

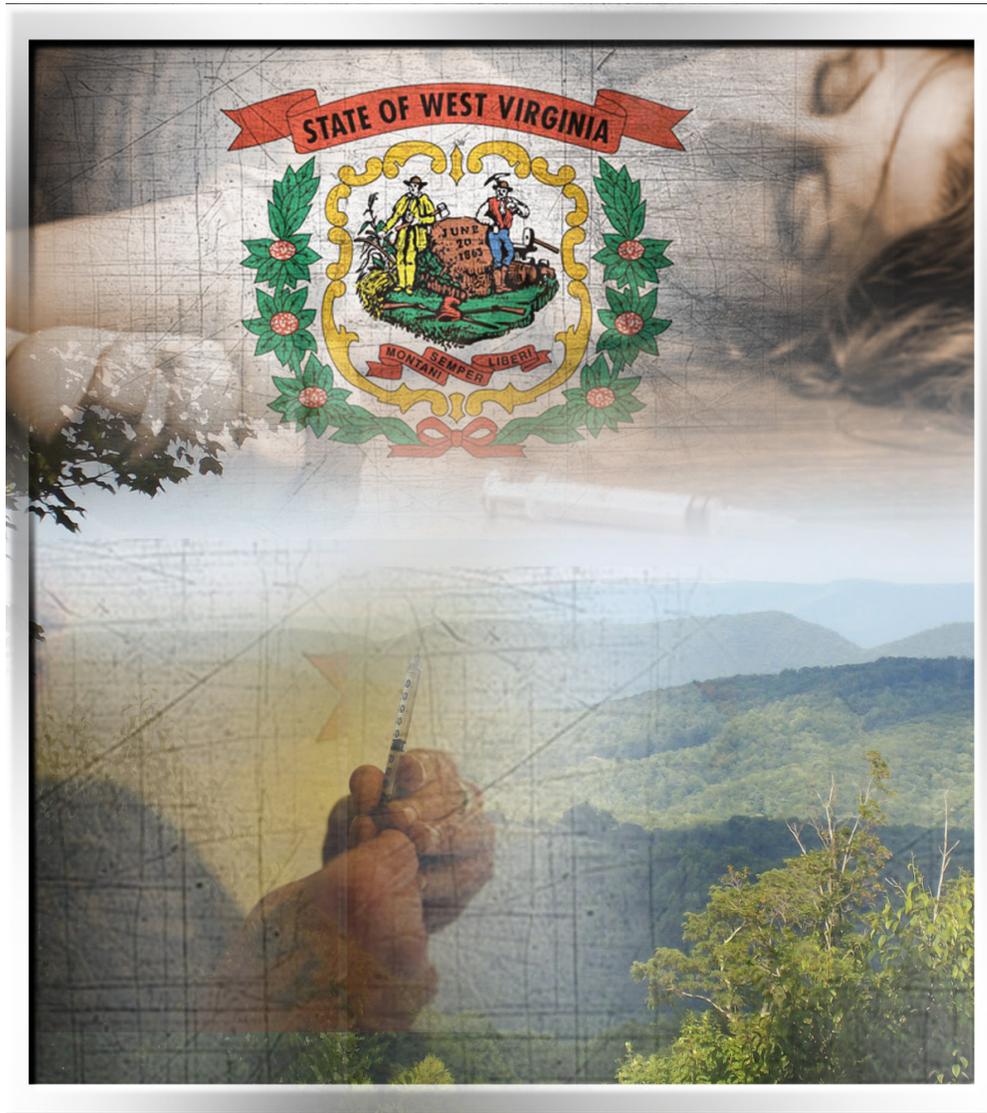


DEA
INTELLIGENCE
REPORT

The West Virginia Drug Situation

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(U) This product was prepared by the DEA Washington Division Office. Comments and questions may be addressed to the Chief, Analysis and Production Section at dea.onsi@usdoj.gov. For media/press inquiries call (202) 307-7977.

Executive Summary

Drug abuse and trafficking, particularly of opioids, is a critical threat to West Virginia. The Centers for Disease Control and Prevention (CDC) report that there was a statistically significant increase (16.9 percent) in drug overdose deaths in West Virginia between 2014 and 2015.¹ The state had the highest rate of overdose deaths in the country in 2015, approximately 42 for every 100,000 people; CDC data indicate that 725 people died of drug overdoses in West Virginia in 2015,² more than double the number who died from car accidents.³

The illegal distribution of controlled prescription drugs (CPDs), heroin, fentanyl, and methamphetamine pose the greatest threats to West Virginia, though cocaine, crack, marijuana, and new psychoactive substances (NPSs) such as synthetic cannabinoids are also available. CPD abuse and trafficking has long been the leading drug problem in West Virginia and is still responsible for the majority of overdose deaths in the state. However, heroin and fentanyl abuse is rapidly expanding and surpassing CPDs as the greatest threat in some parts of the state. Mexico-sourced crystal methamphetamine is increasingly available as well, pushing into a market previously dominated by locally manufactured powder methamphetamine. Crack and cocaine availability and abuse have declined somewhat since 2010, while the marijuana and NPS markets remain stable. Pressure on retail stores to cease selling unregulated (and usually illegal) products helps to limit the availability of NPSs, but the periodic emergence of stronger or more potent strains often causes spikes in emergency room admissions and overdoses.

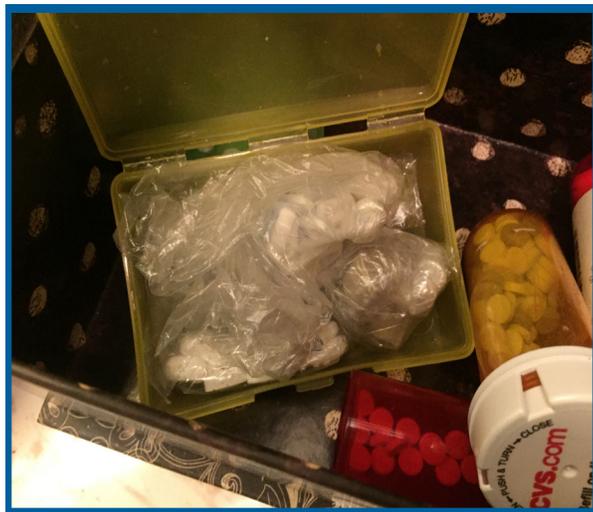
Details

Controlled Prescription Drugs

Controlled prescription drug abuse and trafficking in West Virginia is widespread, and the state has one of the highest prescription rates for opioids in the United States. Statistics show that illicit pharmaceutical drug use contributed to approximately 61 percent of state overdose deaths in 2015.⁴ The extraordinarily high abuse rate of opioids is attributed in part to the large number of jobs in heavy manual labor such as mining, timbering, and manufacturing. These professions often cause injuries to workers that are treated with opioid pain relievers, which in turn can lead to addiction.⁵ Another contributor is unemployment. As of March 2016, West Virginia has the second-highest unemployment rate in the United States at 6.5 percent.⁶ Addiction professionals link joblessness with illegal drug use; prescription opioids such as oxycodone, Opana®, and Percocet® represent the recreational drugs of choice.⁷ Controlled pharmaceutical drug abusers and traffickers in West Virginia obtain the drugs from either licensed providers or out-of-state drug traffickers who have expanded into West Virginia. In some instances, doctors and other health care providers, acting outside medical guidelines, write prescriptions for CPDs without a legitimate need on the part of the “patient.” In other cases, the prescriptions are written by doctors in good faith, for unsuspected “doctor shoppers” who are providing for their own addictions, supplying pills to dealers, or both.

Pharmacies in West Virginia both wittingly and unwittingly fill fraudulent prescriptions. Some pharmacists fill legitimate prescriptions written by doctors who are known to be overprescribing CPDs, often for patients from out of state. There have also been cases of pharmacy employees stealing CPDs and selling them to street

(U) Figure 1. Controlled pharmaceutical drugs.



Source: DEA

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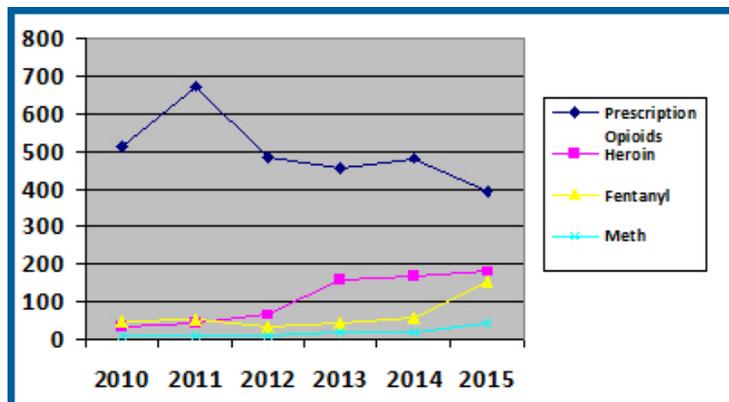
dealers. Pharmacies are also targeted by robbers who steal drugs either to distribute themselves or to sell to larger distributors.

Out-of-state drug traffickers are increasingly transporting CPDs into West Virginia and are often involved directly in local sales. Detroit-based traffickers represent the majority of CPD traffickers bringing pills into West Virginia. In some cases, couriers travel by bus or private vehicle to deliver the CPDs to local dealers and then collect the drug proceeds before returning to Detroit. In most instances though, the Detroit-based dealers transport the drugs to West Virginia and distribute them—typically within the cities of Huntington, Charleston, and Morgantown—sometimes staying for weeks at a time. Members of the Detroit-based groups often rotate in and out of West Virginia, returning to Detroit to re-supply while another faction of the group is arriving. This “model” has been adopted by other out-of-state groups as well.

CPD abuse has decreased somewhat since 2011 because of increasing public awareness and law enforcement pressure. Continued focus by law enforcement agencies, prevention, and treatment organizations may further reduce the problem. Many CPD users who have developed an opioid addiction are seeking heroin, which is generally cheaper and sometimes easier to obtain, as their opiate of choice.

Heroin, Fentanyl, and Pharmaceutical Narcotics

(U) Figure 2. Opioid drugs contributing to overdoses in West Virginia.



Source: West Virginia Health Statistics Center

Detroit for their supply, or they travel to Detroit themselves to “re-up” on heroin. Huntington, in particular, has a growing heroin market, earning the moniker “Little Detroit” locally.⁹ Nearby Steubenville, Ohio, serves as a source city for users just over the border in northern West Virginia, and both locales are serviced by Chicago-based gangs. Pittsburgh-based dealers also supply northern West Virginia and, to a lesser extent, user populations in Charleston and Huntington.

Between 2012 and 2015, fentanyl overdose deaths in West Virginia increased by more than 20 percent. Since fentanyl is either mixed with or sold as heroin, addicts often are not aware that they are ingesting fentanyl with or instead of heroin. Much of the fentanyl (and mixed heroin-fentanyl) sold in West Virginia is sourced from Detroit. Anecdotal

Although West Virginia has a long history of CPD abuse and illegal distribution, the CPD market is likely to be supplanted by less-expensive heroin, fentanyl, fentanyl analogues, and other novel opioids. A recent open source article noted, “[at] some point in the past five or so years, heroin began to rival pills as the predominant opioid in the region.”⁸

The heroin market in West Virginia has traditionally been dominated by “end users” (addicts), but the market is evolving. In order to meet rising demand, Detroit- and Columbus-based dealers, some of whom are gang-affiliated, bring large quantities of heroin into West Virginia for distribution. Local distributors either rely on “runners” (couriers) from

(U) Figure 3. Counterfeit oxycodone tablets.



Source: Bluefield (Virginia) Police

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information suggests that Detroit is the source city for so-called “blue heroin,” meant to signify that the heroin is laced with fentanyl.

Exacerbating the problem, some drug dealers sell counterfeit pharmaceuticals made with illicit opiates that are inconsistent in quality and could prove deadly. Given the pervasive and multi-headed nature of the opioid threat in the state, West Virginia will likely continue to have a high incidence of opioid overdose injuries and deaths.

Methamphetamine

(U) Figure 4. Crystal methamphetamine.



Source: DEA

Methamphetamine, in both powder and crystal form, is available throughout West Virginia. Although clandestine labs, which typically produce small quantities of methamphetamine in powder form, remain a problem in some parts of the state, most of the methamphetamine available in West Virginia is supplied by dealers in secondary or tertiary markets who are, in turn, supplied by Mexico-based traffickers.

Mexico-based methamphetamine suppliers and dealers are not active in the user-level (retail) market in West Virginia, but they dominate the higher levels of supply. Well-established networks smuggle Mexico-produced crystal methamphetamine from cities along the U.S. Southwest Border (primary markets) into urban southeastern U.S. hubs (secondary markets) along with other illicit drugs such as heroin and cocaine. Independent dealers in West Virginia then bring the methamphetamine into the state from these secondary market

areas (such as Atlanta and Charlotte) or from smaller regional markets (i.e., cities in western Virginia) for local distribution.

Powder methamphetamine is typically produced in small clandestine “one pot” labs in West Virginia, which yield multi-gram to multi-ounce quantities. In 2014 (the most recent figures available), the National Precursor Log Exchange system denied over 13,000 pseudoephedrine purchase transactions in the state (the blocked purchases represented just over 4 percent of the pseudoephedrine sold in the state). Given the increased availability of crystal methamphetamine in the state, as well as the oversight (however limited) of pseudoephedrine purchases, local methamphetamine manufacturing is likely to decrease even further.

Statistics compiled by the West Virginia Poison Control Center between 2012 and 2015 show a gradual, albeit uneven, increase in the number of calls for toxic exposure to methamphetamine. In the most recent data from 2015, methamphetamine exposure increased to 46 reported incidents, a 19 percent increase compared to 2014.¹⁰ Methamphetamine abuse is likely to rise in West Virginia as the availability of Mexico-sourced crystal methamphetamine increases.

Cocaine and Crack Cocaine

In West Virginia, as in most of the United States, cocaine availability has shown a steady decline since 2013. West Virginia Poison Control Center statistics between 2010 and 2015 show a commensurate decline in the number of calls for toxic exposure to cocaine.¹¹ In the areas of the state where cocaine is distributed, it is sold in relatively small quantities by dealers unaffiliated with gangs or other established networks. As with other illegal drugs, out-of-state distributors from Michigan, Georgia, Pennsylvania, and Ohio supply cocaine throughout the state via parcel delivery services or couriers traveling by bus or private vehicle.

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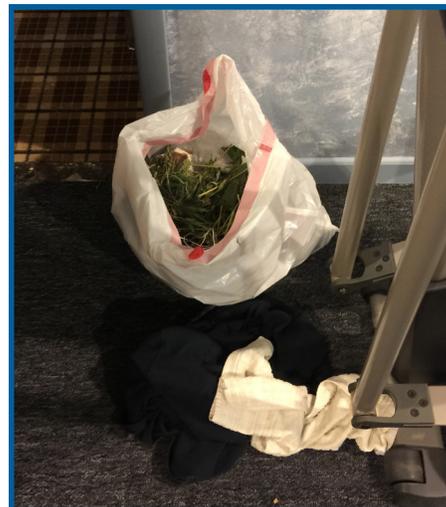
Crack distribution is slightly more prevalent than powder cocaine sales in West Virginia, and is concentrated in the state's urban areas. Although crack can be (and is) produced in West Virginia, dealers generally obtain the cocaine already in rock form from metropolitan areas in surrounding states. Many of the same Detroit-based dealers who sell heroin and other opioids in West Virginia also distribute crack.

Marijuana

Marijuana is abused and distributed throughout West Virginia. Due to both a favorable climate and large areas of remote and/or rough terrain, West Virginia has numerous outdoor cannabis fields under cultivation during the growing season. Some growers also cultivate marijuana in indoor settings. According to DEA's Domestic Cannabis Eradication/Suppression Program statistics, 275 outdoor grows and 22 indoor grows were eradicated in West Virginia in 2015.¹² The state was among the five highest-ranked marijuana-producing states in 2015.¹³

Marijuana grown in West Virginia is usually consumed locally, but does not provide a sufficient supply to meet demand throughout the state. As a result, Mexico-sourced marijuana is far more prevalent in West Virginia than locally cultivated marijuana. There are no organized street gangs or specific groups responsible for importing and selling marijuana within West Virginia. Instead, independent local traffickers obtain marijuana from wholesale-level suppliers in nearby states such as North Carolina and Georgia. Some dealers also obtain high-grade, domestically cultivated marijuana from contacts in California, or from Mexico-based suppliers living in California. Marijuana distributors in West Virginia typically use privately owned vehicles or tractor-trailers to transport marijuana from the source area to the state. Distributors also use mail services to bring in smaller quantities of marijuana.

(U) Figure 5. Marijuana from indoor grow.



Source: DEA

New Psychoactive Substances (NPS)

With the exception of synthetic cannabinoids and cathinones (K2, Spice, bath salts, etc.), NPSs are not widely available in West Virginia. Synthetic cannabinoids and cathinones are usually mailed to West Virginia from other states, and delivered to gas stations, convenience stores, and variety stores where the drugs are sold "under the counter." Some packages contain smaller quantities of the drugs, pre-packaged for retail sale, while others arrive in bulk and are broken down and repackaged by the retailer. In addition to the retail stores that sell synthetic drugs, there are also distributors who sell synthetic cathinones and cannabinoids on the street. There was a sharp increase in overdose reports related to NPSs in the summer of 2015, but the numbers have since decreased slightly. The American Association of Poison Control Centers reported that as of August 31, 2015, 3.5 percent of the state's population had contacted a poison control center about synthetic cannabinoid exposure.¹⁴ West Virginia ranked fifth in the nation for the percentage of population making such calls.

Outlook

The abuse and trafficking of CPDs, heroin, fentanyl, and crystal methamphetamine represent a significant threat to West Virginia. Although CPD overdose deaths have declined in recent years, these accidental deaths remain higher than any other type of overdose death. Meanwhile, heroin and fentanyl availability and trafficking are increasing, as is the availability of crystal methamphetamine. Mexico-based suppliers and distributors have gained a foothold in West Virginia. Government officials, the healthcare community, and law enforcement agencies will need to dedicate significant resources to lowering the demand for pharmaceutical drugs as well as disrupting the organizations that distribute CPDs, heroin, fentanyl, and methamphetamine.

¹ Centers for Disease Control and Prevention, "Drug Overdose Death Data," December 16, 2016, <https://www.cdc.gov/drugoverdose/data/statedeaths.html> (accessed February 2017).

² Ibid.

³ National Highway Traffic Safety Administration, "State Motor Vehicle Crash Statistics"; <http://cdan.nhtsa.gov/SASStoredProcess/guest> (accessed February 2016).

⁴ West Virginia Health Statistics Center, March 2016.

⁵ David Gutman, "How did WV come to lead the nation in overdoses?" *Charleston Gazette-Mail*, October 17, 2015; <http://www.wvgazettemail.com> (accessed May 2016).

⁶ Ibid.

⁷ Harrison Jacobs, "Here's why the opioid epidemic is so bad in West Virginia – the state with the highest overdose rate in the US," *Business Insider*, May 1, 2016; <http://www.businessinsider.com> (accessed May 2016).

⁸ David Gutman, "How did WV come to lead the nation in overdoses?" *Charleston Gazette-Mail*, October 17, 2015; <http://www.wvgazettemail.com> (accessed May 2016).

⁹ Katie Griffith, "A City on the Mend;" *West Virginia Focus*, January 30, 2015, <http://www.wvfocus.com>.

¹⁰ West Virginia Poison Control Center, February 2016.

¹¹ Ibid.

¹² DEA, "2015 Domestic Cannabis Eradication/Suppression Program Statistical Report," <https://www.dea.gov/ops/cannabis/shtml> (accessed May 2016).

¹³ Ibid.

¹⁴ Criminal Justice Coordinating Council, September 2015 Symposium Report, "Demanding More Vigilance: Synthetic Drugs in the District of Columbia, Maryland, and Virginia," September 2015.



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	Very Satisfied	Somewhat Satisfied	Neither Satisfied nor Dissatisfied	Somewhat Dissatisfied	Very Dissatisfied
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Additional Comments: