



# DRUG TRENDS AND DISTRIBUTION IN ILLINOIS

A survey of drug task forces





**DRUG TRENDS AND DISTRIBUTION IN ILLINOIS:  
A survey of drug task forces**

*First in a series*

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# Key findings

Drug trafficking is the cultivation, manufacture, distribution, and sale of drugs (UNODC, 2016). Drug distribution networks exist to oversee operations to obtain, transport, deliver, and finally sell to individuals in communities all over the United States (Johnson, 2003). Globally, money exchanged through the illicit drug trade is around \$500 billion per year (UNDCP, 1998). Despite great risk, individuals in the illegal drug trade are drawn to the potentially lucrative enterprise. However, the economic cost to U.S. society for drug distribution including criminal activity, as well as users' medical costs and lost productivity, was estimated at \$76 billion per year (Parsons & Kamenca, 1992; UNDCP, 1998).

In Illinois, the distribution of controlled substances is a significant problem. In 1995, the Office of the National Drug Control Policy established the High Intensity Drug Trafficking Area program in Chicago (Chicago HIDTA, n.d.). Chicago HIDTA's mission is to enhance and coordinate drug control efforts among federal, state, and local law enforcement agencies in order to eliminate or reduce drug trafficking in critical regions in Illinois. In addition to establishing programs like HIDTA, drug task forces also were created to combat the distribution of controlled substances at the local level. Drug task forces arrest and prosecute drug offenders, identify and respond to emerging drug problems, and enhance interagency cooperation (Applied Research Services, Inc., 2014; Hollist et al., 2014). The Illinois Criminal Justice Information Authority has supported drug task forces with federal funding for more than 20 years.

Enlisting the participation of the 19 drug task force directors, this study sought to understand the extent of the drug problem in the jurisdictions covered by each drug task force. To do so, Authority researchers analyzed data from a survey administered to the 19 Authority-funded drug task forces on types of drugs frequency, trends, use, and distribution.

## Most problematic and emerging drugs

Drug task force officials encountered cannabis (n=19), heroin (n=18), prescription drugs (n=16), cocaine (n=15), and crack cocaine (n=14) in their jurisdictions. These drugs were identified as the most problematic in terms of illegal use and distribution.

Use and distribution of heroin was identified as the most serious problem drug by 16 of 19 drug task force communities, and most drug task force officials indicated an increase in the heroin problem in their communities over the two years examined (n=17).

Although less frequently noted, many drug task forces also indicated they have seen an increased drug problem associated with cannabis (n=12), prescription drugs (12), and methamphetamines (n=12) in their communities over the past two years (2014-2015). Other emerging drugs identified were cannabis oils and cannabis wax (n=4) and synthetic cathinones (n=2).

These findings were also consistent with the Authority's 2016 Illinois Drug Threat Assessment. Thirty-seven out of 77 police chiefs and sheriffs identified heroin as the greatest drug threat followed by prescription drugs (n=24). However, in the central and southern regions of Illinois,

methamphetamine was most commonly identified as a considerable drug threat. Cannabis was fairly evenly spread out among the rankings for greatest drug threat across each region (Gleicher, in press). The National Drug Threat Assessment also corroborates these findings, with an identified increase in heroin, methamphetamine, marijuana, and controlled prescription drugs.

## **Implications for policy and practice**

### **Collaborate to combat the spread of heroin**

Drug task forces in Illinois reported a growing concern about the spread of heroin use and the larger geographical distribution network for heroin compared to other drugs. Their perceptions that the heroin problem has grown and spread are supported by other data (Kane-Willis, 2015; Kane-Willis and Schmitz, 2012; National Drug Intelligence Center, 2001). Multi-jurisdictional and multi-agency law enforcement efforts are necessary to combat the heroin problem in Illinois. Illinois law enforcement and drug task force members should collaborate among themselves, as well as with agencies in neighboring states, to learn the distribution patterns than channel heroin to Illinois communities. Several local law enforcement task forces have been formed to examine and combat heroin, but existing multi-jurisdictional drug task forces are in a position to work together on this issue.

### **Train law enforcement officers to prevent heroin overdoses**

Several respondents explained that their drug task force noticed that heroin overdoses appeared to be increasing in their communities. Anecdotal reports are strengthened by data, which shows that the number of deaths due to heroin overdose in Illinois is increasing (Kane-Willis & Schmitz, 2012). Such findings are consistent with recent trends in the United States, which according to previous studies, is experiencing an opioid overdose epidemic (Paulozzi et al., 2012; SAMHSA, 2012). In 2014, Illinois passed the Heroin Crisis Act [20 *ILCS* 301/5-23], requiring first responders like law enforcement agents to carry Narcan (generic name Naloxone), a medicine used to prevent overdoses of heroin or other opioids from becoming fatal. However, a survey of local law enforcement agents across the country showed that only 4 percent reported carrying Narcan (Police Executive Research Forum, 2014). Patrol officers should be trained to use Naloxone and should be required by their task forces to carry it.

### **Enhance community outreach**

Community outreach efforts and successfully working in coordination with both criminal justice and non-criminal agencies on drug enforcement and drug cases is one strategy to addressing drug availability and use at the local level. Drug task force officers use community outreach to inform the public about substance use disorders, heroin, opioids, and other drugs. Task forces can share information about Illinois' Emergency Medical Services Access Act (or the "Good Samaritan Law") [PA 097-0678]. The Act encourages people to get emergency medical assistance and provides protection from prosecution for persons making a call for help. One study recommended that law enforcement "alleviate the concerns of the individuals that fear being arrested at an overdose" (Follett, Piscitelli, Parkinson, & Munger, 2014, p. 24).

# Introduction

According to a 2013 Substance Abuse and Mental Health Services Administration (SAMHSA) survey, an estimated 24.6 million Americans had used an illicit drug—including marijuana—in the past month, representing 9.4 percent of the American population, up from 8.3 percent in 2002 (SAMHSA, 2013). According to a 2015 study conducted by the CDC, 44 people die every day in the United States as a result of prescription opioid overdoses. In 2013, drug overdose was the leading cause of death from injury, causing more fatalities than motor vehicle crashes (CDC, 2014).

The transportation and sale of controlled substances, including heroin, is a significant problem in Illinois. In 2015, the Office of the National Drug Control Policy classified Chicago and neighboring counties as a “High Intensity Drug Trafficking Area.” Chicago, in particular, is a major transshipment and distribution center for drugs throughout the Great Lakes Region and the Midwest because there are multiple transportation options to and from the city—trains, highways, airports—through which smaller quantities of drugs can be distributed to neighboring states (National Drug Intelligence Center, 2001). While drug distribution operations are mainly concentrated in Chicago, suburban law enforcement agencies also report the gang-led distribution of drugs in their jurisdictions (National Drug Intelligence Center, 2008).

In 2015, Authority researchers surveyed the directors of 19 drug task forces awarded federal funding through Authority-administered grant funded. The study was designed to further understand the extent of the drug problem including drug types, frequency of encounters, trends and use over time, and distribution in the jurisdictions covered by each drug task force.



# Section 1: Literature review

## Drug trafficking

Drug trafficking involves the cultivation, manufacture, distribution, and sale of drugs while smuggling is best defined as the illegal secretive movement of a product across national borders (UNODC, 2016). Around 435 million people enter the United States annually by sea, land, and air and through these means drug traffickers smuggle drugs into the country (DEA, n.d.; Decker & Chapman; Finckenauer, Fuentes, & Ward, 2007). Despite great risk in illegal drug trade by rival drug groups, the monetary rewards make it alluring.

## History of U.S. drug trafficking

Drug trafficking arguably began in the 19<sup>th</sup> century with the trading of opium (Musto, 1999; cited by Johnson, 2003). There were several inventions that helped drive the illegal drug trade. First was the invention of the hypodermic needle in the 1850s which offered the ability to deliver drugs directly into the blood stream (Johnson, 2003). Second was the isolation of morphine from opiates, which led to the creation of a new drug called heroin. Heroin has a potency three times that of morphine, which leads to more individuals with substance use disorders (Johnson, 2003; Hogshire, 2004). During the 1860s cocaine was derived from the coca plant giving rise to more individuals with substance use disorders (Johnson, 2003). The black market demand for drugs increased dramatically due a tax on cocaine and opium by the Harrison Act of 1914, as well as making it illegal for doctors to prescribe, heroin, morphine, and cocaine to individuals with substance use disorders (Mutso, 1999; cited by Johnson, 2003; Sacco, 2014).

## Drug smuggling into the U.S.

Smuggling is the means by which drugs are brought into the United States and these means have grown in sophistication over the years (Decker & Chapman, 2008). The countless in-and-out of individuals from the country allow drugs to be transported through everyday operations. Traditional means of drug smuggling include tractor-trailers, rental vehicles, maritime vessels, carrying it on one's own person, and concealment in hidden vehicle compartments (Department of Justice, 2010; Finckenauer, Fuentes & Ward, 2007). These means of smuggling have become known to police, so new methods were devised. Drug traffickers use encrypted messages via cell phone texts and e-mails to communicate and smuggle drugs across the southwest border (Ledwith, 2000; cited by Finckenauer, Fuentes & Ward, 2007). Mexican drug traffickers work with legitimate lawyers, businesses, and accountants who help conceal their illegal behavior (Finckenauer, Fuentes, & Ward, 2007).

Transportation of drugs by vehicle, is more common than other means of smuggling combined (Department of Justice, 2010). Of other methods of smuggling drugs into the country, one of the more unique ones is *semisubmersibles*. These vehicles can travel long distances underwater and help drug traffickers smuggle drugs from other countries to the United States. However, this method of smuggling drugs into the country occurs significantly less than overland methods (Department of Justice, 2010).

## Drug distribution networks

Contrary to popular belief, drug distribution networks are not controlled by a single entity typically referred to as a “cartel.” Columbian based drug distribution, for example, operates through interconnected networks (Kenney, 2007). Individual groups collaborate together through a common objective to form a larger network (Kenney, 2007).

Research on drug distribution networks reveals that large drug shipments are most often conducted by small and highly organized groups (Bruinsma & Bernasco 2004, Dorn et al., 1998, Pearson & Hobbs 2001; cited by Malm & Bichler, 2011). While suppliers are loose groups of people involved in many different areas (Eck & Gersh 2000, Natarajan & Belanger 1998; Pearson & Hobbs, 2001; cited by Malm & Bichler, 2011).

The logistics of these networks typically involves older individuals closer to the source of product while younger individuals are involved in the sale of the product (Malm & Bichler, 2011). Those involved in higher level activity tend to deal with multiple different drugs while lower level individuals are only entrusted with one specific type of drug (Malm & Bichler, 2011).

There are two main types of drug distribution networks: *wheel* and *chain* (Kenney, 2007). Wheel networks have a group that controls all tasks and sub-groups. The main control group serves as the capital and knowledge center of the network, typically acting as the pilot for all sub-group operations. These networks work to corrupt government officials and teach drug smugglers about the practices of law enforcement (Kenney, 2007). Wheel networks operate at a national-level scale.

Chain networks are more decentralized and not controlled by a central group (Kenney, 2007). Like wheel networks, chain networks use corrupt government officials to accomplish many of their goals. However, while wheel networks work on a national level, chain networks work in local jurisdictions (Kenney, 2007).

Within these different networks are *cells*. Cells are different groups that conduct a range of drug operations. Roles can range from transportation, storage, distribution, pick up, and delivery (Kenney, 2007). These cells have relatively few layers, combatting the myth that a central cartel body control all drug operations in Colombia (Kenney, 2007).

Individual players within the networks include:

- Upper-level distributors or organized criminal groups- import drugs from other countries, buy and sell large quantities of drugs, oversee operations from financing to transportation, develop and maintain networks of individuals to perform drug operations (Johnson, 2003).
- Wholesale distributors-purchase large quantities of a drug.
- Retail sellers-responsible for money and drugs.
- Low-level distributors-responsible for tasks such as transportation, delivery, and acting as lookouts (Johnson, 2003).

Individuals who work in drug trafficking tend to isolate their work from those around them, except those who they work closely with, to avoid bringing attention to their illegal activities (Johnson, 2003).

### **Street-level distribution**

Once drugs are in the United States, drug traffickers have several different routes, referred to as corridors, they use to get the drugs to different parts of the country (Department of Justice, 2010). Corridor A, which consists of Interstate 10, 8, and 20, is the primary route for traffickers transporting large amounts of cocaine, heroin, marijuana, and methamphetamine from the Mexican border to the eastern part of the country (Department of Justice, 2010). Corridor B is also widely used by traffickers and includes Interstates 15, 80, 70, and 40 (Department of Justice, 2010).

There are two main types of drug networks—private and public. Private networks buy or sell drugs in more private settings such as home or a car; public networks buy or sell in more open settings such as streets, bars, and stores. Public drug networks usually involve two parties that do not know each other personally. Some drug groups may employ a “day laborer”, who they hire for a single day to sell drugs and act as lookouts, and pay in drugs as a means of cheap labor (Johnson, 2003).

### **Internet distribution**

Another means of distribution is the internet and the main site is *Silk Road*. First appearing in 2011, Silk Road is a website where users can buy and sell drugs anonymously, with a high probability of avoiding detection by law enforcement (Martin, 2014). This allows buyer and seller to never have to meet. Transactions are completed using an encrypted e-currency known as Bitcoin, and all product is sent by mail (Martin, 2014). Recent estimates of Silk Road place its value at \$23 million annually (Martin, 2014). Like other websites, Silk Road has ratings and forums where users rate suppliers and product, and discuss ways to avoid detection by law enforcement (Martin, 2014). Some have argued that Silk Road has its benefits in that it reducing the violence associated with typical drug distribution practices (Martin, 2014). However, Silk Road remains dependent on Internet access; therefore, it does not completely eliminate the need for intermediary/middle-man parties (Martin, 2014).

### **Illinois and Chicago drug distribution**

The City of Chicago has been identified as one of seven cities (others include Denver, Detroit, Houston, Miami, New York, and Tuscon) with a majority of major drug seizures (Department of Justice, 2010). Heroin has recently spread through the streets of Chicago, however, law enforcement officials identify crack/cocaine as the biggest drug threat facing the city (Department of Justice, 2011). Furthermore, Chicago drug enforcement efforts are complicated by a gang known as “Latin Kings.” This gang is able to act as its own supply because many of the gang members have family members living in Mexico, making it easier for those individuals to smuggle drugs (Department of Justice, 2011). For example, an individual may frequently travel back and forth across the border saying they are visiting family as a cover up for the drug

smuggling activities. With law enforcement placing more pressure on drug traffickers, street gangs have adapted with advanced technology. Some street gangs use global positioning systems and cameras to keep track of drug shipments, as well as prepaid cell phones because the devices are cheap and anonymous (Department of Justice, 2011). In addition, social media allows street gangs to communicate with each other to set up meetings and make threats to other gang members while remaining relatively undetected (Department of Justice, 2011).

Chicago is an active drug trafficking area due in part to its location in relation to major interstates including Interstates 55, 57, 80, 88, 90, and 94. These routes, along with O’Hare International Airport and Midway Airport, are means of transportation for drug traffickers (Department of Justice, 2011) (*Figure 1*).

**Figure 1**  
Chicago-area interstate drug trafficking routes



Source: Chicago High Intensity Drug Trafficking Area Drug Market Analysis, National Drug Intelligence Center and Chicago HIDTA (2007).

## **Distribution by drug type**

### **Cocaine distribution**

Originally dominating the drug market in the United States during the 1990s, Colombian-based drug groups no longer control the drug market. Mexico-based drug groups today have control over a larger percentage of the United States' cocaine trade (DEA, n.d.). Colombian drug groups withdrawal as a major player in the drug market stems from an effort to avoid extradition (DEA, n.d.).

Colombian drug groups provide the product to Mexican groups who then smuggles the drug into the country (DEA, n.d.). Increased federal drug enforcement in south Florida forced Colombia to seek other smuggling routes into the country (Finckenauer & Fuentes & Ward, 2007). The DEA estimates 65 percent of all cocaine was brought into the United States by individuals crossing the Mexico/U.S. border (DEA, n.d.). Colombian drug groups primarily control the markets in the north and east of the United States: Boston, Miami, Newark, New York, and Philadelphia (DEA, n.d.). Colombian and Mexican-based drug groups dominate the wholesale market of cocaine and Dominican Republic-based drug groups have been primarily responsible for the street-level sales (DEA, n.d.). Cocaine is smuggled into the country, left in pre-determined locations, and retrieved and transported to different locations across the country (Finckenauer & Fuentes & Ward, 2007).

### **Heroin distribution**

Heroin is produced in four different regions of the world:

- South America (Colombia)
- Southeast Asia (mainly Burma)
- Mexico
- Southwest Asia/Middle East (mainly Afghanistan) (Heroin.net)

All are available in the United States (DEA, n.d.). Originally heroin from Southeast Asia market dominated the U.S. illegal heroin market. However, in the 1990s market dominance shifted to South American heroin, primarily in the eastern portion of the country. With regards to the western portion of the country, black tar heroin and Mexican brown powdered heroin dominates (DEA, n.d.). The differences between the types of heroin are:

- White heroin – Taken by injection, insufflation, smoking/inhalation, rectally, and orally.
- Brown heroin – Less soluble than white heroin and less powerful; typically smoked.
- Black Tar – Solid form; it is heated up, mixed with water and injected using a needle.

South American heroin is smuggled in sizes ranging from 500 grams to 1 kilogram via couriers on commercial airlines through concealment or corrupt workers (Caulkins, Burnett, & Leslie, 2009). Heroin is also smuggled across the southwest border by illegal immigrants and migrant workers. However, the largest loads smuggled across the border come by means of privately owned vehicles often intermingled with legitimate commerce (DEA, n.d.; Caulkins, Burnett, & Leslie, 2009). When heroin is successfully smuggled across the border, drug groups rely on intricate networks to deliver to their markets throughout the country (DEA, n.d.).

## **Methamphetamine production and distribution**

Production, trafficking, and use of methamphetamine in the United States are primarily concentrated in the Western, Southwestern, and Midwestern parts of the country (DEA, n.d.). Methamphetamine is produced in super laboratories primarily found in California and Mexico (DEA, n.d.; Finckenaue, Fuentes & Ward, 2007). These super labs are able to produce 10 pounds of product in a single 24-hour period. While these labs are responsible for the majority of the methamphetamine found in the United States, the drug is also produced on smaller scales. Often referred to as “mom-and-pop” labs, small scale labs are operated by independent cooks who get their materials from local convenience stores. Typically the product produced in these labs is for personal use and limited distribution (DEA, n.d.).

Methamphetamine labs produce meth either in base form, powdered form (speed), and crystal form. Producing crystal methamphetamine involves extra steps that are done to remove impurities from the drug creating a more potent end product.

## **Marijuana cultivation and distribution**

Estimated to have been tried at least once by one-third of the U.S. population, marijuana is mainly smuggled into the country across the Mexican border and Canada (DEA, n.d.). Canada’s influence in the marijuana market has grown considerably in recent years as demand for high potency marijuana has increased. (DEA, n.d.). Marijuana is smuggled into the country through concealment in false compartment of vehicles, being hidden in shipments of legitimate agricultural or industrial products, trains, horses, rafts, and even backpacks (DEA, n.d.; Finckenaue, Fuentes & Ward, 2007).

While much of the marijuana found in the country can have its origins traced back to Mexico and Canada, there is a fair amount of the drug that is domestically produced. The 2000 Domestic Cannabis Eradication/Suppression Program (DCE/SP) reports that the states of California, Florida, Oregon, Washington, and Wisconsin lead the way in indoor growing activity, while California, Hawaii, Kentucky, and Tennessee lead the way in outdoor growing operations (DEA, n.d.).

## **Other drug distribution**

Other drugs such as MDMA, lysergic acid diethylamide (LSD) and steroids are also a problem facing the United States. MDMA is a lab produced drug and of the product found in the United States, its origins are typically traced back to Vancouver, Toronto, and Montreal, Canada. LSD is reported to be produced on the West Coast of the United States. Steroids are found in fitness centers and are most often consumed by weightlifters. The drug is smuggled into the country from Mexico and Europe. The DEA reports that the lack of international control over the drug makes it impossible to counter the trafficking (DEA, n.d.).

## **Combatting drug distribution: Drug task forces**

In addition, to federal and local law enforcement efforts, states have relied on drug task forces. Drug task forces developed to more efficiently and effectively combat the distribution of controlled substances. The United States spends more than half of its federal drug control spending on domestic law enforcement, which includes drug task forces (Mazerolle, Soole, & Rombouts, 2007). The three primary goals of drug task forces are (1) arresting and prosecuting drug offenders, (2) identifying and responding to emerging drug problems, and (3) enhancing interagency cooperation (Applied Research Services, Inc., 2014; Hollist et al., 2014). Drug task forces target mid-level drug wholesalers, “many of whom would otherwise fall through the cracks because of the difference between federal practices and the street-level focus of uniformed law enforcement” (Lombardo & Olson, 2009, p. 46).

### **Drug task force role**

Drug task forces combat drug markets through supply reduction (Olson, 2004; Mazerolle, Soole, & Rombouts, 2007; Lombardo & Olson, 2009). The United States spends 67 percent of its federal drug control spending on supply reduction via drug task forces (Mazerolle et al., 2007). Supply reduction focuses on reducing the production and cultivation of drugs; breaking supply chains by seizing drugs and assets; conducting systematic investigations; and prosecuting drug organizations, suppliers, and distributors (Moore, 1990). In addition, drug task forces focus on preventing drug use by reducing demand through education, deterrence, and treatment (Lombardo & Olson, 2009; Olson, 2004).

### **Drug task force characteristics**

Jurisdictional restraints on local police make it difficult to fight drug markets extending through multiple cities and counties (Smith, Novak, Frank, & Travis, 2000). Research has indicated that “communication and coordination between police agencies are essential for effective strategies and the ability to perform the complex and demanding tasks associated with the enforcement of drug laws” (Hollist et al., 2014, pg. 9). Drug task forces use of formalized interagency collaborations can lead to more thoroughly investigated cases and more prosecutions (Vohryzek-Bolden et al., 2003). Studies have found that task force membership improves interagency communication, as well as officers’ perceptions of the likelihood of conviction (Smith, Novak, Frank, & Travis, 2000). A 2003 study found that 40 percent of Illinois task force arrests involved multiple offenses, whereas only about 5 percent of local police arrests resulted in multiple charges, indicating that task force investigations result in more comprehensive court cases (Ramker et al., 2003). Training officers of drug task forces is an important way to ensure that they understand how to communicate with other agencies and to improve their competence and professionalism (Albanese & Finckenauer, 1996).

Successful drug task forces set clear goals and protocols in order to ensure a system of accountability to the local community (Cardenas, 2002). More specifically, the creation of operation and procedures manuals for drug task forces is helpful in standardizing drug task force activity in certain states. For example, in Minnesota, a drug task force operations manual

increased inter-task force collaborations almost 500 percent from 2004 to 2010 and helped to better identify underperforming task forces (National Criminal Justice Association, n.d.).

Other structural factors influencing the effectiveness of a task force include the distance of a drug task force unit from an urban center, an interstate highway, and/or state boundaries (Applied Research Services, Inc., 2014; Jefferis et al., 1998). Studies have also pointed to the different challenges faced by drug task forces in rural and urban locations. Hayeslip and Russell-Einhorn (2003) suggest that rural and semi-rural jurisdictions are confronted by unique obstacles because they cover larger areas and encounter drug-related activities that are influenced by distinctive local customs.

### **Drug task force effectiveness**

Although an abundance of anecdotal evidence about the effectiveness of multi-jurisdictional drug task forces exists, there is little empirical evidence on the success of such task forces. Drug task forces cannot, at this time, be classified as evidence-based practices. Researchers debate the most appropriate way to evaluate their effectiveness (Smith et al., 2000; Applied Research Services, Inc., 2014; Hollist et al., 2014), and this debate is complicated by the difficulties differentiating between the impact of drug task forces and other anti-drug measures (Olson et al., 2002).

A common measure of drug task force success is the number and type of arrests made by the task force (Mazerolle et al., 2007). Drug task forces tend to have lower arrest rates than local police departments and target different crimes. Drug task forces tend to focus on violations of the Controlled Substances Act (which covers cocaine, heroin, and methamphetamine) while local police departments tend to focus on cannabis-related offenses (Adams, 2012; Olson et al., 2002; Mazerolle et al., 2007). Additionally, drug task forces focus on removing higher-level distributors, who are fewer in number, rather than large numbers of low-level offenders and users (Olson, 2004). Street-level enforcement rarely involves multi-agency cooperation (Mazerolle et al., 2007), a common feature of drug task forces.

Periodically, the Authority has provided profiles of individual Illinois drug task forces to provide a general overview of the drug crime problems in various jurisdictions and to share responses to these problems (Adams, 2012; Illinois Criminal Justice Information Authority, 2004). The profiles provide drug task force directors and policy board members with information to guide decision-making and the allocation of resources.<sup>1</sup> In addition, Authority researchers have conducted focus groups with representatives of all Illinois drug task forces (Reichert, 2012).

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<sup>1</sup> Previous profiles can be accessed on the Authority's website: <http://www.icjia.state.il.us>.



## Section 2: Current study

For more than 20 years, the Illinois Criminal Justice Information Authority (Authority) has been awarding federal funding to local law enforcement agencies to support drug task forces. Drug task forces in Illinois are composed of officers from federal, state, county, and local police agencies. There are two kinds of drug task forces in Illinois—metropolitan enforcement groups and multi-jurisdictional drug task forces.

Metropolitan enforcement groups (MEGs) have existed in Illinois since the 1970s through the Intergovernmental Drug Enforcement Act [30 *ILCS* 715/1]. MEG policy boards engage actively and formally in operations management. MEG policy boards are required to include an elected official and the chief law enforcement officer, or their designees, from each participating level of government. An elected official from one of the participating agencies is designated the financial officer of the MEG to receive operational funds. MEG operations are limited to enforcing drug laws, responding to delineated weapons offenses, and investigating gang-related crimes.

Multi-jurisdictional drug task forces were first formed in the 1980s under the organizational authority of the Intergovernmental Cooperation Act [5 *ILCS* 220/1]. Unlike MEGs, drug task force policy boards are not subject to legislated structure or composition requirements, nor are they restricted by statute in their scope of operations.

The Authority is designated as Illinois's State Administering Agency (SAA) making it responsible for criminal justice planning, coordination, management, research, training, and/or technical assistance, as well as the distribution and administration of federal grants. The Edward Byrne Memorial Justice Assistance Grants (JAG) program, administered by the Authority, funds Illinois drug task forces and supports efforts to prevent or reduce crime and violence. In 2011, 39 states and territories supported 585 drug task forces through JAG (Center for Justice and Planning, n.d.). A 2012 study found that an additional 11 states also use state funding to support drug task forces (Center for Justice and Planning, n.d.).

JAG awards pay for personnel, equipment, travel, vehicle maintenance, and communications. In 2014, the Authority funded 19 of 22 multi-jurisdictional drug task forces in Illinois (*Map 1*). Out of the 102 counties in Illinois, these 19 multi-jurisdictional drug task forces cover 62 counties, or 61 percent of the state. Three other drug task forces receive the majority of their funding through the Illinois State Police.

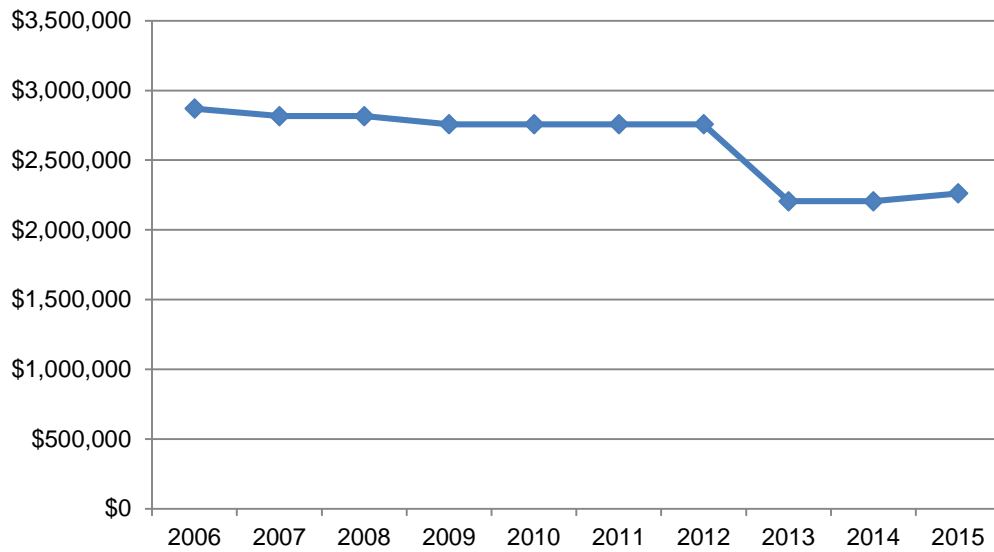
**Map 1  
Authority-funded Illinois drug task forces, 2014**



*Figure 1* indicates the amount of federal funds distributed through Justice Assistance Grants (JAG) by the Authority to drug task forces between federal fiscal years (FFY) 2006 and 2015. Between FFY 2007 and 2012, the award amount remained stable, at approximately \$2.8 million, and then decreased by \$551,371 in FFY 2013. In FFY 2015, there was a \$56,027 increase in the federal funds allocated by the Authority to drug task forces, which totaled \$2,261,505. This accounts for about one-third of JAG funds (*Figure 2*).<sup>2</sup>

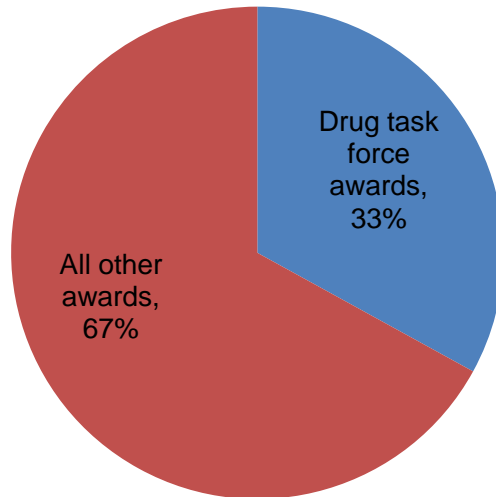
<sup>2</sup> Note: Each year, grantees may spend awards from different or multiple federal fiscal years.

**Figure 1**  
**Justice Assistance Grant awards administered to Illinois drug task forces, FFY 2006-2015**



Source: ICJIA Federal and State Grants Unit

**Figure 2**  
**Illinois Justice Assistance Grant awards, FFY 2015**



Source: ICJIA Federal and State Grants Unit

## Methodology

Researchers surveyed law enforcement officials from Illinois’s 19 Authority-funded drug task forces (multijurisdictional drug task forces as well as metropolitan enforcement groups). The purpose of the survey was to: (1) obtain perspectives on the extent and nature of the drug problem within each task force’s jurisdiction, (2) gain knowledge of the task force’s response to illegal drug activity, and (3) assess task force interactions with other law enforcement and drug treatment agencies.

Researchers sent an email with a link to an online survey to directors of the 19 drug task forces between July 2015 and August 2015. The survey was created using SurveyGizmo online survey software (*Appendix B*). All survey data was imported and analyzed using SPSS (Statistical Package for the Social Sciences) software. The response rate was 100 percent—representatives of all 19 individuals took the survey.

The research was approved by an Institutional Review Board. All respondents were required to agree to the contents of a consent form, which described the research and their rights as research participants.

Responses were analyzed with consideration for whether jurisdictions were in urban or rural settings. According to the survey, ‘rural’ was defined as a county that is not part of a metropolitan statistical area (MSA) or a county that is part of an MSA but has a population less than 60,000. Seven of the drug task units cover rural jurisdictions, five cover urban jurisdictions, and seven cover jurisdictions with urban and rural counties. *Table 1* provides the coverage area type (urban or rural or both) for each drug task force unit in Illinois.

**Table 1**  
**Drug task force unit coverage area type**

<b>Drug task force unit name</b>	<b>Coverage area</b>
Blackhawk Area Task Force	Rural
Central Illinois Enforcement Group	Urban and rural
DuPage Metropolitan Enforcement Group	Urban
East Central Illinois Task Force	Rural
Kankakee Metropolitan Enforcement Group	Urban and rural
Lake County Metropolitan Enforcement Group	Urban
Joliet Metropolitan Area Narcotics Squad	Urban and rural
Multi-County Narcotics Enforcement Group	Urban and rural
Metropolitan Enforcement Group of Southwestern Illinois	Urban and rural
North Central Narcotics Task Force	Urban
Quad Cities Metropolitan Enforcement Group	Urban
South Central Illinois Drug Task Force	Rural
Southeastern Illinois Drug Task Force	Rural
Southern Illinois Drug Task Force	Rural
Southern Illinois Enforcement Group	Rural
State Line Area Narcotics Team	Urban and rural
Task Force 6	Urban and rural
Vermilion County	Urban
WCITF – West Central Illinois Task Force	Rural

## **Limitations**

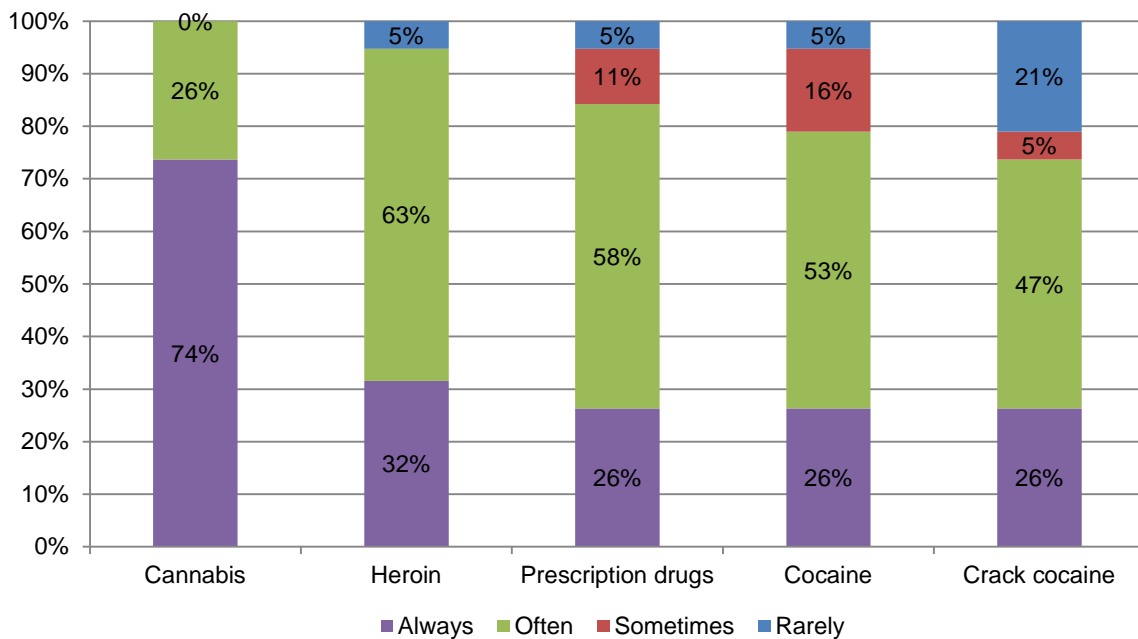
This report only provides the responses of single representatives from each of the 19 Illinois drug task forces and therefore not generalizable to all areas of, or the whole state of, Illinois. The information in this report is strictly descriptive. It does not offer an evaluation of task force operations or outcomes.

# Section 3: Drug trends

## Drugs encountered by task forces

Respondents were asked to rate how frequently the officers in their drug task force encounter certain drugs in their community. As seen in *Figure 3*, almost all of the drug task force units encountered the following drugs *always* or *often*: cannabis (n=19), heroin (n=18), prescription drugs (n=16), cocaine (n=15), and crack cocaine (n=14).

**Figure 3**  
**Frequency of encounters with illegal drugs in drug task force jurisdictions (n=19)**



Note: No drug task forces responded *never*.

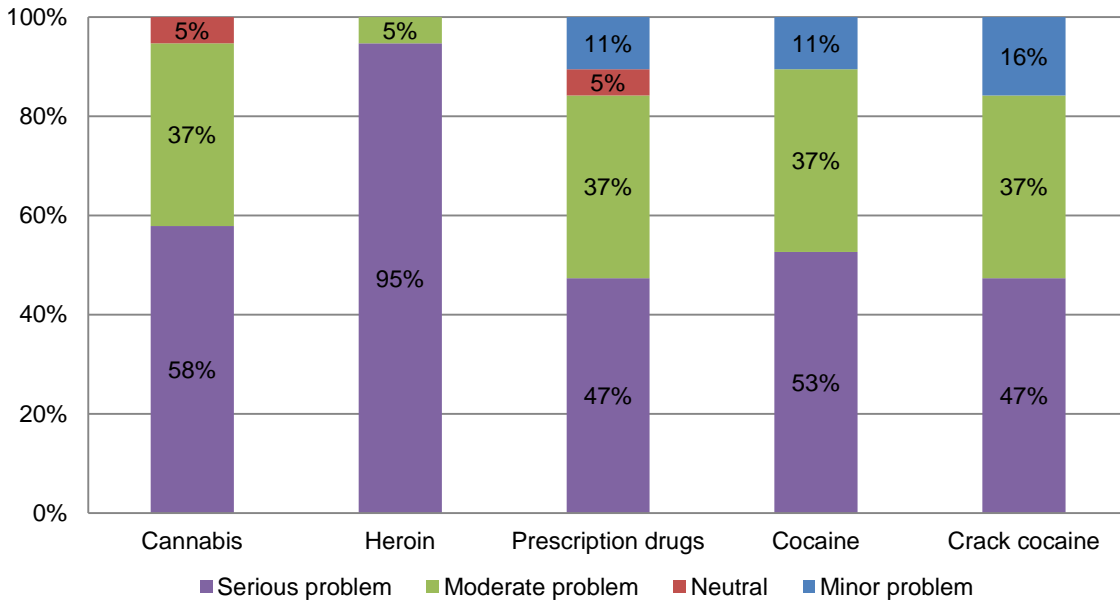
Of the five drug task force units that *rarely* encountered crack cocaine, two operated in rural jurisdictions, one operated in an urban jurisdiction, and one operated in a jurisdiction composed of urban and rural counties.

Most tasks force units indicated they *rarely* or *never* encountered hallucinogens, which included PCP (n=16), LSD (n=12), and other synthetic drugs (n=9). See *Appendix A, Table A* for the frequencies of encounters with the complete list of drugs included in the survey.

## Drug use

Heroin was identified as the most serious problem overall. Aside from heroin, the drugs identified as either *moderate* or *serious* problems in terms of their *use* included cannabis (n=18), cocaine (n=17), prescription drugs (n=17), and crack cocaine (n=16) (*Figure 4*). *Table B* in *Appendix A* provides more detail on the extent of illegal drug use by drug.

**Figure 4**  
Extent of illegal drug use in drug task force jurisdictions (n=19)



Note: No drug task forces responded *not a problem at all*.

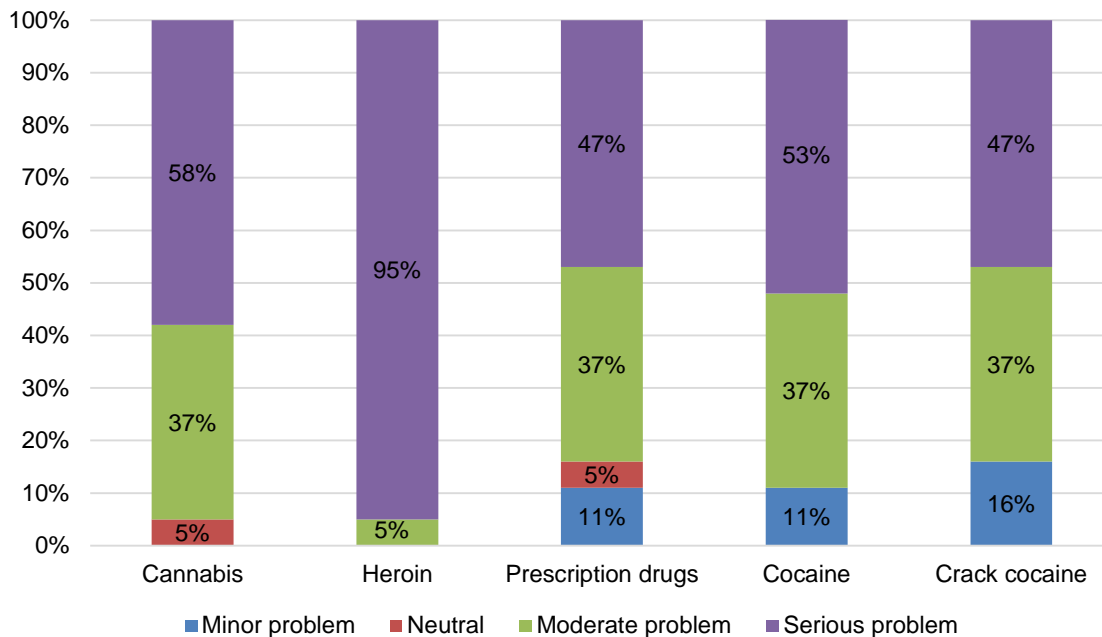
## Drug distribution

Drug task forces reported problems with the illegal use and distribution of the same five drugs. In terms of illegal drug distribution, drug task force units identified heroin (n=19), cannabis (n=18), cocaine (n=17), prescription drugs (n=16), and crack cocaine (n=16) as *moderate* or *serious* problems. Eight drug task forces identified PCP and LSD as *not a problem at all* or as a *minor problem*.

In general, whether a drug task force unit was located in a rural jurisdiction or an urban jurisdiction did not make a significant difference to its responses to these survey items.

Table C in Appendix A provides more detail on the extent of illegal drug distribution for the complete list of drugs in this survey.

**Figure 5**  
**Extent of illegal drug distribution in drug task force jurisdictions (n=19)**



Note: No drug task forces responded *not a problem at all*.

## Most problematic drugs

When asked which drug(s) task force officials consider to be the most problematic in their jurisdiction in general, heroin was once again the most commonly identified drug (n=16). In addition to heroin, methamphetamine also was commonly identified as one of the most problematic drugs by task force unit officials (n=9). One respondent explained that “crystal methamphetamine is the most problematic in our community. It is the most prevalent and currently easier to acquire than powder methamphetamine.” Several respondents identified “meth labs” as a problem, with one citing “an increase in meth labs as well as an increase in meth ice seizures.” One respondent noted the drug as problematic because its importation “is on the rise.” Another respondent believed methamphetamines to be problematic because, like heroin, it “is causing several other crimes such as violence and theft.”

Other drugs that were identified as most problematic in drug task force communities were cannabis (n=5), cocaine (n=4), crack cocaine (n=4), and prescription drugs (n=3). These drugs were identified due to their “prevalence” and their “easy availability.” Cannabis was specifically identified by one respondent because of “the amount coming into the county from a multitude of sources....cartel, local growers, and from medical states.” Synthetic drugs like bath salts (n=1) and synthetic opiates (n=1) were rarely identified as problematic.

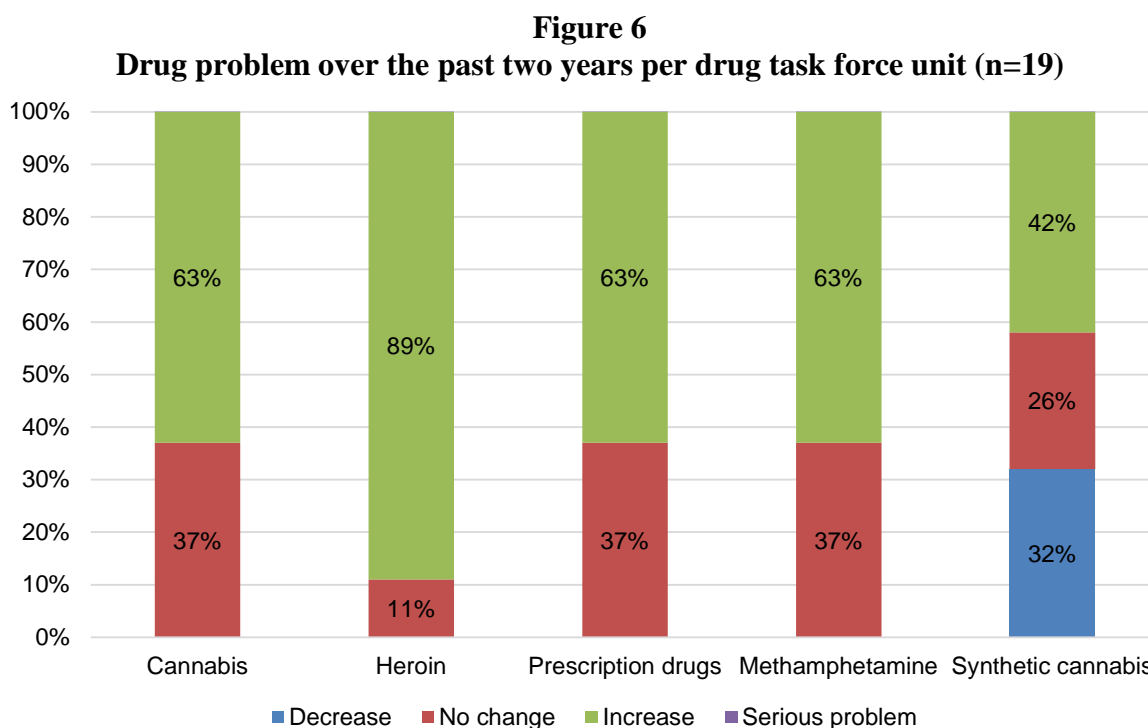


## Changes in drug problem

Respondents were asked about changes in the drug problem in their community in the past two years. Almost all of the drug task forces (n=17) identified an increase in heroin as a problem and two indicated no change.

Twelve task forces noted an increase in prescription drugs, methamphetamine, and cannabis. Half of the 12 drug task force units that indicated an increase in methamphetamine is located in rural jurisdictions. Some drug task force units identified a decrease in synthetic cannabis (n=6) and synthetic cathinones (n=5). In general, responses were similar no matter whether a task force was located in an urban or a rural county.

Figure 6 summarizes the responses to questions about changes in drug problems over the past two years for the five most commonly identified drugs. See Table D in Appendix A for the complete list of drugs included in this survey item.



Note: No drug task forces responded *no drug problem*.

## **Emerging drugs**

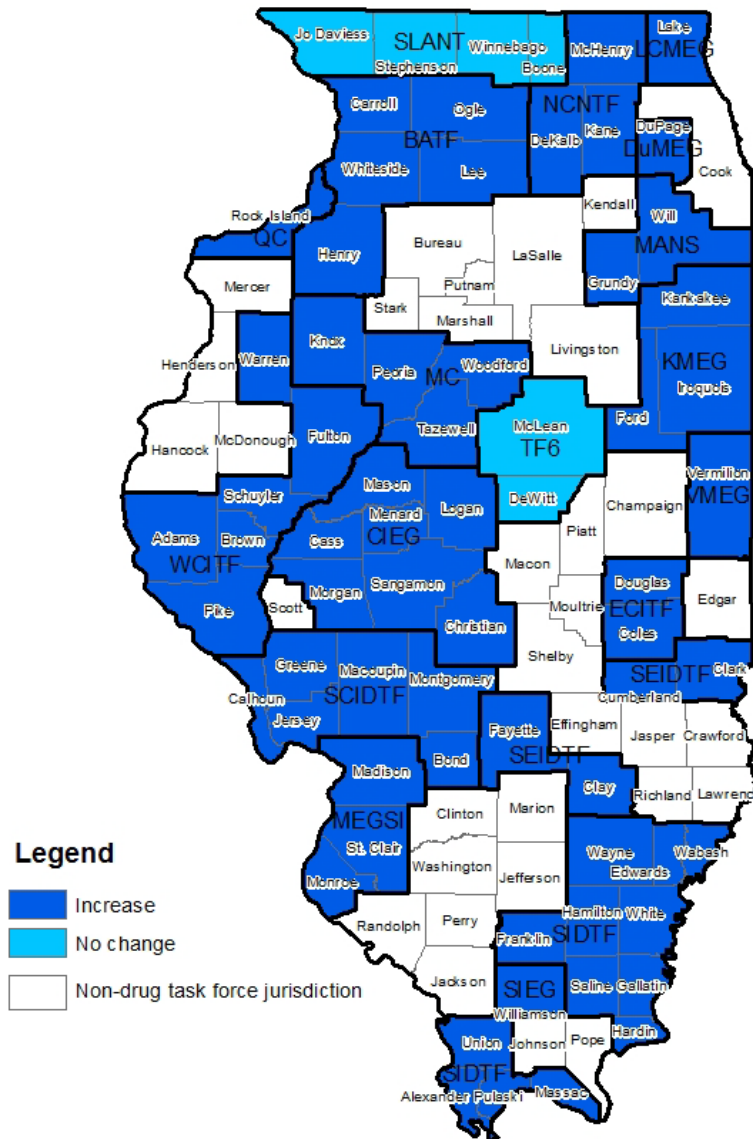
When asked to identify any new or emerging drugs in their jurisdiction of which drug task force units have become aware during the past two years, responses varied. Of the 11 who responded, four individuals identified “cannabis oils” and “cannabis wax” as emerging drugs, and three drug task units identified heroin as a “re-emerging” drug. Two individuals identified methamphetamine because of its “prevalence” and its recent “importation into the area.” Another two individuals noted seeing “an increase in Molly (MDMA) and designer drugs like it in capsule form. Its availability has increased from sources of supply.” Other emerging drugs that were identified were the “mixing prescription drugs” (n=2) and synthetic cathinones (n=2), which one respondent described as being “easily obtainable through the internet.”

# Section 3: Heroin concerns

## Increase in heroin

As noted, in the past two years, 17 of the 19 task forces noted an increase in heroin. Of those, seven were in rural jurisdictions, five were in urban jurisdictions, and five were in jurisdictions composed of both urban and rural counties. In 2014, municipal law enforcement in the U.S. reported that the availability of heroin was not only high but increasing (Drug Enforcement Administration [DEA], 2015). *Map 2* indicates the drug task forces and counties in Illinois that noted an increase in heroin.

**Map 2**  
**Drug task forces noting changes in heroin availability, past two years**



Note: Drug task force survey administered in 2015.

## Problems with heroin

While all drug task forces indicated that they encounter marijuana more often than other drugs, almost all reported the use of heroin (n=18) and distribution of heroin (n=18) posed a serious problem.

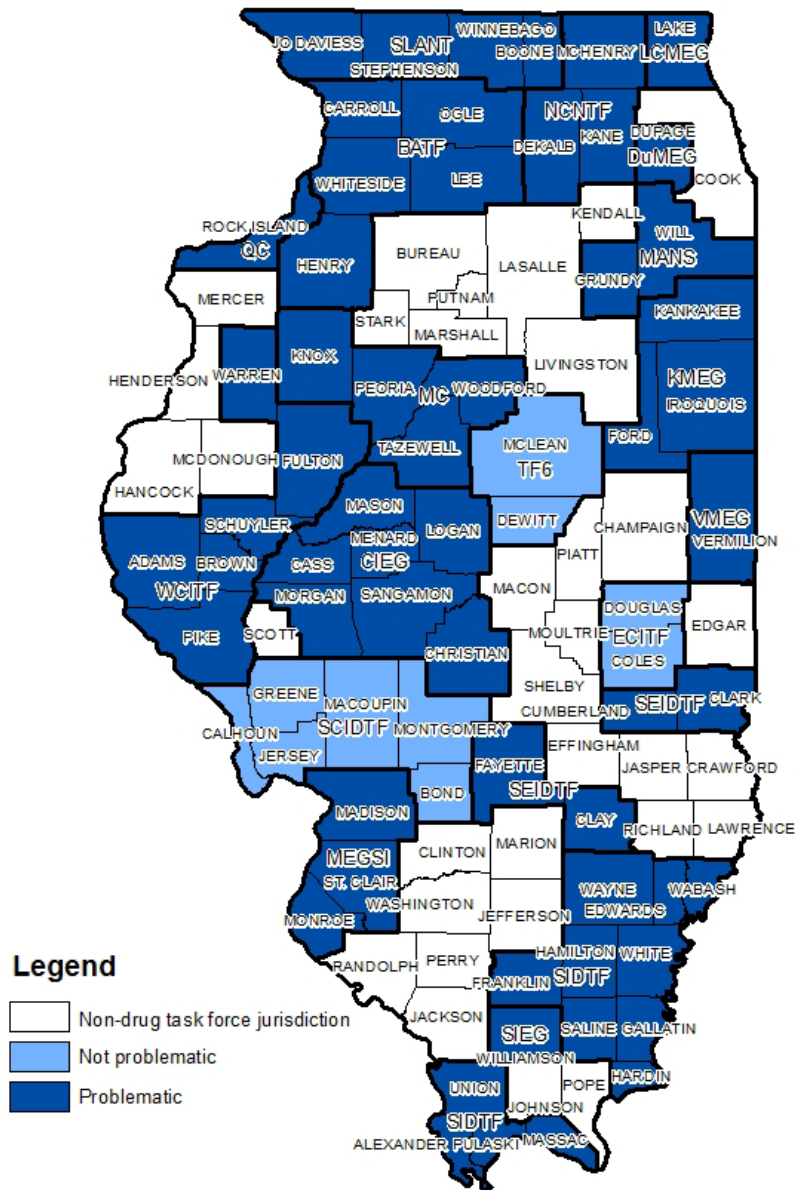
Sixteen of 19 drug task forces considered heroin to be the most problematic drug in their communities. This was due to heroin's "addictive qualities" and "deaths from overdoses." Respondents explained that their jurisdictions have "had several overdoses this year and the issue seems to be growing" or "increasing." Heroin overdoses are increasing in many areas of the Midwest in particular (DEA, 2015).

One respondent explained that one difficulty was the fact that "the overall distribution network stretches from Chicago all the way out to the far western suburbs, which is typically much larger than what we normally deal with." According to the Drug Enforcement Administration, Mexican transnational criminal organizations traffic heroin and other drugs throughout the United States, including Illinois, using established transportation routes and distribution networks and are expanding heroin networks (DEA, 2015).

Another respondent identified heroin as the most problematic drug due to its "relation to other crimes (retail thefts, robbery, etc.)." Such a perception is consistent with research on this topic, which has consistently found a relationship between heroin use and street crime (Gandossy, Williams, Cohen, & Harwood, 1980; Inciardi, 1979; Incardi & Pottleger, 1998) and regular heroin use leads to street crimes such as robbery and theft to obtain drugs (Allen, 2004; McBride, 1981; McBride & McCoy, 1985). Bennet, Holloway, & Farrington conducted a meta-analysis of research on drug misuse and crime and concluded that "heroin use and crime are positively associated and that the odds of offending are about 3.0 to 3.5 times greater for heroin users than non-heroin users" (2008, p. 112). Another study found that drug-driven crimes committed by heroin-dependent users could number in the millions (Hough, 1996).

*Map 3* depicts the drug task forces and counties in Illinois that noted heroin as the most problematic drug.

**Map 3**  
**Drug task forces noting heroin as most problematic drug, 2015**



Note: Drug task force survey administered in 2015

## Section 4: Implications for policy and practice

### Collaborate to combat the spread of heroin

Both urban and rural drug task forces in Illinois reported a growing concern about the spread of heroin use, which is in line with national trends identifying an increase in heroin use (Kane-Willis & Schmitz, 2012). There is a growing body of evidence that suggests that prescription opiate drugs are a main cause of increased heroin use (America's addiction to opioids, 2014; Pradip, Gfroerer, Davies, 2013). Heroin and other opioids are chemically and pharmacologically very similar (United Nations Office on Drugs and Crime, 2014), and research indicates that heroin may be cheaper or easier to obtain in some communities than prescription opiates (Pradip et al., 2013).

Drug task force representatives reported a larger geographical distribution network for heroin than other drugs. The United Nations Office on Drugs and Crime (2010, p. 37) confirmed the enormity of this global enterprise:

*Getting opiates from producer to consumers worldwide is a well-organized and, most importantly, profitable activity. The most lucrative of illicit opiates, heroin, presently commands an estimated annual market value of US\$55 billion. When all opiates are considered, the number may reach up to US\$65 billion. Traffickers, essential to the transportation of drugs from production areas to lucrative end-user markets, pocket most of the profits of this trade. A rough estimate of the number of traffickers involved in moving this illegal commodity across countries and regions would likely stand at well above 1 million people.*

Therefore, a multi-jurisdictional and multi-agency law enforcement effort is necessary to combat heroin (The White House, 2015). In 2015, the White House created the Heroin Response Strategy, which offered \$2.5 million to 15 states (not including Illinois) to work together to fight heroin (The White House, 2015). The strategy focuses on developing a collaborative law enforcement network that shares intelligence (The White House, 2015). Illinois law enforcement agents and drug task force members can collaborate among themselves, as well as with neighboring states, to learn the distribution patterns that channel heroin to communities in Illinois. Although several local law enforcement task forces have been formed to examine and combat heroin, but existing multi-jurisdictional drug task forces are also in a position to work together on this issue.

### Train officers to prevent heroin overdose

Several respondents explained that their drug task force had noted that heroin overdoses appeared to be increasing. This observation is in line with data suggesting that the United States is experiencing an opioid overdose epidemic, involving both prescription opioids and heroin

(Paulozzi et al., 2012; SAMHSA, 2012), and, more particularly, that the number of deaths in Illinois due to heroin overdose is increasing (Kane-Willis & Schmitz, 2012).

In 2014, Illinois passed the Heroin Crisis Act [20 *ILCS* 301/5-23], which requires first responders like law enforcement officers to carry Naloxone, a medicine that prevents overdoses of heroin or other opioids from becoming fatal. One study of Narcan (generic name Naloxone) distribution programs in the country found that Narcan resulted in 10,171 overdose reversals (CDC, 2012). While more than 220 law enforcement agencies in 24 states carry Narcan, many agencies do not carry the medicine, which might be attributable to an unfounded concern about officer and agency liability among some agencies (Davis, Carr, Southwell, & Beletsky, 2005). In a nation-wide survey of local law enforcement agencies, only 4 percent of the agencies reported their officers carrying Narcan (Police Executive Research Forum, 2014). Drug task force officers working undercover rarely come in contact with drug users in the field and cannot keep Narcan safely stored and temperature-controlled (A. Kestner, personal communication, April 28, 2016). However, patrol officers and first responders should carry Naloxone and be trained in its use.

### **Enhance community outreach**

The majority of Illinois drug task force units indicated that they had conducted outreach efforts and successfully worked in coordination with other agencies in drug enforcement and drug cases (Rajae, Rodriguez, Adison, Radio, & Longwood, 2013). During community outreach, drug task force officers can inform the public about substance use disorders, and more specifically about heroin and opioids. An Illinois study recommended that parents and the general public need to be educated on heroin and opioids, how those two drugs can be misused with other drugs, while also offering a list of local resources to assist those with substance use concerns (Kane-Willis & Schmitz, 2012).

In particular, task forces can share information about Illinois's Emergency Medical Services Access Act (or the "Good Samaritan Law") [PA 097-0678]. The Act encourages bystanders, who possess a small amount of drugs, to seek emergency medical assistance for anyone experiencing a drug-related overdose by granting the bystanders immunity from "criminal prosecution for Class 4 felony violations of the Illinois Controlled Substances Act and Class 3 felony violations of the Methamphetamine Control and Community Protection Act" (Public Act 097-0678). Research has found that individuals fearing police involvement and prosecution for drug charges are unlikely to call 911 in the event of an overdose (Bonhert et al., 2011; Follett, Piscitelli, Parkinson, & Munger, 2014; Tracy et al., 2005). One study recommended that law enforcement agencies "alleviate the concerns of the individuals that fear being arrested at an overdose" (Follett et al., 2014, p. 24).

## Section 5: Conclusion

Most drug task force officials encountered cannabis, heroin, prescription drugs, and cocaine in their jurisdictions. Many drug task force officials also indicated an increase in the drug problem of cannabis, prescription drugs, and methamphetamines over the past two years in their communities. These drugs were identified as the most problematic drugs in terms of illegal use and distribution. The Authority's 2016 Illinois Drug Threat Assessment reveals similar findings, with heroin and controlled prescription drugs becoming increasingly problematic. However, methamphetamine was seen as a greater drug threat than other drugs in the central and southern regions of Illinois (Gleicher, in press)am. The National Drug Threat Assessment reports similar findings for heroin and prescription drugs. Additionally, the report identifies an increase in methamphetamine distribution and availability.

All of the drug task force units identified heroin as a problem and were concerned about heroin overdoses. Drug task force officers and other officers in their departments should be trained to use and required to carry Naloxone to reverse opioid overdoses. A multi-jurisdictional and multi-agency law enforcement effort could also better combat heroin, as could stronger community outreach programs. During community outreach events, drug task force officers can inform the public about substance use disorder, and more specifically about the use of heroin and opioids. Drug task forces can share information about the "Good Samaritan Law" that protects from prosecution anyone assisting a person overdosing.



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# Appendix A: Data tables

**Table A**  
**Frequency of drug encounter per drug task force (n=19)**

	Never	Rarely	Sometimes	Often	Always	Missing
<b>Drugs</b>	<b>n</b>	<b>n</b>	<b>n</b>	<b>n</b>	<b>n</b>	<b>n</b>
Cocaine	0	1	3	10	5	0
Crack cocaine	0	4	1	9	5	0
Cannabis	0	0	0	5	14	0
Heroin	0	1	0	12	6	0
PCP	8	8	1	1	0	1
Methamphetamine	0	4	4	4	7	0
LSD	2	10	6	0	0	1
Prescription drugs	0	1	2	11	5	0
Synthetic cathinones	1	7	7	3	1	0
Synthetic cannabis	1	3	9	4	2	0
Other synthetic drugs	2	7	9	1	0	0
Stimulants	2	2	5	7	2	1
Depressants	2	2	6	6	2	1

**Table B**  
**Extent of illegal drug use problem per drug task force jurisdiction (n=19)**

	Not a problem at all	Minor problem	Neutral	Moderate Problem	Serious Problem
<b>Drugs</b>	<b>n</b>	<b>n</b>	<b>n</b>	<b>n</b>	<b>n</b>
Cocaine	0	1	1	8	9
Crack cocaine	1	2	0	6	10
Cannabis	0	0	1	7	11
Heroin	0	0	0	1	18
PCP	8	3	8	0	0
Methamphetamine	0	3	1	4	11
LSD	2	9	6	2	0
Prescription drugs	1	1	0	7	10
Synthetic cathinones	3	2	5	6	3
Synthetic cannabis	2	2	2	9	4
Other synthetic drugs	2	4	7	6	0
Stimulants	1	4	1	10	3
Depressants	1	4	2	9	3

**Table C**  
**Extent of illegal drug distribution problem per drug task force jurisdiction (n=19)**

	<b>Not a problem at all</b>	<b>Minor problem</b>	<b>Neutral</b>	<b>Moderate Problem</b>	<b>Serious Problem</b>	<b>Missing</b>
<b>Drugs</b>	<b>n</b>	<b>n</b>	<b>n</b>	<b>n</b>	<b>n</b>	<b>n</b>
Cocaine	0	2	0	7	10	0
Crack cocaine	0	3	0	7	9	0
Cannabis	0	0	1	7	11	0
Heroin	0	0	0	1	18	0
PCP	5	3	9	1	1	0
Methamphetamine	1	3	1	4	10	0
LSD	2	6	8	2	0	1
Prescription drugs	0	2	1	7	9	0
Synthetic cathinones	3	2	5	5	4	0
Synthetic cannabis	2	3	2	7	5	0
Other synthetic drugs	2	5	6	4	2	0
<b>Stimulants</b>	<b>1</b>	<b>5</b>	<b>2</b>	<b>7</b>	<b>4</b>	<b>0</b>
<b>Depressants</b>	<b>1</b>	<b>5</b>	<b>2</b>	<b>6</b>	<b>4</b>	<b>1</b>

**Table D**  
**Change in drug problem per drug task force in the past two years (n=19)**

	<b>Increase</b>	<b>Decrease</b>	<b>No change</b>	<b>No drug problem</b>	<b>Missing</b>
<b>Drugs</b>	<b>n</b>	<b>n</b>	<b>n</b>	<b>n</b>	<b>n</b>
Cocaine	3	1	15	0	0
Crack cocaine	1	4	14	0	0
Cannabis	12	0	7	0	0
Heroin	17	0	2	0	0
PCP	0	0	12	7	0
Methamphetamine	12	0	7	0	0
LSD	1	0	15	3	0
Prescription drugs	12	0	7	0	0
Synthetic cathinones	6	5	7	1	0
Synthetic cannabis	8	6	5	0	0
Other synthetic drugs	3	2	14	0	0
<b>Stimulants</b>	<b>6</b>	<b>0</b>	<b>12</b>	<b>1</b>	<b>0</b>
<b>Depressants</b>	<b>3</b>	<b>0</b>	<b>12</b>	<b>2</b>	<b>2</b>