

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

Proceedings of the Community
Epidemiology Work Group

Volume I
Highlights and Executive Summary

June 2012

U.S. Department of Health and Human Services
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COMMUNITY EPIDEMIOLOGY WORK GROUP

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL INSTITUTES OF HEALTH
Division of Epidemiology, Services and Prevention Research
National Institute on Drug Abuse
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The information presented in this Executive Summary is primarily based on CEWG area reports and meeting presentations prepared by CEWG representatives for the June 2012 CEWG meeting. Data/information from Federal sources supplemental to the meeting presentations and discussions have been included in this report to facilitate cross-area comparisons.

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

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Foreword

This Executive Summary provides a synthesis of findings from the 72nd semiannual meeting of the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG) held in La Quinta, California, on June 5–7, 2012. The CEWG is a network of researchers from sentinel sites throughout the United States. It meets semiannually to provide ongoing community-level public health surveillance of drug abuse through presentation and discussion of quantitative and qualitative data. CEWG representatives access multiple sources of existing data from their local areas to report on drug abuse patterns and consequences in their areas and to provide an alert to potentially emerging new issues. Local area data are supplemented, as possible, with data available from federally supported projects, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), Drug Abuse Warning Network (DAWN); Drug Enforcement Administration (DEA), National Forensic Laboratory Information System (NFLIS); the Arrestee Drug Abuse Monitoring (ADAM) II program; and the DEA, Heroin Domestic Monitor Program (HDMP). This descriptive and analytic information is used to inform the health and scientific communities and the general public about the current nature and patterns of drug abuse, emerging trends, and consequences of drug abuse.

The CEWG convenes twice yearly, in January and June. For the June meetings, CEWG representatives prepare full reports on drug abuse patterns and trends in their areas. After the meeting, a Highlights and Executive Summary Report is produced, and the full CEWG area reports are included in a second volume.

The majority of the June 2012 meeting was devoted to the CEWG area reports and presentations. CEWG area representatives presented data on local drug abuse patterns and trends. Presentations on drug abuse patterns and issues were also provided by guest researchers from Australia, Canada, the European Centre for Drugs and Drug Monitoring, the Inter-American Drug Abuse Control Commission, Office of American States, and New Zealand. Other highlights of the meeting included presentations by DEA representatives Jeffrey H. Comparin, on the forensic chemistry of drugs of concern, and Sarah Bourne, who gave a drug trafficking update; an update from the Office of National Drug Control Policy on the ADAM II data system by M. Fe Caces, Ph.D.; and a presentation by U.S. Food and Drug Administration representative James Hunter, R.Ph., M.P.H., on the challenges in evaluating abuse deterrent drug product formulations. Presentations on community-based prescription drug abuse research included “Prescription Opioid Diversion: Mechanisms, Street Prices, and Prevention Measures,” by Steven Kurtz, Ph.D., Nova Southeastern University; “Initiation to Prescription Drug Use: Social Contexts of Use,” by Sheigla Murphy, Ph.D., Center for Substance Abuse Studies, Institute for Scientific Analysis; “Prescription Drug Misuse Among High-Risk Young Adults: Findings from New York and Los Angeles,” by Stephen Lankenau, Ph.D., Drexel University; “Prescription Drug Misuse Among Socially Active Urban Young Adults,” by Brian Kelly, Ph.D., Purdue University; and “Drug Use Practices Among Illicit Users of Pharmaceutical Opioids,” by Robert Carlson, Ph.D., Wright State University.

The *Proceedings of the Community Epidemiology Work Group* for the June 2012 CEWG meeting is published in two volumes. This volume highlights findings across CEWG areas. Full local area and international reports are presented in Volume II. Readers of this report are directed to Volume II for a more detailed description of data sources and presentation of data from the CEWG areas.

Moira P. O'Brien

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Department of Health and Human Services

Section I. Introduction

The 72nd semiannual meeting of the Community Epidemiology Work Group (CEWG) was held on June 5–7, 2012, in La Quinta, California. During the meeting, researchers from 20 geographically dispersed areas in the United States reported on current trends and emerging issues in their areas. In addition to the information provided for 18 sentinel areas that have contributed to the network for many years and two additional areas (Colorado and Broward County, Florida, in the Miami Metropolitan Statistical Area [MSA]), guest researchers from Cincinnati and Maine provided data from their respective areas. International representatives from Australia, Canada, the European Centre for Drugs and Drug Monitoring, the Inter-American Drug Abuse Control Commission, Office of American States, and New Zealand reported on drug trends and issues in their respective countries.

The CEWG Network

The CEWG is a unique epidemiology network that has functioned since 1976 to identify and assess current and emerging drug abuse patterns, trends, and issues, using multiple sources of information. Each source provides information about particular drugs, drug-using populations, and/or different facets of the behaviors and outcomes related to drug abuse. The information obtained from each source is considered a drug abuse *indicator*. Typically, indicators do not provide estimates of the number (prevalence) of drug abusers at any given time or the rate at which drug-abusing populations may be increasing or decreasing in size. However, indicators do help to characterize drug abuse trends and drug abusers (such as those who have been treated in hospital emergency departments, admitted to substance abuse treatment programs, or died with drugs found in their bodies). Data on items submitted for forensic chemical analysis serve as indicators of availability of different substances and engagement of law enforcement at the local level, and data such as drug price and purity are indicators of availability, accessibility, and potency of specific drugs.

Drug abuse indicators are examined over time to monitor the nature and extent of drug abuse and associated problems within and across geographic areas. The CEWG areas on which presentations were made at the June 2012 meeting are depicted in the map below, with one presentation including data on the Baltimore/Maryland/Washington, DC, area.



CEWG Meetings

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

Through the meetings, the CEWG accomplishes the following:

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

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

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

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

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

Data Sources

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

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

- Admissions to drug abuse treatment programs by primary substance of abuse or primary reason for treatment admission reported by clients at admission

- Drug-involved emergency department (ED) reports of drugs mentioned in ED records in the Drug Abuse Warning Network (DAWN) or reports from local and State sources
- Seizure, average price, average purity, and related data obtained from the Drug Enforcement Administration (DEA) and from State and local law enforcement agencies
- Drug-related deaths reported by medical examiner (ME) or local coroner offices or State public health agencies
- Arrestee urinalysis results and other toxicology data
- Surveys of drug use
- Poison control center data¹

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

Treatment data were derived from CEWG area reports. For this report, they represent data for 18 CEWG metropolitan areas and 6 States: Colorado, Florida, Hawaii, Maine, Maryland, and Texas. Recent or complete treatment admissions data were not available for Chicago and Washington, DC. Data for some States are included with metropolitan data for comparison, including data for Colorado with Denver, Florida with the South Florida/Miami-Dade and Broward Counties area, Hawaii with Honolulu, and Maryland with Baltimore City. South Florida/Broward County data are included with South Florida/Miami-Dade County data for comparison. The latter two counties, with Palm Beach County, are part of the Miami MSA. The reporting period is cited as calendar year (CY) 2011 for all of the CEWG areas. Appendix table 1 shows overall treatment admissions data by drug and CEWG area for the current reporting period. Table 2 in section II and several tables in section III (tables 3–13, 15, and 17–23) also display cross-area treatment admissions data.

DAWN ED² weighted estimates for 12 CEWG areas for 2004–2009 were available on the DAWN Web site (<http://www.samhsa.gov/data/dawn.aspx>) maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA). The data represent drug reports for drug-involved visits for illicit drugs (derived from the category of “major substances of abuse,” excluding alcohol) and the nonmedical use of selected pharmaceutical drugs. Nonmedical use of pharmaceuticals is use that involves taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed

¹Poison control center data are reported here as they are reported by area representatives in their full area reports and slide presentations. The terminology used by area representatives in this report does not necessarily mean that particular substances, such as cannabimimetics (also known as synthetic cannabinoids) and substituted (or synthetic) cathinones, are chemically verified.

²DAWN uses a national sample of non-Federal, short-stay, general surgical, and medical hospitals in the United States that operate 24-hour EDs. The American Hospital Association (AHA) 2001 Annual Survey is the source of the sample. ED medical records are reviewed retrospectively for recent drug use. Visits related to most types of drug use or abuse cases are identified and documented. Drug cases encompass three visit categories: those related to illegal or illicit drugs; nonmedical use of prescription, over-the-counter, or other pharmaceutical drugs; and alcohol among patients under the legal drinking age of 21 and patients of all ages when used in combination with other drugs.

or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs, especially illegal drugs or alcohol. Since drug reports exceed the number of ED visits because a patient may report use of multiple drugs (up to six drugs plus alcohol), summing of drugs across categories is not recommended. CEWG full area reports in Volume II that include DAWN data are Denver and San Francisco.

Forensic laboratory data on drug seizures for a total of 24 CEWG sites were available for CY 2011. Data for all CEWG metropolitan areas in 2011 were provided by the National Forensic Laboratory Information System (NFLIS), maintained by the DEA. The data presented are a combined count including primary, secondary, and tertiary reports for each drug item submitted. NFLIS is a program in the DEA Office of Diversion Control that systematically and continuously collects results from drug analyses of items received from drug seizures by law enforcement authorities. Drug analyses are conducted by Federal (DEA) forensic laboratories and participating State and local forensic laboratories. As of March 2012, in addition to the DEA laboratories, the NFLIS system included 48 State systems and 91 local or municipal laboratories/laboratory systems, representing a total of 288 individual laboratories. In 2011, approximately 1.7 million drug analysis records were reported to NFLIS. Data are entered daily based on seizure date and the county in which the seizure occurred. NFLIS provides detailed information on the prevalence and types of controlled substances secured in law enforcement operations and assists in identifying emerging drug problems and changes in drug availability and in monitoring illicit drug use and trafficking, including the diversion of legally manufactured drugs into illegal markets. A list of participating and reporting State and local forensic laboratories is included in Appendix B of the U.S. Drug Enforcement Administration, Office of Diversion Control report, *National Forensic Laboratory Information System: Year 2011 Midyear Report* (Washington, DC: U.S. Drug Enforcement Administration)³. In most cases, data are for MSAs, rather than single metropolitan counties, but the exact geographic areas covered in this report are defined in appendix table 2. A map displaying NFLIS data for 2011 for 24 CEWG areas is included as figure 5 in section II, while table 1 in section II and a number of other figures and tables in section III (figures 6–12 and tables 14, 16, 24, and 25), along with appendix tables 2.1–2.24, are provided to display the data on forensic laboratory drug items identified for the period across areas. Full area reports in Volume II of this report also include NFLIS data for CEWG areas.

Average price and purity data for heroin for 19 CEWG metropolitan areas in CY 2010 (the most recent period available) were provided by the DEA in April 2012 based on the *2010 Heroin Domestic Monitor Program (HDMP) Drug Intelligence Report*. This report is prepared by the Domestic Strategic Intelligence Unit of the Special Strategic Intelligence Section and reflects analysis of program data through December 31, 2010. Drug price and purity data from this report or from local DEA Field Divisions are included in full area reports in Volume II for the following CEWG areas: Atlanta, Chicago, Denver, Detroit, New York City, South Florida/Miami-Dade and Broward Counties, Philadelphia, St. Louis, San Francisco, and Seattle.

³This report and other information about NFLIS can be found at <http://www.deadiversion.usdoj.gov/nflis/index.html>.

Drug prices and trafficking trends also came from the National Drug Intelligence Center (NDIC)'s report, *National Illicit Drug Prices—Mid Year 2009*. Data from this report are included in the full area reports in Volume II for Chicago and Denver.

ADAM (Arrestee Drug Abuse Monitoring) II program data were presented for five areas in full reports included in Volume II: Fulton County (Atlanta); Cook County (Chicago); Hennepin County (Minneapolis/St. Paul); Borough of Manhattan (New York City); and Washington, DC (Baltimore/Maryland/Washington, DC, area). ADAM II is a data collection program sponsored by the Office of National Drug Control Policy (ONDCP) that is designed to gather information on drug use and related issues from adult male booked arrestees in 10 counties across the country. ADAM II data come from two sources: a 20–25-minute face-to-face interview and urinalysis of a test sample for the presence of nine different drugs. Participation in both the interview and the urine test is voluntary and confidential. In 2011, across all 10 sites, data were collected with 5,051 interviews with booked arrestees. Of these interview respondents, 4,412 provided a urine specimen. Data were collected over two quarters in 2011 and then statistically annualized to represent the entire year. The ADAM II 2011 annual report is available at <http://www.whitehouse.gov/ondcp/ondcp-fact-sheets/adam-ii-2011-annual-report-highlights>.

Local drug-related mortality data from medical examiners/coroners (ME/Cs) or State public health agencies were reported for 15 CEWG areas: Atlanta; Baltimore/Maryland/ Washington, DC; Chicago; Denver; Honolulu; Los Angeles; Maine; Minneapolis/St. Paul; Philadelphia; St. Louis; San Diego; San Francisco; South Florida/Miami-Dade and Broward Counties; Seattle; and Texas. These are described in Volume II.

Other data cited in this report were local data accessed and analyzed by CEWG representatives. The sources included the Centers for Disease Control and Prevention (CDC)'s Youth Risk Behavior Surveillance System (YRBSS) and Youth Risk Behavior Survey (YRBS) data; local law enforcement (e.g., data on drug arrests or law enforcement seizures); DEA Automation of Reports and Consolidated Orders System (ARCOS) data on the flow of DEA-controlled substances from their point of manufacture through commercial distribution channels to point of sale or distribution at the dispensing or retail level; local DEA offices (DEA field reports); High Intensity Drug Trafficking Area (HIDTA) reports; arrestee drug information from local and State corrections departments and facilities; poison control centers, crisis lines, and help lines; prescription drug monitoring systems; hospital admissions and discharge data; local and State surveys; interviews with key informants and ethnographers; and human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) data from local and State health departments.

A Note to the Reader—Caveats

Terminology and Geographic Coverage—CEWG representatives use existing data, which are subject to the definitions and geographic coverage of the source data. Representatives generally use the terminology as it is used in the data source. For example, many treatment systems use the phrases “other opiates” for classifying “opiates⁴ other than heroin” to categorize a primary problem

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

at admission. The term “other opiates⁵” is therefore retained in this summary report, and the terms, “other opiates” and “opioids” may be used in a single area report. Similarly, the term, “prescription-type opioid,” is used by some representatives to distinguish synthetic or semisynthetic opioids, such as oxycodone and hydrocodone, from heroin. The geographic coverage of data sources may vary within a CEWG area report. Readers are directed to the Volume II full CEWG area reports for a more complete description of data sources used in specific areas. In this summary report, in most cases, the general name of the CEWG area will be used for data sources. For the treatment admissions and NFLIS data, the specific geographic coverage will be noted in footnotes. For example, appendix table 1 presents the treatment admissions data for each area, and footnotes specify the geographical coverage; appendix table 2 presents local area NFLIS data with notes on spatial composition.

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

Treatment Admissions—Many variables affect treatment admission numbers, including program emphasis, capacity, data collection methods, and reporting periods. Therefore, changes in admissions bear a complex relationship to drug abuse prevalence. Treatment data on primary abuse of specific drugs in this report represent percentages of total substance abuse treatment admissions. Data on demographic characteristics (gender, race/ethnicity, and age group) and route of administration of particular drugs were provided for most CEWG areas and reported in full area reports. The numbers of admissions for alcohol and other drugs in 2011 are presented for 23 reporting CEWG sites/areas in appendix table 1, with rankings documented in section II, table 2. Treatment data are not totally comparable across CEWG areas, and differences are noted insofar as possible. Treatment numbers are subject to change. Most of the CEWG area representatives report treatment admissions data provided by States to the Treatment Episode Data Set (TEDS)⁶, and these local and State data are included in cross-area comparison tables in this report (section II, table 2; section III, tables 3–13, 15, and 17–23; and appendix table 1). CEWG areas were not included in treatment data tables where primary substance (benzodiazepine or methamphetamine) admissions were less than 1.0 percent of total substance abuse treatment admissions in 2011. Data for several areas were omitted from trend tables (section III, tables 6, 10, 13, 20, and 23) due to lack of availability for 3 or more years in the reporting period or for noncomparability of 2011 treatment admissions data with past years’ data. Due to changes in the reporting system in Maryland in 2010, treatment admissions data presented in this report should not be compared with data in previous CEWG reports prior to that year. There, enrollments not admissions were reported, with enrollment numbers including numbers for both “admissions” at the initial entry into treatment and “enrollments” when a client changes a level of care. Maryland treatment enrollment data for 2010 also included data for State-funded treatment programs only in contrast to years prior to 2010. In Texas, the Department of State Health Services changed the reporting requirements for treatment admissions in 2010, although all treatment trend data are comparable over time in this report, according to the area representative. In addition, the Detroit area representative provided calendar year data for 2011 in Volume I tables contained in this report for cross-area comparability, but reported treatment data for Detroit by fiscal year (FY) in the full area report contained in Volume II of this June 2012 report.

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

⁶TEDS is an administrative data system providing descriptive information about the national flow of admissions to specialty providers of substance abuse treatment, conducted by the Center for Behavioral Health Statistics and Quality, SAMHSA.

ED Drug Reports—For this meeting report, weighted estimate data were available at the DAWN Web site (<http://www.samhsa.gov/data/dawn.aspx>). These data were used in full area reports by CEWG area representatives for 2 of the 12 metropolitan areas for which such data were available for 2004–2009 in the DAWN system: Denver and San Francisco. Some area representatives reported weighted DAWN data in their January 2012 update briefs and did not include those data in their full area reports for June 2012. When comparisons are made across time periods with a CEWG area, this caveat is needed: statements about drug-involved ED weighted rates in CEWG areas being higher or lower in 1 year than another year are only made when their respective *t*-test *p*-values are significant at the .05 level or below. Otherwise, no difference is reported⁷.

NFLIS Drug Reports from Drug Items Seized and Analyzed by Forensic Laboratories—NFLIS includes drug chemistry results from completed analyses only; drug evidence secured by law enforcement but not analyzed in laboratories is not included in the NFLIS database. State and local policies related to the enforcement and prosecution of specific drugs may affect drug evidence submissions to laboratories for analysis. Laboratory policies and procedures for handling drug evidence vary and range from analysis of all evidence submitted to the laboratory to analysis of selected items only. Many laboratories did not analyze the evidence when a case was dismissed or if no defendant could be identified (see NFLIS 2011 Midyear Report cited earlier). Differences in local/State laboratory procedures and law enforcement practices across areas make area comparisons inexact. Also, the data cannot be used for prevalence estimates, because they are not adjusted for population size. They are reported as the percentage that each drug represents of the total number of drug reports, including up to three drugs identified among drug items seized and identified by forensic laboratories in a CEWG area, and cases are assigned to a geographic area by the location of the seizure event, not the laboratory. Because NFLIS counted primary, secondary, and tertiary reports for each drug from analyzed drug items for the first time, NFLIS data for 2011 cannot be compared with data presented in prior CEWG reports. The nature of the NFLIS reporting system is such that there may be a time lag between the time of seizure, the time of analysis of drug items and drug reports based on them, and the time of reporting to the NFLIS system. Therefore, differences in the number of drug reports for a specified time period may occur when NFLIS is queried at different times, since data input is daily and cases may be held for different periods of time before analysis and reporting in various areas and agencies. Numbers of drug reports presented in these reports are subject to change and may differ when drawn on different dates. Not all forensic laboratories report on substances that are not controlled, rendering some comparisons of such drugs inaccurate.

⁷Estimates of ED visits associated with misuse and abuse of drugs are derived by applying sampling weights to data from a stratified probability sample of hospitals. The estimates obtained are of drug-involved visits. A single ED visit may involve multiple drugs, which are counted separately. When ED visits involve multiple drugs, such visits appear multiple times in a table. Therefore, summing ED visits as reported in these tables will produce incorrect and inflated counts of ED visits. Combining estimates for categories of drugs is subject to a similar limitation. Multiple drugs may be involved in a single visit, so categories are not mutually exclusive and will not sum to 100 percent when percentages are calculated. Because multiple substances may be recorded for each DAWN case, caution is necessary in interpreting the relationship between a particular drug and the number of associated visits. It is important to note that a drug-involved ED visit is any ED visit related to recent drug use. This is the new definition of a DAWN case as of 01/01/03. One or more drugs have to be implicated only in the visit; they do not necessarily have to have precipitated or caused the visit. These are visits, not patients, such that they are duplicated numbers to an unknown extent rather than being unique numbers.

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

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

Local Area Comparisons

The following methods and considerations pertain to local area comparisons:

- Local areas vary in their reporting periods. Some indicators reflect fiscal periods that may differ among local areas. In addition, the timelines of data vary, particularly for death and treatment indicators. Spatial units defining a CEWG area may also differ depending on the data source. Care has been taken to delineate the definition of the geographic unit under study for each data source, whether a city, a single metropolitan county, an MSA, or some subset of counties in an MSA. In some instances, data were compiled by region defined by the U.S. Census Bureau as northeastern, southern, midwestern, and western regions. Texas is included in the western region in this report, rather than in the census-defined southern region, based on member recommendations concerning area comparability of drug patterns and similarity of population characteristics to other western areas.
- In section III of this report, percentages for treatment program admissions are calculated and presented with primary alcohol admissions included in the total on which percentages are based. All cross-area comparisons use this measure, although in past CEWG reporting, percentages of specific drug-related primary admissions were calculated using totals both including and excluding alcohol admissions in denominators. All treatment data in the cross-area comparison section of this report cover January through December 2011, which is characterized as the current reporting period.
- Some indicator data are unavailable for certain cities. Therefore, the symbol, “NR,” in tables refers to data not reported by the CEWG area representative.
- The population racial/ethnic composition differs across CEWG areas. Readers are directed to the individual CEWG full area reports in Volume II of this report for information regarding treatment patterns and trends pertaining to race/ethnicity, age, and gender.

Section II. Highlights and Summary of Key Findings and Spotlights on Emerging Drug Issues From the June 2012 CEWG Meeting

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

In presenting area reports, CEWG representatives are invited to use their professional judgment and knowledge of the local context to provide an overall characterization of the indicators for their areas, as possible, given available data; that is, to assess whether indicators appear to be stable, increasing, decreasing, or mixed, with some indicators increasing, decreasing, and stable). CEWG area representatives may also provide an overall characterization of the level of the indicators as high, moderate, or low, or identify when particular drugs are considered to be the dominant drugs of abuse in an area. Some indicators are sensitive to recent changes in local policy or law enforcement focus; therefore, representatives use their knowledge of the local context in describing and interpreting data available for their area. The key findings of this CEWG meeting are presented this section.

For the June 2012 CEWG meeting, CEWG representatives were invited to provide an update on drug abuse trends in their areas for 2011 (January–December). Key findings and issues identified at the CEWG meeting are highlighted in this section, with detail provided in the local area full area reports included in Volume II of this report. These area reports document and summarize drug abuse trends and issues in specific CEWG areas, with an emphasis on information newly available since the June 2011 meeting reports. The availability of data varies by area. Readers are directed to the Data Sources section of the full area reports to determine which data sources were reviewed for particular areas. Subsequent to the CEWG meeting, data available across a majority of CEWG areas, such as substance abuse treatment admissions data and drug reports information from the National Forensic Laboratory Information System (NFLIS), are reviewed. These data are presented in tabular and graphical formats in table 1, table 2, and figure 5, in other tables and charts in section III of this report, and in appendix tables 1 and 2.1–2.24. Highlights from these cross-area tabulations are also included in this section in shaded summary boxes, and results are described in section III. Key findings are also summarized in the five regional maps in this section.

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

Highlights: June 2012 CEWG Meeting

This box summarizes the key findings of the June 2012 CEWG meeting. Figures 1a through 4 present highlights for CEWG areas grouped by region based on reporting by CEWG area representatives. Supplementing these maps are detailed substance abuse treatment admissions and NFLIS data contained in tables 1 and 2 and figure 5. NFLIS top 10 rankings are shown in table 1, while figure 5 is a map displaying proportions of cocaine, heroin, methamphetamine, and marijuana/cannabis drug reports among drug items seized and analyzed in 2011 across all CEWG areas. Table 2 shows the top-ranked primary drugs in treatment admissions across the CEWG areas, as a percentage of total substance abuse treatment admissions, including primary alcohol admissions.

Cocaine:

- Representatives from 16 CEWG areas (Atlanta; Baltimore/Maryland/Washington, DC; Boston; Chicago; Denver/Colorado; Detroit; Los Angeles; Maine; South Florida/Miami-Dade and Broward Counties; Minneapolis/St. Paul; Phoenix; St. Louis; San Diego; San Francisco; Seattle; and Texas) reported mostly decreasing indicators. Four area representatives, from Honolulu/Hawaii, Maine, New York City, and Philadelphia, reported mixed indicators (some increasing, some decreasing, and some stable). The Cincinnati representative reported slightly increasing indicators for 2011.
- Based on total 2011 treatment admissions, cocaine did not rank either first or second in any of the 23 CEWG reporting areas. It ranked third in five areas: Atlanta, Boston, Detroit, South Florida/Miami-Dade County, and Texas (table 2).
- Cocaine ranked first among reports from drug items seized and analyzed in NFLIS laboratories in eight CEWG areas, including two of the nine CEWG areas in the western region (Denver and Seattle), in one of the five areas in the midwestern region (Minneapolis/St. Paul), in three of the four areas in the northeastern region (Maine, New York City, and Philadelphia), and in two of the five areas in the southern region (Atlanta and Miami). Cocaine ranked second in drug reports among drug items seized and analyzed in 2011 in 11 of 24 CEWG reporting areas: Baltimore City, Boston, Chicago, Cincinnati, Colorado, Detroit, Los Angeles, Maryland, Michigan, Texas, and Washington, DC (table 1).

Heroin:

- Increasing heroin trends were reported by area representatives for Boston, Cincinnati, Denver/Colorado, Detroit, Honolulu/Hawaii, Minneapolis/St. Paul, San Diego, Seattle, and Texas. The area representatives from Atlanta, Chicago, Los Angeles, St. Louis, and Washington, DC, reported mostly stable indicators. Mixed indicators (some stable, some declining, and some increasing) were reported by area representatives from Baltimore/Maryland, Maine, New York City, Philadelphia, Phoenix, and the South Florida/Miami-Dade and Broward Counties area. Decreasing indicators were reported by the representative for the San Francisco area.

- Among all substance abuse treatment admissions, including those for whom alcohol was the primary drug in 2011, heroin ranked first in 3 of the 23 CEWG reporting areas: Baltimore City, Boston, and St. Louis. Heroin ranked second in three areas (Detroit, Maryland, and San Diego) among all treatment admissions. Heroin ranked third in five areas: Los Angeles, Minneapolis/St. Paul, New York City, San Francisco, and Seattle (table 2).
- In more than one-half (13) of the 24 CEWG areas, heroin items accounted for less than 10.0 percent of the drug reports from drug items seized and analyzed in forensic laboratories in 2011. As a proportion of total drug reports, heroin reports were highest in Baltimore City and lowest in Honolulu (figure 5). Heroin did not rank first or second among drug reports in the 24 reporting CEWG areas in 2011, with the exception of St. Louis, where heroin ranked second among total drug reports. Heroin placed third in the rankings of drug reports in 11 CEWG reporting areas. In the West, heroin ranked third in two of the nine reporting areas (Phoenix and Seattle). It ranked third in four of six areas in the Midwest (Chicago, Cincinnati, Detroit, and Michigan); in three of four northeastern areas (Boston, New York City, and Philadelphia); and in two of five southern CEWG areas (Baltimore City and Maryland) (table 1).

Evidence of Increasing Heroin Use by Youth:

- Area representatives from Denver/Colorado, Los Angeles, San Diego, San Francisco, Seattle, and Texas reported on young heroin users in current indicator data, suggesting increases in proportions of young heroin treatment admissions. For example, in the Denver/Colorado area, the proportion of clients younger than age 25 increased from 13 percent of all heroin admissions in 2007 to 28 percent of all admissions in 2011. The proportion of clients in their twenties similarly increased in the Seattle area and the State of Texas, and the proportion of clients younger than age 35 increased in Los Angeles and San Diego. The New York City representative reported that although no quantitative indicator data were available at the time of reporting, field reports suggest an increase in youth heroin use in the city.

Emergence of Heroin Indicators Outside Major Metropolitan Areas:

- Several area representatives reported on the emergence of heroin in indicators outside of major metropolitan areas where it has been traditionally reported. For instance, in Seattle, the area representative reported an increasing heroin presence in mid-size towns outside the Seattle/King County area. Increasing heroin use in the suburbs outside Chicago and New York City was reported by the area representatives from those urban centers. In Missouri, heroin was appearing in indicator data in rural areas outside of St. Louis, according to that area representative. Some area representatives also reported on a continuing relationship between heroin use and the use of prescription opioids.

Opiates/Opioids Other Than Heroin:

- Area representatives in all of the CEWG areas except one reported increasing, stable, or mixed indicators for the nonmedical use of other opiates/opioids in 2011. The Seattle area representative reported slightly declining indicators.

- Hydrocodone and oxycodone continued as the prescription opioids appearing most frequently in indicator data, but concerns about buprenorphine and methadone continued to be reported in some CEWG areas.
- Other opiates/opioids ranked first among primary substances of abuse in percentages of total treatment admissions in 1 of the 21 CEWG reporting areas (Florida), and other opiates/opioids ranked second in Maine and South Florida/Broward County. This drug category did not rank third in any area, but it ranked fourth in five areas—Atlanta, Boston, Maryland, Minneapolis/St. Paul, and South Florida/Miami-Dade County (table 2).
- Of total drug items seized and identified in NFLIS forensic laboratories in 24 CEWG areas, oxycodone and hydrocodone often appeared among the top 10 ranked reports from drug items in terms of frequency in 2011 (table 1).

Benzodiazepines:

- Among the 17 of 20 CEWG area representatives reporting indicator data for benzodiazepines at the June 2012 meeting, indicators for these areas continued to be stable, mixed, or increasing in 2011. Alprazolam was the benzodiazepine occurring most frequently in indicator data, as in the recent past.

Methamphetamine:

- Methamphetamine indicators continued in 2011 to be higher in the West (where indicators were stable, mixed, or increasing) than in other regions of the country. All three CEWG areas in the South reported low and either stable or decreasing indicators, and in the Midwest, methamphetamine indicators were also stable or decreasing. Such indicators remained low or very low relative to other drugs in all four CEWG areas in the Northeast.
- Based on rankings of primary drugs as a percentage of total treatment admissions, including primary alcohol admissions, methamphetamine ranked first in Hawaii and San Diego; second in San Francisco; third in Colorado, Denver, and Phoenix; and fourth in Los Angeles (table 2).
- Methamphetamine ranked first among reports from drug items identified in San Diego and San Francisco; second in Atlanta, Honolulu, Phoenix, and Seattle; and third in Colorado, Denver, Los Angeles, Minneapolis/St. Paul, and Texas in this reporting period (table 1).

Marijuana/Cannabis:

- Area representatives from all CEWG areas continued to report high levels for marijuana/cannabis indicators in 2011. Marijuana/cannabis indicators were increasing, stable, or mixed in all areas except one; the San Francisco area representative reported declining indicators.
- Marijuana/cannabis ranked as the most frequently reported drug by primary treatment admissions in 3 of the 23 CEWG reporting areas in 2011, when primary alcohol admissions were included in the total; these were Los Angeles and South Florida/Miami-Dade and

Broward Counties. Marijuana/cannabis ranked second among primary drugs of admission in 10 areas (Atlanta, Cincinnati, Colorado, Denver, Minneapolis/St. Paul, New York City, Philadelphia, Phoenix, Seattle, and Texas) (table 2).

- Marijuana/cannabis ranked in either first or second place in frequency in the proportion of NFLIS reports among drug items seized and identified in forensic laboratories in 2011 in all except three CEWG areas. The exceptions were Atlanta, Maine, and Seattle, where marijuana ranked sixth, third, and fourth, respectively (table 1).

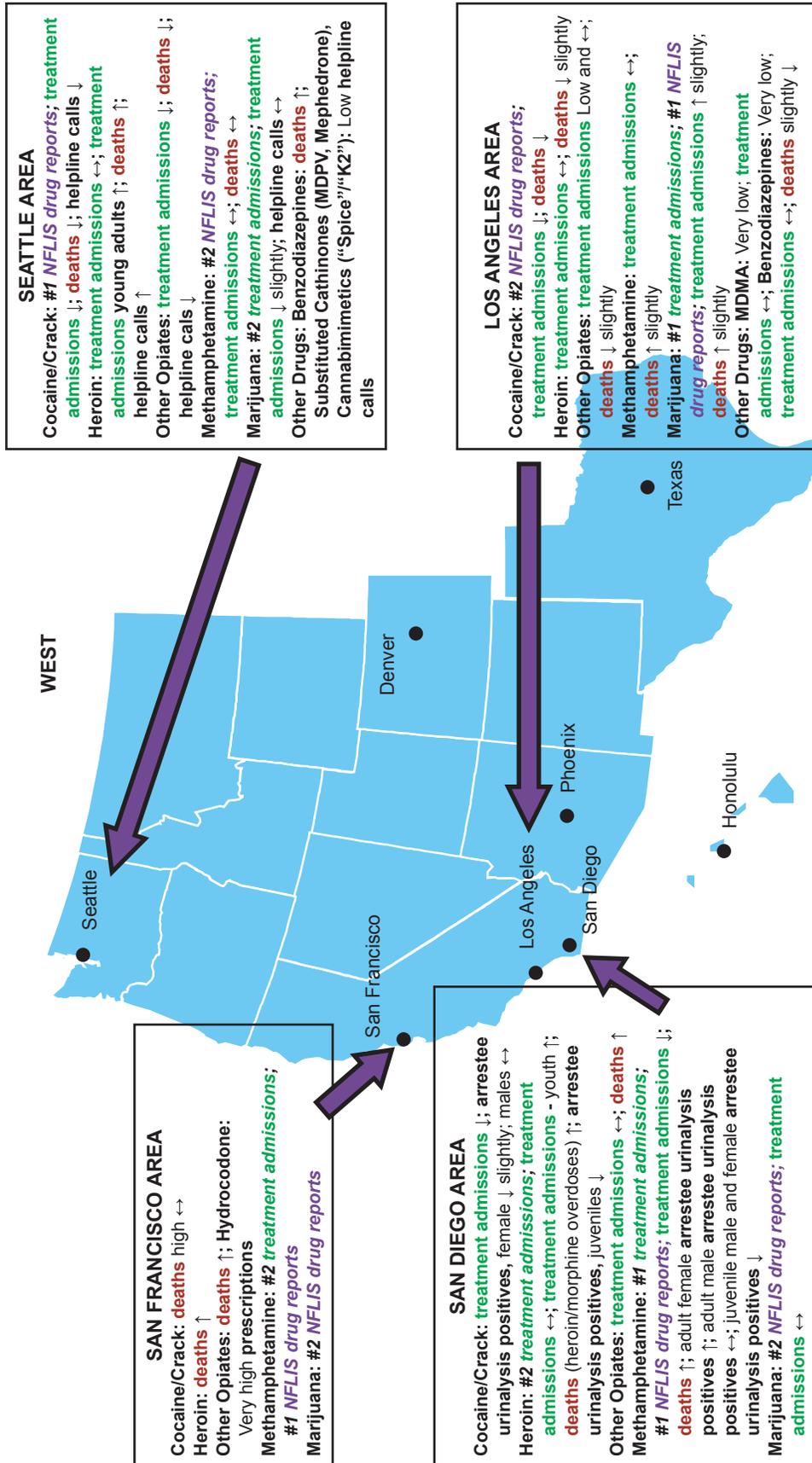
MDMA, PCP, BZP, and TFMPP:

- As in previous recent reporting periods, **MDMA** (3,4-methylenedioxyamphetamine) indicators were low or very low in 2011 across all CEWG regions, compared with most other drug indicators.
- While **PCP** (phencyclidine) indicators were low relative to other drugs in most CEWG areas in 2011, PCP remained a drug of concern in some CEWG areas, particularly in the north-eastern region.
- **BZP** (1-benzylpiperazine), which was permanently controlled in 2004 as a Schedule I substance under the Controlled Substances Act, continued to be reported in all CEWG areas; it was identified in NFLIS drug report data in 24 CEWG areas in 2011 (section III, table 25).
- **TFMPP** (1-(3-trifluoromethylphenyl)piperazine), which was often reported as combined with BZP, was also reported in indicators in several CEWG areas in 2011 and in the NFLIS data for 21 of 24 CEWG areas (section III, table 25).
- **Foxy methoxy** (5-MeO-DIPT) was reported in several CEWG area reports, and was identified in 20 of 24 CEWG areas in drug report data from NFLIS forensic laboratories in 2011 (section III, table 25).

Other Synthetic and “Designer” Substances:

- Calls to poison control centers reporting exposures to **cannabimimetics (also known as synthetic cannabinoids and on the street as “K2” and “Spice”)** were reported by area representatives in 2011 in all four CEWG regions of the country.
- Thirteen of the CEWG area representatives reported on **substituted cathinones (mephedrone and MDPV [3,4-methylenedioxypropylvalerone])** and associated products, sold as **“bath salts”** in the designer drug market in their areas in 2011.
- Several CEWG area representatives reported on the group of synthetic designer drugs collectively known as **phenethylamines** from the **2C** family (e.g., 2C-E, 2C-I, and 2C-T-2) in 2011.

Figure 1a. Regional Highlights: West CEWG Area Reports for Los Angeles, San Francisco, San Diego, and Seattle: Reported as of June 2012

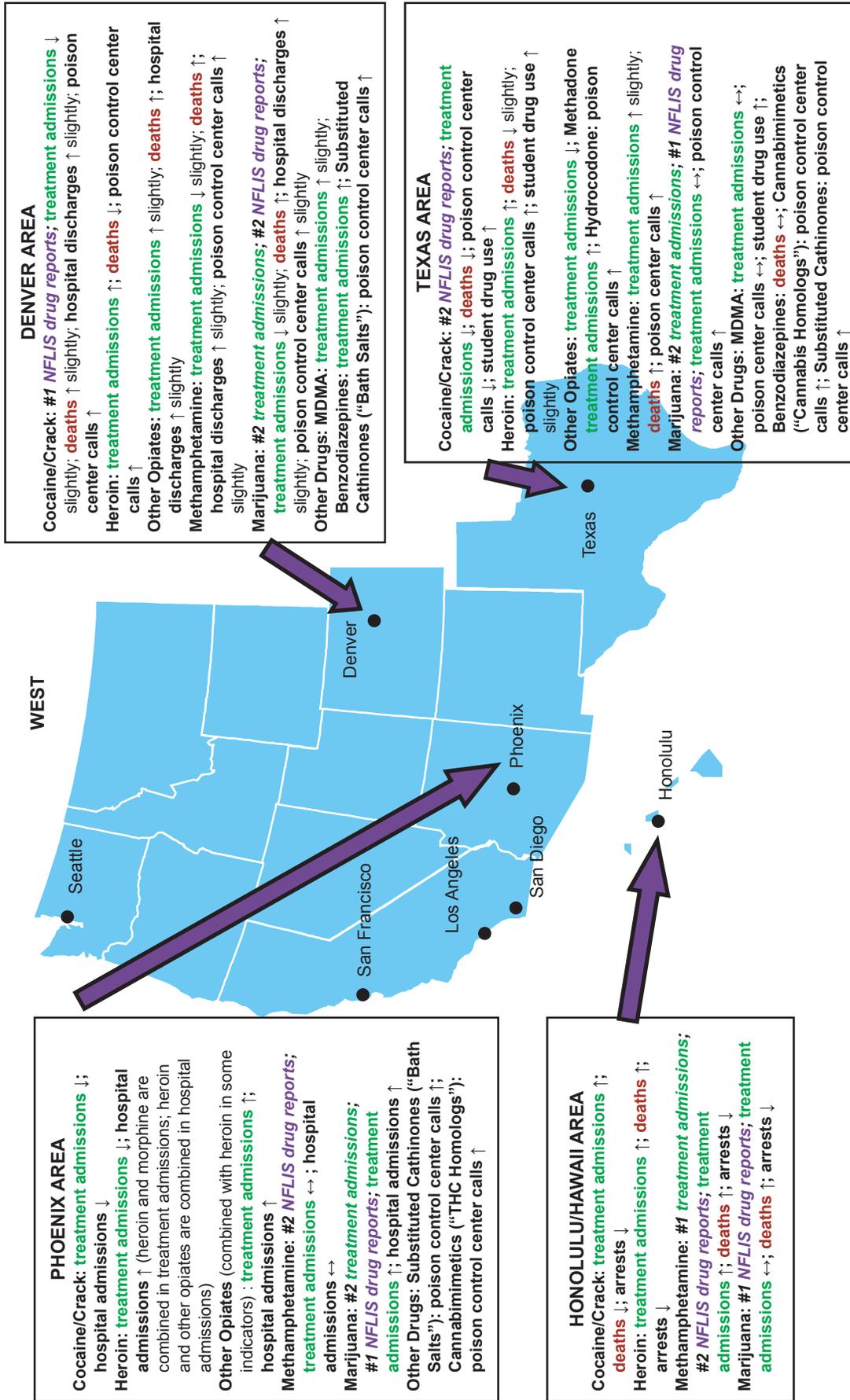


SYMBOLS USED: ↑ = Increasing or Up; ↓ = Decreasing or Down; ↔ = Stable

NOTES: Most comparisons are between 2010 and 2011. Data sources include the following: **Treatment admissions data** for Los Angeles, San Diego, and San Francisco came from the California Outcomes Measurement System (CalOMS); treatment admissions data for Seattle were provided by the State Health Department. Due to the implementation of a new Electronic Health Record and billing system in San Francisco in July 2010, treatment admissions data prior to that date may not be comparable to data submitted after the new system implementation. San Francisco data for 2011 are therefore preliminary and subject to change, and comparisons with 2010 data are not included in this map, although 2011 treatment data rankings are reported. **Death data** for Los Angeles, San Diego, and Seattle came from city and county ME's or coroner's offices, while data for San Francisco are from the ME's Annual Report for Fiscal Years 2009–2010 and DAWN ME data for 2009. Data for San Diego, San Francisco, and Seattle were for drug overdose deaths, while Los Angeles data denoted drugs detected in coroner toxicology screens. **NFLIS drug reports data** came from the DEA NFLIS system; rankings are included in the table, but no comparisons between 2010 and 2011 data are used due to lack of comparability over time. Data for the San Francisco Police Department Laboratory and Alameda County are not reported for 2011. There are no data for the San Bernardino Laboratory for April through December 2011. The California Department of Justice Forensic Laboratory did not report data for November and December 2011. Only top rankings are reported due to lack of comparability of data on drug reports for 2010 and 2011. **Help line data** for the Seattle/King County area were for the second half of 2011 and were provided by the Recovery Help Line. Opioid **prescription** data in San Francisco were obtained from the Prescription Drug Monitoring Program. See section I for discussion of data sources.

SOURCE: June 2012 CEWG meeting materials

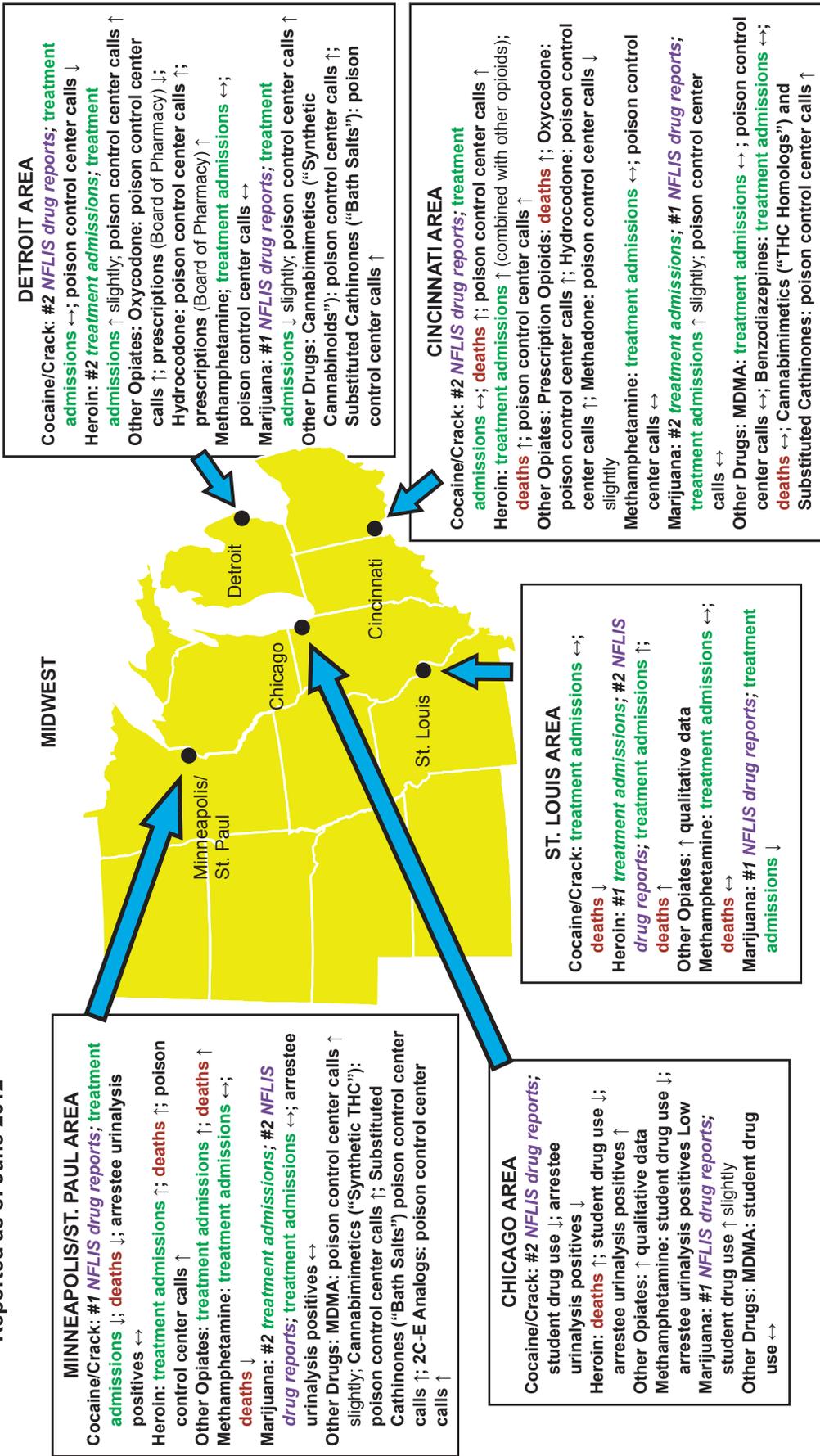
Figure 1b. Regional Highlights: West CEWG Area Reports for Denver, Honolulu/Hawaii, Phoenix, and Texas: Reported as of June 2012



SYMBOLS USED: ↑ = Increasing or Up; ↓ = Decreasing or Down; ↔ = Stable

NOTES: Most comparisons are between 2010 and 2011. Data sources include the following: **Treatment admissions data** for Denver, Hawaii, Phoenix, and Texas were provided by State Health Departments in those areas. **Death data** for Denver and Hawaii came from city and county ME’s or coroner’s offices. Deaths reported in Denver and Honolulu represent drug-related deaths. Texas death data were provided by the Department of State Health Services and were drug-involved deaths. **NFLIS drug reports data** came from the DEA NFLIS system; rankings are included in the table, but no comparisons between 2010 and 2011 data are used due to lack of comparability over time. For Denver and Colorado, the Colorado Bureau of Investigation and the Colorado Springs Police Department, respectively, did not report to NFLIS in November and December. For Colorado, data for the Colorado Denver **hospital discharge data** came from the Colorado Hospital Association; **hospital admissions data** for Phoenix came from analyses by the University of Arizona using hospital discharge data from the Arizona Department of Health Services. Heroin and other opioids are combined in Phoenix hospital admissions data. **Poison control center call data** were provided by the Texas Poison Control Network for that State. Denver data were from the Rocky Mountain Poison and Control Center. Phoenix data came from the Phoenix Poison Center. **Student drug use data** for Texas are from the YRBS. **Arrest data** for Honolulu came from the Honolulu Police Department. See section I for a description of data sources. SOURCE: June 2012 CEWG meeting materials

Figure 2. Regional Highlights: Midwest CEWG Area Reports for Chicago, Cincinnati, Detroit, Minneapolis/St. Paul, and St. Louis: Reported as of June 2012

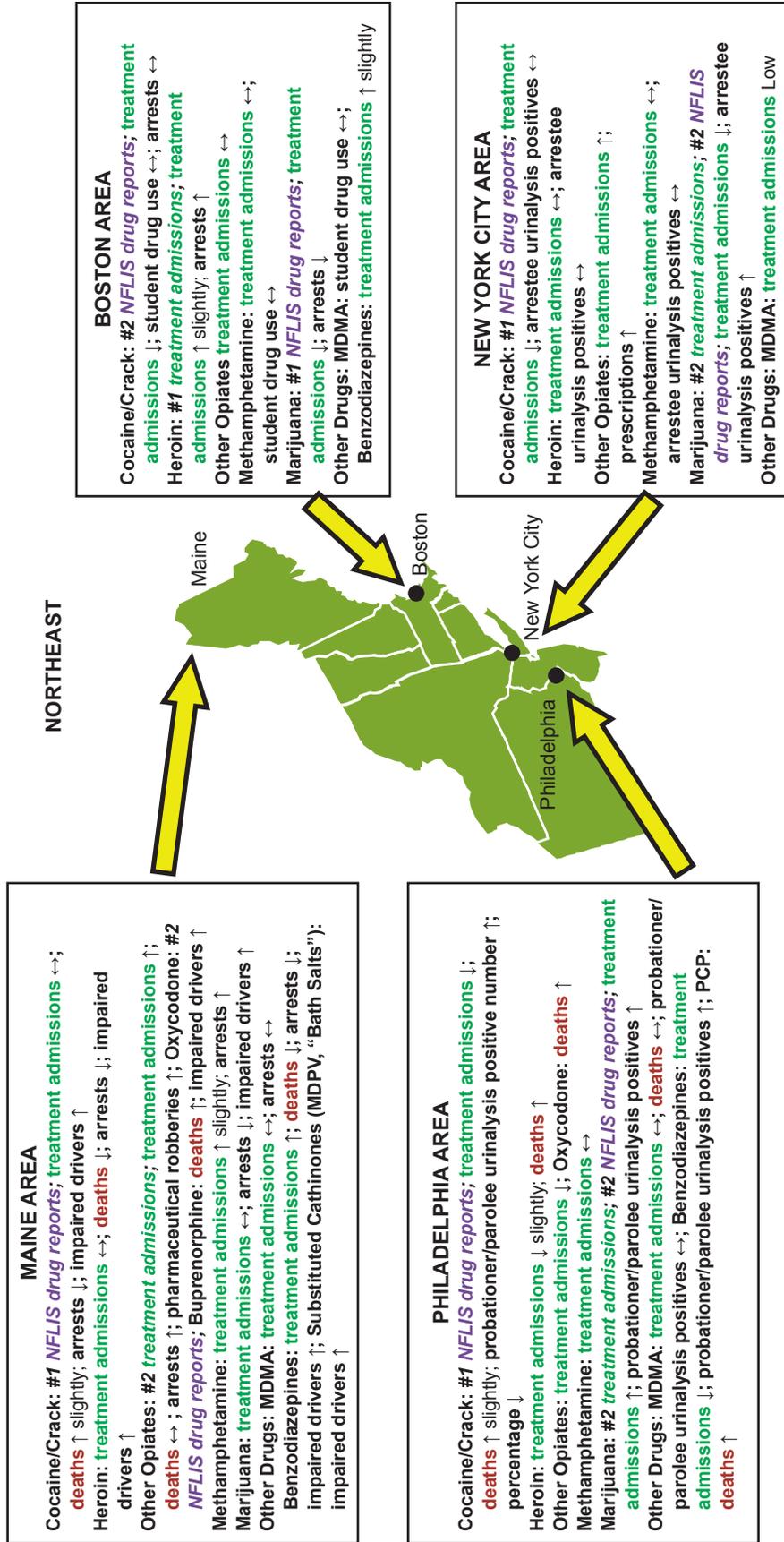


SYMBOLS USED: ↑ = Increasing or Up; ↓ = Decreasing or Down; ↔ = Stable

NOTES: Most comparisons are between 2010 and 2011. Data sources include the following: **Treatment admissions data** for the Minneapolis/St. Paul and Detroit areas came from State Health and Human Services Departments and for St. Louis from TEDS. No treatment admissions data were provided for Chicago for 2011. **Death data** for Minneapolis/St. Paul, St. Louis, Detroit, and Cincinnati came from city and county ME’s offices. Minneapolis/St. Paul data included drug-caused deaths, as well as deaths in which recent drug use contributed to the death; St. Louis data included deaths in which drugs were present; Detroit data included deaths with a positive drug toxicology; and Cincinnati data included deaths in which a drug was detected as present. **NFLIS drug report data** came from the DEA NFLIS system; Cincinnati seizure data also included data from the Cincinnati Regional Enforcement Narcotics Unit. In Detroit, the Michigan State Police Forensic Laboratory did not report for November and December. In Minneapolis/St. Paul, the St. Paul Police Department did not report for November and December. Due to noncomparability of drug report data over time, rankings for areas are reported, but 2010 and 2011 comparisons are not made in this table. **Student drug use data** for Chicago came from the YRBS. **Arrestee urinalysis positive data** for Minneapolis/St. Paul and Chicago were from the ONDCP’s ADAM II system. **Poison control center call data** for Minneapolis/St. Paul, St. Louis, Detroit, and Cincinnati came from regional poison control centers. Numbers of **prescriptions** filled in the State of Michigan for 2011 were provided by the Board of Pharmacy, Michigan Department of Health. See section I for discussion of data sources.

SOURCE: June 2012 CEWG meeting materials

Figure 3. Regional Highlights: Northeast CEWG Area Reports for Boston, Maine, New York City, and Philadelphia: Reported as of June 2012

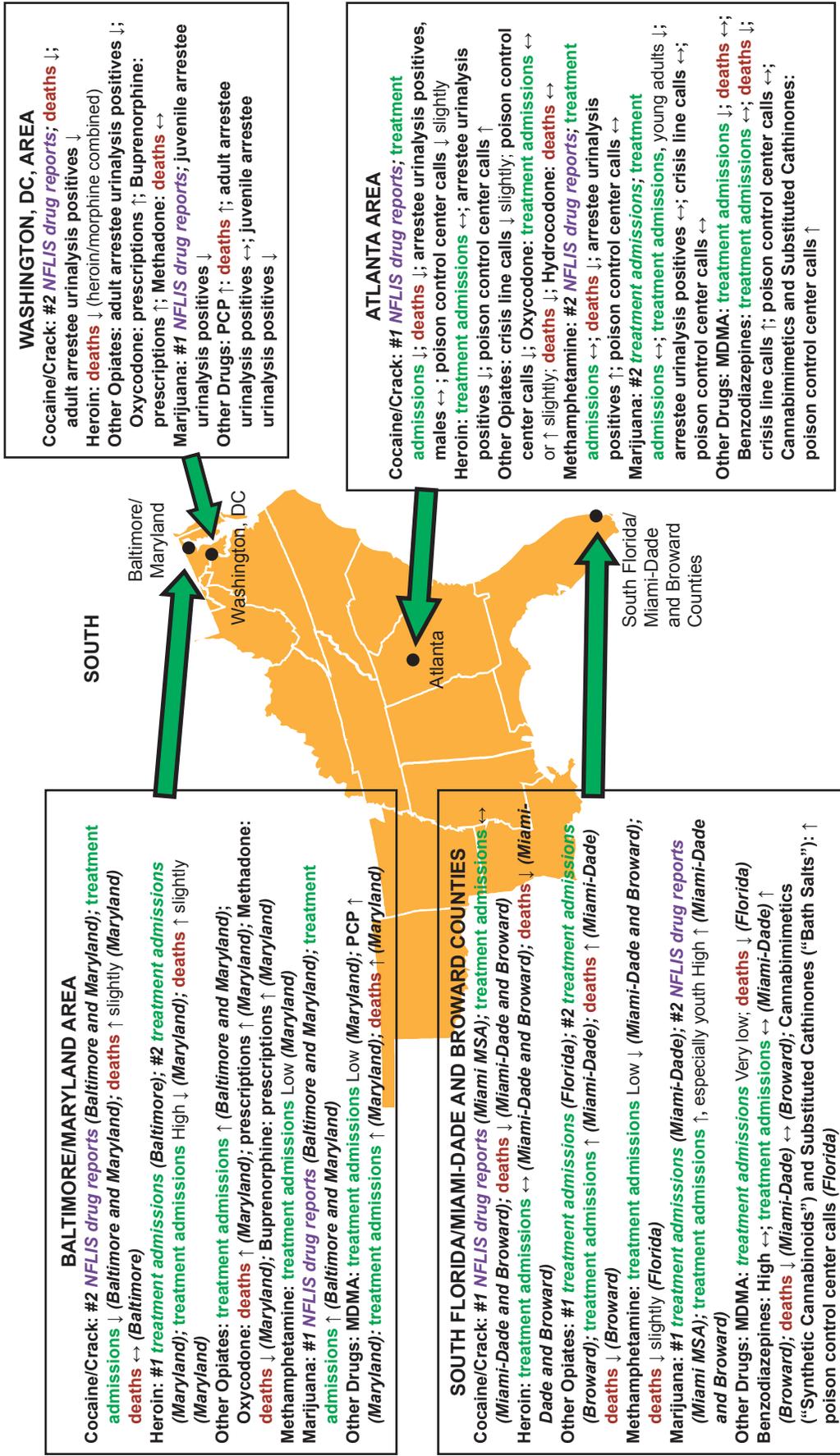


SYMBOLS USED: ↑ = Increasing or Up; ↓ = Decreasing or Down; ↔ = Stable

NOTES: Most comparisons are between 2010 and 2011. Data sources include the following: **Treatment admissions data** came from State Health Departments or State data sources in Boston, Maine, and New York City; treatment admissions data for Philadelphia were retrieved from local sources and include non-Medicaid enrolled clients (the uninsured and underinsured). **Death data** for Maine and Philadelphia came from ME's offices; data for Maine included drug-induced deaths; Philadelphia data included drug-caused deaths, as well as deaths in which a drug was detected as present. **NFLIS drug report data** for Philadelphia, Boston, and New York City came from the DEA NFLIS system; rankings are included in this table, but lack of comparability of data over time preclude comparisons of 2010 with 2011 data. Seizure data for Maine were provided by the Maine State Health and Environmental Testing Laboratory. **Probationer/parolee urinalysis positive data** for Philadelphia came from the Adult Probation/Parole Department in Philadelphia's First Judicial District; **arrestee urinalysis data** for New York City were from the ONDCP's ADAM II system. **Poison control center call data** for Florida came from the Florida Poison Information Center. **Arrest data** for Maine came from the Maine Drug Enforcement Agency and included drug arrests for possession or trafficking only; arrest data for Boston were provided by the Boston Police Department and included drug arrests for possession, distribution, manufacturing, trafficking, needle possession, and forging prescriptions. **Impaired driver data** in Maine came from urine samples from drivers suspected of driving under the influence of drugs and were provided by the Maine State Health and Environmental Testing Laboratory. **Prescription data** for New York City came from Opioid Analgesics in New York City; Prescriber Practices. New York City Department of Health and Mental Hygiene. *Epi Data Briefs* (15), May 2012. **Pharmacy robbery data** were retrieved from the Maine Department of Public Safety. See section I for a discussion of data sources.

SOURCE: June 2012 CEWG meeting materials

Figure 4. Regional Highlights: South CEWG Area Reports for Atlanta, Baltimore/Maryland, South Florida/Miami-Dade and Broward Counties, and Washington, DC: Reported as of June 2012



SYMBOLS USED: ↑ = Increasing or Up; ↓ = Decreasing or Down; ↔ = Stable
 NOTES: Most comparisons are between 2010 and 2011. Data sources include the following: **Treatment admissions data** for the South Florida/Miami-Dade and Broward Counties area were provided by the Florida Department of Children and Families, and for Atlanta, they were provided by the State Department of Human Services. Data for Washington, DC, were not available for 2011. **Death data** came from local and State ME’s offices; Baltimore/Maryland death data included deaths with drug intoxication; Washington, DC, data included drug overdose and drug-positive deaths; and South Florida/Miami-Dade County and Atlanta data included drug-related deaths (deaths in which a drug was detected). **NFLIS drug report data** came from the DEA NFLIS system. Drug rankings are reported from NFLIS data, but comparisons of 2010 with 2011 data are excluded due to noncomparability. **Arrestee urinalysis positive data** for Washington, DC, and Atlanta were from the ONDCP’s ADAM II system; additional arrestee urinalysis data for Washington, DC, were provided by the District of Columbia Pretrial Services Agency. **Crisis line call data** for Atlanta were from the Georgia Department of Human Resources. **Prescription data** for the Baltimore/Maryland/Washington, DC area were provided by DEA/ARCOS. See section I for discussion of data sources.
 SOURCE: June 2012 CEWG meeting materials

Table 1. NFLIS Top 10 Identified Drug Reports Among Drug Items Seized and Analyzed by CEWG Area by Region and Rank (Based on Frequency): January–December 2011

CEWG Areas	Cocaine/ Crack	Heroin	Oxy- codone	Hydro- codone	Alpraz- olam	Clonaze- pam	Metham- phetamine	Marijuana/ Cannabis	MDMA	PCP	Possible Levami- sole	Bupre- nor- phine	Other Drugs
SOUTHERN REGION													
Atlanta	1	7	3	5	4	—	2	6	—	—	10	—	TFMPP=8; Amphetamine=9
Baltimore City	2	3	4	—	6	10	—	1	—	—	—	5	Mannitol/Mannitol=7; Caffeine=8; 5-MeO-DIPT=9
Maryland	2	3	4	9	5	8	—	1	—	7	—	6	Methadone=10
Miami	1	5	3	—	4	—	10	2	8	—	9	—	Hallucinogen (Nonspecified)=6; Caffeine=7
Washington, DC	2	5	—	—	—	—	—	1	—	6	3	—	Caffeine=4; 5-MeO-DIPT/5- MeO-DPT=7; 1-Piperidino- cyclohexanecarbonitrile=8; Quinine=9; BZP=10
NORTHEASTERN REGION													
Boston	2	3	4	—	8	6	—	1	—	—	—	5	Naloxone=7; Amphet- amine=9; Gabapentin=10
Maine	1	4	2	6	—	—	8	3	10	—	5	7	MDPV=9
New York City	1	3	4	—	5	9	—	2	—	6	—	8	Methadone=7; Ketamine=10
Philadelphia	1	3	4	9	5	8	—	2	—	6	—	10	Codeine=7
MIDWESTERN REGION													
Chicago	2	3	—	5	8	—	—	1	4	10	7	—	BZP=6; 5-MeO-DIPT=9
Cincinnati	2	3	4	5	6	7	—	1	—	—	—	8	Diazepam=9; Methadone=10
Detroit	2	3	6	4	5	—	—	1	—	—	7	—	TFMPP=8; Caffeine=9; BZP=10
Michigan	2	3	8	4	6	—	5	1	—	—	—	—	Morphine=7; Amphet- amine=9; Methadone=10
Minneapolis/ St. Paul	1	4	6	—	—	—	3	2	—	—	8	—	Acetaminophen=5; Amphet- amine=7; 6-Monoacetylmor- phine=8 (tied with Possible Levamisole); Caffeine=10
St. Louis	3	2	7	6	5	—	4	1	—	—	—	10	Acetaminophen=8; Pseudoephedrine=9
WESTERN REGION													
Colorado	2	4	5	7	—	—	3	1	6	—	9	—	Psilocin/Psilocybin/ Psilocyn/Psilocybine=8; Acetaminophen=10
Denver	1	4	5	7	10	—	3	2	5	—	9	—	Psilocin/Psilocybin/Psilocyn=8
Honolulu	3	6	7	8	8	—	2	1	—	—	10	—	Acetaminophen=4 (tied with Dimethylsulfone)
Los Angeles	2	4	9	6	8	—	3	1	5	7	—	—	Codeine=10
Phoenix	4	3	5	7	6	10	2	1	—	—	—	9	Carisprodol=8
San Diego	3	4	8	5	10	—	1	2	7	—	6	—	Dimethylsulfone=9
San Francisco	3	5	6	4	—	—	1	2	7	—	8	—	Dimethylsulfone=9; Methadone=10
Seattle	1	3	5	—	8	—	2	4	6	—	7	—	Dimethylsulfone=8; Methadone=10
Texas	2	6	—	4	5	—	3	1	9	—	7	—	Carisprodol=8; Amphetamine=10

SOURCE: NFLIS, DEA, data for all areas were retrieved on May 7–8, 2012; see appendix table 2.1–2.24; data are subject to change and may differ according to the date on which they were queried, and drug reports include up to three drugs identified per drug item analyzed

Table 2. Top-Ranked Primary Drugs as a Percentage of Total Treatment Admissions, Including Primary Alcohol Admissions, in 23 CEWG Areas¹, by Region and Ranking: CY 2011²

CEWG Areas	Alcohol	Cocaine/ Crack	Heroin	Opiates/ Opioids, Not Heroin	Metham- phetamine	Marijuana	Benzodiaz- epines	Other Drugs
SOUTHERN REGION								
Atlanta	1	3	6	4	5	2	7	8
Baltimore City	2	4	1	5	8	3	6	7
Maryland	1	5	2	4	8	3	7	6
South Florida/ Broward County	3	4	6	2	8	1	7	5
South Florida/ Miami-Dade County	2	3	6	4	8 ³	1	7	5
State of Florida	2	4	6	1	8	3	7	5
NORTHEASTERN REGION								
Boston ⁴	2	3	1	4	7	5	6	8
Maine	1	6	4	2	8	3	7	5
New York City	1	4	3	5	8	2	7	6
Philadelphia	1	5	4	6	8	2	7	3
MIDWESTERN REGION								
Cincinnati	1	4	— ⁵	— ⁵	7 ³	2	6	5
Detroit	1	3	2	5	7	4	NR ⁶	6
Minneapolis/St. Paul	1	6	3	4	5	2	8	7
St. Louis	2	4	1	5	6	3	8	7
WESTERN REGION								
Colorado	1	4	5	6	3	2	8	7
Denver	1	5	4	6	3	2	8	7
Hawaii	2	5	6	NR ⁶	1 ³	3	NR ⁶	4
Los Angeles	2	5	3	7	4	1	8	6
Phoenix ⁷	1	6	4 ⁸	5	3	2	NR ⁶	7
San Diego	3	6	2	5	1	4	NR ⁶	7
San Francisco ⁹	1	4	3	7	2	5	8	6
Seattle	1	4	3	6	5	2	8	7
Texas	1	3	4	5	6	2	8	7

¹CEWG areas not included in the table due to lack of availability of treatment admissions data for the reporting period are Chicago and Washington, DC.

²Data are for calendar year (CY) 2011: January–December 2011. Admissions for which there was no primary drug of abuse are excluded from totals. Other Drugs category includes cases for which no primary drug of abuse was known; see appendix table 1.

³Methamphetamine and amphetamine are grouped together for the State of Florida. Methamphetamine, amphetamine, and MDMA are grouped together in Cincinnati treatment data. Hawaii reported combined methamphetamine and stimulants admissions.

⁴Treatment data for Boston do not include admissions younger than 14.

⁵Rankings are excluded because heroin and other opiates are grouped together in Cincinnati treatment data.

⁶NR=Not reported by the CEWG area representative.

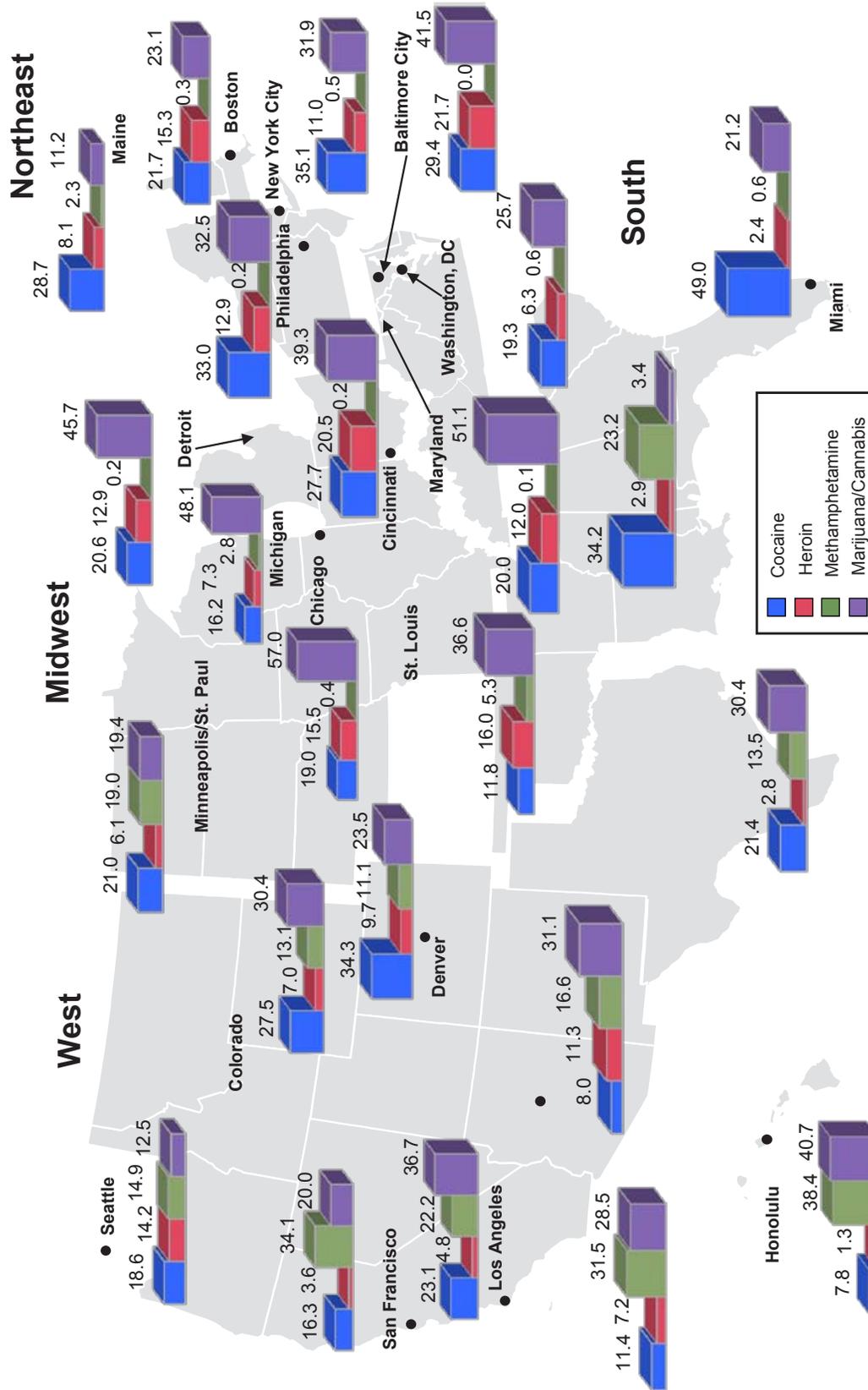
⁷Treatment data for Phoenix do not include admissions younger than 18.

⁸Heroin and morphine are grouped together in Phoenix data.

⁹Due to the implementation of a new Electronic Health Record and billing system in San Francisco in July 2010, treatment admissions data prior to that date may not be comparable to data submitted after the new system implementation. San Francisco data for 2011 are therefore preliminary and subject to change.

SOURCE: June 2012 State and local CEWG reports

Figure 5. Percentages of Cocaine, Heroin, Methamphetamine, and Marijuana/Cannabis Drug Reports Identified Among Drug Items Seized and Analyzed by Forensic Laboratories in 24 CEWG Areas in 4 U.S. Regions, Each as a Percentage of Total Drug Reports¹: 2011²



¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each selected drug item seized and analyzed.
²Data are for calendar year (CY) 2011: January–December 2011; see appendix tables 2.1–2.24. Data are subject to change. Data queried on different dates may reflect differences in the timing of data analysis and reporting.
 SOURCE: NFLIS, DEA, data for all areas were retrieved on May 7–8, 2012

Key Findings

The following represents a summary of the key meeting findings and highlights from the CEWG meeting. Key findings are summarized from meeting materials, in particular, full area reports that compose Volume II of the meeting report. Cross-area comparisons from common data sources, including treatment admissions data and NFLIS drug reports among items seized and analyzed in forensic laboratories, are contained in section III of this Volume I meeting proceedings. However, some NFLIS drug report data for Other Drugs are spotlighted and summarized in this section (see section I for data source descriptions).

Cocaine/Crack

While cocaine continued to be a drug of concern in CEWG areas in all four regions of the country, the decline in cocaine/crack indicators reported by area representatives in previous reporting periods continued in 2011. Representatives from 16 CEWG areas (Atlanta; Baltimore/Maryland/Washington, DC; Boston; Chicago; Denver/Colorado; Detroit; Los Angeles; Maine; South Florida/Miami-Dade and Broward Counties; Minneapolis/St. Paul; Phoenix; St. Louis; San Diego; San Francisco; Seattle; and Texas) reported mostly decreasing indicators. In the Northeast, the representatives from Maine, New York City, and Philadelphia reported mixed indicators (some increasing, some decreasing, and/or some stable), and the Honolulu/Hawaii representative in the West also reported mixed indicators (some increasing and some decreasing). The Cincinnati representative reported slightly increasing indicators for 2011.

- **Western Region:** Downward trends in cocaine indicators were reported in all eight CEWG areas in the West. All of the western CEWG areas reported declining primary treatment admissions for cocaine. For example, in Los Angeles, the decline that began in 2008 continued. In 2008, there were 8,662 primary cocaine admissions (15.6 percent of total admissions). These declined to 6,690 admissions (12.6 percent of the total) in 2009, 4,717 admissions (9.7 percent of the total) in 2010, and 3,906 admissions (8.5 percent of the total) in 2011. Despite declining indicators, cocaine abuse continued to be elevated in the western region CEWG areas, compared with other major drugs of abuse, except in San Diego, where cocaine indicators remained low relative to other drugs.
- **Midwestern Region:** While indicators for cocaine remained relatively high in the Chicago, Detroit, Minneapolis/St. Paul, and St. Louis areas, the declines noted by representatives from these areas in 2010 persisted in 2011. For example, the proportion of cocaine primary treatment admissions for the Minneapolis/St. Paul area declined from 14.4 percent ($n=3,166$) of all admissions in 2005 to 5.7 percent ($n=1,116$) in 2010 and 5.2 percent ($n=1,083$) in 2011. Among the three exceptions to declining cocaine indicators in the midwestern region was Cincinnati. The slight increase in cocaine indicators in Cincinnati that was reported by the area representative at the January 2012 meeting continued. In Cincinnati, both calls to poison control centers and deaths in which evidence of cocaine was documented increased. Poison control center data recorded a total of 80 cocaine (salt/crack) human exposure calls in Cincinnati during 2011, representing an approximately 43-percent increase from 56 calls in 2010. All cases involved the intentional use of cocaine

(salt/crack). The Hamilton County Coroner's Office recorded 50 deaths attributed to cocaine during 2011, representing a 51-percent increase from 33 deaths in 2010.

- **Northeastern Region:** Cocaine indicators remained relatively high in the Northeast in 2011, despite some reported declines. Cocaine levels continued to be high in Boston and in Maine, but most indicators were trending down in both areas. Cocaine indicators were very high and mixed (with some stable and some decreasing) in New York City, according to the area representative. In Philadelphia, the area representative reported that cocaine remained one of the most popular street drugs, and indicators there were high but mixed. The number of deaths in Philadelphia with the presence of cocaine in 2011 was higher ($n=264$) than in 2010 ($n=233$), a reversal of the decline observed since 2006. However, treatment admissions (primary and secondary mentions) for cocaine continued the decrease that began in 2006 (declining from $n=2,868$ in 2010 to $n=2,731$ in 2011).
- **Southern Region:** The three southern CEWG areas (Atlanta; the South Florida/Miami-Dade and Broward Counties area; and the Baltimore/Maryland/Washington, DC, area) reported continued declines in cocaine indicators in 2011. Indicators of cocaine problems in South Florida continued to be high, despite declines in cocaine-related deaths. Cocaine continued to be one of the most serious drugs of abuse in Washington, DC, according to the representative for the Baltimore/Maryland/Washington, DC, area, and urinalysis data showed that more adult arrestees tested positive for cocaine than for any other drug. The percentage of adult arrestees testing positive for cocaine had declined yearly, however, in Washington, DC, since 2006. In 2009, the proportion was 28.7 percent; this decreased to 24.0 percent in 2010 and to 21.5 percent in 2011.

Other Highlights:

- **Adulterants (Levamisole):** Several area representatives noted the continuing presence of levamisole (a potentially life-threatening contaminant) as an adulterant (cutting agent) in cocaine. Thirteen area representatives discussed levamisole in their meeting reports, mainly in relation to NFLIS drug reports among seized and analyzed drug items. These areas included Denver, San Diego, San Francisco, Seattle, and Texas in the western region; Cincinnati and Detroit in the Midwest; all four CEWG areas in the Northeast (Boston, Maine, New York City, and Philadelphia); and two areas in the southern region—Miami and Baltimore/Maryland/Washington, DC. In addition to NFLIS data, death data indicated reports of levamisole in a number of areas. In Philadelphia, levamisole was detected in 87.5 percent of cocaine-positive decedents in 2011, the highest percentage ever recorded for the substance. In 2010, levamisole was found by the ME in Washington, DC, in 15 accidental deaths and in 22 deaths overall (compared with 11 deaths overall in 2009). Cocaine was also found in each of the accidental deaths.
- Some area representatives (specifically, South Florida/Miami-Dade and Broward Counties, Minneapolis/St. Paul, and Texas) suggested that the decline in cocaine indicators across all regions of the country may be related to the decline in purity resulting from the addition of levamisole during the production process before it is sold on the streets.
- **NFLIS Drug Reports From Seized Items Identified as Possible Levamisole (Phenylimidothiazole Isomer Undetermined):** Possible levamisole ranked among the top 10 drug reports from items seized and identified in NFLIS laboratories in 14 CEWG areas. It ranked 3rd in Baltimore

City; 5th in Maine; 6th in San Diego; 7th in Chicago, Detroit, Seattle, and Texas; 8th in San Francisco and Minneapolis/St. Paul; 9th in Colorado, Denver, and Miami; and 10th in Atlanta and Honolulu (see table 1). The highest percentage of drug reports of possible levamisole in 2011 NFLIS data were for Washington, DC, at 14.9 percent of total drug reports, followed by Maine, at 5.5 percent (section III, table 25; and appendix table 2).

Heroin

Most CEWG area representatives reported continuing high indicators for heroin in 2011. Still a drug of concern in most CEWG areas, upward heroin trends were reported by area representatives for Boston, Cincinnati, Denver/Colorado, Detroit, Honolulu/Hawaii, Minneapolis/St. Paul, San Diego, Seattle, and Texas. The area representatives from Atlanta, Chicago, Los Angeles, St. Louis, and Washington, DC, reported mostly stable indicators. Mixed indicators (some stable, some declining, and some increasing) were reported by area representatives from Baltimore/Maryland, Maine, New York City, Philadelphia, Phoenix, and South Florida/Miami-Dade and Broward Counties. Decreasing indicators were reported by the San Francisco area representative.

- **Western Region:** Heroin indicators were trending upward in five of the eight western CEWG areas: Denver/Colorado, Honolulu/Hawaii, San Diego, Seattle, and Texas. Primary treatment admissions for heroin in both Colorado and Denver have increased yearly since 2008; for example, the proportion of primary heroin treatment admissions for Denver increased from 8.7 percent of total admissions in 2010 to 10.4 percent of primary treatment admissions in 2011. While primary treatment admissions for heroin were stable in 2011 in San Diego and Seattle, admissions for young adults were reported as increasing by area representatives. All indicators for heroin were stable in Los Angeles, and they were trending down in the San Francisco area. Area representatives from both Phoenix and San Francisco were reporting new forms of heroin surfacing in those areas. For many years, black tar heroin and Mexican brown heroin were essentially the only forms of the drug available in Arizona. In 2011, however, white powder heroin was being sold on the streets as well. There were several anecdotal reports from the field of a more potent form of heroin available in San Francisco in 2011. Indicators of negative consequences associated with this drug (which was commonly reported to look very similar to the usual black tar and sometimes called “gun powder”) were reported by the area representative as including increased numbers of overdoses and more requests for overdose prevention kits containing naloxone, along with some deaths.
- **Midwestern Region:** Heroin levels continued to be high relative to other drugs in all of the CEWG areas in the Midwest, and heroin indicators continued to increase in Cincinnati, Detroit, and the Minneapolis/St. Paul area, including what the area representative from Minneapolis/St. Paul reported as “unprecedented” increases in heroin indicators in that area. All midwestern CEWG area representatives reported increases in heroin use by young adults. Although levels were high in Chicago and St. Louis, heroin indicators there were assessed as mostly stable by area representatives. A sharp decline in heroin purity from 2009 to 2010 was reported by the Chicago representative, from 26.6 to 11.3 percent.
- **Northeastern Region:** CEWG representatives in the Northeast reported continuing high levels for heroin in Boston, New York City, and Philadelphia and continuing low levels in Maine in relation

to levels of other drugs. Heroin indicators were mixed (some increasing, some stable, and some declining) in Maine, New York City, and Philadelphia, but they were mostly increasing in Boston. The proportions of both primary treatment admissions for heroin and Class A drug arrests (mostly heroin) increased in Boston from 2010 to 2011.

- **Southern Region:** Indicators for heroin were stable, decreasing, or mixed in the three CEWG areas in the South. Heroin levels continued to be low relative to other drugs in Atlanta, according to the area representative, and most heroin indicators there were stable. The area representative from the South Florida/Miami-Dade and Broward Counties area also continued to report relatively low levels for heroin across the State of Florida, with mixed indicators in southern Florida. Heroin-related deaths decreased in both counties in 2011 (from $n=26$ in 2010 to an estimated $n=10$ in 2011 in Miami-Dade County and from $n=10$ to an estimated $n=2$ deaths in Broward County). Heroin indicators were mixed in Baltimore City and Maryland and mostly down in Washington, DC. For instance, while still at high levels, primary treatment enrollments for heroin were declining slightly in 2011 in both the city of Baltimore (from $n=7,710$ in 2010 to $n=6,860$ in 2011) and the State of Maryland (from $n=12,973$ in 2010 to $n=12,236$ in 2011).

Spotlight on Heroin Issues

Three trends in heroin indicators were identified by CEWG representatives from across the country: an increase in numbers and proportions of young heroin users; the emergence of indicators of heroin use in nonmetropolitan areas—mid-size and small cities and towns, as well as suburban and rural areas—of their States in addition to in larger metropolitan areas; and a relationship between indicators of the abuse of prescription opioids and heroin.

- **Younger Heroin Users:** Area representatives from all regions of the country (including representatives from Denver/Colorado, Los Angeles, San Diego, San Francisco, Seattle, and Texas in the West; all area representatives in the Midwest—Chicago, Cincinnati, Detroit, Minneapolis/St. Paul, and St. Louis; the Baltimore/Maryland/Washington, DC, representative in the southern region; and the Maine representative from the Northeast) reported problems in their areas related to increasing numbers of young adult heroin users.
- **Western CEWG Region:** Most of the CEWG area representatives from the western region, with the exception of the Honolulu/Hawaii and Phoenix representatives, reported a trend toward younger heroin users in their areas and States and younger clients entering treatment for heroin as the primary substance of abuse.
 - **Denver/Colorado:** In Denver in 2011, the average age of heroin clients entering treatment was 32.6 years; this represented a decline from 34.3 years in 2010. The Denver/Colorado representative reported that the Denver/Boulder metropolitan area experienced a decline in heroin admissions among substance abuse treatment clients age 35–44 (from 23.4 percent in 2007 to 16.9 percent in 2011), along with steady increases in percentages of clients younger than 25 from 2007 to 2011 (from 12.9 percent to 28.3 percent, respectively).
 - **Los Angeles and San Diego:** In Los Angeles, the percentage of clients age 18–34 in treatment for heroin as their primary drug problem increased from 24.0 percent of all admissions in 2004 to 40.3 percent of the total in 2011. In San Diego, clients younger than 35 constituted

65.6 percent of primary heroin admissions in 2011; this was an increase from 63.2 percent in 2010, 55.7 percent in 2009, and 48.0 percent in 2008.

- **Seattle:** In the State of Washington, first-time admissions to treatment for a primary heroin problem between the ages of 18 and 29 have been increasing since fiscal year (FY) 2007. In FY 2011, there were 820 first-time admissions in this age group in King County, an increase from 332 in FY 2008, 479 in FY 2009, and 599 in FY 2010.
- **Texas:** In Texas, the proportion of clients in their twenties increased from 35 percent of all heroin admissions in 2005 to 45 percent in 2011.
- **San Francisco:** Qualitative data by the San Francisco area representative indicated increased heroin use among youth and young adults. In the San Francisco area, multiple information sources, including research studies, treatment providers, health services data, overdose prevention programs, youth programs, human immunodeficiency virus (HIV) treatment projects, and needle exchange programs, reported young adults using heroin, according to the area representative.
- **Midwestern CEWG Region:** In the Midwest, all of the area representatives—from Chicago, Cincinnati, Detroit, Minneapolis/St. Paul, and St. Louis—reported an increase in younger heroin users in their areas and States.
 - **Chicago:** The Chicago area representative reported that recent research conducted by the area representative indicated that while African-American injection drug users were an aging cohort, new cohorts of young injectors were emerging among Whites⁸.
 - **Cincinnati, Detroit, Minneapolis/St. Paul, and St. Louis:** Combined treatment admissions data for heroin grouped together with opiates/opioids in the Cincinnati area in 2011 revealed that more than 70 percent of those admissions were between the ages of 18 and 34. There was also an increase among Detroit heroin primary treatment admissions in the proportion who were younger than 30; this age group constituted 4.9 percent in 2003 and 7.8 percent in 2011. In Michigan outside of Detroit, this age group represented 27.6 percent of primary heroin admissions in 2003 and 54.6 percent in 2011. In the Twin Cities area of Minneapolis/St. Paul, 41.6 percent of the primary admissions for heroin were age 18–25 in 2011. The proportion of treatment admissions among clients younger than 35 has been high since 2009 in the St. Louis area, according to the area representative. In 2011, approximately 69 percent of primary heroin treatment admissions were younger than 35, and 25.3 percent were younger than 25. In 2010, the percentage of clients younger than 35 was 71 percent, and in 2009, it was 68 percent.
- **Northeastern CEWG Region, Maine:** While there has been a decline in the proportion of primary heroin treatment admissions among clients age 18–25 in Maine, from a peak of approximately 50 percent of all heroin treatment admissions in 2003 to 29 percent in 2011, proportions of young

⁸Braz, D and Ouellet, LJ. Racial and ethnic changes in heroin injection in the United States: Implications for the HIV/AIDS Epidemic. *Drug and Alcohol Dependence* 2008, 44 (1–3): 221–233.

adult heroin treatment admissions clients age 26–34 have increased, from about 30 percent in 2003 to 50 percent in 2011.

- **Southern CEWG Region, Maryland:** The area representative from the Baltimore/Maryland/Washington, DC, area reported on increases in younger heroin clients in treatment in Maryland. Primary treatment enrollments for heroin in the State of Maryland for clients age 18–30 increased from 2010 to 2011. In 2011, 35.1 percent of heroin enrollments in Maryland were among clients age 18–30; in 2010, 30.6 percent of heroin clients were in this age group.
- **Heroin Indicators Outside Major Metropolitan Areas:** Several representatives from CEWG areas across the country reported both qualitative and quantitative data showing the emergence of heroin use beyond major metropolitan areas in smaller cities and towns and rural and suburban areas. These representatives included Seattle, Chicago, Cincinnati, Detroit, Minneapolis/St. Paul, St. Louis, and New York City.
 - **Chicago:** The Chicago area representative presented data suggesting that heroin use has been a substantial and increasing problem across many of Chicago’s suburbs since the 1990s. Local studies conducted of people age 30 and younger who inject drugs, almost all of whom primarily inject heroin, found that the proportion residing in the suburbs has risen from negligible levels in the early 1990s, to 30–50 percent in the late 1990s to early-2000s, and to 75 percent in the late 2000s. Another indicator of the spread of heroin to Chicago’s suburbs was the number of heroin purchases and seizures by the DuPage Metropolitan Enforcement Group in 2011 ($n=59$). It was more than three times greater than in 2008 ($n=16$). The amount of heroin seized was more than 16 times greater in 2011 ($n=1,835$ grams) than in 2008. In Will County, heroin overdose deaths reported by the coroner’s office increased from 6 in 1999 to 26 in 2011; 11 of those 2011 heroin overdose deaths involved persons younger than 30.
 - **Detroit:** Primary heroin treatment admissions proportions in metropolitan (or the city of) Detroit declined from 34.2 percent of total admissions in 2009 to 31.4 percent in 2011. Percentages of such admissions in Michigan outside of Detroit, however, increased during the same period, from 14.0 percent in 2009 to 16.6 percent in 2011.
 - **St. Louis:** In Missouri, there were 40 heroin-related deaths in rural counties around St. Louis in 2010 (reported by the ME offices for Jefferson, Franklin, and St. Charles Counties). In 2011, heroin-related deaths in these counties rose to 85.
 - **Cincinnati and Seattle:** The Cincinnati area representative noted the role of motorcycle gangs in disseminating drugs to nonmetropolitan areas, and the Seattle area representative noted a possible shift in methamphetamine coming from Mexico, influencing the heroin supply in nonmetropolitan areas of the State of Washington.
- **A Relationship Between Prescription Opioids and Heroin Use/Abuse:** Some area representatives continued to report a relationship between indicators of heroin use and the use of prescription opioids. Both qualitative (such as anecdotal reports) and quantitative data (such as death data involving both heroin and prescription opioids, and treatment data in which clients state that they started to use prescription opioids before switching to heroin) indicate in several CEWG areas that

heroin consequences also involve nonmedical use of prescription opioids. For example, according to the Denver/Colorado area representative, **Denver** area clinicians continued to report seeing an increase in the number of young heroin users. These providers report that it is not uncommon for young patients who have been prescribed prescription opioids after an injury to start doctor-shopping and, ultimately, to buy prescription opioids on the street. Once the cost gets prohibitive, they switch to heroin, which is less expensive. Reportedly, new users start by smoking or snorting, but eventually they begin to inject. Prescription drug suppliers on the street also offer heroin eventually, thus introducing some new users to heroin. In **San Francisco**, the area representative reported that sources in the field suggested that when young prescription drug users are unable to obtain additional pills from legitimate medical sources, they may begin to purchase opiates from dealers or move to heroin use. According to the area representative from **Minneapolis/St. Paul**, anecdotal reports indicate that young adults entering treatment for heroin report initially using prescription opiates and eventually progressing to heroin addiction.

Opiates/Opioids Other Than Heroin (Narcotic Analgesics)

All area representatives except one (from Seattle) reported increasing, stable, or mixed indicators for other opiates/opioids. Indicators for other opiates/opioids were increasing in 2011 in Baltimore/Maryland/Washington, DC; Denver/Colorado; Detroit; Maine; Minneapolis/St. Paul; New York City; Philadelphia; Phoenix; St. Louis; San Francisco; and Texas, as reported by the area representatives. In Chicago, Cincinnati, Los Angeles, San Diego, and the South Florida/Miami-Dade and Broward Counties areas, CEWG representatives reported stable indicators. Mixed indicators (with some increasing and some stable) were reported for Atlanta and Boston by the representatives there. The area representative from Seattle in the West reported slightly declining indicators, although indicators of other opiates/opioids continued to be prevalent in that area. Hydrocodone and oxycodone were the prescription opioids appearing most frequently in indicator data in 2011, as was the case in 2009 and 2010, but concerns about buprenorphine and methadone continued to be reported in some CEWG areas. The Texas area representative continued to report on the drug combination of hydrocodone, alprazolam, and carisoprodol, which is called the “Houston Cocktail” or the “Holy Trinity,” and the continuing abuse of codeine cough syrup and products that imitate codeine cough syrup. Increases in the proportions of younger clients entering treatment for prescription opioids were reported by area representatives from Baltimore/Maryland/Washington, DC; Detroit; San Francisco; and South Florida/Miami-Dade and Broward Counties.

- **Western Region CEWG Areas:** The CEWG area representatives from Denver/Colorado, Honolulu/Hawaii, San Diego, San Francisco, and Texas reported increasing indicators for other opiates/opioids in those areas in 2011. The Los Angeles area representative reported mostly stable indicators. Although most indicators were stable in San Diego, overdose deaths with prescription opioids (oxycodone, hydrocodone, or codeine) detected increased slightly in that area from 2010 to 2011. Namely, deaths with oxycodone detected increased from 51 in 2010 to 68 in 2011; deaths with hydrocodone detected increased from 49 to 60; and deaths with codeine detected increased from 64 to 99. In San Francisco, methadone was detected in 33 percent of drug-related ME deaths in 2010 (ranking second), and the rate of methadone across all ME deaths was 10 percent, an increase from 2009. The Seattle area representative was the only representative at the June 2012 meeting to report declining levels and indicators for other opiates/opioids. Primary treatment

admissions and calls to the helpline for prescription other opiates/opioids were reported as down in 2011, compared with 2010, and deaths involving prescription opioids declined for the second year in a row to 120 deaths in 2011 (from a peak of 161 in 2009).

- **Midwestern Region CEWG Areas:** Indicators for other opiates/opioids remained stable in Chicago and Cincinnati, and indicators were reported as increasing in Detroit, Minneapolis/St. Paul, and St. Louis. In Detroit, the number of poison control center (PCC) calls for intentional human usage of hydrocodone increased in 2011 ($n=732$), compared with 2009 ($n=541$). Calls for intentional human exposure to oxycodone also increased, from 105 in 2010 to 127 in 2011. In Minnesota, the number of dosage units seized for oxycodone increased by approximately 174 percent from 2010 ($n=944$) to 2011 ($n=2,586$), according to the Minnesota Drug Task Force, as reported by the Minneapolis/St. Paul area representative. The Cincinnati representative continued to report on increases in calls involving buprenorphine to PCCs in Cincinnati and Ohio. In 2011, 856 identification calls were received by the Cincinnati Drug and Poison Information Center for buprenorphine-containing pharmaceuticals, an approximately 128-percent increase from 2010. Because 41 percent of the buprenorphine human exposures reported to PCCs in Ohio in 2011 involved children younger than 3, the area representative suggested that buprenorphine remains an area for increased education about storage practices. In addition, 31 percent of the buprenorphine human exposures in Cincinnati in 2011 involved intentional misuse or abuse of buprenorphine; this was a 10-percent increase from 2010.
- **Northeastern Region CEWG Areas:** The area representative from Boston reported moderate levels and mixed indicators for other opiates/opioids (with some indicators increasing and some stable from previous reporting periods). Most indicators for other opiates/opioids were increasing in Philadelphia, and although the level remained relatively low in New York City, other opiates/opioid indicators were reported as increasing slightly in that area. Levels for other opiates/opioids continued to be high in Maine, with increasing indicators. Arrests for possession and trafficking of narcotic analgesics, primary other opiates/opioid treatment admissions, impaired drivers testing positive for other opiates/opioids, along with the number of related pharmacy robberies (demanding prescription opioids), all increased in Maine in 2011 and in the first quarter of 2012. Primary treatment admissions for other opiates/opioids have increased yearly in Maine for the past decade; they constituted 35 percent of all primary admissions in 2011, which was an increase from 32 percent in 2010. Buprenorphine has emerged as a key component of other opiates/opioid indicators in Maine, according to the area representative. Buprenorphine was involved in five deaths during 2010 and two in the first half of 2011. It ranked sixth among all substances confirmed in law enforcement seizures in 2011, and the drug was found in 11 percent of drug impaired driver urinalyses in 2011, compared with 7 percent in 2010.
- **Southern Region CEWG Areas:** While indicators for other opiates/opioids continued to be high in the South Florida/Miami-Dade and Broward Counties area, they stabilized in this reporting period, according to the area representative. Despite the stability in other opiate/opioid indicators in these two southern counties, prescription opioids became the leading category for primary addiction treatment admissions in the State of Florida for the first time, ranking above all other drugs during 2011. Numerous new laws and regulations to control prescription diversion took effect in the second half of 2011. The representative from Atlanta reported mixed indicators for other opiates/opioids, with poison control center calls and crisis center calls decreasing, treatment admissions increasing, and ME death data stable or slightly declining for oxycodone and hydrocodone in the

current reporting period. Other opiate indicators were mostly increasing in the Baltimore/Maryland/Washington, DC, area. Based on ARCOS data, retail distribution of oxycodone and buprenorphine continued the yearly increases that began in 2005 in Baltimore City and Washington, DC. For example, in Washington, DC, the retail distribution of buprenorphine increased from 224 grams in 2005 to 2,767 grams in 2011. Oxycodone distribution increased from 51,636 grams in 2005 to 83,657 grams in 2011. Both methadone-related ($n=164$) and oxycodone-related ($n=152$) deaths outnumbered cocaine-related ($n=139$) deaths in Maryland in 2011.

Other Highlights

- **Young Adults in Treatment for Prescription Opioids:** A predominance of and often an increase in young clients in treatment for prescription other opiates/opioids were reported by area representatives from Florida; Baltimore/Maryland/Washington, DC; Detroit; and San Francisco.
 - **Florida:** In the State of Florida in 2011, treatment clients between the ages of 18 and 30 constituted a majority (approximately 62 percent) of all primary prescription opioid treatment admissions (stable from 61 percent in 2010), as reported by the South Florida/Miami-Dade and Broward Counties representative.
 - **Maryland:** Treatment enrollments in the State of Maryland for clients age 18–30 constituted the majority of enrollments in 2011 with prescription opiates as their primary problem, as reported by the Baltimore/Maryland/Washington, DC, area representative (62.8 percent, compared with 63.5 percent in 2010).
 - **Detroit and Michigan:** The area representative from Detroit reported increases in the proportions of treatment admissions who were younger than 30 among people admitted for other opiates treatment in both the city of Detroit and the State of Michigan. In Detroit, the proportion rose from 21.3 percent in 2003 to 28.5 percent in 2011, while in Michigan outside of Detroit, the increase was from 39.7 percent in 2003 to 50.4 percent in 2011.
 - **San Francisco/California:** In San Francisco, the area representative reported that many diverse data sources (research studies, treatment providers, data collected from health services programs, overdose prevention projects, youth treatment programs, HIV treatment projects, and needle exchange programs) reported young adults using prescription opiates. Some reports suggested that youth access prescription opioids by raiding legitimate prescriptions of family members, and when they are unable to obtain additional pills, they may begin to purchase opiates from dealers or progress to heroin use. There were several reports of attempts to render opiate pills suitable for snorting, smoking, or injection, the latter of which resulted in injection-site injuries and vein damage associated particularly with the new “tamper-proof” formulations of prescription opiates. There were numerous reports of young other opiates/opioid users seeking substance abuse treatment, primarily for problems with buprenorphine or methadone.
- **Codeine Drinks:** The Texas area representative continued to report on the abuse of codeine cough syrup mixed in sweet soft drinks and noted that this phenomenon has been popularized by rap music that celebrates “sippin’ syrup.” The Chicago representative also reported the continuing popularity of “Lean” (a drink made with codeine, soda, and Jolly Rancher candies), which was sometimes combined with ecstasy in that area.

Benzodiazepines/Depressants

Seventeen of the 20 CEWG area representatives reporting at the June 2012 meeting included indicator data for benzodiazepines. Alprazolam indicators continued to be reported as high in the Midwest in Cincinnati and in the South Florida/Miami-Dade and Broward Counties area in the South, but they were seen as stabilizing in both areas in 2011. Benzodiazepine indicators were also reported to be stable in Los Angeles in the West. Mixed indicators (some stable and some increasing) were reported in the Denver/Colorado area in the West; Atlanta in the South; and Boston, Maine, and Philadelphia in the Northeast. Alprazolam continued to be the benzodiazepine occurring most frequently in indicator data, but clonazepam appeared among the top 10 NFLIS drug reports in items seized and identified in Baltimore City, Boston, Cincinnati, Maryland, New York City, Philadelphia, and Phoenix.

- **Western Region CEWG Areas:** Benzodiazepine indicators continued to be reported as low and stable in the Los Angeles area, and they were seen as low and mixed in the Denver/Colorado area. Alprazolam continued to have a presence in Texas, according to the area representative, as one of the ingredients in the “Houston Cocktail,” along with hydrocodone and carisoprodol.
- **Midwestern Region CEWG Areas:** Although indicators were stabilizing in 2011 in Cincinnati, levels of abuse of benzodiazepine-based prescription drugs there remained high based on calls to poison control centers, according to the area representative. Poison control center data showed 1,089 intentional human exposure cases related to benzodiazepines in 2011, compared with 1,044 such cases in 2010. Of these 2011 cases, 31.5 percent involved alprazolam, and another 35.6 percent involved clonazepam.
- **Northeastern Region CEWG Areas:** In the Northeast, CEWG representatives from both Boston and Maine reported moderate levels and mixed indicators for benzodiazepines (some stable and some increasing in Boston and some decreasing and some increasing in Maine). Benzodiazepine indicators were also mixed in Philadelphia in 2011. Benzodiazepines, particularly alprazolam, continued to be reported as popular, according to focus group participants, and they were used in combination with other drugs in Philadelphia, based on death and treatment admissions data. Treatment admissions for benzodiazepines (primary and secondary mentions) in Philadelphia declined from 738 in 2010 to 675 in 2011. However, Adult Probation and Parole Department urinalysis data of adults on probation or parole in 2011 revealed the presence of benzodiazepines in 7.8 percent of all individuals tested; this represented the highest percentage in the last 5 years. In addition, alprazolam was detected in 155 drug intoxication deaths in Philadelphia in 2011, which was an increase from 120 in 2010.
- **Southern Region CEWG Areas:** Benzodiazepine abuse in general, and specifically alprazolam, was reported as continuing at high levels in South Florida, particularly when benzodiazepines were used in combination with other substances. The area representative from South Florida/Miami-Dade and Broward Counties reported that numbers of alprazolam reports among decedents in South Florida continued to be high and slightly lower than those for opioids. Benzodiazepines were found most often in combination with other opioids in these deaths. Numbers of alprazolam or diazepam reports detected in benzodiazepine-related deaths in Miami-Dade County were stable, with 80 deaths involving both in the first half of 2011, compared with 169 in all of 2010. Such

deaths were reported as declining, however, in Broward County, based on detection of alprazolam or diazepam in 138 benzodiazepine-related deaths in the first half of in 2011, compared with 315 such deaths in all of 2010.

Methamphetamine

In 2011, methamphetamine indicators continued to be higher in the West than in other regions of the country, based on area representatives' reports. In the western CEWG region, methamphetamine indicators were stable in Phoenix and Seattle and mixed (some indicators increasing, some decreasing, and some stable) in Denver/Colorado, Honolulu/Hawaii, Los Angeles, and San Diego. Indicators for methamphetamine were increasing according to the area representatives in San Francisco and Texas. In the Midwest, methamphetamine indicators were assessed as moderate to low in all areas. They were mostly stable in Chicago, Cincinnati, and St. Louis, and they were decreasing in Minneapolis/St. Paul, according to the area representatives. The Atlanta representative in the South reported low and stable methamphetamine indicators. Methamphetamine indicators continued to be reported as low or very low relative to other drugs in all four CEWG areas in the Northeast. Levels of methamphetamine indicators were assessed as very low by the representative from Baltimore/Maryland/Washington, DC. They were reported as low and decreasing by the South Florida/Miami-Dade and Broward Counties representative.

- **Western Region CEWG Areas:** While indicators for methamphetamine continued to be reported as mixed in the Denver/Colorado, Los Angeles, and San Diego areas and stable in Phoenix and Seattle, they were described as mostly increasing in this reporting period in San Francisco and Texas. For example, in Texas, calls to poison control centers related to methamphetamine in the State increased slightly from 180 in 2010 to 212 in 2011. Methamphetamine indicators in the San Francisco Bay area remained high, and primary treatment admissions for methamphetamine continued to rank second only to alcohol in 2011. In Hawaii, methamphetamine indicators have continued to be high for many years, according to the area representative, and methamphetamine continued to rank high relative to other drugs in several indicators in 2011 in that State. Indicator trends for methamphetamine in that area were mixed, however, with a decrease in methamphetamine-related arrests in Honolulu and increases in both methamphetamine-related deaths in Oahu and primary treatment admissions in the State.
- **Midwestern Region CEWG Areas:** The area representatives from Chicago and Detroit in the Midwest continued to report very low levels and low indicators for methamphetamine in those areas. In Cincinnati and St. Louis, methamphetamine indicators, including primary treatment admissions, were reported as relatively low and stable, according to the CEWG representatives. Overall, methamphetamine indicators in the Minneapolis/St. Paul area continued the decline that began in 2005. However, while primary treatment admissions for methamphetamine in the Twin Cities area were stable from 2010 to 2011, accounting for 6.4 percent of total admissions each year, methamphetamine-related deaths declined. In Ramsey and Hennepin Counties combined, there were 10 methamphetamine-related deaths in 2011, compared with 13 in both 2009 and 2010.

- **Northeastern Region CEWG Areas:** Indicators for methamphetamine continued to be reported as low in Boston, New York City, and Philadelphia, according to those area representatives. The Maine representative, however, reported that although indicators remained low in the State of Maine, primary treatment admissions, arrests, and law enforcement seizures related to methamphetamine were increasing in this reporting period. In addition, confirmed clandestine methamphetamine laboratories (“one pot, shake and bake”) quadrupled in the State of Maine from 2011 to January–May 2012 (from 5 laboratories in 2011 to an estimated 22 in 2012, based on the first 5 months of the year).
- **Southern Region CEWG Areas:** Indicators for methamphetamine were reported as low in relation to other drugs in the southern CEWG area. The Baltimore/Maryland/Washington, DC, area representative continued to report very low indicators for methamphetamine in that area. In Atlanta, indicators for the drug were low and mostly stable, and in the South Florida/Miami-Dade and Broward Counties area, they were low and mostly declining. Deaths related to methamphetamine were down in 2011 compared with 2010 in both areas. Primary treatment admissions for methamphetamine in the Atlanta metropolitan area have been stable, between 5 and 6 percent of total treatment admissions, since 2009. In Miami-Dade County, numbers of primary methamphetamine treatment admissions decreased from 22 in 2010 to 17 in 2011 (accounting for 0.3 percent of admissions); in Broward County, methamphetamine primary admissions decreased from 34 admissions in 2010 to 12 in 2011 (accounting for 0.2 percent of admissions).

Marijuana/Cannabis

Area representatives from all CEWG areas continued to report high levels for marijuana/cannabis indicators in 2011, and marijuana continued to be widely available across all areas. Marijuana/cannabis indicators were reported as increasing in Honolulu/Hawaii, Los Angeles, and Phoenix in the western CEWG region; Chicago in the Midwest; and in the Baltimore/Maryland/Washington, DC, areas in the South. CEWG representatives reported indicators to be stable in three areas in the West—San Diego, Seattle, and Texas. They were stable in four of the areas in the midwestern region (Cincinnati, Detroit, Minneapolis/St. Paul, and St. Louis), in Atlanta in the South, and in Philadelphia in the Northeast, as reported by the representatives. Indicators were mixed in Boston (where some indicators were stable and some declined), Maine (where some were stable, some declined, and some increased), and New York City (where indicators were stable, increased, or decreased). One area representative, from San Francisco in the western region, reported mostly declining marijuana/cannabis indicators. Several area representatives reported on the effects of recently implemented medical marijuana/cannabis legislation or policy changes in their areas, including representatives from Boston, Denver/Colorado, Detroit, Maine, and Seattle.

- **Western Region CEWG Areas:** Three representatives in the western CEWG region—from Honolulu/Hawaii, Los Angeles, and Phoenix—reported increasing marijuana indicators. In the Phoenix area, for example, the proportion of primary treatment episodes for marijuana continued a 5-year increase, representing 24 percent of all admissions in 2011, up from 17 percent in 2010. Marijuana indicators were stable in San Diego, Seattle, and Texas, according to those area representatives. The Seattle representative described marijuana use as “pervasive,” based on numbers of treatment admissions, calls to the Help Line, and large numbers of indoor grow operations. The

representative noted, however, that a proposed policy change that would allow possession of a 60-day supply (or 15 plants) may further increase availability in the future. In the Denver/Colorado area, marijuana indicators were seen as mixed, with some stable and some declining. Supply and demand for marijuana in that area continued to be very high, as reported by the area representative, and a large influx of marijuana care centers (due to the medical marijuana law in Colorado) appeared to be contributing to the high quality, availability, and use of marijuana. The representative from San Francisco reported a continuing decline in marijuana indicators, with primary treatment admissions for marijuana decreasing from 3,226 admissions in 2008 to 2,778 in 2009, to 2,388 in 2010, and to 2,110 in 2011 (although 2011 data are preliminary and subject to change).

- **Midwestern Region CEWG Areas:** In 2011, four area representatives in the Midwest—from Cincinnati, Detroit, Minneapolis/St. Paul, and St. Louis—reported high and stable indicators for marijuana. While most marijuana indicators in these areas were seen as stable in 2011, calls to the Poison Control Center in Detroit about intentional human exposure to marijuana rose to 112 calls in 2011 from 98 in 2010. Marijuana/cannabis continued to be the most widely available and used illicit drug in Chicago and Illinois, according to the area representative, who reported increasing indicators in 2011. According to police and DEA data in Chicago, there were substantial increases in large marijuana seizures and in local grow houses.
- **Northeastern Region CEWG Areas:** The representatives from New York City and Philadelphia reported continuing high levels for marijuana indicators in their areas in 2011. Indicators in New York City were assessed as mixed (with some increasing and some decreasing), and they were stable in Philadelphia, according to the area representatives. The CEWG representatives from Boston and Maine reported moderate levels for marijuana indicators with mixed trends in 2011. Representatives from both Boston and Maine reported substantial decreases in arrests due to recent marijuana legislation adopted in their States. Legislation passed in 2009 in Massachusetts decriminalized small amounts of marijuana/cannabis; in Maine, a new State medical marijuana law has resulted in licensed marijuana distributors. The percentage of marijuana drug arrests in Maine was down, from 23 percent of all drug-related arrests in 2010 to 11 percent in 2011. In Boston, the proportion of Class D drug arrests (mainly marijuana) continued to decline; these arrests constituted 18 percent of all arrests in 2011, compared with 21 percent in 2010.
- **Southern Region CEWG Areas:** All representatives in the southern region reported high levels of marijuana use in their areas. The Atlanta area representative reported that although indicators there continued to be stable, marijuana continued to be the most commonly used illicit drug in Atlanta, based on primary treatment admissions data. Area representatives from the Baltimore/Maryland/Washington, DC, and South Florida/Miami-Dade and Broward Counties areas reported high and increasing marijuana indicators. The representative from South Florida reported that consequences of marijuana use and addiction (including deaths and treatment admissions) continued at high levels in the two South Florida counties, particularly among adolescents and young adults. In Miami-Dade County, among the 2011 primary marijuana treatment clients, 63 percent were younger than 18 (compared with 60 percent in 2010), and 19 percent were age 18–25 (compared with 22 percent in 2010). In Broward County in 2011, 55 percent of the primary marijuana treatment clients were younger than 18 (compared with 47 percent in 2010), and 27 percent were age 18–25 (compared with 30 percent in 2010).

Other Drugs

As in previous recent reporting periods, MDMA indicators were reported as low or very low in 2011 across all CEWG regions, compared with most other drug indicators. The primary data source for these other drugs is NFLIS drug reports; cross-area results for MDMA and selected other drugs are described in section III of this report.

Spotlight on New Synthetic or “Designer” Drugs (Cannabimimetics and Substituted Cathinones)

Cannabimimetics

Cannabimimetics⁹ (drugs that imitate the effects of cannabinoids, also called synthetic cannabinoids) have been detected in products marketed under various names, including “Spice” and “K2.” These cannabimimetics bind to the same receptors in the body as THC (tetrahydrocannabinol), the primary psychoactive component of marijuana. Some of these compounds, however, bind more strongly to the receptors, which could lead to much more powerful and unpredictable effects. These compounds have not been fully characterized for their effects and their toxicity in humans. Reported use of products containing cannabimimetics has been linked to ED visits and calls to poison control centers. On June 26, 2012, the Synthetic Drug Abuse Prevention Act of 2012 was passed, placing 26 synthetic drugs in Schedule I under the Controlled Substances Act to avoid an imminent hazard to public safety¹⁰. This legislation was revised prior to passing to include not just the cannabimimetics, but also to include Mephedrone and MDPV as well as phenethylamines, including 2C-E, 2C-D, 2C-C, 2C-I, 2C-T-2, 2C-T-4, 2C-H, 2C-N, and 2C-P.

- **NFLIS Drug Reports From Seized Items Identified as Cannabimimetics:** The Synthetic Drug Abuse Prevention Act of 2012 designated the following cannabimimetic agents as Schedule I drugs: CP-47,497; CP-47,497 C8-homolog; JWH-018 and AM678; JWH-073; JWH-019; JWH-200; JWH-250; JWH-081; JWH-122; JWH-398; AM2201; AM694; SR-19 and RCS-4; SR-18 and RCS-8; and JWH-203. None of these substances ranked among the top 10 drug reports from drug items seized and analyzed in NFLIS laboratories in any CEWG area in 2011. However, 1 or more of these cannabimimetics was identified in 21 CEWG areas—Atlanta, Boston, Chicago, Cincinnati, Colorado, Denver, Detroit, Honolulu, Los Angeles, Maine, Maryland, Miami, Michigan, Minneapolis/St. Paul, New York City, Phoenix, St. Louis, San Diego, Seattle, Texas, and Washington, DC.¹¹

⁹More information about the cannabimimetics can be found at: <http://www.whitehouse.gov/ondcp/ondcp-fact-sheets/synthetic-drugs-k2-spice-bath-salts>; <http://www.drugabuse.gov/drugs-abuse/emerging-drugs>; <http://www.drugabuse.gov/publications/drugfacts/spice-synthetic-marijuana>; and http://www.deadiversion.usdoj.gov/drugs_concern/spice/index.html.

¹⁰Because this Federal legislation uses the term “cannabimimetic” to describe synthetic cannabinoids, the term is used in this report, along with the street names for the substances (e.g., Spice and K2).

¹¹The total number of reports were as follows: Texas: 1,850 (544=AM-2201; 303=JWH-122; 209=JWH-018; 231=JWH-210; 165=synthetic cannabinoid; 115=JWH-250; 69=JWH-081; 44=JWH-073; 34=JWH-203; 29=RCS-4; 17=JWH-019; 2=AM-694;2=JWH-201; 2=synthetic tetrahydrocannabinol; 1=CP 47,497-C9 homolog; 1=JWH-200; 1=JWH-302); Maryland: 370 (172=AM-2201; 56=JWH-018; 36=JWH-210; 35=JWH-122; 33=JWH-250; 10=JWH-073; 8=JWH-019; 6=RCS-4; 5=JWH-081; 3=JWH-203; 2=JWH-251; 2=synthetic cannabinoid; 1=synthetic

- Twelve CEWG area representatives from the following areas reported on continuing or increasing concerns regarding the use of cannabimimetics and related products: Atlanta, Chicago, Cincinnati, Denver/Colorado, Detroit, Los Angeles, Minneapolis/St. Paul, Philadelphia, Phoenix, South Florida/Miami-Dade and Broward Counties, Seattle, and Texas.
- **Calls to Poison Control Centers in CEWG Areas Involving Cannabimimetics (Synthetic Cannabinoids or THC Homologs):** Human exposure calls for cannabimimetics and other cannabimimetic-related calls¹² to poison control centers increased in 2011 in all four CEWG regions of the country. The area representative from **Atlanta** reported that the number of human exposure calls concerning synthetic cannabinoids to the Georgia Poison Control Center increased from 3 calls in 2010 to 154 calls in 2011. Calls to the **Cincinnati** Drug and Poison Control Information Center related to THC homologs also showed substantial increases in 2010 and the 2011 reporting period, from 16 calls in 2010 to 117 in 2011. A growing concern about the use and abuse of cannabimimetics continued in the **Denver/Colorado** area, as reported by the area representative. The Rocky Mountain Poison and Drug Center recorded 44 synthetic cannabinoid exposure calls in 2011, a similar number from 2010. In **Detroit**, the area representative reported that there were 224 THC homolog calls to the Poison Control Center in 2011 and 126 in 3 months from January to March 2012. The **Minneapolis/St. Paul** representative reported an increase in reported human exposures related to THC homologs to the Hennepin Regional Poison Center, from 28 calls in 2010 to 149 calls in 2011. The **Phoenix** Poison Center reported 190 cases involving THC homologs in 2011; this compared with 51 cases reported in 2010. The area representative from the **South Florida/Miami-Dade and Broward Counties** area reported an 876-percent increase in calls to Florida Poison Information Centers for human exposure to synthetic cannabinoids from 2010 to 2011 (there were 516 such calls in 2011). From 2010 to May 2012, the **Texas** Poison Center Network received 1,339 calls involving human exposures to synthetic cannabinoids, as reported by that area representative.

Substituted Cathinones

Substituted cathinones include mephedrone (4-methylmethcathinone or 4-MMC), methyldone (N-methyl-3,4-methylenedioxycathinone or bk-MDMA), and MDPV (3,4-methylenedioxyprovalerone). One or more synthetics have been detected in products labeled as “bath

tetrahydrocannabinol; 1=JWH-200); Chicago: 223 (75=JWH122; 69=JWH-018; 43=AM-2201; 14=JWH-073; 9=JWH-210; 6=JWH-081; 5=JWH-250; 2=JWH-203); St. Louis: 209 (70=AM-2201; 37=JWH-122; 26=JWH-250; 24=JWH-081; 23=JWH-018; 17=JWH-210; 4=AM-694; 3=JWH-073; 2=RCS-4; 2=RCS-8; 1=JWH-203); Michigan: 130 (76=JWH-250; 52=JWH-018; 2=JWH-073); Minneapolis/St. Paul: 81 (24=JWH-122; 20=AM-2201; 12=JWH-081; 10=JWH-203; 9=JWH-250; 4=JWH-018; 1=JWH-210; 1=RCS-4); Atlanta: 38 (24=JWH-250; 8=JWH-018; 4=JWH-081; 2=AM-2201); Colorado: 28 (14=JWH-018; 5=AM-2201; 4=JWH-081; 3=JWH-250; 2=synthetic cannabinoid); Detroit: 28 (13=JWH-018; 15=JWH-250); San Diego: 24 (18=JWH-250; 12=JWH-018; 3=JWH-073; 1=JWH-019); Miami: 21 (19=JWH-018; 1=AM-2201; 1= synthetic tetrahydrocannabinol); Cincinnati: 18 (16=AM-2201; 1=JWH-250; 1=RCS-4); Phoenix: 17 (10=JWH-018; 6=JWH-250; 1=JWH-073); Denver: 16 (5=AM-2201; 4=JWH-018; 4=JWH-081; 3=JWH-250); Honolulu: 14 (3=JWH-210; 2=JWH-018; 2=JWH-073; 2=JWH-122; 2=JWH-250; 2=RCS-4; 1=AM-2201); Los Angeles: 11 (11= synthetic tetrahydrocannabinol); Seattle: 7 (4=AM-2201; 1=JWH-018; 1=JWH-122; 1=JWH-250); Washington, DC: 5 (2=AM-2201; 2=JWH-018; 1=JWH-250); Boston: 3 (2=JWH-018; 1=JWH-073); New York City: 2 (1=JWH-018; 1=JWH-250); and Maine: 1 (AM-2201).

¹²Poison control center data are reported here as they are reported by area representatives in their full area reports and slide presentations. The terminology used by area representatives in this report does not necessarily mean that particular substances, such as cannabimimetics (also known as synthetic cannabinoids and THC homologs) are chemically verified.

salts,” “insect repellent,” “plant food,” or “stain remover,” and they are marketed under various names, including “White Lightning,” “Zoom,” “Euphoria,” and “Cloud 9.” Whereas substituted cathinones may be sought for their perceived stimulant effects, the contents of these products are largely unknown, and therefore effects are unpredictable. These products became prominent in the designer drug market in the United States in 2010, and law enforcement and poison control center data indicated that use continued to rise in the first half of 2011. Serious health effects reported include chest pain, increased heart rate, hallucinations, extreme paranoia, and delusions. An increase in calls to poison control centers across the country related to these substances in 2010 prompted the ONDCP to release a statement of concern on February 1, 2011. The DEA emergency scheduled three of the substituted cathinones (mephedrone, methylone, and MDPV) in October 2011 under the Controlled Substances Act to avoid an imminent hazard to public safety. In June 2012, mephedrone and MDPV were designated Schedule I drugs under the Controlled Substances Act with the passage of the Synthetic Drug Abuse Prevention Act of 2012.

- **NFLIS Drug Reports From Seized Items Identified as MDPV or Other Substituted Cathinones:** MDPV ranked ninth among the top 10 drug reports among drug items seized and analyzed in NFLIS laboratories in Maine (table 1; appendix table 2). Substituted cathinones were identified in drug reports for seized and analyzed items in all 24 CEWG areas in 2011¹³.
- The substituted cathinone **MDPV**, marketed as “bath salts¹⁴,” continued to be reported in some CEWG areas at the June 2012 meeting. Marketed and sold as legal substances under names such as “Ivory Wave,” “Purple Wave,” “Bath Crystals Pure Euphoria,” or “Vanilla Sky,” they may cause serious medical reactions when ingested. **Mephedrone**¹⁵ is another substituted cathinone that has been popular in Europe and is monitored by the European Union’s European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Mephedrone is also known as “Meow-Meow,” “M-CAT,” “Bubbles,” and “Mad Cow.” Use and abuse of the substituted cathinone **methylone** has also been reported in CEWG areas.
- Thirteen CEWG representatives reported on substituted cathinones in their areas in 2011: Atlanta, Denver/Colorado, Chicago, Cincinnati, Detroit, Los Angeles, Minneapolis/St. Paul, Maine, South Florida/Miami-Dade and Broward Counties, Phoenix, Seattle, St. Louis, and Texas.

¹³The total number of reports for mephedrone, methylone, or MDPV among drug items identified by NFLIS laboratories are as follows: Texas: 502 (240=MDPV; 222=methylone; 4=mephedrone); Chicago: 159 (138=MDPV; 19=methylone; 2=mephedrone); Maryland: 92 (73=MDPV; 18=methylone; 1=mephedrone); Michigan: 73 (67=MDPV; 6=mephedrone); Atlanta: 72 (48=MDPV; 24=methylone); Miami: 71 (32=MDPV; 27=methylone; 12=mephedrone); St. Louis: 67 (59=MDPV; 5=methylone; 3=mephedrone); Washington, DC: 67 (58=MDPV; 9=methylone); Minneapolis/St. Paul: 33 (19=MDPV; 11=mephedrone; 3=methylone); New York City: 33 (25=MDPV; 5=methylone; 3=mephedrone); Maine: 24 (22=MDPV; 2=methylone); San Diego: 24 (15=methylone; 8=MDPV; 1=mephedrone); Detroit: 23 (21=MDPV; 2=mephedrone); Boston: 20 (11=MDPV; 7=methylone; 2=mephedrone); Colorado: 20 (14=methylone; 4=mephedrone; 2=MDPV); Denver: 20 (14=methylone; 4=mephedrone; 2=MDPV); Los Angeles: 12 (11=methylone; 1=MDPV); Phoenix: 9 (6=MDPV; 3=methylone); Honolulu: 6 (4=MDPV; 2=methylone); Seattle: 6 (4=methylone; 2=MDPV); Cincinnati: 4 (MDPV); Baltimore City: 3 (2=MDPV; 1=methylone); San Francisco: 3 (2=methylone; 1=MDPV); Philadelphia: 1 (MDPV)

¹⁴More information about substances sold as “bath salts” can be found at: http://www.nlm.nih.gov/medlineplus/news/fullstory_108485.html.

¹⁵More information on mephedrone can be found at: http://www.deadiversion.usdoj.gov/drugs_concern/mephedrone.htm.

- **Calls to Poison Control Centers in CEWG Areas Involving Substituted (or Synthetic) Cathinones¹⁶:** The **Atlanta** area representative reported an increase in human exposure calls for synthetic cathinones to the Georgia Poison Center from 3 calls in 2010 to 54 in 2011. In the **Denver/Colorado** area, the area representative reported that the Rocky Mountain Poison and Drug Center recorded 44 exposure calls for “bath salts” in 2011. The **Cincinnati** poison control center reported 2 synthetic cathinone human exposure calls in 2010 but 329 in 2011. The area representative from **Detroit** reported 164 calls related to synthetic cathinones in 2011, compared with 4 calls in 2010. Human exposures to “bath salts” reported to the Hennepin Regional Poison Center, in the **Minneapolis/St. Paul** area, increased from 5 in 2010 to 144 in 2011. Similarly, the **Phoenix** Poison Center reported 247 cases involving “bath salts” in 2011, compared with 2 reported cases in 2010. The area representative from the **South Florida/Miami-Dade and Broward Counties** area reported 150 exposure calls for “bath salts” to Florida Poison Information Centers in 2011. Numbers of human exposure calls to the **Texas** Poison Control Network for synthetic cathinones increased from 22 in 2010 to 340 in 2011.

Other Synthetic Drugs

2C-Phenethylamines: Another group of synthetic designer drugs, collectively known as 2C-phenethylamines from the 2C family, has been identified in CEWG areas¹⁷. The Synthetic Drug Abuse Prevention Act of 2012, signed into law in July, 2012, designated 2C-E, 2C-D, 2C-C, 2C-I, 2C-T-2, 2C-T-4, 2C-H, 2C-N, and 2C-P as Schedule I drugs under the Controlled Substances Act¹⁸.

- **NFLIS Drug Reports From Seized Items Identified as 2C-Phenethylamines (2C-E, 2C-I, 2C-B, 2C-C, 2C-P, and 2C-T-2):** One or more of these drugs from the phenethylamines were identified in 11 CEWG areas in 2011—Baltimore City, Chicago, Colorado, Denver, Maine, Maryland, Miami, Minneapolis/St. Paul, St. Louis, Seattle, and Texas¹⁹.
- **Minneapolis/St. Paul.** The area representative from Minneapolis/St. Paul reported that numbers of human exposures to 2C-E and related analogs reported to the Hennepin Regional Poison Center increased from 5 in 2009 to 10 in 2010 and to 23 in 2011 ($n=6$ such calls were reported in 2012 from January through April).

HIV/AIDS Related to Drug Abuse

The CEWG continues to monitor trends in injection drug use as important for understanding the consequences of drug use, including transmission of human immunodeficiency virus (HIV), which may develop into acquired immunodeficiency syndrome (AIDS). Seventeen out of 20 area representatives reported HIV/AIDS data at the June 2012 meeting. Area

¹⁶Poison control center data are reported here as they are reported by area representatives in their full area reports and slide presentations. The terminology used by area representatives in this report does not necessarily mean that particular substances, such as substituted (or synthetic) cathinones (or “bath salts”), are chemically verified

¹⁷Information on 2C-I and 2C-B can be found at: http://www.deadiversion.usdoj.gov/drugs_concern/index.html.

¹⁸See <http://www.govtrack.us/congress/bills/112/S3187/text>.

¹⁹The following 2C-phenethylamines were identified in drug reports in NFLIS laboratories in 2011 in CEWG areas: Texas: (9: 2C-E; 4: 2C-I; 2: 2C-B; 1: 2C-T-2; 1: 2C-C); Maryland: (5: 2C-E; 3: 2C-I; 2: 2C-B; 1: 2C-P); Minneapolis/St. Paul: (4: 2C-B; 4: 2C-E); Chicago: (3: 2C-I; 2: 2C-B; 1: 2C-T-2); Baltimore City: (1: 2C-P); Colorado: (4: 2C-B); Denver: (4: 2C-B); Maine: (1: 2C-B); Miami: (2: 2C-B); St. Louis: (2: 2C-P); and Seattle: (1: 2C-I).

representatives reported that transmission of or exposure to HIV and AIDS through injection drug use decreased in Los Angeles; Phoenix; Texas; Chicago; Minneapolis/St. Paul; St. Louis; Maine; Philadelphia; and the Baltimore/Maryland/Washington, DC, area. Injection drug use as an exposure factor in HIV/AIDS was stable in San Diego, San Francisco, Seattle, Detroit, New York City, Atlanta, and the South Florida/Miami-Dade and Broward Counties area. A slight increase in the proportion of injection drug use among newly diagnosed HIV cases in the current reporting period was observed by the area representative from Denver/Colorado.

- **Western Region CEWG Areas:** Three CEWG area representatives from the western region—Los Angeles, Phoenix, and Texas—reported declining rates of HIV/AIDS from injection drug use as a mode of transmission in the current reporting period. According to the Texas area representative, the number of new HIV diagnoses in that State reporting the risk factor of injection drug use has declined over time. These cases constituted 11 percent of new diagnoses in 2011, compared with 12 percent in 2009 and 14 percent in 2008. Area representatives from Los Angeles and Phoenix reported similar declines of injection drug use involvement over the past several years in both new diagnoses and cumulative HIV/AIDS cases. Representatives from San Diego, San Francisco, and Seattle reported stable levels of injection drug use as a risk factor in HIV/AIDS cases in their areas in the current reporting period. For example, in San Francisco, as of March 2012, a total of 22.2 percent of cumulative 29,125 AIDS cases were associated with drug-related transmission categories, including 2,125 heterosexual male and female injection drug users (IDUs), 4,347 men who have sex with men (MSM)/IDUs, and 61 lesbian or bisexual female IDUs. This percentage was stable from 2010, and new infections continued to decline, according to the area representative. In the Denver/Colorado area, the representative reported a slight increase in the percentage of newly diagnosed HIV cases with injection drug use as a risk factor; 5 percent of those newly diagnosed reported injection drug use in 2011, compared with 3 percent the previous year.
- **Midwestern Region CEWG Areas:** Of the four area representatives reporting on the proportions of injection drug use transmission for HIV/AIDS in the Midwest, three reported declines over time or from the previous reporting period; these were Chicago, Minneapolis/St. Paul, and St. Louis. In Chicago, after a continual decline over the past decade, 14 percent of newly diagnosed HIV/AIDS cases reported injection drug use in 2009. Proportions of HIV/AIDS cases in Minneapolis/St. Paul and St. Louis reporting the risk factor of injection drug use were relatively low and declining in both areas, according to CEWG area representatives. For instance, in the Twin Cities area, in 2011, no newly diagnosed HIV cases reported injection drug use, compared with 2 percent in 2010. In 2011, 3 percent identified as MSM/IDU, compared with 4 percent in 2010. Injection drug use among newly diagnosed HIV/AIDS cases in Detroit was stable from 2010 in 2011, at 5 percent.
- **Northeastern Region CEWG Areas:** In the Northeast, the Philadelphia area representative continued to report declining numbers and percentages of AIDS and HIV diagnoses with injection drug use as the exposure category. The IDU proportion of adult HIV/AIDS cases decreased in Philadelphia, from 13.6 percent in 2008 to 11.1 percent in 2009 and to 10.2 percent in 2010. Proportions of IDU cases also declined in Maine, where IDUs among newly diagnosed HIV cases constituted 2 percent of the total in 2011, compared with 5 percent in 2010. Of the people living with HIV/AIDS in New York City, 19 percent reported injection drug use in 2011, stable from the 20 percent reported in 2010, according to that area representative.

- **Southern Region CEWG Areas:** In the South, the Baltimore/Maryland/Washington, DC, area representative reported that the proportion of IDUs (including IDUs and MSM/IDUs) among newly reported HIV cases in Washington, DC, continued to decrease, from 12.6 percent in 2008 to 8.6 percent in 2009 to 6.8 percent in 2010. The proportion of newly reported AIDS cases with injection drug use as the mode of transmission (IDUs and MDM/IDUs) also decreased, from 16.5 percent in 2008 to 10.3 percent in 2010. Injection drug use as an exposure factor in HIV/AIDS cases remained low and stable in Atlanta and stable in the South Florida/Miami-Dade and Broward Counties area (with 15.5 percent of cumulative AIDS cases identified as IDUs in Miami-Dade County and 11.5 percent in Broward County).

International Drug Abuse Patterns/Issues

Australia

- According to the representative from the Drug Trends Monitoring program at the National Drug and Alcohol Research Centre in Australia, past-year ecstasy use among the general population declined in 2010, compared with previous years. Proportions of regular ecstasy users reporting ecstasy as their drug of choice were at an all-time low in 2011, at 27 percent, due to low availability and purity, according to the representative.
- Past-year methamphetamine use among the general population in Australia declined in 2010, to 2.1 percent of the population, compared with 2009. However, numbers of detected clandestine laboratories producing methamphetamine locally were at an all-time high ($n=703$ in 2010–2011).
- Past-year cocaine use among the general population in Australia increased significantly in 2010, to 2.1 percent, compared with 2009. Most Australians who use cocaine do so monthly or less frequently.

Canada

- According to the representative from Health Canada, marijuana/cannabis continued to be the dominant illicit drug in Canada, both from self-reported past-year use (from general population surveys) and from laboratory analysis of drug exhibits from seized substances. The highest percentage of drug exhibits analyzed from items seized by police and border services continued to be marijuana/cannabis; these accounted for 57,000 exhibits in 2011 (a stable number since 2010). However, among the general population age 15 and older, reported past-year use of cannabis decreased from 14 percent in 2004 to 11 percent in 2010 (a proportion stable from 2009). Student surveys showed that among students in grades 7 through 12, prevalence of past-12-month cannabis use decreased, from 27 percent in 2008–2009 to 21 percent in 2010–2011.
- There was no change in self-reported past-year cocaine use among Canadian adults age 15 and older from 2004 to 2010 (it remained stable at approximately 1 percent). However, there was a decrease in the prevalence of past-year use among youth age 15–24, from 6 percent in 2004 to 3 percent in 2010. There was also a decrease in prevalence of past-12-month cocaine use in students in grades 7 through 12, from 3 percent in 2008–2009 to 2 percent in 2010–2011. The number of drug exhibits seized and analyzed that contained cocaine continued the downward trend that began in 2007. Slightly fewer than 24,000 exhibits containing cocaine/crack cocaine

were analyzed by chemical analysis laboratories in 2011; this represents a 27-percent decrease from the peak of 35,000 exhibits in 2007.

- Past-year heroin use is not reportable in Canada among Canadians age 15 and older in the general population survey. Among students in grades 7 through 12, there was no change in the prevalence of past-12-month heroin use, at 1 percent in 2008–2009 and 2010–2011. Overall in Canada, the number of drug exhibits analyzed as containing heroin increased from 1,517 exhibits in 2010 to 1,892 exhibits in 2011.
- The prevalence of past-year pharmaceutical drug use (including medical use of such drugs as opioid pain relievers, stimulants, sedatives, or tranquilizers) among Canadians age 15 and older was stable, at 26 percent, from 2009 to 2010. Among these users, 1 percent reported that they used such a drug to get high. In 2010–2011, 5 percent of students in grades 7 through 12 indicated that they had used a pharmaceutical drug in the past year “to get high.” This represents a statistically significant decrease from 7 percent in 2008–2009. The number of analyzed exhibits in Canada containing prescription opioids increased in most regions of Canada from 2005 to 2011.
- Past-year methamphetamine use is not reportable among Canadians age 15 and older in the general population survey, and less than 1 percent reported using amphetamine in 2010. The numbers of seized and analyzed exhibits containing methamphetamine continued to increase, however, from 2005 to 2010. There were 9,625 exhibits containing methamphetamine analyzed in 2011, compared with 8,480 in 2010.
- Approximately 1 percent of Canadians reported past-year use of hallucinogens (including *Salvia divinorum*) and ecstasy in 2010, a stable proportion from the previous reporting period. The total number of exhibits containing ecstasy (MDMA, MDA [3,4-methylenedioxyamphetamine], MDEA [methylenedioxyethylamphetamine], and MMDA [3-methoxy-4,5-methylenedioxy-amphetamine]) decreased by 38 percent in 2011, from 5,600 in 2010 to 3,482 in 2011.
- According to the representative, Health Canada was continuing to monitor emerging substances through surveys, exhibit analyses, or both. These included phenethylamine drugs from the 2-C family; cannabimimetics; *Salvia divinorum*; BZP, TFMPP; dextromethorphan; substituted cathinones, such as mephedrone; and polysubstance use. Results from the laboratory analyses of seized substances showed that the number of exhibits containing BZP and/or TFMPP continued to increase, with the largest number of exhibits ($n=2,679$) containing these substances to date recorded in 2011.

Europe

- Marijuana/cannabis is the illicit drug most widely available in Europe, as reported by the representative from the EMCDDA. Cannabis cultivation is widespread in Europe and appears to be increasing. However, recent data from general population and school surveys point to an overall stable situation.
- Cocaine continued to be the second most commonly used illicit drug in Europe, although prevalence levels and trends differ considerably among countries. High levels of cocaine use are observed in only a few mostly western European countries. Surveys indicate that the drug’s

popularity is stable or declining overall. Spain, the Netherlands, Portugal, and Belgium appear to be the main points of entry to Europe. Germany, France, and the United Kingdom are reported as important transit or destination countries. Reports indicated that cocaine trafficking was expanding eastward along the Balkan routes in harbors in Latvia and Lithuania.

- Heroin was reported as largely stable across several indicators in Europe. However, qualitative changes have been identified, such as an aging cohort of users and increases in polydrug use. Information about heroin shortages in a number of countries in late 2010 and early 2011, and a decline in heroin seizures, point to changes in heroin availability that might be associated with shifts in drug use patterns, according to the representative.
- Fentanyl is reported as used in a small number of countries (Bulgaria, Czech Republic, Estonia, and Slovakia), and illicit use of buprenorphine is reported in Finland. In Hungary and Romania, a shift to injecting substituted cathinones has been noted.

Latin America

- According to the representative from the Red Latinoamericana de Investigadores en Drogas (REDLA), and data from the Inter-American Drug Abuse Control Commission (CICAD) Inter-America Observatory on Drugs (OID), marijuana/cannabis is the most frequently consumed illicit drug in the southern hemisphere, and patterns regarding marijuana/cannabis use are seen at the subregional level. For instance, past-month prevalence of marijuana/cannabis is higher than tobacco prevalence among high school students in eight Caribbean countries.
- According to the representative, while cocaine prevalence appears to be declining in the United States, the prevalence appears to be increasing in the southernmost region of South America (Argentina, Chile, and Uruguay) and in Brazil. In some of these countries, cocaine prevalence exceeds that in the United States.
- CICAD data indicate a continuing increase in heroin use in Colombia and the Dominican Republic. While heroin use prevalence is low in these countries, requests for treatment are increasing. In the past 3 years in Colombia, heroin has transitioned from being primarily smoked to being injected.
- Based on representative reporting, prescription drug use without medical prescription appears highest in the countries with low illicit drug use. For example, Haiti has extremely low illicit drug prevalence, but it has some of the highest rates of pharmaceutical misuse.
- Inhalant use is found among high school and university students across the southern hemisphere, and several countries showed higher inhalant prevalence than that of marijuana/cannabis among high school students. National reports showed high prevalence of inhalant use among female university students in Bolivia, Chile, Colombia, and Peru.

New Zealand

- According to the presenter from Massey University, New Zealand, methamphetamine continued to be the highest drug control priority in New Zealand. The 2009 Methamphetamine Action Plan extended police surveillance powers, enhanced border control, restricted availability of

pseudoephedrine, and expanded drug treatment services in the country. The availability of methamphetamine has declined slightly since 2009; the price has increased steadily over the past 6 years; and the potency has declined slightly since 2008 and 2009. However, methamphetamine use remained high among specific groups of the population, such as arrestees (38 percent of arrestees reported past-year methamphetamine use in 2011).

- The ecstasy market has expanded in New Zealand over the past 6 years, and a range of chemicals other than MDMA have been identified in ecstasy, including BZP, methylone, mephedrone, and MDPV. The price for an ecstasy pill has declined and potency is low, but recent reports have pointed to an increased supply.
- The marijuana/cannabis and opioid markets remained largely stable. New drugs most commonly identified were phenethylamines, cannabimimetics, mephedrone, and unidentified “research” chemicals.
- The prohibition of BZP in 2008 has been found in research studies to be largely successful, with lower levels of BZP use, a substantial decline in availability, and an increase in the price of a BZP pill.
- The New Zealand government is operating the Temporary Class Drug Notices scheme, which has allowed for the immediate banning of a range of cannabimimetics for a 12-month period. The government is also in the process of developing the New Psychoactive Substances Regime, which will allow the legal sale of low harm psychoactive substances.

Section III. Across CEWG Areas: Treatment Admissions and Forensic Laboratory Analysis Data

Cocaine/Crack

Treatment Admissions Data on Cocaine/Crack

Table 3 presents the most recent data from 23 Community Epidemiology Work Group (CEWG) areas²⁰ on primary cocaine treatment admissions as a proportion of total admissions (see also appendix table 1). The reporting period is calendar year (CY) 2011, January through December 2011, for all reporting CEWG areas.

South Florida/Miami-Dade County had the highest percentage (19.7 percent) of primary cocaine admissions, followed by Detroit (17.7 percent). The lowest proportions of primary cocaine treatment admissions were observed for Hawaii (2.9 percent) and Maine (3.7 percent) (table 3).

Based on total 2011 treatment admissions, cocaine did not rank either first or second in any of the 23 CEWG reporting areas. It ranked third in five areas: Atlanta, Boston, Detroit, South Florida/Miami-Dade County, and Texas (section II, table 2).

Route of Administration of Cocaine. Data from 19 CEWG areas indicate that smoking²¹ was the most common mode of cocaine administration among primary cocaine treatment admissions in 2011 (table 4). The range was from 51.3 percent in Maine to 94.4 percent in Detroit. After Detroit, the highest percentages of smoking cocaine were reported in St. Louis (88.9 percent), San Francisco (86.4 percent), and Los Angeles (86.1 percent).

Inhaling or sniffing cocaine was the primary route of administration in approximately 32–36 percent of cocaine admissions in New York City, South Florida/Broward County, Denver, Colorado, and South Florida/Miami-Dade County (36.3, 34.4, 33.3, 32.1, and 31.7 percent, respectively). The lowest proportions reporting inhaling or sniffing cocaine as the primary administration route were in Detroit and Philadelphia, at 5.1 and 2.0 percent, respectively.

Across the CEWG areas reporting data on mode of administration of cocaine, the proportions of cocaine admissions who reported injecting the drug as the primary route tended to be low, with the highest proportions being in Maine, at 21.3 percent, followed distantly by Boston, at 10.0 percent (table 4).

²⁰Treatment admissions data for Colorado and Florida are reported by the Denver and South Florida area representatives, respectively, and are shown in treatment tables along with data for the CEWG areas.

²¹SAMHSA's Treatment Episode Data Set (TEDS) report (2003) notes that, "Smoked cocaine primarily represents crack or rock cocaine, but can also include cocaine hydrochloride (powder cocaine) when it is free-based." TEDS does not separately report crack and cocaine; however, several CEWG sites have different codes for crack compared with cocaine, and area representatives may separate these out in their reporting.

Table 3. Primary Cocaine Treatment Admissions in 23 CEWG Areas as a Percentage of Total Substance Abuse Admissions, Including Primary Alcohol Admissions¹: CY 2011²

CEWG Areas	Number of Primary Cocaine Admissions	Percentage of Total Admissions
	#	%
Atlanta	985	10.7
Baltimore City	1,800	12.3
Boston ³	923	5.2
Cincinnati	455	9.1
Colorado	2,283	7.7
Denver	1,199	9.5
Detroit	1,701	17.7
Florida	4,441	7.9
Hawaii	314	2.9
Los Angeles	3,906	8.5
Maine	456	3.7
Maryland	5,292	10.1
Minneapolis/St. Paul	1,083	5.2
New York City	11,332	14.7
Philadelphia	788	8.8
Phoenix ³	328	5.0
St. Louis	1,397	10.9
San Diego	577	4.2
San Francisco	3,338	15.2
Seattle	934	9.4
South Florida/Broward County	555	9.4
South Florida/Miami-Dade County	1,052	19.7
Texas	10,622	14.3

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for CY 2011: January–December 2011.

³Treatment data for Boston do not include admissions younger than 14, and Phoenix treatment data do not include admissions younger than 18.

SOURCE: June 2012 State and local CEWG reports

Table 4. Primary Route of Administration of Cocaine Among Treatment Admissions in 19 CEWG Areas as a Percentage¹ of Primary Cocaine Treatment Admissions: CY 2011²

CEWG Areas ³	Smoked		Inhaled		Injected		Oral/Other/ Unknown		Total N
	#	%	#	%	#	%	#	%	
CY 2011									
Atlanta	741	75.2	182	18.5	20	2.0	42	4.3	985
Baltimore City	1,545	85.8	108	6.0	134	7.4	13	0.7	1,800
Boston ⁴	621	67.3	185	20.0	92	10.0	25	2.7	923
Colorado	1,361	59.6	733	32.1	144	6.3	45	2.0	2,283
Denver	713	59.5	399	33.3	69	5.8	18	1.5	1,199
Detroit	1,606	94.4	86	5.1	0	0	9	0.5	1,701
Los Angeles	3,362	86.1	447	11.4	18	0.5	79	2.0	3,906
Maine	234	51.3	108	23.7	97	21.3	17	3.7	456
Maryland	4,125	77.9	822	15.5	291	5.5	54	1.0	5,292
Minneapolis/St. Paul	814	75.2	223	20.6	15	1.4	31	2.9	1,083
New York City	6,798	60.0	4,119	36.3	178	1.6	237	2.1	11,332
Philadelphia	587	74.5	16	2.0	50	6.3	135	17.1	788
Phoenix ⁴	213	64.9	69	21.0	12	3.7	34	10.4	328
St. Louis	1,242	88.9	111	7.9	24	1.7	20	1.4	1,397
San Diego	458	79.4	100	17.3	*5	*5	*5	*5	577
San Francisco	2,885	86.4	363	10.9	24	0.7	66	2.0	3,338
South Florida/ Broward County	332	59.8	191	34.4	7	1.3	25	4.5	555
South Florida/ Miami-Dade County	667	63.4	334	31.7	16	1.5	35	3.3	1,052
Texas	NR ⁶	59.0	NR ⁶	34.5	NR ⁶	4.1	NR ⁶	1.8	10,622

¹Percentages may not sum to 100 due to rounding.

²Data are for CY 2011: January–December 2011.

³No data were available for Cincinnati, Florida, Hawaii, and Seattle.

⁴Treatment data for Boston do not include admissions younger than 14; Phoenix treatment data do not include admissions younger than 18.

⁵These data on route of administration for San Diego are suppressed as required by the California State Alcohol and Drug Program, because they represent fewer than 16 cases, as reported by the San Diego area representative.

⁶NR=Not reported.

SOURCE: June 2012 State and local CEWG reports

Gender of Cocaine/Crack Admissions. Across all reporting CEWG areas in 2011, the majority of primary cocaine admissions were male (table 5). The highest proportions of male cocaine admissions were in Philadelphia (72.2 percent), New York City (69.7 percent), and San Francisco (69.3 percent), while the lowest percentages were in Boston (53.6 percent) and Maine (54.6 percent).

Age of Cocaine/Crack Admissions. In 20 of 21 reporting CEWG areas in 2011, at least one-half of the primary cocaine treatment admissions were age 35 or older (or 36 and older in Florida and 40 and older in Seattle), with the largest proportions reported in Detroit and Baltimore City (86.7 and 86.5 percent, respectively) (table 5). In Maine, proportions of older cocaine admissions were lowest,

Table 5. Demographic Characteristics of Primary Cocaine Treatment Admissions in 21 CEWG Areas as a Percentage¹ of Primary Cocaine Admissions: CY 2011²

CEWG Areas ³	Gender ⁴		Age Group	
	Male	Female	Younger Than 26	35 and Older
Atlanta	56.3	43.7	6.2	75.3
Baltimore City	56.8	43.2	3.0	86.5
Boston ⁵	53.6	46.0	9.4	67.9
Cincinnati	57.8	42.2	9.2	77.6
Colorado	59.4	40.6	13.0	61.2
Denver	61.6	38.7	11.6	63.7
Detroit	61.3	38.7	3.5	86.7
Florida	55.8	44.2	14.0	57.8
Los Angeles	59.7	40.2	7.5	78.3
Maine	54.6	45.4	21.1	43.0
Maryland	56.9	43.1	8.4	72.2
Minneapolis/St. Paul	63.0	37.0	8.3	73.2
New York City	69.7	30.3	4.6	79.4
Philadelphia	72.2	27.8	6.7	66.1
Phoenix ⁵	58.2	41.8	9.5	71.0
St. Louis	62.9	37.1	3.5	81.5
San Diego	65.2	34.8	8.3	78.5
San Francisco	69.3	30.6	1.9	81.4
Seattle	60.3	39.7	6.7	68.1 ⁶
South Florida/ Broward County	64.0	36.0	10.5	73.7
South Florida/ Miami-Dade County	59.6	40.4	12.9	61.1

¹Percentages are rounded to one decimal place.

²Data are for CY 2011: January–December 2011.

³Data on gender and age group were not available for Hawaii and Texas.

⁴Percentages may not add to 100 due to the presence of unknown gender.

⁵Treatment data for Boston do not include admissions younger than 14; treatment data for Phoenix do not include admissions younger than 18.

⁶Data from Seattle are for clients age 40 and older.

SOURCE: June 2012 State and local CEWG reports

at 43.0 percent. The highest percentages of younger cocaine treatment admissions (age 25 and younger) were in Maine (21.1 percent), followed by Florida (14.0 percent), Colorado (13.0 percent), and South Florida/Miami-Dade County (12.9 percent).

Changes in Cocaine/Crack Admissions, 2007–2011

Table 6 shows changes in primary cocaine/crack treatment admissions as a percentage of total admissions between 2007 and 2011. In the 5-year period, declines were noted in all 17 areas with data. Decreases from 2007 to 2011 in the proportion of primary cocaine admissions were highest in St. Louis, Philadelphia, Detroit, and Atlanta, at 11.9, 10.4, 10.4, and 10.2 percentage points, respectively. Decreases of approximately 4–8 percentage points were observed for 9 of the 17 CEWG areas reporting data for this 5-year period: Baltimore City, Denver, Los Angeles, Maine, Maryland, Minneapolis/St. Paul, New York City, Phoenix, and Seattle (table 6). Other areas experiencing declines of approximately 1–3 percentage points in the proportion of primary cocaine treatment admissions were Boston, Hawaii, and San Diego.

Declines in cocaine treatment admission proportions were reported in 15 of 20 CEWG areas for which comparable data were available from the more recent period, 2010–2011. Declines ranged from a low of 0.1–0.9 percentage points in Boston, Colorado, Denver, Maryland, San Diego, and South Florida/Miami-Dade and Broward Counties, to a high of 4.5 percentage points in Minneapolis/St. Paul (table 6). Low-level increases (up to 1.0 percentage points) were observed for five areas—Baltimore City, Detroit, Hawaii, Maine, and Phoenix

Forensic Laboratory Data on Cocaine/Crack

According to the rankings of NFLIS data for 2011, cocaine ranked among the top three drugs in drug reports from items seized and analyzed in forensic laboratories in all but one CEWG reporting area, Phoenix, where it ranked fourth. Cocaine was the drug most frequently identified in drug reports in 8 of the 24 CEWG areas shown on the map (figure 5) and table (table 1) in section II. In 2011, in two of the five southern region CEWG areas (Atlanta and Miami), cocaine ranked first as the most frequently reported drug in forensic laboratories. Cocaine also ranked first among drug reports in 2011 in three of the four CEWG areas in the northeastern region (Maine, New York City, and Philadelphia), in two of the nine CEWG areas in the western region (Denver and Seattle), and in one of the five areas in the midwestern region (Minneapolis/St. Paul).

Cocaine ranked second in drug reports among drug items seized and analyzed in 2011 in 11 of 24 CEWG reporting areas: Baltimore City, Boston, Chicago, Cincinnati, Colorado, Detroit, Los Angeles, Maryland, Michigan, Texas, and Washington, DC.

Cocaine reports as a percentage of the total drug reports among drug items identified in the NFLIS system were particularly high in Miami (49.0 percent), followed by New York City (35.1 percent). The lowest reported frequencies of cocaine drug reports among items seized and analyzed in forensic laboratories were in Phoenix and Honolulu, at 8.0 and 7.8 percent, respectively (figure 6; appendix table 2).

Table 6. Primary Cocaine Treatment Admissions in 20 CEWG Areas as a Percentage of Total Substance Abuse Treatment Admissions, Including Primary Alcohol Admissions, and Percentage-Point Changes for Two Time Periods: 2007–2011 and 2010–2011¹

CEWG Areas ²	Years (in Percent)					Percentage-Point Change	
	2007	2008	2009	2010	2011	2007–2011	2010–2011
Atlanta ³	20.9	18.5	15.7	12.8	10.7	-10.2	-2.1
Baltimore City ³	16.7	15.0	14.1	12.2	12.3	-4.4	+0.1
Boston ^{3,4}	8.2	8.0	6.8	5.3	5.2	-3.0	-0.1
Colorado	NR ⁵	11.6	9.3	8.3	7.7	— ⁶	-0.6
Denver	15.0	13.7	11.2	10.2	9.5	-5.5	-0.7
Detroit	28.1	22.5	19.3	17.1	17.7	-10.4	+0.6
Hawaii	3.9	3.9	3.8	1.9	2.9	-1.0	+1.0
Los Angeles	16.2	15.6	12.6	9.7	8.5	-7.7	-1.2
Maine	7.3	6.0	4.0	3.3	3.7	-3.6	+0.4
Maryland ³	17.7	21.2	12.5	10.5	10.1	-7.6	-0.4
Minneapolis/St. Paul	11.6	9.9	6.4	9.7	5.2	-6.4	-4.5
New York City	20.4	18.5	16.5	15.8	14.7	-5.7	-1.1
Philadelphia ³	19.2	17.3	14.5	12.4	8.8	-10.4	-3.6
Phoenix ⁴	9.6	8.5	5.3	4.4	5.0	-4.6	+0.6
St. Louis	22.8	17.8	13.6	12.3	10.9	-11.9	-1.4
San Diego	6.8	6.6	5.4	4.8	4.2	-2.6	-0.6
Seattle	17.3	17.3	11.1	11.1	9.4	-7.9	-1.7
South Florida/ Broward County	NR ⁵	NR ⁵	13.5	9.5	9.4	— ⁶	-0.1
South Florida/ Miami-Dade County	NR ⁵	NR ⁵	28.1	20.2	19.7	— ⁶	-0.5
Texas ³	23.7	21.7	17.9	15.3	14.3	-9.4	-1.0

¹Calendar year (January–December) data.

²Noncomparability of data precludes inclusion of Cincinnati in this table.

³Data for these areas do not match data contained in previous June reports, as these data were updated by the area representatives.

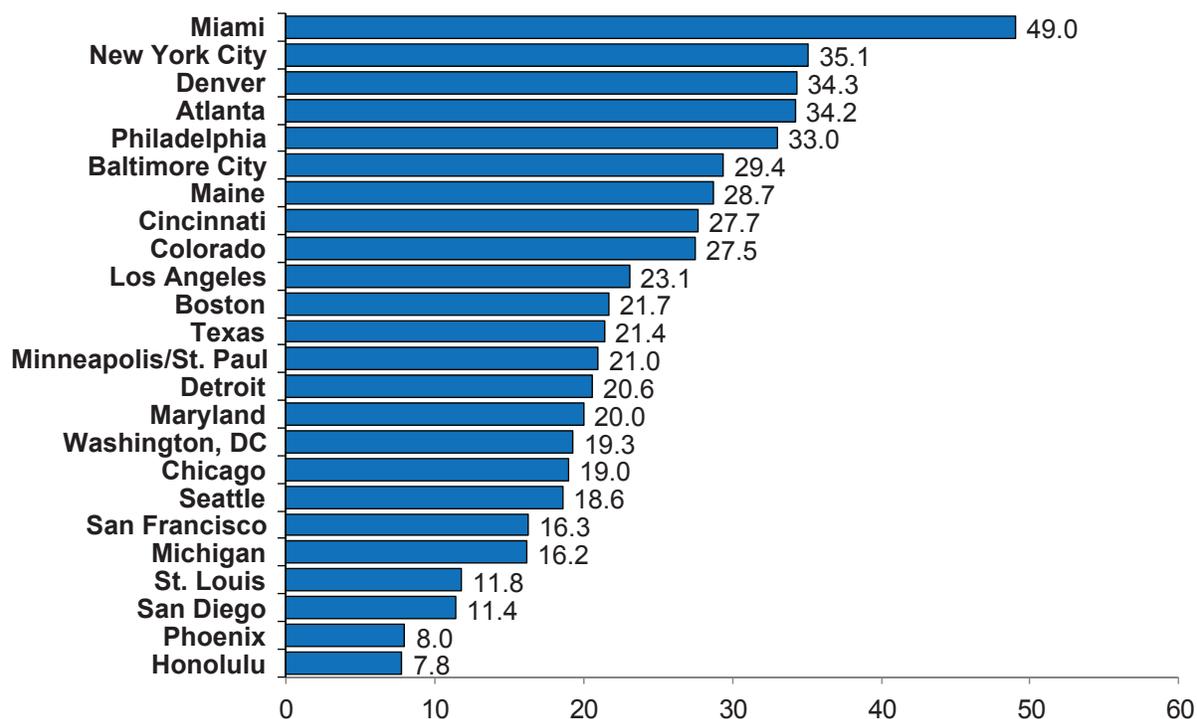
⁴Treatment data for Boston do not include admissions younger than 14; Phoenix treatment data do not include admissions younger than 18.

⁵NR=Not reported.

⁶Percentage-point changes could not be calculated due to missing data.

SOURCES: June 2012 State and local CEWG reports; *June 2011 Highlights and Executive Summary Volume I* CEWG report, p 80; *June 2010 Highlights and Executive Summary Volume I* CEWG report, p. 59; *June 2009 Highlights and Executive Summary Volume I* CEWG report, p. 40; and *June 2008 Highlights and Executive Summary Volume I* CEWG report, p 70

Figure 6. Cocaine Drug Reports Identified Among Drug Items Seized and Analyzed in Forensic Laboratories, as a Percentage of Total NFLIS Drug Reports¹, in 24 CEWG Areas: 2011²



¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each selected drug item seized and analyzed.

²Data are for CY 2011: January–December 2011; see appendix tables 2.1–2.24. 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 were retrieved on May 7–8, 2012

Heroin

Treatment Admissions Data on Heroin

In this 2011 reporting period for 21 of 22 CEWG areas, primary heroin treatment admissions, as a proportion of total admissions for substance abuse treatment, ranged from approximately 1 to 52 percent. After Boston at 52.1 percent, Baltimore City had the highest proportion of heroin admissions, at 46.8 percent of all primary admissions (table 7; see also appendix table 1). The lowest percentage of primary heroin admissions was in Hawaii, at 1.2 percent.

When all substance abuse treatment admissions are examined, heroin ranked first in 3 of the 23 CEWG reporting areas: Baltimore City, Boston, and St. Louis. Heroin ranked second in three areas (Detroit, Maryland, and San Diego) among all treatment admissions. Heroin ranked third in five areas: Los Angeles, Minneapolis/St. Paul, New York City, San Francisco, and Seattle (section II, table 2).

Route of Administration of Heroin. Injection was the most frequently reported mode of heroin administration in 15 of 19 reporting CEWG areas in 2011. Proportions of heroin admissions injecting the drug ranged from a low of approximately 37 percent in Maryland to a high of approximately 89 percent in South Florida/Broward County (table 8).

Inhalation or intranasal use was the most frequent mode of heroin administration reported by heroin admissions in 4 of 19 areas: Maryland, at 61.0 percent; Detroit and New York City, at 56.2 percent each; and Baltimore City, at 54.3 percent. However, this mode was relatively rarely reported among treatment admissions in Philadelphia, Los Angeles, and San Diego (1.2, 3.2, and 3.2 percent, respectively).

Smoking was reported by less than 2.0 percent of the heroin admissions in 11 of 19 CEWG areas reporting. San Diego had the highest proportion of heroin treatment admissions whose primary mode of administration was smoking, at 26.8 percent, followed by Phoenix, Denver, Colorado, and Los Angeles, at 22.4, 15.4, 14.7, and 14.0 percent, respectively (table 8).

Gender of Heroin Admissions. There were proportionally more male than female primary heroin admissions in all 21 CEWG areas reporting in 2011 represented in table 9. The largest proportions of male heroin admissions were in South Florida/Broward County, at 79.3 percent, and New York City (78.1 percent). Conversely, the largest proportion of females was in Maine, at 45.2 percent (table 9).

Age of Heroin Admissions. In 7 of 20 reporting CEWG areas, more than one-half of the primary heroin admissions in 2011 were age 35 or older, with the highest proportions in Baltimore City (83.3 percent) and Detroit (86.2 percent). Minneapolis/St. Paul reported the highest percentages of heroin treatment admissions among clients age 25 and younger, at 42.4 percent, followed by Colorado (37.9 percent) (table 9).

Table 7. Primary Heroin Treatment Admissions in 22 CEWG Areas as a Percentage of Total Substance Abuse Treatment Admissions, Including Primary Alcohol Admissions¹: CY 2011²

CEWG Areas ³	Number of Primary Heroin Admissions	Percentage of Total Admissions
	#	%
Atlanta	306	3.3
Baltimore City	6,860	46.8
Boston ⁴	9,291	52.1
Colorado	2,150	7.3
Denver	1,314	10.4
Detroit	3,009	31.4
Florida	1,304	2.3
Hawaii	130	1.2
Los Angeles	9,417	20.6
Maine	1,058	8.5
Maryland	12,236	23.3
Minneapolis/St. Paul	2,223	10.7
New York City	18,716	24.2
Philadelphia	1,363	15.1
Phoenix ^{4,5}	881	13.3
St. Louis	4,029	31.4
San Diego	3,019	22.0
San Francisco	3,493	15.9
Seattle	1,523	15.3
South Florida/Broward County	169	2.8
South Florida/Miami-Dade County	227	4.2
Texas	9,542	12.8

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for CY 2011: January–December 2011.

³Data for Cincinnati are excluded from this table due to noncomparability of data. Heroin and other opiates are grouped together for Cincinnati ($n=1,210$ and 24.2 percent).

⁴Treatment data for Boston do not include admissions younger than 14. Phoenix treatment data do not include admissions younger than 18.

⁵Heroin and morphine are grouped together in Phoenix data.

SOURCE: June 2012 State and local CEWG reports

Table 8. Primary Route of Administration of Heroin Among Treatment Admissions in 19 CEWG Areas as a Percentage¹ of Primary Heroin Treatment Admissions: CY 2011²

CEWG Areas ³	Smoked		Inhaled		Injected		Other/Unknown		Total N
	#	%	#	%	#	%	#	%	
CY 2011									
Atlanta	3	1.0	50	16.3	240	78.4	13	4.2	306
Baltimore City	59	0.9	3,723	54.3	3,015	44.0	63	0.9	6,860
Boston ⁴	30	0.3	1,170	12.6	7,993	86.0	98	1.0	9,291
Colorado	315	14.7	93	4.3	1,709	79.5	33	1.5	2,150
Denver	203	15.4	59	4.5	1,032	78.5	20	1.5	1,314
Detroit	18	0.6	1,691	56.2	1,295	43.0	5	0.2	3,009
Los Angeles	1,318	14.0	302	3.2	7,633	81.1	164	1.7	9,417
Maine	14	1.3	183	17.3	814	76.9	47	4.4	1,058
Maryland	75	0.6	7,469	61.0	4,534	37.1	158	1.3	12,236
Minneapolis/St. Paul	194	8.7	543	24.4	1,438	64.7	48	2.2	2,223
New York City	128	0.7	10,524	56.2	7,846	41.9	218	1.2	18,716
Philadelphia	2	0.1	17	1.2	805	59.1	539	39.5	1,363
Phoenix ⁴	197	22.4	72	8.2	557	63.2	55	6.2	881
St. Louis	21	0.5	1,423	35.3	2,542	63.1	43	1.1	4,029
San Diego	809	26.8	97	3.2	2,083	69.0	30	1.0	3,019
San Francisco	122	3.5	713	20.4	2,556	73.2	102	2.9	3,493
South Florida/ Broward County	4	2.4	11	6.5	150	88.8	4	2.4	169
South Florida/ Miami-Dade County	1	0.4	44	19.4	179	78.9	3	1.3	227
Texas	NR ⁵	1.3	NR ⁵	18.4	NR ⁵	78.8	NR ⁵	1.5	9,542

¹Percentages may not sum to 100 due to rounding.

²Data are for CY 2011: January–December 2011. See also appendix table 1.

³No data were available for Florida, Hawaii, and Seattle. Data for Cincinnati combine heroin with other opiates/opioids and are excluded. Phoenix data combine heroin and morphine.

⁴Treatment data for Boston do not include admissions younger than 14. Phoenix treatment admissions do not include those younger than 18.

⁵NR=Not reported.

SOURCE: June 2012 State and local CEWG reports

Table 9. Demographic Characteristics of Primary Heroin Treatment Admissions in 21 CEWG Areas as a Percentage¹ of Primary Heroin Admissions: CY 2011²

CEWG Areas ³	Gender ⁴		Age Group	
	Male	Female	Younger Than 26	35 and Older
Atlanta	65.7	34.3	29.4	38.9
Baltimore City	65.1	34.9	4.8	83.3
Boston ⁵	73.1	26.9	18.4 ⁶	43.9
Colorado	64.9	35.1	37.9	30.1
Denver	63.9	36.1	33.3	33.6
Detroit	65.5	34.5	3.7	86.2
Florida	66.6	33.4	20.9	37.7
Los Angeles	71.6	28.4	20.5	59.1
Maine	54.8	45.2	29.5	20.5
Maryland	62.4	37.6	21.9	56.8
Minneapolis/St. Paul	68.0	32.0	42.4	33.1
New York City	78.1	21.9	5.9	76.7
Philadelphia	73.3	26.7	16.4	42.6
Phoenix ^{5,7}	64.0	36.0	31.7	33.9
St. Louis	59.9	40.1	26.2	31.3
San Diego	70.1	29.9	34.1	34.4
San Francisco	66.4	33.5	9.8	67.6
Seattle	63.2	36.8	25.0	39.2 ⁸
South Florida/ Broward County	79.3	20.7	20.1	48.5
South Florida/ Miami-Dade County	76.7	23.3	15.4	54.2
Texas	59.4	40.6	NR ⁹	NR ⁹

¹Percentages are rounded to one decimal place.

²Data are for CY 2011: January–December 2011.

³No data were available for Hawaii. Heroin and other opiates are grouped together for Cincinnati and are excluded from this report. For further information see appendix table 1.

⁴Percentages may not add to 100 percent due to the presence of unknown gender.

⁵Treatment data for Boston do not include admissions younger than 14, and those for Phoenix do not include admissions younger than 18.

⁶Data for Boston treatment admissions in the age group from 14 to 17 are suppressed from this total because they number fewer than 5.

⁷Heroin is combined with morphine in Phoenix treatment admissions data.

⁸Data from Seattle are for clients age 40 and older.

⁹NR=Not reported.

SOURCE: June 2012 State and local CEWG reports

Changes in Heroin Admissions, 2007–2011

Over the period from 2007 to 2011, proportions of primary heroin treatment admissions increased in 12 of 17 CEWG areas with no missing data for the period, namely Atlanta, Boston, Denver, Detroit, Los Angeles, Maine, Minneapolis/St. Paul, Phoenix, St. Louis, San Diego, Seattle, and Texas. The largest increase over the 5-year period was for St. Louis, at approximately 16 percentage points. While two of the five areas that experienced declining proportions of primary heroin admissions over the 5 years (Hawaii and Maryland) showed small decreases of 1.0 percentage point or less, the largest decline in primary heroin treatment proportions was for Philadelphia, at 11.3 percentage points. The two other areas showing declines were Baltimore City and New York City, at 8.0 and 3.5 percentage points, respectively (table 10).

During the more recent period, from 2010 to 2011, 12 of the 20 reporting areas showed increases in proportions of primary heroin treatment admissions (Boston, Colorado, Denver, Los Angeles, Maine, Minneapolis/St. Paul, New York City, St. Louis, San Diego, Seattle, South Florida/Miami-Dade County, and Texas). Three reporting areas showed increases of approximately 3 percentage points or more (Minneapolis/St. Paul, St. Louis, Seattle, and Texas, at 2.9, 5.0, 2.7, and 2.8 percentage points, respectively). Decreased proportions of heroin admissions from 2010 to 2011 were noted in eight reporting areas (Atlanta, Baltimore City, Detroit, Hawaii, Maryland, Philadelphia, Phoenix, and South Florida/Broward County), with the largest declines noted for Phoenix, at 6.8 percentage points, and Baltimore City, at 5.1 percentage points (table 10).

Forensic Laboratory Data on Heroin

In more than one-half (13) of the 24 CEWG areas shown on the map in figure 5 (section II), heroin items accounted for less than 10.0 percent of the drug reports from drug items seized and analyzed in forensic laboratories. As a proportion of total drug reports, heroin reports were highest in Baltimore City (21.7 percent), compared with other CEWG areas. Heroin drug reports were lowest in Honolulu (1.3 percent) (figure 7; appendix table 2).

Heroin was not ranked as the number one or two most frequently identified drug among drug reports in any of the CEWG areas in 2011, with the exception of St. Louis, where it ranked second among total drug reports. Heroin placed third in the rankings of drug reports in 11 CEWG reporting areas. It ranked third in two of five southern CEWG areas (Baltimore City and Maryland); in three of four northeastern areas (Boston, New York City, and Philadelphia); and in four of six areas in the Midwest (Chicago, Cincinnati, Detroit, and Michigan). In the West, heroin ranked third in two of the nine reporting areas (Phoenix and Seattle) (section II, table 1).

Table 10. Primary Heroin Treatment Admissions in 20 CEWG Areas as a Percentage of Total Admissions, Including Primary Alcohol Admissions, and Percentage-Point Changes for Two Time Periods: 2007–2011 and 2010–2011¹

CEWG Areas ²	Years (in Percent)					Percentage-Point Change	
	2007	2008	2009	2010	2011	2007–2011	2010–2011
Atlanta ³	3.1	3.5	3.9	3.8	3.3	+0.2	-0.5
Baltimore City ³	54.8	57.0	54.2	51.9	46.8	-8.0	-5.1
Boston ^{3,4}	49.2	50.2	50.9	50.0	52.1	+2.9	+2.1
Colorado	NR ⁵	4.2	5.5	5.9	7.3	— ⁶	+1.4
Denver	6.7	6.2	8.0	8.7	10.4	+3.7	+1.7
Detroit	29.4	34.2	34.3	32.7	31.4	+2.0	-1.3
Hawaii	2.0	1.9	1.9	1.5	1.2	-0.8	-0.3
Los Angeles	19.6	18.5	18.8	20.4	20.6	+1.0	+0.2
Maine	8.0	8.5	8.6	6.8	8.5	+0.5	+1.7
Maryland ³	24.3	26.4	26.5	24.9	23.3	-1.0	-1.6
Minneapolis/St. Paul	6.4	6.7	8.0	7.8	10.7	+4.3	+2.9
New York City	27.7	26.7	26.3	23.9	24.2	-3.5	+0.3
Philadelphia ³	26.4	24.3	19.1	17.9	15.1	-11.3	-2.8
Phoenix ⁴	9.8	14.0	16.8	20.1	13.3	+3.5	-6.8
St. Louis	15.5	18.8	22.5	26.4	31.4	+15.9	+5.0
San Diego	17.2	18.5	19.4	21.4	22.0	+4.8	+0.6
Seattle	11.8	12.6	11.8	12.6	15.3	+3.5	+2.7
South Florida/ Broward County	NR ⁵	NR ⁵	1.8	3.1	2.8	— ⁶	-0.3
South Florida/ Miami-Dade County	NR ⁵	NR ⁵	2.7	4.0	4.2	— ⁶	+0.2
Texas ³	9.7	11.0	13.0	10.0	12.8	+3.1	+2.8

¹Calendar year (January–December) data.

²Noncomparability of data precludes inclusion of Cincinnati in this table.

³Data for these areas do not match data contained in previous June reports, as these data were updated by the area representatives.

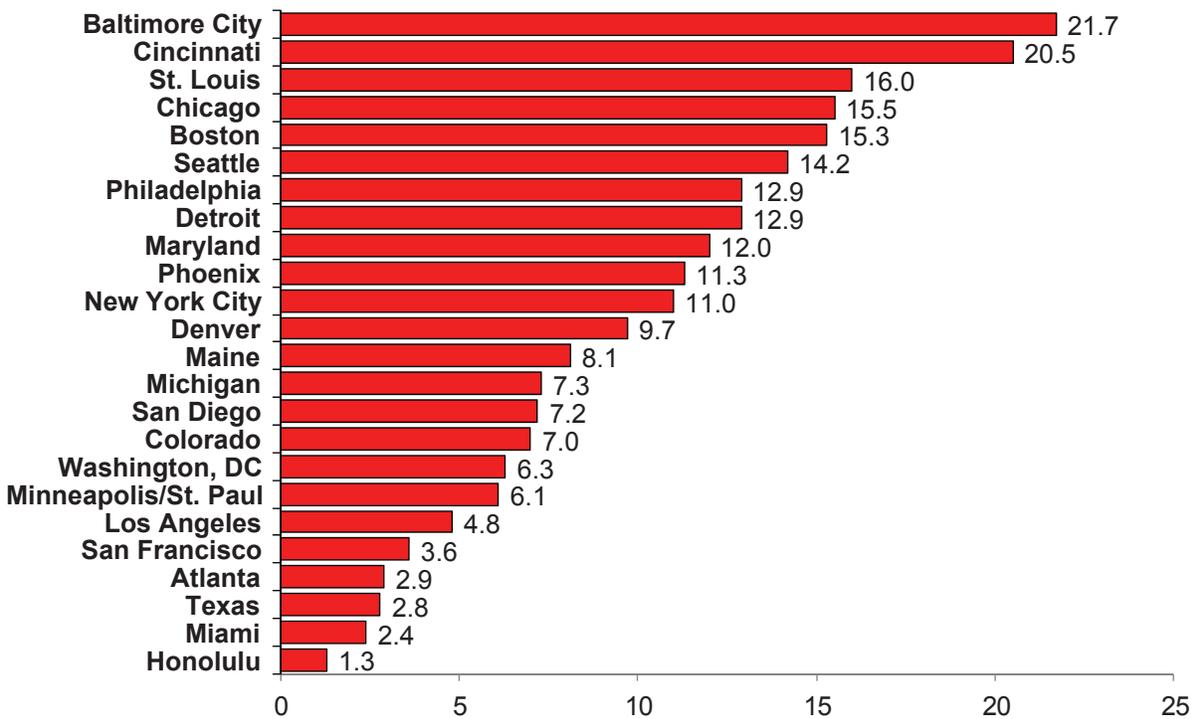
⁴Treatment data for Boston do not include admissions younger than 14. Phoenix treatment admissions do not include those younger than 18.

⁵NR=Not reported.

⁶Percentage-point changes could not be calculated due to missing data.

SOURCES: June 2012 State and local CEWG reports; *June 2011 Highlights and Executive Summary Volume I* CEWG report, p 87; *June 2010 Highlights and Executive Summary Volume I* CEWG report, p. 66; *June 2009 Highlights and Executive Summary Volume I* CEWG report, p. 47; and *June 2008 Highlights and Executive Summary Volume I* CEWG report, p. 71

Figure 7. Heroin Drug Reports Identified Among Drug Items Seized and Analyzed in Forensic Laboratories, as a Percentage of Total NFLIS Drug Reports¹, in 24 CEWG Areas: 2011²



¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each selected drug item seized and analyzed.

²Data are for CY 2011: January–December 2011; see appendix tables 2.1–2.24. 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 were retrieved on May 7–8, 2012

Opiates/Opioids Other Than Heroin

Treatment Admissions Data on Opiates/Opioids Other Than Heroin

In 2011, 21 CEWG areas provided data on treatment admissions for primary abuse of opiates/opioids other than heroin (also referred to as other opiates/opioids) as a category separate from heroin (table 11; appendix table 1). Treatment admissions for primary abuse of opiates other than heroin as a percentage of total substance abuse treatment admissions ranged from approximately 3 to 10 percent in 17 of the 21 reporting CEWG areas in 2011. The other opiates admissions group accounted for a high of 35.3 percent of the primary treatment admissions in Maine. This was followed distantly by Florida, at 29.2 percent, and South Florida/Broward County, at 24.6 percent. At the low end of the range, other opiates/opioids accounted for approximately 3 percent of total admissions in Detroit, Los Angeles, New York City, St. Louis, and San Francisco.

Other opiates/opioids ranked first as the primary substance of abuse in percentages of total treatment admissions in 1 of the 21 CEWG reporting areas (Florida), and second in South Florida/Broward County and Maine. This drug category did not rank third in any area, but it ranked fourth in five areas—Atlanta, Boston, Maryland, Minneapolis/St. Paul, and South Florida/Miami-Dade County (section II, table 2).

Gender of Other Opiate/Opioid Admissions. A majority of primary admissions for other opiates/opioids were male in 13 of 19 reporting CEWG areas, with the highest male percentages in Philadelphia (71.8 percent) and New York City (70.5 percent). However, females predominated slightly over males in Denver, Detroit, Florida, Phoenix, St. Louis, and Seattle among treatment admissions for other opiates/opioids (table 12).

Age of Other Opiate/Opioid Admissions. In only 3 of 19 CEWG areas reporting, namely Baltimore City, Detroit, and Los Angeles, a majority of primary other opiate admissions were age 35 or older (at approximately 51, 63, and 58 percent, respectively). Clients age 25 and younger were more highly represented among other opiate admissions in Maryland (44.3 percent) than in other CEWG areas (table 12).

Changes in Other Opiate/Opioid Admissions, 2007–2011

Of the 16 CEWG areas reporting complete 5-year data on other opiate treatment admissions, all areas showed increased percentages of such admissions between 2007 and 2011 (table 13). Increases ranged from 0.3 percentage points in San Diego to 10.0 percentage points in Maine over the 5-year period (table 13).

In the period from 2010 to 2011, 17 of 19 CEWG areas reporting data for the period showed increases in other opiate admissions. The largest increases were for Maine (3.1 percentage points), followed by Texas (2.6 percentage points) and South Florida/Broward County (2.5 percentage points). Two areas showed negligible declines over the period, Boston and Seattle, at 0.1 and 0.3 percentage points (table 13).

Table 11. Primary Other Opiate/Opioid Treatment Admissions in 21 CEWG Areas as a Percentage of Total Substance Abuse Admissions, Including Primary Alcohol Admissions¹: CY 2011²

CEWG Areas ³	Primary Other Opiate Admissions	Percentage of Total Admissions
	#	%
Atlanta	647	7.1
Baltimore City	635	4.3
Boston ⁴	865	4.8
Colorado	1,894	6.4
Denver	814	6.4
Detroit	288	3.0
Florida	16,386	29.2
Los Angeles	1,454	3.2
Maine	4,409	35.3
Maryland	6,395	12.2
Minneapolis/St. Paul	1,987	9.5
New York City	2,277	2.9
Philadelphia	348	3.9
Phoenix ^{4,5}	404	6.1
St. Louis	401	3.1
San Diego	580	4.2
San Francisco	697	3.2
Seattle	656	6.6
South Florida/Broward County	1,459	24.6
South Florida/Miami-Dade County	302	5.6
Texas	5,641	7.6

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for CY 2011: January–December 2011.

³Heroin and other opiates are grouped together in Cincinnati treatment data and are excluded from this table. Data for this table were not reported for Hawaii. For further information see appendix table 1.

⁴Treatment data for Boston do not include admissions younger than 14; Phoenix treatment admissions data exclude those younger than 18.

⁵Heroin and morphine are combined for Phoenix.

SOURCE: June 2012 State and local CEWG reports

Table 12. Demographic Characteristics of Primary Treatment Admissions for Opiates/Opioids Other Than Heroin in 19 CEWG Areas as a Percentage¹ of Primary Admissions for Opiates/Opioids Other Than Heroin: CY 2011²

CEWG Areas ³	Gender ⁴		Age Group	
	Male	Female	Younger Than 26	35 and Older
Atlanta	50.2	49.8	27.7	33.4
Baltimore City	52.1	47.9	20.5	50.7
Boston ⁵	65.0	35.0	23.1 ⁶	43.7
Colorado	50.4	49.6	32.0	31.7
Denver	46.4	53.6	27.9	35.4
Detroit	45.8	54.2	15.3	63.2
Florida	49.4	50.6	35.2	22.9
Los Angeles	55.0	45.0	16.8	58.0
Maine	53.9	46.1	32.6	24.3
Maryland	54.6	45.4	44.3	24.3
Minneapolis/St. Paul	53.4	46.6	29.7	35.5
New York City	70.5	29.5	36.5	33.2
Philadelphia	71.8	28.2	22.7	25.0
Phoenix ⁵	43.6	56.4	17.1	36.4
St. Louis	46.4	53.6	24.9	32.4
San Diego	54.0	46.0	19.1	42.4
Seattle	45.9	54.1	30.9	21.3 ⁷
South Florida/ Broward County	59.7	40.3	— ³	— ³
South Florida/ Miami-Dade County	57.0	43.0	— ³	— ³

¹Percentages are rounded to one decimal place.

²Data are for CY 2011: January–December 2011.

³Heroin and other opiates are grouped together for Cincinnati and are excluded here. Data for this table were not available for Hawaii or Texas, while data reported for San Francisco contained 476 cases with gender unknown and 180 cases with unknown age; data for South Florida/Broward and Miami-Dade Counties contained 573 and 150 cases of unknown age, respectively. These data are excluded from this table.

⁴Percentages may not add to 100 percent due rounding.

⁵Treatment data for Boston do not include admissions younger than 14. Phoenix treatment data exclude admissions younger than 18.

⁶Data for Boston treatment admissions in the 14–17 age group are suppressed because they number fewer than 5.

⁷Data from Seattle are for clients age 40 and older.

SOURCE: June 2012 State and local CEWG reports

Table 13. Treatment Admissions with a Primary Substance Abuse Problem With Opiates Other Than Heroin in 19 CEWG Areas as a Percentage of Total Admissions, Including Primary Alcohol Admissions, and Percentage-Point Changes for Two Time Periods: 2007–2011 and 2010–2011¹

CEWG Areas ²	Years (in Percent)					Percentage-Point Change	
	2007	2008	2009	2010	2011	2007–2011	2010–2011
Atlanta ³	3.3	4.1	5.2	6.6	7.1	+3.8	+0.5
Baltimore City ³	1.9	2.2	2.9	3.2	4.3	+2.4	+1.1
Boston ^{3,4}	3.3	4.0	4.4	4.9	4.8	+1.5	-0.1
Colorado	NR ⁵	3.9	5.2	5.8	6.4	— ⁶	+0.6
Denver	3.3	3.8	5.2	5.9	6.4	+3.1	+0.5
Detroit	1.3	1.5	2.2	2.3	3.0	+1.7	+0.7
Los Angeles	2.2	1.5	2.5	2.8	3.2	+1.0	+0.4
Maine	25.3	30.7	28.9	32.2	35.3	+10.0	+3.1
Maryland ³	4.6	5.7	8.0	10.3	12.2	+7.6	+1.9
Minneapolis/St. Paul	4.9	6.2	8.3	8.4	9.5	+4.6	+1.1
New York City	0.9	1.2	1.5	2.2	2.9	+2.0	+0.7
Philadelphia ³	0.4	0.8	1.6	2.8	3.9	+3.5	+1.1
Phoenix ⁴	3.1	3.3	4.1	5.2	6.1	+3.0	+0.9
St. Louis	1.9	2.0	2.7	2.7	3.1	+1.2	+0.4
San Diego	3.9	3.9	3.9	4.1	4.2	+0.3	+0.1
Seattle	4.1	4.3	5.6	6.9	6.6	+2.5	-0.3
South Florida/ Broward County	NR ⁵	NR ⁵	5.9	22.1	24.6	— ⁶	+2.5
South Florida/ Miami-Dade	NR ⁵	NR ⁵	2.0	5.4	5.6	— ⁶	+0.2
Texas ³	5.3	5.9	6.6	4.8	7.4	+2.1	+2.6

¹Calendar year (January–December) data.

²Noncomparability of data precludes inclusion in this table of Cincinnati.

³Data for these areas do not match data contained in previous June reports, as these data were updated by the area representatives.

⁴Treatment data for Boston do not include admissions younger than 14. Treatment data for Phoenix do not include admissions younger than 18.

⁵NR=not reported.

⁶Percentage-point changes could not be calculated due to missing data.

SOURCES: June 2012 State and local CEWG reports; *June 2011 Highlights and Executive Summary Volume I* CEWG report, p 92; *June 2010 Highlights and Executive Summary Volume I* CEWG report, p. 73; *June 2009 Highlights and Executive Summary Volume I* CEWG report, p. 54; and *June 2008 Highlights and Executive Summary Volume I* CEWG report, p. 42

Forensic Laboratory Data on Opiates/Opioids Other Than Heroin

Of the opiate/opioid drug reports among drug items seized and analyzed by forensic laboratories across CEWG areas in 2011, oxycodone and hydrocodone were the two most frequently reported in most areas. However, neither drug accounted for more than 15.0 percent of total drug reports in any area in 2011, and in most areas (14 of 24 areas for oxycodone and 18 of 24 areas for hydrocodone), less than 3.0 percent of total drug reports in 2011 were for these 2 drugs (table 14; figures 8 and 9; appendix table 2).

Oxycodone. Maine reported the highest frequency of oxycodone reports among drug items seized and analyzed in forensic laboratories in the period (at 14.3 percent), followed by Boston (9.5 percent) and Atlanta (8.1 percent) (table 14; figure 8). Oxycodone ranked among the top 10 drug reports from drug items identified in NFLIS laboratories in 21 of 24 CEWG areas in 2011. It ranked second among drug reports in one area, Maine. Oxycodone ranked third in Atlanta and Miami, and it placed fourth in Baltimore City, Boston, Cincinnati, Maryland, New York City, and Philadelphia (section II, table 1). In 5 of 24 CEWG areas, oxycodone represented less than 1.0 percent of the total drug reports in the reporting period (table 14; figure 8).

Hydrocodone. Hydrocodone ranked fourth among NFLIS drug reports in Detroit, Michigan, San Francisco, and Texas and fifth among drug reports in 4 of 24 areas, namely Atlanta, Chicago, Cincinnati, and San Diego (section II, table 1). The highest percentage of hydrocodone drug reports was in Texas, at 5.1 percent, followed by Atlanta, at 4.9 percent; the lowest percentages were for Washington, DC, and Baltimore City, at 0.1 percent each. Percentages of less than 1.0 percent characterized 9 of 24 areas reporting in 2011 (table 14; figure 9).

Buprenorphine. While buprenorphine was identified among NFLIS drug reports in all 24 reporting CEWG areas in 2011, in only 7 areas (Baltimore City, Boston, Maine, Maryland, New York City, Phoenix, and Seattle) was the drug identified in at least 1.0 percent of drug items identified. Percentages were 1.4, 3.5, 2.8, 1.5, 1.2, 1.2, and 1.1, respectively (table 14). Based on ranking of drug reports in the NFLIS system, buprenorphine was among the top 10 drugs identified in 9 of 24 areas. It ranked fifth in identified drugs in both Baltimore City and Boston (section II, table 1).

Methadone. Atlanta, Maine, New York City, and Seattle were the only areas reporting a percentage of 1.0 or higher for methadone drug reports, at 1.1, 1.4, 1.3, and 1.3 percent, respectively (table 14). Methadone ranked 7th among identified drugs in drug reports in New York City and 10th in five areas (Cincinnati, Maryland, Michigan, San Francisco, and Seattle) during this reporting period (section II, table 1).

Table 14. Selected Opiates/Opioids Other Than Heroin Reports¹ Among Drug Items Analyzed by Forensic Laboratories in 24 CEWG Areas, by Number and Percentage of Total Drug Reports: CY 2011²

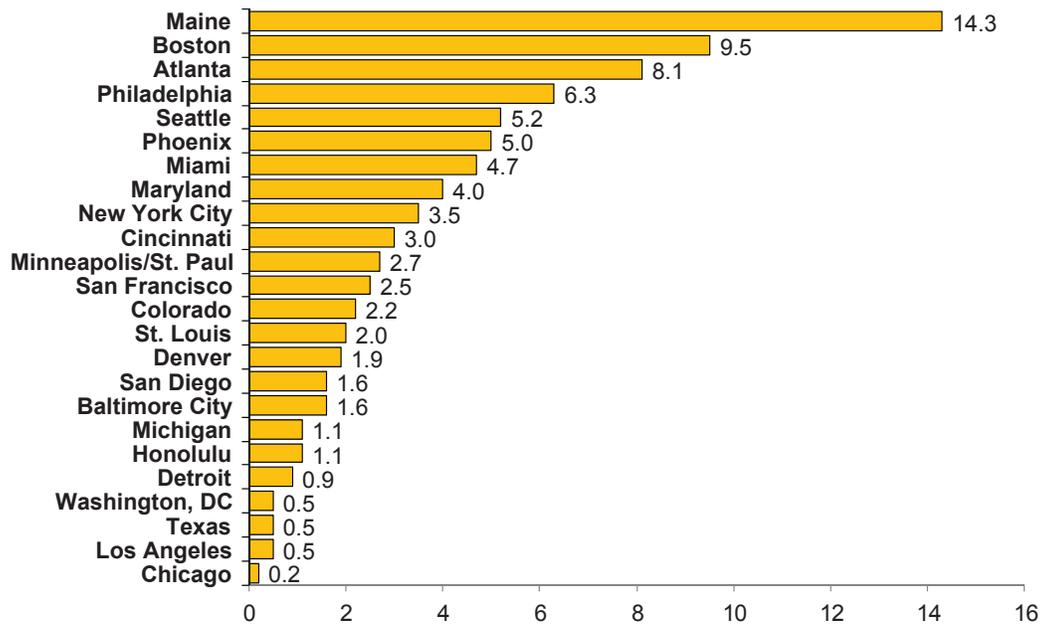
CEWG Area	Oxycodone		Hydrocodone		Methadone		Fentanyl		Buprenorphine		Total Reports
	#	(%)	#	(%)	#	(%)	#	(%)	#	(%)	
Atlanta	930	8.1	564	4.9	123	1.1	0	—	46	0.4	11,442
Baltimore City	487	1.6	38	0.1	80	0.3	0	—	449	1.4	31,326
Boston	2,088	9.5	137	0.6	116	0.5	6	0.0	768	3.5	21,920
Chicago	128	0.2	641	0.9	102	0.1	3	0.0	156	0.2	72,261
Cincinnati	324	3.0	167	1.5	0	—	4	0.0	55	0.5	10,893
Colorado	206	2.2	148	1.6	11	0.1	8	0.1	5	0.1	9,273
Denver	117	1.9	70	1.1	5	0.1	7	0.1	4	0.1	6,205
Detroit	62	0.9	296	4.2	18	0.3	1	0.0	19	0.3	7,123
Honolulu	22	1.1	19	0.9	3	0.0	0	—	2	0.0	2,037
Los Angeles	193	0.5	470	1.2	57	0.1	4	0.0	27	0.1	40,337
Maine	149	14.3	34	3.3	15	1.4	1	0.1	29	2.8	1,044
Maryland	3,067	4.0	363	0.5	297	0.4	10	0.0	1,120	1.5	77,082
Miami	1,202	4.7	115	0.4	66	0.3	1	0.0	47	0.2	25,697
Michigan	313	1.1	1,284	4.6	237	0.9	27	0.1	157	0.6	27,791
Minneapolis/ St. Paul	170	2.7	86	1.3	0	—	0	—	26	0.4	6,387
New York City	1,732	3.5	310	0.6	633	1.3	7	0.0	592	1.2	49,008
Philadelphia	1,715	6.3	147	0.5	80	0.3	7	0.0	144	0.5	27,172
Phoenix	575	5.0	266	2.3	59	0.5	2	0.0	134	1.2	11,563
St. Louis	391	2.0	493	2.5	62	0.3	5	0.0	150	0.8	19,832
San Diego	252	1.6	425	2.7	72	0.5	0	—	74	0.5	15,695
San Francisco	206	2.5	333	4.0	72	0.9	3	0.0	16	0.2	8,238
Seattle	114	5.2	27	1.2	28	1.3	10	0.5	25	1.1	2,180
Texas	420	0.5	4,604	5.1	277	0.3	26	0.0	113	0.1	89,616
Washington, DC	35	0.5	9	0.1	11	0.2	0	—	34	0.5	6,472

¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each drug item seized and analyzed.

²Data are for January–December 2011; see appendix tables 2.1–2.24. 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 were retrieved on May 7–8, 2012

Figure 8. Oxycodone Drug Reports Identified Among Drug Items Seized and Analyzed in Forensic Laboratories, as a Percentage of Total NFLIS Drug Reports¹, in 24 CEWG Areas: 2011²

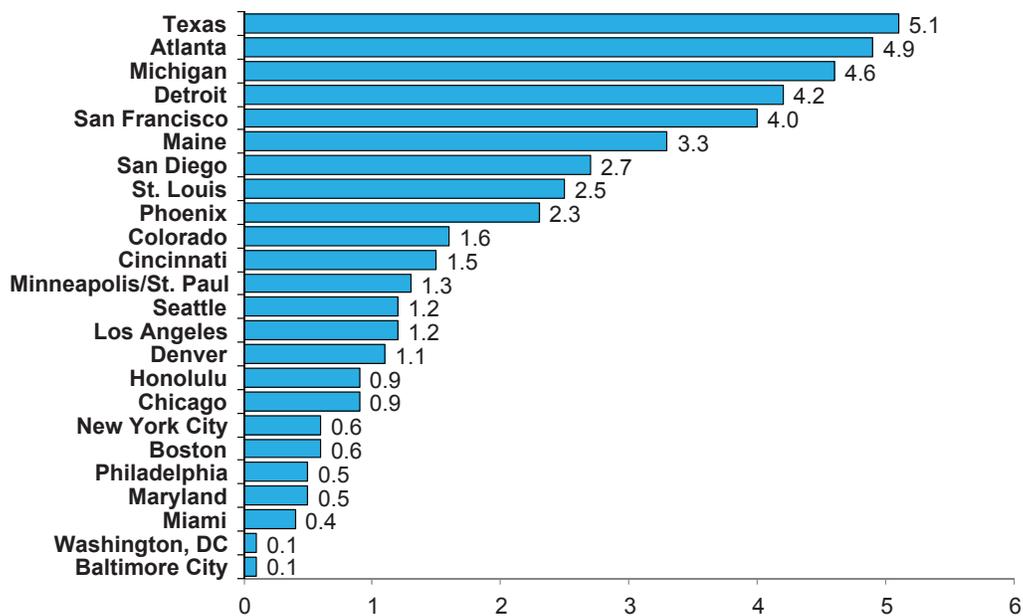


¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each selected drug item seized and analyzed.

²Data are for CY 2011: January–December 2011; see appendix tables 2.1–2.24. 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 were retrieved on May 7–8, 2012

Figure 9. Hydrocodone Drug Reports Identified Among Drug Items Seized and Analyzed in Forensic Laboratories, as a Percentage of Total NFLIS Drug Reports¹, in 24 CEWG Areas: 2011²



¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each selected drug item seized and analyzed.

²Data are for CY 2011: January–December 2011; see appendix tables 2.1–2.24. 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 were retrieved on May 7–8, 2012

Benzodiazepines/Depressants

Treatment Admissions Data on Benzodiazepines

Table 15 shows proportions of primary benzodiazepine treatment admissions for 10 areas reporting such admissions at 1.0 percent or more of total substance abuse treatment admissions. Percentages ranged from 1.0 percent in Maine to 2.4 percent in Atlanta and South Florida/Broward County. Benzodiazepine admissions as a separate category in treatment data did not rank higher than sixth among primary drugs of abuse in any of the 19 CEWG areas reporting these data. Benzodiazepines ranked in sixth place in the proportion of total substance abuse admissions in Baltimore City, Boston, and Cincinnati in 2011 (section II, table 2).

Forensic Laboratory Data on Benzodiazepines

Three benzodiazepine-type items—alprazolam, clonazepam, and diazepam—were the most frequently reported benzodiazepines identified in drug reports among items seized and analyzed by forensic laboratories in 24 CEWG areas in the 2011 reporting period. Table 16 shows the numbers and percentages of drug reports containing alprazolam, clonazepam, and diazepam in each of the reporting CEWG areas.

Alprazolam. In the 24 CEWG areas for which NFLIS data were reported for 2011, the highest percentages of alprazolam drug reports among items seized and analyzed were in Atlanta (6.0

Table 15. Primary Benzodiazepine Treatment Admissions in 10 CEWG Areas Reporting Such Admissions at 1.0 Percent or More of Total Admissions, as a Percentage of Total Substance Abuse Treatment Admissions¹: CY 2011²

CEWG Areas ³	Primary Benzodiazepine Admissions	Percentage of Total Admissions
	#	%
Atlanta	223	2.4
Baltimore City	157	1.1
Boston	234	1.3
Florida	1,081	1.9
Maine	121	1.0
Maryland	642	1.2
Philadelphia	135	1.5
South Florida/Broward County	140	2.4
South Florida/Miami-Dade County	79	1.5
Texas	1,201	1.6

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for CY 2011: January–December 2011.

³Data for this table were not reported for areas with benzodiazepine-related primary treatment admissions of less than 1.0 percent (Cincinnati, Colorado, Denver, Los Angeles, Minneapolis/St. Paul, New York City, St. Louis, San Francisco, and Seattle) and for those areas where benzodiazepines are not reported separately from other substance abuse treatment admissions (Detroit, Hawaii, Phoenix, and San Diego). For further information, see appendix table 1.

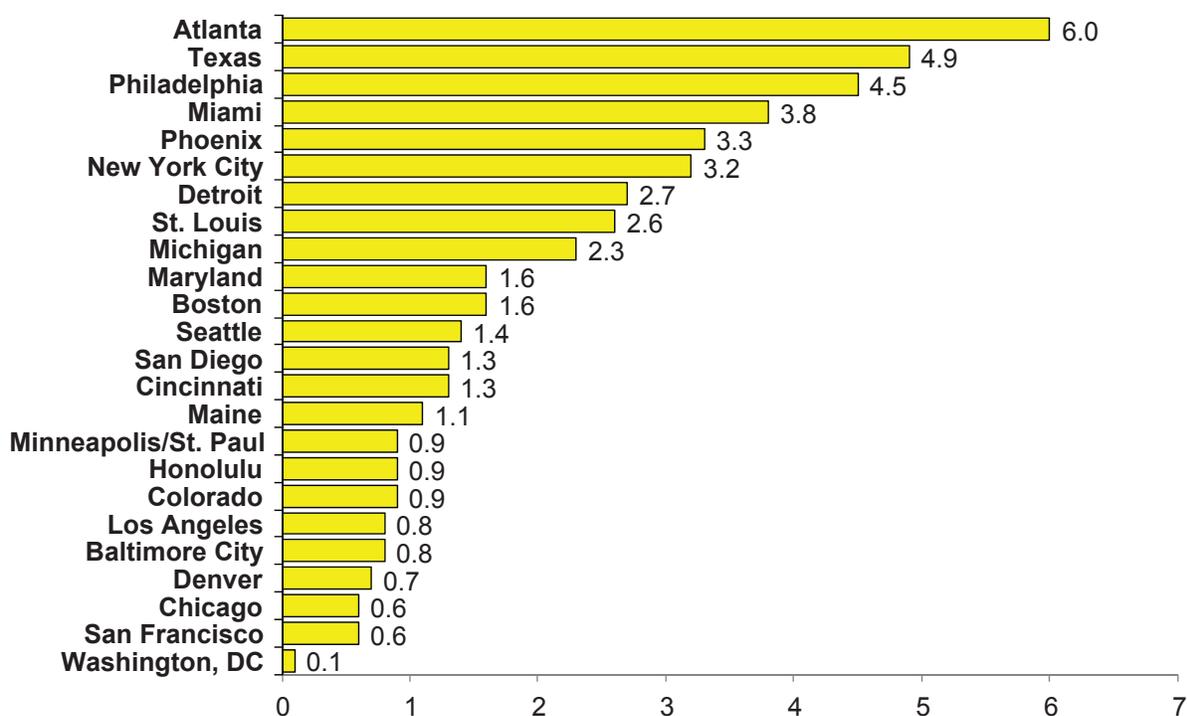
SOURCE: June 2012 State and local CEWG reports

percent), Texas (4.9 percent), and Philadelphia (4.5 percent). Alprazolam drug reports represented 1.0–3.8 percent of total drug reports in 12 areas—Boston, Cincinnati, Detroit, Maine, Maryland, Miami, Michigan, New York City, Phoenix, St. Louis, San Diego and Seattle—and less than 1.0 percent in the remaining 9 reporting CEWG areas (table 16; figure 10). In section II, table 1, which shows the rankings of the most frequently reported drugs in NFLIS data for 2011, alprazolam ranked in the top 10 in 19 reporting areas. It ranked fourth in frequency among the top 10 drug reports in Atlanta and Miami and fifth in Detroit, Maryland, New York City, Philadelphia, St. Louis, and Texas (section II, table 1).

Clonazepam. Reports of clonazepam accounted for 2.7 percent of all drug reports among drug items analyzed by NFLIS laboratories in Boston. Its presence was minimal in the 23 other CEWG areas, with the exception of Maine and Phoenix, where percentages were approximately 1 percent (table 16). Clonazepam was identified in drug reports in all 24 CEWG areas, with the exception of Washington, DC. In Boston, clonazepam was the sixth most frequently identified drug reported in forensic laboratories in 2011 (section II, table 1).

Diazepam. While reported in all 24 CEWG areas, diazepam accounted for less than 1.0 percent of all drug reports in 23 CEWG areas (table 16). The exception was Maine, where 1.0 percent of all drug reports in 2011 involved diazepam. Diazepam ranked ninth in Cincinnati among drug reports in items identified in NFLIS forensic laboratories in 2011 (section II, table 1).

Figure 10. Alprazolam Drug Reports Identified Among Drug Items Seized and Analyzed in Forensic Laboratories, as a Percentage of Total NFLIS Drug Reports¹, in 24 CEWG Areas: 2011²



¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each selected drug item seized and analyzed.

²Data are for CY 2011: January–December 2011; see appendix tables 2.1–2.24. 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 were retrieved on May 7–8, 2012

Table 16. Number of Selected Benzodiazepine Reports Identified Among Drug Items Analyzed by Forensic Laboratories in 24 CEWG Areas, by Number and Percentage of Total Reports¹ Identified: CY 2011²

CEWG Area	Alprazolam		Clonazepam		Diazepam		Total Reports
	#	(%)	#	(%)	#	(%)	
Atlanta	682	6.0	106	0.9	45	0.4	11,442
Baltimore City	263	0.8	97	0.3	46	0.1	31,326
Boston	356	1.6	597	2.7	95	0.4	21,920
Chicago	419	0.6	85	0.1	69	0.1	72,261
Cincinnati	141	1.3	73	0.7	54	0.5	10,893
Colorado	79	0.9	44	0.5	54	0.6	9,273
Denver	43	0.7	28	0.5	26	0.4	6,205
Detroit	193	2.7	9	0.1	14	0.2	7,123
Honolulu	19	0.9	3	0.1	8	0.4	2,037
Los Angeles	303	0.8	82	0.2	76	0.2	40,337
Maine	11	1.1	11	1.1	10	1.0	1,044
Maryland	1,203	1.6	390	0.5	211	0.3	77,082
Miami	981	3.8	72	0.3	42	0.2	25,697
Michigan	646	2.3	167	0.6	80	0.3	27,791
Minneapolis/St. Paul	56	0.9	48	0.8	20	0.3	6,387
New York City	1,579	3.2	417	0.9	147	0.3	49,008
Philadelphia	1,233	4.5	248	0.9	92	0.3	27,172
Phoenix	383	3.3	118	1.0	61	0.5	11,563
St. Louis	516	2.6	121	0.6	116	0.6	19,832
San Diego	197	1.3	94	0.6	81	0.5	15,695
San Francisco	49	0.6	35	0.4	51	0.6	8,238
Seattle	30	1.4	17	0.8	10	0.5	2,180
Texas	4,395	4.9	640	0.7	452	0.5	89,616
Washington, DC	8	0.1	0	—	3	0.0	6,472

¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each drug item seized and analyzed.

²Data are for January–December 2011; see appendix tables 2.1–2.24. 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 were retrieved on May 7–8, 2012

Methamphetamine

Treatment Admissions Data on Methamphetamine

Data on primary methamphetamine treatment admissions in the 2011 reporting period were available and reported for 13 CEWG areas (where methamphetamine was the major substance of abuse in at least 1.0 percent of total admissions)²². As a percentage of total treatment admissions, Hawaii had the highest proportion of methamphetamine admissions, at 38.2 percent, followed by San Diego, at 29.0 percent (table 17; appendix table 1). In the same period, primary methamphetamine admissions accounted for approximately 11–20 percent of total primary admissions in five areas—Colorado, Denver, Los Angeles, Phoenix, and San Francisco. Ten CEWG areas, all east of the Mississippi River (Baltimore City, Boston, Chicago, Cincinnati, Detroit, Maryland, Miami, New York

Table 17. Primary Methamphetamine Treatment Admissions in 13 CEWG Areas Reporting Such Admissions at 1.0 Percent or More of Total Admissions, as a Percentage of Total Substance Abuse Treatment Admissions¹, Including Primary Alcohol Admissions: CY 2011²

CEWG Areas ³	Primary Methamphetamine Admissions	Percentage of Total Admissions
	#	%
Atlanta	522	5.7
Colorado	4,226	14.3
Denver	1,400	11.1
Florida ⁴	957	1.7
Hawaii ⁴	4,138	38.2
Los Angeles	7,451	16.3
Minneapolis/St. Paul	1,326	6.4
Phoenix ⁵	1,333	20.2
St. Louis	320	2.5
San Diego	3,968	29.0
San Francisco	4,200	19.2
Seattle	816	8.2
Texas	4,413	5.9

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for CY 2011: January–December 2011.

³Data for CEWG areas where primary methamphetamine admissions represented less than 1.0 percent of total substance abuse treatment admissions were not included in this table (Baltimore City, Boston, Cincinnati, Detroit, Maine, Maryland, New York City, Philadelphia, South Florida/Broward, and South Florida/Miami-Dade). For further information, see appendix table 1.

⁴Hawaii reported combined methamphetamine and stimulants admissions. Methamphetamine and amphetamines are grouped together for the State of Florida.

⁵Treatment data for Phoenix do not include admissions younger than 18.

SOURCE: June 2011 State and local CEWG reports

²²Data for 10 areas were excluded due to small numbers (less than 1.0 percent of admissions were for methamphetamine).

City, Philadelphia, and Washington, DC), reported that less than 1.0 percent of admissions were for primary methamphetamine abuse (due to small numbers, data not shown). Based on rankings of primary drugs as a percentage of total treatment admissions, methamphetamine ranked first in Hawaii and San Diego; second in San Francisco; third in Colorado, Denver, and Phoenix; and fourth in Los Angeles (section II, table 2).

Route of Administration of Methamphetamine. In the 10 CEWG areas represented in table 18, smoking was the most common mode of administering methamphetamine among primary methamphetamine admissions in all reporting areas. Smoking was reported at levels ranging from 44.1 percent in St. Louis to 78.6 percent in Los Angeles, with relatively high percentages of smoking reported in Minneapolis/St. Paul, Phoenix, San Diego, and San Francisco (approximately 72–73 percent each).

St. Louis had the highest percentage of methamphetamine treatment admissions who injected the drug (at 42.8 percent), while the highest percentages reporting inhalation as the primary route of methamphetamine administration were in Los Angeles, at 11.2 percent, and Atlanta, at 10.7 percent (table 18).

Table 18. Primary Route of Administration of Methamphetamine Among Treatment Admissions in 10 CEWG Areas Reporting Such Admissions at 1.0 Percent or More of Total Admissions, as a Percentage¹ of Primary Methamphetamine Treatment Admissions: CY 2011²

CEWG Areas ³	Smoked		Inhaled		Injected		Oral/Other/ Unknown		Total N
	#	%	#	%	#	%	#	%	
Atlanta	287	55.0	56	10.7	120	23.0	59	11.3	522
Colorado	2,638	62.4	327	7.7	1,140	27.0	121	2.9	4,226
Denver	808	57.7	129	9.2	411	29.4	52	3.7	1,400
Los Angeles	5,854	78.6	835	11.2	558	7.5	204	2.7	7,451
Minneapolis/St. Paul	955	72.0	84	6.3	218	16.4	69	5.2	1,326
Phoenix ⁴	965	72.4	81	6.1	118	8.9	169	12.7	1,333
St. Louis	141	44.1	28	8.8	137	42.8	14	4.4	320
San Diego	2,890	72.9	319	8.0	699	17.6	56	1.4	3,964
San Francisco	3,067	73.0	313	7.5	689	16.4	131	3.1	4,200
Texas ⁵	NR ⁵	52.5	NR ⁵	7.6	NR ⁵	35.6	NR ⁵	3.6	4,413

¹Percentages may not sum to 100 due to rounding.

²Data are for CY 2011: January–December 2011.

³No data were available for Florida, Hawaii, and Seattle, while cases reported in CEWG areas where percentages of primary methamphetamine admissions represented less than 1.0 percent of total substance abuse treatment admissions were not included in this table. These include Baltimore City, Boston, Cincinnati, Detroit, Maine, Maryland, New York City, Philadelphia, South Florida/Broward, and South Florida/Miami-Dade. For further information, see appendix table 1.

⁴Treatment data for Phoenix do not include admissions younger than 18.

⁵NR=Not reported.

SOURCE: June 2012 State and local CEWG reports

Gender of Methamphetamine Admissions. In 9 of 11 CEWG areas reporting on the gender of primary methamphetamine admissions, males represented the majority. The largest proportions of male methamphetamine admissions were in Minneapolis/St. Paul, Seattle, and Texas, at approximately 63 percent each. In 2 of 11 reporting areas (Atlanta and Phoenix), females predominated among primary methamphetamine admissions, representing 57.3 and 56.9 percent of treatment admissions, respectively (table 19).

Age of Methamphetamine Admissions. In the nine CEWG areas reporting at more than 1.0 percent of total admissions for which methamphetamine was reported, San Diego (at 50.5 percent) had the highest proportion of methamphetamine admissions age 35 and older. Los Angeles (27.0 percent), Minneapolis/St. Paul (25.3 percent), and Atlanta (25.1 percent) had the highest proportions of methamphetamine admissions age 25 and younger (table 19).

Table 19. Demographic Characteristics of Primary Methamphetamine Treatment Admissions in 11 CEWG Areas Reporting Such Admissions at 1.0 Percent or More of Total Substance Abuse Admissions, as a Percentage¹ of Primary Methamphetamine Treatment Admissions¹: CY 2011²

CEWG Areas ³	Gender		Age Group	
	Male	Female	Younger Than 26	35 and Older
Atlanta	42.7	57.3	25.1	35.1
Colorado	53.8	46.2	19.4	38.9
Denver	58.6	41.4	17.0	42.6
Los Angeles	51.1	48.9	27.0	37.0
Minneapolis/St. Paul	63.0	37.0	25.3	35.4
Phoenix ⁴	43.1	56.9	17.4	44.3
St. Louis	53.4	46.6	19.1	43.4
San Diego	55.1	44.9	18.3	50.5
San Francisco	60.9	39.0	— ⁵	— ⁵
Seattle	62.6	37.4	21.8	27.1 ⁶
Texas	62.5	37.5	NR ⁷	NR ⁷

¹Percentages are rounded to the first decimal place.

²Data are for CY 2011: January–December 2011.

³Data on methamphetamine admissions by gender and age group were not available for Hawaii; cases reported in CEWG areas where primary methamphetamine admissions represented less than 1.0 percent of total substance abuse treatment admissions were not included in this table. These include Baltimore City, Boston, Cincinnati, Detroit, Maine, Maryland, New York City, Philadelphia, South Florida/Broward County, and South Florida/Miami-Dade County. For further information, see appendix table 1.

⁴Treatment data for Phoenix do not include admissions younger than 18.

⁵San Francisco methamphetamine admissions data include 590 cases in which age was not known; these data are excluded.

⁶Data from Seattle are for clients age 40 and older.

⁷NR=Not reported.

SOURCE: June 2012 State and local CEWG reports

Changes in Methamphetamine Admissions, 2007–2011

Table 20 compares percentages of primary methamphetamine substance abuse treatment admissions for 10 CEWG areas where primary methamphetamine admissions accounted for 1.0 percent or more of total admissions and for which data were available for at least one of the two time periods: 2007–2011 and 2010–2011. Six of nine CEWG areas with data for the 5-year period showed declines in methamphetamine admissions from 2007 to 2011. The largest percentage-point decrease in methamphetamine-related primary admissions over the 5-year period was in Phoenix, at 8.4 percentage points. San Diego and Los Angeles experienced declines in methamphetamine admissions of 6.6 percentage points each over the period. In one area, St. Louis, there was no change from 2007 to 2011, while in two areas, Atlanta and Hawaii, methamphetamine admissions increased by 1.1 and 1.8 percentage points, respectively, over the 5-year period.

In the more recent period, from 2010 to 2011, 7 of the 10 reporting areas experienced decreases in primary methamphetamine treatment admissions. Seattle had the largest decline in methamphetamine admissions (1.1 percentage points) from 2010 to 2011. Two areas, Hawaii and Phoenix,

Table 20. Primary Methamphetamine Treatment Admissions in 10 CEWG Areas Reporting Such Admissions at 1.0 Percent or More of Total Admissions, as a Percentage of Total Substance Abuse Treatment Admissions, and Percentage-Point Changes for Two Time Periods: 2007–2011 and 2010–2011¹

CEWG Areas ²	Years (in Percent)					Percentage-Point Change	
	2007	2008	2009	2010	2011	2007–2011	2010–2011
Atlanta ³	6.8	4.9	4.9	5.2	5.7	+1.1	-0.5
Colorado	NR ⁴	15.8	14.5	14.6	14.3	— ⁵	-0.3
Denver	13.9	12.7	11.5	11.7	11.1	-2.8	-0.6
Hawaii ⁶	36.4	31.9	42.0	34.4	38.2	+1.8	+3.8
Los Angeles	22.9	19.0	17.9	16.4	16.3	-6.6	-0.1
Minneapolis/St. Paul	6.7	5.7	5.5	6.4	6.4	-0.3	0
Phoenix ⁷	28.6	24.5	21.0	19.8	20.2	-8.4	+0.4
St. Louis	2.5	2.7	2.5	2.8	2.5	0	-0.3
San Diego	35.6	30.7	29.2	29.2	29.0	-6.6	-0.2
Seattle	11.0	9.5	6.9	9.3	8.2	-2.8	-1.1

¹Calendar year (January–December) data.

²Data for CEWG areas were not included in this table when data were not available for 3 or more years in the period, were not comparable over time, or where primary methamphetamine admissions were less than 1.0 percent of total substance abuse treatment admissions (Baltimore City, Boston, Cincinnati, Detroit, Maine, Maryland, New York City, Philadelphia, South Florida/Broward County, and South Florida/Miami-Dade County). Data for all years were lacking for Chicago, Florida, and San Francisco. In Texas, amphetamines and methamphetamine are combined. For further information, see appendix table 1.

³Data do not match data contained in previous June reports, as these data were updated by the area representative.

⁴NR=Not reported.

⁵Percentage-point changes could not be calculated due to missing data.

⁶Hawaii reported combined methamphetamine and stimulants admissions.

⁷Treatment data for Phoenix do not include admissions younger than 18.

SOURCES: June 2012 State and local CEWG reports; *June 2011 Highlights and Executive Summary Volume I* CEWG report, p 102; *June 2010 Highlights and Executive Summary Volume I* CEWG report, p. 82; *June 2009 Highlights and Executive Summary Volume I* CEWG report, p. 67; and *June 2008 Highlights and Executive Summary Volume I* CEWG report, p. 72

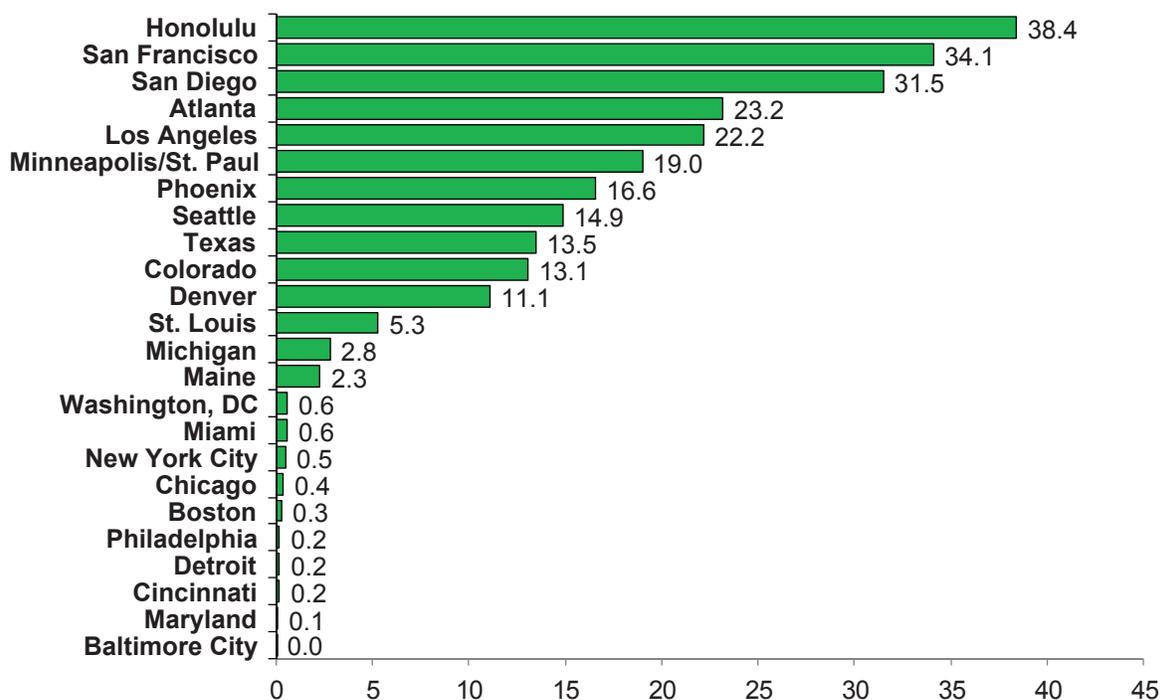
showed increases in methamphetamine admissions (of 3.8 and 0.4 percentage points, respectively) during the period. One area, Minneapolis/St. Paul, showed no change over the 2010–2011 period (table 20).

Forensic Laboratory Data on Methamphetamine

In 2011, forensic laboratory data for CEWG reporting areas (figure 11; section II, figure 5; appendix table 2) show that methamphetamine was the drug reported most frequently among total drug reports in Honolulu (38.4 percent of total drug reports). Reports of methamphetamine were next most frequently identified among total drug reports in San Francisco (34.1 percent) and San Diego (31.5 percent) (figure 11). In 10 of the CEWG reporting areas, methamphetamine accounted for less than 1.0 percent of the total reports from drug items seized and analyzed; all were located east of the Mississippi River. These areas included Baltimore City, Boston, Chicago, Cincinnati, Detroit, Maryland, Miami, New York City, Philadelphia, and Washington, DC (figure 11; section II, figure 5; appendix table 2).

Methamphetamine ranked first among drug reports from items identified in San Diego and San Francisco; second in Atlanta, Honolulu, Phoenix, and Seattle; and third in Minneapolis/St. Paul, Colorado, Denver, Los Angeles, and Texas in this reporting period (section II, table 1).

Figure 11. Methamphetamine Drug Reports Identified Among Drug Items Seized and Analyzed in Forensic Laboratories, as a Percentage of Total NFLIS Drug Reports¹, in 24 CEWG Areas: 2011²



¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each selected drug item seized and analyzed.

²Data are for CY 2011: January–December 2011; see appendix tables 2.1–2.24. 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 were retrieved on May 7–8, 2012

Marijuana/Cannabis

Treatment Admissions Data on Marijuana/Cannabis

In the 2011 reporting period, marijuana/cannabis ranked as the most frequently reported drug by primary treatment admissions in 3 of the 23 CEWG reporting areas, when primary alcohol admissions were included in the total (section II, table 2); these were Los Angeles and South Florida/Miami-Dade and Broward Counties. Marijuana/cannabis ranked second among primary drugs of admission in 10 areas (Atlanta, Cincinnati, Colorado, Denver, Minneapolis/St. Paul, New York City, Philadelphia, Phoenix, Seattle, and Texas) (section II, table 2).

As shown in table 21, South Florida/Miami-Dade County had the highest percentage of primary marijuana/cannabis treatment admissions, including primary alcohol admissions, at 37.6 percent, followed closely by South Florida/Broward County, at 32.9 percent (also see appendix table 1). The lowest proportion of marijuana/cannabis treatment admissions was reported in Boston, at 3.9 percent.

Gender of Marijuana/Cannabis Admissions. Males predominated in all 21 CEWG areas reporting on the gender of primary marijuana/cannabis admissions in 2011 (table 22). The proportion of males ranged from a high of approximately 88 percent of marijuana/cannabis admissions in Philadelphia to a low of approximately 60 percent in Phoenix.

Age of Marijuana/Cannabis Admissions. Across 17 of the 20 CEWG areas for which age distributions were reported, the majority of primary marijuana/cannabis treatment admissions were 25 and younger. Exceptions were New York City, Philadelphia, and Phoenix. South Florida/Miami-Dade County, Florida, Los Angeles, and South Florida/Broward County had the highest proportions of primary marijuana/cannabis treatment admissions who were younger than 18, at more than one-half (63.0, 60.7, 58.0, and 54.9 percent, respectively). Phoenix (42.2 percent), Philadelphia (40.8 percent), and Boston (40.5 percent) had the highest proportions of marijuana/cannabis admissions in the next age cohort, 18–25. Older primary marijuana/cannabis treatment admissions (35 and older) were most common in New York City, at 24.4 percent, followed by Detroit, Phoenix, and Boston, at approximately 23 percent each (table 22).

Changes in Marijuana/Cannabis Admissions, 2007–2011

Table 23 compares percentages of primary marijuana/cannabis treatment admissions for 20 CEWG areas for which data were available for at least one of two time periods: 2007–2011 (17 areas) and 2010–2011 (20 areas). Over the 5-year period, primary marijuana/cannabis treatment admissions decreased as a percentage of total admissions in 5 of the 17 reporting areas—Boston, Denver, Detroit, Maine, and St. Louis—with the largest decrease in Denver, at 1.9 percentage points. Conversely, 2007–2011 proportions of primary marijuana/cannabis admissions increased in 12 reporting areas (Atlanta, Baltimore City, Hawaii, Los Angeles, Maryland, Minneapolis/St. Paul, New York City, Philadelphia, Phoenix, San Diego, Seattle, and Texas). The largest increases occurred in Phoenix and Los Angeles, at 10.5 and 6.5 percentage points, respectively (table 23).

In the more recent period from 2010 to 2011, for which data were available for 20 CEWG areas, increases in marijuana/cannabis admissions were observed for six areas—Baltimore City, Los Angeles, Maryland, Philadelphia, Phoenix, Seattle, and Texas. The largest increase, of 6.7 percentage points, occurred in Phoenix. In 13 of 20 areas, declines in primary marijuana treatment admissions were found, with Hawaii, Denver, and St. Louis showing the largest declines, at 3.2, 2.6, and 2.4 percentage points, respectively. In Maine, there was no change over the period (table 23).

Table 21. Primary Marijuana Treatment Admissions in 23 CEWG Areas as a Percentage of Total Substance Abuse Admissions, Including Primary Alcohol Admissions¹: CY 2011²

CEWG Areas	Primary Marijuana Admissions	Percentage of Total Admissions
	#	%
Atlanta	1,582	17.3
Baltimore City	2,288	15.6
Boston ³	691	3.9
Cincinnati	1,522	30.4
Colorado	6,088	20.6
Denver	2,726	21.6
Detroit	1,392	14.5
Florida	13,088	23.4
Hawaii	2,497	23.1
Los Angeles	11,356	24.8
Maine	1,179	9.4
Maryland	10,476	20.0
Minneapolis/St. Paul	3,464	16.6
New York City	19,960	25.8
Philadelphia	1,644	18.3
Phoenix ³	1,560	23.6
St. Louis	2,448	19.1
San Diego	2,520	18.4
San Francisco	2,110	9.6
Seattle	1,944	19.5
South Florida/Broward County	1,949	32.9
South Florida/Miami-Dade County	2,008	37.6
Texas	17,723	23.8

¹More information on these data is available in the footnotes and notes for appendix table 1.

²Data are for the CY 2011: January–December 2011.

³Treatment data for Boston do not include admissions younger than 14; Phoenix treatment data do not include admissions younger than 18.

SOURCE: June 2012 State and local CEWG reports

Table 22. Demographic Characteristics of Primary Marijuana Treatment Admissions in 21 CEWG Areas, as a Percentage of Total Marijuana Admissions¹: CY 2011²

CEWG Areas ³	Gender ⁴		Age Group ⁴			
	Male	Female	Younger Than 18	18–25	26–34	35 and Older
Atlanta	67.1	32.9	19.8	35.8	26.5	17.8
Baltimore City	81.3	18.7	38.9	32.3	17.1	11.7
Boston ⁵	72.5	27.1	15.8	40.5	20.8	22.9
Cincinnati	72.9	27.1	44.0	27.6	17.1	11.3
Colorado	76.6	23.4	30.1	30.5	23.2	16.2
Denver	76.4	23.6	35.4	28.1	21.5	15.0
Detroit	66.1	33.9	17.8	39.0	19.8	23.3
Florida	73.2	26.8	60.7	21.1	11.8	6.2
Los Angeles	66.6	33.4	58.0	20.4	10.0	11.5
Maine	70.6	29.4	31.0	32.1	19.3	17.4
Maryland	77.7	22.3	35.5	37.4	17.1	9.9
Minneapolis/St. Paul	78.4	21.6	32.4	36.9	17.9	12.8
New York City	77.0	23.0	11.0	34.1	30.4	24.4
Philadelphia	87.8	12.2	5.4	40.8	35.2	18.6
Phoenix ⁵	59.7	40.3	— ⁵	42.2	34.7	23.1
St. Louis	73.0	27.0	30.3	27.7	22.6	19.5
San Diego	74.7	25.3	50.8	19.8	16.0	13.4
Seattle	74.8	25.2	46.9	25.0	19.3 ⁶	8.7 ⁶
South Florida/ Broward County	82.0	18.0	54.9	27.1	10.9	7.1
South Florida/ Miami-Dade County	72.9	27.1	63.0	19.4	10.9	6.6
Texas	71.1	28.9	NR ⁷	NR ⁷	NR ⁷	NR ⁷

¹Percentages are rounded to one decimal place.

²Data are for CY 2011: January–December 2011.

³No data were available for Hawaii. Data for San Francisco contained unknown gender data for 157 cases and unknown age data for 35 cases; percentages are excluded in this table. For further information see appendix table 1.

⁴Percentages may not add to 100 percent due to the presence of unknown gender or age.

⁵Treatment data for Boston do not include admissions younger than 14. Phoenix treatment data do not include admissions younger than 18; therefore, reports of treatment admissions for clients younger than 18 do not apply to Phoenix.

⁶The age ranges are 26–39 and 40 and older for Seattle.

⁷NR=Not reported.

SOURCE: June 2012 State and local CEWG reports

Table 23. Primary Marijuana Treatment Admissions as a Percentage of Total Admissions in 20 CEWG Areas and Percentage-Point Changes for Two Time Periods: 2007–2011 and 2010–2011¹

CEWG Areas ²	Years (in Percent)					Percentage-Point Change	
	2007	2008	2009	2010	2011	2007–2011	2010–2011
Atlanta ³	17.1	17.6	18.5	18.7	17.3	+0.2	-1.4
Baltimore City ³	11.3	10.8	11.9	13.5	15.6	+4.3	+2.1
Boston ^{3,4}	4.1	3.9	4.6	4.5	3.9	-0.2	-0.6
Colorado	NR ⁵	21.5	21.6	22.0	20.6	— ⁶	-1.4
Denver	23.5	23.6	23.3	24.2	21.6	-1.9	-2.6
Detroit	15.5	13.9	14.9	15.2	14.5	-1.0	-0.7
Hawaii	22.1	22.3	28.7	26.3	23.1	+1.0	-3.2
Los Angeles	18.3	19.9	23.0	24.0	24.8	+6.5	+0.8
Maine	10.9	10.1	9.0	9.4	9.4	-1.5	0
Maryland ³	17.9	18.5	18.6	19.2	20.0	+2.1	+0.8
Minneapolis/St. Paul	16.1	16.6	18.1	18.3	16.6	+0.5	-1.7
New York City	21.3	23.1	25.0	27.4	25.8	+4.5	-1.6
Philadelphia ³	15.8	17.4	21.1	20.0	18.3	+2.5	-1.7
Phoenix ⁴	13.1	14.1	14.9	16.9	23.6	+10.5	+6.7
St. Louis	20.3	23.7	21.3	21.5	19.1	-1.2	-2.4
San Diego	15.6	18.9	19.9	18.5	18.4	+2.8	-0.1
Seattle	16.2	16.4	18.4	18.6	19.5	+3.3	+0.9
South Florida/ Broward County	NR ⁵	NR ⁵	35.8	33.3	32.9	— ⁶	-0.4
South Florida/ Miami-Dade County	NR ⁵	NR ⁵	38.2	38.3	37.6	— ⁶	-0.7
Texas ³	22.7	22.8	23.7	26.5	23.8	+2.7	+1.1

¹Calendar year (January–December) data.

²Data were not included in this table for CEWG areas with less than 3 years of data in the period or where data were not comparable over time.

³Data for these areas do not match data contained in previous June reports, as these data were updated by the area representatives.

⁴Treatment data for Boston do not include admissions younger than 14. Treatment data for Phoenix do not include admissions younger than 18.

⁵NR=Not reported.

⁶Percentage-point changes could not be calculated due to missing data.

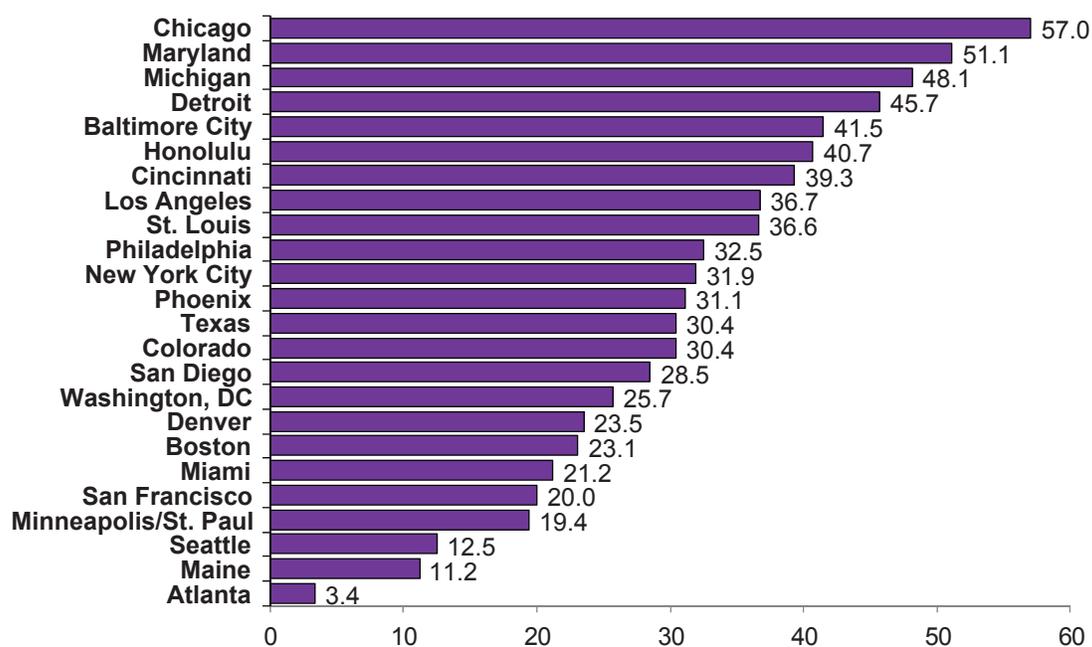
SOURCES: June 2012 State and local CEWG reports; *June 2011 Highlights and Executive Summary Volume I* CEWG report, p 107; *June 2010 Highlights and Executive Summary Volume I* CEWG report, p. 88; *June 2009 Highlights and Executive Summary Volume I* CEWG report, p. 74; and *June 2008 Highlights and Executive Summary Volume I* CEWG report, p. 72

Forensic Laboratory Data on Marijuana/Cannabis

Chicago had the highest percentage of marijuana/cannabis drug reports among drug items identified by NFLIS laboratories in 2011 (57.0 percent), followed by Maryland, Michigan, and Detroit (51.1, 48.1, and 45.7 percent, respectively) (figure 12; appendix table 2). The remaining 20 CEWG sites had percentages ranging from 3.4 percent in Atlanta²³ to 41.5 percent in Baltimore City for marijuana/cannabis drug reports identified (figure 12).

Marijuana/cannabis ranked in either first or second place among drug reports most frequently identified in all but three CEWG areas; the exceptions were Atlanta, Maine, and Seattle, where it ranked sixth, third, and fourth, respectively. In 2011, marijuana/cannabis ranked in first place among reported drugs in 14 of 24 CEWG areas, including 5 of 9 areas in the West—Colorado, Honolulu, Los Angeles, Phoenix, and Texas. Marijuana/cannabis also ranked first in five of six areas in the Midwest (Chicago, Cincinnati, Detroit, Michigan, and St. Louis) and Boston in the Northeast. It

Figure 12. Marijuana/Cannabis Drug Reports Identified Among Drug Items Seized and Analyzed in Forensic Laboratories, as a Percentage of Total NFLIS Drug Reports¹, in 24 CEWG Areas: 2011²



¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each selected drug item seized and analyzed.

²Data are for CY 2011: January–December 2011; see appendix tables 2.1–2.24. 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 were retrieved on May 7–8, 2012

²³In 2004, Georgia initiated a statewide administrative policy that laboratory testing is not required when 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.

ranked first among drug reports in three southern areas—Baltimore City, Maryland, and Washington, DC. It was the second most frequently identified drug among total drug reports in 2011 NFLIS data in another seven CEWG areas—Denver, Miami, Minneapolis/St. Paul, New York City, Philadelphia, San Diego, and San Francisco (section II, table 1).

Other Drugs

Treatment Admissions Data on MDMA

Admissions for primary treatment of MDMA (3,4-methylenedioxymethamphetamine) are not captured in all treatment data systems, but they appeared low in those areas that do report on these drugs. This is also the case with the other drugs reported on here.

Forensic Laboratory Data on MDMA

MDMA or ecstasy ranked among the top 10 drug reports (primary, secondary, and tertiary reports) from items seized and identified in NFLIS laboratories in 10 of 24 CEWG areas. It ranked 4th in Chicago; 5th in Denver and Los Angeles; 6th in Colorado and Seattle; 7th in San Diego and San Francisco; 8th in Miami; 9th in Texas; and 10th in Maine (section II, table 1; appendix table 2).

The proportions of MDMA among analyzed NFLIS drug reports from items seized and identified in forensic laboratories ranged from less than 1.0 percent in 14 areas (Atlanta, Baltimore City, Boston, Chicago, Cincinnati, Detroit, Honolulu, Maryland, Michigan, Minneapolis/St. Paul, New York City, Philadelphia, St. Louis, and Washington, DC) to a high of 3.8 percent in Seattle. Of 10 CEWG areas with 1.0 percent or more MDMA drug reports among items seized and analyzed in this reporting period, Seattle's proportion was highest, followed by San Francisco, at 2.3 percent (table 24).

Forensic Laboratory Data on Other Drugs

Other drugs reported on in this section for which NFLIS data are available include MDA (3,4-methylenedioxyamphetamine), GHB (gamma hydroxybutyrate), PCP (phencyclidine), LSD (lysergic acid diethylamide), psilocin, ketamine, BZP (1-benzylpiperazine), carisoprodol, TFMPP (1-(3-trifluoromethylphenyl)piperazine), and Foxy methoxy (5-methoxy-N,N-diisopropyltryptamine, or 5-MeO-DIPT) (table 25).

MDA. MDA was reported among drugs identified in NFLIS drug reports in 19 of 24 reporting areas in 2011. MDA, however, represented very low numbers and proportions that were lower than 1.0 percent in all reporting areas: Atlanta, Baltimore City, Chicago, Colorado, Denver, Honolulu, Los Angeles, Maryland, Miami, Michigan, New York City, Philadelphia, Phoenix, St. Louis, San Diego, San Francisco, Seattle, Texas, and Washington, DC (data not shown).

GHB. GHB drug reports were identified among drug items analyzed in forensic laboratories in 14 CEWG areas of the 24 reporting NFLIS data in 2011, including Atlanta, Boston, Chicago, Colorado, Los Angeles, Miami, Minneapolis/St. Paul, New York City, Philadelphia, St. Louis, San Diego, San Francisco, Texas, and Washington, DC. Numbers were very low, and in no case did the percentage reach higher than 0.1 percent of total reports (no data shown).

Table 24. Number of MDMA Reports Identified and MDMA Reports as a Percentage of Total Reports¹ Identified Among Drug Items Analyzed in Forensic Laboratories in 24 CEWG Areas: CY 2011²

CEWG Area	MDMA Items	Total Reports Identified	Percentage of Total Reports Identified
Atlanta	99	11,442	0.9
Baltimore City	59	31,326	0.2
Boston	88	21,920	0.4
Chicago	677	72,261	0.9
Cincinnati	32	10,893	0.3
Colorado	193	9,273	1.9
Denver	117	6,205	1.9
Detroit	41	7,123	0.6
Honolulu	6	2,037	0.3
Los Angeles	743	40,337	1.8
Maine	18	1,044	1.7
Maryland	180	77,082	0.2
Miami	299	25,697	1.2
Michigan	110	27,791	0.4
Minneapolis/St. Paul	56	6,387	0.9
New York City	358	49,008	0.7
Philadelphia	31	27,172	0.1
Phoenix	111	11,563	1.0
St. Louis	88	19,832	0.4
San Diego	263	15,695	1.7
San Francisco	193	8,238	2.3
Seattle	82	2,180	3.8
Texas	993	89,616	1.1
Washington, DC	11	6,472	0.2

¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each drug item seized and analyzed.

²Data are for January–December 2011; see appendix tables 2.1–2.24. 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 were retrieved on May 7–8, 2012

Table 25. Number and Percentage of TFMPP, BZP, PCP, Carisoprodol, Ketamine, Psilocin, LSD, and Reports for Other Emerging Drugs¹, as a Proportion of the Total Reports Identified Among Drug Items Analyzed in Forensic Laboratories, in 24 CEWG Areas: CY 2011²

CEWG Area	TFMPP # (%)	BZP # (%)	PCP # (%)	Cariso- prodol # (%)	Keta- mine # (%)	Psilocin ³ # (%)	Possible Levamisole ⁴ # (%)	LSD # (%)	5-MeO- DIPT ⁵ # (%)	Total
Atlanta	164 (1.4)	25 (0.2)	1 (0.0)	103 (0.9)	8 (0.1)	47 (0.4)	143 (1.2)	15 (0.1)	61 (0.5)	11,442
Baltimore City	0	75 (0.2)	10 (0.0)	0	5 (0.0)	10 (0.0)	4 (0.0)	3 (0.0)	98 (0.3)	31,326
Boston	2 (0.0)	115 (0.5)	16 (0.1)	19 (0.1)	25 (0.1)	74 (0.3)	181 (0.8)	23 (0.1)	292 (0.4)	21,920
Chicago	10 (0.0)	461 (0.6)	306 (0.4)	0	50 (0.1)	116 (0.2)	448 (0.6)	39 (0.1)	380 (0.5)	72,261
Cincinnati	0	31 (0.3)	0	4 (0.0)	3 (0.0)	18 (0.2)	6 (0.1)	12 (0.1)	2 (0.0)	10,893
Colorado	5 (0.1)	53 (0.6)	2 (0.0)	0	8 (0.1)	133 (1.4)	87 (0.9)	6 (0.1)	30 (0.3)	9,273
Denver	2 (0.0)	39 (0.6)	1 (0.0)	0	6 (0.1)	63 (1.0)	48 (0.8)	3 (0.0)	29 (0.5)	6,205
Detroit	51 (0.7)	46 (0.6)	6 (0.1)	1 (0.0)	3 (0.0)	10 (0.1)	53 (0.7)	1 (0.0)	34 (0.5)	7,123
Honolulu	1 (0.0)	1 (0.0)	0	7 (0.3)	1 (0.0)	0	14 (0.7)	0	0	2,037
Los Angeles	33 (0.1)	56 (0.1)	334 (0.8)	147 (0.4)	53 (0.1)	151 (0.4)	121 (0.3)	41 (0.1)	6 (0.0)	40,337
Maine	0	8 (0.8)	1 (0.1)	1 (0.1)	0	8 (0.8)	57 (5.5)	5 (0.5)	0	1,044
Maryland	16 (0.0)	167 (0.2)	419 (0.5)	35 (0.0)	29 (0.0)	122 (0.2)	258 (0.3)	41 (0.1)	292 (0.4)	77,082
Miami	83 (0.3)	130 (0.5)	481 (1.9) ⁶	42 (0.2)	32 (0.1)	14 (0.1)	286 (1.1)	10 (0.0)	133 (0.5)	25,697
Michigan	85 (0.3)	104 (0.4)	6 (0.0)	1 (0.0)	11 (0.0)	109 (0.4)	88 (0.3)	29 (0.1)	0	27,791
Minneapolis/ St. Paul	27 (0.4)	52 (0.8)	13 (0.2)	6 (0.1)	1 (0.0)	51 (0.8)	100 (1.6)	9 (0.1)	60 (0.9)	6,387
New York City	22 (0.0)	302 (0.6)	969 (2.0)	2 (0.0)	414 (0.8)	67 (0.1)	336 (0.7)	38 (0.1)	3 (0.0)	49,008
Philadelphia	5 (0.0)	35 (0.1)	475 (1.7)	0	3 (0.0)	3 (0.0)	51 (0.2)	2 (0.0)	3 (0.0)	27,172
Phoenix	64 (0.6)	29 (0.3)	15 (0.1)	149 (1.3)	18 (0.2)	24 (0.2)	18 (0.2)	1 (0.0)	3 (0.0)	11,563
St. Louis	1 (0.0)	62 (0.3)	36 (0.2)	24 (0.1)	5 (0.0)	33 (0.2)	143 (0.7)	14 (0.1)	66 (-0.3)	19,832
San Diego	4 (0.0)	39 (0.2)	34 (0.2)	7 (0.0)	16 (0.1)	79 (0.5)	315 (2.0)	10 (0.0)	0	15,695
San Francisco	4 (0.0)	5 (0.1)	14 (0.2)	26 (0.3)	17 (0.2)	41 (0.5)	99 (1.2)	12 (0.1)	12 (0.1)	8,238
Seattle	7 (0.3)	15 (0.7)	19 (0.9)	3 (0.1)	5 (0.2)	22 (1.0)	41 (1.9)	4 (0.2)	17 (0.8)	2,180
Texas	168 (0.2)	637 (0.7)	368 (0.4)	1,085 (1.2)	16 (0.0)	166 (0.2)	1,338 (1.5)	19 (0.0)	179 (0.2)	89,616
Washington, DC	40 (0.6)	64 (1.0)	311 (4.8)	1 (0.0)	3 (0.0)	2 (0.0)	966 (14.9)	0	240 (3.7)	6,472

¹NFLIS methodology allows for the accounting of up to three drug reports per item submitted for analysis. The data presented are a combined count including primary, secondary, and tertiary reports for each drug item seized and analyzed.

²Data are for January–December 2011; see appendix tables 2.1–2.24. Data are subject to change; data queried on different dates may reflect differences in the time of data analysis and reporting.

³Psilocybine, psilocybin, psylocin, and psilocin are grouped together in this table under the category, "Psilocin."

⁴Phenylimidothiazole Isomer Undetermined.

⁵5-Methoxy-N,N-Diisopropyltryptamine or "Foxy methoxy." M-MEO-DPT, DIPT, and 5-MEO-DPT are included in these totals.

⁶Miami does not report PCP as a separate category; PCP is included in the category "hallucinogens."

SOURCE: NFLIS, DEA, data for all areas retrieved on May 7–8, 2012

PCP. PCP (phencyclidine) was identified among total drug reports in 22 of 24 CEWG areas reporting on items seized and identified in NFLIS laboratories in 2011. The two exceptions were Cincinnati and Honolulu. PCP items were highest in Washington, DC, at 4.8 percent of total drug reports, followed by New York City, at 2.0 percent, and Philadelphia, at 1.7 percent. In Miami, hallucinogens, which included mainly PCP, represented 1.9 percent of drug reports identified in 2011 (table 25; appendix table 2).

PCP ranked among the top 10 most frequent NFLIS drug reports from items seized and analyzed in NFLIS laboratories in 6 of 24 CEWG areas in this 2011 reporting period. In New York City, Philadelphia, and Washington, DC, PCP ranked sixth as the most frequently reported drug in forensic laboratories in 2011. PCP ranked 7th in Los Angeles and Maryland and 10th in Chicago (section II, table 1). The Miami NFLIS laboratories reported a general category of hallucinogens, which accounted for 481 cases (or 1.9 percent) of drug reports among items seized and analyzed in 2011 (table 25; appendix table 2). Hallucinogens, mostly PCP, ranked sixth among the most frequently identified drug reports in Miami in this period. (section II, table 1).

LSD. LSD was not among the top 10 drugs reported in the NFLIS system for any CEWG reporting area, but it was reported in all but 2 of the 24 CEWG areas. These areas were Honolulu and Washington, DC. The proportion did not reach 1.0 percent of drug reports in any area (table 25).

Psilocin/Psilocybin. Psilocin/psilocybin, a hallucinogen, was reported among drugs identified in forensic laboratories in 23 of 24 CEWG areas in 2011; the exception was Honolulu (table 25). This drug ranked among the top 10 drugs in drug reports in the NFLIS system in 2011 in two CEWG areas, ranking eighth in Colorado and Denver (section II, table 1).

Ketamine. Ketamine was identified among drug reports in the NFLIS system in 2011 in 23 of 24 areas, in all but Maine (table 25). Ketamine represented less than 1.0 percent of total drug reports in all reporting areas. Ketamine appeared among the top 10 reported drugs from identified drug items in any CEWG area for the first time in 2011. It ranked 10th in New York City, at 0.8 percent of total drug reports (section II, table 1; appendix table 2).

BZP. In 2011, BZP was among the drugs identified in drug reports in NFLIS forensic laboratories in all 24 CEWG areas (table 25). In one CEWG area, Washington, DC, BZP was identified in 1.0 percent of drug reports among drug items seized and analyzed. Proportions of drug reports for BZP were less than 1.0 percent in all other areas in 2011 (table 25; appendix table 2). In 2011, BZP ranked among the top 10 drug reports from items seized and identified in NFLIS forensic laboratories in 3 of 24 areas. It ranked 6th in Chicago and 10th in Detroit and Washington, DC (section II, table 1).

Carisoprodol. Carisoprodol²⁴ is a muscle relaxant and central nervous system depressant that is available by prescription as Soma®. As of January 2012, carisoprodol is a Schedule IV drug. Carisoprodol was identified among NFLIS drug reports in 19 of 24 reporting areas in 2011. It was not identified in five areas (Baltimore City, Chicago, Colorado, Denver, and Philadelphia) (table 25). In 2011, carisoprodol ranked among the top 10 NFLIS drug reports from items seized and identified in

²⁴More information on carisoprodol may be found at: http://www.deadiversion.usdoj.gov/drugs_concern/carisoprodol/index.html and <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682578.html>.

forensic laboratories in two CEWG areas; it ranked eighth in Phoenix (with 1.3 percent of all drug reports) and Texas (with 1.2 percent) (section II, table 1; appendix table 2).

TFMPP. TFMPP²⁵ is a synthetic substance with no accepted medical use in the United States that is used for its hallucinogenic effects. TFMPP was identified among drug reports from drug items analyzed in NFLIS laboratories in all but 3 of the 24 reporting areas in 2011—Baltimore City, Cincinnati, and Maine (table 25). In forensic laboratory data for this period, TFMPP ranked among the top 10 drug reports in 1 area, Atlanta, where it ranked eighth (section II, table 1; appendix table 2). It should be noted that since TFMPP is not a controlled substance, it may not be reported to NFLIS by forensic laboratories in all areas.

Foxy Methoxy. Foxy methoxy was identified as contained in drugs reported (primary, secondary, and tertiary drug reports) among items seized and analyzed in NFLIS forensic laboratories in 20 of 24 CEWG areas in 2011; not included were Honolulu, Maine, Michigan, and San Diego (table 25). It ranked among the top 10 drug reports in 2011 in 3 CEWG reporting areas, ranking seventh in Washington, DC, and ninth in Baltimore City and Chicago (section II, table 1; appendix table 2).

Khat (Cathinone/Cathine). Cathinone was identified in NFLIS drug report data in 5 of 24 CEWG areas in 2011, but it did not reach 1.0 percent of total drug reports in any area nor was it ranked among the top 10 most frequent drug reports (data not shown).

Salvia Divinorum. Available over the Internet and controlled in some States, *Salvia divinorum* is a perennial herb that produces short-acting hallucinogenic effects when chewed, smoked, or brewed in tea. Salvinorin A, the primary active ingredient in the plant *Salvia divinorum*, was identified in 8 of 24 CEWG areas among total NFLIS drug reports, including Baltimore City, Boston, Chicago, Honolulu, Maryland, Michigan, Minneapolis/St. Paul, and Texas (data not shown).

Quetiapine. Quetiapine and quetiapine fumarate are antipsychotic drugs marketed as Seroquel®. CEWG areas where quetiapine and/or quetiapine fumarate were analyzed in 2011 numbered 17 of 24 reporting areas. In NFLIS data, quetiapine did not rank among the top 10 drug items identified in any of the CEWG areas in 2011 (data not shown).

Gabapentin. In 2011, gabapentin (marketed as Neurontin® and Gabarone®) was identified in 10 of 24 CEWG areas among drug reports from drug items seized and analyzed in NFLIS laboratories, and numbers were very low. However, in Boston, gabapentin, representing 1.1 percent of drug reports, ranked as the 10th most frequently identified drug in NFLIS drug reports in the period (section II, table 1; appendix table 2).

Cannabimimetics. Cannabimimetic agents, or synthetic cannabinoids, were identified among drug reports in 21 areas (see description of cannabimimetics in section II). A total of 1,850 drug reports were identified as cannabimimetics in Texas, and there were 370 such reports in Maryland, 223 reports in Chicago, and 209 reports in St. Louis. Other areas where cannabimimetic agents were reported in NFLIS data included the following: 130 reports in Michigan; 81 in Minneapolis/St. Paul; 38 in Atlanta; 28 in Colorado and Detroit; 24 in San Diego; 21 in Miami; 18 in Cincinnati; 17 in Phoenix; 16 in Denver; 14 in Honolulu; 11 in Los Angeles; 7 in Seattle; 5 in Washington, DC; and 1–3

²⁵More information on TFMPP can be found at: http://www.deadiversion.usdoj.gov/drugs_concern/tfmpp.pdf.

reports in Boston, Maine, and New York City. Cannabimimetics did not rank among the top 10 drug reports identified in any CEWG area.

Substituted Cathinones. MDPV was identified in all 24 CEWG areas among total drug reports from drug items seized and analyzed in NFLIS forensic laboratories in 2011. This substituted cathinone held ninth place among NFLIS drug reports in this reporting period in Maine, although the numbers were small (section II, table 1; appendix table 2). Two other substituted cathinones in addition to MDPV—mephedrone and methylone—were identified in CEWG drug reports. Methylone was reported in all but 4 areas—Cincinnati, Detroit, Michigan, and Philadelphia—while mephedrone was not reported in 11 of 24 areas (Atlanta, Baltimore City, Cincinnati, Honolulu, Los Angeles, Maine, Philadelphia, Phoenix, San Francisco, Seattle, and Washington, DC). The total of these 3 drugs among reports ranged from 502 in Texas to 159 in Chicago and 92 in Maryland; 13–72 reports were identified in 13 areas, and 8 areas had 12 or fewer reports among analyzed items.

2C-E, 2C-I, and Analogs (2C-Phenethylamines). 2C-E, 2C-I, 2C-B, 2C-C, 2C-P, and 2C-T-2 drug reports were identified in 11 of 24 areas by NFLIS forensic laboratories. The total of these reports ranged from 17 in Texas; to 11 in Maryland; to 8 in Minneapolis/St. Paul; to 6 in Chicago; and to 4 or fewer items in Baltimore City, Colorado, Denver, Maine, Miami, St. Louis, and Seattle. Details of numbers of drug reports for individual drugs in this category are reported in section II.

Section IV. Community-Based Prescription Drug Abuse Research Abstracts

Drug Use Practices Among Illicit Pharmaceutical Opioid Users

Robert G. Carlson, Russel Falck, Ramzi W. Nahhas, and Raminta Daniulaitye²⁶

ABSTRACT

This report describes drug use practices of 396 illicit pharmaceutical opioid users recruited between April 2009 and May 2010 in the Columbus, Ohio, area using respondent-driven sampling²⁷. Participants, age 18–23, were not opioid dependent (DSM-IV criteria) at recruitment. This natural history study, in which structured interviews are conducted every 6 months over 3 years, is focused on identifying the characteristics of those users who transition to opioid dependence (or cease to use/maintain opioid use). The study is also examining characteristics associated with transition to injection, particularly heroin, and the relationship between drug use practices and human immunodeficiency virus (HIV)/sexually transmitted disease (STD) risk behaviors. About 55 percent of the sample were male; about 50 percent were non-White; 42 percent had a high school diploma; and about 67 percent were single. In the 6 months prior to baseline, about 27 percent used NP (non-prescription) pain pills monthly, compared with 49 percent 1 to 2 times/week and 24 percent 3 to 7 times/week. About 93 percent used oxycodone IR; 84 percent used hydrocodone; 26 percent used codeine; 30 percent used oxycodone ER; and about 7 percent used methadone or morphine. About 35 percent were daily marijuana users; 14 percent used cocaine; 32 percent used tranquilizers; 15 percent used stimulants; 21 percent used ecstasy; and 16 percent used LSD (lysergic acid diethylamide) or psilocybin. Seventy percent had at least one prescription for a legitimate health problem in their lifetimes. The mean age of first opioid prescription was 17, which is about equal to the age of first illicit use. About 52 percent used NP opioids, both to self-medicate pain and to get “high.” At baseline, about 29 percent were dependent on alcohol and 30 percent on marijuana; 71 percent had at least one NP opioid abuse or dependence symptom. Only 5 percent believed they needed professional treatment for any drug. Over 18 months, 34 participants used Suboxone® for the first time, compared with 13 new initiates of Subutex®. Lifetime illicit use of buprenorphine (primarily Suboxone®) at baseline was reported by 31 participants (7.8 percent). White ethnicity, intranasal insufflation of pharmaceutical opioids, a greater number of symptoms of opioid dependence, and a greater number of illicit pharmaceutical opioids used in one’s lifetime were significant predictors of illicit buprenorphine use²⁸. Over 24 months, 15 participants (4 percent) transitioned to heroin

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²⁷See article by authors, “Respondent-driven sampling to recruit young adult nonmedical users of pharmaceutical opioids: problems and solutions.” Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21885213>.

²⁸See article by authors, “Illicit use of buprenorphine in a community sample of young adult nonmedical users of pharmaceutical opioids.” Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22036303>.

injection, and 2 initiated pain pill injection. Of the 17 participants initiating injection, 53 percent were male, and all were White. This study is limited by recruitment of participants in one area of the Midwest and self-reports. Nevertheless, the initial findings provide important data that can help to inform public health. Identifying the characteristics of those who transition to opioid dependence over 3 years will help to develop targeted interventions.

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Prescription Opioid Diversion: Mechanisms, Street Prices, and Prevention Measures

Steven P. Kurtz and Hilary L. Surratt²⁹

ABSTRACT

Background: Access to prescription opioids by individuals for whom they were not prescribed (nonpatients) is the result of their unlawful channeling from legal sources to the illicit marketplace (diversion). Empirical data on diversion remain largely absent from the literature. This presentation examines prescription opioid diversion, using data from two independent research studies. Publications and information are available at arsh.nova.edu.

Study 1

Aims: Researchers at Nova Southeastern University examined the sources of diverted opioids reported by participants in a South Florida study targeting diverse populations of opioid abusers ($N=782$). Sources of diverted medications were hypothesized to differ according to abusers' health insurance status, physical health status, injection drug use, and primary opioid of abuse.

Methods: Eligible respondents were age 18 or older and reported misuse of a prescription drug five or more times in the previous 90 days. Those who reported a prescription opioid as their most frequently misused drug were included in the analyses. Hydromorphone, morphine, and fentanyl were rarely reported and were combined into a single "high potency opioid" category. Trained interviewers administered standardized health and social risk assessments, including detailed drug use histories and sources of abused prescription medications.

Analyses: Bivariate logistic regression models were developed to predict use of each diversion source by demographics and by the hypothesized independent variables.

²⁹The authors are affiliated with the Center for Applied Research on Substance Use and health Disparities, Nova Southeastern University.

Results: The most common sources of diverted medications were dealers; sharing/trading; legitimate medical practice (e.g., unknowing medical providers); illegitimate medical practice (e.g., pill mills or “rouge prescribers”); and theft, in that order. Sources varied by users’ age, ethnicity, health insurance status, physical health status (including pain), injection drug use, and primary opioid of abuse.

Conclusions: Individual and health factors, as well as the potency of the abuser’s preferred drug, appear to impact the choice of drug sources. Understanding these aspects of diversion can be used to develop prescription drug control policy.

Support: This research was supported by NIH Grant R01DA021330.

Study 2

Aims: Monitoring trends in street prices for prescription opioids may provide an indicator of drug availability, demand, and abuse potential within targeted geographic areas.

Methods: Researchers examined street prices of diverted prescription opioids using surveillance data from a nationwide network of law enforcement officers, collected as part of the Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS®) System. Drug diversion investigators were surveyed quarterly during 2010 and 2011 regarding the street prices of diverted prescription opioids in their areas.

Analyses: Study researchers computed mean and median prices per milligram for the targeted prescription opioids in order to make standardized price comparisons across drug classes. Trends in price data over time were also examined.

Results: Street prices per milligram ranked as follows: hydromorphone (\bar{x} = \$5.87; \tilde{x} = \$5.00); oxymorphone (\bar{x} =\$3.00; \tilde{x} =\$2.00); methadone (\bar{x} =\$1.30; \tilde{x} =\$1.00); oxycodone (\bar{x} =\$1.14; \tilde{x} =\$1.00); hydrocodone (\bar{x} =\$1.05; \tilde{x} =\$1.00); morphine (\bar{x} =\$0.95; \tilde{x} =\$0.96); tramadol (\bar{x} =\$0.14; \tilde{x} =\$0.10); and, tapentadol (\bar{x} =\$0.13; \tilde{x} =\$0.10).

Conclusions: Analyses yielded substantial differences in street price by opioid class, and a high level of stability within each class over time. Street price appears to be a useful indicator of drug popularity among abuser groups.

Support: This research was supported by a contract with Denver Health & Hospital Authority.

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Initiation to Prescription Drug Use: Social Contexts of Use

Sheigla Murphy³⁰, Heather Mui, and Paloma Sales

ABSTRACT

The Center for Substance Abuse Studies at the Institute for Scientific Analysis recently completed a 36-month NIDA-funded qualitative study of nonmedical prescription drug use in San Francisco. Employing ethnographic sampling techniques, researchers recruited and interviewed 120 female and male participants between the ages of 18 and 25 who had used one or more drugs from three drug groups (opiates, stimulants, and central nervous system depressants) for nonmedical purposes at least 12 times in the 6 months prior to the interview. The study defined nonmedical prescription drug use as the use of prescription drugs, whether prescribed or not, to get “high,” or for the experience(s) or feelings they cause; to enhance school/work performance; or to modify the effects of other drug or alcohol use.

One difficult aspect of this study design was the problem of the diversity of nonmedical prescription drugs used and the combinations in which they and other drugs were consumed. Study participants used, in varying combinations, alcohol, marijuana, club drugs, and prescription drugs. The researchers’ and others’ previous work indicate these drugs represent the predominant drugs of abuse among nonmedical prescription drug users in the targeted age group. Most of these drugs are used in combination (e.g., amphetamines and marijuana, valium/cocaine and alcohol), and the kinds of drugs that are consumed together change over time. This study was not intended to provide a representative sample of San Francisco’s nonmedical prescription drug users but to provide initial understandings about their beliefs, motivations, and perceptions of the consequences of nonmedical prescription drug use.

Nonmedical prescription drug use has been on the rise, especially among the 18–25 age group. Interviewees expressed different motives and manners of initiation. They each brought their own sets of beliefs, expectations, and attitudes to the experience, and were surrounded by varying physical and social settings at the time of initiation. But it was the interaction of their set and setting that led each to nonmedical prescription drug initiation. For initiation to occur, one must first be exposed to the behavior. Witnessing such conduct often contributes to one’s expectations and motivations. With access to the prescription drug(s) in an appropriate setting, the physical and social space provided the time and place for experimentation. Together, the set and setting provided the opportunity and occasion for the initiation of nonmedical prescription drug use. This paper outlines four dimensions or themes of the initiation process described by our interviewees that may help to explain the upsurge in young adult misuse of prescription drugs. The four themes are: *exposure*, or “everybody’s doing it”; *motivation* (curiosity, performance enhancement, and self-medication); *access*, or the power of prescription; and, finally, *setting*, or places where participants felt safe with people they trusted.

³⁰The principal author is the Director of the Center for Substance Abuse Studies, Institute for Scientific Analysis, San Francisco, California.

Initiation to prescription drug use is unique compared with initiations to illegal drugs, due to the historical moment. Prescribing is at an all-time high, and more and varied prescription drugs are available to young adults. These young adults have also been exposed to unprecedented levels of drug education and prevention programs which have successfully warned them of the dangers of street drug use (with the exception of marijuana) but have been less successful regarding prescription drug use. Prescription drugs were viewed by this study's participants as "cleaner" and less "risky" than street drugs. The notion that "everybody's doing it," or what is called the social acceptability aspect of nonmedical prescription drug use initiation, poses new challenges for interventionists and policy makers.

Support: This research was supported by NIH Grant R01DA033594.

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Appendix Tables

Appendix Table 1. Total Treatment Admissions by Primary Substance of Abuse, Including Primary Alcohol Admissions, and CEWG Area: CY 2011¹

CEWG Areas	Number of Total Substance Abuse Treatment Admissions								Total (N) ³
	Alcohol	Cocaine/ Crack ²	Heroin	Other Opiates	Meth- amphet- amine	Marijuana	Benzo- diazep- ines	Other Drugs/ Unknown	
CY 2010									
Atlanta	4,706 ⁴	985	306	647	522	1,582	223	192	9,163 ²
Baltimore City	2,847	1,800	6,860	635	3	2,288	157	53	14,643
Boston ⁵	5,758	923	9,291	865	52	691	234	33	17,847
Cincinnati	1,538	455	1,210 ⁶	— ⁷	7 ⁸	1,522	21	251	5,004
Colorado	12,179	2,283	2,150	1,894	4,226	6,088	117	661	29,598
Denver	4,782	1,199	1,314	814	1,400	2,726	51	336	12,622
Detroit	3,166	1,701	3,009	288	2	1,392	NR ⁹	29	9,587
Florida	16,174	4,411	1,304	16,386	957 ⁸	13,088	1,081	2,626	56,027
Hawaii	3,212 ⁴	314	130	NR ⁸	4,138 ⁸	2,497	NR ⁹	538	10,829
Los Angeles	10,482	3,906	9,417	1,454	7,451	11,356	170	1,500	45,736
Maine	4,726 ⁴	456	1,058	4,409	44	1,179	121	488	12,481
Maryland	16,491	5,292	12,236	6,395	23	10,476	642	911	52,466
Minneapolis/ St. Paul	10,240	1,083	2,223	1,987	1,326	3,464	130	358	20,811
New York City	23,091	11,332	18,716	2,277	284	19,960	555	1,018	77,233
Philadelphia	3,233	788	1,363	348	2	1,644	135	1,484	8,997
Phoenix ⁵	1,990	328	881 ⁷	404	1,333	1,560	NR ⁹	118	6,614
St. Louis	3,997	1,397	4,029	401	320	2,448	61	169	12,822
San Diego	2,856	577	3,019	580	3,968	2,520	NR ⁹	176	13,696
San Francisco ¹⁰	6,863	3,338	3,493	697	4,200	2,110	24	1,187	21,912
Seattle	3,762	934	1,523	656	816	1,944	32	316	9,983
South Florida/ Broward County	1,302	555	169	1,459	12	1,949	140	344	5,930
South Florida/ Miami-Dade County	1,406	1,052	227	302	17	2,008	79	255	5,346
Texas ⁶	21,556	10,622	9,542	5,641	4,413	17,723	1,201	3,737	74,435

¹Data are for CY 2011: January–December 2011.

²Cocaine values were broken down into crack or powder/other cocaine for the following areas: Atlanta (crack=705; powder or other cocaine=280); Baltimore City (crack=1,545; powder or other cocaine=255); Boston (crack=535; powder or other cocaine=388); Maine (crack=178; powder or other cocaine=278); Maryland (crack=4,125; powder or other cocaine=1,167); Minneapolis/St. Paul (crack=826; powder or other cocaine=257); New York City (crack=6,798; powder or other cocaine=4,534); Philadelphia (crack=201; powder or other cocaine=587); St. Louis (crack=1,135; powder or other cocaine=262); South Florida/Broward County (crack=432; powder or other cocaine=123); South Florida/Miami-Dade County (crack=615; powder or other cocaine=437); and Texas (crack=5,632; powder or other cocaine=4,990). No breakdowns by type of cocaine were available for the other areas.

³These Ns are used in all percentage calculations involving total treatment admissions data for each area. Treatment data contain unknown primary admissions in Cincinnati ($n=7$), Florida ($n=2,327$), Maine ($n=365$), Minneapolis/St. Paul ($n=128$), Philadelphia ($n=1,297$), Phoenix ($n=118$), South Florida/Broward County ($n=110$), and South Florida/Miami-Dade County ($n=15$). 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. The category, “No primary drug of abuse” was treated as unknown in all areas except Atlanta, Hawaii, Maine, and South Florida/Broward County and South Florida/Miami-Dade County, where they were excluded from the totals. These cases of no primary drug numbered as follows: Atlanta ($n=204$), Hawaii ($n=223$), Maine ($n=29$), Broward County ($n=68$), and Miami-Dade County ($n=76$). Total admissions data for all other areas exclude unknowns. Unknowns are also excluded from the “Other Drugs/Unknown” category for Boston and from the total for all drugs in that area, although in past reports, this “Other Drug/Unknown” category has included unknowns. This fact makes these numbers noncomparable with data reported prior to 2010 for Boston.

⁴Alcohol data for Atlanta are alcohol only=2,355 and alcohol-in-combination with other drugs=2,351.

⁵Treatment data for Boston do not include admissions younger than 14. Treatment data for Phoenix do not include admissions younger than 18.

⁶The numbers for each drug category for 2011 are shown for Cincinnati; however, because these numbers are noncomparable with previous reporting years before 2010, this area is not included in the tables showing percentage-point changes over time periods. Some Texas data are reported as percentages without the accompanying numbers and may differ from previous reports, as they were updated by the area representative.

⁷Heroin and other opiates are grouped together in Cincinnati treatment data. Heroin and morphine are grouped together in Phoenix data.

⁸Methamphetamine, amphetamine, and MDMA are grouped together in Cincinnati treatment data. Methamphetamine and amphetamines are grouped together for the State of Florida. Methamphetamine and stimulants are grouped together in Hawaii treatment data.

⁹NR=Not reported by the CEWG area representative.

¹⁰Due to the implementation of a new Electronic Health Record and billing system in San Francisco in July 2010, treatment admissions data prior to that date may not be comparable to data submitted after the new system implementation. San Francisco data for 2011 are therefore preliminary and subject to change. Comparisons with 2010 data for San Francisco are not included in this report, although 2011 treatment data and associated top 10 rankings are reported in figure 1a and elsewhere.

NOTES: Treatment data coverage for CEWG areas for CY 2011 includes the following areas and programs. Atlanta data cover the 28-county MSA and include public treatment admissions of all ages. Baltimore City data cover enrollments with publicly funded treatment providers in the city of Baltimore. Boston data cover admissions 14 and older 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 methadone maintenance (MM) programs. Colorado data include admissions of all ages statewide to all Colorado alcohol and substance abuse 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 substance abuse 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. 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 all ages and MM admissions. Maryland data cover enrollments with publicly funded treatment providers in the State of Maryland. 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 for people who are uninsured or underinsured (Medicaid enrollees were not included); some programs provide medication assisted treatment. Phoenix data are for Maricopa County and cover admissions 18 and older with public support. 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. 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. Seattle data are for King County and include admissions of all ages to public pay, private pay MM programs and Department of Corrections programs. South Florida/Broward County and South Florida/Miami-Dade County data include all admissions to publicly supported addiction programs, for all ages and MM admissions. Texas data are for all admissions reported to the State in Texas.

SOURCE: June 2012 State and local CEWG reports

Appendix Tables 2.1–2.24. NFLIS Top 10 Most Frequently Identified Drug Reports Among Drug Items Seized and Analyzed in Forensic Laboratories for 24 CEWG Areas: January–December 2011

Appendix Table 2.1. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Atlanta: CY 2011¹

Drug	Number	Percentage
Cocaine	3,913	34.2
Methamphetamine	2,660	23.2
Oxycodone	930	8.1
Alprazolam	682	6.0
Hydrocodone	564	4.9
Marijuana/Cannabis	389	3.4
Heroin	328	2.9
1-(3-Trifluoromethylphenyl)-piperazine (TFMPP)	164	1.4
Amphetamine	161	1.4
Possible Levamisole	143	1.2
Other ²	1,508	13.2
Total	11,442	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the 28-county Atlanta/Sandy Springs/Marietta GA MSA: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton Counties.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 7, 2012

Appendix Table 2.3. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Boston: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	5,067	23.1
Cocaine	4,766	21.7
Heroin	3,361	15.3
Oxycodone	2,088	9.5
Buprenorphine	768	3.5
Clonazepam	597	2.7
Naloxone	371	1.7
Alprazolam	356	1.6
Acetaminophen	291	1.3
Gabapentin	232	1.1
Other ²	4,023	18.4
Total	21,920	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data include seven counties in the Boston MSA: Essex, Middlesex, Norfolk, Plymouth, Rockingham, Strafford, and Suffolk Counties.

2. "Negative Results-Tested for Specific Drugs" represents 319 reports and are included under "Other."

3. "No Controlled Drug Identified" represents 325 reports and are included under "Other."

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 7, 2012

Appendix Table 2.2. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Baltimore City: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	12,997	41.5
Cocaine	9,215	29.4
Heroin	6,804	21.7
Oxycodone	487	1.6
Buprenorphine	449	1.4
Alprazolam	263	0.8
Mannitol/Manitol	148	0.5
Caffeine	99	0.3
5-Methoxy-N,Ndiisopropyl-tryptamine (5-MeODIPT)	98	0.3
Clonazepam	97	0.3
Other ²	669	2.1
Total	31,326	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for Baltimore City only.

2. The Maryland State Police Laboratory began full reporting in July 2010.

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2011

Appendix Table 2.4. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Chicago: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	41,165	57.0
Cocaine	13,727	19.0
Heroin	11,214	15.5
3,4-Methylenedioxy-methamphetamine (MDMA)	677	0.9
Hydrocodone	641	0.9
1-Benzylpiperazine (BZP)	461	0.6
Possible Levamisole	448	0.6
Alprazolam	419	0.6
5-Methoxy-N,Ndiisopropyltryptamine (5-MeODIPT)	380	0.5
Phencyclidine (PCP)	306	0.4
Other ²	2,823	3.9
Total	72,261	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for 13 counties in the Chicago/Naperville/Joliet, IL/IN/WI MSA: Cook, DeKalb, DuPage, Grundy, Kane, Kendall, McHenry, and Will Counties in IL; Jasper, Lake, Newton, and Porter Counties in IN; and Kenosha County in WI.

2. As of November 2010, the Westchester branch of the Illinois State Police Laboratory System ceased performing drug analyses.

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.5. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Cincinnati: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	4,284	39.3
Cocaine	3,022	27.7
Heroin	2,238	20.5
Oxycodone	324	3.0
Hydrocodone	167	1.5
Alprazolam	141	1.3
Clonazepam	73	0.7
Buprenorphine	55	0.5
Diazepam	54	0.5
Methadone	38	0.3
Other ²	497	4.6
Total	10,893	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for Hamilton County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.6. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Colorado: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	2,822	30.4
Cocaine	2,552	27.5
Methamphetamine	1,219	13.1
Heroin	653	7.0
Oxycodone	206	2.2
3,4-Methylenedioxy-methamphetamine (MDMA)	193	2.1
Hydrocodone	148	1.6
Psilocybin/Psilocyn/Psilocin/Psilocybine	133	1.4
Possible Levamisole	87	0.9
Acetaminophen	83	0.9
Other ²	1,177	12.7
Total	9,273	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the State of Colorado.

2. "Noncontrolled Nonnarcotic Drug" represents 367 reports and are included under "Other."

3. Data for the Colorado Springs Police Department for November and December 2011 are not included.

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 7, 2012

Appendix Table 2.7. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Denver: CY 2011¹

Drug	Number	Percentage
Cocaine	2,129	34.3
Marijuana/Cannabis	1,460	23.5
Methamphetamine	691	11.1
Heroin	602	9.7
3,4-Methylenedioxy-methamphetamine (MDMA)	117	1.9
Oxycodone	117	1.9
Hydrocodone	70	1.1
Psilocin/Psilocybin/Psilocyn	63	1.0
Possible Levamisole	48	0.8
Alprazolam	43	0.7
Other ²	865	13.9
Total	6,205	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for Denver, Arapahoe, and Jefferson Counties.

2. "Noncontrolled Nonnarcotic Drug" represents 367 reports and are included under "Other."

3. The Colorado Bureau of Investigation forensic laboratory did not report to NFLIS in November and December.

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.8. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Detroit: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	3,254	45.7
Cocaine	1,464	20.6
Heroin	919	12.9
Hydrocodone	296	4.2
Alprazolam	193	2.7
Oxycodone	62	0.9
Possible Levamisole	53	0.7
1-(3-Trifluoromethylphenyl)-piperazine (TFMPP)	51	0.7
Caffeine	50	0.7
1-Benzylpiperazine (BZP)	46	0.6
Other ²	735	10.3
Total	7,123	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for Wayne County.

2. "No Controlled Drug Identified" represents 208 reports and are included under "Other."

3. The Michigan State Police Forensic Laboratory did not report for November and December 2011.

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.9. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Honolulu: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	829	40.7
Methamphetamine	782	38.4
Cocaine	159	7.8
Acetaminophen	29	1.4
Dimethylsulfone	29	1.4
Heroin	27	1.3
Oxycodone	22	1.1
Alprazolam	19	0.9
Hydrocodone	19	0.9
Possible Levamisole	14	0.7
Other ³	108	5.3
Total	2,037	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for Honolulu County.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.10. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Los Angeles: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	14,806	36.7
Cocaine	9,330	23.1
Methamphetamine	8,973	22.2
Heroin	1,933	4.8
3,4-Methylenedioxy-methamphetamine (MDMA)	743	1.8
Hydrocodone	470	1.2
Phencyclidine (PCP)	334	0.8
Alprazolam	303	0.8
Oxycodone	193	0.5
Codeine	175	0.4
Other ²	3,077	7.6
Total	40,337	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for Los Angeles County.

2. "Negative Results-Tested for Specific Drugs" represents 543 reports and are included under "Other."

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.11. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Maine: CY 2011¹

Drug	Number	Percentage
Cocaine	300	28.7
Oxycodone	149	14.3
Marijuana/Cannabis	117	11.2
Heroin	85	8.1
Possible Levamisole	57	5.5
Hydrocodone	34	3.3
Buprenorphine	29	2.8
Methamphetamine	24	2.3
3,4-Methylenedioxy-pyrovalerone (MDPV)	22	2.1
3,4-Methylenedioxy-methamphetamine (MDMA)	18	1.7
Other ²	209	20.0
Total	1,044	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the State of Maine.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 7, 2012

Appendix Table 2.12. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Maryland: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	39,377	51.1
Cocaine	15,440	20.0
Heroin	9,265	12.0
Oxycodone	3,067	4.0
Alprazolam	1,203	1.6
Buprenorphine	1,120	1.5
Phencyclidine (PCP)	419	0.5
Clonazepam	390	0.5
Hydrocodone	363	0.5
Methadone	297	0.4
Other ²	6,141	8.0
Total	77,082	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the State of Maryland.

2. "No Controlled Drug Identified" represents 882 reports and are included under "Other."

3. The Maryland State Police Laboratory began reporting in July 2010.

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 7, 2012

Appendix Table 2.13. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Miami: CY 2011¹

Drug	Number	Percentage
Cocaine	12,599	49.0
Marijuana/Cannabis	5,436	21.2
Oxycodone	1,202	4.7
Alprazolam	981	3.8
Heroin	618	2.4
Hallucinogen (Nonspecified)	481	1.9
Caffeine	306	1.2
3,4-Methylenedioxy-methamphetamine (MDMA)	299	1.2
Possible Levamisole	286	1.1
Methamphetamine	161	0.6
Other ³	3,328	13.0
Total	25,697	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the Miami/Fort Lauderdale/Pompano Beach MSA and include Miami-Dade, Broward, and Palm Beach Counties.

2. "Controlled Substance represents 981 reports and are included under "Other."

3. "Negative Results-Tested for Specific Drugs" represents 418 reports included under "Other."

4. "No Controlled Drug Identified" represents 244 reports and are included under "Other."

5. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.15. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Minneapolis/St. Paul: CY 2011¹

Drug	Number	Percentage
Cocaine	1,339	21.0
Marijuana/Cannabis	1,239	19.4
Methamphetamine	1,213	19.0
Heroin	389	6.1
Acetaminophen	180	2.8
Oxycodone	170	2.7
Amphetamine	105	1.6
6-Monoacetylmorphine	100	1.6
Possible Levamisole	100	1.6
Caffeine	90	1.1
Other ²	1,462	22.9
Total	6,387	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

NOTES:

1. Data are for seven counties in Minnesota: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.

2. The St. Paul Police Department did not report data for November and December 2011.

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.14. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Michigan: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	13,367	48.1
Cocaine	4,490	16.2
Heroin	2,016	7.3
Hydrocodone	1,284	4.6
Methamphetamine	786	2.8
Alprazolam	646	2.3
Morphine	335	1.2
Oxycodone	313	1.1
Amphetamine	259	0.9
Methadone	237	0.9
Other ²	4,058	14.6
Total	27,791	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the State of Michigan.

2. "No Controlled Drug Identified" represents 1,930 reports and are included under "Other."

3. The Michigan State Police Forensic Laboratory did not report for November and December 2011.

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 7, 2012

Appendix Table 2.16. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, New York City: CY 2011¹

Drug	Number	Percentage
Cocaine	17,221	35.1
Marijuana/Cannabis	15,655	31.9
Heroin	5,390	11.0
Oxycodone	1,732	3.5
Alprazolam	1,579	3.2
Phencyclidine (PCP)	969	2.0
Methadone	633	1.3
Buprenorphine	592	1.2
Clonazepam	417	0.9
Ketamine	414	0.8
Other ²	4,406	9.0
Total	49,008	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the New York City Police Department and five New York boroughs: Bronx, Kings, Queens, New York, and Richmond.

2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.17. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Philadelphia: CY 2011¹

Drug	Number	Percentage
Cocaine	8,967	33.0
Marijuana/Cannabis	8,834	32.5
Heroin	3,499	12.9
Oxycodone	1,715	6.3
Alprazolam	1,233	4.5
Phencyclidine (PCP)	475	1.7
Codeine	281	1.0
Clonazepam	248	0.9
Hydrocodone	147	0.5
Buprenorphine	144	0.5
Other ²	1,629	6.0
Total	27,172	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for Philadelphia County.
2. "No Controlled Drug Identified" represents 407 reports and are included under "Other."
3. "Noncontrolled Nonnarcotic Drug" represents 407 reports and are included under "Other."
4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.18. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, Phoenix: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	3,597	31.1
Methamphetamine	1,924	16.6
Heroin	1,305	11.3
Cocaine	923	8.0
Oxycodone	575	5.0
Alprazolam	383	3.3
Hydrocodone	266	2.3
Carisoprodol	149	1.3
Buprenorphine	134	1.2
Clonazepam	118	1.0
Other ²	2,189	18.9
Total	11,563	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the Maricopa County.
2. "Unspecified Prescription Drug" represents 372 reports and are included under "Other."
3. "Negative Results-Tested for Specific Drugs" represents 284 reports and are included under "Other."
4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.19. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, St. Louis: CY 2011¹

Drug	Number	Percentage
Marijuana/Cannabis	7,262	36.6
Heroin	3,175	16.0
Cocaine	2,350	11.8
Methamphetamine	1,060	5.3
Alprazolam	516	2.6
Hydrocodone	493	2.5
Oxycodone	391	2.0
Acetaminophen	347	1.7
Pseudoephedrine	288	1.5
Buprenorphine	150	0.8
Other ²	3,800	19.2
Total	19,832	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the St. Louis MO/IL MSA, which includes St. Louis City and 16 counties: St. Louis, St. Charles, St. Francis, Jefferson, Franklin, Lincoln, Warren, and Washington Counties in MO; and Madison, St. Clair, Macoupin, Clinton, Monroe, Jersey, Bond, and Calhoun Counties in IL.
2. "Negative Results-Tested for Specific Drugs" represents 1,482 reports and are included under "Other."
3. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.20. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Reports, San Diego: CY 2011¹

Drug	Number	Percentage
Methamphetamine	4,938	31.5
Marijuana/Cannabis	4,477	28.5
Cocaine	1,784	11.4
Heroin	1,123	7.2
Hydrocodone	425	2.7
Possible Levamisole	315	2.0
3,4-Methylenedioxy-methamphetamine (MDMA)	263	1.7
Oxycodone	252	1.6
Dimethylsulfone	243	1.5
Alprazolam	197	1.3
Other ²	1,678	10.7
Total	15,695	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the San Diego County.
2. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.21. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Francisco: CY 2011¹

Drug	Number	Percentage
Methamphetamine	2,813	34.1
Marijuana/Cannabis	1,646	20.0
Cocaine	1,339	16.3
Hydrocodone	333	4.0
Heroin	298	3.6
Oxycodone	206	2.5
3,4-Methylenedioxy-methamphetamine (MDMA)	193	2.3
Possible Levamisole	99	1.2
Dimethylsulfone	83	1.0
Methadone	72	0.9
Other ²	1,156	14.0
Total	8,238	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the five counties in the San Francisco/Oakland/Fremont MSA: Alameda, Contra Costa, Marin, San Francisco, and San Mateo Counties.

2. "Unknown" represents 380 reports and are included under "Other."

3. Data for the San Francisco Police Department Laboratory and Alameda County are not reported for 2011. There are no data for the San Bernardino Laboratory for April–December 2011. The California Department of Justice Forensic Laboratory had not reported for November and December 2011.

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.23. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Texas: CY 2010¹

Drug	Number	Percentage
Marijuana/Cannabis	27,228	30.4
Cocaine	19,153	21.4
Methamphetamine	12,058	13.5
Hydrocodone	4,604	5.1
Alprazolam	4,395	4.9
Heroin	2,538	2.8
Possible Levamisole	1,338	1.5
Carisoprodol	1,085	1.2
3,4-Methylenedioxy-methamphetamine (MDMA)	993	1.1
Amphetamine	659	0.7
Other ²	15,565	17.4
Total	89,616	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the State of Texas.

2. November and December data are incomplete due to reporting issues with the Fort Worth Police Department Laboratory.

3. "Negative Results-Tested for Specific Drugs" represents 1,472 reports and are included under "Other."

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 7, 2012

Appendix Table 2.22. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Seattle: CY 2011¹

Drug	Number	Percentage
Cocaine	405	18.6
Methamphetamine	325	14.9
Heroin	310	14.2
Marijuana/Cannabis	272	12.5
Oxycodone	114	5.2
3,4-Methylenedioxy-methamphetamine (MDMA)	82	3.8
Possible Levamisole	41	1.9
Alprazolam	30	1.4
Dimethylsulfone	30	1.4
Methadone	28	1.3
Other ²	543	24.9
Total	2,180	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for King County.

2. "Unknown" represents 161 reports and are included under "Other."

3. "Some Other Substance" represents 39 reports and are included under "Other."

4. Percentages may not sum to the total due to rounding.

SOURCE: NFLIS, DEA, May 8, 2012

Appendix Table 2.24. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Washington, DC: CY 2010¹

Drug	Number	Percentage
Marijuana/Cannabis	1,663	25.7
Cocaine	1,250	19.3
Possible Levamisole	966	14.9
Caffeine	441	6.8
Heroin	406	6.3
Phencyclidine (PCP)	311	4.8
5-Methoxy-N,Ndiisopropyltryptamine (5-MeODIPT) & 5-Methoxy-Ndipropyltryptamine (5-MeO-DPT)	240	3.7
1-Piperidinocyclohexanecarbonitrile	171	2.6
Quinine	118	1.8
1-Benzylpiperazine (BZP)	64	1.0
Other ²	842	13.1
Total	6,472	100.0

¹Data are for January–December 2011, and include primary, secondary, and tertiary reports.

²All other analyzed reports.

NOTES:

1. Data are for the District of Columbia.

2. "Noncontrolled Nonnarcotic Drug" represents 91 reports and are included under "Other."

3. Percentages may not sum to the total due to rounding.

SOURCE: NFLS, DEA, May 8, 2012

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