NIDA NATIONAL INSTITUTE ON DRUG ABUSE

Epidemiologic Trends in Drug Abuse

Proceedings of the Community Epidemiology Work Group

Volume I

Highlights and Executive Summary

June 2009

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

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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
6001 Executive Boulevard
Bethesda, Maryland 20892

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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 2009 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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Contents

Foreword ..... **v**

Section I. Introduction **1**

Section II. Highlights and Summary of Key Findings and Emerging Drug Issues From the June 2009 CEWG Meeting **9**

Section III. Across CEWG Areas: Treatment Admissions, Forensic Laboratory Analysis Data, and Emergency Department Data **39**

Cocaine/Crack 39

Heroin 46

Opiates/Opioids Other Than Heroin (Narcotic Analgesics) 53

Benzodiazepines/Depressants 63

Methamphetamine 66

Marijuana/Cannabis 73

Club Drugs (MDMA, MDA, GHB/GBL, LSD, and Ketamine) 79

Phencyclidine (PCP) 83

Other Drugs (including BZP, TFMPP, Foxy Methoxy, and Carisoprodol) 86

Appendix Tables **87**

Appendix Table 1. Total Treatment Admissions by Primary Substance of Abuse, Including Primary Alcohol Admissions, and CEWG Area: CY 2008 87

Appendix Tables 2.1–2.22. NFLIS Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items in Forensic Laboratories for 22 CEWG Areas: January–December 2008 88

Participant List **95**

Foreword

This Executive Summary provides a synthesis of findings from reports presented and data prepared for the 66th semiannual meeting of the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group (CEWG) held in Chicago, Illinois, on June 10–12, 2009. The CEWG is a network of researchers from sentinel sites throughout the United States. It meets semiannually to provide ongoing community-level public health surveillance of drug abuse through presentation and discussion of quantitative and qualitative data. CEWG representatives access multiple sources of existing data from their local areas to report on drug abuse patterns and consequences in their areas and to provide an alert to potentially emerging new issues. Local area data are supplemented, as possible, with data available from federally-supported projects, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) Drug Abuse Warning Network (DAWN), Drug Enforcement Administration (DEA) National Forensic Laboratory Information System (NFLIS), and the DEA Heroin Domestic Monitor Program (HDMP). This descriptive and analytic information is used to inform the health and scientific communities and the general public about the current nature and patterns of drug abuse, emerging trends, and consequences of drug abuse.

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

The majority of the June 2009 meeting was devoted to the CEWG area reports and presentations. CEWG area representatives presented data on drug abuse patterns and trends. After the area reports, breakout groups were formed to discuss key drug abuse indicators and to review meeting findings by area and region. In addition, discussions were held on emerging drug problems and issues across CEWG areas. Presentations on drug abuse patterns and issues were also provided by guest researchers from Canada and the Netherlands. Other highlights of the meeting included: presentations by DEA representatives Cassandra Prioleau, Ph.D., and Artisha Polk, M.P.H., on emerging drugs of concern, and Michael Vrakatitsis, J.D., on recent trends in methamphetamine trafficking; a presentation on findings from DAWN emergency department data for 2004–2007 by Elizabeth Crane, Ph.D., M.P.H., from SAMHSA; an update from the Office of National Drug Control Policy on the Arrestee Drug Abuse Monitoring (ADAM) II data system by M. Fe Caces, Ph.D.; a presentation on the Latin American drug abuse network, the Inter-America Drug Abuse Control Commission, by Marya Hynes Dowell, M.H.S.; and a presentation from Chyvette Williams, Ph.D., on NIDA-supported HIV research in the Chicago area. The *Proceedings of the Community Epidemiology Work Group* for the June 2009 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.

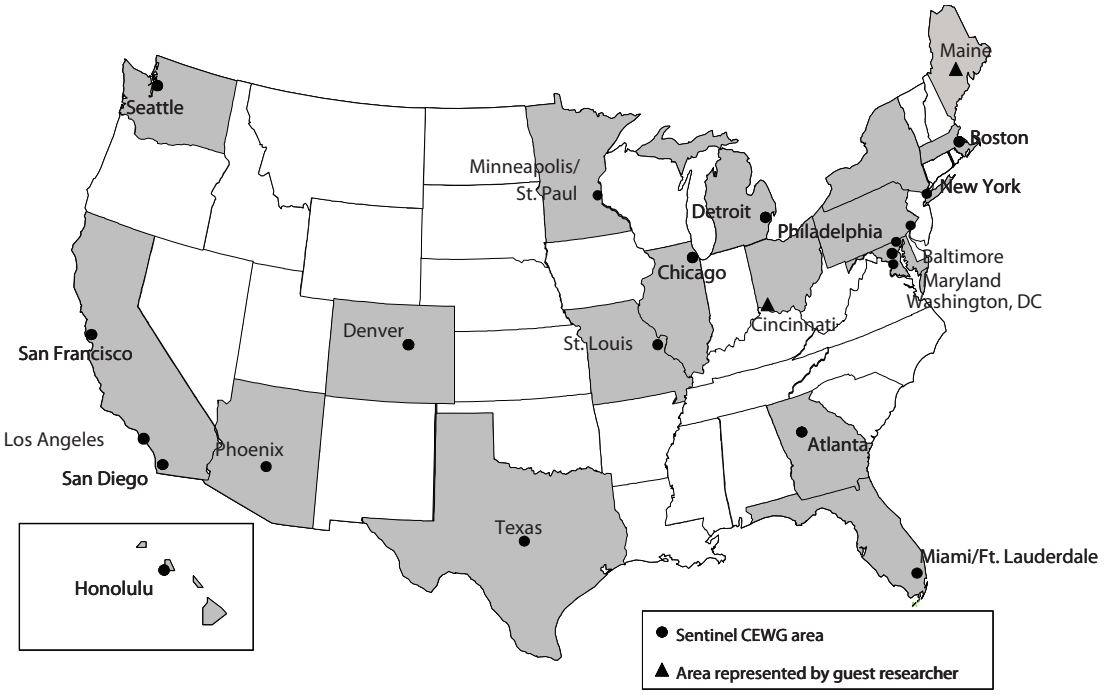
Moira P. O'Brien
Division of Epidemiology, Services and Prevention Research
National Institute on Drug Abuse
National Institutes of Health
Department of Health and Human Services

Section I. Introduction

The 66th semiannual meeting of the Community Epidemiology Work Group (CEWG) was held on June 10–12, 2009, in Chicago, Illinois. 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, guest researchers from Cincinnati and Maine provided data from their respective areas, as did international representatives from Canada, the Netherlands, and Latin America.

The CEWG Network

The CEWG is a unique epidemiology network that has functioned since 1976 as a drug abuse surveillance system to identify and assess current and emerging drug abuse patterns, trends, and issues, using multiple sources of information. Each source provides information about the abuse of particular drugs, drug-using populations, and/or different facets of the behaviors and outcomes related to drug abuse. The information obtained from each source is considered a drug abuse *indicator*. Typically, indicators do not provide estimates of the number (prevalence) of drug abusers at any given time or the rate at which drug-abusing populations may be increasing or decreasing in size. However, indicators do help to characterize drug abuse trends and different types of drug abusers (such as those who have been treated in hospital emergency departments, admitted to drug treatment programs, or died with drugs found in their bodies). Data on items submitted for forensic chemical analysis serve as indicators of availability of different substances and engagement of law enforcement at the local level, and data such as drug price and purity are indicators of availability, accessibility, and potency of specific drugs. Drug abuse indicators are examined over time to monitor the nature and extent of drug abuse and associated problems within and across geographic areas. The CEWG areas on which presentations were made at the June 2009 meeting are depicted in the map below, with one area



presentation including data on Baltimore, Maryland, and Washington, DC.

CEWG Meetings

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

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

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

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

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

Identification of changing drug abuse patterns is part of the discussions at each CEWG meeting. Through this process, CEWG representatives can alert one another to the emergence of a potentially new drug of abuse. The CEWG is uniquely positioned to bring crucial perspectives to bear on urgent drug abuse issues in a timely fashion, and to illuminate their various facets within the local context through its semiannual meetings and 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) *Live!* data system, along with weighted estimates from the DAWN system available for 2004–2007 for this report
- Seizure, average price, average purity, and related data obtained from the Drug Enforcement Agency (DEA) and from State and local law enforcement agencies
- Drug-related deaths reported by medical examiner (ME) or local coroner offices or State public health agencies
- Arrestee urinalysis results and other toxicology data
- Surveys of drug use
- Poison control center data

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

Treatment data were derived from CEWG area reports. For this report, they represent data for 15 CEWG metropolitan areas and 6 States: Hawai'i, Florida, Maine, Maryland, Texas, and Colorado. Recent or complete treatment admissions data were not available for San Francisco, Chicago, Cincinnati, and Washington, DC. Data for several States are included with metropolitan data for comparison, including data for Colorado with Denver, Hawai'i with Honolulu, and Florida with Miami/Dade County and Ft. Lauderdale/Broward County. The latter two counties in South Florida are part of the Miami Metropolitan Statistical Area (MSA). The reporting period is cited as calendar year (CY) 2008, since all area representatives reported data for that time interval. 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 3–6, 8–11, 13–14, 23, 26, 28–30) also display cross-area treatment admissions data as do several figures in section II (figures 2, 8, 10, and 15).

DAWN ED[1] weighted estimates for 12 CEWG areas for 2004 through 2007 were provided by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA). DAWN ED data are presented in Section III tables as estimated numbers and rates per 100,000 population for ED visits for selected drugs (tables 7, 12, 16–20, 22, 27, 31, 34–36). The data represent drug reports for drug-involved visits for illicit drugs (derived from the category of "major substances of abuse," excluding alcohol) and the nonmedical use of selected pharmaceutical drugs. Nonmedical use of pharmaceuticals is use that involves: taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs, especially illegal drugs or alcohol. Since drug reports exceed the number of ED visits because a patient may report use of multiple drugs (up to six drugs plus alcohol), summing of drugs across categories is not recommended. A description of the DAWN system can be found at *http://dawninfo.samhsa.gov*. The estimates in section III represent MSAs for all reporting CEWG areas, with three exceptions: New York City, which represents the Five Boroughs Division only; Miami, which represents the Miami/Dade County Division only; and San Francisco, which represents the San Francisco Division only, including San Francisco, San Mateo, and Marin Counties.

Forensic laboratory data for a total of 22 CEWG sites were available for CY 2008. Data for all CEWG metropolitan areas in 2008 were provided by the National Forensic Laboratory Information System (NFLIS), maintained by the DEA. NFLIS is a program in the DEA Office of Diversion Control which 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 October 2008, in addition to the

[1]DAWN 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.

DEA laboratories, the NFLIS system included 47 State systems, 95 local or municipal laboratories, and 1 territorial laboratory, representing a total of 278 individual laboratories. These laboratories handled over 88 percent of the Nation's nearly 1.2 million annual State and local drug analysis cases. 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 Office of Diversion Control (2008) report, National Forensic Laboratory Information System: Midyear Report 2008 (Washington, DC: U.S. Drug Enforcement Administration). Boston reports forensic drug seizure data from the Massachusetts Department of Public Health Drug Analysis Laboratory to supplement NFLIS reports. 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 2008 for 22 CEWG areas is included as figure 17 in section II, while table 1 in section II and a number of tables and figures in section III (tables 15, 21, 32–33, and figures 18–21), along with appendix tables 2.1–2.22, are provided to display the data on forensic laboratory drug items identified for the period across areas. CEWG area reports in Volume II of this meeting report also include NFLIS data for CEWG areas.

Illicit drug price data for CEWG metropolitan areas in CY 2008 were provided by the report, "National Illicit Drug Prices," published in June and December 2008 by the National Drug Information Center (NDIC), U.S. Department of Justice. Data from these reports are included for the following CEWG areas: Atlanta, Chicago, Cincinnati, Detroit, Los Angeles, Maine, Miami, New York City, Philadelphia, San Francisco, St. Louis, Texas, and the Baltimore, Maryland, and Washington, DC area. Information from the DEA report, 2007 Heroin Domestic Monitor Program (HDMP) Drug Intelligence Report, published November 2008, was included in reports from the Minneapolis/St. Paul area and Texas. The reader is referred to the January 2009 CEWG meeting report (*www.drugabuse.gov/PDF/CEWG/CEWGJan09508Compliant.pdf*) for the most recent price and purity data (CY 2007) from the DEA for other areas.

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

Local drug-related mortality data from medical examiners/coroners (ME/Cs) or State public health agencies were reported for 19 CEWG areas: Atlanta, Boston, Chicago, Cincinnati, Denver, Detroit, Honolulu, Los Angeles, Maine, Miami, Minneapolis/St. Paul, New York City, Philadelphia, San Diego, San Francisco, Seattle, St. Louis, Texas, and the Baltimore, Maryland, and Washington, DC area. These are described in Volume II and shown in figures 1, 5b, 9, and 11 in section II of this report.

Other data cited in this report were local data accessed and analyzed by CEWG representatives. The sources included: local law enforcement (e.g., data on drug arrests); local DEA offices (DEA field reports); High Intensity Drug

Trafficking Area (HIDTA) reports; arrestee drug information from the Arrestee Drug Abuse Monitoring (ADAM) II system; poison control centers and help lines; prescription drug monitoring systems; local and State surveys; and key informants and ethnographers (figure 6, section II reports poison control call data, while figures 4 and 5a display hospital admissions/discharge data for CEWG areas, and figure 12, prison admissions data).

A Note to the Reader—Caveats

Terminology and Geographic Coverage—The CEWG representatives use existing data, which are subject to the definitions and geographic coverage of the source data. Representatives generally use the terminology as it is used in the data source. For example, many treatment systems use the phrase "other opiates" for classifying opiates[2] or opioids[3] other than heroin as the primary problem at admission. The term "other opiates" is therefore retained in this summary report, and the terms "other opiates" and "opioids" may be used in a single area report. Similarly, the term "prescription-type opioid" is used by some representatives to distinguish synthetic or semisynthetic opioids, such as oxycodone and hydrocodone, from heroin. The geographic coverage of data sources may vary within a CEWG area report. Readers are directed to the 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 DAWN and NFLIS data, the specific geographic coverage will be noted in footnotes. For example, appendix table 2 presents the NFLIS data for each area and footnotes specify the coverage. The geographic coverage for the DAWN weighted estimates presented in this report has been described previously under Data Sources.

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

Treatment Admissions—Many variables affect treatment admission numbers, including program emphasis, capacity, data collection methods, and reporting periods. Therefore, changes in admissions bear a complex relationship to drug abuse prevalence. Treatment data on primary abuse of specific drugs in this report represent percentages of total admissions, both including and excluding primary alcohol admissions. Percentage distributions based on total treatment admissions by drug, including primary alcohol admissions, were used for all cross-area comparisons. Data on demographic characteristics (gender, race/ethnicity, and age group) and route of administration of particular drugs were provided for some CEWG areas and reported in full area reports. The numbers of admissions for alcohol and other drugs in 2008 are presented for 21 reporting CEWG sites/areas in appendix table 1, with rankings documented in section II, table 2. Treatment data are not totally comparable across CEWG areas, and differences are noted insofar as possible. Treatment numbers are subject to change. Most of the CEWG area representatives report Treatment Episode Data Set (TEDS)[4] data accessed from local treatment programs or States, and these data are included in cross-area comparison tables in this report (table 2; section III, tables 3–6, 8–11, 13–14, 23–26, 28–30, and appendix table 1).

ED Drug Reports—For this meeting report, weighted estimate data were provided to area representatives by OAS, SAMHSA, from the DAWN system for 2004–2007, with statistical tests of differences using *t*-tests and *p*-values. These data were used in full area reports by 6 of the 11 area representatives for whom such data were available in the DAWN system. These areas are: Chicago, Denver, Minneapolis/St. Paul, New

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

[3] Opioid 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.

[4] TEDS is an administrative data system providing descriptive information about the national flow of admissions to speciality providers of substance abuse treatment, conducted by OAS, SAMHSA.

York City, San Francisco, and Phoenix. When comparisons are made across time periods with a CEWG area, this caveat is needed: statements about drug-involved ED weighted rates in CEWG areas being higher or lower in 1 year than another year are only made when their respective *t*-test *p*-values are significant at the .05 level or below. Otherwise, no difference is reported.[5]

Forensic Laboratory Drug Items Identified—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 2008 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 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 the method of case assignment for the data provided by DEA to the CEWG has changed recently to assignment based on the geographic location from which items were submitted for identification, rather than the location of the laboratory that performed the item identification, 2007 and 2008 NFLIS data cannot be compared with pre-2007 data presented in prior CEWG reports. The nature of the reporting system is such that there may be a time lag between the time of seizure, the time of analysis of drug items, and the time of reporting to the NFLIS system. Therefore, differences in the number of drug items for a specified time period may occur when NFLIS is queried at different times, since data input is daily and cases may be held for different periods of time before analysis and reporting in various areas and agencies. Numbers of drug items presented in these reports are subject to change and may differ when drawn on different dates.

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,

[5]Estimates 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. Where 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. See: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, Drug Abuse Warning Network, 2006: *National Estimates of Drug-Related Emergency Department Visits*. DAWN Series D-30, DHHS Publication No. (SMA) 08-4339, Rockville, MD, 2008.

and their meaning may depend upon the local reporting standards and definitions. Cross-area tabulations of mortality drug abuse indicators are not included in this report.

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

Local Area Comparisons

The following methods and considerations pertain to local area comparisons:

- Local areas vary in their reporting periods. Some indicators reflect fiscal periods that may differ among local areas. In addition, the timelines of data vary, particularly for death and treatment indicators. Spatial units defining a CEWG area may also differ depending on the data source. Care has been taken to delineate the definition of the geographic unit under study for each data source, whether a city, a single metropolitan county, an MSA, or some subset of counties in an MSA. In some instances, data were compiled by region defined by the U.S. Census as northeastern, southern, midwestern, and western regions. Texas is included in the western region in this report, rather than in the census-defined southern region, based on member recommendations concerning area comparability of drug patterns and similarity of population characteristics to other western areas.
- In section III of this report, percentages for treatment program admissions are calculated and presented in two ways: excluding primary alcohol admissions from the total on which the percentages are based, and including primary alcohol admissions in the total on which percentages are based. However, all cross-area comparisons use only the latter measure, with the exception of tables 6, 11, 26, and in section III, 30, which show changes in treatment admissions over the 5-year period from 2004–2008, where data were available, and exclude primary alcohol treatment admissions from denominators.
- Nearly all treatment data in the cross-area comparison section of this report cover January through December of 2008, which is characterized as the current reporting period.
- Weighted ED estimates are available for 2004–2007, and statistically significant differences over time within an area are provided in tables 7, 12, 16–20, 22, 27, 31, and 34–36 in section III of this report.
- 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 Emerging Drug Issues From the June 2009 CEWG Meeting

The cornerstone of the CEWG meeting is the CEWG area report. Area representatives provide 20-minute presentations summarizing the most recent data pertaining to illicit and abused drugs and noting changes since the prior meeting. These data are viewed as indicators of the drug problem in an area. Indicators reflect different aspects of the drug abuse situation in an area, such as prevalence of abuse of drugs (e.g., survey findings), consequences of drug abuse (e.g., drug-involved ED reports, substance abuse treatment admissions, and drug-related deaths), and availability of abused substances or law enforcement engagement (e.g., drug seizures). Qualitative information from ethnographic studies or local key informants is also used to describe drug use patterns and trends, and 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 are mixed so that no consistent pattern is discernable. CEWG representatives may also provide an overall characterization of the level of the indicators as high, moderate, or low, or identify when particular drugs are considered to be the dominant drugs of abuse in an area. Some indicators are sensitive to recent changes in local policy or law enforcement focus; therefore, representatives use their knowledge of the local context in describing and interpreting data available for their area.

Abstracts and full area reports reflecting the CEWG area presentations are included in Volume II of this report. Area reports document and summarize drug abuse trends and issues in specific CEWG areas, with an emphasis on information newly available since the January 2009 meeting reports. The availability of data varies by area. Readers are directed to the Data Sources section of the Volume II 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 and information from NFLIS and DAWN, are reviewed. These data are presented in section III of this report and in appendix tables 2.1–2.22. Highlights from these cross-area tabulations are also included in this section.

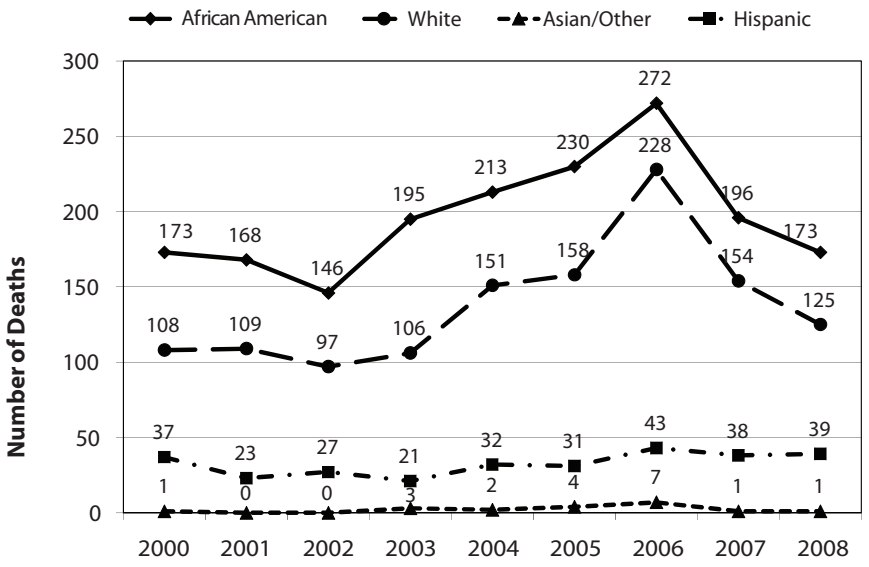
For the June 2009 CEWG meeting, CEWG representatives were invited to provide an overview and update on drug abuse trends in their areas for the most recent calendar year. Following the June 2009 area presentations, CEWG representatives convened in small work groups organized by region to discuss local issues in the regional context and to facilitate the identification of issues and patterns within and across regions. Key findings and issues identified at the CEWG meeting are highlighted in section II, with more detail provided in Volume II.

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

Cocaine/Crack

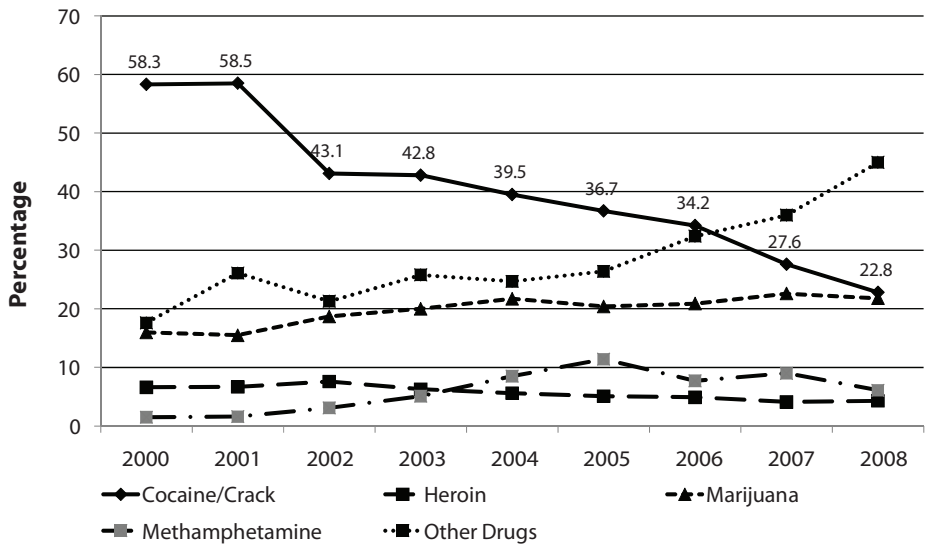
- Cocaine remained a major drug of concern in CEWG areas in all regions of the country—the Midwest, Northeast, South, and West. However, cocaine indicators for the most recent reporting period decreased in most CEWG areas.
- In Maine, cocaine arrests declined in 2008, and cocaine-induced deaths decreased sharply, from 18 percent of all drug-induced deaths in 2007 to 7 percent in 2008. Elsewhere in the Northeast, either stable or downward trends were reported for Boston and Philadelphia. Figure 1 shows that in Philadelphia the number of deaths reported with the presence of cocaine fell from 2006 through 2008 overall among both Whites and African Americans, after increasing from 2002 through 2006. In New York City, however, cocaine continued to be reported as a major problem, with several indicators, including ED visits, increasing, and more clients in treatment having primary, secondary, or tertiary problems with cocaine than any other drug.
- In the southern region, in Atlanta, where cocaine was still the primary illicit drug concern, cocaine declines were observed in 2008 compared with previous years in multiple data sources, including Medical Examiner data, treatment admissions, and NFLIS data. The decline in primary cocaine treatment admissions from approximately 58 percent in 2000 to 23 percent of total admissions in 2008 in Atlanta is shown in figure 2. The Miami area representative reported that although indicators have declined from previous reporting periods, in two southern Florida counties, Miami/Dade and Broward, cocaine continues to be a problem. Cocaine/crack was the top-ranked primary drug of abuse in treatment admissions in Miami/Dade County. Cocaine also remained a problem in Washington, DC, where more adult arrestees tested positive for cocaine in urine toxicology screens than for any other drug, amounting to one-third of these arrestees in 2008, according to the area representative.

Figure 1. Number of Deaths with the Presence of Cocaine by Race/Ethnicity, Philadelphia: 2000–2008[1]



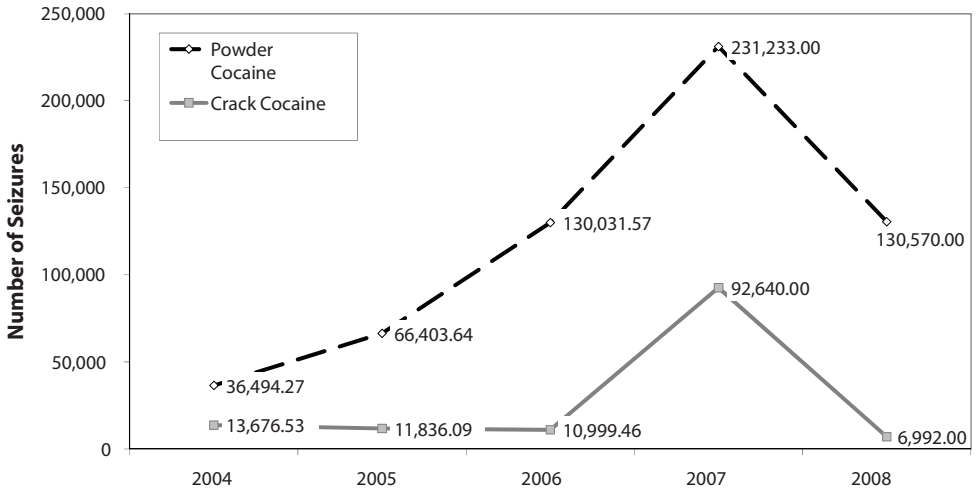
[1]Forty (40) of the 338 deaths with the presence of cocaine in 2008 were with just one drug.
SOURCE: Philadelphia Medical Examiner's Office, as reported by Samuel Cutler at the June 2009 CEWG meeting

Figure 2. Percentage of Primary Public Substance Abuse Treatment Admissions for Cocaine/Crack and Other Selected Drugs in Metropolitan Atlanta: 2000–2008



SOURCE: Georgia Department of Human Resources, as reported by Brian Dew at the June 2009 CEWG meeting

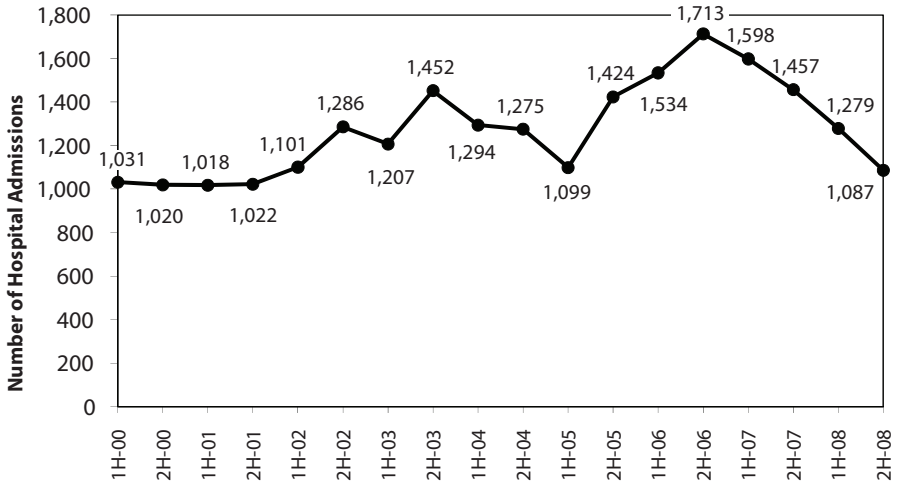
Figure 3. Seizures of Cocaine Hydrochloride (HCI) (Powder Cocaine) and Crack, in Grams, Cincinnati: 2004–2008



SOURCE: Cincinnati Police Department 2008 data through September, as reported by Jan Scaglione at the June 2009 CEWG meeting

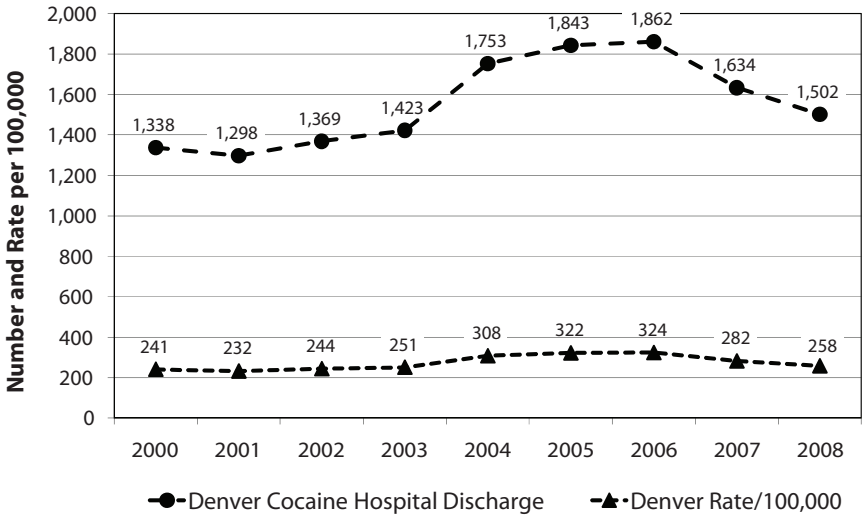
- Cocaine trends were largely declining or, in a few cases, stable in the Midwest. The CEWG area representative from the Minneapolis/St. Paul area reported a 40-percent decline in cocaine-related treatment admissions since 2005, as well as declines in male arrestees testing positive for cocaine. Cocaine availability, primary cocaine treatment admissions, and cocaine-related deaths decreased in St. Louis. Several indicators, including treatment admissions, deaths, poison control center calls, and ED reports, were said to be either down or stable by the Detroit area representative. While cocaine remains a problem in Chicago, cocaine ED reports for the city had declined from 2006 to 2007. In Cincinnati, police seizures of both crack and powder cocaine decreased between 2007 and 2008, after increasing between 2006 and 2007 (figure 3).
- In the western region, cocaine abuse indicators were down in Honolulu, where cocaine-related police cases were among the lowest in 18 years, and treatment and death data were at some of the lowest levels in the last decade. In figure 4, the decline in cocaine-related hospital admissions is shown for Phoenix/Maricopa County, where these admissions dropped from a high of 1,713 in the second half of 2006 to 1,087 in the second half of 2008. Slightly downward trends in cocaine indicators were also reported in Los Angeles, where primary cocaine treatment admissions, as a percentage share of total admissions, were the lowest in 2008 in 8 years, and in San Diego, where arrestee and forensic laboratory indicators were down in the current reporting period (although treatment admissions and ED reports were stable). The Denver area representative also reported declining cocaine trends in numbers of cocaine-related hospital discharges, from 1,862 in 2006 to 1,502 in 2008 (figure 5a), and in numbers of cocaine-related deaths, from 85 in 2006 to 60 in 2008 (figure 5b). Nevertheless, cocaine accounted for the highest number of drug-related mortality cases in Denver from 2003 to 2008. Indicators continued to be high in Seattle, where cocaine was the most common substance detected in local law enforcement evidence, and adult treatment admissions reached the highest level in a decade. The Texas CEWG area representative

Figure 4. Number of Cocaine-Related Hospital Admissions, Phoenix (Maricopa County), Arizona: 2000–2008 in Half-Yearly Intervals



SOURCE: The University of Arizona, Department of Family and Community Medicine, as reported by James Cunningham at the June 2009 CEWG meeting

Figure 5a. Number of Cocaine-Related Hospital Discharges and Rate per 100,000 Population, Denver: 2000–2008



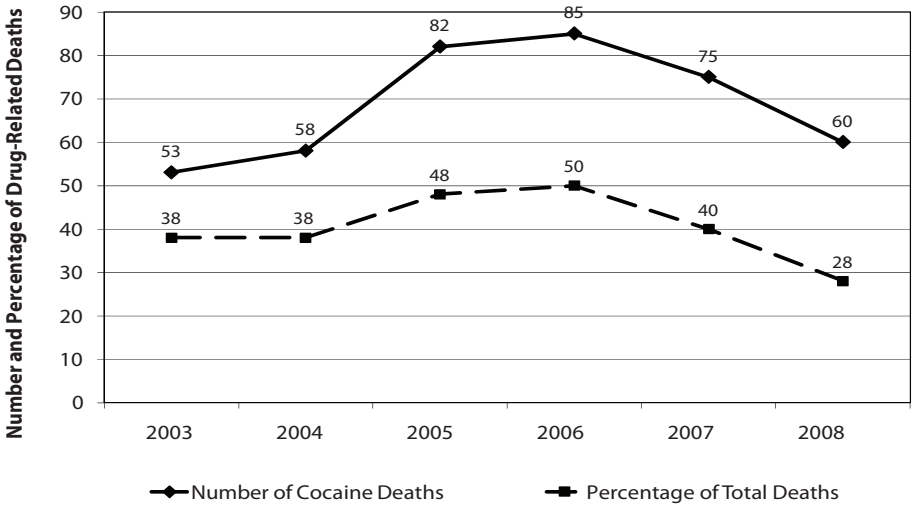
SOURCE: Colorado Hospital Association, as reported by Bruce Mendelson at the June 2009 meeting

reported mixed indicators, with cocaine continuing as a major problem along the United States–Mexico border. The San Francisco area representative reported stable and unchanged indicators, with cocaine leading in treatment admissions, ED visits, and deaths.

- Cocaine purity, price, and availability changes were reported in several CEWG areas based on NDIC data or local qualitative information. The Denver area representative reported that cocaine has been supplied by Mexican drug trafficking organizations (DTOs), but in the summer of 2008, investigations showed that DTOs were having trouble obtaining cocaine consistently. Prices began to rise, and distributors began cutting cocaine more (with some ounces as low as 20 percent pure). Cocaine availability was reported to have declined in Detroit and St. Louis. Wholesale cocaine prices increased and purity decreased in several CEWG areas. In Chicago, the low end of the range of cocaine wholesale prices increased by $6,000 from December 2007 to June 2008; ethnographic reports there suggested that quality declined. The CEWG area representative reported that law enforcement officials in Detroit suspected a decrease in quality. In Texas, cocaine prices increased and purity decreased, which was reported as due to the effects of border security and gang trafficking. The St. Louis CEWG area representative also reported an increase in cocaine prices. New York City street reports indicated that while cocaine availability was high, crack quality had possibly diminished. The Miami area representative suggested that the decrease in indicators of cocaine consequences in southern Florida may be related to a decrease in cocaine quality in that area.

- The presence of levamisole in conjunction with cocaine was reported by some CEWG area representatives. Levamisole is used in veterinary medicine as an anti-parasitic drug and is no longer an approved drug for use in humans. In Maine, 25 percent of cocaine forensic laboratory samples analyzed between January and May 2009 contained levamisole, up from 2 percent in CY 2006. The Denver crime laboratory reported that 50 percent of current cocaine exhibits were cut with levamisole, according to the Denver representative.

Figure 5b. Number of Cocaine-Related Deaths and Deaths as a Percentage of Total Drug-Related Deaths, Denver: 2003–2008



SOURCE: Denver Medical Examiner's Office, as reported by Bruce Mendelson at the June 2009 CEWG meeting

Based on communication with the Medical Examiners' offices in Miami/Dade and Broward Counties, the CEWG area representative from South Florida reported that levamisole was detected in 30 to 40 percent of deaths in which cocaine was detected in Miami/Dade and Broward Counties in 2008, and in 40 percent of both living and deceased Driving Under the Influence (DUI) cocaine-positive toxicology cases in Broward in that year. An alert was issued by Public Health - Seattle and King County in June 2009 informing the public about the presence of levamisole in cocaine and the associated risk of agranulocytosis. A guest presenter from Vancouver, British Columbia, also discussed levamisole, reporting that 22 cases of agranulocytosis (neutropenia) encountered in British Columbia from January 2008 through March 2009 were associated with levamisole in cocaine.

- Smoking continued as the dominant route of administration of cocaine across the 19 reporting CEWG areas (section III, table 4). Based on treatment admissions data, 86 percent of people entering treatment for primary cocaine abuse in Philadelphia in 2008 were identified as crack smokers; 91 percent of primary cocaine treatment admissions in Detroit were crack smokers; and in Atlanta, 8 out of 10 cocaine users who entered treatment reported smoking as the major route of administration of the drug.
- While the majority of primary cocaine treatment admissions were male and age 35 and older (section III, table 5), the changes in race/ethnicity and age of cocaine users reported in previous years have continued in several CEWG areas. In Cincinnati, the proportion of primary cocaine treatment admissions who were African American declined, and proportions of young, White, non-Hispanic admissions increased. In Boston, there was a shift in treatment admissions to higher White and lower African American proportions. The Atlanta area representative reported a 6 percent increase in White, non-Hispanic cocaine treatment admissions. Crack use was reportedly increasing in

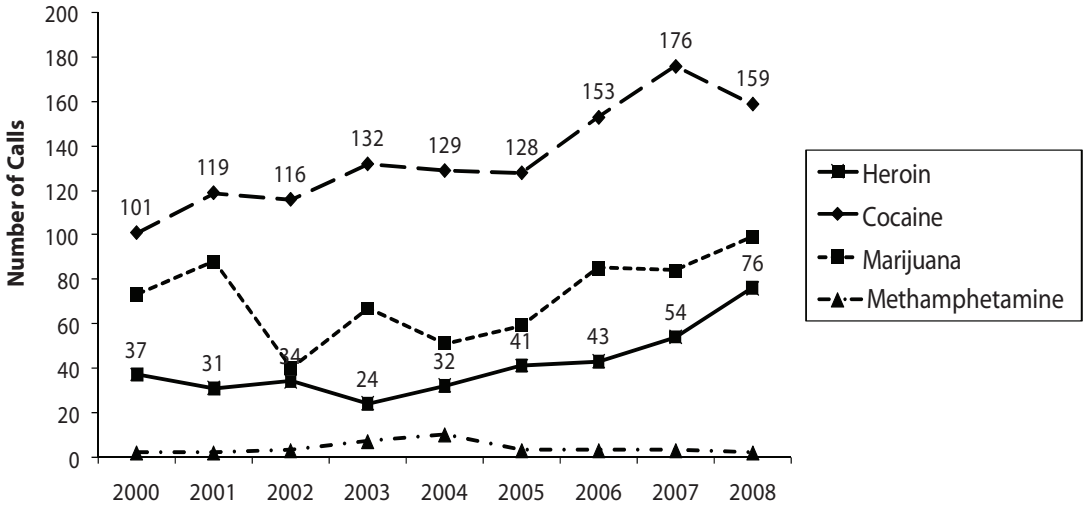
Texas among Whites and Hispanics, and among Hispanics in Denver, based on data presented by CEWG representatives from those areas. A continuing increase in treatment clients age 40 and older was reported for Philadelphia, San Francisco, Denver, and New York City. The average age of deaths in Texas attributed to cocaine has increased yearly since 1998, and was 41 in 2007.

- Treatment admissions data for 2008 revealed that treatment admissions for primary cocaine/crack, as a percentage of total drug treatment admissions, including primary alcohol admissions, ranked first in frequency in only 1 of 21 reporting CEWG areas—Miami/Dade County (table 2). It ranked second in Atlanta, Philadelphia, and Seattle. Miami and Atlanta had the highest proportions of cocaine treatment admissions in 2008 among CEWG reporting areas, while Honolulu and San Diego had the lowest.
- The largest decreases in primary cocaine admissions, excluding primary alcohol admissions, between 2007 and 2008 were observed in St. Louis and Detroit, at approximately 9 and 7 percentage points, respectively (section III, table 6). Over the 5-year period from 2004 through 2008, Atlanta and St. Louis saw the largest declines in cocaine admissions, at approximately 18 and 14 percentage points, respectively (section III, table 6).
- Cocaine was the drug most frequently identified by forensic laboratories in 10 of 22 reporting CEWG areas. Based on forensic laboratory analysis of drug items identified in 2008, cocaine/crack ranked first in three of five areas in the southern region (Miami, Atlanta, and Washington, DC); two of four areas in the northeastern region (Maine and New York City); one of five areas in the Midwest (Minneapolis/St. Paul); and four of eight areas in the western region (San Francisco, Seattle, Denver, and Texas) (table 1; appendix table 2).
- Based on weighted DAWN data, 5 CEWG areas among the 12 reporting areas showed statistically significant increases in estimated numbers and rates of cocaine-involved ED visits from 2004 through 2007, namely Detroit, Denver, New York City, Seattle, and Boston (section III, table 7).

Heroin

- Heroin trends were identified as a concern at the June 2009 CEWG meeting. Eight CEWG areas characterized heroin indicators as increasing overall for the current reporting period: Boston, Detroit, St. Louis, Cincinnati, Minneapolis/St. Paul, Miami/Dade County, Atlanta, and Phoenix.
  - After 4 years of gradual decreases, the proportion of heroin-related Helpline calls, drug arrests, and forensic laboratory samples increased slightly in Boston from 2007 to 2008.
  - In Detroit, primary heroin treatment admissions increased, a focus group of law enforcement officials reported an increase in crime associated with heroin, and poison control center calls related to heroin increased in eastern Michigan (to 76 in 2008, from 32 in 2004) (figure 6).
  - Heroin-related drug seizure and identification data from the NFLIS system nearly doubled in Atlanta in 2008. Figure 7 shows increased total heroin seizures in Cincinnati, which rose from approximately 5,400 grams in 2007 to more than 6,800 grams in 2008.
  - Primary heroin treatment admissions also increased as a percentage of total treatment admissions in Phoenix in 2008.
  - Figure 8 shows the increase in primary heroin treatment admissions from 2002 through 2008 in Minneapolis/St. Paul.

Figure 6. Number of Poison Control Center Calls on Human Intentional Use Related to Heroin and Selected Other Drugs, Michigan: 2000–2008

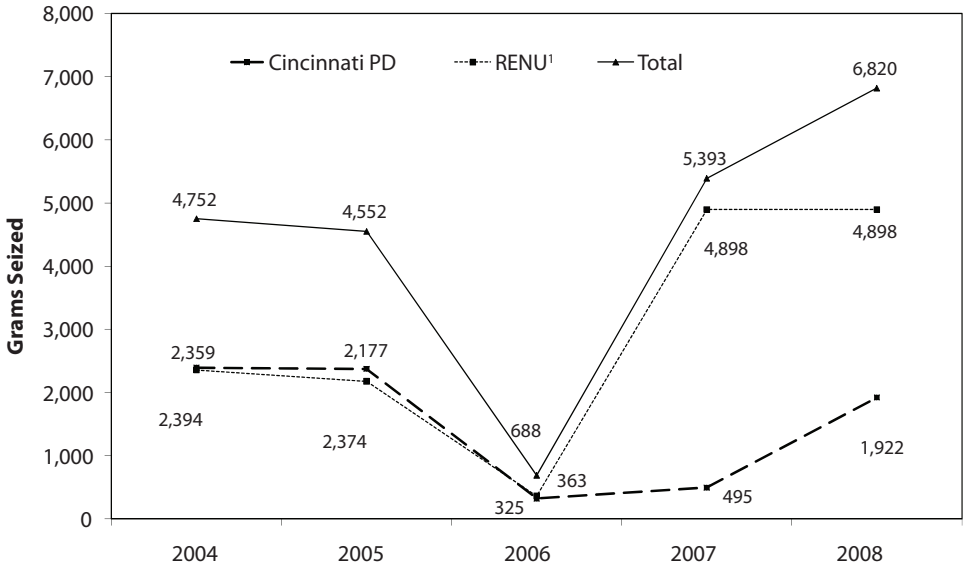


SOURCE: Children's Hospital of Michigan Regional Poison Control Center, Detroit, as reported by Cynthia Arfken at the June 2009 CEWG meeting

- o Treatment admissions for heroin were up in St. Louis (where primary heroin admissions increased by 51 percent from 2006 to 2008, and surpassed cocaine for the first time), and deaths in which heroin was detected more than doubled from 2007 to 2008.
- o In Cincinnati, poison center data showed a 50-percent increase in heroin exposure cases reported in 2008, and the Medical Examiner recorded a 211-percent increase in deaths attributed to heroin, compared with the previous year.

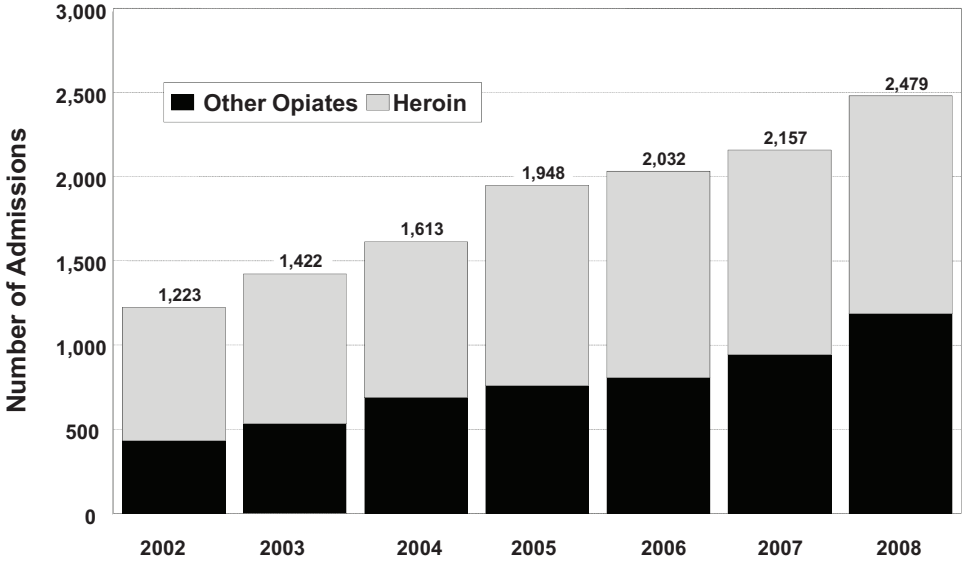
- However, heroin deaths declined in 2008 in Maine and Seattle, where all heroin abuse indicators were reported as slightly down.
- Several CEWG areas reported mixed indicators:
  - o New York City (where primary heroin treatment admissions and ADAM II male arrestee opiate-positive urine toxicology tests remained stable from 2007 to 2008).
  - o Philadelphia (where the number of deaths in which heroin was detected increased in 2008).
  - o Chicago (where arrestee data for opiates including heroin showed increases, but ED reports declined from 2006 to 2007).
  - o The Baltimore/Maryland/Washington, DC area (where the number of HIDTA heroin seizures more than tripled from 2007 to 2008).
  - o San Diego (where heroin treatment admissions and NFLIS data all showed increases, but arrestee data and overdose deaths were stable).
  - o Denver (where treatment admissions declined, while ED visits increased from 2004 to 2007).
- Heroin indicators were stable in Honolulu, Los Angeles, and San Francisco, after declines from 2000 to 2004 in the latter area, and they were low and stable in Texas.
- Heroin user demographics were reported as changing in some CEWG areas. Area representatives from Boston, Detroit, and Cincinnati reported an increase in young, White heroin users. In Texas, young primary heroin treatment admissions were on the rise.

Figure 7. Seizures of Heroin, in Grams, Cincinnati: 2004–2008



[1]Regional Enforcement Narcotic Unit.
SOURCE: Cincinnati Police Department and Regional Enforcement Narcotics Unit, Cincinnati, as reported by Jan Scaglione at the June 2009 CEWG meeting

Figure 8. Number of Admissions to Twin Cities (Minneapolis/St. Paul) Addiction Treatment Programs With Heroin and Other Opiates as the Primary Substance Problem: 2002–2008



SOURCE: Minnesota Department of Human Services, Drug and Alcohol Abuse Normative Evaluation System (DAANES), May 2009, as reported by Carol Falkowski at the June 2009 CEWG meeting

- Gender and ethnicity shifts were also reported by some CEWG area representatives. The number of female injectors was reported by the Philadelphia representative to have increased in that city. The racial distribution for heroin treatment admissions in Boston remained stable during this reporting period, after shifting toward higher percentages of Whites and lower percentages of African Americans among treatment admissions in previous reporting periods. In Philadelphia, however, treatment admissions continued to shift to more White users, with an increase in 2008 to approximately 69 percent of all admissions (from 54 percent in 2001). African-American heroin admissions showed corresponding declines from 42 percent in 2001 to close to 24 percent in 2008.
- New types or packaging of heroin emerged in some CEWG areas. Black tar heroin continued to dominate the market in Texas, but reports of availability of Colombian white heroin surfaced there in 2008. While South American heroin has been entering Miami for two decades, the Miami representative reported that Mexican black tar heroin was seized in South Florida for the first time in more than a decade. The St. Louis representative described a type of heroin known locally as "concrete," which has a reputation on the street for higher purity. It is believed to be South American heroin, but the St. Louis representative reported that this has not yet been verified. The New York City representative described a new packaging method called "Triple Threat," based on reports from the Street Studies Unit, in which dealers offer a three-in-one pack combination which includes a $10 bag of crack cocaine, a $10 bag of powder cocaine, and a $10 bag of heroin.
- The San Diego area representative noted changes in 2008 in the street price of Mexican black tar heroin, particularly with regard to pound and kilogram quantities, with a substantial drop in the price per pound between 2007 and 2008, from $10,000–$17,000 to $8,000–$10,000. Kilogram quantities were also down substantially over the 2004–2008 5-year period, dropping from $30,000–$40,000 to $19,000–$21,000 in 2008.
- Primary heroin treatment admissions, as a percentage of total admissions, including primary alcohol admissions, were particularly high in Baltimore (approximately 55 percent), followed by Boston (approximately 47 percent[6]) in 2008 (section III, table 8). In both Baltimore and Boston, along with Detroit, heroin primary admissions ranked first as the most frequent substance abuse admissions in the reporting period (table 2; appendix table 1).
- Injection of heroin was the main mode of administration of the drug reported among primary treatment admissions in 2008 in most areas. Exceptions were Baltimore, Detroit, and New York City, where inhalation was more commonly reported as the primary route of administration (section III, table 9).
- From 2007 to 2008, the largest increases in the proportion of primary heroin treatment admissions (excluding primary alcohol admissions) were seen in Detroit, Phoenix, and St. Louis (at 7.8, 6.4, and 4.3 percentage points, respectively), while the largest decline was seen in Boston, at 6.7 percentage points over the 2-year period. In the 5 years between 2004 and 2008, St. Louis and Minneapolis/St. Paul had the largest increases in primary heroin treatment admissions, at 10.0 and 8.5 percentage points, respectively. Declines of 5 or more percentage points were noted for Seattle, Los Angeles, Maine, and New York City (section III, table 11).
- In 17 of 22 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in NFLIS forensic laboratories in 2008. Proportions were highest in Baltimore and Maryland (21.8 and 20.5 percent, respectively). They were lowest in Texas, Honolulu, and Minneapolis/St. Paul, at approximately 2 percent of drug items identified (section III, figure 19;

[6]In the Boston full report in Volume II of this document, the area representative reported this figure as 49 percent, excluding unknowns from the total admissions.

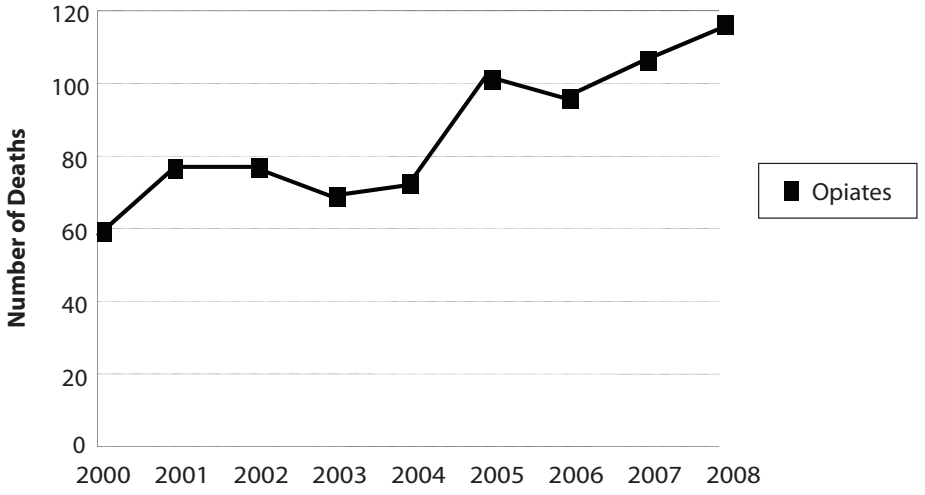
appendix table 2). Heroin was not ranked first in drug items identified in forensic laboratories in any CEWG area (table 1).

- Statistically significant changes in weighted DAWN ED reports and rates in 2007, compared with 2004, were noted for 3 of 12 reporting CEWG areas, with increased ED reports in Denver and Detroit, and decreased reports in San Francisco (section III, table 12).

Opiates/Opioids Other than Heroin (Narcotic Analgesics)

- The increasing prevalence of opiates/opioids other than heroin in indicators reported at recent CEWG meetings continued across regions and in most CEWG areas throughout 2008.
- Increases in narcotic analgesic indicators were reported in Philadelphia, New York City, Maine, Minneapolis/St. Paul, Cincinnati, Miami, Atlanta, San Diego, Phoenix, Denver, Texas, Seattle, Honolulu, and Los Angeles. Mixed indicators were reported in Detroit, Chicago, St. Louis, Baltimore, Maryland, and Washington, DC. Boston and San Francisco reported stable indicators.
- The number of deaths in which pharmaceutical opioids were detected in Philadelphia increased by 9.1 percent from 2007 to 2008. ED reports for oxycodone and hydrocodone increased significantly in New York City between 2004 and 2007. A record high number of treatment admissions in the Minneapolis/St. Paul Twin Cities area reported other opiates as their primary substance abuse problem in 2008; this represented a three-fold increase since 2002. The area representative from Minneapolis/St. Paul also reported increased opiate-related deaths, including heroin, in combined data for Hennepin and Ramsey Counties from 2000 through 2008 (figure 9).
- Arrests for pharmaceutical narcotics increased in Maine, from 22 percent in 2007 to 32 percent in 2008. Narcotic analgesics were involved in 65 percent of all drug-induced deaths in that State. Figure 10 shows that primary treatment admissions for opiates other than heroin

Figure 9. Number of Opiate-Related Deaths, Including Heroin, in Hennepin and Ramsey Counties Combined, Minneapolis/St. Paul Area: 2000–2008

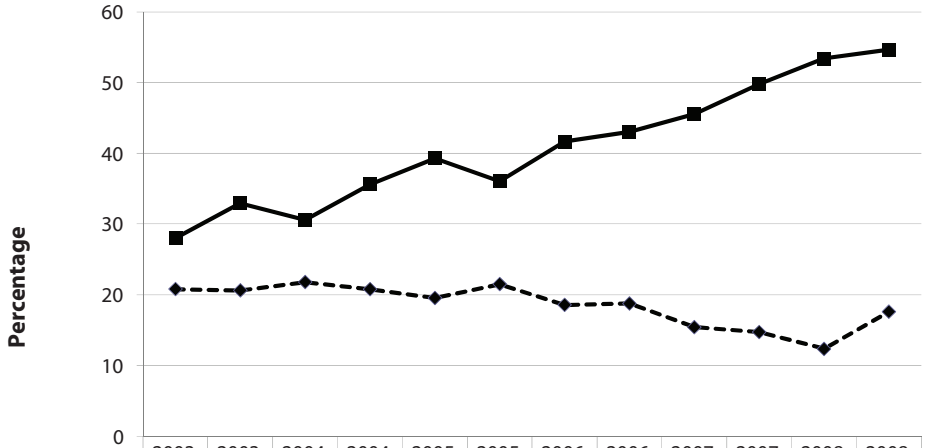


SOURCE: Hennepin County Medical Examiner and Ramsey County Medical Examiner, as reported by Carol Falkowski at the June 2009 CEWG meeting

increased from 28 percent in the first half of 2003 to 55 percent in the second half of 2008.

- Consequences associated with prescription-type opioids continued to be reported as high in Florida, particularly in Broward County (Ft. Lauderdale). The number of treatment admissions with a primary problem with other opiates/opioids increased by 26 percent from 2007 to 2008, a 142-percent increase since 2004. The detection of three opioids (hydrocodone, oxycodone, and methadone) in deaths in Florida increased by 8 percent between 2007 and 2008.
- In the western region of the Nation, CEWG area representatives from Seattle, Denver, Los Angeles, and San Diego all reported increases in 2008 in other opiate/opioid indicators. Deaths in Seattle related to prescription-type opiates continued to rise in 2008. These deaths represented 153 out of 256 drug-caused deaths—more than double the number related to any other substance. Both Colorado and Denver area treatment admissions for other opioids increased from 2001 to 2008. Increases in hospital discharges and the proportion of other opioids in Denver drug mortality cases were also reported by the Denver CEWG representative. Data from the Colorado Prescription Drug Monitoring Program showed substantial increases in the number and rate of hydrocodone and oxycodone prescriptions filled for Denver residents in 2008. Other opiate indicators in Los Angeles increased over 2007 numbers, with the percentage of primary oxycodone admissions doubling from 2007 to 2008. Primary treatment admissions for narcotic analgesics in San Diego increased in 2008, driven by an increase in admissions that cited oxycodone as their primary admissions problem. A relatively high percentage of young oxycodone admissions (48 percent were 25 or younger) was observed by the San Diego area representative.
- In Atlanta, primary treatment admissions for hydrocodone increased by 50 percent in 2008 over the previous year. Hydrocodone was

Figure 10. Percentage of Primary Substance Abuse Treatment Admissions for Heroin, Compared With Percentage of Primary Admissions for Pharmaceutical Narcotic Analgesics, Maine: 2003–2008 in Half-Yearly Intervals



	2003 1H	2003 2H	2004 1H	2004 2H	2005 1H	2005 2H	2006 1H	2006 2H	2007 1H	2007 2H	2008 1H	2008 2H
Heroin	21%	21%	22%	21%	20%	22%	19%	19%	15%	15%	12%	18%
Rx Narcotics	28%	33%	31%	36%	39%	43%	42%	43%	46%	50%	53%	55%

SOURCE: Maine Office of Substance Abuse Treatment Data System, as reported by Marcella Sorg at the June 2009 CEWG meeting

reported as a larger problem in Texas than oxycodone (with 360 deaths attributed to hydrocodone, compared with 65 deaths attributed to oxycodone in 2007).

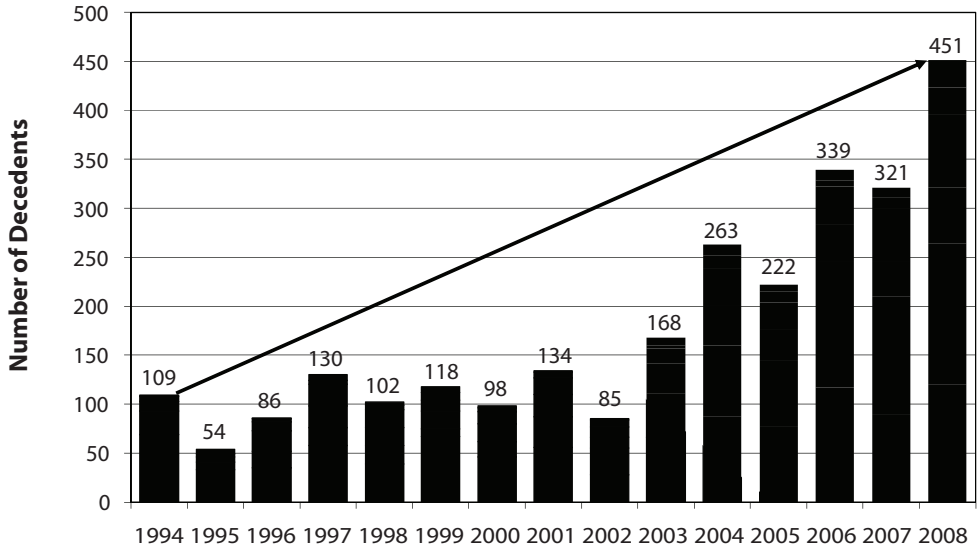
- Methadone indicators were mixed in most CEWG areas across the country, but stable or increased methadone indicators were reported by area representatives for Texas, Maine, Chicago, and New York City.
- Of the 12 CEWG areas for which area representatives reported data on buprenorphine, increased indicators were noted in 6 areas, namely Maine, Washington, DC, Baltimore, Chicago, Cincinnati, and Detroit. In Chicago, one of the areas where nonprescription buprenorphine use was increasing, the area representative reported, based on ethnographic studies, that heroin users were using buprenorphine to avoid withdrawal or better manage their addiction. Similarly, street outreach workers in Denver reported users on the street using buprenorphine to treat themselves, rather than entering formal treatment.
- Human exposure cases reported to the Cincinnati poison control center with buprenorphine-containing pharmaceuticals increased by 176 percent in 2008 over the previous year. Nearly one-half (45 percent) of the exposures involved children age 3 or older.
- Fentanyl indicators continued their downward trend in Chicago, Detroit, and Philadelphia from their peak in 2005/2006. Medical Examiner data in St. Louis, however, indicated a few deaths in 2008, attributed to the diversion of prescription fentanyl patches, while the South Florida CEWG representative reported increased fentanyl-related deaths in Florida. Other increases in fentanyl indicators were noted in Los Angeles and Maine, based on ARCOS and prescription monitoring program data, respectively, for the current reporting period.
- Treatment admissions for primary abuse of other opiates as a percentage of total admissions, including primary alcohol admissions, ranged from approximately 1 to close to 10 percent in 19 of 20 reporting CEWG areas. The outlier was Maine, where nearly 31 percent of primary treatment admissions were for other opiate problems (section III, table 13; appendix table 1). In Maine, other opiate treatment admissions ranked second as a percentage of total treatment admissions in 2008; no other areas had higher than a fourth place ranking for this primary drug category among treatment admissions (table 2).
- Of total drug items identified in forensic laboratories in 22 CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in 2008. In Baltimore, Boston, Maine, Cincinnati, and Maryland, oxycodone ranked fourth in drug items identified, and it ranked fifth in New York City, Philadelphia, Phoenix, and Seattle. Hydrocodone ranked fourth in Detroit and fifth in frequency of drug items identified in Atlanta, Cincinnati, Texas, and San Diego (table 1; section III, table 15). Maine and Boston had the highest percentages of identified drug items containing oxycodone, at 4.9 and 4.3 percent, respectively, while the highest proportions of hydrocodone drug items were identified in Detroit, at 6.4 percent (section III, table 15).
- Based on NFLIS data, buprenorphine ranked fifth in identified drug items in Boston, Baltimore, and Maryland, and eighth in Maine in 2008 (table 1). Buprenorphine-related items were highest in Boston and Maine, at approximately 2 percent each in the reporting period (section III, table 15).
- Methadone ranked fifth in identified drug items from NFLIS data in Maine, and seventh in New York City during the reporting period (table 1). Methadone drug items were highest in Maine, at 4 percent of those identified in 2008 (section III, table 15).
- Between 2004 and 2007, estimated ED visits involving nonmedical use of opiate/opioid drugs other than heroin increased significantly

in 8 of the 12 CEWG DAWN reporting areas: Denver, Detroit, New York City, Minneapolis/St. Paul, Houston, Phoenix, Seattle, and Boston (section III, table 16). Oxycodone-involved visits were estimated to have increased in 5 of the 12 areas: Denver, New York City, San Diego, Minneapolis/St. Paul, and Miami/Dade County (section III, table 17). ED visits involving nonmedical use of hydrocodone increased in 4 of the 12 areas: Denver, Houston, Detroit, and New York City (section III, table 18). While methadone-involved visits increased in five areas (Detroit, Denver, New York City, Boston, and Seattle), they declined in one area, Chicago, over the 4-year period (section III, table 19). Finally, visits involving fentanyl increased in two areas from 2004–2007, Detroit and Minneapolis/St. Paul (section III, table 20).

Benzodiazepines/Depressants

- Alprazolam and clonazepam continued to be the most frequently reported benzodiazepines in the indicator data in the current reporting period across the CEWG areas and regions, although diazepam appeared to be increasing in popularity in some areas.
- Increases in benzodiazepine indicators in 2008 were reported in Cincinnati, Atlanta, Denver, Miami, Texas, Boston, and Philadelphia.
  - o Abuse of prescription drugs, specifically benzodiazepine-based tranquilizers, continued to increase in Cincinnati, where qualitative indicators showed a relatively high availability of benzodiazepine-based tranquilizers, and a slight increase in 2008, compared with 2007. Both nonmedical users and law enforcement cited alprazolam as the most desirable benzodiazepine in Cincinnati, but there was a 16-percent increase in 2008 over 2007 in the number of clonazepam exposures reported to poison control centers in that area.
  - o Medical Examiner reports in Atlanta cited benzodiazepines as third in frequency associated with deaths, after cocaine and prescription-type opioids.
  - o In the Denver area, benzodiazepine indicators from ED reports increased significantly from 2004 to 2007, and benzodiazepine-related deaths increased from 2003 to 2008. Alprazolam and diazepam were the most frequently identified benzodiazepines in that CEWG area.
  - o The Miami area representative reported that Dade County saw a 25-percent increase in reported deaths attributed to benzodiazepines in 2008.
  - o The area representative from Texas reported an increase in alprazolam indicators, particularly in Houston, where the DEA reported that benzodiazepines were among the most commonly abused drugs in that city.
  - o Boston indicators for benzodiazepine abuse remained moderate and high, with a slight proportionate increase in calls to the Helpline noted from 1999 to 2008.
  - o In Philadelphia, benzodiazepine indicators increased slightly; they ranked third in mortality data, fifth in treatment admissions, and fourth in NFLIS data. Detection of benzodiazepines in decedents in Philadelphia has risen from 109 in 1994 to 321 in 2007 and 451 in 2008 (figure 11).
  - o Although indicators were still low, the 2004 to 2007 DAWN weighted data for New York City showed a 59-percent increase in ED visits involving benzodiapezines, with increases of 60 and 46 percent, respectively, for visits involving alprazolam and clonazepam during the period. Benzodiazepine indicators were still considered a problem in Maine, despite decreased indicators. Benzodiazepines were listed as a cause of death in 21 percent of

Figure 11. Detection of Benzodiazepines in Decedents[1], Philadelphia: 1994–2008



[1]27.6 percent of all mortality cases were positive for at least one benzodiazepine in 2008.
SOURCE: Philadelphia Medical Examiner's Office, as reported by Samuel Cutler at the June 2009 CEWG meeting

2008 drug-induced deaths, down slightly from 24 percent in the previous year.

- Texas and Atlanta had the highest percentage of alprazolam drug items identified in forensic laboratories in 2008, at 4.4 and 4.3 percent, respectively (section III, table 21). Alprazolam ranked third in frequency among the top 10 drug items identified in forensic laboratories in Atlanta, and ranked fourth in four CEWG areas: Miami, Philadelphia, New York City, and Texas (table 1).
- Drug items containing clonazepam accounted for 1.8 percent of all drug items in Boston, where clonazepam figured as the sixth most frequently identified drug in forensic laboratories in 2008 (table 1; section III, table 21).
- Diazepam ranked 8th in Cincinnati, 9th in San Diego, and 10th in Philadelphia among drug items identified in NFLIS forensic laboratories in 2008 (table 1).
- Estimated ED visits for nonmedical use of benzodiazepines increased significantly in one-half of the 12 reporting DAWN CEWG areas from 2004 to 2007. These were Denver, Minneapolis/St. Paul, Detroit, New York City, Seattle, and Boston (section III, table 22).

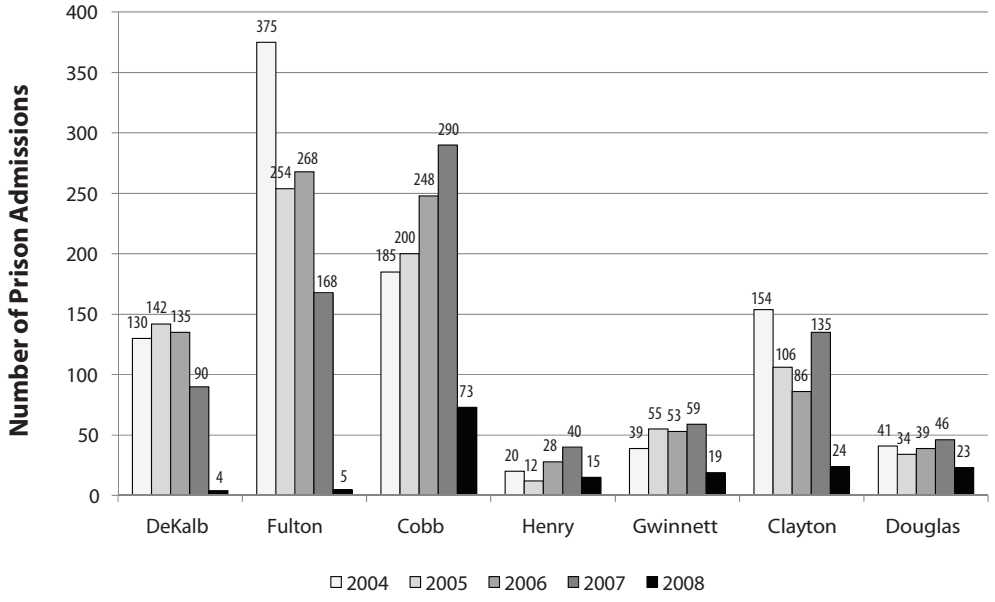
Methamphetamine

- In 2008, continued declines were reported for most methamphetamine consequences indicators. However, some increases in supply indicators were noted, and new methods of local production of methamphetamine were reported, raising concern.
- Several areas, particularly in the Midwest, reported significant declines in methamphetamine indicators in 2008. In Cincinnati, where

methamphetamine abuse indicators remained low, the area representative reported a decrease in clandestine laboratory seizures coupled with an increase in price. The Minneapolis/St. Paul area experienced a decline in methamphetamine treatment admissions, from 12 percent in 2005 to 6 percent in 2008. ED reports related to methamphetamine in the Twin Cities also declined, by 50 percent from 2005 to 2007, as did the percentage of males arrested in Hennepin County who tested positive for methamphetamine.

- Indicators in other areas of the Midwest, South, and Northeast, including Detroit, Boston, New York City, Maryland, and Washington, DC, remained low. Consequences related to methamphetamine were also reported as low in Miami, but methamphetamine was reported to be increasingly showing up in pills labeled as "ecstasy," according to the Miami representative. Indicators were low and stable in St. Louis, but clandestine laboratory operations appeared to be increasing. Maine reported mixed indicators; arrests and treatment admissions were down, but seizures had increased slightly. While treatment admissions for methamphetamine remained extremely low in Philadelphia, mortality cases increased.
- Methamphetamine continued to be a more substantial drug abuse issue in the western States than in other regions of the country. Based on indicator data, methamphetamine use/abuse was limited east of the Mississippi, with the exception of Atlanta, where methamphetamine ranked third in indicators behind cocaine and marijuana. The Atlanta representative reported that the largest seizure of methamphetamine ever to occur east of the Mississippi took place in May 2009, when 351 pounds of Mexican crystal methamphetamine were seized in Gwinnett County, Georgia. Methamphetamine-related treatment admissions in

Figure 12. Prison Admissions Related to Possession of Methamphetamine for Select Metropolitan Atlanta Counties: 2004–2008

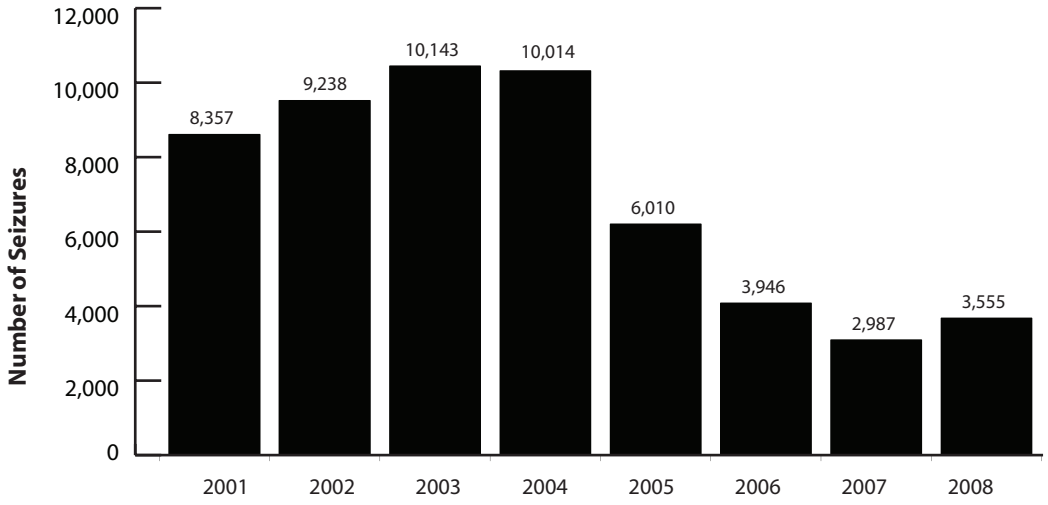


SOURCE: Georgia Department of Corrections, as reported by Brian Dew at the June 2009 CEWG meeting

Atlanta did, however, show decreases in 2008, as did prison admissions related to possession of methamphetamine (figure 12).

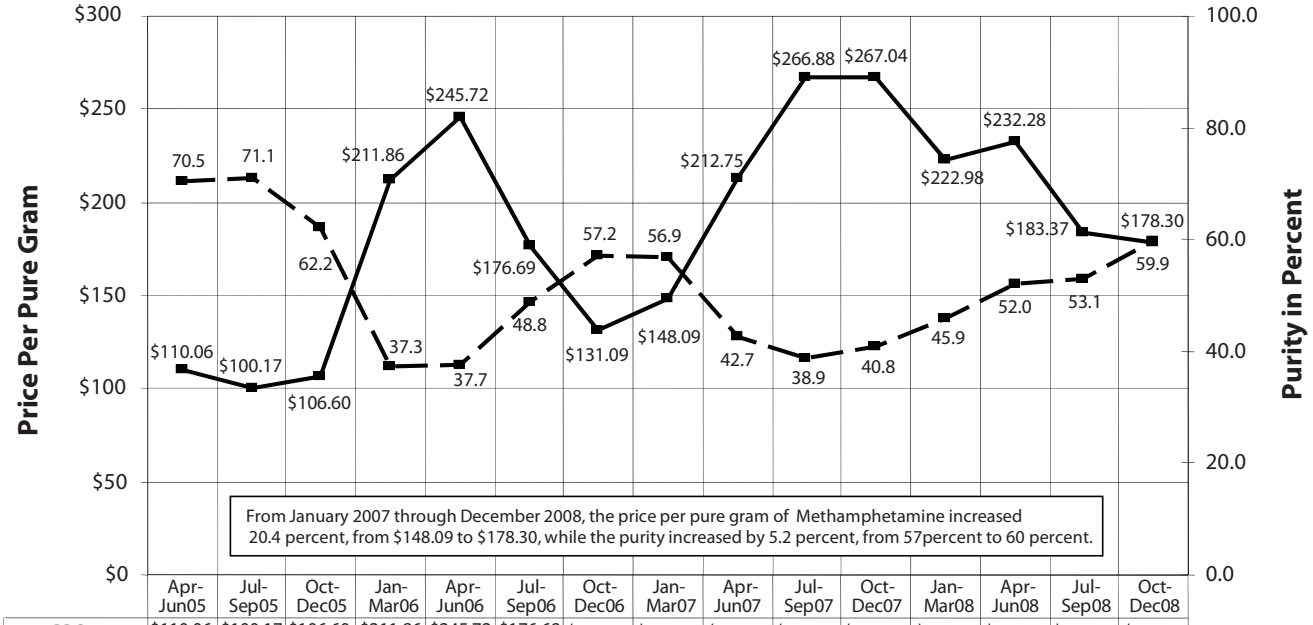
- In the West, methamphetamine abuse indicators remained high in some areas, but declines reported in previous CEWG reporting periods continued. Still high in Honolulu, methamphetamine declines were reported there in Medical Examiner cases, treatment admissions, and police department cases. In San Francisco, methamphetamine indicators continued a steady decline, and prices increased. Seattle and Denver reported stable and declining indicators, as did San Diego, Los Angeles, and Phoenix. In Texas, methamphetamine indicators continued the decrease which began in 2005, although abuse continued in several areas of the State. Overall, prices were up, and both purity and availability were down, according to the Texas area representative.
- The DEA representative in attendance at the June 2009 CEWG meeting provided an overview of trends in methamphetamine drug trafficking/distribution in the United States, describing decreases in methamphetamine laboratory seizures in the country, from a peak in 2003 to a low in 2007. In 2008, however, there was a slight increase in clandestine laboratory seizures (figure 13). DEA System to Retrieve Information from Drug Evidence (STRIDE) data on methamphetamine price and purity showed that the average purity of methamphetamine, as measured by the STRIDE program, has been rising since mid-2007, and the average price is at the lowest point since March of 2007 (figure 14).
- The CEWG representatives from St. Louis and Texas discussed new approaches to local methamphetamine production. It was reported that in the St. Louis area methamphetamine is made and used in networks of small methamphetamine

Figure 13. Total Numbers of Methamphetamine Laboratory Seizures, United States: 2001–2008



SOURCE: National Seizure System (NSS) database as of May 20, 2009, as reported by DEA representative Michael Vrakatitsis at the June 2009 CEWG meeting

Figure 14. All Methamphetamine Purchase Prices per Pure Gram with Purity in Percent from United States STRIDE[1] Data: April 2005–December 2008



	Apr-Jun05	Jul-Sep05	Oct-Dec05	Jan-Mar06	Apr-Jun06	Jul-Sep06	Oct-Dec06	Jan-Mar07	Apr-Jun07	Jul-Sep07	Oct-Dec07	Jan-Mar08	Apr-Jun08	Jul-Sep08	Oct-Dec08
PPG_mean	$110.06	$100.17	$106.60	$211.86	$245.72	$176.69	$131.09	$148.09	$212.75	$266.88	$267.04	$222.98	$232.28	$183.37	$178.30
Purity_mean	70.5	71.1	62.2	37.3	37.7	48.8	57.2	56.9	42.7	38.9	40.8	45.9	52.0	53.1	59.9

[1]STRIDE is a database of drug exhibits sent to DEA laboratories from the DEA, FBI, CBP, ICE, USCG, and Washington MPD. STRIDE is not a representative sample of drugs available in the United States, but reflects all evidence submitted to DEA laboratories for analysis. STRIDE data are not collected to reflect national market trends. Nonetheless, these data reflect the best information currently available on changes in methamphetamine price and purity.
SOURCE: STRIDE Program, as of 2/24/2009, as reported by DEA representative Michael Vrakatitsis at the June 2009 CEWG meeting

laboratories where "cooks" make small amounts for their own network. These small laboratories use personal networks to obtain the precursors in small amounts to lessen the likelihood of detection by law enforcement. The Texas representative reported that local manufacturers are using a "shake and bake" or "one pot" method to make methamphetamine.

- The proportions of primary treatment admissions including primary alcohol admissions for methamphetamine abuse in 18 reporting CEWG areas were especially high in Hawai'i and San Diego, at approximately 32 and 31 percent, respectively. They were also relatively high in Phoenix and Los Angeles, at 25 and 19 percent, respectively (appendix table 1; section III, table 23).
- Methamphetamine ranked first in treatment admissions as a percentage of total admissions in San Diego, and ranked second in Hawai'i and Phoenix (table 2).
- In all but 3 of the 15 CEWG areas reporting data, smoking was the most common route of administration of methamphetamine among primary treatment admissions; the 3 were Maine, Maryland, and Florida (section III, table 24).
- Between 2007 and 2008, eight of nine CEWG areas for which data on primary methamphetamine admissions were available had declines in these admissions as a percentage of total admissions, excluding primary alcohol admissions. The highest declines over the period were observed in Phoenix and San Diego, at approximately 6 percentage points each, followed by Los Angeles, at 4.0 percentage points. Atlanta and Hawai'i had approximate declines of 3 percentage points, while St. Louis showed virtually no change in the 2-year period. In the 5 years from 2004 to 2008, seven of eight reporting CEWG areas showed

overall declines in methamphetamine admissions, with one area (Denver) showing an increase. The largest declines were in Minneapolis/St. Paul and Hawai'i, at 7.5 and 7.3 percentage points, respectively, followed by San Diego (6.1 percentage points) (section III, table 26). While treatment data for 2004 were not reported for Phoenix, there was a noteworthy decrease of 11.8 percentage points in the proportion of primary methamphetamine admissions from 2005 to 2008.

- Methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in Honolulu in 2008, and second in Atlanta, Phoenix, and San Diego (table 1). The largest proportions of methamphetamine items identified were reported in Honolulu (close to 45 percent), followed by Minneapolis/St. Paul (approximately 27 percent), Phoenix (approximately 22 percent), and San Diego (20 percent). In contrast, less than 2 percent of drug items identified as containing methamphetamine were reported in most CEWG metropolitan areas east of the Mississippi, including Detroit, Chicago, Miami, New York City, Cincinnati, Boston, Philadelphia, Maryland, and Baltimore (section III, figure 20; appendix table 2).
- Estimated numbers and rates of methamphetamine-involved ED visits increased in 1 of the 12 reporting CEWG areas in the DAWN system (Boston), and decreased in 1 area (San Francisco) from 2004–2007. Although low, rates of methamphetamine-involved ED visits in Boston rose from 2.2 to 4.3 per 100,000 population between 2004 and 2007, while they fell in San Francisco from 127.2 to 104.3 per 100,000 in the same period. In three areas—Phoenix, San Diego, and San Francisco—decreases were also estimated for 2006–2007, at 20, 32, and 26 percent, respectively (section III, table 27).

Marijuana/Cannabis

- Marijuana indicators continued at high levels relative to other drugs as noted in previous reporting periods. Most CEWG areas experienced stable or increasing marijuana indicators, with a few exceptions.
- Marijuana indicators increased in several CEWG areas in 2008. The increases reported in the last reporting period in New York City continued throughout 2008, and indicators remained high. Marijuana primary treatment admissions represented almost one-quarter of all treatment admissions in New York City, and weighted DAWN data for marijuana increased by 145 percent between 2004 and 2007. During 2008, treatment admissions for marijuana increased in Los Angeles and in Seattle, where, in the latter, marijuana-growing operations increased substantially in 2008. According to the San Francisco representative, data indicated an increase in 2008 in numbers and percentages of primary marijuana treatment admissions in San Francisco County.
- Marijuana was reported as widely available in Cincinnati; while indicators remained high, they were mostly stable. Marijuana use indicators were stable in Detroit. Indicators for marijuana were considered high and stable in Chicago in 2008, where it ranked alongside cocaine and heroin as one of the top three drugs of abuse. Both Maine and Boston reported stable marijuana indicators. Marijuana continued as a primary drug problem, along with cocaine and heroin, in Baltimore, Maryland, and Washington, DC.
- Mixed indicators for marijuana abuse were reported in Honolulu by the CEWG area representative. Most indicators remained stable, but seizures of plants and dried marijuana decreased in 2008. Marijuana indicators in San Diego were also mixed. There, proportions of primary treatment admissions for marijuana increased, but most other indicators declined or remained unchanged. Texas also reported mixed indicators.
- In Atlanta, marijuana remained the leading reason for adolescents seeking treatment in 2008, and it accounted for 72 percent of all primary

treatment admissions (including alcohol) for youth under 18 in Miami. Over one-half (54 percent) of marijuana treatment admissions in 2008 in Los Angeles were adolescents younger than 18. During 2008, juvenile arrestees in Washington, DC, were more likely to test positive for marijuana (54 percent) than for any other drug. Percentages of marijuana-positive urine toxicology tests among juvenile arrestees rose from 40 percent in 2007 to 44 percent in 2008 in San Diego, while primary treatment admissions for marijuana rose from 15.6 percent of all 2007 admissions to 18.9 percent in 2008 in the same area.

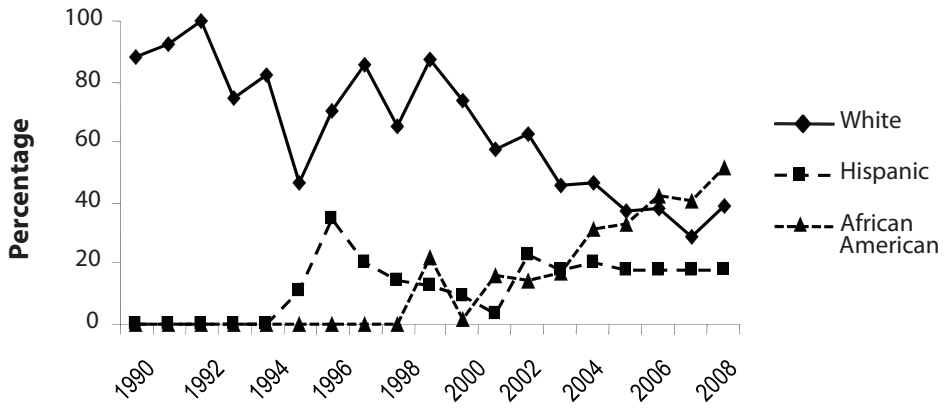
- Percentages of primary marijuana treatment admissions, including primary alcohol admissions, were highest in 2008 in Ft. Lauderdale/Broward County (38.5 percent), followed by the State of Florida (31.0 percent), and Miami/Dade County (29.0 percent). The lowest proportions of such admissions were in Boston (3.5 percent) (section III, table 28; appendix table 1).
- In 2008, marijuana ranked first as the primary drug problem in total drug admissions (including alcohol admissions) in 3 of 21 CEWG areas: Philadelphia, Ft. Lauderdale/Broward County, and the State of Florida. Marijuana ranked second in 7 of 21 CEWG areas: Miami/Dade County, Minneapolis/St. Paul, St. Louis, Colorado, Denver, Los Angeles, and Texas (table 2).
- Changes in percentages of primary marijuana treatment admissions, excluding alcohol admissions, in 15 CEWG areas did not exceed 5 percentage points from 2007 through 2008. However, over the 5 years from 2004–2008, primary marijuana treatment admissions declined by approximately 13 percentage points in Maine, and increased by at least 5 percentage points in 4 of 14 reporting areas—Hawai‘i, New York City, Los Angeles, and Detroit (treatment data for 2004 were not reported for Phoenix, although data for 2005–2008 showed a 5.2 percentage point increase in proportions of primary marijuana treatment admissions for that area) (section III, table 30).
- Cannabis/marijuana ranked first in frequency in the proportion of drug items identified in forensic laboratories in 2008 in 11 of 22 CEWG areas. These areas were Baltimore, Maryland, Boston, Philadelphia, Chicago, Cincinnati, Detroit, St. Louis, Los Angeles, Phoenix, and San Diego (table 1). The highest proportions of marijuana items identified were in Chicago, San Diego, and St. Louis, at approximately 56, 52, and 50 percent, respectively (section III, figure 21; appendix table 2).
- Estimated DAWN ED visits involving marijuana increased in 3 of 12 reporting areas and decreased in 1 area. Increases in estimated marijuana ED visits were reported in Denver, New York City, and Detroit from 2004–2007, while decreased marijuana visits were observed for Houston over the 4-year period (section III, table 31).

MDMA/Ecstasy and Other Club Drugs, Including MDA, GHB/GBL, LSD, and Ketamine

MDMA/Ecstasy

- In 2008, MDMA (3,4-methylenedioxymethamphetamine, or ecstasy) indicators continued to be low when compared with other drug use indicators. However, MDMA abuse remained a problem in several CEWG areas, as reported by CEWG area representatives, with MDMA abuse indicators increasing in Chicago, Cincinnati, Maine, Los Angeles, and Honolulu.
- In the Midwest, the Detroit area representative reported that MDMA use continued to be troublesome, where it was still a popular drug in that metropolitan area. Several MDMA indicators increased in Chicago, including use among 9th to 12th graders from 2005 to 2007. Ethnographic and survey reports continued to show the popularity of MDMA among young low-income African Americans in Chicago.

Figure 15. Percentage of Clients Admitted to DSHS-Funded Treatment With a Primary Problem With MDMA/Ecstasy by Race/Ethnicity, Texas; 1990–2008



SOURCE: Texas Department of Safety and Human Services (DSHS), as reported by Jane Maxwell at the June 2009 CEWG meeting

Availability and use indicators for MDMA showed noticeable increases in 2008 over 2007 in Cincinnati. Indicators for MDMA were stable in St. Louis, where MDMA use continued in select populations, and in Minneapolis/St. Paul.

- MDMA indicators remained low across all CEWG areas in the Northeast, but arrests and treatment admissions increased slightly in Maine, where the drug was sometimes found in capsule form.
- In the South, indicators for MDMA continued to remain stable in 2008, including in Atlanta, after increases were observed in 2007. The Miami CEWG area representative reported stable MDMA indicators, but both methamphetamine and 1-benzylpiperazine (BZP) continued to be found in pills sold as ecstasy, with or without MDMA.
- In the western region, continuing increases in MDMA indicators were reported for Los Angeles, where primary MDMA treatment admissions increased slightly, and Honolulu, where the area representative reported that forensic laboratory samples identified as MDMA in 2008 equaled heroin sample numbers. MDMA was reported as a problem as a street drug in both Denver and Texas, with increases in Texas in proportions of both African American, non-Hispanic, and White non-Hispanic primary MDMA/ecstasy treatment admissions between 2007 and 2008 (figure 15). Law enforcement reports indicated an overall increase in MDMA supply in Colorado over the past 2 years. Other areas in the West reported low MDMA indicators, including San Francisco and Phoenix, and MDMA law enforcement seizure drug tests decreased substantially in Seattle from 2007 to 2008.
- MDMA was the fourth most frequently identified drug item in Atlanta, Chicago, and Minneapolis/St. Paul in 2008 (table 1; section III, table 32). MDMA represented 4.1, 3.7, 3.4, and 3.3 percent of total drug items identified in forensic laboratories in 2008 in Minneapolis/St. Paul, Detroit, Atlanta, and San Francisco, respectively (section III, table 32).
- Estimated MDMA-associated ED visits increased in Denver and Detroit, and decreased in San Francisco from 2004 to 2007 (section III, table 34).

Other Club Drugs (MDA, GHB/GBL, LSD, and Ketamine)

- While gamma hydroxybutyrate (GHB), ketamine, and 3,4-methylenedioxyamphetamine (MDA) appeared relatively infrequently in indicator data for all areas, in Atlanta, ethnographic research suggested continued frequency in use, particularly among metropolitan Atlanta's young adult population. The New York City area representative reported that GHB and ketamine can easily be obtained in many dance clubs in the city. The Miami area representative reported a significant decline in abuse of GHB in recent years. In Boston, ketamine laboratory samples decreased in number, from a peak of 43 in 2002 to 3 in 2008.
- GHB drug items were not among the top 25 drug items identified for any CEWG area in 2008. Ketamine ranked in the top 25 in 9 areas: Atlanta, Chicago, Denver, Los Angeles, Miami, New York City, San Francisco, Texas, and Washington, DC (section III, table 33).
- Lysergic acid diethylamide (LSD) use by high school seniors increased slightly in the Minneapolis/St. Paul area, from 4.9 to 6.2 percent, in 2007. Use among Texas students, however, continued to decrease according to the Texas secondary school survey.
- LSD ranked in the top 25 identified drug items in 6 of 22 CEWG areas: Chicago, Cincinnati, Denver, Maine, San Francisco, and Seattle, although it made up 1 percent or less of all drug items identified in those areas (section III, table 33).
- MDA was reported among the top 25 drug items identified in 10 of 22 areas: Atlanta, Baltimore, Denver, Honolulu, Maine, Maryland, New York City, Philadelphia, Seattle, and Washington, DC (section III, table 33). While neither ketamine, GHB, nor LSD figured among the top 10 most frequently identified drug items in any CEWG area in 2008, MDA ranked in 10th place among drugs identified in 2008 in forensic laboratories in Denver (table 1).

Phencyclidine (PCP)

- Phencyclidine (PCP) persisted on the drug scene in several CEWG areas, with some indicators continuing to increase in Texas, New York City, Maryland, and Washington, DC.
- In Texas, the number of poison control cases reported for PCP increased from 102 in 1998 to 290 in 2008. Primary treatment admissions for PCP increased by 39 percent in the past 2 years in Maryland, from 340 in 2006 to 473 in 2008. PCP remained popular with youth in Washington, DC.
- PCP indicators, reported as increasing in the previous reporting period, appeared to stabilize at moderate levels in 2008 in Philadelphia. Indicators were mixed in Chicago; street reports showed PCP use was common in some neighborhoods, although overall use remained low. Ethnographic reports suggested that PCP "sticks" the size of toothpicks were reportedly available for $10–$30 in Chicago. CEWG area representatives in St. Louis and Seattle reported that PCP remained a drug abuse issue in those cities.
- In Washington, DC, PCP ranked fourth as the most frequently identified drug item in forensic laboratories in 2008. PCP was also among the top drug items identified in Philadelphia and New York City, where it ranked sixth in each (table 1).
- Washington, DC, Philadelphia, and New York City reported the highest percentages of PCP drug items identified in 2008 in NFLIS data, at 6.5, 2.6, and 1.2 percent of drug items identified, respectively (section III, table 33).
- Weighted estimated ED visits involving PCP increased in 1 of the 12 CEWG areas reporting DAWN data, New York City, and decreased in 1,

Chicago, over the 2004–2007 period (section III, table 35).

Other Drugs and Drug Abuse Patterns/ Issues

BZP (1-Benzylpiperazine)

- BZP, a synthetic stimulant that is illegal and has no accepted medical use in the United States, continued during this reporting period as an emerging drug of concern in several CEWG areas. BZP was permanently controlled in 2004 as a Schedule I substance under the Controlled Substance Act. Increases in seizures in 2007 and 2008 were noted by the DEA.
- In Atlanta, numbers of BZP drug items identified in NFLIS drug seizure data for the city in 2008 rose from 5 to 32, compared with 2007, while piperazine seizures increased from 16 to 227 in the same period. Ethnographic reports showed that BZP was being manufactured and sold as MDMA on the streets of Atlanta. In the South Florida area, BZP was increasingly detected, with or without MDMA, in ecstasy pills. Although not yet a substantial problem in Denver, BZP, in combination with TFMPP, showed up in Denver law enforcement data in 2008. In the Seattle area in 2008, 203,897 BZP tablets were seized entering the United States at the Washington border with Canada. The Seattle representative reported that the BZP was being manufactured in Canada, where it is not a controlled drug.
- BZP ranked 6th in drug items identified in 2008 in Chicago; 7th in Washington, DC, Honolulu, and Seattle; 9th in Miami; and 10th in Detroit, St. Louis, and Texas (table 1). All but 4 of 22 reporting CEWG areas included BZP drug items in the top 25 identified in 2008, with exceptions being Cincinnati, Maryland, New York City, and San Francisco (section III, table 33). This contrasts with 2007 when only one CEWG area, Detroit, listed any BZP-containing drug items among the top 25 drug items identified in forensic laboratories.

TFMPP[7] or 1-(3-Trifluoromethylphenyl) piperazine

- TFMPP is a synthetic substance with no accepted medical use in the United States that is abused for its hallucinogenic effects. TFMPP is currently an uncontrolled substance. Seizures of TFMPP increased across the country from 2007 to 2008, according to the DEA, and indicators for TFMPP have increased in this reporting period in Denver, Texas, and Atlanta, based on reports from those area representatives.
- According to NFLIS data for 2008, TFMPP ranked eighth among drug items identified in forensic laboratories in the reporting period in both Atlanta and Washington, DC (table 1). TFMPP drug items constituted close to 2 percent of Atlanta's drug items in 2008, and represented nearly 1 percent of those for Washington, DC (section III, table 33).

Foxy Methoxy[8] (5-Methoxy-N, N-diisopropyl-tryptamine, or 5-MeO-DIPT)

- Foxy Methoxy is a synthetic substance abused for its hallucinogenic effects which is illegal in the United States and is controlled as a Schedule I substance under the Controlled Substance Act. This drug was identified among NFLIS drug items in 2008 in only one CEWG area, Denver (n=19) (section III, table 33).

Salvia Divinorum[9]

- Salvia divinorum is a perennial herb native to Mexico, whose active ingredient, salvinorin

[7]More information on TFMPP can be found in the Federal Register Notice 68 FR 52872.

[8]More information on 5-MeO-DIPT can be found at *www.deadiversion.usdoj.gov/drugs_concern/5meodipt.htm*.

[9]More information on Salvia divinorum is available at *www.usdoj.gov/dea/drugs_concern/salvia_d/salvia_d.htm* and at *www.drugabuse.gov/infofacts/salvia.html*.

A, produces hallucinogenic effects when it is smoked or chewed. It is not currently federally controlled, although some States control it as a Schedule I drug. Seizures of salvia divinorum have seen a steady increase since 2004. Salvia divinorum was described as an emerging drug of concern in Texas by the Texas CEWG representative at the January 2009 meeting.

Carisoprodol[10] (Soma®)

- Carisoprodol is a muscle relaxant and central nervous system depressant that is available by prescription as Soma®. It is not controlled on the Federal level, but several States have scheduled Soma® as a controlled substance. Increased abuse of carisoprodol in Texas, noted in the last reporting period, continued, where poison control cases, deaths, and laboratory exhibits identified as carisoprodol increased.
- NFLIS data for 2008 showed that carisoprodol was identified among the top 25 drug items analyzed in area forensic laboratories in 9 of 22 CEWG reporting areas: Atlanta, Denver, Detroit, Honolulu, Los Angeles, Miami, Phoenix, San Francisco, and Texas (section III, table 33). In 2008, drug items containing carisoprodol ranked 8th in Texas and Phoenix, and 10th in Atlanta and Los Angeles among the top 10 most frequently identified NFLIS drug items in the period (table 1).
- Estimated ED visits involving the nonmedical use of carisoprodol increased significantly in 2 of 12 CEWG reporting areas—Houston and Denver—over the period from 2004 through 2007. A significant decline of 15 percent in estimated ED visits involving carisoprodol was observed for San Diego over the 4-year period (section III, table 36).

Antipsychotics

- **Quetiapine,** an antipsychotic drug, appeared in the NFLIS data in Boston (70 samples identified) and Texas (164 samples identified) for the first time in this reporting period.
- Mortality data pertaining to antipsychotics were reported by the representatives from Philadelphia and Maine. In Philadelphia, the number of deaths in which antipsychotics were detected hovered between 95 and 105 from 2004 through 2007, with a slight increase to 117 in 2008. Deaths in which quetiapine was detected increased in Philadelphia from 29 in 2007 to 49 in 2008. Illicit substances were also detected in some of these decedents. The Philadelphia representative reported that antipsychotics have not been identified as "street drugs" in Philadelphia. In Maine, the CEWG representative reported that 8 percent of drug-induced deaths were due to antipsychotics as a general category, and in 8 percent, quetiapine was identified specifically. Information on whether quetiapine was found in combination with other drugs in the decedents in Maine was not reported.

Levamisole

- During this reporting period, several CEWG area representatives reported data pertaining to levamisole, a veterinary anti-parasitic medication not approved for human use in the United States. Data pertaining to levamisole and cocaine are reported under the Cocaine heading in this section of the report. Data available subsequent to the June 2009 CEWG meeting from the DEA Cocaine Signature Program indicate that in early 2009, levamisole was detected in 69 percent of cocaine bricks tested from bulk seizures. The CEWG representative from Maine also reported that levamisole has been detected in heroin. Levamisole has been linked to agranulocytosis, in which there is a marked decrease in white blood cells, suppressing immune function and the body's ability to fight infection. On September 21, 2009, SAMHSA released a Public Health Alert regarding the risk posed by cocaine laced with levamisole. The Public Health Alert can be viewed on the SAMHSA

[10]Information on carisoprodol and Soma® can be found at *www.deadiversion.usdoj.gov/drugs_concern/carisoprodol.htm.*

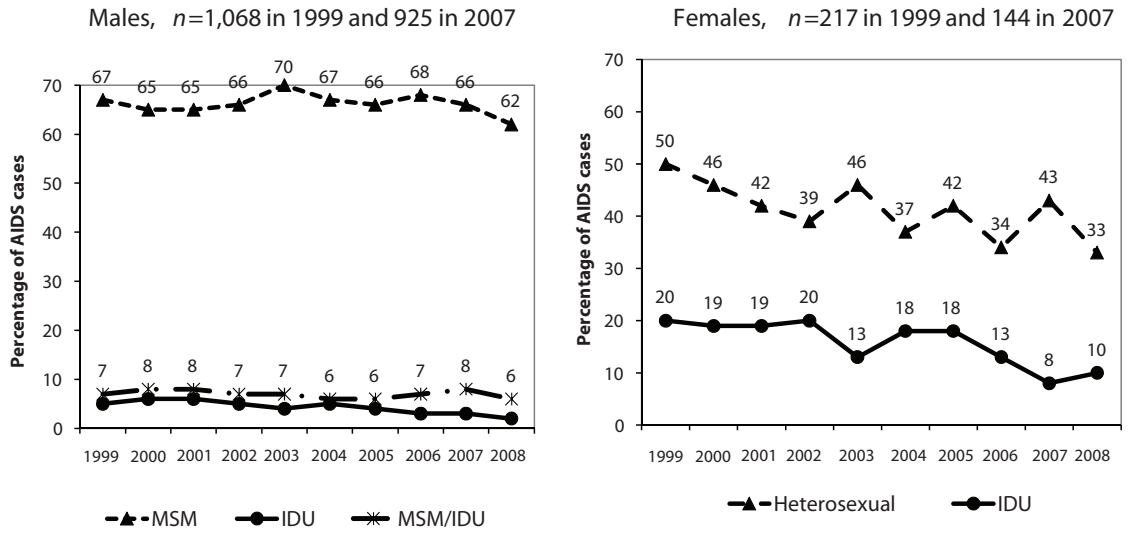
Web site at *www.samhsa.gov/newsroomadvisories/090921vet5101.aspx.*

- Among the other drugs of concern across the Nation for this reporting period, noted by a representative from the DEA in attendance at the June CEWG meeting, were the Five Spice Cannabinoids ("designer cannabinoids," or synthetic cannabinoid-like chemicals) and benzylamines (along with BZP, TFMPP, Foxy Methoxy, and Salvia divinorum).

U. S. Border Drug Abuse Patterns and Issues

- Four CEWG areas are located in States that share the northern U. S. border with Canada—Detroit and Minneapolis/St. Paul in the Midwest, Maine in the Northeast, and Seattle in the West—and illicit drugs continued to be transported back and forth between the two countries across this border.
- Most of Maine's borders are shared with Canada, and the Maine representative reported that the State has a substantial cross-border drug trafficking pattern. The CEWG area representative from Detroit reported the transportation of drugs in and out of Michigan along the United States–Canada border. Michigan has three bridges and a tunnel connecting to Canada. Marijuana frequently crosses the border from Canada into Michigan in commercial vehicles; ecstasy is more often transported from Canada to the United States in private vehicles. Cocaine, however, was transported in large amounts from Michigan into Canada.
- In the Seattle area in 2008, 203,897 BZP tablets were seized entering the United States at the Washington border with Canada. The Seattle representative reported that the BZP was being manufactured in Canada, where it is not a controlled drug. Marijuana trafficking into Washington from Canada has decreased, however, due possibly to the significant increase in marijuana growing operations in Washington State. The Northwest HIDTA Threat Assessment reported that outdoor grows totaled 538,918 plants in 2008, compared with 241,097 in 2007. The report also noted that there was evidence that Southeast Asian growers had moved their growing operations from Canada to Washington.
- In the western region of the United States, three CEWG areas—San Diego, Phoenix, and Texas—share or are close to the southern border with Mexico and reported on border issues in this reporting period.
- San Diego continues to be a major transshipment point along the United States–Mexico border for both methamphetamine and marijuana. San Diego County shares 80 miles of border with Mexico. The San Ysidro border crossing, which links San Diego with its sister city of Tijuana, Mexico, is the busiest border crossing in the world, accommodating approximately 40 million legal crossings annually. Both Tijuana and San Diego County are located on major drug trafficking routes that bring illicit drugs from Mexico and South America to the United States.
- The Phoenix CEWG area representative reported the law enforcement discovery of 11 tunnels in Nogales, a city along the border, in the second half of 2008. That said, increased law enforcement efforts in Mexico and along the United States–Mexico border have made it more difficult to transport cocaine from Mexico to Arizona, possibly impacting the cocaine supply in that State.
- In Texas, illicit drugs continued to enter the State from Mexico through several cities and smaller towns along the border. The drugs then move northward for distribution through Dallas/Fort Worth and Houston, according to the Texas CEWG area report. In 2008, several drug patterns in Texas were affected by border issues. Similar to Phoenix, the availability of cocaine in Texas decreased in the last half of 2008 due to violence and gang warfare on the

Figure 16. Percentage of Annual AIDS Cases by Selected Exposure Categories[1], Los Angeles County: 1999–2008



[1]Note: MSM=male-to-male sexual contact, IDU=injection drug user.
SOURCE: County of Los Angeles Department of Public Health, HIV/AIDS Semiannual Surveillance Summary, January 2009 (cases reported as of 12/31/08—may under-represent late 2008 cases), as reported by Mary-Lynn Brecht at the June 2009 CEWG meeting

border. The Texas CEWG area representative also reported that border security and seizures of Mexican methamphetamine have encouraged local manufacturers to return to "cooking," using over-the-counter pseudoephedrine with the "one pot" or "shake and bake" method. While drug trafficking problems are not new along the Texas–Mexico border, street outreach workers were reporting more trauma and mental health issues in border areas related to drug violence.

HIV/AIDS Related to Drug Abuse

Injection drug use contributes to HIV transmission both directly through sharing injection equipment and indirectly through risky sexual behaviors. The CEWG continues to monitor trends in injection drug use as important for understanding the consequences of drug use, including human immunodeficiency virus (HIV) infection.

- Exposure to HIV and acquired immune deficiency syndrome (AIDS) through injection drug use (IDU) has been steadily decreasing or has remained stable across the CEWG areas. CEWG area representatives from the following areas reported decreases in the prevalence of HIV/AIDS through IDU transmission in recent years: Chicago (from 2000–2006); Baltimore (from 2001–2006); Maryland (from 2001–2006); Phoenix (from 2000–2007); Washington, DC (from 2006–2007, AIDS data only); and Texas (from 1999–2008).
- The incidence of new AIDS cases in San Francisco attributed to IDU continued to decelerate, as was the case in Los Angeles, where annual AIDS cases among both males and females have declined since 2005 (figure 16). The Seattle representative reported a significant decline in King County from earlier years in the proportion of HIV positive individuals with IDU as their exposure category in the 2006 to

2008 data. As reported by the Denver representative, the proportion of newly diagnosed HIV and AIDS cases in Colorado attributed to IDU has remained stable since 2001; 9.1 percent were IDUs, and 10.6 percent were men who have sex with men (MSM)/IDUs.

- Data from several CEWG areas indicated that the risk factor of injection drug use did not play a major role in HIV/AIDS transmission. In St. Louis, less than 3 percent of HIV cases had a primary risk factor of IDU. In Minnesota, 5 percent of HIV infections were attributed to IDU, with 7 percent in the MSM/IDU exposure category. Injection drug use was a primary exposure factor for women (8 percent) in Minnesota. Hawai‘i had similar numbers, with 8 percent of AIDS cases in the IDU category, and 7 percent identified as MSM/IDU.
- Injection drug users (IDUs) accounted for 16 percent of people living with HIV/AIDS in Detroit; 12 percent had only this risk factor, and 4 percent were IDUs who were also MSM. In Florida, 16.4 percent of cumulative AIDS cases in Miami/Dade County and 12 percent in Broward County were identified as IDUs; 4.1 percent in Miami/Dade County and 3.9 percent in Broward County reported the dual risk of MSM/IDU. Maine transmission data showed that 12 percent of the new HIV diagnoses in 2008 had an IDU source.
- The Los Angeles CEWG area representative reported that exposure to AIDS through IDU was particularly high in that area for African Americans (13 percent) and Asian/Pacific Islanders (11 percent), compared with 2 to 6 percent for other ethnic categories.
- Three CEWG areas in the Northeast reported higher IDU proportions than other areas. In Boston, cumulative adult AIDS cases in 2008 included 25 percent who were IDUs, and 7 percent who had sex with IDUs. Transmission risk factors were also high in New York City, where 31 percent of people who were living with HIV/AIDs were MSM, and 21 percent had an injection drug use history. In 2007, the death rate among IDUs living in New York City was almost 60 percent higher than the overall death rate (30.9 compared with 19.3 per 1,000 population). One-third of the cumulative AIDS cases in Philadelphia involved IDUs.

Table 1. NFLIS Top 10 Drug Items Analyzed by CEWG Area and Rank (Based on Frequency): January–December 2008

CEWG Area	Cocaine/ Crack	Heroin	Oxy-codone	Hydro-codone	Alprazolam	Clonazepam	Metham-phetamine	Cannabis	MDMA	Phencyclidine (PCP)	Other Drugs
SOUTHERN REGION											
Atlanta	1	7	6	5	3	--[1]	2	9[2]	4	--	1-(3-Trifluoromethylphenyl) piperazine=8; Carisoprodol=10
Baltimore	2	3	4	9	6	7	--	1	10	--	Buprenorphine=5; Methadone=8
Maryland	2	3	4	--	6	7	--	1	9	10	Buprenorphine=5; Methadone=8
Miami	1	3	7	10	4	--	8	2	5	--	Hallucinogens=6; 1-Benzylpiperazine=9
Washington, DC	1	3	9	--	--	--	6	2	5	4	1-Benzylpiperazine=7; 1-(3-Trifluoromethylphenyl) piperazine=8; Cathinone=10
NORTHEASTERN REGION											
Boston	2	3	4	8	7	6	--	1	10	--	Buprenorphine=5; Methadone=9
Maine	1	3	4	6	9	--	7	2	--	--	Methadone=5; Buprenorphine=8; Psilocin=10
New York City	1	3	5	8	4	9	--	2	10	6	Methadone=7
Philadelphia	2	3	5	8	4	9	--	1	--	6	Codeine=7; Diazepam=10
MIDWESTERN REGION											
Chicago	2	3	--	7	8	--	5	1	4	9	1-Benzylpiperazine=6; Acetaminophen=10
Cincinnati	2	3	4	5	7	9	10	1	6	--	Diazepam=8
Detroit	2	3	7	4	6	--	8	1	5	--	Codeine=9; 1-Benzylpiperazine=10
Minneapolis/St. Paul	1	5	6	7	--	--	3	2	4	--	Acetaminophen=8; Codeine=9; Amphetamine=10
St. Louis	2	3	9	6	7	--	4	1	5	--	Pseudoephedrine=8; 1-Benzylpiperazine=10
WESTERN REGION											
Denver	1	4	6	7	9	--	3	2	5	--	Psilocin=8; 3,4-Methylenedioxyamphetamine=7, Tetrahydrocannabinols=8, Morphine=9
Honolulu	3	4	6	10	--	--	1	2	5	--	1-Benzylpiperazine=7; Testosterone=8; Methadone=9
Los Angeles	2	4	--	6	8	--	3	1	[5]	7	Codeine=9; Carisoprodol=10
Phoenix	3	4	5	6	10	--	2	1	7	--	Carisoprodol=8; Morphine=9
San Diego	3	4	7	5	8	10	2	1	6	--	Diazepam=9
San Francisco	1	4	6	7	--	10	3	2	5	--	Methadone=8; Morphine=9
Seattle	1	4	5	8	--	--	3	2	6	10	1-Benzylpiperazine=7; Dimethylsulfone=9
Texas	1	6	--	5	4	9	3	2	7	--	Carisoprodol=8; 1-Benzylpiperazine=10

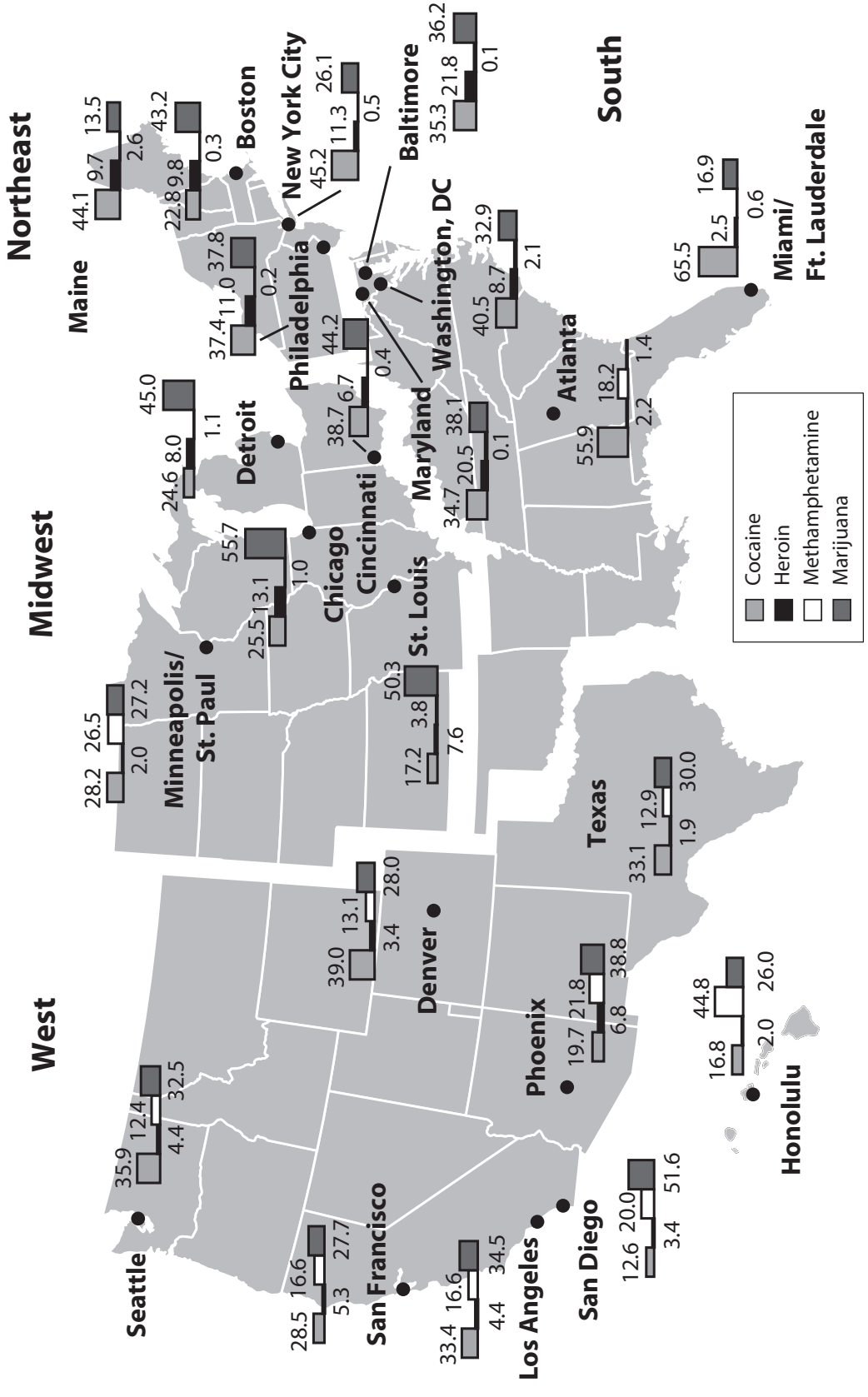
[1]The "--" symbol indicates that the drug did not appear in the top 10 ranked drug items for that area.
[2]The CEWG representative from Atlanta reported that in 2004, Georgia initiated a statewide administrative policy that when cannabis is seized by law enforcement officers, laboratory testing is not required. This results in artificially low numbers of such drug items identified in this CEWG area relative to other CEWG areas.
SOURCE: NFLIS, DEA (see appendix tables 2.1–2.22); data are subject to change and may differ according to the date on which they were queried

Table 2. Top Ranked Primary Drugs as a Percentage of Total Treatment Admissions, Including Primary Alcohol Admissions, in 21 CEWG Areas[1], by Region and Ranking: CY 2008[2]

CEWG Area	Alcohol	Cocaine/ Crack	Heroin	Opiates/ Opioids Other Than Heroin	Metham-phetamine	Marijuana/ Cannabis	Other Drugs
SOUTHERN REGION							
Atlanta	1	2	7	6	4	3	5
Baltimore	2	3	1	5	7	4	6
Maryland	1	4	2	5	7	3	6
Miami/Dade County	3	1	5	6	7	2	4
Broward County (Ft. Lauderdale)	2	3	6	5	7	1	4
Florida[3]	2	3	6	4	7	1	5
NORTHEASTERN REGION							
Boston	2	3	1	6	7	5	4
Maine	1	5	4	2	7	3	6
New York City	1	4	2	6	7	3	5
Philadelphia	3	2	4	6	7	1	5
MIDWESTERN REGION							
Detroit	2	3	1	5	7	4	6
Minneapolis/St. Paul	1	3	4	5	6	2	7
St. Louis	1	4	3	6	5	2	7
WESTERN REGION							
Colorado	1	4	5	6	3	2	7
Denver	1	3	5	6	4	2	7
Hawai‘i	1	4	6	NR[4]	2	3	5
Los Angeles	1	5	4	7	3	2	6
Phoenix	1	5	4	6	2	3	7
San Diego	2	5	4	6	1	3	7
Seattle	1	2	4	6	5	3	7
Texas[3]	1	3	4	6	5	2	7

[1]CEWG areas not included in the table due to lack of availability of treatment admissions data for the reporting period are Washington, DC in the southern region, Chicago and Cincinnati in the midwestern region, and San Francisco in the western region.
[2]Data are for January–December 2008.
[3]Methamphetamine and amphetamine are grouped together.
[4]NR=Not reported by the CEWG area representative.
SOURCE: June 2009 State and local CEWG reports

Figure 17. Percentage of Cocaine, Heroin, Methamphetamine, and Marijuana Items Analyzed by Forensic Laboratories in 22 CEWG Areas in Four U.S. Regions, Each as a Percentage of Total Items Analyzed: CY 2008[1]



[1]Data are for January–December 2008 (see appendix tables 2.1–2.22). 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 received April 14, 2009

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

Cocaine/Crack

- Treatment admissions data for 2008 revealed that treatment admissions for primary cocaine/crack, as a percentage of total drug treatment admissions, including primary alcohol admissions, ranked first in frequency in only 1 of 21 reporting CEWG areas—Miami/Dade County (section II, table 2). The most common route of administration in all reporting areas was smoking (table 4). The largest decreases were observed in primary cocaine admissions, excluding primary alcohol admissions, between 2007 and 2008 in St. Louis and Detroit, at approximately 9 and 7 percentage points, respectively (table 6). Over the 5-year period from 2004 through 2008, Atlanta and St. Louis saw the largest declines in cocaine admissions, at approximately 18 and 14 percentage points, respectively (table 6).
- Cocaine was the drug most frequently identified by forensic laboratories in 10 of 22 reporting CEWG areas. Based on forensic laboratory analysis of drug items identified in 2008, cocaine/crack ranked first in three of five areas in the southern region (Miami, Atlanta, and Washington, DC); two of four areas in the northeastern region (New York City and Maine); and four of eight areas in the western region (San Francisco, Seattle, Denver, and Texas). Cocaine also ranked first in one of the five CEWG areas in the midwestern region, Minneapolis/St. Paul, in frequency of drug items identified (section II, table 1; appendix table 2).
- Based on weighted DAWN data, 5 CEWG areas among the 12 reporting areas showed statistically significant increases in estimated numbers and rates of cocaine-involved ED visits from 2004 through 2007, namely Detroit, Denver, New York City, Seattle, and Boston (table 7).

Treatment Admission Data on Cocaine/Crack

Table 3 presents the most recent data from 21 CEWG areas on primary cocaine treatment admissions as a proportion of total admissions, including those for alcohol (see also appendix table 1). In all cases, the reporting period covers CY 2008, January through December, 2008.

Miami/Dade County had the highest percentage (37.8 percent) of primary cocaine admissions, followed distantly by Philadelphia (23.3 percent), Atlanta (22.9 percent), Detroit (22.5 percent), and Texas (21.7 percent). The lowest proportions of primary cocaine treatment admissions, including primary alcohol admissions, were observed for Hawai‘i (3.9 percent), Maine (6.0 percent), and San Diego (6.6 percent) (table 3).

Based on total 2008 treatment admissions, including those for primary alcohol problems, cocaine ranked first in Miami/Dade County and ranked second in 3 of the 21 reporting CEWG areas: Atlanta, Philadelphia, and Seattle (section II, table 2).

Table 3. Primary Cocaine Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: CY 2008[1,2]

CEWG Area	Primary Cocaine Admissions	Total Admissions with Primary Alcohol Admissions Excluded[3]		Total Admissions with Primary Alcohol Admissions Included	
	#	#	%	#	%
Atlanta	1,853	5,339	34.7	8,105	22.9
Baltimore	2,700	15,558	17.4	18,355	14.7
Boston	1,440	12,217	11.8	18,256	7.9
Colorado	3,256	16,449	19.8	28,036	11.6
Denver	1,623	7,346	22.1	11,872	13.7
Detroit	2,005	6,457	31.1	8,927	22.5
Florida	8,902	34,019	26.2	47,264	18.8
Hawai‘i	355	5,769	6.2	9,058	3.9
Los Angeles	8,662	43,709	19.8	55,530	15.6
Maine	768	7,318	10.5	12,849	6.0
Maryland	8,463	42,839	19.8	65,373	12.9
Miami/Dade County	1,273	2,504	50.8	3,371	37.8
Ft. Lauderdale/ Broward County	775	3,183	24.3	4,184	18.5
Minneapolis/ St. Paul	1,905	9,132	20.9	19,263	9.9
New York City	15,596	60,645	25.7	84,309	18.5
Philadelphia	3,439	11,363	30.3	14,741	23.3
Phoenix	429	3,350	12.8	5,049	8.5
San Diego	995	12,010	8.3	15,041	6.6
Seattle	2,455	9,079	27.0	14,203	17.3
St. Louis	2,127	7,930	26.8	11,968	17.8
Texas	19,247	64,943	29.6	88,871	21.7

[1]More information on these data is available in the footnotes and notes for appendix table 1.
[2]Data are for January–December 2008.
[3]Percentages of primary cocaine admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.
SOURCE: June 2009 State and local CEWG reports

Route of Administration of Cocaine

Data from 18 CEWG areas indicate that smoking[11] was the most common mode of cocaine administration among primary cocaine treatment admissions in 2008 (table 4). The range is from approximately 46 percent in Maine to 97 percent in Detroit. The highest percentages of smoking cocaine were reported in Detroit (97.0 percent), followed by St. Louis (89.3 percent), Philadelphia (85.8 percent), and Los Angeles

[11] SAMHSA'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 4. Primary Route of Administration of Cocaine Among Treatment Admissions in 18 CEWG Areas as a Percentage[1] of Primary Cocaine Treatment Admissions: CY 2008[2]

CEWG Area	Smoked		Inhaled		Injected		Oral/Other/ Unknown		Total *n*[3]
	#	%	#	%	#	%	#	%	
Atlanta	1,396	75.3	357	19.3	25	1.4	75	4.0	1,853
Baltimore	2,332	86.4	174	6.4	175	6.5	19	0.7	2,700
Boston	952	66.1	303	21.0	106	7.4	79	5.5	1,440
Colorado	2,002	61.5	1,021	31.4	173	5.3	60	1.8	3,256
Denver	931	57.4	596	36.7	62	3.8	34	2.1	1,623
Detroit	1,945	97.0	52	2.6	1	0.1	7	0.3	2,005
Los Angeles	7,360	85.0	1,077	12.4	35	0.4	190	2.2	8,662
Maine	356	46.4	233	30.3	156	20.3	23	3.0	768
Maryland	6,789	80.2	1,194	14.1	344	4.1	136	1.6	8,463
Miami/Dade County	769	60.4	465	36.5	5	0.4	34	2.7	1,273
Ft. Lauderdale/ Broward County	469	60.5	280	36.1	8	1.0	18	2.3	775
Minneapolis/ St. Paul	1,427	74.9	394	20.7	38	2.0	46	2.4	1,905
New York City	9,447	60.6	5,674	36.4	266	1.7	209	1.3	15,596
Philadelphia	2,950	85.8	148	4.3	43	1.2	298	8.7	3,439
Phoenix	319	74.4	85	19.8	8	1.9	17	3.9	429
San Diego	799	80.3	167	16.8	19	1.9	0	0	995[3]
St. Louis	1,899	89.3	136	6.4	26	1.2	66	3.1	2,127
Texas	10,593	55.0	6,899	35.9	940	4.9	794	4.1	19,247[3]

[1]Percentages may not sum to 100 due to rounding.
[2]Data are for January–December 2008.
[3]Totals may differ from those in appendix table 1 due to the presence of unknown or missing values, which are included in the denominator (10 cases for San Diego and 21 cases for Texas).
SOURCE: June 2009 State and local CEWG reports

(85.0 percent). Inhaling or sniffing cocaine was the primary route of administration in approximately 36–37 percent of cocaine admissions in Texas, New York City, Ft. Lauderdale/Broward County, Miami/Dade County, and Denver. The lowest proportions reporting inhaling or sniffing cocaine, as the primary administration route, were in Detroit, at 2.6 percent, and Philadelphia, at 4.3 percent. 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 by far the highest proportions being in Maine, at 20.3 percent, followed by Boston and Baltimore (at approximately 7 percent each) (table 4).

Gender of Cocaine/Crack Admissions

Across all 20 reporting CEWG areas in 2008, the majority of primary cocaine admissions were male (table 5). The highest proportions of male cocaine admissions were in New York City

(68.6 percent), while the lowest percentages were in Maine (51.2 percent) and Atlanta (51.5 percent) (table 5).

Age of Cocaine/Crack Admissions

In 19 of 20 reporting CEWG areas in 2008, 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 Baltimore (86.3 percent) and Detroit (83.9 percent) (table 5). In Maine, Florida, and Texas, proportions of older cocaine admissions were lowest, at 43.6, 52.7, and 53.5 percent, respectively. The highest percentages of cocaine treatment admissions age 25 and younger were in Maine (22.1 percent) and Miami/Dade County (19.6 percent) (table 5).

Table 5. Demographic Characteristics of Primary Cocaine Treatment Admissions in 20 CEWG Areas as a Percentage[1]: CY 2008[2]

CEWG Area	Gender		Age Group	
	Percent Male	Percent Female	Percent 25 and Under	Percent 35 or Older
Atlanta	51.5	48.5	10.5	68.6
Baltimore	53.7	46.3	3.4	86.3
Boston	56.3	43.5	9.7	69.2
Colorado	57.5	42.5	16.8	55.6
Denver	56.5	43.5	14.9	58.0
Detroit	54.4	45.6	4.5	83.9
Florida[3]	52.0	48.0	18.7	52.7
Los Angeles	64.1	35.8	8.5	75.9
Maine	51.2	48.8	22.1	43.6
Maryland	57.5	42.5	10.4	71.2
Miami/Dade County	63.1	36.9	19.6	56.8
Ft. Lauderdale/ Broward County	51.6	48.4	17.0	60.3
Minneapolis/ St. Paul	64.9	35.1	10.5	69.6
New York City	68.6	31.4	5.7	78.3
Philadelphia[3]	65.5	27.5	11.1	62.6
Phoenix	55.5	44.5	9.8	67.8
San Diego	64.2	35.8	12.6	72.9
Seattle[4]	65.6	34.4	9.7	56.9
St. Louis	59.0	41.0	6.3	72.9
Texas	50.1	49.8	18.3	53.5

[1]Percentages are rounded to one decimal place.
[2]Data reported are for January–December 2008.
[3]Data from Florida and Philadelphia are for age 36 and over.
[4]Data from Seattle are for age 40 and older.
SOURCE: June 2009 State and local CEWG reports

Changes in Cocaine/Crack Admissions, 2004–2007

Table 6 shows changes in primary cocaine/crack treatment admissions as a percentage of total admissions, excluding primary alcohol admissions, between 2004 and 2008. Declines were noted in all but 3 of 14 areas reporting data, specifically Baltimore, Boston, and Seattle, with the latter showing the only relatively large increase in cocaine admission proportions in the period, at 5.2 percentage points. Decreases from 2004–2007 in the proportion of primary cocaine admissions were highest in Atlanta (nearly 18 percentage points) and St. Louis (approximately 14 percentage points). Declines of approximately 5–6 percentage points were observed for Texas, Minneapolis/St. Paul, and Detroit over the 5-year period (table 6). Other areas experiencing moderate (2 to 4 percentage points) declines in the proportion of primary cocaine treatment admissions were Los Angeles and New York City. In the period from 2007–2008, St. Louis and Detroit had the largest percentage

Table 6. Primary Cocaine Treatment Admissions in 15 CEWG Areas as a Percentage of Total Drug Treatment Admissions, Excluding Primary Alcohol Admissions, and Percentage Point Changes for Two Time Periods: 2004–2008 and 2007–2008[1]

	Year (in Percent)					Percentage Point	
CEWG Area	2004[2]	2005[2]	2006[3]	2007[2]	2008[2]	% Change, 2004–2008	% Change, 2007–2008
Atlanta	52.5	49.8	50.6	38.4	34.7	-17.8	-3.7
Baltimore	15.8	16.4	17.7	18.7	17.4	+1.6	-1.3
Boston[4]	11.0	13.1	12.8	10.6	11.8	+0.5	+1.2
Denver	23.2	20.0	23.5	23.4	22.1	-1.1	-1.3
Detroit	35.6	34.7	41.1	37.7	31.0	-4.6	-6.7
Hawai‘i	6.3	4.1	6.3	5.7	6.2	-0.1	+0.5
Los Angeles	22.0	20.5	20.9	19.9	19.8	-2.2	-0.1
Maine	11.4	12.7	14.2	13.7	10.5	-0.9	-3.2
Minneapolis/ St. Paul	26.1	26.5	27.3	23.7	20.9	-5.2	-2.8
New York City	29.5	29.2	29.9	28.1	25.7	-3.8	-2.4
Phoenix	NR[5]	16.1	15.2	14.5	12.8	–	-1.7
San Diego	8.7	8.2	8.2	8.5	8.3	-0.4	-0.2
Seattle	21.8	24.6	25.6	27.2	27.0	+5.2	-0.2
St. Louis	40.9	33.5	33.8	35.5	26.8	-14.1	-8.7
Texas	35.7	34.1	32.4	31.5	29.6	-6.1	-1.9

[1]Chicago and San Francisco data were not available for this report, although values for 2004 through 2008 will be reported in subsequent reports.
[2]Calendar year (January–December) data.
[3]Boston and Detroit reported FY 2006 (October 2005–September 2006) data; Atlanta and San Diego reported first half CY 2006 (January–June 2006) data; all others reported full-year CY 2006 data.
[4]The Boston representative updated CY data for this table; the previous figures were as follows: 2004, 11.3 percent; 2005, 12.5 percent; 2006, 12.0 percent.
[5]NR=Not reported by the CEWG area representative.
SOURCES: June 2009 State and local CEWG reports; June 2008 Highlights and Executive Summary CEWG report, p. 70; June 2007 Volume I CEWG report, p.15; and updates in January 2009 from previous years for Boston

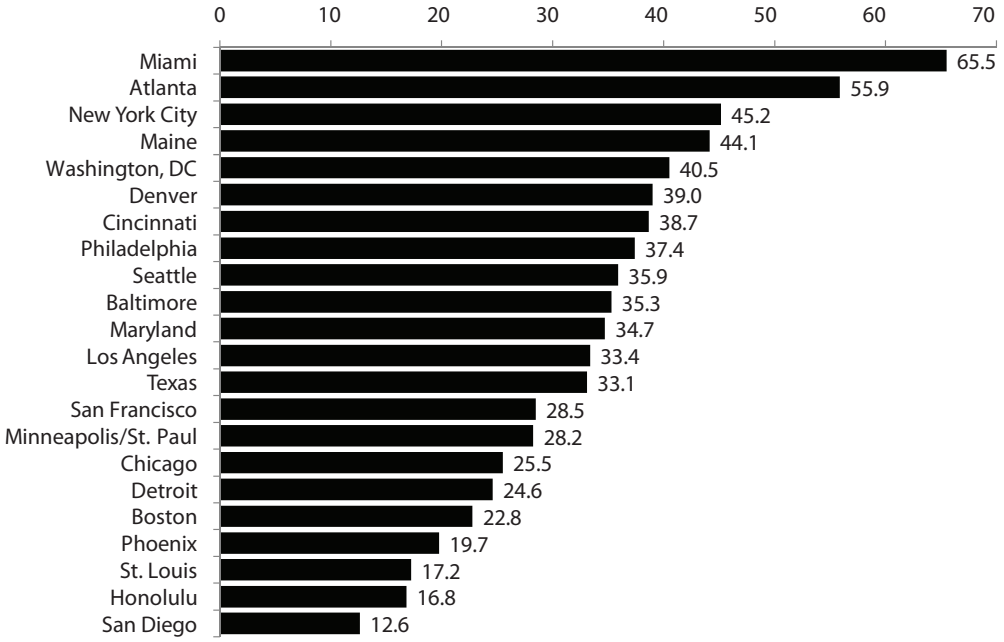
point declines in proportions of primary cocaine admissions of 15 reporting CEWG areas, at approximately 9 and 7 percentage points, respectively. Declines in cocaine treatment admission proportions were reported in 13 of 15 CEWG areas for which comparable data were available from the more recent period, 2007 to 2008. Exceptions to this overall trend were observed in Boston and Hawai'i, with very slight increases noted. Declines in all other areas reporting ranged from minimal (0.1–0.2 percentage points) in Los Angeles, San Diego, and Seattle, where percentages remained relatively constant over the period, to a high of an 8.7 percentage point decline in St. Louis. The largest declines in the 2007–2008 period were in St. Louis and Detroit, at nearly 9 and 7 percentage points, respectively. Atlanta, Maine, Minneapolis/St. Paul, New York City, Phoenix, and Texas reported moderate declines of between approximately 2 and 4 percentage points over the 2 years (table 6).

Forensic Laboratory Data on Cocaine/Crack

In 2008, cocaine was the drug most frequently reported for 10 of the 22 CEWG areas shown on the map (figure 17), and table (table 1) in section II. Cocaine items as a percentage of the total drug items reported in the NFLIS system were particularly high in the Miami/Dade MSA (65.5 percent) and Atlanta (55.9 percent). The lowest reported frequencies of cocaine drug items among those identified in forensic laboratories were in Honolulu and San Diego, at 16.8 and 12.6 percent, respectively (figure 18; appendix table 2).

Based on rankings shown in section II, table 1, in three of the five southern region CEWG areas (Miami, Atlanta, and Washington, DC), cocaine ranked as the most frequently identified drug in forensic laboratories in 2008. In two of the four CEWG areas in the northeastern region, Maine and New York City, cocaine ranked first

Figure 18. Cocaine Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: CY 2008[1]



[1]Data are for January–December 2008.
SOURCE: NFLIS, DEA, received April 14, 2009; see appendix table 2

among drug items identified. It was first in four of eight areas in the western region (Denver, San Francisco, Seattle, and Texas). Cocaine ranked first in one of the five areas in the midwestern region, Minneapolis/St. Paul, although it ranked second in drug items identified in 2008 in the other four areas in the Midwest, as well as in Boston, Philadelphia, Baltimore, Maryland, and Los Angeles.

Weighted DAWN Estimates of ED Visits Involving Cocaine, 2004–2007

Estimated numbers and rates of ED visits involving cocaine increased significantly in 5 of 12 CEWG reporting areas between 2004 and 2007—namely Boston, Denver, Detroit, New York City, and Seattle. Estimated visits involving cocaine increased by approximately 142 and 132 percent over the period in Detroit and

Table 7. Weighed Estimates[1] of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Cocaine[2], and Rates per 100,000 Population for 12 CEWG Areas: 2004–2007[3]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[4]	Percent and Direction of Change, 2006–2007[4]	Percent and Direction of Change, 2004–2007[4]
Boston	**9,408 (212.6)**	**11,175 (251.2)**	**11,295 (253.5)**	**13,582 (303.0)**	--	--	**+44%**
Chicago	**31,113 (331.3)**	**30,224 (320.0)**	**34,857 (366.7)**	**31,188 (327.4)**	--	**-11%**	--
Denver	**2,164 (92.9)**	**4,079 (172.7)**	**4,942 (205.2)**	**5,027 (204.0)**	--	--	**+132%**
Detroit	**5,221 (116.2)**	**9,860 (220.1)**	**12,676 (283.6)**	**12,631 (282.7)**	**+28%**	--	**+142%**
Houston	10,850 (209.4)	6,691 (125.0)	9,925 (179.2)	10,884 (193.4)	--	--	--
Miami/Dade County	**9,469 (400.6)**	**13,061 (549.3)**	**9,944 (413.9)**	**9,827 (411.7)**	**-25%**	--	--
Minneapolis/ St. Paul	6,228 (199.9)	6,076 (193.4)	6,764 (213.0)	5,189 (161.8)	--	--	--
New York City	**20,445 (252.3)**	**30,478 (371.1)**	**36,791 (447.9)**	**35,706 (431.5)**	--	--	**+75%**
Phoenix	3,717 (100.1)	3,607 (93.0)	5,804 (143.7)	5,065 (121.2)	--	--	--
San Diego	808 (27.6)	1,224 (41.7)	1,355 (46.1)	1,188 (39.9)	--	--	--
San Francisco	4,419 (261.6)	6,944 (411.1)	5,773 (339.9)	6,055 (352.0)	--	--	--
Seattle	**8,079 (255.1)**	**9,900 (308.6)**	**11,111 (340.5)**	**11,972 (361.8)**	--	--	**+48%**

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[4]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol,"--", indicates no statistically significant changes in the estimates between the reporting periods shown.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA,11/2008 update, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information

Heroin

- Heroin primary treatment admissions, as a percentage of total admissions, including primary alcohol admissions, were particularly high in Baltimore (approximately 55 percent) and Boston (close to 50 percent) in 2008. In Boston, Baltimore, and Detroit, heroin was the substance most frequently reported as the primary problem at treatment admission in the reporting period (section II, table 2; table 8; appendix table 1).
- Injection of heroin was the main mode of administration of the drug reported among primary heroin treatment admissions in 2008 in most areas, with the exception of Baltimore, Detroit, and New York City, where inhalation was more commonly reported as the major route of administration (table 9).
- The largest increases in the proportion of primary heroin treatment admissions, excluding primary alcohol admissions, from 2007 to 2008 were seen in Detroit, Phoenix, and St. Louis, where proportions of heroin admissions increased by 7.8, 6.4, and 4.3 percentage points, respectively. In Boston, proportions of primary heroin admissions declined by 6.7 percentage points in the 2-year period. In the 5 years between 2004 and 2008, St. Louis and Minneapolis/St. Paul had the largest increases in primary heroin treatment admissions, at 10.0 and 8.5 percentage points, respectively, with declines of 5 or more percentage points noted for Seattle, Los Angeles, Maine, and New York City (table 11).
- In 17 of 22 CEWG areas, heroin items accounted for less than 10 percent of total drug items identified in NFLIS forensic laboratories in 2008. Proportions were highest in Baltimore and Maryland (approximately 22 and 21 percent, respectively). They were lowest in Texas, Honolulu, and Minneapolis/St. Paul, at approximately 2 percent of drug items identified in each area (figure 19; appendix table 2). Heroin was not ranked first in drug items seized in any CEWG area (section II, table 1).
- Statistically significant changes in weighted DAWN ED reports and rates in 2007 compared with 2004 were noted for 3 of 12 reporting CEWG areas, consisting of increased ED reports in Denver and Detroit, and decreased reports in San Francisco (table 12).

Denver, respectively. In New York City, Seattle, and Boston, the approximate increases were 75, 48, and 44 percent, respectively (table 7). Two other reporting CEWG areas showed declines in cocaine-involved ED visits and rates for different time periods.

In Chicago, ED visits involving cocaine decreased by 11 percent from 2006–2007, while in Miami/Dade, they declined by 25 percent from 2005–2007.

Treatment Admissions Data on Heroin

In this reporting period (CY 2008) for 18 of 22 CEWG areas, primary heroin treatment admissions, as a proportion of total admissions for substance abuse treatment, including primary alcohol admissions, ranged from approximately 2 to 55 percent. After Baltimore at 54.6 percent, Boston had the highest proportion of heroin admissions, at 47.3 percent of all admissions (table 8). The lowest percentage of primary heroin admissions, after Hawai‘i (1.9 percent), was in Florida (2.3 percent).

When all admissions, including those for whom alcohol was the primary drug, are examined, heroin ranked first in Boston, Baltimore, and Detroit, and second in New York City and Maryland (section II, table 2).

Route of Administration of Heroin

Inhalation or intranasal use was the most

frequent mode of heroin administration reported by heroin admissions in New York City, at close to 60 percent, Detroit, at 57.0 percent, and Baltimore, at 56.5 percent (table 9). This mode was relatively rarely reported among treatment admissions in Philadelphia, Los Angeles, and San Diego (3.0, 4.4, and 4.5 percent, respectively). Proportions of heroin admissions injecting the drug ranged from a low of 39.0 percent in New York City to a high of 82.7 percent in Los Angeles. The percentage of injection among heroin treatment admissions ranged from 80–82 percent in Ft. Lauderdale/Broward County, Boston, and Phoenix, and from 76–79 percent in Denver, Colorado, San Diego, Maine, and Texas in 2008. San Diego, Denver, Colorado, Phoenix, and Los Angeles reported the highest proportions of heroin treatment admissions whose primary mode of administration was smoking, at between approximately 11 and 17 percent. Smoking was reported by less

Table 8. Primary Heroin Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: CY 2008[1,2]

	Primary Heroin Admissions	Total Admissions with Primary Alcohol Admissions Excluded[3]		Total Admissions with Primary Alcohol Admissions Included	
CEWG Area	#	#	%	#	%
Atlanta	349	5,339	6.5	8,105	4.3
Baltimore	10,019	15,558	64.4	18,355	54.6
Boston	8,641	12,217	70.7	18,256	47.3
Colorado	1,172	16,449	7.1	28,036	4.2
Denver	738	7,346	10.0	11,872	6.2
Detroit	3,050	6,457	47.2	8,927	34.2
Florida	1,080	34,019	3.2	47,264	2.3
Hawai'i	174	5,769	3.0	9,058	1.9
Los Angeles	10,250	43,709	23.5	55,530	18.5
Maine	1,092	7,318	14.9	12,849	8.5
Maryland	16,879	42,839	39.4	65,373	25.8
Miami/ Dade County	94	2,504	3.8	3,371	2.8
Ft. Lauderdale/ Broward County	110	3,183	3.5	4,184	2.6
Minneapolis/ St. Paul	1,292	9,132	14.1	19,263	6.7
New York City	22,474	60,645	37.1	84,309	26.7
Philadelphia	2,503	11,363	22.0	14,741	17.0
Phoenix	709	3,350	21.2	5,049	14.0
San Diego	2,777	12,010	23.1	15,041	18.5
Seattle	1,784	9,079	19.6	14,203	12.6
St. Louis	2,249	7,930	28.4	11,968	18.8
Texas	9,945	64,943	15.3	88,871	11.2

[1]More information on these data is available in the footnotes and notes for appendix table 1.
[2]Data are for January–December 2008.
[3]Percentages of primary heroin admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.
SOURCE: June 2009 State and local CEWG reports

than 2 percent of the heroin admissions in 11 of 17 CEWG areas reporting (table 9).

Gender of Heroin Admissions

There were proportionally more male than female primary heroin admissions in all 20 CEWG areas represented in table 10. The largest proportions of male heroin admissions were in Miami/Dade County (close to 82 percent), New York City (at approximately 78 percent), and Los Angeles and Boston (at approximately 73 percent each). Conversely, the largest proportions of females were in Maine, at approximately 47 percent.

Age of Heroin Admissions

In 13 of 20 reporting CEWG areas, more than one-half of the primary heroin admissions in 2008 were age 35 or older, with the highest proportions in Detroit (90.9 percent) and Baltimore (82.0 percent) (table 10). Maine reported the highest percentages of heroin treatment admissions among those age 25 and younger, at 40.6 percent.

Changes in Heroin Admissions, 2004–2008

Over the period from 2004 through 2008, proportions of primary heroin treatment

Table 9. Primary Route of Administration of Heroin Among Treatment Admissions in 18 CEWG Areas as a Percentage[1] of Primary Heroin Treatment Admissions: CY 2008[2]

	Smoked		Inhaled		Injected		Other/Unknown[3]		
CEWG Area	#	%	#	%	#	%	#	%	Total *n*
Atlanta	3	0.9	96	27.5	234	67.0	16	4.6	349
Baltimore	106	1.1	5,662	56.5	4,136	41.3	115	1.1	10,019
Boston	69	0.8	1,211	14.0	6,901	79.9	460	5.3	8,641
Colorado	139	11.9	83	7.1	929	79.3	21	1.8	1,172
Denver	95	12.9	51	6.9	581	78.7	11	1.5	738
Detroit	33	1.1	1,739	57.0	1,267	41.5	11	0.4	3,050
Los Angeles	1,123	11.0	455	4.4	8,480	82.7	192	1.9	10,250
Maine	7	0.6	201	18.4	839	76.8	45	4.1	1,092
Maryland	184	1.1	7,362	43.6	9,084	53.8	249	1.5	16,879
Miami/Dade County	4	4.3	21	22.3	62	66.0	7	7.4	94
Ft. Lauderdale/ Broward County	0	0.0	18	16.4	90	81.8	2	1.8	110
Minneapolis/ St. Paul	65	5.0	406	31.4	804	62.2	17	1.3	1,292
New York City	132	0.6	13,389	59.6	8,764	39.0	189	0.8	22,474
Philadelphia	3	0.1	75	3.0	1,241	49.6	1,184	47.3	2,503
Phoenix	80	11.3	42	5.9	568	80.1	19	3.0	709
San Diego	461	16.6	126	4.5	2,169	78.1	213	0.6	2,777
St. Louis	26	1.2	879	39.1	1,318	58.6	26	1.2	2,249
Texas	80	0.8	2,023	20.3	7,583	76.2	2,593	2.6	9,945

[1]Percentages may not sum to 100 due to rounding.
[2]Data are for January–December 2008.
[3]Where missing values were detected, cases were assigned to the "Other/Unknown Route of Administration" category. This occurred in San Diego and Texas, where the *n*'s were 2,772, with 5 missing values, and 9,931, with 14 missing values, respectively.
SOURCE: June 2009 State and local CEWG reports

admissions, excluding primary alcohol admissions, increased in 5 of 14 reporting areas, namely Baltimore, Detroit, Texas, St. Louis, and Minneapolis/St. Paul; these last two areas showed the largest increases of 10.0 and 8.5 percentage points (ppts), respectively. While no treatment data were reported for Phoenix for 2004, data reported for 2005 through 2008 show percentage point increases in proportions of primary heroin admissions of 6.1 for that area. Declines in heroin admissions were found for 8 of 14 reporting areas (with 1 area showing no change). The highest decreases over the 5-year period were for Seattle (7.4 ppts); Los Angeles (6.6 ppts); Maine (6.4 ppts); and New York City (5.0 ppts) (table 11).

During the more recent 2-year period, from 2007 through 2008, 3 of the 15 reporting areas showed changes of 5 or more percentage points,

Table 10. Demographic Characteristics of Primary Heroin Treatment Admissions in 20 CEWG Areas as a Percentage[1]: CY 2008[2]

CEWG Area	Gender[3]		Age Group	
	Percent Male	Percent Female	Percent 25 and Under	Percent 35 or Older
Atlanta	69.1	30.9	15.8	54.2
Baltimore	60.5	39.5	5.0	82.0
Boston	73.2	26.8	22.2	45.5
Colorado	63.9	36.1	22.5	51.5
Denver	64.0	36.0	18.6	57.2
Detroit	62.7	37.3	2.4	90.9
Florida	62.1	37.9	26.6	35.0[4]
Los Angeles	73.4	26.6	13.7	69.2
Maine	52.8	47.2	40.6	16.4
Maryland	60.7	39.3	18.2	61.2
Miami/Dade County	81.9	18.1	16.0	56.4
Ft. Lauderdale/ Broward County	71.8	28.2	19.1	50.9
Minneapolis/ St. Paul	66.5	33.5	25.1	49.4
New York City	77.5	22.5	5.0	78.2
Philadelphia	70.0	25.3	22.1	41.6[4]
Phoenix	63.9	36.1	24.1	53.0
San Diego	70.1	29.9	19.5	52.4
Seattle	64.5	35.5	14.0	51.0[5]
St. Louis	55.1	44.9	28.7	30.8
Texas	62.2	37.8	29.4	38.8

[1]Percentages are rounded to one decimal place.
[2]Data are for January–December 2008.
[3]Percentages may not add to 100 percent due to the presence of unknown gender.
[4]Data for Florida and Philadelphia are for age 36 and over.
[5]Data from Seattle are for age 40 and older.
SOURCE: June 2009 State and local CEWG reports

Table 11. Primary Heroin Treatment Admissions in 15 CEWG Areas as a Percentage[1] of Total Admissions, Excluding Primary Alcohol Admissions, and Percentage Point Change For Two Time Periods: 2004–2008 and 2007–2008[2]

CEWG Area	Year (in Percent)					Percentage Point	
	2004[3]	2005[3]	2006[4]	2007[2]	2008[2]	% Change, 2004–2008	% Change, 2007–2008
Atlanta	7.6	7.0	7.2	5.7	6.5	-1.1	+0.8
Baltimore	60.7	59.5	54.3	63.8	64.4	+3.7	+0.6
Boston[5]	75.2	72.7	73.6	77.4	70.7	-3.5	-6.7
Denver	13.6	14.1	10.6	10.5	10.0	-3.6	-0.5
Detroit	46.0	43.6	38.1	39.4	47.2	+1.2	+7.8
Hawai‘i	3.0	3.1	3.3	2.9	3.0	-0.0	+0.1
Los Angeles	30.1	24.4	24.3	24.1	23.5	-6.6	-0.6
Maine[6]	21.3	20.5	18.7	15.0	14.9	-6.4	-0.1
Minneapolis/ St. Paul	5.6	9.8	11.2	13.0	14.1	+8.5	+1.1
New York City	42.1	40.8	37.9	38.2	37.1	-5.0	-1.1
Phoenix	NR[7]	15.1	16.7	14.8	21.2	—	+6.4
San Diego	23.4	22.8	22.3	21.5	23.1	-0.3	+1.6
Seattle	27.0	25.4	20.9	18.7	19.6	-7.4	+0.9
St. Louis	18.4	16.0	17.5	24.1	28.4	+10.0	+4.3
Texas	13.7	11.6	12.8	13.0	15.3	+1.6	+2.3

[1]Percentage of primary nonalcohol admissions are rounded to one decimal place.
[2]All CEWG areas reported calendar year data for 2007 and 2008.
[3]Data for 2004 and 2005 for all areas are calendar year data.
[4]Boston and Detroit report FY 2006 (October 2005–September 2006) data; Atlanta and San Diego report first half CY 2006 (January–June) data; all others report full-year CY 2006 data.
[5]The Boston representative provided updated CY data for this table; the original values were as follows: 2004, 74.2 percent; 2005, 75.6 percent; 2006, 75.9 percent.
[6] Heroin is included with other opiates for classifying primary drug treatment admissions in Maine.
[7]NR=Not reported by the CEWG area representative.
SOURCES: June 2009 State and local CEWG reports; June 2008 Highlights and Executive Summary CEWG report, p. 71; June 2007 Volume I CEWG report, p. 25; and updates in January 2009 from previous years for Boston

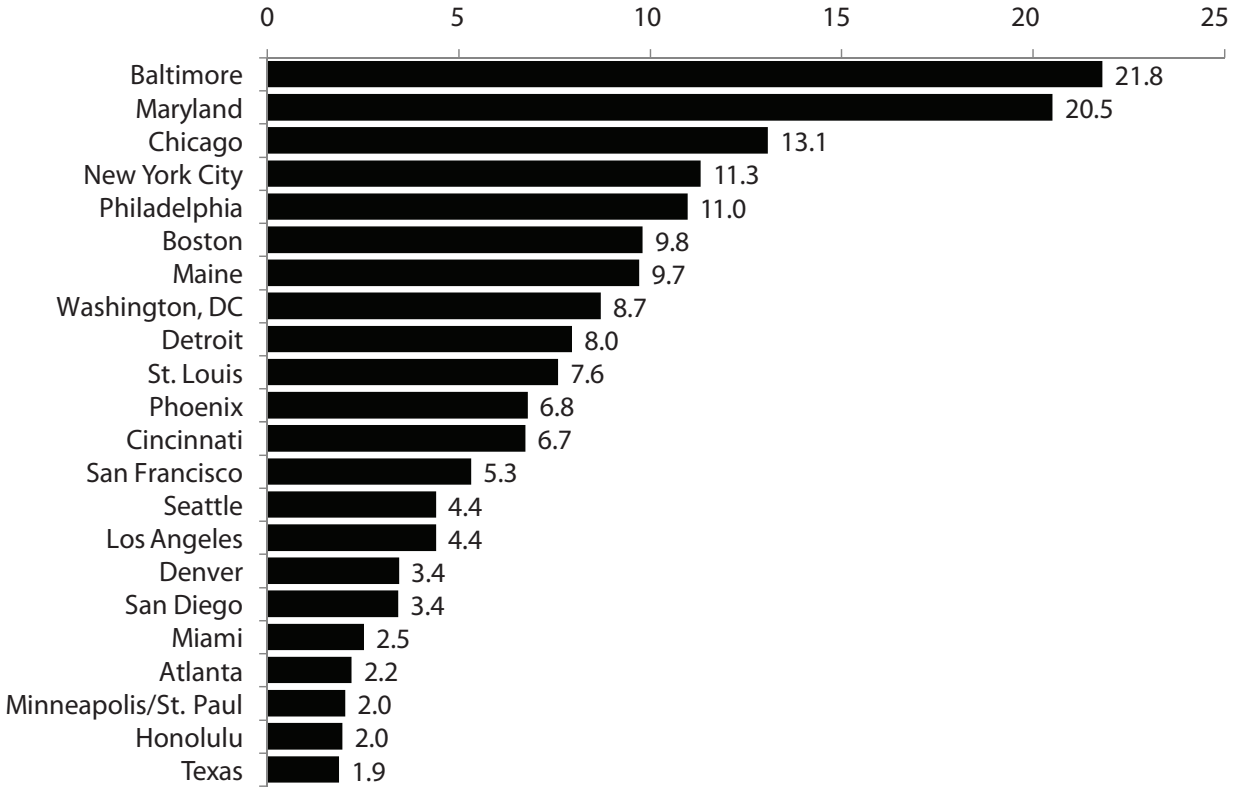
with increased percentages of heroin admissions in Detroit (7.8 ppts) and Phoenix (6.4 ppts), and decreased proportions of heroin admissions in Boston (6.7 ppts) (table 11).

Forensic Laboratory Data on Heroin

In 17 of the 22 CEWG areas shown on the map in figure 17 (section II), heroin items accounted for less than 10 percent of the total drug items reported by NFLIS. The exceptions were New York City, Philadelphia, Chicago, Baltimore, and Maryland. As a proportion of total drug items, heroin items were highest in Baltimore (21.8 percent) and Maryland (20.5 percent), compared with other CEWG areas. Heroin drug items identified were lowest in Texas (1.9 percent) and Minneapolis/St. Paul and Honolulu (2.0 percent each) (figure 19; appendix table 2).

Heroin was not ranked as the number one most frequently identified drug in any of the

Figure 19. Heroin Items Identified as a Percentage of Total NFLIS Drug Items in 22 CEWG Areas: CY 2008[1]



[1]Data are for January–December 2008.
SOURCE: NFLIS, DEA, received April 14, 2009; see appendix table 2

CEWG areas in 2008 (section II, table 1), and it appeared as no higher than third in the rankings of drug items identified in that reporting period. However, it ranked third in all areas within the northeastern, southern, and midwestern regions, with the exception of Atlanta (where it ranked seventh) and Minneapolis/St. Paul (where it ranked fifth) in the South and Midwest, respectively.

Weighted DAWN Estimates of ED Visits Involving Heroin, 2004–2007

Estimated heroin-involved ED visits and associated rates per 100,000 population increased significantly in 2 of 12 CEWG reporting areas between 2004 and 2007, namely Detroit and Denver, and decreased significantly in 1 area, San Francisco. Estimated ED visits involving heroin increased by 73 and 70 percent over the period in Detroit and Denver, respectively. In San Francisco, the decline in ED visits was reported at 18 percent over the period. No other CEWG areas showed significant changes in rates or visits between 2004 and 2007 (table 12). However, declines in estimated ED visits involving heroin were found in three areas for the period, 2006–2007; these were Chicago, Detroit, and San Diego, where respective declines were 22, 6, and 37 percent. In Phoenix, such visits increased by 74 percent from 2005–2007.

Table 12. Weighted Estimates[1] of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Heroin[2], and Rates per 100,000 Population for 12 CEWG Areas: 2004–2007[3]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[4]	Percent and Direction of Change, 2006–2007[4]	Percent and Direction of Change, 2004–2007[4]
Boston	10,295 (232.7)	8,667 (194.8)	9,413 (211.3)	11,003 (245.5)	--	--	--
Chicago	**21,921 (233.4)**	**18,899 (200.1)**	**25,036 (263.4)**	**19,581 (205.6)**	--	**-22%**	--
Denver	**768 (32.9)**	**1,054 (44.6)**	**1,272 (52.8)**	**1,308 (53.1)**	--	--	**+70%**
Detroit	**3,236 (72.0)**	**4,801 (107.2)**	**5,951 (133.2)**	**5,591 (125.1)**	--	**-6%**	**+73%**
Houston	449 (8.7)	185 (3.5)	462 (8.3)	372 (6.6)	--	--	--
Miami/Dade County	2,336 (98.8)	2,721 (114.4)	1,058 (44.1)	…[5]	[6]	[6]	[6]
Minneapolis/ St. Paul	1,189 (38.1)	1,023 (32.6)	1,309 (41.2)	1,691 (52.7)	--	--	--
New York City	13,383 (165.1)	18,179 (221.3)	17,892 (217.8)	16,884 (204.1)	--	--	--
Phoenix	**1,772 (47.7)**	**1,357 (35.0)**	**2,085 (51.6)**	**2,364 (56.6)**	**+74%**	--	--
San Diego	**950 (32.4)**	**1,145 (39.0)**	**1,393 (47.3)**	**876 (29.5)**	--	**-37%**	--
San Francisco	**2,424 (143.5)**	**3,138 (185.7)**	**1,994 (117.4)**	**1,993 (115.9)**	--	--	**-18%**
Seattle	6,791 (214.4)	5,140 (160.2)	5,171 (158.4)	6,253 (189.0)	--	--	--

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[4]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol, "--", indicates no statistically significant changes in the estimates between the reporting periods shown.
[5]Three dots (…) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count or estimate less than 30 has been suppressed.
[6]No significance tests could be performed due to lack of data for 1 or more of the comparison years.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, 11/2008 update, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information

Opiates/Opioids Other Than Heroin (Narcotic Analgesics)

- Treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from approximately 1 to close to 10 percent in 19 of 20 reporting CEWG areas. The outlier was Maine, where nearly 31 percent of primary treatment admissions were for other opiate problems (table 13; appendix table 1).
- While none of the 20 CEWG areas ranked other opiates as being first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions, other opiates ranked second in Maine, and fourth in Florida (section II, table 2).
- Of total drug items identified in forensic laboratories in 22 CEWG areas, oxycodone and hydrocodone often appeared in the top 10 ranked drug items in terms of frequency in 2008. In Baltimore, Maryland, Boston, Maine, and Cincinnati, oxycodone ranked fourth in drug items identified, and it ranked fifth in New York City, Philadelphia, Phoenix, and Seattle. Hydrocodone ranked fourth in Detroit and fifth in frequency of drug items identified in Atlanta, Cincinnati, San Diego, and Texas (section II, table 1; table 15).
- Buprenorphine ranked fifth in identified NFLIS drug items in Boston, Baltimore, and Maryland in 2008, and ranked eighth in Maine (section II, table 1).
- Methadone ranked in the top 10 identified drugs in Maine (fifth), New York City (seventh), Baltimore, Maryland, and San Francisco (eighth each), and Boston and Honolulu (ninth each) during this reporting period (section II, table 1).
- Between 2004 and 2007, estimated ED visits involving nonmedical use of opiate/opioid drugs other than heroin increased significantly in 8 of the 12 CEWG DAWN reporting areas; these included Boston, Denver, Detroit, Houston, Minneapolis/St. Paul, New York City, Phoenix, and Seattle (table 16). Oxycodone-involved visits were estimated to have increased in 5 of the 12 areas (Denver, Minneapolis/St. Paul, Miami/Dade, New York City, and San Diego) (table 17). ED visits involving nonmedical use of hydrocodone increased in 4 of the 12 areas (Denver, Detroit, Houston, and New York City) (table 18). While methadone-involved visits increased in five areas (Boston, Denver, Detroit, New York City, and Seattle), they declined in one area, Chicago, over the 4-year period (table 19). Estimated fentanyl-involved ED visits increased in two areas—Detroit and Minneapolis/St. Paul—from 2004–2007. Respective increases were 143 and 73 percent (table 20).

Treatment Admissions Data on Opiates/ Opioids Other Than Heroin

In 2008, 20 CEWG areas provided data on treatment admissions for primary abuse of opiates other than heroin as a category separate from heroin. Treatment admissions for primary abuse of opiates other than heroin as a percentage of total admissions, including primary alcohol admissions, ranged from approximately 1 to close to 10 percent in 19 of the 20 reporting CEWG areas. Including primary alcohol admissions, the other opiates admissions group accounted for a high of 30.7 percent of the primary treatment admissions in Maine. This was followed distantly by Florida and Maryland, where 9.9 and 7.6 percent, respectively, of total primary treatment admissions were for other opiates. At the low end, other opiates accounted for approximately 1 percent of total admissions in Philadelphia, New York City, and Miami/Dade County (table 13). While none of the 21 CEWG areas ranked other opiates as being first as primary substances of abuse in percentages of total treatment admissions, including alcohol admissions (section II, table 2), in Maine other opiates ranked second, while it ranked fourth in Florida.

Gender of Other Opiate Admissions

A majority of primary admissions for other opiates were male in 11 of 20 reporting CEWG areas, with the highest male percentages in Philadelphia (72.1 percent), New York City (68.9 percent), and Boston (65.6 percent) (table 14). However, females predominated in Baltimore, Denver, Detroit, Florida, Miami/Dade County, Phoenix, St. Louis, and Texas among treatment admissions for other opiates (table 14).

Age of Other Opiate Admissions

In 4 of 20 CEWG areas—namely Detroit, Los Angeles, Miami/Dade County, and Baltimore—a majority of primary other opiate admissions were age 35 or older (approximately 52–77 percent). The age group 25 and younger was more highly represented among other opiate admissions in Maine (38.3 percent), Philadelphia (36.8 percent), Seattle (36.5 percent), and Maryland (36.4 percent) than other CEWG areas (table 14).

Table 13. Primary Other Opiate Treatment Admissions in 20 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions: CY 2008[1,2]

	Primary Other Opiates Admissions	Total Admissions with Primary Alcohol Admissions Excluded[3]		Total Admissions with Primary Alcohol Admissions Included	
CEWG Area	#	#	%	#	%
Atlanta	414	5,339	7.8	8,105	5.1
Baltimore	564	15,558	3.6	18,355	3.1
Boston	613	12,217	5.0	18,256	3.4
Colorado	1,089	16,449	6.6	28,036	3.9
Denver	453	7,346	6.2	11,872	3.8
Detroit	137	6,457	2.1	8,927	1.5
Florida	4,699	34,019	13.8	47,264	9.9
Los Angeles	828	43,709	1.9	55,530	1.5
Maine	3,951	7,318	54.0	12,849	30.7
Maryland	4,982	42,839	11.6	65,373	7.6
Miami/Dade County	32	2,504	1.3	3,371	0.9
Ft. Lauderdale/ Broward County	264	3,183	8.3	4,184	6.3
Minneapolis/ St. Paul	1,187	9,132	13.0	19,263	6.2
New York City	1,017	60,645	1.7	84,309	1.2
Philadelphia	136	11,363	1.2	14,741	0.9
Phoenix	167	3,350	5.0	5,049	3.3
San Diego	594	12,010	4.9	15,041	3.9
Seattle	614	9,079	6.8	14,203	4.3
St. Louis	235	7,930	3.0	11,968	2.0
Texas	5,381	64,943	8.3	88,871	6.0

[1]More information on these data is available in the footnotes and notes for appendix table 1.
[2]Data are for January–December 2008.
[3]Percentages of primary other opiates admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.
SOURCE: June 2009 State and local CEWG reports

Table 14. Demographic Characteristics of Primary Treatment Admissions for Opiates/Opioids Other than Heroin in 20 CEWG Areas, by Percent[1]: CY 2008[2]

CEWG Area	Gender[3]		Age Group	
	Percent Male	Percent Female	Percent 25 and Under	Percent 35 and Older[4]
Atlanta	50.2	49.8	23.4	41.8
Baltimore	44.0	56.0	20.2	52.3
Boston	65.6	34.4	29.7	43.9
Colorado	50.3	49.7	22.9	45.2
Denver	49.0	51.0	21.6	46.6
Detroit	42.3	57.7	5.1	77.4
Florida	48.1	51.9	35.0	26.3[4]
Los Angeles	53.9	46.1	11.4	69.2
Maine	53.2	46.8	38.3	25.6
Maryland	54.1	45.9	36.4	33.8
Miami/Dade	46.9	53.1	15.6	53.1
Ft. Lauderdale/ Broward County	59.1	40.9	34.1	34.8
Minneapolis/ St. Paul	54.6	45.4	25.7	46.2
New York City	68.9	31.1	25.6	46.6
Philadelphia	72.1	24.3	36.8	25.0[4]
Phoenix	44.3	55.7	29.3	38.9
San Diego	59.9	40.1	34.7	37.2
Seattle	56.0	44.0	36.5	22.1[5]
St. Louis	48.9	51.1	29.4	36.6
Texas	42.4	57.6	22.9	43.3

[1]Percentages are rounded to one decimal place.
[2]All areas report calendar year 2008 data: January–December 2008.
[3]Percentages may not add to 100 percent due to the presence of unknown gender.
[4]Data from Florida and Philadelphia are for age 36 and older.
[5]Data from Seattle are for age 40 and older.
NOTE: Missing values are reported for Philadelphia (5 for the gender distribution; 4 for the age distribution); Maine (4 in the age distribution); and San Diego (8 in the age distribution); however, these do not affect the results.
SOURCE: June 2009 State and local CEWG reports

Forensic Laboratory Data on Opiates/ Opioids Other Than Heroin (Narcotic Analgesics)

Of the narcotic analgesic/opiate items identified by forensic laboratories across CEWG areas in 2008, oxycodone and hydrocodone were the two most frequently reported in most areas. However, they rarely accounted for more than 6 percent of all drug items identified in any area (table 15; appendix table 2).

Oxycodone

Maine reported the highest frequency of oxycodone items identified in forensic laboratories in the period (at 4.9 percent), followed by Boston (4.3 percent) and Seattle (3.5 percent) (table 15). Oxycodone ranked fourth in drug

items identified in Baltimore, Maryland, Boston, Maine, and Cincinnati (section II, table 1). It ranked fifth in frequency of drug items identified in forensic laboratories in four other CEWG areas—New York City, Philadelphia, Phoenix, and Seattle. Oxycodone ranked sixth in Atlanta, Minneapolis/St. Paul, Denver, San Francisco, and Honolulu (section II, table 1). In 6 of 22 CEWG areas, oxycodone represented less than 1 percent of the total drug items identified among the top 25 in the reporting period (table 15).

Table 15. Selected Narcotic Analgesic Items Reported Among the Top 25 by Forensic Laboratories in 22 CEWG Areas, by Number and Percentage of Total Items Identified[1]: CY 2008[2]

CEWG Area	Oxycodone		Hydrocodone		Methadone		Fentanyl		Buprenorphine		Total Items
	#	%	#	%	#	%	#	%	#	%	
Atlanta	339	2.8	400	3.3	88	*	0	*	0	*	12,207
Baltimore	715	1.3	139	*	181	*	0	*	567	1.0	54,167
Boston	852	4.3	153	*	130	*	0	*	403	2.0	20,046
Chicago	65	*	365	*	79	*	0	*	86	*	77,456
Cincinnati	272	2.1	197	1.5	47	*	0	*	0	*	13,151
Denver	113	1.4	83	1.1	13	*	0	*	0	*	7,870
Detroit	86	1.4	405	6.4	27	*	0	*	8	*	6,323
Honolulu	17	*	8	*	9	*	0	*	0	*	1,892
Los Angeles	141	*	718	1.3	93	*	0	*	0	*	53,627
Maine	41	4.9	27	3.2	34	4.0	0	*	15	1.8	845
Maryland	728	1.3	139	*	182	*	0	*	567	1.0	57,968
Miami	205	*	65	*	23	*	0	*	0	*	29,239
Minneapolis/ St. Paul	65	1.4	48	1.0	16	*	0	*	0	*	4,628
New York City	686	1.2	448	*	601	1.1	0	*	219	*	55,693
Philadelphia	860	2.8	165	*	78	*	15	*	32	*	30,238
Phoenix	98	1.6	86	1.4	15	*	0	*	12	*	6,198
San Diego	202	1.0	364	1.8	53	*	0	*	41	*	19,821
San Francisco	690	2.9	589	2.4	229	1.0	0	*	0	*	24,057
Seattle	89	3.5	35	1.4	11	*	0	*	7	*	2,546
St. Louis	181	1.1	294	1.7	30	*	0	*	32	*	17,153
Texas	352	*	3,322	3.9	270	*	0	*	0	*	85,244
Washington, DC	27	*	0	*	6	*	0	*	8	*	3,715

[1]Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated by the symbol *.
[2]Data are for January–December 2008.
SOURCE: All data were received from NFLIS, DEA, April 14, 2009 (see appendix table 2); data are subject to change and may differ according to the date on which they were queried

Hydrocodone

Hydrocodone ranked fourth in drug items identified in Detroit, and fifth in drug items identified in 4 of 22 areas, namely Atlanta, Cincinnati, San Diego, and Texas (section II, table 1). Identified percentages ranged from 6.4 percent in Detroit and 3.9 percent in Texas to less than 1.0 percent in 9 of 22 areas reporting in 2008 (table 15).

Buprenorphine

Boston, Maine, Maryland, and Baltimore were the only CEWG areas with at least 1 percent of drug items identified containing buprenorphine. Percentages were 2.0, 1.8, 1.0, and 1.0, respectively (table 15). According to CEWG area reports reflected in section II, table 1, buprenorphine ranked fifth in identified drugs in Boston, Baltimore, and Maryland in 2008.

Methadone

Maine, New York City, and San Francisco were the only areas reporting a percentage of 1 or higher for methadone drug items, at 4.0, 1.1, and 1.0 percent, respectively (table 15). Methadone ranked fifth in identified drugs in Maine, seventh in New York City, eighth in Baltimore, Maryland, and San Francisco, and ninth in Boston and Honolulu during this reporting period (section II, table 1).

Weighted DAWN Estimates of Pharmaceutical Opiate/Opioid-Involved ED Visits, 2004–2007

Estimated numbers and rates of ED visits involving nonmedical use of opiates/opioids from 2004 through 2007 are shown in table 16; this category includes all narcotic analgesics and other opiates not otherwise specified. Data are also provided for estimated visits for nonmedical use of four specific opiates—oxycodone, hydrocodone, methadone, and fentanyl—for 12 CEWG areas for which weighted DAWN data are collected (tables 17–20).

Eight of the 12 reporting areas experienced statistically significant increases in estimated ED visits involving nonmedical use of opiate/opioids over the 4-year period. These areas included Denver, Detroit, New York City, Minneapolis/St. Paul, Houston, Phoenix, Seattle, and Boston. Between 2004 and 2007, estimated ED visits involving the nonmedical use of opiates/opioids increased by 191 percent in Denver, 123 percent in Detroit, 99 percent in New York City, 74 percent in Minneapolis/St. Paul, with percentage increases of 66 percent for Houston, 50 percent for Phoenix, 47 percent for Seattle, and 34 percent for Boston. Two areas, Chicago and San Francisco, showed respective declines of 13 and 20 percent in ED visits involving nonmedical use of opiates/opioids in the period from 2006–2007 (table 16).

Overall, estimated ED visits involving nonmedical use of oxycodone increased significantly in 5 of 12 CEWG areas reporting. In particular, estimated ED visits involving nonmedical oxycodone use increased by 297 percent in Denver, 152 percent in New York City, 108 percent in San Diego, 98 percent in Minneapolis/St. Paul, and 68 percent in Miami/Dade County over the period from 2004 through 2007 (table 17). In Boston, estimated ED visits involving nonmedical use of oxycodone increased by 25 percent from 2006–2007, and in Detroit and Seattle, increases of 46 and 44 percent, respectively, were noted for 2005–2007, with no other significant changes for these areas (table 17).

Four of 12 CEWG areas reported significant increases in estimated ED visits involving nonmedical use of hydrocodone, including Denver, Houston, Detroit, and New York City, respective increases for which were 176, 139, 112, and 65 percent (table 18). In two other areas, increases in estimated hydrocodone-involved ED visits were observed for 2005–2007 (Seattle and Minneapolis/St. Paul, with increases of 24 and 89 percent, respectively), and increases in such visits in the range of 32 to 47 percent were estimated in Denver, Detroit, Houston, and Minneapolis/St. Paul in the period from 2006–2007 (table 18).

Estimated ED visits involving nonmedical use of methadone were found to have increased in 5 of 12 CEWG areas reporting: Detroit, by 220 percent; Denver, by 110 percent; New York City, by 69 percent; Boston by 64 percent; and

Seattle, by 42 percent. However, a significant decline in estimated ED visits involving nonmedical use of methadone was noted in Chicago, amounting to 34 percent over the 4-year period (table 19). Table 19 also shows changes for two reporting CEWG areas from 2005–2007: Chicago, where methadone-involved ED visits decreased by 21 percent, and Phoenix, where they increased by 70 percent in the same period.

Finally, estimated ED visits involving nonmedical use of fentanyl were found to have increased in two areas—Detroit and Minneapolis/St. Paul—from 2004–2007. Respective increases were 143 percent and 73 percent (table 20). From 2005–2007, ED visits involving the nonmedical use of fentanyl rose by 105 percent in Minneapolis/St. Paul, and by 213 percent in Denver (table 20). From 2006–2007, fentanyl-involved ED visits rose by 72 percent in Denver (table 20).

Table 16. Weighted Estimates[1] of Emergency Department (ED) Visits[2] for Nonmedical Use of Pharmaceuticals[3] Involving Opiates/Opioids, and Rates per 100,000 Population, for 12 CEWG Areas: 2004–2007[4]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[5]	Percent and Direction of Change, 2006–2007[5]	Percent and Direction of Change, 2004–2007[5]
Boston	**3,982 (90.0)**	**4,417 (99.3)**	**4,164 (93.5)**	**5,346 (119.3)**	--	**+28%**	**+34%**
Chicago	**4,964 (52.9)**	**5,054 (53.5)**	**5,949 (62.6)**	**5,178 (54.4)**	--	**-13%**	--
Denver	**851 (36.5)**	**1,450 (61.4)**	**1,963 (81.5)**	**2,479 (100.6)**	**+71%**	**+26%**	**+191%**
Detroit	**2,725 (60.7)**	**4,149 (92.6)**	**4,769 (106.7)**	**6,068 (135.8)**	**+46%**	**+27%**	**+123%**
Houston	**4,170 (80.5)**	**3,211 (60.0)**	**5,915 (106.8)**	**6,935 (123.2)**	**+116%**	--	**+66%**
Miami/Dade County	464 (19.6)	730 (30.7)	654 (27.2)	741 (31.1)	--	--	--
Minneapolis/ St. Paul	**1,878 (60.3)**	**1,923 (61.2)**	**2,687 (84.6)**	**3,263 (101.7)**	**+70%**	**+21%**	**+74%**
New York City	**3,615 (44.6)**	**5,291 (64.4)**	**6,245 (76.0)**	**7,193 (86.9)**	**+36%**	--	**+99%**
Phoenix	**2,629 (70.8)**	**2,762 (71.2)**	**3,593 (89.0)**	**3,941 (94.3)**	**+43%**	--	**+50%**
San Diego	875 (29.8)	1,304 (44.4)	1,437 (48.8)	1,517 (51.0)	--	--	--
San Francisco	**1,055 (62.5)**	**2,172 (128.6)**	**1,703 (100.3)**	**1,369 (79.6)**	--	**-20%**	--
Seattle	**3,528 (111.4)**	**4,062 (126.6)**	**5,010 (153.5)**	**5,194 (157.0)**	**+28%**	--	**+47%**

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Nonmedical use is use that involves: taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs.
[4]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[5]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol, "--", indicates no statistically significant changes in the estimates between the reporting periods shown.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information

Table 17. Weighted Estimates[1] of Emergency Department (ED) Visits[2] for Nonmedical Use of Pharmaceuticals[3] Involving Oxycodone, and Rates per 100,000 Population, for 12 CEWG Areas: 2004–2007[4]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[5]	Percent and Direction of Change, 2006–2007[5]	Percent and Direction of Change, 2004–2007[5]
Boston	**1,978 (44.7)**	**1,873 (42.1)**	**1,551 (34.8)**	**1,940 (43.3)**	--	**+25%**	--
Chicago	289 (3.1)	230 (2.4)	255 (2.7)	236 (2.5)	--	--	--
Denver	**234 (10.1)**	**432 (18.3)**	**707 (29.4)**	**931 (37.8)**	**+115%**	**+32%**	**+297%**
Detroit	**355 (7.9)**	**360 (8.0)**	**478 (10.7)**	**524 (11.7)**	**+46%**	--	--
Houston	155 (3.0)	121 (2.3)	…[6]	246 (4.4)	--	[7]	--
Miami/Dade County	**127 (5.4)**	**199 (8.4)**	**195 (8.1)**	**214 (9.0)**	--	--	**+68%**
Minneapolis/ St. Paul	**601 (19.3)**	**654 (20.8)**	**859 (27.1)**	**1,191 (37.1)**	**+82%**	**+39%**	**+98%**
New York City	**258 (3.2)**	**343 (4.2)**	**523 (6.4)**	**652 (7.9)**	**+90%**	--	**+152%**
Phoenix	755 (20.3)	796 (20.5)	1,098 (27.2)	1,170 (28.0)	--	--	--
San Diego	**174 (5.9)**	**189 (6.4)**	**253 (8.6)**	**361 (12.1)**	**+91%**	**+42%**	**+108%**
San Francisco	104 (6.1)	251 (14.9)	246 (14.5)	217 (12.6)	--	--	--
Seattle	**897 (28.3)**	**982 (30.6)**	**1,263 (38.7)**	**1,414 (42.7)**	**+44%**	--	--

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Nonmedical use is use that involves: taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs.
[4]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[5]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol, "--", indicates no statistically significant changes in the estimates between the reporting periods shown.
[6]Three dots (…) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count or estimate less than 30 has been suppressed.
[7]No significance tests could be performed due to lack of data for 1 or more of the comparison years.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information

Table 18. Weighted Estimates[1] of Emergency Department (ED) Visits[2] for Nonmedical Use of Pharmaceuticals[3] Involving Hydrocodone, and Rates per 100,000 Population, for 12 CEWG Areas: 2004–2007[4]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[5]	Percent and Direction of Change, 2006–2007[5]	Percent and Direction of Change, 2004–2007[5]
Boston	528 (11.9)	464 (10.4)	480 (10.8)	472 (10.5)	--	--	--
Chicago	1,162 (12.4)	922 (9.8)	1,095 (11.5)	1,107 (11.6)	--	--	--
Denver	**218 (9.3)**	**405 (17.2)**	**456 (18.9)**	**600 (24.3)**	**+48%**	**+32%**	**+176%**
Detroit	**1,007 (22.4)**	**1,315 (29.4)**	**1,450 (32.4)**	**2,132 (47.7)**	**+62%**	**+47%**	**+112%**
Houston	**1,746 (33.7)**	**1,450 (27.1)**	**3,081 (55.6)**	**4,166 (74.0)**	**+187%**	**+35%**	**+139%**
Miami/Dade County	…[6]	…[6]	…[6]	…[6]	[7]	[7]	[7]
Minneapolis/ St. Paul	**456 (14.6)**	**398 (12.7)**	**514 (16.2)**	**754 (23.5)**	**+89%**	**+47%**	--
New York City	**282 (3.5)**	**360 (4.4)**	**369 (4.5)**	**465 (5.6)**	--	--	**+65%**
Phoenix	526 (14.2)	594 (15.3)	666 (16.5)	673 (16.1)	--	--	--
San Diego	358 (12.2)	436 (14.8)	472 (16.0)	433 (14.5)	--	--	--
San Francisco	239 (14.1)	440 (26.1)	335 (19.7)	299 (17.4)	--	--	--
Seattle	**574 (18.1)**	**511 (15.9)**	**627 (19.2)**	**635 (19.2)**	**+24%**	--	--

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Nonmedical use is use that involves: taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs.
[4]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[5]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol, "--", indicates no statistically significant changes in the estimates between the reporting periods shown.
[6]Three dots (…) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count or estimate less than 30 has been suppressed.
[7]No significance tests could be performed due to lack of data for 1 or more of the comparison years.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information.

Table 19. Weighted Estimates[1] of Emergency Department (ED) Visits[2] for Nonmedical Use of Pharmaceuticals[3] Involving Methadone, and Rates per 100,000 Population, for 12 CEWG Areas: 2004–2007[4]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[5]	Percent and Direction of Change, 2006–2007[5]	Percent and Direction of Change, 2004–2007[5]
Boston	**653 (14.8)**	**953 (21.4)**	**841 (18.9)**	**1,071 (23.9)**	--	--	**+64%**
Chicago	**1,363 (14.5)**	**1,125 (11.9)**	**1,129 (11.9)**	**893 (9.4)**	**-21%**	--	**-34%**
Denver	**141 (6.1)**	**207 (8.8)**	**240 (10.0)**	**297 (12.1)**	--	--	**+110%**
Detroit	**224 (5.0)**	**537 (12.0)**	**569 (12.7)**	**716 (16.0)**	--	--	**+220%**
Houston	323 (6.2)	408 (7.6)	498 (9.0)	379 (6.7)	--	--	--
Miami/Dade County	…[6]	82 (3.4)	…[6]	…[6]	[7]	[7]	[7]
Minneapolis/ St. Paul	422 (13.5)	414 (13.2)	530 (16.7)	564 (17.6)	--	--	--
New York City	**2,288 (28.2)**	**3,270 (39.8)**	**3,555 (43.3)**	**3,874 (46.8)**	--	--	**+69%**
Phoenix	**423 (11.4)**	**325 (8.4)**	**492 (12.2)**	**554 (13.3)**	**+70%**	--	--
San Diego	107 (3.6)	148 (5.0)	146 (4.9)	176 (5.9)	--	--	--
San Francisco	311 (18.4)	805 (47.7)	560 (33.0)	496 (28.9)	--	--	--
Seattle	**1,090 (34.4)**	**1,311 (40.9)**	**1,714 (52.5)**	**1,552 (46.9)**	--	--	**+42%**

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Nonmedical use is use that involves: taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs.
[4]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[5]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol,"--", indicates no statistically significant changes in the estimates between the reporting periods shown.
[6]Three dots (…) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count or estimate less than 30 has been suppressed.
[7]No significance tests could be performed due to lack of data for 1 or more of the comparison years.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information

Table 20. Weighted Estimates[1] of Emergency Department (ED) Visits[2] for Nonmedical Use of Pharmaceuticals[3] Involving Fentanyl, and Rates per 100,000 Population, for 12 CEWG Areas: 2004–2007[4]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[5]	Percent and Direction of Change, 2006–2007[5]	Percent and Direction of Change, 2004–2007[5]
Boston	165 (3.7)	218 (4.9)	163 (3.7)	226 (5.0)	--	--	--
Chicago	…[6]	…[6]	165 (1.7)	195 (2.0)	[7]	--	[7]
Denver	**…[6]**	**74 (3.1)**	**135 (5.6)**	**232 (9.4)**	**+213%**	**+72%**	[7]
Detroit	**137 (3.1)**	**234 (5.2)**	**250 (5.6)**	**334 (7.5)**	--	--	**+143%**
Houston	…[6]	…[6]	…[6]	…[6]	[7]	[7]	[7]
Miami/ Dade County	…[6]	…[6]	…[6]	…[6]	[7]	[7]	[7]
Minneapolis/ St. Paul	**94 (3.0)**	**79 (2.5)**	**192 (6.1)**	**162 (5.0)**	**+105%**	--	**+73%**
New York City	…[6]	…[6]	…[6]	…[6]	[7]	[7]	[7]
Phoenix	…[6]	94 (2.4)	140 (3.5)	135 (3.2)	--	--	[7]
San Diego	…[6]	88 (3.0)	70 (2.4)	77 (2.6)	--	--	[7]
San Francisco	…[6]	…[6]	…[6]	…[6]	[7]	[7]	[7]
Seattle	…[6]	96 (3.0)	137 (4.2)	81 (2.5)	--	--	[7]

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Nonmedical use is use that involves: taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs.
[4]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[5]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol, "--", indicates no statistically significant changes in the estimates between the reporting periods shown.
[6]Three dots (…) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count or estimate less than 30 has been suppressed.
[7]No significance tests could be performed due to lack of data for 1 or more of the comparison years.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information
[8]No significance tests were provided by OAS, although overlapping confidence intervals suggest lack of statistical significance across years.

Benzodiazepines/Depressants

- Texas and Atlanta had the highest percentage of alprazolam drug items identified in forensic laboratories in 2008, at 4.4 and 4.3 percent, respectively (table 21). Alprazolam ranked third in frequency among the top 10 drug items identified in forensic laboratories in Atlanta, and ranked fourth in four CEWG areas: Miami/Dade County, Philadelphia, New York City, and Texas (section II, table 1).
- Drug items containing clonazepam accounted for 1.8 percent of all drug items in Boston, where clonazepam figured as the sixth most frequently identified drug in forensic laboratories in 2008 (section II, table 1; table 21).
- Diazepam ranked 8th in Cincinnati, 9th in San Diego, and 10th in Philadelphia among drug items identified in NFLIS forensic laboratories in 2008 (section II, table 1).
- Estimated ED visits involving nonmedical use of benzodiazepines increased significantly in one-half of the 12 reporting DAWN CEWG areas from 2004 to 2007. These were Boston, Denver, Detroit, Minneapolis/St. Paul, New York City, and Seattle (table 22).

Treatment Admissions Data on Benzodiazepines

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

Forensic Laboratory Data on Benzodiazepines

Three benzodiazepine-type items—alprazolam, clonazepam, and diazepam—were the most frequently reported benzodiazepines identified by forensic laboratories in 22 CEWG areas in the 2008 reporting period. Table 21 shows the numbers and percentages of drug items containing alprazolam, clonazepam, and diazepam in each of the reporting CEWG areas.

Alprazolam

In the 22 CEWG areas for which NFLIS data were reported for 2008, the highest percentages of alprazolam drug items identified were in Texas (4.4 percent) and Atlanta (4.3 percent), followed by Philadelphia (2.9 percent), Detroit (2.6 percent), and New York City (2.5 percent). Alprazolam drug items were reported at 1.0–1.9 percent in Boston, Maine, St. Louis, and Miami, and at less than 1 percent in the remaining 13 reporting CEWG areas (table 21). In section II, table 1, which shows the rankings of the most frequently reported drugs in NFLIS for 2008 data, alprazolam ranked third in frequency among the top 10 drug items identified in Atlanta, and fourth in four CEWG areas: Miami, New York City, Philadelphia, and Texas.

Clonazepam

Drug items containing clonazepam accounted for 1.8 percent of all drug items in Boston and 1.3 percent in Maine. Its presence was minimal in the 20 other CEWG areas (table 21). In Boston, clonazepam figured as the sixth most frequently identified drug in forensic laboratories in 2008. Clonazepam ranked seventh in Baltimore and Maryland. It ranked in 9th place in New York City, Philadelphia, Cincinnati, and Texas,

Table 21. Selected Benzodiazepine Items Reported Among the Top 25 by Forensic Laboratories in 22 CEWG Areas, by Number and Percentage of Total Items Identified[1]: CY 2008[2]

CEWG Area	Alprazolam		Clonazepam		Diazepam		Total Items
	#	%	#	%	#	%	
Atlanta	522	4.3	67	*	57	*	12,207
Baltimore	360	*	218	*	75	*	54,167
Boston	224	1.1	370	1.8	70	*	20,046
Chicago	206	*	38	*	42	*	77,456
Cincinnati	100	*	59	*	61	*	13,151
Denver	45	*	24	*	16	*	7,870
Detroit	164	2.6	14	*	24	*	6,323
Honolulu	3	*	7	*	7	*	1,892
Los Angeles	227	*	116	*	127	*	53,627
Maine	13	1.5	11	1.3	7	*	845
Maryland	360	*	218	*	76	*	57,968
Miami	558	1.9	21	*	24	*	29,239
Minneapolis/ St. Paul	20	*	13	*	9	*	4,628
New York City	1,395	2.5	314	*	85	*	55,693
Philadelphia	884	2.9	140	*	79	*	30,238
Phoenix	34	*	32	*	24	*	6,198
San Diego	171	*	95	*	97	*	19,821
San Francisco	79	*	157	*	144	*	24,057
Seattle	10	*	11	*	9	*	2,546
St. Louis	267	1.6	52	*	75	*	17,153
Texas	3,750	4.4	618	*	379	*	85,244
Washington, DC	8	*	5	*	0	*	3,715

[1]Only percentages of 1.0 or higher are reported in this table; percentages of less than 1.0 are indicated with the symbol *.
[2]Data are for January–December 2008.
SOURCE: All data were received from NFLIS, DEA, April 14, 2009 (see appendix table 2); data are subject to change and may differ according to the date on which they were queried

and was 10th in San Diego and San Francisco (section II, table 1).

Diazepam

Drug items containing diazepam accounted for less than 1 percent of all drug items in each of the 22 CEWG areas (table 21). However, diazepam ranked 8th in Cincinnati, 9th in San Diego, and 10th in Philadelphia among drug items identified in NFLIS forensic laboratories in calendar year 2008 (section II, table 1).

Weighted DAWN Estimates of ED Visits Involving Nonmedical Use of Benzodiazepines, 2004–2007

Estimated numbers and rates of ED visits involving nonmedical use of benzodiazepines for 12 CEWG areas for which weighted DAWN data were collected from 2004 through 2007 are shown in table 22. Six of the 12 reporting areas saw statistically significant increases in estimated ED visits involving nonmedical benzodiazepine

over the 4-year period. Between 2004 and 2007, estimated ED visits involving nonmedical use of benzodiazepines increased by 207 percent in Denver, 103 percent in Minneapolis/St. Paul, 93 percent in Detroit, 59 percent each in New York City and Seattle, and 30 percent in Boston. Four of these areas showed increases of 22–43 percent in these ED visits from 2006–2007, namely Boston, Denver, Detroit, and Minneapolis/St. Paul, while increases in ED visits involving nonmedical use of benzodiazepines were reported for two other areas from 2005–2007. Houston had a 66 percent increase, and Phoenix, a 35 percent increase (table 22).

Table 22. Weighted Estimates[1] of Emergency Department (ED) Visits[2] for Nonmedical Use of Pharmaceuticals[3] Involving Benzodiazepines, and Rates per 100,000 Population, for 12 CEWG Areas: 2004–2007[4]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[5]	Percent and Direction of Change, 2006–2007[5]	Percent and Direction of Change, 2004–2007[5]
Boston	**4,096 (92.6)**	**4,160 (93.5)**	**4,241 (95.2)**	**5,321 (118.7)**	**+28%**	**+25%**	**+30%**
Chicago	3,369 (35.9)	3,208 (34.0)	3,660 (38.5)	3,782 (39.7)	--	--	--
Denver	**551 (23.6)**	**1,049 (44.4)**	**1,379 (57.3)**	**1,689 (68.5)**	**+61%**	**+22%**	**+207%**
Detroit	**2,111 (47.0)**	**2,878 (64.2)**	**3,125 (69.9)**	**4,083 (91.4)**	**+42%**	**+31%**	**+93%**
Houston	**6,603 (127.5)**	**4,666 (87.2)**	**7,441 (134.3)**	**7,750 (137.7)**	**+66%**	--	--
Miami/Dade County	1,372 (58.1)	1,788 (75.2)	1,497 (62.3)	1,362 (57.1)	--	--	--
Minneapolis/St. Paul	**943 (30.2)**	**883 (28.1)**	**1,337 (42.1)**	**1,916 (59.7)**	**+117%**	**+43%**	**+103%**
New York City	**2,213 (27.3)**	**2,888 (35.2)**	**3,238 (39.4)**	**3,519 (42.5)**	**+22%**	--	**+59%**
Phoenix	2,269 (61.1)	**2,247 (57.9)**	**3,082 (76.3)**	**3,030 (72.5)**	**+35%**	--	--
San Diego	755 (25.7)	1,075 (36.6)	1,225 (41.7)	1,150 (38.7)	--	--	--
San Francisco	775 (45.9)	1,253 (74.1)	896 (52.7)	998 (58.0)	--	--	--
Seattle	**1,916 (60.5)**	**2,240 (69.8)**	**2,798 (85.7)**	**3,042 (91.9)**	**+36%**	--	**+59%**

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Nonmedical use is use that involves: taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs.
[4]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[5]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol,"--", indicates no statistically significant changes in the estimates between the reporting periods shown.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information

Methamphetamine

- The proportions of primary treatment admissions, including primary alcohol admissions, for methamphetamine abuse in 16 reporting CEWG areas were especially high in Hawai‘i and San Diego, at approximately 32 and 31 percent, respectively. They were also relatively high in Phoenix and Los Angeles, with respective percentages of approximately 25 and 19 (table 23; appendix table 1).
- Methamphetamine ranked first in treatment admissions as a percentage of total admissions in San Diego, second in Hawai‘i and Phoenix, and third in Colorado and Los Angeles (section II, table 2).
- In all but 2 of the 13 CEWG areas reporting data, smoking was the most common route of administration of methamphetamine among primary treatment admissions; the two were Maine and Maryland (table 24).
- Between 2007 and 2008, eight of nine CEWG areas for which data on primary methamphetamine treatment admissions were available had declines in these admissions as a percentage of total admissions, excluding primary alcohol admissions. The highest declines over the period were observed in Phoenix and San Diego, with decreases of approximately 6 percentage points each, followed by Los Angeles, at 4.0 percentage points. Atlanta and Hawai‘i had approximate declines of 3 percentage points, while Denver showed a 2.9-percentage point increase in the 2-year period. In the 5 years from 2004 to 2008, all but one reporting area showed decreases in methamphetamine admissions, with the largest declines in Minneapolis/St. Paul and Hawai‘i, at approximately 7 percentage points each. Treatment data were not reported for 2004 for Phoenix; however, there was a noteworthy decline of approximately 12 percentage points in the proportion of primary methamphetamine treatment admissions from 2005 to 2008. One area, St. Louis, showed virtually no change in admissions, with a 0.1-percentage point increase in the period (table 26).
- In 2008, methamphetamine ranked first among all drugs in proportions of forensic laboratory items identified in Honolulu, second in Atlanta, Phoenix, and San Diego, and third in six CEWG areas: Minneapolis/St. Paul, Denver, Los Angeles, San Francisco, Seattle, and Texas (section II, table 1). The largest proportions of methamphetamine items identified were reported in Honolulu (close to 45 percent), followed by Minneapolis/St. Paul (approximately 27 percent), Phoenix (approximately 22 percent), and San Diego (approximately 20 percent). In contrast, less than 2 percent of drug items identified as containing methamphetamine were reported in nine CEWG metropolitan areas east of the Mississippi, including Detroit, Chicago, Miami, New York City, Cincinnati, Boston, Philadelphia, Maryland, and Baltimore (figure 20; appendix table 2).
- Estimated numbers of ED visits involving methamphetamine increased from a low base in 1 of the 12 reporting CEWG areas in the DAWN system, Boston, and decreased from a high base in one area, San Francisco, from 2004–2007. In the period from 2005–2007, decreases in methamphetamine-involved ED visits were observed for six CEWG areas, including Denver (declining by 32 percent), Minneapolis/St. Paul (50 percent), Phoenix (9 percent), San Diego (40 percent), San Francisco (59 percent), and Seattle (38 percent). In three areas—Phoenix, San Diego, and San Francisco—decreases were also reported for 2006–2007, at 20, 32, and 26 percent, respectively (table 27).

Treatment Admissions Data on Methamphetamine

Data on primary methamphetamine treatment admissions in the CY 2008 reporting period were available and reported for 16 CEWG areas (table 23).[12] As a percentage of total treatment admissions, including primary alcohol admissions, Hawai'i had the highest proportion of methamphetamine admissions, at 31.9 percent, followed by San Diego, at 30.7 percent. In the same period, primary methamphetamine admissions accounted for approximately 16–25 percent of total primary admissions in Phoenix, Los Angeles, and Colorado. Four CEWG areas, all east of the Mississippi River (Boston, Maine, Maryland, and New York City), reported that less than 1 percent of admissions were for primary

[12] Data for Baltimore, Detroit, Miami/Dade County, Ft. Lauderdale/Broward County, and Philadelphia were excluded due to small numbers (less than 30). These areas reported 8, 2, 12, 16, and 2 total primary methamphetamine-related admissions, respectively.

Table 23. Primary Methamphetamine Treatment Admissions in 16 CEWG Areas as a Percentage[1] of Total Admissions, Including and Excluding Primary Alcohol Admissions: CY 2008[2]

	Primary Methamphetamine Admissions[3]	Total Admissions with Primary Alcohol Admissions Excluded[4]		Total Admissions with Primary Alcohol Admissions Included	
CEWG Area[3]	#	#	%	#	%
Atlanta	497	5,339	9.3	8,105	6.1
Boston	117	12,217	1.0	18,256	0.6
Colorado	4,442	16,449	27.0	28,036	15.8
Denver	1,508	7,346	20.5	11,872	12.7
Florida[5]	732	34,019	2.2	47,264	1.5
Hawai'i	2,885	5,769	50.0	9,058	31.9
Los Angeles	10,564	43,709	24.2	55,530	19.0
Maine	31	7,318	0.4	12,849	0.2
Maryland	58	42,839	0.1	65,373	0.1
Minneapolis/ St. Paul	1,101	9,132	12.1	19,263	5.7
New York City	186	60,645	0.3	84,309	0.2
Phoenix	1,238	3,350	37.0	5,049	24.5
San Diego	4,618	12,010	38.5	15,041	30.7
Seattle	1,353	9,079	14.9	14,203	9.5
St. Louis	318	7,930	4.0	11,968	2.7
Texas[5]	7,458	64,943	11.5	88,871	8.4

[1]Percentages are rounded to one decimal place.
[2]Data are for calendar year 2008: January–December 2008.
[3]Data for five CEWG areas—Baltimore, Detroit, Philadelphia, Miami/Dade County, and Ft. Lauderdale/Broward County—were excluded from this table due to small numbers (less than 30 total primary methamphetamine treatment admissions). For further information, see appendix table 1.
[4]Percentages of primary methamphetamine admissions were obtained from admissions with primary alcohol admissions excluded for comparability with past data.
[5]Florida and Texas reported combined methamphetamine and amphetamine admissions.
SOURCE: June 2009 State and local CEWG reports; more information on these data is available in the footnotes and notes for appendix table 1

methamphetamine abuse. On the other hand, seven areas—Atlanta, Denver, Florida, Minneapolis/St. Paul, Seattle, St. Louis, and Texas—reported that between approximately 2 and 13 percent of primary treatment admissions were for methamphetamine abuse problems in this reporting period (table 23).

Based on rankings of primary drugs as a percentage of total treatment admissions, including primary alcohol admissions, methamphetamine ranked first in San Diego, second in Hawai'i and Phoenix, third in Colorado and Los Angeles, and fourth in Atlanta and Denver (section II, table 2).

Route of Administration of Methamphetamine

In the 13 CEWG areas represented in table 24, smoking was the most common mode of administering methamphetamine among primary methamphetamine admissions in all but Maine (35.5 percent) and Maryland (27.6 percent). Smoking was reported at levels ranging from 27.6 percent in Maryland to 77.8 percent in Los Angeles, with relatively high percentages of smoking reported in Phoenix (76.1 percent) and San Diego (74.4 percent). St. Louis and Texas had the largest proportions of methamphetamine admissions who injected the drug (at 36.2 and 33.1 percent of total admissions, respectively), while the highest percentages reporting inhalation as the primary route of methamphetamine administration were in Maine, at approximately 42 percent, followed remotely by Boston (14.5 percent) and St. Louis (14.2 percent) (table 24). It should be noted that because numbers of primary

Table 24. Primary Route of Administration of Methamphetamine Among Treatment Admissions in 13 CEWG Areas as a Percentage[1] of Primary Methamphetamine Treatment Admissions: CY 2008[2,3]

CEWG Area	Smoked		Inhaled		Injected		Oral/Other/Unknown		Total *n*
	#	%	#	%	#	%	#	%	
Atlanta	295	59.4	61	12.3	68	13.7	73	14.7	497
Boston	59	50.4	17	14.5	33	28.2	5	4.3	117
Colorado	2,876	64.7	449	10.1	1,013	22.8	104	2.3	4,442
Denver	898	59.5	182	12.1	382	25.3	46	3.1	1,508
Los Angeles	8,222	77.8	1,373	13.0	629	6.0	340	3.2	10,564
Maine	11	35.5	13	41.9	4	12.9	3	9.7	31
Maryland	16	27.6	5	8.6	12	20.7	25	43.1	58
Minneapolis/St. Paul	764	69.4	92	8.4	175	15.9	70	6.4	1,101
New York City	98	52.7	25	13.4	49	26.3	14	7.5	186
Phoenix	942	76.1	88	7.1	166	13.4	42	3.4	1,238
San Diego[4]	3,437	74.4	471	10.2	645	14.0	60	1.3	4,618
St. Louis	145	45.6	45	14.2	115	36.2	13	4.1	318
Texas	3,680	49.3	682	9.1	2,470	33.1	626	8.4	7,458

[1]Percentages may not sum to 100 due to rounding.
[2]Data are for January–December 2008.
[3]No data were available for Hawai'i or Seattle, while cases reported in Philadelphia, Detroit, Baltimore, Miami/Dade County, and Ft. Lauderdale/Broward County were not included here due to small numbers. For further information, see appendix table 1.
[4]Missing values are reported as "Other/Unknown" for San Diego.
SOURCE: June 2009 State and local CEWG reports

methamphetamine admissions were relatively small in Maine and Maryland, caution should be used in interpreting route of administration data.

Gender of Methamphetamine Admissions

In 13 of 15 CEWG areas reporting on the gender of primary methamphetamine admissions, males represented the majority. The largest proportions of male methamphetamine admissions were in New York City, at 92.5 percent, followed by Boston, at 91.5 percent. In 4 of 15 areas—Atlanta, Florida, Texas, and Phoenix—females predominated among primary methamphetamine admissions, representing 63.0, 58.7, 55.1, and 52.9 percent of treatment admissions, respectively (table 25).

Age of Methamphetamine Admissions

In the 15 CEWG areas for which age of methamphetamine admissions was reported, the majority of methamphetamine admissions were age 35 or older in two CEWG areas—Boston and

Table 25. Demographic Characteristics of Primary Methamphetamine Treatment Admissions in 15 CEWG Areas, by Percent[1]: CY 2008[2, 3]

CEWG Area	Gender		Age Group	
	Percent Male	Percent Female	Percent 25 and Under	Percent 35 or Older
Atlanta	37.0	63.0	24.9	37.8
Boston[4]	91.5	6.8	14.5	63.2
Colorado	56.0	44.0	24.2	38.9
Denver	60.1	39.9	24.5	38.3
Florida[5,6]	41.3	58.7	27.5	29.6[5]
Los Angeles	58.5	41.4	28.3	37.9
Maine	61.3	38.7	29.0	41.9
Maryland	70.7	29.3	50.0	24.1
Minneapolis/ St. Paul	63.1	36.9	26.2	35.1
New York City	92.5	7.5	12.4	60.2
Phoenix	47.1	52.9	19.5	43.8
San Diego	55.3	44.7	20.2	49.3
Seattle	67.4	32.6	23.3	25.9[7]
St. Louis	54.7	45.3	19.5	46.5
Texas[6]	44.9	55.1	23.5	39.2

[1]Percentages are rounded to the first decimal place.
[2]Data are for January–December 2008.
[3]Data for Detroit, Philadelphia, Baltimore, Miami/Dade County, and Ft. Lauderdale/Broward County are not reported here due to small numbers. For further information, see appendix table 1.
[4]It is Boston Substance Abuse Services (BSAS) policy to suppress (*) cell counts when they are five or less to preserve confidentiality; consequently their cell totals may not add to the overall totals.
[5]Data for Florida are for age 26 and older.
[6]Includes amphetamine as well as methamphetamine (Florida and Texas).
[7]Data from Seattle are for age 40 and older.
SOURCE: June 2009 State and local CEWG reports

New York City (63.2 and 60.2 percent, respectively). Maryland had the highest proportions of methamphetamine admissions age 25 and younger (50.0 percent), followed by Maine, at 29.0 percent, and Los Angeles, at 28.3 percent. It should be noted, however, that the total numbers of such admissions were small for Maine and Maryland. New York City and Boston had relatively low percentages of young methamphetamine treatment admissions (less than 15 percent in each area were age 25 and younger) (table 25).

Changes in Methamphetamine Admissions, 2004–2008

Table 26 compares percentages of primary methamphetamine treatment admissions, excluding primary alcohol admissions, for nine CEWG areas for which data were available from 2004 or 2005 through 2008. The largest percentage-point decreases in methamphetamine-related primary admissions over the 5-year period were in Minneapolis/St. Paul and Hawai'i, at 7.5 and 7.3 percentage points, respectively. San Diego saw a decline in methamphetamine admissions of 6.1 percentage points over the period. One of eight reporting areas (Denver) had an increase in these admissions, at approximately 3 percentage points.

In the more recent period from 2007 through 2008, eight of the nine reporting areas had declines in methamphetamine admissions. These included declines of approximately 6 percentage points for Phoenix and San Diego, 4.0 percentage points for Los Angeles, and approximately 3 percentage points each for Atlanta and Hawai'i. Areas with smaller decreases were Denver, Minneapolis/St. Paul, and Seattle, while a negligible increase (0.1 percentage point) was noted for St. Louis (table 26).

Table 26. Primary Methamphetamine Treatment Admissions in Nine CEWG Reporting Areas, as a Percentage of Primary Drug Admissions, Excluding Primary Alcohol Admissions, and with Percentage Point Changes for Two Time Periods: 2004–2008 and 2007–2008[1]

CEWG Area	Year (in Percent)					Percentage Point Change, 2004–2008	Percentage Point Change, 2007–2008
	2004	2005	2006[2]	2007	2008		
Atlanta	11.3	15.5	11.4	12.5	9.3	-2.0	-3.2
Denver	17.6	20.7	21.4	21.7	20.5	+2.9	-1.2
Hawai'i	57.3	56.3	54.3	53.1	50.0	-7.3	-3.1
Los Angeles	26.7	31.4	29.7[3]	28.2	24.2	-2.5	-4.0
Minneapolis/ St. Paul	19.6	22.1	15.4	13.7	12.1	-7.5	-1.6
Phoenix	NR[4]	48.8	42.4	43.3	37.0	—	-6.3
San Diego	44.6	50.2	47.0[5]	44.3	38.5	-6.1	-5.8
Seattle	15.2	16.9	17.6	17.3	14.9	-0.3	-2.4
St. Louis	6.5	5.7	4.0	3.9	4.0	-2.5	+0.1

[1]Calendar year data are reported for all years and areas with exceptions noted below.
[2]Atlanta reports first half of CY 2006 (January–June) data; all other areas report full-year CY 2006 data.
[3]This is an updated figure for Los Angeles provided by the CEWG representative to replace the figure of 31.0 percent for CY 2006.
[4]NR = Not reported by the CEWG area representative.
[5]This is an updated figure for San Diego provided by the CEWG representative to replace the figure of 49.0 percent for the first half of CY 2006.
SOURCES: June 2009 State and local CEWG reports; June 2008 Highlights and Executive Summary CEWG report, p. 72; June 2007 Volume I CEWG report, p. 45; and updated in January 2009 for Los Angeles and San Diego

Forensic Laboratory Data on Methamphetamine

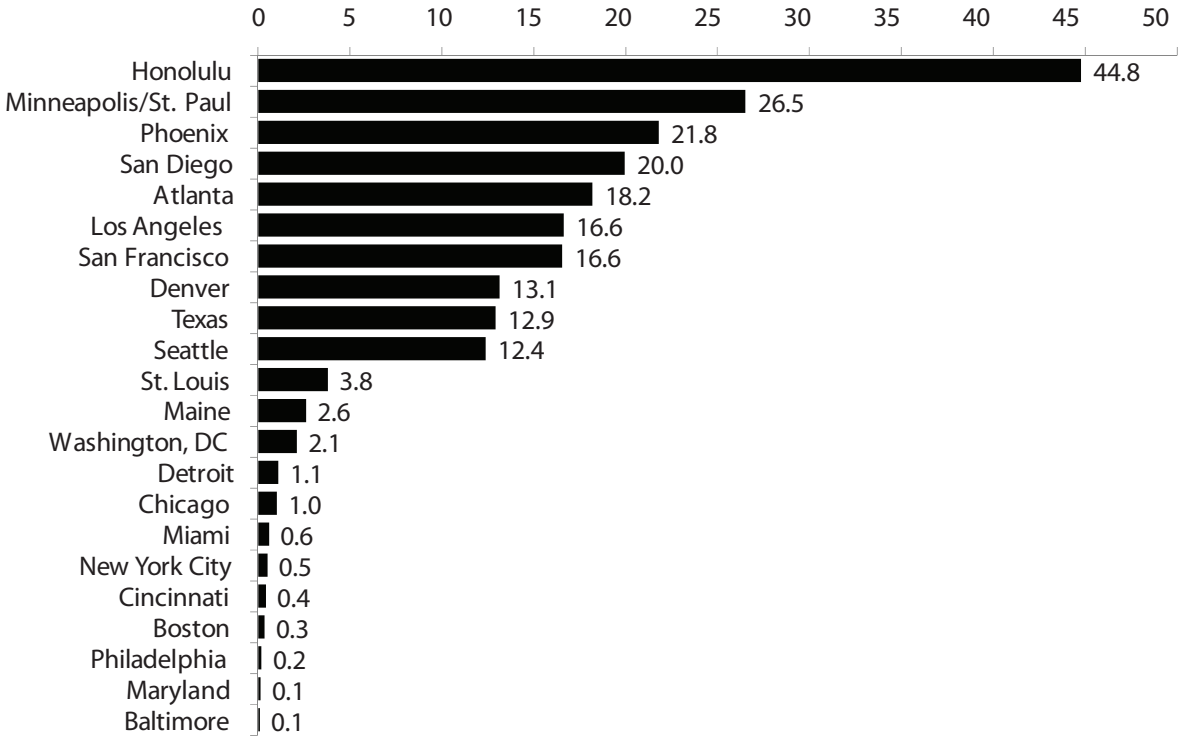
In 2008, forensic laboratory data for CEWG reporting areas (figure 20 and on the map in section II, figure 12) show that methamphetamine was the drug identified most frequently in Honolulu (44.8 percent of total drug items). Items containing methamphetamine were next most frequently identified among total drug items in Minneapolis/St. Paul (26.5 percent), Phoenix (21.8 percent), and San Diego (20.0 percent) (figure 20). In nine of the CEWG reporting areas, less than 2 percent of the total drug items contained methamphetamine; all were in areas east of the Mississippi River (figure 20; appendix table 2).

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

Weighted DAWN Estimates of ED Visits Involving Methamphetamine, 2004–2007

Estimated numbers and rates of ED visits involving methamphetamine increased slightly from a low base in 1 of the 12 CEWG areas for which weighted DAWN data were reported, and decreased in 1 area from a relatively high base. Boston showed a 105-percent increase in ED visits involving methamphetamine in the period from 2004 through 2007, with rates increasing from 2.2 to 4.5 per 100,000 population over the period. San Francisco showed a 17 percent decline in such visits over the period, with rates decreasing from 127.2 to 104.2 per 100,000

Figure 20. Methamphetamine Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: CY 2008[1]



[1]Data are for January–December 2008.
SOURCE: NFLIS, DEA, received April 14, 2009; see appendix table 2

from 2004 to 2007 (table 27). In the period from 2005–2007, decreases in methamphetamine-involved ED visits were estimated for six CEWG areas, including Denver (declining by 32 percent), Minneapolis/St. Paul (50 percent), Phoenix (9 percent), San Diego (40 percent), San Francisco (59 percent), and Seattle (38 percent). In three areas—Phoenix, San Diego, and San Francisco—decreases were also estimated for 2006–2007, at 20, 32, and 26 percent, respectively (table 27).

Table 27. Weighted Estimates[1] of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Methamphetamine[2], and Rates per 100,000 Population for 12 CEWG Areas: 2004–2007[3]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[4]	Percent and Direction of Change, 2006–2007[4]	Percent and Direction of Change, 2004–2007[4]
Boston	**99 (2.2)**	**222 (5.0)**	**141 (3.2)**	**203 (4.5)**	--	--	+105%
Chicago	201 (2.1)	253 (2.7)	183 (1.9)	159 (1.7)	--	--	--
Denver	**756 (32.4)**	**1,794 (76.0)**	**1,381 (57.3)**	**1,216 (49.4)**	-32%	--	--
Detroit	…[5]	…[5]	…[5]	…[5]	[6]	[6]	[6]
Houston	468 (9.0)	605 (11.3)	668 (12.1)	705 (12.5)	--	--	--
Miami/Dade County	60 (2.5)	132 (5.6)	70 (2.9)	…[5]	[6]	[6]	[6]
Minneapolis/ St. Paul	**1,741 (55.9)**	**2,209 (70.3)**	**1,120 (35.3)**	**1,103 (34.4)**	-50%	--	--
New York City	214 (2.6)	330 (4.0)	296 (3.6)	325 (3.9)	--	--	--
Phoenix	**3,476 (93.6)**	**4,119 (106.2)**	**4,706 (116.5)**	**3,762 (90.0)**	-9%	-20%	--
San Diego	**1,470 (50.2)**	**2,601 (88.6)**	**2,297 (78.1)**	**1,551 (52.1)**	-40%	-32%	--
San Francisco	**2,149 (127.2)**	**4,343 (257.1)**	**2,429 (143.0)**	**1,794 (104.3)**	-59%	-26%	-17%
Seattle	**2,613 (82.5)**	**4,217 (131.5)**	**3,294 (100.9)**	**2,608 (78.8)**	-38%	--	--

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[4]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol,"--", indicates no statistically significant changes in the estimates between the reporting periods shown.
[5]Three dots (…) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count or estimate less than 30 has been suppressed.
[6]No significance tests could be performed due to lack of data for 1 or more of the comparison years.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, 11/2008 update, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information

Marijuana/Cannabis

- Percentages of primary marijuana treatment admissions, including primary alcohol admissions, were highest in 2008 in Ft. Lauderdale/Broward County (38.5 percent), followed by Florida (31.0 percent) and Miami/Dade County (29.0 percent). The lowest proportions of such admissions were in Boston (3.5 percent) (table 28; appendix table 1).
- Marijuana ranked first as the primary drug problem in total drug admissions, including alcohol admissions, in 3 of 21 CEWG areas; these were Ft. Lauderdale/Broward County, Florida, and Philadelphia. Marijuana ranked second among primary drugs of admission in seven additional areas: Miami/Dade County, Minneapolis/St. Paul, St. Louis, Denver, Los Angeles, and the States of Colorado and Texas (section II, table 2).
- Changes in percentages of primary marijuana treatment admissions, excluding alcohol admissions, in 15 CEWG reporting areas did not exceed 5 percentage points from 2007 through 2008, although they rose by approximately 4 percentage points in St. Louis and San Diego. However, over the 5 years from 2004–2008, primary marijuana treatment admissions declined by approximately 13 percentage points in Maine and increased by at least 5 percentage points in 4 of 14 reporting areas—Hawai'i, New York City, Los Angeles, and Detroit (table 30).
- Cannabis/marijuana ranked in either first or second place in frequency in the proportion of drug items identified in forensic laboratories in 2008 in all CEWG areas, with the exception of Atlanta. Cannabis ranked in first place among identified drugs in 11 of 22 CEWG areas in this reporting period: Baltimore, Maryland, Boston, Philadelphia, Detroit, Chicago, St. Louis, Cincinnati, Los Angeles, San Diego, and Phoenix. It ranked second in the remaining 10 areas (section II, table 1). The highest proportions of marijuana items identified in the NFLIS system were in Chicago, San Diego, and St. Louis, at approximately 56, 52, and 50 percent, respectively (figure 21; appendix table 2).
- Estimated DAWN ED visits involving marijuana increased in 3 of 12 reporting areas and decreased in one area. Increases in estimated marijuana-involved ED visits were reported in Denver, Detroit, and New York City from 2004–2007, while decreased marijuana visits were observed for Houston over the 4-year period (table 31).

Treatment Admissions Data on Marijuana

In the 2008 reporting period, marijuana/cannabis ranked as the most frequently reported drug by primary treatment admissions in 3 of 21 CEWG areas, when primary alcohol admissions were included in the total (section II, table 2); these were Ft. Lauderdale/Broward County, Florida, and Philadelphia. Marijuana ranked second among primary drugs of admission in Miami/Dade County, Minneapolis/St. Paul, St. Louis, Denver, Los Angeles, and the States of Colorado and Texas (section II, table 2).

As shown in table 28, Ft. Lauderdale/Broward County had the highest percentage of primary marijuana treatment admissions, including primary alcohol admissions, at 38.5 percent. In all, two other CEWG areas, besides Broward, had percentages of marijuana treatment admissions close to one-third—Florida (31.0 percent) and Miami/Dade County (29.0 percent). The lowest proportion of marijuana treatment admissions was reported in Boston, at 3.5 percent.

Gender of Marijuana Admissions

Males predominated in all 20 CEWG areas reporting on the gender of primary marijuana admissions in 2008 (table 29). The proportion of

males ranged from a high of 80.4 percent of marijuana admissions in Baltimore and Maryland to lows of 66.1 percent in Atlanta and 66.5 percent in Phoenix.

Age of Marijuana Admissions

Across 16 of the 20 CEWG areas for which age distributions were reported, the majority of primary marijuana treatment admissions were age 25 and younger. Exceptions were New York City, Philadelphia, and Phoenix. Los Angeles and San Diego had the highest proportion of primary marijuana treatment admissions who were younger than 18, at more than one-half (53.8 and 53.6 percent, respectively). Phoenix (45.7 percent), Boston (43.2 percent), and Minneapolis/

Table 28. Primary Marijuana Treatment Admissions in 21 CEWG Areas as a Percentage of Total Admissions, Including and Excluding Primary Alcohol Admissions[1]: CY 2008[2]

	Primary Marijuana Admissions	Total Admissions with Primary Alcohol Admissions Excluded[3]		Total Admissions with Primary Alcohol Admissions Included	
CEWG Area	#	#	%	#	%
Atlanta	1,769	5,339	33.1	8,105	21.8
Baltimore	2,079	15,558	13.4	18,355	11.3
Boston	641	12,217	5.2	18,256	3.5
Colorado	6,020	16,449	36.6	28,036	21.5
Denver	2,799	7,346	38.1	11,872	23.6
Detroit	1,239	6,457	19.2	8,927	13.9
Florida	14,671	34,019	43.1	47,264	31.0
Hawai‘i	2,016	5,769	34.9	9,058	22.3
Los Angeles	11,031	43,709	25.2	55,530	19.9
Maine	1,304	7,318	17.8	12,849	10.1
Maryland	11,069	42,839	25.8	65,373	16.9
Miami/ Dade County	979	2,504	39.1	3,371	29.0
Ft. Lauderdale/ Broward County	1,611	3,183	50.6	4,184	38.5
Minneapolis/ St. Paul	3,199	9,132	35.0	19,263	16.6
New York City	19,512	60,645	32.2	84,309	23.1
Philadelphia	3,592	11,363	31.6	14,741	24.4
Phoenix	711	3,350	21.2	5,049	14.1
San Diego	2,839	12,010	23.6	15,041	18.9
Seattle	2,326	9,079	25.6	14,203	16.4
St. Louis	2,836	7,930	35.8	11,968	23.7
Texas	20,257	64,943	31.2	88,871	22.8

[1]More information on these data is available in the footnotes and notes for appendix table 1.
[2]Data are for January–December 2008.
[3]Percentages of primary marijuana admissions are obtained from admissions with primary alcohol admissions excluded for comparability with past data.
SOURCE: June 2009 State and local CEWG reports

St. Paul (41.0 percent) had the highest proportions of marijuana admissions in the next youngest age group, 18–25. Older primary marijuana treatment admissions (age 35 and older) were highest in Philadelphia, at 28.8 percent, followed by Phoenix, Boston, New York City, and Maine, at approximately 21 to 23 percent (table 29).

Changes in Marijuana Admissions, 2004–2008

Table 30 compares percentages of primary marijuana treatment admissions, excluding primary alcohol admissions, for 14 CEWG areas for which data were available from 2004 through 2008. Over the 5-year period, primary marijuana treatment admissions decreased as a percentage of

Table 29. Demographic Characteristics of Primary Marijuana Treatment Admissions in 20 CEWG Areas, as a Percentage[1]: CY 2008[2]

CEWG Area	Gender		Age Group			
	Percent Male	Percent Female	Percent ≤ 17	Percent 18–25	Percent 26–34	Percent 35 or Older
Atlanta	66.1	33.9	26.8	32.0	22.2	19.1
Baltimore	80.4	19.6	35.7	30.2	20.9	13.2
Boston	71.3	28.7	9.4	43.2	24.8	22.6
Colorado	76.7	23.3	28.2	32.4	22.6	16.7
Denver	77.6	22.4	32.0	31.1	21.5	15.4
Detroit	68.3	31.7	34.9	25.3	22.1	17.6
Florida	71.3	28.7	49.1	29.9	12.6[3]	8.4[3]
Los Angeles	69.7	30.3	53.8	20.9	11.9	13.5
Maine	72.5	27.5	27.1	29.6	21.9	21.2
Maryland	80.4	19.6	35.8	39.1	15.7	9.4
Miami/Dade County	75.4	24.6	49.4	28.3	13.0	9.3
Ft. Lauderdale/ Broward County	78.6	21.4	37.3	38.3	13.2	11.2
Minneapolis/St. Paul	78.2	21.8	27.4	41.0	18.3	13.3
New York City	79.8	20.2	10.1	38.2	30.1	21.6
Philadelphia	75.6	16.4	2.6	34.3	34.3[3]	28.8[3]
Phoenix	66.5	33.5	0.0	45.7	31.2	23.1
San Diego	73.5	26.5	53.6	20.9	14.2	11.3
Seattle	78.1	21.9	35.1	28.7	25.5[4]	10.7[4]
St. Louis	77.3	22.7	24.4	32.5	26.4	16.7
Texas	71.0	29.0	31.8	36.5	20.7	11.0

[1]Percentages are rounded to one decimal place.
[2]Data are for January–December 2008.
[3]The age ranges are 26–35, and 36 and older in Florida and Philadelphia.
[4]Data from Seattle are for age 30–39 and 40 and older.
NOTE: Missing values were reported by Texas (5 in the gender distribution); Maine (1 in the age distribution); and Philadelphia (287 in the gender distribution).
SOURCE: June 2009 State and local CEWG reports

Table 30. Primary Marijuana Treatment Admissions in 15 CEWG Areas by Percentage of All Admissions, Excluding Primary Alcohol Admissions, and Percentage Point Change for Two Time Periods: 2004–2008 and 2007–2008[1,2]

CEWG Area	Year (in Percent)					Percentage Point Change	
	2004	2005	2006	2007	2008	2004–2008	2007–2008
Atlanta	28.8	27.7	30.9	31.4	33.1	+4.3	+1.7
Baltimore	16.2	15.8	18.3	12.8	13.4	-2.8	+0.6
Boston[3]	5.9	5.5	5.4	4.9	5.2	-1.4	+0.3
Denver	38.6	37.0	36.9	36.6	38.1	-0.5	+1.5
Detroit	13.5	15.4	19.0	20.8	19.2	+5.7	-1.6
Hawai‘i	25.2	29.2	29.6	32.3	34.9	+9.7	+2.6
Los Angeles	17.0	18.7	20.2[4]	22.5	25.2	+8.2	+2.7
Maine	30.5	25.6	21.7	20.5	17.8	-12.7	-2.7
Minneapolis/ St. Paul	39.1	32.6	35.5	32.8	35.0	-4.1	+2.2
New York City	23.5	25.3	27.8	29.3	32.2	+8.7	+2.9
Phoenix	NR[5]	16.0	18.6	19.9	21.2	—	+1.3
San Diego	20.2	15.4	16.6	19.5	23.6	+3.4	+4.1
Seattle	28.2	25.2	24.4	25.5	25.6	-2.6	+0.1
St. Louis	35.1	29.0	27.5	31.5	35.8	+0.7	+4.3
Texas	26.4	27.1	28.7	30.2	31.2	+4.8	+1.0

[1]CY 2007 and CY 2008 data are reported for all areas, as are CY 2004 and CY 2005 data.
[2]2006 data for Boston, Chicago, Detroit, and San Francisco cover the fiscal year, while Atlanta and San Diego report first half (January–June) of CY 2006. All other CEWG areas report full-year CY 2006 data.
[3]The Boston representative updated CY data for this table; previous data that was replaced is as follows: 2004, 6.6 percent; 2005, 5.0 percent; 2006, 4.2 percent.
[4]The Los Angeles representative provided updated data for CY 2006, replacing the previous value of 19.7 percent.
[5]NR = Not reported by the CEWG area representative.
SOURCES: June 2009 State and local CEWG reports; June 2008 Highlights and Executive Summary CEWG report, p. 72; and June 2007 Volume I CEWG report, p. 51

total nonalcohol admissions in one area, Maine, by 12.7 percentage points. Conversely, proportions of primary marijuana admissions increased by 5 or more percentage points in 4 of the remaining 13 areas reporting, namely Hawai‘i, New York City, Los Angeles, and Detroit. Respective percentage point increases were 9.7, 8.7, 8.2, and 5.7 (no 2004 treatment data were reported for Phoenix, although data for 2005–2008 showed a 5.2 percentage point increase in proportions of primary marijuana treatment admissions for that area) (table 30).

In the more recent period from 2007 through 2008, only minimal changes were observed of less than 3 percentage points in 13 of 15 CEWG reporting areas, with the exception of increases in marijuana treatment admissions in St. Louis and San Diego, each at approximately 4 percentage points over the 2-year period (table 30).

Forensic Laboratory Data on Marijuana/ Cannabis

Chicago had the highest percentage of marijuana identified by NFLIS laboratories in 2008

(55.7 percent), followed by San Diego and St. Louis (51.6 and 50.3 percent, respectively) (figure 21; appendix table 2). The proportions of cannabis drug items identified in the other 19 CEWG areas were highest in Detroit (45.0 percent), Cincinnati (44.2 percent), and Boston (43.2 percent). The remaining CEWG sites had percentages ranging from 1.4 percent in Atlanta[13] to 38.8 percent in Phoenix for cannabis drug items identified (figure 21).

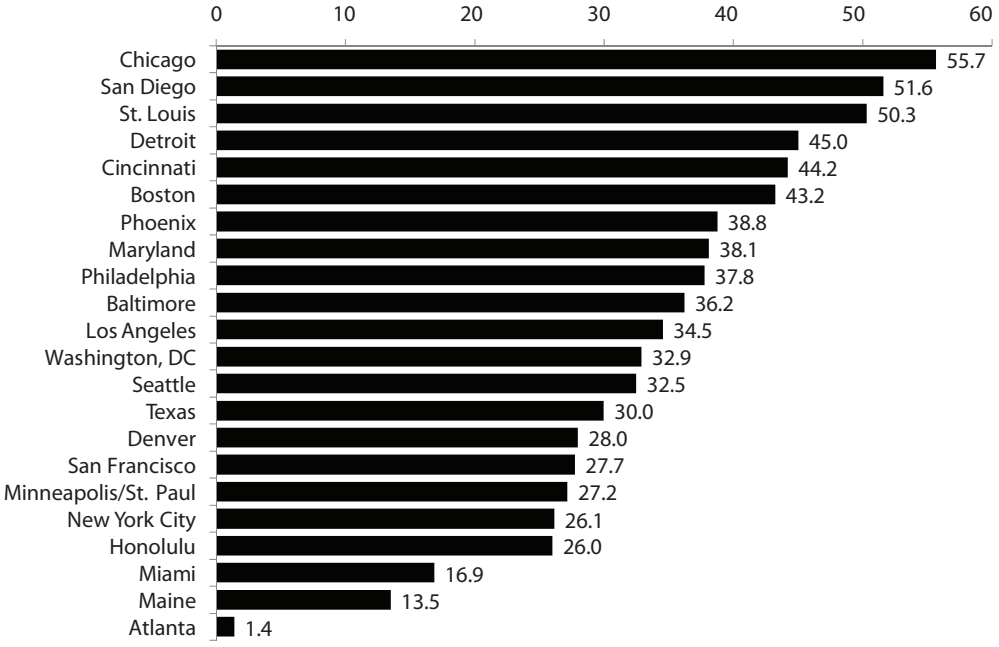
Cannabis ranked in either first or second place among drug items most frequently identified in all CEWG areas, with the exception of Atlanta, in 2008. Cannabis ranked in first place among identified drugs in 11 of 22 CEWG areas in the period: Baltimore, Maryland, Boston, Philadelphia, Detroit, Chicago, St. Louis, Cincinnati, Los Angeles, San Diego, and Phoenix. It was the second most frequently identified drug item in 2008 NFLIS data in another 10 CEWG areas (section II, table 1).

[13] The CEWG representative from Atlanta reported that in 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.

Weighted DAWN Estimates of ED Visits Involving Marijuana, 2004–2007

Estimated numbers and rates of ED visits involving marijuana increased in 3 of 12 CEWG areas for which weighted DAWN data were reported; they decreased in 1 area. Statistically significant increases in marijuana visits were reported for Denver, New York City, and Detroit, with respective increases of 207, 145, and 111 percent from 2004 through 2007. In Houston, ED visits involving marijuana based on weighted estimates for the 4-year period declined significantly, by 19 percent (table 31). Three areas—Denver, Detroit, and New York City—showed increases in estimated ED visits involving marijuana of 70, 38, and 42 percent, respectively, for the period, 2005–2007, while in one area, Boston, marijuana-involved ED visits increased by 21 percent in 2006–2007.

Figure 21. Marijuana Items Identified as a Percentage of Total NFLIS Drug Items, 22 CEWG Areas: CY 2008[1]



[1]Data are for January–December 2008.
SOURCE: NFLIS, DEA, received April 14, 2009; see appendix table 2

Table 31. Weighted Estimates[1] of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving Marijuana[2], and Rates per 100,000 Population for 12 CEWG Areas: 2004–2007[3]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[4]	Percent and Direction of Change, 2006–2007[4]	Percent and Direction of Change, 2004–2007[4]
Boston	**5,252 (118.7)**	**5,661 (127.3)**	**5,414 (121.5)**	**6,556 (146.2)**	--	**+21%**	--
Chicago	11,544 (122.9)	10,808 (114.4)	11,644 (122.5)	11,335 (119.0)	--	--	--
Denver	**1,172 (50.3)**	**2,126 (90.0)**	**3,287 (136.5)**	**3,605 (146.2)**	**+70%**	--	**+207%**
Detroit	**2,935 (65.3)**	**4,496 (100.4)**	**5,268 (117.9)**	**6,207 (138.9)**	**+38%**	--	**+111%**
Houston	**8,214 (158.6)**	**5,003 (93.5)**	**7,219 (130.3)**	**6,643 (118.0)**	--	--	**-19%**
Miami/Dade County	3,755 (158.9)	5,192 (218.3)	4,333 (180.4)	3,576 (149.8)	--	--	--
Minneapolis/ St. Paul	4,455 (143.0)	4,467 (142.2)	4,302 (135.5)	5,757 (179.4)	--	--	--
New York City	**5,920 (73.0)**	**10,192 (124.1)**	**12,938 (157.5)**	**14,500 (175.2)**	**+42%**	--	**+145%**
Phoenix	2,671 (71.9)	2,830 (73.0)	3,730 (92.3)	3,433 (82.1)	--	--	--
San Diego	837 (28.6)	1,644 (56.0)	1,660 (56.4)	1,622 (54.5)	--	--	--
San Francisco	1,166 (69.0)	2,179 (129.0)	1,566 (92.2)	1,549 (90.0)	--	--	--
Seattle	3,881 (122.6)	4,399 (137.1)	4,136 (126.7)	4,729 (142.9)	--	--	--

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[4]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol,"--", indicates no statistically significant changes in the estimates between the reporting periods shown.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, 11/2008 update, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information

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

Treatment Admissions Data on Club Drugs

The club drugs reported on in this section include MDMA (3,4-methylenedioxymethamphetamine, or ecstasy), MDA (3,4-methylenedioxyamphetamine), GHB (gamma hydroxybutyrate), GBL (gamma butyrolactone), LSD (lysergic acid diethylamide), and ketamine. Admissions for primary treatment of club drugs or MDMA are not captured in all treatment data systems, but they appear low in those areas that do report on these drugs.

Table 32. Number of MDMA Items Identified and MDMA Items as Percentage of Total Items Identified by Forensic Laboratories in CEWG Areas: CY 2008[1]

CEWG Area	MDMA Items	Total Items Identified	Percentage of Total Items Identified
Atlanta	410	12,207	3.4
Baltimore	119	54,167	0.2
Boston	106	20,046	0.5
Chicago	1,163	77,456	1.5
Cincinnati	194	13,151	1.5
Denver	177	7,870	2.2
Detroit	232	6,323	3.7
Honolulu	30	1,892	1.6
Los Angeles	1,248	53,627	2.3
Maine	11	845	1.3
Maryland	175	57,968	0.3
Miami	259	29,239	0.9
Minneapolis/ St. Paul	190	4,628	4.1
New York City	283	55,693	0.5
Philadelphia	57	30,238	0.2
Phoenix	57	6,198	0.9
San Diego	313	19,821	1.6
San Francisco	786	24,057	3.3
Seattle	56	2,546	2.2
St. Louis	521	17,153	3.0
Texas	1,288	85,244	1.5
Washington, DC	78	3,715	2.1

[1]Data are for January–December 2008.
SOURCE: All data were received from NFLIS, DEA, April 14, 2009 (see appendix table 2); data are subject to change and may differ according to the date on which they were queried

Forensic Laboratory Data on Club Drugs

MDMA

MDMA was the club drug most frequently reported among NFLIS data in the 22 CEWG areas depicted in table 32. As shown, MDMA equaled or exceeded 2 percent of all drug items in nine areas. These include Minneapolis/St. Paul and Detroit, which had the highest percentages (4.1 and 3.7 percent, respectively), followed by Atlanta (3.4 percent), San Francisco (3.3 percent), and St. Louis (3.0 percent). Other areas whose MDMA NFLIS items equaled 2 percent or greater were Los Angeles, Denver, Seattle,

Table 33. MDA, GHB[1], Ketamine, LSD, PCP, and Other Drug Items[2,3] Reported by Forensic Laboratories in the Top 25 Most Frequently Identified Drug Items in 22 CEWG Areas, by Number of Total Items Identified: CY 2008[4]

CEWG Area	MDA	PCP	LSD	Psilocin	Ketamine	BZP	Carisoprodol	Total
Atlanta	43	--	--	30	36	32	114	12,207
Baltimore	102	107	--	--	--	63	--	54,167
Boston	--	--	--	--	--	53	--	20,046
Chicago	--	195	33	72	41	380	--	77,456
Cincinnati	--	--	14	12	--	--	--	13,151
Denver	36	--	18	65	7	27	9	7,870
Detroit	--	--	--	13		32	4	6,323
Honolulu	6	--	--	--	--	14	4	1,892
Los Angeles	--	485		158	53	93	173	53,627
Maine	4	--	9	12	--	3	--	845
Maryland	109	171	--	35	--	--	--	57,968
Miami	--	236[5]	--	--	20	95	15	29,239
Minneapolis/ St. Paul	--	--	--	21	--	10	--	4,628
New York City	253	674	--	35[6]	154	--	--	55,693
Philadelphia	18	782	--	--	--	5	--	30,238
Phoenix	--	19	--	11	--	11	47	6,198
San Diego	--	38	--	37[6]	--	37	--	19,821
San Francisco	--	--	23	91	46	--	28	24,057
Seattle	4	13	10	8	--	41	--	2,546
St. Louis	--	25	--	32	--	143	--	17,153
Texas	--	349	--	166	186	402	787	85,244
Washington, DC	6	240	--	--	5	62	--	3,715

[1]No GHB drug items were identified in the top 25 in these CEWG areas.
[2]Foxy Methoxy was identified in one area, Denver, with 19 items containing it identified.
[3]TFMPP was identified in 227 drug items identified in Atlanta, and in 32 drug items in Washington, DC.
[4]Data are for January–December, 2008.
[5]Miami reports hallucinogens only, which are included under PCP.
[6]Psilocibine/psilocybine is reported by New York City, and psilocybin/psilocin items by San Diego.
SOURCE: All data were received from NFLIS, DEA, April 14, 2009 (see appendix table 2); data are subject to change and may differ according to the date on which the data were queried

and Washington, DC. As shown in section II, table 1, MDMA was the fourth most frequently identified drug item in Atlanta, Chicago, and Minneapolis/St. Paul in 2008. It ranked fifth in 8 of 22 reporting areas: Miami, Washington, DC, Detroit, St. Louis, Denver, Honolulu, Los Angeles, and San Francisco (section II, table 1).

MDA

MDA was reported among the top 25 drug items identified in 10 of 22 areas: Atlanta, Baltimore, Denver, Honolulu, Maine, Maryland, New York City, Philadelphia, Seattle, and Washington, DC (table 33). While neither ketamine, GHB, nor LSD figured among the top 10 most frequently identified drug items in any CEWG

Table 34. Weighted Estimates[1] of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving MDMA[2], and Rates per 100,000 Population for 12 CEWG Areas: 2004–2007[3]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[4]	Percent and Direction of Change, 2006–2007[4]	Percent and Direction of Change, 2004–2007[4]
Boston	**320 (7.2)**	**356 (8.0)**	**378 (8.5)**	**261 (5.8)**	--	**-31%**	--
Chicago	333 (3.5)	378 (4.0)	525 (5.5)	425 (4.5)	--	--	--
Denver	**105 (4.5)**	**162 (6.8)**	**241 (10.0)**	**272 (11.0)**	**+68%**	--	**+160%**
Detroit	**153 (3.4)**	**364 (8.1)**	**324 (7.2)**	**381 (8.5)**	--	--	**+149%**
Houston	**438 (8.5)**	**359 (6.7)**	**543 (9.8)**	**371 (6.6)**	--	**-32%**	--
Miami/Dade County	209 (8.8)	209 (8.8)	144 (6.0)	194 (8.1)	--	--	--
Minneapolis/ St. Paul	204 (6.5)	254 (8.1)	252 (8.0)	433 (13.5)	--	--	--
New York City	372 (4.6)	380 (4.6)	451 (5.5)	506 (6.1)	--	--	--
Phoenix	…[5]	73 (1.9)	162 (4.0)	94 (2.3)	--	--	[6]
San Diego	…[5]	68 (2.3)	113 (3.9)	110 (3.7)	--	--	[6]
San Francisco	**210 (12.4)**	**398 (23.6)**	**286 (16.9)**	**188 (10.9)**	**-53%**	**-34%**	**-10%**
Seattle	284 (9.0)	295 (9.2)	426 (13.0)	334 (10.1)	--	--	--

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[4]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol,"--", indicates no statistically significant changes in the estimates between the reporting periods shown.
[5]Three dots (…) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count or estimate less than 30 has been suppressed.
[6]No significance tests could be performed due to lack of data for 1 or more of the comparison years.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, 11/2008 update, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf

area in 2008, MDA ranked in 10th place among drugs identified in 2008 in forensic laboratories in Denver (section II, table 1).

GHB

GHB drug items were not among the top 25 drug items identified for any CEWG area in 2008 (table 33).

LSD

LSD was not among the top 10 drugs reported in the NFLIS system for any CEWG reporting area, but it ranked in the top 25 ranked drug items identified in forensic laboratory data in 6 of 22 CEWG reporting areas: Chicago, Cincinnati, Denver, Maine, San Francisco, and Seattle. Only one area, Chicago, had 30 or more cases, and in only one area, Maine, was the percentage at 1 percent of drug items identified (table 33).

Ketamine

Ketamine ranked in the top 25 drug items identified in the NFLIS system in 2008 in 9 of 22 areas: Atlanta, Chicago, Denver, Los Angeles, Miami, New York City, San Francisco, Texas, and Washington, DC (table 33). While ketamine represented less than 1 percent of total drug items identified in any reporting area, six areas reported 30 cases or more: Texas, New York City, Los Angeles, Chicago, San Francisco, and Atlanta (table 33). Ketamine did not figure among the top 10 most frequently identified drug items in any CEWG area (section II, table 1).

Weighted DAWN Estimates of ED Visits Involving MDMA, 2004–2007

Estimated numbers of ED visits and visit rates per 100,000 involving MDMA significantly changed in 3 of 12 CEWG areas for which weighted DAWN data were reported. MDMA-involved visits increased in Denver and Detroit, by 160 and 149 percent, respectively, while decreasing by 10 percent in San Francisco from 2004 through 2007. Declines of 53 percent from 2005 to 2007 and 34 percent from 2006 to 2007 were also noted for San Francisco. In Denver, estimated ED visits involving MDMA increased by 68 percent from 2005 to 2007, while during the period from 2006 to 2007, such visits decreased by 31 percent in Boston and 32 percent in Houston (table 34).

Phencyclidine (PCP)

Forensic Laboratory Data on PCP

As a percentage of all identified items, PCP items were highest in Washington, DC, at 6.5 percent, followed by Philadelphia, at 2.6 percent, and New York City, at 1.2 percent (table 33).

PCP figured among the top 10 most frequently identified drug items in seven CEWG areas from NFLIS data for 2008. In Washington, DC, PCP ranked fourth as the most frequently identified drug item in forensic laboratories in 2008. PCP was also among the top drug items identified in Philadelphia and New York City, where it ranked sixth in each. In 2008, PCP ranked 7th in Los Angeles, 9th in Chicago, and 10th each in Maryland and Seattle (section II, table 1). No PCP items were documented among the top 25 in forensic laboratory data on drug items identified in 10 CEWG areas: Atlanta, Boston, Cincinnati, Denver, Detroit, Honolulu, Maine, Miami, Minneapolis/St. Paul, and San Francisco, although Miami NFLIS reported a general category of hallucinogens, which totaled 236 cases in 2008 (table 33; appendix table 2). Fewer than 30 such items were identified in three areas (Seattle, Phoenix, and St. Louis). The areas reporting 30 or more PCP items were Baltimore, Chicago, Los Angeles, Maryland, New York City, Philadelphia, Texas, and Washington, DC.

It should be noted that hallucinogens, reported as a category of drug items in one area only, ranked 6th in Miami/Dade County in drug items identified in 2008, while another hallucinogen, psilocin, ranked 8th in Denver and 10th in Maine in the NFLIS data for the current reporting period (section II, table 1). Psilocin (and psilocybin) was reported among the top 25 drug items in forensic laboratories in 16 of 22 CEWG areas in 2008 (table 33).

Weighted DAWN Estimates of ED Visits Involving PCP, 2004–2007

Estimated numbers of PCP-involved ED visits and visit rates per 100,000 increased significantly over the 4-year period from 2004–2007 in 1 of the 12 CEWG areas for which weighted DAWN data were available, New York City, which saw a 96-percent increase in PCP ED visits for the period 2004–2007 (New York City also saw a 34-percent increase in such visits in 2006–2007). A significant decline in such visits was found for an additional area, Chicago, where ED visits involving PCP fell by 52 percent over the 4-year period. In Phoenix and Houston, PCP-involved ED visits increased from 2005–2007 by 126 and 184 percent, respectively, while in Seattle, they increased by 59 percent in 2006–2007 (table 35).

Table 35. Weighted Estimates[1] of Drug Misuse/Abuse-Related Emergency Department (ED) Visits Involving PCP[2], and Rates per 100,000 Population for 12 CEWG Areas: 2004–2007[3]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[4]	Percent and Direction of Change, 2006–2007[4]	Percent and Direction of Change, 2004–2007[4]
Boston	…[5]	…[5]	…[5]	…[5]	[6]	[6]	[6]
Chicago	**837 (8.9)**	**354 (3.7)**	**380 (4.0)**	**398 (4.2)**	--	--	-52%
Denver	…[5]	…[5]	…[5]	…[5]	[6]	[6]	[6]
Detroit	…[5]	…[5]	…[5]	68 (1.5)	[6]	[6]	[6]
Houston	**1,090 (21.0)**	**431 (8.1)**	**1,012 (18.3)**	**1,226 (21.8)**	+184%	--	--
Miami/Dade County	…[5]	…[5]	…[5]	…[5]	[6]	[6]	[6]
Minneapolis/ St. Paul	…[5]	69 (2.2)	132 (4.2)	…[5]	[6]	[6]	[6]
New York City	**451 (5.6)**	**794 (9.7)**	**660 (8.0)**	**884 (10.7)**	--	+34%	+96%
Phoenix	**91 (2.4)**	**67 (1.7)**	**134 (3.3)**	**150 (3.6)**	+126%	--	--
San Diego	…[5]	87 (2.9)	…[5]	…[5]	[6]	[6]	[6]
San Francisco	93 (5.5)	111 (6.6)	116 (6.8)	159 (9.2)	--	--	--
Seattle	**262 (8.3)**	**237 (7.4)**	**176 (5.4)**	**280 (8.5)**	--	+59%	--

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[4]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol,"--", indicates no statistically significant changes in the estimates between the reporting periods shown.
[5]Three dots (…) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count or estimate less than 30 has been suppressed.
[6]No significance tests could be performed due to lack of data for 1 or more of the comparison years.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, 11/2008 update, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information

Table 36. Weighted Estimates[1] of Emergency Department (ED) Visits[2] for Nonmedical Use of Pharmaceuticals[3] Involving Carisoprodol, and Rates per 100,000 Population, for 12 CEWG Areas: 2004–2007[4]

CEWG Area	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2004	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2005	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2006	Estimated Numbers of ED Visits and (Rates per 100,000 Population), 2007	Percent and Direction of Change, 2005–2007[5]	Percent and Direction of Change, 2006–2007[5]	Percent and Direction of Change, 2004–2007[5]
Boston	165 (3.7)	159 (3.6)	122 (2.7)	132 (2.9)	--	--	--
Chicago	…[6]	…[6]	…[6]	…[6]	[7]	[7]	[7]
Denver	**80 (3.4)**	**101 (4.3)**	**162 (6.7)**	**191 (7.8)**	**+88%**	--	**+138%**
Detroit	**435 (9.7)**	**364 (8.1)**	**360 (8.0)**	**557 (12.5)**	**+53%**	**+55%**	--
Houston	**1,632 (31.5)**	**1,394 (26.0)**	**3,794 (68.5)**	**4,335 (77.0)**	**+211%**	--	**+166%**
Miami/Dade County	…[6]	…[6]	…[6]	…[6]	[7]	[7]	[7]
Minneapolis/ St. Paul	…[6]	83 (2.7)	…[6]	151 (4.7)	--	[7]	[7]
New York City	…[6]	…[6]	…[6]	…[6]	[7]	[7]	[7]
Phoenix	487 (13.1)	531 (13.7)	752 (18.6)	710 (17.0)	--	--	--
San Diego	**232 (7.9)**	**273 (9.3)**	**175 (5.9)**	**197 (6.6)**	--	--	**-15%**
San Francisco	97 (5.8)	200 (11.8)	155 (9.1)	115 (6.7)	--	--	--
Seattle	193 (6.1)	181 (5.6)	169 (5.2)	232 (7.0)	--	--	--

[1]Estimates of ED visits are based on a representative sample of non-Federal, short-stay hospitals with 24-hour EDs in the United States.
[2]It should be noted that summing or combining visits for drugs, cocaine, heroin, methamphetamine, and other drugs, produces incorrect and inflated counts, since ED visits often involve multiple drug reports, and these visits will appear multiple times in the data tables.
[3]Nonmedical use is use that involves: taking a prescription or over-the-counter (OTC) pharmaceutical differently than prescribed or recommended, especially taking more than prescribed or recommended; taking a pharmaceutical prescribed for another individual; deliberate poisoning with a pharmaceutical agent by another person; and documented misuse of a prescription or OTC pharmaceutical or dietary supplement. Nonmedical use may involve pharmaceuticals alone or in combination with other drugs.
[4]Bold numbers indicate that a statistically significant percentage difference was observed for at least one of the time periods for that CEWG area.
[5]This column denotes statistically significant ($p<.05$) increases or decreases between estimates for the periods shown. Results of statistical testing were provided by OAS, SAMHSA. The symbol,"--", indicates no statistically significant changes in the estimates between the reporting periods shown.
[6]Three dots (…) indicate that an estimate with a relative standard error (RSE) greater than 50 percent or a count or estimate less than 30 has been suppressed.
[7]No significance tests could be performed due to lack of data for 1 or more of the comparison years.
SOURCE: Area-specific data were obtained by request from DAWN, OAS, SAMHSA, received 5/18/2009; see *https://dawninfo.samhsa.gov/files/ED2006/DAWN2k6ED.htm* or pdf for more information

Other Drugs (including BZP, TFMPP, Foxy Methoxy, and Carisoprodol)

BZP (1-Benzylpiperazine)

In 2008, BZP emerged among the top 25 identified drugs in NFLIS forensic laboratories in 18 of 22 CEWG areas. The four exceptions were: Cincinnati, Maryland, New York City, and San Francisco (table 33). This contrasts with 2007 when none of the 22 CEWG areas, with the exception of Detroit, listed BZP-containing drug items among the top 25 drugs identified in forensic laboratories. In Detroit, for example, 11 BZP items were identified in 2007, representing 0.1 percent of all drug items identified, while in 2008, 32 items, or 0.5 percent of drug items in the period, were so identified. In Seattle, 1.6 percent (n=41) of drug items identified in 2008 contained BZP, compared with none in 2007. Section II, table 1 shows BZP rankings among the top 10 most frequently identified drug items in NFLIS data in 2008. BZP ranked 6th in Chicago, 7th in Washington, DC, Honolulu, and Seattle, 9th in Miami, and 10th in Detroit, St. Louis, and Texas.

TFMPP or 1-(3-Trifluoromethylphenyl) piperazine

The identification of this drug in top 25 NFLIS data for 2008 was localized to two areas—Atlanta and Washington, DC. Atlanta reported an increase in items containing TFMPP in 2008, compared with 2007, reporting 16 such drug items in 2007 and 227 in 2008. This represents an increase from 0.1 percent to 1.9 percent of drug items identified in the respective periods. In 2008 forensic laboratory data, TFMPP ranked eighth in frequency among drug items identified in Atlanta and Washington, DC (section II, table 1).

Foxy or Foxy Methoxy (5-Methoxy-N,N-Diisopropyltryptamine, or 5-MeO-DIPT)

The only CEWG area in which Foxy Methoxy drug items were identified among the top 25 in the NFLIS system was Denver, with 19 items in 2008, compared with none in 2007 (table 33, footnote 2).

Carisoprodol

Carisoprodol was identified among the top 25 drugs in 9 of 22 reporting areas in 2008: Atlanta, Denver, Detroit, Honolulu, Los Angeles, Miami, Phoenix, San Francisco, and Texas (table 33). Reported among the top 25 most commonly identified drugs in both 2007 and 2008, carisoprodol items increased slightly over the two periods in Atlanta, Los Angeles, and Texas. In 2008, drug items containing carisoprodol ranked eighth in Texas and Phoenix and 10th in Atlanta and Los Angeles among the 10 most frequently identified items from 22 CEWG areas (section II, table 1).

Weighted DAWN Estimates of ED Visits Involving Nonmedical Use of Carisoprodol, 2004–2007

Estimated numbers of ED visits and visit rates per 100,000 involving nonmedical use of carisoprodol increased significantly in 2 of 12 CEWG areas for which weighted DAWN data were available, namely Houston, where such visits increased by 166 percent, and Denver, which saw a 138-percent increase for the period 2004–2007. A significant decline of 15 percent in ED visits involving carisoprodol was observed for another area, San Diego, over the 4-year period. From 2005–2007, carisoprodol-involved ED visits rose by 211 percent in Houston, by 88 percent in Denver, and by 53 percent in Detroit. In Detroit, estimated ED visits involving carisoprodol also rose significantly in the period from 2005 to 2006 (by 55 percent) (table 36).

Appendix Tables

Appendix Table 1. Total Treatment Admissions by Primary Substance of Abuse, Including Primary Alcohol Admissions, and CEWG Area: CY 2008[1]

CEWG Areas	Number of Total Admissions							Total (*N*[4])
	Alcohol	Cocaine/ Crack[2]	Heroin	Other Opiates	Metham-phetamine[3]	Marijuana	Other Drugs/ Unknown	
Atlanta	2,766	1,853	349	414	497	1,769	457	8,105
Baltimore	2,797	2,700	10,019	564	8	2,079	188	18,355
Boston	6,039	1,440	8,641	613	117	641	765	18,256
Colorado	11,587	3,256	1,172	1,089	4,442	6,020	470	28,036
Denver	4,526	1,623	738	453	1,508	2,799	225	11,872
Detroit	2,470	2,005	3,050	137	2	1,239	24	8,927
Florida	13,245	8,902	1,080	4,699	732[3]	14,671	3,935	47,264
Hawai'i	3,289	355	174	NR[5]	2,885	2,016	339	9,058
Los Angeles	11,821	8,662	10,250	828	10,564	11,031	2,374	55,530
Maine	5,531	768	1,092	3,951	31	1,304	172	12,849
Maryland	22,534	8,463	16,879	4,982	58	11,069	1,388	65,373
Miami/Dade County	867	1,273	94	32	12	979	114	3,371
Ft. Lauderdale/ Broward County	1,001	775	110	264	16	1,611	407	4,184
Minneapolis/ St. Paul	10,131	1,905	1,292	1,187	1,101	3,199	448	19,263
New York City[6]	23,664	15,596	22,474	1,017	186	19,512	1,860	84,309
Philadelphia	3,378	3,439	2,503	136	2	3,592	1,691	14,741
Phoenix	1,699	429	709	167	1,238	711	96	5,049
San Diego	3,031	995	2,777	594	4,618	2,839	187	15,041
Seattle	5,124	2,455	1,784	614	1,353	2,326	547	14,203
St. Louis	4,038	2,127	2,249	235	318	2,836	165	11,968
Texas	23,928	19,247	9,945	5,381	7,458[3]	20,257	2,655	88,871

[1]Data are for January–December 2008.
[2]Cocaine values were broken down into crack or powder/other cocaine for the following areas: Atlanta (crack=1,080; powder or other cocaine=773); Baltimore (crack=2,332; powder or other cocaine=368); Boston (crack=1,068; powder or other cocaine=372); Colorado (crack=2,002; powder or other cocaine=1,254); Denver (crack=935; powder or other cocaine=688); Detroit (crack=1,851; powder or other cocaine=154); Florida (crack=5,758; powder or other cocaine=3,144); Los Angeles (crack=7,360; powder or other cocaine=1,302); Maine (crack=201; powder or other cocaine=567); Maryland (crack=6,789; powder or other cocaine=1,674); Miami/Dade County (crack=769; powder or other cocaine=504); Ft. Lauderdale/Broward County (crack=469; powder or other cocaine=306); Minneapolis/St. Paul (crack=1,444; powder or other cocaine=461); New York City (crack=8,119; powder or other cocaine=7,477); Phoenix (crack=319; powder or other cocaine=110); St. Louis (crack=1,899; powder or other cocaine=228); and Texas (crack=11,160; powder or other cocaine =8,087). No breakdowns by type of cocaine were available for Hawai'i, Philadelphia, San Diego, and Seattle.
[3]Methamphetamine and amphetamine are grouped together in Texas and Florida treatment data.
[4]These *N*'s are used in all percentage calculations involving total treatment admissions data for each area. Treatment data contain unknown primary admissions in Atlanta (*n*=3), Boston (*n*=565), Florida (*n*=3,044), Hawai'i (*n*=338), Maryland (*n*=2), Minneapolis/St. Paul (*n*=169), New York City (*n*=676), Philadelphia (*n*=12), and St. Louis (*n*=13). Since these cases may be classified as to route of administration and demographic characteristics, they are included in the numbers for these areas and are included with "Other Drugs/Unknown" in this table. Total admissions data for all other areas exclude unknowns.
[5]NR = Not reported by the CEWG area representative.
[6]Alcohol data for New York City are alcohol only=10,289, and alcohol in combination with other drugs=13,375.
ADDITIONAL NOTES to APPENDIX TABLE 1:
Hawai'i data report total admissions of 9,241, of which 183 did not report using any drugs at admission for substance abuse treatment; the *N* of 9,058 includes only cases in which a primary drug was reported. Phoenix data report total admissions of 9,156, of which 4,107 did not report using any drugs at admission for substance abuse treatment; the *N* of 5,049 includes only cases in which a primary drug was reported. Treatment data were provided by CEWG representatives between May 2009 and July 2009. Treatment admissions data for San Francisco were received for FY 2008 and were reported in the January 2009 CEWG meeting report. As such, they are not included in the cross-area treatment data presentations in section III, which focuses on the 2008 reporting period.
SOURCE: June 2009 State and local CEWG reports

Appendix Tables 2.1–2.22. NFLIS Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items in Forensic Laboratories for 22 CEWG Areas: January–December 2008

Appendix Table 2.1. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Atlanta: 2008[1]

Drug	Number	Percent
Cocaine	6,820	55.9
Methamphetamine	2,223	18.2
Alprazolam	522	4.3
3,4-Methylenedioxy-methamphetamine	410	3.4
Hydrocodone	400	3.3
Oxycodone	339	2.8
Heroin	268	2.2
1-(3-Trifluoromethylphenyl)-piperazine	227	1.9
Cannabis	175	1.4
Carisoprodol	114	0.9
Other Drugs[2]	709	5.8
Total	**12,207**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
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, April 14, 2009

Appendix Table 2.2. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Baltimore: 2008[1]

Drug	Number	Percent
Cannabis	19,611	36.2
Cocaine	19,112	35.3
Heroin	11,806	21.8
Oxycodone	715	1.3
Buprenorphine	567	1.0
Alprazolam	360	0.7
Clonazepam	218	0.4
Methadone	181	0.3
Hydrocodone	139	0.3
3,4-Methylenedioxy-methamphetamine	119	0.2
Other Drugs[2]	1,339	2.5
Total	**54,167**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for the Baltimore MSA, including Baltimore City and six counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, and Queen Anne's Counties.
2. "Negative Results—Tested for Specific Drugs" represents 221 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.3. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Boston: 2008[1]

Drug	Number	Percent
Cannabis	8,667	43.2
Cocaine	4,564	22.8
Heroin	1,964	9.8
Oxycodone	852	4.3
Buprenorphine	403	2.0
Clonazepam	370	1.8
Alprazolam	224	1.1
Hydrocodone	153	0.8
Methadone	130	0.6
3,4-Methylenedioxy-methamphetamine	106	0.5
Other Drugs[2]	2,613	13.0
Total	**20,046**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for all counties in the Boston MSA: Essex, Middlesex, Norfolk, Plymouth, Rockingham, Strafford, and Suffolk Counties.
2. "Noncontrolled Nonnarcotic Drug" represents 225 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.4. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Chicago: 2008[1]

Drug	Number	Percent
Cannabis	43,123	55.7
Cocaine	19,745	25.5
Heroin	10,121	13.1
3,4-Methylenedioxy-methamphetamine	1,163	1.5
Methamphetamine	781	1.0
1-Benzylpiperazine	380	0.5
Hydrocodone	365	0.5
Alprazolam	206	0.3
Phencyclidine	195	0.3
Acetaminophen	180	0.2
Other Drugs[2]	1,197	1.5
Total	**77,456**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
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. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.5. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Cincinnati: 2008[1]

Drug	Number	Percent
Cannabis	5,814	44.2
Cocaine	5,084	38.7
Heroin	886	6.7
Oxycodone	272	2.1
Hydrocodone	197	1.5
3,4-Methylenedioxy-methamphetamine	194	1.5
Alprazolam	100	0.8
Diazepam	61	0.5
Clonazepam	59	0.4
Methamphetamine	57	0.4
Other Drugs[2]	427	3.2
Total	**13,151**	**100.0**

[1] Data are for CY 2008: January 2008–December 2008.
[2] All other analyzed items.
NOTES:
1. Data are for Hamilton County.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.6. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Denver: 2008[1]

Drug	Number	Percent
Cocaine	3,069	39.0
Cannabis	2,202	28.0
Methamphetamine	1,034	13.1
Heroin	270	3.4
3,4-Methylenedioxymeth-amphetamine	177	2.2
Oxycodone	113	1.4
Hydrocodone	83	1.1
Psilocin	65	0.8
Alprazolam	45	0.6
3,4-Methylenedioxy-amphetamine	36	0.5
Other Drugs[2]	776	9.9
Total	**7,870**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008
[2]All other analyzed items.
NOTES:
1. Data are for Denver, Arapahoe, and Jefferson Counties.
2. "Noncontrolled Nonnarcotic Drug" represents 454 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.7. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Detroit: 2008[1]

Drug	Number	Percent
Cannabis	2,847	45.0
Cocaine	1,555	24.6
Heroin	503	8.0
Hydrocodone	405	6.4
3,4-Methylenedioxy-methamphetamine	232	3.7
Alprazolam	164	2.6
Oxycodone	86	1.4
Methamphetamine	70	1.1
Codeine	46	0.7
1-Benzylpiperazine	32	0.5
Other Drugs[2]	383	6.1
Total	**6,323**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for Wayne County.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.8. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Honolulu: 2008[1]

Drug	Number	Percent
Methamphetamine	847	44.8
Cannabis	492	26.0
Cocaine	318	16.8
Heroin	37	2.0
3,4-Methylenedioxy-methamphetamine	30	1.6
Oxycodone	17	0.9
1-Benzylpiperazine	14	0.7
Testosterone	14	0.7
Methadone	9	0.5
Hydrocodone	8	0.4
Other Drugs[2]	106	5.6
Total	**1,892**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for Honolulu County.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.9. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Los Angeles: 2008[1]

Drug	Number	Percent
Cannabis	18,527	34.5
Cocaine	17,892	33.4
Methamphetamine	8,923	16.6
Heroin	2,357	4.4
3,4-Methylenedioxy-methamphetamine	1,248	2.3
Hydrocodone	718	1.3
Phencyclidine	485	0.9
Alprazolam	227	0.4
Codeine	183	0.3
Carisoprodol	173	0.3
Other Drugs[2]	2,894	5.4
Total	**53,627**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for Los Angeles County.
2. "Negative Results—Tested for Specific Drugs" represents 561 cases and are included under "Other."
3. "No Controlled Drug Identified" represents 240 cases and are included under "Other."
4. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix 2.11. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maryland: 2008[1]

Drug	Number	Percent
Cannabis	22,090	38.1
Cocaine	20,121	34.7
Heroin	11,882	20.5
Oxycodone	728	1.3
Buprenorphine	567	1.0
Alprazolam	360	0.6
Clonazepam	218	0.4
Methadone	182	0.3
3,4-Methylenedioxy-methamphetamine	175	0.3
Phencyclidine	171	0.3
Other Drugs[2]	1,474	2.5
Total	**57,968**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for the State of Maryland.
2. "Negative Results—Tested for Specific Drugs" represents 221 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.10. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Maine: 2008[1]

Drug	Number	Percent
Cocaine	373	44.1
Cannabis	114	13.5
Heroin	82	9.7
Oxycodone	41	4.9
Methadone	34	4.0
Hydrocodone	27	3.2
Methamphetamine	22	2.6
Buprenorphine	15	1.8
Alprazolam	13	1.5
Psilocin	12	1.4
Other Drugs[2]	112	13.3
Total	**845**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for the State of Maine.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix 2.12. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Miami: 2008[1]

Drug	Number	Percent
Cocaine	19,156	65.5
Cannabis	4,928	16.9
Heroin	736	2.5
Alprazolam	558	1.9
3,4-Methylenedioxy-methamphetamine	259	0.9
Hallucinogen	236	0.8
Oxycodone	205	0.7
Methamphetamine	168	0.6
1-Benzylpiperazine	95	0.3
Hydrocodone	65	0.2
Other Drugs[2]	2,833	9.7
Total	**29,239**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for the Miami/Fort Lauderdale/Pompano Beach MSA and include Broward, Dade, and Palm Beach Counties.
2. "Controlled Substance" represents 1,647 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.13. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Minneapolis/St. Paul: 2008[1]

Drug	Number	Percent
Cocaine	1,307	28.2
Cannabis	1,257	27.2
Methamphetamine	1,228	26.5
3,4-Methylenedioxy-methamphetamine	190	4.1
Heroin	94	2.0
Oxycodone	65	1.4
Hydrocodone	48	1.0
Acetaminophen	33	0.7
Codeine	32	0.7
Amphetamine	28	0.6
Other Drugs[2]	346	7.5
Total	**4,628**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for 7 counties in Minnesota in the 13-county Minneapolis/St. Paul/Bloomington MN/WI MSA: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.14. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, New York City: 2008[1]

Drug	Number	Percent
Cocaine	25,162	45.2
Cannabis	14,557	26.1
Heroin	6,301	11.3
Alprazolam	1,395	2.5
Oxycodone	686	1.2
Phencyclidine	674	1.2
Methadone	601	1.1
Hydrocodone	448	0.8
Clonazepam	314	0.6
3,4-Methylenedioxy-methamphetamine	283	0.5
Other Drugs[2]	5,272	9.5
Total	**55,693**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for the New York City Police Department and five NYC boroughs: Bronx, Kings, Queens, New York, and Richmond.
2. "No Drug Found" represents 3,428 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.15. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Philadelphia: 2008[1]

Drug	Number	Percent
Cannabis	11,420	37.8
Cocaine	11,304	37.4
Heroin	3,316	11.0
Alprazolam	884	2.9
Oxycodone	860	2.8
Phencyclidine	782	2.6
Codeine	216	0.7
Hydrocodone	165	0.5
Clonazepam	140	0.5
Diazepam	79	0.3
Other Drugs[2]	1,072	3.5
Total	**30,238**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for Philadelphia County.
2. "No Controlled Drug Identified" represents 459 cases and are included under "Other."
3. "Noncontrolled Nonnarcotic Drug" represents 210 cases and are included under "Other."
4. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix 2.16. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Phoenix: 2008[1]

Drug	Number	Percent
Cannabis	2,402	38.8
Methamphetamine	1,351	21.8
Cocaine	1,224	19.7
Heroin	421	6.8
Oxycodone	98	1.6
Hydrocodone	86	1.4
3,4-Methylenedioxy-methamphetamine	57	0.9
Carisoprodol	47	0.8
Morphine	41	0.7
Alprazolam	34	0.5
Other Drugs[2]	437	7.1
Total	**6,198**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for Maricopa County.
2. "Noncontrolled Nonnarcotic Drug" represents 52 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.17. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Diego: 2008[1]

Drug	Number	Percent
Cannabis	10,226	51.6
Methamphetamine	3,955	20.0
Cocaine	2,498	12.6
Heroin	676	3.4
Hydrocodone	364	1.8
3,4-Methylenedioxy-methamphetamine	313	1.6
Oxycodone	202	1.0
Alprazolam	171	0.9
Diazepam	97	0.5
Clonazepam	95	0.5
Other Drugs[2]	1,224	6.2
Total	**19,821**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for San Diego County.
2. "Plant Material, Other" represents 276 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.18. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, San Francisco: 2008[1]

Drug	Number	Percent
Cocaine	6,845	28.5
Cannabis	6,675	27.7
Methamphetamine	3,983	16.6
Heroin	1,280	5.3
3,4-Methylenedioxy-methamphetamine	786	3.3
Oxycodone	690	2.9
Hydrocodone	589	2.4
Methadone	229	1.0
Morphine	204	0.8
Clonazepam	157	0.7
Other Drugs[2]	2,619	10.9
Total	**24,057**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
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. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.19. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Seattle: 2008[1]

Drug	Number	Percent
Cocaine	914	35.9
Cannabis	827	32.5
Methamphetamine	315	12.4
Heroin	112	4.4
Oxycodone	89	3.5
3,4-Methylenedioxy-methamphetamine	56	2.2
1-Benzylpiperazine	41	1.6
Hydrocodone	35	1.4
Dimethylsulfone	14	0.5
Phencyclidine	13	0.5
Other Drugs[2]	130	5.1
Total	**2,546**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for King County.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.20. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, St. Louis: 2008[1]

Drug	Number	Percent
Cannabis	8,630	50.3
Cocaine	2,958	17.2
Heroin	1,301	7.6
Methamphetamine	650	3.8
3,4-Methylenedioxy-methamphetamine	521	3.0
Hydrocodone	294	1.7
Alprazolam	267	1.6
Pseudoephedrine	230	1.3
Oxycodone	181	1.1
1-Benzylpiperazine	143	0.8
Other Drugs[2]	1,978	11.5
Total	**17,153**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for the St. Louis MO/IL MSA, which includes the City of St. Louis and 16 counties: St. Louis, St. Charles, Crawford, Jefferson, Franklin, Lincoln, Warren, and Washington Counties in Missouri; and Madison, St. Clair, Macoupin, Clinton, Monroe, Jersey, Bond, and Calhoun Counties in Illinois.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.21. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Texas: 2008[1]

Drug	Number	Percent
Cocaine	28,215	33.1
Cannabis	25,554	30.0
Methamphetamine	11,014	12.9
Alprazolam	3,750	4.4
Hydrocodone	3,322	3.9
Heroin	1,594	1.9
3,4-Methylenedioxy-methamphetamine	1,288	1.5
Carisoprodol	787	0.9
Clonazepam	618	0.7
1-Benzylpiperazine	402	0.5
Other Drugs[2]	8,700	10.2
Total	**85,244**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for the State of Texas.
2. "Noncontrolled Nonnarcotic Drug" represents 885 cases and are included under "Other."
3. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Appendix Table 2.22. Top 10 Most Frequently Identified Drugs of Total Analyzed Drug Items, Washington, DC: 2008[1]

Drug	Number	Percent
Cocaine	1,505	40.5
Cannabis	1,224	32.9
Heroin	324	8.7
Phencyclidine	240	6.5
3,4-Methylenedioxy-methamphetamine	78	2.1
Methamphetamine	77	2.1
1-Benzylpiperazine	62	1.7
1-(3-Trifluoromethylphenyl) piperazine	32	0.9
Oxycodone	27	0.7
Cathinone	14	0.4
Other Drugs[2]	132	3.6
Total	**3,715**	**100.0**

[1]Data are for CY 2008: January 2008–December 2008.
[2]All other analyzed items.
NOTES:
1. Data are for the District of Columbia only.
2. Percentages may not sum to the total due to rounding.
SOURCE: NFLIS, DEA, April 14, 2009

Participant List

National Institute on Drug Abuse
Community Epidemiology Work Group Meeting

Hotel Allegro
Chicago, Illinois
June 10–12, 2009

Cynthia L. Arfken, Ph.D.
Associate Professor
Wayne State University
2761 East Jefferson Avenue
Detroit, MI 48207
Phone: 313-993-3490
Fax: 313-993-1370
E-mail: carfken@med.wayne.edu

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

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

Joyce Bernstein, MSc., Ph.D.
Epidemiologist
Toronto Public Health
125 Memorial Park Avenue
Toronto, Ontario M4J 4Y6
Phone: 416-338-7855
Fax: 416-338-0921
E-mail: jbernste@toronto.ca

Caroline L. Brakat
Intelligence Analyst Assistant
National Drug Intelligence Center
U.S. Department of Justice
319 Washington Street, Fifth Floor
Johnstown, PA 15901
Phone: 814-532-4073
Fax: 814-532-5858
E-mail: Caroline.l.brakat@usdoj.gov

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

Jane Buxton, M.B.B.S., M.H.Sc., F.R.C.P.C.
Physician Epidemiologist and
Assistant Professor
BC Centre for Disease Control
University of British Columbia
655 West 12th Avenue
Vancouver, British Columbia
V5Z 4R4
Phone: 604-707-2573
Fax: 604-707-2516
E-mail: jane.buxton@bccdc.ca

M. Fe Caces, Ph.D.
Statistician/Demographer
Office of National Drug Control Policy
Executive Office of the President
Room 534
750 17th Street, N.W.
Washington, DC 20503
Phone: 202-395-3173
Fax: 202-395-6562
E-mail: mcaces@ondcp.eop.gov

Jennifer Choate
Facility Liaison
Drug Abuse Warning Network
48 Lawton Road, Apt. 3
Riverside, IL 60546
Phone: 708-442-7359
E-mail: jenniferchoate@westat.com

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

Elizabeth H. Crane, Ph.D., M.P.H.
Analyst
Office of Applied Studies
Drug Abuse Warning Network
Division of Facility Surveys, Office of
Applied Studies
Substance Abuse & Mental Health
Services Administration
U.S. Department of Health and
Human Services
Room 7-1044
1 Choke Cherry Road
Rockville, MD 20857
Phone: 240-276-1275
Fax: 240-276-1260
E-mail: elizabeth.crane@samhsa.hhs.gov

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

Samuel J. Cutler
Program Manager
Office of Addiction Services
Department of Behavioral Health/
Mental Retardation Services
City of Philadelphia
Suite 800
1101 Market Street
Philadelphia, PA 19107-2908
Phone: 215-685-5414
Fax: 215-685-4977
E-mail: sam.cutler@phila.gov

Damian Denson, M.P.H.
Doctoral Graduate Student
Community Health Sciences, School of
Public Health
University of Illinois at Chicago
1603 West Taylor Street
Chicago, IL 60612
Phone: 312-355-3991
Fax: 312-996-1450
E-mail: damianjdenson@yahoo.com

Brian J. Dew, Ph.D.
Associate Professor
Department of Counseling and
Psychological Services
Georgia State University
1210 Beech Haven Road
Atlanta, GA 30324
Phone: 404-808-5436
Fax: 404-413-8013
E-mail: bdew@gsu.edu

Kristen Dixion, M.A., L.P.C.
Evaluation Researcher
Division of Behavioral Health
Data and Evaluation
State of Colorado
3824 West Princeton Circle
Denver, CO 80236-3111
Phone: 303-866-7407
Fax: 303-866-7428
E-mail: kristen.dixion@state.co.us

Daniel P. Dooley
Senior Researcher
Boston Public Health Commission
Sixth Floor
1010 Massachusetts Avenue
Boston, MA 02118
Phone: 617-534-2360
Fax: 617-534-2422
E-mail: ddooley@bphc.org

Marya Hynes Dowell, M.H.S.
Drug Abuse Research Specialist
Inter-American Drug Abuse Control
Commission, Observatory on Drugs
1889 F. Street, N.W.
Washington, DC 20006
Phone: 202-458-6119
Fax: 202-458-3658
E-mail: mhynes@oas.or

Carol L. Falkowski
Director
Alcohol and Drug Abuse Division
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55115
Phone: 651-431-2457
Fax: 651-431-7449
E-mail: carol.falkowski@state.mn.us

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

Robert Hanson, M.A.
Manager, Surveillance
Office of Research and Surveillance
Drug Strategy and Controlled
Substances Programme
Healthy Environments and Consumer
Safety Branch
Health Canada
Room D982, A.L. 3509C
123 Slater Street
Ottawa, ON K1A 1B9
Canada
Phone: 613-948-8954
Fax: 613-948-7977
E-mail: robert_hanson@hc-sc.gc.ca

Heidi Israel, Ph.D., F.N.P., R.N., L.C.S.W.
Assistant Professor
Department of Orthopaedic Surgery
St. Louis University
School of Medicine
3625 Vista, FDY7N
St. Louis, MO 63104
Phone: 314-577-8851
Fax: 314-268-5121
E-mail: israelha@slu.edu

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

Jane C. Maxwell, Ph.D.
Senior Research Scientist
Gulf Coast Addiction Technology Transfer Center
University of Texas at Austin
Suite 335
1717 West 6th Street
Austin, TX 78703
Phone: 512-232-0610
Fax: 512-232-0617
E-mail: jcmaxwell@sbcglobal.net

Erin E. McKenna, M.S.
Intelligence Research Specialist
Drug Enforcement Administration
U.S. Department of Justice
700 Army-Navy Drive
Arlington, VA 22202
Phone: 202-307-7932
E-mail: EEMcKenna@dea.usdoj.gov

Bruce Mendelson, M.P.A.
Senior Data Consultant
Office of Drug Strategy
Denver Department of Human Services
1200 Federal Boulevard
Denver, CO 80204
Phone: 720-944-2158
Fax: 720-944-3083
E-mail: bruce.mendelson@denvergov.org

Corinne P. Moody
Science Policy Analyst
Controlled Substance Staff
Center for Drug Evaluation and Research
Office of the Center Director
U.S. Food and Drug Administration
Building 51, Room 5144
10903 New Hampshire Avenue
Silver Spring, MD 20993
Phone: 301-796-3152
Fax: 301-847-8736
E-mail: corinne.moody@fda.hhs.gov

John A. Newmeyer, Ph.D.
Epidemiologist
Haight-Ashbury Free Clinics, Inc.
2004 Gough Street
San Francisco, CA 94109
Phone: 415-931-5420
Fax: 415-776-8823
E-mail: jnewmeyer@aol.com

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

Lawrence Ouellet, Ph.D.
Research Associate Professor
Division of Epidemiology and Biostatistics
School of Public Health
University of Illinois at Chicago
MC-923
1603 West Taylor Street
Chicago, IL 60612-4394
Phone: 312-355-0145
Fax: 312-996-1450
E-mail: ljo@uic.edu

Artisha Polk, M.P.H.
Mathematical Statistician
Drug Enforcement Administration
U.S. Department of Justice
8701 Morrissette Drive
Springfield, VA 22152
Phone: 202-307-7180
Fax: 202-353-1263
E-mail: Artisha.R.Polk@usdoj.gov

Robin Pollini, Ph.D., M.P.H.
Assistant Professor
Division of Global Public Health
Institute of the Americas
MC 0507
10111 North Torrey Pines Road
La Jolla, CA 92093-0507
Phone: 858-534-0710
Fax: 858-534-7566
E-mail: rpollini@ucsd.edu

Cassandra Prioleau, Ph.D.
Pharmacologist
Drug and Chemical Evaluation Section
Office of Diversion Control
Drug Enforcement Administration
U.S. Department of Justice
8701 Morrissette Drive
Springfield, VA 22152-2490
Phone: 202-307-7294
Fax: 202-353-1263
E-mail: cassandra.prioleau@usdoj.gov

Sandra Putnam, Ph.D.
Project Director
Community Epidemiology Work Group
Social Solutions International, Inc.
1541 Stewartstown Road
Morgantown, WV 26505
Phone: 304-292-5148
Fax: 304-292-5149
E-mail: sputnam@socialsolutions.biz

Jan Scaglione, M.T., Pharm.D., DABAT
Clinical Toxicologist/Senior Specialist
Poison Information
Cincinnati Drug and Poison Information Center
ML-9004
3333 Burnet Avenue
Cincinnati, OH 45229
Phone: 513-636-5060
Fax: 513-636-5072
E-mail: jan.scaglione@cchmc.org

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

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

Margriet van Laar, Ph.D.
Program Director
Drug Monitoring
Coordinator, National Drug Monitor/
Focal Point
Trimbos Institute
Da Costakade 45
P.O. Box 725, 3500 AS Utrecht
The Netherlands
Phone: 31-30-297-11-00
Fax: 31-30-297-11-11
E-mail: mlaar@trimbos.nl

Michael G. Vrakatitsis, J.D.
Intelligence Research Specialist
Drug Enforcement Administration
U.S. Department of Justice
700 Army-Navy Drive
Arlington, VA 22202
Phone: 202-307-8430
E-mail: michael.g.vrakatitsis@usdoj.gov

Richard Weisskopf
State Opiate Treatment Authority
Illinois Department of Human Services
Suite 5-600
Division of Alcoholism and Substance Abuse
100 W. Randolph ST
Chicago, IL 60601
Phone: 312-814-6380
Fax: 312-814-2419
E-mail: richard.weisskopf@illinois.gov

Chyvette Williams, Ph.D.
Assistant Professor
Health Policy and Administration
Associate Director
Community Outreach Intervention Projects
School of Public Health
University of Illinois at Chicago
1603 West Taylor Street, MC923
Chicago, IL 60612
Phone: 312-355-5299
Fax: 312-996-5356
E-mail: chevy@uic.edu

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

Meeting Coordinator

Patricia Evans
MasiMax Resources, Inc.
Suite 175
1375 Piccard Drive
Rockville, MD 20850
Phone: 240-683-1756
Fax: 301-926-3156
E-mail: pevans@masimax.com

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