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Epidemiologic Trends In Drug Abuse

Volume I

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Community Epidemiology Work Group

Highlights and Executive Summary

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This publication, *Volume I*, is based primarily on papers presented and data reported by CEWG representatives from 21 areas at the June 2004 CEWG meeting, and presentations by an expert panel on prescription drug abuse. The text from the CEWG research papers appears in *Volume II. Volume II* also contains papers presented by the Panel on Prescription Drug Abuse, other researchers and law enforcement personnel, participants from Federal agencies, and researchers from Mexico's Epidemiologic Surveillance System of Addictions.

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

Both Volumes I and II (available in limited supply) can be obtained by contacting the National Clearinghouse for Alcohol and Drug Information

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FOREWORD

This *Executive Summary* is a synthesis of findings presented at the 56th semiannual meeting of the Community Epidemiology Work Group (CEWG) held in Arlington, Virginia, on June 8–11, 2004, under the sponsorship of the National Institute on Drug Abuse, National Institutes of Health.

Representing 21 sentinel areas in the United States, CEWG members presented reports, citing the most current data on drug abuse patterns, trends, and emerging drug problems in their areas. The areas represented in the CEWG are Atlanta, Baltimore, Boston, Chicago, Denver, Detroit, Honolulu, Los Angeles, Miami/Ft. Lauderdale, Minneapolis/St. Paul, New Orleans, New York City, Newark, Philadelphia, Phoenix, St. Louis, San Diego, San Francisco, Seattle, Texas, and Washington, DC. To enhance nonurban representation in the CEWG, information was provided by guest researchers from Maine and Ohio. One highlight of the meeting was a series of presentations by researchers in a Panel on Prescription Drug Abuse.

Findings from the CEWG network are supplemented by national data and by special presentations at each meeting. Publications are disseminated to drug abuse prevention and treatment agencies, public health officials, researchers, and policymakers. The information is intended to alert authorities at the local, State, regional, and national levels, and the general public, to current conditions and potential problems so that appropriate and timely action can be taken. Researchers also use the information to develop research hypotheses that might explain social, behavioral, and biological issues related to drug abuse.

At the June 2004 CEWG meeting, a keynote address was given by the Honorable John P. Walters, Director, White House Office of National Drug Control Policy. In addition to presentations by the 21 CEWG representatives and members of the Panel on Prescription Drug Abuse, the meeting included presentations on the following:

- NIDA's epidemiology research
- Emerging drugs, based on Drug Enforcement Administration data
- How to access local and State arrest data
- The status of and most recent data produced by the Canadian Community Epidemiology Network on Drug Use

In addition, updates were presented on three data sources: the Drug Abuse Warning Network, the Forensic Laboratory Information System, and the Arrestee Drug Abuse Monitoring program.

Moira P. O'Brien
National Institute on Drug Abuse
National Institutes of Health
Department of Health and Human Services

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INTRODUCTION

This *Executive Summary* is based on findings presented at the 56th semiannual meeting of the Community Epidemiology Work Group (CEWG) held in Arlington, Virginia, on June 8–11, 2004, under the sponsorship of the National Institute on Drug Abuse (NIDA), National Institutes of Health.

At the June 2004 meeting, CEWG members presented findings on illicit and licit drug abuse from the 21 CEWG areas. Their individual papers will appear in *Volume II* of the June 2004 *Proceedings*. To enhance nonurban representation in the CEWG, information was provided by guest researchers from Ohio and Maine. A keynote address was given by the Honorable John P. Walters, Director, White House Office of National Drug Control Policy.

One highlight of the June meeting was a special panel presentation on *Emerging/Current Trend: Prescription Drug Abuse*. Findings from this expert panel, and those from the CEWG that focused on prescription drug abuse, were published in NIDA's CEWG June 2004 *Advance Report*; they also appear in this volume and in *Volume II* of the June 2004 *Proceedings*.

In addition to the presentations by the 21 CEWG representatives and the Panel on Prescription Drug Abuse, the meeting included presentations on the following:

- NIDA's epidemiology research
- Emerging drugs, based on Drug Enforcement Administration data
- How to access local and State arrest data
- The status of the most recent data produced by the Canadian Community Epidemiology Network on Drug Use
- Updates on the Drug Abuse Warning Network, the Forensic Laboratory Information System, and the Arrestee Drug Abuse Monitoring Program

A brief description of the CEWG roles, functions, and attributes, as well as the major data sources used by the CEWG are presented below.

THE CEWG NETWORK:
ROLES, ATTRIBUTES, AND DATA SOURCES

Roles of the CEWG

The CEWG is a unique epidemiologic network designed to inform drug abuse prevention and treatment agencies, public health officials, policymakers, and the general public about current and emerging drug abuse patterns. CEWG members represent the 21 geographic areas shown in the map below.

The Functions of CEWG Meetings

The CEWG convenes twice each year, with ongoing communication between meetings via e-mail, conference calls, and mailings.

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

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

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

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

- Presentations by a panel of experts on a current or emerging drug problem identified in the previous CEWG meeting
- The "drug scene" in the host city and its surrounding environs, as depicted in presentations by local researchers, service providers, law enforcement personnel, and, in some meetings, substance abusers
- Updates by Federal personnel on key data sets used by CEWG members
- Drug abuse patterns and trends in Maine and Ohio
- Drug abuse patterns and trends in other countries, such as Canada and Mexico

Identification of changing drug abuse patterns is part of the interactive discussions at each CEWG meeting. Through this process, members can alert one another to the emergence of a potentially new drug of abuse that could spread from one area to another. The CEWG has pioneered in identifying the emergence of several drug epidemics, such as those involving abuse of methaqualone (1979), crack (1983), methamphetamine (1983), and "blunts" (1993).

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

Emerging/Current Trend is an approach followed at CEWG meetings since December 2002, and this is a direct product of the planning at the prior meeting and the subsequent followup activities. The Emerging/Current Trend at the June 2004 meeting was, as noted earlier, the Panel on Prescription Drug Abuse. In June 2003, a special panel was convened on Methadone-Associated Mortality, and in December 2003, a PCP Abuse Panel addressed the issue of phencyclidine abuse as a localized emerging trend.

The Emerging/Current Trend approach draws upon the following:

- CEWG members' knowledge of local drug abuse patterns and trends
- Small exploratory studies
- Presentations of pertinent information from federally supported data sources
- Presentations by other speakers knowledgeable in the selected topic area

The CEWG, with its semiannual meetings, is uniquely positioned to bring crucial perspectives to bear on urgent drug abuse issues in a timely fashion and to illuminate its various facets within the local context.

In discussions at the December 2003 meeting, CEWG members identified the issue of prescription drug abuse. This issue was an integral part of

the June 2004 CEWG meeting, and it constitutes major sections of this *Executive Summary*.

A listing of the CEWG reports and other papers published in *Volume II* of the June 2004 *Proceedings* appears in *Appendix A*.

Attributes of the CEWG

CEWG members bring the following attributes to the network:

- Extensive experience in community research, which over many years has fostered information sharing between members and local agencies
- Knowledge about their local communities, drugs, and drug-abusing populations; the social and health consequences of drug abuse; drug trafficking and other law enforcement patterns; and emerging drugs within and across communities
- Ongoing collaborative relationships with one another and other researchers and experts in the field, which allows for both learning about new issues and sharing information
- The capability to access relevant drug-related data from the literature, media, and Federal, State, community, and neighborhood sources
- An understanding of the strengths and limitations of each data source
- The skills required to systematically analyze and synthesize multiple sources of information, and interpret findings within the community context

While members rely on quantitatively based data sets and sources, they also use a variety of qualitative research methods at the local level to obtain more indepth information on drug-abusing populations and trends; these include ethnographic techniques, focus groups, and key informant interviews.

CEWG Data Sources

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

Emergency department (ED) mentions data for 19 CEWG metropolitan statistical areas were provided by the Drug Abuse Warning Network (DAWN), Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA), through 2002. The data reported here represent the most recent testing periods reported in the DAWN ED system for 2002 (1995, 2000, and 2001 compared with 2002). Up to four drugs may be recorded for each patient (age 6–97) who may visit the 24-hour non-Federal facilities more than once in a reporting year; thus, data cannot be used for prevalence estimates. Statistically significant changes ($p<0.05$) are reported as "percent change;" relative standard errors for DAWN tables are published on the Internet, as are other DAWN data, at *http//:samhsa.gov/oas/dawn.htm.* Subsequent CEWG publications will report data from the new DAWN ED system initiated in 2003. A brief description of the DAWN ED system from 1994 to 2002 is presented in *Appendix B*.

Drug-related mortality data are from the DAWN medical examiner/coroner mortality system, OAS, SAMHSA, for the years 1999–2002. The data include "drug-induced" deaths (i.e., those directly caused by a drug) and "drug-related" deaths (those in which a drug played a contributory role). Not all jurisdictions test for marijuana. Jurisdictional participation varies across areas, so that cross-area comparisons are not comparable. CEWG areas with full participation in the system are identified in the DAWN mortality exhibits in this report. A brief description of this DAWN data set appears in *Appendix C*.

Local medical examiner data from eight CEWG areas on major drugs are presented and cover the years 2000–2003. These data are not totally comparable across the eight sites or to the DAWN data. Miami data are for three counties (except cocaine, which is for two counties), and Minneapolis/St. Paul data are for two counties. Mortality data are also presented for a few States (see *Volume II* of the CEWG *Proceedings*).

Substance abuse treatment admissions data for 2000–2003 were extracted from State treatment databases (18 CEWG areas); the Treatment Episode Data Set (TEDS), maintained by OAS, SAMHSA (Washington, DC); and samples from Broward County, Florida. Arizona, Colorado, Hawaii, Illinois, and Texas representatives report statewide treatment admissions data. Data from some CEWG areas represent calendar years, while others represent a fiscal year (FY). Most areas reported full-year preliminary or final data for 2003; however, Baltimore reported data for the first half of 2003, and Miami reported sample data from the second half of 2003. The findings represent percentages of admissions for primary drugs of abuse; the denominators exclude alcohol admissions. *Appendix D* presents information on treatment admissions in each CEWG area in 2003.

Arrestee drug-testing data for 2000–2003 were derived primarily from the Arrestee Drug Abuse Monitoring (ADAM) program, supported by the National Institute of Justice (NIJ). In this final year of data collection, ADAM covered adult male arrestees in 18 CEWG areas. The data on males in 2003 were collected in various quarters: New York City, all 4 quarters; Los Angeles, 2 quarters; Boston, Houston, and Miami, the 4th quarter only; and in the other 13 areas, 3 quarters. Males were selected by probability sampling, and the data are weighted. Convenience sampling continued to be used to select the smaller samples of females during the same quarters; findings represent unweighted data and, thus, are not comparable to data on adult males. Urinalysis tests for 10 drugs, with confirmation to distinguish methamphetamine from amphetamines. Additional information can be accessed at *www.adam-nij.net.* A brief description of ADAM is provided in *Appendix E*.

Student survey data are from 12 CEWG areas that participated in the Youth Risk Behavior Survey (YRBS), supported by the Center for Disease Control and Prevention (CDC) and published in *Morbidity and Mortality Weekly Report* 53 (SS–2):1–29, 2004. The weighted samples represent students in grades 9–12 who reported using a drug "one or more times during their lifetime," and, for some drugs, use in the 30 days prior to the survey. Additional information on this survey can be accessed at *www.cdc.gov/HealthyYouth/yrbs/about_yrbss.htm.* A brief description of YRBS appears in *Appendix F.*

Forensic drug laboratory testing data for 2003 are from the National Forensic Laboratory Information System (NFLIS). Sponsored by the Drug Enforcement Administration (DEA), NFLIS accumulates drug analysis results from State and local forensic labs, which, as of May 2003, included 187 of the Nation's approximately 300 State and local labs, with 162 reporting regularly. Labs in 18 CEWG cities participated in NFLIS (the exceptions are Phoenix and San Francisco); also, the Texas Department of Public Safety submitted data from 13 Texas sites to NFLIS. Comparisons across CEWG areas are subject to distortion for several reasons. First, the data are not adjusted for population size. Also, there are variations within and across areas that can result in differences in drug seizures and analyses (e.g., police priorities, types of arrests from which drug specimens are taken, and other criminal justice procedures), and there are some inconsistencies in reporting times. A brief description of NFLIS is presented in *Appendix G*.

Heroin price and purity data are for 21 cities in 19 CEWG areas included in DEA's Domestic Monitor Program (DMP) in 2003. These data are preliminary. The DMP effort is described in *Appendix H*.

Drug seizure, trafficking, price, and purity data are extracted from the Department of Justice's *Narcotics Digest Weekly*, Volume 3, Number 29, July 20, 2004. DEA and other data on drug seizures, trafficking, price, and purity are extracted from CEWG reports.

Issues identified by the CEWG are highlighted for each drug category, followed by data from the major indicator sources. Information derived from CEWG meeting discussions and papers appears in *italic* type.

KEY FINDINGS

Prescription Drug Abuse. Abuse of prescription-type psychotherapeutic drugs has escalated substantially across the Nation and in CEWG areas since the early 1990s. Problems associated with the nonmedical use of prescription drugs have appeared increasingly in indicator data. The types of prescription drugs abused and the patterns of abuse differ notably by geographic area and population group. However, indicators of abuse of pain relievers appear across all CEWG areas. Particularly alarming is the abuse of prescription drugs among teenagers and young adults. Polydrug abuse is common among abusers of prescription drugs. Prescription drugs are often used nonmedically in sequence or in combination with other prescription drugs, illicit drugs, and alcohol. Among the combinations reported are central nervous system depressants such as benzodiazepines and alcohol—a potentially life-threatening mixture.

Polydrug Abuse. Abuse of both licit and illicit drugs, sequentially or in combination, continues to characterize a majority of drug abusers. Increased abuse of prescription-type drugs has contributed to the complexity of polydrug abuse, with potentially serious health consequences.

Heroin. Heroin abuse indicators remain relatively low (compared with cocaine/crack, marijuana, and, in some areas, methamphetamine indicators) across CEWG areas. The most notable exceptions are in Baltimore and Newark, where large numbers of heroin items were analyzed by forensic laboratories in 2003, and where rates of heroin ED mentions were highest in 2002. Heroin purity levels remained highest in northeastern cities, where South American heroin was widely available.

Cocaine/Crack. Cocaine/crack abuse indicators, which have remained stable at high levels over the years in most CEWG areas, began trending upwards in some northeastern cities. In 2002, rates of cocaine/crack ED mentions per 100,000 population were highest in Atlanta, Baltimore, Chicago, Miami, and Philadelphia, ranging from 239 (Atlanta) to 275 (Chicago). Cocaine-involved deaths in 2002–2003 were high in Baltimore, Chicago, Detroit, Miami, New York City, and Philadelphia. Changes in the demographics of abusers and patterns of cocaine/crack abuse were reported in most CEWG areas, with increased use of cocaine among Hispanic populations being one of the most frequently reported demographic changes.

Methamphetamine. Methamphetamine abuse indicators continued at very high levels in Honolulu, the west coast, southwest, and some midwestern areas, while they spread to and within areas east of the Mississippi River. Higher purity methamphetamine continued to be available from "super labs," located primarily in California and Mexico. At the same time, small clandestine labs continued to proliferate throughout the Nation, particularly in rural areas, and they continued to supply a low-quality methamphetamine.

KEY FINDINGS (cont.)

MARIJUANA. Marijuana abuse indicators were uniformly high in most CEWG areas. The percentages of male arrestees testing positive for marijuana in 2003 ranged from 30.9 percent in Honolulu to 53.2 percent in Chicago. Rates of marijuana ED mentions ranged between 111 and 150 per 100,000 population in Boston, Detroit, Miami, Philadelphia, and St. Louis in 2002. Increases in primary abuse of marijuana among treatment admissions were reported in Arizona, Detroit, Illinois, Los Angeles, and Philadelphia, while admissions continued to be highest in Minneapolis/St. Paul, at 46 percent of illicit drug admissions in 2003.

METHYLENEDIOXYMETHAMPHETAMINE (MDMA). MDMA abuse indicators decreased in almost all CEWG areas, with ED mentions increasing only in New Orleans and decreasing in nine CEWG areas between 2001 and 2002. CEWG members continue to report that pills sold as ecstasy may contain some or no MDMA and may be adulterated with various other substances.

PHENCYCLIDINE (PCP). PCP abuse indicators remain at low levels in most CEWG areas. They continue to be highest in Philadelphia and Washington, DC, where, respectively, around 11 and 12 percent of adult male arrestees tested positive for the drug in 2003, and 4.5 and 3.8 percent of treatment admissions were for primary abuse of PCP.

ISSUES AND FINDINGS FROM THE CEWG

PRESCRIPTION DRUG ABUSE

Much of the available data reported by the CEWG covers the general categories of "narcotic analgesics" or "other opiates" (i.e., opiates other than heroin). These data are presented first, followed by information on specific analgesics and opiates. The section concludes with indicator data on benzodiazepines/other depressants.

NARCOTIC ANALGESICS/ "OTHER OPIATES"

Narcotic analgesics are commonly referred to as "painkillers" or "pain relievers." "Other Opiates" refers to opiates other than heroin; this classification is used for some indicators and includes narcotic analgesics. Treatment admissions for the abuse of "other opiates" (excluding heroin) are increasing in some CEWG areas. Various narcotic analgesics are among the drug items analyzed by forensic laboratories.

DAWN ED Data on Narcotic Analgesics

The most recent DAWN data available at the time of the June 2004 CEWG meeting were from 2002. The characterization of trends using DAWN ED data is therefore limited to the period up to the end of 2002.

DAWN emergency department data show that rates for narcotic analgesics/combinations per 100,000 population increased significantly in 17 CEWG areas from 1995 to 2002 and in 2 other CEWG areas from 2000 to 2002 (*see exhibit 1 on the following page*). Rates continued to increase significantly from 2001 to 2002 in Baltimore, Newark, Philadelphia, and St. Louis, but they decreased in San Diego and Seattle. In 2002, the rates were highest in Baltimore, Boston, Detroit, New Orleans, and Seattle, ranging from 95 in Seattle to 165 per 100,000 population in Baltimore.

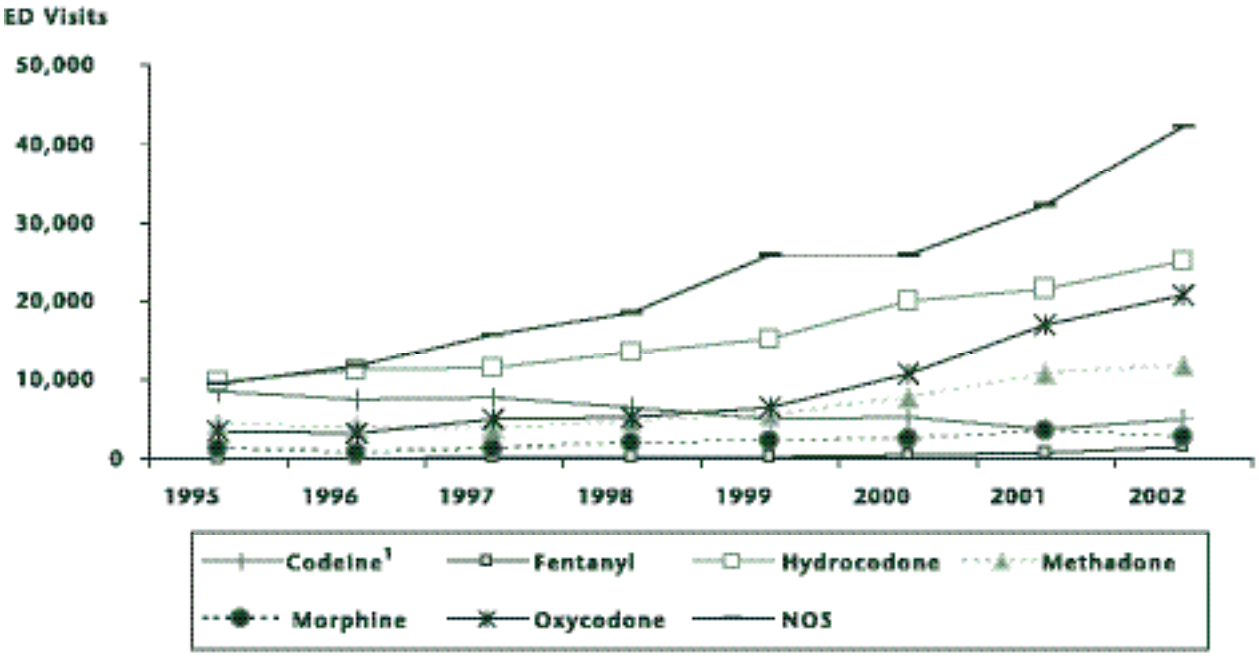
Hydrocodone and oxycodone were the narcotic analgesics most frequently mentioned in drug abuse-related ED visits in 2002. It should be noted that substantial percentages of the narcotic analgesic/combinations visits in all 21 DAWN areas in 2002 were in the "not otherwise specified" (NOS) category (*see exhibit 2 on the following page*), which means that the specific narcotic analgesic product was not identified in the hospital records. Data across all 21 DAWN areas in 2002 show that there were 108,320 mentions of narcotic analgesics/combinations; of these, 42,214 (nearly 40 percent) were in the NOS category.

Exhibit 1. Rates of Narcotic Analgesics/Combinations ED Mentions Per 100,000 Population in 19 CEWG Areas: 1995–2002

					Percent Change[1]		
CEWG Area	1995	2000	2001	2002	1995, 2002	2000, 2002	2001, 2002
Atlanta	24	37	30	30	27.2		
Baltimore	30	80	114	165	444.5	105.9	45.0
Boston	38	53	81	97	151.6	82.4	
Chicago	31	39	65	61	95.5	55.9	
Denver	22	38	41	34	50.1		
Detroit	58	56	69	97	71.7		
Los Angeles	18	23	25	28	54.0		
Miami	11	19	21	22	98.1		
Mpls./St. Paul	20	27	37	40	97.7	44.5	
New Orleans	41	55	74	98	141.0	79.3	
New York	34	30	41	55		82.5	
Newark	25	31	43	64	152.9	102.9	49.3
Philadelphia	31	55	67	81	164.0	47.4	21.0
Phoenix	24	63	64	62	155.5	47.4	
St. Louis	17	34	48	68	291.6	100.5	40.0
San Diego	20	41	52	46	128.0	10.2	-11.7
San Francisco	34	43	53	52	51.9	22.0	
Seattle	51	86	120	95	84.7	9.8	-21.1
Washington, DC	20	17	26	26		50.7	

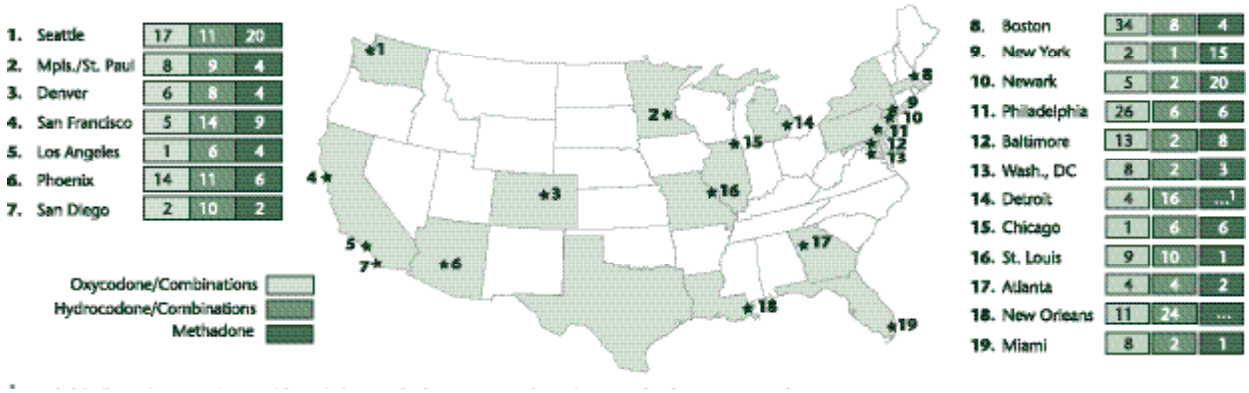
[1]These columns denote statistically significant ($p<0.05$) increases and decreases between estimates for the time periods noted.
SOURCE: DAWN, OAS, SAMH

Exhibit 2. Narcotic Analgesics That Changed in Frequency from 1995 to 2002



[1]Codeine-involved visits decreased from 1995 to 2002, but they increased from 2001 to 2002.
SOURCE: DAWN, OAS, SAMHSA <*http://oas.samhsa.gov/2k4analgesics.cfm*>

Exhibit 3. Rates of Hydrocodone/Combinations, Oxycodone/Combinations, and Methadone ED Mentions Per 100,000 Population in 19 CEWG Areas: 2002



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

Exhibit 3 depicts the rates of hydrocodone/combinations, oxycodone/combinations, and methadone mentions in 19 CEWG areas in 2002.

Mortality Data on Narcotic Analgesics

DAWN data on narcotic analgesics-involved deaths in 19 CEWG areas in 2002 are shown in exhibit 4.

The majority of the narcotic analgesics-related deaths in DAWN involved more than one drug. In 2002, the five CEWG areas where the largest proportion of deaths in which a narcotic analgesic was the only drug identified were Boston (24 percent), Denver (21 percent), Minneapolis/St. Paul (19 percent), and Atlanta and Chicago (each 15 percent). In the other 14 areas, the proportions of single-drug deaths ranged between 1 and 10 percent.

Of note is that the number of narcotic analgesics-involved death mentions reported to DAWN in 11 CEWG areas in 2002 exceeded those for cocaine, heroin/morphine, marijuana, and methamphetamine; these were Detroit, Minneapolis/St. Paul, New Orleans, Newark, New York, Philadelphia, Phoenix, St. Louis, San Diego, San Francisco, and Seattle.

Local/State mortality data were reported by several CEWG members and the Maine participant, all of whom obtain data from local or State medical examiners. The data are primarily for 2003 and thus provide more recent information than is available through DAWN; they also may cover areas not included in DAWN. State-level reports provide a regional perspective on trends impacting local CEWG areas. Note that because CEWG areas that report local medical examiner data categorize deaths involving "other opiates/narcotics"

Exhibit 4. Number of Narcotic Analgesics-Involved Death Mentions in 19 CEWG Areas: 1999–2002

CEWG Area	1999	2000	2001	2002
Atlanta	51	83	79	106
Baltimore[1]	122	147	164	236
Boston	74	118	206	176
Chicago	175	171	142	185
Dallas	61	101	115	172
Denver[1]	71	64	106	94
Detroit	284	298	354	410
Miami[1]	54	126	110	69
Mpls/St.Paul	37	47	77	90
New Orleans	124	118	200	352
New York	271	590	NR[2]	641
Newark	44	75	190	151
Philadelphia	370	501	460	440
Phoenix	291	318	261	217
St. Louis	65	77	78	123
San Diego[1]	137	179	164	123
San Francisco[1]	198	164	124	125
Seattle	43	75	85	133
Washington, DC	55	72	70	108

[1]In these sites, 100 percent of the population are covered.
[2]NR=Not reported (data were incomplete).
SOURCE: DAWN, OAS, SAMHSA

differently, the findings are not comparable across sites or to DAWN data.

Florida: *More people died from a lethal dose of a prescription drug than from an illicit street drug in Florida during 2003, continuing a pattern identified in 2002. Narcotic analgesics (as well as benzodiazepines) were the medications most frequently cited in these deaths.* —JAMES HALL

Maine: *Most deaths (82 percent) caused by pharmaceuticals were related to at least one narcotic or 'polydrug toxicity' with narcotics. Of the 113 narcotic pharmaceutical deaths in 2003, 39 (35 percent) involved a single substance and 65 percent involved narcotics in combination with other drugs. The most frequent combination was 2 or more narcotics (n=32); 6 of these deaths involved a combination of 3 narcotics.* —MARCELLA SORG

Seattle: *Other opiates were identified in 84 deaths in 2003, 5 of which involved no other drugs. The total number of prescription opiate-involved deaths has tripled since 1997; this increase is related almost entirely to prescription opiates in combination with other drugs.* —CALEB BANTA-GREEN

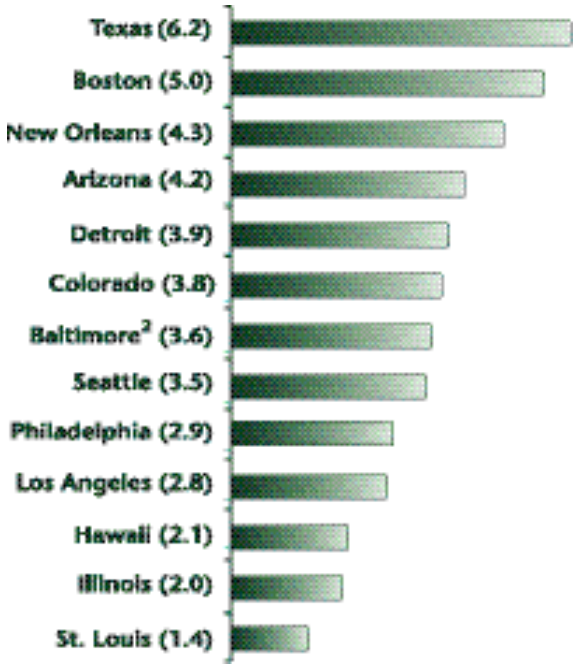
The Seattle representative provided the following caveat, which may well apply to other areas:

What constitutes a prescription opiate-related death is unclear, particularly among opiate-tolerant individuals. Issues of tolerance, potentiation with other drugs, and overlapping therapeutic and lethal dose levels complicate assigning causation in prescription opiate-involved fatalities. The cause of death in 11 percent of deaths involving prescription opiates is ruled to be undetermined. The source and form of prescription opiates involved in deaths are often undetermined as well.

Treatment Data on Other Opiates

Treatment admissions data on other opiates were reported by 17 CEWG areas (exceptions were Atlanta, Miami, Minneapolis/St. Paul, and San Francisco). Exhibit 5 shows the most recent data for 13 CEWG areas where primary "other opiate" admissions exceeded 1 percent of all illicit drug admissions.

Exhibit 5. Percentages of Primary "Other Opiate" Treatment Admissions (Excluding Alcohol) in 13 CEWGAreas: 2003[1]



[1]Represents either calendar or fiscal year 2003.
[2]Represents only the first half of calendar year 2003.
SOURCE: CEWG June 2004 reports on State and local data

Four other CEWG areas reported that between 0.2 and 0.9 percent of primary admissions (excluding alcohol) in 2003 were for other opiates. These were New York, Newark, San Diego, and Washington, DC. In Illinois, treatment data related to other opiates include other drugs (tranquilizers, sedatives) and are not reported here.

Several CEWG members described the increase in other opiate treatment admissions in their areas; some provided demographic data on these admissions and some provided statewide data.

Baltimore: *Treatment admission rates for opiates other than heroin more than doubled between 1999 and 2002, from 19 per 100,000 population age 12 and older to 44 per 100,000, and were projected to reach 52 per 100,000 in 2003.*—LEIGH HENDERSON

Boston: *Comparison of the last full year of data (FY 2003) to previous years shows the number reporting other opiates as their primary drug (n=780) increased 242 percent from FY 2000 and 622 percent from FY 1996. The number of mentions of current other opiate use (n=1,452) increased 87 percent from FY 2000, and 196 percent from FY 1996.… In the first half of FY 2004, there were 352 admissions (4 percent of all admissions) identifying other opiates/synthetics as the primary drug and 745 mentions (8 percent of all admissions) of past-month other opiate use among those admitted to State-funded treatment programs.* —DANIEL DOOLEY

Los Angeles: *Between July and December 2003, 645 (2.4 percent) of all admissions to Los Angeles County-based treatment and recovery programs reported other opiates/synthetics as their primary drug. This number was 11 percent higher than [that] reported in the previous 6 months of 2003 and 58 percent higher than the number reported in the second half of 2002….Sixty-four percent of the primary other opiate/synthetic admissions reported no secondary or tertiary drug of abuse; 7 percent reported heroin use and 9 percent reported primary alcohol use.* —BETH FINNERTY

Maryland: *Treatment admissions related to opiates nearly tripled in Maryland from FY 1999 to 2003.* —ERIC WISH

New Orleans: *In the first 9 months of FY 2004, 68 (4 percent) treatment admissions in Orleans Parish were for primary abuse of other opiates; all but 7 were White.* —GAIL THORNTON-COLLINS

Newark: *In 2003, primary admissions for 'other opiates or synthetics' in Newark City totaled only 12 (0.2 percent of admissions, excluding alcohol admissions). The number was higher in the metropolitan statistical area—189 (1.3 percent of admissions, excluding alcohol)…. However, in the State as a whole, primary admissions for other opiates totaled 1,049, or 2.7 percent of all admissions, excluding alcohol. This is more than double the number of admissions reported in 1997 (513). The largest increase in numbers of other opiate admissions occurred between 2000 (592) and 2002 (1,124). In 2003, admissions reporting other opiates as a primary, secondary, or tertiary drug of abuse numbered 2,303 and accounted for nearly 6 percent of all drug admissions statewide. In the Treatment Episode Data Set for New Jersey in the first half of 2003, 91.6 percent of the primary other opiate admissions were White and 6.6 percent were Black. About 62 percent were male.* —ANNA KLINE

Seattle: *The number of treatment admissions for prescription opiate use increased from 343 in 1999 to 921 for adults in 2003 and from 6 to 41 for youth. (Only data on use of prescription opiates as the primary drug are available.) Past analyses showed that 15 percent of those admitted to methadone maintenance programs in 2001 reported prescription opiates as one of the three main drugs they were currently using. These analyses also indicate that private-pay methadone treatment clients are more likely to report prescription opiate use than those who receive public funding.* —CALEB BANTA-GREEN

Texas: *Of the 2,293 clients who entered treatment for use of opiates other than heroin in 2003 (4 percent of all clients), 66 used illicit methadone. Of the other 2,227, 54 percent were female; the average age was 35; 84 percent were White; 35 percent had never been in treatment; 8 percent were homeless; 16 percent were employed; and 30 percent were referred by the criminal justice system.* —JANE MAXWELL

NFLIS Data on Narcotic Analgesics

Small numbers of narcotic analgesic items were reported to NFLIS from CEWG areas in 2003. Data on the four narcotic analgesics most frequently reported are presented in exhibit 6. The data were reported from 17 of the 18 CEWG areas included in NFLIS. The Department of Public Safety submitted data to NFLIS from its 13 Texas sites. Because these data are not adjusted for population size and represent variations in law enforcement practices, they are not comparable across sites.

Exhibit 6. Estimated Numbers of Analyzed Narcotic Analgesic Items in 18 CEWG Areas: 2003

NFLIS Area	Hydrocodone	Oxycodone	Methadone	Codeine
Atlanta	244	184	61	22
Boston	43	79	19	6
Chicago	36	0	59	12
Denver	33	17	5	7
Detroit	0	0	5	39
Honolulu	14	8	8	0
Los Angeles[1]	1	143	14	73
Miami	27	61	6	8
New Orleans	95	18	21	6
New York	99	96	426	51
Newark	0	11	0	0
Philadelphia	76	331	28	98
St. Louis	29	36	17	36
St. Paul	18	42	0	7
San Diego	124	30	11	29
Seattle	23	29	13	6
Texas	1,212	174	63	58
Wash., DC	6	25	23	5

[1]Data are not complete for all months.
SOURCE: NFLIS, DEA

Polydrug Abuse

Use of narcotic analgesics/other opiates with other drugs is indicated in the DAWN data systems, as well as local mortality and treatment data. Several CEWG members report on the use of these drugs with other substances:

Chicago: *The occasional use of other opiates is common among young noninjecting heroin users in Chicago. Seventy percent of participants in one study reported ever trying codeine, Tylenol 3 and 4, Dilaudid, Demerol, morphine, or methadone without a legal prescription.* —**DITA BROZ**

Minneapolis/St. Paul: *One local middle school reported several incidents of students bringing handfuls of prescription medications, including narcotic analgesics and benzodiazepines, to school to share with friends.* —**CAROL FALKOWSKI**

Polydrug patterns are also prominent in the abuse of specific narcotic analgesics/opioids described in the remainder of this section.

Hydrocodone

Hydrocodone products abused include Vicodin, Lortab, and Lorcet. In Los Angeles County, Vicodin retails for $5–$10 per tablet, and in Tyler, Texas, a tablet sells for $5. In San Antonio, hydrocodone sells for $1–$5 per pill. Across CEWG areas, hydrocodone indicators appear in ED, mortality, treatment, poison control center, and law enforcement data.

DAWN ED Data on Hydrocodone

Across the coterminous United States from 1995 to 2002, drug abuse-related ED visits involving hydrocodone increased 159 percent; from 2001 to 2002, a 17-percent increase was observed.

In CEWG areas, rates of hydrocodone/combinations ED mentions per 100,000 population in 2002 were highest in New Orleans (24), Detroit (16), San Francisco (14), Phoenix and Seattle (each 11) (*see exhibit 3, page 9*). Hydrocodone/combinations mentions increased significantly in Seattle from 2001 to 2002, while they decreased in Baltimore and San Diego.

CEWG reports detail the DAWN data, as illustrated in the examples below:

Chicago: *Hydrocodone/combinations ED mentions increased between 1995 (n=152) and 2002 (330), a change of 117 percent. Mentions remained level between 2001 (339) and 2002.* —Dita Broz

Denver: *The number of hydrocodone/combinations ED mentions climbed from 65 in 1995 to 150 in 2002, a statistically significant increase of 130.8 percent.* —Bruce Mendelson

Detroit: *Hydrocodone and hydrocodone/combinations ED mentions began to be reported in southeast Michigan in 1994. The number of hydrocodone/combinations ED mentions increased significantly by 407 percent between 1995 (n=129) and 2002 (654), and between 2000 (371) and 2002.* —Phil Chvojka

Miami: *Hydrocodone-in-combination with acetaminophen ED mentions increased 300 percent, from 10 mentions in 1995 to 40 in 2002.* —James Hall

San Francisco: *Hydrocodone ED mentions rose sharply from 2000 to 2002. Local street-based observers concur that the use of this drug is on the rise.* —John Newmeyer

Local/State Mortality Data on Hydrocodone

Medical examiner data on hydrocodone-related deaths were reported from five CEWG areas:

Detroit: *Hydrocodone was identified by the Wayne County ME lab in 60 decedents in 2000, 80 in 2001, 120 in 2002, and in 108 cases in 2003.* —Phil Chvojka

Miami/Florida: *Miami-Dade County reported 15 hydrocodone-related deaths during 2003; 5 (33 percent) were hydrocodone-induced. Broward County recorded 38 hydrocodone-related deaths during that period; 20 (53 percent) were hydrocodone-induced. In Palm Beach County, 9 (17 percent) of the 52 hydrocodone-related deaths in 2003 were hydrocodone-induced.*

Statewide, the number of hydrocodone deaths increased 3 percent between 2002 and 2003 to 572 cases, after having increased 32 percent from 420 in 2001 to 554 in 2002. Hydrocodone was the cause of death in 31 percent of the hydrocodone-related deaths in 2003. —James Hall

Philadelphia: *Hydrocodone mentions in mortality cases have increased. There were 40 positive toxicology ME reports for hydrocodone in 2003 and a total of 188 cases in the 10-year period from 1994 through 2003. Hydrocodone-positive deaths now rank 15th among all substances tested by the ME.* —Samuel Cutler

Seattle: *There were 12 hydrocodone-related deaths in Seattle in 2003, an increase from 1997.* —Caleb Banta-Green

Texas: *Statewide, there were 25 deaths involving hydrocodone in 1999, compared with 52 in 2000, 107 in 2001, and 168 in 2002.* —Jane Maxwell

Treatment and Poison Control Center (PCC) Data on Hydrocodone

The hydrocodone abuse problem is also reflected in treatment and PCC data, as exemplified by excerpts from several CEWG reports:

Denver: *In areas throughout the State, clinicians are anecdotally reporting clients' increased use of Vicodin.* —BRUCE MENDELSON

Detroit: *In 2003, 186 cases of intentional exposure to hydrocodone were reported to the Detroit-area poison control center, which is more than 3 times as many cases as in 2002. For the first 4 months of 2003, 54 intentional exposures to hydrocodone were reported to the statewide poison control network.* —PHIL CHVOJKA

Texas: *The penetration rate of hydrocodone cases (rate per 100,000 population) reported to Texas Poison Control Centers increased by 112 percent between 1998 and 2003. The average age of the cases in 2003 was 32, and 52 percent were male.* —JANE MAXWELL

NFLIS Data on Hydrocodone

Forensic laboratories reporting to NFLIS in 2003 analyzed hydrocodone items in 16 of the CEWG areas shown earlier in exhibit 6 (*see page 12*). The numbers of hydrocodone items analyzed were high in Atlanta (244), Los Angeles (143), San Diego (124), New York City (99), and New Orleans (95).

Reporting on lab cases in Broward County, Florida (a non-NFLIS site), the CEWG Miami/Ft. Lauderdale representative noted that "there were 88 hydrocodone lab cases in the first 6 months of 2003, compared with 77 cases in the last half of 2002."

Diversion Data on Hydrocodone

Diversion of hydrocodone products is reported from three CEWG areas:

Atlanta: *Hydrocodone (Vicodin), which is abused in Atlanta, is obtained by doctor-shopping or purchasing from dealers. Some dealers steal prescription pads or rob pharmacies.* —KRISTIN WILSON

Detroit: *Law enforcement sources report that Vicodin is commonly available, with some of it being diverted from pain clinic patients.* —PHIL CHVOJKA

New Orleans: *Hydrocodone, especially Vicodin, is widely diverted in New Orleans.* —GAIL THORNTON-COLLINS

OXYCODONE

Oxycodone is marketed in a variety of products including OxyContin, Percocet, Percodan, and Tylox, all of which have been diverted to the illicit market. OxyContin sells on the streets of several CEWG cities for the equivalent of $1 per milligram or less, as reported by representatives from Atlanta, Boston, Denver, Los Angeles, New York, St. Louis, San Antonio and Tyler, Texas, and Washington, DC. Tablets, obtained illegally, are sometimes crushed and dissolved in water, and the solution is injected. Indicators of oxycodone abuse were reported in emergency department, mortality, treatment, poison control center, Helpline, and law enforcement data across CEWG areas.

DAWN ED Data on Oxycodone

Across the coterminous United States, drug abuse-related visits involving oxycodone (specifically identified) increased 512 percent from 1995 to 2002; however, the number of visits was stable from 2001 to 2002.

Across CEWG areas, rates of DAWN ED mentions of oxycodone/combinations in 2002, as shown earlier in exhibit 3 (*see page 9*), were highest in Boston (34) and Philadelphia (26), followed by Seattle (17), Phoenix (14), and Baltimore (13). Oxycodone/combinations ED mentions did not decrease significantly in any CEWG area from 2001 to 2002, but they did increase significantly in five—Baltimore, Detroit, St. Louis, San Francisco, and Seattle.

Excerpts from several CEWG reports exemplify the attention given to the DAWN ED data by CEWG members:

Boston: *Of the 21 cities covered in DAWN, Boston had the highest estimated rate of oxycodone/combinations ED mentions (34), 3.8 times the national rate of 9.0.* —**Daniel Dooley**

Chicago: *Oxycodone/combinations ED mentions increased significantly between 2000 and 2002, from 24 to 80. Oxycodone ED mentions also increased significantly from 2000 to 2002. Between 2001 and 2002, oxycodone ED mentions rose from 37 to 72 mentions, a change of 95 percent. Reports of OxyContin use remain uncommon.* —**Dita Broz**

Denver: *ED mentions of oxycodone/combinations increased from 57 in 1995 to 116 in 2002, a statistically significant increase of 103.5 percent.* —**Bruce Mendelson**

Miami: *Oxycodone ED mentions increased significantly from 1 in 1995 to 107 in 2002. Oxycodone-in-combination with acetaminophen ED mentions increased 133 percent, rising from 24 ED mentions to 56 over the same 7-year period.* —**James Hall**

San Francisco: *From 2000 through 2002, oxycodone ED mentions rose steeply. Street observers also found abuse of this narcotic analgesic to be increasing.* —**John Newmeyer**

Seattle: *Trends in oxycodone vary by formulation: oxycodone-in-combination with acetaminophen (e.g., Percocet) stayed level for the prior 8 years, while oxycodone (e.g., OxyContin) as the sole drug increased from a rate of zero to 11 per 100,000 population. Oxycodone-involved mentions represented 18 percent of narcotic-involved ED mentions in 2002.* —**Caleb Banta-Green**

Data from a local Florida ED exemplify the use of other drugs among cases involving oxycodone:

In the **Broward County** *emergency department, co-ingestants in the oxycodone cases included benzodiazepines in 35 percent of the cases, marijuana in 15 percent, cocaine in 28 percent, and other opioids such as heroin or methadone in 15 percent.* —**James Hall**

Local/State Mortality Data on Oxycodone

Mortality data from seven areas show increases in oxycodone-related deaths in five:

Detroit: *Oxycodone was found in 10 decedents in Wayne County in 2000, 13 in 2001, 12 in 2002, and 19 in 2003.* —**Phil Chvojka**

Honolulu: *Of the 40 other opiate deaths in Honolulu in 2003, the majority involved oxycodone.* —**D. William Wood**

Maine: *Oxycodone-related deaths more than quadrupled from 2001 to 2002, increasing from 5 to 22; they decreased slightly to 19 in 2003 (14 percent of deaths). An additional five cases caused by 'polydrug toxicity' had oxycodone and other drugs present in the toxicology findings.* —**Marcella Sorg**

Florida: *Miami-Dade County reported 19 oxycodone-related deaths during 2003; 7 (37 percent) were oxycodone-induced deaths. Broward County recorded 81 oxycodone-related deaths; 57 (70 percent) were oxycodone-induced. Only five of the deaths involved oxycodone alone. In Palm Beach County, there were 53 oxycodone-related deaths; 21 (40 percent) were oxycodone-induced. Another drug was present in 87 percent of the cases…. Statewide, the number of oxycodone deaths increased 7 percent between 2002 and 2003 after having increased 10 percent from 537 in 2001 to 589 in 2002. Oxycodone was the cause of death in 47 percent of the oxycodone cases in 2003. When the above ME mentions are added to those for heroin, these opioid-related ME mentions in Florida in 2003 totaled 2,073, a 2-percent increase from the previous year. With the addition of other opioids that were first tracked in 2003, the total of deaths for this category for that year was 3,401 statewide. Most were polydrug episodes, including 87 percent of the oxycodone ME cases, 86 percent of the methadone ME cases, 78 percent of the hydrocodone ME cases, 81 percent of the heroin deaths, 79 percent of propoxyphene deaths, and 70 percent of morphine ME cases.* —**James Hall**

Philadelphia: *Oxycodone was detected in 318 decedents from 1994 through 2003 (tied for eighth most frequently detected drug during that time period). Detections of oxycodone have been rapidly increasing since 2000. In 2003, oxycodone was present in 9.6 percent of all drug-positive deaths.* —SAMUEL CUTLER

Seattle: *There were 14 oxycodone-related deaths in Seattle in 2003, a decrease from a peak of 20 in 2002.* —CALEB BANTA-GREEN

Texas: *There were 8 deaths statewide with a mention of oxycodone in 1999, 20 in 2002, 40 in 2001, and 56 in 2002.* —JANE MAXWELL

Treatment, PCC, and Helpline Data on Oxycodone

Representatives from several CEWG areas continued to report data from treatment facilities, PCCs, and Helplines on the use and abuse of oxycodone products:

Boston: *Helpline mentions of oxycodone continued to show dramatic increases. In 2003, there were 642 calls to the Helpline during which oxycodone or a derivative was self-identified as a substance of abuse (8 percent of all mentions). The percentage of Helpline call mentions attributable to oxycodone and derivatives increased 45 percent from 2002 and 77 percent from 2001.*—DANIEL DOOLEY

Colorado: *Clinicians across the State are anecdotally reporting increased use of OxyContin.* —BRUCE MENDELSON

Detroit: *Oxycodone was involved in 15 cases reported to the 2 statewide poison control centers through the first 4 months of 2004.*—PHIL CHVOJKA

Philadelphia: *The nonmedical use of oxycodone products, including OxyContin, Percocet, Percodan, Roxicet, and Tylox, continues to be reported by individuals in treatment.* —SAMUEL CUTLER

Texas: *In Texas, there was a 390-percent increase in the rate of oxycodone misuse or abuse cases reported to Texas Poison Control Centers between 1998 and 2003. The average age was 30.6, and 63.0 percent were male.* —JANE MAXWELL

NFLIS Data on Oxycodone

Forensic laboratory data for 2003 show that oxycodone items were reported in all areas except Chicago and Detroit (*see exhibit 6, page 12*). The number of oxycodone items analyzed were high in Philadelphia (331) and Atlanta (184), with the numbers ranging between 8 (Honolulu) and 96 (New York City) in the other 14 areas.

Availability, Diversion, Trafficking, and Seizure Data on Oxycodone

Oxycodone products continue to be diverted, e.g., through pharmacy thefts, "doctor shopping," and forged prescriptions, as indicated in several reports from CEWG participants:

Boston: *Drug lab submissions show a 30-percent increase in the number of oxycodone samples from 2002 to 2003 (212 and 275 samples, respectively) and a 99-percent increase from 2001 (n=138). [However], statewide, OxyContin thefts have continued to decrease in number. There were 62 statewide OxyContin thefts from pharmacies during 2003, compared with 93 thefts in 2002, and the peak of 139 thefts in 2001. First quarter 2004 OxyContin thefts are down as well (7 thefts).*—DANIEL DOOLEY

Denver: *The DEA reports that the diversion of OxyContin continues to be a 'major problem' in the Rocky Mountain West [and] that pharmacy break-ins are common, with OxyContin leading the list of the drugs stolen.* —BRUCE MENDELSON

Detroit: *Reports continue of oxycodone being smuggled from Canada [and] of household (especially homes of cancer patients) break-ins and armed robberies related to the drug. Some pharmacies have posted signs that they no longer carry OxyContin.* —PHIL CHVOJKA

Florida: *Florida is one of the largest markets for OxyContin. In July 2002, a tractor-trailer truck containing $3 million in prescription drugs was hijacked en route to Broward County.* —JAMES HALL

Los Angeles: *[Regarding oxycodone], LA CLEAR reports increases in the prevalence of burglaries, thefts, and robberies of residences and pharmacies.* —BETH FINNERTY

Maryland: *A case study of OxyContin abusers recruited through physicians in Maryland showed that OxyContin is diverted to the illicit market. The OxyContin abusers had an extensive history of polysubstance abuse.* —ERIC WISH

Minneapolis/St. Paul: *Law enforcement seizures of oxycodone increased.* —CAROL FALKOWSKI

New Orleans: *Oxycodone (e.g., Percodan) is widely diverted in New Orleans.* —GAIL THORNTON-COLLINS

New York City: *According to the Street Studies Unit (SSU), OxyContin is available on the street in New York City; however, you have to know who is selling it. In the Bronx, the SSU continues to report instances of OxyContin being sold to dealers who scrape the top coloring off, reduce the balance of the pill to powder, and mix it with heroin to produce an enhanced high… In one area of New York City, researchers were able to obtain information that OxyContin was selling for $5 a pill (unknown milligrams), but it was very difficult to get because most dealers sell only the whole bottle, not individual pills.* —ROZANNE MAREL

Ohio: *OxyContin remains the primary pharmaceutical opioid of choice among drug abusers; however, higher prices and lower availability (related to increased media attention) have made the drug more difficult to obtain. Information from Ohio's Substance Abuse Monitoring (OSAM) Network (based on archival data and ethnographic research) from Akron, Cleveland, Columbus, Dayton, Toledo, and Youngstown shows increasing availability and abuse of OxyContin, predominately by White females.* —HARVEY SIEGAL

Texas: *In Texas, hydrocodone is a much larger problem than oxycodone.* —JANE MAXWELL

It was reported that OxyContin abuse continues to be of concern to law enforcement officials in Atlanta and St. Louis.

METHADONE

Methadone, widely used since the 1960s to treat heroin addiction, has gained popularity as an analgesic (pain reliever) since the late 1990s. DEA data (ARCOS–2) show a continued increase in the retail distribution of methadone to pharmacies, hospitals, practitioners, and teaching institutions (see page 98. Concern about the increase in methadone-related deaths, emergency department visits, and diversion of the drug was addressed by the CEWG "Panel on Methadone-Associated Mortality" at the June 2003 meeting are presented on pages 81–106. Methadone sells on the streets of Dallas for $40 per tablet and in Chicago for $0.75 to $1 per milligram. Updates on these issues are provided in national data and by CEWG members in this section.

DAWN ED Data on Methadone

Rates of methadone ED mentions in 2002 were highest in Newark and Seattle (each 20 per 100,000 population) and in New York City (15) (*see exhibit 3, page 9*). Rates of methadone ED mentions increased significantly from 2001 to 2002 in Baltimore, Newark, and Philadelphia, but decreased in Atlanta, Denver, St. Louis, San Diego, San Francisco, and Seattle.

In some CEWG areas, methadone ED mentions accounted for a substantial proportion of the narcotic analgesic ED mentions in 2002, as in the examples below:

Newark: *Of the 1,115 ED narcotic analgesics/combinations mentions in 2002, methadone accounted for 346, or 31 percent, of the mentions, which is a significant increase from the 152 mentions reported in 2000.* —ANNA KLINE

Seattle: *Methadone was the most commonly identified type of opioid drug, constituting 21 percent of all opioid ED mentions in 2002.* —CALEB BANTA-GREEN

Local/State Mortality Data on Methadone

Drug-related mortality data were reported by six CEWG participants:

Chicago: *According to the Chicago Department of Public Health, methadone was mentioned in 25 death certificates as the cause of death in 2002.* —DITA BROZ

Florida: *Methadone-related deaths statewide increased 9 percent between 2002 and 2003, when they reached 608. This followed a larger increase of 56 percent between 2001 and 2002. Methadone was the cause of death in 60 percent of the methadone cases in 2003.… Miami-Dade County reported three methadone-related deaths in 2003; all were methadone-induced. Broward County recorded 51 methadone-related deaths during that period, with 20 (39 percent) considered methadone-induced. In Palm Beach County, there were 73 methadone-related deaths in 2003; 60 (82 percent) were considered methadone-induced.* —JAMES HALL

Maine: *The number of deaths in which methadone was indicated by the medical examiner to be a cause of or contributing factor to a death quadrupled from 2001 to 2002, but decreased from 57 in 2002 to 38 in 2003, when methadone was implicated in 28 percent of all drug deaths. Another 4 cases in 2003 are pending with regard to determination of the cause and manner of death, and another 11 cases were methadone-associated, caused by 'polydrug toxicity' with methadone and other drugs present. A detailed study of the deaths in 2001 revealed that in approximately one-quarter of the methadone deaths, the decedent had a prescription for liquid methadone (addiction treatment), and about one-quarter had a prescription for the pill form (pain treatment); half had no known prescription. State policy changes in methadone clinic regulations in early 2003 tightened control on take-home medication.* —MARCELLA SORG

Maryland: *In Maryland, methadone-related deaths more than tripled from 24 in 1998 to 76 in 2002. Two-thirds of the decedents were White. Since 2002, the mean age of the decedents was 39.2, and more decedents have been from suburban and rural areas. Few of the decedents were known to be patients in methadone treatment programs.* —ERIC WISH

Seattle: *Methadone was the most common type of other opiate-involved death in 2003; such deaths totaled 47, representing a more than threefold increase from 1997.* —CALEB BANTA-GREEN

Texas: *There were 36 deaths involving methadone in 1999, followed by 62 in 2000, 93 in 2001, and 131 in 2002.* —JANE MAXWELL

Treatment and PCC Data on Methadone

Treatment and poison control center data related to methadone were reported by two CEWG members:

New Orleans: *In St. Tammany Parish, 21 of the 216 'other opiate' treatment admissions were for non-prescribed methadone, the highest number in any of the 9 parishes reported on in the first 3 quarters of fiscal year 2004. These admissions represented only 2 of 68 primary 'other opiate' admissions in Orleans Parish during the same time period.* —GAIL THORNTON-COLLINS

Texas: *Of the 66 treatment admissions in Texas who reported a primary problem with illicit methadone in 2003, 58 percent were female. Seventy-three percent were White, 15 percent were Hispanic, and 12 percent were Black. Nine percent were homeless, 12 percent were employed, 33 percent were referred by the criminal justice system, and 32 percent had never before been in treatment.… The number of poison control cases in Texas involving misuse or abuse of methadone increased by 134 percent between 1998 and 2002. In 2003, the average age was 31, and 68 percent were male. Of the 41 cases, 31 took the drug orally, 1 injected, and 4 reported having inhaled methadone pain pills; the average age of the inhalers was 29.6 years.* —JANE MAXWELL

NFLIS Data on Methadone

Forensic laboratory data in 2003 show that some number of methadone items were reported to NFLIS from 16 sites (*see exhibit 6, page 12*). The number analyzed in New York, the most highly populated CEWG area, totaled 426. The next highest numbers were Atlanta (61) and Chicago (59).

Other Narcotic Analgesics

A variety of other prescription-type narcotic analgesics appear in drug indicators in CEWG areas. Two of the most frequently identified are codeine and hydromorphone products. Fentanyl is also discussed below because, in its new forms, there are signs of increasing abuse of this narcotic analgesic.

CODEINE is made in tablets alone or in combination with aspirin or acetaminophen (Tylenol with Codeine), as well as in a number of liquid forms used for cough suppression. On the illicit market, acetaminophen-codeine pills sell for $1 to $3.50 each in Chicago, while codeine syrup sells for about $30 for 4 ounces. In Los Angeles, codeine sells for $5 per tablet. In Houston, promethazine or Phenergan cough syrup with codeine sells for $75–$100 for 4 ounces, $125 for 8 ounces, and $1,600 for a gallon. In Dallas, promethazine syrup with codeine sells for $200–$300 per pint and $20–$40 per ounce. The Dallas/Fort Worth DEA reports increases in seizures of codeine cough syrup. Mentions of codeine/combinations appear in the 2002 DAWN ED data in all CEWG areas covered.

DAWN ED Data on Codeine

From 1995 to 2000, drug abuse-related visits involving codeine (specifically identified) decreased 43 percent across the coterminous United States. However, from 2001 to 2002, a 34-percent increase was observed.

ED mentions of codeine/combinations decreased significantly from 1995 to 2002 in 13 CEWG areas and increased in none. The numbers of mentions in 2002 were highest in Detroit (420), Los Angeles (203), Chicago (133), Philadelphia (117), Phoenix (93), and Minneapolis/St. Paul (90). The number of codeine/combinations ED mentions in the other 13 CEWG areas ranged from a low of 8 (Newark) to a high of 75 (New York). Between 2001 and 2002, these mentions increased significantly in Phoenix (from 77 to 93), while they decreased significantly in Newark and San Diego.

Local/State Mortality Data on Codeine

Mortality data on codeine-related deaths in 2003 were reported from Maine and Philadelphia:

Maine: *Codeine-related deaths have assumed a prominent role in drug deaths since 1997, increasing to 12 (7 percent) in 2002 and 12 (9 percent) in 2003.* —Marcella Sorg

Philadelphia: *Medications that contain codeine are commonly abused in Philadelphia. The ME detected codeine in 120 cases in 2003 and in 373 cases from 1994 through 2003 (the sixth most commonly occurring drug).* —Samuel Cutler

Street Data on Codeine

The **Texas** CEWG member reports the following information on codeine from street-level workers and informants:

Codeine cough syrup, 'Lean,' continues to be abused. Lean has long been popular in Houston, and it is reported by street outreach workers as becoming more popular in Beaumont, San Antonio, and Waco, as well as among youth and young adults in the suburban areas of Fort Worth.… There are reports of older adults now using Lean…and drinking Lean has spread from the Black community to Hispanics and Whites. Pineapple-flavored soda water is now a favorite mix with cough syrup.
—Jane Maxwell

NFLIS Data on Codeine

Less than 7 percent of all narcotic analgesic items reported to NFLIS from CEWG areas in 2003 were codeine.

HYDROMORPHONE (Dilaudid) was identified as a problem in several CEWG areas. Hydromorphone mentions appear in the 2002 DAWN ED data in 14 CEWG areas.

DAWN ED Data on Hydromorphone

Small numbers of hydromorphone ED mentions were reported across 13 CEWG areas in 2002 (data were suppressed in Denver, Los Angeles, New York, and Phoenix, and there were no mentions in New Orleans or Newark). The 108 mentions in Seattle in 2002 were considerably higher than the 44 in Detroit, the area with the next highest number. Philadelphia and Washington, DC, had the third highest number of hydromorphone ED mentions, each at 32. Numbers in the other 9 areas ranged between 5 and 14. Hydromorphone ED mentions increased significantly from 2001 to 2002 in San Diego and Seattle.

Diversion and Price Data on Hydromorphone

CEWG reports show increases in sales of hydromorphone to hospitals and pharmacies in Seattle, as documented by DEA. Prices of hydromorphone varied across four CEWG areas reporting price data:

Chicago: *Hydromorphone (Dilaudid), the pharmaceutical opiate once preferred by many Chicago injection drug users, continued to be available, although in limited quantities (typical sources are said to be cancer patients). The drug sells for approximately $25 per tablet.* —DITA BROZ

New Orleans: *Hydromorphone is widely diverted in New Orleans.* —GAIL THORNTON-COLLINS

St. Louis: *The use of hydromorphone (Dilaudid) remained common among a small population of White chronic addicts. The drug costs $30–$75 per 4-milligram pill.* —HEIDI ISRAEL-ADAMS

Texas: *In San Antonio, hydrocodone sells for $1–$5 per pill. Dilaudid sells for $10–$15 per dose in McAllen.* —JANE MAXWELL

FENTANYL is currently available in an injectable formulation; in lozenge form (Actiq); and in transdermal patches (Duragesic) from which the liquid may be removed and injected by illicit abusers. Patches sell for between $10 and $100 on the illicit market, depending on the dosage unit and geographic area. The lozenges sell for $20–$25 on the street.

DAWN ED Data on Fentanyl

Across the coterminous United States, DAWN ED mentions of fentanyl increased significantly from just 22 in 1995 to 1,506 in 2002. Across CEWG areas covered in this system, fentanyl mentions were reported in 12. (None were reported in Baltimore, and data were suppressed in Atlanta, Denver, Los Angeles, New York, Newark, and Washington, DC.) Mentions were highest in Detroit (63), followed by Chicago (32), Philadelphia and Seattle (each 27), and Boston (24). Numbers in the other 7 CEWG areas ranged from 3 (Miami) to 14 (Phoenix). The number of fentanyl ED mentions increased significantly from 2001 to 2002 in San Diego and Seattle, with no changes in other areas.

Local/State Mortality Data on Fentanyl

The Maine participant reported on deaths associated with fentanyl, as did the Philadelphia and Texas CEWG representatives:

Maine: *Fentanyl-related deaths more than doubled between 2001 and 2002, increasing from 6 to 14; they decreased to 7 in 2003 (5 percent of drug-related deaths). An additional death caused by polydrug toxicity had fentanyl and other drugs present in the toxicology findings.* —MARCELLA SORG

Philadelphia: *From 1994 through 2003, the ME recorded 35 deaths with the presence of fentanyl. Of these, seven occurred in the first half of 2003 and nine occurred in the second half of 2003.* —SAMUEL CUTLER

Texas: *There were 9 deaths in 2001 involving fentanyl and 22 in 2002.* —JANE MAXWELL

Fentanyl Reports

In a press conference in April 2003, the Pennsylvania Attorney General's Office called attention to the abuse of Actiq, noting that the diverted products were being encountered in Philadelphia, where they were selling on the street for $20 per "narco-pop" or "perc-o-pop," with the retail price being $9.10 (Mark Scoiforo, The Associated Press, April 28, 2004).

The **Ohio** participant also reported on fentanyl abuse in that State:

Fentanyl abuse is also being reported from several areas in Ohio through the statewide OSAM system: The first accounts of Duragesic abuse in Akron, Columbus, Dayton, and Youngstown were reported in January 2003. In January 2004, Akron, Columbus, and Youngstown reported continued abuse of fentanyl, and the first account of fentanyl abuse was reported in Cincinnati. In 2003, crime lab investigators in Dayton reported increasing availability of fentanyl patches and 'suckers' [lozenges]. Active drug users from Dayton reported increasing appearance of the drug on the streets and increasing demand for the drug among veteran heroin users. —HARVEY SIEGAL

BENZODIAZEPINES/OTHER DEPRESSANTS

Benzodiazepines (BZDs) abused in CEWG areas include alprazolam (Xanax), diazepam (Valium), lorazepam (Ativan), and clonazepam (Klonopin). Alprazolam sells on the streets of Los Angeles for $2–$3 per 0.5-milligram tablet and for $5–$10 for a 1-milligram tablet. A 2-milligram Xanax tablet sells for $3–$5 in Dallas. A Valium tablet costs $4 in Los Angeles. Diazepam sells for $1–$10 in Dallas, Fort Worth, and Tyler. The specific BZD most widely abused varied by CEWG area, but alprazolam was noted as a particular problem in several areas. CEWG members report that BZDs are commonly used in combination or sequentially with other drugs to increase or sustain the effects of other drugs, or to reduce the negative effects of other drugs.

DAWN ED Data on Benzodiazepines

Rates of benzodiazepine ED mentions per 100,000 population increased significantly in 6 CEWG areas from 1995 to 2002, with continuing increases in Baltimore and Newark (*see exhibit 7 on the following page*). From 2001 to 2002, the rates of benzodiazepine ED mentions decreased significantly in four CEWG areas. Across the annual periods shown in exhibit 7, Boston and Philadelphia continued to have the highest rates, at 102 and 95, respectively, in 2002.

Exhibit 7. Rates of Benzodiazepine ED Mentions Per 100,000 Population in 19 CEWG Areas: 1995–2002

					Percent Change[1]		
CEWG Area	1995	2000	2001	2002	1995, 2002	2000, 2002	2001, 2002
Atlanta	31	45	32	34			
Baltimore	29	45	59	60	105.0	33.8	2.2
Boston	107	77	95	102			
Chicago	34	42	46	47	37.0		
Denver	38	35	33	26			-22.7
Detroit	51	39	57	69		75.3	
Los Angeles	27	24	21	28			
Miami	41	49	52	49	20.7		
Mpls./St. Paul	24	24	27	26			
New Orleans	57	53	67	82			
New York	15	20	23	22			
Newark	35	38	49	57	62.7	49.3	15.5
Philadelphia	69	84	95	95	38.4		
Phoenix	66	58	52	53		-9.7	
St. Louis	44	46	55	78			
San Diego	29	49	52	45	57.1	-8.1	-13.6
San Francisco	51	41	52	42			-20.1
Seattle	48	62	63	50		-19.2	-21.2
Washington, DC	33	21	22	21			

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

Note that a substantial proportion of the benzodiazepine ED mentions across CEWG areas in 2002 were in the "not otherwise specified" category, which means the specific benzodiazepine product was not identified in the hospital record. Across the coterminous United States in 2002, there were 105,752 benzodiazepine ED mentions; 34,697, or 32.8 percent, were in the NOS category.

Representatives from CEWG areas included in this DAWN system elaborated on findings relevant to their own areas in their reports. The following excerpts provide examples of CEWG coverage of the 2002 DAWN ED data:

Baltimore: *Benzodiazepines were mentioned in 11 percent of drug-related ED episodes in 2002, representing a small (2 percent) increase from 59 mentions per 100,000 population in 2001 to 60 per 100,000 in 2002. The specific benzodiazepines involved were identified for only 25 percent of mentions. The most frequently specified were alprazolam, clonazepam, diazepam, and lorazepam. From 1995 to 2002, the rate of benzodiazepine mentions increased by 105 percent.* —**LEIGH HENDERSON**

Boston: *As a group, benzodiazepines are showing high levels of abuse. In 2002, Boston's benzodiazepines rate of 102 ED mentions per 100,000 population was highest among all 21 DAWN sites and 2.42 times the national rate of 42.* —**DANIEL DOOLEY**

Chicago: *Benzodiazepine ED mentions increased significantly between 1995 (n=1,959) and 2002 (2,776), a 42-percent change. Alprazolam ED mentions were relatively stable between 1995 (331) and 2002 (300); alprazolam was the most often mentioned benzodiazepine. Clonazepam was the second most often mentioned benzodiazepine in 2002 (227), followed by lorazepam (196) and diazepam (148). Consistent with ED mentions, ethnographic reports indicate that alprazolam appears to be the benzodiazepine most readily available on the street, closely followed by clonazepam and lorazepam, with variations in different areas of the city.* —**DITA BROZ**

Miami: *In Miami-Dade County, there were 1,029 benzodiazepine-related DAWN ED mentions in 2002, representing a 39-percent increase from 1995. Alprazolam accounted for 409 of these mentions in 2002, up 32 percent from the 309 mentions in 2000.* —JAMES HALL

New York City: *Alprazolam and clonazepam ED mentions increased from 1995 to 2002, while diazepam mentions decreased. From 1995 to 2002, alprazolam mentions increased 92 percent (from 333 to 638) and clonazepam mentions increased 182 percent (from 117 to 330). Clonazepam mentions also increased 48 percent from 2000 to 2002 (from 223 to 330). The decreases in diazepam mentions continued: 58 percent from 1995 to 2002 (from 450 to 189); 43 percent between 2000 and 2002; and 32 percent between 2001 and 2002. Lorazepam mentions remained stable with 143 mentions in 2002. In addition to these specific benzodiazepines, mentions for benzodiazepines not otherwise specified (NOS) increased 620 percent, from 73 in 1995 to 526 in 2002.*

—ROZANNE MAREL

Data from a local ED were reported by the Miami/Ft. Lauderdale representative:

At **Broward General Medical Center** *in the last 6 months of 2003, there were 219 benzodiazepine ED mentions, including 51 percent that specifically cited alprazolam. Males accounted for 64 percent of the cases. Teenagers accounted for 5 percent of these mentions; 27 percent were in their twenties, 31 percent were in their thirties, another 30 percent were in their forties, and 8 percent were age 50 or older.* —JAMES HALL

Local/State Mortality Data on Benzodiazepines

Deaths involving different depressant drugs in 2002 or 2003 were reported by two CEWG representatives and the Maine participant:

Florida: *Statewide, there were 1,794 benzodiazepine-related deaths during 2003, representing a 10-percent increase over 1,307 ME mentions in 2002. Of the deaths in 2003, a benzodiazepine was identified as the cause of death in 368 cases (or 21 percent), the same proportion for this category as in 2002…. Benzodiazepines were second only to alcohol in their involvement in drug-related deaths throughout Florida in 2002…. Miami-Dade County reported 40 alprazolam-related deaths during 2003; 12 (30 percent) were alprazolam-induced deaths. In 2003, Broward County recorded 90 alprazolam-related deaths; 41 (46 percent) were alprazolam-induced, but only 7 of the deaths involved alprazolam alone. In Palm Beach County, there were 94 alprazolam-related deaths; 18 (19 percent) were alprazolam-induced. Another drug was present in 95 percent of the cases…. Miami-Dade County reported 25 diazepam-related deaths during 2003; 2 (8 percent) were diazepam-induced. Broward County recorded 98 diazepam-related deaths during that period, and 30 (31 percent) were diazepam-induced. In Palm Beach County, 6 (15 percent) of the 41 diazepam-related deaths in 2003 were diazepam-induced.*

—JAMES HALL

Maine: *About one-third of Maine's drug deaths have some form of benzodiazepine present in their toxicology findings. Nine (6 percent) had a benzodiazepine mentioned on the death certificate in 2003, down from 18 (11 percent) in 2002. One of these, diazepam, is in the 'top 10' list for Maine, causing 21 deaths over the past 6 years. An additional 15 deaths caused by polydrug toxicity had one or more benzodiazepines present in the toxicology findings.* —MARCELLA SORG

Philadelphia: *Diazepam, having been detected by the ME in 497 decedents from 1994 through 2003, with 66 cases in 2003, ranks fourth among drugs present in mortality cases in Philadelphia…. Alprazolam was the 13th most frequently detected drug among decedents by the Philadelphia ME (n=213) from 1994 through 2003, with 45 cases in 2003…. Deaths with the presence of oxazepam (Serax) have been increasing. In 2003, there were 16 positive toxicology reports for oxazepam and 129 cases in the 10-year period from 1994 through 2003 (the 19th most frequently detected drug)…. Deaths with the presence of olanzapine (Zyprexa) have been increasing. In 2003, there were 43 positive toxicology reports for olanzapine and 119 cases in the 10-year period from 1994 through 2003 (the 20th most frequently detected drug).*

—SAMUEL CUTLER

Treatment Data on Depressants

Primary depressants (including Rohypnol) admissions are not always distinguished by the type of depressant, and some CEWG areas include depressants in an "other drug" category. Twelve CEWG areas reported treatment data on depressants:

Atlanta: *In metropolitan Atlanta, about 1 percent of primary heroin users chose benzodiazepines as a secondary drug choice, as did 2 percent of methamphetamine users. These FY 2003 percentages are consistent with the figures from the previous 2 years.* —KRISTIN WILSON

Chicago: *Treatment data…indicate that depressants are not primary drugs of choice for most users.* —DITA BROZ

Colorado: *In 2003, 15 clients were admitted to treatment claiming Rohypnol (flunitrazepam) as their primary drug of abuse. Thirteen were male and only two were female. As to race, 10 were White and 5 were Hispanic. Also, 10 were 35 and older. Eleven had taken the drug orally, while 2 reported smoking, and 2 said they had injected.* —BRUCE MENDELSON

Hawaii: *The impact of benzodiazepine admissions on the treatment system is minimal, with less than 10 in 2003.* —D. WILLIAM WOOD

Los Angeles: *In the second half of 2003, treatment and recovery program admissions associated with primary barbiturate, benzodiazepine, or other sedative/hypnotic abuse continued to account for less than 1 percent of all admissions in Los Angeles County.* —BETH FINNERTY

New Orleans: *Treatment admissions data for the first three quarters of FY 2004 show six admissions for primary benzodiazepine abuse in Orleans Parish, with the same number in both East Baton Rouge and Ouachita Parishes. The numbers were higher in 4 other parishes—Lafayette (14), St. Tammany (18), Calcasieu (23), and Rapides (26). Benzodiazepine admissions in another two parishes were zero (Bossier) and two (Terrebonne).* —GAIL THORNTON-COLLINS

Newark: *Treatment data for the Newark primary metropolitan statistical area (PMSA) in 2003 showed increases in use of benzodiazepines among treatment admissions, with their use as a primary, secondary, or tertiary drug accounting for 2.8 percent of treatment admissions, compared with 1.6 percent in 2001.* —ANNA KLINE

Philadelphia: *The preliminary treatment admission reports for 2003 show benzodiazepines as primary drugs of abuse in 67 cases; however, these drugs were reported as secondary drugs of abuse in 187 additional cases and as tertiary drugs of abuse in 153 more cases. Most of the reports of benzodiazepines as secondary or tertiary drugs of choice indicated that heroin was the primary drug.* —SAMUEL CUTLER

Phoenix: *Clonazepam was reported to be in high demand by heroin addicts who are in methadone treatment programs…. Heroin addicts report consuming clonazepam when in methadone treatment to produce a heroin 'high' feeling… [they] prefer 0.5-milligram tablets because the dosage is not time released.* —ILENE DODE

St. Louis: *A few private treatment programs often provide treatment for benzodiazepine, antidepressant, and alcohol abusers. Social setting detoxification has become the treatment of choice for individuals who abuse these substances. Since many of the private treatment admissions are polysubstance abusers, particular drug problems are not clearly identified.* —HEIDI ISRAEL-ADAMS

Seattle: *Depressants were the primary drug for less than 1 percent of treatment clients in 2003 and in recent years. (Treatment admission data for depressants are limited to where they are noted as the primary drug.)* —CALEB BANTA-GREEN

Texas: *The number of youths and adults admitted into treatment with a primary, secondary, or tertiary problem with Rohypnol has varied: 247 in 1998, 364 in 1999, 324 in 2000, 397 in 2001, 368 in 2002, and 331 in 2003. Clients abusing Rohypnol were the youngest of the 'club drug' patients and they were predominately Hispanic, which would reflect the availability and use of this*

drug along the border. Some 75 percent were involved with the criminal justice or legal system. While 15 percent of these clients said that Rohypnol was their primary problem drug, 55 percent reported a primary problem with marijuana.

—JANE MAXWELL

PCC and Helpline Data on Benzodiazepines

Poison control center and Helpline data on benzodiazepines were reported from two CEWG areas:

Boston: *In 2003, there were 185 calls to the Helpline during which benzodiazepines (including Ativan, Valium, Xanax, Klonopin, Rohypnol, Halcion, and others) were self-identified as substances of abuse (2.3 percent of all mentions)… remaining fairly stable from 2000 to 2003.*

—DANIEL DOOLEY

Detroit: *Michigan Poison Control Centers reported 75 intentional benzodiazepine exposures statewide in the first 4 months of 2004, with 2 deaths resulting. Of these 75 exposures, 17 were for youths age 6–19.*

—PHIL CHVOJKA

NFLIS Data on Benzodiazepines

Forensic laboratory data in exhibit 8 depict the number of benzodiazepine items analyzed in 2003 in CEWG areas covered by NFLIS. As shown, alprazolam was the benzodiazepine most likely to be identified, but it accounted for only small percentages of the total items analyzed. In 2003, relatively high numbers of alprazolam items were identified in New York (545), Philadelphia (465), Atlanta (320), and Miami (292). In San Diego, diazepam was the benzodiazepine most often identified (n=100). The numbers of diazepam items identified were also relatively high in Philadelphia (94), Atlanta (84), and Los Angeles (82). The numbers of clonazepam items identified were high in New York City (124), Texas (93), and San Diego (75). No benzodiazepine items were identified in Baltimore or Detroit.

Exhibit 8. Estimated Number of Analyzed Benzodiazepine Items in 17 CEWG Areas: 2003

NFLIS Area	Alprazolam	Diazepam	Clonazepam
Atlanta	320	84	28
Boston	32	17	41
Chicago	32	21	19
Denver	8	19	8
Honolulu	11	23	5
Los Angeles[1]	38	82	41
Miami	292	15	10
New Orleans	74	39	5
New York	545	67	124
Newark	17	0	0
Philadelphia	465	94	51
St. Louis	32	31	5
St. Paul	12	16	12
San Diego	56	100	75
Seattle	8	13	17
Texas	216	53	93
Washington, DC	20	0	9

[1]Data are not complete for all months.
SOURCE: NFLIS, DEA

CEWG members typically elaborate on NFLIS findings, as in the examples below:

Los Angeles: *Approximately 581 of the 45,443 items analyzed by participating Los Angeles County laboratories and reported to the NFLIS system were positively identified as pharmaceutical/prescription medications (as opposed to illicit substances). Of those, 30 percent (174 items) were found to be benzodiazepines, and another 2 percent (12 items) were found to be a barbiturate (Phenobarbital). The most frequently cited benzodiazepines were diazepam (82 items), clonazepam (41 items), and alprazolam (38 items).*

—BETH FINNERTY

Seattle: *Law enforcement exhibits tested by the State toxicology laboratory showed that 1.2 percent (n=38) of exhibits from the Seattle area lab were benzodiazepines (i.e., alprazolam, diazepam, and clonazepam) and that 0.9 percent (105) of exhibits from the rest of the State were benzodiazepines.*

—CALEB BANTA-GREEN

Other Data on Benzodiazepines

Qualitative and other quantitative data on benzodiazepines were reported by representatives from four CEWG areas, with some exemplifying multiple drug use patterns among benzodiazepine abusers and the popularity of alprazolam:

Atlanta: *Depressants, especially benzodiazepines, are on the rise in Atlanta. The most commonly abused benzodiazepine is alprazolam (Xanax).* —KRISTIN WILSON

Chicago: *Lifetime use of tranquilizers or barbiturates without a prescription (Valium, Elavil, Ativan, Xanax) was reported by 32 percent of young noninjecting heroin users. Fourteen percent reported using in the past 30 days. Young injectors reported moderate use of barbiturates. In the Family Process study, 41 percent of young injectors reported ever using barbiturates, and 30 percent used them during the previous 12 months.* —DITA BROZ

Philadelphia: *Benzodiazepines, particularly alprazolam and diazepam, continue to be used in combination with other drugs.… Benzodiazepine abuse was reported by focus group participants as common among users of heroin, oxycodone, cocaine, marijuana, and cough syrup. Since spring 2000, all focus groups have reported that alprazolam has overtaken diazepam as the 'most popular pill' on the street.… While users new to treatment report that diazepam has become less popular in recent years, alprazolam use has increased.* —SAMUEL CUTLER

Seattle: *Key informants note that promethazine is often used by those on methadone to potentiate the high. Benzodiazepines (e.g., clonazepam and diazepam) are purchased on the street for three reasons: 1) to get high on, 2) to potentiate other drugs, and 3) for 'home detoxes' whereby users, of heroin in particular, try to stop using on their own.* —CALEB BANTA-GREEN

POLYSUBSTANCE ABUSE

CEWG members continue to document the proliferation of polysubstance abuse. The availability of prescription-type drugs on the street and through "doctor shopping," theft, and other means adds to the many illicit drugs on the market. Combinations of drugs are used concomitantly or sequentially, in various ways (e.g., swallowing, snorting, smoking, injecting) and in various forms (e.g., tablets, capsules, liquid, powder, crystal, tar). Different polysubstance patterns across CEWG areas are exemplified in the quotes below.

Atlanta: *[Among treatment admissions in 2003], alcohol was the most popular secondary drug of choice for marijuana users, followed by cocaine (14 percent).* —KRISTIN WILSON

Baltimore: *Polydrug use in general appears to be the norm in the Baltimore PMSA. Three-quarters of drug-related treatment admissions in the first half of 2003 reported problems with at least one substance other than their primary substance. An average of 1.8 drugs was mentioned per ED visit in 2002. In 2002 (the latest year for which mortality data were available), multiple drugs were found in the majority of the 600 drug-involved deaths. Only 11 percent of the deaths involved a single drug—27 percent involved two drugs, 27 percent involved three, and 35 percent involved four or more. The average number of drugs found was 3.1.* —LEIGH HENDERSON

Chicago: *…multidrug consumption is the normative pattern among a broad range of substance abusers in Chicago.… Recent reports from young heroin snorters indicate that PCP use may be more common in this population. Fifty-one percent of study participants reported ever trying PCP, and 14 percent admitted use within 6 months prior to their interview.* —DITA BROZ

Denver: *Treatment programs across Colorado report cocaine/crack use in combination with other drugs like heroin (speedballs) and marijuana (primos).… Among the 38 clients claiming MDMA as their primary drug of abuse in 2003, 25 used a secondary drug: 9 used marijuana, 5 used alcohol, 4 used cocaine, and 4 used methamphetamine (3 used other drugs).* —BRUCE MENDELSON

Los Angeles: *Alcohol was the most commonly reported secondary drug among primary cocaine admissions (40 percent), followed by marijuana (19 percent).* —**Beth Finnerty**

Miami: *Polysubstance abuse patterns continue to be revealed in cases of drug-related deaths, medical emergencies, and addiction treatment admissions…. Marijuana cigarettes to which powder cocaine has been added are called 'dirties.' Dirties are promoted as a less severe marijuana and cocaine combination than 'Geek joints,' which are made with crack cocaine. Dirties are often used in sexual situations, as is the combination of smoking marijuana and ingesting pills of sildenafil.* —**James Hall**

New York: *A disturbing trend that seems to be catching on with teenagers is to sprinkle heroin over marijuana before rolling it up in a blunt cigar. While the teenagers did not give this method a name, it refers to what was called smoking 'woolas.' They prefer to use White Owl cigars because the leaf is stronger and burns longer than other brands.*

—**Rozanne Marel**

Newark: *Nearly 82 percent of the cocaine ED mentions in 2002 represented multidrug episodes, [as did] nearly 79 percent of the marijuana ED mentions.*

—**Anna Kline**

Philadelphia: *The four major drugs of abuse in Philadelphia continue to be cocaine, heroin, marijuana, and alcohol. These are frequently used in combination with each other and with other supplemental drugs…. The combination of marijuana and PCP, frequently mixed in blunts…remained a popular combination among users into the spring of 2004.* —**Samuel Cutler**

St. Louis: *Polydrug use is evident in the treatment data. The reported use of marijuana, heroin, and methamphetamine in addition to cocaine suggest this trend will likely continue.* —**Heidi Israel-Adams**

Seattle: *Approximately 84 percent of those who mentioned marijuana [in 2002] were also using other drugs at the time of the ED visit.* —**Caleb Banta-Green**

Texas: *Carisoprodol (Soma) is abused in combination with other drugs. Thirty-nine percent of abuse and misuse calls to poison control centers also involved other drugs and 97 percent of deaths involving carisoprodol also involved other drugs such as hydrocodone, propoxyphene, alcohol, and benzodiazepines* —**Jane Maxwell**

Washington, DC: *Nearly three-quarters (71 percent) of the cocaine ED mentions in 2002 represented multidrug episodes.* —**Eric Wish**

Exhibit 9 below summarizes some popular drug combinations, together with their street names.

Exhibit 9. Examples of Popular Drug Combinations and Their Street Names

Drug Combination	Street Name
Cocaine/crack and heroin (injected)	Speedball
Cocaine/crack and marijuana	Primos Dirties (powder cocaine) Geek joints (crack cocaine)
Marijuana (blunts) with heroin	Woolas
LSD and MDMA	Candy flipping
Mushrooms and MDMA	Hippie flipping
Mescaline and MDMA	Love flipping
DXM and MDMA	Robo flipping
PCP and MDMA	Elephant flipping

SOURCE: June 2004 CEWG Reports

COCAINE/CRACK

Cocaine/crack abuse indicators remain "mixed" in some CEWG areas, with some indicators increasing, some decreasing, and others remaining stable. However, there are indications that cocaine/crack abuse is increasing in some CEWG areas. Changes in user demographics are being reported in some CEWG areas, and there are reports of more aggressive marketing of powder cocaine and crack. The St. Louis CEWG representative noted that crack cocaine is considered a primary risk for HIV in many research trials, and that continued use of cocaine has potentially long-term consequences by contributing to the spread of sexually transmitted diseases.

Cocaine/crack abuse continues to be high in most CEWG areas, with indicators increasing in some.

Atlanta: *Cocaine and crack are highly available and widely abused in metropolitan Atlanta, according to most of the key indicators. The most frequently mentioned illicit drug in EDs and in medical examiner's offices is cocaine…. It is also the primary drug of choice in 40 percent of all treatment admissions in metropolitan Atlanta and in Georgia. The powder form is increasingly popular among young adults, though most epidemiological data still indicate that most users are older.* —KRISTIN WILSON

Baltimore: *In northeastern cities where cocaine abuse indicators had been declining, data now show they are trending up again. In Baltimore, cocaine indicators (treatment admission rates, rates of ED mentions, and cocaine-involved deaths) all began to increase in 2001.* —LEIGH HENDERSON

Boston: *Powder cocaine and crack are heavily abused drugs in Boston. The most recent cocaine/crack indicators are stable and show continued levels of high use and abuse…. It is easy to understand why cocaine indicators are so high and patterns of use (i.e., smoking) change, since cocaine is relatively easy to get, the price is cheap, and it is easy to use. In Boston, as in other areas, people have been using crack since the beginning of the epidemic 18 to 20 years ago. There are aging populations and new user populations being identified.* —DANIEL DOOLEY

Chicago: *Quantitative cocaine indicators varied, but they suggested that use remained stable or at high levels and that cocaine continues to be a serious drug problem for Chicago and Illinois.* —DITA BROZ

Denver/Colorado: *Trends show increases in new cocaine users in Colorado. Overall, cocaine indicators were mixed from 2001 to 2003. Statewide, both treatment admissions and new users in treatment remained relatively stable. However, cocaine-related deaths increased, as did hospital discharges and the proportion of arrestees in Denver with positive cocaine urine screens.* —BRUCE MENDELSON

Miami/Ft. Lauderdale: *Cocaine-related deaths increased in 2003, while other indicators of its abuse remained stable at high levels.* —JAMES HALL

Minneapolis/St. Paul: *The consequences of cocaine abuse and addiction remained apparent in the Minneapolis/St. Paul metropolitan area throughout 2003, as overdose deaths increased from 34 to 44 in Hennepin County.* —CAROL FALKOWSKI

New York: *Cocaine indicators in New York City, which had declined at the end of the last decade, continued to show some signs of increasing.* —ROZANNE MAREL

Newark/New Jersey: *The proportion of primary cocaine/crack admissions statewide increased from 13.4 percent in 2002 to 15.6 percent in 2003. In 2003, the proportion of primary cocaine/crack admissions statewide was more than double that reported in Newark City and almost 6 percentage points higher than in the primary metropolitan statistical area. Admissions for crack abuse accounted for more than two-thirds of the primary cocaine admissions statewide.* —ANNA KLINE

Philadelphia: *Cocaine/crack remains the major drug of abuse in Philadelphia.* —Samuel Cutler

San Francisco: *Cocaine use in the bay area is low compared with the rest of the United States. Indicators suggest a decline in usage between 2001 and 2002 and a leveling off in 2003. However, there are signs that the indicators will be trending up in San Francisco in the near future.* —John Newmeyer

Seattle: *Cocaine continues to be a major drug of abuse among those arrested and seen in emergency departments, while deaths are near the lowest level in 10 years…. The number and proportion of cocaine-related calls to the Alcohol and Drug Helpline for adults increased in the first half of 2003, while youth numbers remained fairly stable. Cocaine was the most common drug cited by adults—33 percent for the first half of 2003 (n=603)—on track to surpass 2001 and 2002 totals. For teenagers, cocaine was the third most common drug mentioned, with 27 calls, representing 10 percent, similar to 2001 and 2002.* —Caleb Banta-Green

Crack abuse indicators continue to be higher than those for powder cocaine, and the drug is widely available in CEWG areas.

Atlanta: *Crack is the most widely available drug in the city. Smoking is still the number one preferred route of administration, as reported by about 78 percent of those admitted for cocaine treatment.* —Kristin Wilson

Los Angeles: *Nearly 9 out of 10 cocaine admissions report smoking crack, followed by inhalers (10 percent). When asked whether they had used any drug intravenously in the year prior to admission, approximately 5 percent of all primary cocaine admissions in 2003 reported that they had used needles to administer one or more drugs intravenously at least once during the specified time period.* —Beth Finnerty

New Orleans: *Cocaine, especially crack, remains a major problem in New Orleans, although indicators suggest some decline in abuse of cocaine/crack.* —Gail Thornton-Collins

New York: *Crack users report that crack continues to be highly available…. The price of crack remains stable at $10 per bag, with increasing numbers of $5 bags being offered.* —Rozanne Marel

Philadelphia: *Since the first half of 1990, at least 80 percent of cocaine treatment admissions have reported smoking the drug. Of all male cocaine admissions in 2003, 78 percent reported smoking the drug; the comparable figure for females was 87 percent.* —Samuel Cutler

Phoenix: *All indicators for cocaine have declined. Only crack cocaine remains in consistently high demand.* —Ilene Dode

St. Louis: *Most cocaine users smoke crack cocaine.* —Heidi Israel-Adams

Texas: *Use of crack cocaine…is at an endemic level.* —Jane Maxwell

Abuse of cocaine/crack is spreading to new populations.

Atlanta: *We are seeing a lot more crack use among middle-class White youth and young adults in the suburbs.* —Kristin Wilson

Baltimore: *There are new cocaine users in all age categories, up to age 45.* —Leigh Henderson

Denver/Colorado: *The trend in increases of new cocaine users in Colorado shows subtle demographic changes, including an increase in Hispanic cocaine users. The smoking of cocaine is trending up again slightly after dropping off for a while. It was associated with a change in trafficking and the increase in Hispanic users…. Treatment programs in southeastern Colorado report increased use among Hispanics who have a history of family use. Likewise, some treatment programs in the Denver metropolitan area report that Hispanics are 'doing what they are bring in—they've always had it, now they are using it.'* —Bruce Mendelson

Texas: *Use of crack cocaine continues to move beyond Black users to White and Hispanic users…. The proportion of Black crack cocaine treatment admissions has fallen from 75 percent in 1993 to*

49 percent in 2003, and the proportion of Hispanic crack admissions has risen from 5 to 15 percent. —JANE MAXWELL

Trafficking of cocaine and cocaine arrests continue to be reported in CEWG areas.

Atlanta: *Other than marijuana, crack is the most widely available drug in the city, and officials estimate that 75 percent of all drug-related arrests involve crack cocaine.* —KRISTIN WILSON

Boston: *There were 1,736 Class B (mainly powder cocaine and crack) drug arrests in 2003. Class B arrests comprised the largest proportion of drug arrests (42 percent) in the city of Boston and did not change from 2002 to 2003, although the proportion did decrease 12 percent from 1997.* —DANIEL DOOLEY

Detroit: *As reported at the December 2003 CEWG meeting, there is an emerging population of Native American crack users living around northern Michigan casinos. According to recent information, these users are reported to be supplied primarily from Detroit-area distribution channels and typically pay much more per rock than it sells for inside Detroit. The drug has already been converted into rocks when it is transported to northern Michigan casino regions.* —PHIL CHVOJKA

Los Angeles: *A total of 3,541 cocaine arrests were made within the city of Los Angeles in calendar year 2003. This represented a 16-percent increase from the number of cocaine arrests made in 2002. Cocaine arrests accounted for 11.4 percent of all narcotics arrests made in 2003…. Citywide cocaine (including crack and powder) seizures increased 107 percent, from 887.01 pounds seized in 2002 to 1,834.97 pounds seized in 2003. The street value of the seized cocaine accounted for 33 percent of the total street value of all drugs seized in 2003.* —BETH FINNERTY

New Orleans: *The New Orleans Police Department reported 2,941 arrests for cocaine possession in 2003, down from 3,649 in 2002. Black males accounted for the majority of these arrests in 2003 (73 percent), followed by Black females (13 percent), White males (10 percent), and White females (3 percent). Cocaine distribution arrests also decreased between 2002 and 2003, by 12 percent. Similar to arrests for cocaine possession, Black males accounted for the majority of cocaine distribution arrests, at 86 percent.* —GAIL THORNTON-COLLINS

New York: *Mexican dealers have moved into some of the traditional drug dealing areas where cocaine and heroin are sold. This has created a situation of more rivalries and violence associated with drug dealing.* —JOHN GALEA

St. Louis: *In St. Louis, drug dealing is territorial. African-Americans have controlled the cocaine market, while Hispanics have a stronghold on methamphetamine trafficking in other parts of the city. Communities are being closely monitored to find out how much crossover there is in cocaine and methamphetamine dealing, how much develops over time, and the consequences.* —HEIDI ISRAEL-ADAMS

Texas: *Across the years, adult male arrestees in Laredo were more likely than those in Dallas and Houston to test cocaine-positive, one indicator of the extent of cocaine/crack abuse in Texas border areas.* —JANE MAXWELL

Cocaine abuse is partly "hidden" because of the tendency to focus on the primary drug of abuse. Cocaine is a major drug in polydrug abuse.

Baltimore: *In Baltimore, like other areas, cocaine is increasingly being reported as a secondary drug by cocaine/crack abusers entering treatment. As part of a multidrug-using pattern, it is often hidden, because there is a tendency to focus on the primary drugs of*

abuse. For example, a sizable percentage of the heroin abusers entering treatment in Baltimore in the first half of 2003 reported using cocaine.... Among heroin injectors, 75 percent reported using other drugs, among them cocaine—49 percent used cocaine by routes other than smoking, and 12 percent smoked cocaine. Cocaine smoking was much more common among heroin intranasal users (38 percent), with 14 percent reporting use of cocaine by other routes.
—LEIGH HENDERSON

Chicago: *In the [NIDA-funded] Non-Injection Heroin Users Study, 22 percent of participants reported using crack cocaine with heroin at least half of the time in the 30 days prior to their interview.*
—DITA BROZ

Miami/Ft. Lauderdale: *At the Broward General Medical Center in the last 6 months of 2003, cocaine was involved in 56 percent of the drug abuse cases. Cocaine was taken in combination with alcohol in 48 percent of the cases, the same proportion as in the first half of 2003. This dangerous combination forms a co-metabolite, cocaethylene, which can dramatically increase toxicity. The combination of cocaine and marijuana was involved in 27 percent of the cases. Crack cocaine was specifically mentioned in 26 percent of the cases in the last half of 2003, which was slightly less than the 31 percent in the previous 6 months.*
—JAMES HALL

Philadelphia: *At least one other drug was found in 83 percent of cocaine-positive death cases in 2002 and 85 percent in 2003.... The preliminary treatment data for 2003 show that cocaine was mentioned by 16.4 percent of admissions as a secondary drug and by 2.9 percent as a tertiary drug.... Crack users continue to report frequent use in combination with 40-ounce bottles of malt liquor, beer, wine, or other drugs, including alprazolam (Xanax), marijuana, or heroin. Powder cocaine, cigarettes, and methamphetamine were less frequently mentioned as drugs used with crack.*
—SAMUEL CUTLER

Seattle: *An average of 1.9 drugs were mentioned per DAWN cocaine ED episode in 2002, up 17 percent from 1995.... Only one in five deaths in which cocaine was identified involved only cocaine, according to the medical examiner data from 1997 through 2003.... In 2003, 39 percent of all people newly admitted to treatment mentioned cocaine as one of the top three drugs they used, down from 45 percent in 1999.*
—CALEB BANTA-GREEN

Texas: *The DAWN medical examiner system reported that the number of deaths in the Dallas metropolitan area involving a mention of cocaine increased from 134 in 1996 to 177 in 2002. Twenty-eight percent of these deaths involved only cocaine, while 72 percent also involved other drugs.*
—JANE MAXWELL

Patterns and Trends Across CEWG Areas

DAWN ED Data on Cocaine/Crack

In 2002, the highest rates of cocaine/crack ED mentions were in Chicago (275), Philadelphia (274), Baltimore (257), Miami (240), and Atlanta (239) (*see exhibit 10 on the following page*). Rates increased significantly in Baltimore in the two most recent testing periods, but otherwise they remained stable from 2001 to 2002.

Exhibit 10. Rates of Cocaine ED Mentions Per 100,000 Population in 19 CEWG Areas: 1995–2002

					Percent Change[1]		
CEWG Area	1995	2000	2001	2002	1995, 2002	2000, 2002	2001, 2002
Atlanta	245	221	244	239		8.0	
Baltimore	384	208	214	257	-33.1	23.6	19.7
Boston	147	108	138	156			
Chicago	188	246	277	275	46.6		
Denver	75	83	69	82	9.3		
Detroit	212	179	186	182			
Los Angeles	61	105	117	108	77.2		
Miami	168	225	225	240	42.9		
Mpls./St. Paul	20	35	43	55	172.8		
New Orleans	174	162	123	145		-10.5	
New York	243	166	166	166	-32.0		
Newark	268	147	152	186			
Philadelphia	208	216	252	274			
Phoenix	59	85	62	59	-0.5		
St. Louis	80	98	134	153	91.4	55.8	
San Diego	28	41	32	32		-23.1	
San Francisco	166	126	158	150		19.7	
Seattle	116	169	160	164			
Wash., DC	96	72	69	71			

[1]These columns denote statistically significant ($p<0.05$) changes between estimates for the time periods noted.
SOURCE: DAWN, OAS, SAMHSA

Mortality Data on Cocaine/Crack

The DAWN mortality data from 12 CEWG areas in 2002 are shown in exhibit 11. In 6 out of 12 CEWG areas listed in exhibit 11, cocaine-related death mentions exceeded those for other drugs; these were Atlanta, Chicago, Dallas, Denver, New York, and Washington, DC.

In Atlanta in 2002, cocaine was the only drug detected in 43 percent of the mentions, as was the case for Chicago and Denver, at 35 and 38 percent, respectively. In the other CEWG areas, single-drug deaths involving cocaine ranged from a low of 7 percent in Baltimore to a high of 29 percent in Washington, DC.

Exhibit 11. Number of Cocaine-Involved Death Mentions in 12 CEWG Areas: 1999–2002

CEWG Area	1999	2000	2001	2002
Atlanta	170	148	136	155
Baltimore[1]	303	243	248	299
Boston	117	118	132	121
Chicago	511	464	514	497
Dallas	153	157	185	176
Denver[1]	82	80	126	108
New Orleans	82	111	90	101
New York	394	492	NR[2]	421
Newark	130	137	148	127
San Diego[1]	74	84	40	36
San Francisco[1]	158	146	106	90
Washington, DC	106	107	90	108

[1]In these sites, 100 percent of the population are covered.
[2]NR=Not reported (data were incomplete).
SOURCE: DAWN, OAS, SAMHSA

Local ME data for 2003 were reported by eight CEWG members (*see exhibit 12*). As shown, the number of cocaine-involved deaths was high in Detroit, Miami, and Philadelphia. The number of cocaine-involved deaths peaked in 2003 in Honolulu, Miami, and Philadelphia.

Exhibit 12. Number of Cocaine-Related Deaths Reported by Local MEs in 8 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003
Detroit	395	406	417	379
Honolulu	22	24	23	26
Miami	224	243	272	327
Mpls./St. Paul	60	48	45	54
Philadelphia	321	300	270	326
Phoenix	167	138	116	63[1]
St. Louis	66	75	58	NR[2]
Seattle	89	49	79	53

[1]Phoenix data for 2003 are prorated, with data unavailable for a 2-month period.
[2]NR=Not reported.
SOURCE: MEs/Coroners as cited in CEWG June 2004 reports

Statewide ME data for 2002 were reported by the Texas CEWG representative:

The number of deaths statewide in which cocaine was mentioned has increased over the years, from 223 in 1992 to 538 in 2002, and the rate has gone from 1.1 per 100,000 population in 1992 to 2.5 per 100,000 population in 2002. The average age of decedents continues to increase, to 39.4 in 2002. Of these, 47 percent were White, 24 percent were Hispanic, and 28 percent were Black. Seventy-six percent were male. —JANE MAXWELL

Treatment Data on Cocaine/Crack

Primary cocaine treatment admissions-excluding alcohol admissions-continued to be proportionately highest among all admissions in 9 of the 21 CEWG areas in 2003. The highest percentages were in Atlanta (58 percent) and St. Louis (44 percent) (*see exhibit 13*). Primary cocaine admissions ranged between approximately 32 and 43 percent of the illicit drug admissions in Miami, Washington, DC, Philadelphia, Detroit, Texas, and New Orleans.

High percentages of the primary cocaine abusers entering treatment in 2003 were crack users (smoked the drug). The highest proportions were in Detroit and St. Louis (93 and 91 percent, respectively), followed by Los Angeles, San Francisco, and Illinois (85–87 percent).

Exhibit 13. Primary Cocaine Treatment Admissions by CEWG Area and Percent of all Admissions (Excluding Alcohol): 2001–2003[1]

CEWG Area/State	Year			Percent Crack 2003[2]
	2001	2002	2003	
Atlanta	68.1	60.8	57.6	78.0
Baltimore[3]	15.1	15.7	15.4	74.3
Boston	16.0	15.0	12.7	57.1
Detroit	38.7	38.6	38.5	93.1
Los Angeles	22.9	23.3	23.0	86.6
Miami (sample)[3]	NR[4]	45.3	32.0	NR
Mpls./St. Paul	26.6	27.2	26.3	82.9
New Orleans	40.0	42.7	43.1	NR
New York	29.3	28.5	28.9	60.8
Newark	7.0	6.8	6.6	73.8
Philadelphia	39.6	40.3	36.4	81.4
St. Louis	44.3	41.9	43.7	90.9
San Diego	12.1	10.2	9.6	77.1
San Francisco	28.1	27.8	27.0	87.2
Seattle	21.9	19.8	22.6	NR
Washington, DC	41.4	41.9	34.9	66.2
Arizona	19.0	16.7	16.2	54.3
Colorado	20.7	20.7	21.4	60.6
Hawaii	8.0	8.5	6.3	57.7
Illinois	31.6	30.0	28.0	85.0
Texas	38.9	38.7	38.2	70.8

[1]Represents either calendar or fiscal year.
[2]Represents the percentage of primary cocaine admissions who reported smoking the drug.
[3]Baltimore data represent only the first 6 months of 2003 and Miami the last 6 months of 2003.
[4]NR=Not reported.
SOURCES: CEWG June 2004 reports on State and local data

ADAM Data on Cocaine

In various quarters of 2003, the average proportions of adult males testing cocaine-positive were near or exceeded one-half of the samples in three CEWG areas: Chicago (50.6 percent), Atlanta (49.8 percent), and New Orleans (47.6 percent) (*see exhibit 14*). In six other ADAM/CEWG sites, between 30 and 38 percent of adult males tested cocaine-positive. The proportions with positive toxicology screens for cocaine were lower than 12 percent in two sites (Honolulu and San Diego). In the three CEWG sites where male arrestees were tested only in the fourth quarter, the proportions testing cocaine-positive were highest in Miami (47.1 percent), followed by Boston (31.8 percent) and Houston (22.6 percent).

Exhibit 14. Percentages of Adult Male Arrestees Testing Cocaine-Positive in 15 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003[1]
Atlanta	48.5	NS[2]	49.9	49.8
Chicago	37.0	40.6	47.9	50.6
Dallas	27.7	30.4	29.9	32.7
Denver	35.4	33.8	32.7	38.3
Honolulu	15.8	10.8	9.1	11.6
Los Angeles	NS	NS	32.1	23.5
Minneapolis	25.7	28.0	30.8	28.4
New Orleans	34.8	37.3	42.4	47.6
New York	48.8	44.6	49.0	35.7
Philadelphia	30.9	36.7	38.7	30.3
Phoenix	31.9	27.2	27.8	23.4
San Antonio	20.4	29.6	32.5	30.5
San Diego	14.8	14.1	12.7	10.3
Seattle	31.3	32.0	38.1	36.6
Wash., DC	NS	NS	27.5	26.5

[1]Weighted estimates are for various quarters in 2003 (*see Data Sources*).
[2]NS=Not sampled.
SOURCE: ADAM, NIJ

The proportions of adult female arrestees testing cocaine-positive in various quarters of 2003 were particularly high in Denver (52.5 percent), New York City (50.0 percent), Minneapolis (40.8 percent), and New Orleans (37.3 percent) (*see exhibit 15*).

Exhibit 15. Percentages of Adult Female Arrestees Testing Cocaine-Positive in 10 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003[1]
Chicago	59.2	NS[2]	NS	33.3
Denver	46.9	45.0	43.6	52.5
Honolulu	19.4	9.7	7.2	8.5
Los Angeles	NS	NS	21.4	25.9
Minneapolis	NS	NS	NS	40.8
New Orleans	41.1	38.1	42.2	37.3
New York	53.0	56.9	38.9	50.0
Phoenix	35.2	31.6	25.9	28.1
San Diego	26.1	16.5	21.2	15.2
Washington, DC	NS	NS	37.5	30.9

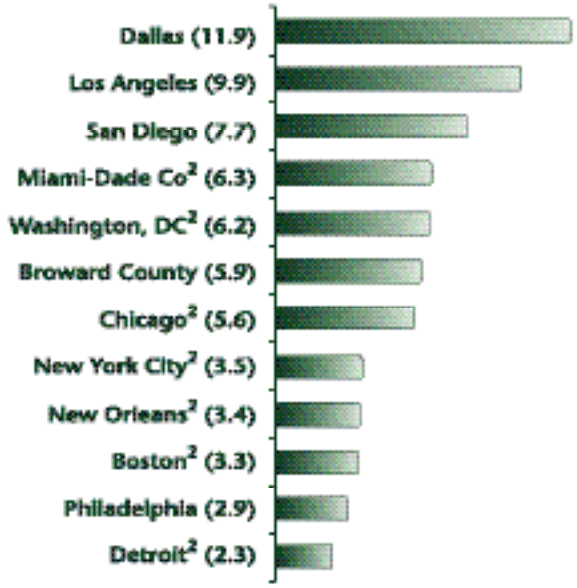
[1]Data are unweighted and represent various quarters in 2003 (*see Data Sources*).
[2]NS=Not sampled or reported.
SOURCE: ADAM, NIJ

Student Survey Data on Cocaine

Exhibit 16 displays the prevalence of "lifetime" (ever used) cocaine use for students in grades 9–12 in 12 CEWG areas that participated in the 2003 Youth Risk Behavior Survey. Use includes powder, "crack," and "freebase" cocaine.

In all 12 CEWG areas, lifetime use of cocaine was higher among male than female students. Across sites, the proportions of male students ever using cocaine ranged from 3.0 percent in Detroit to 13.6 percent in Dallas. Among female students, the proportions ranged from 1.5 percent in New Orleans to 10.3 percent in Dallas.

Exhibit 16. Lifetime Use[1] of Cocaine Among Students in Grades 9–12 in 12 CEWG Areas, by Percent: 2003



[1]Used cocaine one or more times during their lifetime.
[2]Represents public school sample; all others represent a "school district," "independent school district," or "unified school district."
SOURCE: YRBS, CDC

The proportions of students reporting use of cocaine in the 30 days prior to the survey tended to be small, ranging from 0.8 percent in Philadelphia to 4.9 percent in Dallas.

NFLIS Data on Cocaine

The numbers of cocaine items analyzed in the NFLIS system in 2003 were high in most areas represented in exhibit 17, exceeding even the number of marijuana items in 11 CEWG cities and in 10 of the 13 sites in Texas. In Baltimore and Newark, where heroin indicators are high, the number of cocaine items analyzed exceeded those for heroin. As a proportion of all items analyzed, cocaine accounted for around one-half or more of all items in Denver, Newark, Miami, and New York.

Cocaine/Crack Availability and Prices

In the first half of 2004, powder cocaine remained readily available in nearly all CEWG areas. As shown in exhibit 18 on the following page, the least expensive prices for a gram of powder cocaine ranged from $20 to $25 in the east coast cities of Baltimore, Philadelphia, and New York City. Prices for a gram of powder cocaine were higher in Honolulu, Minneapolis, and St. Louis, where they started at $100. The least expensive kilogram of powder cocaine was reported in Seattle ($10,000).

Mexico-based drug trafficking organizations (DTOs) were reported as the primary suppliers of cocaine in Atlanta, where members of the DTOs are able to blend into communities of Hispanic workers. In New Orleans, cocaine is reportedly supplied by Colombia- and Mexico-based DTOs that operate out of California and Texas. Mexican gangs in Queens and Staten Island, New York, are reportedly taking over the sale of cocaine from Dominicans, and the two groups are fighting over territory. Also in New York were reports of an increase in the number of female cocaine sellers.

Exhibit 17. Estimated Number of Analyzed Cocaine Items and Percentage of All Items Tested in 19 CEWG Areas: 2003

CEWG Area	Percent	Number
Miami	66.7	9,401
New York	51.3	20,118
Denver	50.3	2,177
Newark	48.3	1,840
Baltimore	46.9	15,297
Detroit	45.2	1,934
St. Louis	45.1	2,839
Philadelphia	43.7	9,269
Seattle	40.5	1,300
Atlanta	39.7	7,811
Washington, DC	39.5	2,628
New Orleans	38.4	4,757
Chicago	33.8	20,733
Los Angeles Co.[1]	32.7	14,874
Texas	30.6	15,426
Boston	27.6	1,880
St. Paul	21.3	758
San Diego	13.1	1,797
Honolulu	12.2	320

[1]Data are not complete for all months.
SOURCE: NFLIS, DEA

Exhibit 18. Powder Cocaine Prices in 21 CEWG Areas: January–June 2004

CEWG Area	Retail	Ounce	Wholesale
Atlanta	$75–$100/g	$600–$1,000	$18,000–$25,000/kg
Baltimore	$10/vial $20–$200/g	$900–$1,200	$20,000–$32,000/kg
Boston	$50–$90/g	$750–$1,200	$25,000–$42,000/kg
Chicago	$75–$100/g	$900–$1,100	$18,000–$22,000/kg
Dallas	$50–$80/g	$650–$950	$15,000–$22,500/kg
Denver	$50–$80/g	$550–$800	$18,000–$20,000/kg
Detroit	$50–$120/g	$750–$1,500	$17,000–$26,000/kg
Honolulu	$25–$35/¼ g $100–$120/g $250–$350/⅛ oz $500–$620/¼ oz	$1,100–$1,500	$26,500–$52,000/kg $13,000–$25,000/lb
Los Angeles	$80/g	$500–$600	$14,000–$17,000/kg
Miami	$30–$60/g	$700–$800	$18,000–$26,000/kg
Minneapolis	$100/g	$700–$2,000	$18,000–$28,000/kg
Newark	$30–$100/g	$500–$1,800	$19,000–$34,000/kg
New Orleans	$80–$150/g	$800–$1,200	$18,000–$25,000/kg
New York	$25–$35/g $120–$150/⅛ oz	$613–$9500	$20,000–$25,000/kg
Philadelphia	$10–$20/bag $25–$125/g	$720–$1,300	$22,800–$35,000/kg
Phoenix	$80–$100/8-ball[1]	$500–$800	$15,000–$16,000/kg
St. Louis	$100–$125/g	$700–$1,200	$20,000-$25,000/kg
San Diego	$25–$35/¼ g $60–$80/g $120–$140/⅛ oz	$550–$800	$7,800–$10,000/lb $12,650–$19,500/kg
San Francisco	$10–$25/¼–½ g $35–$50/g	$530–$800	$16,000–$21,000/kg
Seattle	$50-$100/g	$550–$900	$10,000–$25,000/kg $10,000/lb
Washington, DC	$60–$100/g	$1,000–$1,200	$27,000–$28,000/kg

[1] 8-ball=one-eighth ounce.
SOURCES: Narcotics Digest Weekly, NDIC, and June 2004 CEWG reports

Crack cocaine was similarly reported to be widely available throughout CEWG areas. Crack continued to have a lower entry-level price than powder cocaine, with rocks available for as little as $5 each in Detroit, New Orleans, and Philadelphia (*see exhibit 19 on page 37*). In Austin, Texas, a price war resulted in two rocks of crack being sold for $15, rather than the usual price of $10 each. At the wholesale level, the lowest price reported for a kilogram of crack was $10,000 in Seattle, while the highest was $35,000 (Newark).

Plastic bags were reported to be the most popular way to package crack in New York City, and both plastic bags and aluminum foil were popular in Detroit.

Exhibit 19. Crack Cocaine Prices in 21 CEWG Areas: January–June 2004

CEWG Area	Retail	Ounce	Wholesale
Atlanta	$50/rock	$800–$1,000	$10,000–$12,000 /lb
Baltimore	$10–$40/piece $40–$200/g $100–$175/⅛ oz	$650–$1,200	$20,000–$26,000/kg
Boston	$10–$20/rock	$850–$1,600	N/A[1]
Chicago	$10 per rock $50–$150/g	$800–$1,000	$22,000–$24,000/kg $10,000–$12,000/lb
Dallas	$10–$50/rock $75–$100/g	$750–$1,100	$18,500–$25,500/kg
Detroit	$5–$25/rock	$750–$1,500	N/A
Denver	$20–$50/rock $50–$100/g	$800–$1,000	$8,800–$10,000/lb
Honolulu	$25–$30/¼ g $50 per paper[2] $100–$250/g	$1,000–$1,500	$24,000/lb
Los Angeles	$10–$40/rock	$500–$1,200	N/A
Miami	$10–$20/rock $100/g	$650–$1,000	$18,000–$26,000 /kg
Minneapolis	$15–$25/rock	$600–$1,750	N/A
Newark	$23–$80/g $100–$200/8-ball[3]	$600–$2,000	$16,000–$35,000/kg
New Orleans	$5–$25/rock $80–$125/g	$900–$1,200	$8,000/lb $20,000–$28,000/kg
New York	$7–$10/rock $5–$10 /bag $23–$40/g	$1,000–$1,500	$18,000/kg
Philadelphia	$5/rock	$700–$1,500	N/A
Philadelphia	$10–$20/bag $25–$125/g	$720–$1,300	$22,800–$35,000/kg
Phoenix	$20 /rock	$500–$700	$7,500/lb
St. Louis	$20/rock $100/g	$800–$1,000	$20,000–$26,000/kg
San Diego	$10–$20/rock	$450–$500	N/A
San Francisco	$20–$50/rock	$600	N/A
Seattle	$20/⅒ g $40/¼ g $60–$100/g	$550–$900	$10,000–$18,000/kg
Wash., DC	$80–$100/g	$1,100	$28,000–$34,000/kg

[1]N/A=Not available.
[2]Paper=Approximately one-quarter gram.
[3]8-ball=one-eighth ounce.
SOURCES: Narcotics Digest Weekly, NDIC, and June 2004 CEWG reports

HEROIN

In most CEWG areas in 2002–2003, heroin abuse indicators remained relatively low (compared with cocaine/crack, marijuana, and methamphetamine abuse indicators). The exceptions were Chicago, Newark, Baltimore, and San Francisco. Baltimore (32.4 percent) and Newark (31.3 percent) had high percentages of heroin items identified by forensic labs in 2003. Heroin purity levels were highest in northeast cities where South American heroin was the primary source. Rates of heroin ED mentions per 100,000 population in 2002 were highest in Chicago (220), Newark (214), and Baltimore (203).

Heroin abuse indicators have increased in several CEWG areas.

Baltimore: *Heroin indicators in 2003 for the Baltimore metropolitan area as a whole generally indicated an increase over 2001 levels…. Heroin use in the Baltimore metropolitan area is complex. There are several groups of heroin users that differ by urbanicity, route of administration, age, and race. The heroin treatment admission rate was almost 5 times higher in Baltimore City than in the suburban counties.* —LEIGH HENDERSON

Chicago: *…heroin continues to be a serious problem in Chicago. The rate of heroin ED mentions per 100,000 population increased 167 percent from 1995 to 2002, and the 2002 rate was the highest in the coterminous United States. Heroin treatment admissions increased 23 percent from FY 2002 to FY 2003. Deaths involving heroin/morphine increased 10 percent in Cook County in 2002, following a 30-percent decrease between 2000 (n=438) and 2001 (307).* —DITA BROZ

Minneapolis/St. Paul: *Heroin-related indicators continued at heightened levels. Opiate-related deaths outnumbered those for cocaine in both Hennepin and Ramsey Counties, a situation fueled by high-purity, low-cost heroin and the continuing abuse of prescription narcotic analgesics.* —CAROL FALKOWSKI

New Orleans: *Heroin abuse in New Orleans has risen over the past several years, and the city has been and continues to have regional markets for heroin. Most heroin-related cases conducted by State and local agencies and the DEA are in the New Orleans area. The New Orleans Police Department views heroin and its abuse as significant, impacting homicides in Orleans Parish. Heroin is not only becoming more available in a purer form, it is also becoming more affordable.* —GAIL THORNTON-COLLINS

New York: *Heroin indicators, including treatment admissions and deaths, have increased…. Primary heroin admissions to treatment programs in New York City gradually increased between 1995 and 2003. Overall, admissions increased from 18,287 to 23,563, a 23-percent increase…. In addition to heroin admissions to traditional treatment programs, heroin admissions for detoxification or crisis services in New York City have become sizable in number. These special services are usually short term, provided in a hospital or community-based setting, and medically supervised. In 1995, 4,503 such admissions were reported for heroin abuse; by 2003 that figure increased to 16,010, essentially the same as in 2002 (16,083).*—ROZANNE MAREL

In other CEWG areas, heroin abuse indicators were mixed, with the drug continuing to pose a serious problem in most of these areas.

Atlanta: *The indicators of heroin use in Atlanta are mixed. ED mentions were up from 1995 to 2002, while treatment rates were stable. In FY 2003, treatment admissions were down. Law enforcement seizures increased in 2003. Deaths were declining. Compared nationally, heroin in Atlanta is more pure and less expensive.* —KRISTIN WILSON

Boston: *Heroin is one of Boston's most abused drugs. A few of the most recent indicators show heroin abuse possibly stabilizing at very high levels after years of continued growth. Heroin/morphine was*

mentioned most often among drug abuse deaths. Heroin emergency department mentions are stable at high levels. The proportion of heroin treatment admissions continues to rise, with nearly half of all clients in treatment reporting heroin as their primary drug. —Daniel Dooley

Denver: *Heroin indicators are mixed, with hospital discharges and ED mentions increasing, ADAM data stable, and deaths, treatment admissions, and new users in treatment down slightly.* —Bruce Mendelson

Los Angeles: *From July to December 2003, just over 6,700 Los Angeles County treatment and recovery program admissions were attributable to primary heroin abuse, compared with 6,891 admissions reported in the county in the first half of 2003. The proportion of primary heroin admissions among all Los Angeles County treatment and recovery programs appears to have leveled off at 25 percent of all admissions. It is too early to make a definitive statement as to the apparent stabilization. Despite a consistent decline over recent years, heroin admissions continue to marginally account for the highest percentage of all treatment and recovery program admissions in the county. However, heroin arrests increased. A total of 10,864 heroin arrests were made within the city of Los Angeles in calendar year 2003. This represented a 24-percent increase from the number of heroin arrests made in 2002. Heroin arrests accounted for approximately 35 percent of all narcotics arrests made from January 1, 2003, to December 31, 2003.* —Beth Finnerty

Newark: *The rate of ED mentions for heroin in 2002 continued to be higher than rates for other drugs [but] was significantly unchanged from 2001. The number of death mentions was down from 2001. As a proportion of illicit drug admissions, primary heroin accounted for 85.4 percent in Newark City in 2003, remaining stable from 2002. In the Newark PMSA, primary heroin admissions accounted for 77.1 percent of illicit drug admissions in 2003 and for 61.1 percent of all treatment admissions (including alcohol).*

—Anna Kline

San Francisco: *Indicators were mixed, with heroin ED rates stable, ME and treatment indicators down, and arrests up. Arrests for heroin-related offenses were 6,136 in 2002, 16 percent higher than in 2001 and 3 percent higher than in 2000. However, the rate of arrests during the first 10 months of 2003 was nearly 30 percent lower than during a similar period of 2002…. Because many heroin users support their habits through property crimes, reported burglaries may be a good indicator of use. The number of such reports in San Francisco fell by 49 percent between 1993 and 1999 (11,164 to 5,704). After that low point, the count rose to 6,706 in 2001, and then fell by 10 percent, to 6,051 in 2003. These changes may reflect the price of heroin more than the prevalence of users: it is noteworthy that reported burglaries and the local price of heroin are both barely one-quarter of what they were 20 years ago.* —John Newmeyer

Washington, DC: *Heroin is one of the three leading drug problems in the District, along with cocaine and marijuana. Treatment admissions for primary heroin abuse increased slightly; however, heroin ED mentions remained stable, while heroin/morphine deaths declined.* —Eric Wish

Injection continues to be the primary route of administration of heroin in many CEWG areas.

Baltimore: *In Baltimore City, intranasal use was the preferred route of administration among treatment admissions, and the admission rate for intranasal use was 10 percent higher than for injection. In the suburban counties, however, the rate for heroin injection was 44 percent higher than for inhalation.* —Leigh Henderson

Los Angeles: *The proportion of primary heroin admissions reporting injection use continued to decrease slightly to 85 percent of the primary heroin admissions.* —Beth Finnerty

New York: *Heroin injection increased among heroin admissions, from 32 percent in the second half of 1998 to 37 percent in 2003.* —Rozanne Marel

San Francisco: *Injection remains, by far, the predominant mode of heroin usage.* —JOHN NEWMEYER

Texas: Research data show that the reasons for injecting heroin are complex.

Heroin is the primary drug of abuse for 10 percent of clients admitted to treatment. Most heroin addicts entering treatment inject heroin.… [Among] heroin addicts in…methadone programs in Austin, Dallas, Fort Worth, and San Diego… [NIDA grant DA–014744]…some injectors never heard or thought about snorting heroin; they were only exposed to people who injected. Others reported that injecting is a 'much better high,' or that injecting was 'more economical.' Others reported that they injected because black tar, which is not inhalable, was the only type of heroin available. Others injected because snorting hurt their noses and sinuses.… Some addicts started as snorters and then shifted to injecting, while others continued to use both routes of administration, depending on whether needles were available, their friends were snorting or injecting, they had lost their veins, or they had to prove they had no needle tracks to their probation or parole officers or to their spouses. In addition, there were older addicts who had started as inhalers, shifted to injecting, then went through treatment and had ceased heroin use. However, they had relapsed and were snorting heroin but were worried about the possibility of shifting to needles and came into treatment this time as snorters. —JANE MAXWELL

Indicator data typically show that heroin abusers are an older group than abusers of other drugs; however, there are concerns of increasing abuse of heroin among young people in some CEWG areas.

New York: *Researchers are beginning to see teenagers, as young as 14 years old, of varied backgrounds, using heroin. In sections of Brooklyn and the Bronx, the staff is reporting that sellers are ranging in age from the late teens to the late thirties and buyers from the early teens to the early sixties.* —ROZANNE MAREL

Newark: *Trend data on treatment admissions who were heroin injectors show increasing proportions of young injectors in the Newark PMSA and statewide. In the PMSA, the proportion of heroin injectors age 18–25 increased dramatically from 17.0 percent in 1992 to 58.6 percent in 2003. A similar increase occurred statewide—from 28.7 percent in 1992 to 59.8 percent in 2003. Since 1993, injection among clients age 26–34 has also risen moderately.… Analysis of injection trends among primary heroin users age 18–25 by regional type shows that the proportion injecting in the major cities (Newark, Camden, Trenton, Elizabeth, and Paterson) has also risen substantially since 1992. In 1993, for example, 15.5 percent of young heroin users in the cities injected, compared with 40.3 percent and 52.7 percent of those in the suburbs and rural areas, respectively. By 2003, however, the cities were comparable to the suburban and rural areas in the proportion injecting, with 56.9 percent of young heroin users in the cities injecting, compared with 58.5 percent in the suburbs and 61.8 percent in the rural areas.*

—ANNA KLINE

Seattle: *Helpline calls from January to June of 2003 for heroin represented 14 percent of all drug-related calls, slightly higher than the 9 and 11 percent seen in 2001 and 2002, respectively. Teens were less likely to call about heroin. Only 3 percent of calls by teens were related to heroin.* —CALEB BANTA-GREEN

Texas: *Calls to Texas Poison Control Centers involving confirmed exposures to heroin ranged from 181 in 1998 to a high of 296 in 2000 and dropped to 208 in 2003. In 2003, the average age of callers was 35 and 66 percent were male. In 2003, 14 involved intentional misuse or abuse of heroin by inhalation (snorting or smoking), and the average age of these inhalers was 33, which shows that injectors tend to be older than inhalers in this dataset as well as in the treatment data.*

—JANE MAXWELL

Patterns and Trends Across CEWG Areas

DAWN ED Data on Heroin

Rates of heroin ED mentions per 100,000 population in 2002 were highest in Chicago (220), Newark (214), and Baltimore (203) (*see exhibit 20*). As shown in exhibit 20, the trends across the

Exhibit 20. Rates of Heroin ED Mentions Per 100,000 Population in 19 CEWG Areas: 1995–2002

					Percent Change[1]		
CEWG Area	1995	2000	2001	2002	1995, 2002	2000, 2002	2001, 2002
Atlanta	15	17	23	20	28.6	13.5	
Baltimore	366	227	195	203	-44.6	-10.7	4.0
Boston	83	102	122	111			
Chicago	83	206	203	220	166.9		
Denver	30	41	40	43	43.2	5.5	9.8
Detroit	58	76	93	93			
Los Angeles	37	37	34	29		-20.8	
Miami	18	74	81	85	366.1	13.9	
Mpls./St. Paul	4	9	13	16	347.8		
New Orleans	23	80	46	53	136.0	-32.9	
New York	132	128	127	123			
Newark	327	238	215	214			
Philadelphia	84	96	119	109			
Phoenix	25	40	27	23	-7.0	-43.2	-16.4
St. Louis	16	44	57	51	215.2		
San Diego	29	42	29	28		-34.4	-4.9
San Francisco	202	168	178	171			
Seattle	109	126	90	128			42.5
Wash., DC	35	49	45	38			

[1]These columns denote statistically significant ($p<0.05$) changes between estimates for the time periods noted.
SOURCE: DAWN, OAS, SAMHSA

years are mixed. Seven areas showed significant increases from 1995 to 2002, and three continued to increase in one or both of the most recent testing periods. Baltimore, which experienced significant decreases in heroin ED mentions from 1995 to 2002 and 2000 to 2002, experienced a significant increase from 2001 to 2002, while heroin ED mentions in Phoenix continued to decrease from 1995 onward. Between 2001 and 2002, only Baltimore, Denver, and Seattle reported significant increases in heroin ED mentions, while Phoenix and San Diego reported significant decreases in that period.

Mortality Data on Heroin

DAWN medical examiner/coroner data on heroin/morphine-related deaths are shown in exhibit 21 for 12 CEWG areas in 2002.

In Atlanta, Boston, Chicago, and Denver, between 21 and 31 percent of the deaths involved only heroin. In the other CEWG areas, single-drug deaths ranged between 1 and 16 percent.

Exhibit 21. Number of Heroin/Morphine-Involved Death Mentions in 12 CEWG Areas: 1999–2002

CEWG Area	1999	2000	2001	2002
Atlanta	38	30	16	14
Baltimore[1]	451	397	349	411
Boston	168	183	195	192
Chicago	456	499	352	376
Dallas	77	94	76	84
Denver[1]	79	66	77	64
New Orleans	38	48	37	19
New York	174	194	NR[2]	224
Newark	128	179	177	149
San Diego[1]	142	145	111	102
San Francisco[1]	192	148	117	95
Wash., DC	95	84	64	86

[1]In these sites, 100 percent of the population are covered.
[2]NR=Not reported (data were incomplete).
SOURCE: DAWN, OAS, SAMHSA

Local/State medical examiner data in 2003 show that heroin-related deaths continue to be high in the Detroit, Miami/South Florida, and Philadelphia areas (*see exhibit 22*).

Exhibit 22. Numbers of Heroin/Morphine-Related Deaths Reported by Local MEs in 8 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003
Detroit	473	465	496	464
Honolulu	22	24	14	18
Miami/So. Florida	174	194	137	176
Mpls./St. Paul	58	77	77	69
Philadelphia	332	316	275	208
Phoenix	137	103	103	122[1]
St. Louis	47	36	35	NR[2]
Seattle	89	49	87	62

[1]Phoenix data for 2003 are prorated, with data unavailable for a 2-month period.
[2]NR=Not reported.
SOURCE: MEs/coroners as cited in CEWG June 2004 reports

More detailed information on heroin-involved deaths reported by local MEs, as well as data for the State of Texas, is provided in the quotes below:

Miami/Ft. Lauderdale: *From 1995 to 2000, Miami-Dade County recorded the greatest number of heroin-induced deaths of any county or medical examiner district in the State. Beginning in 2002, Palm Beach and Broward Counties ranked first and second in the State. In 2003, Broward County ranked first, with 43 heroin-induced deaths, followed by Orlando (33), Miami-Dade County (28), and Palm Beach County (27).* —JAMES HALL

Philadelphia: *Heroin/morphine was detected in 2,822 decedents from January 1994 through December 2003, the second most commonly detected drug in decendents. For the 4-year period of 1999 through 2002, positive heroin/morphine toxicology reports occurred in 47 percent of all deaths with the presence of drugs. In 2003, heroin/morphine was detected in only 25 percent of all decedents with drug-positive toxicology reports.… From 2000 through 2002, heroin/morphine alone was identified in 14, 11, and 10 percent of the respective heroin/morphine toxicology reports. In 2003, heroin/morphine alone was identified in 7 percent of the heroin/morphine toxicology reports. The combination of heroin/morphine and cocaine was detected in 20, 19, and 17 percent of all decedents, respectively, from 2000 through 2002, but in only 10 percent of drug-positive toxicology reports in 2003.* —SAMUEL CUTLER

Seattle: *Deaths involving heroin are near their lowest level since 1992, with 62 such deaths in 2003 and 58 in 1992. A spike in heroin-associated mortality was evident around 1998, when there was a peak of 144 heroin-involved deaths, 65 of which were related to heroin alone. This spike was during a time of relatively high-purity heroin, 21 percent pure compared to 10 percent in 2003.* —CALEB BANTA-GREEN

Texas: *There were 371 deaths statewide with a mention of heroin or narcotics. The rate has increased from 0.85 per 100,000 in 1992 to 1.73 per 100,000 in 2002. Those who died in 2002 were White (58 percent), Hispanic (32 percent), or Black (10 percent). Approximately 80 percent were male. The average age continued to increase; in 2002 it was 39.3 years.… In Austin… multiple heroin overdoses and some deaths have been reported by the outreach team. In addition, there are reports of Southwest Asian heroin, which is being brought home by troops rotating out of Iraq.* —JANE MAXWELL

Treatment Data on Heroin

Patterns of primary heroin admissions (excluding alcohol) show little change from the last CEWG reporting period in most CEWG areas (*see exhibit 23*). However, data suggest small decreases in the proportion of primary heroin abusers in some CEWG areas.

Excluding alcohol, the proportions of primary heroin abusers admitted to treatment in 2003 were very high in Newark (85.4 percent) and Boston (73.4 percent). These proportions reflect the type of treatment program (e.g., methadone maintenance) offered in these cities. Other CEWG areas with high proportions of primary heroin abusers include Baltimore (61.6 percent), Washington, DC (51.2 percent), San Francisco (44.0 percent), Detroit (43.1 percent), New York (42.3 percent), Philadelphia (31.4 percent), and Los Angeles (31.1 percent).

Exhibit 23. Primary Heroin Treatment Admissions by CEWG Area and Percent of all Admissions (Excluding Alcohol): 2001–2003[1]

CEWG Area	2001	2002	2003
Atlanta	8.6	5.2	8.5
Baltimore[2]	60.4	62.0	61.6
Boston	74.1	72.6	73.4
Detroit	46.9	42.7	43.1
Los Angeles	46.3	37.4	31.1
Miami (sample)[2]	NR[3]	9.0	4.1
Mpls./St. Paul	6.4	7.1	6.7
New Orleans	18.3	14.6	13.4
New York	43.2	41.1	42.3
Newark	85.9	85.8	85.4
Philadelphia	33.9	29.6	31.4
St. Louis	15.0	13.7	12.8
San Diego	12.3	11.7	10.9
San Francisco	47.2	45.7	44.0
Seattle	23.7	26.6	25.1
Washington, DC	47.0	46.9	51.2
Arizona	15.4	14.0	11.7
Colorado	13.9	13.5	13.2
Hawaii	5.1	4.7	3.6
Illinois	24.7	23.4	28.6
Texas	16.4	15.9	13.6

[1]Represents either calendar or fiscal year.
[2]Baltimore represents only the first 6 months of 2003 and Miami the last 6 months of 2003.
[3]NR=Not reported.
SOURCE: CEWG June 2004 reports on State and local data

In 16 CEWG areas, the proportions of primary heroin treatment admissions were relatively stable from 2001 to 2003. However, there were substantial percentage-point decreases from 2001 to 2003 in San Francisco (18.8 percentage points), Los Angeles (15.2), and New Orleans (4.9). The largest percentage-point increases between the 2 years were in Washington, DC (4.2 percentage points) and Illinois (3.9). Such changes may reflect, in part, shifts in funding of treatment programs.

ADAM Data on Heroin

The CEWG/ADAM sites that reported the highest percentages of adult male arrestees testing opiate-positive in various quarters of 2003 were Chicago (24.9 percent), New York (15.0 percent), New Orleans (14.0 percent), and Philadelphia (11.5 percent) (*see exhibit 24*).

Exhibit 24. Percentages of Adult Male Arrestees Testing Opiate-Positive in 15 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003[1]
Atlanta	2.8	NS[2]	3.2	3.0
Chicago	27.0	21.8	26.0	24.9
Dallas	3.0	4.8	7.1	6.9
Denver	3.4	5.2	4.0	6.8
Honolulu	6.8	3.4	3.5	4.6
Los Angeles	NS	NS	5.8	2.0
Minneapolis	3.0	5.4	5.1	5.8
New Orleans	15.5	15.6	16.3	14.0
New York	20.5	18.7	15.0	15.0
Philadelphia	11.8	13.2	15.9	11.5
Phoenix	6.6	6.0	4.9	4.4
San Antonio	10.2	9.1	11.0	9.1
San Diego	6.0	7.6	5.6	5.1
Seattle	9.9	10.3	10.0	6.8
Washington, DC	NS	NS	9.5	9.8

[1]Weighted estimates are for various quarters in 2003 (*see Data Sources*).
[2]NS=Not sampled.
SOURCE: ADAM, NIJ

The percentages of male arrestees testing positive for opiates were low in Atlanta, Honolulu, Los Angeles, and Phoenix, ranging from 2.0 to 4.6 percent. The proportions ranged between 5.1 and 5.8 percent in San Diego and Minneapolis, with somewhat higher proportions in Denver and Seattle (each 6.8 percent), Dallas (6.9 percent), San Antonio (9.1 percent), and Washington, DC (9.8 percent). Among male arrestees tested only in the fourth quarter of 2003, the proportions testing opiate-positive were highest in Boston (17.3 percent), followed by Houston (5.7 percent), and Miami (2.5 percent).

Of the 10 CEWG sites where adult female arrestees were tested in 2003, the highest proportions of opiate-positives were recorded in New York (23.3 percent), Chicago (22.2 percent), and New Orleans (13.3 percent) (*see exhibit 25*).

Exhibit 25. Percentages of Adult Female Arrestees Testing Opiate-Positive in 10 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003[1]
Chicago	40.0	NS[2]	NS	22.2
Denver	5.8	5.2	5.3	6.1
Honolulu	8.3	4.2	5.8	6.4
Los Angeles	NS	NS	14.3	0.0
Minneapolis	NS	NS	NS	6.6
New Orleans	8.5	7.6	9.2	13.3
New York	19.1	13.9	13.9	23.3
Phoenix	6.5	6.3	5.1	6.1
San Diego	7.5	8.6	5.8	8.7
Wash., DC	NS	NS	17.5	10.9

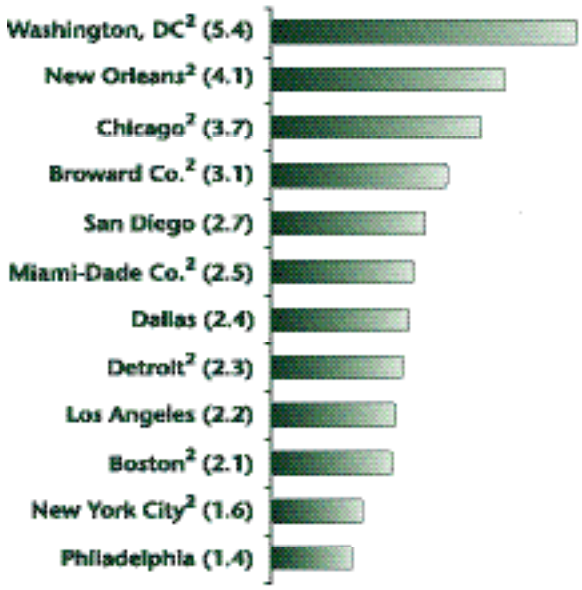
[1]Weighted estimates are for various quarters in 2003 (*see Data Sources*).
[2]NS=Not sampled.
SOURCE: ADAM, NIJ

Student Survey Data on Heroin

Only small percentages of secondary school students in CEWG areas in 2003 reported using heroin one or more times during their lifetime. Lifetime use of heroin was most likely to be reported by students in Washington, DC (5.4 percent), followed by New Orleans (4.1 percent), Chicago (3.7 percent), and Broward County, Florida (3.1 percent) (*see exhibit 26*).

In all 12 CEWG areas, male students were more likely than their female counterparts to say they had ever used heroin. The proportions of male students reporting lifetime use of heroin ranged from 2.3 percent in New York City to 8.8 percent in Washington, DC. Among female students, lifetime heroin use ranged from a low of 0.4 percent in Philadelphia to a high of 2.6 percent in New Orleans.

Exhibit 26. Lifetime Use[1] of Heroin Among Students in Grades 9–12 in 12 CEWG Areas, by Percent: 2003



[1]Used heroin one or more times during their lifetime.
[2]Represents public school sample; all others represent a "school district," "independent school district," or "unified school district."
SOURCE: YRBS, CDC

NFLIS Data on Heroin

With the exception of Chicago, where forensic labs identified 11,050 heroin items in 2003, northeast and mid-Atlantic areas tended to have the highest numbers of heroin items. These areas included Baltimore (10,558), New York (5,615), Philadelphia (2,606), Newark (1,192), and Boston (1,005). Baltimore and Newark had the highest percentages of heroin items analyzed by forensic labs—nearly one-third of all items analyzed (*see exhibit 27*) .

DEA: Domestic Monitor Program Data on Heroin

According to the DEA, 92.4 percent of the qualified samples purchased east of the Mississippi River in 2003 were determined to be South American heroin. In contrast, 98.4 percent of the qualified samples purchased west of the Mississippi in 2003 were from Mexico.

Exhibit 27. Number of Analyzed Heroin Items and Percentage of All Items Tested in 19 CEWG Areas: 2003

CEWG Area	Percent	Number
Baltimore	32.4	10,558
Newark	31.3	1,192
Chicago	18.0	11,050
Boston	14.7	1,005
New York	14.3	5,615
Detroit	13.7	586
Philadelphia	12.3	2,606
Washington, DC	12.1	803
St. Louis	7.6	480
New Orleans	6.2	773
Denver	5.3	228
Seattle	5.0	161
Miami	4.2	593
Los Angeles[1]	3.4	1,544
Honolulu	1.9	49
San Diego	1.7	235
Texas	1.2	598
Atlanta	1.0	195
St. Paul	0.8	30

[1]Data are not complete for all months.
SOURCE: NFLIS, DEA

DEA data also show that heroin purity levels vary considerably within each city. For example, the average purity level of exhibits purchased in Atlanta in 2002 was 52 percent; however, the purity of the exhibits ranged from 13 to 94 percent. The exhibits in Baltimore ranged in purity from 7 to 83 percent in 2002.

In 2003, average purity levels were highest in Newark (61 percent), Philadelphia (60 percent), Atlanta (57 percent), and New York (54 percent) (*see exhibit 28*).

In areas west of the Mississippi, average heroin purity levels were highest in El Paso, Phoenix, and San Diego (each 45 percent)—areas near the Mexican border. Heroin purity remained low in San Francisco, an area in which heroin indicators are high.

In most CEWG areas, the percentages of heroin purity remained stable from 2001 to 2003. However, average purity percentages decreased from 2001 to 2003 in northeast and mid-Atlantic cities, including Boston, New York, Philadelphia, and Washington, DC.

Exhibit 28. Domestic Monitor Program—Average Percentage Heroin (Based on Primary Source) Purity[1] in CEWG Areas: 2001–2003

CEWG Area	Mexican Heroin Exhibits			CEWG Area	South American Heroin Exhibits		
	2001	2002	2003		2001	2002	2003
Phoenix	41	49	45	Newark	71	71	61
San Diego	45	48	45	Philadelphia	74	66	60
El Paso	43	40	45	Atlanta	51	52	57
Los Angeles	17	27	30	New York	58	62	54
Houston	9	28	27	Detroit	53	46	48
Denver	18	18	19	Boston	57	50	40
St. Louis	15	14	14	Baltimore	29	24	35
Dallas	12	17	13	New Orleans	39	30	32
San Francisco	10	12	11	Miami	21	29	26
Seattle	13	11	10	Wash., DC	35	21	20
				Chicago	20	20	16

[1]Data are preliminary.
SOURCE: DMP, DEA

From 2001 to 2003, average purity percentages remained relatively stable in areas west of the Mississippi. Increases were reported in Los Angeles—from 17 percent in 2001 to 30 percent in 2003.

The prices per milligram pure are shown in exhibit 29 for cities east of the Mississippi (EOM) and west of the Mississippi (WOM).

Exhibit 29. Average Price[1] of Heroin Per Milligram Pure in Areas East (EOM) and West (WOM) of the Mississippi River: 2003

EOM Area	Price	WOM Area	Price
Newark	$0.33	San Diego	$0.25
Baltimore	0.34	Los Angeles	0.34
Chicago	0.46	El Paso	0.40
New York	0.48	Houston	0.45
Philadelphia	0.60	Phoenix	0.51
Washington, DC	0.73	Denver	0.81
Boston	0.73	Dallas	0.98
Detroit	0.80	San Francisco	0.98
Miami	0.90	Seattle	1.18
Atlanta	1.30	St. Louis	1.89
New Orleans	1.62		

[1]Heroin price per milligram pure is based on retail or street-level samples obtained by the DEA.
SOURCE: DMP, DEA

In WOM cities, there was a relationship between the price and purity of heroin and the city's closeness to the Mexican border. Heroin purity was relatively high and prices were relatively low in San Diego and Los Angeles. Likewise, heroin purity was high and the average price of the drug was low in El Paso.

In EOM areas, the lowest average prices of heroin samples, per milligram pure, were found in Newark ($0.33), Baltimore ($0.34), Chicago ($0.46), and New York City ($0.48).

METHAMPHETAMINE

Methamphetamine abuse indicators continue at very high levels in Honolulu and in west coast areas, and in some southwestern and midwestern areas, and abuse continues to spread to areas east of the Mississippi River. While methamphetamine abuse indicators remain low in metropolitan areas east of the Mississippi, CEWG members report increasing abuse in outlying nonmetropolitan areas. Small-scale clandestine labs continue to proliferate, especially in rural areas, increasing the availability of low-quality methamphetamine. Higher quality methamphetamine production also continues at "super labs" (e.g., in California and Mexico), although NDIC reports that seizures of super labs remained stable from 2002 to 2003. CEWG members call attention to the fact that purity of methamphetamine, and even appearance, texture, and color of the drug, affects how it is used. Methamphetamine abuse is spreading in different populations, often for different reasons: for example, there are reports of females using the drug to lose weight, club attendees using methamphetamine in place of MDMA, and men who have sex with men (MSM) using methamphetamine to enhance sex.

Methamphetamine abuse indicators continued to be reported at high levels in Honolulu and in west coast and southwestern CEWG areas, and showed signs of increasing in five CEWG areas.

Colorado: *Reports from clinicians, researchers, and street outreach workers around the State describe the widespread and growing availability and use of methamphetamine…. Methamphetamine treatment admissions… rose to their highest level in 2003 (23.2 percent of all admissions); the proportion who were new users (entering treatment within the first 3 years of use) rose to 3.1 percent of this admissions group…. Smoking has become increasingly common; nearly 61.0 percent of the 2003 methamphetamine admissions smoked the drug, compared with only 29.1 percent in 1997.* —BRUCE MENDELSON

Honolulu: *All agencies reporting to the Hawaii CEWG indicate that without question, crystal methamphetamine remains their major issue. It remains the drug of choice in the island chain…. Methamphetamine treatment admissions remained extremely high and rose yet again in 2003 to 3,182 admissions, representing 44 percent of all admissions in 2003. The increase in demand for treatment space for methamphetamine abusers has been nearly 2,000 percent since 1991. This situation has so far outstripped the treatment system's capacity that even people who might want treatment would not be likely to receive it in a timely manner.* —D. WILLIAM WOOD

Los Angeles: *Primary methamphetamine admissions to Los Angeles County treatment and recovery programs increased further from the first to the second half of 2003…. Recent ADAM data collected from a sample of Los Angeles adult male arrestees during 2003 showed that an average of 28.7 percent had methamphetamine-positive urine screens, which is much higher than the percentage seen in 2002 (14.8 percent).* —BETH FINNERTY

Phoenix: *Most indicators for methamphetamine/amphetamine continue to trend upward.* —ILENE DODE

San Francisco: *All indicators for methamphetamine use were up between 2001 and 2002, and treatment admissions continued up during 2003.* —JOHN NEWMEYER

In areas where methamphetamine abuse indicators are lower than those in the far west and some southwestern areas, CEWG participants report increases in abuse of the drug, mostly in nonmetropolitan areas of their State.

Atlanta: *Methamphetamine is the most abused stimulant in Atlanta, and its use is increasing. Law enforcement efforts to stop the spread of this drug have involved seizures and closing down clandestine labs. Moreover, frequent media reports, such as a*

June 6, 2004, Atlanta Journal and Constitution cover story on methamphetamine in Georgia, fuel the growing concern over the dangers the drug poses. —KRISTIN WILSON

Boston: *Though still relatively small in number, methamphetamine treatment admissions have increased from 5 in FY 2001 to 19 in FY 2002 to 66 in FY 2003.`* —DANIEL DOOLEY

Chicago: *Methamphetamine ('speed') use in Chicago remains low, but it is more prevalent in many downstate counties.* —DITA BROZ

Detroit: *Indicator data showed increasing levels of methamphetamine abuse in the State, continuing primarily in the southwestern corner of lower Michigan.* —PHIL CHVOJKA

New Orleans: *Stimulants such as amphetamines and methamphetamine do not appear to be major substances of abuse in New Orleans. In rural areas of the State, however, methamphetamine is a problem, with the abuse reported to be primarily among members of biker organizations.* —GAIL THORNTON-COLLINS

Ohio: *In the club scene in Ohio, methamphetamine is replacing drugs like MDMA as the drug of choice. Throughout the State, law enforcement agents are aggressively attempting to show that there is a methamphetamine epidemic. Individuals have been arrested for having equipment or supplies that can be used to produce methamphetamine. More people are entering treatment for methamphetamine abuse, but the numbers are still relatively small. Judges are referring first time offenders to treatment.* —HARVEY SIEGAL

Philadelphia: *Focus group members continued to report that methamphetamine is still difficult to obtain—is not usually sold outdoors, and requires a connection—but that use has increased since 2001.* —SAMUEL CUTLER

St. Louis: *Methamphetamine ('crystal' or 'speed') was found at very low levels in city indicators in 1995, but reported use has slowly increased over the past 8 years…. Methamphetamine, along with alcohol, remained a primary drug of abuse in both the outlying rural areas and statewide (because most of Missouri, outside of St. Louis and Kansas City, is rural). Methamphetamine continued to be identified as a huge problem in rural communities.* —HEIDI ISRAEL-ADAMS

Texas: *There were 178 calls to poison control centers involving exposure to methamphetamine in 2002—162 in 2001, 248 in 2002, and 212 in 2003. The average age of callers was 27.7, and 65.0 percent were male. In 2003, there were 46 mentions of 'ice' and 25 mentions of 'crystal.' Of the cases in 2003, 47 involved intentional inhalation of methamphetamine. The average age was 24.3, which shows the same pattern as the treatment data, where snorters and smokers were younger than injectors…. The presence of ice, the most abundant form of methamphetamine in some areas of the State, is also seen in the treatment data. The percentage of clients who injected methamphetamine dropped from 84 percent in 1988 to 55 percent in 2003, while the proportion smoking ice dropped from less than 1 percent in 1988 to 30 percent in 2003.* —JANE MAXWELL

Methamphetamine abuse is spreading in some CEWG areas among MSM, youth and young adults, and in some racial/ethnic minority populations.

Atlanta: *High Intensity Drug Trafficking Area investigators report an increase among African-Americans using methamphetamine in Atlanta. Ethnographic data from Atlanta-area drug research studies among 18–25-year-olds support this trend.* —KRISTIN WILSON

Colorado: *In the Denver metropolitan area, one program described more gay White men entering treatment for methamphetamine use…. In northeast and northwest Colorado, treatment programs report younger age groups (adolescents and early twenties). Some programs report more females using 'speed' both for the psychotropic effects and for weight loss. In general, across the State, clinicians attribute methamphetamine's increased use to its cheap price and its 'longer lasting high' (i.e., in comparison to cocaine).* —BRUCE MENDELSON

Los Angeles: *In Los Angeles, there is evidence that more Mexicans are using methamphetamine. In a recent training program on 'Methamphetamine and HIV' on the U.S.-Mexico border, participants focused on increased use of methamphetamine by migrant farm workers. Treatment providers stated that many of these workers are coming into*

treatment for all kinds of help. Some are reportedly being given methamphetamine on the job to increase their productivity. —**Beth Finnerty**

Miami/Ft. Lauderdale: *Numerous indicators confirm problematic crystal methamphetamine use among some sexually active men who have sex with other men (MSM) and who refer to the drug as 'Tina.' A local study of gay men attending a Miami circuit party, conducted by Steven P. Kurtz, Ph.D., and Jason C. Weaver of the University of Delaware Center for Drug and Alcohol Studies, revealed 62 percent reported using crystal methamphetamine, and an equal proportion reported high-risk sexual behavior.* —**James Hall**

Minneapolis/St. Paul: *Methamphetamine abuse took hold among a younger population in 2003. Most high school-based drug counselors reported the rapidly rising abuse of methamphetamine, particularly among girls attracted by the promise of heightened energy and significant, rapid weight loss…. Adolescent users described the open scabs and unsightly skin lesions from the abuse of methamphetamine as 'lithium scabs,' and better grade methampheta—mine as 'lithium,' ranking in quality somewhere in between basic 'crank' and top grade 'ice' or 'glass.' Some youths also noted they could spot exceptionally good methamphetamine 'if it makes you cough blood.' The use of light bulbs as pipes for smoking methamphetamine was commonplace, especially among youth.* —**Carol Falkowski**

New Orleans: *The proportion of New Orleans secondary students who reported lifetime use of methamphetamine increased from 4.5 percent in 1999 to 5.8 percent in 2003. In 2003, reported lifetime use of methamphetamine was highest among 9th (6.5 percent) and 12th graders (8.7 percent), compared with 3.9 percent for 10th graders and 4.1 percent for 11th graders.* —**Gail Thornton-Collins**

New York: *The Street Studies Unit, which collects information at the community and neighborhood levels, reported that methamphetamine was more available and being sold on the street in some areas of the city. In some areas it is called 'bling-bling' and in others it is called 'Tina.' Tina is reportedly being used with crack to produce desired effects. Street Studies Unit staff are also reporting more methamphetamine abuse in Mexican communities.* —**John Galea**

Texas: *Use of ice is growing, with sales in clubs and raves now rivaling the volume of ecstasy sales. Ravers who previously used ecstasy have tried ice and now prefer it.* —**Jane Maxwell**

Methamphetamine, including crystal methamphetamine ("ice"), continues to be widely available in many CEWG areas, with production by super labs and small clandestine labs. Trafficking patterns are changing in some CEWG areas.

Atlanta: *According to the DEA and High Intensity Drug Trafficking Area (HIDTA), methamphetamine popularity continues to rise in part because of its low price and availability. Methamphetamine accounted for about 23 percent of NFLIS tests of seized drugs in 2003, ranking third after cocaine and marijuana. The HIDTA task force seized more methamphetamine in 2003 than in recent years… 11.32 kilograms of methamphetamine and 8.51 kilograms of crystal methamphetamine or 'ice.'* —**Kristin Wilson**

Boston: *The DEA reports that methamphetamine costs $200 per gram and is available 'in limited (user-level) quantities' in New England. The purity level is unknown.* —**Daniel Dooley**

Detroit: *In 2002, Michigan State Police seized 189 labs, twice as many as in 2001. During 2003, Michigan State Police seized 186 methamphetamine labs, and they note that an additional number were seized by other law enforcement agencies. The State Police also reported that there were 202 methamphetamine-related complaints in 2002, compared with 373 such complaints in 2003 (these include dumpsites and component cases). Through mid-May 2004, there have been 51 labs seized…. Most of the lab seizures have been in southwestern lower-Michigan.* —**Phil Chvojka**

Honolulu: *Ice continues to dominate the Hawaiian drug market. Prices have increased slightly, and this is likely reflective of several seizures. It is now easier to purchase larger quantities than in the past. The final police evidence of increased ice availability is that of clandestine labs, almost exclusively reprocessing labs that continue to be*

closed at a regular pace-10 during this reporting period.... California-based Mexican sources use Hawaii's cultural diversity to facilitate smuggling and distribution to and within the islands. Analysis of confiscated methamphetamine reveals that the product is still a high-quality d-methamphetamine hydrochloride in the 90–100-percent purity range.
—D. WILLIAM WOOD

Los Angeles: *Los Angeles is considered by the National Drug Intelligence Center to be one of the largest methamphetamine markets in the United States. Domestically based Mexican criminal groups control the wholesale and midlevel distribution of methamphetamine and distribute the drug via private vehicles and commercial trucks. Not only does a large quantity of the drug stay in the southern California region, but methamphetamine gets transported to other major cities and regions, including San Francisco and Phoenix, and the West Central, Southwest, and Southeast areas of the United States.* —BETH FINNERTY

Minneapolis/St. Paul: *Seizures of methamphetamine by law enforcement continued upward trends. Cases handled by the State crime lab, for example, grew from 289 in 1996 to 2,160 in 2003. Minneapolis data indicate increased purity levels of methamphetamine as well, with an average weight-based purity of 13.8 percent in 2001, compared with 26.9 percent in 2003, and 40.7 percent in 2004 (first quarter). It comes in the form of crystals, powder, or chunks that are white, off-white, tan, orange, reddish, greenish, or light purple-colored.* —CAROL FALKOWSKI

New York: *In the past few years, more and more methamphetamine lab seizures were reported in New York State. Police in areas outside the city made more than 23 methamphetamine lab seizures during the past year, primarily 'mom and pop' labs that distributed the drug locally. A number of small labs were also confiscated in the Chelsea area of Manhattan, which is frequented by the gay community.* —JOHN GALEA

Phoenix: *'Ice' dominates street sales, with purity ranging from 71 to 98 percent. Ice is readily available, and the demand continues to increase.... Methamphetamine seizures tripled along the Arizona-Mexico border in FY 2003, when 1,307 pounds of methamphetamine were seized, compared with 398 pounds in 2002. In 2002, only Texas and California seized more kilograms than Arizona.* —ILENE DODE

St. Louis: *In the new methamphetamine scene, Hispanic traffickers, rather than the old network of motorcycle gangs, are the predominant distributors. Shipments from 'super labs' in the Southwest are trucked in via the interstate highway system. This network is in contrast to the local 'mom and pop' labs that produce personal quantities for family and friends. These local labs tend to use the 'Nazi method' of production with an output of 60 percent of the quantity of the starting products. Purity of the drugs produced by these labs and percent of finished product depends on the experience/attentiveness of the 'cooker.' Most of the available methamphetamine is produced in Mexico and trafficked through these Hispanic traffickers.* —HEIDI ISRAEL-ADAMS

Seattle: *Methamphetamine incidents peaked in 2001 statewide, in King County, and in Pierce County to the south (which has the largest number of labs in the State), but they continued to increase in Snohomish County (immediately to the north of King County). In King County, there were 202 incidents in 2003, down from 271 in 2001, but still up substantially from 1990, when there were 6 incidents. Generally, methamphetamine incidents have increased in rural areas, while declining in urban areas.... Anecdotal reports from law enforcement indicate that large scale labs represent a minority of manufacturing labs in the State.* —CALEB BANTA-GREEN

Texas: *According to DEA, methamphetamine is readily available in all areas of the El Paso Field Division. The Houston Field Division reports that most methamphetamine is made by motorcycle gangs and small home producers using pseudoephedrine, anhydrous ammonia, red phosphorous, iodine, lithium batteries, or muriatic acid. Blister packs of cold tablets are the predominant supply source for pseudoephedrine, although the 240-milligram tablets are also seen. Red phosphorous can be purchased at gun shows, and there are reports of increasing use of lithium metal/anhydrous ammonia ('Nazi method') in the manufacturing pro-*

cess. There are also numerous laboratories operating in East Texas, Corpus Christi, and the Austin and Waco areas. Crystal methamphetamine is being encountered on an increasing basis, and it is more expensive than powdered methamphetamine.... The Dallas DEA Field Division reports availability is high at the retail level. Mexican methamphetamine dominates the market and can be purchased in multipound quantities from a variety of sources. Methamphetamine in the form of ice is the most abundant form now seen in the area.... Intelligence indicates that drug traffickers are shifting their efforts to ice, which is more profitable than regular methamphetamine. —JANE MAXWELL

Patterns and Trends Across CEWG Areas

DAWN ED Data on Methamphetamine

In 2002, rates of methamphetamine ED mentions per 100,000 population were highest in San Francisco (46), Seattle (25), San Diego (23), and Los Angeles (20) (*see exhibit 30*). Rates increased significantly from 2000 to 2002 and from 2001 to 2002 in San Francisco, while they remained stable in Los Angeles and San Diego. Rates increased significantly in Atlanta across all three testing periods.

Exhibit 30. Rates of Methamphetamine ED Mentions Per 100,000 Population in 19 CEWG Areas: 1995–2002

					Percent Change[1]		
CEWG Area	1995	2000	2001	2002	1995, 2002	2000, 2002	2001, 2002
Atlanta	6	4	5	7	18.8	69.7	39.0
Baltimore	0	0	0	0	92.7		
Boston	0	0	0	0			
Chicago	1	...[2]	1	1		...	
Denver	11	7	5	5	-56.1		
Detroit	0	...	...	0			
Los Angeles	16	16	18	20			
Miami	0	1	1	1	161.0		-45.5
Mpls./St. Paul	4	6	12	12	199.3		
New Orleans	2	2	...	5	196.2	109.7	...
New York	0	0	...	1	163.2		
Newark	...	0	0	0		-82.4	
Philadelphia	2	1	1	1	-44.5		
Phoenix	39	29	21	17			
St. Louis	3	7	5	7	96.7		
San Diego	30	31	27	23			
San Francisco	72	36	39	46	-35.3	28.5	19.4
Seattle	14	27	18	25	80.7		35.3
Wash., DC	1	2	1	1			

[1]These columns denote statistically significant ($p<0.05$) changes between estimates for the time periods noted.
[2]Dots (...) indicate that an estimate with a relative standard error greater than 50 percent has been suppressed.
SOURCE: DAWN, OAS, SAMHSA

Mortality Data on Methamphetamine

DAWN mortality data on methamphetamine-involved deaths across 14 CEWG areas in 2002 are presented in exhibit 31.

Exhibit 31. Methamphetamine-Involved DAWN Death Mentions in 14 CEWG Areas: 1999-2002

CEWG Area	1999	2000	2001	2002
Atlanta	3	2	8	6
Baltimore[1]	16	1	-	-
Boston	10	-	1	1
Chicago	-	2	1	-
Dallas	9	22	37	46
Denver[1]	8	10	19	17
Miami	2	3	5	1
New Orleans	-	-	-	3
New York	2	3	NR[2]	6
Newark	1	1	-	-
St. Louis	9	9	3	6
San Diego[1]	88	112	94	81
San Francisco[1]	58	45	32	38
Washington, DC	5	1	1	1

[1]In these sites, 100 percent of the population are covered.
[2]NR=Not reported (data were incomplete).
SOURCE: DAWN, OAS, SAMHSA

In 2002, deaths involving only methamphetamine across the 14 CEWG areas totaled only 31, with 13 being in Dallas, 10 in San Diego, 4 in San Francisco, and 2 each in Denver and St. Louis.

Local/State ME data from seven CEWG areas for 2003 are presented below. The data are not comparable to DAWN or across local sites.

Detroit: *Mortality data from the Wayne County ME lab show 2 methamphetamine-positive cases in decedents between April and September 2001, 1 case between October 2001 and March 2002, 10 cases total for 2002, and 6 cases in 2003. The majority of these cases had multiple drugs present, including methylenedioxyamphetamine (MDA) or methylenedioxymethamphetamine (MDMA). Almost all were homicide cases; two were drownings.* —PHIL CHVOJKA

Florida: *Either d-methamphetamine or 1-methamphetamine was identified in 58 percent of the 139 methylated amphetamine-related deaths in Florida in 2003 in which the specific type of methylated amphetamine was identified. These same 2 drugs were detected in 43 percent of the 126 methylated amphetamine-related deaths in Florida in 2002 and in 30 percent of the 147 such deaths statewide in 2001.* —JAMES HALL

Honolulu: *Over the past 8 years, the Oahu ME has usually mentioned crystal methamphetamine in 25 to 35 cases per year. In 2002, as in the year before, an increase in decedents with a positive toxicology screen for 'ice' increased to 62 deaths. For 2003, the numbers of deaths with ice found was 56 for the 850,000 residents of the island of Oahu (65.4 deaths per million population).* —D. WILLIAM WOOD

Minneapolis/St. Paul: *From 2002 to 2003, accidental deaths related to methamphetamine abuse grew from 3 to 10 in Ramsey County and from 11 to 15 in Hennepin County.* —CAROL FALKOWSKI

Philadelphia: *There were 81 deaths with the presence of methamphetamine from January 1994 through December 2003 and 72 deaths with the presence of amphetamine during that same 10-year period.* —SAMUEL CUTLER

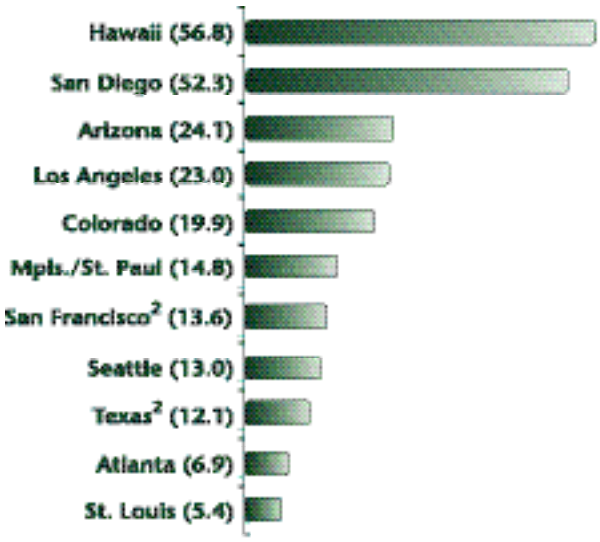
Phoenix: *The drug-related death data revealed a 17-percent decrease (n=132) in 2002 for methamphetamine-related deaths. Methamphetamine/combination deaths totaled 35 in 2001, rose to 44 in 2002, and are projected to increase to 71 for 2003 for a 103-percent increase.* —ILENE DODE

Seattle: *The 18 amphetamine-involved deaths in 2003 were the highest since at least 1987, when there were no such deaths. From 1997 to 2003, there were 70 amphetamine-involved deaths, of which 65 were determined to be methamphetamine. Almost one in three deaths in which amphetamines was identified was related to just the single drug, a relatively high proportion of deaths and second only to heroin/opiates. Whites (98 percent) and males (79 percent) predominated among methamphetamine-involved deaths from 1997 to 2003. Accidental/overdose deaths represented 94 percent of amphetamine deaths from 1997 to 2003.* —CALEB BANTA-GREEN

Treatment Data on Methamphetamine

In the most recent reporting periods, the proportions of primary methamphetamine treatment admissions (excluding alcohol) were reported separately from amphetamine or "other drug" admissions in nearly all CEWG areas. Nine areas reported either no primary methamphetamine admissions or proportions of less than 1 percent of illicit drug admissions. Exhibit 32 depicts the proportions at 11 sites, illustrating the dominance of this drug in Hawaii and other western areas.

Exhibit 32. Primary Methamphetamine Treatment Admissions in 11 CEWG Areas and Percent of all Admissions (Excluding Alcohol): 2003[1]



[1]Represents either calendar or fiscal year.
[2]Classified as "amphetamines," includes methamphetamine.
SOURCE: CEWG June 2004 reports on State and local data

ADAM Data on Methamphetamine

As shown in exhibit 33, the proportions of male arrestees testing positive for methamphetamine have tended to increase in most ADAM/CEWG sites. In the first three quarters of 2003, very high percentages of adult male arrestees tested positive for methamphetamine in Honolulu (40.3 percent), Phoenix (38.3 percent), and San Diego (36.2 percent). Not shown in exhibit 33 is the appearance of methamphetamine-positive toxicologies among small percentages of adult male arrestees in Chicago (1.4 percent), New Orleans (2.7 percent), Philadelphia (0.6 percent), and Washington, DC (0.7 percent). Small proportions of male arrestees also tested methamphetamine-positive in the fourth quarter of 2003 in Houston (2.1 percent) and Miami (0.4 percent).

Exhibit 33. Percentages of Adult Male Arrestees Testing Methamphetamine-Positive in 10 CEWG Areas: 2000-2003

CEWG Area	2000	2001	2002	2003[1]
Atlanta	0.5	NS[2]	2.3	2.0
Dallas	2.1	1.7	3.1	5.8
Denver	2.6	3.4	3.8	4.7
Honolulu	35.9	37.4	44.8	40.3
Los Angeles	NS	NS	14.8	28.7
Minneapolis	1.6	2.4	3.9	3.3
Phoenix	19.1	25.3	30.9	38.3
San Antonio	0.2	2.6	2.3	3.5
San Diego	26.3	27.9	31.7	36.2
Seattle	9.2	11.1	10.9	12.1

[1]Weighted estimates are for various quarters in 2003 (*see Data Sources*).
[2]NS=Not sampled.
SOURCE: ADAM, NIJ

The percentages of adult female arrestees testing methamphetamine-positive in six CEWG areas are shown in exhibit 34.

Exhibit 34. Percentages of Adult Female Arrestees Testing Methamphetamine-Positive in 6 CEWG Areas: 2001–2003

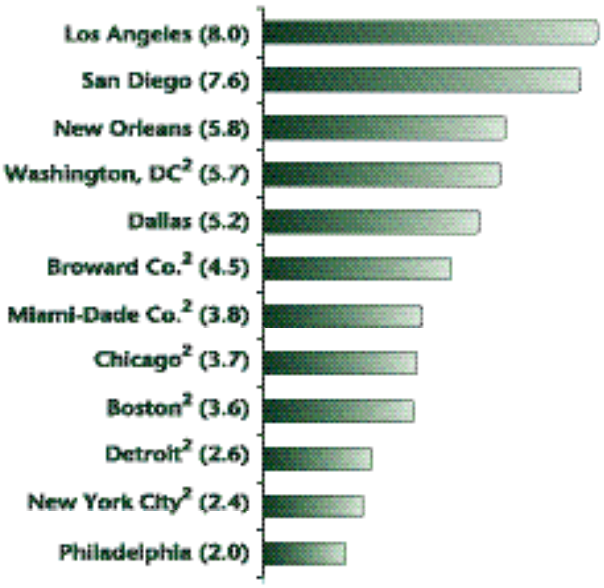
CEWG Area	2000	2001	2002	2003[1]
Denver	5.3	4.3	6.6	5.0
Honolulu	47.2	36.1	49.3	57.4
Los Angeles	12.3	NS[2]	14.3	18.5
Minneapolis	0.0	NS	NS	2.6
Phoenix	24.1	32.3	41.4	41.6
San Diego	28.7	32.0	36.8	47.1

[1]Data are unweighted and represent various quarters in 2003 (*see Data Sources*).
[2]NS=Not sampled or reported.
SOURCE: ADAM, NIJ

Student Survey Data on Methamphetamine

As with other methamphetamine indicators, lifetime indicators of methamphetamine abuse in the YRBS were highest among secondary school students in west coast areas: Los Angeles (8.0 percent) and San Diego (7.6 percent) (*see exhibit 35*).

Exhibit 35. Lifetime Use[1] of Methamphetamine Among Students in Grades 9–12 in 12 CEWG Areas, by Percent: 2003



[1]Used methamphetamine one or more times during their lifetime.
[2] Represents public school sample; all others represent a "school district," "independent school district," or "unified school district."
SOURCE: YRBS, CDC

Across the 12 CEWG areas, the proportions of male students using methamphetamine 1 or more times during their lifetime ranged from a low of 2.2 percent in Philadelphia to 9.4 percent in Los Angeles. Among female students, lifetime use of methamphetamine ranged from 1.1 percent in Chicago to 6.7 percent in Los Angeles.

NFLIS Data on Methamphetamine

As with other indicators, forensic laboratory analyses show high concentrations of methamphetamine items in west coast areas, including Honolulu (*see exhibit 36*). A substantial number of methamphetamine items were also analyzed in Atlanta, St. Paul, and Texas.

Methamphetamine accounted for approximately 61 percent of the items analyzed in Honolulu and St. Paul, and for between approximately 26 and 36 percent of the items reported in Los Angeles, Seattle, and San Diego. There were no methamphetamine items reported in Baltimore and Boston. In nine other CEWG cities not shown in exhibit 36, methamphetamine accounted for less than 1.3 percent of all items analyzed.

Exhibit 36. Estimated Number of Analyzed Methamphetamine Items and Percentage of All Items Tested in 8 CEWG Areas: 2003

CEWG Area	Percent	Number
Honolulu	61.5	1,613
St. Paul	61.0	2,173
Los Angeles[1]	35.7	16,241
Seattle	27.2	872
San Diego	25.9	3,559
Atlanta	23.0	4,516
Texas	22.9	11,558
Denver	11.2	486

[1]Data are not complete for all months.
SOURCE: NFLIS, DEA

Texas data illustrate how forensic laboratory reports of methamphetamine might vary across a State. In Texas, methamphetamine is more of a problem in the northern half of the State. In Amarillo, a city in the Texas Panhandle , 49 percent of the items examined were methamphetamine. In contrast, in the border areas of McAllen and

Laredo, less than 1 percent of the items tested were methamphetamine. Further, labs in northern Texas were more likely to report analyzing chemicals used to manufacture methamphetamine (i.e., ammonia or pseudoephedrine).

Methamphetamine Availability and Prices

As in previous years, methamphetamine availability was widespread in western CEWG areas in the first half of 2004. Crystal methamphetamine, "ice," dominated street sales in Phoenix, where purity levels ranged between 71 and 98 percent. In Texas, ice has become the most common form of methamphetamine available in the area. Drug traffickers there have reportedly shifted their efforts to ice, since it is more profitable than regular methamphetamine. In eastern CEWG areas, however, methamphetamine availability was mixed. It was reportedly "difficult to obtain" in Chicago, and only limited user-level quantities were available in Boston. In Atlanta, however, more methamphetamine was seized in 2003 than in previous years, possibly reflecting increased availability. Similarly, during the most recent reporting period in New York City, there have been an increased number of arrests for methamphetamine sale and possession.

Methamphetamine prices varied depending on geographic location and type purchased (*see exhibit 37*). On the West Coast, grams of methamphetamine sold for as little as $30 (Seattle) or $40 (Los Angeles). Higher gram prices were reported on the East Coast: $250 in Boston and $300 in New York City. Crystal methamphetamine commanded prices as high as $19,000 per pound in Dallas.

"Super labs" in Mexico and California remained the primary sources for methamphetamine available in the United States. Local clandestine labs continued to be seized in other parts of the country, including small labs in Miami and Atlanta.

Exhibit 37. Methamphetamine Prices in 21 CEWG Areas: January–June 2004

CEWG Area	Retail	Ounce	Wholesale
Atlanta	$100–$120/g MX[1] $200/g CM[2]	$1,000/oz CM $500-$1,100/oz MX	$4,500–$8,000/lb MX $15,000/lb CM
Baltimore	$150/g	N/A[3]	N/A
Boston	$250/g	N/A	N/A
Chicago	$20/bag $80–$100/g	$1,000–$1,300/oz	N/A
Dallas	$70–$100/g DO[4]	$400/oz MX $700–$1,500/oz DO $1,000–$2,000/oz CM	$4,000–$10,500/lb DO $5,800–$9,000/lb MX $8,500–$19,000/lb CM
Denver	$70–$100/g	$700/oz $3,800/¼ lb	$5,000/½lb $14,000–$16,000/lb
Detroit	$175/g	$1,200/oz	$16,000/lb
Honolulu	$50/¼g "wash" $75/⅛g "clear" $200–$300/g "wash" $600–$900/g "clear"	$1,000–$2,000/¼oz "clear" $2,200–$3,000/¼oz "wash"	$30,000/lb $50,000–$70,000/kg
Los Angeles	$20/¼g $40–$100/g	$450-$550/oz $600-$800/oz CM	$5,000-$7,000/lb $8,000-$11,000/lb CM
Miami	$50–$60/¼g CM	$650–$700/⅛oz CM	$2,000–$3,000/oz CM
Minneapolis	$70–$150/g $200/1/16 oz $240–$280/1/8oz	$600–$2,000/oz	$6,000–$14,000/lb
Newark	$100–$200/g $120–$180/g CM $140–$200/⅛oz $400–$1,200/½oz	$800–$1,000/oz	$8,500–$20,000/kg $10,000–$19,600/lb
New Orleans	$100/g $400–$500/¼oz	$1,400–$1,600/oz	$20,000/lb
New York	$10–$20/pill $100–$300/g	$1,600–$3,000/oz	N/A
Philadelphia	$100/g	$700–$2,000/oz	$8,000–$12,000/lb
Phoenix	$40/0.85 g CM $150/⅛oz CM	$250/¼oz CM $620–$800/oz CM	$2,600/¼lb CM $7,000–$9,000/lb CM
St. Louis	$100–$150/g	$900–$1,400/oz	$10,000–$20,000/lb
San Diego	$20–$25/¼g $60/g $100–$140/⅛oz $150–$300/¼oz	$500–$800/oz $800–$900/oz CM	$4,000$10,000/lb $8,000–$10,000/lb CM
San Francisco	$80–$125/g CM	$450–$600/oz $600–$1,500/oz CM	$3,600–$10,000/lb $10,000–$13,000/lb CM $26,000/kg CM
Seattle	$30–$100/g	$500–$1,100/oz $850–$1,400/oz CM	$5,000–$15,000/lb $10,000–$25,000/kg $10,000–$12,000/lb CM
Wash., DC	$400/8–ball[5]	N/A	$4,800/½lb

[1]MX=Mexico-produced.
[2]CM=Crystal methamphetamine.
[3]N/A=Not available.
[4]DO=Domestic.
[5]8-ball=one-eighth ounce.
SOURCE: Narcotics Digest Weekly, NDIC, and June 2004 CEWG reports

MARIJUANA

Marijuana abuse indicators remain high, increasing in some CEWG areas and stabilizing in others. Primary marijuana abuse accounted for large percentages of treatment admissions. Arrests involving marijuana continued to account for considerable proportions of total arrests.

Marijuana remains widely available in CEWG areas and is widely abused, especially among youth, as exemplified in excerpts from CEWG reports. Smoking marijuana in "blunts" continues to be popular in some areas.

Atlanta: *Ethnographic sources consistently confirm that marijuana is the most commonly abused drug in Atlanta. Most epidemiological indicators show an upward trend in marijuana use.* —KRISTIN WILSON

Miami/Fort Lauderdale: *Marijuana is still the most common illicit drug involved in ED visits and addiction treatment admissions among young people, while cocaine is the most common illicit drug among older patients.* —JAMES HALL

New Orleans: *Marijuana continues as a major problem among youth in the city of New Orleans, but indicators suggest the problem is stabilizing.* —GAIL THORNTON-COLLINS

New York: *According to the Street Studies Unit, marijuana remains the most sought after illicit substance in New York City. Marijuana purity and availability remain high, while the price fluctuates…. Marijuana continues to be very popular with inner city youth. Field researchers have observed youth as young as 12 or 13 smoking 'pot' in the parks…. Teenagers feel that the best way to smoke marijuana is in a blunt cigar. Flavored blunt wraps and cigars are the most popular. Teenagers will sprinkle 'angel dust' or cocaine on the marijuana when rolling their blunts.* —ROZANNE MAREL

Philadelphia: *Focus group participants in the spring of 2004 continued to report the increasing use of blunts, especially the use of flavored cigars. These groups and outreach workers continued to report that marijuana use is widespread in Philadelphia.* —SAMUEL CUTLER

Treatment data reflect the growing problems of marijuana abuse among youth.

Baltimore: *Persons entering treatment for marijuana use in the first half of 2003 were young: 46 percent were younger than 18, and the median age at admission to treatment was 18. Marijuana admissions were primarily male (83 percent) and increasingly likely to be African-American (52 percent in the first half of 2003, compared with 45 percent in 1999). A large proportion of marijuana treatment admissions (63 percent) represented referrals through the criminal justice system. Admissions were likely to be experiencing their first treatment episode (69 percent), and more than one-third (38 percent) reported daily marijuana use.* —LEIGH HENDERSON

Chicago: *Statewide, the number of treatment episodes for marijuana increased from 20,773 in FY 2000, to 25,626 in FY 2001, 26,371 in FY 2002, and 32,077 in FY 2003. Marijuana was the most commonly reported secondary drug among persons receiving treatment for alcohol.* —DITA BROZ

Ft. Lauderdale: *In the second half of 2003, primary marijuana abuse accounted for 361 of the 565 addiction treatment cases at Spectrum Programs (64 percent) for which a primary drug of abuse was cited. Of these marijuana clients, 48 percent were White, 35 percent were Black, and 17 percent were Hispanic/other. Most of the marijuana clients (40 percent) were younger than 18, 25 percent were age 18–25, 20 percent were age 26–35, and 15 percent were 35 or older.* —JAMES HALL

Minneapolis/St. Paul: *Marijuana was overwhelmingly the primary drug among adolescents and young adults in treatment. Among treatment admissions younger than 18, 73.2 percent reported marijuana as the primary substance problem, and among youth age 18–25, 34.8 percent did so.* —CAROL FALKOWSKI

New York: *Primary marijuana admissions to all treatment programs had been increasing steadily over the past several years. The number increased more than ninefold between 1991 and 2002, from 1,374 to 14,310, the highest annual number....[but] fell to 13,471 in 2003…. In 1991, primary marijuana admissions represented less than 5 percent of all treatment admissions; by 2003, these admissions represented 20 percent of admissions (excluding alcohol only) to all New York City treatment programs…. In 2003, the vast majority were male (79 percent), and 34 percent were younger than 21….. Alcohol was the secondary drug of abuse for 39 percent of the marijuana admissions, and two-thirds had some criminal justice status.* —ROZANNE MAREL

Newark/New Jersey: *Statewide primary marijuana admissions (excluding alcohol) were more than twice the proportion of such admissions in Newark City (15.2 vs. 7.0 percent) and more than 5 percentage points higher than those in the Newark primary metropolitan statistical area. Statewide TEDS data for the first half of 2003 indicate that 82.4 percent of primary marijuana admissions were male, 54.3 percent were White, and 40.7 percent were Black. About 18 percent of primary marijuana admissions statewide were Hispanic. Across the State, approximately 50 percent of primary marijuana admissions were younger than 21, and about 72 percent were younger than 26.* —ANNA KLINE

St. Louis: *Marijuana treatment admissions more than doubled from 1997 (1,573 admissions) to 2001 (3,210 admissions) and remained stable in 2003. Marijuana, viewed by young adults as acceptable to use, is often combined with alcohol. The 25-and-younger age group accounted for 65.6 percent of primary marijuana treatment admissions in 2003.* —HEIDI ISRAEL-ADAMS

Seattle: *Half of the people entering drug treatment mentioned current use of marijuana as one of their top three drugs, similar to the prior 4 years. A higher proportion of males than females reported marijuana use (54 vs. 44 percent in 2003). Marijuana was the only major illicit drug for which a smaller proportion of users were female.* —CALEB BANTA-GREEN

Texas: *Marijuana was the primary problem for 19 percent of admissions to treatment programs in 2003. The average age was 21. Clients referred from the criminal justice system were not as impaired as those who were non-CJS referrals. They used marijuana on fewer days and had lower scores on the Addiction Severity Index for employment, sickness or health, family, emotional, social, and substance abuse problems. Short-term intervention may be more appropriate for the CJS referrals, with the more impaired marijuana abusers needing more intensive services* —JANE MAXWELL

Washington, DC: *Primary admissions for marijuana abuse accounted for 7.0 percent of the 2003 treatment admissions, up from 4.8 percent in 2002. Nearly 76 percent of the 336 primary marijuana admissions in 2003 were male, and nearly 88 percent were Black. The majority of these admissions were younger than 26 (61 percent), with nearly one-third being 17 or younger.* —ERIC WISH

Helplines and poison control centers continue to record calls related to marijuana abuse.

Boston: *In 2003, there were 246 calls to the Helpline during which marijuana was self-identified as a substance of abuse (3 percent of all mentions).* —DANIEL DOOLEY

Colorado: *Marijuana calls to the Rocky Mountain Poison and Drug Center were nearly nonexistent between 1994 and 1998, with only one or two per year. However, in 1999, 2000, and 2001, there were 47, 58, and 97 calls, respectively, related to marijuana effects. In 2002, the number of calls dropped slightly to 89.* —BRUCE MENDELSON

Seattle: *In the first half of 2003, marijuana represented 21 percent of the calls to the Helpline. A substantial difference between adults and teens is evident, with approximately three times the percentage of teens (53 percent) as adults (16 percent) calling about marijuana during the first half of 2003. The percentage of all calls citing marijuana declined slightly from 24 to 21 percent between the second half of 2002 and the first half of 2003.* —Caleb Banta-Green

Texas: *The Texas Poison Control Centers reported there were 135 calls of exposure to marijuana in 1998, compared with 406 in 2003, an increase of 172 percent in the rate per 100,000 population. The average age of callers in 2003 was 22.5, and 67 percent were male.* —Jane Maxwell

Arrests related to marijuana, especially marijuana possession, increased or stabilized in several CEWG areas.

Boston: *There were 1,366 Class D (mainly marijuana) drug arrests in 2003. The percentage of Class D arrests among total arrests (32.7 percent) in the city of Boston in 2003 did not change from 2002, but increased 14 percent from 2001…. The percentage of White, Class D arrests (32 percent) decreased 12 percent from 2002 to 2003 and 25 percent from 1997 to 2003, while the percentage of Black, Class D arrests (66 percent) increased 7 and 19 percent in the same periods, respectively.* —Daniel Dooley

Los Angeles: *A total of 5,367 marijuana arrests were made within the city of Los Angeles in 2003; this represents an 11-percent increase over the number of marijuana arrests made in 2002. Marijuana arrests accounted for approximately 17 percent of all narcotics arrests made in 2003.* —Beth Finnerty

New York: *In spite of decriminalizing possession of small amounts of marijuana, the New York Police Department continues to make a large number of marijuana-related arrests in New York City, although the number of arrests has stabilized. Cannabis-involved arrests reached a low of 4,762 in 1991, but increased more than 12 times in the next 9 years to 60,455 in 2000. Arrests in 2002 (47,250) were at the same level as in 2001, which was the second largest yearly total. In 2002, 32 percent of involved persons were age 20 or younger. Cannabis arrests accounted for 48 percent of all drug arrests in New York City in 2002.* —Rozanne Marel

San Francisco: *Arrests for marijuana-related offenses in San Francisco County numbered 1,736 in 2000 and then fell to a lower level during the next 2 years: 1,364 in 2001 and 1,420 in 2002. During the first 10 months of 2003, the arrest rate was about 10 percent lower than in 2002.* —John Newmeyer

Patterns/Trends Across CEWG Areas

DAWN ED Data on Marijuana

As shown in exhibit 38 on the following page, rates of marijuana ED mentions per 100,000 population in 2002 were highest in Philadelphia (150), Detroit (146), St. Louis (124), Boston (119), and Miami (111).

Rates of marijuana ED mentions increased significantly from 1995 to 2002 in 10 CEWG areas and remained stable in the other 9. Significant increases occurred across the three testing periods shown in exhibit 38 only in Baltimore and Miami, although increases were reported for Newark in the two most recent testing periods. Marijuana ED rates showed significant declines from 2001 to 2002 in Chicago, San Francisco, and Seattle.

ED data from Broward County, Florida (not covered in DAWN) show that 34 percent of the 1,285 drug abuse-related cases in the first half of 2003 involved marijuana. Case data on these ED patients included the following:

Males accounted for 74 percent of the marijuana cases; 57 percent were White, 39 percent were Black, and 4 percent were Hispanic/other or unknown. With regard to age, 12 percent of the cases were teenagers, 32 percent were in their twenties, another 25 percent were in their thirties, 24 percent were in their forties, and 6 percent were 50 or older. However, marijuana continues to be the most commonly abused illicit drug among young people visiting the emergency department.

Exhibit 38. Rates of Marijuana ED Mentions Per 100,000 Population in 19 CEWG Areas: 1995–2002

					Percent Change[1]		
CEWG Area	1995	2000	2001	2002	1995, 2002	2000, 2002	2001, 2002
Atlanta	63	86	96	96	53.0		
Baltimore	42	68	78	88	108.4	29.1	13.2
Boston	67	78	96	119			
Chicago	51	89	89	78	51.8		-12.2
Denver	33	51	50	38			
Detroit	94	99	121	146		47.6	
Los Angeles	21	67	67	64	209.0		
Miami	53	91	94	111	110.5	22.6	18.7
Mpls./St. Paul	20	33	46	47	129.4		
New Orleans	88	87	71	72			
New York	37	41	42	47			
Newark	43	29	37	54		85.5	44.4
Philadelphia	67	101	122	150	124.2	47.9	
Phoenix	24	51	45	46	93.5		
St. Louis	37	72	101	124	231.7	72.1	
San Diego	21	39	44	46	121.4	17.4	
San Francisco	33	38	45	39			-13.5
Seattle	53	72	75	65			-13.2
Wash., DC	55	64	51	55			

[1]These columns denote statistically significant ($p<0.05$) changes between estimates for the time periods noted.
SOURCE: DAWN, OAS, SAMHSA

Nearly half (47 percent) of all illicit substance abuse cases in the 12–25 age group involved marijuana.… Marijuana in combination with cocaine was found in 44 percent of the cases; 15 percent of the cases involved benzodiazepines. Marijuana was also found in combination with ecstasy or amphetamine in 3 percent, or 12, of the cases. Alcohol was the only documented co-ingestant with marijuana in 16 percent of the cases.
—JAMES HALL

Mortality Data on Marijuana

DAWN medical examiners/coroners in some CEWG areas do not test for marijuana in all or selected years. In 2002, marijuana was one of the drugs mentioned in 462 deaths across 16 of the 18 CEWG areas that tested for the drug (*see exhibit 39*).

Local/State ME data were reported by two CEWG members:

Honolulu: *The Oahu ME reports that over the past 5 years, there have been 15–20 deaths per year in which marijuana was found in the specimens sub-*

Exhibit 39. Marijuana-Involved DAWN Death Mentions in 18 CEWG Areas: 1999–2002

CEWG Area	1999	2000	2001	2002
Atlanta	14	14	18	42
Boston	-	4	8	4
Chicago	17	23	15	11
Dallas	98	74	65	43
Denver[1]	20	20	31	5
Detroit	93	98	74	111
Miami[1]	3	1	3	1
Mpls./St. Paul	14	19	11	27
New Orleans	58	55	39	51
New York	19	37	NR[2]	55
Newark	21	14	38	15
Philadelphia	32	37	42	46
Phoenix	3	8	1	1
St. Louis	60	49	39	46
San Diego[1]	1	-	5	1
San Francisco[1]	5	1	5	3
Seattle	-	1	-	-
Washington, DC	-	3	1	-

[1]In these areas, 100 percent of the population are represented.
[2]NR=Not reported (data were incomplete).
SOURCE: DAWN, OAS, SAMHSA

mitted for toxicology screening. In 2001, there were 36 marijuana-related deaths, and in 2002, there were 30 such deaths, a continuation of the 4-year rise. For 2003, a total of 32 such deaths were recorded. —**D. William Wood**

Florida: *Cannabinoids were detected in 722 deaths statewide in Florida during 2003, a 6-percent increase from the 682 marijuana-related deaths in the previous year.* —**James Hall**

Treatment Data on Marijuana

Excluding Miami, most CEWG areas reported comparable data on primary marijuana treatment admissions from 2001 to 2003 *(see exhibit 40)*. In the most recent reporting periods, primary marijuana admissions (excluding alcohol) continued to be highest in Minneapolis/St. Paul, at 45.0 percent of illicit drug admissions, although this reflected a 4.2-percentage-point decline from 2001. Marijuana admissions in 16 areas remained relatively stable between 2001 and 2003. Marijuana admissions increased more than 4 percentage points from 2001 to the most recent reporting period in Atlanta and Los Angeles, while they declined in Colorado by around 7 percentage points. Such changes, as noted earlier, may be associated with changes in funding.

Exhibit 40. Primary Marijuana Treatment Admissions by CEWG Area[1] and Percent of all Admissions (Excluding Alcohol): 2001–2003

CEWG Area	2001	2002	2003
Atlanta	20.9	NR[3]	27.0
Baltimore[2]	19.1	17.5	18.1
Boston	7.7	6.6	6.7
Detroit	10.4	13.4	13.5
Los Angeles	11.3	14.2	16.3
Miami (sample)[2]	NR	45.6	64.0
Mpls./St. Paul	49.2	47.7	45.0
New Orleans	37.5	37.0	36.7
New York	25.2	26.1	24.2
Newark	6.1	6.3	7.0
Philadelphia	19.7	22.4	23.7
St. Louis	35.5	36.3	34.4
San Diego	25.9	25.3	24.5
Seattle	34.4	34.0	32.9
Washington, DC	7.9	5.9	8.5
Arizona	36.5	36.1	39.6
Colorado	40.6	36.5	33.4
Hawaii	28.6	28.5	28.2
Illinois	25.9	28.1	26.5
Texas	26.1	25.8	26.5

[1]Represents either calendar or fiscal year. San Francisco did not report marijuana specifically and, thus, is not represented in the exhibit.
[2]Baltimore represents only the first 6 months of 2003 and Miami the last 6 months of 2003.
[3]NR=Not reported.
SOURCE: CEWG June 2004 reports on State and local data

ADAM Data on Marijuana

In 2003 time periods, high percentages of adult male arrestees tested positive for marijuana in the 15 ADAM/CEWG sites shown in exhibit 41, varying from 30.9 percent in Honolulu to 53.2 percent in Chicago. Among the three CEWG sites where male arrestees were tested only in the fourth quarter of 2003, the proportions testing marijuana-positive were highest in Boston (51.3 percent), followed by Houston (47.5 percent) and Miami (40.7 percent).

Exhibit 41. Percentages of Adult Male Arrestees Testing Marijuana-Positive in 15 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003[1]
Atlanta	38.2	NS[2]	34.3	41.8
Chicago	45.0	50.2	49.4	53.2
Dallas	35.8	32.9	36.2	39.1
Denver	40.9	40.0	40.3	42.3
Honolulu	30.4	30.2	32.2	30.9
Los Angeles	NS	NS	36.4	40.7
Minneapolis	54.2	53.6	54.2	48.3
New Orleans	46.6	44.9	46.9	50.8
New York	40.6	40.5	44.3	43.1
Philadelphia	49.4	42.7	47.7	45.8
Phoenix	33.7	39.7	41.1	40.9
San Antonio	40.7	40.7	42.0	41.9
San Diego	38.7	36.4	37.8	41.0
Seattle	37.7	35.1	38.5	37.2
Wash., DC	NS	NS	40.7	37.4

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

In the 10 CEWG areas where females were tested in 2003, the proportions of females testing marijuana-positive ranged from 28.6 percent in Los Angeles to 38.9 percent in Chicago (*see exhibit 42*).

Exhibit 42. Percentages of Adult Female Arrestees Testing Marijuana-Positive in 10 CEWG Areas: 2000–2003

CEWG Area	2000	2001	2002	2003[1]
Chicago	25.4	NS[2]	NS	38.9
Denver	33.8	33.0	32.6	34.3
Honolulu	19.4	13.9	20.3	29.8
Los Angeles	NS	NS	35.7	28.6
Minneapolis	NS	NS	NS	34.2
New Orleans	28.0	25.1	26.0	30.3
New York	28.2	32.1	30.6	36.7
Phoenix	23.3	26.5	29.2	31.6
San Diego	27.2	27.2	33.3	29.1
Wash., DC	NS	NS	32.5	29.1

[1]Data are unweighted and represent various quarters in 2003 (see Data Sources).
[2]NS=Not sampled or not reported.
SOURCE: ADAM, NIJ

Student Survey Data on Marijuana

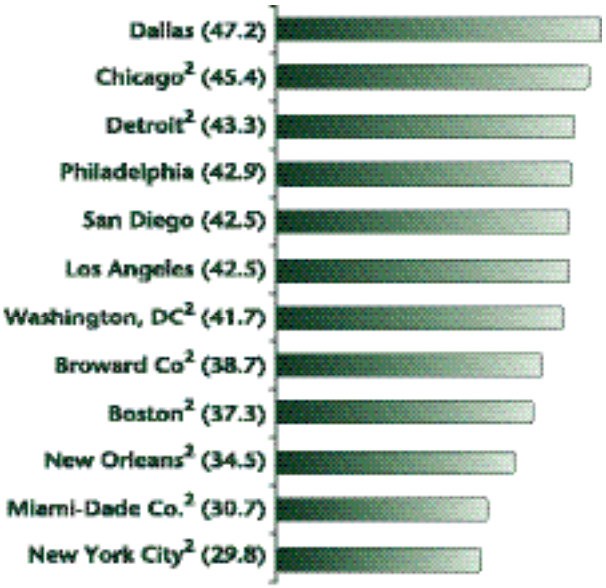
As shown in exhibit 43, the proportions of secondary school students in 2003 who reported using marijuana one or more times in their lifetime were highest in Dallas and Chicago, at approximately 47 and 45 percent, respectively. The proportions were also high in Detroit, Philadelphia, San Diego, Los Angeles, and Washington, DC, where they ranged between 42 and 43 percent.

Gender differences in lifetime use of marijuana were not great across CEWG areas, being higher for males in seven areas and higher for females in five. The proportions for male students ranged from 31.8 percent in New York City to 51.9 percent in Dallas.

Lifetime marijuana use among females ranged from a low of 27.9 percent in New York City to a high of 44.2 percent in Chicago.

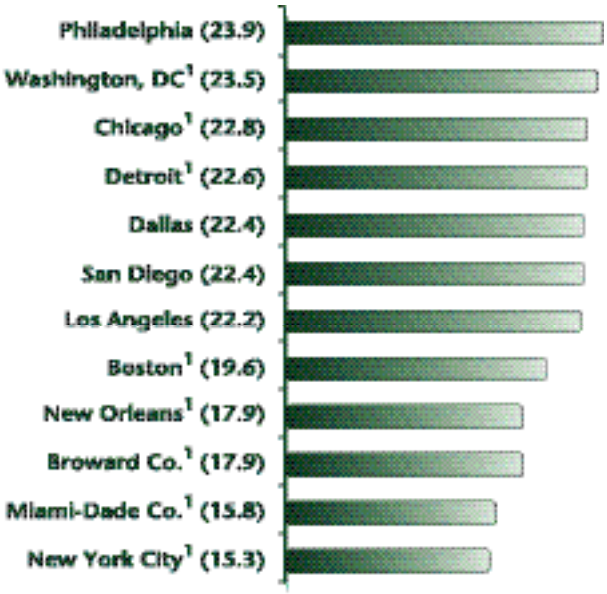
Reported marijuana use in the 30 days prior to the 2003 survey was highest in Philadelphia (23.9 percent) and Washington, DC (23.5 percent) (*see exhibit 44*). The percentages reporting past-30-day marijuana use were similar in Chicago, Detroit, Dallas, San Diego, and Los Angeles, all in the 22 percent range.

Exhibit 43. Lifetime[1] Use of Marijuana Among Students in Grades 9–12 in 12 CEWG Areas, by Percent: 2003



[1]Used marijuana one or more times during their lifetime.
[2]Represents public school sample; all others represent a "school district," "independent school district," or a "unified school district."
SOURCE: YRBS, CDC

Exhibit 44. Past-30-Day Marijuana Use Among Students in Grades 9–12 in 12 CEWG Areas, by Percent: 2003



[1]Represents public school sample; all others represent a "school district," "independent school district," or a "unified school district."
SOURCE: YRBS, CDC

NFLIS Data on Marijuana

Marijuana (cannabis) tended to rank first or second in most CEWG areas in numbers of items analyzed by police labs in 2003. The numbers were especially high in Chicago (28,872), Texas (14,566), Los Angeles (11,311), and New York (10,783). As a percentage of all items analyzed, cannabis accounted for approximately one-half of the items in Boston, Chicago, New Orleans, and San Diego (*see exhibit 45*).

Exhibit 45. Number of Analyzed Cannabis Items and Percentage of All Items Tested in 19 CEWG Areas: 2003

CEWG Area	Percent	Number
San Diego	52.7	7,251
New Orleans	52.2	6,465
Boston	49.1	3,349
Chicago	47.0	28,872
Detroit	39.8	1,706
Atlanta	39.7	7,811
St. Louis	39.2	2,471
Washington, DC	37.3	2,485
Philadelphia	31.9	6,760
Texas	28.9	14,566
New York	27.5	10,783
Los Angeles[1]	24.9	11,311
Miami	22.3	3,144
Baltimore	20.7	6,759
Denver	17.6	764
Seattle	17.2	551
Honolulu	16.5	433
Newark	13.3	505
St. Paul	5.3	190

[1]Data are not complete for all months.
SOURCE: NFLIS, DEA

Price Data on Marijuana

A wide array of varieties and prices characterized the marijuana markets in CEWG areas in the first half of 2004 (*see exhibit 46 on the following page*). The popularity of the drug was reflected in the many types available: domestic, commercial grade, sinsemilla, hydroponic, "BC Bud" (a seedless, hybrid type from British Columbia), and Mexican, Jamaican, and Colombian.

Marijuana prices were related to both the type purchased and the location of the sale. Joints were available for $1 or $2 in Baltimore, Dallas, Newark, New Orleans, and New York City. Ounces of Mexican marijuana were available for $50–$60 in Denver and San Diego, while ounces of BC Bud sold for $600 in Denver and Minneapolis. In New Orleans, marijuana prices have decreased recently because of the abundant availability of Mexico-produced marijuana.

In San Francisco, a large and increasing quantity of marijuana is sold legally from medical marijuana outlets to certified purchasers. Other CEWG members reported on the marketing and packaging of illegal marijuana. In New York City, for instance, "Coffins" refer to sales of marijuana in small plastic containers for $20. Popular types of marijuana available in Washington, DC, and Maryland include "chronic," "kind bud," "purple haze," "blueberry," and "orange tulip."

Exhibit 46. Marijuana Prices by Type and Amount in 21 CEWG Areas: January–June 2004

CEWG Area	Retail	Ounce	Wholesale
Atlanta	$5–$10/g	$100–$140/oz	$800/lb
Baltimore	$2–$5/joint CG[1] $20–$40/bag CG $35–$60/¼oz CG	$130/oz CG $275/oz HY[2]	$1,000–$1,600/lb CG $2,300–$4,000/lb HY
Boston	$5/joint	$200–$250/oz CG	$800–$1,500/lb CG
Chicago	$3–$5/g $5–$20/bag	$50–$75/oz CG	$900–$1,200/lb CG
Dallas	$2/cigarette CG $10/g CG	$60–$100/oz CG $400/oz LP[3]	$350–$600/lb CG $900–$1,200/lb SN[4] $6,000/lb LP
Denver	$5/bag MX[5]	$50–$80/oz MX $200 to $400/oz LP $600/oz BC[6]	$400 to $1,000/lb MX $1,500 to $4,000/lb LP $2,000–$4,500/lb BC
Detroit	$20/g CG	$150/oz CG	$1,000–$1,300/lb SN $1,600–$1,800/lb CG
Honolulu	$5–$20/joint $25/g $100–$200/⅛oz	$400–$800/oz	$6,000–$9,000/lb
Los Angeles	$10/g CG $25/g DO[7] $60–$80/⅛oz SN	$60–$80/oz CG $200–$250/oz DO $300–$600/oz SN	$300–$400/lb MX $1,000–$1,200/lb DO $2,500–$6,000/lb SN $6,000/lb BC
Miami	$5–$10/g $100–$120/¼oz SN	$100–$150/oz MX $350/oz HY	$800–$1,000/lb MX $2,500–$4,000/lb SN, HY
Minneapolis	$5/joint $50/1⁄4oz	$80–$600/oz $600/oz BC	$600–$2,400/lb
Newark	$1/joint $30/¼oz	$100–$200/oz $300–$1,200/oz HY	$1,000–$2,000/lb $3,000–$5,000/lb HY
New Orleans	$2/joint $10/g	$125–$160/oz	$800–$1,000/lb
New York	$1/joint $30/¼oz	$100–$200/oz $300–$1,200/oz HY	$1,000–$2,000/lb $3,000–$5,000/lb HY
Philadelphia	$5–$35/bag	$150–$200/oz	$750–$1,400/lb
Phoenix	$10–$25/7 gs	$75–$150/oz	$500–$750/lb
St. Louis	$10–$20/bag	$150–$175/oz	$700–$1,800/lb SN
San Diego	$20/g SN $20–$50/¼oz MX	$60–$100/oz MX $200–$450/oz SN	$250–$400/lb MX $3,000–$5,200/lb SN
San Francisco	$40/⅛oz CG	$160/oz MX $200/oz DO	$380–$400/lb MX $3,000–$6,000/lb SN $4,000–$5,000/lb BC $4,000–$5,000/lb DO
Seattle	$10–$20/g BC $10–$40/g LP	$250–$350/oz BC $250–$500/oz LP	$500–$700/lb MX $1,500–$3,500/lb DO $2,500–$3,500/lb LP $2,200–$4,000/lb BC $5,000–$6,500/kg LP $5,200/kg BC
Washington, DC	$5–$10/joint	$100–$150/oz	$1,800/lb CG $5,000/lb HY

[1]CG=Commercial grade.
[2]HY=Hydroponic.
[3]LP=Locally produced.
[4]SN=Sinsemilla.
[5]MX=Mexico-produced.
[6]BC=BC Bud.
[7]DO=Domestic.
SOURCES: Narcotics Digest Weekly, NDIC, and June 2004 CEWG reports

Club Drugs (MDMA/Ecstasy, GHB, Ketamine)

MDMA/ecstasy abuse indicators decreased or were stable in most CEWG areas. Concerns and issues raised by CEWG members regarding MDMA/ecstasy included the fact that users do not always know exactly what is contained in the pills they are taking. In some CEWG areas, there were reports of increased use of MDMA among school students and in African-American and Hispanic populations. Gamma hydroxybutyrate (GHB) and ketamine indicators continue to be low in CEWG areas.

MDMA/Ecstasy

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

Several CEWG areas report that MDMA abuse is declining or continues at low levels.

Atlanta: *Abuse of MDMA (ecstasy) appears to be declining.* —Kristin Wilson

Boston: *MDMA (ecstasy) indicators show stable and relatively low levels of abuse .* —Daniel Dooley

Miami/Ft. Lauderdale: *Ecstasy abuse appears to have peaked and is even considered passé by some former users, and it is being replaced by methamphetamine among some groups.* —James Hall

St. Louis: *DAWN ED data show few mentions of methylenedioxymethamphetamine (MDMA) (55 in 2001 and 35 in 2002).... While MDMA remained readily available at raves and other dance parties and cost $20–$30 per tablet, the popularity of the drug seems to be declining. In a behavioral study of club drug users by Dr. Linda Cottler and colleagues, recruiting current users into the study has become more difficult. Most of the reports about high levels of MDMA abuse are anecdotal or are part of a poly-drug user's history.* —Heidi Israel-Adams

Washington, DC: *Abuse of MDMA and other club drugs is relatively low in the District.*—Eric Wish

MDMA abuse continues to spread into more diverse populations, including African-American and Hispanic populations.

Atlanta: *Abuse of MDMA continues to spread into more diverse populations in Atlanta. Other club/party drugs are also barely registering in the epidemiological data, but still are encountered frequently in ethnographic contexts.* —Kristin Wilson

New York: *According to the Street Studies Unit, there has been little change in ecstasy use from the last CEWG reporting period. Although ecstasy remains a club drug and is sold and used mainly in clubs, street sales continue to increase in the Bronx, Manhattan, and Brooklyn to young Black and Puerto Rican youth. Ecstasy remains a drug that is used mainly indoors.* —Rozanne Marel

Texas: *Ecstasy has spread outside the White club scene into Hispanic and Black communities.* —Jane Maxwell

MDMA abuse among high school students, college students, and young adults continues to be reported.

Chicago: *Ecstasy remained available in most mainstream dance clubs and at many house parties, according to ethnographic reports. Street reports suggest that ecstasy—or drugs sold as ecstasy—is widely available among high school and college students.* —Dita Broz

Detroit: *Ecstasy users remain college students or young professionals, often in dance settings. Many urban and suburban areas outside Detroit continue to be noted as having significant ecstasy use. There are additional reports of some ecstasy use by high school students. Some sources report ecstasy has become more difficult to buy and that consequently some users have returned to marijuana use.* —PHIL CHVOJKA

Florida: *The 2003 Florida Youth Substance Abuse Survey revealed lifetime ecstasy use statewide among 12th graders was at an all time high at 15.1 percent, and was used more often than any other illicit drug except marijuana. Florida 12th graders' lifetime ecstasy use is now greater than the national average. In fact, roughly twice as many Florida 12th graders had used ecstasy in their life as had used cocaine, and 15 times as many 12th graders had used ecstasy as had used crack cocaine.* —JAMES HALL

Los Angeles: *YRBS began to assess ecstasy use among area high school students in 2003. According to the survey results, 4.7 percent of all Los Angeles Unified School District (LAUSD) high school students (in grades 9 through 12) who responded to the survey in 2003 had ever used ecstasy; past-30-day-use of the drug was not assessed. A breakdown of the lifetime ecstasy use data by gender illustrated that LAUSD males were more likely than their female classmates to report lifetime use (5.7 vs. 3.8 percent). San Bernardino USD had a much higher percentage of high school students who reported lifetime use (9.0 percent). San Diego USD high school students were also more likely than LAUSD students to report lifetime ecstasy use (6.3 percent).* —BETH FINNERTY

New Orleans: *Among New Orleans secondary school students in 2003, 7.2 percent reported lifetime use of ecstasy, higher than the proportions reporting lifetime use of methamphetamine, heroin, or cocaine/crack.* —GAIL THORNTON-COLLINS

Texas: *Drug abuse counselors in the McAllen area report an increase in teenagers being referred to treatment for ecstasy use after the end of spring break.* —JANE MAXWELL

Calls to Helplines and poison control centers involving MDMA were reported from some CEWG areas.

Boston: *In 2003, there were 30 calls to the Helpline during which MDMA was self-identified as a substance of abuse (fewer than 1 percent of all mentions). The number of MDMA Helpline calls has been similar for the 4 fiscal years 2000 to 2003.* —DANIEL DOOLEY

Detroit: *The Children's Hospital of Michigan Poison Control Center (Detroit-area) received reports of 31 cases involving ecstasy misuse in the 10-month period between January and November 2003. This is about the same number of cases as reported in 2002. There were 26 cases statewide involving intentional abuse of ecstasy reported by both Michigan poison control centers in the first 4 months of 2004.* —PHIL CHVOJKA

Minneapolis/St. Paul: *The Hennepin Regional Poison Center received nine MDMA exposure-related calls in 2004 and six calls seeking information (through May 27).* —CAROL FALKOWSKI

CEWG reports continue to document the variable content of ecstasy pills.

Miami/Ft. Lauderdale: *Ecstasy pills generally contain 75–125 milligrams of MDMA, although pills are often adulterated and may contain no MDMA…. The major sources of the designer logo-emblazoned pills seem to be clandestine labs in Western Europe, especially the Netherlands and Belgium (and more recently Spain). The pills enter South Florida from the Caribbean because of post 9-11 airline security.* —JAMES HALL

Minneapolis/St. Paul: *Crime labs continued to confirm that some pills sold as 'ecstasy' actually contained no MDMA, but rather a combination of other drugs, such as methamphetamine, ketamine, caffeine, N,N-Diisopropyl-5-methoxy-tryptamine (known as '5-MeO-DIPT' and 'Foxy Methoxy'), or methylenedioxyamphetamine (MDA), a chemical similar in effect to MDMA.* —CAROL FALKOWSKI

New York: *MDMA is often called 'ecstasy' or 'XTC,' although other substances are often sold as ecstasy.* —ROZANNE MAREL

Patterns/Trends Across CEWG Areas

DAWN ED Data on MDMA

From 1995 to 2002, the rates of DAWN MDMA ED mentions per 100,000 population increased dramatically in 11 CEWG areas and tended to fluctuate from 2000 to 2002 (*see exhibit 47*). From 2001 to 2002, rates decreased in eight CEWG areas and increased only in New Orleans. In 2002, the rates of MDMA ED mentions per 100,000 population were highest in Miami (6), New Orleans (7), and San Francisco (8). In another eight CEWG areas, rates of MDMA ED mentions also exceeded the rate of 2 per 100,000 population in the coterminous United States.

Mortality Data on MDMA/Club Drugs

The DAWN medical examiner/coroner system does not report specifically on MDMA-involved deaths, but it combines five drugs under the category of "club drugs"—MDMA, ketamine, gamma hydroxybutyrate (GHB), gamma butyrolactone (GBL), and Rohypnol.

Local/State mortality data on deaths involving MDMA or methylenedioxyamphetamine (MDA) were documented by local or State medical examiners in six areas:

Detroit: *The Wayne County ME lab identified one MDMA/MDA death in 1998, two in 1999, three in 2000, and two in 2001. In 2002, there were 11 decedents with MDMA present; multiple drugs were found in all these cases. Most of the MDMA decedents in 2002 were homicide victims. Three MDMA/MDA ME cases were reported in 2003.* —**PHIL CHVOJKA**

Exhibit 47. Rates of MDMA ED Mentions Per 100,000 Population in 19 CEWG Areas: 1995–2002

					Percent Change[1]		
CEWG Area	1995	2000	2001	2002	1995, 2002	2000, 2002	2001, 2002
Atlanta	…[2]	2	5	3	…	30.5	-34.5
Baltimore	0	3	3	3	670.9		-15.6
Boston	0	3	4	3	1,547.6		
Chicago	0	4	2	1	951.3	-58.5	
Denver	0	4	2	2	753.1	-52.4	-22.4
Detroit	0	1	3	3		89.0	
Los Angeles	0	2	2	2	348.3		
Miami	0	5	9	6	2,836.5	19.2	-28.0
Mpls./St. Paul	…	3	3	3	…		
New Orleans	…	4	3	7	…	91.8	131.7
New York	…	2	2	2	…		
Newark	…	1	3	3	…		
Philadelphia	…	3	5	4	…		
Phoenix	0	4	3	2	3,257.5		-49.6
St. Louis	0	2	2	2	3,387.7		
San Diego	0	2	2	1	352.6	-39.0	-43.2
San Francisco	2	7	10	8	337.9	25.9	-14.8
Seattle	1	6	5	4	640.9	-38.7	-26.1
Wash., DC	…	2	3	2	…		

[1]These columns denote statistically significant ($p<0.05$) changes between estimates for the time periods noted.
[2]Dots (…) indicate that an estimate with a relative standard error greater than 50 percent has been suppressed.
SOURCE: DAWN, OAS, SAMHSA

Florida: *There were 139 methylated amphetamine-related deaths in the State of Florida during 2003, representing a 10-percent increase from the 126 such deaths in 2002. The drug was considered the cause of death in 22 percent of the 2003 cases. Florida recorded 147 methylated amphetamine-related deaths statewide in 2001. The types of methylated amphetamine detected in 2003 included methamphetamine (58 percent), MDMA (26 percent), MDA (15 percent), and other methylated amphetamines (1 percent).* —JAMES HALL

Minneapolis/St. Paul: *The abuse of MDMA contributed to the death of a 21-year-old African-American male in Hennepin County in 2003.* —CAROL FALKOWSKI

Philadelphia: *MDMA was present in 6 mortality cases in 1999 (the first year this drug was detected by the ME), in 8 cases in 2000, 14 cases in 2001, 5 cases in 2002, and 4 cases in 2003.*

The Philadelphia ME first detected MDA in the second half of 1999. There have been 24 positive toxicology reports for MDA since then, including 3 cases in the first half of 2003 and 2 cases in the second half of 2003. —SAMUEL CUTLER

Seattle: *In 2003, there were seven deaths involving MDMA. Of the seven MDMA-involved deaths, four involved MDMA alone; the three other deaths involved either methamphetamine or cocaine.* —CALEB BANTA-GREEN

Texas: *In 1999, there were two deaths involving ecstasy in Texas. There was one death in 2000, five in 2001, and five in 2002. Of those who died in 2002, the average age was 23.4; all were White, and 60 percent were male.* —JANE MAXWELL

Treatment Data on MDMA/Club Drugs

Three CEWG areas reported treatment data on one or more of the "club drugs," as shown below:

Colorado: *In 2003, there were 38 clients admitted to treatment claiming MDMA as their primary drug of abuse. Twenty-eight of the MDMA admissions were male…. 24 were White (non-Hispanic), and 7 were Hispanic. Nine were age 12–17, 15 were 18–25, 4 were 26–34, and 10 were 35 and older. Interestingly, 24 of the MDMA users took it orally, while 11 were smokers, 1 inhaled, and 1 injected…. 25 used a secondary drug.* —BRUCE MENDELSON

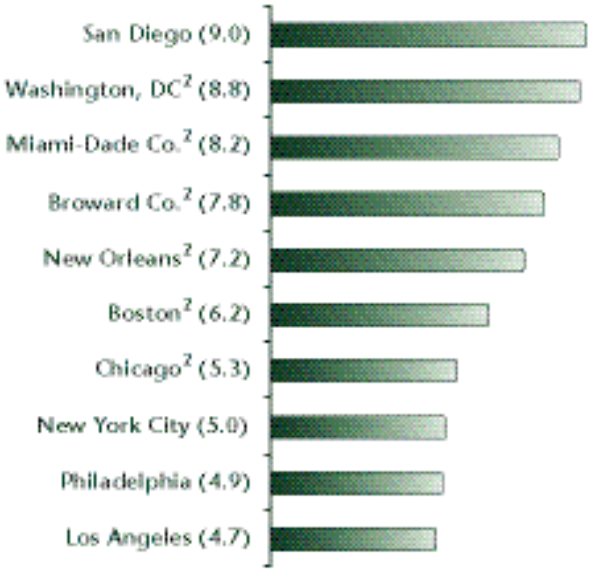
Illinois: *In FY 2002, 50 'club drug' admissions were reported. In FY 2003, 79 admissions were reported, of which 63 percent were among males and 54 percent were among Whites.* —DITA BROZ

Texas: *Admissions for a primary, secondary, or tertiary problem with ecstasy were 63 in 1998, 114 in 1999, 199 in 2000, 349 in 2001, 521 in 2002, and 502 in 2003…. In comparison to users of other club drugs, those who used ecstasy were more likely to be young and racially diverse; 41 percent reported marijuana as their primary problem drug, while only 14 percent reported ecstasy as their primary problem drug.* —JANE MAXWELL

Student Survey Data on Ecstasy Use

Across 10 CEWG areas, the 2003 YRBS survey of students in grades 9–12 show the largest percentages for lifetime use in San Diego, Washington, DC, and Miami-Dade County, Florida (*see exhibit 48*).

Exhibit 48. Lifetime Use[1] of Ecstasy Among Students in Grades 9–12 in 10 CEWG Areas, by Percent: 2003

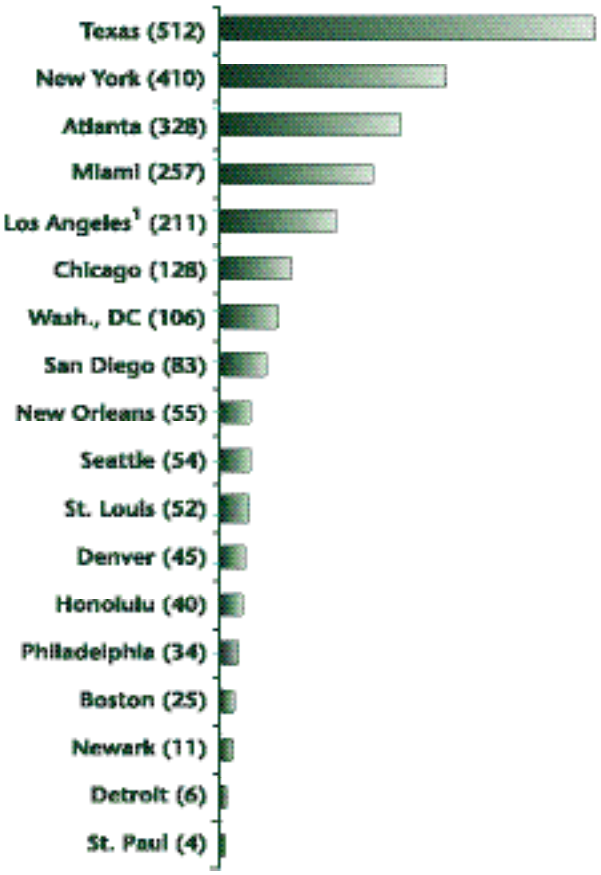


[1]Used ecstasy one or more times during their lifetime.
[2]Represents public school sample; all others represent a "school district," "independent school district," or a "unified school district."
SOURCE: YRBS, CDC

NFLIS Data on MDMA

Of the "club drugs" analyzed by NFLIS labs in 2003, most were MDMA or MDA (88 and 12 percent, respectively). New York and Texas had a large number of items—410 and 512, respectively (*see exhibit 49*). However, MDMA/ MDA as a percentage of all items analyzed in each area was quite small. The highest proportions ranged between 1 and nearly 2 percent of all items in only eight CEWG areas: Denver and New York City (1.0 percent each), Washington, DC, and Texas (1.1 percent each), Seattle (1.4 percent), Honolulu (1.5 percent), Atlanta (1.7 percent), and Miami (1.8 percent). At all other sites, the percentages of MDMA/MDA items ranged from zero (Baltimore) to 0.1 percent (Detroit).

Exhibit 49. Number of MDMA/MDA Items Analyzed by Forensic Laboratories in CEWG Areas: 2003



[1]Data are not complete for all months.
SOURCE: NFLIS, DEA

MDMA Availability and Prices

Mixed availability of MDMA continued to be reported throughout CEWG areas in the first half of 2004. It was readily available in Boston, Denver, and San Francisco, and "less difficult to obtain" in Atlanta. In Detroit, however, MDMA became more difficult to purchase. MDMA use and sales are reported as mainly taking place at dance clubs, raves, and house parties, although street sales were reported in New York City and Washington, DC.

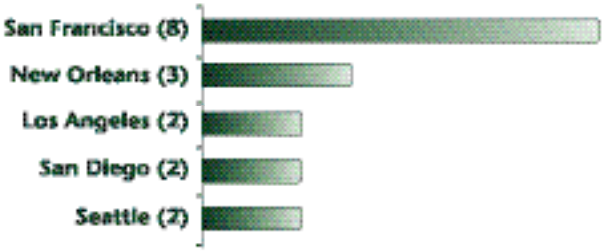
As shown in exhibit 50 on the following page, retail prices for MDMA in the first half of 2004 were as low as $6 per tablet in Denver and Washington, DC, but the more common retail price remained at $15–$20. As with prices for other drugs, MDMA prices decreased as the quantity purchased increased. In Minneapolis, for example, the retail price for MDMA was $45 per dosage unit, but the wholesale price was $8 per dosage unit when the pills were bought in bulk.

GHB

DAWN ED Data on GHB

From 1995 to 2002, rates of GHB ED mentions per 100,000 population increased significantly in 7 CEWG areas. Between 2000 and 2002 and/or 2001 and 2002, rates of GHB ED mentions decreased significantly in nine CEWG areas. A significant increase from 2001 to 2002 occurred only in Seattle, where the rate was 2 per 100,000 population. Exhibit 51 shows the five CEWG areas where the rates in 2002 exceeded those for the coterminous United States (1 per 100,000 population).

Exhibit 51. Rates of GHB ED Mentions Per 100,000 Population in 5 CEWG Areas[1]: 2002



[1]Includes only areas that exceeded the rate in the coterminus United States.
SOURCE: DAWN, OAS, SAMHSA

Exhibit 50. MDMA Prices in 20 CEWG Areas: January–June 2004

CEWG Area	Retail	Ounce	Wholesale
Atlanta	$25–$30/tablet	N/A[1]	$5–$10/tablet
Baltimore	$20/tablet	N/A	$10–$15/tablet
Boston	$20–$25/tablet	N/A	$5–$15/tablet
Chicago	$10–$30/dosage unit	$15/dosage unit	$4–$10/dosage unit
Dallas	$6–$10/tablet	N/A	$4–$6/tablet
Denver	$15–$25/tablet	$12/tablet	$8–$16/tablet
Detroit	$20–$28/dosage unit	$10–$15/dosage unit	N/A
Los Angeles	$20–$30/pill	N/A	$8,000/boat[2]
Miami	$10–$20/pill	N/A	$5–$7/pill
Minneapolis	$45/dosage unit	N/A	$8/dosage unit
Newark	$20–$30/tablet	N/A	$7–$12/tablet
New Orleans	$15–$20/tablet	N/A	N/A
New York	$20–$28/tablet	$8–$13/tablet	$4–$6/tablet
Philadelphia	$9–$35/tablet	N/A	$7.50–$13/tablet
Phoenix	$20–$30/tablet	$10–$15/roll[3]	$7–$12/boat
St. Louis	$15–$30/tablet	$1,100–$1,300/jar[4]	$10,000–$11,000/boat
San Diego	$15–$30/tablet	N/A	$5,500–$10,000/boat
San Francisco	$15–$40/tablet	N/A	$6–$11/tablet
Seattle	$20/dosage unit	N/A	N/A
Wash., DC	$6–$12/tablet	N/A	$20/bottle $150/gram

[1]N/A=Not available. (No price data were available in Honolulu.)
[2]Boat=1,000 tablets.
[3]Roll=25–100 tablets.
[4]Jar=100 tablets.
SOURCES: *Narcotics Digest Weekly*, NDIC, and June 2004 CEWG reports

Local ED data show a decrease in GHB cases in Broward County, Florida:

There has been a dramatic decrease in the number of GHB cases treated in emergency departments since 2001. The Broward General Medical Center Emergency Department treated 13 people with GHB or GHB precursor overdose in the first 6 months of 2003; in the last 6 months, 17 people were treated, for a total of 30. The ages of the GHB toxicity patients ranged from 19 to 41, with an average of 28.9 years. There was one teenager (6 percent); 76 percent of the patients were in their twenties, 11 percent were in their thirties, and 12 percent were in their forties. The reason for coming to the hospital for 64 percent of the GHB ED visits was because of withdrawal, while 17 percent were brought in because of unresponsiveness. —**James Hall**

Mortality Data on GHB

Two CEWG members reported on GHB-involved deaths:

Florida: *There were 11 GHB-related deaths reported statewide in 2003, 3 of which were considered to have been caused by the drug. In all of Florida, GHB-related deaths increased from 23 in 2000 to 28 in 2001 and then declined to 19 in 2002 and again to 11 in 2003.* —**James Hall**

Seattle: *In 2003, there was one GHB-involved death.* —**Caleb Banta-Green**

Treatment Data on GHB

The Colorado, Michigan, and Texas CEWG representatives reported on GHB clients in their States:

Colorado: *In 2003, there were five clients admitted to treatment claiming GHB as their primary drug of abuse. Four were female, two were White, and one each was Black, Native American, and Asian. Three of the five were 35 and older. Four had taken the drug orally, while one smoked it.* —**Bruce Mendelson**

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

Texas: *Adult and adolescent clients with primary, secondary, or tertiary problems with GHB, GBL, or 1,4 butanediol are seen in treatment. In 1998, 2 were admitted, compared with 17 in 1999, 12 in 2000, 19 in 2001, 35 in 2002, and 31 in 2003. Clients who used GHB tended to be the oldest of all the club drug users (age 28) and the most likely to be White. GHB users were more likely to have used the so-called 'hard-core' drugs: 36 percent had a history of injection drug use. Forty-five percent had a primary problem with amphetamines or methamphetamine. Because of the sleep-inducing properties of GHB, users will also use methamphetamine so they can stay awake while they are 'high.'* —**Jane Maxwell**

Poison Control Center GHB Cases

The Detroit and Texas representatives also reported on poison control center cases involving GHB:

Detroit: *The Children's Hospital of Michigan Poison Control Center GHB case reports totaled 100 in 1999, about 35 in 2000, and about half that many in 2001. In 2002, there were only about 10 cases of intentional GHB abuse reported to the Detroit area poison center. It is believed that GHB is no longer reported to this source, since only five cases were reported during the first 10 months of 2003, and only two cases were reported statewide in the first 4 months of 2004.* —**Phil Chvojka**

Texas: *The number of cases of misuse or abuse of GHB reported to Texas Poison Control Centers was 110 in 1998, 150 in 1999, 120 in 2000, 119 in 2001, 100 in 2002, and 66 in 2003. The average age of the abusers in 2003 was 24, and of the callers whose gender was known, 64 percent were male.* —JANE MAXWELL

NFLIS Data on GHB

In 2003, GHB was detected in 117 items across 5 CEWG sites. More than 85 percent of the items were reported from Dallas, Texas. Fifteen GHB items were identified in Los Angeles, compared with 8 in Miami, 5 in Chicago, and 4 in Washington, DC.

Price Data on GHB

Four CEWG members reported on the price of GHB in their areas:

- Chicago—$10–$25 per capful
- Colorado—$5–$10 per capful ("dosage unit")
- St. Louis—$40 per ounce
- Texas—$20 per dose in Dallas; $5–$10 per dose in Lubbock and San Antonio; $100 per 16-ounce bottle in San Antonio; and $109.00 per 2-ounce bottle in Fort Worth

KETAMINE

DAWN ED Data on Ketamine

In 1995, the rate of ketamine ED mentions per 100,000 population was zero across the 21 DAWN areas. In 2002, only San Diego and San Francisco had rates above zero, at 1 per 100,000 population each.

Mortality Data on Ketamine

Only Philadelphia reported on ketamine-involved deaths:

Ketamine was first detected in decedents in Philadelphia in 1996; it was detected in four decedents in 2000, four decedents in 2001, two decedents in 2002, and three decedents in 2003. —SAMUEL CUTLER

Treatment and Poison Control Center Data on Ketamine

Three CEWG members reported the following:

Chicago: *Only two patients were served for ketamine use in FY 2003 in publicly funded treatment programs in Illinois.* —DITA BROZ

Colorado: *In 2003, there were seven clients admitted to treatment reporting ketamine as their primary drug of abuse. Six were White and one was Hispanic; six were male and five were younger than 35.* —BRUCE MENDELSON

Detroit: *The Children's Hospital of Michigan Poison Control Center (Detroit-area) was consulted on fewer than 10 cases of intentional ketamine abuse during the first 10 months of 2003.… There were 11 ketamine-involved treatment admissions statewide in FY 2002 and 32 in FY 2003.* —PHIL CHVOJKA

NFLIS Data on Ketamine

Across 12 CEWG cities and 8 Texas sites, the NFLIS identified 282 ketamine items in 2003. Sixty percent of the ketamine items were in two areas—New York City (86) and Texas (78, with 30 of these items reported from the Dallas area).

Price Data on Ketamine

In Chicago, ketamine sells for $5–$30 per "bag" in powder or liquid form. In Texas, ketamine sells for $2,200–$2,500 per liter in Fort Worth, $65 per vial in Tyler, $50–$65 per milliliter in San Antonio and Tyler, and $20 per pill in San Antonio and Tyler.

Phencyclidine (PCP)

PCP abuse indicators continue to be at much lower levels than abuse indicators for many other drugs (e.g., cocaine, heroin, marijuana). PCP abuse indicators continue to be highest in Los Angeles, Philadelphia, and Washington, DC, following the trend reported by the PCP panel at the December 2003 CEWG meeting.

PCP continues to be available in some CEWG areas, often as a dip on marijuana joints or cigarettes.

New York: *According to observations by the Street Studies Unit, there has been an increase in the sale and use of PCP or 'Angel Dust' from the last CEWG report period. In the Bronx, a 20-year-old Black male was observed selling 'Dippy Bo,' which is a blunt dipped in PCP. In some areas, this is also called 'wet.' The buyers were mainly young Black and Hispanic youth in their late teens and early twenties…. In Harlem, Angel Dust seems to be on the rise among young adults. A field researcher was told by a youth, 'You don't need the weed, just the PCP to get high. PCP at $10 a bag is cheaper than weed, and you don't need as much to get high.' He said that he and his friends stopped buying marijuana and only buy PCP.* —Rozanne Marel

Philadelphia: *PCP has become easier to obtain than ever. It is more commonly available on mint leaves for use in lacing blunts or for rolling and smoking. Additionally, PCP in liquid form is available and is used by applying the drug to cigarettes. This method is referred to as 'sherms' or 'dip sticks.'*—Samuel Cutler

St. Louis: *PCP has been available in limited quantities in the inner city and has generally been used as a dip on marijuana joints. While PCP is not seen in quantity, it remains in most indicator data, including ED mentions, police exhibits, and as a secondary drug in ME data. Most of the users of this drug in the inner city are African-American. PCP ED mentions increased significantly by 93.2 percent from 2000 to 2002 (from 74 to 143).* —Heidi Israel-Adams

Washington, DC: *In 2003, Washington DC, had a growing PCP problem, including an increase in DAWN ED mentions and adult arrests related to PCP. According to the Washington/Baltimore High Intensity Drug Threat Assessment, PCP was rapidly becoming the drug of choice at raves and nightclubs, sometimes used in combination with marijuana and/or MDMA. Other indicators, such as pretrial drug tests of adult arrestees, however, point towards a leveling off or even a decrease in use in 2004.* —Eric Wish

ED data through 2002 point to increases in PCP mentions among females and/or youth in some CEWG areas.

Baltimore: *The number and rate of phencyclidine (PCP) ED mentions increased significantly, from 75 mentions (3 per 100,000 population) in 2001 to 120 mentions (5 per 100,000) in 2002. PCP episodes in 2002 were more likely to involve women and youth than in 2001. In 2002, 44 percent of PCP-related episodes involved women, compared with 33 percent in 2001, and 29 percent were age 12–17, compared with 13 percent in 2001.* —Leigh Henderson

Newark: *There was a significant increase in the rate of PCP ED mentions in 2002, with a rate of 7 per 100,000 population, up from 2 per 100,000 in 2001. Of the 124 PCP ED mentions, 73.4 percent were multidrug episodes. Seventy percent were for patients who were male, and 64 percent were for patients age 18–25. Patients in the 18–25 age group, moreover, exhibited the greatest increase in PCP mentions of all age groups, with the rate of mentions increasing from 8 per 100,000 in 2001 to 39 in 2002. More than 58 percent of patients cited psychic effects as a motive for using PCP. The most frequently cited reasons for visiting the ED were overdose (41 percent) and unexpected reaction (37 percent).* —Anna Kline

Philadelphia: *Rates of DAWN ED PCP mentions were 12, 17, and 25, respectively, for the years 2000 through 2002, reflecting a statistically significant increase of 103.4 percent during that time period.*

The demographic groups that showed statistically significant changes were females, whose rate of PCP mentions increased by 221.8 percent from 2000 to 2002 (from 5 to 16) and all age groups from age 12 through 55-and-older. Overall, rates continued to be higher among males (35) than females (16) in 2002. The highest rate occurred in 2000 among 18–19-year-olds (129). —**SAMUEL CUTLER**

Seattle: *PCP-involved ED mentions remained at a higher level of 6 per 100,000 from 2000 to 2002, up from 2 per 100,000 in 1995. In 2002, 83 percent of mentions involved other drugs, similar to prior years. The proportion of females increased from 8 to 30 percent from 1995 to 2002. Half of PCP-involved mentions were African-American in 2002; missing data in the 1990s precludes race trend comparisons. Those age 18–25 consistently constituted the largest group of PCP users.* —**CALEB BANTA-GREEN**

Patterns/Trends Across CEWG Areas

DAWN ED Data on PCP

Rates of PCP ED mentions per 100,000 population increased significantly in all three testing periods shown in exhibit 52 in Newark and Philadelphia, and they increased significantly from 2000 to 2002 and 2001 to 2002 in Baltimore and Washington, DC. In 2002, rates were highest in Washington, DC (31) and Philadelphia (25).

The majority of PCP-related ED visits in 2002 involved PCP in combination with other drugs. In Philadelphia, 80 percent of the PCP mentions involved other drugs, as did 65 percent in Washington, DC. In these two areas, between 30 and 50 percent of the PCP-related ED visits involved either alcohol or marijuana.

Mortality Data on PCP

The **DAWN ME system** includes PCP in the category of "hallucinogens." Of the 19 CEWG areas included in the 2002 reporting period, hallucinogen-related deaths were documented in 13. The highest numbers of hallucinogen-related deaths were reported from Baltimore (11), Washington, DC (27), and Philadelphia (46).

Local ME data for 2003 were reported by two CEWG representatives:

Minneapolis/St. Paul: *Two young African-American males (ages 18 and 19) died in 2003 in Hennepin County, with recent PCP use reported as a significant contributing condition.* —**CAROL FALKOWSKI**

Philadelphia: *PCP was detected in 421 decedents from January 1994 through December 2003, the fifth most frequently detected drug during that time period, behind cocaine, heroin/morphine, alcohol-in-combination, and diazepam.* —**SAMUEL CUTLER**

Exhibit 52. Rates of ED PCP Mentions Per 100,000 Population in 9 CEWG Areas[1] and Percent Change: 1995–2002

					Percent Change[2]		
CEWG Area	1995	2000	2001	2002	1995, 2002	2000, 2002	2001, 2002
Baltimore	10	3	3	5	-47.9	68.2	58.2
Chicago	15	17	15	8	-49.2	-53.1	-47.9
Los Angeles	15	9	12	11			
New York	9	3	2	4			
Newark	2	2	2	7	193.3	236.7	250.6
Philadelphia	13	12	17	25	93.9	103.4	44.8
St. Louis	3	3	5	6	103.6	104.6	
Seattle	2	6	6	6	194.4		
Wash., DC	23	8	13	31		279.4	143.0

[1]Represent areas with rates above the national rate of 3 per 100,000 population in 2002.
[2]These columns denote statistically significant ($p<0.05$) increases and decreases between the time periods noted.
SOURCE: DAWN, OAS, SAMHSA

Treatment Data on PCP

Five CEWG members reported on PCP abuse among treatment admissions in 2003, most noting increases in these admissions over the past several years. The use of multiple drugs in this admissions group is also noted.

Los Angeles: *Primary PCP treatment admissions accounted for 1 percent of all admissions in the second half of 2003. While the proportion of PCP admissions among all admissions has been stable for several years, the overall number of PCP admissions increased 89 percent from 1999 to the first half of 2003. However, in the second half of 2003, the number of PCP admissions decreased slightly (16 percent) to 263 admissions. Alcohol (23.2 percent), marijuana (20.5 percent), and cocaine/crack (15.6 percent) were the secondary drugs used most frequently by primary PCP admissions. A vast majority (93 percent) of the primary admissions smoked the drug.* —**Beth Finnerty**

Newark: *There were 180 treatment admissions for primary PCP use in 2003, up from 135 in 2002. A total of 514 admissions, however, reported using PCP as a primary, secondary, or tertiary drug of abuse.* —**Anna Kline**

Philadelphia: *In 2003, PCP was mentioned as a primary, secondary, or tertiary drug by 4.8 percent of all treatment admissions. The average number of drugs of abuse mentioned by primary PCP treatment admissions was 1.92. Excluding alcohol, PCP accounted for 2.4 percent of primary treatment admissions in the preliminary 2003 data, up slightly from 2.1 percent in 2002.*—**Samuel Cutler**

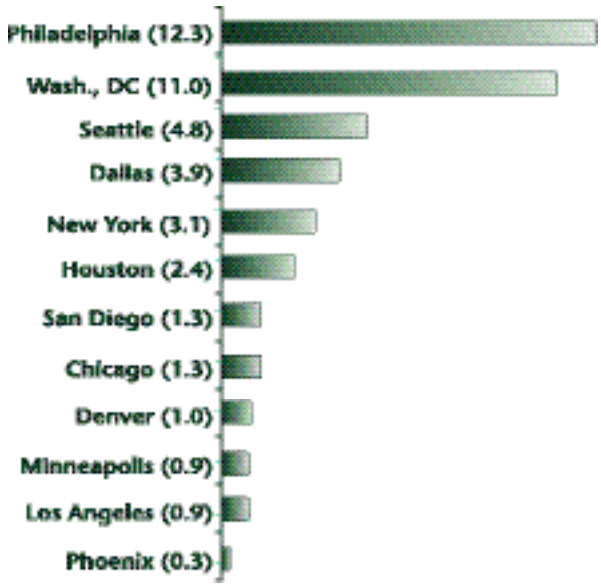
Texas: *Adolescent and adult admissions to treatment with a primary, secondary, or tertiary problem with PCP are increasing, rising from 164 in 1998 to 417 in 2003. Of these clients in 2003, 79 percent were Black, 61 percent were male, 59 percent were involved in the criminal justice system, 21 percent were employed, and 19 percent were homeless. While 45 percent reported a primary problem with PCP, another 35 percent reported a primary problem with marijuana, which demonstrates the link between these two drugs and the use of 'fry.'* —**Jane Maxwell**

Washington, DC: *In 2003, PCP accounted for 3.9 percent of primary treatment admissions, similar to 2002 but an increase from 2001 (1.8 percent) and 2000 (0.7 percent). Of the 189 primary PCP admissions in 2003, 63 percent were male and nearly all were Black. Most were age 18–25 (55.0 percent) or 26–35 (32.8 percent).* —**Eric Wish**

ADAM Data on PCP

In 2003, the proportions of adult male arrestees who tested positive for PCP continued to be highest in Philadelphia (12.3 percent) and Washington, DC (11.0 percent) (*see exhibit 53*), and there were slight increases from 2002 in both sites. In Seattle, the proportion of males testing PCP-positive more than doubled from 2002 to 2003 (2.0 vs. 4.8, respectively), and the cases nearly doubled in New York (1.6 vs. 3.1). Comparisons of 2003 versus 2002 show declines in Chicago (1.3 vs. 2.2 percent), Los Angeles (0.9 vs. 1.6 percent), and Phoenix (0.3 vs. 1.6 percent). The percentages testing PCP-positive from 2002 to 2003 remained basically stable in Dallas, San Diego, and Denver. (Houston was not sampled in 2002.)

Exhibit 53. Percentages of Adult Male Arrestees Testing PCP-Positive: 2003[1]



[1]Weighted estimates are for various quarters in 2003.
SOURCE: ADAM, NIJ

ADAM data from four CEWG sites on female arrestees show that 12.7 percent of the women tested PCP-positive in Washington, DC, followed by Chicago (5.6 percent), San Diego (1.4 percent), and Phoenix (1.0 percent). In the other six CEWG sites where females were tested in 2003, none was PCP-positive.

NFLIS Data on PCP

In 2003, some number of PCP items were reported in most CEWG areas included in NFLIS. The number of items reported from Philadelphia (945) was relatively high and represented 5.1 percent of all items analyzed in Philadelphia. While the numbers of items in Los Angeles and New York City were relatively high, PCP accounted for only 1 percent of the items analyzed in these areas. In Washington, DC, the 336 PCP items accounted for 4.5 percent of all items analyzed in the District in 2003. In Baltimore, Boston, Chicago, Denver, and Newark, between 2 and 11 PCP items were reported by NFLIS.

Seizures and Cost of PCP

Chicago: *On the West Side, 2–3 PCP 'sticks' about the size of toothpicks were reportedly available for $5–$10, as cited in the June 2003 CEWG report. Some 'wicky sticks' are said to also include embalming fluid, and these cost more. Sherm sticks typically are cigarettes or small cigars dipped in PCP, drained, and dried. The cigarettes are sold for about $20–$30 each and are mainly available on the far South Side. PCP was also said to be sold in sugar cubes for $20 each. Liquid PCP ('water') was said to sell for $120 for a vial.* —DITA BROZ

Los Angeles: *Because of a major PCP operation that took place in Los Angeles in summer 2003 (Operation Running Waters), the wholesale price range for a gallon of PCP virtually doubled overnight, from $8,500 to $15,000–$20,000. The ounce price remained high and stable at $600. A sherm cigarette dipped in liquid PCP continues to sell for $20–$30. A tight-knit group of Los Angeles-based African-American street gang members continue to produce, supply, and distribute PCP in the Los Angeles area.… The street value of the PCP seized between January and December 2003 represented approximately 6 percent of the total street value of all drugs seized during that time period. The total amount of PCP seized in 2003 (30.9 pounds) was 83 percent lower than the amount seized during the same time period in 2002 (187 pounds). This decrease continues the declining trend first seen in 2001.… Two recent Narcotics Digest Weekly Bulletins (NDIC 2004) reported disruptions in the Nation's PCP market. California and/or Los Angeles was mentioned in both reports. The first (March 30, 2004; Vol. 3, No. 13) noted that 1 gallon of liquid PCP was seized in Oklahoma. The second (April 6, 2004; No. 14) reported on a PCP distribution group that was dismantled in Washington, DC. The PCP was shipped via mail services, private vehicles, and commercial airlines from California to the District.… Nearly 200 PCP arrests were made within the city of Los Angeles in 2003. This represented a very minor, 2.4-percent increase from the number of PCP arrests made in 2002. Like amphetamine arrests, PCP arrests accounted for less than 1 percent of all narcotics arrests made in Los Angeles in 2003.* —BETH FINNERTY

Texas: *The DEA reports that PCP sells for $25 per cigarette and $10 per piece of 'sherm stick' in Dallas. It costs $350–$500 per ounce and $26,000–$28,000 per gallon in the Dallas/Ft. Worth area. Its availability in the Houston area is increasing, and it sells for $45–$80 per ounce. PCP sells for $700–$1,200 per gallon in San Antonio and $30 per dose in McAllen.* —JANE MAXWELL

Washington, DC: *According to the DEA Washington Division and the Metropolitan Police Department (MPD), PCP sold for $350–$800 per ounce during the last quarter of FY 2002. In 2003, leafy vegetable matter to use with PCP was sold in $20, $30, and $40 bags. One ounce of PCP can treat 4.5 ounces of vegetable matter for a net profit of $5,000 to $6,000. Another profitable way of selling liquid PCP is 'dippers,' which sold for $20–$25 each in 2003. The MPD reported prices as high as $35 per dip.* —ERIC WISH

Other Drugs (LSD, Rohypnol, DXM)

Indicators for abuse of lysergic acid diethylamide (LSD), Rohypnol (flunitrazepam), and dextromethorphan (DXM) were low across CEWG areas. The most notable findings are presented in the remainder of this section.

LSD

The sparse indicator data on LSD abuse suggest that use of this drug is not widespread and continues to decline. Nationally, Monitoring the Future Study researchers report they have never seen such a drop in reported use of an illicit drug as is occurring with LSD. Among high school seniors, reports of used LSD in the past year dropped from 6.6 percent in 2000, to 3.5 percent in 2002, to 1.9 percent in 2003.

In the 2002 DAWN data, there were only 347 LSD ED mentions across the 16 CEWG areas where data were not suppressed (because of a low relative standard error). The highest rates of LSD ED mentions per 100,000 population in 2002 were in Miami and Seattle, at 2 each. In the 16 areas, ED mentions of LSD declined significantly between 1995 and 2002, and they continued to decline in 10 of the same areas from 2001 to 2002. The highest numbers of LSD ED mentions in 2002 were in New York City (49) and Miami (42). Baltimore, Philadelphia, and Seattle reported between 30 and 33 mentions, while Chicago and St. Louis reported 21 and 24, respectively. The number of LSD ED mentions ranged between 13 and 19 in Atlanta, Boston, Minneapolis/St. Paul, Phoenix, San Francisco, and Washington, DC, and between 4 and 8 in Denver, New Orleans, and San Diego.

LSD items were analyzed in only two forensic laboratories in 2003, with seven items reported from Atlanta and four documented in Chicago.

There were few references to LSD abuse in the June 2004 CEWG reports. The three most notable are:

Atlanta: *LSD is beginning to emerge in the club/party scenes, and it is sometimes mixed with ecstasy.* —Kristin Wilson

St. Louis: *Over the years, lysergic acid diethylamide (LSD) has sporadically reappeared in local high schools and rural areas. Blotters sell for $2–$7 per 35-microgram dose. Much of this LSD is imported from the Pacific coast.* —Heidi Israel-Adams

Texas: *Texas Poison Control Centers reported 82 mentions of abuse or misuse of LSD in 1998, 113 in 1999, 97 in 2000, 70 in 2001, 129 in 2002, and 20 in 2003.* —Jane Maxwell

LSD sells for $5–$10 a "hit" (single dose) in Chicago and Los Angeles. A "blotter" (35-microgram dose) sells for $2–$7 in St. Louis. Costs for a dosage unit vary in Texas areas: $1–$10 in Dallas, $5–$10 in Tyler, $6–$10 in Fort Worth, $7 in Lubbock, and $8–$12 in San Antonio.

Rohypnol

Indicators of Rohypnol were low across CEWG areas.

The rate of DAWN ED mentions per 100,000 population for Rohypnol in 2002 was suppressed for the coterminous United States because the relative standard error was greater than 50 percent. Estimates were also suppressed for Chicago, Los Angeles, and Minneapolis/St. Paul. The rate in all other CEWG areas in 2002 was zero. The highest numbers of Rohypnol ED mentions in 2002 were in San Diego (5), Dallas and Miami (each 3 mentions), and Detroit and Seattle (each 1 mention).

The Colorado CEWG member reported poison control center and treatment data related to Rohypnol abuse, and the Texas representative provided information on treatment admissions:

Colorado: *There does not appear to be widespread use of this drug among either the general population or those in the rave scene in Colorado. The number of calls received by Rocky Mountain Poison and Drug*

Center about this drug jumped from 1 in 1994 to 22 in 1998. In 1999, however, such calls declined to only seven. Also, there were only two Rohypnol ED mentions from 1994 through 2002.

In 2003, there were 15 clients admitted to treatment claiming Rohypnol as their primary drug of abuse. Thirteen were male…. 10 were White, 5 were Hispanic, and 10 were 35 and older. Eleven had taken the drug orally, while two reported smoking, and two said they had injected Rohypnol.—**BRUCE MENDELSON**

Texas: *The number of youths and adults admitted into treatment with a primary, secondary, or tertiary problem with Rohypnol has varied: 247 in 1998, 364 in 1999, 324 in 2000, 397 in 2001, 368 in 2002, and 331 in 2003. Clients abusing Rohypnol were the youngest of the club drug patients, and they were predominately Hispanic, which would reflect the availability and use of this drug along the border. Some 75 percent were involved with the criminal justice or legal system. While 15 percent of these clients said that Rohypnol was their primary problem drug, 55 percent reported a primary problem with marijuana.* —**JANE MAXWELL**

DXM

Dextromethorphan, a widely available cough suppressant found in many nonprescription medications, continues to be abused in several CEWG areas.

Six CEWG members reported the following information from their areas on DXM abuse:

Detroit: *In the first 4 months of 2004, the 2 Michigan Poison Control centers reported a statewide total of 46 intentional misuse cases involving Coricidin…. Abuse of cough syrup (also containing dextromethorphan) continued to be noted, with shoplifting being a common way of obtaining the substance. The 2 poison control centers reported a statewide total of 96 instances of intentional abuse of dextromethorphan, with 64 of these exposures involving persons younger than 20.* —**PHIL CHVOJKA**

Minneapolis/St. Paul: *Products that contain dextromethorphan…are ingested by adolescents in doses many times in excess of the recommended amount for the long-acting, hallucinogenic effects…. Recent growth in the abuse of these products by younger teenagers prompted many pharmacies, discount stores, and grocery stores to place these products behind the counter to prevent shoplifting. Being under the influence of these products is known as 'Robo-tripping' or 'Skittle-ing.'* —**CAROL FALKOWSKI**

Philadelphia: *Focus group participants in the spring of 2004 indicated that DXM use is increasing among people age 30–40, particularly in combination with alprazolam and diazepam. The Philadelphia ME detected dextromethorphan in 40 cases in 2003 and in 87 cases from January 1994 through December 2003.* —**SAMUEL CUTLER**

Phoenix: *Schools, parents, and the media have focused education efforts on reducing the abuse of over-the-counter and prescription drugs. Youth prefer Coricidin HBP because it contains 30 milligrams of DXM, the highest amount of DXM per dosage of any over-the-counter cold and cough medicine. It is swallowed, although it is sometimes ground up and snorted. It is called robo, skittles, triple C's, red devils, rojo, dex, tussin, and Vitamin D. DXM abuse is called 'Robotripping' or 'Tussing.'* —**ILENE DODE**

Seattle: *Dextromethorphan is considered a respiratory agent in the lexicon that DAWN uses; DAWN lists 31 drugs that include dextromethorphan-in-combination, with 1 additional listing for dextromethorphan alone. The number of ED mentions totaled 39 in 2002, a very small number of patients.* —**CALEB BANTA-GREEN**

Texas: *Poison control centers reported the number of abuse and misuse cases involving dextromethorphan rose from 99 in 1998 to a high of 432 in 2002, and then dropped to 365 in 2003. The number of cases involving abuse or misuse of Coricidin HBP was 7 in 1998, rose to 268 in 2002, and then decreased to 189 in 2003. The average age of callers in 2003 was 16.3…. The Texas Department of Public Safety labs examined 2 substances in 1998 that were dextromethorphan, 13 in 1999, 36 in 2000, 18 in 2001, 42 in 2002, and 9 in 2003. The labs also examined one substance in 1999, five in 2000, five in 2001, two in 2002, and four in 2003 that were Coricidin HBP.* —**JANE MAXWELL**

INFECTIOUS DISEASES RELATED TO DRUG ABUSE

AIDS

The Centers for Disease Control and Prevention reported an estimated 849,778 adult and adolescent AIDS cases from the beginning of the epidemic through 2002 (CDC HIV Surveillance Report, Volume 14, December 2003). Of the cumulative adult/adolescent AIDS cases, 25 percent were among injection drug users (IDUs), compared with only 17 percent of cases diagnosed in 2002 (*see exhibit 54*). The proportion of cumulative cases among men who have sex with men and are IDUs (MSM/IDUs) was 6 percent, compared with 3 percent of cases diagnosed in 2002.

Five CEWG members reported trend data for modes of transmission for HIV/AIDS. Four noted declines in the proportion of new cases versus cumulative cases related to injection drug use, similar to declines noted by the CDC. In Chicago, IDUs as a proportion of AIDS cases peaked at 33 percent in 1996; only 19 percent of HIV cases reported there in 2003 were attributable to injection drug use. The proportion of males in Los Angeles exposed to HIV/AIDS solely through injection drug use dropped to 4 percent in 2003, after ranging between 5 and 7 percent from 1997 to 2002. For females in Los Angeles, the drop in cases related to injection drug use was more dramatic, from 18 percent in 2002 to 10 percent in 2003. A substantial decline in the proportion of new HIV/AIDS cases attributed to injection drug use was also noted in New Jersey: 42 percent of cumulative cases were related to injection drug use, compared with only 18 percent of cases diagnosed in 2003. In New York City, persons newly diagnosed with HIV (not AIDS) in 2002 were less likely to be IDUs (10 percent) than those among cumulative cases of people living with HIV/AIDS (26 percent).

The only CEWG area that experienced an increase in the proportion of AIDS cases related to injection drug use during the most recent reporting period was San Francisco County. Among San Franciscans diagnosed in 2003 and 2004, heterosexual IDUs accounted for 16 percent of all cases, up from 10 percent among those diagnosed in 1994–1996, 14 percent of those diagnosed in 1997–1999, and 14 percent of those diagnosed in 2000–2002.

Exhibit 54. Number and Percent of AIDS Cases Related to Injection Drug Use in the United States: New and Cumulative Cases Through 2002

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

[1]Involved heterosexual contact.
[2]Nearly 45 percent of the cumulative cases involved male-to-male sexual contact, compared with only 33 percent of new cases in 2002.
SOURCE: CDC HIV Surveillance Report

HEPATITIS B (HBV) AND HEPATITIS C (HCV)

A few CEWG members reported on HBV and HCV infection as a consequence of drug abuse. In Minneapolis, the level of HCV infection among injection drug abusers remained high, with estimated prevalence rates reported to be 90 percent among patients in methadone treatment programs. Among participants in the Urban Health Study in San Francisco in 2003, two-thirds of all IDUs in the sample self-reported HCV seropositivity, but the study staff believe that the true prevalence is between 90 and 95 percent. The pace of reported cases of HBV in San Francisco County rose to about one every 8 days in 2003 from one every 12 days in 2002. In Seattle, HBV and HCV are reported to be "endemic" among area drug injectors. Epidemiologic studies conducted there among more than 4,000 IDUs since 1994 reveal that 85 percent of King County IDUs may be infected with HCV, and 70 percent show markers of prior infection with HBV. In Texas, 8,798 tests for HCV exposure were administered in 2003 and 18 percent were positive; 41 percent of the positive tests were among people exposed through injection drug use.

PRESCRIPTION DRUG ABUSE:
AN EMERGING/CURRENT TREND

Prescription drug abuse was the focus of a special panel of researchers who presented findings on this growing problem at the June 2004 CEWG meeting. An overview of the panel findings and indepth discussions on the more commonly abused prescription drugs are included in the sections that follow. Summarized below are some key findings on prescription drug abuse. These findings are based not only on the panel's research, but also on CEWG area reports, and data/information reviewed and analyzed subsequent to the June meeting.

- Abuse of prescription-type psychotherapeutic drugs has escalated substantially across the Nation and in CEWG areas since the early 1990s.
- Problems associated with the nonmedical use of prescription drugs have appeared increasingly in indicator data.
- The types of prescription drugs abused and the patterns of abuse differ notably by geographic area and population group. However, indicators of abuse of pain relievers appear across all CEWG areas. According to the most recent national household survey, the number of lifetime nonmedical users of pain relievers age 12 and older in the United States increased significantly from 2002 to 2003.
- Particularly alarming is the abuse of prescription drugs among teenagers and young adults. Indicators show, for example, that…
  - ✧ Vicodin was the second most frequently abused drug among high school seniors in 2003.
  - ✧ Benzodiazepines were the prescription-type drug most frequently identified in teenage abuse/misuse cases reported by poison control centers to the Toxic Exposure Surveillance System in 2000–2003.
  - ✧ Alprazolam-related ED visits were as likely among youths age 12–17 as among older age groups (through age 34) in 2002.
  - ✧ The incidence rate of new stimulant users increased fourfold from 1991 to 2001 among persons age 12–17.
  - ✧ Lifetime nonmedical use of tranquilizers and current nonmedical use of pain relievers increased significantly from 2002–2003 among young adults age 18–25.
  - ✧ Treatment admissions for primary abuse of narcotic painkillers among males in their twenties increased substantially from 1997 to 2002.
- Polydrug abuse is common among abusers of prescription drugs. Prescription drugs are often used nonmedically in sequence or in combination with other prescription drugs, illicit drugs, and alcohol. Among the combinations reported are central nervous system depressants such as benzodiazepines and alcohol—a potentially life-threatening mixture.
- Risks associated with nonmedical use and mixing of prescription drugs appear to be greatly underestimated by users.

PANEL ON PRESCRIPTION DRUG ABUSE

Emerging/Current Trend—Panel on Prescription Drug Abuse: Overview and Summary of Findings

Wilson M. Compton, M.D., M.P.E

Dr. Compton, Director, Division of Epidemiology, Services and Prevention Research, NIDA, noted that in planning the Panel on Prescription Drug Abuse, NIDA recognized the critical need to expand knowledge about the abuse of prescription drugs at the local, State, regional, and national levels. The CEWG model emphasizes the use of multiple sources of data and the interpretation of the data within and across communities. Data sources utilized by the CEWG include federally supported monitoring systems with varying potential for regional, State, and local sociodemographic analyses; State and local data; relevant studies generated by independent organizations; and NIDA-supported research studies. The CEWG meeting provides a unique platform to bring together various perspectives on issues related to prescription drug abuse. Through this venue, CEWG representatives and the Panel on Prescription Drug Abuse have enhanced our understanding of prescription drug abuse. They have also provided insight into how research resources can be used to further understand prescription drug abuse and more effectively address problems associated with abuse of these drugs.

The Panel on Prescription Drug Abuse was designed to accomplish the following objectives:

- To better characterize the nature and extent of abuse of prescription drugs across national, regional, State, and local levels, with an emphasis on youth and young adults
- To identify key issues and research questions

Participants presenting information from large data sets—the National Survey on Drug Use and Health (NSDUH), the Monitoring the Future (MTF) survey, the Drug Abuse Warning Network (DAWN), the Treatment Episode Data Set (TEDS), the National Forensic Laboratory Information System (NFLIS), System to Retrieve Information from Drug Evidence (STRIDE), the Automation of Reports and Controlled Orders System (ARCOS), and Toxic Exposure Surveillance System (TESS)—were asked, if possible, to present geographic and demographic analyses of the data, and to provide data on three major classes of drugs (narcotic analgesics/opioids, CNS depressants, and stimulants) and on generic drugs within drug classes (e.g., hydrocodone, oxycodone, alprazolam, and methylphenidate).

A number of key issues and findings emerge from the data presented by the panel, including the following:

- Prescription drug abuse has increased across the United States in recent years. There has been an increase in the retail distribution and the theft and loss of many of these drugs, an increase in their nonmedical use among Americans age 12 and older, and increases in patients treated for nonmedical use of prescription drugs in hospital emergency departments (EDs) and substance abuse treatment facilities.
- There are notable differences by geographic area and population groups in the types of prescription drugs abused and in the patterns of abuse.
- Abuse of prescription drugs among teenagers and young adults is particularly alarming. For example, Vicodin (hydrocodone) is the second most frequently abused drug among high school seniors; alprazolam-related ED visits are as likely among teenagers as older age groups; treatment admissions for primary abuse of narcotic painkillers among males in their twenties has increased substantially; benzodiazepines were the prescription medications most commonly reported to TESS in teenage abuse/misuse cases in 2000–2003; and the incidence rate of new stimulant users increased fourfold from 1991 to 2000 among the 12–17 and 18–25 age groups.

- Hydrocodone and oxycodone abuse indicators suggest that they are the most widely abused narcotic analgesics, and alprazolam appears to be the most widely abused benzodiazepine in many areas. However, methadone abuse indicators are relatively high in some areas, and other prescription drugs, such as clonazepam and fentanyl, have been identified as emerging abused drugs.
- Prescription drugs are often used nonmedically in sequence or in combination with other prescription drugs, illegal drugs, and alcohol. Combinations reported include potentially life-threatening mixtures of CNS depressants such as benzodiazepines and alcohol.
- Users underestimate risks associated with nonmedical use and the mixing of prescription drugs.
- A high proportion of nonmedical users of prescription drugs have used illicit drugs.

In conducting studies of prescription drug abuse, researchers need to be aware of methodological problems and issues. For example, there are so many different prescription drugs available, and different street names for these drugs, that it is difficult to distinguish the specific drugs used. Therefore, in developing and testing questionnaires to be used in studies, researchers need to pilot test the nomenclature (names of drugs). Many respondents may not know the "generic" designation of a class of drugs, only the specific name of a prescribed drug or, perhaps, only the street name. There is evidence also of use of multiple prescription drugs, often in combination with illicit drugs or alcohol. Development of methods to characterize the use, in combination or in sequence, of different substances will enhance understanding of the interactions and effects of different "polydrug" patterns. Geographic Information Systems techniques offer great potential for illuminating variations in patterns of abuse and consequences and changes over time. Several panelists made effective use of geocoded maps to vividly display data by drug and geographic areas and for different periods of time.

In a presentation on the 2002 NSDUH, it was shown that an estimated 47 million Americans age 12 and older had used prescription drugs nonmedically during their lifetime, nearly 15 million had done so in the past year, and more than 6 million had used in the past month. Dr. James Colliver noted that lifetime use of prescription drugs was highest for pain relievers (e.g., hydrocodone, oxycodone, methadone, and codeine products). Use of more than one drug was most common among 12–25-year-old users of pain relievers.

Nonmedical use of Vicodin, a hydrocodone product, ranked second (after marijuana) among drugs used by 12th graders, according to the 2003 Monitoring the Future survey. Approximately 10.5 percent of seniors had used Vicodin in the past year, and 4.5 percent had used OxyContin. According to Dr. Colliver, students' nonmedical use of prescription drugs remained at relatively high levels. Over the survey years, new patterns of prescription drug abuse have emerged. Students who had used Vicodin or OxyContin were likely to have used other drugs as well.

Rates of DAWN hospital emergency department drug abuse-related visits involving hydrocodone, oxycodone, and methadone increased significantly from 1995 to 2002. Fentanyl-related ED visits also increased significantly during this period, although the number of visits remained relatively small. Rates for narcotic analgesics were most likely to increase among young adults (age 20–25). Dr. Elizabeth Crane noted that ED visits involving alprazolam and clonazepam also increased. Rates for alprazolam-involved ED visits were equivalent across age groups, indicating that teenagers were as likely to enter the ED for this drug as older groups. Multiple drug use was common in the narcotic analgesics abuse cases.

The TEDS data show that increasing numbers of drug abusers entering treatment in recent years had abused narcotic painkillers (excluding nonprescribed methadone). Of the 84,000 admissions in 2002 who reported using narcotic painkillers, more than one-half identified these drugs as their primary drug of abuse. Using geocoded maps, Dr. Leigh Henderson presented rates (per 100,00 population) of narcotic painkiller admissions by State and by year (1992, 1997, and 2002). Eleven States provided multiyear admissions data for specific types of

narcotic painkillers by treatment clients. From 1997–2002, admissions increased 129 percent for all narcotic painkillers, but admissions involving oxycodone products increased 1,267 percent over the 6-year period.

From 2000 to 2003, benzodiazepines were the most common group of prescription medications reported in teenage abuse/misuse cases to poison control centers across the Nation. Dr. William Watson mentioned that nearly one-half (49 percent) of the teenage benzodiazepine cases involved more than one substance.

In 2001–2003, ARCOS data showed that retail distribution increased for hydrocodone, oxycodone, methadone, morphine, and codeine, while theft and loss of oxycodone and hydrocodone peaked in 2002. Hydrocodone and oxycodone items were much more likely than items for other types of narcotic analgesics to be analyzed/identified by forensic laboratories (NFLIS, STRIDE); these two drugs were also more likely to be seized by Drug Enforcement Administration (DEA) agents. Liqun Wong pointed to geographic differences in the NFLIS data. For example, a higher proportion of the narcotic analgesic items analyzed in Atlanta, Dallas, Denver, and San Diego were hydrocodone, while oxycodone items predominated in Boston, Miami, and Philadelphia.

An exploratory study conducted in Colorado showed that clonazepam abuse was a problem in different parts of the State. Based on secondary analysis of State treatment data and information from clinicians who served as key informants, Bruce Mendelson, CEWG member, found that individuals entering State drug treatment facilities in 2002 and 2003 were more likely to report using clonazepam than any other benzodiazepine. The clinician key informants indicated that some reasons given for using clonazepam included using it to "come down" from other drugs or to boost the effects of other drugs. Other substances most often used with clonazepam included alcohol and/or other benzodiazepines, marijuana, and cocaine.

In a 2004 pilot study of students at a mid-Atlantic university (mostly freshman and sophomores), 15.5 percent had used pain relievers nonmedically, and 13.4 percent had used prescription stimulants nonmedically. The vast majority of the prescription drug abusers had also used other drugs (e.g., 92 percent had used marijuana and 54 percent had used hallucinogens). According to Dr. Amelia Arria, some of the students mixed drugs without knowing the differences between specific types of prescription medications and their potential dangers.

In a study of ecstasy abusers in Miami, which utilized quantitative and qualitative methods, 87 percent of the abusers reported using prescription drugs nonmedically more than five times during their lifetime. Dr. Steven Kurtz identified many of the reasons prescription drugs were so popular in the club drug scene, including the fact that they were perceived as easily accessible; cheaper, more pure, and less harmful than other drugs; and less likely to lead to arrest than use of illicit drugs. The prescription drugs were used in many ways, including as a substitute for or in combination with other substances. Thus, personal expectations may play a role in prescription drug abuse.

Prescription Drug Abuse in the American Population

James Colliver, Ph.D.

Major findings from the 2002 National Survey on Drug Use and Health on prescription drug abuse in the noninstitutionalized population are as follows:

- **An estimated 46.6 million Americans age 12 and older had used a prescription-type psychotherapeutic drug nonmedically at least once in their lifetime, nearly 15 million had done so in the past year, and more than 6 million had used in the past month.**
- **The percentage of lifetime use was highest for pain relievers (12.6 percent), followed by stimulants (9.0 percent), tranquilizers (8.2 percent), and sedatives (4.2 percent).**
- **Among pain relievers, Darvocet (propoxyphene), Darvon (dextropropoxyphene), or Tylenol with Codeine (acetaminophen with codeine) were the drugs most frequently abused (18.9 million, lifetime use), followed by Vicodin, Lortab, or Lorcet (13.1 million, life-**

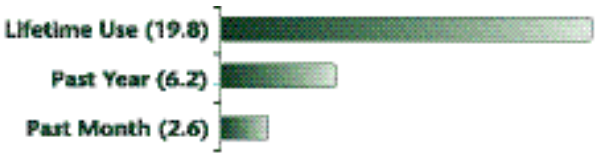
time use). Nearly 2 million people used OxyContin (oxycodone) nonmedically at some time in their life.

- **Nonmedical use of a psychotherapeutic drug was highest among persons younger than 26, especially those age 18–25.**
- **Young abusers of prescription pain relievers were more likely than their nonusing counterparts to have used other drugs, such as marijuana, cocaine, inhalants, ecstasy, other hallucinogens, and heroin.**
- **The incidence rate for nonmedical use of prescription pain relievers, tranquilizers, and stimulants increased sharply over the last decade, and, in 2002, more than 2 million abusers of prescription-type psychotherapeutic drugs met diagnostic criteria for abuse or dependence in the past year.**

Dr. Colliver, NIDA, reported these and other findings from the 2002 NSDUH, which is conducted by Research Triangle Institute and funded by OAS, SAMHSA.

Estimates of the percentages of Americans age 12 and older who reported using prescription-type drugs nonmedically in the 2002 survey are shown in exhibit A.

Exhibit A. Estimated Percentages of Lifetime, Past-Year, and Past-Month Nonmedical Use of Prescription Drugs Among Americans Age 12 and Older: 2002

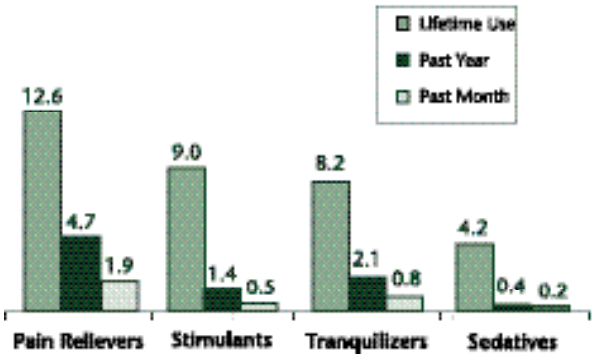


SOURCE: NSDUH, OAS, SAMHSA

Overall, the data show that use of these psychotherapeutic drugs varies by type of drug and demographic group.

As shown in exhibit B, pain relievers are the most frequently used prescription-type drug, followed by stimulants, tranquilizers, and sedatives.

Exhibit B. Percentages of the Population Age 12 and Older Reporting Nonmedical Use of Prescription-Type Psychotherapeutic Drugs, by Type of Drug: 2002

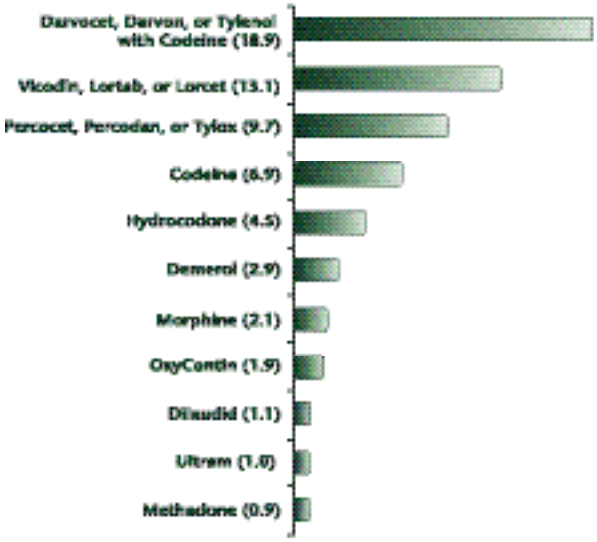


SOURCE: NSDUH, OAS, SAMHSA

PAIN RELIEVERS. An estimated 29.6 million Americans age 12 and older (12.6 percent) had ever used pain relievers nonmedically in 2002. An estimated 1.5 million of the nonmedical users met *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) criteria of abuse or dependence on pain relievers in the past year.

As shown in exhibit C, Darvocet, Darvon, or Tylenol with Codeine were "ever used" nonmedically by nearly 19 million persons in 2002. In 2002, 13.1 million persons had used the hydrocodone products Vicodin, Lortab, or Lorcet in their lifetime, and 9.7 million had used the oxycodone products Percocet, Percodan, or Tylox. Also, 1.9 million had used OxyContin, and 1 million had used Ultram (tramadol).

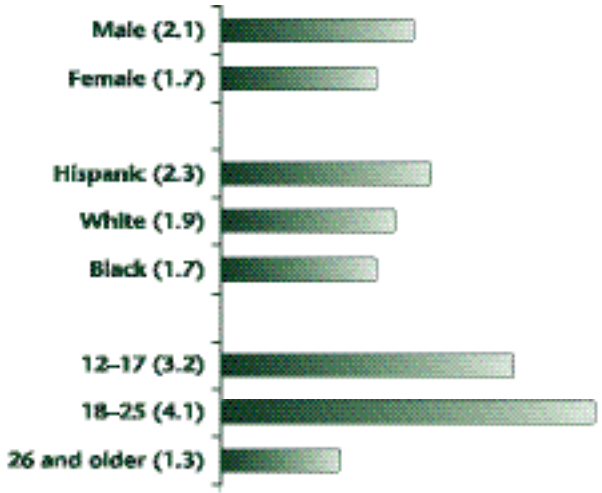
Exhibit C. Estimated Numbers (in Millions) of Lifetime Nonmedical Use of Selected Pain Relievers Among Persons Age 12 or Older: 2002



SOURCE: NSDUH, OAS, SAMHSA

Past-month nonmedical use of pain relievers was higher among persons age 12–25 than among those age 26 and older (*see exhibit D*). Around 2.1 percent of males, compared with 1.7 percent of females, were currently abusing prescription pain relievers. The proportions of use by race/ethnicity were 2.3 percent for Hispanics, 1.9 percent for Whites, and 1.7 percent for Blacks.

Exhibit D. Demographic Differences in Past-Month Nonmedical Use of Pain Relievers, by Percentage of Each Group: 2002

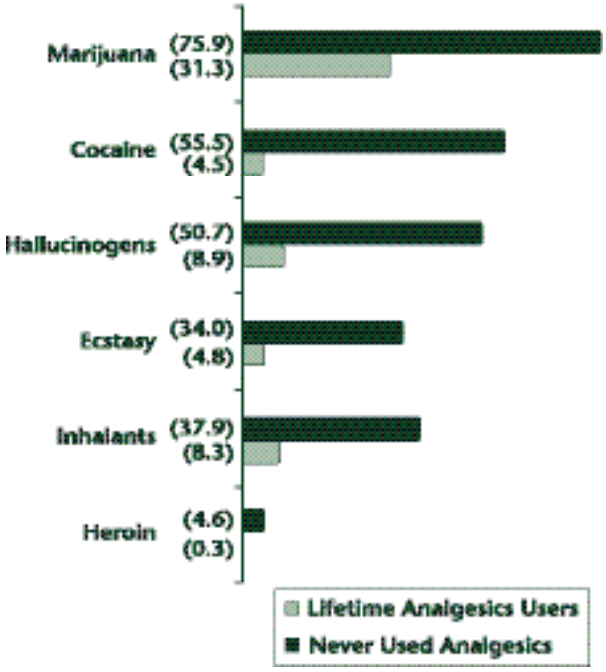


SOURCE: NSDUH, OAS, SAMHSA – SAMHDA Online Analysis

The incidence rate for nonmedical use of pain relievers remained relatively low and stable for those age 12–17 and 18–25 from 1969 to the early 1990s. Around 1994, the rates rose to approximately 12–13 per 1,000 persons for these age groups. Rates rose sharply thereafter to nearly 50 per 1,000 among 12–17-year-olds and to more than 30 for the 18–25 age group in 2001.

Adolescents and young adults who have used pain relievers nonmedically generally have tried other drugs as well, as shown in exhibit E. Lifetime use of marijuana was 2.4 times more common among 12–25-year-olds who had abused pain relievers than among persons in that age range who had not. Use of cocaine was 12.3 times more common, and similar patterns were found for hallucinogens (5.7 times more common among those who had used pain relievers nonmedically), ecstasy (7.1 times more common), inhalants (4.6 times more common), and heroin (15.3 times more common).

Exhibit E. Lifetime Use of Other Drugs by Persons Age 12–25 Who Had and Had Not Used Pain Relievers Nonmedically, by Percent: 2002



SOURCE: NSDUH, OAS, SAMHSA

STIMULANTS. An estimated 21 million Americans age 12 and older in 2002 had used prescription-type stimulants nonmedically during their lifetime, and 3.2 million reported abuse of these drugs in the past year. More than 400,000 met DSM-IV criteria for abuse of or dependence on stimulants in the past year.

There was little difference in use between males (0.6 percent) and females (0.5 percent) in past-month nonmedical use of stimulants. Past-month use was more likely to be reported by Whites (0.6 percent) than Hispanics (0.3 percent) or Blacks (0.1 percent). Such use was considerably more prevalent among those age 18–25 (1.3 percent) than those age 12–17 (0.7 percent) and those 26 and older (0.4 percent).

The incidence rates for nonmedical use of stimulants in both the 12–17 and 18–25 age groups increased over the recent decade. In 1991, for every 1,000 nonusers in these age groups, there were 4.5 new users age 12–17 and 4.1 new users age 18–25. In 2000, the respective rates for these two age groups were 17.6 and 13.2—a fourfold increase.

TRANQUILIZERS. Of the estimated 19.3 million Americans age 12 and older in 2002 who reported ever using tranquilizers nonmedically, 4.8 million had used them in the past year, and more than 500,000 met DSM-IV criteria for abuse or dependence in the past year.

There was little difference in past-month tranquilizer use by gender (0.8 and 0.7 percent of males and females, respectively). Among Whites, 0.9 percent had used tranquilizers nonmedically in the past month, compared with 0.4 percent of Hispanics and 0.2 percent of Blacks. The most striking difference in past-month use was by age group: 1.5 percent of 18–25-year-olds, 0.7 percent of 12–17-year-olds, and 0.6 percent of those age 26 and older.

The incidence rate for nonmedical tranquilizer use in 1990 was 3.9 (new users per 1,000 persons at risk) for 12–17-year-olds and 5.5 for 18–25-year-olds. Over the ensuing decade, the numbers of new users of these drugs in these two age groups increased dramatically to 16.5 and 19.8, respectively—a more than threefold increase.

Student Use of Prescription Drugs: Monitoring the Future Survey

James Colliver, Ph.D

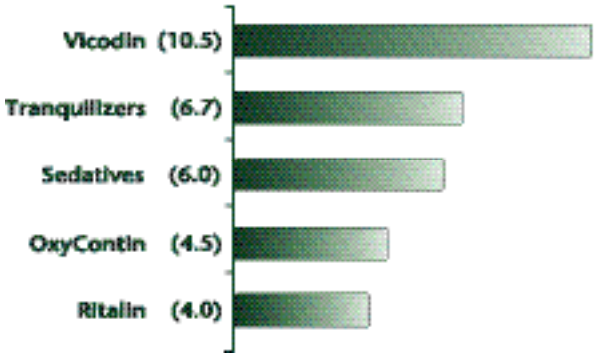
Major findings from the 2003 MTF project include the following:

- **Vicodin ranked second (after marijuana) in past-year use among 12th grade students nationwide. Past-year nonmedical use of Vicodin was reported by 10.5 percent of seniors, 7.2 percent of 10th graders, and 2.8 percent of 8th grade students.**
- **Among seniors, nonmedical use of Vicodin was highest among males and Whites, students in the West Region, and students outside large metropolitan statistical areas (MSAs).**
- **Sedatives (barbiturates) were used nonmedically by 6 percent of seniors during the past year. Nonmedical use of sedatives by seniors increased from 1992 to 2002 and may have reached a plateau; however, higher levels were reported from 1975 to 1981.**
- **Nonmedical past-year use of OxyContin was reported by 4.5 percent of high school seniors in 2003, with use being highest among males, Whites, and students outside large MSAs.**
- **Ritalin was used nonmedically by 4 percent of seniors in the past year, the same as in 2002.**

These and other findings are from the 2003 Monitoring the Future survey conducted by the Institute for Social Research, University of Michigan, through NIDA grant R01DA01Y11. The findings presented below cover nonmedical use of Vicodin, tranquilizers, sedatives (barbiturates), OxyContin, and the stimulant Ritalin (methylphenidate).

PAST-YEAR USE. As shown in exhibit A, Vicodin was the prescription drug most likely to be used nonmedically by 12th graders in the 2003 school year, followed by tranquilizers, sedatives (barbiturates), OxyContin, and Ritalin.

Exhibit A. Percentages of 12th Graders Nationally Who Used 5 Prescription-Type Drugs Nonmedically in the Past Year: 2003

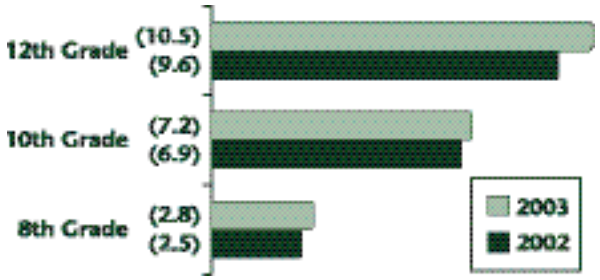


SOURCE: MTF (University of Michigan and NIDA)

VICODIN. Of note is the fact that Vicodin ranked second, after marijuana, in past-year use. However, Vicodin use remained statistically unchanged from the previous school year, when 9.6 percent of seniors reported using the drug nonmedically.

Comparing grades, past-year nonmedical use of Vicodin in 2003 was higher among seniors, followed by those in grade 10, as shown in exhibit B.

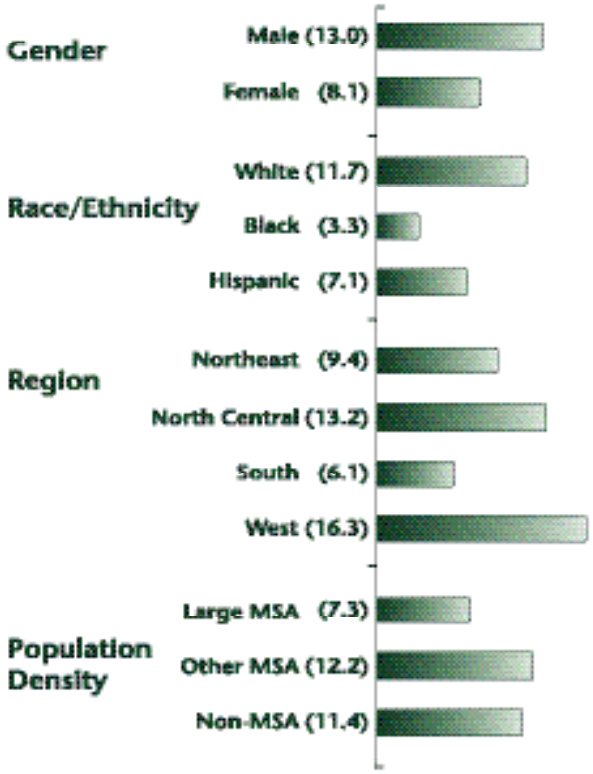
Exhibit B. Percentages of Students Reporting Nonmedical Use of Vicodin in the Past Year: 2002–2003



SOURCE: MTF (University of Michigan and NIDA)

Seniors' nonmedical use of Vicodin in the past year was higher among males, Whites, those in the West Region of the United States, and those outside large metropolitan areas (*see exhibit C*).

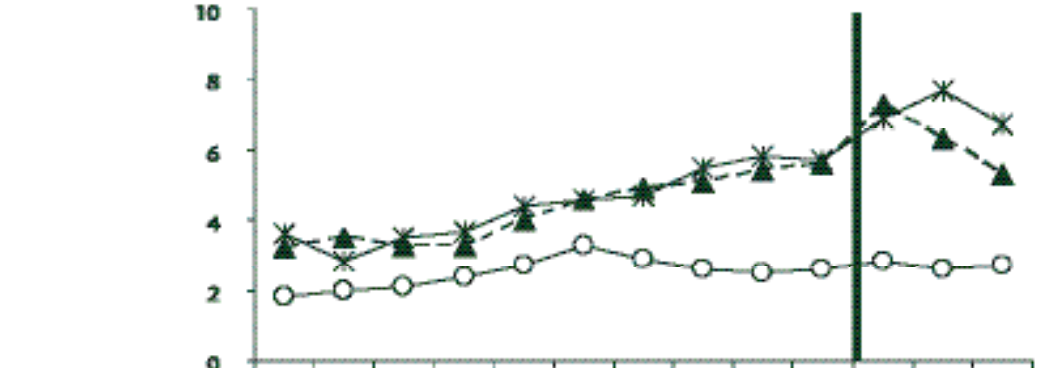
Exhibit C. Percentages of 12th Graders Reporting Past-Year Vicodin Use by Selected Demographic Characteristics and Population Density: 2003



SOURCE: MTF (University of Michigan and NIDA)

TRANQUILIZERS. Nonmedical use of tranquilizers among 10th and 12th grade students increased from 1991 to 2000, when a change in the instrument interrupted the trends. More recently, past-year tranquilizer use declined from 7.3 percent in 2001 to 5.3 percent in 2003 among 10th graders and from 7.7 percent in 2002 to 6.7 percent in 2003 among 12th graders (*see exhibit D on the following page*).

Exhibit D. Percentages of Students Reporting Nonmedical Use of Tranquilizers in the Past Year, by Grade and Year: 1991–2003[1]

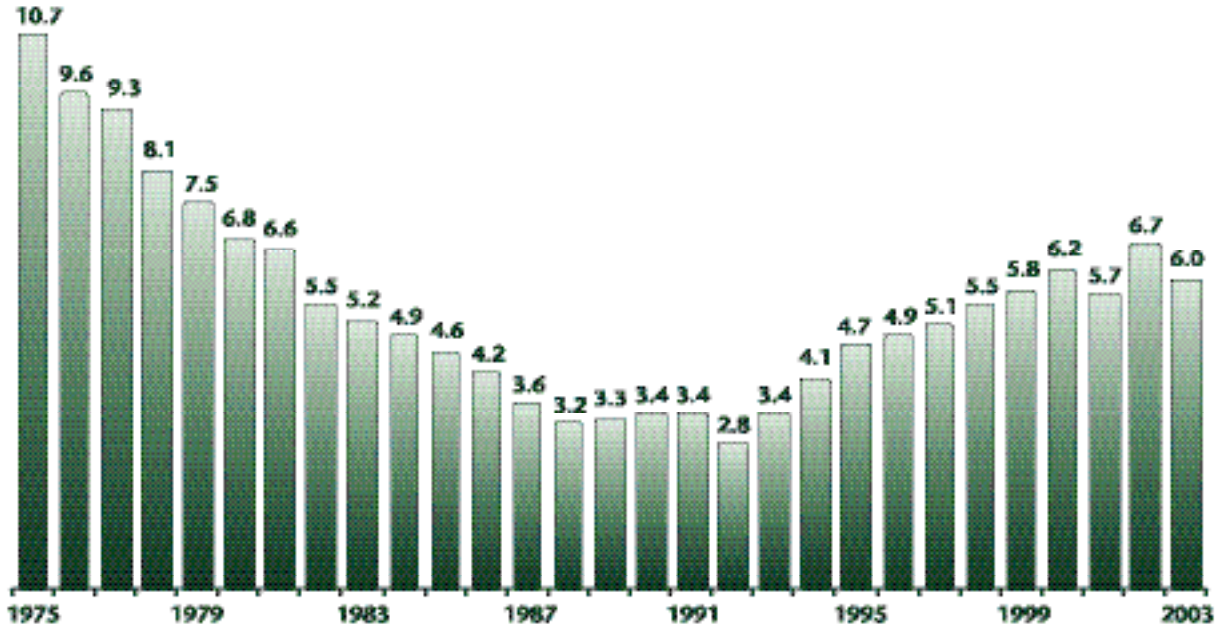


	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03
8th Grade	1.8	2.0	2.1	2.4	2.7	3.3	2.9	2.6	2.5	2.6	2.8	2.6	2.7
10th Grade	3.2	3.5	3.3	3.3	4.0	4.6	4.9	5.1	5.4	5.6	7.3	6.3	5.3
12th Grade	3.6	2.8	3.5	3.7	4.4	4.6	4.7	5.5	5.8	5.7	6.9	7.7	6.7

[1]Xanax replaced Miltown in tranquilizer items beginning in 2001.
SOURCE: MTF (University of Michigan and NIDA)

SEDATIVES. Among seniors, the only grade level asked about barbiturate/sedative use, past-year use of these drugs declined gradually from 10.7 percent in 1975 to 2.8 percent in 1992, then rose to a recent high of 6.7 percent in 2002 and ended at 6.0 percent in 2003, statistically unchanged from the previous year (*see exhibit E*).

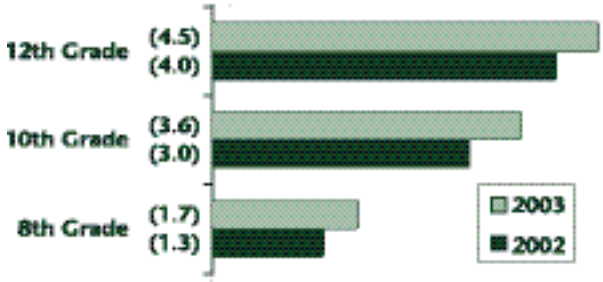
Exhibit E. Percentages of Seniors Reporting Past-Year Nonmedical Use of Sedatives, by Year: 1975–2003



SOURCE: MTF (University of Michigan and NIDA)

OxyContin. Nonmedical use of OxyContin remained statistically unchanged from 2002 to 2003 for students in all three grades, as shown in exhibit F.

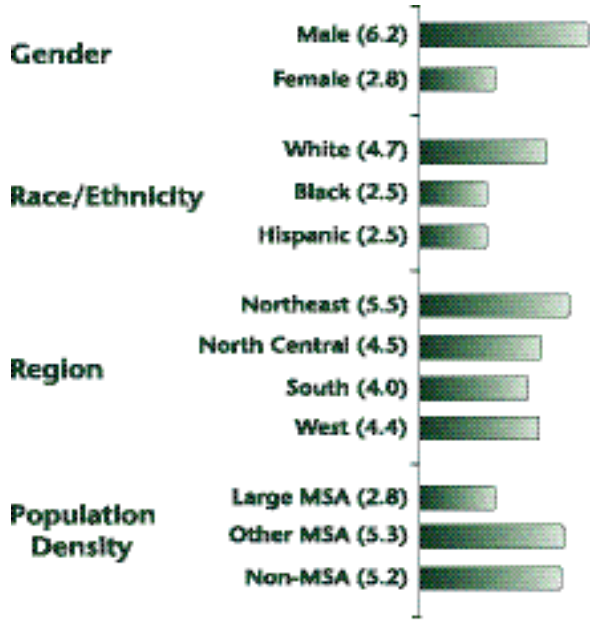
Exhibit F. Percentages of Students Reporting Past-Year Nonmedical Use of OxyContin by Grade and Year: 2002–2003



SOURCE: MTF (University of Michigan and NIDA)

Nonmedical use of OxyContin in the past year was higher among males and Whites, as shown in exhibit G. Differences by region were not great. Areas outside large metropolitan areas tended to have higher percentages of student use than areas inside large metropolitan areas.

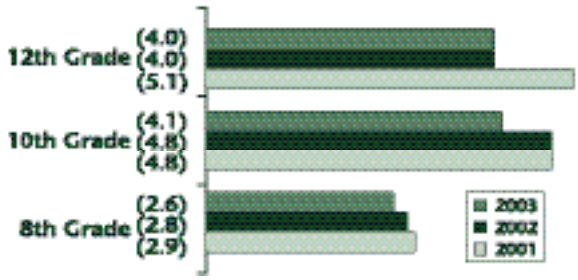
Exhibit G. Percentages of 12th Graders Reporting Past-Year Use of OxyContin by Selected Demographic Characteristics and Population Density: 2003



SOURCE: MTF (University of Michigan and NIDA)

Ritalin. Nonmedical use of Ritalin in the past year was reported by 4.0 percent of 10th and 12th graders and 2.6 percent of 8th graders in 2003, as shown in exhibit H. There were no statistically significant changes in the period from 2001 to 2003.

Exhibit H. Percentages of Students Reporting Nonmedical Past-Year Use of Ritalin: 2001–2003



SOURCE: MTF (University of Michigan and NIDA)

Prescription Drugs and Teens and Young Adults in Drug Abuse-Related Emergency Department Visits: 1995–2002

Elizabeth Crane, Ph.D., M.P.H.

Trend data from the Drug Abuse Warning Network on drug abuse-related hospital emergency department visits involving nonmedical use of narcotic analgesics and benzodiazepines show the following:

- **ED visits involving nonmedical use of hydrocodone, oxycodone, methadone, and fentanyl increased between 1995 and 2002. ED visits involving hydrocodone exceeded 25,000, and those for oxycodone exceeded 20,000 in 2002.**
- **Rates of ED visits involving narcotic analgesics were most likely to increase among patients age 20–25.**
- **Rates for methadone visits increased from 1995 to 2002 for groups in the 12 to 34 age categories.**
- **Rates for methadone, hydrocodone, and oxycodone visits increased among males and females from 1995 to 2002 and continued to increase among males from 2000 to 2002.**

- **Polydrug use was common among drug abuse-related ED cases involving narcotic analgesics.**
- **Drug abuse-related visits involving the benzodiazepines alprazolam and clonazepam increased from 1995 to 2002. In 2002, visits involving alprazolam totaled more than 27,000, but they only increased among patients age 20–25. Visits involving clonazepam totaled slightly more than 17,000 in 2002.**
- **Rates for alprazolam-involved ED visits were equivalent across age groups, indicating that teenagers were as likely to enter the ED for this drug as the older groups.**
- **Visits involving diazepam were stable from 1995 to 2002, when the total reached nearly 11,200.**

These and other findings from the Drug Abuse Warning Network were presented by Dr. Crane, who is directly involved in DAWN efforts at the Office of Applied Studies, SAMHSA.

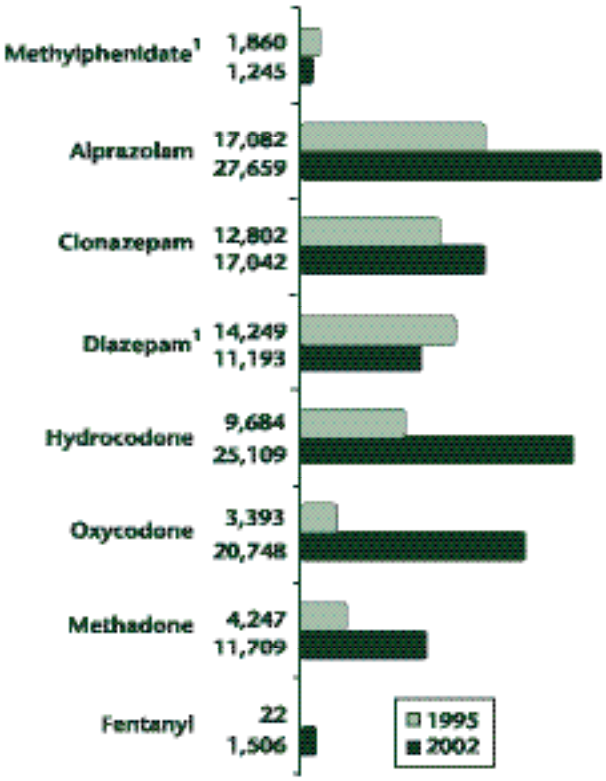
OVERVIEW. Data reported here represent ED visits from 1995 to 2002 that resulted from the nonmedical use of a prescription drug to achieve a psychic effect or because of dependence or suicidal behavior. Each visit may have involved more than one substance (including illicit, prescription, and over-the-counter drugs, and inhalants), and polydrug abuse was common.

The major drugs covered here are as follows:

- Narcotic Analgesics—hydrocodone, oxycodone, methadone, and fentanyl
- Benzodiazepines—alprazolam, clonazepam, and diazepam
- Stimulants—methylphenidate

The number of drug abuse-related ED visits for each of these drugs is shown in exhibit A.

Exhibit A. Drug-Abuse Related ED Visits for Selected Narcotic Analgesics, Benzodiazepines, and Methylphenidate: 1995–2002



[1]Stable from 1995 to 2002.
SOURCE: DAWN, OAS, SAMHSA

Other findings are presented by drug type and will focus on trends in gender and age differences in drug abuse-related ED visits. Changes over time that were statistically significant ($p<0.05$) will be noted.

Narcotic Analgesics

The magnitude of the problem of drug abuse-related ED visits involving hydrocodone, oxycodone, methadone, and fentanyl from 1995 to 2002 is depicted above in exhibit A. All differences in the number of visits between 1995 and 2002 are statistically significant.

Age Observations. Analyses show age group differences in ED visits for hydrocodone, oxycodone, and methadone.* ED rates per 100,000 population for each of these drugs and age groups are shown in exhibit B. Rates for 12–17-year-olds were lower than those for the other age groups for each of the three drugs. The shaded cells for the 12–17 age group represent a statistically significantly lower rate compared with the other groups for the specified drugs. As the exhibit footnote indicates, there were increases from 1995 to 2002 in methadone-involved visits for all four age groups. ED visits also increased for hydrocodone- and oxycodone-involved visits among the 20–25 age group, with increases in hydrocodone-involved visits also reflected in the shorter term (2000–2002). Oxycodone-involved visits also increased from 1995 to 2000 and from 2000 to 2002 for the 26–34 age group. The 18–19-year-old group had a higher rate of oxycodone-involved visits from 2000 to 2002, but because the 1995 estimate was too imprecise for publication, the trend from 1995 to 2002 could not be calculated.

Exhibit B. Rates of ED Visits Per 100,000 Population for Selected Narcotic Analgesics and Benzodiazepines, by Age Group: 2002[1]

Drug	12–17	18–19	20–25	26–34
Hydrocodone	4	14	16+*	16
Oxycodone	1	14*	13+	18+*
Methadone	0.3+	4+	7+*	8+
Alprazolam	9	15	15+*	18
Clonazepam	3	9	8	12
Diazepam	1	6	4-	7-

[1]The plus (+) sign indicates a statistically significant ($p<0.05$) increase from 1995 to 2002, while the minus (-) sign indicates a decrease. An asterisk (*) indicates a statistically significant increase from 2000 to 2002. Because the trend in oxycodone-involved visits from 1995 to 2002 could not be measured for the 18–19-year-olds, the increase noted is for 2000–2002.
SOURCE: DAWN, OAS, SAMHSA

*Small numbers prohibited further analysis of fentanyl visits.

Gender Observations. Combined age group data show few differences by gender. In 2002, the ED rates per 100,000 population were equivalent for males and females for each of the three narcotic analgesics (*see exhibit C*). The rates for each drug increased for both gender groups from 1995 to 2002. However, between 2000 and 2002, the rates for each drug leveled off for females, while the increases for males were statistically significant.

Exhibit C. Rates of Drug Abuse-Related ED Visits Per 100,000 Population Age 12–34 for Selected Narcotic Analgesics and Benzodiazepines, by Gender: 2002[1]

[1]The plus (+) sign indicates a statistically significant ($p<0.05$) increase from 1995 to 2002, while the minus (-) sign indicates a decrease. An asterisk (*) indicates a statistically significant increase from 2000 to 2002.

Drug	Males	Females
Hydrocodone	11+*	14+
Oxycodone	14+*	10+
Methadone	6+*	4+
Alprazolam	12+	15
Clonazepam	6	10
Diazepam	4-	5

SOURCE: DAWN, OAS, SAMHSA

Comparison Across CEWG Areas. Rates also varied by metropolitan area. In 2002, New Orleans and Detroit had the highest rates of hydrocodone-involved visits for the 20–25-year-old group, although the Detroit rate overlapped with some other metropolitan areas. No metropolitan area stood out for the 26–34 age group. Rates for oxycodone-involved visits were highest in Boston and Philadelphia for both the 20–25 and 26–34 age groups, although Philadelphia overlapped with some other metropolitan areas. Methadone rates were highest in Newark and Seattle among the 26–34 age group, but rates for the 18–25 age group were similar across metropolitan areas.

Benzodiazepines

The magnitude of the problem with the benzodiazepines alprazolam, clonazepam, and diazepam is depicted in exhibit A on page 90. In 1995 and 2002, alprazolam-involved ED visits were more numerous than those for clonazepam and diazepam. Differences between 1995 and 2002 in the number of ED visits involving alprazolam and clonazepam were statistically significant.

AGE OBSERVATIONS. Rates per 100,000 population for alprazolam-involved ED visits were equivalent across age groups, which means that teenagers were as likely to enter the ED as persons in the older groups (*see exhibit B on page 91*). Between 1995 and 2002, and between 2000 and 2002, the rate of alprazolam-involved ED visits increased only for the 20–25 age group. The only decreases occurring during this period were for diazepam-involved ED visits from 1995 to 2002 among the two older age groups.

GENDER OBSERVATIONS. Rates of benzodiazepine-involved ED visits among the 12–34 age group were equivalent for males and females for alprazolam and diazepam in 2002 (*see exhibit C on page 91*). The female patients had a higher rate of drug abuse-related visits involving clonazepam, however. From 1995 to 2002, male patients experienced an increase in the rate of alprazolam-involved ED visits and a decrease in the rate of diazepam-involved visits. The trends between 2000 and 2002 were stable for both genders.

COMPARISON ACROSS CEWG AREAS. The rates of drug-abuse ED visits involving alprazolam in 2002 were highest in Philadelphia among patients age 20–25 and 26–34, with the latter age group also having a high rate in New Orleans. Rates for clonazepam were highest in Boston and Philadelphia among patients age 20–25 and in Boston for those age 26–34. The rates of diazepam-involved visits were similar across the metropolitan areas.

Stimulants

Drug abuse-related ED visits that involved methylphenidate were stable from 1995 (n=1,860) to 2002 (1,245). Because of small numbers, no further analysis was feasible for this drug.

Treatment Admissions for Abuse of Narcotic Painkillers—Treatment Episode Data Set: 1992–2002

Leigh Henderson, Ph.D.

Highlights from the TEDS data include the following findings on admissions (age 12 and older) reporting use of narcotic painkillers:

- **There were 84,000 admissions for narcotic painkillers in 2002: 51 percent were for primary abuse of a narcotic painkiller.**
- **Among the polydrug abusers in this group, alcohol and heroin were the most prominent primary drugs.**
- **Of the narcotic painkiller admissions in 2002, 87 percent were White, 6 percent were Black, 4 percent were Hispanic, and 3 percent were members of other racial/ethnic groups.**
- **The age pattern of treatment admissions has shifted in recent years, with higher proportions of younger admissions being in their twenties in 2002 than was the case in 1997. This shift was particularly pronounced for males in their twenties, the age group with the highest number of admissions in 2002. Admissions for females were highest in the 35–45 age group.**
- **Narcotic painkiller admissions were relatively stable from 1992 to 1997 (at approximately 30,000 each year), but rose sharply thereafter. In 1992, 5 States had narcotic painkiller admission rates of 24 or more per 100,000 population; by 1997, the number rose to 12 States, and, by 2002, to 31 States. From 1992 to 2002, one-quarter of the admissions were in five States, with New York and California ranking first and second, respectively. In 2002, rates were higher in non-central metropolitan areas and the highest rate was in Maine (207 per 100,000 population).**
- **An analysis of data from 11 States that used detailed drug codes showed that narcotic painkiller admissions increased 129 percent**

from 1997 to 2002. During that time period, admissions for oxycodone abuse increased 1,267 percent.

- **Among 10 CEWG cities with the highest rates of narcotic painkiller admissions, 4 exceeded the national rate of 40, with Boston and Baltimore highest at 111 and 86, respectively.**

Data for this presentation, as reported by CEWG member, Leigh Henderson, Ph.D., Drug and Alcohol Services Information System (DASIS) Project Manager, Synectics for Management Decisions, Inc., was prepared in coordination with Deborah Trunzo and staff of OAS, SAMHSA.

OVERVIEW. TEDS, maintained by SAMHSA, collects client-level information on admissions from States. The data represent admissions (rather than individuals) age 12 and older who receive treatment in publicly funded facilities.

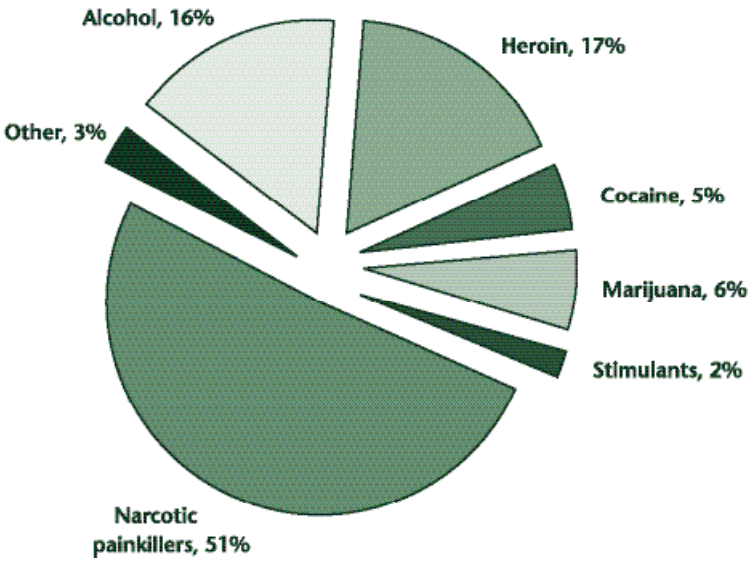
The focus of this presentation is on admissions for which narcotic painkillers ("Other opitates/synthetics") are the primary, secondary, or tertiary drug of abuse, excluding admissions for nonprescription use of methadone.

SELECTED FINDINGS. In 2002, 84,000 of the 1.9 million admissions in TEDS used a narcotic painkiller as a primary, secondary, or tertiary drug. Some 51 percent reported a narcotic painkiller as their primary drug, a 246-percent increase from the primary admissions in 1992. The 2002 admissions were primarily White (87 percent), with 6 percent being Black, 4 percent Hispanic, and 3 percent members of other racial/ethnic groups. This group of admissions was most likely to use heroin or alcohol, indicating some level of dual addiction (*see exhibit A*).

From 1992 to 2002, admissions involving narcotic painkillers rose from approximately 28,000 to 84,000. The upward trend began in 1998, as depicted in exhibit B on the following page.

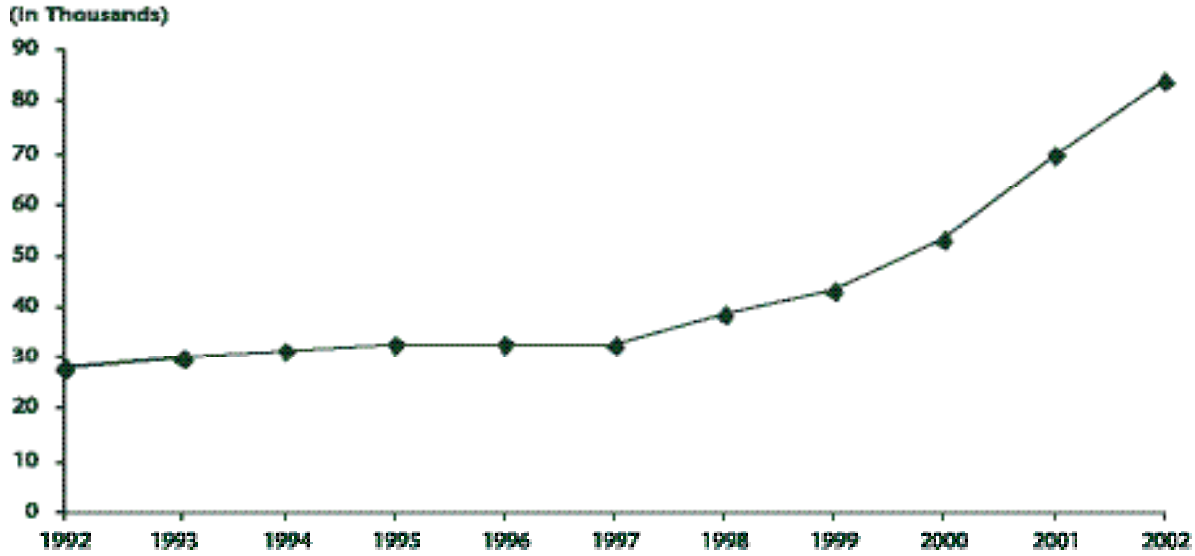
Other trend data show there has been a shift in the age pattern of narcotic painkiller admissions in recent years. As depicted in exhibit C on the following page, there has been a dramatic increase in the proportion of male admissions in their twenties, when 1997 and 2002 data are compared. Admissions for females were highest for those in the 35–45 age range.

Exhibit A. Admissions Involving Narcotic Painkillers, by Primary Substance: 2002



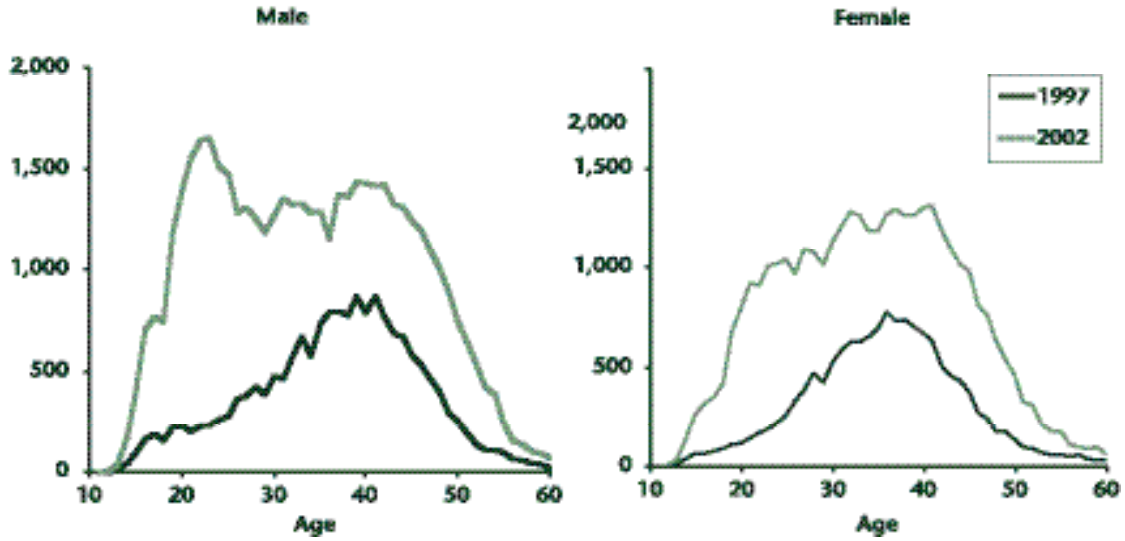
SOURCE: TEDS, OAS, SAMHSA

Exhibit B. Admissions Involving Narcotic Painkillers: 1992–2002



SOURCE: TEDS, OAS, SAMHSA

Exhibit C. Narcotic Painkiller Admissions by Gender and Age: 1997 and 2002

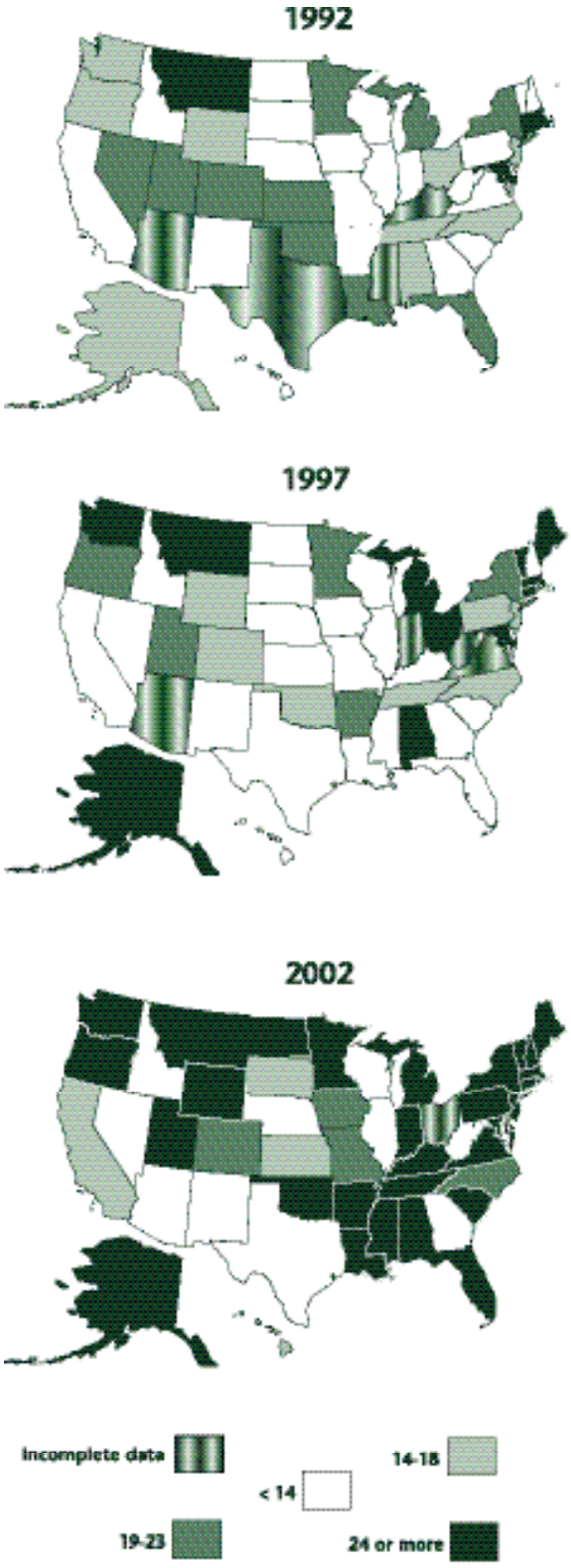


SOURCE: TEDS, OAS, SAMHSA

Five States accounted for 25 percent of the increase in narcotic painkiller admissions from 1992 to 2003 (the 2003 data are preliminary). These were, in rank order, New York (*n*=55,663), California (45,129), Washington (22,992), Texas (13,668), and Maine (10,894). The admissions were primarily White (87 percent in 2002).

The maps on the following page show narcotic painkiller admission rates per 100,000 population by State for 1992, 1997, and 2002 (*see exhibit D*). In 1992, 5 States (shown in dark green) had narcotic painkiller admission rates of 24 or more per 100,000 population. By 1997, another 7 States had rates of 24 or more, bringing the total to 12. In 2002, 31 States had narcotic painkiller admission rates of 24 or higher. The highest rates were in the New England States and ranged from 89 per 100,000 population in Connecticut to 207 in Maine. In each of the 3 years depicted in the maps, those in pale green fell below the median rate of narcotic painkiller admissions in reporting States.

Exhibit D. Rates of Narcotic Painkiller Admissions Per 100,000 Population: 1992, 1997, and 2002



SOURCE: TEDS, OAS, SAMHSA

DEA Data on Prescription Drug Abuse: Narcotic Analgesics

Liqun Wong, M.S.

Drug Enforcement Administration data for 2001–2003 on narcotic analgesics show the following:

- **Hydrocodone and oxycodone were, by far, the narcotic analgesics most frequently analyzed by DEA, State, and local laboratories, followed by methadone and codeine.**
- **Hydrocodone items were more prevalent in the West and South Regions of the Nation, while oxycodone items were more numerous in the Northeast.**
- **From 2001 to 2003, retail distribution of narcotic analgesics increased for hydrocodone, oxycodone, methadone, morphine, and codeine; total theft and loss of oxycodone and methadone peaked in 2002.**

Documentation of these findings, as presented by Liqun Wong, DEA, are based on data that are primarily from the following sources:

- **The National Forensic Laboratory Information System, sponsored by DEA, which systematically collects results from State and local forensic laboratories on analyses of drug seizures**
- **The System to Retrieve Information from Drug Evidence, a DEA program that analyzes drugs seized by DEA, the Federal Bureau of Investigation, the U.S. Customs Service, and others**
- **Automation of Reports and Controlled Orders System, an automated DEA database that tracks the flow of controlled substances from the manufacturer to controlled distribution systems to sales at the dispensary/retail level (e.g., hospitals, pharmacies, and practitioners)**

NFLIS DATA. As shown in exhibit A, narcotic analgesics accounted for between 2.1 and 2.9 percent of all items analyzed by State and local forensic laboratories in 2001–2003. Of the total narcotic analgesic items analyzed, hydrocodone and oxycodone accounted for nearly 70 percent in each of the 3 years. Across the 3 years, the percentage of items that were methadone increased slightly by 2003, while those for codeine decreased slightly.

There were regional differences in the distribution of the drugs seized/analyzed by NFLIS labs, as the combined data for 2001–2003 show (*see exhibit B on the following page*). Hydrocodone was more prevalent in the West and South Regions, while oxycodone was highest in the Northeast Region.

Exhibit C on the following page depicts the percentages of the four most frequently analyzed narcotic analgesic items in nine CEWG areas and Portland, Oregon, from 2001 to 2003. Hydrocodone items dominate in Atlanta and in west coast and southwestern CEWG areas. Oxycodone is most predominant in Boston, Philadelphia, and Miami. Methadone accounted for the highest percentage of the narcotic analgesic items in Chicago, while codeine accounted for the largest percentage in St. Louis.

The pattern of seizures/analyses reported by STRIDE shows that hydrocodone and oxycodone account for the majority each year (*see exhibit D on the page 98*).

The pattern of STRIDE seizures/analyses differs little from that reported by NFLIS (*see exhibit A*). In both, hydrocodone and oxycodone account for the majority of items. As a percentage of all items seized, codeine and morphine were more prominent in STRIDE, while methadone and propoxyphene accounted for a larger percentage of NFLIS items by 2003.

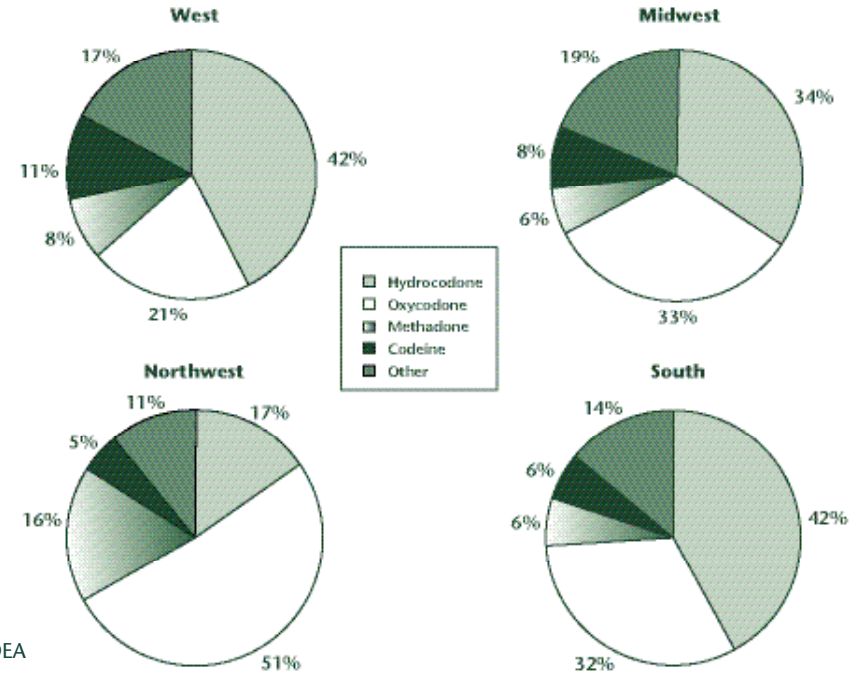
RETAIL DISTRIBUTION DATA. ARCOS data for 2001, 2002, and 2003 on retail distribution of five narcotic analgesic drugs show a slightly upward trend for hydrocodone, with the amount distributed rising approximately 5,600 kilograms from 2001 to 2003 (*see exhibit E on page 98*). Oxycodone also shows an upward trend, with 6,000 more kilograms distributed retail from 2001 to 2003. Retail distribution of methadone, morphine, and codeine also increased over the 3 years.

Exhibit A. Estimated Numbers and Percentages of Narcotic Analgesic Items Analyzed by Forensic Laboratories: 2001–2003

Drug	Total		2001		2002		2003	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Hydrocodone	47,399	34.5	13,659	34.9	16,838	34.2	16,903	34.6
Oxycodone	47,093	34.3	13,004	33.2	17,569	35.7	16,520	33.8
Methadone	11,299	8.2	2,490	6.4	3,842	7.8	4,967	10.2
Codeine	9,932	7.2	3,572	9.1	3,603	7.3	2,757	5.6
Morphine	7,037	5.1	2,103	5.4	2,400	4.9	2,534	5.2
Propoxyphene	6,853	5.0	2,264	5.8	2,486	5.0	2,103	4.3
Other Narcotic Analgesics	7,719	5.6	2,083	5.3	2,507	5.1	3,130	6.4
Total Narcotic Analgesic Items	137,332		39,174		49,244		48,914	
Total Analyzed Items	5,366,149		1,828,838		1,821,714		1,715,597	
Percent Identified as Narcotic Analgesics		2.6		2.1		2.7		2.9

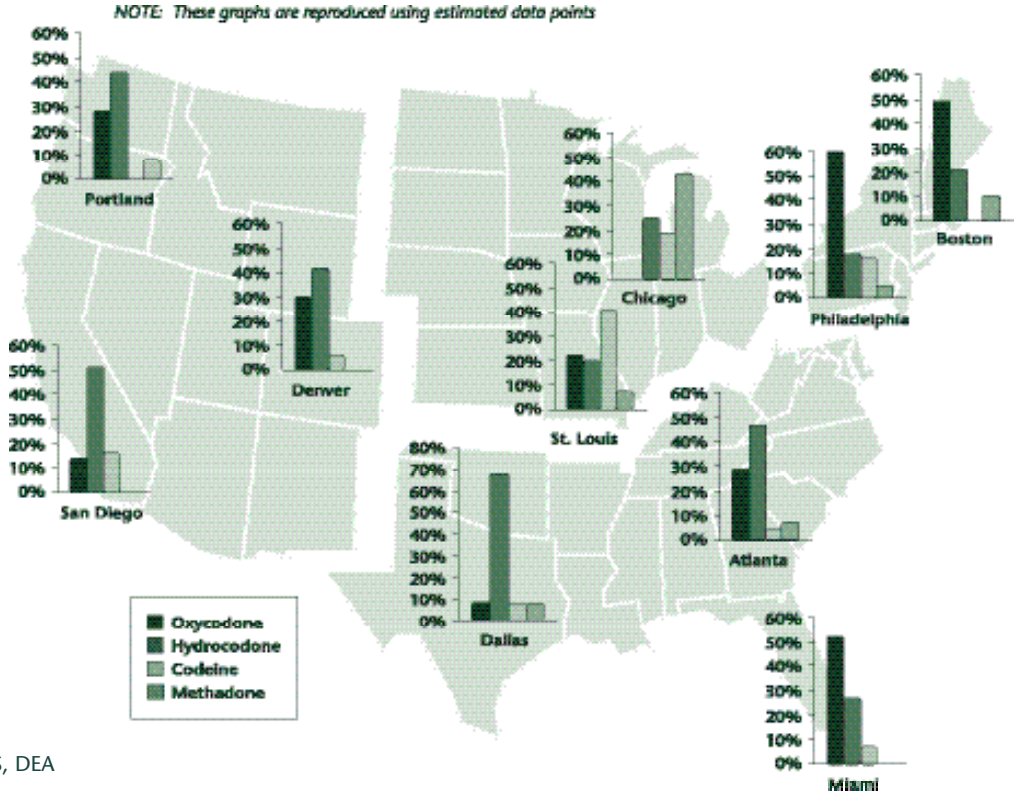
SOURCE: NFLIS, DEA

Exhibit B. Distribution of Narcotic Analgesic Items Analyzed by NFLIS, by Region and Percent: 2001–2003



SOURCE: NFLIS, DEA

Exhibit C. Narcotic Analgesic Items Analyzed in 10 Cities, by Percent of All Narcotic Analgesic Items: 2001–2003



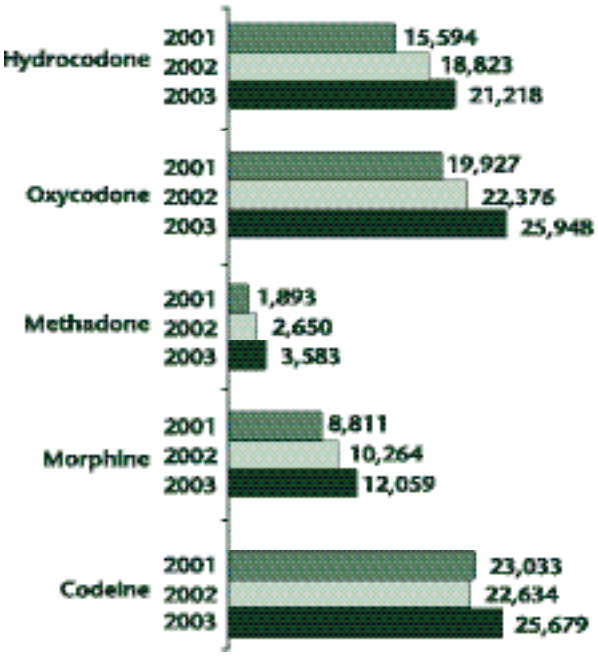
SOURCE: NFLIS, DEA

Exhibit D. Seizures of Narcotic Analgesic Drugs Reported by STRIDE: 2001–2003

Drug	Total		2001		2002		2003	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Hydrocodone	1,120	32.8	291	25.1	344	32.8	485	40.2
Oxycodone	1,079	31.6	480	41.4	308	29.4	291	24.1
Methadone	299	8.8	84	7.2	97	9.2	118	9.8
Codeine	257	7.5	82	7.1	78	7.4	97	8.0
Morphine	220	6.4	59	5.1	80	7.6	81	6.7
Propoxyphene	174	5.1	71	6.1	58	5.5	45	3.7
Other Narcotic Analgesics	266	7.8	93	8.0	84	8.0	89	7.4

SOURCE: STRIDE, DEA

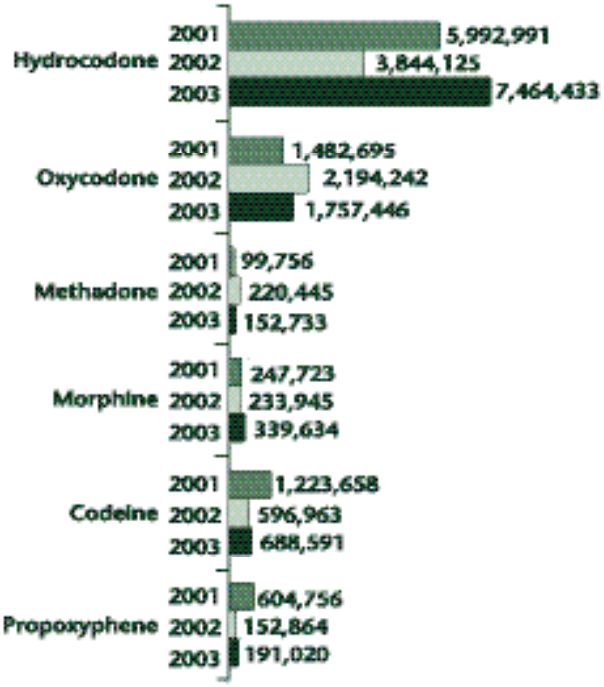
Exhibit E. Retail Distribution of 5 Narcotic Analgesic Drugs, in Kilograms: 2001–2003



SOURCE: ARCOS–2, DEA

THEFT AND LOSS. Information from another DEA database shows the dosage units of six narcotic analgesics and is based on information from registered narcotic analgesic handlers that are mandated to report theft or loss to the DEA. As shown in exhibit F, theft and loss for hydrocodone increased between 2002 and 2003, while oxycodone theft and loss declined during that time. For the other four drugs, codeine and propoxyphene loss decreased from 2001 to 2003, while morphine and methadone theft and loss increased in that period.

Exhibit F. Narcotic Analgesics Theft and Loss, in Number of Dosage Units: 2001–2003



SOURCE: DEA

Teenage Benzodiazepine Abuse and Misuse and United States Poison Control Centers: 2000–2003

William Watson, Pharm.D.

The Toxic Exposure Surveillance System (TESS) notes the following findings from 2000 through 2003 on teenagers reporting to poison control centers reporting to TESS. In 2003, 64 poison control centers (PCCs) reported to TESS, including 51 regional PCCs. The entire population of the 50 States, District of Columbia, and Puerto Rico were served by PCCs in 2003. However, because of variations in penetrance, the data, strictly speaking, cannot be considered national.

- **Benzodiazepines were the most commonly abused and misused prescription medications involving teen cases reported to TESS.**
- **Alprazolam accounted for 48 percent of the teenage cases.**
- **Nearly half (49 percent) of the teenage benzodiazepine cases involved more than one substance.**
- **Of the cases followed up by poison control centers and for which treatment was indicated, 17.9 percent had moderate (e.g., disorientation) or major (e.g., life-threatening symptoms) outcomes.**

These findings from the American Association of Poison Control Centers (AAPCC), TESS, represent center cases involving abuse and misuse of prescription drugs, especially benzodiazepines, by teenagers (age 13–19) from 2000 to 2003.

Overview of TESS. TESS was developed to provide uniformity in data collection from poison control cases. The AAPCC publishes an annual report each year in The American Journal of Emergency Medicine that summarizes human poisoning exposures. The information is available on the AAPCC Web site at <*http://www.aapcc.org/annual.htm*>.

The TESS data are useful for identifying the abuse of new or uncommon substances and changing patterns of abuse, since these cases may be more likely to result in health care providers contacting a poison center than is the case for more frequently encountered drugs. The predominance of calls to centers from the general public is unique among "real-time" surveillance systems and provides a different perspective on substance abuse. Geomapping permits comparison of rates of abuse and misuse by State and county.

Teenage Substance Abuse and Misuse. From 2000 through 2003, 670,064 poison center cases reported to TESS involved teenagers. More than half (55.9 percent) of the calls came from home, and 43.2 percent of cases were managed outside a health care facility. The reason for exposure was intentional in 306,213 cases (45.7 percent). The most common reasons for intentional poisoning exposures in this age group were suspected suicide (n=187,393), abuse (62,021), and misuse (43,480).

An assessment of the 200 most commonly abused and misused substances among teenagers shows that nonprescription drugs accounted for 33.7 percent of the cases and prescription medications accounted for 26.2 percent of the cases, followed by ethanol and illicit substances.

Benzodiazepines are the most common group of prescription medications reported in teenage abuse/misuse cases to poison control centers participating in TESS. This pattern was somewhat more common in 2000 and 2003 than in 2001 and 2002. From 2000 onward, the most commonly reported benzodiazepines were as follows:

- Alprazolam—48 percent
- Clonazepam—23 percent
- Diazepam—12 percent
- Lorazepam—11 percent
- Flunitrazepam—5 percent

More than one substance was involved in 49 percent of the benzodiazepine abuse or misuse cases.

Two-thirds of the benzodiazepine cases were followed up by the poison control center, and 17.9 percent had a moderate or major outcome. Moderate outcomes are those with symptoms that are not life threatening, rapidly respond to treatment, and have no residual disability (e.g., disorientation or hypotension); some

form of treatment is usually indicated in these moderate cases. Major outcomes are defined as cases with life-threatening symptoms or those that result in significant residual disability or disfigurement (Watson et. al 2003).

Across the 4 years, 11 teenage deaths involved abuse or misuse of benzodiazepines. In all 11 deaths, benzodiazepines were in combination with at least one other drug, and the benzodiazepine was not listed as the primary drug in any of these cases.

Reference

Watson, W.A.; Litovitz, T.L.; Rodgers, Jr., G.C.; Klein-Schwartz, W.; Youniss, J.; Rose, S.R.; Borys, D.; and May, M.E. 2002 Annual Report of the American Association of Poison Control Centers Toxic Exposure Surveillance System. *The American Journal of Emergency Medicine* 21(5): 353-421, 2003.

Examining Clonazepam and Other Sedative Hypnotics Using Treatment and Qualitative Data

Bruce Mendelson, M.P.A.

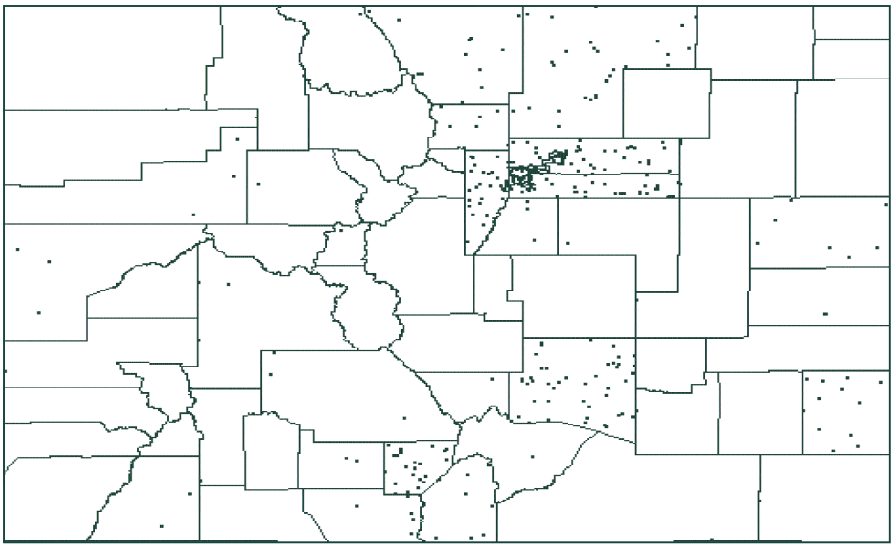
This exploratory study in Colorado focused on clonazepam (an anxiolytic/sedative benzodiazepine used medically to treat anxiety, panic, and seizure disorders) and resulted in the following findings/conclusions:

- **In 2002 and 2003, relatively high percentages of sedative abusers who entered treatment in Colorado reported clonazepam as their primary drug of abuse.**
- **Results from this exploratory study suggest that clonazepam is widely available, especially in some areas of the State, and that it may be preferred because of its anti-anxiety effects and the long duration of effects.**

METHODS. Bruce Mendelson, CEWG representative from Denver, described how secondary analysis of treatment data and a qualitative study were conducted in early 2004 to learn more about clonazepam abuse in Colorado. Clinicians from 13 treatment programs were contacted as key informants for the qualitative study. Additionally, treatment admissions data were examined to better characterize the drug-abusing population and the treatment experience of clonazepam abusers, and to assess clinical information from treatment programs.

FINDINGS. Of the 451 clients who reported sedative hypnotic abuse in 2002, 60 percent specified clonazepam as their primary drug. Among the sedative hypnotic treatment admissions in 2003 (n=361), 42.1 percent were primary clonazepam abusers. Individuals admitted to treatment in 2002 and 2003 were plotted on a map to determine where in the State they lived (*see exhibit A*). It was learned that most clonazepam treatment admissions resided in the Denver metropolitan area and in the southeast and south central sections of the State.

Exhibit A. Clonazepam Treatment Admissions by Colorado County: 2002–2003



SOURCE: Colorado Alcohol and Drug Abuse Division

Clonazepam abusers were less likely than other types of sedative hypnotic abusers to be daily users (14.7 vs. 30.3 percent), new users (5.7 vs. 16.0 percent), or to have been arrested. They were also less likely to have medical/physical problems at treatment admission and discharge. Clonazepam abusers were more likely to have made progress in achieving treatment goals. At discharge, some 36.6 percent received "high" ratings for achievement of treatment goals (compared with 22.1 percent for the other sedative hypnotic admissions), and 44.6 percent received "moderate" ratings (compared with 27.0 percent for other sedative hypnotic admissions).

Clinician informants identified primary reasons for using clonazepam, which included the following:

- Wide street availability and easy access were reported for the drug.
- Younger methadone clients liked it for the "high."
- Clients older than 18 had the ability to get prescriptions.
- The drug helps with ethanol withdrawal (i.e., shakes, fear of seizures).

The following were some of the desired effects from clonazepam identified by key informants:

- Relaxation, calm, reduced anxiety, sedation high
- Euphoria (i.e., feel good)
- Avoidance of withdrawal
- Reduction/elimination of pain
- Sleep enhancement

The treatment data show that 84.0 percent of the clonazepam abusers took the drug orally, 13.0 percent smoked it, and 1.4 percent inhaled the substance. Less than 1 percent reported that they injected clonazepam.

According to the informants, clonazepam is obtained from a variety of sources, including prescriptions from physicians and doctor shopping, family and friends, and dealers. The cost of the drug depends on the strength (i.e., 0.5, 1.0, 2.0 milligrams). Clonazepam pills typically sell for $2–$5 on the street.

Nonmedical Use of Prescription Drugs: Preliminary Findings from the College Life Study

Amelia Arria, Ph.D.

This pilot study, conducted in early 2004 at a mid-Atlantic university (primarily with freshmen and sophomores), led to the following estimates:

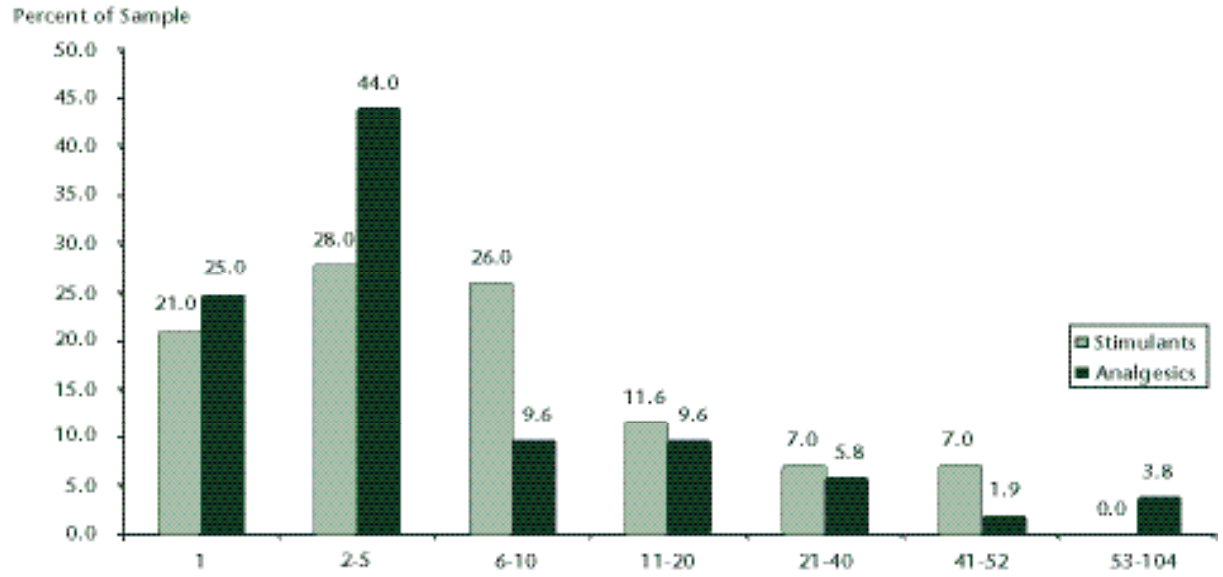
- **An estimated 15.5 percent of the students had used prescription pain relievers nonmedically at least once in their lifetime.**
- **An estimated 13.4 percent of the students had used prescription stimulants nonmedically at least once in their lifetime.**
- **A high proportion of nonmedical users of prescription drugs had a history of using other illicit or licit drugs, including alcohol.**

Dr. Arria, who serves as the Principal Investigator of this study at the Center for Substance Abuse Research (CESAR), University of Maryland, presented these and other findings from the pilot study supported through NIDA grant R01DA14845.

Sample and Methods. The pilot study included 468 students, age 18–25. Eighty percent were freshmen and sophomores. Half were males, 69 percent were White, and 12 percent were African-American. All participants were administered a classroom-based questionnaire that included items on nonmedical use of prescription drugs, as well as use of alcohol, tobacco, and illicit drugs.

Findings. Of the pilot sample, 13.4 percent had used prescription stimulants nonmedically and 15.5 percent had used prescription pain relievers nonmedically at least once during their lifetime. More than half (51.6 percent) had used prescription stimulants nonmedically six or more times in the past year, compared with 31.0 percent of nonmedical prescription pain reliever users (*see exhibit A on the following page*).

Exhibit A. Number of Occasions Prescription Stimulants and Analgesics Were Used Nonmedically by Students in the Past Year, by Percent: 2004



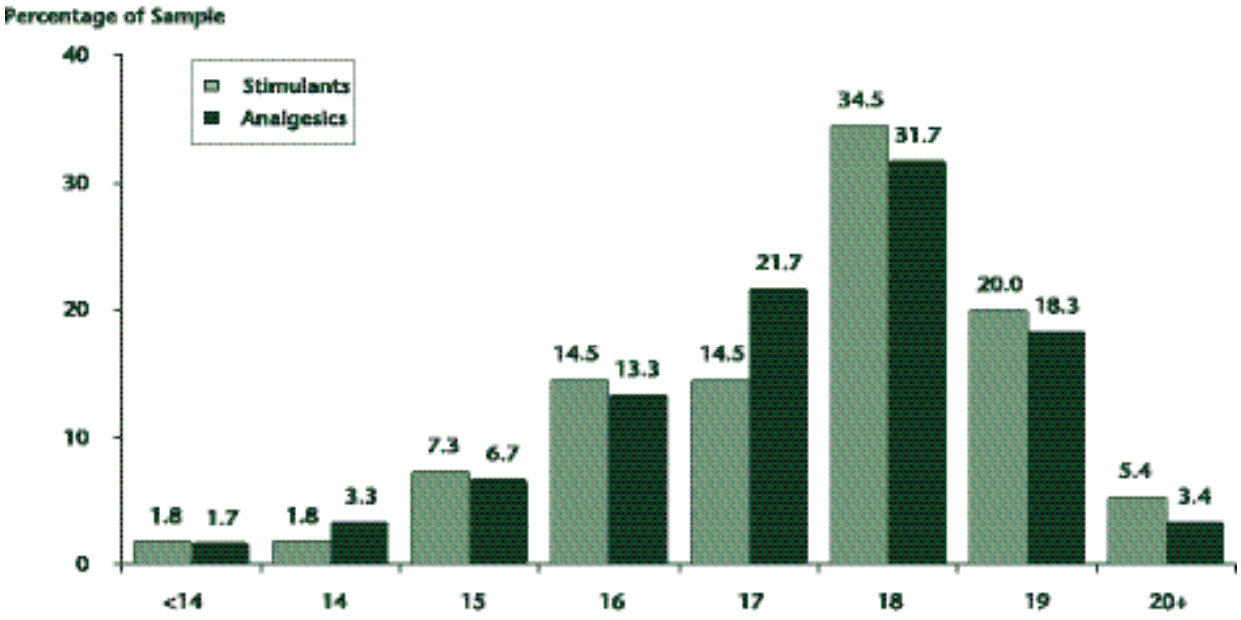
SOURCE: CESAR

Nearly one-half (47.2 percent) of the nonmedical prescription pain reliever users and 39.9 percent of the nonmedical prescription stimulant users began using these drugs before the age of 18 (*see exhibit B*).

Males were more likely than females to use prescription drugs nonmedically.

Comparisons were made between three groups of students: prescription analgesic users, prescription stimulant users, and nonusers of these prescription drugs. The Scholastic Achievement Test (SAT) scores and ages were comparable in all three groups. However, a higher proportion of prescrip-

Exhibit B. Age of First Use of Prescription Analgesics and Stimulants Nonmedically, by Percent: 2004



SOURCE: CESAR

tion drug users than nonusers reported attention deficit or hyperactivity disorders.

Ninety-two percent of the nonmedical users of prescription stimulants had used marijuana, compared with 44 percent of the nonusers of either prescription drug. In addition, half of the nonmedical prescription pain reliever users had used hallucinogens, compared with only 5 percent of the nonusers.

The longitudinal "College Life Study" is now in its implementation phase. It builds on what was learned from the pilot study and is designed to assess the impact of alcohol and drug (nonmedical and illicit) use on students' behaviors, performance, and opportunities over time. A Federal Certificate of Confidentiality and Institutional Review Board approval have been obtained. Plans are to interview nearly 2,000 of the 4,500 incoming freshmen in the fall of 2004. In addition, an effort will be made to obtain funding for a qualitative study to obtain more insight into the process of initiation and consequences of nonmedical prescription drug use.

Prescription Drug Abuse Among Ecstasy Users in Miami

Steven Kurtz, Ph.D.

Major findings from this qualitative study of prescription drug/ecstasy users in Miami include the following:

- **Polydrug use was the norm among the young people in the study. Use patterns crossed age, gender, and ethnic boundaries.**
- **Many different prescription drugs were used with illicit drugs to "get high."**
- **Prescription drugs were perceived as safer and purer, more respectable, and more available than illicit drugs, and also as less expensive and less likely to have negative side effects than illicit drugs.**
- **There were many potential prescription drug suppliers, including families, friends, pharmacies in other countries, and street- and nightclub-based dealers. The drugs were obtained in a variety of ways, including insurance fraud and theft from pharmacies and hospitals. Online pharmacies were not trusted for fear they were monitored by authorities.**

Dr. Kurtz, University of Delaware, reported these and other findings from this research in Miami. The effort was informed by a multisite study funded through NIDA grant R01DA1854, which is described by the Principal Investigator, Linda Cottler, Ph.D., in the June 2003 CEWG Volume II Proceedings.

Background. Based on quantitative data, it was found that 87 percent of ecstasy users in study of "club drug users" were also prescription drug abusers and had used prescription drugs for nonmedical purposes more than five times during their lifetime. Qualitative observational studies showed that the number of drugs used for partying in Miami clubs appears to keep expanding and that more clubs are reverting to being "cocaine friendly," meaning that customers can visit the restrooms regularly to get high without creating a problem with security guards. In fact, the term "club drugs" is not a very helpful one in Miami, because so many drugs and combinations of drugs are being used in the club cultures. Of note also is the fact that in a study of students in Delaware, it was found that those who used narcotic painkillers were more likely to be polydrug abusers than other students (Inciardi et al. 2004). Given such information, this followup qualitative study was designed and implemented.

Study Sample and Methods. The qualitative data were gathered through eight 60–90-minute focus groups comprised of three to four members each, who were recruited through flyers in nightclub districts and print media advertisements. One indepth interview was also conducted with a 39-year-old Hispanic prescription drug dealer. The study was also informed by a focus group of health professionals conducted in 2002.

The 30 focus group members included 24 males and 6 females. Thirteen of the 24 males were Hispanic, 5 were Anglo, 2 were African-American, and 4 were members of other racial/ethnic groups. Fourteen of the males were heterosexual, and 11

were homosexual or bisexual. The males ranged in age from 18 to 45. The six females differed little in age from the males (19–43); five females were heterosexual, two were Hispanic, two were members of other racial groups, and the others were Anglo or African-American.

Based on eligibility criteria, all focus group members had used ecstasy in the prior 3 months and had used prescription drugs recreationally more than 5 times in the prior 12 months and at least once in the 30 days prior to the group meeting. All frequented nightclubs in the Miami area. Pseudonyms were used to link demographic questionnaire data to transcribed focus group discussion data. A grounded theory approach guided the study.

FINDINGS. The results cover attitudes, onset patterns, continuing use patterns, sources of supply, and health and social consequences of prescription drug abuse.

ATTITUDES. Typically, focus group members perceived prescription drugs to be safer and purer than illicit street drugs. Prescription drugs were perceived to be more "respectable," legal, and available than illicit drugs, and also to be less expensive and less likely to have side effects. The following quotes from participants express some of these perceptions:

Knowing that some scientist somewhere said 'Yeah, it's safe enough to sell to a pharmacy' helps. **(ANGLO MALE, AGE 32)**

If you're taking prescription drugs, you're not really on drugs, you know? These are like products that you can sell. There's advertising for them. They just kind of fit into a capitalist framework better than marijuana, which is not packaged in proper packages. Whereas, Eli Lilly, you know that's a respectable name. They're traded on the New York Stock Exchange. **(ANGLO MALE, AGE 35)**

I know certain people who don't touch street drugs. They think they're horrible and grimy. But they'll blow [prescription drugs] up their nose like every day. **(ASIAN FEMALE, AGE 20)**

With regard to legality, participants generally agreed that they would be less concerned about being caught by police with OxyContin or Xanax in their pocket than with ecstasy or cocaine. They felt any number of excuses could be used to explain why they could legally carry the drug (e.g., "I left my prescription at home," "I was carrying them for my girlfriend").

ONSET PATTERNS. There were two distinct patterns related to use of prescription drugs. "Early onset" describes those who first abused prescription drugs in junior or senior high school. Commonly used were Xanax, Ritalin, and diet pills. Use was peer-driven, no money usually changed hands, and onset often coincided with first use of alcohol and marijuana. For many early onset users, there was a period when they stopped using prescription drugs before they resumed, with the later abuse usually occurring in the context of the onset of "harder" street drug use.

The "later onset" pattern usually took the form of using benzodiazepines or opioids after using stimulants. Prescription drug use was engaged in specifically to "take the edge off" or "come down from" street stimulants, such as ecstasy, cocaine, and methamphetamine.

Another common pattern was using benzodiazepines and opioids with alcohol as a way of getting drunk without drinking so much. This cuts expenses at nightclubs, which typically charge a $25 cover and an average of $8 to $10 for an alcoholic beverage.

Prescription pills generally cost about $1–$2 each and are available through a wide range of sources, including peers and dealers. Prices vary by drug. OxyContin is the most expensive and is not particularly popular in this ecstasy-using population; however, a number of participants reported that OxyContin is a "sex enhancer." Polydrug patterns were typical, as indicated earlier and described in more detail below.

CONTINUING USE PATTERNS. In addition to the patterns of onset discussed above, there were other common themes expressed about using prescription drugs to "get high." Combining different prescription drugs or prescription drugs with street drugs was commonplace, with some users experimenting with many different combinations to see what psychic effect they would have. Surprisingly,

antipsychotics were mentioned rather frequently as part of the drug "mix." One theory was that if the user were not psychotic, the drugs would induce a psychotic-type state. With respect to Xanax, participants felt they were more likely to take ecstasy if they already had a Xanax pill, because they would have a "smooth come down." It was frequently mentioned that dealers are now packaging either benzodiazepines or opioids with ecstasy so you "buy two for one."

Some prescription and illicit drug combinations used to get high were as follows:

- Ritalin, marijuana, and alcohol
- Benzodiazepines, opioids, and alcohol
- Codeine and ecstasy
- Hydrocodone and cocaine
- Antipsychotics, alprazolam, cocaine, marijuana, and alcohol

Some participants described using prescription drugs as substitutes for street drugs when the street drugs became unavailable, too expensive, or of poor quality. These included such combinations as phentermine plus cocaine rather than methamphetamine; Valium instead of marijuana; and Klonopin plus Marinol rather than heroin.

Some participants described using prescription drugs as alternatives to illicit drugs, or combinations believed to be "equal" to a street drug. These included the following:

- Vicodin plus marijuana = ecstasy
- Xanax plus methamphetamine = ecstasy
- Painkillers plus alcohol = GHB (gamma hydroxybutyrate)

Sources of supply for prescription drugs include leftover personal or family member medications; prescriptions obtained through false statements; family or friends with legitimate medical conditions (especially HIV/AIDS); Medicare/insurance fraud; pharmacies in Mexico, South America, and the Caribbean; street- and nightclub-based dealers; flyer advertisements; online pharmacies; and pharmacy and hospital theft. Note, however, that online pharmacies were unpopular with this group because of fears that the sites are monitored by authorities.

Overall, this group of participants reported experiencing social problems from their abuse of prescription drugs, with isolation being common. Financial and employment problems, school problems, and problems with relationships with family and friends were also reported.

There is concern about the normalized integration of prescription and street drug cultures as well as the potential for seeking new drug experiences through experimentation with the types of drug combinations found in this study.

Reference

Inciardi, J.A.; Martin, S.S.; Surratt, H.L.; and Gealt, R. 2004. Prevalence of narcotic analgesic abuse among students: Individual or poly-drug abuse? *Archives of Pediatric and Adolescent Medicine* 158:498–499, 2004.

INTERNATIONAL PAPER: MEXICO

A component of the National Surveillance System of Mexico, the Epidemiologic Surveillance System of Addictions of Mexico (SISVEA) was established in 1990 to provide periodic and timely information on tobacco, alcohol, and other illegal drugs of use. Data and information are collected from 53 cities, and data sources include government treatment centers (GTCs), nongovernment treatment centers (NGCs), Juvenile Detention Centers, and medical examiners (for drug-related death data).

In 2003, cocaine was the most common primary drug of abuse among patients at GTCs, accounting for 29.8 percent, and the second most common primary drug at NGCs (19.1 percent). Nearly 19 percent of the 9,561 juveniles arrested during 2003 used cocaine.

At NGCs in 2003, heroin was the most common primary drug of abuse (accounting for 21.1 percent of patients), while at GTCs primary heroin abuse ranked fifth (2.4 percent). Information from the Juvenile Detention Centers showed that 0.8 percent of juveniles arrested in 2003 used heroin.

Marijuana was the third most commonly reported primary drug of use at GTCs in 2003 (16.7 percent), and it was the fifth most common at NGCs (9.7 percent). Marijuana use was the most frequently reported illicit drug used by juveniles arrested in 2003 (34.5 percent). Medical examiner data indicated that 3.3 percent of deaths reported were associated with marijuana.

Inhalants ranked as the fourth most common primary drug of abuse at both GTCs (9.8 percent) and NGCs (11.2 percent) in 2003. According to Juvenile Detention Centers, 14.6 percent of juvenile arrestees used inhalants.

APPENDIX A.
LIST OF PAPERS IN VOLUME II

Epidemiology of Drug Abuse: CEWG Area Papers

Atlanta
Metropolitan Atlanta Drug Use Trends
Kristin J. Wilson, M.A., Claire E. Sterk, Ph.D., and Kirk W. Elifson, Ph.D.

Baltimore
Drug Use in the Baltimore Metropolitan Area: Epidemiology and Trends, 1999 Through the First Half of 2003
Leigh A. Henderson, Ph.D., and Doren H. Walker, M.S.

Boston
Patterns and Trends in Drug Abuse: Greater Boston
Daniel P. Dooley

Chicago
Patterns and Trends of Drug Abuse in Chicago
Dita Broz, M.P.H., Matthew Magee, Susan Bailey, Ph.D., Wayne Wiebel, Ph.D., and Lawrence Ouellet, Ph.D.

Denver
Patterns and Trends in Drug Abuse: Denver and Colorado
Bruce Mendelson, M.P.A.

Detroit
Drug Abuse Trends in Detroit/Wayne County and Michigan
Philip Chvojka and Richard Calkins

Honolulu
Illicit Drug Use in Honolulu and the State of Hawaii
D. William Wood, M.P.H., Ph.D.

Los Angeles
A Semiannual Update of Drug Abuse Patterns and Trends in Los Angeles County, California
Beth Finnerty, M.P.H.

Miami
Drug Abuse in Miami and Ft. Lauderdale, Florida
James N. Hall and Madeline Camejo, Pharm.D.

Minneapolis/St. Paul
Drug Abuse Trends in Minneapolis/St. Paul
Carol Falkowski

Newark
Drug Abuse in the Newark Primary Metropolitan Statistical Area
Anna Kline, Ph.D.

New Orleans
Overview of Drug Abuse Indicators in New Orleans
Gail Thornton-Collins

New York City
Drug Use Trends in New York City
Rozanne Marel, Ph.D., John Galea, M.A., and Robinson B. Smith, M.A.

Philadelphia
Drug Use in Philadelphia, Pennsylvania
Samuel Cutler and Marvin F. Levine, M.S.W.

Phoenix
Drug Abuse Trends in Phoenix and Arizona
Ilene L. Dode, Ph.D.

St. Louis
Patterns and Trends in Drug Abuse in St. Louis
Heidi Israel, Ph.D., R.N., L.C.S.W., and Jim Topolski, Ph.D.

San Francisco
Patterns and Trends of Drug Use in the San Francisco Bay Area
John A. Newmeyer, Ph.D.

Seattle

Recent Drug Abuse Trends in the Seattle-King County Area

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

Washington, DC

Patterns and Trends of Drug Abuse in Washington, DC

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

Panel on Prescription Drug Abuse

Emerging/Current Trend—Panel on Prescription Drug Abuse: Overview and Summary of Findings

Wilson Compton, M.D., M.P.E.

Prescription Drug Abuse in the American Population

James Colliver, Ph.D.

Student Use of Prescription Drugs: Monitoring the Future Survey

James Colliver, Ph.D.

Prescription Drugs and Teens and Young Adults in Drug Abuse-Related Emergency Department Visits: 1995–2002

Elizabeth Crane, Ph.D., M.P.H.

Treatment Admissions for Abuse of Narcotic Painkillers—Treatment Episode Data Set: 1992–2002

Leigh Henderson, Ph.D.

DEA Data on Prescription Drug Abuse: Narcotic Analgesics

Liqun Wong, M.A.

Teenage Benzodiazepine Abuse and Misuse and United States Poison Control Centers: 2000–2003

William Watson, Pharm.D.

Examining Clonazepam and Other Sedative Hypnotics Using Treatment and Qualitative Data

Bruce Mendelson, M.P.A.

Nonmedical Use of Prescription Drugs: Preliminary Findings from the College Life Study

Amelia Arria, Ph.D.

Prescription Drug Abuse Among Ecstasy Users in Miami

Steven Kurtz, Ph.D.

Special Presentation

Prescription Drug Abuse in Maine

Marcella H. Sorg, R.N., Ph.D., D-ABFA

International Report

Update of the Epidemiologic Surveillance System of Addictions (SISVEA) in Mexico: 2003

Roberto Tapia-Conyer, Patricia Cravioto, Pablo Kuri, Mario Cortés, and Fernando Galván

APPENDIX B.
THE DRUG ABUSE WARNING NETWORK (DAWN) EMERGENCY DEPARTMENT DATA

This data collection system, managed by the Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA), provides semiannual and annual estimates of substance use based on visits to hospital emergency departments (EDs) in 21 metropolitan areas, including 20 CEWG areas. Data from 19 CEWG areas are included in this report.

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

ED data are reported for each "episode" (case or admission) that meets the criteria for "drug abuser age 6–97," who is taking one or more substances without proper medical supervision or for psychic effect, dependence, or suicide attempt or gesture. Each drug reported by a patient may be counted as a "mention." Up to four drugs for each episode may be recorded. Some drugs are classified in a combined category, such as "cocaine/crack," "marijuana/hashish," and "PCP/PCP combinations."

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

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

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

APPENDIX C.
THE DAWN MORTALITY SYSTEM

The medical examiner/coroner component of the Drug Abuse Warning Network, administered by the Office of Applied Studies at the Substance Abuse and Mental Health Services Administration, collects data on drug abuse-related deaths from metropolitan areas in the United States. In 2002, this DAWN system covered 127 jurisdictions and 38 metropolitan areas. This report presents data from 19 CEWG areas included in the system in 2002.

DAWN does not produce a national estimate of drug abuse-related deaths, because it does not cover a statistical sample of medical examiner jurisdictions. For this reason, mortality data are reported at the metropolitan level. Also, not all jurisdictions are covered in all DAWN areas; those in which all jurisdictions and 100 percent of the population are covered are represented in footnotes to the DAWN exhibits in this report.

Within each metropolitan area, medical examiners from its jurisdiction (usually counties) report directly to DAWN. Therefore, the data for a given metropolitan area may or may not include all the drug abuse-related deaths, depending on whether all medical examiner jurisdictions participate in DAWN.

DAWN collects information about the circumstances of the death (motive of drug abuse, manner/cause of death, disposition) and demographic information about the decedent. Data are collected on illicit drugs; inhalants; and prescription drugs, over-the counter (OTC) drugs, and dietary supplements that were used for nonmedical reasons.

For each death related to drug abuse, DAWN collects information on up to six drugs and alcohol. Data on multiple drugs are collected because most drug abuse-related deaths usually involve more than one drug. When more than one drug is involved in a death, assigning causation to a single drug is problematic; the death could have been caused by one drug, or the interaction of drugs. Therefore, not all drugs mentioned in the death necessarily contributed to the death. Because only one motive is assigned to each death, it is also possible that some of the drugs were incidental to the drug abuse, for example, a prescription drug taken as directed, or a pain reliever taken for a headache.

The DAWN data can be accessed at *<http://dawninfo.samhsa.gov/>*.

APPENDIX D.

TOTAL ADMISSIONS BY PRIMARY SUBSTANCE OF ABUSE AND CEWG AREA: 2003[1]

CEWG Area	Alcohol Only	Alcohol/ Other Drug	Cocaine/ Crack	Heroin	Marijuana	Stimulants	Other Drugs	Total
Atlanta	NR2	1,848	3,071	451	1,438	369	1	7,178
Baltimore[3]	3,208	2,202	2,092	8,367	2,462	22	640	18,993
Boston		8,868	1,985	11,430	1,046	70	1,041	24,440
Detroit	2,643	2,639	3,991	4,460	1,401	8	494	15,636
Los Angeles	4,175	5,619	10,057	13,595	7,121	10,314	2,622	53,503
Miami (Sample)[3]	NR		181	23	361	NR	NR	565
Mpls./St. Paul	9,199		2,474	627	4,235	1,393	686	18,614
New Orleans	538		862	268	734	0	135	2,537
New York	NR	13,522	16,114	23,563	13,471	224	2,350	69,244
Newark	174	264	324	4,169	340	3	44	5,318
Philadelphia	1,765		2,153	1,858	1,400	33	465	7,674
St. Louis	1,572	1,394	3,632	1,061	2,856	493	261	11,269
San Diego	1,311	1,917	1,152	1,318	2,952	6,365	264	15,279
San Francisco	3,153		2,274	3,700	NR	1,144	2,398	11,559
Seattle	3,364		1,225	1,364	1,783	740	314	8,790
Wash., DC	552	330	1,378	2,023	336	10	203	4,832
Arizona	9,046	7,092	2,132	1,539	5,212	3,272	1,010	29,303
Colorado	50,324	5,919	3,160	1,949	4,932	3,629	1,087	71,000
Hawaii	1,580		355	201	1,593	3,207	291	7,227
Illinois	51,651		33,882	34,615	32,077	4,508	15,837	172,570
Texas	8,002	7,860	14,210	5,061	9,875	4,491	3,570	53,069

[1]Unless otherwise noted, data represent calendar or fiscal year 2003.
[2]NR=Not reported.
[3]Represents only the first half of 2003 for Baltimore, and only the second half of 2003 for Miami (sample).
SOURCE: June 2004 CEWG Reports

APPENDIX E. THE ARRESTEE DRUG ABUSE MONITORING (ADAM) PROGRAM

Managed by the National Institute of Justice (NIJ), the ADAM program gathered drug use data quarterly from male adult arrestees in 39 sites in the United States in 2003; 15 of these sites provided data relevant to the CEWG for various quarters of 2003. Data were also collected on adult female arrestees in 25 sites; 10 sites provided data relevant to the CEWG. The 2003 data cover less than four quarters in all but one CEWG site, as indicated in the Data Sources section of this report.

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

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

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

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

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

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

APPENDIX F.
THE YOUTH RISK BEHAVIOR SURVEY

The Youth Risk Behavior Survey (YRBS) is part of the Youth Risk Behavior Surveillance System, developed by the Centers for Disease Control and Prevention. Beginning in 1991, the YRBS has been conducted every other year by education and health agencies. State and local school-based YRBS efforts are based on a two-stage cluster sample design to produce representative samples of students in grades 9–12 within their jurisdictions (50 States and the District of Columbia). Data are weighted and statistical tests are used to determine differences between selected categories.

The YRBS covers lifetime use of many illicit drugs including cocaine (powder, crack, freebase), heroin, marijuana, methamphetamine, inhalants, and ecstasy, as well as "current" (past-30-day) use of some drugs (e.g., cocaine, inhalants, marijuana), and injection of any illicit drugs. Nonmedical use of steroids is also covered. The use of drugs among students included in CEWG YRBS sites is the focus in this report. However, the survey also covers other risk behaviors (e.g., alcohol and tobacco use, risky sexual behaviors, and behaviors that contribute to unintentional injuries and violence). More detailed information can be accessed at *<http://www.cdc.gov/yrbs>*.

The 2003 YRBS data for 32 States and 18 local jurisdictions are also available in CDC's *Morbidity and Mortality Weekly Report*, May 21, 2004.

APPENDIX G.
THE NATIONAL FORENSIC LABORATORY INFORMATION SYSTEM (NFLIS)

The NFLIS, established by the Drug Enforcement Administration, published its first annual report in 2000, under the auspices of Research Triangle Institute. The data in this report are for calendar year 2003 and represent 18 CEWG cities as well as 13 Texas sites. The Texas data are submitted to NFLIS by the Department of Public Safety.

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

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

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

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

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

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

APPENDIX H.
THE DOMESTIC MONITOR PROGRAM (DMP)

Under the jurisdiction of the Intelligence Division of Drug Enforcement Administration (DEA), the DMP reports on the origin, types, cost, and purity of retail-level heroin available in the open-air drug markets in the major metropolitan areas of the United States. The preliminary information for 2003 is based on actual undercover heroin purchases made by the DEA on streets in 23 metropolitan areas, 21 of which are in or near CEWG areas.

The heroin buys provide information on the type of heroin (Asian, Mexican, Colombian, or undetermined) and the type of diluents and adulterants present in the drug. DMP reports indicate where the buy was made, the brand name (if any), purity level, and price per milligram pure.

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

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