**

**St. Louis:** *Marijuana continues to be a very popular drug of abuse among younger adults. After more than doubling between 1997 and 2001, primary marijuana treatment admissions have remained at an elevated level.*—**Heidi Israel**

**Texas:** *In the past 4 years, the percentage of treatment admissions reporting marijuana as their primary drug of abuse remained relatively stable at slightly more than one-quarter of all admissions. The percentage of cannabis items identified by DPS laboratories dropped from 35 percent of all exhibits in 2000 to 29 percent in the first half of 2004.*—**Jane Maxwell**

**Three CEWG areas reported that marijuana abuse indicators were mixed or declining...**

**Denver:** *Marijuana indicators are mixed. In 2004, high percentages of primary marijuana treatment admissions were reported in Denver and the State.*—**Nancy Brace**

**Honolulu:** *Marijuana abuse indicators decreased slightly in Honolulu. Statewide, marijuana treatment admissions decreased a bit in*

*2004, with only 708 reported in the first half of 2004.*—**D. William Wood**

**San Francisco:** *Marijuana indicators peaked in 2001 and have been declining since that time. However, several bay area counties have been cited as areas where considerable cultivation of marijuana has occurred in recent years.*—**John Newmeyer**

**Two CEWG members focused on the widespread availability and use of marijuana in their areas, with a focus on youth behaviors related to marijuana...**

**Phoenix:** *Marijuana is widely available. Adolescent males, age 15–17, from communities along the southern border of Arizona, are recruited by trafficking organizations as drivers to transport marijuana supplies.*—**Ilene Dode**

**Seattle:** *Marijuana is widely used in the Seattle-King County area, particularly by youth. One-half of all people admitted to treatment from 1999 to June 2004 reported current marijuana use.*—**Caleb Banta-Green**

**As pointed out by Dita Broz, Chicago representative, “The abundance and popularity of marijuana has let to an increasing array of varieties and price.”** **Marijuana potency varies considerably based on the source and selection of plant material and the THC (delta-9-tetrahydrocannabinol) content. In each CEWG area, names have been established for different brands and quality of marijuana. For example...**

**New York City:** *Most of the marijuana available in New York City is considered ‘good’ to ‘very good’ in quality and is available in a variety of forms. ‘Purple Haze’ seems to be the most popular and most readily available type of marijuana. Other known brands include ‘Hydro’ and ‘Chocolate.’*—**Rozanne Marel**

**Washington, DC:** *Popular types of marijuana in the District and Maryland suburbs include ‘chronic,’ ‘kind bud,’ ‘Blueberry,’ and ‘orange tulip.’ All of these types are reputed to have high levels of THC.*—**Erin Artigiani**

**Blunt use continued to be common in two east coast areas...**

**Philadelphia:** *There is widespread and increasing use of blunts in Philadelphia. The wrappers from flavored cigars are favored for making blunts. The combinations of marijuana and PCP continue to be frequently used in blunts. Blunts laced with crack (called 'Turbo') are common, but less so than the marijuana/PCP combination.—Samuel Cutler*

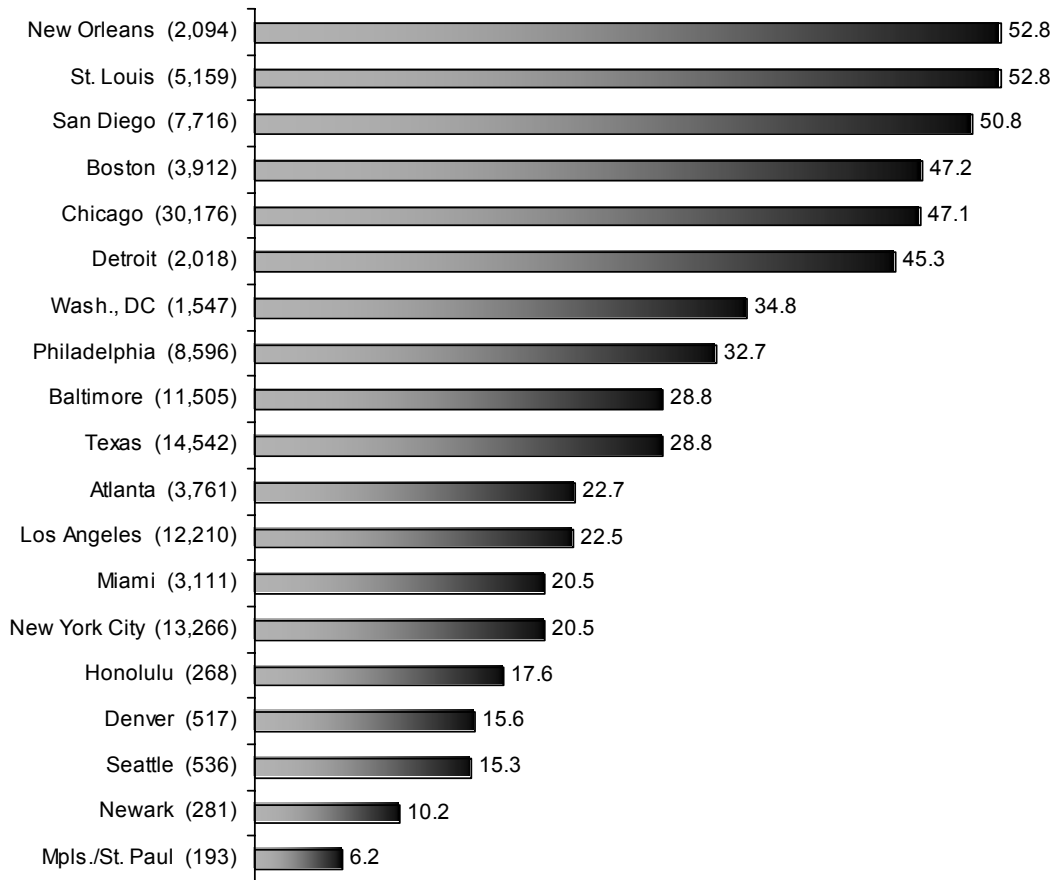
**Washington, DC:** *Marijuana is most often smoked in blunts or joints, which can be combined with rocks of cocaine or dipped in liquid PCP.—Erin Artigiani*

**Patterns and Trends in Marijuana Abuse Across CEWG Areas**

**NFLIS Data on Marijuana**

Marijuana was the most frequently identified illicit drug in items analyzed by forensic labs in six CEWG areas during the period from October 2003 to September 2004. The CEWG areas with the highest percentages of items testing positive for marijuana included New Orleans and St. Louis (52.8 percent each), San Diego (50.8 percent), Boston (47.2 percent), Chicago (47.1 percent), and Detroit (45.3 percent) (see exhibit 3).

**Exhibit 3. Number of Cannabis Items Analyzed by Forensic Laboratories, Ordered by Percentage of Total Items in 19 CEWG Areas: FY 2004**



SOURCE: NFLIS, DEA

Surprisingly, areas that had the highest percentages of items testing positive for marijuana were generally different than the areas in which large proportions of treatment capacity were devoted to primary marijuana abusers.

### **Treatment Data on Marijuana**

In many CEWG areas, a considerable proportion of drug abuse treatment capacity has been and continues to be devoted to individuals reporting marijuana as their primary drug of abuse. The

areas with the highest proportions of primary marijuana abusers entering treatment in 2004 periods included Minneapolis/St. Paul (42.1 percent), New Orleans (39.5 percent), Miami (35.7 percent), St. Louis (31.5 percent), and Seattle (29.4 percent). Among States, Colorado reported the highest percentage of marijuana abusers entering treatment (38.9 percent) (see exhibit 4). Marijuana admissions increased more than 5 percentage points from 2001 to the most recent reporting period in Atlanta and Los Angeles, declined 15 percentage points in Arizona and 7 percentage points in Minneapolis/St. Paul, but remained relatively stable in the other CEWG areas (excluding Miami, where data are not comparable across years).

**Exhibit 4. Primary Marijuana Treatment Admissions (Excluding Alcohol), by CEWG Area and Percent: 2001–2004<sup>1</sup>**

CEWG Area/State	2001	2002	2003	2004
Atlanta	20.9	NR <sup>2</sup>	27.0	28.6
Baltimore	19.1	17.5	17.3	17.0
Boston	7.7	6.6	6.7	6.6
Detroit	10.4	13.4	13.5	13.5
Los Angeles	11.3	14.2	16.3	16.5
Miami (sample)	NR	45.6	64.0	35.7
Mpls./St. Paul	49.2	47.7	45.0	42.1
New Orleans	37.5	37.0	36.7	39.5
New York	25.2	26.1	24.2	23.9
Newark	6.1	6.3	7.0	7.9
Philadelphia	19.7	22.4	23.7	21.6
St. Louis	35.5	36.3	34.4	31.5
San Diego	25.9	25.4	24.5	23.8
San Francisco	10.6	12.2	13.2	11.2
Seattle	34.4	34.0	32.9	29.4
Washington, DC	7.9	5.9	8.5	NR
Arizona	36.5	36.1	39.6	21.4
Colorado	42.3	40.2	35.4	38.9
Hawaii	28.6	28.5	28.2	27.3
Illinois	25.9	28.1	26.5	NR
Texas	26.1	25.8	26.5	26.5

<sup>1</sup>Represents either CY or FY data for the first half of 2004 ( $n=12$ ), all of 2004 (7), or 2003 (2); see *Data Sources*.

<sup>2</sup>NR=Not reported; note that the Miami samples are not comparable by year.

SOURCE: CEWG January 2005 reports on State and local data

Given the relatively high proportion of publicly supported treatment capacity devoted to marijuana abusers, some CEWG members focused attention on the types of problems presented by marijuana drug abusers who entered drug abuse treatment. For example, Dr. Maxwell, the Texas representative, reported: *In Texas,*

*marijuana was the primary drug of abuse for 19 percent of all treatment admissions (including alcohol admissions) in the first half of 2004. Seventy-six percent had legal problems or had been referred to treatment from the criminal justice system. These clients used marijuana less frequently than those who were referred to*

treatment by other sources (including self-referral). In addition, Addiction Severity Index scores (measuring severity of problems) were lower for criminal justice referrals than referrals from other sources.

## Prices of Marijuana

While marijuana “joints” or “bags” can be purchased in many CEWG areas for \$2–\$10, the prices vary considerably by type and potency. Hydroponic, sinsemilla, and “BC Bud” are considerably more expensive than commercial grade marijuana, as indicated in excerpts from CEWG reports.

**Atlanta:** Marijuana, which is readily available in Atlanta and the rest of Georgia, retails for about \$10–\$20 per gram, and \$100–\$350 per ounce, according to the DEA. Atlanta serves as a regional distribution center for marijuana.—**Brian Dew**

**Baltimore:** Midlevel prices were \$275 per ounce for hydroponic and \$130 per ounce for commercial grade. At the retail level, prices were \$35–\$60 per one-quarter ounce or \$20–\$40 per bag.—**Leigh Henderson**

**Boston:** The DEA’s most recent data reports that marijuana is readily available in Massachusetts and sells for \$800–\$1,500 per pound for ‘commercial grade.’ A marijuana cigarette or joint typically costs \$5.—**Daniel Dooley**

**Chicago:** Marijuana prices, which remained level since the June CEWG 2003 report, ranged from \$650 to \$4,000 per pound, depending on the type and quality. Ounces typically sold for about \$80–\$250. On the street, marijuana was most often sold in bags for \$5–\$20 or as blunts. The NDIC reported the following prices for marijuana in Chicago in 2003: \$900–\$1,200 per pound, \$50–\$75 per ounce, and \$3–\$5 per gram.—**Dita Broz**

**Denver:** BC Bud sells for \$700–\$1,000 per ounce and \$3,200–\$4,500 per pound. On the street, BC Bud is \$10 per joint. Domestic marijuana grown indoors is preferred over Mexican grown marijuana and sells for \$1,000–\$3,000 per pound and \$200–\$300 per ounce.—**Nancy Brace**

**Honolulu:** Marijuana sold for \$5–\$20 per joint, \$25 per gram, and \$6,000–\$9,000 per pound in 2004.—**D. William Wood**

**Los Angeles:** The wholesale price of Mexican-grade marijuana ranges from \$300 to \$400 per pound. The midlevel and retail prices of commercial grade marijuana are \$60–\$80 per ounce and \$10 per gram. All prices have been stable since early 2003. The wholesale price of domestic mid-grade marijuana ranges from \$1,000 to \$1,200 per pound. Midlevel and retail prices are \$200–\$250 per ounce and \$25 per gram. The wholesale price of high-grade sinsemilla is \$2,500–\$6,000 per pound. An ounce of sinsemilla sells for \$300–\$600, and one-eighth ounce sells for \$60–\$80.—**Beth Finnerty**

**Miami:** Marijuana is still described as widely available throughout Florida, with local commercial, sinsemilla, and hydroponic grades available. A pound of commercial grade marijuana sells for \$450–\$1,000 per pound. Hydroponic grades sell for \$2,500 to \$4,000 per pound. Commercial grade prices range from \$100 to \$150 dollars per ounce, while hydroponic grade sells for \$350 to \$450 per ounce. Depending on its potency, marijuana may sell for \$5 to \$18 per gram.—**James Hall**

**Minneapolis:** Marijuana, readily available according to multiple sources, sold for \$5 per joint. Standard, commercial grade marijuana sold for \$50 per quarter ounce. Prices varied considerably depending on alleged potency, from \$80–\$600 per ounce and \$600–\$2,400 per pound.—**Carol Falkowski**

**New Orleans:** According to the New Orleans Police Department, the price of marijuana was stable in 2004. Joints sold for as low as \$2, and grams could be purchased for \$10. Marijuana was sold by the ounce for \$125–\$160 and by the pound for \$800–\$1,000.—**Gail Thornton-Collins**

**New York:** Street-level marijuana is sold in \$10 and \$20 amounts, although the \$10 package seems to be on a decline. While individuals can buy multiple \$20 packets, an individual desiring larger quantities at a discount must go through a house-connection, which requires an introduction from a regular ‘trusted’ buyer. According to the SSU, in the Bronx an ounce of chocolate marijuana sells for \$250 to \$300. Purple Haze and Hydro are slightly more expensive, selling for

\$325–\$400. In Manhattan, Purple Haze and Hydro are more expensive and sell for about \$450–\$480 an ounce. A pound of Purple Haze or Hydro can cost about \$6,000. The most commonly used packaging method for the sale of marijuana in New York City is the plastic bag. The thumb-nail size sells for \$10. There is also a slightly larger size bag that sells for \$20.—**Rozanne Marel**

**Newark:** Between July and December 2004, locally produced marijuana sold in Newark for \$5–\$30 per bag.—**Allison Gertel-Rosenberg**

**Philadelphia:** According to the National Drug Intelligence Center, the retail/street-level prices per bag of marijuana ranged from \$5 to \$35 in the first half of 2004.—**Samuel Cutler**

**St. Louis:** In 2004, 1 pound of sinsemilla sold for \$750–\$1,800 in St. Louis.—**Heidi Israel**

**San Francisco:** In 2004, sinsemilla marijuana sold for \$3,000–\$6,000 per pound, and domestic marijuana sold for \$4,000–\$5,000 per pound. Domestic marijuana sold at about \$200 per ounce.—**John Newmeyer**

**Seattle:** HIDTA data collected from King County law enforcement in 2003 show the following prices for marijuana: \$10–\$40 per gram, \$250–\$500 per ounce, and \$2,200–\$4,000 per pound. Price depends on the quality and a variety of other factors, but 'BC Bud' from British Columbia, Canada, is widely available and the most expensive of the marijuana varieties available in King County.—**Caleb Banta-Green**

**Texas:** High quality sinsemilla sells for \$900–\$1,200 per pound in the Dallas/Fort Worth area, \$800 per pound in Lubbock, and \$600 per pound in Houston. Canadian BC Bud sells for \$3,300 and hydroponic sells for \$3,500 in Houston, compared with \$3,000 in Austin and \$4,600 in McAllen. The average price for a pound of commercial grade marijuana is \$140–\$160 in Laredo, \$125–\$425 in McAllen, \$350–\$450 in San Antonio, \$350–\$375 in Austin, \$280–\$350 in Houston, \$500 in El Paso, \$500–\$700 in Alpine, \$300–\$400 in Midland, \$350–\$600 in the Dallas/Fort Worth areas, \$500–\$600 in Lubbock, and \$340–\$500 in Tyler. Locally grown indoor marijuana sells for \$3,800 per pound in Dallas.—**Jane Maxwell**

**Washington, DC:** The NDIC reported that commercial grade marijuana sold for \$1,800 per pound and hydro sold for \$5,000 per pound during

the first 6 months of 2004. Joints sold for \$5 to \$10 during this time.—**Erin Artigiani**

## Phencyclidine (PCP)

In 2003, there was growing concern, based on CEWG reports, that PCP abuse was increasing in six CEWG areas and might be spreading to others. PCP indicators were consistently high in Philadelphia and Washington, DC. As a participant in a PCP Panel at the December 2003 CEWG meeting, a NIDA grantee presented data from an ongoing "club drug" study suggesting a resurgence of PCP abuse in Hartford, Connecticut. Exploratory studies were conducted in Los Angeles and Washington, DC, in 2003 to learn more about PCP patterns and trends.

At the January 2005 CEWG meeting, indicators of PCP abuse were reported in nine CEWG areas. Although there were reports that PCP was readily available in these areas, there was little evidence to suggest that PCP indicators increased in 2003–2004. The numbers and percentages in the PCP indicators were relatively small compared with those for other drugs. PCP treatment admissions decreased in Los Angeles and were at low levels in the other areas. It was reported that PCP indicators decreased in Washington, DC. Given the small numbers, it was difficult to determine whether PCP indicators had changed in the other CEWG areas.

**Chicago:** Recent reports from young heroin snorters indicate that PCP is common in this population. More than one-half (51 percent) of the study participants reported ever trying PCP, and 14 percent admitted using this drug within 6 months prior to their interview. The amount of PCP samples received by the Illinois State Police laboratory for analysis decreased significantly from 4.2 kilograms in 2002 to 0.56 kilograms in 2003.—**Dita Broz**

**Los Angeles:** Primary treatment admissions for PCP abuse are declining. California Poison Control System calls involving exposure to PCP among Los Angeles County residents fluctuated between 10 and 20 calls from 2000 to 2003. In the first half of 2004, there were five PCP-related exposure calls. About 100 PCP arrests were made in the city of Los Angeles in the second half of 2004, the same number made in the first half of 2003.—**Beth Finnerty**

**Minneapolis/St. Paul:** In 2003, two young African-American males (age 18 and 19) died in Hennepin County and PCP was reported as a contributing factor. PCP is often used in combination with marijuana. Marijuana joints dipped in formaldehyde (that is often mixed with PCP), are known as 'wets,' 'amp,' 'wet sticks,' and 'wet daddies.'—**Carol Falkowski**

**New York City:** Street sources claim that PCP is becoming more readily available in the city. It is available in liquid and powdered form. Recently, a street observer was informed that a bodega in the Bronx was selling cocaine laced with PCP.—**Rozanne Marel**

**Philadelphia:** PCP remains readily available in Philadelphia. Urinalysis data of booked arrestees from Philadelphia's Adult Probation/Parole showed that 4.1 percent (n=1,023) of 25,178 arrestees tested positive for PCP. This drug was also identified in 441 decedents from 1994 through the first half of 2004.—**Samuel Cutler**

**St Louis:** While PCP indicators are relatively low, the drug remains in most indicator data, including ED cases, police exhibits, and as a secondary drug in medical examiner data. Most of the users of this drug in the inner city are African-Americans. PCP has been available in limited quantities in the inner city and has generally been used as a dip for marijuana joints.—**Heidi Israel**

**Seattle:** Fifty-three PCP ED cases were reported from January to June 2004. Twenty-eight of the cases identified the drug as 'sherm,' which is the street term for a marijuana joint laced with PCP. There are specific case reports of embalming fluid being used as the liquid in which PCP is dissolved.—**Caleb Banta-Green**

**Texas:** PCP indicators are continuing to rise. DPS labs identified only 10 substances as PCP in 1998, compared with 143 in 2003 and 83 in the first half of 2004. The number of reported Texas

Poison Control Centers cases involving PCP increased from 102 in 1998 to a high of 237 in 2002, 172 in 2003, and 102 in the first half of 2004. In these cases, marijuana joints were often dipped in formaldehyde containing PCP, or PCP was sprinkled on the joint.—**Jane Maxwell**

**Washington, DC:** In 2002 and 2003, PCP was rapidly becoming the drug of choice at raves and nightclubs in the District. It was often used in combination with marijuana and/or MDMA. In 2004, however, PCP indicators declined. While most of the PCP in the District is transported from southern California, a seizure of the precursor chemicals and PCP at a clandestine laboratory in Baltimore in 2003 indicates that the drug has also been produced in the region. Data from police forensic labs (NFLIS) show that approximately 5 percent of analyzed items in the District tested positive for PCP. There were also 201 ED PCP reports in the first half of 2004. Most (82 percent) were African-Americans, with about 37 percent in the 24 and younger age category.—**Erin Artigiani**

## Patterns and Trends in PCP Abuse Across CEWG Areas

### **NFLIS Data on PCP**

In FY 2004, 2,678 PCP items were analyzed by forensic laboratories in 9 CEWG areas (including the combined Texas sites). The PCP items accounted for 4.8 percent of the drug items in Washington, DC (n=214 PCP items), 3.3 percent in Philadelphia (857), and 1.2 percent of the items in New York City (773). In the other CEWG areas, PCP items accounted for less than 1 percent of the total items reported: Los Angeles (n=345), Chicago (320), Texas (120), San Diego and Seattle (20 each), and Baltimore (9).

### **Treatment Data on PCP**

**Baltimore:** Treatment admissions for PCP abuse have been erratic in recent years, but there were between 2.5 and 5.0 per 100,000 population (age 12 and older) from 2001 to 2003.—**Leigh Henderson**



**Los Angeles:** Primary PCP treatment admissions accounted for only 1.0 percent of all admissions in the first half of 2004. The proportion of PCP admissions had been stable for several years. The overall numbers of PCP admissions increased 89 percent from 1999 to the first half of 2003. In the second half of 2003, however, the number of PCP admissions decreased 16 percent to 262 admissions and continued to decrease further (12 percent) in the first half of 2004.—**Beth Finnerty**

**Philadelphia:** PCP was mentioned as the primary, secondary, or tertiary drug by 4.3 percent of all treatment admissions in 2003 and 4.6 percent in the first half of 2004. The average number of drugs mentioned by primary PCP treatment admissions was 1.89.—**Samuel Cutler**

**Seattle:** Treatment admissions in which PCP is mentioned as a primary drug are infrequent, well under 1 percent of the admissions from 1999 to June 2004.—**Caleb Banta-Green**

**Texas:** Adolescent and adult treatment admissions with PCP as a primary, secondary, or tertiary drug of abuse increased from 164 in 1998 to 417 in 2003 and 175 in the first half of 2004. Of the 2004 clients, 83 percent were African-American, 56 percent were male, 54 percent involved the criminal justice system, only 22 percent were employed, and 20 percent were homeless. While 38 percent reported a primary problem with PCP, another 31 percent reported marijuana as the primary drug problem.—**Jane Maxwell**

## Dextromethorphan (DXM)

Indicators of dextromethorphan abuse were reported in four CEWG areas. This psychoactive drug is found in common over-the-counter cough medicines and is in the family of compounds called dissociative anesthetics. Used in high doses, the drug can be especially dangerous. DXM products, which can be purchased over-the-counter, include Robitussin-DM, Tussin, and Coricidin Cough and Cold Tablets HBP.

As pointed out by Carol Falkowski, Minneapolis/St. Paul: *People intoxicated on DXM experience profound hallucinations and altered time perception, slurred speech, sweating, uncoordinated movements, and high blood pressure. Recent growth in the abuse of DXM products by young teenagers prompted many pharmacies, discount stores, and grocery stores in Minneapolis/St. Paul to place the products containing DXM behind the counter to prevent shoplifting. Being under the influence of these products is known as 'Robo-tripping' or 'Skittle-ing.'*

**Los Angeles County:** The California Poison Control System tracks calls relating to Coricidin HBP and DXM exposures. Between January 2003 and June 2004, 50 Coricidin HBP calls and 17 DXM calls were logged in the system. Fifty-two percent of the Coricidin HBP calls and 59 percent of DXM calls were male. Eighty-four percent of the Coricidin HBP calls and 65 percent of the DXM calls were made because of exposure to individuals under 18 years of age.—**Beth Finnerty**

**Illinois:** *Between 2003 and 2003, the Illinois Poison Control Center reported a 55-percent increase in calls involving recreational abuse of Coricidin HBP, which contains 30 milligrams of dextromethorphan HBr (DXM) per tablet. The majority of the cases involving DXM were between the ages of 13 and 19 (90 percent).—Dita Broz*

**Philadelphia:** *Key informants indicated that DXM use is increasing among people age 30–40, often in combination with alprazolam and diazepam. The Philadelphia medical examiner detected DXM in 40 cases in 2003 and an additional 35 cases in the first half of 2004.—Samuel Cutler*

**Texas:** *Poison control centers reported that the number of abuse and misuse cases involving DXM rose from 99 in 1998 to a high of 432 in 2002, and then dropped to 365 in 2003 and to 91 in the first half of 2004. The average age was 23.8. Seven cases involved the abuse or misuse of Coricidin HBP in 1998, increasing to 268 in 2002 and then decreasing to 189 in 2003. In the first half of 2004, 175 cases were reported. The average age in 2004 was 16.2 years, which shows that this substance can be easily accessed and misused by youth. The 2004 Texas school survey reported 4.3 percent of secondary students and 5.8 percent of twelfth graders had used DXM.—Jane Maxwell*

## PRESCRIPTION DRUG ABUSE

Prescription drug abuse has been a focus of attention at recent CEWG meetings. A special panel was convened at the June 2004 meeting to present, review, and report on what has been learned about prescription drug abuse from a variety of sources, including the National Survey on Drug Use and Health; Monitoring the Future survey; Drug Abuse Warning Network; Treatment Episode Data Set; National Forensic Laboratory Information System; Automation of Reports and Controlled Orders System; System to Retrieve Information from Drug Evidence; and Toxic Exposure Surveillance System. In addition, the 21 CEWG members reported on the most recent indicator data accessed from national and local sources. The findings are published in the June 2004 *Advance Report*. Findings from the data were highlighted, providing insight on how research resources could be utilized to address the research questions and issues that emerged from the meeting. It was clear that prescription drug abuse had escalated across the Nation and within CEWG areas. Particularly alarming was the increased abuse of prescription drugs by youth. It was concluded that ongoing research and monitoring of data sources were required to identify populations at risk and determine how these drugs were obtained and used, why they were being used, and the consequences of abuse.

At the January 2005 CEWG meeting, members again addressed what has been learned in each area about prescription drug abuse from the most recent indicator data (e.g., forensic laboratory analyses, drug treatment admissions, hospital emergency department and discharge cases, and drug-related deaths). This section provides an update on the abuse of prescribed narcotic analgesics/opiates/opioids and benzodiazepines.

### Nonmedical Use of Narcotic Analgesics/Opiates

At the January 2005 meeting, it was reported that narcotic analgesic drug abuse indicators increased in almost all CEWG areas in 2003–2004.

**Oxycodone abuse indicators were identified more often than indicators for other narcotic analgesics.**

**Atlanta:** *Most indicators suggest that narcotic pain relievers are growing in popularity in metropolitan Atlanta. OxyContin, the most widely recognized oxycodone product, is a growing threat in Georgia according to the DEA. —Brian Dew*

**Boston:** *Boston's drug abuse indicators continue to show growing levels of narcotic analgesic abuse fueled primarily by oxycodone and hydrocodone. Narcotic analgesics such as oxycodone and other opiates are continuing to show alarming increases among the various indicators. —Daniel Dooley*

**Colorado:** *Based on hospital discharge data from 1997–2003, narcotic analgesics (all combined) have been steadily increasing, with the rate almost doubling in 7 years from 37 per 100,000 in 1997 to 73 per 100,000 in 2003. Hospital discharge data and treatment providers indicate a rapid rise in the popularity of prescription narcotic drugs such as OxyContin and hydrocodone products. —Nancy Brace*

**Minneapolis/St. Paul:** *Prescription narcotic analgesics were increasingly used nonmedically as drugs of abuse for the strong, euphoric, heroin-like effects. Of particular concern are drugs containing oxycodone such as Percodan, Percocet, and the long-acting OxyContin. —Carol Falkowski*

**San Francisco:** *Local sources note a significant increase in oxycodone availability and usage. —John Newmeyer*

**Several CEWG members provided some detailed information on opiate-related treatment admissions (see also next section, page 65)...**

**Atlanta:** Treatment data for other opiates or narcotics were only available for secondary and tertiary drug abuse categories. Continuing a stable trend, other opiates accounted for about 2–3 percent of secondary drugs abused statewide and about 1.5 percent of tertiary drugs abused from January 2004 through June 2004. The use of opiates as a secondary abuse category was cited more often in nonmetropolitan areas (2.5 percent) than in metropolitan Atlanta.—**Brian Dew**

**Baltimore:** Treatment admission rates for opiates other than heroin more than doubled, from 23 per 100,000 population (age 12 and older) to 55 per 100,000 in 2003. Based on preliminary data, it was projected that they should reach 57 per 100,000 for all of 2004. In the first half of 2004, opiates other than heroin were reported by 4 percent of admissions as a primary substance of abuse and 4 percent as a secondary or tertiary substance. Treatment admissions reporting primary opiates other than heroin were mostly (88 percent) White, and 68 percent used opiates other than heroin daily. Forty-two percent were entering treatment for the first time.—**Leigh Henderson**

**Boston:** The ‘Other Opiate’ category of primary treatment admissions reached the same proportion as marijuana by increasing tenfold from FY 1997 to FY 2004.—**Daniel Dooley**

**Colorado:** Treatment providers have reported an increasingly young population in their early teens using OxyContin and any other drug they can obtain, usually stolen from their parents.—**Nancy Brace**

**Los Angeles:** Other opiates/synthetics continue to constitute a marginal proportion of all Los Angeles County treatment admissions. But their representation as a primary drug of abuse has increased slightly in the local treatment data, rising from 1.5 percent of all admissions in 1999 to 1.9 percent (583 admissions) in the first half of 2004. The number of other opiate/synthetic admissions reported in the first half of 2004 was 10 percent lower than the number of primary other opiates/synthetic admissions reported in the second half of 2003, but nearly identical to the number of other opiate/synthetic admissions reported in the first half of 2003 (n=582). In 2004,

other opiates/synthetics admissions were typically male (60 percent), White non-Hispanic (74 percent), and age 36–50 (52 percent). Only 1 percent of the primary other opiate/synthetic admissions were younger than 18. Interestingly, 80 percent administered other opiates/synthetics orally, but an additional 16 percent reported smoking. Sixty-one percent of primary other opiate/synthetic admissions reported no secondary or tertiary substance use. An additional 12 percent reported secondary alcohol use, and 7.5 percent reported secondary cocaine/crack use. Reports of primary non-prescription methadone admissions continued to be minimal among Los Angeles County treatment admissions (47 admissions, 0.2 percent of all admissions).—**Beth Finnerty**

**Newark:** In the first half of 2004, primary treatment admissions for ‘other opiates or synthetics’ in Newark City totaled six (0.3 percent of the admissions, excluding alcohol admissions). The number was higher in the PMSA—86 (1.4 percent of the admissions, excluding alcohol). In 2003, figures for the city and PMSA, respectively, were 0.2 and 1.3 percent. In the State as a whole, primary admissions for other opiates in the first half of 2004 totaled 679, or 3.4 percent of all admissions, excluding alcohol. In 2003, the number of primary admissions for other opiates totaled 1,049, representing more than double the admissions reported in 1997 (513). The biggest increase in numbers of other opiate admissions occurred between 2000 (592) and 2002 (1,124). In 2003, the last year of full data for New Jersey, admissions reporting other opiates as primary, secondary, or tertiary drug of abuse numbered 2,303 and accounted for nearly 6 percent of all drug admissions statewide. In the TEDS data for 2003, 92.0 percent of the primary ‘other opiate’ admissions were White, 6.1 percent were Black; 5.5 percent fell into a Hispanic category. About 63 percent were male.—**Allison Gertel-Rosenberg**

**St. Louis:** Other opiates continue to represent less than 1 percent of all treatment admissions (including alcohol). Methadone remains available, which is probably a result of prescription abuse and not patient diversion.—**Heidi Israel**

**Seattle:** Treatment admissions where other opiates were the primary drug increased from 0.8 to 2.3 percent of all admissions from 1999 to the first half of 2004. Over this same time frame, the proportion of 18–29-year-olds increased from 16 to 42 percent. More than one-half of the admissions in the first half of 2004 were female, 55

percent, much higher than the 33 percent for all substances. Other opiate users were much more likely to be White, 77 percent, compared with users of all substances, 58 percent. The proportion of primary other opiate users who reported ever injecting drugs was nearly identical to all drug users, 35 vs. 34 percent, respectively.

—**Caleb Banta-Green**

**Data on calls to Helplines and/or poison control centers in CEWG areas substantiate the concern about the nonmedical use of narcotic analgesics, especially oxycodone products.**

**Boston:** In FY 2004, there were 1,025 calls to the Helpline during which opiates were mentioned (18 percent of all calls). Oxycodone (including OxyContin) was mentioned in 691 calls. Helpline calls with oxycodone mentions (12 percent of total) increased 25 percent from FY 2003, 52 percent from FY 2002, and 261 percent from FY 2001. Other narcotic analgesics including methadone, codeine, morphine, Percocet, Vicodin, and Roxicet were mentioned among 401 calls (7 percent of total calls).—**Daniel Dooley**

**Colorado:** Heroin and other narcotic analgesic-related calls to the Rocky Mountain Poison Control Center peaked in 2002 at 22 and declined slightly to 18 in 2004.—**Nancy Brace**

**Los Angeles:** In the first half of 2004 alone, 31 opiate/analgesic exposure calls were reported to poison control, which may indicate a stabilizing of the trend line. Between January 2003 and June 2004, calls involving an exposure to hydrocodone were more likely than calls involving an exposure to oxycodone (58 calls vs. 11 calls, respectively).—**Beth Finnerty**

**Seattle:** In the first half of 2004, there were 98 Helpline calls specifically about OxyContin and 198 about prescription pain pills. Combined, calls for OxyContin and prescription pain pills represented 14 percent of all adult calls for illicit, over-the-counter, and prescription drugs.—**Caleb Banta-Green**

**Texas:** Hydrocodone is a much larger problem than oxycodone or methadone, as documented by a study of poison control centers, deaths, and NFLIS lab exhibits.—**Jane Maxwell**

**Six CEWG members provided updates on deaths related to narcotic analgesics and/or opiate-type drugs. (DAWN mortality data for 2002 can be found in the June 2004 Advance Report.)**

**Colorado:** Data for 2003 show that opiate-related deaths decreased slightly to 152, or 33.3 per million population.—**Nancy Brace**

**Florida/South Florida:** Methadone-related deaths statewide increased 32 percent between the last 6 months of 2003 and the first half of 2004, when they reached 392. This continues a steady increase of methadone-related deaths since 2001. Methadone was the cause of death in 67 percent of the methadone cases during the first half of 2003. Oxycodone-related deaths increased 9 percent statewide between the last 6 months of 2003 and the first half of 2004, when they reached 333. Miami-Dade County recorded 16 oxycodone-related deaths during the first half of 2004, of which 6 (38 percent) were oxycodone-induced. Fourteen of these deaths (88 percent) involved oxycodone found in combination with at least one other drug. Miami-Dade County also recorded 10 hydrocodone-related deaths during the first half of 2004, 3 (30 percent) were hydrocodone-induced; 6 methadone-related deaths, with 4 (67 percent) considered methadone-induced; 22 morphine-related deaths, of which 6 (27 percent) were morphine-induced; and 7 propoxyphene-related deaths, of which 2 (29 percent) were propoxyphene-induced. Broward County recorded 37 oxycodone-related deaths during the first half of 2004, of which 25 (68 percent) were oxycodone-induced. All of these deaths involved oxycodone found in combination with at least one other drug. Broward County also recorded the following: 18 hydrocodone-related deaths during the first half of 2004, of which 10 (56 percent) were hydrocodone-induced; 39 methadone-related deaths, with 22 (56 percent) considered methadone-induced; 23 morphine-related deaths, of which 6 (26 percent) were morphine-induced; and 13 propoxyphene-related deaths, of which 4 (31 percent) were propoxyphene-induced. The two drugs for which there were increases in related deaths between 2003 and the first half of 2004 in Broward County were methadone and morphine.—**James Hall**

**Honolulu:** Decedents with a positive toxicological result for opiates were primarily comprised of those in whom oxycodone was detected. The exact medication (OxyContin or another) used was not specified. In 2004, there

were 25 decedents with a positive toxicology screen for methadone. There were 22 decedents with methadone in their toxicology results in 2003 and 28 in 2002. —**D. William Wood**

**Philadelphia:** Medical examiner detections of oxycodone have been rapidly increasing since 2000. In the first half of 2004, oxycodone was present in 10.9 percent of the drug-positive mortality cases. Hydrocodone mortality cases have also been increasing. Hydrocodone detections currently rank 14th among all deaths with positive toxicology reports.—**Samuel Cutler**

**Seattle:** The number of deaths involving prescription opiates is at an all time high—48 in the first half of 2004, up from 13 in the first half of 1997. Decedents were more likely to be female, 42 percent, than the average for all drugs, 29 percent. They were also slightly more likely to be Caucasian, 87 percent, compared with 84 percent for all drugs. And, the median age was older, 43 years, compared with 42 for all drugs.—**Caleb Banta-Green**

**Texas:** A study of deaths in methadone programs compared with the standardized Texas population found that clients in these programs were 4.6 times more likely to die of a drug overdose, 3.4 times more likely to die of liver disease, 1.5 times more likely to die from a homicide, and 1.4 times more likely to die of AIDS.—**Jane Maxwell**

**DEA and other sources point to increases in the diversion and sale of oxycodone and hydrocodone products.**

**South Florida:** The Broward Sheriff's Crime Lab worked 139 oxycodone cases in the first 6 months of 2004, representing a 15-percent increase from the second half of 2003. There were also 96 hydrocodone cases in the first 6 months of 2004.—**James Hall**

**Newark:** The DEA reported an increase in the diversion of OxyContin in Newark and South Jersey, where it has become a problem among

teenagers and young adults. Hydrocodone products (e.g., Percocet, Percodan, Dilaudid, and Vicodin) are also being diverted to the street market. In November 2004, 18 members of an OxyContin distribution network were arrested in a DEA operation called 'Doctor Feelgood.' Tens of thousands of prescription drug tablets were seized. —**Allison Gertel-Rosenberg**

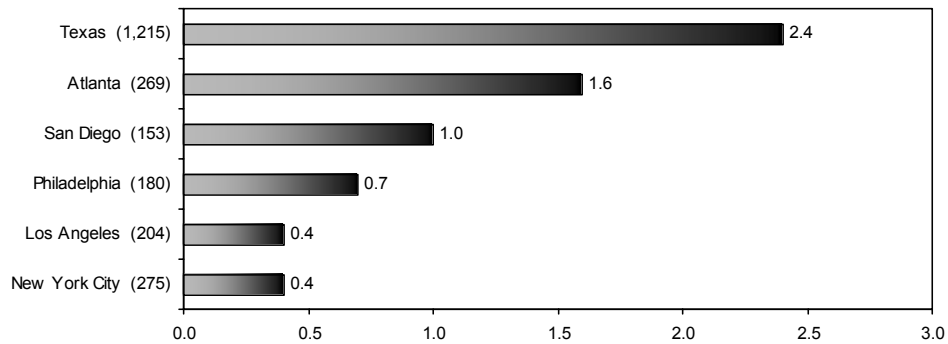
**Phoenix:** The DEA Diversion unit reported the most commonly abused drugs are Vicodin, Lortab, and other hydrocodone products; Percocet, OxyContin, and other oxycodone products... methadone, hydromorphone, morphine, Demerol; codeine products; and anabolic steroids. Soma in combination with other analgesic controlled substances, Ultram (Tramadol), and Nubain continue to be highly abused prescription-only substances. Soma sells for \$2–\$5 per tablet. —**Ilene Dode**

## Patterns and Trends of Narcotic Analgesics/Opiate Abuse Across CEWG Areas

### ***NFLIS Data on Narcotic Analgesics/Other Opiates***

Of the approximately 7,300 narcotic analgesic/opiate items analyzed by forensic laboratories across 19 CEWG areas in FY 2004, nearly 91 percent represented four drug classes: hydrocodone (35.3 percent), oxycodone (23.1 percent), methadone (19.1 percent), and codeine (13.3 percent). All accounted for only small percentages of the total drug items reported. Exhibit 1 shows the number of hydrocodone items in 6 CEWG sites where more than 100 items were reported in FY 2004.

**Exhibit 1. Number of Hydrocodone Items Reported by Forensic Laboratories in 6 CEWG Areas, Ordered by Percentage of Total Items: FY 2004**

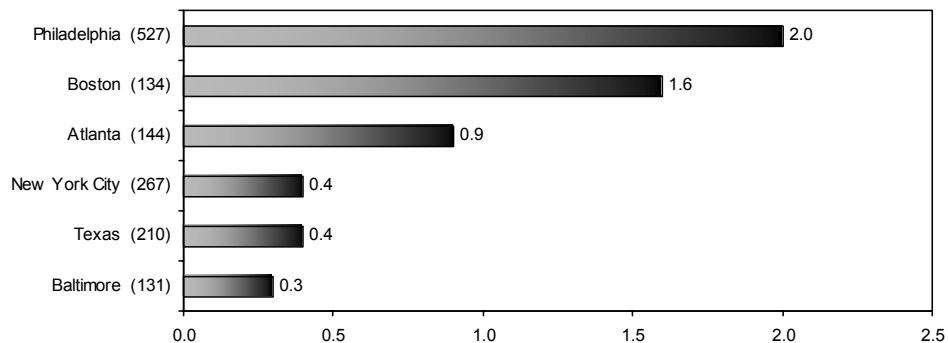


SOURCE: NFLIS, DEA

The number of hydrocodone items in St. Louis totaled 46; in other CEWG areas, the numbers ranged from zero (Detroit and Newark) to 33.

Exhibit 2 depicts the number of oxycodone items analyzed by forensic laboratories in 6 CEWG areas where more than 100 were reported.

**Exhibit 2. Number of Oxycodone Items Reported by Forensic Laboratories in 6 CEWG Areas, Ordered by Percentage of Total Items: FY 2004**



SOURCE: NFLIS, DEA

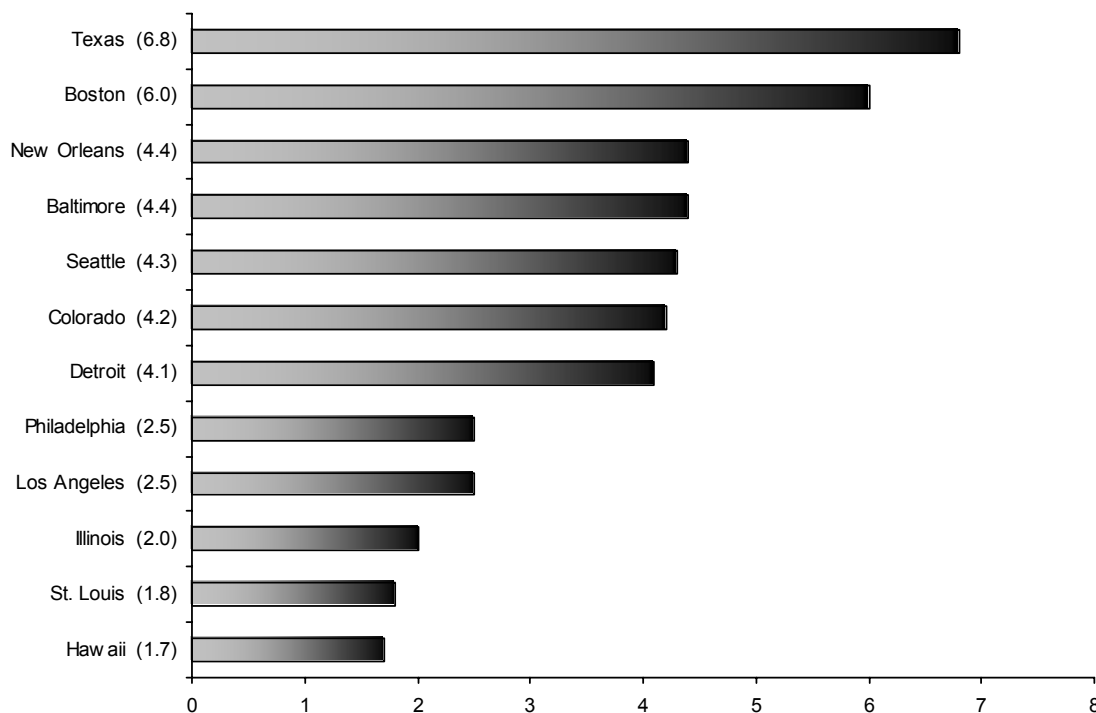
In Miami, St. Louis, and Seattle, between 50 and 51 oxycodone items were reported by forensic labs in FY 2004. None was reported in Detroit. In the other 9 CEWG areas participating in NFLIS, the numbers of oxycodone items reported ranged between 21 and 37.

Atlanta, Arizona, Miami, Minneapolis/St. Paul, and San Francisco). Exhibit 3 shows the most recent data for 12 CEWG areas where primary “other opiate” admissions exceeded 1 percent of all illicit drug admissions. The percentages shown were the same or similar to those reported in the prior 6–12 months.

### ***Treatment Data on Other Opiates***

Treatment admissions data on other opiates were reported by 16 CEWG areas (exceptions were

**Exhibit 3. Percentages of Primary “Other Opiate” Treatment Admissions (Excluding Alcohol) in 12 CEWG Areas: 2003–2004<sup>1</sup>**



<sup>1</sup>Represents either calendar or fiscal year data for the first half of 2004 (n=9), all of 2004 (2), or 2003 (1); see *Data Sources*.

SOURCE: CEWG January 2005 reports on State and local data

### **Prices of Narcotic Analgesics/Opiates**

**Street prices for various prescription-type narcotic analgesics and opiate substances were cited by 10 CEWG members...**

**Atlanta:** Twenty-milligram [OxyContin] tablets sold on the illegal market for \$20 in 2003. —**Brian Dew**

**Boston:** The most recent DEA data report OxyContin’s price at \$1 per milligram on the street. —**Daniel Dooley**

**Chicago:** [Hydromorphone] sells for approximately \$25 per tablet. Street sales of methadone are more common, with the drug typically costing \$0.75–\$1.00 per milligram. Codeine syrup is reported to sell for about \$30 for 4 ounces. On the street, acetaminophen-codeine pills sell for \$1.00–\$3.50 each, although lower if bought in quantities of 10 or more. —**Dita Broz**

**Denver:** A \$4 prescription dose of OxyContin sells on the street for \$40 or \$1 per milligram, 10 times the legal prescription price. —**Nancy Brace**

**Los Angeles:** Vicodin, a member of the hydrocodone family of opiate pain relievers, continues to retail for \$5 per 5-milligram tablet in Los Angeles County. OxyContin, the trade name for the powerful analgesic oxycodone hydrochloride, sells on the streets for \$1 per milligram. LA CLEAR reports reveal that OxyContin is ‘readily available’ in the LA HIDTA. Percocet sells for \$5–\$10 per 5-milligram tablet; MS Contin sells for \$20 per 60-milligram tablet; codeine sells for \$5 per tablet; Dilaudid (hydromorphone) sells for \$100 per 4-milligram tablet; Fentanyl patches sell for \$25–\$100 per patch; and methadone sells for \$10 per tablet. —**Beth Finnerty**

**New York:** Although street researchers have not observed people hawking OxyContin, they have encountered a number of street buyers asking for OxyContin and claiming that the tablets are selling for \$10 per pill. —**Rozanne Marel**



**Phoenix:** Law enforcement agencies reported that the OxyContin 40-milligram tablet sold for \$20–\$25 and the 80-milligram tablet sold for \$20–\$80 per tablet. The price for one tablet of Percocet was \$5; one tablet of Vicodin ES also sold for \$5. —**Ilene Dode**

**St. Louis:** OxyContin costs \$40 for an 80-milligram tablet on the street. The use of hydromorphone (Dilaudid) remained common among a small population of White chronic addicts. The drug costs \$30–\$75 per 4-milligram pill. —**Heidi Israel**

**Texas:** In the Dallas DEA Field Division, there has been an increase in seizures of codeine cough syrup, and, in Tyler, OxyContin has surpassed hydrocodone as the drug of choice among abusers of pharmaceuticals. Dilaudid sells for \$20–\$80 per tablet, and hydrocodone (Vicodin) sells for \$2–\$10 per tablet. OxyContin sells for \$1 per milligram. Methadone sells for \$10 per 10-milligram tablet, and promethazine syrup with codeine sells for \$200–\$325 per pint in Dallas and Fort Worth and \$20 per ounce. In the Houston Field Division, hydrocodone, promethazine with codeine, and other codeine cough syrups are the most commonly abused pharmaceutical drugs. In Houston, promethazine or phenergan cough syrup with codeine sells for \$75–\$100 for 4 ounces, \$125 for 8 ounces, and \$1,600 for a gallon. In San Antonio, hydrocodone sells for \$1–\$3 per pill, OxyContin costs \$1 per milligram, and one pill costs \$25 in McAllen. Dilaudid sells for \$10–\$15 per dose in McAllen. —**Jane Maxwell**

**Washington, DC:** OxyContin abuse is low and scattered. According to the Metropolitan Police Department, the OxyContin available at street markets in northeast DC sells for less than pills sold in the surrounding suburbs (\$0.50 per milligram vs. \$1 per milligram in 2003). —**Erin Artigiani**

## Nonmedical Use of Benzodiazepines

**Benzodiazepine indicators continue to show that this class of prescription drugs is abused in CEWG areas. Alprazolam (Xanax) was identified as the most frequently abused benzodiazepine in most CEWG areas.**

**Benzodiazepines are commonly abused and easily obtained in some CEWG areas...**

**Atlanta:** The use of depressants, especially benzodiazepines, is on the rise in Atlanta. The most commonly abused benzodiazepine is alprazolam (Xanax). Only a few people admitted for drug treatment chose benzodiazepines as their secondary or tertiary drug of choice, but emergency department and medical examiner mentions for these drugs have increased in recent years. —**Brian Dew**

**New York:** According to the Street Studies Unit, Xanax is among the most popular and commonly sold pharmaceuticals on the street. Based on field observations, these pills are readily available throughout the city. Given the high number of sellers and the number of transactions observed, the use of these illicit medications is high and is not expected to decline in the near future. Since these drugs are manufactured by legitimate pharmaceutical companies, purity is not an issue. Most of these medications come in a variety of strengths found on the street. —**Rozanne Marel**

**Philadelphia:** Benzodiazepine abuse was reported by focus group participants as common among users of heroin, oxycodone, cocaine, marijuana, and cough syrup. Since spring 2000, all focus groups have reported that alprazolam has overtaken diazepam as the ‘most popular pill’ on the street. —**Samuel Cutler**

**Phoenix:** The DEA reported that benzodiazepines are among the most commonly abused prescription drugs.—**Ilene Dode**

**Texas:** Alprazolam, clonazepam, and diazepam are among the 15 most commonly identified substances according to Department of Public Safety lab reports, although none of them represent more than 3 percent of all items examined in a year. The proportion of cases that are alprazolam (Xanax) continues to increase. Alprazolam sells for \$3–\$5 in Dallas, Fort Worth, and Houston, and for \$5–\$10 in Tyler. Depending on the dosage unit, diazepam sells for \$1–\$10 in Dallas, Fort Worth, and Tyler.—**Jane Maxwell**

**One CEWG member reported on Helpline calls, another reported on poison control center calls involving benzodiazepine products...**

**Boston:** In FY 2004, there were 175 calls to the Helpline during which benzodiazepines (including Ativan, Valium, Xanax, Klonopin, Rohypnol, Halcion, and others) were self-identified as substances of abuse (3 percent of all calls). The number and proportion of Helpline call mentions attributable to benzodiazepines remained fairly stable from FY 2000 to FY 2004.—**Daniel Dooley**

**Los Angeles:** Los Angeles County-based California Poison Control System calls involving exposure to benzodiazepines fluctuated. The number of calls increased from 64 to 83 in 2001, decreased to 52 in 2002, and increased to 70 in 2003. In the first half of 2004 alone, 52 benzodiazepine exposure calls were reported, indicating a further increase from the number of calls in 2003. Between January 2003 and June 2004, 19 of the benzodiazepine-related exposure calls were for alprazolam, 29 were for clonazepam, and 20 were for diazepam.—**Beth Finnerty**

**Three CEWG members reported on deaths involving benzodiazepines...**

**Florida/South Florida:** Benzodiazepines in general and alprazolam (Xanax) in particular are a substantial problem. Benzodiazepines were second only to alcohol in their involvement in drug-related deaths throughout Florida for the past several years and again in the first half of 2004. There were 994 benzodiazepine-related deaths across Florida in the first 6 months of 2004, representing a 15-percent increase over the 866 such deaths in the previous 6 months. Of the

related deaths in the first half of 2004, a benzodiazepine was identified as the cause of death in 233 cases (or 31 percent). In Miami-Dade County, there were 37 alprazolam-related deaths during the first half of 2004, of which 9 (33 percent) were alprazolam-induced. Seventy-three percent of the deaths involved at least one other drug. There were also 15 diazepam-related deaths in Miami-Dade, of which 2 (13 percent) were caused by the drug, and 87 percent involved at least 1 other drug. Broward County recorded 57 alprazolam-related deaths during the first half of 2004, of which 18 (32 percent) were induced by the drug; only 3 of the deaths involved alprazolam alone. In the same period, Broward County recorded 60 diazepam-related (Valium) deaths, of which 11 (18 percent) were diazepam induced; all of these cases involved at least 1 other drug.—**James Hall**

**Philadelphia:** Diazepam, having been detected by the medical examiner (ME) in 559 decedents from 1994 through the first half of 2004, ranks fourth among drugs present in mortality cases in Philadelphia. Alprazolam tied for the 12th most frequently detected drug among decedents by the Philadelphia ME (n=244) from 1994 through the first half of 2004, including 31 cases in the lattermost half-year.—**Samuel Cutler**

**Seattle:** Deaths involving depressants were at the highest level in the year from July 2003 to June 2004, with 79 deaths, compared with 45 in 1997. The depressant-involved deaths were older, 43 compared with 42 for all drug-involved deaths; more likely to be Caucasian, 89 percent compared with 84 percent; and more likely to be female, 43 percent compared with 29 percent for all drug involved deaths. Few depressant-involved deaths were related solely to depressants, 7 percent overall, the second lowest proportion next to muscle relaxants.—**Caleb Banta-Green**

## Patterns and Trends in Benzodiazepine Abuse Across CEWG Areas

### **NFLIS Data on Benzodiazepines**

In FY 2004, there were 6,604 reports of benzodiazepine items analyzed by forensic laboratories in 17 CEWG areas and the 13 Texas sites. Nearly

two-thirds (63.8 percent) of the items were alprazolam; 18.2 percent were clonazepam items; 14.7 percent were diazepam; and 3.3 percent were lorazepam items.

The numbers of items in each CEWG area are presented in exhibit 4. In five CEWG areas, alprazolam accounted for more than 1 percent of all drug items analyzed (New York City, 1.6

percent; Miami, 1.7 percent; Atlanta, 2.0 percent; Philadelphia, 2.5 percent; and Texas, 3.0 percent). The numbers of items shown for alprazolam in other CEWG areas, and for clonazepam, diazepam, and lorazepam in all areas, accounted for less than 1 percent of the total drug items in each area.

**Exhibit 4. Number of Alprazolam, Clonazepam, Diazepam, and Lorazepam Items Analyzed by Forensic Laboratories in 18 CEWG Areas<sup>1</sup>: FY 2004**

CEWG Area	Alprazolam	Clonazepam	Diazepam	Lorazepam
Atlanta	362 <sup>2</sup>	35	62	6
Baltimore	51	28	33	12
Boston	33	47	28	16
Chicago	42	16	24	10
Denver	9	10	14	2
Honolulu	6	3	11	0
Los Angeles	40	48	75	0
Miami	259 <sup>2</sup>	6	14	0
Mpls./St. Paul	6	3	7	0
New Orleans	24	0	13	1
New York City	1,061 <sup>2</sup>	327	128	70
Newark	20	0	0	0
Philadelphia	662 <sup>2</sup>	99	106	0
St. Louis	46	4	19	8
San Diego	59	77	91	22
Seattle	5	12	12	4
Texas	1,507 <sup>2</sup>	480	336	68
Wash., DC	19	6	0	0

<sup>1</sup>No benzodiazepine-type items were reported from Detroit.

<sup>2</sup>Accounted for more than 1 percent of total items, ranging from 1.6 percent in New York City to 3.0 percent in Texas.

SOURCE: NFLIS, DEA

### **Treatment Data on Benzodiazepines/Depressants**

Treatment data on benzodiazepines or depressants were reported from several CEWG areas.

**Atlanta:** The treatment data from publicly funded programs included benzodiazepines as secondary and tertiary drug choices for the first 6 months of 2004. In metropolitan Atlanta, nearly 1 percent of primary heroin and methamphetamine

users chose benzodiazepines as a secondary drug choice. These percentages are consistent with the figures from the previous 3 years.

—**Brian Dew**

**Baltimore:** Treatment admissions for benzodiazepines and other tranquilizers declined slightly, from 5.0 per 100,000 population age 12 and older to 3.9 per 100,000 in 2003.

Benzodiazepines were mentioned in 11 percent of drug-related ED episodes in 2002, representing a small (2 percent) increase from 59 mentions per 100,000 population in 2001 to 60 per 100,000 in 2002. —**Leigh Henderson**

**Philadelphia:** *Treatment admission reports show benzodiazepines as primary drugs of abuse in 67 cases in 2003 and 19 in the first half of 2004; however, these drugs were reported as secondary or tertiary drugs of abuse in 382 additional cases in 2003 and 172 additional cases in the first half of 2004. Most of the reports of benzodiazepines as secondary or tertiary drugs of choice indicated that heroin was the primary drug. Those who reported*

*using benzodiazepines as their primary drugs of abuse used an average of 2.0 drugs in 2003 and 1.63 drugs in the first half of 2004.*—**Samuel Cutler**

**Seattle:** *Less than 1 percent of admissions during the period of January 1999 to 2004 were for depressants.*—**Caleb Banta-Green**

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## APPENDIX A

### Total Admissions by Primary Substance of Abuse and CEWG Area: 2003–2004<sup>1</sup>

Area	Alcohol Only	Alcohol/ Other Drug	Cocaine/ Crack	Heroin	Marijuana	Stimulants	Other Drugs	Total
Atlanta	1,033		1,756	249	943	350	0	4,331
Baltimore	2,847	2,195	2,205	7,822	2,225	48	793	18,135
Boston	7,064		1,470	9,621	857	61	955	20,028
Detroit	4,705		3,747	4,843	1,419	11	518	15,243
Los Angeles	2,499	2,826	5,137	6,942	3,812	5,985	1,170	28,371
Miami (Sample) <sup>2</sup>	NR <sup>3</sup>		1,919	528	1,450	NR	160	4,057
Mpls./St. Paul	4,614		1,173	268	1,999	887	425	9,366
New Orleans	432		729	255	740	11	93	2,306
New York	4,811	6,437	8,208	11,878	6,746	108	1,399	39,587
Newark	83	135	167	1,857	178	1	45	2,466
Philadelphia	809		980	1,105	663	19	304	3,880
St. Louis	854	661	1,625	565	1,352	261	120	5,438
San Diego	3,826		1,312	1,310	2,998	6,376	290	16,428
San Francisco	2,680		2,527	3,646	950	1,235	162	11,200
Seattle	1,788		561	755	824	413	247	4,588
Wash., DC	552	330	1,378	2,023	336	10	203	4,832
Arizona	16,005		3,274	4,001	4,365	7,639	1,091	36,375
Colorado	8,580		2,614	1,090	4,988	3,352	780	21,404
Hawaii	860		172	72	708	1,516	121	3,449
Illinois	51,651		33,882	34,615	32,077	4,508	15,837	172,570
Texas	3,726	4,218	7,358	2,782	5,372	2,748	2,018	28,222

<sup>1</sup>Data represent calendar or fiscal year 2003 or 2004; see *Data Sources*.

<sup>2</sup>Represents two programs in Broward County.

<sup>3</sup>NR=Not reported.

SOURCE: January 2005 CEWG Reports

## APPENDIX B

### New Drug Abuse Warning Network (DAWN) Emergency Department Data and DAWN Live!: Major Features and Individual CEWG Area Summaries

#### New DAWN Emergency Department (ED) Data

Major changes to DAWN were instituted at the beginning of 2003. These changes are a result of a redesign that altered virtually every feature of DAWN except its name. New DAWN data cannot be trended with prior years.

**DAWN Hospitals and Areas.** A sample of hospitals has been selected for the Nation as a whole, with oversampling in selected metropolitan areas. Eligible hospitals in DAWN are short-term, general, non-Federal hospitals that operate 24-hour emergency departments. Some hospitals operate more than one emergency department (ED). DAWN uses metropolitan-area boundary definitions issued by the Office of Management and Budget (OMB) in 2003. These are based on the 2000 Census.

**A DAWN Case.** In the new DAWN system, a DAWN case is defined as any emergency department visit related to recent drug use. The patient may be any age. The visits may be associated with substance abuse but also include drug misuse, both intentional and accidental. Included are visits related to the use of drugs for legitimate therapeutic purposes. Current medications unrelated to a visit are not reported.

To be considered a DAWN case, a drug need not be the cause of the visit but must be implicated in the visit. Only recent drug use is included. Case criteria are “broad enough to encompass all types of drug-related events, which include, but are not limited to, explicit drug abuse” (OAS 2004).<sup>1</sup>

**Case Finding.** DAWN cases are found through a retrospective review of medical charts for all patients treated in an ED. Reporters who review charts and report DAWN cases are rigorously trained, and quality assurance protocols identify points where threats to data quality can be avoided or identified and corrected.

**Case Types.** Each DAWN case is assigned hierarchically into one and only one case type, based on a series of questions and rules. Cases are classified into the first case type that applies. Even if a case might fit into more than one type, it is assigned to the first one that applies. The eight case types in hierarchical order are...

- Suicide attempt
- Seeking detoxification
- Alcohol only in patients under age 21
- Adverse reactions
- Overmedication
- Malicious poisoning (includes drug-facilitated sexual assault or product tampering)
- Accidental ingestion
- Other

The eighth case type, which is called *other*, is designed to capture all drug-related ED visits that could not be classified in any of the prior seven case types. *Other* is the case-type category designed to capture most drug abuse cases.

**Drugs.** A maximum of six drugs, plus alcohol, may be reported for each DAWN case. The substances reported may include illicit drugs, prescription and over-the-counter pharmaceuticals, dietary supplements, non-pharmaceutical inhalants, alcohol in combination with other drugs, and alcohol only for patients younger than 21.

<sup>1</sup>For additional details on case definitions and other aspects of DAWN, see *DAWN, 2003: Interim National Estimates of Drug-Related Emergency Department Visits* (DAWN Series D-26, DHHS Publication No. (SMA) 04-3972). Rockville, MD: SAMHSA, Office of Applied Studies, December 2004. Available on-line at <<http://DAWNinfo.samhsa.gov>>.



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**DAWN Publications.** After each annual data collection, the cleaned DAWN data are weighted to produce estimates for each metropolitan area and for the coterminous United States, and an annual report is published and disseminated.

## DAWN *Live!*

The new DAWN includes capability for “real-time” surveillance of ED visits through DAWN *Live!*, an online query system. Access to DAWN *Live!* is limited to authorized users. Data in DAWN *Live!* are raw and unweighted reports of de-identified DAWN cases from participating hospitals. The cases from participating hospitals may not be representative of all cases in the area; other hospitals may treat different types of cases or users of different drugs. Also, data from some hospitals may be reported more rapidly than data from other hospitals. DAWN *Live!* does not produce estimates, i.e., measures extrapolated from participating hospitals to an entire metropolitan area.

In examining DAWN *Live!* data, it is important to consider how many hospitals are reporting and the completeness of their data.

Since data available from DAWN *Live!* are raw and unweighted, they cannot be generalized to the entire metropolitan area or be used to compare one metropolitan area with another. However they can help answer the following questions:

- What is the nature of the drug-related ED visits in participating hospitals?
- What drugs were involved?
- What was the relative mix of case types?

Data from DAWN *Live!* may be useful in quickly identifying the emergence of new drugs in an area and may provide some insights into the characteristics of users of these drugs and the associated health consequences of their drug use.

The remainder of this appendix provides summaries of raw, unweighted DAWN ED data by CEWG metropolitan area for 2004, based on cases submitted to DAWN as of April 13–14, 2005. The findings on specific drugs are expressed as the number of reports of that drug. As noted earlier, a DAWN case may include multiple drug reports.

# Atlanta ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Atlanta	39	30	33	16–18	0–2	0–1	14–16

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13–4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	943
Seeking detox	2,398
Alcohol only (age<21)	255
Adverse reaction	2,684
Overmedication	1,408
Malicious poisoning	29
Accidental ingestion	163
Other	5,547

<sup>1</sup>Unweighted data from Atlanta hospitals reporting to DAWN.  
SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13–4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>13,401</b>
Alcohol	3,964
Alcohol-in-combination with other drugs	3,709
Alcohol only (age<21)	255
Cocaine	5,758
Heroin	483
Marijuana	2,001
Stimulants	934
Amphetamines	367
Methamphetamine	567
MDMA (ecstasy)	75
GHB	57
Ketamine	4
LSD	24
PCP	47
Miscellaneous hallucinogens	8
Inhalants	31
Combinations not tabulated above	14

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

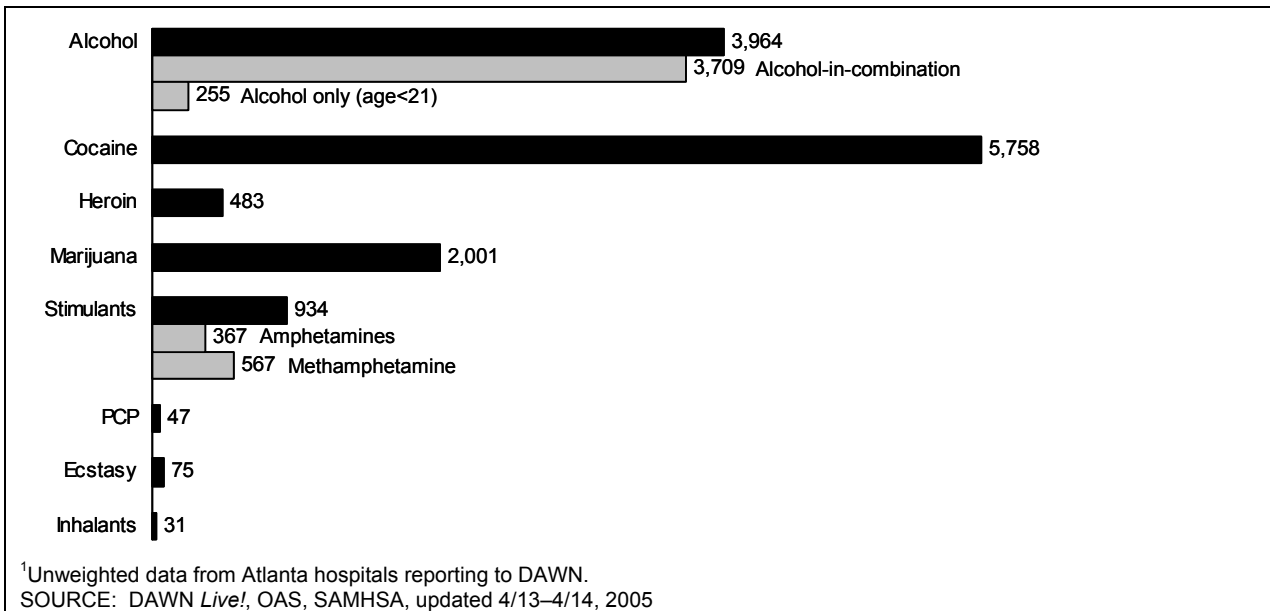
<sup>2</sup>Unweighted data from Atlanta hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13–4/14, 2005

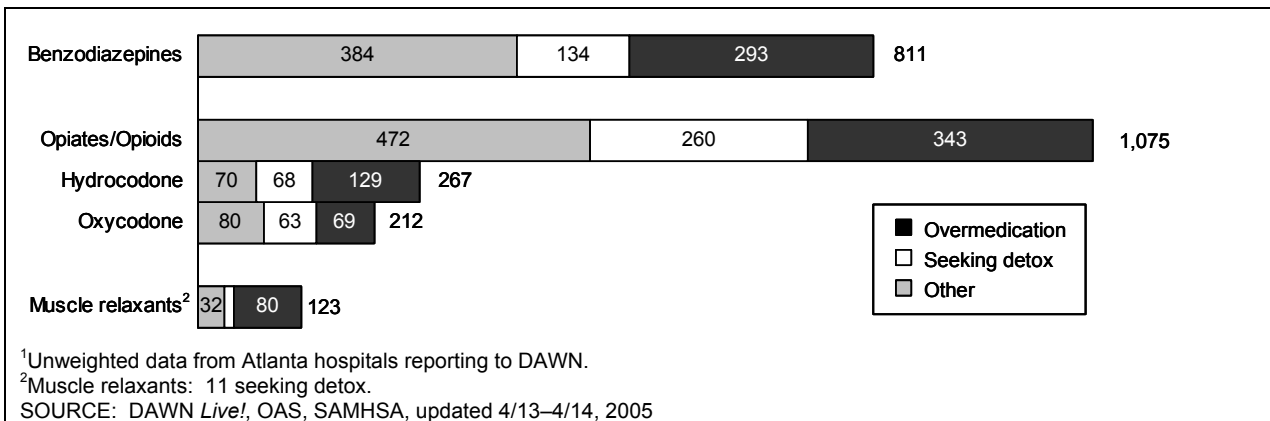
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Baltimore ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Baltimore	21	21	24	10–21	1–5	0–7	1–9

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	582
Seeking detox	1,942
Alcohol only (age<21)	468
Adverse reaction	2,152
Overmedication	1,376
Malicious poisoning	11
Accidental ingestion	208
Other	5,818

<sup>1</sup>Unweighted data from Baltimore hospitals reporting to DAWN. SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>13,617</b>
Alcohol	3,089
Alcohol-in-combination with other drugs	2,621
Alcohol only (age<21)	468
Cocaine	4,511
Heroin	4,533
Marijuana	1,219
Stimulants	103
Amphetamines	88
Methamphetamine	15
MDMA (ecstasy)	59
GHB	4
Ketamine	7
LSD	18
PCP	34
Miscellaneous hallucinogens	9
Inhalants	19
Combinations not tabulated above	12

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

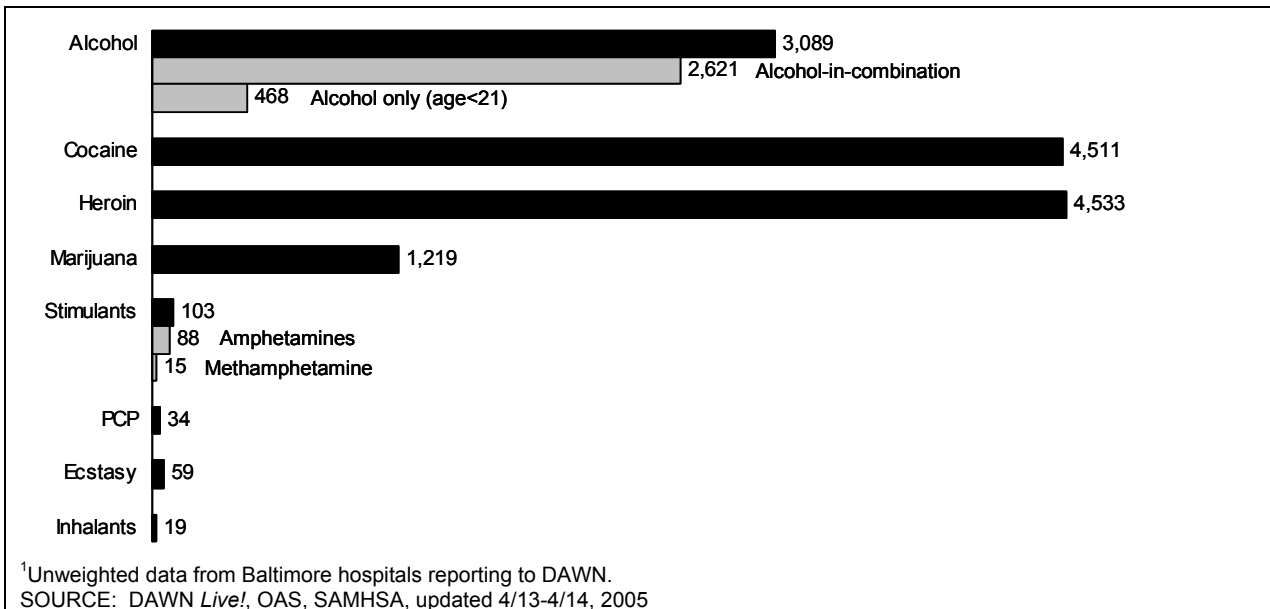
<sup>2</sup>Unweighted data from Baltimore hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

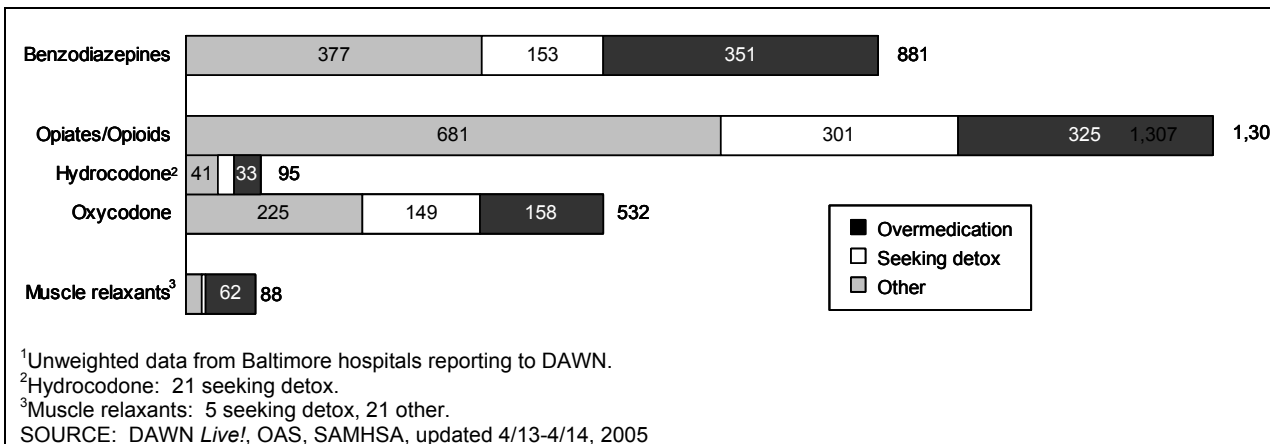
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Boston ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Boston	41	29	34	15–23	0–3	0–4	11–16

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	618
Seeking detox	2,823
Alcohol only (age<21)	1,046
Adverse reaction	5,011
Overmedication	2,128
Malicious poisoning	26
Accidental ingestion	309
Other	5,353

<sup>1</sup>Unweighted data from Boston hospitals reporting to DAWN. SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>13,274</b>
Alcohol	4,317
Alcohol-in-combination with other drugs	3,271
Alcohol only (age<21)	1,046
Cocaine	3,348
Heroin	3,341
Marijuana	1,801
Stimulants	223
Amphetamines	184
Methamphetamine	39
MDMA (ecstasy)	101
GHB	18
Ketamine	3
LSD	6
PCP	22
Miscellaneous hallucinogens	23
Inhalants	55
Combinations not tabulated above	14

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

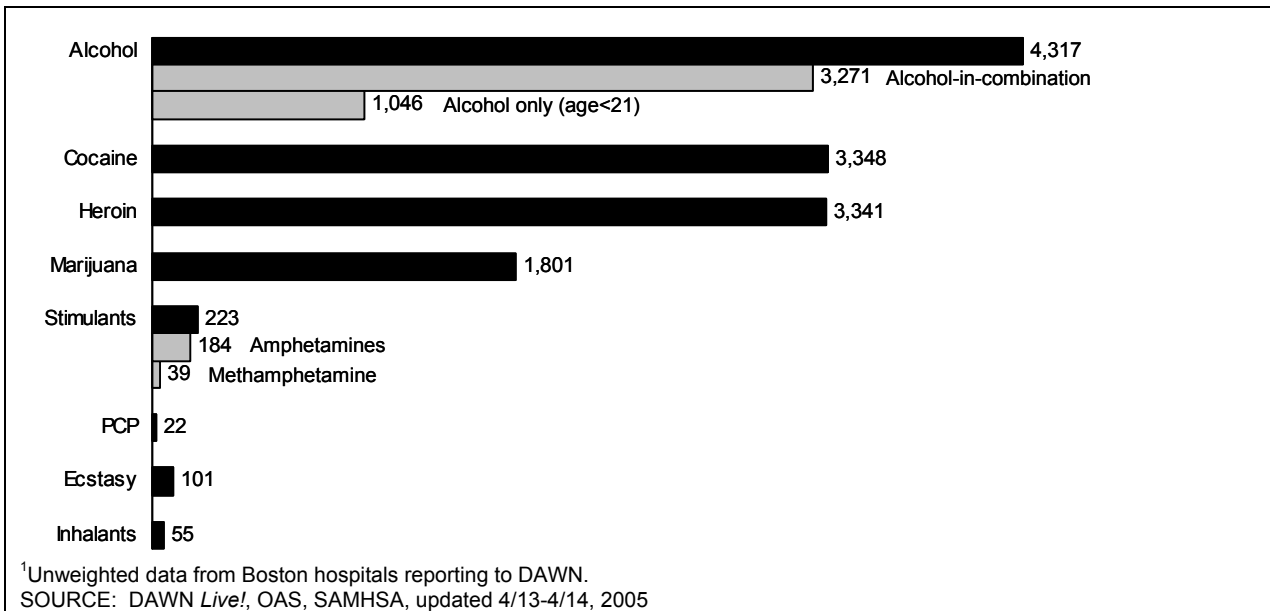
<sup>2</sup>Unweighted data from Boston hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

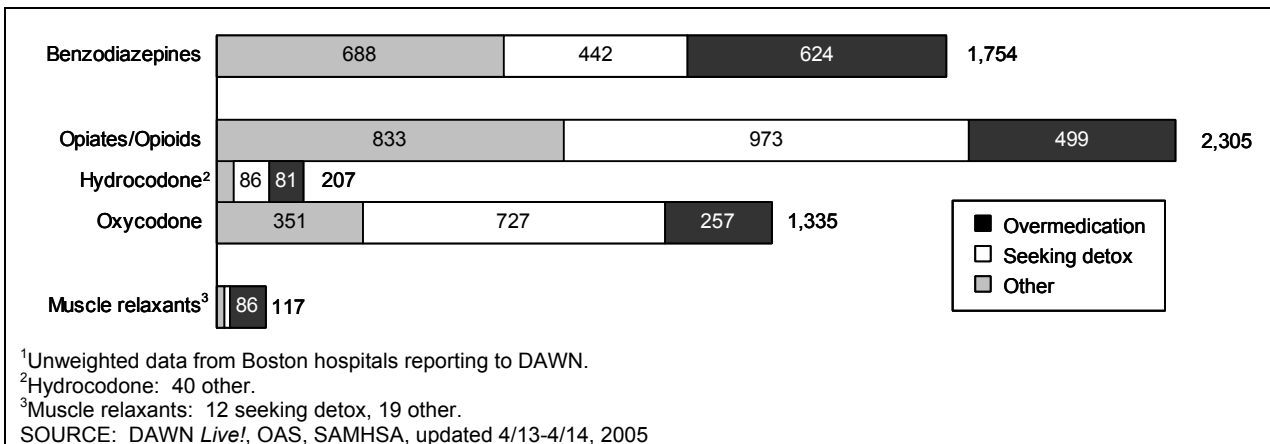
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Chicago ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Chicago	88	74	76	19–31	0–6	0–7	44–52

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	849
Seeking detox	1,838
Alcohol only (age<21)	777
Adverse reaction	8,801
Overmedication	1,745
Malicious poisoning	77
Accidental ingestion	384
Other	9,203

<sup>1</sup>Unweighted data from Chicago hospitals reporting to DAWN. SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>17,537</b>
Alcohol	4,628
Alcohol-in-combination with other drugs	3,851
Alcohol only (age<21)	777
Cocaine	5,981
Heroin	4,163
Marijuana	2,222
Stimulants	128
Amphetamines	81
Methamphetamine	47
MDMA (ecstasy)	63
GHB	45
Ketamine	3
LSD	17
PCP	158
Miscellaneous hallucinogens	18
Inhalants	80
Combinations not tabulated above	26

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

<sup>2</sup>Unweighted data from Chicago hospitals reporting to DAWN.

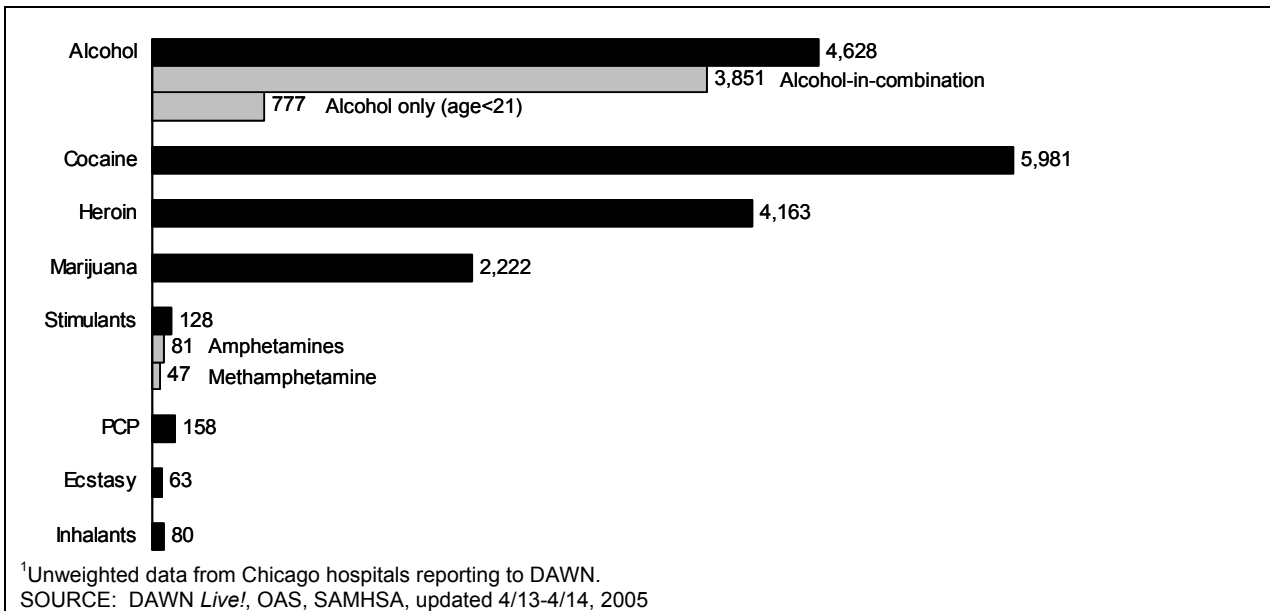
<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005



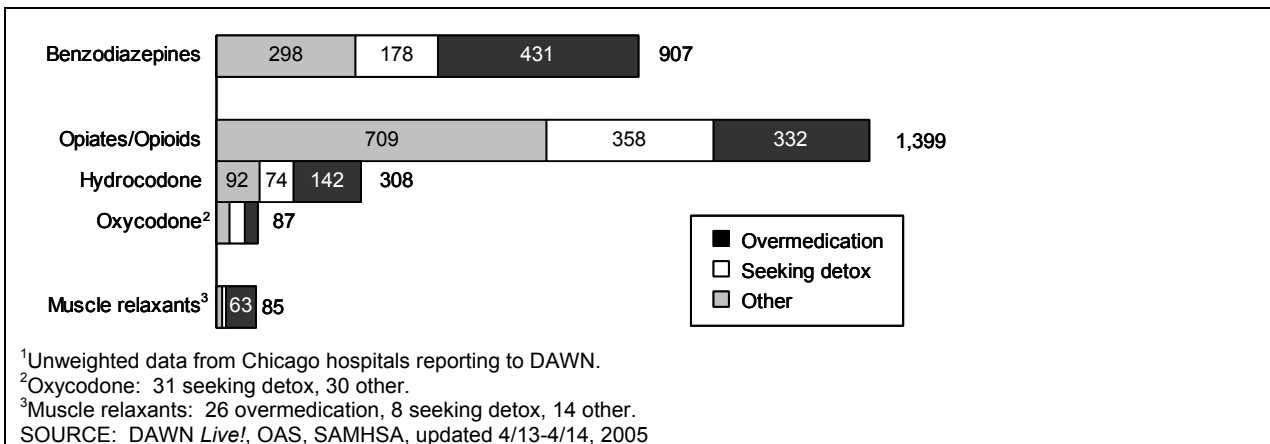
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



## Dallas/Ft. Worth ED Data Summary: 2004

### DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Dallas/Ft. Worth	49	48	49	8–13	0–4	0–2	33–39

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	751
Seeking detox	495
Alcohol only (age<21)	321
Adverse reaction	3,000
Overmedication	1,560
Malicious poisoning	33
Accidental ingestion	248
Other	4,074

<sup>1</sup>Unweighted data from Dallas/Ft. Worth hospitals reporting to DAWN.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>7,075</b>
Alcohol	1,825
Alcohol-in-combination with other drugs	1,504
Alcohol only (age<21)	321
Cocaine	2,329
Heroin	361
Marijuana	1,281
Stimulants	1,027
Amphetamines	450
Methamphetamine	577
MDMA (ecstasy)	45
GHB	41
Ketamine	1
LSD	10
PCP	71
Miscellaneous hallucinogens	19
Inhalants	42
Combinations not tabulated above	23

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

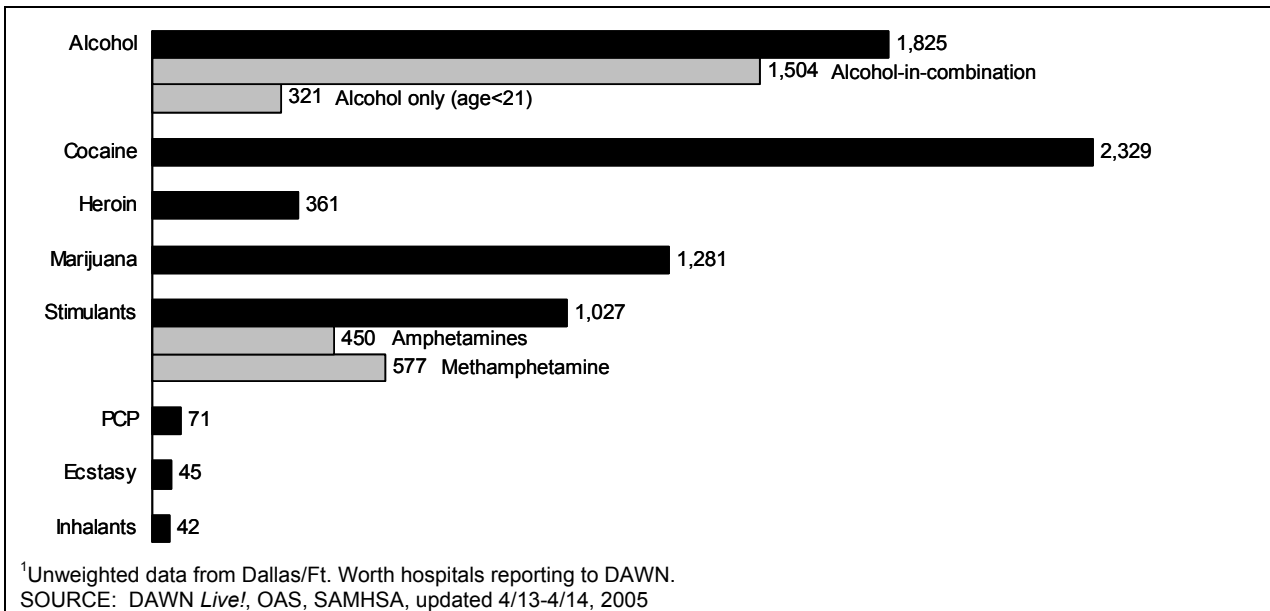
<sup>2</sup>Unweighted data from Dallas/Ft. Worth hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

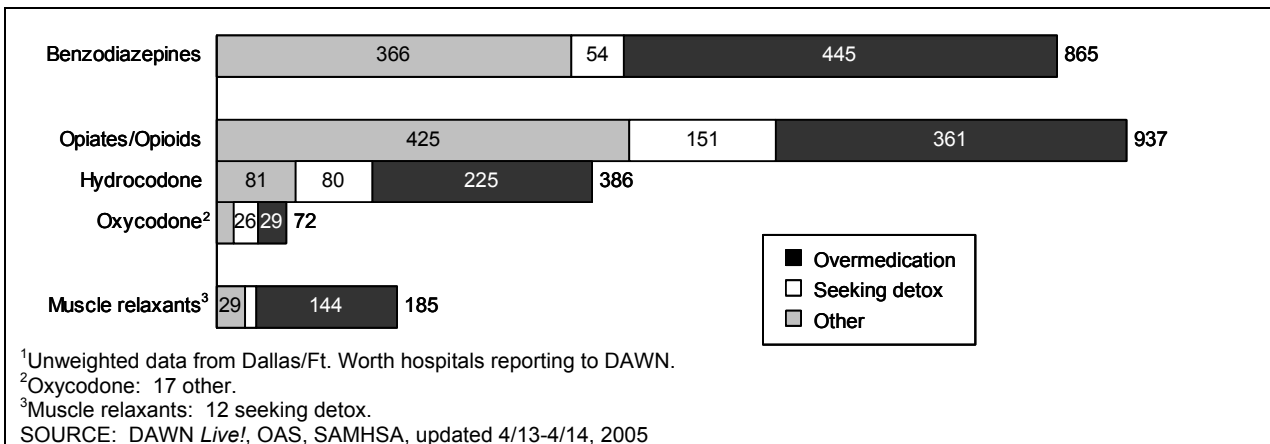
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Denver ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Denver	14	14	14	5–8	0–1	0–1	6–9

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	600
Seeking detox	412
Alcohol only (age<21)	755
Adverse reaction	1,370
Overmedication	1,235
Malicious poisoning	12
Accidental ingestion	196
Other	2,979

<sup>1</sup>Unweighted data from Denver hospitals reporting to DAWN. SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>6,186</b>
Alcohol	2,304
Alcohol-in-combination with other drugs	1,549
Alcohol only (age<21)	755
Cocaine	1,569
Heroin	609
Marijuana	755
Stimulants	755
Amphetamines	280
Methamphetamine	475
MDMA (ecstasy)	64
GHB	5
Ketamine	2
LSD	9
PCP	12
Miscellaneous hallucinogens	32
Inhalants	62
Combinations not tabulated above	8

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

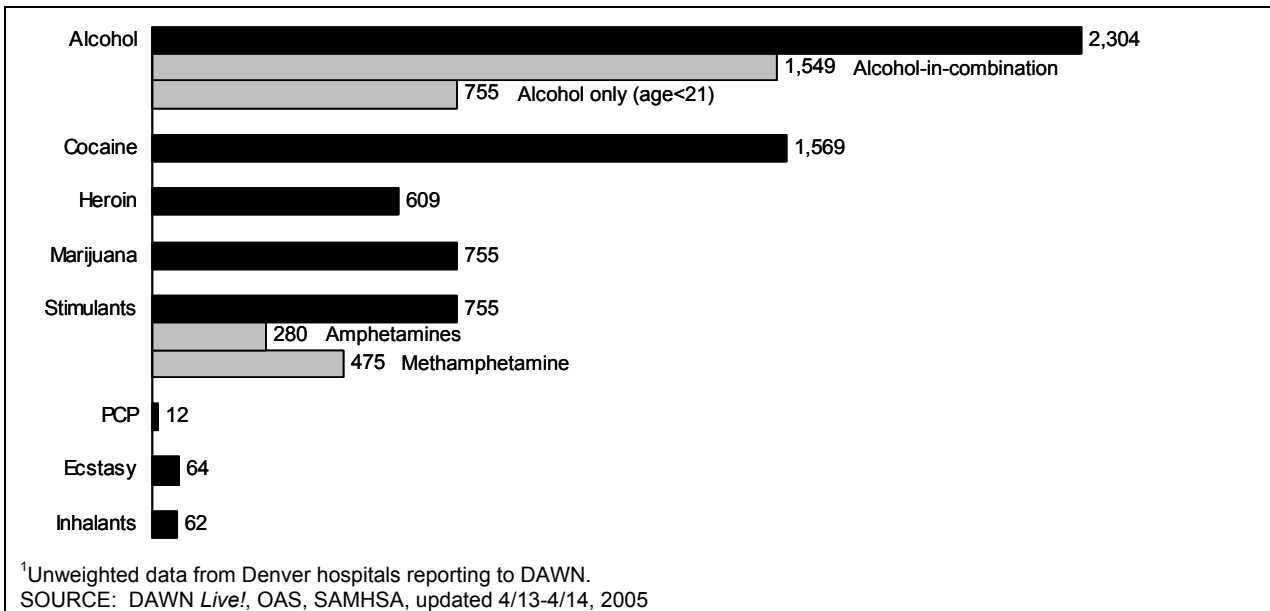
<sup>2</sup>Unweighted data from Denver hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

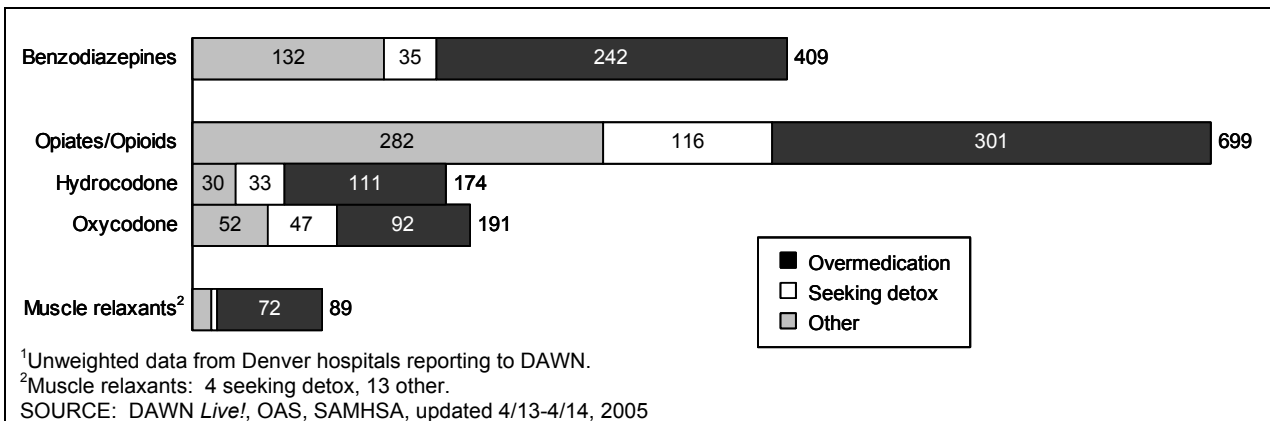
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Detroit ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Detroit	38	23	24	7–21	0–2	0–2	3–15

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	846
Seeking detox	381
Alcohol only (age<21)	392
Adverse reaction	4,272
Overmedication	1,664
Malicious poisoning	25
Accidental ingestion	399
Other	5,568

<sup>1</sup>Unweighted data from Detroit hospitals reporting to DAWN.  
SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>9,987</b>
Alcohol	2,997
Alcohol-in-combination with other drugs	2,605
Alcohol only (age<21)	392
Cocaine	3,287
Heroin	1,885
Marijuana	1,525
Stimulants	115
Amphetamines	99
Methamphetamine	16
MDMA (ecstasy)	76
GHB	4
Ketamine	0
LSD	6
PCP	13
Miscellaneous hallucinogens	10
Inhalants	63
Combinations not tabulated above	5

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

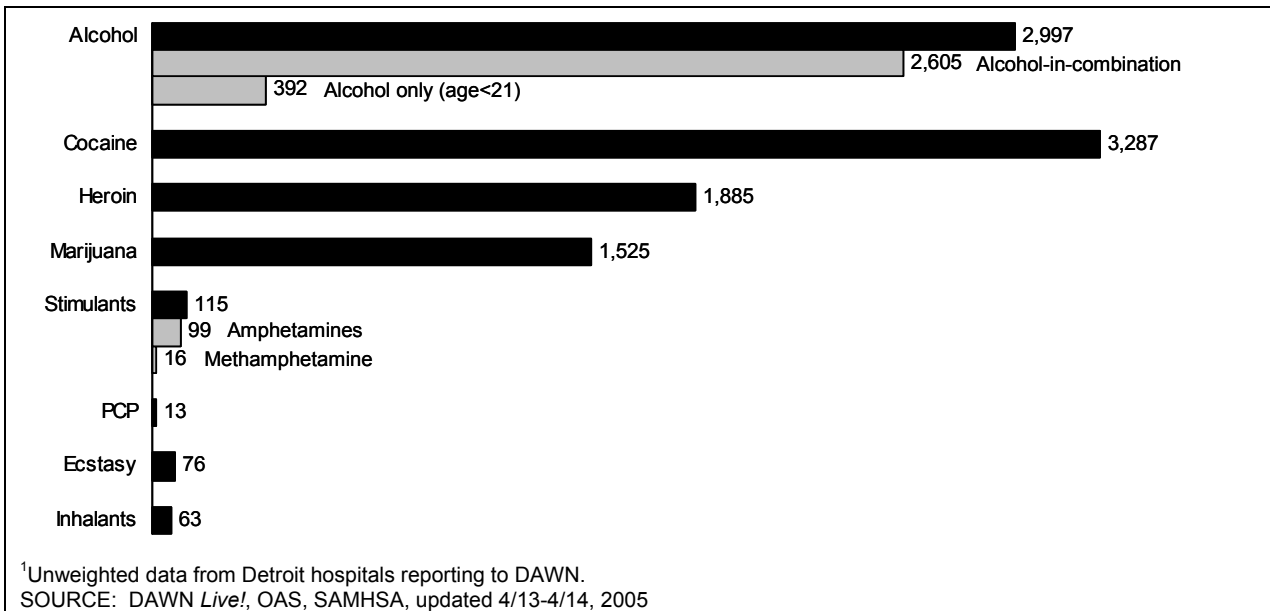
<sup>2</sup>Unweighted data from Detroit hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

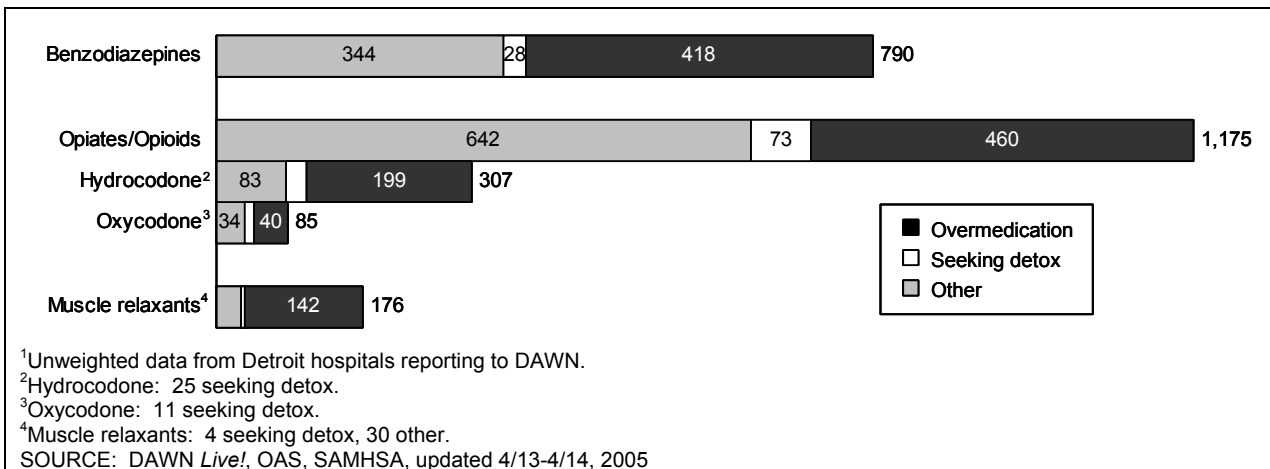
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Houston ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Houston	44	37	39	9–14	0–4	0–1	24–25

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	705
Seeking detox	463
Alcohol only (age<21)	224
Adverse reaction	1,286
Overmedication	1,424
Malicious poisoning	69
Accidental ingestion	201
Other	4,593

<sup>1</sup>Unweighted data from Houston hospitals reporting to DAWN. SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>8,773</b>
Alcohol	2,339
Alcohol-in-combination with other drugs	2,115
Alcohol only (age<21)	224
Cocaine	3,296
Heroin	166
Marijuana	2,078
Stimulants	445
Amphetamines	319
Methamphetamine	126
MDMA (ecstasy)	109
GHB	4
Ketamine	0
LSD	17
PCP	239
Miscellaneous hallucinogens	13
Inhalants	52
Combinations not tabulated above	11

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

<sup>2</sup>Unweighted data from Houston hospitals reporting to DAWN.

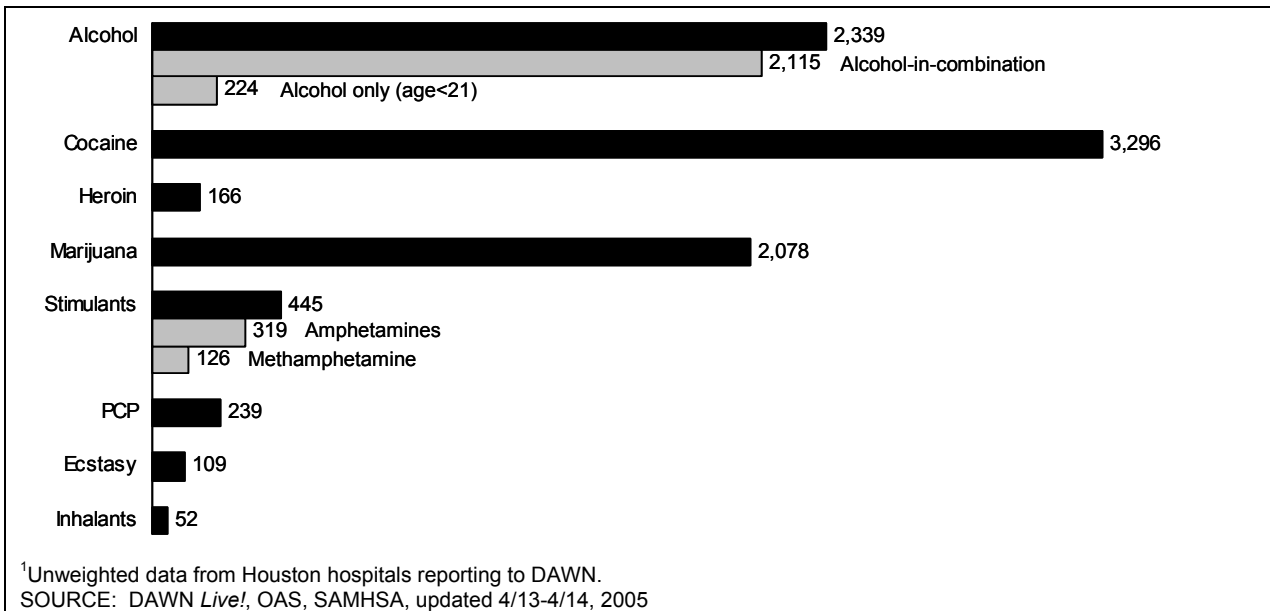
<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005



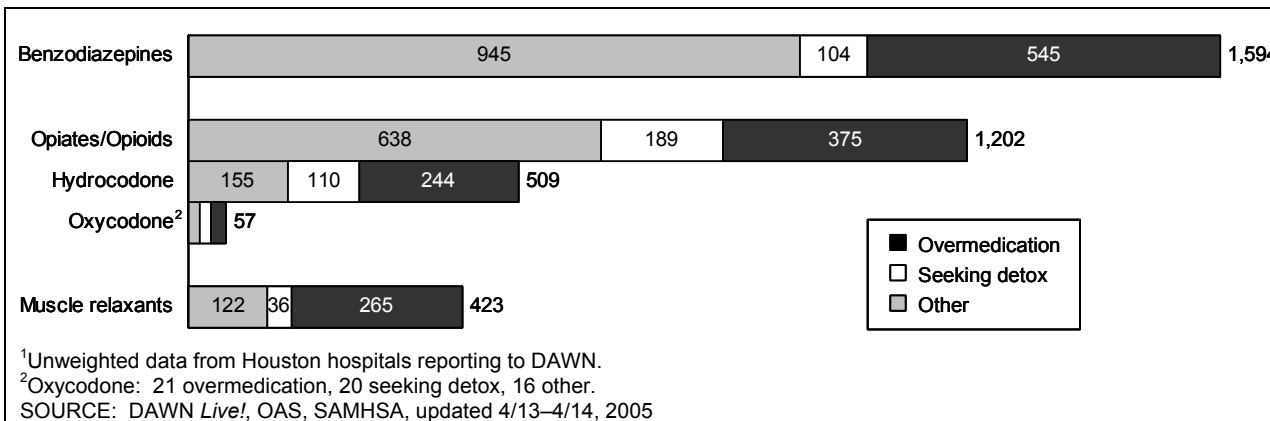
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Los Angeles ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Los Angeles	79	34	37	7–12	0–3	0–3	23–28

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	516
Seeking detox	190
Alcohol only (age<21)	531
Adverse reaction	1,467
Overmedication	894
Malicious poisoning	28
Accidental ingestion	119
Other	4,739

<sup>1</sup>Unweighted data from Los Angeles hospitals reporting to DAWN.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>8,982</b>
Alcohol	3,307
Alcohol-in-combination with other drugs	2,776
Alcohol only (age<21)	531
Cocaine	2,348
Heroin	712
Marijuana	1,067
Stimulants	1,235
Amphetamines	326
Methamphetamine	909
MDMA (ecstasy)	65
GHB	5
Ketamine	1
LSD	5
PCP	164
Miscellaneous hallucinogens	3
Inhalants	44
Combinations not tabulated above	26

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

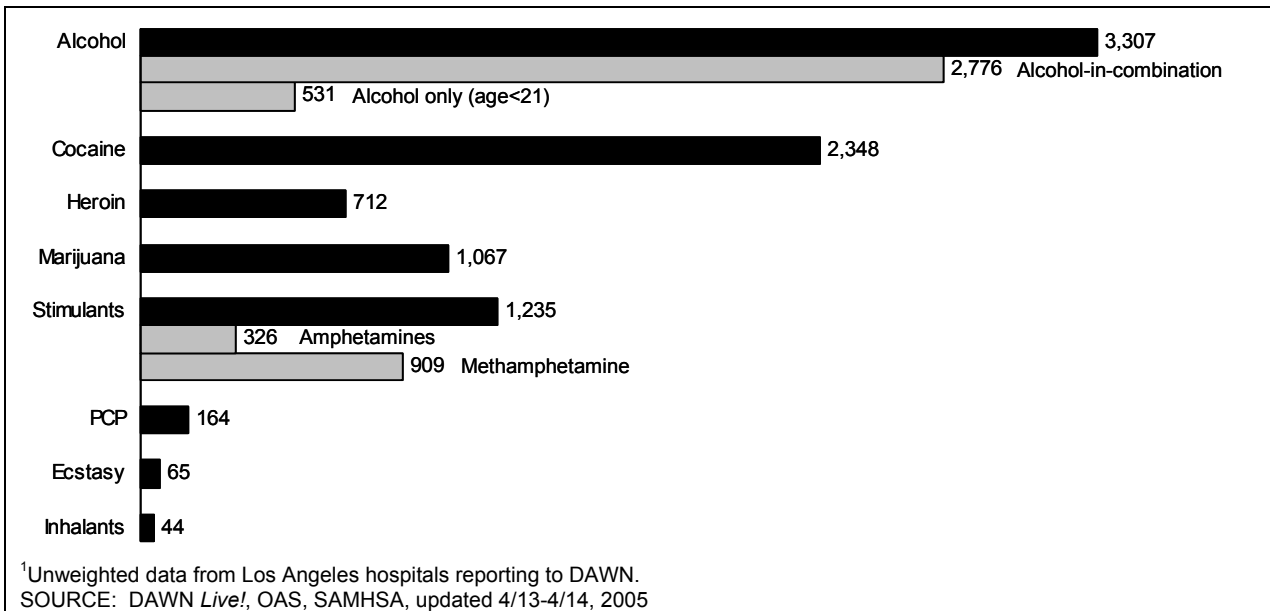
<sup>2</sup>Unweighted data from Los Angeles hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

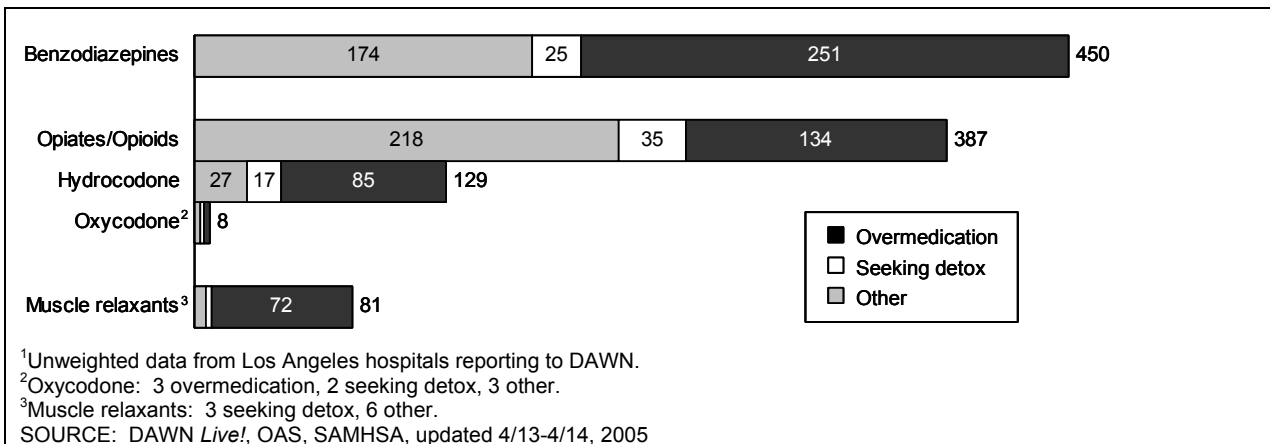
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Miami-Dade County ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Miami-Dade County	21	17	17	5–9	1–3	0–1	7–9

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	463
Seeking detox	2,551
Alcohol only (age<21)	232
Adverse reaction	1,118
Overmedication	772
Malicious poisoning	8
Accidental ingestion	83
Other	5,050

<sup>1</sup>Unweighted data from Miami-Dade County hospitals reporting to DAWN.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>12,896</b>
Alcohol	3,671
Alcohol-in-combination with other drugs	3,439
Alcohol only (age<21)	232
Cocaine	5,420
Heroin	1,387
Marijuana	2,098
Stimulants	87
Amphetamines	49
Methamphetamine	38
MDMA (ecstasy)	106
GHB	21
Ketamine	5
LSD	35
PCP	10
Miscellaneous hallucinogens	13
Inhalants	24
Combinations not tabulated above	18

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

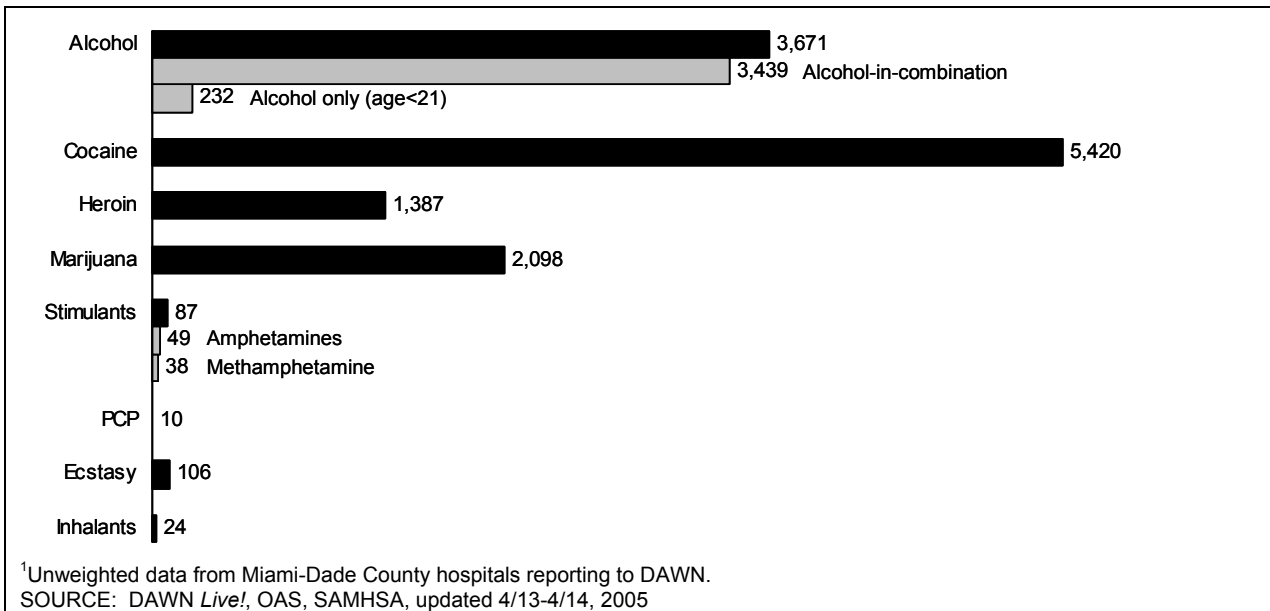
<sup>2</sup>Unweighted data from Miami-Dade County hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

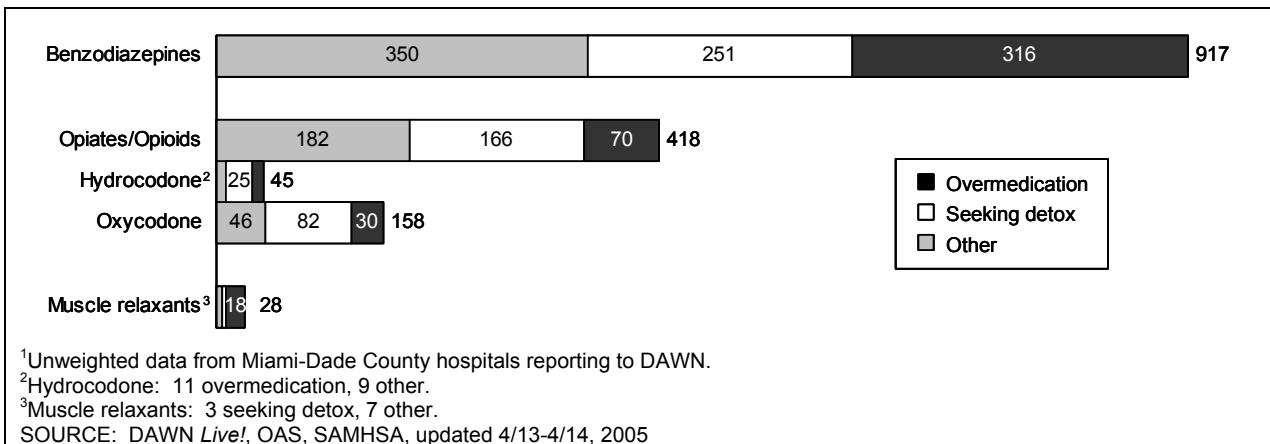
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Minneapolis/St. Paul ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Minneapolis/St. Paul	28	26	26	6–13	0–1	0–1	13–19

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	851
Seeking detox	1,511
Alcohol only (age<21)	760
Adverse reaction	4,419
Overmedication	1,525
Malicious poisoning	90
Accidental ingestion	154
Other	5,339

<sup>1</sup>Unweighted data from Minneapolis/St. Paul hospitals reporting to DAWN.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>11,922</b>
Alcohol	4,140
Alcohol-in-combination with other drugs	3,380
Alcohol only (age<21)	760
Cocaine	3,046
Heroin	779
Marijuana	2,556
Stimulants	1,058
Amphetamines	184
Methamphetamine	874
MDMA (ecstasy)	102
GHB	22
Ketamine	4
LSD	20
PCP	21
Miscellaneous hallucinogens	57
Inhalants	89
Combinations not tabulated above	25

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

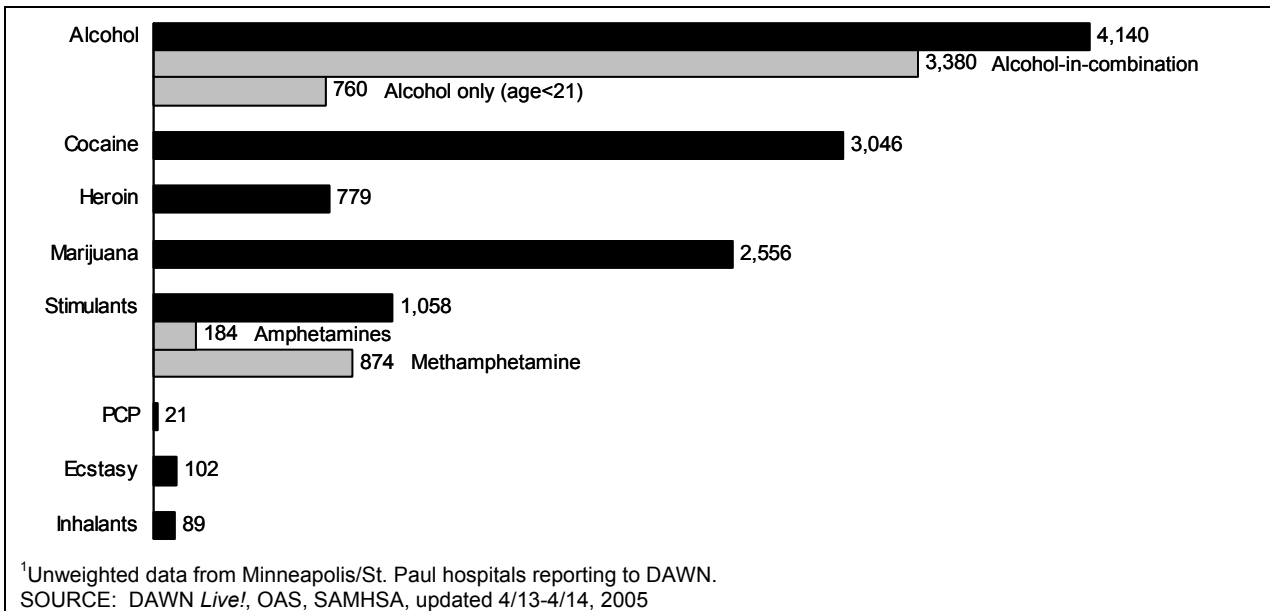
<sup>2</sup>Unweighted data from Minneapolis/St. Paul hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

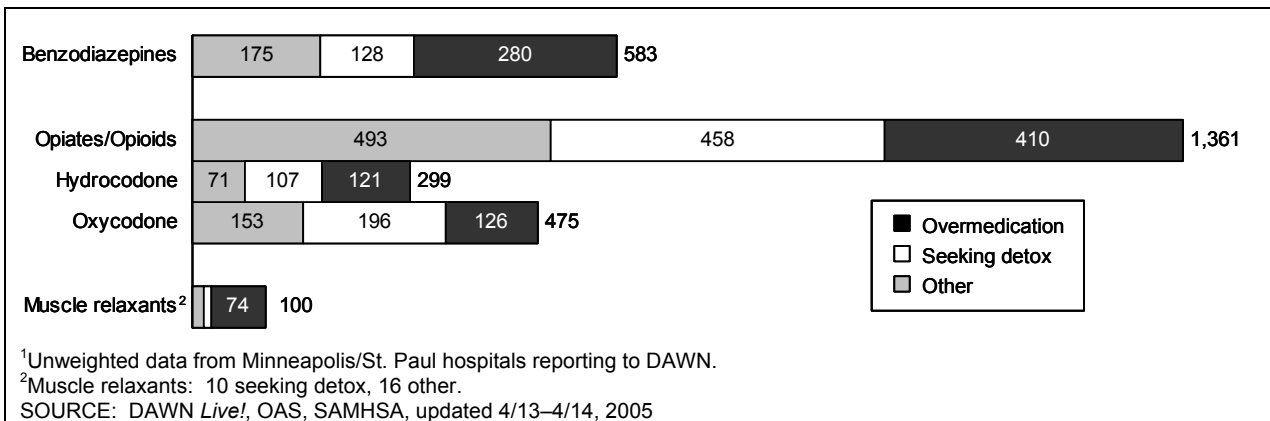
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Newark ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Newark	47	39	43	7–10	0–2	0–3	31–33

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	184
Seeking detox	516
Alcohol only (age<21)	250
Adverse reaction	1,063
Overmedication	505
Malicious poisoning	20
Accidental ingestion	122
Other	2,585

<sup>1</sup>Unweighted data from Newark hospitals reporting to DAWN. SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>5,174</b>
Alcohol	1,273
Alcohol-in-combination with other drugs	1,023
Alcohol only (age<21)	250
Cocaine	1,505
Heroin	1,764
Marijuana	505
Stimulants	46
Amphetamines	42
Methamphetamine	4
MDMA (ecstasy)	21
GHB	3
Ketamine	1
LSD	3
PCP	22
Miscellaneous hallucinogens	0
Inhalants	27
Combinations not tabulated above	4

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

<sup>2</sup>Unweighted data from Newark hospitals reporting to DAWN.

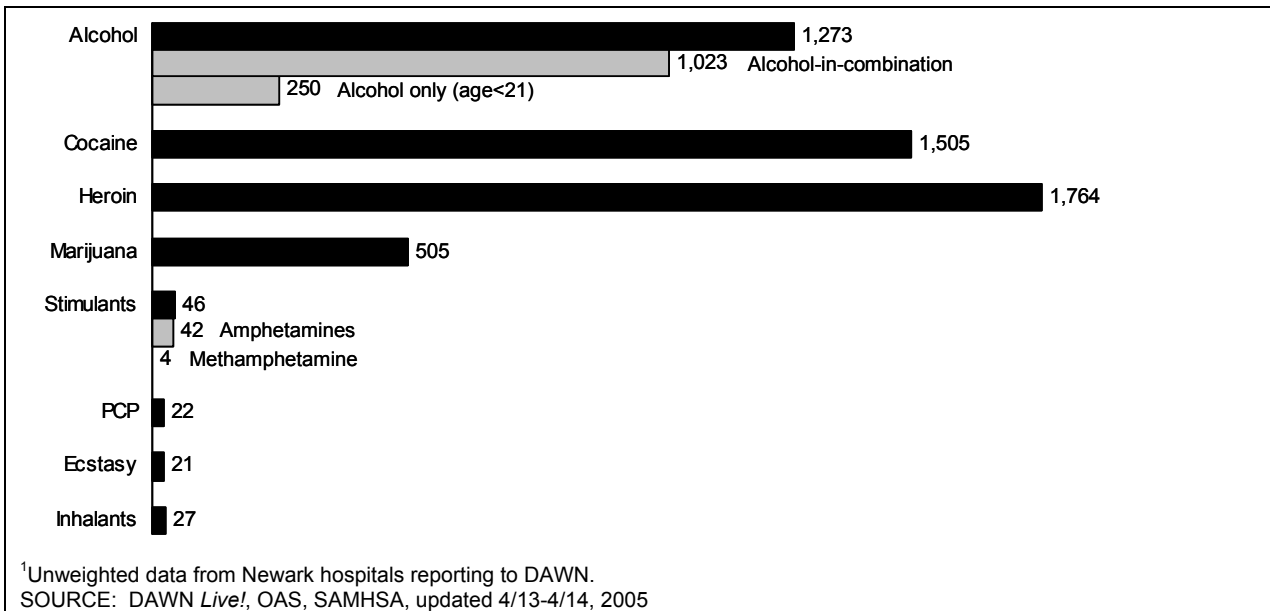
<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005



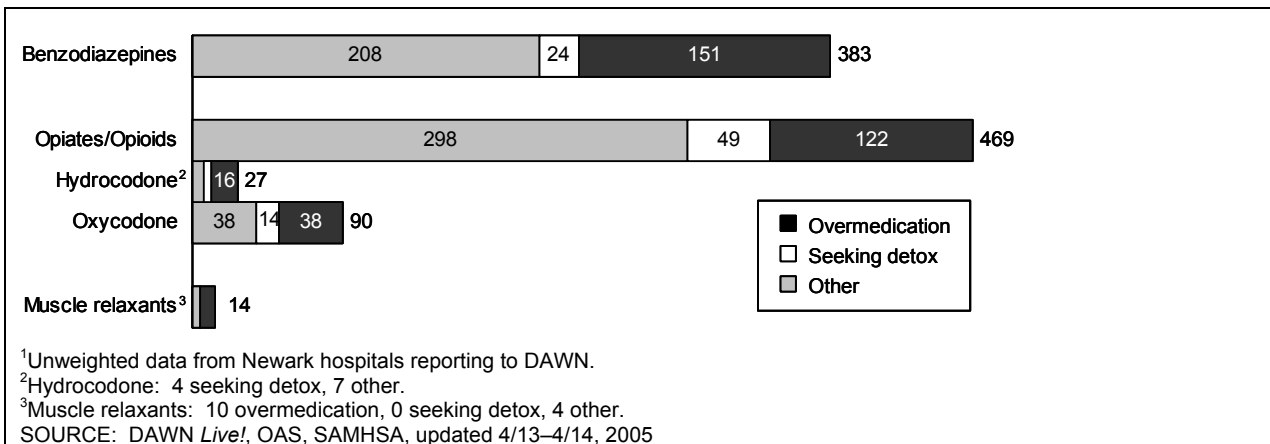
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# New Orleans ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
New Orleans	21	19	21	9–11	0–2	0–2	10–13

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	352
Seeking detox	365
Alcohol only (age<21)	133
Adverse reaction	1,352
Overmedication	1,181
Malicious poisoning	29
Accidental ingestion	131
Other	2,721

<sup>1</sup>Unweighted data from New Orleans hospitals reporting to DAWN.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>4,598</b>
Alcohol	1,350
Alcohol-in-combination with other drugs	1,217
Alcohol only (age<21)	133
Cocaine	1,607
Heroin	490
Marijuana	821
Stimulants	137
Amphetamines	112
Methamphetamine	25
MDMA (ecstasy)	98
GHB	13
Ketamine	2
LSD	5
PCP	19
Miscellaneous hallucinogens	7
Inhalants	35
Combinations not tabulated above	13

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

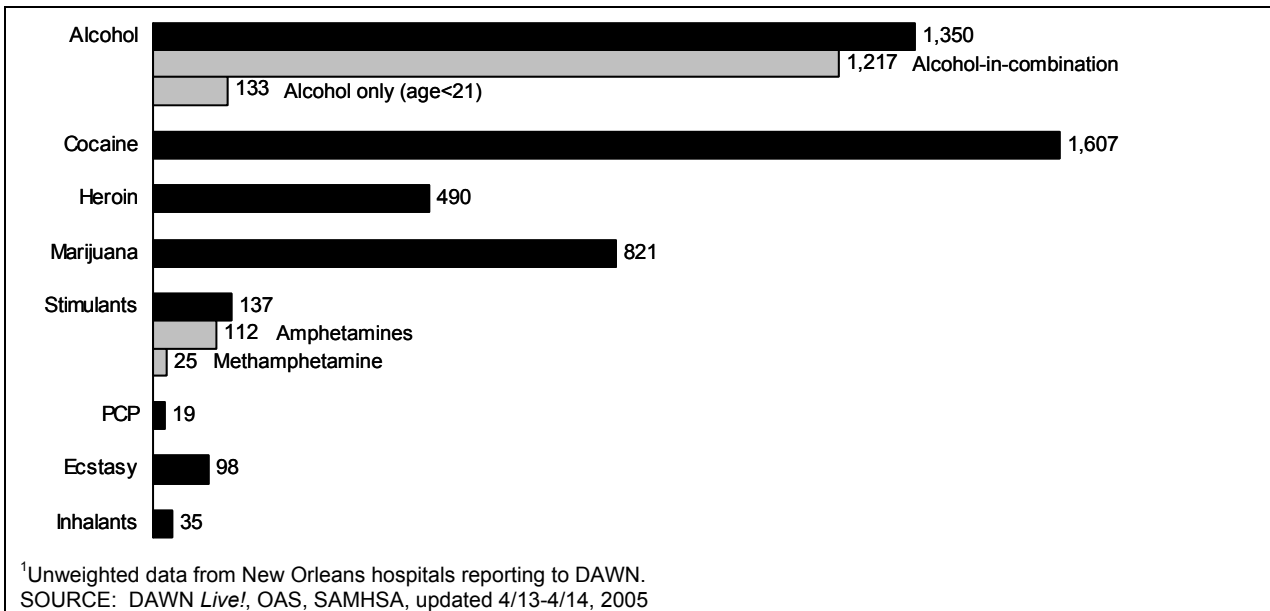
<sup>2</sup>Unweighted data from New Orleans hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

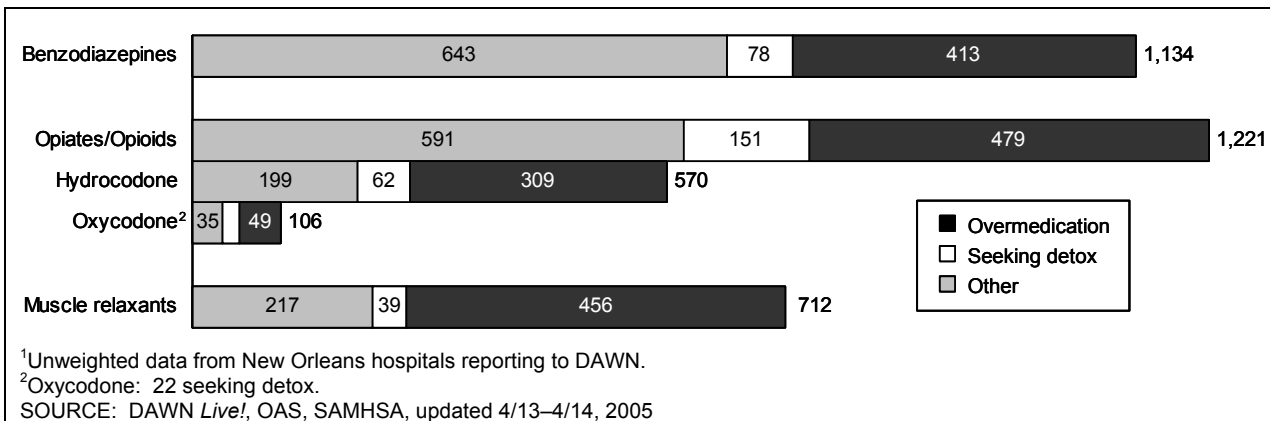
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# New York City ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
New York City	93	72	94	22–36	3–9	1–8	51–62

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	871
Seeking detox	7,264
Alcohol only (age<21)	1,098
Adverse reaction	9,321
Overmedication	2,700
Malicious poisoning	72
Accidental ingestion	572
Other	12,069

<sup>1</sup>Unweighted data from New York City hospitals reporting to DAWN.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>32,199</b>
Alcohol	10,504
Alcohol-in-combination with other drugs	9,406
Alcohol only (age<21)	1,098
Cocaine	10,686
Heroin	6,574
Marijuana	3,442
Stimulants	170
Amphetamines	65
Methamphetamine	105
MDMA (ecstasy)	165
GHB	36
Ketamine	22
LSD	38
PCP	355
Miscellaneous hallucinogens	16
Inhalants	168
Combinations not tabulated above	20

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

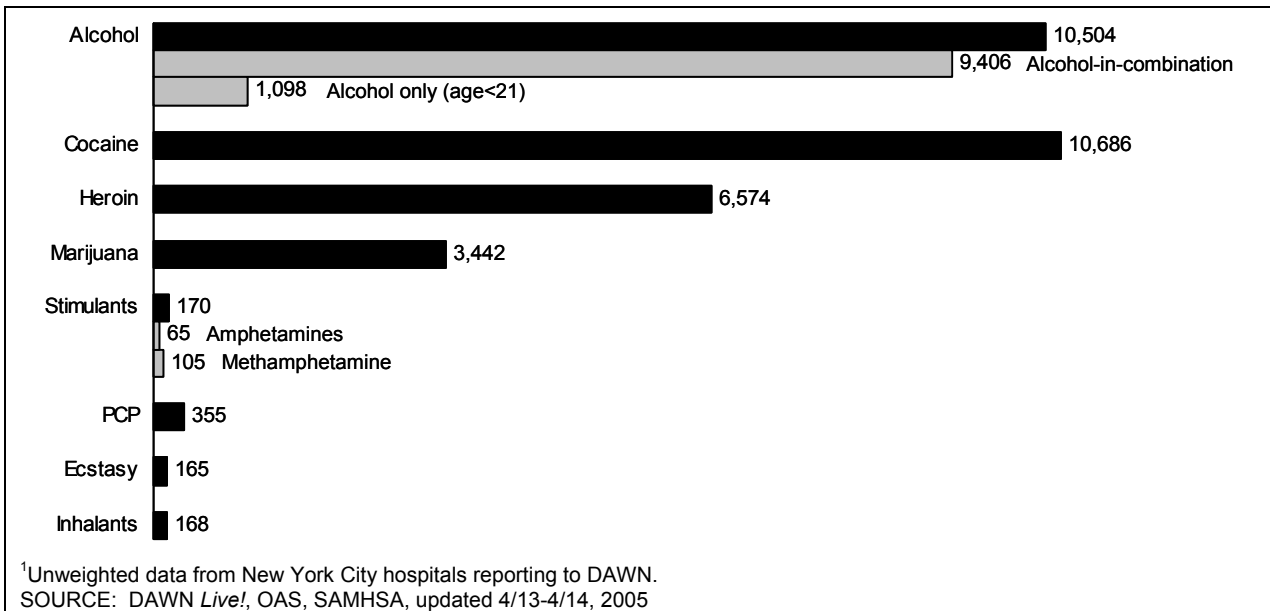
<sup>2</sup>Unweighted data from New York City hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

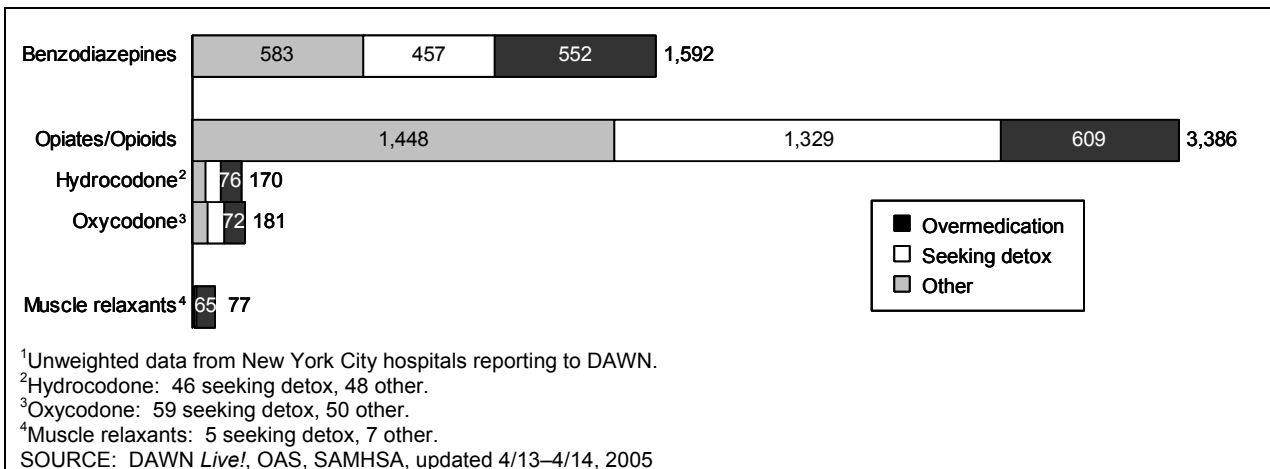
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Philadelphia ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Philadelphia	56	33	40	13–23	2–6	0–2	13–23

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	826
Seeking detox	1,552
Alcohol only (age<21)	486
Adverse reaction	2,074
Overmedication	1,996
Malicious poisoning	30
Accidental ingestion	194
Other	4,776

<sup>1</sup>Unweighted data from Philadelphia hospitals reporting to DAWN.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>10,664</b>
Alcohol	3,251
Alcohol-in-combination with other drugs	2,765
Alcohol only (age<21)	486
Cocaine	3,739
Heroin	1,935
Marijuana	1,270
Stimulants	130
Amphetamines	89
Methamphetamine	41
MDMA (ecstasy)	62
GHB	16
Ketamine	1
LSD	12
PCP	183
Miscellaneous hallucinogens	18
Inhalants	23
Combinations not tabulated above	24

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

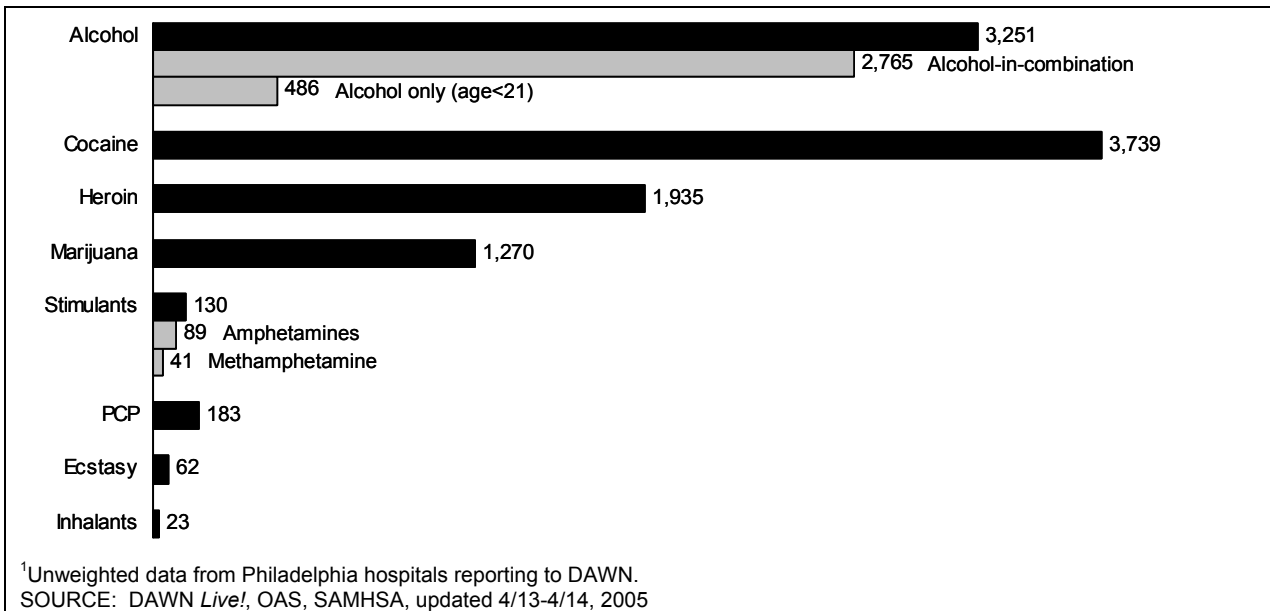
<sup>2</sup>Unweighted data from Philadelphia hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

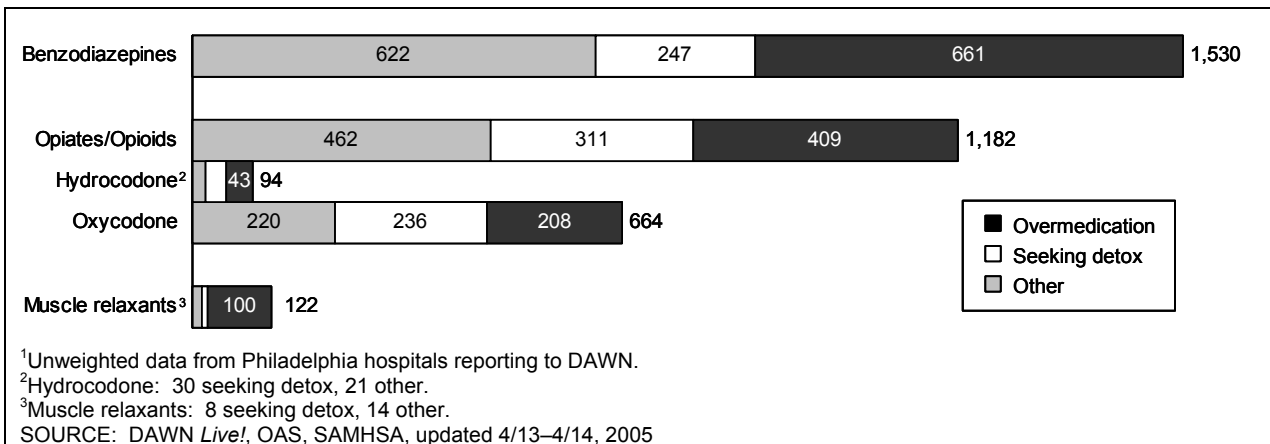
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Phoenix ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Phoenix	25	25	26	9–13	1–2	0–1	12–15

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	634
Seeking detox	502
Alcohol only (age<21)	409
Adverse reaction	2,293
Overmedication	2,293
Malicious poisoning	41
Accidental ingestion	220
Other	4,599

<sup>1</sup>Unweighted data from Phoenix hospitals reporting to DAWN. SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>8,116</b>
Alcohol	2,333
Alcohol-in-combination with other drugs	1,924
Alcohol only (age<21)	409
Cocaine	1,591
Heroin	755
Marijuana	1,122
Stimulants	2,165
Amphetamines	819
Methamphetamine	1,346
MDMA (ecstasy)	20
GHB	4
Ketamine	1
LSD	16
PCP	39
Miscellaneous hallucinogens	28
Inhalants	30
Combinations not tabulated above	12

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

<sup>2</sup>Unweighted data from Phoenix hospitals reporting to DAWN.

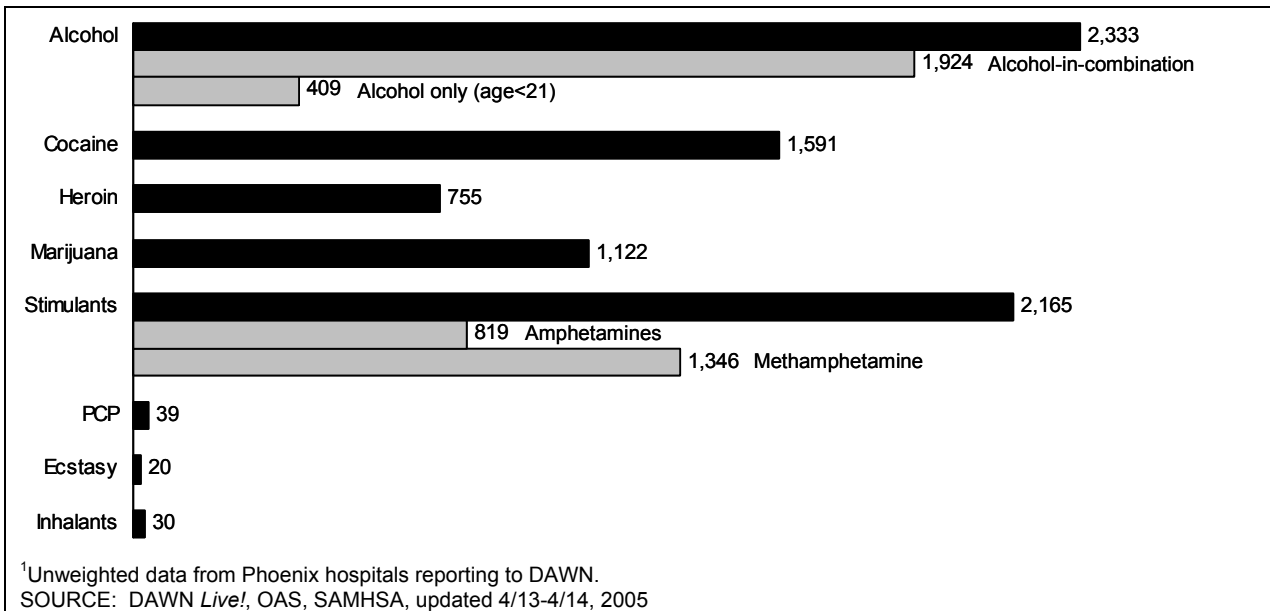
<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005



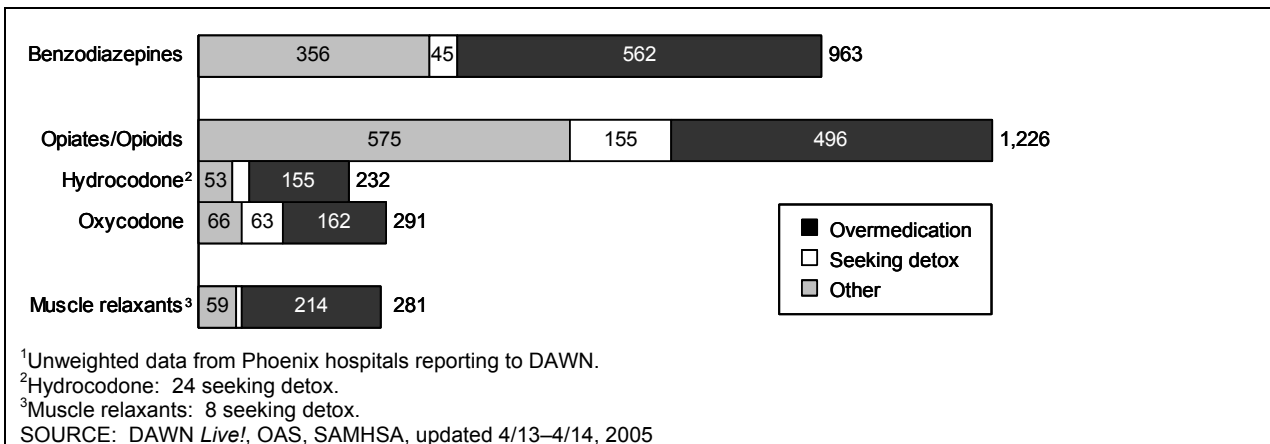
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# St. Louis ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
St. Louis	37	36	38	15–18	0–2	0–2	20–23

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	955
Seeking detox	641
Alcohol only (age<21)	392
Adverse reaction	3,374
Overmedication	1,574
Malicious poisoning	24
Accidental ingestion	217
Other	2,866

<sup>1</sup>Unweighted data from St. Louis hospitals reporting to DAWN. SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>6,074</b>
Alcohol	1,982
Alcohol-in-combination with other drugs	1,590
Alcohol only (age<21)	392
Cocaine	1,702
Heroin	601
Marijuana	1,230
Stimulants	431
Amphetamines	145
Methamphetamine	286
MDMA (ecstasy)	27
GHB	3
Ketamine	1
LSD	9
PCP	29
Miscellaneous hallucinogens	12
Inhalants	43
Combinations not tabulated above	4

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

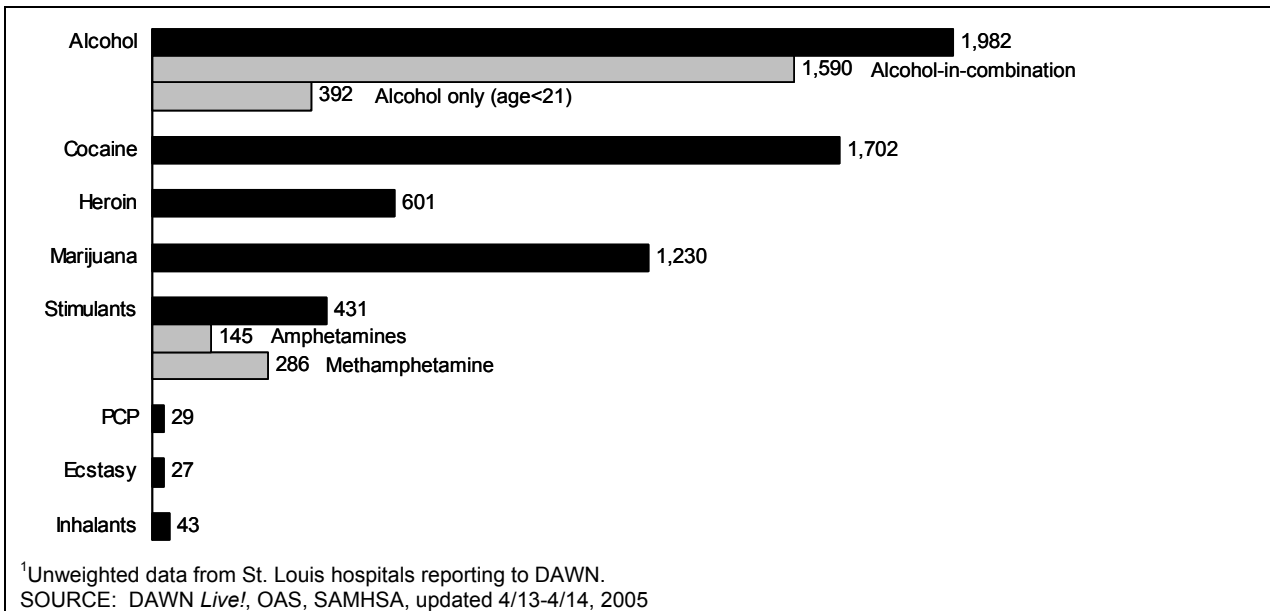
<sup>2</sup>Unweighted data from St. Louis hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

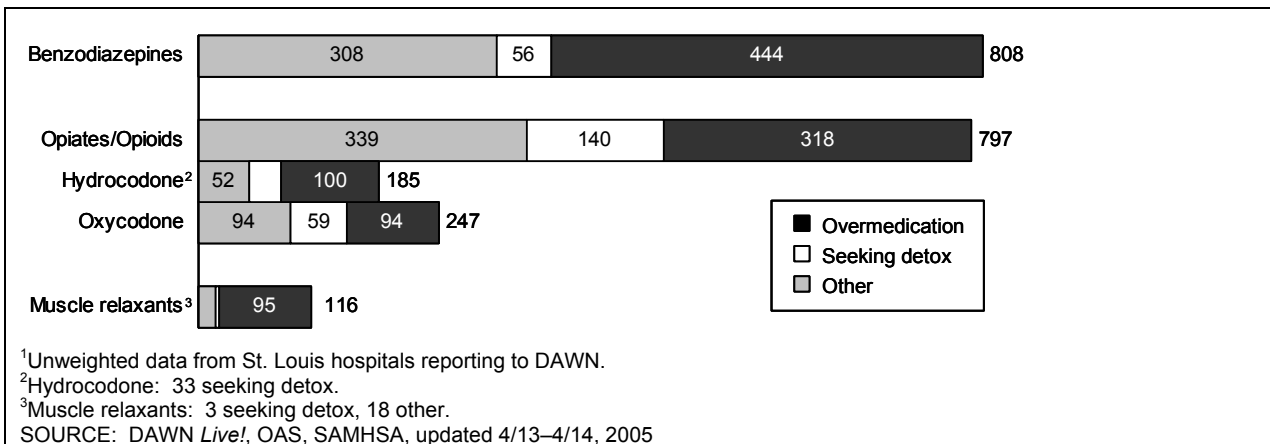
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# San Diego ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
San Diego	17	16	16	6–9	0–1	0–1	6–10

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	487
Seeking detox	319
Alcohol only (age<21)	184
Adverse reaction	1,633
Overmedication	1,159
Malicious poisoning	21
Accidental ingestion	113
Other	2,298

<sup>1</sup>Unweighted data from San Diego hospitals reporting to DAWN.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>4,158</b>
Alcohol	1,159
Alcohol-in-combination with other drugs	975
Alcohol only (age<21)	184
Cocaine	558
Heroin	492
Marijuana	641
Stimulants	1,185
Amphetamines	388
Methamphetamine	797
MDMA (ecstasy)	23
GHB	11
Ketamine	3
LSD	3
PCP	23
Miscellaneous hallucinogens	23
Inhalants	29
Combinations not tabulated above	8

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

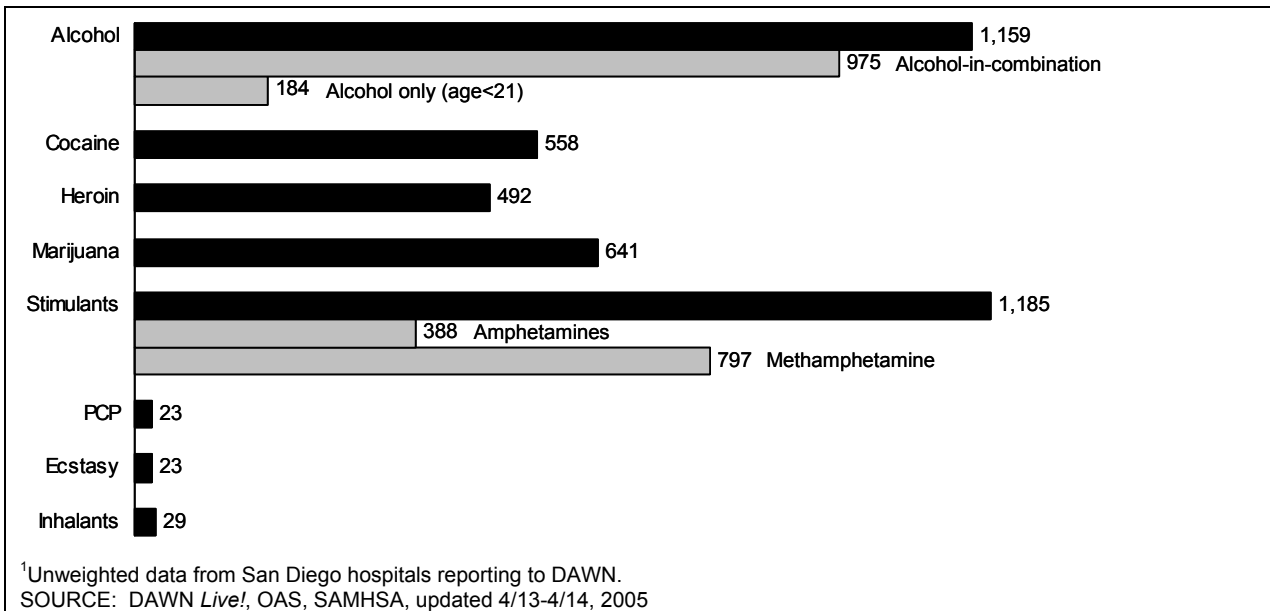
<sup>2</sup>Unweighted data from San Diego hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

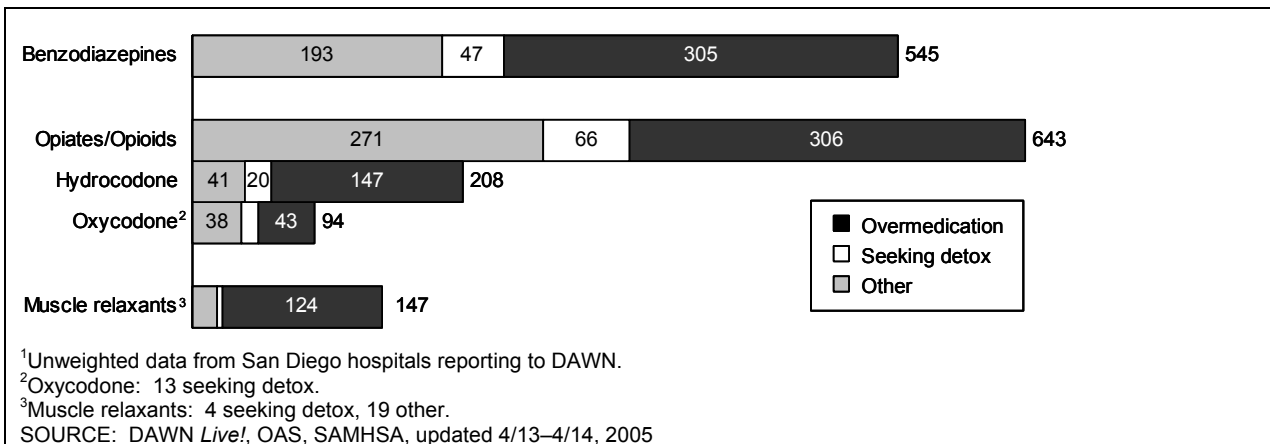
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# San Francisco ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
San Francisco	18	17	19	7–10	0–1	0–3	8–11

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	292
Seeking detox	280
Alcohol only (age<21)	388
Adverse reaction	1,330
Overmedication	788
Malicious poisoning	64
Accidental ingestion	71
Other	4,901

<sup>1</sup>Unweighted data from San Francisco hospitals reporting to DAWN.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>8,433</b>
Alcohol	2,362
Alcohol-in-combination with other drugs	1,974
Alcohol only (age<21)	388
Cocaine	2,456
Heroin	1,278
Marijuana	593
Stimulants	1,471
Amphetamines	379
Methamphetamine	1,092
MDMA (ecstasy)	90
GHB	26
Ketamine	3
LSD	11
PCP	56
Miscellaneous hallucinogens	26
Inhalants	24
Combinations not tabulated above	37

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

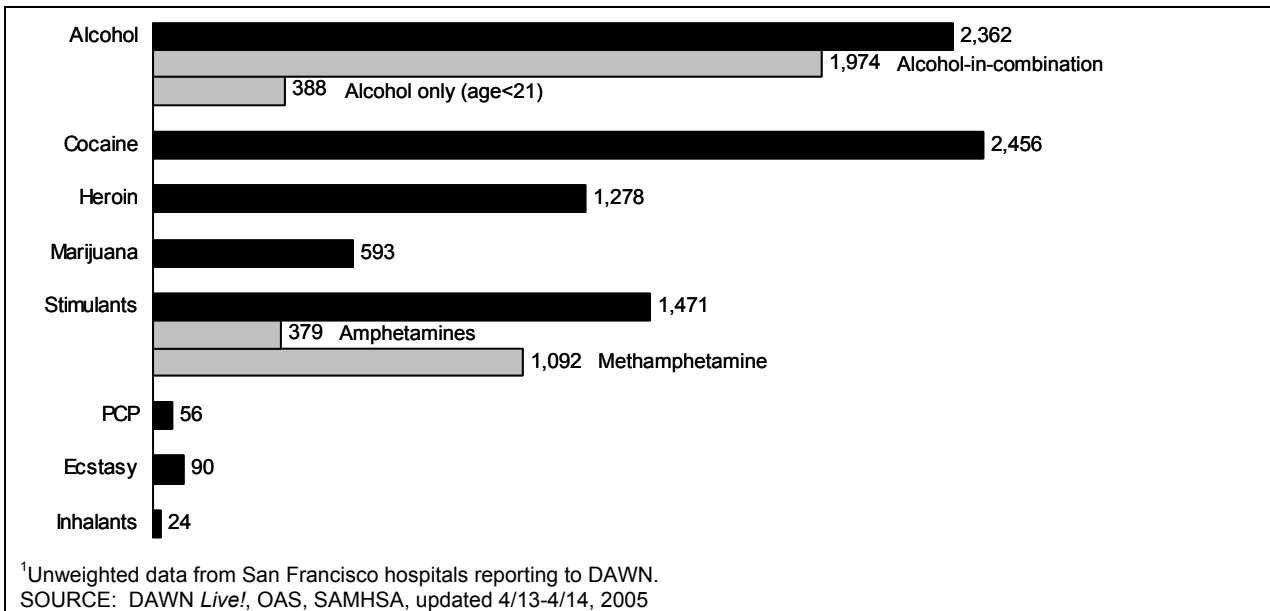
<sup>2</sup>Unweighted data from San Francisco hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

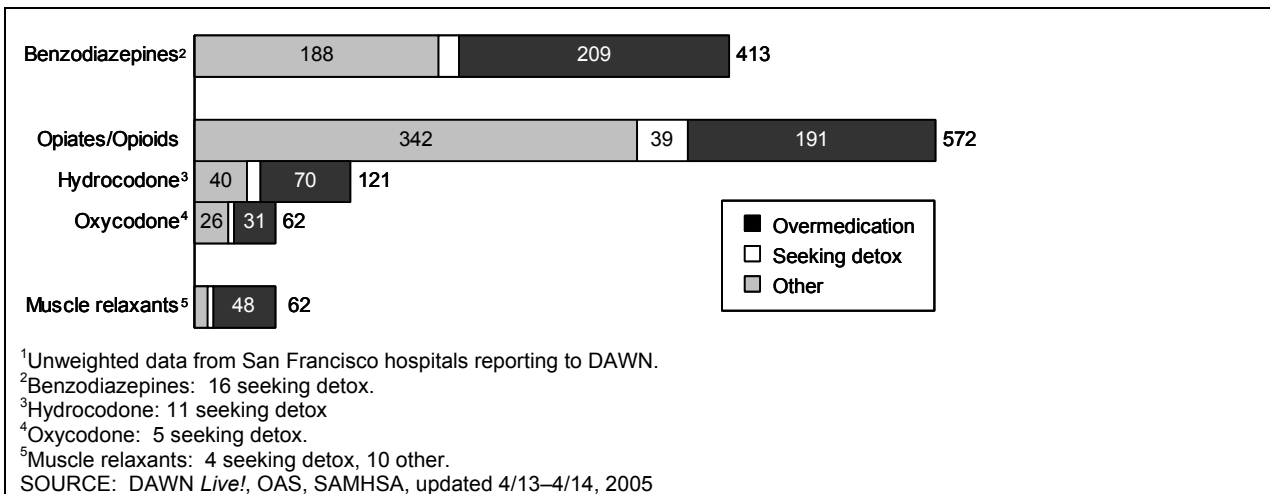
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Seattle ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Seattle	22	22	23	8–12	0–2	0–4	10–13

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	478
Seeking detox	573
Alcohol only (age<21)	403
Adverse reaction	2,478
Overmedication	1,514
Malicious poisoning	23
Accidental ingestion	87
Other	6,198

<sup>1</sup>Unweighted data from Seattle hospitals reporting to DAWN. SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>10,020</b>
Alcohol	2,575
Alcohol-in-combination with other drugs	2,172
Alcohol only (age<21)	403
Cocaine	2,725
Heroin	2,171
Marijuana	1,159
Stimulants	1,068
Amphetamines	213
Methamphetamine	855
MDMA (ecstasy)	91
GHB	17
Ketamine	0
LSD	24
PCP	85
Miscellaneous hallucinogens	54
Inhalants	18
Combinations not tabulated above	33

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

<sup>2</sup>Unweighted data from Seattle hospitals reporting to DAWN.

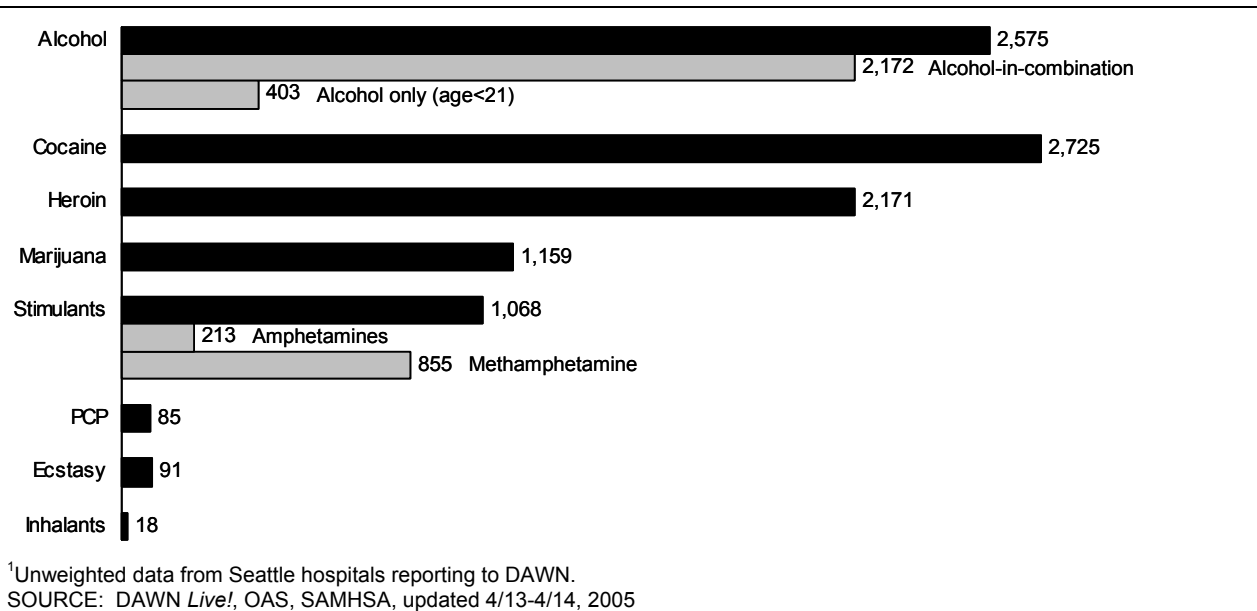
<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005



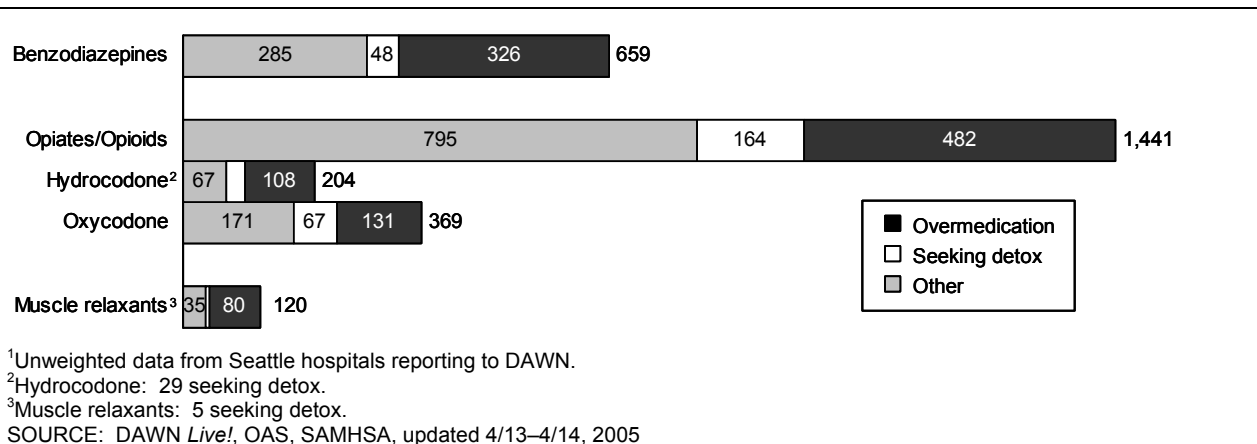
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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



# Washington, DC ED Data Summary: 2004

## DAWN ED Sample and Reporting Information: January–December 2004

CEWG Area	Total Eligible Hospitals <sup>1</sup>	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample <sup>2</sup>	No. of EDs Reporting per Month: Completeness of Data (%)			No. of EDs Not Reporting
				90–100%	50–89%	<50%	
Washington, DC	34	29	30	8–12	1–5	0–2	15–19

<sup>1</sup>Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

<sup>2</sup>Some hospitals have more than one emergency department.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of DAWN ED Cases, by Case Type (Unweighted<sup>1</sup>): 2004

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

Case Type	Number
Suicide attempt	619
Seeking detox	1,019
Alcohol only (age<21)	477
Adverse reaction	2,917
Overmedication	1,438
Malicious poisoning	16
Accidental ingestion	288
Other	4,683

<sup>1</sup>Unweighted data from Washington, DC, hospitals reporting to DAWN.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

### Number of Drug Reports<sup>1</sup> in Drug-Related ED Visits, by Drug Category (Unweighted<sup>2</sup>): 2004

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

Drug Category and Selected Drugs <sup>3</sup>	Drug Reports
<b>Major Substances of Abuse</b>	<b>8,701</b>
Alcohol	2,518
Alcohol-in-combination with other drugs	2,041
Alcohol only (age<21)	477
Cocaine	2,849
Heroin	1,486
Marijuana	1,255
Stimulants	110
Amphetamines	79
Methamphetamine	31
MDMA (ecstasy)	83
GHB	9
Ketamine	1
LSD	8
PCP	289
Miscellaneous hallucinogens	18
Inhalants	60
Combinations not tabulated above	15

<sup>1</sup>Drug-related ED visits often involve multiple drugs (e.g., both cocaine and heroin may be reported for the same case). Therefore, the number of drug reports will exceed the number of ED visits.

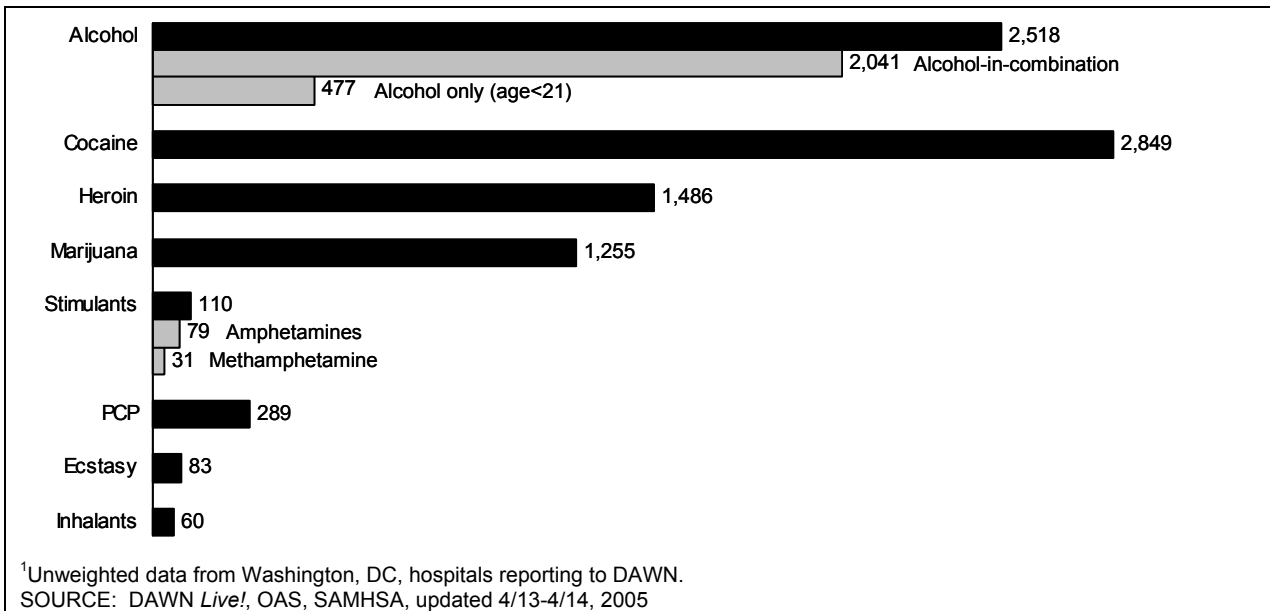
<sup>2</sup>Unweighted data from Washington, DC, hospitals reporting to DAWN.

<sup>3</sup>This classification of drugs is derived from the Multum Lexicon, Copyright 2003, Multum Information Services, Inc. The classification has been modified to meet DAWN's unique requirements (2004). The Multum Licensing Agreement governing use of the Lexicon is provided in most DAWN publications and can be found on the Internet at <http://www.multum.com>.

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 4/13-4/14, 2005

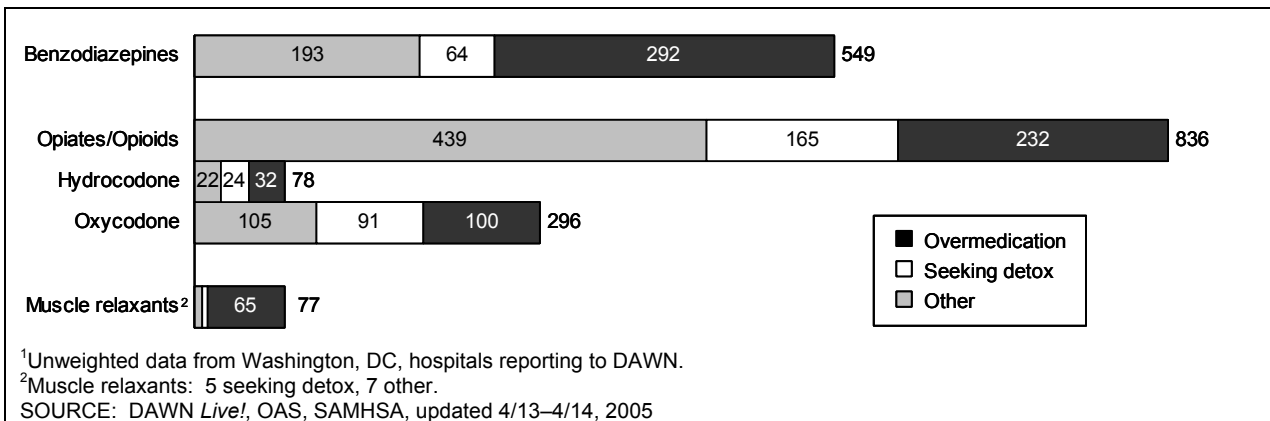
### Number of Drug Reports in Drug-Related ED Visits, by Drug Category (Unweighted<sup>1</sup>): 2004

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



### Prescription Drug Misuse—Number of Drug Reports in Drug-Related ED Visits, Selected Drugs, by Case Type (Unweighted<sup>1</sup>): 2004

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





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