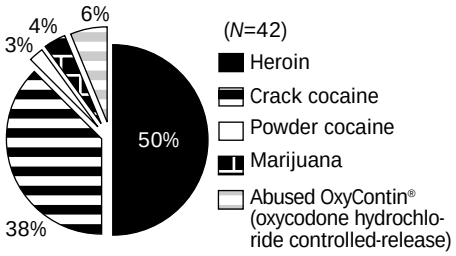
CLEVELAND PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 2,250,871
- Median age: . . . . . 37.3 years
- Race (alone):
  - White 76.9%
  - Black 18.5%
  - American Indian/ Alaska Native 0.2%
  - Asian/Pacific Islander 1.4%
  - Other race 1.4%
  - Two or more races 1.6%
- Hispanic (of any race): . . . 3.3%
- Unemployment rate: 3.4%
- Median household income: $42,089
- Families below poverty level with children <18 years: 13.1%

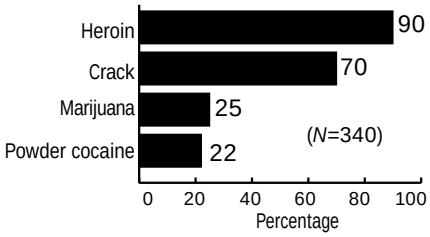
*Source: U.S. Census 2000**

What are the primary drugs of abuse among clients in a non-methadone treatment program? (Fall 2002)



Source: Non-methadone treatment respondent

What drugs do clients in a methadone program use+? (Fall 2002)



+Includes any use, whether as a primary, secondary, or tertiary drug; responses for methamphetamine, OxyContin®, and benzodiazepine abuse were less than 1 percent.

Source: Methadone treatment respondent

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. When possible, the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

THE BIG PICTURE: WHAT'S CHANGED? (SPRING 2002 VS FALL 2002)

All four respondents consider Cleveland's illegal drug problem very serious, and one[M] considers it somewhat worse. However, respondents do report positive trends:

- As in many *Pulse Check* cities, task forces are rated as highly successful in combating illegal drug activity in Cleveland.[L,E]
- Marijuana use among methadone treatment admissions decreased slightly.[M] That source believes that the media has become more responsible about marijuana by increasingly exposing the negative consequences of its use.[M]
- Several drugs, including two types of marijuana and two types of methamphetamine, are more difficult for undercover officers to buy.[L]

Sources also point to other developments:

- Polydrug use, which is the norm, increased. Drug users' decreasing "allegiance" to one drug has made treatment more difficult.[M]
- More cocaine (crack and powder) is coming into the area, it is easier to buy, prices have dropped, and the drug may be more marketable.[L,E]
- Powder cocaine use in general increased.[E] Among methadone treatment clients, crack use increased slightly, especially among females.[M]
- One respondent reports that diverted OxyContin® availability has declined because doctors and pharmacists are more stringent with prescriptions.[E] Other respondents, however, report abuse and activity as increasing.
- Heroin activity seems to be increasing: diverted OxyContin® users often switch to heroin, which is cheaper and easier to buy.[E,M]
- Among treatment admissions, methamphetamine use is low.[N,M] Declines are reported in one treatment program,[N] while a slight increase is reported in the other.[M]
- Methylenedioxymethamphetamine (MDMA or ecstasy) activity increased. The drug is easier to buy, but much that is sold is not really ecstasy.[L]
- Among non-methadone treatment admissions, tramadol (Ultram®) abuse increased.[N]
- Phencyclidine (PCP) use has begun to emerge among Blacks.[M]

Crack and heroin remain the most widely abused drugs and are related to the most serious consequences.

- *One program's typical clients are polydrug users who tend to use "whatever is available, easy to obtain, and cheap as their drug of choice."*[N]
- *Among non-methadone treatment clients, percentages for primary drugs of abuse remained relatively stable between spring and fall 2002.*[N]
- *Marijuana use among methadone treatment admissions decreased.*[M] *By contrast, abuse of several drugs increased, including heroin, crack, powder cocaine (among admissions new to treatment), and three drugs that still remain at low levels of use: methamphetamine, OxyContin®, and benzodiazepines.*

Most widely abused drug:
- Crack[L,E]
- Heroin[N,M]

No reported changes between spring and fall 2002[L,E,N,M]

Second most widely abused drug:
- Crack[N,M]
- Heroin[L]
- Marijuana[E]

No reported changes between spring and fall 2002[L,E,N,M]

Drug related to the most serious consequences:
- Crack[L,E,N]
- Heroin[M]

No reported changes between spring and fall 2002[L,E,N,M]

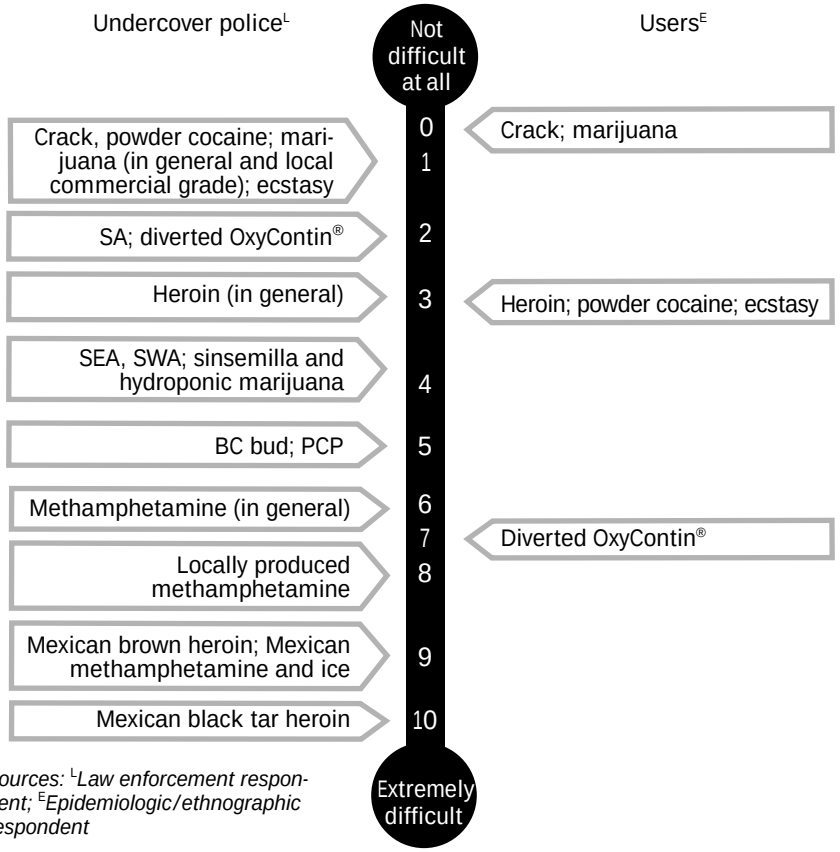
Drug related to the second most serious consequences:
- Heroin[L,E,N]
- Powder cocaine[E]
- Crack[M]

No reported changes between spring and fall 2002[L,E,N,M]

New or emerging problems:
- Ecstasy[L]
- Abused OxyContin®[M]

Sources: [L]Law enforcement, [E]Epidemiologic/ethnographic, [N]Non-methadone treatment, and [M]Methadone treatment respondents
Note: These symbols appear throughout this city profile to indicate type of respondents.

How difficult is it for undercover police and users to buy drugs? (Fall 2002)



Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

Note: SA=South American (Colombian) heroin; SWA=Southwest Asian heroin; SEA=Southeast Asian heroin; ice=highly pure methamphetamine in smokable form; and BC bud=British Columbian marijuana.

- *Several drugs are more difficult for undercover officers to buy since spring 2002:*[L] *sinsemilla, BC bud, Mexican methamphetamine, and ice.*
- *Diverted OxyContin® has become more difficult for users to buy on the street. Doctors and pharmacists are more stringent with prescriptions, and street prices have increased.*[E]
- *As reported in five other* Pulse Check *cities (New York, St. Louis, San Francisco, Seattle, and Portland, OR), diverted OxyContin® has become less difficult for undercover officers to buy since spring 2002.*[L]
- *Sources agree that heroin, cocaine, marijuana, and ecstasy remain relatively easy to buy.*[L,E]
- *As reported in seven other* Pulse Check *cities (Atlanta, Baltimore, Minneapolis, San Diego, San Francisco, Seattle, and Washington, DC), ecstasy has become easier for undercover officers to buy.*[L]
- *Powder cocaine has become less difficult for users to buy. Between spring and fall 2002, prices have dropped, and the drug may be more marketable.*[E]
- *In a 6-month period, heroin availability fluctuates: "droughts" are typically related to large law enforcement busts.*[E]

HEROIN

Two reports indicate that heroin activity and use are increasing:

- Methadone treatment admissions for heroin increased between spring and fall 2002.[M]
- Diverted OxyContin® abusers are switching to heroin because diverted OxyContin® is more expensive than heroin and more difficult to buy.[E,M]

COCAINE

Several observations suggest increased cocaine activity and use:

- The cocaine supply in Cleveland increased, and the drug is easier to buy.[L,E]
- In general, powder cocaine use increased since spring 2002.[E]
- Among methadone treatment clients, crack use increased slightly, especially among females who start taking heroin at an early age.[M]

MARIJUANA

Marijuana use remains relatively stable, according to most respondents. Among methadone treatment admissions, it decreased slightly between spring and fall 2002.[M]

METHAMPHETAMINE

Methamphetamine use and activity are low in Cleveland.

- Among non-methadone treatment admissions, methamphetamine use continues to decline from its peak several years ago.[N]
- Among methadone treatment admissions use increased slightly between spring and fall 2002.[M]

MDMA (ECSTASY)

Ecstasy activity has increased:

- The drug is easier to buy (but much that is sold is not really ecstasy).[L]
- However, ecstasy use and treatment admissions remain low.

DIVERTED OXYCONTIN®

One respondent reports that diverted OxyContin® availability declined due to doctors and pharmacists being more stringent with prescriptions.[E] *Other respondents, however, report diverted OxyContin® abuse and activity as increasing:*

- Diverted OxyContin® has become less difficult for undercover officers to buy.[L]
- OxyContin® abuse, in general, increased.[E]
- The non-methadone treatment respondent's program tends to see OxyContin® abusers "in droves." In the program's chronic pain division, 90 percent of clients abuse the drug.[N]
- One source "suspect[s] that OxyContin® will become a rising concern in Cleveland" and suggests that "physicians be alerted to its consequences and specifically trained to refer clients to opiate addiction programs."[M]

OTHER DRUGS

- Benzodiazepines: Abuse increased among methadone treatment admissions, especially among females.[M]
- Tramadol: Abuse increased among non-methadone treatment admissions.[N] People "doctor shop" for it or buy it on the street and then come into treatment for detox.
- PCP: The practice of dipping cigarettes in liquid PCP has begun to emerge among Blacks.[M]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

Treatment capacity and availability

- The *Pulse Check* non-methadone treatment respondent's program, which operates at about 75 percent capacity (42 of 56 inpatient and outpatient slots filled), sees mostly heroin clients, followed closely by crack cocaine clients (*see the pie chart on the first page of this chapter*).
- The methadone treatment respondent is with a public facility that operates over capacity, with 340 of 300 slots filled.[M] Beyond that specific facility, methadone maintenance treatment is available only in selected areas of the city, and public programs are at full capacity.[E] Cleveland has no private methadone clinics.
- Treatment respondents agree that limited slot capacity is the main barrier to treatment. One respondent explains that "opiate addiction and use have increased but funds have not."[M]
- One source reports increases in barriers to treatment: lack of trained staff to treat comorbidity among clients (due to lack of integrated training for counselors) and lack of child care for clients.[M]

Consequences of drug use

- The treatment sources note that hepatitis C and drug overdoses are common among clients.[N,M] The methadone treatment source further notes that several health consequences have increased since spring 2002, including HIV/AIDS (especially among males who have sex with males and are also injecting drug users), drug-related automobile accidents (due to increased polydrug use), high-risk pregnancies (because drug use among females has increased), drug overdoses (due to increased polydrug

use), and tuberculosis (due to increased homelessness and poor health care).[M] The non-methadone treatment source adds that heart attacks (related to cocaine use) and narcotic-related withdrawal sicknesses (including deaths caused by breathing difficulties) are relatively common health problems within the treatment program.[N]

- Several comorbid disorders are common among treatment clients, including mood disorders,[N,M] suicidal thoughts and attempts,[N] borderline personality disorders,[N] eating disorders,[N] and post-traumatic stress disorder (PTSD) related to childhood abuse[N].

Increased complications for drug treatment over the past 10 years

- Increasing availability of new and substitute drugs: The increasing availability of heroin, crack, and ice over the past 10 years has complicated methadone treatment dramatically.[M]
- More polydrug use: The increased combination of heroin and crack or powder cocaine and the declining price of crack cocaine over the past 10 years have made methadone clients more difficult to treat.[M]

WHO USES ILLICIT DRUGS?

The *Pulse Check* epidemiologic, non-methadone treatment, and methadone treatment sources were asked to describe the populations most likely to use heroin, cocaine, marijuana, methamphetamine, and ecstasy. They were also asked to describe any emerging user groups and to report on how the drugs are used. As shown on the following pages, user characteristics vary by drug. Further, because of the different perspective each brings, the three sources sometimes describe quite different populations and use patterns for each drug. For example, all methadone clients are primary opiate users who may use drugs other than opiates in a secondary or tertiary manner.

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	18–30	>30
Mean age (years)	40	24	40
Gender	70% male	60% male	70% male
Race/ethnicity	White and Black	White	White
Socioeconomic status	Low	High	Low
Residence	Central city	All	Central city
Referral source	N/A	Other heroin addicts	Individual
Level of education completed	N/A	High school and 2-year college	High school
Employment at intake	N/A	Unemployed	Part time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Heroin use, in general, increased between spring and fall 2002.[E] Heroin (now referred to as "dog food" or "garbage") use among methadone treatment admissions increased.[M]*
- *Between spring and fall 2002, heroin admissions to the methadone program are increasingly younger, female, and Black.[M]*
- *New heroin users are much more likely than the general heroin-using population to be young adults (early twenties versus 40 years), female (equally split between genders versus 70 percent male), and of a higher socioeconomic status.[E]*
- *New heroin users buy the drug in the central city but use it in the suburbs.[E]*
- *Many well-educated adolescents of upper socioeconomic status use heroin.[M]*
- *Heroin users are referred to the non-methadone treatment program by other heroin addicts and by heroin dealers whose supply "runs out."[N]*

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting and snorting	Injecting	Injecting
Other drugs taken	Powder or crack cocaine (speedball)	Cocaine (speedball); prescription opiates (as substitutes)	Crack (speedball)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	In groups	Alone	In groups

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Injecting is the most common route of heroin administration in Cleveland. Speedball use is common.*[E,N,M]
- *New users tend to snort heroin. They often use other drugs.*[E]
- *Between spring and fall 2002, polydrug use increased, especially powder or crack cocaine with heroin in a speedball and prescription opiates abused as heroin substitutes.*[M]

Who's most likely to use cocaine?

	Crack			Powder cocaine		
Characteristic	E	N	M	E	N	M
Age group (years)	>30	>30	18–30	18–30	>30	18–30
Mean age (years)	35	30–50	27	NR	30–50	28
Gender	Male	Split evenly	60% male	Split evenly	Split evenly	70% male
Race/ethnicity	Black	White and Black	Black	White	White, Black, and Hispanic (any race)	White
Socioeconomic status	Low	High	Low	Middle	High	Middle
Residence	Central city	All	Central city	Suburbs	Suburbs	Suburbs
Referral source	N/A	Individual	Criminal justice	N/A	Individual	Criminal justice
Level of education completed	N/A	4-year college	None	N/A	4-year college	High school
Employment at intake	N/A	Part time	Unemployed	N/A	Full time	Part time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *In addition to injecting heroin in speedballs, crack users often smoke "crumbs" of crack in marijuana blunts.*[E]
- *Among methadone treatment clients, crack use increased slightly, especially among females who start taking heroin at an early age. The most common route of administration among methadone clients is injecting, especially with heroin in a speedball.*[M]
- *In general, powder cocaine ("connie") use increased since spring 2002.*[E]
- *Among non-methadone treatment admissions, snorting and injecting are the most common routes of administration for powder cocaine.*[N]

Who's most likely to use marijuana?

Characteristic	E	N	M
Age group (years)	>13	18–30	>30
Mean age (years)	Wide age range	Wide age range	42
Gender	Split evenly	Split evenly	77% male
Race/ethnicity	White and Black	White and Black	Black
Socioeconomic status	All	Middle	Low
Residence	All	All	Central city
Referral source	N/A	Other health care provider	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Full time	Part time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

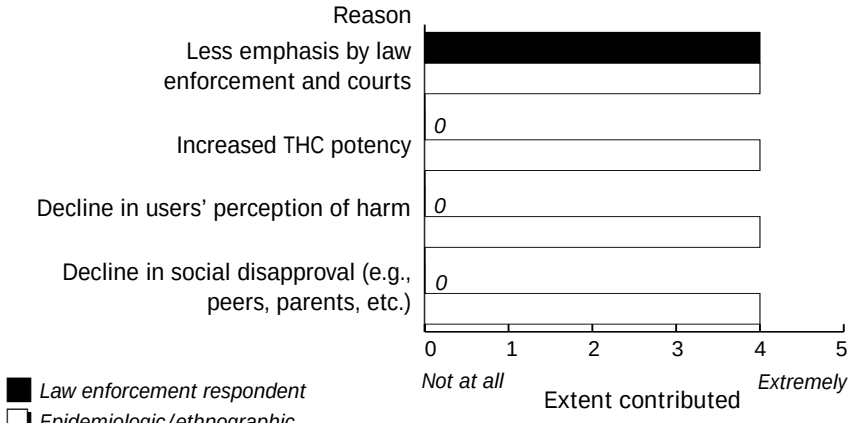
- *Marijuana use among methadone treatment admissions decreased slightly between spring and fall 2002.[M] New terms for marijuana include "sticky icky" and "trees."[M]*
- *In rural and suburban areas, most marijuana is smoked in joints; in central city areas, most is smoked in blunts.[E]*
- *A small percentage of non-methadone treatment clients use marijuana only, but most other drug clients use marijuana as a secondary or tertiary drug. Furthermore, insurance companies prefer not to pay for treatment if marijuana is the primary drug.[N]*
- *"Wet" is a new term for a marijuana combination that users are smoking; it could refer to marijuana joints or blunts dipped in embalming fluid or in PCP, but users are not sure.[E]*

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

Marijuana, used either alone or with other drugs, is associated with the following consequences, which remained stable between spring and fall 2002:

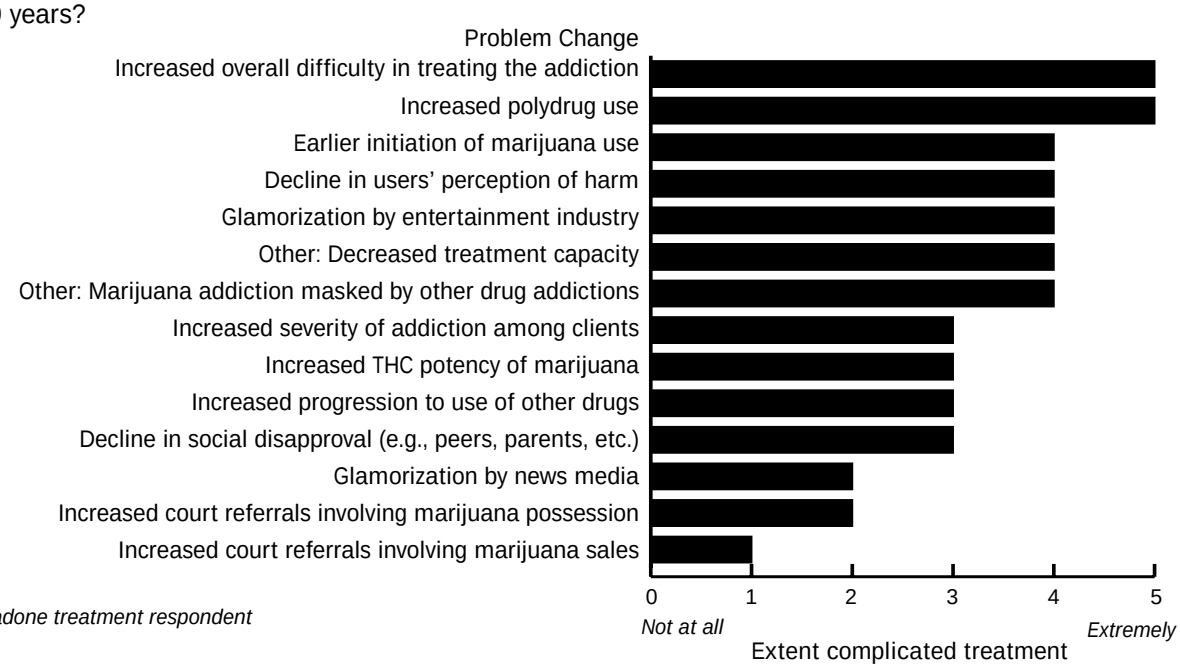
- Drug-related deaths[M]
- Drug-related emergency room visits[M]
- Drug-related arrests[E,M]
- Automobile accidents[M]
- High-risk pregnancies[M]
- Short-term memory loss[M]
- Deteriorating family and social relationships[M]
- Poor academic performance[M]
- School absenteeism, truancy, and dropping out of school[M]
- Poor workplace performance[M]
- Workplace absenteeism[M]

Widespread marijuana availability and use over the past 10 years: To what extent have the following contributed?



- *The law enforcement and epidemiologic/ethnographic sources differ widely in their opinions.*
- *They do agree on one belief: law enforcement and the courts have placed less emphasis on marijuana over the years.*
- *The law enforcement respondent adds that the penalties for marijuana possession or sales are too light.*

Marijuana-using clients: To what extent have changes in the following problems complicated their treatment over the past 10 years?



Source: Methadone treatment respondent

What they have to say...

- *Increased polydrug use: The decreasing "allegiance" of drug users to one drug, including marijuana, has made treatment more difficult over the past 10 years.*[M]
- *Decreased treatment capabilities for THC addiction: Too few programs treat THC as a primary addiction, particularly for adult clients. Moreover, THC addiction is often masked by other drug addictions (such as heroin, cocaine, or alcohol) and not treated.*[M]
- *Glamorization by news media: The methadone treatment source believes that the media has become more responsible about marijuana by increasingly exposing the negative consequences of its use.*[M]

Who's most likely to use methamphetamine?

Characteristic	N	M
Age group (years)	18–30	18–30
Mean age (years)	18–20	26
Gender	80% male	80% male
Race/ethnicity	White	White
Socioeconomic status	High	Middle
Residence	Suburbs	Suburbs
Referral source	Emergency room and parents	Individual
Level of education completed	4-year college	High school
Employment at intake	Full-time students	Part time

Sources: [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Among treatment admissions, methamphetamine ("tina") use is low.*[N,M] *Among methadone treatment admissions, use increased slightly between spring and fall 2002,*[M] *but among non-methadone treatment admissions, methamphetamine use continues to decline from its peak several years ago.*[N]
- *Non-methadone clients inject methamphetamine and take many other drugs (such as marijuana, heroin, and prescription pills) in combination with the drug.*[N]
- *Most methadone treatment clients take the drug orally and as a substitute for heroin.*[M]

- *The epidemiologic source claims that ecstasy use is low in Cleveland.*[E] *Ecstasy use among non-methadone treatment admissions is secondary and tertiary to other drugs, especially benzodiazepines.*[N]
- *Most ecstasy users are adolescent or young adult females.*[E,N]
- *Sources report no changes in use or user characteristics between spring and fall 2002.*

Who's most likely to use ecstasy?

Characteristic	E	N
Age group (years)	13–30	18–30
Mean age (years)	NR	18–24
Gender	Split evenly	70% female
Race/ethnicity	White and Black	White
Socioeconomic status	Low and middle	High
Residence	All	Suburbs
Referral source	N/A	Emergency rooms and parents
Level of education completed	N/A	High school
Employment at intake	N/A	Full-time students

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent

Who's most likely to abuse OxyContin®?

Characteristic	E	N
Age group (years)	18–30	18–30
Gender	Split evenly	Split evenly
Race/ethnicity	White	White
Socioeconomic status	Low and middle	Middle and High
Residence	Central city and suburbs	Central city and rural areas
Route of administration	Oral	Injecting

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent

- *In general, OxyContin® abuse increased since spring 2002.*[E]
- *The non-methadone treatment respondent's program tends to see OxyContin® abusers "in droves," causing the proportion of clients over time to "fluctuate wildly." That program also has a chronic pain division in which 90 percent of clients abuse OxyContin®. Over the past 2 years, OxyContin® abuse increased dramatically.*[N]
- *Many abusers start out taking the drug orally, as prescribed. They then move to snorting or injecting.*[E]
- *Most OxyContin® abusers are young adults: "once they reach an older age, they have already moved on to heroin."*[E]
- *Most OxyContin® abusers switch to heroin use because OxyContin is more expensive and more difficult to buy.*[E]
- *Opiate abusers take "whatever is available": OxyContin® abusers often use heroin as a substitute, and heroin users often take OxyContin® as a substitute.*[N]

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Illegal drugs in Cleveland are sold mostly in the central city, with the exceptions of methamphetamine and diverted OxyContin® (sales are equally distributed in all geographic areas) and ecstasy (sales occur mostly in the suburbs).[L]

Heroin, powder cocaine, marijuana, ecstasy, and especially crack are sold on streets and in open-air markets[L] as well as at the following locations:

- Crack houses and shooting galleries (excluding ecstasy)[L,E]
- Private residences[L,E]
- Public housing developments[L,E]
- In or around schools[L]
- Nightclubs and bars[L,E]
- Private parties[L,E]
- Raves[L]
- Concerts (excluding heroin)[L]
- Hotels/motels[L]
- Around drug treatment clinics (excluding ecstasy)[L]
- Inside cars[L]

Additionally, ecstasy is often sold on college campuses.[L,E]

Methamphetamine and diverted OxyContin® are not typically sold on streets or in open-air markets, but sales take place at the following locations:[L]

- Private residences
- Public housing developments
- Nightclubs and bars
- Raves
- Concerts
- Hotels/motels
- Around drug treatment clinics (excluding methamphetamine)
- Inside cars

HOW DO ILLEGAL DRUGS GET FROM BUYER TO SELLER?

To purchase heroin and crack and powder cocaine, buyers may go to an open-air market to exchange the drug hand to hand on the street or contact a dealer via cell phones, landline phones, or two-way pagers to set up a meeting for exchange of the drug.[L,E] Crack, in particular, is available at open-air markets, and dealers will "walk up to buyers' cars to sell it."[E]

Most ecstasy sales are venue oriented (at raves, concerts, and nightclubs), and buyers "ask around" at these locations to find a dealer and make the exchange hand to hand.[L]

Abusers buy most OxyContin® from dealers on the street, who obtain the drug either by legal prescription or by stealing it from their families or acquaintances.[E]

WHO SELLS ILLEGAL DRUGS?

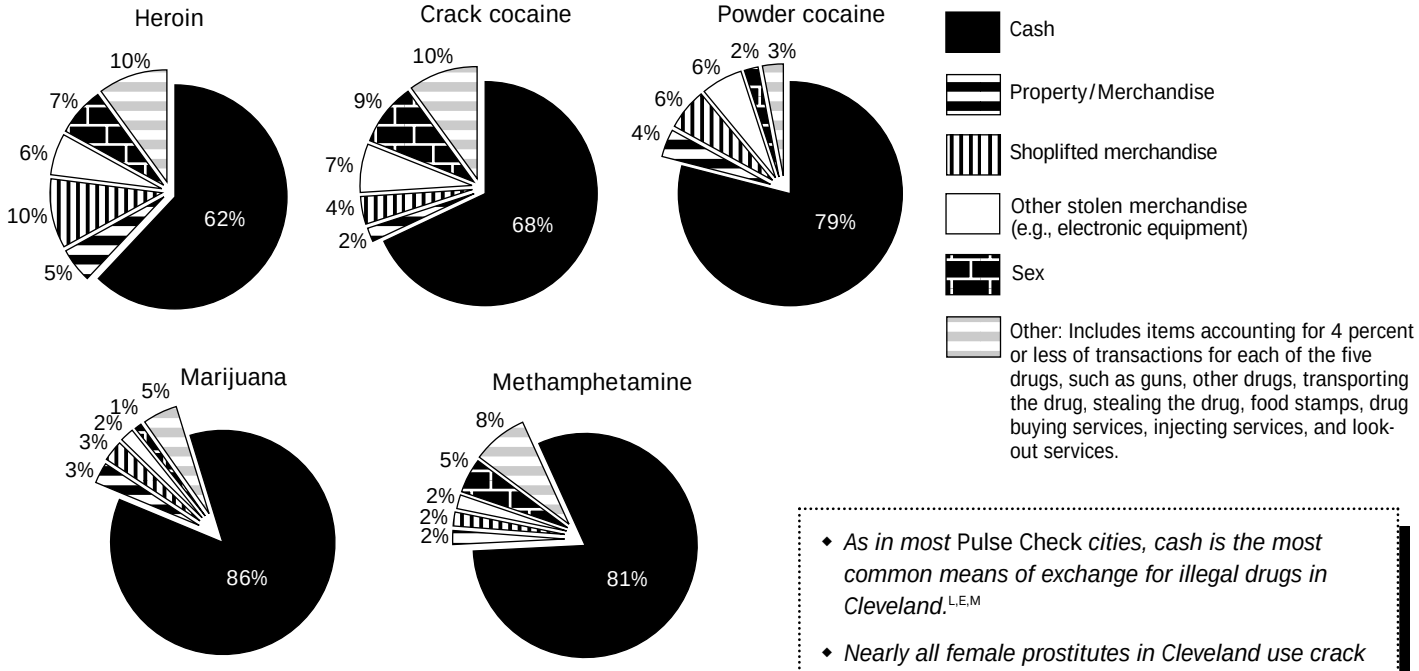
Heroin, crack, and powder cocaine dealers are organized, often into street gangs. Most heroin and powder cocaine dealers are older than 30, whereas most crack cocaine dealers are 18–30 years old.

Most crack and powder cocaine dealers sell only cocaine, but dealers who primarily sell heroin often deal cocaine as well.[L]

Heroin and powder cocaine dealers are often involved in prostitution and violent crimes such as robberies. In addition, powder cocaine dealers are involved in escort services and gang-related activity.[L]

Most other dealers who sell drugs such as marijuana, methamphetamine, ecstasy, diverted OxyContin®, and PCP are independent young adults (18–30 years).[L]

Beyond cash: What else is accepted in exchange for drugs?



Source: Mean of response ratings given by law enforcement, epidemiologic/ethnographic, and methadone treatment respondents. The non-methadone treatment respondent did not provide percentages for any drugs.

- *As in most* Pulse Check *cities, cash is the most common means of exchange for illegal drugs in Cleveland.*[L,E,M]
- *Nearly all female prostitutes in Cleveland use crack and exchange sex for the drug.*[E]

How much do illegal drugs cost?

Drug	Unit	Price
South American heroin	0.1 g (dime bag)	$10–$20[E]
	One bag (1 g)	$20[L]
Crack cocaine	One rock	$10–$20[L,E]
Powder cocaine	0.1 g	$20[E]
	Eightball	$180[L]
Marijuana	One blunt	$5–$10[E]
	1 oz (10–12 blunts)	$100–$200[L,E]
"Wets" (marijuana blunts dipped in formaldehyde or PCP)	One blunt	$10–$20[E]
PCP	One bottle	$40–$100[L]
Methamphetamine	1 g	$75[L]
Ecstasy	One pill	$15–$20[L] $8–$10[E]
Diverted OxyContin®	20-, 40-mg pills	$20, $40[E]

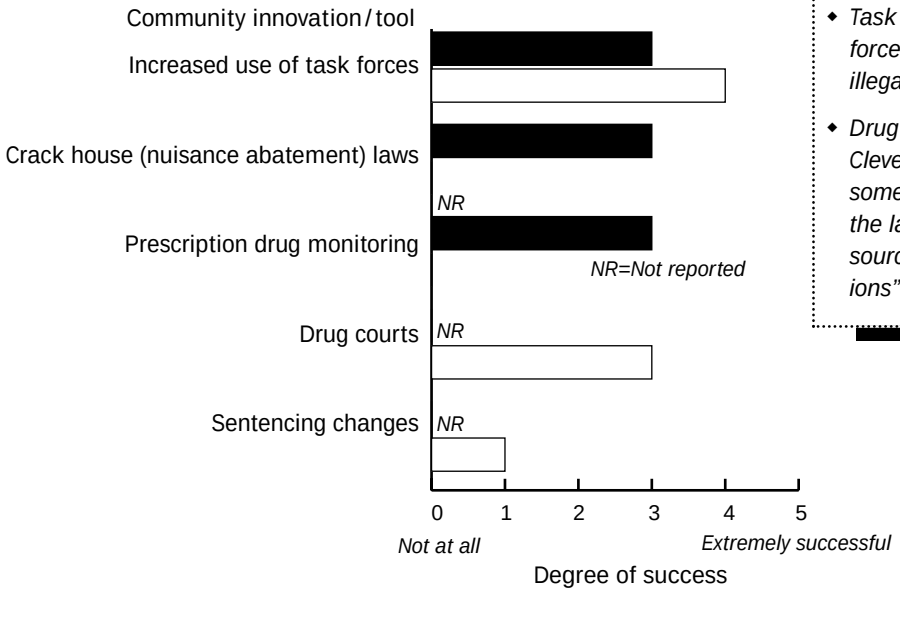
Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent

- *Drug prices in Cleveland remained relatively stable between spring and fall 2002.*
- *Respondents did not report drug purity, but they identified several adulterants new in fall 2002: baby formula is a new heroin adulterant; fingernail polish remover is a new crack adulterant; and twigs are now sold in packages and blunts of marijuana.*[N]

Drug marketing innovations and tools over the past 10 years: To what degree have they complicated efforts to detect or disrupt illicit drug activity in Cleveland?

As in many *Pulse Check* cities, the use of throwaway cell phones has made it much harder over the past 10 years to disrupt drug activity in Cleveland.[L]

Community innovations and tools over the past 10 years: How successful have they been?



What they have to say...

- *Task forces: As in many* Pulse Check *cities, task forces are rated as highly successful in combating illegal drug activity in Cleveland.*[L,E]
- *Drug courts: Drug courts, which have existed in Cleveland for the past 3–5 years, are described as somewhat successful in combating drug activity by the law enforcement respondent. The epidemiologic source states that experts have "conflicting opinions" about the effects of drug courts.*

SEPTEMBER 11 FOLLOWUP

Three of the four Cleveland *Pulse Check* sources believe that the September 11 attacks and their aftermath have had no effects on the drug abuse problem. The methadone treatment respondent believes that the increase in opiate addiction may be due to increased anxiety levels. That source further states that antidepressants, prescribed or bought from the streets, are increasingly used.