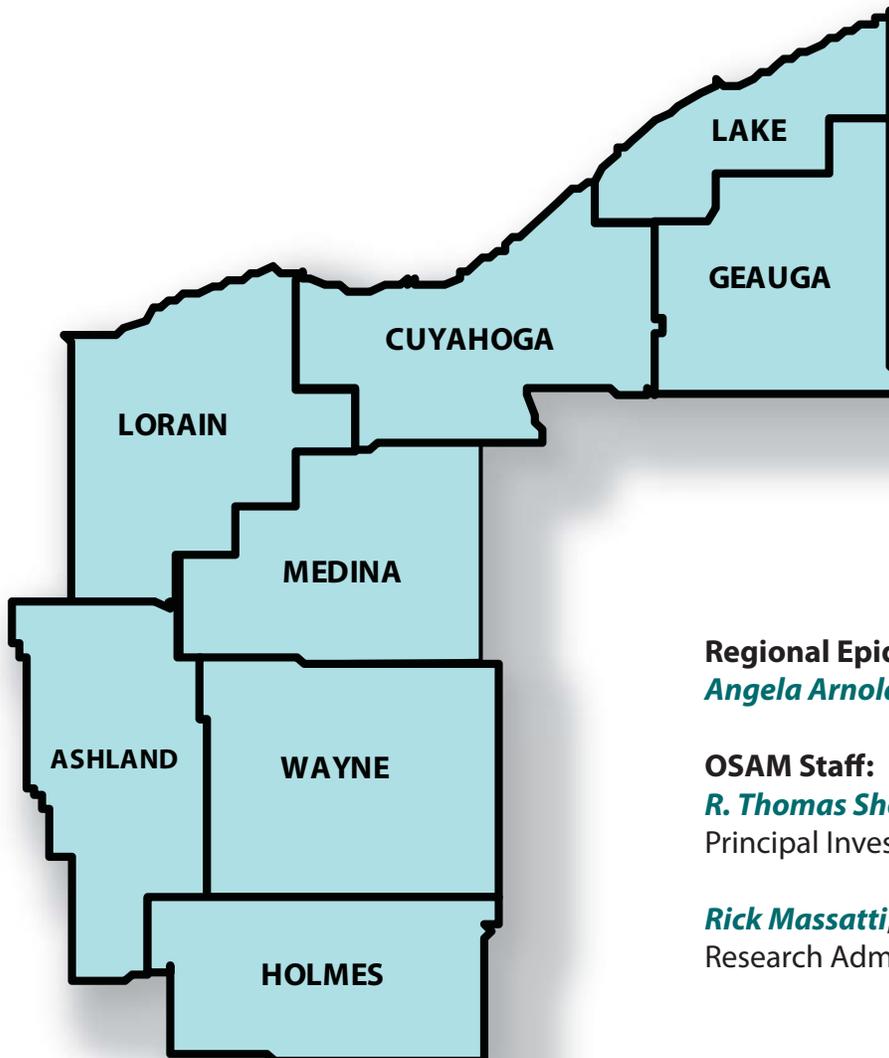


Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Cleveland Region

January-June 2011

John R. Kasich, Governor
Orman Hall, Director



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Dear Reader,

The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) is pleased to present its latest Ohio Substance Abuse Monitoring Network (OSAM) *Surveillance of Drug Abuse Trends in the State of Ohio* report covering the period January 1 - June 30, 2011. As you will see, this detailed document is full of qualitative data and first-hand accounts that accurately depict the drug abuse landscape in all regions of the state.

OSAM is a collaborative effort funded by ODADAS in association with stakeholders in the substance abuse and law enforcement community throughout Ohio. The primary mission of OSAM is to provide a dynamic picture every six months of substance abuse trends and newly emerging problems within Ohio's communities. The OSAM Network provides substance abuse professionals and policy makers with the information necessary to plan for alcohol and drug addiction prevention, treatment and recovery services, and to respond to previously unrecognized drug and alcohol problems among underserved populations.

Highlights of the June 2011 report include findings that opiates (prescription painkillers and heroin), cocaine and crack cocaine remain highly available in all regions. Evidence continues to show a progression from prescription opioid abuse to heroin abuse, earning the latter the reputation of being "one of the most available street drugs." In fact, OSAM researchers noted that many entrepreneurial dealers are now peddling prescription opiates in an effort to "cash in" on this increased demand.

For the first time OSAM tracked bath salts -- synthetic compounds that produce a high similar to a stimulant or hallucinogenic drug sold under labels such as *Cloud 9*, *Dove*, *Ivory Wave* and *Vanilla Sky* -- characterizing the substances as "highly available in all regions."

The report also examines patterns of abuse with Suboxone, an FDA-approved medication that has been proven to be effective in treating opioid addiction. Research has shown that most opiate-addicted clients relapse without a comprehensive treatment plan that includes medication-assisted treatment (MAT) and counseling. When appropriately used, Suboxone does not produce euphoria.

For opiate naïve individuals (those individuals who are not using heroin or prescription opiates), Suboxone has a potential for abuse when illegally diverted to the streets. ODADAS is committed to educating treatment providers and prescribers on the value of MAT and the importance of following established policies and practices designed to safeguard supplies and ensure successful outcomes for Ohioans with addiction.

I hope you find this report an informative and valuable tool as we continue to work together to promote health, safety and economic opportunity for all Ohioans.

Sincerely,

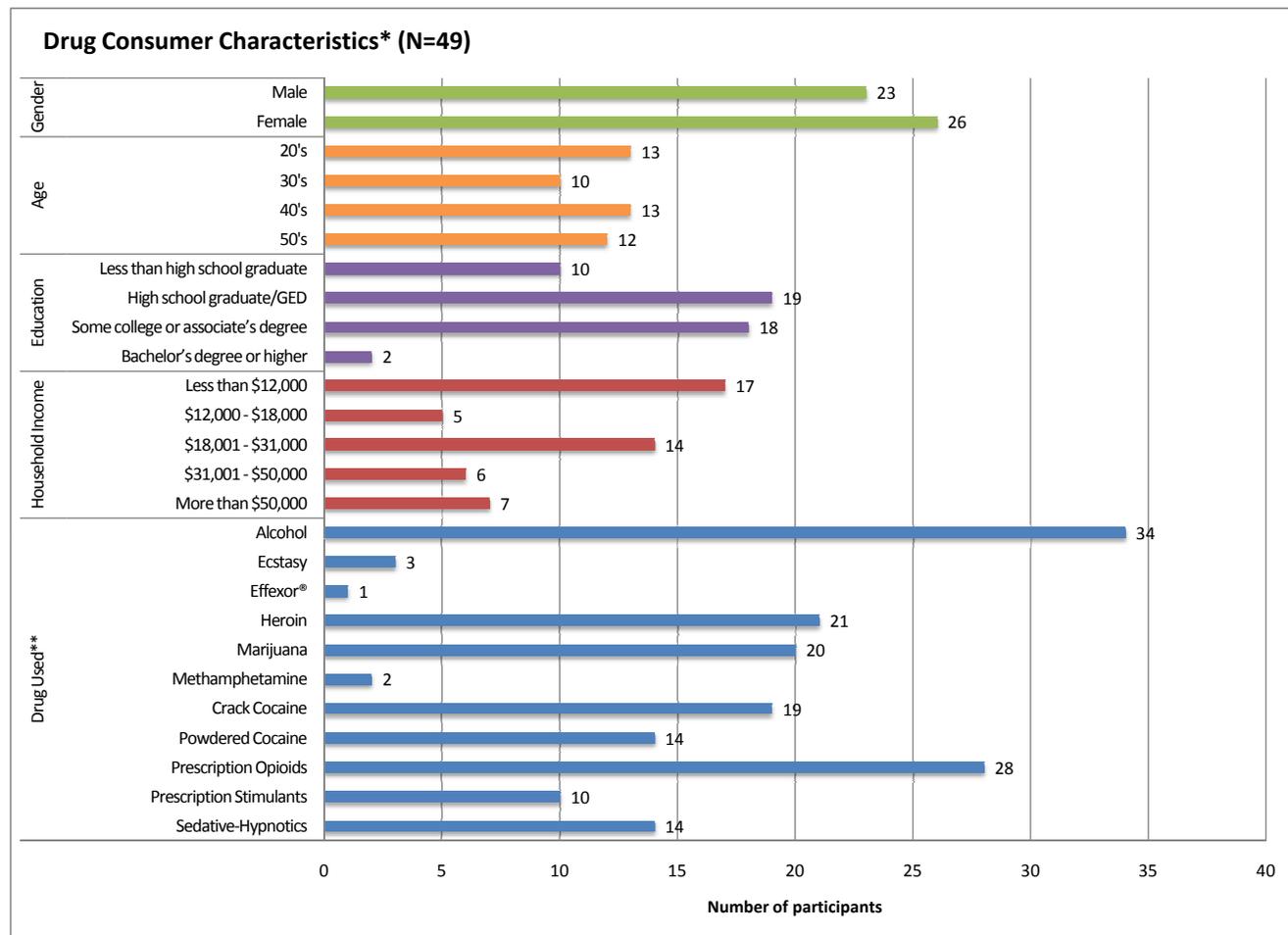
Orman Hall, Director

Regional Profile

Indicator ¹	Ohio	Cleveland Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,542,645	2,302,406	49
Gender (Female), 2009	51.2%	51.8%	53.1%
Whites, 2009	82.2%	75.1%	63.3%
African Americans, 2009	11.9%	17.6%	22.4%
Hispanic or Latino Origin, 2009	2.8%	4.2%	10.2%
High school graduates, 2009	83.0%	90.0%	79.6%
Median household income, 2009	\$45,467	\$47,820	\$18,000 to \$31,000 ²
Persons below poverty, 2009	15.1%	14.9%	30.6%

Ohio and Cleveland statistics are derived from the U.S. Census Bureau¹.

Respondents reported income by selecting a category that best represented their household's approximate income for 2009².



*Not all participants filled out forms; therefore numbers may not add to 49.

**Some respondents reported multiple drugs of use over 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 focus group interviews, as well as to data surveyed from the Cuyahoga County Coroner's Office and the Bureau of Criminal Identification and Investigation (BCI) Richfield Office, which serves the Cleveland, Akron and Youngstown areas. All secondary data are summary data of cases processed from July to December 2010. 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 BCI data correspond to the current reporting period of participants. In addition to the aforementioned data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2011.

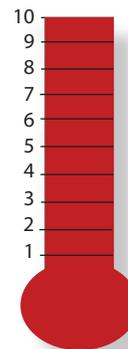
Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was readily available in the region. Participants most often reported the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants indicated that the availability of powdered cocaine had decreased somewhat over the previous six months, with widespread agreement that powdered cocaine was not as easy to obtain as crack cocaine. The most common participant quality score for powdered cocaine was '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). A common theme to emerge among participants was the belief that the quality of powdered cocaine was greatly dependent on factors such as when shipments arrived and how closely the supplier was connected to his/her source. BCI Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine as common cutting agents for powdered cocaine. Participants reported a gram of powdered cocaine ranged in price from \$40 to \$80. The most common route of administration for this form of cocaine was intranasal inhalation (snorting). Both law enforcement and participants reported that cooking powdered cocaine to create crack cocaine was the other most common technique for administering cocaine. Smoking powdered cocaine after it had been "rocked up" was reportedly extremely common, due in part to concerns about the quality of the cocaine. Intravenous injection and lacing

cigarettes or marijuana with powdered cocaine were also cited as common methods. The drug continues to be popular for users in a club or party-scene.

Current Trends

Powdered cocaine remains highly available in the region, but often perceived to be harder to get than crack cocaine. 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 '8'. Although it was perceived as a drug that would require connections to obtain, especially powdered cocaine of good quality, users still supplied high availability scores. A participant stated, "*Crack [cocaine] is guaranteed, powder [cocaine] is a little harder [to locate].*" Law enforcement most often reported the drug's current availability as '8'. A law enforcement officer said, "*I just got some [powdered cocaine] the other day. I worked one shift, and here's a guy walking down the street drunk. Shook him down and he had a dollar bill rolled up really tight, and there's cocaine all over it. I don't think it's hard to get.*" Collaborating data also indicated that powdered cocaine is readily available in the region. The Cuyahoga County Coroner's office reported 11.5 percent of all deaths it investigated were drug related (i.e., had an illegal substance present or legal drug above the therapeutic range); in the last reporting period, 10.7 percent of all deaths were drug related. Furthermore, the coroner reported cocaine as present in 35.7 percent of all drug-related deaths (this is an increase from 29.8 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 across the State reported on significant arrests this reporting period involving cocaine trafficking in the region. In March, *The Columbus Dispatch* reported that 28 people were indicted in federal court in Cleveland on several charges, including conspiracy and cocaine dealing. Allegedly, the 28 were involved in smuggling \$6 million worth of cocaine to Ashtabula County via a stash house (house used for drug storage and distribution) in Eastlake (www.dispatch.com, March 15, 2011). In June, *The Plain Dealer* reported that Cleveland Police found 16 kilograms of powdered cocaine in a disabled tractor-trailer on Interstate 77 in the city (www.cleveland.com, June 8, 2011).



Participants agreed that user demand for powdered cocaine is driven by the desire to obtain powdered cocaine to make into crack cocaine (a.k.a., “rocking it up”), allowing users to improve the quality of their crack cocaine. There was agreement that dealers are more tightly controlling the supply of powdered cocaine because of this trend. A participant reported, *“Everybody’s cooking it [powdered cocaine] up, making more money off crack [cocaine]. You can double your money. That’s why it’s harder to get.”* However, most participants reported that the availability of powdered cocaine has remained the same over the past six months. Law enforcement professionals also reported that availability has remained the same over the past six months. BCI Richfield crime lab reported that the number of powdered cocaine cases it processes has remained stable.

Most participants rated the quality of powdered cocaine as ‘5’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the previous most common score was ‘7’. Participants supplied a range of quality scores because the quality of powdered cocaine was said to be inconsistent and varied widely. As one participant explained, *“[Quality of powdered cocaine] changes so much, you never know. You can go one time and get a ‘10’ [highest quality score], then go again and get a ‘2.’”* Participants reported that powdered cocaine in Cleveland is cut (adulterated) with baby aspirin, baby formula, baby laxative, caffeine, hallucinogens, inositol, methamphetamine, Orajel® and PCP (phencyclidine). Participants reported that the overall quality of powdered cocaine has decreased over the past six months. Some participants speculated that as supply fluctuates, powdered cocaine is cut more with other agents. BCI Richfield crime lab continues to cite the following substances as commonly used to cut powdered cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), procaine and lidocaine (local anesthetics) and caffeine.

Current street jargon includes many names for powdered cocaine. The most commonly cited names were “blow” and “girl.” Participants listed the following as other common street names: “chowder,” “snow,” “soft,” “toot” and “white girl.” Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine, and prices tended to be higher in rural areas in the east and west of the region. Participants reported that a gram of powdered cocaine sells for \$40–\$120, depending on the quality; 1/16 ounce, or “teener,” sells for \$60–\$100; 1/8 ounce, or “eight ball,” sells for \$120–\$200; an ounce sells for \$700–\$2,000. Users reported that the price for higher quality powdered cocaine is increasing, possibly due to higher demand. Participants reported that the most common way to use powdered cocaine remains intranasal inhalation (snorting). Out of 10 powdered cocaine consumers,

participants reported that, on average, approximately five would snort it, three would intravenously inject it or “shoot it,” and another two would smoke it. It should also be noted 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 used for the freebase smoke method. Participants also stated that the method for using powdered cocaine is largely governed by a user’s method for his or her drug of choice: *“People that shoot [inject] other drugs are more likely to shoot this drug [powdered cocaine]. People are typically not just doing powder [cocaine]. It’s usually one of multiple drugs they are using.”* No participants indicated that powdered cocaine as their primary drug of choice.

A profile for a typical powdered cocaine user did not emerge from the data. Participants described typical users of powdered cocaine as young, old, of all incomes and races. The conventional wisdom that held that powdered cocaine was a “rich man’s drug” was negated by participants. One participant explained, *“To me they [powdered cocaine users] come in all shapes, forms, sizes and colors. The drug itself doesn’t discriminate. They say it’s a rich man’s drug, but I’ve seen it in the poorest neighborhoods and in the richest, and it’s the same all around.”* There are some generalities that can be made about powdered cocaine use: Younger users are more inclined to “speedball” (inject a combination of heroin and cocaine) and are more inclined to use powdered cocaine with marijuana. Older users (≥ 50 years), and wealthier users prefer to snort powdered cocaine, more so than smoking or shooting. One participant explained drug administration this way, *“It depends on the class of the person, whether or not they’re smoking or snorting [powdered cocaine]. People with money that I knew do not want to smoke drugs.”*

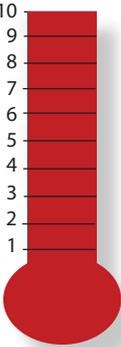
Reportedly, powdered cocaine is used in combination with alcohol, Ecstasy, heroin, marijuana and sedative-hypnotics. Specifically, heroin users will use powdered cocaine to “come back up,” as one participant explained, *“Personally, in my age group, junkies [heroin addicts] will use it [powdered cocaine] to come back up.”* When powdered cocaine is abused and sleeping becomes difficult, users will turn to sedatives or alcohol to “come back down.” Bar-goers who have consumed too much alcohol will often use powdered cocaine to “sober up.” A participant explained, *“A lot of people use [powdered] cocaine if they drank too much [alcohol] at the bar and don’t want a DUI- to straighten up the drive home. That’s bar people, regardless of age.”*

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' (high availability, extremely easy to get). Participants described crack cocaine as one of the easiest drugs to acquire. Law enforcement also rated the availability of crack cocaine as high, reporting availability as '9'. The most common participant quality score for crack cocaine was '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut (adulterated) with other substances. BCI Richfield crime lab cited as cutting agents: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine. Participants reported 1/4 gram of crack cocaine sold for \$40; 1/8 ounce, or "eight ball," sold for about \$150. The majority of crack cocaine users reported buying the drug in small quantities ("20 rocks" for \$20). 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, and 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'. Unlike other drugs, crack cocaine is readily available from unknown dealers at street corners. Several participants echoed these sentiments: "You can go to every corner, and someone's hollering to you [to buy crack cocaine]; You can go to that street corner and get it [crack cocaine, pointing to a corner outside the window of the interview location]." While crack cocaine has remained perennially available in the City of Cleveland, law enforcement and treatment professionals in rural southern and eastern locales of the region most often reported the drug's current availability as '9', indicating that crack cocaine is just as available in these areas. Participants overwhelmingly agreed that the availability of crack cocaine has remained the same over the past six months. A participant said, "The [crack cocaine] availability of six months ago is the same. Things just don't change." Law enforcement officers reported that the availability of crack cocaine has remained high over the past six months, but

that the urgency to respond to crack cocaine has been eclipsed by the emergence of other drugs such as heroin and prescription opioids. A law enforcement officer said, "Two years ago it [our focus] was crack cocaine ... It's [crack cocaine] still out there, and we still can buy it." BCI Richfield crime lab reported that the number of crack cocaine cases it processes has remained stable over the past six months.

Most participants rated the quality of crack cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '7'. Most participants agreed that the quality of crack cocaine sold on the street is very poor: "You can get it [crack cocaine] anywhere. As far as quality—the last time I smoked it, it was garbage. But I still felt the need to chase it. I called back my dealer and he just laughed. It had PCP in it. But, did I buy some more? Yeah, I did." Participants reported that crack cocaine is cut (adulterated) with large amounts of baking soda, and other elements that increase the size of each rock such as baby formula, vitamin B-12 and yeast. Participants reported other substances used to cut crack cocaine to include: acetone, ammonia, ether, heroin, kerosene, Orajel® and PCP (phencyclidine). Over the past six months, participants reported that the quality of crack cocaine decreased. Referring to the quality scale above, a user stated, "I've seen guys get stuff [cocaine] in that was a '7'. By the time they get done poofing it up it's a '2.'" In an effort to improve the quality of crack cocaine, many users "re-cook" the drug to eliminate impurities: "Users get less, they're cooking it [crack cocaine] down when there's too much soda in it, that's when they cook it down to get the purity." A user reported, "They [dealers] use the baking soda to stretch it [cocaine]. Sometimes they use the ether to cook it [crack cocaine]. You cook it and it drops down to little or nothing. Because nowadays [dealers keep] the 'good good.'" BCI Richfield crime lab continues to cite the following substances as commonly used to cut crack cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetics) and caffeine.

Current street jargon includes many names for crack cocaine. The most commonly cited names remain "hard" and "rock." Participants listed the following as other common street names: "boulders," "crack," "girl," "stones" and "work." Current street prices for crack cocaine were consistent among participants with experience buying crack cocaine. Participants reported that crack cocaine is still sold in \$10, \$20 and \$50 units, which vary in size and are seldom measured by users. Typically, a \$20 rock was estimated to be .2 grams, and a \$10 rock was half of that. Participants said dealers will also sell "crumbs" for a few dollars. One user said an "orange" was a \$50 rock, and another user referred to an "onion" as an ounce. Larger quantities of crack cocaine were

also available: 1/8 ounce, or “eight ball,” sells for \$100–\$220; an ounce sells for \$800–\$900.

While there were a few reported ways of administering crack cocaine, generally, the most common route of administration continues to be smoking. Out of 10 crack cocaine users, participants reported that approximately nine would smoke, and one would intravenously inject or “shoot” crack cocaine. Injecting crack cocaine is related to a user’s previous experience with needle use: *“There’s a lot of people that smoke [crack cocaine] that don’t shoot [inject]. I think you almost have to be a shooter first. Most people don’t roll up and buy a 20 piece and shoot. They roll up and smoke. Unless they’re already shooting something else.”*

A profile of a typical crack cocaine user did not emerge from the data. Participants continued to describe typical users of crack cocaine as being of every age, race and socio-economic class. A law enforcement officer said, *“Years ago you could say heroin was with Dominicans and Hispanics. Crack [cocaine] was with African-Americans. Ecstasy was with White, younger kids. You used to say certain drugs were with different groups. Nowadays, it’s a free for all. That’s true for pills and street drugs.”*

Participants mentioned many combinations of drugs commonly used with crack cocaine. Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana and sedative-hypnotics to “come down” from the high of crack cocaine. A participant reported, *“If you’re shooting crack [cocaine], it goes with heroin. If you’re smoking crack, it goes with alcohol.”* Sometimes methamphetamine is mixed with crack cocaine to augment its poor quality. In addition to “primo,” which is a combination of marijuana and crack cocaine, users mentioned “love boat” and “wet” to denote a combination of crack cocaine and marijuana dipped in PCP, which is dried and then smoked. Many users also indicated that crack cocaine is being purchased in small amounts more frequently by heroin users who are unable to obtain powdered cocaine required to “speedball” (mixture of heroin and cocaine for concurrent use). A participant reported, *“When shooters [heroin addicts] can’t find powder cocaine they’ll go buy a rock [crack cocaine] and melt it down because it’s hard to get powder cocaine in a small amount for a speedball.”*

Heroin

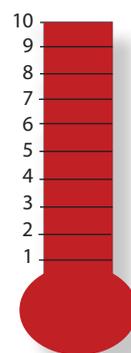
Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants most often reported the drug’s availability as ‘10’ and law enforcement as ‘9’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). There was agreement among

participants and community professionals that heroin was as available as crack cocaine. However, several participants noted that heroin’s availability was relative to one’s drug connections. Law enforcement agreed that while there was plentiful supply, the network of heroin dealers and users was much smaller than for other drugs (crack cocaine). *The Plain Dealer* quoted the U.S. District Attorney for the Northern District of Ohio as saying that heroin was the fastest growing drug problem in the region. The most common type of heroin available was brown powder. Some participants also reported having encountered white powder. Black tar heroin, on the other hand, was reportedly rare. Participants cited a link between prescription opioid abuse and an increase in heroin use. Participants noted that heroin was cheaper to buy than prescription opioids. The most common participant quality score for heroin was ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). BCI Richfield crime lab reported that heroin was “very pure,” and occasionally cut (adulterated) with diltiazem (medication used to treat heart conditions/high blood pressure). Participants reported a gram of heroin ranged in price from \$45–\$150. Many participants reported buying heroin bundles, consisting of eight to 10 bags, ranging in price from \$80–\$100, which equates to \$10 per bag (bags were reported to be 1/10 gram). Participants agreed that injection of heroin was the preferred route of administration by 80–90 percent of heroin users, with snorting being the second-most popular method. Participants and community professionals agreed that heroin was gaining popularity among younger users, especially high school teens and very young adults. Participants mentioned overdose more frequently with heroin than with any other drug in the survey.

Current Trends

Heroin remains highly available in the region. Participants most often reported overall 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’. Almost all participants stated that heroin was easy or very easy to get. A participant reported, *“I’m from Detroit, and I was here in Cleveland, and in one day I found drugs [heroin].”* Law enforcement and treatment providers most often reported the drug’s current availability as ‘8’; the previous most common score was ‘9’. When asked to identify the most urgent or emergent drug trends in their purview, all professionals indicated that heroin is a concern for their service population. Law enforcement in Medina County reported, *“Availability is very easy to get ... 95 percent of what we buy [heroin] is in the powder form. We have a few*



chunk or rock [heroin buys]. I can only remember one black tar [heroin buy] but most of it's brown [powdered heroin]. Really fine consistency ... It's not manufactured in this area. It comes in smaller quantities here from a big city—Chicago and Akron."

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 across both the east and west sides and within the City of Cleveland. Participants rated brown powdered heroin's availability as '10'. Reportedly, black tar and white powdered heroin can also be had, but require closer connections to obtain and are dependent on the user's location. Outer suburban east side users reported the occasional appearance of a gray form of powdered heroin. Black tar heroin is also reportedly scarcer than the other two forms, especially on the east side. One former dealer described the origins of each form as thus: "*Tar [black tar heroin] is on the west side. White powder and light tan/brown [powdered heroin] on the east side. If it is brown on the east side, it is cut [adulterated] with something. It [heroin] ranges from cocaine to peanut butter in terms of consistency--that depends on what they're [dealers] doing with it.*" West side law enforcement professionals agreed that brown powder tends to originate from the east side, with one agent stating: "*It's always tan or brown heroin in this area. Yes, this is easy to get. You generally have to make the phone call first. We used to see the Dominican or the Hispanic dope [heroin], and now we see African-American heroin from the east side ... Cleveland chapters [dealers] are responding [delivering heroin] to west sides ... much as they would deliver a pizza.*"

Collaborating data also indicated that heroin is highly available in the region. The Cuyahoga County Coroner's office reported heroin as the most common drug present in drug-related deaths (the previous most common drug was cocaine); it was present in 37.1 percent of all drug-related deaths (this is an increase from 28.2 percent for the previous six-month reporting period). In addition to the coroner's data, regional media outlets reported on heroin-related deaths and arrests involving heroin trafficking this reporting period. In April, *The Morning Journal* reported on two separate heroin-related deaths in Lorain which had local police "*concerned that a bad or particularly powerful supply of heroin is circulating in the area*" (www.morningjournal.com, March 30, 2011). The article also cited the Lorain County Coroner as reporting that there were an additional two deaths in the county previous to the two recent deaths which were also suspected heroin overdoses. In April, *The Morning Journal* reported that police stopped one source of "bad" heroin coming into the region with the arrest of two local men; allegedly the men were bringing in heroin from

out of state and were found to have \$25,000 worth of heroin (www.morningjournal.com, April 12, 2011).

Participants were equally divided on their opinions on whether the availability of brown powdered heroin has increased or remained the same over the past six months. Those who felt heroin is more available reasoned that increasing availability is due to 1) increased demand among younger users, 2) prescription opiate abuse and 3) pressure from dealers who desire to switch their clients from crack cocaine sales to more-profitable heroin. Said two users about this phenomenon: "*The new dealers, they have a baggy full [of heroin] and they'll just take a whole lot of junk, make up a piece of paper and throw it in. No measuring, they just give it away; I did [high-quality heroin] and I didn't want any crack [cocaine]. My dealer was trying to hook me on heroin.*" Another participant said, "*People started doing OxyContin® and opiates and getting hooked on it, and the withdrawals are really bad. People were introduced to heroin, and the dealers saw it as an opportunity.*" Law enforcement and treatment providers reported that the availability of heroin has remained highly available over the past six months. A provider reported, "*It's [heroin] easy to get, and it's cheap, so we're seeing it more in the poorer population because it's affordable. Someone said to me [that] the people that used to smoke crack [cocaine] are now using heroin because it's cheap.*" BCI Richfield crime lab reported that the number of powdered heroin cases it processes has increased, reporting having processed approximately 1,500 heroin cases over the last six months up from 803 cases for the previous reporting period. The number of heroin cases has surpassed the number of marijuana cases, making powdered heroin the most processed drug through BCI Richfield crime lab. The lab reported a decrease in the number of black tar heroin cases it processed over the last 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 previous most common score was '10'. Participants reported that heroin in Cleveland is cut (adulterated) with cocaine, fentanyl, paregoric (antidiarrheal agent), prescription opioids (OxyContin®), sleeping pills and vitamin B. A participant called heroin cut with fentanyl, "Mac 22." BCI Richfield crime lab cited procaine and lidocaine (local anesthetics) as commonly used to cut powdered heroin. Fake heroin was also more commonly reported as being bought by law enforcement agents. Over the past six months, participants reported that the quality of heroin has varied, even when purchased from the same source. Participants were equally divided on their perceptions of heroin quality improving, decreasing, or remaining the same, but most users agreed that high-quality, potent

heroin is available at times. A participant said, *“Stuff [heroin] was stronger the last few times I was doing it. It was just all of a sudden. I was doing half of what I was normally doing and falling out from it.”*

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: “brown,” “H,” “horse,” “smack,” “stamps” and “tickets.” Participants reported that brown powdered heroin is available in different quantities. The most common units are small “bags,” which contain a small amount used for one “hit” (1/10 gram folded in corners of a piece of paper to keep the heroin from sticking to the baggie). These sell for \$10, with larger bags selling for \$20–\$30 for double and triple hits. Participants also reported buying heroin in “bundles” (10–12 small packs of heroin). Bundles ranged from \$80–\$120; a gram of brown powdered heroin ranged in price from \$60–\$225, depending on location and purity; 1/2 gram sells for \$60–\$80; 1/8 ounce, or “eight ball,” sells for \$400; an ounce sells for \$3,600. Overall, participants reported heroin pricing has fluctuated in the past six months. Said one participant about pricing: *“Mostly down [heroin pricing], on the east side, it’s \$180/gram, but it’s good. It’ll kill you though. I’ve never bought bags, but the bags and bundles are all garbage. On the west side, you can get it [heroin] for \$120/gram, depending on the quality. You’re going to pay more for good stuff.”* Participants reported that the most common way to use heroin is intravenous injection, or “shooting.” Out of 10 heroin consumers, participants reported that approximately nine would intravenously inject it, one would snort it, and none would smoke it. Many users noted the pill progression to heroin: users begin with prescription opioids, move to snorting heroin, then progress to shooting heroin. This was observed to be an extremely popular trend among those aged 16–30 years. When asked if younger users new to heroin would begin with injecting the drug, participants reported: *“I never snorted heroin or pills. I went straight to shooting when my friend introduced me to it [heroin] and was a shooter; Some of the younger kids are now shooting up [heroin] out the gate. Some of them never did a line of coke [cocaine]; I shot up heroin before I ever started snorting oxy [OxyContin®]; Where I live, because I’m 18, everyone starts with pills and snorting heroin and then they’ll start shooting. I’ve never seen anyone starting with shooting.”*

A profile of a typical user of heroin did not emerge from participant data. Participants reported that typical users of heroin could be of any age, any race, and typically lower socioeconomic levels. Although, two types of new users to the drug were identified. Those included persons who become addicted to pharmaceuticals, such as those that have experienced an injury and young people who

experiment with pills. A participant reported, *“Seems like it’s absolutely everyone. Everywhere you look. It’s any race at all. It really doesn’t matter at all. It seems like lately the younger people have been using a lot more heroin, but it also seems like something an older person would do. Lately, it’s getting younger and younger. I’ve heard of 13 year olds shooting up.”* Another user said, *“When I was in a residential treatment facility . . . December [2010], it was all 18, 19, 20 year olds who started with the pills, then they were all on heroin. Shooting is more common; the younger people are just starting off shooting it.”* Professionals noted an increase in younger users. A law enforcement officer reported, *“Heroin is becoming something that the younger generation is picking up in the upper- and middle-class. It caters to those people right now who have more money to get it. It’s the kids of middle- and upper-class people that are doing it.”* Another said, *“Snorting [heroin] is easier, and [younger users] don’t need a kit. They take mom or dad’s car and there’s no trail left behind. You smoke marijuana there’s a trail left behind. If you take a pill or snort heroin, you need absolutely nothing.”* Law enforcement officers agreed in the description of the heroin users they encountered: *“Most of our people [heroin users] are of lower socioeconomic status. There are plenty of them in the upper echelons of society, but we don’t end up finding that person all the time. It’s primarily Caucasians. We don’t see a lot of African-Americans using it. Heroin doesn’t seem to be their thing. They might be dealing it some, but we don’t see a lot of [African-American] people using it and catching them.”*

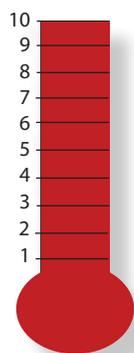
Reportedly, heroin is used in combination with alcohol, crack cocaine, ketamine, marijuana, powdered cocaine, prescription opioids (methadone, OxyContin® and Percocet®) and sedatives-hypnotics (Valium® and Xanax®). Stimulants such as crack cocaine are used to “come up” off heroin, and other opioids are used to stave off withdrawal symptoms when heroin cannot be obtained. Many users mentioned “speedballing” (combining heroin and cocaine) as a common practice for some heroin users. One law enforcement official remarked about overdose/ambulance responses in the area: *“We’ll get an ambulance respond, and sometimes it’ll be a heroin overdose, sometimes at traffic stops. Not a whole lot. But sometimes we’ll get it with the medical squad . . . We have speedball occasionally too. More often they don’t know what they’re doing or they take too much. A lot of new users don’t know what they’re doing, and they’re playing with fire.”*

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants and treatment providers most often reported street availability of these

drugs as '9' or '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Reportedly, OxyContin® OC was once the most preferred prescription opioid, but this drug became scarce and more expensive after the manufacturer's replacement with a new formulation, OxyContin® OP, that resists use in any other method besides oral ingestion. Increased availability of prescription opioids was thought to be tied to an increase in demand from heroin addicts who often begin drug use with prescription opioids and continue to seek them in order to supplement their heroin addiction. Almost all groups noted that while these drugs were very available on the street through dealers, family and friends, they also had no trouble exploiting the legal avenues for medical prescriptions. Hospital emergency rooms, pain clinics and certain physicians were cited as reliable sources of pills. The most common methods of pill consumption were oral ingestion and intranasal inhalation (snorting). Participants reported some intravenous (IV) use, but this was mainly among IV heroin users. Law enforcement officers perceived that prescription opioids had become an explosive trend over the previous 24 months. While a profile of a typical heroin user did not emerge from the data, participants and community professionals noted a user's likely progression from use of prescription opioids to heroin.

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 '9' or '10'. Participants identified OxyContin® OP, Percocet® and Vicodin® as the most available prescription opioids in terms of widespread use. OxyContin® OC (the discontinued crushable form) continues to become more difficult to obtain. A participant reported, "Oxy's [OxyContin® OC] are harder to get now.

Percocet® is really easy; Vicodin® is easy; in general they are easy to get." Law enforcement and treatment providers agreed that the aforementioned three drugs are the most popular prescription opioids in terms of widespread use. Community professionals most often reported the current availability of Vicodin® as '9', Percocet® as '9' and OxyContin® OP as '8'. A law enforcement officer said, "I think the primary ones being used by the street level users are Percocet®, Vicodin®, OxyContin®. Oxy's [OxyContin®] are a little more expensive, so people are moving down to vikes [Vicodin®] and perc's [Percocet®].

And those are the three I see. That's what I'm picking out of people's pockets left and right. They're a given in any traffic stop." Opana® and methadone were cited as up-and-coming opioids that are gaining in popularity. A participant summed up multiple opinions, "I have a hard time finding oxy's [OxyContin® OC]. Opana®s—those are like oxy's [OxyContin® OC] now [highly desirable]." A law enforcement undercover agent agreed that Opana® is growing in popularity: "We're just starting to see Opana's® coming into the picture. You ask me about it in a couple months it may be an '8' [availability rating]. For now, it's a '5.'" Collaborating data also indicated that prescription opioids are highly available in the region. The Cuyahoga County Coroner reported prescription opioids as commonly present in drug-related deaths; they were present in 35 percent of all drug-related deaths (this is an increase from 29 percent for the previous six-month reporting period).

Participants reported that the availability of prescription opioids has remained the same over the past six months, that is, extremely available. Exceptions were noted for OxyContin® OC, which were reported to be much less available, as reported by one participant: "[OxyContin® OC] are harder to get. There are so many [law enforcement people] looking at that now because so many prescriptions are wrote, things like that. So, that's why it's getting harder." Law enforcement and treatment professionals reported that availability of prescription opioids has increased over the past six months. A drug task force administrator stated, "We've seen an increase, a tremendous increase in our area. We bought pills [prescription opioids] last year 121 times, 60 or so the year before. There's been a tremendous increase in availability on the streets this year. The diversion unit is looking at the gamut: housewives, husbands, nurses." BCI Richfield crime lab reported that generally, the number of prescription opiate cases it processes has remained stable; a noted exception was a decrease in the number of OxyContin® cases over the past six months.

Reportedly, many different types of prescription opioids (a.k.a., "pharmies," "skittles" and "willies") are currently sold on the region's streets. Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Darvocet® (\$1–\$2 per pill), Dilaudid® (\$40–\$50 per pill), fentanyl (50 mg patch sells for \$25–\$30; 100 mg patch sells for \$50), methadone (10 mg sells for \$5; 40 mg wafer sells for \$20–\$30), Opana® (\$.50–\$1.75 per milligram), OxyContin® (a.k.a., "oxy's"), OxyContin® OC (old formulation, a.k.a., "chairs," "OC's," "old couches," "Orange County," "oscars" and "tall ones," \$.75–\$1.50 per milligram), OxyContin® OP (new formulation, a.k.a., "OP's," \$.25–\$.50 per

milligram), oxycodone (a.k.a., “roxies;” 30 mg sells for \$30), Percocet® (a.k.a., “cets;” “perkys;” “pennies” and “perc’s;” 5 mg sells for \$.50–\$.75; 10 mg sells for \$3–\$10), Tylenol® 3’s and 4’s (\$.25 per pill), Ultram® (a.k.a., “trams” and “trammies;” \$0.50–\$.75 per pill); Vicodin® (a.k.a., “V’s;” “vikes” and “vikies;” 2.5 mg sells for \$.50–\$.75; 5 mg sells for \$3–\$5; 7.5 mg sells for \$5–\$7; 10 mg sells for \$5–\$7).

In addition to obtaining prescription opioids on the street from dealers who buy prescriptions and from friends, participants also reported that their primary resource in getting prescription opioids remains from doctors at pain clinics and emergency rooms. Many participants knew of specific physicians who write prescriptions for cash. A participant reported, “I know the doctor will give it [prescription opioids] to you for a hangnail. The doctors are guilty of the whole thing.” Counseling professionals and police officers agreed with this assessment: “If doctors are prescribing them [prescription opioids] less, than how could they become more available? How could they be more available if they’re doing their due diligence?” Another treatment provider said, “I myself went to the doctor for a slight back problem. He prescribed me something that took me two days to recuperate from. I took one pill [prescription opioid], and I couldn’t function. I think we’re looking too much at pills. All you see on TV is commercials for pills.” A police officer reported, “The prescriptions for a dental procedure will be written for 30 or 40 pills [prescription opioids] when a person would need a day or two. The rest are sold. The other thing is that kids will pass them around, they see them as harmless. It’s from a doctor—it’s medicine, and safe to take. So they pass them around to their friends.”

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 continues to be oral ingestion, either chewing or swallowing. Out of 10 prescription opioid users, participants reported that approximately five would take them by mouth, three would use intranasal inhalation, or “snort” them, and that two would inject them. Users also mentioned that dealers provide guidance to users on various routes of abuse. Differences were noted based on medication formulation (liquid, pill and wafer), and the nature of the drug’s effect on the body. A participant reported: “If it’s like oxy’s [OxyContin®] or Opana®, eight [users] will probably snort. Low end pills like little Percocet® or Vicodin®—those [users] are probably all swallowing.” Participants also continued to note difficulty manipulating the new OxyContin® OP formulation. A participant stated, “OxyContin® OP, they [users] try to put them in the freezer and snort them. I’ve seen people sit there and experiment with them for days.”

A profile of a typical user of prescription opioids did not emerge from the data. Participants and community professionals described users of prescription opioids as from every socioeconomic income level, all ages and all races. A participant said, “I saw people using pills [prescription opioids] I never would have thought do pills; houses in Shaker Heights, the lady doing pills there.” A law enforcement officer reported, “I see a lot with pills [prescription opioids]. It’s a mix of people 18–80 [years old], deaf, dumb or crippled ... Seriously, everybody’s doing it.” Another officer said, “In the past you could say ‘typical’ [prescription opioid user]. You could, but now there are no racial, age, walks of life barriers. Adults are specifically looking for a type of pill; whereas, the juveniles are looking for everything and anything.” Participants, law enforcement and treatment providers all cited two types of new users: people who have suffered a physical injury and then develop a dependency, and young people under 25 years of age. A treatment provider said, “If they had a legitimate pain and they went to a doctor who prescribed them something ... then they become dependent [on prescription opioids]. Then the doctor says, ‘I’m not prescribing it anymore; and they have to turn somewhere. In my mind, I think of middle-aged women and men, who have arthritis who are now dependent.”

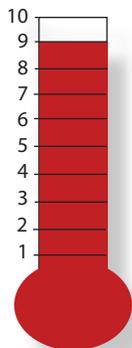
Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, crack cocaine, marijuana, powdered cocaine and sedative-hypnotics. Combining prescription opioids with these drugs is common, as the effects of prescription opioids are said to enhance the effects of the other drugs. Heroin users had more familiarity with prescription opioids because they reported using both types of drugs on a regular basis. Said one participant about why some users inject opioids, “Because they’re doing heroin, and if they didn’t have heroin, they’d shoot up [inject] OxyContin®.”

Suboxone® Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported street availability of Suboxone® as ‘8’ or ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Although Suboxone® was reportedly available through legal prescription channels as well as through illegal purchase, participants in both participant and law enforcement groups had limited knowledge of Suboxone®. Most participant experience with and knowledge of Suboxone® derived from legal prescriptions. A minority of the law enforcement personnel reported having experience with arrests involving the drug. Participants most frequently reported the price for Suboxone® 8 mg as \$15. Participants and police officers alike reported that Suboxone®

was most often used illicitly by those addicted to heroin. Consensus among participants was that those addicted to opioids mostly seek the drug, only on the occasions when their preferred opiate was unavailable in order to avoid withdrawal. Reportedly, the most common method of administering Suboxone® was sublingually, as directed.

Current Trends



Suboxone® remains highly available in the region. Participants most often reported the street availability of Suboxone® 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' or '10'. While only a small number of participants had knowledge of the drug, only one participant reported that Suboxone® is difficult to obtain. Other participants echoed comments such as the following regarding the availability of Suboxone®: "They're everywhere. Get them [Suboxone®] from doctors, friends. They're

[doctors] giving it to everyone." Narcotics agents most often reported the drug's current availability as '8'. Their opinions aligned with drug consumers about how easily Suboxone® can be obtained: "It's not hard to get [Suboxone®] because there are so many people addicted to heroin. They're [heroin addicts] getting Suboxone® and turning around and selling it; There used to be only six doctors in northeast Ohio that can prescribe [Suboxone®], but now a lot of regular family doctors can prescribe. They are available on the street and outside the pharmacy door as well." Participants, law enforcement and treatment providers reported that the availability of Suboxone® has remained stable over the past six months. BCI Richfield crime lab reported that the number of Suboxone® cases it processes has increased over the past six months.

Street jargon for this drug was not reported. Participants indicated that Suboxone® 2 mg sells for \$7–\$10; Suboxone® 8 mg sells for \$5–\$25; two strips sell for \$25. A narcotics officer remarked on the relative price of Suboxone®, "Occasionally we see Suboxone® abuse. That's rare because it's available for treatment. We do have complaints every now and then. But you can't get the dollar amount for the Suboxone® that you can for the OC's [OxyContin® OC] and Vicodin® or perc's [Percocet®]. If they [users] can't get them [prescription opioids], they'll get Suboxone® occasionally." Out of 10 Suboxone users, participants reported that, on average, approximately 5.5 would take it by mouth as indicated, 3.5 would snort it, and one would intravenously inject it or "shoot it." Intravenous use of this drug is considered by those with experience to be less-desirable than other methods, with one participant

stating, "There's always one idiot who tries to shoot [inject] Suboxone®."

Suboxone® continues to be primarily acquired from doctors, friends and dealers. Few participants in each session had in-depth knowledge about Suboxone®, but among those that did, they cited the drug as widely available from other heroin users and/or from heroin dealers. Participants reported, "People pick up prescriptions [for Suboxone®] and call [their dealer] and sell them; Seems like it's [Suboxone®] available through friends."

A profile for a typical Suboxone® user emerged from the data. Participants described typical users of Suboxone® as heroin users who are trying to avoid withdrawal symptoms when heroin cannot be obtained. A participant said, "If you're trying not to get sick, you use Suboxone®." Law enforcement agents agreed: "Users are the people that are getting busted and then being forced into treatment. They've hit rock bottom, gone to treatment, get a script [prescription] for Suboxone®, then they end up selling or abusing [Suboxone®]." Another officer said, "Is this [Suboxone® use] limited to heroin abusers? Yes. You don't see new users with this."

Reportedly, Suboxone® is used in combination with crack and powdered cocaine, marijuana and sedative-hypnotics (Xanax®). A participant commented on how abuse conflicts with the intended purpose of the drug: "People use marijuana and Suboxone® ... But you're [supposed to be] trying to get off of dope when you're taking it [Suboxone®]."

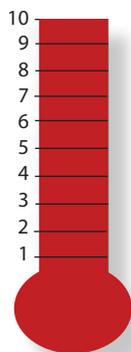
Sedative-Hypnotics

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' (high availability, extremely easy to get). Participants listed the most common sedative-hypnotics in terms of widespread use as Klonopin®, Soma®, Valium® and Xanax®. There was little consensus among participants about the change in availability over the previous six months; participants on the east side of Cleveland thought that availability had decreased while participants on the west side thought that availability had remained the same. Participants did not report buying sedative-hypnotics from street dealers. Most frequently participants obtained sedative-hypnotics from friends,

family members and physicians. Participants also noted that physicians seemed inclined to prescribe these pills to anyone who requested them, even to patients involved in inpatient and outpatient drug treatment programs. The most common routes of administration were oral consumption and intranasal inhalation (snorting).

Current Trends



Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain 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'. More specifically, participants most often reported the availability of Ativan® as '10', Klonopin® as '8', Soma® as '10', Valium® as '10' and Xanax® as '8'. Participants identified Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Law enforcement

and treatment professionals did not cite sedative-hypnotics to be either a newly urgent or emergent drug class, although they did express this drug class is a constant enforcement challenge. As one police officer explained, these drugs are widely available: "Adderall® and Xanax® are pretty common. Undercover operatives buy crazy amounts of that stuff right now. All you gotta do is ask." Collaborating data also indicated that sedative-hypnotics are highly available in the region. The Cuyahoga County Coroner's office reported sedative-hypnotics as a common drug present in drug-related deaths; they were present in 30.8 percent of all drug-related deaths (this is an increase from 21.8 percent over the previous six-month reporting period). Participants reported that the availability of sedative-hypnotics has remained stable over the past six months. One participant observed, "It's like [sedatives] came back around ... It seems like people that used to smoke crack cocaine, they're on Xanax® now. They're taking them now to be cool. But it's a drug, and they're getting them from the doctor." BCI Richfield crime lab reported that the number of sedative-hypnotic cases it processes has remained stable over the past six months.

Reportedly, many different types of sedative-hypnotics (a.k.a., "downers" and "willies") 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® (\$2 per pill), Ativan® (\$1–\$2 per pill), Klonopin® (\$2 per pill), Lunesta® (\$3 per pill), Soma® (a.k.a., "same old same old;" \$2 per pill), Valium® (a.k.a., blue guys"

and "V's;" \$1–\$3 per pill), Xanax® (a.k.a., "footballs" and "xani's;" 0.25 mg–1 mg sells for \$2–\$4; 2 mg, a.k.a., "bars," sells for \$3–\$5). While sedative-hypnotics may be 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. A participant explained getting his drugs this way, "For [sedative-hypnotic] pills you don't just go down the street to ask. If you know the person [dealer] well enough, you go to their house. They're not like a crack [cocaine] dealer you can just see on the street." Law enforcement talked about how easy it is to get sedative-hypnotics prescribed by a doctor: "They [users] get prescribed so many [sedative-hypnotics] from the psychiatrist, they sell them. They can't take them all, so they sell them ... just get rid of the extra for extra cash."

While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, the most common routes of administration remain oral consumption and intranasal inhalation (snorting). Out of 10 sedative-hypnotic users, participants reported that on average, seven would take them by mouth, and three would snort them. Reportedly, intravenous injection of sedative-hypnotics is rare except for Xanax®, which heroin users are said to inject. A participant observed the connection: "I'm seeing more Xanax®. People want it for the heroin come down a lot more."

A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants could not describe a typical user of sedative-hypnotics that are said to be widely used by all groups of people. Part of the widespread appeal for sedative-hypnotics is their low cost: "Everybody is using these pills [sedative-hypnotics]. You could take two V's [Valium®] for like \$4 and be good for the rest of the day. It's a cheap high." However, when asked if this was a drug group particularly favored by younger users, a participant disagreed, saying, "I think it's a mix 50/50 [old/young]. You can't really say an age group."

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, crack cocaine, heroin and marijuana. Two participants commented on this phenomenon: "Most people buy benzos [benzodiazepines] to come down from other drugs that they took before; They use it [sedative-hypnotics] to boost the cocaine, same thing with heroin."

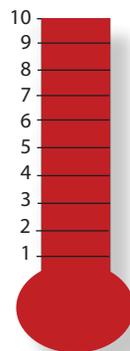
Marijuana

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' (high availability, extremely easy to get). Participants described marijuana as being extremely easy to get, available on nearly any street corner or available within minutes of a phone call to a dealer. BCI Richfield crime lab reported that marijuana cases made up the greatest proportion of drug cases it reviewed over the previous six months. Participants reported that the quality of marijuana varied from '7' to '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that a marijuana "blunt" (single cigar) sold for \$5 and 1/2 ounce of marijuana sold for \$45–\$100, with high-grade marijuana at the upper end of that price range. The most common route of administration for marijuana was smoking. Participants were not able to establish a profile for the typical user, and they explained marijuana use was so common that it defied limitation to one type of user, age group or race.

Current Trends

Marijuana remains highly available in the region. Every participant that supplied a score 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'. A participant said, *"It's easy to get [marijuana]. Very easy. You can get it 24/7."* Law enforcement and treatment providers also unanimously reported the drug's current availability as '10'. One professional quipped, *"If it was on your [availability] scale, it's [marijuana's current availability] an '11' or a '12.'"* Participants and community professionals reported that the availability of marijuana has remained the same over the past six months. However, higher quality marijuana was reported to be more available by both drug consumers and professionals. Media reports from the region reported several marijuana busts over this reporting period. In March, *The Plain Dealer* reported that during a routine traffic stop, the State Highway Patrol pulled over a Colorado man with \$1 million of high-grade marijuana. Police reported, *"The marijuana is an expensive kind that comes from British Columbia, Canada. It is one of the most potent strains of marijuana available, with a THC content of 30 percent compared with only 4 percent in traditional marijuana"* (www.cleveland.com; March 16, 2011). BCI Richfield crime lab reported that the number of marijuana cases it processes has remained stable over the past six months.



Several participants explained that the quality of marijuana depends on whether the user buys "regular weed" (low- to mid-grade marijuana) or hydroponically grown (high-grade marijuana). Participant quality scores of high-grade marijuana varied from '8' to '10', with the most common score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participant quality scores of regular-grade marijuana varied from '2' to '10', with the most common score being '10'. Many participants commented on the improvement of quality across both types: *"There's some pretty good weed [marijuana] out there. Pretty good quality!"* A law enforcement officer agreed, *"The quality of marijuana has been increasing. The group who's using marijuana, they're trying to get the better bud, the BC [British Columbia], Blaze, Fire—stuff that has higher THC levels. We've seen the quality increasing in the last six months."*

Current street jargon includes countless names for marijuana. Consumers listed the following as common street names for marijuana: "bottom browns," "dank," "dirt" and "swag" for low-grade marijuana; "B-sters," "commercial," "middies" and "merch" for regular or mid-grade marijuana; and "Bobby Browns," "diesel," "G13," "hydro," "ice princess," "kush," "lemon G," "northern G" and "northern lights" for high-grade or hydroponic marijuana. If high-grade marijuana was flavored, then it was sometimes also known by the flavor: lemon, mango and orange. The price of marijuana depends on the quality desired. Participants reported commercial grade marijuana is the cheapest form: a blunt (single cigar) or two joints (cigarettes) sell for \$3–\$5; 1/8 ounce sells for \$20; 1/4 ounce sells for \$30–\$40; an ounce sells for \$80–\$150; a pound sells for \$1,000. Higher quality marijuana ("hydro") continues to sell for significantly more: 1/8 ounce sells for \$50–\$60; 1/4 ounce sells for \$100–\$120; an ounce sells for \$320–\$380; a pound sells for \$3,000. A police officer stated, *"Now the quality [of marijuana] is better because these guys are getting smarter. Years ago it was 20 percent, now it's 30 percent or 40 percent THC."*

While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Out of 10 marijuana users, participants reported that on average, 10 would smoke it. Participants continued to mention oral ingestion of marijuana, specifically in brownies, butter, oils and creams. Notably, several participants mentioned 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. Many participants were unaware of the devices and professionals had not yet encountered them. A participant familiar with vaporizers explained, *"A vaporizer heats it [marijuana] just to the point below combustion where it releases THC, and it's not smoke. It doesn't break it down"*

like putting a flame to it. A lot more people are using those [vaporizers]."

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 participant observed, "It's kids to grandma and grandpa [who use marijuana]. Lawyers, cops, everyone." A discussion between treatment providers focused on the wide use of marijuana because it is not perceived to be harmful as other drugs: "I have a good couple, friends, we know; attorney, political consultant and they get high [on marijuana] three or four times a week." When asked whether the friends of the treatment professional smoked crack cocaine with marijuana, the treatment provider said, "No, that [crack cocaine] would be a 'hard' drug."

Reportedly, marijuana is used in combination with alcohol, crack cocaine, powdered cocaine, prescription opioids (OxyContin®) and PCP (phencyclidine). As noted in previous sections, marijuana is commonly combined with crack cocaine to create "primos." PCP use with marijuana (a.k.a., "love boat" and "wet") reportedly is not as common as use with crack cocaine, but it was mentioned by a few participants.

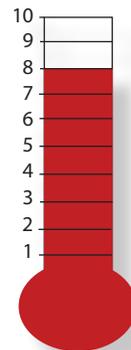
Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was reportedly rare in the region. None of the participants reported active methamphetamine use within the last year, and most were unable to offer an opinion about its availability. Only one participant had experience with methamphetamine, and he indicated that methamphetamine could be bought on Cleveland's west side. Law enforcement also had little experience with the drug. However, BCI Richfield crime lab reported that the number of cases of both powdered and crystal methamphetamine it processed had increased. Reportedly, the most common route of administration for this drug was smoking. Participants and law enforcement perceived use of methamphetamine to be limited to rural Whites, especially within the Appalachian region of Ohio.

Current Trends

Methamphetamine is highly available in the region. Few participants had knowledge of methamphetamine outside of Cuyahoga and Geauga Counties, but those with experience most often reported its availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). However, few participants

had personal knowledge of the drug, and the availability ranking was usually qualified by participants to mean that the drug is highly available to a limited number of users who are connected with a tight-knit network of methamphetamine dealers and users. A knowledgeable participant said, "You can get it [methamphetamine] in Berea, Medina, places like that. You got more labs out there with the home-grown meth [methamphetamine]." Participants reported that methamphetamine is available in powdered and crystal forms. A participant described the powdered form, "It [powdered methamphetamine] looked just like cocaine, a little chalkier than that." Several participants reported that users can find the crystal form of the drug: "I've seen it [crystal methamphetamine]: glass and ice. There's meth all over Cleveland, but there's different circles. They [methamphetamine users] don't talk about it, they don't share it. You either know people or you don't know anything about it." Another participant had not seen methamphetamine in Cleveland: "The meth I hear about is from Ashtabula [County]. I haven't been able to find it here and couldn't find any. Akron has tons of it." Law enforcement and treatment providers most often reported the drug's current availability as '4.' They agreed with the drug consumers' views about availability; they thought it was highly available, but only to a select few. Said one law enforcement officer, "If you ask somebody if you can buy meth, most people are going to tell you, 'no' because they don't have that connect ... You'd have to make a lot of phone calls if you don't know someone ... It's expensive and it takes that much work to get it. Most people aren't going to put that much effort into it." Participants reported that the availability of methamphetamine has remained the same over the past six months; whereas, law enforcement and treatment providers believed that the drug has become slightly less available recently. An officer noted, "We have it [methamphetamine], but it goes in waves. It's out there, but we haven't purchased it or seized it in about a year." Media outlets throughout the region reported on methamphetamine seizures during this reporting period. The *Times-Gazette* reported the "one-pot" or "shake 'n' bake" method for producing methamphetamine that has become popular in residential areas around Ashland and Loudonville. By using common household chemicals along with ammonium nitrate found in cold packs and pseudoephedrine (typically found in some allergy medications), users can cook the drug in two-liter bottles (www.times-gazette.com; Feb. 4, 2011). The *Plain Dealer* also reported that law enforcement met with the Amish in Wayne and Holmes Counties to discuss the rising methamphetamine problem coming into their communities. According to police, methamphetamine cooks are moving into these counties because they are less likely to be caught



due to the low population density. Law enforcement said they had found eight methamphetamine labs in Holmes County alone over that past 12 months (www.cleveland.com; May 7, 2011). BCI Richfield crime lab reported that the number of crystal and powdered methamphetamine cases it processes has increased over the past six months.

Only one participant was able to rate the quality of crystal methamphetamine, supplying a score of '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The participant noted that methamphetamine from another state was rated '10', saying, "You will get high off the meth [methamphetamine] here, but it's garbage. It's got more harmful chemicals in it ... I stopped getting it here [locally] because it's garbage, and who wants to keep spending that kind of money for garbage?" Over the past six months, the participant reported that the quality of methamphetamine has remained the same.

Current street jargon includes a few names for methamphetamine. The most commonly cited names were "glass" and "ice." Few participants had any experience buying the drug. A participant commented on pricing, "Good meth [methamphetamine from elsewhere] costs \$700 for an eight-ball worth. You can get [locally] about \$300 for an eight-ball." Reportedly, the most common route of administration for powder methamphetamine is intranasal inhalation, or snorting. Other routes of administration that were cited as less common included smoking and intravenous injection. A participant said, "I knew millionaires who snort meth. They love it. Then they go run a marathon."

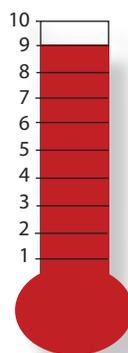
A profile for a typical methamphetamine user did not emerge from the data. A participant described typical users of methamphetamine as people with money who can afford a relatively expensive, high quality crystal methamphetamine. However, law enforcement and treatment providers thought that the typical user would more likely live in a rural area and be poor and White. An officer observed that a larger scale methamphetamine production operation would be difficult to establish in an area with high population density because it would be easily identifiable. The officer said, "Meth's [methamphetamine] more of a poor person's drug. Lower socioeconomic status. It's almost a rural drug in the sense that it's manufactured by people outside of the city [Cleveland] and county [Cuyahoga] cooking it in a trailer." Reportedly, methamphetamine is used in combination with alcohol, crack cocaine and heroin.

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 '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Both participants and law enforcement groups agreed that the drug was most commonly available in dance clubs, nightclubs and strip clubs. Law enforcement noted that distribution of Ecstasy was limited to a few dealers who dealt in very large quantities. Participants reported a "single stack" (low dose) Ecstasy tablet sold for \$3-\$7 and a "double stack" or "triple stack" (high dose) sold for \$10. The only route of administration noted was oral consumption. Law enforcement stated that the typical participant was younger (teenagers up to about 40 years of age), and that race did not seem to be a factor in the Cleveland area.

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 '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 '10'. Participants frequently commented that the drug continues to be regularly used in night clubs: "Yeah, you can get it [Ecstasy], but that is more available in clubs and stuff like that." Participants reported that the availability of Ecstasy has remained stable over the past six months. Law enforcement was split as to whether the drug's availability has remained the same, increased or decreased. An officer that reported a decrease in Ecstasy availability over the last six months said, "We don't see Ecstasy in traffic stops as much anymore. It's fallen by the wayside. I'm sure it's out there a lot, but we're not seeing it nearly as much. Today it's Ritalin®, Adderall® and Xanax®." BCI Richfield crime lab reported that the number of Ecstasy cases it processes has decreased over the past six months.

Current street jargon includes a few different names for Ecstasy. The most commonly cited name was "X." Participants named "skittles" as another common street name. Participants reported a "double stack" (high dose) Ecstasy tablet sells for \$10-\$15 and a "triple stack" (higher dose) sells for \$15-\$20. BCI Richfield crime lab cited methcathinone

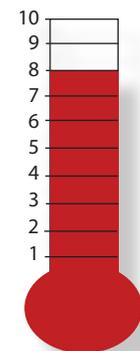
analog (psychoactive stimulants) and other clandestine uncontrolled substances (bath salts) as cutting agents for Ecstasy.

A profile for a typical Ecstasy user emerged from the data. Participants described typical users of Ecstasy as young people in their early to mid-20s, who use the drug in night clubs. As stated by one participant, *“Most people buying it [Ecstasy] would be young people. I’ll tell you that ... maybe 20 [years old].”* Reportedly, Ecstasy is used in combination with alcohol, marijuana and nitrous oxide.

Prescription Stimulants
Historical Summary

In the previous reporting period, prescription stimulants (Adderall® and Desoxyn®) were moderately available in the region. Participants most often reported the availability of these drugs as ‘6’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Most police officers noted that they did not normally encounter this class of drug as part of regular vice operations because they are legal and sold infrequently by drug dealers in the region. Typical use of prescription stimulants was perceived to be popular among younger users (>18 years) and shared among high school students.

Current Trends

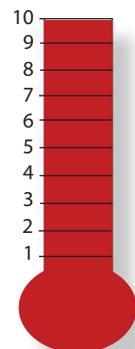


Prescription stimulants (Adderall® and Ritalin®) are highly available in the region. Participants rated the current availability of these drugs as ‘8’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was ‘6’. Participants reported that the availability of prescription stimulants has increased over the past six months. Law enforcement and treatment professionals did not report on the availability of prescription stimulants. BCI Richfield crime lab reported that the number of prescription stimulant cases it processes has remained stable over the past six months.

No slang terms or common street names were reported for prescription stimulants. Participants infrequently bought these pills, so only one price was mentioned for prescription stimulants: Adderall® 30 mg (\$5). These drugs are reportedly obtained from friends and dealers and are favored by young people. Participants stated that pills are crushed and snorted or dissolved and then injected. Reportedly, prescription stimulants are used in combination with alcohol and sedative-hypnotics.

Bath Salts¹

Bath salts are highly available in the region. Participants 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). Participants gave a high availability rating because bath salts are sold legally in drug stores and convenience marts. Law enforcement and treatment providers also most often reported the drug’s current availability as ‘10’. The comments of a treatment provider summarize the opinions of both groups: *“You can still buy it [bath salts] in the head shops. It’s packaged pretty. It looks like crystal form. You crush them and you can snort them, inject them ... They’re like \$40. You can walk into a store, so they’re readily accessible.”* Both groups reported that the availability of bath salts has increased over the past six months. Drug consumers frequently cited this drug as up-and-coming. Two police officers described the rise in bath salt popularity as, *“It’s available, but it [bath salt cases] just doesn’t come across our desk because it’s not illegal yet. It’s everywhere around us, so it’s coming.”* The Plain Dealer reported that police were called on several occasions to investigate people high on bath salts. On one occasion, a Medina man was high on bath salts, and he hallucinated *“intruders disguised as chairs,”* and on another occasion, a 15-year-old girl in Willoughby went into seizures after smoking the drug (www.cleveland.com; March 23, 2011).



No slang terms or common street names were reported for bath salts. Bath salts sell for approximately \$40 per 500 mg. Participants reported obtaining bath salts from drug stores, convenience stores and head shops, but did not report getting them from dealers. The most common route of administration is smoking and intranasal inhalation (snorting).

A profile for a typical bath salts user did not emerge from the data. Participants reported observed use by younger users, but were unable to supply other general characteristics. Treatment professionals agreed that young adults and younger users under 18 years are likely to try bath salts. Bath salts were not reported to be used with other drugs. When asked if a user of methamphetamine might switch to legal bath salts, a treatment professional said, *“No, they would continue to make their own meth [methamphetamine]. Maybe that’s my perception, but they’re not going to be able to get the same high ... Now, I can see somebody going from bath salts to meth.”*

¹ Bath salts were not mentioned in this region during the last reporting period; therefore, there is no historical summary.

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 by the majority of people interviewed: over-the-counter (OTC) cough medicines and PCP (phencyclidine). Participants believed that abuse of OTC cough medicines was popular among younger people, especially among school-aged students who cannot procure other substances. PCP was somewhat available in the region. Law enforcement cited PCP availability scores of '1' or '2' for the west side of Cleveland and from '7' to '10' on the east side of Cleveland on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Law enforcement said PCP was more available in the east side of Cleveland because of a small area of the city known as "water world." Both participants and law enforcement reported that the drug was sold by the "dip" (tobacco cigarette and marijuana blunt/joint dipped in PCP) with pricing approximately \$20–\$25 per dip. Law enforcement reported that they were most likely to encounter Black males between 20–40 years of age with PCP.

Current Trends

Participants and professionals listed a variety of other drugs as being present in the region, but these drugs were not mentioned by the majority of people interviewed. Ketamine (a.k.a., "special K") is rarely available in the region. Participants most often reported availability as '0' or '2' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants agreed that Ketamine was very hard to come across: *"It's [Ketamine] available in certain places, but mostly available in rural areas; It's hard to get. You gotta rob a vet's office."*

GHB (gamma-hydroxybutyrate) is moderately available in the region. Participants on the east side of Cleveland most often reported availability as '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). However, law enforcement officers in the south of the region had another opinion: *"You hear about somebody who has GHB, but you never see it. It's very rare. Everything comes here last. It starts in the big cities and gets here last."*

PCP (phencyclidine) is highly available in the region. Participants most often reported availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant explained availability this way: *"It's [PCP] plentiful, and it's been plentiful for years."* As with the last reporting period, most participants

reported obtaining PCP from a place called "water world" on Cleveland's east side. Most participants generally rated the quality of PCP as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). PCP is commonly sold on a per dip basis or as ready-to-smoke tobacco or marijuana. Rarely the drug is sold as a crystalline powder. Pricing is consistent with the previous reporting period: one dip of a cigarette costs between \$10–\$20; however, a participant noted wholesale pricing, too: *"You charge users \$20/cigarette, but if you go to the dealer it's \$100/ounce, which will dip 25 cigarettes."* PCP is reportedly mixed with embalming fluid for users who want to lace cigarettes or marijuana. A participant explained, *"Where I live they be smoking that 'wet'—the stuff they embalm you with. They soak the joint or cigarette, let it dry and smoke it."*

LSD (lysergic acid diethylamide) is highly available in the region according to the few participants with experience purchasing the drug. Participants most often reported LSD's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While most participants had not encountered the drug, those with experience said, *"It's [LSD] around. There's always one place you can get it."* 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 did not provide pricing information, but they said that LSD was available in microdots (small tablets) and sugar cubes. These respondents disagreed as to whether LSD quality has remained the same, increased or decreased over the past six months. As one participant said, *"It [LSD quality] fluctuates. Sometimes it's garbage. Sometimes it's one-hit wonders."*

Psilocybin mushrooms are relatively rare in the region. In fact, the only available mushroom named was called "blueberry caps," which reportedly is a type of mushroom with *"blue stems and yellow caps."* Participants most often reported psilocybin mushrooms availability as '3' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Only four participants were able to rate the quality of psilocybin mushrooms, and they gave scores ranging from '7' to '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Current street prices for psilocybin mushrooms were consistent among participants with experience buying the drug: 1/8 ounce sells for \$40; 1/4 ounce sells for \$50–\$60; 1/2 ounce sells for \$100. Oral ingestion is the most commonly reported route of administration for psilocybin mushrooms. The only participant who tried smoking psilocybin mushrooms was not very happy with the end result: *"I smoked them [psilocybin mushrooms] one time. It's not common. It didn't work."* Psilocybin mushrooms are commonly used in combination with alcohol, crack cocaine, Ecstasy and marijuana. DMT (dimethyltryptamine), a naturally occurring psychedelic

compound, was reportedly available on the west side of the Cleveland region. Law enforcement most often reported its availability as '1' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Due to two arrests in the prior three months for DMT possession, law enforcement thought the drug's availability was trending upward. Said an agent, *"Obviously we'd have to say with two [DMT] incidents recently that's an increase."* One agent described their next steps: *"We're connecting with other agencies. We have another supplier outside the [Cleveland region]. We have to make some inroads on this because it's [DMT] going to be sought."* Law enforcement reported one knowledgeable user as a 19 year-old male who had been selling DMT to a network of friends. The drug user said the drug's attraction was that it had relatively few side effects and was reportedly non-addictive. A police officer explained, *"The user said it's [DMT] readily available in our far western ... The thing about this is that the young user gave me links off the Internet. Doctors, scientists and chemists have said it's not addictive. The user said it's much like marijuana, saying it's a sedative and very calming and very effective. I was shocked that in reading all these professionals say it's not addictive. That was the reason why he chose that drug."* The drug reportedly costs \$50 per gram, and it is sold as a powder. The most common method of administration is intranasal inhalation (snorting).

Synthetic marijuana ("K2" and "Spice") is highly available in the region. Many participants had heard of synthetic marijuana, but could not supply personal knowledge of the drug. Participants frequently mentioned its rising popularity due to the belief that the drug delivers a marijuana-like high but cannot be detected in urine drug screens. As one participant explained, *"Spice, it's the same as marijuana ... A lot of people are doing it because it can't be detected."* Another participant felt that demand was decreasing as the product came under more scrutiny and local legislation: *"That K2 stuff is falling off, because you can't get it at the drug store anymore. They were selling it at Rite Aid."* Like marijuana, the most popular route of administration for this drug is smoking. A regional media outlet reported on the health consequences of synthetic marijuana consumption. *The News Herald* reported that 11 people were recently admitted to area hospitals after ingestion of synthetic marijuana, which caused *"dangerous fluctuations in heart rate and blood pressure"* (news-herald.com; March 24, 2011).

Conclusion

Crack cocaine, Ecstasy, heroin, marijuana, powdered cocaine, prescription opioids, prescription stimulants, sedative-hypnotics and Suboxone® are the most available drugs in the Cleveland Region. While powdered cocaine remains highly available, most respondents continued to perceive

powdered cocaine as more difficult to obtain than crack cocaine. Participants agreed that user demand for powdered cocaine is driven by the desire to obtain powdered cocaine to "rock up" (manufacture) into crack cocaine, allowing users to improve the quality of their crack cocaine. Users reported that the price for higher quality powdered cocaine is increasing, possibly due to higher demand. Most participants agreed that the quality of crack cocaine sold on the street is very poor. Reportedly, methamphetamine is sometimes mixed with crack cocaine in order to augment its poor quality. Many users also indicated that crack cocaine is being purchased in small amounts more frequently by heroin users who are unable to obtain powdered cocaine required to "speedball" (mixture of heroin and cocaine for concurrent use). All data sources indicated that heroin remains highly available, with a few sources noting a believed increase in the region. The Cuyahoga County Coroner's office reported heroin as the most common drug present in drug-related deaths. BCI Richfield crime lab reported that powdered heroin is now the most processed drug through their lab. Many participants reasoned that increased heroin availability is due to 1) increased demand among younger users, 2) prescription opiate abuse and 3) pressure from drug dealers who desire to switch their clients from crack cocaine sales to more profitable heroin. Participants and community professionals continued to report brown powdered heroin as most available. When asked to identify the most urgent or emergent drug trends in their purview, all professionals indicated that heroin is a concern for their service population. Out of 10 heroin consumers, participants reported that approximately nine would intravenously inject it. Many users continued to note the pill progression to heroin: users begin with prescription opioids, move to snorting heroin and then progress to injecting heroin. This progression was observed to be an extremely prevalent trend among those aged 16 – 30 years. Many users mentioned "speedballing" as common among heroin users. Participants identified OxyContin® OP, Percocet® and Vicodin® as the most available prescription opioids in terms of widespread use. Opana® and methadone were cited as up-and-coming opioids that are gaining in popularity. Participants continued to report that their primary way of obtaining prescription opioids is from doctors at pain clinics and emergency rooms. Many participants knew of specific physicians who write prescriptions for cash. Suboxone® remains highly available in the region. Participants continued to describe typical users of Suboxone® as heroin users who are trying to avoid withdrawal symptoms when heroin cannot be obtained. Reportedly, Suboxone® is widely available from other heroin users and from heroin dealers. In terms of marijuana, higher quality marijuana was reported to be more available by both drug consumers and community professionals. Notably, several participants mentioned 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.