NDEWS National Drug Early Warning System

Funded at the Center for Substance Abuse Research by the National Institute on Drug Abuse

Atlanta Metro
Sentinel Community Site (SCS)
Drug Use Patterns and Trends, 2016

October 2016

NDEWS Coordinating Center

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National Drug Early Warning System (NDEWS)
Sentinel Community Site (SCS)
Drug Use Patterns and Trends, 2016

The National Drug Early Warning System (NDEWS) was launched in 2014 with the support of the National Institute on Drug Abuse (NIDA) to collect and disseminate timely information about drug trends in the United States. The Center for Substance Abuse Research (CESAR) at the University of Maryland manages the NDEWS Coordinating Center and has recruited a team of nationally recognized experts to collaborate on building NDEWS, including 12 Sentinel Community Epidemiologists (SCEs). The SCEs serve as the point of contact for their individual Sentinel Community Site (SCS), and correspond regularly with NDEWS Coordinating Center staff throughout the year to respond to queries, share information and reports, collect data and information on specific drug topics, and write an annual *SCE Narrative* describing trends and patterns in their local SCS.

This *Sentinel Community Site Drug Use Patterns and Trends* report contains three sections:

- The *SCS Snapshot*, prepared by Coordinating Center staff, contains graphics that display information on drug use, substance use disorders and treatment, drug poisoning deaths, and drug seizures. The *SCS Snapshots* attempt to harmonize data available for each of the 12 sites by presenting standardized graphics from local treatment admissions and four national data sources.

- The *SCE Narrative*, written by the SCE, provides their interpretation of important findings and trends based on available national data as well as sources specific to their area, such as data from local medical examiners or poison control centers. As a local expert, the SCE is able to provide context to the national and local data presented.

- The *SCS Data Tables*, prepared by Coordinating Center staff, include information on demographic and socioeconomic characteristics of the population, drug use, substance use disorders and treatment, drug poisoning deaths, and drug seizures for the Sentinel Community Site. The *SCS Data Tables* attempt to harmonize data available for each of the 12 sites by presenting standardized information from local treatment admissions and five national data sources.

The *Sentinel Community Site Drug Use Patterns and Trends* reports for each of the 12 Sentinel Community Sites and detailed information about NDEWS can be found on the NDEWS website at www.ndews.org.

National Drug Early Warning System (NDEWS)
Sentinel Community Site (SCS)
Drug Use Patterns and Trends: SCS Snapshot

The *SCS Snapshot* is prepared by NDEWS Coordinating Center staff and contains graphics that display information on drug use, substance use disorders and treatment, drug poisoning deaths, and drug seizures. The *SCS Snapshots* attempt to harmonize data available for each of the 12 sites by presenting standardized graphics from local treatment admissions and four national data sources:

- National Survey on Drug Use and Health;
- Youth Risk Behavior Survey;
- SCE-provided local treatment admissions data;
- National Vital Statistics System mortality data queried from CDC WONDER; and
- National Forensic Laboratory Information System.

The *SCS Snapshots* for each of the 12 Sentinel Community Sites and detailed information about NDEWS can be found on the NDEWS website at www.ndews.org.

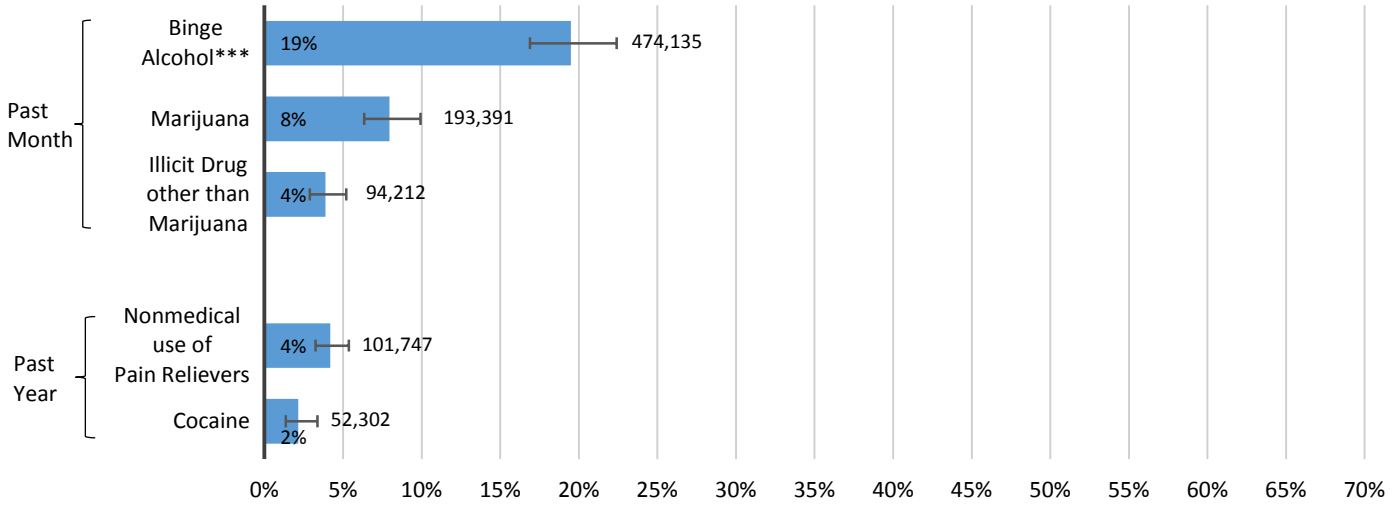
Atlanta Metro SCS Snapshot, 2016

Substance Use

*National Survey on Drug Use and Health (NSDUH): Survey of U.S. Population**

Persons 12+ Years Reporting Selected Substance Use, Atlanta Region^, 2012-2014

Estimated Percent, 95% Confidence Interval, and Estimated Number of Persons**



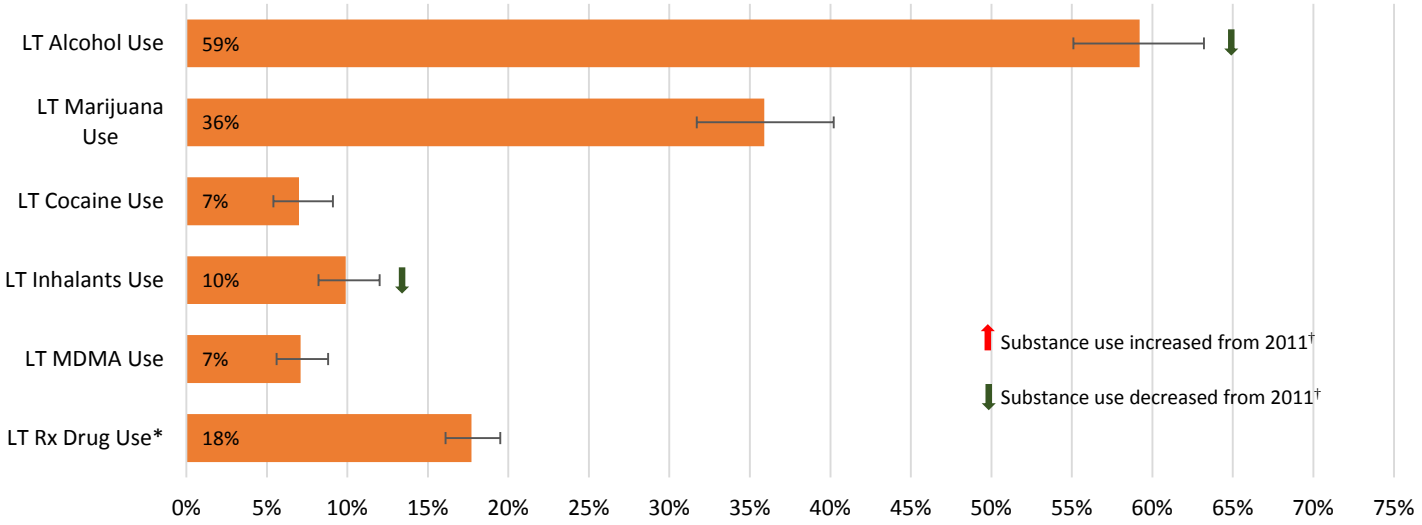
*U.S. Population: U.S. civilian non-institutionalized population. ^Atlanta Region: NSDUH Region 3 (Clayton, DeKalb, Fulton, Gwinnett, Newton, and Rockdale counties). **Estimated Number: Calculated by multiplying the prevalence rate and the population estimate of persons 12+ years (2,431,810) from Table C1 of the NSDUH Report. ***Binge Alcohol: Defined as drinking five or more drinks on the same occasion.

Source: Adapted by the NDEWS Coordinating Center from data provided by SAMHSA, NSDUH. Annual averages based on combined 2012 to 2014 NSDUH data.

Youth Risk Behavior Survey (YRBS): Survey of Student Population

Public High School Students Reporting Lifetime (LT) Use of Selected Substances, Georgia^, 2013[1]

Estimated Percent and 95% Confidence Interval



[1]2013: 2015 YRBS data not available for Atlanta or Georgia so 2013 Georgia data are presented.

^Georgia: Data not available for Atlanta so data for State of Georgia provided.

*LT Rx Drug Use: Defined as ever took prescription drugs without a doctor's prescription.

†Statistically significant change: $p<0.05$ by t-test.

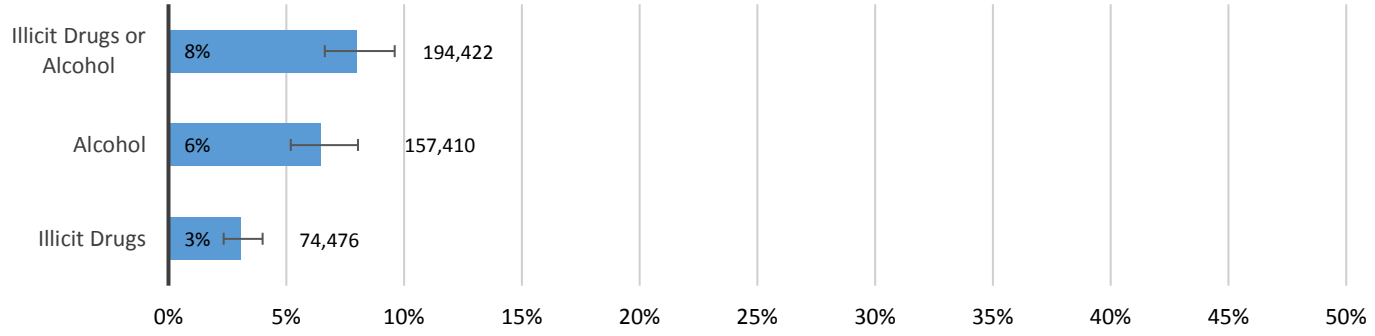
Source: Adapted by the NDEWS Coordinating Center from data provided by CDC, 2001-2013 high school YRBS data.

Substance Use Disorders and Treatment

*National Survey on Drug Use and Health (NSDUH): Survey of U.S. Population**

Substance Use Disorders in Past Year Among Persons 12+ Years, Atlanta Region^, 2012-2014**

Estimated Percent, 95% Confidence Interval, and Estimated Number of Persons***



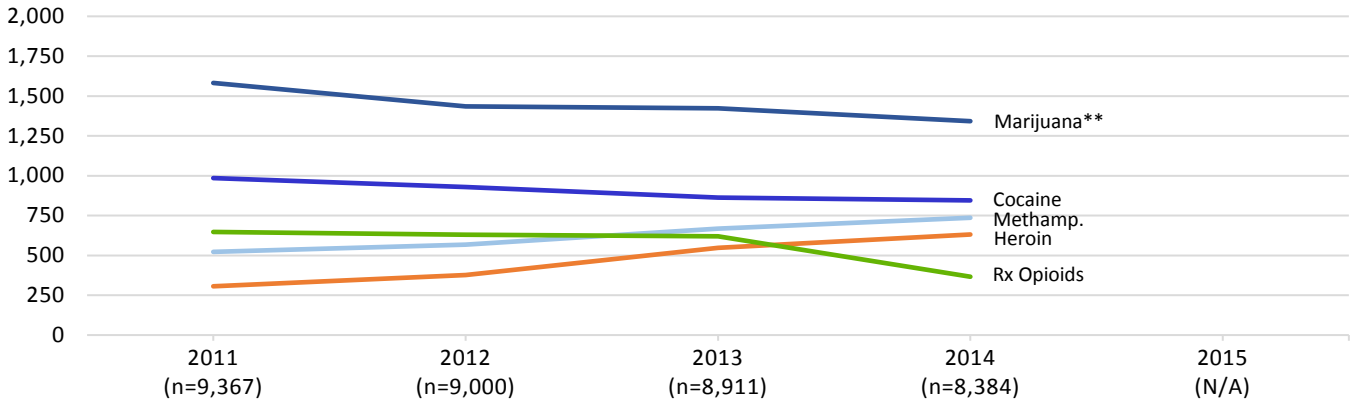
*U.S. Population: U.S. civilian non-institutionalized population. **Substance Use Disorders in Past Year: Persons are classified as having a substance use disorder in the past 12 months based on responses to questions that meet the criteria specified in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. ^Atlanta Region: NSDUH Region 3 (Clayton, DeKalb, Fulton, Gwinnett, Newton, and Rockdale counties). ***Estimated Number: Calculated by multiplying the prevalence rate and the population estimate of persons 12+ years (2,431,810) from Table C1 of the NSDUH Report.

Source: Adapted by the NDEWS Coordinating Center from data provided by SAMHSA, NSDUH. Annual averages based on combined 2012 to 2014 NSDUH data.

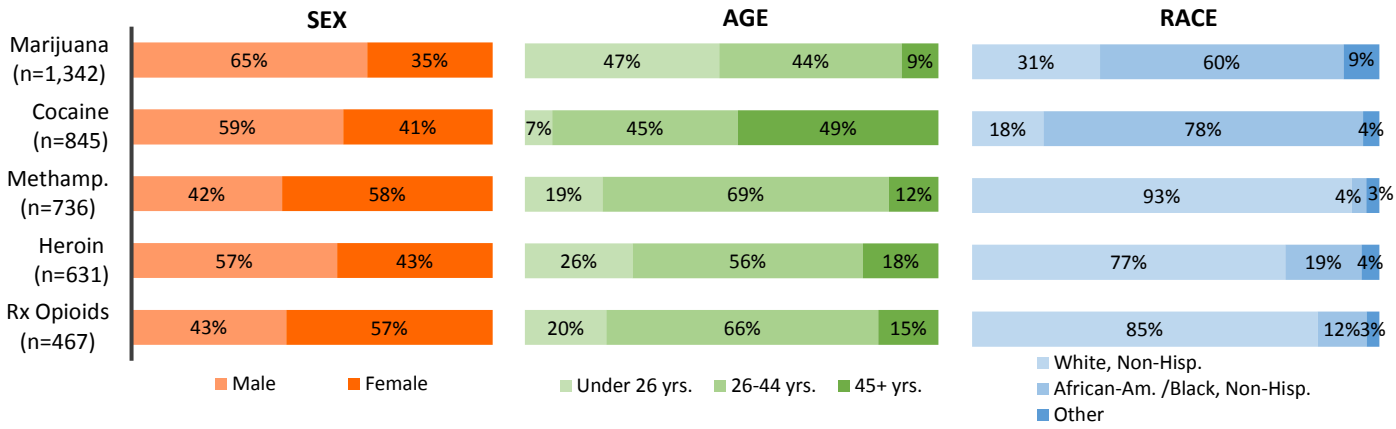
Treatment Admissions Data from Local Sources

Trends in Treatment Admissions*, by Primary Substance of Abuse, Atlanta MSA^, 2011-2015

(n = Number of Treatment Admissions)



Demographic Characteristics of Treatment Admissions*, Atlanta MSA^, 2014



Calendar year data is not available for the Atlanta MSA SCS at this time. 2011-2014 treatment admissions data is from last year's (2015) Snap Shot.

*Treatment Admissions: Includes admissions to publicly-funded programs. ^Atlanta MSA: Includes the following 29 counties; Barrow, Bartow, Butts, Carroll Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnet, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Morgan, Newton, Paulding, Pickents, Pike Rockdale, Spalding, and Walton. **Marijuana: The data does not differentiate between marijuana and synthetic cannabinoids. See *Sentinel Community Site (SCS) Data Tables* and *Overview & Limitations* section for more information regarding the data.

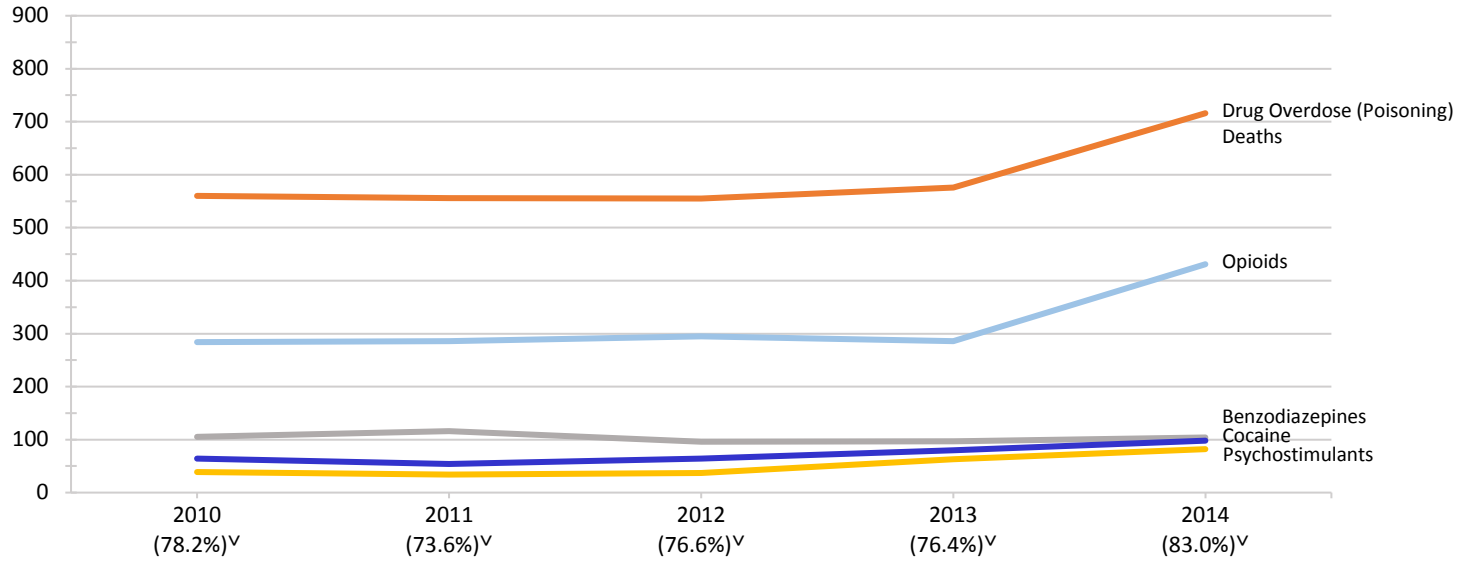
Source: Data provided to the Atlanta Metro NDEWS SCE by the Georgia department of Human Services.

Drug Overdose (Poisoning) Deaths

National Vital Statistics System (NVSS) via CDC WONDER

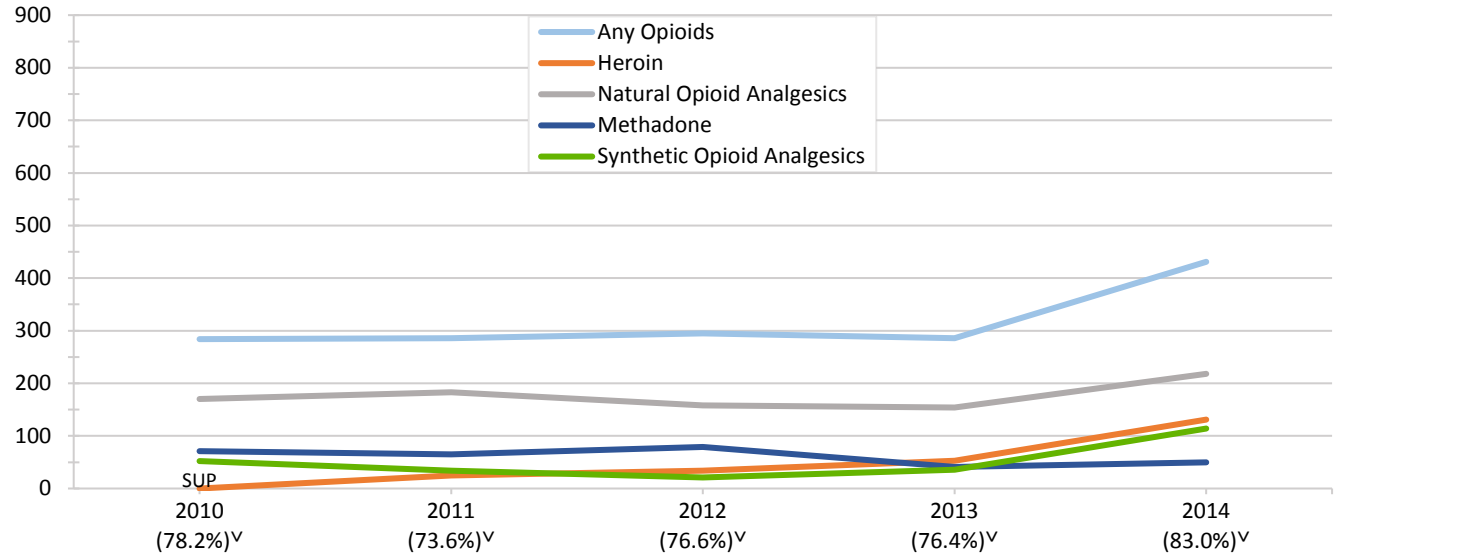
Trends in Drug Overdose (Poisoning) Deaths*, by Drug, Atlanta MSA^, 2010–2014**

(Number of Deaths and Percent of Drug Overdose (Poisoning) Deaths with Drug(s) Specified˅)



Trends in Opioid Overdose (Poisoning) Deaths*, by Opioid, Atlanta MSA^, 2010–2014

(Number of Deaths, by Drug** and Percent of Drug Overdose (Poisoning) Deaths with Drug(s) Specified˅)



*Drug Overdose (Poisoning) Deaths: Defined as deaths with ICD-10 underlying cause-of-death (UCOD) codes: X40-X44, X60-X64, X85, and Y10-Y14. **Drug Overdose (Poisoning) Deaths, by Drug: Drug overdose (poisoning) deaths with ICD-10 multiple cause-of-death (MCOD) T-codes: Benzodiazepines (T42.4); Cocaine (T40.5); Psychostimulants with Abuse Potential [excluding cocaine] (T43.6)—may include amphetamines, caffeine, MDMA, methamphetamine, and/or methylphenidate; Any Opioids (T40.0-T40.4, OR T40.6). Specific opioids are defined: Opium (T40.0); Heroin (T40.1); Natural Opioid Analgesics (T40.2)—may include morphine, codeine, and semi-synthetic opioid analgesics, such as oxycodone, hydrocodone, hydromorphone, and oxymorphone; Methadone (T40.3); Synthetic Opioid Analgesics [excluding methadone] (T40.4)—may include drugs such as tramadol and fentanyl; and Other and Unspecified Narcotics (T40.6). ^Atlanta MSA: Comprised of Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Morgan, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton Counties. ˅Percent of Drug Overdose (Poisoning) Deaths with Drug(s) Specified: The percentage of drug overdose (poisoning) deaths with specific drugs mentioned varies considerably by state/catchment area. This statistic describes the annual percentage of drug overdose (poisoning) deaths that include at least one ICD-10 MCOD code in the range T36-T50.8. SUP=Suppressed: Counts are suppressed for subnational data representing 0–9 deaths. See *Sentinel Community Site (SCS) Data Tables* and/or *Overview & Limitations* for additional information on mortality data.

Source: Adapted by the NDEWS Coordinating Center from data provided by the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, Multiple cause of death 1999-2014, available on the CDC WONDER Online Database, released 2015. Data compiled in the Multiple cause of death 1999-2014 were provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved between December 2015 - May 2016, from http://wonder.cdc.gov/mcd-icd10.html

Law Enforcement Drug Seizures

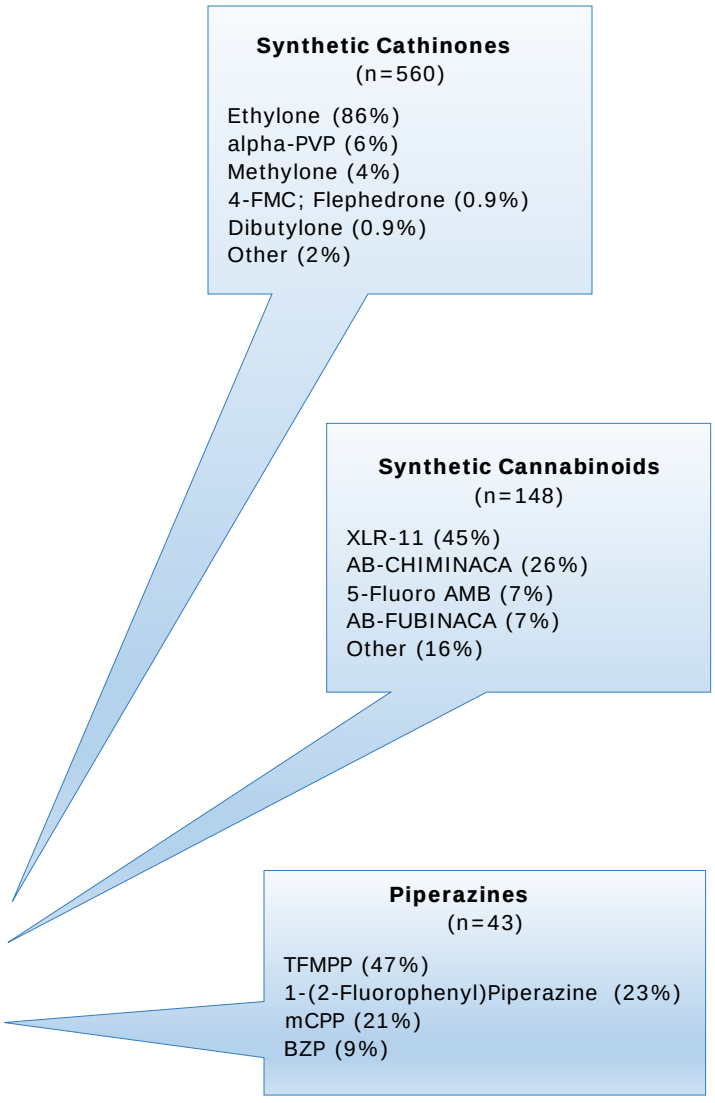
National Forensic Laboratory Information System (NFLIS)

Drug Reports* for Items Seized by Law Enforcement in the Atlanta MSA^ in 2015
DEA National Forensic Laboratory Information System (NFLIS)

Top 10 Drug Reports and Selected Drug Categories

Drug Identified	Number (#)	Percent of Total Drug Reports (%)
TOTAL Drug Reports	**17,815**	**100%**
Top 10 Drug Reports		
Methamphetamine	5,328	29.9%
Cocaine	3,359	18.9%
Unspecified Pharmacuetical Preparation	2,809	15.8%
Heroin	1,112	6.2%
Alprazolam	966	5.4%
Oxycodone	784	4.4%
3,4-methylenedioxyethylcathinone (Ethylone)	483	2.7%
Hydrocodone	471	2.6%
Cannabis	380	2.1%
Amphetamine	224	1.3%
Top 10 Total	**15,916**	**89.3%**
Selected Drugs/Drug Categories		
Opioids	2,863	16.1%
Fentanyl	49	0.3%
Other Fentanyls***	2	<0.1%
Synthetic Cathinones	560	3.1%
Synthetic Cannabinoids	148	0.8%
Piperazines	43	0.2%
Tryptamines	21	0.1%
2C Phenethylamines	18	0.1%

Top 5 Drugs, by Selected Drug Category
(% of Category)**



*Drug Reports: Drug that is identified in law enforcement items, submitted to and analyzed by federal, state, or local forensic labs, and included in the NFLIS database. The NFLIS database allows for the reporting of up to three drugs per item submitted for analysis. The data presented are a total count of first, second, and third listed reports for each selected drug item seized and analyzed.

^Atlanta MSA: Includes the following 29 counties--Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Morgan, Newton, Paulding, Pickents, Pike, Rockdale, Spalding, and Walton.

**Percentages may not sum to 100 due to rounding. ***Other Fentanyls are substances that are structurally related to fentanyl (e.g., acetylfentanyl and butyrl fentanyl). See *Notes About Data Terms* in *Overview and Limitations* section for full list of Other Fentanyls that were reported to NFLIS during the January to December 2015 timeframe. See *Sentinel Community Site (SCS) Data Tables* and *Overview & Limitations* for more information regarding the data.

Source: Adapted by the NDEWS Coordinating Center from data provided by the U.S. Drug Enforcement Administration (DEA), Diversion Control Division, Drug and Chemical Evaluation Section, Data Analysis Unit. Data were retrieved from the NFLIS Data Query System (DQS) on May 18, 2016.

National Drug Early Warning System (NDEWS)
Sentinel Community Site (SCS)
Drug Use Patterns and Trends: SCE Narrative

The *SCE Narrative* is written by the Sentinel Community Epidemiologist (SCE) and provides their interpretation of important findings and trends based on available national data as well as sources specific to their area, such as data from local medical examiners or poison control centers. As a local expert, the SCE is able to provide context to the national and local data presented.

This *SCE Narrative* contains the following sections:

- ◊ SCS Highlights
- ◊ Changes in Legislation
- ◊ Substance Use Patterns and Trends
- ◊ Local Research Highlights (if available)
- ◊ Infectious Diseases Related to Substance Use (if available)

The *SCE Narratives* for each of the 12 Sentinel Community Sites and detailed information about NDEWS can be found on the NDEWS website at www.ndews.org.

National Drug Early Warning System (NDEWS)
Atlanta Metro Sentinel Community Site (SCS)
Drug Use Patterns and Trends, 2016: SCE Narrative

Brian J. Dew, Ph.D., and Ned Golubovic, M.S.
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Highlights

- Numerous indicators suggest that **alprazolam** is the primary **benzodiazepine** abused in metropolitan Atlanta and throughout Georgia. It is the benzodiazepine most frequently detected in Georgia Poison Control calls, Georgia Medical Examiner results, Fulton County Medical Examiner results, and ethnographic reports with users.

- Conversations with local users indicate an increase in the supply of, and demand for**, liquid alprazolam**. Although "super pills" have caused deaths in Florida and have been confiscated in Kentucky and Tennessee in 2016, this combination of alprazolam and fentanyl has not been reported in the Atlanta metropolitan statistical area (MSA).

- Compared with the previous two years, the availability of, and purity and pricing for, **cocaine hydrochloride** and **crack/cocaine** in Atlanta remained stable in 2015. The majority of cocaine in Atlanta continues to be Colombian, and the City remains a primary hub for distribution along the East Coast.

- Although the supply of and demand for **cocaine** remains stable, deaths related to the drug's use increased more than 33% both in Atlanta and throughout Georgia in 2015 versus deaths in 2013.

- Local ethnographic reports suggest an increased demand for higher quality **marijuana** and **tetrahydrocannabinol (THC)**-based liquids, with the latter being increasingly smoked in vapor pens and e-cigarettes.

- Multiple data sources indicate increased supply of **methamphetamine** in Atlanta with elevated average purity levels of between 85% and 90%. Increased purity levels of methamphetamine have led to more deaths both in Atlanta and throughout Georgia.

- Two large seizures of methamphetamine totaling more than $18 million in street value were made in the Atlanta suburbs in 2015. Law enforcement officials confiscated more than 65 gallons of **liquid methamphetamine** at these two "conversion labs."

- The types and amounts of **synthetic cathinones** available in Atlanta continue to change with the influx of ethylone in 2015. In South Georgia, law enforcement and public health officials indicate an increasing amount of **alpha-PVP (Flakka)** entering the State via Florida.

- **Heroin** use in Atlanta continues to increase. Calls into Georgia Poison Control have doubled in the past three years, and multiple death-related data (drug poisoning, Georgia Medical Examiner, and Fulton County Medical Examiner) suggest over a 100% surge in heroin-related fatalities in 2015 compared with 2013.

- From conversations with local HIDTA and law enforcement officials, Atlanta is increasingly being considered a primary distribution center for **heroin**.

Changes in Legislation

In April 2014, a bill authorizing Georgia practitioners, including medical professionals and pharmacists, to begin issuing prescriptions for opioid antagonists (naloxone) was passed. Under this law, opioid antagonist prescriptions do not have to be issued to a particular person. Rather, practitioners are allowed to prescribe an opioid antagonist in the name of an organization, clinic, or law enforcement agency. For example, practitioners can prescribe naloxone to harm reduction organizations, pain management clinics, and police and fire departments. Additionally, practitioners can now prescribe these medications to family members, friends, or other persons in a position to assist a person at risk of experiencing an opioid-related overdose.

On April 2015, the Haleigh's Hope Act, a bill regulating medical marijuana use in the state of Georgia, went into effect. This law permits the therapeutic and treatment application of cannabis and its derivatives. Such therapeutic and treatment applications include consumption of cannabis as liquid, pill, injection, or other delivery system that does not include smoking. Although, this law decriminalized possession of cannabis for certain qualified individuals, it did not legalize the production or sales of marijuana in the state of Georgia. To qualify for exemption from prosecution for possession of marijuana in Georgia, the patient must suffer from one of these qualifying illnesses: cancer, amyotrophic lateral sclerosis (ALS), seizure disorders, multiple sclerosis, Crohn's disease, mitochondrial disease, Parkinson's disease, or sickle cell disease.

During the 2016 legislative session, a medical marijuana expansion bill was introduced. This legislation intended to legalize in-state medical marijuana cultivation for up to five licensed producers. This bill passed the Georgia House of Representatives and was moved to the Senate with slight modification. Nevertheless, the bill was held by the Senate Health and Human Services Committee and did not get a hearing.

Substance Use Patterns and Trends

BENZODIAZEPINES

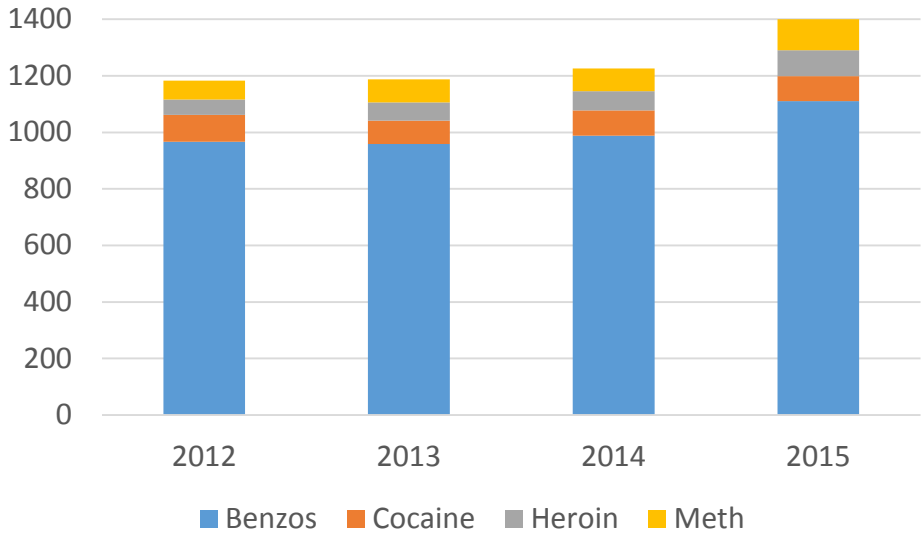
- Numerous indicators suggest that alprazolam is the primary benzodiazepine abused in metropolitan Atlanta and throughout Georgia. It is the benzodiazepine most frequently detected in Georgia Poison Control calls, Georgia Medical Examiner results, Fulton County Medical Examiner results, and ethnographic reports with users.

- Conversations with local users indicate an increase in the supply of, and demand for, liquid alprazolam. Although "super pills" have caused deaths in Florida and have been confiscated in

Kentucky and Tennessee in 2016, this combination of alprazolam and fentanyl has not been reported in the Atlanta metropolitan statistical area (MSA).

The supply, use of, and demand for benzodiazepines remained mostly stable in metropolitan Atlanta in 2015. Alprazolam continued to be the preferred benzodiazepine, followed by diazepam, and lorazepam. Statewide mortality data from 2007 to 2011 indicated significant increases in deaths with benzodiazepines on board at time of death. Nevertheless, since 2011, this prevalence has stabilized. Similar trends were also found among benzodiazepine-related deaths in Fulton County during the past four years. As indicated in Exhibit 1, the number of benzodiazepine-related drug poisoning calls in Atlanta during 2015 increased nearly 10% after four years of stable trends.

Exhibit 1. Drug Poisoning Calls in Metropolitan Atlanta by Select Drug (2012-2015)



Source: Georgia Poison Control Call Volume Database

Results from ethnographic reporting indicated a growing supply of, and preference for, liquid alprazolam, which could be purchased for between $2 and $3 per milliliter in metropolitan Atlanta. Retail pricing for 1-milligram “blue footballs” (nickname commonly used to describe a 1-mL dose of alprazolam in pill form) in Atlanta remained consistent at between $2 and $4, whereas 2-mg alprazolam bars cost between $5 and $10. Although “super pills,” consisting of both alprazolam and fentanyl, were found in Florida, Kentucky, Tennessee, and Ohio in late 2015 and early 2016, law enforcement officials have not discovered this combination in Atlanta.

Atlanta has witnessed a recent increase in public attention related to illicit use of benzodiazepines. In March 2016, a three-year investigation culminated in the arrest and firing of two pharmacists and three technicians at a prominent, university-affiliated hospital located in Midtown Atlanta. These arrests involved illegally ordering large amounts of alprazolam and illegally selling the product on Atlanta’s streets.

COCAINE

- Compared with the previous two years, the availability of, and purity and pricing for, cocaine hydrochloride and crack/cocaine in Atlanta remained stable in 2015. The majority of cocaine in Atlanta continues to be Colombian, and the City remains a primary hub for distribution along the East Coast.

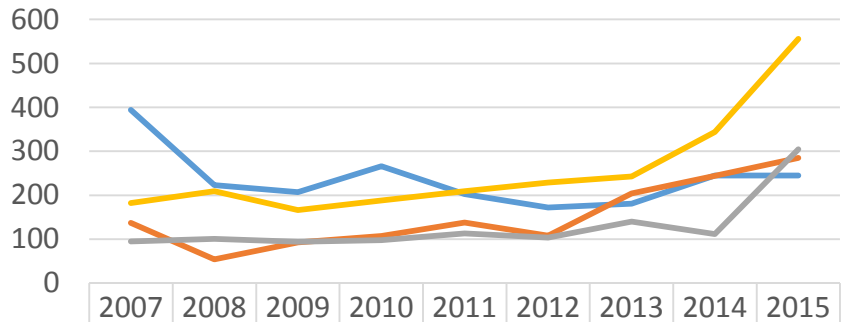
- Although the supply of and demand for cocaine remains stable, deaths related to the drug's use increased more than 33% both in Atlanta and throughout Georgia in 2015 versus deaths in 2013.

Although Atlanta has historically been known for its high use of both cocaine hydrochloride and crack cocaine, multiple data sources (e.g., substance abuse public treatment admissions, Georgia Medical Examiner's Office, and Georgia Poison Control Center) indicated a decrease in the drug's use from 2000 to 2013. Nevertheless, from 2013 to 2015, multiple sources indicated a stabilization at these lower levels. Cocaine-related telephone calls to the Georgia Poison Control Center for metropolitan Atlanta and cocaine law enforcement seizures were stable for the past three years. Although the use and price (retail and wholesale levels) of cocaine remained consistent in 2015, there were mixed reports as to potential changes in purity levels and supply. The DEA confirmed local cocaine purity levels to be stable at between 40% and 50%, but ethnographic results among local users suggest an increase in 2015. The cocaine in Atlanta continues to be predominantly Columbian, although there have been increasing amounts of higher grade Peruvian cocaine transported into Atlanta.

In 2015, local High Intensity Drug Trafficking Administration (HIDTA) officials found an inconsistent supply of cocaine in the City, while reporting that dealers who could not obtain cocaine began selling methamphetamine. Local HIDTA officials report early 2016 retail prices for crack cocaine to be between $20 and $40 for a rock and $80 and $100 for a gram of cocaine hydrochloride. Whole prices for cocaine in the first three months of 2016 averaged between $32,000 and $36,000 per kilogram. These prices reflect a stable market for cocaine prices over the past two years.

Although cocaine use has stabilized, the number of deaths associated with cocaine use has increased in metropolitan Atlanta and Georgia. Since 2012, the number of cocaine-related drug poisoning deaths in Atlanta rose from 64 to 98, whereas the number of statewide deaths with cocaine found on board, as indicated in Exhibit 2, increased more than 42% from 172 to 245.

Exhibit 2. Georgia's Number of Decedents with Select Drugs on Board at Time of Death (2007-2015)



	2007	2008	2009	2010	2011	2012	2013	2014	2015
Cocaine	394	223	207	266	203	172	181	245	245
Methamphetamine	137	54	93	107	138	108	204	244	285
Fentanyl	95	101	94	98	113	104	140	112	305
Heroin/Morphine	182	209	166	188	209	229	243	344	556

Source: Georgia Medical Examiner's Office

Results from the Fulton County Medical Examiner's Office for 2015 indicate that nearly 20% of all decedents tested positive for cocaine, with 66% being African American and 80% male. The primary reason for the increase in deaths is largely a result of the increase in local polysubstance use, especially heroin and fentanyl.

Using patterns and preferred routes of administration related to local cocaine use remained consistent in 2015. Crack cocaine comprised nearly two thirds of all cocaine users in metropolitan Atlanta, and its users continued to be predominantly African American and older than 35 years of age. Users of cocaine hydrochloride tended to be White, young, affluent, and residing in suburban counties.

MARIJUANA

- Local ethnographic reports suggest an increased demand for higher quality marijuana and tetrahydrocannabinol (THC)-based liquids, with the latter being increasingly smoked in vapor pens and e-cigarettes.

Marijuana remained the most widely available and commonly used illicit drug in both metropolitan Atlanta and Georgia. Availability remained high, whereas demand for marijuana containing elevated THC increased. In addition, recent results from ethnographic reporting and discussions with local Drug Enforcement Administration (DEA) officials indicated a sharp increase in demand for liquid THC that could be consumed via e-cigarette and/or vapor technologies. Liquid forms of THC were purchased in local smoking-oriented stores (e.g., head shops), via the Internet, and bought in states like Colorado and Washington. Prices for liquid THC in 2015 ranged from $15 to $35 per cartridge, and users reported that supply was increasing in metropolitan Atlanta.

Atlanta continued to serve as a primary distribution center for marijuana. The majority of marijuana available in Atlanta continued to come from Mexico, with smaller amounts originating in Canada and the

Caribbean. Local HIDTA officials, along with results from local ethnographic reporting, noted increases in THC levels found in Mexican-produced marijuana in Atlanta. Law enforcement officials suggested that this increase in purity was an effort on behalf of Mexican growers and distributors to compete with higher quality domestic marijuana grown in Colorado, Washington, and California.

Results from the Georgia Poison Control center indicated a recent uptick in marijuana-related calls, especially at the state level. Marijuana-related calls for metropolitan Atlanta increased from 51 in 2012, 58 in 2013, 61 in 2014 and 85 in 2015, whereas statewide calls increased from 87 to 140 during this same time period.

METHAMPHETAMINE

- Multiple data sources indicate increased supply of methamphetamine in Atlanta with elevated average purity levels of between 85% and 90%. Increased purity levels of methamphetamine have led to more deaths both in Atlanta and throughout Georgia.

- Two large seizures of methamphetamine totaling more than $18 million in street value were made in the Atlanta suburbs in 2015. Law enforcement officials confiscated more than 65 gallons of liquid methamphetamine at these two "conversion labs."

Atlanta has traditionally had the highest rates of methamphetamine use than any other major U.S. city east of the Mississippi River. In 2015, death-related data and Georgia Poison Control Center call results suggest that methamphetamine use in Atlanta continued to increase, supply was up, and demand continued to be strong. Most importantly, the purity levels of crystal methamphetamine reached an average of nearly 90%. Increasingly, conversion of methamphetamine from a liquid to a crystallized form was conducted in the City. In fact, two of Atlanta's largest methamphetamine-related raids on record took place in 2015 with nearly $18 million worth of the drug being seized. During these two busts, law enforcement officers confiscated 65 gallons of liquid methamphetamine, preventing nearly 300 pounds of crystal methamphetamine to be distributed. The Atlanta Field Division of DEA classified local methamphetamine availability as high compared with stable in 2013. The number of methamphetamine reports among drug items seized and analyzed by NFLIS in 2015 continued a multiple-year increase in 2015 (*n* = 5,328), compared with 5,104 in 2014, 4,068 in 2013, and 3,339 in 2012.

The number of poisoning deaths related to psychostimulants with abuse potential, which includes methamphetamine, doubled from 2010 to 2014 (39 vs. 82), and the frequency of Georgia deaths where methamphetamine was on board increased from 193 to 263 in the last three years. In Fulton County, more than 20 decedents were identified as involving methamphetamine in 2015. Although 90% of these cases were White and male, greater than 70% of deaths also involved the use of heroin. The number of methamphetamine-related calls to the Georgia Poison Control Center also reflected a large increase from 2014 to 2015. Calls related to methamphetamine within the metropolitan Atlanta area increased from 80 in 2014 to 111 in 2015, whereas statewide calls for methamphetamine jumped from 210 to 278.

Pricing for methamphetamine in Atlanta continued to decrease in 2015 and for the first three months of 2016. During this time period, local HIDTA officials report that a gram of crystal methamphetamine could be purchased for $65 per gram and an ounce of the drug could be bought for between $350 and

$1,500 with an average cost of $550. Wholesale prices of methamphetamine fluctuated between $10,000 and $16,000. These retail and wholesale values indicate a three-year downward trend in price in the metropolitan Atlanta area.

Although ethnographic reports and local HIDTA officials report increasing use of the drug in Atlanta's African American community, local users of methamphetamine continue to be mostly White. Historically, separate drug distribution systems have existed between methamphetamine and cocaine at the retail level. Therefore, it was uncommon for street dealers to sell both types of stimulants. Conversations with law enforcement officials and results from local ethnographic reporting suggest that greater numbers of retail distributors are now selling both methamphetamine and cocaine.

NEW PYSCHOACTIVE SUBSTANCES (OTHER THAN OPIOIDS)

- The types and amounts of synthetic cathinones available in Atlanta continue to change with the influx of ethylone in 2015. In South Georgia, law enforcement and public health officials indicate an increasing amount of alpha-PVP (flakka) entering the State via Florida.

Synthetic Cathinones

In this section, local epidemiological results for synthetic cannabinoids, cathinones, and MDMA will be presented. Reports from street-level ethnographers suggest that use of both substances remains popular, especially among adults younger than 30 years of age. Synthetic cannabinoids, typically sold in local head shops, convenient stores, and gas stations, were available under several product names identified as "not for human consumption." Supply and cost of synthetic cannabinoids remained stable in the metropolitan area. Nevertheless, ethnographic reports suggested these drugs are increasingly being used via e-cigarettes and other vaporization pens to avoid detection. Poison Control Center call data for counties representing the Atlanta MSA indicated an increase in drug exposure cases related to synthetic cannabinoids.

Significant changes among the number of metropolitan Atlanta-based drug seizures of cathinones have occurred between 2013 and 2015. The number of seized methylone items as identified by NFLIS, after doubling from 2012 to 2013, decreased from 695 reports in 2013, to 183 reports in 2014, to 22 reports in 2015. Although a significant three-year decrease was found in methylone, just the opposite was reported among seizures of ethylone. In 2013, only 1 report was found for ethylone compared with 359 reports in 2014 and 483 reports in 2015. Ethnographic reporting indicates that retail drug dealers are marketing mollies as pure MDMA, but in reality, mollies are predominantly ethylone.

Drug indicators for cathinones must be interpreted with caution as a result of uncertain classifications of data related to the drug, Molly. Results from conversations with law enforcement officers and street-level ethnographic efforts suggest that Molly is marketed as "pure ecstasy" or "pure MDMA." Nevertheless, results from the Georgia Crime Lab suggest that a low percentage of pills sold as Molly in metropolitan Atlanta contain MDMA. Rather, the primary substance found in Molly is a cathinone product, specifically ethylone and methylone. Although methylone was frequently found in Molly in 2013, it was mostly replaced in Molly by ethylone in 2014 and 2015. The Georgia Poison Control Center, while identifying a drug exposure call as "Molly," does not differentiate based on the chemical

composition of the drug. As a result, it is unknown if the exposure call relates to a drug that consists of MDMA, a cathinone, or a mixture of these substances.

Although not prevalent in Atlanta, HIDTA and other law enforcement officials suggest that Alpha PVP has crossed over into South Georgia from Florida. Also known as flakka or gravel, the use of this drug has caused multiple psychotic episodes in users in Valdosta, Georgia, and neighboring towns. Yet, there have no arrests of persons under the influence of Alpha PVP nor confiscation of the drug in metropolitan Atlanta.

OPIOIDS

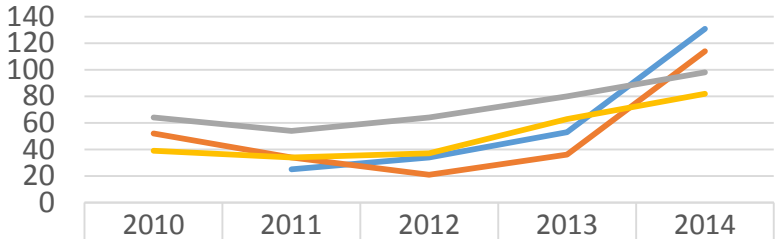
- Heroin use in Atlanta continues to increase. Calls into Georgia Poison Control have doubled in the past three years, and multiple death-related data (drug poisoning, Georgia Medical Examiner, and Fulton County Medical Examiner) suggest over a 100% surge in heroin-related fatalities in 2015 compared with 2013.

- From conversations with local HIDTA and law enforcement officials, Atlanta is increasingly being considered a primary distribution center for heroin.

Heroin

The increase in heroin use appeared in all drug indicators for 2015, and Atlanta has been identified by local DEA officials as an emerging primary distribution center for the drug. Traditionally known for having low indicators for heroin, Atlanta witnessed elevated use of the drug starting in 2013. Drug poisoning deaths, as cited by the CDC Wonder Online Database, increased from 25 in 2011, to 34 in 2012, 53 in 2013, and 131 in 2014.

Exhibit 3. Drug Poisoning Deaths in Metropolitan Atlanta Related to Select Drugs (2010-2014)



	2010	2011	2012	2013	2014
Heroin		25	34	53	131
Synthetic Opioid Analgesics	52	34	21	36	114
Cocaine	64	54	64	80	98
Psychostimulants with Abuse Potential	39	34	37	63	82

Source: Adapted by the NDEWS Coordinating Center from data taken from the Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple causes of death 1999–2014, available on the CDC Wonder Online Database, released 2015.

Heroin-related cases from the Georgia Medical Examiner's Office more than doubled from 2013 to 2015 (243 vs. 556) indicating an increase not only in metropolitan Atlanta but in statewide data as well. In 2015, more than 34% of all decedents tested positive for heroin and a third of this total reported positive results for fentanyl. Calls from the Georgia Poison Control for metropolitan Atlanta doubled from 54 in 2012 to 91 in 2015, and statewide, the number of calls increased from 60 to 123 during this same period. Heroin-related drug reports for items seized by law enforcement in metro Atlanta in 2015 also indicated an increase in use compared with previous years. Greater than 6.2% (*n* = 1,112) of heroin-related reports were identified in 2015, compared with 5.6% in 2014, 5.0% in 2013, and 2.9% in 2012.

The supply of heroin has increased significantly because of large shipments from South America and Mexico coming directly into Atlanta. New and continued use of heroin among young adults (18–28 years old) in mostly White, suburban areas have largely fueled the increased demand for the drug. For years prior to 2014, the sale of heroin had been conducted in open air markets in a part of the inner City named "The Bluff." When substance abuse treatment admissions for heroin were less than 3.5% annually, the exchange of the drug, even among those persons who lived in the suburbs and other parts of the City, largely took place in this neighborhood. Users would enter The Bluff by car or public transportation, purchase their heroin, and return home. In 2014, retail distribution of heroin, as a result of increased law enforcement presence in the Bluff and of increased demand among more affluent young adults, was conducted more extensively throughout the City, especially in less urban, White suburbs in Northwest and Northeast Atlanta.

The increased presence of fentanyl appeared in multiple data indicators as well as a drug that is frequently used in combination with other opiates (e.g., heroin) and stimulants (e.g., cocaine). Among decedents reported by the Georgia Medical Examiner's Office, there was nearly a tripling of cases that tested positive for fentanyl from 2014 to 2015. In Fulton County alone, nearly 30% of all deaths tested positive for the drug in 2015. Local HIDTA officials have corroborated local ethnographic reports that Atlanta's heroin supply is being cut with fentanyl. Nevertheless, the increase in heroin-related deaths could also be caused by high-purity batches, young and inexperienced users of the drug, especially if they are injecting, and increasing amounts of other adulterants.

Infectious Diseases Related to Substance Use

According to the Georgia Department of Public Health reports, the number of new HIV diagnosis in the Atlanta MSA increased slightly from 2013 to 2014. In 2013, there were 1,665 new HIV infections, whereas in 2014, the Georgia Department of Public Health recorded 1,764 new infections. Males accounted for the majority of new infections in 2014, although the percentage of new infections among females increased from 16% to 19% from 2013 to 2014.

Male-to-male sexual contact (MSM) remained the most prevalent transmission category accounting for 61% of total transmissions (1,083). Nevertheless, these results for MSM sexual contact reflect a 5% decrease from 2013. Injection drug use (IDU) accounted for 3% of new transmissions (55) in 2014, which

was identical to the rate reported in the previous year, and MSM/IDU accounted for additional 2% (29), indicating no change in percentage of prevalence compared with 2013.

Among persons diagnosed in 2014, African American/Black accounted for 64% (1,131), Whites accounted for 13% (224), and Hispanic/Latino made up 6% (107) of new infections. In 2014, 54 new acute cased of hepatitis B were recorded with an estimated number of 1,270 chronic cases. In regard to hepatitis C, 19 new acute cases were reported with an estimated number of 3,124 chronic cases.

Data Sources

Data for this report were drawn from the following sources:

Drug poisoning death data were from the NDEWS Coordinating Center from data taken from the Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple causes of death 1999–2014, available on the CDC Wonder Online Database, released 2015.

Forensic drug analysis data came from the National Forensic Laboratory Information System (NFLIS) and represent evidence seized in suspected drug cases throughout metropolitan Atlanta that were tested by the GBI Forensic Laboratory from 2011 to 2015. NFLIS methodology allows for the accounting of up to three drugs for each item submitted for analysis. The data presented are a combined count, including primary, secondary, and tertiary reports for each drug. Data for 2015 are preliminary and subject to change.

Newly diagnosed and ongoing HIV/AIDS cases in Metro Atlanta and Georgia were provided by the Georgia Department of Human Resources' Public Health Department. Results from 2013 and 2014 were compared in this report.

Law enforcement reports of local drug use trends, prices, and availability were obtained from officials at the Atlanta High Intensity Drug Trafficking Area (HIDTA). Annual meetings with HIDTA staff are supplemented with multiple telephone consultations throughout the year. Drug use trends, prices, and supply have been reported from 2010-2015.

Fulton County decedent data were provided by the Fulton County Medical Examiner's Office. Data represent the number of postmortem specimens that tested positive for a particular drug and were collected from fiscal years (FYs) 2007 through 2015.

Public substance abuse treatment admissions have been provided by the Georgia Department of Human Resources from 1995 to 2014. Due to a recent changeover in reporting systems, no data were included in this report for 2015. Historical trends for select drugs prior to 2015 were included in this report.

State drug-related mortality data were obtained from the Georgia Medical Examiner's Office. Data represent the number of postmortem specimens that tested positive for a particular drug and were collected from fiscal years (FYs) 2007 through 2015.

Poison exposure call data were extracted using general terms from the Georgia Poison Control Center and represent the count of drug exposure calls by drug from 2006 to 2015.

Qualitative information and purity data are a result of street-level ethnographic reporting with drug users and law enforcement officials in the metropolitan Atlanta area. Due to the SCE's research efforts over the past 13 years, relationships with persons involved with local illicit drug distribution have been maintained that allow for the corroboration of information with other data sources.

For additional information about the drugs and drug use patterns discussed in this report, please contact Brian J. Dew, Ph.D., Associate Professor and Chair, Department of Counseling and Psychological Services, Georgia State University, P.O. Box 3980, Atlanta, GA 30302, Phone: 404–413–8168, E-mail: bdew@gsu.edu.

National Drug Early Warning System (NDEWS)
Sentinel Community Site (SCS)
Drug Use Patterns and Trends: SCS Data Tables

The *SCS Data Tables* are prepared by NDEWS Coordinating Center staff and include information on demographic and socioeconomic characteristics of the population, drug use, substance use disorders and treatment, drug poisoning deaths, and drug seizures for the Sentinel Community Site. The *SCS Data Tables* attempt to harmonize data available for each of the 12 sites by presenting standardized information from local treatment admissions and five national data sources:

- ◊ American Community Survey;
- ◊ National Survey on Drug Use and Health;
- ◊ Youth Risk Behavior Survey;
- ◊ SCE-provided local treatment admissions data;
- ◊ National Vital Statistics System mortality data queried from CDC WONDER; and
- ◊ National Forensic Laboratory Information System.

The *SCS Data Tables* for each of the 12 Sentinel Community Sites and detailed information about NDEWS can be found on the NDEWS website at www.ndews.org.

Table 1: Demographic and Socioeconomic Characteristics
Atlanta Metropolitan Statistical Area (MSA)^, Georgia
2010–2014 ACS 5-Year Estimates

	Estimate	Margin of Error
Total Population (#)	**5,455,053**	**
Age		
18 years and over (%)	74.1%	+/-0.1
21 years and over (%)	70.0%	+/-0.1
65 years and over (%)	9.9%	+/-0.1
Median Age	35.4	
Race (%)		
White, Not Hisp.	49.9%	+/-0.1
Black/African American, Not Hisp.	32.3%	+/-0.1
Hispanic/Latino (of any race)	10.4%	**
American Indian/Alaska Native	0.2%	+/-0.1
Asian	5.1%	+/-0.1
Native Hawaiian/Pacific Islander	0.0%	+/-0.1
Some Other Race	0.2%	+/-0.1
Two or More Races	1.8%	+/-0.1
Sex (%)		
Male	48.6%	+/-0.1
Female	51.4%	+/-0.1
Educational Attainment (*Among Population Aged 25+ Years*) (%)		
High School Graduate or Higher	87.9%	+/-0.2
Bachelor's Degree or Higher	35.3%	+/-0.3
Unemployment (*Among Civilian Labor Force Population Aged 16+ Years*) (%)		
Percent Unemployed	10.8%	+/-0.2
Income ($)		
Median Household Income (in 2014 inflation-adjusted dollars)	$56,618	+/-325
Health Insurance Coverage (*Among Civilian Noninstitutionalized Population*) (%)		
No Health Insurance Coverage	18.1%	+/-0.2
Poverty (%)		
All People Whose Income in Past Year Is Below Poverty Level	15.7%	+/-0.3

NOTES:
Margin of Error: Can be interpreted roughly as providing a 90% probability that the interval defined by the estimate minus the margin of error and the estimate plus the margin of error (the lower and upper confidence bounds) contains the true value.
^Atlanta MSA: In 2013, the U.S. Office of Management and Budget (OMB) revised MSA delineations across the country; the new Atlanta-Sandy Springs-Roswell, Georgia MSA comprises 29 counties (previously, 28 counties). The 29 counties are Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Morgan, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton. The principal cities of the Atanta MSA include Atlanta, Sandy Springs, Roswell, Alpharetta, and Marietta.
**The estimate is controlled; a statistical test for sampling variability is not appropriate.

SOURCE: Adapted by the NDEWS Coordinating Center from data provided by the U.S. Census Bureau, 2010–2014 American Community Survey (ACS) 5-Year Estimates.

Table 2a: Self-Reported Substance Use Behaviors
Among Persons 12+ Years in Atlanta Region^, 2012–2014
Estimated Percent, 95% Confidence Interval, and Estimated Number*
Annual Averages Based on Combined 2012 to 2014 NSDUH Data

Substance Use Behaviors	Substate Region: Atlanta^	
	Estimated % (95% CI)*	Estimated #*
Used in Past Month		
Alcohol	49.91 (45.72 – 54.10)	1,213,751
Binge Alcohol**	19.50 (16.89 – 22.40)	474,135
Marijuana	7.95 (6.34 – 9.93)	193,391
Use of Illicit Drug Other Than Marijuana	3.87 (2.88 – 5.20)	94,212
Used in Past Year		
Cocaine	2.15 (1.36 – 3.37)	52,302
Nonmedical Use of Pain Relievers	4.18 (3.25 – 5.37)	101,747
Substance Use Disorders in Past Year* **		
Illicit Drugs or Alcohol	**7.99 (6.64 – 9.60)**	**194,422**
Alcohol	6.47 (5.19 – 8.04)	157,410
Illicit Drugs	3.06 (2.34 – 4.00)	74,476

NOTES:
^Atlanta Region: NSDUH Substate Region 3, which comprises Clayton, DeKalb, Fulton, Gwinnett, Newton, and Rockdale counties.
***Estimated %:** Substate estimates are based on a small area estimation methodology in which 2012–2014 substate level NSDUH data are combined with county and census block group/tract-level data from the state; **95% Confidence Interval (CI):** Provides a measure of the accuracy of the estimate. It defines the range within which the true value can be expected to fall 95 percent of the time; **Estimated #:** The estimated number of persons aged 12 or older who used the specified drug or are dependent/abuse a substance was calculated by multiplying the prevalence rate and the population estimate of persons 12+ years (2,431,810) from Table C1 of the NSDUH report. The population estimate is the simple average of the 2012, 2013, and 2014 population counts for persons aged 12 or older.
****Binge Alcohol:** Defined as drinking 5 or more drinks on the same occasion on at least 1 day in the past 30 days.
*****Substance Use Disorders in Past Year:** Persons are classified as having a substance use disorder in the past 12 months based on reponses to questions that meet the criteria specified in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* .

SOURCE: Adapted by the NDEWS Coordinating Center from data provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), Substate Estimates of Substance Use and Mental Illness from the 2012–2014 National Surveys on Drug Use and Health. Available at: http://www.samhsa.gov/data/population-data-nsduh/reports?tab=38

Table 2b: Self-Reported Substance Use Behaviors Among Persons in Atlanta Region^, by Age Group, 2012–2014
Estimated Percent and 95% Confidence Interval (CI)*, Annual Averages Based on Combined 2012 to 2014 NSDUH Data

Substance Use Behaviors	Substate Region: Atlanta^					
	12–17		18–25		26+	
	Estimated Percent (95% CI)*		Estimated Percent (95% CI)*		Estimated Percent (95% CI)*	
Used in Past Month						
Binge Alcohol**	4.90	(3.65 – 6.57)	28.47	(24.13 – 33.25)	19.88	(16.74 – 23.45)
Marijuana	6.78	(5.09 – 8.97)	19.82	(16.09 – 24.17)	6.07	(4.37 – 8.36)
Use of Illicit Drug Other Than Marijuana	4.44	(3.11 – 6.30)	6.04	(4.29 – 8.43)	3.43	(2.33 – 5.02)
Used in Past Year						
Cocaine	0.49	(0.25 – 0.96)	3.67	(2.30 – 5.81)	2.11	(1.22 – 3.61)
Nonmedical Use of Pain Relievers	5.14	(3.70 – 7.11)	7.72	(5.92 – 10.02)	3.45	(2.44 – 4.86)
Substance Use Disorder in Past Year***						
Illicit Drugs or Alcohol	5.03	(3.67 – 6.85)	15.88	(12.74 – 19.61)	7.03	(5.54 – 8.89)
Alcohol	2.02	(1.38 – 2.93)	11.55	(8.99 – 14.74)	6.19	(4.74 – 8.04)
Illicit Drugs	3.96	(2.80 – 5.57)	7.63	(5.64 – 10.24)	2.16	(1.45 – 3.21)

NOTES:
^Atlanta Region: NSDUH Substate Region 3, which comprises Clayton, DeKalb, Fulton, Gwinnett, Newton, and Rockdale counties.
***Estimated %:** Substate estimates are based on a small area estimation methodology in which 2012–2014 substate level NSDUH data are combined with county and census block group/tract-level data from the state; **95% Confidence Interval (CI):** Provides a measure of the accuracy of the estimate. It defines the range within which the true value can be expected to fall 95 percent of the time.
****Binge Alcohol:** Defined as drinking 5 or more drinks on the same occasion on at least 1 day in the past 30 days.
*****Substance Use Disorders in Past Year:** Persons are classified as having a substance use disorder in the past 12 months based on responses to questions that meet the criteria specified in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* .

SOURCE: Adapted by the NDEWS Coordinating Center from data provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), Substate Estimates of Substance Use and Mental Illness from the 2012–2014 National Surveys on Drug Use and Health. Available at: http://www.samhsa.gov/data/population-data-nsduh/reports?tab=38

Table 3: Self-Reported Substance Use Behaviors Among *Georgia* ^ Public High School Students, 2013[1]

Estimated Percent and 95% Confidence Interval (CI)

2011 and 2013 YRBS*

Substance Use Behaviors	2013 vs 2011			2013 by Sex			2013 by Race		
	2013	2011	p-value	Male	Female	p-value	White	Black	Hispanic
	Percent			Percent			Percent		
	Estimate (95% CI)	Estimate (95% CI)		Estimate (95% CI)	Estimate (95% CI)		Estimate (95% CI)	Estimate (95% CI)	Estimate (95% CI)
Used in Past Month									
Alcohol	27.9 (23.8 - 32.3)	34.6 (30.7 - 38.7)	**0.02**	25.0 (20.1 - 30.7)	30.3 (25.7 - 35.4)	0.06	31.9 (25.4 - 39.2)	22.6 (18.3 - 27.5)	30.8 (23.4 - 39.5)
Binge Alcohol**	13.3 (11.1 - 15.8)	17.5 (14.4 - 21.0)	**0.04**	13.8 (10.5 - 17.9)	12.7 (10.4 - 15.4)	0.58	17.4 (13.5 - 22.1)	7.9 (6.1 - 10.1)	15.8 (10.8 - 22.6)
Marijuana	20.3 (17.0 - 23.9)	21.2 (18.8 - 23.9)	0.64	21.3 (17.5 - 25.7)	19.1 (15.8 - 22.9)	0.20	16.9 (13.0 - 21.8)	23.1 (18.4 - 28.6)	23.9 (18.5 - 30.3)
Ever Used in Lifetime									
Alcohol	59.2 (55.1 - 63.2)	66.1 (62.2 - 69.8)	**0.01**	55.5 (50.5 - 60.3)	62.8 (57.8 - 67.5)	**0.01**	61.2 (55.1 - 66.9)	55.2 (51.3 - 59.1)	65.4 (57.2 - 72.7)
Marijuana	35.9 (31.7 - 40.2)	37.9 (34.4 - 41.6)	0.44	38.0 (32.6 - 43.7)	33.7 (29.8 - 37.7)	0.06	31.3 (25.3 - 38.0)	41.2 (35.6 - 47.0)	40.0 (30.6 - 50.2)
Cocaine	7.0 (5.4 - 9.1)	6.7 (5.3 - 8.5)	0.80	8.0 (5.8 - 10.9)	5.6 (4.2 - 7.6)	0.07	5.3 (3.6 - 7.6)	6.5 (4.0 - 10.4)	11.0 (7.8 - 15.4)
Hallucinogenic Drugs	—	—	~	—	—	~	—	—	—
Inhalants	9.9 (8.2 - 12.0)	13.2 (11.8 - 14.8)	**0.01**	11.2 (8.6 - 14.5)	8.2 (6.7 - 9.9)	0.06	8.1 (5.7 - 11.4)	9.1 (6.7 - 12.1)	15.0 (10.5 - 21.0)
Ecstasy also called "MDMA"	7.1 (5.6 - 8.8)	8.5 (6.8 - 10.6)	0.24	8.7 (6.6 - 11.4)	5.0 (3.8 - 6.7)	**0.00**	5.6 (3.8 - 8.2)	6.2 (3.7 - 10.3)	11.2 (7.7 - 15.9)
Heroin	—	4.7 (3.4 - 6.3)	~	—	—	~	—	—	—
Methamphetamine	—	6.0 (4.8 - 7.6)	~	—	—	~	—	—	—
Rx Drugs without a Doctors Prescription	17.7 (16.1 - 19.5)	—	~	19.5 (16.7 - 22.6)	15.7 (13.4 - 18.4)	0.08	18.5 (14.8 - 22.9)	14.9 (11.7 - 18.9)	18.7 (13.3 - 25.6)
Injected Any Illegal Drug	—	2.9 (2.2 - 3.9)	~	—	—	~	—	—	—

NOTES:

[1]2013: 2015 YRBS data not available for Atlanta or Georgia so 2013 Georgia data is presented.

'—' = Data not available; **~ =** P-value not available; **N/A =** < 100 respondents for the subgroup.

^Georgia: data not available for Atlanta so data for State of Georgia provided; weighted data were available for Georgia in 2011 and 2013; weighted results mean that the overall response rate was at least 60%. The overall response rate is calculated by multiplying the school response rate times the student response rate. Weighted results are representative of all students in grades 9–12 attending public schools in each jurisdiction.

***Sample Frame for the 2011 and 2013 YRBS:** sampling frame consisted of public schools with students in at least one of grades 9-12. The sample size for 2011 was 1,969 with an overall response rate of 72%; the 2013 sample size was 1,992 with a 61% overall response rate.

****Binge Alcohol:** defined as had five or more drinks of alcohol in a row within a couple of hours on at least 1 day during the 30 days before the survey.

Source: Adapted by the NDEWS Coordinating Center from data provided by the Centers for Disease Control and Prevention (CDC), 1991-2013 High School Youth Risk Behavior Survey Data. Available at http://nccd.cdc.gov/youthonline/. Accessed on [3/12/2015].

Table 4a: Trends in Admissions* to Programs Treating Substance Use Disorders, *Atlanta MSA*^ Residents, 2011-2015

Number of Admissions and Percenage of Admissions with Selected Substances Cited as Primary Substance of Abuse at Admission, by Year and Substance

	Calendar Year									
	2011		2012		2013		2014		2015	
	(#)	(%)	(#)	(%)	(#)	(%)	(#)	(%)	(#)	(%)
Total Admissions (#)	**9,367**	**100%**	**9,000**	**100%**	**8,911**	**100%**	**8,384**	**100%**	**unavail**	**unavail**
Primary Substance of Abuse (%)										
Alcohol	4,706	50.2%	4,470	49.7%	4,205	47.2%	3,856	46.0%	unavail	unavail
Cocaine/Crack	985	10.5%	928	10.3%	862	9.7%	845	10.1%	unavail	unavail
Heroin	306	3.3%	377	4.2%	548	6.1%	631	7.5%	unavail	unavail
Prescription Opioids	647	6.9%	629	7.0%	619	6.9%	366	4.4%	unavail	unavail
Methamphetamine	522	5.6%	567	6.3%	667	7.5%	736	8.8%	unavail	unavail
Marijuana**	1,582	16.9%	1,435	15.9%	1,423	16.0%	1,342	16.0%	unavail	unavail
Benzodiazepines	223	2.4%	185	2.1%	192	2.2%	140	1.7%	unavail	unavail
MDMA	4	<1%	6	<1%	6	<1%	3	<1%	unavail	unavail
Synthetic Stimulants	71	0.8%	69	0.8%	118	1.3%	119	1.4%	unavail	unavail
Synthetic Cannabinoids**	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail
Other Drugs/Unknown	321	3.4%	334	3.7%	271	3.0%	346	4.1%	unavail	unavail

NOTES:

Calendar Year 2015 data are not available for the Atlanta Metro SCS at this time.

***Admissions:** Includes admissions to publicly funded programs. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.

^Atlanta MSA: Includes the following 29 counties—Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Morgan, Newton, Paulding, Pickents, Pike, Rockdale, Spalding, and Walton.

****Marijuana/Synthetic Cannabinoids:** The data do not differentiate between marijuana and synthetic cannabinoids.

unavail: Data not available.

SOURCE: Data provided to the Atlanta Metro NDEWS SCE by the Georgia Department of Human Resources.

Table 4b: Demographic and Drug Use Characteristics of Primary Treament Admissions* for Select Substances of Abuse, *Atlanta MSA*^ Residents, 2014**

Number of Admissions, by Primary Substance of Abuse and Percentage of Admissions with Selected Demographic and Drug Use Characteristics

	Primary Substance of Abuse													
	Alcohol		Cocaine/Crack		Heroin		Prescription Opioids		Methamphetamine		Marijuana***		Benzo-diazepines	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Number of Admissions (#)	**3,856**	**100%**	**845**	**100%**	**631**	**100%**	**467**	**100%**	**736**	**100%**	**1,342**	**100%**	**140**	**100%**
Sex (%)														
Male	2,622	68.0%	495	58.6%	359	56.9%	200	42.8%	307	41.7%	875	65.2%	82	58.6%
Female	1,234	32.0%	350	41.4%	272	43.1%	267	57.2%	429	58.3%	467	34.8%	58	41.4%
Race/Ethnicity (%)														
White, Non-Hisp.	1,819	47.2%	148	17.5%	485	76.9%	396	84.8%	686	93.2%	421	31.4%	120	85.7%
African-Am/Black, Non-Hisp	1,859	48.2%	663	78.5%	118	18.7%	56	12.0%	26	3.5%	803	59.8%	15	10.7%
Hispanic/Latino	97	2.5%	21	2.5%	13	2.1%	3	0.6%	8	1.1%	69	5.1%	5	3.6%
Asian/Pacific Islander	11	0.3%	0	0.0%	9	1.4%	4	0.9%	5	0.7%	6	0.4%	0	0.0%
Other	70	1.8%	13	1.5%	6	1.0%	8	1.7%	11	1.5%	43	3.2%	0	0.0%
Age Group (%)														
Under 18	9	0.2%	1	0.1%	4	0.6%	4	0.9%	5	0.7%	178	13.3%	2	1.4%
18-25	307	8.0%	55	6.5%	160	25.4%	88	18.8%	133	18.1%	453	33.8%	30	21.4%
26-44	1,816	47.1%	379	44.9%	352	55.8%	307	65.7%	510	69.3%	592	44.1%	82	58.6%
45+	1,724	44.7%	410	48.5%	115	18.2%	68	14.6%	88	12.0%	119	8.9%	26	18.6%
Route of Administration (%)														
Smoked	0	0.0%	612	72.4%	7	1.1%	12	2.6%	349	47.4%	1,282	95.5%	2	1.4%
Inhaled	0	0.0%	188	22.2%	80	12.7%	34	7.3%	112	15.2%	5	0.4%	0	0.0%
Injected	0	0.0%	15	1.8%	523	82.9%	48	10.3%	215	29.2%	0	0.0%	2	1.4%
Oral/Other/Unknown	3,856	100.0%	30	3.6%	21	3.3%	373	79.9%	60	8.2%	55	4.1%	136	97.1%
Secondary Substance (%)														
None	1,477	38.3%	239	28.3%	143	22.7%	130	27.8%	218	29.6%	581	43.3%	23	16.4%
Alcohol	0	0.0%	341	40.4%	71	11.3%	46	9.9%	115	15.6%	447	33.3%	12	8.6%
Benzodiazepines	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	0	0.0%
Cocaine/Crack	1,050	27.2%	12	1.4%	99	15.7%	12	2.6%	38	5.2%	103	7.7%	8	5.7%
Heroin	84	2.2%	19	2.2%	0	0.0%	20	4.3%	36	4.9%	8	0.6%	15	10.7%
Prescription Opioids	84	2.2%	6	0.7%	79	12.5%	0	0.0%	65	8.8%	23	1.7%	34	24.3%
Methamphetamine	131	3.4%	12	1.4%	72	11.4%	5	1.1%	0	0.0%	118	8.8%	19	13.6%
Marijuana**	837	21.7%	196	23.2%	78	12.4%	9	1.9%	212	28.8%	0	0.0%	14	10.0%

NOTES:

***Admissions:** Includes admissions to publicly funded programs. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.

^Atlanta MSA: Includes the following 29 counties—Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Morgan, Newton, Paulding, Pickents, Pike, Rockdale, Spalding, and Walton.

****2014:** Calendar Year 2015 data are not available for the Atlanta Metro SCS at this time; data presented is CY 2014 data.

*****Marijuana/Synthetic Cannabinoids:** The data do not differentiate between marijuana and synthetic cannabinoids.

unavail: Data not available.

SOURCE: Data provided to the Atlanta Metro NDEWS SCE by the Georgia Department of Human Resources.

Table 5: Drug Overdose (Poisoning) Deaths*, by Drug and Year, *Atlanta MSA*^, 2010–2014**

Number, Crude Rate, and Age-Adjusted Rate*** (per 100,000 population)

	2010			2011			2012			2013			2014		
	Number (#)	Crude Rate	Age-Adjusted Rate	Number (#)	Crude Rate	Age-Adjusted Rate	Number (#)	Crude Rate	Age-Adjusted Rate	Number (#)	Crude Rate	Age-Adjusted Rate	Number (#)	Crude Rate	Age-Adjusted Rate
Drug Overdose (Poisoning) Deaths	**560**	**10.6**	**10.2**	**556**	**10.3**	**10.0**	**555**	**10.2**	**9.9**	**576**	**10.4**	**10.1**	**716**	**12.8**	**12.5**
Opioids‡	**284**	**5.4**	**5.1**	**286**	**5.3**	**5.1**	**295**	**5.4**	**5.2**	**286**	**5.2**	**5.1**	**431**	**7.7**	**7.5**
Heroin	SUP	SUP	SUP	25	0.5	0.4	34	0.6	0.6	53	1.0	0.9	131	2.3	2.3
Natural Opioid Analgesics	170	3.2	3.1	183	3.4	3.3	158	2.9	2.8	154	2.8	2.7	218	3.9	3.8
Methadone	71	1.3	1.3	65	1.2	1.2	79	1.4	1.4	41	0.7	0.7	50	0.9	0.9
Synthetic Opioid Analgesics	52	1.0	0.9	34	0.6	0.6	21	0.4	0.4	36	0.7	0.6	114	2.0	2.0
Benzodiazepines	**105**	**2.0**	**1.9**	**116**	**2.2**	**2.1**	**96**	**1.8**	**1.7**	**97**	**1.8**	**1.7**	**104**	**1.9**	**1.8**
Benzodiazepines **AND** Any Opioids	90	1.7	1.6	95	1.8	1.7	81	1.5	1.4	86	1.6	1.5	89	1.6	1.6
Benzodiazepines **AND** Heroin	SUP	SUP	SUP	SUP	SUP	SUP	SUP	SUP	SUP	SUP	SUP	SUP	14	UNR	UNR
Psychostimulants															
Cocaine	64	1.2	1.1	54	1.0	0.9	64	1.2	1.1	80	1.4	1.4	98	1.7	1.7
Psychostimulants with Abuse Potential	39	0.7	0.7	34	0.6	0.6	37	0.7	0.7	63	1.1	1.1	82	1.5	1.5
Cannabis (derivatives)	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**
Percent with Drugs Specified‡	**78.2%**			**73.6%**			**76.6%**			**76.4%**			**83.0%**		

NOTES:

***Drug Overdose (Poisoning) D**efined as deaths with **underlying cause-of-death** codes from the World Health Organization's (WHO's) *International Classification of Diseases, Tenth Revision* (ICD-10) of X40-X44, X60-X64, X85, and Y10-Y14. See *Overview & Limitations* section for additional information on mortality data and definitions of the specific ICD-10 codes listed.

****Drug Overdose (Poisoning) Deaths, by Drug:** Among the deaths with drug poisoning identified as the underlying cause, the specific drugs are identified by ICD-10 **multiple cause-of-death (MCOD)** T-codes (see below). Each death certificate may contain up to 20 causes of death indicated in the MCOD field. Thus, the total count across drugs may exceed the actual number of dead persons in the selected population. Some deaths involve more than one drug; these deaths are included in the rates for each drug category. This is not a complete list of all drugs that may have been involved with these drug poisoning deaths.

^Atlanta MSA: Comprised of Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Morgan, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton Counties.

****Age-Adjusted Rate:** Age-adjusted rates are weighted averages of the age-specific death rates, where the weights represent a fixed population by age (2000 U.S. Population). Age adjustment is a technique for removing the effects of age from crude rates, so as to allow meaningful comparisons across populations with different underlying age structures. Age-adjusted rates should be viewed as relative indexes rather than as direct or actual measures of mortality risk. See http://wonder.cdc.gov/wonder/help/mcd.html for more information.

‡**Opioids:** Includes any of these MCOD codes T40.0-T40.4, or T40.6

Opium (T40.0); *Heroin* (T40.1); *Natural Opioid Analgesics* (T40.2)—may include morphine, codeine, and semi-synthetic opioid analgesics, such as oxycodone, hydrocodone, hydromorphone, and oxymorphone; *Methadone* (T40.3); *Synthetic Opioid Analgesics [excluding methadone]* (T40.4)—may include drugs such as tramadol and fentanyl; *Other and Unspecified Narcotics* (T40.6)

Benzodiazepines: (T42.4)

Benzodiazepines AND *Any Opioids* (T42.4 AND T40.0-T40.4, or T40.6)

Benzodiazepines AND *Heroin* (T42.4 AND T40.1)

Psychostimulants:

Cocaine (T40.5); Psychostimulants with Abuse Potential [excluding cocaine] (T43.6) (e.g., amphetamines, caffeine, MDMA, methamphetamine, and methylphenidate)

Cannabis (derivatives): (T40.7)

‡**Percent of Drug Overdose (Poisoning) Deaths with Drug(s) Specified:** Among drug overdose (poisoning) deaths, deaths that mention the type of drug(s) involved are defined as those including at least one ICD-10 MCOD in the range T36-T50.8. See *Overview & Limitations* section for more information about this statistic.

SUP = Suppressed: Counts and Rates are suppressed for subnational data representing 0–9 deaths. **UNR = Unreliable:** Rates are Unreliable when the death count <20.

SOURCE: Adapted by the NDEWS Coordinating Center from data taken from the Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple cause of death 1999-2014, available on the CDC WONDER Online Database, released 2015. Data compiled in the Multiple cause of death 1999-2014 were provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved between December 2015 - May 2016, from http://wonder.cdc.gov/mcd-icd10.html

Table 6a: Drug Reports* for Items Seized by Law Enforcement in *Atlanta MSA*^ in 2015
DEA National Forensic Laboratory Information System (NFLIS)
Number of Drug-Specific Reports and Percent of Total Analyzed Drug Reports

Drug Identified	Number (#)	Percent of Total Drug Reports* (#)
Total Drug Reports*	**17,815**	**100.0%**
METHAMPHETAMINE	5,328	29.9%
COCAINE	3,359	18.9%
UNSPECIFIED PHARMACUETICAL PREPARATION	2,809	15.8%
HEROIN	1,112	6.2%
ALPRAZOLAM	966	5.4%
OXYCODONE	784	4.4%
3,4-METHYLENEDIOXYETHYLCATHINONE (ETHYLONE)	483	2.7%
HYDROCODONE	471	2.6%
CANNABIS	380	2.1%
AMPHETAMINE	224	1.3%
CLONAZEPAM	112	0.6%
MORPHINE	107	0.6%
TRAMADOL	99	0.6%
METHADONE	93	0.5%
3,4-METHYLENEDIOXYMETHAMPHETAMINE (MDMA)	67	0.4%
XLR-11 (1-(5-FLUOROPENTYL-1H-3-YL)(2,2,3,3-TETRAMETHYLCYCLOPROPYL)METHANONE)	66	0.4%
PSILOCIN	58	0.3%
METHYLPHENIDATE	53	0.3%
TESTOSTERONE	52	0.3%
FENTANYL	49	0.3%
LISDEXAMFETAMINE	46	0.3%
1,4-BUTANEDIOL	45	0.3%
CODEINE	44	0.2%
PHENYLIMIDOTHIAZOLE ISOMER UNDETERMINED	43	0.2%
CARISOPRODOL	41	0.2%
AB-CHMINACA (N-[(1S)-1-(AMINOCARBONYL)-2-METHYLPROPYL]-1-(CYCLOHEXYLMETHYL)-1H-INDAZOLE-3-CARBOXAMIDE)	39	0.2%
HYDROMORPHONE	39	0.2%
BUPRENORPHINE	36	0.2%
DIAZEPAM	35	0.2%
ALPHA-PYRROLIDINOPENTIOPHENONE (ALPHA-PVP)	34	0.2%
KETAMINE	33	0.2%
LYSERGIC ACID DIETHYLAMIDE (LYSERGIDE)	30	0.2%
NO CONTROLLED DRUG IDENTIFIED	28	0.2%
ZOLPIDEM	28	0.2%
PSEUDOEPHEDRINE	27	0.2%
CAFFEINE	23	0.1%
DIPHENHYDRAMINE	23	0.1%
LORAZEPAM	22	0.1%
N-METHYL-3,4-METHYLENEDIOXYCATHINONE (METHYLONE)	22	0.1%
1-(3-TRIFLUOROMETHYL)PHENYL-PIPERAZINE (TFMPP)	20	0.1%
BENZOCAINE	19	0.1%
PROMETHAZINE	19	0.1%
LIDOCAINE	18	0.1%

Drug Identified	Number (#)	Percent of Total Drug Reports* (#)
DIMETHYLSULFONE	16	< 0.1%
3,4-METHYLENEDIOXYAMPHETAMINE (MDA)	15	< 0.1%
DIMETHYLTRYPTAMINE (DMT)	15	< 0.1%
PHENTERMINE	15	< 0.1%
2-(4-IODO-2,5-DIMETHOXYPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-I-NBOME)	13	< 0.1%
CANNABINOL	13	< 0.1%
DOXYLAMINE	13	< 0.1%
OXYMORPHONE	12	< 0.1%
NICOTINAMIDE	11	< 0.1%
1-(2-FLUOROPHENYL)PIPERAZINE	10	< 0.1%
5-FLUORO AMB	10	< 0.1%
AB-FUBINACA	10	< 0.1%
NANDROLONE	10	< 0.1%
META-CHLORPHENYLPIPERAZINE (MCPP)	9	< 0.1%
METHOXETAMINE (MXE; 2-(3-METHOXYPHENYL)-2-(ETHYLAMINO)CYCLOHEXANONE)	9	< 0.1%
METHORPHAN	8	< 0.1%
ACETAMINOPHEN	7	< 0.1%
GAMMA HYDROXY BUTYL LACTONE	7	< 0.1%
GUAIFENESIN	7	< 0.1%
QUETIAPINE	7	< 0.1%
QUININE	7	< 0.1%
SILDENAFIL CITRATE (VIAGRA)	6	< 0.1%
TRENBOLONE	6	< 0.1%
4-FLUOROMETHCATHINONE (4-FMC; FLEPHEDRONE)	5	< 0.1%
DIBUTYLONE (BETA-KETO-N,N-DIMETHYL-1,3-BENZODIOXOLYLBUTANAMINE; BK-DMBDB)	5	< 0.1%
ETIZOLAM	5	< 0.1%
IBUPROFEN	5	< 0.1%
STANOZOLOL	5	< 0.1%
2-(2,5-DIMETHOXY-4-NITROPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-N-NBOME)	4	< 0.1%
BENOCYCLIDINE (1-[1-(1-BENZOTHIOPHEN-2-YL)CYCLOHEXYL]PIPERIDINE)	4	< 0.1%
CANNABIDIOL	4	< 0.1%
LACTOSE	4	< 0.1%
METHANDROSTENOLONE (METHANDIENONE)	4	< 0.1%
N-BENZYLPIPERAZINE (BZP)	4	< 0.1%
TRAZODONE	4	< 0.1%
4-CHLORO-2,5-DIMETHOXYAMPHETAMINE (DOC)	3	< 0.1%
5F-AB-PINACA	3	< 0.1%
5-METHOXY-N,N-DIISOPROPYLTRYPTAMINE (5-MEO-DIPT)	3	< 0.1%
AB-PINACA	3	< 0.1%
ALPHA-PYRROLIDINOHEXANOPHENONE (ALPHA-PHP)	3	< 0.1%
AM-2201 (1-(5-FLUOROPENTYL)-3-(1-NAPHTHOYL)INDOLE)	3	< 0.1%
BUTALBITAL	3	< 0.1%
DEHYDROCHLORMETHYLTESTOSTERONE	3	< 0.1%
JWH-250 (1-PENTYL-3-(2-METHOXYPHENYLACETYL)INDOLE)	3	< 0.1%
MANNITOL	3	< 0.1%
NICOTINE	3	< 0.1%

Drug Identified	Number (#)	Percent of Total Drug Reports* (#)
NM2201 (NAPHTHALEN-1-YL 1-(5-FLUOROPENTYL)-1H-INDOLE-3-CARBOXYLATE)	3	< 0.1%
OXANDROLONE	3	< 0.1%
TADALAFIL	3	< 0.1%
TAPENTADOL	3	< 0.1%
TEMAZEPAM	3	< 0.1%
ZOPICLONE	3	< 0.1%
5-METHOXY-N-METHYL-N-ISOPROPYLTRYPTAMINE (5-MEO-MIPT)	2	< 0.1%
6-MONOACETYLMORPHINE	2	< 0.1%
ALPHA-PYRROLIDINOHEPTAPHENONE (PV8)	2	< 0.1%
ANASTROZOLE	2	< 0.1%
ASPIRIN	2	< 0.1%
BOLDENONE	2	< 0.1%
BUTYRYL FENTANYL	2	< 0.1%
CITALOPRAM	2	< 0.1%
DILTIAZEM	2	< 0.1%
DIMETHYLONE (3,4-METHYLENEDIOXYDIMETHYLCATHINONE; bk-MDDMA)	2	< 0.1%
FUB-PB-22 (QUINOLIN-8-YL-1-(4-FLUOROBENZYL)-1H-INDOLE-3-CARBOXYLATE)	2	< 0.1%
GABAPENTIN	2	< 0.1%
METHYLENEDIOXYPYROVALERONE (MDPV)	2	< 0.1%
MITRAGYNINE	2	< 0.1%
NAPROXEN	2	< 0.1%
OLANZAPINE	2	< 0.1%
PHENACETIN	2	< 0.1%
PHENAZEPAM	2	< 0.1%
PHENDIMETRAZINE	2	< 0.1%
PREGABALIN	2	< 0.1%
SERTRALINE	2	< 0.1%
2-(4-BROMO-2,5-DIMETHOXYPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-B-NBOMe)	1	< 0.1%
4-CHLOROMETHCATHINONE (4-CMC; CLEPHEDRONE)	1	< 0.1%
4-HYDROXY-N-METHYL-N-ISOPROPYLTRYPTAMINE (4-OH-MIPT)	1	< 0.1%
5-FLUORO-ADB	1	< 0.1%
ACETYLCYSTEINE	1	< 0.1%
ACYCLOVIR	1	< 0.1%
AM-2233 (1-[(N-METHYL-2-PIPERIDINYL)METHYL]-3-(2-IODOBENZOYL)INDOLE)	1	< 0.1%
AMITRIPTYLINE	1	< 0.1%
AMLODIPINE	1	< 0.1%
AMOXICILLIN	1	< 0.1%
BACLOFEN	1	< 0.1%
BORIC ACID	1	< 0.1%
BREPHEDRONE (4-BROMOMETHCATHINONE) (4-BMC)	1	< 0.1%
BUPROPION	1	< 0.1%
BUSPIRONE	1	< 0.1%
BUTABARBITAL	1	< 0.1%
CATHINE	1	< 0.1%
CATHINONE	1	< 0.1%
CLOMIPHENE	1	< 0.1%
CYCLOBENZAPRINE	1	< 0.1%

Drug Identified	Number (#)	Percent of Total Drug Reports* (#)
DRONABINOL	1	< 0.1%
ESTAZOLAM	1	< 0.1%
ETHYLMORPHINE	1	< 0.1%
FLUOROAMPHETAMINE	1	< 0.1%
FLUOROMETHAMPHETAMINE	1	< 0.1%
FUB-AMB	1	< 0.1%
GAMMA HYDROXY BUTYRATE	1	< 0.1%
HYDROQUINONE	1	< 0.1%
ISOBUTYL NITRITE	1	< 0.1%
JWH-210 (1-PENTYL-3-(4-ETHYL-1-NAPHTHOYL)INDOLE)	1	< 0.1%
LETROZOLE	1	< 0.1%
MAM-2201 (1-(5-FLUOROPENTYL)-3-(4-METHYL-1-NAPHTHOYL)INDOLE)	1	< 0.1%
METAXALONE	1	< 0.1%
METHOCARBAMOL	1	< 0.1%
METRONIDAZOLE	1	< 0.1%
NALOXONE	1	< 0.1%
NAPHAZOLINE	1	< 0.1%
NAPHTHALENE	1	< 0.1%
NOSCAPINE	1	< 0.1%
PERPHENAZINE	1	< 0.1%
PROCAINE	1	< 0.1%
PROPRANOLOL	1	< 0.1%
SIBUTRAMINE	1	< 0.1%
STS-135 (N-ADAMANTYL-1-FLUOROPENTYLINDOLE-3-CARBOXAMIDE)	1	< 0.1%
TAMOXIFEN	1	< 0.1%
TERBINAFINE	1	< 0.1%
ZALEPLON	1	< 0.1%

NOTES:

^Atlanta MSA: The Atlanta-Sandy Springs-Roswell, Georgia MSA includes the following 29 counties: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Morgan, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton. The principal cities of the Atanta MSA include: Atlanta, Sandy Springs, Roswell, Alpharetta, and Marietta. Note that this 29 county catchment area is different than that previously reported for the NFLIS Atlanta Metro area, which only included 28 counties.

***Drug Report:** Drug that is identified in law enforcement items, submitted to and analyzed by federal, state, or local forensic labs, and included in the NFLIS database. The time frame is January to December 2015.

The NFLIS database allows for the reporting of up to three drugs per item submitted for analysis. The data presented are a total count of first, second, and third listed reports for each selected drug item seized and analyzed.

Source: Adapted by the NDEWS Coordinating Center from data provided by the U.S. Drug Enforcement Administration (DEA), Diversion Control Division, Drug and Chemical Evaluation Section, Data Analysis Unit. Data were retrieved from the NFLIS Data Query System (DQS) on May 18, 2016.

Table 6b: Drug Reports* for Items Seized by Law Enforcement in *Atlanta MSA*^ in 2015
DEA National Forensic Laboratory Information System (NFLIS)
Drug Reports* by Select Drug Categories of Interest
Number of Drug-Specific Reports, Percent of Analyzed Drug Category Reports**, & Percent of Total Analyzed Drug Reports

NPS Category Drug Identified	Number (#)	Percent of Drug Category** (%)	Percent of Total Reports (%)
Total Drug Reports*	**17,815**	**100.0%**	**100.0%**
Opioids Category	**2,863**	**100.0%**	**16.1%**
Heroin	**1,112**	**38.8%**	**6.2%**
Narcotic Analgesics	**1,739**	**60.7%**	**9.8%**
OXYCODONE	784	27.4%	4.4%
HYDROCODONE	471	16.5%	2.6%
MORPHINE	107	3.7%	0.6%
TRAMADOL	99	3.5%	0.6%
METHADONE	93	3.2%	0.5%
FENTANYL	49	1.7%	0.3%
CODEINE	44	1.5%	0.2%
HYDROMORPHONE	39	1.4%	0.2%
BUPRENORPHINE	36	1.3%	0.2%
OXYMORPHONE	12	0.4%	< 0.1%
BUTYRYL FENTANYL	2	< 0.1%	< 0.1%
MITRAGYNINE	2	< 0.1%	< 0.1%
ETHYLMORPHINE	1	< 0.1%	< 0.1%
Narcotics	**12**	**0.4%**	**< 0.1%**
METHORPHAN	8	0.3%	< 0.1%
6-MONOACETYLMORPHINE	2	< 0.1%	< 0.1%
NALOXONE	1	< 0.1%	< 0.1%
NOSCAPINE	1	< 0.1%	< 0.1%
Synthetic Cathinones Category	**560**	**100.0%**	**3.1%**
Synthetic Cathinones	**536**	**95.7%**	**3.0%**
3,4-METHYLENEDIOXYETHYLCATHINONE (ETHYLONE)	483	86.3%	2.7%
ALPHA-PYRROLIDINOPENTIOPHENONE (ALPHA-PVP)	34	6.1%	0.2%
4-FLUOROMETHCATHINONE (4-FMC; FLEPHEDRONE)	5	0.9%	< 0.1%
DIBUTYLONE (BETA-KETO-N,N-DIMETHYL-1,3-BENZODIOXOLYLBUTANAMINE; BK-DMBDB)	5	0.9%	< 0.1%
ALPHA-PYRROLIDINOHEXANOPHENONE (ALPHA-PHP)	3	0.5%	< 0.1%
ALPHA-PYRROLIDINOHEPTAPHENONE (PV8)	2	0.4%	< 0.1%
DIMETHYLONE (3,4-METHYLENEDIOXYDIMETHYLCATHINONE; bk-MDDMA)	2	0.4%	< 0.1%
4-CHLOROMETHCATHINONE (4-CMC; CLEPHEDRONE)	1	0.2%	< 0.1%
BREPHEDRONE (4-BROMOMETHCATHINONE) (4-BMC)	1	0.2%	< 0.1%
Synthetic Cathinones (Hallucinogen)	**24**	**4.3%**	**0.1%**
N-METHYL-3,4-METHYLENEDIOXYCATHINONE (METHYLONE)	22	3.9%	0.1%
METHYLENEDIOXYPYROVALERONE (MDPV)	2	0.4%	< 0.1%
Synthetic Cannabinoids Category	**148**	**100.0%**	**0.8%**
XLR-11 (1-(5-FLUOROPENTYL-1H-3-YL)(2,2,3,3-TETRAMETHYLCYCLOPROPYL)METHANONE)	66	44.6%	0.4%
AB-CHMINACA (N-[(1S)-1-(AMINOCARBONYL)-2-METHYLPROPYL]-1-(CYCLOHEXYLMETHYL)-1H-INDAZOLE-3-CARBOXAMIDE)	39	26.4%	0.2%
5-FLUORO AMB	10	6.8%	< 0.1%
AB-FUBINACA	10	6.8%	< 0.1%
5F-AB-PINACA	3	2.0%	< 0.1%

NPS Category Drug Identified	Number (#)	Percent of Drug Category** (%)	Percent of Total Reports (%)
AB-PINACA	3	2.0%	< 0.1%
AM-2201 (1-(5-FLUOROPENTYL)-3-(1-NAPHTHOYL)INDOLE)	3	2.0%	< 0.1%
JWH-250 (1-PENTYL-3-(2-METHOXYPHENYLACETYL)INDOLE)	3	2.0%	< 0.1%
NM2201 (NAPHTHALEN-1-YL 1-(5-FLUOROPENTYL)-1H-INDOLE-3-CARBOXYLATE)	3	2.0%	< 0.1%
FUB-PB-22 (QUINOLIN-8-YL-1-(4-FLUOROBENZYL)-1H-INDOLE-3-CARBOXYLATE)	2	1.4%	< 0.1%
5-FLUORO-ADB	1	0.7%	< 0.1%
AM-2233 (1-[(N-METHYL-2-PIPERIDINYL)METHYL]-3-(2-IODOBENZOYL)INDOLE)	1	0.7%	< 0.1%
FUB-AMB	1	0.7%	< 0.1%
JWH-210 (1-PENTYL-3-(4-ETHYL-1-NAPHTHOYL)INDOLE)	1	0.7%	< 0.1%
MAM-2201 (1-(5-FLUOROPENTYL)-3-(4-METHYL-1-NAPHTHOYL)INDOLE)	1	0.7%	< 0.1%
STS-135 (N-ADAMANTYL-1-FLUOROPENTYLINDOLE-3-CARBOXAMIDE)	1	0.7%	< 0.1%
Piperazines Category	**43**	**100.0%**	**0.2%**
Piperazines (Hallucinogen)	**39**	**90.7%**	**0.2%**
1-(3-TRIFLUOROMETHYL)PHENYL-PIPERAZINE (TFMPP)	20	46.5%	0.1%
1-(2-FLUOROPHENYL)PIPERAZINE	10	23.3%	< 0.1%
META-CHLORPHENYLPIPERAZINE (MCPP)	9	20.9%	< 0.1%
Piperazines (Stimulant)	**4**	**9.3%**	**< 0.1%**
N-BENZYLPIPERAZINE (BZP)	4	9.3%	< 0.1%
Tryptamines Category	**21**	**100.0%**	**0.1%**
DIMETHYLTRYPTAMINE (DMT)	15	71.4%	< 0.1%
5-METHOXY-N,N-DIISOPROPYLTRYPTAMINE (5-MEO-DIPT)	3	14.3%	< 0.1%
5-METHOXY-N-METHYL-N-ISOPROPYLTRYPTAMINE (5-MEO-MIPT)	2	9.5%	< 0.1%
4-HYDROXY-N-METHYL-N-ISOPROPYLTRYPTAMINE (4-OH-MIPT)	1	4.8%	< 0.1%
Phenethylamines (2C Series) (H) Category	**18**	**100.0%**	**0.1%**
2-(4-IODO-2,5-DIMETHOXYPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-I-NBOME)	13	72.2%	< 0.1%
2-(2,5-DIMETHOXY-4-NITROPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-N-NBOME)	4	22.2%	< 0.1%
2-(4-BROMO-2,5-DIMETHOXYPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-B-NBOMe)	1	5.6%	< 0.1%

NOTES:

^Atlanta MSA: The Atlanta-Sandy Springs-Roswell, Georgia MSA includes the following 29 counties: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Morgan, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, and Walton. The principal cities of the Atanta MSA include: Atlanta, Sandy Springs, Roswell, Alpharetta, and Marietta. Note that this 29 county catchment area is different than that previously reported for the NFLIS Atlanta Metro area, which only included 28 counties.

***Drug Report:** Drug that is identified in law enforcement items, submitted to and analyzed by federal, state, or local forensic labs, and included in the NFLIS database. The time frame is January to December 2015.

****Selected Drug Categories:** Opioids, Synthetic Cannabinoids, Synthetic Cathinones, 2C Phenethylamines, Piperazines, and Tryptamines are drug categories of current interest to the NDEWS Project because of the recent increase in their numbers, types, and availability.

The NFLIS database allows for the reporting of up to three drugs per item submitted for analysis. The data presented are a total count of first, second, and third listed reports for each selected drug item seized and analyzed.

Source: Adapted by the NDEWS Coordinating Center from data provided by the U.S. Drug Enforcement Administration (DEA), Diversion Control Division, Drug and Chemical Evaluation Section, Data Analysis Unit. Data were retrieved from the NFLIS Data Query System (DQS) on May 18, 2016.

National Drug Early Warning System (NDEWS)
Sentinel Community Site (SCS)
Drug Use Patterns and Trends, 2016:
Overview and Limitations About Data Sources

The *Overview and Limitations About Data Sources,* written by Coordinating Center staff, provides a summary and a detailed description of the limitations of some of the national data sources used this report, including indicators of substance use, treatment, consequences, and availability.

Area Description Indicators

American Community Survey (ACS): Population Estimates, by Demographic and Socioeconomic Characteristics

Overview and Limitations

Data on demographic, social, and economic characteristics are based on 2010–2014 American Community Survey (ACS) 5-Year Estimates. The U.S. Census Bureau's ACS is a nationwide survey designed to provide communities with reliable and timely demographic, social, economic, and housing data on an annual basis. Although the main function of the decennial census is to provide counts of people for the purpose of congressional apportionment and legislative redistricting, the primary purpose of the ACS is to measure the changing social and economic characteristics of the U.S. population. As a result, the ACS does not provide official counts of the population in between censuses. Instead, the Census Bureau's Population Estimates Program will continue to be the official source for annual population totals, by age, race, Hispanic origin, and sex.[a]

The ACS selects approximately 3.5 million housing unit addresses from every county across the nation to survey. Data are based on a sample and are subject to sampling variability. The degree of uncertainty for an estimate arising from sampling variability is represented through the use of a margin of error (MOE). The values shown in the table are the margin of errors. The MOE can be interpreted roughly as providing a 90% probability that the interval defined by the estimate minus the MOE and the estimate plus the MOE (the lower and upper confidence bounds) contains the true value.[a]

Sources

***Data Sources*:** Adapted by the NDEWS Coordinating Center from data from the American Community Survey; *2010–2014 American Community Survey 5-Year Estimates;* Tables DP02, DP03, and DP05; using American FactFinder; http://factfinder2.census.gov; Accessed on [5/24/2016]; U.S. Census Bureau.

***Overview/Methods/Limitations Sources*:** [a]Adapted by the NDEWS Coordinating Center from U.S. Census Bureau, *A Compass for Understanding and Using American Community Survey Data: What General Data Users Need to Know.* U.S. Government Printing Office, Washington, DC, 2008. Available at: https://www.census.gov/library/publications/2008/acs/general.html

Substance Use Indicators

National Survey on Drug Use and Health (NSDUH): Substance Use Among Population 12 Years or Older

Overview and Limitations

NSDUH is an ongoing survey of the civilian, noninstutionalized population of the United States aged 12 years or older that is planned and managed by the Substance Abuse and Mental Health Administration's (SAMHSA) Center for Behavioral Health Statistics and Quality (CBHSQ). Data is collected from individuals residing in households, noninstitutionalized group quarters (e.g., shelters, rooming houses, dormitories) and civilians living on military bases. In 2012–2014, NSDUH collected data from 204,048 respondents aged 12 years or older; this sample was designed to obtain representative samples from the 50 states and the District of Columbia.[a]

The **substate estimates** are derived from a hierarchical Bayes model-based small area estimation procedure in which 2012–2014 NSDUH data at the substate level are combined with local area county and census block group/tract-level data from the area to provide more precise estimates of substance use and mental health outcomes. [See 2012–2014 NSDUH Methods Report for more information about the methodolgy used to generate substate estimates]. Comparable estimates derived from the small area estimation procedure were also produced for the 50 states and the District of Columbia. We present these estimates for Maine and Texas. Because these data are based on 3 consecutive years of data, they are not directly comparable with the annually published state estimates that are based on only 2 consecutive years of NSDUH data.[a]

Substate regions were defined by officials from each of the 50 states and the District of Columbia and were typically based on the treatment planning regions specified by the states in their applications for the Substance Abuse Prevention and Treatment Block Grant (SABG) administered by SAMHSA. There has been extensive variation in the size and use of substate regions across states. In some states, the substate regions have been used more for administrative purposes than for planning purposes. The goal of the project was to provide substate-level estimates showing the geographic distribution of substance use prevalence for regions that states would find useful for planning and reporting purposes. The final substate region boundaries were based on the state's recommendations, assuming that the NSDUH sample sizes were large enough to provide estimates with adequate precision. Most states defined regions in terms of counties but some defined them in terms of census tracts. Estimates for 384 substate regions were generated using the 2012–2014 NSDUH data. Substate regions used for each SCS are defined in the Notes sections of Tables 2a and 2b.[a]

Notes about Data Terms

Estimated percentages are based on a survey-weighted hierarchical Bayes estimation approach, and the 95% prediction (credible) intervals are generated by Markov Carlo techniques.

95% Confidence Interval (CI) provides a measure of the accuracy of the estimate. It defines the range within which the true value can be expected to fall 95% of the time.

Estimated # is the estimated number of persons aged 12 years or older who used the specified drug or are dependent on/abuse a substance; the estimated number of persons using/dependent on a particular drug was calculated by multiplying the prevalence rate and the population estimate from Table C1 of the NSDUH report.

The population estimate is the simple average of the 2012, 2013, and 2014 population counts for persons aged 12 years or older.

Binge Alcohol is defined as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days.

Use of Illicit Drug Other Than Marijuana is defined as any illicit drug other than marijuana and includes cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used nonmedically.

Substance Use Disorder in Past Year: Persons are classified as having a substance use disorder in the past 12 months based on responses to questions that meet the criteria specified in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Sources

***Data Sources*:** Adapted by the NDEWS Coordinating Center from data provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), Substate Estimates of Substance Use and Mental Disorders from the *2012–2014 National Surveys on Drug Use and Health: Results and Detailed Tables.* Rockville, MD. 2014. Available at: http://www.samhsa.gov/data/population-data-nsduh/reports?tab=38; Accessed on [8/5/2016].

***Overview/Methods/Limitations Sources*:** [a]Adapted by the NDEWS Coordinating Center from Substance Abuse and Mental Health Services Administration (SAMHSA), *2012–2014 National Surveys on Drug Use and Health: Guide to Substate Tables and Summary of Small Area Estimation Methodology.* Rockville, MD 2016. Available at: http://www.samhsa.gov/data/sites/default/files/NSDUHsubstateMethodology2014/NSDUHsubstateMethodology2014.html; Accessed on [8/5/2016].

Youth Risk Behavioral Survey (YRBS): Substance Use Among Student Populations

Overview and Limitations

The Youth Risk Behavior Surveillance System (YRBSS) was designed to enable public health professionals, educators, policy makers, and researchers to 1) describe the prevalence of health-risk behaviors among youths, 2) assess trends in health-risk behaviors over time, and 3) evaluate and improve health-related policies and programs. YRBSS also was developed to provide comparable national, State, territorial, and large urban school district data as well as comparable data among subpopulations of youths (e.g., racial/ethnic subgroups) and to monitor progress toward achieving national health objectives. The YRBSS monitors six categories of priority health risk behaviors among youth and young adults: 1) behaviors that contribute to unintentional injuries and violence; 2) tobacco use; 3) alcohol and other drug use; 4) sexual behaviors that contribute to unintended pregnancy and sexually transmitted infections; 5) unhealthy dietary behaviors; and 6) physical inactivity.[a] We have included selected drug and alcohol survey questions from the YRBSS.

One component of the Surveillance System is the school-based Youth Risk Behavior Survey (YRBS) which includes representative samples of high school students in the nation, States, tribes, and select large urban school district across the country. The ongoing surveys are conducted biennially; each cycle begins in July of the preceding even-numbered year (e.g., in 2010 for the 2011 cycle) when the questionnaire for the upcoming year is released and continues until the data are published in June of the following even-numbered year (e.g., in 2012 for the 2011 cycle).[a]

For States and large urban school districts, the YRBSs are administered by State and local education or health agencies. Each State, territorial, tribal, and large urban school district YRBS employs a two-stage, cluster sample design to produce a representative sample of students in grades 9–12 in its jurisdiction. All the data presented in these tables area based on weighted data. Weighted results are representative of all students in grades 9–12 attending public schools in each jurisdiction. According to CDC, “weighted results mean that the overall response rate was at least 60%. The overall response rate is calculated by multiplying the school response rate times the student response rate.”[a]

Limitations. All YRBS data are self-reported, and the extent of underreporting or overreporting of behaviors cannot be determined, although there have been studies that demonstrate that the data are of acceptable quality.

The data apply only to youths who attend school and, therefore, are not representative of all persons in this age group. Nationwide, in 2009, approximately 4% of persons aged 16–17 years were not enrolled in a high-school program and had not completed high school.[b] The NHIS and Youth Risk Behavior Supplement conducted in 1992 demonstrated that out-of-school youths are more likely than youths attending school to engage in the majority of health-risk behaviors.[c]

Local parental permission procedures are not consistent across school-based survey sites. However, in a 2004 study, the CDC demonstrated that the type of parental permission typically does not affect prevalence estimates as long as student response rates remain high.[d]

Notes about Data Terms

Binge Alcohol use is defined as having five or more drinks of alcohol in a row within a couple of hours on at least 1 day during the 30 days before the survey.

Sources

Data Sources: Adapted by the NDEWS Coordinating Center from data provided by Centers for Disease Control and Prevention (CDC), 1991–2013 High School Youth Risk Behavior Survey Data. Available at http://nccd.cdc.gov/youthonline/. Accessed on [3/12/2015].

***Overview/Methods/Limitations Sources*:** Adapted by the NDEWS Coordinating Center from:

[a]*Methodology of the Youth Risk Behavior Surveillance System— 2013* Report in the Centers for Disease Control and Prevention (CDC) *March 1, 2013 Morbidity and Mortality Weekly Report* (MMWR); 62(1). Available at http://www.cdc.gov/mmwr/pdf/rr/rr6201.pdf. Accessed on [4/10/2015].

[b]Chapman C, Laird J, Ifill N, KewalRamani A. Trends in high school dropout and completion rates in the United States: 1972–2009 (NCES 2012–006). Available at http://nces.ed.gov/pubs2012/2012006.pdf. Accessed on [2/11/2013].

[c]CDC. Health risk behaviors among adolescents who do and do not attend school—United States, 1992. MMWR 1994;43:129–32.

[d]Eaton DK, Lowry R, Brener ND, Grunbaum JA, Kann L. Passive versus active parental permission in school-based survey research: does type of permission affect prevalence estimates of self-reported risk behaviors? Evaluation Review 2004;28:564–77.

Treatment for Substance Use Disorders

Treatment Admissions Data from Local Data Sources

Overview and Limitations

Drug treatment admissions data provide indicators of the health consequences of substance misuse and their impact on the treatment system.[a] Treatment admissions data can provide some indication of the types of drugs being used in geographic areas and can show patterns of use over time. However, it is important to note that treatment data only represent use patterns of individuals entering treatment programs and the availability of particular types of treatment in a geographic area will also influence the types of drugs being reported. Also, most sites report only on admissions to publicly funded treatment programs; thus, information on individuals entering private treatment programs may not be represented by the data. It should also be noted that each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.[b]

Treatment admissions data are made available to the NDEWS Coordinating Center by the NDEWS Sentinel Community Epidemiologist for each SCS. Calendar year 2015 treatment admissions data were available for 10 of 12 SCSs. Calendar Year 2015 data were not available for the Chicago Metro SCS; Fiscal Year 2015 for Chicago (not entire Chicago metro area) is provided. No treatment data for the Atlanta Metro SCS was available for 2015. See below for site-specific information about the data.

Site-Specific Notes about 2015 Treatment Data and Sources of the Data

- **Atlanta Metro**

  Data Availability: Calendar year 2015 treatment data are not available for the Atlanta Metro SCS.

  Catchment Area: Includes residents of: Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Heard, Henry, Jasper, Lamar, Meriwether, Morgan, Newton, Paulding, Pickents, Pike, Rockdale, Spalding, and Walton counties.

  Notes & Definitions:
  Admissions: includes admissions to publicly-funded programs.
  Marijuana/Synthetic Cannabinoids: the data do not differentiate between marijuana and synthetic cannabinoids.

  Source: Data provided to the Atlanta Metro NDEWS SCE by the Georgia Department of Human Resources.

❖ **Chicago Metro**

Data Availability: Only fiscal year data are available at this time.

Catchment Area: Data were only available for residents of Chicago, not for the entire Chicago MSA.

Notes & Definitions:
Admissions: Includes admissions to publicly funded programs. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.

Declines in overall treatment admissions are due to several factors, including budget cuts and changes in providers and payers that affect the reporting of these data (e.g., the expansion of Medicaid under the ACA to cover some forms of drug treatment).
Prescription Opioids: Includes oxycodone/hydrocodone, nonprescription methadone, and other opiates.

Source: Data provided to the NDEWS Chicago SCE by the Illinois Department of Substance Use.

❖ **Denver Metro**

Catchment Area: Includes admissions data for residents of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Gilpin, and Jefferson counties.

Notes & Definitions:
Admissions: Includes admissions to all Colorado alcohol and drug treatment agencies licensed by the Colorado Department of Human Services, Office of Behavioral Health (OBH). Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.
Prescription Opioids: Includes nonprescription methadone and other opiates and synthetic opiates.
MDMA: Coded as "club drugs," which are mostly MDMA.
Other Drugs/Unknown: Includes inhalants, over-the-counter, and other drugs not specified.

Source: Data provided to the Denver Metro NDEWS SCE by the Colorado Department of Human Services, Office of Behavioral Health (OBH), Drug/Alcohol Coordinated Data System (DACODS).

❖ **King County (Seattle Area)**

Notes & Definitions:
Admissions: Includes admissions to all modalities of care in publicly funded programs. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.
Prescription Opioids: Includes oxycodone/hydrocodone, nonprescription methadone, and other opiates.

Source: Data provided to the King County (Seattle Area) NDEWS SCE by the Washington State Department of Social and Health Services (DSHS), Division Behavioral Health and Recovery, Treatment Report and Generation Tool (TARGET).

❖ **Los Angeles County**

Notes & Definitions:

Admissions: Includes all admissions to programs receiving any public funds or to programs providing narcotic replacement therapy, as reported to the California Outcomes Monitoring System (CalOMS). An admission is counted only after all screening, intake, and assessment processes have been completed, and all of the following have occurred: 1) the provider has determined that the client meets the program admission criteria; 2) if applicable, the client has given consent for treatment/recovery services; 3) an individual recovery or treatment plan has been started; 4) a client file has been opened; 5) the client has received his/her first direct recovery service in the facility and is expected to continue participating in program activities; and 6) in methadone programs, the client has received his/her first dose. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.

Prescription Opioids: Includes drug categories labeled "oxycodone/OxyContin" and "other opiates or synthetics."

Source: Data provided to the Los Angeles NDEWS SCE by the California Department of Health Care Services, Mental Health Services Division, Office of Applied Research and Analysis, CalOMS (2013 and 2014 data) and the California Department of Drug and Alcohol Programs (2011 and 2012 data).

❖ **Maine**

Notes & Definitions:

Admissions*:* includes all admissions to programs receiving State funding.

Source: Data provided to the Maine NDEWS SCE by the Maine Office of Substance Abuse.

❖ **New York City**

Notes & Definitions:

Non-Crisis Admissions: Includes non-crisis admissions to outpatient, inpatient, residential, and methadone maintenance treatment programs licensed in the state.

Crisis Admissions: Includes detox admissions to all licensed treatment programs in the state

Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.

Prescription Opioids: Includes nonprescription methadone, buprenorphine, other synthetic opiates, and OxyContin.

Benzodiazepines: Includes benzodiazepines, alprazolam, and rohypnol.

Synthetic Stimulants: Includes other stimulants and a newly created category, synthetic stimulants (created in 2014).

Source: Data provided to the New York City NDEWS SCE by the New York State Office of Alcoholism and Substance Abuse Services (OASAS), Client Data System accessed May 2016 from Local Governmental Unit (LGU) Inquiry Reports.

❖ **Philadelphia**

Notes & Definitions:
Admissions: Includes admissions for uninsured and underinsured individuals admitted to any licensed treatment programs funded through the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS). Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.

2015 Data: Pennsylvania expanded Medicaid coverage under the Affordable Care Act and more than 100,000 additional individuals became eligible in 2015. As individuals who historically have been uninsured become insured, the number of individuals served through the BHSI (Behavioral Health Special Initiative) program has declined; thus treatment admissions reported by BHSI declined from 8,363 in 2014 to 4,810 in 2015. However, similar patterns of substance use were observed among those seeking treatment in 2014 and in 2015.

Methamphetamine: Includes both amphetamines and methamphetamine.

Other Drugs: May include synthetics, barbiturates, and over-the-counter drugs. Synthetic Stimulants and Synthetic Cannabinoids are not distinguishable from "Other Drugs" in the reporting source.

Source: Data provided to the Philadelphia NDEWS SCE by the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS), Office of Addiction Services, Behavioral Health Special Initiative.

❖ **San Francisco County**

Notes & Definitions
Admissions: Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.

Source: Data provided to the San Francisco NDEWS SCE by the San Francisco Department of Public Health, Community Behavioral Health Services Division.

❖ **Southeastern Florida (Miami Area)**

Catchment Area: Includes the three counties of the Miami MSA—Broward, Miami-Dade, and Palm Beach counties.

Notes & Definitions:
Admissions: Includes all admissions to programs receiving any public funds. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.
2011–2013: Data for Palm Beach County is not available for 2011-2013, therefore, 2011–2013 only includes data for Broward and Miami-Dade counties.

Source: Data provided to the Southeastern Florida NDEWS SCE by the Florida Department of Children and Families and the Broward Behavioral Health Coalition.

❖ **Texas**

Notes & Definitions:
Admissions: Includes all admissions reported to the Clinical Management for Behavioral Health Services (CMBHS) of the Department of State Health Services (DSHS). Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.
Methamphetamine: Includes amphetamines and methamphetamine.
Synthetic Cannabinoids: DSHS collects data on "other Cannabinoids," which may not include all the synthetic cannabinoids.
Females: Calculated using formula "1 minus Male %."

Source: Data provided to the Texas NDEWS SCE by the Texas Department of State Health Services (DSHS).

❖ **Wayne County (Detroit Area)**

Notes & Definitions:
Admissions: Admissions whose treatment was covered by Medicaid or Block Grant funds; excludes admissions covered by private insurance, treatment paid for in cash, and admissions funded by the Michigan Department of Corrections. Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.
Synthetic Stimulants: Includes amphetamines and synthetic stimulants; data suppressed to protect confidentiality.

Source: Data provided to the Wayne County (Detroit Area) NDEWS SCE by the Michigan Department of Health and Human Services, Bureau of Behavioral Health and Developmental Disabilities, Division of Quality Management and Planning, Performance Measurement and Evaluation Section.

Sources

Data Sources: Adapted by the NDEWS Coordinating Center from data provided by NDEWS SCEs listed above.

***Overview/Methods/Limitations Sources*:** Adapted by the NDEWS Coordinating Center from:

[a]National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services, *Assessing Drug Abuse Within and Across Communities, 2nd Edition*. 2006. Available at: https://www.drugabuse.gov/publications/assessing-drug-abuse-within-across-communities

[b]National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services, *Epidemiologic Trends in Drug Abuse, Proceedings of the Community Epidemiology Work Group, Highlights and Executive Summary, June 2014*. Available at: https://www.drugabuse.gov/sites/default/files/cewgjune2014.pdf

Consequences of Drug Use Indicators

Drug Overdose (Poisoning) Deaths

Overview and Limitations

The multiple cause-of-death mortality files from the National Vital Statistics System (NVSS) (queried from the CDC WONDER Online Database) were used to identify drug overdose (poisoning) deaths. Mortality data are based on information from all death certificates for U.S. residents filed in the 50 states and the District of Columbia. Deaths of nonresidents and fetal deaths are excluded. The death certificates are either 1) coded by the states or provided to the CDC's National Center for Health Statistics (NCHS) through the Vital Statistics Cooperative Program; or 2) coded by NCHS from copies of the original death certificates provided to NCHS by the respective state registration office. Each death certificate contains a single underlying cause of death, up to 20 additional multiple causes, and demographic data.[1] (Click here for more information about CDC WONDER Multiple Cause of Death data)

The drug-specific poisoning deaths presented in the 2016 National Drug Early Warning System (NDEWS) reports are deaths that have been certified "as due to acute exposure to a drug, either alone or in combination with other drugs or other substances" (Goldberger, Maxwell, Campbell, & Wilford, p. 234)[2] and are identified by using the World Health Organization's (WHO's) *International classification of diseases, 10th Revision* (ICD-10)[3] **underlying cause-of-death** codes X40–X44, X60–X64, X85, and Y10–Y14. Drug-specific poisoning deaths are the subset of drug overdose (poisoning) deaths with drug-specific **multiple cause-of-death** codes (i.e., T-codes). For the definitions of specific ICD-10 codes, see the section titled ***Notes About Data Terms***. Each death certificate may contain up to 20 causes of death indicated in the multiple cause-of-death (MCOD) field. Thus, the total count across drugs may exceed the actual number of dead persons in the selected population. Some deaths involve more than one drug; these deaths are included in the rates for each drug category.

As stated in its report, *Consensus Recommendations for National and State Poisoning Surveillance,* the Safe States Injury Surveillance Workgroup on Poisoning (ISW7)[a] identified the limitations of using mortality data from NVSS to measure drug poisoning deaths:

[a] The Safe States Alliance, a nongovernmental membership association, convened the Injury Surveillance Workgroup on Poisoning (ISW7) to improve the surveillance of fatal and nonfatal poisonings. Representation on the ISW7 included individuals from the National Center for Injury Prevention and Control (NCIPC), the National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Council of State and Territorial Epidemiologists (CSTE), the American Association of Poison Control Centers (AAPCC), the Association of State and Territorial Health Officials (ASTHO), the Society for the Advancement of Injury Research (SAVIR), state health departments, academic centers, the occupational health research community, and private research organizations.

> Several factors related to death investigation and reporting may affect measurement of death rates involving specific drugs. At autopsy, toxicological lab tests may be performed to determine the type of legal and illegal drugs present. The substances tested for and circumstance in which tests are performed vary by jurisdiction. Increased attention to fatal poisonings associated with prescription pain medication may have led to changes in reporting practices over time such as increasing the level of substance specific detail included on the death certificates. Substance-specific death rates are more susceptible to measurement error related to these factors than the overall poisoning death rate. (The Safe States Alliance, p. 63)[4]

Warner et al.[5] found that there was considerable variation in certifying the manner of death and the percentage of drug intoxication deaths with specific drugs identified on death certificates and that these variations across states can lead to misleading cross-state comparisons. Based on 2008–2010 data, Warner et al.[5] found that the percentage of deaths with an "undetermined" manner of death ranged from 1% to 85%. Comparing state-specific rates of "unintentional" or "suicidal" drug intoxication deaths would be problematic because the "magnitude of the problem will be underestimated in States with high percentages of death in which the manner is "undetermined."[5] The drug overdose (poisoning) deaths presented in the NDEWS tables include the various manner of death categories: unintentional (X40–X44); suicide (X60–X64); homicide (X85); or undetermined (Y10–Y14).

Based on 2008–2010 data, Warner et al.[5] found that the percentage of drug overdose (poisoning) deaths with specific drugs mentioned varied considerably by state and type of death investigation system. The authors found that in some cases, deaths without a specific drug mentioned on the death certificate may indicate a death involving multiple drug toxicity. The **Percent of Drug Overdose (Poisoning) Deaths with Drug(s) Specified** statistic is calculated for each NDEWS SCS catchment area so the reader can assess the thoroughness of the data for the catchment area. This statistic is defined as drug poisoning deaths with at least one ICD-10 multiple cause of death in the range T36–T50.8.

Notes About Data Terms

Underlying Cause of Death (UCOD): The CDC follows the WHO's definition of *underlying cause of death*: "[T]he disease or injury which initiated the train of events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury." Underlying cause of death is selected from the conditions entered by the physician on the cause-of-death section of the death certificate. When more than one cause or condition is entered by the physician, the underlying cause is determined by the sequence of condition on the certificate, provisions of the ICD, and associated selection rules and modifications. (Click here for more information about CDC WONDER Multiple Cause of Death data)

Specific ICD-10 codes for *underlying cause of death*[3] (Click here to see full list of WHO ICD-10 codes)

X40: Accidental poisoning by and exposure to nonopioid analgesics, antipyretics, and antirheumatics.

X41: Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism, and psychotropic drugs, not elsewhere classified.

X42: Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified.

X43: Accidental poisoning by and exposure to other drugs acting on the autonomic nervous system.

X44: Accidental poisoning by and exposure to other and unspecified drugs, medicaments, and biological substances.

X60: Intentional self-poisoning (suicide) by and exposure to nonopioid analgesics, antipyretics, and antirheumatics.

X61: Intentional self-poisoning (suicide) by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism, and psychotropic drugs, not elsewhere classified.

X62: Intentional self-poisoning (suicide) by, and exposure to, narcotics and psychodysleptics [hallucinogens], not elsewhere classified.

X63: Intentional self-poisoning (suicide) by and exposure to other drugs acting on the autonomic nervous system.

X64: Intentional self-poisoning (suicide) by and exposure to other and unspecified drugs, medicaments, and biological substances.

X85: Assault (homicide) by drugs, medicaments, and biological substances.

Y10: Poisoning by and exposure to nonopioid analgesics, antipyretics, and antirheumatics, undetermined intent.

Y11: Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism, and psychotropic drugs, not elsewhere classified, undetermined intent.

Y12: Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent.

Y13: Poisoning by and exposure to other drugs acting on the autonomic nervous system, undetermined intent.

Y14: Poisoning by and exposure to other and unspecified drugs, medicaments, and biological substances, undetermined intent.

Multiple Cause of Death: Each death certificate may contain up to 20 *multiple causes of death*. Thus, the total count by "any mention" of cause in the *multiple cause of death* field may exceed the actual number of dead persons in the selected population. Some deaths involve more than one drug; these deaths are included in the rates for each drug category. (Click here for more information about CDC WONDER Multiple Cause of Death data)

Drug-specific ICD-10 T-codes for *multiple cause of death*[3]
(Click here to see full list of WHO ICD-10 codes)

Any Opioids (T40.0–T40.4 or T40.6) [T40.0 (Opium) and T40.6 (Other and Unspecified Narcotics)]

Heroin (T40.1)

Methadone (T40.3)

Natural Opioid Analgesics (T40.2)

Please note the ICD-10 refers to T40.2 as *Other Opioids*; CDC has revised the wording for clarity: http://www.cdc.gov/drugoverdose/data/analysis.html

Synthetic Opioid Analgesics (T40.4)

Please note the ICD-10 refers to T40.4 as *Other Synthetic Narcotics*; CDC has revised the wording for clarity: http://www.cdc.gov/drugoverdose/data/analysis.html

Cocaine (T40.5)

Psychostimulants with Abuse Potential [excludes cocaine] (T43.6)

Cannabis (derivatives) (T40.7)

Benzodiazepines (T42.4)

Percentage of Drug Overdose (Poisoning) Deaths with Drug(s) Specified: Percentage of drug overdose (poisoning) deaths that mention the type of drug(s) involved, by catchment area. This statistic is defined as drug poisoning deaths with at least one ICD-10 multiple cause of death in the range T36–T50.8.

Population (used to calculate rates): The population estimates used to calculate the crude rates are bridged-race estimates based on Bureau of the Census estimates of total U.S., state, and county resident populations. The year 2010 populations are April 1 modified census counts. The year 2011–2014 population estimates are bridged-race postcensal estimates of the July 1 resident population. Click here for more information about CDC WONDER Multiple Cause of Death data)

Age-Adjusted Rate: Age-adjusted death rates are weighted averages of the age-specific death rates, where the weights represent a fixed population by age. They are used to compare relative mortality risk among groups and over time. An age-adjusted rate represents the rate that would have existed had the age-specific rates of the particular year prevailed in a population whose age distribution was the same as that of the fixed population. Age-adjusted rates should be viewed as relative indexes rather than as direct or actual measures of mortality risk. The rate is adjusted based on the age distribution of a standard population allowing for comparison of rates across different sites. The year "2000 U.S. standard" is the default population selection for the calculation of age-adjusted rates. (Click here for more information about CDC WONDER Multiple Cause of Death data)

5-Year Percent Change: Change in age-adjusted rate between 2010 and 2014.

Suppressed Data: As of May 23, 2011, all subnational data representing 0–9 deaths are suppressed (privacy policy). Corresponding subnational denominator population figures are also suppressed when the population represents fewer than 10 persons. (Click here for more information about CDC WONDER Multiple Cause of Death data)

Unreliable Data: Estimates based on fewer than 20 deaths are considered unreliable and are not displayed. (Click here for more information about CDC WONDER Multiple Cause of Death data

Sources

Data Sources: Adapted by the NDEWS Coordinating Center from data taken from the Centers for Disease Control and Prevention, National Center for Health Statistics, *Multiple cause of death 1999–2014*, available on the CDC WONDER Online Database, released 2015. Data compiled in the *Multiple cause of death 1999–2014*

were provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved between December 16, 2015 and February 9, 2016, from http://wonder.cdc.gov/mcd-icd10.html

***Overview/Methods/Limitations Sources*:** Adapted by the NDEWS Coordinating Center from:

[1]Center from Centers for Disease Control and Prevention, National Center for Health Statistics. (2015). *Multiple cause of death 1999–2014*. Retrieved December 16, 2015, from http://wonder.cdc.gov/wonder/help/mcd.html

[2]Goldberger, B. A., Maxwell, J. C., Campbell, A., & Wilford, B. B. (2013). Uniform standards and case definitions for classifying opioid-related deaths: Recommendations by a SAMHSA consensus panel. *Journal of Addictive Diseases*, *32*, 231–243.

[3]World Health Organization (WHO). (2016). *International statistical classification of diseases and related health problems 10th Revision*. Retrieved March 14, 2016, from http://apps.who.int/classifications/icd10/browse/2016/en

[4]The Safe States Alliance. (2012). *Consensus recommendations for national and state poisoning surveillance*. Atlanta, GA: Injury Surveillance Workgroup 7.

[5]Warner, M., Paulozzi, L. J., Nolte, K. B., Davis, G. G., & Nelson, L.S. (2013). State variation in certifying manner of death and drugs involved in drug intoxication deaths. *Acad Forensic Pathol,* 3(2),231–237.

Availability Indicators

Drug Reports from the National Forensic Laboratory Information System (NFLIS)

Overview and Limitations

NFLIS systematically collects results from drug analyses conducted by state and local forensic laboratories. These laboratories analyze controlled and noncontrolled substances secured in law enforcement operations across the United States. The DEA describes NFLIS as:

> "a comprehensive information system that includes data from forensic laboratories that handle the Nation's drug analysis cases. The NFLIS participation rate, defined as the percentage of the national drug caseload represented by laboratories that have joined NFLIS, is currently over 97%. Currently, NFLIS includes 50 State systems and 101 local or municipal laboratories/laboratory systems, representing a total of 277 individual laboratories. The NFLIS database also includes Federal data from DEA and U.S. Customs and Border Protection (CBP) laboratories."[a]

Limitations. NFLIS includes results from completed analyses only. Drug evidence secured by law enforcement but not analyzed by laboratories is not included in the NFLIS database.

State and local policies related to the enforcement and prosecution of specific drugs may affect drug evidence submissions to laboratories for analysis.

Laboratory policies and procedures for handling drug evidence vary. Some laboratories analyze all evidence submitted to them, whereas others analyze only selected case items. Many laboratories do not analyze drug evidence if the criminal case was dismissed from court or if no defendant could be linked to the case.[a]

Notes about Reporting Labs

Reporting anomalies were identified in several NDEWS SCSs in 2015 and are described below:

- **Denver Metro Area:** The Aurora Police Department laboratory's last reported data are from July 2014, following the migration to a new laboratory information management system (LIMS).
- **San Francisco County:** The San Francisco Police Department (SFPD) laboratory has been closed since 2010; however, beginning in January 2012, the Alameda Sheriff Department laboratory began reporting their SFPD cases to NFLIS. All available data from the SFPD were included in the counts.
- **Texas:** The Austin Police Department laboratory closed, and no data were provided for 2015. The Houston Forensic Science Government Corporation (formerly Houston Police Department Crime Lab) lab was added in April 2014 and has been reporting data since then.

Notes about Data Terms

Drug Report: Drug that is identified in law enforcement items, submitted to and analyzed by federal, state, or local forensic labs and included in the NFLIS database. This database allows for the reporting of up to three drug reports per item submitted for analysis. The data presented are a total count of first, second, and third listed reports for each selected drug item seized and analyzed.

For each site, the NFLIS drug reports are based on submissions of items seized in the site's catchment area. The catchment area for each site is described in the Notes section below each table. The time frame is January–December 2015. Data were queried from the DEA's NFLIS Data Query System (DQS) on May 18, 2016 using drug item submission date.

Five new psychoactive substance (NPS) drug categories and Fentanyls are of current interest to the NDEWS Project because of the recent increase in their numbers, types, and availability. The five NPS categories are: synthetic cannabinoids, synthetic cathinones, piperazines, tryptamines, and 2C Phenethylamines.

Other Fentanyls are substances that are structurally related to fentanyl (e.g., acetylfentanyl and butyrl fentanyl).

A complete list of drugs included in the Other Fentanyls category that were reported to NFLIS during the January to December 2015 timeframe includes:

3-METHYLFENTANYL

ACETYL-ALPHA-METHYLFENTANYL

ACETYLFENTANYL

Beta-HYDROXYTHIOFENTANYL

BUTYRYL FENTANYL

P-FLUOROBUTYRYL FENTANYL (P-FBF)

P-FLUOROFENTANYL

Sources

***Data Sources*:** Adapted by the NDEWS Coordinating Center from data provided by the U.S. Drug Enforcement Administration (DEA), Office of Diversion Control, Drug and Chemical Evaluation Section, Data Analysis Unit. Data were retrieved from NFLIS Data Query System (DQS) May 18, 2016.

***Overview/Methods/Limitations Sources*:** [a]Adapted by the NDEWS Coordinating Center from U.S. Drug Enforcement Administration (DEA), Office of Diversion Control. (2016) *National Forensic Laboratory Information System: Midyear Report 2015.* Springfield, VA: U.S. Drug Enforcement Administration. Available at: https://www.nflis.deadiversion.usdoj.gov/DesktopModules/ReportDownloads/Reports/NFLIS_MidYear2015.pdf