NDEWS National Drug Early Warning System

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

Los Angeles County
Sentinel Community Site (SCS)
Drug Use Patterns and Trends, 2016

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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.

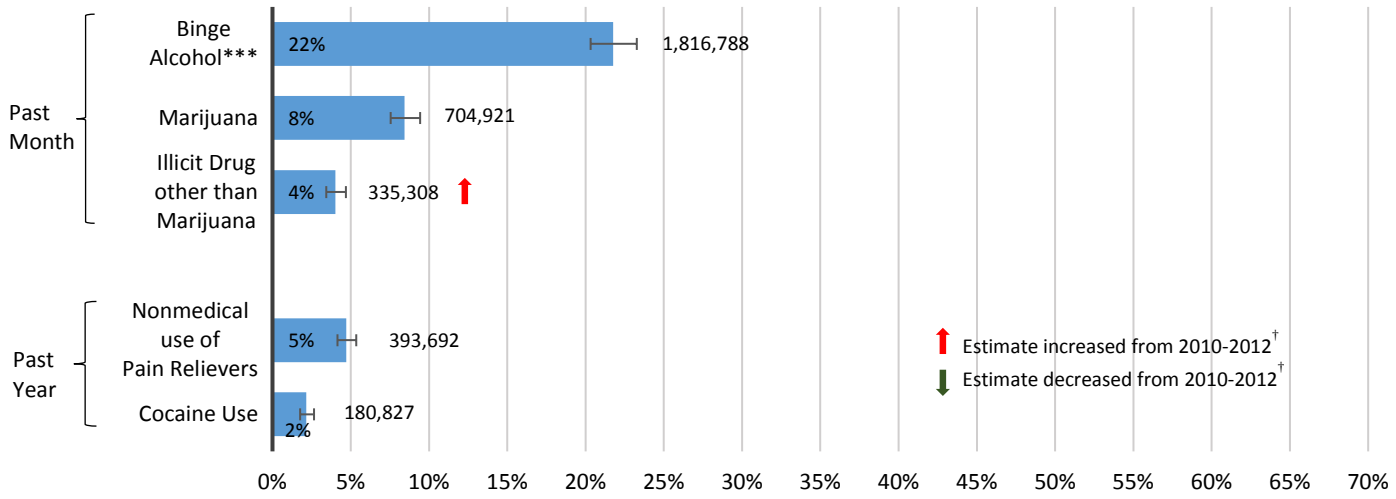
Los Angeles County SCS Snapshot, 2016

Substance Use

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

Persons 12+ Years Reporting Selected Substance Use, Los Angeles County^, 2012-2014

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

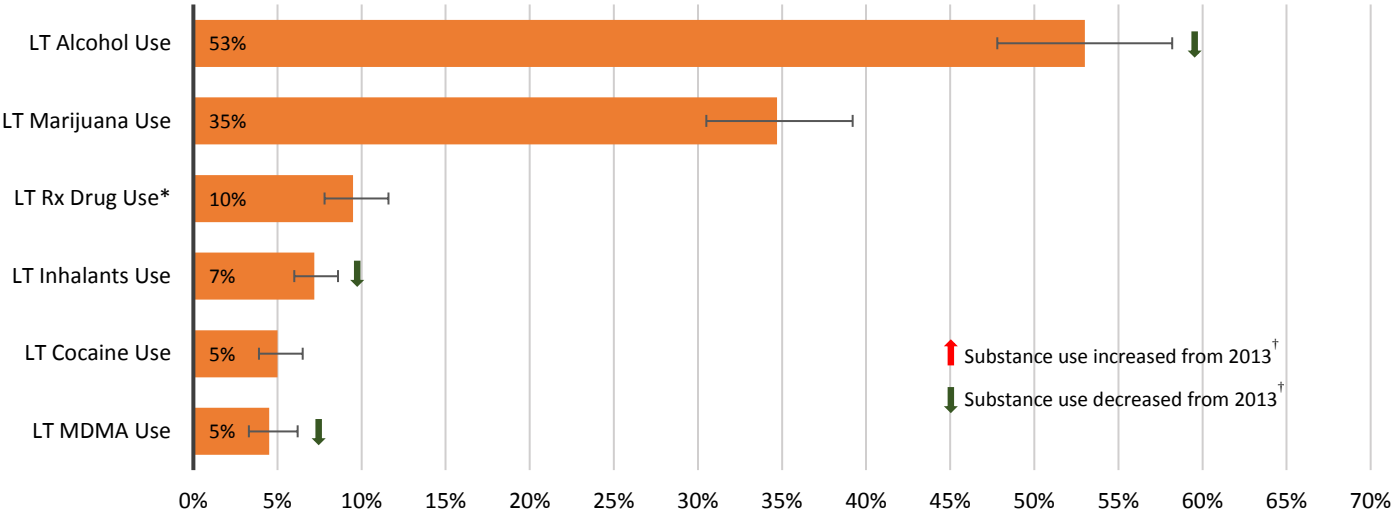


*U.S. Population: U.S. civilian non-institutionalized population. ^Los Angeles County: NSDUH Region 11 (Los Angeles County). **Estimated Number: Calculated by multiplying the prevalence rate and the population estimate of persons 12+ years (8,347,839) from Table C1 of the NSDUH Report.
***Binge Alcohol: Defined as drinking five or more drinks on the same occasion. †Statistically significant change: p<0.05.
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, Los Angeles, 2015

Estimated Percent and 95% Confidence Interval



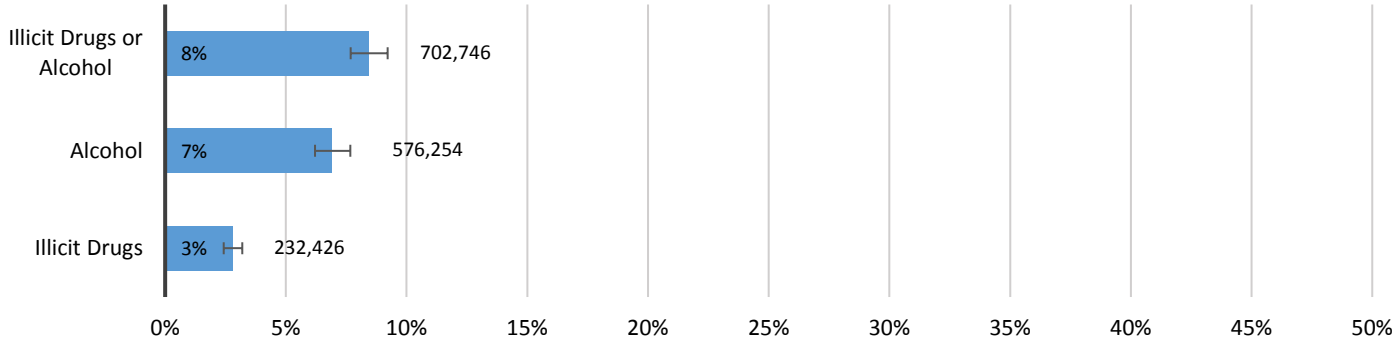
*LT Rx Drug Use: Defined as ever taking prescription drugs without a doctor's prescription one or more times during their life.
†Statistically significant change: p<0.05 by t-test.
See *Sentinel Community Site (SCS) Data Tables* and *Overview & Limitations* section for more information regarding the data.
Source: Adapted by the NDEWS Coordinating Center from data provided by CDC, 1991-2015 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, Los Angeles County^, 2012-2014**

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



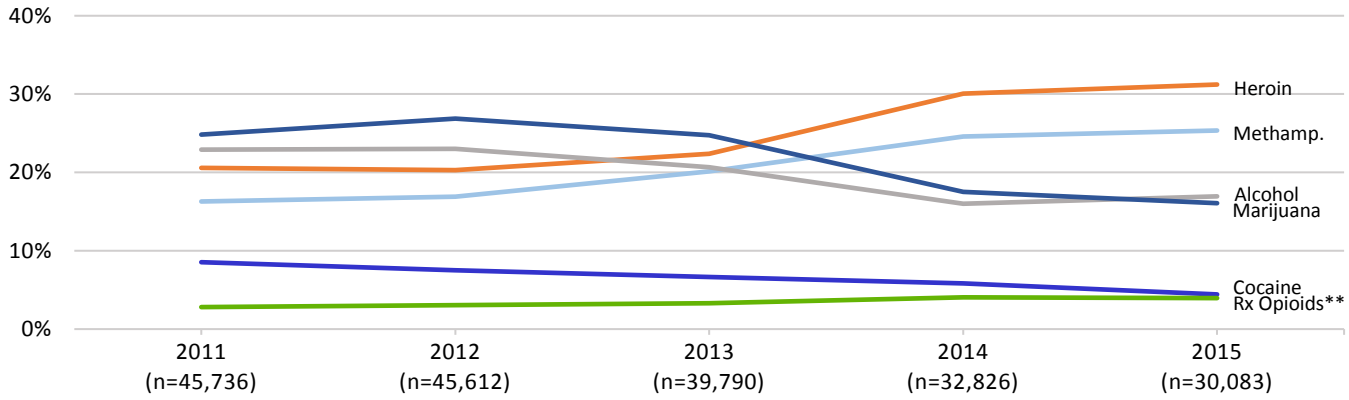
*U.S. Population: U.S. civilian non-institutionalized population. **Substance Use Disorders in Past Year: Persons are classified as having a substance use disorder in the past 12 months based on responses to questions that meet the criteria specified in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. ^Los Angeles County: NSDUH Region 11 (Los Angeles County). ***Estimated Number: Calculated by multiplying the prevalence rate and the population estimate of persons 12+ years (8,347,839) 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.

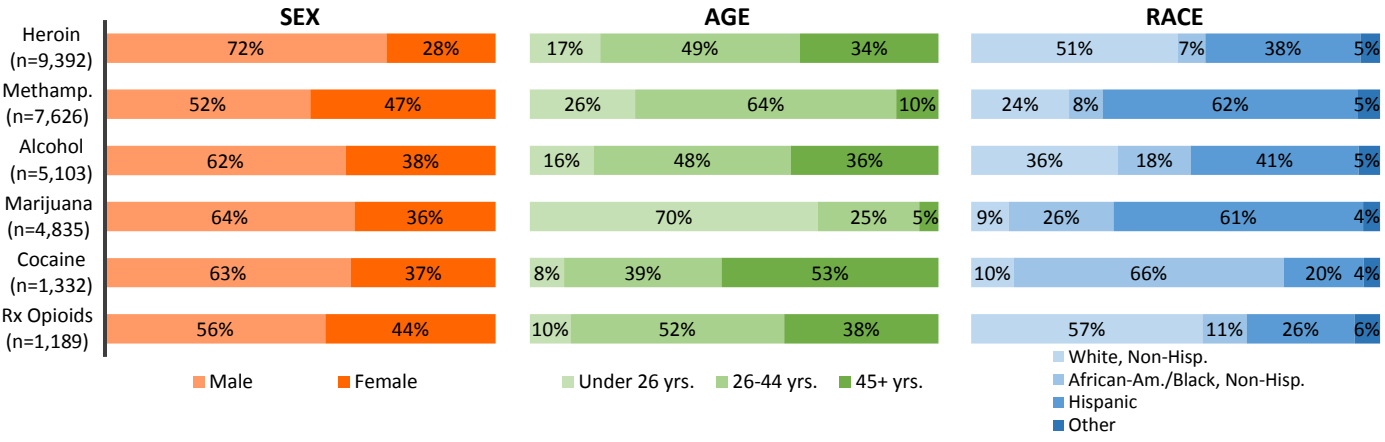
Treatment Admissions Data from Local Sources

Trends in Treatment Admissions*, by Primary Substance of Abuse, Los Angeles County, 2011-2015

Percentage of Admissions with Substance Cited as Primary Substance of Abuse at Admission (n = Number of Treatment Admissions)



Demographic Characteristics of Treatment Admissions*, Los Angeles County, 2015



*Treatment 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). **Rx Opioids: Includes drug categories labeled "oxycodone/OxyContin" and "other opiates or synthetics." Percentages may not sum to 100 due to rounding.

See *Sentinel Community Site (SCS) Data Tables* and *Overview & Limitations* section for more information regarding the data.

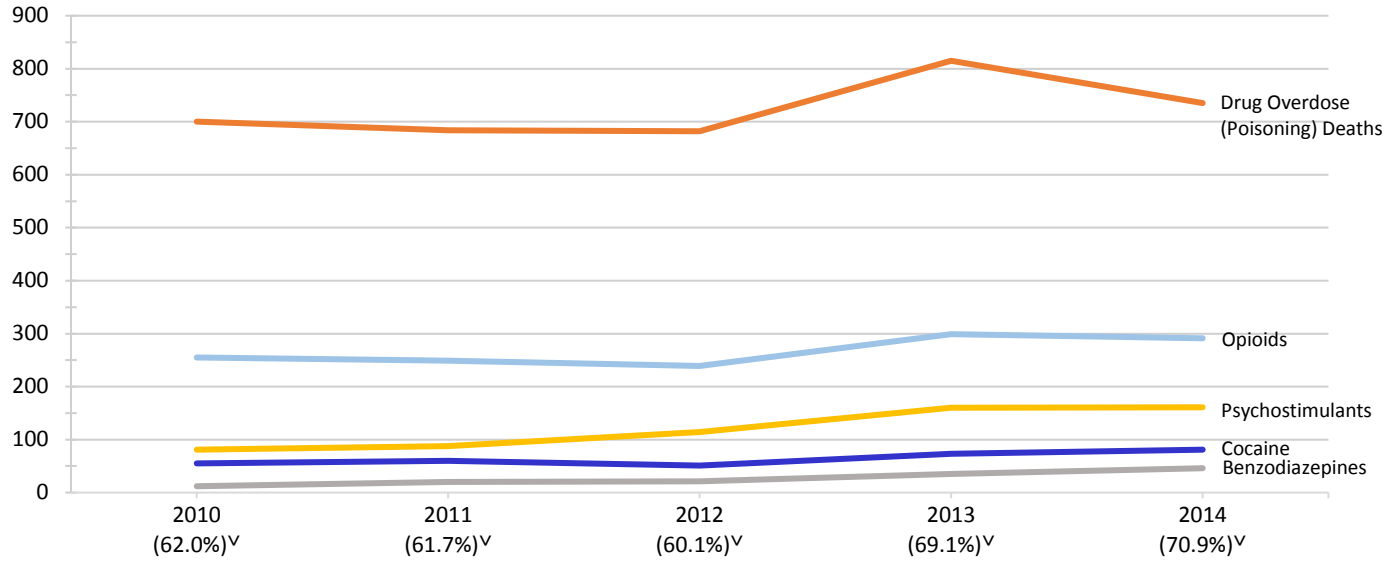
Source: Data provided to the Los Angeles NDEWS SCE by the California Department of Health Care Services, Mental Health Services Division, Office of Applied Research and Analysis, CalOMS (2013 and 2014 data) and the California Department of Drug and Alcohol Programs (2011-2012 data).

Drug Overdose (Poisoning) Deaths

National Vital Statistics System (NVSS) via CDC WONDER

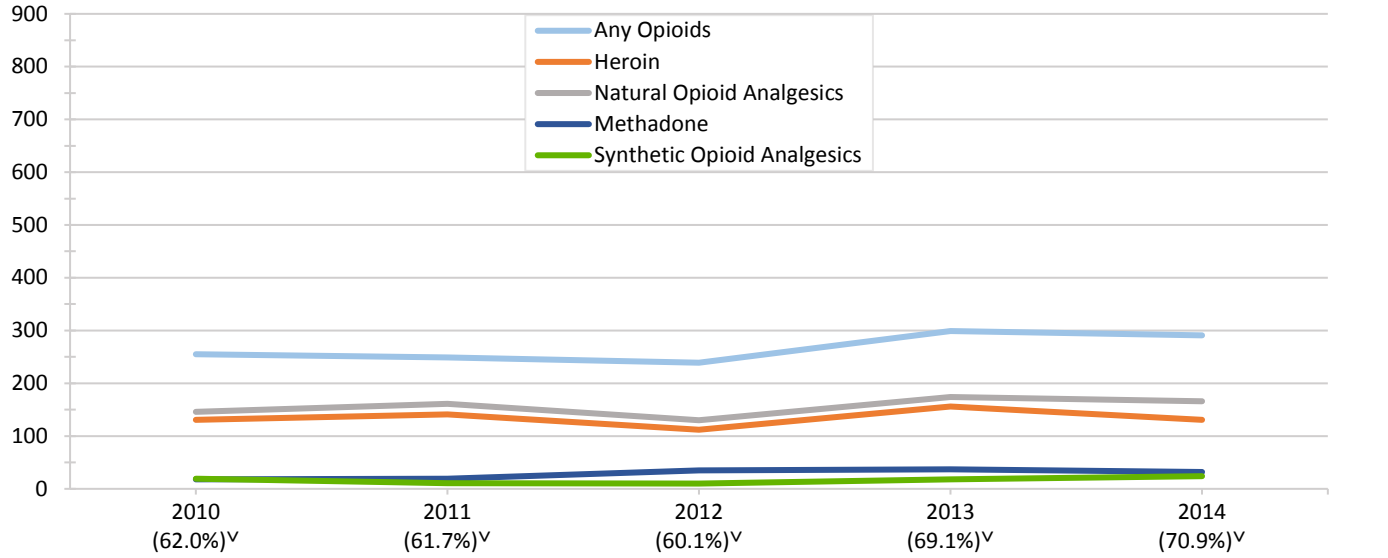
Trends in Drug Overdose (Poisoning) Deaths*, by Drug, Los Angeles^, 2010–2014**

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



Trends in Opioid Overdose (Poisoning) Deaths*, by Opioid, Los Angeles^, 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). ^Los Angeles: Comprised of Los Angeles County. ˅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. 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

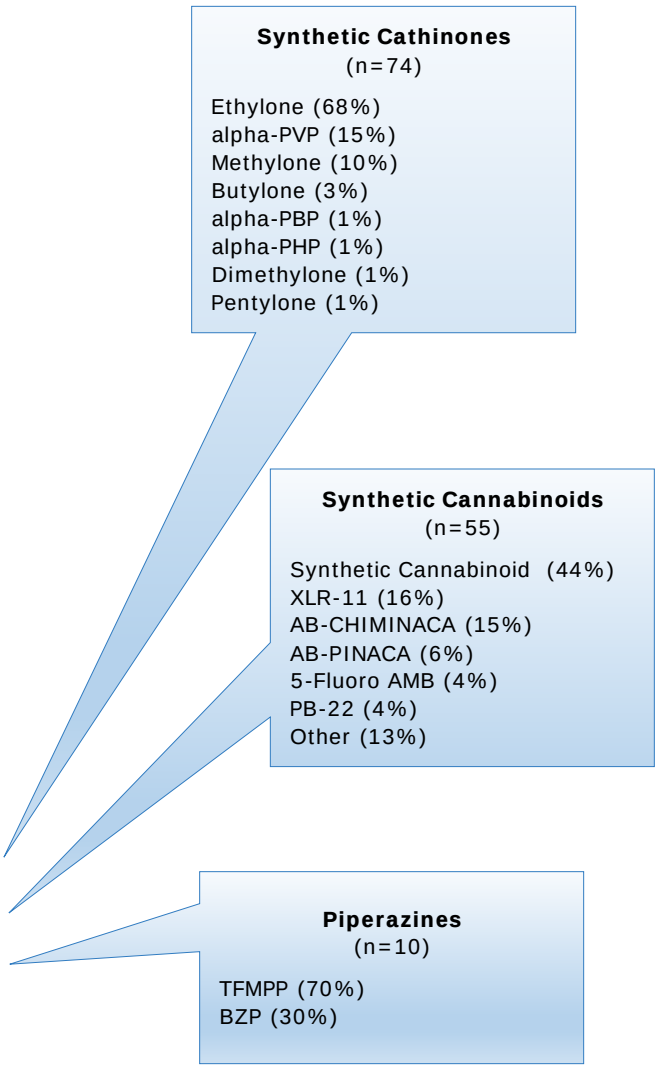
National Forensic Laboratory Information System (NFLIS)

Drug Reports* for Items Seized by Law Enforcement in Los Angeles County 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	**27,390**	**100%**
Top 10 Drug Reports* **		
Methamphetamine	10,610	38.7%
Cannabis	7,490	27.3%
Cocaine	3,913	14.3%
Heroin	2,019	7.4%
Alprazolam	384	1.4%
3,4-methylenedioxymethamphetamine (MDMA)	287	1.0%
Phencyclidine	230	0.8%
Oxycodone	130	0.5%
Hydrocodone	124	0.5%
Psilocybin/Psilocyn	68	0.2%
Top 10 Total	**25,255**	**92.2%**
Selected Drugs/Drug Categories		
Opioids	2,574	9.4%
Fentanyl	31	0.1%
Other Fentanyls[+]	11	<0.1%
Synthetic Cathinones	74	0.3%
Synthetic Cannabinoids	55	0.2%
Piperazines	10	<0.1%
2C Phenethylamines	7	<0.1%
Tryptamines	7	<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. **Percentages may not sum to 100 due to rounding. ***Note that 2 non-drug-specific categories had prevalence as follows: 'negative results'=1.0%, 280 reports; 'no controlled drug identified'=0.6%, n=160 reports.

[+]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) Los Angeles County Sentinel Community Site (SCS) Drug Use Patterns and Trends, 2016: SCE Narrative

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Highlights

- Across five major indicators of Los Angeles County substance use and consequences trends (treatment admissions, National Forensic Laboratory Information System (NFLIS) drug reports, medical examiner toxicology cases, poison control center calls, and nonfatal emergency department (ED) visits consistent increases were seen for **methamphetamine** for 2015 over 2014 (for ED visits, 2014 over 2013), which showed continuing upward trends for the past 4–6 years.

- For other substances, including **benzodiazepines**, **cocaine**, **heroin**, **other opioids**, **marijuana**, and **emerging synthetics**, indicators were mixed.

- Local concern remains for **heroin**, which registered small increases in percentages of treatment admissions and NFLIS reports, rates of ED visits (when considered as a category that also included other opioids), and percentages of poison control calls and had reports of increased law enforcement activity in 2015. However, a decrease was noted in heroin reports among medical examiner toxicology cases.

- Local concern remains for misuse of **prescription opioids**. However, opioid trends decreased in 2015 from 2014 for treatment admissions, medical examiner toxicology cases, and poison control center calls. The ED visit rate for opioids (including heroin) increased in 2014 over 2013.

- Indicators of emerging **synthetic drugs** remained at very low levels in Los Angeles County in 2015 compared with other substances; however, monitoring of these classes of drugs has not yet been implemented across all major indicator systems.

Changes in Legislation

No major statewide drug-related legislation went into effect in 2015. Counties and cities continue local decisions about whether, where, and under what conditions to allow dispensaries for medical marijuana.

Substance Use Patterns and Trends

To provide some context relevant to specific data sources, a brief summary of results by data source will be given before providing summaries for each specific drug across data sources.

Admissions for substance abuse treatment in calendar year (CY) 2015 totaled 30,083, continuing a decline from 32,826 in 2014 and from 48,762 in 2010. This decline is a result of several factors, including decreases in state funding and changes in service delivery. In 2015, four substances accounted for 89.6% of admissions: heroin 31.2%, methamphetamine 25.3%, marijuana 16.1%, and alcohol 17.0%. Cocaine/crack accounted for 4.4% and prescription opioids for 4.0%.

The number of drugs reported to the *Los Angeles County Poison Control Center* in 2015 totaled 4,529. Reports were predominantly for nonillicit substances (85.7%); for example, benzodiazepines accounted for 23.3% of drugs reported and prescription narcotics for 15.2%. Illicit substances accounted for 14.3% of substance reports, which was an increase from 12.1% in 2014. Among illicit substances, methamphetamine accounted for the largest share (33.6% of the illicit substance reports, 4.8% of total reports), followed by marijuana (24.2% of illicit substance reports, 3.4% of total reports), cocaine/crack (10.5% of illicit, 1.5% of total), and heroin (12.9% of illicit, 1.8% of total).

Drug reports from seized items analyzed by the U.S. Drug Enforcement Administration's (DEA's) National Forensic Laboratory Information System (NFLIS) totaled 27,390 for Los Angeles County in 2015. Methamphetamine was identified in 38.7% of the drug reports and cannabis in 27.3%. Other drugs with more than 1% of reports included cocaine (14.3%), heroin (7.4%), alprazolam (a benzodiazepine, 1.4%), and MDMA (1.0%).

Toxicology cases compiled by the Medical Examiner's office for 2015 with results available on 4/11/16 totaled 2,741; 24.5% were females, and 75.5% were males. Note that many results from October–December 2015 were not yet available for processing for this NDEWS report; based on historical annual totals, it is estimated that the 2015 totals could be approximately 15% higher when result reports are completed. Percentages reported below for toxicology cases represent fractions of the available total for 2015. Alcohol was detected most frequently (in 38.5% of cases), followed by methamphetamine (28.3%), THC (tetrahydrocannabinol, an active ingredient in marijuana; 21.9%), prescription narcotics (19.4%), heroin/morphine metabolites (12.5%), and cocaine (12.7%).

Emergency department (ED) visits for nonfatal cases with alcohol or drugs (AOD) as the primary diagnosis show the following rates per 100,000 population in 2014 (the most recent year available): amphetamines 30.6, opioids (heroin or prescription) 21.4, sedatives 15.3, cannabis 13.3, and cocaine 7.0.

BENZODIAZEPINES

- Benzodiazepines indicators were mixed.

In 2015, treatment admissions associated with primary benzodiazepine use comprised 0.5%. Although the numbers of benzodiazepines reported in NFLIS were small, there was a slight increase in reports of alprazolam (1.4%) in 2015 over 2014 (1.0%). Other benzodiazepines accounted for less than 0.5% of reports. Among 2015 Los Angeles County medical examiner toxicology cases, benzodiazepines were reported in 4.8% of the cases, which was a substantial decrease from 9.5% in 2014; the percentage was higher among female toxicology cases (7.3%) than among males (4.0%). Among ED visits in 2014 (the most recent year available), the general sedatives category (which includes benzodiazepines) showed a rate of 15.3 per 100,000 population, which was a slight increase from a rate of 14.2 in 2013. Benzodiazepines were reported in 25.3% of 2015 Los Angeles County Poison Control calls, which was an increase from 23.9% in 2014 and from 22.1% in 2013.

COCAINE

- Cocaine indicators were mixed.

Of Los Angeles County treatment admissions in 2015, 4.4% (*n* = 1,332) reported crack or powder cocaine as the primary drug of abuse. This represents a continuing decrease from previous years when cocaine/crack admissions constituted 5.8% of total admissions in 2014, 6.7% in 2013, and 8.5% in 2011 (Table 4a). Continuing with historical gender distribution, a majority (62.8%) of primary cocaine/crack admissions in 2015 were male (Table 4b). Non-Hispanic African Americans/Blacks continued to represent a majority of cocaine admissions (at 66.1% of the total in 2015). Among substances accounting more than 1% each of 2015 admissions, cocaine/crack displayed the highest percentage of African Americans/Blacks, where this group was substantially overrepresented compared with their general representation across all treatment admissions (15.0%). Cocaine admissions were predominantly 45 years of age and older, with this age group comprising 53.1% of cocaine admissions; note that this 45 and older age group constituted 24.5% of total admissions.

Cocaine retained a rank of third among drugs from NFLIS drug reports in 2015 for Los Angeles County. Continuing decreases in percentages were seen with cocaine accounting for 14.3% of reports in 2015 compared with 15.4% in 2014.

Cocaine was detected in 12.7% of Los Angeles County medical examiner toxicology cases in 2015, which was similar to levels in 2014 (12.5%). This was a lower percentage of cases than for narcotic analgesics, methamphetamine, THC, and heroin/morphine. Percentages for cocaine were similar for males (12.8%) and females (12.2%).

The ED visit rate in 2014 for cocaine as a primary diagnosis among nonfatal ED visits in Los Angeles County was 7.0 per 100,000 population, which was a very slight increase from a rate of 6.8 per 100,000 in 2013.

Cocaine was reported in 1.5% of 2015 Los Angeles County Poison Control calls, which was a slight increase

from 1.2% in 2014 and attenuating a slow decline over several years (e.g., 2.1% in 2008). Note that all illicit drugs together accounted for 14.3% of all substances reported in relevant poison control calls; thus, cocaine accounted for 10.5% of reports within the illicit drug category.

MARIJUANA

- Marijuana indicators were mixed.

Marijuana as primary drug accounted for 16.1% of Los Angeles County treatment admissions, which was a slight decline from levels in 2014 (17.5%) and down from the 24.8% to 26.9% range in 2011–2013. In 2015, approximately two thirds of the primary marijuana admissions were male (63.9%; Table 4b), which was a slight decrease from 2014 (67.7% male). Marijuana admissions had the largest proportion of clients younger than 18 years (45.6% in 2015, a decrease from 48.4% in 2014), compared with this age group share of methamphetamine admissions [3.4%], alcohol admissions [4.4%], cocaine [1.3%], heroin [0.3%], and other opioids [0.7%]). A majority of marijuana admissions were Hispanics (at 61.0%), followed by non-Hispanic African American/Blacks (at 25.6%). Of the major illicit substances, the smallest percentage of non-Hispanic Whites (9.2%) was reported for marijuana.

Cannabis was identified in 27.3% of NFLIS drug reports in 2015, with a ranking of second among drugs for Los Angeles County. This was a slight decrease from 28.2% in 2014.

THC was detected in 21.9% of Los Angeles County medical examiner toxicology cases in 2015, which was a slight increase from 2014 (19.8%). Among male toxicology cases, 24.6% reported THC, whereas among female cases, 13.4% reported THC.

In 2014, marijuana/cannabis was reported as a primary diagnosis in nonfatal ED visits with a rate of 13.3 per 100,000 population, which was an increase from a rate of 10.1 in 2013.

Marijuana was reported in 3.4% of 2015 Los Angeles County Poison Control calls, which was similar to 2014 levels (3.3%).

METHAMPHETAMINE

- Across five major indicators of Los Angeles County substance use and consequences trends (treatment admissions, National Forensic Laboratory Information System (NFLIS) drug reports, medical examiner toxicology cases, poison control center calls, and nonfatal emergency department (ED) visits), consistent increases were seen for methamphetamine for 2015 over 2014 (for ED visits, 2014 over 2013), which showed continuing upward trends for the past 4–6 years.

Methamphetamine accounted for 25.3% (*n* = 7,626) of admissions to Los Angeles County substance abuse treatment programs in 2015 (Table 4a), which was a slight increase from 24.6% in 2014 and continuing a generally increasing trend since 2011. Other amphetamines were reported as the primary substance in 0.05% of the total treatment admissions. Compared with admissions for other major illicit drugs, primary methamphetamine admissions had the largest proportion of females (47.4%; Table 4b). Methamphetamine admissions were most likely to be Hispanic (62.5%), followed by non-Hispanic Whites (24.5%). Among methamphetamine admissions, 3.4% were by clients younger than 18 years of age; 22.4%

of admissions were for clients ages 18–25; 63.9% were for clients ages 26–44; and clients 45 or older represented 10.3% of methamphetamine admissions. Smoking continued as the most frequently mentioned route of administration by primary methamphetamine admissions (77.1%). Proportions of injectors (8.8%) and inhalers (11.4%) have generally declined from the 1990s (from 15.2% and 29.9%, respectively, in 1999).

Methamphetamine was ranked first among drugs for Los Angeles County based on drug reports from NFLIS; methamphetamine accounted for 38.7% of reports in 2015, which was a very slight increase from 38.5% in 2014.

Methamphetamine was detected in 28.3% of Los Angeles County medical examiner toxicology cases in 2015, which was an increase from 24.3% in 2014 and continuing an increasing trend since 2010. Among male toxicology cases, 30.9% reported methamphetamine, whereas among female cases, 20.4% reported methamphetamine. Little change was seen in the age distribution of toxicology cases reporting methamphetamine from 2014 to 2015; in 2015, 3.2% of cases were for those younger than 18 years of age, 15.0% for 18–25 years, 39.7% for 25–44 years, and 42.1% for those 45 years or older.

Among nonfatal ED visits in 2014, the category of amphetamines (including, but not distinguishing, methamphetamine) was primary diagnosis with a rate of 30.6 per 100,000 population, which continued an increasing trend (from 15.0 in 2010 and 25.9 in 2013).

Methamphetamine was reported in 4.8% of 2015 Los Angeles County Poison Control calls, which was the largest percentage among illicit drugs and continuing an increasing trend from 1.2% in 2008 and 3.9% in 2014.

The wholesale price of methamphetamine continued to decrease to historic lows during 2015: Wholesale prices were at $2,800 to $3,500 per pound near the end of 2015 compared with $3,400 to $4,000 at the end of 2014 and $17,500 to $19,500 in 2008. According to LA CLEAR (Los Angeles Criminal Information Clearing House), methamphetamine remained readily available throughout 2015. Street prices at the end of 2015 were reported at $80 to $140 per 1/8 ounce compared with $150 in 2014 and $250 in 2008.

NEW PSYCHOACTIVE SUBSTANCES (OTHER THAN OPIOIDS)

- Indicators of emerging synthetic drugs remained at very low levels in Los Angeles County in 2015 compared with other substances; however, monitoring of these classes of drugs has not yet been implemented across all major indicator systems.

The prevalence of emerging synthetic drugs remains very low for Los Angeles County across indicator systems that report these substances. These substances are not yet recorded for statewide treatment admission data, not reported in the public data system for ED primary diagnosis summary statistics, and are not routinely examined in all coroner toxicology cases. Synthetic cathinones (reported as bath salts by callers) were reported in <0.1% (*n* = 3) of 2015 Los Angeles County Poison Control calls, which was a decrease from 0.3% (*n* = 13) in 2014. Synthetic cathinones accounted for 67 reports or 0.2% of NFLIS drug reports, which was a decrease from 201 reports or 0.6% in 2014; 50 of the 67 total in 2015 were reported as ethylone. Synthetic cannabinoids (most reported as “spice” by callers) were reported in 0.7% (*n* = 33) of 2015 Los Angeles Poison Control calls, which was an increase from 0.5% in 2014 (*n* = 23). Synthetic

cannabinoids accounted for 0.2% (*n* = 55) of NFLIS drug reports, which was a decrease from *n* = 86 in 2014. In 2015, there were 54 reports of *piperazines* among Los Angeles County toxicology cases (2.0% of toxicology cases). There were 10 reports of piperazines in NFLIS, most of which were identified as TFMPP. One report of piperazines (BZP) was identified among 2015 Los Angeles Poison Control calls. In NFLIS data, there were 7 reports of tryptamines.

OPIOIDS

- Local concern remains for heroin, which registered small increases in percentages of treatment admissions and NFLIS reports, rates of ED visits (when considered as a category that also included other opioids), and percentages of poison control calls and had reports of increased law enforcement activity in 2015. However, a decrease was noted in heroin reports among medical examiner toxicology cases.

- Local concern remains for misuse of prescription opioids. However, opioid trends decreased in 2015 from 2014 for treatment admissions, medical examiner toxicology cases, and poison control center calls. The ED visit rate for opioids (including heroin) increased in 2014 over 2013.

Heroin

In 2015, 9,392 Los Angeles County treatment admissions reported heroin as the primary drug. These heroin admissions represented 31.2% of Los Angeles County admissions (Table 4a), which was a slight (1.1%) increase from 2014 (30.1%) after a substantial increase from 2013 (22.4%) to 2014. In 2015, heroin admissions were predominantly for males (72.0%) and were most likely to be for non-Hispanic Whites (50.6%) or Hispanics (38.0%). Heroin admissions were predominantly for clients in the 26–44-year age range (48.8%) or who were 45 years of older (33.9%). Although an increasing proportion of the heroin admissions was observed for the 18–25 age group from 2008 (9.0%) to 20.2% in 2013, the percentage of heroin admissions for that age group declined somewhat in 2014 (17.7%) and again slightly in 2015 (17.0%).

Heroin/morphine or metabolites were detected in 12.5% of Los Angeles County medical examiner toxicology cases in 2015, which was a decrease from 2014 (16.5%). Percentages of heroin/morphine/metabolites were relatively similar for male (12.3%) and female (12.8%) toxicology cases. The age distribution in toxicology reports for heroin/morphine/metabolites was similar in 2015 to 2014, with the largest percentage (52.6%) for cases in the 45 or older age category in 2015; 1.5% were for cases for those younger than 18 years of age, 10.2% for ages 18–25, and 35.7% for ages 26–44.

Heroin ranked fourth among drugs for Los Angeles County based on NFLIS drug reports. Heroin was identified in 7.4% of NFLIS drug reports, which was a small increase over 2014 (6.5%) and continuing a slight upward trend.

The ED visit rate in 2014 for the category of opioids as a principal diagnosis (not distinguished in the data source by subcategory, e.g., heroin or other opioids) among nonfatal ED visits was 21.4 per 100,000 population, up from a rate of 19.0 per 100,000 population in 2013. The opioid category had a 2014 rate lower than for the amphetamines category (30.6 per 100,000 population) and higher than for sedatives (15.3), cannabis (13.3), and cocaine (7.0).

Heroin was reported in 1.8% of 2015 Los Angeles County Poison Control calls (or 12.9% of reports for illicit

drugs), which was an increase over 2014 (1.1% of all relevant drug reports).

Los Angeles High Intensity Drug Trafficking Area (LA HIDTA) reported that law enforcement operations related to heroin increased during 2015 and that there were indications of increasing availability of Mexican brown heroin on the street.

Other Opioids

Admissions for primary drug in the categories "Other opioids/synthetics" or "Oxycodone/OxyContin" continued to constitute a small percentage (*n* = 1,189 or 4.0%) of Los Angeles County treatment admissions in 2015. The gradual increase since 2010 appears to have stabilized in 2015 with levels similar to 2014 (4.1%; Table 4a). Admissions for these opioid categories remain predominantly non-Hispanic White (56.6%) and older than 25 years (52.3% were 26–44, which was an increase from 47.9% in this age category in 2014, and 37.8% were 45 or older, which was a decrease from 42.1% in 2014; Table 4b). The percentage of opioid admissions for younger users remained stable in 2015 (10.0% were 25 or younger in 2015).

Oxycodone ranked 8 and hydrocodone ranked 9 among drugs for Los Angeles County based on NFLIS drug reports for 2015, which accounted for 0.5% each of total reports. These two prescription opioids were the most prevalent among drugs in the general category of narcotic analgesics, which as a category accounted for 2.0% of NFLIS drug reports for Los Angeles County in 2015, which remained stable from 2014.

One or more narcotic analgesics (not including heroin/morphine) were detected in 19.4% of 2015 Los Angeles County medical examiner toxicology cases in 2015, which was a decrease from 24.4% in 2014. Narcotics were identified at a level lower than that of methamphetamine and THC (tetrahydrocannabinol, an active ingredient in marijuana) and higher than for other specific categories of illicit drugs, including cocaine and heroin/morphine. Of male toxicology cases, 20.6% reported narcotic analgesics; among female cases, 25.0% reported narcotic analgesics. A majority (58.3%) of cases reporting narcotic analgesics were for those 45 years of age or older, whereas 59.9% of all toxicology cases were for this age group.

Because the opioid category for ED visit data does not distinguish between heroin and other opioids, we repeat the data summary presented in the heroin section earlier. The ED visit rate in 2014 for the category of opioids as a principal diagnosis (which includes heroin) was 21.4 per 100,000 population, which was up from a rate of 19.0 per 100,000 population in 2013.

Narcotic analgesics were reported in 15.2% of 2015 Los Angeles County Poison Control calls, which was a very slight decrease from 15.7% in 2014; of these narcotic analgesic reports, 59.7% were for hydrocodone products in 2015 and 21.0% were for oxycodone products.

We looked specifically at fentanyl because of current concern with fentanyl-related deaths in several locations across the United States. Fentanyl was identified in 0.1% of NFLIS drug reports for Los Angeles County in 2015 (*n* = 31), which was an increase from 10 reports in 2014. Fentanyl was reported in 20 calls to the Poison Control System, which was down slightly from 23 reports in 2014. Fentanyl was reported in 47 toxicology cases by the Los Angeles medical examiner for 2015. Nevertheless, because results for 2015 were not yet complete for this NDEWS report, it is likely that the final tally may be similar to 2014 (56 cases). As with the general

category of narcotic analgesics, the majority (51.1%) of the toxicology cases with fentanyl identified were for those ages 45 or older.

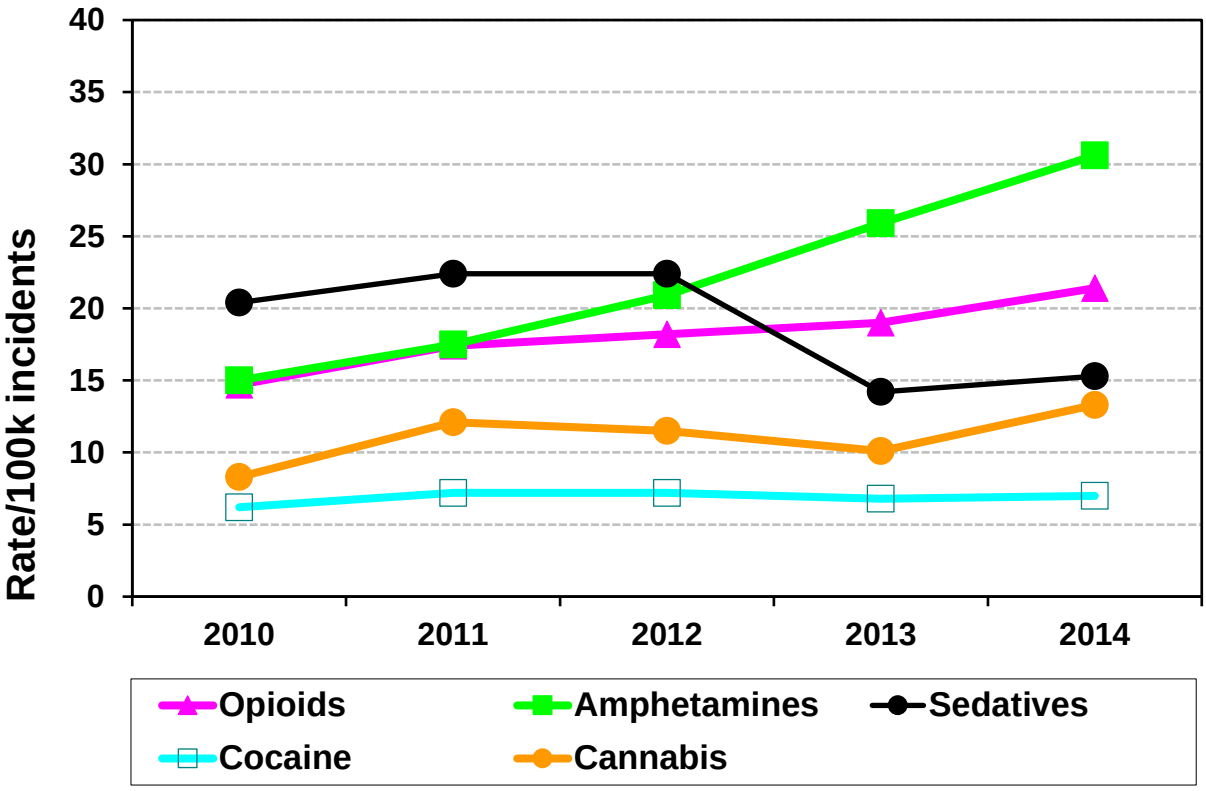
Infectious Diseases Related to Substance Use

According to Los Angeles Department of Public Health reports, the number of HIV diagnoses in Los Angeles County has gradually declined from *n* = 2,740 in 2007 to 1,820 in 2013. Note that because of reporting delays, figures for 2013 years may still be considered a slight underestimate. Males accounted for a large proportion of diagnoses (88% in 2013); among males, male-to-male sexual (MSM) contact remained the predominant vector of transmission (94% in 2013), with injection drug use (IDU) at 3% and MSM/IDU at 3%. Among females (12% of diagnoses, a slight increase from 10% in 2012), heterosexual contact was the primary vector of transmission (79%). Although IDU remained a secondary vector of transmission at 20%, this was a substantial increase over 15% in 2012. The racial/ethnic distribution among 2013 diagnoses was as follows: 24% non-Hispanic White, 24% non-Hispanic Black, 45% Hispanic, and 5% other. The largest percentage of 2013 diagnoses by age group was 37% for persons younger than 30 years; 28% were 30–39 years; 21% 40–49 years; and 14% 50 years or older.

According to the Los Angeles County Department of Public Health Acute Communicable Disease Control, new cases of hepatitis A in Los Angeles County numbered 42 in 2014, with an annual incidence rate of 0.44 per 100,000 population; this was a decrease from a rate of 0.64 in 2013. Note that the incidence rate for California for 2014 was 0.37 and for the United States 0.39. New cases of (acute) hepatitis numbered 42 in 2014 (rate of 0.4 4 per 100,000), which was a decrease from a rate of 0.58 in 2013. The rate for California was 0.29 and for the United States was 0.93. Five new cases of (acute) hepatitis C (rate of 0.05) were reported in 2014; this rate was consistent with the previous four years. The rate of hepatitis C for California was 0.19 and for the United States was 0.69.

Exhibits

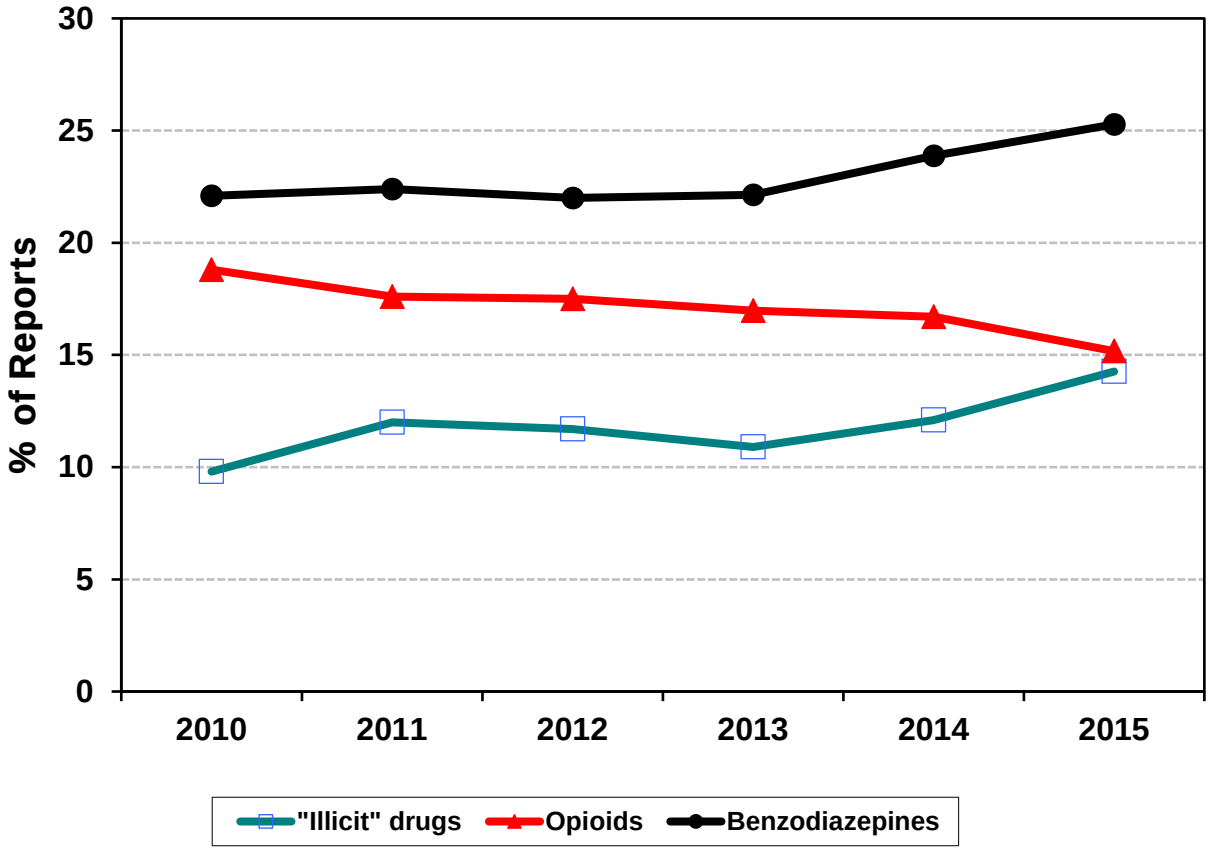
Exhibit 1. Rates of Primary Diagnosis Among Nonfatal Emergency Department Visits for Selected Major Drug Categories, Los Angeles County, 2010–2014[1]



[1] Incidents include poisoning ("overdose"), mental disorder, and physical disease, where AOD was reported as principal diagnosis but not indirect consequences such as injuries due to drug or alcohol impairment. Rates are number of relevant incidents per 100,000 population.

Source: CA Dept. of Public Health, EpiCenter CA Injury Data Online, accessed 5/18/16

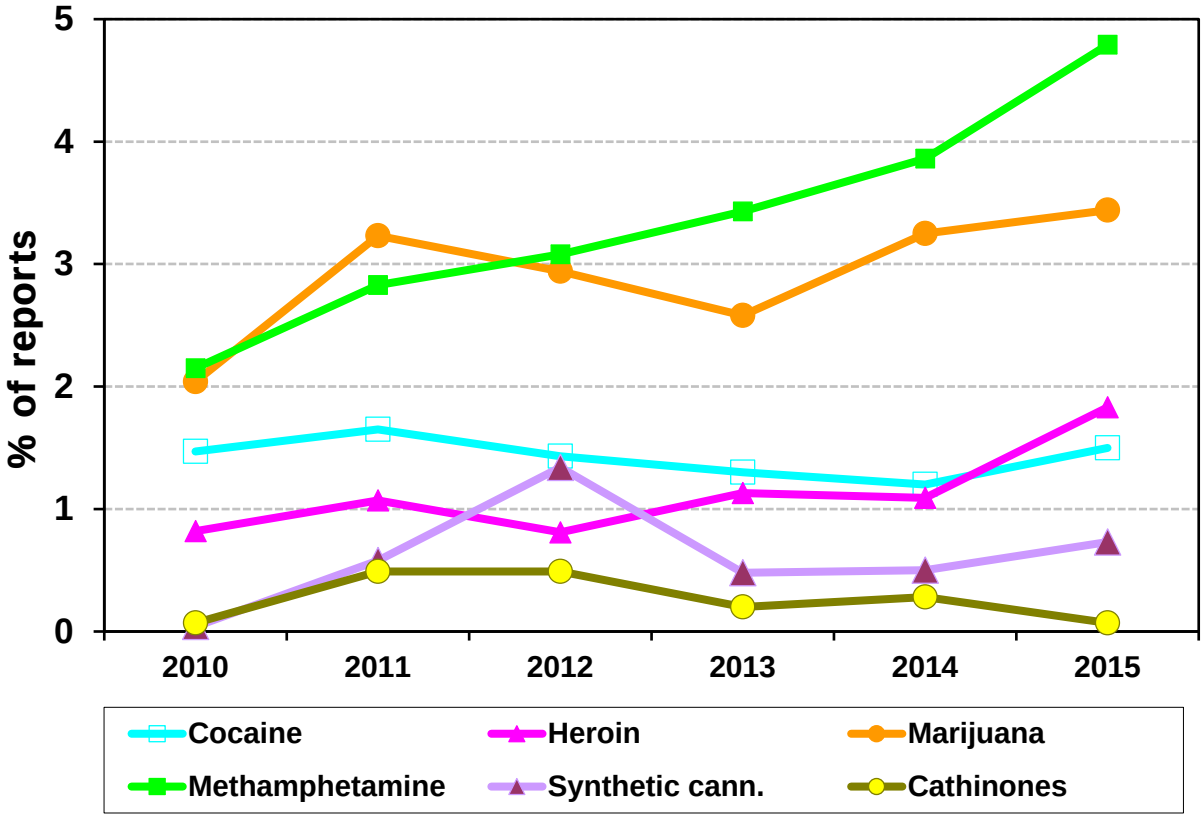
Exhibit 2. Percentage of Reports to California Poison Control Center, Los Angeles County, 2010–2015[1]



[1]Notes: a) reports for illicit drugs or for cases (for other drugs) with "intentional/suspected suicide, misuse, abuse, unknown," "contamination/tampering," or "malicious" reasons; b) illicit drugs include heroin, marijuana, cocaine/crack, methamphetamine, PCP, LSD, MDMA, GHB, piperazine, tryptamines, Rohypnol, cannabamimetics, and cathinones (see Exhibit 3 for selected illicit drugs); and c) opioid category includes opioids other than heroin.

Source: California Poison Control System (3/5/16) 2015 data, *n* = 4,529 total drug reports

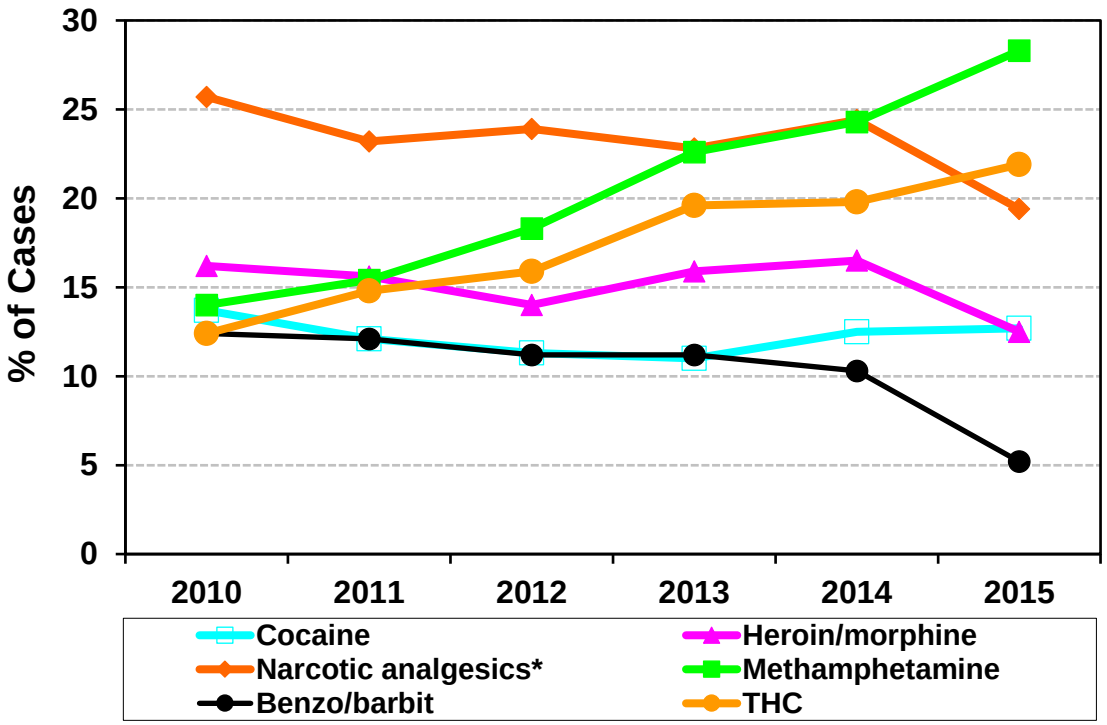
Exhibit 3. Percentage of Reports to California Poison Control Center for Selected "Illicit" Drugs, Los Angeles County, 2010–2015[1]



[1] Reports for illicit drugs or for cases (for other drugs) with "intentional/suspected suicide, misuse, abuse, unknown," "contamination/tampering," or "malicious" reasons.

Source: California Poison Control System (3/5/16) 2015 data, *n* = 4,529 total drug reports

Exhibit 4. Percentage of Medical Examiner Toxicology Cases with Drugs Detected, Los Angeles County, 2010–2015



Notes: *narc.analgesics and narc-like analgesics (other than heroin/morphine) include codeine, hydrocodone, hydromorphone, oxycodone, oxymorphone, methadone, fentanyl, other narcotics, and tramadol.

Number of toxicology cases: 2010 *n* = 2,981, 2011 *n* = 2,866, 2012 *n* = 3,068, 2013 *n* = 3,109, 2014 *n* = 3,038,

2015 *n* = 2,741 (incomplete)

Source: Data for analysis from Los Angeles County Medical Examiner 4/11/16

Data Sources

Data for this report were drawn from the following sources:

Data for admissions to substance abuse treatment are reported from the California Outcomes Monitoring System (CalOMS) for Los Angeles County for 2015 and earlier years for comparison (compiled by the California Department of Health Care Services, Mental Health Services Division, Office of Applied Research and Analysis, 3/24/16). Data include all admissions to programs in Los Angeles County receiving any public funding and all admissions to programs providing narcotic replacement therapy (whether or not the program receives public funding). The total number of admissions for Los Angeles County has experienced a continuing a decline from 48,762 in 2010 to 30,083 in 2015. Decreases in annual admissions have occurred statewide and are a result of factors such as reductions in certain state funding and changes in the overall delivery system.

Drug prices and trafficking data were derived from U.S. Department of Justice sources. Prices were reported by the Los Angeles County Regional Criminal Information Clearinghouse (LA CLEAR) fourth quarter 2015 and 2014 for comparison. The prices included in these reports reflect the best estimates of the analysts in the Research and Analysis Unit at LA CLEAR and reported in National Drug Intelligence Center (NDIC) publications. Price estimates are based primarily on field reports, interviews with law enforcement agencies throughout the Los Angeles High Intensity Drug Trafficking Area (HIDTA), and postseizure analysis.

Drugs detected in Los Angeles County Medical Examiner toxicology cases were extracted from data provided by the Los Angeles County Medical Examiner's office for calendar year 2015 (data provided 4/11/2016) with reference to earlier years from the same source. Note that many results from October–December 2015 were not yet available for processing for this NDEWS report; based on historical annual totals, it is estimated that the 2015 totals could be approximately 15% higher when result reports are completed. Percentages reported in the current NDEWS report represent fractions of the available total for 2015. Percentages reflect fractions of the total number of cases for which toxicology tests were conducted (i.e., not just drug-related deaths). Each case may have more than one drug detected; therefore, percentages should not be summed across drug categories. Note that heroin and morphine and their metabolites were not distinguished into separate categories. Emerging synthetic drugs typically were not included in the toxicology testing. For reporting purposes, we have combined narcotic analgesics and narcotic-like analgesics (other than heroin/morphine) into one category; these include codeine, hydrocodone, hydromorphone, oxycodone, oxymorphone, methadone, fentanyl, other narcotics, and tramadol.

Emergency department (ED) visits for nonfatal cases with alcohol or drugs (AOD) as primary diagnosis were accessed from the California Department of Public Health, EpiCenter CA Injury Data Online for 2014 (these were the most recent data available, accessed 5/18/2016), and references to earlier years are from the same source. Incidents reported here include only those listed as poisoning ("overdose"), mental disorder, and physical disease, where AOD was reported as principal diagnosis, but do not include indirect consequences, such as injuries due to drug or alcohol impairment. Rates are number of

relevant incidents per 100,000 population. Note that opioids as a principal diagnosis included, but did not distinguish, heroin.

Poison Control calls were summarized from data from the California Poison Control Center for calendar year 2015 (data extracted as of 3/5/2016). References to prior years are from the same source. Drug mentions are included for cases (calls) that reported illicit drugs or cases for which the reason for the call was labeled as "intentional/suspected suicide, misuse, abuse, unknown," "contamination/tampering," or "malicious."

Human immunodeficiency virus (HIV) diagnosis data (through December 2013) were obtained from the Los Angeles County Department of Health Services, Division of HIV and STD Programs, "Supplemental Tables for HIV Summary Report 2014," February 2016. Hepatitis data for 2014 were from the Los Angeles County Department of Health Services, Acute Communicable Disease Control Program, "Annual Morbidity Report 2014."

The author wishes to thank individuals and agencies that have provided data, statistics, and information, including (but not limited to) C. Chaffee (California Department of Health Care Services, Mental Health Services, Division, Office of Applied Research & Analysis); Los Angeles Criminal Information Clearinghouse (LA Clear); O. Brown (Los Angeles County Medical Examiner's office); and T. Carlson (California Poison Control Center).

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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
Los Angeles County, California
2010–2014 ACS 5-Year Estimates

	Estimate	Margin of Error
Total Population (#)	**9,974,203**	**
Age		
18 years and over (%)	76.5%	**
21 years and over (%)	71.9%	+/-0.1
65 years and over (%)	11.5%	**
Median Age	35.3	
Race (%)		
White, Not Hisp.	27.2%	+/-0.1
Black/African American, Not Hisp.	8.0%	+/-0.1
Hispanic/Latino (of any race)	48.1%	**
American Indian/Alaska Native	0.2%	+/-0.1
Asian	13.8%	+/-0.1
Native Hawaiian/Pacific Islander	0.2%	+/-0.1
Some Other Race	0.2%	+/-0.1
Two or More Races	2.2%	+/-0.1
Sex (%)		
Male	49.3%	**
Female	50.7%	**
Educational Attainment (*Among Population Aged 25+ Years*) (%)		
High School Graduate or Higher	76.8%	+/-0.1
Bachelor's Degree or Higher	29.9%	+/-0.1
Unemployment (*Among Civilian Labor Force Population Aged 16+ Years*) (%)		
Percent Unemployed	11.0%	+/-0.1
Income ($)		
Median Household Income (in 2014 inflation-adjusted dollars)	$55,870	+/-244
Health Insurance Coverage (*Among Civilian Noninstitutionalized Population*) (%)		
No Health Insurance Coverage	20.9%	+/-0.2
Poverty (%)		
All People Whose Income in Past Year Is Below Poverty Level	18.4%	+/-0.2

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.
**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 Los Angeles^, 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: Los Angeles^	
	Estimated % (95% CI)*	Estimated #*
Used in Past Month		
Alcohol	47.64 (45.55 – 49.73)	3,976,548
Binge Alcohol**	21.76 (20.32 – 23.27)	1,816,788
Marijuana	8.44 (7.55 – 9.43)	704,921
Use of Illicit Drug Other Than Marijuana	4.02 (3.44 – 4.69)	335,308
Used in Past Year		
Cocaine	2.17 (1.77 – 2.65)	180,827
Nonmedical Use of Pain Relievers	4.72 (4.15 – 5.35)	393,692
Substance Use Disorders in Past Year***		
Illicit Drugs or Alcohol	**8.42 (7.68 – 9.22)**	**702,746**
Alcohol	6.90 (6.21 – 7.67)	576,254
Illicit Drugs	2.78 (2.43 – 3.19)	232,426

NOTES:
^Los Angeles: NSDUH Substate Region 11 which comprises Los Angeles County.
***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 (8,347,839) 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 Los Angeles,^ 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: Los Angeles^					
	12–17		18–25		26+	
	Estimated Percent (95% CI)*		Estimated Percent (95% CI)*		Estimated Percent (95% CI)*	
Used in Past Month						
Binge Alcohol**	6.27	(5.39 – 7.28)	34.73	(32.17 – 37.38)	21.27	(19.58 – 23.07)
Marijuana	8.04	(6.95 – 9.29)	19.95	(18.02 – 22.03)	6.34	(5.36 – 7.49)
Use of Illicit Drug Other Than Marijuana	3.76	(3.07 – 4.59)	6.26	(5.23 – 7.49)	3.63	(2.96 – 4.44)
Used in Past Year						
Cocaine	0.92	(0.64 – 1.32)	5.96	(4.86 – 7.28)	1.61	(1.20 – 2.17)
Nonmedical Use of Pain Relievers	4.70	(3.88 – 5.70)	8.34	(7.26 – 9.56)	4.04	(3.40 – 4.80)
Substance Use Disorder in Past Year***						
Illicit Drugs or Alcohol	5.88	(5.03 – 6.87)	18.01	(16.20 – 19.98)	6.94	(6.11 – 7.87)
Alcohol	2.96	(2.38 – 3.67)	13.19	(11.66 – 14.90)	6.22	(5.42 – 7.12)
Illicit Drugs	4.17	(3.44 – 5.05)	8.02	(6.86 – 9.36)	1.63	(1.28 – 2.07)

NOTES:
^Los Angeles: NSDUH Substate Region 11 which comprises Los Angeles County.
***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 *Los Angeles* ^ Public High-School Students, 2015
Estimated Percent and 95% Confidence Interval (CI)
2013 and 2015 YRBS*

Substance Use Behaviors	2015 vs 2013			2015 by Sex			2015 by Race			
	2015 Estimate (95% CI)	2013 Estimate (95% CI)	*p* value	Male Estimate (95% CI)	Female Estimate (95% CI)	*p* value	White Estimate (95% CI)	Black Estimate (95% CI)	Hispanic Estimate (95% CI)	Asian Estimate (95% CI)
Used in Past Month										
Alcohol	21.7 (18.0 - 26.0)	27.6 (24.4 - 31.1)	**0.02**	20.0 (14.6 - 26.7)	23.4 (20.4 - 26.6)	0.18	28.1 (18.5 - 40.2)	16.1 (11.4 - 22.2)	22.4 (18.6 - 26.7)	12.8 (7.8 - 20.1)
Binge Alcohol**	10.2 (8.0 - 12.9)	13.3 (11.2 - 15.7)	0.06	9.7 (6.5 - 14.3)	10.6 (8.2 - 13.5)	0.70	11.8 (6.2 - 21.3)	2.3 (1.0 - 5.0)	11.2 (8.7 - 14.3)	3.8 (2.3 - 6.4)
Marijuana	16.6 (14.1 - 19.4)	20.3 (16.1 - 25.3)	0.14	17.4 (13.5 - 21.9)	15.9 (12.4 - 20.1)	0.63	18.2 (11.4 - 27.9)	22.8 (18.1 - 28.3)	15.8 (13.1 - 18.9)	9.8 (6.8 - 14.1)
Ever Used in Lifetime										
Alcohol	53.0 (47.8 - 58.2)	59.9 (56.4 - 63.4)	**0.03**	50.2 (44.0 - 56.4)	55.7 (50.7 - 60.6)	**0.00**	55.5 (43.7 - 66.7)	50.1 (40.2 - 60.0)	55.0 (49.0 - 60.8)	30.6 (23.8 - 38.4)
Marijuana	34.7 (30.5 - 39.2)	39.3 (34.2 - 44.7)	0.16	32.7 (27.8 - 38.1)	36.5 (31.6 - 41.8)	0.15	28.5 (18.7 - 40.9)	43.4 (35.2 - 52.0)	35.6 (30.8 - 40.6)	14.2 (9.8 - 20.3)
Cocaine	5.0 (3.9 - 6.5)	6.5 (5.3 - 7.8)	0.10	5.8 (4.5 - 7.5)	4.2 (2.8 - 6.3)	0.11	4.4 (2.1 - 8.7)	4.0 (1.2 - 12.5)	5.2 (3.9 - 6.8)	2.3 (0.5 - 10.2)
Hallucinogenic Drugs	—	—	~	—	—	~	—	—	—	—
Synthetic Marijuana	6.5 (5.5 - 7.7)	—	~	6.4 (4.9 - 8.2)	6.4 (5.1 - 8.1)	0.96	8.8 (4.5 - 16.6)	4.8 (2.1 - 10.3)	6.3 (5.6 - 7.0)	6.7 (3.3 - 13.0)
Inhalants	7.2 (6.0 - 8.6)	10.5 (8.7 - 12.7)	**0.00**	6.4 (4.9 - 8.3)	8.0 (6.0 - 10.5)	0.29	6.9 (4.3 - 10.8)	7.8 (3.8 - 15.3)	7.6 (6.1 - 9.5)	4.2 (1.8 - 9.3)
Ecstasy also called "MDMA"	4.5 (3.3 - 6.2)	10.9 (8.5 - 13.8)	**0.00**	5.1 (3.9 - 6.5)	3.9 (2.4 - 6.2)	0.14	9.1 (6.3 - 13.2)	2.3 (0.7 - 7.9)	4.1 (3.1 - 5.5)	1.4 (0.4 - 5.0)
Heroin	2.0 (1.1 - 3.7)	3.0 (2.1 - 4.3)	0.23	2.8 (1.4 - 5.5)	1.1 (0.6 - 2.1)	**0.02**	5.1 (2.3 - 10.8)	2.8 (0.8 - 9.0)	1.3 (0.7 - 2.4)	2.3 (0.5 - 10.1)
Methamphetamine	3.4 (2.1 - 5.5)	5.1 (3.6 - 7.3)	0.14	4.6 (2.9 - 7.3)	2.2 (1.1 - 4.1)	**0.00**	7.4 (3.9 - 13.7)	3.2 (1.1 - 9.5)	2.9 (1.7 - 4.8)	3.4 (0.9 - 11.9)
Rx Drugs without a Doctor's Prescription	9.5 (7.8 - 11.6)	10.6 (8.1 - 13.8)	0.50	10.7 (8.7 - 13.2)	8.4 (6.5 - 10.8)	**0.03**	11.7 (6.7 - 19.6)	12.1 (8.5 - 16.9)	8.7 (7.0 - 10.7)	9.4 (5.6 - 15.6)
Injected Any Illegal Drug	1.9 (1.2 - 3.2)	2.1 (1.4 - 3.2)	0.83	2.6 (1.4 - 4.7)	1.3 (0.7 - 2.2)	0.08	2.9 (1.1 - 7.7)	3.9 (1.4 - 10.0)	1.3 (0.7 - 2.5)	4.4 (2.0 - 9.7)

NOTES:
^Los Angeles: Weighted data were available for Los Angeles in 2013 and 2015; 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.
'—': Data not available; **~:** *p* value not available.
***Sample Frame for the 2013 and 2015 YRBS:** Consisted of public schools with students in at least one of grades 9-12. The sample size for 2013 was 1,619 with an overall response rate of 84%; the 2015 sample size was 2,336 with an 81% overall response rate.
****Binge Alcohol:** Defined as having 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), 1991-2015 High School Youth Risk Behavior Survey Data. Available at http://nccd.cdc.gov/youthonline/. Accessed on [7/5/2016].

Table 4a: Trends in Admissions* to Programs Treating Substance Use Disorders, *Los Angeles County* Residents, 2011-2015

Number of Admissions and Percentage 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 (#)	**45,736**	**100%**	**45,612**	**100%**	**39,790**	**100%**	**32,826**	**100%**	**30,083**	**100%**
Primary Substance of Abuse (%)										
Alcohol	10,482	22.9%	10,496	23.0%	8,216	20.6%	5,253	16.0%	5,103	17.0%
Cocaine/Crack	3,906	8.5%	3,416	7.5%	2,654	6.7%	1,909	5.8%	1,332	4.4%
Heroin	9,417	20.6%	9,256	20.3%	8,900	22.4%	9,866	30.1%	9,392	31.2%
Prescription Opioids**	1,285	2.8%	1,402	3.1%	1,307	3.3%	1,331	4.1%	1,189	4.0%
Methamphetamine	7,451	16.3%	7,710	16.9%	8,012	20.1%	8,070	24.6%	7,626	25.3%
Marijuana	11,356	24.8%	12,256	26.9%	9,851	24.8%	5,752	17.5%	4,835	16.1%
Benzodiazepines	170	0.4%	195	0.4%	195	0.5%	135	0.4%	148	0.5%
MDMA	211	0.5%	83	0.2%	57	0.1%	27	0.1%	27	0.1%
Synthetic Stimulants	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail
Synthetic Cannabinoids	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail	unavail
Other Drugs/Unknown	1,289	2.8%	696	1.5%	514	1.3%	413	1.3%	431	1.4%

NOTES:

***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; 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."

unavail: Data not available.

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 (2011–2012 data).

Table 4b: Demographic and Drug Use Characteristics of Primary Treament Admissions* for Select Substances of Abuse, *Los Angeles County* Residents, 2015

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 (#)	**5,103**	**100%**	**1,332**	**100%**	**9,392**	**100%**	**1,189**	**100%**	**7,626**	**100%**	**4,835**	**100%**	**148**	**100%**
Sex (%)														
Male	3,146	61.7%	837	62.8%	6,762	72.0%	671	56.4%	4,002	52.5%	3,088	63.9%	76	51.4%
Female	1,956	38.3%	492	36.9%	2,627	28.0%	518	43.6%	3,614	47.4%	1,745	36.1%	72	48.6%
Race/Ethnicity (%)														
White, Non-Hisp.	1,833	35.9%	138	10.4%	4,751	50.6%	673	56.6%	1,827	24.0%	445	9.2%	unavail	unavail
African-Am/Black, Non-Hisp	906	17.8%	881	66.1%	627	6.7%	128	10.8%	626	8.2%	1,240	25.6%	unavail	unavail
Hispanic/Latino	2,098	41.1%	260	19.5%	3,571	38.0%	315	26.5%	4,764	62.5%	2,951	61.0%	unavail	unavail
Asian	87	1.7%	19	1.4%	107	1.1%	22	1.9%	174	2.3%	58	1.2%	unavail	unavail
Other	179	3.5%	34	2.6%	336	3.6%	51	4.3%	235	3.1%	141	2.9%	unavail	unavail
Age Group (%)														
Under 18	227	4.4%	17	1.3%	26	0.3%	8	0.7%	262	3.4%	2,205	45.6%	7	4.7%
18-25	569	11.2%	95	7.1%	1,592	17.0%	110	9.3%	1,705	22.4%	1,202	24.9%	37	25.0%
26-44	2,463	48.3%	513	38.5%	4,587	48.8%	622	52.3%	4,870	63.9%	1,200	24.8%	57	38.5%
45+	1,844	36.1%	707	53.1%	3,187	33.9%	449	37.8%	789	10.3%	228	4.7%	47	31.8%
Route of Administration (%)														
Smoked	0	0.0%	1,044	78.4%	1,943	20.7%	16	1.3%	5,876	77.1%	4,752	98.3%	0	0.0%
Inhaled	0	0.0%	221	16.6%	295	3.1%	24	2.0%	869	11.4%	10	0.2%	1	0.7%
Injected	0	0.0%	11	0.8%	6,964	74.1%	16	1.3%	668	8.8%	0	0.0%	0	0.0%
Oral/Other/Unknown	5,103	100%	56	4.2%	190	2.0%	1,133	95.3%	213	2.8%	73	1.5%	147	99.3%
Secondary Substance (%)														
None	2,903	56.9%	482	36.2%	5,084	54.1%	644	54.2%	3,212	42.1%	2,528	52.3%	50	33.8%
Alcohol	0	0.0%	387	29.1%	538	5.7%	82	6.9%	1,617	21.2%	1,246	25.8%	25	16.9%
Cocaine/Crack	316	6.2%	0	0.0%	518	5.5%	31	2.6%	250	3.3%	142	2.9%	3	2.0%
Heroin	64	1.3%	28	2.1%	0	0.0%	68	5.7%	288	3.8%	27	0.6%	5	3.4%
Prescription Opioids**	97	1.9%	10	0.8%	384	4.1%	29	2.4%	74	1.0%	23	0.5%	17	11.5%
Methamphetamine	734	14.4%	120	9.0%	1,903	20.3%	76	6.4%	0	0.0%	700	14.5%	15	10.1%
Marijuana	817	16.0%	126	9.5%	475	5.1%	73	6.1%	2,024	26.5%	0	0.0%	22	14.9%
Benzodiazepines	85	1.7%	1	0.1%	232	2.5%	86	7.2%	39	0.5%	27	0.6%	0	0.0%

NOTES:

***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; 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."

unavail: Data not available; **Percentages** may not sum to 100 due to either rounding, missing data and/or because not all possible categories are presented in the table.

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.

Table 5: Drug Overdose (Poisoning) Deaths*, by Drug and Year, *Los Angeles*^ , 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	**700**	**7.1**	**6.9**	**684**	**6.9**	**6.7**	**682**	**6.8**	**6.6**	**815**	**8.1**	**7.8**	**735**	**7.3**	**6.9**
Opioids‡	**255**	**2.6**	**2.5**	**249**	**2.5**	**2.4**	**239**	**2.4**	**2.3**	**299**	**3.0**	**2.8**	**291**	**2.9**	**2.7**
Heroin	131	1.3	1.3	141	1.4	1.4	112	1.1	1.1	156	1.6	1.5	131	1.3	1.2
Natural Opioid Analgesics	146	1.5	1.4	161	1.6	1.5	130	1.3	1.3	174	1.7	1.6	166	1.6	1.5
Methadone	18	UNR	UNR	19	UNR	UNR	35	0.4	0.3	37	0.4	0.3	32	0.3	0.3
Synthetic Opioid Analgesics	19	UNR	UNR	11	UNR	UNR	10	UNR	UNR	18	UNR	UNR	24	0.2	0.2
Benzodiazepines	**12**	**UNR**	**UNR**	**20**	**0.2**	**0.2**	**21**	**0.2**	**0.2**	**35**	**0.3**	**0.3**	**46**	**0.5**	**0.5**
Benzodiazepines **AND** Any Opioids	SUP	SUP	SUP	SUP	SUP	SUP	16	UNR	UNR	19	UNR	UNR	37	0.4	0.4
Benzodiazepines **AND** Heroin	SUP	SUP	SUP	SUP	SUP	SUP	SUP	SUP	SUP	SUP	SUP	SUP	10	UNR	UNR
Psychostimulants															
Cocaine	55	0.6	0.6	60	0.6	0.6	51	0.5	0.5	73	0.7	0.7	81	0.8	0.8
Psychostimulants with Abuse Potential	81	0.8	0.8	88	0.9	0.9	114	1.1	1.1	160	1.6	1.5	161	1.6	1.5
Cannabis (derivatives)	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**	**SUP**
Percent with Drugs Specified‡	**62.0%**			**61.7%**			**60.1%**			**69.1%**			**70.9%**		

NOTES:

***Drug Overdose (Poisoning) Deaths:** Defined 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.

^Los Angeles: Comprised of Los Angeles County.

*****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 *Los Angeles County* 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*	**27,390**	**100.0%**
METHAMPHETAMINE	10,610	38.7%
CANNABIS	7,490	27.3%
COCAINE	3,913	14.3%
HEROIN	2,019	7.4%
ALPRAZOLAM	384	1.4%
3,4-METHYLENEDIOXYMETHAMPHETAMINE (MDMA)	287	1.0%
NEGATIVE RESULTS - TESTED FOR SPECIFIC DRUGS	280	1.0%
PHENCYCLIDINE	230	0.8%
NO CONTROLLED DRUG IDENTIFIED	160	0.6%
OXYCODONE	130	0.5%
HYDROCODONE	124	0.5%
PSILOCYBIN/PSILOCYN	68	0.2%
3,4-METHYLENEDIOXYAMPHETAMINE (MDA)	67	0.2%
CODEINE	67	0.2%
CARISOPRODOL	63	0.2%
TRAMADOL	63	0.2%
GAMMA HYDROXY BUTYL LACTONE	59	0.2%
AMPHETAMINE	56	0.2%
3,4-METHYLENEDIOXYETHYLCATHINONE (ETHYLONE)	50	0.2%
PHENYLIMIDOTHIAZOLE ISOMER UNDETERMINED	47	0.2%
KETAMINE	45	0.2%
ACETAMINOPHEN	36	0.1%
DIMETHYLSULFONE	36	0.1%
MITRAGYNINE	34	0.1%
DIAZEPAM	33	0.1%
IBUPROFEN	33	0.1%
LYSERGIC ACID DIETHYLAMIDE (LYSERGIDE)	33	0.1%
FENTANYL	31	0.1%
CLONAZEPAM	30	0.1%
QUETIAPINE	27	< 0.1%
CAFFEINE	25	< 0.1%
GAMMA HYDROXY BUTYRATE	24	< 0.1%
SYNTHETIC CANNABINOID	24	< 0.1%
LORAZEPAM	23	< 0.1%
OPIUM	22	< 0.1%
UNKNOWN	22	< 0.1%
METHOCARBAMOL	20	< 0.1%
TRAZODONE	20	< 0.1%
METHADONE	19	< 0.1%
TADALAFIL	19	< 0.1%
GABAPENTIN	18	< 0.1%

Drug Identified	Number (#)	Percent of Total Drug Reports* (#)
LACTOSE	18	< 0.1%
MORPHINE	18	< 0.1%
CYCLOBENZAPRINE	17	< 0.1%
PSILOCIN	16	< 0.1%
CATHINONE	14	< 0.1%
SILDENAFIL CITRATE (VIAGRA)	14	< 0.1%
BUPRENORPHINE	13	< 0.1%
STEROIDS	13	< 0.1%
TESTOSTERONE	13	< 0.1%
NAPROXEN	12	< 0.1%
ZOLPIDEM	12	< 0.1%
ACETYLFENTANYL	11	< 0.1%
ALPHA-PYRROLIDINOPENTIOPHENONE (ALPHA-PVP)	11	< 0.1%
DIPHENHYDRAMINE	11	< 0.1%
SERTRALINE	11	< 0.1%
PHENTERMINE	10	< 0.1%
BACLOFEN	9	< 0.1%
HYDROMORPHONE	9	< 0.1%
XLR-11 (1-(5-FLUOROPENTYL-1H-3-YL)(2,2,3,3-TETRAMETHYLCYCLOPROPYL)METHANONE)	9	< 0.1%
AB-CHMINACA (N-[(1S)-1-(AMINOCARBONYL)-2-METHYLPROPYL]-1-(CYCLOHEXYLMETHYL)-1H-INDAZOLE-3-CARBOXAMIDE)	8	< 0.1%
LORATADINE	8	< 0.1%
1-(3-TRIFLUOROMETHYL)PHENYL-PIPERAZINE (TFMPP)	7	< 0.1%
1,4-BUTANEDIOL	7	< 0.1%
BUSPIRONE	7	< 0.1%
MANNITOL	7	< 0.1%
N-METHYL-3,4-METHYLENEDIOXYCATHINONE (METHYLONE)	7	< 0.1%
AMOXICILLIN	6	< 0.1%
ASPIRIN	6	< 0.1%
CLONIDINE	6	< 0.1%
DIMETHYLTRYPTAMINE (DMT)	6	< 0.1%
ESCITALOPRAM	6	< 0.1%
HYDROCHLOROTHIAZIDE	6	< 0.1%
HYDROXYZINE	6	< 0.1%
TIZANIDINE	6	< 0.1%
CITALOPRAM	5	< 0.1%
LAMOTRIGINE	5	< 0.1%
LIDOCAINE	5	< 0.1%
LISINOPRIL	5	< 0.1%
METHYLPHENIDATE	5	< 0.1%
PROMETHAZINE	5	< 0.1%
TRENBOLONE	5	< 0.1%
4-ANILINO-1-PHENETHYLPIPERIDINE	4	< 0.1%
ARIPIPRAZOLE	4	< 0.1%
CONTROLLED SUBSTANCE	4	< 0.1%

Drug Identified	Number (#)	Percent of Total Drug Reports* (#)
DIACETAMIDE	4	< 0.1%
LEVETIRACETAM	4	< 0.1%
LEVOTHYROXINE	4	< 0.1%
METFORMIN	4	< 0.1%
NANDROLONE	4	< 0.1%
NOSCAPINE	4	< 0.1%
OLANZAPINE	4	< 0.1%
ONDANSETRON	4	< 0.1%
OXANDROLONE	4	< 0.1%
PAROXETINE	4	< 0.1%
PROPRANOLOL	4	< 0.1%
SULFAMETHOXAZOLE	4	< 0.1%
AB-PINACA	3	< 0.1%
AMITRIPTYLINE	3	< 0.1%
ATENOLOL	3	< 0.1%
BOLDENONE	3	< 0.1%
BUPROPION	3	< 0.1%
DICLOFENAC	3	< 0.1%
DOXYCYCLINE	3	< 0.1%
DROSTANOLONE	3	< 0.1%
FLUOXETINE	3	< 0.1%
METHOXETAMINE (MXE; 2-(3-METHOXYPHENYL)-2-(ETHYLAMINO)CYCLOHEXANONE)	3	< 0.1%
METOPROLOL	3	< 0.1%
METRONIDAZOLE	3	< 0.1%
MONOACETYLMORPHINE	3	< 0.1%
N-BENZYLPIPERAZINE (BZP)	3	< 0.1%
PHENACETIN	3	< 0.1%
PSILOCYBINE	3	< 0.1%
TEMAZEPAM	3	< 0.1%
2-(4-BROMO-2,5-DIMETHOXYPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-B-NBOMe)	2	< 0.1%
2-(4-CHLORO-2,5-DIMETHOXYPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-C-NBOME)	2	< 0.1%
4-BROMO-2,5-DIMETHOXYPHENETHYLAMINE (2C-B)	2	< 0.1%
5-FLUORO AMB	2	< 0.1%
AMLODIPINE	2	< 0.1%
ANASTROZOLE	2	< 0.1%
ATORVASTATIN	2	< 0.1%
BENZOCAINE	2	< 0.1%
BUTYLONE (ß-KETO-N-METHYLBENZO-DIOXYLPROPYLAMINE)	2	< 0.1%
CEPHALEXIN	2	< 0.1%
CLINDAMYCIN	2	< 0.1%
CREATINE	2	< 0.1%
DIVALPROEX	2	< 0.1%
DIVALPROEX SODIUM	2	< 0.1%
ETIZOLAM	2	< 0.1%

Drug Identified	Number (#)	Percent of Total Drug Reports* (#)
LISDEXAMFETAMINE	2	< 0.1%
LURASIDONE	2	< 0.1%
MAGNESIUM SULFATE	2	< 0.1%
METHANDROSTENOLONE (METHANDIENONE)	2	< 0.1%
MIRTAZAPINE	2	< 0.1%
NALOXONE	2	< 0.1%
NICOTINE	2	< 0.1%
OXYBUTYNIN	2	< 0.1%
OXYMORPHONE	2	< 0.1%
PB-22 (1-PENTYL-1H-INDOLE-3-CARBOXYLIC ACID 8-QUINOLINYL ESTER)	2	< 0.1%
PENICILLIN	2	< 0.1%
PHENDIMETRAZINE	2	< 0.1%
PHENOBARBITAL	2	< 0.1%
POLYACRYLAMIDE	2	< 0.1%
PREDNISONE	2	< 0.1%
PROCAINE	2	< 0.1%
SIMVASTATIN	2	< 0.1%
SODIUM BICARBONATE	2	< 0.1%
SOME OTHER SUBSTANCE	2	< 0.1%
STANOZOLOL	2	< 0.1%
TOPIRAMATE	2	< 0.1%
UREA	2	< 0.1%
VARDENAFIL	2	< 0.1%
VENLAFAXINE	2	< 0.1%
VITAMIN	2	< 0.1%
ZALEPLON	2	< 0.1%
2-(4-IODO-2,5-DIMETHOXYPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-I-NBOME)	1	< 0.1%
2-FLUOROMETHAMPHETAMINE	1	< 0.1%
2-MAPB (N,A-DIMETHYL-2-BENZOFURANETHANAMINE)	1	< 0.1%
4-FLUOROAMPHETAMINE (4-FA)	1	< 0.1%
4-METHOXYMETHAMPHETAMINE	1	< 0.1%
6-MONOACETYLMORPHINE	1	< 0.1%
AB-FUBINACA	1	< 0.1%
ACETYLCODEINE	1	< 0.1%
ACETYL-L-CARNITINE HYDROCHLORIDE	1	< 0.1%
ADD'L SUBSTAN.BELVD.PRESNT-NOT IDEN	1	< 0.1%
AGMATINE SULFATE	1	< 0.1%
AKB48 N-(5-FLUOROPENTYL)	1	< 0.1%
ALPHA-PYRROLIDINOBUTIOPHENONE (ALPHA-PBP)	1	< 0.1%
ALPHA-PYRROLIDINOHEXANOPHENONE (ALPHA-PHP)	1	< 0.1%
AM-2201 (1-(5-FLUOROPENTYL)-3-(1-NAPHTHOYL)INDOLE)	1	< 0.1%
AMANTADINE	1	< 0.1%
AZITHROMYCIN	1	< 0.1%
BACTERIOSTATIC WATER	1	< 0.1%
BENAZEPRIL	1	< 0.1%

Drug Identified	Number (#)	Percent of Total Drug Reports* (#)
BENZALDEHYDE	1	< 0.1%
BISACODYL	1	< 0.1%
BUFOTENINE	1	< 0.1%
BUMETANIDE	1	< 0.1%
BUTALBITAL	1	< 0.1%
CARBAMAZEPINE	1	< 0.1%
CARVEDILOL	1	< 0.1%
CHORIONIC GONADOTROPIN	1	< 0.1%
CLORAZEPATE	1	< 0.1%
CYANOCOBALAMIN	1	< 0.1%
CYPROHEPTADINE	1	< 0.1%
DAPOXETINE	1	< 0.1%
DARUNAVIR	1	< 0.1%
DEHYDROCHLORMETHYLTESTOSTERONE	1	< 0.1%
DESLORATIDINE	1	< 0.1%
DIMETHYLONE (3,4-METHYLENEDIOXYDIMETHYLCATHINONE; bk-MDDMA)	1	< 0.1%
DIPHENOXYLATE	1	< 0.1%
DIPHENYLHYDANTOIN	1	< 0.1%
DIPYRONE	1	< 0.1%
EG 018 (NAPHTHALEN-1-YL(9-PENTYL-9H-CARBAZOL-3-YL)METHANONE)	1	< 0.1%
EMTRICITABINE	1	< 0.1%
ESZOPICLONE	1	< 0.1%
ETHYLPHENIDATE	1	< 0.1%
ETODOLAC	1	< 0.1%
FAMOTIDINE	1	< 0.1%
FLURAZEPAM	1	< 0.1%
FUB-PB-22 (QUINOLIN-8-YL-1-(4-FLUOROBENZYL)-1H-INDOLE-3-CARBOXYLATE)	1	< 0.1%
FUROSEMIDE	1	< 0.1%
GLUCOSAMINE	1	< 0.1%
INDOLEBUTYRIC ACID	1	< 0.1%
KETOROLAC TROMETHAMINE	1	< 0.1%
LOSARTAN POTASSIUM	1	< 0.1%
MAB-CHMINACA (ADB-CHMINACA)	1	< 0.1%
MELOXICAM	1	< 0.1%
MEPIVACAINE	1	< 0.1%
MESTEROLONE	1	< 0.1%
METAXALONE	1	< 0.1%
METHENOLONE	1	< 0.1%
N,N-DIMETHYL-4-HYDROXYPHENYLETHYLAMINE (HORDENINE)	1	< 0.1%
NEURONTIN	1	< 0.1%
NIACINAMIDE	1	< 0.1%
NM2201 (NAPHTHALEN-1-YL 1-(5-FLUOROPENTYL)-1H-INDOLE-3-CARBOXYLATE)	1	< 0.1%
OCTOPAMINE HYDROCHLORIDE	1	< 0.1%
OMEPRAZOLE	1	< 0.1%
OXYMETHOLONE	1	< 0.1%

Drug Identified	Number (#)	Percent of Total Drug Reports* (#)
OXYTOCIN	1	< 0.1%
PENTYLONE (ß-KETO-METHYLBENZODIOXOLYLPENTANAMINE)	1	< 0.1%
PHENETHYLAMINE	1	< 0.1%
PLANT MATERIAL, OTHER	1	< 0.1%
POTASSIUM	1	< 0.1%
PREGABALIN	1	< 0.1%
PRILOCAINE	1	< 0.1%
PROTONIX (PANTOPRAZOLE)	1	< 0.1%
RANITIDINE	1	< 0.1%
RISPERIDONE (RISPERDAL)	1	< 0.1%
RITONAVIR	1	< 0.1%
SALSALATE	1	< 0.1%
SENNOSIDES	1	< 0.1%
SODIUM CARBONATE	1	< 0.1%
TITANIUM DIOXIDE	1	< 0.1%
TOREMIFENE	1	< 0.1%
TRIMETHOPRIM	1	< 0.1%

NOTES:

***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 *Los Angeles County* 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*	**27,390**	**100.0%**	**100.0%**
Opioids Category	**2,574**	**100.0%**	**9.4%**
Heroin	**2,019**	**78.4%**	**7.4%**
Narcotic Analgesics	**544**	**21.1%**	**2.0%**
OXYCODONE	130	5.1%	0.5%
HYDROCODONE	124	4.8%	0.5%
CODEINE	67	2.6%	0.2%
TRAMADOL	63	2.4%	0.2%
MITRAGYNINE	34	1.3%	0.1%
FENTANYL	31	1.2%	0.1%
OPIUM	22	0.9%	< 0.1%
METHADONE	19	0.7%	< 0.1%
MORPHINE	18	0.7%	< 0.1%
BUPRENORPHINE	13	0.5%	< 0.1%
ACETYLFENTANYL	11	0.4%	< 0.1%
HYDROMORPHONE	9	0.3%	< 0.1%
OXYMORPHONE	2	< 0.1%	< 0.1%
ACETYLCODEINE	1	< 0.1%	< 0.1%
Narcotics	**11**	**0.4%**	**< 0.1%**
NOSCAPINE	4	0.2%	< 0.1%
MONOACETYLMORPHINE	3	0.1%	< 0.1%
NALOXONE	2	< 0.1%	< 0.1%
6-MONOACETYLMORPHINE	1	< 0.1%	< 0.1%
DIPHENOXYLATE	1	< 0.1%	< 0.1%
Synthetic Cathinones Category	**74**	**100.0%**	**0.3%**
Synthetic Cathinones	**67**	**90.5%**	**0.2%**
3,4-METHYLENEDIOXYETHYLCATHINONE (ETHYLONE)	50	67.6%	0.2%
ALPHA-PYRROLIDINOPENTIOPHENONE (ALPHA-PVP)	11	14.9%	< 0.1%
BUTYLONE (ß-KETO-N-METHYLBENZO-DIOXYLPROPYLAMINE)	2	2.7%	< 0.1%
ALPHA-PYRROLIDINOBUTIOPHENONE (ALPHA-PBP)	1	1.4%	< 0.1%
ALPHA-PYRROLIDINOHEXANOPHENONE (ALPHA-PHP)	1	1.4%	< 0.1%
DIMETHYLONE (3,4-METHYLENEDIOXYDIMETHYLCATHINONE; bk-MDDMA)	1	1.4%	< 0.1%
PENTYLONE (ß-KETO-METHYLBENZODIOXOLYLPENTANAMINE)	1	1.4%	< 0.1%
Synthetic Cathinones (Hallucinogen)	**7**	**9.5%**	**< 0.1%**
N-METHYL-3,4-METHYLENEDIOXYCATHINONE (METHYLONE)	7	9.5%	< 0.1%
Synthetic Cannabinoids Category	**55**	**100.0%**	**0.2%**
SYNTHETIC CANNABINOID	24	43.6%	< 0.1%
XLR-11 (1-(5-FLUOROPENTYL-1H-3-YL)(2,2,3,3-TETRAMETHYLCYCLOPROPYL)METHANONE)	9	16.4%	< 0.1%
AB-CHMINACA (N-[(1S)-1-(AMINOCARBONYL)-2-METHYLPROPYL]-1-(CYCLOHEXYLMETHYL)-1H-INDAZOLE-3-CARBOXAMIDE)	8	14.5%	< 0.1%
AB-PINACA	3	5.5%	< 0.1%
5-FLUORO AMB	2	3.6%	< 0.1%
PB-22 (1-PENTYL-1H-INDOLE-3-CARBOXYLIC ACID 8-QUINOLINYL ESTER)	2	3.6%	< 0.1%
AB-FUBINACA	1	1.8%	< 0.1%
AKB48 N-(5-FLUOROPENTYL)	1	1.8%	< 0.1%
AM-2201 (1-(5-FLUOROPENTYL)-3-(1-NAPHTHOYL)INDOLE)	1	1.8%	< 0.1%

NPS Category Drug Identified	Number (#)	Percent of Drug Category** (%)	Percent of Total Reports (%)
EG 018 (NAPHTHALEN-1-YL(9-PENTYL-9H-CARBAZOL-3-YL)METHANONE)	1	1.8%	< 0.1%
FUB-PB-22 (QUINOLIN-8-YL-1-(4-FLUOROBENZYL)-1H-INDOLE-3-CARBOXYLATE)	1	1.8%	< 0.1%
MAB-CHMINACA (ADB-CHMINACA)	1	1.8%	< 0.1%
NM2201 (NAPHTHALEN-1-YL 1-(5-FLUOROPENTYL)-1H-INDOLE-3-CARBOXYLATE)	1	1.8%	< 0.1%
Piperazines Category	**10**	**100.0%**	**< 0.1%**
Piperazines (Hallucinogen)	**7**	**70.0%**	**< 0.1%**
1-(3-TRIFLUOROMETHYL)PHENYL-PIPERAZINE (TFMPP)	7	70.0%	< 0.1%
Piperazines (Stimulant)	**3**	**30.0%**	**< 0.1%**
N-BENZYLPIPERAZINE (BZP)	3	30.0%	< 0.1%
Phenethylamines (2C Series) (H) Category	**7**	**100.0%**	**< 0.1%**
2-(4-BROMO-2,5-DIMETHOXYPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-B-NBOMe)	2	28.6%	< 0.1%
2-(4-CHLORO-2,5-DIMETHOXYPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-C-NBOME)	2	28.6%	< 0.1%
4-BROMO-2,5-DIMETHOXYPHENETHYLAMINE (2C-B)	2	28.6%	< 0.1%
2-(4-IODO-2,5-DIMETHOXYPHENYL)-N-(2-METHOXYBENZYL)ETHANAMINE (25-I-NBOME)	1	14.3%	< 0.1%
Tryptamines Category	**7**	**100.0%**	**< 0.1%**
DIMETHYLTRYPTAMINE (DMT)	6	85.7%	< 0.1%
BUFOTENINE	1	14.3%	< 0.1%

NOTES:

***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