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U.S. Department of Justice
Drug Enforcement Administration



National Drug Threat Assessment Summary

2014

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



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From the Administrator



I am pleased to present the 2014 National Drug Threat Assessment Summary, a strategic assessment of the threats posed to our communities by transnational criminal organizations and the illicit drugs they distribute throughout the United States. This annual assessment provides policymakers, law enforcement personnel, and prevention and treatment specialists with relevant strategic drug intelligence to assist in formulating counterdrug policies, establishing law enforcement priorities, and allocating resources.

The Drug Enforcement Administration produces the National Drug Threat Assessment in partnership with local, state, tribal, and federal agencies. To accurately depict a national-level perspective of the drug issues facing the United States, the report integrates the most recently available reporting from law enforcement and intelligence agencies with the most current data from public health agencies regarding national substance abuse indicators. This report also draws on information from more than 1,200 local, state, tribal, and federal law enforcement partners who provided input for the assessment.

During the past year, the counterdrug community celebrated a number of achievements, including the arrest of Joaquin "El Chapo" Guzman, one of the leaders of the Sinaloa Cartel. These successes signify major progress in our shared fight against transnational organized crime, violence, and drug trafficking. Despite these accomplishments, we still have significant areas of concern within our country, including the threats from prescription drug abuse, increased heroin overdoses, marijuana legalization, and the continued dominance of Mexican transnational criminal organizations in the US illicit drug market.

My thanks to all participating agencies and organizations for your contributions to this vital report. Your views and opinions continue to be important and help us to best meet the needs of the law enforcement, intelligence, prevention, and treatment provider communities, as well as shape drug policies. I look forward to collaborating on future initiatives that will protect our national security interests abroad and at home.

Respectfully,

A handwritten signature in black ink that reads "Michele Leonhart". The signature is written in a cursive, flowing style.

Michele M. Leonhart
Administrator
Drug Enforcement Administration

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Scope and Methodology

The 2014 National Drug Threat Assessment (NDTA) Summary addresses emerging developments related to the trafficking and use of primary illicit substances of abuse and the nonmedical use of controlled prescription drugs (CPDs). In the preparation of this report, DEA considered quantitative data from various sources (seizures, investigations, arrests, drug purity or potency, and drug prices; law enforcement surveys; laboratory analyses; and interagency production and cultivation estimates) and qualitative information (subjective views of individual agencies on drug availability, information on the involvement of organized criminal groups, information on smuggling and transportation trends, and indicators of changes in smuggling and transportation methods).

The 2014 NDTA Summary uses information provided by 1,226 state and local law enforcement agencies through the 2014 National Drug Threat Survey (NDTS). At a 95 percent confidence level, the 2014 NDTS results are within 2.59 percentage points of the estimates reported. NDTS data used in this report do not imply that there is only one drug threat per state or region or that only one drug is available per state or region. A percentage given for a state or region represents the proportion of state and local law enforcement agencies in that state or region that identified a particular drug as their greatest threat or as available at low, moderate, or high levels.

Overview

The threat from CPD abuse is persistent and deaths involving CPDs outnumber those involving heroin and cocaine combined. The economic cost of nonmedical use of prescription opioids alone in the United States totals more than \$53 billion annually. Transnational Criminal Organizations (TCOs), street gangs, and other criminal groups, seeing the enormous profit potential in CPD

diversion, have become increasingly involved in transporting and distributing CPDs. The number of drug overdose deaths, particularly from CPDs, has grown exponentially in the past decade and has surpassed motor vehicle crashes as the leading cause of injury death in the United States. Rogue pain management clinics (commonly referred to as pill mills) also contribute to the extensive availability of illicit pharmaceuticals in the United States. To combat pill mills and stem the flow of illicit substances, many states are establishing new pill mill legislation and prescription drug monitoring programs (PDMPs).

Heroin abuse and availability are increasing, particularly in the eastern United States. There was a 37 percent increase in heroin initiates between 2008 and 2012. Increased demand for heroin is largely being driven by a subset of CPD abusers switching to heroin because heroin is more available and less expensive. Further, some OxyContin® abusers switched to heroin after the reformulation of that drug made it more difficult to abuse.

Many cities and counties across the United States, particularly in the Northeast and Midwest, are reporting increasing heroin overdose deaths. Some areas are also reporting overdoses due to heroin tainted with fentanyl or fentanyl being sold as heroin. Fentanyl is much stronger than heroin and can cause even experienced abusers to overdose.

Several drug data sources indicate that methamphetamine availability is increasing in the United States; however, drug demand indicators are less certain. High methamphetamine availability is directly related to high levels of methamphetamine production in Mexico; domestic production remains low in comparison. The number of methamphetamine laboratories seized in Mexico has increased significantly since 2008, and methamphetamine seizures at the

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Southwest Border increased more than three-fold over the past five years. Mexico-produced methamphetamine has extremely high purity and potency levels. In 2012, purity levels¹ averaged close to 90 percent, while prices remained low and stable.

Cocaine availability rebounded slightly in 2013 compared to 2012. However, it remains stable at historically low levels throughout most domestic markets along the East Coast. These lower levels constitute a new normal in comparison to pre-2007 levels when US markets had high levels of cocaine availability with low prices and high purity. Since 2007 cocaine availability levels in the United States have fluctuated slightly but continued at consistently lower levels than prior to 2007.

Marijuana is the most commonly abused drug in the United States. High availability levels are due to large-scale marijuana importation from Mexico, as well as increasing domestic indoor grows and an increase of marijuana cultivated in states that have legalized marijuana or passed state-approved “medical marijuana”² initiatives. More people use marijuana than all other illicit drugs combined, and there has been an increase in the medical consequences associated with marijuana abuse nationwide. There was a 62 percent increase in marijuana-related emergency department visits between 2004 and 2011. Marijuana-related visits were second only to cocaine in 2011, and nearly matched the number of cocaine-related emergency department visits.

The abuse of marijuana concentrates (“wax,” “butane honey oil,” etc.) is increasing throughout the United States. These concentrates can be abused using e-cigarettes or consumed in edibles, and have significantly higher tetrahydrocannabinol (THC) levels than leaf marijuana. In 2013, the THC content of leaf marijuana averaged 12.55 percent, while the THC content of marijuana concentrates averaged 52 percent, with some samples testing over 80 percent. Highly flammable

butane gas is used to extract the THC from the marijuana leaf, and has resulted in explosions, injuries, and deaths.

The abuse of synthetic cannabinoids (“K2,” “Spice,” “Herbal Incense”) and synthetic cathinones (“bath salts”) remain a concern, as these drugs are still available in convenience stores, head shops, gas stations, and online. Additionally, synthetic designer drugs being sold as “Molly” have become increasingly available and are sold as a substitute for methylenedioxymethamphetamine (MDMA).

¹ Purity refers to the ratio of a drug to the additives, adulterants, and/or contaminants it contains. Potency is the ability for the drug to produce euphoria or a “high”.

² When the term “medical marijuana” is used in this publication it is exclusively in reference to state-approved “medical marijuana”. Marijuana is a Schedule I substance under the Controlled Substance Act with no accepted medical use in the United States.

Controlled Prescription Drugs (CPDs)

The threat from CPD abuse is persistent. The annual economic cost of nonmedical use of prescription opioids in the United States was estimated at more than \$53 billion in 2011, the most recent data available; lost productivity and crime account for most (94%) of these costs. Nationally, 21.5 percent of law enforcement agencies responding to the 2014 NDTs reported CPDs as the greatest drug threat, up from 9.8 percent in 2009. (See Table B1 in Appendix B.) Additionally, 90.6 percent of law enforcement agencies surveyed indicated that CPD availability ranges from moderate to high.

Opioid analgesics, or pain relievers, are the most common type of CPD abused. The most common opioid CPDs are oxycodone (OxyContin®, Roxicodone®, Percocet®), hydrocodone (Vicodin®, Lorcet®, Lortab®), oxymorphone (Opana®), and hydromorphone (Dilaudid®). According to the National Seizure System (NSS), nearly 1.2 million dosage units of oxycodone were seized by law enforcement in 2013, up 535 percent from 2012. (See Table B2 in Appendix B.) Further, there was a 100 percent increase in hydrocodone seizures from 2012 (41,668 dosage units) to 2013 (83,448 dosage units). Law enforcement officers seized 1,363 dosage units of hydromorphone in 2013, down from 1,570 in 2012.

Demand and treatment data indicate the abuse of CPDs is a continuing and significant problem. According to the National Survey on Drug Use and Health (NSDUH), while the number of people reporting current non-medical use has increased, the statistical rate of current users has remained relatively steady over the past several years.

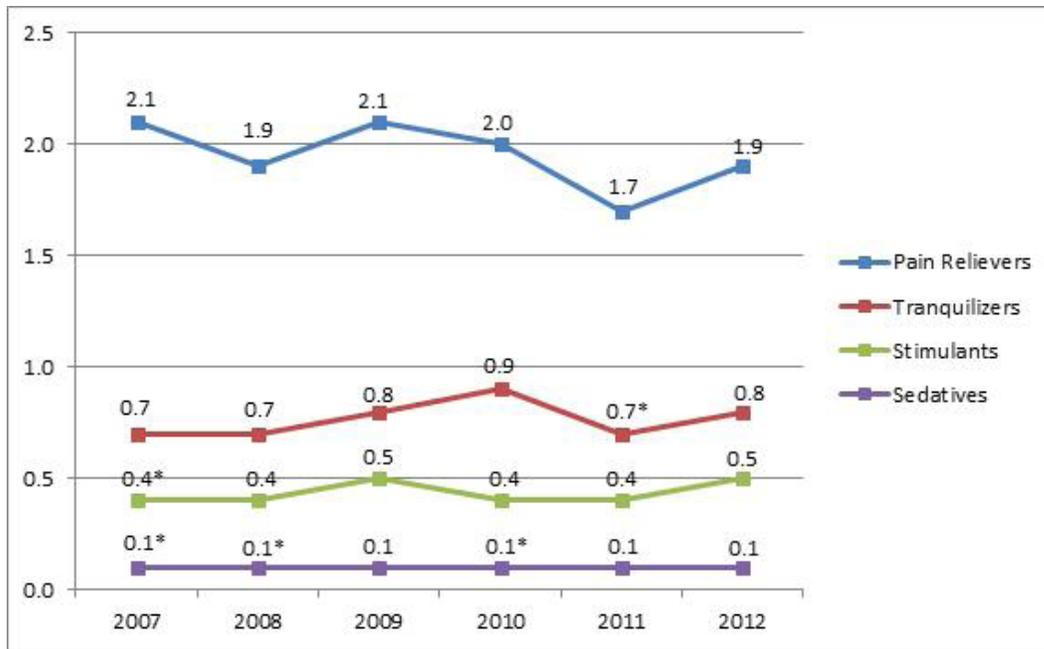
- NSDUH data indicate that in 2012, 6.8 million people aged 12 or older were current nonmedical users of psychotherapeutic drugs, 11.5 percent

higher than the number of users (6.1 million) reported for 2011 (See Chart 1.) These 6.8 million users included 4.9 million users of pain relievers, 2.1 million users of tranquilizers, 1.2 million users of stimulants, and 270,000 users of sedatives.³ The number of persons 12 and older who were current nonmedical users of pain relievers in 2012 (4.9 million) was statistically similar to the numbers over the last 10 years.

- CPDs are increasingly the first drug abused by initiates of illicit drug abuse. In 2012, an estimated 2.9 million persons aged 12 or older used an illicit drug for the first time within the past 12 months. More than 1 in 4 initiated with nonmedical use of prescription drugs (26.0 %, including 17.0 % with pain relievers, 4.1 % with tranquilizers, 3.6 % with stimulants, and 1.3 % with sedatives). (See Chart 2.) This is second only to marijuana as the first drug used by most abusers.
- According to the Drug Abuse Warning Network (DAWN), the estimated number of emergency department (ED) visits for nonmedical use of pharmaceuticals involving prescription opiates/opioids increased 81 percent—94,448 to 170,939—between 2007 and 2011. The number of ED visits in Minneapolis/St. Paul/Bloomington and Phoenix showed the greatest increase during that same time period with 115.9 percent and 108.4 percent increases, respectively. (See Table B3 in Appendix B.)

³ Numbers do not add up to 6.8 million because some survey respondents likely admitted to using more than one type of psychotherapeutic drug.

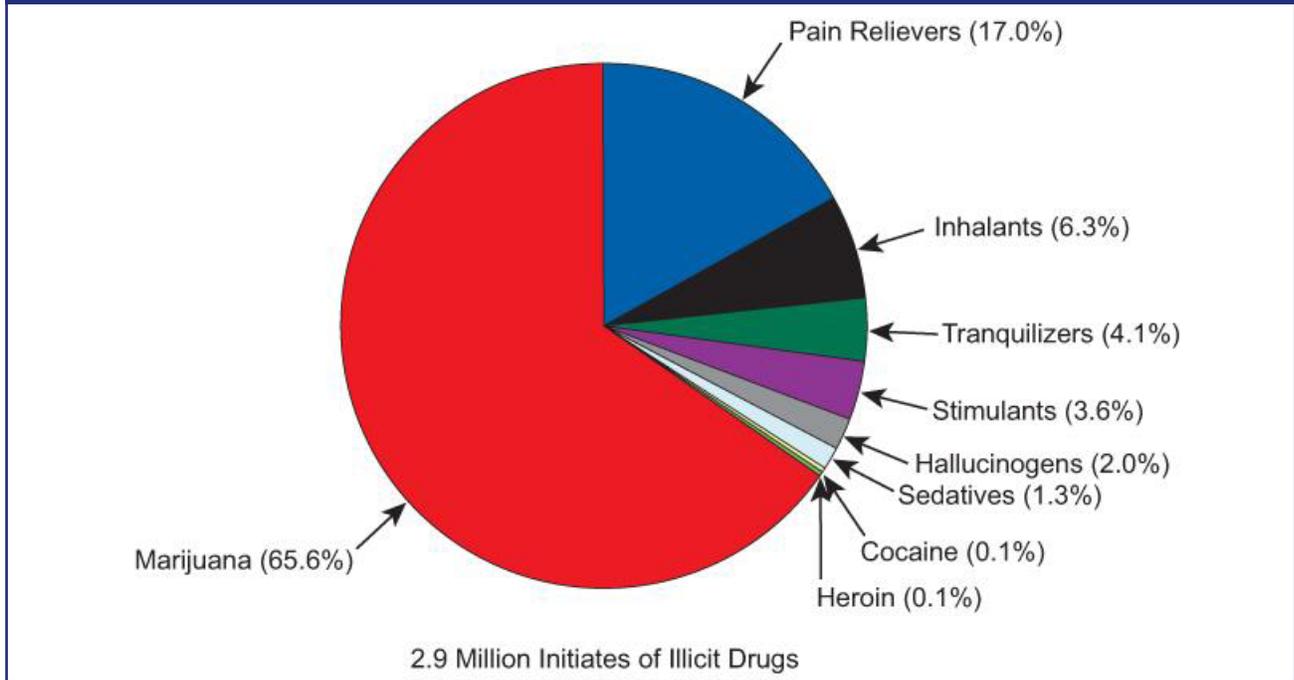
Chart 1. Past Month Nonmedical Use of Types of Psychotherapeutic Drugs Among Persons Aged 12 or Older 2007 - 2012 (in Percent)



* Difference between this estimate and the 2012 estimate is statistically significant at the 0.05 level.

Source: National Survey on Drug Use and Health, 2012

Chart 2. First Specific Drug Associated with Initiation of Illicit Drug Use Among Past Year Illicit Drug Initiates Aged 12 or Older 2012



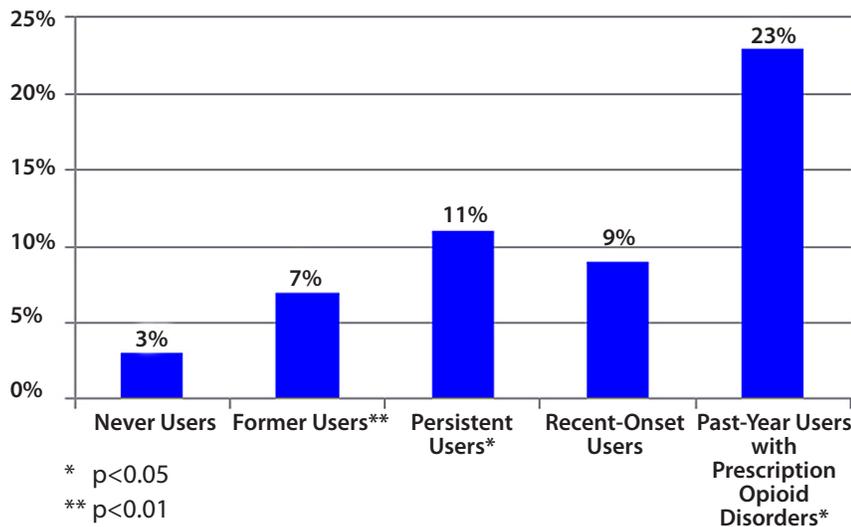
Source: National Survey on Drug Use and Health, 2012

- Treatment data further reflect the magnitude of the opioid abuse problem in the United States. Treatment Episode Data Set (TEDS) reporting indicates the number of other (non-heroin) opiate-related treatment admissions to publicly-funded facilities increased 89 percent from 2007 (98,909) to 2011 (186,986), the latest year for which national-level data is available. (See Table B4 in Appendix B.) Further, the number of treatment admissions for other opiates in 2011 was greater than the number of admissions for cocaine (143,827) and for amphetamines (110,471). According to TEDS, of the total number of abusers admitted to publicly-funded facilities for opiate-related treatment, over 60 percent reported their frequency of use as daily. Additionally, the number of admissions for benzodiazepines has continually risen since 2006 from 9,265 to 17,460 in 2011.

The number of drug overdose deaths, particularly from CPDs, has grown exponentially in the past decade and has surpassed motor vehicle (MV) crashes as the leading cause of injury death in the United States. The number of drug poisoning deaths now exceeds the number of deaths caused by MV crashes in 29 states and Washington, DC.

- The National Center for Health Statistics (NCHS) indicated that mortality data from 2009 suggested a large decline in MV crash deaths and a continued increase in prescription drug overdoses, leading to the conclusion that drug poisoning alone now causes more deaths than MV crashes in the United States.
- The NCHS further reported that nearly 90 percent of poisoning deaths were due to drugs and that drug poisoning mortality was due primarily to prescription drugs, especially opioid painkillers.

Chart 3. Percentage of Respondents Who Had Suicidal Thoughts During the Past 12 Months



Source: National Institute on Drug Abuse, the Science of Drug Abuse & Addiction

- In 2010, West Virginia, a state with a significant CPD abuse problem, had the highest rate of drug overdose deaths (28.9 per 100,000 people). This is significantly higher than the rate in 1999 when it was 4.1 per 100,000 people in the state.
- In 1999, no state had a drug overdose death rate above 15.0 per every 100,000 residents. In 2010, four states had rates over 20 per 100,000 residents, and 15 states had rates of 15 or higher per 100,000.

CPD abuse also contributes to increased thoughts of suicide in the United States.

- A recent National Institute on Drug Abuse (NIDA)-supported study indicated that individuals who use prescription opiates other than as ordered by a doctor are more likely to consider suicide than those who use these medications appropriately or not at all. Both persistent users (those who initiated use more than two years ago with continued use in the past year) and former users (those who initiated use more than two years ago, with no use in the past year) reported suicidal

thoughts at significantly higher rates than individuals who had never used a non-prescribed opioid medication.⁴ (See Chart 3.)

State Legislation Aimed at Combatting Pill Mills

Rogue pain management clinics (commonly referred to as “pill mills”) contribute to the extensive availability of illicit pharmaceuticals in the United States. Pill mill operations are primarily cash-based businesses and are run by operators who often don’t see patients or perform any type of physical exam. It is not uncommon to see lines of people waiting to get into these pill mills.

Many states are establishing new legislation in an effort to combat pill mills and stem the flow of prescription drugs to abusers. Currently, 44 states and Washington, DC require that a

⁴ Individuals who reported past-year symptoms consistent with a diagnosis of opioid dependence were more than twice as likely as never-users to say that they had considered self-destruction. The number of individuals who converted suicidal thoughts into suicide attempts ranged from 7 to 19 percent, with no significant differences between groups.

patient receive a physical exam by a healthcare provider, be screened for signs of substance abuse and addiction, or have a bona fide patient-physician relationship that includes a physical exam prior to prescribing. The state laws differ in their definition of the conditions in which an exam is required and the consequences for the physician for prescribing without a required exam (in some states it constitutes a criminal liability). Currently, Maryland, Michigan, Montana, Nebraska, South Dakota, and Wyoming are the only states that do not require a healthcare provider to conduct the exam, the screening, or have a patient-physician relationship.

- Thirty-two states have a law requiring or permitting a pharmacist to require identification (ID) prior to dispensing a controlled substance. Some of these states require customers to present an ID at all times when obtaining controlled substances, but some state laws limit the presentation of an ID to only people unknown to the pharmacists.
- Forty-six states and Washington, DC have a pharmacy lock-in program under the state Medicaid plan in which individuals suspected of misusing controlled substances must use a single prescriber and pharmacy.

Prescription Drug Monitoring Programs

Prescription Drug Monitoring Programs (PDMPs) are another tool used to reduce the amount of illicit CPDs available for abuse. PDMPs are state-run databases used to track the amount of CPDs prescribed and dispensed to patients. PDMPs can be used to quickly identify rogue subscribers, inadvertent prescribing, and “doctor shopping.” Currently, 49 states have an active PDMP. Missouri and Washington, DC do not have active PDMPs, although there is pending legislation for a PDMP in Washington, DC.

- Only 16 states have some form of mandatory use of PDMPs for providers.
- Of these 16 states, eight have laws that require the PDMP to be accessed before the initial prescribing or dispensing of a controlled substance.
- Of these 16 states, six require accessing the PDMP in limited situations, such as for certain prescribers or specific drugs.

State Prescription Drug Monitoring Programs

PDMPs vary in each state as to the type of information collected, who is allowed access to the data and under what circumstances, the requirements for use and reporting, including timeliness of data collection, the triggers that generate reports, and the enforcement mechanisms in place for noncompliance.

Drug Quality and Security Act

In November 2013, the Federal Drug Quality and Security Act (HR 3204) was signed into law. The Act establishes a system to track prescription drugs from the time they are manufactured until they are sold to the consumer. The Act calls for drug manufacturers, repackagers, wholesale distributors, and dispensers to maintain and to issue key information about each drug's distribution history. Within four years of the law's establishment, prescription drugs are to be serialized in a consistent way industry-wide. This will allow for efficient tracking in order to respond to recalls and notices of theft and counterfeiting.

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Heroin

The threat posed by heroin in the United States is increasing in areas across the country, especially in the Northeast and North Central regions. According to the 2014 NDTs, 29.1 percent of respondents reported heroin was the greatest drug threat in their area. This was more than any other drug except methamphetamine (31.8 percent.) (See Table B1 in Appendix B.) The Organized Crime and Drug Enforcement Task Force (OCDETF) regions with the largest number of respondents ranking heroin as the greatest drug threat were New England, Mid-Atlantic, Great Lakes, and New York/New Jersey. (See Map A4 in Appendix A.)

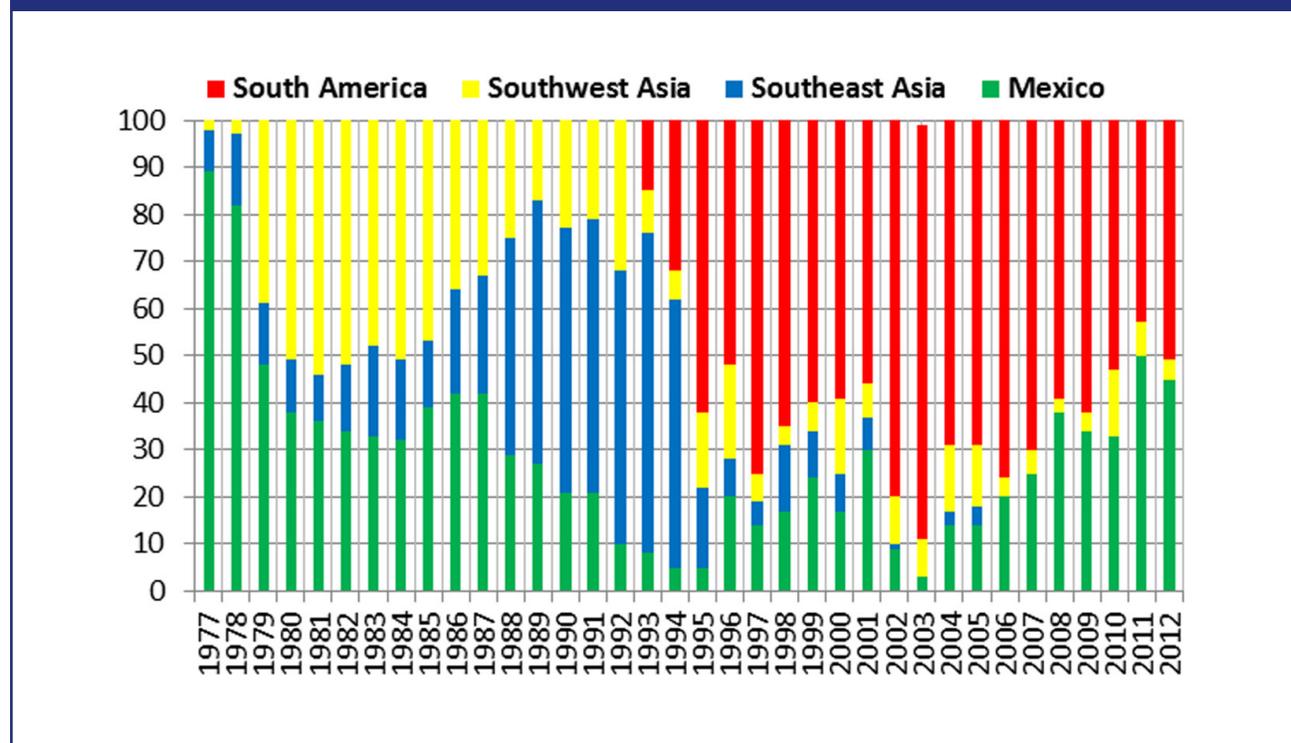
Heroin Source Areas

Four geographic source areas (South America, Mexico, Southwest Asia, and Southeast Asia) produce the world's heroin supply. Since 1977, different regions have dominated the

US market. For the past 20 years, the US retail heroin market has been roughly divided by the Mississippi River, with Mexican black tar and brown powder heroin dominating west of the Mississippi and South American white powder heroin more common in the East. Southwest Asia, while the dominant supplier of most of the world's heroin markets, represents a small portion of the US heroin market. Southeast Asian heroin has rarely been encountered in US markets in recent years. In 2012, heroin from South America accounted for 51 percent (by weight) of the heroin analyzed through the DEA Heroin Signature Program. Heroin from Mexico accounted for 45 percent and Southwest Asia accounted for four percent. (See Chart 4.)

South American, Southeast Asian, and Southwest Asian heroin are white, off-white, or tan powders, and are usually found in Eastern US markets where white powder heroin is

Chart 4. Source of Origin for US Wholesale-level Heroin Seizures 1977 - 2012



Source: Heroin Signature Program

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preferred. Mexican heroin traditionally is sold in brown powder and black tar forms, and is usually found in Western US markets.

Increasing Availability

Reporting from federal, state, and local law enforcement agencies indicates heroin availability is increasing throughout the nation. According to the 2014 NDTs, 61.7 percent of respondents said heroin availability was high or moderate in their areas. In addition, 54.7 percent of respondents reported that heroin availability was increasing and 53.8 percent said that heroin demand was increasing.

Seizure data also indicate a substantial increase in heroin availability in the United States. According to NSS data, heroin seizures in the United States increased 87 percent over five years, from 2,540 kilograms in 2009 to 4,761 kilograms in 2013. (See Chart 5.) Traffickers are also transporting heroin in larger amounts. The average size of a heroin seizure in 2009 was 0.86 kilograms; in 2013, the average heroin seizure was 1.56 kilograms.

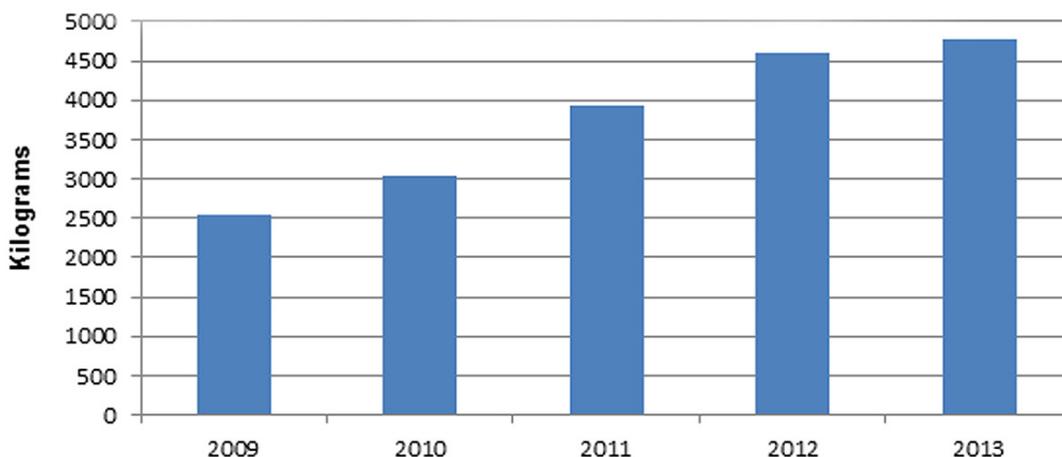
Seizures at the Southwest Border are also rising as Mexican TCOs increase heroin production and transportation. Heroin seizures at the

border more than doubled over five years, from 2009 (846 kilograms) to 2013 (2,196 kilograms). (See Chart 6.) During that time, the average seizure size increased from 2.9 kilograms to 3.8 kilograms and the number of seizure incidents increased from 295 incidents to 580 incidents.

Abusers Switching from CPDs to Heroin

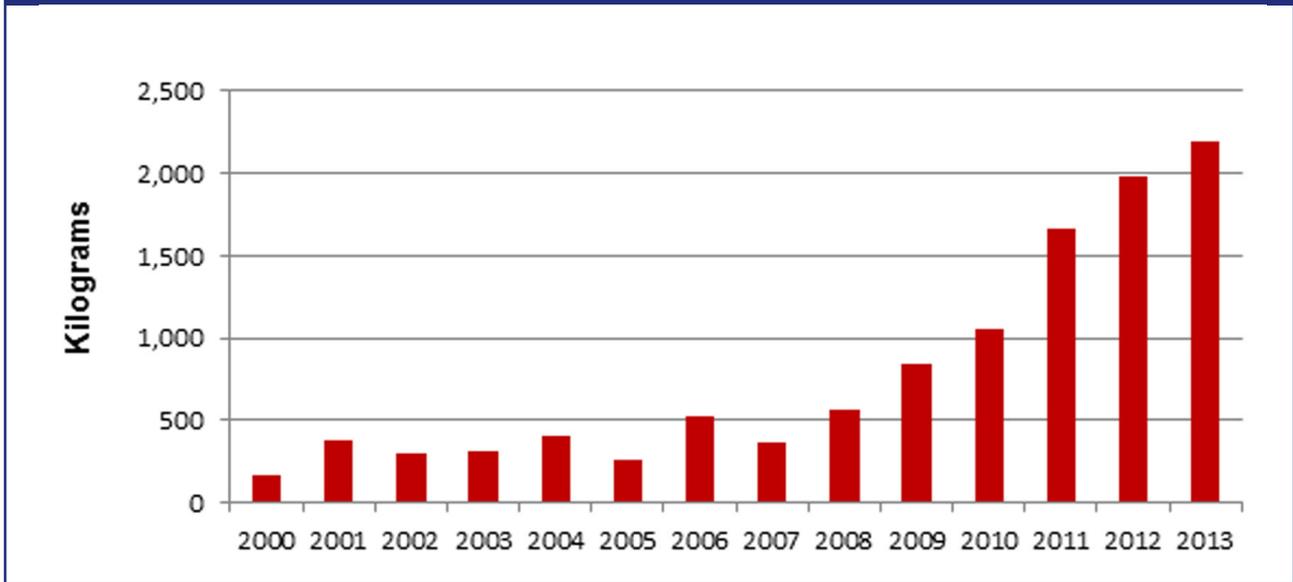
Increased demand for and abuse of heroin is largely being driven by a subset of CPD abusers switching to heroin. Treatment and law enforcement officials across the nation report increases in heroin abuse due to people switching from CPDs. A recent NSDUH study found that heroin abuse was 19 times higher among those who had previously abused pain reliever CPDs. The study also found that four out of five recent heroin initiates had previously abused pain reliever CPDs. While the number of CPD abusers switching to heroin abuse is a relatively small percentage (an estimated 3.6%) of the total number of CPD abusers, it represents a large percentage of heroin initiates (79.5%). Those who switch from abusing CPDs to abusing heroin do so because of availability, price differences, and the reformulation of OxyContin®, a commonly abused prescription opioid.

**Chart 5. US Heroin Seizures
2009 - 2013**



Source: National Seizure System

**Chart 6. Heroin Seizures at the Southwest Border
2000 - 2013**



Source: National Seizure System

Reasons for CPD abusers to switch to abusing heroin

- Decreasing availability of CPDs vs. increasing availability of heroin

CPD availability in many areas has been curbed by enforcement and legislative efforts against illicit pill mills and unscrupulous physicians. Implementation of PDMP databases and increased awareness among physicians and the public about the dangers of CPD abuse have helped to reduce CPD availability in some communities. Heroin availability, conversely, has increased in many areas, and because the physiological effects of heroin are similar to those of prescription opioids, heroin is a viable alternative for CPD abusers who cannot obtain CPDs.

- The relatively low cost of heroin in comparison with CPDs

As CPD abusers progress in their addiction, they require larger and larger amounts of opioid medications to achieve a high or simply stave off withdrawal symptoms. The expense of CPD abuse quickly mounts, causing

some abusers to turn to heroin as a cheaper alternative.

- The reformulation of OxyContin®, making it more difficult to abuse

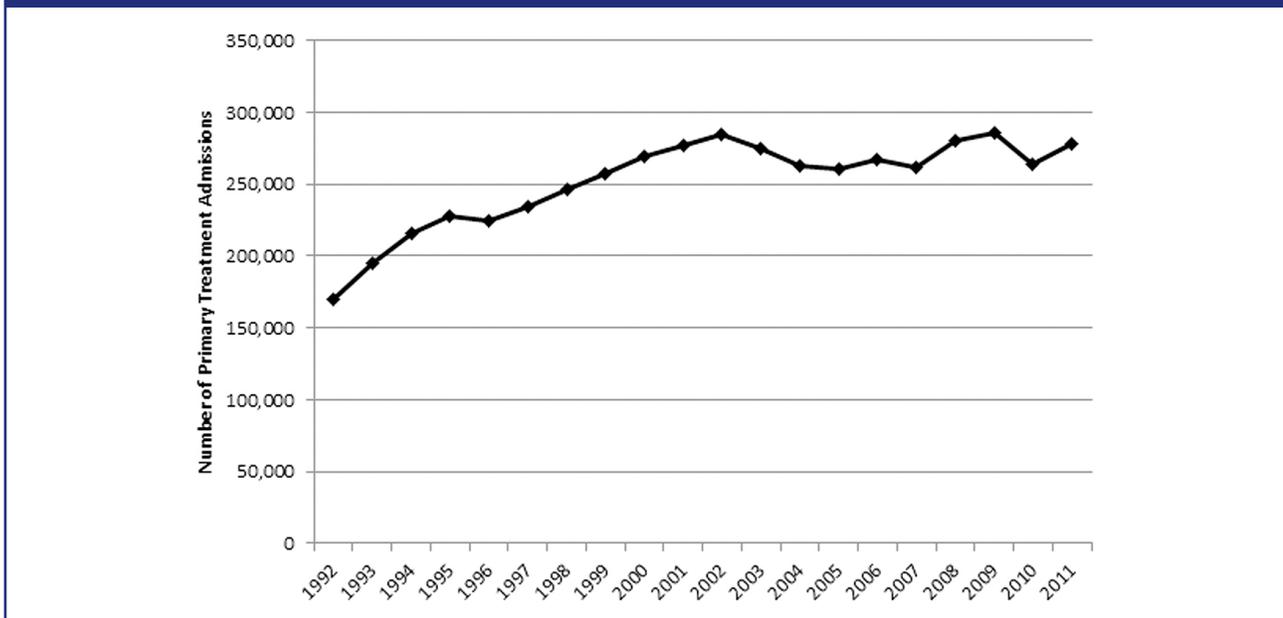
In 2010, OxyContin® was reformulated to include a tamper-resistant ingredient that made it much more difficult to abuse and made it less potent to those who did.⁵

Abuse and Demand

National-level treatment, survey, and epidemiological data indicate heroin abuse is increasing, particularly among young adults; abuse is also increasing among adolescents. Indicators of increased abuse were reported in cities across the United States in 2013.

⁵ When crushed, the reformulated OxyContin® tablet does not disintegrate into a fine powder for snorting or dissolving/injecting. Instead, it crumbles into medium-sized pieces, which cannot be snorted. When mixed with water for dissolving, the pill turns into a gummy substance that cannot be injected. Reformulated OxyContin® can still be abused by being crushed and taken orally, but it does not provide as potent a high, because the pieces retain some of their time-release ingredient, delaying absorption.

**Chart 7. Heroin-related Treatment Admissions
1992 - 2011**

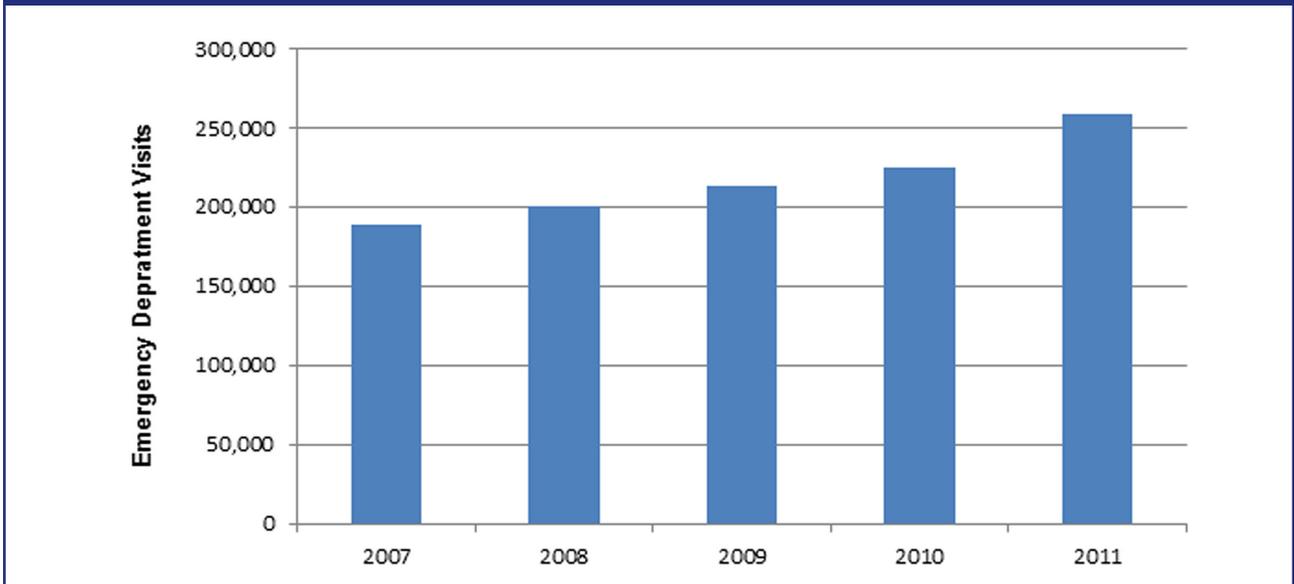


Source: Treatment Episode Data Set

- According to TEDS information, heroin-related treatment admissions to publicly-funded facilities increased slightly over five years, rising 6.3 percent from 2007 (261,951) to 2011 (278,481). (See Table B4 in Appendix B.) Of the total number of abusers admitted for heroin-related treatment in 2011, 67.4 percent reported their frequency of use as daily and 69.8 percent reported their preferred route of administration as injection.
 - o Young adults (aged 20-34) comprise the largest group admitted for heroin treatment. In 2011, young adults made up 53.2 percent of all heroin-related treatment admissions. This was a 23 percent increase over 2007, when they comprised 43.2 percent.
 - o Treatment admissions among adolescents (aged 12-17), while comprising a small percentage of the total treatment admissions, increased 32 percent between 2007 (1,142) and 2011 (1,503). (See Chart 7.)
- Epidemiology data indicates increasing abuse of heroin in cities across the country. According to the NIDA Community Epidemiology Working Group (CEWG), increasing indicators of heroin abuse in 2013 were noted as the key finding in 17⁶ of the 20 CEWG metropolitan areas.
- According to DAWN data, medical consequences related to heroin abuse are increasing. The number of heroin-related ED visits increased 37 percent over five years, from 188,162 in 2007 to 258,482 in 2011. (See Chart 8.)
- According to the NSDUH, the number of heroin abusers reporting current (past month) abuse increased nearly three-

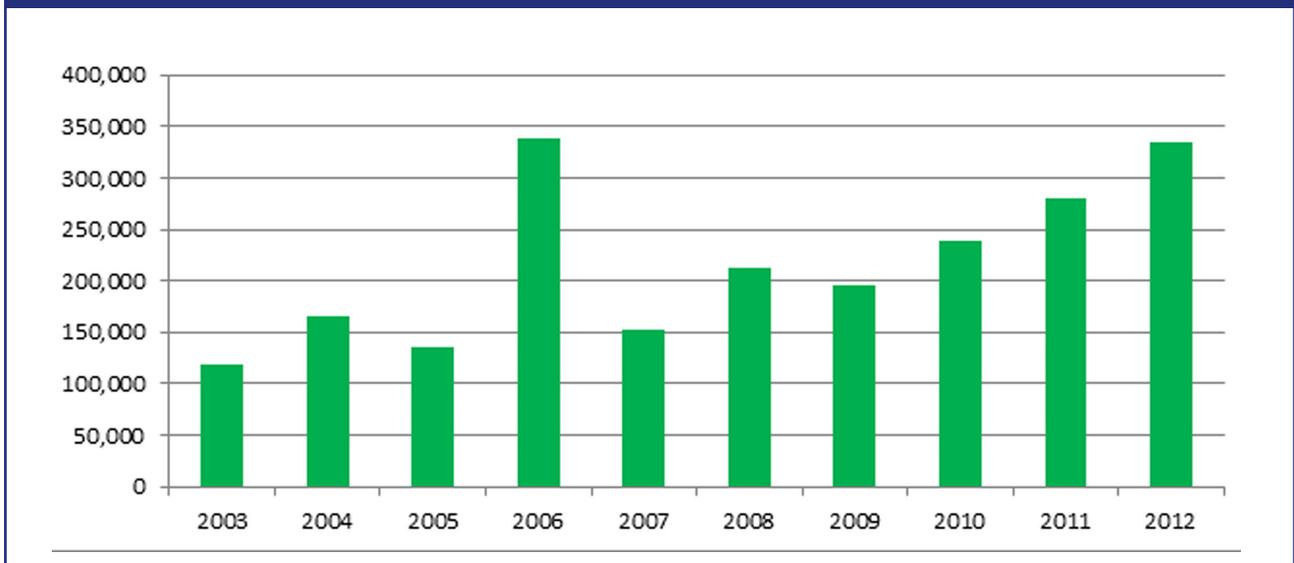
⁶ The following areas reported increasing or predominant heroin indicators under the CEWG program: Albuquerque and New Mexico; Atlanta; Baltimore and Washington, DC; the Greater Boston area; Chicago; Cincinnati; Denver and Colorado; Detroit, Wayne County, and Michigan; Maine; Miami-Dade and Broward Counties; Minneapolis and St. Paul; New York City; Philadelphia; San Diego County; Seattle, St. Louis; and Texas.

**Chart 8. Heroin-related Emergency Department Visits
2007 - 2011**



Source: Drug Abuse Warning Network

**Chart 9. Current Heroin Abusers
2003 - 2012**



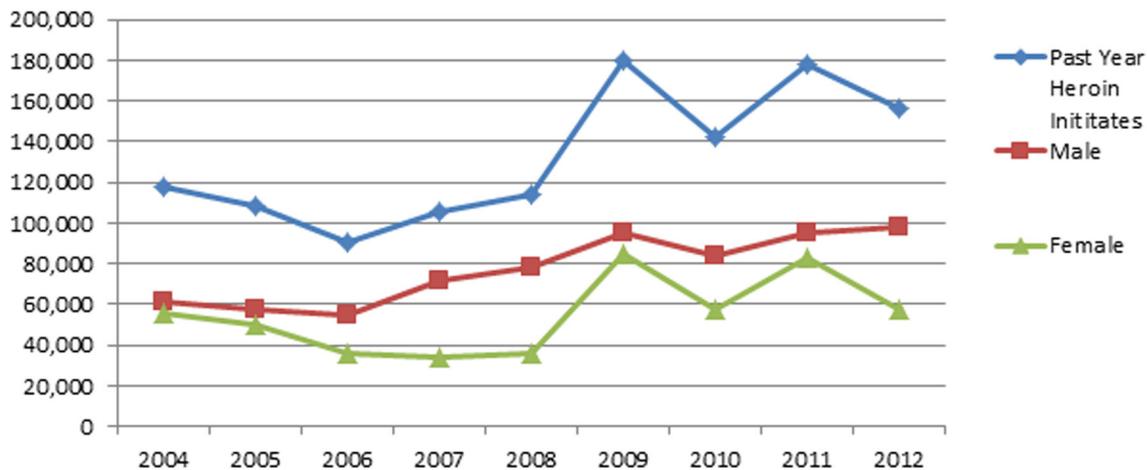
Source: National Survey on Drug Use and Health, 2012

fold between 2004 and 2012. (See Chart 9.) There was a 113 percent increase in abusers who reported past year heroin abuse during that time, and a 22 percent increase in abusers who reported heroin abuse during their lifetime.

- NSDUH data also indicate an increase in the number of people who initiated

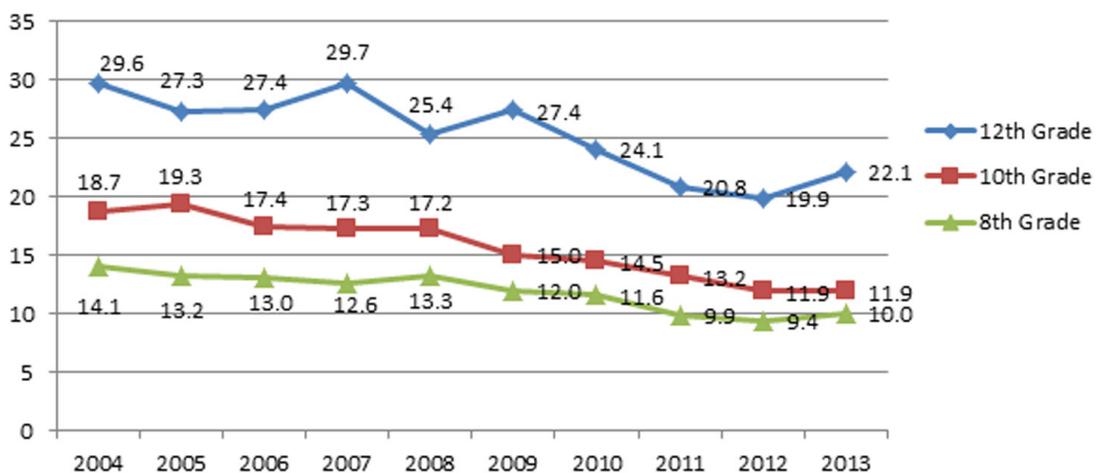
heroin abuse in the past year. The number of new heroin initiates fluctuated, but increased 32 percent overall between 2004 (118,000) and 2012 (156,000). Male initiates make up the majority of initiates each year; the increase in male initiates between 2004 and 2012 was 61 percent. (See Chart 10.)

Chart 10. Number of Individuals Initiating Heroin Abuse in the Past Year 2004 - 2012



Source: National Survey on Drug Use and Health, 2012

Chart 11. Percentage of Students Reporting that Heroin Would be "fairly easy" or "very easy" to get 2004 - 2013



Source: 2013 Monitoring the Future Survey

- Monitoring the Future (MTF) Survey data indicate the perception among adolescents of high heroin availability has recently increased, after a long period of decreases. The percentage of students who said heroin would be either "very easy" or "fairly easy" to get had been decreasing for all grade levels from 2004

through 2012. However, between 2012 and 2013, that percentage either stayed static (10th graders) or increased (8th and 12th graders). (See Chart 11.)

Fentanyl

In 2013 and 2014, areas throughout the Northeast and Midwest reported a spike in overdose deaths due to fentanyl being sold as heroin, or to heroin tainted with fentanyl or fentanyl analogs such as acetylfentanyl. Fentanyl, a synthetic opioid, is 30 to 50 times stronger than heroin and can cause even experienced abusers to overdose. The potency of fentanyl analogs varies.

The abusers who have overdosed on fentanyl represent a diverse population ranging across a wide geographic area, covering a wide range of ages and races, both sexes, and include both new and experienced abusers. Users have overdosed from heroin mixed with fentanyl or fentanyl analogs, fentanyl that is sold as heroin (usually to abusers who think they are buying only heroin), and, in a few cases, fentanyl mixed with cocaine. Fentanyl-related overdoses have been reported in Buffalo, the Cleveland area, Philadelphia, Pittsburgh and its surrounding counties, Dutchess and Nassau Counties in New York, as well as in areas in Maryland, Rhode Island, and other parts of New England.

The most recent prior fentanyl outbreak occurred between 2005 and 2007, and resulted in over 1,000 deaths, the majority of which occurred in Chicago, Detroit, and Philadelphia. Fentanyl was mixed with heroin and was found in counterfeit pharmaceutical opioid tablets. The fentanyl from that outbreak was traced to a single clandestine laboratory in Mexico. After that laboratory was seized and dismantled, the fentanyl-related deaths subsided. The current outbreak, while not as deadly as the 2005-2007 outbreak, covers a wider geographic area and involves both fentanyl and fentanyl analogs, also believed to be clandestinely manufactured or illicitly imported.

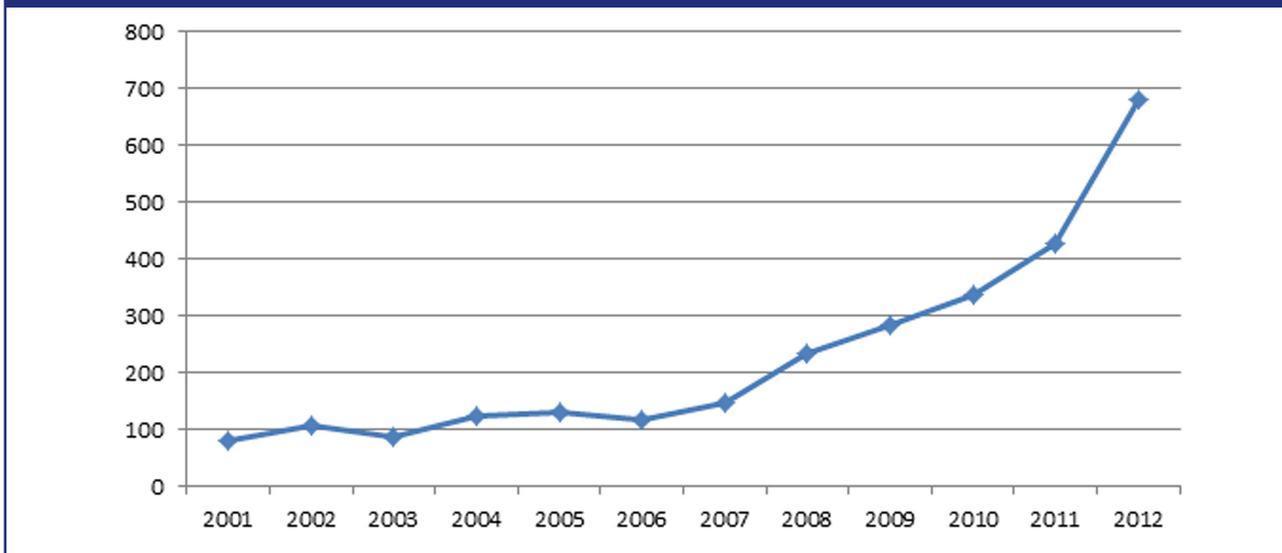
Krokodil

In 2013, several reports surfaced in the United States regarding suspected abuse of "Krokodil," or desomorphine, a drug derived from codeine that is primarily abused in Russia. Abuse of the drug gives a high similar to that of heroin and is a cheap, highly addictive alternative to heroin for Russia's opiate-abuser population. Krokodil abuse causes tissue decay at the injection site. Massive tissue damage in the limbs from dead and dying flesh, internal bleeding, and necrosis can occur, often resulting in death.

Currently, there are no confirmed cases of Krokodil abuse in the United States. The tissue decay in suspected cases was likely the result of injection of tainted heroin or injection using tainted needles, both of which can lead to infections and cause open wounds at the injection site.

It is unlikely that desomorphine will become widely available in the United States. Codeine, the precursor drug for desomorphine, is regulated by prescription in the United States, unlike in Russia, where codeine is available as an over-the-counter drug. Further, the ready availability of high-purity, low-cost heroin in the United States makes it unnecessary for abusers to seek a cheaper alternative, particularly one with such serious side effects.

**Chart 12. Heroin Overdose Deaths in Ohio
2001 - 2012**



Source: Ohio Department of Health

Increasing Heroin Overdoses

Heroin overdose deaths are increasing in many cities and counties across the United States, particularly in the Northeast and Midwest. Cities such as Cleveland, Minneapolis/St. Paul, and Philadelphia have reported increased overdoses and overdose deaths due to heroin. Many cities are reporting that the increase in heroin overdose deaths is more common in the suburban areas and outlying counties surrounding the cities. In Chicago, the largest increase in heroin overdoses has occurred in the suburban areas surrounding the city, and, in New York City, the greatest increase in overdoses has been reported in the suburban areas of Staten Island.

In the Cleveland area (Cuyahoga County), heroin overdose deaths quadrupled between 2007 (40) and 2012 (161). Heroin overdose deaths across Ohio increased nearly six-fold between 2006 (117) and 2012 (680). (See Chart 12.) In response, the Ohio Attorney General's Office announced the creation of a heroin unit to provide law enforcement and legal assistance to fight the heroin threat in Ohio communities.

Reasons for these increases in overdose deaths include high purity heroin in certain markets causing abusers to accidentally overdose; an increase in new heroin initiates, many of whom are young and inexperienced; and abusers switching from prescription opioids (which have a set dosage amount and no other adulterants) to heroin, an illicitly manufactured drug with varying purities, dosage amounts, and adulterants.

Naloxone

In response to increasing overdoses caused by the abuse of heroin and other opioids, some communities are training law enforcement officers and first responders to administer naloxone, a drug that can reverse the effects of opioid overdose. Law enforcement officers are often the first responders in overdose cases, sometimes arriving before emergency medical personnel. Naloxone can be nasally-administered and is not harmful if administered

to a person who is not suffering from opioid overdose.

- The Quincy, MA Police Department (PD) was the first in the nation to require every officer on patrol to carry naloxone. Quincy PD officers began carrying naloxone in October 2010. Since that time they have administered the drug more than 200 times and have reversed more than 95 percent of those overdoses.
- Police departments in other areas, including Buffalo, NY; DuPage County, IL (Chicago area); Lorain County, OH (Cleveland area); and Ocean County, NJ are training officers to carry naloxone in response to increased opioid overdoses in those areas. All Vermont State Troopers will also be issued naloxone.
- In March 2014, the US Attorney General publicly urged law enforcement agencies to train and equip their personnel to administer naloxone, noting that 17 states and Washington, DC have amended their laws to increase access to naloxone, resulting in over 10,000 overdose reversals since 2001.
- In March, 2014, Massachusetts Governor Deval Patrick declared the growing opioid addiction in Massachusetts was a public health emergency. Governor Patrick used his emergency powers to permit first responders to carry and administer naloxone, and to make naloxone widely available through a standing order prescription in pharmacies to provide greater access to family and friends of opioid abusers.

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Methamphetamine

Seizure data, law enforcement reporting, and localized treatment information all indicate methamphetamine trafficking and abuse continues to increase throughout the nation. According to the 2014 NDTs, 31.8 percent of responding agencies indicated methamphetamine was the greatest drug threat in their areas. Also, 40.6 percent of responding agencies indicated that methamphetamine is highly available, meaning the drug is easily obtained at any time. As in previous years, abuse and availability are much higher in the Western United States.

- Between calendar year (CY) 2012 and CY 2013, the amount of powder and crystal methamphetamine seized at the Southwest Border increased 18.5 percent. From CY 2009 to CY 2013, seizures at the border increased over 200 percent. (See Chart 13.)
- Methamphetamine reports to the National Forensic Laboratory Information System (NFLIS) increased 11.9 percent between 2011 (160,960 reports) and 2012 (180,187), a significant change.

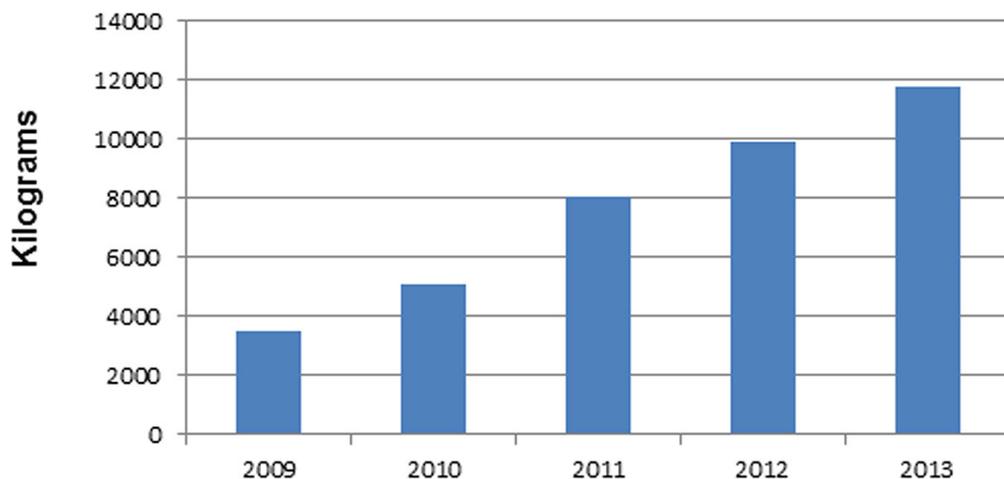
Mexico-Produced Methamphetamine

The majority of methamphetamine available in the United States is Mexico-produced. It is highly pure and potent and is increasingly available. Thousands of kilograms of Mexican methamphetamine are seized along the Southwest Border annually. In 2013, as in 2012, methamphetamine seizures at the border continued to rise. Large shipments (50 pounds or more) are regularly seized at the Southwest Border. However, as availability has increased, areas beyond the Southwest Border experienced large seizures during 2013.

Liquid Methamphetamine

Liquid methamphetamine trafficking continues to be challenging for law enforcement because of its ease of concealment. While most methamphetamine is smuggled into the United States in powder or crystal form, methamphetamine is increasingly smuggled into the United States in liquid form for conversion into crystal methamphetamine. The term “liquid methamphetamine” refers to finished methamphetamine that has been dissolved in a liquid solvent, or methamphetamine-in-suspension. A process

Chart 13. Methamphetamine Seizures at the Southwest Border 2009 - 2013



Source: National Seizure System

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that evaporates the solvent results in powder methamphetamine, which is then crystallized.

- Seizures of methamphetamine-in-suspension have been reported in multiple regions, including the West, Midwest, and Southeast. The product was concealed in gasoline tanks, windshield wiper reservoirs, liquor bottles, laundry and antifreeze containers, and flavored water bottles. Often, commercial product containers (e.g., beverage, antifreeze, and laundry containers) appear to be factory sealed.

Methamphetamine Hydrochloride (“ice”) Conversion Laboratories

Methamphetamine hydrochloride (“ice”) conversion laboratories are more difficult to identify than typical methamphetamine laboratories because they do not produce the same characteristic odors. Also, conversion laboratories use acetone, a common solvent easily available for purchase at most home improvement stores, as part of the extraction process.

Acetone’s high flammability poses dangers when used in conversion laboratories. Most conversion laboratories are located in residential areas.

Small Capacity Production Laboratories: “One-pot,” “Shake-and-Bake Laboratories”

The vast majority of methamphetamine laboratories seized in the United States are the small capacity production laboratories (SCPL), also known as “one-pot” or “shake-and-bake” laboratories. These laboratories produce small amounts of methamphetamine, generally for personal use or use among a small group of people. Though they produce small amounts of methamphetamine, the associated environmental harms caused by these laboratories are immense.

- SCPLs produce small amounts, generally one to three grams per laboratory, of high quality methamphetamine using pseudoephedrine or ephedrine.
- SCPL operators use simple methods to manufacture methamphetamine. Producers mix pseudoephedrine and other household items in a plastic soda-type bottle. The mixture creates a chemical reaction, which produces methamphetamine.
- Due to its exothermic reaction, this method of production is highly volatile and dangerous, and is susceptible to error resulting in fires or explosions. It also exposes bystanders to dangerous, sometimes lethal, chemicals.
- Although these laboratories produce very small amounts of methamphetamine, they produce large amounts of toxic waste. DEA’s Office of Diversion Control estimates that one pound of methamphetamine produced by a SCPL can produce five to six pounds of toxic waste.

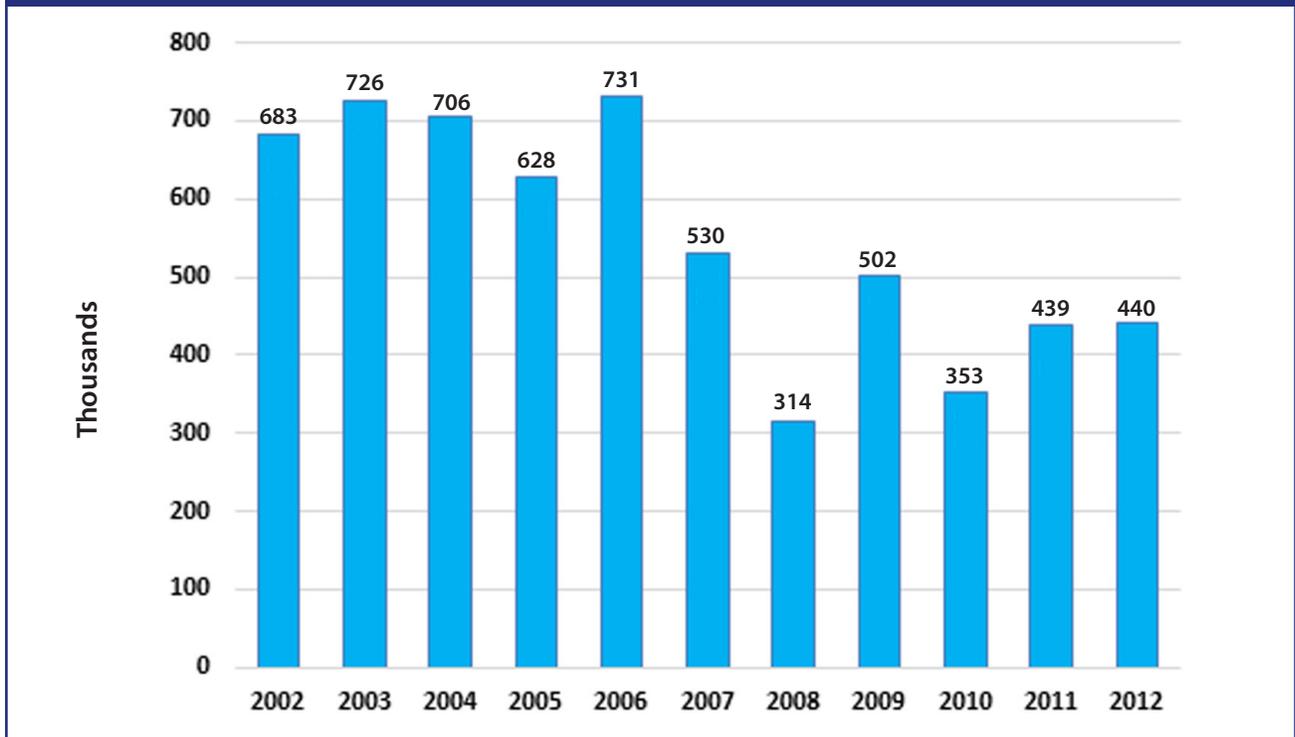
Methamphetamine Abuse

National Level Data and Abuse Trends

Although availability indicators show an increase of methamphetamine availability, survey data on illicit drug use does not currently reflect a corresponding increase in abuse. Data from the NSDUH indicate the use of methamphetamine remained stable from 2008 through 2012, but at levels much lower than 2002 through 2006. (See Chart 14.) However, information and reporting from localized public health officials indicate that methamphetamine abuse may be increasing.

- Minneapolis/St. Paul public health reporting indicates that methamphetamine abuse may be increasing in that area. Although not the

**Chart 14. Current Trends in Methamphetamine Abuse
2002 - 2012**



Source: National Survey on Drug Use and Health, 2012

dominant drug in the area, the previous downward trend of methamphetamine abuse seems to be reversing. Between 2009 and 2011, methamphetamine-related hospital visits increased almost 60 percent. Further, treatment admissions increased almost 19 percent between 2011 and 2012.

- King County, WA (Seattle area) public health information indicates that after years of stability, methamphetamine-related deaths increased substantially⁷ in 2012.

- As law enforcement officials in Ohio report an increase in methamphetamine availability throughout the state, the Ohio Substance Abuse Monitoring Network reported the number of people entering treatment for methamphetamine is trending upward, from 776 in 2009 to 1,040 in 2012.

- According to the San Diego Medical Examiner’s Office, deaths from methamphetamine use increased from 83 in 2008 to 142 in 2012.

⁷ Since 2003, methamphetamine deaths have numbered around 20 per year. In 2012, that number rose to 42.

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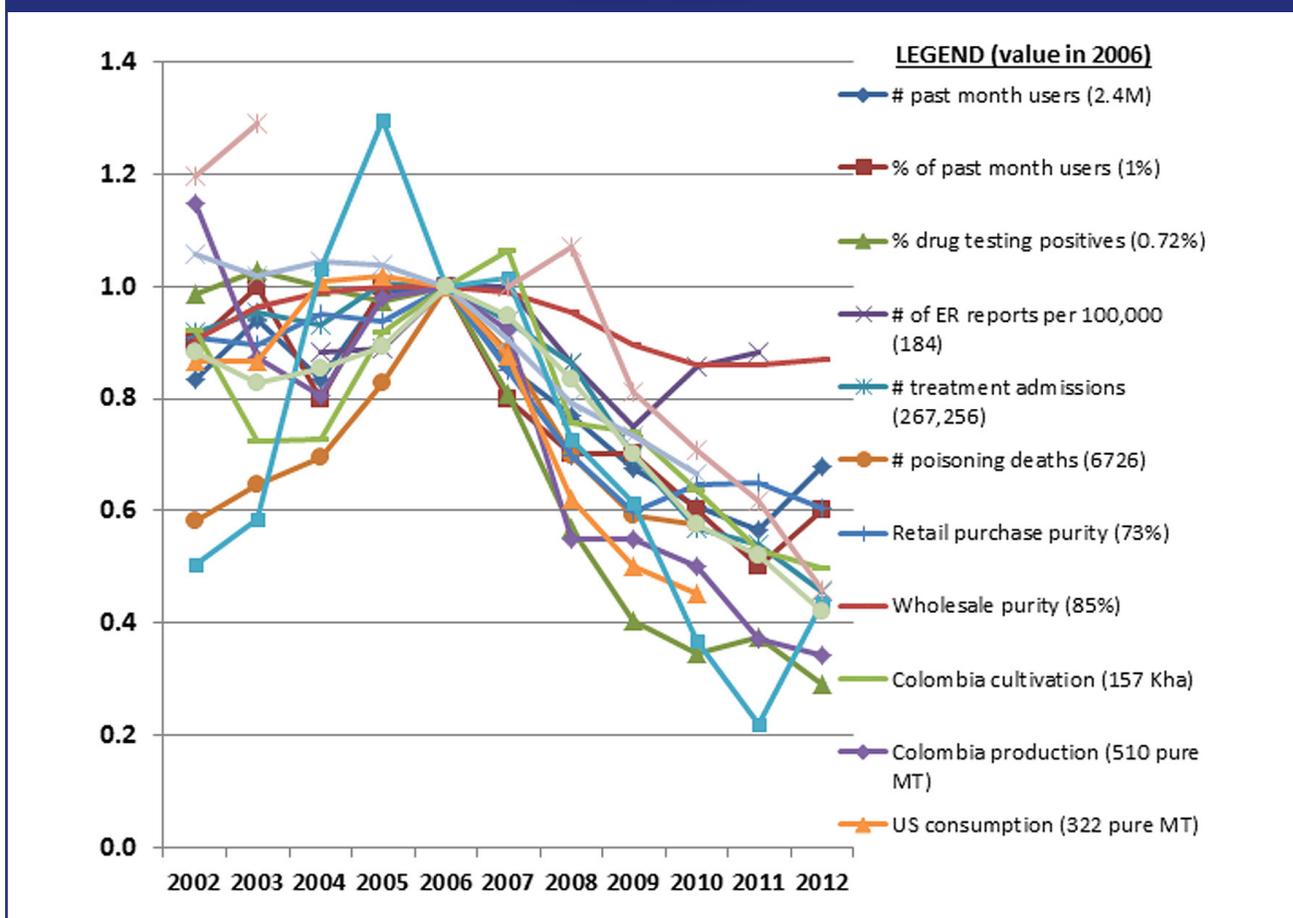
Cocaine

Most cocaine available in the United States continues to be produced in Colombia and smuggled across the Southwest Border and, to a lesser extent, through the Caribbean. Cocaine remains available in many US markets despite the overall decrease in cocaine availability since 2007, when the trend of lower cocaine availability first began. Availability and consumption indicators all continue to remain at lower levels than in 2006. (See Chart 15.) These lower levels constitute a new normal in comparison to pre-2007 levels where US markets had high levels of cocaine availability with low prices and high purity. Since 2007 cocaine availability levels in the United States have fluctuated slightly but continued at consistently lower levels than prior to 2007.

Cocaine availability rebounded slightly in 2013 compared to 2012. However, it remains relatively stable at historically low levels throughout most domestic markets along the East Coast. In 2012, some regions reported a decrease in availability and an increase in price. While cocaine prices continued to remain high in 2013, six DEA domestic Field Divisions (FDs) reported high availability or an increase in availability for the first half of 2013.

Treatment data and ED visits also indicate that an overall decrease in cocaine abuse continues to occur. ED visits for cocaine decreased nine percent from 553,535 in 2007 to 505,224 in 2011, while admissions to publicly-licensed treatment facilities dropped over 40 percent

Chart 15. Cocaine Indicators, based on 2006 Value
2002 - 2012



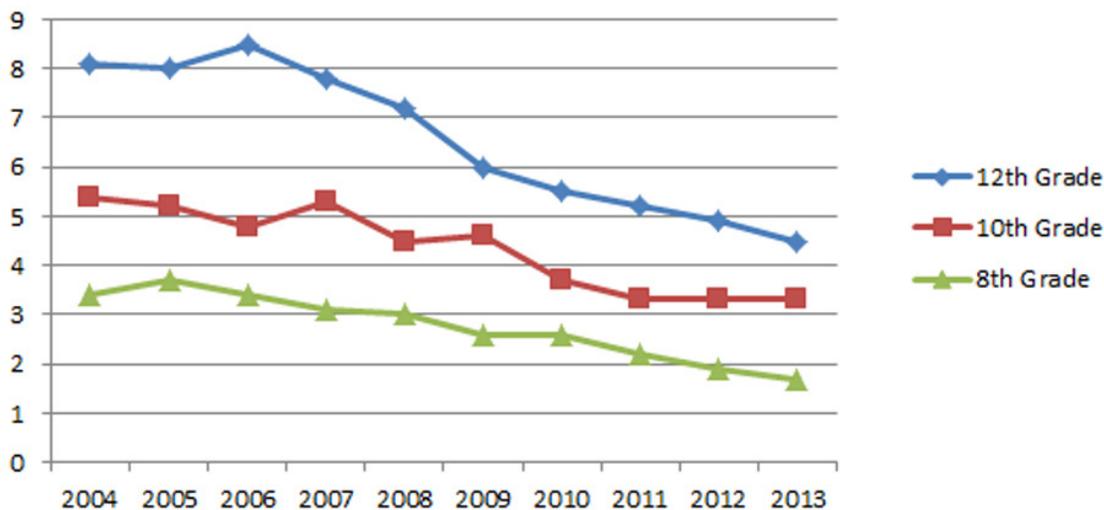
Source: Office of National Drug Control Policy

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between 2007 (250,761) and 2011 (143,827). (See Tables B3 and B4 in Appendix B.) This decline may be the result of lower cocaine availability or lower purity levels of the cocaine available in US markets.

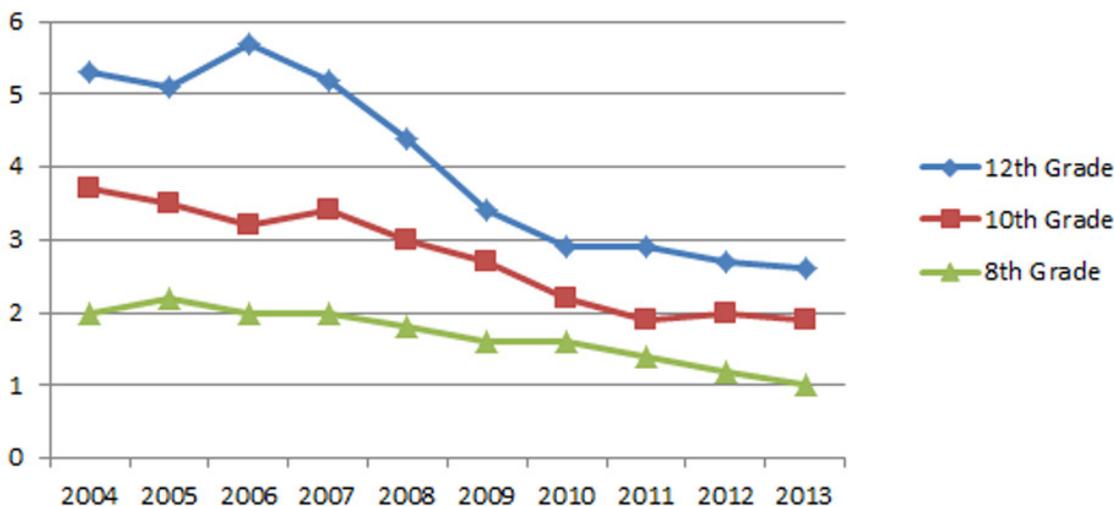
National-level survey data also indicates a decrease in adolescent cocaine abuse. MTF data shows an overall decrease in reported lifetime and annual cocaine abuse among 8th, 10th, and 12th graders since 2004. (See Charts 16 and 17.)

Chart 16. Trends in Lifetime Prevalence of Cocaine Use in Grades 8, 10, and 12



Source: 2013 Monitoring the Future Survey

Chart 17. Trends in Annual Prevalence of Cocaine Use in Grades 8, 10, and 12



Source: 2013 Monitoring the Future Survey

Marijuana

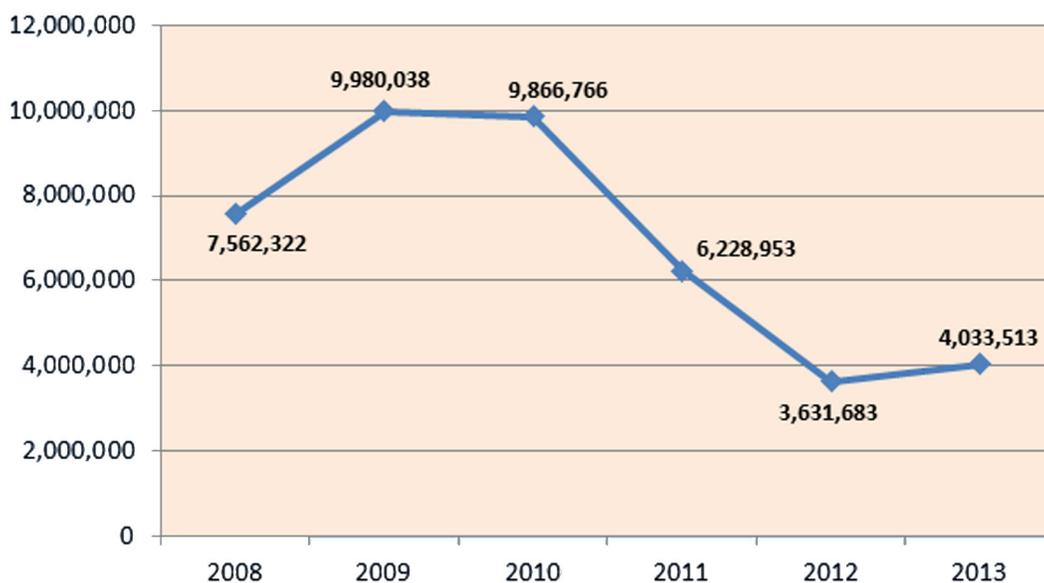
Marijuana is the most widely available and commonly abused illicit drug in the United States. According to the 2014 NDTs, 80 percent of responding agencies reported that marijuana availability was high in their jurisdictions. High availability levels are due to large-scale marijuana importation from Mexico, as well as increasing domestic indoor grows and an increase of marijuana cultivated in states that have legalized marijuana or passed “medical marijuana” initiatives. As a result, abuse among adolescents is increasing and the medical consequences of marijuana abuse are rising. Further, marijuana concentrates, produced with new and dangerous extraction methods that elevate their THC content, are an increasing concern to law enforcement and public health officials.

Domestic Cultivation

Domestic cannabis cultivation appears to be increasing, particularly indoor grows and cultivation on private lands. Under

DEA’s Domestic Cannabis Eradication and Suppression Program (DCE/SP), a program in coordination with state and local law enforcement agencies that addresses domestic marijuana cultivation, a total of 4,395,240 plants were seized from indoor and outdoor grows in CY 2013. This was an increase of 10 percent from CY 2012. However, domestic marijuana plant seizures, both indoor and outdoor, declined from 2010 through 2012, before increasing slightly in 2013. According to DCE/SP statistics, nearly 10 million cannabis plants were seized from outdoor sites in 2009. The number seized in 2012, just over 3.6 million, marked a 64 percent decline. (See Chart 18.) This sharp decline could be a result of several factors including lingering law enforcement budgetary constraints from the 2008 financial crisis and a shift in prioritizing marijuana-related investigations in light of new state and local laws decriminalizing the drug. This decline also can be attributed in part to successful eradication operations on public lands, which are driving cultivators to change

Chart 18. Cultivated Plants Seized from Outdoor Operations 2008 - 2013



Source: DEA Domestic Cannabis Eradication/Suppression Program

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their modus operandi. Marijuana growers are moving their cultivation operations to private lands and indoor grows. (See Chart 19.) This shift makes it more difficult for law enforcement to detect grows and conduct eradication efforts. Indoor grows and outdoor grows on private land require prosecutors and judges to approve search warrants; this is a difficult task in areas where state marijuana laws have changed.

Booby traps and weapons are often found at marijuana grow site locations. DCE/SP seized 4,652 weapons from marijuana grow sites in 2013. Booby traps found at grow sites include hidden nails, bear traps, and explosives.

Mexico-produced Marijuana

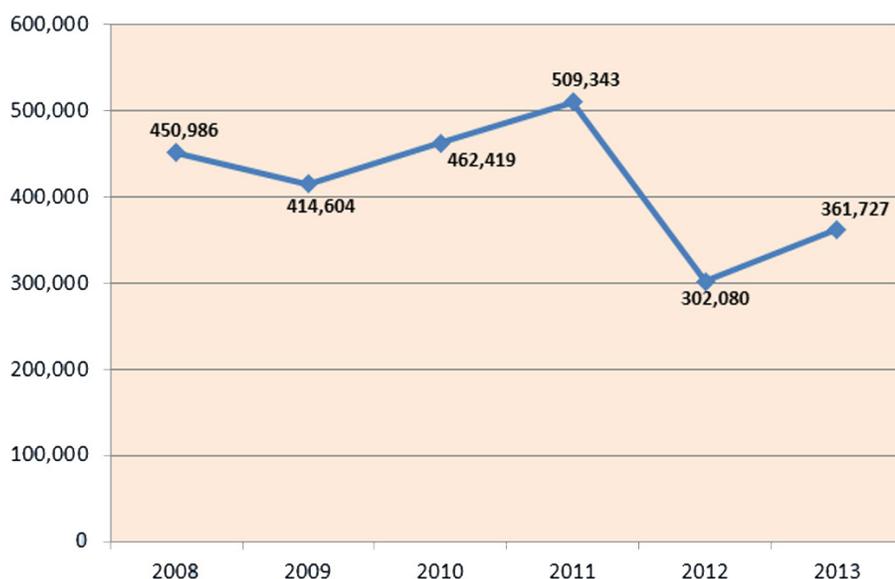
Mexico-produced marijuana continues to be transported into the United States across the Southwest Border. Between 2010 and 2013, marijuana seizures by U.S. Customs and Border Protection (CBP) remained stable at 1.3 to 1.4 million kilograms per year along the Southwest Border. Seizures of Mexico-

produced marijuana are typically larger than domestic seizures. Mexico-produced marijuana is smuggled into the United States by various means: subterranean tunnels, shipment containers, and hidden compartments in personal vehicles. Tunnels along the US-Mexico border are often used to transport large quantities of drugs, particularly bulk quantities of marijuana. Tunnels often include sophisticated rail and lighting systems. In October 2013, more than eight tons of marijuana were seized linked to an elaborate cross border tunnel. Since 2006, federal authorities have detected at least 80 cross-border smuggling tunnels, most of them in California and Arizona.

Increasing THC potency

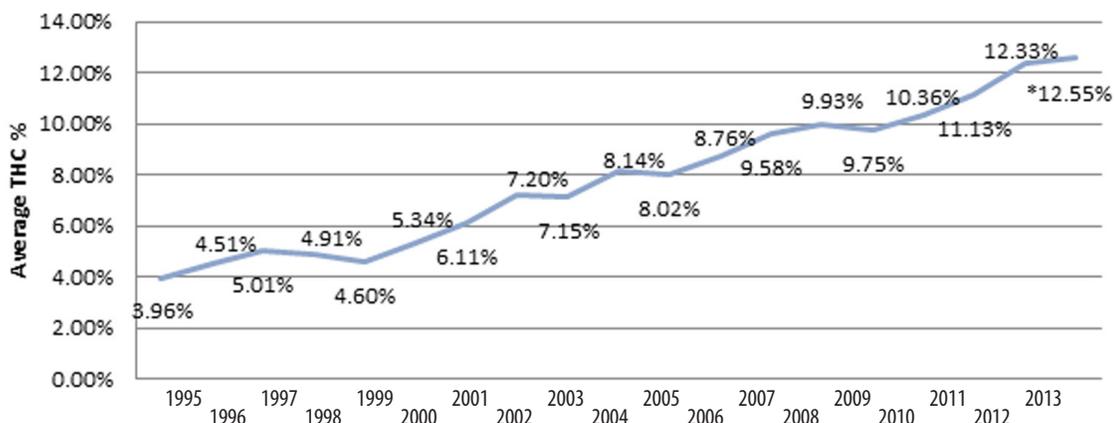
The average THC content of marijuana and hash oil available in the United States continues to increase, according to data from the University of Mississippi National Center for Natural Projects Research’s (NCNRP) Potency Monitoring Program. In 1995, the average THC potency of leaf marijuana was 3.96 percent;

Chart 19. Cultivated Plants Seized from Indoor Operations 2008 - 2013



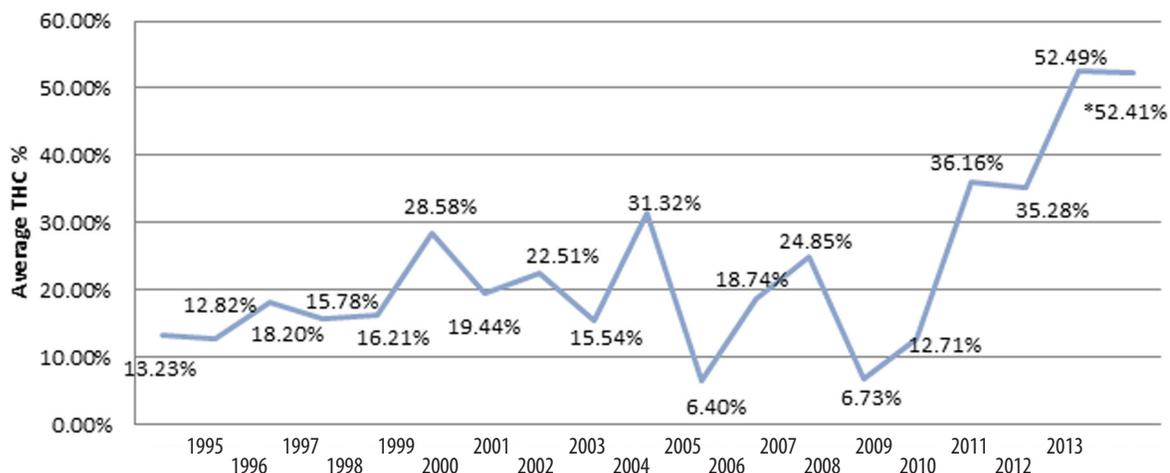
Source: DEA Domestic Cannabis Eradication/Suppression Program

**Chart 20. Potency Monitoring Program
Average THC Percent of DEA Submitted Samples
1995 - 2013**



Source: Potency Monitoring Program

**Chart 21. Potency Monitoring Program
Average THC Percent of all Submitted Hash Oil Samples
1995 - 2013**



*Percentage likely to change as more samples are tested

Source: Potency Monitoring Program, Quarterly Report 124

in 2013, the average THC potency was 12.55 percent. (See Chart 20.) In the 1990s, the average THC content of hash oil, a type of marijuana concentrate, ranged from 13 to 16 percent; today the average THC content of hash oil is 52 percent; one recent sample tested at 82 percent.⁸ (See Chart 21.)

⁸ The NCNRP performs analysis of illicit marijuana samples submitted by DEA and state and local law enforcement agencies. Since 2010, the NCNRP has not had funding to do analysis of samples submitted from state and local law enforcement agencies. The percentages referenced in the above paragraph are based on marijuana samples reported in the NCNRP's Quarterly Report Number 124 for reporting period 12/15/2013 – 03/15/2014. Chart 20 references DEA submitted traditional leafy marijuana samples; it should be noted that at this time only 550 samples have been tested for 2013; the percentage for 2013 is likely to change as more samples are tested. Chart 21 references DEA and state and local law enforcement submitted hash oil seizures; only 17 samples have been tested for 2013 and the percentage is likely to change as more samples are tested.

Marijuana Concentrates

DEA, state and local law enforcement, and open source reporting indicate that abuse of marijuana concentrates is increasing throughout the United States. Hash oil has been available for centuries; however, advanced methods to obtain high-THC concentrates from marijuana plant material are now being used across the United States. The marijuana concentrates obtained by these methods have significantly higher levels of THC than previously observed, with potency reportedly exceeding 80 percent.

Methods of Extraction

Marijuana concentrates are extracted from the leafy material in many ways, but the most common, and potentially most dangerous, method is butane extraction, which uses highly flammable butane gas to extract the THC from marijuana plant material. Butane extraction has resulted in numerous explosions and injuries, particularly on the West Coast, where production is most common. The San Diego Narcotics Task Force seized approximately 30 hash oil extraction laboratories in San Diego County in 2013; 12-15 of those laboratories were identified after an explosion or fire.

Edibles

Ingestion of marijuana edibles by children is an increasing concern, particularly in states with “medical marijuana” availability. Examples of edibles include brownies, cookies, peanut butter, candy, and soda drinks. The nature of these edibles makes them attractive to children; however, they are dangerously high in THC content. According to the Rocky Mountain Poison Control Center, since 2009, the Children’s Hospital in Colorado has seen a spike in children under the age of five being treated in the emergency room due to ingestion of marijuana edibles.

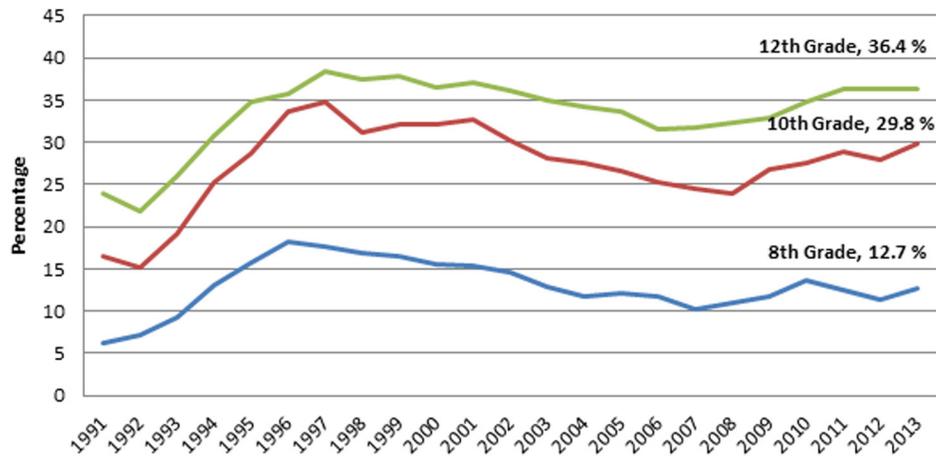
Treatment and Demand Data

Treatment, survey, and demand data indicate marijuana abuse is increasing, particularly among young people. National survey data show an increasing number of adolescents do not perceive marijuana abuse as harmful. Further, a significant number of young people living in states with “medical marijuana” laws obtain marijuana from the “medical marijuana” recommendations⁹ of other people. At the same time, medical consequences from the abuse of marijuana continue to rise. Marijuana-related ED visits and treatment admissions are increasing.

- National level survey data show an increase in marijuana abuse among adolescents. The 2013 MTF reported more than one-third (36.4%) of 12th graders used marijuana in the past year, an 11 percent increase over the past five years. MTF survey data also showed an increase in annual marijuana use for 10th and 8th graders. (See Table B5 in Appendix B.) More than one-quarter (29.8%) of 10th graders reported using marijuana in the past year, an increase of 12 percent from 2009; and 12.7 percent of 8th graders reported using marijuana in the past year, an increase of 8 percent over the past five years. (See Chart 22.)
- The 2013 MTF also showed an increase in lifetime use of marijuana for all three grades surveyed: 45 percent of 12th graders have used marijuana in their lifetime, up 8 percent over five years; 35.8 percent of 10th graders have used marijuana in their lifetime, an increase of 11 percent over five years; 16.5 percent of 8th graders have used marijuana in their

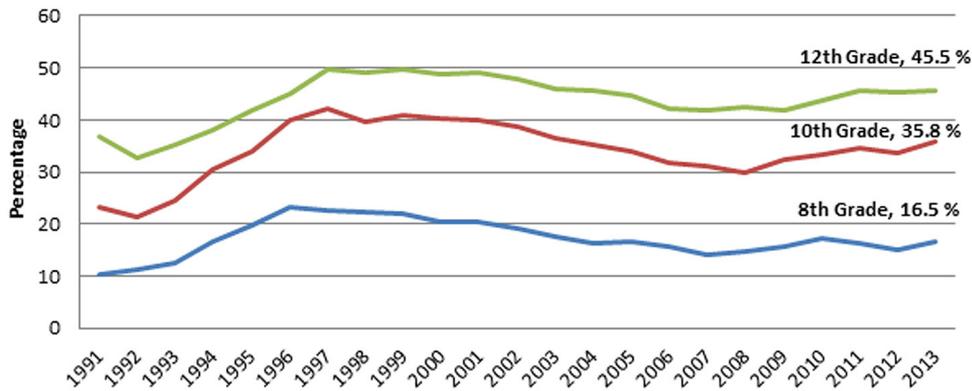
⁹ Medical professionals cannot write prescriptions for marijuana as there is currently no accepted medical use in the United States. Unlike a prescription written by a medical professional with a DEA registration number, then dispensed by a pharmacy with a DEA registration number, state-approved “medical marijuana” recommendations and marijuana dispensaries are not monitored by the federal government.

Chart 22. Prevalence of Annual Marijuana Use Among 8th, 10th, and 12th Grade Students 1991 - 2013



Source: 2013 Monitoring the Future Survey

Chart 23. Prevalence of Lifetime Marijuana Use Among 8th, 10th, and 12th Grade Students 1991 - 2013



Source: 2013 Monitoring the Future Survey

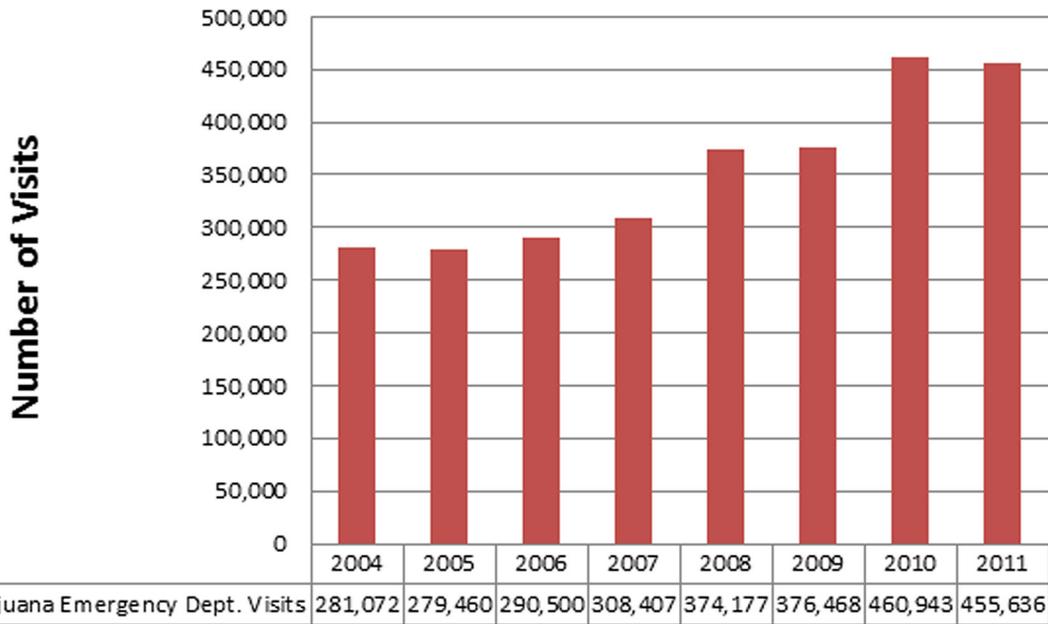
lifetime, an increase of 5 percent over five years. (See Chart 23.)

- MTF data on the impact of “medical marijuana” laws indicate that a significant number of teens living in states with “medical marijuana” laws obtain marijuana from other people’s physician recommendations.¹⁰ The survey showed that 34 percent of 12th graders who used marijuana in the past 12 months and lived in states that have passed “medical marijuana” legislation stated

that one of their sources of marijuana is another person’s “medical marijuana” recommendation; six percent said they got it from their own recommendation. MTF data on the perception of marijuana showed that 60 percent of 12th graders do not view regular marijuana use as harmful.

¹⁰ The MTF survey used the word “prescription,” but marijuana is classified as a Schedule I drug under the Controlled Substances Act (CSA), which prevents physicians from legally prescribing marijuana. Physicians in states that have approved “medical marijuana” provide their patients with “recommendations.”

**Chart 24. Marijuana-Related Emergency Department Visits
CY 2004 - CY 2011**



Source: Drug Abuse Warning Network, January 10, 2014

- DAWN data shows an increase in medical consequences resulting from marijuana abuse. According to DAWN, there was a 62 percent increase in marijuana-related ED visits from 2004 to 2011. In 2011, only cocaine-related ED visits outnumbered those for marijuana. (See Chart 24.)
- According to TEDS data, marijuana-related primary treatment admissions averaged approximately 300,000 from 2002 to 2007. Between 2008 and 2011 admissions averaged approximately 350,000, a 17 percent increase.

Synthetic Designer Drugs

Synthetic designer drugs, also referred to as “new psychoactive substances,” are substances of abuse that are frequently not under international control, but constitute a significant public health threat in the United States. Since 2009, US law enforcement officials have encountered more than 240 new synthetic compounds, including 99 synthetic cannabinoids, 52 synthetic cathinones, and 89 other compounds. Most wholesale quantities of synthetic drugs are purchased over the Internet and are shipped from distributors in China.

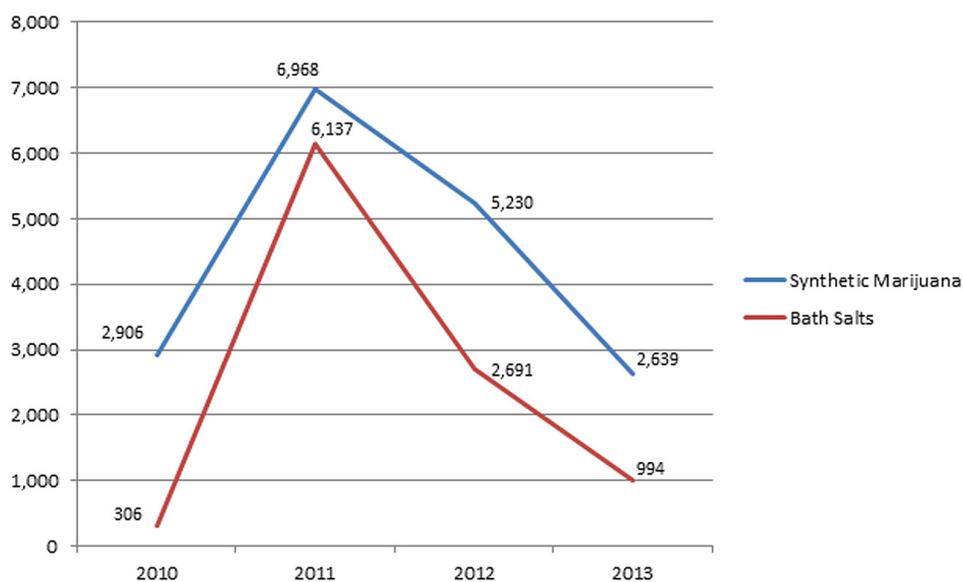
- Synthetic cannabinoids, often marketed as synthetic marijuana under names such as “K2” and “Spice,” are a mixture of plant matter in addition to chemical grade synthetic cannabinoids. Synthetic cannabinoid users experience severe agitation and anxiety, racing heartbeat and high blood pressure, intense hallucinations, and psychotic episodes.

Overdose deaths have occurred as a result of smoking synthetic cannabinoids.

- Synthetic cathinones, commonly sold as “bath salts,” are drugs that cause powerful reactions and often violent behavior. Some users have experienced nausea, vomiting, paranoia, hallucinations, delusions, suicidal thoughts, seizures, chest pains, and increased blood pressure and heart rate. Synthetic cathinones have resulted in a number of overdose deaths.

While the number of calls to US poison control centers has declined, this is not a true indicator that abuse levels have likewise declined. When these drugs first emerged on the illicit market in 2009 their popularity soared. From 2010 to 2011, the number of calls to the American Association of Poison Control Centers (AAPCC) skyrocketed for both synthetic cannabinoid and cathinone exposures. (See Chart 25.) Those numbers have since declined sharply.

Chart 25. Number of Exposure Calls to the American Association of Poison Control Centers 2010 - 2013



Source: American Association of Poison Control Centers

However, experts agree that the number of calls to poison control centers initially skyrocketed because of the unfamiliarity with the drugs and how to counter their effects. As ED doctors have become aware of how to treat victims of synthetic cannabinoid and cathinone abuse, the number of calls to poison control centers has naturally declined.

Nationally, 33.4 percent of respondents to the 2014 NDTs reported an increase in synthetic cannabinoid availability, while 24.5 percent reported an increase in synthetic cathinone availability. Conversely, however, most respondents reported that availability was low for both cannabinoids (34.9%) and cathinones (43.7%). (See Maps 1 and 2.) Contributing to this decline is likely several coordinated interagency operations, which resulted in hundreds of arrests and the seizure of significant amounts of synthetic drugs and millions of dollars. (See Text Box.)

The Synthetic Drug Abuse Prevention Act of 2012 was signed into law on July 9, 2012. This law amended the Federal Controlled Substances Act (CSA) and placed 26 synthetic drugs in Schedule I. (See Table B6 in Appendix B.) In April 2013, methylone (typically sold as “Molly”) was added to Schedule I. Also, DEA has exercised its emergency scheduling authority to temporarily control 20 other synthetic compounds. (See Table 1.)

As synthetic drugs, such as cannabinoids and cathinones, are scheduled under the CSA or placed under emergency scheduling by DEA, producers quickly change the one or two elements in the banned substance thereby creating a new compound that has similar psychoactive effects. This was evident recently in Colorado. During the first half of 2013, law enforcement officials in Colorado encountered 25i (also known as 25-NBOMe, Smiles, 25I-NBOMe, NBOMe), a new, highly potent hallucinogen. The drug has been encountered as a white powder, as a liquid in dropper bottles, and soaked onto blotter paper. 25i is related to, but much more potent

Project Synergy

In June 2013, DEA and its law enforcement partners announced enforcement operations in 35 states targeting the upper echelon of dangerous designer synthetic drug trafficking organizations. This series of enforcement actions included retailers, wholesalers, and manufacturers. In addition, these investigations uncovered the massive flow of drug-related proceeds back to countries in the Middle East and elsewhere.

Since Project Synergy began in December 2012, more than 227 arrests have been made and 416 search warrants served in 35 states, 49 cities, and five countries, along with more than \$51 million in cash and assets seized. Altogether, 9,445 kilograms of individually packaged, ready-to-sell synthetic drugs, 299 kilograms of cathinone drugs (labeled “bath salts”), 1,252 kilograms of cannabinoid drugs, and 783 kilograms of treated plant material have been seized.

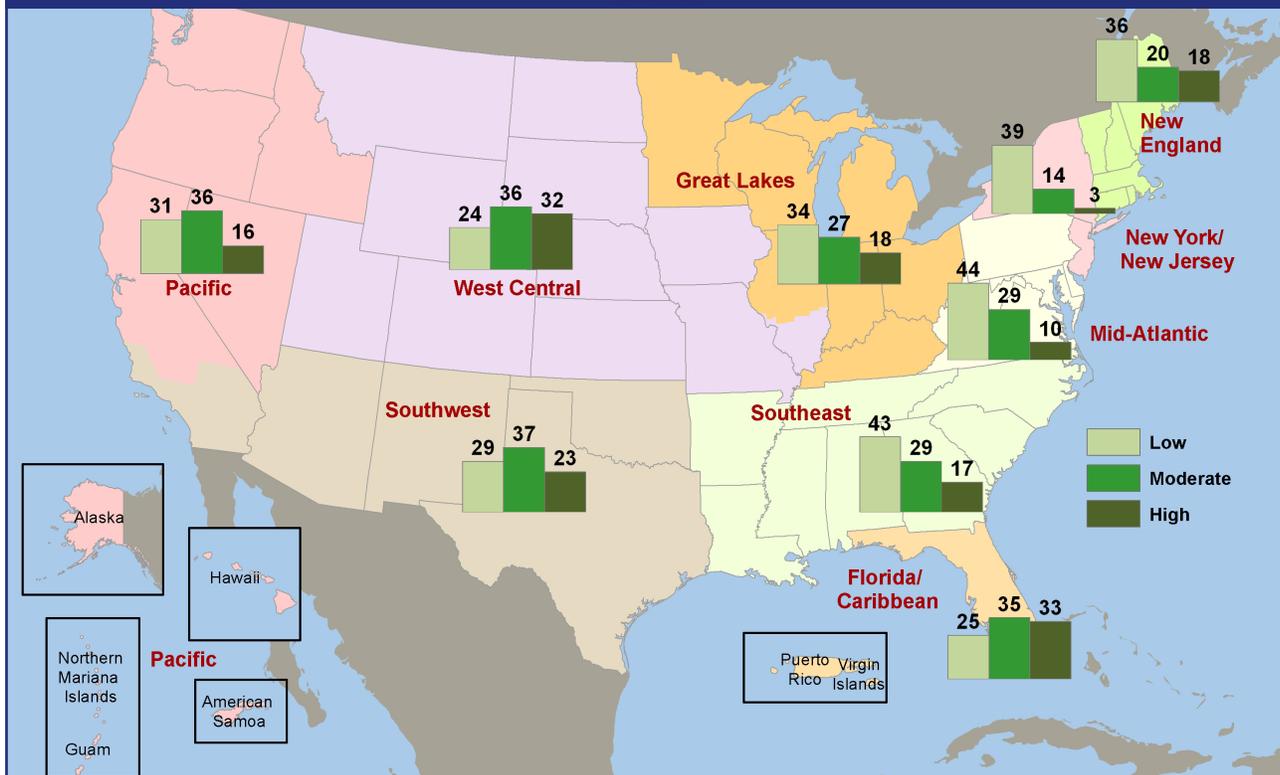
Project Synergy was coordinated by DEA’s Special Operations Division, working with the DEA Office of Diversion Control, and included cases led by DEA, CBP, ICE, FBI, and the IRS. In addition, law enforcement counterparts in Australia, Barbados, Panama, and Canada participated in the operation, as well as many U.S. state and local law enforcement agencies.

than, the hallucinogens 2C-I, and 2C-B, and can be made from 2C-I or from other available commercial chemicals. This drug is one of several potent new hallucinogens, which are simply modifications, or analogs, of older controlled hallucinogenic drugs (e.g., 2C-B, 2C-C, and 2C-I).

As synthetic cannabinoids and cathinones become more abused, the potential for overdoses and overdose deaths increases.

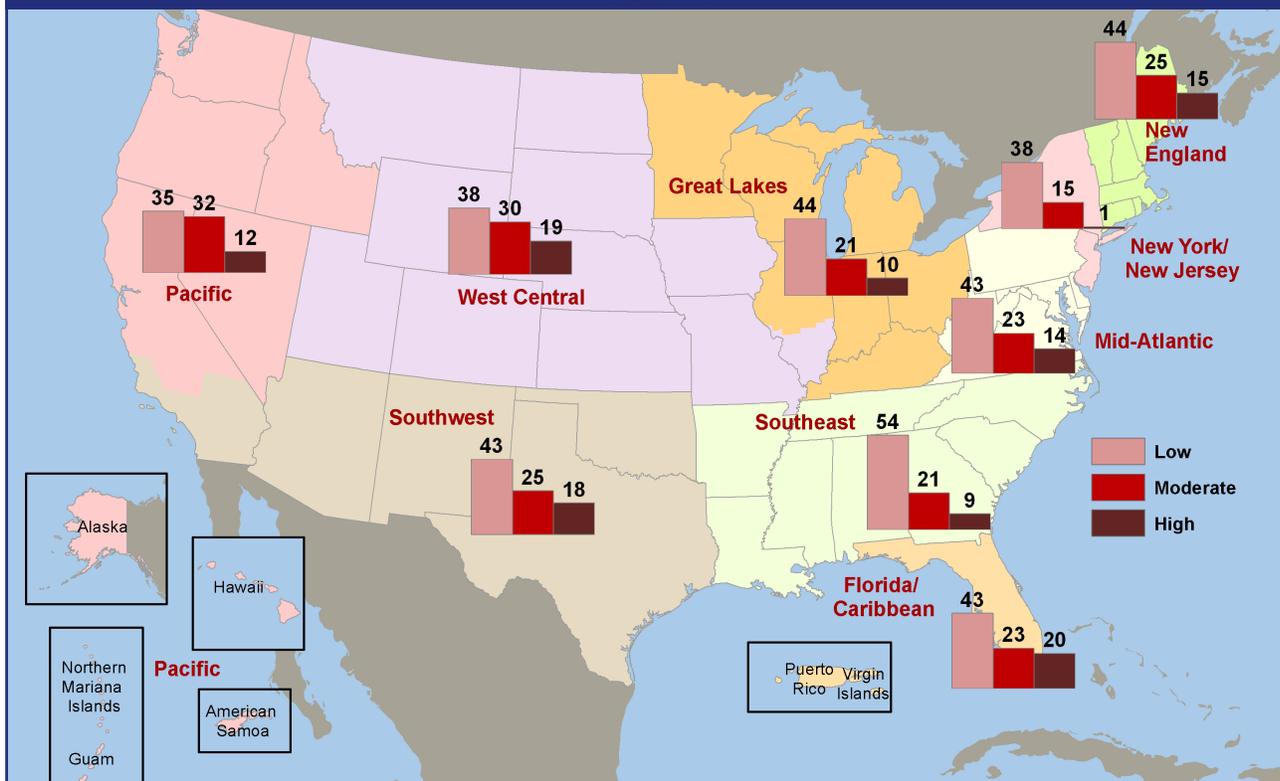
- In August 2013, Colorado EDs saw a significant increase in the number of patients who reported use of a synthetic

Map 1. Percentage of NDTs Respondents Reporting Cannabinoid Availability 2014



Source: Drug Enforcement Administration, National Drug Threat Survey, 2014

Map 2. Percentage of NDTs Respondents Reporting Cathinone Availability 2014



Source: Drug Enforcement Administration, National Drug Threat Survey, 2014

TABLE 1: Synthetic Drugs Listed Under DEA Emergency Scheduling
CURRENTLY CONTROLLED UNDER TEMPORARY SCHEDULE 1 STATUS
(1-pentyl-1H-indol-3-yl)(2,2,3,3-tetramethylcyclopropyl)methanone (UR-144)
[1-(5-fluoro-pentyl)-1H-indol-3-yl](2,2,3,3-tetramethylcyclopropyl)methanone (5-fluoro-UR-144, XLR11)
N-(1-adamantyl)-1-pentyl-1H-indazole-3-carboxamide (APINACA, AKB48)
2-(4-iodo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25I-NBOMe)
2-(4-bromo-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25B-NBOMe)
2-(4-chloro-2,5-dimethoxyphenyl)-N-(2-methoxybenzyl)ethanamine (25C-NBOMe)
quinolin-8-yl 1-pentyl-1H-indole-3-carboxylate (PB-22; QUPIC)
quinolin-8-yl 1-(5-fluoropentyl)-1H-indole-3-carboxylate (5-fluoro-PB-22; 5F-PB-22)
N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)-1H-indazole-3-carboxamide (AB-FUBINACA)
N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide (ADB-PINACA).
4-methyl-N-ethylcathinone ("4-MEC")
4-methyl-alpha-pyrrolidinopropiophenone ("4-MePPP")
alpha-pyrrolidinopentiophenone ("alpha-PVP")
1-(1,3-benzodioxol-5-yl)-2-(methylamino)butan-1-one ("butylone")
2-(methylamino)-1-phenylpentan-1-one ("pentedrone")
1-(1,3-benzodioxol-5-yl)-2-(methylamino)pentan-1-one ("pentylone")
4-fluoro-N-methylcathinone ("4-FMC")
3-fluoro-N-methylcathinone ("3-FMC")
1-(naphthalen-2-yl)-2-(pyrrolidin-1-yl)pentan-1-one ("naphyrone")
alpha-pyrrolidinobutiophenone ("alpha-PBP")

Source: Federal Register

cannabinoid. These patients exhibited symptoms of excited delirium, an altered mental status, tachycardia followed by bradycardia, and seizures. During a one-month time frame (August 21 to September 19, 2013), EDs in Denver had approximately 100 patients admitted for synthetic cannabinoid use. During that same time period, there were 221 patients admitted to Colorado EDs with similar symptoms. Multiple product brands were recovered from patients and the Denver PD Crime Laboratory identified a consistent synthetic cannabinoid compound —ADB PINACA¹¹—in the samples.

- Also in August 2013, 22 patients reported to the ED in Brunswick, GA after becoming ill from inhaling synthetic cannabinoids, sold under the name of "Crazy Clown." Eight of the patients were hospitalized, five of them in intensive care.

Retail-level quantities of synthetic cannabinoids and cathinones are sold primarily over the Internet and in head shops, tobacco and smoke shops, adult stores, convenience stores, and gas stations. These drugs are often packaged in shiny plastic bags with bright

¹¹ ADB-PINACA (N-[1-amino-3,3-dimethyl-1-oxobutan-2-yl]-1-pentyl-1H-indazole-3-carboxamide)

logos, marketed as incense or potpourri. Many states are now introducing legislation aimed at penalizing owners/operators of local businesses that sell synthetic cannabinoids and cathinones.

- According to Indiana state law, stores selling these drugs face penalties including the loss of their retail business certificates for one year. They must also bear the cost of court and laboratory testing of the substances by the state.
- In Tennessee, a law was passed in 2012 making the sale of synthetic cannabinoids a felony and businesses accused of selling the product can be padlocked as public nuisances. In July 2012, the Metro Nashville PD, DEA, and the Tennessee Bureau of Investigation shut down 11 Nashville convenience markets for their alleged sale of synthetic cannabinoids and similar substances. A state criminal court order provided that the markets be searched, any contraband and monies related to illegal activity be seized, and that the stores be padlocked pending a court appearance.
- Georgia has a law that allows categories of synthetic drugs to be banned even before the specific compound is added to the Georgia code.

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Outlook

Legislation and the implementation of PDMPs in the states that have these tools will continue to help curb the diversion and abuse of CPDs. However, states with little or no legislation, or PDMPs that are not fully funded or operational, will likely see an increase in the CPD threat as more distributors and abusers will travel to these states to obtain their illicit supplies.

Heroin abuse and availability are likely to increase in the near term, particularly as more CPD abusers switch to heroin as a more available and cheaper alternative.

Methamphetamine availability shows little sign of diminishing. As cocaine availability remains lower than in previous years, methamphetamine has become a viable alternative for traffickers and users alike. Increased availability of a lower-priced, high-potency, high-purity product is likely attractive to potential users. Additionally, information indicates that methamphetamine traffickers are moving further east and have established distribution hubs throughout the Midwest and South.

Domestic cocaine markets will remain steady in the near term and Colombian cocaine will continue to dominate domestic markets; however, it is unlikely that cocaine availability will return to pre-2007 levels in the near term.

The availability of marijuana will increase and abuse of marijuana will escalate, especially in states that legalize or reduce the criminal penalties associated with the sale and possession of small quantities of marijuana. Marijuana possession and distribution still violate federal law, and although some states have legalized the sale of marijuana, there will continue to be a "black market" in these states due to high taxes and state-imposed restrictions. Domestic production

of marijuana is likely to increase, especially in states that allow unregulated personal grows; marijuana from these unregulated grows will likely be trafficked to other states. In addition to domestically-produced marijuana, Mexico-produced marijuana will continue to be trafficked to the United States in large quantities.

The availability of marijuana concentrates, such as hash oil, and marijuana edibles will likely increase. The elevated THC levels of marijuana concentrates will pose serious medical consequences to abusers, and the dangerous methods used to extract concentrates will pose serious risks to producers, law enforcement personnel, and innocent civilians.

Synthetic cannabinoids and synthetic cathinones will continue to pose a significant drug threat. While some indicators show slight declines, targeted law enforcement operations across the country show that the availability of these drugs has not significantly diminished. Most law enforcement officials believe that the abuse of these drugs will continue to increase.

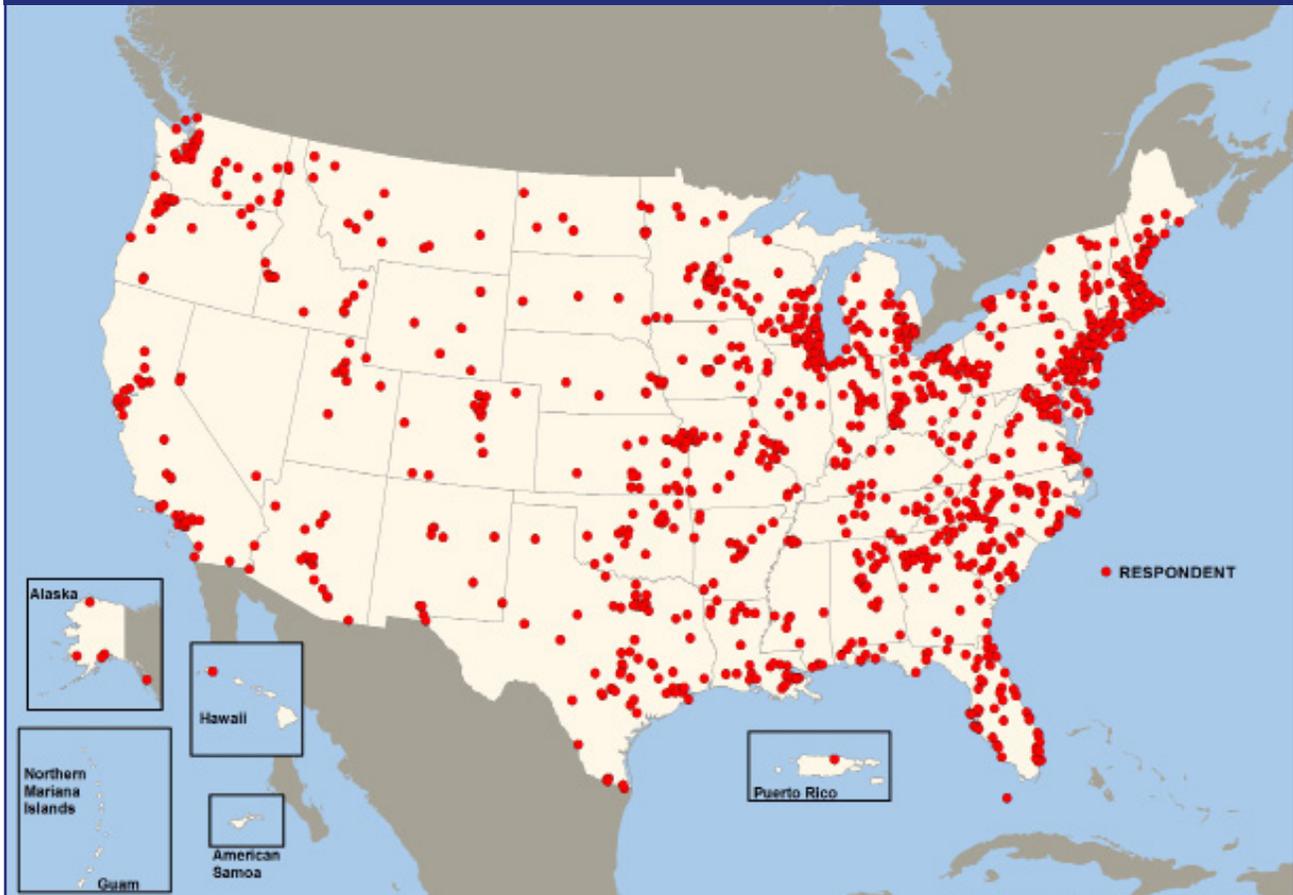
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Appendix A: Maps

Map A1. Nine OCDETF Regions

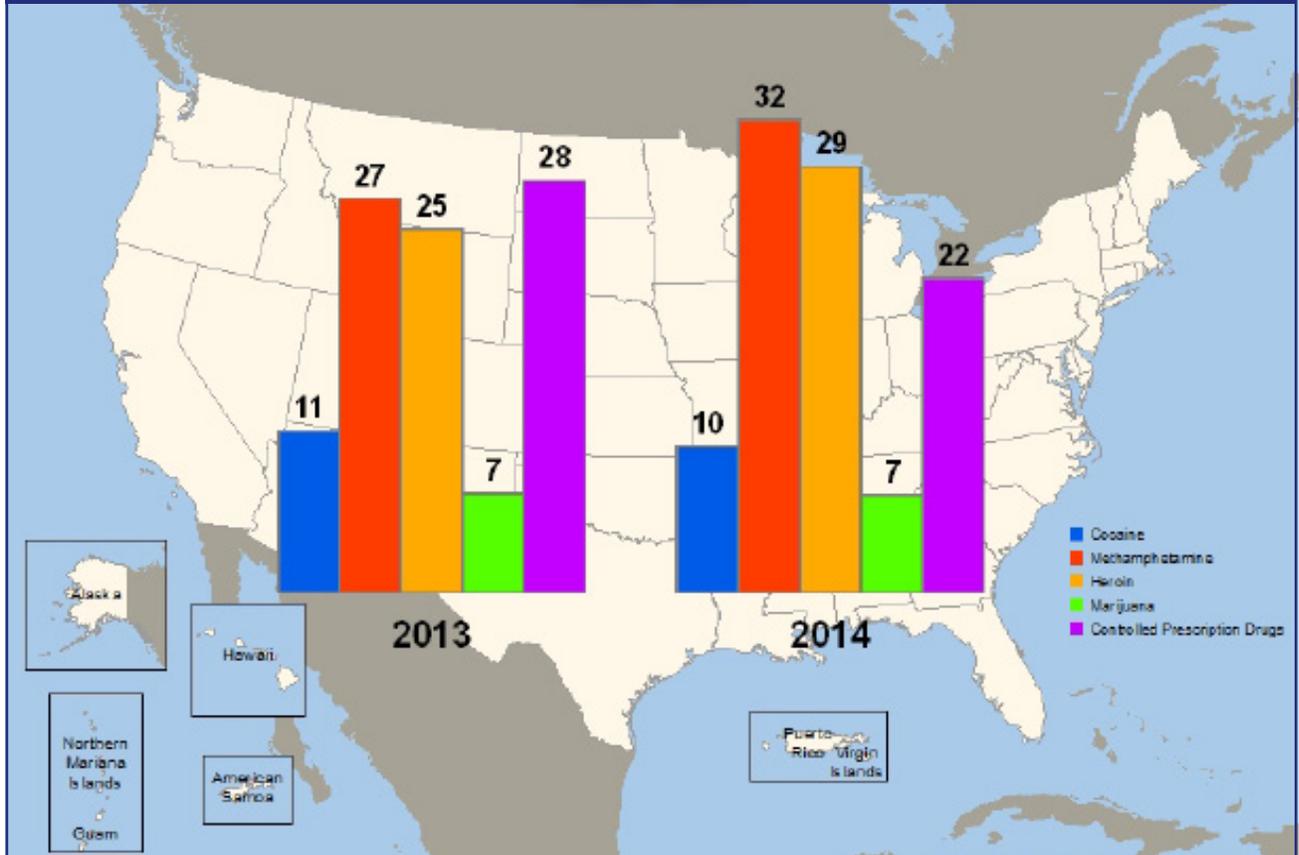


Map A2. Locations of Respondents to 2014 NDTs



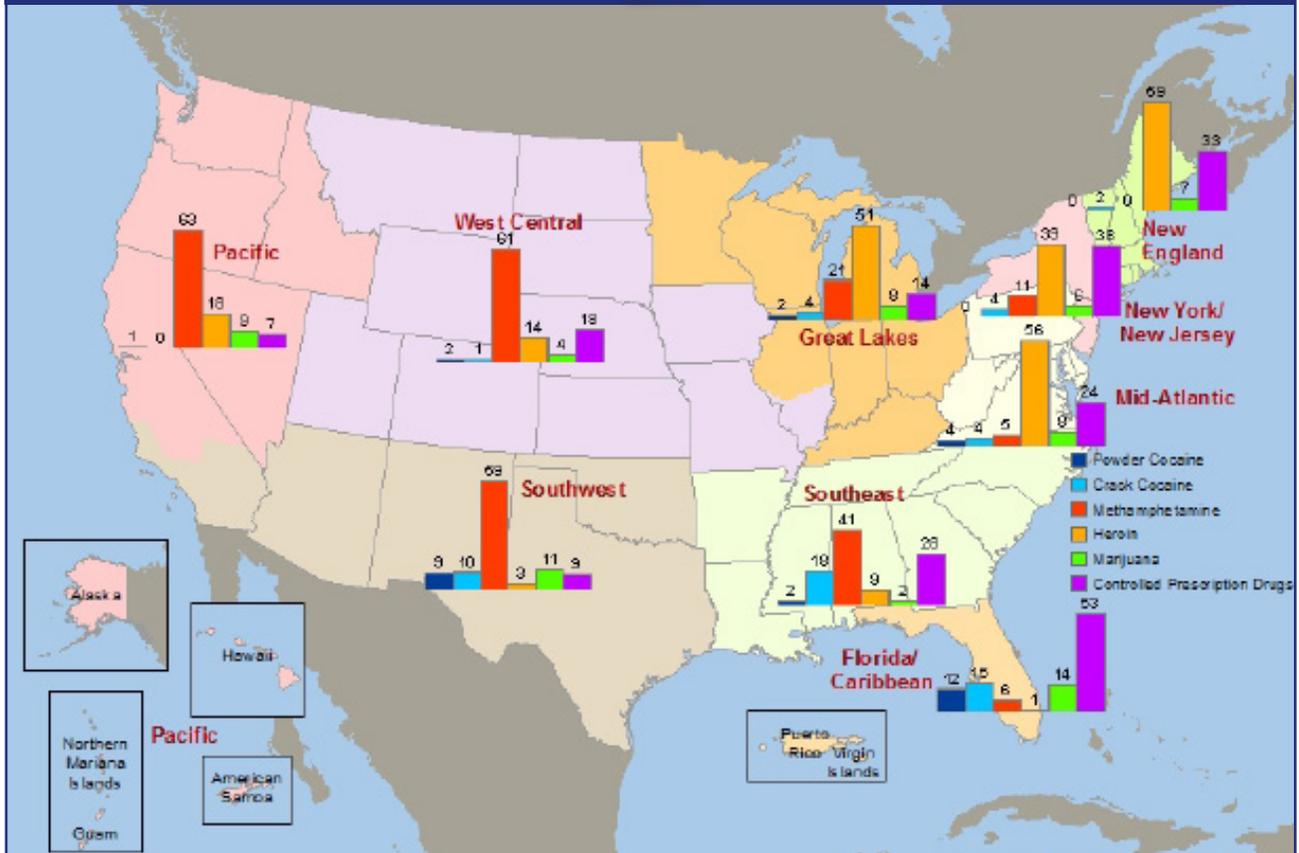
Source: National Drug Threat Survey, 2014

**Map A3. Greatest Drug Threat Represented Nationally
As Reported by State and Local Agencies
2013 - 2014**



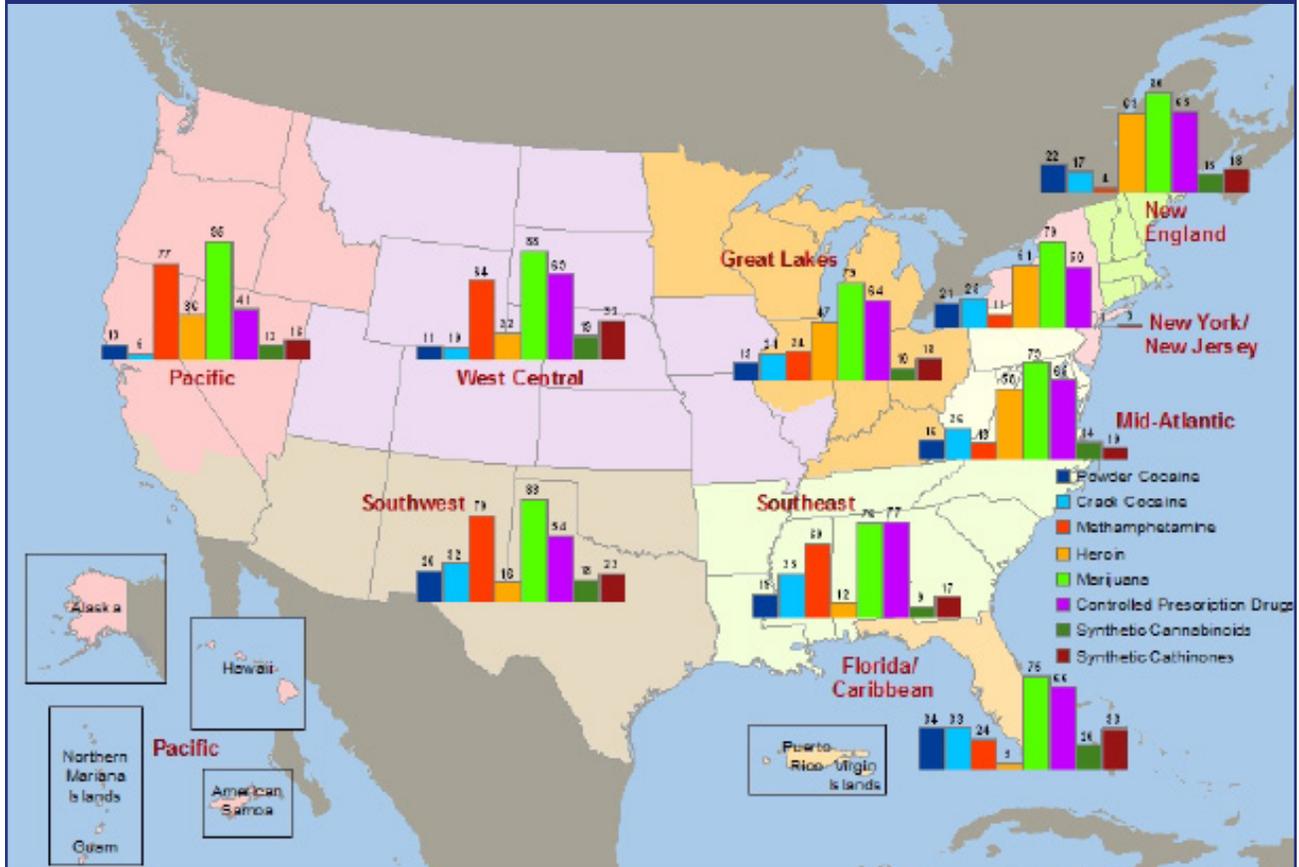
Source: National Drug Threat Survey, 2013 and 2014

**Map A4. Greatest Drug Threat Represented Regionally
As Reported by State and Local Agencies
2014**



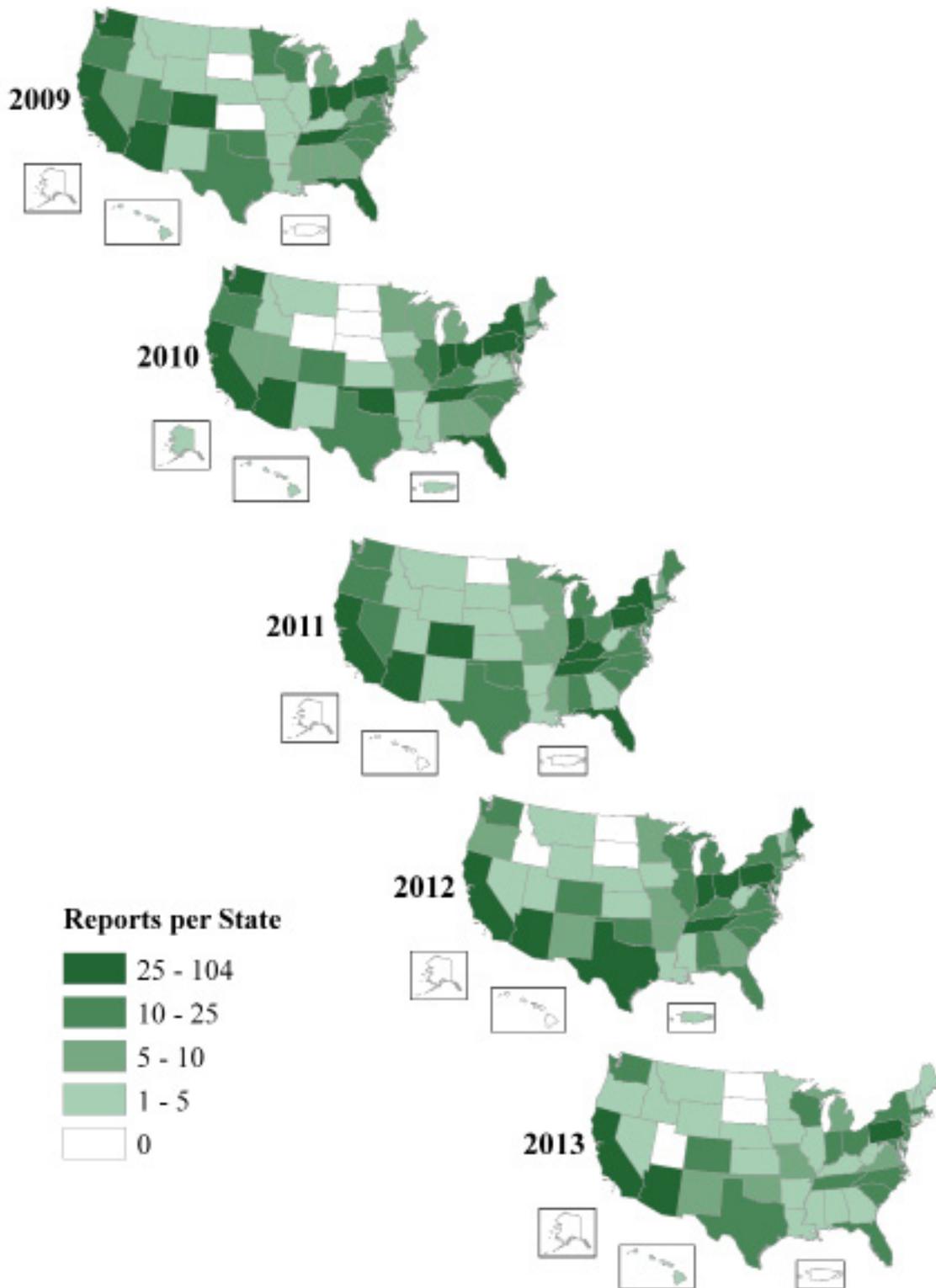
Source: National Drug Threat Survey, 2014

Map A5. 2014 Drug Availability by Region
Percentage of State and Local Agencies Reporting High Availability



Source: National Drug Threat Survey, 2014

**Map A6. Armed Robberies Reported by Pharmacies
2009 - 2013**



Source: DEA Drug Theft and Loss Database

Appendix B: Tables

TABLE B1. PERCENTAGE OF 2014 NDTs RESPONDENTS REPORTING GREATEST DRUG THREAT, BY DRUG, BY REGION

OCDETF REGION	POWDER COCAINE	CRACK COCAINE	METHAMPHETAMINE	HEROIN	MARIJUANA	CPDs
FLORIDA/CARIBBEAN	12.0	14.7	6.1	0.7	13.9	52.5
GREAT LAKES	2.3	4.2	21.3	50.7	7.7	13.8
MID-ATLANTIC	3.5	4.0	5.4	56.1	7.5	23.5
NEW ENGLAND	0.0	2.0	0.0	58.7	6.7	32.6
NEW YORK/NEW JERSEY	0.2	3.8	11.4	39.1	5.9	37.9
PACIFIC	0.8	0.0	63.1	18.2	9.1	7.2
SOUTHEAST	2.4	18.1	38.3	8.6	2.3	27.6
SOUTHWEST	9.1	9.5	58.5	3.1	10.6	8.6
WEST CENTRAL	1.6	1.3	61.0	13.7	4.4	17.9
NATIONWIDE	3.0	7.0	31.8	29.1	6.7	21.5

Source: National Drug Threat Survey, 2014

TABLE B2. TOTAL US SEIZURES, BY DRUG, IN KILOGRAMS*, CY2009 – CY2013

	2009	2010	2011	2012	2013
COCAINE	50,296.1	51,830.9	61,435.6	34,742.4	36,315.3
HEROIN	2,540.0	3,044.0	3,924.0	4,607.0	4,761.0
METHAMPHETAMINE	6,915.9	10,538.9	12,620.9	19,531.3	21,558.9
PHARMACEUTICALS (DU)					
OXYCODONE	102,361.8	362,556.6	255,865.5	188,122.5	1,194,747.8
HYDROCODONE	290,356.0	388,285.5	179,610.3	41,668.0	83,448.5
HYDROMORPHONE	4,661.0	437.5	44.5	1,570.5	1,363.0

Source: National Seizure System

* EXCEPT WHERE NOTED
DU = DOSAGE UNIT

TABLE B3. ESTIMATED NUMBER OF EMERGENCY DEPARTMENT VISITS INVOLVING ILLICIT DRUGS, CY2007 – CY2011					
	2007	2008	2009	2010	2011
COCAINE	553,535	482,188	422,902	488,101	505,224
HEROIN	188,162	200,666	213,118	224,706	258,482
MARIJUANA	308,407	374,177	376,468	460,943	455,636
METHAMPHETAMINE	67,954	66,308	64,117	94,929	102,961
MDMA	12,751	17,888	22,847	21,836	22,498
CPD PAINKILLERS	94,448	124,020	146,377	179,787	170,939

Source: Drug Abuse Warning Network

TABLE B4. ADMISSIONS TO PUBLICLY LICENSED TREATMENT FACILITIES, BY PRIMARY SUBSTANCE, CY2007 – CY2011					
	2007	2008	2009	2010	2011
COCAINE	250,761	230,568	186,994	152,404	143,827
HEROIN	261,951	280,692	285,983	264,277	278,481
MARIJUANA	307,053	347,755	362,335	346,268	333,578
METHAMPHETAMINE	145,936	127,137	116,793	115,022	110,471
NON-HEROIN OPIATES/SYNTHETIC*	98,909	122,633	143,404	163,444	186,986

Source: Treatment Episode Data Set

* These drugs include codeine, hydrocodone, hydromorphone, meperidine, morphine, opium, oxycodone, pentazocine, propoxyphene, tramadol, and any other drug with morphine-like effects. Non prescription use of methadone is not included.

Note: Tennessee included heroin admissions in the “other opiates” category through June 2009. In this report, Tennessee’s 2009 heroin admissions are still included in the other opiates category since there is less than a full year of disaggregated heroin data.

TABLE B5. ADOLESCENT TRENDS IN PERCENTAGE OF PAST YEAR DRUG USE CY2009–CY2013					
	2009	2010	2011	2012	2013
COCAINE (ANY FORM)					
8TH GRADE	1.6	1.6	1.4	1.2	1.0
10TH GRADE	2.7	2.2	1.9	2.0	1.9
12TH GRADE	3.4	2.9	2.9	2.7	2.6
CRACK					
8TH GRADE	1.1	1.0	0.9	0.6	0.6
10TH GRADE	1.2	1.0	0.9	0.8	0.8
12TH GRADE	1.3	1.4	1.0	1.2	1.1
HEROIN					
8TH GRADE	0.7	0.8	0.7	0.5	0.5
10TH GRADE	0.9	0.8	0.8	0.6	0.5
12TH GRADE	0.7	0.9	0.8	0.6	0.5
MARIJUANA					
8TH GRADE	11.8	13.7	12.5	11.4	12.7
10TH GRADE	26.7	27.5	28.8	28.0	29.8
12TH GRADE	32.8	34.8	36.4	36.4	36.4
METHAMPHETAMINE					
8TH GRADE	1.0	1.2	0.8	1.0	1.0
10TH GRADE	1.6	1.6	1.4	1.0	1.0
12TH GRADE	1.2	1.0	1.4	1.1	0.9
MDMA					
8TH GRADE	1.3	2.4	1.7	1.1	1.1
10TH GRADE	3.7	4.7	4.5	3.0	3.6
12TH GRADE	4.3	4.5	5.3	3.8	4.0
PRESCRIPTION NARCOTICS					
8TH GRADE	NA	NA	NA	NA	NA
10TH GRADE	NA	NA	NA	NA	NA
12TH GRADE	9.2	8.7	8.7	7.9	7.1
SYNTHETIC MARIJUANA (SYNTHETIC CANNABINOIDS)					
8TH GRADE	NA	NA	NA	4.4	4.0
10TH GRADE	NA	NA	NA	8.8	7.4
12TH GRADE	NA	NA	NA	11.3	7.9
SALTS (SYNTHETIC CATHINENES)					
8TH GRADE	NA	NA	NA	6.8	1.0
10TH GRADE	NA	NA	NA	0.6	0.9
12TH GRADE	NA	NA	NA	1.3	0.9

Source: 2013 Monitoring the Future Survey

TABLE B6: SYNTHETIC DRUGS SCHEDULED UNDER THE SYNTHETIC DRUG ABUSE PREVENTION ACT OF 2012

5-(1,1-DIMETHYLHEPTYL)-2-[(1R,3S)-3-HYDROXYCYCLOHEXYL]-PHENOL (CP-47,497)
5-(1,1-DIMETHYLOCTYL)-2-[(1R,3S)-3-HYDROXYCYCLOHEXYL]-PHENOL (CANNABICYCLOHEXANOL OR CP-47,497 C8-HOMOLOG)
1-PENTYL-3-(1-NAPHTHOYL)INDOLE (JWH-018 AND AM678)
1-BUTYL-3-(1-NAPHTHOYL)INDOLE (JWH-073)
1-HEXYL-3-(1-NAPHTHOYL)INDOLE (JWH-019)
1-[2-(4-MORPHOLINYL)ETHYL]-3-(1-NAPHTHOYL)INDOLE (JWH-200)
1-PENTYL-3-(2-METHOXYPHENYLACETYL)INDOLE (JWH-250)
1-PENTYL-3-[1-(4-METHOXYNAPHTHOYL)]INDOLE (JWH-081)
1-PENTYL-3-(4-METHYL-1-NAPHTHOYL)INDOLE (JWH-122)
1-PENTYL-3-(4-CHLORO-1-NAPHTHOYL)INDOLE (JWH-398)
1-(5-FLUOROPENTYL)-3-(1-NAPHTHOYL)INDOLE (AM2201)
1-(5-FLUOROPENTYL)-3-(2-IODOBENZOYL)INDOLE (AM694)
1-PENTYL-3-[(4-METHOXY)-BENZOYL]INDOLE (SR-19 AND RCS-4)
1-CYCLOHEXYLETHYL-3-(2-METHOXYPHENYLACETYL)INDOLE (SR-18 AND RCS-8)
1-PENTYL-3-(2-CHLOROPHENYLACETYL)INDOLE (JWH-203)
4-METHYLMETHCATHINONE (MEPHEDRONE)
3,4-METHYLENEDIOXYPYROVALERONE (MDPV)
2-(2,5-DIMETHOXY-4-ETHYLPHENYL)ETHANAMINE (2C-E)
2-(2,5-DIMETHOXY-4-METHYLPHENYL)ETHANAMINE (2C-D)
2-(4-CHLORO-2,5-DIMETHOXYPHENYL)ETHANAMINE (2C-C)
2-(4-iodo-2,5-DIMETHOXYPHENYL)ETHANAMINE (2C-I)
2-[4-(ETHYLTHIO)-2,5-DIMETHOXYPHENYL]ETHANAMINE (2C-T-2)
2-[4-(ISOPROPYLTHIO)-2,5-DIMETHOXYPHENYL]ETHANAMINE (2C-T-4)
2-(2,5-DIMETHOXYPHENYL)ETHANAMINE (2C-H)
2-(2,5-DIMETHOXY-4-NITRO-PHENYL)ETHANAMINE (2C-N)
2-(2,5-DIMETHOXY-4-(N)-PROPYLPHENYL)ETHANAMINE (2C-P)
3,4-METHYLENEDIOXYMETHCATHINONE (METHYLONE)

Source: S. 3190 (112th): Synthetic Drug Abuse Prevention Act of 2012

TABLE B7. TRENDS IN PERCENTAGE OF PAST-YEAR DRUG USE, CY2007–CY2012						
	2007	2008	2009	2010	2011	2012
COCAINE (ANY FORM)						
INDIVIDUALS (12 AND OLDER)	2.3	2.1	1.9	1.8	1.5	1.8
ADOLESCENTS (12-17)	1.5	1.2	1.0	1.0	0.9	0.7
YOUNG ADULTS (18-25)	6.4	5.5	5.3	4.7	4.6	4.6
ADULTS (26 AND OLDER)	1.7	1.6	1.4	1.4	1.0	1.4
CRACK						
INDIVIDUALS (12 AND OLDER)	0.6	0.4	0.4	0.3	0.2	0.4
ADOLESCENTS (12-17)	0.3	0.1	0.1	0.1	0.1	0.1
YOUNG ADULTS (18-25)	0.8	0.6	0.5	0.5	0.3	0.4
ADULTS (26 AND OLDER)	0.6	0.4	0.4	0.4	0.2	0.4
HEROIN						
INDIVIDUALS (12 AND OLDER)	0.1	0.2	0.2	0.2	0.2	0.3
ADOLESCENTS (12-17)	0.1	0.2	0.1	0.1	0.2	0.1
YOUNG ADULTS (18-25)	0.4	0.5	0.5	0.6	0.7	0.8
ADULTS (26 AND OLDER)	0.1	0.1	0.2	0.2	0.2	0.2
MARIJUANA						
INDIVIDUALS (12 AND OLDER)	10.1	10.3	11.3	11.6	11.5	12.1
ADOLESCENTS (12-17)	12.5	13.0	13.6	14.0	14.2	13.5
YOUNG ADULTS (18-25)	27.5	27.6	30.6	30.0	30.8	31.5
ADULTS (26 AND OLDER)	6.8	7.0	7.7	8.0	7.9	8.6
METHAMPHETAMINE						
INDIVIDUALS (12 AND OLDER)	0.5	0.3	0.5	0.4	0.4	0.4
ADOLESCENTS (12-17)	0.5	0.4	0.4	0.4	0.4	0.3
YOUNG ADULTS (18-25)	1.2	0.8	0.9	0.8	0.7	1.0
ADULTS (26 AND OLDER)	0.4	0.3	0.4	0.3	0.4	0.4
MDMA						
INDIVIDUALS (12 AND OLDER)	0.9	0.9	1.1	1.0	0.9	1.0
ADOLESCENTS (12-17)	1.3	1.4	1.7	1.9	1.7	1.2
YOUNG ADULTS (18-25)	3.5	3.9	4.3	4.4	4.1	4.1
ADULTS (26 AND OLDER)	0.3	0.3	0.5	0.4	0.3	0.5
PRESCRIPTION PSYCHOTHERAPEUTICS						
INDIVIDUALS (12 AND OLDER)	5.0	4.8	4.9	4.8	4.3	4.8
ADOLESCENTS (12-17)	6.7	6.5	6.6	6.3	5.9	5.3
YOUNG ADULTS (18-25)	12.1	12.0	11.9	11.1	9.8	10.1
ADULTS (26 AND OLDER)	3.6	3.3	3.5	3.6	3.2	3.8

Source: 2012 National Survey on Drug Use and Health

2014 National Drug Threat Assessment Summary

TABLE B8. PERCENTAGE OF NDTs RESPONDENTS REPORTING NATIONWIDE HIGH AVAILABILITY, BY DRUG, BY CALENDAR YEARS 2013 - 2014		
	2013	2014
POWDER COCAINE	22.9	18.1
CRACK COCAINE	24.1	23.6
METHAMPHETAMINE	39.5	40.6
HEROIN	30.3	34.0
MARIJUANA	88.2	80.0
CONTROLLED PRESCRIPTION DRUGS (CPDs)	75.4	63.2
SYNTHETIC CATHINONES	*	11.9
SYNTHETIC CANNABINOIDS	*	18.1

Source: National Drug Threat Survey, 2014

* INFORMATION NOT AVAILABLE

TABLE B9. PERCENTAGE OF NDTs RESPONDENTS REPORTING HIGH AVAILABILITY, BY DRUG, BY REGION						
OCDETF REGION	POWDER COCAINE	CRACK COCAINE	METHAMPHETAMINE	HEROIN	MARIJUANA	CPDs
FLORIDA/CARIBBEAN	29.3	33.7	22.7	3.3	78.9	70.5
GREAT LAKES	11.9	20.9	30.4	40.1	90.2	70.6
MID-ATLANTIC	25.9	34.1	11.8	51.5	94.8	81.8
NEW ENGLAND	32.1	21.6	6.0	55.4	93.1	76.7
NEW YORK/NEW JERSEY	27.4	21.8	0.1	45.1	91.3	70.6
PACIFIC	11.8	8.7	76.5	40.2	97.2	64.1
SOUTHEAST	30.5	40.8	47.7	3.9	82.4	87.2
SOUTHWEST	33.9	15.9	87.5	22.3	87.3	82.8
WEST CENTRAL	13.1	13.2	50.7	20.6	82.3	64.2
NATIONWIDE	22.9	24.1	39.5	30.3	88.2	75.4

Source: National Drug Threat Survey, 2014

Appendix C: Acronym Glossary

AAPCC	American Association of Poison Control Centers
CBP	US Customs and Border Protection
CEWG	Community Epidemiology Working Group
CPD	Controlled Prescription Drugs
CSA	Controlled Substances Act
CY	Calendar Year
DAWN	Drug Abuse Warning Network
DCE/SP	Domestic Cannabis Eradication/Suppression Program
DEA	US Drug Enforcement Administration
ED	Emergency Department
FBI	US Federal Bureau of Investigation
FD	Field Division (DEA)
FDA	Food and Drug Administration
ICE	Immigration and Customs Enforcement
ID	Identification
IRS	US Internal Revenue Service
MDMA	Methylenedioxymethamphetamine (frequently referred to as ecstasy)
MTF	Monitoring the Future
MV	Motor Vehicle
NCHS	National Center for Health Statistics
NCNRP	National Center for Natural Projects Research
NDTA	National Drug Threat Assessment
NDTS	National Drug Threat Survey
NFLIS	National Forensic Laboratory Information System
NIDA	National Institute on Drug Abuse
NSDUH	National Survey on Drug Use and Health
NSS	National Seizure System
OCDETF	Organized Crime Drug Enforcement Task Force
PD	Police Department
PDMP	Prescription Drug Monitoring Program
SCPL	Small Capacity Production Laboratories
TCO	Transnational Criminal Organization
TEDS	Treatment Episode Data Set
THC	Tetrahydrocannabinol

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