NIDA NATIONAL INSTITUTE ON DRUG ABUSE

Epidemiologic Trends in Drug Abuse

Proceedings of the Community Epidemiology Work Group

Highlights and Executive Summary

January 2007

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

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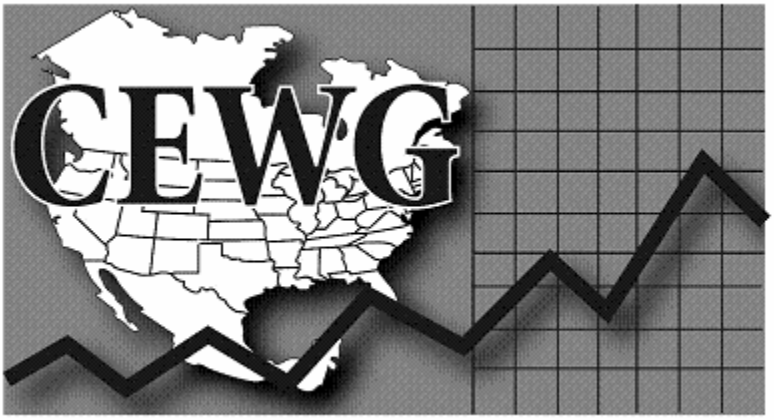

COMMUNITY EPIDEMIOLOGY WORK GROUP

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

The National Institute on Drug Abuse (NIDA) acknowledges the contributions made by the representatives of the Community Epidemiology Work Group (CEWG) who prepare the reports presented at the meetings. Appreciation is extended also to other participating researchers who contribute information. This publication was prepared by Masi-Max Resources, Inc., under contract number N01-DA-1-5514 from the National Institute on Drug Abuse.

The information presented in this *Executive Summary* is from the *Abstracts* and PowerPoint slides prepared by 22 CEWG representatives for the CEWG meeting in San Antonio, Texas; tape recordings from the half-day meeting; and the information provided through followup telephone conference calls in February. Data/information supplemental to the meeting presentations and discussions have been included in this report.

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

Both Volumes I and II (available in limited supply) can be obtained by contacting the National Clearinghouse for Alcohol and Drug Information

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Foreword

This *Executive Summary* is a synthesis of findings from data prepared by CEWG representatives for the 61st semiannual meeting of the Community Epidemiology Work Group (CEWG) scheduled in San Antonio, Texas, on January 17–19, 2007, under the sponsorship of the National Institute on Drug Abuse (NIDA). Because inclement weather prevented many CEWG representatives and invited guests from traveling to the site, the meeting was shortened and included presentations on January 17 by eight CEWG representatives, a guest researcher from Latin America, and a representative of the Drug Enforcement Administration. However, all 22 CEWG representatives submitted data they had prepared for the meeting; later in February, they participated in followup telephone conference calls to discuss findings and issues.

For the January 2007 meeting, representatives prepared 2006 half-year data and/or fiscal year 2006 data. The primary emphasis of the meeting and subsequent followup telephone conferences was on pursuing, discussing, reviewing, and providing updates on drug abuse issues that emerged at the June 2006 meeting and the 6-month period leading up to the January meeting. Through focused discussions at meetings, participants report on, share insight about, and review…

- What has was learned about drugs patterns and trends and emerging drug problems from available data sources
- What was learned from local sources of information, such as key informants
- The emerging questions and issues that need to be addressed

The information from the CEWG network presented in this report includes an overview of drug abuse patterns and trends in 22 CEWG areas. The findings are taken from the CEWG representatives' *Abstracts* and PowerPoint presentations, from presentations at the meeting, and two followup telephone conference calls. Data/information supplemental to the meeting presentations and discussions has been included as appropriate. The report focuses on the abuse of cocaine/crack, heroin, opiates/narcotic analgesics (other than heroin), methamphetamine, marijuana, club drugs, phencyclidine (PCP), and benzodiazepines. An update on the emerging problems related to fentanyl and fentanyl mixtures in the United States is included in the section on Other Opiates/ Narcotic Analgesics.

The information published after each CEWG meeting represents findings from CEWG area representatives across the Nation, which are supplemented by national data and by special presentations at each meeting. Publications are disseminated to drug abuse prevention and treatment agencies, public health officials, researchers, and policymakers. The information is intended to alert authorities at the local, State, regional, and national levels, and the general public, to current conditions and potential problems so that appropriate and timely action can be taken. Researchers also use the information to develop research hypotheses that might explain social, behavioral, and biological issues related to drug abuse.

Moira P. O'Brien
Division of Epidemiology, Services and Prevention Research
National Institute on Drug Abuse
National Institutes of Health
Department of Health and Human Services

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NIDA'S Public Health Division: The Division of Epidemiology, Services and Prevention Research

Wilson M. Compton, M.D., M.P.E., Director

This presentation provides an overview of DESPR, its components (including the CEWG), objectives, recent findings, questions posed for 2006 and 2007, and new research opportunities. In addition to its epidemiology program, DESPR includes the Prevention Research Branch (PRB), the Services Research Branch (SRB), and the Community Epidemiology Work Group (CEWG).

The primary goal of DESPR is to develop scientific knowledge that can be applied in public health policy and practice. Based on an integrated population-based approach and a public health orientation, DESPR supports research aimed at…

- Understanding the interactions between individuals who abuse or are at risk for using drugs and their environments
- Assessing the continuum of problems and causes related to drug abuse
- Determining the most effective drug abuse prevention and treatment intervention methods
- Impacting public policy and practice at all levels (e.g., local State and Federal), including the financing of interventions that have proven to be effective
- Fostering and providing a guide for new research

Each year, key findings produced by researchers supported by DESPR are reviewed. Some examples of recent efforts are as follows:

- Results produced by the Monitoring the Future survey updated the annual trends on drug use among young people (Johnston et al. 2005). It was reported, for example, that cigarette smoking among secondary school students had declined markedly since the mid-1990s.
- SRB-supported research provided a better understanding of the recovery and cost benefits of a life course approach to treatment (Zarkin et al. 2005). Such studies have provided an increased understanding of drug addiction as a chronic relapsing condition like other diseases (e.g., hepatitis).
- Based on randomized studies, PRB-supported researchers (Spoth et al. 2005) produced findings on the long-term effectiveness of brief partnership-based universal prevention interventions (e.g., school-based) with adolescent methamphetamine abusers.
- Studies showed that HIV screening can be as cost-effective as screenings for hypertension and other medical conditions (Paltiel et al. 2005; Sanders et al. 2005).

The major DESPR research questions posed for 2006 included the following:

- What new theoretical approaches can inform researchers? For example, what are the pathways to drug abuse? How can we assess co-morbidity as it relates to prevention and treatment intervention?
- What intrapersonal and environmental factors interact with each other and with genetic factors? Factors might include policies, laws, police enforcement, availability of drugs, and family factors. It is difficult to conduct such studies because of the potential interaction of different factors.

- How can science and services be blended to measurably impact public health outcomes? For example, studies have shown that contingency management can be an effective treatment intervention.

NIDA has been placing more emphasis on a "network of networks" approach. The objective is to assist researchers in taking advantage of the infrastructures that have been established. This approach is designed to make maximum use of resources, especially during a period when funding is limited.

The CEWG is a good example of an existing network because it is well-established, vigorous, cost-efficient, produces current data/information about drug abuse patterns and trends, and serves as an early warning system (identifying emerging drugs and drug problems) that could be of use to other researchers. Other networks include the Clinical Trials Network, Criminal Justice Network, and AIDS networks.

There are challenges facing the CEWG and the need to maintain the early warning system. The Arrestee Drug Abuse Monitoring program was discontinued, and there have been reductions in the scope of metropolitan coverage in the Drug Abuse Warning Network. A critical question is: What can be done to supplement existing Federal and local data sources?

Some CEWG areas have been more successful than others in accessing relevant data from local sources, and there is a need for opportunities for CEWG representatives to learn from one another, for example, on ways of accessing local Poison Control Center data and local medical examiner/coroner data.

There is also the problem of assessing drug abuse trends when there is no verifiable denominator for a specific drug abuse indicator or in cases where, for methodological reasons, data cannot be compared across time or CEWG area (e.g., as with DAWN *Live*!). Understanding drug abuse patterns and trends can be augmented by qualitative research. CEWG representatives can and do get anecdotal information from street contacts, key informants, and other qualitative research methods; such information increases understanding of changes in drug use over time.

References

Johnston, L.D.; O'Malley, P.M.; Bachman, J.G.; and Schulenberg, J.E. (2005). *Monitoring the Future national results on adolescent drug use: Overview of key findings, 2004.* (NIH Publication No. 05-5726). Bethesda, MD: National Institute on Drug Abuse.

Paltiel, A.D., Weinstein, M.C.; Kimmel, A.D.; Seage, G.R.; Losina, E.; Zhang, H.; Freedberg, K.A.; and Walensky R.P. (2005). Expanded screening for HIV in the United States—an analysis of cost-effectiveness. *New England Journal of Medicine* 352(6):586-595.

Sanders, G.D.; Bayoumi, A.M.; Sundaram, V.; Bilir, S.P.; Neukermans, C.P.; Rydzak, C.E.; Douglass, L.R.; Lazzeroni, L.C.; Holodniy, M.; and Owens, D.K. (2005). Cost-effectiveness of screening for HIV in the era of highly active antiretroviral therapy. *New England Journal of Medicine* 352(6):570-585.

Spoth, R.L.; Clair, S.; Shin, C.; and Redmond, C. (2006). Long-term effects of universal preventive interventions on methamphetamine use among adolescents. *Archives of Pediatrics & Adolescent Medicine* 160: 876–882.

Zarkin, G.A.; Dunlap, L.J.; Hicks, K.A.; and Mamo, D. (2005). Benefits and costs of methadone treatment: results from a lifetime simulation model. *Health Economics* 14(11):1133-1150.

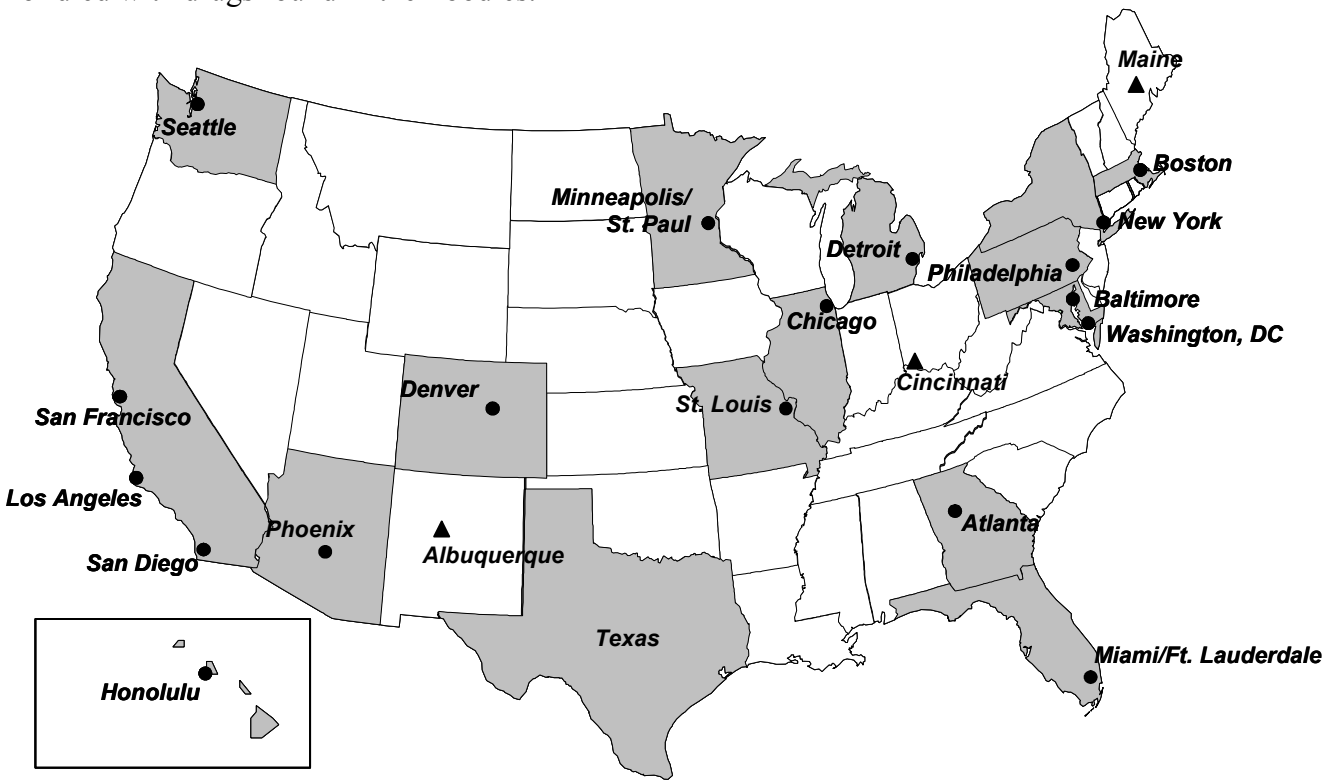
The CEWG Network: Roles, Functions, and Data Sources

Roles of the CEWG

The CEWG is a unique epidemiology network that has functioned for nearly 31 years as a drug abuse surveillance system to identify and assess current and emerging drug abuse patterns, trends, and issues, using multiple sources of information. Each source provides information about the abuse of particular drugs, drug-using populations, and/or different facets of the behaviors and outcomes related to drug abuse. The information obtained from each source is considered a drug abuse *indicator*. Typically, indicators do not provide estimates of the number (prevalence) of drug abusers at any given time or the rate at which drug-abusing populations may be increasing or decreasing in size. However, indicators do help to characterize drug abuse trends and different types of drug abusers, such as those who have been treated in emergency rooms, have been admitted to drug treatment programs, or died with drugs found in their bodies.

Data on items submitted for forensic chemical analysis serve as indicators on availability of different substances and engagement of law enforcement at the local level, and data such as drug price and purity are indicators of availability, accessibility, and potency of specific drugs. Drug abuse indicators are examined over time to monitor the nature and extent of drug abuse and associated problems within and across geographic areas.

In January–February 2007, researchers from 22 geographically dispersed areas participated in the CEWG meeting and/or telephone conference followup discussions. In addition to the information provided by the 19 sentinel areas that have served in the network for many years, guest researchers from Albuquerque, Cincinnati, and Maine provided data from their respective areas. The 22 participating areas are depicted in the map below.



The Functions of CEWG Meetings

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

Through the meetings, the CEWG accomplishes the following:

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

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

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

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

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

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

Planning for followup on issues and problems identified at a meeting is initiated during discussion sessions at meetings, with postmeeting planning continuing through e-

mails and conference calls. 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 a prior meeting and subsequent followup activities. The Emerging/Current Trend at the January 2005 meeting featured a panel on methamphetamine abuse. The focus in the June 2006 meeting was on fentanyl and fentanyl mixtures. In June 2004, a special panel addressed the abuse of prescription drugs. 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.

The Emerging/Current Trend approach draws upon the following:

- CEWG representatives' 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

The agenda for January 2007 meeting was patterned after previous CEWG meetings. However, because inclement weather prevented many CEWG representatives and guest researchers from traveling to the host city (San Antonio, Texas), the meeting was shortened and included presentations by eight CEWG representatives who provided updates on drug abuse patterns and trends in their areas. A guest researcher from the CICAD Inter-American Observatory on Drugs, OAS, Inter-American Drug Abuse Control Commission, provided information on drug patterns and trends in Latin America. An official from the Drug Enforcement Administration focused on the emerging threats from abuse of prescription drugs, especially fentora (fentanyl buccal tablet) used in treatment for breakthrough pain in opioid-tolerant cancer patients, and tramadol, also used in pain management. Abuse of fentora may lead to respiratory depression.

Information that would have been presented by all CEWG representatives at the full meeting was available for inclusion in this publication. All 22 CEWG representatives provided copies of their PowerPoint presentations and *Abstracts,* and, in February, participated in telephone conference calls in which they discussed issues and provided additional information on drug abuse patterns and trends in their areas. Data/information supplemental to the CEWG meetings and discussions are included in this report.

Primary sources of data used by the CEWG and presented in this *Executive Summary* are summarized below.

Treatment data are from CEWG reports and represent statewide data for Arizona, Hawaii, Maine, and Texas, and metropolitan-area data for 16 CEWG areas. No recent data were available for Albuquerque and Washington, DC. Because the States of Illinois and California had not completed changes in their treatment database systems by the time of the January 2007 CEWG meeting, only 2005 data were available for Chicago, Los Angeles, and San Diego. Also, because Philadelphia data for 2006 did not distinguish between primary, secondary, and tertiary drugs of abuse, 2005 data were retained for Philadelphia to depict trends, by drug, over time. Five CEWG areas provided fiscal year (FY) 2006 data, one provided data for calendar year (CY) 2006, and 10 reported data for the first half of CY 2006. The various reporting periods for each CEWG area are depicted in *Appendix A*. The FY 2006 data from Cincinnati were not yet complete for the entire year,

and represent approximately 65 to 75 percent of the data for this city. The South Florida treatment data for the first half of 2006 were from nine Broward County Addiction Recovery Center (BARC) programs that serve 51.5 percent of admissions to county treatment facilities. Treatment data on primary abuse of specific drugs are reported as percentages of total admissions, excluding alcohol. Data on demographic characteristics (gender, race/ethnicity, age) and route of administration of particular drugs were provided for some CEWG areas. The number of admissions for alcohol and other drugs in the 2005–2006 time periods are presented for the 20 CEWG areas in *Appendix A*. Treatment data are not totally standardized across CEWG areas.

Drug Abuse Warning Network (DAWN) emergency department (ED) data for 13 CEWG areas for the first half of 2006 were accessed through DAWN *Live!,* a restricted-access online service administered by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA). Participation by EDs in each DAWN sample was incomplete; completeness data are summarized in *Appendix B-1*. The percentages and unweighted numbers cited in this *Executive Summary* represent drug reports involved in drug-related visits for illicit drugs (derived from the category of "major substances of abuse," excluding alcohol) and the nonmedical use of selected prescription drugs (derived from the category of "other substances.") Drug reports exceed the number of ED visits because a patient may report use of multiple drugs (up to six drugs plus alcohol). Since all DAWN cases are reviewed for quality control, the data may be corrected or deleted, and, therefore, are subject to change. The numbers of DAWN *Live!* reports represent unweighted estimates of ED visits and cannot be compared across CEWG areas or across data collection years. A full description of the DAWN system can be found at <http://dawninfo.samhsa.gov>.

Local drug-related mortality data from medical examiners/coroners (ME/Cs) were reported for 17 CEWG areas. Five reported county-level data for selected drugs for the first half of 2006 (Broward County, Florida; Cincinnati/Hamilton County; Honolulu; Miami/Dade County; and Seattle/King County) and two reported for the first 9 months of 2006 (Detroit/Wayne County and Minneapolis/St. Paul [Hennepin and Ramsey Counties]). Philadelphia and St. Louis reported city-level data for the first half of 2006, and San Diego presented data on methamphetamine-related deaths in 2005. Recent statewide ME/C data were reported for Florida (first half of 2006) and for Georgia (FY 2006). Deaths involving fentanyl in 2006 were reported for the States of New York and Maryland. Colorado, Maine, and Texas data are for 2005. The New Mexico data represent age-adjusted rates per 100,000 population for drug overdose deaths in Albuquerque/Bernalillo County and the State of New Mexico for 2003–2005. Mortality data from all other sites represent the presence of a drug in a decedent and are not defined as overdose deaths. The mortality data are not comparable across areas because of variations in methods and procedures used by ME/Cs. Drugs may cause a death or simply be detected in a death, and multiple drugs may be identified in a single case, with each reported in a separate drug category.

National Forensic Laboratory Information System (NFLIS) data are maintained by the Drug Enforcement Administration (DEA); these are reported for FY 2006 in 21 CEWG metropolitan areas and in Texas (statewide). The data are based on State and local forensic laboratory analyses of items received from drug seizures by law enforcement authorities. There are differences in local/State lab

procedures and law enforcement practices across areas, making area comparisons inexact. Also, the data cannot be used for prevalence estimates because they are not adjusted for population size. They are reported as the percentage that each drug represents in the total drug items analyzed by labs in a CEWG area.

Law enforcement data include drug price data from the National Drug Intelligence Center (NDIC), U.S. Department of Justice (June 2006), and data on methamphetamine lab incidents from DEA's National Clandestine Laboratory Database (updated October 2006).

Also cited in this report are local data accessed and analyzed by CEWG representatives. The sources include local law enforcement (e.g., data on drug arrests); local DEA offices; High Intensity Drug Trafficking (HIDTA) reports; poison control centers and Helplines; local and State surveys; and key informants and ethnographers.

Key Findings and Considerations for the June 2007 CEWG Meeting

Key Findings

Methamphetamine abuse indicators decreased in Atlanta in the first half of 2006, but they remained at relatively high levels. Indicators continued at low levels in all other 10 CEWG areas east of the Mississippi River. In areas west of the Mississippi, where methamphetamine indicators were higher, decreases were reported in four areas (Denver, Honolulu, Minneapolis/St. Paul, and St. Louis); increases were reported in five (New Mexico, Phoenix, San Diego, Seattle, and Texas); and indicators remained stable in two (Los Angeles and San Francisco).

From 2002 to 2005, the numbers of clandestine laboratory incidents reported by the DEA decreased sharply in most CEWG States west of the Mississippi River. While lab incidents remained low in areas east of the Mississippi, there were dramatic increases in incidents reported in Florida, Ohio, Michigan, and Pennsylvania.

Although methamphetamine abuse indicators decreased or remained stable in most CEWG areas, CEWG representatives expressed a growing concern about the…

- Increased trafficking, availability, and abuse of higher purity methamphetamine (e. g., "ice," "crystal") from Mexico, reported in most CEWG areas
- Increased indicators of methamphetamine abuse in different populations (e.g., youth, women, African-Americans, Hispanics)

Cocaine/crack abuse indicators remained stable in 19 CEWG areas and increased in 3 areas (Honolulu, Maine, and New Mexico). Indicators continued to be lowest in San Diego (where methamphetamine indicators remain high). There were reports in some areas that…

- Cocaine/crack indicators had increased among populations in which methamphetamine abuse indicators had decreased
- Cocaine/crack abuse indicators increased in different populations (e.g., Whites, Hispanics)

Heroin abuse indicators were stable or mixed in 15 CEWG areas, lower in 5, and higher in 2 (Chicago and New Mexico). These indicators remained at high levels in Baltimore, Boston, Detroit, Los Angeles, New York City, Philadelphia, St. Louis, and San Francisco. Other data show that…

- The proportions of heroin treatment admissions who injected the drug were especially high in Hawaii (90 percent), Los Angeles (87 percent), Denver (83), San Diego (82), and Maine (76 percent).
- Increasingly, prescription opiate drugs are being used in combination with heroin in Hawaii, Maine, Miami, New York City, and Philadelphia.

Prescription opiate/narcotic analgesic drug abuse indicators continued to be closely monitored by CEWG representatives. Selected findings show…

- Across 13 CEWG areas reporting 2006 data on primary treatment admissions (excluding heroin and alcohol admissions) for other opiate abuse, increases occurred in Baltimore, Boston, Maine, and Seattle; decreases occurred in Denver and Detroit; and the proportions were relatively stable in Broward County, Florida, Cincinnati, New York City, St. Louis, and Texas. In Maine, other opiate drug treatment admissions constituted 42 percent of illicit drug treatment admissions in 2006. In the first half of 2006, the proportions of primary other opiate admissions, relative to total admissions, excluding alcohol, were also fairly high in Broward County (15.3 percent), Cincinnati (8.6 percent), Minneapolis/St. Paul (7.6 percent), Baltimore (7.4 percent), Texas (6.8 percent), Seattle (6.7 percent), and Boston (5.5 percent). In areas reporting 2005 treatment data, the proportions (excluding alcohol) of other opiate admissions were relatively low, ranging from 1.1 to 1.2 percent in Chicago and Los Angeles, respectively, to between 2.2 percent in San Diego and 3.2 and 3.6 percent, respectively, in Hawaii and Philadelphia.
- Of the 13 CEWG areas participating in DAWN in the first half of 2006, the unweighted hospital ED opiate/opioid reports accounted for substantial proportions of the reports in the "other substances" category, which includes prescription-type drugs, over-the-counter drugs, and dietary supplements. As a proportion of the "other substances," opiate/opioid reports were high in Minneapolis/St. Paul (32.6 percent), Ft. Lauderdale (34.6 percent), New York City (35.2 percent), and Seattle (36.2 percent), and they were lowest in Miami-Dade County and Houston (21.2 and 22.9 percent, respectively). As a proportion of the total unweighted opiate/opioid ED reports, oxycodone reports were high in Boston (48.3 percent), Ft. Lauderdale (47.6), Miami (35.1), Minneapolis (38.6), Denver (31.2), and Phoenix (29.3 percent), while

hydrocodone ED reports were high in Houston (47.5), San Diego (31.3), Detroit (27.0), and San Francisco (20.7). Areas with the highest proportions of methadone reports were New York City (56.1), Seattle (29.8), San Francisco (27.5), and Chicago (20.0). The proportions of fentanyl reports were relatively low compared with the proportions for other opiate/opioid drugs and were highest in Denver (6.7), Minneapolis (4.9), Detroit (4.5), Phoenix and San Diego (each 3.3 percent), and Boston (2.8). In the other seven CEWG areas, fentanyl reports accounted for between 0.4 percent (Houston) and 2.3 percent (Chicago and San Francisco) of the opiate/opioid reports. Across CEWG areas, substantial proportions of the reports (from 9 to 37 percent) were for unspecified opiates/opioids (*see exhibit 9b*).

- Fentanyl-related deaths increased in Chicago (291 in 2006), Detroit (176 in the first 9 months of 2006), Philadelphia (103 in the first half of 2006), Florida (51 in the first half of 2006), Georgia (36 in FY 2006), Maryland (36 in 2006), and New York State (29 in January–November 2006). Fentanyl-related deaths remained stable in the St. Louis area, at 30 in 2006. Thirty fentanyl-related deaths were reported in Texas in 2005.

Marijuana abuse indicators remained stable at high levels in 15 CEWG areas, increased in 5, and decreased in 2 (Maine and San Francisco). Marijuana continues to be the most widely available and widely used drug across CEWG areas, especially among adolescents and young adults.

Considerations for the June 2007 CEWG Meeting

Findings and issues identified by CEWG representatives in slide presentations, *Abstracts*, and telephone conference calls that should be considered in preparing for the June 2007 CEWG meeting included the following:

- ***The types/forms/purity/place of origin of methamphetamine available in communities.*** It was reported that ice and/or crystal methamphetamine had become more available in many CEWG areas, but the drug's type, form, and purity were not always distinguished. So, where possible, CEWG representatives should try to determine the types, forms, and purity of the methamphetamine available in communities. There were anecdotal reports in some CEWG areas that methamphetamine was being marketed in different colors and/or flavors. A 2006 HIDTA report indicated that "Strawberry" methamphetamine had been marketed in Carson City, Nevada.

- ***The demographic characteristics of methamphetamine abusers*** (e.g., treatment admissions). If possible, comparisons should be made between methamphetamine abusers entering treatment for the first time and those who are reentering treatment.

In addition, representatives should continue to…

- Monitor opiate/opioid abuse indicators, especially for fentanyl, methadone, oxycodone, and hydrocodone abuse
- Monitor cocaine/crack abuse indicators, especially in areas in which methamphetamine abuse indicators have decreased
- Monitor heroin purity and price data, and the impact of changes on heroin abuse patterns and trends, including the combinations of drugs used

Drug Abuse Patterns and Trends Across CEWG Areas

COCAINE/CRACK

In 2005 and the first half of 2006, most cocaine/crack indicators were at higher levels than indicators for other drugs in 15 of the 22 CEWG areas. For example, in FY 2006, cocaine was the drug most frequently identified in items analyzed by forensic labs in 19 of 21 areas reported by NFLIS. In 10 CEWG areas, cocaine/crack treatment admissions (excluding alcohol) exceeded those for heroin and methamphetamine. Among treatment admissions in 2005 and/or 2006, the most common route of administration of cocaine was smoking. In 2006, the proportions of primary cocaine admissions who smoked the drug were highest in Detroit (94.5 percent), St. Louis (89.9 percent), Minneapolis/St. Paul (83.8 percent), Atlanta (78.5 percent), and Baltimore (77.4 percent); in 2005, between 83.0 and 86.0 percent of the primary cocaine admissions in Los Angeles and San Diego smoked the drug. In the 13 areas participating in DAWN, unweighted cocaine reports exceeded those for other major substances of abuse (excluding alcohol) in 12.

In 16 CEWG areas, cocaine abuse indicators remained relatively stable at high levels.

ATLANTA: *Cocaine remains Atlanta's primary drug concern, but patterns were relatively stable. Cocaine was the most mentioned drug among treatment admissions, drug abuse deaths, and NFLIS drug seizure data.* ***—Brian Dew***

BALTIMORE: *Treatment admissions for primary abuse of cocaine/crack increased slightly from around 16 percent in 2003–2005 to 17 percent of admissions (excluding alcohol) in the first half of 2006. NFLIS items also increased slightly from 41 percent of drug items analyzed by forensic labs in FY 2005 to 43 percent in FY 2006.* ***—Leigh Henderson***

BOSTON: *Cocaine abuse indicators for Boston are stable at high levels. Twenty-six percent of all treatment admissions indicated past-month cocaine use. The number of treatment admissions with past-month cocaine (including crack) use did not change from FY 2005 to FY 2006. Similarly, the number of cocaine calls to the Helpline remained stable from 2005 to 2006. Though the number of cocaine drug arrests (Class B) and drug lab samples increased, the proportion of cocaine drug arrests and drug lab samples remained stable from 2004 to 2005.* ***—Daniel Dooley***

CHICAGO: *Epidemiological indicators continue to show that cocaine and marijuana are among the most commonly used illicit substances in Chicago. Cocaine was the second most frequently reported reason for entering treatment in FY 2005, and the trend was stable over the prior 5 years. Preliminary unweighted data from DAWN Live! show that cocaine accounted for the largest proportion of illicit drug reports in the first half of 2006, and cocaine was among the most frequently seized drugs by law enforcement in both FY 2005 and FY 2006, at 32 percent of all drug items.* ***—Lawrence Ouellet***

CINCINNATI: *Drug abuse indicators continue to show cocaine/crack cocaine at high levels throughout Cincinnati. Twenty-six percent of the known public treatment admissions for FY 2006 included primary cocaine use (including alcohol). Cocaine submissions recorded by NFLIS accounted for 48 percent of the total items reported and for 36 percent of the drug items recorded by the Hamilton County Coroner's Office Laboratory. The average purity of cocaine items submitted to the Drug Enforcement Administration (DEA) Laboratory for analysis was 80 percent. Hamilton County law enforcement seizures of powder cocaine for the first 11 months of 2006 were twice those of the first 11 months of the previous year. Cocaine was detected in 49 decedents, second only to alcohol-related deaths during the first 6 months of 2006. Intentional exposure cases where cocaine was recorded as an involved substance in poison control center data*

*doubled from 2005 through 2006. —**Jan Scaglione***

DENVER: *In the first half of 2006, primary cocaine treatment admissions, excluding alcohol, were relatively stable, at 23 percent of illicit drug admissions. Cocaine accounted for the highest illicit drug rate per 100,000 persons for hospital discharges from 1996 through 2005, for the highest number of illicit unweighted drug ED reports in the first half of 2006, and for 45 percent of the items reported by NFLIS in FY 2006, down from 49 percent in FY 2005. —**Tamara Hoxworth***

DETROIT: *Cocaine continues to be a major drug of abuse in the area. Cocaine treatment admissions increased from FY 2005 to FY 2006, when this group accounted for 41 percent of the primary treatment admissions (excluding alcohol); 95 percent of the 2006 cocaine admissions were for crack abuse. Fifty-one percent of the unweighted ED illicit drug reports in the first half of 2006 were cocaine reports. In both FY 2005 and FY 2006, 46 percent of the drug items reported by NFLIS contained cocaine. In the first 9 months of 2006, deaths involving cocaine were higher than those for all other drugs. —**Cynthia Arfken***

MIAMI/FT. LAUDERDALE: *Cocaine was responsible for the highest number of drug consequences in Miami-Dade County, but indicators remained relatively stable. —**James Hall***

MINNEAPOLIS/ST. PAUL: *Treatment admissions for primary abuse of cocaine/crack continued to account for between 26 and 27 percent of illicit drug admission (excluding alcohol) from 2003 to the first half of 2006. Cocaine also accounted for 26–27 percent of the items reported by NFLIS in FY 2005 and FY 2006. Nearly 38 percent of the unweighted illicit drug reports in DAWN Live! in the first half of 2006 were cocaine reports. —**Carol Falkowski***

NEW YORK CITY: *Cocaine indicators continue to be stable, and cocaine remains a major problem in New York City. Excluding alcohol admissions, more than 56 percent of clients in treatment in the first half of 2006 reported cocaine as a primary, secondary, or tertiary drug. —**Rozanne Marel***

PHILADELPHIA: *Most cocaine indicators remained relatively stable. Cocaine abuse, particularly in the form of crack, continued to lead the consequence data in the first half of 2006 with respect to deaths with the presence of drugs, treatment admissions, and laboratory tests performed by NFLIS. It was the second substance most frequently encountered in urine/drug screens performed by the Philadelphia Adult Probation and Parole Department. —**Samuel Cutler***

ST. LOUIS: *Crack cocaine continued to be the major problem in the area, but most indicators have remained relatively stable. Treatment admissions were down slightly (6 percent) from the first half of 2005 to the first half of 2006 in the St. Louis area, but they were up 9 percent statewide. —**James Topolski***

SAN FRANCISCO: *Indicators for cocaine use showed a level trend in the 2003–2006 time period. —**John Newmeyer***

SEATTLE: *Both the rate and number of cocaine-involved deaths are at the highest levels seen in at least 10 years. According to unweighted data from area emergency departments, cocaine is the most commonly identified illicit drug. Treatment admissions for primary cocaine abuse remained relatively stable at around 24 percent of admissions (excluding alcohol). —**Caleb Banta-Green***

TEXAS: *Cocaine is the primary illicit drug for which Texans enter treatment and it is a major problem on the border with Mexico, with increased purity levels and seizures. Indicators of cocaine use remain stable or are increasing. —**Jane Maxwell***

WASHINGTON, DC: *Cocaine remains one of the most serious drugs of abuse in the District, as evidenced by the fact that more adult arrestees tested positive for cocaine than for any other drug in 2006, and that number is increasing. In the first 9 months of 2006, approximately 40 percent of adult arrestees tested positive for cocaine at the Pretrial Services Agency. More seized items tested positive for cocaine than for any other drug, as reported by NFLIS in both FY 2005 and FY 2006 (44 vs. 41 percent). —**Erin Artigiani***

Increases in selected indicators were reported in three areas where cocaine abuse indicators are relatively low.

HONOLULU: *In the first half of 2006, there were 50 percent more decedents with positive cocaine toxicology screens, 50 percent more cocaine cases reported by the Honolulu Police Department, and 10 percent more cocaine admissions to treatment in the State. —**D. William Wood***

MAINE: *Fourteen percent of all 2006 treatment admissions involved a primary problem with cocaine; the proportion and number have risen steadily each year. Cocaine arrests by the Maine Drug Enforcement Agency rose 2 percent from 2004 to 2005, and 5 percent from 2005 to 2006. Deaths related to cocaine were level from 2004 to 2005, but projections suggest a 2006 decrease. —**Marcella Sorg***

NEW MEXICO: *Seizures of cocaine (in kilograms) increased 159 percent from 2003 to 2004, according to the El Paso Intelligence Center. —**Nina Shah***

In three CEWG areas where cocaine/crack indicators are relatively low, patterns tended to remain relatively stable.

LOS ANGELES: *Treatment admissions for primary abuse of cocaine/crack (excluding alcohol) decreased slightly from 2003 to 2005 (23 vs. 21 percent), while cocaine items reported by forensic labs increased slightly from 36 to 39 percent from FY 2005 to FY 2006. —**Beth Rutkowski***

PHOENIX/ARIZONA: *Statewide, treatment admissions for cocaine/crack varied from 14 to 16 percent from FY 2003 to FY 2006. Cocaine accounted for approximately 30 percent of drug items analyzed by forensic labs in both FY 2005 and FY 2006. Hospital discharges for cocaine in Maricopa County increased slightly from the second half of 2005 to the second half of 2006. —**Ilene Dode***

SAN DIEGO: *Treatment admissions remained relatively stable between 2004 and 2005, at around 8 percent of illicit drug admissions (excluding alcohol). Similarly, there was little change in the percentage of cocaine items reported by NFLIS in FY 2005 and FY 2006 (14–15 percent of all drug items). Cocaine accounted for 14 percent of the unweighted DAWN Live! ED reports in the first half of 2006. —**Robin Pollini***

PATTERNS AND TRENDS IN COCAINE ABUSE ACROSS CEWG AREAS

Treatment Data on Cocaine/Crack

Exhibit 1a shows recent 2006 data on primary cocaine/crack treatment admissions from 16 CEWG areas; also presented in ***italic bold*** are data from 4 areas in which only 2005 data were available. In the 2006 time periods, primary cocaine/crack admissions as a proportion of all admissions, excluding alcohol, exceeded those for all other illicit drugs in Atlanta, Broward County, Cincinnati, Detroit, and St. Louis; in the four areas where 2005 data are shown, cocaine admissions exceeded those for other illicit drugs in Philadelphia.

Exhibit 1a. Primary Cocaine Treatment Admissions in 20 CEWG Areas, by Percent of All Admissions (Excluding Alcohol): 2003–2006[1]

CEWG Area/State	Year				Percent Smoked 2005—2006
	2003	2004	2005	2006	
Atlanta	57.6	52.5	49.8	50.6	78.5
Baltimore	15.5	15.8	16.4	17.3	77.4
Boston	12.7	11.3	12.5	12.0	60.0
Broward Co. (BARC)[2]	NR[3]	NR	41.0	37.9	NR
Chicago	***32.4***	***32.7***	***26.5***	***NR***	***90.7***
Cincinnati[4]	44.5	41.7	41.7	36.0	83.9
Denver	22.4	23.2	20.0	23.5	56.7
Detroit	38.5	35.6	34.7	41.1	94.5
Los Angeles	***23.0***	***22.0***	***20.5***	***NR***	***85.9***
Mpls./St. Paul	26.3	26.1	26.5	27.0	83.8
New York	28.9	29.5	29.2	29.4	62.1
Philadelphia[5]	***36.4***	***33.8***	***34.3***	***NR***	***NR***
St. Louis	40.2	40.9	33.5	32.2	89.9
San Diego	***NR***	***8.7***	***8.2***	***NR***	***82.8***
San Francisco	25.9	29.7	26.8	29.4	81.7
Seattle	22.6	21.8	24.6	24.0	NR
Arizona	16.2	16.1	14.1	14.6	NR
Hawaii	6.3	6.3	4.1	6.4	NR
Maine	10.9	11.4	12.7	14.2	53.8
Texas	38.2	35.7	34.1	33.2	56.9

[1]Represents different time periods (FY 2005 or 2006, or 1H CY 2006, or full year CY 2005 or 2006); see *Appendix A*.
[2]The Broward County sample is from 9 programs that serve 51.5 percent of admissions to county treatment facilities.
[3]NR=Not reported by the CEWG representative.
[4]Represents 65–75 percent of the Cincinnati/Hamilton County admissions in the first half of 2006.
[5]In the first half of 2006, cocaine/crack accounted for 33.5 percent of all drug mentions (excluding alcohol); data were not available for the "primary drug" category.
SOURCES: June 2006 and January 2007 State and local reports

In January 2006, 12 areas reported on the route of cocaine administration. In all 12 areas, more than one-half of the primary cocaine admissions reported smoking cocaine.[1] In Detroit in FY 2006, 94.5 percent of these admissions were for crack abuse. In St. Louis in the first half of 2006, nearly 90 percent of this admissions group smoked the drug. In Atlanta, Baltimore, Cincinnati, Minneapolis/St. Paul, and San Francisco, between 77 and 84 percent of the primary cocaine admissions smoked the drug. In 2005, the proportions smoking cocaine were highest in Chicago, at nearly 91 percent.

Gender. In 13 of 14 CEWG areas for which gender data were available, primary cocaine/crack treatment admissions were more likely to be male than female in both 2005 and 2006 (*see exhibit 1b*). The exceptions were Cincinnati and Texas, where just over one-half of the cocaine/crack admissions were female in the first half of 2006.

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

Exhibit 1b. Demographic Characteristics of Primary Cocaine Treatment Admissions in Reporting CEWG Areas, by Percent[1]: 2005–2006[2]

CEWG Area	Gender		Race/Ethnicity			Age
	Male	Female	White	Afr.-Amer.	Hispanic	35 or 36 or Older
Atlanta	59	41	25	73	1	82
Baltimore	56	44	41	56	2	71
Chicago	***59***	***41***	***10***	***82***	***6***	***NR[3]***
Cincinnati[4]	49	51	53	45	NR	NR
Denver	62	38	45	21	32	60
Detroit	59	41	5	93	1	85
Los Angeles	***67***	***33***	***14***	***57***	***25***	***70***
Maine	53	47	NR			36
Mpls./St. Paul	70	30	39	52	5	69
New York City	68	32	15	58	24	77
Philadelphia	***NR***		***27***	***63***	***11***	***59***
St. Louis	59	41	29	70	1	71
San Diego	***66***	***34***	***28***	***58***	***11***	***74***
Seattle	***62***	***38***	***33***	***51***	***5***	***57[5]***
Texas	48	52	31	36	32	NR

[1]Percentages rounded.
[2]Percentages shown in bold italic represent 2005 data.
[3]NR=Not reported by the CEWG representative.
[4]Represents 65–75 percent of the Cincinnati/Hamilton County admissions in the first half of 2006.
[5]Represents admissions age 30–44 (another 25 percent were age 45–54).
SOURCES: June 2006 and January 2007 State and local reports

Race/Ethnicity. In six of the nine CEWG areas reporting on race/ethnicity in 2006, more than one-half of the primary cocaine/crack admissions were African-American, with the highest proportions being in Detroit (93 percent), Atlanta (73 percent), and St. Louis (70 percent); the lowest proportions were in Denver (21 percent), Texas (36 percent), and Cincinnati (45 percent) (*see exhibit 1b*). In Baltimore, Denver, and Cincinnati in 2006, Whites accounted for between 41 and 53 percent of these admissions groups, while in New York City, Denver, and Texas, between 24 and 32 percent of the cocaine/crack admissions were Hispanic. In 2005 in Chicago, 82 percent of the cocaine admissions were African-American.

Age. With the exception of Maine, a majority of the cocaine/crack admissions in 11 CEWG areas were age 35 or 36 or older in 2005 or 2006. In Maine in 2006, cocaine/crack admissions were nearly evenly divided between the 35 or older and 25–34 age groups, at 36 and 37 percent, respectively. Atlanta reported the highest proportion of cocaine/crack admissions age 35 and older (82 percent) in the first half of 2006.

Trend Data. A comparison of 2003 to 2006 data from 15 CEWG areas shows that cocaine/crack admissions as a proportion of total admissions, excluding alcohol, decreased 7–8 percentage points in Atlanta, St. Louis, and Cincinnati (*see exhibit 1a*). Given the stable pattern in Cincinnati over

the prior years, the pattern may continue to be stable when total figures are available for 2006. In Baltimore, Detroit, Maine, and San Francisco, there were small increases from 2003 to 2006 (from 1.8 to 3.5 percentage points). In the other nine CEWG areas, the trend was stable. In the four areas where only 2005 data are available, a 6 percentage-point decrease occurred in Chicago from 2004 to 2005; the trend was relatively stable in the other four areas in 2005.

In many CEWG areas, cocaine/crack was reported as a secondary or tertiary drug by treatment admissions, so it is often used in combination with other substances. The most recent data reported from eight areas show the following:

ATLANTA: Cocaine was the secondary drug of use among 30 percent of all treatment admissions in the first half of 2006.

BALTIMORE: The cocaine situation is complicated by the fact that for every drug-related treatment admission (includes primary alcohol with secondary drug use) reporting primary cocaine use, 2.4 reported secondary use. Cocaine was the secondary drug of use among 35 percent of all admissions in the first half of 2006, and the secondary drug for 55 percent of the primary heroin admissions who abused another drug. Cocaine smoking and intranasal use were associated with intranasal heroin use in 34 percent of those who smoked cocaine or used it intranasally. Cocaine injection was associated with heroin injection in 89 percent of all admissions who injected cocaine.

BOSTON: Forty percent of all treatment admissions (including alcohol) in FY 2006 reported past-month use of cocaine.

BROWARD COUNTY: Cocaine was used as a primary, secondary, or tertiary drug by 39 percent of the admissions (excluding alcohol) in the first half of 2006.

DETROIT: Crack was reportedly the secondary drug of abuse among primary heroin admissions in FY 2006.

MINNEAPOLIS/ST. PAUL: Cocaine was the secondary drug of abuse among 30 percent of the primary heroin admissions, 29 percent of the primary alcohol admissions, and 13 percent of the primary marijuana admissions in the first half of 2006.

SEATTLE: In the first half of 2006, 42 percent of all treatment admissions (including alcohol) reported any use of cocaine.

TEXAS: In the first half of 2006, 22 percent of the primary heroin admissions had a problem with powder cocaine and 6 percent had a problem with crack cocaine. Of the primary marijuana admissions, 11 percent had a problem with powder cocaine and 2 percent had a problem with crack cocaine.

DAWN ED Data on Cocaine/Crack

The map in exhibit 2 depicts the proportion of unweighted ED cocaine reports as a percentage of the total major substances of abuse (excluding alcohol) in the 13 CEWG areas participating in DAWN in the first half of 2006. Of all major substances (excluding alcohol), the unweighted cocaine reports accounted for the largest percentages of the reports in 12 of the 13 CEWG areas. The exception was San Diego, where methamphetamine ED reports exceeded those for other major substances.

Mortality Data on Cocaine/Crack

Eight CEWG representatives reported the most recent data on deaths with the presence of cocaine for their metropolitan or county areas. Detroit and Minneapolis/St. Paul reported for the first 9 months of 2006; the others reported for the first half of 2006. The numbers are as follows:

- 320 in Detroit/Wayne County
- 248 in Philadelphia
- 75 in Miami-Dade County
- 57 in Broward County, Florida
- 54 in Seattle/King County
- 49 in Cincinnati/Hamilton County
- 38 in Minneapolis/Hennepin County and St. Paul/Ramsey County
- 12 in Honolulu

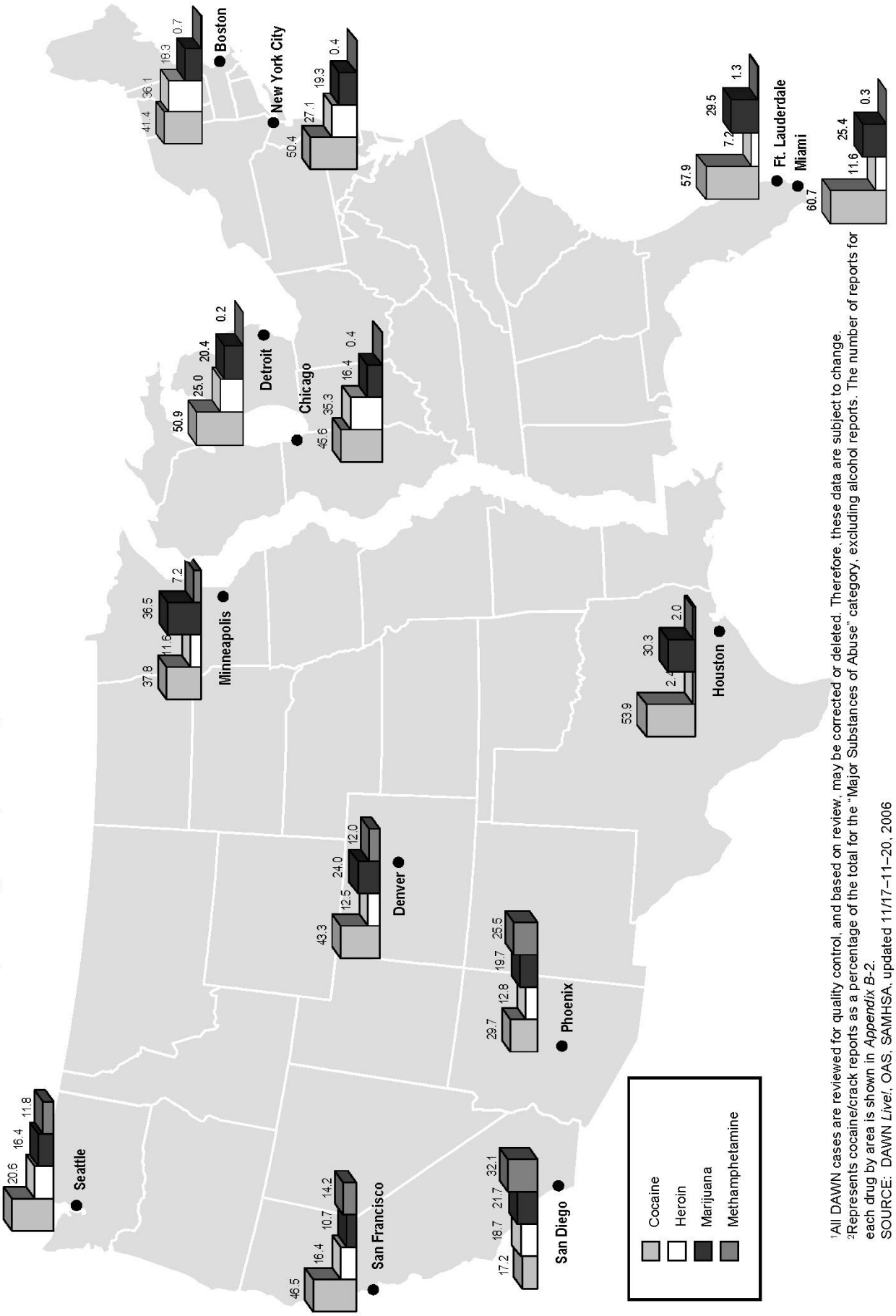
In addition, five CEWG representatives provided data on cocaine-related deaths specific to their States. In the first half of 2006, 927 cocaine-related deaths were reported in Florida. In FY 2006, 288 cocaine-involved deaths were reported in Georgia, and 432 were listed as positive for benzoylecgonine (a cocaine metabolite that is excreted in the urine of cocaine users); these may represent some duplicate counts. In 2005, cocaine-involved deaths totaled 723 in Texas and 217 in Colorado. Maine reported 23 cocaine-induced deaths in 2005.
Drug overdose deaths in Albuquerque/ Bernalillo County and the State of New Mexico in 2003–2005 were reported as rates per 100,000 population. The rate in the county in this time period was 7.72, higher than that for the State overall (5.49).

NFLIS Data on Cocaine/Crack

In FY 2006, cocaine was the drug most frequently reported by forensic laboratories in 15 of the 20 areas shown in exhibit 3, and it ranked second in 5 other areas. Cocaine accounted for more than one-half of all drug items analyzed by forensic labs in Miami, Ft. Lauderdale, Atlanta, and New York City in FY 2006, with Miami and Ft. Lauderdale substantially higher (71.3 and 68.8 percent, respectively) than other CEWG areas. The proportions of cocaine items to total items were considerably lower in San Diego and Honolulu than in other CEWG areas.

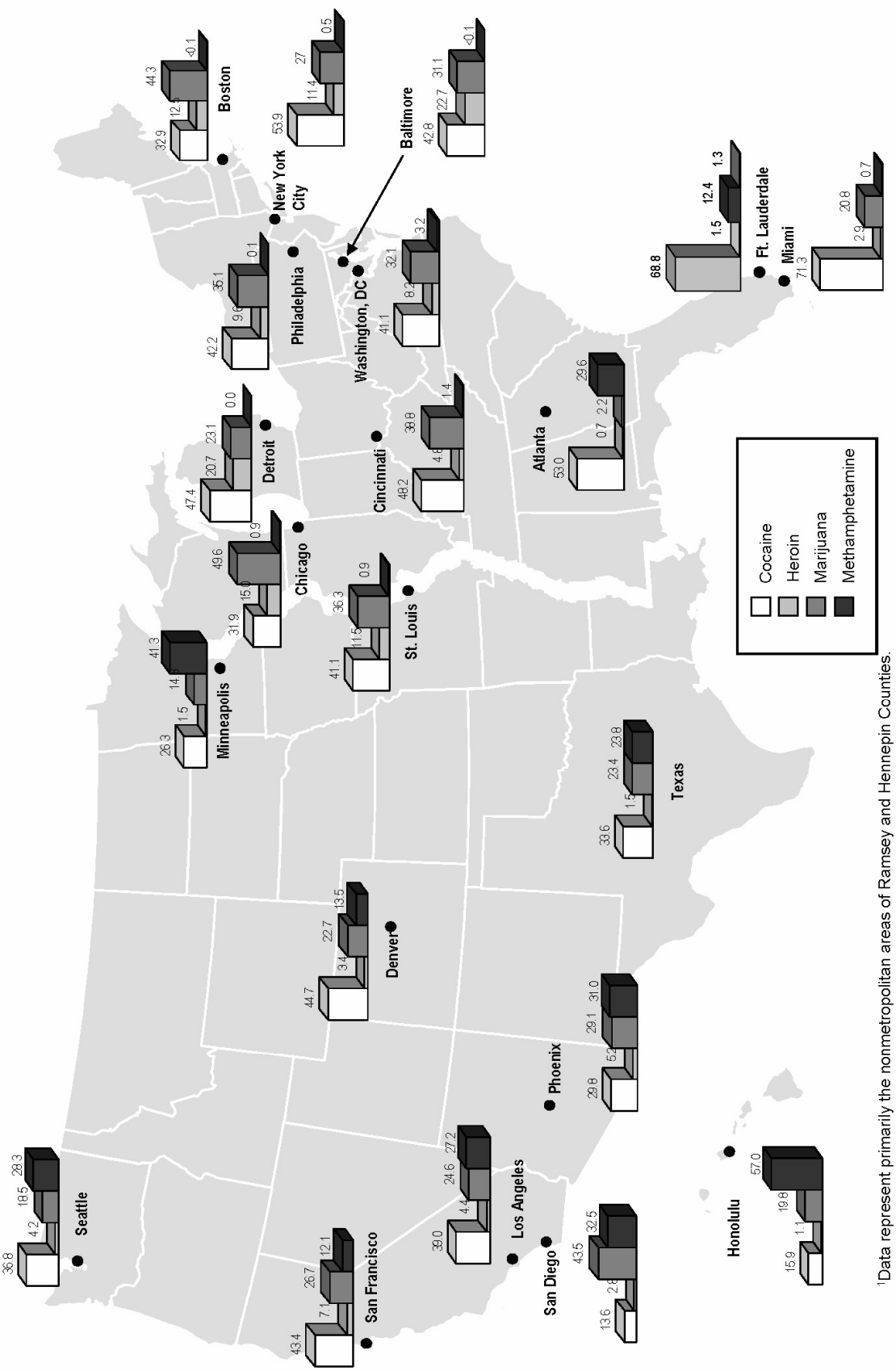
Not shown in exhibit 3 is Albuquerque, where 37 percent of the items collected and analyzed by forensic labs in 2006 contained cocaine.

Exhibit 2. Unweighted[1] DAWN ED Reports of Cocaine, Heroin, Methamphetamine, and Marijuana in 13 CEWG Areas as a Percentage of Major Substances of Abuse (Excluding Alcohol)[2]: January–June 2006



[1]All DAWN cases are reviewed for quality control, and based on review, may be corrected or deleted. Therefore, these data are subject to change.
[2]Represents cocaine/crack reports as a percentage of the total for the "Major Substances of Abuse" category, excluding alcohol reports. The number of reports for each drug by area is shown in *Appendix B-2*.
SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 11/17–11–20, 2006

Exhibit 3. Percentages of Cocaine, Heroin, Marijuana, and Methamphetamine Items Analyzed by Forensic Labs in 21 CEWG Areas, Each as a Percentage of Total Items Analyzed: FY 2006



[1]Data represent primarily the nonmetropolitan areas of Ramsey and Hennepin Counties.
SOURCE: NFLIS, DEA

Price Data on Cocaine/Crack

Exhibit 4a presents the cost per gram of powder cocaine in 21 CEWG areas, as reported by NDIC at mid-year 2006. As shown, the low end street price of a gram of cocaine was cheapest on the streets of New York City, Baltimore, and Phoenix, at $20 in both New York City and Baltimore, and $25 in Phoenix. The highest price for a gram of cocaine was $100 in Bangor, Maine, Cincinnati, and Minneapolis.

Exhibit 4a. Powder Cocaine Retail (Street) Price[1] in 21 CEWG Areas[2], Ordered by Lowest Price: June 2006

CEWG Area	Price Per Gram
New York City	$20–$30
Baltimore	$20–$200
Phoenix	$25–$30
Miami	$40–$100
San Francisco	$50–$60
Dallas	$50–$80
Denver	$50–$80
Seattle	$50–$100
Detroit	$50–$120
Albuquerque	$60–$120
San Diego	$60–$160
Honolulu	$60–$200
Philadelphia	$70–$125
Chicago	$75–$100
Los Angeles	$80
Atlanta	$80–$100
Boston	$80–$100
Wash., DC	$80–$100
Bangor, ME	$100
Cincinnati	$100
Minneapolis	$100

[1]Most current available price at mid-year 2006.
[2]Price per gram was not available for St. Louis.
SOURCE: NDIC, DOJ

Street prices for crack cocaine during the same time period are presented in exhibit 4b. In 19 areas, the prices were reported for a "rock," and in 3 areas the prices were reported for a gram of crack. As can be seen, the street the price for a rock was lowest in New York City ($7). In 11 other areas, a rock could be purchased for $10. The street price for a gram was $100 in both Bangor and Washington, DC.

Exhibit 4b. Crack Retail (Street) Price[1] in 22 CEWG Areas, Ordered by Lowest Price: June 2006

CEWG Area	Price Per Rock
New York City	$7–$10
Miami	$10
Boston	$10–$20
Chicago	$10–$20
Detroit	$10–$20
Phoenix	$10–$20
San Diego	$10–$20
Seattle	$10–$20
Baltimore	$10–$40
Honolulu	$10–$40
Los Angeles	$10–$40
Dallas	$10–$100
Minneapolis	$15–$25
Albuquerque	$20
Atlanta	$20
Cincinnati	$20
Denver	$20
St. Louis	$20
San Francisco	$20
	Price Per Gram
Philadelphia	$70
Bangor, ME	$100
Wash., DC	$100

[1]Most current available price at mid-year 2006.
SOURCE: NDIC, DOJ

Heroin

Heroin abuse indicators increased in 2 CEWG areas, were mixed or stable at high levels in 5, were low and mixed or stable in 10, and decreased in 3 areas where abuse levels are relatively high and in 2 areas where indicators are at relatively low levels. Decreases in heroin purity levels are reportedly associated with changes in heroin use (mode of administration or use of other drugs) in some CEWG areas.

Heroin abuse indicators increased in two CEWG areas.

CHICAGO: *Heroin use indicators have increased or remained at elevated levels since the mid-1990s. Drug treatment services for heroin use, which surpassed those for cocaine in FY 2001, have since nearly doubled to 33,662 episodes in FY 2005. According to preliminary unweighted DAWN Live! data, heroin was the second most commonly reported illicit substance in emergency departments during the first 6 months of 2006.* ***—Lawrence Ouellet***

NEW MEXICO: *Heroin is the most significant drug threat in New Mexico in terms of abuse. In 2005, heroin caused the most unintentional overdose deaths…increasing roughly 40 percent from 2004. The rate of heroin overdose deaths from 2003 to 2005 was higher in Bernalillo County, where Albuquerque is located, than in the State overall.* ***—Nina Shah***

Heroin abuse indicators remained stable or mixed at relatively high levels in five CEWG areas.

BALTIMORE: *Heroin remained the most significant substance of abuse among drug-related treatment admissions in Baltimore in the first half of 2006, accounting for 55 percent of drug admissions (excluding alcohol). Heroin use in the area is complex. Several groups of heroin users differ by urbanicity, route of administration, age, and race. In the first half of 2006, Baltimore continued to have a core of older African-American heroin users, both intranasal users and injectors (39 and 21 percent of all heroin treatment admissions, respectively). White users entering treatment for heroin abuse were younger and were predominantly injectors rather than intranasal users (27 and 9 percent, respectively).* ***—Leigh Henderson***

BOSTON: *Heroin abuse remains stable at very high levels in Boston. In FY 2006, 76 percent of treatment admissions (excluding alcohol) identified heroin as their primary drug of abuse, and heroin admissions accounted for one-half of the total admissions (including alcohol). Though levels of heroin drug arrests (Class A) and drug lab samples decreased from 2004 to 2005, analysis of data for the first half of 2006 suggest that these levels may have stabilized.* ***—Daniel Dooley***

DETROIT: *In FY 2006, heroin abuse indicators were mixed but remained at high levels. Heroin treatment admissions declined, but the number of heroin items reviewed by forensic laboratories increased. This followed an increase in heroin purity and a drop in price in 2005, as documented by the Domestic Monitor Program. The number of heroin items reviewed by forensic laboratories increased, possibly because of fentanyl surveillance.* ***—Cynthia Arfken***

LOS ANGELES: *Heroin abuse indicators continued at relatively high levels, with increases in some indicators and decreases in others. The percentage of primary heroin treatment admissions (including alcohol) decreased from 23.9 percent in 2004 to 20.3 percent in 2005. In 2005, nearly 49 percent of the heroin treatment admissions were Hispanic. Heroin-related deaths appear to have increased by approximately 75 percent from 2002 to 2005, and this jump in deaths*

*was most prevalent among users older than 40. —**Beth Rutkowski***

NEW YORK CITY: *Heroin indicators were mixed… In the first half of 2006, 38 percent of treatment admissions (excluding alcohol) were primary heroin abusers, down from 42 percent in 2003. Of the heroin admissions in the first half of 2006, 49 percent were Hispanic. There was concern that fewer heroin abusers were coming into methadone treatment. —**Rozanne Marel***

Heroin abuse indicators were relatively low and mixed or stable in 10 CEWG areas.

CINCINNATI: *Heroin abuse continued to be relatively low. However, heroin treatment admissions (excluding alcohol) increased from 12 percent in FY 2003 to nearly 17 percent in FY 2006; also heroin accounted for 4 to 5 percent of law enforcement drug seizures in Cincinnati. —**Jan Scaglione***

HONOLULU: *Heroin abuse indicators remained relatively low and stable. Heroin accounted for less than 4 percent of illicit drug admissions and for less than 2 percent of the NFLIS items. Three deaths were positive for heroin, and there were six heroin arrest cases in the first half of 2006. —**D. William Wood***

MAINE: *Heroin indicators were mixed in Maine. The number of primary heroin admissions increased from 2005 to 2006, but the proportion decreased slightly—from 20 to 19 percent. Heroin/morphine-related deaths doubled from 2004 to 2005, but a review of these data indicate that many of the deaths involved pharmaceutical morphine. Heroin exposure calls to poison control centers were level from 2003 to 2005, but dropped in the first three quarters of 2006. Arrests for heroin possession or use made by the Maine Drug Enforcement Agency were stable from 2004 to 2005. —**Marcella Sorg***

MIAMI: *Heroin abuse indicators continued to be low in Miami-Dade. Less than 3 percent of the items analyzed by Miami forensic labs in FY 2006 contained heroin; there were 22 heroin-related deaths in 2005 and 5 were reported in the first half of 2006. In the first half of 2006, heroin reports accounted for approximately 12 percent of the unweighted illicit drug DAWN ED reports in Miami-Dade County. —**James Hall***

MINNEAPOLIS/ST. PAUL: *Heroin abuse indicators, while relatively low, remained stable at somewhat elevated levels. —**Carol Falkowski***

PHOENIX: *In 2006, heroin abuse indicators remained relatively low. Statewide, primary heroin treatment admissions remained stable from FY 2003 to FY 2006, at about 11 percent of illicit drug admissions (excluding alcohol). Heroin accounted for 13.3 percent of the unweighted illicit drug ED reports, for approximately 12.0 percent of treatment admissions in the State, and for 5.5 percent of the items analyzed by NFLIS. —**Ilene Dode***

SAN DIEGO: *Heroin ranked behind methamphetamine and marijuana in the number of ED reports in the unweighted DAWN data for the first half of 2006 and fourth in the number of NFLIS items reported in FY 2006. Heroin was the primary drug of abuse for nearly 24 percent of those admitted to treatment in 2005 (excluding alcohol), down slightly from 2004. Heroin was the primary drug of abuse for 72.4 percent of the primary injectors among treatment admissions in 2005. —**Robin Pollini***

SEATTLE: *The total of 30 heroin/opiate-involved deaths is down somewhat compared with prior years. Treatment admissions for heroin remain relatively stable, with approximately 1 in 5 persons*

*reporting any heroin use at treatment entry for all ages and treatment modalities. In FY 2006, slightly more than 4 percent of the items analyzed by forensic labs (NFLIS) contained heroin. —**Caleb Banta-Green***

TEXAS: *Heroin indicators in Texas areas were stable or dropping; most heroin addicts entering treatment were injectors. Heroin purity is increasing, and 'cheese,' a mixture of Tylenol PM and 1 percent heroin, has been reported in Dallas schools. —**Jane Maxwell***

WASHINGTON, DC: *Reports from the Pretrial Services Agency indicate that the percentage of adult arrestees testing positive for opiates remained about the same from 2001 through the first 3 months of 2006. From January through March 2006, almost 9 percent of the adult arrestees tested positive for opiates. NFLIS data for 2005 show that about 11 percent of the items analyzed by forensic labs in the District tested positive for heroin. —**Erin Artigiani***

Heroin abuse indicators decreased in five CEWG areas, remaining relatively high in Philadelphia, St. Louis, and San Francisco and relatively low in Atlanta and Denver.

ATLANTA: *Heroin abuse indicators continued to decrease in 2006, with the majority of abusers concentrated in Atlanta's Bluff district. Rates of injecting South American (SA) heroin remained stable, although reports indicated a decrease in purity levels and an increase in price. The types (origin) of heroin exhibits purchased by DMP in 2005 varied: 13 were from South America, 5 from Southwest Asia, and 4 from Southeast Asia. The average street price for SA heroin in Atlanta was $2.04 per milligram pure, the most expensive average price for heroin (of any type) in all DMP areas reported by the program in 2005. —**Brian Dew***

DENVER: *Most heroin abuse indicators decreased over the past several years, although poison control calls remained stable. In the first half of 2006, heroin was reported as a primary drug for about 9 percent of Denver treatment admissions (excluding alcohol), down from 22 percent in 2003. —**Tamara Hoxworth***

PHILADELPHIA: *Indicators remained mostly stable at high levels. The decline in street-level purity of heroin since 2000 (73 percent) appears to have caused users to seek or approximate a high through the use of increased amounts or adding other drugs to use in combination. —**Samuel Cutler***

ST. LOUIS: *Heroin activity had been increasing, but treatment admissions in the St. Louis area decreased 11 percent from the first half of 2005 to the first half of 2006 and decreased statewide over the same period by 5 percent. —**James Topolski***

SAN FRANCISCO: *Heroin abuse indicators, while continuing at high levels, have been consistently declining since 2000, although FY 2005 treatment data suggest the trend may be reversing. The 27 DMP exhibits purchased in 2005, all from Mexico, averaged 12.3 percent in purity. —**John Newmeyer***

Heroin purity remained low in most CEWG areas east of the Mississippi River—areas in which South American (SA) heroin dominated the heroin markets in 2005. The average purity of SA heroin was lower than 50 percent per milligram pure in all CEWG areas east of the Mississippi, including Chicago (17.1 percent), Miami (19.4), Washington, DC (20.2), Baltimore (29.1), Boston (29.4), Atlanta (39.3), and Detroit (46.6). An exception may be St. Louis, where South American heroin is becoming more available, as indicated below.

Decreases in heroin purity were reported in two eastern CEWG areas that have been identified as significant heroin markets and distribution centers by the DEA, while

increases in heroin purity are being reported in St. Louis.

NEW YORK CITY: *The heroin purity level was at 49.4 percent in 2005, up from the last reporting period, but still lower than the 60.0 percent reported in recent years. However, there is some evidence that purity levels are increasing, back to the 50.0 percent range.* ***—Rozanne Marel***

PHILADELPHIA: *The street-level of heroin purity declined from 73 percent pure in 2000 to 38 percent in the first quarter of 2006.* ***—Samuel Cutler***

ST. LOUIS: *In St. Louis, the heroin problem is becoming more complex. In past years, most heroin available on the street was low purity black tar heroin. In the past year, DMP reported seizures of South American heroin that were almost 30 percent pure; it sold for $1 per milligram pure—$0.50 less per milligram than a couple of years ago. DEA also seized Southwest Asian samples in 2005; they cost less than $2 per milligram and were nearly 30 percent pure. Historically, these are the cheapest and purest heroin samples identified in St. Louis.* ***—James Topolski***

Mexican black tar and brown-powder heroin dominate the market west of the Mississippi (DMP 2005).

Most 2005 DMP heroin exhibits purchased on the street in the western region originated in Mexico. Of these CEWG areas, heroin purity levels (per milligram pure) were highest in areas on or close to the U.S.-Mexico border, including San Diego (averaging 55.9 percent) and Phoenix (53.1 percent). The heroin purchases in these two areas were exclusively black tar heroin selling at low prices on the street, e.g., $0.20 per milligram pure in San Diego and $0.49 in Phoenix. The DMP 2005 average purity levels were lower in other western region areas, including Seattle (10.4 percent), San Francisco (11.1 percent), St. Louis (14.4 percent), Dallas (16.3 percent), Los Angeles (31.4 percent), and Denver (34.4 percent).

CEWG representatives monitor the purity of drugs by area because of the potential impact purity levels can have on the way heroin is administered, the extent to which other drugs are used sequentially or in combination with heroin, and the types of other substances used with heroin. For example…

MIAMI: *Less pure heroin may explain the substantial increases in the abuse and consequences of narcotic analgesics in recent years.* ***—James Hall***

NEW YORK CITY: *The Street Studies Unit of the New York State Office of Alcoholism and Substance Abuse Services is currently assessing the extent to which heroin abusers are stabilizing heroin with multiple pharmaceuticals.* ***—Rozanne Marel***

PHILADELPHIA: *Clients who are new to treatment identify six behavior changes associated with low heroin purity: switching to injecting from other routes of administration; injecting more heroin; injecting more frequently; using additional drugs; switching to pharmaceutical drugs that have more reliable purity and predictable effects; and entering treatment.* ***—Samuel Cutler***

PATTERNS AND TRENDS IN HEROIN ABUSE ACROSS CEWG AREAS

Treatment Data on Heroin

Primary heroin admissions as a proportion of all admissions, excluding alcohol, exceeded those for all other illicit drug admissions in four CEWG areas reporting 2006 data:

Baltimore, Boston, New York City, and San Francisco. In 2005 (shown in ***italic bold)***, heroin admissions exceeded those for other illicit drugs in Chicago. Data for 2003–2006 are depicted in exhibit 5a.

Exhibit 5a. Primary Heroin Treatment Admissions in 20 CEWG Areas, by Percentage of All Admissions (Excluding Alcohol): 2003–2006[1]

CEWG Area/State	2003	2004	2005	2006	Percentage-Point Change 2003–2006
Atlanta	8.5	7.6	7.0	7.2	-1.3
Baltimore	61.7	60.7	59.5	55.2	-6.5
Boston	73.4	74.2	75.6	75.9	2.5
Broward Co. (BARC)[2]	NR[3]	NR	21.8	18.0	…
Chicago	***48.1***	***47.3***	***53.0***	***NR***	***…***
Cincinnati[4]	12.2	13.2	10.8	17.2	5.0
Denver	22.5	13.6	14.1	9.2	-13.3
Detroit	43.1	46.0	43.6	38.1	-5.0
Los Angeles	***31.1***	***30.1***	***24.4***	***NR***	***…***
Mpls./St. Paul	6.7	5.6	9.8	10.9	4.2
New York	42.3	42.1	40.8	38.4	-3.9
Philadelphia[5]	***31.4***	***36.0***	***22.7***	***NR***	***…***
St. Louis	11.7	18.4	16.0	16.1	4.4
San Diego	***NR***	***25.0***	***23.8***	***NR***	***…***
San Francisco	35.6	42.8	41.0	42.0[6]	…[6]
Seattle	25.1	27.0	25.4	21.8	-3.3
Arizona	11.7	19.6	10.6	11.0	-0.7
Hawaii	3.6	3.0	3.1	3.6	0.0
Maine[7]	20.7	21.3	20.5	18.7	-2.0
Texas	13.6	13.7	11.6	11.8	-1.8

[1]Represents different time periods (FY 2005 or 2006, or 1H CY 2006, or full year CY 2005 or 2006); see *Appendix A*.
[2]The Broward County sample is from 9 programs that serve 51.5 percent of admissions to county treatment facilities.
[3]NR=Not reported by the CEWG representative.
[4]Represents 65–75 percent of the Cincinnati/Hamilton County admissions in the first half of 2006.
[5] In the first half of 2006, heroin accounted for 23.5 percent of all drug mentions (excluding alcohol); data were not available for the "primary drug" category.
[6] Includes a small but unknown number of admissions for other opiates; therefore, the percent change from 2003 to 2006 could not be determined.
[7] Includes morphine as well as heroin.
SOURCES: June 2006 and January 2007 CEWG reports

Gender. In 16 reporting CEWG areas, there were more males than females among primary heroin admissions groups in the 2005–2006 reporting periods *(see exhibit 5b)*. Note, however, that nearly one-half of this group in Chicago and Maine were female.

Race/Ethnicity. In the nine CEWG areas reporting 2006 data, African-Americans were the most frequently represented racial/ethnic group among heroin admissions in Baltimore, Detroit, and St. Louis; Whites were more frequently represented in Atlanta, Cincinnati, Denver, and Minneapolis/St. Paul; and Hispanics were most frequently represented in New York City and Texas *(see exhibit 5b)*. In 2005, African-Americans accounted for the largest proportion of primary heroin admissions in Chicago, and Whites were the most dominant group in Hawaii, Philadelphia, San Diego, and Seattle. Hispanics accounted for 49 percent of primary heroin admissions in Los Angeles in

2005 and for 40 percent of the heroin admissions in San Diego in that year.

Age. In nine CEWG areas in the 2005–2006 reporting periods, between 55 and 88 percent of the primary heroin admissions were older than 35 or 36 (or 30–44 in Seattle), indicating an aging cohort *(see exhibit 5b).* In Maine and St. Louis in the first half of 2006, the largest proportions of primary heroin admissions were younger than 35.

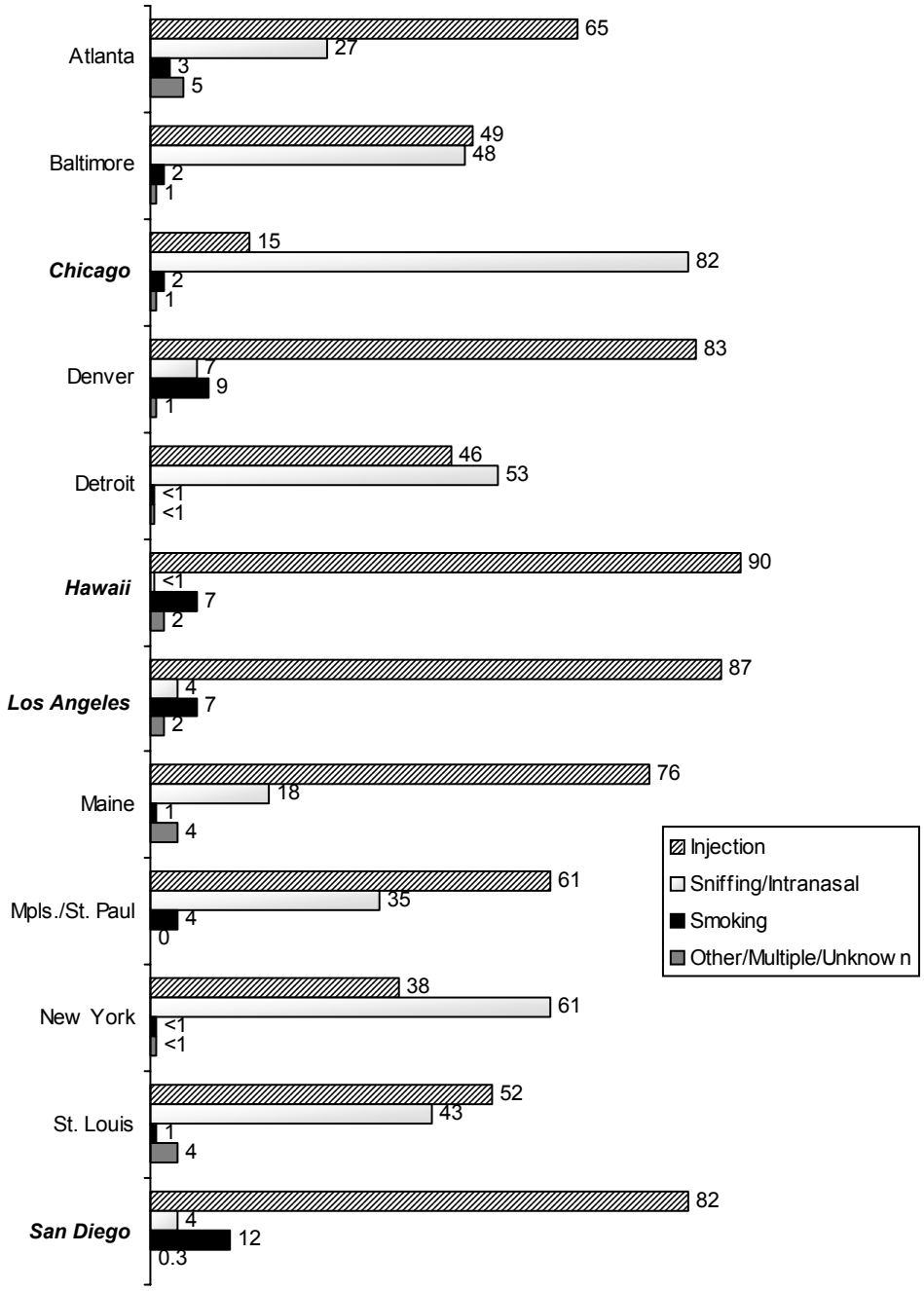
Exhibit 5b. Demographic Characteristics of Primary Heroin Treatment Admissions in Reporting CEWG Areas, by Percent[1]: *2005*–2006

CEWG Area	Gender		Race/Ethnicity			Age
	Male	Female	White	Afr.-Amer.	Hispanic	35 or 36 or Older
Atlanta	69	31	49	47	4	81
Baltimore	58	42	37	61	2	68
Chicago	***51***	***49***	***8***	***82***	***8***	***NR[2]***
Cincinnati	56	44	85	<15	NR	NR
Denver	68	32	63	8	25	59
Detroit	59	41	7	90	1	85
Hawaii	***72***	***28***	***66***	***<1***	***8***	***NR***
Los Angeles	***74***	***26***	***36***	***10***	***49***	***75***
Maine	52	48	NR			(18)[3]
Mpls./St. Paul	69	31	61	33	3	55
New York	75	25	20	26	49	77
Philadelphia	***77***	***23***	***51***	***21***	***13***	***NR[4]***
St. Louis	63	37	46	53	2	(32)[5]
San Diego	***72***	***28***	***50***	***6***	***41***	***58***
Seattle	***62***	***38***	***67***	***16***	***7***	***80***
Texas	64	36	33	11	56	NR

[1]Percentages rounded.
[2]NR=Not reported by the CEWG representative.
[3] Heroin/morphine admissions were evenly divided at 41 percent each for clients under age 25 and those 25–34.
[4] Heroin admissions younger than 26 accounted for 26 percent and those 26–35 accounted for 36 percent.
[5]St. Louis heroin admissions are somewhat evenly divided with 38 percent being age 26–34 and 29 percent being younger than 26.
SOURCES: June 2006 and January 2007 CEWG reports

Route of Administration. Exhibit 5c depicts the major routes of heroin administration in 12 CEWG areas, showing that injection was the most common mode in 9 of the 12 areas in 2005 or 2006. In 2006, injection was the most frequently reported mode of heroin administration in Atlanta, Denver, Maine, Minneapolis/St. Paul, and St. Louis (ranging from 52 to 83 percent) and was slightly dominant in Baltimore at 49 percent. Including both 2005 and 2006 data, the highest percentages of heroin injection tended to be in West Coast areas, where black tar heroin is the most available form of the drug; figures ranged from 82 percent of the heroin admissions in San Diego to 90 percent in Hawaii. In the other five CEWG areas, sniffing/intranasal use was the predominant mode of heroin administration; this tended to be more common in areas where South American heroin is the dominant form of the drug or at least is available in the area. Sniffing/intranasal use was almost as dominant as injection among heroin admissions in Baltimore and ranged between 53 and 82 percent in Detroit, New York City, and Chicago.

Exhibit 5c. Major Routes of Administration of Heroin Among Treatment Admissions in 12 CEWG Areas, by Percent[1]: *2005*–2006[2]



[1]Percentages rounded.
[2]Represents different time periods (FY 2005 or 2006, or 1H CY 2006, or full year CY 2005 or 2006); see *Appendix A.*
SOURCES: June 2006 and January 2007 CEWG reports

In Texas, 84 percent of the treatment admissions in the first half of 2006 injected heroin.

Trends. Across CEWG areas reporting 2006 data, primary heroin admissions, as a proportion relative to all treatment admissions, excluding alcohol, increased 4–6 percentage points in Minneapolis/St. Paul, St. Louis, Cincinnati, and San Francisco, when 2003 data are compared with those for 2006 (*see exhibit 5a*). Conversely, primary heroin admissions decreased approximately 7 and 13 percentage points in Baltimore and Denver, respectively, over the same time period.

DAWN ED Data on Heroin

Unweighted DAWN *Live!* data for the first half of 2006 show that heroin was the second most frequently cited major substance of abuse (excluding alcohol) among ED reports in Boston, Chicago, Detroit, New York City, San Francisco, and Seattle (*see the map in exhibit 2*). In Boston and Chicago, the unweighted heroin reports accounted for 35–36 percent of the major substance of abuse reports (excluding alcohol), and in Detroit and New York City, heroin accounted for 25 and 27 percent of the reports, respectively. The approximate proportions were lower in San Francisco (16 percent) and Seattle (21 percent).

Mortality Data on Heroin

The most recent data on deaths with the presence of heroin are summarized below. The data for Detroit/Wayne County are for the first 9 months of 2006; heroin-related mortality data for the other metropolitan/county areas are for the first half of 2006.

- Detroit/Wayne County, 185
- Philadelphia, 165 (including morphine)
- Seattle/King County, 38 (that approximate heroin)
- Broward County, 9
- Miami/Dade County, 5
- Cincinnati, 5
- Honolulu, 3

Statewide in 2005, there were 446 deaths with the presence of heroin/morphine in Texas and 42 heroin-involved deaths reported in Colorado; Maine reported 44 heroin/morphine-induced deaths. In Florida in the first half of 2006, there were 36 heroin-related deaths.

The rate of heroin overdose deaths in Albuquerque/Bernalillo County in 2003–2005 was 8.58 per 100,000 population, higher than the rate of 5.72 for the State of New Mexico overall.

NFLIS Data on Heroin

In CEWG areas in FY 2006, heroin was the third most frequently reported drug by NFLIS labs in 10 of the 21 areas depicted earlier in exhibit 3. Heroin as a percentage of total drug items was relatively high in Baltimore (22.7 percent) and Detroit (20.7); it ranged between 11.4 and 15.0 percent of the drug items in New York City, St. Louis, Boston, and Chicago; and heroin represented 8.2 and 9.6 percent of the items in Washington, DC, and Philadelphia, respectively.

Heroin Price Data

NDIC Data on Price

Exhibit 6 presents the cost per gram of white powder heroin in 10 CEWG areas and for

black tar heroin in 8 CEWG areas, as reported by the NDIC at mid-year 2006. As shown, the low end range for white powder heroin street prices per gram was cheapest in New York City and Boston, while black tar heroin was cheapest in San Francisco, Seattle, and Los Angeles.

Exhibit 6. Retail (Street) Price[1] per Gram of White Powder and Mexican Black Tar Heroin in 18 CEWG Areas, Ordered by Lowest Price: June 2006

White Powder Heroin	
CEWG Area	**Price Per Gram**
New York City	$45–$100
Boston	$53–$100
Baltimore	$65–$165
Philadelphia	$65–$300
Chicago	$70–$200
Miami	$100–$150
Washington, DC	$100–$150
Atlanta	$100–$400
Bangor, ME	$300
Minneapolis	$300–$400

Mexican Black Tar Heroin	
CEWG Area	**Price Per Gram**
San Francisco	$40
Seattle	$40–$80
Los Angeles	$40–$100
San Diego	$50–$100
Phoenix	$60–$80
Dallas	$150–$250
Honolulu	$150–$300
Denver	$200

[1]Most current available price at mid-year 2006.
SOURCE: NDIC, DOJ

In Cincinnati, a bag of heroin cost $20. In Detroit, a bag of white heroin sold for $10–$20. In St. Louis, a "button" of heroin cost $10.

Other Opiates/Narcotic Analgesics

The abuse of a variety of prescription-type opiates/narcotic analgesic drugs was reported across CEWG areas. The particular types of opiate/narcotic analgesics, populations using these drugs, the reasons for using these drugs, and the consequences of use, differed across and within CEWG areas. An update of the fentanyl data reported at the June 2006 CEWG meeting shows that substantial numbers of fentanyl-related deaths continued to be reported in six CEWG areas, with increases reported in five. Methadone abuse indicators, reported from 15 CEWG areas, signal the serious consequences of the drug, especially the mortality data from 9 areas. In 17 reporting areas, abuse indicators were typically highest for oxycodone and hydrocodone. Oxycodone abuse indicators were higher than hydrocodone indicators in eight areas, while hydrocodone indicators were higher in seven. Indicators of abuse of codeine continued to be high in Detroit and Philadelphia. Excerpts from the January CEWG data and telephone conference calls are presented below; more quantitative data appears in the following section.

Fentanyl

Fentanyl and fentanyl mixture abuse indicators continued to increase in Chicago, Detroit, Georgia, Maryland, and Philadelphia. The following data provide an update to the information from the June 2006 CEWG meeting.

As in 2005, the 2006 CEWG treatment data did not specifically differentiate fentanyl from "other opiates." The FY 2006 NFLIS data show 216 fentanyl items reported in 8 CEWG areas, where they accounted for less than 1 percent of all drug items; 63 percent of the 216 items were reported from Philadelphia (n=137) and St. Louis (56). In the other six areas, the numbers of fentanyl items were small: Boston (1), Chicago (2), Baltimore (4), Minneapolis/St. Paul and San Diego (each 5), and San Francisco (6). As in 2005, there were a few reports of fentanyl in the first half of 2006 in the DAWN *Live!* data, as shown in exhibit 7; their proportion in comparison to other opiate/opioid ED reports is depicted later in exhibit 9.

Exhibit 7. Fentanyl ED Reports in 13 CEWG Areas (Unweighted[1]): January–June 2006

CEWG Area	Fentanyl Reports[2]	Fentanyl Reports as a Percentage of Other Opiates/ Opioids Reports
Boston	38	2.8
Chicago	23	2.3
Denver	29	6.7
Detroit	60	4.5
Ft. Lauderdale	19	2.1
Houston	3	0.4
Miami-Dade	5	1.8
Mpls./St. Paul	46	4.9
New York City	11	0.6
Phoenix	28	3.3
San Diego	15	3.3
San Francisco	8	2.3
Seattle	30	2.0

[1]All DAWN cases are reviewed for quality control, and based on review, may be corrected or deleted. Therefore, these data are subject to change.
[2]Reports include those for "seeking detox," "overmedication," and "other."
SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 11/17–11/20, 2006

Recent data from six CEWG areas where fentanyl abuse signaled an "alarm" for the June 2006 meeting are presented below. Most of the data refer to deaths related to fentanyl; these may be underreported because medical examiners do not consistently test for the presence of fentanyl.

CHICAGO: *There were 291 deaths involving fentanyl and fentanyl mixtures in 2006 (another 22 were reported in the last half of 2005). Of the 313 deaths from May 1, 2005, to November 11, 2006, 85 percent were male, 60 percent were African-American, and 40 percent were White; the median age was 41; and 20 percent died outside the city of Chicago. Data from the Chicago Forensic Science Center, Illinois State Police, show dramatic increases in the number of items from metropolitan Chicago containing fentanyl: 1 in 2003, 3 in 2004, 22 in 2005, and 1,330 in 2006.* ***—Lawrence Ouellet***

DETROIT: *Deaths involving fentanyl increased more than 272 percent from 2005, with 176 reported between January and September 2006. Trend data show 3 such deaths in 2000, 7 in 2001, 12 in 2002, 20 in 2003, 29 in 2004, and 63 in 2005. A local work group has been created in response to the growing fentanyl problem, and a formal investigation is underway by the Centers for Disease Control and Prevention.* ***—Cynthia Arfken***

GEORGIA: *Deaths involving fentanyl totaled 36 in FY 2006, compared with 12 in FY 2005.* ***—Brian Dew***

MARYLAND: *There have been 2 spikes in fentanyl-related deaths in Maryland—1 in 2003 and the other in 2006, when 36 fentanyl deaths were reported. About one-half of last year's fentanyl-related deaths also tested positive for heroin, and about one-half tested positive for cocaine.* ***— Erin Artigiani***

PHILADELPHIA: *By June 2006, there were 103 deaths with the presence of fentanyl; of the 556 drug mortality cases in the first half of 2006, fentanyl was detected in 19 percent. Most of the deaths were classified as Adverse Reactions, and some were called Overdoses. Trend data show between 4 and 5 per year from 2000 to 2002, 16 in 2003, and 36 in both 2004 and 2005. Of 43 deaths with the presence of fentanyl from April 17 to May 31, 2006, an average of 6.25 drugs were detected in the fentanyl-positive cases. Of the 103 deaths with fentanyl reported by June 30, some included fentanyl in combination with cocaine but not heroin; 69 were a combination of heroin and fentanyl. The first mortality cases in which fentanyl was added to packets containing and sold as heroin were recorded on April 17, 2006.* ***—Samuel Cutler***

ST. LOUIS: *In 2006, 30 deaths involving fentanyl were reported; 14 were in the city of St. Louis. The problem appears to be relatively contained. It is likely that only one source from Chicago was involved, and things got 'quiet' after the bust of the fentanyl-dealing gang in Chicago. Little has appeared in the media since the summer of 2006.* ***—James Topolski***

Data from six other CEWG areas provide some information from one particular fentanyl abuse indicator.

CINCINNATI: *There were 28 calls involving fentanyl to the Cincinnati Poison Control Center in 2006.* ***—Jan Scaglione***

FLORIDA: *Statewide in the first half of 2006, 51 deaths involving fentanyl were reported. Fentanyl was lethal in 60 percent of these deaths.* ***—James Hall***

LOS ANGELES: *From 2000 through 2005, sales of fentanyl base to pharmacies and hospitals in Los Angeles County increased 122 percent. In 2005, 20,224 grams of fentanyl base were sold, accounting for 0.3 percent of the sales of opiate-type drugs to pharmacies and hospitals in the county.* ***—Beth Rutkowski***

MINNEAPOLIS/ST. PAUL: *Seven deaths involving fentanyl were reported from Hennepin and Ramsey Counties from January through September, 2006.* ***—Carol Falkowski***

NEW YORK CITY: *From January through November 2006, there were 29 deaths involving fentanyl; 5 were in Harlem. Ethnographic interviews with active users in Harlem in the summer and fall of 2006 indicated there was no increase in nonfatal overdoses or strange reactions to heroin, no changes in marketing, no new sellers, and a general unawareness among users of fentanyl to the dangers associated with the drug.* ***—Rozanne Marel***

TEXAS: *In 2005, there were 30 death certificates with a mention of fentanyl in Texas.* ***—Jane Maxwell***

Methadone

Methadone abuse indicator data were reported from 15 CEWG areas. Nine areas reported on deaths involving methadone, indicating the most serious problem related to abuse of this drug.

ATLANTA/GEORGIA: *In FY 2006, there were 153 deaths involving methadone; these accounted for 7.7 percent of positive drug-type specimens. In the Atlanta metropolitan area in FY 2006, there were 93 methadone items reported by NFLIS, accounting for 0.55 percent of all drug items.* ***—Brian Dew***

ALBUQUERQUE/NEW MEXICO: *The age-adjusted rate of methadone deaths per 100,000 population in 2003–2005 was higher in Albuquerque/Bernalillo County than in the State overall (3.13 vs. 2.00), and methadone continues to be the opiate most likely to cause overdose death.* ***—Nina Shah***

BALTIMORE: *Of the 9,626 drug-related calls to the poison control center in 2005, 31 involved methadone. In FY 2006, there were 117 methadone items identified by forensic labs, accounting for 0.3 percent of all drug items.* ***—Leigh Henderson***

BOSTON: *Methadone represented nearly 17 percent of the unweighted opiate/opioid ED reports in the first half of 2006 and 0.3 percent (n=23) of the total drug items reported by NFLIS.* ***—Daniel Dooley***

CHICAGO: *In the first half of 2006, methadone accounted for one-fifth of the unweighted opiate/opioid ED reports in the metropolitan area. Methadone was contained in 82 (0.1 percent) of the drug items reported by NFLIS in FY 2006.* ***—Lawrence Ouellet***

CINCINNATI: *There were 41 methadone Intentional Exposure Cases reported by the poison control center in 2006, making it the third most frequently reported opiate drug. Methadone accounted for 0.4 percent (n=68) of the drug items reported by NFLIS.* ***—Jan Scaglione***

DETROIT: *In the first 9 months of 2006, there were 77 deaths involving methadone in Wayne County, compared with 86 in all of 2005. Methadone accounted for nearly 12 percent of the unweighted opiate/opioid ED reports in the first half of 2006.* ***—Cynthia Arfken***

HONOLULU: *There were 10 deaths involving methadone in the first half of 2006.* ***—D. William Wood***

LOS ANGELES: *Sales of methadone to hospitals and pharmacies in Los Angeles County increased 117 percent between 2001 and 2005.* ***—Beth Rutkowski***

MAINE: *Methadone has caused more deaths than any other drug (38 percent of the drugs deaths in 2005), with the majority involving tablets; the rate appears to have stabilized. Some methadone treatment clients are now using cocaine for a 'high.' Methadone prescribed by physicians appears to be one 'gateway' to heroin use.* ***—Marcella Sorg***

MIAMI/FT. LAUDERDALE/FLORIDA: *Methadone leads all other opiates in drug-related deaths locally and statewide. In Broward County, 45 percent of the 29 deaths involving methadone were lethal (i.e., the cause of death). Methadone was lethal in all three methadone deaths reported in Miami-Dade County.—****James Hall***

NEW YORK CITY: *Methadone ED reports represented 56 percent of the unweighted*

*opiate/opioid ED reports in the first half of 2006. Many kinds of prescription drugs are increasingly popular and available on the street. —**Rozanne Marel***

PHILADELPHIA: *Deaths with the presence of methadone increased from 10 in 1998 to 132 in 2004, decreased to 113 in 2005, and are projected to reach 138 in 2006. —**Samuel Cutler***

TEXAS: *Deaths with a mention of methadone increased from 30 in 1998 to 164 in 2004 to 205 in 2005. Calls to the poison control center increased from 16 in 1998 to 106 in 2004 but decreased to 71 in 2005. Treatment admissions for a primary problem with non-prescription methadone increased from 55 in 1998 to 91 in 2005 and totaled 43 in the first half of 2006. Forensic lab items containing methadone increased from 1 in 1998 to 133 in 2005 and totaled 101 in 2006. Methadone users are predominately White, and the more adverse events appear to be related to methadone pain pills. —**Jane Maxwell***

Hydrocodone, Oxycodone, and Codeine

Hydrocodone and oxycodone continue to be the most widely abused other opiates in many CEWG areas; misuse of codeine is also reported. Examples are presented below.

ATLANTA/GEORGIA: *Excluding alcohol, narcotic analgesics accounted for nearly one-half of the drug-related deaths statewide in the last half of 2006. Deaths with the presence of codeine, hydrocodone, methadone, and morphine increased statewide from 2005 to FY 2006. Multiple abuse indicators show that hydrocodone is the most commonly abused narcotic analgesic in Atlanta, followed by oxycodone. —**Brian Dew***

BOSTON: *Helpline calls for opiates decreased slightly in 2006. The number of oxycodone drug lab samples increased from 2004 to 2005; however, the estimate for 2006, based on data for the first half of the year, was similar to 2004 and previous years. —**Daniel Dooley***

DETROIT: *Deaths related to codeine, fentanyl, hydrocodone, methadone, and oxycodone increased in Wayne County from 2005 to the first 9 months of 2006. —**Cynthia Arfken***

MAINE: *In 2005, poison control calls involving exposure to methadone constituted the largest proportion of all narcotics-related calls, but was followed closely by hydrocodone (20 percent) and oxycodone (19 percent). Oxycodone primary admissions dominate the2006 narcotic analgesic distribution at 31 percent of drug treatment admissions (excluding alcohol); 41 percent of heroin admissions report oxycodone as a secondary or tertiary problem. Maine's prescription monitoring program reports that hydrocodone/ acetaminophen is the most common controlled substance prescription (21 percent), followed by oxycodone preparations (11 percent) and lorazepam (8 percent). The Maine Drug Enforcement Administration arrests involving prescription drugs increased from 22 to 25 percent from 2004 to 2006. —**Marcella Sorg***

PHILADELPHIA: *Deaths with a presence of most narcotic analgesics increased over the past several years, including deaths involving codeine, methadone, and oxycodone. Deaths with the presence of codeine increased steadily from 3 in 1998 to 139 in 2005, and they are projected to reach 198 in 2006. Deaths with the presence of oxycodone increased from 1 in 1996 to 119 in 2005, and are projected to total 136 in 2006. —**Samuel Cutler***

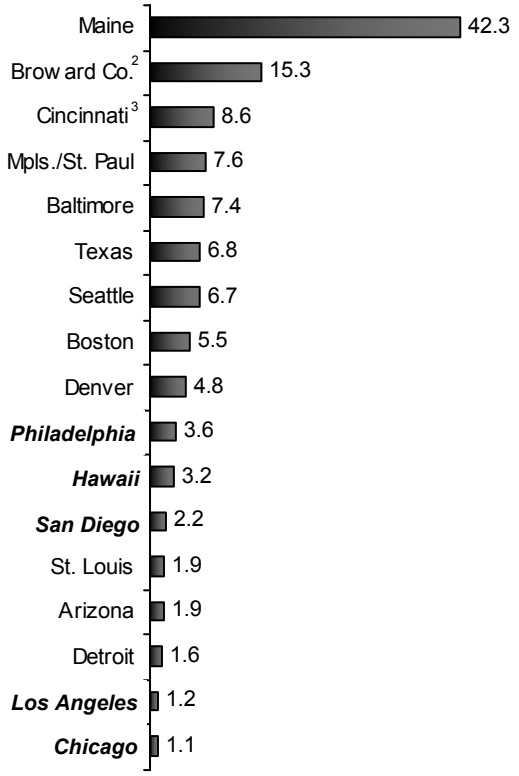
TEXAS: *Codeine cough syrup, 'Lean,' continues to be abused in Texas.* ***—Jane Maxwell***

PATTERNS AND TRENDS IN OTHER OPIATE ABUSE ACROSS CEWG AREAS

Treatment Data on Other Opiates

In the 2005 and 2006 reporting periods, 18 CEWG areas provided data on admissions for primary abuse of opiates other than heroin. Excluding alcohol, this admissions group accounted for more than 1 percent of illicit drug admissions in 17 (the exception was New York City). These data are depicted in exhibit 8. As shown, the State of Maine exceeded all other areas, with more than 42 percent of illicit drug admissions in 2006 reporting other opiates as their primary drug. Of the 2,282 primary admissions for other opiates, nearly 74 percent were for abuse of OxyContin/oxycodone. In the other 16 areas, the highest proportion of primary other opiate admissions, relative to total admissions, excluding alcohol, was reported from the sample of programs in Broward County, Florida, (15.2 percent), followed by Cincinnati (8.6 percent), Minneapolis/St. Paul (7.6 percent), and Baltimore (7.4 percent). Other opiate admissions as a proportion of all admissions, excluding alcohol, ranged between 6.7 and 6.8 percent in Seattle and Texas.

Exhibit 8. Primary Admissions for Other Opiate Abuse in 17 CEWG Areas, by Percent of All Admissions (Excluding Alcohol): 2005–2006[1]



[1]The five areas shown in italic bold reported 2005 data; all others reported data for some period in 2006 data *(see Appendix A)*.
[2]The Broward County sample is from 9 programs that serve 51.5 percent of admissions to county treatment facilities.
[3] Represents 65–75 percent of the Cincinnati/Hamilton County admissions in the first half of 2006.
SOURCES: June 2006 and January 2007 State and local reports

Demographic data. Seven CEWG representatives reported on the demographic characteristics of treatment admissions for primary abuse of opiates other than heroin in 2006. The predominant characteristics are reported for each area. In Baltimore, 53 percent of this admissions group were male, 83 percent were White, and 51 percent were age 35 or older. In Cincinnati, 58 percent were female and 92 percent were White. In Denver, 54 percent of the other opiate admissions were male, 85 percent were White, and 51 percent were age 35 or older. In Detroit, 61 percent of these admissions were female, 80 percent were African-

American, and 78 percent were age 35 or older. The large OxyContin/oxycodone admissions group in Maine was 57 percent male; the group was rather evenly divided between clients in the 24 and younger category and 25–34 age group, at around 39 percent in each age category; 22 percent were 35 or older. Other opiate admissions in St. Louis in the first half of 2006 were 55 percent female and 85 percent White, and they were more likely to be age 26–34 (42 percent) or 35 or older (34 percent). In Texas, 43.5 percent of the other opiate admissions were male, and 82 percent were White. In 2005 in Los Angeles, 39 percent of the other opiate admissions were female, 55 percent were White non-Hispanic, and 49 percent were 36 or older.

The Baltimore representative reported a wide range of secondary substances was used by primary other opiate admissions. Similar numbers of treatment admissions reported primary and secondary opiate use. Secondary users were also predominantly White, and a little more than one-half were male. Most reported opiate abuse secondary to heroin injection (33 percent) or intranasal heroin use (21 percent).

DAWN ED Data on Other Opiates

In the first half of 2006, opiates/opioids reports accounted for substantial percentages of the unweighted "other substances" ED reports in each of the 13 CEWG areas participating in DAWN. The total unweighted number of "other substances" reports for each CEWG area is presented in exhibit 9a, together with the percentage of the opiate/opioid reports in the total for each area. In Detroit, Ft. Lauderdale, Minneapolis/St. Paul, New York City, and Seattle, the unweighted opiate/opioid reports accounted for approximately 32 to 36 percent of the other substances reports. In the other eight CEWG areas, the opiate/opioid reports accounted for between 21 and 29 percent of the total reports.

Exhibit 9a. Number of ED Reports for "Other Substances" and the Percentage of Opiates/Opioid Reports to the Total "Other Substances" Reports in 13 CEWG Areas (Unweighted[1]): January–June 2006

CEWG Area	Total Other Substances[2]	Percent Opiates/Opioids
Boston	4,583	29.2
Chicago	3,533	28.0
Denver	1,734	25.1
Detroit	4,176	32.3
Ft. Lauderdale	2,627	34.6
Houston	3,001	22.9
Miami-Dade	1,342	21.2
Mpls./St. Paul	2,874	32.6
New York City	5,609	35.2
Phoenix	3,414	24.7
San Diego	1,781	25.8
San Francisco	1,278	27.6
Seattle	4,219	36.2

[1]All DAWN cases are reviewed for quality control, and based on review, may be corrected or deleted. Therefore, these data are subject to change.
[2]Includes prescription drugs (benzodiazepines, opiates/opioids, muscle relaxants), over-the-counter drugs, and dietary supplements; case types include detox, overmedication, and other.
SOURCE: DAWN *Live!,* OAS, SAMHSA, updated 11/17–11/20, 2006

Unweighted DAWN *Live!* ED data on opiate/opioid reports for the first half of 2006 are depicted on the map in exhibit 9b and represent the proportion of total opiate/opioid ED reports represented by oxycodone, methadone, hydrocodone, fentanyl, and unspecified opiates/opioids. As can be seen, the category of "opiates/opioids, unspecified" accounts for the largest percentage of reports in Chicago and Detroit and for the second largest percentages in Denver, Ft. Lauderdale, Houston, Miami, New York City, Phoenix,

San Diego, San Francisco, and Seattle. Oxycodone reports represent the highest percentages of the opiate/opioid reports in six CEWG areas. Oxycodone reports were especially high in Boston and Ft. Lauderdale, each approximately 48 percent, and they ranged between 29 and 39 percent of the reports in Denver, Miami-Dade County, Minneapolis/St. Paul, and Phoenix. Methadone accounted for 56 percent of the unweighted ED reports in New York City and for 28 and 30 percent of the reports in San Francisco and Seattle, respectively. Hydrocodone reports ranked first in Houston, at 47.5 percent of the unweighted reports, and in San Diego, where they accounted for 31.3 percent of the reports. Hydrocodone reports were also relatively high in Detroit, where they accounted for 27 percent of the unweighted ED reports.

Mortality Data on Other Opiates

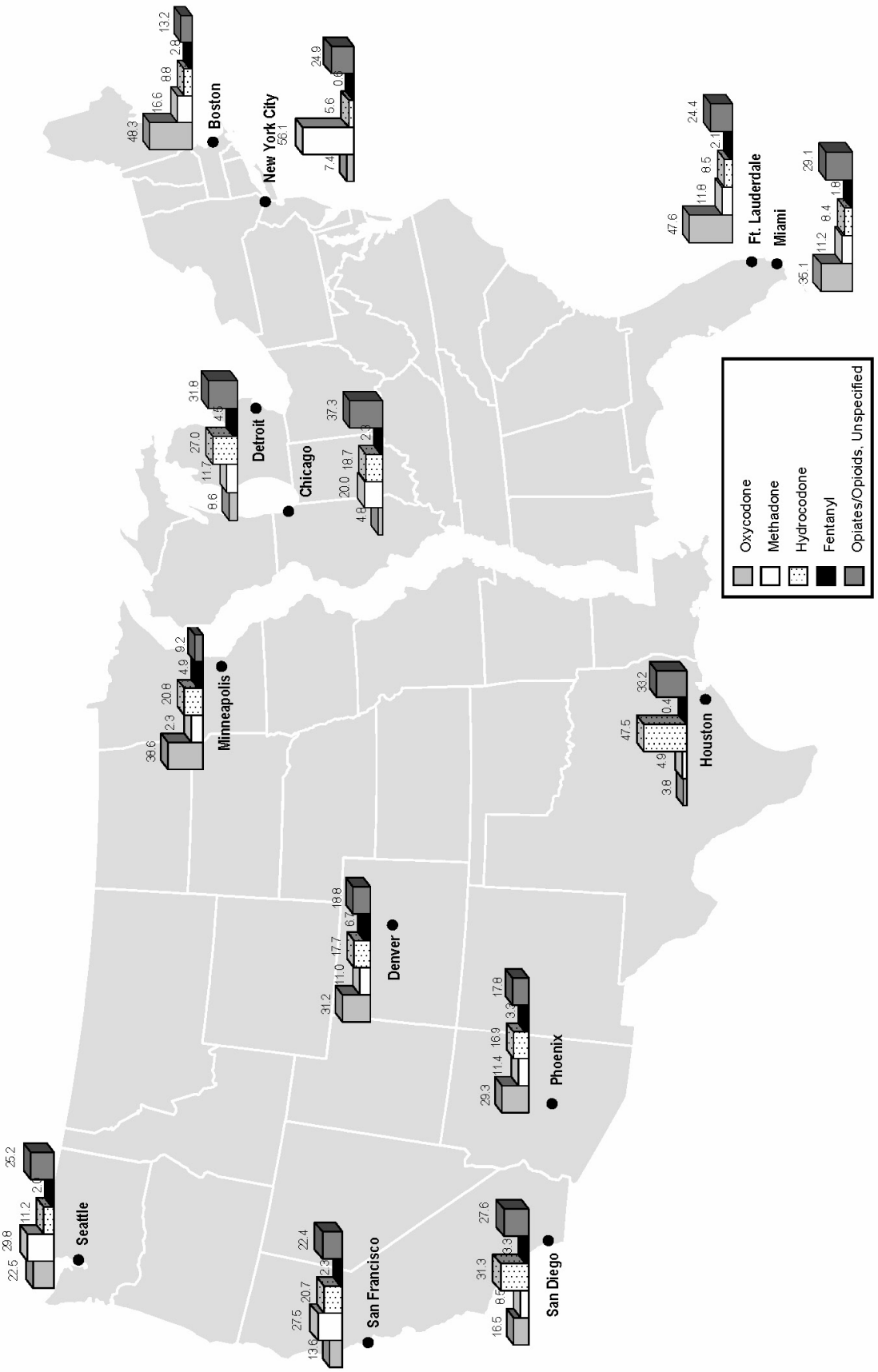
CEWG representatives reported data on deaths involving opiates (other than heroin) in eight local areas and six States. Note that any "total" numbers shown may include decedents who had more than one other opiate (or other type of drug) in their system.

Data from metropolitan and county areas are shown below. The data from Detroit/Wayne County and Hennepin and Ramsey Counties in Minnesota are for the first 9 months of 2006; the other six areas reported for the first half of 2006…

- In Broward County, Florida, there were 29 deaths involving methadone, 23 involving oxycodone, 9 with the presence of morphine, 6 involving propoxyphene, and 5 related to hydrocodone.
- In Cincinnati, there were 47 deaths involving opiates/opioids other than heroin and 10 involving methadone.
- In Detroit/Wayne County, there were 176 deaths involving fentanyl, 138 involving hydrocodone, 77 with the presence of methadone, and 31 involving oxycodone.
- In Hennepin/Ramsey Counties, there were 18 deaths involving methadone and 7 involving fentanyl.
- In Honolulu, there were 10 deaths involving methadone and 37 deaths with the presence of other opiates (excluding heroin).
- In Miami-Dade County, there were 15 deaths with the presence of morphine, 5 each with the presence of oxycodone or hydrocodone, and 3 involving methadone.
- In Philadelphia, there were 99 deaths with the presence of codeine, 69 with the presence of methadone, 68 with the presence of oxycodone, 26 with the presence of hydrocodone, and 15 with the presence of propoxyphene.
- In Seattle/King County, there were 83 deaths involving other opiates.

In FY 2006, other opiate deaths in Georgia included 153 involving methadone, 137 involving hydrocodone, 108 involving morphine, 100 involving oxycodone, and 36 involving fentanyl. In the first half of 2006, Florida reported 428 deaths involving methadone, 377 involving oxycodone, and 346 involving hydrocodone. In 2005, Colorado reported 301 deaths involving opiates other than heroin. In Maine in 2005, there were 72 methadone-induced deaths, 17 involving oxycodone, 8 involving propoxyphene, and 7 involving hydrocodone. In Texas in 2005, there were 203 deaths with a mention of methadone, 61 with a mention of oxycodone, 26 with a mention of hydrocodone, and 30 with a mention of fentanyl.

Exhibit 9b. Unweighted[1] ED Reports of Selected Opiates/Opioids in 13 CEWG Areas, As a Percentage[2] of Total Opiates/Opioids Reports: January–June 2006



[1]All DAWN cases are reviewed for quality control, and based on review, may be corrected or deleted. Therefore, these data are subject to change.
[2]Percentages do not sum to 100 percent because only selected opioids are profiled.
SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 11/17–20, 2006

In New Mexico from 2003 to 2005, the rate of overdose deaths involving methadone was higher in Albuquerque/Bernalillo County than in the State overall—3.13 versus 2.00 per 100,000 population. The rates for deaths from other opiates were 4.62 and 4.07 for the county and State, respectively.

NFLIS Data on Other Opiates

Across CEWG areas in FY 2006, hydrocodone and oxycodone were the prescription-type opiate drugs most likely to be identified by forensic laboratories, followed by methadone, codeine, and morphine. The numbers of items by CEWG area are shown in exhibit 10. The exhibit does not include all opiate/opioid items identified by NFLIS but does present the number of items for those most frequently analyzed by forensic labs in 20 CEWG metropolitan areas and the State of Texas.

Exhibit 10. Number of Selected Narcotic Analgesic/Opiate Items Analyzed by Forensic Laboratories in 21 CEWG Areas: FY 2006

CEWG Area	Hydrocodone	Oxycodone	Methadone	Codeine	Morphine
Atlanta	333	201	93	21	45
Baltimore	68	308	117	10	28
Boston	38	153	23	10	39
Chicago	113	12	82	38	15
Cincinnati	164	262	68	14	40
Denver	65	80	10	15	10
Detroit	NR[1]	NR	NR	362	NR
Ft. Lauderdale	82	193	NR	NR	NR
Honolulu	11	13	1	1	10
Los Angeles	392	55	32	104	37
Miami	28	34	7	6	2
Mpls./St. Paul[2]	75	77	26	38	38
New York City	235	239	509	74	43
Philadelphia	176	750	69	106	25
Phoenix	45	34	8	4	22
St. Louis	33	51	23	24	10
San Diego	244	82	25	31	30
San Francisco	168	197	70	72	69
Seattle	54	78	36	6	6
Wash., DC	28	84	37	13	2
Texas	1,957	228	146	267	86

[1] NR=Not reported.
[2] Data represent primarily the nonmetropolitan areas of Ramsey and Hennepin Counties.
SOURCE: NFLIS, DEA

Hydrocodone. In FY 2006, small relatively small numbers of hydrocodone items were reported from 20 CEWG areas. Hydrocodone was contained in nearly 4 percent of all drug items reported in Texas. In Atlanta, San Francisco, and Seattle, approximately 2

percent of all items contained hydrocodone. In the other 16 CEWG areas, hydrocodone was detected in 1 percent or less of all drug items.

Oxycodone. In FY 2006, oxycodone accounted for 3.5 percent of all drug items in Ft. Lauderdale, and for approximately 2.0 percent of the items in Boston, Cincinnati, San Francisco, and Seattle. In other CEWG areas, oxycodone represented 1 percent or less of all drug items.

Methadone. New York City and Seattle were the only areas where methadone accounted for as much as 1 percent of total items.

Codeine. In 17 areas in FY 2006, codeine accounted for less than 1 percent of all drug items. In Detroit, 8.4 percent of the drug items contained codeine.

Morphine. Across 19 CEWG areas in FY 2006, morphine accounted for less than 1 percent of all drug items.

Methamphetamine

Methamphetamine abuse indicators continued at high levels in Honolulu, Los Angeles, San Diego, Seattle, Phoenix, Denver, Minneapolis/St. Paul, St. Louis, and Atlanta. However, indicators point to declines in methamphetamine abuse in Atlanta, Denver, Honolulu, Minneapolis/St. Paul, and St. Louis. Indicators were stable in San Francisco. Except for Atlanta, methamphetamine abuse indicators continued to be low in CEWG areas east of the Mississippi River. Indicator data also point to increases in methamphetamine abuse among youth, women, and Hispanics in some CEWG areas.

Methamphetamine abuse indicators increased in four CEWG areas where indicator levels have been relatively high.

LOS ANGELES: *Methamphetamine abuse continues to dominate the treatment system. Findings from the Los Angeles County Evaluation System show the proportion of clients admitted for primary methamphetamine use increased from 19.0 percent in 2001 to 36.4 percent in 2005. Primary methamphetamine admissions, excluding alcohol, increased from 23 percent in 2003 to more than 31 percent in 2005. In the 2005 YRBS survey, slightly more females (10.9 percent) than males (9.5 percent) reported lifetime methamphetamine use, but this difference was not statistically significant. Eighty-six percent of the 14 super labs seized throughout the United States from January to June 2006 were located in California; of those, 25 percent were located in LA HIDTA counties. —**Beth Rutkowski***

PHOENIX: *Statewide, primary admissions for methamphetamine and other stimulants increased from 24 percent of admissions (excluding alcohol) in FY 2003 to 36 percent in FY 2006. Hospital discharge data continue to show that methamphetamine is the major substance of abuse in Maricopa County. Stimulants accounted for the largest proportion of the major substances of abuse reports (excluding alcohol) in the unweighted DAWN Live! system in the first half of 2006. —**Ilene Dode***

SAN DIEGO: *Methamphetamine is the primary illicit drug of abuse in San Diego County, leading all other drugs in most data sources used to assess drug abuse patterns and trends. Methamphetamine was the primary drug of abuse for 49.2 percent of all drug treatment admissions (excluding alcohol) in San Diego County in 2005, up from 45.2 percent in 2004. Methamphetamine was the drug most commonly cited in the unweighted DAWN ED reports involving major illicit drugs in the first half of 2006, and it was the most prevalent illicit drug detected among male (44 percent) and female (51 percent) adult arrestees in 2005. —**Robin Pollini***

SEATTLE: *Methamphetamine morbidity and mortality indicators continue to increase, while local manufacturing appears to be continuing its rapid descent. Deaths involving methamphetamine totaled 13, similar to recent years, while treatment admissions continued to increase; 19 percent of clients admitted to treatment reported any methamphetamine use. Excluding alcohol, 18 percent of clients were primary methamphetamine abusers in the first half of 2006, compared with 13 percent in 2003. —**Caleb Banta-Green***

Methamphetamine abuse indicators decreased in five CEWG areas where levels remain relatively high.

ATLANTA: *In Atlanta, methamphetamine abuse indicators decreased in the first half of 2006 for the first time in 10 years. The increased availability of, and reduced cost for, crystal methamphetamine was associated with an 11-percent increase (from FY 2005 to the first half of 2006) in methamphetamine treatment admissions who preferred to smoke to drug. The proportion of items containing methamphetamine in the NFLIS drug seizure data*

*for FY 2006 remained stable, while local law enforcement officials reported use of methamphetamine in suburban Atlanta. There are also reports of increases in methamphetamine abuse in African-American communities. —**Brian Dew***

DENVER: *Methamphetamine has exceeded cocaine in statewide treatment admissions since 2003, and in Denver/Boulder treatment admissions since 2005. However, the first half of 2006 showed the first decline in several years for methamphetamine admissions and poison control center calls. Clandestine lab closures have decreased steadily since 2003. The amount of methamphetamine seized increased through 2005, most likely because an estimated 80 percent of Colorado's methamphetamine comes from outside the State, predominantly Mexico. Drug enforcement officials have reported increased purity levels of methamphetamine seized in Colorado. —**Tamara Hoxworth***

HONOLULU: *During the first half of 2006, there was a slight decrease in Medical Examiner (ME) reports of positive decedent toxicology for methamphetamine, in primary treatment admissions for methamphetamine abuse, and in methamphetamine cases reported by the Honolulu Police Department. In late 2005, HIDTA reported that both the price and purity of methamphetamine had declined. There was also a small reduction in ME methamphetamine cases in the last half of 2006. Pseudoephedrine is generally not available over the counter in Honolulu, and many drug stores are not ordering antihistamines that contain ephedrine. —**D. William Wood***

MINNEAPOLIS/ST. PAUL: *Numerous indicators of methamphetamine abuse declined in 2006, reversing previous upward trends. Collectively, these new data demonstrate that the growth in methamphetamine abuse has slowed and, possibly, there has been a decline in such abuse in the Twin Cities area. The number of clandestine methamphetamine labs decreased statewide to 59 in 2006 (through November), compared with 112 in 2005 (full year) and 212 in 2004. Adult and youth admissions to addiction treatment programs for methamphetamine abuse declined, falling 37 percent from the last half of 2005 to the first half of 2006. It remains to be seen whether these findings reflect the beginning of a decline in the actual prevalence of methamphetamine abuse, especially among the younger, adolescent population group. —**Carol Falkowski***

ST. LOUIS: *In the St. Louis area, methamphetamine abuse treatment admissions decreased 21 percent from the first half of 2005 to the first half of 2006, while statewide treatment admissions increased 4 percent over the same timeframe. Only 53 methamphetamine items (less than 1 percent of all items) were reported by forensic labs in St. Louis. Law enforcement personnel in the St. Louis area continued to devote many resources to methamphetamine, and clandestine laboratory incidents have decreased dramatically since legislation to reduce access to pseudoephedrine-based cold medications was enacted in the summer of 2005. Access to methamphetamine from Mexico and the Southwest is considered to be a major problem confronted by law enforcement agencies in the area. —**James Topolski***

In three States with large rural populations, methamphetamine abuse indicators are increasing, especially in some areas of these States.

MAINE: *Methamphetamine abuse continues to rise, as indicated by increased arrests from 2005 to 2006. The Maine Drug Enforcement Administration (MDEA) made 8 methamphetamine arrests and seized 4 labs in 2005; in 2006, MDEA made 40 arrests and seized 7 labs. —**Marcella Sorg***

NEW MEXICO: *Although the numbers are relatively small, there has been an increase in ME overdose cases involving methamphetamine, with the rate of methamphetamine overdose deaths per 100,000 population being lower in Bernalillo County than statewide (0.98 vs. 1.44 in 2003–2005). An increasing proportion of methamphetamine treatment admissions reported smoking the drug, from 18 percent in 2001 to 47 percent during January 2004–March 2005. In the first 4 months of 2005, about 10 percent of Albuquerque treatment admissions were primary methamphetamine abusers. Nearly 6 percent of the Albuquerque area students in grades 9–12 reported current (past 30 days) methamphetamine use —**Nina Shah***

TEXAS: *Increasingly, 'ice,' a higher purity form of methamphetamine, is becoming available in the State. Most of the higher purity ice is produced in Mexico, and local methamphetamine clandestine laboratories are using different ingredients to replace pseudoephedrine, which is becoming more limited in supply. Methamphetamine is a growing problem across the State, and smoking is the major route of administration for methamphetamine abusers entering treatment. In 2006, 53 percent of the primary methamphetamine treatment admissions smoked the drug. These clients tend to have more physical and emotional problems than those who do not smoke the drug. —**Jane Maxwell***

Methamphetamine abuse indicators continued at low levels in 10 CEWG areas in the East and Midwest, as shown in the following examples from 5 areas.

BOSTON: *Methamphetamine abuse indicators remain very low in Boston. Methamphetamine abuse treatment admissions account for less than 1 percent of all treatment admissions; the number of primary admissions for methamphetamine abuse decreased from 75 in FY 2005 to 31 in FY 2006. Methamphetamine forensic lab samples increased from 17 in 2004 to 55 in 2005 and appeared stable through the first half of 2006. —**Daniel Dooley***

CINCINNATI: *In Cincinnati and the State of Ohio, methamphetamine abuse indicators have remained low and stable. The number of methamphetamine lab seizures recorded by the DEA decreased from 444 in 2005 to 243 in 2006. Methamphetamine abuse indicators stabilized across the State of Ohio, accounting for few treatment admissions. —**Jan Scaglione***

DETROIT: *Indicators for methamphetamine abuse remained low. —**Cynthia Arfken***

MIAMI: *Indicators of methamphetamine abuse remain low, yet criminal cases are rising as high potency 'Mexican Ice' is being trafficked into the area via Atlanta into Florida. Sexual activity related to methamphetamine abuse is cited by public health officials as a key factor for Miami-Dade and Broward Counties ranking first or second in the Nation in per capita rates of HIV infection. —**James Hall***

PHILADELPHIA: *Methamphetamine abuse indicators continue to be low compared with indicators for other illicit drugs. Methamphetamine abuse is largely confined to a relatively small segment of the population. —**Samuel Cutler***

There are reports of changing demographics in methamphetamine-abusing populations in 13 CEWG areas, with reports in some areas of increases of abuse among youth, women, and Hispanics.

Youth

ATLANTA: *Indicators of methamphetamine abuse among youth have been increasing. —**Brian Dew***

DENVER: *YRBS data show a decline in methamphetamine use among youth. —**Tamara Hoxworth***

LOS ANGELES: *Findings from the 5-year Los Angeles County Evaluation System show that the proportion of 18–25-year-old treatment admissions reporting primary methamphetamine use increased from 31.3 percent to 52.8 percent. —**Beth Rutkowski***

MINNEAPOLIS/ST. PAUL: *Treatment admissions for primary methamphetamine abuse among clients younger than 18 declined in the first half of 2006, to 4.5 percent of this admissions group, compared with 11.5 percent in the first half of 2005. —**Carol Falkowski***

PHOENIX: *At the Treatment Assessment Screening Center from October 2005 to October 2006, there was a slight decrease (about 3–4 percent) in positive methamphetamine (urine) tests among juvenile arrestees. **—Ilene Dode***

SAN DIEGO: *The prevalence of methamphetamine use among juvenile arrestees in San Diego increased 75 percent from 2002 to 2005. —**Robin Pollini***

Women

ATLANTA: *In Atlanta, the proportion of female to male methamphetamine abusers seeking treatment widened in the past 6 months, both in metropolitan Atlanta and in rural areas of the State. About 70 percent of the methamphetamine primary treatment admissions in Atlanta in the first half of 2006 were women. —**Brian Dew***

LOS ANGELES: *Findings from the Los Angeles County Evaluation System show that female admissions were more likely to report primary methamphetamine use than males over the entire 5 years of the evaluation. —**Beth Rutkowski***

NEW MEXICO: *Although most methamphetamine overdose deaths from 2003 to 2005 were male, there was a growing proportion of female decedents. **—Nina Shah***

SAN DIEGO: *The prevalence of methamphetamine use among female arrestees in San Diego increased by 38 percent from 2002 to 2005. —**Robin Pollini***

Hispanics

NEW MEXICO: *The most interesting aspect of the increase in methamphetamine overdose deaths from 2003 to 2005 is that, while most were White, there was a growing proportion of Hispanic decedents. —**Nina Shah***

TEXAS: *The proportion of Hispanics entering treatment for a primary problem with methamphetamine increased from 29 percent in 2000 to 31 percent in 2006, and the term 'La Tina' is being heard in Hispanic communities. **—Jane Maxwell***

PATTERNS AND TRENDS IN METHAMPHETAMINE ABUSE ACROSS CEWG AREAS

Treatment Data on Methamphetamine

In the 2006 reporting periods, methamphetamine primary admissions, as a proportion of all admissions, excluding alcohol, continued to be highest in Hawaii (55.2 percent) and Arizona (33.4 percent) Exhibit 11a shows the data from these two areas and seven others where methamphetamine admissions accounted for more than 1 percent of this illicit drug admissions group in ***2005*** or 2006.

Exhibit 11a. Primary Methamphetamine Treatment Admissions in 9 CEWG Areas, by Percent of All Admissions (Excluding Alcohol): 2003–2006[1]

CEWG Area	2003	2004	2005[1]	2006	Percentage-Point Change 2003–2006
Atlanta	6.9	11.3	15.5	11.4	4.5
Denver	16.8	17.6	20.7	21.8	5.0
Los Angeles	***23.0***	***26.7***	***31.4***	***NR[2]***	***…***
Mpls./St. Paul	14.8	19.6	22.1	15.7	0.9
St. Louis	5.9	6.5	5.7	4.6	-1.3
San Diego	***NR***	***45.4***	***49.2***	***NR***	***…***
Seattle	13.1	15.2	16.9	18.0	4.9
Arizona	24.1	37.5	32.5	33.4	9.3
Hawaii	56.3	57.3	56.3	55.2	-1.1

[1]Arizona represents FY 2006; Los Angeles and San Diego are CY 2005; all others are for the first half of 2006 *(see Appendix A).*
[2]NR=Not reported by the CEWG representative.
SOURCES: June and January 2007 CEWG reports

In seven other CEWG areas that reported treatment data specifically related to methamphetamine admissions, this group accounted for 1 percent or less of illicit drug admissions in **2005** in Chicago and in the 2006 reporting periods in Baltimore, Boston, Broward County, Florida, Cincinnati, Maine, and New York City. In Philadelphia in the first half of 2006, less than 1 percent of admissions mentioned use of methamphetamine.

In San Francisco (FY 2006) and Texas (first half of 2006), methamphetamine was included in a category with amphetamines or "stimulants," where they accounted for 16.0 and 16.9 percent of illicit drug admissions, respectively.

The 2005 treatment data from seven CEWG areas suggest that, compared with cocaine and heroin admissions, primary methamphetamine admissions are more likely to be female, White, and younger than 25.

Gender. In Atlanta, females accounted for 70 percent of the primary methamphetamine admissions in the first half of 2006. In other CEWG areas, males accounted for between 52 (Denver) and 63 (Hawaii) percent of the primary methamphetamine admissions in the **2005** or 2006 reporting periods *(see exhibit 11b).*

Age. Data from **2005** or 2006 show that a majority of primary methamphetamine admissions in five CEWG areas were age 34 or younger. In Atlanta, 81 percent were age 35 or older, and in Seattle, 53 percent were age 30 or older.

Exhibit 11b. Demographic Characteristics of Primary Methamphetamine Admissions in 8 CEWG Areas, by Percent[1]: 2005–2006

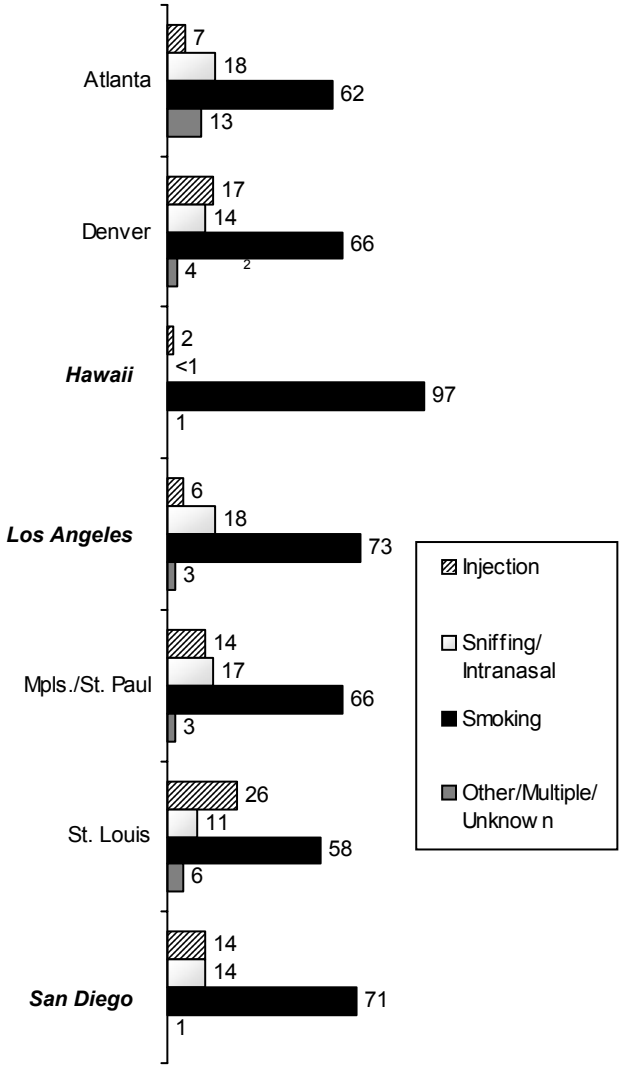
CEWG Area	Gender		Race/Ethnicity			Age	
	Male	Female	White	Afr.-Amer.	Hispanic	≤34	35+
Atlanta	30	70	93	4	2	19	81
Denver	52	48	82	2	13	70	30
Hawaii	***63***	***37***	***14***	***1***	***4[2]***	***NR[3]***	
Los Angeles	***58***	***42***	***37***	***3***	***54***	***72***	***28***
Mpls./St. Paul	62	38	89	1	4	71	29
St. Louis	53	47	98	<1	1	60	40
San Diego	***60***	***40***	***53***	***6***	***32***	***58***	***42***
Seattle	60	40	79	4	5	(see [4])	

[1]Percentages rounded.
[2]In Hawaii in 2005, 47 percent of the methamphetamine admissions were "Mixed-Part Hawaiian," 12 percent were Filipino, 8 percent were "Mixed-Not Hawaiian," 6 percent were Japanese, and small percentages were members of various other racial/ethnic groups.
[3]NR=Not reported by the CEWG representative.
[4]In Seattle in the first half of 2006, 44 percent were age 18–20; other age group data were not reported.
SOURCES: June 2006 and January 2007 CEWG reports

Race/Ethnicity. In five CEWG areas, Whites constituted the largest majority of primary methamphetamine admissions, ranging from 82 percent in Denver to 98 percent in St. Louis *(see exhibit 11b)*. In San Diego in **2005**, 53 percent of this admissions group were White, and 32 percent were Hispanic. In Los Angeles in **2005**, 54 percent of the methamphetamine admissions were Hispanic, and 37 percent were White. In Hawaii in **2005**, primary methamphetamine abusers were more likely to be part or mixed Hawaiian (47 percent) or members of various racial/ethnic groups.

Route of Administration. Exhibit 11c depicts the routes of administration of methamphetamine among treatment admissions in seven CEWG areas in ***2005*** or 2006. As shown, smoking was the most frequently reported route of administering methamphetamine in all areas. In **2005**, 97 percent of this admissions group smoked the drug in Hawaii, as did 71 and 73 percent in San Diego and Los Angeles, respectively. Injection of methamphetamine was most likely to be reported by admissions in Denver (17 percent) and St. Louis (26 percent) in the first half of 2006.

Exhibit 11c. Major Routes of Administration of Methamphetamine Among Treatment Admissions in CEWG Areas, by Percent[1]: 2005– 2006[2]



[1]Percentages rounded.
[2]Classified as "oral."
SOURCES: June 2006 and January 2007 CEWG reports

Recent Trends. As shown in exhibit 11a, methamphetamine admissions increased approximately 5 percentage points in Atlanta, Denver, and Seattle when 2003 admissions are compared with those for the first half of 2006. The decrease shown for Atlanta from 2005 to the first half of 2006 is consistent with decreases found in other Atlanta methamphetamine abuse indicators in 2006. The increase from FY 2003 to FY 2006 in Arizona was higher, at approximately 9 percentage points. In Los Angeles from 2003 to 2005, methamphetamine treatment admissions (excluding alcohol) increased more than 8 percentage points. Not shown in exhibit 11a are data from Maine. In Maine, this admissions group accounted for less than 1 percent of illicit drug admissions from 2003 to 2006; however, the number of primary methamphetamine admissions increased from 24 in 2003 to 49 in 2006.

DAWN ED Data on Methamphetamine

Unweighted DAWN *Live!* data, presented earlier in exhibit 2, show that ED reports for methamphetamine in San Diego exceeded those for other major substances of abuse (excluding alcohol), representing 32 percent of the reports. Methamphetamine accounted for the second highest number of the ED reports in Phoenix (25.5 percent), the third highest number in San Francisco (14.2 percent), and the fourth highest number in Minneapolis/St. Paul (7.2 percent), Seattle (11.8 percent), and Denver (12.0 percent).

Mortality Data on Methamphetamine

The most recent data on deaths with the presence of methamphetamine were reported for six CEWG metropolitan/county areas. The San Diego data are for the year 2005. The data from the Detroit and in Minneapolis/St. Paul areas are for the first 9 months of 2006; in the other three areas, the data are for the first half of 2006.

- 245 in San Diego County
- 22 in Honolulu
- 13 in Seattle/King County

- 10 in Minneapolis/Hennepin and St. Paul/Ramsey Counties
- 9 in Philadelphia
- 9 in Detroit/Wayne County

Methamphetamine-involved deaths were also reported for four States. In Texas in 2005, there were 174 death mentions of methamphetamine. In the first half of 2006, Florida reported 58 deaths involving methamphetamine. Georgia reported 85 positive methamphetamine specimens in decedents in FY 2006.

The rate of methamphetamine overdose deaths in Albuquerque/Bernalillo County in 2003–2005 was 0.98 per 100,000 population, lower than the State rate of 1.44.

NFLIS Data on Methamphetamine

As shown earlier on the map in exhibit 3, the proportions of methamphetamine items reported from forensic labs were high in several CEWG areas. Methamphetamine items were the most frequently reported drug items in Honolulu (57.0 percent), Minneapolis/St. Paul (41.3 percent), and Phoenix (31.0 percent). Methamphetamine was the second most frequently identified drug item in San Diego (32.5 percent), Atlanta (29.6 percent), Seattle (28.3 percent), Los Angeles (27.2 percent), and Texas (23.8 percent). In areas east of the Mississippi River, with the exception of Atlanta, 1 percent or less of the items identified by NFLIS contained methamphetamine.

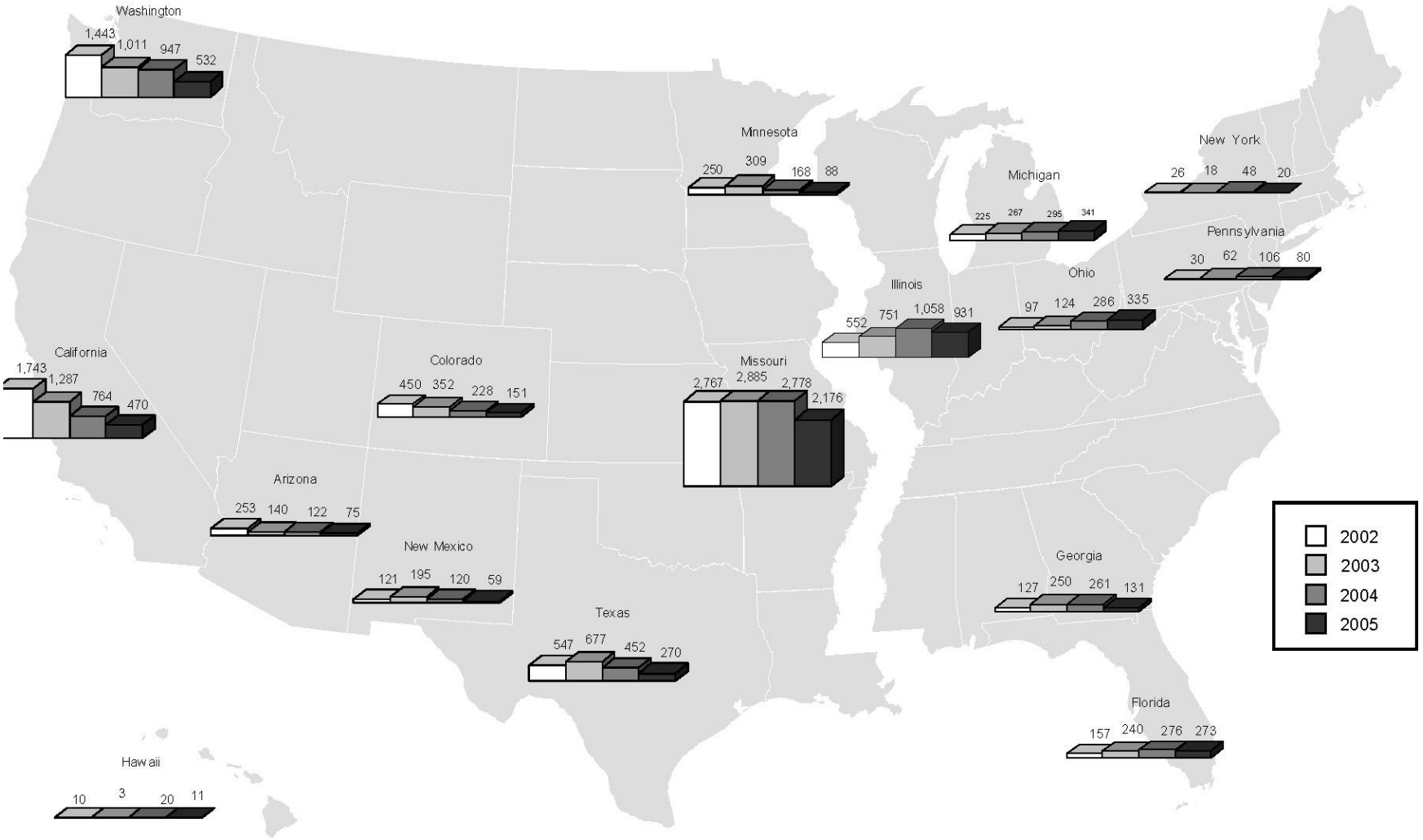
Seizure Data on Methamphetamine

Methamphetamine laboratory seizures (incidents), as reported by DEA's National Clandestine Laboratory Database, decreased in the nine CEWG States west of the Mississippi River from 2002 to 2005, while they increased in six of the seven States east of the Mississippi. These data are shown on the map in exhibit 12.

In areas west of the Mississippi River, laboratory incidents continued to be highest in Missouri, followed by Washington and California. However, the decrease in lab incidents in Missouri from 2002 to 2005 was only 21 percent, compared with 63 and 73 percent in Washington State and California, respectively. Lab incidents decreased 51 percent in both New Mexico and Texas, 65 percent in Minneapolis, 66 percent in Colorado, and 70 percent in Arizona during that period. Seizures in Hawaii continued to be very low, totaling 11 in 2005.

East of the Mississippi River, the number of seizures continued to be highest in Illinois, but they decreased 69 percent from 2002 to 2005, when they totaled 931. In Ohio, lab incidents were nearly 2.5 times higher in 2005 than in 2002, rising from 97 to 335. In Pennsylvania, lab incidents were 1.7 times higher in 2005 than in 2002 (80 vs. 31). In Michigan, lab incidents increased 52 percent over the 4-year period, while those in Florida increased 74 percent. A slight increase in lab incidents occurred in Georgia, and a slight decrease was found in New York State.

Exhibit 12. Trends in Laboratory Incidents[1] in 16 States Represented in the CEWG Meeting[2]: 2002–2005



[1]Includes labs, dumpsites, and chemicals/glass/equipment.
[2]Maine, Maryland, Massachusetts, and the District of Columbia (areas included in the CEWG) had less than 5 incidents in any one year and are not included on this map.
SOURCE: National Clandestine Laboratory Database, DEA; updated October 2006

Price of Methamphetamine

For mid-year 2006, NDIC reported street prices for several forms of methamphetamine. As shown in exhibit 13, a gram of powder methamphetamine was least expensive in Seattle and most expensive in Bangor, Maine. A gram of ice appeared to be cheapest in Phoenix and most expensive in Honolulu.

Exhibit 13. Methamphetamine Retail (Street) Price[1] in 19 CEWG Areas[2], Ordered by Lowest Price: June 2006

CEWG Area	Price Per Gram
Seattle	$20–$60 PM[3]
Phoenix	$40–$50 MX[4] Ice[5]
Wash., DC	$40–$150 PM
San Diego	$50–$100 PM
Albuquerque	$60–$80 MX, LP[6]
San Francisco	$60–$100 PM
Dallas	$70–$100 PM, LP
Chicago	$80–$100 PM
Minneapolis	$90–$100 Ice
Denver	$90–$100 PM, MX, LP
Cincinnati	$100 PM LP
Atlanta	$100–$150 Ice
New York City	$100–$300 PM
Philadelphia	$100–$250 PM
Detroit	$125–$175 PM, LP
Honolulu	$100–$400 Ice
Bangor, ME	$200 PM
	Other Quantities
Los Angeles	$40–$50 1/32 oz MX Ice
Boston	$400–$500 ¼ oz PM

[1]Most current available price at mid-year 2006.
[2] Street-level prices were not available for Baltimore, Miami, or St. Louis.
[3]PM=Powder methamphetamine.
[4]MX=Mexico-produced.
[5]Ice=Ice methamphetamine.
[6]LP=Locally produced.
SOURCE: NDIC, DOJ

Marijuana

Marijuana continues to be widely available across CEWG areas. Use was especially high among adolescents and young adults, as indicated by treatment data, arrestee data, and survey data.

Survey and other data point to high levels of marijuana use, relative to other drugs, among youth and young adults.

ALBUQUERQUE/NEW MEXICO: *Marijuana is the most widely available and commonly used drug in New Mexico, especially among teenagers. The 2005 New Mexico Youth Risk and Resiliency Survey showed that high school students in the Albuquerque area were considerably more likely to report past-month use of marijuana than students nationally (30.5 vs. 20.2 percent). —**Nina Shah***

FLORIDA: *In 2006, 11.4 percent of students surveyed statewide reported current (past-month) use of marijuana. This represented a 21-percent decrease from 2000 but a 10-percent increase from 2005. —**James Hall***

LOS ANGELES: *In the 2005 YRBS survey, approximately 38 percent of female and 42 percent of male students reported lifetime use of marijuana. —**Beth Rutkowski***

MINNEAPOLIS/ST. PAUL: *Past-30-day use of marijuana was high among undergraduate students at the University of Minnesota in 2006. Among students of all ages, 37.7 percent of those who used tobacco reported current marijuana use, compared with only 7.8 percent of students who did not use tobacco. Use was highest among students age 18 to 24. —**Carol Falkowski***

PHOENIX: *The proportion of juvenile arrestees testing positive for marijuana in the Treatment Assessment Screening Center continued to be high and increased slightly from the third quarter of 2005 to the third quarter of 2006 (75.6 to 76.2 percent). — **Ilene Dode***

WASHINGTON, DC: *As in past years, juvenile arrestees were more likely to test positive for marijuana than for any other drug in 2006. Over the past several years, approximately 50 percent of the juveniles have tested positive for marijuana. However, there was a steady decrease in the percentages of young arrestees testing marijuana positive from 1999 to 2004. The percentages have leveled off since 2004. —**Erin Artigiani***

Primary marijuana treatment admissions increased in five CEWG areas.

ATLANTA: *Marijuana remains the most commonly used substance in Atlanta. Treatment admissions for primary marijuana abuse (excluding alcohol) have increased since 2003. Ethnographic reports suggest that marijuana is easily available, and prices for the drug have remained stable. —**Brian Dew***

BALTIMORE: *Primary marijuana admissions, excluding alcohol, have increased since 2003 and represented 18 percent of admissions (excluding alcohol) in the first half of 2006. In the first half of 2006, 57 percent of primary marijuana admissions reported the use of other substances, primarily alcohol (48 percent), although 10 percent reported cocaine. Some 38 percent were younger than 18, and 81 percent were male. Criminal justice referrals continued to constitute the majority of marijuana treatment admissions—65 percent in the first half of 2006. Marijuana ranked second (after cocaine) in the number of the drug items reported by NFLIS in FY 2006. —**Leigh Henderson***

CHICAGO: *Reported marijuana-related treatment services continued to increase in*

*Chicago, though less rapidly than in the rest of the State. —**Lawrence Ouellet***

DETROIT: *Treatment admissions for marijuana increased steadily since 2003, accounting for 19 percent of illicit drug admissions in FY 2006…the drug represented one-fifth of the unweighted ED reports for illicit drugs in the first half of 2006, and for 23 percent of the drug items reported by NFLIS in FY 2006. —**Cynthia Arfken***

ST. LOUIS: *Marijuana indicators continued to increase, with treatment admissions increasing 11 percent in the St. Louis area and 21 percent statewide from the first half of 2005 to the first half of 2006. This may be related to a funding issue. —**James Topolski***

Marijuana abuse indicators were mixed but at high or relatively high levels in seven CEWG areas.

BOSTON: *Treatment admissions for marijuana have steadily decreased in number and as a proportion of all admissions during the past 7 years. The number of marijuana Helpline calls was unchanged from 2005 to 2006. Marijuana drug arrests (Class D) and forensic lab samples increased in 2005. —**Daniel Dooley***

DENVER: *In the Denver area, marijuana abuse (excluding alcohol) has continued to result in the highest number of illicit treatment admissions annually since 1997, but such admissions have remained fairly stable over the past 3 years. There have been decreases in marijuana abuse indicators in other data sources, including the YRBS survey, poison control center call data, and seizure data (amounts of marijuana seized). —**Tamara Hoxworth***

HONOLULU: *Primary marijuana treatment admissions sharply increased from 1996 to 2005; data for the first half of 2006 suggest the high levels for marijuana admissions will continue. Deaths involving marijuana followed a similar trend, but marijuana arrests have continued to decline over the 10-year period. Marijuana arrest data are of little value, since law enforcement is not focusing attention on this drug, except for seizures. —**D. William Wood***

MIAMI/FT. LAUDERDALE: *Marijuana abuse remains relatively stable at high levels. In the 2005–2006 school survey, current marijuana use increased slightly over the prior year. In the sample of treatment programs in Broward County, primary marijuana admissions (excluding alcohol) decreased from 2005 to the first half of 2006, remaining low in both time periods. In Miami-Dade County, marijuana ranked second after cocaine (excluding alcohol) in unweighted ED reports in the first half of 2006 and in crime lab items in FY 2006. —**James Hall***

PHILADELPHIA: *Primary marijuana admissions (excluding alcohol) remained relatively stable from 2003 to 2005. However in 2006, marijuana was the most frequently detected drug by the Adult Probation/Parole Department urinalysis tests, ranked second in the NFLIS study, and was third in treatment admissions. —**Samuel Cutler***

SAN DIEGO: *Most marijuana indicators are mixed. The proportion of treatment admissions for primary abuse of marijuana (excluding alcohol) decreased slightly from 2004 to 2005 (17.6 vs. 15.2 percent, respectively). In the first half of 2006, marijuana accounted for nearly 22 percent of the illicit ED reports. However, cannabis accounted for 43.5 percent of the drug items reported by NFLIS in FY 2006. —**Robin Pollini***

TEXAS: *Marijuana abuse indicators showed increases in primary marijuana treatment admissions from 2002 to the first half of 2006. During that time frame, the Department of Public Safety lab data showed slight decreases in the percentage of items con-*

*taining marijuana. Poison control center calls involving marijuana fluctuated from 2002 to 2005, ranging from 412 to 525. Among treatment admissions in the first half of 2006, those with criminal justice problems continued to be less impaired than those referred from other sources.—**Jane Maxwell***

Marijuana abuse indicators remained relatively stable at high levels in four CEWG areas.

CINCINNATI: *Marijuana indicators remain at a high level. Primary marijuana admissions (excluding alcohol) have been relatively stable since 2003 and accounted for 19 percent of illicit treatment admissions during FY 2006. Marijuana submissions reported to NFLIS accounted for 39 percent of the total submissions and for 46 percent of drug items submitted to the Hamilton County Coroner Laboratory. —**Jan Scaglione***

NEW YORK CITY: *Marijuana indicators, which had been reaching new peaks, seem to have stabilized. —**Rozanne Marel***

PHOENIX/ARIZONA: *Marijuana indicators remained high but relatively stable. For most of the years between 2003 and 2006, primary marijuana admissions accounted for approximately 33 to 35 percent of admissions (excluding alcohol) statewide; at three Maricopa County treatment facilities in 2006, the proportions of clients treated for marijuana ranged between 27 and 30 percent (excluding alcohol). Tests positive for marijuana among juvenile arrestees increased slightly in the prior year. The number of marijuana items reported by NFLIS remained relatively stable from 2005 to 2006, at around 31 percent of all drug items. Arizona is becoming the gateway for marijuana smuggling, with 331.3 tons confiscated in FY 2006. —**Ilene Dode***

SEATTLE: *Treatment admissions for primary abuse of marijuana remained relatively stable from 2004 through the first half of 2006, accounting for approximately 25–28 percent of admissions, excluding alcohol. However, among all persons admitted to treatment in King County from 1999 to the first half of 2006, marijuana was the drug most likely to be reported for 'any use' among all admissions, ranging between approximately 48 and 52 percent in each of the 8 years. —**Caleb Banta-Green***

Indicators of marijuana abuse decreased in Maine and San Francisco.

MAINE: *In Maine, marijuana abuse indicators have been decreasing. The decreases appear in treatment admissions data, and in the slight decline in marijuana arrests. Maine youth reported less marijuana use in the 2006 survey than previously. —**Marcella Sorg***

SAN FRANCISCO: *The proportion of treatment admissions in San Francisco County (excluding alcohol) decreased from 13.2 percent in FY 2003 to 10.7 percent in FY 2006. Marijuana arrests decreased 35 percent from 2004 to 2005; arrests dropped 11 percent between the first 4 months of 2005 and the first 4 months of 2006. —**John Newmeyer***

PATTERNS AND TRENDS IN MARIJUANA ABUSE ACROSS CEWG AREAS

Treatment Data on Marijuana

Exhibit 15a presents treatment data on marijuana admissions from 16 CEWG areas for 2006 time periods and from 4 areas where data are available only for ***2005***. The data represent primary marijuana admissions as a proportion of all admissions, excluding alcohol. In 2006, primary marijuana admissions—relative to total admissions, excluding alcohol—continued to exceed those for any other illicit drug in Denver

(38.6 percent), Minneapolis/St. Paul (35.8 percent), and Seattle (25.7 percent); they were essentially equal to the proportion of primary methamphetamine admissions in Arizona. In Atlanta, Cincinnati, Maine, New York City, St. Louis, Hawaii, and Texas, primary marijuana admissions (excluding alcohol) accounted for between approximately 22 and 31 percent of illicit drug admissions in 2006 reporting periods.

Exhibit 15a. Primary Marijuana Treatment Admissions in 20 CEWG Areas, by Percent of All Admissions (Excluding Alcohol): 2003–2006[1]

CEWG Area/State	2003	2004	2005	2006	Percentage-Point Change 2003–2006
Atlanta	27.0	28.8	27.7	30.9	3.9
Baltimore	17.0	16.2	15.8	18.2	1.2
Boston	6.7	6.6	5.0	4.2	-2.5
Broward Co. (BARC) [2]	NR[3]	NR	16.5	13.5	…
Chicago	***NR***	***16.4***	***14.7***	***NR***	***…***
Cincinnati [4]	29.6	30.5	33.6	27.3	-2.3
Denver	30.2	38.6	37.0	38.6	8.4
Detroit	13.5	13.5	15.4	19.0	5.5
Los Angeles	***16.3***	***17.0***	***18.7***	***NR***	***…***
Mpls./St. Paul	45.0	39.1	32.6	35.8	-9.2
New York	24.2	23.5	25.3	27.8	3.6
Philadelphia[5]	***23.7***	***22.0***	***22.8***	***NR***	***…***
St. Louis	34.4	35.1	29.0	31.4	-3.0
San Diego	***NR***	***17.6***	***15.2***	***NR***	***…***
San Francisco	13.2	11.2	9.4	10.7	-2.5
Seattle	32.9	28.2	25.2	25.7	-7.2
Arizona	39.6	21.4	33.5	33.6	-6.0
Hawaii	28.2	25.2	29.2	28.8	0.6
Maine	33.5	30.5	25.6	21.7	-11.8
Texas	26.5	26.4	27.1	28.3	1.8

[1]Represents different time periods (FY 2005 or 2006 or 1H CY 2006, or full year 2005 or 2006, or FY 2006, *see Appendix A).*
[2]NR=Not reported by the CEWG representative.
[3]Broward County samples are from 9 programs that serve 51.5 percent of admissions to county treatment facilities.
[4]Represents 65-75 percent of the Cincinnati/Hamilton County admissions in the first half of 2006.
[5]In the first half of 2006, 26 percent of admissions mentioned use of marijuana.
SOURCES: June 2006 and January 2006 CEWG reports

Gender. In 16 CEWG areas reporting on the gender of primary marijuana admissions, males predominated in each area *(see exhibit 15b).* The areas with the highest proportions of female marijuana admissions were Atlanta and Cincinnati, each at 35 percent.

Exhibit 15b. Demographic Characteristics of Primary Marijuana Treatment Admissions in Reporting CEWG Areas, by Percent[1]: *2005*[2]–2006

CEWG Area	Gender		Race/Ethnicity			Age			
	Male	Female	White	Afr.-Amer.	Hispanic	<17 (20)	18–25	26–34	35+
Atlanta	65	35	37	56	4	10	3	6	81
Baltimore	81	19	45	52	2	38	40	14	9
Boston	***73***	***27***	***21***	***52***	***22***	***64***	***24***	***24***	***12***
Chicago	***77***	***23***	***7***	***76***	***15***	***NR[3]***			
Cincinnati	65	35	36	64	NR	NR			
Denver	75	25	46	20	30	40	27	21	12
Detroit	73	27	3	94	2	29	25	28	18
Los Angeles	***72***	***28***	***14***	***30***	***51***	***50***	***23***	***13***	***13***
Maine	74	26	NR			33	30	20	18
Mpls./St. Paul	80	20	61	26	5	38	34	15	13
New York	78	22	7	60	29	NR[4]	NR	NR	22
Philadelphia	***83***	***17***	***19***	***60***	***10***	***53 (30 or younger)[5]***			
St. Louis	73	27	42	56	1	25	34	25	17
San Diego	***73***	***27***	***43***	***20***	***32***	***38***	***24***	***19***	***18***
Seattle	***75***	***25***	***44***	***31***	***8***	***40[4]***	***37***	***20***	***3***
Texas	70	30	32	22	44	NR			

[1]Percentages rounded.
[2]The four areas reporting 2005 data are shown in ***italic bold.***
[3]NR=Not reported by the CEWG representative.
[4]New York reports for "24 and younger" (45 percent) and 25–34 (33 percent), and Seattle reports "18 and younger."
[5]Philadelphia reports: <21 (8 percent); 21–25 (28 percent); 26-30 (19 percent); 31–35 (13 percent); and 36+ (shown above).
SOURCES: June 2006 and January 2007 CEWG reports

Race/Ethnicity. African-Americans accounted for one-half or more of primary marijuana admissions in 8 of 15 reporting CEWG areas, with the proportions being highest in Chicago and Detroit (76–94 percent) *(see exhibit 15b)*. Whites accounted for 61 percent of the marijuana admissions in Minneapolis/St. Paul and for the largest proportions in Denver, San Diego, and Seattle. Hispanics ranked first in Los Angeles (51 percent) and Texas (44 percent) and ranked second in Boston, Chicago, Denver, New York City, and San Diego.

Age. Primary marijuana admissions tended to be younger than admissions for other drugs across 12 reporting CEWG areas. However, there was more variation across the marijuana age groups than was the case for other drugs. As shown in exhibit 15b, marijuana admissions age 17 and younger accounted for the largest proportion in Boston (64 percent), Denver (40 percent), and Los Angeles (50 percent), and slightly exceeded admissions for the 18–25-year-old group in Minneapolis/St. Paul and Seattle. In Atlanta, marijuana admissions were most likely to be 35 or older (81 percent).

Six CEWG areas reported on the mode of administration among primary marijuana admissions. The percentages who smoked marijuana ranged from 92 in Denver to 97 in Baltimore, Maine, and New York City. In St. Louis, 94 percent smoked the drug, as did 95 percent of the marijuana admissions in Atlanta.

In the 2006 reporting periods, four CEWG areas reported on secondary drug use among primary marijuana admissions. Among primary marijuana admissions who used a second drug, alcohol was the most frequent-

ly reported secondary drug in Baltimore, Detroit, New York City, Minneapolis/ St. Paul, and St. Louis. The proportions reportedly using alcohol were 48 percent in Baltimore, 26 percent in St. Louis, and nearly 71 percent in Minneapolis/St. Paul. In **2005**, Boston and Los Angeles reported that alcohol was the secondary drug most frequently used by marijuana admissions.

Recent Trends. Of the 15 CEWG areas for which 2003 and 2006 data were reported *(see exhibit 15a),* primary marijuana admissions as a proportion of total admissions, excluding alcohol, increased between approximately 6 and 9 percentage points in Detroit and Denver, respectively. Decreases of more than 6.0 percentage points or more were reported for Arizona (6.0 percentage points), Seattle (7.2), Minneapolis/St. Paul (9.2), and Maine (11.8). In the other nine CEWG areas, the proportions of primary marijuana admissions (excluding alcohol) were relatively stable, increasing or decreasing less than 4 percentage points.

DAWN ED Data on Marijuana

Unweighted DAWN *Live!* data for the first half of 2005 in 13 CEWG areas were presented earlier in exhibit 2. Marijuana reports were the second most frequently recorded major substance of abuse (excluding alcohol) in six CEWG areas. Marijuana accounted for between 30.3 and 36.5 of the illicit drug reports in Houston and Minneapolis/St. Paul, respectively (*see the map in exhibit 2*). The proportions were lower in San Diego (21.7 percent), Denver (24.0 percent), Miami (25.4 percent), and Ft. Lauderdale (29.5 percent).

Mortality Data on Marijuana

The presence of marijuana in decedents is not tested in all CEWG areas. In the first half of 2006, Honolulu reported 26 deaths with the presence of marijuana, and the Cincinnati/ Hamilton County ME reported 2 such deaths. In Florida in the first half of 2006, 471 deaths with the presence of marijuana were reported. In FY 2006 in the State of Georgia, mortality data show there were 102 positive drug-type specimens for the THC metabolite; these accounted for 5.1 percent of the positive type specimens.

NFLIS Data on Marijuana

Across CEWG areas in FY 2006, the proportions of cannabis/THC items were higher than those for other drug items in Boston and Chicago, where they accounted for approximately 44 and 50 percent of the items reported by NFLIS (*see the map shown earlier in exhibit 3).* In Baltimore, Washington, DC, Philadelphia, St. Louis and Cincinnati, between 31 and 39 percent of all drug items contained cannabis. In Honolulu, Miami, Denver, Detroit, Los Angeles, New York City, Phoenix, San Francisco, and Texas, cannabis was found in 20 to 29 percent of all drug items. Except for heroin items, cannabis items were low compared with other drug items reported in Atlanta (2.2 percent), Ft. Lauderdale (12.4 percent), and Minneapolis/St. Paul (14.3 percent).

Price Data on Marijuana

The price of different forms of marijuana continued to vary across CEWG areas. The price per gram was higher in Honolulu than

in the other eight areas shown in exhibit 16. Typically a "joint" or "cigarette" could be purchased for $5 to $10 dollars in Albuquerque, Boston, Denver, and San Francisco. Note the higher prices for the sinsemilla and hydroponic forms of the drug in Seattle.

Exhibit 16. Marijuana Retail (Street) Price[1] in 18 CEWG Areas,[2] Ordered by Lowest Price: June 2006

CEWG Area	Price Per Gram
Chicago	$5–$7 MX[3]
Minneapolis	$5–$7 CG[4]
Baltimore	$5–$10
Los Angeles	$5–$10 MX
Atlanta	$10 CG
Dallas	$10 CG
Detroit	$10 CG
Wash., DC	$10 CG
Honolulu	$20–$30 DO[5]
	Other Prices
Albuquerque	$5 per joint
Boston	$5 per joint
Denver	$5 per joint
San Francisco	$5–$10 per cigarette
San Diego	$10 per bag (1–3 oz) MX
New York City	$10–$20 per bag CG
Philadelphia	$25 per 1/8 oz CG
Bangor, ME	$30 per 1/8 oz
Seattle	$40–$50 per 1/8 oz SN[6], HY[7]

[1]Most current available price at mid-year 2006.
[2]Street-level prices not available for Miami, Phoenix, or St. Louis.
[3]MX=Mexico-produced.
[4]CG=Commercial-grade.
[5]DO=Domestic.
[6]SN=Sinsemilla.
[7]HY=Hydroponic.
SOURCE: NDIC, DOJ

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

The club drugs in this section include MDMA (methylenedioxymethamphetamine, or ecstasy), GHB (gamma hydroxybutyrate), GBL (gamma butyrolactone), lysergic acid diethylamide (LSD), and ketamine.

While these drugs continue to be used at "raves" and in other party settings, data indicators continue to suggest that use of GHB, LSD, and ketamine is quite low in most CEWG areas. MDMA continues to be the most widely used of the club drugs, but its use/misuse is also relatively low.

Indicators of abuse of club drugs from several CEWG areas indicate that these drugs, particularly MDMA, continue to be abused, especially among young people. Levels of MDMA abuse were low and stable in most areas; however, increases among some populations, or in some MDMA indicators, were reported in Atlanta, Chicago, Miami/Ft. Lauderdale, Seattle, and Texas. In Detroit and Seattle, there were reports of MDMA being smuggled from Canada, and in Seattle and South Florida, there were reports of the drug being produced locally.

Indicators of increases in MDMA abuse among youth and/or African-Americans were reported in the following CEWG areas:

Atlanta: *In Atlanta, MDMA abuse is continuing to increase in African-American communities.* ***—Brian Dew***

CHICAGO: *Increases in MDMA abuse have been reported among lower income African-American youth. In some street drug markets, MDMA is routinely available along with the usual staples of heroin and crack cocaine. The typical price is $20 per pill, but $10 pills of low potency have been reported. Users often perceive three classes of MDMA: 1) MDMA that is cut with heroin, 2) MDMA that is cut with cocaine, and 3) low potency or bogus MDMA. Pills are branded with logos, and, though the different logos reappear in markets, a single logo normally is not steadily available from any one dealer.* ***—Lawrence Ouellet***

MIAMI/FT. LAUDERDLE: *While MDMA abuse indicators stabilized from 2002 to 2003, the 2006 data show increases. There were increases in the number of MDMA items analyzed by forensic labs and in deaths related to MDMA. Also, the 2005–2006 survey of middle and high school students points to an increase in current (past-month) use among youth. In 2000, 2.8 percent of students surveyed reported current use; the figure dropped to 1.0 percent in 2005 but increased to 1.2 percent in 2006. The DEA reported that MDMA precursors were being sold out of mom and pop clandestine labs.* ***—James Hall***

SEATTLE: *Customs data show an increase in MDMA dosage units seized. Most of the MDMA is coming into the State from Canada, but there are reports that it is being produced locally as well.* ***—Caleb Banta-Green***

TEXAS: *Indicators of ecstasy use are increasing as the drug spreads from the White club scene to a diverse racial/ethnic population. Treatment data show a 30-percent increase in MDMA use among African-American admissions. Texas Poison Control Centers reported 23 calls involving misuse or abuse of ecstasy in 1998… 119 in 2000… 172 in 2002… 302 in 2004, and 343 in 2005. In 2005, the average age of callers was 21.—****Jane Maxwell***

Examples of data from CEWG areas where MDMA indicators were low and stable are as follows:

BOSTON: *Levels of MDMA abuse continue to be low, as indicated by forensic lab and Helpline data for 2006.* ***—Daniel Dooley***

CINCINNATI: *Epidemiologic indicators for MDMA indicate limited use across the Cincinnati area in 2006. There were 16 intentional exposure calls to poison control in 2005 involving MDMA and 7 in 2006; calls involving GHB totaled 1 in 2005 and 5 in 2006 (these unconfirmed data are from 38 of 88 counties in Ohio). —**Jan Scaglione***

DETROIT: *Ecstasy use is still troublesome, as evidenced by treatment admissions and medical examiner reports. There were three poison calls related to MDMA in the first 9 months of 2006. MDMA is being smuggled in from Canada, but there are no signs of a real surge in abuse. —**Cynthia Arfken***

PATTERNS AND TRENDS IN ABUSE OF CLUB DRUGS ACROSS CEWG AREAS

Treatment Data on Club Drugs

Two CEWG areas reported 2006 data on primary abuse of one or more club drugs among treatment admissions. In addition, Chicago reported 2005 data for the overall category of "club drugs."

CHICAGO: *In FY 2005, there were 76 admissions for primary abuse of club drugs; most were male (92 percent) and African-American (74 percent). The 2005 admissions represent an increase over the 30 club drug admissions in FY 2004. —**Lawrence Ouellet***

DETROIT: *There were 10 admissions for primary abuse of ecstasy in Detroit/Wayne County in 2006. —**Cynthia Arfken***

TEXAS: *In the first half of 2006, admissions to treatment for a primary problem with ecstasy totaled 45. There were two admissions each for primary abuse of GHB and ketamine. —**Jane Maxwell***

DAWN ED Data on Club Drugs

Unweighted DAWN *Live!* data for the first half of 2006 show that MDMA was the most frequently reported club drug in all 13 CEWG areas *(see exhibit 17)*. LSD (unweighted) reports tended to be second in frequency among these four drugs. A small number of (unweighted) ED reports were shown for GHB in all 13 areas. Ketamine ED reports were few in number and were documented in only 10 of the 13 CEWG areas.

Exhibit 17. Numbers of MDMA, GHB, LSD, and Ketamine ED Reports in 13 CEWG Areas (Unweighted[1]): January–June 2006

CEWG Area	MDMA	GHB	LSD	Ketamine
Boston	72	9	10	5
Chicago	67	7	6	1
Denver	41	7	14	3
Detroit	101	7	13	1
Ft. Lauderdale	51	9	10	0
Houston	97	2	13	0
Miami-Dade	47	2	15	1
Mpls./St. Paul	63	3	28	0
New York City	90	21	15	11
Phoenix	30	6	8	5
San Diego	29	3	7	1
San Francisco	62	17	28	5
Seattle	72	12	26	1

[1]All DAWN cases are reviewed for quality control. Based on the review, cases may be corrected or deleted. Therefore, these data are subject to change.
SOURCE: DAWN *Live!,* OAS, SAMHSA, updated 11/17–11/20, 2006

The unweighted MDMA ED reports constituted 1 percent or less of the ED reports in Chicago, Ft. Lauderdale, Miami, New York City, and Phoenix. In the other

eight CEWG areas, MDMA accounted for between 1.2 percent (Seattle) and 2.4 percent (Houston) of the reports. (See *Appendix B-2* for the total number of major substances of abuse reports, excluding alcohol, in each CEWG area.)

Mortality Data on Club Drugs

Deaths with the presence of one or more club drugs were reported from the following five CEWG areas:

- In Detroit/Wayne County in the first 9 months of 2006, there were 11 deaths involving MDMA and 4 involving ketamine.
- In Florida in the first half of 2006, there were 25 deaths related to MDMA, 18 involving methylenedioxyamphetamine (MDA), and 3 involving GHB; deaths involving MDMA and MDA increased 56 and 50 percent, respectively, from the second half of 2005.
- In Georgia in FY 2006, there were 20 deaths with positive screens for MDMA.
- In Philadelphia in the first half of 2006, there were 7 deaths with the presence of MDMA; 59 such deaths were reported since 1994.
- In Texas in 2005, there were 11 death certificates with a mention of MDMA.

NFLIS Data on Club Drugs

In FY 2006, a total of 4,696 reports of the 4 club drugs were reported from 20 CEWG metropolitan areas, and another 1,082 were reported from Texas forensic laboratories. The data on each of these drugs follow.

MDMA. MDMA was the club drug most frequently reported by forensic labs in the 21 CEWG areas depicted in exhibit 18. As shown, MDMA exceeded 2 percent of all drug items only in Atlanta, Denver, Minneapolis/St. Paul, St. Louis, San Francisco, and Seattle.

Exhibit 18. Number of MDMA Items and Percentage of MDMA to Total Items Reported by Forensic Labs in 21 CEWG Areas: FY 2006

CEWG Area	MDMA Items	
	Number	Percent
Atlanta	847	5.0
Baltimore	109	0.2
Boston	27	0.4
Chicago	519	0.8
Cincinnati	91	0.6
Denver	177	2.7
Detroit	5	0.1
Ft. Lauderdale	84	0.9
Honolulu	41	1.7
Los Angeles	606	1.1
Miami	217	1.2
Mpls./St. Paul	182	2.5
New York City	254	0.5
Philadelphia	112	0.4
Phoenix	51	0.8
St. Louis	283	4.7
San Diego	196	0.9
San Francisco	251	2.3
Seattle	100	3.2
Washington, DC	122	1.6
Texas	956	1.7

NFLIS, DEA

Ketamine. Ketamine was the second most frequently reported drug item in the NFLIS FY 2006 data. Ketamine items were reported from all areas except Detroit, Honolulu, Philadelphia, and Seattle. Ketamine accounted for less than 1 percent of the total drug items in all 17 reporting CEWG areas.

LSD. In FY 2006, LSD was the third most frequently reported club drug and was

reported in 17 metropolitan CEWG areas. LSD was not among the top 25 drug items reported from the State of Texas, and no LSD items were reported from Baltimore, Honolulu, and Philadelphia. The number of LSD items in all 17 reporting areas was small, accounting for less than 1 percent of the total drug items.

***GHB*.** Items containing GHB were reported from nine CEWG areas in FY 2006, including Texas. In all nine areas, GHB items accounted for less than 1 percent of the total drug items.

Price Data on MDMA

As shown in exhibit 19, the low end retail (street) price of an MDMA dosage unit in mid-2006 was cheapest in Minneapolis and Philadelphia, at $5 and $8, respectively. The low end price of $20 per tablet/dosage unit was consistent across eight CEWG areas—Denver, San Francisco, Seattle, Bangor, St. Louis, Miami, Washington, DC, and Boston.

Exhibit 19. MDMA Retail (Street) Price[1] in CEWG Areas,[2] Ordered by Lowest Price: June 2006

CEWG Area	Price Per Tablet/ Dosage Unit
Minneapolis	$5–$45
Philadelphia	$8–$35
Los Angeles	$10–$15
New York City	$10–$35
Honolulu	$10–$40
Dallas	$12–$20
San Diego	$15–$18
Detroit	$15–$28
Atlanta	$15–$30
Chicago	$15–$30
Albuquerque	$17–$25
Denver	$20
San Francisco	$20
Seattle	$20
Bangor, ME	$20–$25
St. Louis	$20–$25
Miami	$20–$30
Wash., DC	$20–$30
Boston	$20–$40

[1]Most current available price at mid-year 2006.
[2]Prices not available for Baltimore, Cincinnati, or Phoenix.
SOURCE: NDIC, DOJ

Phencyclidine (PCP)

The most recent indicator data suggest that PCP is not a major problem in any CEWG area, although indicators of PCP abuse continue to be higher in Los Angeles, Philadelphia, and Washington, DC, than in other areas.

BALTIMORE: *In 2005, there were three calls to the Baltimore poison control center involving PCP.* ***—Leigh Henderson***

ST. LOUIS: *Whether PCP is reversing the trend and increasing in St. Louis/Missouri is a question to be addressed in the future.* ***—James Topolski***

WASHINGTON, DC: *Among adult arrestees tested in the Pretrial Services Agency, positive tests for PCP have fluctuated over the years, peaking in 2001–2003, decreasing in 2004, and increasing again in 2006. From January through November 2006, 10 percent of adult arrestees and 3 percent of juvenile arrestees tested positive for PCP. The drug continues to be used with marijuana in blunts. Key informants from criminal justice and public health identified PCP as one of the greatest drug threats in the area.* ***—Erin Artigiani***

TEXAS: *PCP abuse indicators are stable or rising.* ***—Jane Maxwell***

PATTERNS AND TRENDS IN PCP ABUSE ACROSS CEWG AREAS

Treatment Data on PCP

PCP is often combined with "other drugs" or a "hallucinogens" category in treatment data sets. Two CEWG areas that reported 2005 data specific to treatment of PCP abuse are cited below, together with PCP treatment data from Texas for the first half of 2006.

LOS ANGELES: *Primary PCP treatment admissions accounted for 0.5 percent of all admissions (n=128) in the latter half of 2005. The proportion of PCP admissions among all admissions has been stable for several years, but the overall number of PCP admissions has fluctuated since the late 1990s. From 1999 to the first half of 2003, the number of admissions increased 89 percent. In the second half of 2003, however, the number of PCP admissions decreased slightly (16 percent) to 262 admissions, and it continued to decrease further (12 percent) in the first half of 2004 to 230 admissions and in the second half of 2004 to 135 admissions (41 percent decrease from the first half of the year). In the first half of 2005, there was a very slight upturn in the number of PCP admissions, representing an 11-percent increase in number. But in the second half of 2005, the number decreased again (7 percent) to 128 admissions. Alcohol (22 percent), cocaine/crack (20 percent), and marijuana (18 percent) were the three drugs most frequently reported as secondary drugs among primary PCP admissions. An overwhelming majority (98 percent) of the primary PCP admissions smoked the drug. About 1 percent reported oral ingestion or inhalation (snorting).* ***—Beth Rutkowski***

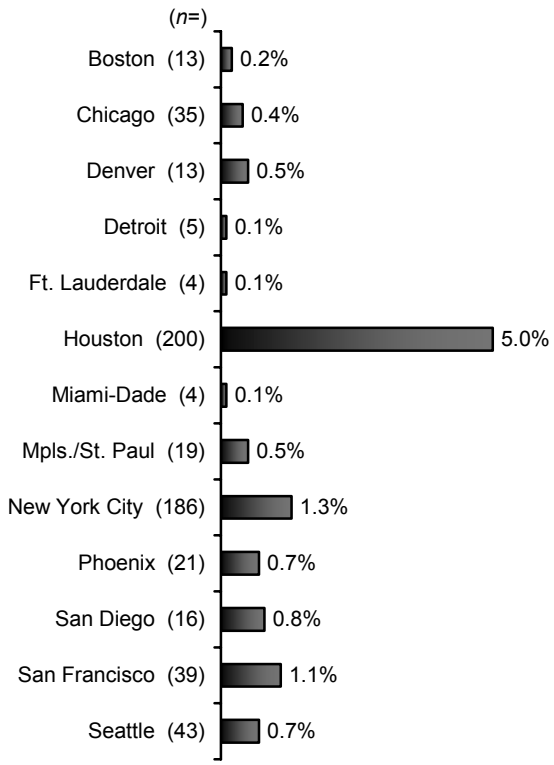
PHILADELPHIA: *Mentions of PCP use at admission to treatment declined precipitously from 2004 to 2005 [from 563 to 347]. African-Americans accounted for 43.6 percent of PCP treatment admissions in 2005, followed by Whites (16.7 percent), Hispanics of any race (16.2 percent), and Asians and others (23.6 percent). Nearly 86 percent were male, and 58 percent were age 30 or younger.* ***—Samuel Cutler***

TEXAS: *Adolescent and adult admissions to treatment with a primary problem with PCP have varied over time, rising from 164 in 1998 to 417 in 2003 and then dropping to 223 in 2005. In the first half of 2006, there were 99 admissions for primary abuse of PCP.* ***—Jane Maxwell***

DAWN ED Data on PCP

As shown in exhibit 20, there were only three CEWG areas where unweighted PCP reports constituted more than 1 percent of the total ED reports for all major substances of abuse (excluding alcohol): San Francisco (1.1 percent), New York City (1.3 percent), and Houston (5.0 percent).

Exhibit 20. Number of ED Reports for PCP and Percentage of Total Major Substances of Abuse (Excluding Alcohol) in 13 CEWG Areas (Unweighted[1]): January–June 2006



[1]All DAWN cases are reviewed for quality control and, based on review, may be corrected or deleted. Therefore, these data are subject to change.
SOURCE: DAWN *Live!,* OAS, SAMHSA, updated 11/17–11/20, 2006

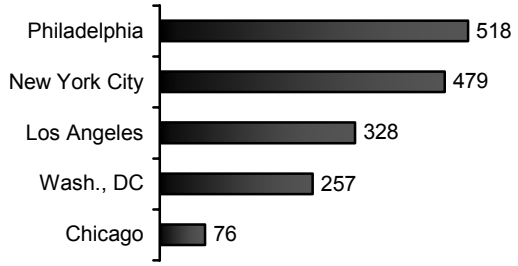
Mortality Data on PCP

Three CEWG representatives reported on deaths with the presence of PCP. Detroit reported 42 PCP-involved deaths in the first 9 months of 2006. Philadelphia reported 42 deaths with the presence of PCP in the first half of 2006. Seattle reported that there were no mentions of PCP (or LSD) in any drug-involved deaths in the first half of 2006.

NFLIS Data on PCP

In FY 2006, 11 metropolitan areas and Texas reported some number of PCP items identified by forensic labs in their areas. The largest numbers of items were reported from the five CEWG areas shown in exhibit 21. PCP accounted for 3.4 percent of the items identified by forensic labs in Washington, DC, for 1.9 percent of the items identified in Philadelphia, and for 1.0 percent of those reported from New York City. In Chicago and Los Angeles, PCP was found in less than 1 percent of the total drug items.

Exhibit 21. PCP Items Reported by Forensic Laboratories in 5 CEWG Areas, Ordered from Highest to Lowest Number: FY 2006



SOURCE: NFLIS, DEA

In Baltimore, Boston, Phoenix, St. Louis, San Diego, and Seattle, between 6 and 24 PCP items were reported, representing less than 1 percent of the total drug items analyzed in these six metropolitan areas. Across the State of Texas, 128 of the total items contained PCP, accounting for less than 1 percent of all drug items analyzed by the Department of Public Safety labs.

Benzodiazepines/ Depressants

Benzodiazepine abuse indicators are relatively high in CEWG areas and seemed to be increasing in some. Deaths with the presence of benzodiazepines are high in such areas as Georgia, Philadelphia, South Florida, and Seattle, attesting to the serious consequences of misuse and abuse of this class of pharmaceuticals. Alprazolam and clonazepam continue to be the most frequently reported benzodiazepines in indicator data.

ATLANTA: *Alprazolam (Xanax) continues to be the most popular benzodiazepine and ranked fourth in the number of drug items reported by NFLIS in FY 2006.* ***—Brian Dew***

BOSTON: *Benzodiazepine misuse and abuse levels remain fairly stable at relatively high levels.* ***—Daniel Dooley***

CHICAGO: *Benzodiazepine-related calls to the Illinois Poison Center in Chicago repeatedly represented nearly one-half of all substance misuse calls between 2001 and 2005. Approximately 500–600 calls annually were reported during this time period.* ***—Lawrence Ouellet***

CINCINNATI: *Benzodiazepines remained a problem across the area. In 2006, there were 116 calls to the poison center related to alprazolam, 168 related to clonazepam, and 65 related to diazepam. The number of benzodiazepine cases seems to be much higher than those for other pharmaceuticals. Xanax tops the list for desirability and also prescriptions among people who get them for legitimate reasons.* ***—Jan Scaglione***

GEORGIA: *Prescription benzodiazepines are second only to cocaine in the number of substance-related deaths across Georgia.* ***—Brian Dew***

LOS ANGELES: *Analgesics and benzodiazepines accounted for 71 percent of the pharmaceutical/non-controlled drug items recorded by NFLIS in FY 2006.* ***—Beth Rutkowski***

MIAMI/FT. LAUDERDALE: *Among drug-related deaths locally and statewide, alprazolam (Xanax) is the most frequently cited benzodiazepine related to nonmedical use. Alprazolam continued to constitute most of the benzodiazepine-related deaths statewide in the first half of 2006. The system is lax in terms of diversion, especially of benzodiazepines, but also for other non-prescribed pharmaceuticals. Xanax is relatively cheap, at about $5 for a 10-milligram pill that can be split for more than one dose. The numbers of deaths, ED reports, and crime lab items related to the non-medical use of benzodiazepines in Broward County are more than double the numbers in Miami-Dade County.* ***—James Hall***

PHILADELPHIA: *The two most frequently abused benzodiazepines continue to be alprazolam and diazepam, although others are abused/misused. As a group, benzodiazepines were the second most frequently detected drugs in decedents in the first half of 2006 and ranked fourth in the NFLIS study. Benzodiazepines ranked sixth among drugs of abuse mentioned by clients in treatment during the same time period.* ***—Samuel Cutler***

SEATTLE: *Benzodiazepine-related deaths have increased steadily in King County since 1999 and totaled 26 in the first half of 2006.* ***—Caleb Banta-Green***

TEXAS: *Abuse of alprazolam (Xanax) is increasing (as in the abuse of Soma). In 2006, the calls related to alprazolam increased 4.5 percent from the previous year, those involving clonazepam increased 0.9 percent, and those involving diazepam increased 0.6 percent.* ***—Jane Maxwell***

PATTERNS AND TRENDS IN BENZODIAZEPINE/DEPRESSANT ABUSE ACROSS CEWG AREAS

Treatment Data on Benzodiazepines

While treatment data on benzodiazepines are included in other drug categories in most CEWG areas, the numbers of admissions in the combined categories are small, typically less than 1 percent (e.g., in Atlanta, Denver, Hawaii, San Diego, Seattle, and Texas). The most recent reports (2005–2006) show that benzodiazepines accounted for only small percentages of admissions in the reporting areas.

BALTIMORE: *Treatment admissions for benzodiazepines and other tranquilizers were between 5.0 and 8.0 admissions per 100,000 population age 12 and older from 2001 to 2005. —**Leigh Henderson***

BROWARD COUNTY, FL: *Excluding alcohol, admissions for primary abuse of benzodiazepines accounted for 2.3 percent of clients (n=57) at Broward Addiction Recovery Center (BARC) programs in the first half of 2006. In the first half of 2006, there were 440 primary, secondary, or tertiary mentions of benzodiazepines, accounting for 8.3 percent of total mentions, excluding alcohol. —**James Hall***

MAINE: *In 2006, 1 percent of treatment admissions, excluding alcohol, were for primary abuse of benzodiazepines. Thirty-five percent were female, and 85 percent were equally divided between the 25–34 and 35-and-older age groups. —**Marcella Sorg***

PHILADELPHIA: *In the first half of 2006, benzodiazepines accounted for 2 percent of the mentions among treatment admissions and ranked fifth among drug mentions. —**Samuel Cutler***

DAWN ED Data on Benzodiazepines

In the 13 CEWG areas participating in DAWN in the first half of 2006, benzodiazepines accounted for a substantial percentage of "other substances" reports. Exhibit 22a presents the total unweighted numbers of "other substances" and the percentages that benzodiazepines represented in that total in each CEWG area in the first half of 2006. As shown, the proportions of (unweighted) benzodiazepines as a percentage of the total "other substances" reports varied by CEWG area. These reports accounted for approximately 30–37 percent of the other substances reports in Houston, Miami-Dade, and Ft. Lauderdale, and for between 13 and 24 percent in the other 10 CEWG areas.

Exhibit 22a. Number of ED Reports for "Other Substances" and the Percentage of Benzodiazepines Reports Among the Total "Other Substances" Reports in 13 CEWG Areas (Unweighted[1]): January–June 2006

CEWG Area	Total Other Substances[2]	Percent Benzodiazepine
Boston	4,583	23.8
Chicago	3,533	17.2
Denver	1,734	16.4
Detroit	4,176	17.7
Ft. Lauderdale	2,627	37.1
Houston	3,001	30.0
Miami-Dade	1,342	34.2
Mpls./St. Paul	2,874	13.5
New York City	5,609	17.5
Phoenix	3,414	17.9
San Diego	1,781	18.7
San Francisco	1,278	16.8
Seattle	4,219	17.0

[1]All DAWN cases are reviewed for quality control and, based on review, may be corrected or deleted. Therefore, these data are subject to change.
[2]Includes prescription drugs (benzodiazepines, opiates/opioids, muscle relaxants), over-the-counter drugs, and dietary supplements; case types include "Seeing Detox," "Overmedication," and "Other."
SOURCE: DAWN *Live!,* OAS, SAMHSA, updated 11/17–11/20, 2006

In all 13 CEWG areas reporting to DAWN, substantial percentages of the unweighted benzodiazepine reports were overmedication cases (*see exhibit 22b*). In Phoenix, nearly 51 percent of the benzodiazepine reports were for overmedication, as were approximately 44 and 45 percent of those in San Diego and San Francisco, respectively, and 30–37 percent of those in Chicago, Detroit, and Denver.

Exhibit 22b. Number of ED Reports for Benzodiazepines (B) and Percent for Overmedication in 13 CEWG Areas (Unweighted[1]): January–June 2006

CEWG Area	Number B Reports[2]	Percent Overmedication
Boston	1,089	25.3
Chicago	609	30.4
Denver	284	37.0
Detroit	739	34.4
Ft. Lauderdale	975	18.0
Houston	900	20.8
Miami-Dade	459	26.6
Mpls./St. Paul	388	26.3
New York City	981	16.1
Phoenix	611	50.7
San Diego	333	43.8
San Francisco	215	44.7
Seattle	716	24.2

[1]All DAWN cases are reviewed for quality control and, based on review, may be corrected or deleted. Therefore, these data are subject to change.
[2]Includes "Overmedication," "Seeking Detox," and "Other."
SOURCE: DAWN *Live!,* OAS, SAMHSA, updated 11/17–11/20, 2006

Mortality Data on Benzodiazepines

Eight CEWG representatives reported on deaths with the presence of benzodiazepines (or alprazolam or diazepam) in their local and/or State areas. The Honolulu medical examiner did not report any benzodiazepine-related deaths in the first half of 2006. Among the other seven areas, Arizona reported 2004 mortality data. The Georgia data are for FY 2006; data from all other areas are for the first half of 2006.

- Arizona—34 benzodiazepine-involved deaths

- Broward County, Florida
  - 128 alprazolam-related deaths; 51 were alprazolam induced, and only 3 involved alprazolam alone
  - 76 diazepam-related deaths; 21 were diazepam induced, and 61 involved at least 1 other drug

- Florida—2,080 benzodiazepine-involved deaths
  - 1,057 alprazolam-related deaths
  - 608 diazepam-related deaths

- Georgia—257 alprazolam-related deaths

- Miami-Dade County
  - 41 alprazolam-related deaths; 10 were alprazolam induced, and 33 involved at least 1 other drug
  - 11 diazepam-related deaths; 1 was caused by the drug, and 9 involved at least 1 other drug

- Philadelphia
  - 77 detections of diazepam, making it the 4th most frequently detected drug since 1994
  - 68 detections of alprazolam, making it the 11th most frequently detected drug since 1994

- Seattle/King County—44 benzodiazepine-involved deaths

NFLIS Data on Benzodiazepines

Three benzodiazepine-type drugs were the most frequently reported by forensic labs in FY 2006—alprazolam, diazepam, and

clonazepam. The numbers are presented for each of these drugs by CEWG area in exhibit 23.

Exhibit 23. Number of Selected Benzodiazepine Items Reported by Forensic Labs in 21 CEWG Areas: FY 2006

CEWG Area	Alprazolam (Xanax)	Diazepam (Valium)	Clonazepam (Clonopin, Rivotril)
Atlanta	424	54	58
Baltimore	255	43	188
Boston	57	15	61
Chicago	63	25	20
Cincinnati	95	90	62
Denver	24	23	19
Detroit	–	–	–
Ft. Lauderdale	574	NR[1]	26
Honolulu	16	7	3
Los Angeles	120	116	82
Miami	295	10	15
Mpls./St. Paul	17	23	24
New York City	759	77	155
Philadelphia	910	86	151
Phoenix	11	21	18
St. Louis	32	20	6
San Diego	72	100	73
San Francisco	19	44	83
Seattle	8	17	13
Wash., DC	41	15	30
Texas	2,432	341	466

[1]NR=Not reported.
SOURCE: NFLIS, DEA

Alprazolam. In FY 2006, alprazolam items were reported from all CEWG areas except Detroit. Alprazolam items accounted for 6.5 percent of the total drug items in Ft. Lauderdale, 3.3 percent of all drug items in Philadelphia, 2.5 percent in Atlanta, and for 1.6 percent of the drug items in both Miami and New York City. Alprazolam items represented 4.4 percent of the top 25 drug items analyzed across Texas sites. In the other 15 CEWG areas, alprazolam accounted for less than 1 percent of the drug items reported.

Clonazepam. In FY 2006, clonazepam items were analyzed by forensic laboratories in 19 CEWG areas, including Texas. In all these areas, clonazepam items represented less than 1 percent of the total drug items.

Diazepam. Diazepam items were reported across 18 metropolitan CEWG areas and Texas in FY 2006. In all 19 areas, diazepam items accounted for less than 1 percent of the total drug items.

Trends in Drug Use and Overdose Death in Albuquerque and New Mexico

Nina Shah, M.S., *Dan Green, M.S.,* and *Brian Woods, B.S.*

ABSTRACT

Heroin is the most significant drug threat in New Mexico in terms of abuse. In 2005, heroin caused the most unintentional overdose deaths, followed by prescription opioids, cocaine, and drug/alcohol combinations. Heroin, cocaine, and methamphetamine overdose deaths increased roughly 40, 20, and 50 percent, respectively, from 2004 to 2005. The heroin and cocaine overdose death rates are highest among Hispanics in New Mexico, yet prescription opioid overdose deaths have sharply increased among Whites (non-Hispanic) in the past few years. Consequently, racial disparity for total drug overdose deaths is diminishing. Compared with the rest of the State, decedents residing in Albuquerque (Bernalillo County) were more likely to die from heroin (rate ratio [RR]=2.5), cocaine (RR=2.2), methadone (RR=2.6), and drug/alcohol combination overdose (RR=2.2) during 2003–2005. The burden from methamphetamine abuse is highest in the southeast and northwest regions of the State, according to indicator data from the medical examiner, HIDTA arrests, NFLIS analyses, and children in protective custody because of methamphetamine exposure; resources to combat methamphetamine abuse are targeted to these localized areas and Albuquerque. The number of methamphetamine lab incidents appears to be declining, and most methamphetamine seized in 2006 was produced in Mexico. This Mexican methamphetamine is highly pure and inexpensive. Law enforcement intelligence suggests that drug traffickers make use of the vast geography of New Mexico tribal lands for transit and refuge. Items collected and analyzed by Albuquerque forensic labs were largely cocaine (37 percent) and marijuana (34 percent). Since heroin-using networks are often familial and relatively immobile, rates of HIV infection remain low among IDUs. From January 2004 through March 2005, treatment for heroin abuse accounted for one-fifth (20.1 percent) of the 1,539 admissions for illicit drugs (excluding alcohol) in Albuquerque, while cocaine abuse accounted for 15.3 percent. (Note, however, that a large proportion of admissions was missing data for the primary drug of abuse: 37.2 percent, n=573.) Of patients admitted because of heroin abuse, 24.5 percent were White (non-Hispanic) and 59.3 percent were Hispanic; in contrast, 54.5 percent of patients admitted for methamphetamine abuse were White and 32.4 percent were Hispanic. Males were treated more often for heroin abuse than females (22.7 vs. 17.4 percent), though females were treated more often than males for abuse of cocaine/crack (17.3 vs. 13.3 percent) and methamphetamine (11.6 vs.7.4 percent). The preferred route of administration for heroin was injection (89 percent), while 65 percent of patients treated for cocaine/crack abuse preferred smoking. There was an increasing trend in the proportion of methamphetamine patients who reported smoking the drug (from 18 percent in 2001 to 47 percent during January 2004–March 2005). Marijuana is the most widely available and commonly used illicit drug in New Mexico, especially among teenagers. Data from the 2005 New Mexico Youth Risk and Resiliency Survey showed that high school students in the Albuquerque area compared with students nationally were considerably more likely to report use of marijuana (30.5 vs. 20.2 percent) and cocaine (9.4 vs.3.4 percent) in the past month, as well as ever injecting an illicit drug (5.5 vs. 2.1 percent). Four percent of the Albuquerque area students reported current (past-month) heroin use; 5.7 percent reported current methamphetamine use; and 8.0 percent reported inhalant use in the month prior to survey. Drug use prevalence among the Albuquerque area students was similar to high school students in New Mexico overall.

Patterns and Trends of Drug Use in Atlanta

Brian Dew, Ph.D.

ABSTRACT

Cocaine, marijuana, methamphetamine, and heroin are the dominant drugs of abuse in the metropolitan Atlanta area. Cocaine remains Atlanta's primary drug concern. Cocaine was the most mentioned drug among treatment admissions, drug abuse deaths, and NFLIS drug seizure data. However, the proportion of cocaine-related treatment admissions continued a 6-year decline (from 59 percent in 2000 to 34.2 percent in the first half of 2006). Atlanta's cocaine users were most likely to be African-American, male, and older than 35. Nearly 8 out of 10 of all cocaine users who entered treatment preferred to smoke the drug. Marijuana remains the most commonly used substance in Atlanta. Ethnographic reports suggest that marijuana is easily available, and price levels for the drug have remained stable. Indicators are mixed with regard to methamphetamine. For the first time in more than 10 years, methamphetamine-related treatment admissions decreased—from 11.4 percent in 2005 to 7.7 percent in the first half of 2006. Methamphetamine-related NFLIS drug seizure data for FY 2006 remained stable, while local law enforcement officials indicated increased use of methamphetamine in suburban Atlanta. The increased availability of and reduced cost for crystal methamphetamine led to an 11-percent increase (from FY 2005 to the first half of 2006) in treatment admissions who preferred to smoke the drug. The proportion of female to male methamphetamine users seeking treatment widened in the past 6 months, both in metropolitan Atlanta and in rural areas of the State. Although White users most frequently used methamphetamine, indicators suggest a growing level of methamphetamine use occurred among African-Americans. Heroin indicators continued to show decreasing levels of use, with the majority of users concentrated in Atlanta's Bluff district. Rates of injecting South American heroin remained stable, although reports indicated a decrease in purity levels and an increase in price. Prescription benzodiazepines are second only to cocaine in the number of substance-related deaths across Georgia. Excluding alcohol, narcotic analgesics accounted for nearly one-half of drug-related deaths in FY 2006. Multiple indicators show that hydrocodone is the most commonly abused narcotic analgesic in Atlanta, followed by oxycodone.

Drug Use in the Baltimore Metropolitan Area: Epidemiology and Trends, 2002–2006 (First Half)

Leigh A. Henderson, Ph.D., and *Doren H. Walker, M.S.*

ABSTRACT

Heroin remained the most significant substance of abuse among drug-related treatment admissions in Baltimore in the first half of 2006 and was responsible for 47 percent of admissions. Heroin use in the Baltimore metropolitan area is complex. There were several groups of heroin users differing by urbanicity, route of administration, age, and race. Baltimore had a core of older African-American heroin users in the first half of 2006, both intranasal users and injectors (39 and 21 percent of all heroin treatment admissions, respectively; median ages 40 and 44, respectively). As a group, White users entering treatment for heroin abuse in the first half of 2006 were younger than African-American users and were predominantly injectors rather than intranasal users (27 and 9 percent of all heroin treatment admissions, respectively; median ages 29 and 32, respectively). The cocaine situation is complicated by the fact that for every treatment admission reporting primary cocaine use, 2.4 reported secondary use. In the first half of 2006, primary cocaine use was reported by 15 percent of treatment admissions; secondary cocaine use was reported by 35 percent. Cocaine smoking was the most prevalent route of administration among both primary and secondary users. Cocaine smoking and intranasal use were associated with intranasal heroin use in 34 percent of those who smoked cocaine or used it intranasally. Cocaine injection was associated with heroin injection in 89 percent of all admissions who injected cocaine. Cocaine users younger than age 35 tended to be White, while those older than 35 tended to be African-American. Marijuana was reported more frequently as a secondary substance by treatment admissions in the first half of 2006 (19 percent) than as a primary substance (15 percent). More than one-half (57 percent) of the primary marijuana admissions reported the use of other substances, primarily alcohol (48 percent), although 10 percent reported cocaine. Some 38 percent were younger than 18, and 81 percent were male. Criminal justice referrals continued to constitute the majority of marijuana treatment admissions—65 percent in the first half of 2006. Opiates and narcotics other than heroin continued to increase as primary substances among treatment admissions. In the first half of 2006, treatment admissions for primary opiate use were 83 percent White; slightly more than one-half were male; these admissions had a median age of 35; and they reported a wide range of secondary substances. Tranquilizer use secondary to primary opiate use was reported by 14 percent of primary opiate treatment admissions. Similar numbers of treatment admissions reported primary and secondary opiate use. Secondary users were demographically similar to primary users—81 percent White and 55 percent male. Most reported opiate abuse secondary to heroin injection (33 percent) or intranasal heroin use (21 percent). Stimulants other than cocaine were rarely mentioned as the primary substance of abuse by treatment admissions.

Greater Boston Patterns and Trends in Drug Abuse—January 2007

Daniel P. Dooley

ABSTRACT

Cocaine indicators for Boston are stable at high levels. Twenty-six percent of all treatment admissions indicated past-month cocaine use. The number of treatment admissions with past-month cocaine (including crack) use did not change from FY 2005 to FY 2006. Similarly, the number of cocaine calls to the Helpline remained stable from 2005 to 2006. Though the number of cocaine drug arrests (Class B) and drug lab samples increased, the proportion of cocaine drug arrests and drug lab samples remained stable from 2004 to 2005. Heroin abuse remains stable at very high levels in Boston. One-half of all treatment admissions identified heroin as the client's primary drug. The proportion of heroin treatment admissions did not change from FY 2005 to FY 2006. The proportion of heroin calls to the substance abuse Helpline did not change from 2005 to 2006. Though levels of heroin drug arrests (Class A) and drug lab samples decreased from 2004 to 2005, analysis of data for the first half of 2006 suggests that these levels may have stabilized. Street-level heroin purchases by the Domestic Monitor Program (DEA) reveal stable price and purity from 2004 to 2005. The 2005 purchase prices averaged $0.88 per milligram pure, with an average purity level of 28 percent. Indicators for other opiates are mixed at historically high levels. The number and proportion of other opiate treatment admissions increased from FY 2005 to FY 2006. Helpline calls for opiates decreased slightly in 2006. The number of oxycodone drug lab samples increased from 2004 to 2005, but the estimate for 2006 based on data for the first half of the year is similar to 2004 and previous years. The methamphetamine abuse level remains very small according to available indicators. Accounting for less than 1 percent of all treatment admissions, the number of primary admissions for methamphetamine decreased from 75 in FY 2005 to 31 in FY 2006. Methamphetamine drug lab samples increased from 17 in 2004 to 55 in 2005 and appear stable through the first half of 2006. Recent marijuana indicators are mixed. Treatment admissions for marijuana have steadily decreased in number and as a proportion of all admissions during the past 7 years. The number of marijuana Helpline calls was unchanged from 2005 to 2006. Marijuana drug arrests (Class D) and lab samples increased in 2005. Benzodiazepine misuse and abuse levels remain fairly stable at relatively high levels. In 2005, there were 254 adult HIV/AIDS cases diagnosed in Boston. Primary transmission risk factor of these cases included 10 percent who were IDUs, 2 percent who had sex with IDUs, and 31 percent with an unknown/ undetermined risk factor.

Patterns and Trends of Drug Abuse in Chicago

Lawrence Ouellet, Ph.D., Dita Broz, M.P.H., and *Wayne Wiebel, Ph.D.*

ABSTRACT

Recent increases in deaths related to fentanyl-laced heroin highlight a growing opiate abuse problem in the Chicago area. Between May 2005 and December 2006, the Cook County Medical Examiner reported 313 deaths linked to fentanyl, with the highest numbers reported in May and June 2006 (47 deaths in each month). The Chicago division of the ISP forensic laboratory reported a significant increase in the number of drug samples positive for fentanyl during the same period. In 2006, the ISP identified fentanyl in 1,330 drug samples from metropolitan Chicago, compared with 22 samples in 2005, 3 in 2004, and 1 in 2003. Heroin is the major opiate abused in this region, and many heroin use indicators have been increasing or at already elevated levels since the mid-1990s. Drug treatment services for heroin use, which surpassed those for cocaine in FY 2001, have since nearly doubled to 33,662 episodes in FY 2005. According to preliminary unweighted data from DAWN Live!, heroin was the second most commonly reported illicit substance in emergency departments during the first 6 months of 2006. DMP data indicate heroin purity decreased in Chicago between 2000 and 2005. Availability of a high potency opiate, such as fentanyl, may be appealing to some heroin users. Epidemiological indicators continue to show that cocaine and marijuana are among the most commonly used illicit substances in Chicago. Cocaine was the second most frequently reported reason for entering publicly funded treatment programs in FY 2005, and this trend was stable over the prior 5 years. Reported marijuana-related treatment services continued to increase in Chicago, though less rapidly than in the rest of the State. According to preliminary unweighted data from DAWN Live!, cocaine and marijuana were among the top three illicit drugs most often reported in emergency departments during the first 6 months of 2006. Cocaine and marijuana, followed by heroin, were the substances most frequently seized by law enforcement in FY 2006; together, the three accounted for 978 percent of all items seized. Most MDMA indicators were stable at low levels; however, ethnographic and survey reports suggest an increased trend in use among young African-Americans. Methamphetamine indicators continued to show low but perhaps increasing levels of use in some areas of Chicago, especially on the north side, where young gay men and clubgoers congregate.

Drug Abuse Patterns and Trends in Cincinnati (Hamilton County)

Jan Scaglione, B.S., M.T. PharmD, DABAT

ABSTRACT

The reader should be aware of the following: in October 2006, the Alcohol and Drug Addiction Services Board merged with the Mental Health and Recovery Services Board in Hamilton County, Ohio. After the merger, treatment data for FY 2006 could not be located. Recovered treatment data presented here are estimated to represent between 65 and 75 percent of the total treatment services provided during FY 2006. The recovered data are expected to closely reflect the overall percentage of total treatment services provided to residents of Hamilton County. Drug abuse indicators continue to show cocaine/crack cocaine at high levels throughout Cincinnati. Twenty-six percent of the known public treatment admissions for FY 2006 included primary cocaine use. Cocaine submissions recorded by the National Forensic Laboratory Information System (NFLIS) accounted for 48 percent of the total items reported, and cocaine represented 36 percent of those drug items recorded by the Hamilton County Coroner's Office Laboratory. The average purity of cocaine items submitted to the Drug Enforcement Administration (DEA) laboratory for analysis was 80 percent. Hamilton County law enforcement seizures of powder cocaine for the first 11 months of 2006 were twice that of the first 11 months of the previous year. Cocaine was detected in 49 decedents, ranking it second only to alcohol-related deaths during the first 6 months of 2006. Intentional exposure cases in which cocaine was recorded as an involved substance in poison control center data doubled from 2005 through 2006. Marijuana indicators also remained at a high level, accounting for 19 percent of all treatment admissions (27 percent excluding alcohol) during FY 2006. Marijuana submissions reported to NFLIS accounted for 39 percent of the total submissions, and 46 percent of drug items submitted to the Hamilton County Coroner Laboratory were marijuana. Indicators for heroin use showed the drug accounted for nearly 17 percent of publicly funded treatment admissions for illicit drugs and for 4–5 percent of law enforcement drug seizures. Methamphetamine abuse stabilized across the State of Ohio, accounting for very few treatment admissions. Prescription opioids and benzodiazepines remained a problem across the area. Epidemiologic indicators for MDMA indicated limited use across the Cincinnati region during 2006.

Patterns and Trends in Drug Abuse in Denver and Colorado: January–June 2006

Tamara Hoxworth, Ph.D.

ABSTRACT

Excluding alcohol, marijuana abuse has continued to result in the highest number of treatment admissions annually since 1997; marijuana treatment admissions have remained fairly stable over the last 3 years. In the first half of 2006, cocaine ranked third in treatment admissions, but the drug accounted for the highest illicit drug rate per 100,000 persons for hospital discharges from 1996 through 2005 and for the highest number of illicit unweighted drug ED reports in the first half of 2006. Cocaine also accounted for the highest drug-related mortality rates from 1996 through 2002; it was surpassed in 2003 by all opiates including heroin and in 2004 and 2005 by opiates other than heroin. Cocaine had the highest number of illicit drug-related calls to the Rocky Mountain Poison & Drug Center from 2001 through 2003 in the Denver area, but was surpassed by methamphetamine in 2004 and 2005. However, in the first half of 2006, there were significantly more poison calls for cocaine than for methamphetamine (67 vs. 17, respectively). Methamphetamine has exceeded cocaine in statewide treatment admissions statewide since 2003, and in Denver/Boulder treatment admissions since 2005. However, the first decline in several years for methamphetamine admissions and poison calls occurred in the first half of 2006. Clandestine laboratory closures have decreased steadily since 2003, but the amount of methamphetamine seized increased through 2005, most likely because an estimated 80 percent of Colorado's methamphetamine comes from outside the State, predominantly Mexico. Moreover, drug enforcement officials have reported increased purity levels of methamphetamine seized in Colorado. Many heroin abuse indicators decreased over the last several years, while poison calls remained stable. In 2003 through 2005, opiate-related drug misuse mortalities exceeded those that were cocaine related. Beyond abuse of illicit drugs, alcohol remained Colorado's most frequently abused substance and accounted for the most treatment admissions, unweighted emergency department reports, poison center calls, drug-related hospital discharges, and drug-related mortality.

Drug Abuse in Detroit, Wayne County, and Michigan

Cynthia L. Arfken, Ph.D.

ABSTRACT

Cocaine and heroin are the two major drugs of abuse in the area, but marijuana is the most widespread. Cocaine treatment admissions increased from FY 2005 to FY 2006, when they accounted for 41 percent of primary illicit drug admissions (excluding alcohol); 95 percent of these admissions were for crack cocaine. Of the cocaine/crack admissions, 59 percent were male, 93 percent were African-American, and 85 percent were older than 35. Cocaine accounted for 51 percent of the unweighted ED illicit drug reports (excluding alcohol) in the first half of 2006 and for 46 percent of the drug items reported by NFLIS in FY 2006. From January through September 2006, the medical examiner (ME) reported 320 deaths involving cocaine, the highest number for all drugs reported in that time period. In FY 2006, heroin treatment admissions declined to represent 38 percent of the primary illicit drug admissions; 59 percent were male, 90 percent were African-American, and 93 percent were older than 35. Heroin accounted for 25 percent of the illicit drug ED reports in the first half of 2005, and 185 deaths involving heroin were reported by the ME in the first 9 months of 2006. The number of heroin items reviewed by forensic laboratories increased; 21 percent of the items analyzed in FY 2006 contained heroin. This increase may be related to fentanyl surveillance; it also followed an increase in heroin purity and a drop in price in 2005, as documented by the Domestic Monitor Program. Opiates other than heroin accounted for 1.6 percent of primary illicit drug admissions in FY 2006. In the unweighted DAWN Live! data for the first half of 2006, there were 1,348 opiates/opioids reports for the metropolitan area; 27.0 percent were hydrocodone reports, 11.7 percent were methadone reports, 8.6 percent were oxycodone reports, and 4.5 percent were fentanyl reports (the remainder were 'unspecified'). In the first 9 months of 2006, the ME reported 176 deaths with the presence of fentanyl, 138 involving hydrocodone, and 77 involving methadone. The deaths involving fentanyl increased more than 272 percent from 2005. The lethal combination of heroin or cocaine and fentanyl, which appeared in Detroit and northern Michigan during the second half of 2005, continues to kill people with no sign of disappearing. Outreach efforts were implemented to disseminate information to at-risk people on the streets about this new threat, and efforts are underway to implement an overdose prevention approach to fentanyl and fentnayl mixtures. Treatment admissions for marijuana increased steadily since 2003, accounting for 19 percent of the primary illicit drug admissions in FY 2006. Of these admissions, 73 percent were male, 94 percent were African-American, and 54 percent were younger than 26. Marijuana represented one-fifth of the unweighted ED reports for illicit drugs in the first half of 2006 and 23 percent of the drug items reported by NFLIS in FY 2006. The indicators for methamphetamine remained low. Ecstasy use is still troublesome, as evidenced by treatment admissions and ME reports

Illicit Drug Use in Honolulu and the State of Hawaii

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

ABSTRACT

During the first half of 2006, methamphetamine continued to dominate the drug abuse scene in Honolulu and the State. While there were slight declines in some methamphetamine abuse indicators, primary methamphetamine admissions continued to account for more than 55 percent of all illicit drug admissions (excluding alcohol), and 57 percent of the drug items reported by NFLIS in FY 2006 contained methamphetamine. In the first half of 2006, the Honolulu medical examiner reported 22 deaths with the presence of methamphetamine, and the Honolulu Police Department (HPD) reported 390 arrest cases involving the drug. According to the 2007 HIDTA Threat Assessment report, law enforcement pressures related to methamphetamine increased in 2006. Asian drug trafficking organizations (DTOs) and criminal groups (including those of Cambodian, Chinese, East Indian, Filipino, Japanese, Korean, Laotian, Thai, and Vietnamese descent) transport and distribute wholesale quantities of ice and power methamphetamine (as well as marijuana, MDMA, and other drugs). In 2005, 12 percent of the methamphetamine samples studied tested positive for Asian manufacture. However, the majority of crystal methamphetamine (and cocaine and heroin) is still supplied from the U.S. west coast and Mexican DTOs. Marijuana abuse indicators remained stable and at high levels. Treatment admissions for primary marijuana abuse were relatively stable, at 29 percent of all illicit admissions in the first half of 2006. Approximately 20 percent of the items tested by forensic labs in FY 2006 were positive for marijuana. Seizures of marijuana plants decreased 29 percent from 6,814 in the second half of 2005 to 4,786 in the first half of 2006; however, the weight of the seizures increased from 81,966 grams in the first half of 2005 to 88,244 grams in the first half of 2006. Cocaine abuse indicators increased during this reporting period. There were 50 percent more decedents with positive cocaine toxicology screens, 50 percent more cocaine arrest cases reported by the HPD, and a 10-percent increase in primary cocaine admissions. Cocaine accounted for approximately 16 percent of the items reported by NFLIS in FY 2006. Heroin abuse indicators remained relatively low and stable. Heroin accounted for less than 4 percent of all illicit treatment admissions and for less than 2 percent of the NFLIS items. Three decedents were positive for heroin, and there were six heroin arrest cases in the first half of 2006. However, in the first half of 2006, there was an increase in positive decedent presence of opiates other than heroin (10 involving methadone and 12 involving other opiates in the first half of 2006).

Patterns and Trends in Drug Abuse in Los Angeles County, California: A Semi-Annual Update

Alison Hamilton, Ph.D. and *Beth Rutkowski, M.P.H.*

ABSTRACT

Along with the rest of California, Los Angeles treatment data are unavailable at this time because of a shift to a new data management system. Cocaine and methamphetamine together accounted for 66 percent of all Los Angeles-based illicit drug items analyzed and recorded by the NFLIS from October 2005 through September 2006; analgesics and benzodiazepines accounted for 71 percent of pharmaceutical/non-controlled drug items. Drug prices and purities were relatively stable from 2005 through the first half of 2006. Los Angeles was just above (8.2 percent) the national average (8.1 percent) of past-month illicit drug use, according to a recent National Survey on Drug Use and Health report about substance use in the 15 largest metropolitan statistical areas. The rates of past-month binge drinking and cigarette use were both lower in Los Angeles than the national average. Weighted adolescent substance use data collected in the Youth Behavior Risk Surveillance Survey (2005) illustrated that past-month usage percentages among Los Angeles County secondary school students decreased or remained stable between the survey periods of 2001, 2003, and 2005, and the number of those initiating drug behavior before age 13 decreased (for alcohol and cigarettes) or remained stable (for marijuana). In the 2005 survey, approximately 40.0 percent of females and males reported lifetime use of marijuana, followed by inhalant use for 14.5 percent of males and 21.5 percent of females. More females (13.2 percent) than males (6.9 percent) reported lifetime cocaine use, and slightly more females (10.9 percent) than males (9.5 percent) reported lifetime methamphetamine use. Mexican black tar heroin continues to be the heroin of choice in Los Angeles, though there has been a 0.3 percentage point decline in average purity and a $0.10 increase in price per milligram pure. Heroin-related deaths appear to have increased by approximately 75 percent from 2002 to 2005, and this jump in deaths was most prevalent among users older than 40. Both indoor and outdoor production of marijuana in California far exceeds production in any other State, with California producing 8,622,831 pounds, and the next highest producing State, Tennessee, producing 2,980,853 pounds. Methamphetamine continues to dominate the treatment system. Findings from the Los Angeles County Evaluation System indicate that participants in this evaluation admitted for primary methamphetamine use increased from 19.0 percent in 2001 to 36.4 percent in 2005. Females were more likely to report primary methamphetamine use than males over the entire 5 years of the evaluation, and the proportion of 18–25-year-olds reporting primary methamphetamine use increased from 31.3 percent to 52.8 percent. The percentage of Asians, Latinos, Native Americans, and Whites entering county-funded treatment for primary methamphetamine use increased from 29.3 percent in 2001 to 49.0 percent in 2005. However, during this period, only 3.3 percent of African-American participants entered treatment for primary methamphetamine use. The Los Angeles HIDTA region (comprised of Los Angeles, Orange, Riverside, and San Bernardino Counties) accounted for 31 percent of the 227 clandestine methamphetamine laboratory incidents in California in the first half of 2006. California had the 5th highest number of laboratory seizures in the United States in the first half of 2006 and remains the home of the domestic methamphetamine 'superlab.' Eighty-six percent of the 14 superlabs seized throughout the United States from January to June 2006 were located in California; of those, 25 percent were located in LA HIDTA counties. There is growing concern about the abuse of dextromethorphan among adolescents, according to a recent study of poison control exposure cases in California. There were dramatic increases in the sales of methadone, fentanyl, and Adderall to hospitals and pharmacies in Los Angeles County between 2001 and 2005. Regarding AIDS cases diagnosed in 2005 in Los Angeles County, 62 percent of males were infected through sexual contact with another male, and 6 percent were infected through sexual contact with an intravenous drug user. Forty percent of females were infected through heterosexual contact, and 17 percent were infected through sexual contact with an IDU.

Maine Trends and Drug Abuse Patterns: January 2007

Marcella H. Sorg, RN, Ph.D., D-ABFA

ABSTRACT

Overall, Maine continues to experience serious problems with prescription drugs, primarily narcotics. Methadone exceeds all other narcotics in mortality. Trafficking in pharmaceuticals across the U.S.-Canadian border is significant. The proportion of cocaine and methamphetamine arrests rose in 2006, although the number of labs seized was stable. Buprenorphine diversion is now reported ethnographically and was the reason for 15 percent of narcotics-related poison control exposure/abuse calls in the first three quarters of 2006. Cocaine indicators for Maine are mixed. Use in the past 30 days reported by Maine youth in grades 6–12 in 2006 was stable or had slightly decreased for students in most grades compared with that reported 2004. Eight percent of Maine 12th graders reported any lifetime use in 2006. Fourteen percent of 2006 drug treatment admissions, excluding alcohol, involved a primary problem with cocaine/crack; the proportion and number have risen steadily each year since 2000. The proportion of cocaine/crack arrests by the Maine Drug Enforcement Agency (MDEA) rose from 39 percent in 2005 to 44 percent 2006. Most arrests involved powder cocaine; however, crack arrests rose from 2005 to 2006, while powder arrests declined. Cocaine-induced deaths were level from 2004 to 2005, and 2006 projected totals appear stable. Poison control cocaine abuse/exposure calls decreased 25 percent from 2004 to 2005, and 2006 projections show a further decrease. Heroin indicators are stable or decreasing. Heroin use reported by Maine youth decreased slightly between 2004 and 2006. Primary heroin/morphine admissions were relatively stable from 2005 to 2006; however, new admissions dropped 20 percent. Heroin/morphine-induced deaths doubled from 2004 to 2005, but the increase appears to be related to pharmaceutical morphine; the projected 2006 total appears level with 2005. Poison control heroin abuse/exposure calls, level from 2003 to 2005, dropped during the first 3 quarters of 2006. Heroin arrests by the MDEA were also stable from 2004 to 2005 but dropped sharply from 13 percent in 2005 to 3 percent in 2006. NDIC reports 2006 Maine heroin prices at $250–$350 per gram in Portland and $75–$100 per gram further north in Lewiston. Pharmaceutical narcotics continue to play a primary role in drug misuse/abuse and trafficking in Maine. Students in grades 6–12 reported less misuse of pharmaceuticals in 2006, down slightly from 2004. However, primary pharmaceutical narcotic treatment admissions in 2006 increased 9 percent over 2005 and constituted 42 percent of 2006 drug admissions; 14 percent of these were first admissions. Oxycodone primary admissions dominated the 2006 narcotic distribution at 31 percent of all drug admissions in 2006; additionally, 41 percent of heroin admissions report oxycodone as a secondary or tertiary problem. Methadone has caused more deaths than any other drug (38 percent of the 2005 drug deaths), with the majority involving tablets; the rate appears to have stabilized in 2006 projections. Similarly, poison control calls involving abuse/exposure to methadone constituted the largest proportion of all 2005 narcotics-related calls (26 percent), followed closely by hydrocodone and oxycodone (both 20 percent). Maine's prescription monitoring program, used to identify and deter prescription drug diversion and misuse, reports that hydrocodone/acetaminophen is the most commonly identified controlled substance prescription (21 percent), followed by oxycodone preparations (11 percent) and lorazepam (8 percent). The proportion of MDEA arrests involving prescription drugs was 27 percent in 2005 and 25 percent in 2006, second only to crack/cocaine. Methamphetamine indicators are low but continue to rise. MDEA arrests increased sharply from 1 percent in 2005 to 7 percent in 2006. Lab seizures stayed level during Maine's first full year with over-the-counter pseudoephedrine controls. Poison control abuse/exposure calls involving metham-phetamine are low, but they nearly tripled between 2005 and 2006. Primary admissions for methamphetamine abuse remained low and stable from 2005 to 2006, at 0.9 percent. Marijuana indicators are down. Maine youth reported less marijuana use in 2006 than previously. Primary admissions for marijuana abuse dropped from 26 percent in 2005 to 22 percent in 2006. The proportion of MDEA arrests for marijuana increased slightly from 17 percent in 2005 to 20 percent in 2006, but they decreased in number.

Drug Abuse in Miami/Ft. Lauderdale, Florida: January–June 2006

James N. Hall

ABSTRACT

Drug-related deaths declined across Florida in the first half of 2006 compared with the previous 6 months for prescription medications and most illicit drugs. The exceptions were methamphetamine and MDMA; drug-related deaths for these substances increased. Miami-Dade County reported fewer deaths from all illicit drugs and medications in the first 6 months of 2006 compared with 2005. In Broward County, only heroin-related deaths increased. Cocaine was responsible for the highest number of drug consequences in Miami-Dade County. Deaths related to the nonmedical use of prescription drugs dominated fatalities in Broward County. While the population of Miami-Dade County exceeds that of Broward County by 1 million people, the numbers of deaths, emergency department reports, and crime lab items related to the nonmedical use of prescription drugs in Broward County were more than double the numbers for Miami-Dade County. Methadone leads all other opiates in drug-related deaths locally and statewide, followed by oxycodone, which is the most frequently mentioned opiate for all other indicators. Alprazolam (Xanax) is the most frequently cited benzodiazepine related to nonmedical use. Marijuana ranks second after cocaine (excluding alcohol) in unweighted emergency department reports, treatment admissions, and crime lab items. Measures of MDMA ('ecstasy') consequences and use increased slightly in the first half of 2006, reversing declining trends since 2001. GHB problems were reported at very low levels and continue to decline. Indicators of methamphetamine abuse also remain low, yet criminal cases are rising as high potency 'Mexican Ice' is being trafficked via Atlanta into Florida. Sexual activity related to methamphetamine abuse is cited by public health officials as the key factor for why Miami-Dade and Broward Counties rank first and second in the Nation in per capita rates of HIV infection. Statewide trends from the Florida Youth Survey on Substance Abuse reflect overall declines in use for all substances of abuse among middle and high school students from 2000 to 2006 but increases between 2005 and 2006.

Drug Abuse Trends in Minneapolis/St. Paul, Minnesota

Carol Falkowski

ABSTRACT

Numerous indicators of methamphetamine abuse declined in 2006, reversing previous upward trends. Collectively, these new findings demonstrate that the growth in methamphetamine abuse is slowing down, possibly reversing itself in the Twin Cities area. The number of clandestine methamphetamine labs declined statewide to 59 in 2006 (through November), compared with 112 in 2005 (full year) and 212 in 2004. Admissions to addiction treatment programs for methamphetamine also declined in 2006; they fell 37 percent from the last half of 2005 to the first half of 2006. There were 806 in 2006 (first half) (representing 8.2 percent of total treatment admissions), compared with 2,465 in 2005 (representing 12.0 percent of total treatment admissions that year). In 2006 (first half), 4.5 percent of methamphetamine treatment admissions were patients younger than 18, compared with 11.5 percent in the first half of 2005. Unweighted methamphetamine-related hospital ED episodes in the Twin Cities totaled 251 in the first half of 2006. It remains to be seen whether these findings reflect the beginning of a decline in the actual prevalence of methamphetamine abuse, especially among the younger, adolescent population group. Alcohol remained the most widely abused drug. According to a new survey of undergraduate students at the University of Minnesota, high-risk drinking, defined as consuming five or more drinks at one sitting in the past 2 weeks, was reported by roughly 42 percent of students age 18–20. Students who reported high-risk drinking were more likely than students who did not to report more negative consequences related to alcohol use, such as elevated rates of driving while intoxicated, getting in an argument, doing poorly on a test, missing a class, and being taken advantage of sexually. High-risk drinking rates were more than two times higher among tobacco users (71.6 percent) than non-tobacco users (34 percent).

Drug Abuse Patterns and Trends in New York City

Rozanne Marel, Ph.D., John Galea, M.A., and *Robinson B. Smith, M.A.*

ABSTRACT

Drug use trends in New York City were again mixed for this reporting period. Cocaine indicators continue to be stable, and cocaine remains a major problem in New York City. Primary cocaine admissions constitute one-quarter of New York City's drug and alcohol treatment admissions, and more than 56 percent of clients in treatment report cocaine as a primary, secondary, or tertiary drug. Heroin indicators were mixed for this reporting period. Heroin remains widely available. While last year there was a substantial decrease in purity and an increase in price, that trend has reversed. The purity level (49.4 percent), however, is still lower than the 60.0 percent levels that had been noted for several years. Almost all heroin in New York City is from South America, although there have been law enforcement reports of Mexican black tar heroin being seized in New York. Marijuana indicators, which had been reaching new peaks, seem to have stabilized. Marijuana continues to be of good quality and available in a wide variety of flavors and colors. Many users mix and combine drugs for simultaneous use. Although the numbers remain small, methamphetamine indicators are showing an increase in the gay community, as well as the nightclub population of New York City. Street sources report that the methamphetamine in New York City is low in quality and high in price. Many kinds of prescription drugs are increasingly popular and available on the street. Of the 96,829 New Yorkers living with HIV or AIDS, men having sex with men and injection drug use history continue to be the 2 major transmission risk factors. While the number and proportion of new HIV diagnoses attributed to injection drug use continue to decline, IDUs are more likely than other transmission categories to delay initiation of care and to die from HIV-related causes.

Drug Use in Philadelphia, Pennsylvania

Samuel J. Cutler and *Marvin F. Levine, M.S.W.*

ABSTRACT

Indicators remained mostly stable for the four major drugs of abuse—cocaine, heroin, marijuana, and alcohol. However, numerous other drugs are used that contribute to the abuse patterns in this city. Cocaine abuse, particularly in the form of crack, continued to lead the consequence data in the first half of 2006 with respect to deaths with the presence of drugs, treatment admissions, and laboratory tests performed by NFLIS. It was the second substance most frequently encountered in urine/drug screens performed by the Philadelphia Adult Probation and Parole Department (APPD). The street-level purity of heroin declined from 2000 (73 percent) through the spring of 2006 (38 percent), which appears to have caused users to seek or approximate a high through the use of increased amounts or adding other drugs to use in combination. In the first half of 2006, heroin ranked fourth among deaths with the presence of drugs and treatment admissions, third in the NFLIS, and fourth in APPD urinalysis. Deaths with the presence of oxycodone ranked seventh among all positive toxicology reports in the first half of 2006. Marijuana, which is not tested for in decedents, was the most frequently detected drug by the APPD, ranked second in the NFLIS study, and was third in treatment admissions. Alcohol in combination with other drugs ranked third in drugs detected in decedents and second in treatment admissions. Alcohol ranked seventh in APPD urinalysis results. The two most frequently abused benzodiazepines continued to be alprazolam and diazepam, although others are abused/misused. As a group, benzodiazepines were the second most frequently detected drugs in decedents in the first half of 2006 and ranked fourth in the NFLIS study. Benzodiazepines ranked sixth among drugs of abuse mentioned by clients in treatment. Methamphetamine indicators continued to be low compared with other drugs. The drug's use is largely confined to a relatively small segment of the population. The average number of drugs detected in decedents leveled off in 2005 but increased in the first half of 2006. The average increased from 1.97 per decedent in 1995 to 4.05 in the first half of 2006. Starting April 17, 2006, packets of drugs sold on the street purporting to be heroin also contained fentanyl. The authors attribute the increases in deaths and the average number of drugs per decedent to the inclusion of fentanyl in the drug packets.

Drug Abuse Patterns and Trends in Phoenix and Arizona

Ilene L. Dode, Ph.D.

ABSTRACT

Arizona has become the fastest growing State in the Nation. Non-Whites constitute 51.7 percent of the population of Phoenix. Besides being the main entry point for undocumented immigrants, Arizona is becoming the key gateway for marijuana smuggling, with 331.3 tons confiscated in FY 2006. In the first quarter of 2007, 106 tons worth $170,000,000 have been seized. The age at which most drug-overdose deaths occur has increased with the aging of the baby boomers. In 1970, the most frequent age was 22; this has progressed with each decade and, by 2004, the peak age range was the late forties. Drug-related death rates for all ages increased from 1.8 in 1985 to 5.4 in 1995 to 8.9 per 100,000 in 2004. Age-adjusted mortality rates per 100,000 population for drug-induced deaths by gender and race in 2004 differed. For males, American Indians had the highest rate of drug-related deaths (23.0 per 100,000), and for females, White non-Hispanics had the highest rate (11.1 per 100,000). Hospital discharge data continue to show that methamphetamine is the major substance of abuse in Maricopa County, while cocaine is the major substance of abuse in Tucson. Stimulants accounted for the largest proportion (34.1 percent) of the major substances of abuse (excluding alcohol) in the unweighted DAWN Live! data for the first half of 2006, with methamphetamine accounting for 25.5 percent of the reports and amphetamines for 8.7 percent. Thirty-six percent of treatment admissions in FY 2006 were for methamphetamine and other stimulants. Only alcohol admissions were greater. Needle exchange began in Pima County (Tucson) in 1996. The mean annual rate per 100,000 county population of injection drug-related annual HIV emergence pre-needle exchange in Maricopa County (Phoenix) was 6.3 per 100,000, and it was 6.4 in Pima County. The post-needle exchange mean annual rate for Maricopa County (no needle exchange) was 3.4 per 100,000, and it was 3.2 per 100,000 in Pima County.

Patterns and Trends in Drug Abuse in St. Louis

Heidi Israel, Ph.D., R.N., L.C.S.W., and *James Topolski, Ph.D.*

ABSTRACT

Recently, St. Louis has been identified as the most dangerous city in the Nation, with drug use cited as a contributing factor. Law enforcement personnel in the St. Louis area continued to devote many resources to methamphetamine, and clandestine laboratory incidents have decreased dramatically since legislation to reduce access to pseudoephedrine-based cold medications was enacted in the summer of 2005. Access to methamphetamine from Mexico and the Southwest is considered to be the major component of the methamphetamine problem in the area. Treatment admissions in the St. Louis area for methamphetamine abuse decreased 21 percent from the first half of 2005 to the first half of 2006, while statewide treatment admissions increased 4 percent over the same timeframe. The St. Louis area continues to experience a two-pronged opiate problem. A major issue was the increase in deaths related to the use of heroin and fentanyl earlier in 2006. While this issue had gained widespread media attention in the St. Louis area, more data need to be collected and analyzed to determine the extent and nature of the problem. There has been confirmation of 30 fentanyl-related deaths in the metropolitan area: 14 in the city of St. Louis and 16 in the surrounding area. Heroin activity had been increasing, but treatment admissions in the St. Louis area decreased 11 percent from the first half of 2005 to the first half of 2006 and decreased statewide over the same period by 5 percent. Reports of white heroin supplies have increased over the past years and have been supported by DEA data. The other side of the opiate problem is the abuse of narcotic analgesics. Treatment admissions for abuse of other opiates increased 19 percent from the first half of 2005 to the first half of 2006, after increasing 62 percent from 2004 to 2005 in the St. Louis area. Statewide admissions for these substances increased 28 percent over the same timeframe. Crack cocaine continued to be the major problem in the area, but most indicators have remained relatively stable. Treatment admissions were down slightly (6 percent) from the first half of 2005 to the first half of 2006 in the St. Louis area, but they were up 9 percent statewide. Marijuana indicators continue to increase, with treatment admissions increasing 11 percent in the St. Louis area and 21 percent statewide from the first half of 2005 to the first half of 2006. Anecdotal reports of the abuse of prescription medications, cough medication, and inhalants continue to be widespread.

Drug Abuse Patterns and Trends in San Diego County, California

Robin Pollini, Ph.D., and *Steffanie Strathdee, Ph.D.*

ABSTRACT

Methamphetamine is the primary illicit drug of abuse in San Diego County, leading all other drugs in most indicator categories. Methamphetamine was the primary drug of abuse for 49.2 percent of all drug treatment admissions (excluding alcohol) in San Diego County in 2005; the drug most commonly cited in unweighted DAWN ED reports involving major illicit drugs from January 1 to June 30, 2006 (32.1 percent); and the most prevalent illicit drug detected among male (44 percent) and female (51 percent) adult arrestees in 2005. The prevalence of methamphetamine use among male, female, and juvenile arrestees in San Diego has increased by 29 percent, 38 percent, and 75 percent, respectively, since 2002. Heroin was the primary drug of abuse for 23.8 percent of those admitted to treatment in 2005 and for 72.4 percent of primary injectors; however, heroin ranked behind methamphetamine and marijuana in unweighted DAWN ED reports in the major illicit drug category. Treatment admissions for primary use of 'other opiates' (e.g., hydrocodone, oxycodone) remained low at 2.2 percent, but this is the only drug category for which the overall number of treatment admissions has increased since 2002 (by 26 percent). The number of unweighted DAWN ED reports for other opiates (n=460) exceeds reports for heroin (n=371), cocaine (n=342), and marijuana (n=432). Primary treatment admissions for cocaine accounted for only 8.2 percent of treatment admissions, but there were only slightly fewer unweighted DAWN ED reports for cocaine than for heroin.

Patterns and Trends of Drug Use in the San Francisco Bay Area

John A. Newmeyer, Ph.D.

ABSTRACT

Indicators for cocaine use showed a level trend in the 2003–2006 period. Similarly, methamphetamine use indicators appear level after significant increases during the 2001–2004 period. Heroin use indicators have been consistently declining since 2000. Very little club drug use is seen. AIDS incidence has been decelerating in San Francisco for many years. However, the increase in reported AIDS cases in the year ending September 30, 2006, was more than twice as great among gay male IDUs as among the overall population (3.5 vs. 1.6 percent), indicating that the 'speed/sex' nexus continues to play a major role in residual HIV contagion. An NSDUH study found that San Francisco adults reported the highest recent use of illicit drugs (12.7 percent), but the lowest recent use of tobacco (17.9 percent), among 15 U.S. metropolitan areas. The likeliest explanation is that San Francisco has more older adults using illicit drugs (especially marijuana) than most U.S. cities; fully 84 percent of FY 2005 treatment admissions in San Francisco County were 26 or older. The NSDUH study also found that reported illicit drug use among nonmetropolitan areas of Northern California was even greater than that in the San Francisco Bay area; this suggests that an 'out-migration' of substance use patterns may have transpired.

Recent Drug Abuse Trends in the Seattle-King County Area

Caleb Banta-Green, T. Ron Jackson, Michael Hanrahan, Steve Freng, Susan Kingston, David H. Albert, Ann Forbes, Richard Harruff, and *Sara Miller*

ABSTRACT

Data for the Seattle-King County region for the first half of 2006 indicate that prescription-type opiates, heroin, cocaine, and methamphetamine are the major drugs associated with morbidity and mortality. Overall, drug-caused deaths are at the highest level in at least 10 years. A total of 150 drug-caused deaths occurred in the first half of 2006—a rate of 8.4 per 100,000 population per half-year. Prescription-type opiate-involved deaths continue to increase and remain the most common drug type identified, totaling 83 in the first half of the year. Treatment admissions for prescription-type opiates continue to increase, though the overall rate remains low. A total of 1,054 (unweighted) drug abuse/'other' case type reports for prescription-type opiates were reported by area emergency departments, similar to the 1,001 unweighted reports for heroin for all case types. The total of 38 heroin/opiate-involved deaths is down somewhat compared with recent years. Treatment admissions for heroin are relatively stable, with approximately 1 in 5 persons reporting any heroin use at treatment entry for all ages and treatment modalities. Stimulant usage remains prevalent, with cocaine morbidity and mortality unrelenting. Approximately 45 percent of persons entering treatment report using cocaine. Both the rate and number (n=54) of cocaine-involved deaths are at the highest levels seen in at least 10 years. In emergency departments, cocaine is the most commonly identified illicit drug (n=1,255 unweighted reports). Local methamphetamine manufacturing appears to be continuing its rapid descent. Methamphetamine ED reports (unweighted) totaled 794. Deaths involving methamphetamine totaled 13, similar to recent years, while treatment admissions continued to increase, with 19 percent of people admitted to treatment reporting any methamphetamine use.

Substance Abuse Trends in Texas, January 2007

Jane Carlisle Maxwell, Ph.D.

ABSTRACT

Cocaine is the primary illicit drug for which Texans enter treatment, and it is a major problem on the border with Mexico, with increased purity levels and seizures. Indicators of cocaine use remain stable or are increasing, although methamphetamine and ice are becoming more popular than cocaine in some areas. Crack cocaine admissions are more likely to be White or Hispanic. Heroin indicators are stable or dropping; addicts entering treatment are primarily injectors. Heroin purity is increasing, and 'Cheese,' a mixture of Tylenol PM and 1 percent heroin, has been reported in the Dallas schools. Hydrocodone is a larger problem than oxycodone or methadone, and fentanyl indicators are low but fluctuate from year to year. Methadone indicators are increasing. Methadone users are predominately White, and more adverse events appear to be related to methadone pain pills. Codeine cough syrup, 'Lean,' continues to be abused. Marijuana indicators are mixed, and treatment admissions with criminal justice problems are less impaired than those who are referred from other sources. Methamphetamine is a growing problem across the State, and smoking ice is the major route of administration for persons entering treatment. Most of the ice and methamphetamine is made in Mexico, but local laboratories are using different ingredients to replace the pseudoephedrine that is becoming more limited in supply. Abuse of alprazolam (Xanax) and carisoprodol (Soma) is increasing. Indicators of ecstasy use are increasing as the drug spreads from the White club scene to a diverse racial/ethnic population. GHB and GBL remain problems, particularly in the Dallas-Fort Worth metroplex area. PCP indicators are stable or rising, and dextromethorphan is a problem among adolescents. Inhalants remain a problem, with different types of users. HIV and AIDS cases are more likely to be persons of color, and the proportions of HIV and AIDS cases related to male-to-male sex are increasing. The heterosexual mode of transmission now exceeds injection drug use.

Patterns and Trends of Drug Abuse in Washington, DC

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ABSTRACT

Cocaine/crack, marijuana, and heroin continued to be the main illicit drug problems in Washington, DC, in 2006. The use and availability of PCP continued to fluctuate. Cocaine remained one of the most serious drugs of abuse in the District, as evidenced by the fact that more adult arrestees tested positive for cocaine than for any other drug in 2006, and the number is increasing. In the first 11 months of 2006, approximately 40 percent of adult arrestees tested cocaine positive at the Pretrial Services Agency. Also, more seized items tested positive for cocaine (42 percent) than for any other drug, as reported by NFLIS in FY 2006. Drug-related deaths, however, were more likely to be related to opiates than to cocaine in 2004 (n=73 vs. 62). Pretrial Services test results indicate that PCP positives increased slightly among adult arrestees during the first 11 months of 2006, with around 10 percent testing PCP positive. Juvenile arrestees were more likely to test positive for marijuana than for any other drug. The percentages of juveniles testing marijuana positive have remained about the same for the past few years (around 50 percent). While other parts of the country have seen shifts in the use of methamphetamine, use remains low and confined to isolated communities in DC. The percent of students reporting lifetime use of cocaine, marijuana, and methamphetamine in the DC YRBS decreased from 2003 to 2005. Marijuana and cocaine accounted for nearly all of the $26 million worth of drugs seized by Washington/Baltimore High Intensity Drug Trafficking Area (W/B HIDTA) Initiatives in 2006. According to the W/B HIDTA, drugs trafficked in DC generally originate from Mexico, Southeast Asia, Canada, South America, the Netherlands, and Jamaica. They are shipped through California, Texas, Arizona, North Carolina, New York, Atlanta, and Miami. Intelligence indicates that illicit drug trafficking in the W/B HIDTA area is carried out primarily by Mexican, African-American, Caucasian, Vietnamese, Jamaican, and Asian DTOs. Most of these are polydrug organizations. Recent interviews with criminal justice and public health contacts confirm these trends. Preliminary findings show that the biggest concerns among these key contacts are crack, heroin, PCP, and marijuana. New trends noted by these key contacts are blunts laced with amphetamines and other drugs and the increase in gang activity in the Hispanic population. Misuse of pharmaceuticals among adolescents in the District and surrounding areas of Maryland and Virginia were also areas of concern.

Recent Trends in Drug-related Emergency Department Visits from DAWN

Elizabeth H. Crane, Ph.D., M.P.H.[1]

The Drug Abuse Warning Network (DAWN) is a public health surveillance system administered by the Substance Abuse and Mental Health Services Administration's Office of Applied Studies. DAWN measures morbidity and mortality related to drug use, misuse, and abuse as reflected in emergency department visits and deaths investigated by medical examiners and coroners.

The DAWN emergency department (ED) component collects data from a nationally representative sample of general, non-Federal hospitals with 24-hour emergency departments. DAWN collects data on all ED visits related to recent drug use, regardless of the motive for the drug use. All types of drugs—illegal drugs, prescription and over-the-counter pharmaceuticals, dietary supplements, and non-pharmaceutical inhalants—are included. Alcohol, when it is the only drug implicated in the ED visit, is included for patients younger than age 21; when alcohol is in combination with another drug, is included for patients of all ages. DAWN produces annual estimates of drug-related ED visits for the Nation and for a selection of metropolitan areas.

National Estimates

In 2005, an estimated 816,696 drug-related ED visits involved illicit drugs. Alcohol was involved in approximately 493,000 ED visits; most of these (394,000 visits) involved another drug. Almost 600,000 ED visits involved the nonmedical use of pharmaceuticals (prescription and over-the-counter drugs and dietary supplements).

The most frequent drug categories in the nonmedical-use visits included the central nervous system (CNS) agents (51 percent of visits) and psychotherapeutic agents (46 percent of visits). Among the CNS agents, the opiate/opioid pain medications were the most common, implicated in 33 percent of the nonmedical use ED visits. The most frequent type of psychotherapeutic agents were the sedatives used to treat anxiety and sleeplessness (primarily benzodiazepines), which occurred in 34 percent of the nonmedical-use ED visits.

Trends

From 2004 to 2005, the total number of emergency department visits in the United States increased 2.3 percent. Drug-related ED visits were stable, as were the ED visits that involved drug misuse/abuse. ED visits that involved the nonmedical use of pharmaceuticals increased 21 percent from 2004 to 2005. ED visits involving opiate/opioid pain medications increased 24 percent, and visits involving benzodiazepines increased 19 percent.

DAWN is unable to measure the extent to which external factors—such as the overall increase in ED visits, population growth, or an increase in the number of prescriptions written—may have influenced the increase in the ED visits involving nonmedical use of pharmaceuticals.

Metropolitan Areas

Rates[2] of drug-related ED visits for 2005 were calculated for the Boston, Denver, Miami (Dade County), New York City (5 boroughs), Phoenix, San Diego, San Francisco, and Seattle metropolitan areas. The rates demonstrate the variability of drug-related ED visits both within and between metropolitan areas.

[1]Dr. Crane is affiliated with the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA).

[2] Rates were calculated using the 2004 intercensal estimates of population.

Illicit Drugs

- Among the illicit drugs, rates for cocaine-related ED visits ranged from 31 visits per 100,000 population in San Diego to 472 visits per 100,000 in Miami-Dade. Boston, Detroit, New York City, San Francisco, and Seattle all had rates exceeding 190 visits per 100,000 population.

- Heroin rates were lowest in the metropolitan areas in the Mountain and Southwest regions (29, 31, and 33 visits per 100,000 population in San Diego, Phoenix, and Denver respectively) and highest in New York City (174 visits per 100,000) and Boston (162 visits per 100,000).

- The rates of marijuana in drug-related ED visits ranged from 46 visits per 100,000 population in San Diego to 185 visits per 100,000 in Miami-Dade.

- The metropolitan areas located in the West and Mountain regions had much higher rates of illicit stimulants (methamphetamine and amphetamines) than metropolitan areas in the East and Midwest. San Francisco had the highest rates of stimulant-related ED visits in 2005 (240 visits per 100,000 population) followed by Phoenix (134), Seattle (128), San Diego (94) and Denver (71). In comparison, the rates in Boston, Detroit, Miami-Dade, and New York City were less than 9 per 100,000 population.

Alcohol

All of the metropolitan areas except San Diego had rates higher than 100 visits per 100,000 population for ED visits involving alcohol with another drug. In San Diego, the rate was 69 visits per 100,000. Miami-Dade, San Francisco, and New York City had rates in excess of 250 visits per 100,000 population.

Nonmedical use of Pharmaceuticals

The rates of ED visits involving the non-medical use of pharmaceuticals ranged from 127 visits per 100,000 population in San Diego to 264 visits per 100,000 in Seattle. Four metropolitan areas—Boston, Detroit, San Francisco and Seattle—had rates exceeding 200 visits per 100,000 population.

- In 9 metropolitan areas, the rate of ED visits involving the nonmedical use of opiates/opioids ranged from 19 visits per 100,000 in Miami to 104 visits per 100,000 in Seattle.

- In Boston, oxycodone was the most frequently reported opiate/opioid; in Detroit, hydrocodone was the most frequently reported.

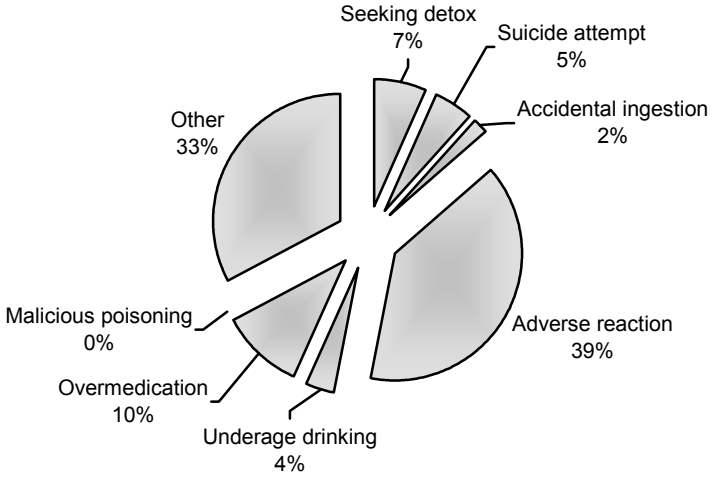
- Methadone stood out in New York City, San Francisco, and Seattle. Methadone is increasingly used to treat pain as well as for opiate replacement therapy, but DAWN data cannot distinguish which type of methadone was involved. If multiple drugs are involved in the ED visit, methadone may be routinely documented in the medical record, but without enough detail to distinguish whether the methadone specifically was related to the ED visit.

Estimated Number of Drug-Related ED Visits in the United States: 2005

Substance	Estimate	2004 vs. 2005
Illicit drugs	816,696 (CI: 666,947 to 966,446)	No change
Alcohol[1]	492,655 (CI: 424,660 to 560,649)	No change
Alcohol-in-combination	394,224 (CI: 331,964 to 456,485)	No change
Nonmedical use of pharmaceuticals	598,542 (CI: 486,771 to 710,314)	+21percent

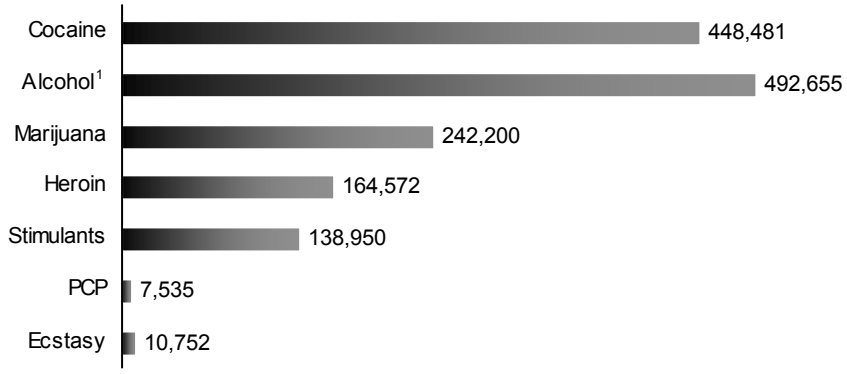
[1]Includes all ED visits where alcohol was involved with at least one other drug, and alcohol-only visits for patients under age 21.
SOURCE: DAWN, OAS, SAMHSA

Percentages of Types of Drug-Related ED Visits in the United States: 2005



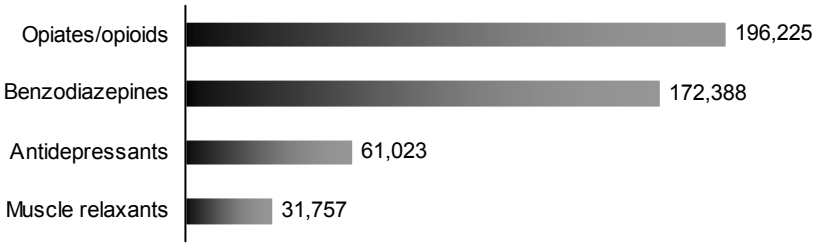
SOURCE: DAWN. OAS, SAMHSA

Estimated Number of ED Visits for Selected Illicit Drugs in the United States: 2005



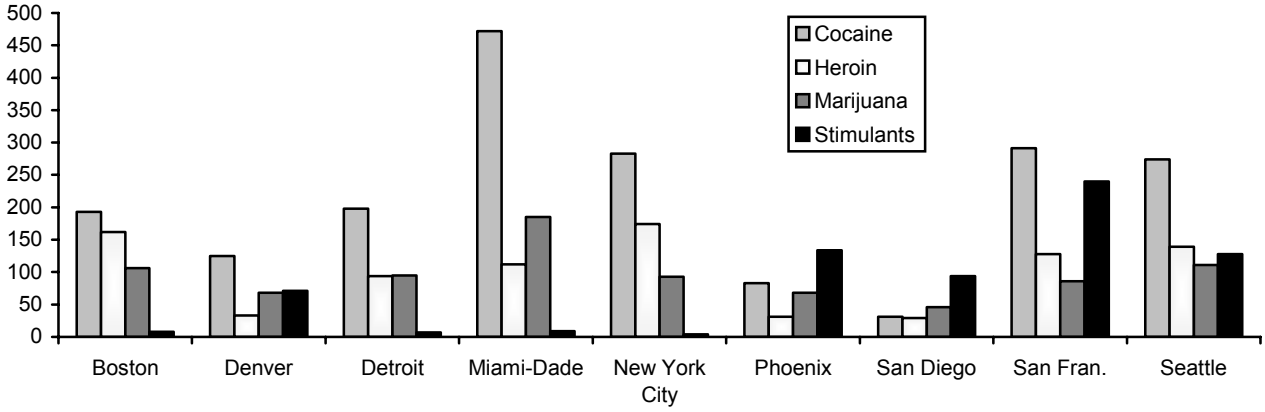
[1]Includes all ED visits where alcohol was involved with at least one other drug, and alcohol-only visits for patients under age 21.
SOURCE: DAWN. OAS, SAMHSA

Estimated Number of ED Visits for Nonmedical Use of Pharmaceuticals in the United States: 2005



SOURCE: DAWN, OAS, SAMHSA

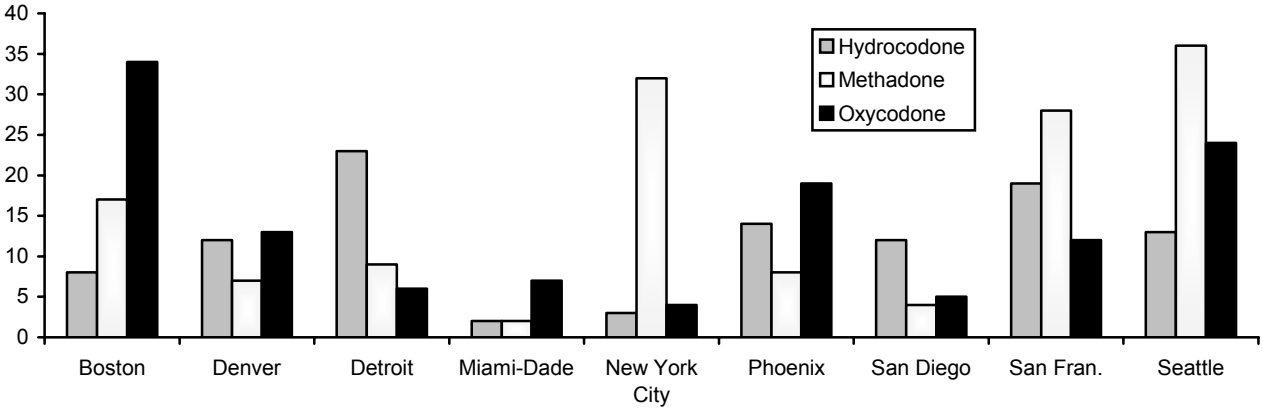
ED Visits Per100,000 Population[1] Involving Cocaine, Heroin, Marijuana, and Stimulants, by Area: 2005



Substance	Boston	Denver	Detroit	Miami-Dade	New York City	Phoenix	San Diego	San Francisco	Seattle
Cocaine	193	125	198	472	283	83	31	291	274
Heroin	162	33	94	112	174	31	29	128	139
Marijuana	106	68	95	185	93	68	46	86	111
Stimulants	8	71	7	9	4	134	94	240	128

[1]Rates for metropolitan areas were calculated using the 2004 intercensal population estimates.
SOURCE: DAWN, OAS, SAMHSA

ED Visits Per 100,000 Population[1] Involving Nonmedical Use of Selected Opiates/Opioids, by Area: 2005



Substance	Boston	Denver	Detroit	Miami-Dade	New York City	Phoenix	San Diego	San Francisco	Seattle
Hydrocodone	8	12	23	2	3	14	12	19	13
Methadone	17	7	9	2	32	8	4	28	36
Oxycodone	34	13	6	7	4	19	5	12	24

[1]Rates for metropolitan areas were calculated using the 2004 intercensal population estimates.
SOURCE: DAWN, OAS, SAMHSA

ED Visits Per 100,000 Population[1] Involving Alcohol,[2] by Area: 2005

Substance	Boston	Denver	Detroit	Miami-Dade	New York City	Phoenix	San Diego	San Francisco	Seattle
Alcohol	271	184	171	280	281	140	95	310	227
In combination	205	134	148	264	251	113	69	252	193

[1]Rates for metropolitan areas were calculated using the 2004 intercensal population estimates.
[2]Includes all ED visits where alcohol was involved with at least one other drug, and alcohol-only visits for patients under age 21.
SOURCE: DAWN, OAS, SAMHSA

APPENDIX A

Total Admissions, by Primary Substance of Abuse and CEWG Area: 2005–2006

Area	Alcohol[1]	Cocaine/ Crack	Heroin	Other Opiates	Marijuana	Stimulants	Other Drugs	Total
FY 2006								
Boston	6,274	1,419	8,975	652	501	31	246	18,098
Cincinnati[2]	1,100	985	460	230	730	19	247	3,771
Detroit	1,791	2,442	2,261	95	1,127	NR [3]	14	7,730
San Francisco	2,251	2,314	3,309		843	1,260	145	10,122
Arizona	22,191	4,011	3,027	514	9,218	9,298	1,358	49,587
1H 2006								
Atlanta	1,430	1,506	214	NR	920	339	NR	4,409
Baltimore	5,006	2,211	7,055	949	2,323	49	198	17,791
Broward County (Sample)[4]	1,571	949	451	382	336	24	360	4,073
Denver	2,246	933	367	192	1,534	864	81	6,217
Mpls./St. Paul	4,694	1,388	560	391	1,836	806	106	9,781
New York City	10,674	8,346	10,918	260	7,915	89	890	39,092
St. Louis	1,297	1,663	830	100	1,619	257	685	6,451
Seattle	2,074	944	856	265	1,012	707	148	6,006
Hawaii	638	193	107	NR	864	1,656	181	3,639
Texas	6,798	7,458	2,657	1,527	6,352	3,808	669	29,269
CY 2006								
Maine	5,519	764	1,007[5]	2,282	1,169	49	122	10,912
FY 2005								
Chicago	12,158	16,845	33,662	685	9,338	174	2,755	75,617
CY 2005								
Los Angeles	8,308	8,418	9,997	510	7,681	13,033	1,328	49,275
Philadelphia	3,385	4,695	3,107	492	3,120	39	2,224	17,062
San Diego	2,576	860	2,507	232	1,599	5,243	102	13,119

[1]Includes alcohol-in-combination with other drugs in Atlanta; other areas include alcohol-only or combine alcohol-only and alcohol-in-combination.
[2]Represents 65–75 percent of the data for FY 2006.
[3]NR=Not Reported
[4]Represents nine programs in Broward County that serve 51.5 percent of the county admissions.
[5]Includes morphine.
SOURCES: June 2006 and January 2007 State and local reports

APPENDIX B-1

DAWN ED Samples and Reporting Information, by CEWG Area: January–June 2006

CEWG Area	Total EDs in DAWN Sample	No. of EDs Reporting per Month: Completeness of Data (%)		No. EDs Not Reporting
		≥90%	<90%	
Boston	37	21–22	1–2	13–15
Chicago	78	24–27	2–5	48–50
Denver	15	6–7	0	8–9
Detroit	30	13–18	1–4	10–14
Ft. Lauderdale	22	4–6	0–2	15
Houston	43	9–13	1–5	29
Miami-Dade County	19	5–9	0–3	10–11
Mpls./St. Paul	26	7–8	1–2	16–17
New York City	63	25–32	5–6	26–33
Phoenix	27	10–15	0–3	12–14
San Diego	17	7–8	0–1	9
San Francisco	19	7–10	0–3	9–10
Seattle	24	10–11	0–1	12–13

SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 11/17–11/20, 2006

APPENDIX B-2

Numbers of Cocaine, Heroin, Methamphetamine (MA), Marijuana (MJ), Methylenedioxymethamphetamine (MDMA), Phencyclidine (PCP), and Lysergic Acid Diethylamide (LSDM) ED Reports in 13 CEWG Areas (Unweighted[1]): January–June 2006

CEWG Area	Cocaine	Heroin	MA	MJ	MDMA	PCP	LSD
Boston	2,273	1,981	39	1,007	72	13	10
Chicago	4,315	3,336	35	1,555	67	35	6
Denver	1,179	340	327	653	41	13	14
Detroit	3,655	1,793	13	1,466	101	5	13
Ft. Lauderdale	2,196	273	51	1,120	51	4	10
Houston	2,145	95	80	1,204	97	200	13
Miami-Dade	3,153	602	16	1,321	47	4	15
Mpls./St. Paul	1,311	401	251	1,265	63	19	28
New York City	7,068	3,807	51	2,714	90	186	15
Phoenix	958	412	821	636	30	21	8
San Diego	342	371	638	432	29	16	7
San Francisco	1,637	578	500	378	62	39	28
Seattle	2,748	1,255	722	1,001	72	43	26

[1]All DAWN cases are reviewed for quality control and, based on review, may be corrected or deleted. Therefore, these data are subject to change.
SOURCE: DAWN *Live!*, OAS, SAMHSA, updated 11/17–11/20, 2006

National Institute on Drug Abuse
Community Epidemiology Work Group Meeting
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