Northwest HIDTA
Northwest High Intensity Drug Trafficking Area
Threat Assessment and Strategy
For Program Year 2018

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Cover Photo: Snoqualmie Falls - by Don Detrick
I. Executive Summary

(U) The opioid epidemic continues to dominate headlines within the state and throughout the region. Powerful synthetic opioids, such as fentanyl and its derivatives, led to the overdose deaths of 70 individuals in Washington State during 2016 - more than twice the number of fentanyl-related deaths in the previous year. Although much of Washington’s focus is on curbing the opioid crisis, methamphetamine remains a critical threat in the Pacific Northwest. The regulation of recreational and medicinal marijuana continues to pose new challenges for law enforcement even as use of the drug in Washington State has been legal for several years. The reemergence of cocaine presents a unique threat to law enforcement and citizens in Washington State. The Northwest High Intensity Drug Trafficking Area (HIDTA) Threat Assessment report combines law enforcement survey responses, reports from local health departments, and drug seizure data to assess the drug threats in Washington and creates strategies to address them. Northwest HIDTA is comprised of 14 counties across the state, enveloping law enforcement partners at the local, tribal, state, and federal levels, many of whom contributed to this report.

Northwest HIDTA’s current drug threats:

- (U//FOUO) The number of opioid-related overdose deaths remains unabated in Washington State, with preliminary data for 2016 reflecting nearly 600 deaths where an opioid/opioids were found in the system, similar to that of 2011 through 2015 where opioid-related overdose deaths exceeded 600. Opioids pose a continued threat in Washington State, with opioid-related treatment admissions surpassing treatment admissions for alcohol in 2015. Heroin-related deaths and treatment numbers continue to reflect high or sustained use of the drug, and King, Pierce, Kittitas and Spokane Counties programs reflect a 19 percent increase in needle exchanges from 2014 to 2016. Naloxone (brand name Narcan ®), an opioid antidote, is easier to obtain in the state and several opioid-focused projects continue to address the heroin epidemic and look for solutions. In 2016, there were 70 fentanyl-related overdose deaths in Washington State, 63 of which involved another drug, most often benzodiazepine. Oxycodone (OxyContin ®) is considered by many to be a precursor to abusing heroin. In January 2017, Everett City Council filed a class action lawsuit against Purdue Pharma, the creator of OxyContin, alleging that the pharmaceutical company knowingly allowed its product to be sold through the black market.

- (U//FOUO) Adult methamphetamine treatment admissions are second only to heroin, and opioid overdose deaths involving methamphetamine increased 72 percent statewide from 2010 to 2015.\(^1\) The rise may be attributed to users combining opioids with methamphetamine when injecting.

- (U//FOUO) In 2016, Washington State’s Senate Bill (SB) 5052 went into effect and medical marijuana became subject to recreational marijuana regulation. While the state continues to adjust its marijuana laws, marijuana continues to represent 70 percent of overall treatment admissions for youth since the time of legalization in 2012.\(^2\) School suspensions have increased

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\(^a\) Opioids refer to both prescription and illicit opioids (e.g. heroin) in this report

\(^b\) Those counties are: Clark, Cowlitz, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Whatcom, Benton, Franklin, Spokane, and Yakima.

\(^c\) Washington State Department of Health data for overdose deaths is preliminary data covering January through September of 2016. The information has not yet been confirmed and may change.
six percent and expulsions have increased 12 percent from the 2013-2014 to the 2014-2015 school year. The number of marijuana-involved DUIs are increasing with 38 percent of total cases submitted in 2016 testing above the 5 nanogram per milliliter of blood legal limit for those over the age of twenty-one. In addition, 10 percent of drivers involved in a fatal accident from 2010 to 2014 were THC-positive.

- (U) According to the 2016 National Drug Threat Assessment (NDTA), Colombia reported a record harvest of the coca plant in 2016. The South American country is US’s leading cocaine supplier and the increase could mean greater availability and falling prices for the drug in Washington.

- (U) MDMA is receiving attention nation-wide as it is being viewed as a potential treatment for post-traumatic stress disorder (PTSD). MDMA was approved by the Food and Drug Administration (FDA) in November 2016 for a Phase 3 study.

**Limitations**

(U) *Treatment Data* – At the time of issuing this Threat Assessment report, drug treatment admission data for adults and youth were not yet available from Washington State’s Department of Social and Health Service’s System for Communicating Outcomes, Performance and Evaluation (SCOPE). The system is being modified to integrate mental health treatment data. Data for the first three months of 2016 was available and used to project possible treatment admission totals.

(U) *Death Certificate Data* – The Washington State Department of Health had not yet completed and verified all death certificate data for 2016. Northwest HIDTA was provided preliminary data for January through September 2016. This information was treated only as an estimate for the number of the various types of drug-involved overdose deaths.

**II. Drug Threats in the Northwest HIDTA Region**

**A. Opioids**

**Assessment of the Threat**

(U) The effects of opioid abuse continue to devastate the State of Washington. Opioid abuse and addiction cross nearly all demographic boundaries. The effects of opioid abuse and addiction are widespread, resulting in increased overdose deaths, increased healthcare costs, lost productivity, increased property crimes, increased criminal justice system costs, and other adverse impacts that is devastating to communities.

![Youth Opioid Admissions](image)

(U//FOUO) Data: SCOPE – includes heroin, other opiates, oxycodone/hydrocodone, prescribed opiate substitutes and non-prescription methadone
Abuse  
(U//FOUO) Adult opioid treatment admissions in Washington in the first quarter of 2016 totaled 3,385\(^d\). If treatment admissions continued at the same rate in 2016, adult opioid treatment admissions would total approximately 13,540 consistent with the 14,180 admissions in 2015.\(^e\) In 2015, 11,405 of those admissions were for heroin, representing Washington’s highest number of heroin treatment admissions since recordkeeping began in 1999. \(^c\)  
(U//FOUO) Youth opioid admissions rose to 530 in 2015, up from 480 admissions in 2014, based on SCOPE data. Reporting for the first quarter of 2016 indicates 90 youth treatment admissions for opioids. If admissions remain consistent, an estimated 360 youths will be admitted for opioid treatment in 2016.  
\(^d\) At the time of this report, complete treatment admission data for 2016 is not available. Initial 2016 reporting suggests opioid treatment admissions for adults, heroin-related deaths, and the number of heroin users will be consistent with 2015.  
\(^e\) In case SCOPE data could change from year to year, data for the years 2012 to 2016 were all pulled again on May 3, 2017, for fair comparison. According to SCOPE, “all counts were rounded to the nearest multiple of 5 to protect confidentiality.”
(U//FOUO) Coinciding with the repeated high number of adult heroin and other opioid treatment admissions is the sustained number of needles exchanged during 2016. In King County alone, there are estimated to be 18,000-20,000 intravenous drug users. Agencies responsible for needle exchange programs in King, Kittitas, Pierce, and Spokane Counties reported 10,064,155 needles were exchanged in 2016, up from 8,645,858 in 2015 and 7,487,088 in 2014. A representative from Public Health – Seattle & King County said the number of needles provided by the agency increased again in 2016 with a total of 7,161,085 needles exchanged. Representatives with the Kittitas County Public Health Department and the Tacoma Needle Exchange also reported increases in needle exchange numbers. Spokane Regional Health District noted a slight decrease in needles exchanged. Although 2016 needle exchange data for Snohomish County is not available at the time of this report, the county reported an increased number of needles exchanged from 968,278 in 2014 to 1,262,294 exchanges in 2015.

(U//FOUO) Part of the increase in heroin abuse may be attributed to opioid prescription drugs. According to the Centers for Disease Control and Prevention (CDC), “While the majority of prescription drug users do not become heroin users, previous research found that approximately 3 out of 4 new heroin users report having abused prescription opioids prior to using heroin.” The CDC also reports that people who abuse or are dependent on prescription opioid painkillers are 40 times more likely to abuse or be dependent on heroin. Additionally, 57 percent of Tacoma Needle Exchange Program clients participating in a 2015 survey indicated that they had been addicted to opioid prescription drugs prior to using heroin.

(U//FOUO) From January through September 2016, Washington State’s Department of Health (DOH) data indicates that more than 500 people in Washington State died with an opioid in their system. The approximation of more than 500 opioid deaths in the state, with three months of data absent at the time of this report as the final numbers have not yet been released by DOH, seems to parallel the total number of overdose deaths in prior years. The King County Medical Examiner’s (KCME) Report from 2015 states that based on toxicology analysis, scene investigation, and circumstances it was determined that out of 142 accidental opioid overdose deaths, 119 were definitely or likely due to heroin. Previous year totals released by KCME reflects either a sustained number of heroin-related deaths through 2015 or the potential for a decline in heroin overdose deaths. There were 146 heroin-related deaths in 2014, 94 in 2013, and 79 in 2012. The Spokane County Medical Examiner (SCME) Report from 2016 shows heroin was among the most prevalent illicit drug present in accidental deaths, second only to methamphetamine.
Synthetic opioids have also adversely impacted Washington State, albeit the threat is not as grave when compared to eastern US. The synthetic opioid, U-47700, sometimes called “pinky” is eight times stronger than morphine. The Washington State Patrol Toxicology Laboratory reported three deaths involving U-47700 in June of 2016. Of the three decedents, one had both U-47700 and fentanyl in their system and another had both U-47700 and furanylfentanyl.22

Factors contributing to the increase in overdose deaths may be an increase in purity levels of heroin, heroin being cut with fentanyl or its analogs, or victims using fentanyl they believed to be heroin. Seattle Police warned citizens of the dangerously high purity levels of heroin after four overdoses occurred along the Aurora Avenue corridor in North Seattle over the span of a few hours in January 2016. Three of the four cases proved fatal.23

While heroin overdoses, fatal and non-fatal, are prevalent in Washington, the number of overdose deaths may actually underestimate the true extent of the heroin epidemic in Washington. An increase in the availability of naloxone has possibly impacted the number of reported overdose deaths. Washington is one of several states to make naloxone available to first responders as well as to those who know opioid abusers. Naloxone is an opioid antidote that temporarily reverses the effects of opioids, including heroin. When given to an overdose victim, naloxone can restore breathing. The drug can be administered even when the victim has been drinking or has combined opioids with other drugs. If given to someone who was not using opioids, naloxone will have a placebo effect on them. It is also not possible to get high from or get addicted to naloxone. Exchange programs in King, Kittitas, Pierce and Spokane Counties issued 1,624 naloxone kits in 2016. The employment of these kits resulted in 223 successful overdose reversals. Comprehensive statewide data on overdose reversals resulting from increased availability of naloxone was not available.

Availability
Heroin availability is high and stable in the DEA Seattle Field Division (FD), according to the 2016 NDTA.24 The majority of the drug in the western US comes from Mexico and is usually brown powder or Mexican black tar heroin.25 Heroin seizure totals at the Southwest Border have steadily increased since 2008, based on the El Paso Intelligence Center’s (EPIC) National Seizure System (NSS).26

Production
The 2016 NDTA indicates that heroin is not produced in the US. Occasionally, the finished heroin product is shipped to the US in wholesale amounts, then prepared for further distribution and retail sale. The heroin may be mixed with other drugs such as fentanyl, in order to stretch the product amount and increase revenue.27

Transportation
The entry point for most heroin destined for Washington State is at the Southwest Border between California and Mexico, according to the 2016 NDTA. From there, the drug is pushed northbound along the Interstate 5 (I-5) corridor by smugglers.28 The 2016 NDTA summary suggests that some of the increase in heroin’s prevalence in western states is the result of the Southwest Border being used more often as a transit area for the drug intended to be sold in the Eastern US. In addition to increase prevalence, the 2016 NDTA summary also mentioned that heroin coming across the Southwest Border in 2014 was averaging a purity level of 82 percent.29 The DEA Seattle FD have noted that local heroin
Traffickers are working for the Knights Templar (Los Caballeros Templarios) or the Sinaloa Mexican cartels.\textsuperscript{30} The local traffickers operate in nearly all areas of Washington.

**Outlook**

(U) Heroin will continue to flow into Washington as the drug remains in high demand by a large demographic group. Looking to turn a better profit, Mexican drug cartels and their local counterparts will attempt to increase the sales of heroin with higher purity levels in Mexican black tar and Mexican brown powder heroin and by mixing fentanyl into the heroin to increase its potency. An increase in the use of these types of heroin may result in greater treatment admission numbers as well as an increase in heroin overdoses or heroin-related deaths. Higher treatment admission numbers will continue to place a strain on the limited number of treatment facilities, and their respective budgets, throughout the state. As opioid abuse affects all areas of Washington, the continued availability of naloxone throughout the state is vital to help reverse overdose deaths by users and accidental exposures by law enforcement personnel investigating opioid crimes.

**B. Diverted Opioid Pharmaceuticals**

**Assessment of the Threat**

(U) Based on data presented by the Kaiser Family Foundation, 73,239,670 retail prescription drugs were filled in Washington pharmacies in 2016.\textsuperscript{31} The number accounts for just 1.8 percent of the total amount of prescriptions filled in the US in 2016,\textsuperscript{32} yet it is still enough to provide each of the approximately 7.2 million Washington residents with 10 bottles of pills.\textsuperscript{33} Prescription drug abuse is of concern in its own right, but it is also well-known by many to have been a path to heroin abuse. People of all ages, races and incomes have been touched by the opioid crisis.

**Abuse**

(U) Many heroin abusers initiated their opioid addiction with prescription drugs. Once it was acknowledged that prescription drugs were prone to abuse, oxycodone and similar opioids had already taken lives through overdoses, filled treatment centers, and strained the budgets of local governments and law enforcement. In Washington State, the Everett City Council unanimously supported Mayor Ray Stephanson in a lawsuit against Purdue Pharma, the maker of OxyContin. The city’s leaders believe the prescription pain killer helps feed the addiction problem plaguing their community and overwhelming the city’s government resources. The civil lawsuit filed January 19, 2017, claims that Purdue Pharma was “knowingly, recklessly, and/or negligently supplying OxyContin to obviously suspicious physicians and pharmacies and enabling the illegal diversion of OxyContin into the black market, including to drug rings, pill mills and other dealers for dispersal of the highly addictive pills in Everett.”\textsuperscript{34} The pharmaceutical company requested that the lawsuit be dismissed and Everett filed its opposition brief. Purdue Pharma has until June 8, 2017, to file its response.\textsuperscript{35}
Pediatric Interim Care Center in 2016 were admitted due to opioid exposure. Whether alone or combined with other drugs, opioids including heroin, oxycodone, methadone and others were responsible for 82 percent of these babies needing specialized care.37

(U//FOUO) Admission numbers for drug treatment are incomplete for 2016, so it is unknown how admissions for prescription drug treatment varied from previous years. Youth treatment admissions in SCOPE varied in the past five years and the totals are much lower than adult admissions making it difficult to determine if the numbers show a trend. Over the span of five years adult admissions in SCOPE were on a downward trend likely due to continued law enforcement efforts, the public’s general awareness and changes to prescribing methods.

(U) Based on preliminary data from the DOH covering the months of January 2016 through September 2016, there were more than 500 overdose deaths where opioid(s) were found in the system. In March of 2016, the CDC published a guideline for doctors who prescribe opioids, hoping to prevent further abuse and addiction of the pain-killers. The guidelines exclude treatment related to

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### Washington's Top 10 Prescribed Drugs

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocodone (all)</td>
<td>3,043,357</td>
<td>2,928,052</td>
<td>2,855,227</td>
<td>2,521,688</td>
<td>2,371,802</td>
</tr>
<tr>
<td>Oxycodone (all)</td>
<td>1,816,171</td>
<td>1,827,750</td>
<td>1,889,380</td>
<td>1,952,720</td>
<td>1,937,349</td>
</tr>
<tr>
<td>Tramadol HCL</td>
<td>0</td>
<td>0</td>
<td>308,803</td>
<td>730,446</td>
<td>718,261</td>
</tr>
<tr>
<td>Zolpidem Tartrate</td>
<td>898,620</td>
<td>838,636</td>
<td>790,571</td>
<td>761,159</td>
<td>712,360</td>
</tr>
<tr>
<td>Dextro/Amphetamine</td>
<td>466,702</td>
<td>323,013</td>
<td>579,927</td>
<td>626,923</td>
<td>701,795</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>632,757</td>
<td>634,566</td>
<td>643,922</td>
<td>640,505</td>
<td>623,551</td>
</tr>
<tr>
<td>Alprazolam</td>
<td>644,377</td>
<td>641,634</td>
<td>644,930</td>
<td>625,209</td>
<td>609,594</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>519,642</td>
<td>521,425</td>
<td>527,935</td>
<td>520,615</td>
<td>502,644</td>
</tr>
<tr>
<td>Methylphenidate HCL</td>
<td>397,021</td>
<td>410,821</td>
<td>422,664</td>
<td>420,891</td>
<td>443,262</td>
</tr>
<tr>
<td>Morphine Sulfate</td>
<td>327,191</td>
<td>330,399</td>
<td>336,190</td>
<td>362,408</td>
<td>351,167</td>
</tr>
</tbody>
</table>

(U//FOUO) Data: PDMP

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(U//FOUO) Washington data from the DOH’s Prescription Drug Monitoring Program (PDMP) reflects the continuing use and popularity of opioids. In 2016, hydrocodone and oxycodone were listed first and second in the PDMP’s Top 10 drug rankings.36

(U//FOUO) The majority of the 79 babies served by the
cancer-related pain, palliative care and end-of-life care. The CDC guidelines make recommendations for determining whether or not a patient should begin or continue treatment with opioids, selecting the type of opioid pain-killer to prescribe; the dosage amount and the length of time the drug should be taken. Recommendations are also provided regarding the risk and potential harm of treating a patient with opioids.  

**Fentanyl**  
(U) Pharmaceutical fentanyl is 100 times more potent than morphine and is used for severe and chronic pain. Just 3 milligrams of the Schedule II drug can be lethal. Fentanyl is occasionally diverted for abuse but the 2016 NDTA reports that the majority of fentanyl overdoses are the result of using an illicit form of the drug with or without knowledge of the potent opioid’s presence in another illicit substance.  

(U) It should be mentioned that the majority of the 70 fentanyl overdose deaths resulting in death in Washington State in 2016 were in combination with another drug. Heroin cut with fentanyl is common among fentanyl overdoses, but according to a study conducted by the DOH based on toxicology reports and preliminary 2016 death certificate data, the majority of fentanyl deaths were in combination with benzodiazepines such as Alprazolam or Xanax. There were 63 fentanyl-related overdose deaths in 2016 involving one or more different drugs. Benzodiazepines accounted for 29 of those overdoses while heroin was found in eight of those overdoses.  

**Codeine**  
(U) Codeine is an opioid often used in prescription cough medicine. In March of 2016, the Seattle Police charged two 15-year-olds with three armed robberies of pharmacies in King and Snohomish Counties. The two teens stole cough syrup containing codeine and promethazine as well as other prescription drugs. The cough syrup is used to make “Purple Drank,” or “Sizzurp,” a mixture of cough syrup, soda and flavored hard candy. Rap stars are known to glamorize the potentially dangerous and addictive mixture in their music. Pharmacy robberies for multiple types of pharmaceutical drugs increased from 10 in 2015 to 13 in 2016 in Washington State, based on information from the DEA.  

**Availability**  
(U) While there is ample supply of prescription drugs, the means of acquiring them legally is becoming more difficult for some longtime users. In July of 2016, Washington State closed the Seattle Pain Center (SPC), leaving 8,000 patients without a doctor to prescribe them pain medication. The recent closure of the SPC and continued attention to the prescribing of prescription opioids may have created an overly cautious atmosphere for doctors and patients. Fear of losing their licenses has caused some doctors to severely lower the dosage amounts for patients who have historically been taking high amounts of pain medications. While taking the least amount of medication possible to prevent pain is the goal, it can cause additional pain to those forced to take smaller doses too quickly.  

(U) When prescription drug abusers cannot obtain their drug of choice because their doctor has become suspicious and refuse to write refills, they may forge prescriptions. The Washington State Pharmacy
Association published a warning to prescribers and pharmacists in which it mentions an increase in the forged prescriptions for promethazine and codeine. Veterinarians have noted that some pet owners are calling in prescriptions for their animal on their own or lie about their pets’ conditions when showing up at a vet clinic to obtain pain killers for their own use.

**Production**

(U) The majority of prescription drugs in the US are manufactured in legal laboratories. New formulas of a prescription and new drugs must first be approved by the FDA before becoming available for a doctor to prescribe. According to the Office of the National Drug Control Policy (ONDCP), there are nine companies producing fentanyl in the US that are registered with DEA. Although illicit fentanyl laboratories in the US are rare, one was discovered at a home in Seattle, Washington, in early 2016. The laboratory was operated by two individuals that had university-level science backgrounds. The lab produced small amounts of fentanyl and was believed to supply just the drug habit of the two producing the drug. The majority of illicit fentanyl is made in China or Mexico. The opioid can be used to cut other drugs or pressed into pills that resemble oxycodone and market them as such on the street.

**Transportation/Distribution**

(U) Prescription drugs are commonly obtained through forged prescriptions, armed robberies, improper prescribing, illegal internet pharmacies, doctor-shopping and stealing prescriptions from family members/friends, based on information from the 2016 NDTA.

**Outlook**

(U) Thousands of patients unsure of where to go for pain management after the recent closures of the SPC likely added to the pressure that prescription opioid drug prescribers are already feeling. Some of those patients may have turned to heroin. Continued monitoring of prescribing habits and patient behavior should stabilize prescription opioid addiction if not reduce it. Heroin use and treatment admissions may rise until prescription opioid abuse is treated and hopefully prevented.

(U) Doctors prescribing fentanyl should keep in mind the increased overdoses involving the pain killer. Few fentanyl overdoses in Washington involved prescription fentanyl and care should be taken to prevent those numbers from increasing. Benzodiazepines were found in the majority of fentanyl overdose deaths in which a second drug was involved. It would be worth taking extra precautions when prescribing benzodiazepines, especially if a patient is known to use illicit drugs.

(U) The abuse of painkillers and the subsequent rise in heroin addiction in Washington and across the nation should be enough to encourage responsible prescribing and the manufacturing of tamper-resistant prescription opioids. As long as there is a legitimate need for prescription opioid drugs there will be a continuous struggle to prevent the abuse of them.

**Illicit Fentanyl**

(U) As indicated by the letter from the ONDCP to the Department of Energy and Commerce, the majority of fentanyl overdoses are the result of the known or unknown use of illicit fentanyl as opposed to diverted prescription fentanyl.

(U) Fentanyl can be 100 times more potent than morphine making it attractive to both drug dealers and drug users. While fentanyl is sometimes diverted and abused in its medicinal form, the majority of
fentanyl abused is manufactured illicitly. Numerous fentanyl overdoses are the result of a dealer attempting to get a higher price for a poor product. The purchaser is unaware that the drug they bought was cut with the potent opioid and just three milligrams of fentanyl can be fatal. Fentanyl pressed into pills disguised as oxycodone is another way in which overdose deaths occur. Unaware of the pill’s true potency, users can unknowingly take a lethal dose.

(U) Fentanyl is often purchased online and shipped directly to the US via USPS or private shipping companies. The drug is also smuggled into the US from Mexico where fentanyl is either made with precursors sent from China or the finished product is added to heroin. Finally, fentanyl is also arriving in the US from the Northern Border. It is common for the drug to be pressed into pills mimicking oxycodone and then smuggled into the US.

(U) A DOH report revealed there were 70 lab-confirmed, fentanyl-related overdose deaths in Washington in 2016. The DOH’s toxicology lab arrived at this number after changing its testing procedure in August of 2016 to find smaller amounts of fentanyl present in samples. Had the lab used the previous procedure, the fentanyl-related overdose death total would have been 53, an 86 percent increase from 2015. The total for 2015 using the test procedure prior to August 2016, was 28.

(U) Of the 70 fentanyl-related overdose deaths, 11 included a fentanyl analog or a similar synthetic opioid. Fentanyl analogs are versions of fentanyl whose chemical structure has been altered to maintain the desired effects of the drug yet not be recognized as a DEA controlled substance. Several of the analogs found in the 2016 samples included acetylfentanyl; furanylfentanyl; and U- 47700.

C. Methamphetamine
Assessment of the Threat
(U) Methamphetamine continues to pose a significant threat to Washington State. Adult treatment admissions for the drug are second only to heroin, but admission totals have remained steady for several years. Deaths related to methamphetamine continue to increase in both King and Spokane Counties. Although methamphetamine labs are rarely found in the state, there is ample supply of the drug as Mexican Drug Trafficking Organizations (DTO) continue to dominate the market.

Abuse
(U//FOUO)
At the time of this report, only data for the first three months of 2016 was available for Washington treatment admissions. SCOPE data shows there were 1,950 adults admitted for methamphetamine treatment from January through March 2016. If adult treatment admissions continued at the same rate through 2016, the total would be slightly more than the past several years - methamphetamine admissions would still make up 18 percent of all treatment admissions, matching previous
years. For comparison, opioid treatment admissions over the past five years account for nearly 19 to 29 percent of all treatment admissions. Youth treatment admissions for methamphetamine have been consistently higher than heroin admissions for the past five years. If SCOPE youth treatment admissions for the first three months of 2016 continued at the same rate through the year, admissions for methamphetamine would have decreased slightly when compared to previous years. However, the total would still be within the 9 or 10 percent range of all drug admissions, aligning with the previous five years.

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(U//FOUO) The increasing trend of users combining heroin and methamphetamine may be a contributing factor in the rise of methamphetamine-related overdose deaths in both King and Spokane counties. In 2010, King County methamphetamine-related overdose deaths totaled 19.63 In 2015, as the use of heroin and methamphetamine together became more popular, King County methamphetamine-related overdose deaths rose to 86.64 Mirroring that trend, the city of Spokane reported 22 methamphetamine-related overdose deaths in 2013 and 49 in 2016. For 2015 overall, Washington’s DOH reported there were 155 opioid overdoses state-wide in which methamphetamine was involved - in 2010, there were 44.65 The combination of methamphetamine and heroin is referred to in Washington State as “goofballs”. In a 2015 survey taken by Public Health – Seattle & King County’s needle exchange clients, 47 percent reported injecting methamphetamine alone. Those who injected methamphetamine and heroin together totaled 36 percent.66 Results from the same survey taken in 2013 revealed that 41 percent of needle-exchange clients injected methamphetamine alone and 27 percent injected both methamphetamine and heroin.67

Availability
(U) Mexican manufactured methamphetamine overwhelmingly sources Washington State and has done so for many years. According to the 2016 NDTA, seizures of methamphetamine along the Southwest
Border increased 305 percent from 2010 (4,024 kg) to 2015 (16,283 kg). The 2016 NDTA reports 78 percent of law enforcement survey respondents listed methamphetamine availability as high in the Pacific Region. The DEA noted in 2015 that the average purity of methamphetamine from Mexico is above 90 percent, yet relatively inexpensive, contributing to the drug’s availability and popularity.68

Production
(U) After the Combat Methamphetamine Epidemic Act (CMEA) went into effect in the US in 2006, the purchase of ephedrine and pseudoephedrine required picture ID and amounts were limited, inhibiting the production of local methamphetamine.69 The cost of production and the risks taken to obtain the necessary precursors are far less for Mexican DTOs than for local entrepreneurs. The ease at which DTOs can produce large amounts of methamphetamine and smuggle it north for sale results in a lower cost for consumers and the ability to monopolize the market.

Transportation/Distribution
(U) As seizures along the Southwest Border increase year after year, it is likely that methamphetamine crosses the US-Mexico border and heads north on I-5 to Washington, with multiple stops along the way.70 Mexican and Caucasian criminal groups distribute the drug within their own markets.71

Outlook
(U) The volume at which Mexican methamphetamine laboratories can produce the drug ensures it will continue to pose a serious threat to Washington. Demand for the drug will continue to be fulfilled, resulting in increased or at least sustained methamphetamine treatment admissions for both adults and youth. Further, needle exchange numbers for those using the drug will remain stable or increase if the combination of injecting both methamphetamine and heroin continues to grow in popularity. The pattern of using heroin and other opioids along with methamphetamine, whether injected or not, will likely result in more overdose deaths.

D. Marijuana
(U) The marijuana section of this assessment gives a brief, overall summary of the use and regulation of marijuana in Washington as well as recent changes in state law regarding the drug. Northwest HIDTA published the Washington State Marijuana Impact Report Volume 1 in March 2016 and Volume 2 in June 2017.72

Assessment of the Threat
(U) Washington State is one of eight states (and the District of Columbia) that has legalized recreational marijuana despite the drug’s illegal status with the federal government. Even as marijuana is legal for use medically and recreationally in the state, the drug still remains a threat to consumers of all ages. Marijuana has always been the drug with the highest number of youth treatment admissions in Washington and continues to be, even though Initiative-502 included within it provisions to prevent youth access. In addition, Washington DUIs and fatalities involving marijuana have increased in combination with the levels of THC found in those drivers.

(U) The developing regulations of Washington marijuana laws results in the state taking on great risk until those laws are completed. The state has a responsibility to follow federal priorities outlined in the Ogden, Cole, and Monty Wilkinson Memorandum due to the drug’s federal illegal status. The Ogden Memorandum is imposed on the medical market, the Cole Memorandum for the recreational market, and the Monty Wilkinson Memorandum for Sovereign-Indian nations. Each has a specific list of priorities
that require states to ensure protection against out-of-state diversion, access to youth, and revenues generated to fund criminal drug cartels.73 74 75

Abuse
(U//FOUO) Data for treatment admissions are gathered from SCOPE. Marijuana treatment admissions for youth continue to be the highest reported among all primary drugs despite the age restriction. Admission data shows a decreasing number of overall admissions - the drug has represented almost 70 percent of overall youth admissions since 2012. SCOPE data for 2016 is incomplete, but the first three months of the year reflect the same pattern. Of the 1,235 treatment admissions, 880 were for marijuana.

(U) In the spring of 2017, Washington’s DOH released the results of the Healthy Youth Survey that surveyed more than 200,000 students in grades 6, 8, 10, and 12 in all counties of the state. According to the 2016 survey, all grades decreased their perception of harm of regular marijuana use.76 Of 12th grade students surveyed, 45 percent perceived no or low risk from regular marijuana use. The driving behaviors of students were also asked in the 2016 survey, half of the 12th grade students surveyed reported that in the past 30 days, they drove at least once within three hours after smoking marijuana.77

(U) According to the Office of the Superintendent of Public Instruction during the 2013-2014 report, 48 percent of statewide student expulsions were for marijuana in comparison to alcohol, tobacco, and other illicit drugs. Noted for the 2014-2015 school year, statewide student expulsions for marijuana increased to 60 percent. Student suspensions for marijuana for the 2013-2014 school year reported 42 percent and for the 2014-2015 school year, suspensions increased to 49 percent.78

(U//FOUO) Adult marijuana treatment admissions began their slow decline after 2009 as SCOPE data shows there were 6,285 adults admitted for marijuana treatment that year. There are several reasons that could explain this trend to include the reduction in perception of harm associated with the legalization as well as a lack of space at treatment facilities due to the opioid epidemic.
(U) The Washington State Poison Center (WAPC) is the primary agency to handle exposures from callers across the state. From 2012 to 2016, reported exposure calls for the marijuana extract increased 105 percent. According to the 2016 Annual Cannabis Toxic Trends Report, exposures related to children under the age of five, 73 percent occurred in those one to three years of age. The counties with the highest reported exposures for both 2015 and 2016 were: King, Spokane, Snohomish, and Pierce.

**Drugged Driving**

(U) The new driving under the influence (DUI) threshold is 5 nanograms of the drug’s active ingredient, Delta-9-THC (tetrahydrocannabinol), per milliliter of blood or more. The Washington State Patrol Toxicology Laboratory is responsible for testing and processing DUI cases across the state. From 2011 to 2016, the percent of total cases testing above the 5ng/ml limit doubled.

(U) Washington State University researchers and the Pullman Police Department are working together to conduct a marijuana breathalyzer study sponsored by Washington State’s Department of Social and Health Services. The study began on May 23, 2017, and should be complete on June 15, 2017. Should the breathalyzer prove to be accurate, law enforcement may have a reliable alternative to the blood draw in the near future.

(U) The AAA Foundation for Traffic Safety published a report titled Prevalence of Marijuana Involvement in Fatal Crashes: Washington 2010-2014, based upon fatality data collected by the Washington State Traffic Safety Commission (WSTSC). The report analysis concluded that from 2010 to 2014, 10 percent of the 3,031 drivers involved in a fatal accident were THC-positive. Of those percent nearly a third (34%) had only THC in their blood. Those drivers with THC and alcohol in their blood totaled 39 percent and 10.5 percent of the drivers had THC, alcohol and other drugs in their blood.

**Availability**

(U) For decades, Washington State has seen widespread availability of marijuana, despite the drug remaining federally illegal. BOTEC, the main drug policy consultant to the Washington State Liquor and Cannabis Board (WSLCB), published a report that quantifies the size of each active marijuana market in the state. The BOTEC report, titled Estimating the Size of the Medical Cannabis Market in Washington State, states equal shares of the marketplace place are divided in thirds between the medical, recreational, and black markets in Washington.
(U) According to the WSLCB, 964 producer/processor and 149 processor licenses were issued as of February 2017. Of the 556 retailers in the state, 482 were licensed. These businesses are in place to supply the demand to consumers across the state under a regulatory framework. However, the taxes imposed on the sale of marijuana lead some to believe that the cost of legally purchased marijuana will keep the black market alive due to its cheaper, non-taxed prices.

Medical Marijuana

(U) Governor Jay Inslee signed Senate Bill 5052, the Cannabis Patient Protection Act, in April 2015 – effective July 1, 2016. Major shifts included in the bill were eliminating collective gardens and allowing licensed recreational stores to sell medical marijuana. Local law enforcement in combination with local governments alerted the dispensaries in their communities before the law took effect.

(U) Qualified patients and designated providers may enter into the voluntary Medical Marijuana Authorization Database (MMAD), which permits the individual with larger possession amounts. The recognition card also provides the patient and provider with arrest protection due to the noted increased possession amount. Records in the database, which include personally identifiable information of patients and designated providers, are exempt from being disclosed. Law enforcement may verify that a recognition card is valid by running the patient or provider recognition card number through the MMAD.

<table>
<thead>
<tr>
<th>Recreational Users (21 Years and Older)</th>
<th>Patients WITH Recognition Cards</th>
<th>Patients WITHOUT Recognition Cards</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ounce useable marijuana</td>
<td>3 ounces useable marijuana</td>
<td>1 ounce useable marijuana</td>
</tr>
<tr>
<td>7 grams concentrate</td>
<td>21 grams concentrate</td>
<td>7 grams concentrate</td>
</tr>
<tr>
<td>16 ounces infused-products (solid)</td>
<td>48 ounces infused-products (solid)</td>
<td>16 ounces infused products (solid)</td>
</tr>
<tr>
<td>72 ounces infused-products (liquid)</td>
<td>216 ounces infused-products (liquid)</td>
<td>72 ounces infused-products (liquid)</td>
</tr>
<tr>
<td>No home grows allowed</td>
<td>6 plants for home cultivation and 8 ounces of useable marijuana from those plants</td>
<td>4 plants for home cultivation and 6 ounces of useable marijuana from those plants</td>
</tr>
</tbody>
</table>

Sovereign-Indian Nations

(U) House Bill 2000 was signed by the Governor in April 2015 and set in place the agreement procedures for Washington State and federally recognized Indian tribes concerning marijuana. There are four tribes recognized within the regulatory marijuana market. Suquamish, Muckleshoot and Squaxin Island tribes have businesses in the recreational marijuana industry and the Puyallup tribe is currently conducting medical marijuana research. Each tribe is bound by state regulations as laid out by the WSLCB and the federal Monty Wilkinson Memo priority points. As of April 2017, six tribes were seeking to enter into marijuana compacts with the state: Port Gamble S’Klallam, Jamestown S’klallam, Samish, Spokane, Stillaguamish, and Tulalip.

Production

(U) The majority of marijuana in Washington State is produced within state boundaries. Illegal outdoor marijuana grows dominate the eastern side of Washington State and indoor grows are also well-known on the western side of the state. Mexican National cartels are primarily responsible for outdoor operations while Asian criminal organizations utilizing entire homes as indoor growing facilities have been reported throughout the Puget Sound area.
THC Potency and Testing
(U) During the month of July 2016, one Seattle-based recreational marijuana retailer’s average potency for concentrate/THC extract was 71.71. The University of Mississippi Potency Monitoring Project is responsible for national scientific testing for marijuana from useable marijuana to marijuana concentrates. The average potency for concentrates submitted in 2014 was 55.85%.  

(U) The WSLCB has 12 certified labs across the state to conduct testing on marijuana, including potency testing for all products. Despite the regulatory mechanism in place, some labs have been inaccurate in their potency results. Verda Bio, a marijuana cannabis biotech company in Seattle, conducted independent tests on eight products bought from various recreational marijuana stores where seven of them had mislabeled potencies – differences in true potency ranged from 3.5 percent to 7 percent. 91 Additionally, at the end of 2015, two of Washington State’s largest producers were subject to a WSLCB investigation for illegal use of prohibited pesticides to include Eagle 20 which produces cyanide when heated.92

Traceability
(U) One of the goals of I-502 was to reduce the diversion of marijuana. According to the Washington Administrative Code 314-55-083, all recreational marijuana businesses are to utilize a software program, BioTrackTHC, to track all products from seed-to-sale.93 BioTrackTHC suffered multiple setbacks as multiple marijuana producers were dissatisfied with the system’s software.94 Shortcomings of the system included a lack in functionality, failure to synchronize with other inventory tracking systems. Washington State accepted bids for a new tracking system until April 26, 2017.95 The new system is expected to be operational by October 31, 2017, as BioTrackTHC’s contract expires at the end of that month and chose not to bid for the next contract.96

Transportation/Distribution
(U) Smuggling marijuana across Washington’s borders not only violates the law but also one of the Cole Memorandum priority points laid out by the federal government. The abundance of local marijuana creates a market favorable to the consumer. Both illicit growers as well as recreational and medical marijuana retailers may find the illegal, out-of-state sales more profitable. Aside from a customer purchasing marijuana, distribution of the drug is restricted to delivery between producer, processor and retailer. A manifest is required to be with the product in transit.

Outlook
(U) Several bills passed by Washington State in 2016 and 2017 created a more organized regulatory structure for medical marijuana and evened the disparity in taxation between medicinal and recreational marijuana. Youth treatment numbers have been declining yet overall, marijuana remains the drug for which most youth under 19 are placed into treatment. Housing medical marijuana in the same store as recreational marijuana takes the risk of making the use of all marijuana appear legal and safe. THC-involved DUls are increasing, perhaps the result of a society that is increasingly more casual on marijuana use. As drugs such as heroin and fentanyl absorb the attention of drug users and the media, fewer treatment admission spaces may be available for marijuana abuse.

(U) As medical and recreational marijuana retail stores become more common the businesses may not be as lucrative as they once were. Illicit growers may witness a smaller customer base. As a result, all three parts of the marijuana market may increase their illegal sales of the drug across state lines. Retail stores will vie for customers, inspiring new strains of marijuana, new marijuana edibles and other
marijuana-related items. Cannabis may be sold with continually higher levels of THC to attract customers.

E. Cocaine

Assessment of the Threat
(U) Even as the DEA Seattle FD reports cocaine availability as moderate, the drug is still considered a threat to Washington because of its association with crime and the physical harm from its use.97 Colombia’s recent increase in cocaine production could present a rise in use by Washington residents as greater availability usually results in a price drop.

Abuse
(U//FOUO) Although cocaine use may be up nationally98, various statistics in Washington do not reflect the trend. Treatment data, youth perception of the drug and wastewater treatment studies show that cocaine use is relatively low and stable. Treatment admission numbers for cocaine in 2016 are not yet complete. Youth treatment admissions are in small quantities making it difficult to detect any patterns. Adult treatment admissions have been declining for several years and other evidence does not indicate there would be an increase in 2016 numbers when complete.

(U) Deaths involving cocaine in King County declined in 2015. The drug was present in 55 drug overdose deaths and was the cause of death in 53 drug overdoses, according to the KCME 2015 Annual Report.99 There were 75 cocaine-involved deaths in 2014 and 64 in 2013.100 101

(U) According to the Monitoring the Future Survey: 1975-2016, cocaine use by seniors in high school is at an all-time low with just 2.3 percent saying they have used the drug in the past three months.102 The perceived availability of cocaine by 12th grade students is also low with 29 percent saying the drug is easy to obtain. In contrast, 59 percent of high school seniors in 1989 believed cocaine was easy to get. Use by seniors in the mid-1980s was around 13 percent.103
Availability
(U) The surge in Colombia’s cultivation of coca suggests that cocaine availability will rise in Washington. The DEA Seattle FD reports cocaine availability in 2015 was moderate but stable, though the drug is becoming more prevalent nationwide, according to the 2016 NDTA Summary. Nationwide, cocaine seizures by CBP increased nearly 57 percent from 2014 to 2015. There were well over 25,000 kilograms of cocaine seized by CBP in the US in 2015 compared to nearly 17,000 kilograms in 2014. The 2015 total was the most since 2010, when CBP seized nearly 33,000 kilograms of cocaine.104

Production
(U) “In 2015 Colombia’s potential pure cocaine production totaled 495 metric tons (MT) and was the largest single-year increase of coca cultivation in Colombia ever recorded.”105 The 2016 NDTA Summary predicted the 42 percent increase in the coca harvest in 2015 would result in an increase in cocaine trafficking in the US in 2016.106 Already, more than 90 percent of cocaine distributed throughout the US in 2015 originated in Colombia, according to the DEA’s Cocaine Signature Program.107 The staggering increase in cocaine production in Colombia is due to several factors, including the peace agreement reached between the Revolutionary Armed Forces of Colombia (FARC) and the country of Colombia in November 2016. The agreement includes eradication of the coca plant, prosecuting criminal organizations and social investment. Believing areas rife with the coca plant would be given the greatest attention, the FARC encouraged people to grow it in the hope that those areas would also receive a greater portion of monetary assistance.108 Not wanting to hinder any progress during the fragile peace negotiations, the US has been hesitant to interfere.109

Transportation/Distribution
(U) Colombia’s shore is split into two by the thin landmass of the country of Panama. The bulk of the cocaine that reaches Washington likely comes from the shore which merges with the Pacific Ocean. The cocaine travels north, past Central America and into Mexico, where it is then smuggled by Mexican DTOs across the Southwest Border into the US via highways.110 According to the 2016 NDTA Summary, the majority of the cocaine seized while the Southwest Border in 2015 passed through San Diego. The total seizure for the year was approximately 4,130 kilograms, or 46 percent of the amount crossing the Southwest Border.111 Cocaine smuggled into Washington is most likely hidden in private and commercial vehicles utilizing major highways such as I-5.

Outlook
(U) Colombia’s record supply of cocaine from the 2016 harvest creates the potential for an increase in supply and use of the drug in Washington. A sustained increase of cocaine to the area would result in a price drop, and multiply and diversify user demographics. Cocaine treatment admissions would gradually increase. Mexican DTOs will likely continue their dominance of the cocaine trade into the US.

F. MDMA
(U) MDMA (3,4-Methylenedioxymethamphetamine), often referred to as “ecstasy” and “molly”, pose a moderate threat to Washington. MDMA is typically sold in tablet form while molly often appears in pure crystalline powder form.112 Molly was known to be a pure form of MDMA, but what dealers sell on the streets now is usually a mixture of MDMA and other substances or, the product sold contains no MDMA and is actually made up of synthetic cathinones.113
Known as a party drug used by college students and at raves, MDMA may have found a place of status in the medical world. Multiple clinical studies conducted by the Multidisciplinary Association for Psychedelic Studies (MAPS) have used MDMA in conjunction with therapy to treat people suffering from post-traumatic stress disorder (PTSD). Participants in one study underwent 12 weeks of psychotherapy with three, eight-hour session in which MDMA was administered. “By the end of study, two-thirds no longer met the criteria for having PTSD. Follow-up examinations found that improvements lasted more than a year after therapy.” The FDA approved a Phase 3 study of MDMA to occur in June of 2017. Depending on the outcome, the FDA could approve the drug for use by 2021.

The majority of MDMA seized in the US is smuggled across the border from Canada, as noted in the 2016 NDTA. The drug is usually manufactured in China and shipped to Canada, or produced in laboratories in Canada. According to the 2016 NDTA, Asian DTOs are known to be the largest distributors of MDMA along the west coast.

MDMA/molly users will continue to be at risk of overdose as dealers frequently tout their product as being a “safe” alternative to “hard drugs,” even though it is usually a mixture of several drugs; none of which are the popular party drug.
VII. Appendices
   A. Abbreviations
   B. Contributing Agencies
   C. Washington State Highway Map
   D. Marijuana Seizure Data
   E. Endnotes
# APPENDIX A. Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATM</td>
<td>Automated Teller Machine</td>
</tr>
<tr>
<td>BC Bud</td>
<td>British Columbia (BC) Canada-produced Marijuana</td>
</tr>
<tr>
<td>CEV</td>
<td>Critical Event</td>
</tr>
<tr>
<td>CEWG</td>
<td>Community Epidemiology Work Group</td>
</tr>
<tr>
<td>CPOT</td>
<td>Consolidated Priority Organization Targets</td>
</tr>
<tr>
<td>CY</td>
<td>Calendar Year</td>
</tr>
<tr>
<td>DEA</td>
<td>Drug Enforcement Administration</td>
</tr>
<tr>
<td>DFI</td>
<td>Department of Financial Institutions</td>
</tr>
<tr>
<td>DHE</td>
<td>Domestic Highway Enforcement</td>
</tr>
<tr>
<td>DOC</td>
<td>Department of Corrections</td>
</tr>
<tr>
<td>DOE</td>
<td>Department of Ecology - Washington State</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health, Washington State</td>
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<tr>
<td>DTO</td>
<td>Drug Trafficking Organizations</td>
</tr>
<tr>
<td>DU</td>
<td>Dosage Unit</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EPIC</td>
<td>El Paso Intelligence Center</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal Year</td>
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<tr>
<td>HIDTA</td>
<td>High Intensity Drug Trafficking Area</td>
</tr>
<tr>
<td>IBET</td>
<td>Integrated Border Enforcement Team</td>
</tr>
<tr>
<td>IBIT</td>
<td>Integrated Border Intelligence Team</td>
</tr>
<tr>
<td>ISC</td>
<td>Investigative Support Center</td>
</tr>
<tr>
<td>LSD</td>
<td>Lysergic Acid Diethylamide</td>
</tr>
<tr>
<td>MDMA</td>
<td>3,4-methylenedioxy-methamphetamine</td>
</tr>
<tr>
<td>MMAD</td>
<td>Medical Marijuana Access Database</td>
</tr>
<tr>
<td>MLO</td>
<td>Money Laundering Organizations</td>
</tr>
<tr>
<td>MMC</td>
<td>Minority Motorcycle Club</td>
</tr>
<tr>
<td>NDTS</td>
<td>National Drug Threat Survey</td>
</tr>
<tr>
<td>NSS</td>
<td>National Seizure System</td>
</tr>
<tr>
<td>OCDETF</td>
<td>Organized Crime Drug Enforcement Task Force</td>
</tr>
<tr>
<td>ODD</td>
<td>Other Dangerous Drug</td>
</tr>
<tr>
<td>OMG</td>
<td>Outlaw Motorcycle Gang</td>
</tr>
<tr>
<td>ONDCP</td>
<td>Office of National Drug Control Policy</td>
</tr>
<tr>
<td>PHSKC</td>
<td>Public Health-Seattle &amp; King County</td>
</tr>
<tr>
<td>PCP</td>
<td>Phencyclidine</td>
</tr>
<tr>
<td>PICC</td>
<td>Pediatric Interim Care Center</td>
</tr>
<tr>
<td>PDMP</td>
<td>Prescription Drug Monitoring Program</td>
</tr>
<tr>
<td>PMP</td>
<td>Performance Management Process</td>
</tr>
<tr>
<td>POE</td>
<td>Port(s) of Entry</td>
</tr>
<tr>
<td>RISS.net</td>
<td>Regional Information Sharing Systems Network</td>
</tr>
<tr>
<td>ROI</td>
<td>Return on Investment</td>
</tr>
<tr>
<td>SAR</td>
<td>Suspicious Activity Report</td>
</tr>
<tr>
<td>SCOPE</td>
<td>System for Communicating Outcomes, Performance &amp; Evaluation</td>
</tr>
<tr>
<td>SFY</td>
<td>State Fiscal Year</td>
</tr>
<tr>
<td>TAS</td>
<td>Threat Assessment Survey</td>
</tr>
<tr>
<td>TBD</td>
<td>To Be Determined</td>
</tr>
<tr>
<td>THC</td>
<td>Delta-9-tetrahydrocannabinol</td>
</tr>
<tr>
<td>WSIN</td>
<td>Western States Information Network</td>
</tr>
</tbody>
</table>
APPENDIX B: Contributing Agencies

The following agencies or programs provide supervisory personnel and analytical resources for the Northwest HIDTA Investigative Support Center Initiative:

- Drug Enforcement Administration
- Northwest High Intensity Drug Trafficking Area
- Washington State Patrol

In addition, the following agencies and programs provided statistics and other data used in the preparation of this document:

**FEDERAL**

Executive Office of the President
  - Office of National Drug Control Policy
National Institute of Justice
  - Substance Abuse and Mental Health Services
  - Office of Applied Studies
    - Drug Abuse Warning Network
    - Treatment Episode Data Set
US Department of Agriculture
  - Forest Service
US Department of Defense
  - Army
    - Fort Lewis (Joint Base Lewis-McChord)
    - Washington National Guard Counterdrug Task Force
  - Air Force
    - McChord Air Force Base (Joint Base Lewis-McChord)
  - Navy
    - Everett Naval Station
US Department of Homeland Security
  - U.S. Immigration and Customs Enforcement
    - Federal Protective Service
  - Customs and Border Patrol
    - Blaine
    - Oroville
    - Spokane
  - Coast Guard
    - 13th District
US Secret Service

US Department of the Interior
  - Bureau of Indian Affairs
US Department of Justice
  - Bureau of Alcohol, Tobacco, Firearms, and Explosives
  - Criminal Justice Division
    - Western States Information Network
  - Drug Enforcement Administration
    - Domestic Cannabis Eradication/Suppression Program
    - Domestic Monitor Program
El Paso Intelligence Center
Clandestine Laboratory Seizure System
Operation Jetway
Operation Pipeline
Seattle Field Division
Bellingham Resident Office
Division Intelligence Group
Spokane Resident Office
Tacoma Resident Office
Yakima Resident Office
Federal Bureau of Investigation
Seattle Field Division
National Drug Intelligence Center
United States Attorney’s Office
Eastern District of Washington
Western District of Washington
United States Marshals Service

US Department of State
   Bureau of International Narcotics and Law Enforcement Affairs
US Department of Treasury
   Internal Revenue Service–Criminal Investigation
US Environmental Protection Agency

STATE

Alcohol/Drug 24-Hour Helpline – WA Alcohol/Drug Clearinghouse
Office of the Washington State Lieutenant Governor
Pediatric Interim Care Center
Washington Association of Sheriffs and Police Chiefs
Washington State Association of Drug Court Professionals
Washington State Attorney General’s Office
   Criminal Investigation Section
Washington State Department of Community, Trade, and Economic Development
Washington State Department of Corrections
Washington State Department of Ecology
Washington State Department of Natural Resources
Washington State Department of Health
Washington State Department of Social and Health Services
   Division of Alcohol and Substance Abuse
Washington State Department of Transportation
Washington State Governor’s Office on Indian Affairs
Washington State Office of Financial Management
Washington State Patrol
   Field Operations Bureau
      K-9 Unit
   Investigative Services Bureau
Investigative Assistance Unit
University of Washington, Alcohol and Drug Abuse Institute

LOCAL

Battle Ground Police Department
Bellingham Police Department
Blaine Police Department
Bonney Lake Police Department
Bothell Police Department
Bremerton Police Department
Buckley Police Department
Camas Police Department
Canada Revenue Agency
Centralia Police Department
Chehalis Police Department
Clackamas County (OR) Sheriff’s Office
Clark County Department of Community Services
Clark County Prosecutor’s Office
Clark County Sheriff’s Office
Clark/Vancouver Deputy Prosecutor’s Office
Clark-Vancouver Narcotics Task Force
Columbia River Drug Task Force
Cowlitz County Corrections Department
Cowlitz County Drug Court
Cowlitz County Prosecutor’s Office
Cowlitz County Sheriff’s Office
Cowlitz Substance Abuse Coalition
Cowlitz-Wahkiakum Narcotics Task Force
Des Moines Police Department
Eastside Narcotics Task Force
Everett Police Department
Grandview Police Department
Granger Police Department
Grant County Sheriff’s Office
Grays Harbor County Drug Task Force
Greater Spokane Substance Abuse Coalition
Interagency Narcotics Enforcement Team
Department of Judicial Administration
King County Jail
King County Medical Examiner’s Office
King County Sheriff’s Office
Kelso Police Department
Kitsap County Department of Personnel and Human Services
Lacey Police Department
Law Enforcement Against Drugs Task Force
Lewis County Sheriff’s Office
Longview Police Department
Marysville Police Department
Morton Police Department
Mossyrock Police Department
Mountlake Terrace Police Department
Multnomah County (OR) Sheriff’s Office
Napavine Police Department
North Central Washington Narcotics Task Force
Northeast Washington Treatment Alternatives
Olympia Police Department
Orting Police Department
Pe Ell Police Department
Pierce County Alliance
Pierce County Department of Human Services
Pierce County Health Department
Pierce County Planning and Land Services
Pierce County Prosecutor’s Office
Pierce County Sheriff’s Office, Tacoma
Port of Seattle Police Department
Portland (OR) Police Bureau
Puyallup Police Department
Quad-Cities Drug Task Force
Redmond Police Department
Regional Organized Crime and Narcotics
Royal Canadian Mounted Police
Seattle Neighborhood Group
Seattle Police Department
Skagit County Department of Human Services
Skagit County Inter-local Drug Enforcement Unit
Skagit Recovery Center
Skamania County Sheriff’s Office
Snohomish County Department of Human Services
Snohomish County Health District
Snohomish County Prosecutor’s Office
Snohomish County Sheriff’s Office
Snohomish Regional Drug and Gang Task Force
Spokane County Prosecutor’s Office
Spokane County Sheriff’s Office
Spokane Police Department
Spokane Regional Safe Streets Task Force
Sumner Police Department
Sunnyside (Clark County) Police Department
Sunnyside (Yakima County) Police Department
Tacoma Police Department
Thurston County Narcotics Task Force
Thurston County Prosecutor’s Office
Thurston County Sheriff’s Office
Thurston County Superior Court
Toledo Police Department
Toppenish Police Department
Tri-City Metro Drug Task Force
Tumwater Police Department
Unified Narcotics Enforcement Team
Union Gap Police Department
Vader Police Department
Valley Narcotics Enforcement Team
Vancouver (WA) Police Department
Vancouver (BC) Police Department
Washington County (OR) Sheriff’s Office
Washougal Police Department
West Sound Narcotics Enforcement Team
Whatcom Gang and Drug Task Force
Whatcom County Prosecutor’s Office
Whatcom County Sheriff’s Office
Whatcom County Superior Court
Winlock Police Department
Yakama Tribal Police
Yakama County Court Services
Yakama County Prosecutor’s Office
Yakama County Sheriff’s Office
Yakama County Superior Court
Yakima Police Department

TRIBAL

Skokomish Tribal Police Department
Spokane Tribal Police Department
Squaxin Tribal Police Department
Suquamish Tribal Police Department
Tulalip Tribal Police Department
APPENDIX C: Washington State Highway Map

APPENDIX E: Endnotes

2 (U//FOUO) System for Communicating Outcomes, Performance & Evaluation
4 (U) Data from Dr. Fiona Couper of the Washington State Patrol Toxicology Laboratory.
14 (U//FOUO) E-mail correspondence with Joe Tinsley, Education & Prevention Services, HIV/STD Program of Public Health – Seattle & King County. April 13, 2017.
17 (U//FOUO) Meisburger, Madeline. Tacoma Needle Exchange Program. E-mail correspondence received March 3, 2017.
22 (U) Noble, L. E-mail received from the Washington State Patrol’s forensic scientist supervisor through the NDEWS group on August 10, 2016.
35 (U) City of Everett webpage. Retrieved May 19, 2017 from https://everettwa.gov/1681/Purdue-Lawsuit
36 (U//FOUO) Garrety, Gary. Washington State Department of Health’s PDMP. E-mail correspondence received March 3, 2017.
37 (U//FOUO) Drennen, Barbara, Executive Director of the Pediatric Interim Care Center (PICC). Letter, received via e-mail on February 14, 2017.

66 (U//FOUO) Chaffee, Frank. Manager, HIV/STD Program of Public Health – Seattle & King County. E-mail correspondence received April 18, 2016.

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