

UNCLASSIFIED

(U) National Heroin Threat Assessment Summary



DEA
INTELLIGENCE
REPORT

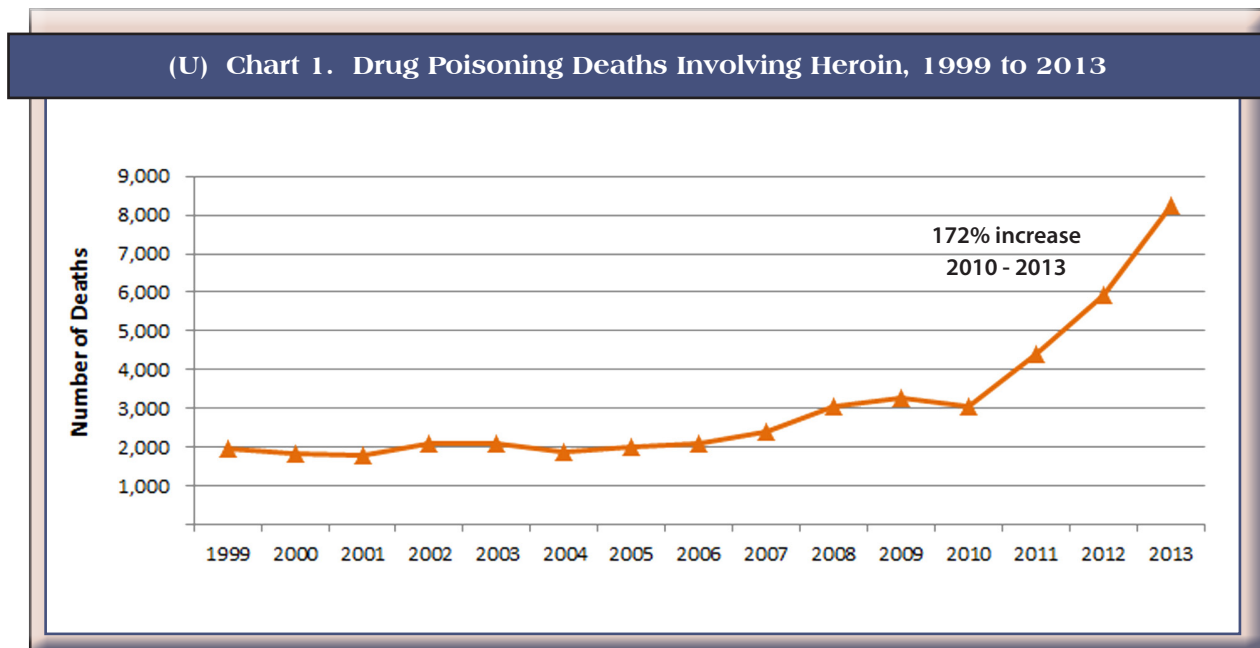
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Overview

(U) **The threat posed by heroin in the United States is serious and has increased since 2007.** Heroin is available in larger quantities, used by a larger number of people, and is causing an increasing number of overdose deaths. In 2013, 8,620 Americans died from heroin-related overdoses, nearly triple the number in 2010. (See Chart 1.) Increased demand for, and use of, heroin is being driven by both increasing availability of heroin in the U.S. market and by some controlled prescription drug (CPD) abusers using heroin. CPD abusers who begin using heroin do so chiefly because of price differences, but also because of availability, and the reformulation of OxyContin®, a commonly abused prescription opioid.



Source: National Center for Health Statistics/CDC

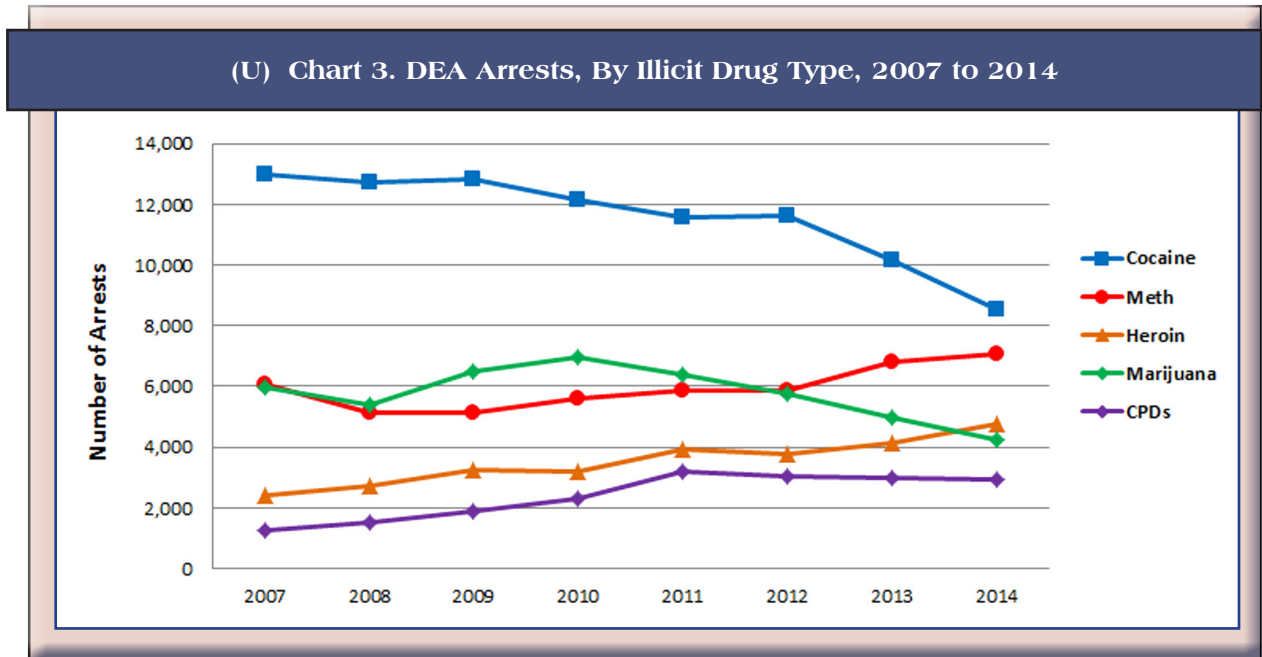
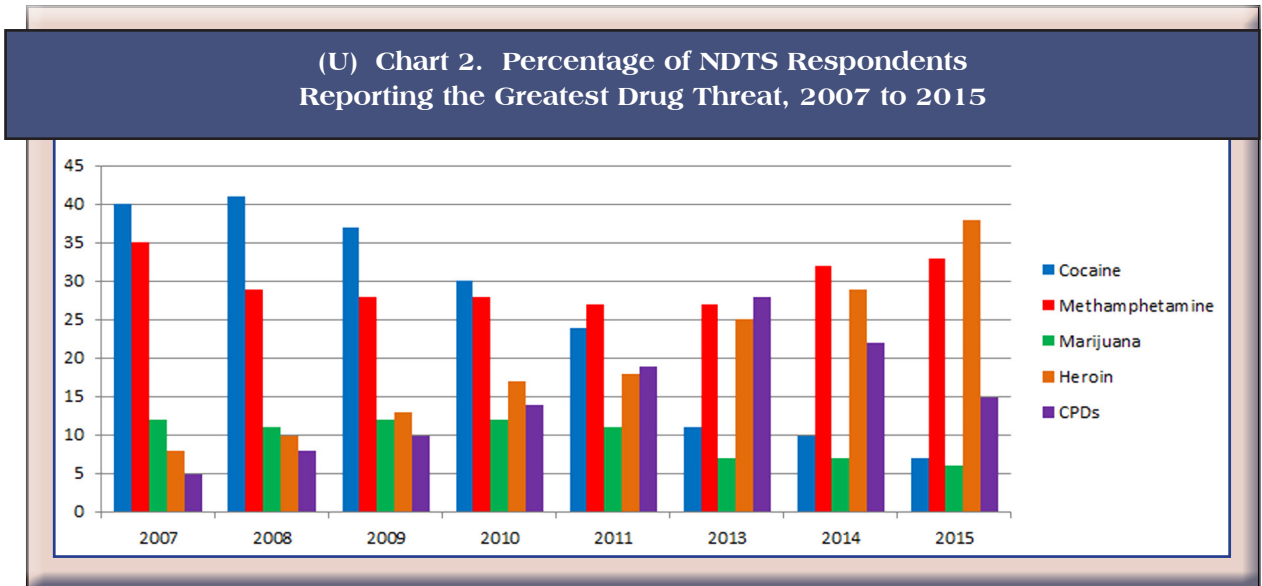
(U) **Heroin overdose deaths are increasing in many cities and counties across the United States,** particularly in the Northeast area [the Mid-Atlantic, New England, and New York/New Jersey Organized Crime Drug Enforcement Task Force (OCDETF) Regions] as well as areas of the Midwest. Many cities are reporting the increase in heroin overdose deaths is more common in the suburban areas and outlying counties surrounding the cities. Possible reasons for these increases in overdose deaths include an overall increase in heroin users; high purity batches of heroin sold in certain markets, causing users to accidentally overdose; an increase in new heroin initiates, many of whom are young and inexperienced; abusers of prescription opioids (drugs with known compositions and concentrations) initiating use of heroin, an illicitly-manufactured drug with varying purities, dosage amounts, and adulterants; and the use of highly toxic heroin adulterants such as fentanyl in certain markets. Further, heroin addicts who have stopped using heroin for a period of time (due to rehabilitation programs, incarceration, etc.) and subsequently return to using heroin are particularly susceptible to overdose, because their tolerance for the drug has decreased.

(U) **The heroin threat is particularly high in the Northeast and Midwest areas of the United States.** According to the 2015 National Drug Threat Survey^a (NDTS), 38 percent of respondents reported heroin was the greatest drug threat

^a (U) The National Drug Threat Survey, or NDTS, is conducted annually to solicit information from a nationally representative sample of state, local, and tribal law enforcement agencies. The recipients of the survey were queried on their perception of the drug threat in their jurisdiction relative to the availability, demand, transportation, and distribution of heroin, methamphetamine, cocaine, marijuana, CPDs, and synthetic drugs. In 2015, the survey was disseminated to 2,761 recipients. There were 1,105 respondents from across the country.

in their area; more than for any other drug. Since 2007, the percentage of NDTs respondents reporting heroin as the greatest threat has steadily grown, from 8 percent in 2007 to 38 percent in 2015. (See Chart 2.) The OCDETF regions with the largest number of respondents ranking heroin as the greatest drug threat were the Mid-Atlantic, Great Lakes, New England, and New York/New Jersey.

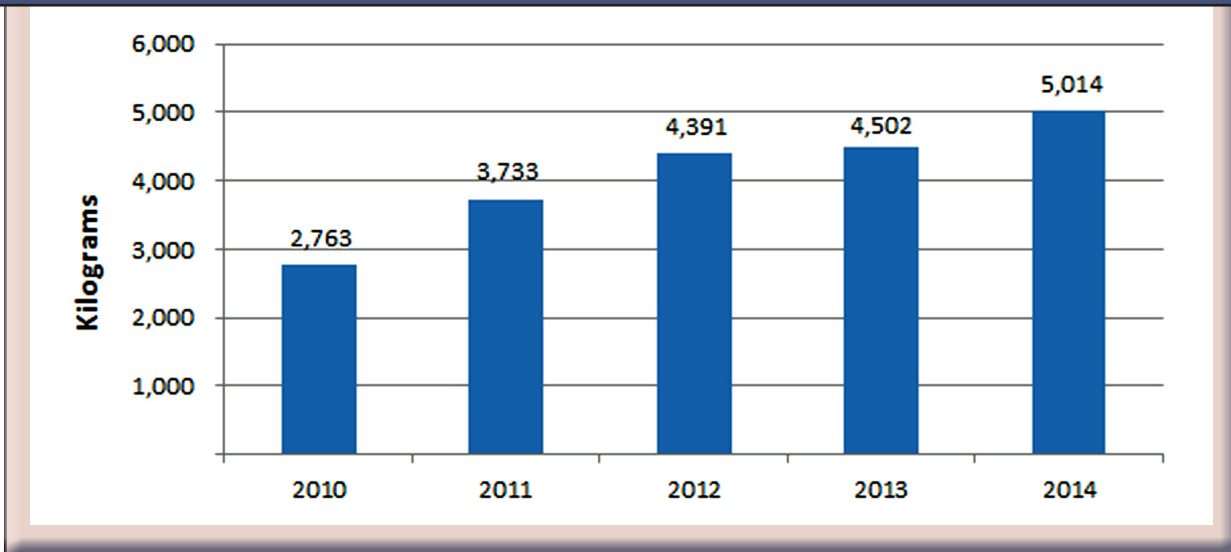
- (U) Seven^b of the 21 domestic Drug Enforcement Administration (DEA) Field Divisions (FDs) ranked heroin as their number one drug threat in 2014. Another six^c FDs ranked heroin as the second greatest threat to their areas. This was an increase over 2013. DEA heroin arrests nearly doubled between 2007 and 2014, and in 2014 heroin arrests surpassed marijuana arrests for the first time. (See Chart 3.)



^b (U) The Chicago, Detroit, New England, New Jersey, New York, Philadelphia, and Washington Field Divisions.

^c (U) The Atlanta, Caribbean, Dallas, Denver, Seattle, and St. Louis Field Divisions.

(U) Chart 4. Heroin Seizures in the United States, 2010 to 2014



Source: National Seizure System

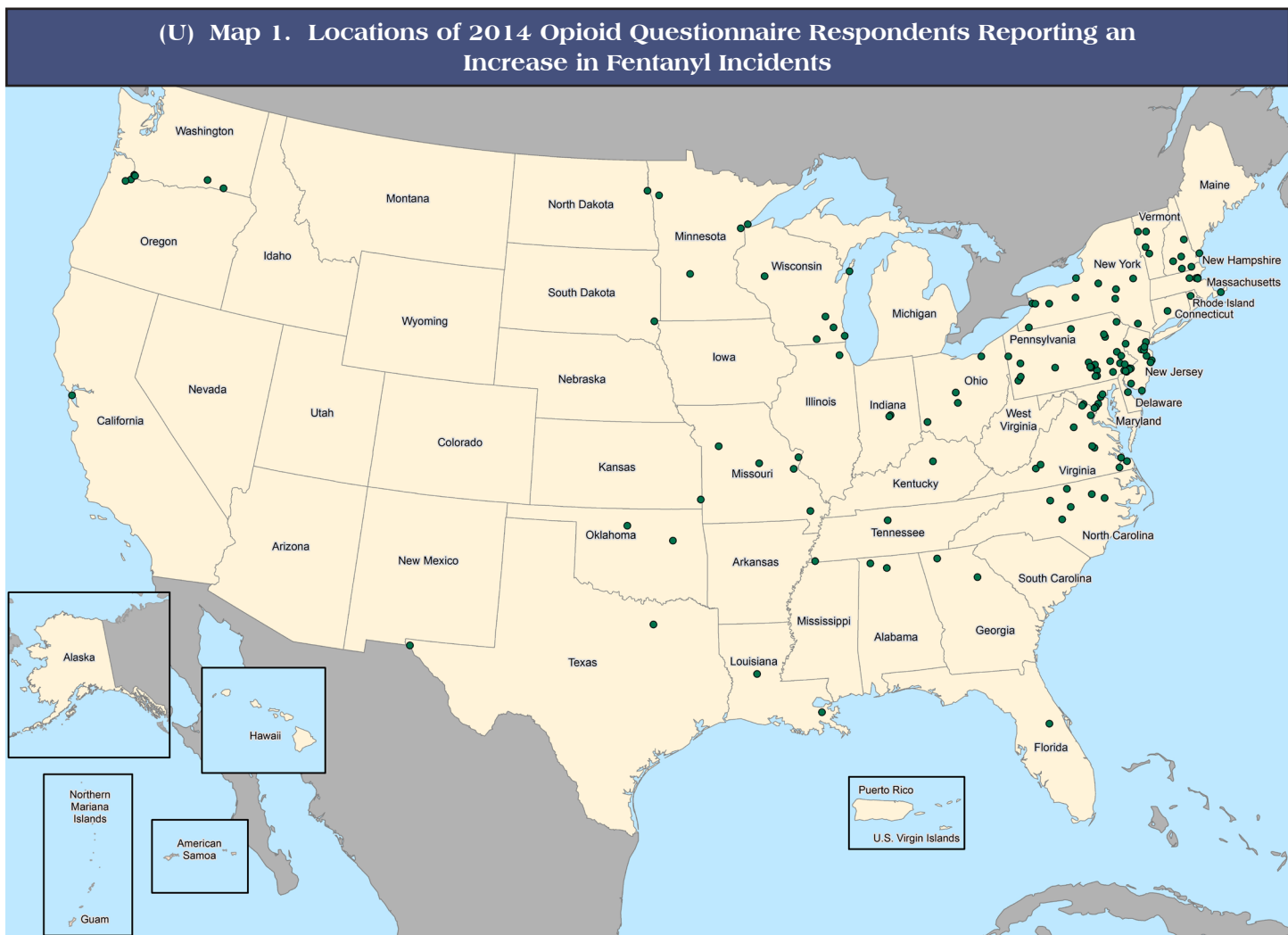
(U) **Heroin availability is increasing in areas throughout the nation.** Availability levels are highest in the Northeast and in areas of the Midwest, according to law enforcement reporting.¹ Seizure data indicates a sizeable increase in heroin availability in the United States. According to National Seizure System^d (NSS) data, heroin seizures in the United States increased 81 percent over five years, from 2,763 kilograms in 2010 to 5,014 kilograms in 2014. (See Chart 4.) Traffickers are also transporting heroin in larger amounts. The average size of a heroin seizure in 2010 was 0.86 kilograms; in 2014, the average heroin seizure was 1.74 kilograms. Law enforcement officials in cities across the country report seizing larger than usual quantities of heroin over the past two years.²

(U) **Mexican traffickers are expanding their operations to gain a larger share of eastern U.S. heroin markets.** The heroin market in the United States has been historically divided along the Mississippi River, with western markets using Mexican black tar and brown powder heroin, and eastern markets using white powder (previously Southeast and Southwest Asian, but over the past two decades almost exclusively South American) heroin. Heroin use in the United States is much more prevalent in the Northeast and Midwest areas, where white powder heroin is used. The largest, most lucrative heroin markets in the United States are the white powder markets in major eastern cities: Baltimore, Boston and its surrounding cities, Chicago, New York City and the surrounding metropolitan areas, Philadelphia, and Washington, D.C., and these are the markets where Mexican traffickers are trying to gain a larger share. Mexican organizations are now the most prominent wholesale-level heroin traffickers in the DEA Chicago, New Jersey, Philadelphia, and Washington FD Areas of Responsibility (AORs), and have greatly expanded their presence in the New York City area.³

^d (U) The National Seizure System (NSS) tabulates information pertaining to drug seizures made by participating law enforcement agencies. NSS also includes data on clandestine laboratories seized in the United States by local, state, and federal law enforcement agencies. The records contained in the system are under the control and custody of DEA, and are maintained in accordance of federal laws and regulations. Seizures are reported to the El Paso Intelligence Center (EPIC) by contributing agencies and may not necessarily reflect the total seizures nationwide. Data is reported without corroboration, modification, or editing by EPIC, and accordingly, EPIC cannot guarantee the timeliness, completeness, or accuracy of the information reported herein. The data and any supporting documentation relied upon by EPIC to prepare this report are the property of the originating agency. Use of the information is limited to law enforcement agencies in connection with activities pertaining to the enforcement of criminal laws. EPIC is the central repository for these data.

(U) The increased role of Mexican traffickers is affecting heroin trafficking patterns. More heroin is entering the United States through the Southwest Border; consequently, the western states' roles as heroin transit areas are increasingly significant. DEA and local law enforcement reporting from several western states indicates heroin is transiting those areas in greater volumes and in larger shipment sizes. An increasing number of shipments of Mexican black tar heroin have also been seized in Northeastern markets where black tar is rarely seen, although black tar heroin seizures still comprise a very small percentage of the heroin seized in the Northeast. Finally, some Mexican trafficking organizations are moving their operations into suburban and rural areas, where they believe they can more easily conceal their activities.

(U) In late 2013 and throughout 2014, several states reported spikes in overdose deaths due to fentanyl and its analog acetyl-fentanyl. Fentanyl is much stronger than heroin and can cause even experienced users to overdose. There have been over 700 overdose deaths reported, and the true number is most likely higher because many coroners' offices and state crime laboratories do not test for fentanyl or its analogs unless given a specific reason to do so.⁴ Most of the areas affected by the fentanyl overdoses are in the eastern United States, where white powder heroin is used, because fentanyl is most commonly mixed with white powder heroin or is sold disguised as white powder heroin. While pharmaceutical fentanyl (from transdermal patches or lozenges) is diverted for abuse in the United States at small levels, this latest rash of overdose deaths is largely due to clandestinely-produced fentanyl, not diverted pharmaceutical fentanyl.⁵



Source: 2014 Opioid Questionnaire

(U) In response to increasing overdoses caused by the use of heroin and other opioids, many law enforcement agencies are training officers to administer naloxone, a drug that can reverse the effects of opioid overdose. Law enforcement officers are often the first responders in overdose cases. Naloxone can be nasally-administered and generally has no adverse effect if administered to a person who is not suffering from opioid overdose. Some areas reported shortages of naloxone and substantial price increases in late 2014 and early 2015. The price increases will have a significant impact on state and law enforcement budgets, and shortages could have an impact on first responders' ability to assist overdose victims.

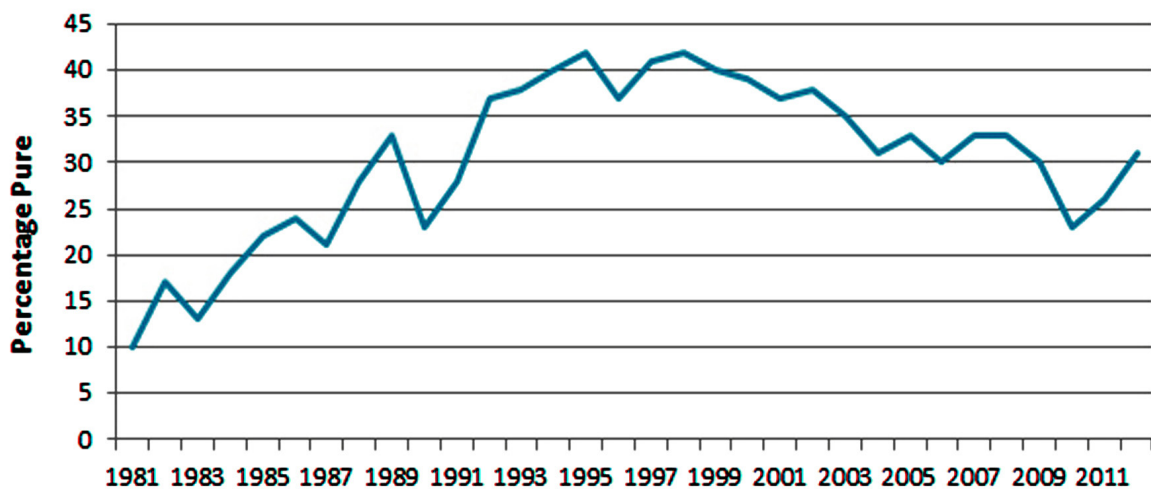
Frequently Asked Questions

(U) How has heroin use and trafficking in the United States changed?

- (U) Heroin today is much higher in purity and lower in price

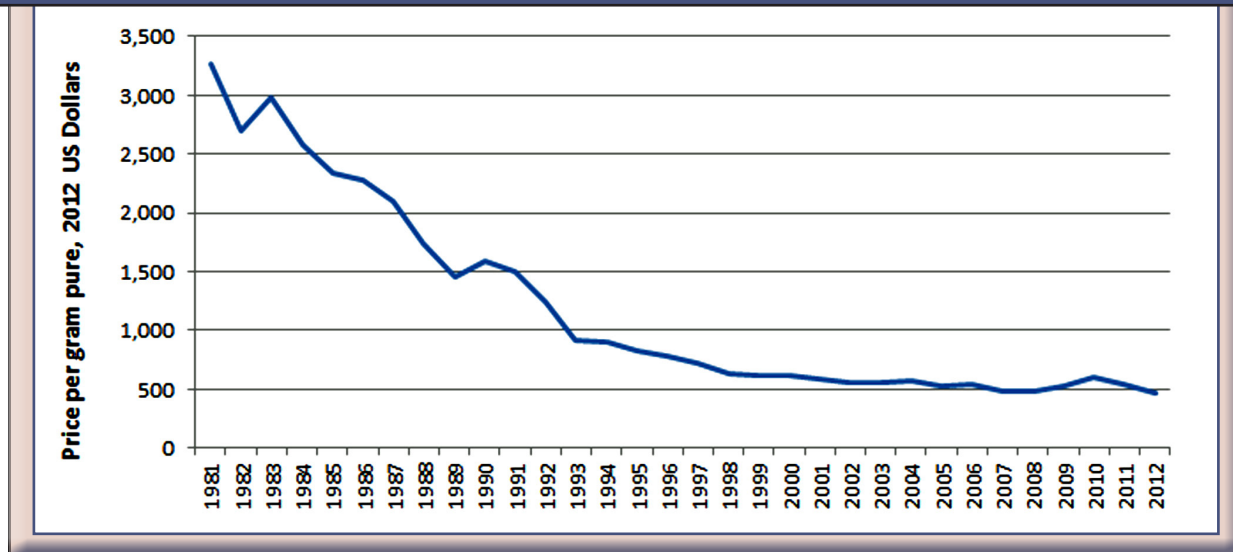
(U) Between the 1980s and 1990s, the purity of the heroin brought into the United States increased significantly. In 1981, the average retail-level purity of heroin was 10 percent. By 1999, that had increased to an average of 40 percent.⁶ (See Chart 5.) During the same time, the price per gram pure decreased greatly. In 1981, the average price per gram of pure heroin was \$3,260 in 2012 U.S. dollars (USD) at the retail-level; by 1999, that price had decreased to \$622 (2012 USD). (See Chart 6.) Since that time, heroin prices have remained low and heroin purity levels, while fluctuating, have remained elevated.

(U) Chart 5. Retail-level Average Purity of Heroin in the United States, 1981 to 2012



Source: Institute for Defense Analyses and ONDCP

(U) Chart 6. Retail-level Average Price Per Gram Pure, for Heroin in the United States, 1981 to 2012



Source: Institute for Defense Analyses and ONDCP

- (U) Heroin is now commonly inhaled

(U) This increase in purity led to an increase in the number of heroin users in the United States. When heroin is higher in purity, it can be snorted or smoked, which broadens its appeal. Many people who would never consider injecting a drug were introduced to heroin by inhalation. In the 1990s, the drug largely lost the stigma associated with injecting, and a new population of heroin users emerged. High-purity heroin is still commonly inhaled and, according to treatment officials, remains a common method of administration by new heroin initiates.

- (U) Heroin use has spread to a broader group of users

(U) This new population of users is more diverse. Whereas in the 1970s and 1980s heroin use was largely confined to urban populations, heroin use in the 1990s and 2000s spread to users in suburban and rural areas, more affluent users, younger users, and users of a wider range of races, according to academic research.⁷ There is no longer a typical heroin user.

- (U) Heroin in the United States is largely controlled by Mexican traffickers

(U) Mexican traffickers have taken a larger role in the U.S. heroin market, increasing their heroin production and pushing into eastern U.S. markets that for the past two decades were supplied by Colombian traffickers. This is notable because Mexican traffickers control established transportation and distribution infrastructures that allow them to reliably supply markets throughout the United States.

- (U) High levels of CPD abuse are contributing to increased heroin use

(U) In the 2000s, a very large number of people became opioid abusers by using CPDs non-medically, many after initially receiving legitimate prescriptions. Some CPD abusers throughout the country continue to use heroin when some CPDs are expensive or unavailable. After the 2010 reformulation of the commonly abused prescription opioid OxyContin®, which made it difficult to inhale or inject, some people who abused OxyContin® migrated to heroin for access to a potent injectable drug. This phenomenon is contributing to the increase in heroin use in the United States.

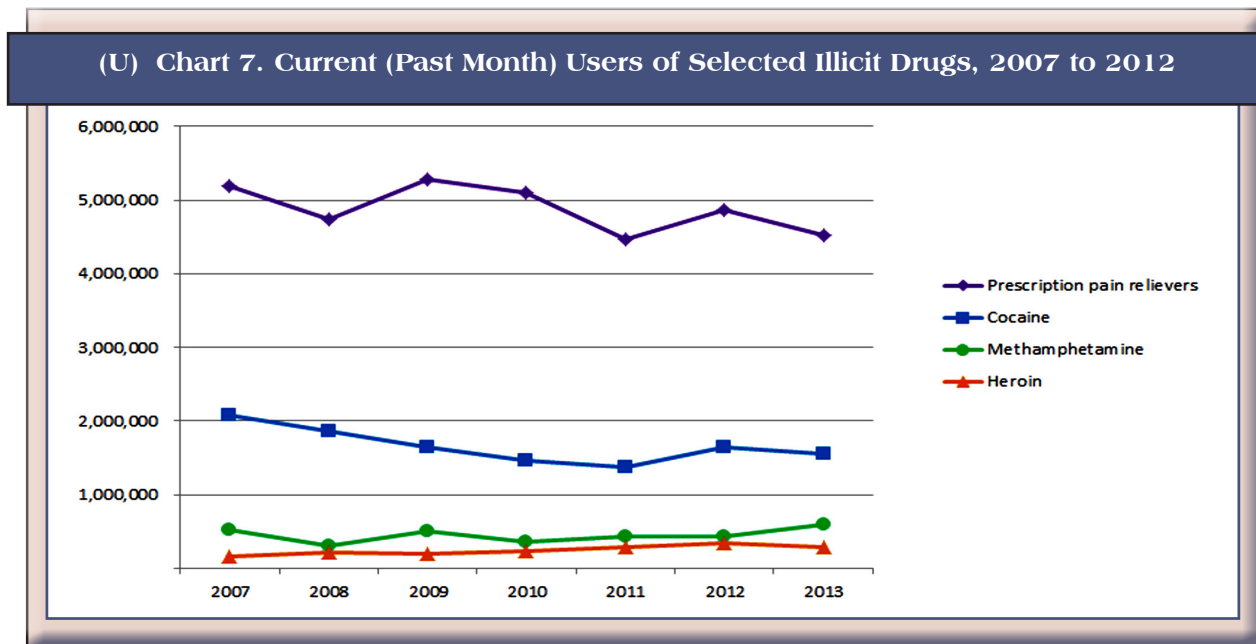
(U) How does heroin compare with other drugs of abuse in the United States?

- (U) Heroin has a smaller user population than other major illicit drugs, but, unlike other drugs, that population is growing aggressively

(U) The U.S. heroin user population is slightly smaller than the estimated methamphetamine user population and significantly smaller than the population reporting current use of marijuana, prescription pain relievers, or cocaine. (See Chart 7.) However, the heroin user population is increasing in size at a much faster rate than any other drug of abuse. The number of people reporting current heroin use nearly doubled between 2007 (161,000) and 2013 (289,000), according to the Substance Abuse and Mental Health Services Administration (SAMHSA) annual National Survey on Drug Use and Health (NSDUH).⁸

- (U) Heroin is far more deadly to its user population than other drugs

(U) Heroin, while used by a smaller number of people than other major drugs, is much more deadly to its users. The population that currently uses prescription pain relievers non-medically was approximately 15 times the size of the heroin user population in 2013; however, opioid analgesic-involved overdose deaths in 2013 were only twice that of heroin-involved deaths. Current cocaine users outnumbered heroin users by approximately 5 times in 2013, but heroin-involved overdose deaths were almost twice those of cocaine. Deaths involving heroin are also increasing at a much faster rate than for other illicit drugs, more than tripling between 2007 (2,402) and 2013 (8,260).⁹ (See Chart 8.)

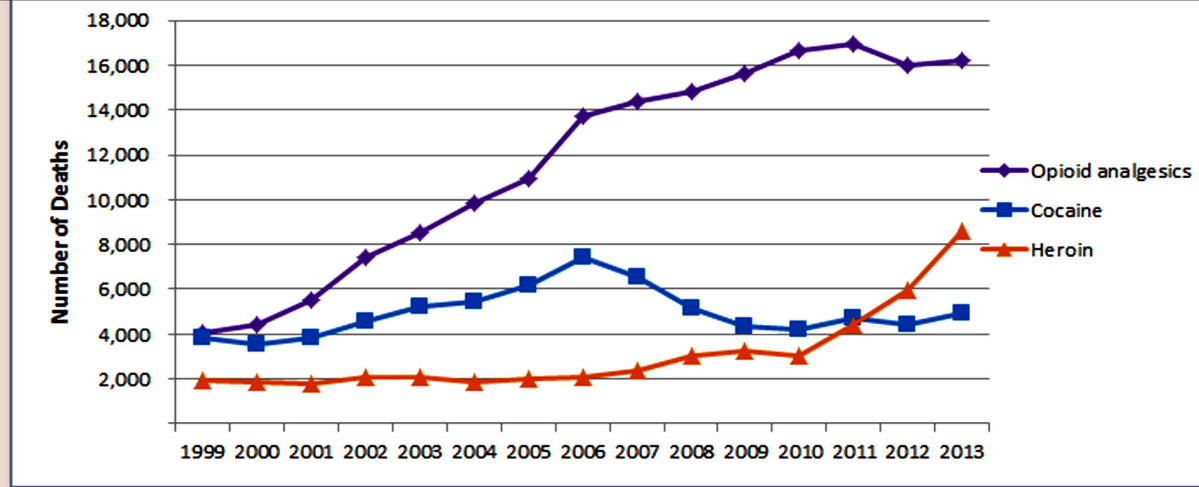


Note: Marijuana is not included on this chart because the user numbers are higher than for all other illicit drugs combined.

Source: National Survey on Drug Use and Health

(U) Heroin deaths are often undercounted because of variations in state reporting procedures, and because heroin metabolizes into morphine very quickly in the body, making it difficult to determine the presence of heroin. Many medical examiners are reluctant to characterize a death as heroin-related without the presence of 6-monoacetylmorphine (6-MAM), a metabolite unique to heroin, but which quickly metabolizes into morphine.¹⁰ Thus many heroin deaths are reported as morphine-related deaths. Further, there is no standardized system for reporting drug-related deaths in the United States. The manner of collecting and reporting death data varies with each medical examiner and coroner.¹¹

(U) Chart 8. Drug Poisoning Deaths Involving Selected Illicit Drugs, 1999 to 2013



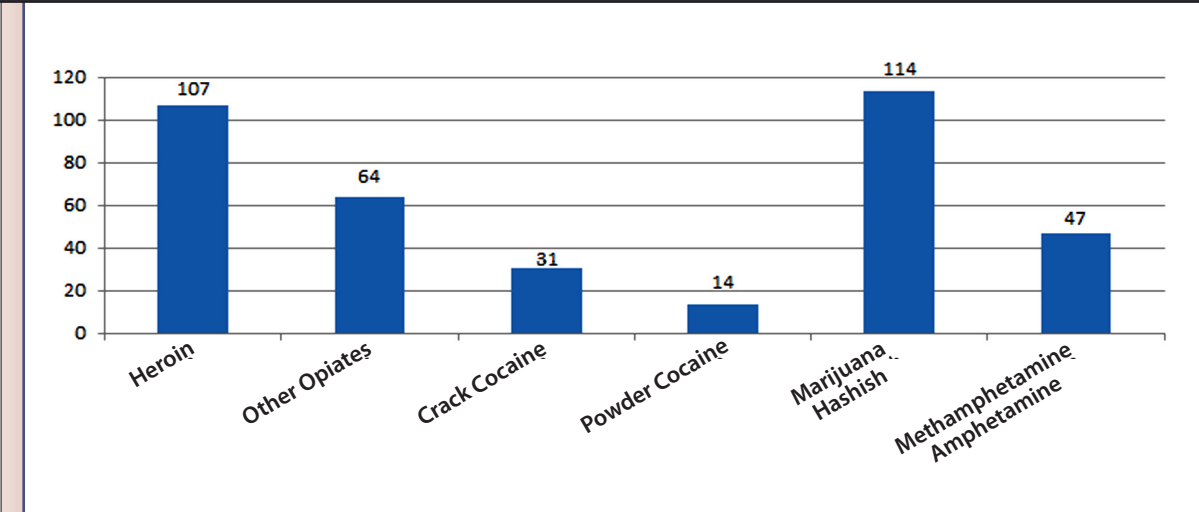
Note: Heroin includes opium.

Source: National Center for Health Statistics/CDC

- (U) More people seek treatment for heroin use than for any other illicit drug, except marijuana

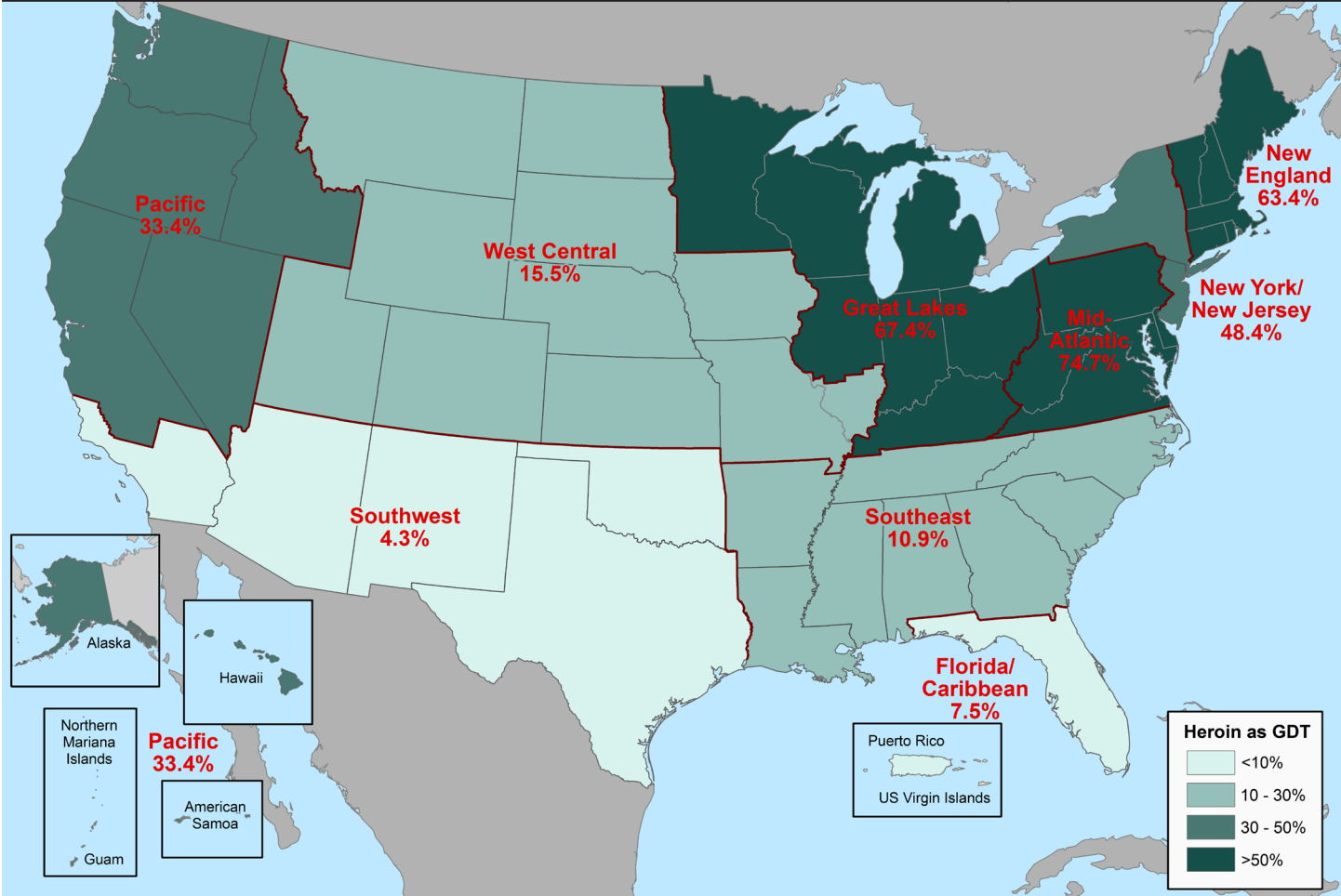
(U) Despite comprising a smaller user population, heroin had a higher rate for treatment admissions to publicly-funded facilities in 2012 (107 per 100,000) than any other illicit drug except marijuana. (See Chart 9.) Heroin treatment rates were almost equal to those of marijuana in 2012, despite the fact that current marijuana users outnumbered heroin users by a factor of 69.

(U) Chart 9. Illicit Drug Treatment Admissions to Publicly-Funded Facilities by Primary Drug, Rate Per 100,000, 2012



Source: Treatment Episode Data Set

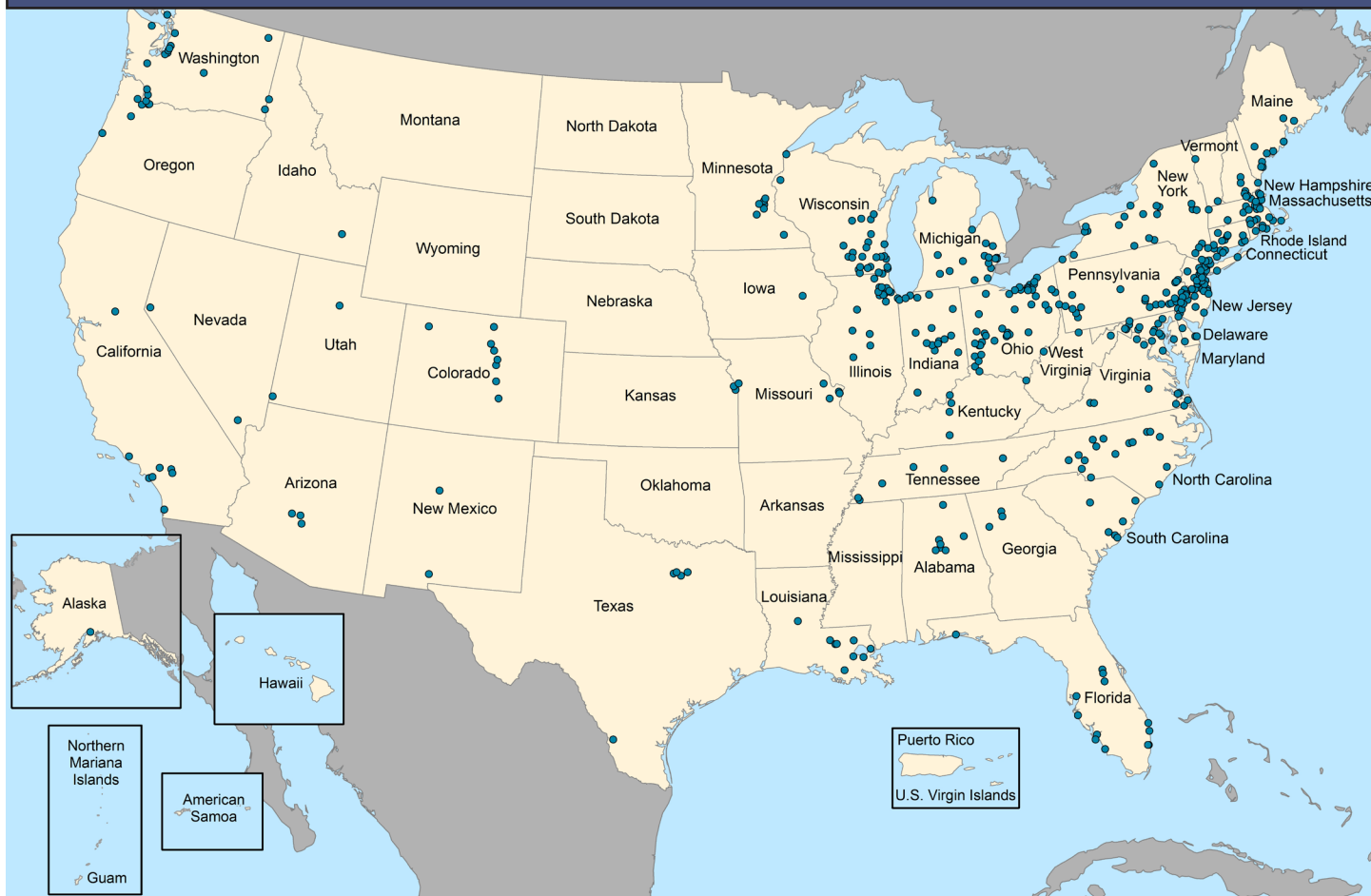
(U) Map 2. Percentage of 2015 NDTs Respondents Reporting Heroin as Greatest Drug Threat, by OCDETF Region



Source: 2015 National Drug Threat Survey

(U) The Organized Crime Drug Enforcement Task Force (OCDETF) Program was established in 1982 to conduct comprehensive, multi-level attacks on major drug trafficking and money laundering organizations. Today, OCDETF combines the resources and expertise of its member federal agencies which include: the Drug Enforcement Administration, the Federal Bureau of Investigation, the Bureau of Immigration and Customs Enforcement, the Bureau of Alcohol, Tobacco, Firearms and Explosives, the U.S. Marshals Service, the Internal Revenue Service, and the U.S. Coast Guard – in cooperation with the Department of Justice Criminal Division, the Tax Division, and the 94 U.S. Attorney’s Offices, as well as with state and local law enforcement. The principal mission of the OCDETF program is to identify, disrupt, and dismantle the most serious drug trafficking and money laundering organizations and those primarily responsible for the nation’s drug supply.

(U) Map 3. Locations of 2015 NDTs Respondents Reporting Heroin as Greatest Drug Threat



Source: 2015 National Drug Threat Survey

- ¹ (U) U.S. Department of Justice, Drug Enforcement Administration, 2015 National Drug Threat Survey; U.S. Department of Justice, Drug Enforcement Administration, All Domestic Field Division Reporting, January 2013 – June, 2014.
- ² (U) U.S. Department of Justice, Drug Enforcement Administration, All Domestic Field Division Reporting, January 2013 – June, 2014.
- ³ (U) U.S. Department of Justice, Drug Enforcement Administration, Chicago, New Jersey, New York, Philadelphia, and Washington Field Division Reporting, January 2015.
- ⁴ (U) U.S. Department of Justice, Drug Enforcement Administration, Historical Overview of the 2005 - 2006 Fentanyl Overdose 'Epidemic: Will History Repeat Itself? (Part 2 of 2), April 2015; U.S. Department of Justice, Drug Enforcement Administration, Detroit Field Division Reporting, email dated January 28, 2015.
- ⁵ (U) U.S. Department of Justice, Drug Enforcement Administration, DEA Investigative Reporting, January 2015.
- ⁶ (U) Office of National Drug Control Policy, National Drug Control Strategy Data Supplement 2014, September 2014.
- ⁷ (U) Cicero, Theodore J., PhD; Matthew S. Ellis, MPE; Hilary L. Surratt, PhD; Steven P. Kurtz, PhD, The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years, July 2014.

- ⁸ (U) Substance Abuse and Mental Health Services Administration, 2013 National Survey on Drug Use and Health, September 2014.
- ⁹ (U) Centers for Disease Control, National Center for Health Statistics, National Vital Statistics Report, Final death data for each calendar year, October 2014.
- ¹⁰ (U) Mayo Clinic, Mayo Medical Laboratories website, Clinical information on 6-Monoacetylmorphine, accessed January 13, 2015.
- ¹¹ (U) Warner, Margaret PhD; Leonard J. Paulozzi MD MPH; Kurt B. Nolte MD; Gregory G. Davis MD MSPH; Lewis S. Nelson MD, State Variation In Certifying Manner of Death and Drugs Involved In Drug Intoxication Deaths, June 2013.

(U) This product was prepared by the DEA Strategic Intelligence Section. Comments and questions may be addressed to the Chief, Analysis and Production Section at DEAIntelPublications@usdoj.gov.