DEA
INTELLIGENCE
REPORT

(U) The Drug Situation in Delaware

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Summary

In April 2016, the Drug Enforcement Administration's (DEA) Philadelphia Field Division (PFD) Intelligence Program conducted an analysis of drug availability and abuse for the State of Delaware. Delaware is home to 935,000 people in three counties: New Castle (including the city of Wilmington), Kent, and Sussex.[1] The primary drug threats to Delaware are heroin and diverted prescription opioids, as measured through information regarding drug availability, seizures, treatment admissions, and drug-related overdose deaths. In 2014, Wilmington ranked third on the Federal Bureau of Investigation's annual list of the most violent cities of comparable size, and it ranked fifth in violent crime when compared to all cities with populations greater than 50,000.[2] As a result, Wilmington was included in the Department of Justice's Violence Reduction Network in 2014. In 2015, the Office of National Drug Control Policy designated New Castle County as part of the Philadelphia/Camden High Intensity Drug Trafficking Area (HIDTA).

Scope

The PFD Intelligence Program analyzed the following indicators in this assessment: illicit drug and diverted pharmaceutical availability; drug prices and purity; fatal drug-related overdoses; naloxone administrations; Prescription Monitoring Program (PMP) data and treatment admissions.

Drug Availability

Powder Cocaine

Cocaine is readily available to users and addicts in Delaware, according to local law enforcement agencies and drug treatment officials, and demand for it has not diminished. Cocaine is primarily supplied to Delaware by Mexican drug trafficking organizations (DTOs) operating in Philadelphia and New York City, though local traffickers are increasingly being supplied by sources in California, Texas, and Arizona. Investigative and law enforcement reporting indicate that wholesale and retail cocaine distribution is concentrated among African American, Hispanic, and independent Caucasian groups operating throughout the state. White males between 25 to 35 years of age comprise the main user population for cocaine.[3]

The most common cocaine transportation methods reported are vehicles equipped with hidden compartments and parcel shipments. The Port of Wilmington is the largest port in Delaware for the importation of fruit and goods originating in South and Central America. Cargo ships arrive from drug source and transshipment countries on a daily basis, and investigative reporting

indicates that these ships often contain kilogram-sized quantities of cocaine ready for distribution throughout the East Coast.[4]

Crack Cocaine

Crack cocaine abuse is widespread in Delaware, with the main user population reported as being African American males between 20 and 40 years of age. Crack cocaine is primarily produced in "cook houses" throughout the state and sold through street distribution and open air markets, mainly in Kent and Sussex counties. Crack cocaine is also produced and distributed in several areas of Wilmington, including low-income housing projects.[5]

Heroin

Heroin is the primary drug threat in Delaware, as DEA and multiple law enforcement agencies continue to report annual increases in heroin trafficking, seizures, and abuse. Several factors are responsible for this continuous threat, including the abundance of cheap, high-purity heroin, as well as an increasing number of pharmaceutical opioid abusers turning to heroin as a cheaper substitute.

DEA investigations indicate that a significant amount of the heroin available for distribution in Delaware is supplied by Philadelphia-based sources of supply, but some comes from other regional cities, including Baltimore. Several Philadelphia-based DTOs are in direct contact with Mexican sources of supply and they utilize a variety of communication methods to arrange the importation of kilogram-sized quantities of heroin from the southwest border through Phoenix, Chicago, New York, and the Caribbean. In Delaware, the city of Wilmington represents the largest local heroin supply base. Land vehicle transport of heroin from source areas into Delaware is common and often achieved with the use of hidden compartments. Delaware's position at the convergence of several major north/south highways makes it a key location in the East Coast transit zone for heroin and other drugs, as well as a logical choke point to focus interdiction and investigative efforts.

Available data about the purity of heroin seized or purchased in Delaware during calendar years 2014 and 2015 was limited. During calendar year 2014, heroin purity among 18 analyzed exhibits ranged from 19 to nearly 87 percent, with the average purity being approximately 50 percent. Only two exhibits from calendar year 2015 had purity results at the time of this writing; one had a purity of approximately 68 percent and the other exhibit was approximately 60 percent pure. Similarly, exhibits purchased or seized in Philadelphia had an average purity of almost 69 percent in 2014 and 50 percent in 2015.[6] Despite year-to-year fluctuations, Philadelphia's heroin

purity averages are consistently among the highest in the country; as a result, heroin purity in Delaware, a market for Philadelphia-based sources, is elevated as well.[a]

Delaware's heroin threat is exacerbated by the use of fentanyl or fentanyl analogues as a heroin adulterant or substitute. According to the Delaware Department of Health and Social Services, more overdose deaths involving fentanyl were reported during the first 9 months of calendar year 2015 (31) than in all of 2014 (11).[7]

Marijuana

DEA reporting indicates that marijuana is readily available in Delaware. Marijuana in Delaware usually originates in California, the southwest border region, or Canada, but Philadelphia occasionally serves as a regional source of supply. Marijuana is generally transported into Delaware in pound-sized quantities using commercial/passenger vehicles or commercial/postal delivery services. DEA does not consider the cultivation of marijuana a serious threat in Delaware.

In June 2015**,** a decriminalization law was signed by the Governor of Deleware that made possession of "personal use" quantities of marijuana (defined as an ounce or less) by an adult a civil offense punishable by a fine of $100. Simple possession remains a criminal offense for anyone under 18. For individuals between the ages of 18 and 21, a first offense will result in a civil penalty, with any subsequent offense charged as a misdemeanor. Smoking marijuana in a moving vehicle, in public areas, or outdoors on private property within 10 feet of a street, sidewalk, or other area accessible to the public is also a misdemeanor according to Delaware law.

In 2011, the Delaware Medical Marijuana Act was enacted (Reference Title 16, Chapter 49A of the Delaware Code), allowing for doctor-recommended medical use marijuana for patients with serious medical conditions.[b] Medical marijuana registration cards generally expire 1 year from date of issuance. Home cultivation of marijuana is prohibited, and the current law allows for patients to possess up to 6 ounces of marijuana for medical use. Delaware currently has one medical marijuana distribution center, known as a compassion center, in Wilmington. The Department of Health and Social Services has published a proposal for up to two more centers. Within Delaware's Division of Public Health (DPH), the Health Systems Protection Section

[a] Based on DEA Heroin Domestic Monitor Program (HDMP) data. Delaware does not have an HDMP-participating city.

[b] Physicians may authorize a patient to use marijuana to treat symptoms of cancer; multiple sclerosis; HIV and AIDS; decompensated cirrhosis; amyotrophic lateral sclerosis; agitation of Alzheimer's disease; autism with aggressive or self-injurious behavior; intractable epilepsy; or the physical manifestations of post-traumatic stress disorder. Conditions that cause severe debilitating pain, wasting syndrome, intractable nausea, and seizures also fall under Delaware's medical marijuana law.

(HSP) is responsible for the policy development and operation of the state's medical marijuana program.[8]

According to the 2014 *Delaware Medical Marijuana Program Annual Report*,[c] in fiscal year 2013, 34 registration cards were issued to new patients and one to a new caregiver.[d] Those numbers increased to 56 registration cards for new patients and five cards for new caregivers fiscal year 2014. In addition, as of August 2015, there were 495 active medical marijuana cardholders—437 patients, 28 caregivers, and 33 agents.[e,f] The two most common debilitating medical conditions among qualified patients during fiscal years 2013 and 2014 were severe debilitating pain and severe persistent muscle spasms.

Methamphetamine

DEA reporting indicates that methamphetamine availability in Delaware is currently at a moderate level and rising. Methamphetamine is available in both powder and crystal forms and is most commonly sourced from Mexico. Recent reporting indicates that outlaw motorcycle gangs are transporting and distributing methamphetamine in Delaware.[9] Additional DEA investigative reporting suggests that Caucasian DTOs and independent laboratory operators are prominent in the transportation of methamphetamine. The wholesale distribution of methamphetamine is dominated by Caucasian DTOs, Mexican DTOs, and motorcycle gangs. The retail distribution of methamphetamine is primarily handled by Caucasian and/or independent DTOs.

Regarding local production, the Delaware Department of Natural Resources and Environmental Control's (DNREC) Emergency Response Team responded to 21 methamphetamine laboratory incidents in calendar year 2015. Of the 21 total incidents, 14 were in Kent County and 7 were in

[c] Represents the most recently published report.

[d] A caregiver is defined as "someone who is at least 21 years of age, unless the person is the parent or legal guardian of a minor who is a qualifying patient; has agreed to assist with a patient's medical use of marijuana; has not been convicted of an excluded felony offense; and assists no more than five qualifying patients (including him/herself if the caregiver is also a registered patient) in the medical marijuana program. Each patient must grant authorization to his/her caregiver. An "excluded felony offense" means (a) a violent crime defined in § 4201(c) of Title 11, that was classified as a felony in the jurisdiction where the person was convicted; or (b) a violation of a state or federal controlled substance law that was classified as a felony in the jurisdiction where the person was convicted, not including: 1) an offense for which the same sentence, including any term of probation, incarceration, or supervised release, was completed 10 or more years earlier; or, 2) an offense that consisted of conduct for which this chapter would likely have prevented a conviction, but the conduct either occurred prior to July 1, 2011, or was prosecuted by an authority other than the State of Delaware."

[e] The term "agent" refers to a "compassion center agent," meaning a principal officer, board member, employee, or agent of a registered compassion center who is 21 years of age or older and has not been convicted of an excluded felony offense for drug misdemeanor within 5 years.

[f] Some people have more than one type of card, so the sums of the types will be more than the total cardholders.

Sussex County. The DNREC estimates that it responds to at least 95 percent of reported methamphetamine laboratories.[10] Information regarding the specific types of methamphetamine laboratories and capacity was not available. Investigative and post-arrest information indicates that laboratory operators are not selling large amounts of methamphetamine, but rather supplying themselves and immediate associates.[11]

Diverted Pharmaceuticals

Diverted pharmaceuticals are in high demand and readily available in Delaware. Analysis of statistical indicators from various law enforcement and public health agencies, including rehabilitation facilities, revealed that prescription drug abuse—including oxycodone, Percocet®, Xanax®, methadone, and Ativan®—has increased over the last several years in Delaware. The main user population is comprised of Caucasian males and females in their 20s to mid-40s.[12]

According to the Delaware State Police (DSP) Drug Diversion Unit, prescription drugs are diverted in various ways in Delaware, including but not limited to: legitimate prescriptions and/or prescription pads being sold to third parties; legitimate prescriptions being filled and the pills sold to third parties; "doctor shopping," individuals obtaining prescriptions from multiple doctors; residential theft, including from real estate open houses; and theft from family members.

Protective measures aimed at curbing prescription drug abuse include implementation of a secured script program and a prescription monitoring program in 2012 (each program is described in further detail later). In addition, the DSP Drug Diversion Unit reported a change in the maximum milligrams that Medicare will allow for coverage of prescription narcotics.[13]

Figure 1: Drug Prices Reported in Delaware, 2015

Drug	Price	Quantity
Cocaine	$50 to $125	gram
	$1,000 to $1,400	ounce
	$30,000 to $42,000	kilogram
Crack Cocaine	$100 to $150	gram
	$900 to $1,200	ounce
Heroin	$5 to $20	bag (~.015 grams)
	$30 to $80	bundle (~13 bags)
	$75 to $150	gram
	$300 to $600	"log" (~ 10 bundles)
	$2,500 to $5,000	ounce
Marijuana		
Domestic	$120-$150	ounce
	$800-$1,000	pound
BC Bud (Canadian)	$600	ounce
	$3,000-$4,500	pound
Methamphetamine	$400-$500	8-ball
	$1,200 to $2,700	ounce
Diverted Pharmaceuticals		
Oxycodone 30mg	$14 to $30	pill
OxyContin® 80mg	$22 to $40	pill
Percocet® 7.5mg	$8 to $10	pill
Alprazolam	$5 to $7	pill

Source: DEA Philadelphia Field Division

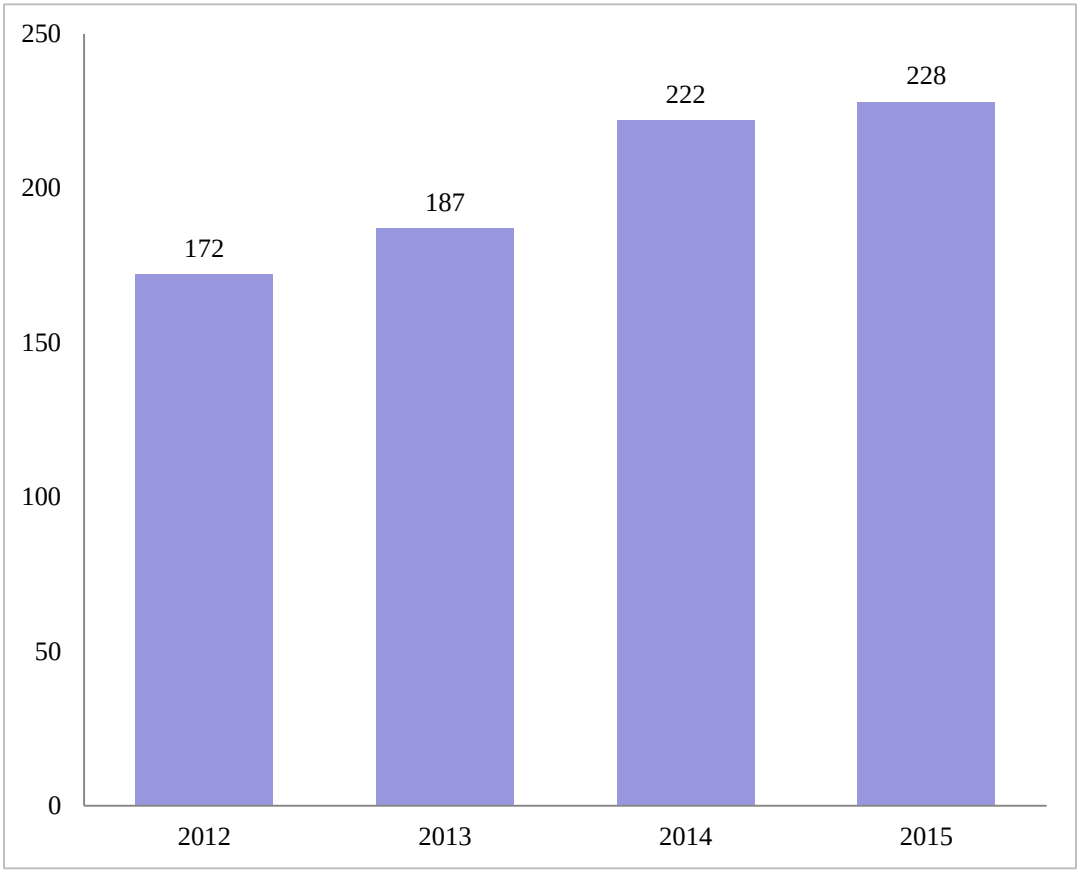
Drug-Related Overdose Deaths

Deaths that result from the abuse or misuse of illicit street drugs and diverted pharmaceuticals reflect how illegal drugs damage and destroy lives. Delaware's drug-related overdose death data for years 2012-2015 was obtained from the Department of Safety and Homeland Security (DSHS) Division of Forensic Science (see Figure 2. Demographic data was not available).[14]

Total Drug-Related Deaths

Drug-related overdose deaths increased between 2012 and 2015 (see Figure 2). The increase from 2014 (222 deaths) to 2015 (228 deaths) was the smallest increase of the reviewed period at 2.7 percent. Drug-related overdose deaths in New Castle County continued to increase during the reviewed period and increased sharply by percentage when compared to statewide figures. In contrast, Kent and Sussex counties experienced an increase in drug-related deaths from 2012 to 2014, but a decrease of 8.3 percent from 2014 to 2015.

Figure 2: Drug-Related Overdose Deaths in Delaware, 2012-2015



Source: Delaware Medical Examiner's Office data obtained through the Delaware Division of Forensic Science, Department of Safety and Homeland Security

The Delaware Medical Examiner's Office identified the following information as it pertains to drug-related deaths by drug type (see Figure 3). Details concerning the methodology used in determining the cause of death by drug type were not available from the Delaware Medical Examiner's Office at the time of this report.

Cocaine-Related Deaths

After experiencing a decrease between 2012 and 2014, cocaine-related deaths in Delaware rose 44.8 percent from 2014 to 2015. Although such deaths in Kent and Sussex counties increased consistently from 2013 to 2015 (including an 85.7 percent increase from 2014 to 2015), fluctuations were noted in New Castle County (decreasing 31.3 percent in 2014 and increasing 31.8 percent in 2015) after being steady between 2012 and 2013.

Heroin-Related Deaths

After a decrease of 17.5 percent between 2012 and 2013, statewide heroin-related deaths rose more than 90 percent from 2013 to 2014. There was a 93.5 percent increase in New Castle County and an 87.5 percent increase in Kent and Sussex counties. Overall, heroin-related deaths decreased by 7.8 percent statewide from 2014 to 2015, but there was an increase of 10 percent in Kent and Sussex counties and a 16.7 percent decrease in New Castle County.

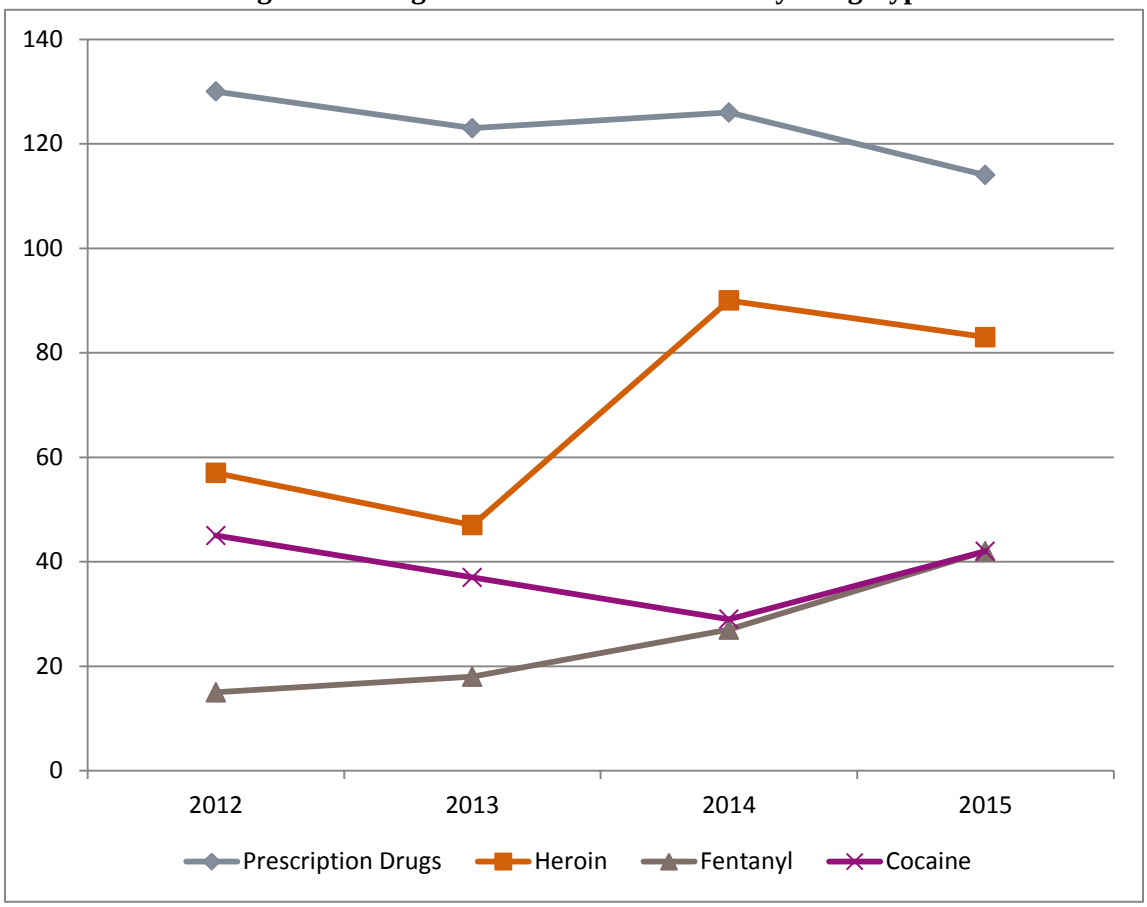
Fentanyl-Related Deaths

Since 2012, fentanyl-related deaths increased steadily at both the state and county levels. Kent and Sussex counties experienced the highest increase between 2013 and 2014 (almost 89 percent), while New Castle County experienced the greatest increase from 2014 to 2015 (130 percent).

Prescription Drug-Related Deaths

Despite a slight increase between 2013 and 2014, prescription drug-related deaths have declined statewide since 2012. A review of 2014 and 2015 figures indicated that Kent and Sussex counties experienced a decrease of 34.6 percent in prescription drug-related overdose deaths between the two years, while New Castle County experienced an increase of 8.1 percent during the same period.

Figure 3: Drug-Related Overdose Deaths by Drug Type



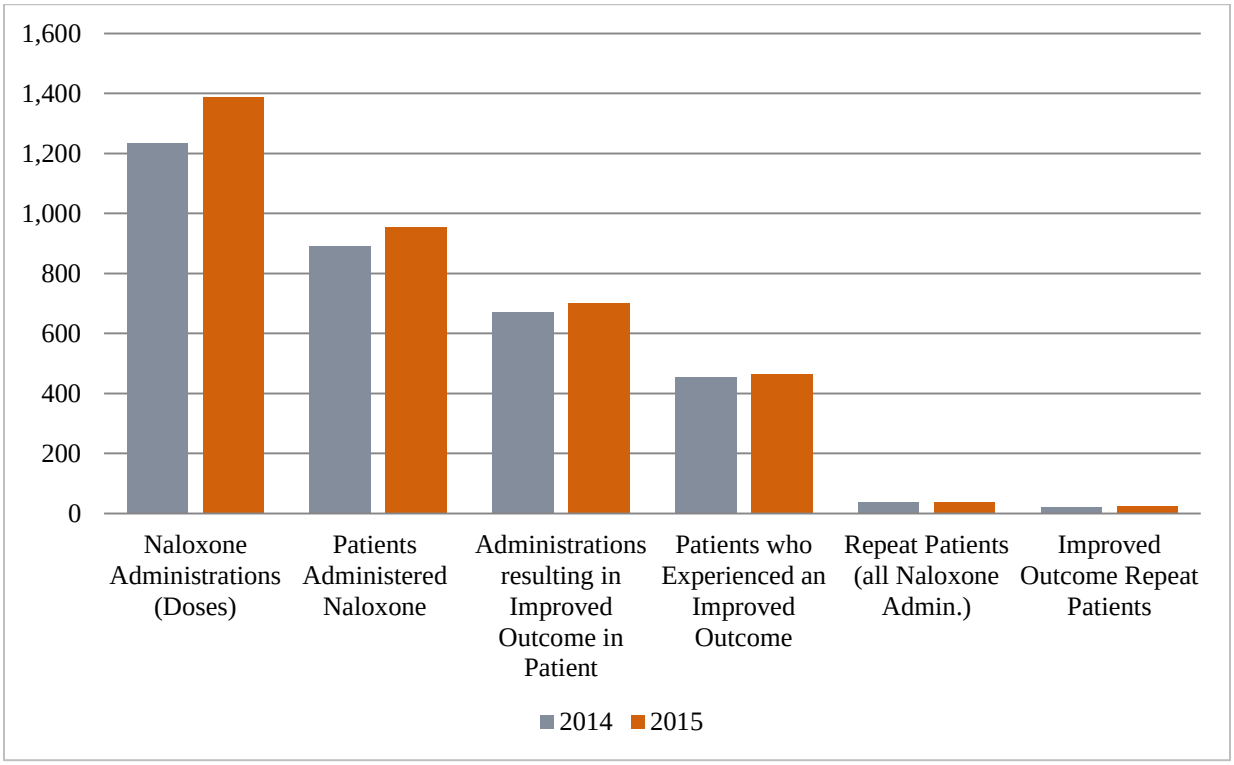
Source: Delaware Medical Examiner's Office data obtained through the Delaware Division of Forensic Science, Department of Safety and Homeland Security

Naloxone Administrations

Legislation allowing Delaware law enforcement officers to carry naloxone (Reference HB 388) and community members to purchase naloxone (Reference SB 219) was approved in 2014. In 2015, the Delaware Department of Health and Social Services (DHSS) received a donation of 2,000 naloxone auto-injectors from a manufacturer of the product. The auto-injectors were provided to the Delaware Department of Education for distribution to public high schools, addiction treatment centers, and participating police departments. Naloxone is among the inventory of medications administered by emergency medical service personnel to revive opiate overdose victims. To date, it is estimated that naloxone is administered by emergency medical service personnel more often than by any other group.[15] A local counseling and community service organization reported that since September 2015, 40 opiate overdose victims have been saved by personnel who have been trained to administer naloxone through the Delaware Overdoses Survival Education (DOSE) Program.[16]

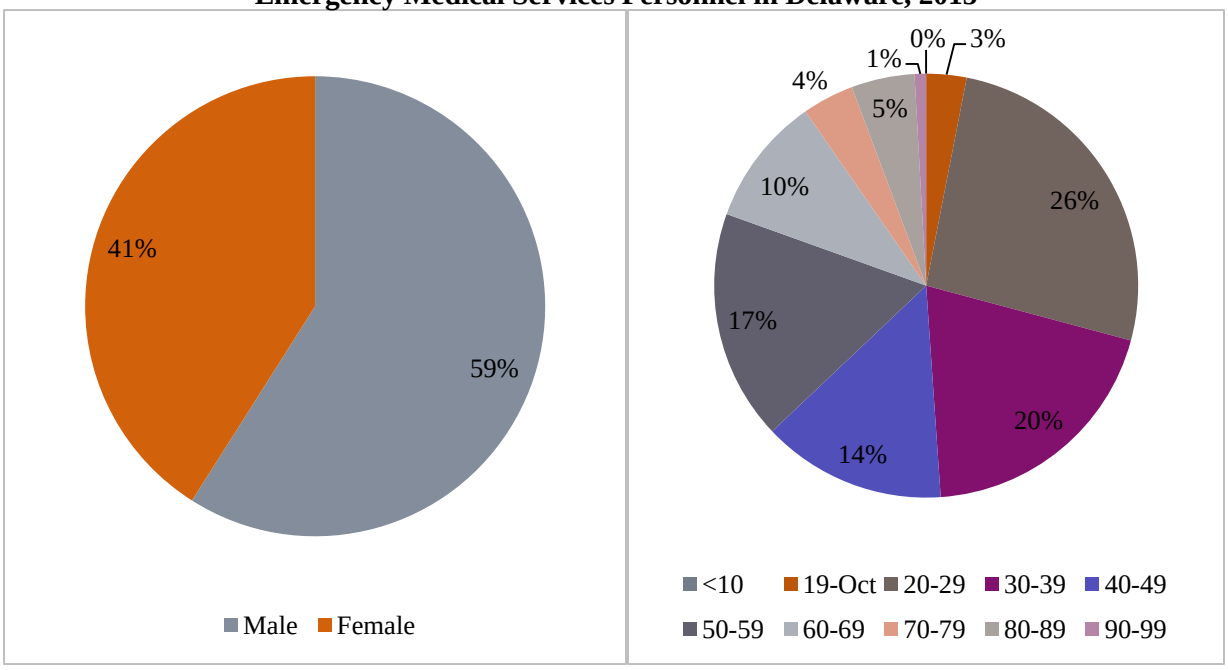
Data regarding naloxone administration by emergency medical services personnel in Delaware indicates that the number of doses administered increased approximately 12 percent from 2014 (1,236 doses) to 2015 (1,389 doses). The number of patients to whom naloxone was administered increased nearly 7 percent during the same period (892 in 2014 and 954 in 2015). In both years, roughly 50 percent of the patients experienced an improved outcome after receiving naloxone. It is this group that is the most likely to have been experiencing an opioid/opiate-related emergency or complication. Males accounted for the majority of the victims administered naloxone in both years (approximately 60 percent). Overdose victims of all genders within the age range of 20-29 years accounted for the largest portion of administrations, followed by the 30-39 age group (see Figure 5).

Figure 4: Data Regarding Naloxone Administrations by Emergency Medical Services Personnel in Delaware, 2014-2015



Source: Delaware Office of Emergency Medical Services, Emergency Medical Services and Preparedness Section

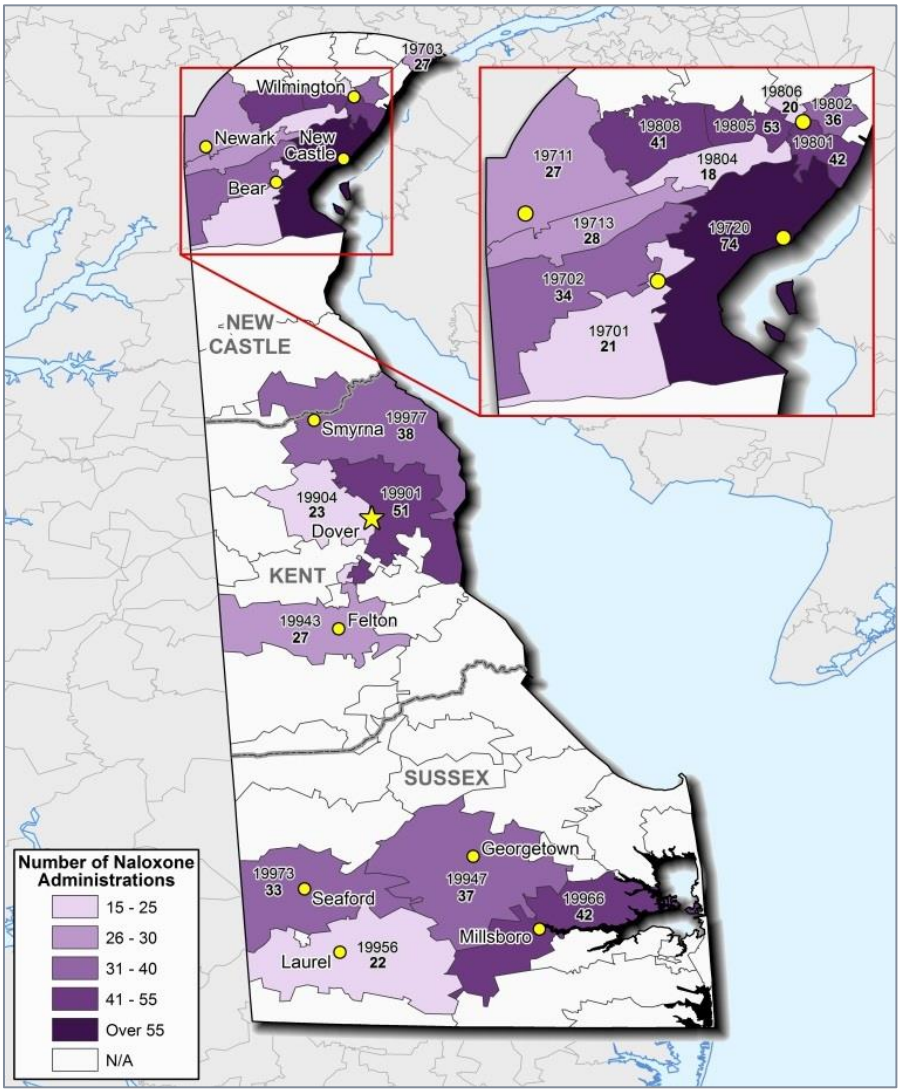
Figure 5: Gender and Age Information Regarding Naloxone Recipients Administered by Emergency Medical Services Personnel in Delaware, 2015



Source: Delaware Office of Emergency Medical Services,
Emergency Medical Services and Preparedness Section

Analysis of naloxone administrations in 2015 revealed that the top 20 zip codes in which they occurred (see Figure 6). Eleven of the top 20 zip codes were in New Castle County, the most populous county in the state.

Figure 6: Top 20 Zip Codes for Naloxone Administrations by EMS in Delaware, 2015



Source: Delaware Office of Emergency Medical Services

Prescription Monitoring Program

The Delaware Prescription Monitoring Program (PMP) is maintained by the Office of Controlled Substances within the Delaware Division of Professional Regulation (DPR). The program went into effect on January 1, 2014, and required all prescribers who hold a Delaware Controlled Substance Registration (CSR) to register with the Delaware PMP. Delaware's PMP includes all controlled substance prescriptions (Schedules II-V) and reporting is mandated on a daily basis. Registered prescribers and dispensers have direct access to PMP reports for current or prospective patients. Law enforcement agencies do not have direct access to Delaware PMP reports, but requests for information can be submitted to the DPR when situations are related to a narcotics investigation.

Pharmacies must report all prescriptions, including those dispensed for non-Delaware residents or mailed/shipped out of state, with a few exceptions.[g] Out-of-state pharmacies must report all Schedule II through V controlled substance prescriptions that they deliver, ship, or mail to Delaware. However, when a Delaware resident travels to a pharmacy outside of Delaware and physically picks up the prescription, that prescription is not required to be reported to the Delaware PMP. Delaware law generally allows for the dispensing of no more than a 72-hour supply of controlled substances by dispensing practitioners. If the maximum is dispensed, it must be reported to the PMP, unless the conditions of an exception are met.[17] Of note, substance abuse treatment programs such as methadone clinics and opioid treatment programs are not required to submit data on controlled substance prescriptions dispensed.

Delaware PMP data revealed that over 962,000 Schedule II prescriptions were written in 2015, representing over 58.6 million dosage units. More than 41,000 (4 percent) of the Schedule II prescriptions were identified as having been paid out of pocket; however, another 15,000 payment methods were identified as "other," suggesting that this figure may be higher. Both of these payment methods are suggestive of potential illicit diversion. By comparison, over 809,000 Schedule II prescriptions were written in 2012, representing over 53.8 million dosage units. Over 54,000 (7 percent) of the Schedule II prescriptions were identified as having been paid out of pocket; however, an additional 40,000 payment methods were "unknown," which suggests that this figure is actually higher. A comparison to previous years of prescribing data was not available, given that the state's PMP was implemented in 2012.

Secured Script Program

Delaware implemented the Secured Script Program in March 2012 to combat prescription fraud. This program requires prescribers of controlled and non-controlled substances to use tamper-resistant prescription forms, which are supplied by DPR-approved vendors. In addition, the DPR issues each practitioner a personal security code that enables vendors to ensure that only licensed healthcare providers and authorized institutions are purchasing prescription forms. Consequently, the DSP Drug Diversion Unit continually observes out-of-state (primarily Maryland, Pennsylvania, and Florida) prescriptions presented in Delaware pharmacies. Delaware doctors also have the option of sending prescriptions to pharmacies electronically.[18]

[g] Exceptions to dispenser (pharmacies and dispensing practitioners) reporting requirements include:

(a) Licensed health care facility pharmacies that dispense/distribute the drugs for inpatient care.
(b) Emergency departments that dispense/distribute the drugs for immediate use.
(c) Any Delaware-licensed pharmacy (in-state or non-resident) or a controlled substance registrant that dispenses/distributes up to a 72-hour supply of the drugs (including samples) at the time of a patient's discharge from emergency department care.
(d) Dispensing of controlled substance(s) prescribed by a veterinarian for the purposes of providing veterinary services.
(e) Substance abuse treatment programs, such as methadone clinics and opioid treatment programs, that are exempted by federal regulations.

Treatment Data

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the State of Delaware received approximately $10 million in substance abuse funding for fiscal years 2015 and 2016. Analysis of SAMHSA's *Behavioral Health Barometer Report for Delaware, 2015* identified the following:

Substance abuse among Delaware adolescents:

- About 7,000 adolescents aged 12-17 (10.2 percent of all adolescents) per year from 2013-2014 reported using illicit drugs[h] within the month prior to being surveyed. The percentage did not change significantly from the 2010-2011 period. Deleware's percentage of illicit drug use among adolescents aged 12-17 was similar to the national average in 2013-2014.[i]
- About 77 percent of adolescents in Delaware perceived no great risk from smoking marijuana once a month, a percentage similar to national trends.[j,k]
- About 3,000 adolescents aged 12-17 (4.7 percent of all adolescents) per year from 2013-2014 reported non-medical use of pain relievers within the year prior to being surveyed, which is a figure similar to the national average for the same category. The Delaware percentage did not change significantly from 2010-2011.[l]

Illicit drug dependence or abuse among individuals aged 12 or older:[m]

- In Delaware, about 27,000 individuals aged 12 or older (3.4 percent of all individuals in this age group) per year from 2013-2014 were dependent on or abused illicit drugs within the

[h] Illicit drugs are defined as marijuana/hashish, cocaine (including crack), inhalants, hallucinogens, heroin, or prescription-type drugs used non-medically, based on data from original National Survey on Drug Use and Health (NSDUH) questions, not including methamphetamine items added in 2005 and 2006.

[i] State estimates are based on a small-area estimation procedure in which state-NSDUH data from two consecutive survey years is combined with local-area county and census block group/tract-level data from the state. This model-based methodology provides more precise estimates at the state level than those based solely on the sample, particularly for states with smaller sample sizes.

[j] Represents the most recently published report.

[k] Risk perceptions were measured by asking respondents to assess the extent to which people risk harming themselves physically and in other ways when they use various illicit drugs, alcohol, and cigarettes, with various levels of frequency. Response options were (1) no risk, (2) slight risk, (3) moderate risk, and (4) great risk. Respondents with unknown risk perceptions were excluded.

[l] Represents the most recently published report.

[m] Represents the most recently published report.

year prior to being surveyed. The percentage did not change significantly from 2010-2011, but was higher than the 2013-2014 national average of 2.6 percent.

Treatment for illicit substance abuse among individuals aged 12 or older:[n]

- Among individuals aged 12 or older with illicit drug dependence or abuse, about 7,000 individuals (29 percent) per year from 2010 to 2014 received treatment for their illicit drug use within the year prior to being surveyed. Delaware's annual average of treatment for illicit drug use among individuals aged 12 or older with drug dependence or abuse was higher than the annual national average (14.1percent) from 2010 to 2014.

Division of Substance Abuse and Mental Health Data

A review of DHSS's Division of Substance Abuse and Mental Health data for fiscal years 2011 to 2014[o] indicated that since 2012, heroin was the most commonly identified primary substance of abuse among state-funded adult substance abuse treatment admissions. The identification of heroin as the primary drug at admission has consistently increased, up 152 percent from fiscal year 2011 to 2014. A historical review of fiscal years 2001 through 2014 indicated that heroin was the illicit substance most frequently identified as the primary drug of adult admissions for 12 of the last 14 fiscal years where data was available (2014 was the highest among those years with 3,182 patients).[p]

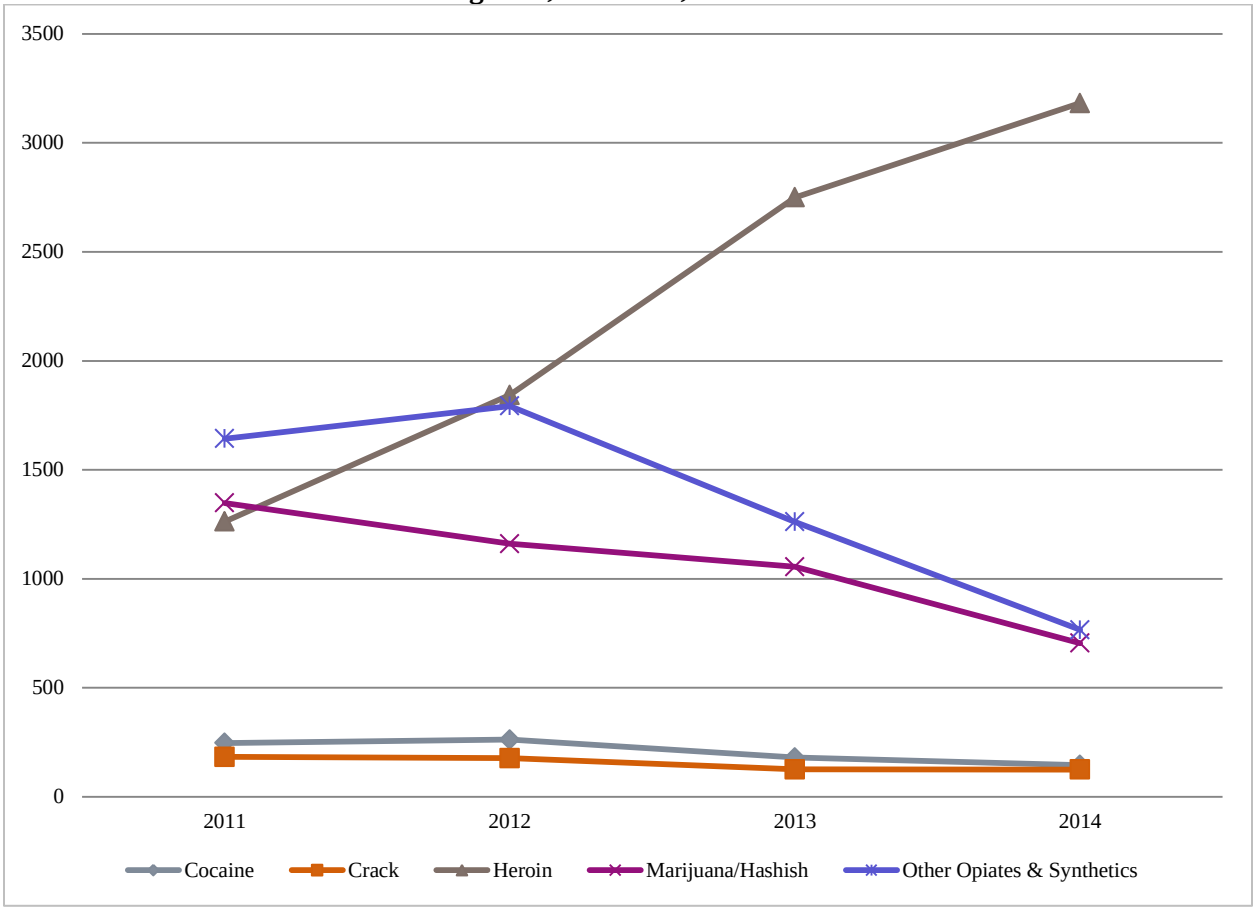
Conversely, the number of adults who identified "other opiates and synthetics" as their primary substance of abuse in fiscal years 2013 and 2014 decreased by 53 percent from fiscal year 2011. Although the fiscal year 2012 implementation of Delaware's PMP and Secure Script Program are likely to have impacted this category, DEA intelligence suggests that such a decrease also correlates to the migration from prescription opioids to heroin use, a common trend among new heroin users and overdose victims.

[n] Estimates are annual averages based on combined 2010-2014 NSDUH data or combined 2007-2014 NSDUH data where indicated. These estimates are based solely on the sample, unlike estimates based on the small-area estimation procedure as stated in footnote m.

[o] Delaware fiscal years run from July 1st to June 30th.

[p] "Marijuana/Hashish" was the most commonly identified primary drug of admission in 2010; "Other Opiates and Synthetics" were the most commonly identified primary drug(s) of admission in 2011. When considering all substances, alcohol was the most commonly identified primary substance of abuse by adults for years 2001 through 2007, as well as 2009, 2010, and 2011.

Figure 7: Excerpted Primary Substances of Abuse for Adults in State-Funded Treatment Programs, Delaware, 2011-2014[q]

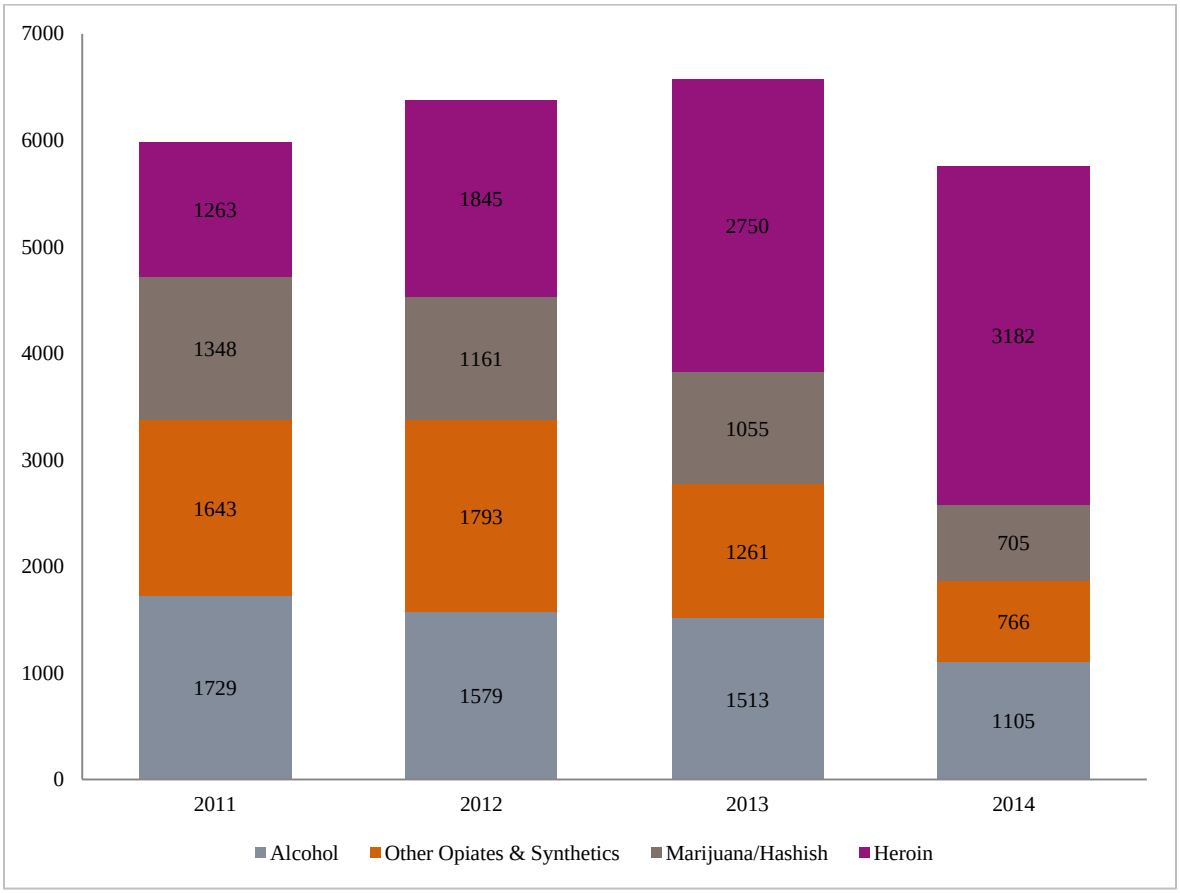


Source: Delaware Health and Social Services
Division of Substance Abuse and Mental Health

Marijuana/hashish was also among the top three primary substances identified in adult treatment admissions. Marijuana/hashish primary drug admissions decreased over the past several years, including a 48 percent decrease from fiscal years 2011 to 2014. A historical review of data from fiscal years 2001 to 2014 revealed that marijuana/hashish was among the top illicit substances reported at admission for 10 of the 14 years, increasing steadily between fiscal years 2001 and 2007.

[q] Demographic information for particular substances was not reported.

Figure 8: Top Four Primary Substances of Abuse in Adult State-Funded Treatment Programs, Delaware, 2011-2014



Source: Delaware Department of Health and Social Services,
Division of Substance Abuse and Mental Health

Delaware Treatment Demographics

SAMHSA reported that for fiscal years 2011 to 2014,[r] 68 to 70 percent of adults admitted to state-funded substance abuse treatment programs were male. The 25- to 34-year-old age group consistently represented the highest percentage (30 to 39 percent) of adult admissions for each of the reported years, followed by the 35-to 44-year-old age group (18-20 percent) and the 21- to 24-year-old age group (17-18 percent). Non-Hispanic Whites accounted for the largest percentage (73-79 percent) of adult treatment admissions, followed by non-Hispanic Blacks (18-24 percent). Hispanics accounted for 4 to 5 percent of adult treatment admissions during the years reviewed.

[r] Missing/unknown values were excluded from percentage calculations.

Law Enforcement Response

New Castle County, specifically the city of Wilmington, is in the midst of a surge in violent crime. In 2013, Wilmington was named the most violent small city in the United States, with a homicide rate 4.5 times the national average. This statistic justified Wilmington's place among the first five major U.S. cities named in the Department of Justice's (DOJ) Violent Reduction Network (VRN). The VRN is a comprehensive approach to violent crime reduction that complements the U.S. Attorney General's Smart on Crime Initiative by leveraging the vast array of existing resources across several DOJ components in the country's most violent cities.

Reporting indicates that a significant amount of gun-related violence in Delaware is directly related to DTOs operating in inner city neighborhoods controlling their "turf" while they distribute heroin, cocaine, and crack cocaine. These DTOs are connected with wholesale suppliers in Philadelphia and New York.[19]

In response, DEA PFD partnered with the United States Attorney's Office in Delaware, as well as with the Philadelphia/Camden HIDTA, in securing HIDTA designation for New Castle County. This designation, approved in early 2015, directly impacts the violent crime and drug trafficking nexus in Delaware through multi-agency task forces staffed by federal, state, and local counterparts.

DEA Presence

The PFD maintains a presence in Wilmington and Dover. The Wilmington Resident Office (WRO) is responsible for the cities of Wilmington and Newark, as well as all localities within New Castle County, Delaware's largest county with the highest population concentration. The WRO presently includes a HIDTA task force group and a tactical diversion squad. The Dover Post of Duty (DPOD) assumes responsibility for the city of Dover and localities in Kent and Sussex counties in Southern Delaware. The DTOD is comprised of a task force group.

Other Legislative Measures

State government leaders in Delaware are proactively working to combat the heroin abuse epidemic. This effort is reflected in two bills that are intended to reduce the number of drug overdoses:

- House Bill 239 created the crime of "drug dealing resulting in death." The legislation can be used to charge a dealer with a Class B felony for supplying a drug that results in death. If convicted, the defendant could face between 2 and 25 years in prison. This bill was passed by the state House of Representatives in March 2016.

- Senate Bill 174 created the Drug Overdose Fatality Review Commission to review the circumstances surrounding an overdose death related to prescription opioids, heroin, and fentanyl. The Drug Overdose Fatality Review Commission also makes recommendations to the state as to how to prevent future overdose deaths.[20] A version of the bill passed in the state Senate in late January 2016 and was passed by the state House of Representatives in March 2016.

Outlook

Heroin abuse represents the biggest threat in Delaware, but the availability of and demand for illicit and prescription drugs is also concerning. Delaware's proximity to Philadelphia, which serves as a source of supply for inexpensive pure heroin (at least some of which may be substituted for or mixed with deadly adulterants such as fentanyl/fentanyl analogues), makes the population vulnerable to addiction, overdose, and the violence commonly associated with drug trafficking. DEA's Philadelphia Field Division will continue to aggressively target DTOs operating in Delaware and Pennsylvania, while also working in conjunction with state and local law enforcement and public health officials to mitigate the threat posed by drug trafficking and its related crimes.

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[1] United States Census Bureau, 2015 estimated population.

[2] Jones, Abigail; "Murder Town USA," *Newsweek*, Published December 9, 2014.

[3] DEA Philadelphia Investigative Reporting, 2015; overall document classification is (U//DSEN).

[4] Ibid.

[5] Ibid.

[6] DEA Investigative Reporting, January 20, 2016; overall document classification is (U//DSEN).

[7] Department of Health and Social Services; "Overdose Deaths involving Fentanyl up Dramatically in Delaware; Health and Law Enforcement Officials Urge Active Users to Seek Treatment," December 28, 2015.

[8] Online Publication; Delaware Medical Marijuana Program Annual Report; URL: http://dhss.delaware.gov/dph/hsp/medmarhome.html; Published January 2016; Accessed on March 24, 2016.

[9] DEA Philadelphia Investigative Reporting, 2015; overall document classification is (U//DSEN).

[10] DEA Reporting, January 22, 2016 ; overall document classification is (U).

[11] DEA Philadelphia Investigative Reporting, 2015; **o**verall document classification is **(**U//DSEN**)**.

[12] Ibid.

[13] Ibid.

[14] DEA Reporting, February 22, 2016; overall document classification is (U).

[15] DEA Reporting, March 4, 2016; overall document classification is (U).

[16] DEA Reporting, March 9, 2016; overall document classification is (U).

[17] Online Publication; Controlled Substances Registration – Practitioners; URL: http://dpr.delaware.gov/boards/controlledsubstances/practitioner_CSR_.shtml; Accessed on February 4, 2016.

[18] DEA Philadelphia Investigative Reporting, 2015; **o**verall document classification is **(**U//DSEN**)**.

[19] Ibid.

[20] Online Publication; Delaware Senate Bill 174; https://legiscan.com/DE/bill/SB174/2015; accessed on February 18, 2016.

(U) This product was prepared by the DEA Philadelphia Field Division. Comments and questions may be addressed to the Chief, Analysis and Production Section at dea.onsi@usdoj.gov.