



EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

Proceedings of the Community Epidemiology Work Group

Highlights and Executive Summary

January 2011

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTES OF HEALTH NATIONAL INSTITUTE ON DRUG ABUSE



COMMUNITY EPIDEMIOLOGY WORK GROUP

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

Proceedings of the Community Epidemiology Work Group

Highlights and Executive Summary

January 2011

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES NATIONAL INSTITUTES OF HEALTH Division of Epidemiology, Services and Prevention Research National Institute on Drug Abuse 6001 Executive Boulevard Bethesda, Maryland 20892 The National Institute on Drug Abuse (NIDA) acknowledges the contributions made by the representatives of the Community Epidemiology Work Group (CEWG), who prepare the reports presented at the semiannual meetings. Appreciation is extended also to other participating researchers and Federal officials who contributed information. This publication was prepared by Social Solutions International, Inc., under contract number HHSN-2712007-000003C from NIDA.

The information presented in this Executive Summary is primarily based on CEWG area reports and meeting presentations prepared by CEWG representatives for the January 2011 CEWG meeting. Data/information from Federal sources supplemental to the meeting presentations and discussions have been included in this report to facilitate cross-area comparisons.

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

For more information about the Community Epidemiology Work Group
and other research-based publications and information on drug abuse
and addiction, visit NIDA's Web site at <<u>http://www.drugabuse.gov</u>>.This report (available in limited supply) can be obtained by contacting
the NIDA DrugPubs Research Dissemination Centerby phone:877–NIDA–NIH (877–643–2644)
240–645–0228 (TTY/TDD)by fax:240–645–0227

by email: <u>drugpubs@nida.nih.gov</u>

National Institute on Drug Abuse September 2011

Contents

Foreword	vi
Section I. Introduction	1
Section II. Highlights and Summary of Key Findings and Emerging Drug Issues From the January 2011 CEWG Meeting	8
Section III. CEWG Area Update Briefs and International Reports— January 2011 CEWG Meeting	
CEWG AREA UPDATE BRIEFS	
Drug Abuse Patterns and Trends in Albuquerque and New Mexico—Update: January 2 Nina Shah, M.S.	2011
Drug Abuse Patterns and Trends in Atlanta—Update: January 2011 Lara DePadilla, Ph.D., and Mary Wolfe, B.S.	61
Drug Abuse Patterns and Trends in Baltimore City, Maryland, and Washington, DC— Update: January 2011 <i>Erin Artigiani, M.A., Maribeth Rezey, M.A., Margaret Hsu, M.H.S., and</i> <i>Eric D. Wish, Ph.D.</i>	63
Drug Abuse Patterns and Trends in Greater Boston—Update: January 2011 Daniel P. Dooley	64
Drug Abuse Patterns and Trends in Chicago—Update: January 2011 Lawrence Ouellet, Ph.D.	66
Drug Abuse Patterns and Trends in Cincinnati (Hamilton County)—Update: January 20 Jan Scaglione, Pharm.D., M.T., DABAT)11 66
Drug Abuse Patterns and Trends in Colorado and the Denver/Boulder Metropolitan Are Update: January 2011 <i>Kristen Dixion, M.A., L.P.C.</i>	∋a— 70
Drug Abuse Patterns and Trends in Detroit, Wayne County, and Michigan— Update: January 2011 <i>Cynthia L. Arfken, Ph.D.</i>	73
Drug Abuse Patterns and Trends in Honolulu and Hawaii—Update: January 2011 D. William Wood, M.P.H., Ph.D.	75
Drug Abuse Patterns and Trends in Los Angeles County—Update: January 2011 Mary-Lynn Brecht, Ph.D.	77

Drug Abuse Patterns and Trends in Maine—Update: January 2011 Marcella Sorg, Ph.D., R.N., D-ABFA	79
Drug Abuse Patterns and Trends in Miami-Dade and Broward Counties, Florida— Update: January 2011 James N. Hall	81
Drug Abuse Patterns and Trends in Minneapolis and St. Paul, Minnesota—Update: January 2011 Carol L. Falkowski	83
Drug Abuse Patterns and Trends in New York City—Update: January 2011 Rozanne Marel, Ph.D.	87
Drug Abuse Patterns and Trends in Philadelphia—Update: January 2011 Samuel J. Cutler	88
Drug Abuse Patterns and Trends in the Phoenix Area and Arizona—Update: January 2011 James K. Cunningham, Ph.D.	91
Drug Abuse Patterns and Trends in St. Louis, Missouri—Update: January 2011 Christopher Long, Ph.D., and Heidi Israel, Ph.D., R.N., F.N.P., L.C.S.W.	92
Drug Abuse Patterns and Trends in San Diego County—Update: January 2011 Robin A. Pollini, Ph.D., M.P.H.	94
Drug Abuse Patterns and Trends in the San Francisco Bay Area—Update: January 2011 John A. Newmeyer, Ph.D., and Alice Gleghorn, Ph.D.	96
Drug Abuse Patterns and Trends in Seattle, Washington—Update: January 2011 Caleb Banta-Green, T. Ron Jackson, Pat Knox, Steve Freng, Michael Hanrahan, David H. Albert, John Ohta, Ann Forbes, Robyn Smith, Steve Reid, Mary Taylor, and Richard Harruff	97
Drug Abuse Patterns and Trends in Texas—Update: January 2011 Jane C. Maxwell, Ph.D.	98

INTERNATIONAL REPORTS

Main and New Drug Trends in the European Union: EMCDDA 2010 Report Julian Vicente, Roumen Sedefov, Ana Gallego, and Paul Griffiths	99
The Drug Situation in Canada—Health Canada's Update: January 2011 Judy Snider, M.Sc.	.100
The Australian Drug Market: Findings From the Ecstasy and Related Drugs Reporting System Natasha Sindicich, M.Psych (Forensic)	.102
Monitoring Systems and the Situation of Substance Abuse and HIV Related to Drug Use in Thailar Usaneya Perngparn, Ph.D., and Chitlada Areesantichai, Ph.D.	nd .103
Community Epidemiology of Illegal Drug Use in Jamaica: The Last 24 Months Ellen Campbell Grizzle, B.Pharm., Ph.D., R.Ph.	.104

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

Foreword

THIS EXECUTIVE SUMMARY PROVIDES A SYNTHESIS OF findings from reports presented and data prepared for the 69th semiannual meeting of the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG) held in Scottsdale, Arizona, on January 19-21, 2011. The CEWG is a network of researchers from sentinel sites throughout the United States. It meets semiannually to provide ongoing community-level public health surveillance of drug abuse through presentation and discussion of quantitative and qualitative data. CEWG representatives access multiple sources of existing data from their local areas to report on drug abuse patterns and consequences in their areas and to provide an alert to potentially emerging new issues. Local area data are supplemented, as possible, with data available from federally supported projects, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Warning Network (DAWN), Drug Enforcement Administration (DEA) National Forensic Laboratory Information System (NFLIS), and the DEA Heroin Domestic Monitor Program (HDMP). This descriptive and analytic information is used to inform the health and scientific communities and the general public about the current nature and patterns of drug abuse, emerging trends, and consequences of drug abuse.

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

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

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

Moira P. O'Brien

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

Section I. Introduction

THE 69TH SEMIANNUAL MEETING OF THE COMMUNITY Epidemiology Work Group (CEWG) was held on January 19–21, 2011, in Scottsdale, Arizona. During the meeting, CEWG area representatives from 21 geographically dispersed areas in the United States reported on current trends and emerging issues in their areas. In addition to the information provided for 18 sentinel areas that have contributed to the network for many years, guest researchers from Albuquerque, Cincinnati, and Maine provided data from their respective areas, as did international representatives from Europe, Canada, Australia, Thailand, and Jamaica.

The CEWG Network

The CEWG is a unique epidemiology network that has functioned since 1976 as a drug abuse surveillance system to identify and assess current and emerging drug abuse patterns, trends, and issues, using multiple sources of information. Each source provides information about the abuse of particular drugs, drug-using populations, and/or different facets of the behaviors and outcomes related to drug abuse. The information

obtained from each source is considered a drug abuse indicator. Typically, indicators do not provide estimates of the number (prevalence) of drug abusers at any given time or the rate at which drug-abusing populations may be increasing or decreasing in size. However, indicators do help to characterize drug abuse trends and different types of drug abusers (such as those who have been treated in hospital emergency departments, admitted to drug treatment programs, or died with drugs found in their bodies). Data on items submitted for forensic chemical analysis serve as indicators of availability of different substances and engagement of law enforcement at the local level, and data such as drug price and purity are indicators of availability, accessibility, and potency of specific drugs. Drug abuse indicators are examined over time to monitor the nature and extent of drug abuse and associated problems within and across geographic areas. The CEWG areas for which presentations were made at the January 2011 meeting are depicted in the map below, with one area presentation including data on Baltimore, Maryland, and



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

CEWG Meetings

The CEWG convenes semiannually; these meetings continue to be a major and distinguishing feature of the workgroup. CEWG representatives and guest researchers present information on drug abuse patterns and trends in their areas, and personnel from Federal agencies provide updates of data sets used by the CEWG. In addition, time is set aside for question-and-answer periods and discussion sessions. The meetings provide a foundation for continuity in the monitoring and surveillance of current and emerging drug problems and related health and social consequences.

Through the meetings, the CEWG accomplishes the following:

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

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

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

- Presentations by researchers in the CEWG host city
- Updates by Federal personnel on key data sets used by CEWG representatives
- Drug abuse patterns and trends in other countries

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

Data Sources

To assess drug abuse patterns and trends, city- and State-specific data were compiled from a variety of health and other drug abuse indicator sources. Such sources include public health agencies; medical and treatment facilities; ethnographic research; key informant discussions; criminal justice, correctional, and other law enforcement agencies; surveys; and other sources unique to local areas.

Availability of data varies by area, so reporting varies by area. Examples of types of data reviewed by CEWG representatives to derive drug indicators include the following:

- Admissions to drug abuse treatment programs by primary substance of abuse or primary reason for treatment admission reported by clients at admission
- Drug-involved emergency department (ED) reports of drugs mentioned in ED visits reported by the Drug Abuse Warning Network (DAWN)
- Seizure, average price, average purity, and related data obtained from the Drug Enforcement Administration (DEA) and from State and local law enforcement agencies
- Drug-related deaths reported by medical examiner (ME) or local coroner offices or State public health agencies
- Arrestee urinalysis results and other toxicology data
- Surveys of drug use
- Poison control center data

Sources of data used by several or most of the CEWG area representatives and presented in this Highlights and Executive Summary Report are summarized below, along with some caveats related to their use and interpretation. The terminology that a particular data source uses to characterize a drug, for example, cannabis versus marijuana, is replicated here.

Treatment data were derived from CEWG area reports. For this report, they represent data for 17 CEWG metropolitan areas and 5 States: Colorado, Hawaii, Maine, New Mexico, and Maryland. Recent or complete treatment admissions data were not available for Chicago, New Mexico, Texas, or Washington, DC. Data for several States are included with metropolitan data for comparison, including data for Colorado with Denver, Hawaii with Honolulu, and Florida with Miami-Dade County and Broward County. The latter two counties in South Florida are part of the Miami MSA. The reporting period is cited as the first half (1H) of calendar year (CY) 2010 (January-June 2010) for all areas except San Francisco, which reported data for fiscal year (FY) 2010 (July 2009-June 2010). Appendix table 1 shows overall treatment admissions data by drug and CEWG area for the current reporting period. Table 2 in section II and several tables in section IV (tables 3, 4, 7, 10, and 11) also display cross-area treatment admissions data, as do several figures in section II (figures 3, 4, 8, 12, 16, 18, and 20).

DAWN ED¹ weighted estimates for 12 CEWG areas for 2004 through 2009 were accessed on the DAWN Web site (*https://dawninfo.samhsa. gov/default.asp*) maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). The data represent drug reports for drug-involved visits for illicit drugs (derived from the category of "major substances of abuse," excluding alcohol) and the nonmedical use of selected pharmaceutical drugs. Nonmedical use of pharmaceuticals is use that involves taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs, especially illegal drugs or alcohol. Since drug reports exceed the number of ED visits because a patient may report use of multiple drugs (up to six drugs plus alcohol), summing of drugs across categories is not recommended. A description of the DAWN system can be found at https://dawninfo.samhsa.gov/default.asp. Several CEWG Update Briefs in section III include DAWN data: Boston, Chicago, Denver, Detroit, Miami-Dade County², Minneapolis/St. Paul, New York City, Phoenix, and San Francisco. Weighted DAWN data for 2004–2009 are reported in section II, figures 7, 14, 15, and 22.

Forensic laboratory data for a total of 23 CEWG sites were available for the first half of 2010. Data for all CEWG metropolitan areas in the first half of 2010 were provided by the National Forensic Laboratory Information System (NFLIS), maintained by the DEA. NFLIS is a program in the DEA Office of Diversion Control that systematically and continuously collects results from drug analyses of items received from drug seizures by law enforcement authorities. Drug analyses are conducted by Federal (DEA) forensic laboratories and participating State and local forensic laboratories. As of December 2010, in addition to the DEA laboratories, the NFLIS system included 48 State systems, 94 local or municipal laboratories/

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

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

laboratory systems, and 1 territorial laboratory, representing a total of 283 individual laboratories. These laboratories handled more than 89 percent of the Nation's estimated 1.1 million annual State and local drug analysis distinct cases (estimated as of 2009). Data are entered daily based on seizure date and the county in which the seizure occurred. NFLIS provides detailed information on the prevalence and types of controlled substances secured in law enforcement operations and assists in identifying emerging drug problems and changes in drug availability and in monitoring illicit drug use and trafficking, including the diversion of legally manufactured drugs into illegal markets. A list of participating and reporting State and local forensic laboratories is included in Appendix B of the U.S. Drug Enforcement Administration, Office of Diversion Control report, National Forensic Laboratory Information System: Year 2009 Annual Report (Washington, DC: U.S. Drug Enforcement Administration)³. In most cases, data are for MSAs, rather than single metropolitan counties, but the exact geographic areas covered in this report are defined in appendix table 2. A map displaying NFLIS data for the first half of 2010 for 23 CEWG areas is included as figure 23 in section II, while a number of other figures and tables in section II (table 1; figure 21) and section IV (figures 24, 25, 27, and 28, and tables 8, 9, 12, and 13), along with appendix tables 2.1–2.23, are provided to display the data on forensic laboratory drug items identified for the period across areas. Update Briefs in section III of this report also include NFLIS data for CEWG areas.

Average price and purity data for heroin for 21 CEWG metropolitan areas in CY 2009 (the most recent period available) came from the DEA report, 2009 Heroin Domestic Monitor Program (HDMP) Drug Intelligence Report, published November 2010 (DEA-NCW-RPT-013-10). This report is prepared by the Domestic Strategic Intelligence Unit of the Special Strategic Intelligence Section and reflects analysis of program data to December 31, 2009. Drug price and purity data from this report or from local DEA Field Divisions are included in Update Briefs for the following CEWG sites/areas: Atlanta; Baltimore/Maryland/ Washington, DC; Boston; Chicago; Cincinnati; Denver; New York City; Philadelphia; St. Louis; San Francisco; Seattle; and Texas. In section IV, figure 26 and tables 5 and 6 show data for average price and purity for CEWG areas.

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

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

Local drug-related mortality data from medical examiners/coroners (ME/Cs) or State public health agencies were reported for 16 CEWG areas: Albuquerque; the Baltimore/ Maryland/ Washington, DC, area; Boston; Cincinnati; Denver; Detroit; Honolulu; Los Angeles; Maine; Miami-Dade and Broward Counties in the Miami MSA in South Florida; Minneapolis/St. Paul; Philadelphia; St. Louis; San Diego; Seattle; and Texas. These are described in Update Briefs in section III and shown in figures 1, 2, 5, 9, and 10 in section II of this report.

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

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

A Note to the Reader—Caveats

Terminology and Geographic Coverage— The CEWG representatives use existing data, which are subject to the definitions and geographic coverage of the source data. Representatives generally use the terminology as it is used in the data source. For example, many treatment systems use the phrase "other opiates" for classifying opiates⁴ or opioids⁵ other than heroin as the primary problem at admission. The term "other opiates" is therefore retained in this summary report, and the terms "other opiates" and "opioids" may be used in a single area report. Similarly, the term "prescription-type opioid" is used by some representatives to distinguish synthetic or semisynthetic opioids, such as oxycodone and hydrocodone, from heroin. The geographic coverage of data sources may vary within a CEWG area report. Readers are directed to the Data Sources paragraph in the CEWG area Update Briefs in section III for a more complete description of data sources used in specific areas. In this summary report, in most cases, the general name of the CEWG area will be used for data sources. For the treatment admissions and NFLIS data, the specific geographic coverage will be noted in footnotes. For example, appendix table 1 presents the treatment admissions data for each area, and footnotes specify the geographical coverage; appendix table 2 presents local area NFLIS data with notes on spatial composition.

Local comparisons are limited, or must be made with caution, for the following indicators:

Treatment Admissions—Many variables affect treatment admission numbers, including program emphasis, capacity, data collection methods, and reporting periods. Therefore, changes in admissions bear a complex relationship to drug abuse prevalence. Treatment data on primary abuse of specific drugs in this report represent percentages of total admissions, both including and excluding primary alcohol admissions. Percentage distributions based on total treatment admissions by drug, including primary alcohol admissions, were used for all cross-area comparisons. Data on demographic characteristics (gender, race/ethnicity, and age group) and route of administration of particular drugs were provided for some CEWG areas and reported in Update Briefs. The numbers of admissions for alcohol and other drugs in the first half of 2010 are presented for 21 reporting CEWG sites/areas in appendix table 1, with rankings documented in section II, table 2. Treatment data are not totally comparable across CEWG areas, and differences are noted insofar as possible. Treatment numbers are subject to change. Most of the CEWG area representatives report Treatment

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

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

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

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

Forensic Laboratory Drug Items Identified—NFLIS data include drug chemistry results from completed analyses only; drug evidence secured by law enforcement but not analyzed in laboratories is not included in the NFLIS database. State and local policies related to the enforcement and prosecution of specific drugs may affect drug evidence submissions to laboratories for analysis. Laboratory policies and procedures for handling drug evidence vary, and they range from analysis of all evidence submitted to the laboratory to analysis of selected items only. Many laboratories did not analyze the evidence when a case was dismissed or if no defendant could be identified (see NFLIS Year 2009 Annual Report cited earlier). Differences in local/State laboratory procedures and law enforcement practices across areas make crossarea comparisons inexact. Also, the data cannot be used for prevalence estimates, because they are not adjusted for population size. NFLIS data are reported as counts and as the percentage that each drug represents of the total number of drug items seized and identified by forensic laboratories in a CEWG area. Cases are assigned to a geographic area by the location of the seizure event, not the laboratory. Because the method of case assignment for the data provided by DEA to the CEWG has changed recently to assignment based on the geographic location from which items were submitted for identification, rather than the location of the laboratory that performed the item identification, NFLIS data for 2007 to the first half of 2010 cannot be compared with pre-2007 data presented in prior CEWG reports. The nature of the reporting system is such that there may be a time lag between the time of seizure, the time of analysis of drug items, and the time of reporting to the NFLIS system. Therefore, differences in the number of drug items for a specified time period may occur

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

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

when NFLIS is queried at different times, since data input is daily and cases may be held for different periods of time before analysis and reporting in various areas and agencies. Numbers of drug items presented in these reports are subject to change and may differ when drawn on different dates. Not all forensic laboratories report on substances that are not controlled, rendering some comparisons of such drugs inaccurate. Only the top 50 drug items identified in an area were retrieved by NFLIS for each CEWG area, resulting in a possible underestimation of less common, but emergent drugs.

Deaths—Mortality data may represent the presence of a drug detected in a decedent or overdose deaths. The mortality data are not comparable across areas because of variations in methods and procedures used by ME/Cs. Drugs may cause a death, be detected in a death, or simply relate to a death in an unspecified way. Multiple drugs may be identified in a single case, with each reported in a separate drug category. Definitions associated with drug deaths vary. Common reporting terms include "drug-related," "drug-detected," "druginduced," "drug-caused," and "drug-involved." These terms may have different meanings in different areas of the country, and their meaning may depend upon the local reporting standards and definitions. Cross-area tabulations of mortality drug abuse indicators are not included in this report.

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

Local Area Comparisons

The following methods and considerations pertain to local area comparisons:

• Local areas vary in their reporting periods. Some indicators reflect fiscal periods that may differ among local areas. In addition, the timelines of data vary, particularly for death and treatment

indicators. Spatial units defining a CEWG area may also differ depending on the data source. Care has been taken to delineate the definition of the geographic unit under study for each data source, whether a city, a single metropolitan county, an MSA, or some subset of counties in an MSA. In some instances, data were compiled by region defined by the U.S. Census as northeastern, southern, midwestern, and western regions. Texas is included in the western region in this report, rather than in the census-defined southern region, based on member recommendations concerning area comparability of drug patterns and similarity of population characteristics to other western areas.

- In section IV of this report, percentages for treatment program admissions are calculated and presented in two ways—excluding primary alcohol admissions from the total on which the percentages are based and including primary alcohol admissions in the total on which percentages are based. However, all cross-area comparisons use only the latter measure.
- Nearly all treatment data in the cross-area comparison section of this report cover January through June of 2010, which is characterized as the current reporting period. However, San Francisco reported FY 2010 data (July 2009–June 2010).
- Some indicator data are unavailable for certain cities. Therefore, the symbol, "NR," in tables refers to data not reported by the CEWG area representative.
- The racial/ethnic population compositions differ across CEWG areas. Readers are directed to the individual CEWG area Update Briefs in section III of this report for information regarding treatment patterns and trends pertaining to race/ethnicity, age, and gender, if discussed.

Section II. Highlights and Summary of Key Findings and Emerging Drug Issues From the January 2011 CEWG Meeting

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

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

Contained in this volume for each CEWG area represented at the meeting are Update Briefs, which document and summarize drug abuse trends and issues in specific CEWG areas, with an emphasis on information newly available since the January and June 2010 meeting reports. The availability of data varies by area. Readers are directed to the Data Sources section of the Update Briefs in section III of this report to determine which data sources were reviewed for particular areas.

Subsequent to the CEWG meeting, data available across a majority of CEWG areas, such as substance abuse treatment admissions and information from NFLIS and HDMP, are reviewed. These data are presented in section IV of this report and in appendix tables 2.1–2.23. Highlights from these cross-area tabulations are also included in section IV.

For the January 2011 CEWG meeting, CEWG representatives were invited to provide an overview and update on drug abuse trends in their areas for the first half of the most recent calendar year (January–June 2010). Key findings and issues identified at the CEWG meeting are highlighted in section II, with more detail provided in the Update Briefs in section III.

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

Cocaine/Crack

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

Western Region CEWG Areas:

• **Phoenix Report.** The area representative from Phoenix reported that a decline in the number of cocaine-related hospital admissions in Maricopa County that began in 2007 continued into the first half of 2010, from 1,598 admissions in the first half of 2007 to 884 admissions in the first half of 2010. Similarly, the number of cocaine-related hospital admissions declined in Pima County (Tucson), from 1,577 in the first half of 2007 to 883 in the first half of 2010. These admissions also declined in the rural Arizona counties, from 104 in the first half of 2007 to 56 in the first half of 2010.

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

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



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

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

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

Southern Region CEWG Areas:

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

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

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

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

Midwestern Region CEWG Areas:

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





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

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

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

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

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

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

Northeastern Region CEWG Areas:

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

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

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

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

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

Other Highlights:

 The reports by CEWG area representatives on cocaine contaminated with adulterants, particularly levamisole¹⁰, which emerged in presentations at the 2009 and 2010 CEWG meetings, continued at the January 2011 meeting. Seven out of 21 area representatives reported on levamisole presence in items containing cocaine in the first half of 2010.

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





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

January 2011 CEWG meeting

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

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

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

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

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

Heroin

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

Western Region CEWG Areas:

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

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

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

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





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

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

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

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

Southern Region CEWG Areas:

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

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

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



¹The *N*'s for this table are 2004, 89; 2005, 125; 2006, 106; 2007, 108; 2008, 150; and 2009, 118. SOURCE: New Mexico Medical Examiners Data, as reported by Nina Shah at the January 2011 CEWG meeting

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

• **Baltimore/Maryland/Washington, DC, Report.** Heroin indicators in the Baltimore/Maryland/ Washington, DC, area were high and mixed in the first half of 2010, after increasing in 2009, yet heroin continued to be a major drug of concern in the area, particularly in Baltimore, according to the area representative. For instance, the percentage of drug items seized and identified as containing heroin in Maryland forensic laboratories was 17.9 percent of all items, compared with 7.1 percent for the Nation.

Midwestern Region CEWG Areas:

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

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

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



¹January–June 2010 data are annualized.

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

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

Northeastern Region CEWG Areas:

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

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

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

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

Other Highlights:

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

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

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



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

¹Statistically significant changes are indicated by the symbol "*", where the visits for a year are significantly different from visits for 2009. No significance testing of data for 2005 or 2006, compared with 2009, was available from CBHSQ. SOURCE: Weighted DAWN, 2009, CBHSQ, SAMHSA, as reported by Rozanne Marel at the January 2011 CEWG meeting

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

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

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

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



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

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