



EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

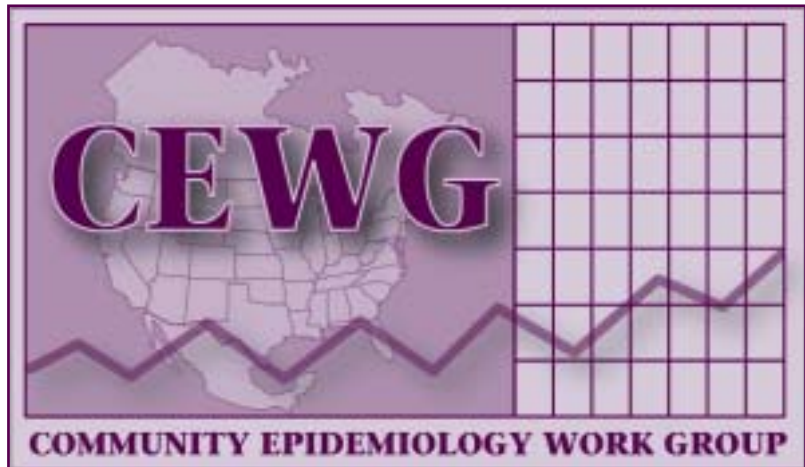
VOLUME I

Proceedings of the Community
Epidemiology Work Group

Highlights and Executive Summary

December 2003

NATIONAL INSTITUTE ON DRUG ABUSE
COMMUNITY EPIDEMIOLOGY WORK GROUP



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IN DRUG ABUSE

Volume I

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December 2003

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
Division of Epidemiology, Services and Prevention Research
National Institute on Drug Abuse
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This publication, *Volume I*, is based primarily on papers presented and data reported by CEWG representatives from 21 areas at the December 2003 CEWG meeting. The text from those research papers appears in *Volume II*. *Volume II* also contains papers presented by researchers and law enforcement personnel, participants from Federal agencies, and presenters from Canada and Mexico.

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

This *Executive Summary* is based on findings presented at the 55th semiannual meeting of the Community Epidemiology Work Group (CEWG) held in Atlanta, Georgia, on December 9–12, 2003, under the sponsorship of the National Institutes of Health, National Institute on Drug Abuse (NIDA). The CEWG is composed of researchers from 21 sentinel areas in the United States who have extensive experience in community research and knowledge of their local communities, drugs, and drug-abusing populations, the social and health consequences of drug abuse, drug trafficking and other law enforcement patterns, and emerging drugs within and across communities. Information from national data sources, studies conducted by NIDA grantees, and data from researchers and agency personnel from the city that hosts a meeting are used to enhance findings presented by CEWG members.

Information reported at each CEWG meeting is disseminated quickly 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 the current drug abuse patterns and trends and emerging drug problems so that appropriate and timely action can be taken. Researchers also use this information to develop research hypotheses that might explain social, behavioral, and biological issues related to drug abuse. As part of the CEWG's monitoring role, members continue work between meetings, using the Internet, conference calls, and mailings to alert one another to new issues and to follow up on issues and emerging drug patterns identified at meetings. The results of this interim monitoring are often agenda items at a subsequent meeting.

In this *Executive Summary*, findings and issues reported from the 21 CEWG areas in the United States are organized by drug to enable quick reference to patterns and trends associated with specific drugs. National data are used to enhance what is presented by CEWG members.

Dr. Wilson Compton provided CEWG members with an update on NIDA's research agenda.

Two sections of the *Executive Summary* are devoted to special panel presentations. One panel focuses on PCP abuse. The second panel focuses on rural and urban differences in drug abuse. Another section is devoted to special presentations on hospital emergency department data.

The concluding section summarizes drug abuse patterns and trends in the bordering countries of Canada and Mexico.

Individual papers presented at the 55th CEWG meeting are published in *Volume II* of the CEWG December 2003 Proceedings.

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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 **KEY FINDINGS**

POLYSUBSTANCE abuse, long the hallmark of most drug abusers, continued to proliferate in ever-changing patterns, mirroring the increasing availability of different types and forms of drugs (*see pages 5–6*).

METHAMPHETAMINE abuse continued to spread eastward, and at a pace unrivaled by any other drug in recent times (*see pages 6–13*).

HEROIN indicators remained relatively stable in most CEWG areas, continuing at high levels in northeastern/mid-Atlantic areas, where high-purity heroin powder from South America was available (*see pages 13–19*).

OTHER OPIATES/NARCOTICS indicators increased in most CEWG areas, especially those for hydrocodone and oxycodone (*see pages 20–23*).

COCAINE, especially crack cocaine, continued to be widely available and a major problem in most CEWG areas (*see pages 24–30*).

CLUB DRUG indicators typically decreased or remained low. Indicators for methylenedioxymethamphetamine (MDMA), the most frequently abused club drug, either decreased or were stable, while those for gamma hydroxybutyrate (GHB) and ketamine remained very low. However, CEWG members raised issues and concerns about MDMA abuse, based on local studies and community sources (*see pages 31–35*).

MARIJUANA abuse indicators remained at very high levels in 2002 and early 2003, even increasing in five CEWG areas (*see pages 37–42*).

BENZODIAZEPINES, widely abused across all CEWG areas, continued to be used by drug abusers to enhance or control the effects of other drugs (*see pages 43–44*).

PHENCYCLIDINE (PCP) indicators increased in five CEWG areas (*see pages 45–47*).

INTRODUCTION

The National Institute on Drug Abuse, National Institutes of Health, is pleased to present an *Executive Summary* of the 55th semiannual meeting of the Community Epidemiology Work Group (CEWG) convened in Atlanta, Georgia, on December 9–12, 2003.

After welcoming participants, Dr. Wilson Compton, M.D., M.P.E., Director, Division of Epidemiology, Services and Prevention Research, provided participants an update on activities at the National Institute on Drug Abuse and described five priorities established for NIDA by Nora Volkow, M.D., Director, NIDA: Prevention, New Treatment Targets, HIV/ AIDS, Training Researchers and Collaborations (with other institutes, other Federal agencies, and State and local partners). Within the Division of Epidemiology, Services and Prevention Research, Dr. Compton described a research priority on interactions between individuals and environments. The Division has ambitious 5-year goals that include measurably improving public health prevention and treatment outcomes. Of particular note, Dr. Compton described how CEWG members provide essential clues that additional epidemiologic or basic science research can explore.

The meeting included the following:

- ◆ A panel on phencyclidine (PCP) abuse based on small studies and a report on PCP trafficking and distribution
- ◆ A panel on rural drug abuse based on small studies in five areas
- ◆ Presentations on different criminal justice indicators of drug abuse in the State of Georgia and on other drug abuse data sources in Georgia including the State household survey, treatment data, and ethnographic studies
- ◆ Presentations by officials from the Centers for Disease Control and Prevention on surveillance systems and studies
- ◆ An update on changes in, and the current status of, the Drug Abuse Warning Network

- ◆ A presentation by a NIDA grant-supported researcher on emerging drugs from a hospital emergency department perspective
- ◆ Papers on the status and most recent drug abuse data produced by the surveillance systems in Mexico and Canada

A listing of the CEWG reports and other papers published in *Volume II* of the December 2003 Proceedings appears in *Appendix F*.

The Functions of the CEWG Meetings

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

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

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

- ◆ The “drug scene” in the host city and its surrounding environs, as depicted in presentations by local researchers, service providers, law enforcement personnel, and, in some meetings, substance abusers

- ◆ Updates by Federal personnel on key data sets used by CEWG members
- ◆ Drug abuse patterns and trends in other countries, such as Canada and Mexico

The special presentations at the December 2003 CEWG meeting are summarized in greater detail in the section that follows. Individual papers by special presenters, as well as those by CEWG members, are published semiannually in *Volume II* of the CEWG Proceedings.

Identification of changing drug abuse patterns is part of the interactive discussions at each CEWG meeting. Through this process, members alert one another to the emergence of a potentially new drug of abuse that may spread from one area to another. In this role, the CEWG has pioneered in identifying the emergence of drug epidemics and patterns of abuse, such as those involving abuse of

methaqualone (1979), crack (1983), methamphetamine (1983), and “blunts” (1993). MDMA abuse indicators were first reported by CEWG members in December 1985.

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

In discussions at the June 2003 meeting, CEWG members identified issues for further exploration: rural drug abuse and increases of PCP abuse. These issues were an integral part of the December 2003 CEWG meeting.

ROLES AND ATTRIBUTES OF THE CEWG

Role of the CEWG

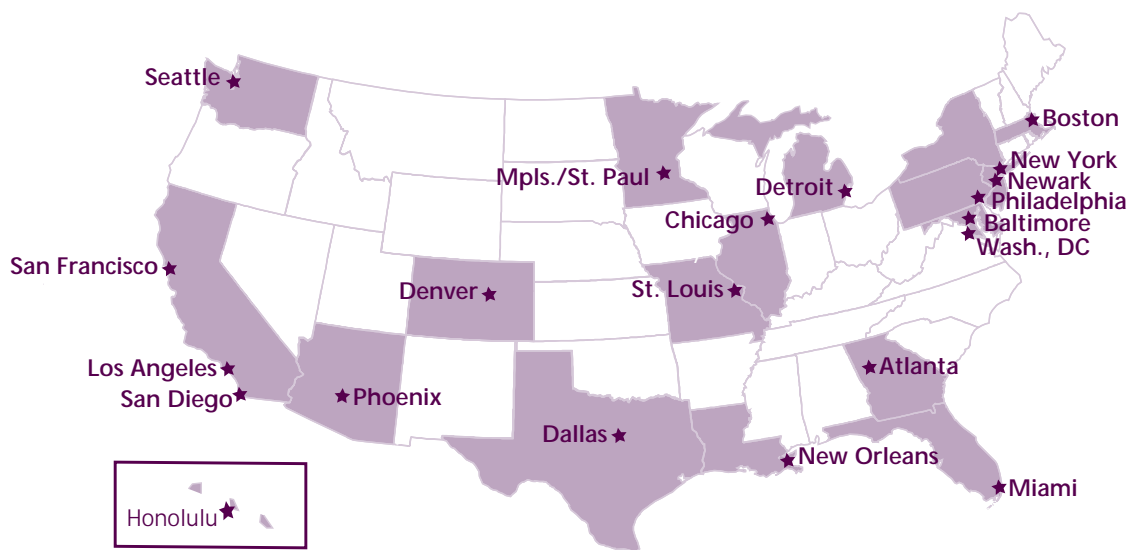
At meetings and through ongoing communication via e-mail, conference calls, and mailings of relevant data, the CEWG serves as a unique epidemiologic surveillance network to inform drug abuse prevention and treatment agencies, public health officials, policymakers, researchers, and the general public about current and emerging drug abuse patterns. The information is disseminated quickly to alert authorities at the local, State, regional, and national levels to current and emerging drug problems so that appropriate action can be taken. Researchers use the information to develop research hypotheses that might explain social, behavioral, and biological issues related to drug abuse.

The 21 areas represented by the CEWG are depicted in the map on page 3.

Attributes of the CEWG

CEWG members bring the following attributes to the network:

- ◆ Extensive experience in community research, which over many years has fostered information sharing between members and local agencies
- ◆ Knowledge about their local communities, drugs, and drug-abusing populations; the social and health consequences of drug abuse; drug trafficking and other law enforcement patterns; and emerging drugs within and across communities
- ◆ Ongoing collaborative relationships with one another and other researchers and experts in the field, which provides for both insight about new issues and sharing information



- ◆ The capability to access relevant drug-related data from the literature, media, and Federal, State, community, and neighborhood sources
- ◆ An understanding of the strengths and limitations of each data source
- ◆ The skills required to systematically analyze and synthesize multiple sources of information, and interpret findings within the community context

CEWG DATA SOURCES

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

Health/Treatment Data

Emergency department (ED) drug mentions data from the Drug Abuse Warning Network (DAWN) were provided by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA), through 2002. A brief description of the DAWN ED system is provided in *Appendix A*.

Local drug-related mortality data are derived from eight CEWG reports for 2001 to the first half of 2003. The 2002 DAWN mortality report was not released in time for this publication; findings from the DAWN mortality system for 1999 to 2001 are

presented in the June 2003 *Advance Report and Volume I Proceedings*.

Substance abuse treatment admissions data for 2000–2002 were extracted from three sources: State treatment databases (18 CEWG areas); the Treatment Episode Data Set (TEDS) maintained by OAS, SAMHSA (Washington, DC); and admissions samples from programs in Broward County, Florida. Arizona, Colorado, Hawaii, Illinois, and Texas representatives report statewide treatment admissions data. Data are reported as percentages of admissions for primary drug of abuse; the denominators exclude alcohol admissions. The total number of admissions by CEWG area or State, including those for alcohol abuse, are shown in *Appendix B*.

Infectious diseases related to drug abuse data are derived from CEWG reports. National data on acquired immunodeficiency syndrome (AIDS) cases are from the Centers for Disease Control and Prevention (CDC) *HIV Surveillance Report*, Volume 14, October 2003.

Law Enforcement/Criminal Justice Data

Arrestee drug-testing data for 2000–2003 are primarily from the Arrestee Drug Abuse Monitoring (ADAM) program supported by the National Institute of Justice (NIJ). Data reported by individual quarters in 2003 have been summed and averaged across quarters to simplify presentation and comparability with prior years' data. Male data, collected in 15 CEWG areas, are weighted, and the averages across quarters in 2003 are estimates. Male estimates are for two quarters of 2003 in 11 sites, for the first quarter only in Dallas, Honolulu, and Los Angeles, and for the first three quarters in Washington, DC. Convenience sampling continued to be used to select the smaller samples of females in nine CEWG areas; findings represent unweighted data and, thus, are not comparable to data on adult males. Female estimates are for two quarters in four sites, the first three quarters in New Orleans and San Diego, and one quarter only in Denver, Los Angeles, and Minneapolis. Urinalysis tests for 10 drugs, with confirmation to distinguish methamphetamine from amphetamines. Additional information on ADAM is presented in *Appendix C*.

Forensic drug laboratory testing data are from the National Forensic Laboratory Information System (NFLIS). Data are reported for October 1, 2002, through September 30, 2003. Sponsored by the Drug Enforcement Administration (DEA), NFLIS accumulates drug analysis results from State and local forensic labs, which, as of May 2003, included 187 of the Nation's approximately 300 State and local labs, with 162 reporting regularly. Labs in or near 18 CEWG areas participated in NFLIS (the exceptions are Minneapolis, Phoenix, and San Francisco). Some CEWG areas represent multiple sites: Chicago, northern Illinois; New York, the City and Erie, Nassau, and Onondaga Counties; and Texas, 14 sites.

Comparisons across CEWG areas are subject to distortion for several reasons. First, the data are not adjusted for population size. Also, there are variations within and across areas that can result in differences in drug seizures and analyses (e.g., police priorities, types of arrests from which drug specimens are taken, and other associated criminal justice procedures), and there are some inconsistencies in times of reporting. For some locales, data were reported for the entire period. For others, the relevant lab or lab system did not report for some months of the period, as was the case in Atlanta (for July 2003); Honolulu (October–December 2002); New York (Erie County, July 2003, and for the other three sites, October–December 2002); Texas (September 2003); and Washington, DC (all months except January–June 2003). In some cases, non-reporting by a lab(s) or lab system occurred because of some operational or technical reason. For example, the Detroit Police Department submitted some data for the entire period, but the Michigan State Police data covering several months had not been received at the time data were produced for the NFLIS report. Also, in Los Angeles, county data were reported for the entire period, but city lab data were not complete “for some months.” A brief description of the NFLIS system appears in *Appendix D*.

Drug price and purity data on selected drugs are from *Narcotics Digest Weekly*, Volume 2, Number 50, December 16, 2003. Data on heroin price and purity in CEWG areas are from DEA's Domestic Monitor Program (DMP) in 2002. The DMP effort is summarized in *Appendix E*.

Drug seizure, trafficking, price, and purity data from DEA and other sources were extracted from CEWG reports.

Issues identified by the CEWG are highlighted in this report for each drug category, followed by data from the major indicator sources. When multiple years appear in an exhibit, the peak year for the time periods presented will appear in **boldface** type. Information derived from CEWG meeting discussions and papers appears in *italic* type.

ISSUES AND FINDINGS FROM THE CEWG

POLYSUBSTANCE ABUSE



CEWG reports included numerous examples of how polydrug abuse has been proliferating in all CEWG areas. A variety of factors contribute to the multidrug abuse patterns, including the apparent increase in the availability of methamphetamine, narcotic analgesics, benzodiazepines, and club drugs; the production of drugs in different forms (e.g., tablets, capsules, liquid, powder, crystal, tar); and the options for administering drugs (e.g., swallowing, snorting, smoking, injecting). For example, the liquid form of PCP can be easily added to cigarettes or marijuana joints. Examples of different polydrug patterns across CEWG areas are provided in the quotes that follow.

Atlanta

All young adult cocaine users in one study reported using marijuana in the past 90 days. Several respondents indicated a preference for ‘hydro,’ and there were continuing mentions of ‘fruities’—lollipop made from marijuana and cocaine. Also, respondents talked about ‘trolling’ or ‘candy flipping,’ in which they used acid and ecstasy together.

Ethnographers reported that gamma hydroxybutyrate (GHB) was often mixed with other club drugs by gay men involved in the Atlanta party scene.

—**Kristin Wilson**

Chicago

Cocaine use is common among heroin users in Chicago.

Recent reports from young heroin users indicate that PCP use may be more common in this population.

Forty percent of young heroin injectors reported using some club drug, including MDMA, in the 3 months prior to interview.

Codeine is often used by heroin users to moderate withdrawal symptoms or help kick a drug habit.

—**Matthew Magee**

New York

Another method of use includes smoking cocaine with marijuana in a blunt cigar called a ‘Woolie.’ The Street Studies Unit (SSU) also reports that many heroin users who buy cocaine are doing so to ‘speed-ball.’ Heroin users who speedball will either snort the combination of cocaine and heroin or inject it.

The SSU reports that in some areas of the city, heroin is being cut with prescription pills, such as Percocet, Valium, and Xanax, to enhance the high and produce increased sales with reduced amounts of heroin in the package. Another report is that dealers are scraping the coating off of OxyContin, pulverizing the pill to powder, and mixing it with heroin to produce an enhanced high.

—**Rozanne Marel**

Philadelphia

Crack users continue to report frequent use of the drug in combination with 40-ounce bottles of malt liquor, beer, wine, or other drugs, including alprazolam (Xanax), marijuana, or heroin.

The combination of marijuana and PCP, frequently mixed in blunts, remains a popular combination among users in 2003. Blunts laced with crack (called ‘Turbo’) are less common. Blunt users commonly ingest beer, wine coolers, whiskey, alprazolam, or diazepam along with blunts. Less common, blunt smokers use powder cocaine, vodka, barbiturates, clonazepam, oxycodone, cough syrup, and/or methamphetamine.

—**Samuel Cutler**

Texas

Use of marijuana joints dipped in embalming fluid that can contain PCP (‘fry’) continues, with cases seen in the poison control centers, emergency departments, and treatment facilities.

‘Red Devil Dust’ is reported to be a combination of PCP, opium, and crystal methamphetamine.

—**Jane Maxwell**

Washington, DC

The High Intensity Drug Threat Assessment staff reports evidence of 'double stack' pills in which at least one side of the pill contains PCP. The Metropolitan Police Department reports that MDMA pills have been dissolved in liquid PCP for use in 'dippers.' Some users believe that MDMA will enhance the effects of PCP.

Marijuana is most often smoked with blunts or joints, which can be combined with rocks of cocaine or dipped in liquid PCP. —Eric Wish

METHAMPHETAMINE/ AMPHETAMINES



Methamphetamine abuse continued to spread eastward, and at a pace unrivaled by any other drug in recent times. Abuse indicators remained at high levels in Hawaii and in west coast and southwestern CEWG areas. Data from some sources show that methamphetamine abuse has been increasing in Hispanic populations, especially in areas near the U.S.-Mexico border. Seizures of methamphetamine labs were reported in most CEWG areas/States, with adverse implications for young children living in/near labs reported in at least two areas. The more recent reports of methamphetamine abuse came from as far east and south as Miami, New Orleans, New York, and Philadelphia. Ice, the most potent form, made greater inroads into areas in north Texas, Minneapolis, Phoenix, and San Diego. CEWG members stressed the importance of distinguishing the types (i.e., texture, size of particles) and purity of methamphetamine and routes of administration, noting that terms like 'ice' and 'crystal methamphetamine' are often used interchangeably.

Methamphetamine abuse indicators remained at high levels in Hawaii and in west coast and southwestern CEWG areas.

Honolulu

Ice continues to dominate the Hawaiian drug market, and it is easier to purchase large quantities than in the past. Clandestine labs, almost exclusively reprocessing labs, continue to be closed at a regular pace. —William Wood

Los Angeles

The number of super labs established throughout California continues to increase. In the past, these large-scale labs were capable of producing 10 or more pounds of finished methamphetamine in a single production cycle. But super labs have stepped up the pace and are now capable of producing 20 or more pounds of finished drug in a single production cycle, according to the National Drug Intelligence Center in 2003.

—Beth Finnerty

Phoenix

The demand and use of methamphetamine and amphetamines continued an upward trend. Purity averaged 25 to 55 percent. The DEA reported that ice/glass now dominates street-level sales throughout Arizona. Street-level purchases of ice exceed 94 percent purity. Reportedly, the majority of methamphetamine for distribution is manufactured in super labs in California and Mexico. A total of 186 clandestine laboratories were seized during the first three quarters of fiscal year 2003 by combined law enforcement groups.

—Ilene Dode

San Diego

Methamphetamine indicators were mixed, with increases in overdose deaths, treatment admissions, and positive tests among adult and juvenile arrestees.

—Michael Ann Haight

San Francisco

Local observers report a significant increase in speed activity in San Francisco. Selling of crystal or 'Tina' is prominent in the Mission, Bayview, Tenderloin, and Castro neighborhoods. Observers note considerable selling via Internet sites, sometimes by means of PNP (Party and Play) postings.

—John Newmeyer

Methamphetamine manufacture and abuse continued to spread eastward and in suburban, urban, and rural areas.

Atlanta

Treatment data show that methamphetamine use is on the rise statewide but most significantly in the counties outside metropolitan Atlanta. The DEA has become alarmed at indicators of a drastically growing number of methamphetamine labs in Georgia.

—Kristin Wilson

Boston

The DEA reports that methamphetamine is available in limited (user-level) quantities in New England.

—**Dan Dooley**

Chicago

A low but stable prevalence of methamphetamine use has been reported in some areas of the city in the past 2 years, especially on the North Side, where young gay men, homeless youth, and club goers congregate. However, the use of methamphetamine is not confined to these groups. It is more likely to occur among drug-using youth who live or travel beyond metropolitan Chicago to areas where methamphetamine is more readily available.

—**Matthew Magee**

Detroit

Indicators for methamphetamine showed continuing increases. Through November 24, 2003, Michigan State Police seized 167 methamphetamine labs and note that an additional number have been seized by other law enforcement agencies. The majority of labs seized so far continue to be relatively small in production capacity, although more recently some larger labs have been found.

—**Richard Calkins**

Miami/Ft. Lauderdale

Methamphetamine abuse is an emergent drug epidemic in the ‘outbreak’ stage across the region... Law enforcement officials and ethnographers report a recent increase in crystal methamphetamine use, particularly among gay men, who refer to the drug as ‘Tina.’

—**James Hall**

New Orleans

In rural areas of Louisiana, methamphetamine is a problem, with the abuse primarily evident among members of biker organizations.

—**Gail Thornton-Collins**

New York

Methamphetamine is available in powder, pill, or liquid form, with pill form being the most popular. While crystal meth found in the Bronx is smoked, methamphetamine found in gay clubs throughout New York City is injectable. Outside the city, the New York State Police have found an increasing number of methamphetamine labs. For example, in 1999 the State Police reported two clandestine lab

incidents in the State. There were 9 lab incidents in 2000, 18 in 2001, 46 in 2002, and 10 in the first 6 weeks of 2003.

—**Rozanne Marel**

Abusers of other drugs are switching to methamphetamine.

Atlanta

In Atlanta, some MDMA abusers have been switching to methamphetamine for the longer term effects.

—**Johanna Boers**

Denver

Clinicians indicate a switch to methamphetamine among some stimulant users... Those in northeast programs say many of the ‘new’ stimulant users [those entering treatment within the first 3 years of use] are using methamphetamine rather than cocaine because it is cheaper and provides a ‘longer high.’

—**Bruce Mendelson**

Miami/Ft. Lauderdale

Ecstasy abuse appears to have peaked and is even considered passé by some former users, and is being replaced by methamphetamine among those who are ignorant about its devastating impact in other communities.

—**James Hall**

Methamphetamine abuse is spreading to new populations.

Colorado

Higher proportions of Hispanics are entering treatment for primary methamphetamine abuse. A comparison of 2002 new methamphetamine users (i.e., entering treatment within the first 3 years of use [n=531]) to old methamphetamine users (i.e., entering treatment after 4 or more years of use [n=2,022]) shows dramatic differences between these two groups. Demographically, the new users are more often female (53.3 percent) than old users (44.6 percent), and less often White/non-Hispanic (77.0 percent) than old users (83.2 percent). Also, a higher proportion of new users are 25 and younger (58.2 percent) than are old users (27.3 percent).

—**Bruce Mendelson**

Los Angeles

The proportion of Hispanic methamphetamine treatment admissions continues to increase. Smoking continued as the most frequently mentioned way for primary methamphetamine abusers to administer the drug (66.7 percent in the first half of 2003).

—**Beth Finnerty**

St. Louis

Use of methamphetamine and its derivatives has become more widespread among high school and college students, who do not consider these drugs as dangerous as others. Because methamphetamine is so inexpensive and easy to produce, it is likely that its use will continue to spread.

—**James Topolski**

Children are at risk.

Minnesota

Of the 57 children who were exposed to meth labs in Minnesota in 2002, 47 lived under the same roof as an operational meth lab, and 2 died. This (the total exposed) compares with only 11 children in 2001.

—**Carol Falkowski**

Missouri

Increased public attention is being given to the methamphetamine problem because of the growing awareness of the danger this drug poses for children exposed to methamphetamine labs and the impact on families.

—**James Topolski**

Phoenix

In Phoenix, it was reported that 61 children were present at clandestine lab locations during the second and third quarters of 2003.

—**Ilene Dode**

CEWG members stressed the importance of distinguishing the type, purity, and routes of administration of methamphetamine.

Los Angeles

Local law enforcement authorities are reporting seizures of ice, a potent form of methamphetamine, with increasing frequency. Asian gangs distribute limited quantities of ice throughout Los Angeles, particularly within Asian communities.

—**Beth Finnerty**

Texas

Ice, which is smoked methamphetamine, is a growing problem. The percentage of primary methamphetamine admissions smoking ice has gone from less than 1 percent in 1988 to 27 percent in 2003.

—**Jane Maxwell**

The high potency, smokeable form of methamphetamine known as glass or ice was reported by numerous law enforcement agencies, whose attention was increasingly directed toward both the growing abuse and in-home manufacture of methamphetamine.

Honolulu

Analysis of confiscated methamphetamine reveals that the product is still a high-quality d-methamphetamine hydrochloride in the 90–100 percent purity range. However, it is sold in the islands as clear (a cleaner, white form) or wash (a brownish less processed form). Prices for ice vary widely according to these two categories and availability.

—**William Wood**

Minneapolis/St. Paul

The biggest change noted by multiple law enforcement sources was the emergence of glass or ice, a type of methamphetamine which is typically smoked and resembles clear glass shards.

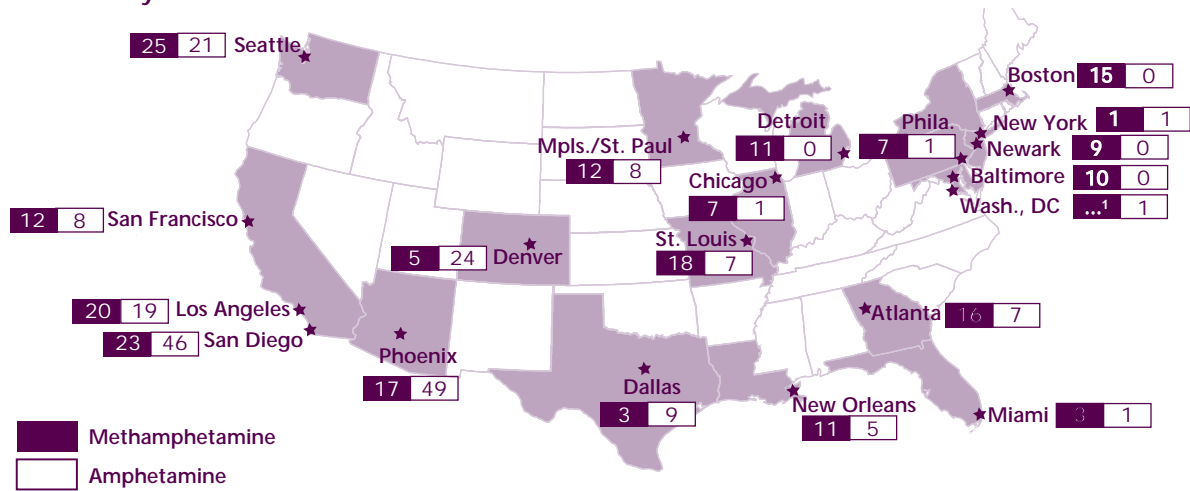
—**Carol Falkowski**

Texas

The Dallas DEA Field Division reported an increase in high purity methamphetamine, with numerous seizures and buys, usually at the multigram to multiounce level. Mexican traffickers are referring to all methamphetamine as ice or crystal, whether it is or not, and the ice form is reported as the most abundant form of the drug in selected areas, such as Tyler.

—**Jane Maxwell**

Exhibit 1. Rates of Methamphetamine and Amphetamine ED Mentions Per 100,000 Population by CEWG Area: 2002



¹Dots (...) indicate that an estimate with a relative standard error greater than 50 percent has been suppressed.
 SOURCE: DAWN, OAS, SAMHSA

Patterns/Trends Across CEWG Areas

DAWN ED Data on Methamphetamine and Amphetamines

The highest rates of methamphetamine ED mentions continued to be in west coast areas (see exhibit 1).

Methamphetamine rates increased significantly between 2001 and 2002 in Atlanta, San Francisco, and Seattle, while they decreased in Miami (see exhibit 2).

In 2002, the rate of amphetamine mentions was highest in Phoenix (49), where it increased significantly from 2000 onward. Amphetamine ED rates were also high and increased significantly (2000 to 2002) in the west coast areas that had high rates of methamphetamine ED mentions, including San Diego and San Francisco (45 each).

Mortality Data on Methamphetamine

Methamphetamine-related mortality data were reported in three CEWG areas. Twenty-nine methamphetamine-related deaths were reported in Honolulu in the first half of 2003. In Minneapolis, 10 methamphetamine-related deaths were reported in Hennepin County and 6 in Ramsey County in the first 9 months of 2003. In Seattle, 18 methamphetamine-involved deaths occurred between July

Exhibit 2. Rates of Methamphetamine ED Mentions Per 100,000 Population in 16 CEWG Areas¹: 2000–2002

CEWG Area	2000	2001	2002	Percent Change ²	
				2000, 2002	2001, 2002
Atlanta	4	5	7	69.7	39.0
Chicago	...	1	1	...	
Dallas	5	4	3	-43.0	
Denver	7	5	5	-56.1	
Los Angeles	16	18	20		
Miami	1	1	1		-45.5
Minneapolis/St. Paul	6	12	12		
New Orleans	2	...	5	109.7	
New York	0	...	1		
Philadelphia	1	1	1		
Phoenix	29	21	17		
St. Louis	7	5	7		
San Diego	31	27	23	28.5	19.4
San Francisco	36	39	46		35.3
Seattle	27	18	25		
Washington, DC	2	1	1		

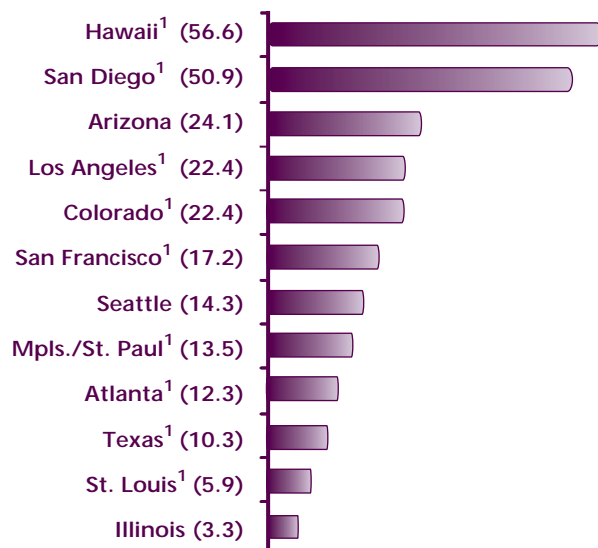
¹Excludes areas with a rate of zero in 2002.
²These columns denote statistically significant (p<0.05) increases and decreases between estimates for the time periods shown.
³Dots (...) indicate that an estimate with a relative standard error greater than 50 percent has been suppressed.
 SOURCE: DAWN, OAS, SAMHSA

2002 and June 2003. There were substantially fewer deaths in Seattle in the intervening years and few prior to 1999.

Treatment Data on Methamphetamine and Amphetamines

In the most recent reporting period, the proportions of primary methamphetamine treatment admissions (excluding alcohol) were reported separately from amphetamine or “other drug” admissions in nearly all CEWG areas. Nine areas reported either no primary methamphetamine admissions or proportions of less than 1 percent of illicit drug admissions. Exhibit 3 depicts the proportions at 12 sites, illustrating the dominance of this drug in Hawaii and other western areas.

Exhibit 3. Percentages of Primary Methamphetamine Treatment Admissions (Excluding Alcohol) in 12 CEWG Areas: 2002–2003



¹Represents only the first 6 months of 2003.
SOURCE: CEWG December 2003 reports

Fourteen CEWG members reported on primary amphetamine treatment admissions; these accounted for either zero or less than one percent of admissions (excluding alcohol).

ADAM Data on Methamphetamine

Very high percentages of adult male arrestees tested positive for methamphetamine in Honolulu (43.8 percent), Phoenix (38.5 percent), and San

Diego (36.7 percent) in early 2003, as shown in exhibit 4. Not shown in exhibit 4 is the appearance of methamphetamine-positive toxicologies among adult male arrestees in Chicago (1.6 percent) and New Orleans (2.0 percent) in the first two quarters of 2003.

Exhibit 4. Percentages of Adult Male Arrestees Testing Methamphetamine-Positive in 10 CEWG Areas: 2001–2003

CEWG Area	2001	2002	2003 ¹
Atlanta	NS ²	2.3	2.0
Dallas	1.7	3.1	5.2
Denver	3.4	3.8	3.3
Honolulu	37.4	44.8	43.8
Los Angeles	NS	14.8	9.2
Minneapolis	2.4	3.9	2.7
Phoenix	25.3	30.9	38.5
San Antonio	2.6	2.3	3.6
San Diego	27.9	31.7	36.7
Seattle	11.1	10.9	12.5

¹Estimates are for various quarters in 2003 (see Data Sources).
²NS = Not sampled.
SOURCE: ADAM, NIJ

In early 2003, the percentages of adult females testing methamphetamine-positive were also highest in Honolulu, followed by San Diego and Phoenix (see exhibit 5).

Exhibit 5. Percentages¹ of Adult Female Arrestees Testing Methamphetamine-Positive in 6 CEWG Areas: 2001–2003

CEWG Area	2001	2002	2003
Denver	4.3	6.6	4.0
Honolulu	36.1	49.3	54.3
Los Angeles	NS ²	14.3	15.4
Minneapolis	32.3	41.4	41.7
Phoenix	NS	NS	2.1
San Diego	32.0	36.8	47.1

¹Data are unweighted and, for 2003, averaged across various quarters.
²NS=Not sampled.
SOURCE: ADAM, NIJ

The 2002 ADAM arrestee data were reported for male and female juvenile arrestees in Phoenix and San Diego. Although the numbers of juvenile arrestees in those areas are relatively small, the percentages testing positive for methamphetamine are of concern; 26.6 percent of the females in Phoenix and 13.8 percent of the males tested positive for methamphetamine (*see exhibit 6*).

Exhibit 6. Percentages of Juvenile Arrestees Testing Methamphetamine-Positive in 2 CEWG Areas: 2002

CEWG Area	Female		Male	
	%	(n)	%	(n)
Phoenix	26.6	(79)	13.8	(218)
San Diego	10.3	(39)	9.3	(118)

SOURCE: ADAM, NIJ

NFLIS Data on Methamphetamine

As with other indicators, forensic laboratory analyses show high concentrations of methamphetamine items in west coast areas including Honolulu (*see exhibit 7*). A substantial number of methamphetamine items were also analyzed in Texas and in the Atlanta site.

Exhibit 7. Estimated Number of Analyzed Methamphetamine Items and Percentage of All Items Tested in 7 CEWG Areas: October 2002–September 2003

Area	Number	Percent
Los Angeles ¹	15,584	33.7
Texas ^{1,2}	10,538	19.1
San Diego	3,386	25.2
Atlanta (Decatur) ¹	3,242	20.5
Honolulu ¹	1,287	62.0
Seattle	846	27.3
Denver	446	10.9

¹Data are not complete for all months.

²Represents multiple sites.

SOURCE: NFLIS, DEA

While the data are not comparable across sites for reasons indicated in the “Data Sources” section, methamphetamine accounted for 62.0 percent of

the items analyzed in Honolulu, followed by Los Angeles (33.7 percent), Seattle (27.3 percent), and San Diego (25.2 percent). In some Texas sites (not shown in exhibit 7), the numbers and proportions of methamphetamine items were quite high: Amarillo, 50.2 percent (n=1,114); Garland, 35.9 percent (3,047); Tyler, 31.6 percent (2,018); and Waco, 28.6 percent (1,514).

Methamphetamine Availability and Prices

While widespread methamphetamine availability continued to be primarily reported west of the Mississippi River, its presence was noted in other CEWG areas as well. In New York City, for example, methamphetamine was available in powder, pill, or liquid form, and researchers in the Bronx detected sales of crystal methamphetamine. The low price and availability of methamphetamine in Atlanta contributed to the drug’s increasing popularity there. In Philadelphia, however, methamphetamine was reportedly “difficult to obtain,” and only limited amounts of it were available in Washington, DC.

Like prices for other drugs, those for methamphetamine varied by geographic location. In the western part of the country, where availability was high, grams sold for as low as \$20 (Seattle) and \$50 (San Diego) in the second half of 2003 (*see exhibit 8 on the following page*). In Boston, however, grams sold for \$250, and the upper range of the gram price was even higher in New York City: \$300. The type of methamphetamine also influenced price. Pounds of crystal methamphetamine, a smokeable form of the drug, sold for up to \$30,000 in Honolulu in the second half of 2003.

Much of the methamphetamine available in the United States continued to be manufactured in “super labs” in California and Mexico, but the numbers of local clandestine labs throughout the country remained on the rise in 2003. Especially notable were the increasing numbers of labs detected in the eastern part of the Nation. In Georgia, for example, the DEA was alarmed at indications of a drastically growing number of labs in the State. Through November 24, 2003, Michigan State Police seized 167 methamphetamine labs; additional labs were seized by other law enforcement agencies.

Exhibit 8. Methamphetamine Prices in 21 CEWG Areas: July–December 2003

City	Retail	Midlevel	Wholesale
Atlanta	\$200/g CM ¹ \$100–\$120/g MX ²	\$1,000/oz CM \$500–\$1,100/oz MX	\$14,000/lb CM \$4,500–\$8,000/lb MX
Baltimore	\$150/g	N/A ³	N/A
Boston	\$250/g	N/A	N/A
Chicago	\$80–\$100/g	\$1,000–\$1,300/oz	N/A
Dallas	\$70–\$100/g \$1,000–\$2,000/g CM	\$750–\$1,250/oz	\$12,000–\$16,000/lb CM \$10,000–\$11,500/lb
Denver	\$80–\$125/g	\$900–\$1,500/oz CM \$700–\$1,100/oz MX	\$14,400–\$24,000/lb CM \$4,000–\$7,500/lb MX
Detroit	\$175/g	\$1,200/oz	\$16,000/lb
Honolulu	\$200–\$300/g CM \$50/¼g CM	\$1,700–\$3,000/oz CM \$300–\$600/⅛ oz CM	\$40,000–\$70,000/kg CM \$20,000–\$30,000/lb CM
Los Angeles	\$100–\$120/½ oz	\$600–\$800/oz CM \$450–\$550/oz	\$7,000–\$11,000/lb CM \$5,000–\$8,000/lb
Miami	\$10–\$20/tablet	N/A	\$5–\$7/tablet
Minneapolis	\$80–\$150/g	\$600–\$1,500/oz	\$6,000–\$14,000/lb
Newark	\$120–\$180/g CM \$120–\$200/g	\$800–\$1,000/oz	\$8,500–\$20,000/kg
New Orleans	\$400–\$500/¼oz \$100/g	\$1,400–\$1,600/oz	\$20,000/lb
New York	\$100–\$300/g \$10–\$20/pill	\$1,600–\$4,000/oz	N/A
Philadelphia	\$100/g	\$700–\$2,000/oz	\$8,000–\$12,000/lb
Phoenix	\$180/1/16 oz CM \$100–\$180/⅙ oz	\$550–\$800/oz	\$10,000/lb CM \$6,000–\$8,000/lb
St. Louis	\$100–\$120/g	\$900–\$1,400/oz	\$15,000 per lb
San Diego	\$225–\$350/¼ oz CM \$100–\$125/⅛ oz \$50–\$75/g \$20/¼ g	\$800–\$950/oz CM \$500–\$1,100/oz	\$9,000–\$11,000/lb CM \$6,000–\$10,000/lb
San Francisco	\$80–\$125/g CM \$20–\$40/¼ g CM	\$1,200–\$1,600/oz CM \$450–\$900/oz	\$12,000–\$16,500/lb CM \$3,600–\$10,500/lb
Seattle	\$20–\$60/g \$20–\$30/¼ g	\$6,000/½ lb CM \$850–\$1,400/oz CM \$350–\$800/oz	\$11,000/lb CM \$3,000–\$5,000/lb
Washington, DC	\$150–\$180/g	\$2,400–\$2,800/oz	\$11,000/lb

¹CM=Crystal methamphetamine.

²MX=Mexico-produced.

³N/A=Not available.

SOURCE: *Narcotics Digest Weekly*, NDIC

HEROIN



Heroin indicators remained relatively stable in most CEWG areas, continuing at high levels in particular sites and relatively low levels in others. Heroin indicators tended to be highest in northeastern/mid-Atlantic areas where high-purity powder from South America was available. However, heroin indicators were also relatively high in two west coast areas (San Francisco and Seattle) where black tar heroin predominates and purity rates are comparatively lower than for white powder heroin. Heroin injection has been increasing in some populations in CEWG areas. CEWG members stressed the importance of considering many factors in assessing heroin abuse patterns and trends, including the type of heroin, price and purity, the number and types of other substances used, and the treatment resources available (e.g., methadone programs).

Heroin indicators are mixed, with some indicators increasing in some CEWG areas.

Boston

Although heroin ED mentions and death mentions appear stable at high levels, heroin/other opiates treatment admissions have increased steadily during the past 8 years, accounting for one-half of all primary drug indicators in FY 2003.

—**Daniel Dooley**

Chicago

Indicators reveal that heroin continues to be a significant problem in Chicago. Participants in a study of young non-injecting heroin users report high availability of heroin on the streets of Chicago.

—**Matthew Magee**

Los Angeles

A total of 5,100 heroin arrests were made within the city of Los Angeles in the first half of 2003. This represented a 20-percent increase from the number of heroin arrests made during the same time period in 2002. Heroin arrests accounted for approximately 34 percent of all narcotics arrests made from January 1 to June 30, 2003.

—**Beth Finnerty**

Minneapolis/St. Paul

The heightened level of heroin-related indicators continued in 2003. Opiate-related deaths, most from accidental heroin overdose, again surpassed those from cocaine in both cities, fueled by high-purity heroin at low prices and in steady supply.

—**Carol Falkowski**

New Orleans

In Orleans Parish, heroin is not only becoming more available in a purer form, it is also becoming more affordable. The New Orleans Police Department continues to view heroin and its abuse as significant, impacting homicides.

—**Gail Thornton-Collins**

Washington, DC

The Metropolitan Police Department describes heroin as having a more steady ongoing market than crack. The number of heroin abusers in the District continues to increase, with estimates of 14,000–18,000 abusers according to the High Intensity Drug Trafficking Area reports. Most heroin is from South America.

—**Eric Wish**

New heroin-abusing populations have been reported.

Denver

In the Denver metro area, treatment programs are reporting more White users from suburban areas who are smoking or inhaling heroin because they do not think they can become addicted and are afraid of infectious diseases (from injecting). However, programs report some conversions to injection because of the faster and more intense high.

—**Bruce Mendelson**

Detroit

Among new heroin users are a number of young, suburban Whites (especially females) who claim to be 'social users' who inhale the drug.

—**Richard Calkins**

Heroin injection and the health risks associated with this mode of administration are of growing concern in many CEWG areas.

Newark

Heroin injection has been increasing among treatment admissions in the 18–25-year-old category, reaching 50.4 percent in the Newark PMSA in the first half of 2002 and 56 percent statewide.

—**Anna Kline**

New York

Intranasal heroin use may have peaked in the second half of 1998, with 62 percent of heroin admissions to all New York City drug treatment programs reporting this as their primary route of administration. Heroin injection increased among heroin admissions, from 32 percent in the second half of 1998 to 37 percent in the first half of 2003.

—**Rozanne Marel**

Philadelphia

Since autumn 2002, all focus groups (former drug users currently in treatment) reported that the average heroin user injects the drug four or five times per day.

—**Samuel Cutler**

San Francisco

Heroin use indicators consistently point to a decline in use from the 1999 peak, but injection remains by far the predominant mode of heroin usage.

—**John Newmeyer**

Washington, DC

Long-term heroin injectors continue to purchase low-quality heroin, while predominately younger and more suburban users from Maryland and Virginia tend to snort the more high-quality heroin.

—**Eric Wish**

Mexican black tar still predominates in the West.

Honolulu

Black tar heroin monopolizes the heroin market of Hawaii and is readily available in all areas of the State.

—**William Wood**

Los Angeles

According to the NDIC, Los Angeles is the largest heroin market in the western United States, and the region is the largest black tar heroin market in the Nation. Mexican black tar heroin is the heroin of choice among Los Angeles County users. Mexican criminal groups control the wholesale, mid-level, and retail activity. African-American and Hispanic gangs control a large portion of the retail distribution as well.

—**Beth Finnerty**

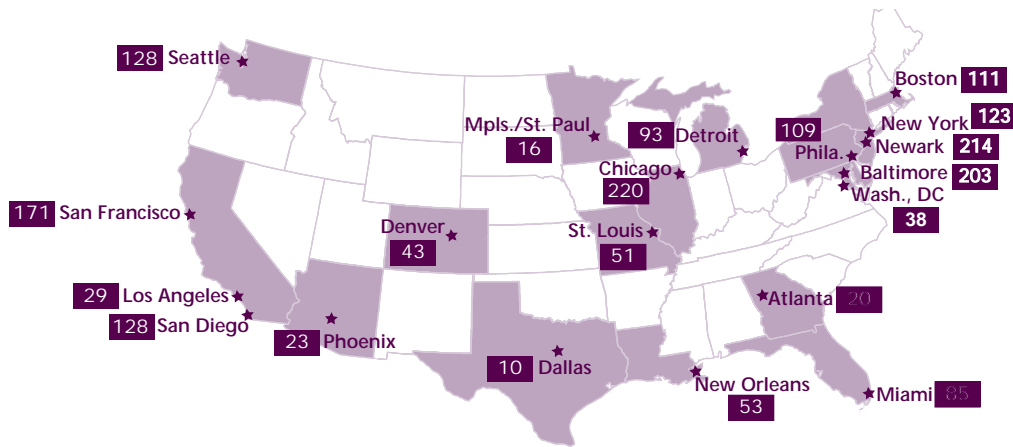
Patterns/Trends Across CEWG Areas

DAWN ED Data on Heroin

The highest rates of heroin ED mentions per 100,000 population were reported in Chicago (220), Newark (214), Baltimore (203), and San Francisco (171) (*see exhibit 9*).

Significant decreases in heroin ED rates occurred between 2001 and 2002 in Dallas, Phoenix, and San Diego, while rates increased in Baltimore, Denver, and Seattle in at least one testing period (*see exhibit 10*). The most recent increase in Baltimore reversed the downward trend reported from 1995 to 2000.

Exhibit 9. Rates of Heroin ED Mentions Per 100,000 Population: 2002



SOURCE: DAWN, OAS, SAMHSA

Exhibit 10. Rates of Heroin ED Mentions Per 100,000 Population in CEWG Areas and Percent Change: 2000–2002

CEWG Area	2000	2001	2002	Percent Change ¹	
				2000, 2002	2001, 2002
Atlanta	17	23	20	13.5	
Baltimore	227	195	203	-10.7	4.0
Boston	102	122	111		
Chicago	206	203	220		
Dallas	19	14	10	-50.1	-33.2
Denver	41	40	43	5.5	9.8
Detroit	76	93	93		
Los Angeles	37	34	29	-20.8	
Miami	74	81	85	13.9	
Minneapolis/ St. Paul	9	13	16		
New Orleans	80	46	53	-32.9	
New York	128	127	123		
Newark	238	215	214		
Philadelphia	96	119	109		
Phoenix	40	27	23	-43.2	-16.4
St. Louis	44	57	51		
San Diego	42	29	28	-34.4	-4.9
San Francisco	168	178	121		
Seattle	126	90	128		42.5
Washington, DC	49	45	38		

¹These columns denote statistically significant (p<0.05) increases and decreases in estimates between the time periods shown.
SOURCE: DAWN, OAS, SAMHSA

Mortality Data on Heroin

Local medical examiner data for various quarters in 2003 suggest heroin-related deaths will continue to be high in the Detroit, Philadelphia, and Phoenix areas, with a possible increase in Honolulu (*see exhibit 11*).

Exhibit 11. Numbers of Heroin/Morphine-Related Deaths Reported by Local MEs in 8 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003 ¹
Detroit	473	465	496	464
Honolulu	22	24	14	16
Miami	174	194	137	38
Mpls./St. Paul	58	77	77	50
Philadelphia	332	316	275	111
Phoenix	137	103	103	75
St. Louis	47	36	35	NR ²
Seattle	89	49	87	29

¹Detroit data are projected for the full year; Minneapolis (Ramsey and Hennepin Counties) are for the first 9 months, Broward County for the first 5 months, Phoenix the first 4 months, and Miami-Dade County and all other areas for the first 6 months.

²NR=Not reported.

SOURCES: MEs/coroners as cited in CEWG December 2003 reports

Treatment Data on Heroin

Patterns of primary heroin admissions (excluding alcohol) show little change from the last CEWG reporting period in most CEWG areas (*see exhibit 12*). However, data for the first 6 months suggest small decreases in the proportion of primary heroin abusers in some sites.

Excluding alcohol, the proportions of primary heroin abusers admitted to treatment in 2003 were very high in Newark (85.1 percent) and Boston (73.6 percent). These proportions reflect the type of treatment program (e.g., methadone maintenance) offered in these cities. Other CEWG areas with high proportions of primary heroin abusers include Detroit (43.0 percent), New York (41.4 percent), San Francisco (38.3 percent), Los Angeles (31.0 percent), and Philadelphia (29.5 percent).

Exhibit 12. Percentages of Primary Heroin Treatment Admissions by CEWG Area (Excluding Alcohol): 2001–2003

CEWG Area/State	2001	2002	2003 ¹
Atlanta ¹	8.6	5.2	3.4
Baltimore	60.4	61.8	NR ²
Boston	74.1	72.6	73.6
Detroit	46.9	42.7	43.0
Los Angeles ¹	46.3	38.4	31.0
Miami (sample) ¹	NR	9.0	4.4
Mpls./St. Paul ¹	6.4	7.1	6.5
New Orleans	18.3	14.6	13.4
New York ¹	43.2	41.1	41.4
Newark ¹	85.9	85.8	85.1
Philadelphia ¹	33.9	29.6	29.5
St. Louis ¹	15.0	13.7	12.1
San Diego ¹	12.3	11.7	10.5
San Francisco ¹	54.4	47.4	38.3
Seattle	23.7	26.6	NR
Washington, DC	47.0	46.9	NR
Arizona	15.4	14.0	11.7
Colorado ¹	13.9	13.5	12.7
Hawaii ¹	5.1	4.7	3.8
Illinois	24.7	23.4	25.0
Texas ¹	16.4	15.9	13.7

¹Represents only the first 6 months of 2003.

²NR=Not reported.

SOURCES: CEWG December 2003 reports on State and local data

ADAM Data on Opiates

The CEWG/ADAM sites reporting the highest percentages of adult male arrestees testing opiate-positive in the earlier quarters of 2003 were Chicago (25.4 percent), New Orleans (16.3 percent), New York (15.2 percent), and Philadelphia (12.8 percent) (*see exhibit 13*).

The percentages of male arrestees testing positive for opiates were low in Los Angeles, Honolulu, Atlanta, and Phoenix, ranging from 1.9 to 4.0 percent. The proportions ranged between 5.3 and 5.7 percent in San Diego and Minneapolis, with somewhat higher proportions in Denver (6.6 percent), Seattle (7.2 percent), San Antonio (7.8 percent), Dallas (8.2 percent), and Washington, DC (9.6 percent).

Exhibit 13. Percentages of Adult Male Arrestees Testing Opiate-Positive in 15 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003 ¹
Atlanta	2.8	NS ²	3.2	3.5
Chicago	27.0	21.8	26.0	25.4
Dallas	3.0	4.8	7.1	8.2
Denver	3.4	5.2	4.0	6.6
Honolulu	6.8	3.4	3.5	2.8
Los Angeles	NS	NS	5.8	1.9
Minneapolis	3.0	5.4	5.1	5.7
New Orleans	15.5	15.6	16.3	16.3
New York	20.5	18.7	15.0	15.2
Philadelphia	11.8	13.2	15.9	12.8
Phoenix	6.6	6.0	4.9	4.0
San Antonio	10.2	9.1	11.0	7.8
San Diego	6.0	7.6	5.6	5.3
Seattle	9.9	10.3	10.0	7.2
Washington, DC	NS	NS	9.5	9.6

¹Estimates are for various quarters in 2001.
²NS = Not sampled or reported.
 SOURCE: ADAM, NIJ

Of the nine CEWG sites where adult female arrestees were tested in 2003, the highest proportions of opiate-positives were recorded in Washington, DC (13.9 percent) and New Orleans (13.3 percent) (see exhibit 14). The partial-year 2003 data suggest there may be a decrease from 2002 in Washington, DC, and an increase in New Orleans.

Exhibit 14. Percentages of Adult Female Arrestees Testing Opiate-Positive in 9 CEWG Areas: 2000–2003¹

CEWG Area	2000	2001	2002	2003 ²
Denver	5.8	5.2	5.3	4.0
Honolulu	8.3	4.2	5.8	5.7
Los Angeles	NS ²	NS	14.3	0.0
Minneapolis	NS	NS	NS	6.3
New Orleans	8.5	7.6	9.2	13.3
New York	19.1	13.9	13.9	NS
Phoenix	6.5	6.3	5.1	6.2
San Diego	7.5	8.6	5.8	9.0
Washington, DC	NS	NS	17.5	13.9

¹Data are unweighted and, for 2003, averaged across various quarters.
²NS = Not sampled or reported.
 SOURCE: ADAM, NIJ

NFLIS Data on Heroin

Northeast areas had the highest numbers of heroin items identified by police forensic labs between October 1, 2002, and September 30, 2003. These areas included Baltimore (10,198), New York (6,053), Philadelphia (2,461), Boston (1,000), and Newark (923) (see exhibit 15).

Exhibit 15. Estimated Number of Analyzed Heroin Items and Percentage of All Items Tested in 18 CEWG Areas: October 2002–September 2003

CEWG Area	Number	Percent
Baltimore	10,198	31.9
New York ^{1,2}	6,053	12.7
Philadelphia	2,461	12.6
Los Angeles ²	1,674	3.6
Boston	1,000	14.4
Newark	923	24.6
New Orleans	739	6.2
Texas ^{1,2}	694	1.3
Detroit	608	13.4
Miami-Dade	573	4.3
St. Louis	472	7.7
Washington, DC ²	431	11.8
San Diego	272	2.0
Denver	226	5.3
Seattle	184	5.9
Atlanta (Decatur) ²	145	0.9
Chicago ¹	69	1.8
Honolulu ²	41	2.0

¹Represents multiple sites.
²Data are not complete for all months.
 SOURCE: NFLIS, DEA

Heroin Price, Purity, and Availability

Heroin remained commonly available in most CEWG areas in 2003. Black tar and, to a lesser extent, brown powder heroin continued to be the predominant types available in areas west of the Mississippi River. Los Angeles is the largest black tar heroin market in the Nation, but as shown on exhibit 16 (on the following page), a wide variety of heroin was available there at the wholesale level. White powdered heroin, often from Colombia, remained the main type available in areas east of the Mississippi River.

Exhibit 16. Heroin Prices in 21 CEWG Areas: July–December 2003

City	Retail	Midlevel	Wholesale
Atlanta	\$80–\$110/g	\$4,000–\$5,000/oz	N/A ¹
Baltimore	\$80–\$115/g \$40/vial \$10–\$20/bag \$10/capsule	\$1,500–\$3,250/oz	\$84,000–\$125,000/kg
Boston	\$75–\$100/g \$60–\$100/bundle \$6–\$20/bag	\$3,100–\$5,000/oz	\$120,000/kg
Chicago	\$100–\$125/g	\$2,500–\$3,000/oz	\$100,000–\$125,000/kg
Dallas	\$150–\$250/g MBT ² \$110/g MBP ³ \$10/capsule MBP	\$800–\$2,000/oz MBT \$800–\$1,600/oz MBP \$2,000/oz SA ⁴	\$65,000–\$70,000/kg SA \$40,000–\$50,000/kg MBT
Denver	\$75–\$300/g MBT or MBP \$40/¼ g	\$1,100–\$1,700/oz MBT or MBP	N/A
Detroit	\$185–\$300/g \$100–\$175/bundle \$10–\$15/bag	\$4,500–\$9,000/oz	\$80,000–\$147,000/kg
Honolulu	200–\$300/g \$50/¼ g	\$2,500–\$5,000/oz \$2,000–\$3,000/¼ oz \$3,000/oz MBT	\$100,000/kg \$50,000/lb
Los Angeles	\$90–\$100/g MBT	\$500–\$800/25 g MBT \$650–\$800/18 g SWA ⁵	\$86,000–\$100,000/kg SA; \$30,000/kg SWA; \$25,000/kg MBP; \$20,000/kg MBT; \$70,000–\$80,000/700–750g SEA ⁶ ; \$35,000– \$40,000/300–350 g SEA
Miami	\$100–\$200/g	\$2,500–\$3,500/oz	\$45,000–\$80,000/kg
Minneapolis	\$150–\$200/g	\$4,500–\$7,500/oz	N/A
Newark	\$58–\$140/g	\$600–\$3,160/oz	\$45,000–\$80,000/kg
New Orleans	\$300–\$600/g \$20–\$25/paper	\$4,000–\$9,000/oz	\$80,000–\$100,000/kg
New York	\$90–\$100/g SEA \$60–\$80/g SA \$75–\$100/bundle \$10–\$14/bag	\$2,100/oz SA	\$60,000–\$75,000/kg SA \$60,000–\$100,000/kg SWA
Philadelphia	\$65–\$300/g \$70–\$200/bundle \$10–\$20/bag	\$2,100–\$3,500/oz	\$95,000–\$105,000/kg
Phoenix	\$80/g MBT \$20/paper	\$1,100–\$1,700/oz	\$42,000–\$48,000/kg MBT
St. Louis	\$100–\$300/g MBT \$10/button (1/10 gram) MBT	\$900–\$1,500/oz MBT \$2,500/oz (white)	N/A
San Diego	\$60/g MBT \$5–\$15/¼ g MBT	\$600–\$1,200/oz MBT	N/A
San Francisco	\$40–\$60/g MBT \$10/dosage unit	\$300–\$600/oz MBT	\$9,200–\$30,000/kg MBT
Seattle	N/A	\$400–\$900/piece	\$8,000–\$10,000/lb
Washington, DC	\$95/g \$10–\$20/bag	N/A	\$80,000–\$110,000/kg

¹N/A=Not available.

²MBT=Mexican black tar.

³MBP=Mexican brown powder

⁴SA=South American.

⁵SWA=Southwest Asian.

⁶SEA=Southeast Asian.

SOURCE: *Narcotics Digest Weekly*, NDIC

Prices for heroin differed based on both the type and the location of the purchase. In the second half of 2003, grams ranged in price from a low of \$40 for Mexican black tar in San Francisco to a high of \$600 in New Orleans. Capsules were available for \$10 in Baltimore and Dallas, while bags of heroin sold for as low as \$6 in Boston. In New York City, sellers reportedly gave buyers a special deal to purchase 10 \$10 bags for \$60, thus earning \$40 for themselves. Those sellers had earned enough profit to reduce their own price to \$8 or \$9 per bag, thus making heroin even more accessible.

DEA: Domestic Monitor Program Data

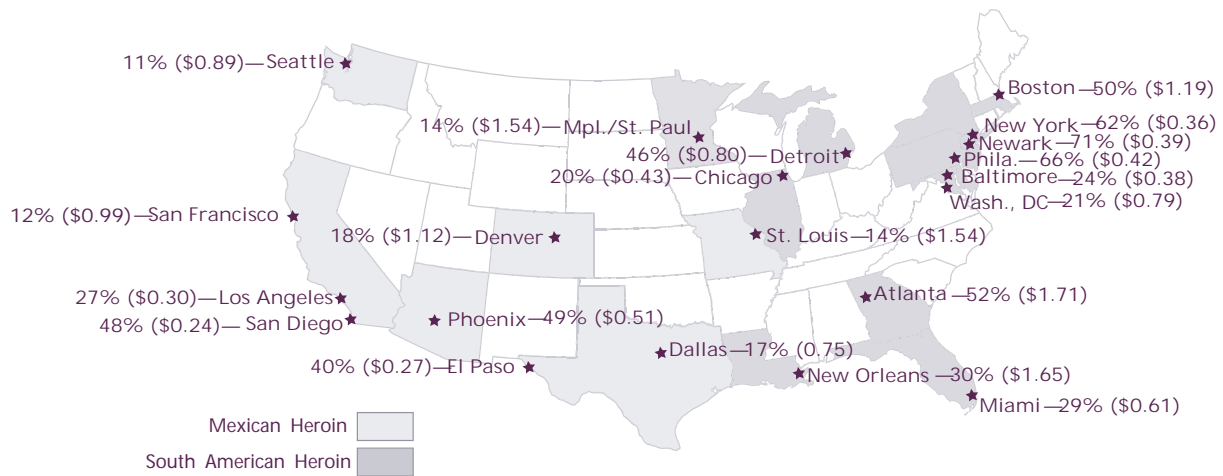
Undercover heroin purchases, made by DEA agents on the streets of CEWG cities in 2002, show high-purity levels of South American heroin in

Newark (71 percent), Philadelphia (66 percent), New York (62 percent), and Boston (50 percent). Purity levels were lower in other east coast cities, ranging from 21 percent in Washington, DC, to 29 percent in Miami (*see exhibit 17*).

The average prices of heroin, per milligram pure, were relatively low in all northeast cities except Boston (\$1.19 per milligram pure).

Purity levels for black tar heroin were relatively low in some western and southwestern areas—Seattle (11 percent), San Francisco (12 percent), and Los Angeles (27 percent)—but somewhat higher in border areas, ranging between 40 and 49 percent in El Paso, San Diego, and Phoenix. Prices per milligram pure were also low in border areas.

Exhibit 17. Domestic Monitor Program—Average Heroin (Based on Primary Source) Purity and Price¹ in 20 Areas: 2002



¹Price per milligram pure.
SOURCE: DMP, DEA

OTHER OPIATES/ NARCOTICS



Narcotic analgesic abuse indicators increased in nearly all CEWG areas in recent years. Rates of ED narcotic analgesics/combinations mentions per 100,000 population rose significantly in 14 CEWG areas from 2000 to 2002. The rates in 2002 were especially high in Baltimore (165), New Orleans (98), Boston (97), Detroit (97), and Seattle (95). The particular types of narcotic analgesics abused varied by geographic area, as indicated in the ED data and supported by forensic data from police labs (NFLIS). Most commonly abused were oxycodone and hydrocodone products, codeine, and methadone.

Boston

Narcotic analgesics, including oxycodone and other opiates, show alarming increases in various indicators. The 2002 narcotic analgesics/combinations rate of 97 ED mentions per 100,000 population was twice the national rate, and Boston had the highest oxycodone/combinations ED rate among all 21 DAWN sites. —**Daniel Dooley**

Denver

The DEA reports that diversion of OxyContin continues to be a ‘major problem’ in the Rocky Mountain West...with pharmacy break-ins common. Across the State, clinicians are anecdotally reporting increased use of Vicodin and OxyContin. —**Bruce Mendelson**

Detroit

In the first 10 months of 2003, about 175 cases of intentional hydrocodone abuse were reported to the poison control center, which is more than 3 times as many cases as in 2002. —**Richard Calkins**

Miami/Ft. Lauderdale

The Broward Crime Lab tested 130 oxycodone cases in the first half of 2003, a 27-percent increase from the 105 such cases in the second half of 2002. —**James Hall**

Minneapolis/St. Paul

Prescription narcotic analgesics, used medically in the treatment of pain, are increasingly used as drugs of abuse for the heroin-like high they produce. —**Carol Falkowski**

New Orleans

Treatment admissions for primary abuse of ‘other opiates’ rose from 1.3 percent of all treatment admissions in 2002 to 3.4 percent in 2003. —**Gail Thornton-Collins**

Newark

ED data show a statistically significant increase in the rate of narcotic analgesics/combinations mentions, rising from 31 per 100,000 population in 2000, to 43 in 2001, to 64 in 2002. —**Anna Kline**

Phoenix

Pain management clinics continue to be the focus of investigation, reportedly because of the excessive prescribing of controlled substances. Ten-miligram methadone tablets were diverted to street-level sales. —**Ilene Dode**

San Francisco

Local street-based observers concur that use of opiates/narcotics other than heroin are on the rise. —**John Newmeyer**

Texas

Hydrocodone abuse indicators continue to be higher than indicators for other narcotic analgesics. The poison control centers reported 429 cases of hydrocodone abuse or misuse in 2002, and 147 in the first half of 2003. In comparison, there were 68 oxycodone abuse or misuse cases in 2002, and 23 in the first half of 2003. Fifty-four cases involved misuse or abuse of methadone in 2002, compared with 20 in the first half of 2003. OxyContin is available on the streets in Austin.

‘Lean’ (codeine cough syrup), long popular in Houston, has reportedly become more popular in Beaumont, San Antonio, and Waco, as well as among youth and young adults in the suburban areas of Fort Worth. In Austin, Lean or ‘Drank’ is called a ‘nighttime drug’ that can be used for nodding or ‘slightly sleep.’ The cough syrup is cut with orange-, strawberry-, or pineapple-flavored water.

—Jane Maxwell

Washington, DC

Both the DEA and the Metropolitan Police Department have units investigating the diversion of prescription narcotics, such as OxyContin and methadone. Narcotic medications are readily available in street markets and are also obtained through ‘doctor shopping’ by organized groups, prescription fraud, and improper prescribing practices. Twelve deaths involving oxycodone and 15 involving methadone were reported in the District in 2001.

—Eric Wish

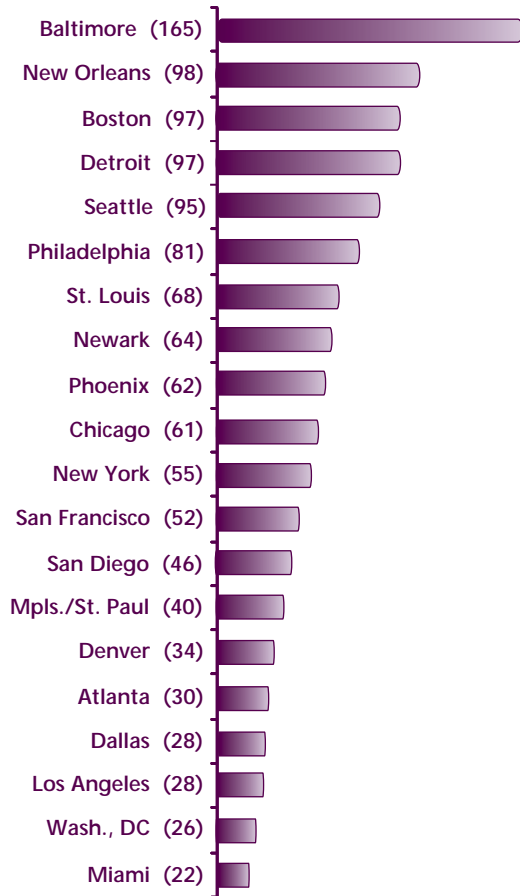
Patterns/Trends Across CEWG Areas

DAWN ED Data on Narcotic Analgesics

In 2002, the rate of narcotic analgesics/combinations mentions per 100,000 population was highest in Baltimore (see exhibit 18). Also, the rate (165) in Baltimore increased significantly from 114 in 2001. The 2002 rates ranged between 95 and 98 in Boston, Detroit, New Orleans, and Seattle, followed by Philadelphia at 81. Rates ranged between 61 and 68 in Chicago, Newark, Phoenix, and St. Louis. Newark, Philadelphia, and St. Louis experienced significant increases, and Seattle and San Diego experienced significant decreases between 2001 and 2002.

Oxycodone/combinations ED mentions were highest in Boston ($n=1,239$) and Philadelphia (1,184) in 2002 (see exhibit 19 on the following page). Significant increases from 2001 were reported in Baltimore, Detroit, St. Louis, San Francisco, and

Exhibit 18. Rates of Narcotic Analgesics/Combinations ED Mentions Per 100,000 Population: 2002

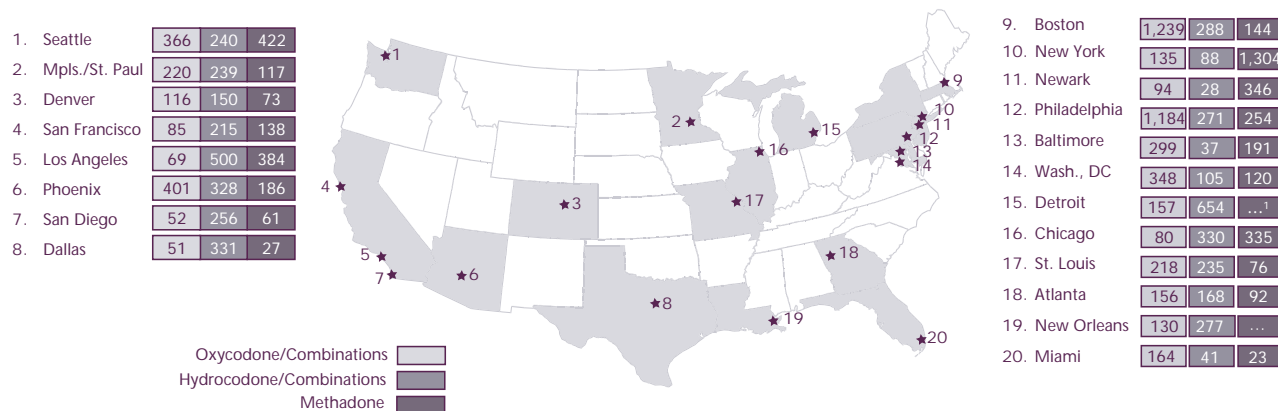


SOURCE: DAWN, OAS, SAMHSA

Seattle. There were no significant decreases across CEWG areas.

Hydrocodone/combinations ED mentions were highest in Detroit (654) and Los Angeles (500), although neither changed significantly from 2001 (see exhibit 19 on the following page). Chicago and Dallas reported 330 and 331 mentions, respectively. In 8 other CEWG areas, hydrocodone/combinations ED mentions ranged between 215 and 288, with a significant increase in Minneapolis/St. Paul. Significant decreases were reported for Baltimore, San Diego, and Seattle between 2001 and 2002.

Exhibit 19. Number of Oxycodone/Combinations, Hydrocodone/Combinations, and Methadone ED Mentions: 2002



¹Dots (...) indicate that an estimate with a relative standard error greater than 50 percent has been suppressed.
SOURCE: DAWN, OAS, SAMHSAS

Methadone ED mentions were much higher in New York than any other CEWG site, at 1,304 (see exhibit 19). Four other areas had between 335 and 422 methadone ED mentions—Chicago, Los Angeles, Newark, and Seattle.

Mortality Data on Other Opiates

Because CEWG areas that report local medical examiner data categorize deaths involving “other opiates/narcotics” differently, the findings are not comparable across sites.

Detroit

Toxicology findings from the Wayne County ME lab showed 241 cases of codeine positivity in 2002, compared with an expected 212 cases in 2003 (based on the first 8 months of 2003).

—Richard Calkins

Miami

Miami-Dade County reported six oxycodone-related deaths during the first half of 2003, five of which were oxycodone-induced deaths. Broward County recorded 28 oxycodone-related deaths, of which 19 (68 percent) were oxycodone-induced. Only one involved oxycodone alone. In Palm Beach County, there were 35 oxycodone-related and 15 oxycodone-induced deaths. Another drug was present in 89 percent of the cases. Methadone-related deaths in the first half of 2003 totaled 1 in Miami-Dade County, 18 in Broward County, and 37 in Palm Beach County.

—James Hall

Phoenix

Deaths related to other narcotics, including propoxyphene-related deaths, declined from 70 in 2000 to 54 in 2001, only to rise to 69 for 2002—a 27-percent increase. In the first 4 months of 2003, deaths involving ‘propoxyphene/ other narcotics’ totaled 33.

—Ilene Dode

Seattle

In the first half of 2003, there were 38 deaths identified by the King County ME that involved other opiates—7 more than in the first half of 2002.

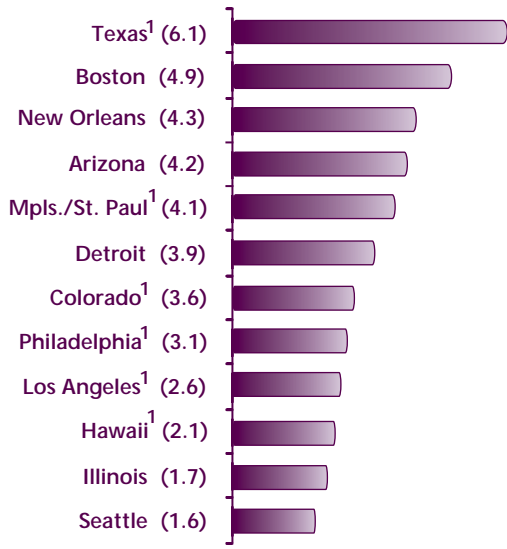
—Caleb Banta-Green

Treatment Data on Other Opiates

Eighteen CEWG areas reported on admissions for primary abuse of an opiate/narcotic other than heroin (exceptions were Atlanta, Miami, and San Francisco). Exhibit 20 shows the most recent data for 12 CEWG areas where primary “other opiate” admissions exceeded 1 percent of all illicit drug admissions.

As shown, “other opiates” accounted for only small proportions of treatment admissions in CEWG areas reporting these data, with admissions being highest in Texas (6.1 percent).

Exhibit 20. Percentages of Primary “Other Opiate” Treatment Admissions (Excluding Alcohol) in 12 CEWG Areas: 2002–2003



¹Represents only the first 6 months of 2003.
SOURCE: CEWG December 2003 reports on State and local data

NFLIS Data on Narcotic Analgesics

In the period from October 1, 2002, to September 30, 2003, oxycodone was found in forensic laboratory analyses in most CEWG sites, with Philadelphia (289), Atlanta (Decatur) (134), and New York (111) reporting the highest numbers of oxycodone items (*see exhibit 21*).

Hydrocodone was reported by forensic laboratories in most CEWG areas, with relatively high numbers of items analyzed in Houston (328). Other areas with relatively high numbers of hydrocodone items included Atlanta (Decatur) (196), Los Angeles (129), New York (123), and San Diego (121).

Codeine items accounted for small proportions of all items analyzed in CEWG areas, with Houston (220), Philadelphia (82), and Los Angeles (77) having the highest numbers reported.

Methadone items also accounted for small proportions of items analyzed in CEWG areas with the highest number, by far, being in New York (403).

Exhibit 21. Estimated Numbers of Analyzed Narcotic Analgesic Items in CEWG Areas: October 2002–September 2003

NFLIS Area	Oxycodone	Hydrocodone	Codeine	Methadone
Atlanta (Decatur) ¹	134	196	20	47
Baltimore	16	15	15	16
Boston	88	44	8	17
Chicago ²	0	31	4	4
Denver	14	25	7	5
Honolulu ¹	7	12	2	5
Houston ¹	20	328	220	0
Los Angeles ¹	18	129	77	12
Miami	53	22	8	5
New Orleans	19	98	6	21
New York ^{1,2}	111	123	65	403
Philadelphia	289	63	82	23
St. Louis	27	31	0	13
San Diego	30	121	25	8
Seattle	27	18	7	13
Washington, DC ¹	4	6	3	15

¹Data are not complete for all months.
²Represents multiple sites.
SOURCE: NFLIS, DEA

COCAINE/CRACK



Cocaine, especially crack cocaine, continues to be widely available and a major problem in most CEWG areas, despite some stabilization in recent years.

Washington, DC

Cocaine, particularly in the form of crack, remains the most serious drug threat in the District, accounting for more ED episodes, admissions to publicly funded treatment, and drug-related deaths than any other drug. It is most often sold at open-air markets in the poorer parts of the city and has decreased in price.

—Eric Wish

Boston

Cocaine/crack indicators are stable, showing continued high levels of use and abuse.

—Daniel Dooley

Chicago

Many cocaine indicators remained highest for all substances except alcohol. Cocaine-related treatment admissions increased by 20 percent (FY 2002–2003), and increases in use among Chicago school students, especially among 8th graders, were observed in 2002.

—Matthew Magee

New Orleans

Cocaine abuse, particularly of crack, continues to be a major drug problem in New Orleans. Cocaine powder continues to be converted into crack and distributed primarily in the lower income areas of the city.

—Gail Thornton-Collins

Philadelphia

Cocaine/crack remains a major drug of abuse in Philadelphia. Since 1999, an average of 83 percent of primary cocaine treatment admissions reported smoking the drug.

—Samuel Cutler

There are reports that use and abuse of powder cocaine are increasing, and that use is emerging in new populations.

Atlanta

Powder cocaine abuse may be increasing. While smoking remained the preferred route of administration among nearly 70 percent of the primary cocaine treatment admissions in the first half of 2003; this represented nearly a 13-percentage-point decrease over the proportion of smokers in the first half of 2002.

—Kristin Wilson

Chicago

Powder cocaine abuse has been increasing in some Chicago communities. Powder cocaine has become more available and is of higher purity—in the 50 to 90 percent range—in these areas.

—Matthew Magee

Denver

One of the reasons for the increase in powder cocaine in Colorado is the shift in how and to whom it is marketed. Cocaine distributors are constantly moving it around. When one market is closed, another is opened. One example is the increase of cocaine use in Hispanic communities.

—Bruce Mendelson

New Orleans

In New Orleans, increases in homicide cases are associated with the increases in powder cocaine indicators.

—Gail Thornton-Collins

New York

Admissions for primary cocaine abuse represented an aging population; crack smokers tend to be older than those using cocaine intranasally. The Street Studies Unit finds cocaine hydrochloride widely available, and buying and use continue to rebound.

The majority of powder cocaine users are Hispanic and Black, but there is a sizable number of White users, including an influx of white-collar professionals, who use cocaine recreationally. Field staff also report large clusters of young buyers in the 18–25-year-old range, suggesting a new generation of users.

—Rozanne Marel

Texas

Between 1987 and 2003, the proportion of treatment admissions using powder cocaine who were Hispanic increased from 23 to 45 percent, while for Anglos the percent dropped from 48 to 44 percent, and for African-Americans, from 28 to 10 percent.
—Jane Maxwell

New populations of crack abusers are also being reported.

Detroit

A newly emerging population of heavy crack users is reported to involve Native Americans living around northern Michigan casinos.
—Richard Calkins

Texas

Use of crack cocaine, which is at an endemic level, continues to move beyond African-American users to Anglo and Hispanic users. The proportion of crack cocaine admissions who were African-American dropped from 75 percent in 1993 to 51 percent in 2003, while the proportion of Anglos increased from 20 percent in 1993 to 33 percent in 2003, and the percentage of Hispanic admissions increased from 5 to 14 percent in the same time period.
—Jane Maxwell

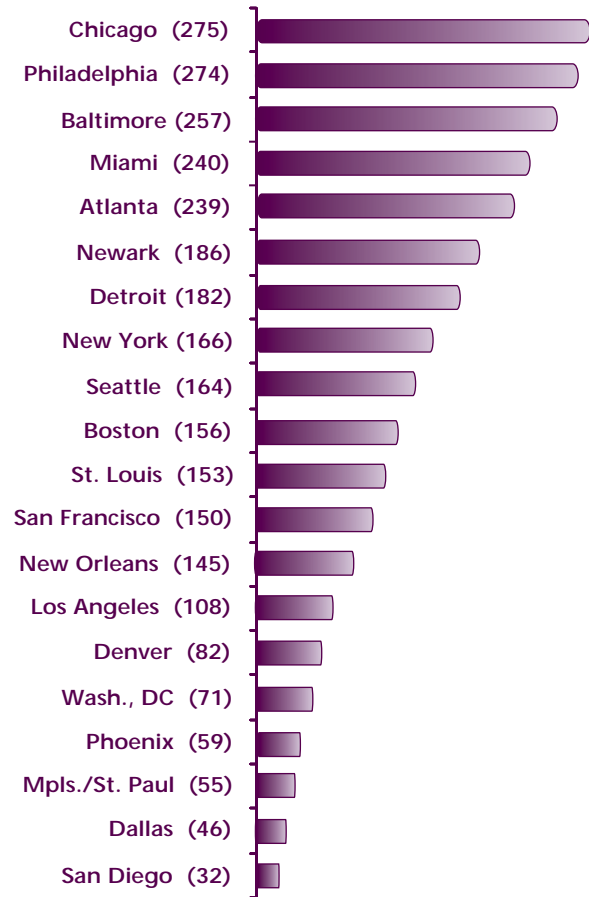
**Patterns/Trends
 Across CEWG Areas**

DAWN ED Data on Cocaine/Crack

Rates of ED mentions per 100,000 population were higher for cocaine than for any other drug in 17 CEWG areas. Two exceptions were Newark and San Francisco, where rates of heroin mentions were higher than those for cocaine (at 214 and 171, respectively).

As shown in exhibit 22, rates in 2002 were highest in Chicago (275), Philadelphia (274), Baltimore (257), Miami (240), Atlanta (239), Newark (186), and Detroit (182).

Exhibit 22. Rates of Cocaine ED Mentions Per 100,000 Population: 2002



SOURCE: DAWN, OAS, SAMHSA

Rates of cocaine ED mentions increased significantly between 2001 and 2002 only in Baltimore and decreased only in Dallas (*see exhibit 23*).

Exhibit 23. Rates of Cocaine ED Mentions Per 100,000 Population in CEWG Areas and Percent Change: 2000–2002

CEWG Area	2000	2001	2002	Percent Change ¹	
				2000, 2002	2001, 2002
Atlanta	221	244	239	8.0	
Baltimore	208	214	257	23.6	19.7
Boston	108	138	156		
Chicago	246	277	275		
Dallas	87	57	46	-47.2	-19.3
Denver	83	69	82		
Detroit	179	186	182		
Los Angeles	105	117	108		
Miami	225	225	240		
Minneapolis/St. Paul	35	43	55		
New Orleans	162	123	145	-10.5	
New York	166	166	166		
Newark	147	152	186		
Philadelphia	216	252	274		
Phoenix	85	62	59		
St. Louis	98	134	153	55.8	
San Diego	41	32	32	-23.1	
San Francisco	126	158	150	19.7	
Seattle	169	160	164		
Washington, DC	72	69	71		

¹These columns denote statistically significant (p<0.05) increases and decreases between estimates for the time periods shown.
SOURCE: DAWN, OAS, SAMHSA

Mortality Data on Cocaine/Crack

Local ME data were reported for varying time periods in 2003 (*see exhibit 24*). Detroit’s projected data suggest cocaine-related deaths may decline over the full year, but the city will likely continue to have the highest number of cocaine-related deaths across the eight CEWG sites reporting death data. Miami-Dade and Broward Counties, Florida, as well as Philadelphia and Phoenix, continue to report sizable numbers of cocaine-related deaths.

Exhibit 24. Number of Cocaine-Related Deaths Reported by Local MEs in 8 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003 ¹
Detroit	395	406	417	399
Honolulu	22	24	23	14
Miami	184	201	215	162
Mpls./St. Paul	60	48	45	36
Philadelphia	321	300	270	155
Phoenix	167	138	116	45
St. Louis	66	NR ²	58	NR
Seattle	89	49	79	23

¹Detroit data are projected for the full year; Minneapolis (Ramsey and Hennepin Counties) are for the first 9 months, Broward County for the first 5 months, Phoenix the first 4 months, and Miami-Dade County and all other areas for the first 6 months.

²NR=Not reported.

SOURCE: MEs/coroners as cited in CEWG December 2003 reports

Treatment Data on Cocaine/Crack

Primary cocaine treatment admissions—excluding alcohol admissions—continued to be proportionately highest in 9 of the 21 CEWG areas, ranging between 40 and 53 percent of the admissions in Philadelphia, St. Louis, New Orleans, Atlanta, and Washington, DC, and between approximately 31 and 39 percent of the illicit drug admissions in Illinois, Miami, Detroit, and Texas (*see exhibit 25*).

Exhibit 25. Percentages of Primary Cocaine Treatment Admissions by CEWG Area (Excluding Alcohol): 2001–2003

CEWG Area/State	Year			% Crack
	2001	2002	2003	
Atlanta ²	68.1	60.8	53.4	67.8
Baltimore	15.1	11.6	NR ³	NR
Boston	16.0	15.0	12.6	NR
Detroit	38.7	38.6	38.6	93.1
Los Angeles ²	22.9	23.3	23.6	86.6
Miami (sample) ²	NR	45.3	33.4	NR
Mpls./St. Paul ²	26.6	27.2	26.1	NR
New Orleans	40.0	42.7	43.1	NR
New York ²	29.3	28.5	29.4	61.0
Newark ²	7.0	6.8	6.7	74.7
Philadelphia ²	39.6	40.3	40.0	82.7
St. Louis ²	44.3	41.9	42.3	90.7
San Diego ²	12.1	10.2	9.0	77.0
San Francisco ²	24.1	24.0	24.1	NR
Seattle	21.9	12.5	NR	NR
Washington, DC	41.4	41.9	NR	NR
Arizona	19.0	16.7	16.2	54.3
Colorado ²	20.7	20.7	21.9	62.1
Hawaii ²	8.0	8.5	6.1	63.7
Illinois	31.6	30.0	31.4	85.0
Texas ²	38.9	38.7	38.8	70.8

¹Represents the percentage of primary cocaine admissions who reported smoking the drug.
²Represents only the first 6 months of 2003.
³NR = Not reported.
 SOURCES: CEWG December 2003 reports on State and local data

High percentages of the primary cocaine abusers entering treatment were crack abusers (smoked the drug). CEWG areas reporting the highest percentages of crack abusers among cocaine admissions in 2003 included Detroit (93.1 percent), St. Louis (90.7 percent), Los Angeles (86.6 percent), Illinois (85.0 percent), and Philadelphia (82.7 percent).

ADAM Data on Cocaine

In the initial quarters of 2003, the proportions of adult males testing cocaine-positive were near or exceeded one-half of the samples in Chicago (54.7 percent), New Orleans (49.0 percent), and Atlanta (48.5 percent) (*see exhibit 26*). In five other ADAM/ CEWG sites, between 33 and 39 percent of adult males tested cocaine-positive. The proportions with positive toxicology screens for cocaine were less than 10 percent in two sites (Honolulu and San Diego).

Exhibit 26. Percentages of Adult Male Arrestees Testing Cocaine-Positive in 15 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003 ¹
Atlanta	48.5	NS ²	49.9	48.5
Chicago	37.0	40.6	47.9	54.7
Dallas	27.7	30.4	29.9	33.5
Denver	35.4	33.8	32.7	38.8
Honolulu	15.8	10.8	9.1	7.6
Los Angeles	NS	NS	32.1	24.6
Minneapolis	25.7	28.0	30.8	27.3
New Orleans	34.8	37.3	42.4	49.0
New York	48.8	44.6	49.0	28.3
Philadelphia	30.9	36.7	38.7	31.6
Phoenix	31.9	27.2	27.8	25.2
San Antonio	20.4	29.6	32.5	31.6
San Diego	14.8	14.1	12.7	9.6
Seattle	31.3	32.0	38.1	36.0
Washington, DC	NS	NS	27.5	26.4

¹Estimates are for various quarters in 2003.
²NS = Not sampled or reported.
 SOURCE: ADAM, NIJ

The proportions of adult female arrestees testing cocaine-positive in the first quarters of 2003 were particularly high in Denver (54.8 percent), Minneapolis (39.6 percent), Washington, DC (38.9 percent), Los Angeles (38.5 percent), and New Orleans (37.3 percent) (*see exhibit 27*).

Exhibit 27. Percentages¹ of Adult Female Arrestees Testing Cocaine-Positive in 9 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003
Denver	46.9	45.0	43.6	54.8
Honolulu	19.4	9.7	7.2	11.4
Los Angeles	NS ²	NS	21.4	38.5
Minneapolis	NS	NS	NS	39.6
New Orleans	41.1	38.1	42.2	37.3
New York	53.0	56.9	38.9	NS
Phoenix	35.2	31.6	25.9	28.3
San Diego	26.1	16.5	21.2	15.2
Washington, DC	NS	NS	37.5	38.9

¹Data are unweighted and, for 2003, averaged across various quarters.
²NS = Not sampled or reported.
 SOURCE: ADAM, NIJ

NFLIS Data on Cocaine

The numbers of cocaine items analyzed in the NFLIS system from October 2002 through September 2003 were high in most areas represented in exhibit 28, exceeding even the number of marijuana items in eight areas. In Baltimore and Newark, where heroin indicators are relatively high, the number of cocaine items analyzed exceeded those for heroin. The numbers of cocaine items were highest in New York (25,270) and lowest in Honolulu (249). As a proportion of all items analyzed, cocaine accounted for around one-half or more of all items in Denver, Miami-Dade County, the New York sites, and Newark.

Cocaine/Crack Availability and Prices

Powder cocaine remained widely available in nearly all CEWG areas in 2003. It was reported to be increasingly available in King County (Seattle), and powder cocaine purchases continued to

Exhibit 28. Estimated Number of Analyzed Cocaine Items and Percentage of All Items Tested in 18 CEWG Areas: October 2002–September 2003

Area	Number	Percent
New York ¹	25,270	52.8
Texas ^{1,2}	17,514	31.8
Los Angeles Co. ²	15,769	34.1
Baltimore	15,128	47.2
Miami-Dade Co.	8,989	67.6
Philadelphia	8,735	44.8
Atlanta (Decatur) ¹	6,491	41.1
New Orleans	4,661	39.0
St. Louis	2,780	45.3
Denver	2,131	50.1
Detroit	2,106	46.4
Boston	1,869	26.9
Newark	1,867	49.7
San Diego	1,702	12.7
Washington, DC ²	1,434	39.0
Seattle	1,227	39.6
Chicago ¹	760	20.4
Honolulu ²	249	11.9

¹Represents multiple sites.
²Data are not complete for all months.
 SOURCE: NFLIS, DEA

rebound in New York City. As shown in exhibit 29, retail prices for a gram of powder cocaine ranged from a low of \$25 and \$28 in New York and Philadelphia, respectively, to a high of \$200 in Baltimore. Additionally, \$10 quantities were available at the street level in Baltimore (per vial) and San Francisco (per one-quarter gram). At the wholesale level, kilogram prices ranged from \$10,000 (lowest price in Seattle) to \$52,000 in Honolulu.

Similar to powder cocaine, crack cocaine remained widely available and readily accessible throughout CEWG areas in 2003. Crack prices were relatively stable, with rocks available for prices as low as \$3

Exhibit 29. Powder Cocaine Prices in 21 CEWG Areas: July–December 2003

City	Retail	Ounce	Wholesale
Atlanta	\$75–\$100/g	\$600–\$1,000	\$18,000–\$25,000/kg
Baltimore	\$50–\$200/g \$10/vial	\$750–\$1,200	\$20,000–\$32,000/kg
Boston	\$50–\$90/g	\$750–\$1,200	\$23,000–\$32,000/kg
Chicago	\$75–\$100/g	\$900–\$1,100	\$18,000–\$22,000/kg
Dallas	\$50–\$80/g	\$650–\$950	\$16,000–\$22,000/kg
Denver	\$50–\$100/g	\$500–\$1,000	\$16,000–\$22,000/kg
Detroit	\$50–\$120/g	\$850–\$1,500	\$17,000–\$26,000/kg
Honolulu	\$250–\$350/⅓ oz \$100–\$120/g \$25–\$35/¼ g	\$1,000–\$1,500	\$24,000–\$52,000/kg \$13,500–\$25,000/lb
Los Angeles	\$80/g	\$500–\$600	\$14,000–\$17,000/kg
Miami	\$30–\$60/g	\$700–\$800	\$18,000–\$26,000/kg
Minneapolis	\$70–\$150/g	\$700–\$2,000	\$18,000–\$28,000/kg
Newark	\$30–\$100/g	\$500–\$1,800	\$19,000–\$34,000/kg
New Orleans	\$250/¼ oz \$80–\$150/g	\$800–\$1,200	\$18,000–\$25,000/kg \$1,200/lb
New York	\$25–\$35/g	\$800–\$1,600	\$22,000–\$26,000/kg
Philadelphia	\$28–\$125/g	\$800–\$1,300	\$23,000–\$35,000/kg
Phoenix	\$120–\$250/eightball	\$400–\$800	\$14,000–\$17,000/kg
St. Louis	\$100/g	\$700–\$1,200	\$25,000/kg
San Diego	\$40–\$80/g \$20–\$30/¼ g	\$500–\$800	\$12,650–\$19,500/kg
San Francisco	\$35–\$50/g \$10–\$25/¼ g	\$350–\$800	\$15,000–\$21,000/kg
Seattle	\$30/g	\$520–\$900	\$10,000–\$24,000/kg
Washington, DC	\$500–\$600/¼ oz \$150–\$335/eightball \$50–\$100/g	\$900–\$1,300	\$17,000–\$35,000/kg

SOURCE: *Narcotics Digest Weekly*, NDIC

in Philadelphia; \$5 in Atlanta, Detroit, and New Orleans; and \$7 in New York (*see exhibit 30 on the following page*). At the wholesale level, kilograms ranged in price from \$16,000 (low end) in Newark and San Francisco to an upper-end price of \$35,000 in Newark.

Distribution networks for cocaine/crack exist throughout the country. Atlanta is reportedly a

growing distribution hub for surrounding States and Europe. The city serves as part of a smuggling corridor along the East Coast. Supplies of cocaine/ crack are brought into Colorado by street gangs from Los Angeles and Chicago. Wholesale cocaine distribution in Los Angeles is controlled by Mexican criminal groups and drug trafficking organizations.

Exhibit 30. Crack Cocaine Prices in 21 CEWG Areas: July–December 2003

City	Retail	Ounce	Wholesale
Atlanta	\$5–\$20/rock	\$800–\$1,000	\$10,000–\$12,000/lb
Baltimore	\$100–\$175/eightball \$50–\$200/g \$10–\$40/piece	\$650–\$1,400	\$20,000–\$26,200/kg
Boston	\$20–\$50/vial \$10–\$20/rock	\$850–\$1,600	N/A ¹
Chicago	\$10/rock	\$700–\$900	\$22,000–\$24,000/kg
Dallas	\$75–\$100/g	\$750–\$1,100	\$18,000–\$25,000/kg
Detroit	\$5–\$25/rock	\$1,000–\$1,500	N/A
Denver	\$50–\$100/g \$10–\$40/rock	\$650–\$1,000	\$8,800–\$10,000/lb
Honolulu	\$100–\$250/g \$25–\$30/¼ g	\$1,000–\$1,500	\$24,000/lb
Los Angeles	\$10–\$40/rock	\$500–\$1,200	N/A
Miami	\$10–\$20/rock	\$650–\$1,000	\$18,000–\$26,000/kg\$50
Minneapolis	\$15–\$25/rock \$50/vial	\$650–\$1,750	N/A
Newark	\$23–\$80/g	\$600–\$2,000	\$16,000–\$35,000/kg
New Orleans	\$5–\$25/rock \$80–\$125/g	\$900–\$1,200	\$20,000–\$28,000/kg \$8,000/lb
New York	\$7–\$10/rock \$27–\$45/g	\$800–\$1,600	\$28,000–\$30,000/kg
Philadelphia	\$18–\$83/g \$3–\$20/vial or rock (0.05–0.10 gram)	\$700–\$1,500	N/A
Phoenix	\$20/rock	\$500–\$600	N/A
St. Louis	\$100/g \$20/rock	\$1,000	\$20,000/kg
San Diego	\$10–\$20/rock	\$420–\$500	\$3,700/8.8 oz
San Francisco	\$20–\$50/rock	\$600	\$16,000–\$20,000/kg
Seattle	\$40/¼ g \$20/1/10 g	\$700–\$800	N/A
Washington, DC	\$80–\$100/g	\$1,000–\$1,300	\$28,000–\$34,000/kg

¹N/A=Not available.

SOURCE: *Narcotics Digest Weekly*, NDIC

CLUB DRUGS (MDMA/ECSTASY, GHB, KETAMINE)

CAVEAT: MDMA, a Controlled Substance Act Schedule I drug, has the properties of both a stimulant and a hallucinogen. Tablets sold as “ecstasy” may contain only MDMA, some MDMA, or other compounds and ingredients. Other ingredients or substances contained in ecstasy tablets and capsules differ by area and often within an area; these are not always distinguished in the data sources used by CEWG members. CEWG references to MDMA and ecstasy are based primarily on how the drug is defined by the local data/information sources used by members.



MDMA abuse indicators decreased or were stable in most CEWG areas. Concerns and issues raised by CEWG members regarding MDMA/ecstasy included the fact that users do not always know exactly what is contained in the pills they are taking. Members were concerned also about the use of other substances with MDMA, and the switching by MDMA users to other drugs, particularly methamphetamine. In some CEWG areas, ethnographers reported increased use of MDMA in African-American and Hispanic populations. GHB and ketamine indicators continue to be low in CEWG areas.

MDMA/ECSTASY

Increased MDMA use among African-American and Hispanic populations.

Atlanta

There is reportedly a growing number of African-American ecstasy users who take the drug at hip-hop clubs. —**Kristin Wilson**

Chicago

There have been increasing reports of ecstasy use from low-income African-Americans in their twenties and thirties who have been involved in club scenes. —**Matthew Magee**

New York

Although MDMA sellers are usually White young males of middle or upper class background, this profile is beginning to expand across racial, ethnic, and social class boundaries. The Street Studies Unit reports that street sales continue to increase to young Black and Puerto Rican youth in various parts of the city. —**Rozanne Marel**

Texas

Ecstasy has spread outside the club scene and into the Hispanic and Black communities. The proportion of White treatment admissions using ecstasy dropped from 92 percent in 1990 to 52 percent in 2003, while the proportion of Hispanics rose from 7 percent in 1990 to 27 percent in 2003 and that for Blacks from 1 to 20 percent. —**Jane Maxwell**

Washington, DC

MDMA abuse has been spreading to other inner city populations and venues. —**Eric Wish**

MDMA use by high school, college students, and young adults.

Denver

In the 2002 Colorado Youth Survey, lifetime (‘ever used’) use of MDMA was reported by 0.7 percent of 6th graders, 1.1 percent of 7th graders, 3.0 percent of 8th graders, 4.4 percent of 9th graders, 5.2 percent of 10th graders, 10.8 percent of 11th graders, and 9.8 percent of 12th graders. —**Bruce Mendelson**

New Orleans

Youth continue to be lured to MDMA because of its hipness and the myth that club drugs are safe. —**Gail Thornton-Collins**

New York

Many MDMA users are older high school students, college students, or young working professionals. These drugs are particularly popular among suburban White youth who regularly venture into the city for entertainment and fun. —**Rozanne Marel**

Seattle

In a community-based survey involving 310 rave attendees (median age, 20) and 64 youth in drug treatment agencies (median age, 17), lifetime use of MDMA was reported by 78 and 37 percent of the respondent groups, respectively.

—**Caleb Banta-Green**

Texas

The 2002 secondary school survey reported lifetime ecstasy use at 8.6 percent in 2002, compared with 4.5 percent in 2000.

—**Jane Maxwell**

Report of switching drugs.

Atlanta

Some MDMA users switched to methamphetamine, and some switched back to MDMA.

—**Johanna Boers**

Polydrug abuse among MDMA users.

Colorado

We are not seeing many primary MDMA abusers coming into treatment. It is often the secondary or tertiary drug reported.

—**Bruce Mendelson**

Michigan

In Michigan treatment data, MDMA is more likely to be a secondary or tertiary drug.

—**Richard Calkins**

Texas

Clients entering treatment with a primary, secondary, or tertiary ecstasy problem reported a primary problem with marijuana (37 percent), methamphetamine (18 percent), and powder cocaine (15 percent).

—**Jane Maxwell**

Washington, DC

The college students who use drugs like MDMA are likely to be using other drugs.

—**Eric Wish**

Ecstasy often contains drugs other than MDMA, and users may not know exactly what they are taking.

Miami

A problem is that they (ecstasy users) really don't know what it is they are taking.

—**James Hall**

Minneapolis/St. Paul

Area crime lab analysis revealed that some pills sold as ecstasy actually contained a combination of other drugs such as methamphetamine, ketamine, or 'MDA' (3,4-methylenedioxyamphetamine), a chemical similar in effect to MDMA.

—**Carol Falkowski**

Phoenix

The DEA reported that tested Pink Mercedes ecstasy tablets contained 8.3 percent MDMA.

—**Ilene Dode**

St. Louis

Toxicology reports showing high levels of MDMA (ecstasy) are rare. Most reports about high levels of MDMA abuse are anecdotal or are part of the polydrug user's history. Public treatment programs report no MDMA admissions.

—**James Topolski**

Washington, DC

PCP in pill form has been sold as ecstasy, according to the Metropolitan Police Department.

—**Eric Wish**

MDMA Patterns/Trends
Across CEWG Areas

DAWN ED Data on MDMA

The highest numbers of MDMA ED mentions in the 2002 period were in Philadelphia (177), Los Angeles (176), New York (143), Miami (135), San Francisco (129), Atlanta (118), Boston (116), and Detroit (108). MDMA ED mentions decreased in nine CEWG areas from 2001 to 2002, with a significant increase reported only in New Orleans (see exhibit 31).

Exhibit 31. MDMA ED Mentions by CEWG Area and Percent Change: 2000–2002

CEWG Area	Number			Change ¹
	2000	2001	2002	2001, 2002
Atlanta	68	175	118	-32.6
Baltimore	64	75	64	-14.7
Boston	125	140	116	
Chicago	215	121	87	
Dallas	71	77	53	-31.2
Denver	57	42	33	-21.4
Detroit	60	111	108	
Los Angeles	177	142	176	
Miami	105	184	135	-26.6
Mpls./St. Paul	65	77	77	
New Orleans	44	34	79	132.4
New York	200	172	143	
Newark	21	49	47	
Philadelphia	141	203	177	
Phoenix	76	96	50	-47.9
St. Louis	52	55	35	
San Diego	47	52	30	-42.3
San Francisco	107	152	129	-15.1
Seattle	128	115	86	-25.2
Washington, DC	78	110	92	

¹This column denotes statistically significant (p<0.05) increases and decreases between estimates for the time period shown.
SOURCE: DAWN, OAS, SAMHSA

Treatment Data on MDMA/Club Drugs

Four CEWG areas reported treatment data on one or more of the “club drugs,” as shown below.

Colorado

In FY 2003, 25 clients were admitted to treatment for primary MDMA abuse; 17 were male and 20 were White. One-third were diagnosed with a concurrent mental health problem.

Illinois

In FY 2002, Illinois began reporting admissions data related to “club drugs,” and 50 such admissions were reported. In FY 2003, 79 such admissions were reported.

Detroit

In FY 2003, there were 69 ecstasy-involved admits in Detroit/Wayne County. Ecstasy continues to be more common as a secondary or tertiary drug.

Texas

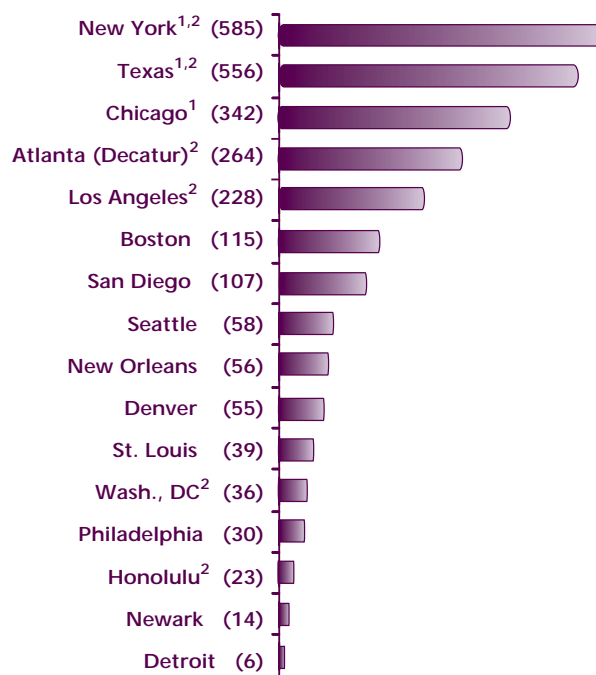
Admissions (all ages) for a primary, secondary, or tertiary problem with ecstasy increased from 63 in 1998 to 521 in 2002, with 312 admitted in the first half of 2003.

NFLIS Data on MDMA/MDA

Of the “club drugs” analyzed by NFLIS labs from October 2002 through September 2003, most were MDMA or 3,4-methylenedioxyamphetamine (MDA). New York and Texas had the largest number of items, both exceeding 500 (*see exhibit 32*). However, MDMA as a percentage of all items analyzed in each area was quite small. The highest

proportions ranged between 1 and nearly 2 percent in only eight CEWG areas: Washington, DC, and Texas (1.0 percent each), Honolulu (1.1 percent), New York (1.2 percent), Denver (1.3 percent), Atlanta (1.7 percent), and Miami and Seattle (each 1.9 percent). At all other sites, the percentages of MDMA items ranged from zero (Baltimore) to 0.8 percent (San Diego).

Exhibit 32. Number of MDMA/MDA Items Analyzed by Forensic Laboratories in CEWG Areas: October 2002–September 2003



¹Represents multiple sites.

²Data are not complete for all months.

SOURCE: NFLIS, DEA

MDMA Availability and Price

MDMA availability varied considerably across CEWG areas in 2003. While it was “widely available” in San Francisco and could be purchased in most mainstream dance clubs and at house parties in Chicago, MDMA became more difficult to buy in Detroit. In fact, some users in Detroit reportedly returned to using marijuana because it was more accessible.

As shown in exhibit 33, retail prices for MDMA in the second half of 2003 were as low as \$7 (Newark) and \$9 (Philadelphia) per tablet, but the more common retail table price was \$15–\$20. As with many drugs, MDMA prices decreased as the quantity purchased increased. In Denver, for example, the retail price was \$20 per tablet, but the wholesale price was \$8–\$12 per tablet when 500 tablets were purchased. Ethnographic data indicated that many users in Atlanta bought in bulk. In New York City, however, the most common sales unit for MDMA was the single pill or tablet.

Exhibit 33. MDMA Prices in 21 CEWG Areas: July–December 2003

City	Retail	Midlevel	Wholesale
Atlanta	\$25–\$30/tablet	N/A ¹	\$5–\$15/tablet
Baltimore	\$20/tablet	N/A	\$10–\$15/tablet
Boston	\$20–\$25/tablet	N/A	\$5–\$15/tablet
Chicago	\$25–\$35/dosage unit	\$14/dosage unit per jar ²	\$10–\$12/tablet
Dallas	\$10–\$25/tablet	N/A	\$4–\$6/tablet
Denver	\$20/tablet	\$12–\$16/tablet for 100 tablets	\$8–\$12/tablet for 500 tablets
Detroit	\$20–\$28/dosage unit	N/A	\$10–\$15/dosage unit per jar
Honolulu	\$15–\$20/tablet	N/A	N/A
Los Angeles	\$20–\$40/tablet	\$12/tablet	\$8,000 per boat ³
Miami	\$10–\$20/tablet	N/A	\$5–\$7/tablet
Minneapolis	\$15–\$45/dosage unit	N/A	\$8–\$11/dosage unit for 500–1,000 tablets
Newark	\$7–\$35/tablet	N/A	N/A
New Orleans	\$15–\$20/tablet	\$12–\$15/tablet	\$8–\$12/tablet
New York	\$15–\$28/tablet	\$700–\$1,800/100 tablets	N/A
Philadelphia	\$9–\$35/tablet	N/A	\$7.50–\$13/tablet
Phoenix	\$20–\$25/tablet	\$12–\$15/tablet	\$7–\$10/tablet
St. Louis	\$20–\$30/tablet	\$15/tablet for 100 tablets	\$10/tablet for 1,000 tablets
San Diego	\$10–\$20/tablet	\$10–\$15/tablet	\$6,000–\$8,000/boat \$30,000/lb powder
San Francisco	\$20–\$30/tablet	N/A	\$10–\$20/tablet
Seattle	\$18–\$25/tablet	\$800–\$1,200/100 tablets	\$6,000–\$9,000/boat \$5,000–\$8,000/lb
Washington, DC	\$18–\$35/tablet	N/A	\$6–\$14/tablet

¹N/A=Not available.

²Jar=100 tablets.

³Boat=1,000 tablets.

SOURCE: *Narcotics Digest Weekly*, NDIC

GAMMA HYDROXYBUTYRATE (GHB)



Gamma hydroxybutyrate indicators declined or remained low in almost all CEWG areas, but GHB remains a drug of concern.

Detroit

During FY 2002, there were 4 admissions to treatment in Michigan involving GHB as the primary drug and 12 total cases in which GHB was involved. In FY 2003, there were 4 admissions statewide with GHB as primary drug, and 11 total cases where it was involved. —**Richard Calkins**

Los Angeles

GHB mentions continued to represent very small proportions of all ED mentions. In 2002, 100 mentions of GHB were reported to the DAWN system in the Los Angeles-Long Beach metropolitan areas accounting for less than 0.5 percent of all mentions. —**Beth Finnerty**

Miami/Broward County

GHB hospital episodes and deaths continue to decline. There was also a dramatic decrease in the number of GHB emergency department cases treated in the most recent reporting period at Broward General Medical Center Emergency Department, where 13 people were treated for GHB or GHB precursor overdose in the first 6 months of 2003. —**James Hall**

Minneapolis/St. Paul

GHB hospital emergencies fell from a high of 93 in 2000 to 34 in 2003. —**Carol Falkowski**

New York

GHB is another club drug of concern in New York, although GHB ED mentions in New York City remain very low. —**Rozanne Marel**

Philadelphia

GHB cases were mentioned in DAWN ED data in only 4 of the last 10 half-year periods; the data were suppressed during the other periods. Most

focus groups composed of users new to treatment in the last 3 years have no familiarity with GHB. Participants since spring 2003 were only aware of its use ‘mostly in clubs and bars’ and ‘predominantly by males.’ —**Samuel Cutler**

St. Louis

GHB remains under scrutiny because its use with alcohol produces an unpredictable reaction. No recent deaths have been reported from this drug. —**Heidi Israel**

Seattle

In a community survey, 30 percent of rave attendees and 19 percent of respondents at gay bars reported ever using GHB, compared with only 3 percent of youth in treatment and 9 percent of respondents from gay bathhouses and sex clubs. —**Caleb Banta-Green**

Texas

Treatment admissions for a primary, secondary, or tertiary problem with GHB increased from 2 in 1998 to 35 in 2002, with 22 in the first half of 2003. —**Jane Maxwell**

Washington, DC

GHB abuse indicators continued at low levels. It has been reported that high school and college students get this drug from independent dealers and sell it at raves and dance parties. —**Eric Wish**

DAWN ED Data on GHB

In 2002, the rate of GHB ED mentions in the coterminous United States was 1 per 100,000 population. Six CEWG areas exceeded the national rate in 2002: San Francisco (8 per 100,000 population), Dallas and New Orleans (each with a rate of 3), and Miami, San Diego, and Seattle (each 2). The rates were zero or suppressed in Baltimore, Detroit, New York, Newark, Phoenix, St. Louis, and Washington, DC. Rates in other CEWG areas were 1 per 100,000 population, consistent with the rate in the coterminous United States. From 2001 to 2002, the rate increased significantly in Seattle while decreasing in Atlanta, Minneapolis/St. Paul, New Orleans, Philadelphia, and San Francisco.

KETAMINE



Small numbers of ketamine abusers were identified in the treatment and survey data accessed by CEWG members. (Ketamine is a dissociative general anesthetic used by veterinarians in the United States.) Ketamine abusers were admitted to treatment in Colorado, Michigan, and Texas, making it possible to assess their characteristics and behaviors.

Colorado

In FY 2003, four clients admitted to treatment reported ketamine as their primary drug of abuse. All were White (non-Hispanic), three were male, and three were 35 and older. Two had taken the drug orally, while one reported smoking, and another reported injecting. Two were diagnosed as being drug abusers or dependent. None was diagnosed with a concurrent mental health problem.

—**Bruce Mendelson**

Michigan

There were 11 ketamine-involved treatment admissions statewide in FY 2002, and 32 such cases in FY 2003. The only reports of ketamine in southeast Michigan ED mentions between 1995 and 2002 involved 12 cases in 2001.

—**Richard Calkins**

Seattle

Nearly one-third of 310 rave attendees and around one-fifth of gay bar survey respondents reported ever using ketamine.

—**Caleb Banta-Green**

Texas

Nine clients were admitted to TCADA treatment programs in the first half of 2003 with a secondary or tertiary problem with ketamine. The clients were older and rather evenly split between White and Hispanic. One-third had a history of injection drug use, and all had problems with the legal or criminal justice system.

—**Jane Maxwell**

DAWN ED Data on Ketamine

In 2002, only San Diego and San Francisco reported a rate of ketamine ED mentions of 1 per 100,000. The rate in other CEWG sites was either zero or suppressed because of incomplete data.

MARIJUANA



Marijuana abuse indicators remained at very high levels in 2002 and early 2003. However, indicators remained stable in most CEWG areas. ED mentions increased significantly in three areas and decreased significantly in four. CEWG members raised particular concern about the increased availability of higher potency marijuana, the use of marijuana in combination with other drugs, and new younger cohorts and older cohorts seeking treatment for marijuana abuse.

Marijuana is readily available and indicators are high.

Detroit

Marijuana indicators remain mostly stable but at high levels. Mexican marijuana continued to be the dominant form available, with reports of increases from Canada.

—**Richard Calkins**

Minneapolis/St. Paul

Marijuana indicators continued upward trends, although hospital emergencies stabilized in 2002. Law enforcement sources noted increased volume of marijuana cases, including a Minneapolis case involving more than 1,000 pounds in which marijuana, concealed inside cookie boxes, was shipped from Texas to a Twin Cities-area warehouse.

—**Carol Falkowski**

New Orleans

Marijuana remains a major problem in New Orleans, particularly among youth, and prices have decreased in some areas of the State because of the abundance of Mexican marijuana.

—**Gail Thorton-Collins**

Philadelphia

Focus group participants throughout 2003 reported the increasing use of blunts. These groups and outreach workers continued to report that marijuana use is widespread throughout Philadelphia.

—**Samuel Cutler**

Phoenix

Marijuana remains readily available in quantities to hundreds of kilograms packaged for delivery despite large quantities of seizures by the U.S. Customs Service and the U.S. Border Patrol at the ports of entry and at remote sites along the international border. A majority of the bulk marijuana seizures along the border were abandoned loads that had been stashed waiting further transport. The size of an average load ranged from 200 to 500 pounds.

—**Ilene Dode**

San Diego

Marijuana indicators continued to be high, with increases in ED mentions, treatment admissions, and adult female arrestee drug screens.

—**Michael Ann Haight**

CEWG members report that marijuana use is increasingly perceived as socially acceptable.

Denver

Uniformly across the State, treatment program staff describe two major aspects of marijuana use: it is readily available in a variety of prices and potencies, and it is ‘not taken seriously as a hard drug by society.’

—**Bruce Mendelson**

St. Louis

Marijuana, viewed by young adults as acceptable to use, is often combined with alcohol. In focus groups with African-American adults from various social groups, more than one-half identified regular use of marijuana, but did not identify this use as problematic. This ethnographic information supports the cultural acceptance of marijuana use.

—**James Topolski**

Many problems are associated with marijuana abuse.

Los Angeles

A total of 2,737 marijuana arrests were made within the city of Los Angeles in the first half of 2003, which represents a 14-percent increase over the number of marijuana arrests made in the first 6 months of 2002. Marijuana arrests accounted for approximately 18 percent of all narcotics arrests made in the first half of 2003. City of Los Angeles marijuana seizures increased 164 percent, from 3,479 pounds seized in the first half of 2002, to 9,185 pounds seized in the first half of 2003.

—**Beth Finnerty**

Miami

Cannabinoids were detected in 378 deaths statewide in Florida during the first half of 2003, a 13-percent increase from the 335 marijuana-related deaths in the previous 6 months.

—**James Hall**

Texas

Three-quarters of all adolescent admissions in 2003 had a primary problem with marijuana, compared with 35 percent in 1987. In 2003, 59 percent of the adolescents were Hispanic, 23 percent were Anglo, and 16 percent were African-American. (In 1987, 7 percent were African-American.) Eighty-three percent had legal problems or had been referred from the juvenile justice system; these clients did not appear to be as impaired as those who did not have legal problems. The juvenile justice clients reported using marijuana on 7.6 days in the month prior to admission, compared with 14.6 days for the non-justice referrals.

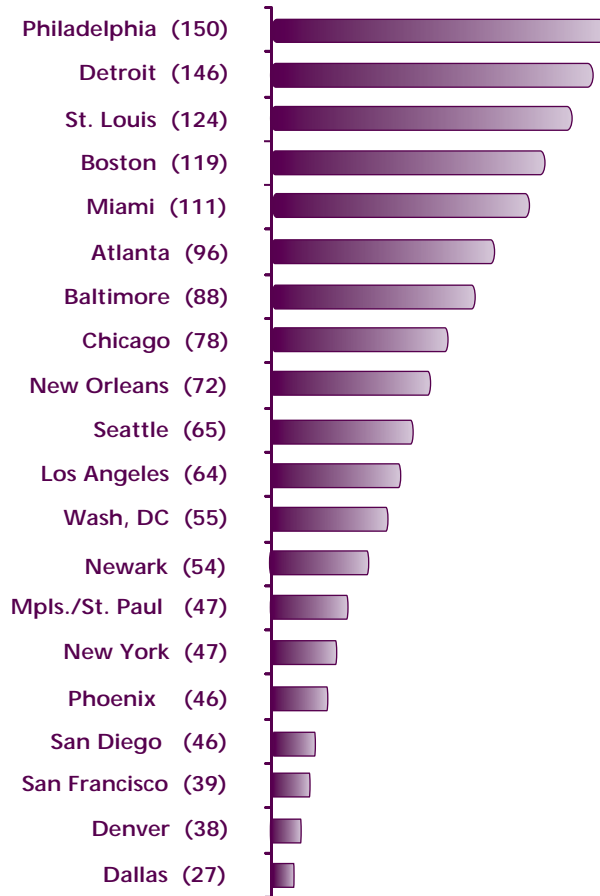
—**Jane Maxwell**

Marijuana Patterns/Trends Across CEWG Areas

DAWN ED Data on Marijuana

In 2002, rates of marijuana ED mentions per 100,000 population were highest in Philadelphia (150), Detroit (146), St. Louis (124), and Boston (119) (*see exhibit 34*).

Exhibit 34. Rates of Marijuana ED Mentions Per 100,000 Population: 2002



SOURCE: DAWN, OAS, SAMHSA

From 2001 to 2002, rates of marijuana ED mentions increased significantly in three east coast areas—Baltimore, Miami, and Newark—while rates decreased significantly in four—Chicago, Dallas, San Francisco, and Seattle (*see exhibit 35*).

Exhibit 35. Rates of Marijuana ED Mentions Per 100,000 Population in CEWG Areas and Percent Change: 2000–2002

CEWG Area	2000	2001	2002	Percent Change ¹	
				2000, 2002	2001, 2002
Atlanta	86	96	96		
Baltimore	68	78	88	29.1	13.2
Boston	78	96	119		
Chicago	89	89	78		
Dallas	49	34	27	-45.5	-21.0
Denver	51	50	38		
Detroit	99	121	146	47.6	
Los Angeles	67	67	64		
Miami	91	94	111	22.6	18.7
Mpls./St. Paul	33	46	47		
New Orleans	87	71	72		
New York	41	42	47		
Newark	29	37	54	85.5	44.4
Philadelphia	101	122	150	47.9	
Phoenix	51	45	46		
St. Louis	72	101	124	72.1	
San Diego	39	44	46	17.4	
San Francisco	38	45	39		-13.5
Seattle	72	75	65		-13.2
Washington, DC	64	51	55		

¹These columns denote statistically significant (p<0.05) increases and decreases in estimates between the time periods shown.

SOURCE: DAWN, OAS, SAMHSA

Treatment Data on Marijuana

Excluding Miami, most CEWG areas reported comparable data on primary marijuana treatment admissions from 2001 to either 2002 or 2003 periods (see exhibit 36). Excluding alcohol admissions, primary marijuana admissions continued to be highest in Minneapolis/St. Paul, at 46.2 percent of illicit drug admissions, although this reflected a 3-percentage-point decline from 2001. Marijuana admissions in eight areas remained relatively stable (changing less than 3 percentage points) between 2001 and 2003, while they increased in Detroit, Los Angeles, Philadelphia, Arizona, and Illinois. Conversely, primary marijuana admissions declined between 2001 and 2003 in Colorado by nearly 8 percentage points.

Exhibit 36. Primary Marijuana Treatment Admissions by CEWG Area and Percent (Excluding Alcohol): 2001–2003

CEWG Area	Year		
	2001	2002	2003 ¹
Atlanta	20.9	NR ³	NR
Baltimore	19.1	16.7	NR
Boston	7.7	6.6	6.6
Detroit	10.4	13.4	13.6
Los Angeles ²	11.3	14.2	16.6
Miami (sample) ²	NR	45.6	62.2
Mpls./St. Paul ²	49.2	47.7	46.2
New Orleans	37.5	37.0	36.7
New York ²	25.2	26.1	24.6
Newark ²	6.1	6.3	6.6
Philadelphia ²	19.7	22.4	22.7
St. Louis	35.5	36.3	36.3
San Diego ²	25.9	25.3	26.7
Seattle	34.4	34.0	NR
Washington, DC	7.9	5.9	NR
Arizona	36.5	36.1	39.6
Colorado ²	40.6	36.5	32.9
Hawaii ²	28.6	28.5	27.7
Illinois	25.9	28.1	29.8
Texas ²	26.1	25.8	26.4

¹San Francisco does not report marijuana specifically and, thus, is not represented in this exhibit.

²Represents only half-year data for 2003.

³NR = Not reported.

SOURCES: CEWG December 2003 reports on State and local data

ADAM Data on Marijuana

In 2003 time periods, high percentages of adult male arrestees tested positive for marijuana in the 15 ADAM/CEWG sites shown in exhibit 37, varying from 33.8 percent in Honolulu to 54.4 percent in Los Angeles.

Exhibit 37. Percentages of Adult Male Arrestees Testing Marijuana-Positive in 15 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003 ¹
Atlanta	38.2	NS ²	34.3	41.2
Chicago	45.0	50.2	49.4	53.3
Dallas	35.8	32.9	36.2	41.0
Denver	40.9	40.0	40.3	44.8
Honolulu	30.4	30.2	32.2	33.8
Los Angeles	NS	NS	36.4	54.4
Minneapolis	54.2	53.6	54.2	46.9
New Orleans	46.6	44.9	46.9	50.4
New York	40.6	40.5	44.3	35.3
Philadelphia	49.4	42.7	47.7	44.3
Phoenix	33.7	9.7	41.1	43.4
San Antonio	40.7	40.7	42.0	42.0
San Diego	38.7	36.4	37.8	43.2
Seattle	37.7	35.1	38.5	39.1
Washington, DC	NS	NS	40.7	37.3

¹Estimates are for various quarters in 2003.

²NS = Not sampled.

SOURCE: ADAM, NIJ

In the nine CEWG areas included in ADAM in 2003, the proportions of females testing marijuana-positive ranged from 25.7 percent in Hawaii to 37.5 percent in New Orleans and Minneapolis (see exhibit 38).

Exhibit 38. Percentages of Adult Female Arrestees Testing Marijuana-Positive in 9 CEWG Areas: 2000–2003¹

CEWG Area	2000	2001	2002	2003
Denver	33.8	33.0	32.6	32.3
Honolulu	19.4	13.9	20.3	25.7
Los Angeles	NS ²	NS	35.7	30.8
Minneapolis	NS	NS	NS	37.5
New Orleans	28.0	25.1	26.0	37.5
New York	28.2	32.1	30.6	30.3
Phoenix	23.3	26.5	29.2	31.9
San Diego	27.2	27.2	33.3	29.1
Washington, DC	NS	NS	32.5	33.3

¹Data are unweighted and, for 2003, averaged across various quarters.

²NS = Not sampled or not reported.

SOURCE: ADAM, NIJ

NFLIS Data on Marijuana

Marijuana (cannabis) tended to rank first or second in most CEWG areas in numbers of items analyzed by police labs. The numbers were especially high in Texas (16,294), New York sites (12,920), and Los Angeles County (11,620). As a percentage of all items analyzed, cannabis accounted for nearly three-quarters of the items in the Chicago area (*see exhibit 39*).

Marijuana Prices and Availability

Marijuana continued to be the most widely available illicit drug in most CEWG areas in 2003. The abundance and popularity of the drug was evidenced by the many types available: domestic, commercial grade, sinsemilla, hydroponic, “BC Bud” (a seedless, hybrid type from British Columbia), and Mexican. Additionally, Colombian and Jamaican marijuana were present, but not widely available, in Atlanta. Hashish, a tetrahydrocannabinol (THC)-rich resinous material of the cannabis plant, was available in some areas, including Minneapolis.

The different varieties of marijuana helped determine its price, as clearly shown by the range of prices for an ounce of the drug (*see exhibit 40 on the following page*). Throughout the 21 CEWG areas in the second half of 2003, marijuana ounce

Exhibit 39. Number of Analyzed Cannabis Items in CEWG Areas and Percentage of All Items Tested: October 2002–September 2003

CEWG Area	Number	Percent
Texas ^{1,2}	16,294	29.6
New York ^{1,2}	12,920	27.0
Los Angeles ²	11,620	25.1
San Diego	7,122	52.9
Baltimore	6,668	20.8
New Orleans	6,141	51.4
Philadelphia	6,099	31.3
Atlanta (Decatur) ²	4,576	28.9
Boston	3,485	50.1
Miami-Dade Co.	2,891	21.7
Chicago	2,789	74.9
St. Louis	2,421	39.5
Detroit	1,768	38.9
Washington, DC ²	1,463	39.0
Denver	736	17.3
Seattle	513	16.6
Newark	363	9.6
Honolulu ²	358	17.1

¹Represents multiple sites.

²Data are not complete for all months.

SOURCE: NFLIS, DEA

prices ranged from \$50–\$150 for Mexican, to \$60–\$250 for commercial grade, to \$125–\$600 for BC Bud, to \$250–\$650 for hydroponic, and to \$300–\$600 for sinsemilla. At the retail level, joints typically sold for \$5 or less, with \$10 joints available in Washington, DC.

Marijuana continued to be marketed and packaged in a variety of ways to entice buyers. Blunts laced with PCP or crack remained common, and in Atlanta there were reports of “fruities,” or lollipops made from marijuana and cocaine. In New York City, marijuana was sometimes sprayed with a watermelon air freshener to make it smell like watermelon and to enhance the drug with the chemicals in the freshener.

Exhibit 40. Marijuana Prices by Type and Amount in 21 CEWG Areas: July–December 2003

City	Retail	Midlevel	Wholesale
Atlanta	\$5–\$10/g	\$100–\$140/oz	\$500–\$800/lb
Baltimore	\$35–\$60/¼ oz CG ¹ \$20–\$40/bag CG \$2–\$5/joint CG	\$275/oz HY ² 130/oz CG	\$2,300–\$3,250/lb HY \$850–\$1,500/lb CG
Boston	\$5/joint CG	\$200–\$250/oz CG	\$1,000–\$2,000/lb SN ³ \$800–\$1,500/lb CG
Chicago	\$3–\$5/g	\$50–\$75/oz	\$900–\$1,200/lb
Dallas	\$10/g CG	\$60–\$80/oz CG	\$450–\$700/lb CG
Denver	\$5/bag MX ⁴	\$600/oz BC ⁵ \$200–\$400/oz LP ⁶ \$50–\$80/oz MX	\$2,000–\$4,500/lb BC \$1,500–\$4,000/lb LP \$400–\$1,000/lb MX
Detroit	\$20/g CG	\$150/oz CG	\$1,100–\$1,300/lb SN \$800–\$1,600/lb CG
Honolulu	\$25/g	\$400–\$800/oz \$100–\$200/½ oz	\$6,000–\$9,000/lb
Los Angeles	\$60–\$80/½ oz SN \$25/g DO ⁷ \$10/g MX	\$300–\$600/oz SN \$200–\$250/oz DO \$60–\$80/oz MX	\$6,000/lb BC \$2,500–\$6,000/lb SN \$1,000–\$1,200/lb DO \$300–\$400/lb MX
Miami	\$5–\$10/g	\$350/oz HY \$100–\$150/oz MX	\$2,500–\$4,000/lb HY \$800–\$1,000/lb MX
Minneapolis	\$5–\$20/g	\$200–\$300/oz hashish \$80–\$600/oz	\$700–\$1,000/lb hashish \$600–\$2,400/lb
Newark	\$5–\$30/bag LP	\$250–\$650/oz HY \$50–\$450/oz LP	\$3,800–\$4,500/lb HY \$600–\$4,500/lb LP
New Orleans	\$10/g \$2/joint	\$125–\$160/oz	\$2,000/kg \$800–\$1,000/lb
New York	\$20–\$25/½ oz CG	\$100–\$400/oz	\$3,000–\$5,000/lb HY \$1,000–\$2,000/lb DO
Philadelphia	\$5–\$35/bag	\$150–\$200/oz	\$800–\$1,200/lb
Phoenix	\$10–\$25/7 g	\$75–\$150/oz CG	\$500–\$575/lb CG
St. Louis	N/A ⁸	\$150–\$175/oz	\$750–\$1,800/lb
San Diego	\$150/¼ oz SN \$40–\$50/¼ oz MX	\$450/oz SN \$60–\$100/oz MX	\$3,000–\$5,000/lb SN \$300–\$500/lb MX \$450–\$1,000/kg MX
San Francisco	\$40/½ oz DO	\$200/oz DO	\$5,000–\$6,000/lb SN \$4,000/lb DO \$500/lb MX
Seattle	N/A ⁸	\$700–\$1,000/¼lb BC \$125–\$250/oz BC \$2,000–\$2,400/½ lb DO \$250/oz DO	\$2,500–\$2,700/lb DO \$2,000–\$4,000/lb BC \$500–\$700/lb MX
Washington, DC	\$5–\$10/joint	\$300/¼ lb \$550–\$600/½ lb	\$3,500–\$6,000/lb HY \$700–\$1,400/lb CG

¹CG=Commercial grade.

²HY=Hydroponic.

³SN=Sinsemilla.

⁴MX=Mexico-produced.

⁵BC=BC Bud.

⁶LP=Locally produced.

⁷DO=Domestic.

⁸N/A=Not available.

SOURCE: *Narcotics Digest Weekly*, NDIC

BENZODIAZEPINES



Benzodiazepine indicators showed no common pattern of change or stability across CEWG areas in 2002–2003. Rates of benzodiazepine ED mentions in 2002 were especially high in Boston (102), Philadelphia (95), New Orleans (82), St. Louis (78), and Detroit (69). The specific benzodiazepine most widely abused varied by CEWG area and population group. CEWG members report that the drugs are also commonly used, in combination or sequentially, to increase, sustain, and/or reduce the negative effects of other drugs, including cocaine, methamphetamine, and opioids (e.g. heroin, methadone, and narcotic analgesics).

Boston

Benzodiazepines are showing high levels of abuse. Boston’s 2002 benzodiazepine rate of 102 ED mentions per 100,000 population was highest among all DAWN sites. —**Daniel Dooley**

Chicago

Consistent with ED mentions, ethnographic reports indicate that alprazolam appears to be the benzodiazepine most readily available on the street, followed closely by clonazepam and lorazepam, with variations in different areas of the city. —**Matthew Magee**

Miami/Ft. Lauderdale

Benzodiazepines in general and alprazolam in particular appear popular among opioid abusers. —**James Hall**

Newark

Benzodiazepine indicators have been increasing in Newark. These drugs are often used by heroin abusers and methadone patients. —**Anna Kline**

Texas

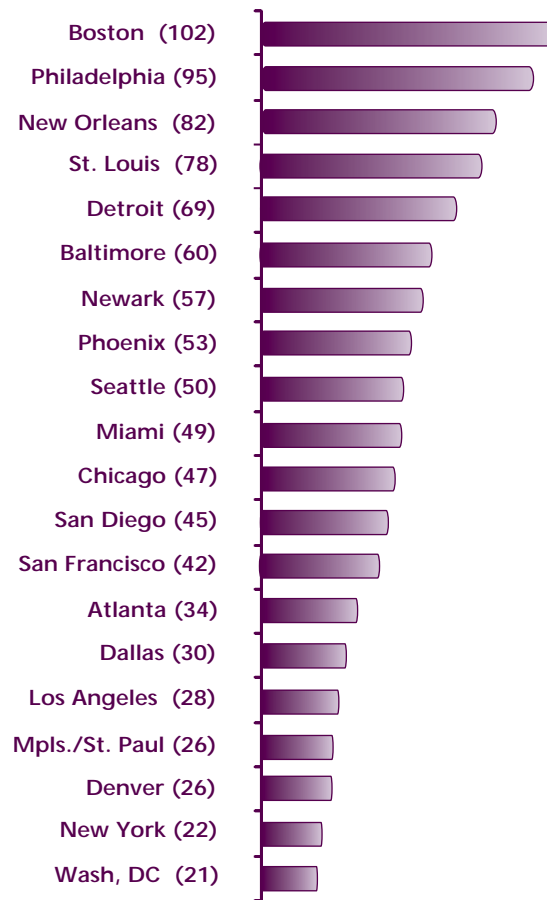
The proportion of cases that are alprazolam continues to increase. Alprazolam, clonazepam, and diazepam are among the 10 most commonly identified substances according to police lab reports, although none of them accounts for more than 2 percent of all items examined in a year. —**Jane Maxwell**

Benzodiazepine Patterns/Trends Across CEWG Areas

DAWN ED Data on Benzodiazepines

As shown in exhibit 41, rates of benzodiazepine ED mentions in 2002 were highest in Boston—102 per 100,000 population—followed by Philadelphia (95), New Orleans (82), St. Louis (78), and Detroit (69). The rate increased significantly in Baltimore between 2001 and 2002, but rates decreased in Dallas, Denver, San Diego, San Francisco, and Seattle.

Exhibit 41. Rates of Benzodiazepine ED Mentions Per 100,000 Population: 2000-2002



SOURCE: DAWN, OAS, SAMHSA

Mortality Data on Benzodiazepines

Representatives from Miami and Philadelphia reported on benzodiazepine-related deaths in the first 5 or 6 months of 2003. In other CEWG areas, benzodiazepine-related deaths were classified in non-specific categories (e.g., “depressants”) or collapsed with barbiturates.

In *Broward County*, Florida, benzodiazepine-related deaths were second only to alcohol. In the first 5 months of 2003, there were 75 deaths related to benzodiazepines; in 28 cases (37 percent), a benzodiazepine was detected at a lethal dose level. In the 75 deaths, there were 83 benzodiazepine mentions, with diazepam and alprazolam accounting for a majority of the cases (42 and 41 percent, respectively). Also of note is that benzodiazepines were involved in 73 percent of the Broward County narcotic analgesic deaths in the first half of 2003, and in 44 percent of heroin-caused fatalities.

In *Philadelphia* in the first half of 2003, diazepam was detected in 33 decedents and continued to rank fourth among drugs detected by the medical examiner. Alprazolam was the 13th most frequently detected drug among decedents ($n=188$) from 1994 through June 2003.

Treatment Data on Benzodiazepines

As with mortality data, treatment data on primary benzodiazepine (including Rohypnol) admissions typically appear in categories such as “depressants” or “other drugs.” Only a few CEWG members reported benzodiazepine treatment data.

In *Philadelphia*, benzodiazepines were the primary drug of abuse among 26 admissions in the first half of 2003 (approximately 1 percent of all admissions excluding alcohol).

In *Colorado* in FY 2003, 16 clients were admitted to treatment for primary Rohypnol abuse. Thirteen were male, and 11 were age 35 and older.

In *Texas* in the first half of 2003, 155 persons were admitted to treatment with a primary, secondary, or tertiary problem with Rohypnol, with 17 percent being for primary abuse of Rohypnol and 48 percent being for primary abuse of marijuana. Of the 155 admissions, 64 percent were male, 91 percent

were Hispanic, and three-quarters had a problem with the criminal justice system. These cases were primarily on the border.

NFLIS Data on Benzodiazepines

Alprazolam was the benzodiazepine most likely to be identified by police laboratories (*see exhibit 42*). In the period from October 1, 2002, to September 30, 2003, relatively high numbers of alprazolam items were identified in New York (670), Houston (464), Philadelphia (408), Miami (283), and Atlanta (277). Labs in four New York sites reported relatively high numbers of clonazepam (150) and diazepam (118) items. In San Diego, diazepam was the benzodiazepine most often identified.

Exhibit 42. Estimated Number of Analyzed Benzodiazepine Items by CEWG Area: October 2002–September 2003

NFLIS Area	Alprazolam	Diazepam	Clonazepam
Atlanta (Decatur) ¹	277	69	26
Boston	33	16	41
Chicago ²	5	2	12
Denver	8	20	9
Houston ¹	464	89	37
Honolulu ¹	11	20	2
Laredo ¹	9	12	53
Los Angeles ¹	28	96	45
Miami	283	16	13
New Orleans	74	34	5
New York ^{1,2}	670	118	150
Newark	22	0	0
Philadelphia	408	85	34
St. Louis	26	35	5
San Diego	52	106	72
Seattle	7	14	12
Washington, DC ¹	8	0	5

¹Data are not complete for all months.

²Represents multiple areas.

SOURCE: NFLIS, DEA

PHENCYCLIDINE (PCP)



PCP indicators increased in five CEWG areas. The indicators (ED rates, arrestees testing positive, treatment admissions, and forensic testing by police) were consistently high in Washington, DC, and Philadelphia. There was concern, based on field reports and indicator data, that PCP was spreading to other east coast cities. CEWG members stressed the importance of assessing the types and quantity of PCP sold on the street.

PCP PANEL REPORTS

In response to concerns and issues raised at the June 2003 CEWG meeting regarding PCP indicators increasing in several areas, a series of steps were taken to obtain more information about this drug. Exploratory studies were quickly designed and conducted in two CEWG areas (Los Angeles and Washington, DC), a NIDA grantee agreed to provide PCP data from an ongoing “club drug” study, and a DEA official agreed to provide up-to-date information about PCP from DEA sources. Findings and study methods were reported by the panel (see pages 50–60).

Excerpts on PCP Abuse From CEWG Reports

Minneapolis/St. Paul

Two young African-American males (age 18 and 19) died in 2003 in Hennepin County; recent PCP use was reported as a significant contributing factor. ED mentions of PCP more than tripled from 2001 to 2002 (from 24 to 85). —Carol Falkowski

Newark

There was a significant increase in the rate of PCP ED mentions in 2002, with a rate of 7 per 100,000 population. Of the 124 PCP ED mentions, 73.4 percent were multidrug episodes. —Anna Kline

New York

According to observations by the Street Studies Unit, PCP use is increasing across the city, especially in upper Manhattan. It is packaged like marijuana and sells for \$10. Blunts laced with PCP cost \$10–\$20 in some parts of the city. Users tend to be in their late teens and twenties. PCP comes in powder or liquid form, although the liquid form appears to be more popular. —Rozanne Marel

Philadelphia

PCP was detected in 388 decedents from January 1994 through June 2003, the fifth most frequently detected drug during that time period, behind cocaine, heroin/morphine, alcohol-in-combination, and diazepam. —Samuel Cutler

St. Louis

PCP has been available in limited quantities in the inner city, generally used as a dip for marijuana joints. While not seen in quantity, PCP was identified in most indicator data, including ED mentions, police exhibits, and as a secondary drug in ME data. Most inner city users are African-American. PCP ED mentions rose significantly from 2000 to 2002. —James Topolski

Washington, DC

In 2002, PCP indicators increased in Washington, DC, and informants from local hospitals reported that patterns of PCP use ranged from weekend use to frequent/addict type use. —Eric Wish

PCP Patterns/Trends Across CEWG Areas

DAWN ED Data on PCP

Rates of PCP ED mentions increased significantly from 2001 to 2002 and from 2000 to 2002 in Philadelphia and Washington, DC, the two areas with the highest rates—25 and 31, respectively, in 2002 (see exhibit 43 on the following page). Although relatively small, rates increased significantly in Newark (7 in 2002), Baltimore (5), and Dallas (4) between 2001 and 2002. Between 2001 and 2002, the rate decreased significantly in Chicago (to 8 in 2002) and was relatively stable in Los Angeles (11 in 2002).

Exhibit 43. Rates of ED PCP Mentions Per 100,000 Population in 10 CEWG Areas¹ and Percent Change: 2000–2002

CEWG Area	2000	2001	2002	Percent Change ²	
				2000, 2002	2001, 2002
Baltimore	3	3	5	68.2	58.2
Chicago	17	15	8	-53.1	-47.9
Dallas	5	3	4		43.0
Los Angeles	9	12	11		
New York	3	2	4		
Newark	2	2	7	236.7	250.6
Philadelphia	12	17	25	103.4	44.8
St. Louis	3	5	6	104.6	
Seattle	6	6	6		
Washington, DC	8	13	31	279.4	143.0

¹Represents areas with rates above the national rate of 3 per 100,000 population in 2002.

²These columns denote statistically significant (p<0.05) increases and decreases between the time periods shown.

SOURCE: DAWN, OAS, SAMHSA

The majority of PCP-related ED visits involved PCP in combination with other drugs. In Philadelphia, 80 percent of the PCP mentions involved other drugs, as did 65 percent in Washington, DC. In these two areas, between 30 and 50 percent of the PCP-related ED visits involved either alcohol or marijuana.

Treatment Data on PCP

The numbers of primary PCP treatment admissions are typically small and often subsumed under “hallucinogens” or “other drugs.” Information on PCP treatment admissions was reported for seven CEWG areas.

Atlanta

PCP was listed 4 times as a secondary drug and 3 times as a tertiary drug out of a total of 14,108 people receiving treatment in the first half of 2003.

Los Angeles

Primary PCP treatment admissions accounted for 1.2 percent of all admissions in 2002; the number of PCP admissions increased 89 percent from 1999 to the first half of 2003.

Michigan

In FY 2003, there were four admissions statewide involving primary PCP abuse.

Seattle

In 2002, there were 12 treatment admissions for PCP abuse, an increase from the 2 reported in 1999.

Philadelphia

In the first half of 2003, PCP was mentioned as a primary, secondary, or tertiary drug by 3.8 percent of all treatment admissions.

Texas

In the first half of 2003, 220 treatment admissions statewide reported a primary, secondary, or tertiary problem with PCP, compared with 321 in 2002.

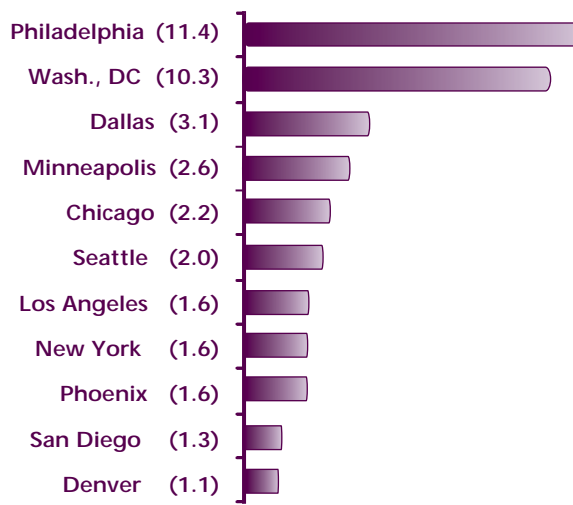
Washington, DC

In 2002, the 205 primary PCP abusers accounted for 4.5 percent of admissions (excluding alcohol).

ADAM Data on PCP

Percentages of adult male arrestees testing positive for PCP in 2002 were highest in Philadelphia (11.4 percent) and Washington, DC (10.3 percent) (see exhibit 44).

Exhibit 44. Percentages of Adult Male Arrestees Testing PCP-Positive: 2002



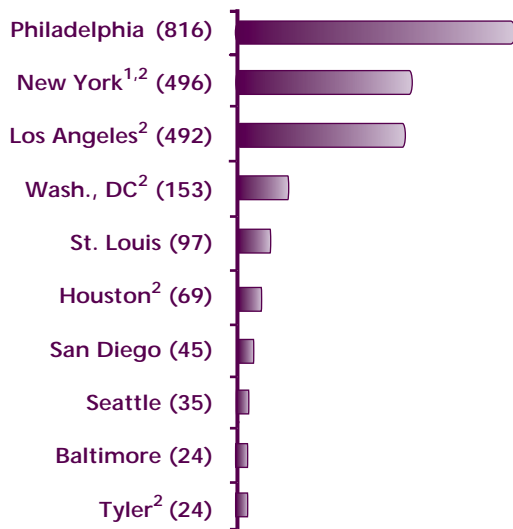
SOURCE: ADAM, NIJ

In Washington, DC, one of the ADAM areas that reported data for female arrestees, 13.9 percent tested positive for PCP.

NFLIS Data on PCP

From October 1, 2002, to September 30, 2003, the highest numbers of PCP items identified by police labs were reported in Philadelphia (816), New York (496), and Los Angeles (492) (see exhibit 45). The police lab in Washington, DC, which reported data only for the first half of 2003, identified 153 items containing PCP.

Exhibit 45. Number of Analyzed PCP Items by CEWG Area: October 2002–September 2003



¹Represents multiple sites.
²Data are not complete for all months.
 SOURCE: NFLIS, DEA

**LYSERIC ACID
 DIETHYLAMIDE (LSD)**



Despite low levels, LSD indicators continued to decrease in most CEWG areas.

Chicago

Recent declines in LSD ED mentions suggest a downward trend in LSD use in Chicago. According to the 2002 Illinois Youth Survey, 5 percent of students in grades 8 through 12 reported ‘any hallucinogen’ (including LSD and PCP) lifetime use. This is a considerable decrease in use from years 2000 (7.0 percent) and 1998 (8.5 percent).

—Lawrence Ouelett

Detroit

LSD indicators continued to decline from already low levels.

—Richard Calkins

Miami/Dade County

LSD appears to be far less available and/or losing popularity among young people. In 2003, the Miami-Dade School Survey found that only 0.6 percent of students in grades 7–12 reported current LSD use, down from 1.7 percent in 2001.

—James Hall

Minneapolis/St. Paul

Hospital ED episodes of LSD declined considerably, falling from 58 in 2000 to 13 in 2002.

—Carol Falkowski

Texas

The secondary school survey shows that use of hallucinogens (including LSD and PCP) is continuing to decrease. Lifetime use peaked at 7.4 percent in 1996 and dropped to 4.5 percent by 2002.

—Jane Maxwell

ED Data on LSD

In 2002, rates of ED mentions for LSD per 100,000 population were either zero or suppressed in 11 CEWG areas. Both Miami and Seattle had a rate of 2 mentions per 100,000 population, and Baltimore, Boston, New York, Philadelphia, Phoenix, and St. Louis each had a rate of 1 per 100,000 population. Statistically significant decreases in LSD rates occurred in 11 CEWG areas. There was no significant increase in any area.

DEXTROMETHORPHAN (DXM)



DXM abuse was reported in four CEWG areas. (DXM is a widely available cough suppressant found in many non-prescription medicines. When taken in high doses, DXM can produce effects similar to those of PCP and ketamine.) It was agreed that all CEWG members should continue to access information from community sources regarding the use of this drug. In addition, the indicators will be monitored.

Atlanta

Ethnographic sources report that students as young as middle-school are doing 'skittles' or using Coricidin as a source of DXM. DXM pills are cheaper than other pills and more readily available.

The use of the name 'skittles' is based on the candy coating and the blue or purple colors.

—**Kristin Wilson**

Detroit

Intentional abuse of Coricidin HBP Cough and Cold formula, the over-the-counter medicine, has been reflected in case reports to Children's Hospital of Michigan since 2000. Multiple tablets are taken for a dissociative effect; use of up to 40 pills at a time has been reported. During 2000, 44 Coricidin HBP cases were reported to the poison control center and about 2 of every 3 cases required hospitalization. In 2001, at least 60 cases involved this drug; about the same level was reported in 2002. In the first 10 months of 2003, 58 cases of intentional Coricidin abuse were reported; most were younger than 21, and cases were split evenly between males and females.

—**Richard Calkins**

Minneapolis/St. Paul

School-based counselors and emergency medicine staff reported the continuing abuse of DXM, a substance found in over-the-counter cough medications and sold as a powder or in clear capsules for \$5. Calls related to the intentional abuse of dextromethorphan grew from 73 in 2001 to 111 in 2003 (through November 12), according to the Hennepin Regional Poison Center. Sixty percent

were specifically in regard to Coricidin HBP Cough and Cold, also known as 'Triple C's,' and 7 percent to Robitussin[®] DM. —Carol Falkowski

Texas

School personnel in Texas have been reporting problems with the abuse of DXM, especially the use of Robitussin[®] DM, Tussin, and Coricidin HBP Cough and Cold tablets. Outreach workers in the Houston area report an emerging trend in the use of Coricidin HBP Cough and Cold pills ('Triple Cs') by adolescents, with some recent admissions to treatment for abuse of these pills. Texas poison control centers reported the number of abuse and misuse cases involving dextromethorphan increased from 93 in 1998, to 188 in 1999, to 263 in 2000, to 366 in 2001, to 429 in 2002, with 150 reported in the first half of 2003.

—**Jane Maxwell**

INFECTIOUS DISEASES RELATED TO DRUG ABUSE

AIDS

According to the Centers for Disease Control and Prevention, there were an estimated 859,000 AIDS cases reported from the beginning of the epidemic through 2002. Of the cumulative adult/adolescent AIDS cases, 25 percent were among injection drug users (IDUs), compared with only 17 percent of the cases diagnosed in 2002 (*see exhibit 46*). The proportion of cumulative cases among men who have sex with men and are IDUs (MSM/IDUs) was 6 percent, compared with 3 percent of cases diagnosed in 2002.

Five CEWG members reported trend data for AIDS modes of transmission in their areas. Two noted declines in the proportion of new cases versus cumulative cases related to injection drug use, similar to declines noted by the CDC. In Boston, 21.9 percent of the 169 new AIDS cases diagnosed in 2002 were among IDUs and 1.8 percent were among MSM/IDUs, compared with 25.6 and 3.8 percent, respectively, for cumulative cases. The difference in mode of exposure between cumulative and new AIDS cases in Philadelphia was even more striking. Among cases diagnosed in

Exhibit 46. Number and Percent of AIDS Cases Related to Injection Drug Use in the United States: New and Cumulative Cases Through 2002

Patient Category	Cumulative						New Cases 2002	
	Male		Female		Total		Total	
	<i>n</i>	%	<i>n</i>	%	<i>N</i>	%	<i>N</i>	%
Adult/Adolescent								
IDU	151,367	22	58,552	39	209,920	25	7,502	17
MSM/IDU	54,224	8	0	0	54,224	6	1,510	3
Sex with IDU ¹	10,412	1	22,939	5	33,351	4	1,504	3
Younger than 13								
Mother at risk:								
IDU	1,637	35	1,622	36	3,259	35	12	8
Sex with IDU ¹	771	16	735	16	1,506	16	9	6
All Cases ²	702,448	82	156,550	18	859,000	100	43,950	100

¹Involved heterosexual contact.

²Nearly 45 percent of the cumulative cases involved male-to-male sexual contact compared with only 33 percent of new cases in 2002.

SOURCE: CDC *HIV Surveillance Report*

Philadelphia in FY 2003, 28.3 percent were IDUs and 2.0 percent were MSM/IDUs, compared with 35.9 and 5.2 percent, respectively, among cumulative cases.

In contrast to the national CDC data, the proportions of AIDS cases attributable to injection drug use increased in three CEWG areas. Among San Franciscans diagnosed in 2000 through 2003, heterosexual IDUs accounted for 15 percent, up from 10 percent among those diagnosed in 1994–1996, and 14 percent of those diagnosed in 1997–1999. In Los Angeles, the proportion of female AIDS cases attributable to injection drug use increased from 15 to 18 percent between 2000 and 2002. Among adult and adolescent AIDS cases in Texas, IDUs and MSM/IDUs together accounted for 25 percent of cases diagnosed in 2003 (through the third quarter), compared with 16 percent of those diagnosed in 1987.

Hepatitis B (HBV) and Hepatitis C (HCV)

In addition to HIV/AIDS, a few CEWG members reported on HBV and HCV infection as a consequence of drug abuse. Local incidence studies in Seattle indicated that 21 percent of non-infected IDUs acquire HCV each year, and 10 percent of IDUs who have not had hepatitis B acquire it each year. In San Francisco, HCV prevalence remained alarmingly high among IDUs in the city, with infection estimates ranging between 72 and 86 percent among that group. Reported cases of HBV infection in San Francisco, however, dropped from about one per week from 1996 to 2001 to approximately one every 10 days in 2002–2003. An ongoing study of young IDUs in Chicago compared injection practices and HCV prevalence between young suburban and urban participants. The HCV prevalence was almost twice as high among urban (19.7 percent) than suburban (10.1 percent) participants. Despite the lower HCV prevalence among suburban IDUs in the study, they were significantly more likely to report high-risk behaviors, including sharing syringes and injection equipment, thus increasing the opportunity for disease transmission.

PCP PANEL

Background

One role of the CEWG is to identify emerging drug problems and trends. Each CEWG meeting is structured to review findings, discuss their implications, and consider followup plans. At the June 2003 meeting, attention was focused on PCP because PCP indicators had increased in four CEWG areas. There was concern that PCP abuse might be spreading on the East Coast.

At the June meeting, Dr. Eric Wish reported that PCP ED mentions had been trending up in Washington, DC, since 2000. Also, 11 PCP-related deaths were identified by MEs in the District and nearby Prince George’s County, Maryland. In 2002, 14 percent of adolescent and adult arrestees screened by the District of Columbia Pretrial Services Agency tested positive for PCP. PCP-related arrests increased 65 percent from 2001 to 2002, when they totaled 234.

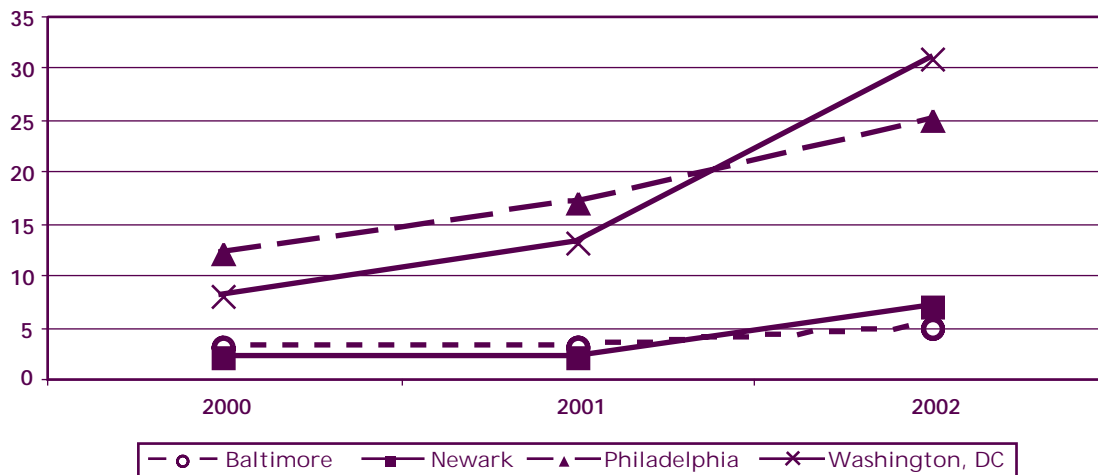
At the June meeting, Dr. Jane Maxwell reported increasing numbers of adolescent and adult treatment admissions in Texas who reported using PCP as a primary, secondary, or tertiary drug. Samuel Cutler expressed concern about reports of increased PCP availability in Philadelphia.

Prior to the June 2003 meeting, there were media stories in several CEWG areas about PCP abuse and associated problems, prompting NIDA to further assess the problem. A May 2003 DEA *PCP Brief* pointed to the emergence of large PCP labs in new locations (Indiana, Maryland) and new distribution patterns, particularly in the east. ADAM and DAWN ED data provided support for PCP abuse problems in eastern CEWG areas. Notable levels of PCP-positive tests were found for male arrestees in the ADAM sites in Philadelphia (11.4 percent) and Washington, DC (10.3 percent) in 2002. Rates of DAWN PCP emergency department mentions per 100,000 population increased significantly from 2001 to 2002 in four eastern CEWG areas (*see exhibit A*), with Washington, DC (31) and Philadelphia (25) having the highest rates in the 21 DAWN sites in 2002.

From 2001 to 2002, rates of PCP ED mentions also increased across the coterminous United States and in two other CEWG areas—Dallas and St. Louis. Although stable, PCP ED rates remained high in Los Angeles, at 11 per 100,000 population in 2002, the third highest rate across DAWN sites.

Based on such reports and concerns, it was concluded that PCP indicators should be closely mon-

Exhibit A. Rates of PCP ED Mentions in 4 Eastern CEWG Areas: 2000—2002



SOURCE: DAWN, OAS, SAMHSA

itored in all CEWG areas and that steps should be taken to learn more about PCP abuse in particular areas where indicators were high and rising. Drs. Beth Finnerty, Los Angeles, and Eric Wish, Washington, DC, planned to conduct short-term qualitative studies in their areas and to report the findings as part of this PCP Panel. It was proposed that the short-term studies be designed not only to learn about PCP abuse but also to explore methods that could be used to go beyond quantitative data to better understand user populations, cultures, and environments as other potentially emerging drugs are identified in future CEWG meetings. Following Institutional Review Board (IRB) approval from their respective organizations, the researchers conducted small-scale studies designed to learn more about PCP abuse from the perspective of current and prior PCP users, as well as people in the community who were knowledgeable about PCP abuse. In addition, attention would be devoted to assessing the qualitative methods to determine whether they might be used in future studies of this type.

Two other persons were contacted to participate in the PCP Panel: Dr. Jean Schensul, The Institute for Community Research, Hartford, Connecticut, and Dr. James Tolliver, Drug Enforcement Administration. Dr. Schensul, a NIDA grantee, has been involved in two research projects in Hartford, Connecticut, in which some data were gathered on PCP abuse. Dr. Tolliver, a pharmacologist with the DEA, has studied and assessed PCP patterns across the Nation.

In summary, the objectives of this PCP Panel are as follows:

- ◆ To present findings from exploratory studies and ongoing grantee research
- ◆ To review and discuss the findings
- ◆ To assess methodologies that may be used by CEWG members to quickly obtain qualitative information about drug abuse problems from local sources
- ◆ To obtain and review the most recent information about the production, trafficking, and distribution of PCP from the DEA

The data and information provided by the four panelists are summarized below. More complete papers appear in *Volume II* of the December 2003 CEWG proceedings.

Phencyclidine (PCP) Production, Distribution, and Trends

James Tolliver, M.S., Ph.D.

PCP is relatively easy but dangerous to make. The liquid form of PCP is commonly produced in clandestine laboratories by the “bucket method” in which chemicals are mixed and left to stand in either a bucket or trash bin. The chemicals are toxic and highly flammable. Precursor chemicals for making PCP have been found to come from commercial and bulk chemical companies situated in California, Connecticut, Nevada, Oklahoma, and Texas. California is by far the major source of PCP trafficked in the United States. Over the last several years, one laboratory each has also been encountered in Indiana, Maryland, and Tennessee.

The vast majority of PCP seizures are made by State and local law enforcement authorities. The National Forensic Laboratory Information System is a computerized database of analysis results of drug exhibits from 187 State and local forensic laboratories located in 40 States. A query of this system for 2002 revealed that of 2,765 total PCP cases, 669 were from California, 476 from Pennsylvania, 467 from New York, 398 from Illinois, 203 from Texas, 148 from Virginia, 140 from Washington, DC, and 114 from Maryland. The NFLIS system does not contain any information on seizures of PCP in the Washington, DC, area. However, for purposes of comparison, there were in 2002 a total of 140 law enforcement cases involving the seizure of exhibits that were sent to the DEA laboratory system and found to contain PCP.

The Los Angeles area is the primary source of PCP, and New York City is one of the largest mid-level distribution hubs. Belizean nationals have been operating as PCP distribution middlemen between African-American distribution organizations in Los Angeles and New York. Distribution networks are also located in Houston and Kansas City. From New York, PCP is distributed to other areas,

including Newark, Philadelphia, Connecticut and other New England areas, Chicago, St. Louis, Dallas, and New Orleans. Chicago also receives PCP from California. Other distribution areas directly from California include Seattle, Nevada, and California.

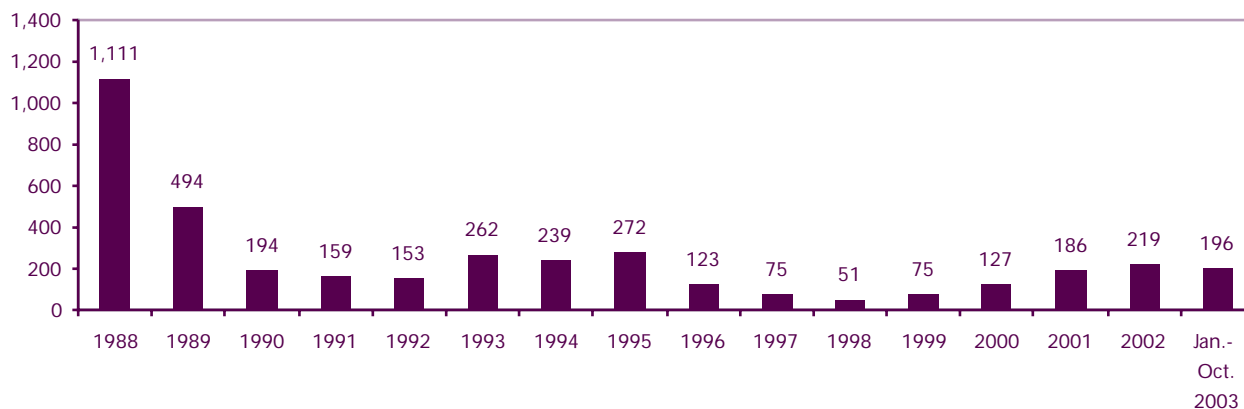
Mexican drug trafficking organizations operating in the United States typically produce PCP in the powder or crystal forms and, reportedly, distribute wholesale quantities to Hispanic street gangs in San Jose, New York City, and Oklahoma.

DEA's System to Retrieve Information on Drug Evidence (STRIDE) includes drug exhibits analyzed by eight regional laboratories. The number of PCP cases reported by STRIDE exceeded 1,100 in 1988, but decreased to less than 500 in 1989 and to less than 200 in 1990 (*see exhibit B*). PCP cases increased to more than 200 cases in 1993, 1994, and 1995 before decreasing once again each year

from 1996 through 1998. In 1999, PCP cases began to increase again. They exceeded 200 in 2002 and are likely to increase even more in 2003.

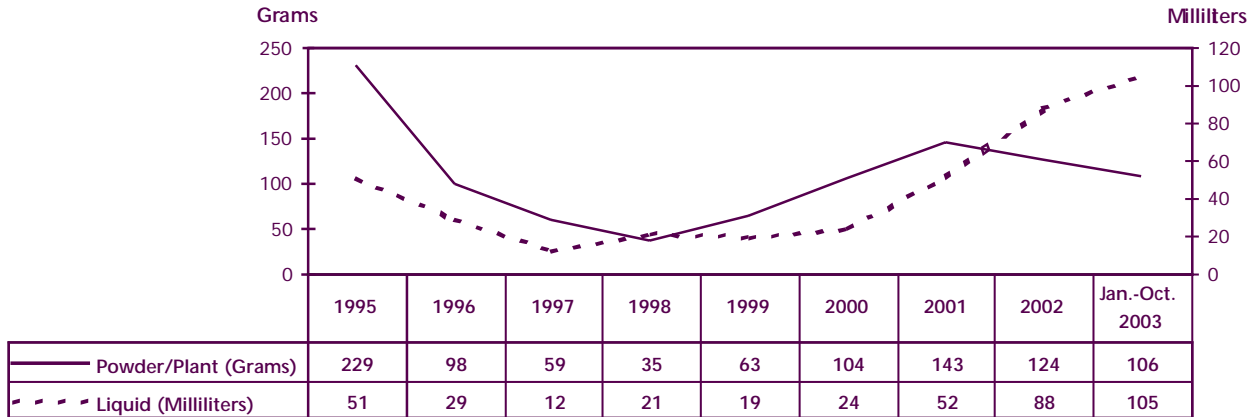
Historically, PCP has been encountered in many forms, including tablet, powder, crystal, paste, and liquid. Currently, the vast majority of PCP seized is either in liquid form or as plant material impregnated with PCP. As shown in exhibit C, more powder/plant (plant material impregnated with PCP) than liquid PCP cases were reported each year from 1995 through 2002. However, in the first three quarters of 2003, there were almost as many liquid PCP cases (105) as powder/plant material cases (106) reported by STRIDE.

Exhibit B. Number of Phencyclidine STRIDE Cases: 1988–October 2003



SOURCE: DEA STRIDE

Exhibit C. Number of Powder/Plant Versus Liquid PCP STRIDE Cases: 1995–October 2003



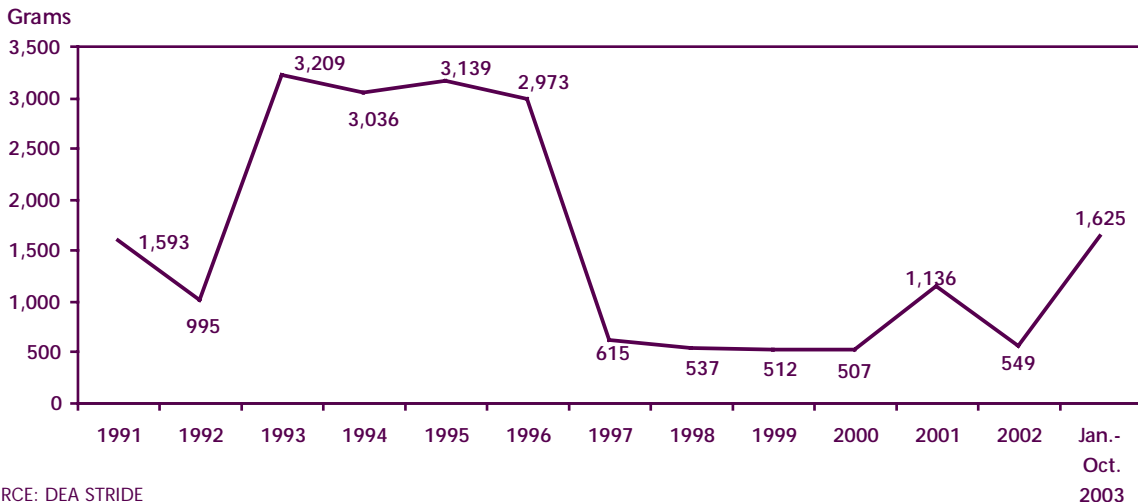
SOURCE: DEA STRIDE

From January through October 2003, more than 1,500 grams of PCP powder/plant material were reported by STRIDE, more than quantities reported in each of the 6 preceding years (1997–2002) (see exhibit D).

There was a sharp increase in the milliliters of liquid PCP reported by STRIDE in 2002 (see exhibit E on the following page). This increase was probably related to a seizure of a large PCP lab in Baltimore in November 2002. In addition to the chemicals, 4 gallons of the finished product were seized.

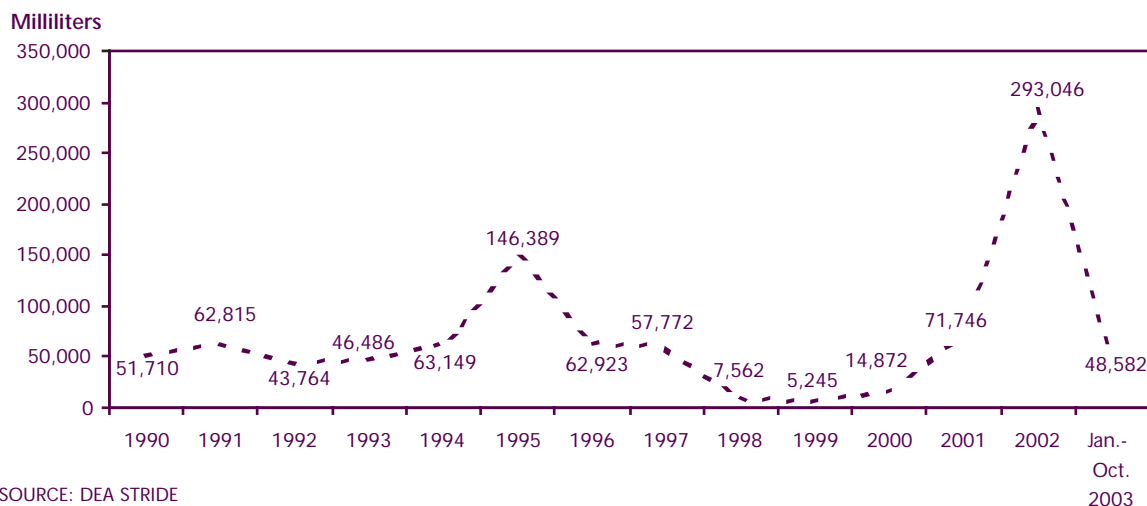
In recent years, PCP has been found in tablets sold as ecstasy. In December 2002, 51,000 tablets containing PCP, MDMA, and ephedrine were seized in New York. Low amounts (2.3 milligrams) of PCP were also found in 28,511 tablets seized in New York in August 2003. In May 2001, tablets containing PCP, MDA, and methamphetamine were seized in Washington State, and tablets containing PCP and ephedrine were seized in Pennsylvania. Tablets containing PCP and a variety of other substances (ketamine, MDMA, ephedrine, guaifenesin, caffeine, acetaminophen, and lidocaine) were seized in Chicago in 2002.

Exhibit D. Quantities of PCP Powder/Plant Material (in Grams): 1991–October 2003



SOURCE: DEA STRIDE

Exhibit E. Quantities of Liquid PCP (in Milliliters): 1990–October 2003



SOURCE: DEA STRIDE

PCP Use and Trends in Washington, DC: Two Qualitative Methods for Investigating Leads from Indicator Data

Eric Wish, Ph.D.¹

Overview

In 2003, indicator data began to show evidence of an increase in the use of PCP in the Washington, DC, metropolitan area. These indicators showed that PCP-related treatment admissions reached a 5-year high among Prince George’s County residents; PCP ED mentions in the metropolitan Washington area increased nearly 100 percent between the first halves of 2001 and 2002; and data from the D.C. Pretrial Services Agency urine testing program showed a rise in PCP positives from the low single digits in the late 1990s to current levels in the mid-teens. While the findings from the quantitative indicators were noteworthy, the data were not current and did not provide descriptive information about PCP use and possible reasons for its increase. The Center for Substance Abuse Research (CESAR) conducted two small exploratory studies with support through the CEWG contract to obtain qualitative information on PCP use in the Washington, DC, area for the December CEWG meeting.

Methods

Two methods were used to recruit 20 subjects to conduct a rapid qualitative study of PCP use in Washington, DC. An ethnographer, who used key informants to recruit PCP users, conducted 10 one-on-one audiotaped interviews. In addition, a research interviewer identified (with the assistance of a recruiter) individuals who had street-level knowledge about PCP and its use. Two trained interviewers conducted 10 interviews.

All interviewees were African-American. Most (7) of the interviews conducted by the ethnographer were with females, while most (7) conducted by the research assistants were with males. PCP users interviewed by the ethnographer were younger (mean age of 26.1) than those contacted by the research interviewer (mean age of 29.0).

The University of Maryland IRB reviewed and approved both qualitative approaches. Each respondent received \$25 as an incentive for participation in an interview. Interviews ranged in time from 30 minutes to 1 hour. The interviewers asked a series of open-ended questions and probed to gain more insight and understanding regarding the subjects discussed.

¹Major contributors to these efforts were Erin Artigiani, M.A.; Jerry Brown, Ed.D.; Sarah Canham, B.A.; Tom Gray, M.A.; and Cherise Matheson.

Findings

The information obtained from the two qualitative approaches was strikingly similar. The findings, including quotes from respondents, are included under the headings below:

Methods of Using PCP

“Dippers” were the most frequently mentioned method of using PCP ($n=19$). Newport® is the most frequently used brand of cigarettes used for dippers.

You had to roll the boat then, but now you just dippin it.

Most people (age 17 to 25) do it as a dipper—a cigarette dipped in PCP or ‘water,’ dried out, and smoked. They buy it by the cigarette.

Other methods identified by respondents involve sprinkling crack on PCP (called “woolies”) or dropping ecstasy pills into vials of liquid PCP.

They have a sack of PCP, then they might buy a dime rock of crack and crunch it down and sprinkle it on the PCP, and they call it a woolie.

Describing PCP

Many of the respondents described PCP as embalming fluid ($n=11$) or as a major ingredient ($n=7$).

I know what it is...embalming fluid...When I was in school, they talked about PCP being embalming fluid.

Ingredients depend, some use embalming fluid, some use peroxide in addition to embalming fluid. There are rumors about bleach.

They make it two different ways. The right way is really marijuana that’s grown from the earth, that’s wet down with embalming fluid.

PCP can’t be smoked straight, so it is cut with different bases (embalming fluid, baby oil, a non-acidic liquid, horse tranquilizers).

Some people know the difference and some don’t. Some people think PCP is embalming

fluid (but it isn’t) and others know it’s an ingredient. Don’t know why there is confusion.

One respondent said that PCP quality varies based on other ingredients it is mixed with.

PCP Effects

Seven respondents indicated that the drug made them feel stronger or more powerful.

PCP keeps you up. It makes you feel stronger than you actually are. The downfall is the same thing... it makes you feel stronger than you actually are.

It brings out courage in a lot of folks; can carry out fantasies that are in the back of your mind... some people bring in strength and think they’re invincible.

...you think you can beat the world.

You don’t make logical decisions when you off of it. You think you are unbreakable and nothing can possibly happen.

They feel like they are powerful and certain things they could not normally do without the drug, they could do it.

Negative Effects

Fifteen respondents indicated that PCP causes users to lose control, as in the following examples.

Really, you can’t think. You don’t have a mind of your own when you’re high. It has you stuck. And, I mean stuck... however you feel before you use the drug, you’re going to react off that feeling.

...it’s something that you can’t control. You don’t control it. It really controls you.

...you hallucinate off it. It has you thinking that you’re something you are actually not.

When you smoking, you got to have a strong mind because when you have a weak mind, it is going to take over you.

Frequency of Bad Trips

Many respondents indicated that bad trips were infrequent. Yet, almost all could identify bad experiences such as the following:

I either wake up and don't know where I'm at or I've ended up with somebody that I don't know who I'm with.

I got stuck and couldn't move.

You're not thinking rationally. You feel stronger, more paranoid, although you're slow. You do not go out of your way to commit crimes, it just happens. It's the stimulus to enhance your potential to be violent.

The baddest experience I had was I really thought I was controlling the trains... the Metro trains.

My friend...was hallucinating, and she made her own heart stop beating or beating faster.

The PCP Experience

When offered a chance by the ethnographer to say anything they wanted about PCP, eight respondents spoke negatively about the drug.

I'll make it straight to the point and very brief. If you haven't smoked it, don't smoke it because it's addictive. It's very addictive.

My advice to others is: If you haven't tried it, don't try it. That's all.

When you first start, you will think the high is real cool. You'll feel good. Then you get addicted... you won't come back.

It's not a good thing... you shouldn't try it.

Findings Regarding the Methodology

Results from both approaches were strikingly similar.

Informants/recruiters played an essential role in identifying and establishing relationships with PCP abusers, ensuring the effectiveness and efficiency of the research.

Community Networking Study: Understanding PCP Abuse in Los Angeles, California

Beth Finnerty

Background

Los Angeles is the primary source for most of the PCP distributed in the United States in recent years. Seventeen of the 24 PCP laboratories seized in the United States from 1998 through 2002 were located in Southern California, according to the Drug Enforcement Administration (DEA). Through a DEA initiative in 2003 called operation "Running Waters," 28 individuals in the central district of California (including the Los Angeles area) were indicted for the illicit production and distribution of PCP. The PCP, manufactured by a Los Angeles-based criminal group, was destined for several States, including Illinois, Kansas, Missouri, and New Jersey.

There was an 11-percent increase in PCP arrests in the city of Los Angeles from 2001 to 2002. There was a 93-percent increase in primary PCP treatment admissions in Los Angeles from the first half of 1999 to the first half of 2003. The sharpest increase in these admissions occurred in the first half of 2003, when 314 PCP abusers were admitted to treatment. Treatment admission data indicated that most PCP use was concentrated in the Metro, South, and East regions of Los Angeles County.

Between 1997 and 2002, there was a 42-percent increase in the number of PCP ED mentions reported in Los Angeles by the Drug Abuse Warning Network. More recently (2001–2002), PCP ED mentions leveled off at 990 mentions.

Data presented at the June 2003 CEWG meeting illustrated that PCP indicators had increased in five CEWG areas and were relatively high in Los Angeles, when compared to other cities. Following the meeting, researchers from UCLA Integrated Substance Abuse Programs (ISAP) planned a qualitative study of PCP abuse to investigate leads from the indicator data. The author collaborated with Elizabeth Hall, Ph.D., and Stacy Calhoun, M.A., to conduct the focus groups and key informant interviews; both have extensive qualitative research

experience in conducting focus groups and key informant interviews. This small exploratory study, supported through the CEWG contract funded by NIDA, was organized to determine what could be learned quickly about PCP patterns and abusers.

Because of unanticipated delays in the human subject protection approval process, the study commenced in mid-November 2003. From November 19 to December 5, 2003, the study team conducted three semi-structured, 30-minute key informant telephone interviews (two with law enforcement personnel, and one with an alcohol and drug treatment program counselor) and two 90-minute focus groups (with individuals enrolled in treatment at one residential program and one outpatient program). Fourteen male clients (evenly divided between African-Americans and Hispanics ranging in age from 28–48) participated in the focus groups. The focus group moderator/key informant interviewer started each discussion with a predetermined set of questions and probed for additional information as questions emerged or to obtain a greater understanding of the responses. Several common themes emerged throughout the various discussions, some of which are highlighted below.

Preliminary Findings

Key Informants

Liquid PCP is the predominant form available in Los Angeles. Cigarettes are dipped in the liquid and smoked. A less frequent method of administration is to add liquid PCP to marijuana or mint leaves, roll a joint, place the joint in the freezer so that the PCP crystallizes, and then smoke the joint. Personal supplies of PCP are often kept in a refrigerator or freezer to keep the supply fresh and avoid evaporation. One key informant stated that some users believe they are using formaldehyde or embalming fluid rather than PCP. Users believe that other substances, such as brake and lighter fluid, are mixed with PCP. Common terms for PCP include “sherm,” “duster,” “fry,” and “willy.” With regards to price, a “half dip” costs \$5–\$10, a “full dip” \$20–\$30, and an ounce \$300–\$400. Because of a recent seizure of a large quantity of PCP, prices *went through the roof*.

A number of effects from using PCP were identified, including feeling super strong, escaping from reality, forgetting problems, and mellowing out. PCP users are easily confused, have difficulty holding a thought, and stutter. Informants mentioned the possibility of PCP-associated violence, but stated that the incidence of violent behaviors is lower now than in the past.

In terms of PCP production, the key informants reported that a tight group of individuals (mostly African-American) manufacture and distribute PCP in Los Angeles. Availability and price of PCP cycle as the main producers are arrested, sentenced to serve time in prison, and released. PCP is generally marketed in South Los Angeles, Compton, but is also available in East Los Angeles.

Focus Groups

The focus group participants also referred to liquid PCP and the dipping of menthol cigarettes (e.g., Kool® brand) in the liquid. Menthol cigarettes are preferred because PCP makes a user’s mouth hot, and menthol cigarettes “cool the mouth” and mask the chemical taste of PCP. Common street names include “superbase,” “kookysticks,” “lovely,” “wet daddy,” and “loogie.”

Focus group participants talked about putting PCP dust on marijuana or mint leaves and keeping supplies in a freezer. More than one participant described an alternative way of administering PCP, called a “20/20 Blast” or “A-1 Blast,” in which a crack rock is added to a marijuana cigarette, which is then dipped in liquid PCP and smoked. A 2-inch brown glass vile costs \$50 (called a “50 pour”), and a “half dip” cigarette costs \$10. Participants talked about the packaging of 1-ounce quantities of PCP in Gerber baby food jars or Gatorade bottles. Colored containers are preferred because PCP can have a color/tint to it (depending on the production process).

A variety of effects from PCP were identified, including extraordinary strength and inner warmth. A number of negative effects were identified from *smoking the stick*, including impaired speech and vision, and the inability to move (referred to by several participants as *getting stuck*). Also of concern were the addictiveness of PCP, and possible

long-term effects such as memory loss, flashbacks, *closing down*, and brain damage.

While many drugs, such as crack cocaine and marijuana, are widely available throughout most of the area, PCP is sold only in certain, distinct areas of the city. Participants stated that it is difficult to find PCP in downtown Los Angeles because it is an *open-air* market, and drug users and dealers are *always on the move*.

In describing patterns of PCP use, focus group participants said the drug is not used with alcohol. Alcohol reportedly “messes up the effects of PCP.” Participants also reported that initially, PCP abusers start using the drug in groups. However, because PCP tends to be an unpredictable drug, users preferred to use it alone and in a safe location.

A detailed final report, which will incorporate additional key informant interviews and focus group data, will be available prior to the June 2004 CEWG meeting.

PCP Abuse in Hartford, Connecticut

Jean J. Schensul, Ph.D.

A NIDA-supported study in Hartford, Connecticut, suggests a probable resurgence of PCP in and outside the city, with PCP being distributed primarily from New York City and adulterated in Hartford. Previous and recent substance testing at regional hospital laboratories and respondents’ reports of effects clarify that at least some users, adults and youth age 16–24, have used PCP, and some products tested contain PCP. However, variations in the presence and amount of PCP in various products used on the street remain unknown.

Data on PCP are from two NIDA-funded grants on drug use among youth and young adults, age 16–30. The first study was conducted from 1999 to 2002 by the Institute for Community Research (ICR) in partnership with the Hispanic Health Council (“Pathways to High Risk Drug Use” [R01DA11421]). The second study (“Club Drugs, Resources, Inequities and Social Health” [R01DA14863]) is currently being conducted by ICR. In both studies, ICR employed a multimethod

approach that included field observations, key informant interviews, semistructured interviews with substance abusers, and surveys.

PCP has been increasingly mentioned in the local media and other publications. Also there have been recent “busts” involving the liquid form of PCP, often referred to as “dust” or “wets” when combined with marijuana or other “leaves.” Arrests have been made in Hartford and Enfield (a city north of Hartford) in the past several months. A few years ago, PCP was used almost exclusively in African-American communities, but it is now sold and widely used in Latino areas and by students on at least one nearby college campus. Once used mainly by adults older than 30, PCP is now widely used by youth and young adults of diverse ethnic groups.

PCP is available in the Hartford area in different mixtures, blends, and forms. Liquid PCP is added to leaves (e.g., mint and tea leaves, parsley, and marijuana). Leaves containing PCP are generally stored in a freezer, packaged, and sold in small bags. The leaves may also be crumbled and used as “dust.”

In this form, PCP can be sprinkled in cigarettes and marijuana joints or blunts. There is no certainty, however, that the substance being reported as PCP is always this drug. It has been reported that, like PCP, formaldehyde (embalming fluid) is also applied to leaves, frozen, and bagged for distribution. Also, this substance may be liquid PCP or may contain powdered PCP.

Users claim they “know PCP when they smell it,” and that they are using it. However, many interviewees have indicated that they were not sure what was in the substances referred to as “wet,” “illy,” “tikal,” “liklik,” “black,” or “dust” that they were buying and using. Most believe these substances contain formaldehyde or embalming fluid.

Ethnographic and survey data “expectancies” with regard to use of the drug show that users believe “dust” (possibly containing PCP) gives them energy, a feeling of being “hot inside,” “butt naked,” and also makes the user “feel crazy” and do things one would not ordinarily do. Yet, the drug is also used socially. It is sold on the street in low doses so the effects are more easily managed. The effects have been compared with the effects from other

drugs, including cocaine and marijuana with high tetrahydrocannabinol (THC) content.

A quantitative exploration of ways in which expectations and behaviors “match” did not show that PCP use was associated with violent behavior, except among Hispanic males—a population with gang and prison affiliations. However, ethnographic and news reports focus on the association between “dust” and violent acts. There have also been several reports that PCP when used as “dust” has resulted in addiction. Recommendations for action included learning more about the actual ingredients of what is thought to be PCP, working with emergency room and provider staff so they will be prepared to treat PCP episodes, and designing educational strategies to alert users and their social networks of the risks of using “dust” (PCP-related substances).

Summary and Suggestions for Future PCP Research

Harvey Siegal, Ph.D.

The PCP Panel and CEWG reports suggest that PCP abuse indicators have been increasing in some areas, especially in the mid-Atlantic areas. There is concern that PCP abuse may be spreading to other areas. The clustering of PCP use in the mid-Atlantic, Northeast, and Los Angeles suggests a possible rapid diffusion of information about the drug and, with it, an interest in experimentation. PCP continues to have a reputation as an unpredictable drug. However, the belief that a PCP “high” can be controlled might encourage use.

Important points made by panel presenters include the following:

- ◆ STRIDE data show that the number of PCP seizures in liquid and plant form (i.e., mixed with other substances) is increasing and that more PCP is being produced and transferred to different locales. PCP is relatively easy to produce from precursor chemicals, which reportedly are not difficult to obtain; maintaining the drug in its liquid form appears to be a more marketable strategy for distributors.
- ◆ Ethnographic interviews conducted in Los Angeles, Hartford, and Washington, DC, docu-

ment users’ experiences with the drug. What constitutes a “bad” experience for some PCP users may be a “good” experience for others. There continues to be a high level of unpredictability in the effects of PCP. As with virtually all illicit drugs, users are uncertain whether the substance they are using is really PCP. Some believe they can identify PCP by smell. Others believe the effects they are feeling are from formaldehyde or some drug other than PCP.

Data from Ohio’s Substance Abuse Monitoring (OSAM) Network, a statewide drug surveillance system that makes use of archival and ethnographic research methods, supports the panel findings. The use of PCP in the form of “wets” and “shermers” has been reported consistently over the past several years. However, confusion exists in that some users maintain the effects they are experiencing may be from formaldehyde or embalming fluid.

The recent upsurge of PCP use follows the pattern of most drug use epidemics. Information is diffused in the drug-using communities and is followed by experimentation. Currently, there seems to be an interest in the drug in the African-American community, while in the early 1980s “Devils’ Dust” (PCP) was primarily used by the majority community.

Today, PCP is marketed on the street in a variety of forms and combinations with other substances. PCP dealers and abusers are more sophisticated than in the past. Rather than marketing a powder containing PCP, today’s distributors dip cigarettes or cigar/tobacco leaves in the liquid base. Sometimes marijuana cigarettes are dipped into liquid PCP. There have also been reports of the use of parsley and other common herbs with PCP.

The PCP user can never be sure of the quality or whether other substances are included in what is sold as PCP. The effects of the drug are also mediated by dosage, psychological set, and the setting in which it is used. With experience, PCP users generally find safe places to use the drug, typically an indoor setting. Smoking can afford the perception that the drug’s effects can be controlled. Any drug, when smoked, rapidly moves into the bloodstream through the lungs, so that the results

are experienced more quickly. It is believed that, with experience, one can stop smoking PCP when the high or desired effect is achieved. This belief—that the PCP high can be controlled—encourages use in the drug culture.

General population research will identify only a small proportion of PCP users. While CEWG indicators suggest an interest in and use of the drug, persistent use still appears to be found among committed drug users who tend to be invisible to general population surveys. The exploratory studies conducted by CEWG members make it clear that PCP abuse is a phenomenon that should be assessed quickly. PCP is potentially a very dangerous drug. If widespread use appears among more naïve users, the public health consequences could be severe.

Effective prevention and intervention strategies are best built on a solid research foundation. Multi-indicator research as well as qualitative studies of active users can provide insight into the actual risk and perceived rewards posed by this PCP trend. Such research will also offer some perspective on whether the public health community, including the treatment community, can expect a rapid increase in use, as occurred with the crack epidemic of the 1980s, or a more constant spread of a phenomenon, such as the current abuse of methamphetamine. It would be useful to coordinate with and obtain information from police forensic laboratories in areas where PCP is reported as a problem. Studies of treatment data focused on PCP admissions should also be undertaken. DAWN and other useful data sources should be monitored as well.

PANEL ON RURAL DRUG ABUSE

Introduction

At the June 2003 CEWG meeting, participants identified and discussed drug abuse in rural areas, with some reporting comparative data from rural and urban areas. Major findings are summarized below:

- ◆ Geographic boundaries for producing, manufacturing, and distributing drugs have become less distinct, and what occurs in one type of area (urban, suburban, rural) is likely to impact on other types of areas.
- ◆ Drugs like methamphetamine and marijuana are more likely to be produced in rural than urban areas. In Missouri, the number of methamphetamine labs seized continued to climb. Also, the rate of methamphetamine treatment admissions in rural areas of the State was much higher than those in urban areas.
- ◆ Polydrug abuse is proliferating in rural as well as urban areas. Drug distributors and dealers are constantly looking for new markets, and drugs such as crack cocaine are no longer confined to urban areas. Advances in electronic and other means of communication have made it easier to reach new markets. The media have

also played a role in identifying substances that can be abused. The Internet provides recipes for making certain drugs.

At the June 2003 meeting, members concurred that the metropolitan focus of the CEWG should be expanded to gather information on drug abuse in rural areas and, if possible, to compare patterns and trends in rural and urban areas. Many large federally supported data systems such as DAWN and ADAM do not collect data from rural areas, and data from treatment centers tend to be weighted toward urban areas because of a lesser capacity to serve rural areas. These factors were acknowledged as barriers to obtaining standardized information on rural drug abuse. Other problems were also identified, including the lack of a standardized definition of “rural area,” the diversity of cultures and populations in rural areas, and the fact that there are few databases that can be accessed for secondary analyses of rural drug abuse patterns and trends.

Five CEWG members volunteered to apply and evaluate methods for collecting data and information in rural areas of their States and, in followup communication, agreed upon the following objectives for the small-scale, quick assessments:

- ◆ To identify or characterize rural drug abuse problems and issues and, when possible, compare the rural CEWG area to other urban area(s) in the State
- ◆ To identify and illustrate methodological issues and approaches, including the types of data or information available, the feasibility of acquiring and compiling the data, and methods of analyzing the data
- ◆ To identify problems and limitations in the study efforts
- ◆ To consider the feasibility of various possibilities for incorporating some data on rural drug abuse into the CEWG process

The outcomes of these five studies are summarized below. More complete papers from the investigators can be found in *Volume II* of the December 2003 proceedings.

Rural and Urban Differences in Missouri Drug Abuse Treatment Admissions

James Topolski, Ph.D.

An exploratory study, based on secondary analysis of State substance abuse treatment data, was conducted to determine whether it was possible to assess differences in drug abuse patterns by rural and urban area. Advantages of using State treatment data are that they are available online, can be coded in different ways, and can be analyzed quickly at relatively little cost.

Limitations in using substance abuse treatment data were recognized. For example, these data are not collected uniformly across all programs; most treatment programs do not establish strict geographic boundaries and serve clients from areas outside their own area; and methamphetamine admissions are classified under the “Stimulants” category together with other amphetamines and stimulants.

An initial issue was how to define the terms “rural” and “urban.” Since the State treatment data did not distinguish between rural and urban clients, “proxy” definitions were developed. It was assumed that urban clients were more likely to be treated in metropolitan statistical areas (MSAs)

and rural clients in non-metropolitan statistical areas. These two categories were used in this quick assessment to analyze treatment data.

Findings show the following:

- ◆ Eleven percent of the non-MSA cocaine treatment admissions for the combined years of 1992 through 2000 injected the drug, compared with only 4.7 percent of MSA admissions.
- ◆ Nearly one-third (31.0 percent) of the non-MSA admissions from 1992 to 2000 were diagnosed with psychiatric problems, compared with only 18.1 percent in MSAs.
- ◆ Among primary methamphetamine abusers who entered treatment in 2002, rates for use of secondary drugs were higher in non-MSA than in MSA areas. Methamphetamine admissions in non-MSA areas were much more likely to also use marijuana (rate, 52) than their counterparts in MSAs (18 per 100,000 population).
 - Methamphetamine admissions in non-MSA areas were also more likely to use alcohol and cocaine than those in MSAs.
 - The 2002 methamphetamine admissions in non-MSA areas had much higher rates of referral from courts than those in MSAs (68 vs. 19 per 100,000 population).

In summary, despite limitations, much can be learned through secondary analysis of State treatment data to characterize patterns and trends in “rural” versus “urban” areas. These data, as noted earlier, are easy and relatively inexpensive to access, and can be used in the planning phase of a study or as a quick assessment to gain some understanding of the problem and generate hypotheses for future studies.

Ideally, these data can be used along with other data (e.g., from surveys, arrests and hospital data) to learn more about drug abuse patterns and trends in rural areas. Also, there is a wealth of literature on rural health (including mental health) that can help guide research. It is particularly important to identify barriers to service and recovery. The information needs to be communicated to policymakers so appropriate interventions can be established in rural areas.

Differences in Substance Use in Rural and Urban Secondary Schools and Treatment Centers in Texas

Jane C. Maxwell, Ph.D.

This study examined rural and urban differences in substance abuse patterns and trends over a 3-year period. “Rural” was considered as any county not associated with the census definition of an urbanized area (50,000 or more inhabitants) and a total metropolitan population of at least 100,000. A school district was considered rural if it was located in a rural county.

Exhibit A shows the lifetime prevalence of different substances used in urban and rural schools (grades 7–12). For urban schools in all three cohorts, the average percentages of use of uppers, hallucinogens, downers, and ecstasy were significantly higher than for rural cohorts. There was no difference between rural and urban schools in lifetime use of tobacco, cigarettes, and smokeless tobacco in 1998–1999. Use of these products decreased in 2000–2001 and 2002–2003, but the decrease was sharper for the urban schools, resulting in a significantly higher pattern of use in rural than urban school students.

Levels of use for marijuana, cocaine, crack, Rohypnol, heroin, and inhalants were higher in

urban schools initially, but by 2002–2003, the differences had disappeared. Of concern is the fact that use of marijuana, cocaine, and crack increased in rural schools at the same time use of these drugs was decreasing in urban schools. This same pattern of increase was also seen for steroids.

Use of inhalants by urban students declined over the years to the point where there were no differences between urban and rural schools in lifetime or past-month use, getting high on inhalants while in class, or on perceptions of dangerousness of using them by 2002–2003.

The pattern of drinking in rural schools is of concern. Rural students were more likely than urban students to report having drunk five or more beers in a setting and to report that when they drank, they usually drank five or more at a time. They were also more likely to have driven after they had a good bit to drink and to have gotten in trouble with police because of alcohol use. And although urban students were significantly more likely to report having been high or stoned on marijuana in class, after 1988–1989, there were no urban and rural differences in terms of getting into trouble with teachers because of use of illicit drugs. Consistently across the panels, urban school students were more likely to report they had gotten into difficulties with their friends because of their drug use.

Exhibit A. Lifetime Prevalence of Use of Various Drugs by Secondary Students in Rural and Urban Texas School Districts, by Percent: 1998–2003

Drug	1998–1999		2000–2001		2002–2003	
	Urban	Rural	Urban	Rural	Urban	Rural
Tobacco	57.1	59.3	52.0 *	56.2	46.1 *	50.0
Alcohol	72.0	73.0	70.9 *	73.6	69.3	71.3
Marijuana	31.5 *	26.8	28.9	27.0	29.8	27.8
Cocaine	7.4 *	6.0	7.5	7.0	7.1	6.6
Crack	3.1 *	2.3	2.6	2.6	2.7	2.9
Rohypnol	5.4 *	3.2	4.8 *	3.2	4.2	3.2
Heroin	2.1 *	1.3	1.6 *	1.2	1.5	1.4
Inhalants	21.5 *	18.6	19.7 *	17.0	17.3	16.3

* Statistically significant at p < .05.

SOURCE: Texas School Surveys

Admission statistics from the Texas Commission on Alcohol and Drug Abuse for the same period (1998–1999, 2000–2001, 2002–2003) were analyzed for clients who lived in the same rural and urban counties.

Clients who lived in rural counties were more likely to be young, married, White or Hispanic, to be first admissions to treatment, employed, have more legal or criminal justice problems, and to have more social and peer problems based on the Addiction Severity Index scales. Clients who lived in urban areas were more likely to be Black and also to be homeless.

Clients from urban counties were more likely to have problems with heroin or crack cocaine, while rural clients were more likely to have problems with alcohol, marijuana, or methamphetamine. Over time, the proportions of rural clients reporting problems with methamphetamine increased at a higher rate than for urban clients. Marijuana admissions, which were higher for urban clients in 1998–1999, were higher for rural clients in 2002–2003, and the difference in powder cocaine use, which was higher in the rural population originally, disappeared.

In conclusion, this study shows that secondary analysis of large datasets can shed light on patterns of use over time.

Rural Drug Abuse in Colorado

Bruce Mendelson, M.P.A.

Researchers in Colorado have used a variety of data sources and methods to assess and compare drug abuse patterns and trends in rural and urban areas, including surveys and secondary analyses of social indicator data conducted under the State Substance Abuse Treatment Needs Assessment Program funded by the Center for Substance Abuse Treatment. The survey and social indicator data were collected and analyzed for each of the State's 64 counties. Indicator data included drug arrests, drug-related deaths, and hospital discharges. Alcohol, drug, and (combined alcohol and drug) composite indices were developed and validated by county using mean rates from 1993 to 1998. Rates were converted to Z-scores and then to 100-point scales. Valuable information about drug

production and trafficking was provided by the Drug Enforcement Administration and High Intensity Drug Threat Assessment task force. Ethnographic data were particularly useful in accessing current information about emerging drugs; where, when, and how drugs are used; and the consequences of use. The rural and urban differences in these studies and data sources were explored further for this study.

Colorado is the 8th largest State in square miles but 26th in size of population. In this study, counties with a census-defined metropolitan population of more than 100,000, or a city or census tract (designated place) with a population of at least 50,000 were classified as urban. All other counties were defined as rural. Rural areas are very different (e.g., topography, demographics) across the State. Fifty-six percent of the State's more than 4.3 million population reside in the Denver area. The proportions of the State's population in other planning areas are as follows: Central Mountain, 14.5 percent; Northeast, 12.5 percent; Northwest, 7.0 percent; Southeast, 6.0 percent; and Southwest, 4.0 percent.

The Drug Need Index (DNI), developed from the indicator data, showed that the highest rates of substance abuse were in the Denver Metropolitan and Pueblo areas. The Central Mountain and Northwest areas also had high rates.

Based on the DNI, other studies, and CEWG research and reports, it was determined that treatment data are one of the best drug abuse indicators because these data were readily available, current, and included information about specific drugs used and the types of people who used them. However, it was acknowledged that it is important to understand the limitations of treatment data because the establishment and treatment capacity of programs are based on funding sources and the availability of personnel.

Rates per 100,000 population were developed for the treatment admissions data, and comparisons were made across planning areas. In 2002, primary methamphetamine admission rates were highest in rural areas, especially in Southeast, Northwest, and Northeast Colorado. Cocaine admission rates were highest in the Southeast and the Denver metro area. Between 1992 and 2002, rates of cocaine

admissions declined in the Northwest as they were increasing in the Southeast.

In 2002, marijuana admission rates were greatest in the Southeast and the Northwest, but they increased in all regions from 1992 to 2002. Heroin admission rates remained high in Denver and were also relatively high in Central Mountain and Southeast planning areas.

In reviewing the methods used to assess drug abuse in rural and urban areas and what was learned, the following conclusions are warranted:

- ◆ Findings produced from treatment data and DNI data were similar, showing that the Southeast and Denver metro areas had the most serious drug problems.
- ◆ Collecting and analyzing multiple indicators Statewide is costly and time consuming.
- ◆ Treatment data are easy to access and provide a considerable amount of information. These data can be used to make rural and urban comparisons across State. However, it is important to recognize that these data are skewed by the type and amount of funding available for treatment in each area.
- ◆ It is useful to assess resources in relation to problem rates.

Substance Abuse Patterns in Plumas County, California

John Newmeyer, Ph.D.

This study explored the feasibility of gathering substance use data in the mountainous rural area of Plumas County, California. The largest data source identified was substance abuse treatment programs. Anecdotal reports about health problems and drug seizures also proved useful.

Plumas County, some 50 miles northwest of Lake Tahoe in the Sierra Mountains, has a population of about 21,000. The great majority of residents are White (88.0 percent); 6.0 percent are Hispanic, 2.5 percent are Native American, and 3.5 percent are of other racial/ethnic groups. The county is attractive to retirees: 18 percent of the population are older than 65. The population annual growth rate is about 0.5 percent.

The average household income in the county is about one-third lower than in the rest of California. However, the home ownership rate is significantly higher than in the rest of California.

Over the past 5 years, about 200 to 250 persons were admitted annually to drug treatment in the county. Approximately 80 percent were primary alcohol users, and 13 percent were primary methamphetamine abusers. Seven percent were treated for problems with narcotic analgesics or other prescription drugs. About 40 percent of treatment referrals were from law enforcement, a reflection of Proposition 36, which mandates treatment for some categories of drug-law arrestees. Notably, the rate of methamphetamine admissions in Plumas County is about the same as that for the San Francisco Bay area: roughly 150 per 100,000 population per year. This suggests that there may not be major differences between rural and urban California in some drug abuse patterns, although it is noteworthy that Plumas does not seem to approach the urban areas in terms of cocaine or heroin use.

There were virtually no admissions for abuse of “club drugs.” However, anecdotal reports suggest that county residents leave the area to use these drugs at “raves.”

There were reports of hepatitis C cases in the county, but these are not necessarily the result of injection drug use.

Methamphetamine labs are very numerous in rural California. Plumas County apparently has its share of these, as evidenced by a handful of “busts” that have occurred there.

While there are few sources of drug abuse data in this rural county, this exploratory effort showed that it is possible to gain a general idea of drug use patterns from treatment data and anecdotal reports.

Monitoring Rural Drug Abuse in Washington State

Caleb Banta-Green

Based on the Community Epidemiology Work Group model, several data sources were accessed and analyzed for a “case study” of rural drug abuse in Clallam County, Washington. Located in the

northwestern part of the State, the county encompasses 1,739 square miles and has a population of 64,525, 26,000 of whom live in 3 small cities. The population density is 38 per square mile, considerably less than that of King County (837 per square mile). There are three Indian reservations, and approximately 5 percent of the population in the county are American Indians or Alaskan Natives. The poverty rate among children in the county is one-third higher than in the rest of the State.

There are 14 city substance abuse treatment providers, a provider at a correction facility, an outpatient service for youth, and inpatient and outpatient services for Native American youths and adults. There are no methadone, medical detoxification, or psychiatric emergency programs in the county; access to these services requires a drive of an hour or more. There is a drug court for adults and youth in the county seat of Port Angeles, and a tribal drug court in a scenic corner of the county. There is also a needle exchange program in the county that has operated one evening a week out of a family planning clinic since June 2000. A juvenile detention center screens arrestees for drug use.

Of the Clallum County treatment admissions to publicly funded programs in 2001, primary alcohol admissions accounted for 55 percent of the adult and 25 percent of the youth admissions—both a higher proportion than in the State overall. Among county youth admissions in 2001, 62 percent were for primary marijuana abuse, as were 22 percent of the adult admissions, with both again proportionately higher than the adult and youth marijuana admissions in the State. Eighteen percent of the adults and 13 percent of the youth admissions in the county were for primary methamphetamine abuse, also higher than the proportions for the State overall. Primary cocaine and heroin admissions among adults in the county were relatively low, considerably lower than cocaine and heroin admissions in the State overall. These patterns were consistent from 1997 to 2001.

Needle exchange program data from January through June 2002 show that 10,177 syringes were exchanged. Staff reported that 90 percent of the individuals exchanging needles were methamphetamine abusers.

Of the 119 juvenile arrestees entering the detention facility in June–July 2002, more than 81 percent tested positive for one or more drugs. Fifty-nine percent tested marijuana-positive, 42 percent tested methamphetamine-positive, 19 percent tested alcohol-positive, and 3 percent were positive for both marijuana and methamphetamine.

Drug court data showed that approximately 80 percent of the cases seen in 2002 involved methamphetamine.

In 2001, 164 calls were made to the Alcohol and Drug Helpline in Clallum County. Most calls from adults involved alcohol. Methamphetamine was the most common illegal drug mentioned. Of the 134 exposures, 106 (79 percent) concerned prescription and over-the-counter drugs. Thirty-seven percent of the 106 calls involved opiates (with oxycodone being the most frequently mentioned), and 12 percent concerned dextromethorphan (DXM).

Data from the Olympic Medical Center emergency department (ED) show that ED visits for detoxification peaked in 1993. However, the length of stay for psychiatric/detoxification-related visits increased steadily from 1.25 days in 1990 to 7.52 days in 2001.

The Northwest High Intensity Drug Trafficking Area and Drug Enforcement Administration reports indicate there have been recent increases in methamphetamine production on Indian reservations. Tribal police cannot arrest non-American Indians and, thus, cannot prevent Mexican Nationals from producing the drug. In 2002, there were 10 seizures of methamphetamine labs and dumpsites in Clallum County; in 1999, there were no such seizures.

In conclusion, indicator data can provide much useful information about drug abuse patterns and trends in a basically rural area. Many sources can be tapped for this purpose. The next step will include obtaining and analyzing toxicology data at the county level, conducting interviews with key informants, accessing more detailed treatment data, and assessing State reports that will be released in spring 2004.

SPECIAL PRESENTATIONS ON HOSPITAL EMERGENCY DEPARTMENT DATA

Update on DAWN

Judy K. Ball, Ph.D., M.P.A.

In previous meetings, CEWG members were informed of a number of changes to come in the DAWN emergency department (ED) system, such as a new data collection instrument and a new system for reporting data. That new system is now in place. Because of the scope and magnitude of the changes, there will be a permanent disruption in trends. No estimates from the old system will be comparable to the new. There is truly a “brick wall” between the new and old system.

The new system was implemented in the field beginning in January 2003. Over the past year, Reporters have been retrained in the new methods. DAWN Reporters must complete a tutorial and demonstrate their mastery of the material before they are actually certified and able to begin reporting to DAWN.

DAWN now collects data on all types of drug-related ED visits for patients of all ages. ED visits in which alcohol was the only drug are now collected for patients under age 21, when alcohol is an illegal drug. Each case is assigned to one of eight case types, which may be of interest to different audiences. The eight case types are suicide attempts, seeking detoxification, underage alcohol only, adverse reactions, accidental ingestions, overmedication, malicious poisonings, and all other drug-related visits. In addition, DAWN now collects new data items, including data on health (presenting complaints and diagnoses), whether the specific drugs were confirmed by toxicology, and more detailed information on disposition.

Many of the methods introduced in the new DAWN ED system were tested during the redesign period. For example, DAWN now requires a review of all medical charts to find reportable cases. This

method of “direct chart review” is superior to the old method of scanning logs or billing codes and choosing patients who were most “likely” to be DAWN cases. When tested, the old methods were found to miss a high proportion of cases of interest (30 percent or more).

DAWN now identifies “drug abuse” by a process of elimination. In the old DAWN, it was learned that drug abuse is often not documented or poorly documented in medical charts. The new method of collecting all drug-related cases and then assigning them to case types will capture cases that were previously missed or reported inconsistently.

The new DAWN data reveal many differences across case types. For example, demographics of patients (age and gender, particularly) differ across case types. Whether drugs are confirmed by toxicology also varies across case types and drugs. For example, lower confirmation rates are found for adverse reactions and accidental ingestions, when the identity of the drug ingested is most likely to be known. In cases of malicious poisoning, the confirmation rates are higher, as would be expected when the identity of the substance ingested may be unknown to the patient. For the new category of alcohol-only cases, nearly one-half are confirmed by toxicology, indicating that alcohol testing is rather widespread in hospitals.

DAWN also has a new sample of hospitals and new metropolitan boundaries based on the 2000 Census that were recently released by the Office of Management and Budget. However, metropolitan area estimates for 2003 are unlikely to be possible, given the low response rates in many of the metropolitan areas.

There are new benefits for hospitals that participate in DAWN. The addition of drug-related cases not related to substance abuse makes the data more

useful for clinical practice. For example, hospitals will have data on adverse reactions and overmedication that might be used to improve patient care. This information will also be useful to SAMHSA and to sister agencies such as the Food and Drug Administration. Since *all* charts are now being reviewed, gathering drug-related cases other than substance abuse is a relatively small task and makes DAWN more attractive to hospitals. Electronic reporting makes it possible to give hospitals real-time access to their own data.

OAS also plans a new way to deliver information to users such as the CEWG. For CEWG members, staff are developing a new system to “make a table” that will replace “pick a table.” Members will be able to specify the tables they want, save them, and retrieve them for later use, thus avoiding stacks of hard copy tables.

Emerging Drugs: A Perspective from the Hospital Emergency Department

Edward W. Boyer, M.D., Ph.D.

Advantages of Emergency Department Studies

Emergency department (ED) data can be effectively used to identify emerging drug abuse problems and patterns of use, including recreational drug use and abuse. Epidemiological studies conducted in EDs have few limitations on the types of patients that can be recruited. One may sample members of the general population and oversample “hidden populations,” such as the homeless, minorities, and immigrant populations. The advantages of ED-based surveillance strategies in many EDs include the application of rigorous testing to confirm self-reported drug use, the opportunity for clinicians to speak at length with drug users, and the availability of medical toxicologists who understand the clinical and neurobehavioral effects of illicit substance use.

The types of patients seen in EDs—those seeking care for primary care complaints—have dramati-

cally increased the volume of patients seeking emergency care across the United States, with many EDs serving more than 75,000–100,000 patients per year. This phenomenon increases the likelihood of drawing adequate sample sizes to study emerging drug abuse patterns.

Academic EDs often include medical toxicologists, many of whom have a clinical interest in drug abuse. Clinicians can speak at length with patients about drug use patterns, and they can compare self-reports with the rigorous analysis of biological specimens using gas chromatography/mass spectroscopy (GCMS) or high performance liquid chromatography (HPLC). Moreover, the existence of toxicology referral centers that accept transferred patients expands the catchment area of a single ED to include patients from a large geographical area.

Observations from the New England Regional Center for Medical Toxicology

The University of Massachusetts operates the New England Regional Center for Medical Toxicology. The center treats acutely poisoned individuals, and a number of observations have been made with regard to psychoactive substances used for recreational purposes, including the following:

- ◆ Increases in so-called “boutique” hallucinogen use
- ◆ Changes in drug formulations and combinations
- ◆ Increased diversion of prescription and over-the-counter (OTC) pharmaceuticals
- ◆ Decreases in presentations for acute toxicity from specific club drugs
- ◆ Dramatic increases in withdrawal presentations

“Boutique” hallucinogens demand and defy definition. These are hallucinogenic substances, sometimes referred to as “entheogens” that are used for “spiritual purposes.” Boutique hallucinogens include not only hallucinogenic plants such as Syrian rue and *Salvia divinorum*, but also the chemicals described in the volumes *PIKHAL*,

Phenethylamines I Have Known and Loved: A Chemical Love Story and *TIHKAL, Tryptamines I Have Known and Loved: The Continuation*, both by Alexander and Ann Shulgin. These are lesser-known drugs that are sometimes used with other substances to produce specific neurobehavioral effects. Under a presumption of legality, they can be easily purchased, either from storefronts or from online vendors. The number of patients who present to an ED for medical care following use of these substances is low, but the increase in their use is suggested from patient interviews.

The most common boutique hallucinogens described by patients appear to be tryptamines such as dimethyltryptamine (“DMT”), 5-methoxydimethyltryptamine (“5-MeO-DMT”), and 5-methoxydiisopropyltryptamine (“5-MeO-DIPT,” “foxy methoxy”). Although these substances can be easily identified in urine by using HPLC or GCMS, it is difficult to obtain biological specimens because patients who use these drugs rarely present to an ED with acute toxicity. Most who do present after using these substances are relatively inexperienced users who suffer trauma. It is perhaps the association of trauma with use of these substances that leads to the recommendation by online drug encyclopedias that a sober “sitter” be used to protect users from adverse effects.

Several modes can be used to administer tryptamines, including snorting, smoking, or rectal administration. The intensity of the neuropsychiatric effect is offset by its brief duration of only a few minutes. Some users have attempted to prolong the effects of tryptamines by the coingestion of Syrian rue extracts that contain the monoamine oxidase inhibitor harmaline with ensuing MAOI poisoning. However, as noted earlier, the appearance in EDs of individuals who have used these substances is uncommon; thus clinicians are required to interview knowledgeable individuals to identify their use.

Similarly, ethnographic data from the ED suggest that several hallucinogenic amphetamines are increasing in popularity. Patients who have used these substances rarely present to an ED with acute toxicity from these drugs, thus requiring clinician interviews to ascertain patterns of use. In Massa-

chusetts, ED patients have described the use in various venues of 2,5-dimethoxy-4-(n)-propylthiophenethylamine (2C-T-7), methylenedioxyamphetamine (MDMA), methamphetamine, and 4-bromo-2,5-dimethoxyphenethylamine (2C-B), ketamine, and other club drugs. Although hallucinogen mixtures are frequently compounded into pill form, some users report the use of powders, the composition of which depends upon the location in which they are consumed. The use of powdered formulations may avoid the cost associated with pill manufacture and allow greater flexibility in compounding mixtures to be sold in specific locations. The extent to which drug users consume alternative formulations of drugs is unknown, but this practice may affect the validity of pill testing programs.

The diversion of pharmaceuticals from legitimate to recreational use is another emerging pattern of use that can be observed in an ED setting. The presentation of individuals with acute opiate and sedative hypnotic overdose is common in EDs; OxyContin and fentanyl abuse are particularly common. OxyContin is reportedly administered by a variety of modes, including ingestion or grinding pills into a powder, injection, or inhalation. Fentanyl users describe either bisecting fentanyl patches prior to ingestion or extracting the drug from the patch matrix. Rarely, fentanyl abusers will apply several patches to the body to achieve the delivery of large amounts of drug, or they will smoke fentanyl vaporized by heating. Diversion of sedative hypnotic agents is also common, with many individuals in New England reporting the illicit use of clonazepam. Many individuals describe using clonazepam to self-detoxify from heroin; occasionally junior high and high school students present for ED care after using this drug during classes.

Lastly, one interesting observation from the ED involves a change in presentations involving club drugs. Formerly, moderate numbers of adolescents and young adults presented to the ED with acute gamma hydroxybutrate (GHB) intoxication. Over about the last year, however, the number of acutely intoxicated GHB users has decreased, while the number of individuals requesting admission for detoxification from GHB has increased. Some of

these individuals avoid direct contact with rehabilitation facilities, claiming that personnel at those facilities have no experience with managing GHB withdrawal. Furthermore, these individuals have remarked that they use emergency medical care because the ED staff offers better pharmacological management for GHB withdrawal states.

In summary, experience at the New England Center indicates that locating future drug surveillance efforts in EDs staffed by medical toxicologists can yield important information on emerging drug patterns and health consequences of drug abuse.

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INTERNATIONAL REPORTS

The Canadian Community Epidemiology Network on Drug Use (CCENDU)

**Colleen Anne Dell, Ph.D., and
Karen Garabedian, M.A.**

The Canadian Community Epidemiology Network on Drug Use was established in 1996 to monitor drug use and adverse consequences of drug use at the community level. Site reports for 2001 were prepared by Vancouver, Edmonton, Regina, Winnipeg, Toronto, and St. John's, and for 2002 by Winnipeg, Fredericton, Vancouver, and Toronto, with interim reports from Regina and Ottawa.

Edmonton, Alberta

Edmonton is estimated to have 5,000 injection drug users (IDUs). The Ethnographic Study of Injection Drug Users, a combination of two studies on 2001–2002 and 2002–2003 data, concluded that among IDUs in Edmonton, the most frequent first drug injected was cocaine (31 percent) followed by methamphetamine/speed (27 percent). The most common current drugs injected were opiates (33 percent), and Talwin and Ritalin (25 percent). Of study participants, 72 percent were infected with hepatitis C.

Fredericton, New Brunswick

Data from the local needle exchange program—the New Brunswick hepatitis C database and the New Brunswick HIV/AIDS database—indicate that injection drug use is on the rise. From 1997 to 2001, 956 persons were recorded as having contracted hepatitis C in New Brunswick, with 47.8 percent identified as IDUs.

Halifax, Nova Scotia

A 2001 study of drug treatment clients (5,262 males and 2,590 females) found that 80 percent were using cocaine, benzodiazepines, and/or opiates. Cannabis use was slightly less than 80 percent.

Heroin, morphine, and Demerol are commonly used among IDUs in Atlantic Canada. Dilaudid is readily prescribed, and there have been documented cases of double-doctoring. Users are typically between the ages of 18 and 44. Injection drug use is becoming more prevalent among youth and is also highly prevalent among men and women who work in the sex trade.

Ottawa, Ontario

The 2001 Ontario Student Drug Use Survey showed that approximately 30 percent of students used cannabis during the previous year, and 34 percent had used it in their lifetime. Cannabis was the most common illicit drug used by students from grade 7 to 13.

According to the 2000 SurVIDU study, there were an estimated 962 cases of HIV related to injection drug use in Ottawa. It was also estimated that Hull had 186 cases.

Regina, Saskatchewan

Data derived from the Regina Integrated Drug Unit reveal an increase in cocaine use. Also, the age of people using drugs, including those injecting, is becoming younger. There is also greater visibility and use of injection drugs reported in upper class or privileged homes. Street drugs of choice are Talwin and Ritalin, ecstasy, lysergic acid diethylamide (LSD), cocaine, and morphine.

St. John's Newfoundland and Labrador

There is a strong presence of rave drugs compared with 3 years ago. There has also been an increase in pharmacy break-ins where OxyContin and Tylenol 4 were sought. In Labrador, gas sniffing continues to be a great problem.

Toronto, Ontario

Designer drug use, a relatively new phenomenon, poses new challenges in the prevention of drug-related harms, especially with respect to drug identification and purity.

Crack cocaine continues to be the most popular street drug. In addition to smoking crack, the injection of this drug is widespread. Both modes of use raise concerns regarding the spread of hepatitis C.

Vancouver, British Columbia (BC)

In 2001, there were 222 illicit drug deaths in BC, of which 90 were in Vancouver. This is the highest absolute number and per capita rate in Canada. Heroin and cocaine remain the major drugs of choice for injection.

Of the 21,937 drug crimes in BC in 2000, 16,730 were cannabis-related, 3,520 involved cocaine, 796 involved heroin, and 891 involved other illicit drugs included in the Controlled Drugs and Substances Act.

Winnipeg, Manitoba

The most prevalent illicit drug in Manitoba is cannabis, and law enforcement agencies continue to effect large seizures of it. Other more commonly reported drugs include powder cocaine, crack cocaine, hashish and hashish oil, Talwin, Ritalin, psilocybin, and LSD. Cocaine is often seized by law enforcement in large quantities, and the Addictions Foundation of Manitoba reports high usage of cocaine among its client populations.

Update of the Epidemiologic Surveillance System of Addictions (SISVEA) in Mexico

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

The Mexico Epidemiologic Surveillance System of Addictions (SISVEA), created in 1990, collects data and information from 53 cities; 38 percent are located along the northern border. SISVEA is the result of collaboration among different government and nongovernment agencies, and the data sources include government treatment centers (GTCs) and nongovernment treatment centers (NGCs), juvenile detention centers, and medical examiners (drug-related deaths).

In the first half of 2003, 23.1 percent of patients admitted to GTCs reported cocaine as their current (primary) drug of abuse, a decline from 32.2 percent in 2002. At NGCs, cocaine was the third most commonly reported primary drug of abuse, at 13.3 percent. According to the Juvenile Detention Centers, cocaine abuse was reported by 18.1 percent of young arrestees in the first half of 2003.

While heroin was the fifth most common primary drug of abuse at GTCs in the first half of 2003 (accounting for 2.4 percent of admissions), it was the most common primary drug of abuse at NGCs (21.7 percent). The proportion of primary heroin

admissions at NGCs reflected a slight decline from 2002, when 26.3 percent of clients reported primary heroin abuse. Only 1.0 percent of juveniles arrested during the first half of 2003 reported heroin use.

Marijuana was the second most common drug of first use at both GTCs and NGCs in the first half of 2003. As a primary drug of use, however, marijuana ranked third at GTCs (16.2 percent) and

fourth at NGCs (10.2 percent). More than one-third (34.6 percent) of the 4,644 juveniles arrested during the first half of 2003 reported use of marijuana.

Inhalant abuse was reported as the primary drug problem by 10.4 percent of patients entering GTCs and 10.2 percent of patients entering NGCs. Fourteen percent of juvenile arrestees reported inhalant use in the first half of 2003.

APPENDIX A.

THE DRUG ABUSE WARNING NETWORK (DAWN) EMERGENCY DEPARTMENT DATA

This national data collection system, managed by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA), provides semiannual and annual estimates of substance use based on visits to hospital emergency departments (EDs) in 21 metropolitan areas, including 20 CEWG areas.

The data reported in this publication were gathered from a national probability sample of hospitals in the 21 areas in 48 States and the District of Columbia. Alaska and Hawaii are not included in the sample. With few exceptions, the geographic area boundaries correspond to the 1983 Office of Management and Budget definitions of Metropolitan Statistical Area and Primary Metropolitan Statistical Area. Periodic minor modifications are made to the ED sample to keep it current. Analyses show that such modifications have little impact on trends across time. Various statistical procedures are used to enhance precision in the sampling frame. In the first half of 2002, the DAWN sample consisted of 564 eligible hospitals. Of these, 458 (81 percent) participated in DAWN.

ED data are reported for each “episode” (case or admission) that meets the criteria for “drug abuser age 6–97,” who is taking one or more substances without proper medical supervision or for psychic effect, dependence, or suicide attempt or gesture.

Each drug reported by a patient may be counted as a “mention.” Up to four drugs for each episode may be recorded. Some drugs are classified in a combined category, such as “marijuana/hashish,” and “PCP/PCP combinations.”

ED mention data are converted to rates per 100,000 population when sample sizes permit. A probability value of less than 0.05 is used to determine statistical significance. Note that the 2000 decennial census was used for the first time in 2001 to calculate rates, resulting in a larger denominator than in the 1994–2000 period, when less precise annual population projections developed by the U.S. Bureau of the Census were used as denominators in calculating rates.

Because an individual may be counted in more than one episode in a reporting period, and may mention more than one drug, the DAWN ED data cannot be used to estimate prevalence.

The 2002 ED data presented in this publication can be accessed electronically through the Internet at <http://samhsa.gov.oas.dawn.htm>. However, the data for 2002 and prior years can no longer be used for trend analysis. Subsequent CEWG publications will report data from the new DAWN ED system initiated in 2003.

APPENDIX B.
TOTAL ADMISSIONS BY PRIMARY
SUBSTANCE OF ABUSE
AND CEWG AREA: 2002¹–2003²

Area	Alcohol Only	Alcohol/ Other Drug	Cocaine/ Crack	Heroin	Marijuana	Stimulants	Other Drugs	Total ³
Atlanta ⁴	NR ⁵	3,484	5,735	369	NR	1,322	NR	14,216
Baltimore ¹	4,503	3,693	3,714	14,828	3,973	0	1,226	31,937
Boston	NR	8,796	1,946	11,376	1,026	70	1,037	24,251
Detroit	2,636	2,626	3,987	4,441	1,401	10	491	15,592
Los Angeles ⁴	2,125	2,789	5,242	6,891	3,669	5,113	1,281	27,110
Miami ⁴	105		283	37	526	0	0	951
Mpls./St. Paul ⁴	4,811		1,200	297	2,125	620	352	9,405
New Orleans	538		862	268	734	0	135	2,537
New York ⁴	4,581	6,893	8,141	11,442	6,808	105	1,164	39,134
Newark ⁴	97	137	162	2,061	160	2	38	2,657
Philadelphia ⁴	891		1,038	766	590	15	188	3,488
St. Louis ⁴	NR	725	1,791	512	1,535	259	133	4,955
San Diego ⁴	737	1,000	492	695	1,765	3,397	188	8,242
San Francisco ⁴	NR	NR	6,561	10,423	NR	5,973	NR	27,187
Seattle ¹	2,955		907	1,036	1,453	613	267	7,231
Wash., DC ¹	638	401	1,889	2,116	264	17	223	5,548
Arizona	9,046	7,092	2,132	1,539	5,212	3,272	1,010	29,303
Colorado ⁴	24,834	2,840	1,555	901	2,332	1,611	681	34,754
Hawaii ⁴	824		171	107	782	1,610	148	3,642
Illinois	51,638		33,836	26,935	32,060	4,058	10,726	159,253
Texas ⁴	3,992	4,094	7,259	2,569	4,949	2,034	1,885	26,782

¹Three sites report only full-year 2002 data: Baltimore, Seattle, and Washington, DC.

²Represents either fiscal or calendar year data.

³Total numbers shown may underrepresent total admissions because "alcohol only" or "other drugs" were not reported.

⁴Represents only half-year data for 2003.

⁵NR=Not reported.

SOURCES: CEWG December 2003 reports

APPENDIX C.

THE ARRESTEE DRUG ABUSE MONITORING (ADAM) PROGRAM

Managed by the National Institute of Justice (NIJ), the ADAM program is designed to gather drug use data quarterly from male adult arrestees in 36 sites in the United States; 15 of these sites provide data relevant to the CEWG for various quarters of 2003. Data were also collected on adult female arrestees in 23 sites; 9 sites provided data relevant to the CEWG. The preliminary 2003 data cover less than four quarters in all sites, as indicated in the Data Sources section of this report. The percentages reported for 2003 represent averages across quarters and, thus, are estimates.

Beginning in 2000, the ADAM instrument for adult arrestees was revised, and the adult male sample was based on probability sampling procedures. For these reasons, the 2000 (and beyond) data are not comparable to data collected prior to 2000. Data on adult males are weighted.

Adult female data are based on convenience sampling, smaller sample sizes, and different data collection methods. For these reasons, the (unweighted) adult female data are not comparable to the adult male arrestee data.

Analyses and reporting of ADAM data focus on urinalysis results. Urinalysis provides confirma-

tion of use of 10 drugs within a 2–3 day period prior to interview using the Enzyme Multiplied Immunoassay Technology. The urinalysis tests for use of cocaine, opiates (e.g., heroin), marijuana, phencyclidine (PCP), methadone, propoxyphene (Darvon), barbiturates (e.g., Seconal, Tuinal), benzodiazepines (e.g., Valium, Ativan), and amphetamines. Testing distinguishes amphetamines from over-the-counter compounds.

Self-report data on drug use are collected for particular drugs and time periods (past 30 days and past 12 months). Self-report data also cover demographic characteristics and information related to need for and utilization of substance abuse treatment.

As in other arrestee data sets, the rate and type of drug arrest may reflect changing law enforcement practices (e.g., “crack downs” on specific population groups at a specific point in time) rather than prevalence of drug use among the sampled arrestees.

Additional information on the ADAM program can be accessed on the Internet at <http://www.adam.nij.net>. The program will be discontinued in 2003.

APPENDIX D.

THE NATIONAL FORENSIC LABORATORY INFORMATION SYSTEM (NFLIS)

The NFLIS, established by the Drug Enforcement Administration, published its first annual report in 2000, under the auspices of Research Triangle Institute.

The primary objectives of NFLIS are to provide chemically verified data that support drug policy and scheduling decisions as well as drug enforcement resource allocations; document regional and local patterns of drugs seized by law enforcement; identify emerging drug problems geographically and over time; supplement other data sources (e.g., DAWN, ADAM); and provide labs with the ability to access data and conduct analysis. The program is voluntary, and a moderate level of assistance is provided.

NFLIS data represent the results of items seized by law enforcement, submitted to a laboratory for analysis, and subsequently analyzed by State and local forensic laboratories. As of May 2003, 187 of the Nation's approximately 300 State and local labs had joined NFLIS, and 162 were reporting regularly. Plans are underway to enroll all local, State, and Federal labs.

The NFLIS database consists of case and item/exhibit level information. Laboratories report data in a convenient format. An Interactive Data Site (IDS) allows remote data analysis. The data are published in annual, semiannual, and special topic reports.

There are many advantages offered by NFLIS. The data are scientifically verified and allow for special studies. Detailed information is provided on drug characteristics. Facilities information exchange and collaboration is also a benefit.

Limitations of NFLIS that can distort comparisons across locales are acknowledged. They include the fact that site data are not adjusted for population size; data for some labs are not available for all months of the most recent reporting period; there are differing policies and procedures among laboratories; and Federal laboratory data are not currently included in the system. Also, the system is subject to law enforcement priorities.

Additional information on NFLIS can be accessed through the Internet at <http://www.deadiversion.usdoj.gov/nflis>.

APPENDIX E.

THE DOMESTIC MONITOR PROGRAM (DMP)

Under the jurisdiction of the Intelligence Division of Drug Enforcement Administration (DEA), the DMP reports on the origin, types, cost, and purity of retail-level heroin available in the open-air drug markets in the major metropolitan areas of the United States. The information for 2002 is based on actual undercover heroin purchases made by the DEA on streets in 23 metropolitan areas, 20 of which are in or near CEWG areas.

The heroin buys provide information on the type of heroin (Asian, Mexican, Colombian, or undeter-

mined) and the type of diluents and adulterants present in the drug. DMP reports indicate where the buy was made, the brand name (if any), purity level, and price per milligram pure.

DMP data are used to assess changes in price per milligram pure and the sources of heroin purchased in an area. Price and purity for particular drugs can vary across years if the number of buys made in a particular area are small.

APPENDIX F.

LIST OF PAPERS IN VOLUME II

Epidemiology of Drug Abuse: CEWG Area Papers

Atlanta

Metropolitan Atlanta Drug Use Trends

Kristin J. Wilson, Johanna H. Boers, B.A.,
Claire E. Sterk, and Kirk W. Elifson, Ph.D.

Boston

Patterns and Trends in Drug Abuse: Greater Boston

Daniel P. Dooley

Chicago

Patterns and Trends of Drug Abuse in Chicago

Lawrence Ouellet, Ph.D., Dita Davis, M.P.H.,
Susan Bailey, Ph.D., and Wayne Wiebel, Ph.D.

Denver

Patterns and Trends in Drug Abuse: Denver and Colorado

Bruce Mendelson, M.P.A.

Detroit

Drug Abuse Trends in Detroit/Wayne County and Michigan

Richard F. Calkins

Honolulu

Illicit Drug Use in Honolulu and the State of Hawaii

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

Los Angeles

Patterns and Trends in Drug Abuse: Los Angeles County, California

Beth Finnerty, M.P.H.

Miami

Drug Abuse in Miami and South Florida

James N. Hall and Madeline Camejo, Pharm.D.

Minneapolis/St. Paul

Drug Abuse Patterns and Trends in Minneapolis/St. Paul

Carol L. Falkowski

Newark

Drug Abuse in the Newark Primary Metropolitan Area

Anna Kline, Ph.D.

New Orleans

Overview of Drug Abuse Indicators in New Orleans

Gail Thornton-Collins

New York City

Drug Use Trends in New York City

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

Philadelphia

Drug Use in Philadelphia, Pennsylvania

Samuel J. Cutler and Mark R. Bencivengo, M.A.

Phoenix

Drug Abuse Trends in Phoenix and Arizona

Ilene L. Dode, Ph.D.

St. Louis

Patterns and Trends in Drug Abuse in St. Louis

Heidi Israel Adams, Ph.D., R.N., L.C.S.W., and
Jim Topolski, Ph.D.

San Diego

Indicators of Drug Abuse in San Diego County

Michael Ann Haight, M.A.

San Francisco

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

John A. Newmeyer, Ph.D.

Seattle

Recent Drug Abuse Trends in the Seattle-King County Area

Caleb Banta-Green, Susan Kingston,
Steve Freng, Geoff Miller, Michael Hanrahan,
T. Ron Jackson, Ann Forbes, Arnold F. Wrede,
Richard Harruff, Greg Hewett, Kris Nyrop,
and Mark McBride

Texas

Substance Abuse Trends in Texas

Jane Carlisle Maxwell, Ph.D.

Washington, D.C.

Patterns and Trends of Drug Abuse in Washington, D.C.

Eric Wish, Ph.D., Erin Artigiani, M.A., and
Thomas Gray, M.A.

Current/Emerging Trend: PCP Abuse

Background

Phencyclidine (PCP) Production, Distribution, and Trends

James Tolliver, M.S., Ph.D.

PCP Use and Trends in Washington, DC: Two Qualitative Methods for Investigating Leads from Indicator Data

Eric Wish, Ph.D.

Community Networking Study: Understanding PCP Abuse in Los Angeles, California

Beth Finnerty

PCP Abuse in Hartford, Connecticut

Jean J. Schensul, Ph.D.

Summary and Suggestions for Future PCP Research

Harvey Siegal, Ph.D.

Rural Drug Abuse

Introduction

Rural and Urban Differences in Missouri Drug Abuse Treatment Admissions

James Topolski, Ph.D.

Differences in Substance Use in Rural and Urban Secondary Schools and Treatment Centers in Texas

Jane C. Maxwell, Ph.D.

Rural Drug Abuse in Colorado

Bruce Mendelson, M.P.A.

Substance Abuse Patterns in Plumas County, California

John Newmeyer, Ph.D.

Monitoring Rural Drug Abuse in Washington State

Caleb Banta-Green

Special Presentations: Substance Abuse Patterns and Trends in Georgia

Introduction

Drug Abuse Trends in Georgia: Estimates from Treatment and General Populations

Fred A. Marsteller, Ph.D.

Georgia Bureau of Investigation (GBI) Forensic Data

Mark D. Burns

Atlanta DEA Trafficking and Seizure Data

James W. Beeks, Sr., M.P.A.

Club Drug Trends in Atlanta

Kirk Elifson, Ph.D.

Drug Abuse Patterns Among Latino Clients Entering Treatment

Pierluigi Mancini, Ph.D.

Being an Addict, Being a Mother

Claire E. Sterk, Ph.D.

Special Presentations: The
Centers for Disease Control and
Prevention

*Youth Risk Behavior Surveillance System Drug
Use Data*

Nancy D. Brener, Ph.D.

Injection Drug Use Behavioral Surveillance

Abu S. Abdul-Quader

*The Epidemic Intelligence Service and
Poisoning Activities of the National Center for
Injury Control and Prevention*

Dan Budnitz, M.D., M.P.H.

Special Presentations on Hospital
Emergency Department Data

Update on DAWN

Judy K. Ball, Ph.D., M.P.A.

*Emerging Drugs: A Perspective from the
Hospital Emergency Department*

Edward W. Boyer, M.D., Ph.D.

International Reports

Canada

*The Canadian Community Epidemiology
Network on Drug Use (CCENDU)*

Colleen Anne Dell, Ph.D., and
Karen Garabedian, M.A.

Mexico

*Update Of The Epidemiologic Surveillance
System of Addictions (SISVEA) in Mexico*

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

