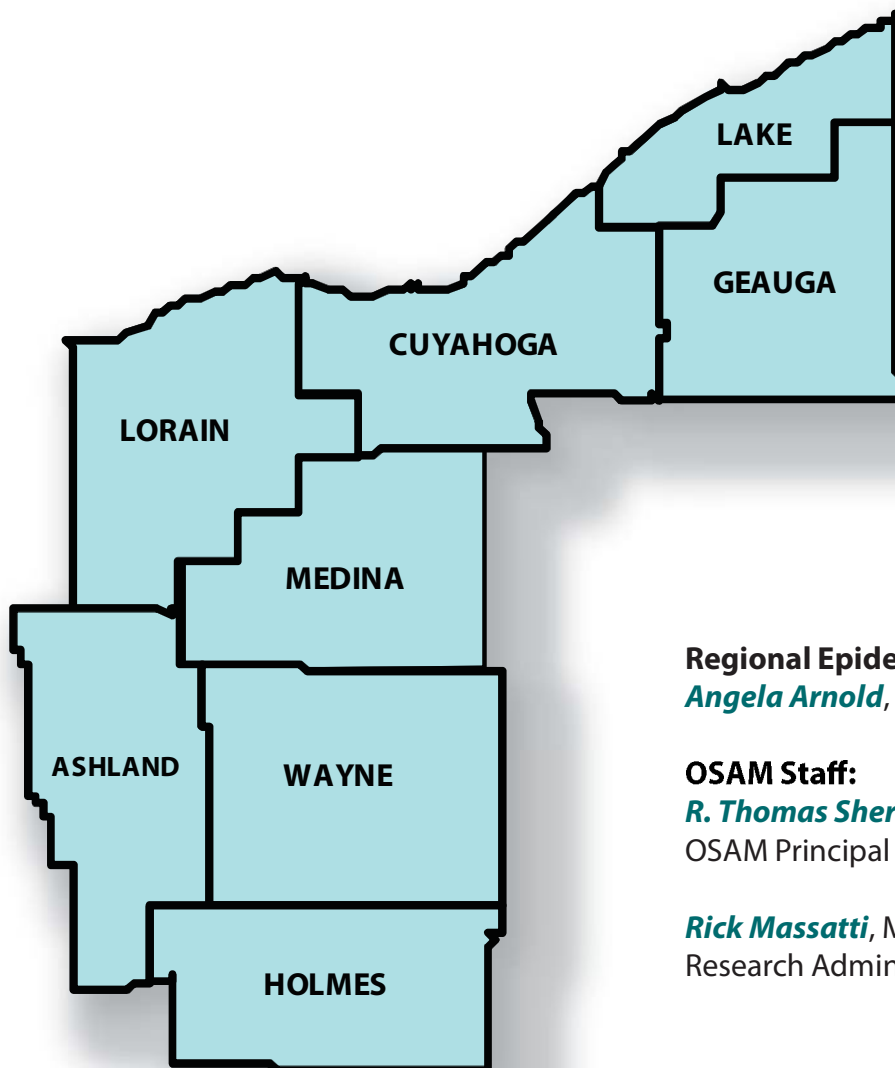


# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Cleveland Region

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# Cleveland Regional Profile

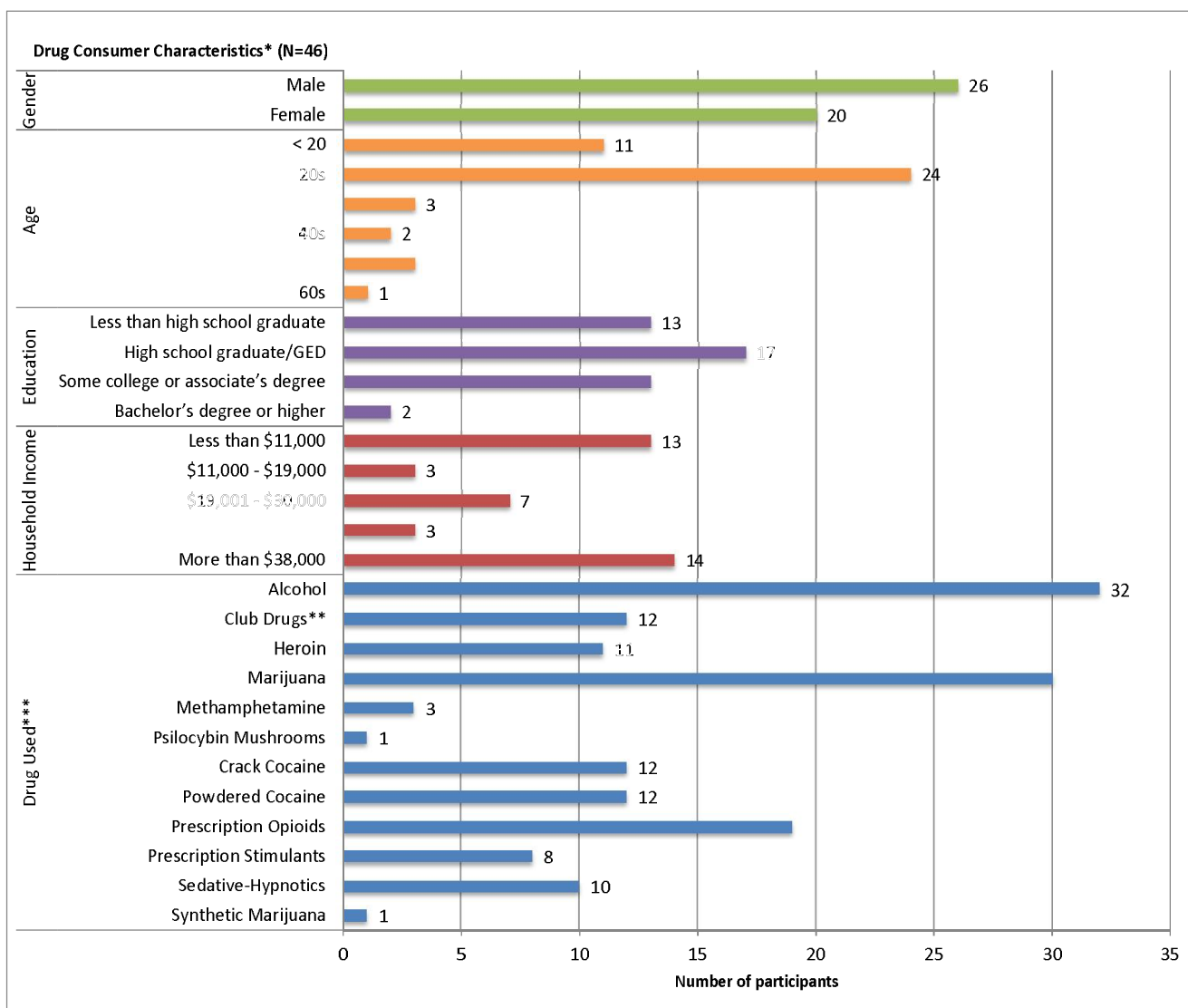
Indicator <sup>1</sup>	Ohio	Cleveland Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	2,287,265	46
Gender (Female), 2010		51.8%	43.8%
Whites, 2010	81.1%		52.2%
African Americans, 2010		18.0%	37.0%
Hispanic or Latino Origin, 2010	3.1%		4.3%
High school graduates, 2009-2010		82.8%	71.1% <sup>2</sup>
Median household income, 2010	\$45,151	\$49,864	\$19,001 - \$30,000 <sup>3</sup>
Persons below poverty, 2010	15.8%		38.5% <sup>4</sup>

Ohio and Cleveland statistics are derived from the U.S. Census Bureau.<sup>1</sup>

Graduation status was unable to be determined for one respondent due to missing data.<sup>2</sup>

Respondents reported income by selecting a category that best represented their household's approximate income for 2011. Income status was unable to be determined for six respondents due to missing data.<sup>3</sup>

Poverty status was unable to be determined for seven respondents due to missing or insufficient income data.<sup>4</sup>



\*Not all participants filled out forms; therefore numbers may not add to 46.

\*\*Club drugs refers to Ecstasy, Ketamine and LSD.

\*\*\*Some respondents reported multiple drugs of use during the past six months.

## Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Cuyahoga, Geauga and Lake counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Cuyahoga Regional Forensic Science Lab, the Cuyahoga County Medical Examiner's Office and the Bureau of Criminal Investigation (BCI) Richfield Office, which serves the Akron, Cleveland and Youngstown areas. All secondary data are summary data of cases processed from January through June 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current secondary data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for July through December 2011.

## Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). However, to obtain powdered cocaine, especially powdered cocaine of good quality, participants reported that one would need connections. Law enforcement most often reported the drug's availability as '8'. Participants agreed that user demand for powdered cocaine was driven by the desire to obtain powdered cocaine to make into crack cocaine, allowing users to improve the quality of their crack cocaine. Most participants rated the quality of powdered cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI Richfield Crime Lab continued to cite the following substances as commonly used to cut (adulterate) powdered cocaine: caffeine, diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetics). Participants reported that a gram of powdered cocaine sold for between \$40-120, depending on the quality. The most common way to use powdered cocaine remained snorting. No participant indicated powdered cocaine as a primary drug of choice. Participants described typical users of powdered cocaine as young, old, of all incomes and races. There were some generalities made about powdered cocaine use: Younger users were said to be more inclined to "speedball" (inject a combination of heroin and cocaine) and more

inclined to use powdered cocaine with marijuana; older users (those older than 50 years of age) and wealthier users were said to prefer snorting powdered cocaine more so than smoking or intravenous injection.

## Current Trends

Powdered cocaine remains highly available in the region. Participants most often reported the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. Participants continued to report that obtaining powdered cocaine requires a phone call or a drive. A participant reported, "I think it [powdered cocaine] is easy to get. It's a phone call. In Cleveland you could probably just walk around, but it's mainly phone calls, and you can get it within an hour." Another participant stated, "[Powdered cocaine] it's harder to get if you don't drive." Other users agreed that dealers retain powdered cocaine, and while obtaining it is not difficult, it often requires a relationship with a dealer to secure the drug: "[Powdered cocaine] it's more expensive because you can blow it up [turn it into crack cocaine]. Dealers hang on to it to double their money; I don't know if it would be easy for a newcomer to get it [powdered cocaine]." Law enforcement most often reported the drug's current availability as '8'; the previous most common score was also '8'. A law enforcement officer said, "[Powdered cocaine] it's there, but it's still more expensive. It's there for the high-end user." A treatment provider contrasted the availability of powdered cocaine to that of crack cocaine, reporting, "For IV [intravenous] drug users, speedballing [concurrent use of cocaine and heroin] went from being powder[ed] cocaine and heroin in the needle to heroin in the needle and smoking crack. It's easier to get crack [cocaine] than powder."

Collaborating data also indicated that powdered cocaine is readily available in the region. The Cuyahoga County Medical Examiner's Office reported that 12 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range); in the last reporting period, 11.5 percent of all deaths were drug-related. Furthermore, the Coroner reported cocaine as present in 26.8 percent of all drug-related deaths (this is a decrease from 35.7 percent from the previous six-month reporting period. Note: Coroner's data is aggregate data of powdered cocaine and crack cocaine and does not differentiate between these two forms of cocaine). In addition to the coroner's data, media outlets throughout the state reported on significant arrests during this reporting period involving cocaine trafficking in the region. In October, *The Plain Dealer* reported that the Ohio State Highway Patrol arrested two individuals from Michigan during a traffic stop on the Ohio Turnpike in Amherst Township (Lorain County) for possession of two pounds of cocaine, valued between

\$26,000-34,000. The pair also possessed a pound of heroin valued at \$70,000 and 181 Xanax® pills valued at nearly \$1,000 ([www.cleveland.com](http://www.cleveland.com), Oct. 5, 2011). In December, *The Morning Journal* reported that the Ohio State Highway Patrol arrested two men from New York during a traffic stop on the Ohio Turnpike in Elyria (Lorain County) for possession of a pound and a half of cocaine, valued at \$70,000 ([www.morningjournal.com](http://www.morningjournal.com), Dec. 6, 2011).

The majority of participants, treatment providers and law enforcement officers reported that the availability of powdered cocaine has remained the same during the past six months. A few participants reported that availability of powdered cocaine has decreased, citing the displacement of the drug by heroin, its “less trendy” status and law enforcement activities. Participants stated, *“I think powder is less available because heroin is taking over. If you want the powder dealers, you better come early because after 9 p.m. they’re through. Then, it’s who you know; in the 1980s powder was the thing. Powder is to the side today.”* The Cuyahoga Regional Forensic Science Lab reported that the number of powdered cocaine cases it processes has increased during the past six months.

Participants most often rated the current quality of powdered cocaine as ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the previous most common score was ‘5.’ However, participants supplied a range of quality scores because the quality of powdered cocaine was said to be inconsistent and varied widely. Factors that were said to influence quality included law enforcement activity and proximity to dealer sources. A participant explained, *“After a big bust in Cleveland, the next day all the coke [cocaine] tasted like soap.”* Another participant reported, *“Around me [powdered cocaine] it’s stomped on [adulterated], but if I go to 185th [Street] in Cleveland, [powdered cocaine quality] it’s better.”* Participants reported that powdered cocaine in the region is cut with baby laxative, baking soda, bath salts, inositol, novocaine, MiraLAX®, Orajel®, Tylenol® and vitamin B-12. When asked about bath salts in powdered cocaine, users noted that this is not “advertised,” per se, by dealers as an additional feature. Participants reported that the overall quality of powdered cocaine has remained the same during the past six months. The Cuyahoga Regional Forensic Science Lab did not examine the constituent parts of powdered cocaine; however, the BCI Richfield Crime Lab cited the following substances as commonly used to cut powdered cocaine: caffeine, benzocaine (local anesthetic), diltiazem (medication used to treat heart conditions/high blood pressure) and levamisole (livestock dewormer).

Current street jargon includes many names for powdered cocaine. The most commonly cited names remain “blow” and “white girl.” Participants listed the following as other

common street names: “birds (for kilos),” “booger sugar,” “chicken little,” “Christina Aguilera,” “Coca-Cola,” “coke,” “fish scales,” “Lindsay Lohan,” “powder,” “scrape,” “snow,” “soft,” “Tony Montana,” “ya-yo” and “yip.” Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine, and prices tended to be higher in rural areas on the eastern and western reaches of the region. Participants reported that a gram of powdered cocaine sells for between \$50-120, depending on the quality; 1/8 ounce, or “eight ball,” sells for between \$80-180; an ounce sells for approximately \$1,100-1,200; a kilo sells for between \$2,500-5,000. Participants reported that the most common way to use powdered cocaine remains snorting. Out of 10 powdered cocaine users, participants reported that on average approximately seven would snort and the remaining three would either intravenously inject or smoke. It is important to note that when users discussed the popularity of smoking powdered cocaine, almost all of them meant that the powder would be “rocked up” to create crack cocaine, and not the freebase smoking method.

A profile of a typical powdered cocaine user did not emerge from the data. Among younger participants (those 25 years of age and younger), powdered cocaine was said to be more often used to intensify the effects of other drugs than to be abused by itself. No participant indicated powdered cocaine as a primary drug of choice. However, a treatment provider described the use of powdered cocaine among certain groups, saying: *“Mid-20 year olds, upper-middle class White females, somewhat educated [tend to use powdered cocaine] ... males in the upper-middle class, too. People in school use it [powdered cocaine] when they take tests. I’ve seen students getting into it for studying purposes. It’s secondary to the Adderall® and Ritalin®. But, they can’t get the Ritalin®, so they use powder.”*

Reportedly, powdered cocaine is used in combination with alcohol, Ecstasy, heroin, marijuana, prescription opioids, sedative-hypnotics and tobacco. Common practices among younger users (those 25 years of age and younger) include lacing marijuana with powdered cocaine (aka, “primo” or “doobie”), or lacing cigarettes with powdered cocaine (aka, “coke smoke” or “snow-cap”). Mixing cocaine with heroin, either together or in sequence, called “speedball,” is also reportedly common among younger users, as well as with some older users. Heroin, marijuana, sedative-hypnotics and other “downers” are used to “come down” from a cocaine high; and cocaine is used to “come up” to allow users to be able to keep using these drugs. A participant reported, *“Drinking [alcohol] and snorting [powdered cocaine] goes together.”* Participants were aware of the dangers of mixing drugs. A participant reported, *“I almost overdosed doing Ecstasy and coke.”* In addition to these use combinations, a trend emerged



during discussions with younger users about powdered cocaine use that involved using the drug to prolong sexual activity.

## Crack Cocaine

### Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Law enforcement also rated the availability of crack cocaine as high, reporting availability as '9'; and explained that the urgency to respond to crack cocaine had been eclipsed by the emergence of drugs like heroin and prescription opioids. The BCI Richfield Crime Lab reported that the number of crack cocaine cases it processes had remained the same during the previous six months. The most common participant quality score for crack cocaine was '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut with other substances. The BCI Richfield Crime Lab continued to cite the following substances as commonly used to cut crack cocaine: caffeine, diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetics). Participants reported that crack cocaine continued to sell in \$10, \$20 and \$50 units. Larger quantities of crack cocaine were also available: 1/8 ounce sold for between \$100-220, and an ounce sold for between \$800-900. By far, the most common route of administration for this form of cocaine was smoking. Participants tended to agree that crack cocaine users varied in age and race; they were unable to identify a "typical" crack cocaine user.

### Current Trends

Crack cocaine remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Like marijuana and oftentimes heroin, crack cocaine is reportedly available from unknown dealers, as well as from established connections. Several participants echoed these sentiments: *"I had to call sometimes [to locate crack cocaine], but sometimes they [dealers] walk up to you on the street; I'm a White girl in the hood ... they [dealers] know what I'm looking for."* Participants noted particular availability near convenience stores and gas stations: *"At the corner gas station there are dope boys that say, 'Take my number' [and call to purchase crack cocaine]; If you can't find a dealer, you can go to this convenience store and buy it [crack cocaine] over the counter. It's loose to just put right in the stem. They sell baggies for 10 cents if you want it to*

*go."* Crack cocaine is available in rural areas far to the west or east of Cleveland, but requires known connections to obtain. A participant reported, *"I had no idea it [crack cocaine] was so popular [until I came to Cleveland]. I thought it was an '80s thing. Where I'm from, it's rural ... [Availability of crack cocaine] it's '0' on that [current availability] scale."* A law enforcement official made a similar observation: *"People that live in urban areas have easier access [to crack cocaine]. They just have to go out their door. People who live in the suburbs have to drive to get it."* Law enforcement and treatment providers reported the drug's current availability as '8', and said availability varied depending on where one lived in the region. An officer reported, *"Door-to-door service [delivery of crack cocaine] is only in certain areas. Dealers might have specialty items, but they will have crack [cocaine]. It's there."* Another officer said, *"[Crack cocaine] it's still available, and our officers are bringing in males and females all the time ... it's there if you want it."* A treatment provider explained, *"[Crack cocaine] it's still out there. I always have a couple clients in my [treatment] group [who are crack cocaine dependent]. Ten years ago it was more prevalent, but there are still people getting it."*

Participants, law enforcement and treatment providers most often agreed that the availability of crack cocaine has remained the same during the past six months. A participant explained, *"As long as you have coke, and somebody that knows how to cook it up, [into crack cocaine] it's always going to be there."* However, three participants in the City of Cleveland noted a decrease in the availability of 'door service' for crack cocaine. One participant stated, *"[Crack cocaine] it's not as available as it used to be. They [dope boys] don't run up to the car now. You gotta know the [dope boy's] number now or have somebody take you to them. This is because of cops cracking down."* A second participant echoed, *"Police are doing their jobs. They've wiped it out [car door service where I live]. The police don't want it [crack cocaine sales] here."* While law enforcement and treatment providers reported that the availability of crack cocaine has remained highly available during the past six months, both groups continued to mention drugs like heroin and prescription opioids beginning to eclipse the popularity of crack cocaine. A law enforcement officer said, *"I don't think [crack cocaine] it's as popular as it used to be."* Likewise, participants noted crack cocaine's decline as dealers begin to favor heroin: *"Dealers are switching [from crack cocaine sales] because there's more money in heroin."* A participant observed, *"[Crack cocaine] it's not the drug of choice anymore. Everyone's switching to heroin."* The Cuyahoga Regional Forensic Science Lab reported that the number of crack cocaine cases it processes has decreased during the past six months.

Most participants rated the quality of crack cocaine as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Most participants

agreed that the quality of crack cocaine varies depending on the dealer and time of day. A participant explained, *"For the first batch, dealers would put more baking soda in it [crack cocaine]. If you had a good relationship, they'd give you the better stuff from the second batch. If I got [my dealer] more clientele, he would hook me up."* Other participants stated, *"[Crack cocaine] quality always fluctuates, even from the same dealer; If you don't know somebody, [crack cocaine quality] it'll be bad. It's getting worse. Out of 10 people you might buy from, maybe one has good crack."* Some participants noted the difference between crack cocaine obtained in the City of Cleveland compared to crack cocaine obtained on the far east or west sides of the city. One participant said, *"In Painesville [Lake County], [crack cocaine quality] it's a '3' on your quality scale ... in Cleveland, it's '7.'" Participants reported that crack cocaine is cut with many other substances. A participant stated, "People in my family say that now [crack cocaine] it's mixed up with so much garbage [that] they're wasting their money. The others [people at this treatment facility] say they weren't even getting high any more from it." Reportedly, crack cocaine is cut with aspirin, baby laxative, baking soda, Kool-Aid®, heroin, MiraLAX®, Percocet®, Tylenol® and Vicodin®. A treatment provider reported, *"I've heard it [crack cocaine] being cut with bath salts and MiraLAX®. Clients tell me that it's not as strong as it was. I've heard more about MiraLAX®, especially now that it's over-the-counter. It used to be prescription only."* Participants also noted that crack cocaine is mixed with substances to increase its potency. A user stated that some dealers, *"Cut it [crack cocaine] with something, and then they say it's fire [very potent]. It depends — sometimes they use heroin or Percocet®. Those are cheaper than coke."* Occasionally, these additives are advertised to crack cocaine consumers as an added feature. Participants reported that the quality of crack cocaine has remained the same during the past six months. The Cuyahoga Regional Forensic Science Lab did not examine the constituent parts of crack cocaine; however, the BCI Richfield Crime Lab continues to cite the following substances as commonly used to cut crack cocaine: caffeine and diltiazem (medication used to treat heart conditions/high blood pressure).*

Current street jargon includes many names for crack cocaine. The most commonly cited names remain "hard" and "work." Participants listed the following as other common street names: "A/C (air conditioning)," "action," "bricks" (for a large quantity), "Charlie," "chunk," "dope," "O2" and "rock." Current street prices for crack cocaine were consistent among participants with experience buying the drug. Participants reported that crack cocaine, when sold anonymously in \$10, \$20 and \$50 units, varies in size from peanut- to chocolate chip-sized pieces. These transactions are quick, and the drug is seldom measured by users. A participant explained, *"They [dealers] don't always weigh it [crack cocaine], and you*

*can't really argue it."* A law enforcement officer explained, *"If users are buying it [crack cocaine] off the street, they don't have a scale. If they go inside a house, the seller will at least have a scale. If you are familiar with it, you can look at it and start to negotiate."* When weighed, users reported better pricing: a .4 gram rock (aka "twomp") sells for \$20; 1/8 ounce sells for between \$100-\$200. Like powdered cocaine, crack cocaine prices are reportedly higher in the far east or west side areas of Cleveland. While there were a few reported ways of administering crack cocaine, the most common route of administration continues to be smoking. Out of 10 crack cocaine users, participants reported that approximately eight would smoke, and the other two would intravenously inject or snort the drug. Injecting crack cocaine was perceived to be on the rise among 18-25 year-old users. A younger participant reported, *"People are shooting it [injecting crack cocaine] more now. They used to just smoke it."* Another participant stated how needle use is related to a user's previous experience: *"People get addicted to the needle. So they shoot other things like crack."*

A typical user profile did not emerge from the data. Law enforcement and treatment providers described typical users of crack cocaine as being of every race and socio-economic class. A law enforcement officer said, *"It's poor people to people with money [that use crack cocaine]. We're getting it through the full spectrum."* However, the perception among community professionals was that while crack cocaine is easy to obtain, crack cocaine is not a popular drug among younger users. A treatment provider reported, *"I haven't had anyone under 30 [years of age] who uses it [crack cocaine]. It's not their drug of choice or even in the top three. They might have tried it though."* A law enforcement officer said, *"Crack goes throughout the spectrum, but I wouldn't say it's a common drug for teenagers. They're still into gateway drugs like marijuana or hallucinogens. The age that kicks in when we start making arrests is in their mid-20s up into the 50s."* The officer also noted a difference between users and traffickers of crack cocaine, saying, *"The crack sellers are early 20s. They're not users yet; they're selling it. When you get into the 30s, they start using it."*

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana (aka "primo"), prescription opioids, sedative-hypnotics and tobacco. Two users noted a preference for Valium® taken with crack cocaine, *"to balance the high,"* or taken, *"after to come down."* Participants also noted "speedballing" (mixing crack cocaine with heroin). A treatment provider observed, *"Heroin with crack, it's huge right now,"* A participant reported, *"I would do heroin, then crack to come down."* While some participants indicated that the speedball combination is injected simultaneously, others noted that the drugs are also taken in sequence (aka "elevator"). Younger participants noted that it is common to obtain crack cocaine in exchange for sex.

## Heroin

### Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Law enforcement and treatment providers most often reported the drug's availability as '8.' When asked to identify the most urgent or emergent drug trends, all professionals indicated that heroin was a concern. While many types of heroin were available in the region, participants continued to report the availability of brown powdered heroin as most available. Reportedly, black tar and white powdered heroin could also be obtained, but required closer connections to obtain and were dependent on the user's location. Those who felt heroin had become more available during the previous six months reasoned that increasing availability was due to increased demand among younger users, prescription opiate abuse and pressure from dealers who desired to switch their clients from crack cocaine to more-profitable heroin. The BCI Richfield Crime Lab reported that the number of powdered heroin cases it processes had increased during the previous six months. Most participants generally rated the quality of heroin as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI Richfield Crime Lab cited lidocaine and procaine (local anesthetics) as commonly used to cut powdered heroin. Participants reported that brown powdered heroin was available in different quantities, with the most common unit being small "bags," containing one "hit" (1/10 gram), which sold for \$10. Participants also reported buying heroin in "bundles" (10-12 small packs), which sold for between \$80-120. Participants reported that the most common way to use heroin remained intravenous injection. Many users continued to note the pill progression to heroin, reportedly an extremely popular trend among those aged 16-30 years: users begin with prescription opioids, move to snorting heroin, then progress to injecting heroin.

### Current Trends

Heroin remains highly available in the region. Participants most often reported overall current availability of heroin as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' While many types of heroin are currently available in the region, participants continued to report the availability of brown powdered heroin as the most available type within the City of Cleveland as well as in both the east and west side areas, most often rating its current availability as '10.' Participants who had knowledge

of white powdered heroin's availability most often rated its availability as also '10;' however, not all users supplied availability scores for this type of heroin. The current availability of black tar heroin was most often reported as '5.' Almost all participants continued to report heroin as easy or very easy to get. A user summarized trends throughout the region, saying, *"[Heroin] it's out there. It [availability] varies. I've never seen tar [black tar heroin], but I've seen dark chunks [of brown powdered heroin]. If you're White and you drive down certain areas, people think you're looking for it ... better quality stuff would be in chunk form, and it's not as good if it's powder, because I guess they [dealers] cut it. Some people that used to sell coke have heroin now. Dealers know people get sick without it [heroin], so they are trying to get users on it."* Participants reported some variations in availability and quality between the east and west sides of Cleveland. Participants agreed that while heroin is plentiful on the west side, participants would often travel to the east side to obtain better-quality heroin. A participant reported, *"If you want the better stuff [heroin], you have to go out to Euclid. If you want garbage and to just not be sick, stick around the west side."* Despite local differences, brown and white powdered forms of the drug are easily obtained, and are perceived to be used at epidemic levels. A participant stated, *"In my area [heroin] it's readily available. As soon as you cross into Cuyahoga County, someone's going to walk up to you. I'd be waiting for my dope boy and get approached by three others. It's everywhere."* Black tar heroin was not reported to be as available as the other forms of the drug.

Community professionals most often reported the drug's current availability as '10;' the previous most common score was '8.' With regard to availability of the different varieties, law enforcement and treatment providers concurred with data supplied by drug consumers, stating, *"It's mostly brown and white [powdered heroin] we see; Brown powder we [law enforcement] buy more than any other kind. You can get tar [black tar heroin] once in a while."* A treatment provider noted, *"My clients share with me that [obtaining heroin] it's a matter of home delivery, like the pizza man. It's not too much of a challenge. It's not a big hassle."* However, when describing clients 25 years of age and younger, treatment providers noted that heroin could be somewhat more difficult to obtain for this age group: *"With an adolescent population, they don't have the connections that some of my older clients do, and some of them don't have cars to drive to get it [heroin]; I've had a lot adolescent heroin addicts. A lot of them drive out to the east side to get it [heroin], so it's a bit more difficult to get"*





than other drugs like marijuana. They know where they can get it around here, and friends at school that have it, but for a lot of it they have to drive to the east side to meet a connection out there." When asked to identify the most urgent or emergent drug trends, law enforcement continued to cite heroin trafficking as a primary concern: "It [heroin] moves from city to town, town to city ... about 85 percent of our [law enforcement] work involves heroin now." Law enforcement officials described large quantity buys that involved bundles as well as multiple bags/bindles, capsules, powder and sleeves (aka "fingers," a long balloon which contains seven to 10 grams of heroin): "Capsules or sleeves up to half a kilo [of heroin] are inserted into the bodies of mules [drug smugglers] from other countries. They arrive here and meet the dealer. There's a lot of that happening." Collaborating data also indicated that heroin is readily available in the region. The Cuyahoga County Medical Examiner's Office reported that 12 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range); in the last reporting period, 11.5 percent of all deaths were drug-related. Furthermore, the Coroner reported heroin as present in 34.2 percent of all drug-related deaths (this is a decrease from 37.1 percent from the previous six-month reporting period).

The majority of participants and community professionals reported that the availability of heroin has increased during the past six months. No one felt heroin's availability has decreased. Participants reinforced two trends identified in previous reports: increased competition among dealers to secure steady heroin users and increased demand for heroin. A participant stated, "Dealers are readily available to serve you. I've seen the dudes and heard about kids as young as eight or nine years old to get into it [heroin sales]." Other participants remarked, "Dealers that used to sell just crack now sell both [crack cocaine and heroin]; [Heroin] it's extremely popular; I have been approached by cocaine sellers who have both [cocaine and heroin]; I used to have to go to Cleveland to get it [heroin]; now it's here. It's a phone call. The crack dealers have realized they can make more money if they carry both." Also, many dealers reportedly have modified their inventory and techniques to attract and retain heroin users. A participant reported on being approached at a store to buy heroin: "The last time the guy tried to give me some heroin for free ... a little bag." Others observed, "There are more dope boys [heroin dealers] every single day." The Cuyahoga Regional Forensic Science Lab reported that the number of heroin cases it processes has increased during the past six months.

Most participants generally rated the quality of heroin as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '4.' Participants reported that heroin in the region is cut with

cocaine, fentanyl, Flexeril®, lidocaine and procaine (local anesthetics), methadone, OxyContin® and other prescription opioids, Tylenol PM®, vitamin B-12 and Xanax®. A participant explained that in a very fine powdered form, heroin, "is probably garbage. You have to cut it [heroin], but not change the color too much." A participant described heroin's consistency as "... like a brown rock crushed up or in chunks." Another participant described heroin as loose, brown powder to be tannish in color, sometimes gray. A participant explained that heroin can be cut with "anything that dissolves in water." Several participants supplied details on the common perception that heroin is cut with fentanyl, with one stating, "When I was in Toledo, they called heroin, 'fentanyl,' even though it was heroin." Another participant stated, "I didn't like the white stuff [white powdered heroin] ... a lot of people cut it with fentanyl. It's usually not that great because it has fentanyl in it. Gray and brown were less cut [adulterated], more reliable." A law enforcement officer said, "About four or five years ago we heard about how fentanyl explodes if you use a NIK [narcotic identification kit] test. Even now if we come across an amount of heroin, we send it to the lab because of the risk of fentanyl being in it." Most participants agreed with the sentiment that powdered heroin contains many other ingredients. One participant said, "They [dealers] aren't going to tell you what's in there [heroin]. You don't always know." When discussing purity, a participant noted, "There are definitely purity wars. Whoever's got the better stuff [heroin] that's where I'm going." Despite this perception, law enforcement stated that laboratory analysis has shown an increase in purity. A law enforcement official said, "Heroin is 70-80 percent [pure] now, compared with the 40-50 percent from a few years ago." The Cuyahoga Regional Forensic Science Lab did not examine the constituent parts of heroin; however, the BCI Richfield Crime Lab cited caffeine and diphenhydramine (antihistamine) as commonly used to cut powdered heroin.

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "dog food." Other names used in the region include: "dope," "H," "heron," "Ronald," "smack" and "tar." It should be noted that among younger users, "dope" refers to a specific drug (usually heroin or crack cocaine), while among older users, dope can be any type of abused substance. A participant stated, "I've never heard anybody but cops call marijuana, 'dope.' Older people use 'dope' for everything." Participants reported that brown powdered heroin is available in different quantities. Bags or bindles (1/10 gram) sell for between \$10-15, with higher prices reported on the west side due to higher demand. A law enforcement official from the west side stated, "[Heroin] it's \$15 per bindle out here. It used to be \$10 per bindle, but that's due to more demand." Participants also reported buying



heroin in “bundles” (10-12 small bags of heroin). Bundles sell for between \$75-120; 1/2 gram sells for between \$60-80; a gram sells for between \$140-150; 1/4 ounce sells for between \$700-1,000. Reportedly, brown powdered heroin is most commonly sold in bags, bundles, and increasingly, loose by weight, indicating a possible shift away from balloons, double hits and capsules. A participant described how heroin is sold, explaining, “When I got it [heroin] in quantity, I would get chunks. Little wax bags are for powder. If you get larger quantity, you probably get chunk. Like a gram chunk.” Another participant said, “You get \$20 per chunk right in your hand or folded in paper. That’s kind of a newer thing. [Weighed] bags don’t let them [dealers] make extra money like loose [heroin] does.” Participants reported that the most common way to use heroin remains intravenous injection. Out of 10 heroin users participants reported that approximately eight would inject, the other two would either snort or smoke the drug. Users who are new to heroin are more likely to snort before progressing to injection.

Participants and law enforcement identified pharmacies as the main source for clean injection needles. Participants reported that injection needles are relatively inexpensive and can be obtained by saying they are for diabetes management. Users noted that many pharmacies are beginning to “crack down” on needle sales by insisting that buyers fill a prescription for insulin or other medication. A participant reported, “You can get needles anywhere, but you have to lie and say you’re a diabetic. Some [pharmacies] will look it up, and then you’re screwed.” Other sources listed by participants included treatment centers, veterinary supply stores, nurses, tattoo shops and needle exchange programs. There was little awareness of needle exchange programs among participants. Dealers do not supply needles to users in the region. Needles are often shared. A law enforcement officer commented on the long term ramifications of shared needle use: “[Users] they’re sharing needles and sharing themselves. Now you’ve got a whole disease dimension of drug use that will develop over the years. We haven’t even begun to see this problem unfold.” When users share needles, many reported that they occasionally attempt to sterilize them through bleaching. Other times the sterilization attempt is not made. A participant reported, “I saw sharing needles often. They [users] would not care, or they would bleach it out. Even strangers would share.” All participants agreed that intravenous drug users are well aware of the risks of sharing needles, but that sharing occurs when users are desperate or because they have stopped caring about contracting diseases. A participant explained, “I saw sharing cottons and dirty water. I didn’t see a difference in behavior [between younger and older users]. Mostly it [needle sharing] had to do with how long they’ve been using. New users are more likely to get clean needles.”

A profile for a typical heroin user did not emerge from the data. Participants noted that heroin is popular with those of all ages, races and socio-economic status. A participant commented, “I think [heroin] it’s big with all ages. It’s all people doing pills [prescription opioids] who run out of pills. They get heron to supplement because it’s cheaper. Instead of paying \$80 for an oxy [OxyContin®] they can spend \$20 and get some heron.” While participants did not cite a particular type of user in terms of age, race, or income, they noted that race is a factor when suburban Whites travel to predominantly Black neighborhoods: the assumption is that Whites are seeking drugs, particularly heroin. A participant reported, “Everyone assumes I’m a heroin user because I have dark hair and tattoos. I stopped at the store and everyone was trying to sell me heroin. I had to check to make sure I didn’t have a sticker on my forehead. The dope boy didn’t ask the Black lady I was with. All the men I saw there would see me, a White girl, and try to sell me heroin.” Law enforcement and treatment providers also reported that heroin use is, “across the board; a cross-trend drug.” A law enforcement officer said, “[Heroin use] it’s higher income and lower income. The youngest [heroin user] we see is about 15-16 years old. We’ve seen them aged 60 and 70 years old.” However, law enforcement and treatment providers noted increases of heroin use among two groups: younger, White, suburban dwellers (15-25 years of age) and older people (older than 35 years of age) of all races. An officer reported, “I see two different types of [heroin] users: the older people who have been using [drugs] for a long time and graduated up to heroin. Then also, the young people who just went right into heroin. They’re young teens, 19, 18 [years of age]. A lot of them are suburban.” As documented in previous reports, both participants and law enforcement noted the abuse progression from prescription opioids to heroin. A participant observed, “People got busted for pills, then everyone switched to heroin.” Another participant observed that the reformulation of OxyContin® OC to a non-crushable form prompted an increase in heroin abuse, saying, “A lot of the pill dealers turned into heroin dealers because nobody wants a pill you can’t snort.”

Reportedly, heroin is used in combination with alcohol and sedative-hypnotics to intensify the effects of heroin, crack cocaine to “come up”, and marijuana and powdered cocaine to prolong the effects of heroin. A participant also stated that a dealer, “would sometimes sell a 50 percent cocaine/50 percent heroin mix. He [dealer] started doing that after recommendations from users who wanted that.” Another user observed: “Putting heroin in your blunt [marijuana cigar] is also a ‘primo’. When they hand you a primo, you gotta ask what’s in it.”

## Prescription Opioids

### Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals identified OxyContin® OP, Percocet® and Vicodin® as the most available prescription opioids in terms of widespread use. OxyContin® OC (the discontinued crushable form) continued to become more difficult to obtain. Opana® and methadone were cited as up-and-coming opioids of abuse that were gaining in popularity. Reportedly, many different types of prescription opioids were sold on the region's streets. In addition to obtaining prescription opioids from dealers who buy prescriptions and from friends, participants also reported that their primary resource for getting prescription opioids remained from doctors at pain clinics and emergency rooms. Many participants knew of specific physicians who wrote prescriptions for cash. While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the most common route of administration continued to be oral ingestion, either chewing or swallowing. Participants and community professionals described users of prescription opioids as from every socio-economic status, income level, all ages and all races, while citing two types of new users: people who had suffered a physical injury and then developed a dependency, and people younger than 25 years of age.

### Current Trends

Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants identified Vicodin®, Percocet®, OxyContin® OP, and Opana® as the most abused prescription opioids in the region. OxyContin® OC (the discontinued crushable form) has continued to become increasingly difficult to obtain. A participant explained, "It's not as easy to get them [prescription opioids] as it used to be for certain pills like OC's [OxyContin® OC] and Opana® they're so expensive. Vic's [Vicodin®] and perc's [Percocet®] you can get." Another participant reported, "[Prescription opioids] they're pretty highly available. Everyone has a family member with a prescription. My aunt has a stock of pain pills. You don't even have to go out on the street to get them because it's in the household." Law enforcement and treatment providers agreed that these drugs are the most popular prescription opioids in terms of widespread use. A treatment provider noted, "It was oxy's [OxyContin®] for a

long time [that was most widely used], but now it's Opana®. Every client I've seen in the last few months has been using Opana®." However, community professionals supplied lower availability scores than participants did for prescription opioids. While users reported the availability of prescription opioids as '10', or "very easy to get," community professionals most often reported the current availability of prescription opioids as follows: Vicodin® as '8', Percocet® as '7', OxyContin® OP as '6' and Opana® as '8'. A law enforcement officer described the vast amount of prescription opioids that are available: "We [law enforcement] do a medicine cabinet drug take-back twice a year to set up sites across the county [Lorain County] to have people bring in narcotics. This year we got 1,378 pounds [of prescription medications] from just 900 people. We have a population of 300,000, so you need to think about what's still out there."

Other drugs that were reported to be popular included fentanyl, methadone, and Ultram®, with methadone reported as gaining in popularity. A law enforcement officer explained, "A lot of insurance plans won't pay for OxyContin® OP, so they [doctors] write [prescriptions] for methadone." Treatment providers said it is common to obtain fentanyl patches from nursing homes. One treatment provider observed, "I see methadone prescribed for pain — which is insane! And, the fentanyl is big. People at the end of life pass away, and then people get it." Several other treatment providers noted the rising popularity of fentanyl among heroin users and military personnel. One treatment provider stated, "In the military community, fentanyl is used a whole lot more. They have a sucker form of the drug that's used for injured vets. In the military it's a whole lot easier to get and I haven't seen it in the civilian channels as much." Collaborating data also indicated that prescription opioids are readily available in the region. The Cuyahoga County Medical Examiner's Office reported that 12 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range); in the last reporting period, 11.5 percent of all deaths were drug-related. Furthermore, the Coroner reported prescription opioids as present in 40.9 percent of all drug-related deaths (this is an increase from 35.0 percent from the previous six-month reporting period). Both law enforcement and treatment providers mentioned seeing increases in overdoses involving prescription opioids.

While participants and community professionals most often reported that the availability of prescription opioids has remained the same during the past six months (extremely available, except for OxyContin® OC), several respondents reported that availability has increased. A law enforcement officer stated, "It's worse every day. We used to get one or two calls per week [regarding prescription opioids]. Now it's every day." The Cuyahoga Regional Forensic Science Lab reported that the number of prescription opioid cases it processes has

generally remained the same or has decreased during the past six months; noted exceptions were increases in cases of codeine, oxycodone hydrochloride (OxyContin®) and morphine.

Reportedly, many different types of prescription opioids are currently sold on the region's streets. Participants reported the following prescription opioids as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): fentanyl (sells for \$1 per milligram), methadone 10 mg (aka "dones;" sells for between \$2-12), Norco® (sells for between \$1.50-3 per pill), Opana® (aka "panda bears;" sells for between \$1-2 per milligram), oxycodone (aka "smurfs;" sells for between \$.50-1 per milligram), OxyContin® OC (old formulation, aka "oxy's" and "oceans;" sells for \$2 per milligram), OxyContin® OP (new formulation, aka "OP's;" sells for between \$.40-.90 per milligram), Percocet® (aka "perc's" and "school buses;" 5 mg, aka "nickels;" sells for between \$5-7; 10 mg, aka "dimes;" sells for between \$8-9), Roxicet® 30 mg (sells for between \$18-25), Ultram® and Vicodin® (aka "V's" and "vikes;" 5 mg sells for between \$4-5; 7.5 mg sells for between \$5-7; 10 mg sells for between \$7-10). Many participants observed that pricing for these pills has gone up recently. A participant reported, "When all the doctors got busted, the prices [of prescription opioids] went way up." While there were a few reported ways of consuming prescription opioids, the most common route of administration is snorting. Out of 10 prescription opioid abusers, participants reported that approximately six would snort, two would inject and two would take the drugs by mouth. Exceptions were noted based on medication formulation (liquid, pill, wafer) and the nature of the drug's effect on the body. A participant explained: "If I had an Opana® or oxy [OxyContin®], I would snort it. If it had acetaminophen in it, I would pop [swallow] it." Participants also continued to note difficulty manipulating the new OxyContin® OP formulation. A participant stated, "I've seen people make a special wood structure to hold them [OxyContin® OP] to scrape them [of their protective coating], then snort them."

In addition to obtaining prescription opioids on the street from dealers, participants continued to list the following other sources for prescription opioids: friends, family, doctors, pain clinics and emergency rooms. Many participants reported having dealer connections in medical careers. A participant said, "I got them [prescription opioids] from the hospital. I know a girl who was writing her own prescription for them." Law enforcement agreed that illegal sales through nurses and doctors accounted for the largest volume of diverted opioids. A law enforcement official said, "We try to focus on the doctors and nurses who are doing the real damage ..." Another officer reported, "We had more than 800

people since June of 2011 coming back to this area with scripts [prescriptions for opioids] written all from one clinic." However, treatment providers reported mixed success with monitoring programs. A treatment provider noted, "They [users] get them [prescription opioids] from the doctor. You can't 'doctor shop' that much anymore, but I haven't heard of users having to go to the street to get them." Another provider said, "I'm also seeing the pain management specialists are starting to wean the clients off. They're making the clients go without [prescription opioids], and I really see doctors are being more selective. They don't want to be sued. But with modern technology they can see what's been filled, and they can spot abuse better." A focus group composed of law enforcement officers noted that nearly all of their prescription opioid arrests resulted from good collaboration with area pharmacies. One officer said, "Mostly, we get someone that stole a script or made a counterfeit. We [law enforcement] get a call from the pharmacist, and when they [users] return to pick up their drugs, we arrest them ... it's the pharmacy that says, 'You need to get up here.'"

Participants, law enforcement and treatment providers described typical users of prescription opioids as from every socio-economic status, age and race. A law enforcement officer stated, "It's regular factory workers, a few professionals, homeless people, lawyers [abusing prescription opioids] ... aged 16-86 [years of age]" However, participants and treatment professionals shared identical observations about two larger user groups; they described how there is abuse by older (those older than 40 years of age), and employed individuals who abuse/sell opioids as a result of injury or for additional income. Participants reported, "They [older users] are using pills to supplement their money; Fifty percent of the people who get pain pills don't use them. They sell them." A treatment provider stated, "[Prescription opioids] they're more available among the older community. They don't present to doctors as junkies, so they leave with more pills." Another user group that emerged during interviews is that of younger users (those 15 years of age, and up to 25 years of age) who abuse their relatives' prescribed opioids or obtain them from friends. A treatment provider described this group as, "White, middle-class, young," and another described this group as, "Fifteen- to 25 year-olds who get into their grandparents' medicine cabinets, primarily Caucasian ... and it's getting younger." A participant said, "[Prescription opioid users] they're younger White kids in school. No money, but they'll buy what they can get." A treatment provider reported, "There are kids at school who just have bags of pills." Community professionals noted that prescription opioids also appeal to both of these groups because use can be concealed. Participants and community professionals also observed that drug runners tend to be younger. A participant recalled, "I met a drug runner that was 11 or 12 [years old]." A law enforcement officer also noted the



difference between users and younger traffickers, explaining, *"The users are a range, but the trafficker is a younger person in their 20s."* Finally, a treatment provider noted prescription opioid abuse among military service personnel, saying, *"I used to work for the Army, and there are a lot of injuries. They get pain meds sooner, and they stay on it longer than your average civilian would ..."*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, marijuana, powdered cocaine, sedative-hypnotics and tobacco. Combining other drugs with prescription opioids is common, as the effects of prescription opioids are said to be enhanced by other drugs. A participant reported, *"I would do Xanax® or any benzo's [benzodiazepines] after opiates. It intensifies the nod. You black out."*

### Suboxone®

#### Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported availability of Suboxone® as '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Law enforcement most often reported the drug's availability as '8'. The BCI Richfield Crime Lab reported that the number of Suboxone® cases it processed had increased during the previous six months. Participants reported that Suboxone® 2 mg sold for between \$7-10; Suboxone® 8 mg sold for between \$5-25; two Suboxone® strips sold for \$25. Out of 10 Suboxone® users, participants reported that, on average, 5.5 users would take Suboxone® orally as directed, 3.5 would snort and one would intravenously inject. Suboxone® continued to be primarily acquired from doctors, friends and dealers. Few participants in each session had in-depth knowledge about Suboxone®, but among those who did, they cited the drug as widely available from heroin users and/or from heroin dealers. Participants described typical users of Suboxone® as heroin users who used the drug to avoid withdrawal symptoms when heroin could not be obtained. Reportedly, Suboxone® was used in combination with crack and powdered cocaine, marijuana and sedative-hypnotics.

#### Current Trends

Suboxone® is moderately available in the region. Participants most often reported the availability of Suboxone® as '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '9'. Participants reported the drug to be available by prescription, through treatment centers and from friends who use heroin. A participant stated, *"Anybody that does*

*opiates or is in treatment, or just got out of treatment has them [Suboxone®]."* Some participants had never heard of abuse of the drug: *"I only heard of it [Suboxone®] in treatment; I didn't know it [Suboxone®] was abused."* Law enforcement did not report data on illicit use of Suboxone®, but a treatment provider reported the current availability of the drug as '10'. Participants reported that the availability of Suboxone® has remained the same during the past six months. The Cuyahoga Regional Forensic Science Lab reported that the number of Suboxone® cases it processes has remained the same during the past six months.

The only street name reported for Suboxone® was "subs." Participants indicated that Suboxone® 2 mg sells for between \$8-10 (pills or strips); Suboxone® 8 mg sells for between \$10-20 (pills or strips); Subutex® 8 mg sells for between \$15-20. On pricing, a participant noted, *"You'll pay more [for Suboxone®] if you're desperate."* Out of 10 Suboxone® users, participants reported that, on average, approximately 8 would take Suboxone® sublingually (dissolving it under the tongue) as indicated, one would snort and one would intravenously inject. Intravenous use of this drug is considered by those with experience to be less-desirable than other methods, with one participant stating, *"You do not want to shoot them [Suboxone®]. It's instant dope sick."* Participants reported that the pill form of the drug is more preferred because, as a participant noted, they can be snorted, whereas, *"[Suboxone®] strips you have to eat. That's why they're so cheap. Nobody wants them."*

Suboxone® continues to be primarily acquired from doctors, friends and occasionally dealers who take them in trade for other drugs. A participant reported, *"People would sell half of their [Suboxone®] prescription and keep half."* The strategy in this case is to reserve Suboxone® for times when heroin cannot be obtained. Participants reported, *"I would only get Suboxone® if I knew that I wouldn't be able to find anything else in the next couple days; I would get my [Suboxone®] script and then keep about five, and then sell the other 25 to get heroin. I only kept those for the days I couldn't get heroin. I chose not to get Suboxone® this time [in treatment] to get clean because it doesn't work for me."* Participants continued to describe typical users of Suboxone® as heroin users who are trying to avoid withdrawal symptoms when heroin cannot be obtained, and those who use it as part of a physician-prescribed treatment program. A participant said, *"People were just using it [Suboxone®] to keep from getting sick. It's not a go-to choice drug."* A treatment provider agreed, reporting that the typical Suboxone® user is, *"the person who can't get their drug of choice."*

Reportedly, Suboxone® is used in combination with alcohol, marijuana and sedative-hypnotics. A participant reported, *"I would do a Xanax® with it [Suboxone®] to try to get high."*




Although, due to its “drug of last resort” nature, and its opiate-blocking effects, a participant noted that people who abuse Suboxone are often “too sick to do anything else with it.”

## Sedative-Hypnotics

### Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants most often reported the availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants listed the most common sedative-hypnotics in terms of widespread use as Ativan®, Klonopin®, Soma®, Valium® and Xanax®. Law enforcement and treatment providers said this drug class was a constant enforcement challenge. The BCI Richfield Crime Lab reported that the number of sedative-hypnotic cases it processes had remained the same during the previous six months. While sedative-hypnotics were obtained on the street from dealers, participants continued to report obtaining them primarily from doctors, friends and family members, as well as from Internet pharmacies. The most common routes of administration were swallowing and snorting. Reportedly, intravenous injection of sedative-hypnotics was rare except for Xanax®, which heroin users were said to inject. Participants could not describe a typical user of sedative-hypnotics; participants and community professionals said these drugs were widely used by all groups of people.

### Current Trends



Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported the current availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10’. More specifically, participants most often reported the availability of Ambien® as ‘5’, Ativan® as ‘10’, Klonopin® as ‘10’, Soma® as ‘8’, Valium® as ‘10’ and Xanax® as ‘8’. Participants identified Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Klonopin® was identified as a drug increasing in popularity. Law enforcement and treatment providers included sedative-hypnotics as a target of their diversion program because of their use by younger people and opioid abusers; they noted Soma®, Valium® and Xanax® to be particularly popular, assigning them availability scores of ‘7’, ‘8’ and ‘8’ respectively. A treatment provider reported, “Klonopin® and Xanax® are the biggest ones [most popular

*sedative-hypnotics].”* A law enforcement officer explained that these drugs are widely available: “Quite a few kids use this [sedative-hypnotics] ... and anyone who says they’re ‘anxious.’” Collaborating data also indicated that sedative-hypnotics are highly available in the region. The Cuyahoga County Medical Examiner’s Office reported that 12 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range); in the last reporting period, 11.5 percent of all deaths were drug-related. Furthermore, the Coroner reported sedative-hypnotics as present in 27.5 percent of all drug-related deaths (this is a decrease from 30.8 percent from the previous six-month reporting period).

Most participants reported that the availability of sedative-hypnotics has increased during the past six months, and no participant or community professional felt that these drugs had become less available. A participant observed, “[Sedative-hypnotics] they’re more available. The doctors know what they’re doing. They got pill mills. And everyone’s got a ‘disorder’ now.” The Cuyahoga County Regional Forensic Science Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months, with the exception of an increase in cases related to Klonopin®.

Reportedly, many different types of sedative-hypnotics (aka “benzo’s” and “downers”) are currently sold on the region’s streets. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ambien® (sells for \$2 per pill), Ativan® (sells for between \$1-5 per pill), Klonopin® (aka “pins;” sells for between \$1-3 per pill), Soma® (sells for between \$1-2 per pill), Valium® (5mg sells for between \$1-4; 10 mg sells for between \$6-10), Xanax® (aka “footballs” and “xani’s;” 0.25 mg-1 mg sells for between \$1-3; 2 mg, aka “bars” and “xanibars;” sells for between \$3-5). While there were a few reported ways of consuming sedative-hypnotics, the most common routes of administration remain swallowing and snorting. Out of 10 sedative-hypnotic users, participants reported that six would swallow the pills, two would snort, one would smoke (with marijuana, aka “primo”) and one would intravenously inject.

In addition to obtaining sedative-hypnotics on the street from dealers, participants continued to list the following primary sources for sedative-hypnotics: doctors, friends and family members. In addition, participants described some apparent homeless individuals selling or exchanging sedative-hypnotics for cigarettes. A participant explained getting his drugs from homeless people: “You can get them [sedative-hypnotics] from ‘bums’ [homeless people] on the street ... For real. It seems like 90 percent of the bums on the street are veterans who get this stuff.” Another participant said, “You

find people walking down the street and they say, 'If you give me some cigarettes, I'll give you a xanibar.'" It should be noted that participants indicated specifically that street-level "dope boys" do not typically carry this class of drug.

A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants compared and contrasted younger versus older users, stating, "I don't know too many older people who would abuse benzo's [benzodiazepines]; I know older people that sell their benzo's." A treatment provider reported, "Older people are getting them [sedative-hypnotics], but they're sitting in the medicine cabinet, and they take one every three months, and then the kids get them." Law enforcement noted, "A typical [sedative-hypnotic] user can look like you or me; anybody who can get a script; People who abuse heroin or opiates [abuse sedative-hypnotics]." Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used with alcohol, heroin, marijuana, and they are often taken after the use of prescription opioids to intensify or extend the high produced by the opioids. A participant stated, "I abused [sedative-hypnotics] when I had something to mix them with."

## Marijuana

### Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Law enforcement and treatment providers also unanimously reported the drug's availability as '10'. The BCI Richfield Crime Lab reported that the number of marijuana cases it processes had remained the same during the past six months. According to participants, the quality of regular-grade and high-grade marijuana was most often '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Many participants discussed the improvement in quality of marijuana over time. Participants reported that for regular-grade marijuana, a "blunt" (cigar) sold for between \$3-5, and an ounce sold for between \$80-150. High-grade marijuana continued to sell for significantly more: 1/8 ounce sold for between \$50-60, and an ounce sold for between \$320-380. The most common route of administration for marijuana continued to be smoking. A minority of participants mentioned oral ingestion of marijuana, specifically in brownies, butter, oils and creams. Notably, several participants mentioned the use of vaporizers. Participants were not able to establish a profile for the typical user of marijuana; they explained that marijuana use was so common that it was not limited to one type of user, age group or race.

### Current Trends

Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Marijuana is the most easily-obtained illegal drug in the region. Nearly every participant supplied a current availability score of '10'. Participants stated: "Weed's [marijuana] everywhere; [Marijuana's current availability] it's a '20' on your [availability] scale." Law enforcement officers and treatment providers agreed, and reported availability at '10' on the same scale. These community professionals reported, "[Marijuana availability] it's off the charts. It's more available than crack; Marijuana is the common denominator. It seems to go with everything. [Treatment] clients always say their drug of choice and marijuana." Media outlets across the state reported on significant arrests during this reporting period involving marijuana trafficking in the region. In November, the Ohio State Highway Patrol stopped a man in Lorain County for a routine traffic violation and confiscated 10 pounds of British Columbia marijuana, worth an estimated \$50,000 ([www.nbc41.com](http://www.nbc41.com), Nov. 3, 2011).

Participants and law enforcement reported that the availability of regular-grade marijuana has remained the same during the past six months, with some variability due to harvest times and drug seizures. A law enforcement officer reported, "Reg [regular-grade marijuana] is about the same [in availability]. Sometimes you hear the market is dried up because of seizures or harvests. Lately [availability of regular-grade marijuana] it's a tad bit less." Participants reported that the availability of high-grade marijuana has been dramatically increasing. A participant stated, "High-grade [marijuana] is more available. It's getting better, and 'mids' [regular-grade marijuana] is not okay anymore." Another participant said, "It used to be lower-grade [marijuana] was all over, but in the last year, there's been so much high-grade the reggie [regular-grade marijuana] is scarce." Several users spoke to the general preference for high-grade marijuana, with one stating, "If you smoke 'loud' [high-grade marijuana], you're not going to smoke 'reg' anymore." Another participant added, "Dealers don't have to have a team meeting anymore to find you good stuff [high-grade marijuana]." The Cuyahoga County Regional Forensic Science Lab reported that the number of marijuana cases it processes has increased during the past six months.

Most participants rated the quality of regular-grade marijuana as '8' and the quality of high-grade marijuana as '10' on a scale of '0' (poor quality, "garbage") to '10' (high



quality); the previous most common score was '10' for both grades of marijuana. Several participants explained that the quality of marijuana depends on whether the user buys "regular weed" or hydroponically grown (high-grade) marijuana. A few users felt the appearance of more high-grade marijuana in the region coincides with more states legalizing the drug for medical use, as explained by a participant: *"Since the medical marijuana thing, I've seen some really hairy, really crystalline [very desirable] bud [marijuana]. I've been told that's medical [aka 'government weed']."* Quality scores were interpreted as a type of 'customer satisfaction' metric to describe how closely the marijuana advertised by dealers met the user's expectations. Many participants commented how quality changes are affecting availability: *"Nobody wants reg. I haven't seen anybody selling reg. My dealers usually sell 'dro' [hydroponically grown marijuana]; I think it's harder to find mids now, because nobody wants it."*

Current street jargon includes countless names for marijuana, with variants of "kush" and "purple haze" most commonly mentioned. Consumers listed the following as common street names for marijuana: "dirt," "kind bud," "reg," "reggie," "skunk" and "swag" for low- and mid-grade marijuana; "Afghani Kush," "AK-47," "Alaskan thunder f\*\*\*," "blueberry yum-yum," "bubble kush," "chronic," "diesel," "dro," "fire," "Fruity Pebble dank," "lemon G," "Orange Crush," "purp," "schwag," "sour diesel," "strawberry cough" and "train wreck" for high-grade or hydroponically grown marijuana. Continuing with previously reported trends, fruit-flavored marijuana is popular, and branding with creative names helps to popularize certain strains. The price of marijuana depends on the quality desired. Participants reported regular-grade marijuana is the cheapest form: a blunt or two joints sell for \$5; 1/8 ounce sells for \$20; 1/4 ounce sells for \$40; 1/2 ounce sells for between \$45-55; an ounce sells for between \$100-120; a pound sells for between \$900-1,000. High-grade or hydroponically grown marijuana continues to sell for significantly more: a blunt or two joints sell for between \$10-20; 1/8 ounce sells for between \$60-65; 1/4 ounce sells for \$125; an ounce sells for between \$350-400; a pound sells for \$2,400-2,600. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Participants reported that 98 percent of marijuana is smoked, and only two percent is ingested in foods like brownies, waffles, pancakes or butters. A participant commented, *"Only hippie dudes will eat it [marijuana]."* Participants shared other observations about preferences: *"Older people smoke joints. Younger users smoke blunts and bongs [water pipes]; There are only blunts in the city. In the country, it's all bowls [pipes]. There are more cops in the city, and you can't throw your bowl out if you get caught."* Several participants continued to mention the use of vaporizers, which are devices that heat marijuana to precise temperatures and boil off marijuana compound's

vapor for inhalation, whereby the user receives a higher dose of THC (Tetrahydrocannabinol). A participant familiar with vaporizers explained that White users are more likely to use vaporizers than Black users.

A profile for a typical marijuana user did not emerge from the data, as participants most often continued to describe typical users of marijuana as "everyone." A treatment provider stated, *"The 55-year-old, blue-collar worker and the 17-year-old, and every age and race in between are who's using it [marijuana]."* A participant observed, *"Come to my church, and my pastor can sell you some 'reggie.'"* Treatment providers and law enforcement officers agreed that because penalties are so low for marijuana possession, many users "don't consider it to even be a drug," as one commented. Law enforcement added, *"Other than alcohol, [marijuana] it's the number-one gateway drug. Kids 12-13 years old smoke weed."* Reportedly, marijuana is used in combination with almost every other drug, including: alcohol, crack and powdered cocaine (used to "come down"), Ecstasy (crushed and added to a blunt), hallucinogens (blunts dipped in liquid lysergic acid diethylamide (LSD) and phencyclidine (PCP), aka "woo" and "wet"), heroin and prescription opioids. Reportedly, younger users are generally more likely to crush prescription opioids for use with marijuana. A participant reported, *"We would sprinkle pills [prescription opioids] on top [of marijuana while rolling a joint] and call it a 'spicy joint.'"*

## Methamphetamine

### Historical Summary

In the previous reporting period, methamphetamine was highly available in the region. Few participants had knowledge of methamphetamine outside of Cuyahoga and Geauga counties, but those with experience most often reported the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Since few participants had personal knowledge of the drug, the availability ranking was usually qualified by participants to mean that the drug was highly available to a limited number of users who were connected with a tight-knit network of methamphetamine dealers and users. Law enforcement and treatment providers most often reported the drug's availability as '4.' They agreed with the participant view of availability; they thought that methamphetamine was highly available, but only to a select few. The BCI Richfield Crime Lab reported that the number of crystal and powdered methamphetamine cases it processes had increased during the previous six months. Reportedly, the most common route of administration for powder methamphetamine was snorting. Law enforcement and treatment providers thought typical users of methamphetamine to be White, economically disadvantaged and likely living in rural areas.



### Current Trends



Methamphetamine remains highly available in the region. Participants with experience buying methamphetamine most often reported the drug's current availability as '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '8'. As was the case in the previous reporting period, participants who assigned an availability ranking usually qualified their scores to mean that methamphetamine is highly available to a limited number of users who are connected with a tight-knit network of dealers and users. Law enforcement most often reported the current availability of methamphetamine as '2'; the previous most common score was '4'. Participants reported that the drug is not widely available in the city of Cleveland, due to the higher population density that prohibits the operation of meth [methamphetamine] labs. One participant stated, "[Methamphetamine] it's one of the things you don't hear about in Cleveland; you can't get that in the city." A law enforcement officer working in the City of Cleveland remarked, "You keep hearing about the meth wave that's supposed to be coming in. [Methamphetamine] it's on the outskirts of Geauga County, Lake County and some places in Cuyahoga County, but we haven't seen it." However, participants indicated methamphetamine can be obtained through personal connections with methamphetamine dealers and users. In two separate focus groups, participants noted that when the drug is available in Cleveland, it is reportedly coming from areas east of the city, particularly Lake and Ashtabula counties. A couple of participants said they would engage directly with methamphetamine "cooks" to obtain the drug: "If I didn't have a lot of money, I would have gotten a box of Sudafed® to trade [for methamphetamine]; A lot of meth guys only get pills [pseudoephedrine] to trade for meth." Media outlets across the state reported on significant arrests during this reporting period involving methamphetamine in the region. In October, *The Morning Journal* reported that Lorain County Sheriff's deputies found chemicals and equipment to manufacture methamphetamine after a car was pulled over for fictitious license plates ([www.morningjournal.com](http://www.morningjournal.com), Oct. 27, 2011).

Participants most often reported that the availability of methamphetamine has increased during the past six months. A participant explained, "There are more houses [methamphetamine labs] in Madison and Perry [Lake County], and it's moving this way [toward Cleveland]." A participant commented, "It's gotten easier to get [methamphetamine] within the past year. It's getting more popular." Another participant mentioned a recent experience, "I don't really have to know anybody. I was approached the first time I ever

saw it [methamphetamine]." Lorain County law enforcement also noted an increase in methamphetamine activity: "In the last two weeks we've had three [methamphetamine] lab busts. That is three more than we've had in the last two years." The Cuyahoga County Regional Forensic Science Lab reported that the number of crystal and powdered methamphetamine cases it processes has decreased during the past six months.

Only two participants were able to rate the quality of methamphetamine, supplying quality scores of '5' and '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); previously, the quality score of methamphetamine was '7'. Participants reported that methamphetamine is primarily available in a home-cooked, powdered form. Crystal methamphetamine, perceived to have a higher purity, is reportedly an exotic variant of the drug that would be imported from the western part of the country. A participant explained, "The stuff [methamphetamine] from Madison, Ashtabula and Perry wasn't as fine as the stuff I had in Arizona. They're making it here ... what they make here is a white powder." A law enforcement officer's observations aligned with participants': "We had a group from Mexico that was trying to establish a super [methamphetamine] lab here. The purity rate was 98.3% compared to the [home-cooked] powder stuff. If they had gotten established, it would have taken off."

Current street jargon includes many names for methamphetamine. The most commonly cited names were "crank" and "crystal." Participants listed the following as other common street names: "bulb," "gear," "home cooked," "ice," "monster," "red dope," "speed" and "tweak." Several participants had experience buying the drug, and they reported that a gram sells for between \$40-120; 1/16 ounce sells for \$70; 1/8 ounce sells for between \$140-150. A participant explained that like other drugs, methamphetamine pricing depends on quality, and that the purer, crystal form of the drug costs more. Reportedly, the most common routes of administration for powdered methamphetamine are snorting and smoking. Out of 10 methamphetamine users, five would snort the drug, four would smoke and one would intravenously inject.

A profile for a typical methamphetamine user did not emerge from the data, but participants supplied their perceptions about those who use the drug. Some participants thought of methamphetamine as a rural drug. One participant said, "[Methamphetamine] it's more of a country thing ... out where I live, we have a lot of labs in the trailer parks." Others participants thought methamphetamine also common in suburban users as well as rural users, and many participants believed the drug not to be typically used by city dwellers. One participant said, "Nobody that walked through those doors [at this facility in Cleveland] uses meth." A treatment provider felt the drug is, "very popular among



*gay males in Lakewood [Cuyahoga County, west of Cleveland].* Reportedly, methamphetamine is used in combination with depressant drugs like alcohol, heroin and sedative-hypnotics, which are used to “come down” from the effects of methamphetamine.

## Ecstasy

### Historical Summary

In the previous reporting period, Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) was highly available in the region. Participants most often reported the drug’s availability as ‘9’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Both participants and law enforcement agreed that the drug was most commonly available in dance clubs and nightclubs. The BCI Richfield Crime Lab reported that the number of Ecstasy cases it processes had decreased during the previous six months. Participants reported that a “double stack” (moderate dose) Ecstasy tablet sold for between \$10-15, and a “triple stack” (high dose) sold for between \$15-20. The BCI Richfield Crime Lab cited methcathinone analogs (psychoactive stimulants) and other clandestine uncontrolled substances (bath salts) as cutting agents for Ecstasy. Participants described typical users of Ecstasy as young people in their early to mid-20s.

### Current Trends

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) remains highly available in the region. Participants most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was ‘9.’ Law enforcement and treatment providers did not rate the current availability of Ecstasy. Media outlets throughout the state reported on a significant arrest during this reporting period involving Ecstasy in the region. In November, the Ohio State Highway Patrol confiscated 200 Ecstasy pills, along with two grams of heroin in Lorain County during a routine traffic stop ([www.nbc4i.com](http://www.nbc4i.com), Nov. 3, 2011). Participants reported that the availability of Ecstasy has remained the same during the past six months; however, a few participants felt that the purest form of Ecstasy (aka “Molly”) has been becoming more available as knowledge about the drug grows. A participant commented, “Once you take a hit [of Molly] you’re going to be back [for more] in 10 minutes.” The Cuyahoga County Regional Forensic Science Lab reported that the number of pure Ecstasy cases it processes has decreased while the number of piperazine cases (synthetic substances similar to Ecstasy) has increased during the past six months.

Participants most often rated the current quality of Ecstasy as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality), even though several participants felt that quality has been decreasing. Participants reported, “I stopped doing it [Ecstasy] because it was garbage; I would not touch it [Ecstasy] again. I don’t know what’s in it now.” Participants did not believe that it is possible to assess ingredients or quality before taking the drug: “You don’t know [what’s in Ecstasy] unless you have a close drug dealer; Some [Ecstasy] have meth effects, some have downer effects.”

Current street jargon includes only a few names for Ecstasy. The most commonly cited names were “X” and “Molly.” Participants said Molly is sold as a yellowish loose powder, and that Ecstasy is sold as small colored tablets that feature popular images or logos: Transformers, Playboy® bunnies, Flintstones™, dolphins or hummingbirds. Participants explained the differences among tablets: “You just choose [Ecstasy] based on how you want to feel [and] based on what it looks like; You can get a testing kit at a head shop or look up the [Ecstasy] stamp online; If it [Ecstasy] had crystals in it, it would get you messed up.” A participant commented, “The stamp tells you how [Ecstasy] it’s supposed to make you feel, but they’re all the same.” Participants reported that a single Ecstasy tablet (low dose) generally sells for between \$2-10; a double stack sells for between \$5-10; a triple stack sells for between \$8-12. When purchased in large quantities, the price is reportedly \$0.70 per tablet. Molly is the most expensive form of Ecstasy and is often pre-bagged as “rails” (approx. 1/10 gram): 1/10 gram sells for between \$10-12; a gram sells for between \$100-150. While there are few reported ways of administering Ecstasy, the most common route of administration is by mouth. Out of 10 Ecstasy users, participants reported that approximately nine would eat Ecstasy and one would snort it. Participants also mentioned other less common methods; some said users “parachute” (wrap a crushed tablet in tissue and swallow it), while others said users insert the tablet anally or dissolve it in warm water and take it like a shot of alcohol.

According to participants, these drugs are most often obtained from friends and dealers via phone call or at night clubs. Several users also described the comeback of raves featuring Ecstasy. A participant reported, “In the past three months, I’ve heard about four or five raves in Kent and Cleveland with music glow sticks and everything. It was in the paper even.” A law enforcement officer noted, “[Our service area] doesn’t really have any clubs so that’s one of the reasons we don’t have a lot of Ecstasy.” A profile for a typical Ecstasy user did not emerge from the data, but the drug was said to be popular in both rural and urban areas. Participants and law enforcement perceived that the drug is more popular with younger users, 18-25 years old. A law enforcement officer stated, “[Ecstasy] it’s more of younger person’s drug.” Reportedly, Ecstasy is used

in combination with alcohol and other depressant drugs, tobacco and VIAGRA®. Users reported the need to follow Ecstasy with a counteracting drug if it contained a stimulant or a sedative. A participant explained, “You take downers when [Ecstasy] is mixed with coke or meth.”

## Prescription Stimulants

### Historical Summary

In the previous reporting period, prescription stimulants were highly available in the region. Participants rated the availability of these drugs as ‘8’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). The BCI Richfield Crime Lab reported that the number of prescription stimulant cases it processes had remained the same during the past six months. Participants reported infrequently buying these drugs, so only one price was mentioned for prescription stimulants: Adderall® 30 mg sold for \$5. Reportedly, these drugs were obtained from friends and drug dealers, and were favored by young people. Participants stated that pills were most often crushed and snorted or dissolved and then intravenously injected.

### Current Trends

Prescription stimulants remain highly available in the region. While few participants had knowledge of these drugs, those with experience rated the current availability of prescription stimulants as ‘9’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was ‘8’. Participants reported Adderall®, Concerta® and Vyvanse® as most popular in terms of widespread use and generally readily available. A participant reported, “I was shooting it [prescription stimulants] for a while. It was a phone call away. It’s out there.” Another participant reported, “I know people that had been purchasing it [prescription stimulants] for school. My son is on it, and someone asked me for it.” Ritalin® is reportedly difficult to obtain due to a national shortage of the drug. Treatment providers most commonly supplied an availability score of ‘9’. Law enforcement did not supply data on prescription stimulants. A treatment provider stated, “[Prescription stimulants] it’s a friend-to-friend drug. It’s big by Case [Western Reserve University] and John Carroll [University]. You can’t even get it at any pharmacy. There is a shortage on any immediate-release pills.” The Cuyahoga Regional Forensic Science Lab reported that the number of prescription stimulant cases it processes has increased during the past six months.

Participants remarked on the high level of abuse among high school- and college-aged people. One participant said, “[Students] use them [prescription stimulants] to study and focus.” A treatment provider reported, “I don’t see clients who say [prescription stimulants] it’s their drug of choice, or that

they need Adderall® to survive. Instead, I see a lot of drinking [alcohol] with it, a lot of using it for studying ... just abuse, but not necessarily dependence.” A couple of participants noted that these drugs are more popular with mothers of children with prescriptions and with younger females. A participant reported, “Vyvanse® and Adderall® are really big with girls. It makes them feel like they’re on coke.” Treatment providers reinforced the connection between school and stimulants: “I know [prescription stimulants] it’s in all the school systems. I have clients that say their kids are all on this stuff. They’re not taking the prescriptions, but it seems like everyone else is.”

No slang terms or common street names were reported for prescription stimulants. Reportedly, prescription stimulants sell for between \$2-5 per pill. According to participants, these drugs continue to be obtained from friends and drug dealers. While there were a few reported ways of administering prescription stimulants, the most common route of administration remains snorting. Out of 10 prescription stimulant users, participants reported that approximately eight would snort and two would orally ingest them. Reportedly, prescription stimulants are used in combination with alcohol, marijuana and prescription opioids.

## Bath Salts

### Historical Summary

In the previous reporting period, bath salts (synthetic compounds containing methylone, mephedrone or MDPV) were highly available in the region. Participants reported the availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Law enforcement and treatment providers also most often reported availability as ‘10’. Participants and community professionals said the high availability was due to bath salts’ legal status, often being sold in head shops. Bath salts sold for approximately \$40 per 500 mg. The most common route of administration for this drug was smoking and snorting. A profile for a typical bath salts user did not emerge from the data; participants and community professionals only agreed that users of bath salts were younger than typical users of other drugs.

### Current Trends

Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) remain highly available in the region. Participants reported the current availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Despite recent legislation that has banned the sale of these synthetic chemicals, packaged products remain widely available from the same convenience stores that previously sold bath salts. Participants frequently made comments like, “Head

shops follow the rules, but [other] stores will continue to sell it [bath salts]; [Bath salts] it's still sold in stores. They might say they don't sell it, but it's behind the counter." Participants also reported obtaining the drug online and in bulk from certain dealers. A participant reported, "My friend was buying it [bath salts] online in larger quantities. It comes in one big chunk ... then he would break it down and put it in bags." Law enforcement officers and treatment providers reported the current availability of these drugs as '9'. A law enforcement official reported, "[Bath salts] it's still out there. They have a different way of marketing, but it's there." A treatment provider said, "My clients said it [bath salts] was really available, and you can still get them at the corner store." A law enforcement officer noted that a nearby hospital had 40 bath salts-related emergency cases in one month. A treatment provider reported, "In the last two months, I have had three clients that have been hospitalized for bath salts. One was in the ICU [Intensive Care Unit] twice and is finally in treatment for it. The other had psychotic features for weeks afterward." Both participants and law enforcement reported that the availability of bath salts has remained the same during the past six months. The Cuyahoga Regional Forensic Science Lab reported that the number of bath salts cases it processes has increased during the past six months.

No slang terms or common street names were reported for bath salts. Bath salts sell for between \$15-25 per 1/2 gram; a gram sells for between \$20-40. Participants did not report a spike in prices after the drug was made illegal in October 2011. A law enforcement officer stated, "[Bath salts] it's being packaged and brought in here. The law has helped, but it's still being imported." Law enforcement officers felt that if the importation of bath salts is disrupted, the price will likely rise. The drug is most typically smoked or snorted, although intravenous injection and oral ingestion were also reported in a minority of cases. Law enforcement and treatment providers reported that bath salts are typically used by younger users. A treatment provider said, "Last week I was explaining what it [bath salts] was to some of my clients, and the older clients over about 25 years old, didn't know what it was. The younger ones were explaining what it was." Another treatment provider shared a similar experience, remarking, "I had one [older] client who used it [bath salts] accidentally. The guy in the store told him it was fake cocaine, and it was legal. He ended up in the psych unit for three days. My clients talk about it being heard in the news, but they don't admit to using it ... but the younger clients know who's using it and what stores have it." Treatment providers described users to be more likely younger than 30 years of age, White and suburban. A law enforcement officer described typical use similarly: "It's a younger group using it [bath salts]. I haven't seen 30s [those in their 30s] or older [using bath salts]. It's mostly teens and 20s [who use bath salts]." Bath salts were not reported to be used in combination with other drugs.

## Other Drugs

### Historical Summary

In the previous reporting period, participants and professionals listed the following other drugs as present in the region, but these drugs were not mentioned in the majority of people interviewed: Ketamine (aka "special K"), GHB (gamma-hydroxybutyrate), hallucinogens [DMT (dimethyltryptamine), LSD (lysergic acid diethylamide) and psilocybin mushrooms], PCP (phencyclidine) and synthetic marijuana ("K2" and "Spice"). Ketamine was rarely available in the region. Participants most often reported the drug's availability as '0' or '2' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). GHB was moderately available in the region. Participants on the east side of Cleveland most often reported its availability as '6'; DMT was reportedly also available on the west side of the region. Law enforcement most often reported its availability as '1'. Due to two arrests in the prior three months for DMT possession, law enforcement thought the drug's availability was trending upward. Reportedly, the drug cost \$50 per gram, and it was sold as a powder. The most common method of administration was snorting. LSD was highly available in the region according to the few participants with experience purchasing the drug. Participants most often reported LSD's availability as '8'. Only three participants were able to rate the quality of LSD, and they gave scores ranging from '7' to '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants disagreed as to whether LSD quality had remained the same, increased or decreased during the previous six months. Participants did not provide pricing information, but they said that LSD was available in microdots (small tablets) and sugar cubes. Psilocybin mushrooms were relatively rare in the region, and participants most often reported the drug's availability as '3'. Only four participants were able to rate the quality of psilocybin mushrooms, and they gave quality scores ranging from '7' to '9'. Street prices for psilocybin mushrooms were consistent among participants with experience buying the drug: 1/8 ounce sold for \$40. Oral ingestion was the most commonly reported route of administration. PCP was highly available in the region. Participants most often reported availability as '10'. As with the previous reporting period, most participants reported obtaining PCP from an area called "Water World" on Cleveland's east side. Most participants generally rated the quality of PCP as '10'. PCP was commonly sold on a per dip basis or as ready-to-smoke tobacco or marijuana. Rarely, the drug was sold as a crystalline powder. Pricing was consistent with the previous reporting period: one dip of a cigarette sold for between \$10-20. Synthetic marijuana was highly available in the region. Participants frequently mentioned rising popularity of the drug due to the belief that synthetic



marijuana delivered a marijuana-like high but could not be detected by urine drug screens. Like marijuana, the most popular route of administration for this drug was smoking.

### Current Trends

Participants and professionals listed a variety of other drugs as being present in the region, but these drugs were not mentioned by a majority of the people interviewed. DMT (dimethyltryptamine), a naturally occurring psychedelic compound, is highly available in the region. Participants most often reported its availability as '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Some participants thought DMT to be an emerging drug in the region. A participant stated, *"I've been hearing a lot about it [DMT] coming up."* The drug is obtained from drug dealers and other users, as one participant explained, *"It [DMT] comes from people that know how to make it. They use it."* A participant described two variants of the drug: a natural compound and a compound made with synthetic chemicals. According to participants, the natural version is a white powder derived from, *"plants and natural ingredients,"* which was reported to be the, *"healthier way"* to create DMT. The other method utilizes household chemicals such as paint thinner; this form of DMT is a yellow-tinted powder that has a slight odor. A participant noted that the white or "natural" form is gaining in popularity and that the quality is improving as the knowledge of the drug-manufacturing process improves. Participants with knowledge of the "natural" form of the drug most often rated its quality as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); quality of the synthetic form of the drug was most often rated '7'. No street names were mentioned for DMT. Participants reported that 1/10 gram of DMT sells for \$10, and a gram sells for \$150. Reportedly, the "natural" form of DMT sells for twice as much as the synthetic varieties. Participants reported that the most common routes of administration are smoking or snorting. Occasional use by mouth was also mentioned. The drug was said to be popular with, *"Kids who like to use hallucinogens. [DMT] it's up and coming,"* and with *"show kids,"* meaning younger people who attend concerts. Another participant talked about the wide variety of users: *"Sixteen to twenty-five year olds are the people who use it [DMT]."* A participant reported that marijuana and LSD are used in combination with DMT because they, *"enhance the effect"* of the drug.

PCP (phencyclidine) remains highly available in certain areas of Cleveland. Participants most often reported current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. As with the previous reporting period, most participants reported obtaining PCP (aka "wet" or "woo") from an area called "water world" on Cleveland's east side. Liquid PCP is still commonly sold on

a per dip basis or as ready-to-smoke tobacco or marijuana. The crystalline powder form was not reported. The Cuyahoga Regional Forensic Science Lab reported that the number of PCP cases it processes has increased during the past six months. On a scale of '0' (poor quality, "garbage") to '10' (high quality) two participants supplied PCP quality scores of '7' and '8'. A participant explained, *"It's only liquid [PCP] that's sold. It's embalming fluid, but they say now it's not like it used to be. [Dealers] they're cutting it with other stuff and it's not as good."* A law enforcement officer noted, *"We hear a lot about it [PCP] from suspects who mix it or they say they were high on it, but we don't actually encounter it."* Pricing is consistent with the previous reporting period: one dip of a cigarette sells for between \$15-20. Law enforcement reported the drug to be most popular among users in their 30s-50s. PCP is most commonly used with alcohol, marijuana and tobacco.

Synthetic marijuana ("K2" and "Spice") remains highly available in the region. Unlike previous reporting periods, many participants had heard of synthetic marijuana. Participants continued to attribute the popularity of synthetic marijuana to the continued belief that the drug delivers a marijuana-like high but cannot be detected in urine drug screens. Despite recent legislation that has made synthetic marijuana illegal, participants most often reported current availability of the drug as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, participants said synthetic marijuana was highly available, but did not assign an availability score. A participant explained, *"People were stocking up before they [synthetic marijuana] got illegal."* Reportedly, synthetic marijuana is still widely available from head shops, convenience stores and independently owned gas stations. A participant reported, *"I just went into a store that had it [synthetic marijuana] last week."* Another participant added that users must develop a relationship with the store owners before purchasing the product: *"They gotta know your face, and you have to know what to ask for."* Treatment providers most often reported the current availability of synthetic marijuana as '9'; however, many thought that the drug is not as popular as before the ban went into effect in October 2011. A treatment provider said, *"[Synthetic marijuana] it's illegal, and clients could be tested for it. They [clients] think, 'I can't use it [synthetic marijuana] now because I could be caught with it.' That was the attraction ... it was a cheap, legal high. We are testing for it on toxicity screens, and parole officers test for it, so it's causing the clients to forget about it."* The Cuyahoga Regional Forensic Science Lab reported that the number of synthetic marijuana cases it processes has increased during the past six months. A crime lab professional reported, *"Synthetic cannabinoids, although listed [prohibited by law] are an epidemic situation in Cuyahoga County."* Participants with knowledge of the drug rated its quality as '9' on a scale of '0' (poor quality, "garbage")



to '10' (high quality). Reportedly, the most available brands of synthetic marijuana are "Mr. Nice Guy" and "Black Magic." Participants reported that a gram of synthetic marijuana sells for between \$1.50-3. Like marijuana, the most popular route of administration for this drug remains smoking. Treatment providers cited the drug's popularity with all races and socio-economic groups, but that it is most favored by younger users (between 25-30 years).

Seroquel® (quetiapine), an antipsychotic medicine, was reported to be widely available and occasionally abused by the 18-25 year-old participants interviewed. Participants reported obtaining the drug from friends and doctors. One participant said, *"Everybody in the world is bipolar, so they get it [Seroquel®]."* Another participant explained, *"You can't get it from a dealer. You don't even buy Seroquel®. People give it away. It's like a cigarette. You trade it."* Reportedly, abuse of this drug produces a detached, "floaty" feeling and reduced or eliminated anxiety. Participants most often reported the availability of Seroquel® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Seroquel® 10 mg and 100 mg sell for between \$7-\$20 per pill. The most common route of administration is oral ingestion. Several participants also mentioned dissolving the pills in liquid (orange juice or sports drinks). Reportedly, the drug is used in combination with alcohol, marijuana and prescription stimulants.

### Conclusion

Bath salts, crack cocaine, Ecstasy, heroin, marijuana, methamphetamine, PCP (phencyclidine), powdered cocaine, prescription opioids, prescription stimulants, sedative-hypnotics and synthetic marijuana remain highly available in the Cleveland region; also highly available for the first time is DMT (dimethyltryptamine), a psychedelic compound with natural and synthetic versions. Some participants thought DMT to be an emerging drug in the region; the drug is popular among younger users (16-25 years of age). Increases in availability exist for heroin and marijuana, and data indicate likely increases in availability for methamphetamine and sedative-hypnotics. While prescription opioids generally remain highly available, participants and community professionals noted that methadone is gaining in popularity. Both law enforcement and treatment providers reported that methadone is increasingly prescribed for pain. The majority of participants and community professionals reported that the availability of heroin has increased during the past six months; no respondent felt heroin's availability has decreased. Participants reinforced two trends identified in previous reports: increased competition among dealers to secure steady heroin users and increased demand for heroin.

Despite local differences, brown and white powdered forms of the drug are easily obtained, and are perceived to be used at epidemic levels. When asked to identify the most urgent or emerging drug trends, law enforcement continued to cite heroin trafficking as a primary concern. Marijuana is the most easily obtained illegal drug in the region. Participants reported that the availability of high-grade marijuana has been dramatically increasing. The Cuyahoga County Regional Forensic Science Lab reported that the number of marijuana cases it processes has increased during the past six months. While methamphetamine appears not to be available in the city of Cleveland for street purchase, the drug remains highly available to a limited number of users who are connected with a tight-knit network of dealers and users. Participants most often reported that the availability of methamphetamine has increased during the past six months; Lorain County law enforcement also noted an increase in methamphetamine activity. Most participants reported that the availability of sedative-hypnotics has increased during the past six months. Klonopin® was identified as a drug increasing in popularity; The Cuyahoga County Regional Forensic Science Lab reported an increase in cases related to Klonopin®. Despite recent legislation that has banned the sale of certain synthetic chemicals, bath salts and synthetic marijuana remain widely available from the same retail outlets (head shops, convenience stores and gas stations) that sold the products previously. A participant reported, *"[Bath salts] it's still sold in stores. They might say they don't sell it, but it's behind the counter; People were stocking up before they [synthetic marijuana] got illegal."*