THREAT ASSESSMENT *2015*

NEW YORK | NEW JERSEY

HIDTA

High Intensity Drug Trafficking Area

NEW YORK / NEW JERSEY HIDTA

HIGH INTENSITY DRUG TRAFFICKING AREA

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Office of National Drug Control Policy

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Since early 2010, the NY/NJ HIDTA Drug Trends Group (DTG) has collected and analyzed available data related to drug abuse from public health agencies in New York and New Jersey. With the extensive cooperation of our public health partners, DTG is able to report on trends in **drug overdose deaths** in several New York HIDTA counties (Bronx, Brooklyn, Kings, Richmond, Queens, Westchester, Orange, Nassau, Suffolk, and Erie) and all New Jersey HIDTA counties. In addition, DTG receives and reports data on drug overdose fatalities from Dutchess and Putnam counties in New York. DTG also receives data on **admissions to drug treatment** for all New York and New Jersey counties. This report presents analyses of drug treatment admissions data for four major categories of drugs: heroin, prescription opioids, cocaine/crack, and marijuana.

Unfortunately, significant gaps remain in the collection and reporting of drug use-related data across the NY/NJ HIDTA region. Given the lack of comprehensive, timely, and accurate data on key indicators such as drug overdose deaths, non-fatal drug overdoses (as captured by Emergency Department, EMS, and hospital data), drug use within the criminal justice population, and self-reported drug use, among others, it is not possible to draw definitive conclusions about current trends in abuse in every NY/NJ HIDTA county. Nonetheless, the following analyses of the available data do inform our understanding and response to the problem.

Available data and information from law enforcement sources indicate that the top drug threats within the NY/NJ HIDTA region are as follows:

Ranking	New York	New Jersey
1	Heroin	Heroin
2	Pharmaceuticals	Pharmaceuticals
3	Cocaine	Cocaine
4	Marijuana	Synthetics
5	Crack	

Overview of Drug Trends

Heroin

Available data and information from law enforcement and public health sources show heroin to be the primary drug threat within the NY/NJ HIDTA. Negative public health and public safety consequences resulting from the distribution and abuse of heroin in the region have increased in recent years. Public health indicators, including drug overdose deaths and drug treatment admissions, suggest recent increases in heroin abuse in many HIDTA counties. The price of heroin in the region is dropping even as purity is increasing. New York City (NYC) and multiple urban centers of New Jersey have long served as distribution hubs for the northeastern United States and will continue to do so as demand for heroin grows throughout the region.

Controlled Prescription Drugs (CPDs)

The threat posed by the misuse of controlled prescription drugs (CPDs), particularly prescription opioids, increased substantially across the region in the past decade, as evidenced by increases in negative health outcomes and increased diversion and availability. However, many NY/NJ HIDTA counties have recently experienced a leveling off or decrease in prescription-opioid involved overdose deaths and admissions to drug treatment for prescription opioid abuse. Law enforcement reporting indicates that theft from pharmacies, doctors'/dentists' offices or hospitals are not a major source of diverted CPDs in the NY/NJ HIDTA region. Other forms of diversion – such as doctor shopping or criminal schemes involving corrupt prescribers, medical office workers, pharmacists, pharmacy employees, among others – likely account for a much larger proportion of CPDs in the illicit market.

Cocaine/Crack

Available law enforcement information and public health indicators suggest that cocaine/crack remains a persistent threat in New York and New Jersey, and that crack cocaine is the drug most commonly associated with violent crime. However, these data also indicate that the availability and abuse of both powder and crack cocaine have declined in recent years.

Marijuana

Availability and abuse of marijuana has remained stable in the NY/NJ HIDTA region in recent years. Since passage of legislation in 2010, three medical marijuana dispensaries have begun operating in New Jersey. New York State is currently considering policy options aimed at legalizing the use of marijuana for medical purposes.

Methamphetamine

There is a fairly low presence of methamphetamine in New York and New Jersey, largely concentrated in southern and northwestern areas of New Jersey and in sections of upstate New

York. Most clandestine domestic labs use the "one pot" method of production, and there is some limited presence of Mexican-produced crystal methamphetamine.

Other Illicit Drugs

MDMA has been encountered on a limited to moderate basis in New York. The availability and abuse of bath salts and synthetic marijuana in New York State rose considerably in 2012, but there seems to have been a substantial decrease in 2013.

Overview of Drug Overdose Deaths

New York

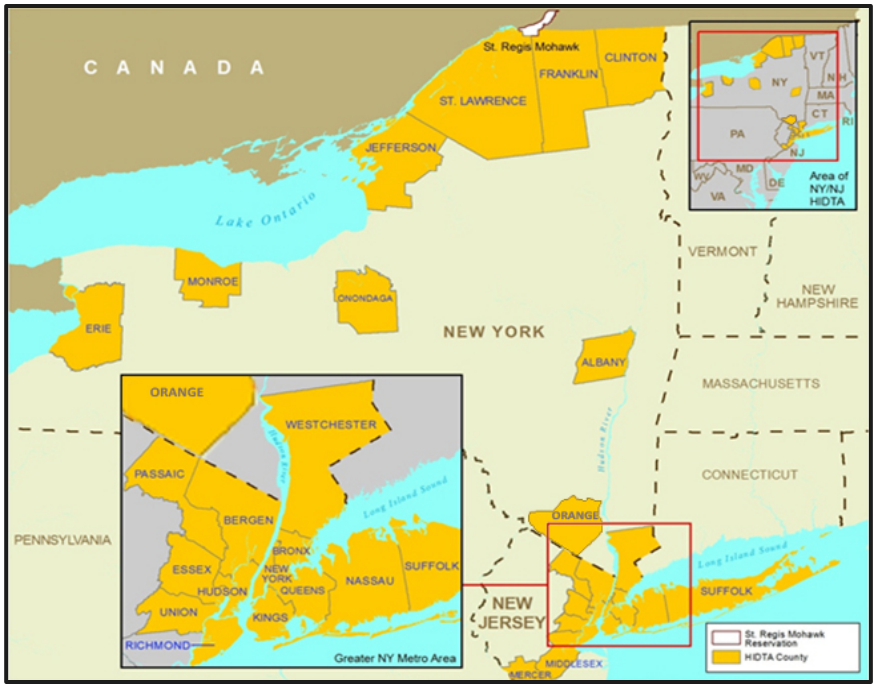
- Data from the NYC Department of Health and Mental Hygiene[1] show that from 2005 to 2012, the number of unintentional drug poisoning deaths decreased in **New York City** from 796 to 730, representing a 12 percent decrease in the age-adjusted rate from 12.4 to 10.9 deaths per 100,000 population. However, from 2010 to 2012 there was a 33 percent increase in the rate of unintentional drug poisoning deaths, from 8.2 per to 10.9 per 100,000 residents. Across years, nearly all deaths (98%) involved multiple substances.
- There were 64 drug overdose deaths reported in **Dutchess County** in 2013, an increase of more than 160 percent since 2009.[2]
- In **Westchester County**, drug overdose deaths more than doubled from 45 in 2010 to 94 in 2013.[3]
- Drug overdose deaths increased 23 percent in **Orange County**, from 56 in 2012 to 63 in 2013.[4] The average age of decedents decreased from 43 to 39, and the number of decedents under 30 years of age doubled, from 11 in 2012 to 22 in 2013.
- In **Putnam County**, a total of 12 overdose deaths were reported in 2013, down from 20 in 2012.[5] Between 2010 and 2013, the year with the highest number overdose deaths and youngest average age of decedents in Putnam County was 2012.
- In **Suffolk County** the number of total overdose deaths decreased ten percent from 247 in 2012 to 223 in 2013. [6]
- Drug-involved overdose deaths increased 32 percent in **Erie County,** from 105 in 2012 to 139 in 2013.[7]

New Jersey

- According to data from the NJ State Department of Health,[8] there were 1,111 accidental overdose deaths in New Jersey in 2012, a 21 percent increase from 2011 and a 50 percent increase from 2004. Preliminary data from 2013 indicates the total number of accidental overdose deaths has further increased since 2012, in part driven by an increase in deaths involving both heroin and prescription opioids.

About the NY/NJ HIDTA

The New York City (NYC) metropolitan area, which consists of the New Jersey, Long Island and lower Hudson Valley HIDTA counties in addition to the New York City counties, is an epicenter for diverse drug trafficking and money laundering organizations and one of country's largest drug consumption areas in the country. NYC and surrounding areas serve as a hub for the importation and disbursement of narcotics from, and to, innumerable cities, states, and countries. Both New York and New Jersey have major interstate highways, roadways, airports, seaports, and other infrastructure capable of accommodating voluminous amounts of passenger and cargo traffic from all over the United States and the world. Numerous secondary drug markets also exist in the New York/New Jersey HIDTA region, including Albany, Buffalo, Rochester, and Syracuse in New York, and Camden, Elizabeth, Jersey City, Newark, Paterson, and Trenton in New Jersey. The region shares a 445-mile border with Canada; 10 official ports of entry (POEs) are located along this border.



The NY/NJ HIDTA has identified a plethora of drug trafficking organizations (DTOs) and money laundering organizations (MLOs) operating at all levels throughout the region. Colombian and Dominican trafficking groups have, historically, controlled the transportation and wholesale distribution of heroin and cocaine to the area. These groups resell to other DTOs, such as African American street gangs. Mexican DTOs continue to make inroads into the NYC metropolitan area, reflecting a national trend.

The New York/New Jersey HIDTA (NY/NJ HIDTA) is comprised of 17 counties in New York and 7 counties in New Jersey. The 17 New York counties include Albany, Clinton, Erie, Franklin, Jefferson, Monroe, Nassau, Onondaga, Orange, St. Lawrence, Suffolk, Westchester and the five counties of New York City – Bronx, Kings, New York, Queens, and Richmond. The seven New Jersey counties are Bergen, Essex, Hudson, Mercer, Middlesex, Passaic and Union. The Executive Board has reviewed the threats of each of the HIDTA designated counties and has affirmed the statutory criteria for HIDTA designation for each county.

III. DRUG TRENDS

This report presents and analyzes available data, from both law enforcement and public health sources, on drug distribution and abuse trends in the New York/New Jersey HIDTA region. Law enforcement sources include drug intelligence reports, drug investigations, and drug threat survey responses from numerous federal, state, and local law enforcement agencies (Appendix A & Appendix B). Reporting from law enforcement sources indicates that the top drug threats within the NY/NJ HIDTA region are as follows:

Ranking	New York	New Jersey
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HEROIN

Available data and information from law enforcement cite heroin as the top drug threat in both New York and New Jersey. Public health indicators, including data on drug overdose deaths and drug treatment admissions, show recent increases in the adverse health consequences of heroin abuse in both states.

Trafficking and Distribution (Heroin)

Survey responses from numerous federal, state, and local law enforcement agencies ranked heroin as the top drug threat in both New York and New Jersey.

Distribution Hubs:

New York City (NYC) and numerous urban areas of New Jersey, such as Newark, Paterson, Trenton, and Camden, serve as major heroin distribution centers and are home to significant heroin markets. Heroin originating in NYC and Newark has been identified by law enforcement

in various locations throughout upstate New York and New England. The Albany area also functions as a major regional distribution hub, with individuals traveling from neighboring states including Vermont, Massachusetts, as well as rural areas of northern New York to purchase heroin. Some police departments also report heroin source areas to be Syracuse, Connecticut, Massachusetts, and Rhode Island. According to the Federal-wide Drug Seizure System, in 2013, eight percent of the federal heroin seizures in the U.S. occurred in New York State (Appendix A).[9] Recent reports indicate that close to 35 percent of the heroin seized by the Drug Enforcement Administration (DEA) nationwide since October 2013 was confiscated by agents in New York State.[10] Newark, with its close proximity to New York wholesale markets, maintains its status as the heroin distribution hub for northern and north central New Jersey. In 2013, the city of Paterson, located in Passaic County, was found to be gaining ground on Newark in its reputation as a hub for heroin distribution for Northern New Jersey and upstate New York and Pennsylvania. This trend has been attributed to a rise in violent crime in Newark, including shootings and carjackings. Intelligence suggests that due to Newark's reputation for violence and volatility buyers are looking to Paterson as a safer source of supply for all illicit substances. Camden, with its close proximity to Philadelphia wholesale markets, is considered the distribution hub for far south, southeast, and southwest New Jersey.

Price/Purity:

Heroin purity in New York and New Jersey remains among the nation's highest. Purity has been increasing as prices have been decreasing. Heroin seizures in New Jersey have an average street level purity of 50 percent with some seizures reaching as high as 80 percent purity.[11] In NYC, heroin seizures from October 1, 2012 to September 30, 2013 had an average purity of 41.3 percent, with some exhibits testing as high as 92 percent.[12] Higher purity increases the ability for users to get high from snorting, thereby reducing the need for users to inject. Since the stigma associated with injecting is considered a barrier to heroin use for some individuals, higher purity can contribute to increased heroin initiation. Given its relatively low price, heroin can offer an attractive alternative to prescription opioids. Prices and purity vary depending on the geographic region where the heroin is marketed, with purity levels dropping and prices rising the further the distance from the primary distribution hubs. In NYC, a bag sells for $5-$20, whereas in the rest of New York State, a bag can sell for up to $50 (Appendix B). As reported in previous years, heroin continues to be packaged in glassine bags and stamped with "brand names." However, there have been recent reports of some dealers forgoing the use of stamps altogether.[13] This trend may represent an attempt by dealers to lower the risk of being associated with and prosecuted for an overdose death, or may be a result of high heroin demand reducing the need for "marketing."

Source(s)/Type of Heroin:

South American heroin is the predominant type found in the Northeast region. Colombia is the primary source country for South American heroin found in the New York metropolitan area, as well as in upstate New York areas and surrounding states. Within the last year, Mexican heroin (both black tar and brown powder) have been found in the New York Division's area of responsibility (AOR), but not on a consistent basis.

Drug Trafficking Organizations:

Colombian and Dominican Drug Trafficking Organizations (DTOs) are prominent in the transportation and distribution of heroin into and within the NYC area. Trafficking is also by Mexican and Puerto Rican traffickers. Local wholesale distribution includes Colombian, Dominican, Puerto Rican, and New York City based traffickers. Colombian, Dominican and independent traffickers distribute at the retail level. In the Albany area, Hispanic and African American street gangs are the primary groups involved in all levels of the local heroin trafficking trade.

Heroin DTOs in urban areas of New Jersey are primarily comprised of African Americans who are often affiliated with a street gang. Trafficking territory is determined by the strength of a particular gang's presence and the availability of secure stash and sales locations, such as public housing buildings. Inner city DTOs have typically purchased heroin wholesale from Dominican or Colombian sources of supply originating in New York City. Traditionally, most of the heroin sold on the streets of New Jersey is packaged into retail sale size packets outside of the state. In northern New Jersey, New York City serves as the source of pre-stamped and pre-packaged heroin. In the southern part of the state, the majority of pre-packaged heroin comes from Camden, Trenton, and Newark, New Jersey, Philadelphia, Pennsylvania, and New York, New York. However, several recent investigations have revealed heroin-packaging operations in Newark and several other cities in the northern part of the state. Even though historically heroin "mill" operations in New Jersey were the exception, their numbers appear to be growing.

These same DTOs have also shown interest in transporting product to western markets in Pennsylvania, southern New Jersey and upstate New York, where they can triple their prices. These DTOs establish a presence in these areas by arranging residences for organization members in these locations to coordinate sales and delivery of supply.

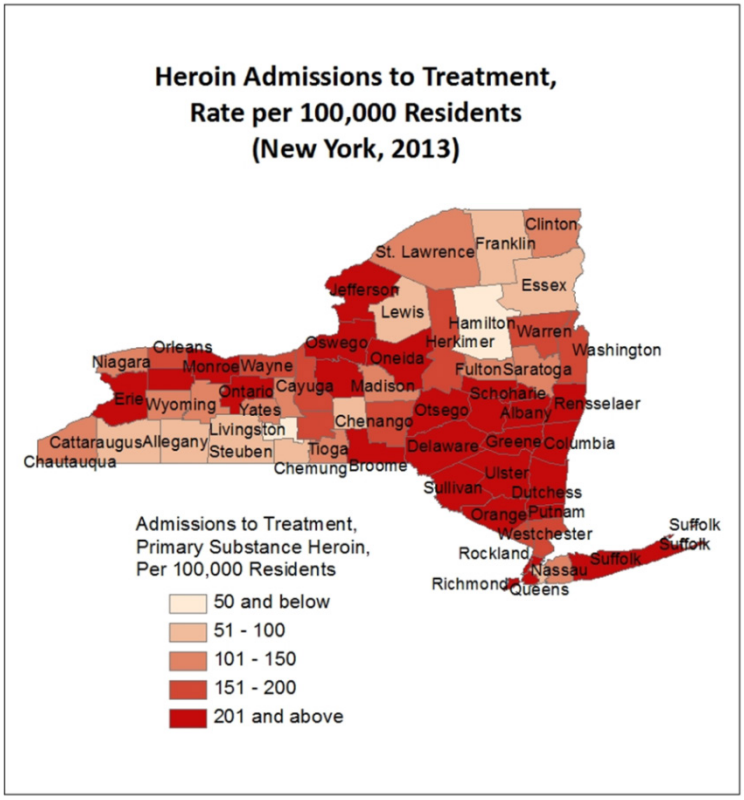
DTOs of all levels (wholesale, retail and street level) transport heroin via passenger vehicles and body carriers. Larger quantities of heroin have been found concealed in commercial vehicles and on couriers traveling via commercial airline.

Trends in Abuse: Heroin

Overdose Deaths[14] & Treatment Admissions

New York

Reporting on drug overdose deaths in New York State is limited. Due in part to differences in reporting across counties, timely and accurate statewide data on heroin-related drug overdose deaths is not currently available. However, detailed data is available on a county or regional level in certain areas within the state. Data is not currently available for the following HIDTA counties: Albany, Erie, Jefferson, St. Lawrence, Franklin, or Clinton. Of the NY HIDTA counties for which heroin overdose death data is available (Westchester, Orange, Nassau, Suffolk, Monroe, Onondaga, and all NYC counties), there have been increases in heroin-involved overdose deaths within the most recent year of reporting for every county except Orange County. In many of these counties these increases began in 2010.



In New York State as a whole, admissions to drug treatment involving heroin as the primary drug of abuse were 25 percent higher in 2013 than in 2007.[15] Heroin admissions increased nine percent from 2007 to 2009, followed by a decrease of ten percent from 2009 to 2011. Heroin admissions then increased 26 percent from 36,794 in 2011 to 46,490 in 2013. Heroin accounted for 34 percent of statewide drug treatment admissions in 2013. The proportion of heroin admissions under 35 years of age increased from 32 percent in 2007 to 50 percent in 2013. Statewide, 36 percent of heroin admissions in New York State were self-referrals; the remaining admissions consisted of referrals from other chemical dependency programs (24 percent), the criminal justice system (19 percent), health care/social services (7 percent), chemical dependency prevention/intervention (3 percent), and other (11 percent).

Most NY HIDTA Counties experienced increases in admissions to drug treatment citing heroin as the primary drug of abuse. From 2007 to 2013, heroin admissions to treatment have notably

increased in Richmond, Suffolk, Westchester, Orange, Albany, Erie, Onondaga, Franklin, Jefferson, and St. Lawrence Counties. In Clinton County, heroin admissions increased from 2010 to 2013, and in Monroe and Nassau counties heroin admissions increased from 2011 to 2013. Heroin admissions in Kings and New York counties increased slightly from 2012 to 2013, and in Bronx and Queens Counties decreased from 2007 to 2013. Many of the NY HIDTA counties in which heroin admissions also experienced increases in the portion of younger individuals admitted.

New York City

The NYC Department of Health and Mental Hygiene[16] reports that in NYC from 2010 to 2012, the rate of unintentional drug poisoning deaths involving heroin increased 84 percent, from 3.1 to 5.7 per 100,000 residents. The number of heroin-involved deaths increased from 209 in 2010 to 382 in 2012. By comparison, the rate of heroin-involved deaths in NYC was 5.9 per 100,000 in 2000 and rose to 6.9 by 2003. The rate then declined by almost 50 percent between 2006 and 2010, dropping from 6.1 to 3.1 per 100,000, before rising again in 2011 and 2012. The percentage of total unintentional drug poisoning deaths involving heroin in NYC also increased, rising from 39 percent in 2010 to 52 percent in 2012. In 2012, heroin was involved in more deaths than any other single drug (including cocaine, opioid analgesics, benzodiazepines, or methadone). Between 2010 and 2012, the rate of heroin-involved accidental overdose deaths based on county of residence increased 191 percent in Staten Island (from 3.5 to 10.2), 54 percent in the Bronx (5.7 to 8.8), 56 percent in Brooklyn (2.7 to 4.2), 260 percent in Manhattan (1.5 to 5.4), and 47 percent in Queens (1.9 to 2.8). In 2012, the rate of heroin-involved accidental overdose deaths of residents per 100,000 residents was the highest in Staten Island (10.2), followed by the Bronx (8.8).

Admissions to treatment of NYC residents citing heroin as the primary drug of abuse decreased 18 percent from 2007 to 2011, followed by a slight (3 percent) increase from 2011 to 2013. In 2013, there were 21,722 heroin admissions, accounting for 38 percent of total drug admissions in NYC. Of the five boroughs, the Bronx had the highest rate of heroin treatment admissions (459 per 100,000 residents) in 2013, followed by Staten Island (328), Manhattan (311), Brooklyn (247), and Queens (97). The Bronx had the highest rate of heroin admissions out of any county in the state in 2013, whereas Queens ranked 52nd out of all 62 counties in the state. Despite this persistently high rate, heroin admissions in the Bronx actually decreased 21 percent from 8,205 in 2007 to 6,509 in 2013. In Brooklyn, heroin admissions increased 16 percent from 2007 to 2010, followed by a 26 percent decline from 2010 to 2012. In 2013, there were 6,390 heroin admissions to treatment in Brooklyn, up 2 percent from 2012. Heroin admissions in Manhattan decreased 20 percent from 6,320 in 2007 to 5,050 in 2013, despite a 3 percent increase from 2012 to 2013. Heroin admissions to treatment in Queens decreased 33 percent from 3,312 in 2007 to 2,225 in 2013. Staten Island was the only borough to experience a net increase in heroin admissions from 2007 to 2013. Heroin admissions in Staten Island increased 83 percent from

844 in 2007 to 1,548 in 2013. The percentage of heroin admissions in NYC under 25 years of age increased from 3 percent in 2007 to 7 percent in 2013. The percentage of admissions over 45 years of age also increased, from 41 percent in 2007 to 49 percent in 2013, while the percentage of admissions aged 25 through 34 stayed stable and the percentage of admissions aged 35 through 44 decreased from 39 percent in 2007 to 26 percent in 2013. In 2013, 44 percent of admissions to heroin treatment in NYC were self-referrals. The next most common sources of referral for heroin treatment in NYC in 2013 were other chemical dependency programs (19 percent) and the criminal justice system (14 percent).

Hudson Valley

Drug overdose death information from the **Westchester County** Medical Examiner[17] shows a 115 percent increase in deaths involving heroin (including heroin metabolites),[18] from 20 in 2010 to 43 in 2013. Almost half (46 percent) of the 94 accidental drug overdose deaths in Westchester County in 2013 involved heroin. The percentage of total accidental overdose deaths involving heroin remained relatively stable between 2010 and 2013, fluctuating between 44 and 47 percent each year. Westchester is experiencing an increase in heroin-involved deaths among a younger population. The number of heroin-involved overdose decedents under 30 years of age increased more than fivefold, from three in 2010 to 16 in 2013. Over the same time period, the percentage of total drug overdose decedents under 30 years of age increased from 22 percent to 31 percent. Admissions to treatment citing heroin as the primary drug of abuse in Westchester County increased 54 percent from 1,215 in 2007 to 1,877 in 2013. In 2013, heroin admissions to treatment in Westchester County outnumbered admissions for cocaine/crack and prescription opioids combined. The proportion of heroin admissions to treatment 34 years of age or younger increased substantially from 27 percent in 2007 to 45 percent in 2012. There were 194 heroin admissions to treatment per 100,000 residents in Westchester County in 2013, placing Westchester 30th out of all 62 counties in the state in heroin admissions per 100,000 residents.

Data reported by the **Orange County** Medical Examiner[19] indicate that drug overdose deaths involving heroin (including heroin metabolites)[20] decreased slightly from 2012 to 2013, from 33 to 27, respectively. However, heroin continues to be involved in a large proportion of deaths (43 percent in 2013). Admissions to treatment citing heroin as the primary drug of abuse in Orange County more than doubled (119 percent increase) from 603 in 2007 to 1,323 in 2013. In 2013, heroin accounted for 45 percent of drug treatment admissions in Orange County, up from 23 percent in 2007. The proportion of heroin admissions 34 years or younger increased from 65 percent in 2007 to 73 percent in 2013. The rate of treatment admissions per 100,000 residents in 2013 in Orange County was the fifth highest out of all counties in the state, with 352 heroin admissions per 100,000 residents.

According to data reported by the **Dutchess County** Medical Examiner,[21] there were 64 drug overdose deaths in Dutchess County in 2013. Heroin-involved deaths (including heroin

metabolites)[22] decreased from 2009 through 2011, followed by a 130 percent increase from 2011 to 2013 (13 in 2011 and 30 in 2013). This increase in heroin-involved deaths has occurred as deaths involving prescription opioids appear to be leveling off. In 2013, heroin-involved deaths surpassed the number of prescription opioid-involved deaths. Heroin was involved in almost half (47 percent) of all drug overdose deaths in 2013. Increasingly, deaths involving heroin are occurring among a younger population. The number of heroin-involved deaths of individuals under 30 years of age increased from four in 2009 to 14 in 2013.

Information supplied by the **Putnam County** Medical Examiner[23] indicates that overdose deaths declined or remained the same in each major drug category, including heroin, from 2010 to 2013. Heroin-involved deaths (including heroin metabolites)[24] decreased from ten in 2012 to six in 2013. Heroin was involved in half of the overdose deaths in Putnam County in 2013.

Long Island

According to figures provided by the **Nassau County** Medical Examiner,[25] deaths in Nassau County where heroin was listed in the cause of death increased over 90 percent from 23 in 2010 to 44 in 2013. Heroin-involved overdose deaths had previously increased at a similar rate, from 24 in 2004 to 46 in 2008, then declined to 23 in 2010 before the latest increase. Admissions to treatment involving heroin as the primary drug of abuse in Nassau County increased 69 percent between 2011 and 2013. In 2013, there were 1,883 heroin admissions, composing 30 percent of total drug treatment admissions in Nassau County, and more than double the amount of cocaine/crack treatment admissions. Out of all heroin admissions in Nassau County, the percentage under 35 years of age increased from 51 percent in 2007 to 78 percent in 2013. In 2013, Nassau ranked 41st out of the 62 New York counties in the rate of heroin admissions to treatment (139 per 100,000 residents).

Heroin-involved deaths (including heroin metabolites)[26] in neighboring **Suffolk County** increased 16 percent from 90 in 2012 to 104 in 2013, according to data from the Suffolk County Medical Examiner.[27] In 2013, heroin was involved in almost half (47 percent) of overdose deaths in Suffolk County, outnumbering any other drug. In Suffolk County, admissions to treatment involving heroin as the primary drug of abuse increased 112 percent, from 2,076 in 2007 to 4,396 in 2013. In 2013, heroin admissions accounted for 41 percent of total drug treatment admissions in Suffolk County, up from 23 percent in 2007. In 2007, cocaine/crack admissions to treatment outnumbered heroin admissions, whereas in 2013, heroin admissions were almost triple the number of cocaine/crack admissions. As in Nassau County, the proportion of heroin admissions under 35 years of age increased from 2007 to 2013. In 2007, 69 percent of heroin admissions in Nassau County were under 35 years of age, and by 2013 this number was 84 percent. In 2013, there were 293 heroin admissions to treatment per 100,000 residents in Suffolk County, as the ninth highest rate in New York State.

Western/Central New York

In **Erie County**, heroin admissions increased 77 percent over six years, rising from 1,069 admissions in 2007 to 1,888 admissions in 2013, accounting for 26 percent of all admissions to drug treatment programs in Erie County. Of these 1,888 admissions in 2013, there were 40 percent between 25 and 34 years of age, 34 percent under 25 years old, 14 percent between 35 and 44 years of age, and eleven percent over 45 years old. In 2013, there were 205 heroin treatment admissions in Erie County per 100,000 residents, placing Erie 27th out of the 62 counties in the state in rate of heroin treatment admissions.

The **Monroe County** Medical Examiner's Office[28] reported on heroin-involved overdose deaths that occurred in seven counties across Western New York—**Monroe, Livingston, Chemung, Ontario, Orleans, Steuben, and Wyoming**. According to the Medical Examiner's Office figures, heroin was involved in 65 deaths across these seven counties in 2013, a 124 percent increase from 29 in 2012, and an almost 500 percent increase from 11 in 2011. In Monroe County specifically, drug treatment program admissions citing heroin as the primary drug of abuse decreased slightly (four percent) from 2007 to 2010, remained stable between 2010 and 2011, then substantially increased by 84 percent from 990 in 2011 to 1,822 in 2013. The proportion of heroin admissions under 35 years of age increased from 52 percent in 2007 to 65 percent in 2013. Of the heroin admissions in 2013, there were 39 percent between 25 and 34 years of age, 26 percent under 25 years old, 18 percent between 35 and 44 years of age, and 17 percent over 45 years old. These age breakdowns were generally consistent with those in Erie County in 2013. There were 243 heroin treatment admissions in Monroe County in 2013 per 100,000 residents, placing Monroe 18th out of the 62 counties in the state in rate of heroin treatment admissions.

According to the **Onondaga County** Medical Examiner's Office,[29] overdose deaths attributable to heroin increased substantially from one in 2010 to at least 27 in 2013. Treatment admissions citing heroin as the primary drug of abuse in Onondaga County increased each year between 2007 and 2013, ultimately increasing 211 percent from 563 admissions in 2007 to 1,753 in 2013. Thirty-eight percent of drug treatment admissions in Onondaga County in 2013 cited heroin as the primary drug of abuse. The proportion of heroin admissions in Onondaga County under 35 years of age increased from 58 percent in 2007 to 74 percent in 2013. Onondaga County had the third highest rate of heroin admissions to treatment in 2013 out of all 62 counties in the state, with 374 heroin admissions per 100,000 residents.

Capital Region

In **Albany County**, admissions to drug treatment programs citing heroin as the primary drug of abuse increased every year between 2007 and 2013. Over these six years there was an 132 percent increase from 361 in 2007 to 837 in 2013, while total drug treatment admissions

increased only eleven percent. In Albany County heroin admissions accounted for 14 percent of all drug treatment admissions in 2007 and 29 percent in 2013. Of all heroin admissions to treatment in Albany County, the proportion under 35 years of age increased from 45 percent in 2007 to 59 percent in 2013. In 2013, Albany had the 12th highest rate of heroin treatment admissions out of all 62 counties in the state, with a rate of 273 heroin admissions per 100,000 residents.

Northern Border

In the Northern Border region (including Clinton, Franklin, Jefferson, and St. Lawrence Counties) admissions to drug treatment programs citing heroin as the primary drug of abuse increased 227 percent from 182 in 2007 to 596 in 2013. In comparison, between 2007 and 2013 there was a 65 percent increase in the number of treatment program admissions for all drugs in the Northern Border region. In 2007 heroin accounted for ten percent of all treatment admissions, whereas in 2013 heroin accounted for 20 percent of treatment admissions. Of the 596 heroin admissions in the Northern Border region in 2013, 48 percent were between 25 and 34 years old and 40 percent were younger than 25, while ten percent were between 35 and 44 years old and only three percent were 45 and older. The rate of heroin admissions per 100,000 residents in 2013 was 137 in Clinton County, 68 in Franklin County, 237 in Jefferson County, and 148 in St. Lawrence County.

In **Clinton County** treatment admissions citing heroin as the primary drug of abuse increased 238 percent from 33 in 2010 to 112 in 2013. Heroin treatment admissions accounted for 11 percent of drug treatment admissions in 2007 and 18 percent in 2013.

In **Franklin County**, treatment admissions citing heroin as the primary drug of abuse increased from 5 in 2007 to 35 in 2013. Heroin accounted for two percent of all drug treatment program admissions in 2007 and nine percent of all admissions in 2013.

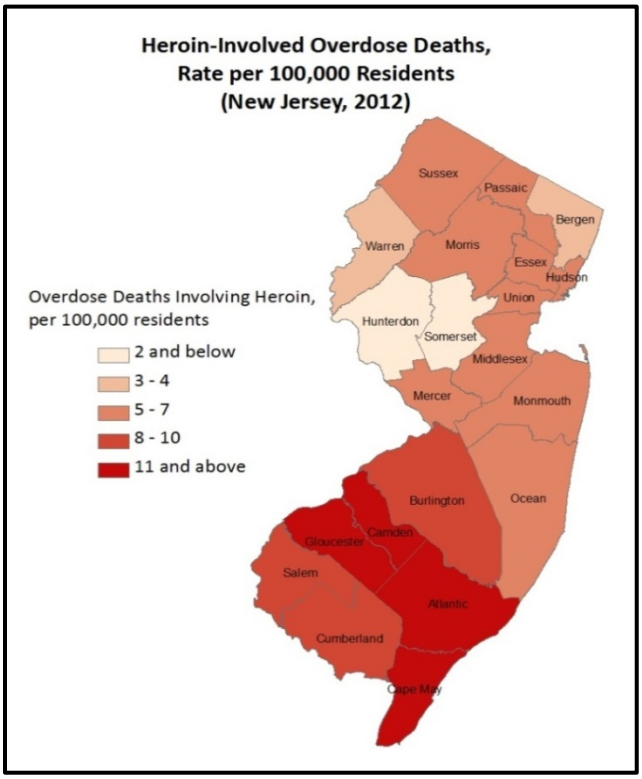
In **Jefferson County** there was a 200 percent increase in drug treatment program admissions citing heroin as the primary drug of abuse from 95 admissions in 2007 to 284 admissions in 2013. Heroin accounted for 18 percent of all drug treatment program admissions in 2007 and 34 percent of all admissions in 2013.

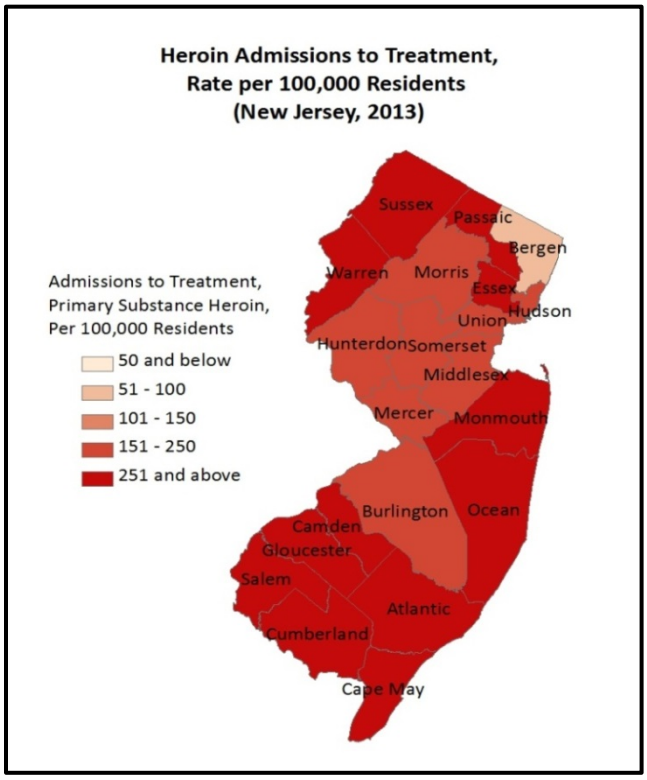
In **St. Lawrence County** there was a 403 percent increase in admissions to drug treatment programs citing heroin as the primary drug of abuse from 33 admissions in 2007 to 166 admissions in 2013. Over these six years, heroin accounted for an increasing percentage of all drug treatment program admissions in the county, increasing from six percent in 2007 to 16 percent in 2013.

New Jersey

According to data provided by the New Jersey Department of Health,[30] heroin was involved in over 50 percent of overdose deaths statewide in 2012 (579 out of 1,111). This represents a 36 percent increase in heroin-involved deaths since 2011 and a 60 percent increase since 2004. Of the 579 heroin-involved overdose deaths in 2012, 35 percent also involved prescription opioids, 15 percent also involved cocaine, and 12 percent involved both cocaine and prescription opioids in addition to heroin. The NJ counties with the highest numbers of overdose deaths involving heroin in 2012 were Camden (83), Middlesex (48), Essex (46), and Ocean (42). Based on the rate per 100,000 residents, the counties with the highest rate of heroin-involved overdose deaths in 2012 were Camden (16.2), Cape May (14.5), Gloucester (11.7), and Atlantic (11.6).

According to data provided by the NJ Substance Abuse Monitoring System,[31] the rate of admissions to drug treatment programs with heroin as the primary drug of abuse has increased 18.6 percent, from 247 admissions per 100,000 residents in 2010 to 293 admissions per 100,000 residents in 2013. The share of total drug admissions (excluding alcohol) in NJ that cited heroin as the primary drug of abuse also increased, from 47 percent in 2010 to 52 percent in 2013. The five counties with the highest rates of heroin treatment admissions per 100,000 residents in 2013 were Cape May (861), Atlantic (651), Ocean (501), Gloucester (466), and Sussex (439), the first four of which match the order of the counties with the highest rates of prescription opioid treatment admissions in 2013.

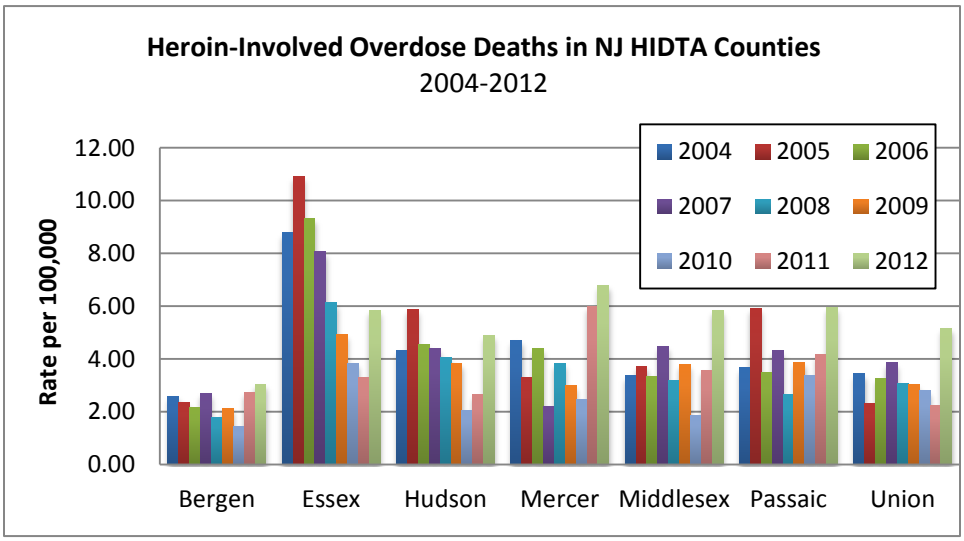




New Jersey HIDTA Counties

Each of the seven NJ HIDTA counties experienced an increase in heroin-involved deaths from 2011 to 2012. In five of the seven NJ HIDTA counties (all but Union and Essex), this increase began in 2010. Out of the years for which data is available (2004–2012), heroin deaths were highest in 2012 in five of the seven HIDTA counties (all but Essex and Hudson). In the seven NJ HIDTA counties combined, heroin treatment admissions decreased 12 percent from 2009 to 2013, and heroin admissions accounted for approximately half of total drug treatment admissions (excluding alcohol) for each year between 2009 and 2013. Between 2009 and 2013, heroin admissions to treatment increased in Bergen, Hudson, Mercer and Middlesex, whereas heroin admissions decreased in Essex, Passaic and Union. From 2012 to 2013, heroin treatment admissions remained relatively stable in four of the NJ HIDTA counties (Bergen, Hudson, Passaic, and Union), increased in Mercer and Middlesex, and decreased in Essex.

In **Bergen County**, 28 of the 62 accidental overdose deaths in 2012 involved heroin, a 115 percent increase from 13 deaths in 2010. Twelve of the 28 overdose deaths involving heroin in 2012 also involved prescription opioids. Heroin was involved in 44 percent of overdose deaths in 2012, less than prescription-opioid involved deaths (56 percent), but more than cocaine involved deaths (16 percent). The county had the lowest rate of drug treatment program admissions for heroin abuse per 100,000 residents in New Jersey every year from 2009 to 2013. Heroin treatment admissions in Bergen County increased 17 percent from 2009 to 2013, despite a 3 percent decline from 2012 to 2013.



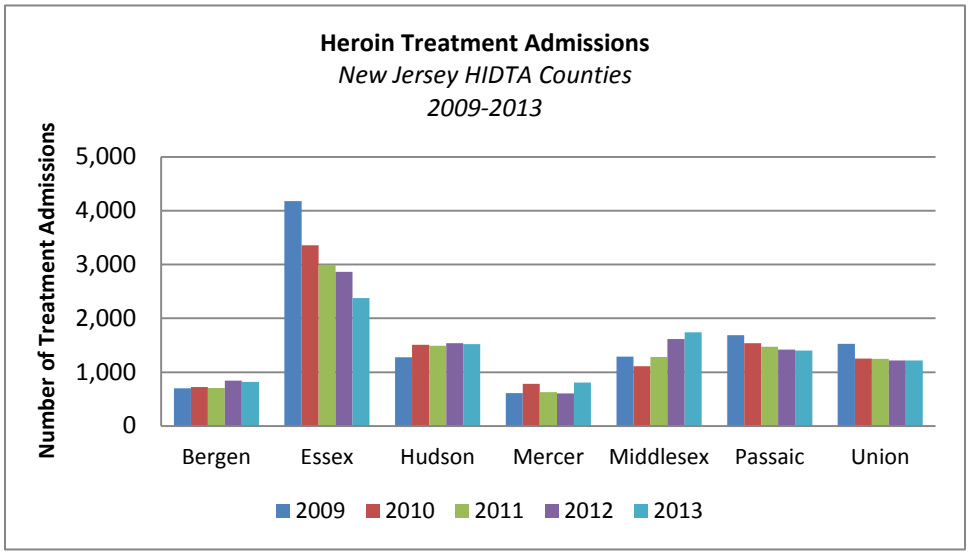
Ninety-three overdose deaths occurred in **Essex County** in 2012, of which 46 (49 percent) involved heroin. By comparison, prescription opioids were involved in 51 percent of deaths, and cocaine in 46 percent of deaths in Essex in 2012. Heroin-involved deaths steadily declined from 85 in 2005 to 26 in 2011, a drop of 70 percent, then increased 77 percent between 2011 and 2012. Drug treatment admissions for heroin in Essex County decreased 43 percent from 4,180 admissions in 2009 to 2,375 admissions in 2013. Despite this decrease, Essex County had the highest rate of admissions in 2013 (301 per 100,000 residents) for heroin abuse treatment as

compared with the other six NJ HIDTA counties and the tenth highest rate of all counties in New Jersey.

In **Hudson County**, of the 64 overdose deaths that occurred in 2012, 32 (50 percent) involved heroin, outnumbering overdose deaths involving prescription opioids (47 percent) and those involving cocaine (22 percent). The number of overdose deaths involving heroin decreased steadily between 2005 and 2010, dropping from 35 to 13, and then increased by almost 150 percent between 2010 and 2012, to a level comparable with 2005. Heroin treatment program admissions in Hudson County increased 18 percent from 2009 to 2010, then from 2010 and 2013 have consistently been around 1,500 heroin admissions each year (rate of between 230 and 243 admissions per 100,000 residents).

In **Mercer County**, 64 percent of overdose deaths (25 out of 39) in 2012 involved heroin. By comparison, prescription opioids were involved in 79 percent of deaths, and cocaine in 28 percent. Of the 25 overdose deaths involving heroin in 2012, 23 also involved prescription opioids. Heroin admissions to treatment in Mercer County increased 33 percent between 2012 and 2013, from 607 to 806.

Heroin-involved overdose deaths in **Middlesex County** more than tripled from 15 in 2010 to 48 in 2012. Heroin was involved in over half of the 95 overdose deaths in 2012. Prescription opioids were also involved in over half of all deaths for that year. For the years 2004 through 2012, 2012 was the year with the highest number of heroin-involved overdose deaths and highest overall number of overdose deaths in Middlesex. For the years 2004 through 2012, the lowest number of heroin-involved deaths (15) occurred in 2010. Heroin treatment admissions in Middlesex County steadily rose between 2010 and 2013, ultimately increasing 57 percent over the three years.



In **Passaic County**, there were 30 overdose deaths involving heroin in 2012, up from 21 in 2011 and 17 in 2010. Heroin was involved in 57 percent of overdose deaths in Passaic County in 2012, more than prescription opioids (51 percent) or cocaine (30 percent). In 2005, there were 29 heroin-involved deaths in the county, but that number declined to 13 in 2008, before rising to 30

in 2012. The number of drug treatment admissions for heroin abuse in Passaic County decreased every year between 2009 and 2013. The rate of admissions per 100,000 residents also decreased over this time period, falling from 23 percent from 343 admissions per 100,000 residents in 2009 to 278 admissions per 100,000 residents in 2013. Nonetheless, in 2013, Passaic County had the second highest rate of admissions per 100,000 residents of all NJ HIDTA counties.

Heroin-involved overdose deaths in **Union County** more than doubled from 12 in 2011 to 28 in 2012. Of the 42 total overdose deaths in 2012 in Union County, 67 percent involved heroin, 43 percent involved prescription opioids and 24 percent involved cocaine. By comparison, in 2005 heroin was involved in 36 percent of deaths, prescription opioids in 48 percent, and cocaine in 64 percent. For the years 2004 through 2012, 2012 was the year with the highest number of heroin-involved overdose deaths in Union. The number of drug treatment admissions for heroin abuse in Union County remained consistent, between 2010 and 2013, decreasing only three percent. However heroin treatment admissions in Union County in 2013 were 21 percent lower than in 2009.

Fentanyl

In early 2014, a rash of fatal and non-fatal heroin overdoses were reported in **New Jersey** and surrounding states, reaching north to Massachusetts and south to Maryland. In some cases, reports indicated that the overdoses were caused by heroin cut with fentanyl, while other reports cited pure fentanyl (with no heroin present) as the substance in question. Several of the affected jurisdictions reported that the tainted heroin/fentanyl may have originated in northern New Jersey. Due to the recent timing of these incidents, the sources of supply for the heroin/fentanyl have not yet been verified and the majority of lab analysis reports regarding the presence of fentanyl are still pending. In the wake of a concerning rise in overdoses, the New Jersey Regional Operations Intelligence Center (ROIC) has created a Drug Monitoring Initiative (DMI) and related task force to identify incidents, collect data and investigate suspect heroin/fentanyl trafficking in a more organized manner resulting in more timely information sharing.

In **New York State**, the upstate regions have been hit hardest with overdoses involving fentanyl. Western New York, in particular, has experienced a recent increase in the availability of clandestinely manufactured fentanyl and fentanyl analogues distributed in the area in powder form and mixed with heroin.

Erie County, which includes the city of Buffalo, reports a substantial increase in fentanyl-involved overdose deaths in the last year. According to the Erie County Medical Examiner, there were 32 deaths identified as involving fentanyl, up from seven such deaths reported in 2012.[32] In 2013, fentanyl was identified as involved in 23 percent of the 139 total chemical intoxication deaths in Erie County. Many of the fentanyl-involved deaths also involved heroin or cocaine.

From 2009 to 2012, there were between one and three overdose deaths involving fentanyl per year in **Dutchess County**[33]. In 2013, seven fentanyl-involved deaths occurred in Dutchess County, all within the last two months of the year. In **Westchester County**[34] , eight accidental drug overdose deaths involving fentanyl were reported in Westchester County between 2010 and 2013, and four of these deaths occurred in 2013. The number of overdose deaths involving fentanyl in **Orange County**[35] increased from four in 2012 to ten in 2013. The majority of these deaths also involved either heroin or a benzodiazepine, and occurred in two clusters, in June 2013 and December 2013. In **Putnam County**,[36] three fentanyl involved deaths were reported from 2010 to 2013, with no more than one occurring in a single year.

In **Nassau County**,[37] deaths involving fentanyl increased from three in 2012 to 12 in 2013. In **Suffolk County**,[38] deaths involving fentanyl decreased from 20 in 2012 to 10 in 2013, despite increases in heroin-involved deaths from 2012 to 2013.

CONTROLLED PRESCRIPTION DRUGS (CPDS)

Law enforcement sources report that heroin has replaced controlled prescription drugs (CPDs) as the most serious drug threat in the region. Nonetheless, the diversion and abuse of CPDs remains a serious concern.

Diversion and Distribution (CPDs)

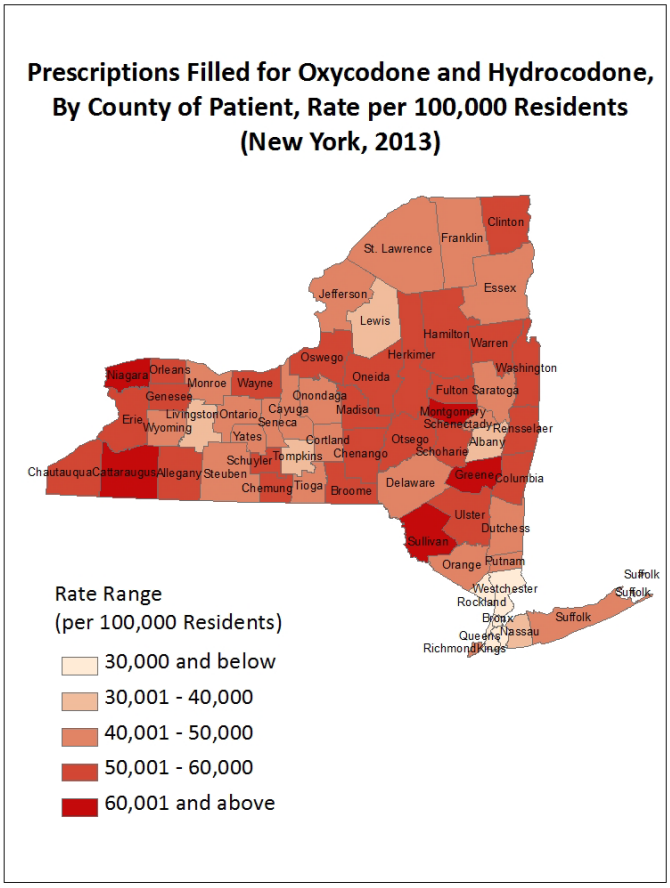
The distribution of controlled pharmaceuticals in New York and New Jersey remains somewhat disorganized and as of yet cannot be attributed to any one specific type of organization. Forged or stolen prescriptions, doctor shopping, internet orders, and diversion of CPDs from doctors/pharmacies are common methods of obtaining CPDs.

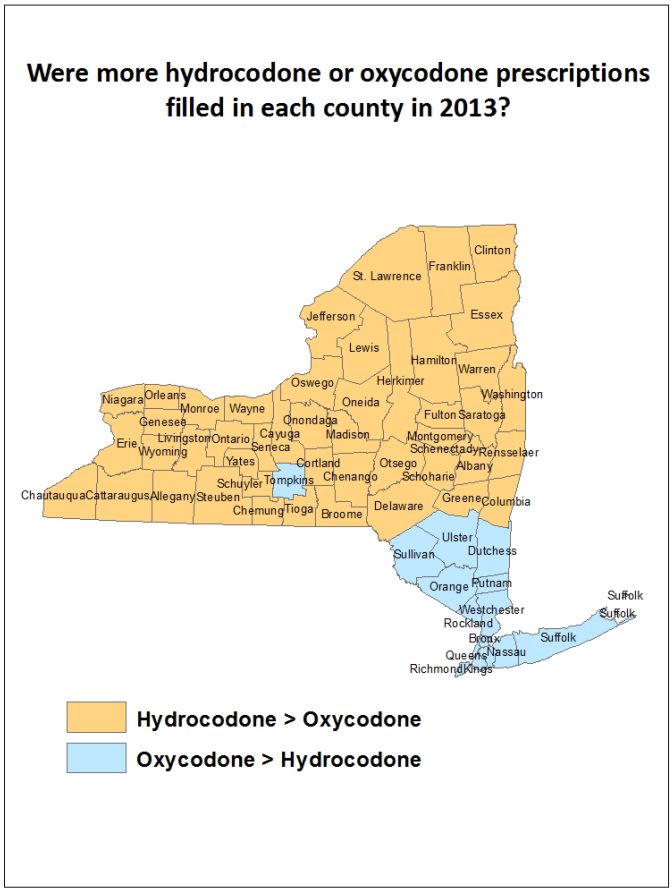
Areas in which agencies reported CPDs as still widely abused included Albany County, Cattaraugus County, Madison County, Erie County, and Tioga County. In the Albany area, hydrocodone was reported by law enforcement to be particularly prevalent. In Madison and Erie counties, agencies reported a substantial increase in the use/abuse of CPDs, particularly opiate-based painkillers and anti-anxiety medications, but also remarked that more of the abusers are switching to heroin. Reports from Tioga County reveal that CPDs are the most abused drug in the area with the brands most frequently abused being Hydrocodone, OxyContin®, Percocet, and Vicodin. In Cattaraugus County, Suboxone, morphine, and fentanyl were reported as having a significant presence, as well as Opana® as an alternative to OxyContin®. Opana® is reported to be most popular among abusers in the cities of Olean and Salamanca in Cattaraugus County. CPDs users in Cattaraugus County are often supplied by dealers (who are also gang members) from the City of Buffalo. Street gang members from the City of Buffalo previously traveled to the area to sell crack and now have switched to CPDs. Some of the gangs operating in the area are the Bloods, the Lombard, Rother, Gibson, and Playter Streets (LRGP), and the Bailey Boys. Anecdotal information from an agency in the Rochester area indicated a rise in abuse of CPDs by former US military personnel being treated at local Veterans Administration hospitals. Additionally heroin dealers in the Rochester area accept CPDs as payment for heroin purchases.

Trends in Prescriptions Filled

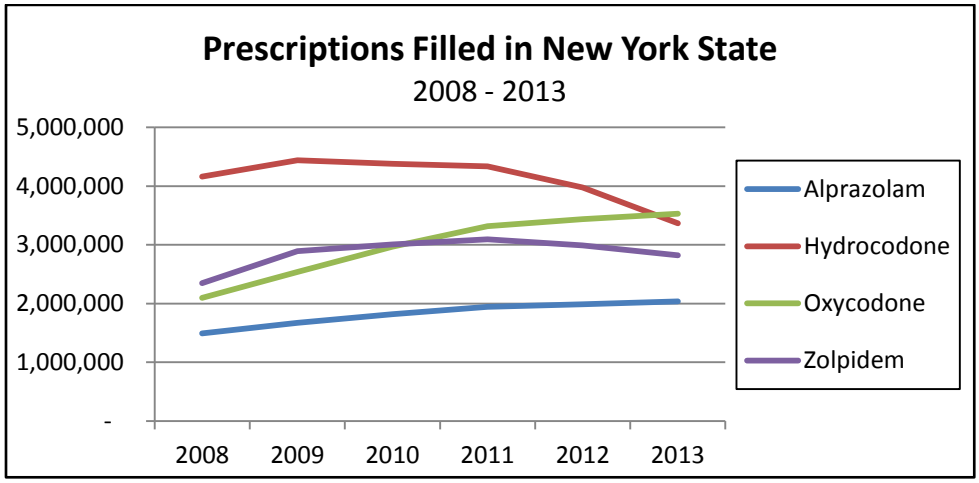
New York State

According to data provided by the New York State Bureau of Narcotics Enforcement,[39] patients across New York State filled approximately 3.5 million oxycodone (e.g., OxyContin®) prescriptions and almost 3.4 million hydrocodone (e.g., Vicodin®) prescriptions in 2013. More prescriptions were filled for oxycodone than any other drug in the state in 2013. Between 2008 and 2013, oxycodone prescriptions increased 68 percent, while hydrocodone prescriptions decreased 19 percent. From 2012 to 2013, oxycodone prescriptions increased three percent, a smaller increase than during the previous four years. Hydrocodone prescriptions decreased 15 percent from 2012 to 2013. The counties with the highest combined rates of hydrocodone and oxycodone prescriptions per 100,000 residents in 2013 were Montgomery, Greene, Sullivan, Niagara, and Cattaraugus, all with rates above 60,000. As shown on the map below, oxycodone is prescribed more than hydrocodone in NYC and the Hudson Valley, whereas hydrocodone is prescribed more than oxycodone in the rest of the state (with the only exception being Tompkins County).

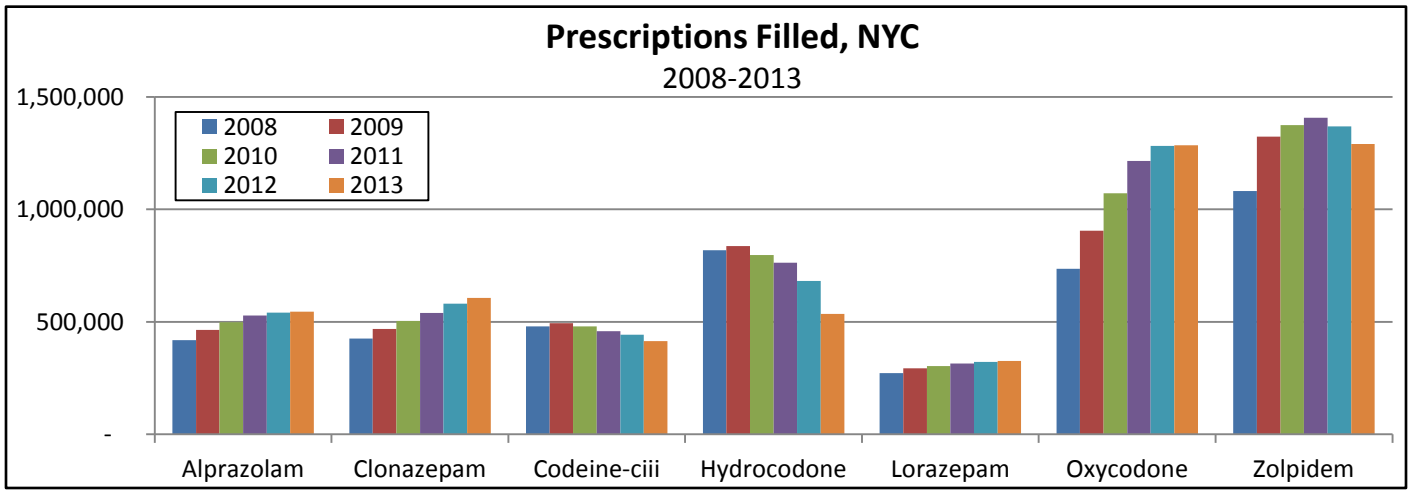




Prescriptions filled for zolpidem (e.g., Ambien®) increased 32 percent statewide from 2008 through 2011, then decreased nine percent from 2011 to 2013. Prescriptions filled for Alprazolam (e.g., Xanax®) increased each year from 2008 to 2013, rising 37 percent in total across the five years.



Prescriptions for oxycodone and hydrocodone followed similar trends in **New York City** as in the rest of the state. Oxycodone prescriptions increased 75 percent from 736,334 in 2008 to 1,282,002 in 2012, then rose by less than one percent to 1,285,918 in 2013. Hydrocodone prescriptions decreased 35 percent from 818,467 in 2008 to 682,460 in 2012, and then declined another 22 percent 535,314 in 2013. The most substantial increase in oxycodone prescriptions occurred among residents of the Bronx, where oxycodone prescriptions almost doubled (99 percent increase). Oxycodone prescriptions in Staten Island actually decreased 3.5 percent from 2011 to 2013. The most substantial decrease in hydrocodone prescriptions occurred among residents of Staten Island, with a 43 percent decrease from 2008 to 2013. As occurred statewide, prescriptions for zolpidem in each of the NYC boroughs peaked in 2011, followed by a decline from 2012 and 2013. In 2013, zolpidem prescriptions in Manhattan and Brooklyn were higher



than prescriptions for any other CPD, unlike in every other NY HIDTA county in 2013, where either oxycodone or hydrocodone was the most frequently filled CPD. In NYC from 2008 to 2013, prescriptions filled for alprazolam increased 30 percent, while clonazepam prescriptions rose by 42 percent and lorazepam by 19 percent; however the increases were smaller between 2012 and 2013 for each of these substances than for the previous four years. Prescriptions for Codeine-ciii decreased 14 percent citywide from 2008 to 2013. Amphetamine prescriptions increased 109 percent from 2009 to 2013 in Brooklyn, 92 percent from 2008 to 2013 in Manhattan, and 16 percent from 2012 to 2013 in Queens.

On Long Island, trends in top ten CPD prescriptions filled were similar in Nassau and Suffolk counties. From 2008 to 2013, oxycodone prescriptions increased 54 percent in **Nassau County** and 64 percent in **Suffolk County**, while hydrocodone prescriptions decreased 37 percent in Nassau County and 39 percent in Suffolk County during the same period. Oxycodone surpassed hydrocodone in the number of prescriptions filled in 2010 in Nassau County and in 2011 in Suffolk County. In 2013, oxycodone was the most frequently filled CPD in both counties, with 282,237 in Nassau and 425,305 in Suffolk. Comparatively, in 2013 172,064 prescriptions were filled for hydrocodone by Nassau County residents, and 284,474 were filled by Suffolk County residents. Zolpidem prescriptions peaked in 2011 in both counties, followed by decreases in 2012 and 2013. From 2009 to 2013, prescriptions filled for amphetamine increased 55 percent in Nassau County and 79 percent in Suffolk County. Alprazolam prescriptions increased 31 percent from 2008 to 2013 in Nassau County and 38 percent in Suffolk County.

From 2008 to 2013, prescriptions for oxycodone increased 55 percent in **Westchester County** and 60 percent in **Orange County**, though from 2012 to 2013, the increases in each county slowed to two percent and less than 1 percent, respectively. Oxycodone prescriptions are the most frequently filled CPD prescriptions in both counties, with 170,418 prescriptions filled in Westchester County and 102,164 filled in Orange County in 2013. The second most frequently filled prescription for a CPD in Westchester County in 2013 was zolpidem, whereas in Orange County it was hydrocodone. Prescriptions for hydrocodone decreased 29 percent in Westchester County and 32 percent in Orange County from 2008 to 2013. Mirroring the statewide trend, zolpidem prescriptions in both counties peaked in 2011, followed by declines. From 2008 to 2013, prescriptions for alprazolam increased 32 percent in Westchester County and 48 percent in Orange County. In 2013, the number of prescriptions filled for Clonazepam (e.g., Klonopin®) in Westchester County was essentially the same as those filled for alprazolam. In Orange County, the number of prescriptions filled for alprazolam was 80 percent higher than for clonazepam.

From 2008 to 2013 prescriptions filled for oxycodone increased 51 percent in **Erie County** and 61 percent in **Monroe County**, while hydrocodone prescriptions decreased 5 percent and 13 percent, respectively. Despite these trends, hydrocodone remained the most frequently filled CPD in both counties, and oxycodone was the second most frequently filled. In Erie County in

2013, 388,706 prescriptions were filled for hydrocodone, compared to 111,263 for oxycodone. In Monroe County in 2013, 181,172 prescriptions were filled for hydrocodone, compared to 142,190 for oxycodone. In both counties, zolpidem prescriptions peaked in 2011, then decreased 8 percent in Erie County and 13 percent in Monroe County over the next two years. From 2008 to 2013 in Monroe County, prescriptions filled for amphetamine (e.g., Adderall®) increased 115 percent and prescriptions filled for methylphenidate (e.g., Ritalin®) increased 37 percent. Hydrocodone prescriptions in **Onondaga County** peaked in 2011, followed by a 20 percent decrease from 2011 to 2013. Oxycodone prescriptions increased 68 percent from 2008 to 2013, but increased at a slower rate from 2012 to 2013 (four percent increase) than the previous four years. Hydrocodone remains the most frequently filled CPD in the county, with 134,351 prescriptions filled in 2013, compared to 83,990 for oxycodone (the second most frequently filled). From 2008 to 2013, amphetamine prescriptions increased 93 percent, methylphenidate prescriptions increased 30 percent, and alprazolam prescriptions increased 43 percent.

In **Albany County**, prescriptions for zolpidem peaked in 2012, then declined 8 percent from 2012 to 2013. Prescriptions for oxycodone increased 114 percent from 2008 to 2013, and hydrocodone prescriptions decreased 14 percent over the same time period. Hydrocodone remained the most frequently filled CPD in the county in 2013 (134,351 prescriptions filled), compared to the second most frequently filled, oxycodone (83,990 prescriptions filled). From 2008 to 2013, amphetamine prescriptions increased 117 percent and alprazolam prescriptions increased 45 percent.

Across all four HIDTA counties composing the Northern Border region (**Clinton, Franklin, Jefferson, and St. Lawrence**), zolpidem and hydrocodone prescriptions both peaked in 2011. From 2011 to 2013, zolpidem prescriptions in the four counties combined decreased 12 percent, but were still 103 percent higher in 2013 than in 2008. From 2011 to 2013, hydrocodone prescriptions decreased 18 percent, but were still 23 percent higher in 2013 than in 2008. Oxycodone prescriptions in the Northern Border counties increased 79 percent from 2008 to 2013. There were 99,437 prescriptions filled for hydrocodone in the Northern Border region in 2013, compared to 70,227 prescriptions filled for oxycodone, placing hydrocodone as most frequently filled CPD in the region in 2013.

I-STOP

In response to diversion and misuse of controlled prescription drugs, Governor Andrew Cuomo signed the I-STOP act into law in 2012, enhancing the statewide Prescription Monitoring Program (PMP). I-STOP requires prescribers to check their patients' prescription histories through PMP when writing prescriptions for Schedule II, III, and IV controlled substances. When such prescriptions are dispensed, pharmacists are required to enter this information into PMP. These requirements went into effect on August 27, 2013.

Rx Crimes Database & DEA 106 Reports

The Rx Crimes database tracks robberies, burglaries, attempted robberies, and attempted burglaries of controlled prescription drugs from pharmacies, doctors'/dentists' offices and hospitals in New York and New Jersey. Created in 2012, Rx Crimes collects information on these incidents in order to assist federal, state and local law enforcement partners in identifying crime patterns and emerging trends. The information contained in the database is entered and managed by NY/NJ HIDTA Drug Intelligence Officers in partnership with the DEA New York and New Jersey Divisions, the NYPD, and other participating law enforcement agencies in the region.

New York State

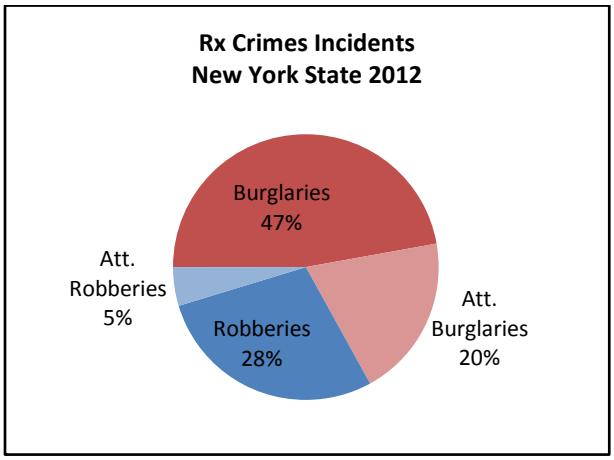
In New York State, there were a total of 190 incidents reported to Rx Crimes during the period January 1, 2012 through December 31, 2013. Of these, 70 percent were burglaries or attempted burglaries, while 30 percent were robberies or attempted robberies. Of the total reported robberies during this period (57), more than 60 percent involved a weapon (36), while the other 40 percent (21) included incidents where the suspect presented a note, issued a verbal threat or simulated a weapon. Of the 133 burglaries reported in 2012 and 2013, the most common method of entry (*modus operandi*) was rear break-in (32 percent), followed by front break-in (22 percent), window entry (17 percent), and roof entry (15 percent), through a wall (8 percent), and through a side door (5 percent). All 77 of the robberies reported to Rx Crimes for New York State in 2012 and 2013 targeted pharmacies. Of the 133 burglaries, 122 (92 percent) targeted pharmacies, while 10 burglaries (8 percent) targeted other locations (doctor's office, dentists' office or hospital). Nine of the ten burglaries that targeted doctor's and dentists' offices occurred in 2013.

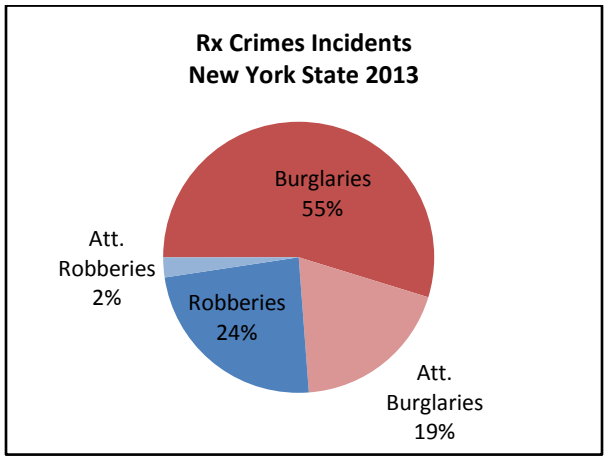
Incident Type	New York State*		New York City*	
	2012	2013	2012	2013
Robbery	35	22	15	3
Burglary	71	62	22	41
Total Incidents	106	84	37	44

**Includes attempted burglaries and robberies where controlled prescription drugs appear to have been the intended target.*

Between 2012 and 2013, there was a slight decline in the number of reported burglaries (including attempts) in NYS, from 71 to 62. The number of reported robberies also declined from 35 in 2012 to 22 in 2013. Bronx County had the highest number of Rx Crimes incidents reported (28) out of all NYS counties for the time period January 1, 2012 through December 31, 2013 (24 burglaries and four robberies). New York City counties (excluding Richmond County) accounted for four of the five counties with the most Rx Crimes incidents during this time

period. There were 21 incidents each in Kings County (16 burglaries and five robberies) and Nassau County (16 burglaries and five robberies) followed by Queens County (14 burglaries and three robberies), New York County (eight burglaries and six robberies), Erie County (six burglaries and seven robberies) Orange County (eight burglaries), and Suffolk County (four burglaries and four robberies). A full breakdown of burglaries, attempted burglaries, robberies, and attempted robberies by county in New York State in 2012 and 2013 is available in Appendix E.



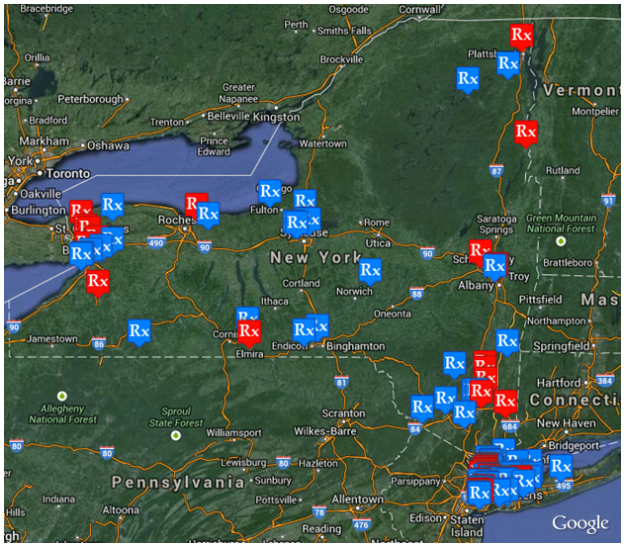


In both 2012 and 2013, **New York City** had the highest density of Rx Crimes incidents of all regions in New York State. There were 18 robberies (including attempts) reported in NYC in 2012 and 2013 combined, accounting for almost one-third of all robberies reported in NYS (57). The 63 burglaries (including attempts) reported in NYC during this time accounted for almost half of all burglaries reported in NYS (133). Between 2012 and 2013, burglaries in NYC reported to Rx Crimes increased nearly twofold, from 22 to 41, while reported robberies dropped from 15 to three.

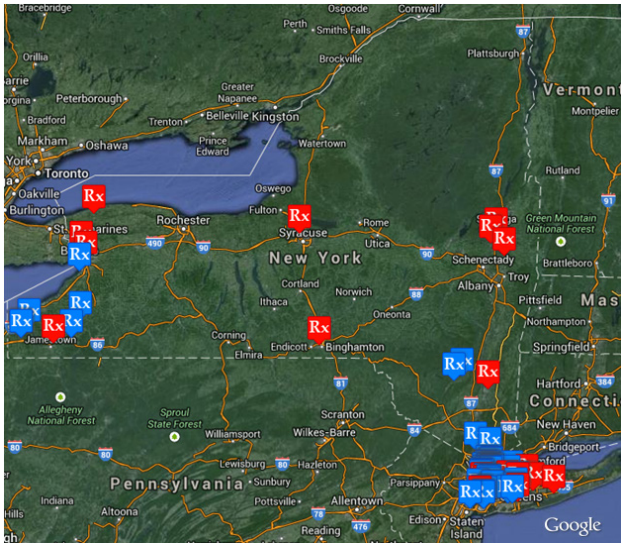
New York City*				
	Burglaries		**Robberies**	
	2012	**2013**	**2012**	**2013**
Bronx	8	16	4	0
Kings	8	8	4	1
New York	0	8	5	1
Queens	6	8	2	1
Richmond	0	1	0	0
Total	**22**	**41**	**15**	**3**

**Includes attempted burglaries and robberies where controlled prescription drugs appear to have been the intended target.*

Rx Crimes Incidents
New York State
2012



Rx Crimes Incidents
New York State
2013



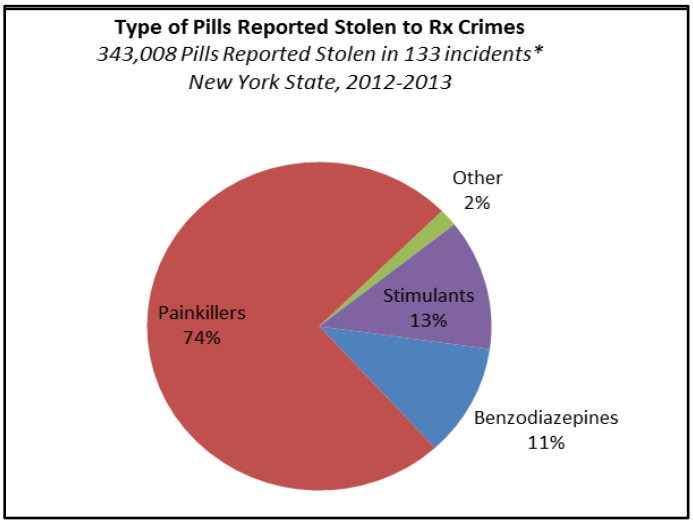
Rx = Burglaries
Rx = Robberies

A burglary ring is alleged to have been responsible for at least 37 of the 63 burglaries and attempted burglaries of pharmacies in Bronx, Kings, New York, and Queens Counties reported to Rx Crimes in 2012 and 2013. Members of the ring frequently entered pharmacies through ceilings, walls, window bars, and doors, often disabling burglar alarms and surveillance cameras. The burglary ring targeted schedule II controlled substances including oxycodone, amphetamine, morphine, hydromorphone, methadone, and oxymorphone as well as non-scheduled substances including Cialis, Viagra, and AIDS medications (Non-scheduled substances are not tracked in Rx Crimes). The crime ring accounted for close to 60 percent of burglaries reported to Rx Crimes in NYC in 2012 and 2013.

Burglaries doubled in Bronx County between 2012 and 2013, increasing from eight to 16. At least ten of the burglaries in Bronx County in 2013 were attributed to the burglary ring while seven in 2012 were attributed to the ring. In New York County there was also an increase in burglaries, from zero in 2012 to eight in 2013 (three of which were attempted). Of the five successful burglaries in New York County in 2013, the burglary ring was alleged to be responsible for at least four of them.

Pills Reported Stolen (NY)

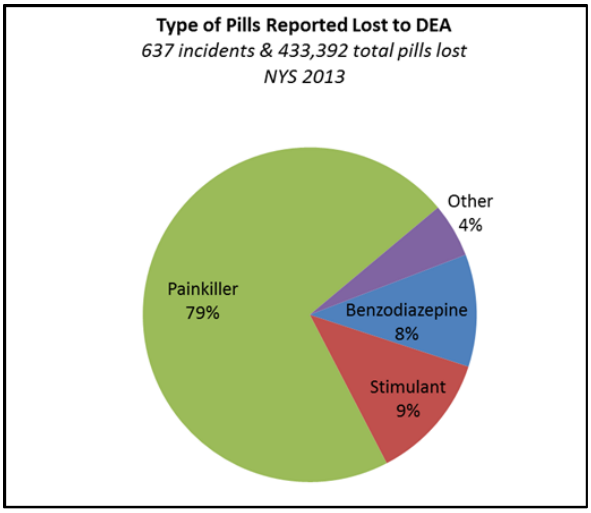
In 2012 and 2013 in New York State, there were 54 robberies and 79 burglaries where CPDs were reported stolen in the Rx Crimes database.[40] In these 133 incidents, a total of 343,008 pills were reported stolen. Of the total, 74 percent were reported to be prescription painkillers. Eighty-nine percent of the total were reported stolen via burglary and 11 percent were reported stolen via robbery. Of the 28,640 prescription painkiller pills stolen via robbery, 56 percent (15,951 pills) were oxycodone (including oxycodone compounds), 24 percent (6,726 pills) were hydrocodone, and ten percent (2,917 pills) were oxymorphone. Of the 226,394 prescription painkiller pills stolen via burglary, 58 percent (131,373 pills) were oxycodone, 24 percent (54,531 pills) were hydrocodone, and five percent (11,598 pills) were morphine.

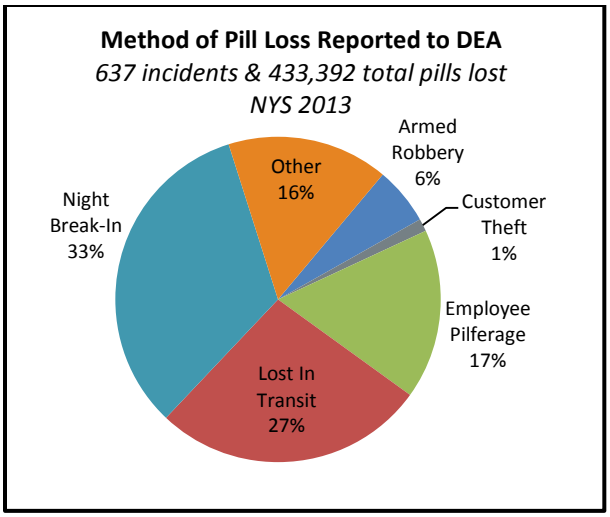


**Pill counts from robberies and burglaries are estimates based on reporting to Rx Crimes and actual numbers may be higher.*

106 Reports (NY)

The DEA also collects information on theft and loss of CPDs using loss reports (known as DEA 106 reports) filed by DEA registrants. The 106 reports contain information on CPD loss via customer theft, employee pilferage, pills lost in transit and other methods of loss in addition to the night break-ins and armed robberies tracked in Rx Crimes. This data collection complements the information gathered in Rx Crimes. In 2013, there were 637 incidents in which CPDs were reported stolen via 106 loss reports. A total of 433,392 pills were reported stolen in these incidents. Thirty-three percent of these pills (143,163) were stolen via night break-in, more than any other method tracked by DEA loss reports, and six percent (24,781 pills) were stolen via armed robbery.





Based on reporting from both Rx Crimes and DEA 106 loss report forms, it does not appear that robberies and burglaries of pharmacies, doctors'/dentists' offices or hospitals are a major source of diverted CPDs in New York State at this time. It is likely that other forms of diversion – such as doctor shopping or criminal schemes involving corrupt prescribers, medical office workers, pharmacists, pharmacy employees, among others – account for a much larger proportion of CPDs in the illicit market. Nonetheless, it is important to continue to monitor these types of crimes, both as a means of prevention and in the event they become more significant methods of CPD diversion.

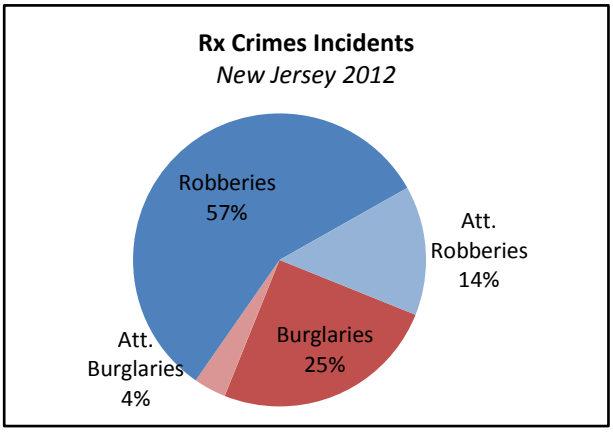
New Jersey

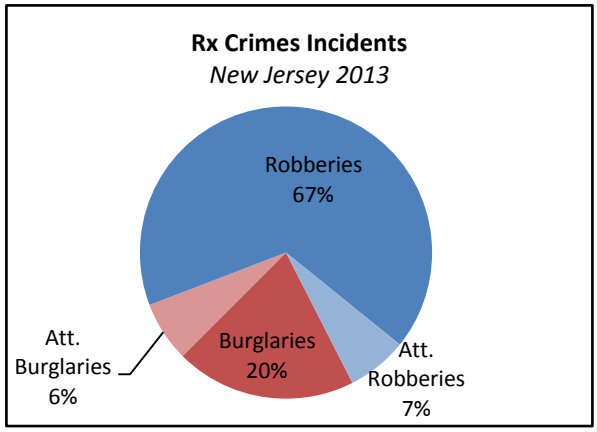
In New Jersey, there were a total of 58 incidents reported to Rx Crimes during the period January 1, 2012 through December 31, 2013. Of these, 28 percent were burglaries or attempted burglaries, while 72 percent were robberies or attempted robberies. More than 57 percent of the total reported robberies during this period (42) involved a weapon, while the other 43 percent included incidents where the suspect presented a note, issued a verbal threat or simulated a weapon. Of the 16 burglaries reported to Rx Crimes in 2012 and 2013, the most common methods of entry (*modus operandi*) were front break-in (31 percent), rear break-in (31 percent), window entry (25 percent), roof entry (six percent), and side door entry (six percent). All 42 robberies and 16 burglaries reported to Rx Crimes in NJ in 2012 and 2013 targeted pharmacies.

Incident Type	New Jersey*	
	2012	2013
Robbery	20	22
Burglary	8	8
Total Incidents	28	30

**Includes attempted burglaries and robberies where controlled prescription drugs appear to have been the intended target.*

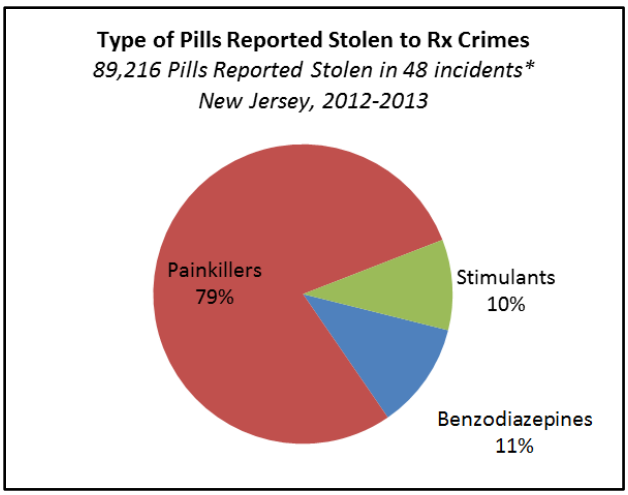
Between 2012 and 2013, there was a slight increase in the number of reported robberies (including attempts) in NJ, from 20 to 22, while the number of reported burglaries in NJ remained consistent (8 each year). For 2012 and 2013 combined, Monmouth County had the highest number of reported Rx Crimes incidents of all counties in New Jersey. There were 10 total incidents reported in Monmouth in total (six robberies and four burglaries), accounting for 17 percent of all incidents reported to Rx Crimes in NJ. There were nine incidents in Essex County (two burglaries and seven robberies), six incidents in Somerset County (five burglaries and one robbery), five robberies in Atlantic County, and five robberies in Gloucester County. A full breakdown of burglaries, attempted burglaries, robberies, and attempted robberies by county in New Jersey in 2012 and 2013 is available in Appendix E.





Pills Reported Stolen (NJ)

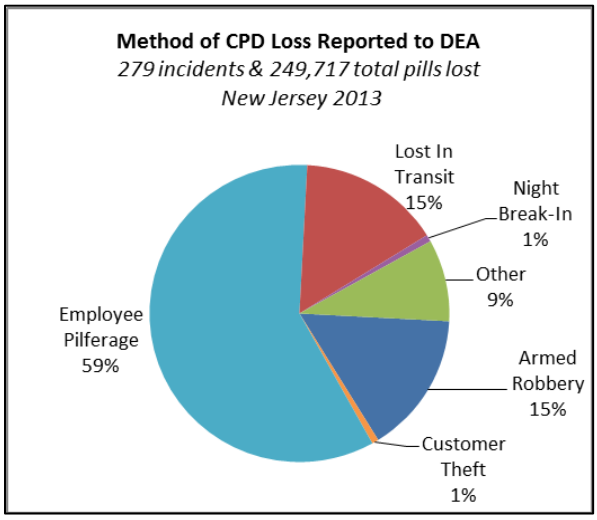
In 2012 and 2013 in New Jersey, there were 35 robberies and 11 burglaries in which CPDS were reported stolen in the Rx Crimes database.[41] In these 46 incidents, 88,135 pills were reported stolen. Fifty-seven percent of these pills were reported stolen via burglary and 43 percent of were reported stolen via robbery. Of the total pills reported stolen, 79 percent were prescription painkillers. Of the 33,196 prescription painkiller pills reported stolen via robbery in NJ, 95 percent (31,624 pills) were oxycodone (including oxycodone compounds), and 3 percent (1027 pills) were hydromorphone. No hydrocodone pills were reported stolen during a robbery in NJ in 2012 or 2013. In the burglaries where prescription painkiller pills were reported stolen, 72 percent (26,548 pills) were oxycodone (including oxycodone compounds), eight percent (3,132 pills) were morphine, eight percent (2,908 pills) were hydromorphone, and seven percent (1,680 pills) were hydrocodone. Overall, oxycodone was the painkiller most commonly targeted in robberies and burglaries in NJ in 2012 and 2013, accounting for 83 percent of all painkillers stolen.

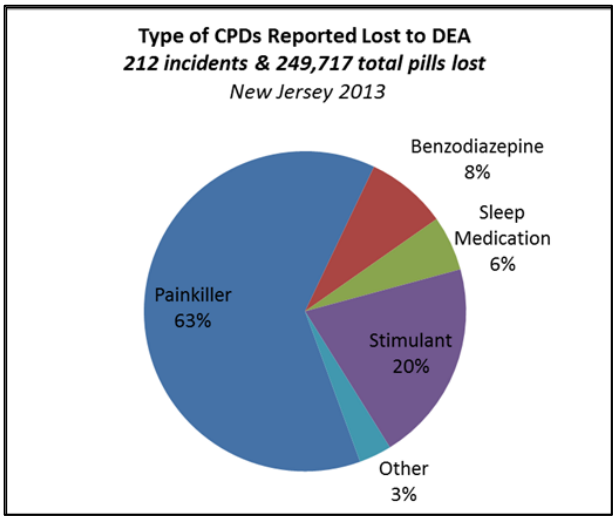


**Pill counts from robberies and burglaries are estimates based on reporting to Rx Crimes and actual numbers may be higher.*

106 Reports (NJ)

According to DEA 106 loss reports, employee pilferage was the dominant type of CPD pill diversion in New Jersey in 2013 as this constituted 59 percent of all pills reported stolen. Fifteen percent of all CPDs (in pill form) reported lost or stolen through DEA 106 reports were reported lost in transit. Armed robbery and night break-ins accounted for a small portion of pill loss, combining to account for 16 percent of all pills lost.





Based on reporting from both Rx Crimes and DEA 106 loss report forms, it does not appear that robberies and burglaries of pharmacies, doctors'/dentists' offices or hospitals are a major source of diverted CPDs in New Jersey at this time. Nonetheless, it is important to continue to monitor these types of crimes, both as a means of prevention and in the event they become more significant methods of CPD diversion.

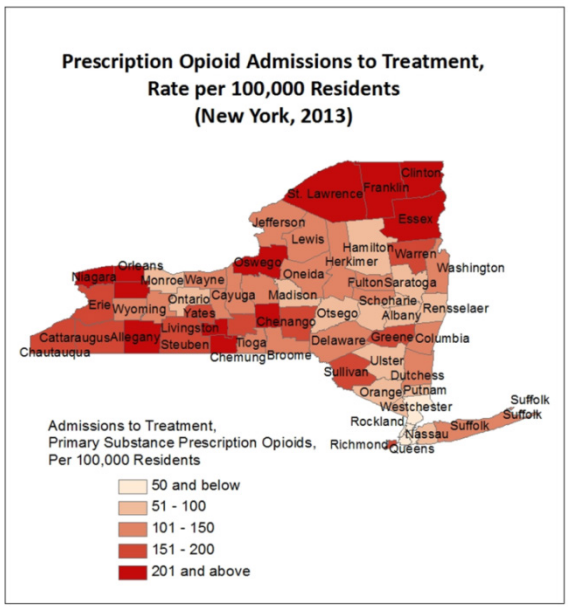
Trends in Misuse: CPDs

Overdose Deaths[42] & Treatment Admissions

New York State

Reporting on drug overdose deaths in New York State is limited. Due in part to differences in reporting across counties, timely and accurate statewide data on prescription opioid-related and benzodiazepine-related overdose deaths is not currently available. However, detailed data is available on a county or regional level in certain areas within the state. Data is not currently available for the following HIDTA counties: Albany, Onondaga, Monroe, Erie, Jefferson, St. Lawrence, Franklin, or Clinton. In the NY HIDTA counties for which data is available (Westchester, Orange, Nassau, Suffolk, and all NYC counties), deaths involving prescription opioids continue to occur at high levels, but have recently declined. Benzodiazepine-involved deaths remain at high levels in many of the counties for which data was available.

In New York State as a whole, admissions to treatment[43] citing prescription opioids as the primary drug of abuse increased 175 percent from 2007 to 2012, followed by an eight percent decrease from 2012 to 2013. In 2013, there were 16,363 prescription opioids admissions accounting for 12 percent of total treatment admissions in New York State, compared to 5 percent of total admissions in 2007. The proportion of prescription opioid admissions under 25 years of age increased from 28 percent in 2007 to 37 percent in 2011, then decreased to 29 percent by 2013. The most common referral source for prescription opioid admissions in 2013 was self-referral (29 percent), followed by the criminal justice referral (23 percent), other chemical dependency program referral (22 percent), a health care/social services referral (11 percent), chemical dependency prevention/intervention referral (3 percent), or other referral source (13 percent).



Admissions to treatment for prescription opioids remain at elevated levels in the NY HIDTA counties, though decreases were seen in prescription opioid treatment admissions from 2012 to 2013 in NYC and Long Island.

New York City

According to the NYC Department of Health and Mental Hygiene,[44] prescription opioids were involved in 28 percent of NYC unintentional drug poisoning deaths in 2012 (201 out of 730), up from 16 percent in 2005 (130 out of 796). The rate of prescription opioid-involved deaths rose by 65 percent between 2005 and 2011, from 2.0 per 100,000 (130 deaths) to 3.3 per 100,000 (220 deaths), before declining 10 percent in 2012. In 2012, prescription opioid-involved deaths of Staten Island residents occurred at a substantially higher rate than the other boroughs. The rate of prescription opioid-involved deaths on Staten Island was 10.0, followed by the Bronx (3.5), Manhattan (2.5), Brooklyn (2.1), and Queens (1.8). Benzodiazepines were involved in more than one-third (38 percent) of unintentional drug poisoning deaths in NYC in 2012 (278 out of 730), up from 24 percent in 2005 (192 out of 796). The rate increased by 40 percent from 3.0 in 2005 to 4.2 per 100,000 New Yorkers in 2012.

Admissions to treatment citing prescription opioids as the primary drug of abuse in NYC more than tripled (210 percent increase) from 2007 to 2012, followed by a 6 percent decrease from 2012 to 2013. In 2013, the 2,648 prescription opioid admissions accounted for 4.7 percent of all admissions to drug treatment in NYC. The highest rate of prescription opioid treatment admissions per 100,000 residents in 2013 was in Staten Island (179), substantially higher than Brooklyn (27), Manhattan (24), Queens (20), and the Bronx (19). Staten Island ranked 17th out of the 62 counties in the state in rate of treatment admissions per 100,000, whereas the other boroughs ranked 59th to 62nd. Staten Island also had the highest total number of prescription opioid treatment admissions in 2013, with 848 admissions. Prescription opioid admissions in Staten Island more than quadrupled (314 percent increase) from 2007 to 2012, followed by a 17 percent decrease from 2012 to 2013. Brooklyn and Queens showed similar trends of recent decreases after years of increase. In Brooklyn prescription opioid admissions increased 256 percent from 2007 to 2012, followed by a 5 percent decrease from 726 in 2012 to 691 in 2013. Prescription opioid admissions in Queens increased 141 percent from 2007 to 2011, followed by an eleven percent decrease from 501 in 2011 to 448 in 2013. From 2007 to 2013, prescription opioid admissions increased 158 percent in the Bronx (106 to 274) and 158 percent in Manhattan (150 to 387). The percentage of prescription opioid admissions in NYC aged 34 or under increased from 45 percent in 2007 to 66 percent in 2013. In 2013, 36 percent of admissions to treatment for prescription opioids in NYC were self-referrals. Other common categories of referral sources in 2013 in NYC were other chemical dependency programs (19 percent), criminal justice (18 percent), and health care/social services (10 percent).

Hudson Valley

Drug overdose deaths involving prescription opioids in **Westchester County**[45] increased 85 percent from 26 in 2010 to 48 in 2013. However, the percentage of total accidental drug overdose deaths involving prescription opioids has decreased, from 2010 (58 percent) to 2013 (51 percent). Overdose deaths involving benzodiazepines or zolpidem in Westchester County increased 130 percent from 16 in 2010 to 37 in 2013. All 37 of the deaths involving a benzodiazepine or zolpidem in 2013 also involved at least one other drug. Westchester admissions to treatment for prescription opioids increased 188 percent from 147 in 2007 to 423 in 2013. Seven percent of drug treatment admissions in Westchester County in 2013 were attributable to prescription opioids. Despite increases in prescription opioid admissions, in 2013 Westchester County was the fifth lowest out of all the counties in the state in rate of prescription opioid admissions, with 44 prescription opioid admissions per 100,000 residents. The proportion of prescription opioid admissions under 25 years of age in Westchester County increased substantially from 16 percent in 2007 to 37 percent in 2013.

In **Orange County**,[46] prescription opioids were involved in over half of the drug overdose deaths in 2012 and 2013. The total number of prescription opioid involved deaths remained consistent between 2012 (32) and 2013 (33). Drug overdose deaths involving benzodiazepines increased 120 percent from ten in 2012 to 22 in 2013. In 2013, the average age of decedents from benzodiazepine-involved drug overdoses was 35, five years younger than decedents from drug overdoses not involving benzodiazepines. Out of the 22 overdose deaths involving a benzodiazepine or zolpidem in 2013, all but one also involved at least one other non-benzodiazepine drug. Admissions citing prescription opioids as the primary drug of abuse in Orange County almost tripled (198 percent increase) from 113 in 2007 to 337 in 2013. Prescription opioids accounted for 12 percent of total drug treatment admissions in Orange County in 2013. The percentage of prescription opioid admissions in Orange County, aged 34 and younger, increased from 51 percent in 2007 to 67 percent in 2013. Out of all 62 counties in the state, Orange County ranked 46th in the rate of prescription opioid treatment admissions, with 90 prescription opioid treatment admissions per 100,000 in 2013.

In 2013, 27 (42 percent) of the 64 drug overdose deaths in **Dutchess County**[47] involved a prescription opioid. From 2009 to 2012, prescription opioid-involved deaths increased by more than 300 percent in the county. However, this trend appears to be slowing, with a decline in prescription opioid-involved deaths of 18 percent from 2012 to 2013. Dutchess County overdose deaths involving benzodiazepines or zolpidem doubled from six in 2009 to 12 in 2013. All but one of the 12 deaths involving benzodiazepines or zolpidem in 2013 involved at least one other drug as well. In addition to the drug overdose deaths where the intent was determined to be accidental or unknown, there were 15 drug-involved suicides in 2013 in Dutchess County, and all but one of these suicides involved at least one prescription drug.[48] Out of all drug-involved overdose deaths in Dutchess County in 2013 (regardless of intent), over half involved at least one prescription drug.

In **Putnam County**,[49] deaths involving prescription opioids increased from 4 in 2010 to 14 in 2012, followed by a decrease to 6 in 2013. Prescription opioids were involved in at least half of all overdose deaths in each year from 2010 to 2013. Heroin and/or prescription opioids were involved in all but one of the twelve overdose deaths in 2013 in Putnam County. Benzodiazepines were involved in five out of the twelve overdose deaths in 2013. Each of the benzodiazepine-involved deaths also involved at least one other drug.

Long Island

In **Nassau County**,[50] after years of substantial increases, prescription opioid-involved deaths appear to be leveling off. From 2012 to 2013, there were decreases in overdose deaths involving oxycodone, hydrocodone, hydromorphone, codeine, methadone, and oxymorphone. Nonetheless, the number of deaths involving prescription opioids remains relatively high; there were 115 such deaths in 2013, more than four times as many as in 2004. Admissions to treatment citing prescription opioids as the primary drug of abuse increased 135 percent from 2007 to 2012 in Nassau County, followed by a 20 percent decrease from 1,287 in 2012 to 1,031 in 2013. Nonetheless, the number of prescription opioid admissions in 2013 were 88 percent higher than in 2007. In 2013, prescription opioids accounted for 17 percent of total drug treatment admissions in Nassau County. There were 76 admissions to treatment for prescription opioid abuse per 100,000 residents the county in 2013, placing Nassau County 53rd out of all 62 counties in the state in the rate of prescription opioid treatment admissions. The percentage of prescription opioid admissions in Nassau County under 35 increased from 55 percent in 2007 to 77 percent in 2012, followed by a decrease to 71 percent in 2013.

In **Suffolk County,**[51] overdose deaths involving prescription opioids decreased over 30 percent from 128 in 2012 to 88 in 2013. In 2013, prescription opioids were involved in 39 percent of drug overdose deaths. From 2012 to 2013, overdose deaths in Suffolk County involving benzodiazepines or zolpidem decreased 30 percent, from 74 to 52, respectively. All 52 of the deaths in 2013 involving a benzodiazepine or zolpidem also included at least one other drug (prescription drug, illicit drug or alcohol). Admissions to treatment citing prescription opioids as the primary drug of abuse in Suffolk County increased 149 percent from 2007 to 2011, followed by a 28 percent decrease from 2,438 in 2011 to 1,762 in 2013. In 2013, prescription opioids accounted for 17 percent of total drug treatment admissions in Suffolk County, the same percentage as in Nassau County. In 2013, there were 118 prescription opioid admissions to treatment per 100,000 residents in the county, placing Suffolk County 33rd out of the 62 counties in the state in the rate of prescription opioid admissions to treatment. The percentage of total prescription opioids admissions under 25 years of age increased from 30 percent in 2007 to 46 percent in 2011, followed by a decrease to 33 percent in 2013.

Western/Central New York

In **Erie County** the number of drug treatment program admissions citing prescription opioids as the primary drug of abuse increased 89 percent from 853 admissions in 2007 to 1,613 admissions in 2013. Prescription opioid admissions also accounted for an increasing proportion of all drug treatment program admissions, increasing from 12 percent in 2007 to 22 percent in 2013. Of all prescription opioid admissions in Erie County in 2013, there were 41 percent between 25 and 34 years of age, 33 percent under 25 years of age, 16 percent between 35 and 44 years of age, and ten percent over 45 years of age. This is similar to the age breakdown of heroin admissions in Erie County in 2013. Erie County ranked 18th out of all 62 counties in the state in 2013 in the rate of prescription opioid admissions, with 175 prescription opioids per 100,000 residents.

In **Monroe County**, between 2007 and 2013 treatment program admissions citing prescription opioids as the primary drug of abuse increased 106 percent, from 324 to 668. Prescription opioids also accounted for an increasing percentage of total drug treatment admissions, increasing from five percent in 2007 to nine percent in 2013. Of the 324 prescription opioid admissions in 2013, there were 42 percent between 25 and 34 years of age, 25 percent under 25 years old, 19 percent between 35 and 44 years of age, and 14 percent over 45 years of age. In 2013, Monroe County ranked 47th out of all 62 counties in the state in the rate of prescription opioid admissions, with 89 prescription opioid admissions per 100,000 residents.

In **Onondaga County** the number of drug treatment program admissions citing prescription opioids as the primary drug of abuse increased every year between 2007 and 2013, resulting in an increase of 182 from 241 admissions in 2007 to 679 admissions in 2013. Prescription opioid admissions also accounted for an increasing proportion of all drug treatment program admissions, increasing from seven percent in 2007 to 15 percent in 2013. Of the 679 prescription opioid admissions in 2013, there were 47 percent between 25 and 34 years of age, 25 percent under 25 years old, 16 percent between 35 and 44 years of age, and twelve percent were over 45 years of age. The percentage of prescription opioid admissions between 25 through 34 years of age increased from 32 percent in 2007 to 47 percent in 2013. In 2013, Onondaga County ranked 24th out of all 62 counties in the state in the rate of prescription opioid treatment admissions, with 145 prescription opioids admissions per 100,000 residents.

Capital Region

In **Albany County**, drug treatment program admissions citing prescription opioids as the primary drug of abuse accounted for an increasing percentage of total drug treatment admissions between 2007 and 2013, increasing from four percent in 2007 to eight percent in 2013. There were 110 prescription opioid admissions to treatment in 2007 and 227 admissions in 2013 (a 106 percent increase). Out of all prescription opioid admissions in Albany County, the proportion under 35 years of age increased substantially from 46 percent in 2007 to 68 percent in 2013. Out

of all 62 counties in the state, Albany ranked 55th in the rate of prescription opioid admissions per 100,000 residents in 2013, with a rate of 74.

Northern Border

In the Northern Border region (Clinton, Franklin, Jefferson, and St. Lawrence Counties) drug treatment program admissions citing prescription opioids as the primary drug of abuse more than tripled over six years, increasing from 319 admissions in 2007 to 1,083 admissions in 2013 (a 240 percent increase). Prescription opioid admissions accounted for an increasing percentage of total drug treatment admissions, increasing from 18 percent in 2007 to 37 percent in 2013. Of the 1,083 prescription opioid admissions in 2013, 48 percent were between 25 and 34 years of age, 30 percent were under 25 years old, 14 percent were between 35 and 44 years of age, and seven percent were over 45 years old. In 2013, the rate of prescription opioid admissions to treatment per 100,000 residents was 415 in Clinton County, 315 in Franklin County, 116 in Jefferson County, and in 395 St. Lawrence County. Out of the 62 counties in the state, Clinton had the highest rate of prescription opioid treatment admissions in 2013, St. Lawrence had the second highest, and Franklin had the fourth highest. Jefferson was ranked 34th out of 62.

In **Clinton County** between 2007 and 2013, drug treatment program admissions citing prescription opioids as the primary drug of abuse accounted for an increasing percentage of total drug treatment admissions, increasing from 21 percent in 2007 to 53 percent in 2013. There were 96 prescription opioid admissions in 2007 and 339 admissions in 2013 (a 253 percent increase).

In **Franklin County** there was a 379 percent increase in drug treatment program admissions citing prescription opioids as the primary drug of abuse, increasing from 34 admissions in 2007 to 163 admissions in 2013. During this time prescription opioid admissions accounted for an increasing percentage of total drug treatment admissions, increasing from 13 percent in 2007 to 41 percent in 2013.

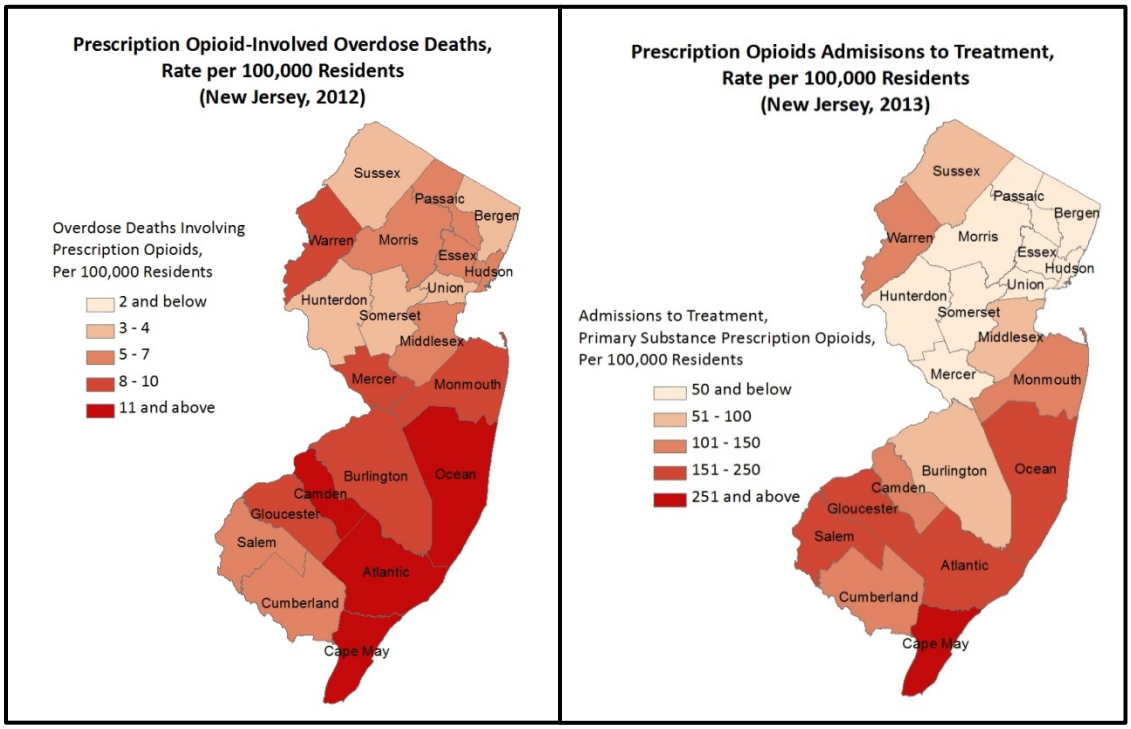
In **Jefferson County** drug treatment program admissions citing prescription opioids as the primary drug of abuse more than tripled from 52 admissions in 2007 to 139 admissions in 2013 (a 170 percent increase). Between 2007 and 2013, prescription opioid admissions accounted for an increasing percentage of total drug treatment admissions, increasing from ten percent in 2007 to 16 percent in 2013.

In **St. Lawrence County** between 2007 and 2013, drug treatment program admissions citing prescription opioids as the primary drug of abuse accounted for an increasing percentage of total drug treatment program admissions, increasing from 26 percent in 2007 to 42 percent in 2013. There were 137 prescription opioid admissions in 2007 and 442 admissions in 2013 (a 223 percent increase).

New Jersey

There were 614 overdose deaths involving prescriptions opioids in New Jersey[52] in 2012, a 14 percent increase from 540 in 2011, and an 85 percent increase from 332 in 2004. By comparison, there were 606 prescription-opioid-involved deaths statewide in 2006. This number declined by one-third to 408 deaths in 2008, before rising again to 614 by 2012. Of the 1,111 total overdose deaths reported in NJ in 2012, 55 percent involved prescription opioids, more than heroin (52 percent) or cocaine (27 percent). The NJ counties with the highest numbers of overdose deaths involving prescription opioids in 2012 were Ocean (85), Monmouth (59), Camden (58), Middlesex (48), and Essex (47). Based on population size, the NJ counties with the highest rates of prescription opioid-involved deaths per 100,000 residents were Atlantic (14.9), Ocean (14.6), Cape May (11.4), and Camden (11.3). Benzodiazepine-involved drug overdose deaths in New Jersey increased 139 percent from 157 in 2004 to 376 in 2012. Thirty-four percent of total drug overdose deaths involved a benzodiazepine in 2012, compared to 21 percent in 2004.

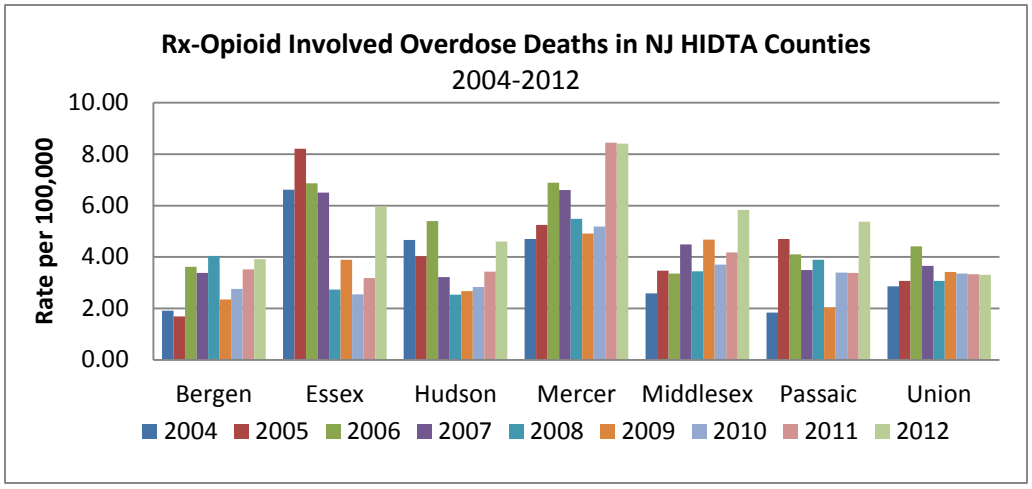
Statewide, the number of admissions to drug treatment programs[53] for prescription opioid abuse increased 63 percent between 2009 and 2011, followed by a 22 percent decrease between 2011 and 2013. Prescription opioid admissions in 2013 were 28 percent higher than admissions in 2009. In 2013, prescription opioid admissions composed 13 percent of total drug admissions (excluding alcohol) in the state. The five counties with the highest rates of prescription opioid treatment admissions per 100,000 residents in 2013 were Cape May (326), Atlantic (180), Ocean (176), Gloucester (170), and Salem (164).



New Jersey HIDTA Counties

Every one of the seven NJ HIDTA counties experienced increases in prescription opioid-involved overdose deaths between 2010 and 2012. Patients citing prescription opioids as their primary drug of abuse accounted for 8.5 percent of all drug treatment program admissions (excluding alcohol) in the seven NJ HIDTA counties in 2013, compared to accounting for 13 percent statewide. In six of the NJ HIDTA counties there was a decrease in the number of prescription opioid treatment admissions between 2012 and 2013 with the exception of Passaic County where there was a 16 percent increase. However, despite these decreases, each of the NJ HIDTA counties had higher levels of prescription opioid treatment admissions in 2013 than in 2009. In all NJ HIDTA counties combined, prescription opioid treatment admissions increased 46 percent from 2009 to 2013, despite a 17 percent decrease from 2010 to 2013.

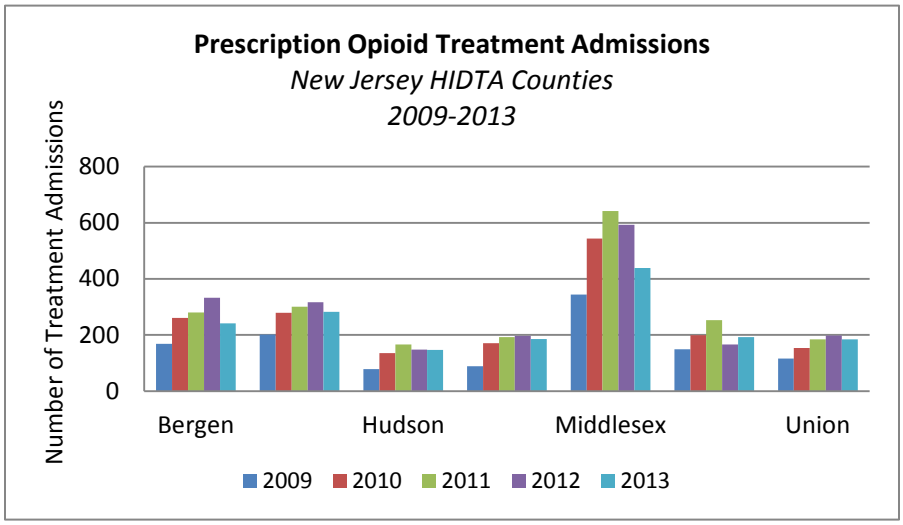
In **Bergen County** in 2012, prescription opioids were involved in 36 overdose deaths (58 percent of total drug overdose deaths). This was higher than the number of deaths involving heroin (45 percent) or cocaine (16 percent). While the number of overdose deaths involving prescription opioids has fluctuated since 2004, from a low of 15 in 2005, to a high of 36 in both 2008 and 2012, there has been a steady increase since 2009. Treatment admissions for prescription opioid abuse in Bergen County nearly doubled (97% increase) between 2009 and 2012. This trend seemed to change in 2012 as the number of prescription opioid abuse treatment admissions in Bergen County decreased 27 percent between 2012 and 2013.



Forty-seven overdose deaths in **Essex County** in 2012 involved prescription opioids, representing an 88 percent increase from 2011 to 2012. Nonetheless, the number of prescription-opioid involved deaths in 2012 (47) was comparable to the number in 2004 (52), and 27 percent lower than in 2005 (64). The increase from 2011 to 2012 was driven largely by deaths that involved both heroin and prescription opioids. Prescription opioids were involved in 51 percent of overdose deaths in 2012, similar to heroin (49 percent), and cocaine (46 percent). The number of treatment admissions for prescription opioid abuse in Essex County increased 57 percent between 2009 and 2012, followed by an 11 percent decrease between 2012 and 2013.

In **Hudson County**, overdose deaths involving prescription opioids increased 36 percent from 22 in 2011 to 30 in 2012. As in Essex County, this increase was driven largely by overdose deaths that involved both prescription opioids and heroin. Prescription-opioid-involved deaths have risen steadily since 2008 when there were 15 deaths. However Hudson reported 32 prescription-opioid-involved deaths in 2006, comparable to number reported in 2012. In 2012, 47 percent of overdose deaths in Hudson County involved prescription opioids, compared to 50 percent for heroin and 22 percent for cocaine. Treatment admissions for prescription opioid abuse in Hudson County increased 112 percent between 2009 and 2011. The number of treatment admissions then decreased by 11 percent between 2011 and 2012, and plateaued between 2012 and 2013. Hudson County had the lowest number of prescription opioid abuse treatment admissions of all NJ HIDTA counties in 2013 as well as the lowest rate of admissions per 100,000 residents.

In **Mercer County**, the number of overdose deaths involving prescription opioids in 2012 (31) was the same as in 2011. In 2004, there were 17 prescription-opioid-involved deaths, 82 percent less than in 2012. Prescription opioids were involved in 79 percent of total overdose deaths in Mercer County in 2012, compared with 64 percent for heroin and 28 percent for cocaine. From 2009 to 2012, treatment admissions for prescription opioid abuse in Mercer County increased 121 percent, followed by a six percent decrease between 2012 and 2013.



Middlesex County experienced a 41 percent increase in prescription opioid-involved deaths from 2011 to 2012, with the number rising from 34 to 48 deaths, respectively. The increase in prescription opioid-involved deaths was driven largely by deaths that also involved heroin. For the years 2004 through 2012, 2012 was the year with the highest number of prescription-involved overdose deaths and highest overall number of overdose deaths in Middlesex. Out of the seven NJ HIDTA counties, the highest number of prescription opioid admissions in 2013 was in Middlesex County where there were 439 admissions, a 32 percent decrease from the 2011 county total, though still 28 percent higher than in 2009. In 2013 Middlesex County also had the highest rate of prescription opioid treatment admissions with 53 admissions per 100,000 residents.

Twenty-seven overdose deaths in **Passaic County** involved prescription opioids in 2012, representing a 59 percent increase from 2011 and 200 percent increase from 2004. In 2012, prescription opioids were involved in 51 percent of total overdose deaths in Passaic County. Heroin was involved in more deaths (57 percent) and cocaine was involved in fewer deaths (30 percent). Passaic County admissions to treatment for prescription opioid abuse increased 70 percent between 2009 and 2011. Between 2011 and 2012 there was a 34 percent decrease followed by a 16 percent increase in the number of admissions between 2012 and 2013. Passaic County was the only NJ HIDTA County to exhibit an increase in the number of prescription opioid treatment admissions between 2012 and 2013.

In **Union County**, the number of prescription-opioid-involved overdose deaths remained unchanged between 2009 and 2012. During that time frame, 18 such deaths have been reported every year. However, due to increases in heroin-involved deaths and cocaine-involved deaths, the percentage of total deaths involving prescription opioids decreased from 62 percent in 2011 to 43 percent in 2012. Admissions to drug treatment programs for prescription opioid abuse in Union County increased 71 percent between 2009 and 2012 followed by a seven percent decrease between 2012 and 2013.

OxyContin Reformulation

In 2010, OxyContin was reformulated to make it abuse deterrent. The reformulation makes it more difficult to cut the pills into powder for snorting or injecting (see image). There have been reports of some individuals bypassing the reformulation by using pedi-eggs or microwaving, but the reformulation seems to have decreased the desirability of OxyContin misuse.

COCAINE/CRACK

Available law enforcement intelligence and public health indicators suggest that cocaine remains a persistent threat in New York and New Jersey, but the availability of cocaine in the area has declined in recent years. Cocaine was identified by law enforcement survey respondents as the third major drug threat in both New York State and in New Jersey, after heroin and CPDs.

Trafficking and Distribution (Cocaine/Crack)

Both powder and crack forms of cocaine are available throughout the NY/NJ HIDTA area. In New Jersey, availability is greater in urban areas that serve as distribution markets (e.g., Newark, Paterson and Camden). Availability fluctuates from high to moderate throughout the New York/New Jersey region, despite reports from various sources indicating that cocaine is in short supply at both wholesale and street levels.

Distribution

Throughout New York State, crack remains a threat. Crack is the drug most commonly associated with violent crime, and street gangs control the majority of crack sales in the area. As heroin and prescription drugs wax in popularity, cocaine and crack cocaine's popularity diminish somewhat. In Albany, crack dealers have also started to distribute heroin as the heroin market has been increasing. Crack dealers from the New York City area and Rochester are known to travel to cities along the Southern Tier and rent hotel rooms or stay with a local user to establish a base/distribution point for selling crack. In the Southern Tier, local crack dealers usually own some type of illegal handgun, which they keep close to their retail distribution point. In the Long Island area, crack is commonly abused and remains available in the low income areas of towns including Amityville, Copiague, Hempstead, and Wyandanch. Police agencies in Niagara and Erie counties indicate they are seeing a decrease in cocaine demand. Urban areas of NJ serve as distribution hubs for the rest of the state with wholesale centers located near New York City and Philadelphia.

Drug Trafficking Organizations

Higher level cocaine distribution organizations are organized in a hierarchy based on nationality. Investigations and intelligence sources reveal that Colombian and Mexican DTOs typically function as the primary wholesale distributors, controlling the transportation of cocaine into NYC, while Dominican and Mexican DTOs are the dominant retail distributors, transporting cocaine throughout the state. Similarly, Colombian trafficking groups have, historically,

controlled the wholesale distribution of cocaine in New Jersey while Dominican groups handle the retail distribution for the Colombians. The Dominican groups then sell to DTOs with ties to street gangs. These street gangs are often African American, but also sometimes Hispanic or Caucasian, and distribute on the street level. This organizational structure is true for both powder and crack cocaine. At the street level, heroin and cocaine suppliers appear to coexist throughout urban areas of New Jersey. In NY, local dealers usually travel to NYC, via privately owned vehicles, to purchase multi-ounce quantities of cocaine and then return to their home area to sell the product, or convert it into crack. In Albany, drug traffickers regularly travel to New York City and neighboring states to purchase ounce and kilogram quantities of cocaine. Cocaine is either repackaged or cooked into crack cocaine for local distribution.

Trends in Abuse: Cocaine/Crack

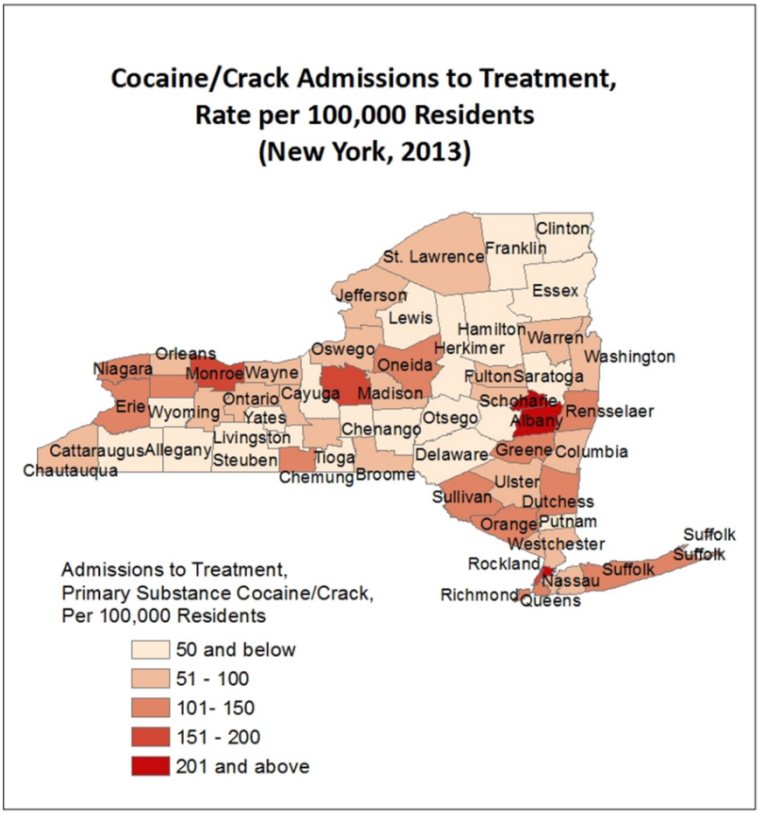
Overdose Deaths[54] & Treatment Admissions

New York State

Reporting on drug overdose deaths in New York State is limited. Due in part to differences in reporting across counties, timely and accurate statewide data on cocaine-related drug overdose deaths is not currently available. However, detailed data is available on a county or regional level in certain areas within the state. Data is not currently available for the following HIDTA counties: Albany, Onondaga, Monroe, Erie, Jefferson, St. Lawrence, Franklin, or Clinton. In the NY HIDTA counties for which data is available (Westchester, Orange, Nassau, Suffolk, and all NYC counties), the number of cocaine-involved overdose deaths is lower than the number of heroin-involved deaths in many counties. In some counties, the number of cocaine-involved deaths is also lower than the number of prescription-opioid-involved deaths.

Admissions to treatment[55] in New York State as a whole citing cocaine/crack as the primary drug of abuse decreased each year from 2007 to 2013, for a total decrease of 47 percent. In 2013, there were 22,693 cocaine/crack admissions statewide, composing 17 percent of total drug treatment admissions, compared to 43,201 cocaine/crack admissions in 2007 (32 percent of total drug treatment admissions). Cocaine/crack admissions also became increasingly older; the percent of cocaine/crack admissions over 45 years of age increased from 28 percent in 2007 to 48 percent in 2013. In 2013, the most frequently reported referral sources for cocaine/crack admissions were the criminal justice system (27 percent) and self-referrals (26 percent). The remaining admissions were accounted for by other chemical dependency program referrals (19 percent), health care/social service referrals (14 percent), chemical dependency prevention/intervention referrals (4 percent), and other referral source (11 percent).

Admissions to drug treatment citing cocaine/crack as the primary drug of abuse decreased in every NY HIDTA county from 2007 to 2013, with the exception of Albany where admissions increased five percent between 2012 and 2013.



New York City

According to the NYC Department of Health and Mental Hygiene,[56] the rate of unintentional drug poisoning deaths involving cocaine decreased steadily between 2005 and 2010 in NYC, dropping 44 percent, from 7.9 to 4.4 per 100,000 residents, followed by an 18 percent increase to 5.2 per 100,000 in 2012. The number of cocaine-involved deaths increased from 289 in 2010 to 348 in 2012. Between 2005 and 2012, cocaine was involved in nearly half of all unintentional drug poisoning deaths in NYC, more than any other drug. In 2012, heroin surpassed cocaine as the drug most commonly involved in accidental overdose deaths in NYC.

NYC admissions for drug treatment citing cocaine/crack as the primary drug of abuse decreased steadily from 20,665 in 2007 to 11,171 in 2013, for a total decrease of 46 percent. Cocaine/crack treatment admissions also steadily decreased in each of the boroughs from 2007 to 2013, with a decrease of 36 percent in the Bronx (4,947 to 3,189), 49 percent in Brooklyn (5,961 to 3,066), 44 percent in Manhattan (5,452 to 3,070), 59 percent in Queens (3,354 to 1,376), and 51 percent in Staten Island (951 to 470). Out of the five boroughs, the highest rate of cocaine/crack treatment admissions per 100,000 residents in 2013 was in the Bronx (225), followed by Manhattan (189),

Brooklyn (118), Staten Island (99), and Queens (60). The Bronx had the second highest rate of cocaine/crack treatment admissions out of all the counties in the state and Manhattan had the sixth highest in the state. In 2013, cocaine/crack accounted for 20 percent of the total admissions to drug treatment in NYC, compared to 30 percent in 2007. The percentage of cocaine/crack admissions under 25 years of age remained unchanged from 2007 to 2013, while the proportion age 35 through 55 decreased from 43 percent to 26 percent, and the proportion age 45 and older increased from 34 percent in 2007 to 55 percent in 2013. In 2013, 32 percent of cocaine/crack admissions in NYC were self-referrals. The next most common referral sources were the criminal justice system (24 percent), followed by other chemical dependency programs (16 percent), and health care/social service entities (13 percent).

Hudson Valley

In **Westchester County**,[57] there were 23 overdose deaths involving cocaine in 2013, a 44 percent increase from 16 in 2010. However, due to increases in the total number accidental overdose deaths in Westchester County, the percentage of accidental overdose deaths involving cocaine decreased from 36 percent in 2010 to 24 percent in 2013. Admissions to treatment for cocaine/crack in Westchester County decreased 44 percent from 1,582 in 2007 to 882 in 2013. In 2013, 15 percent of admissions to drug treatment in the county were cocaine/crack admissions, and, of the State's 62 counties, Westchester ranked 20th in rate of cocaine/crack treatment admissions, with 91 cocaine/crack admissions per 100,000 residents. The percentage of cocaine/crack admissions under 35 years of age remained stable between 2007 (29 percent) and 2013 (28 percent) whereas the percentage age 35 to 44 decreased (41 percent to 24 percent) and the percentage 45 and older increased (29 percent to 48 percent).

In **Orange County**,[58] cocaine-involved drug overdose deaths increased from eight in 2012 to eleven in 2013, but remained under 20 percent of the total drug overdose deaths in both years. Admissions to treatment citing cocaine/crack as the primary substance of abuse declined steadily in Orange County from 939 in 2007 to 380 in 2013, for a total decrease of 60 percent. In 2013, 13 percent of treatment admissions in Orange County were cocaine/crack admissions, compared to 36 percent in 2007. In 2013, Orange County had the 17th highest rate of cocaine/crack treatment admissions per 100,000 residents out of all the counties in the state with 101 cocaine/crack admissions per 100,000 residents. The proportion of cocaine/crack admissions in Orange County under 45 years of age decreased from 79 percent in 2007 to 61 percent in 2013.

From 2009 to 2013, the number of cocaine-involved overdose deaths rose from 8 to 15 in **Dutchess County**[59]. Despite this rise, cocaine was involved in less than 25 percent of total drug overdose deaths in 2013.

Cocaine-involved overdose deaths have remained stable in **Putnam County**[60] from 2010 to 2013, with one cocaine-involved death in 2010 and two in each year from 2011 through 2013.

Long Island

In **Nassau County**, admissions for drug treatment citing cocaine/crack as the primary drug of abuse have steadily decreased from 1,750 in 2007 to 809 in 2013, for a total decrease of 54 percent. In fact, in 2013, the number of cocaine/crack admissions was smaller than the number of heroin or prescription opioid admissions. Thirteen percent of total drug treatment admissions in 2013 in Nassau County were crack/cocaine admissions. In 2013, there were 60 cocaine/crack admissions per 100,000 residents in Nassau County, placing Nassau 39th out of all 62 counties in the state in rate of cocaine/crack treatment admissions. The proportion of cocaine/crack admissions, 45 years of age and older, have increased from 21 percent in 2007 to 41 percent in 2013, while those under 45 years of age have correspondingly decreased from 79 percent to 59 percent.

Cocaine-involved deaths in **Suffolk County**[61] increased 45 percent, from 38 in 2012 to 55 in 2013. However, heroin-involved deaths and prescription opioid-involved deaths continue to outnumber cocaine-involved deaths. In 2013, heroin was involved in 47 percent of total drug overdose deaths in Suffolk County, prescription opioids were involved in 39 percent, and cocaine was involved in 25 percent. Similar to Nassau County, admissions for drug treatment citing cocaine/crack as the primary drug of abuse have steadily decreased in Suffolk County from 3, 099 in 2007 to 1,494 in 2013, for a total decrease of 52 percent. In 2013, 14 percent of the total drug treatment admissions were cocaine/crack admissions, compared to 35 percent in 2007. In 2013, Suffolk County ranked 18th in the state in the rate of cocaine/crack treatment admissions: 100 cocaine/crack admissions per 100,000 residents. The proportion of cocaine/crack admissions under 45 years of age have decreased from 80 percent in 2007 to 63 percent in 2013, while those 45 years of age and older increased from 20 percent in 2007 to 37 percent in 2013.

Western/Central New York

In **Erie County** there was a 55 percent decrease in drug treatment program admissions citing cocaine/crack as the primary drug of abuse from 2,810 admissions in 2007 to 1,259 admissions in 2013. In 2013, 17 percent of all admissions to drug treatment programs in Erie County were cocaine/crack admissions, which represented a decline from 38 percent in 2007. Of the 1,259 cocaine/crack admissions in 2013, there were 45 percent over 45 years of age, 29 percent between 35 and 44, 20 percent between 25 and 34, and six percent under 25. In fact, the proportion of treatment cocaine/crack admissions for 45 years and older increased from 29 percent in 2007 to 45 percent in 2013. Erie County had the seventh highest rate of cocaine/crack admissions of all the counties in the state in 2013, with 137 cocaine/crack admissions per 100,000 residents.

In **Monroe County** there was a 45 percent decrease in drug treatment program admissions citing cocaine/crack as the primary drug of abuse from 2,738 in 2007 to 1,495 in 2013. Cocaine/crack also accounted for a decreasing percentage of total drug treatment admissions over this time period, decreasing from 40 percent of all admissions in 2007 to 20 percent in 2013. In 2007, 32 percent of cocaine/crack admissions were over 45 years of age; this number rose to 51 percent in 2013. In 2013, Monroe County had the fourth highest rate of cocaine/crack admissions to treatment out of all 62 counties in New York State, with 199 cocaine/crack admissions per 100,000 residents.

In **Onondaga County** between 2007 and 2013 drug treatment program admissions citing cocaine/crack as the primary drug of abuse accounted for a decreasing percentage of total drug treatment program admissions, decreasing from 40 percent in 2007 to 19 percent in 2013. During this time there was a 38 percent decline in the number of cocaine/crack admissions to drug treatment, from 1,436 in 2007 to 889 in 2013. In 2013, 39 percent of cocaine/crack admissions were 45 years of age or older, while 29 percent were between 35 and 44, 23 percent were between 25 and 34, and nine percent were under 25. The proportion of cocaine/crack admissions who were 45 years or older increased from 23 percent in 2007 to 39 percent in 2013. Onondaga County ranked fifth out of all counties in the state in the rate of cocaine/crack admissions in 2013, with 190 cocaine/crack admissions per 100,000 residents.

Capital Region

In **Albany County**, between 2007 and 2012 there was a 39 percent decrease in the number of drug treatment program admissions citing cocaine/crack as the primary drug of abuse, from 1,037 admissions in 2007 to 629 admissions in 2012. However, there was a slight (five percent) increase from 629 admissions in 2012 to 661 admissions in 2013. The portion of cocaine/crack admissions over 45 years of age increased from 29 percent in 2007 to 49 percent in 2013. In 2013, Albany had the third highest rate of cocaine/crack admission out of all counties in the state, with 215 cocaine/crack admissions per 100,000 residents.

Northern Border

In the Northern Border region (including Clinton, Franklin, Jefferson, and St. Lawrence Counties) between 2007 and 2013, drug treatment program admissions citing cocaine/crack as the primary drug of abuse accounted for a decreasing percentage of total drug treatment program admissions in the region, decreasing from 20 percent in 2007 to seven percent in 2013. Of the 202 cocaine/crack admissions in the Northern Border region in 2013, there were 38 percent between 25 and 34 years of age, 30 percent between 35 and 44, 20 percent under 25 years old, and 12 percent over 45 years old. In 2013, the rate of cocaine/crack admissions per 100,000

residents was 23 in Clinton County, 32 in Franklin County, 78 in Jefferson County, and 65 in St. Lawrence County.

In **Clinton County**, between 2007 and 2013 drug treatment program admissions citing cocaine/crack as the primary drug of abuse accounted for a decreasing percentage of total drug treatment program admissions, decreasing from 12 percent in 2007 to three percent in 2013. There were 57 cocaine/crack admissions in 2007 and 19 in 2013 (a 66 percent decrease).

In **Franklin County** there was a 63 percent decrease in the number of drug treatment program admissions citing cocaine/crack as the primary drug of abuse from 45 in 2007 to 17 in 2013. During this time period cocaine/crack admissions accounted for a decreasing percentage of total drug treatment admissions, decreasing from 17 percent in 2007 to four percent in 2013.

In **Jefferson County**, between 2007 and 2013 drug treatment program admissions citing cocaine/crack as the primary drug of abuse accounted for a decreasing percentage of total drug treatment program admissions, decreasing from 29 percent in 2007 to 11 percent in 2013. There were 149 cocaine/crack admissions in 2007 and 93 in 2013 (a 38 percent decrease).

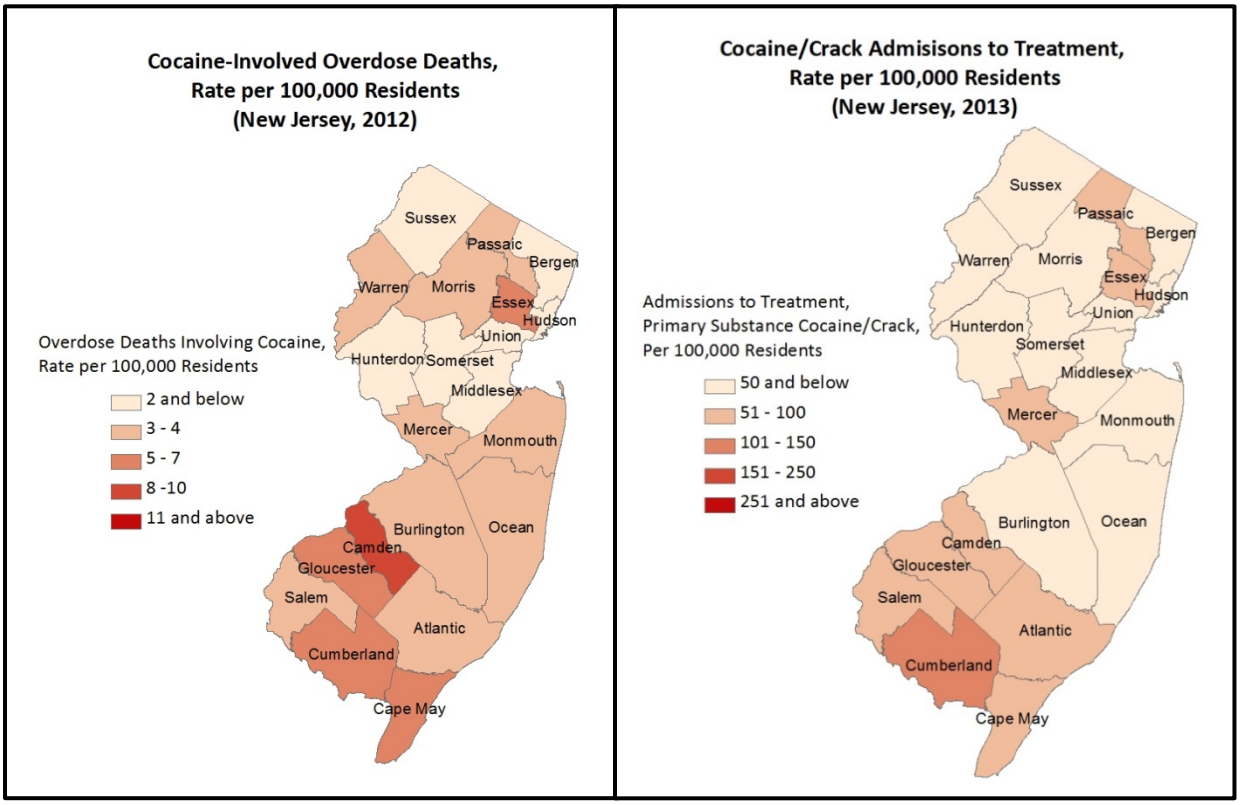
In **St. Lawrence County** drug treatment program admissions citing cocaine/crack as the primary drug of abuse accounted for a decreasing percentage of total drug treatment program admissions, decreasing from 20 percent in 2007 to seven percent in 2013. Cocaine/crack admissions decreased 28 percent over this period, decreasing from 102 in 2007 to 73 in 2013.

New Jersey

In New Jersey,[62] there were 301 cocaine-involved deaths in 2012, a 30 percent increase from 232 in 2011. Despite this increase, cocaine-involved deaths in 2012 were 43 percent lower than in 2006. Furthermore, in 2012, cocaine-involved deaths composed a substantially lower percentage of overall overdose deaths in NJ (27 percent) than heroin-involved deaths (52 percent) or prescription-opioid-involved deaths (55 percent). By comparison, in 2006, cocaine was involved in 51 percent of total overdose deaths in NJ, more than heroin (44 percent) and less than prescription opioids (59 percent). The NJ counties with the highest numbers of overdose deaths involving cocaine in 2012 were Camden (51), Essex (43), Ocean (23), and Monmouth (22).The NJ counties with the highest rates of cocaine-involved overdose deaths per 100,000 residents were Camden (9.9), Cape May (7.3), and Cumberland (7.0).

Patients citing cocaine or crack as their primary drug of abuse accounted for a decreasing proportion of drug program treatment admissions[63] (excluding alcohol) in NJ, from 11 percent of all admissions in 2009 to 7.6 percent of all admissions in 2013. Statewide, there has been a 26 percent decrease in the number of cocaine abuse treatment admissions since 2009. The counties

with the highest rates of cocaine treatment admissions per 100,000 residents in 2013 were Cumberland (103), Salem (91), Mercer (84), and Cape May (78).

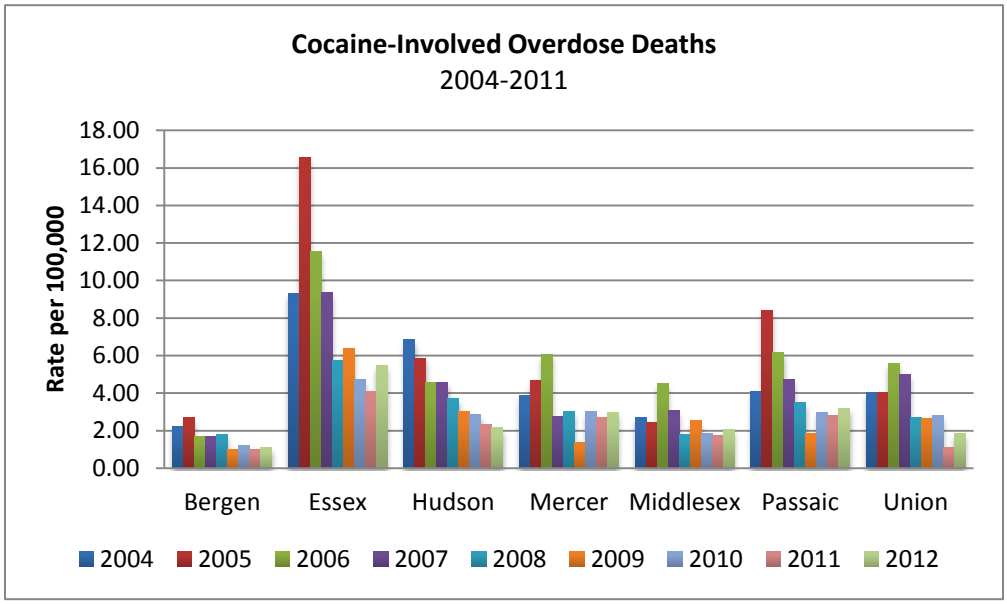


New Jersey HIDTA Counties

Cocaine-involved overdose deaths increased in each of the seven NJ HIDTA counties from 2011 to 2012. However, the increases were generally not substantial, and were largely driven by increases in overdose deaths that included heroin and/or prescription opioids in addition to cocaine. Furthermore, out of the years for which data is available (2004-2012), cocaine-involved deaths were highest in every county between 2004 and 2006. By 2012, the number of deaths in each county was substantially lower compared with this earlier period. In the seven NJ HIDTA counties combined, cocaine treatment admissions declined 21 percent from 2009 to 2013, including a 12 percent decrease from 2012 to 2013. The percentage of cocaine treatment admissions out of all drug treatment program admissions (excluding alcohol) in the seven NJ HIDTA counties combined declined from 11.6 percent in 2009 to 9.4 percent in 2013. Each of the NJ HIDTA counties had a lower number of cocaine treatment admissions in 2013 than in 2009, except Mercer, which had a 7 percent increase. Cocaine treatment admissions decreased in six of the NJ HIDTA counties between 2012 and 2013, with the exception of Passaic County where there was a slight (one percent) increase.

Cocaine-involved deaths in **Bergen County** increased slightly from 9 in 2011 to 10 in 2012. Cocaine-involved deaths in 2012 were 50 percent lower than in 2004. In 2012, cocaine was involved in 16 percent of total overdose deaths in the county, compared to 47 percent in 2004. Cocaine treatment admissions decreased 19 percent in Bergen County between 2012 and 2013 and decreased 35 percent between 2009 and 2013. By rate per 100,000 residents, Bergen County had the third lowest cocaine treatment admissions rate in NJ in 2013.

In **Essex County**, after three years of decline, overdose deaths involving cocaine increased 34 percent from 32 in 2011 to 43 in 2012. The increase in cocaine-involved deaths was driven largely by deaths that also involved heroin and/or prescription opioids, while the number of cocaine-only overdose deaths remained the same. Overall, there were 41 percent fewer deaths involving cocaine in 2012 than in 2004. The rate of cocaine treatment admissions in Essex County per 100,000 residents decreased between 23 percent between 2009 and 2013. There were 77 treatment admissions per 100,000 residents in 2009, which was reduced to 59 per 100,000 residents in 2013. In 2013, Essex County had the highest number of cocaine abuse treatment admissions in the state, and the seventh highest rate per 100,000 residents.

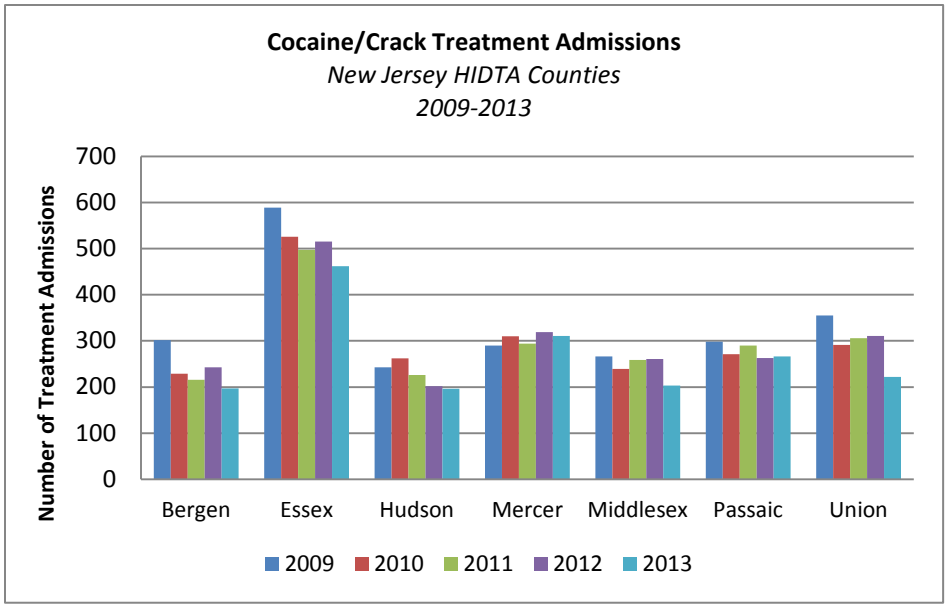


In **Hudson County**, overdose deaths involving cocaine have decreased steadily from 41 deaths in 2004, to 14 deaths in 2012, a drop of 66 percent. Cocaine-involved deaths remained fairly stable between 2011 and 2012, dropping from 15 to 14. Cocaine was involved in 22 percent of total overdose deaths in Hudson County in 2012, down from 73 percent of total overdose deaths in 2004. Rates of cocaine treatment admissions per 100,000 residents steadily decreased in Hudson County from 2009 to 2013, for a total decrease of 27 percent. There were 41 admissions per 100,000 residents in 2009 and 30 admissions per 100,000 residents in 2013.

Cocaine involved deaths in **Mercer County** increased slightly from 10 in 2011 to 11 in 2012. The average number of cocaine-involved deaths per year was higher from 2004 to 2006 than from 2007 to 2012. In 2012, cocaine was involved in 28 percent of total overdose deaths in Mercer County, compared to 64 percent for heroin and 79 percent for prescription opioids.

Mercer County has consistently had a much higher rate of drug treatment admissions for cocaine/crack abuse than any other NJ HIDTA county between 2009 and 2013 (though it did not have the highest total number of heroin admissions). The county had the third highest rate in the state in 2013 with 84 admissions per 100,000 residents.

In **Middlesex County**, overdose deaths involving cocaine increased from 14 in 2011 to 17 in 2012. Cocaine was involved in 18 percent of total overdose deaths in Middlesex County in 2012, fewer than heroin (51 percent) or prescription opioids (51 percent). The number of treatment admissions in Middlesex County decreased 24 percent between 2009 and 2013. In 2013, the rate of cocaine treatment admissions per 100,000 residents in Middlesex County was the lowest it has been in the five years from 2009 to 2013, with 24 admissions per 100,000 residents.



Overdose deaths in **Passaic County** that involved cocaine increased slightly from 14 in 2011 to 16 in 2012. This increase was driven by deaths which involved heroin as well as cocaine. In 2012, cocaine was involved in 30 percent of total overdose deaths in Passaic County, less than heroin (57 percent) or prescription opioids (51 percent). By comparison, in 2006, cocaine was involved in 68 percent of deaths, while heroin was involved in 39 percent and prescription opioids in 45 percent. The rate of cocaine treatment admissions per 100,000 residents in Passaic County has decreased 13 percent from 61 per 100,000 in 2009 to 53 admissions per 100,000 residents in 2013.

From 2011 to 2012, overdose deaths in **Union County** involving cocaine increased from 6 to 10. Nonetheless, cocaine-involved deaths in 2012 were 52 percent lower than in 2004. Cocaine was involved in 24 percent of total overdose deaths in Union in 2012, substantially less than heroin (67 percent) or prescription opioids (43 percent). There was a 29 percent decrease in the number of cocaine treatment admissions between 2012 and 2013 in Union County and a 37 percent decrease between 2009 and 2013. Between 2009 and 2013 the rate of admissions per 100,000 residents decreased from 67 to 40.

MARIJUANA

Marijuana continues to be ranked among the top five drug threats in the New York City area. Availability has remained stable and it remains a drug of choice in the area. Marijuana also remains readily available in New Jersey and the market has remained stable.

Trafficking and Distribution: Marijuana

The types of marijuana that are available in New York and New Jersey are domestic, Mexican, and hydroponically grown. Indoor marijuana grows are typically identified through citizen complaints substantiated through the confirmation of increased power usage. The size and scope of indoor grows within New Jersey ranges from a small cultivation of eight plants to a large wholesale cultivation consisting of 283 plants.

Intelligence from DEA-NYD investigations indicates Mexican and Jamaican DTOs are involved in distributing marijuana at the wholesale level, while African American street gangs, Dominican and Puerto Rican DTOs and various other gangs distribute marijuana at the retail level.

Marijuana is transported and/or smuggled into the area utilizing a variety of methods including concealed compartments in passenger vehicles, commingled with legitimate goods on tractor trailers, hidden on trucks, buses and other land conveyances. Other transportation and smuggling methods uncovered include human smuggling, the use of freight carriers, and shipping via express parcel mail delivery services. Large quantities of Mexican marijuana are typically transported from southwestern states, such as Texas, Arizona and California, to the New York area via tractor-trailers, trucks, buses and passenger vehicles, which are often times equipped with concealed compartments. Seizures in New Jersey are predominantly made from Small Parcel Interdiction programs at Newark Liberty International Airport. Based on reporting from the Albany area, there is a significant decrease in marijuana coming from Canada, while there has been a marked increase of marijuana from California and the Southwest Border. Another marijuana source of supply for the Albany area is the St. Regis Mohawk Reservation in the United States and the adjoining Akwesasne Mohawk Indian Reservation (AMIR) along the US/Canada border. Large DTOs and independent traffickers purchase marijuana from sources located on the AMIR. Marijuana obtained from the AMIR originates in Canada. The smuggling of multi-ton shipments of marijuana into New Jersey most commonly occurs via motor vessel from the Caribbean to Port Newark/Port Elizabeth, NJ, concealed in containerized cargo. Nearby Newark area hotels and motels are used as stash locations.

Medical Marijuana in New York

In January 2014, New York Governor Andrew Cuomo announced plans to allow up to 20 hospitals in the state to prescribe medical marijuana.[64] Under his proposal, the New York State Department of Health would be in charge of establishing guidelines and determining which hospitals can participate.

Medical Marijuana in New Jersey

As elsewhere in the United States, the State of New Jersey has advanced toward the legalization of medical marijuana. The New Jersey Compassionate Use Medical Marijuana Act (S119) was signed by former Governor Jon Corzine in January 2010. Since that time, there have been significant debates about the location of grow facilities, the individuals/companies who will be authorized to control them, and the doctors who will be authorized to dispense.

To date, there are three medical marijuana dispensaries operating in New Jersey: the Greenleaf Compassion Center in Montclair, the Compassionate Care Foundation in Egg Harbor, and the Garden State Dispensary in Woodbridge. These dispensaries have been plagued with problems. Greenleaf Compassion Center has been plagued with supply issues and has been closed more than it has been open. The Compassionate Care Foundation has been criticized by patients for providing medical marijuana that is of lower quality than the black market.

Trends in Abuse: Marijuana

Drug Treatment Admissions

New York State

Admissions to treatment[65] of New York State residents citing marijuana as the primary drug of abuse increased 21 percent from 2007 to 2010, followed by a 17 percent decrease from 2010 to 2013; in fact, the number of marijuana admissions in 2013 was about the same as it was in 2007. There were 43,970 marijuana admissions in 2013, accounting for 33 percent of total drug treatment admissions in the state. Almost half (48 percent) of the marijuana admissions in 2013 were the result of criminal justice referrals. The remaining marijuana admissions were accounted for by health care/social service referrals (14 percent), self-referrals (11 percent), other chemical dependency programs (7 percent), chemical dependency prevention/intervention referrals (4 percent), and other referral sources (16 percent).

New York City

Admissions for drug treatment citing marijuana as the primary drug of abuse increased 23 percent from 19,923 in 2007 to 24,483 in 2010, followed by a 23 percent decrease from 2010 to 18,971 in 2013. With the exception of Staten Island, each of the boroughs in NYC mirrored this trend, with increases from 2007 to 2010, followed by decreases from 2010 to 2013. In Staten Island, marijuana admissions peaked in 2009, decreased from 2009 to 2012, then increased slightly from 2012 to 2013. In 2013, marijuana admissions accounted for 38 percent of total drug treatment admissions in NYC. Unlike heroin, prescription opioid, and cocaine/crack admissions in NYC, the primary referral source for marijuana admissions was the criminal justice system, rather than self-referrals. In 2013, in NYC 52 percent of marijuana admissions were referred from the criminal justice system, whereas only 15 percent were self-referrals.

Hudson Valley

Admissions to drug treatment citing marijuana as the primary drug of abuse in **Orange County** decreased 15 percent from 869 in 2007 to 739 in 2013. Conversely, in **Westchester County**, marijuana admissions increased by 11 percent from 2,125 in 2007 to 2,366 in 2013. Fifty percent of admissions to treatment for marijuana in Orange and 49 percent in Westchester in 2013 were the result of criminal justice referrals, whereas self-referrals contributed to only 6 percent of marijuana admissions in Westchester County and 9 percent in Orange County.

Long Island

In Long Island (**Nassau County** and **Suffolk County**), admissions to drug treatment citing marijuana as the primary drug of abuse have remained fairly stable between 2007 and 2013, increasing by only six percent (4,337 to 4,580). In 2013, 46 percent of marijuana admissions were referred by the criminal justice system, whereas only 12 percent were self-referrals, for the other primary drugs of abuse (cocaine/crack, heroin, and prescription opioids), self-referrals accounted for about 28-34 percent of admissions in 2013.

Western/Central New York

In **Erie County** between 2007 and 2013, drug treatment program admissions citing marijuana as the primary drug of abuse accounted for anywhere between 32 and 40 percent of total drug treatment admissions each year. In 2013, marijuana accounted for 32 percent of all drug treatment admissions that year. Of the 2,367 marijuana admissions in 2013, there were 53 percent under 25, years of age, 28 percent between 25 and 34, 12 percent between 35 and 44 , and seven percent over 45.

In **Monroe County** between 2007 and 2013 drug treatment program admissions citing marijuana as the primary drug of abuse accounted for anywhere between 39 and 49 percent of total drug treatment admissions each year. Of the 3,340 marijuana admissions in 2013, there were 48 percent under 25 years of age, 29 percent between 25 and 34, 15 percent between 35 and 44, and eight percent over 45 years.

In **Onondaga County** drug treatment program admissions citing marijuana as the primary drug of abuse accounted for an increasing proportion of total drug treatment admissions between 2007 and 2009, increasing from 35 percent to 38 percent. Marijuana admissions have since accounted for a decreasing percentage of drug abuse treatment admissions, decreasing to 25 percent of admissions in 2013. Of the 1,152 marijuana admissions in 2013, there were 50 percent under 25 years of age, 33 percent between 25 and 34, 12 percent between 35 and 44, and five percent over 45.

Capital Region

In **Albany County**, between 2007 and 2013 drug treatment program admissions citing marijuana as the primary drug of abuse accounted for anywhere between 39 and 46 percent of total drug treatment program admissions, each year. There was a 20 percent increase in the number of marijuana admissions from 1,096 admissions in 2007 to 1316 admissions in 2010, followed by a 13 percent decrease to 1,143 admissions in 2013.

Northern Border

In the Northern Border region (Clinton, Franklin, Jefferson, and St. Lawrence Counties), drug treatment program admissions citing marijuana as the primary drug of abuse accounted for a decreasing percentage of all drug abuse treatment program admissions over six years, decreasing from 50 percent in 2007 to 32 percent in 2013. However, the number of marijuana admissions increased over this time period from 881 in 2007 to 945 in 2013. Of the 945 marijuana admissions in 2013, there were 58 percent under 25 years of age 28 percent between 25 and 34, nine percent between 35 and 44 and five percent over 45 years.

In **Clinton County**, drug treatment program admissions citing marijuana as the primary drug of abuse accounted for a decreasing percentage of drug abuse treatment admissions in the county, decreasing from 53 percent in 2007 to 22 percent in 2013. The number of marijuana admissions also decreased from 246 admissions in 2007 to 141 admissions in 2013, a 43 percent decrease.

In **Franklin County** drug treatment program admissions citing marijuana as the primary drug of abuse fluctuated between 2007 and 2013, remaining between 177 and 214 admissions. Over six

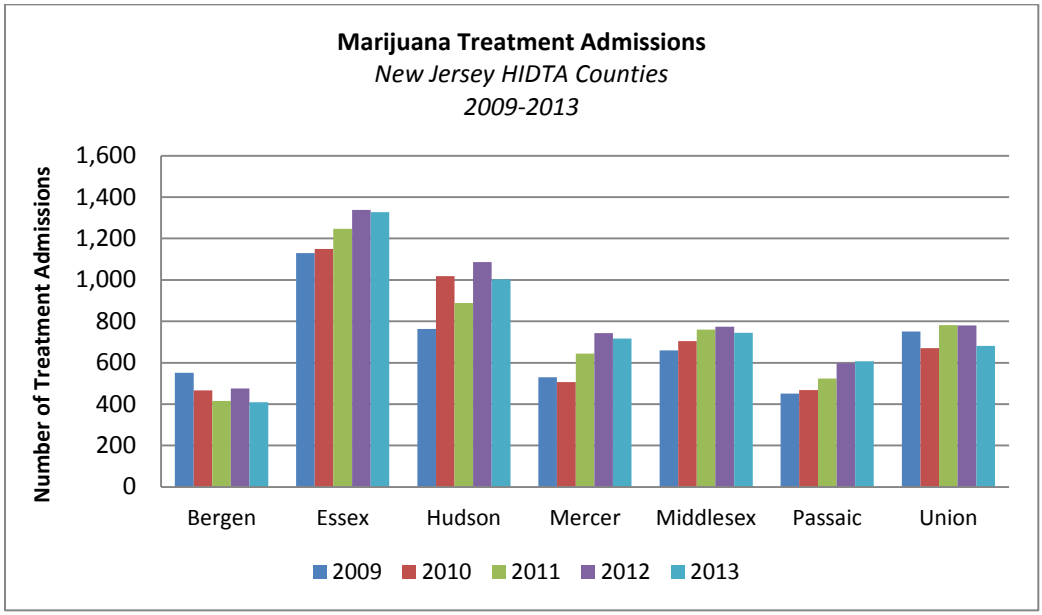
years, marijuana admissions accounted for a decreasing percentage of drug abuse treatment admissions in the county, decreasing from 67 percent in 2007 to 45 percent in 2013.

In **Jefferson County** drug treatment program admissions citing marijuana as the primary drug of abuse increased 35 percent, from 217 admissions in 2007 to 293 admissions in 2013. However, the percentage of drug treatment program admissions that marijuana admissions accounted for decreased slightly, from 42 percent in 2007 to 35 percent in 2013.

In **St. Lawrence County** drug treatment program admissions citing marijuana as the primary drug of abuse increased 39 percent from 240 in 2007 to 334 in 2013, but have nonetheless accounted for a decreasing percentage of drug abuse treatment admissions in the county, decreasing from 46 percent in 2007 to 32 percent in 2013. Total drug treatment program admissions more than doubled in the county, increasing from 519 in 2007 to 1044 in 2013.

New Jersey

Treatment admissions in NJ citing marijuana as the primary drug of abuse increased six percent from 2009 to 2013, despite a seven percent decrease from 2012 to 2013. In 2013, 23 percent of drug treatment admissions (excluding alcohol) in NJ were attributable to marijuana.



NJ HIDTA Counties

Each year from 2009 to 2013, between 25 percent and 28 percent of patients admitted to drug treatment programs[66] (excluding alcohol) in the seven NJ HIDTA counties have cited marijuana as their primary drug of abuse. In all NJ HIDTA counties combined, admissions to treatment for marijuana increased 13 percent from 2009 to 2013, despite a 5 percent decrease from 2012 to 2013. From 2009 to 2013, marijuana treatment admissions increased in five of the seven NJ HIDTA counties (all but Bergen and Passaic). From 2012 to 2013, each of the seven NJ HIDTA counties experienced decreases in marijuana treatment admissions, though mostly fairly modest decreases.

In **Bergen County** there was a 26 percent decrease in marijuana treatment admissions between 2009 and 2013. The rate of marijuana treatment admissions per 100,000 residents decreased from 62 in 2009 to 44 in 2013.

Treatment admissions for marijuana abuse in **Essex County** increased 17 percent between 2009 and 2013. The rate of admissions per 100,000 residents was the second highest of all NJ HIDTA counties in 2013 with 168 per 100,000 in 2013, up from 147 per 100,000 residents in 2009.

In **Hudson County,** marijuana treatment admissions increased 31 percent between 2009 and 2013 despite an 8 percent decrease between 2012 and 2013.

Treatment admissions for marijuana abuse in **Mercer County** increased 35 percent from 2009 to 2013. In 2013, Mercer County had the highest rate of marijuana treatment program admissions per 100,000 residents compared with the other six NJ HIDTA counties and the sixth highest rate of all counties in NJ in 2013. The rate decreased from 202 per 100,000 residents in 2012 to 194 per 100,000 residents in 2013.

In **Middlesex County** there was a 17 percent increase in the number of marijuana treatment program admissions between 2009 and 2012. This number decreased 4 percent between 2012 and 2013.

In **Passaic County** the number of marijuana treatment admissions increased 35 percent between 2009 and 2013. The rate of admissions increased 30 percent, rising from 92 per 100,000 residents in 2009 to 120 per 100,000 in 2013.

In **Union County** there was a 13 percent decrease in marijuana treatment program admissions between 2012 and 2013. The rate of admissions also decreased 13 percent, from 143 per 100,000 residents in 2009 to 124 per 100,000 in 2013.

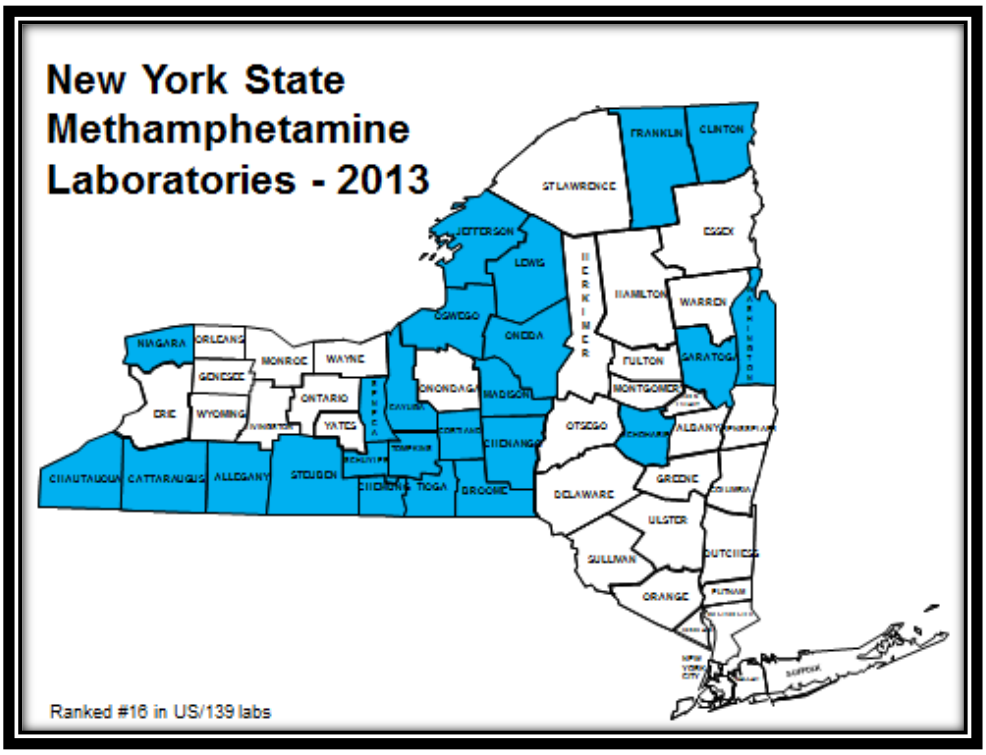
METHAMPHETAMINE

The majority of survey responses indicated low methamphetamine availability and production in 2013; however clandestine laboratory (lab) seizures in New York were still up significantly from the 45 labs seized in 2011. From 2012 to 2013, lab seizures decreased 7.3% from 150 to 139. The majority of these "labs" are being discovered upstate in rural outlying counties. Ninety-eight (98) percent were produced from small "mom and pop" operations involving the "one pot" production method to produce powdered methamphetamine. Two incidents involved anhydrous ammonia and two involved red phosphorous.

The availability of methamphetamine in New Jersey remains low. The majority of methamphetamine seized in New Jersey has been identified as produced in the United States, with some reports of Mexican produced product. Methamphetamine can still be considered one of the drugs of choice in some southern and northwestern areas of New Jersey. In southern New Jersey, local traffickers are traditionally associated with members of Outlaw Motorcycle Gangs. Organizations involved in the manufacturing of methamphetamine in New Jersey tend to be independent, more of a "mom and pop" set up.

With regard to crystal methamphetamine, Mexican DTOs have been increasingly active. Recent investigations have shown that Mexican DTOs have the capability and willingness to bring large shipments of high quality crystal methamphetamine to the New York City and Western New York area, in an attempt to expand distribution and market in the New York area. Traditionally, crystal methamphetamine has only been prevalent in New York City's club scene and in the Chelsea area, within the homosexual community. In addition to Mexican DTOs, traffickers and distributors tend be Asian DTOs and Caucasian DTOs. Mexican DTOs smuggle methamphetamine across the southwest border in vehicles equipped with concealed compartments. From the southwest border, the methamphetamine is body carried or shipped via mail and parcel delivery services.

New York State Incidents of Methamphetamine Lab Seizures (2013)[67]



County	# Labs	County	# Labs	County	# Labs	County	# Labs
Oswego	25	**Cortland**	8	**Cattaraugus**	3	**Franklin**	2
Clinton	15	**Chemung**	6	**Cayuga**	3	**Lewis**	2
Oneida	13	**Schuyler**	5	**Chautauqua**	3	**Tompkins**	2
Broome	11	**Steuben**	4	**Madison**	3	**Washington**	2
Jefferson	9	**Tioga**	4	**Seneca**	3	**Saratoga**	1
Niagara	9	**Allegany**	3	**Chenango**	2	**Schoharie**	1

New York State Incidents of Methamphetamine Lab Seizures (2013)[68]

County	# Labs	County	# Labs	County	# Labs	County	# Labs
Warren	3	**Camden**	1	**Hudson**	1	**Ocean**	1

OTHER ILLICIT DRUGS

MDMA has been encountered on a limited to moderate basis in New York. MDMA is not considered a "mainstream" drug; it is encountered mainly in the club scene and is used by a small segment of the population.

MDMA availability in New Jersey remains low with demand remaining stable for the past year. Ecstasy is mainly a concern during the summer months in the beach towns. Ecstasy still appeals to young adults and teenagers in clubs, but is not seen as a major concern. MDMA comes into the area primarily from the Netherlands and Canada. The drug is transported via passenger vehicles, postal services and concealed on airline carriers.

Investigations and source information indicates "Molly" being advertised as a pure, powdered form of MDMA. Recent reporting indicates "Molly" has been glamorized in the hip-hop culture. According to DEA's Northeast Regional Laboratory, however, the majority of "Molly" that has been analyzed did not, in fact, contain MDMA, but methylone, mephedrone, 3-MEC, PMA, or other substances. These substances all have an effect similar to MDMA, which is why users/traffickers call it all "Molly." Users for the most part believe that "Molly" is in fact MDMA.

On August 31, 2013, two concert goers died from apparent "Molly" overdoses and at least four others were hospitalized while attending the Electric Zoo Rave concert on Randall's Island in NYC. The two individuals, a 23 year-old male from Rochester, NY and a 20 year-old female from Providence, RI were taken to local hospitals, where they were later pronounced dead. The deaths were widely publicized in the media for several weeks. Findings by the Medical Examiner's Office listed the female's cause of death as Acute Methylenedioxymethamphetamine (MDMA) Intoxication with Hyperthermia. The male's cause of death was listed as Acute Intoxication by the combined effects of MDMA and Methylone with Hyperthermia.

An influx of synthetic drugs into the NJ area has Poison Control Centers on alert. Calls related to K2/Spice, Bath Salts, 2CE and 2CI have forced the State of New Jersey to take action in creating legislation making the compounds of these synthetics illegal. In MDMA cases in emergency rooms throughout New Jersey, many of the patients claim they took "Mollies". Intelligence data identifies "Mollies" as MDMA and/or 4MEC (bath salts). Symptoms for both drugs are similar so without proper screening from hospitals, it is difficult to determine which drug is actually involved.

Synthetic marijuana has not maintained a hold in the New York City area. Bath salts and cannabinoids in New York State appear to be less available than during previous reporting periods. The Upstate New York Poison Center[69] handles calls from all counties in New York

State except Westchester County and the counties of NYC and Long Island. There were no calls involving bath salts placed to the Upstate New York Poison Center in 2010. In 2011, there were 117 calls involving bath salts, and by 2012 this number had increased substantially to 412 calls. Calls involving bath salts then decreased almost 90 percent to 47 calls in 2013. Onondaga County (which includes the city of Syracuse) was reported to be an "epicenter" of bath salt abuse in the region in 2012. Indeed, in 2012 Onondaga County had the highest number of calls to the Upstate New York Poison Center out of the counties covered. However, the number of poison control calls from Onondaga involving bath salts dropped 90 percent from 78 calls in 2012 to just 6 calls in 2013. Similarly, from 2012 to 2013, calls involving bath salts decreased from 49 to three in Jefferson County, 59 to one in Oneida County, and 38 to zero in Oswego County. Calls to the Upstate New York Poison Center related to synthetic marijuana followed similar trends. There were no calls involving synthetic marijuana in 2010, followed by an influx of calls in 2011 (224) and 2012 (276), and followed by a substantial decrease to 56 calls in 2013. As with bath salts, the county with the highest number of synthetic marijuana calls in 2012 was Onondaga County, with 73 calls. In 2013, this number decreased 66 percent, to 25 calls. Monroe County had the second highest reported number of calls involving synthetic marijuana in 2012, with 27 calls, and this decreased almost 90 percent to three calls in 2013.

Periodic intelligence shows that narcotic dealers in New Jersey are distributing promethazine (cough medicines) with or without codeine. Patients get doctors to prescribe it, and then they sell the medicine to the dealers for $70 for a 6 ounce bottle, or $90 per 8 ounce bottle. The dealers then mix the prescription with gummy bears, or gummy fish in order to make the product thicker. The finished product is called "juicy red" and "grape juice," and is sold in sips. A one ounce sip of promethazine without codeine is $21, and $30 for a sip with codeine.

IV. MONEY LAUNDERING

New York City is one of the world's largest principal financial centers and the economic capital of the United States. Hundreds of millions of dollars are laundered each year by drug traffickers operating in the NY/NJ HIDTA region. Drug Trafficking Organizations (DTOs) operating in the region rely on multiple methods to move and launder illicit drug proceeds, such as bulk cash smuggling, money transmissions though money service businesses, structured deposits in traditional depository institutions, trade based money laundering, and crypto currency.

In 2013, the Financial Crimes Enforcement Network (FinCEN)[70] reported a total of 102,119 suspicious activity reports (SARs) filed by depository institutions in New York and 31,265 in New Jersey, a 24.9 percent and 15.66 percent increase from 2012, respectively. In New York, 51.7 percent of SARs and 48.2 percent in New Jersey indicated the type of suspicious activity as structured financial transactions (a practice known as smurfing). In addition, FinCEN reported a total of 91,593 SARs filed by money service businesses (MSBs) in New York and 24,400 in New Jersey, a 6.5 percent and a 15.8 percent increase from 2012, respectively.

Homeland Security Investigations (HSI) National Bulk Cash Smuggling Center (BCSC)[71] reports that in the NY/NJ HIDTA region, from October 1, 2012 through September 30, 2013 (FY13), there have been a total of 283 seizures for a total of approximately $129.4 million. Approximately 247 seizures occurred in, were destined for, or originated in, New York State totaling nearly $121.7 million, and 36 seizures occurred in, were destined for or originated in New Jersey totaling nearly $7.7 million.

Note: For FY 13, there were a total of 3,210 incidents reported in the NSS (National Seizure System) totaling $578,386,770. The NY/NJ HIDTA accounted for 8.8% of the total number of seizures (which occurred in, originated in or were destined for the NY/NJ HIDTA area) and 22.4% of the total money seized nationally. Although the number of seizures is comparatively low, the average amount of money seized per incident is much higher, suggesting the NY/NJ HIDTA area is a major source of illicit funds.

Since the financial sector has been effective in preventing illicit proceeds from entering the banking system through increased due diligence, bulk cash smuggling has increasingly become the preferred method of moving illicit proceeds. Most incidents involving bulk cash smuggling New Jersey. Seizure activity was also significant at ports of entry, such as Buffalo, as well as New York City. (See Figure 1).

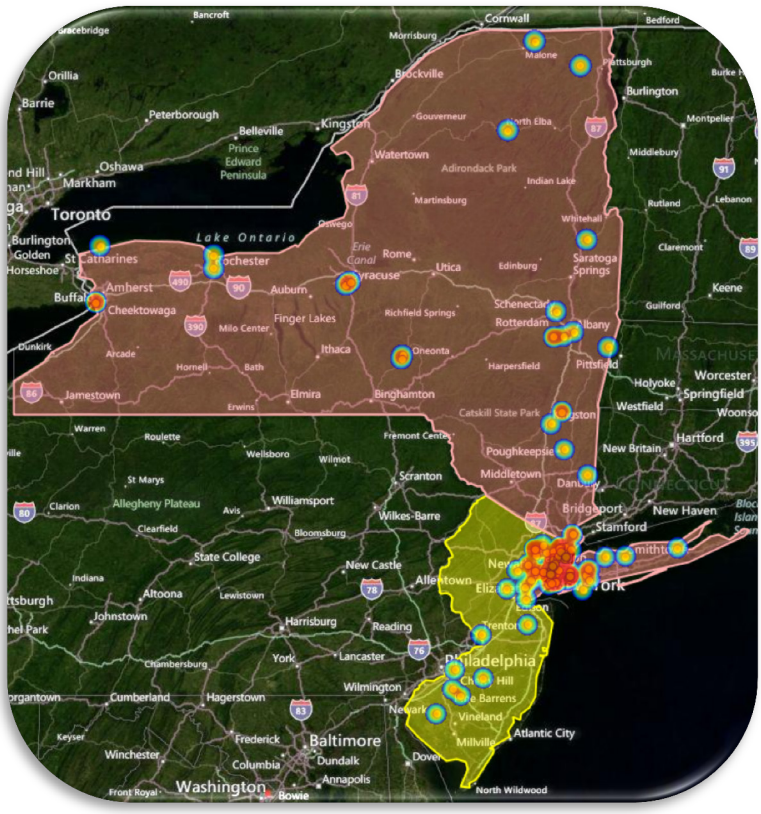


Figure 1 (NY/NJ Seizure Heatmap)[72]

Bulk cash smuggling couriers were interdicted largely on major interstates, such as Interstate 95 and Interstate 80. Couriers were most often interdicted operating personally owned vehicles (small cars and trucks) and rental vehicles.[73] Currency smuggled from the NY/NJ HIDTA region can be destined for a variety of areas across the United States. The top U.S. destinations for bulk cash shipments from the NY/NJ HIDTA region were California and Texas. These two states are considered consolidation points where cash is transported and eventually smuggled across the border to Mexico.

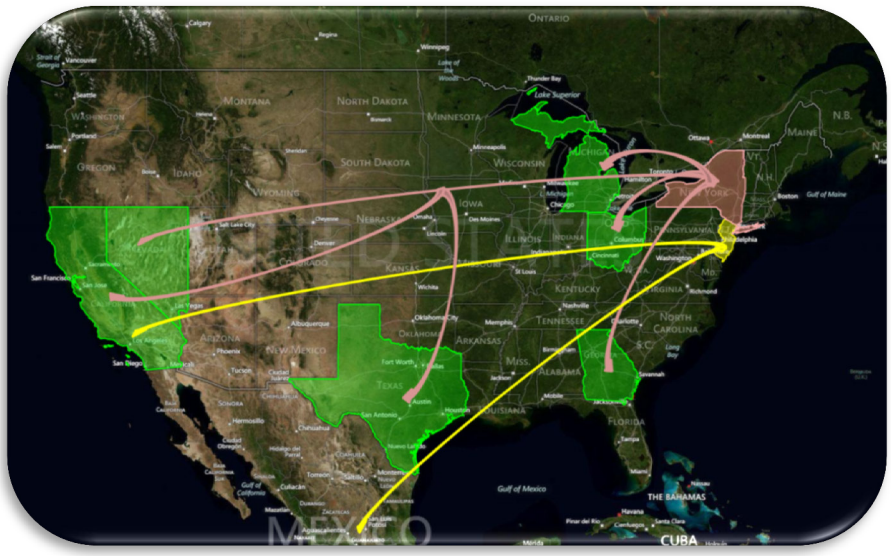


Figure 2 (Money Flow)[74]

Prepaid and stored valued cards are also used as an alternative method to launder drug proceeds. Their physical advantage over bulk cash expedites the transfer value of large quantities of currency.

In addition to bulk cash smuggling, law enforcement officials from the NY/NJ HIDTA region report that wholesale drug traffickers utilize money service businesses for moving illicit finance and laundering money in the area.

Trade based money laundering, including black market peso exchange, remains prevalent in the NY/NJ HIDTA region, primarily in the New York metropolitan area. Many legitimate businesses are unwittingly used to launder drug proceeds through black market peso exchange.[75]

Crypto currency is a digital or virtual currency that is not backed by financial institutions and uses encryption or coding as a means of security and privacy. The encryption method is what makes this currency unique, secure, anonymous, and therefore susceptible to money laundering. There are currently over 140 different types of digital currencies that are being utilized. Crypto currencies are being used as a resource to buy and sell narcotics and other illegal goods over online marketplaces. In particular, Bitcoins were exchanged on the infamous online marketplace known as Silk Road, which was shut down by the FBI in October, 2013. In January, 2014 Charlie Shrem, the CEO of the Bitcoin exchange BitInstant and his co-conspirator, Robert Faiella, who ran a business exchanging cash for Bitcoins, were arrested and charged with conspiracy to launder money and operating an unlicensed money transmitting business. In their scheme, Shrem sold Faiella the Bitcoins that were exchanged with the drug buyers and sellers on Silk Road. Together the partners exchanged and sold over $1 million worth of Bitcoins to Silk Road customers over a 10 month period ending in October, 2012.[76] Although the original Silk

Road was shut down, Silk Road 2.0 launched in early November, 2013 with a new security feature that allows its users to utilize their PGP encryption key to further conceal their identities.[77]

New York City is a primary location in the United States for money pickup operations and placement activity. According to Homeland Security Investigations, El Dorado Task Force money pickup operations continue to hold steady. In June 2008, members of the HSI New York El Dorado Task Force initiated "Operation Money Trail," an investigation targeting individuals, businesses, and bank accounts being utilized to launder proceeds derived from a Colombian DTO operating in the United States and abroad. The investigation has uncovered several techniques being utilized by the DTO to launder proceeds such as bulk cash movement, black market peso exchange, wire transfers and the use of stored value cards. Since the beginning of the investigation, EDTF Group III has coordinated a total of 45 undercover money pickups. At the direction of EDTF Group III and in coordination with the respective HSI Domestic and Attaché Offices, the undercover money pickups have taken place in New York, New Jersey, Atlanta, Houston, Los Angeles, Chicago, Miami, Tampa, Boston and Mexico City. To date, the investigation has resulted in the identification of money laundering and narcotics cells operating within the United States at the behest of the Colombia based money brokers. Based on the information developed by EDTF Group III, the Colombian based wire intercepts and the subsequent identification of the money pickup targets, HSI has domestically seized a total of $6,569,755.11 in U.S. currency, 32 kilograms of cocaine, 52.5 kilograms of heroin, 63 pounds of marijuana, 4 firearms and 8 vehicles. In furtherance of the joint international March 2013 enforcement action, the Colombian National Police arrested 13 money brokers and seized approximately 214,798,000 Colombian Pesos (approximately $115,650.00 USD), approximately $14,000.00 in USC, approximately 210 Euros (approximately $273.00 USD) and 1 gun. To date the investigation has also resulted in the successful prosecution and conviction of 24 of 32 defendants identified during the course of the investigation. Additionally, 12 of the 13 money brokers arrested in Colombia have been successfully extradited to the Eastern District of New York.[78]

V. OUTLOOK

Heroin abuse and availability are likely to continue to increase in the near term. Increased production of heroin in Mexico and continued production in Colombia will provide a steady supply to US markets. Heroin abuse will also increase as more CPDs abusers switch to heroin as a more available and cheaper alternative.

The abuse and availability of diverted **prescription opioids** will likely continue to decline in the NY/NJ HIDTA region. This seems likely due to a combination of factors, including changes in prescribing patterns, the presence of an enhanced PMP in New York (which prescribers are required to consult), and elevated availability of heroin.

The trafficking and abuse of **cocaine and crack cocaine** will likely remain at a diminished level compared to a decade ago, but cocaine and crack cocaine will still play significant roles in DTO activity.

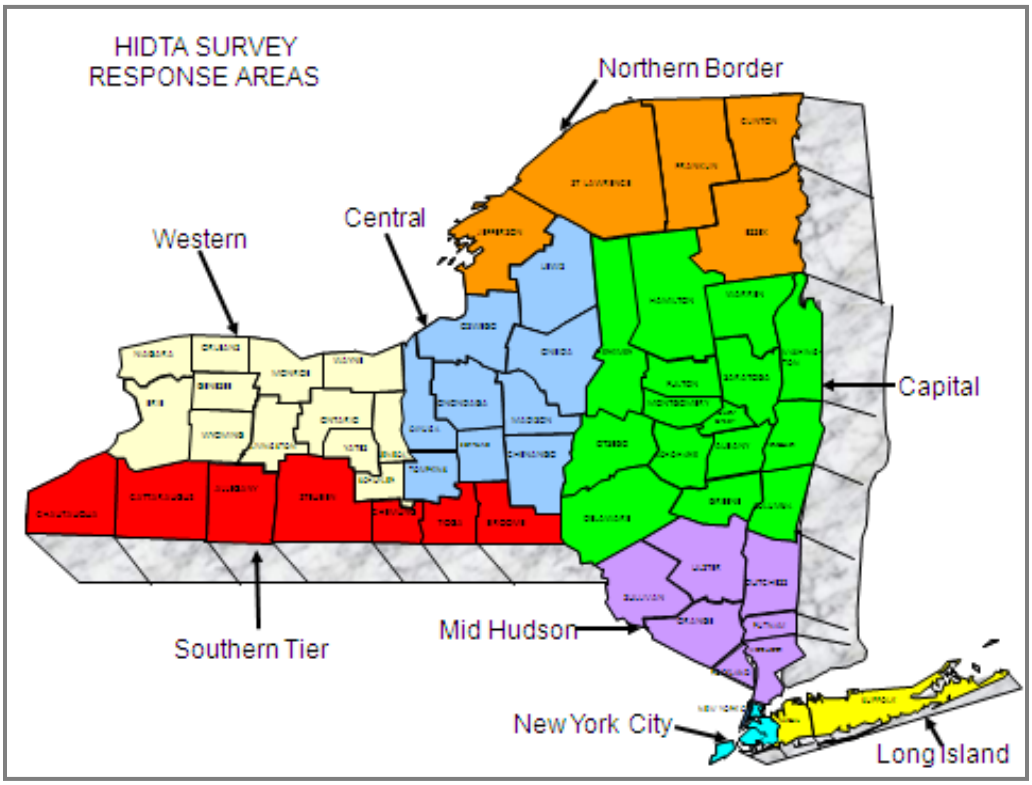
Mexican Drug Trafficking Organizations will likely continue to increase their presence throughout the NY/NJ HIDTA region and try to establish a new market for **crystal methamphetamine** and attempt to promote it as an alternative for cocaine. However, it is unclear if the DTOs will be able to develop a sufficient consumer base and avenues of distribution.

Marijuana availability and abuse may increase in response to the reduction in criminal penalties associated with the sale and possession of small quantities of marijuana. The availability of marijuana concentrates, such as hash oil, will likely increase. The elevated THC levels of marijuana concentrates will pose medical consequences to abusers, and the dangerous methods used to extract concentrates will pose serious risks to producers as well as to first responders.

Synthetic cannabinoids and **synthetic cathinones** will likely not increase to their previous levels, but will continue to pose a challenge to law enforcement agencies, since manufacturers are capable of tweaking the chemical composition of the product.

VI. METHODOLOGY

The 2015 New York/New Jersey HIDTA Threat Assessment is a comprehensive evaluation of the threat posed by the trafficking and abuse of illicit drugs. It was prepared through detailed analysis of the most recent law enforcement, intelligence, and public health data available through the date of publication. DEA and HIDTA personnel analyzed data provided by various federal, state, and local law enforcement agencies within the region. Numerous personal interviews with law enforcement officers in the region also supplement this assessment.



VII. APPENDICES

Appendix A: Federal-Wide Drug Seizure System (FDSS) – Calendar Year 2013

	Heroin	Cocaine	Marijuana	Meth	MDMA
New York	244 kg	616 kg	209 kg	64 kg	3,456 du
New Jersey	70 kg	901 kg	2,060 kg	37 kg	128 kg/35,548 du
50 States Total	3,072 kg	38,973 kg	1,492,394 kg	16,803 kg	190 kg/2,819,635 du

The Federal-wide Drug Seizure System (FDSS) contains information about drug seizures made by the Drug Enforcement Administration, the Federal Bureau of Investigation, the Bureau of Customs and Border Protection, and the Bureau of Immigration and Customs Enforcement, within the jurisdiction of the United States.

Appendix B: Drug Prices in New York and New Jersey

Drug Prices – New York

HEROIN	**New York Metro Area**	**Central**	**Western**	**North**
Kilogram (South American/SA)	$40,000 - $80,000		$65,000 - $100,000	
Ounce (SA)	$1,000 - $2,500		$2,400 - $5,500	
Gram (SA)	$45 - $120		$80 - $150	
"8-ball"	$180 - $210			
Sleeve *(100 bags)* (SA)	$900 - $1,000	$800		
Bundle *(10 bags)* (SA)	$60 - $200	$90 - $300	$80 - $150	$275 - $350
Bag (SA)	$5 - $20	$10 - $40	$10 - $20	$20 - $50
COCAINE	**New York Metro Area**	**Central**	**Western**	**North**
Kilogram	$23,500 - $54,000	$20,000 - $32,000	$26,000 - $45,000	
Ounce	$700 - $1,900	$1,000 - $1,500	$1,200 - $2,000	
"8-ball"	$90 - $200	$150 - $400	$150 - $500	$250 - $300
Gram ("Big Boy" - Albany area)	$25 - $100	$50 - $125	$43 - $135	$100
Bag/Vial	$5 - $50	$10 - $20	$10 - $20	
CRACK	**New York Metro Area**	**Central**	**Western**	**North**
Kilogram	$40,000 - $45,000	$25,000 - $40,000	$30,000 - $45,000	
Ounce	$700 - $1,500	$800 - $1,600	$300 - $1,500	
"8-ball"	$120 - $350	$100 - $400		
Gram	$28 - $55	$60 - $150	$50 - $125	$100
Rock	$5 - $40	$10 - $100	$10 - $50	$80 - $100
MARIJUANA	**New York Metro Area**	**Central**	**Western**	**North**
Pound (Domestic)	$300 - $2,400		$800 - $1,200	$2,000 - $2,200
Pound (Mexican)	$1,200		$1,400 - $1,600	
Pound (Hydroponic)	$2,000 - $8,000	$4,000 - $6,000	$1,800 - $2,200	$2,000 - $2,500
Ounce (Domestic)	$50 - $350	$100 - $400	$140 - $400	$180 - $250
Ounce (Hydroponic)	$300 - $400			
Bag (Domestic)	$10 - $150			

Bag (BC Bud)	$5- $10			
Butane Honey Oil - Gram		$80 - $100		
METHAMPHETAMINE	**New York Metro Area**	**Central**	**Western**	**North**
Pound (Crystal/"Ice")	$10,000 - $25,000			
Ounce (Powder)			$1,000	
Ounce (Crystal/"Ice")	$2,500 - $3,000			
Gram (Powder)	$50 - $240	$70 - $200	$80 - $120	$100
Gram (Crystal/"Ice")	$100 - $250			
Other Drugs	**New York Metro Area**	**Central**	**Western**	**North**
Adderal	$10	$4 - $5		
Carisopradol (Soma)		$10 - $25		
Diazepam (Valium)	$2 - $5	$3 - $20	$1 - $2	
Fentanyl (50 mcg/hr)			$60 - $100	
Fentanly - tablet		$15		
Hydrocodone (Vicodin) {30 mg}	$5 - $25	$15 - $30		
Hydrocodone (Vicodin) {10 mg}	$3 - $7	$3 - $10	$5 - $12	$5 - $10
Ketamine	$25 - $80/10 ml	$10 - $75 du		
Klonopin	$3 - $5	$2 - $25	$2	
LSD (dosage unit)	$10 - $25	$5 - $25	$5 - $10	$20
MDMA - retail (per pill)	$10 - $40	$5 - $30	$9 - $40	$10 - $20
MDMA - wholesale (per pill)	$1.50 - $4.50			
MDMA (ounce)	$1,100 - $1,300	$1,100		
Methadone (10 mg)	$5 - $30	$5 - $10	$5 - $12	$6 - $12
Methylone *(Molly)* - kilogram	$17,000			
Methylone *(Molly)* - gram	$1,900			
Methylone *(Molly)* - ounce	$600 - $1,000	$1,400		
Morphine	$10 - $20	$20 - $30	$10	$15 - $50
Opana (40 mg)	$35 - $60		$40 - $160	
Oxycodone (30 mg)	$10 - $30	$15 - $30	$8 - $28	
OxyContin (about $1 per mg)	$15 - $80	$20 -$40	$60 - $110	$100
PCP (bag/dosage unit)	$8 - $25	$5 - $30		
PCP (ounce)	$400 - $450			
Percocet	$4 - $10	$3 - $25	$5 - $10	$5 - $20
Psilocybin (ounce)	$120 - $200	$80 - $280	$320	$120 - $140
Suboxone (8 mg)		$20	$20 - $25	
Xanax	$2 - $5	$5 - $30	$2 - $7	$3 - $7

Drug Prices – New Jersey Area

HEROIN	**Newark**	**Atlantic City**	**Camden**
Kilogram (South American/SA)	$56,000 - $62,000	$70,000 - $110,000	$70,000 - $80,000
Ounce (SA)	$1,000 - $3,300	$1,800 - $2,4000	$2,000 - $2,3000
Gram (SA)	$55 - $80		
Brick *(10 bags)* (SA)	$50 - $80	$250 - $300	
Bag (SA)	$5 - $6		$10 - $20
COCAINE	**Newark**	**Atlantic City**	**Camden**
Kilogram	$27,000 -$45,000	$30,000 - $35,000	$30,000 - $41,000
Ounce	$800 - $1,000		$1,200 - $2,000
"8-ball"	$130 - $500		$200 - $275
Gram	$38 - $65	$75 - $100	$70 - $100
Bag/Vial			$10 - $20
CRACK	**Newark**	**Atlantic City**	**Camden**
Kilogram	$14,000 - $24,000		$30,000 - $41,000
Ounce	$900 - $1,300	$800 - $1,500	$1,200 - $2,000
"8-ball"			$200 - $275
Gram	$38 - $50		$70 - $100
Rock			$10 - $20
MARIJUANA	**Newark**	**Atlantic City**	**Camden**
Pound (Domestic)	$600 - $4,000	$1,000 - $3,000	$1,500 - $2,000
Pound (Hydroponic)	$2,500 - $6,000		
Ounce (Domestic)	$120 - $340	$120 - $150	$200 - $600
Ounce (Hydroponic)	$400 - $450		
Bag (Domestic)	$5 - $10		
METHAMPHETAMINE	**Newark**	**Atlantic City**	**Camden**
Kilogram (Crystal/"Ice")	$30,000	$25,000 - $30,000	$30,000 - $40,000
Pound (Powder)	$14,000 - $24,000		
Ounce (Powder)	$900 - $1,500		
Ounce (Crystal/"Ice")	$1,250 - $1,50	$1,000 - $1,500	$900 - $2,500
Gram (Crystal/"Ice")	$24 - $90	$75 - $125	$50 - $150
Other Drugs	**Newark**	**Atlantic City**	**Camden**
MDMA - retail (per pill)	$2 - $10	$20 - $25	$10 - $20
Methylone *(Molly)* - kilogram	$10,000 - $25,000		
Methylone *(Molly)* - ounce	$700 - $1,500		
Methylone *(Molly)* - gram	$17 - $18		
Oxycodone (30 mg)	$12 - $25	$17 - $30	$10 - $22
Percocet (10 mg)	$5 - $11	$6 - $10	$10 - $15
Xanax	$8 - $10	$6 - $8	

Appendix C: *DEA Drug Threat Survey 2014*

Greatest Drug Threat and Drug-Related Crime

1. For your jurisdiction, please indicate the drug that poses the greatest threat, the drug that most contributes to violent crime, and the drug that most contributes to property crime. (Choose only ONE drug on each list.)

Greatest Drug Threat **(Choose only ONE.)**	
Powder cocaine	○
Crack cocaine	○
Heroin	○
Methamphetamine	○
Marijuana	○
Controlled Prescription Drugs	○
Not applicable	○
Don't know	○

Violent Crime **(Choose only ONE.)**	
Powder cocaine	○
Crack cocaine	○
Heroin	○
Methamphetamine	○
Marijuana	○
Controlled Prescription Drugs	○
Not applicable	○
Don't know	○

Property Crime **(Choose only ONE.)**	
Powder cocaine	○
Crack cocaine	○
Heroin	○
Methamphetamine	○
Marijuana	○
Controlled Prescription Drugs	○
Not applicable	○
Don't know	○

1a. Over the past year, has your agency experienced a significant change in a drug trafficking attribute (availability, demand, distribution, production, transportation) for any of the drugs listed? If so, please choose whether the change is an INCREASE (Inc), a DECREASE (Dec), or has REMAINED THE SAME (Same) for each drug and each attribute. Choose NA for not applicable.

	Availability				**Demand**				**Distribution**				**Transportation**			
	Inc	Dec	Same	NA	Inc	Dec	Same	NA	Inc	Dec	Same	NA	Inc	Dec	Same	NA
Example Drug	●	○	○	○	●	○	○	○	●	○	○	○	●	○	○	○
Powder Cocaine	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Crack Cocaine	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Heroin	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Methamphetamine	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Marijuana	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
MDMA	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Controlled Prescription Drugs	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Synthetic Cathinones (Bath Salts)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Synthetic Cannabinoids (Spice, K2)	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Drug Availability

2. Indicate the level of availability of the following drugs in your jurisdiction using the following definitions:

***High* availability** - **drug is easily obtained at any time;**
***Moderate* availability** - **drug is easily obtained most of the time;**
***Low* availability** - **drug is difficult to obtain most of the time.**

	High	**Moderate**	**Low**	**Not Available**	**Don't Know**		**High**	**Moderate**	**Low**	**Not Available**	**Don't Know**
Powder cocaine	○	○	○	○	○	Controlled Prescription Drugs	○	○	○	○	○
Crack cocaine	○	○	○	○	○	Synthetic Cathinones (Bath Salts)	○	○	○	○	○
Heroin	○	○	○	○	○	Synth. Cannabinoids (Spice, K2)	○	○	○	○	○
Methamphetamine	○	○	○	○	○	MDMA	○	○	○	○	○
Marijuana	○	○	○	○	○	Hallucinogens (LSD, PCP, etc)	○	○	○	○	○

Drug Trafficking Activities

3. Please choose the race or ethnicity of the DOMINANT criminal group or organization that is responsible for transportation, and wholesale and retail distribution for each drug. (Choose only ONE group/organization for EACH drug in each category.)

	Transportation							**Wholesale** Distribution							**Retail** Distribution						
	Powder Cocaine	Crack Cocaine	Heroin	Methamphetamine	Marijuana	MDMA	Prescription Drugs	Powder Cocaine	Crack Cocaine	Heroin	Methamphetamine	Marijuana	MDMA	Prescription Drugs	Powder Cocaine	Crack Cocaine	Heroin	Methamphetamine	Marijuana	MDMA	Prescription Drugs
African American	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Asian	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Caucasian	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colombian	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Dominican	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Hispanic	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Jamaican	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Mexican	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Other:	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

3a. Please choose the race or ethnicity of OTHER criminal group(s) or organization(s) that transport, and distribute (wholesale and retail quantities) each drug in your area. (Choose up to THREE groups/organizations for EACH drug in each category.)

	Transportation							**Wholesale** Distribution							**Retail** Distribution						
	Powder Cocaine	Crack Cocaine	Heroin	Methamphetamine	Marijuana	MDMA	Prescription Drugs	Powder Cocaine	Crack Cocaine	Heroin	Methamphetamine	Marijuana	MDMA	Prescription Drugs	Powder Cocaine	Crack Cocaine	Heroin	Methamphetamine	Marijuana	MDMA	Prescription Drugs
African American	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Asian	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Caucasian	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colombian	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Dominican	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Hispanic	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Jamaican	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Mexican	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Other 1:	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Other 2:	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Drug Production

4. **Please indicate the level of the methamphetamine production problem in your jurisdiction using the following definitions:**
   ***High* production - methamphetamine is frequently produced in your area;**
   ***Moderate* production - methamphetamine is sometimes produced in your area;**
   ***Low* production - methamphetamine is rarely produced in your area.**

   High production ◯ Moderate production ◯ Low production ◯ Not produced ◯ Don't know ◯

5. **Please indicate how cannabis is cultivated in your jurisdiction. (Check ALL that apply.)**

   Indoors ◯ Outdoors ◯ Hydroponically ◯ Not cultivated ◯ Don't know ◯

Diversion/Illicit Use of Controlled Prescription Drugs

6. **Please indicate the levels of diversion (e.g. doctor shopping, fraud, forgery) and illicit use for the following types of controlled prescription drugs in your jurisdiction using the following definitions:**
   ***High* diversion/illicit use - drugs are frequently diverted/used illicitly in your area;**
   ***Moderate* diversion/illicit use - drugs are sometimes diverted/used illicitly in your area;**
   ***Low* diversion/illicit use - drugs are rarely diverted/used illicitly in your area.**

	Level of Diversion					*Level of Illicit Use*				
	High	**Moderate**	**Low**	**None**	**Don't Know**	**High**	**Moderate**	**Low**	**None**	**Don't Know**
Narcotics (e.g., Vicodin®, OxyContin®)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Depressants (e.g., Valium®, Xanax®)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Stimulants (e.g., Adderall®, Ritalin®)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Steroids (e.g., Anadrol®, Oxandrin®)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

Appendix D: Summary of Drug Threat Survey Results

New York responses:

Drug	Greatest Drug Threat	Most Contributes to Violence	Most Contributes to Property Crime
Powder Cocaine	1	1	0
Crack	5	17	5
CPDs	9	0	6
Heroin	24	14	25
Marijuana	0	0	0
Methamphetamine	1	1	2

New Jersey responses:

Drug	Greatest Drug Threat	Most Contributes to Violence	Most Contributes to Property Crime
Powder Cocaine	0	2	0
Crack	4	10	3
CPDs	11	4	4
Heroin	39	27	46
Marijuana	0	2	1
Methamphetamine	0	1	0

Appendix E: *Rx Crimes Incidents*

Rx Crimes Incidents in New York State by County (2012 and 2013 combined)

Counties	Burglary	Attempted Burglary	Robbery	Attempted Robbery	Total
Albany	0	1	2	0	**3**
Allegany	3	0	0	0	**3**
Bronx	19	5	3	1	**28**
Broome	1	0	1	0	**2**
Cattaraugus	0	2	0	0	**2**
Chautauqua	3	1	1	0	**5**
Chemung	2	0	1	0	**3**
Chenango	0	1	0	0	**1**
Clinton	1	0	1	0	**2**
Dutchess	1	0	3	2	**6**
Erie	6	0	7	0	**13**
Essex	0	0	1	0	**1**
Franklin	1	0	0	0	**1**
Kings	12	4	5	0	**21**
Monroe	0	0	1	0	**1**
Nassau	12	4	4	1	**21**
New York	5	3	6	0	**14**
Niagara	1	0	3	0	**4**
Onondaga	1	5	1	0	**7**
Orange	3	5	0	0	**8**
Oswego	1	0	0	0	**1**
Putnam	0	0	0	1	**1**
Queens	11	3	2	1	**17**
Richmond	0	1	0	0	**1**
Rockland	1	0	0	0	**1**
Saratoga	0	0	3	0	**3**
Schenectady	0	0	1	0	**1**
Suffolk	2	2	3	1	**8**
Tioga	1	0	1	0	**2**
Ulster	4	0	0	0	**4**
Wayne	1	0	0	0	**1**
Westchester	4	0	0	0	**4**
Total	**96**	**37**	**50**	**7**	**190**

Rx Crimes Incidents in New Jersey by County (2012 and 2013 combined)

County	Burglary	Attempted Burglary	Robbery	Attempted Robbery	Total
Atlantic	0	0	5	0	**5**
Bergen	1	0	0	0	**1**
Burlington	0	1	0	0	**1**
Camden	0	0	2	1	**3**
Cape May	0	0	2	0	**2**
Essex	2	0	7	0	**9**
Gloucester	0	0	3	2	**5**
Hudson	0	0	2	0	**2**
Mercer	0	0	4	0	**4**
Middlesex	0	0	0	1	**1**
Monmouth	4	0	5	1	**10**
Morris	0	0	1	0	**1**
Ocean	0	1	2	0	**3**
Passaic	0	0	1	0	**1**
Somerset	5	0	0	1	**6**
Sussex	0	0	1	0	**1**
Union	2	0	0	0	**2**
Warren	0	0	1	0	**1**
Total	**14**	**2**	**36**	**6**	**58**

VIII. ENDNOTES

[1] Data for the New York City section were provided by the NYC Department of Health and Mental Hygiene (DOHMH), Bureau of Alcohol and Drug Use Prevention, Care and Treatment (BADUPCT). All data is subject to revision as case details are added or revised. Mortality data were abstracted from two linked sources for 2005-2012 – the DOHMH Office of Vital Statistics and the associated case files at the Office of the Chief Medical Examiner (OCME). For this analysis DOHMH defined an unintentional drug poisoning death as a death occurring in NYC during the period 2005 through 2012 and whose death certificate recorded 1) manner of death as "accidental," and 2) where the underlying causes of death were coded to "poisoning by a psychoactive substance" or "mental or behavioral disorder due to psychoactive substances" *(based on International Classification of Disease, 10th Revision).* This includes 'overdoses' from illegal and legal drugs taken for non-medical reasons; poisonings where the intent was intentional, undetermined or homicide were excluded. A diagnosis of death caused by intoxication by one or more drugs requires that the toxicology be consistent with a fatal intoxication and that the autopsy failed to disclose a disease or physical injury with an extent or severity inconsistent with continued life. When toxicology results reveal the presence of more than one drug in concentrations greater than trace amounts, all identified drugs are reported.

[2] Office of the Medical Examiner, Dutchess County Department of Health (2013 data compiled February 2014; 2012 data compiled February 2013; 2011 data compiled February 2012; 2010 data compiled January 2011; 2009 data compiled March 2010). All data is subject to revision as case details are added or revised. Data includes all deaths where illicit and/or prescriptions drugs were identified via toxicology or case reports as a contributing factor and the intent was unknown or accidental. Alcohol-only overdoses were removed from the analyzed dataset.

[3] Office of the Medical Examiner, Westchester County Department of Laboratories and Research. 2013 data collected and compiled as of March 28, 2014 by the Westchester Intelligence Center; 2009-2012 data collected and compiled as of June 1, 2013 by the Westchester Intelligence Center. All data is subject to revision as case details are added or revised. Data includes all deaths where illicit and/or prescriptions drugs were identified via toxicology or case reports as a contributing factor and the intent was unknown or accidental. Alcohol-only overdoses were removed from the analyzed dataset.

[4] Orange County Office of the Medical Examiner. 2013 data collected and compiled as of April 28, 2014. 2012 data collected and compiled as of February 27, 2013. All data is subject to revision as case details are added or revised. Data includes all deaths where illicit and/or prescriptions drugs were identified via toxicology or case reports as a contributing factor and the intent was unknown or accidental. Alcohol-only overdoses were removed from the analyzed dataset.

[5] Putnam County Office of the Medical Examiner. 2010-2013 data collected and compiled as of February 4, 2014. All data is subject to revision as case details are added or revised. Data includes all deaths where illicit and/or prescriptions drugs were identified via toxicology or case reports as a contributing

factor and the intent was unknown or accidental. Alcohol-only overdoses were removed from the analyzed dataset.

[6] Suffolk County Office of the Medical Examiner. 2013 data collected and compiled as of April 4, 2014. 2012 data collected and compiled as of December 11, 2014. All data is subject to revision as case details are added or revised. Data includes all deaths where illicit and/or prescriptions drugs were identified via toxicology or case reports as a contributing factor and the intent was unknown or accidental. Alcohol-only overdoses were removed from the analyzed dataset.

[7] Erie County Medical Examiner's Office. 2013 data collected and compiled as of May 9, 2014. All data is subject to revision as case details are added or revised. Data includes all deaths where at least one chemical (including but not limited to illicit and/or prescription drugs) were identified via toxicology or case reports as a contributing factor. The data includes deaths where intent was unknown, accidental, or suicide.

[8] New Jersey's Office of the State Medical Examiner (NJ OSME). Compiled and provided (with permission) by the New Jersey Department of Health (NJ DOH), Center for Health Statistics (CHS) as of April 9, 2014. All data are subject to revision as case details are added or revised. The data represents drug-related deaths from the Medical Examiner's offices throughout NJ, with "drug-related" defined as including illicit drugs, prescription drugs, and alcohol. For this report prescription opioid-involved deaths refers to any accidental drug overdose death where prescription opioids were present; heroin-involved deaths refers to any accidental drug overdose death where heroin was present; and cocaine-involved deaths refers to any accidental drug overdose death where cocaine was present. Deaths in each of these categories are not mutually exclusive and are determined by the type and combination of drugs present at toxicology.

[9] The Federal-wide Drug Seizure System (FDSS) contains information about drug seizures made by the Drug Enforcement Administration, the Federal Bureau of Investigation, the Bureau of Customs and Border Protection, and the Bureau of Immigration and Customs Enforcement, within the jurisdiction of the United States.

[10] J. David Goodman, "New York Is a Hub in a Surging Heroin Trade," *New York Times*, May 19, 2014, accessed at http://www.nytimes.com/2014/05/20/nyregion/new-york-is-a-hub-in-a-surging-heroin-trade.html?_r=1.

[11] Drug Enforcement Administration (DEA), New Jersey Division

[12] Drug Enforcement Administration (DEA), New York Division, Special Intelligence Group

[13] NY/NJ HIDTA DIO Intelligence Report for Albany County, March 2014

[14] Drug overdose death data for counties in New York State were provided by individual county Medical Examiner Offices and in the case of NYC, the NYC Department of Health and Mental Hygiene (DOHMH), Bureau of Alcohol and Drug Use Prevention, Care and Treatment (BADUPCT). Data from counties outside NYC are reported according to each Office's individual method for determining drug-related or overdose deaths. These methods are not standardized and rates of death are not age-adjusted. Comparing across counties may not be accurate and would, at minimum, require addressing the discrepancies in reporting processes across different counties. Deaths in each of these categories are not mutually exclusive and may be counted in multiple categories if multiple drugs were present in toxicology.

[15] Data provided by NYS OASAS Client Data System, April 14, 2014. Annual treatment admissions figures represent the number of admissions by county residents to an OASAS licensed facility in a given year, and admissions are categorized according to primary substance of abuse indicated on the form for each admission. The data presented do not represent unique individuals admitted for treatment, only unique substances reported during individual admissions. Thus, the data includes individuals experiencing multiple admissions to the same or different levels of care, and, as a result, individuals residing in counties with access to multiple levels of service may be over-represented. For these reasons, any differences among counties in level of admission activity and admission rates should be interpreted with caution since counties vary in terms of access to multiple levels of service. Only non-crisis admissions were considered due to data availability and additional confounding variables associated with crisis admissions (e.g., proximity of services). Admissions citing alcohol as the primary drug of abuse were excluded from the analysis. All data is subject to revision as case details are added or revised. OASAS treatment data are considered complete after six months. CY 2013 will be considered complete by July 1, 2014. For admissions counts, the data collected through April 14, 2014 should be accurate within a very small percent of the final total number of admissions. In accordance with client confidentiality, OASAS cannot provide admissions figures in any category with fewer than five admissions. For the purposes of this analysis, categories with fewer than five admissions were counted as representing 2.5 admissions (totals were rounded up to the nearest whole number where relevant). As a result, figures on the rate of admissions by drug category represent estimates, not exact counts. Rates per population are not age-adjusted.

[16] Previously Cited, See Endnote 1

[17] Previously Cited, See Endnote 3

[18] Heroin breaks down in the body to morphine. Thus, toxicology tests performed in the case of deaths involving heroin often indicate morphine as present instead of heroin. For the purposes of this assessment, morphine-involved deaths are included in the counts of heroin-involved deaths for Westchester, Putnam, Orange, Dutchess, and Suffolk.

[19] Previously Cited, See Endnote 4

[20] Previously Cited, See Endnote 18

[21] Previously Cited, See Endnote 2

[22] Previously Cited, See Endnote 18

[23] Previously Cited, See Endnote 5

[24] Previously Cited, See Endnote 18

[25] Nassau County Medical Examiner's Office, Department of Forensic Toxicology, May 5, 2014. Data include only deaths where an opioid (heroin and/or prescription opioids) were identified as contributing to the deaths. All data is subject to revision as case details are added or revised. Unless otherwise specified, data does not include all drugs that were present in toxicology, only those that were identified in the cause of death. This does not include information on deaths involving illicit drugs other than heroin and/or prescription opioids. Prescription opioids include oxycodone, hydrocodone, hydromorphone, codeine, morphine, methadone, fentanyl, buprenorphine and oxymorphone. Unless otherwise specified, rate per 100,000 residents calculations are based on the county's total population that year and are not age-adjusted.

[26] Previously Cited, See Endnote 18
[27] Previously Cited, See Endnote 6
[28] Monroe County Medical Examiner's Office. 2011, 2012, and 2013 statistics publicly released as of February 4, 2014. Retrieved from: http://www.whec.com/whecimages/repository/cs/files/Heroin%20data%20for%20release%202-4-14.pdf
[29] Onondaga County Medical Examiner's Office. Reported in article published in The Post-Standard on May 31, 2014. Retrieved from: http://www.syracuse.com/news/index.ssf/2014/05/heroin-gone-wild_in_central_new_york_causes_jumps_in_overdoses_deaths.html
[30] Previously Cited, See Endnote 8
[31] New Jersey Substance Abuse Monitoring System (NJ SAMS). New Jersey Department of Human Services (NJ DHS), Division of Mental Health and Addiction Services (DMHAS), Office of Research, Planning, Evaluation and Information Systems & Technology. All data is subject to revision as case details are added or revised. Total admissions by drug are based on primary drug admissions only and represent seven drug categories: alcohol, heroin, cocaine/crack, marijuana/hashish, other opiates, sedatives, and other. The other opiates category (referred to as prescription opioids in this analysis) includes "OxyContin," "Opiate-Other," and "Methadone (non-prescription use)." Treatment types in this data include: outpatient care, intensive outpatient care, partial hospitalization, opioid maintenance OP, opioid maintenance IOP, extended care, halfway house, long-term residential, short-term residential, hospital-based residential, detox residential, detox hospital, detox outpatient non-methadone, detox outpatient methadone, and non-traditional programs. Rates per population are not age-adjusted.
[32] Erie County Medical Examiner's Office. 2013 data collected and compiled as of May 9, 2014. All data is subject to revision as case details are added or revised. Data includes all deaths where at least one chemical (including but not limited to illicit and/or prescription drugs) were identified via toxicology or case reports as a contributing factor. The data includes deaths where intent was unknown, accidental, or suicide. Alcohol-only overdoses were removed from the analyzed dataset. Not every death indicates which substances were involved; therefore, the counts of fentanyl deaths indicate the number of deaths for which fentanyl was reported but do not necessarily cover all of the fentanyl deaths in the given time periods.
[33] Previously Cited, See Endnote 2
[34] Previously Cited, See Endnote 3
[35] Previously Cited, See Endnote 4
[36] Previously Cited, See Endnote 5
[37] Previously Cited, See Endnote 25
[38] Previously Cited, See Endnote 6
[39] Data on prescriptions filled was provided by New York State Bureau of Narcotic Enforcement, compiled on May 12, 2014. Data covers top ten controlled prescription drugs filled in each county in New York State, based upon the zip code of the patient who filled the prescription.
[40] The numbers reported in this section represent estimates of how many pills were stolen in each Rx Crimes incident. These estimates are based on information that has been entered into Rx Crimes by law

enforcement authorities. In some instances the type and quantity of stolen pills are not made available to law enforcement or not reported so actual numbers are likely higher than these estimates suggest.

[41] Previously Cited, See Endnote 40

[42] Previously Cited, See Endnote 7

[43] Previously Cited, See Endnote 15

[44] Previously Cited, See Endnote 1

[45] Previously Cited, See Endnote 3

[46] Previously Cited, See Endnote 4

[47] Previously Cited, See Endnote 2

[48] Not limited to prescription opioids or benzodiazepines. Also includes other forms of prescription drugs, such as anti-depressants, barbiturates, etc.

[49] Previously Cited, See Endnote 5

[50] Previously Cited, See Endnote 25

[51] Previously Cited, See Endnote 6

[52] Previously Cited, See Endnote 8

[53] Previously Cited, See Endnote 31

[54] Previously Cited, See Endnote 14

[55] Previously Cited, See Endnote 15

[56] Previously Cited, See Endnote 1

[57] Previously Cited, See Endnote 3

[58] Previously Cited, See Endnote 4

[59] Previously Cited, See Endnote 2

[60] Previously Cited, See Endnote 5

[61] Previously Cited, See Endnote 6

[62] Previously Cited, See Endnote 8

[63] Previously Cited, See Endnote 15

[64] Kristina Sgueglia and Greg Botelho, "New York Governor Announces Plan for Medical Marijuana at Hospitals," *CNN*, January 10, 2014, available at: http://www.cnn.com/2014/01/08/health/new-york-state-medical-marijuana/

[65] Previously Cited, See Endnote 15

[66] Previously Cited, See Endnote 31

[67] DEA New York Division based on National Seizure System (NSS) data

[68] El Paso Intelligence Center – NSS

[69] Upstate New York Poison Center. Data compiled as of May 2014. Data includes calls placed for synthetic marijuana and calls placed for bath salts for the years 2010 through 2013, covering all counties in New York State except Westchester County, NYC counties (Bronx, Kings, New York, Richmond, and Queens), and Long Island counties (Suffolk and Nassau).

[70] Financial Crimes Enforcement Network, Suspicious Activity Report Filings by Depository Institutions, New York and New Jersey, 2013

[71] Financial Crimes Enforcement Network, Suspicious Activity Report Filings by Money Service Businesses, New York and New Jersey, 2013

[72] AOR Seizure Heat Map FY13, Prepared by National Bulk Cash Smuggling Center Assessment Prepared for New York/New Jersey HIDTA, March 14, 2014

[73] National Seizure System (NSS) data collected for New York/New Jersey HIDTA, March 14, 2014. The National Seizure System ONLY**.** NSS captures Seized Assets and Case Tracking System (SEACATS) data and most roadside seizures reported by state and local law enforcement, HSI generates many of its cases from the same data that is collected through the National Seizure System (NSS). HSI reports were omitted to avoid duplicate reporting.

[74] Money Flow Map, Prepared by the National Bulk Cash Smuggling Center for New York/New Jersey HIDTA, April 25, 2013

[75] Homeland Security Investigations, Interviewed by HIFCA Analyst (March 28,2014)

[76] http://money.cnn.com/2014/01/27/technology/security/bitcoin-arrest/

[77] http://www.forbes.com/sites/andygreenberg/2013/11/06/silk-road-2-0-launches-promising-a-resurrected-black-market-for-the-dark-web/

[78] Review of OCDETF Case: NYNYE-678, "Operation Money Trail"