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DEA
INTELLIGENCE
REPORT

The Opioid Threat in the Chicago Field Division

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Executive Summary

All available indicators—including investigative intelligence, case initiations, seizure and arrest data, abuse indicators, and anecdotal information—indicate that opioids present the greatest illegal drug threat to the Drug Enforcement Administration (DEA) Chicago Field Division (CFD), which encompasses the states of Indiana, Minnesota, North Dakota, Wisconsin, and the Northern and Central U.S. Federal Judicial Districts in Illinois. Although this threat is affecting urban and suburban areas most severely, it has been expanding throughout almost every state.

In the past, a discussion of drug threats commonly would be conducted individually about specific drugs, such as cocaine or heroin. However, recent developments with regard to the heroin threat dictate that the terms of the discussion must change. Previous discussions centered around the narrow diversion, heroin, or fentanyl threats; today's discussion must be broadened to include all opioids—drugs, regardless of origin, that induce narcotic-like symptoms, including fentanyl, fentanyl-related compounds, and U-47700. Because these other drugs are available domestically and quickly are becoming integral to the heroin problem, the goal of this report is to describe the opioid threat as a whole. Nonetheless, it is important to keep in mind that the driving force within this threat has been, and is likely to remain, heroin.

There are a number of factors that ensure that heroin will remain the primary opioid trafficked and used.

- In addition to the relatively steady supply of the drug produced in South America, production of heroin in Mexico has surged over the past 5 years and it is now the primary source country for heroin throughout much of the United States, ensuring that a steady supply of high-quality heroin is available.
- This increase in production has strengthened the position of Mexican cartels as primary heroin suppliers to the United States.
- Transportation networks and distribution routes established by Mexican drug trafficking organizations (DTOs) continue to be effective ways of bringing this product to illicit markets within the United States.
- Retail-level heroin distribution in most U.S. cities is controlled by street gangs that have established relationships with Mexican sources of supply.
- The sourcing, smuggling, and distribution of the newer, non-heroin opioids are a novel phenomenon, so a reliable supply chain has not yet been fully developed.
- Creation of the ideal mixture of opioid and diluent and/or adulterant, which generates a maximum level of physiological effects within the therapeutic index (i.e., the difference between an effective dose and lethal dose), has yet to be achieved, necessitating that the experimentation process will continue to evolve.
- Until the prices for diverted pharmaceuticals decrease substantially, high-quality heroin available at \$10 U.S. currency (USC) per dosage unit will remain an attractive solution to users of other opioids.
- Increasingly, heroin users are unaware of the actual drug in the retail packages they purchase so they may not know that they are ingesting another opioid. Nonetheless, there are increasing anecdotal reports of users specifically seeking out other opioids, specifically fentanyl.

Narcotics Defined

Also known as “opioids,” the term “narcotic” comes from the Greek word for “stupor” and originally referred to a variety of substances that dulled the senses and relieved pain. Although some people still refer to all drugs as “narcotics,” today “narcotic” refers to opium, opium derivatives, and their semi-synthetic substitutes. A more current term for these drugs, with less uncertainty regarding its meaning, is “opioid.” Examples include the illicit drug heroin and pharmaceutical drugs like OxyContin®, Vicodin®, codeine, morphine, methadone, and fentanyl.

Details

CFD STATE THREAT SUMMARIES

Illinois

Heroin availability in Illinois has surged in recent years, as indicated by record volumes of heroin seized by law enforcement authorities. Demand for heroin remains high in large part due to an abundant supply and low pricing, which in turn filters the drug into more rural areas of Illinois, especially as individuals addicted to prescription opioids transition to heroin in search of a cheaper and more readily available opiate. As a result, and reflecting a nationwide trend, several Illinois counties have experienced a rise in heroin-related overdose deaths in recent years. Chicago serves as the primary distribution hub for opioids and other illegal drugs in the region, with the West Side of Chicago being the region's most significant opioid market. This market is easily accessible using Interstate 290, a route that has been dubbed "the heroin highway." The vast majority of illegal drugs moving into the region are smuggled across the U.S.–Mexico border and transshipped primarily via tractor-trailers, commercial bus lines, personal vehicles, and parcel delivery services to the Midwest. Drug transporters continue to employ sophisticated concealment techniques to minimize the risk of seizure. Chicago is one of the nation's largest trucking centers due to easy access to several U.S. interstates and the presence of numerous trucking depots throughout the metropolitan area. These factors help make Chicago both an ideal transportation hub for moving drugs from the Southwest Border to the Midwest, as well as a consolidation point for drug proceeds destined for the Southwest Border and Mexico.

Indiana

Heroin availability in Indiana remains at high levels, as evidenced by a 43 percent increase in seizures during the last 6 months of 2015 when compared to the previous 6-month period. The southern part of the state receives Mexican brown heroin directly from the Southwest Border and Texas via Hispanic trafficking groups, often as part of poly-drug shipments. White heroin is obtained from sources in Chicago and other markets in neighboring states. Throughout Southern Indiana, the Indianapolis District Office (DO) has seen an increase of clusters of heroin-related overdoses in specific areas, particularly in Bartholomew and Jennings counties. Indiana continues to experience an increase in the use of heroin as users shift from abusing pharmaceuticals. This shift has been the result of various factors, including law enforcement authorities revoking the licenses of several doctors who were large prescribers of pain medications to patients without a legitimate medical need. Although users are shifting from abusing pharmaceuticals to abusing heroin, prescription drugs still continue to be diverted within the Indianapolis DO's area of responsibility. From 2013 through 2015, Indiana was the number one state in the country for pharmacy robberies. Due to increased enforcement and awareness, pharmacy robberies throughout Indiana were cut in half in 2016. Nevertheless, in 2016, Indiana was ranked second nationwide for pharmacy robberies—a stark reminder that there is much more work to do in this effort.

Combating the Opioid Epidemic in Northwest Indiana

In response to a growing number of overdoses in Northwest Indiana, the Lake County High Intensity Drug Trafficking Area (HIDTA), in conjunction with DEA, the U.S. Attorney's Office, and the Porter County Sheriff's Department established the Heroin Response Project (HRP). This effort was initiated to collect and analyze information from the scenes of overdoses, with the end goal of identifying and prosecuting sources of supply. As of May 2017, the initiative has analyzed information from 279 drug overdoses, included 75 fatal overdoses, which led to the identification of 68 retail-level dealers and uncovered links to 42 ongoing investigations. In addition, the effort has opened lines of communication among those impacted by the opioid epidemic in Northwest Indiana.

Wisconsin

Most of the heroin distributed in Milwaukee is obtained from sources of supply in Chicago. Traffickers from Milwaukee and surrounding areas often travel the approximately 90 miles to Chicago one or more times per week to obtain heroin from Hispanic or African American sources of supply. These traffickers usually obtain quantities between 50 and 100 grams each trip to bring back to Wisconsin for retail distribution. Traffickers from Northern Wisconsin (i.e., Green Bay) often travel to Milwaukee to obtain their heroin and then travel back to their region for further distribution. Traffickers often charge considerably higher prices in many northern areas of the state. Chicago sources of supply also travel from Chicago to Milwaukee and other areas as well, in order to take advantage of the higher prices commanded for heroin in Wisconsin. This increase in heroin abuse in Wisconsin has affected many rural areas that were previously unfamiliar with heroin overdoses and deaths. The increased heroin activity also collaterally affects many of these communities due to the subsequent rise in property crimes, thefts, and break-ins. Many communities around the state have organized heroin “summits” to raise awareness of the problem and to assist communities in coming up with strategies to combat this problem. Many of the heroin users report switching to heroin after initially becoming addicted to prescription opioids and made the switch due to the high availability and cheaper price of heroin.

Minnesota

Heroin distribution and use have increased significantly in Minnesota, based on reports from hospital emergency rooms, first responders, and medical examiners throughout the state. The increase in heroin use has been noted primarily in the greater Minneapolis/St. Paul area, with notable increases in use in St. Cloud, Duluth, Rochester, and various Native American tribal lands. Many heroin users in Minnesota report that their addiction began with prescription opioids, but were quickly enticed by the low cost and high availability of heroin. Current investigations indicate that diversion of OxyContin® and Vicodin® continues to be a problem in Minnesota. Additionally, as of June 13, 2017, Carfentanil-related overdose deaths have primarily occurred in the Minneapolis/St. Paul metropolitan area with 10 overdose deaths in the metropolitan area and one overdose death in Southern Minnesota since January 30, 2017. Carfentanil has a clinical potency 10,000 times that of morphine and 100 times that of fentanyl. Fentanyl is 50 to 100 times more potent than morphine.

North Dakota

Heroin is readily available throughout the State of North Dakota. Sources of information controlled by state and local law enforcement agencies report an increase in demand for heroin over recent years. According to these sources of information, many local, street-level methamphetamine distributors are now attempting to develop criminal relationships with heroin sources of supply in an attempt to cash in on the increased demand for heroin. Some heroin abusers in the Fargo area report switching from high-priced opioid analgesic prescription pills such as oxycodone to heroin because heroin is easily obtained and is cheaper than prescription drugs. This increased demand for heroin is evident in the increase in the number of heroin seizures, as well as the quantities of heroin seized throughout the state. North Dakota Bureau of Criminal Investigation (BCI) reporting shows that the number of heroin exhibits seized nearly doubled from 2013 to 2014. In addition to the threat of heroin, there has been a significant increase in the amount of fentanyl abuse throughout North Dakota, leading to an inordinate number of fentanyl overdose deaths throughout the state.

ORGANIZATIONAL THREAT

The CFD’s most significant organizational threat is posed by Mexican DTOs that dominate the wholesale supply of illegal drugs to the region. In order to move drugs to Chicago and the surrounding states, Mexican cartels often employ a series of intermediaries who oversee the shipment of drugs across the Southwest Border and facilitate sales to

wholesale and mid-level customers. These key intermediaries are most often based in the United States, but they maintain close relationships with family members or associates in Mexico involved in cartel operations. For cartel leadership, these individuals are very beneficial not only due to their ability to broker drug deals and facilitate smuggling operations, but also because they help insulate cartel members in Mexico by assuming a majority of the risk and thwarting law enforcement's efforts to directly trace the supply of drugs back to sources in Mexico.

Chicago-based street gangs, with an estimated membership of over 100,000 in the metropolitan area, serve as mid-level and retail-level distributors of illegal drugs in the city. In addition, Chicago street gangs are actively involved in drug transportation and distribution to associated gang members and independent dealers in other states. For example, the Black P Stones, Latin Kings, and Latin Dragons are among the street gangs in Northwest Indiana that are heavily involved in drug distribution. Street gangs pose a multi-faceted threat to law enforcement agencies in the region, as many of the gangs that are most heavily involved in heroin distribution are also responsible for a significant portion of violent crime in the area. It is important to note that most of the drug arrests effected in the CFD result in the seizure of weapons and more than one drug—strong evidence of the poly-drug and violent nature of drug trafficking in general—and retail drug sales operations specifically—within the Division.

Diverted pharmaceutical opioids, namely hydrocodone and oxycodone, are obtained and distributed in a number of ways, such as improper prescribing practices by physicians, “doctor shopping” (going to a number of doctors to obtain prescriptions) by opioid users, theft and forgery of prescriptions, theft from pharmacies or pharmacy staff, and illegal internet pharmacy purchases. Some of the groups that are involved in obtaining and selling diverted pharmaceuticals are well organized and use a variety of methods to obtain prescription opioids. Due to the demand for opiates, some dealers traditionally involved in the sale of heroin also distribute pharmaceutical opioids. Counterfeit pharmaceuticals have also become more prevalent, and are typically obtained from vendors on the Dark Web or from Mexican sources. Although counterfeit pills may have the color and marking of a prescription opioid, they may contain dangerous amounts of harmful substances like fentanyl, thereby posing significant risk to unsuspecting users.

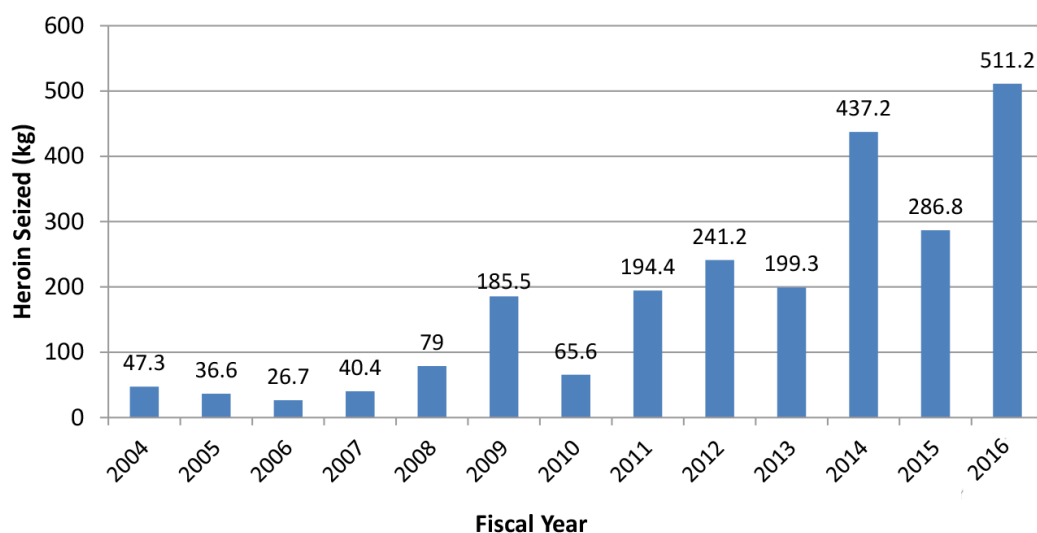
DIVISION-WIDE STATISTICS

Seizures

Continuing a multi-year trend, large quantities of heroin continue to be seized in the DEA CFD. In fact, heroin seizures in the CFD have climbed to record levels with a total of 511.3 kilograms of heroin seized to date in Fiscal Year (FY) 2016 (see Figure 1). Large, multi-kilogram seizures—some of which total more than 20 kilograms—are now more common. Typically, seizures of this magnitude cause some disruption in the supply of the drug to the street because of fluctuations in price, purity, or both. However, despite the increase in seizures, the price and purity of heroin in Chicago has remained relatively stable in recent years, particularly at the retail-level, indicating that the effect of these seizures on the overall supply and availability of heroin in Chicago has been minimal. Most of the heroin available in Chicago is white, gray, or tan powder heroin that was either produced in or (to a lesser extent) transited through Mexico, and has an average retail-level purity of approximately 12 percent.

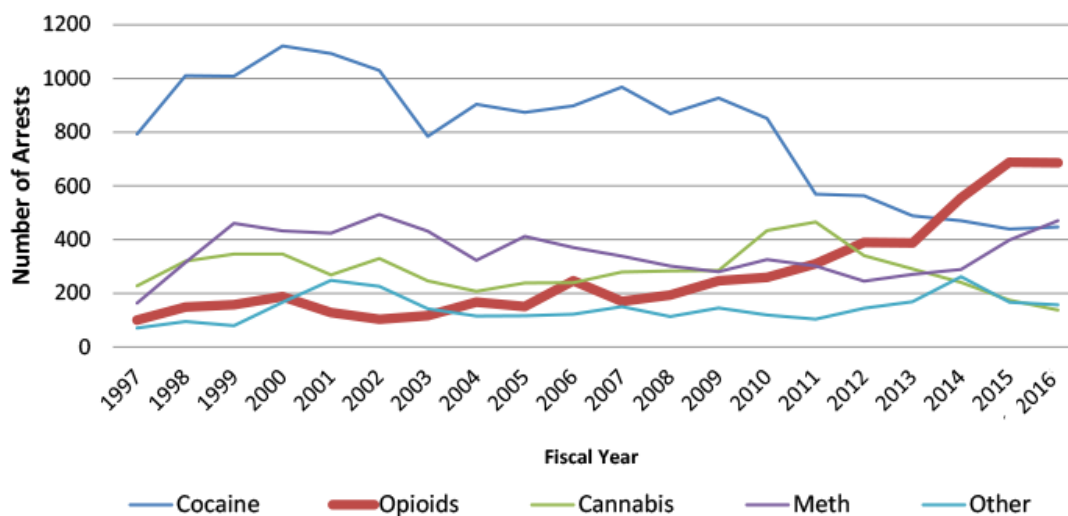
Arrests

CFD arrests on charges related to opioids have surged over the past 5 years, from 310 in FY11 to a CFD-record 686 arrests in FY16 (see Figure 2). Opioid arrests during each of the past 5 years were more than double the average number of such arrests during the preceding 15 years, and opioid arrests exceeded cocaine arrests during each of the past 3 years. Of similar concern are arrests associated with controlled prescription drugs, given the link between the abuse of prescription opioids and heroin. Arrests associated with

Figure 1: Chicago Field Division heroin seizures.*

*Source: Concorde/Impact Reports Appendix A. Total includes analyzed and info-only seizures.

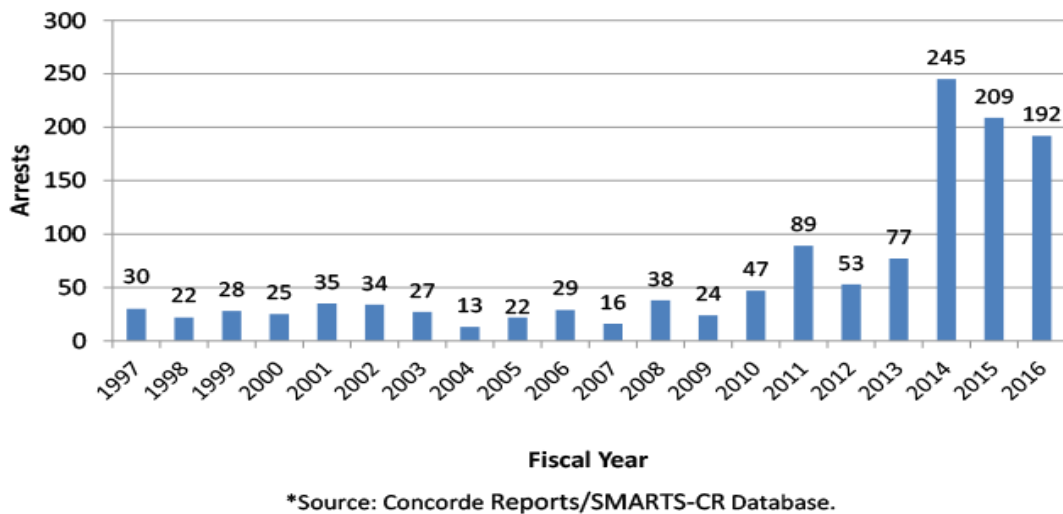
Source: DEA

Figure 2: Chicago Field Division arrests by drug.*

*Source: Concorde Reports/Smarts-CR Database.

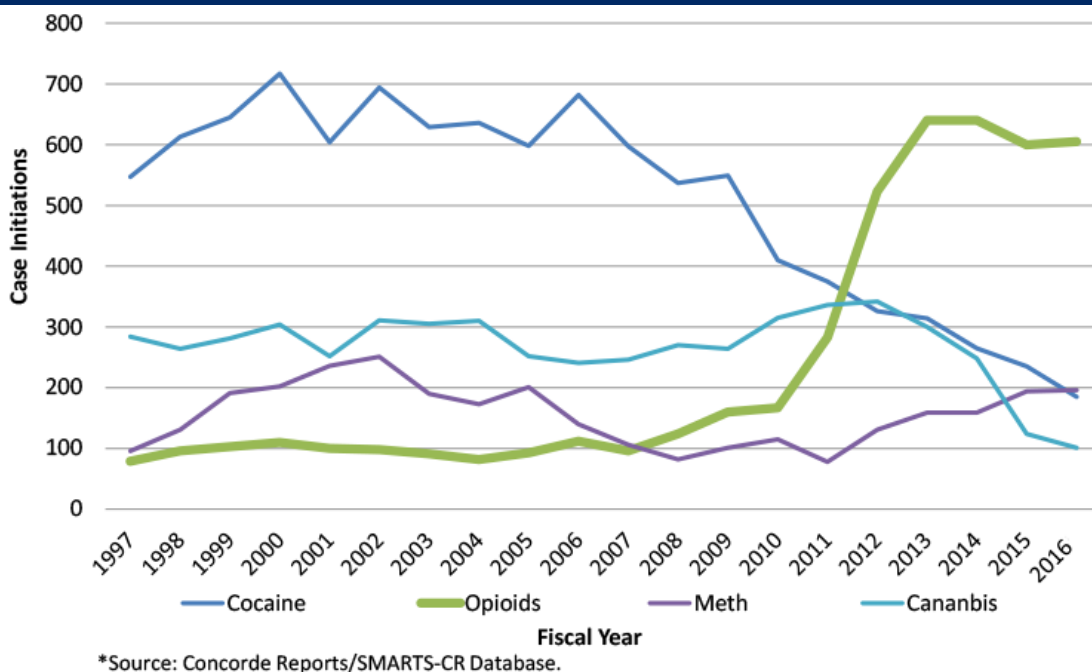
**FY 2016 data is preliminary

Source: DEA

Figure 3: DEA Chicago Field Division arrests for controlled prescription drugs.

Source: DEA

controlled prescription drugs (CPD) peaked during FY14 and, while declining slightly in FY15 and FY16, such arrests still were more than double the number in any preceding year and increased 10 fold since FY05 (see Figure 3). It is likely that the increased number of CPD arrests was directly related to the recent establishment of additional Tactical Diversion Squads within the CFD, as well as increased CPD activity.

Figure 4: DEA Chicago Field Division case initiations.*

Source: DEA

CASE INITIATIONS

CFD case initiations similarly reflect the divergent trends in the traffic of cocaine and opioids, with the number of cocaine cases (combined cocaine and crack) declining nearly 70 percent over the past decade, and opioid cases quintupling (see Figure 4). Although the number of methamphetamine cases initiated after FY05 declined substantially, they surged after FY11 and the number of methamphetamine cases initiated during FY16 was nearly double the number initiated a decade ago. Marijuana case initiations declined precipitously between FY12 and FY16.

ABUSE AND OVERDOSES

Levels of opiod abuse in the CFD area of responsibility are among the highest in the country. From 2006 to 2012, heroin was the second most common reason for Illinoisans to enter state-funded treatment, after alcohol. In 2000, it was the fourth most common reason. Adding to the problem of heroin abuse in Illinois is a decline in treatment capacity. According to a recent study, in 2012, Illinois's state funded treatment rate of 265 per 100,000 population was the third most severe in the nation and over 50 percent lower than the overall U.S. rate. Abuse among teenagers is also increasing at a troubling rate. In 2007, 2.5 percent of Illinois youth reported using heroin in the past year, while that number increased to 3.8 percent in 2013, a nearly 50 percent increase in just 6 years.

Several regions of the CFD area of responsibility have experienced an increase in heroin-related overdoses in recent years. In addition to the increase in numbers, heroin overdoses have also become more widespread and occur more frequently in suburban and rural areas of the Division. According to the Illinois Department of Public Health, there were 844 heroin-related overdose deaths in Illinois in 2015, up from 583 deaths in 2013 and 711 deaths in 2014. Over half of these deaths occurred in Chicago and its suburbs.

According to the Indiana State Department of Health, in 2014—the most recent year for which final data are available—452 individuals in Indiana died of drug overdoses involving opioids, and 2,822 people visited emergency rooms due to opioid overdoses. In northwest Indiana, heroin-related overdose deaths have increased in both Lake and Porter Counties. In Lake County, there have been 41 heroin-related overdose deaths to-date in 2016, compared to 43 in 2015 and 32 in 2014. In Porter County—an area with a population of only 167,076 citizens according to the 2014 census—heroin-related deaths number 15 so far in 2016, up from 12 deaths in both 2014 and 2015.

In Minnesota, St. Louis County—in the northeastern corner of the state—leads the state in opioid overdose deaths per capita at 13.4 deaths per 100,000 residents. Hennepin County (Minneapolis) saw 8.4 deaths per 100,000 residents, and Anoka (Anoka) and Ramsey (St. Paul) Counties saw 6.1 deaths per 100,000 residents through 2015, according to the Minnesota Department of Health. Overall, opioid drug overdose deaths in St. Louis County increased by 108 percent between 2011 and 2015. In Hennepin County, there were 103 opioid-related overdose deaths between January 1 and September 19, 2016.

Opioid-related overdose deaths have also increased in the State of Wisconsin. According to a report from the Milwaukee County Medical Examiner's Office, 191 people died in 2016 from opioid overdoses as of September 24, 2016, compared to 176 deaths during the same time period in 2015.

It should be noted that these increases in overdose deaths occurred concurrently with more widespread distribution and use of naloxone (commonly known as Narcan®) to reverse the effects of opioid overdoses which likely prevented numerous additional deaths. In response to the high amount of overdoses involving heroin and other opioids, an increasing number of law enforcement agencies are training officers to administer naloxone. Naloxone may either be prescribed by a physician, or in some states, purchased over-the-counter in a pharmacy.

HEROIN SIGNATURE PROGRAM

The Heroin Signature Program (HSP) was initiated in 1977 and examines the wholesale aspect of the domestic heroin trafficking situation with the principal objective being to enhance DEA's ability to identify the geographic source of heroin seized and purchased within the United States. In addition to identifying the heroin source area, the HSP provides intelligence on wholesale-level purity and tracks transition in heroin smuggling patterns into and throughout the United States.

The latest HSP results provide additional proof of the Mexican cartels' dominance in the heroin trade. Recent improvements in the forensic analysis of heroin seizures by the DEA Special Testing and Research Laboratory (STRL) have brought the prevalence of heroin from Mexico in the wholesale supply of the drug in the CFD area of responsibility into better focus.¹ The most significant recent improvement in HSP chemical analysis has been the fine-tuning of the identification of heroin produced in Mexico. STRL now identifies four distinct signatures of this heroin—the traditional black tar and brown powder forms, a white powder modeled after the South American signature, and an additional classification for other refined or crudely manufactured heroin from Mexico.

Prior to 2013, a significant portion of heroin seized in the CFD area of responsibility and analyzed through the HSP was categorized as “unclassified” since it did not match one of the established signature profiles. With the establishment of new signatures since that time, STRL has been able to ascertain source information for an increasing proportion of the heroin seized within the CFD area of responsibility (this includes heroin seizures by other agencies in addition to DEA). Although unclassified exhibits accounted for as much as one-half of the net weight of heroin analyzed in the past, the volume of unclassified exhibits seized during 2013, 2014, and 2015 never exceed 1 percent. The fact that source of origin for virtually all of the heroin seized now can be identified is a significant achievement and allows for a greater level of detail to an analysis of the heroin threat.

Mexican Heroin Signatures:

MEX/T: Mexican black tar; previously classified as MEX.

MEX/BP: Mexican brown powder; previously classified as MEX.

MEX-SA: Mexican-South American; white heroin that originated from Mexico with processing signatures classified as South American; previously classified as UNK-AMW.

MEX: Refined or crudely manufactured heroin from Mexico. This classification is assigned when MEX/T, MEX/BP, or MEX-SA are not applicable.

INC-SA: Resembles SA heroin in appearance; processing signatures are characterized as South American with an “inconclusive” origin component where either Mexico or South America could be the origin. Extremely adulterated and diluted (low purity) heroin is likely to generate this classification.

Other Heroin Signatures:

SA: South American (primarily Colombia).

SEA: Southeast Asian (Burma (Myanmar) and Laos).

SWA: Southwest Asian (Afghanistan and Pakistan).

The percentage of Mexican heroin as it relates to the overall amount of heroin analyzed has been exceedingly high for the past 3 years. In fact, of the heroin seized in the CFD area of responsibility and analyzed under the HSP, heroin from Mexico accounted for 96.4 percent in 2014 and topped 98 percent in 2015.

The average purity of Mexican heroin, as expected, varied considerably among the three signatures identified (no Mexican brown heroin was identified recently). For example, black tar heroin purity never averaged more than 40 percent over the past few years, while Mexican SA purity averaged more than 80 percent in 2013 and 2014. The quality of this Mexican SA heroin is on par with the white powder heroin produced in South America, Southeast Asia, or Southwest Asia. As shown in Figure 5, from 2014 through 2016 there

were a total of 102 heroin exhibits that were seized in the CFD area of responsibility and analyzed through DEA's Heroin Signature Program. The total weight of these exhibits was 434.5 kilograms, and the average purity was 66.7 percent. Mexico was the predominant source area identified, with heroin from this area constituting nearly three-quarters of both the number and weight of all the exhibits analyzed.

With regard to the presence of SA heroin, investigative intelligence developed during the cases in which SA heroin was seized indicates that, although this heroin was produced in Colombia, Mexican DTOs were responsible for much of its importation and distribution. This forensic and investigative evidence conclusively shows that Mexican DTOs are the primary sources of supply for heroin distributed at the wholesale level within the CFD area of responsibility. This is a radical change from previous years when heroin from a variety of source areas, albeit in limited quantities, continued to be available and was trafficked by a variety of international DTOs. For example, heroin from South America dominated HSP results between 2007 and 2012, but the volume of this heroin within the HSP has declined precipitously since then. In addition, there has been no confirmed seizure of heroin from Southwest Asia within the area of responsibility since 2011, and none from Southeast Asia

Figure 5: Source of origin for heroin seizures within the Chicago Field Division area of responsibility.

	ILLINOIS			INDIANA			MINNESOTA			WISCONSIN		
SOURCE	NO.	GRAMS	PURITY (%)	NO.	GRAMS	PURITY (%)	NO.	GRAMS	PURITY (%)	NO.	GRAMS	PURITY (%)
MEX	2	763.10	14.65	1	2,460.00	57.30	0	0.00	0	0	0.00	0.00
MEX-SA	56	328,271.38	78.61	2	1,885.00	51.90	3	311.12	19.45	4	1,372.90	37.18
MEX/T	1	983.14	50.40	2	9,000.00	42.50	3	7,113.87	27.53	1	17.27	32.00
INC-SA	7	57,611.80	79.20	0	0.00	0.00	0	0.00	0.00	1	43.80	14.70
SA	9	19,914.50	74.28	1	2,000.00	67.90	1	351.50	38.40	2	96.60	70.95
UNK	6	2,297.77	58.30	0	0.00	0.00	0	0.00	0.00	0	0.00	0.00
Total	81	409,841.69	74.57	6	15,345.00	52.33	7	7,776.49	26.65	8	1,530.57	42.16

Source: DEA Heroin Signature Program

	CFD		
SOURCE	NO.	GRAMS	PURITY (%)
MEX	3	3,223.10	28.87
MEX-SA	65	331,840.60	73.17
MEX/T	7	17,114.28	35.71
INC-SA	8	57,655.50	69.99
SA	13	22,362.60	70.52
UNK	6	2,297.77	58.03
Total	102	434,493.75	66.71

Source: DEA Heroin Signature Program

since 2005, despite the fact that heroin from these sources was seized regularly over the past three decades.

Among the Mexican heroin exhibits, there was some diversity in form, with black tar heroin (MEX/T) encountered in four of the five CFD states along with the more numerous MEX-SA exhibits. The average purity of Mexican heroin, as expected, varied considerably among the three signatures identified (no Mexican brown heroin was identified recently). For example, black tar heroin purity averaged 35.7 percent, while Mexican-SA purity averaged 73.2 percent.

These results suggest that traffickers who have access to heroin from other source areas find it increasingly difficult to compete with Mexican cartels. This may be due to a number of factors including changes in the availability of opium poppy and heroin within those source areas, and the challenges inherent in moving illegal contraband in large volumes on a continual basis over long distances from

South America, Southeast Asia, and Southwest Asia to the United States. The competitive advantages enjoyed by the Mexican cartels, such as improved heroin production capabilities and well-established smuggling and transportation networks, almost guarantee that they will remain the primary sources of supply for heroin in the CFD area of responsibility in the future by supplying large amounts of high-quality heroin at prices that other traffickers cannot match.

HEROIN DOMESTIC MONITOR PROGRAM

The DEA Heroin Domestic Monitor Program (HDMP) is a retail-level heroin purchase program that provides data analysis about the price, purity, and geographic source of heroin sold at the retail level in 27 U.S. cities, including Chicago.

Historically, the HDMP has shown the heroin market in Chicago to be diverse, with heroin from multiple source areas appearing on its streets on a regular basis. In fact, since 1988, there have been 10 years when heroin from three source areas has been observed, and 3 years when heroin from all four source areas was found. This is indicative of a highly competitive illicit market. During the 28 years of the program, there have been only 5 years in which heroin from only one source area was found—that source area was South America and those years were relatively recent (between 2006 and 2013). This suggests that one powerful player emerged as the victor in the competition over this lucrative market.

Figure 6: Heroin Domestic Monitor Program results for Chicago (FY).

	2013		2014		2015		2016	
SOURCE	NO.	PURITY	NO.	PURITY	NO.	PURITY	NO.	PURITY
MEX	1	0.4	0	0	0	0	0	0
MEX-SA	--	--	--	--	--	--	5	15.2
INC-SA	--	--	--	--	9	9.3	21	11.5
SA	16	12.5	24	17.1	4	11.1	3	11.6
SEA	0	0.0	0	0.0	0	0.0	0	0.0
SWA	0	0.0	0	0.0	0	0.0	0	0.0
UNK	22	11.9	14	16.4	17	11.0	9	12.5
TOTAL	39	11.9	38	16.9	30	10.5	38	12.3

Source: DEA Heroin Signature Program

However, as with any indicator program, the results must be considered in light of other evidence. Investigative intelligence and arrest data show that, while the primary source area for heroin available in Chicago during the mid-2000s was South America, the primary traffickers of this heroin were clearly from Mexico. As was observed during the late 1980s and early 1990s with regard to control over the domestic cocaine market, Colombian sources of supply began ceding control of the movement of heroin to Mexican cartels during the early 2000s. For example, up until about 2004, when South American heroin was seized from Mexican citizens within the CFD area of responsibility, a Colombian national was almost inevitably the ultimate intended recipient of that heroin. However, in the following

years, seizures of South American heroin were affected almost exclusively within the Mexican trafficking infrastructure, with little (if any) involvement by Colombian nationals. In fact, only three Colombian citizens have been arrested on heroin-related charges in the CFD since 2010 (none since 2014), while more than 300 Mexican citizens were arrested on heroin charges during that time.

Recent HDMP results mirror the results of the HSP provided above, confirming that a significant proportion of all the heroin sold on the streets of Chicago is sourced in Mexico. Also, as observed with the HSP results, there have been no purchases of Southwest Asian heroin in Chicago since 2007 (one exhibit) and none of Southeast Asian heroin since 2003 (one exhibit).

FENTANYL AND NOVEL SYNTHETIC OPIOIDS

No single drug captures the dynamics of all of the major threats to the CFD than fentanyl. This drug appears as a diverted pharmaceutical, as a clandestinely manufactured synthetic, and as a potentially lucrative substitute for heroin trafficked by Mexican cartels and distributed by street gangs. The lethality of this drug poses a significant threat to heroin users who ingest the drug, emergency personnel who treat these users, and law enforcement officers who handle it as evidence. Traffickers have identified new sources for fentanyl—to include sources in China—and are acquiring the drug through direct purchase over the internet and shipment via express parcel delivery services. This new trafficking scheme poses additional challenges to law enforcement authorities by creating opportunities for criminals who traditionally never served as sources of supply or who possibly were never even involved in illegal drug trafficking. The fentanyl threat is exacerbated by the availability and use of fentanyl analogs and fentanyl-related compounds, such as acetyl fentanyl, furanyl fentanyl, and carfentanil. Fentanyl is most commonly distributed in powder form either mixed with heroin or in pure form, and sold on the street in areas where heroin has historically been available for purchase. Fentanyl has also been pressed into counterfeit pharmaceutical pills and sold on the street.

The threat posed by fentanyl became painfully evident in 2006 when more than 300 people died of fentanyl-related overdoses in Cook County, Illinois, and hundreds more nationwide, due to the introduction of a large volume of fentanyl manufactured in a clandestine laboratory in Mexico. This laboratory was identified during a CFD investigation of a Mexican DTO, and upon alerting the authorities in Mexico, it was successfully dismantled. Since this one laboratory supplied all of the fentanyl sold on U.S. streets at that point, fentanyl-related overdoses declined sharply.

Fentanyl has again emerged as a serious threat as it has become increasingly available in the CFD area of responsibility and across the country. When not dosed properly, fentanyl distribution can easily result in numerous overdoses. For example, over a 5 day period in October 2015, there were approximately 95 overdoses, including four fatal overdoses, attributed to fentanyl distributed on the West Side of Chicago.

Fentanyl use has also led to an increase in overdose deaths in other areas of the Division. For example, in North Dakota and western Minnesota, there were a total of 64 opioid-related overdoses between January 1 and June 30, 2016. Thirteen of the 64 overdoses resulted in death, with eight of those deaths being attributed to fentanyl toxicity. In Milwaukee County, Wisconsin, fentanyl was identified as a contributing factor in 56 deaths in 2016, compared to 30 fentanyl-related deaths in all of 2015, 16 in 2014, 11 in 2013, and five in 2012.

Overdose deaths related to fentanyl and fentanyl-related compounds have risen significantly throughout the region in recent years. In Cook County, which encompasses

Figure 7: Submissions of fentanyl and fentanyl-related compounds to local/state/federal laboratories in the Chicago Field Division area of responsibility.

	ILLINOIS	INDIANA	WISCONSIN	MINNESOTA	NORTH DAKOTA
2013	37	22	25	7	10
2014	64	120	33	4	5
2015	392	216	73	18	21
2016*	1,332	391	203	35	72

*Data for 2016 is Preliminary/Incomplete
Source: NFLIS

Chicago, in 2016, the number of opiate-related overdoses increased to 1,091, up from 649 opiate-related deaths in 2015. Of the 1,091 deaths in 2016, 562 were found to be related to fentanyl or fentanyl-related compounds. (The Cook County Medical Examiner's Office began routine testing for fentanyl in June 2015) According to the Cook County Medical Examiner, acrylfentanyl has been detected in 44 overdose deaths in between January 1 and April 8, 2017. By comparison, acrylfentanyl was only detected in 7 deaths in all of 2016. In the suburban Chicago counties of DuPage and Will, fentanyl-related deaths rose from 10 to 35 in Will County, and from 15 deaths to 42 in DuPage County from 2015 to 2016.

Seizures of fentanyl have increased significantly within the Division's area of responsibility. Data from the National Forensic Laboratory Information System (NFLIS) indicate that fentanyl seizures have increased significantly in each state in the Division between 2013 and 2016 (see Figure 7). Notably, fentanyl submissions increased sharply between 2015 and 2016, especially in Illinois where submissions jumped from 392 to over 1,300 during that time (data for 2016 are preliminary/incomplete). The majority of fentanyl seized in the Division is seized in powder form, either combined with heroin or by itself. Forms of pharmaceutical-grade fentanyl, such as fentanyl patches, sprays, and lollipops, continue to pose a risk for illicit diversion but account for only a small portion of the fentanyl seized in the Division.

In addition to fentanyl, other dangerous synthetic opioids such as U-47700 have also been encountered within the Division area of responsibility. U-47700 is a novel synthetic opioid, and its abuse parallels that of heroin, prescription opioids, and other synthetic opioids. U-47700 may be found in powder form or pressed into a tablet to mimic a pharmaceutical drug. Nationwide, U-47700 has been associated with at least 46 fatalities. According to the NFLIS, U-47700 has been found in 15 drug exhibits submitted to local, state, and federal drug laboratories in the CFD area of responsibility during 2016. Nine of the exhibits were submitted to laboratories in Wisconsin, while laboratories in Indiana (four exhibits) and North Dakota (two exhibits) accounted for the remainder. In August 2016, two individuals in Bloomington, Indiana, overdosed and died from U-47700 that had been obtained over the internet from a vendor in China. In response to the threat to public safety, on November 14, 2016, DEA placed U-47700 into Schedule I of the Controlled Substances Act.

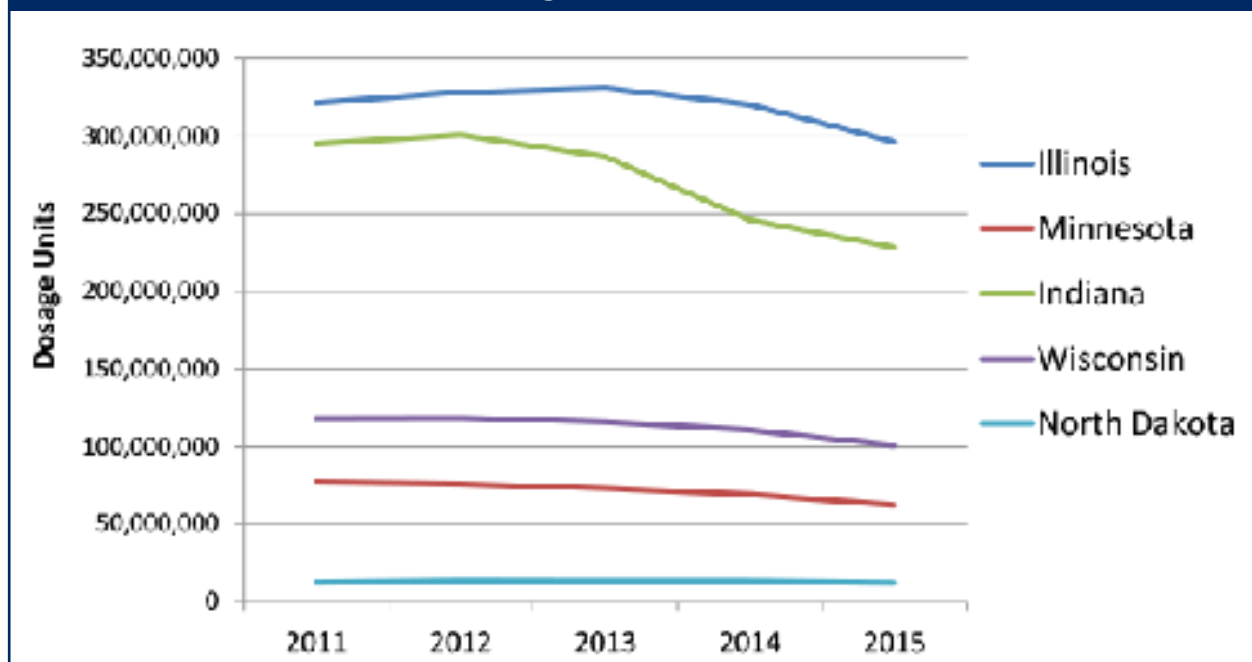
Fentanyl also poses a serious threat to law enforcement officers who may unknowingly be exposed to it. In some cases in the Division, undercover agents have made purchases of what was thought to be heroin, only later to find out that it was fentanyl. Law enforcement officers are urged to use extreme caution when dealing with substances known or suspected to be fentanyl or fentanyl-related compounds.

PRESCRIPTION OPIOID DIVERSION

The diversion of prescription opioids is a significant problem in the Division. The most commonly diverted prescription opioids include hydrocodone (such as Vicodin®), hydromorphone (such as Dilaudid®), and oxycodone products (such as OxyContin® and Percocet®). A national increase in the use of methadone as a pain killer, rather than for addiction maintenance, has contributed to the rise of methadone use and abuse within the Division. Primary methods of diversion are illegal sale and distribution by health care professionals and workers, theft of prescription opioids by pharmacy employees, doctor shopping, and the use of stolen or forged prescriptions. In addition, pharmacy robberies continue to occur throughout the Division, and the problem of purchasing pharmaceuticals over the internet has grown dramatically.

The implementation of state-run Prescription Drug Monitoring Programs (PDMP) in the Division's area of responsibility has proven to be effective in helping prevent diversion and abuse of prescription opioids. PDMPs allow prescribers and dispensers to view a patient's prescription history in order to identify high-risk patients and make informed decisions on how such patients are treated. If, for example, a physician observes that a patient has obtained prescription opioids in a manner that indicates potential abuse, then he or she may decline to issue a prescription and instead seek other forms of treatment or intervention. Similarly, pharmacists may opt to consult with prescribing physicians on certain prescriptions after reviewing the patient's prescription history. All five states in the Division area of responsibility have PDMPs in place, though the policies governing access to PDMP and information sharing vary by state. Near real-time access to PDMP data has proven to be a useful tool for law enforcement in identifying cases of prescription opioid diversion.

Figure 8. Amount of hydrocodone distributed in the Chicago Field Division.



Source: DEA

Hydrocodone and oxycodone continue to be the two primary prescription opioids abused within the Division's area of responsibility. In October 2014, hydrocodone was moved from Schedule III to Schedule II of the Controlled Substances Act, which led to a drop in its availability between 2015 and 2016. Data from DEA's Automation of Reports and Consolidated Orders System (ARCOS), which monitors the flow of controlled substances from the manufacturer to the retail distributor, show that the amount of hydrocodone distributed within the five states of the Division's area of responsibility declined from

approximately 819.6 million dosage units in 2013 to 700.3 million dosage units in 2015. The sharpest declines in the Division's area of responsibility were observed in Illinois and Indiana (see Figure 8).

Figure 9: Dosage units of hydrocodone and oxycodone dispensed in the Chicago Field Division — 2011-15.

	ILLINOIS	INDIANA	WISCONSIN	MINNESOTA	NORTH DAKOTA
Hydrocodone					
2011	321,282,475	295,068,258	118,284,644	77,075,058	12,445,400
2012	328,178,118	300,791,520	118,590,561	76,041,511	13,363,359
2013	330,894,109	286,815,209	115,772,939	72,883,560	13,236,013
2014	320,330,445	245,885,811	110,703,258	69,229,253	13,341,215
2015	296,375,876	228,276,151	100,678,632	62,667,036	12,263,764
Oxycodone					
2011	47,910,909	90,580,498	108,991,618	76,416,142	7,617,259
2012	48,498,497	100,999,487	113,573,046	80,088,363	8,216,559
2013	47,818,250	97,929,194	107,431,013	78,779,089	8,537,522
2014	51,314,342	95,324,390	111,687,150	83,495,917	8,782,002
2015	56,129,430	98,423,385	112,958,878	84,423,458	8,940,932

Source: Automation of Reports and Consolidated Orders System

Concurrent with the decrease in hydrocodone distribution, ARCOS data indicate that the amount of oxycodone available in the Division's area of responsibility has increased slightly, from approximately 340.5 million dosage units in 2013 to 360.9 dosage units in 2015. Notably, doctors in Wisconsin tend to prescribe oxycodone more than their counterparts in the Division's other states. For example, in 2015 there were approximately 113 million dosage units of oxycodone and approximately 101 million dosage units of hydrocodone dispensed in Wisconsin, whereas in other states the ratio of oxycodone to hydrocodone heavily favors hydrocodone. In Illinois in 2015, there were approximately 296 million dosage units of hydrocodone dispensed (almost triple the amount dispensed in Wisconsin) compared to approximately 56 million dosage units of oxycodone (almost half of the amount dispensed in Wisconsin). See Figure 9 below for a complete summary of ARCOS data for hydrocodone and oxycodone for the Division's area of responsibility.

Seizure data from NFLIS mostly correlate with the trends in the supply of prescription opioids (see Figure 10). For example, all states in the Division (with the exception of North Dakota) have registered a decrease in the amount of hydrocodone submissions to forensic laboratories for analysis, likely a result of the movement of hydrocodone to Schedule II of the Controlled Substances Act. In addition, the preference for oxycodone in Wisconsin is also apparent, with oxycodone submissions being significantly higher than that of hydrocodone. Data for Minnesota and North Dakota show a similar trend in those states.

Figure 10: Submissions of Hydrocodone and Oxycodone to Local/State/Federal Laboratories in the Chicago Field Division Area of Responsibility.

	ILLINOIS	INDIANA	WISCONSIN	MINNESOTA	NORTH DAKOTA
Hydrocodone					
2013	1,027	1,195	152	79	141
2014	1,140	710	143	50	95
2015	1,072	639	136	52	70
2016*	930	462	78	35	97
Oxycodone					
2013	247	572	338	115	151
2014	283	479	292	75	183
2015	316	441	259	113	181
2016*	260	344	226	84	181

*Data for 2016 is Preliminary/Incomplete; Query conducted on 1/17/2017

Source: NFLIS

Outlook

At the wholesale level, there appear to be no viable competitors to Mexican DTOs that serve as the primary sources of supply of illegal drugs—including heroin—being abused in the CFD. Similarly, street gangs are expected to maintain control of the retail-level drug market places within the major cities of the area of responsibility. The supply of a larger volume of high-quality heroin is not receding and it is interesting to note that, despite the higher availability of the drug, there has been neither a corresponding increase in purity at the retail-level nor a massive drop in wholesale-level price, as would be expected.

Prescription opioid abuse has resulted in thousands of deaths over the past several years, and many current heroin users have admitted to switching to heroin after becoming addicted to prescription pain medication. Therefore, an important component of attacking the overall opioid threat is reducing the non-medical use of prescription opioids. This effort requires a mix of law enforcement efforts to arrest those involved in the illegal distribution of opioids, regulatory efforts to control the type and amounts of opioids available for medical use, and community engagement to educate the public and medical practitioners on the dangers of opioid abuse. Although it may require several years for these efforts to yield noticeable results, they are critical in slowing the momentum of the opioid epidemic. Recently, there have been some signs of progress, such as a reduction in the availability of hydrocodone after it was placed in Schedule II of the Controlled Substances Act. As public awareness and education on the dangers of opioid abuse expand across the country, in tandem with prudent regulation and aggressive law enforcement, there is hope that additional signs of progress will follow.

The overall opioid threat is compounded by the reintroduction of fentanyl and novel synthetic opioids into the illegal heroin market, as well as the continued abuse of prescription opioids. Furthermore, the threat has grown more complex with the emergence of China as a source of supply for synthetic opioids, as well as the employment of the Dark Web to facilitate the distribution of opioids and other illegal substances. These developments have the potential to alter traditional distribution routes and supplier-customer relationships. Historically, wholesale distributors operating in the United States have required a connection with a Mexican source of supply to acquire fentanyl and other illegal drugs. With the emergence of the Dark Web, U.S.-based distributors no longer have to rely on Mexican sources of supply and can order synthetic opioids—most of which are sourced in China—via underground markets and have them delivered through the mail. Although the clandestine production of heroin and fentanyl in Mexico continues to have the greatest impact on opioid abuse in the United States, the availability and abuse of fentanyl-related compounds and powerful synthetic opioids such as U-47700, coupled with the relative ease with which these substances can be ordered from sources in China or from independent vendors on the Dark Web, pose a growing threat to the country.

¹ DEA; The Heroin Signature Program and Heroin Domestic Monitor Program 2014 Reports, <http://intranet/sites/nc/Reports/HSP%20and%20DMP%202014%20Reports.pdf>.



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



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Additional Comments: