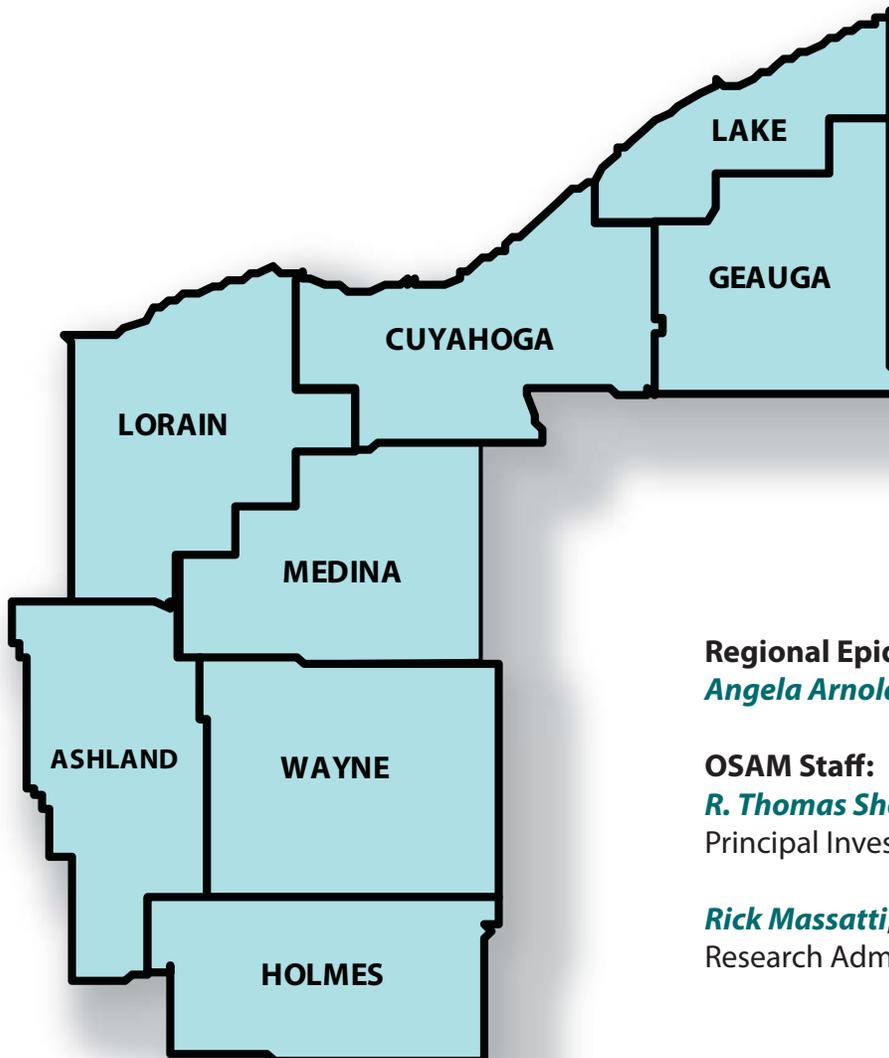


# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Cleveland Region

June 2010-January 2011

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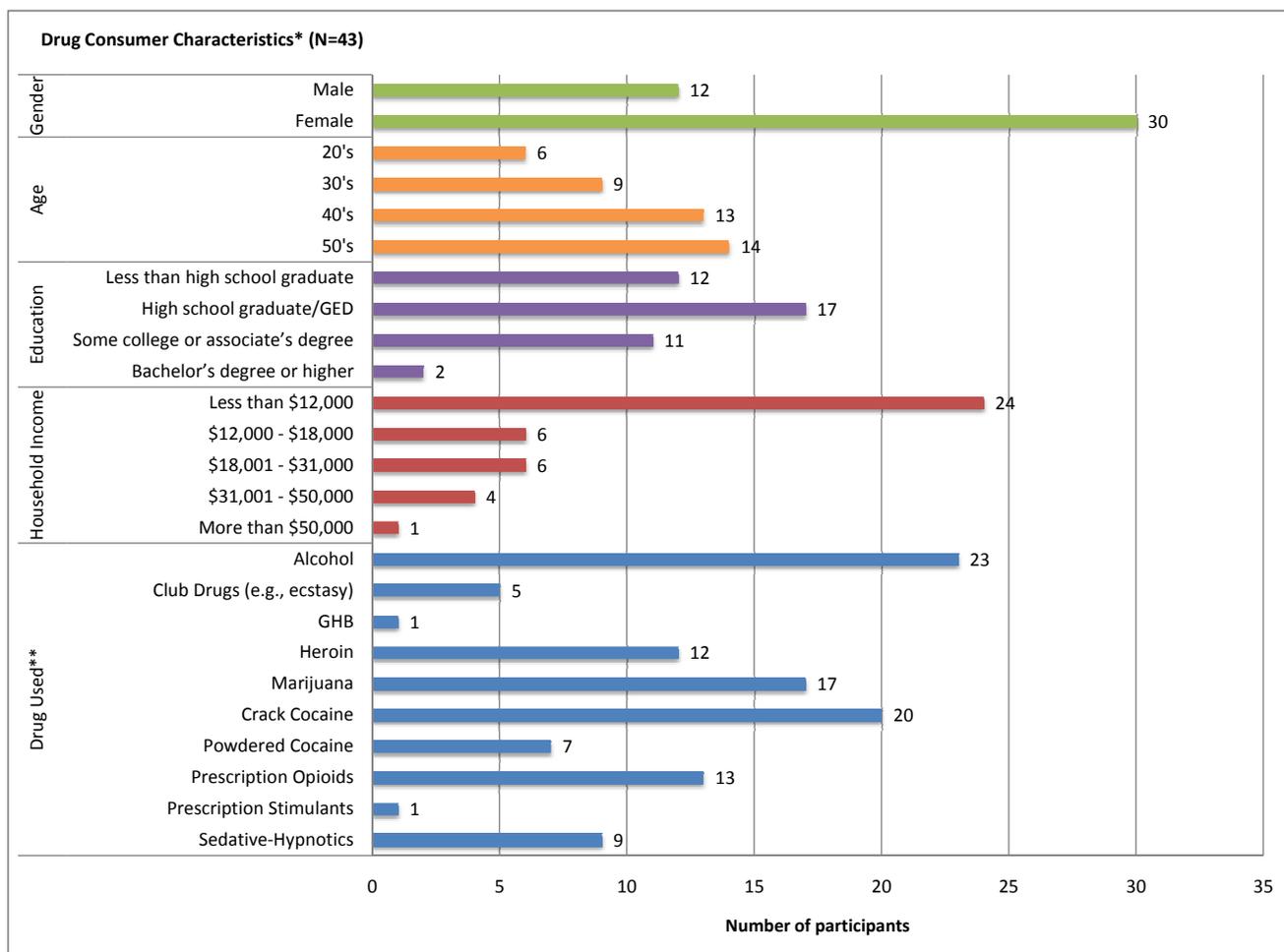
### Regional Profile

Indicator <sup>1</sup>	Ohio	Cleveland Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	2,302,406	43
Gender (Female), 2009	51.2%	51.8%	69.8%
Whites, 2009	82.2%	75.1%	46.3%
African Americans, 2009	11.9%	17.6%	53.7%
Hispanic or Latino Origin, 2009	2.8%	4.2%	0.0%
High school graduates, 2008	84.6%	90.6%	71.4%
Median household income, 2009	\$45,467	\$47,820	Less than \$12,000 <sup>2</sup>
Persons below poverty, 2009	15.1%	12.4%	56.1% <sup>3</sup>

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

Respondents reported income by selecting a category that best represented their household's approximate income for 2009<sup>2</sup>.

Poverty status was unable to be determined for two respondents due to missing or insufficient income data<sup>3</sup>.



\*Not all participants filled out forms; therefore numbers may not add to 43.

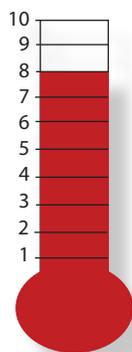
\*\*Some respondents reported multiple drugs of use over the past six months.

## 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 County. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (i.e., law enforcement officers) via focus group interviews, as well as to data surveyed from Cuyahoga County Coroner's Office and the Bureau of Criminal Identification and Investigation (BCI&I) Richfield Office, which serves the Cleveland, Akron and Youngstown areas. The aforementioned secondary data sources reported summary data for January to June 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the last six months (i.e., from time of interview through prior six months); thus, all current secondary data correspond to the current reporting period of participants. In addition to the aforementioned data sources, *The Plain Dealer*, Ohio's largest newspaper, was queried for information regarding regional drug abuse for June 2010 through January 2011.

## Powdered Cocaine

### Current Trends



Powdered cocaine is readily available in the region. Participants most often reported the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants indicated that the availability of powdered cocaine has decreased somewhat in recent months, with widespread agreement that powdered cocaine is not as easy to obtain as crack cocaine. A respondent reported, "The powder [powdered cocaine] is harder to get now than it was when I first started using drugs

*because crack [crack cocaine] took over. Everybody wants crack now instead of powder. Powder now is so broken down [diluted]. Now, when you re-cook it down, it don't even come back. So, people usually have rocks [crack cocaine] instead of powder."* Collaborating data also indicate that powdered cocaine is readily available in the region. The Cuyahoga County Coroner reported 10.7 percent of all deaths it investigated were drug related (i.e., had an illegal substance present or legal drug above the therapeutic range). Furthermore, the coroner reported cocaine as the most common drug present in drug-related deaths; it was present in 29.8 percent of all drug-related deaths (this is a decrease from 43.1 percent for

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). *The Plain Dealer* reported police arrests of several individuals for cocaine possession and trafficking in the region. In July, the newspaper reported that an Arizona man was arrested with three kilos of cocaine in his vehicle while driving through Lake County ([www.cleveland.com](http://www.cleveland.com), July 13, 2010) while in September, it reported that police raids in Medina County resulted in two separate arrests for cocaine trafficking (one arrest for crack cocaine trafficking) ([www.cleveland.com](http://www.cleveland.com), Sept. 16, 2010). BCI&I Richfield crime lab reported that the number of powdered cocaine cases it processes has remained stable.

Participant quality scores of powdered cocaine varied from '0' to '10' with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). A common theme to emerge among participants is the belief that the quality of powdered cocaine is greatly dependent on factors such as when shipments arrive and how closely the supplier is connected to his/her source. For example, when a shipment arrives, and many dealers are able to obtain powdered cocaine, they are less likely to "cut" (i.e., dilute) their product. In addition, dealers who are higher in the distribution chain seem to offer a consistently higher quality product. A participant said, "You might have six months where you get nothing but garbage, then another six months where all the dope is good all over the city." Participants reported that powdered cocaine is "stepped on," or cut with, many other substances such as baby aspirin, baby laxative, baking soda, NoDoz®, prescription medications (e.g., local anesthetics such as procaine and Nubain®), rat poison, Similac® baby formula and Vitamin B12. A participant stated, "I know when I first started using powdered cocaine it was absolutely great. But, I had got some a couple months ago and it was garbage. I don't know what it was cut with. But it wasn't no powder cocaine." BCI&I Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine (e.g., NoDoz®). Police officers indicated a shifting demand away from powdered cocaine due to quality and purity inconsistencies. An officer noted, "We're finding that more of the dealers want to deal with the crack cocaine because when they deal with the powder, it's been cut [diluted] so many times it won't rock up, and the end purchaser is very leery. These guys are strictly working with crack even though the penalties are greater."

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "girl" and

"white girl." Participants listed the following as other common street names: "blow," "coke," "powder," "skirt," "snow," "soft" and "sugar." Participants reported that the price of a gram sells for \$40-\$80; 1/16 ounce, or "teener," sells for \$100-\$375; 1/8 ounce, or "eight ball," sells for \$120-\$375; 1/4 ounce sells for \$325-\$350. Participants in the region most commonly use powdered cocaine by intranasal inhalation (i.e., snorting). Both law enforcement and participants reported that cooking powdered cocaine to create crack cocaine is the other most common technique for administering cocaine. Smoking powdered cocaine after it has been "rocked up" is extremely common, due in part to concerns about the quality of the cocaine. A police officer stated, "A lot of these guys [users] wanna cook it [crack cocaine] up right then and there. Sometimes that assures the purchaser that they're getting the real thing." Intravenous injection and lacing cigarettes or marijuana with powdered cocaine were also cited as common methods.

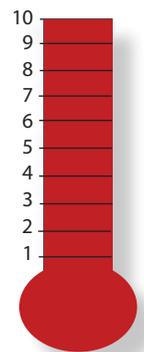
A profile of a typical user of powdered cocaine did not emerge in the data. While most participants were reluctant to ascribe powdered cocaine use to any particular race, age, or income level, they did indicate that use of powder was affected by social context. The drug continues to be popular for users in a club or party scene. A participant stated, "I bartended for 18 years, and powdered cocaine is like peanut butter and jelly, hand in glove at bars. All bars, you can find powdered cocaine." Several participants also indicated that older users tend to prefer to snort powdered cocaine, whereas younger users more often consume powdered cocaine intravenously or laced in tobacco and marijuana cigarettes as previously noted. Reportedly, powdered cocaine is often used in conjunction with "downers" like alcohol, heroin and marijuana. A participant reported, "I would blow coke [powdered cocaine] and have to come down. I would either snort an oxy [OxyContin®] or shoot up [inject] heroin."

### Crack Cocaine

#### Current Trends

Crack cocaine is highly available the region. Participants most often reported the drug's current availability as '10,' and law enforcement reported it as '9' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Universally, participants reported crack cocaine as being one of the easiest drugs to acquire. Unlike the dealers of other drugs, participants indicated that crack cocaine dealers are often actively soliciting new customers. As a participant said, "It's [crack cocaine] everywhere. And, I mean I walk out

of my apartment and I get approached by three people at least. And that's real." Another participant echoed the sentiment, "You walk in the liquor store, and the dope boy will ask you, 'Whatcha need? Whatchu want?' So, no matter where you go, somebody is going to have it [crack cocaine] 24-7." BCI&I Richfield crime lab reported an increase in the number of crack cocaine cases it processes. Law enforcement and participants indicated there has been no change in the availability of crack cocaine in the last six months.



Participants most often reported the quality of crack cocaine as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that the quality of crack cocaine depended on factors like their relationship with the dealer, and the availability of high quality powdered cocaine, but that in general, the average quality of crack has been decreasing. A participant commented, "I just recently had a relapse. It [crack cocaine] wasn't even worth my lapse. I thought it was going to be this big thing, but I thought afterward, I'm about to be sober, I'm just gonna stay sober. It was bad [quality], it was real bad." Participants cited numerous substances used to "cut" [i.e., dilute] crack cocaine. As a participant said, "It's horrible. They're cutting it [crack cocaine] with anything." More specifically, they listed baking soda, baby medicines, Sprite® and vitamins as cutting agents. Recently, police noted a few more sales of fake crack cocaine where they thought, "People [were] just trying to make money," and Westside participants reported crack cocaine being cut with heroin. BCI&I Richfield crime lab cited as cutting agents: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine (e.g., NoDoz®).

Current street jargon includes many names for crack cocaine. The most commonly cited names were "hard" and "rock." Consumers listed the following as other common street names: "butter," "chicken," "crack," "giddy-up," "ice," "scooby snacks," "work" and "yay-yo." Participants reported 1/4 gram of crack cocaine currently sells for \$40; 1/8 ounce, or "eight ball," sells for about \$150; 1/4 ounce sells for \$375 and up. The majority of crack cocaine consumers reported buying the drug in small quantities. For example, a "20 rock" is \$20 worth of crack cocaine, equivalent to a pinkie nail sized piece of crack cocaine or about six grams. The "20 rock" units can also be purchased in \$50 increments: three "20s" for \$50 worth of crack cocaine. A "50 rock" ranges in size from the equivalent

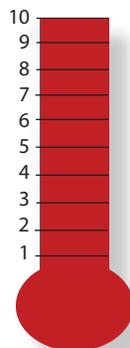
of one thumbnail plus a pinkie nail or a doughnut hole. As a participant said, *"The average for \$50 is about three clumps [rocks]. It depends on your relationship with the dope boy."* Pricing and rock size has remained stable for the last six months. Users also reported getting two-for-one specials from regular dealers: *"That's a dub. That's a double whatever. A fifty dub is two 50's for \$50."*

Reportedly, smoking is the most common way crack is consumed, with participants most frequently citing that "10 out of 10" crack users choose this method. Other ways mentioned included intranasal inhalation (i.e., snorting) and lacing it into marijuana or cigarettes. A few participants had observed intravenous injection of crack cocaine: *"I saw they [users] were melting it [crack cocaine] down with vinegar and using it like cocaine. They would draw it up in a syringe [and inject]."* Users who preferred smoking did not typically overlap with users who preferred injecting. As observed by one participant, *"The ones that would normally smoke [crack cocaine] never shot up [inject] heroin."* Indeed, many crack cocaine smokers reported never having observed other methods.

A profile of a typical user of crack cocaine did not emerge in the data. Participants tended to agree that crack users varied in age, race, and they were unable to identify a "typical" crack cocaine user. On the other hand, law enforcement noted that the majority of their crack cocaine arrests are comprised of poor Blacks and poor suburban Whites. An officer observed, *"[Whites] go in their house and they smoke their rocks so they don't get caught, but the people we deal with are wandering the streets at two in the morning ... It's not discriminatory. It's about where they are."* Police cited a growing number of older crack cocaine users, especially females aged 40 and above: *"From basic patrol, I've noticed more females in their fifties, more arrests for females with crack [cocaine]. I don't know if they're muling [transporting] it or if they're actually using it. But definitely more involved with it."*

In addition to alcohol, participants reported that crack cocaine is used in combination with heroin (a.k.a., "speedball" when "shot" together), marijuana (a.k.a., "primo") and prescription opioids. Using crack cocaine with all of the aforementioned is reportedly very common. Many participants explained that the use of these substances is necessary in order to "come down" from the crack cocaine high. A participant explained, *"For me personally, you would not catch me with a rock [crack cocaine] unless I had a beer and a shorty [marijuana]."*

## Heroin Current Trends



Heroin is 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' (high availability, extremely easy to get). Law enforcement (area police officers) most often rated current availability as '9'. There was agreement among participants and community professionals that heroin is as available as crack cocaine. However, several participants noted that heroin's availability is relative to one's drug connections. A participant said, *"It [heroin availability] all depends on who you know."* This statement was recorded across all focus groups. Another participant said, *"It's [heroin] just as easy as getting crack [cocaine] ... I take that back, because I couldn't go stand on the corner and someone would come up to me."* Law enforcement agreed that while there is plentiful supply, the network of heroin dealers and users is much smaller. An officer stated, *"For every 20 crack [cocaine] dealers there's one heroin dealer. Crack dealers are all over the place. There aren't so many heroin dealers."*

Collaborating data also indicate that heroin is highly available in the region. The Cuyahoga County Coroner reported heroin as a common drug present in drug-related deaths; it was present in 28.2 percent of all drug-related deaths (this is an increase from 24.1 percent for the previous six-month reporting period). *The Plain Dealer* reported a couple of large heroin busts in the region. In September, the newspaper reported that federal prosecutors had charged 24 individuals in the Cleveland area in *"the largest-ever heroin bust in Ohio,"* during which police reportedly seized 44 pounds of heroin ([www.cleveland.com](http://www.cleveland.com), Sept. 21, 2010). In the same article, a Cleveland Police Detective was quoted as saying, *"It's [heroin use] real huge in the suburbs now."* In another *Plain Dealer* article published online in January entitled, "Heroin Bust Points to Drug's Growing Popularity in Northeast Ohio," the U.S. District Attorney for the Northern District of Ohio was attributed with saying that heroin is the fastest growing drug problem in the region ([www.cleveland.com](http://www.cleveland.com), Jan. 13, 2011). BCI&I Richfield crime lab reported an increase in the number of heroin cases it processes.

The most common type of heroin available in the Cleveland region is brown powder. Some participants also reported

having encountered white powder. Black tar heroin, on the other hand, is reportedly rare. Law enforcement noted that they had not made an arrest for black tar heroin in over a year and a half. Many participants did not know what black tar heroin was. All participants stated that over the last six months, either heroin's availability has remained unchanged, or it has increased. In nearly all sessions, participants cited a link between prescription opioid abuse and an increase in heroin use. Participants noted that heroin is cheaper to buy than prescription opioids. A heroin user explained, *"When I went from using pain pills [to heroin], I was paying \$50 – \$60 for an 80 mg OxyContin® and you can go get five or six \$10 bags of heroin for that amount. You do one bag of heroin of good quality, and that's your day. So you figure one bag is \$10, one pill is \$60 and you need two pills for the whole day."* Law enforcement and participants both noted that heroin use seems to be growing in popularity among young people.

Participant quality scores of heroin varied from '5' to '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The most common score among participants was '10,' and '9' was most often scored by police. Both groups qualified their scores with the caveat, *"It [quality] all depends on who you know."* In addition, there seemed to be some discrepancy between the west side and the east side of Cleveland with regard to heroin's quality. For example, 'East sider' echoed the following participant comment: *"Yeah, there's been a big change [in quality]. Like I said, it's [heroin] the drug of choice now for a lot of people doing the heroin and OxyContin®. With the heroin, a lot of people are getting some really good stuff, chopping it down with baking soda, and taking the quality away from it. So I'd say it went down."* West sider reported an improvement in quality. Besides baking soda, participants did not have specific knowledge about cutting agents used with heroin. However, a user mentioned that buying rocks of heroin ensured better quality: *"Depending on who you get it [heroin] from, you can either get it rocked hard which is the best way to buy it because you know it's not as cut, or crushed up."* BCI&I Richfield crime lab reported that heroin is "very pure," and occasionally "cut" (i.e., diluted) with diltiazem (medication used to treat heart conditions/high blood pressure).

Current street jargon includes many names for heroin. The most commonly cited names were "boy" and "dog food." Participants listed the following as other common street names: "diesel," "food," "H," "heavy," heron, "nod" (denotes higher quality), "ron" (short for "heron"), "smack," and "slips" and "tickets" (named for the slim wax craft baggies heroin is

packaged in). Participants reported a gram of heroin currently sells for \$45-\$150, with 1/2 gram selling for \$80; 1/8 ounce sells for \$550; an amount about the size of a quarter coin reportedly sells for \$50 – \$200; bundles consisting of eight to 10 bags sell for \$80 – \$100, which equates to \$10 per bag (bags were reported to be 1/10 gram or approximately half of a McDonald's® coffee stir spoon). Smoking, intranasal inhalation (i.e., snorting) and intravenous injection were the most common ways reported to administer the drug. Across several focus groups, participants agreed that injection of heroin is preferred by 80 – 90 percent of users, with snorting being the second-most popular method. Users new to heroin begin with snorting. A participant said, *"Everybody I know nowadays is shooting it [injecting heroin]. The people who are sniffing [snorting] it are the people who are just starting out using it. It doesn't matter the ages—when you first start out, you start out sniffing it. Then, it could be a week or a few months later, you end up shooting it because it's a better rush."*

When asked who uses heroin, a police officer replied, *"Everyone: poor people, rich people, White people, Hispanics. All of them ... affluent kids. Middle class to lower-upper class kids into heroin. We know that poor inner city kids are into it too. It's a widespread drug."* Focus group participants agreed that heroin is gaining popularity among younger users, especially high school teens and very young adults. Heroin is also making inroads into the young, urban black population as dealers begin to offer both crack cocaine and heroin to inner city populations. The City of Cleveland continues to supply the eastern suburban population that drives in to obtain heroin. Use seems to be accelerating very quickly on the west side beyond Hispanics and into young, White populations. A former heroin dealer recollected, *"That dog food [heroin]—man, people on the west side, they be lovin' it. That's all they be wanting."* It also continues to be popular with older, functioning users over 50 who tend to prefer needles.

Heroin is reportedly used in combination with benzodiazepines (i.e., Valium® and Xanax®), cocaine (most commonly used drug with heroin; a.k.a., "speedball" when "shot" together), marijuana and prescription opioids (i.e., OxyContin®). A participant reported, *"I would use heroin with OxyContin®. It was like a cherry on top of it [heroin high]."* Another participant observed heroin used in combination with marijuana: *"I know a lot of the younger kids who do it [heroin] like to smoke marijuana when they come down. Actually some of them say that it gets their high going more by smoking marijuana ... Younger kids [use heroin with] marijuana."*

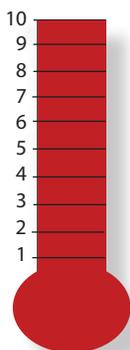
Mentions of overdose were cited more frequently with heroin than any other drug in the survey, and two participants said that an overdose situation would attract new business for the heroin dealer: *"I heard people say, 'Who got that killer D [drug]?' Somebody OD'd [overdosed] off it and that's what they want."*

## Prescription Opioids

### Current Trends

Prescription opioids are highly available in the region. Participants most frequently reported the availability of prescription opioids as either '9' or '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). OxyContin® OC were once the most preferred prescription opioid, but this drug has become scarce and more expensive due to the manufacturer's replacement with a new formulation, OxyContin® OP, that resists use in any other method besides oral ingestion. A participant explained, *"Back when oxy's [OxyContin®] were the regular OC's, I would pay \$60 for an 80 mg ... But now if you can find a REAL OC, today, they're going for 80 mg for \$80 ... dollar per milligram. Because people want them, they don't want the new formula."* Darvocet®, Dilaudid®, fentanyl, morphine, Opana®, Percocet®, Roxicet® and Vicodin® were cited as readily available. Only a few participants reported that the availability of prescription opioids has decreased over the last six months, whereas the greatest number of participants reported that prescription opioids are now more available or that availability has remained about the same. Increased availability is 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. Collaborating data also indicate that prescription opioids are highly available in the region. The Cuyahoga County Coroner reported prescription opioids as very commonly present in drug-related deaths; prescription opioids were present in 29 percent of all drug-related deaths (this figure is similar to the 29.2 percent reported for the previous six-month reporting period).

Almost all groups noted that while these drugs are 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. As a participant noted, *"All you have to do is say your back hurt, or either pay the doctor an extra \$50 to write you a script [prescription]. Seriously!"* The names of such prescribing physicians are known and shared among the community of pill users. A police officer exclaimed, *"I think the problem with pills are the doctors. We had a search warrant for a lady; we had info that she was selling OxyContin® and everything else. We got over there and she has a whole table full of pills prescribed by the same doctor, and I'm thinking how did that happen?"*

In the Cleveland region, prescription opioids are typically referred to by their full brand names or abbreviations of the brand. For example, "vikes" for Vicodin®, "perc's" for Percocet®, or "V10" and "P10" to indicate brand and strength. OxyContin® has several aliases: "big boys," "OC," "ocean's 11," "ocean city," "oxy" and "oysters." Participants reported the current per pill street pricing of prescription opioids as follows: morphine 200 mg sells for \$10 and higher; Opana® 20 mg sells for \$10; prices for original OxyContin® OC 80 mg reportedly sold for \$40 – \$60 prior to reformulation; currently OxyContin® OC sells for \$1 per milligram; OxyContin® OP, the new formulation, sells for \$20 for 80 mg, and \$10 for 40 mg; Percocet® 5 mg sells for \$3 – \$6, and 10 mg sells for \$5 – \$10; and Vicodin® 750/1,000 mg sells for \$5, and 500 mg sells for \$2 – \$5. The most common methods of pill consumption are oral administration and intranasal inhalation (i.e., snorting) of crushed pills. Snorting or chewing is preferred for a quicker effect as many of the prescription opioids are time-released formulas when taken orally. The Cleveland region did report some intravenous (IV) use; this use is mainly among IV heroin users.

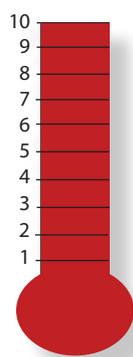
Law enforcement officers perceived that prescription opioids have become an explosive trend over the last 24 months and that new groups of users now abuse or sell these substances. Namely, they cited young, street-level crack cocaine dealers, young people less than 20 years of age, heroin addicts, and older, unemployed people with pills. Officers also indicated that it is more common to see arrests of White males aged 20 – 60 years for illegal prescription opioids. An officer recalled, *"One guy in the second district had over 1,000 pills. He's working in some factory. He was 67 years old! He's not abusing the pills, just selling."* While a typical user did not emerge during discussion with participants, both groups noted a user's likely progression from use of prescription opioids to heroin. A participant said, *"People start off with the pills. Doctors*

*within the last six months or year have been restricted on what they can write as far as narcotics go. People get cut off of their pain pills and have that addiction, then go to heroin."*

Reportedly, prescription opioids are often used in combination with alcohol, crack or powdered cocaine and marijuana. A participant stated that OxyContin® and Xanax® are often combined: *"It's like mixing an upper and a downer. OxyContin® and heroin, or oxy and crack [cocaine]. You can pretty much mix the prescriptions with anything."* Other participants agreed that the combination of OxyContin® and Xanax® is popular.

### Suboxone®

#### Current Trends



Although Suboxone® is available through legal prescription channels as well as through illegal purchase, participants in both participants and law enforcement had limited knowledge of this drug. Of the three participants who had used Suboxone® in the last six months, they reported street availability scores of '8' and '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Most experience with and knowledge of Suboxone® derived from legal prescriptions.

A respondent with some street knowledge of Suboxone® stated, *"It seems like when I didn't need it [Suboxone®], it was always there, but when I needed it, I couldn't find it. It was hit or miss whether or not somebody had it. And, it also depended on if you know people that are prescribed it and if they can sell you a few."*

A minority of the law enforcement personnel reported having experience with arrests involving Suboxone®. An officer said, *"Heroin's like a clique of people. You talk to one person on the west side and if they could hold hands with all the people they know ... you'll make it all the way across the city. They just know everybody; it's a net [network]. They all meet at the methadone clinics; they've all been in the hospital for it. For me to get Suboxone® might be difficult, but I would bet a large sum of money that any heroin user could pick up the phone and get it."*

No slang terms or common street names were reported for Suboxone®. Participants reported current prices for

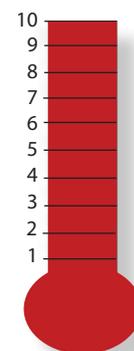
Suboxone® 8 mg to range from \$5 – \$50, with the most frequently reported price being \$15. Participants and police officers alike reported that Suboxone® is most often used illicitly by those addicted to heroin. Consensus among participants was that those addicted to opioids mostly seek the drug, only on the occasions when their preferred opiate is unavailable in order to avoid withdrawal: *"Sometimes if I didn't have any dope [heroin] and I was dope sick [in withdrawal] I would take a quarter of an 8 mg [of Suboxone®] and two hours later I'd get dope."* The most common method of consuming Suboxone® is orally, as directed. Only one respondent had heard of, but not witnessed, intravenous Suboxone® use. Only sedative-hypnotics were reported to be used with Suboxone. A participant explained, *"If you're gonna use anything else you can only use like a benzo [benzodiazepine] or Xanax® or Valium® because it's [Suboxone®] an opium blocker. You can use as many opiates as you like, but you won't feel anything off it."*

### Sedative-Hypnotics

#### Current Trends

Sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) are 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). Responses regarding these types of drugs centered on a few major brands that are widely available, including Klonopin®, Soma® Valium® and Xanax®.

When asked about trends within the region, some areas had more access to sedative-hypnotics than others. Participants living on the east side of Cleveland explained that these drugs were becoming less available: *"Because ain't nobody use them [sedative-hypnotics], ain't nobody want them."* An officer from the east side agreed, *"Valium® fell off. I don't see those as often as I used to."* On the other hand, all participants living on the west side of Cleveland indicated that these drugs' availability has remained the same—consistently high. Collaborating data also indicate that sedative-hypnotics are highly available in the region. The Cuyahoga County Coroner reported sedative-hypnotics as a common drug present in drug-related deaths; they were present in 21.8 percent of all drug-related deaths (this is an increase from 16.8 percent for the previous six-month reporting period).



Participants all indicated these drugs are referred to either by the generic term, “benzo’s,” or by their brand names. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ativan® .5 mg (\$1 – \$2.50); Valium® 10 mg (\$1 – \$2); and Xanax® 1 mg (a.k.a., “bars,” “footballs,” “totem poles,” “xani’s,” and “xanibars;” \$1 – \$2) and Xanax® 2 mg (\$2.50 – \$4). Both participants and law enforcement officers downplayed the relative impact of sedative-hypnotics versus other drugs. A law enforcement officer explained, “We’re seeing more of those pills [sedative-hypnotics]. Small possessions. Not large quantities. I think that’s always going to be an issue. Because they’re not even scheduled.” Police officers also described how most dealers of prescription pills will carry a bottle with their name on it to prove that the medication was legally prescribed to them. As a result, narcotics officers do not make an exceptional effort to attempt arrests for sedative-hypnotics: “When you look through a drug addict’s purse and you see a prescription pill sometimes you look at it, sometimes you don’t.”

Participants did not report buying sedative-hypnotics from street dealers. Most frequently participants obtained sedative-hypnotics from friends, family members and physicians. As one participant said, “At one point I was able to get ‘em [sedative-hypnotics] on my own, but I probably shouldn’t have.” 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.

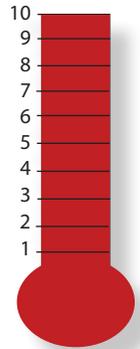
Intranasal inhalation (i.e., snorting) and oral consumption were the use methods most frequently cited, though two participants mentioned use by intravenous injection, with one participant saying, “I’ve shot [injected] xani’s before.” No typical user profile emerged from focus group participants, most likely because all agreed that nearly anyone could get these drugs prescribed from a physician. A participant said, “Everyone I knew was getting them [sedative-hypnotics] from friends or family members who had prescriptions.”

Reportedly, several other drugs are used in conjunction with sedative-hypnotics, which are typically used as an aid to “come down” from the high of other drugs. In addition to alcohol, drugs used in combination with sedative-hypnotics include heroin, marijuana, OxyContin® and other opiates, and Seroquel®.

## Marijuana

### Current Trends

Compared to all other drugs included in the survey, Marijuana was reported to be the most widely available drug in the region. Participants indicated an availability score of ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Although reported herein as ‘10,’ many participants gave a number higher than ‘10’ to indicate the extreme prevalence of the drug (e.g., ‘20,’ ‘50,’ etc.). Participants described marijuana’s availability as being extremely easy to get, available on nearly any street corner or available within minutes of a phone call to a dealer. A participant stated, “You can go to an elementary school and get weed [marijuana]. You can get that from anybody and everybody. Everybody sells weed.” Media outlets across the region (i.e., *The Plain Dealer* and the *West Geauga Sun*) have reported on marijuana arrests over this current reporting period in almost every county in the region.



Not a single participant indicated that marijuana is becoming less available. A few stated its availability has remained the same, but most participants said it was more available than ever, especially high-grade marijuana. A police officer commented, “The higher end stuff is more available. A few years ago, you [would] see the kush [high-grade marijuana] every now and then. Now, everyone out there has it.” When further questioned, both participants and police said the reason for the increase in high-grade marijuana is largely due to a surge in home-grow and commercial-grow operations. One officer explained, “In the past year we came across three commercial [marijuana] indoor grow operations in the City of Cleveland, and there’s more out there in the city that we’re working on.” Other contributing factors to the increase of high-grade marijuana include advancements in lighting technology, growing techniques and online sales in states where marijuana is legal. BCI&I Richfield crime lab reported that the number of marijuana cases it processes has remained stable, and noted that marijuana cases make up the greatest proportion of drug cases it reviews.

Police noted that large shipments of inexpensive, low-grade marijuana arrive in the Cleveland area via Lake Erie from Canada and other routes. Law enforcement explained,

*"They're coming straight across the lake [Lake Erie]. It's only 41 miles. Our border in Ohio is not patrolled like it should be. They come in drop it [marijuana shipments] off and they're gone." Another officer stated, "If we stop a truck that has 1,000 pounds [of marijuana], another truck drives by that's got 5,000. It's a decoy." Officers also expressed their concerns that limited budgets constrain them to focus more on heroin, crack cocaine, prescription opioids and other drugs more than marijuana. An officer commented, "Marijuana is not as detrimental to society;" and another added, "Since marijuana is so prevalent now, we would rather spend our time on the more dangerous drugs rather than marijuana."*

Consumers reported that the quality of marijuana varied from '7' to '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Several consumers explained that the quality of marijuana depends on whether the user buys "commercial weed" (i.e., low to mid-grade marijuana, also called "reg") or hydroponically grown (i.e., high-grade marijuana, also called "hydro"). High-grade marijuana was reported to be more potent, and to have a more pleasing aroma. One police officer explained, *"It's [high-grade marijuana] higher level of THC [tetrahydrocannabinol]. You don't have to smoke a lot of it to get where you need to go. We've run into a lot of people growing it in their houses. They've got the technique down, the lighting; they have the whole thing together. They're just growing the weed [marijuana]."* A user indicated that much of the marijuana product is available seasonally, saying that near the autumn, high quality "hydro" becomes available. While there seems to be a steady supply of commercial grade marijuana, one officer stated that it is sold after high grades have been exhausted: *"The lower quality [marijuana] is still the same. They'll sell that at the end ... I see 'kush' [high-grade marijuana]. Lotta the hydro. We got a guy with [British Columbian weed] not too long ago. About three months ago."* Given the competitive market for marijuana, it is unsurprising that participants reported no impurities or cutting agents included with marijuana.

Current street jargon includes countless names for marijuana. The most commonly cited names were "reg" and "weed." Consumers listed the following as other common street names: "backyard boogie," "brown," "dark weed," "garbage weed," "good," "mids," "nuggs," "rags," "skunk" and "swag" for low to mid-grade marijuana; and "chronic," "kush," "monkey paw," "orange crush," "purple haze" and "redbud" for high-grade marijuana; and "hydro" or for hydroponically grown marijuana. Pricing is fairly consistent across the city. Participants reported that they can buy marijuana in many

different quantities: a "blunt" (i.e., marijuana cigar, known as the "five-dollar holla") sells for \$5; a gram currently sells for \$7; 2.5 grams sells for \$20; 1/8 ounce sells for \$15 – \$20; 1/4 ounce sells for \$30; 1/2 ounce sells for \$45 – \$100, with high-grade marijuana at the upper end of that range. While there were a few reported ways of consuming marijuana, the most common route of administration is smoking. Some users reported eating marijuana in food or chewing on "weed sticks." As one participant explained, *"People make it [marijuana] in food like brownies and stuff. I chewed on weed sticks—never got me high but they said it should have."*

When asked to describe the typical user of marijuana, participants were unable to come to consensus. Participants were not able to establish a profile for the 'typical user,' and they explained marijuana use is so common that it defies limitation to one type of user, age group, race, etc. In contrast, law enforcement were able to identify categories of users through citing recent trends they've observed with marijuana arrests, obtained largely through traffic violations. One law enforcement officer explained, *"I work in the 4th district. It's 90 percent Black. About 98 percent of our arrests are African-Americans. With marijuana the age range is mid [to] lower 20's."* Another spoke to his experience with arrests for marijuana possession, *"The age range is going all the way from 13 years old to up to 30 ... Teenagers are really huge in it [marijuana] now."* A police officer who works on the west side of Cleveland had a slightly different opinion: *"Late teens, early 20's. It's Whites and Blacks both that we deal with [marijuana]. For older people, I think it's more prevalent with White males who are smoking marijuana that we run into on the west side."* Law enforcement and participants agreed that changing perceptions about marijuana account for its widespread use, especially among younger users. One officer observed, *"I've come across a ton of people that don't really think that marijuana's illegal. It's amazing to me. They hear a lot of talk on TV ... about the possibility of marijuana being legalized, and a guy [I arrested] saying 'I don't have any drugs.' He's got a pocket full of marijuana! No, it's drugs."*

In addition to alcohol, participants reported heroin, crack and powdered cocaine (a.k.a., "Primo"), prescription pills and PCP as substances commonly used with marijuana. Marijuana use among abusers of other drugs seems to be sought to aid in "coming down" from, or augmenting the high of, another drug.

## Methamphetamine

### Current Trends



Methamphetamine is relatively unknown in this region. None of the participants reported active methamphetamine use within the last year and most were unable to offer an opinion about its availability. All participants (except one) who did supply an availability score reported '0' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Only one participant had experience with methamphetamine, and he indicated that methamphetamine could be bought

on Cleveland's west side. Law enforcement also had very limited experience with this drug, with one officer stating, "It [methamphetamine] hasn't really hit. I've never arrested anybody with crystal meth [methamphetamine]. Thousands of arrests, and none [for methamphetamine]." Both groups of participants stated availability has remained unchanged within the last six months, and no one was able to offer information about its quality. BCI&I Richfield crime lab reported that the number of cases of both powdered and crystal methamphetamine it processes has increased.

Participants and law enforcement perceived use of methamphetamine to be limited to rural Whites, especially within the Appalachian region of Ohio. Participants were aware that it was smoked, and one reported a friend who preferred use by intranasal inhalation (i.e., snorting), but participants could not offer information about different types of methamphetamine available. Terms for this drug that have been heard in the Cleveland region include: "crank," "glass," "ice" and "meth." A participant reported that three grams of the drug could be purchased for \$80. Use of this drug was believed to be done in combination with sedative-hypnotics and crack cocaine. One participant reported that the drug had recently been used as a cutting agent in local crack cocaine. The participant explained, "[Crack cocaine users] probably haven't realized that that's what they were smoking [methamphetamine]. But, when you do that hit of crack [cocaine] and you got that extra zing and it didn't go away for quite some time, you weren't just smoking crack, you were smoking crystal meth. If you've ever got that zing that lasted, that was meth, and if you ever got sick with your crack it was mixed with heroin."

## Ecstasy

### Current Trends



Ecstasy [methylenedioxymethamphetamine (MDMA)] is highly available in the region. Participants most often reported the availability of ecstasy as '10' and law enforcement as '7' 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 is most commonly available in dance clubs, nightclubs and strip clubs. Law enforcement noted that distribution of ecstasy is limited to a few dealers who deal in very large quantities. More specifically, one officer said, "We don't get many calls on [ecstasy] But when we do we're able to get a quantity—100, 200, 300 pills. It could be any side; east side, west side, suburbs; it's all over the place." Participants and law enforcement thought there was a slight decrease in the availability of ecstasy because the drug's popularity is on a slight decline. BCI&I Richfield crime lab reported processing a small number of cases involving club drugs.

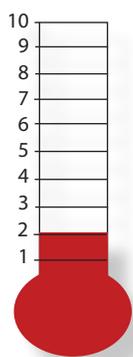
Current street jargon includes a few names for ecstasy. The drug is commonly referred to as "E," "ecstasy," "molly" or "X." Additional jargon for this drug seemed to be related to the imprint or stamped image on the pill itself, with one consumer observing, "They [dealers] got Scooby Doo, Bart Simpson, Obama Head ... naked ladies, Transformers, they got everything on x-pills ... They got Dora the Explorer, whatever you think of, they got it." Participants reported a "single stack" (i.e., low dose) ecstasy tablet sells for \$3 – \$7 and a "double stack" or "triple stack" (i.e., high dose) sells for \$10. The only route of administration noted was through oral consumption.

Law enforcement shared their observations about a third chemical variant that has recently appeared in the Cleveland region being sold as ecstasy. While chemicals like MDMA and BZP (i.e., benzylpiperazine) are commonly found in ecstasy, law enforcement said that a new ecstasy formulation containing, MDPV (i.e., methylenedioxypropylvalerone), had recently been involved in several recent drug busts. As one law enforcement officer explained, "We go to buy and they order it up, and the lab results say there are three different kinds [of ecstasy] now. I couldn't tell you what the difference is; they all give you the same high from what they [users] say." Another

officer also talked about the chemical makeup of the drugs: *"The ones [ecstasy tablets] the guy had, they all had the same logo stamps but they all had different lab results."* Police officers noted that ecstasy consumers are unaware of the chemical compounds included in their products. Law enforcement stated that the typical participant is younger (teenagers up to about 40 years of age), and that race does not seem to be a factor in the Cleveland area. One officer commented, *"I think [ecstasy] is the same, White and Black. When it first was introduced it was mainly White, but then it made its way into the Black community."*

## PCP

### Current Trends



PCP (i.e., phencyclidine) is somewhat available in the region. Police cited availability scores of '1' or '2' for the west side of Cleveland on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get), and they rated availability on the east side of Cleveland from '7' to '10'. Law enforcement said PCP is more available in the east side of Cleveland because of a one small area of the city known as "waterworld." A law enforcement officer explained, *"Waterworld, that whole area is pretty much what they do [make/use PCP]. I*

*work part time over there. I go over to my office and shut that door [because of the stench.]"* Citywide, this location seems to be the main source of the drug with a tight-knit network of suppliers. Street jargon for PCP include names like "wet" and "embalming fluid," and participants reported the highly odorous brown liquid is transported in vials. Both participants and law enforcement reported that the drug is sold by the "dip" (tobacco cigarettes and marijuana blunts/joints dipped in PCP) with pricing approximately \$20 – \$25 per dip. Officers report that they are most likely to encounter Black males between 20 – 40 years of age with PCP. An officer posted to the fifth district where "Waterworld" is located, stated that appearance of the drug has "picked up" within the last year.

### Other Drugs

Participants and professionals listed a variety of other drugs as being present in the area, but these drugs were not mentioned by the majority of people interviewed. Most participants did not have recent, personal familiarity with

abuse of prescription and over-the-counter (OTC) cold medicines. They believed that abuse of these drugs is popular among younger people, with a participant stating that these cold medicines are popular with school-aged students who cannot procure other substances: *"In elementary schools they are doing Robitussin®. They call it 'tussin."* Prescription stimulants (i.e., Adderall® and Desoxsyn®), likewise, were perceived to be popular among younger users (>18) and shared among high school students. A participant said the availability of Desoxsyn® is '6' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get), stating, *"Desoxsyn®, they don't prescribe too much anymore to ADHD kids but it's readily available."* A law enforcement officer assigned to a high school confirmed this belief, explaining use of prescription stimulants among students: *"We think there might be abuse in that group sharing, but what the hell are we going to do? There's 1,000 of them and at least 25 percent are on Individual Education Plans/Special Education. At least. They're giving them drugs [prescription stimulants] and an extra check. Their mothers are throwing them on workman's comp like water. And, they gotta take these meds to get this check ... it's the truth. They share it with their friends."* Most police officers noted that they do not normally encounter this class of drug as part of regular vice operations because they are legal and are sold infrequently by drug dealers in the Cleveland area.

### Conclusion

Crack cocaine, heroin (i.e., brown powdered), prescription opioids, sedative-hypnotics, marijuana and ecstasy are the most available drugs throughout the Cleveland Region. Noted increases in availability over the previous six months exist for heroin, prescription opioids and marijuana. Marijuana, the most widely available drug in the region, is reportedly more available today than it has ever been, especially high-grade marijuana due to a surge in home-grow and commercial-grow operations. Heroin is currently as available as crack cocaine, and its popularity is increasing, largely due to a decrease in availability of some preferred prescription opioids (i.e., OxyContin® OC). Heroin is becoming particularly more popular among young people. Alarming, the most common route of heroin administration is intravenous injection. Crack cocaine remains one of the easiest street drugs to acquire, although its overall quality has decreased. OxyContin® remains the most popular prescription opioid, but Darvocet®, Dilaudid®, fentanyl, morphine, Opana®, Percocet®, Roxicet® and Vicodin® are also

popular. Sedative-hypnotics (i.e., Klonopin®, Soma®, Valium® and Xanax®) are also highly available and widely desired for their ability to help in “coming down” from the high of other drugs. Ecstasy continues as a popular “club drug,” found most commonly in regional dance clubs, nightclubs and strip clubs. A new ecstasy formulation containing MDPV (i.e., methylenedioxypropylvalerone) has recently been involved in several drug busts.