

UNCLASSIFIED

(U) National Heroin Threat Assessment Summary - Updated



DEA
INTELLIGENCE
REPORT

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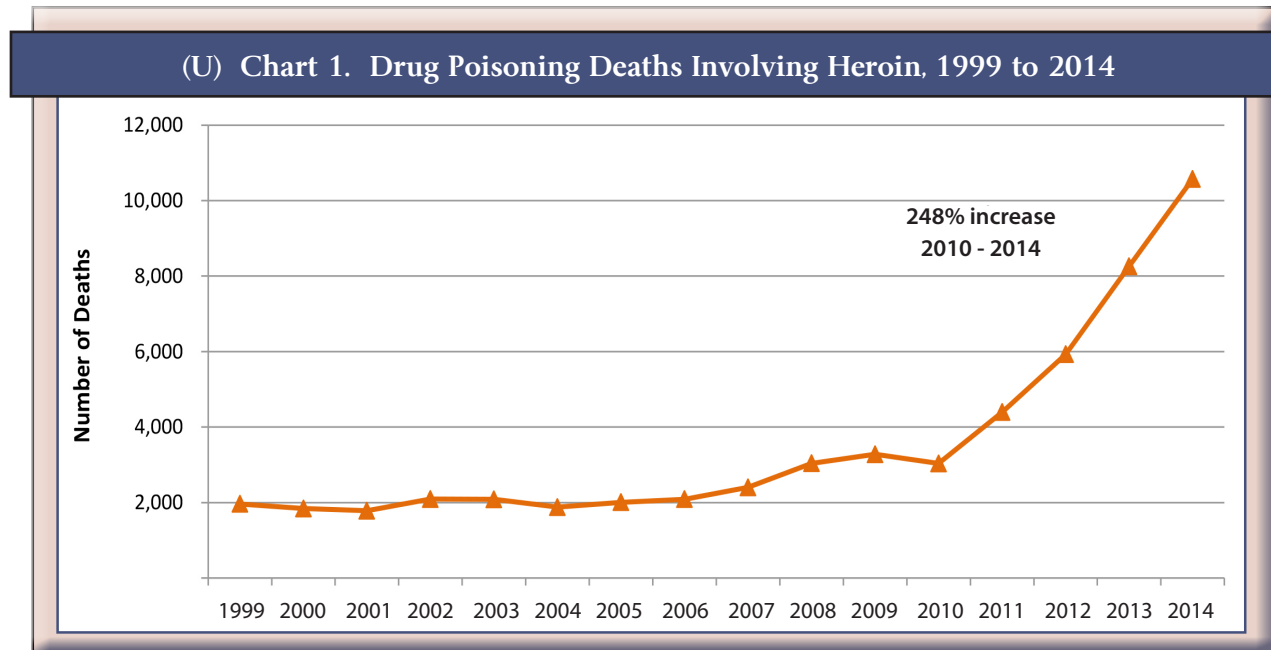
JUNE 2016



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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 2014, 10,574 Americans died from heroin-related overdoses, more than 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.



Source: National Center for Health Statistics/CDC

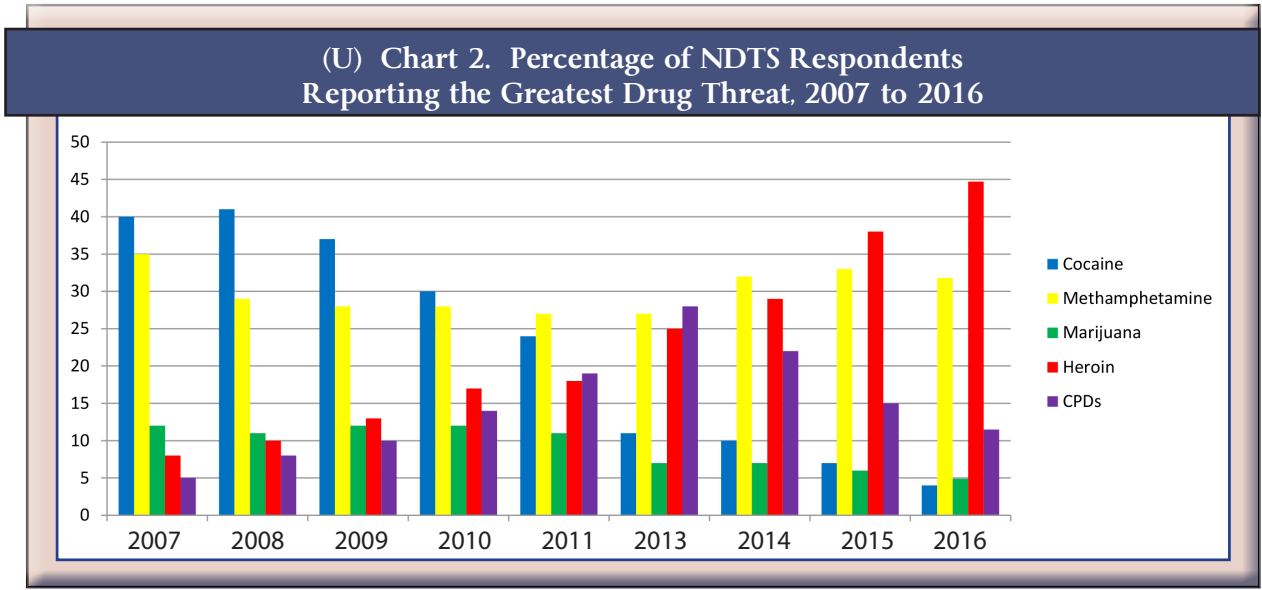
(U) **Heroin overdose deaths are increasing in many cities and counties across the United States,** particularly in the Northeast area [the Mid-Atlantic, New England, and New York/New Jersey Organized Crime Drug Enforcement Task Force (OCDETF) Regions] as well as areas of the Midwest. Many cities are 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 users 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 2016 National Drug Threat Survey^a (NDTS), 45 percent of respondents reported heroin was the greatest drug threat in their area; more than for any other drug. Since 2007, the percentage of NDTS respondents

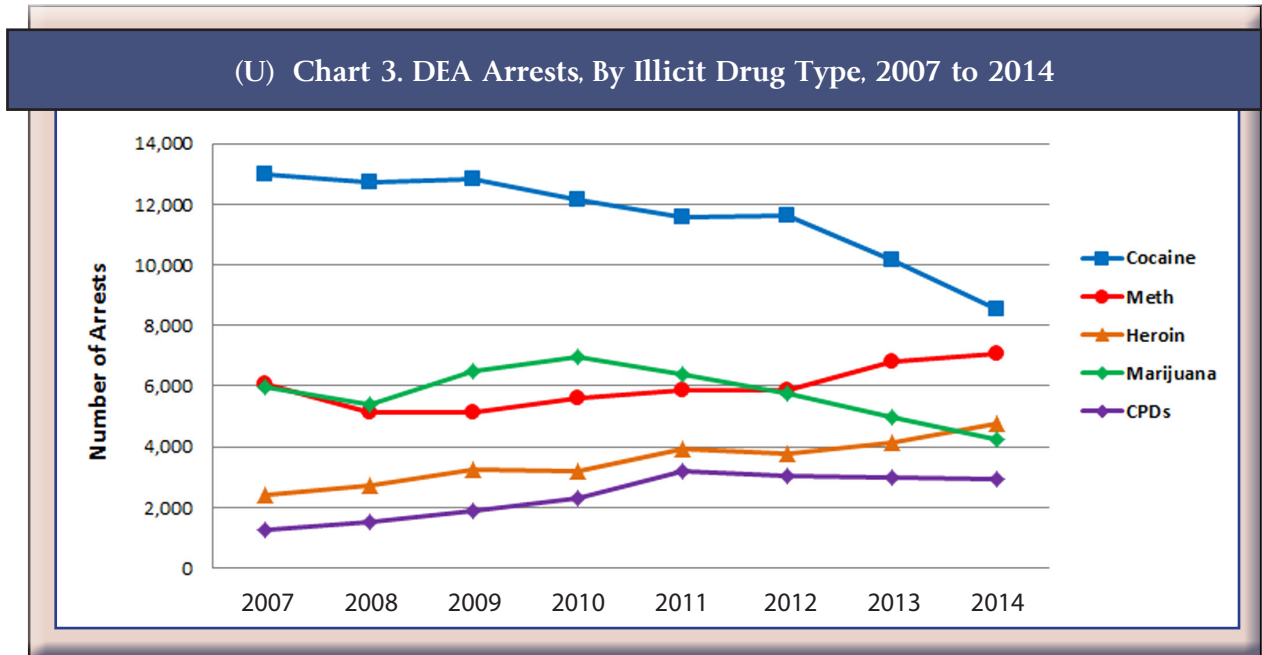
^a (U) The National Drug Threat Survey, or NDTS, is conducted annually to solicit information from a nationally representative sample of state, local, and tribal law enforcement agencies. The recipients of the survey were queried on their perception of the drug threat in their jurisdiction relative to the availability, demand, transportation, and distribution of heroin, methamphetamine, cocaine, marijuana, CPDs, and synthetic drugs. In 2016, the survey was disseminated to 2,761 recipients. There were 1,444 respondents from across the country.

reporting heroin as the greatest threat has steadily grown, from 8 percent in 2007 to 45 percent in 2016. (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) Nine^b of the 21 domestic Drug Enforcement Administration (DEA) Field Divisions (FDs) ranked heroin as their number one drug threat in 2015. Another nine^c FDs ranked heroin as the second greatest threat to their areas. This was an increase over 2014. DEA heroin arrests nearly doubled between 2007 and 2014, and in 2014 heroin arrests surpassed marijuana trafficking arrests for the first time. (See Chart 3.)



Source: National Drug Threat Survey

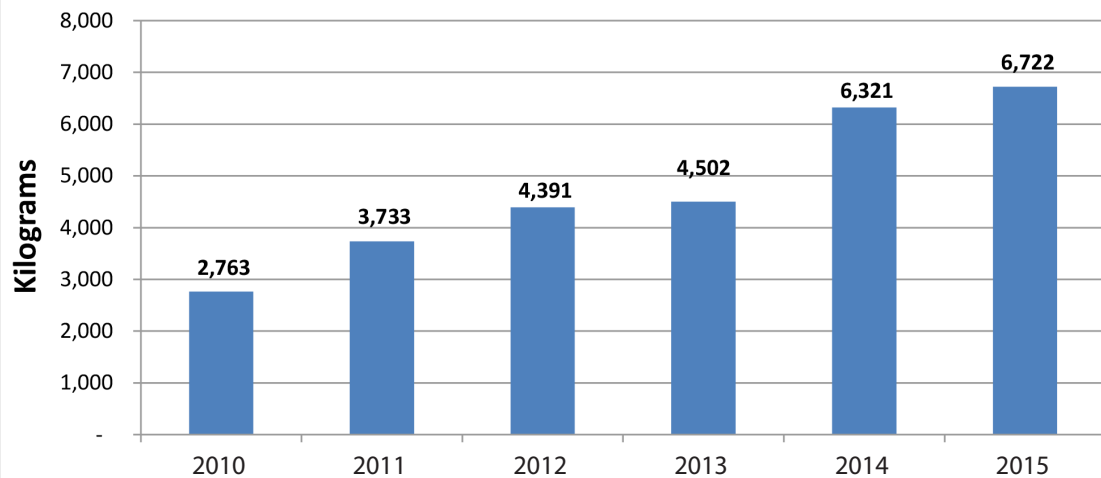


Source: Drug Enforcement Administration

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

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

(U) Chart 4. Heroin Seizures in the United States, 2010 to 2015



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 80 percent over five years, from 3,733 kilograms in 2011 to 6,722 kilograms in 2015. (See Chart 4.) Traffickers are also transporting heroin in larger amounts. Law enforcement officials in cities across the country report seizing larger than usual quantities of heroin over the past two years.²

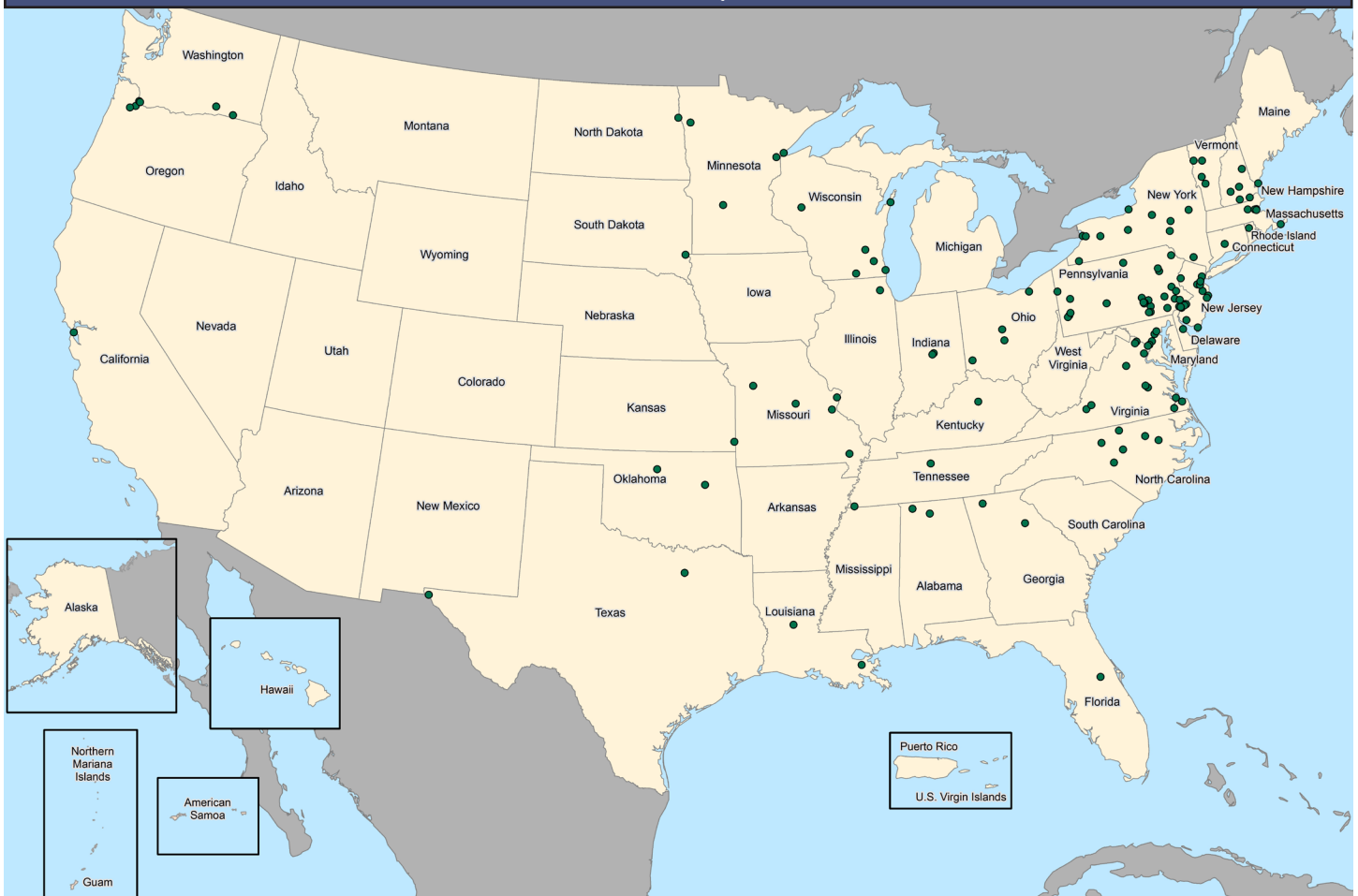
(U) **Mexican traffickers are expanding their operations to gain a larger share of eastern U.S. heroin markets.** The heroin market in the United States has been historically divided along the Mississippi River, with western markets using Mexican black tar and brown powder heroin, and eastern markets using white powder (previously Southeast and Southwest Asian, but between 1997 and 2010 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 gaining 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 Submissions of Mexican heroin to the DEA Heroin Signature Program (HSP) have accounted for a steadily increasing percentage of the total weight seized and analyzed since 2003. In 2014, Mexican heroin accounted for 79 percent of the total weight of heroin analyzed under the HSP.

^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) **Starting in late 2013, 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. Between 2013 and 2014, there was a 79 percent increase in deaths related to synthetic opioids, the category under which fentanyl falls.⁴ There were 5,544 synthetic-opioid-related deaths in 2014, and the true number is most likely higher because of non-standardized reporting and because many coroners' offices and state crime laboratories initially did not test for fentanyl or its analogs unless given a specific reason to do so.⁵ 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.⁶

(U) Map 1. Locations of 2014 Opioid Questionnaire Respondents Reporting an Increase in Fentanyl Incidents



Source: 2014 Opioid Questionnaire

(U) Fentanyl Increasingly Disguised as Prescription Pills

(U) Hundreds of thousands of counterfeit prescription pills, some containing deadly amounts of fentanyl, have been introduced into U.S. drug markets, exacerbating the fentanyl and opioid crisis. Motivated by enormous profit potential, traffickers are exploiting high consumer demand for prescription medications by producing inexpensive, fraudulent prescription pills containing fentanyl. The equipment and materials necessary to produce these counterfeit drugs are widely available online for a small initial investment, greatly reducing the barrier of entry into production for small-scale drug trafficking groups and individuals. In addition, fentanyl pill press operations have been identified in the United States, Canada, and Mexico, indicating a vast expansion of the traditional illicit fentanyl market.

(U) Opioid painkillers such as oxycodone tablets are the most commonly counterfeited medications; however, traffickers are also counterfeiting benzodiazepine medications such as Xanax[®]. Between January and March 2016, nine people in Pinellas County, Florida died after consuming counterfeit Xanax[®] pills containing fentanyl. In March 2016, 32 overdoses and 10 deaths occurred in northern California in a two-week time span due to counterfeit Norco[®] pills containing fentanyl. Laboratory analysis indicated that the pills contained a variety of fentanyl doses; one sample of pills contained between 0.6 and 6.9 milligrams of fentanyl per pill (2 milligrams of fentanyl is a lethal dose for non-opioid users). Such wide disparity in dosing reveals that the producers were likely amateurs and new to pill production, as the fentanyl was not thoroughly mixed with the other powders before binding and pressing into pills.

(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.

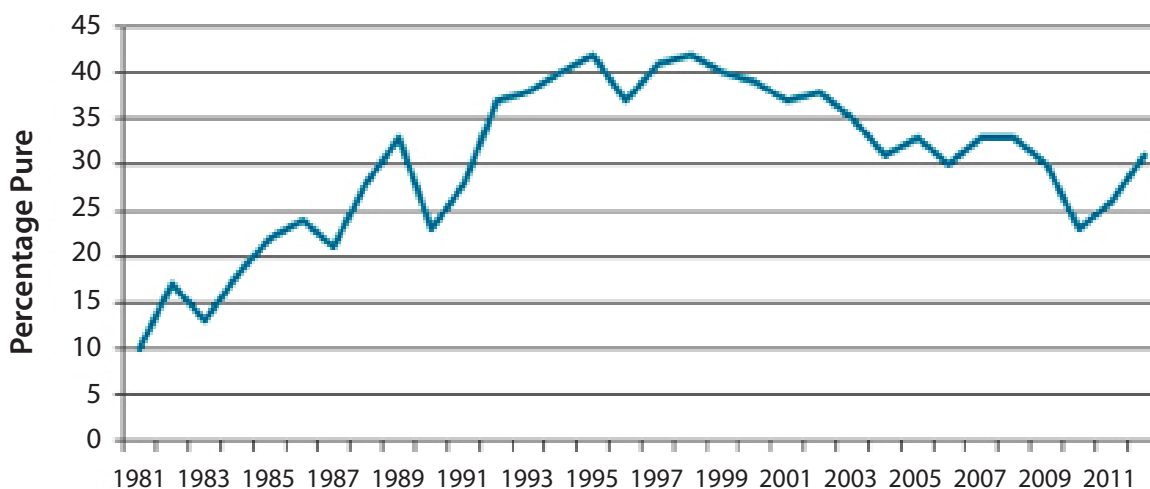
Frequently Asked Questions

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

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

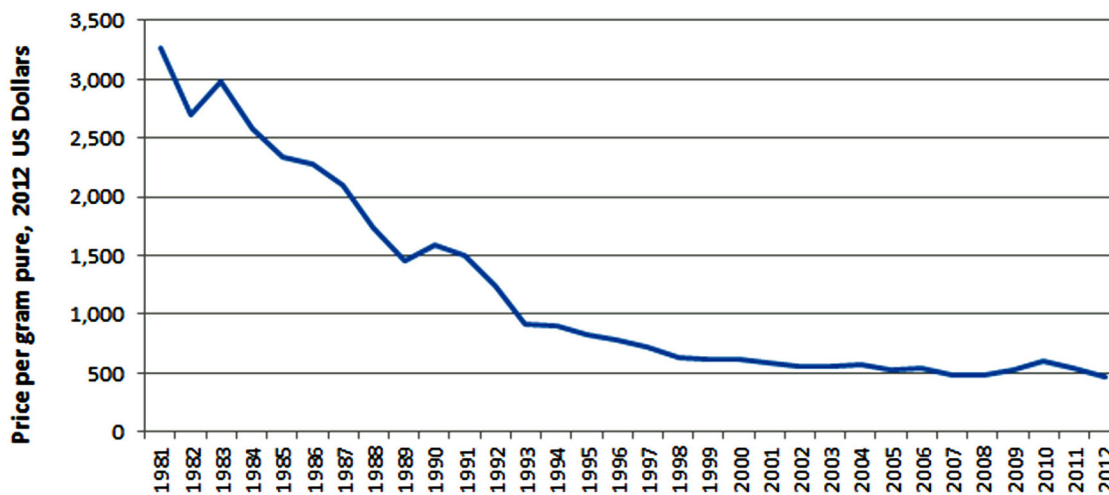
(U) Between the 1980s and 1990s, the purity of the heroin brought into the United States increased significantly. In 1981, the average retail-level purity of heroin was 10 percent. By 1999, that had increased to an average of 40 percent.⁷ (See Chart 5.) During the same time, the price per gram pure decreased 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.⁸ 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**

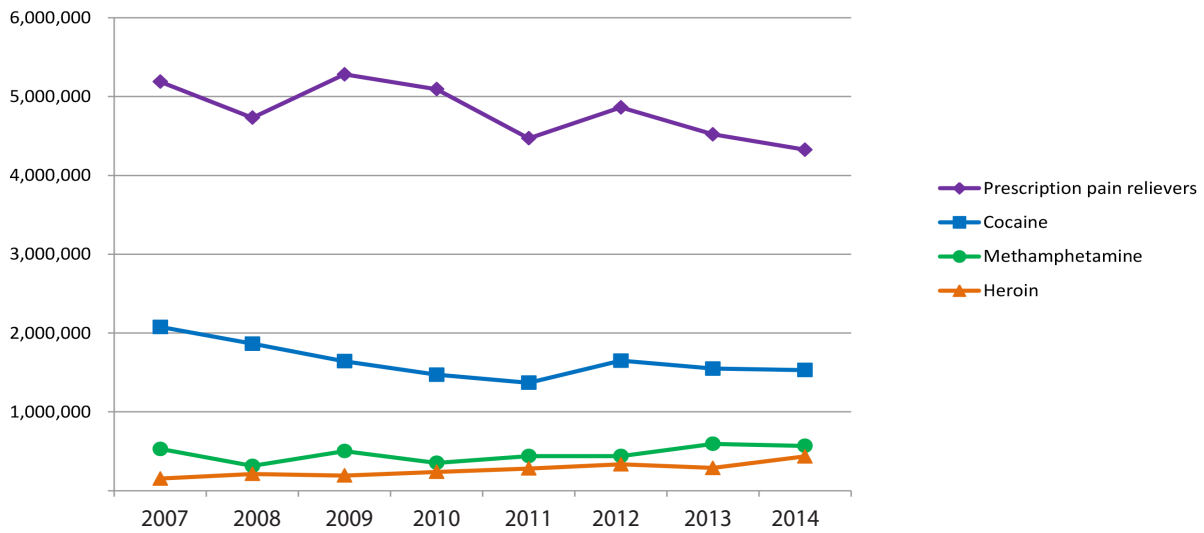
(U) In the 2000s, a very large number of people became opioid abusers by using CPDs non-medically, many after initially receiving legitimate prescriptions. Some CPD abusers throughout the country continue to use heroin when CPDs are expensive or unavailable. Although only a small number (approximately 4 percent) of CPD abusers initiate heroin use, this represents a significant amount of heroin users because the size of the CPD abuser population is so much larger than the heroin user population.

(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 tripled between 2007 (161,000) and 2014 (435,000), according to the Substance Abuse and Mental Health Services Administration (SAMHSA) annual National Survey on Drug Use and Health (NSDUH).⁹

(U) Chart 7. Current (Past Month) Users of Selected Illicit Drugs, 2007 to 2014



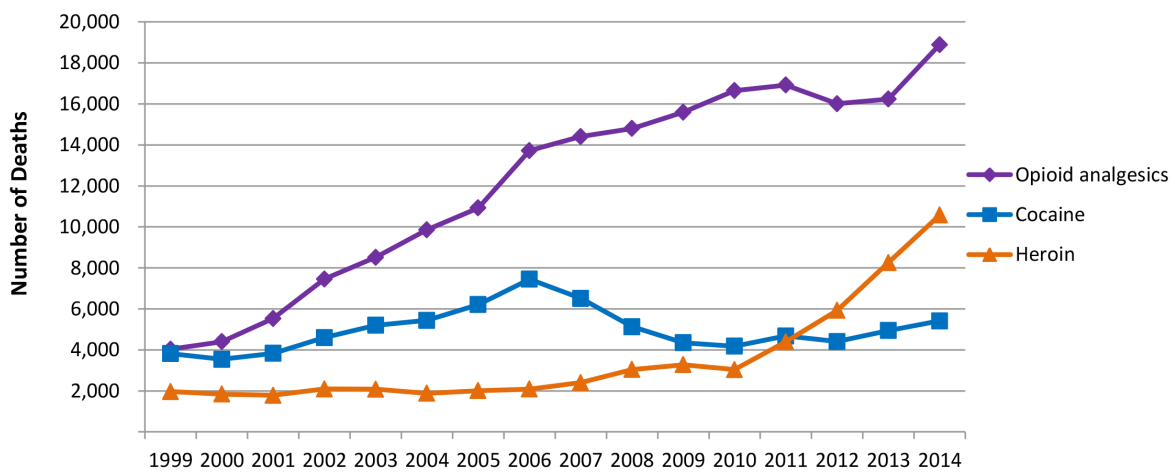
Note: Marijuana is not included on this chart because the user numbers are higher than for all other illicit drugs combined.

Source: National Survey on Drug Use and Health

• (U) Heroin 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 10 times the size of the heroin user population in 2014; however, opioid analgesic-involved overdose deaths in 2014 were less than twice that of heroin-involved deaths. Current cocaine users outnumbered heroin users by approximately 3.5 times in 2014, but heroin-involved overdose deaths were twice those of cocaine. Deaths involving heroin are also increasing at a much faster rate than for other illicit drugs, more than tripling between 2010 (3,036) and 2014 (10,574).¹⁰ (See Chart 8.)

(U) Chart 8. Drug Poisoning Deaths Involving Selected Illicit Drugs, 1999 to 2014



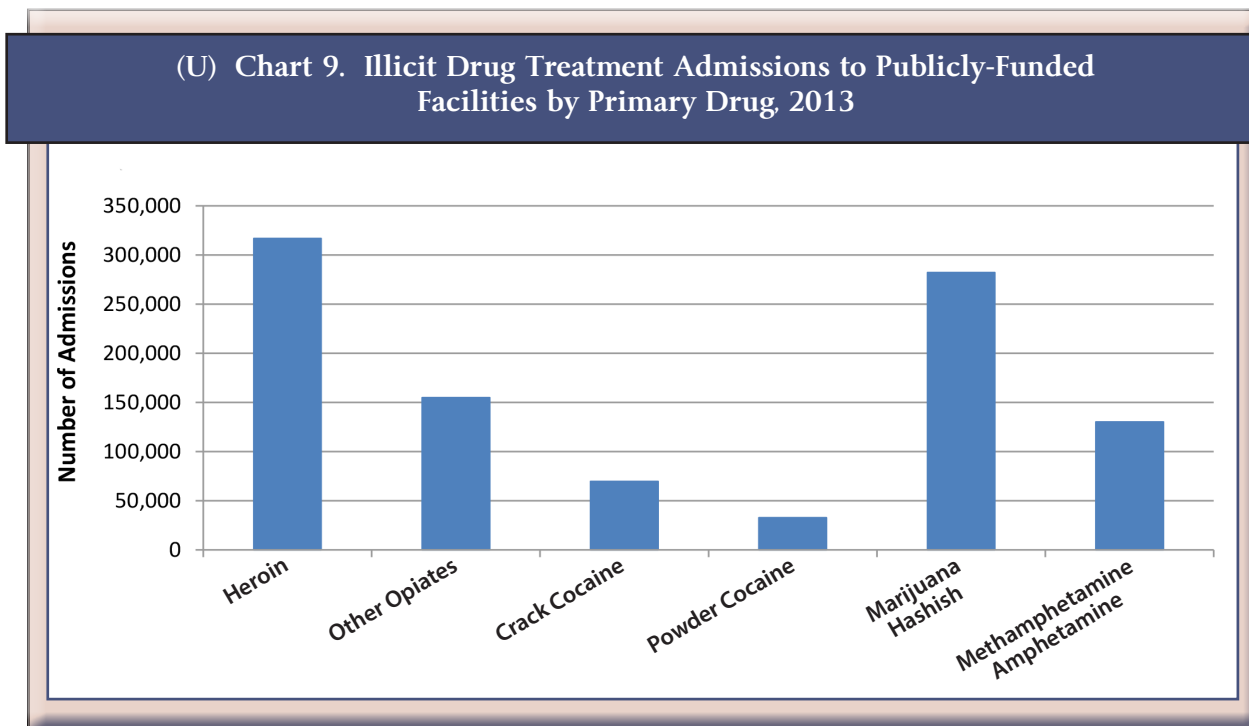
Note: Heroin includes opium.

Source: National Center for Health Statistics/CDC

(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.¹¹ 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.¹²

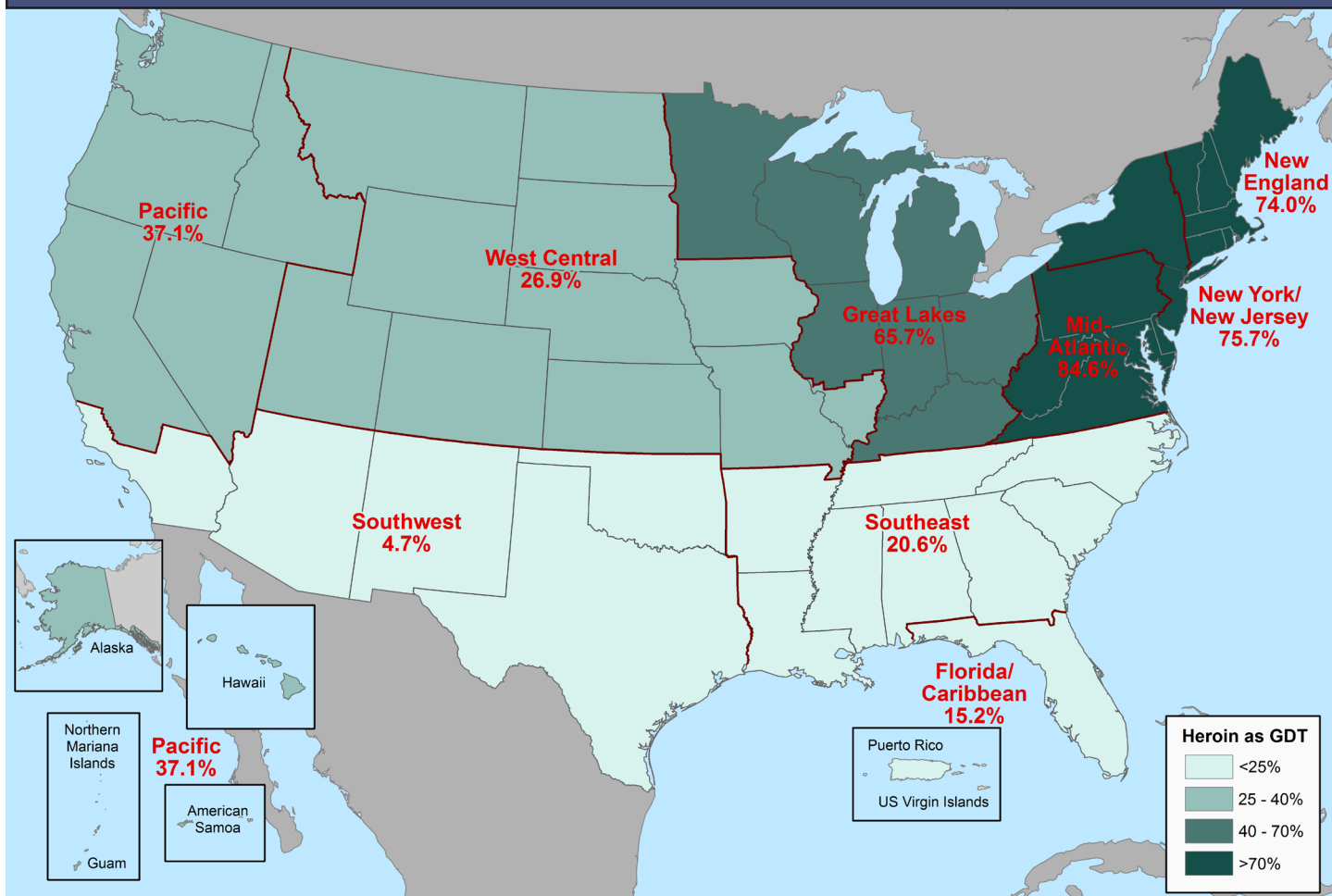
- (U) **More people seek treatment for heroin use than for any other illicit drug**

(U) Despite comprising a smaller user population, there were more treatment admissions to publicly funded facilities for heroin than for any other drug. (See Chart 9.)



Source: Treatment Episode Data Set

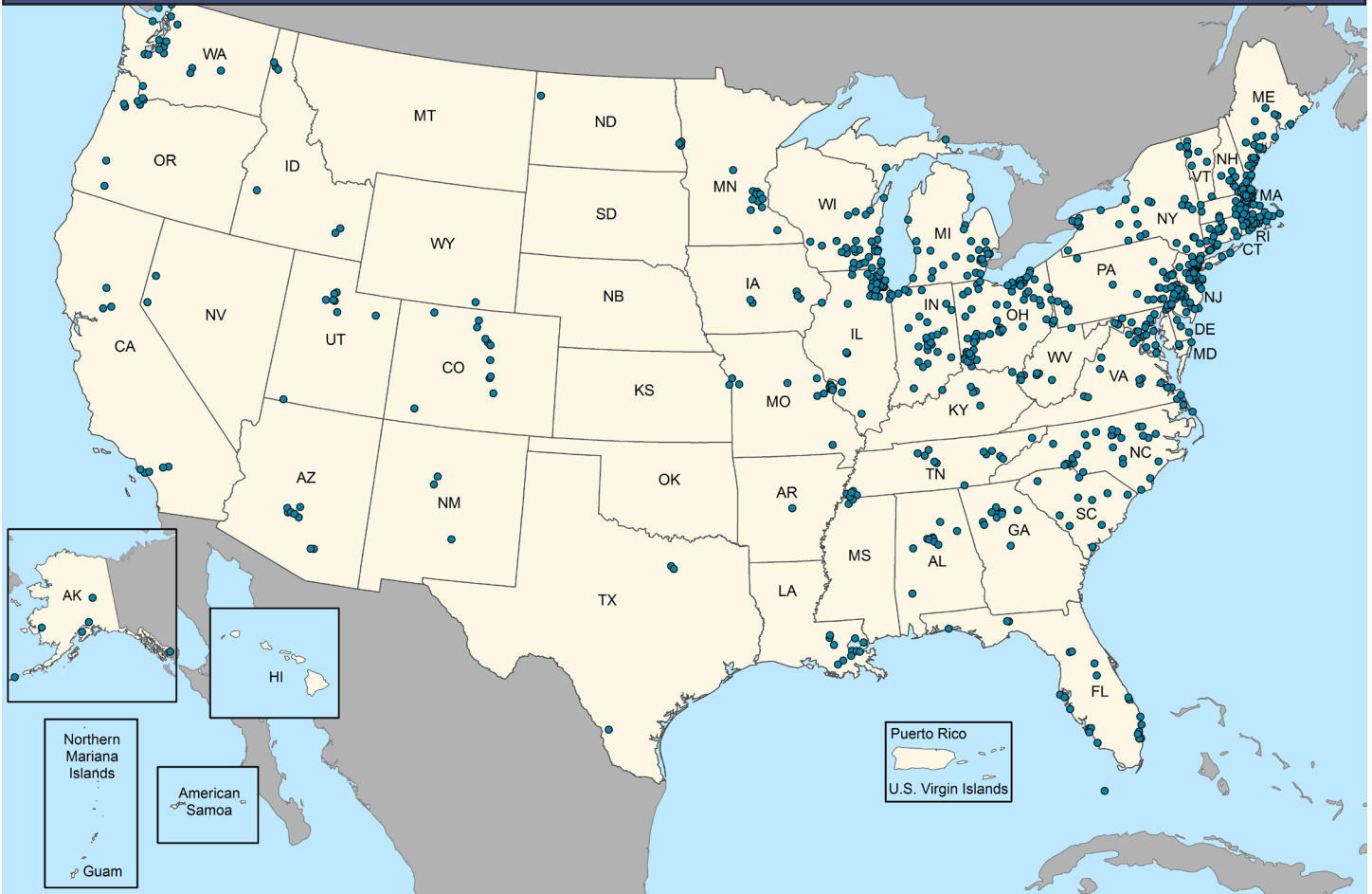
(U) Map 2. Percentage of 2016 NDTs Respondents Reporting Heroin as Greatest Drug Threat, by OCDETF Region



Source: 2016 National Drug Threat Survey

(U) The Organized Crime Drug Enforcement Task Force (OCDETF) Program was established in 1982 to conduct comprehensive, multi-level targeting 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 2016 NDTs Respondents Reporting Heroin as Greatest Drug Threat



Source: 2016 National Drug Threat Survey

- ¹ (U) U.S. Department of Justice, Drug Enforcement Administration, 2016 National Drug Threat Survey; U.S. Department of Justice, Drug Enforcement Administration, All Domestic Field Division Reporting, January 2013 – June, 2015.
- ² (U) U.S. Department of Justice, Drug Enforcement Administration, All Domestic Field Division Reporting, January 2013 – June, 2015.
- 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) Centers for Disease Control, National Center for Health Statistics, "Number of drug-poisoning deaths involving synthetic opioids: United States, 2013–2014," December 2015.
- ⁵ (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.
- ⁶ (U) U.S. Department of Justice, Drug Enforcement Administration, DEA Investigative Reporting, January 2015.
- ⁷ (U) Office of National Drug Control Policy, National Drug Control Strategy Data Supplement 2014, September 2014.

- ⁸ (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.
- ⁹ (U) Substance Abuse and Mental Health Services Administration, 2014 National Survey on Drug Use and Health, September 2015.
- ¹⁰ (U) Centers for Disease Control, National Center for Health Statistics, National Vital Statistics Report, Final death data for each calendar year, October 2014.
- ¹¹ (U) Mayo Clinic, Mayo Medical Laboratories website, Clinical information on 6-Monoacetylmorphine, accessed January 13, 2015.
- ¹² (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 dea.onsi@usdoj.gov.



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	Very Satisfied	Somewhat Satisfied	Neither Satisfied nor Dissatisfied	Somewhat Dissatisfied	Very Dissatisfied
Overall satisfaction with DEA Product	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Readability/Understanding of DEA Product	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Value/Usefulness of NNP Product	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Report Increased my Understanding or Knowledge of the report subject	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Product Relevance to my agency's mission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How will you use this report? (Check all that apply)	<input type="checkbox"/> Policy Formulation <input type="checkbox"/> Situational Awareness <input type="checkbox"/> Operational Planning <input type="checkbox"/> Training <input type="checkbox"/> Resource Allocation <input type="checkbox"/> Other				

Additional Comments: