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

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

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

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

*Rozanne Marel, Ph.D.*

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

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

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

(SSU), there was little methamphetamine street selling activity, although the drug was available to users. **MDMA** indicators were increasing. NFLIS data on drugs seized and identified may indicate increases in MDMA use, as it continued to rank 6th among all drugs in the first half of 2010, compared with 11th in 2008. DAWN ED data found a significant increase in MDMA-involved visits for all comparison years. **Prescription drug** indicators were mixed. Although most indicators remained low, there continued to be street study reports that pills were available and gaining in popularity. Treatment admissions for other opiates remained low but have increased. DAWN weighted ED visit data showed significant increases in prescription drug-involved visits for opiates/opioids from 2004 to 2009 (specifically methadone, oxycodone, and hydrocodone) and for benzodiazepines from 2004 to 2009 (specifically alprazolam). Although prescription drugs represented only a small number of NFLIS items analyzed, the specific drugs that accounted for more than 100 items each were alprazolam, oxycodone, methadone, buprenorphine, hydrocodone, and clonazepam. **Other drugs:** DAWN **PCP** (phencyclidine)-involved ED visits increased significantly for all comparison years. **BZP** (1-benzylpiperazine) moved from 32nd on the list of NFLIS items seized and identified to 13th—from 4 items analyzed in the first half of 2008 to 155 items in the first half of 2010. **HIV/AIDS Update:** Of the 107,177 New Yorkers living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) as of June 30, 2009, men having sex with men and injection drug use history continued to be the two major transmission risk factors. The proportion of new HIV diagnoses among injection drug users fell, from 6.7 percent in the first half of 2008 to 4.6 percent in the first half of 2009. People living with HIV/AIDS (PLWHA) were aging. Between 2004 and 2008, the numbers of PLWHA age 50 and older increased by 45 percent in males and by 58 percent in females.

**Data Sources:** *Weighted ED data are based on a representative sample of hospitals in the five boroughs of New York City, DAWN, 2009: Selected Tables of National Estimates of Drug-Related Emergency Department Visits, Center for Behavioral Health Statistics and Quality, SAMHSA, 2010. A full description of the DAWN system can be found at* http://dawninfo.samhsa.gov. *Treatment admissions data were provided by OASAS for 1991 through the first half of 2010 and included both State-funded and nonfunded admissions. Demographic data were for the first half of 2010. Forensic laboratory testing data for New York City were provided by the Drug Enforcement Administration's (DEA) NFLIS for the first half of 2010. The data include New York Police Department laboratory data for the five boroughs of New York City, as well as data from New York State and DEA laboratories. Drug price, purity, and trafficking data were provided by the DEA Domestic Monitor Program, "The DEA—New York Field Division, Intelligence Bulletin: Heroin Domestic Monitor Program FY 2010—Preliminary Results, November 2010," "DEA-NYFD, New York Area Drug Prices, January–June 2010;" and OASAS SSU reports. AIDS and HIV data were provided by the New York City Department of Health and Mental Hygiene, HIV Epidemiology and Field Services Program, including the "HIV Epidemiology and Field Services Semiannual Report, Vol. 5, No. 1" covering January 1, 2009–June 30, 2009.*

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

### Samuel J. Cutler

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

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

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

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

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

trends from 2001 through 2009, with the exception of the period of the fentanyl outbreak from spring 2006 to spring 2007; based on mid-year 2010 data, a small decline in deaths with the presence of heroin was projected. People in treatment most commonly reported heroin use in combination with cocaine, and mortality data showed heroin most frequently detected along with benzodiazepines and/or cocaine. The nonmedical use of (prescription) **other opioids** has been in the background of the drug scene since the late 1990s until consequence data began increasing more recently, especially with respect to treatment admissions. Primary treatment admissions for oxycodone products increased from 10 clients in 2007, to 80 in 2008, to 387 in 2009, and to 410 in the first half of 2010. Secondary mentions of oxycodone increased similarly during these time periods. Among drug-positive decedents in the first half of 2010 whose cause of death was drug intoxication, oxycodone was the fourth most frequently detected drug, behind cocaine, heroin, and alprazolam. Four pharmaceutically produced opioids were in the top 10 drugs in the NFLIS report for the first half of 2010—oxycodone (4th), codeine (8th), hydrocodone (9th), and buprenorphine (10th). **Benzodiazepine** use, while lower than use of marijuana, alcohol, cocaine, or heroin, continued to be common in conjunction with other drugs, according to trend data and focus group participants. Based on treatment admissions data for the first half of 2010, there could be an 8-percent increase over 2009. Alprazolam was clearly the most widely used benzodiazepine, ranking third in the Medical Examiner (ME) toxicology reports when the cause of death was drug intoxication. In the NFLIS data, 3 benzodiazepines appeared in the top 12: alprazolam (5th), clonazepam (7th), and diazepam (12th). At mid-2010, the mortality data revealed that benzodiazepines were frequently detected among decedents who also tested positive for cocaine, alcohol, heroin, other opioids, PCP, or antidepressants. **PCP** (phencyclidine) continued to be primarily used by being smoked in combination with marijuana in "blunts." Indicators reflected medium levels of use, compared with other drugs, and were projected to increase with respect to primary treatment admissions and detections in decedents. There was stability in the PCP NFLIS rank (sixth) and APPD urinalysis results (9.1 percent of all positives). Characteristics of people who entered treatment for PCP included male (79.9 percent); African-American (68.2 percent); age 21–30 (57.1 percent); and age 31–40 (29.5 percent). Regarding **antidepressants,** 26.6 percent of all drug-positive decedents tested positive in the first half of 2010, compared with 32.0 percent in 2009. Use of **methamphetamine and other amphetamines** remained at very low levels. There were 24 treatment admissions for methamphetamine and 7 for other amphetamines in the first half of 2010. Mortality data for these drugs were also low; in the first half of 2010, there were a total of 11 detections of methamphetamine, amphetamine, MDMA (3,4-methylenedioxymethamphetamine), or MDA (3,4-methylenedioxyampheta-mine) among the 8 cases.

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

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

*James K. Cunningham, Ph.D.*

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

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

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

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

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

**Data Sources:** *Treatment data came from the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services. Hospital admissions (inpatient) data came from analyses conducted by the University of Arizona, Department of Family and Community Medicine, using hospital discharge records from the Arizona Hospital Discharge Data System operated by ADHS. Estimated ED visits came from DAWN, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Law enforcement data, including clandestine laboratory seizure data, were from the Drug Enforcement Administration (DEA). Forensic drug analysis data were from NFLIS, DEA.*

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

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

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

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

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

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

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

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

**Data Sources:** *Analysis of drug trends for the St. Louis region requires multiple data sources; a number of sources were used for this report. Missouri Treatment Episode Data Set admissions for the first 6 months of CYs 2008–2010 provided invaluable indicators for **treatment data**. The January–June 2010 NFLIS reports for the St. Louis MSA provided **forensic information** and offered a unique view of drug trends for a variety of substances. The Missouri Department of Health and Senior Services **HIV/AIDS** data FY 2006–2009 and the local St. Louis City Health Department provided measures of HIV, AIDS, and other data by risk factor that is helpful in understanding the*

*role of injection drug use on health. Missouri School Survey data for 2006–2008 gave a glimpse of general **youth trends** in current and lifetime use of some of the major substances. Data from the National Monitoring of Adolescent Prescription Stimulant Study (NMAPSS) and the Prescription Drug Use, Misuse, and Depression Study conducted by the Washington University Epidemiology and Prevention Research Program were used to address an important knowledge gap on adolescent drug trends in our area. **Death data** from the St. Louis City and County Medical Examiner for the first 6 months of CYs 2008–2010 provided insight to the extent that drug use results in death, along with basic demographic data helpful to understanding emerging trends. Ongoing reports of **drug use, price, and purity** from the Drug Enforcement Administration and the National Drug Intelligence Center are invaluable, as are the frequent formal written reports and anecdotal insight provided by the staff of these agencies.*

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

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

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

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

**Updated Drug Abuse Trends and Emerging Patterns:** Indicators of methamphetamine use/abuse had been decreasing since peaking in 2005; however, in 2009 prevalence of **methamphetamine** use increased among adult arrestees. Prevalence among female arrestees was 38 percent in 2009, compared with 31 percent in 2008, and among males it was 22 percent in 2009 and 20 percent in 2008. Remaining indicators were mixed. In contrast to adult arrestees, methamphetamine prevalence among juvenile arrestees decreased from 10 percent in 2008 to 6 percent in 2009. Primary substance abuse treatment admissions for methamphetamine were stable, accounting for 29 percent (*n*=2,006) of all admissions in the first half of 2010, compared with 30 percent (*n*=2,195) in the first half of 2009. Meanwhile, street prices of methamphetamine remained relatively steady for smaller quantities from 2007 to 2009, while they decreased for larger quantity purchases. Regarding the latter, price per pound was $9,000–$12,000 in 2009, compared with $10,000–$20,000 in 2007. Interviews conducted with adult arrestees who used methamphetamine also suggested prices were stabilizing, with 67 percent perceiving higher prices over the past year, compared with a peak of 76 percent in 2008. **Cocaine/crack** indicators continued to show reductions in use and abuse. Prevalence of use among male, female, and juvenile arrestees in 2009 was 7, 11, and 1 percent, respectively, compared with 11, 16, and 3 percent, respectively, in 2007. Primary cocaine treatment admissions decreased to 350 in the first half of 2010, from 527 in the first half of 2008; the former represented 5 percent of all treatment admissions, compared with 7 percent in 2008. Further, 9 percent of drug seizures in the first half of 2010 tested positive for cocaine, compared with 13 percent in calendar year 2008. **Marijuana** indicators were mixed; primary treatment admissions decreased slightly from 21 percent of total treatment admissions in the first half of 2009 to 19 percent in the first half of 2010. In contrast, after recording a 9-year low in prevalence in 2008, 28 percent of female arrestees tested positive for marijuana in 2009, compared with 26 percent in the previous year. Prevalence among male arrestees was also up slightly (37 percent in 2009 versus 36 percent in 2008), and juvenile prevalence increased from 44 to 51 percent. **Heroin** indicators were also mixed. Primary heroin treatment admissions increased 1 percentage point, from 19 percent in the first half of 2009 to 20 percent in the first half of 2010, and laboratory items testing positive for heroin increased from 3.7 percent in 2009 to 4.9 percent in the first half of 2010. However, other indicators remained stable. Treatment admissions for narcotic analgesics remained low and stable at 4 percent of primary treatment admissions, and **MDMA**/ecstasy indicators were low but continued to inch upward.

**Data Sources:** *Arrestee data were from the San Diego Association of Governments' Substance Abuse Monitoring program, a regional continuation of the Federal Arrestee Drug Abuse Monitoring program that was discontinued in 2003. This report presents 2009 data for both adult (*n=766*) and juvenile (*n=154*) arrestees. Forensic laboratory data were from the National Forensic Laboratory Information System, Drug Enforcement Administration. There were 10,675 drug items analyzed by local forensic laboratories between January and June 2010. Treatment data came from the San Diego Department of Alcohol and Drug Programs (ADP) (tables produced by the California Department of ADP) using the California Outcomes Measurement System (CalOMS). CalOMS is a statewide client-based data collection and outcomes measurement system for alcohol and other drug (AOD) prevention and treatment services. Submission of admission/discharge information for all clients is required of all counties and their subcontracted AOD providers, all direct contract providers receiving public AOD funding, and all private-pay licensed narcotic treatment providers. Data for this report include admissions to San Diego County for the period January–June 2010. Note that CalOMS was implemented in early 2006, replacing the earlier California Alcohol and Drug Data System (CADDS) system. Therefore, data reported for periods prior to July 2006 may not be comparable to more recent periods. Mortality*

*data* were obtained from the Emergency Medical Services Medical Examiner Database, which is maintained by the County of San Diego Health and Human Services Agency.

## Drug Abuse Patterns and Trends in the San Francisco Bay Area—Update: January 2011

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

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

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

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

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

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

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

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

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

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

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

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

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

**Data Sources:** *Drug overdose data were obtained from the King County Medical Examiner, Public Health—Seattle & King County for the first half of 2010. Data on seized drug samples submitted for analysis were obtained from the National Forensic Laboratory Information System, Drug Enforcement Administration (DEA), for January–June 2010. Drug testing results for law enforcement seizures in King County were reported by the county where the drug was seized. Drug treatment data were provided by Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, Treatment Report and Generation Tool, from 1999 through June 2010. Treatment modalities included outpatient, intensive inpatient, recovery house, long-term residential, and opiate substitution admissions. Department of Corrections and private-pay admissions were included. Methamphetamine incident, DUI, and fatality data were provided by the Washington State Patrol Forensic Laboratory Services Bureau. Heroin purity data were provided by the DEA based on their Domestic Monitoring Program and include heroin obtained in the larger Seattle area.*

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

### Jane C. Maxwell, Ph.D.

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

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

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

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

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

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

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

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

**Cannabis** remained the most popular illicit drug used in Europe, estimated at an average of 7 percent last-year prevalence (LYP) and 4 percent last-month prevalence (LMP) based on survey data for 2009. There were large differences between countries, with a factor of 30 times between the highest and lowest national prevalence. Overall, the trends in consumption showed stable or declining trends, although with different national patterns. In most European Union (EU) countries, **stimulants** were the second most common illegal drug, though the pattern was complex. In the United Kingdom, Spain, Ireland, Italy, and Denmark, cocaine was the most popular stimulant, whereas in other countries amphetamines or ecstasy were more popular. **Cocaine** use increased markedly from 1995 in some of the mentioned countries, but in recent years it has stabilized. Some Nordic and central European countries presented a traditional pattern of problem amphetamine use (usually by injection) and, to a lesser extent, methamphetamine use, also by injection. In some cases, methamphetamine may have been displacing amphetamine among established problem drug users. **Heroin** use continued to account for the greatest share of recorded morbidity and mortality related to drug use in the EU; it was estimated that there were between 1.2 and 1.5 million chronic opiate users. These prevalence estimations have remained relatively stable in recent years, although the number of new users (incidence) appeared to have decreased in many western countries since peaks in the 1980s or 1990s. Although there were some moderate increases in different heroin indicators (drug seizures, deaths, and treatment admissions), they are difficult to interpret (with factors such as an aging population or increased service availability).

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

### References:

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

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

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

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

### *Further Information:*

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

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

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

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

*Judy Snider, M.Sc.*

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

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

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

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

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

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

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

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

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

*Natasha Sindicich, M.Psych (Forensic)*

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

**Abstract:** The Ecstasy and Related Drugs Reporting System (EDRS) is currently the most comprehensive and detailed Australian monitoring system of the ecstasy and related drug (ERD) markets. The EDRS monitors the price, purity, and availability of "ecstasy" (MDMA, or 3,4-methylenedioxymethamphetamine) and other related drugs, such as methamphetamine, cocaine, GHB (gamma hydroxybutyrate), and LSD (lysergic acid diethylamide). It also examines trends in the use and harms associated with these drugs. The EDRS has been monitoring the Australian ERD markets nationally since 2003.

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

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

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

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

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

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

*For inquiries concerning this report, please contact Usaneya Perngparn, Ph.D., Assistant Dean, College of Public Health Sciences, Drug Dependence Research Centre, WHO Collaborating Centre for Research and Training in Drug Dependence, Chulalongkorn University, Bangkok 10330, Thailand, Phone: 662 218–8200, E-mail:* usaneya.p@chula.ac.th.

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

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

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

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

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

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

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

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

*For inquiries concerning this report, please contact Ellen Campbell Grizzle, B. Pharm., Ph.D., R.Ph., Director, Information and Research, National Council on Drug Abuse; Adjunct Associate Professor Pharmacy, University of Technology, 2-6 Melmac Avenue, Kingston 5, Jamaica, Phone: 876–926–9002–4, Fax: 876–960–1820, E-mail:* ncda@cwjamaica.com.

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

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

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

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

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

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

Nonmedicinal use of pharmaceuticals was an emerging problem. The pharmacy community has detected "drug boosting efforts" related to alprazolam, trihexiphendyl, diphenydramine, clomipramine, and cyproheptadine.

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

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

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

## Cocaine/Crack

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

### Treatment Admissions Data on Cocaine/Crack

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

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

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

**Table 3.**   **Primary Cocaine Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions[1]: FY 2010[2] and 1H 2010[3]**

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

[1]More information on these data is available in the footnotes and notes for appendix table 1.
[2]Data are for fiscal year 2010: July 2009–June 2010.
[3]Data are for the first half of calendar year 2010 (1H 2010): January–June 2010.
[4]For comparability with past data, percentages of primary cocaine admissions are obtained from admissions with primary alcohol admissions excluded.
[5]Treatment data for Phoenix do not include admissions younger than age 18.
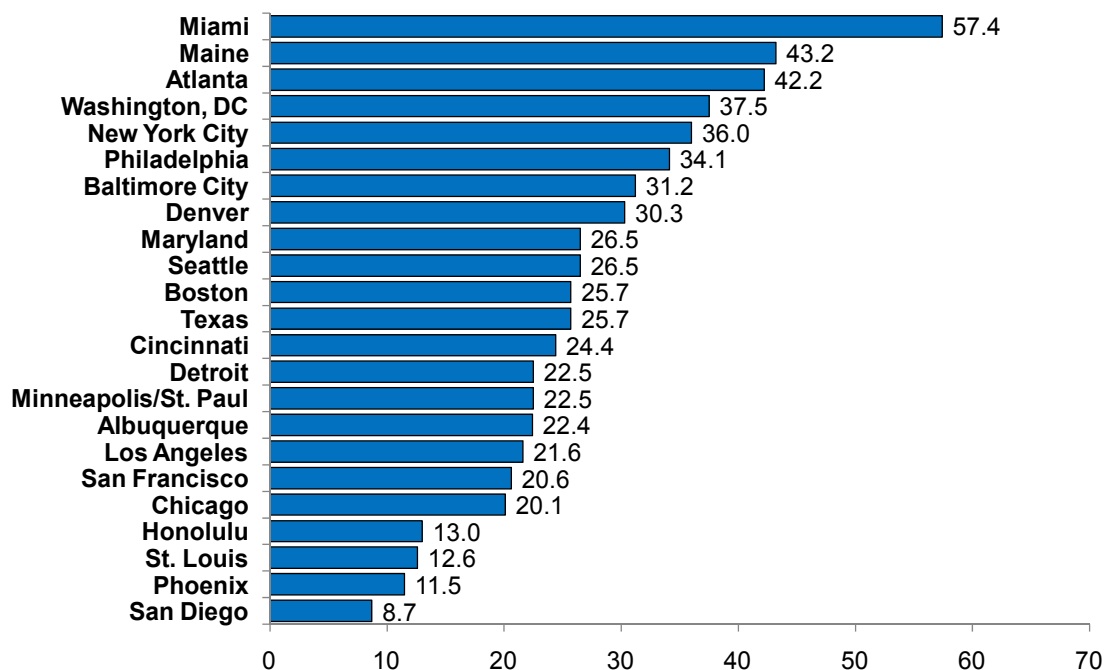SOURCE: January 2011 State and local CEWG reports

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

## Forensic Laboratory Data on Cocaine/Crack

Based on rankings shown in section II, table 1, in all 23 reporting CEWG areas, cocaine ranked no lower than third in drug items identified in the NFLIS system for the first half of 2010. In 8 of the 23 areas, cocaine ranked as the most frequently identified drug in forensic laboratories. These were three of the five southern region CEWG areas (Atlanta, Miami, and Washington, DC); two of the four CEWG areas in the northeastern region (Maine and New York City); and three of nine areas in the western region (Albuquerque, Denver, and Seattle). Cocaine did not rank first among drug items identified in any of the CEWG areas in the midwestern region. However, it ranked second in three of the five areas in the Midwest (Chicago, Cincinnati, and Detroit), along with another six CEWG areas. The other areas in which cocaine ranked second in identified drug items in the 2010 reporting period were Baltimore and Maryland; Boston and Philadelphia; and Los Angeles and Texas in the southern, northeastern, and western regions, respectively (section II, table 1 and figure 23; appendix table 2). Cocaine items as a percentage of the total drug items reported in the NFLIS system were highest in Miami (57.4 percent), followed by Maine (43.2 percent) and Atlanta (42.2 percent). The lowest reported frequencies of cocaine drug items among those identified in forensic laboratories were in San Diego, at 8.7 percent (figure 24; appendix table 2).

**Figure 24.   Cocaine Items Identified as a Percentage of Total NFLIS Drug Items, 23 CEWG Areas: 1H 2010[1]**

| Area | Percentage |
|---|---|
| Miami | 57.4 |
| Maine | 43.2 |
| Atlanta | 42.2 |
| Washington, DC | 37.5 |
| New York City | 36.0 |
| Philadelphia | 34.1 |
| Baltimore City | 31.2 |
| Denver | 30.3 |
| Maryland | 26.5 |
| Seattle | 26.5 |
| Boston | 25.7 |
| Texas | 25.7 |
| Cincinnati | 24.4 |
| Detroit | 22.5 |
| Minneapolis/St. Paul | 22.5 |
| Albuquerque | 22.4 |
| Los Angeles | 21.6 |
| San Francisco | 20.6 |
| Chicago | 20.1 |
| Honolulu | 13.0 |
| St. Louis | 12.6 |
| Phoenix | 11.5 |
| San Diego | 8.7 |

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

# Heroin

- Heroin primary treatment admissions, as a percentage of total admissions including primary alcohol admissions, were particularly high in Baltimore (approximately 54 percent) and Boston (approximately 51 percent) in the first half of 2010 (table 4). In none of the 21 CEWG areas reporting did heroin rank below sixth place in treatment admissions in the reporting period. In 2 of 21 CEWG areas—Baltimore and Boston—heroin was the substance most frequently reported as the primary problem at treatment admission. Heroin ranked second in treatment admissions in Detroit, Maryland, Phoenix, and St. Louis (section II, table 2; appendix table 1).

- Heroin ranked in the top 10 most frequently identified drug items in the NFLIS system in the first half of 2010 in all 23 CEWG areas, placing no less than sixth in any area. In 10 of 23 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in forensic laboratories in the first half of 2010. Proportions were highest in Baltimore and Maryland (approximately 24 and 18 percent, respectively). They were lowest in Honolulu, at less than 2 percent of drug items identified in the reporting period (figure 25; appendix table 2). Heroin was not ranked first in drug items seized and analyzed in any CEWG area, although it ranked second in one area—St. Louis (section II, table 1).

- Data from the HDMP suggest that for CY 2009, South American (SA) heroin continued to be the primary type of heroin east of the Mississippi River, as has been the case since the mid-1990s. Mexican black tar and, to a lesser extent, Mexican brown powder heroin dominated markets west of the Mississippi. Average purity levels for SA heroin increased in 5 of 10 CEWG areas (Atlanta, Chicago, Detroit, St. Louis, and Washington, DC) from 2008 to 2009; they declined in 5 other areas—Baltimore, Boston, Miami, New York City, and Philadelphia. Average prices for SA heroin fell in 5 of 10 CEWG areas (Atlanta, Boston, Miami, St. Louis and Washington, DC), remained the same in 1 (Chicago), and rose in 4 (Baltimore, Detroit, New York City, and Philadelphia) (table 5). From 2008 to 2009, Mexican heroin average purity declined in 9 of 11 CEWG areas, namely Denver, El Paso, Houston, Los Angeles, Minneapolis, Phoenix, San Diego, San Francisco, and Seattle, while average purity increased slightly in 2 areas (Dallas and San Antonio) (table 6). The average price of Mexican heroin was lower in 2009, compared with 2008, in 4 of 11 CEWG reporting areas (Dallas, Los Angeles, Minneapolis, and San Antonio), and it was higher in 7 areas (Denver, El Paso, Houston, Phoenix, San Diego, San Francisco, and Seattle) (table 6).

## Treatment Admissions Data on Heroin

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

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

**Table 4.** **Primary Heroin Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions[1]: FY 2010[2] and 1H 2010[3]**

| CEWG Areas | Primary Heroin Admissions | Total Admissions with Primary Alcohol Admissions Excluded[4] | | Total Admissions with Primary Alcohol Admissions Included | |
|---|---|---|---|---|---|
| | # | # | % | # | % |
| **FY 2010** | | | | | |
| San Francisco[5] | 4,483 | 18,871 | 23.8 | 27,963 | 16.0 |
| **1H 20108.4** | | | | | |
| Atlanta | 208 | 2,483 | 8.4 | 4,655 | 4.5 |
| Baltimore | 4,722 | 7,328 | 64.4 | 8,790 | 53.7 |
| Boston | 4,881 | 6,368 | 76.6 | 9,549 | 51.1 |
| Cincinnati[5] | 628 | 2,057 | 30.5 | 3,015 | 20.8 |
| Colorado | 865 | 8,844 | 9.8 | 15,442 | 5.6 |
| Denver | 548 | 4,106 | 13.3 | 6,677 | 8.2 |
| Detroit | 1,171 | 2,663 | 44.0 | 3,849 | 30.4 |
| Hawaii | 66 | 2,665 | 2.5 | 3,868 | 1.7 |
| Los Angeles | 4,849 | 18,385 | 26.4 | 23,870 | 20.3 |
| Maine | 489 | 3,947 | 12.4 | 7,139 | 6.8 |
| Maryland | 8,374 | 21,428 | 39.1 | 31,206 | 26.8 |
| Miami MSA/Broward County | 89 | 2,056 | 4.3 | 2,658 | 3.3 |
| Miami MSA/Miami-Dade County | 97 | 1,745 | 5.6 | 2,415 | 4.0 |
| Minneapolis/St. Paul | 694 | 5,036 | 13.8 | 10,315 | 6.7 |
| New York City | 9,975 | 29,873 | 33.4 | 41,432 | 24.1 |
| Philadelphia | 1,148 | 5,975 | 19.2 | 7,593 | 15.1 |
| Phoenix[6] | 816 | 2,547 | 32.0 | 3,677 | 22.2 |
| St. Louis | 1,799 | 4,838 | 37.2 | 7,332 | 24.5 |
| San Diego | 1,431 | 5,497 | 26.0 | 7,000 | 20.4 |
| Seattle | 819 | 4,443 | 18.4 | 7,080 | 11.6 |

[1]More information on these data is available in the footnotes and notes for appendix table 1.
[2]Data are for FY 2010: July 2009–June 2010.
[3]Data are for the first half of calendar year 2010 (1H 2010): January–June 2010.
[4]For comparability with past data, percentages of primary heroin admissions are obtained from admissions with primary alcohol admissions excluded.
[5]Heroin and other opiates are grouped together for Cincinnati and San Francisco and are reported in this Heroin table only.
[6]Treatment data for Phoenix do not include admissions younger than age 18.
SOURCE: January 2011 State and local CEWG reports

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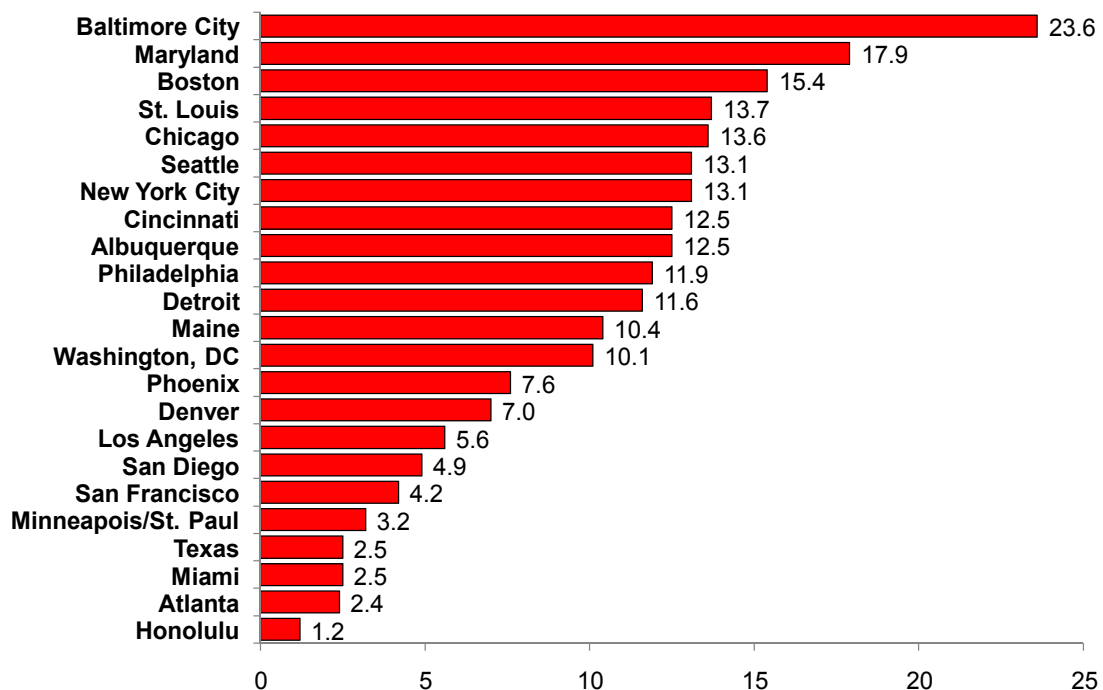
## Forensic Laboratory Data on Heroin

In 10 of the 23 CEWG areas shown on the map in figure 23 (section II) and in figure 25 below, heroin items accounted for less than 10 percent of the total drug items reported by NFLIS. The exceptions were Albuquerque, Baltimore City, Boston, Chicago, Cincinnati, Detroit, Maine, Maryland, New York City, Philadelphia, St. Louis, Seattle, and Washington, DC. As a proportion of total drug items, heroin items were highest in Baltimore (23.6 percent) and Maryland (17.9 percent), compared with other CEWG areas. Heroin drug items identified were lowest in Honolulu, at 1.2 percent (figure 25; appendix table 2).

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

**Figure 25.  Heroin Items Identified as a Percentage of Total NFLIS Drug Items, 23 CEWG Areas: 1H 2010[1]**

| Area | Percentage |
|------|-----------|
| Baltimore City | 23.6 |
| Maryland | 17.9 |
| Boston | 15.4 |
| St. Louis | 13.7 |
| Chicago | 13.6 |
| Seattle | 13.1 |
| New York City | 13.1 |
| Cincinnati | 12.5 |
| Albuquerque | 12.5 |
| Philadelphia | 11.9 |
| Detroit | 11.6 |
| Maine | 10.4 |
| Washington, DC | 10.1 |
| Phoenix | 7.6 |
| Denver | 7.0 |
| Los Angeles | 5.6 |
| San Diego | 4.9 |
| San Francisco | 4.2 |
| Minneapois/St. Paul | 3.2 |
| Texas | 2.5 |
| Miami | 2.5 |
| Atlanta | 2.4 |
| Honolulu | 1.2 |

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

## Heroin Domestic Monitor Program (HDMP) Price and Purity Data

Figure 26 depicts the most recent data on the average price per milligram pure and the average percentage of heroin purity across CEWG areas, as reported by the DEA's HDMP for 2009. Data from the HDMP suggest that for CY 2009, South American heroin continued to be the primary type of heroin east of the Mississippi River, as has been the case since the mid-1990s. Mexican black tar and, to a lesser extent, Mexican brown powder heroin dominated markets west of the Mississippi.

Data shown here are confined to South American and Mexican heroin, since the availability of Southwest Asian heroin was limited in the CEWG areas where it was reported—Atlanta, Baltimore, Detroit, Los Angeles, New York City, and Washington, DC[25]—and no Southeast Asian heroin was purchased in the HDMP program in 2009, as in the previous 3 years.

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

**Figure 26.  Heroin Domestic Monitor Program—Average Heroin Purity and Average Price Per Milligram Pure by Predominant Source in CEWG Areas[1]: 2009**
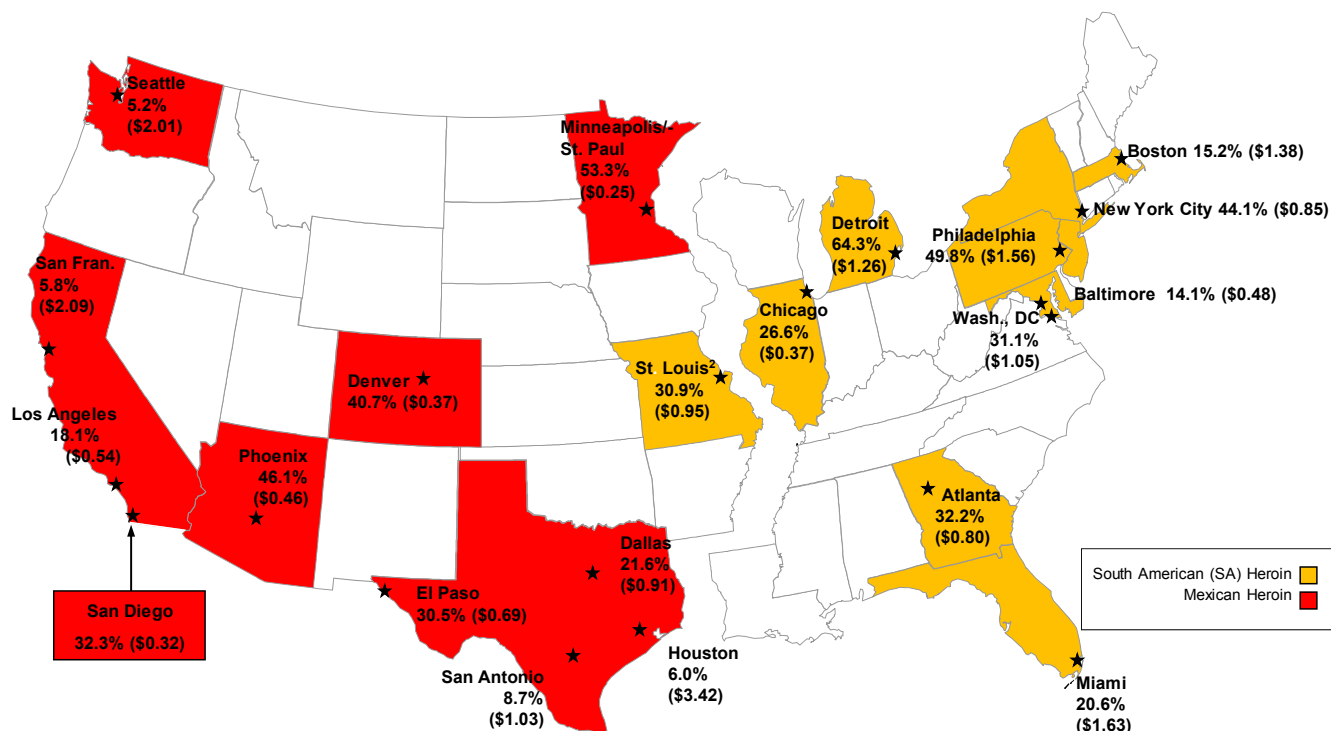


[1]Not included here are some types, e.g., Southeast and Southwest Asian heroin. Where both South American (SA) and Mexican heroin purchases were made, the more prevalent drug source identified is reported as predominant.
[2]In St. Louis, Mexican heroin was the predominant source in 2006, unlike 2005–2009, when SA heroin samples were more frequently identified. Therefore, only SA heroin average price and purity data are presented on this map.
SOURCE: DEA, *2009 HDMP Drug Intelligence Report,* published November, 2010, p. 6

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

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

Over the 1-year period from 2008 to 2009, average prices for SA heroin fell in 5 of 10 CEWG areas (Atlanta, Boston, Miami, St. Louis, and Washington, DC), rose in 4 (Baltimore, Detroit, New York City, and Philadelphia), and remained the same in 1 area (Chicago) (table 5). Average 2009 heroin prices ranged from a low of $0.37 in Chicago to a high of $1.63 in Miami. The largest price increase for 2009 was in Philadelphia, at an average of $0.96 per milligram pure, followed by Detroit, at $0.70.

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

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

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

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

[2]In 2005, SA rather than Mexican heroin emerged for the first time as the predominant form of heroin in St. Louis. However, in 2006, Mexican heroin reestablished itself as the predominant form. In 2007, 2008, and 2009, SA heroin was again the predominant form purchased in St. Louis. Therefore, while data are reported for St. Louis in both SA heroin and Mexican heroin tables in the HDMP report for 2009 (table 6), only St. Louis SA heroin purchases are discussed in the text of this report and are shown in this table and in figure 26.

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

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

The average price per milligram pure of Mexican black tar heroin ranged in 2009 from a low of $0.25 in Minneapolis to a high of $3.42 in Houston. The average price was lower in 2009, compared with 2008, in 4 of 11 reporting CEWG reporting areas (Dallas, Los Angeles, Minneapolis, and San Antonio), and it was higher in 7 areas (Denver, El Paso, Houston, Phoenix, San Diego, San Francisco, and Seattle). The largest increase of $1.02 per milligram pure was seen in San Francisco, with average prices approximately doubling over the 1-year period, from $1.07 to $2.09. In Seattle, average prices increased by an average of $0.54 in the 1-year period (table 6).

**Table 6.    Average Percent Purity and Average Price of Mexican Heroin per Milligram Pure in 11 CEWG Areas[1]: 2006–2009**

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

[1]South American heroin was the most dominant form of heroin reported in 2005, 2007, 2008, and 2009 in St. Louis, while Mexican heroin predominated in that area in 2006. Therefore, Mexican heroin purchase data are not included in this table and are not discussed in the text. St. Louis respective purity and price data are as follows: 15.9 percent and $1.47 in 2005; 19.5 percent and $0.99 in 2006; 3.1 percent and $6.95 in 2007; 3.6 percent and $4.87 in 2008; and 40.0 percent and $2.00 in 2009.
[2]The following number of samples form the basis for 2009 averages: Dallas, 34; Denver, 32; El Paso, 10; Houston, 27; Los Angeles, 36; Minneapolis, 4; Phoenix, 41; San Antonio, 17; San Diego, 36; San Francisco, 27; and Seattle, 29. St. Louis' data were based on 5 samples of Mexican heroin, with 17 samples of South American heroin. One sample of Southwest Asian heroin was reported for Los Angeles, at 71.0 percent pure and an average price of $0.04.
SOURCE: DEA, *2009 HDMP Drug Intelligence Report,* published November 2010; see also figure 26

# Opiates/Opioids Other Than Heroin (Narcotic Analgesics)

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

## Treatment Admissions Data on Opiates/Opioids

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

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

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

**Table 7.** **Primary Other Opiate Treatment Admissions in 18 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions[1]: 1H 2010[2]**

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

[1]More information on these data is available in the footnotes and notes for appendix table 1.
[2]Data are for the first half of calendar year 2010 (1H 2010): January–June 2010.
[3]Heroin and Other Opiates are grouped together for Cincinnati and San Francisco and are reported in the Heroin table only. Data for this table were not reported for Hawaii. For further information see appendix table 1.
[4]Percentages of primary other opiates admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.
[5]Treatment data for Phoenix do not include admissions younger than age 18.
SOURCE: January 2011 State and local CEWG reports

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

## Forensic Laboratory Data on Opiates/Opioids (Narcotic Analgesics)

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

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

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

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

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

**Table 8.** **Selected Narcotic Analgesic Items Identified by Forensic Laboratories in 23 CEWG Areas, by Number and Percentage of Total Items Identified[1]: 1H 2010[2]**

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

[1]Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated with the symbol *.
[2]Data are for January–June 2010.
SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010; see appendix table 2.1–2.23; data are subject to change and may differ according to the date on which they were queried

# Benzodiazepines/Depressants

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

## Treatment Admissions Data on Benzodiazepines

In most CEWG area treatment data systems, benzodiazepines are included with other depressants, barbiturates, and sedative/hypnotics; these admissions continued to account for small proportions of total treatment admissions. However, some CEWG areas noted that benzodiazepines or sedative/hypnotics were secondary or tertiary drugs of abuse among some treatment admissions.

## Forensic Laboratory Data on Benzodiazepines

Three benzodiazepine-type items—alprazolam, clonazepam, and diazepam—were the most frequently reported benzodiazepines identified by forensic laboratories in 23 CEWG areas in the first half of 2010 reporting period. Table 9 shows the numbers and percentages of drug items containing alprazolam, clonazepam, and diazepam in each of the reporting CEWG areas.

**Alprazolam.** In the 23 CEWG areas for which NFLIS data were reported for the first half of 2010, the highest percentages of alprazolam drug items identified were in Texas (5.7 percent)

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

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

**Table 9.    Number of Selected Benzodiazepine Items Identified by Forensic Laboratories in 23 CEWG Areas, by Number and Percentage of Total Items Identified[1]: 1H 2010[2]**

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

[1]Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated with the symbol *.
[2]Data are for January–June 2010.
SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010; see appendix table 2.1–2.23; data are subject to change and may differ according to the date on which they were queried

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

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

# Methamphetamine

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

## Treatment Admissions Data on Methamphetamine

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

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

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

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

**Table 10.    Primary Methamphetamine Treatment Admissions in 18 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions[1]: FY 2010[2] and 1H 2010[3]**

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

[1]More information on these data is available in the footnotes and notes for appendix table 1.
[2]Data are for fiscal year 2010: July 2009–June 2010.
[3]Data are for the first half of calendar year 2010 (1H 2010): January–June 2010.
[4]Data for three CEWG areas—Baltimore (*n*=5), Cincinnati (*n*=7), and Detroit (*n*=1)—were excluded from this table due to small numbers (fewer than 15 total primary methamphetamine treatment admissions for the half year). For further information, see appendix table 1.
[5]Percentages of primary methamphetamine admissions were obtained from admissions with primary alcohol admissions excluded for comparability with past data.
[6]Hawaii reported combined methamphetamine and stimulants admissions.
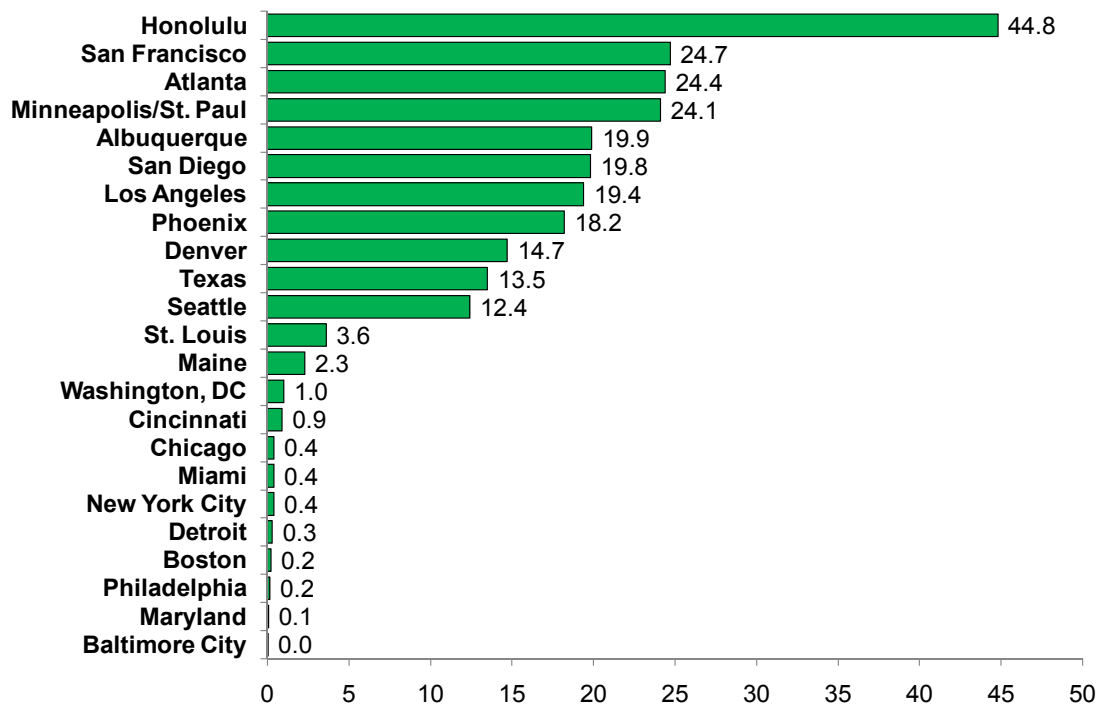[7]Treatment data for Phoenix do not include admissions younger than age 18.
SOURCE: January 2011 State and local CEWG reports

## Forensic Laboratory Data on Methamphetamine

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

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

**Figure 27. Methamphetamine Items Identified as a Percentage of Total NFLIS Drug Items, 23 CEWG Areas: 1H 2010[1]**



| Area | Percent |
|------|---------|
| Honolulu | 44.8 |
| San Francisco | 24.7 |
| Atlanta | 24.4 |
| Minneapolis/St. Paul | 24.1 |
| Albuquerque | 19.9 |
| San Diego | 19.8 |
| Los Angeles | 19.4 |
| Phoenix | 18.2 |
| Denver | 14.7 |
| Texas | 13.5 |
| Seattle | 12.4 |
| St. Louis | 3.6 |
| Maine | 2.3 |
| Washington, DC | 1.0 |
| Cincinnati | 0.9 |
| Chicago | 0.4 |
| Miami | 0.4 |
| New York City | 0.4 |
| Detroit | 0.3 |
| Boston | 0.2 |
| Philadelphia | 0.2 |
| Maryland | 0.1 |
| Baltimore City | 0.0 |

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

# Marijuana/Cannabis

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

## Treatment Admissions Data on Marijuana

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

As shown in table 11, Miami-Dade and Broward Counties in the Miami MSA in South Florida had the highest percentages of primary marijuana treatment admissions, including primary alcohol admissions, at approximately 39 and 34 percent, respectively. Two CEWG areas had percentages of marijuana treatment admissions at approximately 28–29 percent—Cincinnati and New York City. The lowest proportion of marijuana treatment admissions was reported in Boston, at 4.1 percent (table 11).

## Forensic Laboratory Data on Marijuana/Cannabis

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

**Table 11.    Primary Marijuana Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions[1]: FY 2010[2] and 1H 2010[3]**

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

[1]More information on these data is available in the footnotes and notes for appendix table 1.
[2]Data are for the fiscal year 2010: July 2009–June 2010.
[3]Data are for the first half of the calendar year 2010 (1H 2010): January–June 2010.
[4]Percentages of primary marijuana admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.
[5]Treatment data for Phoenix do not include admissions younger than age 18.
SOURCE: January 2011 State and local CEWG reports

represented the outlier, at 2.3 percent[27], while the remaining CEWG areas had percentages ranging from 11.6 percent in Maine to 40.1 percent in Los Angeles for marijuana/cannabis drug items identified (figure 28).

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

**Figure 28.  Marijuana/Cannabis Items Identified as a Percentage of Total NFLIS Drug Items, 23 CEWG Areas: 1H 2010[1]**
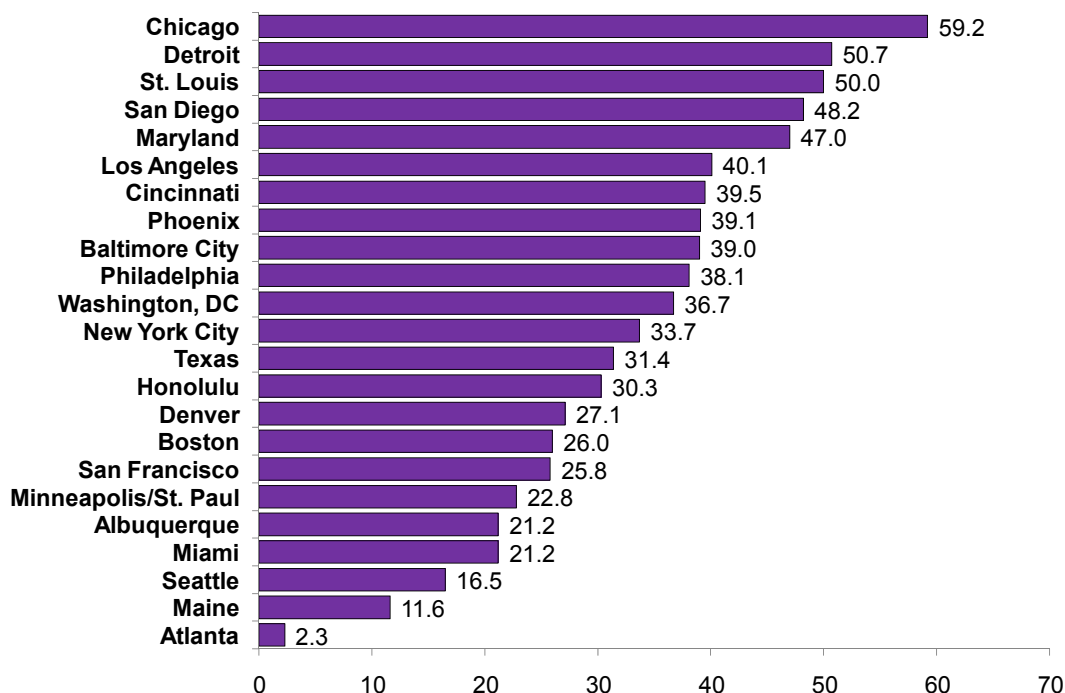


[1]Data are for January–June 2010; see appendix tables 2.1–2.23. Data are subject to change; data queried on different dates may reflect differences in the time of data analysis and reporting.
SOURCE: NFLIS, DEA , data for all areas except New York City were retrieved on December 16, 2010; New York City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

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

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

## Treatment Admissions Data on Club Drugs

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

## Forensic Laboratory Data on Club Drugs

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

**MDA.** MDA (3,4-methylenedioxyamphetamine) was reported among drug items identified in 9 of 23 areas: Atlanta, Baltimore, Denver, Honolulu, Maryland, New York City, Philadelphia, San Francisco, and Texas. The range in numbers was from 1 to 81 (Texas) (table 13). However, MDA was not reported among the top 10 most frequently identified drug items in any CEWG area in the first half of 2010 (section II, table 1).

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

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

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

**Table 12.    Number of MDMA Items Identified and MDMA Items as a Percentage of Total Items Identified by Forensic Laboratories in 23 CEWG Areas: 1H 2010[1]**

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

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

**Table 13.   Number of MDA, GHB, Ketamine, LSD, PCP, and Other Drug Items[1] Identified by Forensic Laboratories, in 23 CEWG Areas: 1H 2010[2]**

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

[1]**TFMPP** was found in 76 drug items identified in Atlanta; 36 in Chicago; 2 in Phoenix and Washington, DC; and 1 in Albuquerque, Honolulu, and Miami. **Quetiapine** and/or quetiapine fumarte were found in 149 items in Texas; 76 in Boston; 38 in Los Angeles; 10 in Cincinnati; 9 in Minneapolis/St. Paul; 7 in Phoenix; 3 in San Diego; and 2 in Honolulu. **Gabapentin** was found in 109 items in Boston; 8 in Los Angeles; 5 in Minneapolis/St. Paul; 4 in Phoenix; and 1 in Honolulu and Maine. **Cathinone** and/or cathine were found in 39 items in Minneapolis/St. Paul; 30 in New York City; 11 in Denver; 4 in Chicago and Cincinnati; 2 in Seattle; and 1 in Detroit, Honolulu, Maine, San Francisco, and Washington, DC. **Tramadol** was found in 116 items in Texas, 20 in Los Angeles, 18 in Cincinnati, 6 in Phoenix, 5 in Minneapolis/St. Paul, 3 in Denver, and 1 in Atlanta and Maine. **Mephedrone** was found in one item in Maine. The drug **mCPP** was found in 24 items in Atlanta. The **synthetic cannabinoid JWH-018** was found in four items in St. Louis; three in San Diego; and one in Honolulu.
[2]Data are for January–June 2010.
[3]GHB and its two precursors, GBL and 1,4-BD, are grouped together in this table under "GHB."
[4]Psilocybine, psilocybin, psylocin and psilocin are grouped together in this table under the category, "Psilocin."
[5]Miami does not report PCP as a separate category, reporting 167 "hallucinogens" identified in 1H 2010.
SOURCE: NFLIS, DEA, data for all areas except New York City were retrieved on December 16, 2010; New York City data were retrieved on December 20, 2010; see appendix table 2.1–2.23; data are subject to change and may differ according to the date on which they were queried

# PCP

## Forensic Laboratory Data on PCP

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

No PCP items were identified in forensic laboratory data in seven CEWG areas: Atlanta, Boston, Denver, Detroit, Honolulu, Maine, and Miami[28] (table 13; appendix table 2). Fewer than 15 such items were identified in 8 areas (Albuquerque, Baltimore, Cincinnati, Minneapolis/St. Paul, Phoenix, St. Louis, San Francisco, and Seattle). The areas reporting 15 or more PCP items in the half-year period were Chicago, Los Angeles, Maryland, New York City, Philadelphia, San Diego, Texas, and Washington, DC. The range in these areas was from 30 in San Diego to 366 in Philadelphia. As a percentage of all identified items, PCP items were highest in Washington, DC, at 5.8 percent, followed by Philadelphia, at 2.1 percent (table 13).

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

# Other Drugs

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

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

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

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

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

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

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

# Appendix Tables

**Appendix Table 1. Total Treatment Admissions by Primary Substance of Abuse, Including Primary Alcohol Admissions, by CEWG Area: FY 2010[1] and 1H 2010[2]**

| CEWG Areas | Number of Total Admissions | | | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | Alcohol | Cocaine/ Crack[3] | Heroin | Other Opiates | Meth- amphet- amine | Marijuana | Other Drugs/ Unknown | (N)[4] |
| **FY 2010** | | | | | | | | |
| San Francisco | 9,092 | 5,377 | 4,483[5] | --[5] | 4,531 | 2,778 | 1,702 | 27,963 |
| **1H 2010** | | | | | | | | |
| Atlanta | 2,172[6] | 640 | 208 | 325 | 225 | 908 | 177 | 4,655 |
| Baltimore | 1,462 | 1,000 | 4,722 | 291 | 5 | 1,228 | 82 | 8,790 |
| Boston | 3,181 | 499 | 4,881 | 446 | 22 | 393 | 127[7] | 9,549 |
| Cincinnati | 958 | 351 | 628[5] | --[5] | 7[8] | 870 | 201 | 3,015 |
| Colorado | 6,598 | 1,254 | 865 | 847 | 2,167 | 3,482 | 229 | 15,442 |
| Denver | 2,571 | 664 | 548 | 373 | 741 | 1,670 | 110 | 6,677 |
| Detroit | 1,186 | 693 | 1,171 | 81 | 1 | 713 | 4 | 3,849 |
| Hawaii | 1,203[6] | 78 | 66 | NR[9] | 1,405[8] | 902 | 214 | 3,868 |
| Los Angeles | 5,485 | 2,414 | 4,849 | 722 | 3,667 | 5,795 | 938 | 23,870 |
| Maine | 3,192[6] | 228 | 489 | 2,253 | 18 | 640 | 319 | 7,139 |
| Maryland | 9,778 | 2,993 | 8,374 | 3,363 | 19 | 5,943 | 736 | 31,206 |
| Miami MSA/Ft. Lauder- dale Broward County | 602 | 253 | 89 | 537 | 20 | 904 | 253 | 2,658 |
| Miami MSA/Miami-Dade County | 670 | 470 | 97 | 115 | 16 | 935 | 112 | 2,415 |
| Minneapolis/St. Paul | 5,279 | 593 | 694 | 898 | 648 | 1,991 | 212 | 10,315 |
| New York City | 11,559 | 6,453 | 9.975 | 839 | 116 | 11,459 | 1,031 | 41,432 |
| Philadelphia | 1,618 | 1,440 | 1,148 | 537 | 24 | 1,733 | 1,093 | 7,593 |
| Phoenix[10] | 1,130 | 170 | 816 | 146 | 667 | 574 | 174 | 3,677 |
| St. Louis | 2,494 | 876 | 1,799 | 205 | 210 | 1,652 | 96 | 7,332 |
| San Diego | 1,503 | 350 | 1,431 | 270 | 2,006 | 1,351 | 89 | 7,000 |
| Seattle | 2,637 | 826 | 819 | 501 | 634 | 1,352 | 311 | 7,080 |

[1]Data are for fiscal year 2010: July 2009–June 2010.
[2]Data are for the first half of calendar year 2010 (1H 2010): January–June 2010.
[3]Cocaine values were broken down into crack or powder/other cocaine for the following areas: Atlanta (crack=438; powder or other cocaine=202); Baltimore (crack=871; powder or other cocaine=129); Boston (crack=280; powder or other cocaine=219); Detroit (crack=628; powder or other cocaine=65); Maryland (crack=2,447; powder or other cocaine=546); Broward County (crack=227; powder or other cocaine=26); Miami-Dade County (crack=302; powder or other cocaine=168); Minneapolis/St. Paul (crack=463; powder or other cocaine=130); New York City (crack=3,890; powder or other cocaine=2,563); Phoenix (crack=118; powder or other cocaine=52); and St. Louis (crack=788; powder or other cocaine=88). No breakdowns by type of cocaine were available for Cincinnati, Colorado, Denver, Hawaii, Los Angeles, Maine, Philadelphia, San Diego, San Francisco, and Seattle.

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

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

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

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

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

[9]NR=Not reported by the CEWG area representative.

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

SOURCE: January 2011 State and local CEWG reports

Additional NOTES on treatment data coverage:

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

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

**Appendix Table 2.1. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Albuquerque: 1H 2010[1]**

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

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

**Appendix Table 2.2. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Atlanta: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data are for the 28-county Atlanta/Sandy Springs/Marietta GA MSA, including Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwe her, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton Counties.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.3. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Baltimore City: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data are for Baltimore City only.
2. The drug item counts exclude the Maryland State Laboratory System data.
3. Percentages may not sum to total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.4. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Boston: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data include all counties in the Boston MSA: Essex, Middlesex, Norfolk, Plymouth, Rockingham, Strafford, and Suffolk Coun ies.
2. "Noncontrolled Nonnarcotic Drug" represents 145 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.5. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Chicago: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data include all counties in the Chicago/Naperville/Joliet Il/IN/WI MSA: Cook, DeKalb, DuPage, Grundy, Kane, McHenry, and Will Counties in IL; Jasper, Lake, Newton, and Porter Counties in IN; and Kenosha County in WI.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.6. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Cincinnati: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data include Hamilton County.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.7. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Denver: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data include Denver, Arapahoe, and Jefferson Counties.
2. "Noncontrolled Nonnarcotic Drug" represents 198 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.8. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Detroit: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data include Wayne County.
2. "Noncontrolled Nonnarcotic Drug" represents 153 cases and are included under "Other."
3. Drug item counts for the Detroit Police Department are included in the Wayne County data.
4. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.9. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Honolulu: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data include Honolulu County.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.10. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Los Angeles: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data include Los Angeles County.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.11. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maine: 1H 2010[1]**

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

[1]January 20108–June 2010.
[2]All other analyzed items.
NOTES:
1. Data include the State of Maine.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.12. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maryland: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data are for the State of Maryland.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.13. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Miami: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data include the Miami/Fort Lauderdale/Pompano Beach MSA: Miami-Dade, Broward, and Palm Beach Counties.
2. "Controlled Substance (Unspecified)" represents 464 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.14. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Minneapolis/St. Paul: 1H 2010[1]**

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

[1]January 2010–June 2010.
[2]1-Benzylpiperazine and Psilocin are tied for 10th place.
[3]All other analyzed items.
NOTES:
1. Data include seven counties in Minnesota: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.15. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, New York City: 1H 2010[1]**

| Drug | Number | Percentage |
|---|---|---|
| Cocaine | 9,717 | 36.0 |
| Cannabis/Marijuana | 9,105 | 33.7 |
| Heroin | 3,534 | 13.1 |
| Alprazolam | 858 | 3.2 |
| Oxycodone | 672 | 2.5 |
| 3,4-Methylenedioxy-methamphetamine | 577 | 2.1 |
| Methadone | 354 | 1.3 |
| Phencyclidine | 350 | 1.3 |
| Buprenorphine | 290 | 1.1 |
| Hydrocodone | 212 | 0.8 |
| Other[2] | 1,347 | 5.0 |
| **Total** | **27,016** | **100.0** |

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data include the New York City Police Department and five New York City boroughs: Bronx, Kings, Queens, New York, and Richmond.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 20, 2010; data are subject to change

**Appendix Table 2.16. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Philadelphia: 1H 2010[1]**

| Drug | Number | Percentage |
|---|---|---|
| Cannabis/Marijuana | 6,647 | 38.1 |
| Cocaine | 5,958 | 34.1 |
| Heroin | 2,075 | 11.9 |
| Oxycodone | 646 | 3.7 |
| Alprazolam | 609 | 3.5 |
| Phencyclidine | 366 | 2.1 |
| Clonazepam | 127 | 0.7 |
| Codeine | 117 | 0.7 |
| Hydrocodone | 82 | 0.5 |
| Buprenorphine | 75 | 0.4 |
| Other[2] | 750 | 4.3 |
| **Total** | **17,452** | **100.0** |

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data are for Philadelphia County.
2. "Noncontrolled Nonnarcotic Drug" represents 433 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.17. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Phoenix: 1H 2010[1]**

| Drug | Number | Percentage |
|---|---|---|
| Cannabis/Marijuana | 1,703 | 39.1 |
| Methamphetamine | 792 | 18.2 |
| Cocaine | 502 | 11.5 |
| Heroin | 329 | 7.6 |
| Oxycodone | 167 | 3.8 |
| Alprazolam Methylenedioxy-methamphetamine | 105 | 2.4 |
| Hydrocodone | 102 | 2.3 |
| 3,4-Methylenedioxy-methamphetamine | 100 | 2.3 |
| Carisoprodol | 42 | 1.0 |
| Clonazepam | 37 | 0.8 |
| Other[2] | 474 | 10.9 |
| **Total** | **4,353** | **100.0** |

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data are for Maricopa County.
2. "Unreported Prescription Drug" represents 101 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.18. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, St. Louis: 1H 2010[1]**

| Drug | Number | Percentage |
|---|---|---|
| Cannabis/Marijuana | 4,398 | 50.0 |
| Heroin | 1,203 | 13.7 |
| Cocaine | 1,108 | 12.6 |
| Methamphetamine | 319 | 3.6 |
| Alprazolam | 181 | 2.1 |
| Hydrocodone | 176 | 2.0 |
| Oxycodone | 142 | 1.6 |
| 3,4-Methylenedioxy-methamphetamine | 127 | 1.4 |
| Pseudoephedrine | 90 | 1.0 |
| 1-Benzylpiperazine | 80 | 0.9 |
| Other[2] | 969 | 11.0 |
| **Total** | **8,793** | **100.0** |

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data are for St. Louis City and 16 counties: St. Louis, St. Charles, St. Francis, Jefferson, Franklin, Lincoln, Warren, and Washington in Missouri; and Madison, St. Clair, Macoupin, Clinton, Monroe, Jersey, Bond, and Calhoun in Illinois.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.19. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Diego: 1H 2010[1]**

| Drug | Number | Percentage |
|---|---|---|
| Cannabis/Marijuana | 5,142 | 48.2 |
| Methamphetamine | 2,115 | 19.8 |
| Cocaine | 929 | 8.7 |
| Heroin | 519 | 4.9 |
| Hydrocodone | 277 | 2.6 |
| 3,4-Methylenedioxy-methamphetamine | 235 | 2.2 |
| Oxycodone | 184 | 1.7 |
| Alprazolam | 142 | 1.3 |
| Buprenorphine | 70 | 0.7 |
| Diazepam | 63 | 0.6 |
| Other[2] | 999 | 9.4 |
| **Total** | **10,675** | **100.0** |

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data are for San Diego only.
2. "Plant Material, Other" represents 395 cases and are included under "Other."
3. Percentages may not sum to total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.20. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Francisco: 1H 2010[1]**

| Drug | Number | Percentage |
|---|---|---|
| Cannabis/Marijuana | 2,042 | 25.8 |
| Methamphetamine | 1,954 | 24.7 |
| Cocaine | 1,626 | 20.6 |
| 3,4-Methylenedioxy-methamphetamine | 380 | 4.8 |
| Heroin | 329 | 4.2 |
| Hydrocodone | 263 | 3.3 |
| Oxycodone | 180 | 2.3 |
| Methadone | 81 | 1.0 |
| Morphine | 64 | 0.8 |
| Diazepam | 56 | 0.7 |
| Other[2] | 925 | 11.7 |
| **Total** | **7,900** | **100.0** |

[1]January 2010–June 2010; San Francisco Police data January–March 2010.
[2]All other analyzed items.
NOTES:
1. Data are for five counties in the San Francisco/Fremont MSA: Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties.
2. "Unknown" represents 481 cases and are included under "Other."
3. "Controlled Substance" represents 76 cases and are included under "Other."
4. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.21. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Seattle: 1H 2010[1]**

| Drug | Number | Percentage |
|------|--------|------------|
| Cocaine | 223 | 26.5 |
| Cannabis/Marijuana | 139 | 16.5 |
| Heroin | 110 | 13.1 |
| Methamphetamine | 104 | 12.4 |
| Oxycodone | 72 | 8.6 |
| 3,4-Methylenedioxy-methamphetamine | 34 | 4.0 |
| Buprenorphine | 17 | 2.0 |
| Hydrocodone | 14 | 1.7 |
| Alprazolam | 12 | 1.4 |
| Amphetamine | 10 | 1.2 |
| Other[2] | 105 | 12.5 |
| **Total** | **840** | **100.0** |

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data are King County.
2. "Unknown" represents 18 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.22. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Texas: 1H 2010[1]**

| Drug | Number | Percentage |
|------|--------|------------|
| Cannabis/Marijuana | 15,165 | 31.4 |
| Cocaine | 12,447 | 25.7 |
| Methamphetamine | 6,535 | 13.5 |
| Alprazolam | 2,748 | 5.7 |
| Hydrocodone | 2,397 | 5.0 |
| Heroin | 1,225 | 2.5 |
| Carisoprodol | 771 | 1.6 |
| 3,4-Methylenedioxy-methamphetamine | 589 | 1.2 |
| Clonazepam | 408 | 0.8 |
| 1-Benzylpiperazine | 389 | 0.8 |
| Other[2] | 5,689 | 11.8 |
| **Total** | **48,363** | **100.0** |

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data are for the State of Texas.
2. The Fort Worth Police Department Laboratory did not report drug exhibits to NFLIS during this time period.
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

**Appendix Table 2.23. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Washington, DC: 1H 2010[1]**

| Drug | Number | Percentage |
|------|--------|------------|
| Cocaine | 733 | 37.5 |
| Cannabis/Marijuana | 718 | 36.7 |
| Heroin | 198 | 10.1 |
| Phencyclidine | 113 | 5.8 |
| 1-Benzylpiperazine | 36 | 1.8 |
| 3,4-Methylenedioxy-methamphetamine | 26 | 1.3 |
| Methamphetamine | 20 | 1.0 |
| Buprenorphine | 15 | 0.8 |
| Caffeine | 14 | 0.7 |
| Oxycodone | 12 | 0.6 |
| Other[2] | 70 | 3.6 |
| **Total** | **1,955** | **100.0** |

[1]January 2010–June 2010.
[2]All other analyzed items.
NOTES:
1. Data are for the District of Columbia.
2. Percentages may not sum to total due to rounding.
SOURCE: NFLIS, DEA, December 16, 2010; data are subject to change

# Participant List

## National Institute on Drug Abuse
## Community Epidemiology Work Group Meeting
*DoubleTree Paradise Valley Resort*
*Scottsdale, Arizona*
*January 19–21, 2011*

**Chitlada Areesantichai, Ph.D.**
Lecturer and Researcher
College of Public Health Sciences
Chulalongkorn University
Chulalongkorn Soi 62, Phyathai Road
Bangkok 10330, Thailand
Phone: 662 218–8200
Fax:    662 255–2177
E-mail: *chitlada.a@chula.ac.th*

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

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

**Aniruddha Banerjee, Ph.D., M.S.U.R.P.**
Assistant Professor
   and Director of Graduate Studies
Indiana University Purdue University
207D Cavanaugh Hall
425 University Boulevard
Indianapolis, IN  46202
Phone: 317–274–3281
Fax:    317–278–5220
E-mail: *rbanerje@iupui.edu*

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

**Janette Beals, Ph.D.**
Director of Research
Centers for American Indian and Alaska
   Native Health
Anschutz Medical Campus
Room 333
13055 E. 17th Avenue
University of Colorado, Denver
Aurora, CO  80045
Phone: 303–724–1453
Fax:    303–724–1474
E-mail: *jan.beals@ucdenver.edu*

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

**M. Fe Caces, Ph.D.**
Statistician/Demographer
Office of National Drug Control Policy
Executive Office of the President
750 17th Street, N.W.
Washington, DC  20503
Phone: 202–395–3173
Fax:    202–395–6562
E-mail: *mcaces@ondcp.eop.gov*

**Karyn Bjornstad Collins, M.P.A.**
CEWG Technical Editor
Social Solutions International, Inc.
441 Keith Avenue
Missoula, MT  59801
Phone: 406–370–9931
E-mail: *kcollins@socialsolutions.biz*

**Raymond B. Craib II**
Chief, Domestic Indicators Program
Drug Enforcement Administration
U.S. Department of Justice
8701 Morrissette Drive
Springfield, VA 22152
Phone: 202–307–4886
E-mail: *raymond.b.craib@usdoj.gov*

**James K. Cunningham, Ph.D.**
Social Epidemiologist
Department of Family and Community
    Medicine
The University of Arizona
1450 North Cherry Avenue
Tucson, AZ  85719
Phone: 520–615–5080
Fax:    520–577–1864
E-mail: *jkcunnin@email.arizona.edu*

**Samuel J. Cutler**
Drug and Alcohol Abuse Program Manager
Office of Addiction Services
Department of Behavioral Health &
    Intellectual disAbility Services (DBH/IDS)
City of Philadelphia
Suite 800
1101 Market Street
Philadelphia, PA  19107–2908
Phone: 215–685–5414
Fax:    215–685–4977
E-mail: *sam.cutler@phila.gov*

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

**Kristen A. Dixion, M.A., L.P.C.**
Evaluation Researcher
Division of Behavioral Health
State of Colorado
3824 West Princeton Circle
Denver, CO 80236
Phone: 303–866–7407
Fax:    303–866–7428
E-mail: *kristen.dixion@state.co.us*

**Daniel P. Dooley**
Senior Researcher
Boston Public Health Commission
1010 Massachusetts Avenue
Boston, MA  02118
Phone: 617–534–2360
Fax:    857–288–2129
E-mail: *ddooley@bphc.org*

**Carol L. Falkowski**
Drug Abuse Strategy Officer
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN  55101
Phone: 651–431–2457
Fax:    651–431–7449
E-mail: *carol.falkowski@state.mn.us*

**Jillian Flight**
Research Analyst
Office of Drug and Alcohol Research and
   Surveillance
Controlled Substances and Tobacco
   Directorate
Department of Health Canada
Sixth Floor, PL 3506D
123 Slater Street
Ottawa, Ontario K1A 0K9
Phone: 613–946–6755
Fax:    613–952–5188
E-mail: *jillian.flight@hc-sc.gc.ca*

**Yvonne Fortier, M.A.**
Director, Clinical Services
Native American Connections
Suites 100 or 600
4520 N. Central Avenue
Phoenix, AZ  85012
Phone: 602–820–6094
E-mail: *y.fortier@nativeconnections.org*

**Alice A. Gleghorn, Ph.D.**
County Alcohol and Drug Administrator
Community Behavioral Health Services
San Francisco Department of Public Health
Room 450
1380 Howard Street
San Francisco, CA  94103
Phone: 415–255–3722
Fax:    415–255–3529
E-mail: *alice.gleghorn@sfdph.org*

**Ellen Grizzle, B.Pharm, Ph.D., R.Ph.**
Director
Information and Research
National Council on Drug Abuse
2-6 Melmac Avenue
Kingston 5, Jamaica
Phone: 876–926–9002–4
Fax:    876–960–1820
E-mail: *ncda@cwjamaica.com*

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

**Heidi Israel, Ph.D., R.N., F.N.P., L.C.S.W.**
Assistant Professor
Department of Orthopaedic Surgery
St. Louis University
School of Medicine
3625 Vista, FDT-7N
St. Louis, MO  63110
Phone: 314–577–8851
Fax:    314–268–5121
E-mail: *israelha@slu.edu*

**Charles M. Katz, Ph.D.**
Watts Family Director
  and Associate Professor
Center for Violence Prevention
  and Community Safety
Arizona State University
Suite 200
500 N. Third Street,
Phoenix, AZ 85004–2135
Phone: 602–496–1471
Fax:    602–496–1494
E-mail: *ckatz@asu.edu*

**Emma Kibisu**
Grants Evaluator
Arizona Department of Health Services
150 N. Eighteenth Street
Phoenix, AZ 85007
Phone:  602–364–4643
E-mail: *kibisue@azdhs.gov*

**Melissa Lee**
Special Agent
DEA Phoenix Field Division
U.S. Department of Justice
Suite 301
3010 North Second Street
Phoenix, AZ 85012
Phone:  602–664–5743
Fax:      602–664–5627
E-mail: *melissa.a.lee@usdoj.gov*

**Marsha Lopez, Ph.D.**
Acting Branch Chief
Epidemiology Research Branch
Division of Epidemiology, Services and
  Prevention Research
Room 5185
6001 Executive Boulevard
Bethesda, MD 20892
E-mail: *lopezmar@nida.nih.gov*

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

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

**Corinne P. Moody**
Science Policy Analyst
Food and Drug Administration
Building 51, Room 5144
10903 New Hampshire Avenue
Silver Spring, MD  20993
Phone:  301–796–3152
Fax:      301–847–8736
E-mail: *corinne.moody@fda.hhs.gov*

**John Newmeyer, Ph.D.**
Epidemiologist
HIV Prevention Planning Council
2004 Gough Street
San Francisco, CA  94109
Phone: 415–441–1158
E-mail: *jnewmeyer@aol.com*

**Clayton Norman**
Reporter, Tombstone Epitaph
Graduate Student
University of Arizona
1650 E. Linden Street
Tucson, AZ
Phone: 936–553–2434
E-mail: *claytonrnorman@gmail.com*

**Moira P. O'Brien, M.Phil.**
Health Scientist Administrator
Epidemiology Research Branch
Division of Epidemiology, Services and
   Prevention Research
National Institute on Drug Abuse
National Institutes of Health
Room 5153, MSC-9589
6001 Executive Boulevard
Bethesda, MD  20892
Phone: 301–402–1881
Fax:    301–443–2636
E-mail: *mobrien@nida.nih.gov*

**Lawrence Ouellet, Ph.D.**
Research Professor
Division of Epidemiology and Biostatistics
School of Public Health
University of Illinois, Chicago
Mailcode 923
1603 West Taylor Street
Chicago, IL  60612
Phone: 312–355–0145
Fax:    312–996–1450
E-mail: *ljo@uic.edu*

**Usaneya Perngparn, Ph.D.**
Assistant Dean
College of Public Health Sciences
Chulalongkorn University
Bangkok 10330, Thailand
Phone: 662 218–8200
E-mail: *usaneya.p@chula.ac.th*

**Artisha R. Polk, M.P.H.**
Mathematical Statistician
Office of Diversion Control/ODE
Drug Enforcement Administration
U.S. Department of Justice
8701 Morrissette Drive
Springfield, VA  22152
Phone: 202–307–7180
Fax:    202–353–1263
E-mail: *artisha.r.polk@usdoj.gov*

**Robin Pollini, Ph.D., M.P.H.**
Assistant Professor
University of California, San Diego
Mail Code 0507
9500 Gilman Drive
La Jolla, CA  92093
Phone: 858–534–0710
Fax:    858–534–7566
E-mail: *rpollini@ucsd.edu*

**Cassandra Prioleau, Ph.D.**
Drug Science Specialist
Drug Enforcement Administration
U.S. Department of Justice
8701 Morrissette Drive
Springfield, VA  22152
Phone: 202–307–7254
Fax:    202–353–1263
E-mail: *cassandra.prioleau@usdoj.gov*

**Sandra Putnam, M.Sc., Ph.D.**
Project Director, CEWG
Social Solutions International, Inc.
1541 Stewartstown Road
Morgantown, WV  26505
Phone: 304–292–5148
Fax:    304–292–5149
E-mail: *sputnam@socialsolutions.biz*

**Nicholas Reuter, M.P.H.**
Senior Public Health Advisor
Substance Abuse and Mental Health
   Services Administration
U.S. Department of Health and Human
   Services
Room 2-1063
One Choke Cherry Road
Rockville, MD 20850
Phone: 240–276–2716
Fax:    240–276–1040
E-mail: *Nicholas.Reuter@samhsa.hhs.gov*

**Jan Scaglione, M.T., Pharm.D.,
DABAT**
Clinical Toxicologist
Cincinnati Drug and Poison Information
   Center
Cincinnati Children's Hospital Medical Center
ML–9004
3333 Burnet Avenue
Cincinnati, OH  45229
Phone: 513–636–5060
Fax:    513–636–5072
E-mail: *jan.scaglione@cchmc.org*

**Nina Shah, M.S.**
Drug Epidemiologist
New Mexico Department of Health
P.O. Box 26110
1190 St. Francis Drive
Santa Fe, NM  87502
Phone: 505–476–3607
Fax:    505–827–0013
E-mail: *nina.shah@state.nm.us*

**Susan A. Seese, Ph.D., M.B.A.**
Senior Intelligence Analyst/SENTRY
   Program Manager
National Drug Intelligence Center
U.S. Department of Justice
Fifth Floor
319 Washington Street
Johnstown, PA  15901
Phone: 814–532–4093
Fax:    814–532–5858
E-mail: *susan.seese@usdoj.gov*

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

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

**John S. Swartz**
Senior Intelligence Specialist
U.S. Drug Enforcement Administration
U.S. Department of Justice
700 Army Navy Drive
Arlington, VA 22202
Phone: 202–307–4453
E-mail: *john.s.swartz@usdoj.gov*

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

**Angela Walker**
Senior Forensic Chemist
DEA South Central Laboratory
U.S. Drug Enforcement Administration
U.S. Department of Justice
10150 East Technology Boulevard
Dallas, TX 75220
Phone: 972–559–7900
Fax:    972–559–7999
E-mail: *angela.z.walker@usdoj.gov*

**Jerry Walker**
Associate Laboratory Director
DEA South Central Laboratory
U.S. Drug Enforcement Administration
U.S. Department of Justice
10150 East Technology Boulevard
Dallas, TX 75235
Phone: 972–559–7900
Fax:    972–559–7999
E-mail: *jerry.a.walker@usdoj.gov*

**D. William Wood, M.P.H., Ph.D.**
Professor and Chair
Department of Sociology
University of Hawaii at Manoa
Room 247
2424 Maile Way
Honolulu, HI  96822
Phone: 808–956–7693
Fax:    808–956–3707
E-mail: *dwwood@hawaii.edu*

## Meeting Coordinator

**Patricia Evans**
Conference Manager
Knowledge Translation and Strategic
   Communication Division
RTI International
Suite 902
6110 Executive Boulevard
Rockville, MD 20852
Phone: 301–816–4612
Fax:    301–230–4647
E-mail: *pevans@rti.org*