

# Heroin in Illinois

2007 UPDATE

The problem of heroin use and abuse in Illinois is a serious one. There were almost 5,000 heroin-related emergency room visits in Chicago in 2005, which was almost a third of all the heroin-, cocaine, methamphetamine-, and marijuana-related ER visits during that period (NIDA, 2006a). And heroin in Illinois is not just an urban problem. New research points to an increasing prevalence of heroin use and abuse in the suburban areas surrounding the city, particularly within the juvenile population. The drug is more available and affordable than it has ever been, and the variety of health-related ailments and risk of death associated with its use pose a threat to the well-being of Illinois' citizens, families, and communities. Since our report of May 2005, heroin use in Illinois has been stable, according to many indicators. However, an alarming outbreak of overdoses due to fentanyl-laced heroin occurred in 2006, which we describe below.

This document updates the *Issues & Statistics: Heroin in Illinois* report of 2005. It provides the most recent information on heroin use, trafficking, and treatment in the Chicago area, and discusses the drug's association with serious infectious diseases transmitted through injection drug use.

## THE DRUG

Heroin is an extremely addictive narcotic drug derived from particular types of poppy plants. First produced in 1874, its use in the treatment of pain and in various medications was widespread by the 1900s. In 1914, heroin was regulated for the first time under the Harrison Narcotic Act. It is currently categorized as a Schedule I drug under the Controlled Substance Act of 1970, which means it has a high potential for abuse and no current accepted medical uses (ONDCP, 2003).

In Illinois, heroin is generally sold in powder form, but it may also be tar-like or hard. It can range in color from white to brown or black. When pure, heroin is a white powder; a brown or black color signals the presence of impurities or additives (ONDCP, 2003). Common street names include "smack," "H," and "junk." Specific varieties may have correlating names, such as "Mexican black tar" (NIDA, 2005a). (See Appendix I for more "slang" terms.)

Heroin can be snorted, smoked, or injected (NIDA, 2005a). Users who inject the drug usually feel its effects within seven to eight seconds, while it takes those who snort or smoke it between 10 and 15 minutes (ONDCP, 2003).

Once administered, heroin enters the brain, converts to morphine, and binds to opioid receptors (ONDCP, 2003), which are designed to recognize the naturally occurring endorphins that enable the human body to function when experiencing pain or stress and have a similar chemical structure as heroin (PBS, 1998). Heroin users usually report feeling a "rush" of euphoria or pleasure (especially when injected), accompanied by dry mouth, skin flushing, and heavy limbs. Other reported effects include nausea, vomiting, and intense itching. Several hours of drowsiness and foggy mental functioning typically follow the initial effects of heroin (ONDCP, 2003).

Continued heroin use requires increased amounts of the drug to achieve the same effect, resulting in tolerance and addiction. Once physically dependent on heroin, users going without it for any length of time experience symptoms of withdrawal, which exhibit in the form of intense cravings, agitation, bone pain, muscle pain, sleeplessness, diarrhea, vomiting, cold flashes with goose bumps, and spontaneous leg movements. These symptoms usually peak anywhere between 24 and 72 hours after the last dose and go on for about a week, though they can last as long as a month. Withdrawal

from heroin can, in rare cases, be fatal in users who are in poor health or to the fetuses of pregnant users (NIDA 2005a; ONDCP, 2003).

Long-term heroin use can lead to extremely harmful effects, including collapsed veins, infection of the heart lining and valves, abscesses, cellulitis, liver disease, and pulmonary complications such as tuberculosis and pneumonia (ONDCP, 2003). Additives that don't dissolve can clog vessels and result in serious injury. The gravest dangers associated with heroin use include the risk of fatal overdose and the risk of contracting infectious diseases transmitted by sharing needles, such as hepatitis and HIV/AIDS (NIDA, 2005a).

Multiple studies and reports propose that a significant percentage of heroin users use crack cocaine to offset heroin's effects. Among non-injecting heroin users in one study, 22 percent reported using crack cocaine along with heroin in the month prior to their interview at least 50 percent of the time (Broz et al, 2004).

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## TRENDS IN USE

### Prevalence

The heroin problem in Chicago is extremely serious. ONDCP's (Office of National Drug Control Policy) *Profile of Drug Indicators* for Chicago names heroin as the most "commonly abused drug in the Chicago area" (ONDCP, 2005b). In 2002, Chicago's rate of heroin-related emergency room visits ranked first in the nation, with 220 per 100,000 residents, and was more than six times the national rate. That number had increased by a colossal 167 percent between 1995 and 2002, while the national rate rose only 22 percent over the same time period, from 30 to 36 per 100,000 residents (SAMHSA, 2003). Additionally, the prevalence of heroin-related deaths in Chicago rose dramatically, from 224 deaths in 1996 to 376 in 2002, the latest year data are available. (SAMHSA, 2002; SAMHSA, 2005a)

These numbers notwithstanding, some studies, nationally and in Illinois, seem to show a reduction, or at least a leveling off, in some prevalence indicators of heroin use. The 2005 *National Survey*

*on Drug Use & Health* reports that there were an estimated 136,000 current heroin users that year (compared to 166,000 in 2002) and 379,000 past-year users that year (compared to 404,000 in 2002) in the U.S. (SAMHSA, 2006a) In Chicago, the Arrestee Drug Abuse Monitoring program (ADAM) reported that the city ranked first in the nation for percentage of adult arrestees testing positive for opiates in 2000, when 27 percent of male arrestees and 40 percent of female arrestees tested positive for opiates (NIJ, 2003). By 2003, the last year data were available, those figures had dropped to 24.9 percent for male arrestees (NDIC, 2005b), and 22 percent for female arrestees (Broz et al, 2004).

But these statistics only show part of the picture. There are signs that the heroin problem in the Chicago metropolitan area is changing in character. It is growing faster outside of the urban center, especially among youth, than it is in the city of Chicago proper. A Roosevelt University study analyzed multiple indicators of the metropolitan area's heroin epidemic, presenting a picture of the growing problem in the region. The best evidence of a growing epidemic (poisoning, abuse, and dependency) was found in the Chicago collar counties of DuPage, Lake, Kane, McHenry, and Will (Kane-Willis, Schmitz-Bechteler, 2005).

There was also evidence that the heroin-using population in Chicago is aging while younger individuals are taking up the drug in the suburbs. In the suburbs, there was a significant increase in the number of heroin-related emergency room visits for individuals under 25 between 1995 and 2002. In the collar counties, opiate-related hospitalizations among teens increased more than 450 percent during this period, and in suburban Cook County, that figure was greater than 200 percent (Kane-Willis, Schmitz-Bechteler, 2005).

Long-time stereotypes of heroin users tend to depict them as adult, African-American men in inner-cities who inject the drug. However, heroin use and addiction affects individuals of all racial, ethnic, and socioeconomic backgrounds. Data on heroin users entering treatment is suggestive of the diversity of heroin users in the state. While 2006 data from the Illinois Department of Alcoholism and Substance

Abuse's Division's Automated Reporting and Tracking System (Illinois DARTS) reveal that African Americans represent 69 percent of Illinois' heroin-related state-funded treatment admissions, a significant number of admissions were not African-American: 21 percent were white, 8 percent were Hispanic, and 2 percent were categorized as "other" (Illinois DASA, 2006). The share of white admissions in Illinois has increased from 16 percent to 21 percent between 1997 and 2005; conversely, the share of African-American admissions has decreased from 73 percent to 69 percent during the same time period (SAMHSA, 2006a). The heroin problem has increased not only for whites in general in the state, but specifically for white youth. In 2002, whites under 30 represented 58 percent of all white treatment admissions in Chicago, while African-Americans under 30 represented only 15 percent of all African-American treatment admissions (Kane-Willis, Schmitz-Bechteler, 2005). Overall, a quarter of admissions for heroin in Illinois were under 30 years old (SAMHSA, 2006b).

### Method of Administration

Illinois Governor Rod Blagojevich signed legislation into law on July 25, 2003, that legalized the purchase and possession of syringes by adults without a prescription, a measure designed to save lives by preventing the transmission of infectious diseases through shared or "dirty" needles (AIDS Foundation of Chicago, 2003). Injection drug use is associated with infectious diseases including HIV/AIDS, hepatitis B and C, and herpes simplex virus 2, all of which can be contracted through needle sharing (SAMHSA, 2005b). Almost all new users in Chicago start out snorting heroin, but many switch to injecting (ONDCP, 2004). Further, statistics from the Treatment Episode Data Set (TEDS) demonstrate that, in contrast to the national trend, the Chicago area experienced a significant increase in injection drug use between 1997 and 2004, possibly because of suburban users transitioning from snorting heroin to injecting it (SAMHSA, 2004a; NDIC, 2005b) Perhaps most alarming is the growing number of younger injection drug users: between 1992 and 2002, the proportion of injecting heroin users admitted to treatment who were under age 30 increased from 21 to 31 percent (SAMHSA, 2004a).

Though recent research points to an increase in the number of heroin users whose primary method of administration is injection, it remains true that the vast majority of heroin users in Illinois snort the drug. According to Illinois DARTS FY 2005 data, 74 percent of individuals admitted to treatment for heroin use in Illinois reported snorting as their main route of administration. Some experts have speculated that the popularity of snorting as a mode of ingestion may be due to a desire to avoid the danger associated with sharing needles, as well as to the increased availability of snortable, high-purity heroin. The number of suburban users began to increase in the early 1990s when high purity South American heroin became available in Chicago. Because of the high purity, new users were able to snort the drug, avoiding the stigma and health consequences associated with injection drug use (NDIC 2005b). Experts have also hypothesized that snorting heroin has become more common due to a popular misconception that this route of administration is less likely to cause addiction (DEA, 2001; ONDCP, 2003).

### Fentanyl

The year 2006 saw an alarming outbreak of fentanyl adulterated heroin which caused overdoses across the country, many of which were in the Chicago area. Fentanyl is a narcotic analgesic that is 50 to 100 times more potent than morphine, and is typically used after surgery or to treat patients with severe pain (NIDA, 2006b). From April 2005 to May 2006, there were 102 confirmed fentanyl-related deaths in Chicago, more than in any other city studied by the Community Epidemiology Work Group (CEWG). Fentanyl was the only substance detected in 40 cases, and other substances were detected in 62 cases (29 involved other opiates including heroin, 34 cocaine, and 17 alcohol). Some fentanyl-related deaths may go unrecognized because medical examiners do not consistently test for the presence of fentanyl. Ethnographic reports suggest that some heroin users attempt to avoid fentanyl, but others may seek out sources where overdoses have occurred, perceiving the overdoses as evidence of higher quality heroin (NIDA, 2006a).

## TRENDS IN PRODUCTION, DISTRIBUTION, AND TRAFFICKING

### Origin

The U.S. DEA (Drug Enforcement Administration) reports that the country's heroin market is supplied wholly by foreign opium sources. The U.S. receives heroin from four major sources: South America (Columbia), Southeast Asia (primarily Burma), Mexico, and Southwest Asia/Middle East (primarily Afghanistan) (DEA, 2001). Chicago continues to be distinctive in that heroin from all four areas is fairly consistently available (DEA, 2005) and is an important market for Mexican brown heroin in the Midwest (NDIC, 2006). Competition between different major suppliers of heroin has made the drug more readily available, purer (averaging between 20 and 25 percent pure in the past few years), and cheaper (DEA, 2005).

### Distribution, Purity, and Price

Within the U.S., Chicago, Los Angeles, and New York City are the chief market areas for heroin (NDIC, 2005a). Because of its location and transportation infrastructure (including commercial trucks, passenger vehicles, delivery services, couriers, and railways), the DEA considers Chicago the most significant drug trade center in the Midwest (DEA, 2005). Teenagers and young adults in the suburban Chicago area drive into the city to purchase heroin for themselves and their friends and acquaintances (ONDCP, 2005a).

Heroin prices in the U.S. ranged from \$13,000 to \$200,000 per kilogram in 2000, depending on origin, type, relationships between buyers and sellers, quantity purchased, transportation costs, purity, and frequency of purchase (DEA, 2001). A 2002 study revealed that heroin sales in Chicago are conducted both in open-air markets and "underground," and are often run by gangs such as the Gangster Disciples, Vice Lords, and Mickey Cobras (ONDCP, 2003). Transactions may involve multiple levels of contact; buyers might be required to indicate their interest in purchasing the drug to one person, pay someone else for it, find out where to get it from a third person, and pick it up from yet another (ONDCP, 2005a).

In a study of non-injection using youth, the majority (63 percent) reported that "a lot" of heroin was available. Only 10 percent of respondents rated the past-month quality of heroin as "very good," while 31 percent rated it "good," and 50 percent rated it "fair." Generally sold in \$10 or \$20 bags, bulk bag discounts (i.e. 11 to 13 \$10 bags for the price of 10) are sometimes available (Broz et al, 2004).

Heroin seizure and arrest reports reflect the overall growth and the geographical expansion of the drug's use and impact. The Illinois Criminal Justice Information Authority notes that while overall heroin seizures in Illinois and Cook County have diminished since 1997, there was a striking increase across the state between 2002 and 2005. The amount of seized heroin increased between 2002 and 2005 by more than 90 percent, from 12.6 kilograms to 24.1 kilograms (ONDCP, 2006a). Although most heroin was seized in the city of Chicago (representing 71 percent of statewide seizures in 2003), of particular note is how the geographical distribution has changed. Between 2002 and 2003, as seizures in Chicago rose by 69 percent, their number in suburban Cook County grew by three times (ICJIA, 2004). The number of narcotics violations resulting in arrests in Chicago rose from 54,205 in 2002 to 59,051 in 2004 (ONDCP, 2006b).

## TRENDS IN TREATMENT & ADMISSIONS

### Advances in Successful Treatment

Because of the tolerance and physical dependence associated with heroin, the cravings and other withdrawal symptoms that occur when the drug is no longer in users' systems can be extreme, creating a powerful barrier to recovery. However, there are various medicinal and behavioral treatment options as well as support services, often used in combination with one another, that have proven effective (NIDA, 2005a).

One of the most acute risks of heroin use is overdosing. Too much of the narcotic can cause the suppression of a user's respiration to the point of oxygen deprivation. Without oxygen, a user's brain functioning can shut down within minutes. If an overdose is caught immediately, a lifesaving drug, naloxene, often carried

by ambulances, can be administered to block heroin's effects. If not caught immediately, overdose can be fatal (ABC Online, 2005).

Addicts who quit taking heroin and go through the resulting withdrawal symptoms are said to be going through "detox" (detoxification). Detox alone is not sufficient treatment for heroin addiction—triggers and cravings, combined with stressors that may have caused an addict to begin using in the first place, can lead to relapse (ONDCP, 2003).

Methadone, which has been used in the treatment of opiate addiction for more than three decades, is a medication that curbs an addict's need for the heroin but does not result in the highs and lows associated with heroin use (NIDA, 2005a). Methadone suppresses withdrawal symptoms for 24 to 36 hours, which helps addicts avoid heroin use and the potentially destructive and compulsive behavior linked with their condition, including injection use and its risks (ONDCP, 2003). While studies have shown methadone maintenance to be an effective aid to recovery in many cases, there is stigma associated with it. Additionally, some addicts find it difficult to quit methadone, and some remain on methadone maintenance programs for extended periods of time. The stigma and addiction potential of methadone coupled with the requirement of daily administration have led some critics to contend that being addicted to methadone is not much of an improvement over being addicted to heroin (ABC Online, 2005).

Naloxone (often used to treat overdose) (NIDA, 2005a) and naltrexone are drugs used to block the effects of heroin. LAAM and buprenorphine are medications similar to methadone. LAAM lasts up to 3 days, allowing for fewer and less frequent administrations. Buprenorphine has less potent effects than methadone, which equates to a lower likelihood of overdose and a less-challenging discontinuation of medication (ONDCP, 2003). Buprenorphine can also be dispensed in a doctor's office, which may be more convenient and reduces the potential stigma associated with methadone clinics (NIDA, 2005). In 2005, Congress passed legislation allowing all physicians, including those in group practices, to dispense buprenorphine to up

to 30 patients at a time, increasing the availability of buprenorphine treatment (Curley, 2007).

In addition to medicinal treatments, there are many behavioral treatments (inpatient and outpatient) that have been proven effective in the treatment of heroin addiction. Among new techniques, two show special potential: contingency management therapy and cognitive-behavioral interventions. In contingency management therapy, participants earn points by testing negative for heroin use, which they can then trade for reward items that promote healthy living. In cognitive-behavioral interventions, patients are assisted in changing the way they think and behave and in coping with stress (NIDA, 2005a).

### Trends in Treatment Admissions

While national prevalence rates have decreased over the past couple of years, heroin still stands out as a grave threat. Of the 379,000 past-year users in 2005, 60 percent (more than 227,000) reported having abused heroin or having a dependence on heroin, which was more than twice the share of any other drug (the second highest was cocaine, with 28 percent of past-year users reporting dependence or abuse) (SAMHSA, 2006).

In Illinois, the number of treatment admissions for heroin as the primary substance of choice in state-funded programs in FY 2005 was higher than for any other illicit drug (45,334) (Illinois DASA, 2006). Over the past decade, these numbers have skyrocketed, increasing more than four times over between 1997 and 2005 (SAMHSA, 2005c). In the Chicago metropolitan area, treatment admissions for heroin also outnumbered those for any other illicit drug of choice or alcohol in FY05 (33,662), representing 47 percent of all admissions in the area (Illinois DASA, 2006). As discussed above, these persons entering treatment represent all age and racial groups and diverse methods of administration.

An issue closely related to heroin addiction and treatment is methadone abuse, which is increasing. As a replacement for heroin, or in addition to it, 5 percent of treatment clients who are in methadone and non-methadone programs in Chicago abuse methadone (ONDCP, 2004).

## CONCLUSION

Heroin use and abuse continues to be a grave problem in Illinois, negatively affecting the health and well-being of users and abusers, their families, and their communities. While Chicago remains a hub for the heroin trade in the U.S., an increased availability of purer, cheaper heroin that can be effectively snorted has contributed to the expansion of what once was primarily an urban issue into a problem affecting users in a wide variety of areas and demographics, especially youth in suburban

Cook Co. and the collar counties. Injection use remains a significant problem, posing the risk of HIV/AIDS, hepatitis, and other communicable diseases. While dangers associated with heroin use remain critical, various treatment methods with significant degrees of success are available, including both inpatient and outpatient options, pharmaceutical interventions like methadone and buprenorphine, and behavioral treatments such as cognitive-behavioral interventions.

### Appendix I

#### 150 SLANG TERMS FOR HEROIN

Al Capone	Bull dog	Dirt	H	Mac	Raw fusion
Antifreeze	Bundle	Dr. Feelgood	H caps	Mexican black tar	Rawhide
Aries	Caballo	Dog food	Hache	Mexican horse	Ready rock
Aunt Hazel	Caca	Dogie	Hairy	Mexican mud	Red eagle
Ballot	Calbo	Doosey	Hard candy	Money talks	Red rock
Bart Simpson	Capital H	Dreck	Harry	Muzzle	Reindeer dust
Big bag	Carga	Duji	Hazel	Nanoo	Rush hour
Big doodig	Came	Dyno	Helen	Nice and easy	Salt
Big H	Chapopote	Dyno-pure	Hell dust	Noise	Second to none
Big Harry	Charley	Estuffa	Henry	Nurse	Sh*t
Bin laden	Chatarra	Ferry dust	Hero	Ogoy	Silk
Black eagle	Cheese	Foil	Him	Old garbage	Skag
Black pearl	China	Furra	Holy terror	Old navy	Slime
Black tar	Chicle	Galloping horse	Hombre	Old Steve	Smack
Blue bag	China cat	Gallup	Horse	Orange line	Snotty
Blue star	Chinese red	Gamot	Horsebite	P-dope	Spider
Bombs away	Chip	Gato	Hot dope	Pangonadalot	Sweet dreams
Bonita	Chiva	George smack	Jee gee	Peg	Sweet Jesus
Bozo	Choco-fan	Glacines	Jerry Springer	Perfect high	Thunder
Brain damage	Crank	Goat	Jones	Pluto	Tootsie roll
Brea	Crap	Golden girl	Joy	Poison	Train
Brick gum	Crown crap	Golpe	Joy flakes	Poppy	White boy
Brown crystal	Dead on arrival	Good and plenty	Junk	Predator	Witch hazel
Brown sugar	Dead president	Good H	Lemonade	Pure	WTC
Brown tape	Diesel	Good horse	Little boy	Rambo	Zoquete

Adapted from ONDCP, 2003 and ONDCP, 2005a.

Prepared by TASC, Inc. TASC is an independent, not-for-profit agency that provides clinical case management and other services to men, women and adolescents with a variety of social and health-related needs. TASC serves approximately 30,000 clients in Illinois each year. For more information visit [www.tasc.org](http://www.tasc.org).

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