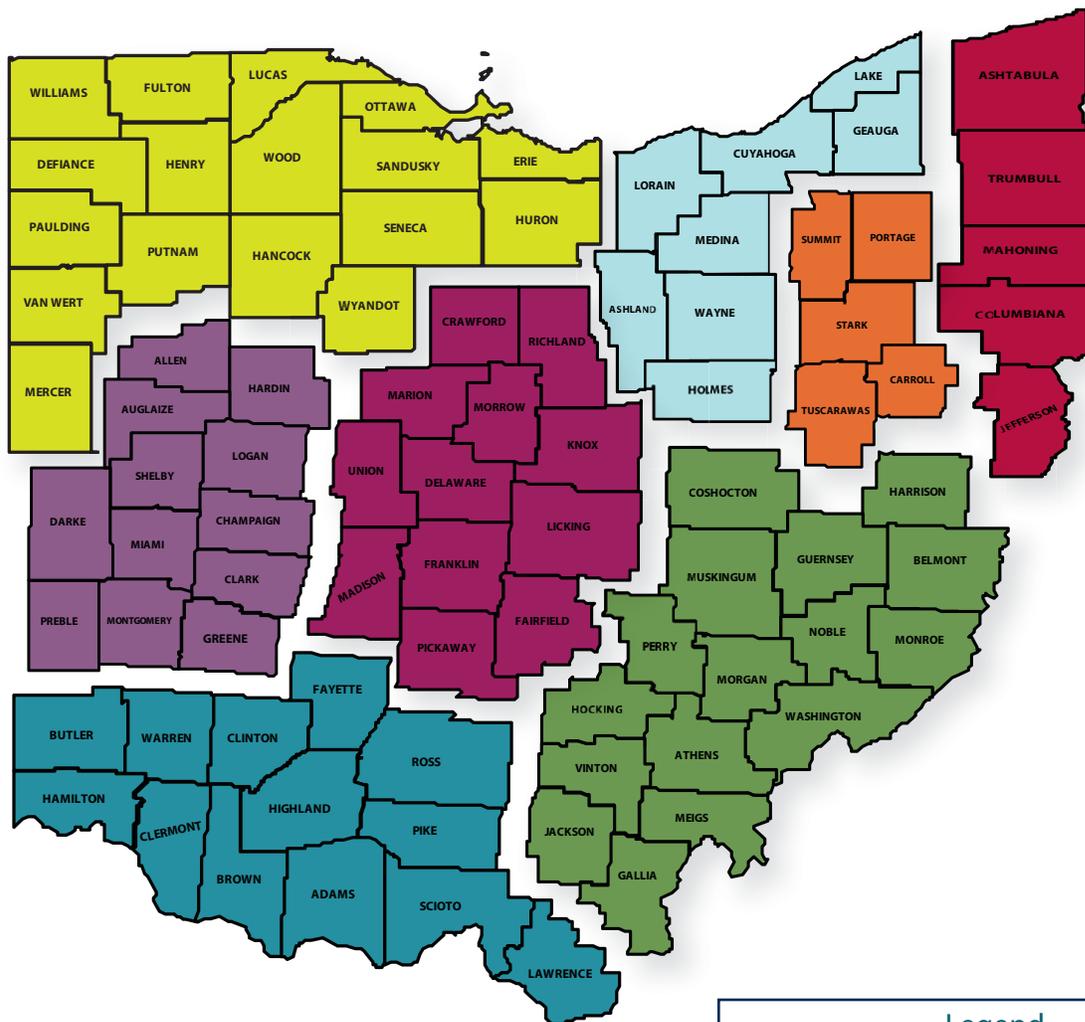


Ohio Substance Abuse Monitoring Network

Surveillance of Drug Abuse Trends in the State of Ohio

January-June 2012

John R. Kasich, Governor
Orman Hall, Director



Legend

- | | |
|---------------------|-------------------|
| Akron-Canton region | Columbus region |
| Athens region | Dayton region |
| Cincinnati region | Toledo region |
| Cleveland region | Youngstown region |



Department of Alcohol & Drug Addiction Services



Ohio Substance Abuse Monitoring Network

Table of Contents

OSAM-O-Gram 1

Executive Summary 2

Drug Abuse Trends in the Akron-Canton Region 10

Drug Abuse Trends in the Athens Region 27

Drug Abuse Trends in the Cincinnati Region 47

Drug Abuse Trends in the Cleveland Region 63

Drug Abuse Trends in the Columbus Region 84

Drug Abuse Trends in the Dayton Region 103

Drug Abuse Trends in the Toledo Region 125

Drug Abuse Trends in the Youngstown Region 141

Prepared by:

Ohio Department of Alcohol and Drug Addiction Services

Division of Planning, Outcomes & Research

Sanford Starr, Chief — MSW, LISW-S

R. Thomas Sherba, OSAM Principal Investigator — PhD, MPH, LPCC

Rick Massatti, Research Administrator, OSAM Coordinator — MSW

Recommended citation of this report:

Ohio Department of Alcohol and Drug Addiction Services [ODADAS] (2012). *Ohio Substance Abuse Monitoring Network: Surveillance of Drug Abuse Trends in the State of Ohio: January-June 2012.*

Ohio Substance Abuse Monitoring Network

Surveillance of Drug Abuse Trends in the State of Ohio

January-June 2012

John R. Kasich, Governor
Orman Hall, Director

Toledo Region

- Likely increased availability of bath salts, heroin and synthetic marijuana; likely decreased availability of Ecstasy
- DEA and BCI reported increase in number of bath salts cases; bath salts chemically altered and re-branded
- Despite decreased availability of Ecstasy, Ecstasy-like substances (2CE and 2CB) available
- DEA reported finding several mobile methamphetamine labs, manufacture through “one-pot” and “shake-and-bake” methods

Cleveland Region

- Increased availability of heroin; likely increased availability of Ecstasy, high-grade marijuana and methamphetamine; likely decreased availability of bath salts
- In Cleveland, heroin is now commonly available through anonymous transactions, as well as through established user networks
- Community professionals and participants reiterated and underscored abuse progression from prescription opioid abuse to heroin among younger users
- Purest form of Ecstasy (aka “Molly”) becoming more available as knowledge of drug grows

Dayton Region

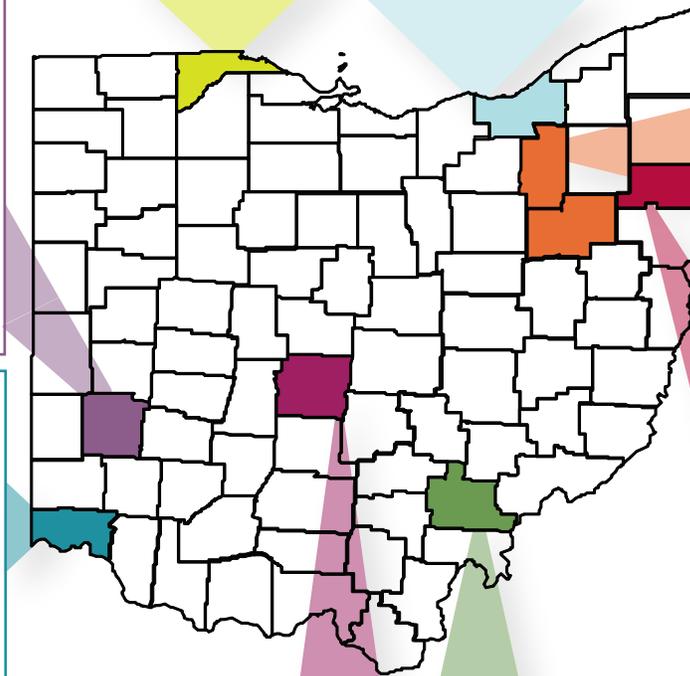
- Decreased availability of Ecstasy; likely increased availability of heroin and Suboxone®; likely decreased availability of crack cocaine
- Numerous participants reported heroin has reached “epidemic” proportions; even those who have not used personally reported friends and family who have
- Free “testers” of heroin remain available in Dayton which makes it difficult for users to avoid the drug

Akron-Canton Region

- Increased availability of methamphetamine, prescription opioids and Suboxone®; likely increased availability of crack cocaine and heroin
- Methamphetamine thought to have increased due to more people with knowledge of “one-pot” or “shake-and-bake” method of manufacture
- Prescription opioids now present in 50 percent of all drug-related deaths according to coroner’s office

Cincinnati Region

- Increased availability of heroin and Suboxone®; likely increased availability of bath salts, methamphetamine and synthetic marijuana; likely decreased availability of powdered cocaine
- Participants reported age of first-time heroin use as decreasing, with those as young as 12 years beginning use
- Current availability of methamphetamine is high in rural counties such as Brown and Clermont, and on Cincinnati’s east side



Youngstown Region

- Increased availability of prescription opioids; likely increased availability of heroin, methamphetamine and Suboxone®; likely decreased availability of bath salts and synthetic marijuana
- Opana®, Roxicet®, Ultram® and Vicodin® more available; prescription opioids now present in 77.8 percent of all drug-related deaths according to the coroner’s office
- Throughout the region, professionals reported heroin to be the primary drug problem

Columbus Region

- Increased availability of bath salts; likely increased availability of heroin, methamphetamine, Suboxone® and synthetic marijuana
- Participants stressed bath salts and synthetic marijuana as highly available and easily obtained at the same stores that previously sold them before the law banning them took effect
- Participants noted an increase in all forms of heroin, attributing increases to users transitioning from prescription opioids, as well as general increase in heroin popularity

Athens Region

- Increased availability of heroin and Suboxone®; likely increased availability of bath salts and methamphetamine; likely decreased availability of crack cocaine and synthetic marijuana
- Treatment facilities have experienced an increase in number of clients seeking treatment for heroin use
- Professionals reported users still coming into emergency rooms high on bath salts
- BCI reported an increase in bath salts cases; as soon as one substance is banned, another chemical analogue takes its place

Executive Summary

The Ohio Substance Abuse Monitoring (OSAM) Network consists of eight regional epidemiologists (REPIs) located in the following regions of the state: Akron-Canton, Athens, Cincinnati, Cleveland, Columbus, Dayton, Toledo and Youngstown. The OSAM Network conducts focus groups and individual qualitative interviews with treatment providers, active and recovering drug users and law enforcement officials, among others, to produce epidemiological descriptions of local substance abuse trends. Qualitative findings are supplemented with available statistical data such as coroner's reports and crime laboratory data. Mass media sources such as local newspapers are also monitored for information related to substance abuse trends. Once integrated, these valuable sources provide the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) with a real-time method of providing accurate epidemiologic descriptions that policymakers need to plan appropriate prevention and intervention strategies.

This Executive Summary presents findings from the OSAM core scientific meeting held in Columbus, Ohio, on June 29, 2012. It is based upon qualitative data collected January through June 2012 via focus group interviews. Participants were 355 active and recovering drug users recruited from alcohol and other drug treatment programs in each of OSAM's eight regions. Data triangulation was achieved through comparison of participant data to qualitative data collected from 102 community professionals via individual and focus group interviews, as well as to data surveyed from coroner's offices, family and juvenile courts, common pleas and drug courts, the Ohio Bureau of Criminal Investigation (BCI), police and county crime labs. In addition to these data sources, media outlets in each region were queried for information regarding regional drug abuse for January through June 2012. OSAM research administrators in the Division of Planning, Outcomes and Research at ODADAS prepared regional reports and compiled this summary of major findings. Please refer to regional reports for more in-depth information about the drugs reported on in this section.

Powdered Cocaine

Powdered cocaine remains highly available in most regions and moderately to highly available in Athens, Cincinnati and Cleveland. A likely decrease in availability exists for Cincinnati. Law enforcement in the Cincinnati region reported that desirability for powdered cocaine has decreased during the past six months as other drugs became more popular. The following themes related to the status of powdered cocaine emerged again during this reporting cycle: a sizeable portion of available powdered cocaine is

held by dealers to sell as crack cocaine, thus crack cocaine remains seemingly more available than powdered cocaine; powdered cocaine has become somewhat displaced or "less trendy" in some areas due to the rise in popularity of heroin; and many treatment providers continued to report that powdered cocaine is not commonly identified as a primary drug of choice by those entering alcohol and other drug treatment programs. The most common participant quality score of powdered cocaine throughout the regions varied from '5' to '10,' with the most common score being '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants supplied a range of quality scores because the quality of powdered cocaine was said to be inconsistent and varied widely. Factors that were said to influence quality included law enforcement activity and proximity to dealer sources. Regional crime labs most often continued to report levamisole (livestock dewormer) along with local anesthetics (benzocaine, lidocaine and procaine) as most frequently used to cut (adulterate) powdered cocaine. Only participants in Toledo reported that bath salts (synthetic compounds containing methylone, mephedrone or MDPV) are also used to cut powdered cocaine. Current street jargon includes many names for powdered cocaine, with the most common names being "blow," "coke," "girl," "powder," "soft," "snow," "white" and "white girl." Depending on desired quality and from whom one buys, a gram of powdered cocaine currently sells for between \$40-120 throughout the regions. Participants reported that the most common way to use powdered cocaine remains snorting; however, participants reported that intravenous injection and smoking are also common methods. Many participants continued to report that new users are more likely to snort powdered cocaine, but eventually progress to either smoking or intravenously injecting powdered cocaine. It is important to note that when users discussed the popularity of smoking powdered cocaine, almost all of them meant that the powder would be "rocked up" to create crack cocaine, and not used for the freebase smoking method. Participants generally described the typical user of powdered cocaine as White, mature, suburban and professional who would prefer to snort the drug, or heroin users who inject cocaine with heroin (aka "speedball"). However, participants and community professionals in almost every region continued to report that powdered cocaine is becoming increasingly more popular among young people of high school and college ages. Treatment providers throughout regions almost universally viewed powdered cocaine as a drug of abuse, rather than dependence, with treatment providers in Akron-Canton identifying the drug as a gateway drug to crack cocaine and intravenous drug use. Reportedly, powdered cocaine is used in combination with alcohol, hallucinogens [LSD (lysergic acid diethylamide) and psilocybin mushrooms], heroin, marijuana, prescription opioids, sedative-hypnotics and

tobacco. There was consensus among participants that it is more common to use powdered cocaine with other drugs than to use it alone, with many participants throughout the regions again noting an increase in users who “speedball” both cocaine and heroin either together or successively.

Crack Cocaine

Crack cocaine remains highly available in all regions. Participants in every region 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). Crack cocaine is reportedly available through street purchase from unknown dealers, as well as from established connections. Participants from small towns and rural areas continued to report that crack cocaine is sometimes difficult to find and said that it is most often obtained from connection with dealers in urban areas. Participants in Cleveland mentioned the role vehicles play in the purchase of crack cocaine. In particular, participants said dealers will pull up behind cars and honk to see if the occupants are interested in purchasing crack cocaine. Most regions reported that availability has remained stable during the past six months; however, three regions reported a change in availability. Athens and Dayton regions reported that availability of crack cocaine has likely decreased. Participants explained that users are switching to heroin because many dealers are now carrying both drugs. This same trend was also mentioned in regions that experienced no change in availability. Some participants also mentioned that heroin is preferred because it is cheaper than crack cocaine. Akron-Canton was the only region that reported a likely increase in crack cocaine. Typically, respondents said the increase was due to a higher demand of the drug by younger users and new dealers moving into the area. Perceived quality of crack cocaine is moderate in all regions; the most common participant quality score for crack cocaine varied throughout the regions from ‘3’ to ‘10’, with the most common score being ‘4’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Reportedly, quality continues to vary depending on several factors, such as the particular dealer, location of purchase and time of the day or time of the month of purchase. Many participants felt that it has become standard practice to “recook” crack cocaine to remove additives and cutting agents. Participants in Cincinnati and Columbus regions reported that the quality of crack cocaine has decreased during the past six months and explained they were seeing more “dummy dope” or “fleece” (substances sold as crack cocaine that have no actual drug content). In Cleveland, participants noted the growing popularity of yellow-colored crack cocaine (aka “butter”), which they perceived as more potent than the white, beige or grey types. Crime labs throughout the state continued to cite levamisole (livestock dewormer) as commonly used to cut

crack cocaine. Current street jargon includes many names for crack cocaine, with the most common names being “crack,” “hard,” “rock” and “work.” Participants continued to report that crack cocaine is most commonly sold as \$10, \$20 and \$50 “rocks” and not commonly sold by weight. Throughout the regions, a gram sells for between \$25-100, but the price largely depends on quality of the drug and connection to the dealer. While there were a few reported ways of using crack cocaine, the most common route of administration continues to be smoking, with a minority of participants reporting intravenous injection. However, participants in the Athens and Youngstown regions said that smoking and intravenous injection are equally common, and participants from rural areas in Dayton said intravenous injection was common. A profile of a typical crack cocaine user did not emerge from the data. Most participants and community professionals agreed that crack cocaine is popular with, “everyone.” However, many participants agreed that a stigma is attached to users of crack cocaine and addicts were perceived to be African-American and of lower socio-economic status. Crack cocaine is often used in combination with alcohol, Ecstasy, heroin, marijuana, prescription opioids, sedative-hypnotics and tobacco. Typically, these drugs are used in combination with crack cocaine to help bring a user “down” from the intense high that is associated with the drug.

Heroin

Heroin remains highly available in all regions. During the previous reporting period, heroin availability had increased in all regions with the exception of Columbus where it remained highly available. During this reporting period, heroin availability has continued to increase in Athens, Cincinnati and Cleveland; likely increases in availability exist for all other regions. Participants commented on the “epidemic” proportions that heroin has reached throughout regions. Even participants who did not use heroin personally reported friends or family members who did. Participants continued to attribute heroin increases to users transitioning from prescription opioids to heroin, along with a general increase in the popularity of heroin; community professionals reiterated the progression from abuse of prescription opioids to heroin, especially among younger users. Participants in Cleveland reported that heroin is now commonly available through anonymous transactions, whereas in previous reporting periods, participants and law enforcement remarked on the “closed network” of heroin users and dealers. In addition, participants in many regions reported that crack cocaine dealers are switching their inventory to accommodate increasing demand for heroin. Treatment providers in Akron-Canton also noted a significant increase in heroin availability in rural areas. In Athens, treatment providers reported that treatment facilities are currently experiencing an increase in the number of clients

seeking treatment for heroin use; several participants compared the availability of heroin to the availability of marijuana. While many types of heroin are currently available throughout the regions, participants continued to report brown powdered heroin as most available in Akron-Canton, Cleveland, Toledo and Youngstown; brown powdered heroin is also currently most available in Cincinnati and Dayton; brown powdered and black tar heroin are most available in Athens; black tar heroin remains most available in Columbus. The most common participant quality score for heroin varied across regions from '7' to '10,' with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that the quality of heroin has varied during the past six months. However, most agreed that the quality goes up and down and largely continues to depend on users' connections. On occasion, users reported encountering fake heroin. According to a representative from the BCI London Crime Lab, heroin remains, "*reasonably pure.*" However, when heroin is cut, state crime labs reported the following substances occasionally used as cutting agents: acetaminophen, caffeine, diltiazem (medication used to treat heart conditions/high blood pressure), diphenhydramine (antihistamine), lactose, local anesthetics (lidocaine and procaine), noscapine (cough suppressant) and quinine (antimalarial). Current street jargon includes many names for heroin, with the most common names remaining "boy" and "dog food." Participants continued to report buying smaller quantities of heroin most often in \$10 and \$20 amounts (aka "baggies," "berries" and "stamps"); a gram sells for between \$40-200, depending on location. Throughout the regions, the most common way to use heroin remains intravenous injection. However, many participants continued to agree that users new to heroin typically start with snorting the drug. There was consensus among participants and community professionals in Dayton, Toledo and Youngstown that typical heroin users are middle-class and White; a profile for a typical heroin user did not emerge in other regional data. However, participants and community professionals consistently noted age of first time heroin use as decreasing, with Cincinnati participants reporting those as young as 12 years of age beginning use of heroin. Other substances used in combination with heroin include alcohol, crack cocaine, Ecstasy, marijuana, methamphetamine, powdered cocaine, prescription opioids and sedative-hypnotics.

Prescription Opioids

Prescription opioids remain highly available in all regions; increases in availability during the past six months exist for Akron-Canton and Youngstown. In Akron-Canton, particularly methadone and Opana®, in particular, have increased in availability according to most participants and community professionals. In addition, the Stark County Coroner's Office reported prescription opioids as present

in 50 percent of all drug-related deaths. In Youngstown, both participants and community professionals reported increased availability, specifically for Opana®, Roxicet®, Ultram® and Vicodin®. In addition, participants continued to report that OxyContin® OC (original formulation) is almost impossible to obtain. The Mahoning County Coroner's Office reported prescription opioids as now present in 77.8 percent of all drug-related deaths. 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 overall most common route of administration is snorting, followed by intravenous injection and then oral ingestion (swallowing and chewing). In addition to obtaining prescription opioids on the street from dealers, participants continued to list the following other sources for prescription opioids: doctors, emergency rooms, family, friends and other people with prescriptions and pain clinics. A profile of a typical prescription opioid abuser did not emerge from the data. However, many participants and community professionals throughout the regions agreed that prescription opioid abuse is common among adolescents and young adults. However, many participants were keen to note the use of these pills among heroin users and their status as a "gateway drug" to heroin abuse.

When used in combination with other drugs, prescription opioids are most often used with alcohol, caffeine, crack cocaine, Ecstasy, heroin, marijuana, powdered cocaine, sedative-hypnotics and other prescription opioids.

Suboxone®

Suboxone® is moderately to highly available throughout the regions; availability remains high in Akron-Canton, Athens, Toledo and Youngstown, has increased to high in Cincinnati, is moderate to high in Cleveland and is moderate in Columbus and Dayton. During the past six months, increases in availability exist for Akron-Canton, Athens and Cincinnati; likely increases exist for Columbus, Dayton and Youngstown. In Akron-Canton and Columbus, participants and community professionals noted that Suboxone® is being prescribed more often, citing the emergence of Suboxone® clinics in these regions. Law enforcement in Cincinnati noted an increase in doctors writing prescriptions for off-label use of Suboxone® for pain to surpass the 100-patient limit for addiction treatment. While many participants reported taking Suboxone® as prescribed, some continued to report trading the drug for heroin or other drugs. Current street jargon includes few names for Suboxone®, including "boxon's," "strips," "stop signs" and "subs." Participants reported that an 8 mg tablet of Suboxone® sells for between \$5-20; 8 mg strips of Suboxone® sell for between \$10-20 per strip. The vast majority of participants continued to report most often taking Suboxone® sublingually (dissolving it under the tongue); snorting and intravenous injection as routes of

administration are considerably less frequent. In addition to obtaining Suboxone® on the street from dealers, participants also reported getting the drug from clinics, doctors, online pharmacies or through purchase from people who are legitimately prescribed them. Those most typically abusing Suboxone® are heroin users; they do not want to get sick due to withdrawal from the drug and need Suboxone® for when they cannot obtain heroin. Reportedly, when used in combination with other substances, Suboxone® is used with alcohol, crack cocaine, marijuana and sedative-hypnotics. Many participants agreed that Xanax® is commonly used in combination with Suboxone®.

Sedative-Hypnotics

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available throughout all regions. Participants from every region reported the overall availability of sedative-hypnotics as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants continued to identify Xanax® as the most popular sedative-hypnotic in terms of widespread use, followed by Ativan®, Klonopin® and Valium. Availability of sedative-hypnotics has remained the same in every region during the past six months. The most common way to obtain sedative-hypnotics remains through friends, family members and physicians. Reportedly, users continue to memorize and feign symptoms of anxiety disorders to obtain prescriptions. The most popular sedative-hypnotics typically sell for between \$2-3 per milligram, but may sell for as little as \$0.40 or as much as \$3.50, depending on the buyer's connections. Less popular sedative-hypnotics (such as Ambien® and Soma®) are commonly sold for between \$0.50-4 per pill. Regions that have secondary data from coroner's offices report that sedative-hypnotics are the second most common drug found in drug-related deaths. The most common routes of administration for sedative-hypnotics are oral ingestion (swallowing or chewing) and snorting. As previously reported, participants in Columbus reported a high frequency of intravenous injection of sedative-hypnotics. Typically, this practice is relatively rare throughout the state. A typical user of sedative-hypnotics did not emerge from the data in most regions. Participants and community professionals in these regions said that users represent people of every demographic. In contrast, respondents in Akron-Canton, Cincinnati and Toledo said there are typical users. Participants and community professionals in Cincinnati and Toledo said that women and Whites represented typical users. In Akron-Canton and Toledo, participants and community professionals were more likely to say that people in certain professions (i.e., restaurant workers) and people under frequent stress are more likely to abuse sedative-hypnotics. For the first time in Athens, participants also identified a subset of

users who they referred to as "pharmies;" people who like to use prescription opioids and sedative-hypnotics. Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used with alcohol, heroin, marijuana and prescription opioids. Participants often used these drugs in combination to increase or extend a high, or to "come down" from the high associated with stimulants. For example, participants might use alcohol with sedative-hypnotics to produce a "forget-me-not" effect (blackout) and others may use Xanax® with heroin to intensify the "nod" or high associated with the drug.

Marijuana

Marijuana remains highly available throughout all regions. Participants from every region most often reported the overall availability of marijuana as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals from nearly every region said that marijuana is the most common drug in the region. Typically, participants reported that the drug is available any time of day or night on any day of the week. While some drugs require significant travel for participants to obtain, marijuana is one of the few drugs which is equally present in both urban and rural areas. Seven of the eight regions experienced stable high availability of marijuana during the past six months; a likely increase in availability exists for Cleveland. Participants in Cleveland commented on the preference for high-grade marijuana if the user has the money to afford it. Every grade of marijuana is available throughout the regions, and participants continued to explain that the quality of marijuana depends on whether the user buys regular- or commercial-grade marijuana (low- to mid-grade marijuana) or hydroponically grown (high-grade marijuana). Participants commonly rated the quality of commercial-grade marijuana as between '3' and '6,' while they rated the quality of higher-grade marijuana as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Some participants believed marijuana to be adulterated with herbs and spices. Cleveland was the only region to report that growers are spraying commercial-grade marijuana with a synthetic cannabinoid to make the high similar to that of high-grade marijuana. Participants from a majority of regions reported that the quality of marijuana has increased during the past six months. Participants reported the increased quality is due to several factors, including increased demand for high-quality marijuana, increased importation of marijuana from states where marijuana is legal and changes in growing practices. The most commonly cited names for marijuana reflected general names for the drug ("pot" and "weed") or specific varieties of high-grade marijuana ("diesel," "loud" and "kush"). Prices for marijuana depend on the quantity and quality desired: for commercial-grade marijuana, a "blunt" (cigar)

sells for between \$5-10; an ounce sells for between \$80-150. Higher quality marijuana (hydroponically grown or high-grade marijuana) sells for significantly more: a blunt sells for between \$10-20; an ounce sells for between \$250-550. The most common route of administration remains smoking, with a minority of users baking marijuana into food. A profile for a typical marijuana user did not emerge from the data. Participants and community professionals throughout the regions continued to describe typical users of marijuana as transcending age, gender and racial categories. Reportedly, marijuana is used in combination with almost every other drug including: alcohol, crack and powdered cocaine (aka "primo"), hallucinogens [liquid LSD and PCP (phencyclidine); aka "woo" and "wet"], heroin and prescription opioids. Participants said marijuana is combined with other drugs to modify or increase the high associated with the other drug. Some participants used marijuana with stimulants to "come down," while other participants laced their marijuana with other drugs to combine effects.

Methamphetamine

Methamphetamine availability is variable throughout most of the regions, generally with lower availability in urban areas and higher availability in rural areas. Participants from throughout the state reported the overall availability of methamphetamine as between '2' and '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). As with previous reporting periods, participants and community professionals agreed that the drug is most available to those who become part of the tight-knit network of dealers and users. Methamphetamine availability appeared highest in the Akron-Canton and Cleveland regions, but select counties in other regions (Ashtabula) also experienced high availability. Six of the eight regions experienced increased availability of methamphetamine during the past six months; five of these regions experienced likely increases and one was a definite increase (Akron-Canton). Participants and community professionals explained that the increase in methamphetamine is likely due to growing knowledge about the "one-pot" or "shake-and-bake" method of production. One-pot refers to the method of manufacturing methamphetamine where users, or "cooks," produce the drug in approximately 30 minutes at nearly any location by mixing common household chemicals, along with ammonium nitrate found in cold packs and pseudoephedrine in a single container, such as a two-liter plastic soda bottle. The Drug Enforcement Administration in Toledo discussed "rolling meth labs," where the drug is produced in vehicles; users from other regions also discussed the popularity of these labs. The quality of methamphetamine depends on several factors including the form of the drug purchased, as well as the knowledge of the manufacturer. While powdered and

crystal methamphetamine are both available in the state, the powdered form of the drug is much more common. Overall, the quality of methamphetamine ranges from '4' to '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality), with crystal methamphetamine being at the higher end of the scale. Typically, participants said that crystal methamphetamine is infrequently manufactured in the state and imported from other states. The most commonly cited names for methamphetamine were "crank," "crystal," "glass," "ice" and "meth." Prices for methamphetamine depend on the quantity and quality of the drug: a rock or vials sell for \$20; 1/2 gram of powdered methamphetamine sells for between \$25-60; a gram of powdered methamphetamine sells for between \$80-150. Prices for crystal methamphetamine were rarely reported. Participants said that dealers would sell the drug at cheaper prices if the buyers could provide some of the ingredients for methamphetamine. Throughout the state, the most common route of administration for this drug is smoking. Snorting remains common in a few regions (Cleveland and Columbus), and intravenous injection is relatively rare unless the user also injects other drugs, especially heroin. Half of the regions described a typical user of methamphetamine. Participants and community professionals in Akron-Canton, Cincinnati, Columbus and Youngstown most often described users as Whites between the ages of 18 and 40 years. Some of these regions explained that male and female users are equally seen, while others said that users are more likely male. Participants in Akron-Canton, Cleveland and Columbus also mentioned that this drug is popular in the gay community, especially at clubs. Reportedly, methamphetamine is most often used in combination with alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics. Participants frequently reported use of alcohol and prescription opioids as "downers" to assist in coming off methamphetamine. Users also combine methamphetamine with heroin to modify the high produced by methamphetamine and to create a "speedball" effect.

Ecstasy

Ecstasy is moderately to highly available throughout all regions. Participants most often reported the overall availability of Ecstasy as between '6' and '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Most regions experienced stable availability of Ecstasy during the past six months; however, Dayton experienced decreased availability; Toledo experienced a likely decrease in availability; and Cleveland experienced a likely increase in availability. Participants in Dayton and Toledo said Ecstasy is highly seasonal and that it was the wrong time of the year to obtain it. Participants in Cleveland reported the increase in availability as linked to a better understanding of the drug's manufacturing process.

Participants in Cleveland offered a quality rating of Ecstasy, most often reporting overall current quality as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). However, many participants felt that quality is difficult to predict. Participants from every region said that "Molly" is the purest and most desirable form of the drug. When crime labs reported substances found in Ecstasy, they explained Ecstasy tablets contain a variety of chemicals including cathinones, dimethyltryptamine (DMT) and benocyclidine (psychoactive drug), which is usually in tablets with 5-MeO-Dipt and caffeine. Current street jargon for Ecstasy is limited to "Molly," "sals," "Skittles®" and "X." Participants reported that a "single stack" (low dose) generally sells for between \$3-10; a "double stack" or a "triple stack" (high doses) sell for between \$10-25. Reportedly, the most common route of administration remains oral ingestion, with several regions mentioning parachuting (wrapping the tablet in tissue and swallowing). Respondents agreed that Ecstasy is most popular with young adults and college students, especially those who go to outdoor music festivals and raves (underground dance parties). Participants reported that Ecstasy is used in combination with alcohol, marijuana and tobacco.

Prescription Stimulants

Prescription stimulants remain highly available throughout all regions. Participants from nearly every region reported the overall availability of these drugs as '8' or '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). However, prescription stimulants are only moderately available in Dayton, and participants in Akron-Canton did not report on these drugs. Participants continued to identify Adderall® as the most popular prescription stimulant in terms of widespread use, followed by Concerta® and Ritalin®. Vyvanse®, a newer prescription stimulant, is also available in some regions. Availability of prescription stimulants has remained the same in every region during the past six months. The most common way to obtain prescription stimulants is through friends, family members and physicians. Current street jargon for prescription stimulants is limited to "addies" for Adderall®. Prices for prescription stimulants vary depending on the region. The following prescription stimulants are available to street-level users: Adderall® (sells for between \$2-10 per pill), Concerta® (27 mg sells for \$2.50; 36 mg sells for between \$2-3), Ritalin® (sells for between \$2-3 per pill) and Vyvanse® (sells for \$7 per pill). The most common routes of administration for prescription stimulants are oral ingestion (swallowing or chewing) and snorting. Participants and community professionals agreed that teenagers (12 years of age and older) and college students are the most likely people to abuse these drugs. Participants in Athens, Columbus and Dayton also identified women who want to lose weight as typical users. Reportedly, prescription stimulants are used in combination with alcohol, crack cocaine, opiates and

sedative-hypnotics. Use of prescription stimulants with alcohol enables the user to, "party longer." Drugs like opiates and sedative-hypnotics help the user "come down" from the high of prescription stimulants, while other drugs like cocaine help to intensify the high produced by these drugs.

Bath Salts

Bath salts (synthetic compounds containing methylenedioxymephedrone or MDPV) have variable availability throughout the state. The generic term, bath salts, is deceiving because they are not substances meant to be put in a bath; rather the name represents a vague term that the average person would not suspect to be a drug of potential abuse. Despite the law that went into effect in October 2011 which banned their sale, bath salts continue to be readily available throughout the state. Participants in Akron-Canton, Athens, Cincinnati and Columbus most often reported the current availability of bath salts as '10', while participants in Cleveland, Dayton, Toledo and Youngstown most often reported current availability as '4' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Four of the eight regions experienced increases in the availability of bath salts during the past six months; Athens, Cincinnati and Toledo experienced likely increases, while Columbus experienced an increase. Cleveland and Youngstown experienced likely decreases in availability during the past six months, while Akron-Canton and Dayton experienced stable availability. Generally, increases in availability were linked with rising popularity of the drug and increased law enforcement seizures, and decreases in availability were linked to the legislation banning the sale of bath salts. Participants disclosed that bath salts are still available through many of the same gas stations and convenience stores that previously sold the drugs as well as through personal connections. Participants said that some of these products are illegal under current law, while others walked a narrow line of legality; they explained that manufacturers are trying to circumvent the law by using chemical analogues or marketing their products as glass cleaner, iPhone® cleaner, pipe cleaner and rim cleaner under names like "Eight Ball," "Pump-it Powder" and "Rush." Most crime labs reported that chemical analogues of the outlawed substances are being seen in their labs, including 4-Fluoroamphetamine, 4-Fluoromethamphetamine and alpha-PVP. Prices for bath salts vary throughout the state. Reportedly, a "lid" (unknown quantity) of bath salts sells for \$10; a "jar" (unknown quantity) of bath salts sells for between \$20-30; and a gram of bath salts sells for between \$20-40. The most common route of administration differs depending on the region; however, every method is most common in at least one region. A profile for a typical user did not appear in any region. Participants and law enforcement from several regions said the drug appeals to younger users younger than 30 years of age. Reportedly, users infrequently combine bath

salts with other substances. Only participants in Cleveland mentioned using heroin with bath salts to come down from the intense high produced through bath salts use.

Synthetic Marijuana

Despite the law that went into effect in October 2011 which banned its sale, synthetic marijuana ("K2" or "Spice") continues to be readily available in most regions of the state. With the exception of Athens, all regions reported high availability of synthetic marijuana. Participants in Akron-Canton, Cincinnati, Cleveland, Toledo and Youngstown most often reported current availability of the drug as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); participants in Athens rated current availability as '4.' Likely increases in availability during the past six months exist for Cincinnati, Columbus and Toledo; likely decreases in availability exist for Athens and Youngstown; all other regions experienced stable availability. Generally, increases in availability were linked with increased seizures by law enforcement and increased processing of the drug by crime labs. Decreases in availability were linked to changes in the law and increased testing for synthetic marijuana by courts. Like bath salts, participants disclosed that synthetic marijuana remains available through many of the same gas stations and convenience stores that previously sold the drugs, as well as through personal connections. Participants reported manufacturers are trying to circumvent the law by using chemical analogues or marketing their products as "mosquito repellent," "plant food" and "potpourri" under brand names such as "Bob Marley," "K3," "Kush," "Mad Hatter," "Mr. Happy" and "Purple K2." Regional and local crime labs reported that both the outlawed substances and chemical analogues have been processed in their labs during the past six months, including AM2201, JWH-122 and JWH-210. While there is significant regional variation in pricing, typically a gram of synthetic marijuana sells for between \$1.50-10; 3.5 grams sells for between \$30-40. As with marijuana, the most popular route of administration for this drug remains smoking. Participants and treatment providers continued to note that individuals who use synthetic marijuana tend to be people on probation who are using the substance to avoid screening positive on urine drug screens.

Other Drugs

OSAM Network participants listed a variety of other drugs as available in Ohio, but these drugs were not reported in all regions. Participants mentioned anabolic steroids as moderately to highly available at fitness centers in the Cincinnati and Dayton regions. Typically a 6-week cycle of anabolic steroids costs \$150; a 10-week cycle costs \$200. Law enforcement reported typical users of anabolic steroids as White males between the ages of 18-40 years who are involved in athletics and body building. Hallucinogens

[dimethyltryptamine (DMT), LSD, PCP and psilocybin mushrooms] remain available in many regions of the state. Participants reported DMT, a psychedelic compound, is occasionally available in Cincinnati, Cleveland and Toledo; however, they noted the drug is not widely used. Reportedly, DMT is sold in powder form and obtained from dealers, other users and through the Internet. Only participants in Cleveland spoke about the quality of DMT, and they rated it as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Current street jargon for DMT was limited to "hippie crack." Participants reported that a "point" (1/10 gram) sells for \$10; a gram sells for between \$90-120. Participants reported that the most common routes of administration are smoking and snorting. Reportedly, DMT is used in combination with heroin and marijuana. While the numbers were relatively low, all three BCI crime labs reported that cases of DMT have increased during the past six months. LSD (aka "acid") is rarely to moderately available in most regions, with the exception of Dayton where it is highly available. Many participants indicated that LSD is considered a seasonal drug and more available at certain times of the year. Reportedly, LSD sells for between \$5-10 per "hit" (dose). In Cincinnati, first time users of LSD are reportedly as young as 14 years of age. While a typical user profile did not emerge in every region, respondents frequently mentioned that users of LSD are teenagers and young adults. Three crime labs reported that cases of LSD have decreased, and only one reported that LSD cases have increased during the past six months. PCP remains highly available in certain areas of Cleveland. As with the last reporting period, most participants reported obtaining PCP (aka "water," "wet" or "woo") from an area called "water world" on the east side of Cleveland. Participants rated the quality of PCP as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Liquid PCP is still commonly sold on a per-dip basis. Pricing has remained consistent with the previous reporting period: a dip of a cigarette sells for between \$10-20. The crystalline powder form is reportedly very rare. PCP is most commonly used in combination with alcohol, marijuana and tobacco. Psilocybin mushrooms (aka "shrooms") are moderately to highly available in most regions; the only regions in which respondents did not report this drug were Cleveland and Toledo. Like other hallucinogens, participants said psilocybin mushrooms were seasonally available, found most often in the spring and summer months. Most crime labs reported that availability of psilocybin mushrooms has stayed the same during the past six months; only two mentioned a decrease in availability. Reportedly, dried psilocybin mushrooms are the most available form of the drug, although spores to grow them are reportedly available for \$8 per vial; 1/8 ounce of dried psilocybin mushroom material sells for between \$20-30; 1/4 ounce sells for between \$40-60; 1/2 ounce sells for between \$70-80. Participants reported typical users as young adults and college students. Inhalants (aka "duster" and "gas") are highly available throughout most regions, but these

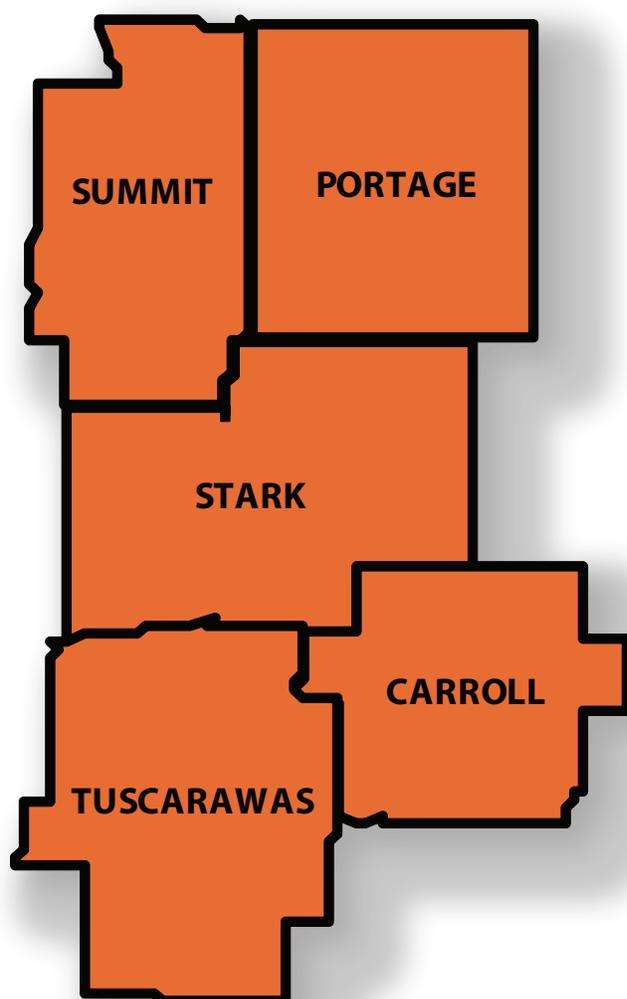
substances are not preferred by most drug users. Participants and community professionals identified the most commonly abused inhalants as computer duster, nitrous oxide and Freon. Treatment providers and law enforcement in the Columbus region reported some heroin users are turning from heroin to inhalants as an alternative to their primary drug of choice. Law enforcement also mentioned other substances (Kratom shots and Eliqweed) with which users are experimenting. Apparently, these new products are so popular that head shops have a hard time keeping them stocked. Typically, inhalant users are junior- and high-school aged adolescents who have little access to other drugs. Over-the-counter (OTC) and prescription cough and cold medications remain highly available across most regions. Participants mentioned abusing Coricidin Cough and Cold® (aka “Triple C’s”) along with other cold and cough medications (chlorpheniramine/hydrocodone or promethazine/codeine) to get high. Typically, participants combine these medications with Sprite® and pieces of Jolly Rancher® candy as described in popular rap music lyrics. Like inhalants, OTC cough and cold medicines were also identified as substances that younger individuals in middle and high school are more likely to abuse. In Cleveland, the abuse of prescription cough and cold medications is strongly associated with young Blacks and “*people at rap shows*” because these medications are a frequent topic of rap songs.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Akron-Canton Region

January-June 2012

John R. Kasich, Governor
Orman Hall, Director



Regional Epidemiologist:

Joseph Cummins, MA, PCC-S, LICDC

OSAM Staff:

R. Thomas Sherba, PhD, MPH, LPCC
OSAM Principal Investigator

Rick Massatti, MSW
Research Administrator,
OSAM Coordinator

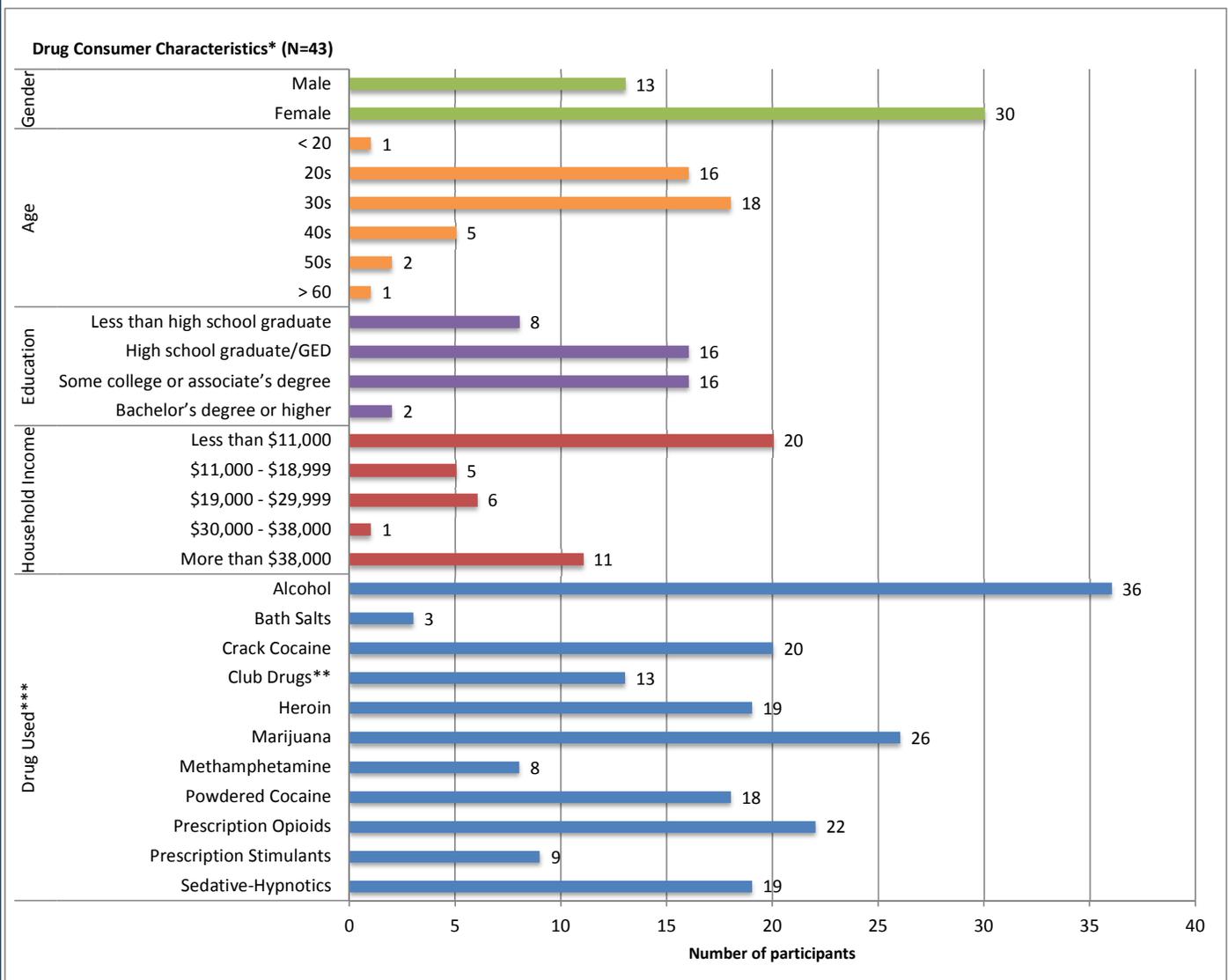
Akron-Canton Regional Profile

Indicator ¹	Ohio	Akron-Canton Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	1,200,204	43
Gender (Female), 2010	51.2%	51.5%	69.8%
Whites, 2010	81.1%	85.4%	83.7%
African Americans, 2010	12.0%	9.4%	11.6%
Hispanic or Latino Origin, 2010	3.1%	1.6%	0.0%
High school graduates, 2009-2010	84.3%	86.3%	81.0% ²
Median household income, 2010	\$45,151	\$43,371	\$11,000 - \$18,999 ³
Persons below poverty, 2010	15.8%	14.7%	53.5%

Ohio and Akron-Canton statistics are derived from the U.S. Census Bureau.¹

Graduation status was unable to be determined for one respondent due to missing data.²

Respondents reported income by selecting a category that best represented their household's approximate income for 2012.³



*Not all participants filled out forms; therefore, numbers may not equal 43.

**Club drugs refer to DMT, Ecstasy, LSD and psilocybin mushrooms.

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Portage, Stark, Summit and Tuscarawas counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Canton-Stark County Crime Lab and the Stark County Coroner's Office. All secondary data are summary data of cases processed from July through December 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current secondary data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2012.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers and law enforcement most often reported the drug's availability as '8' and '7' respectively. Participants and treatment providers generally did not agree as to whether the availability of powdered cocaine had increased, decreased or remained the same during the previous six months. Law enforcement reported that availability had remained the same, while the Canton-Stark County Crime Lab reported that the number of powdered cocaine cases it processed had increased during the previous six months. Most participants rated the quality of powdered cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The Canton-Stark County Crime Lab cited the following substances as commonly used to cut (adulterate) powdered cocaine: levamisole (livestock dewormer), maltose (disaccharide sugars) and procaine (local anesthetic). Participants reported that the quality of powdered cocaine had decreased during the previous six months. The most commonly cited street names for powdered cocaine were "blow," "soft," "snow" and "white girl." Participants reported that 1/4 gram, or "baggie," of powdered cocaine sold for between \$25-40, depending on the quality; a gram sold for between \$40-60. The most common route of administration for powdered cocaine remained snorting. Many participants commented, however, that in some groups, intravenous use of cocaine was more common than snorting. A profile for a typical powdered

cocaine user did not emerge from the data, though some participants commented that the typical user of powdered cocaine was White. Treatment providers described typical users as "upper-middle class; Caucasian females between ages 20 and 30 [years]." Regarding typical age of users, treatment providers noted a "minimal increase" in powdered cocaine use among high-school-aged youth. Law enforcement reported that between the ages of 18 and 25 years, there was an "exponential jump" in powdered cocaine use.

Current Trends

Powdered 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'. Participants commented, "You can get it [powdered cocaine] anywhere in Akron. Just go down the street and get it; you can go to any part of Akron, you don't have to know anybody." Treatment providers most often reported current availability of powdered cocaine as '8'; the previous most common score was also '8'. However, many treatment providers noted that powdered cocaine is not commonly identified as a primary drug of choice. A treatment provider commented, "[Powdered cocaine is] easy to get, but my experience is that it is often not the drug of choice." Other treatment providers commented: "[Powdered cocaine is] very widely available, but the trend is more that powdered cocaine is mixed with other chemicals; I hear a lot of [powdered] cocaine being used with alcohol, marijuana, heroin ... not just cocaine itself." Law enforcement reported the drug's current availability as '8'; the previous most common score was '7'. The Stark County Coroner's Office reported that 24 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range at time of death); in the last reporting period, 10.9 percent of all deaths were drug related. Furthermore, the coroner's office reported cocaine as being present in 23.2 percent of all drug-related deaths; in the last reporting period, cocaine was present in 16 percent of all drug-related deaths (Note: coroner's data is aggregate data of powdered cocaine and crack cocaine and does not differentiate between these two forms of cocaine).

Participants most often reported that the availability of powdered cocaine has remained the same during the past six months. However, participants in Portage County reported an increase in availability, commenting, "More people I'd never expect [to sell cocaine] are selling it [powdered cocaine]; Heroin dealers are carrying cocaine also; There's less jobs, selling [cocaine] is a quicker way to make money. People are desperate to make money ..." Treatment providers and law enforcement also most often reported that the availability of powdered

cocaine has remained the same during the past six months. A law enforcement officer described availability as “pretty level.” The Canton-Stark County Crime Lab reported that the number of powdered cocaine cases it processed has decreased during the past six months.

Most participants rated the quality of powdered cocaine as ‘6’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the previous most common score was ‘5’. Participants reported that powdered cocaine in the region is cut with baby aspirin, baby laxatives, baby powder, baking soda, benzodiazepines, dietary supplements, ether, methamphetamine, NoDoz®, Orajel® and vitamin B-12. In terms of the quality of powdered cocaine, most participants agreed with the following comments, “It [quality of powdered cocaine] depends. It’s 50/50. Depends on where you are at, who you go to, if there is a middleman or not. It could be fine one time, shit another time.” A participant also reported that there are “a lot of new dealers on the street, trying to rip people off.” A participant noted, “I’ve been sold soap [fake/dummy cocaine] several times.” The Canton-Stark County Crime Lab cited the following substances as commonly used to cut cocaine: baking soda, levamisole (livestock dewormer), lidocaine and procaine (local anesthetics). (Note: crime lab data is aggregate data of powdered cocaine and crack cocaine and no longer differentiates between these two forms of cocaine.)

Current street jargon includes many names for powdered cocaine. The most commonly cited names were “blow,” “snow” and “white girl.” Participants listed the following as other common street names: “bitch,” “coke,” “fire,” “fish scales,” “fuel,” “girl,” “powder,” “soft,” “white,” “winter time” and “ya-yo.” In addition, participants reported the phrase, “You want to go skiing?” as jargon to buy powdered cocaine. Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine. Participants reported that 1/4 gram, or “baggie,” of powdered cocaine sells for \$20; a gram typically sells for between \$50-100; 1/16 ounce, or “teener,” sells for between \$70-120; 1/8 ounce, or “eight ball,” sells for between \$100-250; an ounce sells for between \$1,200-1,300. Participants reported different variables that affect the price of powdered cocaine. For example, a participant reported that, “really good cocaine,” cocaine cut with methamphetamine, known by the street name “fire,” sells for as high as \$250 for an eight ball. A participant also reported, “It [price of powdered cocaine] depends on how much you buy. If you work with someone [a particular dealer] consistently, they will hook you up for cheaper prices.” Most participants reported that for users, it is most common to purchase powdered cocaine by the gram, though it was reported that it is also common to buy quantities of \$20, \$40, \$50 or \$100. Participants continued to report that the most common route of administration for powdered cocaine remains snorting. Out of 10 powdered cocaine

users, participants reported that seven would snort and three would intravenously inject. A participant stated, “It [route of administration] depends on who you use it with.” In addition, a participant reported smoking powdered cocaine, mixing the drug with water on foil and smoking it off the foil, while another participant reported oral use of cocaine, sucking powdered cocaine into the mouth with a straw when the sinuses are blocked or irritated.

A profile for a typical powdered cocaine user did not emerge from the data, though some participants commented that the typical user of powdered cocaine is from the upper-middle class. A participant commented, “I know people you’d never expect to use drugs who use cocaine ... doctors, lawyers. There’s not as much stigma with [powdered] cocaine use as other drugs.” It was noted in one group that there are “a lot” of children (as young as 12 or 13 years old) who are using powdered cocaine. Treatment providers described typical users as Caucasian, middle- to upper-class, and generally older. Powdered cocaine was viewed by treatment providers to be more of a drug of abuse, rather than dependence, used by individuals with more resources (such as people who are “employed or in college with student loans, or have a significant other with resources,” as one treatment provider stated. However, it was cautioned by a treatment provider that powdered cocaine often serves as a “gateway drug to crack cocaine” or to intravenous drug use. Treatment providers reported that there has been an increase in powdered cocaine use among younger, college-aged individuals. A treatment provider reported, “College students have some extra funds [student loans] to dabble in powdered cocaine.” A treatment provider, who is also a graduate student, reported that at her school, “crack cocaine is looked down on, while powdered cocaine is more acceptable.” A law enforcement official reported, “Distributors tend to be African-American ... their customers tend to be a little bit of everyone.”

Reportedly, powdered cocaine is used in combination with alcohol, hallucinogens [LSD (lysergic acid diethylamide) and psilocybin mushrooms], heroin, marijuana and prescription opioids. Participants reported that alcohol is used to prolong the use and intensify the effects of powdered cocaine. A participant stated, “I would be drunk, and I would use [powdered] cocaine to keep me going. [Powdered cocaine] it gives you super human drinking power.” Individuals who use heroin with cocaine (“speedball”) expressed, “[Speedballing] it’s a different high with an upper and a downer ... You get the rush of heroin, but you still have energy ...” Other participants noted that prescription opioids provide a buffer, helping the user to come down from the stimulant high. In the same way, marijuana was reported by a participant to “calm me,” also serving as a buffer when used with cocaine. A participant reported “strange visions, hallucinations” when using powdered cocaine with hallucinogens. Participants continued

to agree that it is more common to use powdered cocaine with other drugs than to use it alone.

Crack Cocaine Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants and treatment providers most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), while law enforcement reported availability as '5' in Stark County and '7' in Summit County. Participants agreed that crack cocaine was easier to find than powdered cocaine. The Canton-Stark County Crime Lab reported that the number of crack cocaine cases it processed had remained the same during the previous 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 Canton-Stark County Crime Lab cited baking soda and procaine (local anesthetic) as commonly used to cut crack cocaine. Participants reported that 1/8 ounce sold for \$180. Reportedly, users most often purchased crack cocaine in \$20 "rocks" (pieces), but they also purchased smaller rocks (aka "crumbs") for as little as \$3-5. The most common route of administration remained smoking. Participants and treatment providers could not identify a typical user of crack cocaine, but said people of all socio-economic classes, races and ethnicities used the drug.

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'. Participants continued to report that crack cocaine is easier to obtain than powdered cocaine. A participant commented, "[Crack cocaine] it's everywhere ... very, very easy to find, every block ... one of the most easily accessible drugs in Akron." However, participants in Stark County commented that it is difficult to find crack cocaine at times. A participant stated, "Crack cocaine's availability] it's down one day, up the next. [Dealers] move from one side of town, they [police] clean it up ... they [dealers] go to the other side ... back and forth, back and forth." As in previous reports, participants noted that it is common for heroin dealers to also sell crack cocaine. Treatment providers most often reported the drug's current availability as '10'; the previous most common score was also '10'. Law enforcement reported the current availability of crack cocaine as '7'. As an officer explained, "Most crack cocaine is home-grown; they buy the powder [cocaine] and cook it."

Participants generally agreed that the availability of crack cocaine has increased during the past six months. Participants reported that dealers like to sell crack cocaine because of the high-profit margin. A participant said, "[Crack cocaine] it's easier to get. There's more money for dealers in selling crack." Participants also thought crack cocaine is more available because there are more users, as one participant said: "[Crack cocaine] it's attracting a younger crowd, so younger people are selling it." However, some participants in Stark County reported a decrease in availability of crack cocaine. A participant stated, "Around this 'hood [Northwest Canton], they [crack cocaine dealers] are either in jail or they moved." Overall, participants thought it is easier to obtain crack cocaine in Northeast Canton. Treatment providers and law enforcement reported that availability of crack cocaine has remained the same during the past six months. The Canton-Stark County Crime Lab reported that the number of crack cocaine cases it processed has increased during the past six months.

Most participants rated the quality of crack cocaine as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Participants typically reported that the quality of crack cocaine varies from dealer to dealer. A participant commented, "Some [dealers] have good stuff [crack cocaine], some have fake stuff." Participants reported that crack cocaine in the region is cut with baby laxative, baking soda and Orajel®. Participants who were disappointed with the quality of crack cocaine reported re-cooking it to remove the impurities. Overall, participants reported that the quality of crack cocaine has remained the same during the past six months.

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: "A1," "butter," "candy," "cookies," "crack," "crack-a-lacken," "Craig," "la roca," "pebbles," "snap-crackle-pop," "white," "white boy" and "ya-yo." Current street prices for crack cocaine were consistent among participants with experience buying the drug. Participants reported that a gram of crack cocaine sells for \$50; 1/8 ounce sells for between \$100-170. Participants agreed that users could purchase crack cocaine in any quantity; however, the drug is most commonly purchased as a "rock" for between \$10-50, depending on size. Participants reported \$20 rocks are most common. A participant noted, "Crack heads [users] don't have scales. They buy rocks, \$20, \$30 [and] \$50. They then just keep coming back, thinking they are going to save money in their pocket." Another participant stated, "I've seen people come up with a dollar and some change, looking to buy crumbs [of crack cocaine]." While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. Out of 10 crack cocaine users, participants reported that approximately eight would smoke and two

would intravenously inject. Some participants thought that intravenous injection is becoming more common. A participant reported, *"Shooting [injecting crack cocaine] is getting more popular."* Participants explained that some users prefer to inject crack cocaine because this method reportedly decreases cravings for more crack cocaine. A participant stated, *"I did not have that 'want more feeling' [after injecting crack cocaine]"* However, most participant groups cited that intravenous use of crack cocaine is relatively rare.

A profile of a typical user of crack cocaine did not emerge from the data. Many participants agreed with a participant who stated, *"[Crack cocaine] does not discriminate ... [its use] crosses all lines, white collar to the ghetto."* Treatment providers also did not believe that there is a typical crack cocaine user. A treatment provider stated, *"[Crack cocaine use] crosses all classes. It's just that the upper-class [is] able to hide it more. I see upper-class people come into the neighborhoods to purchase crack."* Another treatment provider commented that crack cocaine users are *"pretty diverse, educated registered nurses to high school drop-outs."* One treatment provider group noted an increase in a certain type of user. A treatment provider explained that he saw *"a spike in [the use of crack cocaine among] middle-aged Caucasian males, related to the use of prostitution."* Law enforcement thought that crack cocaine use is more common among some groups. An officer said, *"The majority [of crack cocaine users] we see are lower-class from African-American neighborhoods."*

Reportedly, crack cocaine is used in combination with alcohol, heroin and prescription opioids (both to "speedball") and marijuana. A participant reported, *"I wouldn't smoke crack unless I had some kind of downer [a way of coming down off crack cocaine] for after."* Another participant stated, *"I have to use heroin to come down, or I will freak out."* Participants could not agree whether it is more common to use crack cocaine by itself or with other drugs. However, one participant's comment seemed typical: *"Many people are too busy looking for more [crack cocaine] to use with anything else. But when you want to sleep, or feel normal, you will use Valium®."*

Heroin Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants and treatment providers most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While many types of heroin remained available in the region, participants continued to report brown powdered heroin as the most available. Participants rated the availability of black tar heroin as '2.' Law enforcement in both Stark and Summit counties reported high availability of heroin, and identified brown powdered heroin as the type of heroin law enforcement in the region most often encountered. Participants and community

professionals reported that the availability of heroin had increased during the previous six months. The Canton-Stark County Crime Lab reported that the number of heroin cases it processed had remained the same during the previous six months. Most participants rated the quality of heroin as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The Canton-Stark County Crime Lab cited the following substances as commonly used to cut heroin: caffeine, diphenhydramine (antihistamine), maltose (disaccharide sugar) and procaine (local anesthetic). Participants generally reported that the quality of heroin depended on where one got it. The most commonly cited street names for heroin remained "boy" and "dog food." Participants reported that powdered heroin was available most frequently in "bags" or "points" (1/10 gram), which sold for between \$10-20; a gram sold for between \$100-150. The most common route of administration for heroin remained intravenous injection. Many participants commented that individuals might start off snorting heroin, but would eventually use it intravenously. A profile for a typical heroin user did not emerge from the data. However, some participants reported that heroin users were more likely to be White, while others commented that heroin was more likely to be used by individuals younger than 35 years. Most participants recognized that heroin use was increasing among very young users, as young as 14-15 years. A number of community professionals also noted that heroin use was becoming more popular with younger people, particularly those between the ages of 18-25 years.

Current Trends



Heroin remains highly available in the region. Participants and treatment providers most often reported overall availability of heroin as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. The following participant comments were typical responses to heroin's availability: *"[Heroin] it's everywhere, everywhere, everywhere, more available than cocaine; It's a drug you get sick on, so everyone has to keep using it; Heroin is the new marijuana, everyone is getting high off it; In my apartment complex, I could walk to any building and get it."* While many types of heroin remain currently available in the region, participants overwhelmingly agreed that the most available type of heroin continues to be brown powdered heroin. Participants described heroin as, *"Usually chunky or powder, usually tan; Mostly powder, rock, white or tan ... can be gritty ... can be real hard; People want rock, but usually find powder."* Participants rated the availability of black tar heroin as '3,' the previous most common score was '2.' Participants noted, *"Tar [black tar heroin] is hard to find; If you find tar, you are lucky."* Law enforcement reported heroin's current availability as '8.' A law enforcement officer commented, *"[Heroin] it's pretty easy to get*

a hold of out there. We are still having a lot of OD [overdose] deaths as a result." Another officer reported that black tar heroin is available in the area: *"We've seen a few examples of tar ... from a big sale out of Dayton."* Collaborating data also indicated that heroin is readily available in the region. The Stark County Coroner's Office reported heroin as present in 17.9 percent of all drug-related deaths; in the last reporting period, heroin was present in 16 percent of all drug-related deaths.

Participants unanimously reported that the availability of powdered heroin has increased during the past six months. A participant commented, *"People get hooked on pills [prescription opioids] first, then found heroin is cheaper. Also, oxy's [reformulated OxyContin® OP] turn to gel [when crushed], so people turn to heroin."* Participants noted that the lack of availability of other drugs (OxyContin® OC) has contributed to the increase availability and use of heroin. Treatment providers most often reported that the availability of heroin has remained the same during the past six months, though all recognized that availability is much higher than it was two years ago. A treatment provider commented, *"We hit it high last year. Now, [heroin availability] it's just staying high."* However, treatment providers in Tuscarawas County noted a significant increase in availability of heroin in rural areas: *"Rural areas are attracting [heroin] dealers. They are recognizing there is a market. There has been a crackdown on prescription pills ... clients are marked at the hospital and pharmacies and no longer get their drug of choice [prescription opioids], and hence are turning to heroin. In our [treatment] groups, it used to be one person in the group reported heroin as their drug of choice ... today, it is three or four."* Law enforcement reported that availability of heroin has remained the same during the past six months. The Canton-Stark County Crime Lab reported that the number of heroin cases it processed has increased during the past six months.

Most participants rated the quality of heroin as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '6.' Participants reported that heroin in the region is cut with brown sugar, cocoa powder, coffee, fentanyl, powdered milk, quinine powder, talcum powder, Valium®, vitamin B-12 powder and, as one participant stated *"whatever looks like the heroin."* A participant commented, *"My boyfriend almost died because of heroin cut with Valium®."* Participants continued to report that the quality of heroin depends on where one obtains the drug. A participant noted that the quality of heroin, *"could be good one week, could be bad. It's why people OD [overdose]. Sometimes it's too gummy to shoot, based on being cut wrong."* Others agreed with this comment, with one participant stating, *"If the dealer uses, [heroin quality] it's not as good, 'cause they will cut it more to get some for themselves. But if the dealer does not use, the quality is better."* The majority of

participants agreed that the quality of heroin has remained the same during the past six months. The Canton-Stark County Crime Lab reported that the heroin cases they process have been almost exclusively powdered heroin: tan, beige, white, off-white and brown in color. The crime lab also reported that heroin is cut with diphenhydramine (antihistamine) and lactose.

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "dog food." Participants listed the following as other common street names: "Afghanistan," "brown," "dirty," "H," "junk," "knock out," "Mr. Brown," "puppy chow," "Ron" and "smack." Participants reported that powdered heroin is available in "bags" or "folds" (1/10 gram), which sell for \$20; 1/4 gram sells for \$50; 1/2 gram sells for between \$75-100; a gram sells for between \$100-150. Reportedly, the most common way to purchase heroin is by the bag, and usually for \$20. However, a few participants noted that it is common to buy a 1/4 gram or 1/2 gram, *"splitting it with a buddy because it's a rip off to pay for a bag,"* as one participant stated. Participants also noted that one can purchase heroin in larger quantities for a lower cost, (aka six grams of heroin sells for \$375). A participant commented, *"I used to get a gram [of powdered heroin] for \$70, then triple the profit [by selling the heroin]."* Participants did not report the price of black tar heroin, as it remains relatively rare in the region. Overall, participants reported that heroin pricing has remained the same during the past six months. Participants reported that the most common route of administration for heroin remains intravenous injection. Out of 10 heroin users, participants reported that approximately eight would intravenously inject it and two would snort it. A couple of participants reported knowledge of smoking heroin off of aluminum foil. Many participants continued to comment that individuals may start off snorting heroin, but will eventually use it intravenously. A participant commented, *"Most [start off using heroin by] snorting ... but inevitably, you end up with a needle in your arm."* Most participants reported that needles are readily available in stores with pharmacies and can be purchased with few questions asked. A participant stated, *"I tell them [pharmacy staff] I need insulin needles for my grandmother. You can buy 100 needles for \$10."* Participants also reported that one can purchase needles from individuals with prescriptions, such as diabetics, or from some heroin dealers. Still, participants reported that it is common to share needles, with one stating: *"People share needles, use bleach [to clean them]. Sharing is prevalent. [People feel] it's better to share [needles] than to not use at all."* In addition to sharing needles, another participant noted, *"People use the same ones; I would use my needle until it was crooked, and there was not a point on it."* Very few participants had any knowledge of needle-exchange programs.

A profile for a typical heroin user did not emerge from the data. The following comment was typical among participants, *"It [heroin] does not discriminate. You can never tell who is using or not."* However, some participants agreed with one, who stated, *"I see more White people using heroin than Black people."* Many agreed that heroin use is becoming more prevalent among younger people: *"In the past five years, heroin is skyrocketing among young people. Most are between ages 20 and 35 [years]; Not many over the age of 35, unless they've been using a long time."* Community professionals also did not identify a profile of a typical heroin user. Many treatment providers agreed with one who stated: *"There is so much [heroin] use ... it crosses all lines, no sub-culture."* Likewise, a law enforcement official reported, *"[Heroin use] it's pretty widespread ... we see it everywhere."* While no profile for the typical heroin user was offered, there was consensus among community professionals that there has been a noted increase in the use of heroin among younger people, with some commenting that use begins as early as adolescence.

Reportedly, heroin is used in combination with alcohol, crack cocaine, marijuana, prescription opioids and sedative-hypnotics. While most participants reported that it is more common to use heroin by itself (not in combination with other substances), some use it with alcohol because *"one drug balances the other out,"* with crack cocaine (speedball) because *"you use crack first, gets you geeky, then use heroin to calm down,"* with marijuana because *"it [marijuana] amplifies the high, until you nod out,"* and with sedative-hypnotics because *"they made me real calm, and it makes me feel like it [the high] lasts longer."*

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants identified Opana®, OxyContin® OP, Percocet®, Roxicet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Treatment providers most often reported availability as '9,' and identified OxyContin® OP, Percocet® and Vicodin® as most popular. Participants and treatment providers reported that the availability of prescription opioids had decreased during the previous six months. Many participants commented on the decline in availability of OxyContin® OC particularly, as the old formulation was no longer available; and while the new formulation, OxyContin® OP, was available, it was said to be not liked by users. A noted exception in the decline in availability was an increase in availability of Opana®, which many participants reported as

gaining in popularity. Generally, the most common routes of administration for these drugs remained swallowing, snorting and intravenous injection. In addition to obtaining prescription opioids on the street from dealers, participants also reported getting them from pain clinics, area doctors, emergency rooms and other individuals with prescriptions. Participants reported that it was most common to acquire these drugs off the street. Participants described the typical user of prescription opioids as a young person, teenaged or twenty-something years in age. Treatment providers also reported that prescription opioid use was more common among the younger population. A law enforcement official in Summit County reported that prescription opioid abuse was widespread *"across the board"* in terms of race, gender and socio-economic status.

Current Trends



Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants identified morphine, Opana®, Percocet®, Roxicet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Treatment providers most often reported the current availability as '8,' the previous most common score was '9'. They identified Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Law enforcement reported current availability as '6,' and identified OxyContin® as most popular, though they reported a rising trend in the availability of Opana®. Collaborating data also indicated that prescription opioids are readily available in the region. The Stark County Coroner's Office reported prescription opioids as present in 50 percent of all drug-related deaths; in the last reporting period, prescription opioids were present in 44 percent of all drug-related deaths.

Participants reported that the availability of prescription opioids has increased during the past six months. However, some participants continued to comment on the decline of availability of Oxycontin® OC, reporting that the old formulation costs too much, or is, as one participant stated, *"not as easy to get and 'OP's' [OxyContin® OP, the new formulation] you really can't shoot [inject] them, people just went to heroin."* Treatment providers also reported a decrease in the availability of OxyContin® OC, but an increase in the availability of other prescription opioids, particularly methadone and Opana®. Overall, most participants reported that it is relatively easy to obtain

prescriptions of these medications, or purchase them on the street. While some participants echoed the sentiment of one participant who reported that *“hospital ER’s are red flagging [refusing to prescribe to certain individuals who may be abusing prescription opioids]”* to prevent abuse, more typical comments included ones similar to this participant who stated: *“[Prescription opioids are] easy to get. Just go to the hospital, say your back hurts, they give you Vicodin®. They cannot tell you are lying. They can’t tell you your back don’t hurt. They have to give you treatment. They will send you home with something.”* Other participants agreed with a participant who stated, *“I know people who go to the ER, saying they cannot be on narcotics, and leave with a prescription for narcotics.”* Treatment providers noted the ease by which prescription opioids are legally obtained by prescription. There was agreement among treatment providers that, as one stated, *“pain management docs are not held to the same standard as primary care physicians.”* In addition, treatment providers reported that it is very easy to obtain these medications on the streets, with one stating: *“People trade pain pills for marijuana, crack and [powdered] cocaine.”* Most treatment providers agreed with the following statement from a fellow treatment provider: *“Most clients we see have had some [prescription opioid] use. It’s not always extensive enough for a diagnosis. But, if you can’t find your drug of choice, they will use pain killers.”* A law enforcement official reported that the availability of Opana® is increasing: *“Opana® is taking over due to the new form of oxy’s [OxyContin® OP] ... users are either switching to Opana® or heroin.”* The Canton-Stark County Crime Lab reported that the number of prescription opioid cases it processed has increased during the past six months for fentanyl, morphine, Opana®, Tylenol® 3 and 4, and Vicodin®; decreases were noted for Dilaudid®, OxyContin® and Percocet®.

Reportedly, many different types of prescription opioids are currently sold on the region’s streets. Participants reported the following prescription opioids as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid® (aka “D’s” and “dots;” 8 mg sells for \$20), methadone (5 mg sells for between \$3-5; 10 mg sells for between \$8-10; 40 mg sells for between \$10-20), morphine (aka “morphs;” sells for \$1 per milligram), Opana® (aka “OP’s,” “pans” and “pandas;” 10 mg sells for \$10; 20 mg sells for between \$15-25; 30 mg sells for \$35; 40 mg sells for between \$35-60), OxyContin® (old formulation, aka “OC’s;” 80 mg sells for between \$50-100; new formulation, aka “OP’s;” 80 mg sells for between \$25-40), Percocet® (aka “P’s,” “perc’s” and “perculators;” sells for between \$0.50-1 per milligram), Vicodin® (aka “V’s” and “vic’s;” 5 mg sells for \$2-3; 7.5 mg, aka “750’s;” sells for between \$3-5; 10 mg sells for between \$4-10). While there were a few reported ways of consuming prescription opioids, participants reported that whenever possible the preferred route of administration

is intravenous injection. A participant stated, *“Some pills [prescription opioids] are too much work to break down, so you eat them. If you are hooked, most people shoot them.”*

In addition to obtaining prescription opioids on the street from dealers, many participants also reported that it is easy to have them prescribed. The following participant comments were typical: *“Fake a broken wrist, a tooth ache, that’s what I did [to get a prescription for opioids]; I used to break my bones, to get them. I broke my wrist one time, four fingers, so I could get pain pills.”* Participants reported it is very easy to acquire these medications on the street: *“People who get prescriptions [for opioids], they know they can make a big profit [selling them]. People wait around, because people who get pain pills will sell them out; People steal them, from older people, or hospitals. Sometimes people are assaulted [and robbed of their prescriptions].”*

A profile for a typical prescription opioid user did not emerge from the data. Participants reported that prescription opioid use *“is an epidemic, across the board,”* as one stated. *“Older men and women who get hurt and prescribed these pills are getting addicted.”* Treatment providers also reported that prescription opioid use is present among any subgroup of the population. However, treatment providers noted that the use of Percocet® and Vicodin® is becoming more popular with high-school-aged youth. Treatment providers also expressed concern about pain management practices among older adults, with one making reference to *“the silent addiction.”* *Many [seniors] get involved for legitimate reasons, but they become addicted ...”*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, heroin, marijuana and sedative-hypnotics (benzodiazepines). Participants reported that the combination of prescription opioids with a depressant drug, including alcohol, *“heightens the pills effect, intensifies the opioid buzz.”* When used with marijuana, participants reported, *“It [marijuana] kicks in the buzz more, intensifies it [prescription opioids] ten times,”* as one participant stated. Participants reported that they use prescription opioids with heroin when, as one stated, *“my heroin is not good.”*

Suboxone® **Historical Summary**

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported availability of Suboxone® as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Treatment providers most often reported availability as ‘9’ or ‘10.’ Treatment providers generally believed that Suboxone® was sought by users primarily for withdrawal maintenance. Law enforcement reported the availability of

Suboxone® as '4.' There was no participant data pertaining to availability status of Suboxone® compared to the previous six months. However, treatment providers reported that availability had increased while noting that there were more Suboxone® clinics opening in the region; law enforcement reported that availability had remained the same. The Canton-Stark County Crime Lab reported that the number of Suboxone® cases it processed had increased during the previous six months. Participants reported that a Suboxone® 8 mg pill sold for between \$10-20; Suboxone® strips/film sold for between \$9-12. Participants reported that sublingual (dissolved under the tongue) use of the drug was far more popular than either snorting or intravenous injection. A participant group cited that 80-90 percent of users used Suboxone® sublingually. In addition to obtaining Suboxone® on the street from dealers, participants continued to report getting the drug from pain clinics, doctors and Suboxone® clinics. Participants commonly reported that some individuals obtained prescriptions to sell Suboxone® and/or trade them for other drugs. A profile for a typical Suboxone® user did not emerge from the data.

Current Trends



Suboxone® remains highly available in the region. Participants most often reported current availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' Participants reported that Suboxone® is used both to avoid withdrawal symptoms and as a drug to get high. A participant stated, *"I would use [Suboxone®] when I couldn't get heroin, to avoid getting sick, about once or twice a month."* Another participant reported, *"Non-heroin users will use it [Suboxone®] to get high. I used Suboxone® twice before I ever used heroin, and I got high."* Treatment providers most often reported the drug's current availability as '8'; the previous most common score was '9' or '10.' Treatment providers also reported that heroin users use Suboxone® when they can't obtain heroin. Law enforcement reported the current availability of Suboxone® as '3'; the previous most common score was '4.' A law enforcement official characterized the availability of Suboxone® as, *"We've seen a couple of cases, but nothing major."*

Participants reported that the availability of Suboxone® has increased during the past six months. Treatment providers also reported that availability has increased while noting that Suboxone® is being prescribed more often. A treatment provider reported, *"We've had several Suboxone® programs opening up ... There is advertising on billboards."* Treatment providers expressed a concern that many consumers are being offered treatment with Suboxone® without being

referred to substance abuse treatment. The Canton-Stark County Crime Lab reported that the number of Suboxone® cases that it processed has remained the same during the past six months.

Participants did not report any street jargon for Suboxone®. Participants reported that a Suboxone® 8 mg pill sells for between \$5-20; Suboxone® strips/film sell for between \$10-20. Participants reported that sublingual use of Suboxone® remains the most common route of administration for the drug, reporting that out of 10 users, eight would use sublingually and two would snort the drug. Reportedly "very few" users use Suboxone® by intravenous injection. A participant reported, *"When you shoot it [inject Suboxone®], it makes you feel weird."* Suboxone® strips continue to be mostly administered sublingually.

A profile for a typical Suboxone® user did not emerge from the data. Treatment providers reported that Suboxone® users are of the *"same group as heroin, across the board,"* as one stated. However, it was noted that one had to have the means to pay for Suboxone®, and one treatment provider posited that users are typically people *"with insurance or a medical card."* A participant noted, *"People with insurance go to the doctors. Others go to the streets."* Participants did not identify any other substances that individuals use in combination with 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' (highly available, extremely easy to get), while law enforcement reported availability as '5.' Participants and treatment providers identified Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Treatment providers most often reported availability as '9' for Xanax®, '8' for Klonopin® and '6' for Valium®. Most participants and community professionals reported that availability of sedative-hypnotics had increased during the previous six months. For the first time, users spoke of synthetic Xanax® in head shops, commonly sold as Zan-X. The most common routes of administration remained snorting and oral ingestion. In addition to obtaining sedative-hypnotics on the street from dealers, participants reported getting them from doctors, individuals with mental health issues and senior citizens. Participants and community professionals did not identify a typical user profile because they said abuse of sedative-hypnotics crossed age, racial and ethnic boundaries.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants and treatment providers identified Ativan®, Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Notably, most participants were not aware of the "synthetic Xanax," mentioned during the last reporting period; only one participant in Summit County reported having heard of this new substance. Treatment providers most often reported current availability of sedative-hypnotics as follows: '10' for Ativan®, Klonopin® and Xanax®, and '7' for Valium®. Treatment providers reported that sedative-hypnotics are readily available due to the frequency by which they are prescribed. A treatment provider noted, *"They [sedative-hypnotics] are highly prescribed, with plenty of refills. Doctors will prescribe them to our patients, knowing they cannot use them in treatment. Almost every woman I've worked with has been treated with Xanax® at some point, often as a means of treating anxiety related to drug use. Very few doctors will work with substance abuse treatment providers, there is very poor collaboration."* Law enforcement reported current availability as '5'; the previous most common score was also '5'. Law enforcement identified Valium® and Xanax® as the most popular sedative-hypnotic in terms of widespread use. Collaborating data also indicated that sedative-hypnotics are readily available in the region. The Stark County Coroner's Office reported sedative-hypnotics as present in 44.6 percent of all drug-related deaths; in the last reporting period, sedative-hypnotics were present in 60 percent of all drug-related deaths.

Participants were divided as to whether the availability of sedative-hypnotics has increased or remained the same during the past six months. A participant shared that availability of these drugs has increased *"due to the prevalence of cocaine and meth [methamphetamine]. You need something to bring you down. They [sedative-hypnotics] are so easy to get from doctors."* Treatment providers and law enforcement reported that availability of sedative-hypnotics has remained the same during the past six months. The Canton-Stark County Crime Lab reported that the number of sedative-hypnotic cases it processed has increased during the past six months; only Ativan® decreased in availability.

Reportedly, many different types of sedative-hypnotics 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): Ativan® (sells for \$0.50 per

milligram); Klonopin® (aka "klonies," "K-pins" and "pins;" sells for between \$0.50-1 per milligram); Valium® (aka "prince Valium®," "V's" and "v-cut;" sells for \$0.50 per milligram); Xanax® (aka "Professor Xavier" and "wagon wheels;" 0.25 mg, aka "white footballs;" sells for \$0.50; 0.5 mg, aka "peach footballs" and "peaches;" sells for \$1; 1 mg, aka "blue footballs;" sells for between \$1.50-3; 2 mg, aka "xanibars" and "bars;" sells for between \$4-5; and 2 mg generic Xanax® (alprazolam), aka "greens;" sells for between \$4-5). While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, generally, the most common routes of administration remain snorting and oral ingestion. Participants reported that out of 10 sedative-hypnotic users, six or seven would snort the drugs, and three or four would take the drugs orally.

In addition to obtaining sedative-hypnotics on the street from dealers, participants also continued to report getting them from doctors. A participant discussed feigning anxiety symptoms for the drugs: *"[Sedative-hypnotics] are easy to get from doctors. I just have to say I have 'panic attacks.' They are very easy to get from doctors, and very easy to get off the streets. I used to get them from my doctor, but quit because it is easier and cheaper to get them off the streets."* Participants reported that users with prescriptions for sedative-hypnotics will sell them to obtain another drug.

A profile of a typical user of sedative-hypnotics did not emerge from the data. However, some treatment providers expressed the opinion that sedative-hypnotic use is more common with women. A treatment provider speculated that women are more prone than men to see a psychiatrist than men when they are experiencing emotional difficulty. Some treatment providers said that there seems to be an increase in the use of sedative-hypnotics among young people, especially among those who use heroin. Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, marijuana and *"any kind of upper [stimulant drug]."* Participants also reported that sedative-hypnotics are used to modify or "intensify the high" of alcohol. Some participants mentioned combining sedative-hypnotics with marijuana.

Marijuana Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), while law enforcement reported availability as '8' in Stark County and '10' in Summit County. Most participants reported that the availability of marijuana had remained

the same during the previous six months. Participant quality scores of marijuana varied from '5' to '10,' with the most common score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported commercial-grade marijuana as the cheapest form: a blunt or two joints sold for \$10; an ounce sold for between \$180-240. Higher quality marijuana sold for significantly more: a blunt or two joints sold for between \$20-50; an ounce sold for between \$300-350. Reportedly, the most common way of purchasing marijuana was by the bag, roughly 3.5 grams, which yielded two to three joints and sold for between \$10-20. The most common route of administration remained smoking. Participants and law enforcement continued to report that there was no typical user profile; people from every population used marijuana.

Current Trends

Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' Participants commonly said marijuana was as close as *"a knock on the neighbor's door, easier to get than grass in your lawn,"* as one participant stated. Another participant explained, *"[Marijuana] is more easy [to obtain] than alcohol. Sometimes you can't get alcohol on Sunday, but you can always get marijuana."* Participants did not think of marijuana as a dangerous or addictive drug. A participant commented, *"Most [people] don't even consider it [marijuana] a drug. It's just as common as smoking cigarettes."* Treatment providers unanimously reported the drug's current availability as '10.' Many treatment providers also agreed with one who stated that marijuana is *"more accessible than alcohol."* Law enforcement reported the drug's current availability as '10,' reporting that in Summit County, more than 300 pounds of marijuana valued at \$1,500 per pound has been confiscated during the past six months. Collaborating data also indicated that marijuana is readily available in the region. The Stark County Coroner's Office reported marijuana as present in 12.5 percent of all drug-related deaths; in the last reporting period, marijuana was present in 24 percent of all drug-related deaths. Most participants reported that the availability of marijuana has increased during the past six months. A participant noted, with general agreement from others, *"You can grow it [marijuana] yourself. You can grow it in your basement."* The Canton-Stark County Crime Lab reported that the number of marijuana cases it processed has decreased during the past six months.

Participants reported that there are a number of grades of marijuana, explaining that the quality of marijuana depends

on whether the user buys "commercial weed" (low- to mid-grade marijuana) or higher-grade marijuana (hydroponic or home-grown marijuana). Most participants rated the quality of lower-grade marijuana as '3' and higher-grade marijuana as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common scores were '5' for lower-grade and '10' for higher-grade marijuana. Regarding lower-grade marijuana, participants described it as frequently having seeds. Several participants agreed that the high produced on lower-grade marijuana is poor; a participant reported, *"You barely get high; it takes five joints to get a buzz."* Participants described higher grades of marijuana as tending to have, as one participant stated, *"crystals that sparkle."* Participants reported that the quality of marijuana continues to increase. A participant explained, *"People grow their own [marijuana]. They buy the seeds on the Internet. They are developing it, growing it with chemicals [and] nurturing it to make a better drug."*

Current street jargon includes countless names for marijuana. The most commonly cited name remains "weed." Participants listed the following as other common street names: "dirt weed," "mersh," "middies," "reggies," "skunk weed" and "swag" for commercial-grade marijuana; "blueberry yum yum," "chronic," "denk," "fire," "kush," "northern light," "nuggets," "red bud" and "tuff" for high-grade marijuana; "dro" and "hydro" for hydroponically grown marijuana. Participants identified medical-grade marijuana as, *"the best, an upgrade from hydro; the best kind of weed you can get."* Street jargon for medical grade marijuana included "loud." The price of marijuana depends on the quality desired. Participants reported commercial-grade marijuana as the cheapest form: a blunt or two joints sells for between \$3-10; 1/8 ounce sells for between \$15-30; 1/4 ounce sells for between \$20-25; an ounce sells for between \$80-150; a pound sells for between \$800-1,200. Higher quality marijuana sells for significantly more: a blunt or two joints sells for between \$15-20; 1/8 ounce sells for between \$35-60; an ounce sells for \$300; a pound sells for \$2,000. Prices for medical-grade marijuana are similar to high-grade marijuana: a gram sells for \$25; 1/4 ounce sells for between \$70-100; an ounce sells for \$300. While there were several reported ways of consuming marijuana, the most common route of administration, by far, remains smoking. In fact, most participant groups did not even make reference to any other route of administration, though one group referred to *"pot brownies"* and making tea with marijuana, both of which are reportedly common at *"hippie fests [festivals],"* as one participant said.

A profile for a typical marijuana user did not emerge from the data. Participants continued to report that people from every population use marijuana. Treatment providers and law enforcement agreed, describing the typical user as *"everyone"*

and his brother, age six to 60 [years old].” Treatment providers expressed that many clients report using marijuana for the first time at a very early age, beginning at age nine years. Reportedly, marijuana is used in combination with alcohol, crack and powdered cocaine, prescription opioids and sedative-hypnotics. Participants did not identify specific effects of using marijuana mixed with other drugs. Generally, participants posited that marijuana goes with any other drug. A participant commented, *“They smoke it [marijuana] because they do, and use other drugs.”*

Methamphetamine

Historical Summary

In the previous reporting period, methamphetamine was highly available in the region. Participants and treatment providers most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants reported that methamphetamine continued to be most available in powdered form. Crystal methamphetamine (aka “ice”), the highest quality form of methamphetamine, was rare in the region. The Canton-Stark County Crime Lab cited brown, pink and white powdered methamphetamine as the most common forms of the drug found in the region. Reportedly, the most common way of manufacturing methamphetamine was through the “shake-and-bake” or “one-pot” method, which was widely known. Participants and treatment providers could not agree whether methamphetamine availability had increased, decreased or remained the same during the previous six months. Most participants rated the quality of powdered methamphetamine as ‘5’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that a “rock” of methamphetamine sold for \$20; a gram of powdered methamphetamine sold for between \$50-100; a gram of crystal methamphetamine (when available) sold for \$100. Participant groups were divided on whether intravenous injection or smoking was the most common route of administration. Participants and community professionals could not agree on a typical user profile.

Current Trends

Methamphetamine 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’. A participant from Summit County commented, *“Everyone is shaking it,”* meaning users are producing methamphetamine in a single sealed container, such as a two-liter soda bottle (aka “shake-and-bake” or “one-pot” method of methamphetamine production). By using common household chemicals,

along with ammonium nitrate found in cold packs, and pseudoephedrine, typically found in some allergy medications, drug manufacturers (aka “cooks”) can produce the drug in approximately 30 minutes at nearly any location by mixing ingredients in easily found containers. While reportedly high in availability in Summit County, some participants from other counties did not believe methamphetamine to be very available; participants from Portage and Stark counties reported lower availability scores for the drug. Participants from Portage County thought methamphetamine to be occasionally available. Participants reported that methamphetamine continues to be most available in powdered form, produced by the “one-pot” or “shake-and-bake” method, as opposed to the more traditional method, described by one participant as *“the kind made with iodine and red phosphorous, cooked [and] not shook.”* Participants reported that crystal methamphetamine (aka “ice”), the highest quality form of methamphetamine, is, as one stated, *“rare around here.”* Treatment providers most often reported methamphetamine’s current availability as ‘7’; and they reported that it is common for users to make their own methamphetamine. Law enforcement reported that methamphetamine is highly available although they did not assign a numerical value to its availability. A law enforcement officer reported, *“People are cooking it [methamphetamine] for themselves and a buddy. If you are looking for it, it’s easier to get on the Internet and learn how to make it on your own. Many [methamphetamine cooks] are able to fly under the radar screen for a while.”*

Media from the region reported on recent arrests related to methamphetamine this current reporting period. In an April media report, the Summit County Drug Task Force reported that mobile meth labs have increased by 400 percent since 2010; law enforcement attributed the increase to user’s increasing knowledge of the “one-pot” and “shake-and-bake” manufacturing methods. (www.newsnet5.com, April 4, 2012).

The majority of participants and community professionals most often reported that the availability of methamphetamine has increased during the past six months. A participant commented, *“[Methamphetamine] it’s more prevalent ... more people know how to make it.”* A treatment provider stated, *“While there has been an overall decline [in methamphetamine availability] during the past couple years, I’m seeing a little surge due to the new way of doing [manufacturing] it.”* However, treatment providers in Tuscarawas County reported that methamphetamine seemed to be less available; a treatment provider commented, *“[Methamphetamine is] on the decline, based on the number of busts ... It was in the Amish areas, but the past six months, we’ve not heard much about methamphetamine. Bath salts are*



seen as safer, and legal. Hence, they seemed to have taken meth [methamphetamine] off the rack." The Canton-Stark County Crime Lab reported that the number of methamphetamine cases it processed has decreased during the past six months. Typically, staff from the crime lab reported methamphetamine in the form of tablets or pink and off-white powders.

Participants with experience using methamphetamine most often rated the quality of powdered methamphetamine as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Participants were split between reporting that the quality of methamphetamine has decreased or remained the same during the past six months, explaining quality typically varies. A participant said, "[Methamphetamine quality] depends on who you get it from. It [quality] could be '4,' could be '8.'" Another participant commented, "I think it [methamphetamine quality] has fallen off ... more people making it who don't know how to, but there is still good stuff out there. The longer it takes to make, the better." Participants commonly reported that the traditional form of powdered methamphetamine as better quality than the more common "shake-and-bake" form.

Current street jargon includes many names for methamphetamine. The most commonly cited names were "cousin crystal," "crank," "crystal," "dope," "embalm," "glass," "go fast," "ice," "meth," "old school," "red dope," "rocket fuel," "shake-and-bake," "shards," "soda pop," "speed" and "tweak." Current street prices for methamphetamine were variable among participants with experience buying the drug. Participants reported that an individual can purchase a "rock" or "vial" of powdered methamphetamine for \$20; 1/4 gram sells for \$25; 0.4 gram sells for \$40; 1/2 gram sells for \$50; 0.8 gram sells for \$100; a gram sells for \$80-150. Powdered methamphetamine made through traditional methods using iodine and red phosphorous or anhydrous ammonia is more expensive: 1/4 gram sells for \$50; 1/2 gram sells for \$100; a gram sells for \$200. Participants reported that the most common route of administration for methamphetamine is smoking. Participants reported that out of 10 methamphetamine users, eight would smoke, one would snort, and one would use by intravenous injection.

There was consensus among respondent groups that methamphetamine is predominately used by Whites. Treatment providers also generally reported that methamphetamine users are almost exclusively White, from lower- to middle-class, with some treatment providers adding that users tend to be younger. Law enforcement reported that users are most often White, but evenly distributed between gender and age groups. In addition, some participants noted that methamphetamine use is

higher in the gay community and among bikers, while other participants noted that methamphetamine is more common with "the working, middle-class."

While participants reported that it is most common to use methamphetamine by itself, they reported that the drug is used in combination with alcohol, bath salts, marijuana and prescription stimulants (Adderall®). Using methamphetamine with other stimulants was said to prevent "crashing" (getting really high and then coming down too fast). A participant explained that the combination of methamphetamine with prescription stimulants helped to "keep it [the high] going. You stay on a constant plateau." Another participant reported that users take methamphetamine to party longer.

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 availability of Ecstasy as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that Ecstasy came in two forms, tablet and powder, with tablets being the most available form. Treatment providers reported availability as '6' or '7'. Law enforcement in Summit County reported on several seizures of Ecstasy, one involving powdered Ecstasy that originated in Pennsylvania, and another involving Ecstasy tablets that originated in Canada. The Canton-Stark County Crime Lab reported that the number of Ecstasy (MDMA) cases it processed had remained the same, while the number of piperazine (typical components of Ecstasy) cases had increased during the previous six months. The most common route of administration was oral ingestion. Participants reported that a "single stack" (low dose) Ecstasy tablet sold for \$4; 1/10 gram (aka "tic") of powdered Ecstasy (aka "Molly") sold for between \$10-20; a gram of powdered Ecstasy sold for between \$100-130. Participants and treatment providers said Ecstasy users were typically young adults between 20-30 years of age who like to frequent bars, dance clubs and "raves" (underground dance parties).

Current Trends

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) remains moderately to highly available in the region. Participants most often reported current availability of the drug from '6' to '10' (median score '7') on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score

was '10'. Participants in Portage County reported that availability of Ecstasy has increased during the past six months. A participant commented, *"Molly [pure, powdered form of Ecstasy] is becoming more popular."* Participants from Stark County reported that availability has remained the same during the past six months. Treatment providers also reported that current availability of Ecstasy has remained the same, while law enforcement reported that availability of Ecstasy varies throughout the year. A law enforcement officer stated, *"[Ecstasy availability] runs in cycles. We'll see a bunch, then nothing."* Law enforcement reported that most of the area's Ecstasy tablets originated in Canada. Reportedly, powdered Ecstasy occasionally comes from Pittsburgh and is marketed at area universities. The Canton-Stark County Crime Lab reported that the number of Ecstasy cases it processed has decreased during the past six months. Participants did not report on the quality of Ecstasy in the area. Current street jargon for Ecstasy is limited to "Molly" and "Skittles®." Participants were unfamiliar with current street prices for the drug. Reportedly, the most common route of administration remains oral ingestion. Participants continued to report that Ecstasy is most commonly used by people who like the club scene. A participant commented, *"[Ecstasy] it's very popular in discos and clubs."* Treatment providers agreed and reported that individuals who use Ecstasy tend to be young, most commonly college students.

Bath Salts

Historical Summary

In the previous reporting period, bath salts (synthetic compounds containing methylenedioxymethamphetamine, mephedrone or MDPV) were highly available in the region. Participants and treatment providers most often reported the availability of bath salts as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Before the ban on the sale of bath salts was instituted in October 2011, participants reported that they were able to purchase bath salts at drive-thru beverage stores, gas stations and head shops. A participant commented that some of these establishments even extended their hours of operation to meet demand. When questioned about the law designed to make the sale of bath salts illegal, most participants did not believe this law would affect availability. Participants believed that manufacturers would find ways around the law, either by changing formulations or changing product names. Treatment providers reported users often seek hospitalization and/or admission to residential treatment facilities in response to the many negative effects and withdrawal symptoms of bath salts. Participant quality scores of bath salts were unanimously '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that 1/2 gram of bath salts sold for between \$16-20. The most common routes of administration for bath

salts were snorting and intravenous injection. Notably, participants with first-hand knowledge of bath salts use were exclusively younger than 25 years of age.

Current Trends

Bath salts (synthetic compounds containing methylenedioxymethamphetamine, mephedrone or MDPV) 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'. Despite the law that went into effect in October 2011 which banned their sale, bath salts continue to be readily available in the region. A participant reported, *"[Bath salts] it's still around at gas stations, just as available as it always was. You can still buy it in convenience stores, if you know where to go."* Other participants discussed the way in which manufacturers circumvent the law. A participant commented, *"They [bath salts] were out of the store, but put back under a new name. You can change one ingredient, change the name, and it's okay until they [make] it illegal."* Another participant agreed, *"Now [bath salts] it's called 'plant food' [and] sold in capsules."* Participants reported that bath salts are now commonly sold as glass cleaner and pipe cleaner and marketed by new names such as "Eight Ball" and "Rush."

Treatment providers most often reported the current availability of bath salts as '7'; the previous most common score was '10'. Most treatment providers believed that availability of bath salts has decreased during the past six months. Treatment providers stated that the reason for the decrease is the negative health consequences associated with the use of bath salts. A treatment provider explained, *"Increased knowledge of reported significant problems, such as permanent psychiatric problems, is deterring use [of bath salts]."* In addition, treatment providers generally felt that the new law and increased law enforcement efforts are having some positive effects. A treatment provider stated, *"Head shops have been hounded by the police [to remove bath salts from their stores]."* However, despite the threat of police raids, treatment providers said some stores and gas stations still sell bath salts illegally. A treatment provider noted, *"If you know what to say [at a store], they will trust you and sell it [bath salts]."* Law enforcement reported some availability of bath salts, with one law enforcement official commenting, *"We get some bath salts now and then."* A law enforcement officer explained that enforcement is difficult because these drugs are constantly being chemically re-engineered and producers remain ahead of the law. The Canton-Stark County Crime Lab reported that the number of bath salt cases it processed has increased during the past six months. The crime lab also reported that other substances similar to bath salts have been seen in the lab; some of these substances are controlled (4-Fluoroamphetamine and

4-Fluoromethamphetamine), while others are uncontrolled chemical analogues. Media outlets reported on law enforcement raids of businesses selling bath salts in the region this reporting period. In February, police raided three businesses in Kent and Streetsboro (both in Portage County) that were selling bath salts and synthetic marijuana; according to police, the raids came after a month-long investigation into the illegal sale of these substances (www.recordpub.com, Feb. 17, 2012).

There was no consensus among participants regarding quality of bath salts. Scores for bath salts quality ranged from '0' to '8,' (median score '6') on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '10.' A participant who thought bath salts were high quality reported they are "better quality than meth." Participants reported that the most common way to buy bath salts is to purchase a "vial" (about 1/2 gram), which sells for between \$25-30. Participants also reported that larger quantities can be obtained: 1/2 ounce of bath salts sells for \$500. While there were several reported ways of consuming bath salts, the most common route of administration is snorting. According to participants, out of 10 bath salts users, five would snort, three would intravenously inject and two would smoke. Participants reported that typical users of bath salts tend to be younger than 30 years of age. Participants also said bath salt users are likely to be on probation, monitored through urine drug screens. A participant stated, "People who can't get meth, they use this [bath salts] as a replacement," or will use bath salts "to pass a pee test."

Other Drugs

Historical Summary

In the previous reporting period, participants and community professionals listed the following other drugs as present in the region, but these drugs were not mentioned by the majority of people interviewed: hallucinogens [lysergic acid diethylamide (LSD)] and synthetic marijuana ("K2" and "Spice"). LSD was moderately to highly available in the region. Participants most often rated LSD's availability as '5' or '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Reportedly, LSD availability increased in the spring and summer when there were more outdoor music festivals. Law enforcement, on the other hand, believed use of hallucinogens was rare. Participants who reported knowledge of LSD rated its overall quality as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Synthetic marijuana remained highly available in the region (the law banning its sale had not gone into effect). Participants most often reported the drug's availability as '8,' while treatment providers most often

reported availability as '10.' Treatment providers explained the drug was commonly used by individuals on probation to avoid drug use detection on urine drug screens. Participants reported that brands like "K2" were easily purchased at drive-thru beverage stores and gas stations. As with marijuana, the most common route of administration for synthetic marijuana was smoking. Treatment providers reported that typical users of synthetic marijuana were young adults and by those on probation.

Current Trends

Participants and community 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: hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms] and synthetic marijuana. LSD is rarely to moderately available in the region. Participants most often reported LSD's current availability as '5' or '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common scores were '5' or '8.' A participant from Portage County reported, "[LSD is] hard to find, uncommon ... but I know I can find it." Participants in Stark and Summit counties reported no availability of LSD. Law enforcement agreed with participants that spoke about the limited availability of LSD. The Canton-Stark County Crime Lab reported that the number of LSD cases it processed has decreased during the past six months. Psilocybin mushrooms are moderately available in the region; participants most often reported current availability as '5' or '6.' A participant in Tuscarawas County reported that psilocybin mushrooms are "a little easier to find [than LSD], but you have to know someone." Treatment providers throughout the region reported little knowledge regarding use of psilocybin mushrooms, other than to report that they are more available during summer months and that users tend to be young. The general view of treatment providers is that the availability of all forms of hallucinogens has remained steady over some time, viewed as relatively low. No participant reported recent use, and participants could not comment on the quality of hallucinogens in the region. The Canton-Stark County Crime Lab reported that the number of psilocybin mushrooms cases it processed has decreased during the past six months.

Synthetic marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '8.' Despite the ban on its sale that went into effect in October 2011, participants reported they could easily obtain synthetic marijuana. A participant reported, "[Synthetic marijuana is] easy to find ... found in head shops, convenient stores [and] in the mall."

Another participant talked about techniques manufacturers use to circumvent the law: *“still get K2 in stores, [manufacturers] just changed it to a different name.”* The most common route of administration for synthetic marijuana remains smoking. Treatment providers also reported that synthetic marijuana is still available in the region, though there was no agreement regarding the level of availability. Some treatment providers reported that suppliers now call synthetic marijuana “potpourri.” Treatment providers in Tuscarawas County reported infrequently encountering users of synthetic marijuana. A treatment provider explained, *“[Synthetic marijuana is] rarely seen here. Marijuana is so available, and Spice is expensive compared to marijuana.”* These treatment providers also credited the new laws as having had an effect on the availability of synthetic marijuana. Law enforcement also reported that they infrequently encounter synthetic marijuana. An officer said in the past six months there have been *“a few examples [cases involving synthetic marijuana], but nothing to say, ‘we have a problem.’”* In February, regional media reported that Ravenna police (Portage County) raided two businesses that were selling synthetic marijuana; officers confiscated synthetic marijuana and other drug paraphernalia (www.recordpub.com, Feb. 7, 2012). The Canton-Stark County Crime Lab reported that the number of synthetic marijuana cases it processed has increased during the past six months. Participants and treatment providers continued to note that individuals who use synthetic marijuana tend to be people on probation who are using the substance to avoid screening positive on urine drug screens.

In addition, treatment providers reported concern over increased abuse of over-the-counter caffeine pills. These pills, referred to by users as “stackers,” reportedly are used primarily by cocaine users to, *“fill the void”* left by bath salts being taken off the market. While not mentioned by participants, the Canton-Stark County Crime Lab reported several other drugs as present in the region. Prescription stimulants are available: the crime lab reported having processed Adderall®, Dexedrine®, Ritalin® and Vyvanse® cases during the past six months. In addition, the lab reported having processed a few cases of a club drug similar to DMT (dimethyltryptamine): 5-MeO-DALT.

Conclusion

Crack cocaine, heroin, marijuana, methamphetamine, powdered cocaine, prescription opioids, sedative-hypnotics and Suboxone® remain highly available in the Akron-Canton region. Increases in availability exist for methamphetamine, prescription opioids and Suboxone®. Data also indicate likely increases in availability for crack cocaine and heroin. Participants and community professionals reported that methamphetamine availability and use have become more

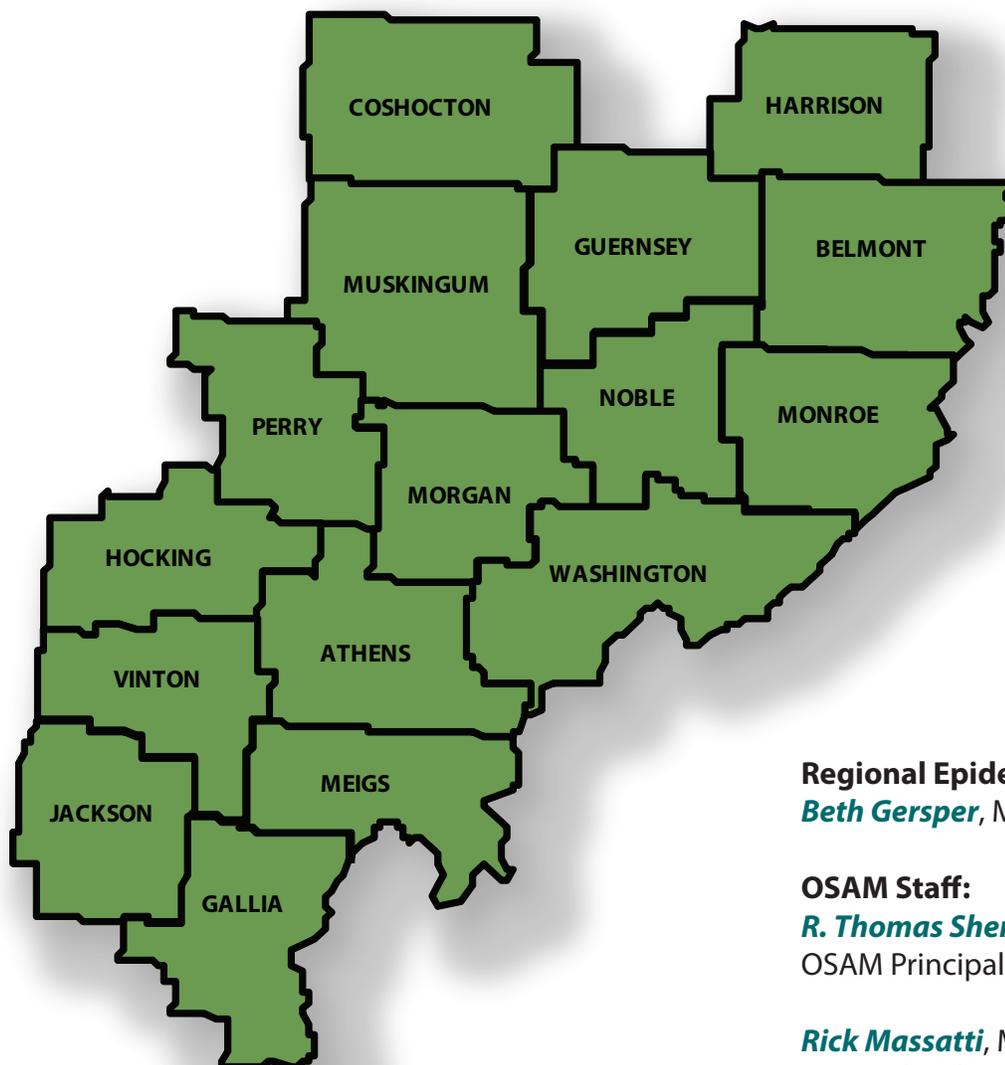
prevalent during the past six months due to more people knowing how to make the drug through the “one-pot” or “shake-and-bake” method. There was also consensus among respondent groups that methamphetamine is predominately used by Whites. Prescription opioids, particularly methadone and Opana®, have increased in availability according to most participants and community professionals. In addition, the Stark County Coroner’s Office reported prescription opioids as present in 50 percent of all drug-related deaths. Participants reported that the availability of Suboxone® has increased during the past six months. Treatment providers also reported that availability has increased while noting that Suboxone® is being prescribed more often, citing the emergence of Suboxone® clinics in the region. Treatment providers continued to report that heroin users use Suboxone® when they can’t get heroin. Participants generally agreed that the availability of crack cocaine has increased during the past six months. Participants thought crack cocaine is more available because there are more users; the drug was said to be, according to a participant, *“attracting a younger crowd, so younger people are selling it.”* The Canton-Stark County Crime Lab reported that the number of crack cocaine cases it processed has increased during the past six months. Participants unanimously reported that the availability of powdered heroin has increased during the past six months. Participants continued to note that the lack of availability of other drugs (OxyContin® OC) has contributed to the increase in heroin availability and use. Treatment providers noted a significant increase in heroin availability in rural areas. There was consensus among participants and community professionals that heroin use is becoming more prevalent among younger people.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Athens Region

January-June 2012

John R. Kasich, Governor
Orman Hall, Director



Regional Epidemiologist:

Beth Gersper, MPA

OSAM Staff:

R. Thomas Sherba, PhD, MPH, LPCC
OSAM Principal Investigator

Rick Massatti, MSW
Research Administrator,
OSAM Coordinator

Athens Regional Profile

Indicator ¹	Ohio	Athens Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	587,004	40
Gender (Female), 2010	51.2%	50.4%	47.5%
Whites, 2010	81.1%	94.7%	100% ²
African Americans, 2010	12.0%	2.1%	0.0%
Hispanic or Latino Origin, 2010	3.1%	0.8%	0.0%
High school graduates, 2009-2010	84.3%	92.9%	73.7% ³
Median household income, 2010	\$45,151	\$37,381	Less than \$11,000 ⁴
Persons below poverty, 2010	15.8%	18.2%	72.2% ⁵

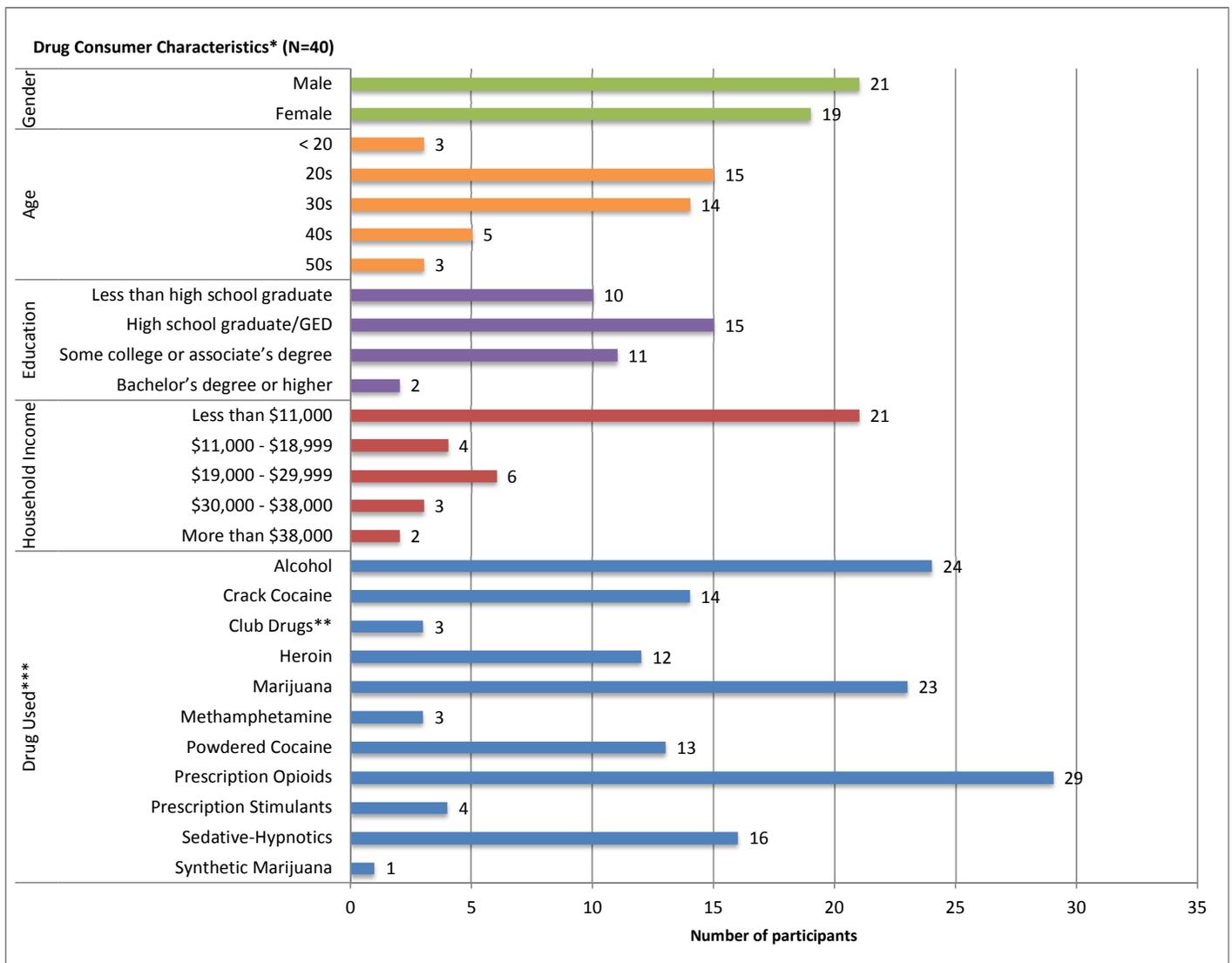
Ohio and Athens statistics are derived from the U.S. Census Bureau.¹

Race was unable to be determined for two respondents due to missing data.²

Graduation status was unable to be determined for two respondents due to missing data.³

Respondents reported income by selecting a category that best represented their household's approximate income for 2012. Income status was unable to be determined for four respondents due to missing data.⁴

Poverty status was unable to be determined for four respondents due to missing or insufficient data.⁵



*Not all participants filled out forms; therefore, numbers may not add to 40.

**Club drugs refer to Ecstasy and psilocybin mushrooms.

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

Data Sources

This regional report was based upon qualitative data collected via individual and focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Athens, Belmont, Hocking and Muskingum counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Scioto County Coroner's Office and the Bureau of Criminal Investigation (BCI) London Office, which serves Central and Southern Ohio. All secondary data are summary data of cases processed from July through December 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, all secondary data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2012.

Powdered Cocaine Historical Summary

In the previous reporting period, the availability of powdered cocaine remained variable in the region, with participants and community professionals reporting differing availability scores by county. Participants in Guernsey and Muskingum counties reported availability of powdered cocaine as moderate, with a mean availability score of '7'; whereas, participants in Athens and Jackson counties most often reported availability as '4' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals reported that the availability of powdered cocaine had remained the same during the previous six months. The BCI London Crime Lab reported that the number of powdered cocaine cases it processed had decreased during the previous six months. Most participants rated the quality of powdered cocaine as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the cutting agent in virtually every sample of powdered cocaine it processed. The most commonly cited street names for powdered cocaine were "coke," "powder" and "snow." Participants reported that a gram of the drug sold for between \$80-100, depending on quality. Participants reported that the most common route of administration for powdered cocaine remained snorting. Although a general profile for a typical powdered cocaine user did not emerge from the data, several participants mentioned that people with occupations that required them

to work long shifts might use powdered cocaine to help them stay awake. Community professionals described the typical user of powdered cocaine as primarily White.

Current Trends

Powdered cocaine 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' (highly available, extremely easy to get). A participant reported, *"I know a lot of people who are actually dealing powder [powdered cocaine]."* Another participant commented on the ease of obtaining powdered cocaine without even knowing a dealer directly: *"If you say you'll smoke your stuff [powdered cocaine] with somebody, they will get it for you in less than five minutes."* Most community professionals described current availability of powdered cocaine as low. The Hocking County Family Drug Court reported no cases involving powdered cocaine during the past six months. Community professionals generally reported opiates as the preferred drug over cocaine: *"Heroin has outpaced cocaine ... cocaine's taken a back seat to heroin; Just right now, the drug of choice is opiates. But we still are getting clients that are using cocaine, and I probably have heard more about powder lately than crack [cocaine]."* A few community professionals noted a current user preference for powdered cocaine over crack cocaine: *"Lately I've heard more about snorting [powdered cocaine] than crack [use] ... I still think there's prejudice in some circles that, 'I use cocaine and there's nothing wrong with that, but I would never touch crack because that makes you a horrible person.' ... It's just the stigma in some circles with crack; They'll buy it [cocaine] in powder form, and when they need to cook it up, they'll cook it up [into crack cocaine]."* Collaborating data also indicated that cocaine is readily available in the region. The Scioto County Coroner's Office reported that 26.4 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range at time of death); in the last reporting period, 28.6 percent of all deaths were drug related. Furthermore, the Coroner reported cocaine as present in 21.4 percent of all drug-related deaths (Note: coroner's data is aggregate data of powdered cocaine and crack cocaine and does not differentiate between these two forms of cocaine).

Participants reported that the availability of powdered cocaine has increased during the past six months throughout the region. A participant commented, *"I think it [availability of powdered cocaine] increased because just more people have been wanting it. People have been using it, and the dealers are getting more of it."* Other participants speculated: *"Cocaine's on the rise again since the painkillers are down [decreased availability of prescription opioids]; I think there's an increase on the powder, but a lot of people take it and cook it and turn it*

into crack." In contrast, community professionals reported a decrease in availability of powdered cocaine during the past six months. A treatment provider reported, "I'm not seeing a lot of that [powdered cocaine use] anymore ... not in the last six months. I just don't hear [about powdered cocaine use]. Not that people aren't using it, but they're so focused on the opiates. It's like, 'Well, I've used cocaine, but my problem's opiates.'" A law enforcement officer reported, "I would say that cocaine is a little bit harder to get than it was. We have done a lot of arrests, a lot of raids for cocaine, and we get intelligence back to us that we have hit the cocaine distribution hard. By no means have we dampened it as far as it coming out, but we have done a lot of arrests, a lot of convictions with cocaine." The BCI London Crime Lab reported that the number of powdered cocaine cases it processed has decreased over the past six months.

Most participants rated the quality of powdered cocaine as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8'. However, participants continued to report on the variability of the quality of powdered cocaine. A participant reported, "[Quality of powdered cocaine] it ranges a lot ... it's crazy ... it's like a roller coaster. You can get good shit, you can get bad shit." Several participants added that quality depends on the dealer: "The powder [powdered cocaine quality] is just like heroin. It depends on the person [dealer] and how many hands it's been through before it gets to you; Seems you never know what you're gonna get ... I guess it's all with the dealer. If he's losing money, or if he's doing it [using the powder cocaine himself], he'll cut [adulterate] it up more ... it's kind of like a crapshoot." Participants reported that powdered cocaine in the region is cut with aspirin, baby laxative, baby powder, baking powder, baking soda, coffee creamer, Enfamil®, ether, isotol (diuretic), laundry soap, prescription opioids (Percocet® and Vicodin®), salt and vitamin B12. The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the cutting agent in virtually every sample of powdered cocaine it processed, while also citing the following substances as occasionally used to cut powdered cocaine: caffeine, inositol (B vitamin), local anesthetics (benzocaine, lidocaine and procaine), mannitol (diuretic), sorbitol (sweetener) and sucrose (table sugar).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "coke," "girl," "powder" and "snow." Participants listed the following as other common street names: "blow," "fish scale," "girlfriend," "johnny white," "melt," "nose candy," "pow pow," "white girl," "ya-yo" and "yea." Several participants reported common phrases for talking about powdered cocaine use, including "going skiing" and "Is it snowing?" Current street prices for powdered cocaine were variable among participants with experience buying powdered cocaine. Participants reported the smallest

amount of 1/10 gram (aka "a point") sells for \$10; 1/2 gram continues to sell for \$50; a gram of powdered cocaine sells for between \$80-100; 1/8 ounce, or "eight ball," sells for between \$180-320; 1/4 ounce sells for \$250; an ounce sells for between \$1,200-1,500. Participants reported that the most common way to use powdered cocaine remains snorting, with the second most common way being intravenous injection. A participant stated, "You can shoot it [inject powdered cocaine] ... you can melt it down with vinegar." In addition, several participants mentioned smoking powdered cocaine, with one stating, "You can also smoke that [powdered cocaine] on tin foil, just like inhaling the fumes." Reportedly, some users and dealers "take it [powdered cocaine] and cook it and turn it into crack," while others "put it [powdered cocaine] in a cigarette and smoke it." In addition, a participant reported, "I put it [powdered cocaine] on my teeth all the time. It numbs your gums, your mouth."

Although a general profile for a typical powdered cocaine user did not emerge from the data, several participants continued to note that people with occupations that require them to work long hours, such as truck drivers, will use powdered cocaine to help stay awake. Other user characteristics noted by participants included: Whites, older people and people who have money. Several participants agreed with one participant who said, "Coke's a rich man's drug." Treatment providers described the typical user of powdered cocaine as primarily professionals. A treatment provider commented, "Usually [powdered cocaine users are] people that are working because they want to pay for that [powdered cocaine] ... more professionals. It's those people who intellectualize things, [it] seems to me, that they are the people [who] are using it ... it just seems the majority of the people [using powdered cocaine] are very narcissistic. Like, 'I can do no wrong' and 'I know everything.'"

Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids, sedative-hypnotics and tobacco. Participants most often reported that marijuana is commonly used with powdered cocaine. One participant stated: "If you're somewhere and there's speed [cocaine, amphetamines, methamphetamine] there, there's almost definitely weed [marijuana] there. But, if there's weed there, that doesn't mean that there's necessarily speed there too. Weed is not an indicator that speed will be there, but speed is definitely an indicator of weed." Participants often reported smoking powdered cocaine by placing it on cigarettes and by mixing it with marijuana or crushed prescription opioids. A participant explained that powdered cocaine users typically use "downers [benzodiazepines] to come down off coke 'cause the crash from cocaine is extremely harsh." Another participant reported, "I would always have Xanax® to come down off of

it [powdered cocaine] or to even it out if I got too speeded ... I'd get paranoid and I'd take two Xanax® with it and drink alcohol." Likewise, heroin is also used to come down from the stimulant effects of powdered cocaine.

Crack Cocaine

Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). However, participants in Gallia, Guernsey and Muskingum counties reported higher availability of crack cocaine than did participants in Athens, Hocking and Jackson counties. Community professionals most often reported availability as '8'. Participants and community professionals most often reported that the availability of crack cocaine had remained the same during the previous six months. The BCI London Crime Lab reported that the number of crack cocaine cases it processed had decreased during the previous six months. Most participants rated the quality of crack cocaine as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the primary cutting agent for crack cocaine. The most commonly cited street names for crack cocaine remained "crack," "hard" and "rock." Participants reported 1/10 gram (aka "rock") of crack cocaine sold for \$10; a gram sold for between \$50-100. While there were a few reported ways of using crack cocaine, generally, the most common routes of administration were smoking and intravenous injection. A profile of a typical crack cocaine user did not emerge from the data.

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'. A participant reported, "You know, crack [cocaine] you can find no matter who you are ... anywhere ... crack is everywhere in this town." There was no consensus among community professionals as to the current availability of crack cocaine. A law enforcement officer described what he saw

in Muskingum County: "I just think the crowd that is using it [cocaine] is going to prefer the soft [powdered cocaine] to the hard [crack cocaine]. [In] drug investigations ... [users] have powder cocaine, and they'll cook it up right there

while our person's waiting. So, a lot of these people [cocaine users] actually have both [forms] of it [cocaine]." The Vinton County Coroner representative said, "There's a mixture of both [powdered cocaine and crack cocaine]. I can't say which one's more prevalent than the other." Media from the region reported on an arrest related to crack cocaine during this reporting period. In June, a Columbus man was arrested at a hotel in Gallia County for possession of 25 grams of crack cocaine. He was charged with trafficking in crack cocaine after police found 48 individually wrapped rocks of crack cocaine in the air conditioning unit of his hotel room (www.mydaily sentinel.com, June 18, 2012).

Most participants reported that the availability of crack cocaine has slightly decreased during the past six months. Participants agreed when one participant mentioned that people are moving away from crack cocaine: "I think everybody's getting sick of geekin' [looking for crack cocaine]." Participants agreed that heroin has become more popular than crack cocaine. A participant stated, "There was a lot of dealers coming down from Columbus that had powdered [cocaine] or hard [crack cocaine], and it seems like, even they've stopped bringing that ... they bring more heroin than anything now; You can go get opiates easier and cheaper than you can buy cocaine." Overall, community professionals perceived a decrease in crack cocaine availability throughout the region. However, a treatment provider reported, "We still are getting clients that are using [crack] cocaine, and I probably have heard more about the powder [cocaine] lately than the crack [cocaine]." The majority of community professionals attributed the perceived decrease in crack cocaine to an increase in user preference for opiates. The BCI London Crime Lab reported that the number of crack cocaine cases it processed has stayed the same during the past six months.

Most participants rated the quality of crack cocaine as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '7'. Most participants reported that the quality of crack cocaine has remained the same during the past six months. Participants reported that crack cocaine in the region is often cut with aspirin, baby powder, baking soda, body soap, heroin, Orajel® and wax. There were continued reports of "dummy dope" (substances falsely sold as crack cocaine, yet containing little or no crack cocaine). A participant stated, "You better watch you ain't buying Dial® soap." The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as commonly used to cut crack cocaine.

Current street jargon includes many names for crack cocaine. The most commonly cited names remain "crack," "hard" and "rock." Participants listed the following as other common street names: "boy," "dope," "drop," "hard tack candy," "melt,"

"scale," "work," "yak" and "ya-yo." Current street prices for crack cocaine were somewhat consistent among participants with experience buying crack cocaine. Most participants reported that the lowest amount they would purchase crack cocaine for was \$10. Reportedly, crack cocaine sells for \$10 per 1/10 gram; 1/2 gram sells \$50; a gram sells for between \$80-100. Several participants commented on crack cocaine being a less expensive drug than other drugs: *"[Crack cocaine] it's a little cheaper [than powdered cocaine]; Crack's cheap ... crack's very cheap; You can do crack by the fives [in \$5 increments] ... from \$5 clear to whatever you want really. It's just number of rocks."* More participants related price to number of rocks or number of hits instead of to the weight of the drug: *"You can get three [crack cocaine rocks] for \$50, two [crack cocaine rocks] for \$30."* While there were a few reported ways of using crack cocaine, the most common routes of administration remain smoking and intravenous injection.

A profile of a typical crack cocaine user did not emerge from the data. However, a participant noted a socio-economic difference with which other participants agreed: *"Usually you don't see a rich person as a ... crack head."* Participants reported knowledge of users as young as 18 years old. A participant stated, *"I know an 18-year-old girl does it [crack cocaine]."* Participant described typical crack cocaine users to include motorcycle bikers, truckers and third-shift workers. Community professionals did not offer any typical user profile for crack cocaine. A treatment provider reiterated that cocaine in general has gone to the wayside because *"you can go get opiates easier and cheaper than you can go buy cocaine."*

Reportedly crack cocaine is used in combination with alcohol, Ecstasy, heroin, marijuana, prescription opioids and sedative-hypnotics. Participants cited marijuana and sedative-hypnotics (benzodiazepines) are used with crack cocaine *"to come down off it [crack cocaine] 'cuz the crash from cocaine is extremely harsh,"* as one participant said. Participants also said that using crack cocaine and heroin together (aka "speedballing") is common. A participant said heroin is also used with crack cocaine when users *"start geekin,"* which was explained as, *"You're out [of crack cocaine] and you need some more right now. You gotta have it and you will give your first-born child for some probably ... [heroin makes it] easier to cope with [that feeling of 'geeking']."*

Heroin

Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); community professionals most often reported availability as

'8.' While many types of heroin were available in the region, participants continued to report the availability of black tar heroin as most available. Participants and community professionals reported that availability had increased during the previous six months, while the BCI London Crime Lab reported that the number of heroin cases it processed had remained the same. Participants most often rated the quality of black tar heroin as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality), while they most often rated the quality of brown powdered heroin most often as '4.' Overall, participants most often reported that the quality of heroin had remained the same during the previous six months. Participants reported that black tar heroin in the region was cut with bath salts, coffee, fentanyl, hot cocoa and Tootsie Rolls®. According to a representative from the BCI London Crime Lab, heroin was *"typically pretty pure."* However, when heroin was cut, the lab reported the following substances as cutting agents: caffeine, diphenhydramine (antihistamine) and local anesthetics (lidocaine and procaine). The most commonly cited street names for heroin remained "boy" and "H." Participants reported that black tar heroin was available in different quantities: a balloon (1/10 gram) sold for between \$20-50; a gram sold for \$100. Participants reported that brown powdered heroin was available in paper and foil packs and sold for between \$20-30. Participants reported that the most common route of administration for heroin remained intravenous injection. There was no participant consensus regarding a profile of a typical heroin user; however, community professionals described typical heroin users as young, approximately 18-30 years of age.

Current Trends



Heroin remains highly available in the region. Participants most often reported overall heroin 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.' Participants commented on the ease of locating heroin throughout the region: *"I know a lot of people have got it [heroin]. It don't seem like it takes 'em long to get it; I could probably just walk across my yard and get it [heroin]; You can find that [heroin] in Athens, Nelsonville, the Plains, Hocking County, Fairfield County, Franklin County, Perry [County] ... [heroin] it's everywhere."* Reportedly, several types of heroin are available. Participants described: *"Soft [powdered heroin] is in the baggies ... stamp bags ... it comes in every color ... it was purple, bluish, dark brown or light brown little packs. It got different stamps on it. It's like the stamps for envelopes ... and the raw [pure heroin], the*

tar [black tar heroin] is melted black looking." Participants reported both brown powdered and black tar heroin as the most available heroin types in the region, rating each type most often as '10' on the availability scale, while most often rating white powdered heroin as '4.' Participants reported white powdered heroin as difficult to find: *"[White powdered heroin] it's kind of hard to find. You gotta have your personal dealer for 'china white,' you really do; You have to really know somebody to get the [white] powdered stuff."* Several participants compared the availability of heroin to the availability of marijuana, with one participant stating: *"It's cheaper to get heroin than marijuana ... because no one wants to sell marijuana because they're not making as much money."*

Community professionals most often rated the overall current availability of heroin as '8'; the previous most common score was also '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers also recognized the ease of obtaining heroin on the street. A treatment provider reported, *"[Heroin] it's very available and very cost effective, meaning it's cheap."* A staff member from a regional coroner's office reported, *"They [users] can get it [heroin] in the county [Vinton County] as well as in Athens, Hocking, Jackson and Pickaway counties."* Collaborating data also indicated that heroin is readily available in the region. The Scioto County Coroner's Office reported heroin as present in 14.3 percent of all drug-related deaths during the past six months. In addition, media outlets in the region reported on significant heroin seizures and arrests during this reporting period. In February, the Athens County Sheriff's Narcotics Enforcement Team arrested a Nelsonville woman for possession of heroin and tampering with evidence when they found 14 grams of heroin concealed in a body cavity (www.newsandsentinel.com, Feb. 14, 2012). In March, the Major Crimes Task Force netted Washington County's largest-ever seizure of heroin when it confiscated 38.5 grams of heroin during a bust in Marietta (www.mariettatime.com, March 3, 2012).

Overall, participants reported that availability of heroin in the region has increased during the past six months. A participant stated, *"My [drug of] choice was marijuana, and I found my friends saying it was easier to get heroin than it is to get marijuana."* Participants reported that the availability of black tar heroin has increased during the past six months. A participant commented that black tar heroin is *"getting easier and easier [to find]."* Another participant explained the increase, *"From personal experience, there was a lot of dealers coming down from Columbus that had powdered [cocaine] or hard [crack cocaine], and it seems like even they've stopped bringing that and they bring more heroin than anything now."* All but one of the participants reported no change in

availability for brown powdered or white powdered heroin. Community professionals reported that the availability of heroin has increased during the past six months. Treatment providers reported that treatment facilities are noticing an increase in the amount of clients seeking treatment for heroin use: *"We've heard a lot more about the use of heroin, particularly in the past six months or so with the pill mills supposedly being shut down. We've had a lot more people call in saying they're trying to find treatment for heroin use; I've been a counselor for 20 some years now and I've been hearing more and more about heroin recently."* Concern about the increase in heroin use was also expressed by professionals in children's services, with one stating: *"Even though the numbers don't always reflect that we're higher, we're getting very intense abuse cases ... and they're almost always linked to some kind of drug use in the home ... and sometimes you find more of the traces of drugs [heroin and cocaine] in the kid's system ... even very young kids."* Health department staff speculated that the heroin increase is *"because the prescription drugs [opioids] aren't as easy [to obtain] and the move is to heroin to replace it,"* as one staff member said. The BCI London Crime Lab reported that the number of brown powdered and black tar heroin cases it processed has increased during the past six months, while noting that the type of powdered heroin most processed is usually beige, brown or tan in color.

Participants most often rated the current quality of black tar heroin as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5.' They rated the quality of brown powdered heroin most often as '7' and white powdered heroin as '8' or '9'; the previous most common score for brown powdered heroin was '4.' A participant commented, *"Black tar always [has] been the top heroin."* Another participant stated, *"I have experience with heroin, and I tell you what ... if you're getting black tar, you're getting good shit."* Another participant added, *"If you get it [black tar heroin] off Mexicans, it seems to be stronger."* Reportedly, the quality of brown powdered heroin varies more than that of black tar heroin. A participant reported, *"I guess when you do pills [prescription opioids], you always know what you're getting exactly, so heroin quality's like ... I just compare it to, 'do two bags [of brown powdered heroin] equal a 30 [Roxicodone® 30 mg]?' you know what I mean? That's how I always looked at it ... If it [brown powdered heroin] equals that, then it was a decent quality, and if it didn't equal that, then it wasn't; [Brown powdered heroin is] not real bad, but there's times ... it's crap ..."* Participants reported that the overall quality of heroin has decreased during the past six months due to the amount of substances cut into the drug: *"... You go to the wrong person, and hell, you're gonna get a bag of*

f*****' coffee; Yeah, because there's too many people getting high on their own supply and that's when the shit comes in like Tootsie Rolls® and chocolate and the other shit that they throw in it 'cause they cut their [heroin] down and then they got to put more shit in it to make money on it." Participants reported that brown powdered heroin is cut with brown sugar and coffee. Reportedly, black tar heroin is cut with "anything that's brown or black," chocolate, crayons, hamburger grease, instant coffee, marijuana resin, road tar spray, shoe polish, tea and tootsie rolls. According to a representative from the BCI London Crime Lab, heroin remains "reasonably pure." However, when heroin is cut, the lab reported that diphenhydramine (antihistamine) is occasionally used.

Current street jargon includes many names for heroin. The most commonly cited names were "boy," "dog food," "dope" and "H." Participants listed the following as other common street names: "balloons," "balls," "brown," "chocolate," "dog shit," "goodies," "heron," "horse," "H-town," "rail," "Ron," "smack" and "stomp." Participants reported that black tar heroin pricing varies depending on location: 1/10 gram (aka "berries") in Belmont County sells for between \$10-20; a gram sells for between \$80-90; while 1/10 gram (aka "balloons") in Athens County sells for between \$25-30. Reportedly, black tar heroin is less expensive in larger cities such as Columbus. Reportedly, brown powdered heroin is sold in individual dose packs (aka "stamps," "bags," "berries") which typically sell for between \$10-30 each; a gram sells for between \$80-100. Participants reported that white powdered heroin thought to be "china white" sells for about the same price as black tar heroin. Participants reported that heroin originates from outside the region, particularly from Columbus. Participants continued to report that the most common way to use heroin remains intravenous injection.

Participants reported obtaining needles used to inject heroin from regional pharmacies, from friends or from dealers on the street. Participants were eager to share their experiences of buying needles at pharmacies: "You go to [an area retail store or drug store] and tell them that you're a diabetic and you want needles – a ten pack of cc needles. Sometimes they'll ask you for your ID, but sometimes they don't; I've seen this one girl walk in and straight up be honest with them [pharmacy staff]. Like she'd be out there sharing if they didn't give them [sell needles to her], and they just sold them to her; My stepfather was a diabetic, and I know exactly how to get his, and they didn't ask for prescription ID." On the street, participants reported that needles sell for between \$2-6. A participant reported, "You can definitely get [needles] off the street. 'Cause people will buy them in bulk and then you can sell them or someone will just give you their dirty needle, so that would be free if it's a dirty needle, but if they're gonna give you like a new,

sealed needle in the little packaging and everything, it would be cheap ... they could charge you five bucks, or they could just give it to you." Sharing needles was rarely reported, but a participant reported, "I've seen people share – boil a needle and share a needle like that." Community health department professionals expressed concern about the rise of Hepatitis C in the region. A staff member from the health department stated, "Hep C [Hepatitis C] is on the rise ... we've been getting new cases, and they're young kids ... teenagers ... 16, 17, 18ish."

There was no participant consensus regarding a profile of a typical heroin user; however, participants noted those who use heroin include those who like to use needles and are already shooting up (injecting) drugs, lower socio-economic drug users and prescription opioid users. Participants stated, "I would say the lower socio-economic group would kind of go towards heroin as opposed to pills [prescription opioids] just because of the price; The funny thing is that the only times I did heroin [was] when I couldn't find pain pills and that was how a lot of people that were in my circle were, too." Community professionals reported that typical heroin users range in age from teens to those into the early thirties. A staff member from children's services commented, "It's not uncommon for teenagers to get involved with heroin anymore." In addition, a staff member from the health department commented on restaurant workers who use heroin: "I just know that when I was treating patients, a lot of them were waiters and waitresses ... there's at least two or three different restaurants here in town [Muskingum County] where I know people are using."

Reportedly, heroin is used in combination with alcohol, crack and powdered cocaine, marijuana, prescription opioids and sedative-hypnotics. It was not uncommon for participants to go back and forth between different drugs when using heroin. Participants explained, "I like to smoke crack and then do heroin ... heroin helps bring you down from the cocaine buzz ... I guess if I got a pocket full of pills, I'll eat them too; I just jump back and forth with whatever I can get. I mean, I can do heroin and then do pain pills ... depends on the money; Usually people snort Xanax® and then shoot dope [heroin] or vice versa; Crack ... you shoot your crack, you shoot your heroin, you're 'speedballing' ... some people smoke pot [marijuana] with it ... it gets you really high," with one stating. Several participants spoke of using sedative-hypnotic drugs to come down from the heroin high: "A lot of people tend to prefer to use the benzo's [benzodiazepines] to come off the high of heroin; ... I did the xani's so I could fade."

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants and community

professionals most often reported availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals also continued to identify OxyContin®, Percocet® and Vicodin® as the three most popular prescription opioids in terms of widespread use, with participants naming Opana® as also popular. Participants and community professionals throughout the region reported that the availability of prescription opioids had generally remained the same during the previous six months. The BCI London Crime Lab reported that the number of prescription opioid cases it processed had remained the same during the previous six months. 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 remained snorting. Participants continued to report obtaining prescription opioids on the street from dealers, as well as from doctors, emergency rooms and people with prescriptions. A profile of a typical user did not emerge from the data.

Current Trends

Prescription opioids remain highly available in the region. Participants and community professionals most often reported 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 '10'. Several participants commented on how quickly supplies of prescription opioids are depleted, with one stating: *"Whenever opiates [are] around, it's gone in no time flat."* Community professionals agreed that prescription opioids are highly available throughout the region. Treatment providers reported: *"Prescription pills, the opiates, are causing us the most problems; Opiates and bath salts are at the top of the list."* Law enforcement commented, *"It [prescription opioid addiction] causes a lot of problems with theft. People steal from their family members; they'll steal from their friends when they see the prescription pills."* Collaborating data also indicated that prescription opioids are readily available in the region. The Scioto County Coroner's Office reported prescription opioids as present in 50 percent of all drug-related deaths during the past six months. In addition, media outlets from the region reported on recent arrests related to prescription opioids during this reporting period. In February 2012, a local police chief's home in Nelsonville was raided after an undercover agent purchased 20 oxycodone pills there (www.wsaz.com, Feb. 16, 2012); 273 hydrocodone and OxyContin® pills were seized during a traffic stop on U.S. 33 in The Plains (www.10tv.com, Feb. 18,

2012); Meigs County Court officials reported that a Columbus man was charged with possession of 200 oxycodone pills in Pomeroy (www.knoxnews.com, Feb. 28, 2012).

Participants and community professionals continued to identify OxyContin®, Percocet® and Vicodin® as the three most popular prescription opioids in terms of widespread use, with participants also naming fentanyl and Opana® as popular. Individual drug availability ratings reflected similar results: methadone, Norco®, Opana®, OxyContin® OP [new formulation], Percocet®, Ultram® and Vicodin® were all rated highly available as '10' on the availability scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Most scores for Dilaudid® fell in the 'moderately available' range of between '5' and '7' on the availability scale. Fentanyl, Lortab® and OxyContin® OC [old formulation] were all ranked with low availability scores. A participant described the excessive availability of Vicodin® as *"I was swimming in them [Vicodin®]. I had prescriptions. Everyone I lived with had prescriptions. I had so many of them that the only time I would ever do them is if I didn't have anything else to do and I just wanted to feel something go up my nose 'cuz they wouldn't even get me high. I was literally sick of them. I could throw them away and still have more."* While availability of OxyContin® OC is low, a participant reported, *"Rare, but yes ... [OxyContin® OC] they're still around ..."* OxyContin® OP is highly available; however, participants reported that many participants do not want them because their abuse-deterrent formula makes them difficult to crush and snort.

Although participants identified a few prescription opioids that increased in availability, participants most often reported that overall availability has remained stable during the past six months. Community professionals also reported that availability has generally remained stable, with the exception of a noted increase in availability of Opana®. A treatment provider reported, *"I had just recently a client that identified Opana® [in his use history], and I wasn't real familiar with that one."* The BCI London Crime Lab reported that the number of prescription opioid cases it processed has generally remained the same during the past six months with the following exceptions: an increase in Opana® cases and a decrease in OxyContin® cases.

Reportedly, many different types of prescription opioids (aka "beans") are currently sold on the region's streets. Participants reported the following prescription opioids as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid® (aka "D8," "D's" and "Dilauda;" 2 mg sells for between \$5-20; 4 mg sells for between \$4-30; 8 mg sells for between

\$7-40), fentanyl patches (25 mg sells for \$20; 50 mg sells for between \$35-45; 75 mg sells for between \$50-65), Lortab® (aka “green beans;” sells for between \$6-7), methadone (10 mg sells for \$10); Norco® (7.5 mg, aka “750s;” sells for \$5; 10 mg sells for between \$5-7), Opana® (aka “banana,” “panas;” “pans;” “pink panthers” and “pinkies;” 5 mg sells for between \$7-8; 10 mg sells for between \$15-20; 20 mg sells for between \$30-35; 30 mg sells for between \$35-50; 40 mg sells for between \$70-120; 60 mg sells for between \$80-120), OxyContin® (aka “oxy’s;” OxyContin® OC, aka “OC’s” and “Ocean City;” 80 mg sells for between \$120-130; OxyContin® OP, aka “OP’s;” 40 mg sells for \$20), Percocet® (aka “P’s;” “Paul;” “p-dawgs;” “perc’s” and “pineapples;” 5 mg sells for between \$5-7; 10 mg sells for between \$5-12); Roxicodone® (aka “roxi;” 15 mg sells for between \$15-17; 30 mg sells for between \$30-40); Vicodin® (aka “V’s;” “Vicki;” “V-dawgs” and “vikes;” 5 mg sells for between \$3-5; 7.5 mg sells for between \$5-6; 10 mg sells for between \$7-12); Ultram® (sells for \$2 per pill). 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 remains snorting. However, there was consensus among participants that there is a graduated way of using prescription opioids in general. A participant explained, “Depends on what stage of addiction you’re in. In the beginning you’d probably eat ‘em [prescription opiates]. Then, you’d snort ‘em and then you’d start shootin’ them up.” Other participants pointed out that there are differences based on the actual type of opioid: “I’d snort or shoot ‘em depending on what they are. I ain’t gonna shoot a vike [Vicodin®] or perc [Percocet®] ... but, like Opana® or an OC [OxyContin® OC] or Dilaudid® or roxy [Roxicodone®] ... people will shoot.” Several participants also reported smoking pills as well as parachuting them (crushing them and placing them in a small piece of toilet paper and swallowing or anally inserting them).

In addition to obtaining prescription opioids on the street from dealers, participants also continued to report getting the drugs from doctors, emergency rooms, pain clinics, friends and family members who have prescriptions. Drug seeking through feigning injury also continues to be a way to obtain drugs. A participant reported, “It’s easy ... all you gotta do is go to the pain clinics. There’s numerous pain clinics, you just walk in, you know. Medical card pays for the prescription; you just have to pay for a doctor’s visit.”

A profile of a typical prescription opioid user did not emerge from the data. However, participants noted the secrecy of people who abuse opioids: “There are more closet pill heads [than closeted crack cocaine users]; A lot of people secretly do it

[abuse opioids] ... like a soccer mom running in [to see a drug dealer] for like three minutes [to] get her pills and leave, and none of her family knew ... literally everybody.” Reportedly, some users begin using prescription opioids as a way of self-medicating. A participant explained, “How I started [doing prescription opioids] was I got back problems ... and I couldn’t find a doctor that would help me out. So what I did, I ended up going and buying it off the street and, you know, I was doing it for my pain ...” Community professionals also had difficulty developing a profile of a typical prescription opioid user, stating that someone of any race, ethnicity or socioeconomic status used prescription opioids.

Participants reported a variety of substances used in combination with prescription opioids: alcohol, crack cocaine, heroin, marijuana, powder cocaine and sedative-hypnotics. Also, reportedly common is mixing prescription opioids with other prescription opioids. Many participants reported poly-substance use. A participant reported, “I always, always, always started out with weed [marijuana], and then if it was a really good day, I would get a bottle of Jack Daniel’s [whiskey], and then I would do the pills [prescription opioids] – in that order.” Another participant reported, “I would start out in the morning by going to opiates [prescription opioids]. I did my opiates and I did heroin. Then I’d drink [alcohol]. If I was drinking, I’d start smoking crack. If I was smoking crack, I’d take xani’s [Xanax®] ... and then I’d do it all over again ...”

Suboxone®

Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported availability of Suboxone® as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Law enforcement and drug court staff agreed that Suboxone® was being abused and was highly available in the region during the previous six months. Both participants and community professionals reported that the availability of Suboxone® had increased during the previous six months. The BCI London Crime Lab reported that the number of Suboxone® cases it processed had remained the same during the previous six months. The most commonly reported street prices for Suboxone® were as follows: 2 mg sold for \$5; 8 mg sold for \$20; 8 mg strips (aka “film”) sold for \$15. Most often participants reported taking Suboxone® 8 mg pills. Among participants who reported on abuse of Suboxone®, snorting was the most common route of administration followed by intravenous injection. Participants reported obtaining Suboxone® from doctors and clinics, but those who abused

the drug reported mainly obtaining it from people with prescriptions. A profile for a typical Suboxone® user did not emerge from the data.

Current Trends



Suboxone® remains highly available in the region. Participants most often reported the current 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 '10'. Participants had a lot to say about the availability of Suboxone®: *"Suboxone® is pretty popular; I think I hear more about Suboxone® around here than I do anything else; It's everywhere; I can almost find Suboxone® faster than I can anything else."* Community professionals most often rated the current availability of Suboxone® as '5' or '6'. A drug court officer expressed a great deal of concern over Suboxone® abuse: *"Suboxone® still continues to be an issue with our participants ... we have seen a lot of illegal use of Suboxone."* Treatment providers agreed that many are misusing Suboxone®: *"They're not taking it [Suboxone®] as prescribed ... from what I see, I think that probably more than 50 percent are not using it like they're supposed to ... selling it or abusing it."*

Participants reported that the availability of Suboxone® has increased during the past six months. A couple of participants noted a decrease in Suboxone® and a subsequent increase in Subutex®: *"I know people who are doing that Subutex® now. A lot of people switch from Suboxone® to Subutex® ... and you see more of it than you do the Suboxone® ...; They [users] are substituting Suboxone® for Subutex® because there is no opiate blocker, and they can take pain pills [prescription opioids] with it."* Community professionals had mixed perceptions regarding a change in Suboxone® availability during the past six months. A health care provider and a staff member from the coroner's office reported an increase in Suboxone® based on an increase in children obtaining the drug. *"In Athens County we had two accidental – not deaths – but young, young children [less than three years old] on Suboxone® [come into the hospital having ingested Suboxone®];"* said the staff member from the coroner's office. The BCI London Crime Lab reported that the number of Suboxone® cases that it processed has increased during the past six months.

No slang terms or street names were reported for Suboxone®. Reportedly, 8 mg Suboxone® sells for between \$15-20. No prices were provided for the Suboxone® 2 mg. However, a

participant noted inflated pricing if demand is high: *"I've seen them [Suboxone®] go for \$40 because there wasn't none, and people were sick, you know, they needed them."* Among participants who reported on abuse of Suboxone®, snorting remains the most common route of administration followed by intravenous injection. Community professionals reported on intravenous injection of Suboxone®. A staff member from the health department reported, *"I am aware of one client who is on the Suboxone® treatment [program] who is crushing it and shooting it ... he does it because he was a heroin addict and he likes this deal of putting needles in himself."* Participants continued to report obtaining Suboxone® from doctors and clinics, but mainly from people with prescriptions. A participant explained, *"You go to people you know get prescription for it [Suboxone®]."*

A profile for a typical Suboxone® user did not emerge from the data. However, treatment providers continued to report that opiate users use the drug when they cannot obtain heroin or a prescription opioid. A treatment provider stated, *"[Suboxone® is] used as a backup if you can't get your drug of choice that's an opiate. You use that to kind of help, you know, get you through 'til you can get it [your drug of choice]."* Reportedly, Suboxone® is used in combination with marijuana and sedative-hypnotics. A participant reported, *"It doesn't really do you much good to do anything else [with Suboxone®], but you can get a buzz with xani's [Xanax®] and Suboxone®."* Treatment providers also reported the combination of benzodiazepines and Suboxone® is fairly common.

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants and community professionals most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants identified Klonopin®, Valium® and Xanax® as the three most popular sedative-hypnotics in terms of widespread use. Collaborating data also indicated that sedative-hypnotics were readily available in the region. The Scioto County Coroner's Office reported that sedative-hypnotics were present in 10.7 percent of all drug-related deaths during the previous six months. The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processed had remained the same during the previous six months. The most common routes of administration remained oral ingestion and snorting. Participants said they frequently feigned symptoms of anxiety to obtain sedative-hypnotics, but they

also obtained the drugs from family and friends. Typical users of sedative-hypnotics were young adults in their 20s.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates, and muscle relaxants) remain highly available in the region. Participants and community professionals most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants continued to identify Klonopin®, Valium® and Xanax® as the three most popular sedative-hypnotics. Participants reported specifically on the availability of different benzodiazepines. One participant spoke about Klonopin®: *"I'd say Klonopin® are probably the easiest to get of all of those because more people get prescribed those than anything else."* Another participant discussed the popularity of Xanax®: *"More people want Xanax® than anything."* Generally, participants thought Ambien® is difficult to obtain; with one stating, *"You have to know someone for Ambien® ... If you know the person, you'll be able to get it. And if you don't, you might as well be looking for gold bars."* A participant spoke about ways in which users obtain Ambien®: *"You have to know someone with a prescription for Ambien® that will sell it. They're not necessarily gonna be like drug dealers. But I used to sell my Ambien®, and I would either trade it for pills that I wanted or I would just let it go for like a dollar a pill."*

Several participants mentioned that users do not want to share or sell their sedative-hypnotics, especially if users feel they "need" them. A participant explained, *"I think people are too stingy with xani's [Xanax®] now, 'cause most people like to use them."* Another participant shared her personal experience: *"I'm very stingy with my xani's [Xanax®] – I did not like to come off of them at all, but I will if I know you got a date ahead of me before I get mine ... I'll give you five if you give me 10."* Community professionals most often reported the current availability of sedative-hypnotics as '10'; the previous most common score was also '10'. Community professionals identified Ativan®, Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics. Collaborating data also indicated that sedative-hypnotics are readily available in the region. The Scioto County Coroner's Office reported sedative-hypnotics as present in 7.1 percent of all drug-related deaths during the previous six months.

Participants reported that the overall availability of sedative-hypnotics has remained the same during the past six months. However, participants noted a few exceptions and reported that Klonopin® and Xanax® have increased in availability, while Soma® and Valium® have decreased in availability. A participant commented, *"People's got a lot stingier with their*

benzo's [benzodiazepines] than they used to be ... you used to be able to get 'em really easy and now people will not come off of 'em." Community professionals agreed that overall sedative-hypnotic availability has remained stable during the past six months. However, treatment providers reported an increase of users with prescription sleep aides. A treatment provider explained, *"We're just hearing more clients that are coming into treatment that are on those other sleeping medications [Ambien®, Lunesta® and Restoril®]. We hadn't heard about those during the past years."* The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processed has stayed the same during the past six months.

Reportedly, many different types of sedative-hypnotics (aka "benzos," "downers" and "nerve pills") 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): Ativan® (1 mg sells for between \$1-3; 2mg sells for between \$4-5); Klonopin® (aka "forgot-o-pins" and "green monsters;" 0.5 mg sells for between \$1-2; 1 mg sells for between \$2-3; 2 mg sells for \$3); Soma® (aka "somatose" and "soma-coma;" sells for \$0.50 per pill); Valium® (2 mg sells for between \$4-5; 5 mg sells for \$1; 10 mg sells for between \$2-3); Xanax® (aka "bars," "basketballs," "blue boys," "blues," "bus bar," "busses," "footballs," "kiwis," "ladders," "peaches," "pies" and "xani's;" 0.5 mg sells for between \$1.50-2; 1 mg sells for between \$2-4; 2 mg sells for between \$5-6; 3mg sells for \$7).

While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among specific types, generally, the most common route of administration remains oral ingestion (aka "popping"). A participant spoke about the various routes of administration: *"I always know people eatin' them [benzodiazepines] by handfuls ... [but] it depends on the person. Some people will chew them up, some people just swallow them, some people just let them sit on their tongue and just dissolve."* Several participants mentioned intranasal ingestion [snorting] and smoking sedative-hypnotics, while only a couple of participants mentioned parachuting them. A participant described the parachuting technique: *"[You] crush it [benzodiazepines] up and put it in ... like break toilet paper or tissue ... and twist it up and swallow it."*

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported getting them from friends, doctors and locations outside the Athens region. Participants continued to discuss feigning symptoms of anxiety to obtain sedative-hypnotics. A participant explained, *"People fake it [anxiety], so they'll go in to see a psychiatrist just so they can get prescribed them [benzodiazepines]."*

Participants described typical users of sedative-hypnotics as people who are under a lot of stress or work in certain industries. A participant explained, *“Restaurant workers, like servers ... pretty much [use] any drug. I mean, because you’re dealing with the public constantly. You’re performing for the public ... it’s a high rate of drug and alcohol use ... you have to take something to deal with that shit.”* For the first time, participants also identified a subset of users who they referred to as “pharmies,” who are people who like to mix prescription opioids and sedative-hypnotics. A participant explained that “pharmies” are *“people who snort ... mix their pills. They’ll snort a Percocet® and then follow it up with a Xanax®. Lots of people do that.”* Community professionals described typical users of sedative-hypnotics as White men and women aged from early 20s through 50s. A treatment provider said, *“You’d be surprised ... people who use opiates and go back and forth on these things [between prescription opioids and benzodiazepines].”*

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with cocaine, heroin, marijuana, prescription opioids, prescription stimulants and other sedative-hypnotics. Participants reported that it is most common to use sedative-hypnotics with prescription opioids. A participant explained, *“Opiates stop working at some point if you’re a daily user. So, I’ll use Xanax® to actually get a buzz – or actually feel high.”* Another participant used sedative-hypnotics to black out: *“Typically, if you’re withdrawing from opiates, Xanax® really helps because you black out and you don’t really remember feeling terrible.”* A participant from Muskingum County discussed using Ambien® to come down off of other drugs: *“A lot of people want to have Ambien® around because it will help you no matter how jacked up [high] you are on stuff. If you take enough Ambien®, you’re going to be able to sleep for a while.”* Treatment providers and staff from an area coroner’s office also observed several combinations of drug use. A treatment provider explained some of the combinations: *“Perc’s [Percocet®] and Valium® go together. Klonopin® and oxycodone go together – it’s not like a gin and tonic, it’s just when they take those, they take the other.”* Another treatment provider mentioned the use of alcohol with sedative-hypnotics: *“A lot of individuals mix alcohol and Xanax® together.”*

Marijuana

Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants and community professionals most often reported the availability of marijuana as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Community professionals reported that users frequently

grew their own marijuana. The BCI London Crime Lab reported that the number of marijuana cases it processed had decreased during the previous six months. Participant quality scores of marijuana varied from ‘2-10’ with the most common score being ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported commercial-grade marijuana as the cheapest form: a blunt (cigar) or two joints (cigarettes) sold for between \$5-10; an ounce sold for between \$100-160. High-grade marijuana sold for significantly more: a gram sold for between \$20-25; an ounce sold for between \$350-525. The most common route of administration remained smoking. Participants and community professionals reported that men and women of all races and ethnicities used marijuana.

Current Trends

Marijuana remains highly available in the region. Participants and community professionals 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.’ All participants believed that marijuana is very easy to obtain. A participant said, *“If someone doesn’t have it [marijuana], someone else is going to have it. You’re going to be able to find it somewhere ‘cause you just don’t know one person [who uses marijuana].”* Participants in all focus groups mentioned peak availability during harvest season (late summer and autumn). A participant said, *“We’re in an area where a lot of people grow it [marijuana]. They’re all starting their plants right now and getting ready for it to hit the ground. It [marijuana] might be a little less available [now] because all your growers are about to run out of their last year’s crops.”* Community professionals commented on the excessive availability of marijuana in the Athens region. A treatment provider stated, *“They’re growing it [marijuana] in their backyard or in their basement.”*

Most participant focus groups, as well as the groups of community professionals, reported stable availability during the past six months. A participant said, *“[Marijuana] it’s been here. It’s gonna stay here.”* A minority of participants and community professionals suggested a possible decrease in marijuana availability. A participant explained why he thought there had been a decrease: *“People are moving to different drugs. Where I live, there’s a lot of crack [cocaine] and pills [prescription opioids and benzodiazepines] and heroin.”* A treatment provider said marijuana use has decreased as a result of increase in prescription opioid use: *“I’m thinking probably use [of marijuana] has gone down because of the opiates. They don’t need it [marijuana].”* The BCI London Crime Lab reported that the number of marijuana cases it processed has decreased during the past six months.

Participants most often rated the overall quality of marijuana in the region as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8'. Participants noted a slight difference in quality between the two grades of marijuana, rating current quality of low- to mid-grade marijuana as '7' and that of high-grade marijuana as '10'. However, generally, participants believed all forms of marijuana in the area to be of high quality. One participant stated: *"Ever since them [sic] other states legalized it, you know, it's like all the [marijuana] brands are like '10' [high quality]. I can get better weed [marijuana] more than I can get dirt [low quality] weed."* According to participants, the quality of marijuana has remained the same during the past six months. Participants reported marijuana as occasionally being cut with Italian spices, oregano, pencil shavings and powdered cocaine. A Belmont County participant discussed cutting marijuana with other substances: *"If it was crappy weed, and I was trying to sell it to someone for more than it was worth, [I] put a little bit of coke [powdered cocaine] on it and they don't know the difference. Even if they don't do coke [powdered cocaine], you just don't tell them."*

Current street jargon includes countless names for marijuana. The most commonly cited names were "pot" and "weed." Other common street names for marijuana include: "beasters," "bud," "ganja," "green," "herb," "schwag," "smoke" and "trees." Street names may also be related to the quality of marijuana: low- to mid-grade marijuana may be referred to as any of these street names, as well as "commercial," "mersh," "mids," "middies" and "shake." High-grade marijuana is called "dank," "dro," "hydro," "kush," "loud," "neon buds" or "skunk." Names for this grade of marijuana may also be related to the specific strand: "blueberry," "bubbalicious," "bubblemum jubilee," "juicy fruit," "mango" and "train wreck." The price of marijuana depends on the quality desired. Participants reported commercial-grade marijuana as the cheapest form: a blunt or two joints sell for \$3; 1 or 2 grams sells for between \$5-10; 1/8 ounce sells for between \$15-30; 1/4 ounce sells for between \$25-60; an ounce sells for between \$125-150; 1/4 pound sells for \$350-400. Reportedly, high-grade marijuana sells for significantly more: 1 or 2 grams sells for between \$10-20; 1/8 ounce sells for between \$50-100; 1/4 ounce sells for between \$60-100; an ounce sells for between \$275-300; 1/4 pound sells for \$1,000; a pound sells for between \$8,900-9,000.

While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Participants reported smoking marijuana in a blunt, a joint, a bowl, a bong, a vaporizer and "cigarillo" [aka cigar]. Participants also discussed cooking with

marijuana in greater frequency than was reported during the last reporting period. A participant explained, *"You can bake it with brownies, cookies. You can eat it, you can smoke it in bowls, you can drink it – boil it up, drink it like tea."* Another participant agreed, *"I know a lot of people that's making butter, cookies [and] brownies."* Participants reported a change in marijuana use as occurring during the past six months: users are adding liquid flavoring to marijuana blunts and cigarettes. A participant explained, *"There's this stuff that people put in blunts now . . . it's liquid stuff and you squirt it in. It's just basically something for the flavor of it [marijuana]. Some people put that in weed [marijuana] just so they can sell it for more – like the brown weed that people call 'Mexican' and doesn't taste good and when you hit it, it burns too fast. If you add that [liquid flavoring], it will make it [marijuana] seem spongier, and it will taste better, so it will seem like higher quality."*

A profile for a typical marijuana user did not emerge from the data. Participants and professionals described typical users of marijuana as "everyone." Participants frequently commented on the diversity of users. A participant commented, *"I've seen uppity lawyers and judges smoke weed. And then, you know, the lowest homeless dude smoking weed."* Participants accepted marijuana as an assumed part of growing up. A participant reported, *"I smoked it [marijuana] when I was in high school, but you know, everybody smokes pot when they're in high school."* Participants also reported marijuana use by children as young as seven years. Community professionals reported that between 80-100 percent of their clients have used marijuana, and they said users come from a variety of labor professions such as factory workers, painters, construction workers and roofers. Typically, treatment providers said professionals only come into treatment when they are referred by the court. A family drug court staff noted that use of marijuana is highly acceptable in the community. A court official explained, *"All of our clientele uses marijuana, parents and juveniles. Parents use with their children."* In addition, law enforcement reported, *"[Marijuana is] so hard for us to enforce. People don't think there's anything wrong with it."*

Reportedly, marijuana is most often used in combination with alcohol and powdered cocaine. However, most participants reported that marijuana can be used with anything, including Ecstasy, embalming fluid, crack cocaine (aka primo), heroin, hallucinogens [LSD (Lysergic acid diethylamide), psilocybin mushrooms and PCP (Phencyclidine)], prescription opioids and tobacco. A participant explained, *"I mix weed with anything. If I had anything, I had weed first."* Participants were eager to share their personal experiences. A participant discussed

combining marijuana with cocaine to modify the high: *"I would sprinkle my coke on top of the weed and smoke the blunt with the coke ... it would sort of intensify [the high]."* Smoking marijuana with crushed prescription pills was also mentioned by several focus groups.

Methamphetamine

Historical Summary

In the previous reporting period, methamphetamine was relatively rare in the region. Overall, participants most often reported the availability of methamphetamine as '2' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that methamphetamine was available in crystal (aka "glass") and powdered forms. Community professionals reported moderate to high availability of methamphetamine in the region. There was disagreement among participants and community professionals about whether the drug's availability had increased, decreased or remained the same during the previous six months. Most participants reported that the quality of methamphetamine was moderate, most often rating its quality as '4' on a scale of '0' (poor quality, garbage) to '10' (high quality). Participants reported that a gram of methamphetamine sold for \$100; 1/8 ounce sold for roughly \$200. The most common route of administration was smoking, but snorting methamphetamine was reportedly also very popular. Participants and community professionals identified typical methamphetamine users as individuals older than 40 years, and said they worked in industries that required long hours and a high degree of concentration (such as construction and trucking).

Current Trends



According to participants, methamphetamine remains relatively rare throughout the region. Participants most often reported the current availability of methamphetamine as '2' 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 '2'. A participant explained why it is so difficult to find the drug: *"It's not the easiest drug to find, you have to be in a certain click. They [methamphetamine users] stick together, and they're very, very particular about who they're going to sell to 'cuz they're ... paranoid."* Another participant commented, *"I've seen it [methamphetamine] during the past six months, but it just really hasn't seemed to hit this area too hard ..."*

Participants reported that methamphetamine is available in powdered and crystal forms. A Belmont County participant reported on the most common form of the drug: *"You can get it [methamphetamine] in powder form, that's personal meth [aka 'shake-and-bake']."* Another participant stated, *"You can ask for crystal [methamphetamine], and they're still gonna give you shake-and-bake."* Contrary to the previous reporting period, more participants had knowledge about methamphetamine, but these stories were related to friend's experimentation with the drug and not personal accounts of drug use. In contrast, community professionals rated current availability of methamphetamine as '7' and '8'; previously, community professionals also reported moderate to high availability of methamphetamine. A law enforcement officer discussed a recent enforcement activity: *"There for six to eight straight weekends, our drug unit was called out for meth labs."* Media from the region reported on an increase in the popularity of the one-pot method (methamphetamine manufacture in a single sealed container, such as a two-liter soda bottle, aka "shake-and-bake"). The Central Ohio Drug Enforcement Task Force, serving Licking, Muskingum, Perry, and Coshocton counties, arrested 11 one-pot methamphetamine cooks (manufacturers) in 2012 www.coshoctontribune.com, March 9, 2012).

Most participants claimed no personal experience with methamphetamine, but many reported increased availability of the drug during the past six months based on what they heard from friends and in media reports. A participant explained, *"For me [methamphetamine availability] it's increased because I just recently seen it for the first time during the past six months."* Law enforcement reported an increase in methamphetamine. An officer said, *"Yes, we've seen an increase in [methamphetamine] the last six months. It used to be in more rural counties, such as Perry County. One of the things we're seeing now is the quick shakes that they can do with just a couple bottles of the material that they need to do it. So, it's readily available. It's so easy to do it in a moving vehicle, and so, we've seen a huge increase in it."* The BCI London Crime Lab reported that the number of methamphetamine cases it processed has increased during the past six months. The lab reported processing white to off-white powdered methamphetamine most often and crystal methamphetamine occasionally, and noted that the one-pot method of manufacturing the drug appears to be increasing.

The few participants with experience using methamphetamine reported current quality of the drug as high quality, most often rating quality as '10' on a scale of '0' (poor quality, garbage) to '10' (high quality); the previous most common score was '4'. As with previous reporting periods, participants said the quality largely depends on

the technical expertise of the “cook.” Participants reported methamphetamine being cut with wax.

Current street jargon includes a few names for methamphetamine. The most commonly cited street names for methamphetamine were: “crank,” “crystal(s),” “glass,” “ice,” “meth” and “shards.” Prices for methamphetamine were consistent among those participants who were familiar with the drug. Participants reported that a gram sells for \$100. In addition, a participant reported purchasing methamphetamine in smaller quantities for less money, but was unsure of the exact weight of the drug: *“If I wanted like \$25 or \$30 worth of it [methamphetamine] ... ‘cuz that’s what I would usually be prepared to spend on a pill [prescription opioid] ... I want to say [I would get] maybe like a quarter of a gram.”* Participants reported that there are several ways of consuming methamphetamine: smoking, snorting and intravenous injection. A participant explained, *“You smoke it [methamphetamine]. You can snort it too, but you’re better off just snorting.”* Another participant reported, *“You get more high off it [methamphetamine] when you smoke it.”* A participant explained her use of methamphetamine: *“I just always snorted it [methamphetamine], but people definitely shoot [inject] it up. It’s very easy to shoot up ...”*

A profile for a typical methamphetamine user did not emerge from the data. However, community professionals in the health care field identified typical methamphetamine users as prostitutes and people of low socio-economic status. A treatment provider described users of methamphetamine as *“people that may not have jobs or people [who are] more destitute.”* Reportedly, methamphetamine is used in combination with alcohol, prescription opioids and sedative-hypnotics. Participants said they used substances to come down from the intense high of the drug. A participant explained, *“You don’t really need to [use anything else with methamphetamine] ... maybe after the four days you are up, you might want to go to sleep, so you can probably take some xani’s [Xanax®] or heroin or something to bring you back down.”*

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants were moderately available in the region. Participants most often reported the availability of prescription stimulants as ‘5’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Community professionals did not rate the availability of prescription stimulants, but identified Adderall®, Ritalin® and Vyvanse® as being available and abused within the region. The BCI London Crime Lab reported that the number of prescription stimulant cases it processed had remained the same during the previous six months with one exception: the

number of Adderall® cases had decreased. Participants and community professionals often expressed concern about how these drugs were prescribed and obtained. According to participants and community professionals, typical users of prescription stimulants were young people, including middle school and high school students, as well as college-aged adults between the ages of 18 and 25 years.

Current Trends

Prescription stimulants are highly available in the region. Participants most often rated 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 ‘5’. Participants identified Adderall®, Concerta® and Ritalin® as the three most popular prescription stimulants in terms of widespread use. Participants commonly believed that these drugs are easily obtained. A participant explained, *“Adderall®’s easy, so is Ritalin® because every kid in America’s on that shit.”* A participant also spoke about the higher availability of Adderall® compared to other prescription stimulants: *“They’re prescribing Adderall® more than Ritalin® nowadays.”* Community professionals reported moderate availability of prescription stimulants in the region, although again they were not able to provide an availability score. Treatment providers and drug court staff identified the top available prescription stimulants as Adderall® and Vyvanse®. Staff from the Vinton County Coroner’s Office spoke about the drug’s availability throughout the region: *“I don’t see it [prescription stimulant use] in Vinton County, but working here [Athens County] in the hospital I see it as overdoses.”*

Participants reported an increase in the availability of the Adderall® during the past six months. A participant reported, *“I know a lot more people getting prescriptions for Adderall® [and diverting them].”* A staff member from the Hocking County Drug Court reported similar findings: *“I would say we’ve had an increase in the use of Adderall® here in the last six months.”* The BCI London Crime Lab reported that the number of prescription stimulant cases it processed has remained the same during the past six months.

Current street jargon for prescription stimulants is limited to “addies” for Adderall®. Prices for prescription stimulants were consistent among those who were familiar with the drugs. Participants reported the following prescription stimulants as available to street-level users: Adderall® 30 mg sells for between \$2-5; Ritalin® sells for between \$1-2. The most common route of administration is swallowing. Participants frequently mentioned diversion of the drugs, and they said users obtain prescription stimulants from family and friends as well as physicians. A participant explained, *“You’d be surprised at how many people’s selling their kids Adderall®.”*

A profile for a typical user of prescription stimulants emerged from the data. Participants and community professionals agreed that adolescents (12 years and older) and young adults in their twenties are the most likely people to use the drugs. A participant with a history of abusing prescription stimulants said, "I was hooked on it [Adderall®] when I was 14 [years old]." Drug court staff confirmed these findings and identified use of Adderall® with adolescents less than 18 years of age. In addition, health care workers in Athens County identified typical users as college students between the ages of 18 and 22 years. Participants also mentioned other categories of typical users, but these were not supported by community professionals. A participant said "speed freaks," people who enjoy using drugs like cocaine and methamphetamine, and truck drivers are typical users. A participant said women use the drugs to lose weight: "I know someone who gets prescribed Adderall®, and she buys 'em [from a dealer] when she runs out because she says they help her lose weight." Another participant said students use the drugs as a study aide: "When I used to go up to visit my brother in college, I would sell 30s [30 mg Adderall®] like crazy. So they [students] could stay up all night." Reportedly, prescription stimulants are used in combination with alcohol and crack cocaine.

Synthetic Marijuana

Historical Summary

In the previous reporting period, synthetic marijuana ("K2" and "Spice") was highly available in the region before the ban on its sale went into effect in October 2011. Participants reported that synthetic marijuana could easily be purchased at convenience stores, head shops and gas stations. Participants did not comment on any change in availability, but professionals believed that availability decreased before the ban went into effect. The BCI London Crime Lab data indicated that the five formally scheduled substances were almost never seen anymore; rather dozens of non-controlled structural analogs took their place. Participants reported that a gram of synthetic marijuana sold for \$5; three grams sold for \$10; 20 grams sold for \$20. The most common route of administration for synthetic marijuana remained smoking.

Current trends

Synthetic marijuana is moderately available in the region. Participants familiar with this drug most often rated its current availability as '4' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, participants did not assign an availability score to synthetic marijuana. Despite the ban that went into effect in October 2011, participants reported synthetic marijuana is still available from some convenience stores. According to a participant, "They're supposed to be not selling



it [synthetic marijuana], but they do it illegally." A participant in Athens County reported, "There are still designer drugs that are here, they're just calling them by different names and selling them kind of in secrecy. They are still available." Generally, participants agreed that interest in the drug is waning. Community professionals did not provide an availability rating, but recognized synthetic marijuana as available in the region. Community professionals also agreed with participants that synthetic marijuana continues to be available from places like convenience stores.

Participants and community professionals reported a decrease in availability of synthetic marijuana during the past six months. A staff member from the Hocking County Drug Court commented, "We went through a spell where K2 [synthetic marijuana] was really prevalent, but [after we began testing for it, our clients began] thinking, 'Well, you know, screw it. If we're gonna pop [fail the drug test] for K2 instead of the real thing, we're just gonna use the real thing.'" The BCI London Crime Lab reported that the number of synthetic marijuana cases it processed has increased during the past six months. The crime lab reported that as soon as one drug is banned (JWH-018) another chemical analogue is likely to take its place (AM2201).

Quality for synthetic marijuana was not rated by participants because few participants had experience with it during the past six months. Current street jargon includes several names for synthetic marijuana. The most common names were "K2," "K3," "plant food," and "mosquito repellent." An Athens County participant said the names of synthetic marijuana have changed to subvert the new law: "Like instead of calling it [synthetic marijuana] 'K2,' they're calling it 'plant food.' There's a couple of other different names they call it, one was like 'mosquito repellent' or something." Reportedly, a gram of synthetic marijuana sells for \$10; 3.5 grams sells for between \$30-40. The most common route of administration for synthetic marijuana remains smoking. Participants did not mention using any drugs in combination with synthetic marijuana.

Bath Salts

Historical Summary

In the previous reporting period, bath salts (synthetic compounds containing methylone, mephedrone or MDPV) were highly available in the region. Participants most often reported the availability of bath salts as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Community professionals in Guernsey, Muskingum and Washington counties reported

more of their clientele using bath salts than did professionals in Athens County. Prior to the current ban on the sale of bath salts, participants reported that bath salts were commonly sold at many gas stations in the region. Participants and community professionals agreed that bath salts availability had decreased during the previous six months after statewide legislation banning certain ingredients found in bath salts went into effect in October 2011. While participants did not provide a rating for the quality of bath salts, they said the quality had decreased. Participants with knowledge of bath salts said the drug sold for \$20 a gram. The most common route of administration of bath salts remained snorting. While participants and community professionals did not mention a specific gender or racial group that was more likely to use bath salts, many treatment providers said their clients were in the 15-35 year age range.

Current Trends



Bath salts (synthetic compounds containing methylenedioxymethamphetamine, mephedrone or MDPV) remain available in the region. While most participants did not have personal knowledge of bath salts, community professionals most often rated current availability of bath salts as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A couple of participants had knowledge of bath salts and disclosed that replacement products are still available through retail stores, as well as through personal

connections. A participant described how manufacturers were trying to circumvent the law: "I heard they changed the name [of the bath salts], and they [the gas stations that sold it] still got it." Another participant spoke about Internet sales of bath salts: "I know [bath salts] still going around just 'cuz I have a friend right now ... his cousin is ... somehow ordering it [bath salts] from somewhere, and he's having [them] sent to my friend's house, and it's my friend's drug of choice." Law enforcement spoke about recent drug seizures in the region involving bath salts. An officer said, "[Bath salts are] still out there. We've [found] probably half a dozen gas-station-type businesses that were selling bath-salt-type substances behind the counter or behind the back wall. We've confiscated a lot of them." Treatment providers agreed with law enforcement. A treatment provider commented, "It [bath salts] seems to be really accessible. I hear clients are getting it without any problem." Staff from a health department concurred with other professionals, and reported users are still coming into emergency rooms high on bath salts. Media outlets in the region reported on new formulations of bath salts increasing in popularity since the statewide ban went into effect. A

official with the Muskingum Behavioral Health reported, "The new wave is 'K3' and 'Gen2' bath salts, which is also referred to as 'jewelry cleaner,' 'pipe cleaner' or 'Cosmic Blast'" (www.coshoctontribune.com, Jan. 22, 2012).

Participants reported the availability of bath salts has decreased during the past six months. They were familiar with the law that banned bath salts. A participant commented, "It is really hard to get [bath salts] because they have taken it off the shelves." However, community professionals reported an increase in bath salts availability. A treatment provider explained, "[Bath salts use] it's in the upswing, increasing. I hear more and more about [bath salts] than I did [prior to the October 2011 legislation] ... I've heard more about it in the last six months." The BCI London Crime Lab reported that the number of bath salt cases it processed has increased during the past six months. In addition, the lab reported that as soon as one drug is banned (MDPV), another chemical analogue is likely to take its place (alpha-PVP).

Participants were not familiar enough with bath salts to report on the drug's quality, nor were they familiar with current street jargon. Reportedly, bath salts sell for \$40. Participants were most concerned with the recent media reports of bath salts leading to hallucinations and paranoia. A participant talked about one user's experience with bath salts: "When I was in jail, there were a couple girls that also used it [bath salts], and they were warning people that like 'We've done a lot of drugs and I tell you what, I will never do bath salts ever again ...'" Participants did not report using bath salts with other substances.

Other Drugs

Historical Summary

In the previous reporting period, participants and community professionals listed the following other drugs as present in the region, but these drugs were not mentioned by the majority of people interviewed: Ecstasy, hallucinogens [lysergic acid diethylamide (LSD), psilocybin mushrooms and dimethyltryptamine (DMT)], inhalants, over-the-counter medications (OTC) and "moonshine" alcohol. Ecstasy was rarely available in the region. Participants with knowledge of the drug most often reported its availability as '3' or '4' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); law enforcement, however rated the availability of Ecstasy as '10'. The BCI London Crime Lab reported the number of Ecstasy cases it processed had remained the same during the previous six months; however, the lab noted a considerable increase in cases containing the designer drug 5-MeO-DiPT (foxy methoxy). Participants said the route of administration varied for Ecstasy; users

could swallow or snort it depending on the type of high they wanted. Hallucinogens were rarely available in the region. Most participants listed LSD and psilocybin mushrooms as the most available hallucinogens; some participants also included dimethyltryptamine (DMT). Law enforcement reported high availability of hallucinogens in the area, rating the availability of LSD as '10' and the availability of psilocybin mushrooms as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). The BCI London Crime Lab reported that the number of LSD cases it processed had increased and the number of psilocybin cases it processed had decreased during the previous six months. According to participants from Guernsey County, DMT was locally made and of high quality. Reportedly, the most common route of DMT administration was smoking. Participants reported the following prices for hallucinogens: DMT sold for \$10 a hit (about 1/10 gram); LSD sold for between \$10-20 a hit, with higher prices at concerts; 1/4 ounce of psilocybin mushrooms sold for between \$40-50. Inhalants (aka "whippets") were highly available in the region. Despite their availability, participants reported that inhalants were rarely abused because they were not a preferred drug. Most community professionals agreed that inhalants were rarely used in the region; however, a treatment provider reported that three of her clients reported abusing inhalants during the past six months. OTC medications (cold and cough syrups) were highly available in the region. However, according to participants and community professionals, these substances were rarely used by those older than 18 years of age. Typically, participants mentioned high school youth between the ages of 16-18 years as abusing OTC medications. Alcohol also was highly available in the region. Participants and community professionals said alcohol abuse was common, and users began using alcohol as young as 11 and 12 years of age. Participants have noticed an increase in different flavors of alcohol, and they believed flavored alcohol to be a marketing ploy. Participants also mentioned the availability of homemade alcohol (aka "moonshine" and "hot apple pie") in the region.

Current Trends

Participants and community 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: Ecstasy, hallucinogens (psilocybin mushrooms) and inhalants. Ecstasy is moderately available in the region. Participants rated the current availability of Ecstasy as between '4' and '9' (average score 6.5) on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common scores were '3' and '4'. Participants familiar with Ecstasy reported that the drug can be difficult to obtain. A participant reported, "It's not like you can say

you want to do [Ecstasy] and set it up for like an hour later; give me three days and I can get it; it's an event drug." Another participant agreed, "You might find some of that [Ecstasy] if you go to a hookah festival, but you ain't gonna find no Ecstasy or anything like that on the street." Treatment providers reported rare availability of Ecstasy. A treatment provider explained, "Every once in a while you'll hear Ecstasy from clients, but it's not something they regularly do. It's [a] here or there thing that they do ... more so probably at a party or something like that." Participants and community professionals did not comment on any change of availability during the past six months; however, participants said that Ecstasy is not as prevalent as it was several years ago. The BCI London Crime Lab reported that the number of Ecstasy cases it processed has remained the same during the past six months. In addition, the lab reported that Ecstasy tablets contain a variety of substances including cathinones, dimethyltryptamine (DMT) and benocyclidine (psychoactive drug), which is usually in tablets with 5-MeO-Dipt and caffeine. Participants reported that the price of Ecstasy (aka "X") commonly depends on the pictures on the tablets. A participant said Ecstasy is priced "... according to what it is. I mean, like superman's [are] \$15 ... the black Mollies [are] \$30 ... you can get blue ones with red hearts, and they're like \$10." The most common route of administration remains oral ingestion. A participant described what witnessed concerning Ecstasy use, "I've seen people take 'X' [Ecstasy] pills, crush them up and put them in a piece of toilet paper and swallow them. It's called parachuting."

Psilocybin mushrooms are highly available in the region, reportedly because they came into season during the past six months. Participants rated current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant spoke about a dealer selling the drug: "I was just approached a couple nights ago [end of March 2012] about a guy with mushrooms being around." Generally, participants reported that psilocybin mushrooms continue to be seasonally available. A participant explained, "Every spring there's 'shrooms around." An Athens health care provider reported moderate availability of psilocybin mushrooms, and rated availability as '5'. Law enforcement did not comment on psilocybin mushroom availability this reporting period. The BCI London Crime Lab reported that the number of psilocybin mushroom cases it processed has remained the same during the past six months. Participants had limited direct experience with psilocybin mushrooms and were unable to rate current quality. A participant provided an anecdotal report: "A buddy of mine said he tried it [psilocybin mushroom], and they're pretty good." Current street jargon for psilocybin mushrooms is limited to "shrooms." Participants reported psilocybin mushrooms sell for between \$15-20 per bag; 1/4 ounce sells for \$40. Participants reported that psilocybin mushrooms

are orally consumed by eating them or drinking them in tea. A participant commented, *"I did them [psilocybin mushrooms] laced on weed. I crush 'em and make it like a powder."* An Athens health care provider spoke about the relationship of psilocybin mushrooms to other drugs: *"A lot of people who are really into marijuana also dabble in hallucinogens."* Participants reported typical users as college students between the ages of 18 and 20 years. Participants also mentioned frequent use at outdoor music festivals like "hippie festivals" and "hookahville" (an outdoor concert). While participants did not report on other hallucinogens, the BCI London Crime Lab reported that cases of LSD and powdered DMT have increased during the past six months.

Lastly, participants reported inhalants (aka "whippets") as available in the region. Participants frequently talked about the inexpensive nature and easy access of inhalants. A participant reported, *"[Inhalants] that's a big one. It's cheap ... if they were looking to get high, and they're broke, go get \$5 and you buy a can of air duster. You can be f***** up for hours."* Another participant talked about the benefits of using inhalants to avoid positive drug screens: *"[Inhalants are] not going to show up on any drug test ..."* Another participant shared, *"My sister be pumpin' my mom's gas – [and] with a rolled up bag she be on the gas tank going [making huffing sound] ... I'm like, 'you're embarrassing me!,' people looking at her and stuff."* Drug court staff reports an increase during the past six months of people using inhalants. Participants and community professionals described typical inhalant users as junior high and high school aged (teens to early 20s).

Conclusion

Crack cocaine, heroin, marijuana, prescription opioids, sedative-hypnotics and Suboxone® remain highly available in the Athens region. Noted changes in availability during the past six months are as follows: increase in availability for heroin and Suboxone®; likely increase in availability for bath salts and methamphetamine; likely decrease in availability for crack cocaine and synthetic marijuana. Overall, participants and community professionals reported that the availability of heroin in the region has increased during the past six months. Treatment providers reported that treatment facilities are noticing an increase in the number of clients seeking treatment for heroin use. Several participants compared the availability of heroin to the availability of marijuana. The BCI London Crime Lab reported that the number of brown powdered and black tar heroin cases it processed has increased during the past six months. Participants continued to report that the most common way to use heroin remains intravenous injection. Community professionals reported that typical heroin users range in age from teens to those into their early thirties. While participants and community professionals reported that the

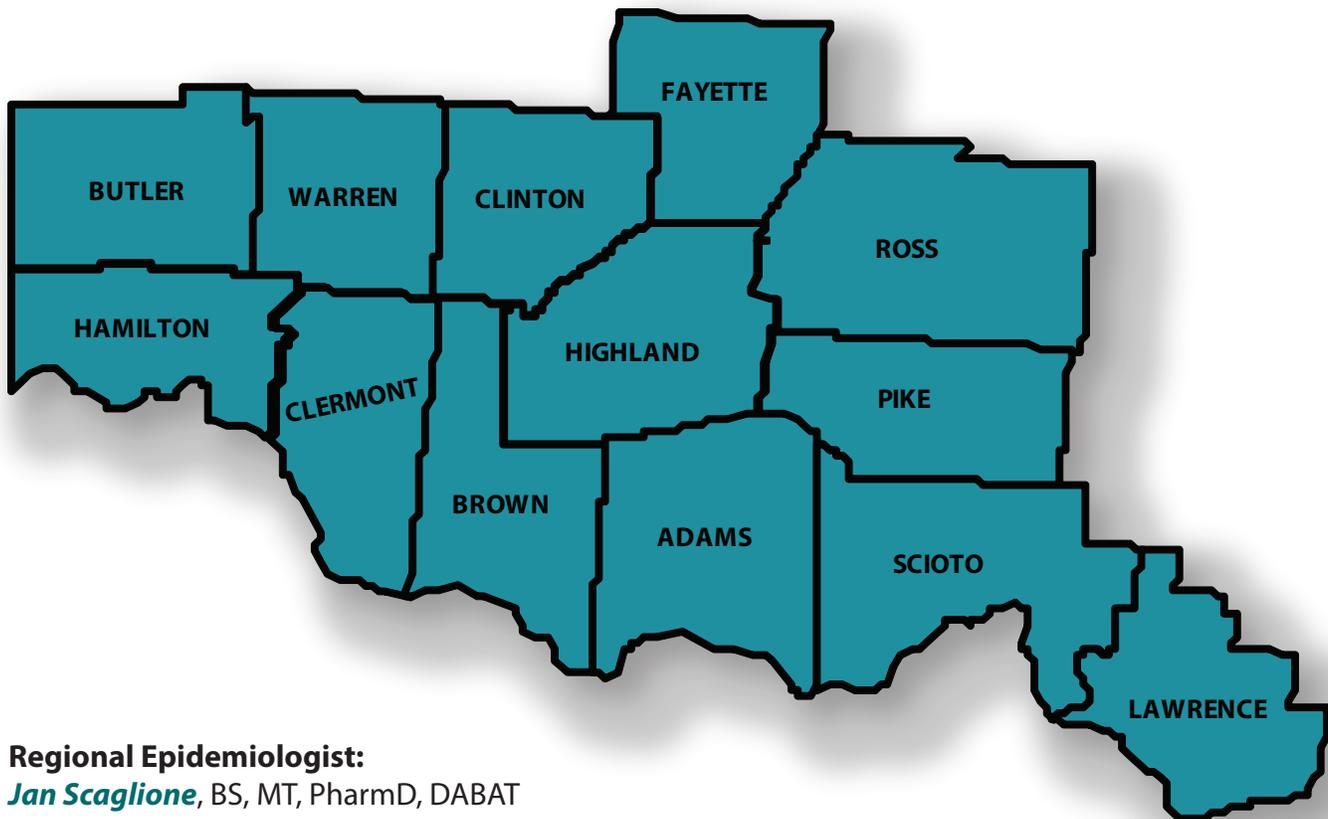
availability of prescription opioids has generally remained stable, at a high level of availability, both respondent groups noted an exception, an increase in the availability of Opana®. The BCI London Crime Lab reported that the number of prescription opioid cases it processed has also generally remained the same during the past six months with the following exceptions: an increase in Opana® cases and a decrease in OxyContin® cases. Participants reported that the availability of Suboxone® has increased during the past six months, with a couple of participants also noting an increase for Subutex®. The BCI London Crime Lab reported that the number of Suboxone® cases it processed has also increased during the past six months. Treatment providers continued to report that opiate users use Suboxone® when they cannot obtain heroin or a prescription opioid. Contrary to the previous reporting period, more participants had knowledge about methamphetamine, but these stories were related to friend's experimentation with the drug and not personal accounts of using the drug. Many participants reported an increase in availability of methamphetamine during the past six months based on what they heard from friends and in media reports. Law enforcement reported an increase in methamphetamine. The BCI London Crime Lab reported that the number of methamphetamine cases it processed has increased during the past six months. While most participants did not have personal knowledge of bath salts, community professionals reported high availability of bath salts. A couple of participants disclosed that bath salts and replacement products are still available through retail stores, as well as through personal connections and the Internet. Staff from a health department concurred with other professionals and reported that users are still coming into emergency rooms high on bath salts. Media outlets in the region reported on new formulations of bath salts increasing in popularity since the statewide ban went into effect in October 2011. The BCI London Crime Lab reported that the number of bath salt cases it processed has increased during the past six months. In addition, the lab reported that as soon as one drug is banned (MDPV) another chemical analogue is likely to take its place (alpha-PVP). Lastly, while current availability remains high for crack cocaine, the majority of participants and community professionals noted a slight decrease in the availability and use of crack cocaine during the past six months. There was consensus that the decrease is due to an increase in preference for opiates. The BCI London Crime Lab reported that the number of crack cocaine cases it processed has remained the same during the past six months.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Cincinnati Region

January-June 2012

John R. Kasich, Governor
Orman Hall, Director



Regional Epidemiologist:

Jan Scaglione, BS, MT, PharmD, DABAT

OSAM Staff:

R. Thomas Sherba, PhD, MPH, LPCC

OSAM Principal Investigator

Rick Massatti, MSW

Research Administrator, OSAM Coordinator

Cincinnati Regional Profile

Indicator ¹	Ohio	Cincinnati Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	2,017,337	40
Gender (Female), 2010	51.2%	51.1%	41% ²
Whites, 2010	81.1%	81.3%	75.0%
African Americans, 2010	12.0%	12.5%	20.0%
Hispanic or Latino Origin, 2010	3.1%	2.3%	0.0%
High school graduates, 2009-2010	84.3%	88.0%	71.8% ³
Median household income, 2010	\$45,151	\$43,997	Less than \$11,000 ⁴
Persons below poverty, 2010	15.8%	15.2%	61.5% ⁵

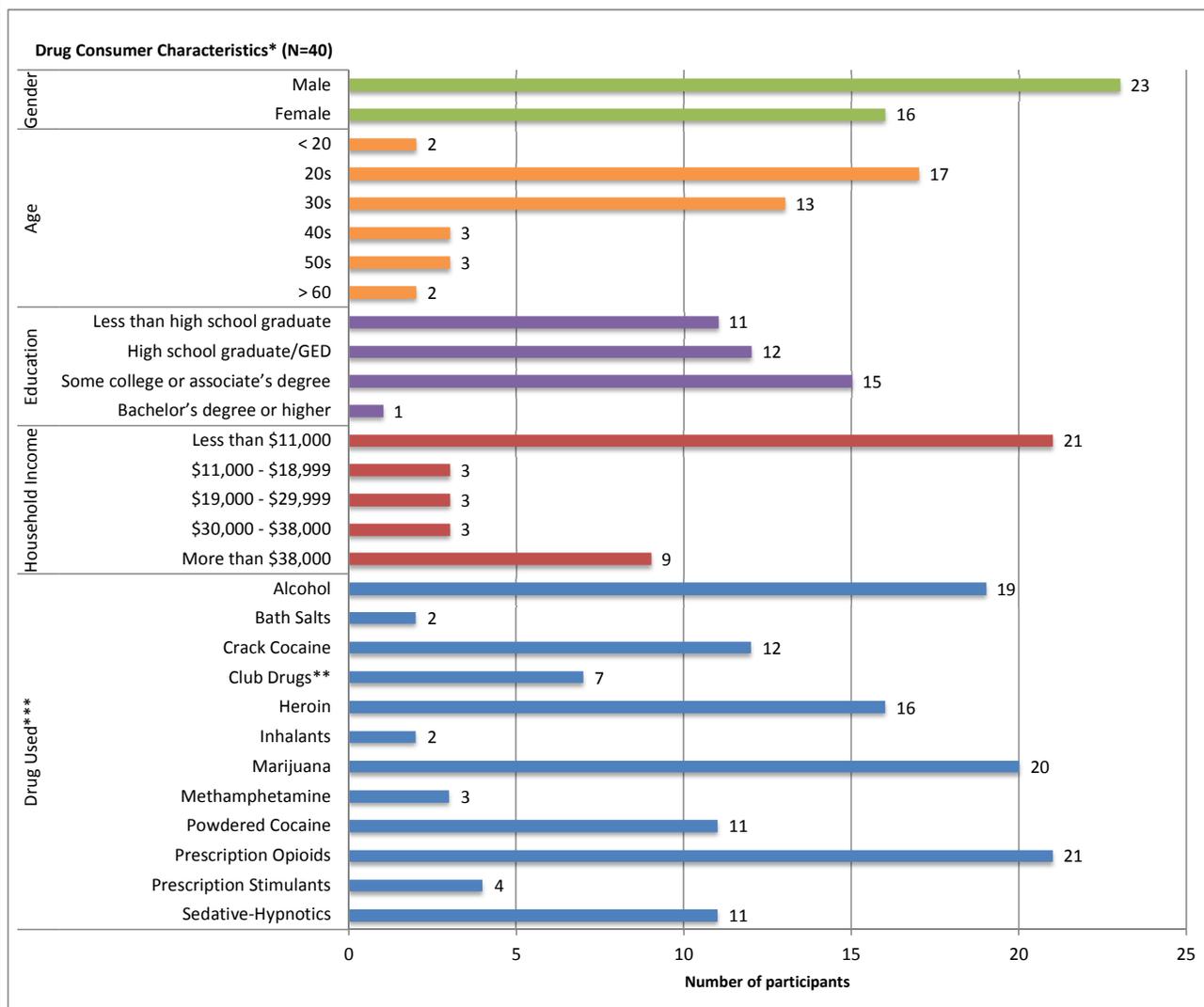
Ohio and Cincinnati statistics are derived from the U.S. Census Bureau.¹

Gender was unable to be determined for one respondent due to missing data.²

Graduation status was unable to be determined for one respondent due to missing data.³

Respondents reported income by selecting a category that best represented their household's approximate income for 2012. Income status was unable to be determined for one respondent due to missing data.⁴

Poverty status was unable to be determined for one respondent due to missing or insufficient data.⁵



*Not all participants filled out forms; therefore, numbers may not equal 40.

**Club drugs refer to Ecstasy, Ketamine, LSD and psilocybin mushrooms.

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Brown, Clermont and Hamilton counties, with participants from Butler County. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers, health educators and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Bureau of Criminal Investigation (BCI) London Office, which serves Central and Southern Ohio. BCI data are summary data of cases processed from July to December 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, BCI data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2012.

Powdered Cocaine

Historical Summary

In the previous reporting period, powdered cocaine was moderately to highly available in the region. Participants most often reported the drug's availability as either '5' or '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants continued to describe variable availability throughout the region. Treatment providers most often reported availability as '8,' while law enforcement most often reported availability as '4.' Participants reported that the availability of powdered cocaine had either remained the same or had slightly decreased during the previous six months. Law enforcement and treatment providers alike believed that the availability of powdered cocaine had remained the same during the previous six months. Participants most often rated the quality of powdered cocaine as '5' or '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI London crime lab cited levamisole (livestock dewormer) as the cutting agent in virtually every sample of powdered cocaine it processed during the previous six months. Participants reported that a gram of powdered cocaine sold for between \$50-70, and up to \$100. Participants reported that the most common route of administration for powdered cocaine remained snorting. Participants described typical powdered cocaine users in terms of age as being late teens and older, citing users of powdered cocaine as young as 16 years of age, with a typical age of first use between 17-18 years. Treatment providers described the typical powdered cocaine user as primarily middle-class, blue-collar workers between 26-33 years of age.

Current Trends



Powdered cocaine remains moderately to highly available in the region. Participants most often reported the drug's current availability as either '5' or '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 '5' or '10'. Those reporting availability as '5' were from more rural counties –

Clermont and Brown – and those reporting availability as '10' were from the urban city of Cincinnati. Participants stated, *"It [availability of powdered cocaine] went down ... people are*

making it into crack [cocaine] immediately ... you have to tell the dealer you want powder [powdered cocaine]; It's harder for me to find [powdered cocaine] ... have to call 10-12 people [to locate powdered cocaine] ..." Law enforcement and treatment providers most often reported the drug's current availability as '5'; the previous most common score was '8' for treatment providers and '4' for law enforcement. An officer stated, *"We're not coming across quantity [of powdered cocaine] ... don't know if it's availability or demand."* A treatment provider reported, *"The drug of choice is heroin ... heroin is cheaper now [than powdered cocaine], so people are switching."* Media outlets throughout the state reported on significant arrests during this reporting period involving cocaine trafficking in the region. In January, during a traffic stop on U.S. 23 in Pike county, the Ohio State Highway Patrol located 363 grams of cocaine with an estimated street value of \$25,000 (www.abc6onyourside.com, Jan. 8, 2012). In April, Hanging Rock Police (Lawrence County), in association with other area law enforcement officers, arrested four individuals for felony possession of crack cocaine, powdered cocaine and oxycodone (www.irontribune.com, April 9, 2012). In May, the Ohio State Highway Patrol seized five kilos of cocaine worth more than \$420,000 during a traffic stop in Warren County; the cocaine was hidden in an electronic compartment behind an airbag in the car's dashboard (www.nbc4.com, May 1, 2012).

Participants most often reported that the availability of powdered cocaine has decreased slightly during the past six months. A participant stated, *"Lately [powdered cocaine] usage has declined quite a lot since heroin came back."* Law enforcement reported that availability of powdered cocaine has remained the same during the past six months, while treatment providers believed that there has been a significant decrease in the availability of powder cocaine. Law enforcement officials believed that desirability of powdered cocaine has dropped during the past six months. An officer

stated, "[Powdered cocaine] it's out there... it's not as popular [as other drugs]." The BCI London Crime Lab reported that the number of powdered cocaine cases it processes has decreased during the past six months.

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 '5' or '10.' Participants reported that powdered cocaine in the region is cut (adulterated) with baby laxative, headache powder and vanilla-flavored coffee creamer. A participant reported, "A lot more cutting it [powdered cocaine] ... stepping on [adulterating] it with vanilla creamer." Participants reported that the quality of powdered cocaine has decreased during the past six months. A participant stated, "[Current quality of powdered cocaine] it's bad ... it's garbage." The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the cutting agent in virtually every sample of powdered cocaine it processes, while also citing the following substances as occasionally used to cut powdered cocaine: caffeine, inositol (B vitamin), local anesthetics (benzocaine, lidocaine and procaine), mannitol (diuretic), sorbitol (sweetener) and sucrose (table sugar).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "girl," "soft" and "white." Participants listed the following as other common street names: "blow," "white girl" and "ya-yo." Current street prices for powdered cocaine were variable among participants with experience buying powdered cocaine. Participants reported that a gram of powdered cocaine sells for between \$40-60, and up to \$80 in rural areas or if there is a poor connection to the dealer; 1/8 ounce, or "eight ball," sells for between \$150-200; an ounce sells for between \$900-1,500. Participants reported that the most common way to use powdered cocaine remains snorting. Out of 100 powdered cocaine consumers, participants reported that approximately 50-75 would snort it, 10-50 would intravenously inject or "shoot" it, and another 5-10 would "rock it up" (form crack cocaine) and smoke it. A participant emphasized, "Most people start out snorting it [powdered cocaine]." Participants cited an increase in the number of people who inject powdered cocaine. Reportedly, those who inject powdered cocaine are also more likely to be users of heroin.

Participants described typical users of powdered cocaine as more likely to be White and between the ages of 18-40 years of age. The youngest age of first use was described as being between 14-15 years of age. Both law enforcement and treatment providers described the typical user of powdered cocaine as a professional from middle- to upper-class, ranging from 20-35 years of age, with disposable income to afford the expense of powdered cocaine.

Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics (benzodiazepines). According to participants, "speedball," the term referring to the combination use of cocaine with heroin, is increasing among users of cocaine. A participant stated, "Shooting together [injecting heroin and powdered cocaine] is on the increase." Participants also noted that marijuana along with prescription opioids and benzodiazepines are used in combination with powdered cocaine to "come down" from the stimulant high of cocaine. A participant stated, "[Marijuana] it's like cigarettes ... to come down." Another participant explained that alcohol in combination with powdered cocaine, "balances you out ... [you] can drink more [alcohol with powdered cocaine use] ..."

Crack Cocaine

Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants and law enforcement most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); treatment providers most often rated availability as '9.' Participants and community professionals reported that overall availability of crack cocaine had remained the same during the previous six months. The Hamilton County Coroner's Crime Lab reported that the number of crack cocaine cases it processes had also remained the same during the previous six months. Participants rated the quality of crack cocaine most often as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants also commonly reported re-cooking crack cocaine with the intent to 'purify' the drug for smoking. The Hamilton County Coroner's Crime Lab continued to cite levamisole (livestock dewormer) as the primary cutting agent for crack cocaine. Participants reported that a gram of crack cocaine sold for between \$30-60; an ounce sold for \$1,000. While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remained smoking from a pipe. A profile of a typical user of crack cocaine did not emerge from the data. However, participants believed that typical users of crack cocaine were more likely to be in their later teen years, and that users started use as early as 16 years of age. In contrast, treatment providers described typical crack cocaine users as older individuals, between 35-45 years of age. Law enforcement also stated that they encountered crack cocaine use most often among African-Americans or among economically disadvantaged Whites.

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'. A participant stated, "[Crack cocaine] it's all over." Both treatment providers and law enforcement most often reported the drug's current availability as '5'; the previous most common scores were '9' and '10'. Media outlets throughout the state reported on significant arrests during this reporting period involving crack cocaine trafficking in the region. In March, Chillicothe police (Ross County) seized more than 100 grams of crack cocaine and stolen guns after a traffic stop and search of a residence (www.nbc4.com, March 7, 2012).

Participants reported that the availability of crack cocaine has remained the same during the past six months, while treatment providers reported that availability of crack cocaine has decreased. A treatment provider stated, "The dealer doesn't have new users ... nobody wants it [crack cocaine]." Another treatment provider stated, "The ones [clients] that are using [crack cocaine] are the ones that have been using ... we're not seeing any new, young crack users." Law enforcement explained that crack cocaine decreased in availability along with powdered cocaine. The BCI London Crime Lab reported that the number of crack cocaine cases it processes has remained the same during the past six months.

Most participants rated the quality of crack cocaine as '4' or '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Participants reported that crack cocaine in the region is cut with baking soda and baby formula. A participant stated, "The quality [of crack cocaine] has gone down ... they [dealers] cut it when they cook it with baking soda." Participants reported that the quality of crack cocaine has decreased slightly during the past six months; many described seeing more "fleece" (substances sold as crack cocaine that have no actual drug content). Substances sold as fleece include the following: baby formula, baby laxative, candle wax, drywall, headache powder and Orajel®. The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as commonly used to cut crack cocaine.

Current street jargon includes many names for crack cocaine. The most commonly cited names were "butter," "hard" and "rock." Participants listed the following as other common street names: "dope" and "melt." Current street prices for crack cocaine were variable among participants with experience buying crack cocaine. Participants reported that a gram of crack cocaine sells for between \$25-60, depending on the quality; 1/8 ounce, or "eight ball," sells for between \$150-200; an ounce sells for between \$700-900. Participants again explained that the price of crack cocaine is associated with one's connection to the dealer. A participant stated that

pricing "depends on who you know, how long you been going to them." In urban Cincinnati, crack cocaine sales to White individuals are associated with the use of a 'middleman' to buy the drug, as reported by a participant, "[You] gotta go through businessman ... only with crack ... go through a middleman ... no other drug ... both the dope boy and buyer pays the middleman." Reportedly, the use of a middleman guarantees better quality of the drug and decreased likelihood that a buyer is "fleeced," since the buyer wouldn't pay for the drug if the returned drug is not crack cocaine. While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. Of 100 crack cocaine consumers in Cincinnati, participants reported that approximately 90-100 would smoke it and 2-10 would intravenously inject or "shoot" it. In Clermont County, the number of participants who described injection of crack cocaine after breaking it down with lemon juice or vinegar was 20 out of 100 users, with 80 users smoking the drug. A participant explained, "I inject it [crack cocaine], but I use vinegar because you can't just put water in it." Approximately 60-90 percent of participants, regardless of demographics, reported re-rocking their crack cocaine to reduce the number of impurities. A participant stated, "If you know what you're doing, you're going to re-rock it."

Participants described typical users of crack cocaine as more likely to be African-American, male and between 18-60 years of age. A participant reported, "[Crack cocaine] it's a more older crowd ... you're looked down upon if you're a crack user." Participants from Clermont County described typical crack cocaine users as White, due to a larger number of Caucasians living in the area: "[Crack cocaine use] it's more White since less African-Americans live here, but it's all races." Treatment providers and law enforcement corroborated that a typical user of crack cocaine is more likely to be African-American, have only a high school education, be economically disadvantaged, between 25-55 years of age and unemployed. Reportedly, crack cocaine is used very commonly along with alcohol. A participant stated, "You gotta have beer [when using crack cocaine]." The use of heroin, marijuana and sedative-hypnotics (benzodiazepines) in combination with crack cocaine is reportedly also common, and the use of all these substances was described as similar to using with powdered cocaine: "[You] use 'em to come down," one participant stated.

Heroin

Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants and community professionals most often reported the drug's availability as '10' on a scale of

'0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While many types of heroin were described in the region, participants continued to describe both white powdered and Mexican brown powdered heroin as most available. Throughout the region, participants and community professionals reported that the overall availability of heroin had increased during the previous six months; participants also noted an increase in the availability of black tar heroin. The Hamilton County Coroner's Crime Lab reported that the number of heroin cases it processes had increased during the previous six months. Most participants generally rated the quality of heroin as '7' or '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The Hamilton County Coroner's Crime Lab continued to cite diphenhydramine (antihistamine) as commonly used to cut heroin. Participants reported that a gram of powdered heroin sold for between \$100-150; black tar heroin sold in small balloons (1/10 gram) for between \$20-25. Law enforcement also described heroin-filled capsules containing 1/10 gram selling for between \$10-20 per capsule. Participants reported that the most common route of administration for heroin continued to be intravenous injection. Participants also continued to describe the typical heroin user as male and White, and noted that heroin use started as young as 13-14 years of age. Treatment providers stated that increased use of heroin by young African-American males was something that had changed during the past six months.

Current Trends



Heroin remains highly available in the region. Participants most often reported overall current availability of heroin as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Community professionals also most often reported the current availability of heroin as '10'; the previous most common score was '9' or '10'. Media outlets throughout the state reported on significant arrests during this reporting period involving heroin trafficking in the region. In January, Hamilton police

(Butler County) arrested a man on drug charges including heroin trafficking when a search of the man's home uncovered 9.1 grams of heroin, a digital scale and marijuana (www.wlwt.com, Jan. 3, 2012). In February, Hamilton police arrested two men when a search of an apartment produced 10 ounces of heroin and about \$4,000 in cash (www.wlwt.com, Feb. 3, 2012). Also in February, Sharonville police (Hamilton County) arrested a suspected drug dealer at a local motel when they found 16 grams of heroin inside the man's rental car (www.news.cincinnati.com, Feb. 3,

2012). In March, the Federal Bureau of Investigation and the Cincinnati police arrested five individuals, charging them with conspiracy to possess with the intent to distribute 100 grams or more of heroin (www.fbi.gov/cincinnati/press-releases, March 29, 2012).

While many types of heroin are currently available in the region, participants reported brown powdered heroin as most available. Participants stated that the availability and use of brown powdered heroin has increased during the past six months. A participant stated, "There's lots more people using [brown powdered heroin]." In terms of black tar heroin, participants in Brown and Clermont counties reported its current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants in Cincinnati reported black tar heroin to be highly available, rating availability most often as '8'. There was no previously reported availability score for black tar heroin, indicating an increase in this form of heroin throughout the region during the past six months. Community professionals and law enforcement most often reported the current availability of black tar heroin as '10'; the previous most common score was '1' or '4'. Law enforcement stated "[We] used to see just capsules [with brown powdered heroin], but now we are seeing more of the other forms ... more are getting black tar [heroin]." Participants reported that the availability of white powdered heroin has remained the same during the past six months, while law enforcement reported that availability of white powder heroin has increased. A law enforcement official stated, "It was [more common to see] a brown color, now starting to see lighter shades of brown." Overall, participants reported that the general availability of heroin in the region has increased during the past six months. The BCI London Crime Lab reported that the number of brown powdered and black tar heroin cases it processes has increased during the past six months, while noting that the type of powdered heroin most processed is usually beige, brown or tan in color.

Most participants generally rated the quality of heroin as '7' or '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '7' or '8'. Participants reported that powdered heroin (brown and white) in the region is cut with baby formula, cocaine or vanilla-flavored coffee creamer; black tar heroin is cut with instant coffee. A participant stated, "More [heroin] demand equals more cut." Participants reported that the quality of heroin has decreased during the past six months. A participant reported, "[Dealers] give you good shit [heroin] till you're hooked ... good dealers getting caught [arrested] ... leads to poor quality." According to the BCI London Crime Lab, heroin remains, "reasonably pure." However, when heroin is cut, the lab reported that diphenhydramine (antihistamine) is occasionally used.

Current street jargon includes many names for heroin. The most commonly cited names remain “boy,” “dog” and “dog food.” Participants reported that brown powdered heroin is available in different quantities: 1/10 gram sells for \$20 in a baggie or capsule; a gram sells for between \$120-180. In addition, participants in Cincinnati reported that a gram of brown powdered heroin could cost as little as \$100 if there is a close connection to the dealer. Participants reported that black tar heroin is available in different quantities: a gram sells for between \$110-180. Participants reported that a gram of black tar heroin is cheaper in Clermont County (\$110) than it is in Cincinnati (\$180). Where participants did not describe the particular form of heroin, but disclosed additional quantities, it was reported that 1/4 ounce sells for between \$400-550; an ounce sells for between \$1,200-2,500. Participants reported that the most common route of administration for heroin remains intravenous injection. Out of 100 heroin consumers, participants reported that approximately 70-99 would inject or “shoot” it, 1-30 would snort it, and five would smoke it. Reportedly, snorting of heroin occurs primarily among first-time users of heroin or those who dislike needles. A participant reported, *“People that snort [heroin] always end up putting it [needles] in them ... I had someone do it [inject heroin] for me ... I hated doing it myself.”*

Participants described obtaining needles from farm supply stores, pharmacies and people who have diabetes. First-time users are more likely than experienced injectors of heroin to use a clean needle. A participant stated, *“When you first start [injecting heroin], you won’t use a dirty needle ... now I won’t wait for a clean needle ... so far gone, you will just use a dirty one, you don’t care.”* Reportedly, syringes are also sold to users by heroin dealers: two syringes for \$5 and \$3-5 for one syringe; diabetics also reportedly sell syringes for similar prices. Participants noted a potential for an increase in infectious diseases with shared needle use, but their impression was that restrictions in place to obtain clean needles indicated a lack of caring by pharmacies and city managers. A participant reported, *“They don’t want us to use ... so it’s our fault for getting an infectious disease.”*

A profile of a typical user of heroin did not emerge from the data. Participants described typical users of heroin as between the ages of 15-60 years, with younger users – those younger than 35 years – more likely to be White, and older users more likely to be African-American. Participants reported that the age of first-time heroin use is decreasing with those as young as 12 years of age beginning use of heroin. Participants and treatment providers also reported that the drive to use heroin resulted from initial prescription opioid use. A treatment provider described, *“They [heroin*

users] usually start, you know, with a prescription [opioid]. They have a supply for whatever reason ... then they get hooked ... [then they realize] heroin’s cheaper.” Treatment providers and law enforcement reported on the switch from prescription opioids and increased use of heroin during the past six months. A treatment provider reported, *“There has been more surveillance of doctors who prescribe pills [prescription opioids] without seeing people for a valid reason ... I think a number of doctors have been shut down in the area because of that, so I think the source of their pills was cut off.”*

Reportedly, heroin is used very commonly in combination with marijuana. Other substances also commonly used in combination with heroin include alcohol, crack and powdered cocaine (“speedball”), methamphetamine (“speedball”), prescription opioids and sedative-hypnotics (benzodiazepines). A participant described the use of methamphetamine with heroin as *“a way better buzz.”* Reportedly, alcohol, benzodiazepines and prescription opioids are all used to intensify the effects of heroin.

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Community professionals also described high availability of prescription opioids, rating overall availability as between ‘9’ and ‘10’. Participants identified Lortab®, methadone, Percocet®, OxyIR® (immediate-release oxycodone), Roxicodone® and Vicodin® as the most popular prescription opioids in terms of widespread use. Participants and treatment providers reported that the availability of prescription opioids had remained the same, at high levels, during the previous six months. Participants and law enforcement reported increases in Opana® and Roxicodone® availability. The BCI London crime lab reported that the number of prescription opioid cases it processes had remained the same during the previous six months. While there were a few reported ways of consuming prescription opioids, the most common route of administration remained oral ingestion. Participants reported that initial prescription opioid access was more likely from legitimate prescriptions written by physicians than from other sources. Once an individual became addicted, then other sources such as emergency rooms, pain clinics or street dealers became sources to obtain the pills. Participants described the typical user of prescription opioids as White – more than any other races/ethnicities, and also more likely to be female. Treatment providers and law enforcement both described users as predominantly

White, with no gender bias. Participants described first use as early as 12-13 years of age, which was corroborated by law enforcement.

Current Trends

Prescription opioids remain highly available in the region. Participants most often reported the current availability of prescription opioids 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'. Treatment providers most often reported current availability as '10'; the previous most common score was '9' or '10'. Participants and treatment providers identified OxyContin®, Roxicodone® and Vicodin® as the most popular prescription opioids in terms of widespread use. A treatment provider stated, *"The drug of choice is opioids over [powdered] cocaine, crack cocaine or alcohol."* Law enforcement most often reported prescription opioid availability as '6'. A law enforcement officer stated, *"Pills [prescription opioids] and heroin are off the hook."* Media outlets throughout the state reported on significant arrests during this reporting period involving prescription opioid trafficking in the region. In February, the Brown County Sheriff and four deputies arrested a family of four for selling hydrocodone, oxycodone and marijuana near Aberdeen (www.maysville-online.com, Feb. 8, 2012). In March, Brown County deputies charged a Mount Orab man with two counts of allegedly trafficking drugs in bulk near juveniles; deputies seized a bag full of prescription drugs along with 21 guns and \$11,400 in cash (www.maysville-online.com, March 6, 2012). Also in March, police in Aberdeen reported that an undercover sting operation resulted in the issuance of an arrest warrant for a local man who sold Lortab®, Suboxone® and marijuana from his home (www.maysville-online.com, March 11, 2012); members of the Southern Ohio Drug Task Force arrested a Lucasville (Scioto County) man for trafficking in oxycodone, heroin, cocaine and hypodermic needles in the vicinity of juveniles (www.wsaz.com, March 15, 2012). In April, police in South Webster (Scioto County) seized nearly 4,000 oxycodone pills along with 39 different firearms and \$17,000 in cash (www.wsaz.com, April 2, 2012).

Participants reported that the availability of prescription opioids has remained relatively stable during the past six months. However, participants reported that the availability of a couple of prescription opioids has increased: Opana® and immediate-release oxycodone (Roxicodone® and OxyIR®). A participant stated, *"Everybody found out about them."* Treatment providers reported that the availability of prescription opioids has remained stable or has increased slightly during the past six months, while law enforcement reported that availability has remained stable. The BCI

London Crime Lab reported that the number of prescription opioid cases it processes has generally remained the same during the past six months with the following exceptions: an increase in cases of Opana® and a decrease in cases of OxyContin®.

Reportedly, many different types of prescription opioids are currently sold on the region's streets. Participants reported the following prescription opioids as available to the street-level user (Note: When reported, current street names and prices are indicated in parentheses): methadone (aka "done" and "dose;" 5 mg sells for between \$2-5; 10 mg sells for between \$5-10), Opana® (aka "OP's," "panna" and "pandas;" 20 mg sells for between \$30-40; 40 mg sells for between \$50-80), OxyContin® (new formulation, aka "OP's," "oxy" and "oxy's;" 20 mg sells for between \$5-10; 40 mg sells for between \$10-20; 60 mg sells for between \$15-40; 80 mg, aka "beans," "big green apples" and "green beans," sells for between \$20-60), Percocet® (aka "512's" and "perc's;" 5 mg sells for between \$4-5; 7.5 mg sells for between \$6-7; 10 mg sells for between \$8-10), Roxicodone® or OxyIR®, both refer to immediate-release oxycodone products (aka "BB's;" 15 mg, aka "15's" and "perc 15's;" sells for between \$10-15; 30 mg, aka "perc 30's;" sells for between \$20-30), and Vicodin® (aka "V's," "V-cuts" and "vikes;" 5 mg sells for between \$1-3; 7.5 mg sells for between \$3-6; 10 mg sells for between \$7-10). 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 routes of administration are oral ingestion and snorting. The only prescription opioids described as being injected are Dilaudid®, immediate-release oxycodone, methadone liquid and the gel from fentanyl patches. Out of 100 prescription opioid consumers, participants reported that approximately 10-50 would orally ingest the drugs, and 50-90 would crush the tablets and snort the powder. Participants described using a cheese grater or automotive hose clamp to 'grate' the reformulated OxyContin® OP down to a powder to snort it. A participant reported, *"Have to scrape them [OxyContin® OP] with a cheese grater ... breaks down into powder ... used to have hose clamps in my car ... just shaves it into fine powder."*

In addition to obtaining prescription opioids on the street from dealers, participants continued to report obtaining them from hospital emergency rooms, pain clinics, stealing prescription pads, doctor shopping, buying bulk from online pharmacies, and traveling to Florida or Georgia to pain clinics there and transporting the opioids back to Ohio. A participant reported, *"I stabbed myself in the calf and was in a wheelchair in the ED [emergency department] ... they only gave me one Percocet®, that's all ... I was so mad I got up and walked out."* Participants also described getting prescription

opioids from pain clinics: *"You gotta have a sponsor [dealer – someone who covers travel expenses] ... go to Florida to get 'em [prescription opioids] ... I got 150 '30's,' 90 '15's' and 90 'xanibars' [Xanax®] ... all for \$1,000 ... the sponsor keeps the '30's,' and you keep the rest."*

A profile of a typical user of prescription opioids did not emerge from the data. However, participants reported that the age of first-time use of prescription opioids is getting younger, between 11-13 years of age. A participant reported, *"People start using pills earlier ... they're in the household ... first opiate after surgery."* Treatment providers reported that prescription opioid users are more likely to be White and between the ages of 18-30 years. A treatment provider stated, *"[Prescription opioid abuse] varies depending on the drug ... used by [high school] dropouts to professionals."* Law enforcement also reported that prescription opioid users are more likely to be White, but between 12-70 years of age. A law enforcement officer stated, *"As soon as they're tall enough to reach the medicine cabinet ... [prescription opioid abuse] runs the whole spectrum."* Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, marijuana and sedative-hypnotics (benzodiazepines). The effect of use with these three substances reportedly intensifies the effect of the opioid. Participants also reported the combination of prescription opioids with prescription amphetamines as producing effects that are, as one participant stated *"just like a speedball."*

Suboxone® Historical Summary

In the previous reporting period, Suboxone® was moderately to highly available in the region. Participants most often reported availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); treatment providers reported availability as '6' and law enforcement as '4.' Suboxone® was available both pills and sublingual film strips. Participants reported that Suboxone® availability was more likely from legitimate sources than through street purchase. Participants and law enforcement reported that availability had increased significantly during the previous six months. The BCI London crime lab reported that the number of Suboxone® cases it processes had remained the same during the previous six months. Participants reported that Suboxone® sold for between \$8-15 per pill or strip. While the Suboxone® strips were more likely to be put under the tongue as intended, the route of administration of pills included crushing the pill for snorting or dissolving in water for injection. The age range of Suboxone® users was reportedly between 20-40

years. Treatment providers reported that some abuse was described by clients; law enforcement also reported some abuse of Suboxone®.

Current Trends



Suboxone® is highly available in the region. Participants reported the current availability of Suboxone® most often 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 reported, *"[Suboxone®] strips are more common [than the pill form]."* Treatment providers and law enforcement most often reported the drug's current availability as '2' or '3' in the urban setting, and law enforcement described availability most often as '4' or '6' in suburban areas. Law enforcement described an increase in Suboxone® availability. An officer reported, *"[Suboxone®] strips are being used ... prescribed ... hearing more about it ... people want it more."* Participants and treatment providers also reported that the availability of Suboxone® has increased during the past six months. A treatment provider stated, *"A few people coming into treatment have Suboxone® listed as their drug of choice ... addicts are trying it out on the street to wean off heroin."* The BCI London Crime Lab reported that the number of Suboxone® cases that it processes has increased during the past six months.

Current street jargon includes few names for Suboxone®, including "boxon's," "strips," "stop signs" and "subs." Participants reported that a Suboxone® 8 mg tablet sells for between \$6-20; Suboxone® 8 mg strips sell for \$10-12 per strip. Most often participants reported taking Suboxone® sublingually (dissolving it under the tongue). Out of 100 Suboxone® consumers, participants reported that approximately 60-80 would dissolve them under the tongue, 20 would crush the tablets and snort them, and approximately 3-10 would either crush and dissolve the tablets or strips and inject them intravenously. A participant reported, *"Can shoot Subutex® ... you don't go through withdrawal"*

In addition to obtaining Suboxone® on the street from dealers, participants also reported getting the drug from clinics, doctors, online pharmacy, or buying from people who are prescribed Suboxone® legitimately. A participant reported, *"Go to the doctor ... it takes \$500 to get you in, and \$400 each time and you get more [Suboxone®] ... might have to sell half the prescription to pay for more."* A profile for a typical Suboxone® user did not emerge from the data. Participants described typical users of Suboxone® as young as 16 years of

age, but more likely to be at least 22 years of age. Treatment providers most often described a typical Suboxone® user as White, between 18-30 years of age, and more likely male than female. Law enforcement noted an increase in doctors writing prescriptions for off-label use of Suboxone® for pain management to get past the 100-patient limit for addiction treatment. Reportedly, Suboxone® is used in combination with alcohol, marijuana and sedative-hypnotics (benzodiazepines); all drug combinations are commonly used to, *"boost the high,"* as one participant stated.

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); treatment providers most often reported availability as '8.' Law enforcement reported availability of Klonopin® as '5' and availability of Valium® and Xanax® as '10.' Both participants and community professionals reported that the availability of sedative-hypnotics had remained the same during the previous six months. The BCI London Crime Lab also reported that the number of sedative-hypnotic cases it processes had remained the same during the previous six months. The most common route of administration remained oral ingestion. Participants described the typical user of sedative-hypnotics as most likely female and White, while citing first-time users of sedative-hypnotics as young as 14-15 years of age.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' A participant commented, *"You hear about people using them [sedative-hypnotics] all the time."* Treatment providers most often reported current availability as '8,' the previous most common score was also '8.' Participants identified Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use; community professionals identified Xanax® as most popular. A treatment provider said, *"Valium® is always around like aspirin."* Law enforcement most often described current availability as '6' for Valium® and Xanax®; the previous most common scores for Valium® and Xanax® were '10.'

Participants reported that the availability of sedative-hypnotics has remained the same during the past six months. Treatment providers and law enforcement both reported that availability has either remained the same or has slightly increased during the past six months. A community professional stated, *"Overall it seems easy for people to get them [sedative-hypnotics] ... more prescriptions [are] getting written."* The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months.

Reportedly, many different types of sedative-hypnotics 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): Klonopin (aka "forget-me-nots," "forgot-a-pins," "kloddi's," "klonni's" and "K-pins;" 0.5 mg sells for \$1; 1 mg sells for \$2; 2 mg sells for \$4), Soma® (aka "coma," 350 mg sells for between \$2-4), Valium (aka "blues," "V's" and "V-cuts;" 5 mg sells for between \$1-3; 10 mg sells for between \$2-3), Xanax® (aka "bars," "footballs," "Lincoln logs," "panty droppers," "xani's" and "xanibars;" 0.25 mg sells for \$0.50; 0.5 mg sells for \$1; 1 mg sells for between \$2-3; 2 mg sells for between \$3-5). In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported obtaining the drugs from legitimate prescriptions or someone they know who has a legitimate prescription. A participant explained, *"My Mom sells her Xanax® all the time."* While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, generally, the most common routes of administration are oral ingestion or crushing and snorting the tablets.

Participants continued to describe typical users of sedative-hypnotics as most likely female and White. Participants also said that while there is a wide age range of users between 12-65 years of age, abuse of sedative-hypnotic typically occurs between 18-35 years of age. A participant talked about the age of first use: *"As young as 12-13 years old ... in high school [sedative-hypnotics use] it's more popular ..."* Law enforcement also reported first use of sedative-hypnotics to be around 12 years of age. An officer stated, *"Anybody that can reach the medicine cabinet will get these [sedative-hypnotics]."* Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, marijuana and prescription opioids. Participants reported that it is common to use heroin in combination with sedative-hypnotics as well. A participant reported, *"Combination of benzo's [benzodiazepines] and heroin ... is carnage [potentially deadly] ... more common to abuse [both drugs] ..."*

Marijuana

Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants and community professionals most often reported the availability of the drug as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Law enforcement described an increasing number of shipments of high-grade marijuana being transported by mail. Participants and community professionals reported that the availability of marijuana had remained the same during the previous six months. Participants reported that low-grade marijuana was the cheapest form: a blunt (cigar) sold for \$15; an ounce sold for between \$75-120. High-grade marijuana sold for significantly more: a blunt sold for between \$30-40; an ounce sold for between \$225-500. The most common route of administration continued to be smoking. A profile for a typical marijuana user did not emerge from the data; respondents typically said marijuana was popular among men and women of all races and ages. Participants described first-time users to be as young as 10-11 years of age.

Current Trends

Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. A participant stated, "*Marijuana's a side dish ... it's always there.*" Both law enforcement and treatment providers most often reported the drug's current availability as '10'; the previous most common score was also '10'. A treatment provider remarked, "*[Marijuana's availability] it's a 10 ... especially with that loud [high-grade marijuana] ... everywhere you go you smell it.*" Several media outlets reported on marijuana seizures in the region during this reporting period. In March, the Butler County Sheriff's Office seized more than 500 pounds of marijuana worth an estimated \$600,000 (www.wlwt.com, March 8, 2012). In April, during a traffic stop, the Ohio State Highway Patrol found 538 pounds of marijuana worth an estimated \$2.1 million (www.wnewsj.com, April 5, 2012).

Participants reported that the availability of marijuana has remained stable, at high levels, during the past six months. A participant commented, "*You can buy it [marijuana] at the corner store.*" Treatment providers and law enforcement both also reported that availability of marijuana has remained stable at high levels during the past six months. The BCI London Crime Lab reported that the number of marijuana cases it processes has decreased during the past six months.

Participant quality scores of marijuana ranged from '6' to '10' with the most common score being '8' for medium- or commercial-grade marijuana and '10' for high-grade marijuana on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '10' for all forms of marijuana. Participants rated low-grade marijuana quality with a score of '0'. Several participants explained that the quality of marijuana depends on whether the user buys low-grade, mid-grade (commercial grade), or high-grade (hydroponically grown) marijuana. A participant explained that the demand for high-quality marijuana is increasing: "... *don't see cheaper stuff [marijuana] anymore, more demand for higher-dollar marijuana.*" Law enforcement believed the quality of marijuana is increasing. An officer said, "*The quality [of marijuana] is much better [now].*"

Current street jargon includes countless names for marijuana. The most commonly cited names were "dirt," "home-grown" and "schwag" for low-grade marijuana; "middies," "reg," "reggie" and "regular" for commercial-grade marijuana; "chronic," "dank," "dro," "kush" and "loud" for high-grade marijuana. The price of marijuana continues to depend on the quality desired. Participants reported low-grade marijuana as the cheapest form: a joint (cigarette) sells for \$2; a blunt (cigar) sells for \$5; a gram sells for between \$5-10; 1/4 ounce sells for between \$25-30; an ounce sells for between \$40-100; a pound sells for between \$800-1,000. Commercial-grade marijuana sells for slightly higher prices; a gram sells for between \$5-15; 1/4 ounce sells for between \$25-40; an ounce sells for between \$120-150; a pound sells for between \$1,300-1,600. Higher quality marijuana sells for significantly more: a blunt sells for \$15; a gram sells for between \$10-40; an ounce sells for between \$280-600; a pound sells for \$2,000-5,000. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Out of 100 marijuana consumers, participants reported that 100 would smoke it, and five would also use it in baked goods.

A profile for a typical marijuana user did not emerge from the data. Participants continued to describe typical users of marijuana as men and women of all races. A participant commented, "*[Marijuana use] it's White, it's Black, it's everybody.*" Participants reported age of first use of marijuana as between 12-13 years of age. Reportedly, marijuana is used in combination with powdered and crack cocaine (aka "primo" or "woolie").

Methamphetamine

Historical Summary



In the previous reporting period, methamphetamine availability was variable in the region. Participants most often reported the drug's availability as '2' and '4' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get) in the City of Cincinnati and surrounding community, but reported availability as '10' in the more rural areas of the region (Clermont County). Participants believed the higher rural availability was due to the manufacturing of methamphetamine in these areas. Law enforcement said that most methamphetamine was locally produced using anhydrous ammonia and pseudoephedrine. Law enforcement also stated that labs were typically small scale and mostly limited to the "one-pot" method (methamphetamine production in a single sealed container, such as a two-liter soda bottle). Participants noted that the overall availability of methamphetamine had decreased during the past six months, and cited that lower availability of precursor chemicals needed to manufacture methamphetamine as the driving force behind the decline. Law enforcement also believed that there was a decrease in methamphetamine availability, and attributed the decrease to lower pseudoephedrine availability with increased scrutiny by pharmacies using MethCheck® (pseudoephedrine sales tracking system) to limit sales to individuals involved in "buying groups." Reportedly, a gram of methamphetamine sold for between \$100-175. Delivering a box of pseudoephedrine to the methamphetamine cook reportedly netted the buyer \$30 in cash or 1/2 gram of the finished product. Participants continued to describe the typical user of methamphetamine as male and White.

Current Trends

Methamphetamine availability remains variable in the region. Participants most often reported current availability of the drug as '2' or '3' in the city and urban areas and '10' on the east side of Cincinnati and in rural counties, such as Brown and Clermont on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '2' and '4' in the urban center and '10' in rural areas. A participant from a rural area explained, "Every trailer park you go to ... every other trailer is cooking it [methamphetamine]." Participants reported that methamphetamine is available in powder and crystal forms. Treatment providers most often reported the drug's current availability as '10'; the previous most

common scores were '2' and '4' in the city and '8' in rural communities. Law enforcement most often reported the drug's current availability as '7'. Media outlets throughout the region frequently reported on methamphetamine seizures during this reporting period. In March, methamphetamine was seized in Adams, Clinton, Pike and Scioto counties; four of the seizures occurred in mobile labs and the other three occurred in home-based labs. Labs in cars or trucks were typically associated with the "one-pot" method of manufacturing methamphetamine (www.wsaz.com, March 28, 2012). In one example, the Ohio State Highway Patrol found the equipment to manufacture methamphetamine (lithium batteries, boxes of Sudafed®, rubber tubing and other paraphernalia) during a traffic stop (www.chillicothe Gazette.com, March 7, 2012).

Participants reported that the availability of methamphetamine has remained stable during the past six months. Participants frequently talked about "shake-and-bake" or "one-pot" methamphetamine. A participant said, "There's no decrease anywhere ... [dealers are making] shake-and-bake [methamphetamine] while driving." Treatment providers reported that availability of methamphetamine has slightly increased during the past six months. A treatment provider explained, "I'm seeing more coming into treatment for meth [methamphetamine] ... through drug court too ... most from the rural areas." Law enforcement also reported a slight increase in the availability of methamphetamine during the last six months. An officer reported, "Seeing the red-phosphorus method ... [and] more one-pot methods ... trading of pseudoephedrine for meth." The BCI London Crime Lab reported that the number of methamphetamine cases it processes has increased during the past six months. The lab also reported processing white to off-white powdered methamphetamine most often and crystal methamphetamine occasionally, and noted that the one-pot method of manufacturing the drug appears to be increasing.

Most participants rated the quality of crystal methamphetamine as '10' and powdered methamphetamine as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common scores were '5' for both forms of methamphetamine. A user explained why quality is so high: "I think it's the competition out there ... more people are cooking ... they want their shit to be better obviously ... the better the cook, obviously, the better the meth." Participants reported that the quality of methamphetamine has increased slightly during the past six months because "cooks" are becoming better at manufacturing the drug.

Current street jargon includes a few names for methamphetamine. The most commonly cited names remain “crank,” “crystal” and “ice.” Current street prices for methamphetamine were variable among participants with experience buying the drug. Participants reported that a gram of methamphetamine sells for between \$25-30 in areas where large amounts of the drug are manufactured, but in general a gram sells for between \$50-70, with a price of up to \$120 to a user not known by the cook. While there were several reported ways of using methamphetamine, the most common routes of administration are smoking, snorting and intravenous injection. Out of 100 methamphetamine consumers, participants reported that approximately 30 would intravenously inject it, 30 would smoke it, another 30 would snort it and 10 would use multiple methods. A participant mentioned “hot railing” (heating the end of a glass pipe and then snorting methamphetamine through the pipe) as popular among users that snort the drug: *“Hot rails is where it’s at if you’re going to snort it [methamphetamine] ... burns really bad ... it’s like razor blades up your nose”*

Participants described typical users of methamphetamine as White males between the ages of 18-35 years, with first-time use reported as young as 17 years. Reportedly, methamphetamine is commonly used in combination with heroin (aka “speedball”). A participant explained his preference for the heroin and methamphetamine speedball: *“I’ve mixed a lot of meth with heroin ‘cause meth is way stronger than cocaine”*

Ecstasy

Historical Summary

In the previous reporting period, Ecstasy was highly available in the region. Participants most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Treatment providers most often reported the drug’s availability as ‘6,’ however, law enforcement most often rated availability as ‘2.’ The BCI London Crime Lab reported that the number of Ecstasy cases it processes had remained the same during the previous six months; however, the lab noted an appreciable increase in the number of cases containing the designer drug 5-MeO-DiPT (foxy methoxy). Participants reported that Ecstasy sold for between \$5-10 per tablet; four grams of Molly, the purest form of Ecstasy, reportedly sold for \$225. The most common route of administration was oral ingestion. A profile for a typical Ecstasy user did not emerge from the data.

Current Trends

Ecstasy (methylenedioxyamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) remains highly available in the region. Participants reported current availability of the drug as ‘8’ or ‘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 ‘10.’ Treatment providers most often reported the drug’s current availability as ‘10,’ the previous most common score was ‘6.’ A treatment provider stated, *“They’re still using Ecstasy ... that’s really big in the urban core.”* Participants reported that the availability of Ecstasy has remained stable during the past six months, while treatment providers reported that availability has increased. The BCI London Crime Lab reported that the number of Ecstasy cases it processes has stayed the same during the past six months. In addition, the lab reported that Ecstasy tablets contain a variety of substances including cathinones, dimethyltryptamine (DMT) and benocyclidine (psychoactive drug), which is usually in tablets with 5-MeO-DiPT and caffeine.

Current street jargon includes several different names for Ecstasy. The most commonly cited name was “sals.” Participants listed the following as other common street names: “Molly,” “rolls” and “sass,” and common imprints on Ecstasy pills included blue dolphins, four-leaf clovers and superman. Participants reported that an Ecstasy tablet sells for between \$6-20. While there were several reported ways of using Ecstasy, the most common route of administration remains oral ingestion.

A profile for a typical Ecstasy user did not emerge from the data. Participants described typical users of Ecstasy as between the ages of 19-35 years. A participant said, *“It’s the young club scene ... none of the older people do it [Ecstasy].”* Reportedly, first-time use of Ecstasy typically occurs between the ages of 15-16 years. Participants said Ecstasy is used in combination with alcohol.

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants were highly available in the region. Participants most often reported the availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Treatment providers most often reported availability as ‘4,’ and law enforcement most often reported availability as ‘5.’ The BCI London Crime Lab reported that the number of prescription stimulant cases it processes had remained the same during the previous six months with one exception: the number of Adderall® cases had decreased. Community professionals described the typical prescription stimulant user as White, aged late-teens to early-20s, coinciding with the typical age of a college student.

Current Trends

Prescription stimulants remain 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 '10'. Participants identified Adderall®, Concerta® and Ritalin® as the most popular prescription stimulants in terms of widespread use. Treatment providers most often reported current availability as '5'; the previous most common score was '4'. Law enforcement most often reported current availability as a '6'; the previous most common score was '5'. Participants reported that the availability of prescription stimulants has remained stable during the past six months, while treatment providers reported that availability has slightly increased. Law enforcement also described increased street diversion of prescription stimulants. An officer explained, *"Addiction level is high [to prescription stimulants] ... they're becoming more popular."* The BCI London Crime Lab reported that the number of prescription stimulant cases it processes has remained the same during the past six months.

No slang terms or common street names were reported for prescription stimulants. The following prescription stimulants are available to street-level users: Adderall® (30 mg sells for between \$4-5), Concerta® (27 mg sells for \$2.50; 36 mg sells for between \$2-3) and Ritalin® (sells for between \$2-3 per pill). In addition to obtaining prescription stimulants on the street from dealers, participants also continued to report getting them from others who have legitimate prescriptions. A participant said, *"Kids get put on 'em [prescription stimulants] ... then they start abusing them."* While there were several reported ways of using prescription stimulants, the most common routes of administration are oral ingestion or snorting. Participants described typical users of prescription stimulants as White and young, between the ages of 17-25 years. A participant explained, *"[Prescription stimulants] it's a White drug ... absolutely, and it's the younger one ... college age."* A law enforcement officer also discussed the drug's popularity at college: *"Mostly they're students using them [prescription stimulants]."*

Other Drugs

Historical Summary

In the previous reporting period, participants and community professionals listed the following other drugs as present in the region, but these drugs were not mentioned by the majority of people interviewed: bath salts, cough and cold over-the-counter (OTC) medications, inhalants and synthetic marijuana. Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) remained highly available in the region. Participants and community professionals agreed that synthetic drugs continued to be highly available even though they were scheduled as controlled substances and banned for sale in October 2011. The BCI London Crime Lab and the Hamilton County Coroner's Crime Lab reported the number of bath salt cases they process had increased during the previous six months. In addition, the BCI London Crime Lab noted that since the ban on the sale of bath salts

went into effect, the formally scheduled substances of MDPV and methylone were almost never seen any more in samples of bath salts, rather dozens of non-controlled analogs took their place. Synthetic marijuana ("K2" and "Spice") was highly available in the region. Much like bath salts, participants and community professionals described high availability of synthetic marijuana, even after the statewide ban of these products went into effect. Treatment providers reported use of synthetic marijuana by individuals attempting to pass drug testing. The BCI London Crime Lab and the Hamilton County Coroner's Crime Lab reported that the number of synthetic marijuana cases they process had increased during the previous six months. Participants reported low to moderate use of inhalants, citing the use of computer duster, nitrous oxide, Freon, paint and Pam® cooking spray as common products abused. Community professionals reported overall low inhalant abuse among their clients. Participants reported abuse of OTC and prescription drugs containing dextromethorphan (Robitussin® DM, Coricidin® HBP cough/cold) as very common. Law enforcement reported little incidence of abuse for this class of drugs. Community professionals also described prescription promethazine-codeine syrup as something that individuals in the 18-25 year age group abused during the past six months.

Current Trends

Participants and community 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: anabolic steroids, bath salts, hallucinogens [lysergic acid diethylamide (LSD), psilocybin mushrooms, DMT (dimethyltryptamine) and salvia divinorum] and synthetic marijuana. Anabolic steroids are relatively rare in the region. Participants did not report an availability score for anabolic steroids, but law enforcement reported street availability as '4' or '5' and fitness center availability as '8' or '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Law enforcement reported use of anabolic steroids by athletes who primarily purchased the drugs through the Internet, so the sale is, as on law enforcement official stated, *"not as obvious"* as a transaction with a dealer on the street. Participants reported purchasing anabolic steroids from the Internet where a vial of testosterone sells for \$150; 150 tablets sells for \$200, enough for a 10-week cycle of anabolic steroid use. Law enforcement reported typical users of anabolic steroids as White males between the ages of 18-40 years who are involved in bodybuilding. Hallucinogens [lysergic acid diethylamide (LSD), psilocybin mushrooms, DMT (dimethyltryptamine) and salvia divinorum] are available in the region. LSD (aka "acid") is rarely to moderately available in the region. Participants reported the availability of the drug as '2' to '5' in urban areas and

'10' in rural Clermont County on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). LSD was reported to be available on a seasonal basis, with higher availability expected in the autumn months. Treatment providers and law enforcement did not report availability of LSD during the past six months. The BCI London Crime Lab reported that the number of LSD cases it processes has increased during the past six months. Participants described blotter paper or gel dots as the most available form, and each 'hit' sells for between \$5-10. A profile for a typical user of LSD did not emerge from the data. First-time use of LSD was reported to be as young as 14 years of age. Psilocybin mushrooms (aka "shrooms") are rarely to highly available in the region. Participants reported the availability in a range from '2' to '5' in urban areas and '4' to '10' in rural counties, such as Brown and Clermont. A participant discussed the availability of psilocybin mushrooms in the area: *"A lot of people grow them [psilocybin mushrooms] around here ... but down south in Kentucky there's a lot of shrooms ... wherever there's cow pastures."* Similar to LSD, psilocybin mushrooms are reportedly available on a seasonal basis. Treatment providers and law enforcement did not report availability of psilocybin mushrooms during the past six months. Law enforcement reported that psilocybin mushrooms are more likely to be available in the late summer or early autumn. The BCI London Crime Lab reported that the number of psilocybin mushroom cases it processes has remained the same during the past six months. Participants described dried psilocybin mushrooms as the most available form of the drug, although spores to grow them are reportedly available for \$8 per vial of spores; 1/8 ounce of dried psilocybin mushroom material sells for between \$20-30; 1/4 ounce sells for between \$40-60; 1/2 ounce sells for between \$70-80. Several participants mentioned DMT (dimethyltryptamine), which is a synthetic hallucinogenic tryptamine, along with salvia divinorum as being available, but not widely used. Participants reported both substances were found on the Internet or through someone else who had purchased them. The BCI London Crime Lab reported that cases of powdered DMT and cases of salvia divinorum have increased during the past six months.



Synthetic marijuana ("K2" and "Spice") availability remains variable in the region. Participants from Brown County most often reported the current availability of synthetic marijuana as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), but other groups of participants indicated availability as much lower, although they did not provide a score; previously, participants most often said synthetic marijuana was highly available. The sale of synthetic marijuana was banned in October 2011, but participants

and law enforcement reported that it is still available. Law enforcement reported that synthetic marijuana is sold in convenience stores, stored under the counter and sometimes given to consumers free of charge with the intent to get them *"hooked on it,"* as one law enforcement official stated. In January, the *Ironton Tribune* reported on an arrest related to synthetic marijuana in Lawrence County; law enforcement seized an estimated \$20,000 worth of synthetic marijuana from a tattoo parlor and retail shop (www.irontontribune.com, Jan. 12, 2012). The BCI London Crime Lab reported that the number of synthetic marijuana cases it processes has increased during the past six months. The crime lab also reported that as soon as one drug is banned (JWH-018) another chemical analogue is likely to take its place (AM2201). Participants reported that 500 mg sells for \$15; a gram sells for between \$10-40. A participant compared pricing of regular marijuana to synthetic marijuana: *"Marijuana is much cheaper than Spice."*



Bath salts (synthetic compounds containing methylene, mephedrone or MDPV) are rarely to highly available across the region. Participants reported the drug's current availability as '3' or '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, participants most often said bath salts were highly available. The sale of bath salts was banned in October 2011, but participants and law enforcement reported that they are still available. A participant said, *"[Obtaining bath salts] it's so easy ... just one phone call away."* On the other hand, law enforcement reported the availability of bath salts as '3'. An officer reported, *"Not sure of the sources, but [we're] definitely seeing them [bath salts]."* In April, regional media reported on a large seizure of bath salts in Warren County. According to law enforcement, two men were distributing bath salts made in China to convenience stores throughout the country; law enforcement seized more than \$500,000 worth of bath salts (www.wlwt.com, April 4, 2012). The BCI London Crime Lab reported that the number of bath salts cases it processes has increased during the past six months. In addition, the lab reported that as soon as one drug is banned (MDPV) another chemical analogue is likely to take its place (alpha-PVP). Law enforcement reported that users are aware of the negative health outcomes associated with ingestion. An officer said, *"People are getting scared of them [bath salts] ... the education is that they're dangerous."* Participants described adverse reactions to the use of bath salts. A participant explained, *"Bath salts tore my stomach up ... [I] had diarrhea ... it made me ultra-paranoid."* Participants reported bath salts are sold in vials or baggies: 500 mg sells for between \$16-20; a gram sells for between \$30-40. While there were several reported ways of using bath salt products, the most common routes of administration include oral

ingestion, intravenous injection, smoking and snorting. A participant with experience injecting bath salts said, "*Shooting them [bath salts] is like meth times one thousand.*" A profile of a typical user did not emerge with the data. Participants reported that consumers of bath salts are more likely to be White and range in age from 30-45 years.

Conclusion

Crack cocaine, Ecstasy, heroin, marijuana, prescription opioids, prescription stimulants and sedative-hypnotics remain highly available in the Cincinnati region. Noted changes in availability during the past six months exist as follows: increased availability for heroin and Suboxone®; likely increased availability for bath salts, methamphetamine and synthetic marijuana; likely decreased availability for powdered cocaine. Overall, participants and community professionals reported that the general availability of heroin in the region has increased during the past six months; BCI London Crime Lab also reported that the number of brown powdered and black tar heroin cases it processes has increased. Treatment providers and law enforcement reported on the switch from prescription opioids as the reason for increased heroin use. Participants reported that age of first-time heroin use is decreasing with those as young as 12 years of age beginning use. The most common route of administration for heroin remains intravenous injection. While participants and community professionals reported that the availability of prescription opioids has remained relatively stable during the past six months, participants reported that availability has increased for Opana® and immediate-release oxycodone (Roxicodone® and OxyIR®); the BCI London Crime Lab also reported an increase in Opana® cases. Participants and community professionals reported that the availability of Suboxone® has increased during the past six months; the BCI London Crime Lab also reported that the number of Suboxone® cases it processes has increased. In addition to obtaining Suboxone® on the street from dealers, participants also reported legitimately obtaining the drug from clinics, doctors, online pharmacies, or buying from people who are prescribed Suboxone®. Treatment providers most often described a typical Suboxone® user as White, between 18-30 years of age, and more likely male than female. Law enforcement noted an increase in doctors writing for off-label use of Suboxone® for pain management to get past the 100-patient limit for addiction treatment. While methamphetamine availability remains variable in the region, participants most often reported current availability as '10' in rural counties like Brown and Clermont or on the east side of Cincinnati. Participants reported that methamphetamine is available in powder and crystal forms. Law enforcement and treatment providers reported a slight increase in the availability of methamphetamine, and the BCI London Crime Lab reported that the number of methamphetamine cases it processes has

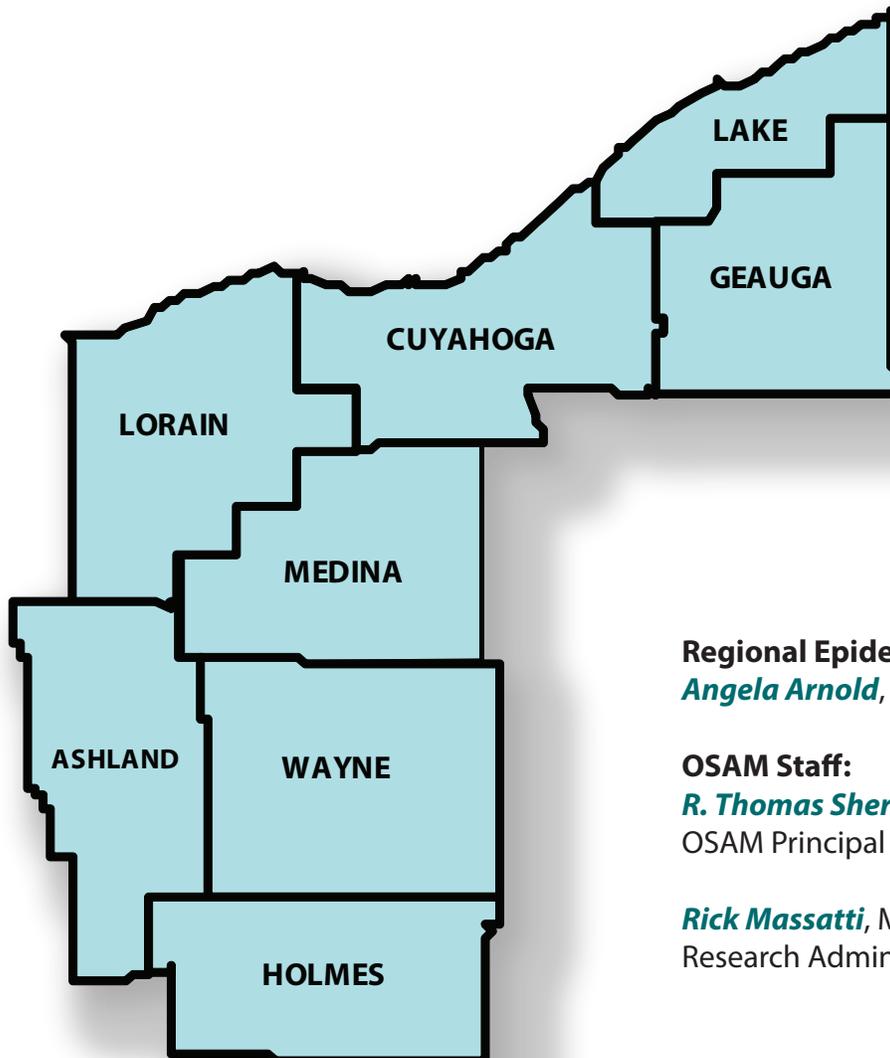
increased during the past six months. Participants described typical users of methamphetamine as White males between the ages of 18-35 years, with first-time use reported as young as 17 years. Reportedly, methamphetamine is used very commonly in combination with heroin ("speedball"). Although sales of synthetic marijuana and bath salts were banned in October 2011, participants and law enforcement reported that they remain available. Law enforcement reported that these drugs are sold in convenience stores, stored under the counter and sometimes given to consumers free of charge with the intent to get users, "*hooked on it,*" as one law enforcement official stated. The BCI London Crime Lab reported that the number of bath salts cases and the number of synthetic marijuana cases it processes have increased during the past six months. The crime lab also reported that as soon as one drug is banned (MDPV; JWH-018) another chemical analogue is likely to take its place (alpha-PVP; AM2201). Lastly, participants and community professionals noted decreases in the availability of powdered cocaine during the past six months. The BCI London Crime Lab also reported that the number of powdered cocaine cases it processes has decreased. Law enforcement believed that desirability of powdered cocaine has decreased during the past six months as other drugs became more popular.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Cleveland Region

January-June 2012

John R. Kasich, Governor
Orman Hall, Director



Regional Epidemiologist:
Angela Arnold, MS

OSAM Staff:
R. Thomas Sherba, PhD, MPH, LPCC
OSAM Principal Investigator

Rick Massatti, MSW
Research Administrator, OSAM Coordinator

Cleveland Regional Profile

Indicator ¹	Ohio	Cleveland Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	2,287,265	50
Gender (Female), 2010	51.2%	51.8%	42.0%
Whites, 2010	81.1%	74.0%	44.9% ²
African Americans, 2010	12.0%	18.0%	49.0%
Hispanic or Latino Origin, 2010	3.1%	4.4%	0.0%
High school graduates, 2009-2010	84.3%	82.8%	72.9% ³
Median household income, 2010	\$45,151	\$49,864	\$11,000 - \$18,999 ⁴
Persons below poverty, 2010	15.8%	15.3%	51.1% ⁵

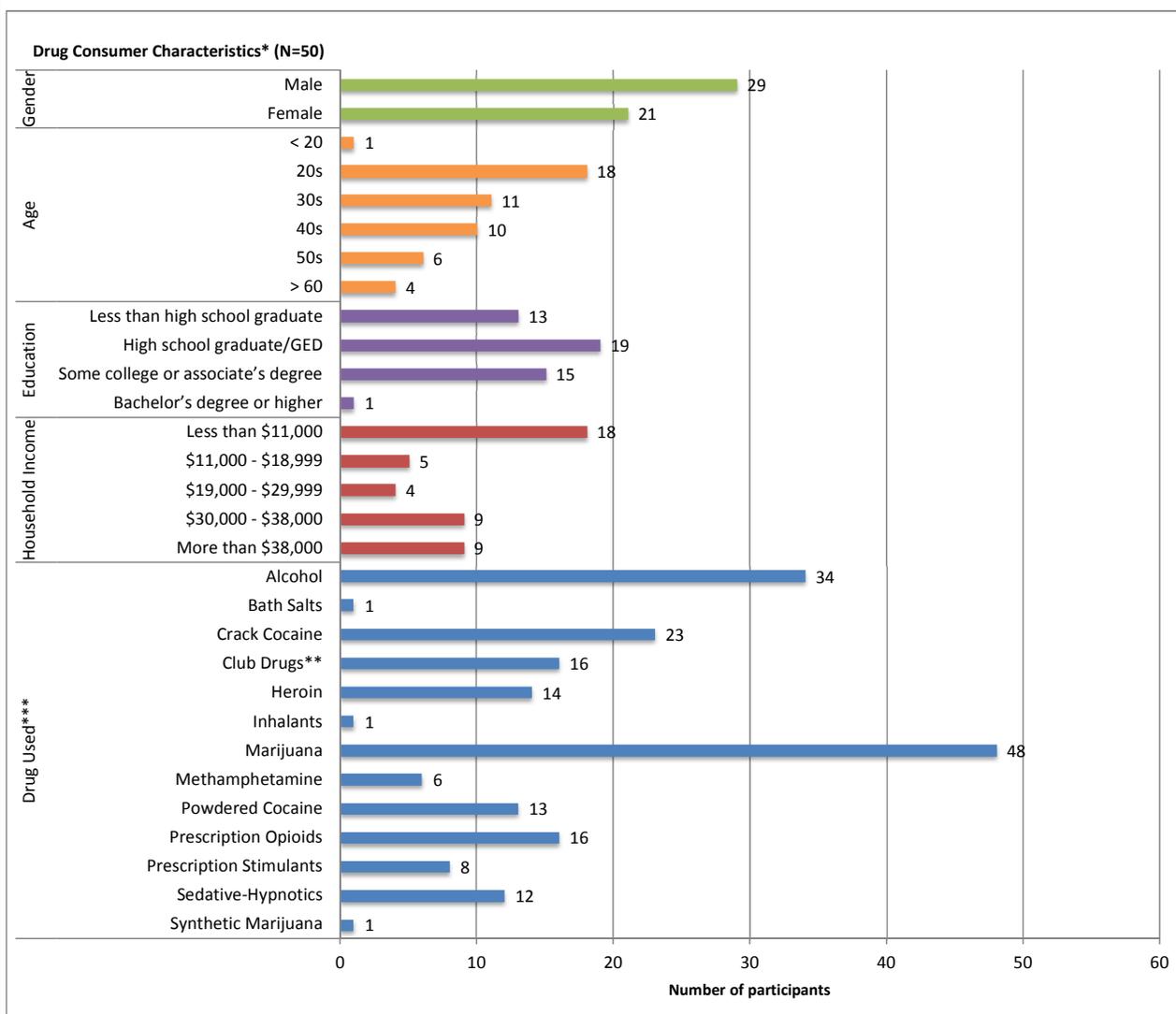
Ohio and Cleveland statistics are derived from the U.S. Census Bureau.¹

Race was unable to be determined for one respondent due to missing data.²

Graduation status was unable to be determined for two respondents due to missing data.³

Respondents reported income by selecting a category that best represented their household's approximate income for 2012. Income status was unable to be determined for five respondents due to missing data.⁴

Poverty status was unable to be determined for five respondents due to missing or insufficient data.⁵



*Not all participants filled out forms; therefore, numbers may not equal 50.

**Club drugs refer to Ecstasy, LSD, PCP and psilocybin mushrooms.

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Cuyahoga County. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals in Lake and Lorain counties (treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Cuyahoga County Medical Examiner's Office and the Bureau of Criminal 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 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, secondary data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2012.

Powdered Cocaine

Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); law enforcement also most often reported the availability of powdered cocaine as '8.' Participants continued to report that obtaining powdered cocaine required a phone call or a drive. The majority of participants, treatment providers and law enforcement officers reported that the availability of powdered cocaine had remained the same during the previous six months. Participants most often rated the quality of powdered cocaine as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI Richfield Crime Lab cited the following substances as commonly used to cut (adulterate) powdered cocaine: caffeine, benzocaine (local anesthetic), diltiazem (medication used to treat heart conditions/high blood pressure) and levamisole (livestock dewormer). Participants reported that a gram of the drug sold for between \$50-120, depending on the quality. The most common route of administration for powdered cocaine remained snorting. A profile of a typical powdered cocaine user did not emerge from the data. Among younger participants (those 25 years of age and younger), powdered cocaine was said to be more often used to enhance the effects of other drugs than be abused by itself. No participant indicated powdered cocaine as a primary drug of choice.

Current Trends

Powdered cocaine is moderately available in the region. Participants most often reported the drug's current availability as '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '8.' Participants continued to report that obtaining powdered cocaine of good quality would require some effort, such as multiple phone calls or a drive. A participant stated, "*[Powdered cocaine] it's easy to get, but you have to go through so many channels, more than one phone call.*" Another participant said, "*Yes, it [powdered cocaine] was easy to get. It was me having to know somebody.*" Other users noted lower availability due to dealers who retained powdered cocaine to produce the more profitable crack cocaine. A participant explained, "*[Powdered cocaine] it's hard to get it in my neighborhood because crack [cocaine] is more coming through ... the dealers withhold it because they will make more money from the crack user than from the sniffer [those who snort powdered cocaine].*" Community professionals most often reported the current availability of powdered cocaine as '6,' the previous most common score was '8.'

Collaborating data also indicated that cocaine is readily available in the region. The Cuyahoga County Medical Examiner's Office reported that 12.9 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range at time of death). Furthermore, the medical examiner's office reported cocaine as present in 32.9 percent of all drug-related deaths (Note: medical examiner'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 medical examiner's data, media outlets throughout the state reported on significant arrests during this reporting period involving cocaine trafficking in the region. In February, the Ohio State Highway Patrol arrested two individuals from Michigan during a traffic stop on the Ohio Turnpike in Lorain County for possession of a half-kilo of cocaine and a small amount of heroin, valued at \$50,000 (www.fox8.com, Feb. 9, 2012). In June, area law enforcement executed Operation Northwest Express, breaking up a major crack and powdered cocaine distribution network; more than 70 street-level and middle-level drug dealers and traffickers were arrested, taking millions of dollars of crack and powdered cocaine off the streets of Northeast Ohio (www.onntv.com, June 13, 2012).

Although participants commonly reported that the drug is often held by dealers, participants most often reported that the availability of powdered cocaine has remained the same during the past six months. A participant reported, "*If they*

[dealers] did have it [powdered cocaine], they would withhold it for people they like ... You can get powder. It'll cost you more, but you can get it." However, a few participants thought that powdered cocaine is becoming less available, citing the displacement of the drug by heroin and its "less trendy" status. A participant commented, *"Powder [cocaine] is more difficult [to obtain] because more people are doing different things [other drugs] than snorting powder."* Another participant noted that for intravenous drug users who like to combine heroin and cocaine, the powdered form would be something they're more likely to obtain: *"[Powdered cocaine] it's not easy to get recently. Not like back in the day. For those that do drugs intravenously, it may be easy to get."* The BCI Richfield Crime Lab reported that the number of powdered cocaine cases it processes has remained the same during the past six months.

Most participants rated the current quality of powdered cocaine as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was also '8'. However, participants supplied a range of quality scores because the quality of powdered cocaine was said to be inconsistent and varied widely. Factors that were said to influence quality included law enforcement activity and proximity to dealer sources. A participant explained, *"I believe the quality of the product has gone down. Unless you know someone personally, it's difficult to get [good powdered cocaine]."* Participants reported that the overall quality of powdered cocaine has decreased during the past six months, and reported that powdered cocaine in the region is cut with baby formula, baking soda, ether, MiraLax® and vitamin B-12. The BCI Richfield Crime Lab continued to cite the following substances as commonly used to cut cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetics). (Note: crime lab data is aggregate data of powdered cocaine and crack cocaine and no longer differentiates between these two forms of cocaine.)

Current street jargon includes many names for powdered cocaine. The most commonly cited names remain "blow," "soft" and "white girl." Participants listed the following as other common street names: "birds (for kilos)," "powder," "snow," "snuff" and "yak." Current street prices for powdered cocaine were consistent among participants with experience buying the drug. Participants reported that a gram of powdered cocaine sells for between \$50-80, depending on the quality; 1/8 ounce, or "eight ball," sells for between \$130-300. Several participants remarked that the drug's pricing is often communicated in terms of dollar amount, instead of by volume. A participant explained, *"They sold powder in \$20s, \$40s, and \$100s."* Participants reported that the most common way to use powdered cocaine remains snorting. Out of 10 powdered cocaine consumers, participants reported

that on average approximately seven would snort it, and the remaining users would either intravenously inject or smoke it. It is important to note that when users discussed the popularity of smoking powdered cocaine, almost all of them meant that the powder would be "rocked up" to create crack cocaine, and not used for the freebase smoking method.

Participants described the typical user of powdered cocaine as likely to be White, mature, suburban and professional (doctors and nurses) who prefer to snort the drug, or heroin users who inject cocaine with heroin (aka "speedballing"). Several participants shared observations on the use of powdered cocaine among certain groups, saying: *"The speedballers I see are older, even late 60s. And they love it. Some of them won't do one without the other; Probably at our age group [older than 40 years] it's easier to get. It's an older person's drug; I always saw it with professionals, doctors, and lawyers."* No participant indicated powdered cocaine as a primary drug of choice.

Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids and tobacco. Common practices among users include lacing marijuana (aka "primo") or lacing cigarettes with powdered cocaine. Mixing cocaine with heroin, either together in the same syringe or in sequence is called a "speedball." A participant reported, *"A friend of mine only uses powder with heroin."* Alcohol, marijuana, heroin, prescription opioids and other "downers" are used to "come down" from a cocaine high and are often used together. A participant stated, *"It's easier to ask for [powdered cocaine] at a bar than crack or dog food [heroin]."*

Crack Cocaine Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Like marijuana and oftentimes heroin, crack cocaine was reportedly available from unknown dealers, as well as from established connections. Law enforcement and treatment providers reported the drug's availability as '8'; and said availability varied depending on where one lived in the region. Participants, law enforcement and treatment providers most often agreed that the availability of crack cocaine had remained the same during the previous six months. Most participants rated the quality of crack cocaine as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine, when sold in \$10, \$20 and \$50 units by dealers not known to the buyer, varied in size from peanut- to chocolate chip-sized pieces. These transactions were often quick, and the drug was seldom measured by

users. The most common route of administration remained smoking. Law enforcement and treatment providers described typical users of crack cocaine as being of every race and socio-economic class.

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'. Crack cocaine remains available from unknown dealers as well as from established connections. Several participants reiterated the drug's continued high availability: *"The dope man [drug dealer] lives next door to me, so I just have to reach my hand out the window to get it [crack cocaine]. Every four blocks you can get it."* Another participant stated, *"If the police ain't right there, crack [crack cocaine] is there. You can fall into it."* Reportedly, crack cocaine is also available in rural areas far to the west or east of Cleveland but requires a known connection or a drive into the city to obtain it. A participant reported, *"I can get it [crack cocaine]. Maybe now more phone calls."* Participants frequently noted how being seen in a vehicle plays a role in purchasing crack cocaine. This contrasts with the sales on foot participants described in previous reports. A participant explained, *"It's easy. Just drive down the road and some of the [crack cocaine] dealers will pull up behind you in a car. They will honk at you."* Another participant said, *"They know what you're there for. If you're White in certain sections of Cleveland, [crack cocaine dealers] they'll find you. I've had people pull up in front of [my car] and stop to come talk to me."* Community professionals most often reported the current availability of crack cocaine as '9'; the previous most common score was '8'.

Participants and law enforcement officers described how many crack cocaine dealers are switching inventory from crack cocaine sales to heroin. A participant reported, *"[Dealers] carry both [crack cocaine and heroin], but they would have a lot more heroin and just a handful of the hard [crack cocaine]."* An officer observed, *"A lot of the crack dealers are switching to heroin because of the mandatory legal consequences."* "Dope boys," or drug runners, are reportedly between 12-50 years of age. A participant explained, *"It's very easy to get [crack cocaine] with walk-up [car] door service, or you go outside and it's there. You walk up and a kid will have it ... like a 12-year-old."* Participants were split as to whether the availability of crack cocaine has remained the same during the past six months or had become more available. Those who felt it had remained the same cited it as a constant fixture on the drug scene in the region, subject to occasional fluctuations in pricing and availability. Those who felt it had become more available cited the poor economy as a driving

force behind the trend. A participant who believed crack cocaine had increased said, *"[Crack cocaine] it's more available because there are more people trying to sell it."* The BCI Richfield Crime Lab reported that the number of crack cocaine cases it processes has remained the same during the past six months.

Most participants rated the quality of crack cocaine as '8' 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 varies depending on the dealer. A participant explained, *"If I didn't get it [crack cocaine] from my people, I had to re-cook it."* Many participants felt that it has become standard practice to "re-cook" crack cocaine to remove additives and cutting agents. Another participant stated, *"Before it [crack cocaine] gets over here, it's garbage. You have to re-cook it like, seven times. I would re-cook it right away. You better re-cook it because it's garbage."* Yet another participant said, *"If you don't know somebody, [crack cocaine quality] it'll be bad. It's getting worse. Out of ten people you might buy from, maybe one has good crack."* Given this common refrain of having to re-cook crack cocaine, the '8' quality score noted above could include both re-cooked crack cocaine, as well as original crack cocaine sold by dealers.

Other participants noted the growing popularity of yellow-colored crack cocaine (aka "butter"). A participant described, *"[Butter] it's yellow like the color of a legal pad, and it's smooth and sparkly."* Participants perceived the yellow variety as more potent than the white, beige or grey types. A participant explained, *"A lot of people like the yellow dope 'cause it's butter. It gets you higher, and the white [crack cocaine] has a lot of soda on it."* However, other users disagreed, saying that it was merely white crack cocaine that had been tinted yellow with mustard or other yellow substances. Participants reported that all crack cocaine is cut with many other substances. A participant stated, *"I have seen somebody literally pour kitchen products in a pot and make some crack with that stuff in there."* Reportedly, crack cocaine is cut with baby formula, baby laxative, "Cut" (a product/brand sold in head shops), local anesthetics (lidocaine and procaine), methamphetamine, mustard, PCP (phencyclidine) and vitamin B12. Participants also noted that crack cocaine is mixed with substances such as methamphetamine and PCP to increase its potency. Sometimes this is a "feature," and sometimes it is a tactic to produce more crack cocaine product with less actual powder cocaine. Participants were split on the overall current quality of crack cocaine: Some reported that quality has remained the same during the past six months, while others reported it has decreased because it is cut more.

Current street jargon includes many names for crack cocaine. The most commonly cited names were "hard" and "rock."

Participants listed the following as other common street names: "action," "boulders," "butter," "dope" and "work." Current street prices for crack cocaine were consistent among participants with experience buying the drug. Participants continued to report that crack cocaine is sold by dealers unknown to the buyer in \$10, \$20 and \$50 sized pieces, or "rocks." When crack cocaine is weighed for purchase, users reported better pricing: a 0.4 gram rock (aka "twomp") sells for \$20; 1/8 ounce sells for between \$125-300; an ounce sells for between \$850-1,350. Like powdered cocaine, crack cocaine prices are reportedly higher in the far east or west sides of Cleveland. While there were a few reported ways of administering crack cocaine, the most common route of administration continues to be smoking. Out of 100 crack cocaine users, participants reported that approximately 85 would smoke, 14 would inject and one would snort the drug.

A profile of a typical user did not emerge from the data. Participants noted the drug is consumed by older and younger people, Whites and Blacks, and people who live on both the east and west sides of the city. Several users noted that race matters in terms of those to whom dealers will sell, and how much they charge. A participant explained that Black dealers, for example, would be reluctant to sell crack cocaine to a White suburbanite looking to sell it at a markup. A participant stated, *"I saw a White boy come up to the store and ask me where to get crack. I thought he was going to hustle [re-sell it], but he says no, 'I'm going smoke that,' [so I sold it to him]."*

Reportedly, crack cocaine is used in combination with alcohol, Ecstasy, heroin and marijuana (aka "primo"). Users noted a preference for Valium® or Klonopin® taken with crack cocaine "to come down." A participant explained, *"Klonopin® makes you come down off it [crack cocaine use]. When you crash coming down off crack, you take a Klonopin® and it totally makes you come back."* Participants also noted "speedballing" (mixing crack cocaine with heroin). A participant explained, *"I would shoot [inject] the crack first, then when I'd be coming off the crack, I'd shoot the heroin to take away the withdrawal, or coming off the crack."* While more participants indicated that the speedball combination is injected simultaneously, others noted that the drugs would be taken in sequence (aka "elevator").

Heroin

Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants and community professionals most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While many types of heroin were

available in the region, participants continued to report the availability of brown powdered heroin as the most available type throughout the region. Participants who had knowledge of the availability of white powdered heroin most often rated it as '10'; the availability of black tar heroin was most often reported as '5.' When asked to identify the most urgent or emergent drug trends, law enforcement continued to cite heroin trafficking as a primary concern. The majority of participants and community professionals reported that the availability of heroin had increased during the previous six months. Participants reiterated two trends identified in previous reports: increased competition among dealers to secure steady heroin users and increased demand for heroin. Most participants generally rated the quality of heroin as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI Richfield crime lab cited caffeine and diphenhydramine (antihistamine) as commonly used to cut powdered heroin. Participants reported that heroin was available in different quantities: bags or bindles (1/10 gram) sold for between \$10-15. Participants reported that the most common route of administration for heroin remained intravenous injection. Out of 10 heroin users, participants reported that approximately eight would inject, and the other two would either snort or smoke the drug. A profile for a typical heroin user did not emerge from the data. Participants noted that heroin was popular with all ages, races and socio-economic levels. However, law enforcement and treatment providers noted increases of heroin use among two groups: younger, White, suburban residents (15-25 years of age) and people older than 35 years of age from all races.

Current Trends



Heroin remains highly available in the region. Participants most often reported overall current availability of heroin as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' While several types of heroin are currently available in the region, participants continued to report the availability of brown powdered heroin as the most available type in both the east and west sides and within the City of Cleveland, most often rating its current availability as '10.' Participants who had knowledge of the availability of white powdered heroin most often rated its current availability as '8'; the previous most common score was '10.' Participants did not have knowledge of the current availability of black tar heroin; most participants thought that this type of heroin is not very available in the region; the previous most common availability score for black tar heroin was '5.' Almost all participants continued to

report heroin as easy or very easy to obtain. A participant stated, *"I think heroin is the easiest drug to obtain, easier than marijuana. I've seen yellow, brown, black tar, mixed colors. It's easy to get."* Another participant stated, *"[Heroin] it's all over the city, and even out in the country, it's easy to find."* Another participant summarized trends throughout the region, stating, *"I only got drugs on the east side, never west side, but brown, white and [black] tar [heroin] were available. Tar was higher quality. Powder was brown and light brown and the lighter was higher quality. It's available not just in the east side of the city, but the suburbs too."*

Despite local differences, brown and white powdered forms of the drug remain the most easily obtained, with several notable trends emerging. In previous reports, participants reported some variations in availability and quality from the east to west sides of Cleveland. Recently, quality and availability were reported to be similar throughout the entire region. A participant recalled, *"I had dealers on the east side with just as good quality as west. Maybe a year ago I would only go to the east side [for heroin]. But within the last six months I've been finding west side dealers who blow the quality out of the water."* Also, heroin is now commonly available through transactions with unknown dealers, as well as through established dealer networks. In previous interviews, participants and law enforcement remarked on the 'closed network' of heroin users and dealers, but this is no longer reported to be the case. A participant reported, *"I've been offered it [heroin] just walking around. It's very easy to find. It's not just a race thing — they ask everybody."* Lastly, many crack cocaine dealers are switching inventory to accommodate increasing demand for heroin. A participant reported, *"[Dealers] are trying to switch you over from crack. The crack game is disintegrating."* Another participant said, *"OxyContin® OC being recalled has gotten a lot of people switched over [to heroin]. Also, a lot of crack dealers are switching over."* A law enforcement officer explained this trend, too: *"Once, in Cleveland, crack was king, but now so many people have converted to heroin. In 30 years as a drug agent, I've seen that it's always been supply and demand. If I'm a dealer, I'm thinking, now I have to supply the demand for heroin and change my product from crack to heroin ..."*

Community professionals most often reported the overall current availability of heroin as '8;' the previous most common score was '10.' With regard to availability of the different types of heroin, law enforcement and treatment providers concurred with data supplied by drug consumers. A treatment provider stated, *"Yeah, it [heroin] is available; I can't recall the last time I had any client mention black tar; it is probably white and brown [powdered heroin that is*

most available]." Another treatment provider said, *"Yes, it is absolutely available; many of my clients go for powdered form. Most of the heroin addicts I deal with might have a preference, but they will take whatever they can get ..."* A law enforcement official reported: *"We see white colored heroin; [Heroin] it's available. We mostly see brown powder; The black tar is a Mexican or regional thing. We haven't seen that often. It's very, very rare we see that. It's a cheap process that doesn't appeal to users. They don't prefer that."* A law enforcement officer described the popularity of powdered heroin as it relates to increasing use by younger users, saying, *"I think the powder [heroin] is for the young kids because they can start by snorting it. It's an easier transition going from the prescription pills. Eventually they'll start shooting [injecting heroin]."*

Collaborating data also indicated that heroin is readily available in the region. The Cuyahoga County Medical Examiner's Office reported heroin as present in 41.9 percent of all drug-related deaths. In addition to the medical examiner's data, media outlets throughout the state reported on significant arrests during this reporting period involving heroin trafficking in the region. In February, the Ohio State Highway Patrol seized a quarter pound of marijuana, 60 bindles of powdered heroin and a half-kilo of brown powdered heroin, estimated at \$102,000, on the Ohio Turnpike in Lorain County (www.wtam.com, Feb. 10, 2012). In June, a law enforcement official from Lorain County reported, *"Instead of 45 percent hit [purity] of heroin, someone is selling pure heroin in Lorain County, and drug users are dropping dead. Five people died in one week on top of the nine who have already died this year from overdosing on heroin in Lorain County"* (www.newsnet5.com, June 7, 2012).

When asked to identify the most urgent or emergent drug trends, both law enforcement and treatment providers continued to cite heroin abuse as a primary concern. Treatment providers noted, *"We've had 41 deaths in the last two years of heroin overdoses; [Heroin] it's very easily available. Three or four years, ago we very rarely saw someone using heroin. Now it is typical or expected. This is linked to prescription pill prices increasing."* A law enforcement official described the impact of heroin on other crime: *"Heroin is very available. We handle a lot of users and they commit thefts when they run out ... almost all of our thefts are [committed by] heroin addicts."* Participants and community professionals most often reported that the overall availability of heroin has increased during the past six months. The BCI Richfield Crime Lab reported that the number of powdered heroin cases it processes has increased during the past six months; the lab also reported that the number of black tar heroin cases seems to also have increased.

Most participants generally rated the quality of brown powdered heroin as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was also '7'. Using the same scale, the quality score for white powdered heroin was most often reported as '9'; the quality score for black tar heroin was most often reported as '10'. Participants reported that heroin in the region is cut with Ecstasy, fentanyl, lactose, methamphetamine and vitamins B-12 and D. On occasion, users reported encountering fake heroin, but many respondents felt that, in general, heroin quality has improved during the past six months. One trend echoed across multiple interview sessions: participants and community professionals reported more cases of grey, blue, or purple-colored heroin that they speculated to contain the prescription opiate fentanyl. Participants said, "It [heroin] has fentanyl in it. The heroin is greyish/bluish if it has that in it; I know someone who overdosed from fentanyl heroin, and it was greyish blue." Another participant remarked, "Everybody is talking about grey [heroin] ... ain't nothing better than that; I hear about that grey, it's more potent. That's what they're pumping." Law enforcement officers were unsure if the grey variety of heroin did indeed contain fentanyl. An officer stated, "I don't think our labs are testing for fentanyl in heroin." Law enforcement agreed that grey heroin seems to be more potent than other varieties found in the region: "I don't think they need to cut this stuff because it's pretty pure; Lately we've been getting a grey-colored, chunky heroin. Users tell us it's very potent. I believe the quality is becoming increasingly better recently. We've worked with Lorain County and they've had this coming through and they've determined with lab results that this grey heroin is laced and causing immediate death. Our sellers and our purchasers are saying this is some potent shit. It's dynamite. It hits you really hard." The BCI Richfield Crime Lab cited the following substances as commonly used to cut cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetics) and noscapine (cough suppressant).

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "dog food." Other names used in the region include: "dope," "H," "heron," "mantequilla (Spanish word for butter)," "Ronald," "smack" and "tar." Note that among different users, "dope" generally refers to their specific drug of choice (usually heroin or crack cocaine). Participants reported that powdered heroin is available in different quantities, but that it is no longer sold in traditional balloons or bindles. Instead, heroin in the region is most likely to be sold in small amounts in a wax or paper baggie, occasionally as a bundle of baggies, or more commonly, as a loose chunk scraped off a solidified block. Participants described, "[Heroin] it's brown and powdery or rocks twisted up in a piece of paper; Bundles were being sold a

while ago. I don't remember the last time I saw bundles. Now, it's a half a gram or more [as chunk]; About six months ago on the east side I saw gram bundles for \$150, but more on the east side now I see it more in chunk form, shaved off the block of it. With smaller amounts they just throw a chunk in your hand." Reportedly, bags (1/10 gram) or small chunks sell for \$10. Participants also reported buying heroin in "bundles" (10 small bags of heroin); bundles sell for between \$75-120; 1/2 gram sells for between \$50-80; a gram sells for between \$110-160; 1/8 ounce, or "eight ball," sells for approximately \$325; a finger (7-10 grams) sells for approximately \$500-1,000; an ounce sells for approximately \$2,000. Participants reported that pricing is holding steady or decreasing slightly. Participants reported that the most common way to use heroin remains intravenous injection. Out of 10 heroin consumers, participants reported that approximately eight would inject and the remainder would either snort or smoke the drug. Users continued to report that those who were new to the drug are more likely to snort before progressing to injection. Participants and law enforcement identified pharmacies as the primary source for clean injection needles, which are relatively inexpensive and can be obtained by saying they are for diabetes management. A participant said, "I get them at [the] pharmacy, [the grocery store], [a big-box retail store], doctors, hospitals ... I never used needle exchange. I just bought them at the store." There were no reports of dealers supplying needles to users. Law enforcement officers believed that IV drug use is on the rise among individuals of high school age, stating, "I'm hearing [that heroin] is more available than pills. It's cheaper and easier to get. It's the go-to for the kids. They shoot up [intravenously inject heroin]." Several participants expressed their concerns about the spread of disease via IV drug use. A participant said, "A lot of diseases are going around. [Needle sharing] it's a problem."

A profile for a typical heroin user did not emerge from the data. Participants continued to note that heroin is popular with all ages, races, and socio-economic levels. A participant commented, "I don't think it [heroin] discriminates. I've been out of high school less than ten years. Of all the people I know that got into heroin or overdosed it was the kids who played football, skateboarded, kids who smoked pot, kids who didn't. It's across the board, and it doesn't pick groups." Law enforcement and treatment providers reported that while use is among all demographic groups, they encounter Whites more commonly in treatment and jails. A law enforcement officer stated, "I agree [heroin use] it's [predominately used by] White [individuals]. You get one Black kid out of ten White kids [using heroin]. [Heroin] it's more of a White drug; We see mostly Whites from early 20s to 50s [using heroin]. Then the second most common [heroin user group] is Hispanic." Another officer

noted a trend in the City of Cleveland: *"I see it [heroin use] in two parts: if you're an older heroin user, you tend to be Black or from the Vietnam [War] era. If you're a new user, you're a White Appalachia-type, newly introduced to it [heroin] or coming off the pills [prescription opioids]."* A treatment provider reported, *"We see [heroin use among] late teens, early 20s, White male, no [particular socio-economic] class."* Treatment providers also remarked on changing trends and new heroin users, identifying more heroin use among females, middle- to upper-middle class individuals and users who began with prescription opioid abuse. They reported, *"[Heroin use] it's really emergent with 18- to 21-year-old girls. Fifty percent of them started between the ages of 14 and 16 [years], using heroin. We're also seeing the emergence of very young rural girls using it [heroin]; I call them Romeo and Juliet. Every time I see a woman using heroin, I find a man that taught her how to do it, and vice versa."* Community professionals and participants reiterated the abuse progression from prescription opioids to heroin among younger users.

Reportedly, heroin is used in combination with alcohol, crack and powdered cocaine, Ecstasy, marijuana, methamphetamine and sedative-hypnotics (benzodiazepines). Participants noted several reasons for combining other drugs with heroin. A participant reported, *"Benzo's [benzodiazepines] sedate you, so you don't have to do as much heroin. But it's dangerous so I stopped doing that."* Another participant explained about speedballing (using heroin with cocaine): *"I would purchase both heroin and crack, and do the crack first and then do the heroin to take off the edge. I would get \$20 of crack and \$80 of heroin. I would feel like garbage without the heroin, but I could live without crack."* More users who preferred speedballing indicated they would mix the drugs in the same syringe, as opposed to doing the two in sequence. Regarding marijuana, a participant said, *"I did it [marijuana] after heroin. You get twice as high."*

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); community professionals rated availability between '6' and '8' depending on specific drug. Participants and community professionals identified Vicodin®, Percocet®, Opana® and OxyContin® OP as the most abused prescription opioids in the region. Other drugs that were reported to be popular included fentanyl, methadone, and Ultram®, with methadone reported as gaining in popularity. The majority of participants and community

professionals most often reported that the availability of prescription opioids had remained the same during the previous six months, that was, extremely available (except for OxyContin® OC). While there were a few reported ways of consuming prescription opioids, the most common route of administration was snorting. Out of 10 prescription opioid abusers, participants reported that approximately six would snort, two would inject and two would orally ingest the drugs. In addition to obtaining prescription opioids on the street from dealers, participants continued to list the following other sources: friends, family, doctors, pain clinics and emergency rooms. Participants and community professionals described typical users of prescription opioids as from every socioeconomic level, age and race. Reportedly, combining other drugs with prescription opioids was common, as the effects of prescription opioids were said to be enhanced by other drugs.

Current Trends

Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants continued to identify Percocet® and Vicodin®, as well as methadone, as the most popular prescription opioids in terms of widespread use in the region. Participants reported: *"[Prescription opioids] they're not hard for me to get. They're in every floor of my building; I've taken all the ones [prescription opioids] you just mentioned. They're available. Especially if you get hurt on a workman's compensation claim. I've been hurt for over 25 years!"* Another participant noted that these drugs are traded commonly through friends and family, saying, *"The housewife connection is where they all trade Percocet® and pills and all the other stuff. They claim they have a bad back, and they all swap pills. I think it's pretty common. It's mostly pain pills."* Community professionals were quick to cite the high availability of this class of drugs as an area of concern. A treatment provider stated, *"In the outpatient setting, I would say, yes, they [prescription opioids] are very available."* Another treatment provider stated, *"People used to go 30-40 miles to get them [prescription opioids], but now they can get them in the suburbs."* Law enforcement reported, *"In a high school these [prescription opioids] are the biggest problem. They're as easy to get as marijuana. They trade them, take them from parents, and are selling them. It's very common in the high schools."* Community professionals continued to identify Percocet®, Vicodin® and OxyContin® OP, as well as methadone, as the most popular prescription opioids in terms of widespread use.

Collaborating data also indicated that prescription opioids are readily available in the region. The Cuyahoga County Medical Examiner's Office reported prescription opioids as present in 36.8 percent of all drug-related deaths. In addition to the medical examiner's data, media outlets throughout the state reported on significant arrests during this reporting period involving prescription opioid trafficking in the region. In March, federal authorities indicted a Cleveland man and six others for running a prescription opioid ring which involved defrauding Medicaid; the seven were accused of forging prescriptions for OxyContin® and Percocet®, hiring others to fill the prescriptions and then selling the drugs on the street (www.newsnet5.com, March 20, 2012). The explosion in the popularity of prescription opioids has been well documented in the media, but participants communicated several new trends. The recent crackdown on "pill mills" and pain clinics has been affecting availability in the Cleveland region. Many participants noted that recently pharmacies, emergency rooms and physicians are subject to more scrutiny, and obtaining pills through these methods is more difficult. A participant explained, *"It's pretty easy to get them [prescription opioids] on the street. But now, the people that get them from doctors are keeping them for themselves. They're not selling them as much, and if they do they're really expensive. They're holding on because of the crackdown."* Another participant stated, *"[Prescription opioids] they're available. The doctor situation has cracked down a lot. I had a doctor who was writing for me and he's in prison now."* Community professionals also commented on this trend. A treatment provider stated, *"By far, we see oxycodone in drug screens in our outpatients. But since SB93, the 'pill mill bill' has been successful in closing down pill mills; availability is going down."* Consequently, participants and law enforcement both noted more incidents of prescription forging. A participant reported, *"More people are forging the scripts [prescriptions]."* Many participants felt that Opana® and OxyContin® OP now fill the void left by the discontinued OxyContin® OC. Participants reported on Opana®: *"Opana's are big; Opana's have gotten really popular in the last few months, even though they're expensive; Nobody wants to give these up. They're like legal heroin."* A participant reported on OxyContin® OP: *"Since the oxy's [OxyContin®] have changed over [to the new formulation] you still take them. It just takes a while [to get high] ..."*

Most often participants reported that overall availability of prescription opioids has remained the same during the past six months. Law enforcement agreed. However, treatment professionals disagreed, and noted that, generally, the availability of prescription opioids has decreased during the past six months due to recent "pill mill" legislation. The BCI Richfield Crime Lab reported that the number of prescription opioid cases it processes has remained the same during the past six months.

Reportedly, many different types of prescription opioids are currently sold on the region's streets. Participants reported the following prescription opioids as available to the street-level user (Note: When reported, current street names and prices are indicated in parentheses): fentanyl (sells for between \$1-1.25 per milligram), methadone (aka "dones;" 10 mg sells for between \$3-7), Opana® (aka "panda bears;" sells for between \$1-1.50 per milligram), OxyContin® (aka "oxy's;" OxyContin® OC, *old formulation*, aka "oceans;" sells for between \$1.50-2 per milligram; OxyContin® OP, *new formulation*, aka "OP's;" sells for between \$0.40-0.90 per milligram), Percocet® (aka "perc's" and "school buses;" 5 mg, aka "512s;" sells for between \$5-7; 10 mg sells for between \$8-9), Roxicet® (30 mg sells for approximately \$30), Tylenol® 3/ Tylenol® 4 (sells for between \$2-6 per pill), and Vicodin® (aka "baby vikes," "V's" and "vikes;" 5 mg sells for between \$4-5; 7.5 mg sells for between \$4-6; 10 mg sells for between \$6-10). Many participants described that pricing for these pills now falls into three tiers: \$1 and up/mg pills such as fentanyl, Opana®, OxyContin® OC and Roxicet®, which are more desirable because they can be crushed for use or as cutting agents for other substances. A participant reported, *"Roxi's [Roxicet®] are still expensive because you can crush and snort them."* Pricing on the top-tier tends to be increasing. A middle tier of less desirable pills such as OxyContin® OP, methadone and morphine are still sought after, but these pills possess characteristics that do not appeal to every user, such as tamper-resistance, and the pricing has remained stable. A participant stated, *"Nobody wants OPs [OxyContin® OP]. They're garbage."* Most other pills mentioned by participants are priced on a per-pill basis, and have become relatively inexpensive at less than \$10 per pill. While there were a few reported ways of consuming prescription opioids, the most common route of administration is oral consumption. Out of 100 prescription opioid abusers, participants reported that approximately 55 would orally ingest the drugs (including crushing, wrapping in tissue and swallowing, aka "parachuting"), 40 would snort and five would inject. Exceptions were noted based on medication formulation (liquid, pill, wafer) and the nature of the drug's effect on the body. A participant explained: *"It depends on the pill. People shoot Opana's and oxy's. Anything else you just take by mouth."* It should be noted that in previous reports, intranasal inhalation and injection were more popular.

In addition to obtaining prescription opioids on the street from dealers, participants continued to list the following other sources for prescription opioids: friends, relatives, doctors, pain clinics and emergency rooms. Several participants noted the rise in thefts of these drugs: *"I see a lot more pharmacy robberies; You could also find them [prescription opioids] in someone's house. We would call it treasure hunting and go looking in bathrooms. Five times out of 10 there's going to be something."* Law enforcement and

participants again reported dealer connections to people in medical careers. A law enforcement officer said, *"We see a lot of professionals in Cleveland, a ton of nurses who are stealing the [fentanyl] patches and Demerol® pills and injections. Typically it's the injections they're stealing."* A participant said, *"There are lots of cancer patients who get them [prescription opioids]."*

Participants again described typical users of prescription opioids as from every socio-economic income level, all ages and all races. Participants from the east side, west side, outlying rural areas and the City of Cleveland had knowledge of these drugs and described their use among friends and family. However, participants were keen to note the use of these pills among heroin users and their status as a "gateway" to heroin abuse. A participant reported, *"I've seen people say, 'I just do pills I don't do heroin.' They think it's better because they're legal and manufactured. They have doctors they pay \$20 to get a prescription."* Another participant explained, *"These pills are all available and these are what gets [users] started on heroin because it's cheaper..."* Community professionals were more definite in listing demographic characteristics, but they agreed that prescription opioids provided a gateway to heroin use. A treatment provider reported, *"I'm seeing mostly male [prescription opioid users], between ages like 18 to 35 [years]; I'm seeing a lot of mid-30s for injuries, work-related, whatever... It's often a young male. They have a job and money to buy the pills."* Law enforcement described use of these drugs among White males and females, from high-school-aged to middle-aged, with more use among the middle-class. An officer explained, *"We see 25-40 [years of age] both male and female in North Olmstead. I agree it's starting to show up younger, with some activity in high school. In the teens and the early 20s once they're done with the marijuana, they're taking that step up. We see more activity/addiction with it in the late 20s."* A law enforcement officer described user trends in the City of Cleveland, saying, *"I see a disproportionate use among what I would call 'White Appalachians.' The lower west side is by far the pill capital of Cleveland. It tends to be generational."* All respondents mentioned increasing use among younger users (15 years of age and older) and high school students.

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, caffeine, Ecstasy, marijuana and methamphetamine. A participant reported, *"Alcohol and marijuana intensify the effects [of prescription opioids]."* Another participant said, *"Meth [methamphetamine] works like a poor man's speedball. It's done in series and you get back up and down. You eat a bunch of pills and then do some lines and see what happens."*

Suboxone®

Historical Summary

In the previous reporting period, Suboxone® was moderately available in the region. Participants most often reported availability of Suboxone® as '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported the drug to be available by prescription, through treatment centers and from friends who use heroin. Participants reported that the availability of Suboxone® had remained the same during the previous six months. The Cuyahoga County Regional Forensic Science Lab reported that the number of Suboxone® cases it processes had remained the same during the previous six months. Participants indicated that Suboxone® 8 mg sold for between \$10-20 (pills or strips). Out of 10 Suboxone® users, participants reported that, on average, approximately eight would take Suboxone® sublingually (by dissolving it under the tongue) as indicated, one would snort and one would intravenously inject. Participants continued to describe typical users of Suboxone® as heroin users who are trying to avoid withdrawal symptoms when heroin could not be obtained, and those who used the drug as part of a physician-prescribed treatment program.

Current Trends

Suboxone® is highly available in the region. Participants most often reported the current availability of Suboxone® 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 '7'. Participants reported the drug to be available by prescription, through treatment centers, the Internet, drug dealers and friends who use heroin. A participant stated, *"[Suboxone®] they're super available."* Another participant said, *"Drug dealers have them [Suboxone®]. They buy the script and sell them to people."* A former heroin dealer said, *"I would keep a bottle [of Suboxone®] for my own use and for the ones who need it."* Another participant noted that it is easy to obtain the drug through legal means, stating, *"You can pay a fee to get on a three week Suboxone® program and get some."* Heroin users reported it is common to reserve Suboxone® for times when heroin cannot be obtained, with one participant explaining, *"I would save them [Suboxone®] for the rainy day when I needed them, and we would trade them like poker chips."* Community professionals most often reported current availability as '7'. A treatment provider said, *"[Suboxone®] it's very easily available from friends of friends and dealers, but mostly friends of friends."* Participants and community professionals most often reported that the availability of Suboxone® has remained the same during the past six

months. BCI Richfield Crime Lab reported that the number of Suboxone® cases (particularly the sublingual film form) it processes has increased during the past six months.

The only street name reported for Suboxone® remains “subs.” Participants indicated that Suboxone® 8 mg sells for between \$10-20 (pills or strips). On pricing, a participant noted that users could expect to pay more for the drug if they are experiencing withdrawal symptoms: *“The dealers would wait until the user was dope sick and then jump the price up.”* Out of 100 Suboxone® users, participants reported that, on average, approximately 76 would take Suboxone® sublingually as indicated, 22 would snort it, and two would intravenously inject it. Suboxone® continues to be primarily acquired from doctors, friends and occasionally dealers who take them in trade for other drugs.

Participants continued to describe typical users of Suboxone® as those who use it as part of a physician-prescribed treatment program, and heroin users who are trying to avoid withdrawal symptoms when heroin cannot be obtained, and. A participant said, *“I see it [Suboxone®] more and more in the suburbs. Parents are putting their kids on it to get off heroin.”* Another participant observed, *“Younger high school kids are taking it [Suboxone®] and circulating it.”* A treatment provider noted that despite these trends, too few people who may benefit from the drug are taking it, commenting, *“I would ballpark the percentage of persons eligible for Suboxone® who are actually taking it is 10 percent. It’s too readily abused. Some use has decreased because of [falling] incomes. The unemployed can’t afford the medication.”*

Reportedly, Suboxone® is used in combination with alcohol, marijuana and sedative-hypnotics (Xanax®). A participant reported, *“I would do it [Suboxone®] with anything other than opiates.”* Although due to its nature as a substitute for heroin, and its opiate-blocking effects, Suboxone® was not reported commonly as a drug sought specifically for abuse.

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants most often reported the availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants listed Valium® and Xanax® as most popular in terms of widespread use. Law enforcement and treatment providers included sedative-hypnotics as a target of their diversion program because of their use by

younger people and opioid abusers; they noted Soma®, Valium® and Xanax® to be particularly popular. The Cuyahoga County Medical Examiner’s Office reported that sedative-hypnotics were present in 27.5 percent of all drug-related deaths during the previous six months. Most participants reported that the availability of sedative-hypnotics had increased during the previous six months, and no participant or community professional felt that these drugs had become less available. The Cuyahoga County Regional Forensic Science Lab reported that the number of sedative-hypnotic cases it processes had remained the same during the previous six months, with the exception of an increase in cases related to Klonopin®. The most common routes of administration for sedative-hypnotics remained swallowing and snorting. Participants and treatment providers continued to report that sedative-hypnotics were widely used by all groups of people.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported the current availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10’. More specifically, participants most often reported the availability of Ambien® as ‘7’, Ativan® as ‘5’, Klonopin® as ‘8’, Soma® as ‘2’, Valium® as ‘9’ and Xanax® as ‘10’. Participants identified Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. In the previous report, Klonopin® was identified as a drug increasing in popularity, now substantiated by participant data collected in this cycle. A participant stated, *“Klonopin® and Ativan® are moving up [increasing in availability].”* Law enforcement and treatment professionals reported an overall current availability score of ‘10’. They noted Klonopin®, Valium® and Xanax® to be particularly popular, assigning them availability scores of ‘10’, ‘8’ and ‘9’, respectively. A treatment provider emphasized that these drugs are easy to obtain, adding, *“Klonopin® are hot now.”*

Collaborating data also indicated that sedative-hypnotics are readily available in the region. The Cuyahoga County Medical Examiner’s Office reported sedative-hypnotics as present in 27.7 percent of all drug-related deaths during the past six months. In addition to the medical examiner’s data, media outlets throughout the state reported on significant arrests during this reporting period involving trafficking in sedative-hypnotics within the region. In March, a man was arrested during a routine traffic stop after State Highway Patrol troopers searched his car after smelling marijuana; they found 57 Xanax® pills along with small amount of crack cocaine, Ecstasy and marijuana (morningjournal.com, March, 16,

2012). Participants and community professionals most often reported that the availability of sedative-hypnotics has remained the same during the past six months. A participant observed, "A lot of people I meet are prescribed them [sedative-hypnotics]. You don't need a dealer." The BCI Richfield Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months.

Reportedly, many different types of sedative-hypnotics (aka, "benzo's" and "downers") are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ambien® (sells for \$2 per pill), Ativan® (sells for \$2 per pill), Klonopin® (aka "pins;" sells for \$3 per pill), Valium® (5 mg sells for \$2; 10 mg sells for \$3), Xanax® (aka "busses," "footballs" and "xani's;" 0.25 mg-1 mg sells for between \$2.50-3; and 2 mg, aka "bars;" sells for \$5). While there were a few reported ways of consuming sedative-hypnotics, the most common routes of administration remain swallowing and snorting. Out of 100 sedative-hypnotic users, participants reported that 73 would swallow the pills, 22 would snort, four would inject and one would also smoke the pills.

While sedative-hypnotics may occasionally be obtained on the street from dealers, participants continued to report primarily obtaining them from doctors, friends and family members, as well as the Internet and from Mexico. A participant explained, "You can order hundreds [of sedative-hypnotics] at a time online." Another participant said, "I knew a dealer who would trade a Xanax® for 0.5 grams of heroin." Participants indicated specifically that street-level 'dope boys' do not typically carry this class of drug. A participant said, "This [sedative-hypnotics] is not a 'walk-up-to-you' kind of drug."

A profile of a typical user of sedative-hypnotics did not emerge from the data. Because participants noted that these drugs were obtained through prescriptions, adults were noted to be the primary source for obtaining these drugs; younger users relied on trade. A participant reported, "It's easier to get Xanax® for anxiety with a prescription versus trying to get pharmaceutical opioids." Another participant said, "[Sedative-hypnotics] they're easy. Just go to a doctor and tell them I can't sleep or my muscles are stiffening." Another participant observed their popularity in correctional facilities: "Guys were trying to swap them [sedative-hypnotics] in jails. They're big in jails."

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used with alcohol, heroin, marijuana, and are often taken after the use of prescription opioids to enhance or extend that high. A participant said, "It

[sedative-hypnotics] brings you down low and keeps you low." Another participant observed, "Sometimes a dealer who sells heroin would sell Xanax® to compliment his product."

Marijuana

Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Marijuana was the most easily obtained illegal drug in the region. Law enforcement and treatment providers also reported the drug's availability as '10'. Participants reported that the availability of high-grade marijuana had dramatically increased during the previous six months. Most participants rated the quality of regular-grade marijuana as '8' and the quality of high-grade marijuana as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported regular-grade marijuana was the cheapest form: a blunt (cigar) or two joints (cigarettes) sold for \$5; an ounce sold for between \$100-120. High-grade or hydroponically grown marijuana continued to sell for significantly more: a blunt or two joints sold for between \$10-20; an ounce sold for between \$350-400. The most common route of administration for marijuana remained smoking. A profile for a typical marijuana user did not emerge from the data, as participants continued to describe typical users of marijuana as men and women of all races and ethnicities.

Current Trends



Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Marijuana remains the most easily-obtained illegal drug in the region. However, a notable trend is the deepening division of the drug into two distinct categories: high-grade marijuana (aka "loud" and "kush") and regular-grade marijuana (aka "reggie"). Nearly every participant supplied a current availability score of '10' for both kinds. A participant stated, "[Marijuana] it's the most consistently available drug out there." Law enforcement officers agreed, and also reported current availability as '10'. Media outlets throughout the state reported on significant arrests this reporting period involving marijuana within the region. In February, the Drug Enforcement Agency raided houses in Ashtabula, Cleveland, Elyria and Lorain; agents confiscated more than

1,000 marijuana plants as well as weapons and U.S. currency (www.newsnet5.com; Feb. 17, 2012).

Participants most often reported that the availability of regular-grade marijuana has remained the same during the past six months, while participants most often reported that the availability of high-grade marijuana has increased. A participant stated, *"Loud [high-grade marijuana] is way more available than reggie [regular-grade marijuana]. The weed man [marijuana dealer] got tired of smoking reggie, so all they have is loud and they get more money for it."* The BCI Richfield Crime Lab reported the number of marijuana cases it processes has remained the same during the past six months.

Participants most often rated the quality of regular-grade marijuana as '5' and the quality of high-grade marijuana as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '10' for both grades of marijuana, underscoring the widening gap in perceived quality between the two products. Also, quality scores were usually supplied as relative to whether one used high-grade or regular-grade marijuana. Participants remarked that high-grade marijuana lasted longer, is often more potent and does not *"give you a headache,"* as one participant stated. Another participant reported, *"The higher grade [marijuana] is fresher and has no seeds ... better quality. It has less tar and mold, and you don't get a headache."* Another participant said, *"When it comes to the high-grade weed, I got high quick. I was watching myself getting high ... it was so potent, but I have to smoke a whole blunt to hit it [obtain the same high] with reggie."* Some participants hypothesized that the quality of high-grade marijuana may be due to the addition of synthetic cannabinoid, sprayed onto regular marijuana. A participant said, *"There's more chemicals put in that high-grade marijuana. It could be anything. It's not regular anymore. They add stuff to make it loud."* Another participant added, *"Anything that could boost it [marijuana's potency], they'll put it in there. It's like Abilify® [medication to supplement anti-depressants] for your weed."*

Current street jargon includes countless names for marijuana, with variants of "kush" and "diesel" most commonly mentioned. Consumers listed the following as common street names for high-grade marijuana: "black widow," "bubble diesel," "crunch," "dank," "dro," "fire," "ghanis (Afghanistan)," "granddaddy kush," "hydro," "kind bud (KB)," "lemon G," "loud," "medicinal (medical grade)," "purp," "purple haze" and "sour diesel." Continuing with previously reported trends, fruity-flavored marijuana is popular, as is branding with creative names to help to popularize certain strains. Two tiers of standard pricing correspond with the two grades of marijuana. Participants reported regular-

grade marijuana is the least expensive form: a blunt or two joints sells for \$5; 1/8 ounce sells for between \$15-20; 1/4 ounce sells for \$25; 1/2 ounce sells for \$50; an ounce sells for between \$90-100; a pound sells for approximately \$1,125. High-grade or hydroponically grown marijuana continues to sell for significantly more: a blunt or two joints sells for between \$10-20; 1/8 ounce sells for between \$40-60; 1/4 ounce sells for between \$100-125; an ounce sells for between \$250-350. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Participants reported that 96 percent of marijuana users would smoke the drug, and approximately only four percent would ingest it in foods like butters, brownies, pancakes or waffles. A participant observed, *"I've seen more oils and butters to cook with ... more teas [containing marijuana]."* Participants had mixed views on the use of vaporizers (devices that heat marijuana to precise temperatures and boil off the marijuana compound's vapor for inhalation). A participant explained, *"Vaporizers are on the rise because it's more economical; it gets you more high."*

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." Reportedly, marijuana is consumed by every age group, socio-economic group, race and gender in all sectors of the region. As previously mentioned, use of high-grade marijuana is perceived to be more prestigious, especially among younger users. A participant explained, *"It seems like younger kids want more [high-grade marijuana]. They freak it [smoke with] in Black & Mild® [cigarillos]. They want the good stuff."*

Reportedly, marijuana is used in combination with almost every other drug, including: alcohol, crack and powdered cocaine (aka "primo;" used to "come down"), hallucinogens (liquid LSD and PCP; aka "woo" and "wet"), heroin and prescription opioids. Several users mentioned use of marijuana with Black & Mild® cigarillos (aka "smooths"). Regarding alcohol, a participant said, *"Weed ain't good without some type of beverage [alcohol]."* Another participant described marijuana with psilocybin mushrooms sprinkled on top: *"It's called a boomer."* A participant discussed the preferences a marijuana user who does not prefer the drug in combination with any other drug: *"Don't lace my weed. If you lace it, you're considered a fiend [drug addict]."*

Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was highly available in the region. Participants with experience using methamphetamine most often reported the drug's

availability as '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). As was the case in the previous reporting period, participants who assigned an availability ranking usually qualified their scores to mean that methamphetamine was highly available to a limited number of users who were connected with a tight-knit network of dealers and users. In two separate focus groups, participants noted that when the drug was available in Cleveland, it was reportedly coming from areas east of the city, particularly Lake and Ashtabula counties. Law enforcement most often reported the availability of methamphetamine as '2.' Participants and law enforcement most often reported that the availability of methamphetamine had increased during the previous six months. Only two participants were able to rate the quality of methamphetamine, supplying quality scores of '5' and '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that methamphetamine was primarily available in a home-cooked, powdered form and reported that a gram of methamphetamine sold for between \$40-120; 1/8 ounce sold for between \$140-150. The most common routes of administration for powdered methamphetamine were snorting and smoking. A profile for a typical methamphetamine user did not emerge from the data; however, participants thought the drug was more popular in rural areas and treatment providers believed the drug was popular in the gay community.

Current Trends



Methamphetamine remains highly available in the region. Participants with experience buying methamphetamine most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '9.' Participants reported that the drug's availability ebbs and flows, and that the Cleveland region is currently experiencing a period of high availability, possibly due to the ease of the "one-pot" method of production (methamphetamine production in a single sealed container, such as a two-liter soda bottle). Community professionals most often reported current availability of methamphetamine as '3;' the previous most common score was '2.' An officer observed, *"The one-pot method is so easy to do. And every [methamphetamine addict] has tried it once or twice. If they succeed, they're going to keep doing it. It's easier than having an entire lab."* Participants indicated methamphetamine can be obtained through personal connections with methamphetamine dealers and users in several points throughout the region, but they also mentioned the drug is typically imported into the region.

Reportedly, the "one-pot" variety of methamphetamine is the most available form of the drug. Participants and community professionals said crystal methamphetamine is infrequently manufactured in the state. A participant explained, *"[Crystal methamphetamine] [is shipped through the mail], and there were some busts in Akron for the shake-and-bake method, but I mostly see the [mailed] kind . . . Atlanta is where it [crystal methamphetamine] comes from."* A law enforcement officer said, *"A lot [of crystal methamphetamine] gets shipped in from western states."* Media outlets in the region reported on several seizures of methamphetamine during this reporting period. In March, law enforcement in Wayne County raided a methamphetamine lab in a house trailer, which was their eighth seizure during the prior two months (www.newsnet5.com, March 26, 2012). In June, law enforcement in Cuyahoga Falls also found a home-based methamphetamine lab and charged four people with illegal manufacturing of drugs among other charges (www.newsnet5.com, June 8, 2012).

Most participants with knowledge of methamphetamine reported that the availability of the drug has increased during the past six months. A participant reported, *"[Methamphetamine] it's definitely around more because there are more ways of making it. I had no problem getting it."* Another participant explained, *"[Methamphetamine] it's gaining popularity because it's so easy to make it with 'shake-and-bake' [one-pot method of manufacture]. You can make it in a couple of hours. In our area it's more shake-and-bake, but every now and then you see a good quality lab product. But shake-and-bake is the way because you can setup anywhere and it doesn't leave a lot of mess."* In contrast, most community professionals said availability had remained the same during the past six months. The BCI Richfield Crime Lab reported that the number of methamphetamine cases it processes has increased during the past six months, mostly due to an increase in "shake-and-bake" methamphetamine.

Participants rated the quality of methamphetamine, supplying a median quality score '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); previously, the quality scores of methamphetamine were '5' and '6.' Participants reported that the home-cooked, "one-pot" powdered form varied in quality from dealer to dealer due to variable production conditions. A participant stated, *"I was close to the guy who made it [methamphetamine], so mine was pure."* Another participant reported, *"[Methamphetamine] it's very cut depending on the source; some dealers cut it more than others. I've had them ask if it was for someone else or for me before they scoop it out."* A participant discussed why regional dealers trade mostly in home-cooked methamphetamine: *"It's easier to make, no importing it. You can do a simple Internet search and spend \$70 of supplies and make \$300 [worth]."* Crystal methamphetamine is perceived to have a

higher purity, but is not typically found in the area. Current street jargon included several names for methamphetamine. The most commonly cited names were “ice” and “crystal.” Participants listed the following as other common street names: “diamond,” and “Tina (aka Christina).” Several participants had experience buying the drug, and they reported that 0.1 gram sells for \$30; 1/4 gram sells for between \$40-60; a gram sells for between \$100-150; 1/8 ounce, or “eight ball,” sells for between \$450-500. A participant explained that like other drugs, methamphetamine pricing depends on quality, with the batches that are more pure costing more. A participant explained, *“Some dealers charge more for high quality [methamphetamine], and they only give you a small amount.”* Reportedly, the most common routes of administration for powdered methamphetamine remain snorting and smoking. Out of 100 methamphetamine users, participants reported that 30 would snort the drug, 52 would smoke and 18 would intravenously inject it.

A profile for a typical methamphetamine user did not emerge from the data. Participants supplied their perceptions about who uses the drug including gay males and motorcyclists. A participant said, *“Bikers use it [methamphetamine] to keep them up for days and days.”* On the other hand, law enforcement supplied typical age and gender information for methamphetamine users. They reported that methamphetamine is a drug primarily used by young males 16-30 years of age. An officer stated, *“[Methamphetamine users] they’re 20 to 30 years old. They get more brain damaged over time and get caught at that age even though they began using earlier than that.”*

Reportedly, methamphetamine is used in combination with depressant drugs like alcohol, marijuana, opioids and sedative-hypnotics (Xanax®) to “come down” from the stimulant effects of methamphetamine. A participant observed that it is common to see gay men combine GHB (Gamma hydroxybutyrate) and methamphetamine. The participant said, *“[Combination of GHB and methamphetamine] it’s called a ‘swirl,’ and it’s an interesting combination of effects. Meth dealers I knew had both [of these drugs].”*

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’ (highly available, extremely easy to

get). The Cuyahoga County Regional Forensic Science Lab reported that the number of pure Ecstasy (aka “Molly”) cases it processes had decreased while the number of piperazine cases (synthetic substances similar to Ecstasy) had increased during the previous six months. Participants most often rated the overall quality of Ecstasy as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants said Molly was sold as a yellowish loose powder, and that Ecstasy was sold as small colored tablets that featured popular images or logos: Transformers, Playboy® bunnies, Flintstones™, dolphins or hummingbirds. Participants reported that a single Ecstasy tablet (low dose) generally sold for between \$2-10; a double stack sold for between \$5-10; a triple stack sold for between \$8-12. The most common route of administration was oral consumption. A profile for a typical Ecstasy user did not emerge from the data, but the drug was said to be popular in both rural and urban areas. Participants and law enforcement perceived that the drug was more popular with younger users, 18-25 years old.

Current Trends



Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) remains highly available in the region. Participants most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10’. Law enforcement most often reported current availability as ‘3’. A few participants felt that the purest form of Ecstasy (aka “Molly”) is becoming more available as knowledge about the drug grows. In fact, the two forms of Ecstasy were often discussed interchangeably, indicating where there’s one there is the other. A participant said about Molly: *“You can go to any community college and you can’t walk 20 feet without being offered some. Community colleges are the place to get it.”* Another participant said about the availability of Ecstasy: *“It’s becoming an everyday drug.”* Yet another participant said Ecstasy is easy to get because of its concurrent use with marijuana: *“The person who normally sells the marijuana sells the Ecstasy pills.”*

Participants reported that the availability of Ecstasy has slightly increased during the past six months. Law enforcement also believed that there has been an increase in Ecstasy in the region. An officer said, *“I hadn’t heard much about Ecstasy in a while, and then there was a restaurant in Westlake [where employees sold it]. They were in the suburbs selling to Black and White kids for two to three bucks a pill, but Ecstasy seems to have come around again. We did a buy and*

the dealer was buying them two to three bucks per pill. The BCI Richfield Crime Lab reported that the number of Ecstasy cases it processes has remained the same during the past six months.

Participants most often reported the overall current quality of Ecstasy as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was also '10'. However, participants felt that quality is difficult to predict. According to one participant, *"I see some people got garbage [Ecstasy], and some people got some fire [potent]."* Another participant agreed, *"Quality [of Ecstasy] depends on what neighborhood you go to."* Participants had mixed opinions as to whether it is possible to assess ingredients or quality before taking the drug. A participant reported, *"All of them [Ecstasy] give you the same high."* Another participant disagreed, stating, *"The different colors [different types of Ecstasy tablets] give you a different high."*

Current street jargon includes only a few names for Ecstasy. The most commonly cited names were "Molly," "Skittles[®]" and "X." Molly typically sells as a yellowish loose powder, and Ecstasy in tablet form sells as small colored pills that featured popular images or logos: cartoon characters, dolphins, the hulk, Mickey Mouse and monkeys. Participants reported that a single Ecstasy tablet (low dose) generally sells for between \$5-10; a triple stack (high dose) sells for \$25. According to participants, these drugs are obtained from friends and dealers, often via a phone call or at night clubs. While there are few reported ways of administering Ecstasy, the most common route of administration remains oral consumption. Out of 100 Ecstasy users, participants reported that approximately 78 would orally ingest Ecstasy while six would snort it. Participants noted the growing trend for anal/vaginal administration, reporting that 16 of 100 users would practice these methods.

Participants reiterated Ecstasy's status as a club drug used by younger people. A participant said, *"[Ecstasy] it's still very popular in the clubs, but most people are doing it when there's nothing to do."* Another participant said, *"High schoolers get together and do it [Ecstasy]."* Law enforcement agreed that the drug is favored by younger users. An officer said, *"We got rid of the clubs that were the problem children and got rid of the Ecstasy."* Another officer characterized use as with *"suburban kids – and it's expensive."* Yet another officer observed, *"It's the Black community selling it [Ecstasy], and the White community taking it."* Reportedly, Ecstasy is used in combination with alcohol, marijuana and tobacco. Alcohol and marijuana are reported to intensify the high of Ecstasy.

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants were highly available in the region. Participants and treatment providers most often rated the availability of these drugs as '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported Adderall[®], Concerta[®] and Vyvanse[®] as most popular in terms of widespread use; Ritalin[®] was difficult to obtain due to a national shortage of the drug. Reportedly, prescription stimulants sold for between \$2-5 per pill. According to participants, these drugs continued to be obtained from friends and drug dealers. The most common route of administration remained snorting. Typical users of prescription stimulants were high school and college-aged youth.

Current Trends

Prescription stimulants remain highly available in the region. While relatively few participants had knowledge of these drugs, those with experience rated the current availability of prescription stimulants 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 '9'. Participants reported Adderall[®], Concerta[®] and Vyvanse[®] as most popular in terms of widespread use. A participant commented, *"Adderall[®] and Vyvanse[®] are high-grade ..."* Ritalin[®] was less-reported by participants, possibly due to a continued national shortage of the drug. Law enforcement most often rated current availability as '9'. The BCI Richfield Crime Lab reported that the number of prescription stimulant cases it processes has stayed the same during the past six months.

No slang terms or common street names were reported for prescription stimulants. Reportedly, prescription stimulants sell for between \$2-5 per pill, with Vyvanse[®] as high as \$7. According to participants, these drugs continue to be obtained from friends and family. While there were a few reported ways of administering prescription stimulants, the most common route of administration remains snorting. Out of 100 prescription stimulant users, participants reported that approximately 63 would snort the medications and 37 would orally ingest them.

Participants and community professionals described typical users of prescription stimulants as younger than 25 years of age. Participants continued to remark on the high level of abuse among high-school and college-aged youth. A participant stated, *"[Prescription stimulant use] it's for college students and high school students around finals so they can study longer and stay up."* A law enforcement officer described

abuse of prescription stimulants by students by saying, *"It's high school kids [who use prescription stimulants]. The prescription is for younger kids. Mom and dad don't control it, and you take it to school and exchange it for weed and do what you want."* Reportedly, prescription stimulants are used in combination with alcohol, marijuana and opiates, which are used to "come down." A participant reported, *"I would eat [take] Adderall®, and to be able to sleep at night, I would eat Xanax®."*

Bath Salts

Historical Summary

In the previous reporting period, bath salts (synthetic compounds containing methylone, mephedrone or MDPV) were highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Law enforcement and treatment providers most often reported availability as '9'. Despite the law banning the sale of bath salts, which went into effect in October 2011, these synthetic chemicals remained widely available from the same convenience stores that previously sold them. A law enforcement officer noted that a nearby hospital had 40 bath-salts-related emergency cases in one month. Reportedly, bath salts sold for between \$15-25 per 1/2 gram; a gram sold for between \$20-40. Participants did not report a spike in prices after the drug was made illegal in October 2011. The most common routes of administration were smoking and snorting, although intravenous injection and oral ingestion were also reported in a minority of cases. Law enforcement and treatment providers reported that bath salts were typically used by users younger than 30 years of age.

Current Trends



Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) are moderately available in the region. On average, participants reported the current availability of these drugs as '4' (median = 4) 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'. Despite recent legislation that banned the sale of these synthetic chemicals, packaged products are available from the same convenience stores and smoke shops that sold bath salts previously. A participant explained, *"I see a lot of synthetic bath salts, K2, LSD, and DMT at the [local convenience] stores. If they know you're a regular [customer], then they bring it out from behind the counter."* Law

enforcement also reported that they continue to encounter bath salts, and they most often reported current availability of these drugs as '4'; the previous most common score was '9'. Participants and law enforcement both reported that bath salts producers have adapted to the ban by changing labels and formulations. A participant noted, *"They just change one little ingredient [in bath salts] and resell them."* Another participant noted, *"The one [bath salts] I saw had balloons on it and people called it 'Balloons.' I also saw a package that said, 'glass cleaner.'" Law enforcement agreed that bath salts are being re-labeled. An officer said, "After the bill passed in October [2011], head shops are selling it [bath salts] backroom only, and it's labeled as many other things."*

Generally, participants believed that the availability of bath salts has decreased during the past six months. A participant reported, *"[Bath salts] they're still around but not as much [as they used to be]."* Law enforcement also agreed that bath salts availability has decreased since the ban went into effect. An officer stated, *"Ever since October [2011] they're on the decline. [Store owners] have to know you before they even admit they have the stuff. The novelty is wearing off and kids are looking at what has happened with bath salt users' [bad drug reactions] and they're thinking, 'screw that.'" Another officer expanded on that idea, explaining, "After October, and in the past year younger people tend to be a little afraid of it [bath salts]. It makes people out of their mind. Especially the younger people that like to try drugs for the first time, I think they're scared of bath salts."* The BCI Richfield Crime Lab reported that the number of bath salts cases it processes has increased during the past six months.

Participants supplied an average quality score for bath salts as between '4' and '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). No slang terms or common street names were reported for bath salts. Previously, bath salts sold for between \$15-25 per half gram. Recently, participants quoted pricing in less distinct quantities, but by most accounts, comparably higher to the previous reporting period. A participant reported, *"[Pricing of bath salts] it's \$30 per jar or package, about like a Ziploc® [baggie]."* Another participant agreed, describing a jar for sale about 1.5 inches tall selling for between \$25-30. The highest price quoted was \$40 for 0.15 ounces. A participant discussed the sale of bath salts: *"[Bath salts] it's available in a jar. On the west side people were buying it scooped out, homemade [loose, unpackaged bath salts that most likely have been adulterated], then put in a jar."* A law enforcement officer also spoke about the sale of bath salts: *"[Bath salts] it's cost-prohibitive for my population. It's more of a suburban drug. It's \$40 for a little lip-balm-sized amount. It's expensive. Now that it's illegal you can't walk into a boutique and buy it."* While there were a few reported ways of administering bath salts, the most common route of

administration remains snorting. Out of 100 bath salts users, participants reported that approximately 77 would snort the drug and 23 would intravenously inject it.

A profile for a typical bath salts user did not emerge from the data, except for observations that bath salts use continues to appeal to younger users younger than 30 years of age. Participants reported that bath salts are used occasionally in combination with alcohol and heroin. Typically, participants said bath salts are combined with heroin, *"to come down from it [bath salts]."* Another user explained this combination could be thought of as a speedball: *"[Bath salts] it's an upper, so you can do it like a speedball."*

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: hallucinogens [DMT (dimethyltryptamine) and PCP (phencyclidine)], Seroquel® and synthetic marijuana ("K2" and "Spice"). DMT, a psychedelic compound, was highly available in the region. Participants most often reported its availability as '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Some participants thought DMT to be an emerging drug in the region. Participants described two variants of the drug: a natural compound and a compound made with synthetic chemicals. A participant noted that the white or "natural" form was gaining in popularity and that the quality was improving as the knowledge of the drug-manufacturing process improved. Participants with knowledge of the "natural" form of the drug most often rated its quality as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); quality of the synthetic form of the drug was most often rated as '7'. Participants reported that 1/10 gram of DMT sold for \$10; a gram sold for \$150. Reportedly, the "natural" form of DMT sold for twice as much as the synthetic varieties. Participants reported that the most common routes of administration were smoking or snorting. Reportedly, the drug was popular with users who preferred hallucinogens, young adults and people who attended concerts and outdoor music festivals. PCP remained highly available in certain areas of Cleveland. Participants most often reported its availability as '8'. Two participants supplied PCP quality scores of '7' and '8'. Pricing was consistent with the previous reporting period: one dip of a cigarette sold for between \$15-20. Law enforcement reported the drug to be most popular among users in their 30s-50s. Synthetic marijuana remained highly available in the region. Despite legislation that made synthetic marijuana illegal in October 2011, participants most often reported availability of the drug as '10'; treatment providers most often reported availability as '9'. However, many thought that the drug was

not as popular as before the law banning its sale went into effect. Reportedly, synthetic marijuana was widely available from head shops, convenience stores and independently owned gas stations. Participants continued to attribute the popularity of synthetic marijuana to the continued belief that the drug delivered a marijuana-like high but could not be detected in urine drug screens. Participants with knowledge of the drug rated its quality as '9'. Participants reported that a gram of synthetic marijuana sold for between \$1.50-3. Like marijuana, the most popular route of administration for this drug remained smoking. Treatment providers cited the drug's popularity with all races and socio-economic groups, but that it was most favored by younger users between 25-30 years of age. Seroquel® (quetiapine), an antipsychotic medicine, was reported to be widely available and occasionally abused by the 18-25 year-old participants interviewed. Participants most often reported the availability of Seroquel® as '10'. Seroquel® 10 mg and 100 mg sold for between \$7-20 per pill. Participants reported obtaining the drug from friends and doctors. The most common route of administration was oral ingestion. Several participants also mentioned dissolving the pills in liquid (orange juice or sports drinks).

Current Trends

Participants and professionals listed a variety of other drugs as being present in the region, but these drugs were not mentioned by a majority of the people interviewed: hallucinogens [DMT (dimethyltryptamine) and PCP (phencyclidine)], prescription cold and cough medications and synthetic marijuana. Participants mentioned DMT, a psychedelic compound, although most participants did not have personal knowledge of the drug. Reportedly, DMT is obtained from dealers and other users and is sold in powder form. A participant explained, *"I only smoked one kind [of DMT]. I'm pretty sure it was the natural kind [as opposed to the synthetic variety]. It was a white powder."* Another participant described DMT as, *"looking like sawdust, really fine, powdery and dusty."* The BCI Richfield Crime Lab reported the number of dimethyltryptamine (DMT; 5-MeO-DMT/DiPT) cases it processes has increased during the past six months. A participant with knowledge of the drug rated the quality as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8'. A participant commented about the quality: *"I guess it [DMT] was good. I was tripping pretty hard."* No street names were mentioned for DMT. Participants reported that a gram of DMT sells for between \$90-120. Participants reported that the most common routes of administration remain smoking and snorting. Reportedly, DMT is used in combination with marijuana and heroin.

PCP (phencyclidine) remains highly available in certain areas of Cleveland. The few participants with knowledge of the drug rated its 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'. As with the last reporting period, most participants reported obtaining PCP (aka "embalming fluid," "water," "wet" or "woo") from an area called "water world" on the east side of Cleveland. A participant reported, "We would have to go to the east Cleveland area ...". Liquid PCP is still commonly sold on a per-dip basis. The crystalline powder form was reported to be very rare. Participants rated the quality of PCP as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was also '10'. A participant explained, "It [PCP] always came as a liquid and you dip cigarettes in it." Pricing remained consistent with the previous reporting period: one dip of a cigarette sells for between \$10-20. PCP is most commonly used in combination with alcohol, marijuana and tobacco. The BCI Richfield Crime Lab reported the number of PCP cases it processes has decreased during the past six months. While not reported by participants, the crime lab also reported that the number of cases it processes for psilocybin mushroom has remained the same, while the number of cases for LSD and salvia divinorum has decreased during the past six months.

Synthetic marijuana ("K2" and "Spice") remains highly available in the region. Despite legislation that has made it illegal, participants most often reported 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'. Treatment providers and law enforcement most frequently reported current availability as '5'; the previous most common score was '9'. A treatment provider reported, "It [availability of synthetic marijuana] had died down for a minute, but it is back up again. It's like [users] know we don't have a test for it." Participants described that synthetic marijuana sells as both "spice" and "potpourri" dried-leaf products and as a liquid. A law enforcement officer reported, "[Synthetic marijuana] it's a chemical liquid that mimics THC [Tetrahydrocannabinol], and you spray it on tea leaves and you smoke it and get high." Reportedly, synthetic marijuana is still widely available from head shops, and less so at convenience stores and independent gas stations. A participant reported, "[Synthetic marijuana] it's at head shops all sealed up and [the packages] are more decorated. They carry a higher quality product [than convenience stores]." Another participant said, "You have to get it [synthetic marijuana] at head shops. There's no more at convenience stores. Unless they have some inventory left ... I never see dealers with it." The BCI Richfield Crime Lab reported the number of synthetic marijuana cases it processes has increased during the past six months. The crime lab also reported that new chemical analogues to synthetic marijuana emerge monthly.

Reportedly, the most available brands mimic the names of popular marijuana strains. Brands cited included, "Bob Marley," "Kush," "Mad Hatter," "Mr. Happy," and "Purple K2." Synthetic marijuana products were said to be high quality, as one participant explained. Two of five participants with knowledge of the drug rated its quality as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). A participant reported, "Spice would get me more high than marijuana. You get the full effect and it lays you out." Participants reported that a gram of synthetic marijuana sells for between \$1.50-3; 3.5 grams sells for as much as \$40. Like marijuana, the most popular route of administration for this drug is smoking. Marijuana was reportedly used in combination with synthetic marijuana, although there was not consensus on that point. A participant said, "[Synthetic marijuana] it's used with real marijuana. I've seen them cut it with real weed." Another participant stated, "If you could get real marijuana it's more preferred than spice." Participants continued to attribute synthetic marijuana's popularity to the belief that the drug delivers a marijuana-like high but cannot be detected in urine drug screens. Law enforcement and participants cited the drug's popularity with all races and socioeconomic groups, particularly with younger users. An officer stated, "It's high school kids ... young White males [who typically use synthetic marijuana]." Another officer noted, "Long-time weed smokers don't want that stuff [synthetic marijuana]. If they're going to smoke they want good old weed."

Prescription cold and cough medications (aka "Lean," "Purple Drank" or "Tussin") were reported to be somewhat available for many participants, and highly available to others. Typically, these medications (chlorpheniramine/hydrocodone or promethazine/codeine syrup) are prescribed for severe cough symptoms. Participants most often reported availability of these drugs as '3' and '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Prescription cold and cough medications are available in liquid form and are combined with Sprite® and pieces of Jolly Rancher® candy. A law enforcement officer explained, "You can spin it to get the codeine or the hydrocodone separate from flavors and colors. And when it's in its elixir form, it's super potent." The term "purple drank" is due to the dyes in the cough syrup. A participant explained, "The real lean is prescribed stuff. For \$10 you're getting about the top of an ink pen amount. You put the Jolly Rancher® in there and shake it till it changes color." Participants reported obtaining the drug from dealers, friends and physicians. A participant commented, "You tell the doctor you have a cough or bronchitis and they prescribe it." An officer described how dealers obtain it in a similar way as methamphetamine smurfing [using buying groups]: "You can time them as [a dealer and a group of buyers] move along the highway to see where they bought the scripts [prescriptions]." Lean sells for \$10-20 per dose (approximately 10 ml or less)

and a “big bottle” sells for \$100. The most common route of administration is drinking the mixture. No White participants mentioned this drug, and its use is strongly associated with young Blacks. Several participants mentioned these medications as a frequent topic of rap songs. A participant said users are “people at rap shows.” Another user said it is consumed by “younger users who get ripped off when they buy other drugs.” A law enforcement officer reported, “It’s huge in the Black community. I haven’t arrested anybody with it who’s White . . . It’s huge in the after-hour joints. Drank with Red Bull costs \$20-40 bucks per shot.” Another officer said, “This Black community was passing fake scripts for Tussionex®. I had over 400 fake scripts, but with no leads it grinds to a halt. I had four Black dealers out of Chicago passing scripts for promethazine with codeine, but the same concept-cough syrup. They were pouring it into cranberry [juice] bottles.”

Conclusion

Crack cocaine, Ecstasy, heroin, marijuana, prescription opioids, prescription stimulants and sedative-hypnotics remain highly available in the Cleveland region. An increase in availability exists for heroin. Data also indicate likely increases in availability for Ecstasy, high-grade marijuana and methamphetamine, and a likely decrease in availability for bath salts. There are three noteworthy trends related to heroin that emerged through analysis of data related to the past six months. First, quality and availability of heroin were reported to be similar throughout the entire region. In previous interviews, participants reported some variations in availability and quality from east to west sides of Cleveland. Second, heroin is commonly available through transactions with unknown dealers, as well as through established dealer networks. In previous interviews, participants and law enforcement remarked on the “closed network” of heroin users and dealers, but this is no longer reported to be the case. Third, many crack cocaine dealers are switching inventory to accommodate increasing demand for heroin. When asked to identify the most urgent or emergent drug trends, both law enforcement and treatment providers continued to cite heroin abuse as a primary concern. Law enforcement and treatment providers reported that while use is in all demographic groups, they encounter Whites more commonly in treatment and jail. Community professionals and participants reiterated the abuse progression from prescription opioids to heroin among younger users. Brown and white powdered heroin remain the most easily obtained types of heroin throughout the region. Participants reported that the availability of Ecstasy has slightly increased during the past six months. Law enforcement also believed that there has been an increase in Ecstasy in the region. A few participants reported that the purest form of Ecstasy (aka

“Molly”) is becoming more available as knowledge about the drug grows. A participant said about the availability of Ecstasy: “It’s becoming an everyday drug.” Participants reiterated Ecstasy’s status as a club drug used by younger people. Law enforcement agreed that the drug is favored by younger users. Participants noted a growing trend for anal/vaginal administration of Ecstasy, reporting that approximately 15 percent of users would practice these methods. Marijuana remains the most easily-obtained illegal drug in the region. However, a notable trend is the deepening division of the drug into two distinct categories: high-grade marijuana and regular-grade marijuana. Participants most often reported that the availability of high-grade marijuana has increased during the past six months. Participants reported that the availability of methamphetamine constantly changes, and that the region is currently experiencing a period of high availability, possibly due to the ease of the “one-pot” method of production (aka “shake-and-bake”). Most participants with knowledge of methamphetamine reported that the availability of the drug has increased during the past six months. The BCI Richfield Crime Lab reported that the number of methamphetamine cases it processes has increased during the past six months, mostly due to an increase in “shake-and-bake” methamphetamine. Despite legislation that banned the sale of bath salts and synthetic marijuana, packaged products are available from the same convenience stores and smoke shops that previously sold them. Participants and law enforcement both reported that producers of these synthetic chemicals have adapted to the ban by changing labels and formulations. Generally, participants and law enforcement believed that the availability of bath salts has decreased during the past six months. Bath salts use continues to appeal to younger users (younger than 30 years of age).

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Columbus Region

January-June 2012

John R. Kasich, Governor
Orman Hall, Director



Regional Epidemiologist:

Randi Love, PhD

Keely Clary, MPH

OSAM Staff:

R. Thomas Sherba, PhD, MPH, LPCC
OSAM Principal Investigator

Rick Massatti, MSW
Research Administrator,
OSAM Coordinator

Columbus Regional Profile

Indicator ¹	Ohio	Columbus Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	2,132,217	51
Gender (Female), 2010	51.2%	50.7%	29.4%
Whites, 2010	81.1%	78.0%	56.3% ²
African Americans, 2010	12.0%	13.4%	35.4%
Hispanic or Latino Origin, 2010	3.1%	3.3%	0.0%
High school graduates, 2009-2010	84.3%	77.0%	75.5% ³
Median household income, 2010	\$45,151	\$51,501	Less than \$11,000 ⁴
Persons below poverty, 2010	15.8%	15.3%	63.3% ⁵

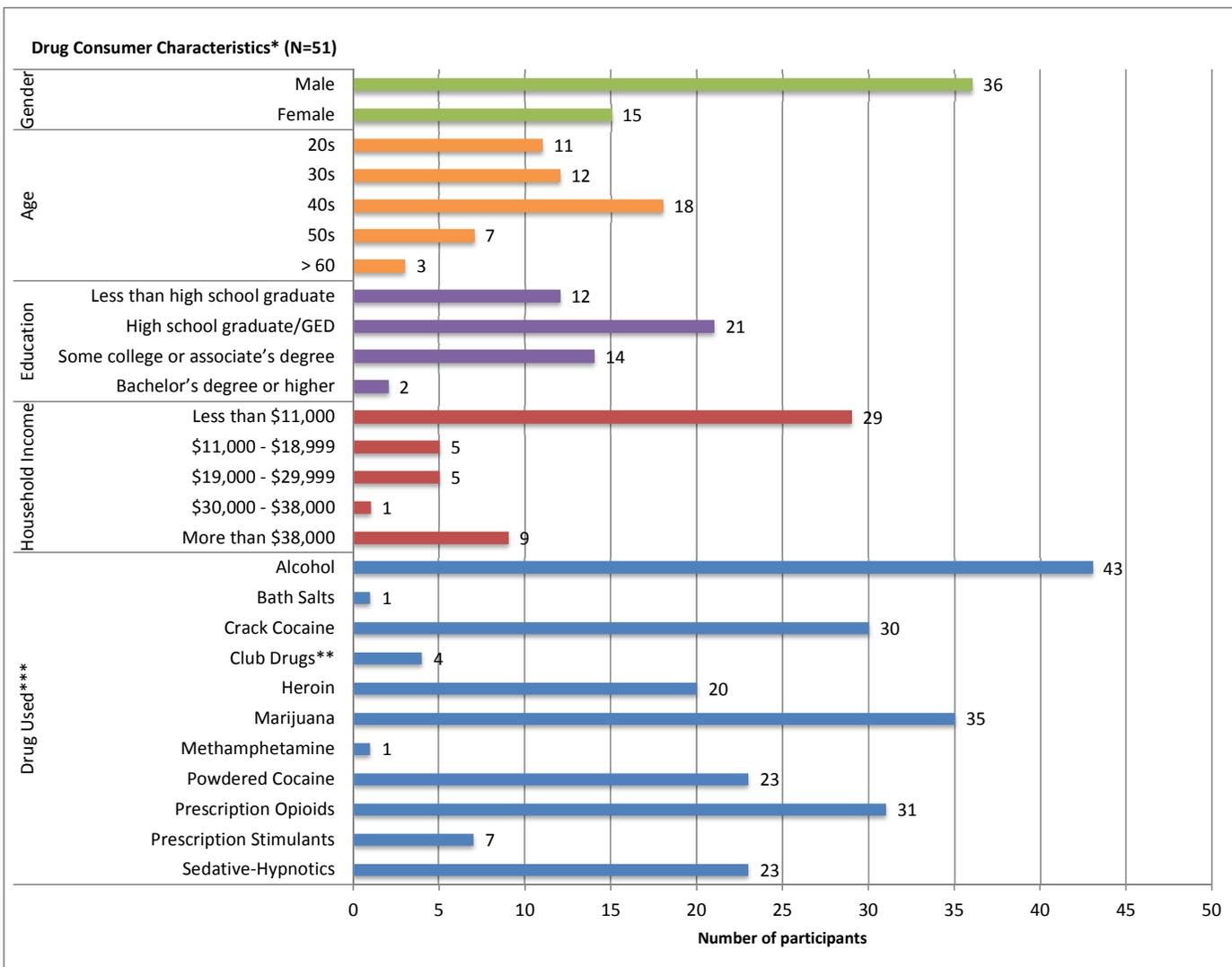
Ohio and Columbus statistics are derived from the U.S. Census Bureau.¹

Race was unable to be determined for three respondents due to missing data.²

Graduation status was unable to be determined for two respondents due to missing data.³

Respondents reported income by selecting a category that best represented their household's approximate income for 2012. Income status was unable to be determined for two respondents due to missing data.⁴

Poverty status was unable to be determined for two respondents due to missing or insufficient data.⁵



*Not all participants filled out forms; therefore, numbers may not equal 51.

**Club drugs refer to Ecstasy.

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

Data Sources

This regional report was based upon qualitative data collected via individual and focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Franklin County. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals in Fairfield, Franklin and Madison counties (treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Columbus Police Crime Lab, the Fairfield County Municipal Drug Court, the Franklin County Coroner's Office, the Franklin County Family Drug Court and the Bureau of Criminal Investigation (BCI) London Office, which serves Central and Southern Ohio. All secondary data are summary data of cases processed from July to December 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, all secondary data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2012.

Powdered Cocaine

Historical Summary

In the previous reporting period, powdered cocaine was moderately to highly available in the region. Participants most often reported the drug's availability as '6' and '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); treatment providers most often reported availability as '7'. The BCI London Crime Lab reported that the number of powdered cocaine cases it processes had decreased during the previous six months. Most participants rated the quality of powdered cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that the quality of powdered cocaine had remained the same during the previous six months. The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the cutting agent in most powdered cocaine cases. Participants reported that a gram of powdered cocaine sold for between \$50-60, depending on quality; 1/8 ounce, or "eight ball," sold for \$120; an ounce sold for between \$900-1,000. Participants reported that the most common route of administration for powdered cocaine remained snorting; intravenous injection and smoking were also commonly reported. A profile of a typical powdered cocaine user did not emerge from the data. However, some participants noted that users appeared to be getting younger.

Current Trends

Powdered cocaine 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' (highly available, extremely easy to get); the previous most common scores were '6' and '8'. While participants described powdered cocaine as available, many reported that it really "depends on the neighborhood" as well as "who you know." Treatment providers most often reported the drug's current availability as '8'; the previous most common score was '7'. A treatment provider stated, "[Drug consumers] use it [powdered cocaine] to speedball [concurrent use with heroin]." Law enforcement also felt that powdered cocaine is highly available in the region. However, a law enforcement officer stated, "It [powdered cocaine] does not appear to be users' primary drug of choice." Collaborating data also indicated that cocaine is readily available in the region. The Franklin County Coroner's Office reported that 8.2 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range at time of death). Furthermore, the Coroner reported cocaine as present in 27.7 percent of all drug-related deaths. (Note: coroner's data is aggregate data of powdered cocaine and crack cocaine and does not differentiate between these two forms of cocaine).

Participants most often reported that the availability of powdered cocaine has decreased during the past six months. Many participants reported dealers turning powdered cocaine into crack cocaine. A participant commented, "Everyone's rockin' it up [re-cooking powdered cocaine to produce crack cocaine]." Participants also noted a decrease in availability during the past six months due to the increasing popularity of other drugs. A participant reported, "Even heroin is easier to get now, more than [powdered] cocaine." Another participant reported, "Now that everybody's on pain killers [prescription opioids], coke [powdered cocaine] took a back seat. It's easy to find, but people pass it up." Law enforcement reported that availability of powdered cocaine has remained the same during the past six months, while treatment providers felt that availability has slightly increased. The Columbus Police Crime Lab reported that the number of powdered cocaine case it processes has increased during the past six months.

Most participants rated the quality of powdered cocaine as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Participants reported that powdered cocaine in the is cut (adulterated) with aspirin, baking soda, creatine, dry wall, laxatives, lidocaine (local anesthetic) and vitamin B-12. Many participants reported that powdered cocaine is cut with, as one participant stated, "whatever you can imagine,

whatever comes to mind." The Columbus Police Crime Lab cited the following substances as used to cut powdered cocaine: caffeine, levamisole (livestock dewormer) and local anesthetics (benzocaine and lidocaine). Participants reported that the quality of crack cocaine has remained the same during the past six months. A participant reported, *"I think that here people been steppin' on it [adulterating powdered cocaine] more than usual. You know, to make more so they can get their money back. They cut it and rock it up."* Another participant reported, *"I can get it [powdered cocaine] real easy, but the quality is crap."*

Current street jargon includes many names for powdered cocaine. The most commonly cited names remain "girl" and "soft." Participants listed the following as other common street names: "blow," "Christina Aguilera," "snow" and "white girl." Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine. Participants reported that a gram of powdered cocaine sells for between \$40-60, depending on the quality; 1/8 ounce, or "eight ball," sells for between \$100-150; and an ounce sells for between \$1,100-1,500. Treatment providers felt that more drug consumers prefer crack cocaine, as one stated, *"because of the high cost [of powdered cocaine]."* Participants reported that the most common way to use powdered cocaine remains snorting; however, participants reported that intravenous injection and smoking are also common methods. Many participants continued to report that new users are more likely to snort powdered cocaine, but eventually progress to either smoking or intravenously injecting it. A participant noted, *"A lot of people shoot it [powdered cocaine]."*

A profile for a typical powdered cocaine user did not emerge from the data. Participants continued to describe typical users of powdered cocaine as "everyone." Most participants agreed with the comment of one participant: *"No discrimination there [no typical powdered cocaine user], [powdered cocaine users] it's everybody."* Other participants reported that while there are no differences in typical use based on user race and age, those who use are typically, *"middle-class, suburbians; Rich people use the powder [powdered cocaine] more."* Law enforcement reported a change in the typical user of cocaine during the past six months. A law enforcement official stated, *"We used to see 30s [years of age] using cocaine, now we're seeing more of the 18 to 25 year olds using it in conjunction with heroin."* Treatment providers also commented on powdered cocaine becoming increasingly more popular with the younger age groups. One treatment provider stated, *"We're seeing more kids doing it [powdered cocaine]. It's really popular in the high schools."*

Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana and prescription opioids. Participants said that alcohol is used in conjunction to, as one participant stated, *"come down [from the stimulant high of cocaine], to take off the edge."* Many participants echoed the response of one participant who reported, *"Heroin's good after that [powdered cocaine use] too, to help bring you down 'cause it [cocaine] keeps you up ... it's a speedball, you put 'em both in the same rig [injection equipment]."* Some treatment providers noted an increasing trend in the amount of drug consumers who report using powdered cocaine to speedball with heroin. A treatment provider stated, *"[Powdered cocaine] it's popular because of the speedballs. I've had three clients die in the past three months from overdosing [while using powdered cocaine to speedball]."* Another participant commented on a growing popularity of the younger users of powdered cocaine: *"The younger generation is mixing blow [powdered cocaine] with perc's [Percocet®]."*

Crack Cocaine Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); treatment providers most often reported current availability as '9'. The BCI London Crime Lab reported that the number of crack cocaine cases it processes had decreased during the previous 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 BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the primary cutting agent for crack cocaine. Participants reported that a gram of crack cocaine sold for \$50; 1/8 ounce sold for \$150. While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remained smoking. Most participants said crack cocaine was popular with men and women of nearly all age groups and races.

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'. Many participants agreed with one participant who reported on crack cocaine always being available. The participant stated, *"Every street corner you can find a piece of crack [crack cocaine] pretty much ... in the urban neighborhoods."* Another participant added, *"Yeah, just walk out your front door; everybody got that [crack cocaine]."*

Treatment providers most often reported the drug's current availability as '10'; the previous most common score was '9.' A treatment provider reported, "It [crack cocaine] will find you," while discussing the current availability of crack cocaine in the region. Participants and treatment providers reported that the availability of crack cocaine has remained stable during the past six months. A treatment provider stated, "[Availability of crack cocaine] it's the same. It's always been here ... all up and down the street here." The Columbus Police Crime Lab reported that the number of crack cocaine cases it processes has increased during the past six months.

Most participants rated the quality of crack cocaine as '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5.' According to one participant, the current quality of crack cocaine is "horrible" and it leaves a user, "always chasing a high they can't get." Participants reported that crack cocaine in the region is cut with baby formula, baking soda, ether and vitamin B-12. Many participants agreed with one who reported: "Everyone out there cuttin' it [adulterating crack cocaine]. Just cuttin' it and cuttin' it down. You never know what you're gonna get ... just like a box of chocolates." Many other participants said that quality depended on the dealer. A participant explained, "If it's your close friend [dealing], they're not going to cut it [crack cocaine] as much. But, if it's someone they don't know, [the dealer] they're going to cut the shit out of it." Another participant added, "You never know, but when you get something good [good quality crack cocaine] you stay with that person [dealer] until they have something as bad as the last." Participants reported that the quality of crack cocaine has decreased during the past six months. A participant said that the quality of crack cocaine is so bad, that it seems like dealers are "selling dry wall for crack now." The Columbus Police Crime Lab cited levamisole (livestock dewormer) as the most common cutting agent for crack cocaine.

Current street jargon includes many names for crack cocaine. The most commonly cited names remain "hard," "rock" and "work." Participants listed the following as other common street names: "butter," "flav," "food" and "water." Current street prices for crack cocaine were consistent among participants with experience buying crack cocaine. Participants reported that a crumb of crack cocaine sells for between \$5-10; a gram sells for between \$50-65; 1/16 ounce, or "teener," sells for \$60; 1/8 ounce, or "eight ball," sells for between \$80-100. Many participants agreed that the price of crack cocaine varies depending on how well users know the dealer. While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remained smoking followed by intravenous injection. Out of 100 crack cocaine consumers, participants reported that approximately 80 would smoke and 20 would intravenously

inject or "shoot it." Many participants commented on the increased popularity of intravenously injecting crack cocaine. A participant reported on the reason for intravenously injecting crack cocaine instead of smoking it: "The high's way different. If you shoot it [crack cocaine], you don't geek [experience paranoia] like you do if you smoke it. Like if you smoke it, you get real paranoid and you go crazy. But, when you shoot it [crack cocaine], it hits you completely different." Despite the growing popularity of intravenous injection, many participants reported that there will always be users who prefer to smoke it. A participant stated, "A lot of people smoke it [crack cocaine] 'cause it's faster. You get high quicker." Another participant added, "Most people don't want to take the time to break it [crack cocaine] down, they just wanna hurry up and get something out of it."

A profile of a typical user of crack cocaine did not emerge from the data. Participants described typical users of crack cocaine as "everyone." According to treatment providers, many crack users during the past six months have been, as one treatment provider stated, "females in their 20s to 30s ... even mothers." Treatment providers also commented on the popularity of crack with heroin users. A treatment provider reported, "They [heroin users] use it [crack cocaine] to function."

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics. Participants agreed that the majority of the time crack cocaine is used in combination with other drugs rather than used by itself. A participant explained, "People don't just use crack, everyone at least drinks [alcohol] on it." Many participants reported using crack cocaine in combination with other drugs to maintain balance or to, as one participant stated, "keep you level."

Heroin Historical Summary



In the previous reporting period, heroin was highly available in the region. Participants and community professionals most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While many types of heroin were available in the region, participants continued to report black tar heroin as the most available. Participants reported that heroin availability had increased during the past six months, while treatment providers reported that availability had remained the same. A representative from the BCI London Crime Lab reported that the number of heroin cases it processes had remained

the same during the previous six months. Most participants generally rated the quality of heroin as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). According to BCI London Crime Lab heroin was "typically pretty pure." Participants reported that black tar heroin sold for between \$10-15 a bag; a gram sold for \$100. Participants reported that the most common route of administration for heroin remained intravenous injection. A profile of a typical user of heroin did not emerge from the data; however, participants noted that users appeared to be getting younger. Treatment providers commented on the progression from prescription opioids to heroin.

Current Trends

Heroin remains highly available in the region. Participants most often reported heroin's overall 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'. Participants agreed with one who said, "Nowadays [heroin] it's everywhere." While many types of heroin are currently available in the region, participants continued to report the availability of black tar heroin as most available. Many participants reported that both powdered and black tar heroin are highly available. A participant reported never knowing which kind of heroin was available, even in the same area: "I went to a dealer the one day and got brown powder [heroin]. I went to the same dealer the next day and got tar [black tar heroin]. It just depends." Participants rated black tar heroin's availability as '10'; the previous most common score was also '10'. A participant reported black tar heroin as highly available at all times: "I can go right out to the street and have tar [black tar heroin] in ten seconds." Participants also rated the availability of brown and white powdered heroin as '10'; the previous most common score was '7'. Many participants agreed that currently powdered heroin is more available than in the past. A participant reported seeing a lot of powdered heroin during the past six months, "I see a lot of powder [heroin], especially white. It looks just like cocaine." Law enforcement and treatment providers most often reported the current availability of heroin as '10', noting that black tar heroin is slightly more available; the previous most common score was also '10'. According to a law enforcement official in Fairfield County, "[heroin] availability is off the charts. It's above a 10 ... if you sit in the parking lot at [a local convenience store] you'll see five to six drug [heroin] deals." Treatment providers agreed, with one rating the availability, "20 out of 10. [Heroin] it's anywhere ... it's everywhere." A treatment provider also reported, "White powder [heroin] is coming out of Dayton." When asked if heroin has been the cause of any drug overdoses, staff from the Fairfield County Coroner's Office reported three deaths were the result of a heroin overdose. The staff member explained why the death rate seemed

low: "That's pretty low compared to what they are seeing in the emergency room and what they are seeing on the fire department. That's tremendously low. Now heroin is one of those things that I think ... they do in groups, and when they pass out, somebody calls for help real quick and a lot of time they are resuscitated. Narcan® ... lets heroin people go on and on and on. I rode the squad for 29 years. I would see the same people over and over and over again ..."

Collaborating data also indicated that heroin is readily available in the region. The Franklin County Coroner's Office reported heroin as present in 20.8 percent of all drug-related deaths. According to the Fairfield County Municipal Drug Court, a low percentage of men and women involved in their court test positive for drugs. However, among those testing positive during the past six months, 39 percent of positive urine drug screens were related to opiates. (Note: Opiates refers to heroin and a class of prescription medication.) According to the Franklin County Family Drug Court, a moderate percentage of men and women involved in their court tested positive for drugs. Among those testing positive during the past six months, 36 percent of positive urine drug screens were related to opiates. In addition, media outlets in the region reported on heroin seizures and arrests during this reporting period. In February, Marion police (Marion County) arrested a woman for trafficking in heroin after months of investigation (www.nbci4.com, Feb. 2, 2012). In March, also in Marion, police arrested four men from Detroit on drug-trafficking charges; police seized 733 pills, heroin and crack cocaine with a combined street value of \$9,500 during the raid (www.marionstar.com, March 9, 2012). In May, police held a forum to address concerns about black tar heroin in the Grandview Heights neighborhood in Columbus (Franklin County), as well as other affluent communities in central Ohio; at the forum a father from Grandview Heights talked about losing his 21-year-old son to a heroin overdose (www.10tv.com, May 29, 2012).

Participants reported that the current availability of black tar heroin has increased during the past six months. Some participants reported preferring black tar heroin to powdered heroin. A participant stated, "I would rather have tar than powder." Many participants reported the availability of black tar heroin increasing because, as one stated, "the users just keep multiplying." A participant reported, "There's more people shootin' [using] heroin than there is doin' crack [crack cocaine]." Another participant agreed with this comment and added, "True, or they go from taking pills to using heroin." Law enforcement reported that availability of black tar heroin has remained stable during the past six months. An officer stated, "I don't think the availability [of black tar heroin] has increased, it's just that the past two years it's been off the charts." Participants also reported that the availability of white powdered heroin has increased during the past six

months. Community professionals did not observe a change in availability of white powdered heroin during the past six months. The Columbus Police Crime Lab reported that the number of heroin cases that it processes has slightly increased overall during the past six months. (Note: the crime lab does not distinguish between black tar and powdered heroin cases).

Most participants generally rated the quality of heroin as '6' or '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was also '7'. Participants reported that heroin in the region is cut with coffee and dark-colored soft drinks. Reportedly, dealers will, as one participant stated, "boil the syrup [from the soft drink] out and cut it [heroin] that way." Another participant echoed this comment, "I've seen it [heroin] cut with coffee ... all kinds of shit." Many participants reported that the quality of heroin depends on who you get it from: "Quality goes from '0' to '10' because there's so many people using it. If you get some bad shit, you just go to someone else." Another participant added, "If you go to a Black or White guy [dealer], it's always cut ... so unless you go to a Mexican [dealer], [quality of heroin] it's crappy." Participants reported that the quality of heroin has varied during the past six months. While many participants report there being, as one stated, "a lot of junk out there," most agreed that the quality goes up and down, and largely depends on users' connections. According to the testing results from the BCI London Crime Lab, heroin remains "reasonably pure." However, when heroin is cut, the lab reported that diphenhydramine (antihistamine) occasionally is used.

Current street jargon includes many names for heroin. The most commonly cited names were "berries," "boy" and "dog food." Participants reported that heroin is available in different quantities: a bag sells for between \$10-15; 15 balloons (1/10 gram per balloon) sells for \$100; 1/8 ounce, or "eight ball," sells for \$300; an ounce sells for between \$1,000-1,200. Participants reported that price does not vary between black tar and powdered heroin. Overall, participants reported that heroin pricing has remained the same during the past six months. Participants reported that the most common way to use heroin remains intravenous injection. Out of 100 heroin consumers, participants reported that approximately 80 would intravenously inject or "shoot," 10 would smoke and another 10 would snort. Participants commented on the overwhelming popularity of intravenous injection among heroin users. A participant stated, "Shooting ... definitely shootin' [injecting heroin is most popular]. If you do it one time, you do it again." Participants also continued to report on the progression of heroin users from smoking the drug to intravenously injecting it. One

participant stated, "Most of the younger crowd is smoking it [heroin] off the foil, and once they know, 'hey this is the best buzz,' they're injecting it. When you first start it [heroin use], you don't want to shoot it [heroin] ... you'll be like, 'Oh, I'll never shoot.' But, after a little while you're like, 'Oh, this [smoking] doesn't do it for me ...' then you try it [intravenous injection] ..." Another participant agreed while adding, "Young people start out smoking [heroin], then they 'graduate.'" Law enforcement discussed the route to heroin use. One law enforcement official stated, "The kids are saying that they start off with the scripts ... prescription drugs. Then they switch to heroin because it's stronger, faster, cheaper."

Reportedly "needles are easy to get" from both drug dealers and pharmacies. Many participants expressed concern with the amount of people sharing needles when using heroin. A participant reported that users do not always clean them when sharing. Law enforcement echoed this concern, with one law enforcement official stating, "A lot of people share needles. Most of our people that come into our programs are Hep C [Hepatitis C] positive because they're all sharing needles." Treatment providers also expressed concern with the amount of people sharing needles. A treatment provider reported, "Hep C [Hepatitis C] is out of control, I'd say 98 percent of our clients have it." Another treatment provider added, "[Hepatitis C] it's becoming socially acceptable, a way of life."

A profile of a typical user of heroin did not emerge from the data. Participants described typical users of heroin as "anybody." Many participants agreed with one user who reported, "After being in this place [treatment program], no! [No common user]. It can be anybody and everybody." Participants reported an increase in the number of people switching from prescription opioids to heroin during the past six months, with one stating, "Since no one wants OxyContin® anymore 'cause they changed, they're [dealers] just pushing more people to heroin." According to a law enforcement official, "[Typical heroin users] it's the 18 to 25-year-old kids. And, we were seeing more males than females, but that has shifted ... we're seeing more females now." Treatment providers noted an increase in younger heroin users. A treatment provider explained, "A lot of the [heroin] dealers are recruiting the younger kids to deal it [heroin], and they're going straight to the schools." Another treatment provider echoed this statement, "The generation [using heroin] is getting younger and younger."

Reportedly, heroin is used in combination with alcohol, crack and powdered cocaine, marijuana, prescription opioids and sedative-hypnotics. According to many participants, heroin is used with, as one stated, "whatever keeps you awake, 'cause

heroin's gonna make you sleepy." Another participant reported on the popularity of using crack cocaine with heroin: *"Crack and H [heroin] ... all my dealers sell both."* Another participant added to this comment, *"Yep, H [heroin] always has a buddy."* Treatment providers also reported on drugs commonly used with heroin. A treatment provider commented, *"Speedballs. Crack and heroin, hand in hand. I've had three clients die in the last three months from overdosing."* Other treatment providers added that many heroin users, *"use other drugs to function. They just can't get up and get stuff done, so they're using [crack] to get their stuff done."* A treatment provider mentioned a growing trend of drug consumers using crack cocaine to avoid withdraw symptoms from heroin: *"For some reason right, now [heroin users] they're saying they don't go through the heroin withdraws if they're on crack."*

Prescription Opioids

Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants and community professionals most often reported street availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals identified Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Participants and community professionals reported that the availability of prescription opioids had decreased during the previous six months. The BCI London Crime Lab reported that the number of prescription opioid cases it processes had remained the same during the previous six months. 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 routes of administration for abuse were snorting and intravenous injection. In addition to obtaining prescription opioids on the street from dealers, participants also continued to report getting them from pain clinics. Treatment providers described the typical user of prescription opioids as male and White.

Current Trends

Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs as '8' to '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'. Participants identified Opana®, Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Many participants reported on the ease of coming across prescription opioids during the past six months. A participant stated, *"Let's go with 11-plus [extremely easy to get on the availability scale] 'cause you can go stand outside any [grocery*

store] right now, and someone gonna sell you their script [prescription]." Community professionals most often reported current availability as '8' or '9'. A treatment provider reported that drug consumers *"stand outside of pharmacies to buy other people's prescriptions off them."* Community professionals most often identified Percocet®, Vicodin® and OxyContin® as the three most popular prescription opioids in terms of widespread use. According to a law enforcement officer the problem of prescription opioid abuse is currently *"huge ... it's still huge."* An official from the Fairfield Drug Court reported that availability of prescription opioids *"remains high, even after a few problem docs have been shut down and are no longer practicing."* Treatment providers reported that prescription opioids are *"like Tylenol"* in the region. Many treatment providers even expressed concern with a growing popularity in *"pill parties,"* as one stated. A treatment provider explained that these parties are *"popular with the junior high kids. They steal pain killers out of their parents' medicine cabinets, and then go throw them in a bowl at the party, and they grab what they want."*

Collaborating data also indicated that prescription opioids are readily available in the region. The Franklin County Coroner's Office reported prescription opioids as present in 55.4 percent of all drug-related deaths during the past six months. In addition, media outlets in the region reported on prescription opioid seizures and arrests during this reporting period. In February, after a 10-month investigation, law enforcement in Circleville (Pickaway County) executed "Operation Rollin' Stone" during which 25 felony arrest warrants were issued to those involved in drug sales in the city; law enforcement seized more than 1,500 pills, cash and weapons during the raid (www.nbc4.com, Feb. 3, 2012). In March, police in Newark (Licking County) reported that a man robbed a pharmacy of prescription medications (www.nbc4.com, March 5, 2012). Also in March, police in Marysville (Union County) charged a man with drug trafficking and corrupting another with drugs after a woman he supplied with oxymorphone died of an overdose (www.dispatch.com, March 13, 2012). In April, officials from the Drug Enforcement Administration reported that 15 vials of hospital-grade drugs were stolen from a commercial pharmacy in Worthington (Franklin County) (www.10tv.com, April 3, 2012). In June, Columbus police reported that pharmacy in the city was robbed of oxycodone (www.nbc4.com, June 10, 2012).

Participants reported that the availability of prescription opioids has remained stable during the past six months. Many participants noted that although OxyContin® OC is now less available, there is no overall shortage of prescription opioids. A participant stated, *"There's a lot of [Roxicodone® 30 mg] and perc 15s [Percocet® 15 mg]. They [dealers] go down*

to Florida and get 'em [prescription opioids], then bring 'em back here 'cause the doctors up here ain't handin' 'em out like they used to." Law enforcement reported that availability of prescription opioids has slightly decreased during the past six months. Treatment providers reported that despite the closing of some local "pill mills," availability of prescription opioids has remained stable. A treatment provider explained, "The availability's there ... they [users] just have to work harder to get them [prescription opioids]." The BCI London Crime Lab reported that the number of prescription opioid cases it processes has generally remained the same during the past six months with the following exceptions: an increase in cases of Opana® and a decrease in cases of OxyContin®.

Reportedly, many different types of prescription opioids 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): Percocet® (10 mg, aka "percs" and "10s," sells for between \$10-12), Roxicodone® (30 mg, aka "perc 30's" and "30s," sells for between \$25-30 or, on average, \$1 per milligram) and Vicodin® (5 mg, aka "V's" and "vics," sells for between \$2-4). 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 routes of administration are snorting and intravenous injection. A law enforcement official noted a high percentage of users snorting: "Almost always they're snorting them [prescription opioids] ... We find straws with residue in them all the time."

In addition to obtaining prescription opioids on the street from dealers, participants also reported obtaining them from doctors and from buying other people's prescriptions. A participant even reported that contracts are made with people in Florida who will sell their prescriptions: "My friends' dad lives in Florida and we know about three or four people down there. Every three months ... we'll wait 'til they build up they'll have about 800 or 900 30s [Roxicodone® 30 mg] saved up and we'll make a trip down there, buy 'em and bring 'em back. We've made contracts, so that when they get enough for us to make a trip, we'll leave tonight and be back tomorrow night." Other participants reported obtaining prescription opioids from doctors and from standing outside pharmacies. Law enforcement also noted users easily obtaining prescriptions from dentists. An officer explained, "One of the problems is, a lot of drug users don't have good teeth and they'll go to the dentist and get a three-to-six month supply of opiates [prescription opioids]."

A profile of a typical user of prescription opioids did not emerge from the data. A participant described typical

users of prescription opioids as "anybody ... the pills don't discriminate. They start from 15 [years of age] on up." Another participant echoed this comment and added, "It could be grandma ... anyone." Law enforcement officials felt that prescription opioids are particularly popular with the younger crowd, with one stating, "We're seeing a lot of the younger crowd on prescription opioids, especially the high schoolers." Treatment providers echoed this statement, "I think [high school] that's where a lot of the kids start." A treatment provider mentioned kids as young as sixth grade using prescription opioids: "Now you've got sixth graders getting busted snorting pills in the bathroom." A law enforcement official also noted that similar to heroin, "Females are becoming more prevalent than the males now [in terms of prescription opioid use]."

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, heroin, marijuana, other prescription opioids and sedative-hypnotics. A participant reported using prescription opioids with "pretty much anything." Many other participants agreed, reporting use of prescription opioids with substances that intensify the high. A participant reflected on why people mix other substances with prescription opioids: "Everything's [all drugs] always mixed [combined]. You can never get high enough ... Never as good as the first time. You can never get it back." When asked if prescription opioids have been the cause of any drug overdoses, a staff member from the Fairfield County Coroner's Office commented on an increase in a mixture of prescription drug deaths: "Yeah, a lot of prescription stuff ... diazepam, stralopram, hydrocodone ... there's morphine itself Xanax®, methadone ... methadone ... methadone. Yea, a tremendous amount. I'm seeing more mixture of prescription opioids." The staff member went on to further express a concern with the growing number of drug-related deaths: "We have a conference every year where all the coroners get together and a big topic this year was all the increases in drug [related] deaths. We didn't even go half a year, and already beat last year [total number of drug-related deaths]."

Suboxone® **Historical Summary**

In the previous reporting period, Suboxone® was moderately to highly available in the region. Participants most often reported the availability of Suboxone® as '4' and '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); treatment providers most often reported availability as '7'. Participants reported that the availability of Suboxone® had remained the same during the previous six months, while treatment providers reported

that availability had increased. The BCI London Crime Lab reported that the number of Suboxone® cases it processes had remained the same during the previous six months. Participants reported that Suboxone® 8 mg sold for \$10. Most often participants reported taking Suboxone® sublingually (dissolving it under the tongue); there were also a few reports of intravenous injection. In addition to obtaining Suboxone® on the street from drug dealers, participants also reported getting the drug from clinics for their own use or to resell on the street. A participant noted that dealers didn't often sell Suboxone®. A profile of a typical Suboxone® user did not emerge from the participant data. However, treatment providers characterized the typical user as "an adult male in his 20s, Caucasian."

Current Trends



Suboxone® is moderately available in the region. Participants reported the availability of Suboxone® as '6' or '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common scores were '4' for those 25 years of age and younger and '8' for those older than 25 years of age. While some participants reported that Suboxone® is difficult to obtain, others reported being able to, as one participant stated, "get it [Suboxone®] like that [with ease]," when going to a clinic. Treatment providers most often reported the drug's current availability as '10'; the previous most common score was '7'. According to law enforcement officials, Suboxone® is prevalent in the area. An officer said there is "tons of Suboxone® in the area."

Participants reported that the availability of Suboxone® has decreased during the past six months. A participant reported, "A lot of the clinics now are making them [those prescribed Suboxone®] bring back the wrappers. Other clinics, to get a script [prescription] filled, they'll have to take a piss test or whatever, and Suboxone® has to be in their system." Other participants reported that although Suboxone® is fairly easy to obtain from clinics, it is not always affordable. A participant explained, "[Suboxone®] it's expensive. It's \$6 a pill to fill at the pharmacy. I was paying \$8 for the strips [Suboxone® film], and the doctor's visit was \$600." Treatment providers reported that availability of Suboxone® has increased during the past six months, reporting that Suboxone® clinics are "all over." The BCI London Crime Lab reported that the number of Suboxone® cases that it processes has increased during the past six months.

There were no street names reported for Suboxone®. Participants reported that Suboxone® 8 mg sells for between

\$10-15 per pill. In addition to obtaining Suboxone® on the street from dealers, participants also reported getting it from clinics and pharmacies. A participant reported on the ease of getting Suboxone® prescribed at clinics: "If you can get to a clinic, they're just like, 'Oh, you're an addict? Here's a script.' But, it [Suboxone®] does help. So, if you're trying to quit [opiates], it really does work." Participants agreed that buying Suboxone® on the street is expensive. A participant said, "I was really trying to buy it [Suboxone®] on the street to get clean ... it's expensive." Most often participants continued to report taking Suboxone® sublingually (dissolving it under the tongue). According to a participant, "People take it [Suboxone®] the way they are supposed to." Many participants agreed with one participant who reported that people take Suboxone® "right under their tongue because you don't get the right effect if you snort it or inject it."

A profile for a typical Suboxone® user did not emerge from the data. Reportedly, Suboxone® is rarely used in combination with any other drugs. The only drug mentioned by participants as being used in combination with Suboxone® is, as one stated, "Xanax® to get high." However, according to most participants agreed with one who stated, "People aren't getting high off it [Suboxone®]. They're taking it to get unsick." A participant reported on personal experience with the drug: "I'm doing it [Suboxone®] to stay clean."

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 drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants continued to identify Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Treatment providers most often reported the availability of sedative-hypnotics as '7'. The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processes had remained the same during the previous six months. The most common routes of administration were intravenous injection and snorting. In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported obtaining the drugs from pain clinics. Participants had a difficult time describing a typical user, while treatment providers characterized the typical user as female and White.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported the current availability of

these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants identified Ativan®, Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Although sedative-hypnotics remain highly available in the region, participants agreed with one participant who reported that *"availability depends on the neighborhood."* Community professionals did not rate current availability; however, law enforcement and treatment providers agreed that sedative-hypnotics are highly available; the previous most common score was '7'. Community professionals identified Xanax® as most popular, closely followed by Klonopin®. Collaborating data also indicated that sedative-hypnotics are readily available in the region. The Franklin County Coroner's Office reported sedative-hypnotics as present in 32.3 percent of all drug-related deaths.

Participants reported that the availability of sedative-hypnotics has decreased during the past six months. Many participants reported the decrease in availability is due to the *"crack down [closing] of doctor's offices,"* as one participant stated. Law enforcement noted a slight decrease in availability in sedative-hypnotics, while treatment providers reported that availability of sedative-hypnotics has remained stable during the past six months. A treatment provider stated, *"We've seen an increase [in sedative-hypnotics use] with the heroin users. A lot of girls using them [sedative-hypnotics] when coming off heroin."* The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months.

Reportedly, many different types of sedative-hypnotics 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®, Ativan®, Klonopin® (aka "pins" and "klonies") and Xanax® (0.25 mg and 0.5 mg, aka "footballs" and "panty droppers;" 1 mg, aka "blues" and "xani's," sells for \$2 per pill; 2 mg, aka "diving boards" and "xanibars," sells for between \$3-5 per pill). While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, generally, the most common routes of administration remain intravenous injection and snorting. Many participants agreed with one who said, *"Most [users] snort [sedative-hypnotics], some shoot [intravenously inject]."*

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported obtaining them from doctors, emergency rooms, pharmacies and from clinics in Florida. A participant reported being able to obtain

sedative-hypnotics by standing outside a pharmacy and purchasing drugs from customers. Another participant discussed sedative-hypnotics purchased in Florida: *"All the benzo's [benzodiazepines] come from Florida. The dealers take 10 to 15 people, drive 'em down there and sit right in the parking lot while they go in and get scripts [prescriptions]. They give 'em \$1,000 bucks or something."* While many participants described obtaining sedative-hypnotics with ease, others commented on the increasing difficulties with the new laws. A participant noted his dealer was arrested and charged, and another participant added, *"I know that personally, last year my husband and I got hit by the DEA. Before that I personally was selling \$10,000 [in pills] a month from a pharmacist in central Ohio."*

A profile of a typical user of sedative-hypnotics did not emerge from the data. However, some participants described typical users of sedative-hypnotics as mothers with children or *"White women."* Other participants reported that typical users *"have anxiety problems,"* or are likely to be *"anyone who's stressin' and feelin' like they got some problems."* Treatment providers frequently noted seeing a lot of young mothers using sedative-hypnotics. Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, heroin and marijuana. Participants reported a growing popularity of injecting Xanax® with heroin to intensify the high. A participant explained, *"A lot of people like the xani's [Xanax®] when they shoot their dope [heroin] because it intensifies your high. I've had five of my friends die from shootin' dope and Xanax®."* That participant was not the only one to have multiple friends die while using heroin and sedative-hypnotics together. Another participant said, *"Yeah, it intensifies it bad, it slows your respiratory [system]. It's like almost ... you can barely see someone breathing once they're out. A lot of people die from doing that [combining heroin with sedative-hypnotics], two of my friends did."*

Marijuana **Historical Summary**

In the previous reporting period, marijuana was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers also most often reported the availability of marijuana as '10'; and they likened the widespread use of the drug to that of cigarettes. In addition to easily obtaining marijuana on the region's streets, some participants mentioned obtaining marijuana from Michigan's prescription marijuana program. Participant quality scores of marijuana varied from '4' to '10' with the most common

score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants continued to explain that the quality of marijuana depended on whether the user bought "commercial weed" (low- to mid-grade marijuana), high-grade or hydroponically grown marijuana. Participants reported commercial-grade marijuana as the cheapest form: a gram sold for \$5; an ounce sold for between \$90-120. For higher quality marijuana, a gram sold for \$20; an ounce sold for \$350. The most common route of administration for marijuana remained smoking. Participants and treatment providers agreed that there was no specific age or other demographic category associated with marijuana use.

Current Trends

Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Many participants echoed the sentiment of one who said, "[*Marijuana is*] always there ... 24 hours [a day] as long as you got someone to bring it to you." Treatment providers noted that marijuana is available on "any street." Law enforcement and treatment providers also most often reported the drug's current availability as '10'; the previous most common score was also '10'. Law enforcement from Fairfield County reported marijuana as highly available, but not as popular as other drugs. A law enforcement officer said drug consumers are, "bored with it." Media outlets throughout the region reported on several marijuana seizures during this reporting period. In March, the Ohio State Highway Patrol discovered that marijuana packages were welded into farm equipment carried by a semi in Columbus (www.nbc4i.com; March 29, 2012). In April, Madison Township law enforcement executed a search warrant after a shooting at a Groveport (Franklin County) residence where they found 223 marijuana plants and seven pounds of marijuana (www.10tv.com; April 30, 2012).

Participants reported that the availability of marijuana has increased during the past six months. A participant reported, "*Marijuana seems to have flooded in the area here.*" Another participant agreed, "[*Marijuana*] it's there all the time ... whenever you want it." Treatment providers, as well as law enforcement reported that availability of marijuana has remained the same during the past six months. The BCI London Crime Lab reported that the number of marijuana cases it processes has decreased during the past six months.

Participant quality scores of marijuana ranged from '4' to '10' with the most common score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '7'. Several participants explained that the

quality depends on whether the user buys "commercial weed" (low- to mid-grade marijuana) or hydroponically grown (high-grade marijuana). A participant reported, "*They [dealers] got everything ... all [marijuana] grades ... Depends on what you want to spend.*" Many participants agreed that during the past six months quality has increased. A participant explained, "*It [marijuana] gets better all the time. More people grow it in the house and that's when it's really good. Grow it outside and it loses its potency.*" Other participants thought that competition among dealers for market share is the cause of the increasing quality. A user explained the quality of marijuana as "*better 'cause they [marijuana dealers] have to keep up with everything else.*"

Current street jargon includes countless names for marijuana. The most commonly cited name remains "weed." Participants listed the following as other common street names: "dirt," "mid," "reg" and "regular" for commercial-grade marijuana; "kush," "blueberry yum yum" and "purple haze" for high-grade marijuana; "dro" and "hydro" for hydroponically grown marijuana. The price of marijuana depends on the quality desired. Participants reported that commercial-grade marijuana is the cheapest form: a blunt (cigar) or two joints (cigarettes) sell for \$5; 1/10 ounce, or a "dime bag," sells for \$25; 1/2 ounce sells for \$85; an ounce sells for between \$150-200. Higher quality marijuana sells for significantly more: 1/8 ounce sells for \$50; 1/4 ounce sells for \$100; an ounce sells for between \$500-700; a pound sells for between \$3,000-5,000. A participant reported, "*An ounce of 'dro proolly [probably] brings you \$300 to \$400, but if it's that good, good green ... you might get about \$600 to \$700 for it.*" A law enforcement officer commented on both an increase in quality of marijuana as well as an increase in price: "*The stuff coming across the border that they're [dealers] are smuggling like crazy probably has a two to four percent THC [tetrahydrocannabinol] level content. And we've seen 19.5 percent levels that came out of Meigs County [in southeastern Ohio] ... and not only high quality, but very expensive. We've seen \$3,000 to \$4,000 a pound.*" While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Out of 100 marijuana consumers, participants reported that approximately 95 would smoke and 5 would use marijuana in baked goods. A participant commented, "*Some people eat it [marijuana in] ... cookies, Rice Krispies® treats, brownies ...*" Most users agreed with the sentiment of one participant: "*Some people do [bake marijuana into food], but more or less everyone smokes.*"

A profile for a typical marijuana user did not emerge from the data. Participants agreed that "marijuana doesn't discriminate," reporting that there are no specific ages or demographics associated with the use of marijuana.

Law enforcement and treatment providers echoed this statement, agreeing that marijuana users could be anyone. Reportedly, marijuana is used in combination with alcohol, crack cocaine and PCP (phencyclidine). Many participants reported using marijuana in combination with a number of various drugs to “come back down” from an intense high.

Methamphetamine **Historical Summary**

In the previous reporting period, methamphetamine was relatively rare in the region. Participants most often reported the drug’s availability as ‘2’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants stated that methamphetamine was difficult to obtain and more available in rural areas. Participants reported that methamphetamine was available in powder and crystal forms. The BCI London Crime Lab reported that the number of methamphetamine cases it processes had decreased during the past six months. The crime lab also reported that white powdered methamphetamine from personal labs was the most common form, and that methamphetamine trafficked on the street was usually crystal methamphetamine. Participants reported that a gram of crystal methamphetamine sold for \$20. Reportedly, the most common route of administration of methamphetamine remained intravenous injection. A profile of a typical methamphetamine user did not emerge from the data.

Current Trends



Methamphetamine is rarely available in the region. Participants most often reported the drug’s current availability as ‘3’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was ‘2’. Participants continued to report that methamphetamine is available in powdered and crystal forms. While community professionals could not rate the current availability of methamphetamine in the region, both treatment providers and law enforcement agreed that the drug

is becoming more popular. A BCI law enforcement officer reported, “Meth [methamphetamine] is not only big, but it’s getting bigger... Our peak for seizing meth labs, we did about 500 labs in 2005. This is July, and we are already at 472.” Participants agreed that the drug is most available to those who become part of the tight-knit network of dealers and users. A participant said, “Everybody who uses it [methamphetamine] has their own connections and they don’t let nobody in. They keep it for themselves.” Another

participant added, “You find meth labs on TV, but I can’t find ‘em, or I’d do it [methamphetamine] everyday.” Media outlets in the region reported on several methamphetamine seizures and arrests during this reporting period. In March, four people were arrested in Newark (Licking County) after a one-pot methamphetamine cook caused a house fire (www.newarkadvocate.com; March 17, 2012); a tip about a marijuana growing operation in Franklin County also yielded a home-based methamphetamine lab (www.nbc4i.com, March 30, 2012).

Participants could not come to consensus about the change in availability for methamphetamine; some thought availability has increased while others thought that it has decreased. Treatment providers and law enforcement reported that the availability of methamphetamine has increased during the past six months. A law enforcement official in Fairfield County noted, “While [methamphetamine availability] it’s never been a 10 on the OSAM [availability] rating scale. We know it’s widely available. It’s hard to go out and find meth users, unless you know, they’re sitting in jail or the hospital. So, it depends on where you’re at, some areas have zero meth labs ... others are off the charts.” The Columbus Police Crime Lab reported that the number of methamphetamine cases it processes has decreased during the past six months.

While no participants were able to rate the quality of powdered methamphetamine, one participant was able to rate the quality of crystal methamphetamine in the region, assigning it an ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Most participants did not have personal experience with the drug, and those who did agreed that quality depends on the dealer and how knowledgeable the cook is. Another participant felt that other drugs are more preferred because of the low quality of methamphetamine; he explained, “The bath salts they [dealers and head shops] are selling, puts crystal meth to shame” The Columbus Police Crime Lab noted that most of the cases they processed during the past six months were crystal methamphetamine.

Current street jargon includes a few names for methamphetamine. The most commonly cited names remain “crystal,” “ice” and “meth.” Current street prices for methamphetamine were consistent among participants with experience buying the drug. Participants reported that 1/2 gram of crystal methamphetamine sells for \$50; a gram sells for \$100; 1/8 ounce, or an “eight ball,” sells for \$200. While there were several reported ways of using methamphetamine, the most common route of administration is smoking, followed by snorting. Out of 100 methamphetamine users, participants reported

that approximately 90 would either smoke or snort it and 10 would intravenously inject it. Participants reported that users commonly, as one participant stated, “*smoke it [methamphetamine] out of a bowl, foil or out of a light bulb.*” Most participants felt intravenous injection is not preferred. A user stated, “*There’s not much injection [of methamphetamine] ... it just hurts too bad.*”

Participants described typical users of methamphetamine as rural Whites. Many agreed with one participant who referred to methamphetamine as “*the drug for country folk.*” The few participants that disagreed reported that methamphetamine is more of a club drug, which they said is popular in the gay clubs. While treatment providers reported that methamphetamine is, as one stated, “*not gender specific,*” law enforcement felt that a typical user is, as one law enforcement official stated, “*Male, White ... [and] 18 to 40 [years old].*” Reportedly, methamphetamine is used in combination with marijuana and other “*downers.*” As explained by one participant, marijuana is used in combination “*to mellow you out*” after using methamphetamine.

Bath Salts

Historical Summary

In the previous reporting period, bath salts (synthetic compounds containing methylone, mephedrone or MDPV) were moderately available in the region, although participants were unable to assign a specific score to that availability. According to participants, bath salts could still be purchased at gas stations and convenience stores. Both participants and treatment providers reported on the negative health consequences associated with the use of bath salts, including symptoms of paranoia and psychosis (hallucinations). Reportedly, bath salts sold for between \$20-60 for a small container of one to three grams. The BCI London Crime Lab noted that since the ban on the sale of bath salts went into effect in October 2011, the formally scheduled substances MDPV and methylone were almost never seen any more in samples of bath salts, rather dozens of non-controlled analogs took their place. Treatment providers believed that White males in their 20s and 30s were most likely to abuse bath salts.

Current Trends

Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) are highly available in the region. While participants did not rate the availability of bath salts, many stressed that the drugs were highly available and could be easily obtained throughout the region; previously,



participants thought the drugs were moderately available. Many participants commented on being able to obtain the drugs at all the same stores that previously sold them before they were banned in October 2011. Participants continued to report on the negative health consequences associated with bath salts use. A participant said, “*That stuff [bath salts] is crazy ... like crystal meth [methamphetamine] times 100.*” Another participant added, “*Last year it [bath salts] put me in ICU [intensive care unit] three times ... they had to jump-start me.*” Treatment

providers and law enforcement also reported that bath salts are highly available. Both law enforcement and treatment providers most commonly rated the current availability of bath salts as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). A BCI law enforcement officer expressed concern that the legislative ban has not decreased the availability of bath salts: “*With the legislation we passed, there are some things to work with out there. But these guys [bath salts manufacturers] are just waiting to introduce a new compound that’s not covered on the statute ... they’re just moving around all the regulations and laws and making it work for them, while keeping the products out there.*” Treatment providers also agreed that manufacturers were finding ways to skirt around the law. A treatment provider said, “*Users are continually reformulating bath salts so that lab tests won’t pick them up.*” Treatment providers agreed with participants that bath salts are available at all, as one participant called them, “*little mom-and-pop stores.*” Collaborating data also indicated that bath salts are readily available in the region. The Franklin County Coroner’s Office reported bath salts as present in 2.3 percent of all drug-related deaths. Regional media outlets also reported on bath salts. During a drug sweep, the Franklin County Drug Task Force, along with the Columbus Division of Police executed 17 search warrants, which yielded 6,000 packages of bath salts and synthetic marijuana-like products worth an estimated \$250,000 (www.nbc4i.com; May 3, 2012). In another incident, SWAT officers shot and killed a man who was high on bath salts after he threatened harm to his girlfriend and law enforcement (www.10tv.com; May 23, 2012).

Participants noted no change in the availability of bath salts during the past six months despite the ban. Law enforcement reported that availability has increased during the past six months. A Fairfield County officer stated, “*Bath salts are exploding. They’re huge. They can be found at any [beverage] drive-through, head shop or gas station. They*

are bigger now than they were before the ban.” Treatment providers also noted an increase in the availability of bath salts. A treatment provider lamented, “It’s a huge problem ... bath salts are a huge problem.” The BCI London Crime Lab reported that the number of bath salts cases it processes has increased during the past six months. The crime lab reported that as soon as one drug is banned (MDPV) another chemical analogue is likely to take its place (alpha-PVP).

While no participants rated the current quality of bath salts on a scale, those with experience taking the drug felt that the quality was high. A participant explained, “[Bath salts quality] it’s like 50 times, no 500 times stronger than coke [cocaine]. Twenty-dollar can of it [bath salts] is like doing \$500 worth of cocaine.” Only one participant commented on a decrease in the quality of bath salts since the ban came into effect, “And now that they’ve outlawed it in Columbus, they have a generic type ... eight-balls and this and that [names of the generic product], but it’s junk compared to the old stuff.”

Current street jargon includes a few names for bath salts. The most commonly cited names were “glass cleaner,” “scratch cleaner,” “hookah cleaner” and “energy powder.” Participants agreed that you have to know how to ask for bath salts or the store owners will not sell it. A participant said, “If you go in there and ask for bath salts, they’re [store owners] like, ‘No. No. We don’t want that here.’ They think you’re a cop. But if you go in and be like, ‘Hey man, do you sell any energy powder?’ they have it.” Reportedly, a “lid” or one hit of bath salts sells for \$10; a jar of bath salts sells for \$20. Participants reported that the most common route of administration is intravenous injection, followed by smoking and snorting. A participant discussed his personal experience injecting the drug: “I would inject it [bath salts] and ... it did not make me geek. And that’s what attracted me to it, I could go to the gas station and get it and it didn’t make me do the stuff that crack did or cocaine did.” Law enforcement from Fairfield County also believed the most common route of administration is intravenous injection. An officer said, “I’ve seen IV [intravenous injection of bath salts] the most, but smoking and snorting are both common as well.”

A profile for a typical user of bath salts did not emerge from the data. Generally, participants felt that the drugs are more popular with young adults. According to a participant, “A lot of those high school kids are doing those bath salts now, and that shit is freaky!” Law enforcement agreed with participants, reporting that a typical user tends to be young adults. An officer commented, “The 18 to 25 year olds and the younger side of that [most commonly use bath salts]. It’s become this, ‘you aren’t gonna catch me’ kind of game while they’re enjoying the high.” Another law enforcement participant echoed this sentiment when asked if there is a

typical user of bath salts, “Oh yeah! Young kids ... Just young kids. I’d say high school and maybe even younger. [Bath salts] it’s marketed and catered to the kids.” In contrast, treatment providers reported seeing bath salts use amongst those with experience in other drugs: “[Bath salts users] it’s a lot of people who just have a high tolerance for other drugs, and the bath salts give them a different high ... It’s such an intense high and that’s what they love.”

Reportedly bath salts have become a popular group activity among drug users. A participant reported, “Heroin seems more like doing it alone, but with bath salts, it’s more of a party. Let’s do it in groups, make it a party.” A law enforcement official noted interviewing a drug consumer who reportedly “was doing them [bath salts] with 12 other people, up for two days just smoking them.” This concept of bath salts being a group activity was echoed by another law enforcement official: “[Bath salts use] it’s more of this 18- to 25-year-old kids doing it for the social aspect. It’s like the new rave party.” Although it begins as a social event for many users, both law enforcement and treatment providers expressed concern with the quick progression of bath salts users becoming addicted. A participant from the Fairfield county drug court reported, “It’s almost like what heroin does to these people in two to three years, bath salts does in two to three weeks. The effects are so quick ...” Another law enforcement official agreed with this: “It’s just a crazy, quick psychosis and the brain damage that it does to these people so quickly ... just boggles my mind. I talked to a kid at the jail a few weeks ago and he would just tune out every once in a while, then snap back in and continue the sentence right where he left off.” Other members of law enforcement noted an increase in deaths related to bath salts, with one stating, “[Bath salts] it’s a really, really nasty high. It affects users differently. There’s been some people who OD [over dose] on it.” Staff from the Fairfield County Coroner’s Office reported, “I have one [drug-related death case] that’s brewing at the lab right now to see whether bath salts were involved.” Participants did not report on whether or not bath salts were used in combination with any other drugs.

Synthetic Marijuana Historical Summary

In the previous reporting period, synthetic marijuana (“K2” and “Spice”) was available in the region, although participants were unable to assign a specific score to that availability. Before the drug was banned in October 2011, participants said this substance was most often sold at gas stations and convenience stores. Many participants said they smoked synthetic marijuana because they thought it would allow them to test negative on urine drug screens. The BCI London Crime Lab reported the number of synthetic marijuana cases it processes had increased during the

previous six months. Data from the crime lab also indicated that the five formally scheduled substances were almost never seen anymore; rather dozens of non-controlled structural analogs had taken their place.

Current Trends



Synthetic marijuana is still available in the region. While participants did not rate the current availability of the drug, many expressed the ease to which the drug can be purchased. A participant said, *"All the head shops by campus still sell it [synthetic marijuana]."* A treatment provider echoed this comment reporting, *"They've got stores over there [campus area] that have it [synthetic marijuana] under the counter ... you just have to ask for it."* According to BCI law enforcement, synthetic marijuana is still highly available despite efforts in legislation to ban the product. The officer explained, *"They're [manufacturers] constantly taking that plant or whatever it's called and just dousing it with different chemicals."* Participants also reported that synthetic marijuana manufacturers are continually altering the product. A participant commented, *"They [manufacturers] just bring another kind [of synthetic marijuana product] out. Then when that's illegal, they bring another kind out."* Media outlets in the region reported on seizures related to synthetic marijuana during this reporting period. Following a tip, law enforcement officials in Marion discovered that a local food market was selling synthetic marijuana; officers seized more than 600 packages of the drug worth an estimated \$9,000, along with other drug paraphernalia and cash (www.nbc4i.com; Jan. 19, 2012). That same week, Marion law enforcement also raided another convenience store and confiscated 50 packs of synthetic marijuana (www.nbc4i.com; Jan. 27, 2012). The BCI London Crime Lab reported that the number of synthetic marijuana cases it processes has increased during the past six months. The crime lab reported that as soon as one drug is banned (JWH-018) another chemical analogue is likely to take its place (AM2201).

The couple of participants with experience using synthetic marijuana said the current quality is *"garbage"* and a *"waste of money."* Reportedly, most drug users will only resort to synthetic marijuana when on probation because they continue to believe it does not appear in urine drug screens. A participant noted, *"I smoked it [synthetic marijuana] everyday 'cause I had to take drug tests and stuff, and I like to get high. And a pill and everything else takes two to three days [to leave one's system]. You can even take Suboxone®, and it would show up [on a drug screen]."*

Current street jargon includes a few names for synthetic marijuana. The most commonly cited names were *"K2," "Spice," "incense" and "Posh."* Many participants stated that synthetic marijuana is still available for purchase at head shops and gas stations. A participant explained, *"You can go to the smoke shop and buy it [synthetic marijuana], or the [local] gas station."* Reportedly, the most common way to buy synthetic marijuana is by the gram. Participants noted that synthetic marijuana typically sells for \$9.99 per gram; 1.5 grams sells for between \$12-14. Reportedly, the most common route of administration of synthetic marijuana is smoking. A participant reported on the powerful effects associated with smoking synthetic marijuana, *"I rolled a pen joint of K2, and I was high for like four hours, and I only hit it two times."* Other participants expressed concern of the health risks brought on by the use of synthetic marijuana. A participant said, *"One of my friends from high school, he smoked K2 a lot ... like out of bong and stuff, and he actually overdosed on the stuff and ended up in the hospital with brain damage."* A BCI law enforcement official echoed participants' statements on health concerns: *"[Manufacturers] they're packaging it [synthetic marijuana] and marketing it harmless, 'This is not a drug ... it's incense.' You know, nobody really knows what stuff [chemicals] is in it or any long-term effects on the stuff."*

Participants and treatment providers reported that a typical user of synthetic marijuana is an individual on probation who wants to use a drug that is undetectable on urine drug screens. A participant explained, *"It's the men and women on probation [who are using synthetic marijuana] 'cause it doesn't show on the drug tests."* A treatment provider reported a recent change in testing procedures, stating that some parole officers now test for the synthetic marijuana: *"Now the POs [parole officers] ... the juvenile POs have a test for it [synthetic marijuana]."* Law enforcement also felt that some drug consumers use synthetic marijuana to escape failing a drug test, and added that the typical user is going to be of the younger generation. An officer said, *"[Synthetic marijuana] it's marketed towards the kids ... that's who the clients are."*

Participants did not comment on synthetic marijuana being used in combination with any other drugs. Reportedly, although associated with marijuana, synthetic marijuana provides users with a more hallucinogenic high. A participant commented, *"It [synthetic marijuana] gives you a high, but a hallucination high ... not like weed [marijuana]."*

Prescription Stimulants Historical Summary

In the previous reporting period, prescription stimulants were moderately available in the region, although

participants were unable to assign a specific score to that availability. The only prescription stimulant mentioned was Adderall®, and participants said that the drug was readily available on college campuses and remained popular among young people. Participants reported that Adderall® 10 mg sold for \$3; 30 mg sold for \$7. Reportedly, the most common routes of administration for prescription stimulants were oral ingestion and snorting. The BCI London Crime Lab reported the number of prescription stimulant cases it processes had remained the same during the previous six months, with one exception: the number of Adderall® cases had decreased.

Current Trends

Prescription stimulants are highly available in the region. Participants most often rated the availability of prescription stimulants as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously participants said the drugs were moderately available. A participant reported, "Go to a college town, [prescription stimulants] it's way overprescribed. It's everywhere ... like a 10 [availability score]." Law enforcement most often reported the current availability of these drugs as '6' or '7'. While participants did not report any change in the availability of prescription stimulants during the past six months, a BCI law enforcement official reported availability as increasing: "Adderall® seems to be going up." Another law enforcement official echoed that sentiment, "Adderall® [is] gaining popularity. We're seeing a lot of amphetamine salts [prescription stimulants] on OARRS [Ohio Automated RX Reporting System] reports." The BCI London Crime Lab reported that the number of prescription stimulant cases it processes has remained the same during the past six months.

No slang terms or common street names were reported for prescription stimulants. The following prescription stimulants are available to street-level users: Adderall® (15 mg sells for \$3; 20 mg sells for \$5). In addition to obtaining prescription stimulants on the street from dealers, participants also reported obtaining them from physicians and from people who are prescribed the drugs. A participant reported, "A lot of parents take them [Adderall®] from their kids and sell them." While there were several reported ways of using prescription stimulants, the most common routes of administration remain oral ingestion and snorting.

Participants described typical users of prescription stimulants as either, "high school and college kids" or females, particularly, "stay-at-home mothers." According to participants, students use prescription stimulants to study and to "stay on their toes," while stay-at-home mothers use it "to lose weight." Other participants also added that people will use prescription stimulants to get tasks accomplished

throughout the day. A participant explained, "I would take it [Adderall®] to keep me going, take my daughter to school." Reportedly, prescription stimulants are not often used in combination with other drugs; however, a participant reported users occasionally combine the drugs with alcohol "to party longer."

Other Drugs

Historical Summary

Participants and community professionals listed Ecstasy as being present in the region, but it was not mentioned by the majority of people interviewed. The only participant who knew about Ecstasy reported that it was highly available in the region; he listed the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). "Molly," the powdered form of the drug was commonly available. The only reported price was \$50 for a triple stack of Ecstasy pills. The BCI London Crime Lab reported that the number of Ecstasy cases it processes had remained the same during the previous six months; however, the lab noted an appreciable increase in cases containing the designer drug 5-MeO-DiPT (foxy methoxy).

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: Ecstasy, hallucinogens [LSD (lysergic acid diethylamide) and psilocybin mushrooms] and inhalants. Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) is moderately to highly available in the region. Participants reported its availability as '7' to '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'. A participant reported being able to, "get X [Ecstasy] any day of the week." Another participant added, "[Ecstasy] it's definitely out there right now." According to participants, the chemical components of Ecstasy are available online. A participant commented, "There's a lot of stuff online. You buy all the chemicals separately and mix it together and sell it as Molly [Ecstasy]." Community professionals did not report on Ecstasy use. The Columbus Police Crime Lab reported that the number of Ecstasy cases it processes has decreased during the past six months. Current street jargon for Ecstasy was limited to "X" and "Molly." Participants reported a "single stack" (low dose) Ecstasy tablet sells for \$3; a gram sells for \$100. A participant reported that it is easy to make money off Ecstasy sales: "You can make it [Ecstasy] for like \$15 a gram, then sell it for like ... \$120 a gram." Participants described typical users of Ecstasy as young adults who like to attend clubs and outdoor music festivals. A participants said, "Young party people that

go to clubs [use Ecstasy].” Another participant agreed that “young people who like to party [use Ecstasy].”

Hallucinogens (LSD and psilocybin mushrooms) are moderately available in the region. Participants most often reported the current availability of these drugs as ‘4’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). While some participants felt that hallucinogens are available, others reported not being able to obtain the drugs. A participant reported, *“There’s mushrooms [psilocybin mushrooms] out there ... and LSD’s out there a little bit,”* while another participant said, *“Shrooms [psilocybin mushrooms] ... love ‘em, but you can’t get ‘em.”* Many participants expressed that availability of hallucinogens is seasonal, and mentioned the drugs are most available in the spring and summer months. A participant commented, *“Every spring ... [is] harvest time.”* Community professionals did not mention any data on hallucinogens in the area. The BCI London Crime Lab reported that the number of LSD cases it processes has increased; the number of psilocybin mushroom cases it processes has remained the same during the past six months. While participants did not report on dimethyltryptamine (DMT), the BCI London Crime Lab reported that cases of powdered DMT have increased during the past six months.

While no participants reported data on inhalants, there were a few members of the law enforcement community that expressed a concern about inhalant use in the region. Reportedly, heroin users are turning to inhalants as an alternative to their primary drug of choice. A representative from the Fairfield County Drug Court reported on the growing popularity of inhalants among heroin users: *“We’ve got two [heroin users using inhalants]. Our problem becomes how to test these people. The only way to successfully test them is to test their blood, but these are primarily heroin users who are switching to inhalants. The last thing we want to do is put a needle in a heroin addict’s arm to test them for inhalants.”* A law enforcement officer noted, *“One kid I talked to said he really didn’t want to do heroin anymore. He was in therapy, but he still had that ‘no-stop’ mentality ... he wanted to get high, so he rationalized it [using inhalants as a replacement to the heroin].”* Staff from the Fairfield County Coroner’s Office recalled a recent overdose caused by inhalants: *“I had one [death due to] huffing [inhalant use] ... like the cans that you get to clean computer screens, you know ... that spray air. That kind of thing. Huffing the propellant off of that.”* Law enforcement also mentioned other substances (Kratom shots and Eliqweed) with which users are experimenting. Typically, these substances are downers, and they are available at head shops. A law enforcement officer explained, *“They [head shops] now [sell] Kratom relaxation substances that you spray in your mouth like the aero shots [caffeine sprays]. The clerk said*

users of other substances use the Kratom to help the side-effects of other drugs. They also sell a liquid called Eliqweed that you put into an e-cigarette (liquid type not cartridge type) that they said was better than the illegal weed [marijuana] ... They said they can’t keep it on the shelves.”

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids and sedative-hypnotics remain highly available in the Columbus region. Noted changes in availability during the past six months exist as follows: increased availability for bath salts; likely increased availability for heroin, methamphetamine, Suboxone® and synthetic marijuana. Participants stressed that bath salts and synthetic marijuana are highly available and can be easily obtained throughout the region. Many participants commented on being able to obtain these drugs at all the same stores that previously sold them before the legislative ban on their sale took effect in October 2011. Participants continued to report on the negative health consequences associated with bath salts and synthetic marijuana use. Reportedly, stores, no longer sell the drugs under the name bath salts, but use other names like “glass cleaner,” “scratch cleaner,” “hookah cleaner” and “energy powder;” synthetic marijuana is usually marketed as “incense.” The BCI London Crime Lab reported that the number of bath salts cases and the number of synthetic marijuana cases it processes have increased during the past six months. The crime lab also reported that as soon as one drug is banned (MDPV; JWH-018) another chemical analogue is likely to take its place (alpha-PVP; AM2201). Participants and law enforcement reported that black tar heroin is the most common form of heroin in the region, but participants also reported brown and white powdered heroin as increasingly available. Participants noted an increase in all forms of heroin and attributed increases to users transitioning from prescription opioids to heroin along with a general increase in the popularity of heroin. The Columbus Police Crime Lab reported a slight increase in heroin availability during the past six months. Intravenous injection remains the most common way to use heroin. Both law enforcement and treatment providers expressed concern that many users are positive for Hepatitis C. Staff from the Fairfield County Coroner’s Office reported three deaths as the result of heroin overdose, and said the overdose death rate would have been much greater if paramedics had not been able to resuscitate users with Narcan®. While methamphetamine remains difficult to obtain in the region, the drug appears to be increasing in popularity, according to law enforcement and treatment providers. Law enforcement officials from the BCI reported that their organization is on track to seize significantly more methamphetamine labs than they had during previous years. Participants reported that

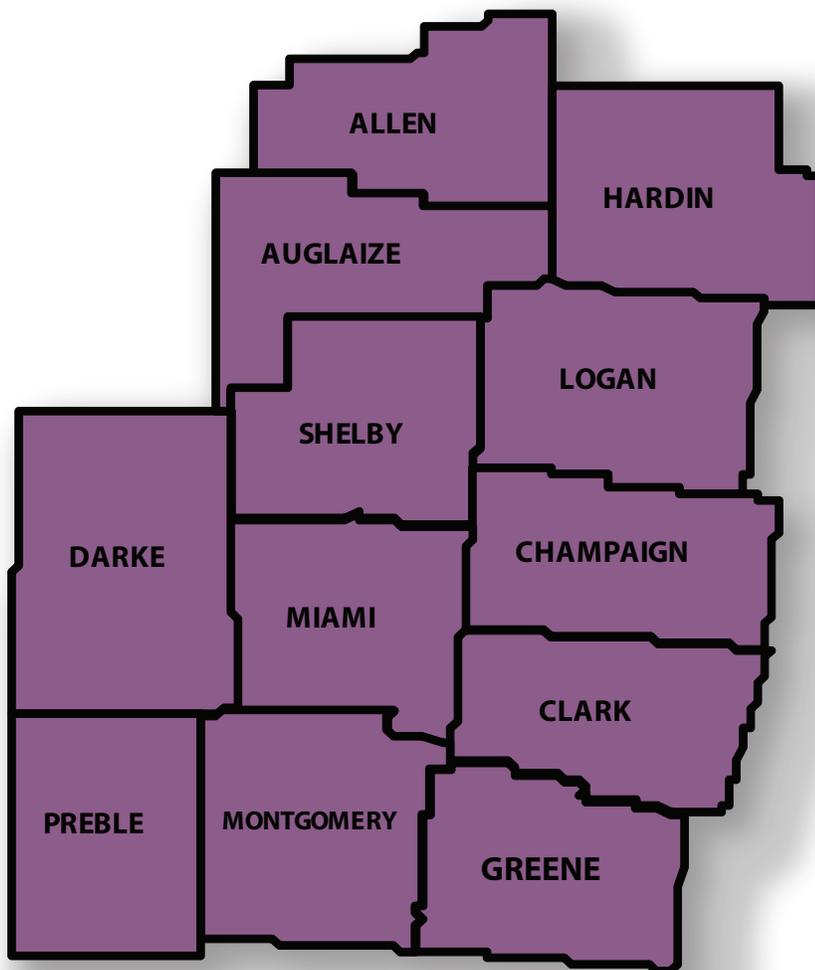
methamphetamine is still most popular in rural areas among White males, although some reported it is also popular as a club drug among gay men. Suboxone® is moderately available and appears to be increasing. While participants reported decreased availability of the pill form, they, as well as community providers, reported that the drug is easy to obtain (usually in film form). Treatment providers attributed the increase to new Suboxone® clinics in the region. Participants agreed that they could easily obtain Suboxone® from these clinics. While many participants reported taking Suboxone® as prescribed, some reported trading the drug for heroin or other drugs. The BCI London Crime Lab reported that the number of Suboxone® cases it processes has increased during the past six months.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Dayton Region

January-June 2012

John R. Kasich, Governor
Orman Hall, Director



Regional Epidemiologist:
Tasha Perdue, MSW

OSAM Staff:
R. Thomas Sherba, PhD, MPH, LPCC
OSAM Principal Investigator

Rick Massatti, MSW
Research Administrator,
OSAM Coordinator

Dayton Regional Profile

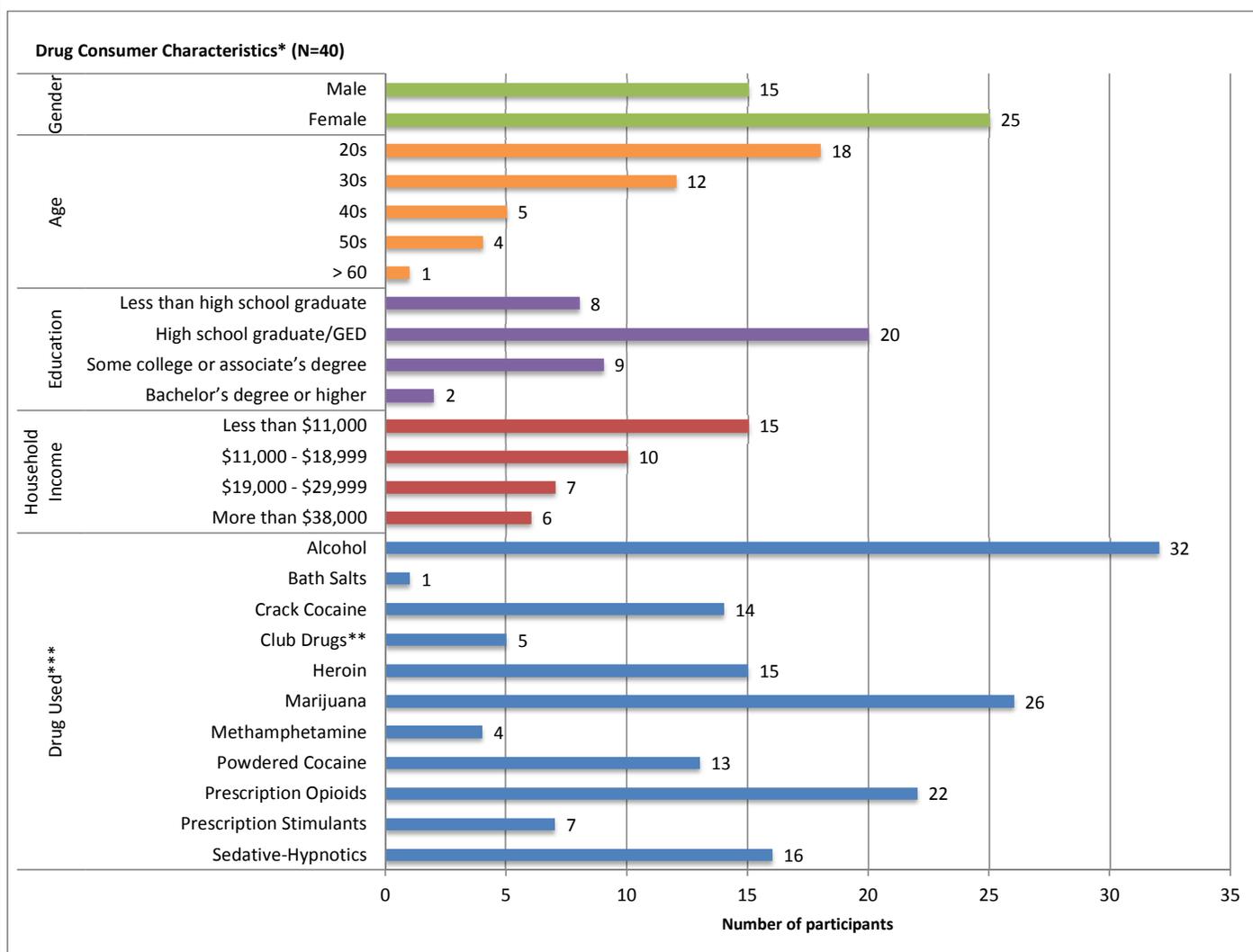
Indicator ¹	Ohio	Dayton Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	1,352,510	40
Gender (Female), 2010	51.2%	51.2%	62.5%
Whites, 2010	81.1%	83.1%	75.0%
African Americans, 2010	12.0%	11.3%	15.0%
Hispanic or Latino Origin, 2010	3.1%	2.0%	0.0%
High school graduates, 2009-2010	84.3%	88.1%	79.5% ²
Median household income, 2010	\$45,151	\$45,115	\$11,000 - \$18,999 ³
Persons below poverty, 2010	15.8%	15.6%	57.9% ⁴

Ohio and Dayton statistics are derived from the U.S. Census Bureau.¹

Graduation status was unable to be determined for one respondent due to missing data.²

Respondents reported income by selecting a category that best represented their household's approximate income for 2012. Income status was unable to be determined for two respondents due to missing data.³

Poverty status was unable to be determined for five respondents due to missing or insufficient data.⁴



*Not all participants filled out forms; therefore, numbers may not equal 40.

**Club drugs refers to Ecstasy and psilocybin mushrooms

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Allen, Hardin, Logan, Miami and Montgomery 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 Logan County Family Court, the Miami Valley Regional Crime Lab and the Montgomery County Juvenile Court. All secondary data are summary data of cases processed from July to December 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, all current secondary data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2012.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine remained highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); community professionals most often reported availability as '7'. Participants reported that the availability of powdered cocaine had remained the same during the previous six months. The Miami Valley Regional Crime Lab reported that the number of powdered cocaine cases it processes had increased during the previous six months. Most participants rated the quality of powdered cocaine as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants closer to Dayton reported better quality, while those in more rural areas reported that powdered cocaine was cut (adulterated) more. The Miami Valley Crime Lab continued to cite levamisole (livestock dewormer) as a common cutting agent for powdered cocaine. Street prices for powdered cocaine were variable among participants with experience buying powdered cocaine, depending on quality and location of the buyer. Participants reported that 1/10 gram of powdered cocaine, or "cap," sold for \$10; a gram sold for between \$30-95. Reportedly, the most common unit of purchase for powdered cocaine was by the gram. Participants continued to report that the most common routes of administration

for powdered cocaine were snorting and intravenous injection. A profile for a typical powdered cocaine user did not emerge from the data. However, powdered cocaine was said to have an elite status, with participants and community professionals identifying those in higher socio-economic classes as more likely to use powdered cocaine.

Current Trends

Powdered 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'. Participants in both rural areas and those within Dayton city limits reported that powdered cocaine is "easy to get." Participants in rural areas stated: *"[Powdered cocaine is] either a phone call or a drive down the highway away; Even if you don't know the right people, the people you do know, know them [cocaine dealers]."* A participant in a rural area commented, *"You can get it [powdered cocaine] through drive-thrus [drive-thru beverage stores] ... there's convenience stores, like corner stores. If you know the right person, ask the right question, you can get it ... you don't have to know who they are."* A participant in Dayton reported, *"You don't even have to know where to go. Just walk down the street and someone's gonna offer it [powdered cocaine] to you."* Another participant commented, *"Even the drug dealers that are forming the crack, you got them using the powder. They using they own product. There's a lot of people that be snorting cocaine."* Community professionals most often reported the drug's current availability as '9'; the previous most common score was '7'. Community professionals agreed that the majority of the powdered cocaine in the community is used to make crack cocaine. A treatment provider discussed, *"Powdered cocaine is available. I think they usually get it in powder and transform it to crack [cocaine]."* Participants and community professionals reported that the availability of powdered cocaine has remained the same during the past six months, although law enforcement identified that current availability is a little lower due to increased demand for heroin. The Miami Valley Regional Crime Lab reported that the number of powdered cocaine cases it processes has increased during the past six months.

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 '6'. Participants reported that powdered cocaine in Dayton is cut with baby laxatives, baking soda and creatine. Other

less-reported substances include: ammonia, ether, ex-lax[®], methamphetamine, powdered sugar, Sudafed[®], Tylenol[®] and Vicodin[®]. A participant reported, "They [dealers] cut it [powdered cocaine] with all kinds of shit." Participants continued to agree that quality depends on from whom you obtain powdered cocaine, with a participant discussing, "It [quality of powdered cocaine] depends on who you get it from. It [quality] can be '10' [high quality]; it can be a '5'; it can be '7'; it can be '1' [poor quality]." Another participant explained, "If you're going to the same person [dealer], you can normally keep it [quality of powdered cocaine] the same. You know, around the same, like it's normally either good or bad. But if you're going to, you know, various amounts of people, yeah, they'll cut it all the way down with laxatives and all kinds of stuff." Participants reported that the quality of powdered cocaine has varied during the past six months, with some respondents in rural areas and within Dayton believing that quality has remained the same, and others reporting that it has decreased, reporting that dealers are "cutting it more ..." A participant explained, "By the time it [powdered cocaine] get up here from down there, by that water, by Miami and everything, it's stepped on [cut with other substances] 10-12 daggone times." The Miami Valley Crime Lab continued to cite levamisole (livestock dewormer) as a common cutting agent for cocaine in addition to benzocaine (local anesthetic). (Note: the crime lab no longer makes distinctions between crack and powdered cocaine).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "blow," "girl," "snow," "soft" and "white." In addition, participants listed the following as other common street names: "bitch," "Christina Aguilera," "Frosty the Snowman," "Fruity Pebbles," "nose candy," "powder," "Richard," "skiing," "skirt," "ya-yo" and "yank." Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine. Participants reported that 1/2 gram of powdered cocaine sells for between \$25-40, depending on quality; a gram sells for between \$40-120; 1/16 ounce, or "teener," sells for between \$80-120; 1/8 ounce, or "eight ball," sells for between \$120-300; 1/4 ounce, or "quarter," sells for \$350; an ounce sells for \$600; a kilo sells for \$17,000. Participants continued to report a gram as the most common way to buy powdered cocaine. Participants also continued to report that the most common ways to use powdered cocaine remain snorting and intravenous injection. Out of 10 powdered cocaine consumers, participants reported that approximately five to seven would snort and three to five would intravenously inject or "shoot." When discussing routes of administration,

a participant explained, "It all depends on what crowd you are around. You can be around 10 people that all snort, you can be around nine people that shoot." Participants discussed a progression from snorting to injecting powdered cocaine, with a participant reporting, "[Route of administration] depends on how long you've done it [used powdered cocaine]. The people I know would be shooting it up." When discussing personal preference for routes of administration a participant reported, "All depends on how much into the needle you are. If they use the needle before, they are going to use the needle all the time." A participant also commented, "Heroin addicts would shoot it. Opiates [prescription opioid users] would snort."

A profile for a typical powdered cocaine user did not emerge from the data. Participants continued to describe typical users of powdered cocaine as "everybody." However, some participants reported that younger individuals are using powdered cocaine more frequently, with one stating, "Younger people like the coke [cocaine] more, 18-30's." Another participant commented on differing perceptions between powdered and crack cocaine: "The younger crowd like, 22-26 [years old], they are coming out and drinking and snorting a little bit of cocaine. And to them, it's like, 'ew, crack and heroin, that's horrible,' but it's okay to sniff a little bit of coke." In discussing the use of powdered cocaine by younger age groups, a participant commented on the ease of access to the drug: "When I was younger, we'd use to have to drive a ways away to get some [powdered cocaine], and now it's five minutes, 10 minutes away." Other participants continued to believe that certain socio-economic classes were more likely to use powdered cocaine. A participant stated, "[Powdered cocaine] that's a rich man's high. You gotta have money to keep doing that." Stigma for powdered cocaine is low, as a participant discussed, "There's not as much stigma on coke as there is crack and heroin and stuff. Coke is a classy drug." Treatment providers described a typical powdered cocaine user as: "partying college students; ... more with Caucasians, specifically men." A law enforcement official agreed, "I think you will find powdered cocaine among the White male and female, fairly affluent party types ... more of the upper-class." However, a community professional differed in opinion and explained, "It doesn't discriminate. However, I've come to find out in the last few months [that] the dealers are buying the powder more than the actual user, 'cause they're the ones that are converting it to crack." Participants and treatment providers agreed that powdered cocaine is more of a "party" type drug.

Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana and sedative-hypnotics.

Participants reported that it is common to use other substances with powdered cocaine, with a participant reflecting, *"I've never seen anybody just use it [powdered cocaine] by itself."* Another participant agreed, *"I think the only time I ever wanted coke was when I was drunk anyway. And then take some sort of opiate or benzo [benzodiazepine] to come down."* Speedballing, mixing heroin with powdered cocaine, was reported as a popular practice, with participants explaining, *"Your heart will race for one minute and then it will slow down and then race back up."* Speedballing will provide the user with, *"two different buzzes"* and is used because *"[Speedballing] it's a better buzz,"* as one participant stated. Another participant discussed the practice of smoking "primos" [marijuana laced with powdered cocaine]: *"Primo keep you level. Just snorting powder ... it have you jittery ... high and fast-paced moving. You on the go like you drunk [sic] 20 cups of coffee somewhere."*

Crack Cocaine Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants and community professionals most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Both groups also agreed that crack cocaine was more available than powdered cocaine. While the availability of crack cocaine remained the same during the previous six months, community professionals thought White users were moving to heroin. Most participants rated the quality of crack cocaine as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The Miami Valley Regional Crime Lab reported that crack cocaine continued to be cut most often with levamisole (livestock dewormer). Participants reported that a "rock" (1/10 gram) sold for between \$10-20; a gram sold for between \$100-120 depending on the quality. The most common route of administration remained smoking, and intravenous injection was reportedly rare. Most participants described typical users of crack cocaine as belonging to both genders and every racial and age group.

Current Trends

Crack cocaine remains highly available in the region. Participants and community professionals 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'. A participant in Dayton remarked that crack cocaine is a *"double ten"* in availability. Individuals from rural areas



closer to Lima remarked *"Lima bound"* when discussing how they obtained crack cocaine. An individual discussed territorial fights over crack cocaine in Dayton: *"You got the dope dealers wanting to fight and rob each other 'cause they are jealous where you are going [to buy crack cocaine]. I know what building I got to and you got three dope spots in the same apartment building ..."* Another participant discussed the link between heroin and crack cocaine: *"I could never find the stuff [crack cocaine] until I started doing heroin. Normally if you're just asking for a bag of weed [marijuana], it's not going to come out, 'oh, yeah I got some hard' [crack cocaine]. But, if you're asking somebody for heroin or cocaine, [the dealer] comes out like with it, you know. You know anybody that wants some hard, you know we got it."* A community professional said crack cocaine is available *"all day and all night."* Participants and community professionals reported that the availability of crack cocaine has remained stable during the past six months with possibly a slight drop because people are *"looking for stronger drugs,"* as one stated. The Miami Valley Regional Crime Lab reported that the number of crack cocaine cases it processes has decreased during the past six months.

Most participants rated the quality of crack cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '7'. Participants reported that crack cocaine in Dayton is cut with baby formula, baking soda, bath salts, and super glue. Participants discussed being sold items that were not crack cocaine. A user explained, *"Some people will sell you soap, candle wax, drywall, peanuts; they will take drywall out and sell that [as crack cocaine]."* Participants reported that the quality of crack cocaine has generally remained the same during the past six months. The Miami Valley Crime Lab continued to cite levamisole (livestock dewormer) as a common cutting agent for cocaine in addition to benzocaine (local anesthetic). (Note: the crime lab no longer makes distinctions between crack and powdered cocaine).

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: "A-1," "candy," "chicken wings," "dope," "medicine," "work" and "ya-yo." Current street prices for crack cocaine were consistent among participants with experience buying the drug. Participants reported that a "rock" (1/10 gram) sells for between \$10-20; 1/2 gram sells for \$30; a gram sells for between \$80-100; 1/8 ounce, or "eight ball," sells for between \$150-250. Participants discussed purchasing different

sized “rocks” with one participant explaining, “You can get a nickel rock if you wanted it, but it ain’t gonna do nothing but tease yo’ ass and make you wanna do that shit some more.” Another participant commented on the common practice of purchasing rocks: “Everyone I’m around gets a \$20 or \$30 [rock of crack cocaine] because they are normally just doing it to shoot it up, so it doesn’t take much [to get high].” Areas differed in the use of scales to weigh the crack cocaine with one participant reporting, “It’s always weighed in my experience. The more quantity you purchase the more likely it [crack cocaine] is to be weighed,” and another stating, “Depends on who you are messing with. If they are legit they’ll weigh it [crack cocaine], but if they are not they’ll just kinda eyeball it and throw it at you cause normally [individuals buying crack cocaine] they’re not going to argue.” While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. Out of 10 crack cocaine consumers, participants reported that approximately 10 would smoke. However, in rural areas participants reported intravenous use and said that out of 10 crack cocaine users, approximately five to six would smoke and four to five would intravenously inject or “shoot.” A participant commented on the rarity of snorting crack cocaine: “If you’re gonna snort it [crack cocaine], you’ll just buy coke [powdered cocaine].”

A profile of a typical user of crack cocaine did not emerge from the data. Participants were divided in how they described typical users. Participants commented that addicts are more likely to use crack cocaine. A participant explained, “An addict [is the typical crack cocaine user]. You can do [powdered] cocaine when you are out at the bars drinking [alcohol] and stuff, but once you really get addicted most everybody turns to doing crack ‘cause it’s cheaper. I don’t see any casual crack users, but there’s casual coke users.” Another participant agreed, “Any addict that their drug of choice is coke probably would [use crack]. Eventually coke would stop working and then, just like me, I was an opiate user and then the pills stopped working.” Other participants did not specify a typical user and explained “everybody’s welcome” and “it could be anybody.” A participant expressed the varied use of crack cocaine, “You got 12 year olds out there smoking [crack cocaine]. It [crack cocaine] ain’t got no discrimination, like a bullet ain’t got no eyes.” Community professionals in the Lima area explained that crack cocaine users are “getting younger” and include “13 year olds.” A community professional discussed the use of crack cocaine in his neighborhood: “[Younger population] they’re getting introduced to it [crack cocaine] by other people they want to hang around with [older

individuals]. In my neighborhood alone I’ve seen an increase in the younger ones that are coming to the different places and visiting [where crack cocaine is used] ... I’m like, golly, that’s somebody’s baby.” Law enforcement identified that lower socio-economic groups are more likely to use crack cocaine. In addition, an officer said “both Blacks and Whites” are likely to use the drug along with “older men that are going through their mid-life crisis.”

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics to assist crack cocaine users in “coming down” and “sleeping.” Participants reported that alcohol is the most common substance to assist the crack cocaine user in “coming down” and that heroin is used for the “speedball” effect. Generally, participants reported that it is not common to use other drugs with crack cocaine. However, several participants also identified using crack cocaine after using prescription opioids as one participant explained, “If you pop a pill [prescription opioid] you be down, you want something to wake you up, so you get to smoking the crack. You’re gonna come back up.”

Heroin Historical Summary

In the previous reporting period, heroin remained highly available in the region. Participants and community professionals most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). While many types of heroin were available in the region, participants reported the availability of brown powdered and black tar heroin as most available. Participants and community professionals reported that the availability of heroin had increased during the previous six months. Participants linked the increase in heroin to the formulation change in OxyContin® that occurred in September 2010. The Miami Valley Regional Crime Lab reported that the number of heroin cases it processed had also increased during the previous six months. Most participants generally rated the quality of heroin as ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality), while also reporting that quality had generally decreased during the previous six months. According to the Miami Valley Regional Crime Lab, cutting agents for heroin continued to include: caffeine, diphenhydramine (antihistamine) and lidocaine (local anesthetic). Participants reported that brown and white powdered heroin were available in different quantities: “balloons” (1/10 gram) sold for \$25; a

gram sold for between \$65-200. The most common way to purchase powdered heroin was by caps, which sold for between \$10-20 depending on location. Those who lived further from Dayton or other larger cities paid more for the drug. Participants reported that black tar heroin was most commonly purchased in single-use amounts, or as a participant identified, “berries,” that sold for between \$15-30. Overall, participants reported heroin pricing had increased during the previous six months. Participants also reported that the most common route of administration for heroin remained intravenous injection. A profile of a typical heroin user did not emerge from the data. However, participants and community professionals agreed that there had been an increase in younger users of heroin, and both groups linked the increase in heroin use to prescription medications and prescribing patterns. Coroner’s office staff reported that heroin was the leading cause of death by overdose, and that heroin-related overdoses had increased in the region.

Current Trends



Heroin remains highly available in the region. Participants and community professionals most often reported the overall availability of the drug as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10’. While many types of heroin are currently available in the region, participants continued to report the availability of brown powdered heroin as most available. However, participants continued to note high availability of black tar heroin as well, rating its availability also as ‘10’. Black tar heroin was said to be available in areas of the region closer to Columbus. A participant in Hardin County explained the availability of black tar heroin: “I’ve seen mostly tar [black tar heroin] around here. It comes from Columbus and powder [powdered heroin comes] from Dayton.” Other participants discussed greater access to powdered heroin: “Here in Lima the most common [type of heroin] is powder; You gotta go to Columbus for that [black tar heroin]; I’ve tried to get it [black tar heroin] several times and I’ve never been able to get it.” Community professionals generally most often reported the current availability of black tar heroin as lower than that of powdered heroin, with law enforcement rating availability of black tar heroin as ‘3’. Black tar heroin was not familiar to many treatment providers. A treatment provider explained,

“I think [black tar heroin] it’s harder for them [heroin users] to melt down [for intravenous injection].”

Participants commented on the “epidemic” proportions that heroin has reached in the region. A participant reported, “[Widespread heroin use] it’s more than an epidemic. It’s a plague. It’s eating away at the people.” Even respondents who did not use heroin personally reported friends or family members who did. A participant recounted his experience with family members and heroin: “I had people in my family do it [heroin], and I seen [sic] how they be nodding. One time I came over to my cousin’s house and I wondered what took him so long [to answer the door]. So the door was open and he was sitting on the toilet with the needle stuck in him, so I picked him up, I put him in the bathtub and ran cold water and went and got some ice and I brought him back ... scared me. If I wouldn’t have done that, he wouldn’t be here.” Free “testers” of heroin remain available in Dayton which makes it difficult for individuals to avoid the drug. A participant commented, “... you can’t even really drive through Dayton and sit at a [traffic] light without somebody going, ‘Testers. Testers. We got free testers.’ Throwing them in your car, like here, ‘just get high and come to me’ ... I mean it’s right there. Even if you weren’t a heroin addict, you know what I mean, you’re gonna want to do it because it’s free, and it’s just right in your face.” Law enforcement also identified free samples as prevalent in the Dayton region. Although brown powdered heroin is the most commonly cited type of heroin, participants consistently also rated the availability of white powdered and black tar heroin as ‘10’. A law enforcement official discussed when heroin became prevalent in the Dayton area: “Probably about two years ago, 2010 [heroin’s popularity exploded], and it’s just cranked up [increased] ... because everything was crack [cocaine]. I can remember never getting heroin arrests ever and then it slowly [increased] and now we hardly ever get crack around here.”

Collaborating data also indicated that heroin is readily available in the region. According to the Logan County Family Court, among adults screening positive on urine drug screens during the past six months, 65.2 percent of the positive screens were related to opiates (Note: Opiates refers to heroin and prescription drugs.). In contrast to adults, 6.0 percent of the positive urine drug screens in juveniles were related to opiates. In addition, media outlets in the region reported on heroin seizures and arrests during this reporting period. In March, Ohio State Highway Patrol troopers discovered eight kilos of heroin estimated at \$1.2 million

when a speeding vehicle was stopped in Preble County (www.nbc4i.com, March 21, 2012). Also in March, Delphos Police (Allen County), along with the West Central Ohio Crime Task Force, arrested 14 drug dealers for trafficking in heroin, marijuana and several other controlled substances (www.timesbulletin.com, March 17, 2012).

Participants and community professionals reported that the availability of powdered heroin has increased during the past six months. Prescription opioid abuse continues to be linked with the increase in heroin availability and use. A treatment provider stated, *"Because the pills [prescription opioids] are expensive, so once the addiction has kicked in, you know, heroin is cheaper."* Participants in rural areas close to Columbus reported that the availability of black tar heroin has increased during the past six months. Law enforcement reported that availability of black tar heroin has remained stable during the past six months. The Miami Valley Regional Crime Lab reported that the number of heroin cases it processes has remained the same during the past six months.

Most participants generally rated the current quality of heroin as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was also '8.' Participants reported that heroin in Dayton is cut with baby formula, bouillon cubes, coffee, dog food, green tea tablets, ramen noodle flavor packets and vitamins. Reportedly, quality *"depends on who you get it from,"* and the cutting agents, *"depends on what they got in their cupboards,"* according to participants. Participants reported that the quality of heroin has remained the same during the past six months. A community professional commented, *"I think the quality of it [heroin] has gone down because there's been an increase in deaths."* According to the Miami Valley Regional Crime Lab, cutting agents for heroin include: acetaminophen, caffeine, diphenhydramine (antihistamine) and lidocaine (local anesthetic). In addition, the crime lab reported that they have processed white, gray, tan and brown colored heroin.

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "dog food." Other common names include: "dope," "fire," "H," "junk," "Kibbles and Bits," "smack," "Superman," "tar" and "yak." Participants reported that brown and white powdered heroin are available in different quantities: 1/2 gram sells for \$40; a gram sells for between \$60-200; 1/2 ounce sells for \$350; an ounce sells for between \$400-500; a kilo sells for \$14,000. A tenth of a gram (aka "caps," "balloons" and "berries") remain the most popular way to purchase powdered and black tar

heroin. Caps of powdered heroin sell for between \$10 in the major cities to \$20 in rural areas. Some respondents reported purchasing three caps for \$20 and eight to nine caps for \$50. Law enforcement identified a cap selling for \$7 or two for \$12 but, as one law enforcement official stated, *"you don't get a full 1/10 gram either. You might get 1/5 or 1/6."* Berries of black tar heroin sell for between \$10-20; balloons sell for between \$10-25. Prices can vary as one participant explained, *"People are out there busting heads [charging high prices]. Twenty to 30 bucks just for one cap."* It is common for individuals from rural areas to travel to larger cities and bring large amounts of heroin back to sell. A participant reported, *"People will go to the bigger cities and buy a gram [of heroin] for \$100 and bring it back to Lima and then flip it [sell it to make a profit]."* The actual amount of heroin sold in rural areas is often less than 1/10 of a gram and is usually cut more. A participant reported, *"It seems like up here [heroin amounts] they're smaller though than what you get in the city; around here most people cut it down."* A law enforcement official discussed the movement of heroin throughout the region: *"A lot of the smaller towns will have one or two runners who will come in and buy a whole bunch [of heroin] and go back to their towns and sell it."* Dayton was identified as a "hub" for heroin, with a law enforcement official discussing the wide range of people from other cities coming in to buy heroin: *"We get them [heroin runners] from Cincinnati; we get them from Columbus ... from Richmond [Indiana], especially your northern counties ... they all follow it [heroin] here to pick it up."* A treatment provider also discussed the movement from rural areas: *"A lot of rural counties are coming into the city, our community and purchasing [heroin]. We noticed it was a lot of like, young Caucasians, the young Caucasians from the rural areas coming into the community."* Overall, participants reported heroin pricing has remained the same during the past six months.

Participants reported that the most common ways to use heroin are snorting and intravenous injection. Out of 10 heroin consumers, participants reported that approximately 0-5 would snort and 5-10 would intravenously inject or "shoot." Most participants continued to report starting out snorting before progressing to shooting heroin. Other heroin users will also teach beginner heroin users about using needles. A participant explained use progression as follows: *"If you're just starting out, usually you snort it [heroin]. Once people see that you're doing it [snorting heroin], they're like, 'here do it this way [inject rather than snort], it's better,' and that's how people really get hooked on it."* A community professional also noted this use progression and commented, *"They [heroin users] start off snorting and then go*

onto intravenous [injection].” The availability of needles was a concern for many participants, especially those in rural areas. Participants reported that pharmacies continue to require a prescription to obtain needles. Participants commented on the difficulty of obtaining needles: *“Used to be you could go into any pharmacy and just show your ID [to purchase needles] but not anymore; You can still go to [a big-box retail store] and get a box with just your ID but that’s about the only place, and it’s only certain [ones].”* Another participant reflected on the consequences of being unable to locate needles: *“Needles were also more readily available a year or two ago. Now it’s like impossible for them to get. So, now it’s like they do share ‘em.”* When participants with experience injecting heroin purchase needles from stores, they usually range in price from \$1.98 for a pack of 10 to \$15 for a pack of 100 at popular retailers. Heroin users can also purchase needles from dealers ranging from \$1-3 per needle, although some participants reported selling their needles for more, with one participant claiming, *“I got someone to pay \$10 for one [needle].”*

The lack of available needles to purchase has caused some heroin users to reuse their own needles or share needles. A participant explained that when sharing needles heroin users will *“rinse it with water, which ain’t cleaning it. They just dip it in the water like twice and squirt it out. That’s it.”* When questioned if heroin users are concerned about sharing needles one participant responded, *“I’m sure people are worried about it [sharing needles] but when you are dope sick and need to get high, you just don’t care.”* Needle exchange programs in other cities were discussed with one participant commenting, *“She [a counselor] was saying that even though she doesn’t want people out getting high she would rather, you know, there be somewhere around that does that [needle exchange] just because of the Hepatitis and AIDS. If they’re gonna do it, at least keep them, you know what I mean, where their blood is healthy.”* Participants agreed that heroin has become a pressing health concern throughout the region. Most participants have personally known someone who has overdosed. Participants reflected on administering life-saving techniques to individuals who overdosed: *“I’ve seen that a bunch of times myself [overdose]. I’ve had to give CPR three different times to people; The one cousin overdosed, and my uncle had to bring him back to life.”* Many participants have had someone they know die from an overdose with one participant commenting, *“I know of at least ten people that has [sic] died from an overdose.”* Another participant stated, *“I know six people in the past two years that have died and about three or four that have overdosed and lived. And those are all from fentanyl patches or heroin.”* Overdoses were reported to

affect smaller towns as one participant discussed, *“My town don’t even have a traffic light, and I know three people that’s died [overdosed], and there’s maybe 300 people that live in that town.”* Another participant shared her history of overdosing: *“I’ve overdosed probably about 10 to 12 times in my life.”* A law enforcement official reflected on the overdose rates in the area and commented, *“We [in Montgomery County] have the highest overdose rate of any county in Ohio.”*

Hepatitis C is another increasing concern among all participants with most participants reporting that they know someone who has Hepatitis C. A few participants discussed the prevalence of Hepatitis C in their circle of friends, with one participant reflecting, *“I don’t think I know anybody who doesn’t have Hepatitis.”* Another stated, *“Eighty percent of the people I run around with [have Hepatitis C].”* In one rural area, some participants discussed that an individual is spreading Hepatitis around the community, *“Just in our little towns, in Champaign County, I know a lot of people that have Hepatitis from one girl. And, that girl that’s giving it to so many people tells them, ‘I have Hepatitis but you can use my needle,’ and they’re so dope sick they don’t care.”* When reflecting on the impact of heroin another participant commented, *“You never hear of an old heroin addict. They’re either dead, in prison or quit.”* Incarceration was also discussed as a consequence of heroin use, as a participant discussed her experience, *“I just got out [of prison] and me and one other girl was the only ones sitting in there for pot and the rest was heroin — and there was [sic] 31 people in there.”* Participants also linked an increased risk of overdose when heroin users are released from jail or prison as a participant explained, *“I’ve heard it often that for heroin users after they do jail time or prison time, after they get out some of them try to do the same amount that they were doing before they got locked up. And that’s what causes them to overdose. Because it’s too strong for them.”*

Community professionals and law enforcement described a typical user as, *“young [late teens, early 20s], middle-class Caucasians,”* with a treatment provider commenting, *“[Heroin use] it’s starting to spill over into the African-American community, but not as much.”* Law enforcement also identified that White individuals are more likely to use heroin while African-American individuals are more likely to sell heroin. Participants described typical users of heroin as younger individuals primarily in their 20s and 30s, and individuals who had previously been prescribed pain medications. This was thought to also be increasing in the high school age group as athletes get injured or students get into accidents and get prescribed pain medications. A participant discussed

a family member's abuse of heroin: *"Even the kids in school playing sports. My niece. She was involved in everything [in high school]. Got in a car wreck and started out with pills and went to heroin. These kids were not addicts before."* Other participants recounted their experience with pain medication: *"I was on it for three months and was addicted. I was eating more and more each month, every day. I'd run out and try to buy some. I got put on oxy's [OxyContin®] ... and I never took pain medicine before ... and I was addicted within the first month I took them. You never took them before, so [you think], 'oh, I won't get addicted.'" Another participant agreed, "That's what happened to me. I tore my ACL [major ligament in the knee]." The participant with health care experience discussed prescribing patterns, *"They [physicians] are giving oxy's to like shoulder surgeries and stuff like that. They don't need to do. [They are prescribing] a couple week's worth, and it only takes a couple of days [to manage the pain]." Addictions in youth were linked to parents being uneducated on the issue, with one participant stating, "A lot of parents trust doctors too [much] you know. If they've never been around anything like that, they trust these doctors' judgments, and they trust them to take care of their children."* A participant who became addicted as a result of surgery agreed, *"This stuff wasn't around when my parents grew up, so they are oblivious to it all."* Another participant mentioned that OxyContin® is so addictive that it's like *"synthetic heroin."* Participants discussed their thoughts on blaming doctors, *"It was all my fault. I'm not blaming the doctors. I'm saying that they can give you something else to start you with. There's something else they can give you; Yeah, they could've given me Vicodin® to take care of what pain I did have."**

Most participants with experience using heroin discussed starting with prescription pain pills and then progressing to heroin once the pills became too expensive or the pills were no longer enough to get them high. Reflecting on the increase in heroin and the varied use, a community professional commented, *"Once the economy plummeted I think, you know, people started getting depressed. People that were working ... and I think they kinda started resorting to drug use. So, I think there may be an increase due to the economy."* Another professional agreed that the economy played a role and also noted the link between prescription pain killers: *"I think there's a correlation with the increase in prescription pain killers in some of it too. When people stopped being able to get Vicodin®, or stopped being OK with the high they get from the Vicodin®, then they can move onto the harder stuff, which is heroin."* Teens were also identified as taking prescription pills from their parents' medicine cabinet as a community professional explained, *"You also hear a lot of them. Their*

usage starting from hitting the medicine cabinet of their parents."

Reportedly, heroin is used in combination with cocaine, marijuana, prescription opioids and sedative-hypnotics. Participants use other substances with heroin because, *"you need less of the opiate [heroin] when you use something else; it's way better that way; after a while you don't get as high from the heroin."*

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids remained highly available in the region. Participants and community professionals most often reported availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants continued to identify methadone, Percocet® and Vicodin®, along with OxyContin® and Roxicet®, as the most popular prescription opioids in terms of widespread use. Community professionals identified methadone, OxyContin® and Vicodin® as most popular. Coroner's office staff reported that methadone was the second-leading drug in drug-overdose deaths (after heroin). While participants reported that the availability of prescription opioids had decreased during the previous six months, the region experienced an increase in availability of methadone. Participants attributed the perceived decrease in availability of prescription opioids to the rise in popularity of heroin. Some participants in Dayton also felt that doctors had cut back on prescribing. Community professionals reported that availability of prescription opioids had remained the same during the previous six months. However, they also reported that methadone and Opana® were increasing in availability. The cost of prescription opioids was said to be a deterrent to using them. 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, snorting was identified as the most common route of administration for prescription opioids, with the exception of methadone. In addition to obtaining prescription opioids on the street from dealers, participants continued to also report obtaining them from doctors, clinics and family or friends. A profile of a typical user of prescription opioids did not emerge from the data.

Current Trends

Prescription opioids remain highly available in the region. Participants and community professionals most often

reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants identified Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use, with Opana® and OxyContin® as popular in different areas of the region. A participant commented on the rising popularity of Opana®: "*[Opana® is] a lot stronger than the oxy's [OxyContin®] were, and you can snort 'em, shoot 'em, whatever.*" Although participants reported that prescription opioids are highly available, they are not the most sought after type of drug. A participant discussed interest in other substances: "*Heroin and cocaine are becoming more, I think, are becoming more of a fad you know. Typically because, you know, there's so many more people experimenting [with] it [heroin] and liking it ...*" Community professionals identified methadone, OxyContin®, Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use. A community professional commented, "*Their choice would be methadone or OxyContin® if they could get it, but ... it's the Vicodin® and Percocet® [that are] readily available.*" Participants and community professionals reported that the availability of prescription opioids has remained stable during the past six months. The Miami Valley Regional Crime Lab reported that the number of prescription opioid cases it processes has generally remained the same during the past six months; noted exceptions were increases in Opana® and fentanyl, and decreases in oxycodone hydrochloride and acetaminophen (Percocet®), hydrocodone and acetaminophen (Lortab®, Norco®, Vicodin®) and morphine.

Reportedly, many different types of prescription opioids (aka "boogers," "candy" and "Easter eggs") are currently sold on the region's streets. Participants reported the following prescription opioids as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): methadone (3 mg sells for \$3; 5 mg for \$5, 10 mg sells for between \$10-15; 80 cc's of liquid methadone sells for between \$15-20), Opana® 40 mg (aka "panners;" sells for between \$40-60), OxyContin® OC (aka "OCs" and "oxy's;" usually sells for \$1 per milligram; 80 mg sells for between \$65-80), Percocet® (aka "Ps" and "perc's;" sells for between \$4-30, with a common amount of \$1 per milligram), Roxicet® 30 mg (aka "roxi's;" sells for \$20), Vicodin® (aka "Vs," "vikes" and "vikings;" 375 mg, aka "baby vikes" sells for \$2.50; 500 mg sells for \$3; 1,000 mg sells for \$10). 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

routes of administration remain snorting and swallowing, with snorting indicated as the preferred method. However, participants indicated that the consumption method varies between individuals and by personal preference, as a participant explained, "*If you want your pill [prescription opioid] to kick in right then, you're going to snort. If you want a slower buzz, [you'll take it] by mouth.*" Another participant discussed that the route of administration depends on what point the user is in his or her addiction: "*People that was just using them [prescription opioids] by the doctor and would start getting addicted to them, they'd eat them, but people that are actual into doing drugs to get high, would snort them.*" A participant discussed the practice of parachuting: "*[Parachuting] is where you crush them [prescription opioids] real fine in a teeny piece of toilet paper and you swallow them.*"

In addition to obtaining prescription opioids on the street from dealers, participants also continued to report obtaining them from the emergency room and doctors. Reportedly, prescription opioids are more difficult to obtain from health care facilities, although a participant claimed, "*I know people, especially girls, somehow that can pull it off [obtaining prescription opioids from a health care setting] any day of the week. There are a lot of girls who get away with getting the pain pills more so than the guys.*" Individuals also reported purchasing prescriptions from individuals with one participant stating, "*Most of the time the people had like three scripts [prescriptions] and you'd pay for their scripts and they'd give you all of them.*"

A profile of a typical user of prescription opioids did not emerge from the data. Participants described typical users of prescription opioids as "same as heroin" and a participant commented that typical users are "*people who have either gotten into an accident or can't find dope [heroin] right away.*" Treatment providers agreed that prescription opioid use is "across the board." A law enforcement officer stated, "*A lot of your heroin users are using it [heroin] because they can't get their scripts [for opioids] filled anymore.*" Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with marijuana, sedative-hypnotics, and most commonly alcohol. Substances are used to, as one participant stated, "*intensify [the high of prescription opioids]; it's a better rush.*" Reportedly, individuals will also use different substances on weekends versus weekdays, as a participant explained, "*Depends on what day it is and stuff like that too. Friday and Saturday is party time. People are gonna drink more [alcohol], so their gonna do pills [prescription opioids] with their drinking. But during the week, they'll just*

snort the pill and smoke a [marijuana] joint and do some Xanax® with them [prescription opioids]."

Suboxone®

Historical Summary

In the previous reporting period, Suboxone® was moderately available in the region. Participants most often reported availability of Suboxone® as '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); community professionals most often reported availability as '3.' Treatment providers identified Suboxone® as difficult to obtain. Most treatment providers identified Suboxone® as being used as directed and for, as one stated, "serious recovery." Community professionals reported that availability of Suboxone® had remained the same during the previous six months. The Miami Valley Regional Crime Lab reported that the number of Suboxone® cases it processes had increased during the previous six months. The most common form of Suboxone® was the 8 mg pill or strip. Participants thought Suboxone® strips were more widely available than pill form. Participants reported that Suboxone® 8 mg sold for between \$10-20 from drug dealers. In addition to obtaining Suboxone® on the street, participants also reported getting the drug from a pharmacy with a prescription or through a clinic. Most often participants continued to report taking Suboxone® sublingually (dissolving it under the tongue). A participant described typical users of Suboxone® as "people who really need to use it [Suboxone®], or those who want to sell it to buy heroin."

Current Trends



Suboxone® remains moderately available in the region. Participants reported availability of Suboxone® as '6' 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 '6.' Participants were divided in opinion regarding the availability of Suboxone®. A participant remarked, "To be honest I think you should be able to get more of those [Suboxone®] around here. That's just me because it's an opiate blocker and people are turning to methadone to get cured." Other participants explained, "If you can't get it [Suboxone®] in the clinic, you get it on the street; if you got the money to go to the clinic, they [Suboxone®] are available." Community professionals most often reported the drug's current availability as '7'; the previous most common

score was '3.' However, community professionals were also generally divided on Suboxone® availability throughout the region with those from rural areas, as well as law enforcement reporting higher availability. Providers from Dayton reported lower availability. A community professional in a rural area commented, "Cause they [users] can get it [Suboxone®] easy from doctors. They prescribing it to them." Another community professional agreed, "I think the mental health agency here is doing a thing, a big thing with Suboxone®, so they're getting more clients." In Dayton, treatment providers discussed limited prescriptions of Suboxone®, with a community professional commenting, "A lot of doctors are not prescribing it [Suboxone®]. Even the doctors that are certified don't want to do it, so it's almost impossible to find a doctor [to prescribe Suboxone®] ... all because of the monitoring piece [for diversion] ..."

Media outlets in the region reported on Suboxone® seizures and arrests during this reporting period. In March, the Ohio State Highway Patrol seized a variety of drugs during a routine traffic stop in Preble County – seized drugs included 36 pounds of hydroponic marijuana, 19.2 grams of hashish and Suboxone® with a combined street value of approximately \$180,000 (www.local12.com, March 15, 2012). Participants reported that the availability of Suboxone® has remained stable during the past six months, while community professionals reported that availability has increased, linking the increase to the increase in opiate use. A community professional stated, "With the increase of the opiate use, now people are getting the Suboxone® to sell them." The Miami Valley Regional Crime Lab reported that the number of Suboxone® cases it processes has increased during the past six months.

No slang terms or street names were reported for Suboxone®. Participants reported that Suboxone® 8 mg sells for between \$8-20; a month's prescription sells for \$300. A treatment provider commented, "I've got a client that can get it [Suboxone®], and it's \$10 a pill ... and that's why he doesn't [use Suboxone®] because it's expensive." Most often participants continued to report taking Suboxone® sublingually. Participants reported that strips are the most common form of Suboxone® available. In addition to obtaining Suboxone® on the street from dealers, participants also continued to report getting the drug from doctors and pain clinics. Suboxone® obtained from the medical field was also identified as expensive. A treatment provider reported, "From what I understand, the first visit for Suboxone® is \$275 and \$150 every visit after that. And you have to be monitored,

so we're talking several hundred dollars a month for something. And that is out-of-pocket, that's not insurance covering. Nobody can afford that."

A profile for a typical Suboxone® user did not emerge from the data. Participants varied in their description of typical users of Suboxone®. A participant explained, *"People only want Suboxone® who are trying to get clean. No one's going to go looking for it to get high."* Other participants discussed misuse of Suboxone®: *"Use it [Suboxone®] to either get out of dope sickness or get a cheap high. If you are not dope sick, you can get off [high] on it; Go get them [Suboxone®], so they can sell and get some heroin."* Community professionals also varied in their discussion of typical users of Suboxone®: *"An individual serious about recovery; individuals prescribed Suboxone® who sell to buy other substances."* Law enforcement officials identified Suboxone® users as, *"White; males, females; younger."* A law enforcement officer stated, *"I don't know of any African Americans we've arrested that have had Suboxone®."*

Reportedly, Suboxone® is used in combination with marijuana because it *"helps to keep from being sick,"* as one participant stated, and sedative-hypnotics because, *"Xanax® goes good with anything,"* as another one said. It was often reported that it is not common to use other substances at the same time as Suboxone®, but individuals may use heroin shortly after the use of Suboxone®. Participants explained, *"Some people will do heroin on top of it [Suboxone®], but that was after they couldn't do heroin first; I've taken Suboxone® before in the past, and then done heroin, and it really didn't ... I didn't feel much of a high from the heroin because of the Suboxone®; I know when I would, if I was to wake up in the morning and not have anything I would take Suboxone®. Two hours later I might be able to get something [heroin], so I would do it. I wouldn't do anything at the same time [with Suboxone®]."*

Sedative-Hypnotics

Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants and community professionals most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Both groups identified Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use, and reported that the availability of these drugs remained the same during the past six months, with

the exception of Klonopin®, which had increased. Many participants said increased availability of Klonopin® was due to physician's new prescribing practices. The coroner's office reported sedative-hypnotics, specifically Xanax®, as the third-leading drug involved in overdose deaths. The Miami Valley Regional Crime Lab reported that the number of sedative-hypnotic cases it processes had remained the same during the previous six months with a few exceptions: an increase in cases of Ambien® and Valium®, and a decrease in cases of Ativan® and Xanax®. The most common routes of administration for sedative-hypnotics were oral ingestion and snorting. Participants and community professionals reported that it was difficult to establish a typical user profile, but Xanax® appeared to be popular among the 18-25 year age group, with the highest use reported to be among those in their late 20s and early 30s.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants and community professionals most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants identified Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use; participants from rural areas also identified Ativan® and Soma® as popular. Community professionals identified Ativan® and Xanax® as most popular. In addition, a treatment provider indicated that Soma® is *"making a comeback ... [Soma®] it's supposed to make some of the psychotropic medications [ones that act on the central nervous system] a little more intense ..."* Participants and community professionals reported that the availability of sedative-hypnotics has generally remained stable during the past six months. However, community professionals noted Soma® and Xanax® as exceptions; both were thought to have increased in availability. The Miami Valley Regional Crime Lab reported that the number of sedative hypnotic cases it processes has decreased during the past six months. Media outlets in the region reported on seizures and arrests involving sedative-hypnotics during this reporting period. In March, police stopped two Kentucky men for a traffic violation and found 518 capsules of Xanax® in Tipp City (Miami County) (www.whiotv.com; March 23, 2012).

Reportedly, many different types of sedative-hypnotics (aka "footballs," "pills" and "pins") 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): Klonopin® 1 mg (aka “forget-a-pins” and “forgets;” sells for between \$1-2), Xanax® (0.5 mg, aka “peaches,” sells for between \$0.25-2; 1 mg, aka “footballs,” sells for between \$2-3; 2 mg, aka “bars” and “school buses,” sells for between \$5-7) and Xanax XR® 3 mg (aka “pinwheels,” sells for between \$6-7). While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, generally, the most common routes of administration are eating (chewing the pills before swallowing), swallowing and snorting. Out of 10 sedative-hypnotics users, participants reported that 5-9 would snort the drugs and 1-5 would eat or swallow the pills. A participant explained, *“A lot of people don’t really swallow. It’s called eat[ing],”* and another participant said this method is preferred because it’s a *“different buzz when you eat them versus swallow.”* A minority of participants reported injecting sedative-hypnotics; heroin addicts were identified as individuals who would be more likely to inject sedative-hypnotics.

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported obtaining them from pharmacies and physicians. Participants reported dealers as the most frequent way to obtain sedative-hypnotics with one participant explaining, *“You’re going to get anything from a dealer before you go to an on-line pharmacy or the hospital. Most people I know had to go through a whole bunch of shit to get the prescription. Like evaluations and everything else.”* Another participant agreed, *“[For] most addicts, it’s a dealer.”*

A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants reported that nearly every demographic used the drugs. A participant explained, *“Because I know a lot of older people too that need ‘em [sedative-hypnotics] because they really need them, so they buy them off the street, you know what I mean ... but then I know younger people who do it to get high to just forget things or to be numb.”* Both treatment providers and law enforcement identified an increase in young adult users (high school and college age). Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, heroin, marijuana and prescription opioids. Participants reported that it is “common” to use other substances with sedative-hypnotics because, as one stated, *“nobody does just that [sedative-hypnotics].”* Sedative-hypnotics are used in combination with other drugs to intensify the effect of the other drugs, and also because they, *“go good together,”* as one participant stated.

Marijuana

Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants and community professionals most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants and community professionals reported that the availability of high-grade marijuana had increased during the previous six months due to “harvest season.” Law enforcement and treatment providers also discussed an increase in “grow houses” (indoor marijuana growing operations); some community professionals felt that this increase coincided with the increased availability of marijuana in the region. Participants reported that the quality of marijuana varied, with the most common quality score continuing to be ‘7’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that for commercial (low- to mid-grade) marijuana, a “blunt” (cigar) sold for between \$5-10; an ounce sold for \$100. Higher quality marijuana sold for significantly more: a “blunt” sold for between \$20-30; 1/4 ounce sold for \$150. While there were a few reported ways of consuming marijuana, the most common route of administration remained smoking. Participants continued to describe typical users of marijuana as being of any age, race, occupation and socio-economic group.

Current Trends

Marijuana remains highly available in the region. Participants and community professionals 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’. To highlight the continued high availability of marijuana, a participant explained, *“Marijuana is available just like ... grass is growing.”* Another participant remarked, *“[Marijuana] it’s grown here, sold here [and] cured here.”* A treatment provider stated, *“[Marijuana] that one’s never going away ... It’s going to stay high [in availability]. I don’t see marijuana decreasing.”* Community professionals continued to report an increase in growing operations in the region. A treatment provider commented, *“People are even growing it [marijuana] in their backyard now.”* Another treatment provider stated, *“They’re doing it [growing marijuana] in their basement. Very high-tech with grow lights. It’s become a small industry.”* Law enforcement reported that grow houses have increased.

Collaborating data also indicated that marijuana is readily available in the region. According to the Logan County

Family Court, among adults screening positive on urine drug screens during the past six months, 18.8 percent of the positive urine drug screens were related to marijuana. In contrast to adults, 86.2 percent of the positive urine drug screens in juveniles were related to marijuana. According to the Montgomery County Juvenile Court, among adolescents screening positive during the past six months, 81.9 percent of positive urine drug screens were related to marijuana. In addition, media outlets in the region reported on marijuana seizures and arrests during this reporting period. In March, police in Dayton stopped a suspicious truck and questioned the driver, and discovered 400 pounds of marijuana worth an estimated \$480,000 (www.wdtn.com; March 7, 2012). Participants and community professionals reported that the overall high availability of marijuana has remained stable during the past six months. The Miami Valley Regional Crime Lab reported that the number of marijuana cases it processes has decreased during the past six months.

Participant quality scores of marijuana varied from '3' to '10' with the most common score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Low-grade marijuana was typically rated between '3' and '6,' mid-grade as '8,' and high-grade as '10,' previously, overall quality was rated '7,' low-grade marijuana was '3,' mid-grade marijuana was '5' and high-grade marijuana was most often rated '10.' Several participants continued to explain that quality of marijuana depends on whether the user buys "commercial weed" (low- to mid-grade marijuana) or hydroponically grown (high-grade marijuana). Participants preferred higher grade marijuana that looked "fluffy" and not lower grades of marijuana that were mostly made up of "seeds." Participants also discussed flavors of marijuana such as "blueberry." Treatment providers also commented on grades of marijuana with one treatment provider explaining, "And now they're coming up with different names and higher highs. 'Purple haze' and 'kush,' whatever they're calling it." Another treatment provider in the Lima area commented, "Not only has the availability of it, the assortment has grown. Like different types that you can get. Like the 'gold,' the 'Mexican' or the 'Acapulco,' [or] the 'sesame.'"

Current street jargon includes countless names for marijuana. The most commonly cited names were "kush," "loud" and "weed." Participants listed the following as other common street names: "dirt" and "ditch" for commercial-grade marijuana; "reggie," "regular" and "mids" for mid-grade marijuana; and "hydro," "kush" and "loud" for high-grade or hydroponically grown marijuana. The price of marijuana depends on the quality desired. Participants reported

commercial-grade marijuana to be the cheapest form: a "blunt" sells for \$5; 1/4 ounce sells for between \$25-70; an ounce sells for between \$50-120. Higher quality marijuana sells for significantly more: a blunt or two joints sell for between \$20-30; 1/8 ounce sells for between \$45-50; 1/4 ounce sells for \$100-225; a pound sells for up to \$1,600. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking with the majority of respondents agreeing that nine out of 10 marijuana users would smoke and one would orally ingest the drug. One respondent had experience vaporizing marijuana and explained, "[Vaporizer use to consume marijuana] it's starting to become more popular. It's more healthier on your lungs." Overall, orally ingesting marijuana was reported as uncommon. Only individuals with health problems that prevent them from smoking, those who grow marijuana and those who are having a special event would be more likely to bake with marijuana or make items such as brownies, butter, cupcakes or tea.

A profile for a typical marijuana user did not emerge from the data. Participants continued to describe typical users of marijuana as "everyone." A respondent remarked on the wide age range of users' ages: "I know old people, 80 years old smoking [marijuana]." Community professionals reported both younger adults and older adults using marijuana, but they said that the trend was not as popular among middle-aged adults. Younger adults were reported to use recreationally, and older adults were thought to use marijuana because, as one participant stated, "[marijuana] it's medicine to them." A treatment provider discussed use within the older population: "I have to agree because of personal issues, experiences with some older people in my family that are on pain medications. And they been buying it [marijuana] illegally because it's been told it alleviates pain and helps with eyesight." Use by the younger generations was tied with popular media icons. A treatment provider explained, "I think, [marijuana use] it's been a lot with a lot of the people in the mainstream ... A lot of younger teens and young adults have been using it [marijuana] more because of what they see in the mainstream."

Reportedly, marijuana is used in combination with crack cocaine, heroin, prescription opioids and powdered cocaine. A participant reported that the practice of lacing marijuana with items like crack and powdered "not as common as is used to be." Individuals most likely to lace marijuana were described by a participant as "crack heads" or "anybody if they want a different buzz."

Methamphetamine

Historical Summary

In the previous reporting period, methamphetamine was relatively rare in the region. Participants most often reported the drug's availability as '2' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Most participants agreed that methamphetamine was not a popular drug in the region; they continued to report that it was only available to a limited number of users with good connections. Community professionals also reported that methamphetamine was rarely seen in the region. According to most respondents, the availability of the drug had remained the same during the previous six months. Participants with knowledge of the quality of methamphetamine most often rated quality as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The Miami Valley Regional Crime Lab reported that they typically see tan, brown and off-white powdered methamphetamine along with crystal methamphetamine in their labs. Participants said that a gram of methamphetamine sold for between \$100-200. Reportedly, the most common route of administration for methamphetamine was smoking, especially for first-time users. A profile for a typical methamphetamine user did not emerge from the data; however, participants and treatment providers agreed that older people and those who have been incarcerated were more likely to use the drug.

Current Trends

Methamphetamine is moderately available in the region. While participants from rural areas most often reported the current availability of the drug as '1' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), participants in Dayton reported current availability as '5' and '7'; the previous most common score was '2'. Participants generally reported a fear of methamphetamine: *"I don't f*** around with that [methamphetamine],"* one participant stated. Another stated, *"I don't even know what it [methamphetamine] looks like."* Most participants in Dayton continued to think of methamphetamine as more prevalent in "rural areas." A participant discussed the lack of connections to purchase methamphetamine on the street: *"You'd be better off going to the store and buying the ingredients to make it [methamphetamine] than you would be to buy it."* Community professionals most often reported the current availability of methamphetamine as '8'. A treatment provider reported, *"I've got quite a few clients that can get a hold of*

it [methamphetamine]." Several media outlets reported on seizures of methamphetamine during this reporting period. The Agency for Combined Enforcement (ACE) Drug Taskforce in Greene County reported that methamphetamine is on the rise in their area. In fact, they have already made seven methamphetamine seizures so far this year, which means they are on track to surpass the 11 seizures made the previous year (www.wdtn.com; March 27, 2012). Reports from Preble County also indicate methamphetamine is in the area. Preble County Sheriff's deputies found the chemicals and equipment to manufacture methamphetamine, and arrested three people in the seizure (fox.daytonnewssource.com; Feb. 22, 2012).

Participants reported that the availability of methamphetamine has remained stable during the past six months. Treatment providers reported that availability of methamphetamine has increased during the past six months and explained that the increase is linked with "one-pot cooks." One-pot refers to the method of manufacturing methamphetamine where by users, or "cooks," produce the drug in approximately 30 minutes at nearly any location by mixing common household chemicals, along with ammonium nitrate found in cold packs and pseudoephedrine in a single container, such as a two-liter plastic soda bottle. A law enforcement official stated this method is popular *"because it's a lot easier to make [methamphetamine] with the one-pot, shake-and-bake method, and Internet access teaches them. The Internet has the recipes on it. You won't need near as much ephedrine with the one-pot."* The Miami Valley Regional Crime Lab reported that the number of methamphetamine cases it processes has decreased during the past six months. The crime lab also continued to describe the crystal and powdered methamphetamine they process as brown, tan and off-white in color. Most participants rated the quality of methamphetamine as '5' and on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that the quality of methamphetamine has remained the same during the past six months.

Current street jargon includes a few names for methamphetamine. The most commonly cited names were "Chrissy," "crank," "glass," "shards" and "windows." Current street prices for methamphetamine came from one participant with experience buying the drug. The participant reported that a gram of methamphetamine sells for \$80. Law enforcement discussed limited sales in the area. An officer stated, *"We have not had a lot of meth sales. We don't see that. I think a lot of it is they make it for themselves. They don't make that much to sell ... just for their own use and to party with their friends,*

to sell locally to their friends.” Reportedly, the most common route of administration of methamphetamine remains smoking; snorting is a less common route of administration. Participants reported that out of 10 methamphetamine users, approximately eight would smoke and two would snort the drug.

A profile for a typical methamphetamine user did not emerge from the data. Participants described typical users of methamphetamine as located in “rural areas.” A participant from a rural area explained, “I think that you find meth in towns smaller than this,” and another participant agreed, “They’re like in rural areas where there’s no population.” Community professionals identified heroin and especially crack cocaine users as more likely to use methamphetamine. A treatment provider commented, “The experience I’ve had with meth has been crack cocaine users have been [going back and forth between drugs] until the meth gets them so bad off that they are a meth head.” A law enforcement official identified typical users as “late 30s, early 40s, and 20s, really. But it’s the White population. I think males more than females. I think most of them smoke it [methamphetamine].” A treatment provider discussed experiences with typical methamphetamine users: “I would say ... they start in their 30s, at least the females that I’ve talked to. It gives them energy, it makes them lose weight; they have like that superpower feeling. They have that ability. It’s very attractive to them that way in the beginning, but then real quick, real quick they can’t control it.” Reportedly, methamphetamine is used in combination with alcohol and “pills” of all kinds. A participant discussed using several different substances with methamphetamine: “Sometimes it’s a better high depending on what you mix it [methamphetamine] with.”

Ecstasy

Historical Summary

In the previous reporting period, Ecstasy [methylenedioxyamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] was moderately available in the region. Participants most often reported the drug’s availability as ‘7’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Most participants and community professionals reported that availability of Ecstasy was limited to certain social circles or only available to well-connected users. There was no agreement on whether the availability of Ecstasy had increased, decreased or remained the same

during the previous six months. However, participants reported “Molly,” the purest form of Ecstasy, as increasingly sought after and used, especially at outdoor music festivals. Most participants rated the quality of Ecstasy as ‘6’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that the price of an Ecstasy tablet depended on a variety of factors including the size of the tablet and the picture that was imprinted on it. Participants reported a “single stack” (low dose) of Ecstasy sold for between \$5-10; a “double stack” or “triple stack” (high dose) sold for between \$40-50. Participants described Ecstasy as a “party drug” or “club drug,” and also discussed its popularity with college students. In addition, treatment providers commented on Ecstasy’s popularity among young people.

Current Trends



Ecstasy [methylenedioxyamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] remains moderately available in the region. Participants reported current availability of the drug as ‘5’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was ‘7’. Most participants believed that Ecstasy is not very available. A participant stated, “You have to go out of town to get it [Ecstasy].” Community professionals most often reported the drug’s current availability as ‘8’. Treatment providers had mixed impressions on current availability. A treatment provider reported, “I think [Ecstasy use] it’s happening ... not here, but in the bigger cities where they are having the raves [underground dance parties].” Another treatment provider agreed, “Ecstasy is up there [in availability in cities].” Law enforcement reported that they have not found much Ecstasy in drug seizures and that the purest form, Molly, was “not popular.”

Participants most often reported that the availability of Ecstasy has decreased during the past six months, while community professionals reported that availability has stayed the same. Treatment providers in the Lima area (Allen County) said that Ecstasy use is seasonal and that the drug is in more demand at certain times of the year. A treatment provider explained, “In Wapakoneta [Auglaize County] where they have the Indian reservation ... where they have the rave parties ... they have it [Ecstasy] ... so the sheriff and the police can’t actually come on [the reservation] because it’s like sovereign land ... they have those in spring and summer,

they have those rave parties, a there'll be a lot of Ecstasy there too." The Miami Valley Regional Crime Lab reported that the number of Ecstasy cases it processes has decreased during the past six months.

Current street jargon includes several different names for Ecstasy. The most commonly cited name was "E." Reportedly, price commonly depends on the amount of Ecstasy being purchased and the quality of the Ecstasy. A participant reported that it is cheaper to buy \$100 worth of Ecstasy because *"the more [Ecstasy] you buy, the better deal you get."* Participants reported that a "double stack" or "triple stack" (high dose) sells for between \$10-25; Molly sells for \$50 a gram. Participants described typical users of Ecstasy as those recently graduated from high school and those in college. "Ravers" (those who attend underground dance parties and music festivals) are another group cited as more likely to use Ecstasy. Community professionals also identified typical users of Ecstasy as "college students," "teenagers" and "ravers." Reportedly, Ecstasy is used in combination with alcohol, although most participants identified the need for large amounts of water because of thirst associated with the use of Ecstasy.

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants were rarely available in the region. Participants most often reported the drug's availability as '3' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Generally, participants attributed low availability to low desirability. The Miami Valley Regional Crime Lab reported that the number of prescription stimulant cases it processes had remained the same during the previous six months with few exceptions; medications based on methylphenidate HCL (Ritalin® and Concerta®) increased in availability. Participants reported that most brands of prescription stimulants sold for between \$2-3 a pill depending on the milligram. Participants also reported obtaining these drugs from people who had been prescribed them. Participants described typical users of prescription stimulants as younger individuals in high school or college.

Current Trends

Prescription stimulants are moderately available in the region. Participants rated the current availability of prescription stimulants generally as '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to

get); the previous most common score was '3'. Participants reported Adderall® and Ritalin® as most available in terms of widespread use, with Adderall® being more popular than Ritalin®. Although prescription stimulants are available, they are not as desired among participants. Community professionals most often reported the drug as highly available, but agreed with participants that the drug class is not desirable. Participants reported that the availability of prescription stimulants has remained stable during the past six months. Miami Valley Regional Crime Lab reported that the number of Adderall® cases it processes has increased while the number of Concerta® and Ritalin® cases it processes has decreased during the past six months.

No slang terms or common street names were reported for specific prescription stimulants, but this category of drug is usually referred to as "poor man's coke." The following prescription stimulants are available to street-level users: Adderall® (20 mg sells for between \$8-9; 30 mg sells for \$10). Like many other drugs, the amount users pay for prescription stimulants varies widely and "depends on who you are and connection." A law enforcement official commented, *"I think it's the amount that they prescribe [which leads to illegal sales]; a lot of people have extra [prescription stimulants]. I think that they just want to get rid of it. I mean they are not just going to throw it away."*

Participants described typical users of prescription stimulants as more likely to be in the younger age group ranging from high school and college. Typically, participants also identified, "bored mommies" and "coke users" as individuals who would use prescription stimulants. A law enforcement professional said students are more likely to seek out prescription stimulants at certain times: *"at exam time [in college] people are always trying to find Adderall® or Concerta®."* Participants did not identify using other substances with prescription stimulants.

Bath Salts

Historical Summary

In the previous reporting period, bath salts (synthetic compounds commonly containing methylone, mephedrone or MDPV) were moderately available in the region. Participants most often reported the drug's availability as '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Reportedly, the availability of bath salts throughout the region had decreased during the previous six months. However, participants reported that they could still easily obtain them. Staff from the Miami

Valley Regional Crime Lab reported bath salts were still being used in the region. A crime lab professional reported that the lab has processed “twenty driving cases and probably roughly 10-15 coroner cases involving bath salts.” Older adults were also identified as dying from the use of bath salts. In contrast to younger users, the coroner’s office explained that the combination of bath salts and people with age-related heart problems made the drug toxic. Participants and community professionals agreed that typical bath salts users were White. While no one age group was believed to be more likely to abuse bath salts, younger individuals were identified as more likely to experiment with them.

Current Trends

Bath salts (synthetic compounds commonly containing methylone, mephedrone or MDPV) remain moderately available in the region. Participants most often rated the current availability of bath salts as ‘4’ 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’. Community professionals rated current bath salts availability as ‘5’, with some areas in the region reporting more use than others. Several media outlets reported on seizures of bath salts during this reporting period. In April, Dayton narcotics officers conducted undercover buys and were able to purchase bath salts and synthetic marijuana. After executing a search warrant, officers seized 1,087 units of bath salts, 1,282 units of synthetic marijuana and various drug paraphernalia. The shop’s owner reported that he made between \$750-1,000 in profit per day on the drugs (www.newstalkradiowhio.com; April 4, 2012).

There was general consensus among participants that the availability of bath salts has decreased since the law banning their sale that took effect in October 2011. A participant commented on the reduced availability: “When it [bath salts] was legal, it was everywhere. You gotta really know somebody now [to obtain bath salts].” However, despite the reduced availability, participants said bath salts could be obtained in stores. A participant in the Lima area explained, “There’s a place in St. Paris [Champaign County] that still sells them [bath salts].” Another participant in Dayton commented, “Tipp City [Miami County], that’s the only place you can find it [bath salts].” Treatment providers felt bath salts availability in Lima has increased. Treatment providers and law enforcement acknowledged that stores may have, as one stated, “gotten it [bath salts] off their shelf. Still, if they know people, they will sell it under the table.” A treatment provider discussed the increased availability of bath salts and linked media reports with

curiosity of users: “I believe once word got out about bath salts, that more people wanted to try it. ... It was a low-key drug of choice, but now since it’s so wide ranged, more people are going to try it to see what it’s about.” The Miami Valley Regional Crime Lab reported that the number of bath salt cases it processes has increased during the past six months.

Participants were not familiar enough with bath salts to report on the drug’s quality, nor were they familiar with current street jargon. Reportedly, bath salts sell for \$20-40 a gram depending on the brand. Most participants heard about the negative health consequences of ingesting bath salts. A participant commented, “There’s been so many deaths and accidents in the past year [because of bath salts use].” A typical user profile for bath salts use did not emerge from the data. Participants said stimulant users might be more likely to use bath salts. A participant stated, “Whoever is into girl [powdered cocaine]” would be more likely to use bath salts. Law enforcement identified “younger, White males” as more likely to use bath salts. Participants did not know specific drugs used in combination with bath salts.

Other Drugs

Historical Summary

In the previous reporting period, participants and community professionals listed the following other drugs as present in the region, but these drugs were not mentioned by the majority of people interviewed: alcohol, anabolic steroids, hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], inhalants and over-the-counter medications. Alcohol was identified as a major substance of abuse by community professionals and participants for those aged 18- 25 years. Participants reported new trends with alcohol including the alcohol-energy drink combinations and increased drinking games like “beer pong.” Anabolic steroids were rarely available in the region. Only two participants identified any knowledge of anabolic steroids, and both participants had not personally used steroids but had recently met a source that could link them with steroids, specifically Deca-Durabolin (aka “deca”). The drugs sold for \$100 for a 30-day cycle of pills or \$250-300 for a 30-day cycle of injections. The Miami Valley Regional Crime Lab reported that the number of steroid cases it processed had increased during the previous six months; 14 different types of anabolic steroids were processed in their lab. Hallucinogens were moderately available in the region. Participants rated the availability of hallucinogens as ‘5’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). The

Miami Valley Regional Crime Lab reported that the number of hallucinogen cases it processes had increased during the previous six months. Reportedly, LSD (aka "acid") sold for between \$10-20 a "hit" (dose, microdot or blotter); an eye drop bottle full of liquid LSD sold for \$400. Participants reported that 1/8 ounce of psilocybin mushrooms sold for between \$20-25; an ounce sold for \$150. Both LSD and psilocybin mushrooms were reportedly popular at outdoor music festivals. Participants believed the quality and purity of LSD and psilocybin mushrooms were high because the drugs were rarely diluted with other substances. Inhalants were highly available in the region. Reportedly, aerosols (aka "duster" and "gas") were most popular among youth in high school or people who could not obtain other drugs. Over-the-counter medicines were highly available in the region. Similar to inhalants, OTC cough and cold medicines were also identified as substances that younger individuals in middle and high school were more likely to abuse.

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: alcohol, anabolic steroids, hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], inhalants, over-the-counter medications and synthetic marijuana ("K2" and "Spice"). Participants discussed the increase in youth using alcohol. A participant mentioned certain products that youth favor: "Younger kids are starting to tend more towards those flavored malt beverages: Blast [and] Four Loko's." Community professionals also identified alcohol as popular with youth. A treatment provider reported, "I've seen a lot of younger [kids] lately ... a lot of younger kids [in] middle school that use alcohol." Participants reported an increase in the popularity of Jell-O® shots containing alcohol and flavored liquor. A participant stated, "Each kind of vodka comes up with all these new flavors ... cotton candy, whipped cream." Another participant discussed new marketing with beer: "New punch top cans; companies [are] making that. Punch the punch top for 'shooting' ['shooting' allows the beer to come out at a rapid pace so the individual can drink the beer fast]." Community professionals also discussed an increase in flavors and brands of alcohol and energy drink combinations and a new practice of soaking gummy bears in vodka. According to one participant, gummy bears are popular with those younger than 21 years of age because "police don't look at these boxes of candy [for alcohol]." In addition, a treatment provider discussed portable alcohol and explained, "They even got the

liquor now where it comes in these disposable squeeze packs that you can just buy right out the store. Like Capri Sun®, they're like that."

Anabolic steroids remain rarely available in most of the region; however, they were identified as highly available in rural areas. Only two participants identified any knowledge of anabolic steroids, and they rated current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Law enforcement rated the availability of anabolic steroids as '2.' The Miami Valley Regional Crime Lab reported that the number of anabolic steroid cases it processes has decreased during the past six months. Pricing for anabolic steroids is consistent with the previous reporting period. A participant talked about her husband's use of anabolic steroids: "Depends on how many cycles you are getting. A six-week cycle costs \$150." Typical anabolic steroid users were described as athletes and body builders. Law enforcement identified anabolic steroids users as younger, White males. An officer commented, "I think [anabolic steroid use] it's pretty prevalent in the schools [high school] for sports. I'm sure it has to do with advertising on TV for sports. [Kids want] scholarships for colleges."

Hallucinogens (LSD and psilocybin mushrooms) are highly available in the region. Participants rated the availability of hallucinogens 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 '5.' A minority of participants reported using hallucinogens, and they said the greatest availability is in rural areas. A community professional rated the availability of hallucinogens as '3.' Participants reported that the availability of LSD has decreased while the availability of psilocybin mushrooms has increased during the past six months. Law enforcement also reported an increase in availability of psilocybin mushrooms during the past six months. The Miami Valley Regional Crime Lab reported that the number of LSD and psilocybin mushroom cases it processes has decreased during the past six months. While not mentioned by participants, the crime lab also reported that the numbers of DMT (dimethyltryptamine) and PCP (phencyclidine) cases it processes have increased during the past six months. Reportedly, LSD (aka "acid") sells for between \$8-10 a "hit" which was identified as a strip. Participants reported that 1/8 ounce of psilocybin mushrooms sells for between \$20-30; 1/4 ounce sells for \$40. Most participants agreed, with one participant who stated that the younger age group, "right after high school" is more likely to use hallucinogens. A law

enforcement official identified a typical user of hallucinogens as "... younger kids. I mean we're talking high school, early college."

Inhalants remain highly available in the region. Participants rated the availability of inhalants as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously participants also reported high available of inhalants. Participants frequently commented on their ready availability because anyone could "pick them up at the store," as one stated. Reportedly, aerosols (aka "duster" and "gas") are most popular among youth in high school. Inhalants were not desired by participants. A participant commented, "I don't really know anybody that has an addiction to air dusting." The dangerous nature of inhalants was discussed, as a participant stated, "Spray paint. My sister's friend died doing that ..."

Over-the-counter medications remain highly available in the region. Like inhalants, OTC cough and cold medicines were also identified as substances that younger individuals in middle and high school are more likely to abuse. A participant explained, "I think everybody has passed the Robitussin® phase." A treatment provider identified an increase in, "syrup" and explained, "They make 'dirty Sprites®,' and they mix it [OTC cough and cold medicines] with alcohol in a Sprite® bottle ... alcohol, wine and the syrup, and that's supposed to be a cocktail. They mix it all together and people sip on it as they say, all day or for a party or whatever. There's been an increase in African-American [users] with the syrup as they call it ..."

Synthetic marijuana ("Funky Monkey," "K2") was also mentioned by a treatment provider who discussed that individuals are "moving away from the synthetics because they have found that there is a lot of fallout from smoking the synthetic that they did not appreciate. They like to get high with marijuana. The side-effects [produced by synthetic marijuana use] it's crazy. It's like induced schizophrenia. They have psychotic episodes, panic attacks they just fall out, and I've had clients tell me it takes days to get over that." However, a treatment provider explained that individuals may consider using synthetic marijuana because, "they feel they can't get in trouble. There's no legal issue in it." However, a treatment provider discussed identifying other illegal substances when performing drug screens: "From testing the ones who have admitted to smoking the fake, the synthetic stuff, they light up our panel: PCP, methamphetamine [and] THC [tetrahydrocannabinol]. Something in that makes our drug test light up ..." The Miami Valley Regional Crime Lab reported

that the number of synthetic marijuana cases it processes has increased during the past six months.

Lastly, for the first time in Dayton, treatment professionals expressed concern about products containing melatonin, as these products seek to mimic the effects of marijuana and have no age restrictions. A treatment professional commented, "You can be 13 [years of age], you can be 12, you can be 11 [to purchase them]," and providers said they are found in gas stations and convenience stores. Treatment providers discussed several things that are popular with clients, including a drink called Marley's Mellow Mood that contains melatonin and valerian root and brownies called Lazy Cakes that contain melatonin.

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids and sedative-hypnotics remain highly available in the Dayton region. Noted changes in availability during the past six months exist as follows: decreased availability for Ecstasy; likely decreased availability for crack cocaine; likely increased availability for heroin and Suboxone®. Most participants believed that Ecstasy is not very available. Law enforcement reported that they have not found much Ecstasy in drug seizures. Participants most often reported that the availability of Ecstasy has decreased during the past six months. In addition, the Miami Valley Regional Crime Lab reported that the number of Ecstasy cases it processes has decreased during the past six months. Participants and community professionals reported that the availability of crack cocaine has remained stable during the past six months with possibly a slight drop because people are "looking for stronger drugs." The Miami Valley Regional Crime Lab reported that the number of crack cocaine cases it processes has decreased during the past six months. Participants commented on the "epidemic" proportions that heroin has reached in the region. Even respondents who did not personally use heroin reported friends or family members who did. Free "testers" of heroin remain available in Dayton which makes it difficult for individuals to avoid the drug. Law enforcement also identified free samples as prevalent in the region. Although brown powdered heroin is the most commonly cited type of heroin, participants consistently also rated the availability of white powdered and black tar heroin as highly available. Participants and community professionals reported that the availability of powdered heroin has increased during the past six months. Prescription opioid abuse continues to be linked with the

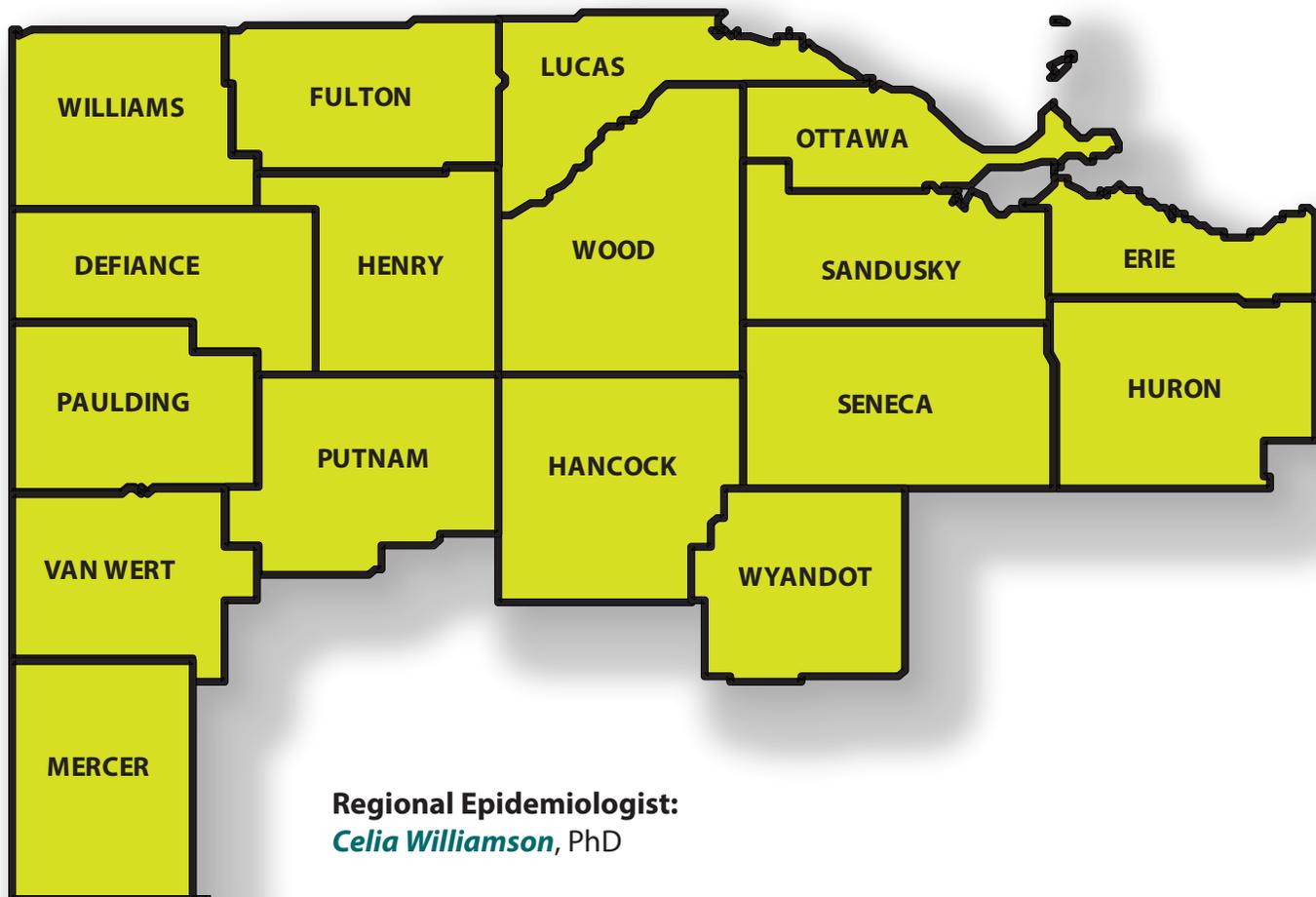
increase in heroin availability and use. Participants in rural areas close to Columbus also reported that the availability of black tar heroin has increased during the past six months. Participants continued to report that Suboxone® is moderately available in the region. Participants explained that if one does not have the means to acquire Suboxone® through a Suboxone® clinic or program, street purchase is an option. While participants reported that the availability of Suboxone® has remained stable during the past six months, community professionals reported that availability has increased, linking the increase to the increase in opiate use. The Miami Valley Regional Crime Lab reported that the number of Suboxone® cases it processes has increased during the past six months.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Toledo Region

January-June 2012

John R. Kasich, Governor
Orman Hall, Director



Regional Epidemiologist:

Celia Williamson, PhD

OSAM Staff:

R. Thomas Sherba, PhD, MPH, LPCC

OSAM Principal Investigator

Rick Massatti, MSW

Research Administrator, OSAM Coordinator

Toledo Regional Profile

Indicator ¹	Ohio	Toledo Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	1,231,785	40
Gender (Female), 2010	51.2%	51.1%	43.6% ²
Whites, 2010	81.1%	83.7%	54.1% ³
African Americans, 2010	12.0%	8.0%	32.4%
Hispanic or Latino Origin, 2010	3.1%	5.4%	0.0%
High school graduates, 2009-2010	84.3%	83.8%	82.1% ⁴
Median household income, 2010	\$45,151	\$46,040	Less than \$11,000 ⁵
Persons below poverty, 2010	15.8%	14.6%	60.5% ⁶

Ohio and Toledo statistics are derived from the U.S. Census Bureau.¹

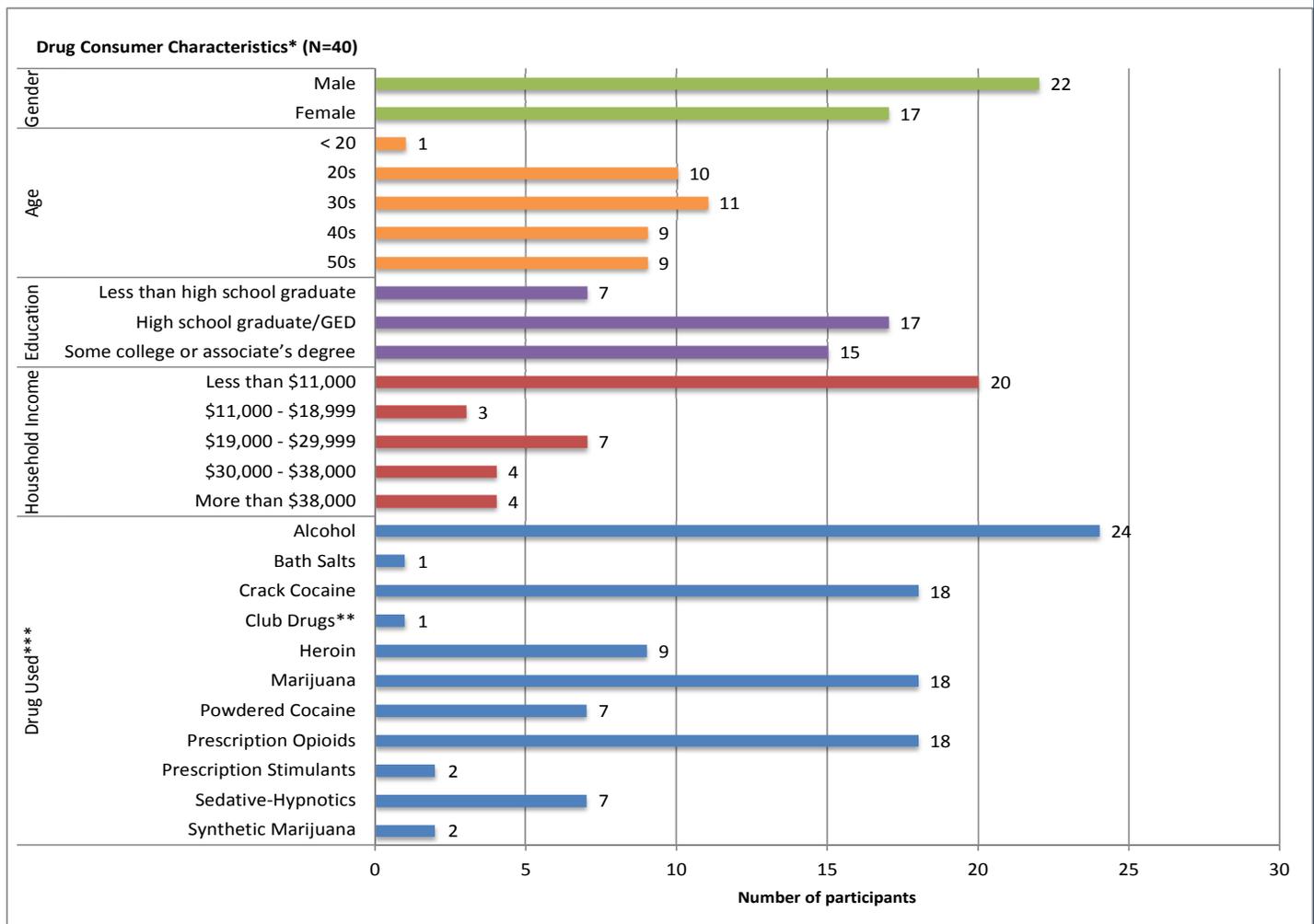
Gender was unable to be determined for one respondent due to missing data.²

Race was unable to be determined for three respondents due to missing data.³

Graduation status was unable to be determined for one respondent due to missing data.⁴

Respondents reported income by selecting a category that best represented their household's approximate income for 2012. Income status was unable to be determined for two respondents due to missing data.⁵

Poverty status was unable to be determined for two respondents due to missing or insufficient data.⁶



*Not all participants filled out forms; therefore, numbers may not equal 40.

**Club drugs refer to Ecstasy.

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Lucas and Sandusky counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Bureau of Criminal Investigation (BCI) Bowling Green Office, which serves northwest Ohio. BCI data are summary data of cases processed from July to December 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current BCI data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2012.

Powdered Cocaine

Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get); community professionals reported availability as '10'. However, in Huron County, powdered cocaine was thought to be less available. Participants and community professionals most often reported that the availability of powdered cocaine had stayed the same during the previous six months. The BCI Bowling Green Crime Lab reported that the number of powdered cocaine cases it processed had also stayed the same during the previous six months. Throughout the region, participants reported variability in the quality of powdered cocaine: most participants in Toledo rated quality of powdered cocaine as '4,' whereas, participants in Huron County most often reported quality as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI Bowling Green Crime Lab cited the following substances as commonly used to cut (adulterate) powdered cocaine: caffeine, inositol (dietary supplement) and dietary supplement dietary supplement dietary supplement levamisole (livestock dewormer). The most commonly cited street name for powdered cocaine remained "soft." Participants reported the following prices for powdered cocaine: a gram sold for between \$40-50 for cut product and between \$70-100 for pure product. The most common route of administration for powdered cocaine remained snorting. Participants described typical users of powdered cocaine as, "college White kids; people in their 20s; professionals; White guys; yuppies" and described powdered cocaine as, "a party thing; a social drug" used while at night

clubs. In Huron County, powdered cocaine was reportedly also accessible to high school students.

Current Trends

Powdered cocaine remains highly available in the region. Participants most often reported the current availability of powdered cocaine 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'. Treatment providers in Lucas County most often reported current availability as '9'; while those in Sandusky County rated availability as '7'; the previous most common score among community professionals was '10'. A Sandusky County treatment provider reported, "Many of our clients are coming here because of [arrests for] possession of cocaine." The U.S. Drug Enforcement Agency (DEA) in Toledo, which covers 24 counties in northwest Ohio and three in southeast Michigan, reported current availability of powdered cocaine as '7'. Media outlets in the region reported on powdered cocaine seizures and arrests this reporting period. In February, 51 people were arrested in Toledo through law enforcement efforts led by Toledo police; raids conducted during a five-day period resulted in the confiscation of \$30,000 worth of illegal drugs, which included: 5.5 pounds of marijuana, an ounce of heroin, 104 prescription opioid pills and 60 grams of cocaine (www.northwestohio.com, Feb. 19, 2012). In March, the Ohio State Highway Patrol seized six kilos of cocaine valued at more than \$500,000 during a traffic stop on the Ohio Turnpike (www.perrysburg.wtol.com, March 23, 2012); a drug sweep in Mercer County resulted in the arrest of 20 people for numerous drug-related crimes, including drug trafficking in cocaine, heroin, marijuana and prescription opioids (www.wane.com, March 20, 2012). In April, law enforcement in Fremont (Sandusky County), following up on complaints of drug activity, found two pounds of marijuana and 50 grams of cocaine worth more than \$13,000 (www.thenews-messenger.com, April 5, 2012).

Participants reported that the availability of powdered cocaine has remained the same during the past six months. However, treatment providers in both Lucas and Sandusky counties reported a slight increase in the number of clients during the past six months entering treatment with cocaine in their systems. A treatment provider in Sandusky County reported, "Charges [police arrests] have increased because [powdered cocaine] it's more prevalent." The BCI Bowling Green Crime Lab reported that the number of powdered cocaine cases it processed has remained the same during the past six months.

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 quality score was either '4' or '10';

depending on location within the region. Most participants agreed with one participant who said that generally the quality of powdered cocaine is “garbage.” A participant commented, “Everybody’s put a cut on it [powdered cocaine] to make money.” Another participant compared the past and current quality of powdered cocaine, reporting, “It [quality of powdered cocaine] was fishy. I mean, it looked like fish scales [high quality cocaine]. Now it sucks. All people do is complain about it.” Participants reported that powdered cocaine in Toledo is cut with B-12, baby powder, baking soda, bath salts, creatine, laxatives and Tylenol®. The BCI Bowling Green Crime Lab continued to cite the following substances as commonly used to cut cocaine: benzocaine (local anesthetic), caffeine, inositol (dietary supplement) and dietary supplement dietary supplement dietary supplement levamisole (livestock dewormer). Overall, participants reported that the quality of powdered cocaine has stayed the same during the past six months. The DEA reported that the quality of the powdered cocaine they encounter in this area is 70-80 percent pure; reportedly, the purity of the cocaine has remained consistent during several seizures.

Current street jargon includes many names for powdered cocaine. The most commonly cited names were “powder” and “soft.” Participants listed the following as other common street names: “bitch,” “blow,” “candy,” “coke,” “Christina Aguilera,” “fish scales,” “good fish” (for raw or pure cocaine), “re-re” (for re-rocked or cocaine that has been rocked and then broken down again into powder), “snow,” “white” and “white girl.” Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine. Participants reported that a gram of powdered cocaine sells for between \$40-50, depending on the quality; 1/16 ounce, or “teener,” sells for between \$70-80; 1/8 ounce, or “eight ball,” sells for between \$120-150; an ounce sells for between \$500-600. Participants reported that the most common way to use powdered cocaine remains snorting. Out of 10-powdered cocaine consumers, participants reported that approximately 7-8 would snort and the rest would either intravenously inject or smoke the drug. However, a participant, in response to discussion of injection of powdered cocaine, reported, “... when you’re shooting cocaine, you keep wanting to do it so you’re shooting so much that you’re collapsing all your veins.”

A profile for a typical powdered cocaine user did not emerge from the data. A participant stated, “Back in the day, it [powdered cocaine] used to be more for a higher class of people.” Another participant reported, “[Powdered cocaine use] it’s [still] acceptable in that arena of people [higher class].” Generally, participants described typical users of powdered cocaine as “anybody.” However, in Sandusky County, participants reported that users were more likely to be under 30 years

of age. Treatment providers in Toledo reported seeing more White women with cocaine present in drug screens coming into treatment.

Reportedly, powdered cocaine is used in combination with alcohol, marijuana and prescription opioids. Alcohol and/ or marijuana were said to be commonly used to intensify the effect of powdered cocaine, while prescription opioids are often used to “come down” from the high of crack cocaine use. A toxicology expert at the coroner’s office stated that cocaine is commonly found in drug-related deaths within the 23 northwest Ohio counties and the three southeast Michigan counties his office serves. He reported, “Cocaine is not often the cause of death, but is often in the system of the deceased.”

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); community professionals most often reported availability as ‘7’; with every professional stating that he or she encountered more cases of heroin and prescription opioid abuse than cases of cocaine abuse. Participants and community professionals reported that availability of crack cocaine had stayed the same during the previous six months. Quality of crack cocaine was variable throughout the region. Participants most often rated the quality of crack cocaine as ‘3’ and ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality), and reported that quality had stayed the same during the previous six months. Participants also reported that crack cocaine was cut with baking soda. The BCI Bowling Green Crime Lab reported that crack cocaine was typically cut with levamisole (livestock dewormer). The most commonly cited street names for crack cocaine were “butter,” “hard” and “work.” Participants reported that a gram of crack cocaine sold for \$40. The most common route of administration for crack cocaine remained smoking. Participants described typical users of crack cocaine as, “poor; no one with a good job; women prostitutes.” Treatment providers agreed that crack cocaine users were typically persons of low income.

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.’ Treatment providers in Lucas County and the DEA reported the current availability of crack cocaine in Toledo as ‘7.’ A treatment provider who works in a substance abuse and methadone maintenance facility commented, “They use it [crack cocaine], but it’s not their drug

of choice here. Treatment providers in Sandusky County also reported that crack cocaine is usually not a primary drug of choice, rating the current availability of crack cocaine as '3.' However, a treatment provider in Sandusky County reported, *"I'm sure if we wanted to buy it [crack cocaine], somebody would come up with it for us ... But, we don't see it here as much."* Media outlets in the region reported on crack cocaine seizures and arrests during this reporting period. In February, the Seneca County Drug Task Force seized a substantial amount of crack cocaine along with marijuana from a Fostoria home, where drug trafficking in crack cocaine was suspected (www.northwestohio.com, Feb. 17, 2012).

Participants reported that the availability of crack cocaine has remained stable during the past six months, while treatment providers reported they've seen a slight increase in the availability of crack cocaine. A treatment provider reported, *"We've seen an increase in clients coming in for treatment, ages 20s and 30s, having done cocaine ..."* The BCI Bowling Green Crime Lab reported that the number of crack cocaine cases it processed has remained the same during the past six months.

Participants most often rated the quality of crack cocaine as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common scores were '3' and '8'. Participants reported that the quality of crack cocaine has stayed the same during the past six months. A participant commented, *"By the time it [crack cocaine] gets to this part of the globe, it's been stepped on [adulterated] too much."* Another participant commented, *"If you playing the game for profit, you really don't think quality ... but, if you did it [crack cocaine] for fun, you think quality."* A participant explained that buyers will sometimes pay a street expert with experience to go with them when they make a crack cocaine purchase: *"That's why an individual who go to buy [crack cocaine] quantity, they pay somebody. You have to have experience [to get high-quality crack cocaine]."* Participants reported that crack cocaine in Toledo is cut with acetone, Anbesol®, aspirin, B-12, baby laxative, baking soda, caffeine, creatine and mannitol. The BCI Bowling Green Crime Lab continued to cite dietary supplement dietary supplement dietary supplement levamisole (livestock dewormer) as commonly used to cut crack cocaine.

Current street jargon includes many names for crack cocaine. The most commonly cited names were "rock" and "hard." Participants listed the following as other common street names: "butter," "candy," "white girl" and "Whitney." Current street prices for crack cocaine were consistent among participants with experience buying crack cocaine. Participants reported that a gram of crack cocaine sells for

\$30; 1/16 ounce, or "teener," sells for between \$50-65; 1/8 ounce, or "eight ball," sells for between \$100-150; an ounce sells for \$800. However, a participant discussed that the time of day crack cocaine is purchased may influence the price: *"If it's midnight or two in the morning, you could pay \$200-250 for an eight-ball [of crack cocaine] if you want it."* Quality of the drug is another consideration. Whereas, an ounce may typically cost \$800, an ounce of high-quality crack cocaine could cost up to \$1,150. Participants reported that most users will buy smaller quantities, such as \$5 rocks or whatever amount of money the user has to spend. While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking through a glass or metal pipe. Out of 10 crack cocaine consumers, participants reported that approximately nine would smoke and one would intravenously inject or "shoot" it.

A profile of a typical user of crack cocaine did not emerge from the data. Participants described typical users of crack cocaine as both older and younger people. A participant commented on the physical deterioration of those who have used crack cocaine for a long time, reporting, *"You can see the toll [crack cocaine use] it's put on them [users]."* Reportedly, crack cocaine is used in combination with heroin, called a "speedball." When the user wants to "come down" and go to sleep after using crack cocaine, he or she reportedly uses Xanax® and/or alcohol. A participant explained, *"I use to never do it [crack cocaine] unless I had some Xanax® to come down."*

Heroin Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants and community professionals most often reported the general availability of heroin as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get).

Participants attributed the high availability of heroin to arrests of area doctors who were prescribing prescription opioids, and to the change in the formulation of OxyContin®, which made it difficult to crush and use intravenously. While many types of heroin were available in the region, participants continued to report the availability of brown powdered heroin as most available. Participants and community professionals reported that the availability of all types of heroin had remained the same during the previous six months. The BCI Bowling Green Crime Lab reported that the number of heroin cases it processed had increased during the previous six months. Participants

generally rated the quality of brown powdered heroin as '6' and white powdered and black tar heroin as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI Bowling Green Crime Lab cited the following substances as commonly used to cut heroin: caffeine, diphenhydramine (medication used to treat allergies) and lidocaine (local anesthetic). The most commonly cited street names for heroin were "dope" and "boy." Participants reported that a gram of brown powdered heroin sold for between \$30-50. The most common route of administration for heroin remained intravenous injection. Participants continued to describe typical users of heroin as most commonly, "White; younger; in their 20s."

Current Trends



Heroin remains highly available in the region. Participants most often reported overall heroin 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'. While many types of heroin are currently available in the region, participants continued to report the availability of brown powdered heroin as most available. The DEA agreed that brown powdered is the most available type of heroin in the region, with an agent stating, "Most [heroin] is brown [powdered] heroin, Mexican heroin, coming from Mexico." A participant

commented, "Heroin is strong [in high demand] right now ... because they [law enforcement] are taking out the pill mills and stuff. Everybody's been switching [from prescription opioids] to heroin. [The crackdown on pill mills] it's just making it worse [heroin demand greater] ... people that was against it [heroin] for years started doing it [due to the expense and increased difficulty of obtaining prescription opioids]." Treatment providers in both Lucas and Sandusky counties also reported that heroin remains highly available, rating it a '10' in Toledo and a '9' in Sandusky County; the previous most common score was '10'. A treatment provider commented, "When I started working here [less than six months ago] there wasn't anybody coming in [to treatment] for heroin, and then, all of the sudden, there was a huge spike, with a lot of people coming in [due to heroin use]." The DEA reports that they are heavily involved in heroin investigations and arrests. A DEA agent reported, "Most of our focus right now is heroin. There's a lot of heroin out here."

Participants reported that the availability of heroin varied by type, rating availability of brown powdered and "china white" heroin as '10'; and availability of black tar heroin

as '3' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Media outlets in the region reported on heroin seizures and arrests this reporting period. In June, the *Toledo Blade* reported that police seized \$545,000 worth of "china white" heroin in west Toledo, which was possibly linked to a number of overdose deaths. A Toledo police sergeant explained in the interview that "china white" heroin is seven times more powerful than brown powdered or black tar heroin. Reportedly, this type of heroin, which is usually imported from Asia and appears white in color due to a refining process, has become more popular in Toledo during the past year (www.toledoblade.com, June 7, 2012). Participants believed pure "china white" is unavailable and always adulterated. Pure "china white" was so potent that one participant commented that it would "put you in the dirt," meaning the user would die from using it. Treatment providers most often reported "china white's" current availability as '10', and reported that they believed its availability to be, as one provider said, "steadily increasing." Participants reported that the availability of black tar heroin has remained stable during the past six months. A participant reported, "[Black tar heroin] that's a little harder to get ... one out of five people might have that." Generally, participants and community professionals reported that the availability of heroin has stayed the same during the past six months. The BCI Bowling Green Crime Lab reported that the number of powdered and black tar heroin cases it processed has increased during the past six months.

Participants reported that the market is currently saturated with heroin dealers in both Toledo and Detroit. Reportedly, because there are ample dealers, the quality of the heroin purchased must be good, or the buyer will purchase it from another dealer. Participants reported that the quality of heroin varies depending on its type and the dealer involved. The quality of heroin ranged from '4' on a bad day to '10' on a good day. A participant said, "[Dealers] they're cutting the hell out of it [heroin]. I seen [sic] them put a five-to-one cut on it [meaning four parts of another substance to one part heroin]." Participants consistently continued to report that "china white" heroin in the region is a heroin/fentanyl mix. However, treatment providers reported that while users report to them that they've used a combination of heroin and fentanyl, these users do not screen positive for fentanyl on urine drug screens. As reported in the *Toledo Blade* article referenced in the previous paragraph, heroin users in the region are used to brown powdered heroin; thus when they obtain "china white" heroin, they do not realize its potency. Participants reported obtaining "china white" heroin from dealers in both Detroit and Toledo. Some participants reported that there is a preference to purchase from Detroit dealers because the drug was said to more pure there and, as one participant said, "less whacked [adulterated]." Participants reported that brown

powdered heroin in Toledo is cut with baby laxative or lactose. Participants also reported that the overall quality of heroin has stayed the same during the past six months. The BCI Bowling Green Crime Lab cited the following substances as commonly used to cut heroin: caffeine, diphenhydramine (medication used to treat allergies) and quinine (anti-malarial).

Current street jargon includes many names for heroin. The most commonly cited names were “boy,” “dope” and “H.” “China white” is commonly called “china;” brown powdered heroin is commonly referred to as “dog food” or “downtown Julie Brown;” black tar heroin is commonly referred to as “tar.” Participants reported that brown powdered heroin is available in different quantities: a gram sells for between \$40-50; 1/4 ounce sells for \$200; an ounce sells for \$700. Participants reported that “china white” heroin is also available in different quantities: 1/10 gram, aka “packs” (1/10 gram usually folded in a scratch-off lottery ticket) sells for \$10; a gram sells for between \$150-200. In addition, participants reported buying “china white” heroin in “bundles” (10-12 small packs of heroin at less than \$10 a pack when purchased in bulk). Participants reported that a gram of black tar heroin sells for between \$100-150; an ounce sells for between \$1,500-4,500. Participants reported that the most common way to use heroin remains intravenous injection. Out of 10 heroin consumers, participants reported that approximately eight would intravenously inject or “shoot” it, and another two would snort it. However, participants were quick to note that the opposite is true for beginning users. A participant reported, “They [new heroin users] snort it when they start out, but then it changes [they progress to injection].” Both participants and treatment providers reported that heroin, users are more likely to inject heroin and more likely to share needles while they are using.

There was consensus among participants and community professionals that typical heroin users are middle-class and White. Participants described typical users as, “Older people that have been shooting [heroin] all their life; middle-class, White people, 16 [years old] and older.” A treatment provider described typical users as “likely to be middle-class and White.” However, treatment providers also reported seeing an increase in African-American use. A Toledo treatment provider commented, “We’re starting to see African-American [heroin] use because the demand for crack cocaine is going down, and heroin use is going up, so the dealers have more heroin, and they’re introducing it to the market [African-American consumers].” The progression from prescription opioids to heroin among young people was again noted by participants and treatment providers. A participant explained that younger users are brought into heroin use

via prescription opioids: “[Heroin] it’s an old person drug, but oxy’s [OxyContin®] brought young people into heroin use.” A treatment provider reported, “They [young users] use pills [prescription opioids] first, then heroin because it’s cheaper.”

Reportedly, heroin is used in combination with crack and powdered cocaine (aka “speedball”), prescription opioids and sedative-hypnotics (benzodiazepines). A participant reported, “The heroin addict is going to do heroin, no matter what. But if I go out to a bar, I wanted to also do some cocaine, but heroin is always a part of it.” Another participant reported, “I’m a drug addict, and my drug of choice is heroin and painkillers, but if there is another drug around, I’ll do it.” The coroner’s office reported that they saw a “fairly big increase in 2011” of heroin-related deaths, and that heroin-related deaths are currently on pace with those of the past year.

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Both participants and treatment providers most often reported 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 continued to identify Percocet® as the most popular prescription opioid in terms of widespread use, followed by Opana®. Treatment providers agreed with participants in identifying the widespread popularity of these two drugs, while adding that OxyContin® OP (new formulation) is also highly available. Participants and treatment providers also identified Dilaudid®, fentanyl, methadone and Vicodin® as other prescription opioids that were highly available and used, although not as popular. Most participants reported experimenting with, having been prescribed or regularly using prescription opioids prior to age 18. Participants reported that the availability of prescription opioids temporarily decreased during the previous six months due to the arrest of an area physician who had operated a pain clinic in Michigan from where many participants reportedly obtained prescription opioids, either directly or indirectly. Law enforcement reported that availability of prescription opioids had increased during the previous few years and reported a “boom” of illegal prescription opioid use in the region. The BCI Bowling Green Crime Lab reported that the number of prescription opioid cases it processed had generally stayed the same during the previous six months; noted exceptions were increases in hydromorphone (Dilaudid®), morphine and oxycodone (Opana®). While there were a few reported ways of consuming prescription opioids, the most common routes of administration were snorting and swallowing.

In addition to obtaining prescription opioids on the street from dealers, participants also reported obtaining the drugs from area senior citizens. Participants continued to describe typical users of prescription opioids as, *“young; 18-25 [years old]; White females; White men.”*

Current Trends

Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10’. Reportedly, the most preferred prescription opioids continue to be Opana® and Percocet®. However, participants in Sandusky County reported that Opana® can be difficult to obtain: *“You have to drive to Bellevue to get them [Opana®]; You gotta know the right person to get those [Opana®]; All you have to do is shake the pill bottle and [Opana®] they’re gone.”* Treatment providers also reported the current availability of prescription opioids as ‘10’; the previous most common score was also ‘10’. Treatment providers reported OxyContin®, Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use. They identified Percocet® as the most desired prescription opioid, and OxyContin® and Vicodin® as less desirable. In speaking about OxyContin®, a participant reported, *“[OxyContin®] those are dwindling out [becoming less desirable].”* The new formulation of OxyContin® OP prevents users from snorting or injecting the drug without going through a long preparation process. Another participant stated, *“Nobody really messes with them [new formulation of OxyContin® OP] anymore.”* In speaking about Vicodin®, many participants reported that they have moved on from using Vicodin® to other stronger prescription opioids. A participant reported, *“I don’t know anybody that wants them [Vicodin®]; Them are like tic tacs®.”* The DEA identified Dilaudid®, Opana®, OxyContin® and Percocet® as prescription opioids that are the most available and desirable among the 23 counties they investigate, while also reporting that Vicodin® is used by low-level street users and not sold as much as other opioids by higher-level drug dealers. Participants with experience using Dilaudid® reported a preference for them over other prescription opioids. In addition, participants reported high availability of fentanyl, thought to be mixed with heroin, as well as availability of fentanyl patches. For those who did obtain fentanyl patches, they reported cutting the patches open and eating the gel. Some other prescription opioids receiving minimal mention included methadone® and Roxicet®. While these drugs were reported to be highly available, participants weren’t able to provide much information about their use.

Participants and treatment providers reported that the availability of prescription opioids has remained the same during the past six months. The BCI Bowling Green Crime Lab reported that the number of prescription opioid cases it processed has generally remained the same during the past six months; noted exceptions were increases in oxycodone hydrochloride (OxyContin®) and oxymorphone (Opana®).

Reportedly, many different types of prescription opioids are currently sold on the region’s streets. Participants reported the following prescription opioids as available to the street-level user (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid® (4 mg sells for \$15); Fentanyl® patches (50 mg sells for \$30; 80 mg sells for \$50); Opana® (sells for a \$1 per mg; however, 40 mg typically sells for \$50); OxyContin® OC (old formulation, aka “OC’s;” sell for \$1-2 per milligram), OxyContin® OP (new formulation, 40 mg sells for between \$35-40; 60 mg sells for \$60; 80 mg sells for \$80; 160 mg sells for \$160), Percocet® (aka “perc’s;” 5 mg sells for \$5; 10 mg sells for \$10; 20 mg sells for \$20; 30 mg sells for \$25); Vicodin® (aka “Vic’s;” 5 mg sells for \$2; 7.5 mg sells for \$8; 10 mg sells for \$10). While there were a few reported ways of consuming prescription opioids, variations in methods of use were noted among types of prescription opioids. Generally, the most common routes of administration include swallowing, snorting and intravenous injection. Although swallowing prescription opioids is a common practice, participants reported that out of 10 prescription opioid consumers, approximately eight would snort and two would inject or “shoot” them. In addition, some participants reported “parachuting” prescription opioids (crushing the pills and wrapping them in toilet paper to swallow). Reportedly, parachuting avoids the damage to the nose produced by snorting, while delivering the immediate sensation of the drug. A few participants also reported knowledge of users who remove the protective pill coating and insert the drugs in the rectum to achieve the same effect as parachuting. Finally, others who wanted to use the drugs intravenously but couldn’t find a suitable vein were said to engage in, as one user stated, “skin popping” in which the user injects the drug into muscle or fat.

In addition to obtaining prescription opioids on the street from dealers, participants also continued to report getting them from doctors or from buying other people’s prescriptions. A participant reported, *“[I would] get them [prescription opioids by] buying scripts [prescriptions from other people] ... I burned up the ER. If they [emergency room staff] see me, I ain’t getting shit.”* Some participants also continued to discuss a common practice of bringing prescription opioids to the region from Florida. A representative from the DEA confirmed these participant reports, by stating, *“We see bulk*

smuggling of opiates from Florida because of all of the pain clinics there."

A profile of a typical user of prescription opioids did not emerge from the data. Participants and treatment providers described typical users of prescription opioids as, "anyone." An agent from the DEA reported that both users and sellers of prescription opioids "cross all racial and socio-economic boundaries." Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol and marijuana to intensify the effect of the opioids. A participant reported, "I don't like to use anything with it [prescription opioids]. Maybe drink [alcohol] or smoke weed [marijuana]."

Suboxone®

Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported availability of Suboxone® as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get); treatment providers most often reported availability as '10'. Both participants and treatment providers reported that the availability of Suboxone® had stayed the same during the previous six months. The BCI Bowling Green Crime Lab reported that the number of Suboxone® cases it processed had increased during the previous six months. Participants reported that Suboxone® 8 mg sold for between \$10-15. In addition to obtaining Suboxone® on the street from dealers, participants also reported getting the drug from those who were prescribed it. Participants reported that some users with Suboxone® prescriptions sold or traded the drug for other drugs. Most often participants reported taking Suboxone® sublingually (dissolving it under the tongue). Participants continued to describe typical street users of Suboxone® as heroin users who wanted to withdraw from using heroin without becoming sick, and those who just desired to avoid "dope sickness" in between periods of using heroin.

Current Trends

Suboxone® remains highly available in the region. Participants in Toledo reported the street availability of Suboxone® 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'. A participant reported, "A lot of people are selling them [Suboxone®]." Treatment providers in Toledo most often reported the current availability of Suboxone® as '10'; the previous most common score was also '10'. However, according to participants and treatment providers in Sandusky County, the drug is considerably less available there; both groups of respondents

couldn't recall knowing anyone that used it without a prescription. Even though it may be available, they rated the current street availability as low. Participants and treatment providers reported that the overall availability of Suboxone® has remained the same during the past six months. The BCI Bowling Green Crime Lab reported that the number of Suboxone® and Subutex® cases it processed has increased during the past six months.

Participants did not report any street jargon for Suboxone®. Reportedly, Suboxone® 8 mg sells for between \$10-15 for the strips and \$10 for the pills. However, a participant commented, "If you're [dope] sick, you will pay \$20 for them [Suboxone®]." Most often participants continued to report taking Suboxone® sublingually, with a few participants reporting placing strips in their nose and snorting them. Almost all participants with experience using Suboxone® reported experience with the strip/film form of the drug; only one person discussed using Suboxone® pills. However, a few participants reported they preferred the pills because, as one participant stated, "they last longer."

In addition to obtaining Suboxone® on the street from dealers, participants also reported obtaining the drug from doctors. A treatment provider commented, "Physicians can prescribe it [Suboxone®] from their offices, so you have some physicians just giving it to their patients." Participants continued to describe the typical user of Suboxone®, as one participant stated, as "a person trying to get off of heroin." Reportedly, Suboxone® is not used in combination with any other drug. As a participant reported, "[Suboxone®] it's an opiate blocker, so you can't take anything with them." Another participant reported, "If you wanna get high, don't do 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 '9' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants identified Xanax® as the most popular sedative-hypnotic in terms of widespread use, followed by Klonopin®. Reportedly, Ativan® and Valium® were moderately desirable among users older than 25 years if other brands could not be obtained. Law enforcement reported that these drugs were most often sold by those with prescriptions; there was no highly organized distribution system for sedative-hypnotics like there was for other drugs. The BCI Bowling Green Crime Lab reported that the number

of sedative-hypnotic cases it processed had stayed the same during the previous six months with some exceptions; Klonopin® and Xanax® increased and Librium®, Restoril®, Lunesta®, Mebaral® and Nembutal® decreased in frequency. The most common routes of administration remained oral ingestion and snorting. A profile of a typical user of sedative-hypnotics did not emerge from the data.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants in Lucas County 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'. Participants from Toledo continued to identify Xanax® as the most popular sedative-hypnotic in terms of widespread use. In contrast, Sandusky County participants reported that Xanax® is no longer as prevalent as it once was, reporting the current availability of Xanax® as '3'. Treatment providers in Toledo most often reported current availability of sedative-hypnotics as '10'. Providers in Toledo identified Xanax® as the most popular sedative-hypnotic in terms of widespread use followed by Ativan® and Klonopin®. Treatment providers in Sandusky County most often reported the current availability of sedatives-hypnotics as '8', identifying Xanax® as most popular. Both participants and treatment providers reported that the availability of sedative-hypnotics has stayed the same during the past six months. The BCI Bowling Green Crime Lab reported the number of sedative-hypnotic cases it processed has increased during the past six months. While most brands have remained stable, the most prevalent ones, Klonopin®, Valium® and Xanax® have increased in availability.

Participants reported the following sedative-hypnotics as available to street-level users in the region (Note: When reported, current street names and prices are indicated in parentheses): Klonopin® (sells for \$1 per milligram), Xanax® (0.5 mg, aka "peaches;" sells for between \$0.25-0.50; 1 mg, aka "blue footballs;" sells for \$2; 2 mg, aka "xanibar;" sells for between \$3-4). While there were a few reported ways of consuming sedative-hypnotics, generally, the most common route of administration is oral ingestion. However, a minority of participants reported crushing and snorting sedative-hypnotics. Participants reported that they did not typically obtain sedative-hypnotics from drug dealers, but rather from friends or doctors. At times, participants reported feigning symptoms of stress or anxiety to the doctor to obtain prescriptions. The DEA supported the notion that dealers did not often possess sedative-hypnotics, reporting that drug dealers typically did not possess them in large quantities.

Participants described typical users of sedative-hypnotics as women or people living with stress. A participant explained, "Women, people that stay around the house a lot, people with anxiety ... or people at home with kids and stress." Treatment providers also described typical users as women or someone living with stress. Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, heroin, marijuana and prescription opioids. When used in combination with one or more of the above, a participant reported, "It's a better high ... it makes you feel better. It intensifies the high." Various drug combinations involving sedative-hypnotics were described. These were referred to by one participant as a "cocktail." A participant reported crushing sedative-hypnotics such as Valium® with Opana® and snorting them together. A few users described combining heroin with Xanax®. A participant reported, "Users shoot heroin and then crush Xanax® and shoot it." A few participants reported strong withdrawal effects from Xanax®.

Marijuana Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants most often reported the availability of marijuana as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants and community professionals reported that the availability of marijuana had stayed the same during the previous six months. Law enforcement reported that most commercial-grade marijuana came through the southwest border with the U.S.; whereas, hydroponic (high-grade) marijuana usually came from Canada or the northwest part of the country. Participant quality scores of marijuana varied from '5' for regular-grade to '10' for high-grade on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported commercial-grade marijuana as the cheapest form: a blunt (cigar) or two joints (cigarettes) sold for between \$5-10; and an ounce sold for between \$75-100. Higher quality marijuana sold for significantly more: a blunt or two joints sold for \$20 and an ounce sold for between \$300-400. While there were several reported ways of consuming marijuana, the most common route of administration remained smoking. Reportedly, vaporizers were becoming more popular amongst users because they saw it as a healthy alternative to smoking. Participants and treatment professionals continued to describe typical users of marijuana as people of all ages, races and ethnicities.

Current Trends

Marijuana remains highly available in the region. Participants, treatment providers and the DEA 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 reported, "You can get that [marijuana] anywhere ... that's all day." Another participant reported, "You can go get a [medical marijuana] card in Michigan and get legal weed [medical marijuana]." Several media outlets reported the seizures of large amounts of marijuana in Lucas and Preble counties during this reporting period. In February, during a traffic stop in Toledo, Ohio State Highway Patrol officers found 100 pounds of hydroponic marijuana worth an estimated \$500,000 (www.nbc4i.com; Feb. 21, 2012). In June, Ohio State Highway Patrol troopers stopped a Michigan vehicle for an unsafe lane change in Preble County; troopers searched the vehicle and found 103 pounds of marijuana, estimated at nearly \$129,000 (www.norwalkreflector.com; June 1, 2012). Participants and treatment providers in Toledo said marijuana has remained stable during the past six months. However, users in Sandusky County said there was a significant increase in the availability of hydroponically grown marijuana. For the first time, participants said they could easily obtain high-grade marijuana. A participant reported, "About a year ago, it [available marijuana] was more like the 'mersh' or 'mids' [commercial-grade marijuana]; they used to call it, 'Mexican weed.' Before now you couldn't get the kush [high-grade marijuana]. It was pretty much mids everywhere ... It's probably been about six [or] seven months that hundo's [high-grade marijuana] in town now." The BCI Bowling Green Crime Lab reported the number of marijuana cases it processed has decreased during the past six months.

Most participants rated the quality of regular-grade (low- to mid-grade) marijuana as '6' and the quality of high-grade or hydroponic marijuana as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common scores varied from '5' for regular-grade to '10' for high-grade marijuana. Participants said the quality of high-grade marijuana was very good. A participant commented, "[High-grade marijuana] it's also called, 'one-hit-quitter,' 'cause you hit it one time and you're done." The DEA also spoke about the quality of marijuana. An agent said, "The THC [tetrahydrocannabinol] content is lower in Mexican marijuana that's grown outdoors. Indoor growers cultivate it to get a higher THC content." The DEA reported that dealers are obtaining high-grade marijuana from domestic growers involved in hydroponic grow operations and users smuggling in medical marijuana from Michigan.

Current street jargon includes many names for marijuana. The most commonly cited name remains "weed." Participants listed the following as other common street names: "reggie" and "regular" for commercial-grade marijuana; "kush," "hundo," "hydro" and "loud" for high-grade marijuana or hydroponically grown marijuana. The price of marijuana depends on the quality desired. Generally, prices were higher in Sandusky County. Participants reported commercial-grade marijuana as the cheapest form: a blunt or two joints sell for between \$5-10; 1/8 ounce sells for between \$15-20; ounce sells for between \$80-120; a pound sells for between \$750-1,100. Higher quality marijuana sells for significantly more: a blunt or two joints sells for between \$10-20; 1/8 ounce sells for \$50; an ounce sells for between \$200-500; a pound sells for between \$3,500-4,000. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. A few participants also reported baking marijuana in brownies, but this practice was said to be uncommon.

A profile for a typical marijuana user did not emerge from the data. Participants described typical users of marijuana as "anybody and everybody." Reportedly, marijuana is used in combination with most other drugs. Most commonly participants reported using marijuana with alcohol and cocaine. In addition, some participants reported "lacing" marijuana with cocaine, called "cocoa puffing" or PCP (phencyclidine), called "wet" to intensify the effects of marijuana. These practices were reportedly not common in Lucas and Sandusky counties. Other participants reported mixing a variety of substances in their marijuana blunts. A participant reported, "I mixed some British Columbian Gold, Red Devil Sensimilia with some Purple Kush [different types of high-grade marijuana]. I had and broken it all down and mixed it together ... and I sprinkled some heroin powder and some coke ..."

Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was relatively rare in the region. Participants most often reported the drug's availability as '0' in urban areas and '6' in rural areas on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants who reported seeing methamphetamine in Toledo encountered methamphetamine in its crystal form. Treatment providers also thought methamphetamine was relatively rare, most commonly describing its availability as '0' for Toledo and as '4' for Huron County. Participants and community professionals reported that the availability of methamphetamine had stayed the same during the previous six months.

Current Trends

Methamphetamine remains relatively rare in the region. This report is the first in which one or two participants at each site reported having personally bought, sold and/or used methamphetamine during the past six months. Participants most often reported the current availability of powdered methamphetamine as '3' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common scores were '0' and '6'. Participants disagreed about the drug's availability. A participant reported, "[Methamphetamine] it's not easy to get here, even if you know a few people." Other users believed methamphetamine to be increasing in prevalence. A participant stated, "[Availability of methamphetamine] it's a '10' for me ... I know people that make it." Reportedly, powdered methamphetamine in the region is created through a process called, "shake-and-bake" or "one-pot method" (methamphetamine produced in a single sealed container, such as a two-liter soda bottle). Participants reported that crystal methamphetamine is much more difficult to obtain. Treatment providers in Toledo most often reported the current availability of methamphetamine as '4'. A treatment provider reported, "[Methamphetamine] it's not yet popular with our population." The DEA reported on "rolling meth labs" where the drug is manufactured in a vehicle. However, the DEA officer infrequently saw methamphetamine: "We don't see a lot of meth here in Toledo. It's in the rural areas. Most of the labs we see are very small. We call them rolling labs, and they are the 'one-pot method.' They can produce an ounce of meth; not for mass distribution."

Various media outlets reported seizures of methamphetamine during this reporting period. In February, a Toledo man was stopped for a registration violation, leading to the discovery of a mobile meth lab disguised in a book bag in his back seat (www.foxtoledo.com; Feb. 14, 2012). In a separate report from Erie County, law enforcement searched a residence in Conneaut, discovering two working methamphetamine labs (www.goerie.com; Feb. 6, 2012). Participants reported that the availability of the one-pot method of powdered methamphetamine has slightly increased during the past six months, while treatment providers reported that availability of methamphetamine has remained the same. The BCI Bowling Green Crime Lab reported the number of methamphetamine cases it processed has decreased during the past six months.

Most participants rated the quality of powdered methamphetamine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). A participant reported, "Meth is like speed. You do a little bit of meth, and you'll be up for a while." Another participant responded, "I stayed up for four

days strong [using methamphetamine]." Other participants had difficulty finding the premium methamphetamine. A participant reported, "... the good meth, that's here, but you'd have to waste your energy finding it." Participants reported that the overall quality of methamphetamine has stayed the same during the past six months. No one had knowledge of the quality of crystal methamphetamine. The BCI Bowling Green Crime Lab said the most frequently encountered types of methamphetamine they processed were brown powdered, crystal and clandestine liquids.

Current street jargon for methamphetamine is limited to "meth." Participants with experience buying the drug reported methamphetamine sells for \$100 per gram. Reportedly, the drug can also be bought in much smaller quantities. A participant reported, "Twenty dollars [worth of methamphetamine] will keep you up all day." Reportedly, the most common route of administration of methamphetamine is smoking. According to users, another way to use powdered methamphetamine is called "hot railing." In this process, the user creates a line of methamphetamine powder, heats up a metal pipe to smoke the powder. Other routes of administration that were cited as less common include intravenous injection and snorting.

A profile for a typical methamphetamine user did not emerge from the data. Some participants indicated people who liked the drug prefer to stay up for long periods of time for work, such as (truck drivers), or to party. Reportedly, methamphetamine is used in combination with heroin (speedballing). A participant reported, "I've seen people mix meth and heroin together and shoot them."

Ecstasy Historical Summary

In the previous reporting period, Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA and/or TFMP) was moderately available in the region. Participants most often reported the availability of Ecstasy as '7' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The BCI Bowling Green Crime Lab reported that the number of Ecstasy cases it processed had stayed the same during the past six months. Participants reported that Ecstasy was often cut with one or more other drugs such as crack cocaine, heroin, methamphetamine or powdered cocaine. Participants reported that a single-stack Ecstasy tablet sold for \$10; a double or triple stack sold for between \$15-20. Typical users of Ecstasy were described as young people who frequented music festivals, "raves" (underground dance parties) and strip clubs.

Current Trends



Ecstasy (methylenedioxyamphetamine: MDMA, or other derivatives containing BZP, MDA and/or TFMPP) remains moderately available in the region. Participants reported the current availability of Ecstasy as '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '7'. Participants indicated that Ecstasy is not desired because it is not a potent drug and is highly adulterated. Participants also reported the availability of Ecstasy-like substances in the region including 2CE and 2CB. The DEA rates the availability of Ecstasy as '4' with reports of it coming in from Canada. Treatment providers believed Ecstasy was rare and most often reported current availability as '2'. A treatment provider reported, *"Every once in a while someone will say they've tried it [Ecstasy]."* A regional media outlet reported on drug seizures and arrests this reporting period involving Ecstasy. In March, Fremont (Sandusky County) police arrested two individuals for the possession of 250 Ecstasy tablets along with 100 Xanax® pills and 100 grams of marijuana (www.wtol.com; March 3, 2012).

Participants reported that the availability of Ecstasy has decreased during the past six months. A participant commented, *"Back in the day ... it [Ecstasy] used to be good. I got some Ecstasy a few times, and I'm like man, these are duds."* Treatment providers reported that the availability of Ecstasy has remained stable during the past six months. The BCI Bowling Green Crime Lab reported the number of Ecstasy cases it processed has decreased during the past six months.

Current street jargon for Ecstasy is limited to 'X'. Participants reported that Ecstasy sells for between \$5-10. Although they did not have specific information, Toledo participants reported the use of MDMA in powder form sells for \$10 "a point" (1/10 gram). A profile for a typical Ecstasy or MDMA user did not emerge from the data, but participants reported that they would most likely find the drug at parties or "raves." Reportedly, Ecstasy is used in combination with alcohol because users are often in environments where both drugs are present.

Prescription Stimulants Historical Summary

In the previous reporting period, prescription stimulants were highly available in the region. Participants most

often reported the availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Treatment providers in Huron and Lucas counties also said these drugs were highly available. The BCI Bowling Green Crime Lab reported that the number of prescription stimulant cases it processed had remained the same during the past six months, while noting a decrease in the number of cases of medications based on methylphenidate HCL (Concerta® and Ritalin®). Reportedly, Adderall® was the most popular prescription stimulant in the region in terms of widespread use. Participants explained that almost everyone in high school and in the 18-25 age range knew someone that would freely give the drug to them or would sell it to them for a low price. Those who purchased Adderall® reported that Adderall® 20 mg sold for between \$1-3 and Adderall® 30 mg sold for between \$5-6. Participants continued to describe typical users of prescription stimulants as adolescents and young adults who want to study, girls trying to lose weight or people who work long hours and like to party without falling asleep.

Current Trends

Prescription stimulants remain highly available in the region. Participants rated the current availability of prescription stimulants 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'. Treatment providers most often reported current availability as '2' and '3'. A treatment provider reported, *"[Prescription stimulant use] it's not popular with our population."* Both participants and treatment providers reported that the availability of prescription stimulants has remained the same during the past six months. The BCI Bowling Green Crime Lab reported the number of prescription stimulant cases it processed has stayed the same during the past six months, while noting that select medications based on methylphenidate HCL (Concerta® and Ritalin®) and dexamethylphenidate HCL (Focalin®) have decreased.

No slang terms or common street names were reported for prescription stimulants. Generally, participants did not have much experience with prescription stimulants, but some reported that Adderall® sells for between \$3-5 per pill. In addition to obtaining prescription stimulants on the street from dealers, participants also reported getting them from family and friends. A participant reported, *"I took my stepson's [medication]. I have a lot of fear. I felt braver; it helped my anxiety."*

Participants described typical users of prescription stimulants as college students. A participant reported, *"You clean your house, you study. [Prescription stimulant use] it's like*

a college kid thing." Another participant responded, "People that you wouldn't think use drugs. People that are clean and sober use it [prescription stimulants] because it helps them study." Participants had no knowledge of other substances used in combination with prescription stimulants.

Bath Salts

Historical Summary

Bath salts were moderately available in the Toledo area and highly available in Huron County despite the ban that went into effect in October 2011. Participants in Toledo most often rated the availability of bath salts as '6' and participants in Huron County as '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Typically, participants reported using bath salts because they were legal during part of this reporting period and could not be detected on work-related drug screens. Participants reported that two grams of bath salts legally sold for between \$10-12 before the ban on their sale went into effect. Participants and treatment providers reported negative health outcomes once bath salts were ingested including hallucinations and paranoia.

Current Trends



Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) remain moderately available in the region. Participants reported the current availability of bath salts as '3' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common scores were '6' in Toledo and '7' in Huron County. Treatment providers reported the current availability of bath salts in Toledo as '8' because users, as one provider stated, "can order it [bath salts] on the Internet."

A minority of participants reported using bath salts during the past six months. A participant reported, "It's not bath salts anymore because the DEA put regulations on it. So, all they did was tweak the formula a little bit and call it rim cleaner or window cleaner. They call it whatever they want just to get the DEA off their back." The DEA reported they have seen an increase in bath salts in at least four rural counties and also in Bowling Green. The BCI Bowling Green Crime Lab reported that the number of bath salts cases it processed has increased during the past six months.

As seen in the prior reporting period, participants discussed the negative health consequences of bath salts use. A participant who ingested bath salts on a daily basis for six months reported, "I heard things. I saw things. I was hiding. I

was seeing things. I was whispering. I thought there were people chasing me. I found myself hiding in a wet field all day, running from people that weren't even there. People had to come and get me and tell me that no one was there." Another participant said that bath salts brought him a lot of energy: "[Bath salts] it's just like meth. One hit off the shooter ... you're zooming around for three or four days."

Current street jargon for bath salts is limited to the process of using bath salts, called "taking a bath." Participants reported that they could obtain bath salts from convenience stores and through the Internet. Typically, 2.5 grams of bath salts sells for \$20. A participant with experience buying bath salts through the Internet reported, "They sell it [bath salts] in little jars, like 3.5 ounce jars and I'd probably got 100 of them because the more you buy the cheaper it is." The most common route of administration is smoking. However, a participant discussed various routes of administration: "You can snort it [bath salts], smoke it, or shoot it ... although that [injecting] can sometimes be difficult. People smoke it. If you sniff it, you'll get big scabs. It burns." A participant who used intravenously reported, "I got it [bath salts] at a corner store. I put it in water and mixed it up and I shot it up ... you can't even talk for like an hour."

Other Drugs

Historical Summary

In the previous reporting period, participants and community professionals listed the following other drugs as present in the region, but these drugs were not mentioned by the majority of people interviewed: hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], inhalants, salvia divinorum (psychoactive plant) and synthetic marijuana ("K2" and "Spice"). Participants and treatment providers reported that synthetic marijuana was moderately available in the region. Participants most often rated the availability of synthetic marijuana as '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Reportedly, synthetic marijuana was smoked using the same techniques used to smoke marijuana. Participants reported using synthetic marijuana as an alternative to marijuana to pass urine drug screens. Inhalants were also highly available in the region. However, not many participants reported inhalant use due to the negative health consequences of their use. Participants said users typically abused computer dusters (compressed gas used to clean computer keyboards) and "whippets" (nitrous oxide) bought from local stores. Participants also described abusing VCR head cleaner (aka "Rush"). Salvia divinorum was moderately available in the region. Participants most often rated the availability of salvia divinorum as '6' on a scale of '0' (not available, impossible to get) to '10' (highly available,

extremely easy to get). Reportedly, the most common way to use the drug was smoking. Participants reported that *salvia divinorum* looked like potpourri and was typically purchased through the Internet for \$30 per gram. The BCI Bowling Green Crime Lab reported that the number of *salvia divinorum* cases it processed had decreased during the previous six months. Reportedly, hallucinogens like LSD and psilocybin mushrooms were periodically available in the region. The BCI Bowling Green crime lab reported that the number of LSD cases it processed had decreased, and the number of psilocybin mushroom cases it processed had increased during the previous six months.

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: dimethyltryptamine (DMT) and synthetic marijuana.



Synthetic marijuana is highly available in the region. Participants most often rated 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 '6'. Both participants in Lucas and Sandusky counties reported that while availability is high, use of the drug is decreasing. Participants reported they preferred marijuana, which is more available. They also reported that synthetic marijuana became more difficult to obtain since the ban on it went into effect in

October 2011. A participant commented on a recent drug seizure: *"It was easy to simply go down to the gas station and get it [synthetic marijuana] ... but they got busted."* Treatment providers most often reported the current availability of synthetic marijuana as '10'. According to one treatment provider, users were *"still getting it [synthetic marijuana] at head shops and gas stations."* The DEA rated the drug's availability lower, as a '5'. The DEA officer explained that users, *"don't have to go anywhere to buy it [synthetic marijuana]. You can order it right off the Internet and it will be shipped to your door from other countries."* Some participants reported that they combined synthetic marijuana with regular marijuana and smoked it. The BCI Bowling Green Crime Lab reported the number of synthetic marijuana cases it processed has increased during the past six months. The crime lab also indicated that AM2201, JWH-122 and JWH-210 were the most common synthetic cannabinoids encountered.

Dimethyltryptamine (DMT) is also available in the region, although only one participant reported first-hand experience

in using this hallucinogenic drug during the past six months. According to this user, DMT is referred to as *"hippie crack."* The most common route of administration is smoking. Reportedly, DMT induces a "super trip" in which the person "blacks out" and hallucinates for 10 to 20 minutes. DMT can be purchased through the Internet or from dealers that specialize in hallucinogens. The participant reported, *"If you hang around hippies, you'll find it [DMT]."* Typically, the drug sells for \$10 "a point" (1/10 gram). The BCI Bowling Green Crime Lab reported the number of DMT cases it processed has increased during the past six months. While not mentioned by participants, other hallucinogens were mentioned by the crime lab. The BCI Bowling Green Crime Lab reported that cases of LSD, PCP and *salvia divinorum* have decreased and cases of psilocybin mushrooms have stayed the same during the past six months.

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids, prescription stimulants, sedative-hypnotics and Suboxone® remain highly available in the Toledo region. Likely increases in availability exist for heroin, bath salts and synthetic marijuana; a likely decrease exists for Ecstasy. While participants and treatment providers reported that brown powdered and black tar heroin have remained highly available during the past six months, they also most often reported the current availability of "china white" heroin as '10', with treatment providers reporting that they believed the availability of "china white" to be steadily increasing. Reportedly, "china white" heroin is several times more powerful than brown powdered or black tar heroin; it appears white in color due to a refining process and is usually imported from Asia. The BCI Bowling Green Crime Lab reported that the number of powdered and black tar heroin cases it processed has increased during the past six months. The DEA and the BCI Bowling Green Crime Lab reported that the number of bath salts cases they process has increased during the past six months, despite the ban on their sale that went into effect in October 2011. While few participants reported using bath salts, they reported that they could still obtain bath salts from convenience stores and through the Internet. They also reported that bath salts have been chemically altered and re-branded as rim cleaner and window cleaner. Participants who used bath salts frequently talked about the negative health consequences, including hallucinations and paranoia. Both participants and community professionals rated the current availability of synthetic marijuana as '10'. Participants reported that while availability is high, use of the drug is decreasing because participants reported that they preferred marijuana. The BCI Bowling Green Crime Lab reported the number of synthetic marijuana cases it processed has increased during the

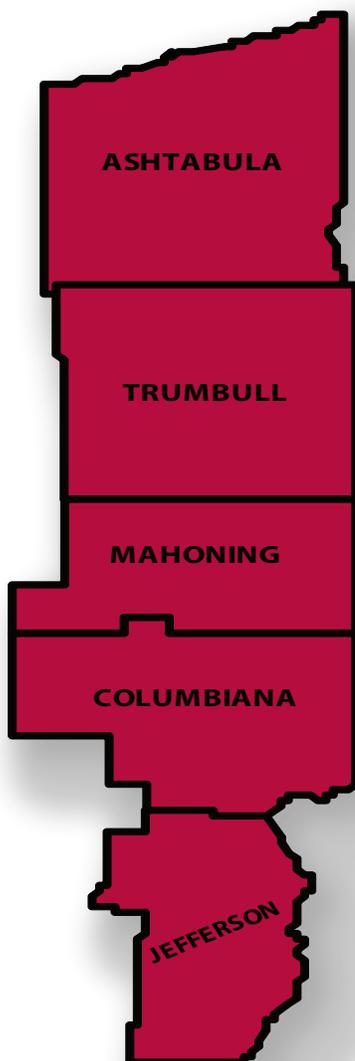
past six months. The crime lab also indicated that AM2201, JWH-122 and JWH-210 were the most common synthetic cannabinoids encountered. Participants reported that the availability of Ecstasy has decreased during the past six months. Participants indicated that Ecstasy is not desired because it is not a potent drug and is highly adulterated. Participants also reported the availability of Ecstasy-like substances in the region including 2CE and 2CB. The BCI Bowling Green Crime Lab reported the number of Ecstasy cases it processed has decreased during the past six months. Lastly, and noteworthy this reporting period, is that, for the first time, one or two participants at each interview location reported having personally bought, sold and/or used methamphetamine during the past six months. Participants reported that the availability of the one-pot method of powdered methamphetamine has slightly increased during the past six months. The DEA reported that methamphetamine is frequently manufactured through a process called, "shake-and-bake" or one-pot method (methamphetamine produced in a single sealed container, such as a two-liter soda bottle). They reported finding several mobile methamphetamine labs during this reporting period.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Youngstown Region

January-June 2012

John R. Kasich, Governor
Orman Hall, Director



Regional Epidemiologist:

Lisa Fedina, MSW

OSAM Staff:

R. Thomas Sherba, PhD, MPH, LPCC
OSAM Principal Investigator

Rick Massatti, MSW

Research Administrator, OSAM Coordinator

Youngstown Regional Profile

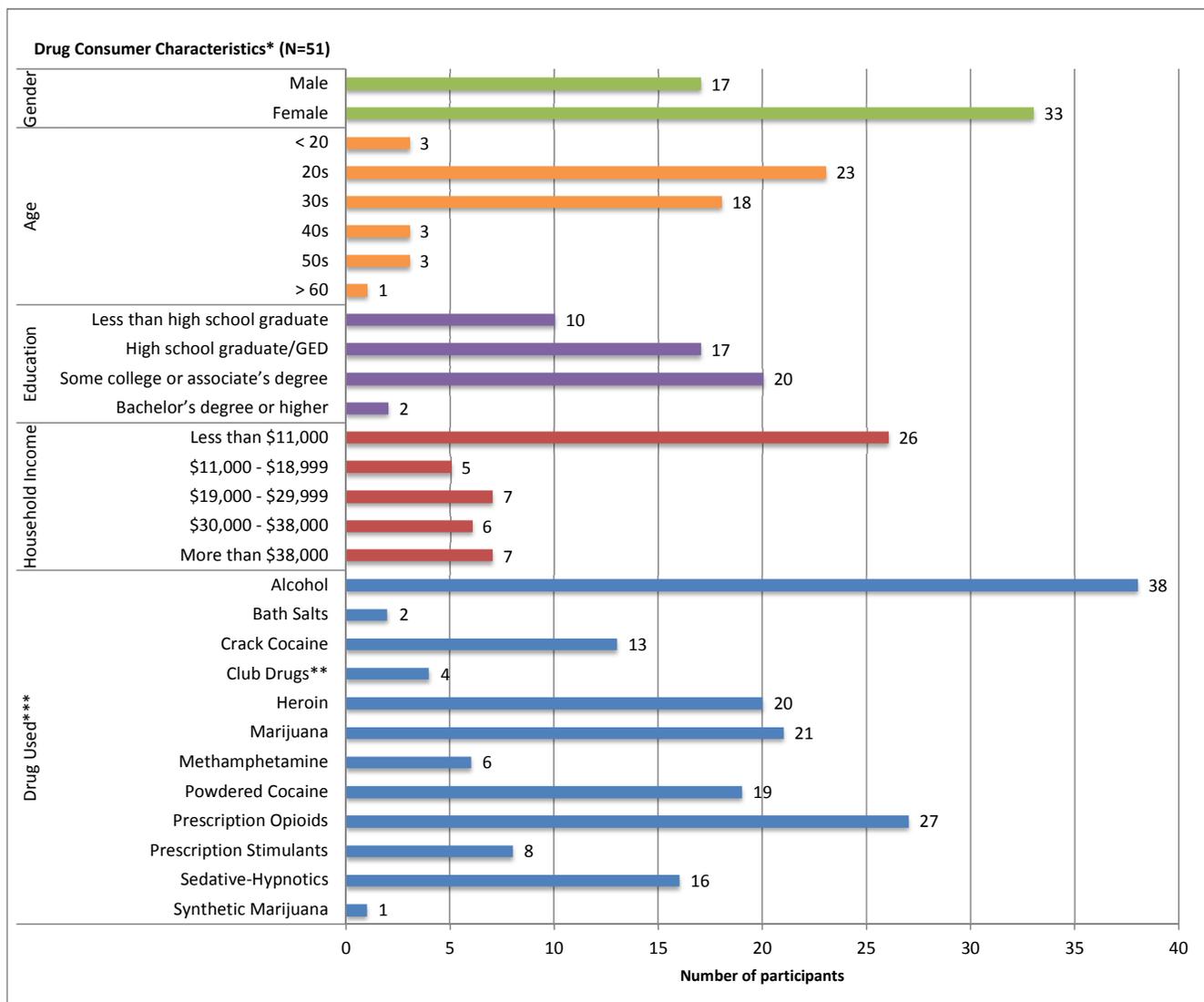
Indicator ¹	Ohio	Youngstown Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	728,182	51
Gender (Female), 2010	51.2%	51.1%	66% ²
Whites, 2010	81.1%	86.3%	86.3%
African Americans, 2010	12.0%	8.7%	3.9%
Hispanic or Latino Origin, 2010	3.1%	2.7%	3.9%
High school graduates, 2009-2010	84.3%	86.8%	79.6% ³
Median household income, 2010	\$45,151	\$38,228	Less than \$11,000 ⁴
Persons below poverty, 2010	15.8%	16.9%	66.70%

Ohio and Youngstown statistics are derived from the U.S. Census Bureau.¹

Gender was unable to be determined for one respondent due to missing data.²

Graduation status was unable to be determined for two respondents due to missing data.³

Respondents reported income by selecting a category that best represented their household's approximate income for 2012.⁴



*Not all participants filled out forms; therefore, numbers may not equal 51.

**Club drugs refers to Ecstasy and psilocybin mushrooms

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Ashtabula, Mahoning and Trumbull counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Mahoning County Coroner's Office and the Bureau of Criminal Investigation (BCI) Richfield Office, which serves the Akron, Cleveland and Youngstown areas. BCI data are summary data of cases processed from July to December 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current BCI data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2012.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants and community professionals most often reported the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals reported that the availability of powdered cocaine had remained the same during the previous six months. The BCI Richfield Crime Lab reported that the number of powdered cocaine cases it processed had also remained the same during the past six months. Most participants rated the quality of powdered cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). There was consensus among participants that the quality of powdered cocaine had decreased during the past six months. The BCI Richfield Crime Lab cited the following substances as commonly used to cut powdered cocaine: caffeine, benzocaine (local anesthetic), diltiazem (medication used to treat heart conditions/high blood pressure) and levamisole (livestock dewormer). The most commonly cited street names for powdered cocaine were "blow," "girl" and "powder." Participants reported that a gram of powdered cocaine continued to sell for between \$60-100, depending on quality. Participants reported that the most common route of administration for powdered cocaine remained snorting,

followed by intravenous injection. Out of 10 powdered cocaine users, participants reported that approximately eight would snort and two would intravenously inject. Participants most often described typical users of powdered cocaine as "teenagers and people in their early 20s," as one participant stated, confirming use among young adults between 18-25 years of age.

Current Trends

Powdered cocaine remains highly available in the region. Participants and community professionals 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.' However, most participants continued to report that crack cocaine is more available in the region than powdered cocaine. One participant stated, "Powder [cocaine] is definitely easy to find. You have to look for it though a little more than rock [crack cocaine]." Treatment providers also noted that crack cocaine is seemingly more available and used than powdered cocaine. One treatment provider stated, "You don't see it [powdered cocaine] as much as crack [cocaine], but it's pretty available. Clients talk about it in groups pretty frequently." A law enforcement official reported, "Powdered cocaine, we might find that in search warrants along with other drugs, but it's largely a suburban drug. Crack cocaine is largely an urban drug." Participants agreed that powdered cocaine, along with other drugs, is more difficult to get in various areas of the region. A participant from Ashtabula County reported, "Powder is harder to find, maybe a six to seven [on the availability scale], and more expensive here than in Youngstown." A participant from Trumbull County agreed, "I think Youngstown has a lot more powder than Warren." Collaborating data also indicated that powdered cocaine is readily available in the region. The Mahoning County Coroner's Office reported that 17.5 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range at time of death). Furthermore, the coroner's office reported cocaine as present in 37.0 percent of all drug-related deaths (Note: coroner's data is aggregate data of powdered cocaine and crack cocaine and does not differentiate between these two forms of cocaine). Both participants and community professionals reported that the availability of powdered cocaine has remained the same during the past six months. The BCI Richfield Crime Lab reported that the number of powdered cocaine cases it processes has remained the same during the past six months.

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 also '5.' Participants reported that powdered cocaine in the region

is cut (adulterated) with baby laxative, baking soda, ether, NoDoz®, prescription opioids, sleeping pills (Sleepinal®) and vitamins (B12). Participants reported, *"I'd say Vitamin B12 is the most common [cutting agent] and baking soda. They are cheap; I used Ultram® to cut powder."* Several participants also reported that head shops (stores that sell drug paraphernalia) sell products that can be used for cutting drugs. One participant said, *"You can get that Bolivian Rock from the head shop that's pretty popular. But, it'll be more expensive than vitamins or something else."* During the past six months, participants reported that the quality of powdered cocaine has remained the same. Participants with experience using powdered cocaine reported, *"People cut the hell out of it [powdered cocaine]. It's garbage ... mostly baking soda; It's low quality because everything is cut. It's junk ... been stepped on [adulterated] so many times."* Participants also noted that the quality of powdered cocaine depends on who you buy it from: *"I've had it [powder cocaine] be a '3' [quality score] all the way through an '8-9'; depending on who you buy it from and how many hands it's gone through; By the time it gets to Ashtabula from Youngstown, and before that, it's just been cut, and it's just shit."* The BCI Richfield Crime Lab continued to cite the following substances as commonly used to cut cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetics). (Note: crime lab data is aggregate data of powdered cocaine and crack cocaine and no longer differentiates between these two forms of cocaine).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "girl," "powder" and "soft." Participants listed the following as other common street names: "bitch," "blow," "candy," "coke," "dirty white girl," "snow," "soft candy," and "white girl." Participants reported that a gram of powdered cocaine sells for between \$50-60, depending on the quality; 1/16 ounce, or "teener," sells for \$100; 1/8 ounce, or "eight ball," sells for between \$150-180; an ounce sells for between \$1,200-1,400. Participants reported that the most common route of administration for powdered cocaine remains snorting, followed less commonly by intravenous injection. In addition, many participants identified powdered cocaine as a drug commonly used in combination with heroin to "speedball." Many users noted the practice of "speedballing," or mixing powdered cocaine with heroin for injection, as producing, as one participant said, a "better high." Out of 10 powdered cocaine users, participants reported that approximately five would snort and five would intravenously inject or "shoot" it. A participant with experience using powdered cocaine reported, *"I don't know. I just don't see that many people using coke [alone]. If they do, it's with heroin [to speedball]."* Out of 10 heroin users, participants reported that eight would "speedball" with powdered cocaine.

A profile for a typical powdered cocaine user did not emerge from the data. Participants often described typical users of powdered cocaine as "anyone and everyone." However, participants also often noted that powdered cocaine users have money and tend to be from more affluent communities and families. Participants reported: *"I think people who are in higher class [with] more money use it [powdered cocaine]. It's more expensive; Powder is pretty expensive ... way more expensive than heroin."* Many participants also noted some age differences with powdered cocaine use: *"I think [powdered cocaine use] it's younger kids, maybe 14-18 [years old]. You don't see it a lot beyond that. You see crack with older people."* Several participants also agreed that some individuals will use powdered cocaine to stay awake and alert: *"I've known a lot of truck drivers that have gotten hooked on that [powdered cocaine] because they have deadlines to meet, so they try to stay awake; I used it [powdered cocaine] when I was younger. High-school and college-aged kids [use it]. I think kids use it to stay awake and study."*

Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana, methamphetamine and prescription opioids. Participants agreed that other drugs are used in combination with powdered cocaine to "level-out" and help "come down" from the high of powdered cocaine. Participants reported using various "downer" drugs after having used powdered cocaine, although some participants reported using other drugs at the same time as powdered cocaine. A participant stated, *"I had to be drunk or have Xanax® to use [powdered] cocaine to balance it out, come down."* Other participants agreed that lacing marijuana with powdered cocaine is relatively common. One participant stated, *"I know a lot of people who will lace their [marijuana] blunts [with powdered cocaine] ... [called] 'woolies.'" Still other participants reported lacing tobacco/cigarettes with powdered cocaine, as one stated: "I've seen people lace their tobacco ... sprinkle it [powdered cocaine] in and roll up their own cigarettes." Several participants with experience using methamphetamine agreed that powdered cocaine is also commonly used with methamphetamine. One participant stated, *"I used it [powdered cocaine] with meth [methamphetamine]. I would shoot cocaine and meth together. Some people will snort coke and then smoke meth ..."**

Crack Cocaine **Historical Summary**

In the previous reporting period, crack cocaine was highly available in the region. Participants and community professionals most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10'

(highly available, extremely easy to get). However, there was consensus among participants that crack cocaine was more difficult to obtain in smaller towns and rural areas. Most participants rated the quality of crack cocaine as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI Richfield Crime Lab continued to cite the following substances as commonly used to cut crack cocaine: caffeine and diltiazem (medication used to treat heart conditions/high blood pressure). Participants reported that crack cocaine was sold in dollar amounts (\$10, \$20, \$50, etc.). The most common route of administration for crack cocaine remained smoking. Participants said that use of crack cocaine was wide-ranging throughout all demographic profiles, and they could not identify a typical user.

Current Trends

Crack cocaine remains highly available in the region. Participants and community professionals most often reported the drug's current availability as a '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 explained, "[Crack cocaine] it's on every street corner." Another participant agreed, "Crack [cocaine] is a '12' [on the above availability scale] in this area ... a 20 [extremely available]." Participants reported that the availability of crack cocaine has remained the same during the past six months. A participant summed up the common belief concerning availability, "Crack [availability] will always be the same [highly available]." Treatment providers and law enforcement were divided on a status change in availability of crack cocaine. Treatment providers reported that availability of crack cocaine has remained the same during the past six months. A provider said, "Crack is our stand-by drug ... pretty consistent ... it's always out there." However, law enforcement noted a decrease in crack cocaine possibly due to the rise in heroin over recent years. A law enforcement officer explained, "Crack has definitely gone down in the last year I would say. You can make more money off of heroin, so we've seen a decrease [in crack cocaine]." The BCI Richfield Crime Lab reported the number of crack cocaine cases it processes has remained the same during 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 '6.' Participants reported that crack cocaine in the region is cut with Anbesol®, aspirin, baby laxative, baking soda and products from head shops (stores that sell drug paraphernalia) such as procaine (local anesthetic). Most participants agreed that quality depends on several factors. A participant explained, "It [quality of crack cocaine] completely depends on where you get it, from whom, and what they cut it with ... how many hands have touched

it before it gets to you." Participants reported that the quality of crack cocaine has remained the same during the past six months.

Current street jargon includes many names for crack cocaine. The most commonly cited names were "crack," "hard" and "work." Participants listed the following as other common street names: "A1," "cream," "girl," "hard work," "her" and "rock." Participants with experience buying crack cocaine reported that current street prices for the drug are as low as \$5. In addition, several participants reported that crack cocaine is priced at \$10 per tenth of a gram with one reporting, "Every tenth of a gram is \$10. So .2 on the scale is \$20, .3 is \$30, .4 is \$40." However, most participants continued to report that crack cocaine is sold in dollar amounts (\$10, \$20, \$50, etc.) and not by exact weight. Another participant explained, "They don't really sell it [crack cocaine] like that though or in a gram. It's like dollar amounts – \$15 or \$20 worth of crack ... \$15 rock, a \$20 bag." Participants who were able to identify prices for larger quantities reported that a gram of crack cocaine sells for between \$40-70; an ounce sells for between \$1,100-1,250. While there were a few reported ways of using crack cocaine, generally, the most common routes of administration are smoking and intravenous injection. Out of 10 crack cocaine users, participants reported that approximately five would smoke, and five would intravenously inject or "shoot" it. Some participants thought use patterns varied depending on age. A participant stated, "Your old-school crack users would [smoke]."

A profile of a typical user of crack cocaine did not emerge from the data. Overall, participants agreed with one participant who described typical users of crack cocaine as, "everybody and anybody." A participant reported, "I saw every type of person [use crack cocaine] ... all lifestyles." However, many participants agreed that a certain "stigma" is attached to users of crack cocaine; therefore, crack cocaine users may have low income and live in lower-income neighborhoods. A participant explained, "Crack is like ... [for] mostly people that's hit rock bottom. It's real cheap." Another participant noted, "Nowadays, it's more acceptable to be a heroin addict than a crack addict." Several participants mentioned race and age differences among users of crack cocaine. A participant explained, "I think it's old people ... like 40s and up [who use crack cocaine]. Younger people are doing heroin." Many participants reported use of crack cocaine to be more common among African-Americans than other racial groups.

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana (aka "primo") and sedative-hypnotics. Participants reported using various drugs to help "come down" and level out the high from crack cocaine. A participant commented, "Heroin, alcohol, marijuana ...

anything to help to come down or level out [from crack cocaine use]. It levels you out, so you're not all tweaked out." Other participants used crack cocaine to simulate a "high-low" roller coaster effect (aka "speedball"). A participant stated, "It [speedballing heroin with crack cocaine] gives you a different kind of high, a body buzz." Many participants believed there has been an increase in this practice. A participant explained, "It [speedballing] has so increased ... so many people, and young too, are speedballing with heroin now."

Heroin

Historical Summary



In the previous reporting period, heroin was highly available in the region. Participants and community professionals most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While many types of heroin were available in the region, participants reported brown powdered heroin as most available. Participants reported that heroin was easier to get than many other drugs. Law enforcement officials noted heroin as the most common drug they encountered,

reporting that throughout the entire region, heroin was the primary drug problem. Participants reported black tar heroin as rarely available, rating its availability as '2'. Participants and community professionals reported that the availability of heroin had either remained the same or had increased in some areas during the past six months. The BCI Richfield Crime Lab reported that the number of heroin cases it processed had increased during the past six months. Most participants generally rated the quality of heroin as an '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI Richfield Crime Lab cited caffeine and diphenhydramine (antihistamine) as commonly used to cut powdered heroin. The most commonly cited street names for heroin included "boy" and "dog food." Participants reported that brown powdered heroin was available in different quantities: a "baggie" or "stamp" (1/10 gram) generally sold for \$20; however, \$10, \$20 and \$30 stamps could also be purchased; a gram sold for between \$75-150, depending on quality and county within the region. Participants continued to report that the most common route of administration for heroin remained intravenous injection. Out of 10 heroin users, participants reported that approximately nine would intravenously inject it and one would snort it. Participants described typical users of heroin as "all types of people." However, most participants and community professionals

agreed that heroin was a significant problem among 18-25 year olds.

Current Trends

Heroin remains highly available in the region. Participants and community professionals most often reported overall availability of the heroin as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. While many types of heroin are currently available in the region, participants continued to report the availability of brown powdered heroin as most available. Law enforcement officials also noted brown powdered heroin as the most common type found in heroin cases. The BCI Richfield Crime Lab continued to describe powdered heroin cases it processes as brown or white. Participants from Ashtabula, Mahoning and Trumbull counties again reported that heroin is easier to obtain than many other drugs. Throughout the entire region, law enforcement reported heroin to be the primary drug problem: "We had four heroin overdoses in the last week; Everyone's getting into the [heroin] 'business' per se; Even some of the informants we've used in the past for crack [cocaine busts], they're not doing crack no more ... they're doing heroin. Everything's transferring over to heroin." Treatment providers also reported heroin to be the primary drug problem among clients: "Heroin is definitely our primary [treatment] problem; Heroin is reaching out the suburbs and people are coming from all over the place to get heroin here." Collaborating data also indicated that heroin is readily available in the region. The Mahoning County Coroner's Office reported heroin as present in 14.8 percent of all drug-related deaths. Media from the region reported on recent arrests related to heroin during this current reporting period. In February, four people were arrested in the Youngstown area for drug trafficking in crack cocaine and heroin, including fake heroin (www.tribtoday.com, Feb. 27, 2012). The following month, Steubenville Police (Jefferson County) arrested a woman for possession of heroin and possession of drug paraphernalia after paramedics found her passed out in a public restroom (www.heraldstaronline.com, March 20, 2012).

Participants reported black tar heroin to be rarely available, rating its current availability as '1' on a scale of '0' (not available, impossible to get) to '10' (highly available extremely easy to get); the previous most common score was '2'. Participants with experience using heroin reported: "I've never seen it [black tar heroin] ... you can't get it around here; Black tar comes in little balls sealed up in balloons ... but it's very hard to get; Black tar ... that's in bigger cities ... New York, Detroit." Treatment providers also reported that black tar heroin is rarely available in the region, but they again noted that clients do not typically identify what types of heroin are being used. Law enforcement reported having one black tar heroin case

during the past year. A law enforcement official stated, *"We haven't seen black tar at all. We've had one case in the last year, but we hadn't seen it in a long time, even at that point."* Most participants agreed that they have not specifically seen all-white powdered heroin, although some brown powdered heroin appears light beige in color or comes in cream-colored light brown or tan chunks. Participants with experience using heroin reported: *"White powder is available, but it's usually has just a little bit of brown or beige to it; [Powdered heroin] it's been about 50/50 brown and white. It varies ... you don't ask for white or brown [powdered] heroin ... you get what you get."* In addition, many participants with experience using heroin noted having used gray-colored heroin during the past six months. Most participants agreed that they did not know if the white or gray colors in brown powdered heroin is heroin itself or substances used to cut heroin. Participants also noted that heroin has been frequently bought in "chunks." A participant stated: *"[Heroin] it used to be more powdery, but now it's coming in chunk. It's white until you put it in water, and then it turns brown, orange, and oily."*

Participants reported that the availability of heroin has increased in the past six months. A participant with experience using heroin reported, *"Heroin is the most in-demand drug in this area. I think it's increased in the last six months because people can't afford pills [prescription opioids] anymore. They start with pills but can no longer afford it."* A second participant with experience using heroin reported, *"Heroin is like a 20 [on the availability scale.] It just keeps growing and growing. It's like a monster ..."* Another participant reported, *"I live in a crack neighborhood, and I'll say, like since last summer, most of them crack users, and now I'd say half of them are heroin users. They're switching to heroin."* Community professionals reported that the availability of heroin has remained the same during the past six months. The BCI Richfield Crime Lab reported that the number of powdered heroin cases it processes has increased during the past six months; the lab also reported that the number of black tar heroin cases seems to have increased as well.

Most participants generally rated the quality of heroin as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8'. Many participants agreed that quality varies within the region. A participant stated, *"[Heroin quality] it's better in Youngstown than it is here [Ashtabula County]. It keeps getting cut and cut ..."* Most participants also agreed that quality varies "depending on who you know." A participant reported, *"I've gotten heroin that's been an '8' or a '9' [quality scores], and other times it's been a '2' or '3.' It depends on what it's been cut with ... how many times it's been cut until it reaches you, and who you*

know ... if they can hook you up." Another participant with experience using heroin reported, *"Heroin [quality] is never consistent. And it affects people differently."* Participants reported that brown powdered heroin in the region is cut with baby laxative, brown-colored baby formula (such as Similac®), cut products sold at head shops, sleeping pills, vitamins (such as Vitamin D) and Xanax®. A participant stated, *"[Dealers] they'll use brown baby formula, vitamin D, Seroquel®, sleeping pills, anything at all."* The BCI Richfield Crime Lab cited the following substances as commonly used to cut cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetics) and noscapine (cough suppressant).

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "dog food." Other common names include: "doo doo," "dog poop," "dope," "H," and "smack." Participants reported that brown powdered heroin is available in different quantities: a "baggie" or "stamp" generally sells for \$20, however \$10, \$20 and \$30 "stamps" can also be purchased; participants also reported buying heroin in "bundles" (10-12 small packs of heroin) for \$100, averaging \$10 per pack with each pack being about the size of a dime, possibly a little larger or smaller; a gram sells for between \$120-150, with a half-gram selling for between \$60-70. Participants again noted that "stamps" are often folded within dense paper, specifically scratch-off lottery tickets. Participants with experience buying heroin reported that prices vary. A participant reported, *"It [heroin pricing] varies and depends on who you know, but I would always get \$50 worth ... like, 'here's \$50 give me some heroin.'"* Participants reported that the most common route of administration for heroin remains intravenous injection. Out of 10 heroin users, participants reported that approximately eight would intravenously inject or "shoot" it. However, many participants agreed that heroin users usually start off snorting it first. Participants explained: *"Majority of people are going to shoot [heroin], but they usually start off snorting. But once you stop getting high [via snorting], you're gonna shoot ... no matter what people say; I think snorting [heroin] is common, but eventually they'll start shooting."*

Most participants with experience using heroin reported obtaining needles from drug dealers and pharmacies. A participant reported: *"Some pharmacies sell them [needles], but they are cracking down on that."* A participant with experience buying needles from drug dealers reported: *"Dealers sell needles too, for one to two bucks."* Other participants reported: *"Dealers just gave them [needles] to me; I know there's a house in Youngstown, and this lady sells her needles ... You just go there and buy your needles; I got mine [needles] from family members ... diabetics."* Most participants unanimously agreed that needle-sharing is a problem in the

region. Participants reported that nine out of 10 intravenous (IV) heroin users potentially share needles. Participants with experience using heroin reported: *"Needle sharing is definitely a problem here. Hep [Hepatitis] C is a big problem. You can't get needles sometimes, so you'll share; I would say 10 out of 10 [of those who use needles] people would share needles. If you're shooting up, you've shared a needle at least once; Nothing else matters ... you know? I know a girl that shares needles all the time, fiending ... like, 'let me use your needle!' ... I'm like, 'can't you wait until you get home?'"* Many participants also agreed that contracting Hepatitis C and HIV/AIDS are concerns in the region. Participants reported, *"Oh yeah ... I know lots of people ... there's lots of Hepatitis going around; I've seen people pick them [needles] up off the side of the street. I bleach mine before I reuse them; Hep C seems to be pretty common nowadays. I was in treatment three times last year, and most of the girls I was in treatment with had Hep C from needles."*

Participants and community professionals described typical heroin users as White. Generally, participants continued to describe typical users of heroin as "all types of people." However, participants noted younger people, females and Whites as using heroin: *"I definitely think younger people are shooting up more. And I've seen a lot more females doing it [heroin]; I've seen very few Black people [use heroin]. [Heroin users] it's mostly younger White people ... male and female."* A law enforcement official reported, *"We've seen teenagers and up [use heroin], but more White users and equal males and females."* Treatment providers agreed, with one reporting, *"We have a lot more White and female heroin users in treatment right now."*

Reportedly, heroin is used in combination with alcohol, crack cocaine, marijuana, methamphetamine, powdered cocaine and sedative-hypnotics (benzodiazepines). A participant reported, *"I'd smoke crack ... smoke it before [using heroin] and after."* Crack cocaine and powdered cocaine are most commonly used in combination with heroin to "speedball." Participants reported that eight out of 10 heroin users might speedball using cocaine because it "intensifies your high." Many participants agreed that injecting heroin with powdered cocaine has become increasingly more popular, and potentially has increased during the past six months. Participants stated: *"Speedballing with heroin and cocaine is definitely common. If I couldn't get powder to speedball [with heroin], I'd melt crack down with vinegar; I think [speedballing] it's becoming more and more common. Every heroin user I know will speedball with coke."* Other participants noted that alcohol and marijuana are used in combination with heroin to help "level off" or "come down" from the high. Benzodiazepines were also noted as commonly used in combination with heroin. Several participants reported injecting heroin and swallowing Xanax® to intensify highs. A participant with

experience using heroin reported, *"I would use Xanax®... any downer [with heroin] to intensify the high."*

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), while community professionals most often reported availability as ranging between '2' and '10,' depending on the drug. Participants and community professionals identified Opana®, oxycodone, Roxycodone® and Ultram® as the most popular prescription opioids in terms of widespread use. Participants reported that the availability of prescription opioids, especially Opana® had increased during the previous six months. Participants also reported that OxyContin® OC (original formulation) was almost impossible to get, and in turn, the availability of Roxycodone® had seemingly increased as people seemed to prefer it over the new reformulated OxyContin® OP. Community professionals reported that the availability of prescription opioids had generally remained the same during the previous six months. The BCI Richfield Crime Lab reported that the number of prescription opioid cases it processes had remained the same during the previous six months. 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 routes of administration were snorting and swallowing. Most participants agreed that prescription opioids were more commonly snorted rather than swallowed among 18-25 years old. Many participants with experience injecting heroin reported also injecting prescription opioids. In addition to obtaining prescription opioids on the street from dealers, participants also reported obtaining them from pain management clinics, private physicians, hospital emergency rooms, and from family and friends who have prescriptions. Generally, prescription opioid use seemed to be very common among those 18-25 year olds. However, participants agreed that all types of people abused prescription opioids. Several law enforcement officials agreed that primarily young people between the ages of 18-25 years used prescription opioids and most often in combination with heroin. Participants agreed that heroin was commonly used with prescription opioids.

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 '8'. Participants identified Opana®, Percocet®, Roxicet® and Ultram® as the most popular prescription opioids in terms of widespread use. Participants with experience using prescription opioids reported: *"Opana's® are the new thing. They've been like steadily increasing for a while now; Opana® is pretty available but the price has increased about \$5-15 in the last six months. They are real expensive. That's why more people are just doing heroin now because it's*

so much cheaper." A participant with experience using heroin reported, *"Ultrams® are popular with heroin addicts. They will substitute out ... and you take a bunch of them, like 10-12 at one time."* Another participant reported, *"Some people love them [Ultram®]. In Youngstown, that's the going thing ... so easy to get."* In addition to these most commonly used prescription opioids, a participant reported for the first time abuse of Nubain® (nalbuphine), a semi-synthetic opioid used commercially as an analgesic: *"I did see something new in the last six months called Nubain®. [A client] was getting her own scripts through the Internet. [Nubain®] it's a synthetic opiate."* Community professionals most often reported the current availability of prescription opioids 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 between '2' and '10'; depending on the drug. Community professionals identified Opana®, Percocet®, Roxicet®, Ultram® as well as oxycodone as the most popular prescription opioids in terms of widespread use.

Both participants and community professionals reported that the availability of prescription opioids has increased during the past six months. Specifically, law enforcement reported increases in Opana®, Roxicet® and Vicodin®. Treatment providers also reported increases in Opana® and Ultram® during the past six months: *"We've seen a return back to prescription opioids in the last six months. For a while, they kind of went away; Ultram is the new crack. They take about 20-30 a day ... mix it with weed [marijuana] ... a lot of weed. Lots of young kids [minors] are taking those [Ultram®]."* The BCI Richfield Crime Lab reported that the number of prescription opioid cases it processes has remained the same during the past six months. Collaborating data also indicated that prescription opioids are readily available in the region. The Mahoning County Coroner's Office reported prescription opioids as present in 77.8 percent of all drug-related deaths. Media from the region reported on recent arrests related to prescription opioids during this reporting period. In February,

a Youngstown corrections officer was arrested on four counts of drug trafficking of OxyContin® (www.wfmj.com, Feb. 27, 2012).

In addition to increases in availability of prescription opioids during the past six months, participants also continued to report that OxyContin® OC is almost impossible to get. Participants reported, *"There are no old ones [OxyContin® OC] around ... been way more than six months [since availability has decreased for them]. The reformulated [OxyContin® OP] you can't snort them, so no one wants them; The new reformulated pills are a '10' [highly available], but no one wants them; ... no one wants to go through the hassle to break them [OxyContin® OP] down, put them in the microwave, whatever."*

Reportedly, many different types of prescription opioids (aka "beans," "cookies," "poppers" and "skittles") 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): Dilaudid® (aka "dilly's" and "dilly bars;" 4 mg sells for \$20; 8 mg sells for \$30); fentanyl (aka "patches;" 100 mg sells for between \$50-70); Opana® (aka "bears," "pana's," "pandas," "panda bears" and "yellow stop signs;" 40 mg sells for between \$40-70); OxyContin® (aka "oxy's"); OxyContin® OC (old formulation, aka "OC's," "old cars" and "Orange County;" sells for a minimum of \$1 per milligram), OxyContin® OP (new formulation, 40 mg, aka "little boys" and "oranges;" sells for between \$20-25); Percocet® (aka "blues," "greens," "peaches" and "perc's;" 7.5 mg sells for \$3; 10 mg sells for between \$5-7; 15 mg sells for between \$12.50-15); Roxicet® (aka "IR 15's," "IR 30's," "blues," "blue gills," and "roxy's;" 30 mg sells for \$20-30); Soma® (sells for \$2 per pill); Ultram® (aka "trims;" sells for between \$.50-1.50 per pill); Vicodin® (aka "vic's;" 5 mg sells for between \$1-2; 7.5 mg sells for between \$2-3; 10 mg sells for between \$4-7). In addition, some participants from Ashtabula County with experience using Opana® identified price increases during the past six months. One participant stated, *"It [Opana®] used to be a dollar per milligram here [Ashtabula County], but they've gone way up ... perc's [Percocet®] too. Opana's use to be \$40 for 40 mg, but they are \$60-65 now."* Another participant reported *"Opana's definitely got more expensive lately ... used to pay \$30-40."* Although low availability, fentanyl was identified as available in some parts of the region; however, most participants agreed that availability of fentanyl is dependent on "who you know." Participants with experience using fentanyl reported, *"They changed [the formation of] them, you can't cut them open no more. You got to put them on now. My buddy got them for surgery and gave them to me. I sold them \$20-25 apiece, but they are re-formulated. They're really hard to*

find; I think [availability of fentanyl] it's decreased in the last six months. You got to know someone ... they are available mostly by the state line [with Pennsylvania]."

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 routes of administration are snorting and intravenous injection. A participant with experience using prescription opioids reported, *"Most people are shooting [injecting] or snorting [prescription opioids], no one is swallowing them. It's a waste."* Many participants reported that snorting is more common than swallowing; however, participants indicated that the route of administration depends on the drug(s) used in combination with prescription opioids. Participants reported, *"[Prescription opioids] they're definitely snorted most commonly. It's more common to snort than eat them. Perc's [Percocet®] and roxy's [Roxicet®] ... always snort those; I think if you're drinking [alcohol], than people are more likely to swallow and drink with them. It depends on your preference."* Many participants agreed that injecting prescription opioids are common. Out of 10 prescription opioid users, participants reported that approximately two to three would intravenously inject or "shoot," and seven to eight would snort. Most participants agreed that users who intravenously inject prescription opioids would also typically use heroin. A participant stated, *"The majority of those people shooting [prescription opioids] are also heroin users, so heroin users are gonna shoot, not snort or swallow."* In addition, participants reported crushing the pills, putting them in their mouth and then swallowing them, or "parachuting" them by crushing the pill, wrapping it in a tissue and then swallowing to avoid bad tastes. A participant reported, *"I would parachute them [prescription opioids]. Crush them up, put it in a piece of toilet paper and swallow them. It would work faster."* Other participants reported "chewing" the pills: *"I always chewed my pills. Chewed and then took them with coffee because I felt like it melted them faster but that might have been in my head; That's what I was taught – to chew [prescription opioids]."*

In addition to obtaining prescription opioids on the street from dealers, participants also continued to report getting them from pain management clinics, family and private physicians, emergency rooms, as well as from family and friends who have prescriptions. Participants with experience obtaining prescription opioids reported, *"I know doctors who will write you a couple scripts [prescriptions] at the same time; Either you go to doctor and pay them in cash or you go to someone who has a script, or the person with the script sells to the dealer, and you buy them from the dealer."* Another

participant reported, *"If you have insurance, they'll write them for you; I got mine like a mixture of ways ... bought off the street and had my own script. Dealers buy whole scripts or people with scripts sell individually."*

A profile of a typical prescription opioid abuser did not emerge from the data. However, many participants agreed that prescription opioid abuse is common among adolescents and young adults. Community professionals reported that "anybody and everybody" uses prescription opioids, with one stating, *"Everybody, professionals, unemployed, teenagers, older people [use prescription opioids.] It's easy to get."* Community professionals also reported an increase in Opana® during the past month specifically among adolescents and young adults: *"We've seen an increase in Opana®, specifically with our young kids 16-21 [years of age]. They're also using marijuana with it ..."*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, heroin, marijuana and methamphetamine. Participants, who used prescription opioids with alcohol, reportedly did so to intensify their high: *"I drank [alcohol] with mine [prescription opioids] ... that's pretty common."* Participants who used methamphetamine reported using prescription opioids to "level-out" or intensify highs: *"I did meth [methamphetamine] with these [prescription opioids] a lot. Back and forth ... smoke meth, pop pills, smoke meth ...; People use meth with this drug group ... injecting meth with opioids [to intensify their high]."*

Suboxone® Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants and community professionals most often reported availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). However, participants in Mahoning and Trumbull counties reported higher availability than participants in Ashtabula County. Participants and community professionals reported that the availability of Suboxone® had remained the same during the previous six months. The BCI Richfield Crime Lab reported that the number of Suboxone® cases it processes had increased during the previous six months. Participants reported that Suboxone® 8 mg most often sold for between \$10-15. In addition to obtaining Suboxone® on the street from dealers, participants also reported obtaining prescriptions from substance abuse treatment clinics and doctors. Participants described typical Suboxone® abusers as heroin users.

Current Trends



Suboxone® remains highly available in the region. Participants and community professionals most often reported the current availability of Suboxone® 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.' However, again participants in Mahoning and Trumbull counties reported higher availability than participants in Ashtabula County. Participants in Ashtabula County reported: *"[Suboxone® availability] it's decreased quite a bit in the last six months. It's hard to find ... I think people are trying to quit [heroin]; [Suboxone® availability] it depends on the time of the month ... when people get their prescriptions, but I think it's gotten harder to find."* Participants in Mahoning and Trumbull counties reported that availability of Suboxone® has remained the same during the past six months; whereas, participants in Ashtabula County reported a decrease in availability. Community professionals reported that availability of Suboxone® has increased during the past six months. Treatment providers reported, *"It [Suboxone®] has increased in the last few months. If they can't get heroin, they [heroin users] don't want to get sick, so they need it [Suboxone®]. With my clients, I'd say four out of 10 heroin consumers inject Suboxone®; We had a young guy here intimidate an older guy to cheek his Suboxone® and give it to him. The demand has increased."* Law enforcement reported, *"We seized it [Suboxone®] in search warrants. They are buying them and selling scripts to dealers; A lot [of users] will buy [Suboxone®] off the street because they can't afford them in the pain clinics, or they are still using heroin and use Suboxone® when they can't get it [heroin]."* The BCI Richfield Crime Lab reported that the number of Suboxone® cases (particularly the sublingual film form, which is dissolved under the tongue) it processes has increased during the past six months.

No slang terms or street names were reported for Suboxone®. Participants most often reported that Suboxone® 8 mg sells for between \$10-12. Participants did not report a price for Suboxone® 2 mg, and most reported that 2 mg is not commonly found. Many participants in all parts of the region reported that 8 mg strips of Suboxone® are more commonly found than 8 mg tablets. Participants with experience using Suboxone® reported, *"I haven't seen the [8 mg Suboxone®] tabs in a while ... it's mostly strips; I only see strips lately, no tabs; I've never seen the pills. The strips are most common ... you can quarter them up and it'll last you a while ... put it under your tongue."* Most often participants reported taking Suboxone® 8 mg orally and less commonly by injecting and snorting. Participants with experience using Suboxone® reported, *"You*

cut the [Suboxone®] strips in pieces and do one-fourth at a time; I would either put it under my tongue or shoot it. But it's a pain in the ass to shoot it. It doesn't even get you high when you shoot it." Some participants reported having snorted the pill: *"I've snorted it [Suboxone®] ... yuck ... it was gross; I know a lot of people that snort them [Suboxone®] – they get a better buzz by snorting."*

In addition to obtaining Suboxone® from prescriptions at substance abuse treatment clinics and doctors, participants also continued to report getting Suboxone® on the street from dealers. Many participants reported having obtained Suboxone® from a clinic using medical insurance. A participant stated, *"Most people I know get theirs [Suboxone®] from the clinic. I got my from the clinic ... but you gotta have insurance. Man, it's expensive."* Others reported having sold prescriptions and/or obtaining Suboxone® from a dealer. Participants reported: *"A lot of people will save them [Suboxone®] for when they can't find heroin ... or people will take them three days before they have to take a drug test; I do know a lot of people who take them [Suboxone®] for treatment, but they don't need their whole script, so they just sell the rest of them."*

Participants and community professionals continued to describe typical Suboxone® abusers as heroin users. A treatment provider reported, *"Suboxone® users are heroin users [ages] 18-29 [years] ... and White ... the same group as heroin users."* Reportedly, when Suboxone® is used with other substances, it is used in combination with alcohol, crack cocaine, marijuana and sedative-hypnotics (Xanax®). Participants with experience abusing Suboxone® reported, *"I didn't use any drugs with it [Suboxone®], but I used to drink [alcohol] on mine [while taking Suboxone®]; I would smoke crack and then shoot my Suboxone® afterwards ... to come down."* Many participants agreed that Xanax® is commonly used in combination with Suboxone®. A participant reported, *"I used Xanax® ... most people [on Suboxone®] I know used Xanax® with 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 and community professionals most often reported the availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants continued to identify Xanax® as the most popular sedative-hypnotic in terms of widespread use, followed by Klonopin® and Valium®. The Mahoning County Coroner's Office reported

that among drug-related deaths, Xanax® and Valium® were frequently seen. The BCI Richfield Crime Lab reported that the number of sedative-hypnotic cases it processes had remained the same during the previous six months, with the exception of a decrease in cases related to Librium®. The most common routes of administration remained oral consumption and snorting. A treatment provider reported that parachuting sedative-hypnotics was becoming more common among adolescents and young adults. A profile of a typical user of sedative-hypnotics did not emerge from the data; participants continued to report that typical use transcended age, gender and race.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants and community professionals 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 '8'. A participant reported, *"So many avenues [through which to obtain sedative-hypnotics], so many people pass them out."* A treatment provider stated, *"We have a good amount of people using benzo's [benzodiazepines] ... If you are using heroin or crack, you can use the benzo's in between as well."* Participants continued to identify Xanax® as the most popular sedative-hypnotic in terms of widespread use, followed by Klonopin® and Valium®. A participant explained, *"Xanax® is probably people's first choice ... then Klonopin® ..."* Community professionals identified Klonopin® and Xanax® as most popular. A law enforcement official reported, *"When we do our prescription pill pick-ups, those [Klonopin® and Xanax®] are the hot items. That's what people are turning in."* Collaborating data also indicated that sedative-hypnotics are readily available in the region. The Mahoning County Coroner's Office reported sedative-hypnotics as present in 55.6 percent of all drug-related deaths. Participants and community professionals most often reported that the high availability of sedative-hypnotics has remained the same during the past six months. The BCI Richfield Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months.

Reportedly, many different types of sedative-hypnotics (aka "B's", "benzo's", "downers", "skittles", "wagon wheels" and "Z's") 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): Klonopin® (aka "pins;" 2 mg sells for between \$2-3), Valium® (aka "V's;" 10 mg sells for between \$1-2) and Xanax® (aka "blues," "greens," "ladders," "peaches" and "xani's;" 0.5 mg sells for \$1;

1 mg, aka "footballs," sells for between \$2-3; and 2 mg, aka "bars," "candy bars" and "xanibars," sells for between \$3-5). In addition, participants reported that Xanax® 2 mg is most popular in terms of widespread use. While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, generally, the most common routes of administration remain oral consumption (swallowing and chewing) and snorting. Participants with experience using Xanax® reported, *"I chewed my Xanax®; I don't know anyone who would swallow Xanax®. Everyone snorts them ... or yeah, chew them."* Community professionals reported smoking as another route of administration. A treatment provider explained, *"There is a new trend, in detox, folks are saying they've started smoking different pills because they say it's faster and doesn't burn their nose like snorting does."* A participant with experience smoking sedative-hypnotics reported, *"I smoked mine in foil. I don't like putting anything up my nose."*

In addition to obtaining sedative-hypnotics on the street from dealers, participants also continued to report getting them from family, friends and physicians. A participant talked about the easy access he has to sedative-hypnotics at home: *"Ativan® is in my dad's cupboard, so I could go get it if I want ..."* Other participants supported this notion and frequently made comments such as, *"Most people I know either have a script or they know someone that does; I always got them [sedative-hypnotics] from family and friends who have prescriptions."* Another participant discussed getting Xanax® from physicians: *"Anyone can get Xanax® from a doctor."* Community professionals talked about the liberal prescribing practices in their community. A treatment provider reported, *"The problem is that [sedative-hypnotics] it's easily prescribed and physicians are not perhaps as discriminating as they should be. You go to the doctor and say you have anxiety [and you can obtain sedative-hypnotics]..."*

A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants continued to describe typical users of sedative-hypnotics as, *"all types of people."* Most participants had a difficult time developing a common category for users. A participant commented, *"I've seen young kids do them [sedative-hypnotics] ... Xanax® mostly, but then, I see older people too ... 40's and up."* Community professionals also described typical users of sedative-hypnotics as "across the board." However, some differences were noted. Law enforcement reported that they see a lot of high school students with sedative-hypnotics. An officer said, *"Mostly teens are using Xanax®."* Community professionals had a very different opinion. A treatment provider reported, *"I see young [sedative-hypnotic users], but also middle-aged 30-40's. For a while we were getting younger ones, but now [sedative-hypnotic use] it's pretty across the board."* Other treatment

professionals spoke about users seeking sedative-hypnotics for the roller coaster effect, with one stating, *“Because benzo’s are a downer, we see a lot of crack users use this [drug] group [sedative-hypnotics] the most. They get high, and then they get down – high and then down. They need [sedative-hypnotics] to ... so they can sleep.”*

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, crack cocaine, heroin and marijuana. Many participants reported using these drugs in combination to either help “come down” or to intensify a high. A participant explained, *“Alcohol goes hand in hand [with sedative-hypnotics]; It [combining alcohol with sedative-hypnotics] gets you more f***** up.”* Another participant reported that she used crack cocaine in combination with Xanax® and explained her rationale: *“I used Xanax® with crack ... it would help me come down.”*

Marijuana **Historical Summary**

In the previous reporting period, marijuana was highly available in the region. Participants and community professionals most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Both groups also reported an increase in the availability of marijuana in the region during the previous six months. Participant quality scores of marijuana ranged from ‘4’ to ‘10’, with the most common score being ‘7’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that for commercial-grade marijuana, a “blunt” (cigar) sold for \$10; for high-grade marijuana, a blunt sold for between \$20-30. The most common route of administration for marijuana continued to be smoking. Participants reported that marijuana use was prevalent for men and women of all races and ages.

Current Trends

Marijuana remains highly available in the region. Participants most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10’. A participant reported, *“On a scale of 1 to 10, [marijuana availability] it’s a ‘30.’”* Participants felt that high-grade marijuana is the most desired and available form of the drug: *“Everyone likes high-grade weed – medical weed from Michigan. No one wants commersh [commercial-grade marijuana]; It’s very easy to get high grade; You don’t even see that Youngstown brown [local low-grade marijuana]*

no more ... it’s kush [high-grade marijuana].” Community professionals also continued to most often report the current availability of marijuana as ‘10’, while identifying marijuana as a primary drug in the region. A law enforcement official reported, *“Marijuana is one of our top three primary drugs [of abuse]. We’re always seeing marijuana – it reaches out to a lot more people than heroin does.”* Collaborating data also indicated that marijuana is readily available in the region. The Mahoning County Coroner’s Office reported marijuana as present in 11.1 percent of all drug-related deaths. Participants and community professionals reported that the availability of marijuana has remained the same during the past six months. A participant explained, *“Weed has always been easy to get. Commercial is out there, but I don’t know ... I see good weed all around.”* The BCI Richfield Crime Lab reported the number of marijuana cases it processes has remained the same during the past six months.

Participant quality scores of marijuana varied from ‘6’ to ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality), with the most common score being ‘6’ for “commercial weed” (low- to mid-grade marijuana); the previous most common score was ‘7’. Participant quality scores for high-grade marijuana varied from ‘8’ to ‘10’, with the most common score being ‘10’. Generally, participants agreed that the quality of marijuana depends on the dealer; however, many participants agreed that overall quality has improved during the past six months. Participants with experience using marijuana frequently reported, *“The quality [of marijuana] is improving every day; Oh, it’s high quality all around. Kush is easily a ‘10’ [high quality score]. I think [quality of kush] it’s increased.”* Community professionals agreed with the assessments of participants. A treatment provider reported, *“What I’m hearing now from people in treatment – across the board – is that the weed is so good right now. It’s really popular because it’s so strong.”* Law enforcement also spoke about the quality marijuana. An officer reported, *“Prices have gone up in the last six months and some of it seems like it’s a bit higher in quality. There’s been an increase in that [high-grade marijuana].”*

Current street jargon includes countless names for marijuana. The most commonly cited names were “buds,” “green,” “pot,” “trees” and “weed.” Participants listed the following as other common street names: “backyard,” “commerish,” “mids,” “middies,” “reggie” and “regular” for commercial-grade marijuana; “AK-47,” “Alaskan big bud,” “Christmas bud,” “Christmas trees,” “dank,” “exotic,” “fruity pebbles,” “hydro,” “orange kush,” “pineapple express” and “white widow” for high-grade or hydroponically grown marijuana. The price of marijuana depends on the quality desired. Participants reported that commercial-grade marijuana is the cheapest form: a blunt, two joints (cigarettes) or a “dimebag” (loose

marijuana sold in a plastic baggie) sells for \$10; 1/8 ounce sells for between \$20-25; an ounce sells for between \$90-120; a quarter-pound, or "QP," sells for between \$400-425; a pound sells for between \$750-1,000. Higher-grade marijuana sells for significantly more: a blunt, two joints or a dimebag sells for between \$20-30; 1/8 ounce sells for between \$50-70; 1/4 of an ounce sells for \$100; an ounce sells for between \$200-400. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. All participants with experience using marijuana reported smoking it. Participants reported that out of 10 marijuana consumers, three might consume marijuana in food products such as brownies and cookies. A participant commented, *"Some people do brownies [bake with marijuana], maybe for a special occasion. I wouldn't say it's that common."* Several participants reported using marijuana to infuse olive oil, butter or to make tea. A participant explained, *"I've made tea before with it [marijuana] ..."* In addition, several participants reported on having used vaporizers to smoke marijuana, and they reported it is common to vaporize the drug. Participants agreed that five out of 10 people would use vaporizers. Participants commonly reported that users would implement this technique for the highest quality marijuana. A participant commented, *"People use vaporizers only with real good weed though, with high quality."*

A profile for a typical marijuana user did not emerge from the data. Participants continued to describe typical users of marijuana as transcending age, gender and race. A participant stated, *"Everybody and everyone smokes weed."* Law enforcement agreed with user's statements. A law enforcement officer stated, *"[Marijuana use] it's across the board ... everyone. Just about anybody can get marijuana."* Treatment providers discussed the problem of youth perceiving marijuana as a harmless drug. A treatment provider noted, *"We see it [marijuana use] with everybody, but it's by far the most popular drug with our adolescents, teens. They don't see a problem with it ... 'It's just weed' [they say]."*

Reportedly, marijuana is used in combination with alcohol, crack and powdered cocaine (aka "woolies"), heroin, over-the-counter (OTC) cough medication, prescription opioids and sedative-hypnotics. A participant discussed using crack cocaine with marijuana: *"I used crack to lace or cocaine to lace blunts ... 'woolies' ... it's pretty common. It [cocaine] intensifies your [marijuana] high."* Another participant gave several reasons users combine marijuana with other substances: *"I think weed [goes] in combination with everything. It helps mellow you out, intensify your high, whatever. Helps you sleep."* Participants also reported dipping or coating "blunts" in cough syrup and reported that three out of 10 people might use this technique to intensify their high. A participant

reported, *"I've seen people dip blunts in NyQuil® or codeine syrup ... prescription cough syrup. It f**** you up."*

Methamphetamine **Historical Summary**

In the previous reporting period, methamphetamine was rarely available in some parts of the region and highly available in other parts. Participants most often reported the drug's availability as '2' in Mahoning and Trumbull counties and as '10' in Ashtabula County on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that methamphetamine was most often available in powdered form, which was homemade using the "shake-and-bake" or "one-pot" method (methamphetamine production in a single, sealed container, such as a two-liter soda bottle). The BCI Richfield Crime Lab reported that the number of methamphetamine cases it processes had remained the same during the previous six months. The crime lab also reported that brown and white powdered methamphetamine were the most commonly processed types. Participants reported that a gram of methamphetamine sold for between \$80-120. Participants also reported powdered methamphetamine sold in \$20 quantities. Reportedly, the most common route of administration of methamphetamine remained smoking. Participants described typical users of methamphetamine as Whites, between 20-40 years of age, possibly from more rural areas.

Current Trends



Methamphetamine remains relatively rare in some parts of the region and highly available in other parts. Participants most often reported the current availability of methamphetamine as '2' in Mahoning and Trumbull counties and '10' in Ashtabula county on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, the most common scores were also '2' in Mahoning and Trumbull counties and '10' in Ashtabula County. Participants reported that methamphetamine is not available in crystal form but in powdered form produced by the "shake-and-bake" method. Participants from Mahoning County talked about difficulty in obtaining the drug. A participant stated, *"Meth [methamphetamine] is more common in the country. I don't even know where to get it."* On the other hand, participants in Ashtabula County noted availability

of “anhydrous,” a red crystal form of methamphetamine, and reported the current availability of anhydrous methamphetamine as ‘7’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). A participant said, *“Little red, little Annie [anhydrous] is available too ... it’s harder to get than shake-and-bake ...”* Some participants from Trumbull County noticed an increase of methamphetamine in the region. A participant spoke about co-workers using methamphetamine: *“I work in Niles [Trumbull County]. I’ve never done it [methamphetamine], but people at work, they’ve been talking about it a lot ... the anhydrous coming around.”* Community professionals most often described the current availability of methamphetamine as moderately to highly available depending on the area in the region. However, community professionals most often reported current availability as ‘10’ in Ashtabula County, while reporting that methamphetamine is less available in Trumbull County, and even less available in Mahoning County. Law enforcement reported, *“[Available methamphetamine] it’s all ‘shake-and-bake,’ ‘one-pot’ method in Trumbull. In Ashtabula, it’s mostly ‘shake-and-bake,’ but the ‘Red P’ [phosphorous-based methamphetamine] they can still get it ... and anhydrous is out there.”* Community professionals from Mahoning County reported, *“We just haven’t started seeing it [methamphetamine yet]. We had one guy ... our first meth client in the last six months.”*

Several media outlets reported on methamphetamine labs in the region during this reporting period. In February, the Trumbull-Ashtabula Group (TAG) Drug Taskforce seized methamphetamine and related drug paraphernalia during two home raids and a traffic stop. A law enforcement official stated, *“Three meth incidents in Trumbull County in one week is huge, considering they’ve only busted five meth labs in the county over the last five years”* (www.wfmj.com, Feb. 23, 2012). In March, a man accidentally started a fire in an Ashtabula nursing home when his methamphetamine lab blew up; the man was unaffiliated with the nursing home and there was no indication of how long he had been manufacturing the drug on the property (www.twincities.com, March 6, 2012).

Participants reported that the overall availability of methamphetamine has remained the same during the past six months, while community professionals most often reported that availability has increased. A law enforcement officer explained, *“We’ve had five or six [methamphetamine] labs in Trumbull in the last year, so there’s been increase in Trumbull in the last six months. Some cooks from Ashtabula have also relocated to Warren [Trumbull County] since then.”* The BCI Richfield Crime Lab reported that the number of methamphetamine cases it processes has increased during

the past six months, mostly due to an increase in “shake-and-bake” methamphetamine. The crime lab also reported that they most often process white-powdered, brown-grit, crystal and liquid methamphetamine. Most participants rated the quality of methamphetamine as ‘7’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). A participant said, *“It [quality of methamphetamine] goes up and down ... it [quality] really depends on who makes it, and how they make it.”*

Current street jargon includes several names for methamphetamine. The most commonly cited names were “crank,” “glass,” “go-go,” “go-fast,” “ice,” “jib,” “jimmy crank,” “meth” and “tweak.” Commonly cited names for anhydrous methamphetamine were “little Annie,” “little red” and “red.” Participants with experience using methamphetamine reported that 1/2 gram of the drug sells for \$50; a gram sells for \$100; 1/16 ounce, or “teener,” sells for \$150; 1/8 ounce, or “eight ball,” sells for \$250. Reportedly, some dealers offer special deals if a user brings the ingredients for methamphetamine. A participant reported, *“You can also buy some materials and trade them in to dealers [for a discount on methamphetamine]. I’ve had a couple [dealers] tell me that, so I’ve brought a box of Sudafed® [and] lithium batteries. They’ll lower the price.”* Reportedly, the most common route of administration of methamphetamine remains smoking; less common routes are snorting and intravenous injection. Participants with experience using methamphetamine reported, *“Smoking is most common. One-hundred out of 100 people would smoke [methamphetamine]; I know quite a few people that snort too. It’s easier to snort it than to find an instrument or something to smoke.”* Many participants said the route of administration depends on whether other substances are used in combination with methamphetamine. A participant explained, *“I think shooting meth is common if you’re going to ‘speedball’ [mix methamphetamine with other drugs.]”* Another participant noted, *“I would say people who shoot meth, like out of 10, five of them might also do heroin. I think it’s common though to shoot it [methamphetamine with heroin].”*

Participants and community professionals described typical users of methamphetamine as White. A participant stated, *“[Methamphetamine] it’s definitely White people [who predominately use it] ... both males and females ... about ages 18-40 [years] on average.”* Community professionals also described typical users of methamphetamine as White. A law enforcement official reported, *“White users – 100 percent, and usually under 30 [years of age]. It’s equal between males and females, although more cooks are males.”* A participant noticed a trend in younger people manufacturing the drug: *“I live in Warren, and I’ve seen older people baking [manufacturing methamphetamine], like 40-50 [years of age], and younger*

people using ... but lately I've seen more younger helping to make it ..."

Reportedly, methamphetamine is used in combination with alcohol, heroin, marijuana and prescription opioids. Participants frequently reported use of alcohol and prescription opioids as "downers" to assist in coming off methamphetamine. A participant stated, *"Any opiates I think people will use to come down [from methamphetamine use]."* Users also combine methamphetamine use with other drugs to modify the high produced by methamphetamine. Several participants talked about creating an up-down roller coaster effect. A participant said, *"I used heroin [with methamphetamine], injected ... speed-balled to intensify the high."*

Ecstasy **Historical Summary**

In the previous reporting period, Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) was moderately available in the region. Participants most often reported the availability of Ecstasy as '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Many participants agreed that Ecstasy was highly available at a quarry in the region where spring, summer and fall music festivals are held. Community professionals and the BCI Richfield Crime Lab reported a decrease in Ecstasy in the region. Participants reported that Ecstasy tablets typically sold for between \$15-20, but they also said users could get discounts for buying large quantities. The most common route of administration was oral consumption. Many community professionals reported that Ecstasy remained popular among young adults.

Current Trends

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) remains moderately available in the region. Participants reported availability of Ecstasy as '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '5'. Most participants nodded their heads in agreement when one talked about the unpopularity of the drug: *"In January my friend used them [Ecstasy], but you really don't hear much about it."* Another participant with experience using Ecstasy explained, *"They [Ecstasy] are cut with all kinds of shit, so I don't think many people want them."* Many community professionals reported a decrease in Ecstasy use among clients during the past several years. Treatment providers frequently made comments like, *"It [Ecstasy use] comes up on the assessment ..."*

that they've done it in the past, but we don't get chronic users. They've move onto something else; I don't have it like I used to. Used to hear about it [Ecstasy] all the time but haven't in a long while." The BCI Richfield Crime Lab reported that the number of Ecstasy cases it processes has remained the same during the past six months.

Participants reported only one common street Ecstasy: "X." Participants also reported that Ecstasy tablets typically sell for \$15-20. The most common route of administration remains oral consumption. A typical user profile did not emerge from the data. A participant thought that drug dealers are the most likely group to use Ecstasy: *"I don't see a whole lot of it [Ecstasy]. I see [more] dealers using Ecstasy than anyone else ... crack, heroin dealers."* Other participants thought Ecstasy use is more likely with younger users: *"I feel like it [Ecstasy] used to be a big thing. When I was younger I did it ... I think maybe people will try it or do that first before they get into something else."*

Prescription Stimulants **Historical Summary**

In the previous reporting period, prescription stimulants were highly available in the region. Participants most often reported the availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that Adderall® was highly available, followed by Concerta® and Ritalin®, which were both believed to be somewhat available. Participants and community professionals reported that availability had remained the same during the previous six months. BCI Richfield Crime Lab reported that the number of prescription stimulant cases it processes had remained the same during the past six months, with the exception of a decrease in cases related to Dexedrine®. Participants reported getting prescription stimulants from doctors or from people with prescriptions. Typical users of prescription stimulants were described as teenagers or young adults.

Current Trends

Prescription stimulants remain highly available in the region. Participants most often 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 also '8'. According to participants, Adderall® remains the most available prescription stimulant followed by Concerta®. A community professional compared the availability of different prescription stimulants: *"I haven't seen Ritalin® in years, Adderall® is really easy to get."* However, a participant spoke of low demand for these drug: *"I don't*

think there's much a demand for it [prescription stimulants] ... there's plenty of meth around here." Community professionals did not report seeing many prescription stimulants in the field. A treatment provider explained, *"I'd say [Adderall®] it's popular with the younger ones. I think it's pretty available though. It's pretty easy to get prescriptions for it."* Participants and community professionals reported that the availability of prescription stimulants has remained stable during the past six months. The BCI Richfield Crime Lab reported the number of prescription stimulant cases it processes has remained the same during the past six months.

The only common street name for prescription stimulants was reported for Adderall®: "addies." Adderall® typically sells for \$2 per pill. In addition to obtaining prescription stimulants on the street from dealers, participants also continued to report getting them from doctors or other people who have prescriptions. Participants commonly made statements like, *"I think most people either have a prescription or they know someone that does; I have friends and people in my family who have been prescribed it [Adderall®]."* Participants continued to describe typical users of prescription stimulants as teenagers or young adults. A participant explained, *"[Prescription stimulant abuse] it's real big in college [and] any [place] that requires time and dedicated work, like food industries."*

Other Drugs

Historical Summary

In the previous reporting period, participants and community professionals listed the following other drugs as present in the region, but these drugs were not mentioned by the majority of people interviewed: alcohol, bath salts, cough and cold over-the-counter (OTC) medications and inhalants. Alcohol was highly available to those younger than 21 years of age and was especially popular among 18-25 year olds. Several participants reported alcohol as their primary drug of choice. Participants noted a few trends common among young people between the ages of 18-25 years, most involving the use of caffeinated alcoholic beverages. Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) were highly available in the region prior to the enactment of legislation in October 2011 which banned their sale. Participants and community professionals mentioned bath salts use numerous times, but availability of bath salts when the ban went into effect was unclear. A participant commented about the popularity of bath salts among high school students. While participants did not speak about the quality of bath salts, they said bath salts were commonly used to cut other drugs. The most common routes of administration for bath salts were snorting and smoking. Treatment providers agreed that adolescents

and young adults predominately used bath salts. Cold and cough OTC medications were also highly available in the region. Several participants reported personally abusing Coricidin®, Robitussin DM® and medicines that contain codeine. Participants reported that OTC medications were predominately abused by teenagers and young adults. Lastly, inhalants were highly available in the region; however, several treatment providers reported a decrease in inhalant-related admissions to treatment facilities during the previous six months. Most participants agreed these drugs were used primarily by adolescents and young adults.

Current Trends

Participants and community 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: alcohol, bath salts, hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], cough and cold over-the-counter (OTC) medications, inhalants and synthetic marijuana ("K2" and "Spice"). Several participants reported that alcohol was their primary drug of choice. Most participants agreed that alcohol is used in combination with many other drugs. Participants noted a few common trends with alcoholic beverages, most involving the use of caffeinated alcoholic beverages or brands that formerly combined alcohol and caffeine. A participant talked about his experience with these drinks: *"Those damn [Four] Loko's. I drank two of them and I was toast. And I shared them too."* Another participant talked about the drink's popularity: *"Four Loko's are pretty popular. They can hardly keep them on the shelf around here – they're pretty popular around here."* A participant spoke about a newer brand of drink that was also popular: *"The 'Blast' [fruity malt liquor] came out too. I think those are more popular now than the Four Loko's."*



Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) are moderately available in the region. Community professionals most often reported the current availability of these drugs as '4' or '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant spoke about bath salts use in her community: *"I just came from Fairfield County Jail, and half of the women in my group were heroin [users] and half were bath salts and meth [users]."*

Bath salts have decreased in availability likely due to the law banning their sale that took effect in October 2011. Participants reported hearing less and less about bath salts from other users during the past six months. A participant reported, *"I think there's been a decrease in [bath salts] the last six months. You can still get*

them from the stores, but people don't want them anymore. I think teens and younger are using it." Some participants spoke about chemical analogues taking the place of banned bath salts. A participant reported, "Once they took the bath salts off the market, they came out with something new ... 'Pump-it Powder' ... or something and that's out there now." Another participant agreed that users are now using these new chemical analogues: "Now people are switching to 'pipe cleaner' you can get at head shops ..." Community professionals also agreed that the availability of bath salts has decreased during the past six months. A treatment provider reported, "They [bath salts] are mostly black market, so I think there's been a decrease." The BCI Richfield Crime Lab reported that the number of bath salt cases it processes has increased during the past six months. Participants mentioned several routes of administration for bath salts, but did not say whether one was more common than another. A participant reported, "I think [bath salts] it's popular among younger, teenagers ... you can snort it, smoke it [and] shoot it. I think people snort it really." No participant reported using bath salts with other substances.

Hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms] are moderately available in the region. Participants most often reported the current availability of hallucinogens as '4' or '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, participants were unable to rate the availability of hallucinogens. Many participants indicated that psilocybin mushrooms and LSD are seasonal drugs and are more available at certain times of the year. A participant reported, "Mushrooms go up [in availability] in summer; it's a seasonal drug." Other participants said they could get psilocybin mushrooms at any time of the year. A participant indicated, "There are times of the year that you can get them [psilocybin mushrooms], but it's easy to grow them and you can still get them." Community professionals reported low availability of hallucinogens. A treatment provider commented, "We never really hear about it [hallucinogens]. It's on their [clients' assessments], that they've done it. They might have done it a few times but it's not chronic use." The BCI Richfield Crime Lab reported the number of LSD cases it processes has decreased, and the number of psilocybin mushroom cases it processes has remained the same during the past six months.

Inhalants remain highly available in the region. Reportedly, these drugs are primarily used among adolescents, teenagers and young adults. A participant said, "Young kids are doing it [inhalants] ... air duster, Freon, air conditioner stuff." Another participant spoke about a brand of inhalant that was popular among youth: "Rush – it's an inhalant – they sell it at head shops ... I see younger kids using it." A participant also spoke

about inhalants being sold at adult stores: "Whippets' [nitrous oxide] you can buy them up at the adult book store ... they're really easy to get."

Over-the-counter (OTC) cough and cold medications remain popular in the region. Participants noted various OTC medications used predominately among teenagers and young adults. A participant explained, "I think kids do the Triple C's [Coricidin®, cough and cold] and all that. I "robo-tripped" [drank an entire bottle of Robitussin®] when I was in high school ... [abuse of OTC cough and cold medications] it's [still] young kids." Treatment providers reported a slight increase in the abuse of OTC cough and cold medications with young adults. A provider commented, "We've seen a small increase with a couple of young adults, 18-19 [years of age], using cough syrup. Some of them have reported taking Jolly Ranchers® and will soak them in cough syrup."



Synthetic marijuana (K2, Spice) is highly available in the region; however, availability of synthetic marijuana was thought to have decreased due to the law banning their sale that took effect in October 2011. Participants reported users can obtain the same substances or newly reformulated substances of synthetic marijuana. A participant said, "There still are stores in [Trumbull County] that sell the legalized coke [bath salts] and Spice." Another participant said, "Spice is easy to get. Some brands you don't see as much anymore, but it's been getting harder to get [synthetic marijuana] I think." Law enforcement officials reported synthetic marijuana is moderately available. An officer said, "K2 and Spice is about a four or five [moderate availability ratings]. They're still selling the stuff that's labeled and doesn't contain anything illegal, but it's all behind the counter. We haven't had any reports on it in a while." However, treatment providers thought that there has been an increase in synthetic marijuana during the past six months. Participants and community professionals both reported the use of synthetic marijuana by those wanting to pass drug testing in courts and treatment programs. A participant reported, "I know a lot of people who are in the courts, drug court [and] mental health court, use that [synthetic marijuana] since they can't smoke weed." Treatment providers agreed with participants. A provider said, "We can't test for it [synthetic marijuana], so they use it ... anything we can't test for. But synthetic drugs are pretty popular." The BCI Richfield Crime Lab reported the number of synthetic marijuana cases it processes has increased during the past six months. The crime lab also reported that new chemical analogues to synthetic marijuana emerge monthly. While not reported by participants, the crime lab also mentioned that cases of

dimethyltryptamine (DMT; 5-MeO-DMT/DiPT) have increased and cases of salvia divinorum (psychoactive plant) have decreased during the past six months.

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids, prescription stimulants, sedative-hypnotics and Suboxone® remain highly available in the Youngstown region. An increase in availability exists for prescription opioids. Data also indicate likely increases in availability for heroin, methamphetamine and Suboxone®, and likely decreases in availability for bath salts and synthetic marijuana. Both participants and community professionals reported that the availability of prescription opioids has increased during the past six months, specifically for Opana®, Roxicet®, Ultram® and Vicodin®. In addition, participants continued to report that OxyContin® OC (original formulation) is almost impossible to obtain. The Mahoning County Coroner's Office reported prescription opioids as present in 77.8 percent of all drug-related deaths. Throughout the entire region, community professionals reported heroin to be the primary drug problem. Participants reported that the availability of heroin has increased; and the BCI Richfield Crime Lab reported that the number of heroin cases it processes has increased during the past six months. While many types of heroin are currently available in the region, participants and community professionals continued to report the availability of brown powdered heroin as most available. Participants also noted that heroin is frequently bought in "chunks." Out of 10 heroin users, participants reported that approximately eight would intravenously inject or "shoot" the drug. Participants and community professionals described typical heroin users as White, with participants further noting younger people and females as using heroin. Crack cocaine and powdered cocaine are most commonly used in combination with heroin to "speedball." Participants reported that eight out of 10 heroin users might speedball using cocaine. Community professionals reported that availability of Suboxone® has increased during the past six months. Treatment providers explained that heroin users do not want to get sick from withdrawal symptoms, so they need Suboxone® for when they cannot obtain heroin. The BCI Richfield Crime Lab reported that the number of Suboxone® cases (particularly the sublingual film form) it processes has increased during the past six months. Many participants agreed that Xanax® is commonly used in combination with Suboxone®. Participants reported that the overall availability of methamphetamine has remained the same during the past six months, while community professionals most often reported that availability has increased. The BCI Richfield Crime Lab reported that the number of

methamphetamine cases it processes has increased during the past six months, mostly due to an increase in "shake-and-bake" methamphetamine. Participants reported that methamphetamine is not available in crystal form but in powdered form produced by the "shake-and-bake" method. In addition, participants in Ashtabula County noted availability of "anhydrous," a red crystal form of methamphetamine, and reported the current availability of anhydrous methamphetamine as '7'. Participants and community professionals described typical users of methamphetamine as White. Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) and synthetic have decreased in availability, likely due to the law banning their sale that took effect in October 2011. Participants reported hearing less about these synthetic substances from other users during the past six months; however, they reported that users can either continue to obtain the same substances or newly reformulated similar substances, such as Pump-it Powder, a designer drug similar to bath salts.