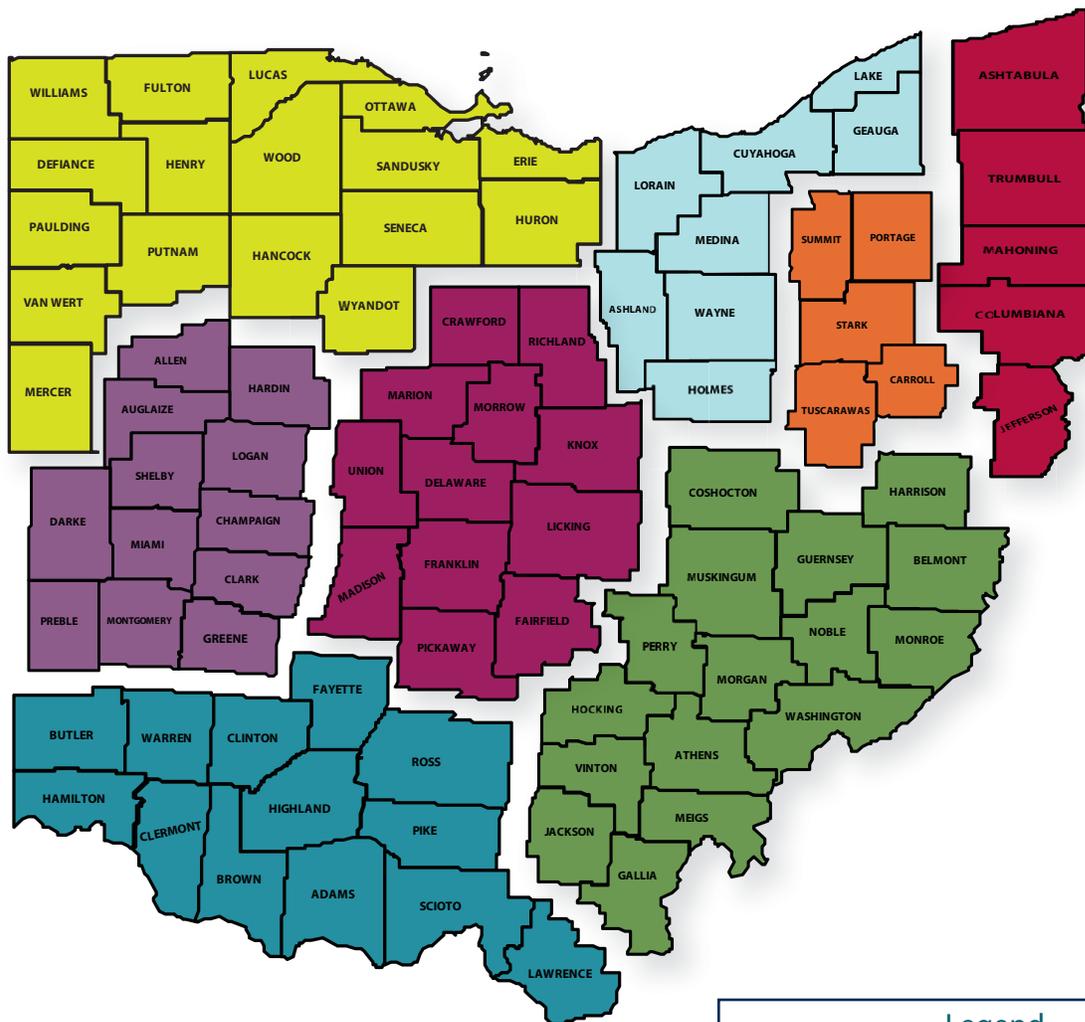


Ohio Substance Abuse Monitoring Network

Surveillance of Drug Abuse Trends in the State of Ohio

June 2011-January 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 |

Ohio

Department of Alcohol &
Drug Addiction Services

OSAM

Ohio Substance Abuse
Monitoring Network

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Toledo Region

- Increased availability of heroin and Suboxone® likely
- Most heroin users report first heroin use occurring between 18-19 years of age, with first use of prescription opioids occurring earlier
- Dealers aggressively push heroin, frequently marketing it as fentanyl to lure more buyers
- Continued availability of bath salts and synthetic marijuana anticipated despite recent bans
- Crime lab reports dozens of non-controlled chemical analogues similar to bath salts

Cleveland Region

- Increased availability of heroin, marijuana, methadone, methamphetamine and sedative-hypnotics
- Heroin availability perceived to be at “epidemic” levels
- Increased availability of high-grade marijuana continues; marijuana is the most easily obtained illegal drug in the region
- Increased availability of methadone attributed to increased prescribing of the drug for pain management
- DMT (dimethyltryptamine), a psychedelic compound popular among users 16-25 years of age is thought to be an emerging drug trend

Dayton Region

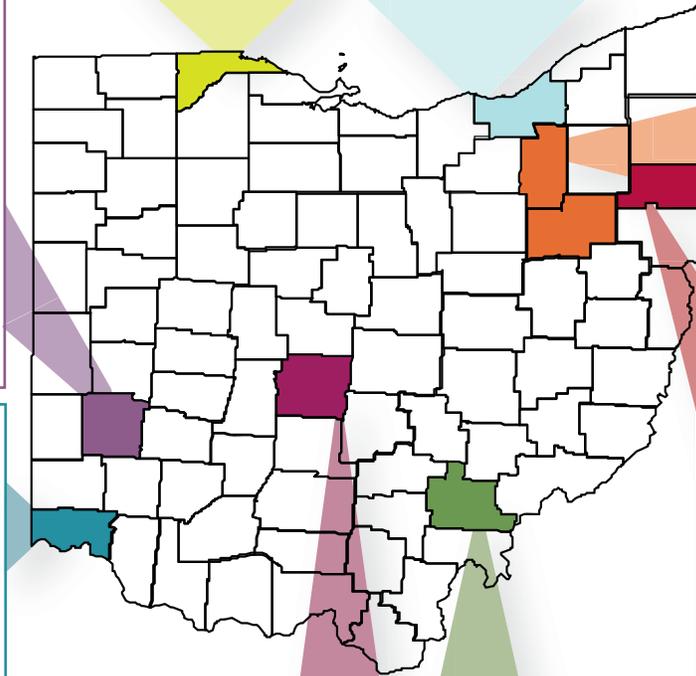
- Increased availability of heroin and marijuana
- Decreased availability of bath salts and prescription opioids (generally)
- Universal agreement that heroin is available; it is “falling out of the sky”
- Methadone abuse increasingly popular; Coroner’s staff reported methadone as the second-leading drug in overdose deaths
- While bath salts have decreased in availability since their ban, they remain easily obtainable

Akron-Canton Region

- Increased availability of heroin, powdered cocaine, sedative-hypnotics and Suboxone®
- Decreased availability of prescription opioids (generally)
- Opana® continues to gain in popularity as a replacement for OxyContin®
- Bath salts highly available; continued high availability despite recent ban
- Synthetic benzodiazepines (Zan-X®) available in head shops

Cincinnati Region

- Increased availability of heroin
- Decreased availability of methamphetamine likely
- Law enforcement attribute methamphetamine decline to increased scrutiny by pharmacies using MethCheck®
- Opana® and Roxicodone® gain in popularity as replacements for OxyContin®
- Heroin becoming prevalent for users in non-urban areas



Youngstown Region

- Increased availability of heroin and marijuana
- Increased availability of some prescription opioids, mainly Opana® and Roxicodone®
- Decreased availability of Ecstasy
- Law enforcement indentified heroin as the region’s primary drug problem
- While methamphetamine remains relatively rare in some parts of the region, reportedly, the drug is highly available in Ashtabula County

Columbus Region

- Decreased availability of methamphetamine and prescription opioids (generally)
- Decline in availability of prescription opioids attributed to closing of physicians’ offices known to liberally prescribe, and increased regulation on pharmacies
- Crime labs report heroin to be “typically pretty pure,” and one noted, “Columbus has an abundant supply of black tar heroin”
- Age of heroin initiation appears to be decreasing; reportedly, first-time users are as young as 15 years and typically White
- Bath salts remain of serious concern due to negative health consequences; users reported panic attacks and suicidal thoughts

Athens Region

- Increased availability of heroin and Suboxone®
- Decreased availability of bath salts
- Opana® continues to gain in popularity as a replacement for OxyContin®
- Increased scrutiny in emergency rooms means that users are looking elsewhere to obtain prescription opioids
- Crime lab reports dozens of non-controlled chemical analogues similar to bath salts

Executive Summary

The Ohio Substance Abuse Monitoring (OSAM) Network consists of eight regional epidemiologists (REPIs) located in 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 ODADAS with a real-time method of providing accurate epidemiologic descriptions that policy makers need to plan appropriate prevention and intervention strategies.

This Executive Summary presents findings from the OSAM core scientific meeting held in Columbus, Ohio, on Jan. 31, 2012. It is based upon qualitative data collected July through December 2011 via focus group interviews. Participants were 359 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 112 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 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 July through December 2011. OSAM research administrators in the ODADAS Division of Planning, Outcomes and Research prepared regional reports and compiled this summary of major findings. Please refer to regional reports for more in-depth information on the drugs reported on in this summary.

Powdered Cocaine

Powdered cocaine remains highly available in the majority of regions; it is moderately to highly available in Athens, Cincinnati and Columbus. Data indicate a likely increase in availability in Akron-Canton where respondents reported an increase in the popularity of the "speedball" among heroin users (concurrent or successive use of cocaine with heroin). The following universal themes related to powdered cocaine emerged throughout regions: street availability is somewhat limited, however users with connections can easily obtain the drug; crack cocaine remains the more prevalent form of cocaine; powdered cocaine is typically not a primary

drug of choice, but rather a drug often used to enhance the effects of other drugs. The most common participant quality score of powdered cocaine throughout regions varied from '4' to '10,' with the most common score being '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants throughout regions reported that the quality of powdered cocaine has either remained the same or has decreased during the past six months, and participants were unanimous in reporting that the quality of powdered cocaine continues to depend on the drug's source. Reportedly, some dealers adulterate powdered cocaine with various substances to increase profitability. Regional crime labs most often continued to report levamisole (livestock dewormer) as the most frequently identified cutting agent for powdered cocaine. In addition, participants in Akron-Canton, Athens and Cleveland reported that bath salts (synthetic compounds containing methylene, mephedrone or MDPV) are also used as a cutting agent. Current street jargon includes many names for powdered cocaine, with the most common names being "blow," "coke," "girl," "powder," "soft," "snow" and "white girl." Depending on desired quality and from whom one buys, a gram of powdered cocaine currently sells for between \$30-120 throughout regions. Participants reported that the most common way to use powdered cocaine remains snorting. Smoking is common among users who "rock up" powdered cocaine to manufacture crack cocaine, while intravenous injection is a common route among those users who are injectors of any drug. In terms of typical use patterns, powdered cocaine continues to be used in social settings such as bars and nightclubs. Reportedly, users are typically White and those with higher incomes, as powdered cocaine remains relatively expensive. However, in every region, participants and community professionals identified that users now include more young people than previously thought: teenagers, those in their 20s, high school and college students. Powdered cocaine is used in combination with alcohol, bath salts, Ecstasy, heroin, marijuana, prescription opioids, sedative-hypnotics and tobacco.

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). Universally, participants agreed that crack cocaine is more available than powdered cocaine. Like marijuana and oftentimes heroin, crack cocaine is reportedly available through street purchase from unknown dealers, as well as from established connections. Participants in several regions noted particular availability of crack cocaine near convenience stores and gas stations; however, participants

in Cleveland noted a decrease in “door service” for crack cocaine, which means “dope boys,” are less likely to approach a potential user’s car and sell the drug through the car’s window. This was perceived to be due to increased law enforcement activities during the past six months. Reportedly, dope boys are now likely to give their cell phone number to potential buyers to call for the drug. Participants also noted that crack cocaine is more difficult to obtain in smaller communities and in rural areas. Both participants and community professionals noted that the popularity of crack cocaine is being eclipsed by the increasing popularity of prescription opioids and heroin. Crime labs in Akron-Canton, Toledo and Youngstown reported that the number of crack cocaine cases they process has remained the same during the past six months, while labs covering all other regions reported a decrease in the number of crack cocaine cases processed. Perceived quality of crack cocaine is moderate in all regions; the most common participant quality score for crack cocaine varied across regions from ‘3’ to ‘8’ with the most common score being ‘5’ or ‘7’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Reportedly, quality continues to vary depending on several factors, such as from whom one purchases, location of purchase and time of the day or time of the month of purchase. Throughout regions, users reported that crack cocaine quality has either remained the same or has decreased during the past six months. Oftentimes, participants said crack cocaine was cut with other substances to add volume to the product to fool the user into thinking that he or she is receiving a good amount of crack cocaine. Participants also reported commonly re-cooking crack cocaine with the intent to ‘purify’ the drug for smoking. Participants in Athens and Cincinnati noted the presence of “dummy dope,” other substances sold to unsuspecting buyers in place of crack cocaine (aka fleecing). Regional crime labs continued to report levamisole (livestock dewormer) as the most frequently identified cutting agent for crack cocaine. Current street jargon includes many names for crack cocaine, with the most common names being “butter,” “crack,” “hard,” “rock” and “work.” Participants continued to report that crack cocaine is most commonly sold as \$10, \$20 and \$50 “rocks.” Throughout the regions, a gram sells for between \$30-120, depending on quality. While there were a few reported ways of using crack cocaine, the most common route of administration continues to be smoking. Out of 10 crack cocaine users, participants reported that approximately seven to nine would smoke, and one to three would intravenously inject the drug. 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, “anybody and everybody.” However, several respondents continued to associate use more commonly with people living in poor economic conditions, with a few professionals noting high

use among female prostitutes. Crack cocaine is often used in combination with alcohol, heroin, marijuana, prescription opioids, sedative-hypnotics and tobacco.

Heroin

Heroin remains highly available in all regions. During the previous reporting period, heroin availability had increased in Akron-Canton, Athens, Cincinnati, Dayton, Toledo and Youngstown. During this reporting period, heroin availability has continued to increase in all of these regions; an increase in availability also exists for Cleveland, while high availability in Columbus has remained the same. The general sentiment among participants was that heroin is, “falling out of the sky.” Law enforcement throughout regions consistently identified heroin trafficking as a primary concern. Universally cited, the primary reason for the increases in the availability of heroin during the past six months is increased demand for heroin, as more prescription opioid-addicted individuals realize that heroin is cheaper and easier to obtain than prescription opioids. Many respondents also continued to attribute the increased demand for heroin to the reformulation of OxyContin®. While many types of heroin are currently available in the regions, participants continued to report brown powdered as the most available type in Akron-Canton, Cleveland, Toledo and Youngstown; brown and white powdered heroin are most available in Cincinnati; brown powdered and black tar are most available in Dayton; black tar remains most available in Athens and Columbus. The most common participant quality score for heroin varied throughout the regions from ‘5’ to ‘10’ with the most common score being ‘7’ or ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). There was no consensus throughout regions as to change in overall heroin quality during the past six months; quality has either remained the same, decreased or was variable. However, there was consensus that quality continues to depend on from whom one purchases the drug; and overall, most participants agreed that heroin most often contains other substances. According to some law enforcement and the BCI London Crime Lab, heroin is, “typically pretty pure.” When heroin is cut, the BCI London Crime Lab reported the following substances as cutting agents occasionally used: caffeine, diphenhydramine (antihistamine), lidocaine and procaine (local anesthetics). 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. The most common way to use heroin remains intravenous injection; throughout regions, out of 10 heroin users, participants reported that approximately seven to nine would intravenously inject, and one to three would most likely snort with a small minority smoking the drug.

There was consensus among participants that needle sharing for injection is a problem; many participants expressed concern about contracting Hepatitis C. A profile for a typical heroin user did not emerge from the data. However, participants and community professionals consistently noted that heroin users are more likely to be White and getting younger. Heroin users in Toledo exemplified the overarching sentiment of heroin use by youth in reporting that their first heroin use occurred between 18-19 years of age, and was preceded by their first prescription opioid use when in high school. Age of first-time heroin use reportedly occurs in users as young as 13-14 years. Other substances often used in combination with heroin include alcohol, crack cocaine, marijuana, methamphetamine, powdered cocaine, prescription opioids and sedative-hypnotics.

Prescription Opioids

Prescription opioids remain highly available in all regions; however, general decreases in availability during the past six months exist for Akron-Canton, Columbus and Dayton. While still highly available in these three regions, decreases in availability of prescription opioids were attributed to the high cost of these drugs, the closing of physicians' offices that would liberally prescribe these drugs, increased regulation at pharmacies and the rise in popularity of heroin. Participants in these regions agreed that it's now more difficult to obtain prescription opioids than to obtain heroin. Participants throughout regions reported a drastic decrease in availability of the original formulation of OxyContin® OC; increases in availability of Opana®, a noted substitute to OxyContin® OC, exist for Akron-Canton, Athens, Cincinnati, Toledo and Youngstown; availability of methadone has increased in Cleveland and Dayton. Both law enforcement and treatment providers reported that methadone is increasingly prescribed for pain, and methadone is the second-leading drug found in drug-overdose deaths (after heroin), according to staff of the Montgomery County Coroner's Office. 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 is snorting, followed by oral ingestion (swallowing or chewing) and then intravenous injection. 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 and friends with prescriptions and pain clinics. In addition, participants in Cincinnati and Toledo reported buying prescription opioids from senior citizens. Participants described the typical user of prescription opioids as a young person, teenaged or twenty-something years in age, and predominately White. Participants and community professionals continued to note that first use of prescription

opioids occurs in early adolescence, with many users describing first use as early as 12-13 years. When used in combination with other drugs, prescription opioids are most often used with alcohol, crack cocaine, heroin, marijuana, powdered cocaine, sedative-hypnotics and other prescription opioids.

Suboxone®

Suboxone® is moderately to highly available throughout regions; availability remains high in Akron-Canton, Athens and Youngstown, has increased to high availability in Toledo, is moderately to highly available in Cincinnati and Columbus and is moderate in Cleveland and Dayton. In addition to Toledo, noted increases in availability of Suboxone® also exist for Akron-Canton and Athens during the past six months. A treatment provider stated, *"We're seeing an increase in the people who are either legally or illegally participating in the Suboxone® program so they can kick the heroin habit."* Participants reported that Suboxone® availability is more likely from legitimate sources than through street purchase; however, there was a high frequency of users who reported buying Suboxone® from other users with prescriptions. Participants and community professionals most often reported that Suboxone® is sought by opiate-addicted individuals for maintenance purposes to fight off cravings and withdrawal symptoms, rather than for recreational use. However, as was the case during the previous report period, there were reports of abuse among individuals who had not previously used opiates. Both the pill and film strip forms of Suboxone® are available. Current street jargon includes a few names for Suboxone®, including "signs," "strips" and "subs." The most commonly reported prices for Suboxone® were as follows: Suboxone® 2 mg sells for between \$5-10; Suboxone® 8 mg sells for between \$8-20; Suboxone® 8 mg film strips sell for between \$9-15. Participants continued to report most often taking Suboxone® sublingually (by dissolving it under the tongue). Among participants who reported on abuse of Suboxone®, snorting is the most common method of abuse, followed by intravenous injection. Reportedly, Suboxone® is used in combination with alcohol, crack cocaine, marijuana, powdered cocaine and sedative-hypnotics.

Sedative-Hypnotics

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) are highly available throughout all regions. In seven of eight regions, availability of sedative-hypnotics has remained the same during the past six months; a likely increase in availability exists for the Akron-Canton region. 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 commonly sold sedative-hypnotics throughout regions remain Klonopin®, Valium®

and Xanax®. Xanax®, the most popular sedative-hypnotic, sells for between \$1-3.50 per milligram, while most other sedative-hypnotics sell for between \$0.20-2 per milligram. In Akron-Canton, participants and law enforcement spoke about the emergence of synthetic designer drugs similar to benzodiazepines. A participant, whose drug of choice is bath salts, reported having experience with a pseudo-benzodiazepine product (the first OSAM Network report related to synthetic designer benzodiazepines): *"You can go to head shops in my area and buy fake xani [Xanax®] pills. They may not be the exact Xanax®, but it's the same thing."* The most common routes of administration for sedative-hypnotics are oral ingestion (swallowing or chewing) and snorting. Participants in Columbus reported a high frequency of intravenous injection of sedative-hypnotics. Illicit use of these drugs appears to be a far-reaching problem that affects all age groups, races and socio-economic backgrounds. However, participants in Athens said youth between 20-22 years of age are most likely to abuse sedative-hypnotics, while Cincinnati respondents reported that females, aged 20-60 years, are those most likely to use sedative-hypnotics. Combining sedative-hypnotics with other drugs is common. Participants reported that sedative-hypnotics are most often used in combination with alcohol, heroin, marijuana and prescription opioids to help intensify or extend a high. In particular, combination with prescription opioids was thought to intensify the effect of sedative-hypnotics. Many participants continued to mention that this class of drug is also used to "come down" from the effects of stimulants such as crack cocaine.

Marijuana

Marijuana remains highly available throughout all regions. Nearly every respondent talked about the ubiquitous availability of marijuana, and participants said they can easily obtain the drug at any time of the day and in any location. Six of the eight regions experienced stable availability of marijuana during the past six months; an increase in availability exists for Dayton; a likely increase in availability exists for Youngstown. Law enforcement in Youngstown likened the increase to an increase of medical marijuana coming from states such as California, and respondents in Dayton attributed the increase to an increase in marijuana indoor-grow operations. The overall quality of marijuana is moderate to high throughout the state, and users said the increase in quality during the past several years has made commercial-grade marijuana (low- to mid-grade marijuana) less desirable. The most commonly cited names for marijuana were "bud," "dank," "dro," "green," "hydro," "kush," "pot," "purple haze" and "weed." Prices for marijuana depend on the quantity and quality desired: for commercial-grade marijuana, a "blunt" (cigar) sells for between \$5-10; 1/8 ounce sells for between \$15-30; an ounce sells for

between \$75-160. Higher quality marijuana (hydroponically grown or high-grade marijuana) sells for significantly more: a blunt sells for between \$20-30; 1/8 ounce sells for between \$45-65; an ounce sells for between \$300-500. The most common route of administration remains smoking, with a minority of users baking marijuana into food. Some users in Athens, Cleveland and Toledo also reported vaporization of marijuana. According to these participants, this process is most popular among those with financial means because of the high cost of the vaporizers. Use of marijuana appears to be a far-reaching problem that affects all age groups, races and socio-economic backgrounds. When asked about the typical user, respondents most often said, "everyone" uses marijuana. Age of first use was most commonly reported as 12-14 years throughout regions; however, treatment providers in Dayton reported age of first use as nine to 10 years. While nearly every drug is used with marijuana, participants reported that the drugs most often used in combination with marijuana are alcohol, crack cocaine and powdered cocaine (aka "primo" or "woolie"). Participants thought that lacing marijuana is relatively uncommon, but reported embalming fluid as the typical lacing agent when marijuana is laced. Participants continued to report that marijuana is used to, "come down" from stimulant highs or to intensify the effects of other drugs.

Methamphetamine

Methamphetamine availability is variable throughout most of the regions, with lower availability in urban areas and higher availability in rural areas. Five of the eight regions experienced stable availability of methamphetamine during the past six months. Previously, an increase in methamphetamine was noted in Northeast Ohio, and this report shows that trend continuing; an increase in the drug's availability was noted in Cleveland. Participants in Cleveland said the drug's availability has increased because there are more methamphetamine labs operating in Lake County. A law enforcement official corroborated the increase in methamphetamine activity: *"In the last two weeks we've had three [methamphetamine] lab busts ..."* Decreases in methamphetamine availability were noted in Cincinnati and Columbus. Participants in Cincinnati attributed the decrease to increased law enforcement seizures of the drug. In Columbus, law enforcement believed the decrease is linked to lower pseudoephedrine availability with increased scrutiny by pharmacies using MethCheck® (a pseudoephedrine sales tracking system). Participants from most regions continued to report that methamphetamine is most available to a limited number of users who are connected with a tight-knit network of methamphetamine dealers and users. The overall quality of methamphetamine is moderate throughout the state. Participants in Akron-Canton believed that quality has decreased during the past six months due to the

incarceration of the most knowledgeable methamphetamine manufacturers. Reportedly, brown- and white-powdered methamphetamine are the most common forms of the drug throughout the state. When crystal methamphetamine is available, participants reported that it comes from the East Coast through biker gangs, from the West Coast (California) or from Mexico. The “one-pot” or “shake and bake” method of methamphetamine manufacture remains the most popular production method. By using common household chemicals, along with ammonium nitrate found in cold packs and pseudoephedrine (typically found in some allergy medications), users (aka “cooks”) can produce the drug in approximately 30 minutes at nearly any location by mixing ingredients in easily obtained containers, such as two-liter plastic soda bottles. The most commonly cited names for methamphetamine were “crank,” “crystal,” “glass,” “ice” and “meth.” Prices for methamphetamine depend on the quantity: a gram sells for between \$40-120; 1/16 ounce sells for between \$70-150; 1/8 ounce sells for between \$200-300, with lower prices indicating powdered methamphetamine and higher prices indicating crystal methamphetamine. The most common route of administration for this drug is smoking. However, intravenous injection remains the most common route of administration in Akron-Canton and Columbus; participants in most other regions reported IV use as relatively rare. Most regions did not describe a typical user of methamphetamine. Of the regions where a profile was identified (Athens, Cincinnati and Youngstown), respondents thought typical users to be mostly White males. In addition, participants in Columbus and treatment providers in Cleveland reported the drug to be popular among homosexual men. Reportedly, methamphetamine is often used in combination with alcohol, heroin and marijuana. Participants reported that alcohol and marijuana help the user to, “come down” or “level out” from the intense high associated with methamphetamine. Participants in Cincinnati continued to report methamphetamine use with heroin to “speedball” to experience an intense high followed by an intense low.

Ecstasy

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) availability is variable throughout regions; availability remains high in Akron-Canton, Cincinnati and Cleveland, appears to be high in Columbus, is moderate in Dayton, Toledo and Youngstown, and appears to be low in Athens. Data indicate that availability in Youngstown has decreased, with availability in all other regions appearing to have remained the same during the past six months. Participants reported that the drug comes in two forms, tablet and powder, with the most available form throughout regions being tablets. A few participants in Cleveland felt that powdered Ecstasy (aka “Molly”) has been increasing in availability as knowledge

about the drug grows. A participant described Molly as, “pure MDMA.” Data on current quality of Ecstasy is limited: participants in Cleveland most often rated the current quality of Ecstasy as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); participants in Dayton most often rated current quality as ‘6’. While participants in Akron-Canton did not identify a rating score for the quality of Ecstasy, some participants commented that the quality of Ecstasy has decreased, as it tends to be, “mixed [adulterated] with all kinds of stuff,” as one participant stated. Participants in Toledo reported that Ecstasy is often cut with one or more other drugs such as crack cocaine, heroin, methamphetamine or powdered cocaine. Current street jargon includes few names for Ecstasy. The most commonly cited names were “Molly” and “X,” and participants described “rolling” to mean a person was high on Ecstasy. Ecstasy is typically sold as small colored tablets that feature popular images or logos; tablet pricing is variable depending on dose amount and region of purchase; reportedly, a gram of Molly sells for between \$100-150. While there are few reported ways of administering Ecstasy, the most common route of administration remains oral ingestion. Participants also mentioned other less common methods such as snorting and intravenous injection. Some said users “parachute” (wrap a crushed tablet in tissue and swallow it), while others said users insert the tablet anally or dissolve it in warm water and take it like a shot of alcohol. Ecstasy is most often obtained from friends and dealers via phone call or at night clubs. Universally, participants reported that Ecstasy is most commonly used by people who like the club scene and “ravers,” and that Ecstasy is easily found in bars. Participants and community professionals also noted use among young adults and college students. Reportedly, Ecstasy is used in combination with alcohol and marijuana (aka “candy flipping”).

Prescription Stimulants

Prescription stimulants are moderately to highly available in all regions, with the exception of Dayton where participants attributed low availability to low desirability for these drugs. In regions where availability has remained high during the past six months (Cleveland, Toledo and Youngstown), participants and community professionals identified Adderall®, Concerta®, Ritalin® and Vyvanse® as most popular in terms of widespread use. Participants and community professionals remarked on the high level of prescription stimulant abuse among high school- and college-aged individuals. Nearly every participant with experience using prescription stimulants mentioned the drugs’ ability to help the user, “focus.” Reportedly, use of prescription stimulants increases on college campuses during exam periods. The only street terms reported to refer to prescription stimulants were, “poor man’s coke” and “addies” for Adderall®. Reportedly, Adderall® continues to dominate in terms of widespread use throughout regions. Those who purchased Adderall®

reported that Adderall® 30 mg sells for between \$5-10. The most common routes of administration of prescription stimulants are oral ingestion and snorting. Participants reported getting prescription stimulants from doctors or from people with prescriptions. Those in the 18-25 age group reported that they obtained Adderall® from others, usually friends, who were prescribed it. Participants explained that most everyone in high school and in the 18-25 year age range knows someone that will freely give the drug to them or will sell it to them at a cheap price. Reportedly, prescription stimulants are used in combination with alcohol, marijuana, prescription opioids and sedative-hypnotics. Typically, participants reported using prescription stimulants to modify the effect of taking a sedative-hypnotic or other depressant drug. However, if used to stay awake while, "partying," the user most often combines Adderall® with alcohol and marijuana.

Bath Salts

Bath salts (synthetic compounds containing methylone, mephedrone 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, but rather meant to be abused by people looking for a legal high and by individuals who need to avoid drug use detection on urine drug screens. This reporting period is unique for synthetic drugs such as bath salts because they were legally sold during the first half of the reporting period (July to mid-October) and banned during the second half of the reporting period (mid-October to January). Prior to the current ban on the sale of bath salts, participants reported that bath salts were commonly sold at many convenience stores, head shops (drug paraphernalia shops) and gas stations throughout the regions. Bath salts were highly available in every region before the ban, and then began to decrease in availability once the ban took effect. Columbus, Dayton and Toledo experienced decreases in the availability of bath salts, while other regions experienced high and stable levels of the drug. Notably, participants from Athens (Guernsey, Muskingum and Washington counties), Cleveland and Cincinnati said bath salts are available from street dealers and from the same stores that sold bath salts before the ban went into effect in October 2011. Most participants in Akron-Canton were interviewed before the ban took effect, but they anticipated the ban to have little effect, while participants in Youngstown were unable to comment on any availability change in bath salts since the ban. Generally, participants reported that the quality of bath salts has decreased during the past six months. The BCI London and Bowling Green crime labs noted that since the ban went into effect, the formally scheduled substances of MDPV and methylone are almost never seen any more in samples of bath salts, rather dozens of non-controlled analogs have taken their place. Reportedly, prices have not increased for bath salts since the

ban took effect. Sealed packages of 1/2 gram of bath salts sell for between \$15-25; a gram of loose bath salts sells for between \$20-40. The most common route of administration for bath salts continues to be snorting, followed by the less common routes of smoking and intravenous injection. Participants indicated that White adolescents and young adults are most likely to abuse bath salts. Participants in two regions mentioned using other drugs in combination with bath salts; participants in Akron-Canton reported using with crack cocaine, prescription opioids and sedative-hypnotics with bath salts, and in Youngstown, participants reported using heroin, salvia divinorum (a psychoactive plant) and synthetic marijuana ("K2" and "Spice") with the drug. Participants from nearly every region talked about the negative health consequences associated with bath salts. Participants said they commonly experienced symptoms associated with psychosis (delusions and hallucinations) or depression (anxiety and suicidal thoughts) when using bath salts. Treatment providers and law enforcement confirmed these symptoms and added that bath salts use can cause, "bizarre [and] violent" behavior in users. Staff from the Miami Valley Regional Crime Lab reported bath salts have been found in 10-15 coroner cases in the Dayton region during this reporting period.

Other Drugs

OSAM Network participants listed a variety of other drugs as being present in Ohio, but these drugs were not reported in all regions. Participants mentioned anabolic steroids (Deca-Durabolin®) as occasionally available in the Cleveland and Youngstown regions. Typically, users obtain these substances at local gyms. Community professionals noted that typical anabolic steroid users are White and male. The Miami Valley Regional Crime Lab reported that the number of steroid cases it processes has increased during the past six months. Hallucinogens [dimethyltryptamine (DMT), lysergic acid diethylamide (LSD), phencyclidine (PCP) and psilocybin mushrooms] remain available in many regions of the state. Participants reported DMT is occasionally available in Athens, and highly available in Cleveland. Participants described two variants of the drug: a natural compound and a compound made with synthetic chemicals. Participants reported that 1/10 gram of DMT sells for \$10, and a gram sells for \$150. The most common routes of administration are smoking or snorting. DMT appears to be most popular among young adults who frequent outdoor music festivals, and by those who abuse other hallucinogens. Reportedly, some users combine DMT with LSD to increase the psychoactive properties of the drugs. LSD is rarely available in most regions, with the exception of Akron-Canton where it is highly available. Participants noted that LSD is also most popular at outdoor music festivals during the summer months. Participants reported the current quality of LSD as high and that a hit (one dose) of the drug typically sells for

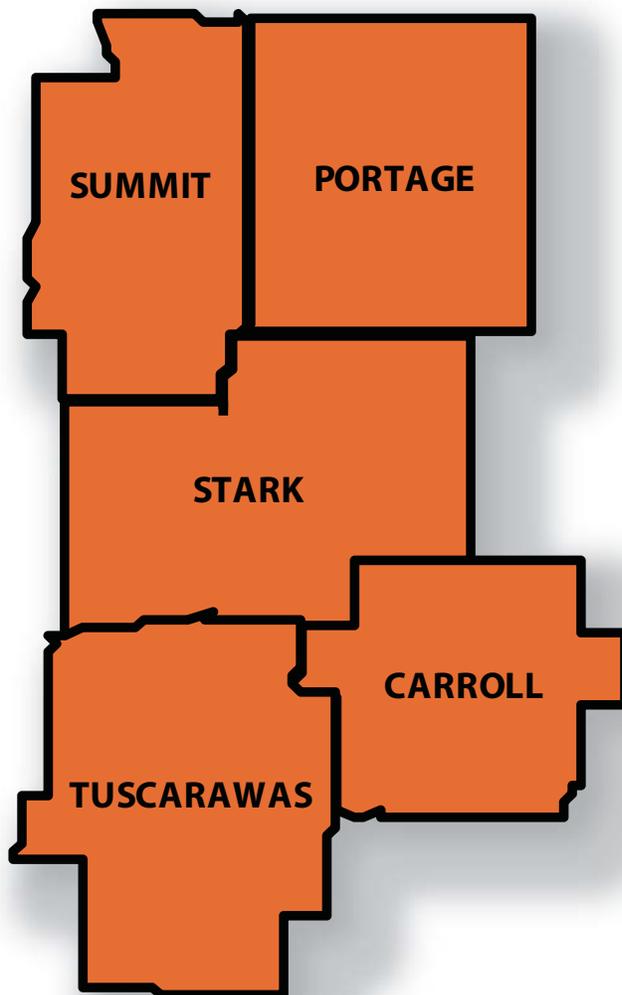
between \$10-20. PCP remains highly available in certain areas of Cleveland. As with the previous reporting period, most participants reported obtaining PCP (aka “wet” or “woo”) from an area called “Water World” on Cleveland’s east side. Liquid PCP is still commonly sold on a per-dip basis or as ready-to-smoke tobacco or marijuana. Pricing is consistent with the previous reporting period: one dip of a cigarette sells for between \$15-20. Law enforcement reported the drug to be most popular among users in their 30s to 50s. PCP is most commonly used with alcohol, marijuana and tobacco. Psilocybin mushrooms have low to moderate availability throughout the regions. Like other hallucinogens, participants reported that psilocybin mushrooms are mostly available during the summer months, and are popular at outdoor music festivals. Reportedly, 1/8 ounce of psilocybin mushrooms sells for between \$20-30; 1/4 ounce sells for between \$40-50. Inhalants 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, Freon, paint, Pam® cooking spray and VCR head cleaner (aka “Rush”). Typically, inhalant users are adolescents (those 18 years of age and younger) who have little access to other drugs. Prescription cold medicines that contain codeine or promethazine along with over-the-counter (OTC) cough medicines containing dextromethorphan (DXM), such as Coricidin Cough and Cold®, also remain popular among teenagers who have limited access to other drugs. Participants continued to describe the ingestion of OTC cough and cold medicines as, “Robo-trippin” or “sippin’ on the syrup.” Synthetic marijuana is moderately to highly available across regions. This reporting period is unique for synthetic marijuana because it was legally sold during the first half of the reporting period (July to mid-October) and banned during the second half of the reporting period (mid-October to January). Prior to the current ban on the sale of synthetic marijuana, participants reported that the drug was commonly sold at many convenience stores, head shops and gas stations. Synthetic marijuana was highly available in every region before the ban, and availability began to decrease once the ban took effect in October 2011. The BCI London Crime Lab indicated that the five formally scheduled substances previously found in synthetic marijuana products are almost never seen anymore; rather dozens of non-controlled structural analogs have taken their place. Reportedly, a gram of synthetic marijuana sells for between \$1.50-3; three grams sell for \$10. Like marijuana, the most popular route of administration for this drug remains smoking. Participants continued to indicate that adolescents, young adults and people on probation are most likely to use synthetic marijuana.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Akron-Canton Region

June 2011-January 2012

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Akron-Canton Regional Profile

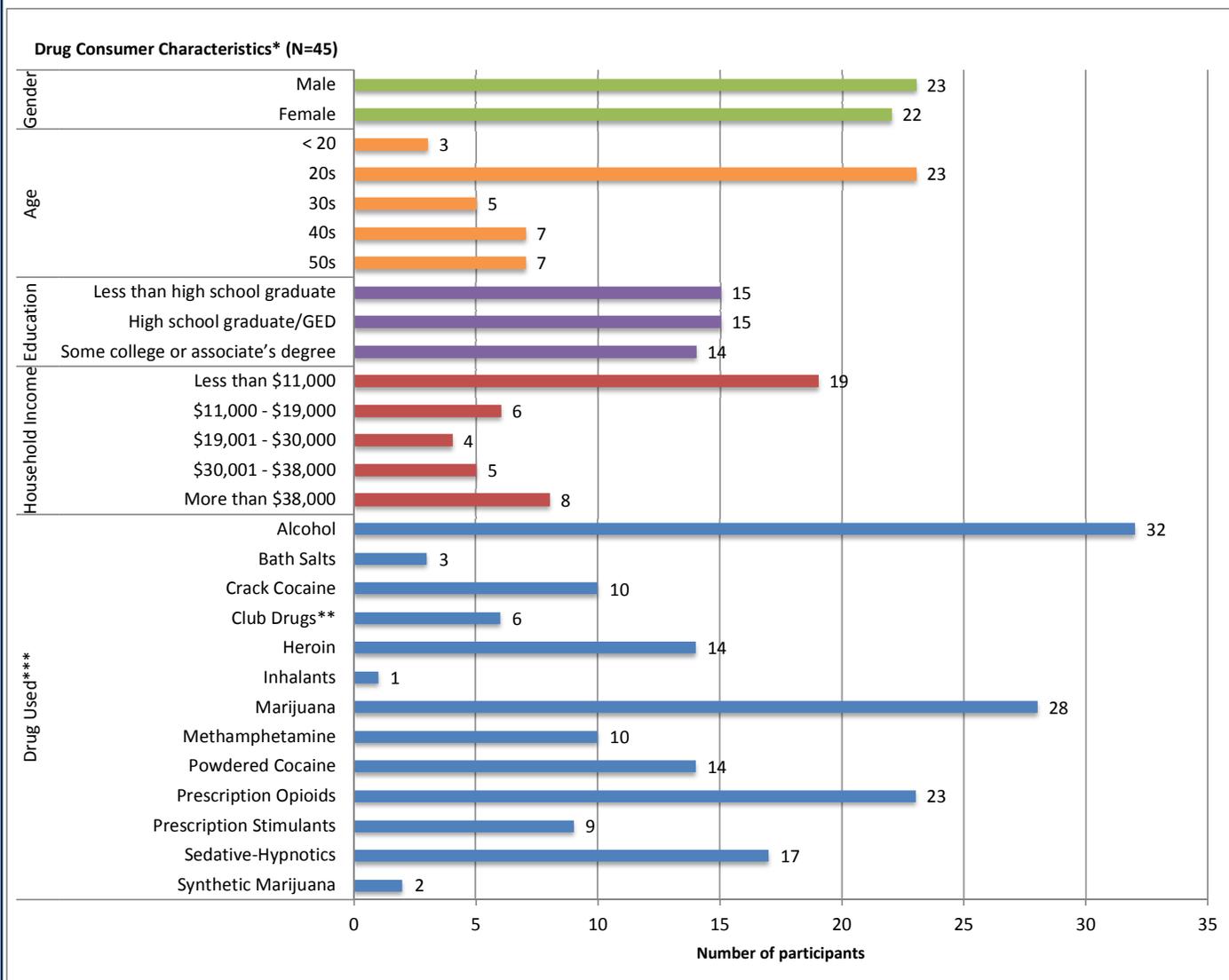
Indicator ¹	Ohio	Akron-Canton Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	1,200,204	45
Gender (Female), 2010	51.2%	51.5%	48.8%
Whites, 2010	81.1%	85.4%	75.6%
African Americans, 2010	12.0%	9.4%	20.0%
Hispanic or Latino Origin, 2010	3.1%	1.6%	0.0%
High school graduates, 2009-2010	84.3%	86.3%	65.9% ²
Median household income, 2010	\$45,151	\$43,371	\$11,000 - \$19,000 ³
Persons below poverty, 2010	15.8%	14.7%	67.5% ⁴

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 2011. Income status was unable to be determined for three respondents due to missing data.³

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



*Not all participants filled out forms; therefore, numbers may not add to 45.

**Club drugs refers to Ecstasy and LSD.

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Portage, Stark and Summit 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, the Stark County Coroner's Office and the Stark County Court of Common Pleas. All secondary data are summary data of cases processed from January through June 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current secondary data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for July through December 2011.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers and law enforcement most often reported the drug's availability as '6.' Treatment providers reported that fewer clients were mentioning powdered cocaine use at intake for treatment, and of those clients who did mention use, powdered cocaine was usually a secondary or tertiary drug of choice: powdered cocaine was not a primary drug of choice. Many participants noted that crack cocaine was more available, as one stated, "*Much of the [powdered] cocaine is already rocked [manufactured into crack cocaine].*" The Canton-Stark County Crime Lab reported that the number of powdered cocaine cases it processes had remained the same during the previous six months. Most participants rated the quality of powdered cocaine as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The Canton-Stark County Crime Lab continued to cite the following substances as commonly used to cut (adulterate) powdered cocaine: caffeine, levamisole (livestock dewormer) and procaine (local anesthetic). Participants reported that a gram of powdered cocaine sold for between \$30-70, depending on quality and from whom one purchased. Participants reported that the most common ways to use powdered cocaine remained snorting and intravenous injection. Many participants commented that use via injection was a growing practice. Participants described typical users of powdered cocaine as more likely female than male and people with money.

Treatment providers also agreed that powdered cocaine users were likely to be of a higher socio-economic class (attorneys and doctors). Reportedly, powdered cocaine was used in combination with numerous different drugs, with the practice of combining powdered cocaine use with other drug use cited as relatively common.

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.' While a few participants agreed with a comment that powdered cocaine is easy to find, "*if you know the right people,*" there was more agreement among participants with the following report: "*You don't even need to know the right people. Just go up to someone who is selling it [powdered cocaine]. I've never had trouble finding it, especially cocaine.*" Another participant commented, "*It's very easy to get, too easy. I could walk to it right now.*" Yet another stated, "*If you know anyone who sells drugs, they either have it [powdered cocaine] or can get it.*" However, a Stark County participant noted, "*If they [dealers] don't know you, they won't sell it [powdered cocaine],*" to which others replied with giving exact locations where "*anyone will sell it [powdered cocaine] to anyone.*" Treatment providers most often reported current availability as '8,' describing powdered cocaine as, "*easy to get.*" A treatment provider stated that powdered cocaine is an, "*old standby, people know cocaine.*" Another provider included powdered cocaine in what is known as, "*the 'holy trinity' [of drug use, consisting] of cocaine, marijuana and alcohol ... still prevalent.*" Law enforcement most often reported the drug's current availability as '7,' describing availability as, "*moderate, you can find it [powdered cocaine]; pretty level [supply of powdered cocaine].*" Collaborating data also indicated that powdered cocaine is readily available in the region. The Stark County Coroner's Office reported that 10.9 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); in the last reporting period, 17.9 percent of all deaths were drug related. Furthermore, the coroner's office reported cocaine as 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). In addition to the coroner's data, the Stark County Day Reporting of the Stark County Court of Common Pleas reported that 22.8 percent of all positive drug screens among adult probationers during the past six months were positive for cocaine use (Note: court data is also aggregate data of powdered cocaine and crack

cocaine and does not differentiate between these two forms of cocaine).

Participants were not in general agreement as to whether the availability of powdered cocaine has increased, decreased or remained the same during the past six months. For example, some agreed with the comment, *"A lot of people like to speedball [use powdered cocaine with heroin], so heroin dealers have [powdered] cocaine to sell as well,"* indicating increased availability. One participant group all agreed with one member that stated that the economic depression, *"has pushed a lot of people into selling drugs,"* thus increasing availability. Others, however, believed that availability has decreased: *"Speed [methamphetamine] and heroin are epidemic. I don't even hear about cocaine anymore; The price [of powdered cocaine is prohibitive] ... My drug of choice is heroin. I can buy a lot more heroin for \$100 than I can buy cocaine for \$100."* Still other participant groups posited that the availability of powdered cocaine has remained the same. Treatment providers also disagreed as to whether the availability of powdered cocaine has decreased or remained the same during the past six months. Some providers reported that at least the use of powdered cocaine seems to be decreasing. A provider commented, *"People know cocaine, but seem to be using other drugs."* Still, most believed availability to have remained the same. Law enforcement reported that availability of powdered cocaine has remained the same during the past six months. The Canton-Stark County 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). Participants reported that powdered cocaine in the region is cut with baby formula, baby powder, baking soda, bath salts, creatine, laxatives, over-the-counter (OTC) medications (aspirin), powdered sugar, prescription opioids and vitamin B. The Canton-Stark County Crime Lab cited the following substances as commonly used to cut powdered cocaine: levamisole (livestock dewormer), maltose (disaccharide sugars) and procaine (local anesthetic). In terms of the quality of powdered cocaine, one participant group agreed with the following comment, *"It [quality of powdered cocaine] depends on who you get it from. Older dealers have more pure cocaine, younger dealers sell more junk."* Another participant noted, *"Drugs around here are not as potent as in Columbus or other large cities."* Participants reported that the quality of powdered cocaine has decreased over the past six months. A participant commented, *"You're only getting 45 percent cocaine."* Participants blame dealers, *"trying to make money,"* for the decrease in quality. A participant noted, *"They [dealers] are bringing in more heroin, so there is less cocaine. They need to cut it [powdered cocaine] more."*

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "blow," "soft," "snow" and "white girl." Participants listed the following as other common street names: "chalk," "chowder," "Christina Aguilera," "dust," "girl," "powder," "s***," "sister," "snowflake," "Snow White," "the devil," "white," "white b****," "white gungi," "yam" and "yay." In addition, a participant commented, *"Anything that is white,"* can be used as jargon for 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 between \$25-40, depending on the quality; a gram sells for between \$40-60; 1/16 ounce, or "teener," sells for between \$100-120, 1/8 ounce, or "eight ball," sells for between \$120-150 (some participants reported paying up to \$300); 1/4 ounce sells for between \$300-400; an ounce sells for between \$1,200-1,400. Participants agreed that one can purchase powdered cocaine for, *"whatever money you can get together; whatever you have in your pocket, put it down, they will sell it [powdered cocaine]."* Participants reported that the most common way to use powdered cocaine remains snorting. Out of 10 powdered cocaine users, participants reported that approximately six to eight would snort and two to four would intravenously inject. Many participants commented, however, that in some groups, intravenous use of cocaine is more common than snorting. A participant reported, *"People I hang with, 80 percent shoot it [inject powdered cocaine], but in the whole county, more snort it."* Another participant noted, *"All my junkie friends shoot it [powdered cocaine]. It depends on who you hang with."* Other participants commented, *"If you are a heavy addict, you will shoot it [powdered cocaine]; Whether you shoot, snort, or smoke [powdered cocaine], the high is different. You don't fiend (crave) for it as quickly if you shoot it."*

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 White; a few participants agreed with the description of powdered cocaine users as, *"high-class Caucasian,"* others identified typical users as, *"working, middle-class people."* Powdered cocaine was described by one participant as, *"the drug of stars."* One participant group agreed with one member, who stated that powdered cocaine is, *"sold by African-Americans, but used by Whites."* Many, however, shared their position that powdered cocaine is used by people of, *"every race, every economic situation, every way of life."* Treatment providers described typical users as, *"upper-middle class; Caucasian females, between ages 20 and 30 [years]."* Others disagreed, one commenting that while users have "traditionally" been Caucasian, *"I've seen more African-Americans using cocaine, the gap is closing."* A provider also reported that individuals are using powdered cocaine, *"later in life. Cocaine is not as scary as some of the other drugs; it's the old standby."* A law enforcement officer stated, *"[There is] a wide variety of users,*

whoever can afford it [powdered cocaine].” A Summit County officer noted, “Distributors tend to be African-American ... getting it [powdered cocaine] usually through gang activity ... in most cases, coming from Mexico. Users, however, come pretty much from the whole spectrum.” 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 is an, “exponential jump” into powdered cocaine use: “Pretty much everyone starts with marijuana. The next step is cocaine ... by the time they turn 25, they like it. It’s available if they can afford it. If not, then they turn to bad guys and go and steal to get it.”

Reportedly, powdered cocaine is used in combination with alcohol, Ecstasy, heroin, marijuana and sedative-hypnotics (Valium® or Xanax®). Participants reported that sedatives (including alcohol) are used “to come down” from the cocaine high. A typical comment regarding the use of alcohol with cocaine was, “You can drink all night, if you are using cocaine.” As another participant put it, “If you are really drunk, a line of cocaine sobers you up, or if you are high on cocaine, alcohol settles you down.” Among individuals using cocaine with Ecstasy, one reported the combination gives, “a better high ... cocaine gives Ecstasy a boost.” Individuals who use heroin with cocaine (“speedball”) express they are seeking the “up and down” sensation of such drug use, “feeling of a different buzz.” Marijuana was reported to “mellow you out” when using with cocaine. Participants agreed that it is more common to use powdered cocaine with other drugs than it is 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 Summit County law enforcement reported availability as ‘6.’ The Canton-Stark County Crime Lab reported that the number of crack cocaine cases it processes had increased during the previous six months. Most participants rated the quality of crack cocaine as ‘3’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants stated that the quality of crack cocaine had remained the same during the previous six months, meaning that quality had been poor for some time. The Canton-Stark County Crime Lab continued to cite baking soda as commonly used to cut crack cocaine. Participants reported that a gram of crack cocaine sold for between \$40-50; 1/8 ounce sold for between \$100-110. A consistent profile of a typical user of crack cocaine did not emerge from the data. However, many treatment providers felt that crack cocaine use was more common among females, and many

reported crack cocaine use to be more common among individuals of lower socio-economic status.

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 agreed that crack cocaine is easier to find than powdered cocaine. Participants commented, “A funny thing, we can’t find [powdered] cocaine, but we can find crack cocaine. People prefer to smoke it; You can walk down the street ... people will come up and ask you if you need some [crack cocaine].” Treatment providers most often reported the drug’s current availability as ‘10;’ the previous most common score was also ‘10.’ A treatment provider described the high prevalence of crack cocaine as, “like blades of grass in the lawn.” Law enforcement reported the current availability of crack cocaine as ‘5’ in Stark County and ‘7’ in Summit County. Media outlets in the region reported on crack cocaine seizures and arrests during this reporting period. In October, the *Record Courier* reported that a father and son pleaded guilty to trafficking cocaine in Ravenna (Portage County) and Canton (Stark County); undercover agents purchased crack cocaine from both men (www.recordpub.com, Nov. 7, 2011).

Participants were generally evenly split as to whether the availability of crack cocaine has increased or remained the same during the past six months. Among those who believed that availability has increased, participants commented, “A lot more kids are doing it [crack cocaine]. Hence, more [dealers] are selling it; Everyone is selling, and it is cheaper to make crack [cocaine].” Treatment providers reported that availability of crack cocaine has remained the same or decreased during the past six months. Providers who posited a decrease in availability talked about the change in drug preferences: “People are going away from crack to heroin and bath salts, which are much easier to get; bath salts are cheaper. People who use crack can spend a lot of money.” However, a few providers warned that while use may have decreased, availability has remained the same: “No one is complaining about the supply [of crack cocaine being low].” Law enforcement reported that availability of crack cocaine has remained the same over the past six months. The Canton-Stark County Crime Lab reported that the number of crack cocaine cases it processes has stayed 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 ‘3.’ Participants typically reported that the quality of crack cocaine varied from dealer to dealer and that crack cocaine in the region is cut with baby laxatives, baking soda, flour, Orajel® and pancake mix. Participants reported that the quality of

crack cocaine has decreased during the past six months. A participant commented, *"Quality [of crack cocaine] has gotten worse. Powder cocaine is less available, so those cooking crack are using baking soda to stretch it out."* Another participant seemed to agree, *"Everyday it [quality of crack cocaine] changes. You don't know what you are going to get."* The Canton-Stark County Crime Lab cited baking soda and procaine (local anesthetic) as commonly used to cut crack 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: "boulders," "biscuits," "candy," "pebbles," "rocks," "slabs," "smack," "swerve," "white," "white girl," "work," "ya-yo" and "yo." Current street prices for crack cocaine were consistent among participants with experience buying crack cocaine. Participants reported that 1/8 ounce sells for \$180. Participants were in general agreement that users could purchase crack cocaine in any quantity: *"Whatever [money] you got, they [crack cocaine dealers] will take it."* Reportedly, it is most common to purchase crack cocaine in \$20 "rocks" (pieces), but one can also purchase smaller rocks (aka "crumbs") for as little as \$3-5. Reportedly, volume discounts apply; participants can purchase two rocks for \$30 or three rocks for \$50. A participant said, *"Sometimes, for a few dollars, you can get a hit [of crack cocaine]."* Another participant talked about different forms of payment: *"In my area, you don't even need money [to obtain crack cocaine];"* stating that sexual favors and loaning the car, *"is paid in crack."* 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 seven to nine users would smoke and one to three would intravenously inject. Some participants agreed with a fellow participant who commented on route of administration, *"Depends on your group, who you hang with [as to how you use crack cocaine]."* Other participants talked about intravenous drug use: *"[A] new trend is to shoot it [inject crack cocaine]."* By and large, most participant groups cited that intravenous use of crack cocaine is relatively rare. A participant commented, *"A few die-hards shoot it [crack cocaine], but it's not the craze."*

A profile of a typical user of crack cocaine did not emerge from the data. Participants commonly agreed, *"Drugs are changing. They are not prejudiced anymore."* Participants also reported that people from, *"every walk of life"* use crack cocaine. A participant stated, *"You see people with nice SUV's pull up [to buy crack cocaine] ... people you'd never think of pull up."* Some participants noted that more young people (under age 18 years) are using crack cocaine. Treatment providers did not believe that there is a typical crack cocaine user. Treatment providers said, *"pretty much anyone"* can be a user of crack cocaine. As one treatment provider stated, crack cocaine addicts could be, *"people who you'd never expect*

... housewives, educators." Generally, treatment providers thought users to be, *"getting younger,"* although no reason for this trend was identified. Law enforcement in Summit County reported that crack cocaine users are more likely to be African-American and to be, *"evenly distributed between male and female,"* and in terms of socio-economic status are, *"more toward the bottom."* A law enforcement officer discussed the transition to crack cocaine among individuals between the ages of 18-25 years: *"Some make the jump from cocaine to crack. Some do, some don't. The real daredevils do."*

Reportedly, crack cocaine is used in combination with alcohol, bath salts, heroin (to "speedball"), marijuana, methamphetamine and sedative-hypnotics. A participant reported, *"I wouldn't smoke crack unless I had some kind of downer for after."* Another participant explained, *"If I shot crack, I did not need the downer. But if I smoked it, I needed something."* A participant spoke about using crack cocaine with bath salts: *"I have no withdrawal effects ... I have smoked more crack since I started using bath salts."* Still another participant reported, *"I used [crack cocaine] with about any drug I could use. It gets me higher. I'm used to doing my drugs with other drugs to get higher."* Participants did not agree whether it is more common to use crack cocaine by itself or with other drugs.

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). All interviewed agreed that brown and white powdered heroin were far more available than black tar heroin in the region. Participants and community professionals reported that overall availability of heroin had increased during the previous six months. Participants commonly cited that due to efforts to make intravenous use of prescription opioids more difficult (changing the formulation of OxyContin®), heroin use and availability had increased. The Canton-Stark County Crime Lab reported that the number of powdered heroin cases it processes had increased while the number of black tar heroin cases had remained the same during the previous six months. Most participants generally rated the quality of heroin as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that heroin in the region is cut with a number of cutting agents. The Canton-Stark County Crime Lab cited the following substances as commonly used to cut heroin: diphenhydramine (antihistamine), lactose and maltose (disaccharide sugars) and procaine (local anesthetics). Participants reported that heroin was available in different quantities: "folds" or "papers" (1/10 gram) sold for between \$10-30; "bundles" (10-12 small packs of heroin) sold for between \$70-80; a gram sold for between \$100-200. However, a number of participants noted that one could purchase

heroin for, “whatever you have to spend.” Participants reported that the most common way to use heroin remained intravenous injection. Participants described typical users of heroin as young and White: “Heroin is a young, White person’s game.” Many participants continued to report that heroin users were, “getting younger and younger,” noting that teenage males, as early as junior high school age, were more commonly using the drug.

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’. While many types of heroin remain currently available in the region, participants continued to report the availability of brown powdered heroin as most available. The following participant comments were typical responses to heroin’s availability: “[Heroin] it’s very, very, very available; It’s everywhere; It’s an epidemic.” Others commented, “[Heroin] it’s as common as going down the street and buying a six-pack of beer; I’m so glad I found heroin. It’s cheaper and easier to find than crack; It’s easier [to obtain] than oxy’s [OxyContin®]. You run out of oxy’s, but never heroin ... it’s always around.” Participants rated the availability of black tar heroin as ‘2’. Participants noted, “No real tar [black tar heroin] around here, unless you know someone. You can’t just go and buy it; You don’t find black tar ... very rare, and when it is here, it’s junk.” It was estimated by one group of participants that the heroin found in the region is, “90 percent fine powder;” another group identified that one needs to go to Columbus to find black tar heroin. Treatment providers commented that while users usually do not identify to them the type of heroin they use, clients rarely speak about black tar heroin. A law enforcement officer in Stark County reported heroin’s current availability as ‘7’, while a law enforcement officer in Summit County reported heroin’s current availability as ‘8’. Both reported that brown powdered heroin is the type law enforcement in the region mostly encounter, though it was reported in Summit County, “We [law enforcement] took [seized] some black tar, but powder is still prevalent.” It was also reported that Stark County has experienced at least 25 deaths from heroin overdose in the past two years, “five or seven [heroin] overdoses right in a row” within one small town in the county. Collaborating data also indicated that heroin is readily available in the region. The Stark County Coroner reported that 10.9 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); in the last reporting period, 17.9 percent of all deaths were drug-related. Furthermore, the Coroner reported heroin as present in 16 percent of all drug-related deaths. In addition to the coroner’s data, the Stark County Day Reporting of the Stark County Court of Common Pleas reported that 13.1 percent of all positive drug screens among adult probationers during the past six months were positive for opiate use (Note: court data is aggregate data of heroin and prescription opioids and does not differentiate between the two drug types).

Participants and treatment providers reported that the availability of powdered heroin has increased during the past six months. A participant commented, “Everyone is doing it [heroin] now, so it is everywhere.” Other participants commented, “It [heroin] keeps getting easier and easier to find; Ever since the oxy [OxyContin®] revolution, once they realize what oxy is, synthetic heroin, people find heroin is cheaper.” A treatment provider noted, “Young people coming out of the military is a growing population [of heroin users].” Law enforcement also reported that availability of heroin has increased during the past six months; an officer stated, “Due to opiate addiction ... they [users] will do whatever they have to get the opiates into them.” The Canton-Stark County Crime Lab reported that the number of heroin cases it processes has remained the same during the past six months.

Most participants rated the quality of heroin as ‘6’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that heroin in the region is cut with baby laxatives, baby powder, prescription opioids, vitamin B-12 powder and other vitamins. 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 depends on where one gets it. A participant noted, “I always went to one person, and the quality [of heroin purchased] was high.” However, many participants reported that the quality fluctuates, sometimes from day to day. Comments included, “Some days, [quality of heroin] it’s very good, then the next day ... it’s s***; It [quality of heroin] can vary in the same day, with the same dealer. It’s scary, you don’t know how much to use.” Participants did not agree whether the quality of heroin has increased, decreased, or remained the same during the past six months. Participant groups from Portage and Stark counties reported that the quality of heroin has remained the same, while groups from Summit County reported that the quality of heroin has decreased. Participants who believed that quality has decreased commented, “[Heroin] it’s less pure; People are stepping on it [adulterating heroin] to make money; People are OD’ing [overdosing], so dealers are cutting it [heroin] more.”

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: "Browns" (as in Cleveland Browns), "Browns tickets," "dirty," "H," "love drug," "smack" and "tar." Participants reported that powdered heroin is available most frequently in "bags" or "points" (1/10 gram), which sell for between \$10-20; 1/2 gram sells for \$80; a gram sells for between \$100-150. A participant group reported that the price of heroin is cheaper, "the closer to Cleveland you are." Reportedly, a "\$20 baggie" of heroin in Akron sells for between \$8-10 in Cleveland. Participants did not report the price of black tar heroin, as it is 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 way to use heroin remains intravenous injection. Out of 10 heroin users, participants reported that approximately eight to nine would intravenously inject and another one to two would snort. Participants reported that intravenous injection of heroin, "was most effective," meaning the most efficient route of administration due to quick absorption of the drug into the bloodstream. Many participants commented that individuals may start off snorting heroin, but will eventually use it intravenously. A participant commented, "Everyone I know shoots [heroin]. If they snort, they won't snort for long; it's a waste of money." Most participants reported that needles are readily available in stores with pharmacies. While it was reported that some pharmacies require identification for purchase, and a few amount require a prescription, there are many that sell them with few questions asked. Members of a participant group from Portage County were aware of a needle exchange program run by the Free Clinic in Cleveland. It was also reported by this group that in Cleveland, "a van gives out needles, along with a card that exempts you from being able to be charged with paraphernalia." It was also reported that people steal needles from individuals with prescriptions (diabetics). A participant noted that some heroin dealers have needles to sell. However, participants aged 18-25 years also reported that it is common to share needles: "People share needles all the time." A participant added, "Almost everyone I know has Hep [Hepatitis] C." Participants older than 25 years of age disagreed, stating that it is not common to share needles, as there is little reason to given high accessibility of needles. This group shared that when needles are shared, it is usually when the user is "dope sick" and more desperate to use heroin. Individuals attempt to clean needles using alcohol, bleach and peroxide. Participants noted that one can find directions on how to clean needles on the Internet.

A profile for a typical heroin user did not emerge from the data. Some participants reported that heroin users are more likely to be White. A participant commented, "Black people sell it [heroin], but I've never seen a Black person use it." Some participants commented that heroin is more likely to be

used by individuals younger than 35 years of age. However, many participants shared that there is, "no typical heroin user." Most participants recognized, and reported that heroin use is increasing among very young users, those as young as 14-15 years. A participant reported, "Younger [teens] is getting flooded with heroin use." Other comments included, "Kids are picking it [heroin] up real young, real strong; Kids saw pills as acceptable ... they get hooked, then learn it's cheaper to get heroin; [Heroin] used to be the last drug you get to, now it's the first drug they get to." A participant group reported that heroin use is fairly common in high schools. Among treatment providers, there was no consensus regarding a profile of a typical user of heroin. A few providers noted that users are more likely to be White. Law enforcement also reported that there is not a "typical heroin user." An officer stated, "[Heroin users] are pretty much across the board, pretty even, from affluent families to kids from poor families." A number of providers noted that heroin use is becoming more popular with younger people as well, particularly those between the ages of 18-25 years. Law enforcement concurred, stating, "Young adults seem to like it [heroin], people in their 20s and 30s." An officer from Stark County did not believe heroin use to be common among high school aged youth, commenting, "Every once in a while, we see it [heroin] in high schools, but not too often." However, an officer from Summit County cited a, "growing trend [in heroin use] with youth, especially with the flood in the market now. [Heroin] it's cheap."

Reportedly, heroin is used in combination with alcohol, crack and powdered cocaine, marijuana, methamphetamine and sedative-hypnotics. While most participants reported that it is more common to use heroin by itself, some use it with marijuana because, "potentiation ... it [marijuana] makes heroin seem stronger," with alcohol because, "the mellowing out [produced by alcohol consumption] counteracts the drug [heroin]," with benzodiazepines because, "[benzodiazepine use] lays you back, and intensifies the heroin," or with cocaine or methamphetamine for the speedball (up and down) effect, "you go up the elevator, and come right back down."

Prescription Opioids

Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and treatment providers identified Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use, with treatment providers additionally naming OxyContin® as most popular. A few participants commented that Opana® was becoming popular as a replacement for OxyContin® as it was easier to use intravenously. The Canton-Stark County

Crime Lab reported that the number of cases it processes for most prescription opioids had remained the same during the previous six months; however, the crime lab reported an increase in the number of cases for fentanyl, morphine, Percocet® and Vicodin® and a decrease in the number of cases for Opana® and OxyContin®. Reportedly, many different types of prescription opioids were sold on the region's streets. In addition to obtaining prescription opioids on the street from dealers, participants also reported getting them from doctors, emergency rooms, robbing pharmacies, family members and friends who work for pharmacies and hospitals, and from family members and friends who were prescribed these medications. Participants reported that it was fairly easy to feign illness or injury in the emergency room to acquire prescription opioids. Participants also noted that drug dealers approach individuals outside of pharmacies, offering to purchase prescriptions. 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, in order of most commonly practiced, were snorting, intravenous injection and oral ingestion (swallowing). Some participants described typical prescription opioid users as, "rich little White kids; older people; housewives; people in the suburbs."

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 Opana®, OxyContin®, Percocet®, Roxicet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Treatment providers most often reported the current availability of prescription opioids as '9'; and identified OxyContin®, Percocet®

and Vicodin® as the most popular prescription opioids in terms of widespread use. Law enforcement reported the current availability of prescription opioids as '5' in Stark County and '6' in Summit County, and identified OxyContin® and Percocet® as most popular. Collaborating data also indicated that prescription opioids are readily available in the region. The Stark County Coroner's Office reported that 10.9 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); in the last reporting period, 17.9 percent of all deaths were drug-related. Furthermore, the coroner's office reported prescription opioids as present in 44 percent of all drug-related deaths.

Participants reported that the availability of prescription opioids has decreased during the past six months. Many participants commented that it is more difficult to have these medications prescribed. A participant stated, "It's more difficult to get a prescription, now that [prescription opioid] abuse is so high." Participants reported that it is particularly difficult for younger people to obtain a prescription for an opioid. A participant shared, "I always buy pills [prescription opioids] on the street. I'm young; doctors won't prescribe meds for pain for me." Many participants commented on the decline in availability of OxyContin®, as the old formulation (OxyContin® OC) is no longer available. A participant reported, "Not that common anymore ... [OxyContin®] it's not the same you can't shoot them [inject OxyContin® OP]. You can't get the real OxyContin® [OxyContin® OC] unless you have cancer or are dying." While the new formulation (OxyContin® OP) is available, it is not liked. A participant commented, "You need to break them [OxyContin® OP] down, which requires dedication that most drug addicts don't do." Other participants agreed, stating, "People still use them [OxyContin® OP], but they chew them. You can burn it in a microwave and snort it, but it's nasty." While participants thought that availability of prescription opioids has generally declined, a participant group noted an exception, an increase in availability for Opana®, which many reported as gaining in popularity. A participant stated, "Everyone I know goes to the doctor to ask for Opana®." Overall, many participants agreed that, "It's harder to get prescription pills [opioids] than heroin." Treatment providers also reported that availability of prescription opioids has decreased during the past six months. Many providers noted that the cost of these drugs is a key factor. A treatment provider commented, "[Users] are leapfrogging to heroin; it's much cheaper [than prescription opioids]." Still, some providers cautioned that these medications are still very available, commenting, "You usually know six or seven people who are prescribed opiate medication, so you call around." Providers in Stark County commented that physicians in the area "generally are on top of monitoring, and understand the relevance of addiction ... still though, people continue to doctor shop, and go around, outside of the community, to get prescriptions [for opioids]." Law enforcement reported that the availability of prescription opioids has remained the same during the past six months. Law enforcement in Summit County reported that by far, most "busts" involving prescription opioids this past year have involved Percocet®. The Canton-Stark County Crime Lab reported that the number of prescription opioid cases it processes has remained the same during the past six months; noted exceptions were increases in cases of hydromorphone (Dilaudid®), oxycodone, and oxycodone hydrochloride and acetaminophen (Percocet®), as well as decreases in cases of codeine, hydrocodone and acetaminophen (Lortab®, Norco®, Vicodin®) and morphine.

Reportedly, many different types of prescription opioids (aka "little guys," "pills" and "scripts") 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® (4 mg sells for \$3; 8 mg sells for \$7), methadone (10 mg sells for \$7), Opana® (aka "pandas" and "stop signs;" 40 mg sells for between \$35-80), OxyContin® (old formulation, aka "OC's;" 80 mg sells for \$200; new formulation, aka "OP's;" 80 mg sells for between \$50-70), Percocet® (aka "perc's" and "gills;" sells for between \$0.50-1 per milligram), Vicodin® (aka "vic's;" 5 mg sells for \$3; 7.5 mg sells for between \$4.50-5). Regarding price, a participant commented, *"There's a lot of range. It depends on who people get these meds [prescription opioids] from. As they run low, they charge more."* 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 oral ingestion, snorting and intravenous injection. Participants reported that the, *"strong pills"* (Opana®) are preferred for snorting and injecting. A participant commented, *"Those who are not fond of needles, snort. But if you are comfortable with needles, everything else you will use with a needle."* Participants reported that opioids such as Percocet® and Vicodin® are most commonly taken orally.

In addition to obtaining prescription opioids on the street from dealers, participants also reported getting them from pain clinics, other doctors (a participant characterized other doctors as, *"crooked doctors"*), emergency rooms and other individuals who are prescribed opioids. A number of participants commented that it has become increasingly more difficult to have these medications prescribed. A participant commented, *"In my area, [if you are prescribed opioids] you are called into the doctor for pill counts and opioid levels."* Other participants commented, *"I can't find a doctor [to prescribe opioids] because I got caught going to two doctors; You need to go to smaller pharmacies [to fill opioid prescriptions] that don't cross-check [with other pharmacies]."* Another participant described what he did to obtain a prescription: *"I intentionally broke my wrist and went to the emergency room. I told them that my pain was a '10.' At first they were going to try Vicodin®. I told them that my body does not respond to Vicodin®, so I got 10 mg Percocet®."* Hence, participants reported that it is most common to acquire these medications off the streets. A participant reported, *"People who have prescriptions will sell [opioids] to users because they need money."*

Participants described the typical user of prescription opioids as a young person, teenaged or twenty-something years of age. A participant commented, *"Older people sell them [prescription opioids]. Adults in pain will use them for pain management. But to use opiates just to get high, usually they [users] are younger people."* Treatment providers, likewise, reported that prescription opioid use is more common

among the younger population. However, a provider disagreed, noting that there are more treatment admissions of middle-aged men and women, who are, *"more apt to stay with opiates [prescription opioids]. Younger people will skip into heroin."* Law enforcement from Stark County noted, *"A lot more White people abuse opiates, from what I see based on overdoses ... no clear pattern among the 18-25 [year] age range. Those who jump to opiates will do what they have to ... fake scripts or go to the doctor and fake an illness."* Law enforcement in Summit County reported that prescription opioid abuse is widespread, *"across the board"* in terms of race, gender and socio-economic status.

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with depressant type drugs such as alcohol, marijuana and sedative-hypnotics (benzodiazepines). Participants reported that the combination of prescription opioids with a depressant drug, *"strengthens [increases] the effect of the pills [prescription opioids],"* and causes one to black out. A participant reported that prescription opioids are also used with bath salts, commenting, *"The only way to come down from bath salts is with opiates."* Still others reported that prescription opioids can and are used with anything: *"There's no real pattern of using [prescription opioids] with a specific drug."*

Suboxone® Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants and treatment providers 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). Participants continued to report that in addition to being used to support one's attempts to quit using opioids, individuals also used Suboxone® to avoid withdrawal during times when they lacked access to their opioid of choice. Treatment providers reported that the availability of Suboxone® had increased during the previous six months. A treatment provider noted, *"It [Suboxone®] is becoming easier to get than methadone."* The Canton-Stark County Crime Lab reported that the number of Suboxone® cases it processes had decreased during the previous six months. Participants reported that a Suboxone® 8 mg pill sold for between \$10-30, and Suboxone® strips/film sold for between \$10-20. Participants noted that strips were not as valuable as one was not able to use them via snorting. Most often participants reported taking Suboxone® sublingually (dissolving it under the tongue) or by snorting. In addition to obtaining Suboxone® on the street from drug dealers, participants also reported getting Suboxone® from doctors and clinics, as well as from individuals with prescriptions. Participants reported that individuals who needed to avoid detection of drug use on urine drug screens

(probationers) would use Suboxone® to get high because Suboxone® was often not screened. Reportedly, users rarely used Suboxone® in combination with other drugs. However, some participants reported that those abusing Suboxone® for a high often combined the drug with sedative-hypnotics (Xanax®), as this combination reportedly exacerbated the high allegedly produced from Suboxone®.

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'. A participant characterized current availability as, "very, very easy to get [Suboxone®]." Another participant stated, "If you know a junkie, you can find [Suboxone®]." Some participants agreed that Suboxone® is primarily used, "to keep someone from getting sick ... it's not like a party drug ...

you keep it in your pocket to stop from getting dope sick." However, another participant commented that Suboxone® is, "a cheaper way to get high ... [for] newly addicted people." Treatment providers most often reported the drug's current availability '9' or '10'; the previous most common score was '10'. A treatment provider stated, "If you want it [Suboxone®], you can go to a clinic and get it." Other providers commented, "Clients know who prescribes it [Suboxone®]. People line up for certain doctors on days they know they are in at the clinic; No one is complaining that they can't find it [Suboxone®] or that they have to go to Cleveland to get it." Treatment providers also reported Suboxone® to be readily available on the street: "It's economics ... people sell Suboxone® to keep using heroin." Providers generally believed that Suboxone® is sought by users, "more for maintenance than recreational use, to avoid being dope sick." Law enforcement reported the current availability of Suboxone® as '4'; the previous most common score was '3'. Summit County law enforcement reported that there have been no Suboxone®-related busts since early 2011. Participants did not report on whether the availability of Suboxone® has increased, decreased or remained the same during the past six months. Treatment providers reported that availability of Suboxone® has increased while noting that there are more Suboxone® clinics opening in the region. Law enforcement reported that availability of Suboxone® has remained the same during the past six months. The Canton-Stark County Crime Lab reported that the number of Suboxone® cases it processes has increased 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 \$10-20; Suboxone® strips/film sells for between \$9-12. A participant noted that a prescription for 60 pills sells for between \$200-300. Participants were not in agreement regarding how users most commonly use Suboxone®. One participant group reported that there is an even split between individuals who prefer sublingual use and those who prefer to snort the drug. Other groups, however, reported that sublingual use is far more popular, with one group citing that 80-90 percent of users use Suboxone® sublingually. Another group reported that while sublingual use is most common, "[Snorting of Suboxone®] is getting big; People are getting high with it [Suboxone®]." This group also reported that some prefer intravenous injection. However, a participant from another group commented, "I shot it [injected Suboxone®]; it almost killed me. I tell people to not shoot it." Suboxone® strips are administered sublingually.

In addition to obtaining Suboxone® on the street from dealers, participants also continued to report getting the drug from pain clinics, doctors and Suboxone® clinics. Participants commonly reported that individuals obtain prescriptions to sell Suboxone® and/or trade them for other drugs: "Dope fiends are prescribed it [Suboxone®]; they sell it to get dope; People have no intention of using, they get them [Suboxone®] just to sell. Others claim they need more [Suboxone®] pills ... they use one, and sell the rest." A profile for a typical Suboxone® user did not emerge from the data. However, the majority of the treatment providers reported that Suboxone® users are more likely female. A provider commented, "Caucasian females are more adept to go to clinics to get Suboxone®, then sell it to support their drug use." Participants did not identify any other substances that individuals use 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). Participants identified Ativan®, Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use, while treatment providers identified Klonopin® and Xanax® as most popular. Treatment providers noted that many of their clients were being treated with sedative-hypnotics and that users did not see themselves as addicts because these medications were legally prescribed. The Canton-Stark County Crime Lab reported that the number of sedative-hypnotic cases it processes had fluctuated during the previous six months.

While processed case numbers had increased for Ativan®, Ambien® and Xanax®, and decreased for Restoril®, generally, the number of cases the crime lab processed for most types of sedative-hypnotics had remained the same. Participants most often reported obtaining sedative-hypnotics through prescription from doctors and from family and friends who had prescriptions. Participants agreed that it was very easy to get a prescription by feigning anxiety symptoms. The most common routes of administration were snorting and oral ingestion. Participants expressed differing views about which of these two methods was most common. Many participants reported that sedative-hypnotic use was common among young people (high school aged youth), while treatment providers noted that typical users tended to be, “suburban kids” and White individuals.

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 Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Treatment providers most often reported current availability as ‘9’ for Xanax®, ‘8’ for

Klonopin®, and ‘6’ for Valium®. Treatment providers reported that sedative-hypnotics are popular because, “many are using them to help with detoxing from heroin or withdrawing from bath salts.” Law enforcement reported the current availability of sedative-hypnotics as ‘5’; and identified 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 reported that 10.9 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); in the last reporting period, 17.9 percent of all deaths were drug-related. Furthermore, the Coroner reported sedative-hypnotics as present in 60 percent of all drug-related deaths.

The majority of participants reported that the availability of sedative-hypnotics has remained the same during the past six months. A participant commented, “[Sedative-hypnotics] they’ve always been very available.” However, participants in Stark County reported that availability has increased during the past six months: “[Sedative-hypnotics] it’s all over the streets; It’s a cheaper drug; It’s very easy to get prescriptions.”

Law enforcement reported that availability of sedative-hypnotics has remained the same during the past six months, while treatment providers reported that availability has increased. Many treatment providers agreed with a provider who commented, “There’s a huge increase in use [of sedative-hypnotics] in the last six months, especially in [use of] Xanax® and Klonopin®. More people are being prescribed these for anxiety.” Another provider commented, “Society is passing more and more individuals, especially of lower economic status. People are having trouble coping day to day, and so they turn to medication [sedative-hypnotics].” Other providers discussed the frequency with which physicians prescribe sedative-hypnotics: “People are demanding more of these medications, and so doctors are prescribing them [sedative-hypnotics] more often; It is now normalized to take these medications.” Finally, a treatment provider reported, “I attribute [the increase in sedative-hypnotic use] to more opiate use,” explaining that many people use sedative-hypnotics to assist with withdrawal from opiates. The Canton-Stark County Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months with a few exceptions: Ambien®, Valium® and Xanax® have decreased in frequency.

New this reporting period is the emergence of synthetic designer drugs similar to benzodiazepines. A participant, whose drug of choice is bath salts, reported having experience with a pseudo-benzodiazepine product (the first OSAM Network report related to synthetic designer benzodiazepines): “The drugs that are coming out now ... they are now selling fake Xanax® pills in head shops. You can go to head shops in my area and buy fake xani [Xanax®] pills. They may not be the exact Xanax®, but it’s the same thing.” A law enforcement officer also spoke about imitation Xanax® now found in head shops: “[Head shops] sell what is packaged as relaxation pills, and sometimes extreme relaxation pills. Basically, they have two different kinds. The Z-Bars are usually sold in three [packs] for around \$17-18. The store employee told me they just recently started selling them. The other one is packaged as Zan-X and is a little cheaper than the Z-Bars.”

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 between \$0.50-1 per pill); Klonopin® (aka “K-pins,” sells for between \$0.50-1 per pill); Valium® (5 mg sells for \$1; 10 mg sells for \$2); Xanax® (0.5 mg, aka “footballs” and “peaches,” sells for between \$0.50-1; 1 mg, aka “footballs” and “blues,” sells for between \$2-3; 2 mg, aka “xanibars,” sells for between \$3-5). 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. Among older participants, those older than 25 years, most noted that the majority of sedative-hypnotic users snort these medications, with one group stating as high as 90 percent of users would snort. However, younger participants, those age 25 years and younger, reported that sedative-hypnotics are more often used by swallowing, with one group estimating that as high as 80 percent of users would swallow.

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported getting them from doctors, mental health patients and senior citizens, with one participant reporting being able to purchase them online. Participants reported: *"[Sedative-hypnotics] are the easiest meds to get by prescription; I never bought it [sedative-hypnotics], I always stole; You buy them [sedative-hypnotics] from older people."* Participants commented that individuals, *"google symptoms of anxiety,"* then go to a doctor seeking these medications. A participant reported that these medications are dispensed, *"like candy ... they [sedative-hypnotics] were always handed to me. It's how my parents calmed me down."* Another participant reported, *"I steal them [sedative-hypnotics] from my grandmother's medicine cabinet."*

A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants described typical users of sedative-hypnotics as, *"anybody, any time."* Participants believed, *"middle-aged women get the prescriptions [for sedative-hypnotics];"* however, they said that many of those women sell their prescriptions to earn extra money during the poor economy. Some treatment providers expressed their belief that sedative-hypnotic use is more common with, *"middle-class, Caucasian, males and females."* Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, bath salts, cocaine, heroin, marijuana and opiates. Participants and community professionals agreed that sedative-hypnotics are most commonly used with other drugs. When sedative-hypnotics are used with other sedatives (alcohol and opiates), the aim is to intensify the effect of the other drugs. A participant commented, *"A lot of pills say, 'don't use with alcohol,' so that's what they do. It [alcohol] boosts your high with the pills [sedative-hypnotics]."* Participants said sedative-hypnotic use with stimulants like cocaine helped them to come down from the stimulant high.

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). The Canton-Stark

County Crime Lab reported that the number of marijuana cases it processes had increased during the previous six months. Participant quality scores of marijuana varied from '3' to '10' with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants commonly believed that the quality of marijuana was increasing as knowledge of advanced growing techniques became widely available. Participants reported that commercial-grade marijuana was the cheapest type: a "blunt" (cigar) or two joints (cigarettes) sold for \$5; and an ounce sold for \$70. Higher quality marijuana sold for significantly more: a blunt or two joints sold for between \$15-25; an ounce sold for between \$275-400. The most common route of administration continued to be smoking. Participants were not able to agree on the profile for a typical user because they believed marijuana use was widely accepted throughout all segments of society.

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, *"always available."* A participant explained, *"[Marijuana] it's like cigarettes [widely used] ... this [marijuana] is the main one [most widely used drug] around here."* Law enforcement in Summit County reported the drug's current availability as '10', while law enforcement in Stark County reported current availability as '8', and commented, *"Marijuana is the number one drug around here."* Collaborating data also indicated that marijuana is readily available in the region. The Stark County Coroner's Office reported that 10.9 percent of all deaths 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, 17.9 percent of all deaths were drug-related. Furthermore, the Coroner reported marijuana as present in 24 percent of all drug-related deaths. Media outlets in the region reported on marijuana seizures and arrests during this reporting period. In December, *The Plain Dealer* reported that after a several-month-long investigation, law enforcement arrested a man in Windham Township (Portage County) for cultivating marijuana in his home. Police seized roughly 10 pounds of marijuana along with an undisclosed amount of cash (www.cleveland.com, Dec. 13, 2011).

Most participants reported that the availability of marijuana has remained the same during the past six months. However, there were a few participants who commented that availability of marijuana has decreased during the past six months. Notably, there were some participants who commented, *"Regular weed" [commercial-grade marijuana] is harder to find with all the other drugs out there. There's no money in regular weed. Most [dealers] are selling the higher*

grade [marijuana]. Law enforcement also reported that the availability of marijuana has remained the same during the past six months. The Canton-Stark County 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 '5' 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 of marijuana depends on whether the user buys "commercial weed" (low- to mid-grade marijuana) or higher-grade marijuana, (hydroponic or home-grown marijuana). Participants also continued to report that marijuana quality, "depends on where you go, who you deal with." A participant expressed a typical comment heard from many others, "Better quality [marijuana] is more common than it used to be."

Current street jargon includes countless 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; "kind bud," "kush" and "Maui wowie" for high-grade marijuana; "dro" and "hydro" for hydroponically grown marijuana. The price of marijuana depends on the quality desired. Participants reported commercial-grade marijuana is the cheapest form: a blunt or two joints (approximately 3-5 grams) sells for \$10; 1/8 ounce sells for \$25-50, 1/4 ounce sells for between \$50-90; an ounce sells for between \$180-240. Higher quality marijuana sells for significantly more: a blunt or two joints sell for between \$20-50; 1/8 ounce sells for \$50, 1/4 ounce sells for between \$100-120; an ounce sells for between \$300-350. Reportedly, the most common way of purchasing marijuana is by the bag, roughly 3.5 grams, which yields two to three joints and sells for between \$10-20. 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.

A profile for a typical marijuana user did not emerge from the data. Participants continued to commonly report that people from every population use marijuana, with law enforcement concurring. A law enforcement officer noted that marijuana use often begins between 18 and 25 years of age or earlier. According to the Stark County Court of Common Pleas data, men and women on probation use marijuana; of all court-ordered drug screens during the past six months, more than 41 percent of positive drug screens were positive for cannabis.

Reportedly, marijuana is used in combination with alcohol, cocaine, Ecstasy, PCP (phencyclidine), sedative-hypnotics and, "any drug." A participant commented that using lower grade marijuana with Ecstasy, "makes it [commercial-grade marijuana] feel like kush [high-grade marijuana]." A participant

referenced using marijuana with PCP as, "smoking 'shermans' ... they give a better high." Most participants reported that marijuana is used with, "everything." A participant commented that marijuana is, "the kick-it drug," inferring that marijuana goes with any other drug.

Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was highly available in the region. Participants most often reported the drug's availability as between '5' and '10' 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 powdered and crystal forms, although the powdered form was considerably more available. Treatment providers and Summit County law enforcement most often reported the availability of methamphetamine as '10.' The Canton-Stark County Crime Lab reported that the number of methamphetamine cases it processes had increased during the previous six months. Participants most often rated the quality of powdered methamphetamine as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that a gram of powdered methamphetamine sold for \$40; a gram of crystal methamphetamine sold for between \$70-100. Reportedly, the most common route of administration was intravenous injection, a practice said to have been increasing among methamphetamine users. Participants described typical users of methamphetamine as White, between the ages of 18-50 years.

Current Trends

Methamphetamine remains highly available in the region. Participants most often reported the current availability of methamphetamine 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 '5' and '10.' A participant commented, "In our town [in Portage County], meth [methamphetamine], bath salts and heroin are the most common drugs." Participants reported that methamphetamine continues to be most available in powdered form. Crystal methamphetamine (aka "ice"), the highest quality form of methamphetamine, was said to be, "very rare" in the region. Treatment providers most often reported methamphetamine's current availability as '10,' and reported that it is common for users to make their own methamphetamine. Law enforcement in Stark County reported the current availability of methamphetamine as '3.' An officer talked about methamphetamine in the region: "[Methamphetamine] it's out there, but we don't seem to have the problem our neighbors in Summit [County] have. We are not seeing it like they are." Law enforcement in Summit County reported the drug's current availability as '5,' while

commenting, *"We've already exceeded last year's take [law enforcement seizures of methamphetamine]. We haven't seen any Mexican import for a long time. Everyone is making it [methamphetamine] for their own use, they're not selling it. One-pot [method] makes one to three grams."*

Reportedly, the most common way of manufacturing methamphetamine is through the *"shake and bake"* or *"one-pot"* method, which has become widely known. By using common household chemicals, along with ammonium nitrate found in cold packs and pseudoephedrine (typically found in some allergy medications), users (aka *"cooks"*) can produce the drug in approximately 30 minutes at nearly any location by mixing ingredients in easily found containers, such as two-liter plastic soda bottles. Participants also mentioned that there are a *"few old-time cooks,"* but the old ways of producing methamphetamine are difficult, take considerably longer and require ingredients that are difficult to obtain. A participant reported, *"Shake and bake' is the most common [method of producing methamphetamine] around here."* Another participant commented, *"It [methamphetamine production] used to be red phosphorous, but is all but out. It's harder to make, harder to get the ingredients. It's 'shake and bake' now."* Media outlets throughout the region have reported on several methamphetamine seizures during this reporting period. In October, the *Record Courier* reported that a Franklin Township (Portage County) man was arrested for possessing the means and intent to manufacture methamphetamine, and a Rootstown (Portage County) resident was also arrested after police found drug paraphernalia, one-pot methamphetamine labs and an unspecified amount of methamphetamine in her home (www.recordpub.com, Oct. 26, 2011). The *Plain Dealer* reported that following an anonymous tip, police raided a house in Stow (Summit County) and arrested two men for manufacturing methamphetamine (www.cleveland.com, Sept. 13, 2011).

The majority of participants reported that the availability of *"shake and bake"* methamphetamine has increased during the past six months. A participant commented, *"[Methamphetamine is] more available, but [quality of methamphetamine] it's crap."* Another participant spoke about why methamphetamine is more available: *"I believe it [increased use and availability of methamphetamine] is due to bath salts. People like the speed effect."* Treatment providers generally reported that the availability of methamphetamine has decreased or remained the same during the past six months. A provider commented, *"I have been shocked on how little methamphetamine I've seen coming through the doors, but the clients indicate that it's because the penalties of being caught are stiffer, so all the meth users are in prison. That's the perceived wisdom I've gotten from the clients, and when I do get a client who has used meth, generally they know how to make it ... which is a problem in recovery because they*

can always go back and make it." Another provider agreed, *"With the availability [of methamphetamine], it's not so much where to go and get it [methamphetamine] ... they [users] just do their shake and bake. They got their own, and it seems to be common knowledge, and so you know that you have that to fall back on."* Law enforcement reported that availability of methamphetamine has remained the same during the past six months. The Canton-Stark County Crime Lab reported that the number of methamphetamine cases it processes 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); the previous most common score was '8.' Participants commonly agreed that overall methamphetamine quality has decreased during the past couple of years, although no change in the past six months was noted. Participants typically believed the quality, *"depends on who makes it."* Participants identified reasons for poorer quality to include: *"The real [good methamphetamine] cooks are all locked up; Quality is down, due to increase in demand. More people are making [methamphetamine with the lower-quality method]."* Participants also discussed high-quality methamphetamine occasionally coming into the region: *"Good stuff [methamphetamine from Mexico] comes into the region by bikers from the East Coast."* The Canton-Stark County Crime Lab cited brown, pink and white powdered methamphetamine as the most common forms of the drug in the region.

Current street jargon includes a few names for methamphetamine. The most commonly cited names were *"crank," "crystal," "ice," "meth," "shake and bake," "shards," "speed"* and *"tweak."* Current street prices for methamphetamine were variable among participants with experience buying the drug. Participants reported that a person can purchase a *"rock"* of methamphetamine for \$20; a gram of powdered methamphetamine sells for between \$50-100; a gram of crystal methamphetamine (when available) sells for \$100. Reportedly, individuals can trade for methamphetamine with ingredients, such as *"boxes of pills [pseudoephedrine]."* A participant talked about the variability in the drug's price: *"It [pricing of methamphetamine] depends. People are making it different. There is not a set price. It depends on the quality; it can't be the same quality every time."* There was no agreement regarding the most common route of administration of methamphetamine. A participant group cited smoking as the most common route of administration (about 60 percent of users were said to smoke methamphetamine), but other groups cited intravenous administration as becoming more popular. Those groups which identified intravenous administration as being more popular reported that injecting methamphetamine delivers the most intense high,

hence the growing popularity of injection. A participant commented, *"I do it [methamphetamine] all ways. Each [route of administration] has different effects from each other."* Another participant noted that younger people tend to snort methamphetamine, while older users (older than 21 years) tend to smoke or inject it.

A profile for a typical methamphetamine user did not emerge from the data. However, some general characteristics were noted by participants: *"A lot of women use [methamphetamine] while cleaning the house; Users tend to be older; it's not as common among teenagers."* Many participants agreed when one said, *"I've never seen a Black person using methamphetamine."* Participants also suggested, *"people living in rural areas"* are more likely to use methamphetamine, *"as anyone can make their own [methamphetamine]."* Some treatment providers reported that users tend to be younger, while others reported they have *"noticed some older adults ... older 30s-50s."* Some providers reported users tend to come from lower socio-economic populations, while other providers noted that users, *"tend to be people with more resources, like a job or family; People you'd be surprised are using it [methamphetamine]."* Treatment providers and law enforcement noted that users tend to be White. A law enforcement officer noted that few people between the ages of 18-25 years use methamphetamine, stating users tend to be older than, *"mid-20s."* As he explained, *"You don't see a lot of young people experimenting [with methamphetamine]. It's a scary drug. People know what it can do."* Another member of law enforcement reported that users range from, *"the top of the socio-economics to the bottom."* Reportedly, methamphetamine is used in combination with alcohol, to help one "come down" from methamphetamine, prescription stimulants (Adderall®), to intensify the effect, cocaine because, *"it [cocaine] gives it [methamphetamine] a kick, keeps the high going"* and heroin for the "speedball effect."

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). Treatment providers generally reported that Ecstasy was rarely used by clients coming in for treatment. Summit County law enforcement reported the availability of Ecstasy as '6' or '7,' and said that availability varied during the year. Law enforcement reported a recent drug seizure that picked up powdered Ecstasy, which was typically more common on the West Coast and a rarity in this region. The Canton-Stark County Crime Lab reported that the number of Ecstasy cases

it processes had decreased during the previous six months. Ecstasy sold for between \$7-10 per tablet, depending on the size of the tablet; powdered Ecstasy sold for \$100 a gram. Participants described typical users of Ecstasy as young, usually in high school or college.

Current Trends

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) remains highly available in the region. Participants reported the current availability of Ecstasy 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 the drug comes in two forms, tablet and powder, with the most available in this region being Ecstasy tablets. Ecstasy powder (aka "Molly") was described by one participant as, *"pure MDMA."* Treatment providers reported the current availability of Ecstasy as '6' or '7.' Providers reported the drug as being used primarily, *"in the rave scene."* Law enforcement in Stark County reported, *"We [law enforcement] don't see a lot of it [Ecstasy]. It's out there, but we don't hear much about it."* However, law enforcement in Summit County reported a couple of drug seizures recently, one involving powdered Ecstasy coming in from Pennsylvania, the other involving Ecstasy tablets coming in from Canada. Participants reported that the availability of Ecstasy has remained the same during the past six months. Treatment providers in Stark County commented, *"More people are talking about it [Ecstasy]; I've had quite a few [clients] reporting [Ecstasy] use."* The Canton-Stark County Crime Lab reported that the number of Ecstasy (MDMA) cases it processes has remained the same, and the number of piperazine cases (typical components of Ecstasy) has increased during the past six months.

While participants did not identify a rating score for the quality of Ecstasy, some participants commented that the quality of Ecstasy has declined, as it tends to be, *"mixed [adulterated] with all kinds of stuff,"* although most participants could not guess how the drug is being cut. However, a participant reported, *"A lot of the Ecstasy comes from Canada, and it's not really MDMA; it's pills for tapeworms."*

Current street jargon includes very few names for Ecstasy. The most commonly cited names were "Molly" and "X." Participants reported that a "single stack" (low dose) Ecstasy tablet sells for \$4; 1/10 gram (aka "tic") of powdered Ecstasy (aka "Molly") sells for between \$10-20; a gram sells for between \$100-130. Participants reported that Ecstasy is most commonly used by people who like the club scene and "ravers," and that Ecstasy is easily found in bars. Reportedly, Ecstasy is most commonly used by younger people, with one participant group citing, *"mostly college kids [use Ecstasy]."* A participant also reported that Ecstasy is commonly used in the male homosexual community. Treatment providers

reported that individuals who use Ecstasy tend to be young, in their 20s and 30s. Participants with direct knowledge of use reported that Ecstasy is taken orally. One participant group reported that Ecstasy is commonly used in combination with alcohol and marijuana. A participant commented, *"It seems like, with all these drugs, they will use something else to counteract it."*

Bath Salts¹

Current Trends

Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) are 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). Notably, participants with first-hand knowledge of the bath salts use were exclusively younger, 25 years of age or younger. A participant commented, *"Out of 10 people I know, nine are addicted to bath salts."* Participants reported that they are able to purchase bath salts at drive-thru beverage stores, gas stations and head shops. A participant commented that some of these establishments have extended their hours of operation to meet demand. When questioned about the new law designed to make the sale of bath salts illegal, most participants did not believe this law would affect availability. Participants commonly believed that manufacturers would find ways around the law banning the sale of bath salts, either by changing the formulation or changing the names of the product. Older participants, who generally reported no first-hand knowledge of the drug, reported that bath salts are now, *"off the market,"* though some reported that bath salts could still be purchased at drive-thru beverage stores and gas stations. A participant shared the following, *"I know a couple of friends who do it [bath salts]. They act crazy ... it freaks them out. Some have a bad reaction, an after-effect like schizophrenia."* Treatment providers most often reported the current availability of bath salts as '10'. Providers believed the drug is popular because, *"it [bath salts] is not that expensive."* A treatment provider commented about the potency of bath salts: *"Bath salts put methamphetamine to shame. People hallucinate for days."* A treatment provider group spoke about bath salts as being "highly addictive," having significant negative impact on users' lives, with significant effects on, *"the emotional and mental state [of users] ... just like methamphetamine."* Treatment providers reported that users report that bath salts have the same effect as using hallucinogens and stimulants and that these effects last up to two days. It was further reported that users often seek hospitalization and/or admission to residential treatment in response to these effects, and to withdraw from the drug. A law enforcement officer in Stark County reported that there had not been many reports of abuse of this drug until

¹ Bath salts were rarely mentioned the past reporting period; therefore, there is no historical summary.

recently and that his department has now started to see bath salts cases. A law enforcement officer in Summit County reported that there have been no arrests for bath salts since the new law was enacted. He commented that an individual's behavior becomes, *"bizarre, violent"* when using bath salts. The Canton-Stark County Crime Lab reported that the number of bath salt cases it processes has increased during the past six months.

Participant quality scores of bath salts were unanimously '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants commonly believed that bath salts are, *"very strong."* A participant commented, *"A lot of people cannot handle it [bath salts use]."* Another participant talked about the lingering effects of the drug months after giving it up: *"I'm two months sober. I still have hallucinations. I used 1/2 gram [of bath salts] a day. I was often up nine or 10 days in a row."* Participants reported that 1/2 gram of bath salts sells for between \$16-20. While there were several reported ways of consuming bath salts, the most common routes of administration are snorting and intravenous injection. While not as common, bath salts are also consumed by smoking. A treatment provider group reported that bath salts are commonly used with heroin and that, *"IV use [of bath salts] is typical."*

A profile for a typical bath salts user did not emerge from the data. However, treatment providers and law enforcement reported that users tend to be young, with use starting during the teen years, as early as middle school. A law enforcement officer noted that users tend to be, *"White males."* Reportedly, bath salts are used in combination with crack cocaine, prescription opioids and sedative-hypnotics. Participants explained the benefits of these use combinations: *"I have no withdrawal effect [when smoking crack cocaine with bath salts use]; The only way to come down from bath salts is with opiates; [Sedative-hypnotics are used] to take the [bath salts] craving off."*

Other Drugs

Historical Summary

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], prescription stimulants and synthetic marijuana ("K2" and "Spice"). Participants with knowledge of LSD stated it was moderately available in the region, and most often reported its availability as '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers reported that LSD was not commonly reported by clients as a primary drug of choice. Reportedly, a "hit" (dose, a microdot or blotter) of LSD sold for between \$5-10, or 100 hits sold for between \$300-400. Overall, participants and treatment providers viewed LSD

as more popular with younger adults like college students. Only two participant groups mentioned the availability of psilocybin mushrooms in the region. Participants said psilocybin mushrooms were still popular, but they explained quality of the mushrooms was poor; participants most often rated psilocybin mushroom quality as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). On the other hand, treatment providers in Portage County reported that psilocybin mushrooms seemed to be very popular. A few participants reported that prescription stimulants were moderately available in the region, although they did not identify specific medications available. Participants most often rated the availability of prescription stimulants as between '7' and '10'. Participants did not view prescription stimulants as a commonly abused substance, other than by young adults. Synthetic marijuana was highly available in the region. A few participants mentioned that they had tried synthetic marijuana, but none reported regular use because they thought the drug was cost-prohibitive. Participants said a small pouch, roughly three grams, sold for \$30. The Canton-Stark County Crime Lab reported that the number of synthetic marijuana cases it processes had increased during the previous six months. Participants reported that synthetic marijuana was more popular with adolescents and other individuals who were subject to urine drug screens. The Canton-Stark County Crime Lab also reported one other drug that was not mentioned by focus group participants; there was an increase in the number ketamine cases it had processed during the previous 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. Participants in Summit County identified LSD as moderately to highly available in the region, rating LSD's current availability most often as '5' or '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'. Reportedly, LSD availability increases in the spring and summer when there are more outdoor music festivals at Nelson's Ledges Quarry Park in Portage County. Law enforcement, on the other hand, noted hallucinogen use in the region as, "very rare." An officer reported that there has only been one case in his department over the past year involving hallucinogens, in particular psilocybin mushrooms. The Canton-Stark County Crime Lab reported that the number of hallucinogen cases it processes has decreased for LSD and increased for psilocybin mushrooms during the past six months. Participants who reported knowledge of LSD use reported the current quality of LSD as, "good," rating current quality as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality).

Synthetic marijuana remains highly available in the region. Participants most often reported the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, participants did not assign an availability score. Participants 25 years of age and younger noted that synthetic marijuana has become less available during the past six months. A participant reported, "[Synthetic marijuana] it's not available anymore; they took it off the market." Though, one participant responded by stating, "Dealers can get it [synthetic marijuana] for us, if we ask for it." Reportedly, synthetic marijuana is, "popular in bars." Treatment providers also reported synthetic marijuana to be highly available in the region, and they most often reported the drug's current availability as '10'. Treatment providers explained that synthetic marijuana is, "the drug of choice in jail" and is commonly used by individuals on probation to avoid drug use detection on drug screens. The Canton-Stark County Crime Lab reported that the number of synthetic marijuana cases it processes has increased during the past six months. One concern raised by treatment providers was that there is a, "general misconception" that synthetic marijuana and bath salts are safe, and people, "won't get messed up." At the time of the interviews, participants reported that brands like "K2" are easily purchased at various stores (drive-thru beverage stores and gas stations); three grams sell for \$10. As with marijuana, the most common route of administration for synthetic marijuana is smoking. Treatment providers reported that synthetic marijuana continues to be used most often by "young kids" and by those on probation.

Conclusion

Crack cocaine, Ecstasy, heroin, marijuana, methamphetamine, powdered cocaine, prescription opioids, sedative-hypnotics, Suboxone® and synthetic marijuana remain highly available in the Akron-Canton region; also highly available are bath salts, which were not reported on during the last reporting period. A slight decrease in availability during the past six months exists for prescription opioids, with the exception of Opana® which was thought to have increased in availability; an increase in availability exists for heroin. Data also indicate likely increases in availability for powdered cocaine, sedative-hypnotics and Suboxone®. Participants reported that they are able to purchase bath salts at drive-thru beverage stores, gas stations and head shops. A participant commented that some of these establishments have extended their hours of operation to meet demand. When questioned about the new law designed to make the sale of bath salts illegal, most participants did not believe this law would affect availability. Participants commonly believed that manufacturers would find ways around the law banning the sale of bath salts, either by changing the formulation or by changing the names of the product. Treatment providers believed bath salts to be popular

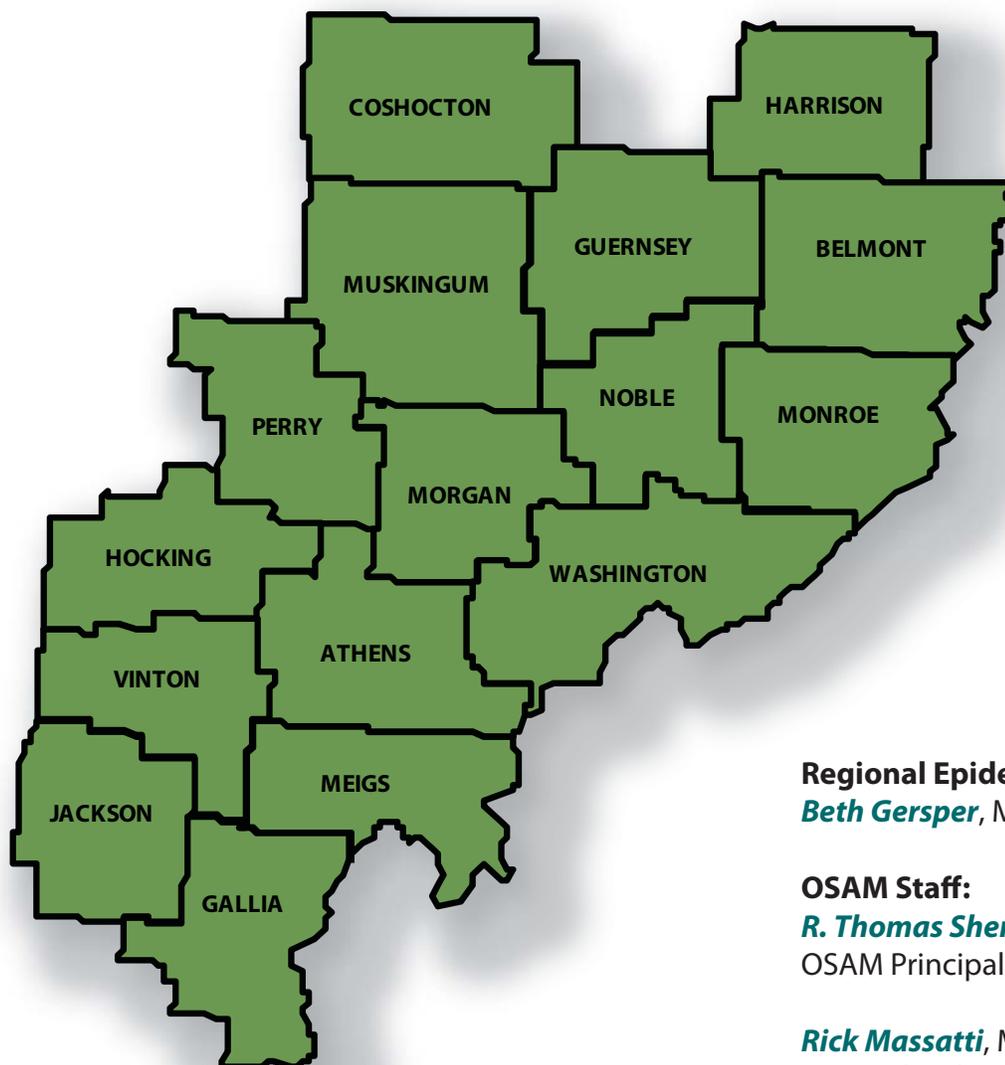
because they are relatively inexpensive and potent. A participant, whose drug of choice is bath salts, reported having experience with a synthetic designer drug similar to benzodiazepine (the first OSAM Network report of imitation benzodiazepine). A law enforcement officer also spoke about “imitation Xanax®” now found in head shops. Participants reported that it is more difficult to obtain a prescription for opioids, particularly for younger people; participants agreed that it’s more difficult to obtain prescription opioids than to obtain heroin. Treatment providers also reported that availability of prescription opioids has decreased during the past six months. Many providers noted the high cost of these drugs as a key factor for decreased availability. A treatment provider commented, “[Users] are leapfrogging to heroin.” While many types of heroin remain currently 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 powdered heroin has increased during the past six months. Participants reported, “It [heroin] keeps getting easier and easier to find; Ever since the oxy [OxyContin®] revolution, once they [users] realize what oxy is ... synthetic heroin ... people find heroin is cheaper.” Participants reported that heroin use is fairly common in high schools; a number of providers noted that heroin use is becoming more popular with younger people, particularly those between the ages of 18-25 years. Participants also reported that many users like to speedball (use powdered cocaine with heroin), so heroin dealers often have powdered cocaine to sell as well, indicating increased availability of powdered cocaine. The Canton-Stark County Crime Lab reported that the number of powdered cocaine cases it processes has increased during the past six months. Treatment providers and some participants reported an increase in the availability and use of sedative-hypnotics, noting that many users are using the drugs increasingly to detox from heroin and to withdraw from bath salts. Participants and treatment providers reported that Suboxone® is readily available for street purchase. Treatment providers reported that availability of Suboxone® has increased; the Canton-Stark County Crime Lab reported that the number of Suboxone® cases it processes has increased during the past six months. Also, while treatment providers and law enforcement both thought that methamphetamine availability and use have decreased or remained the same during the past six months, it is noteworthy that the majority of participants reported that the availability of “shake and bake” methamphetamine has increased. A participant linked the high popularity of bath salts to the increased use of methamphetamine in the region: “I believe it [increased use and availability of methamphetamine] is due to bath salts. People like the speed effect.”

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Athens Region

June 2011-January 2012

John R. Kasich, Governor
Orman Hall, Director



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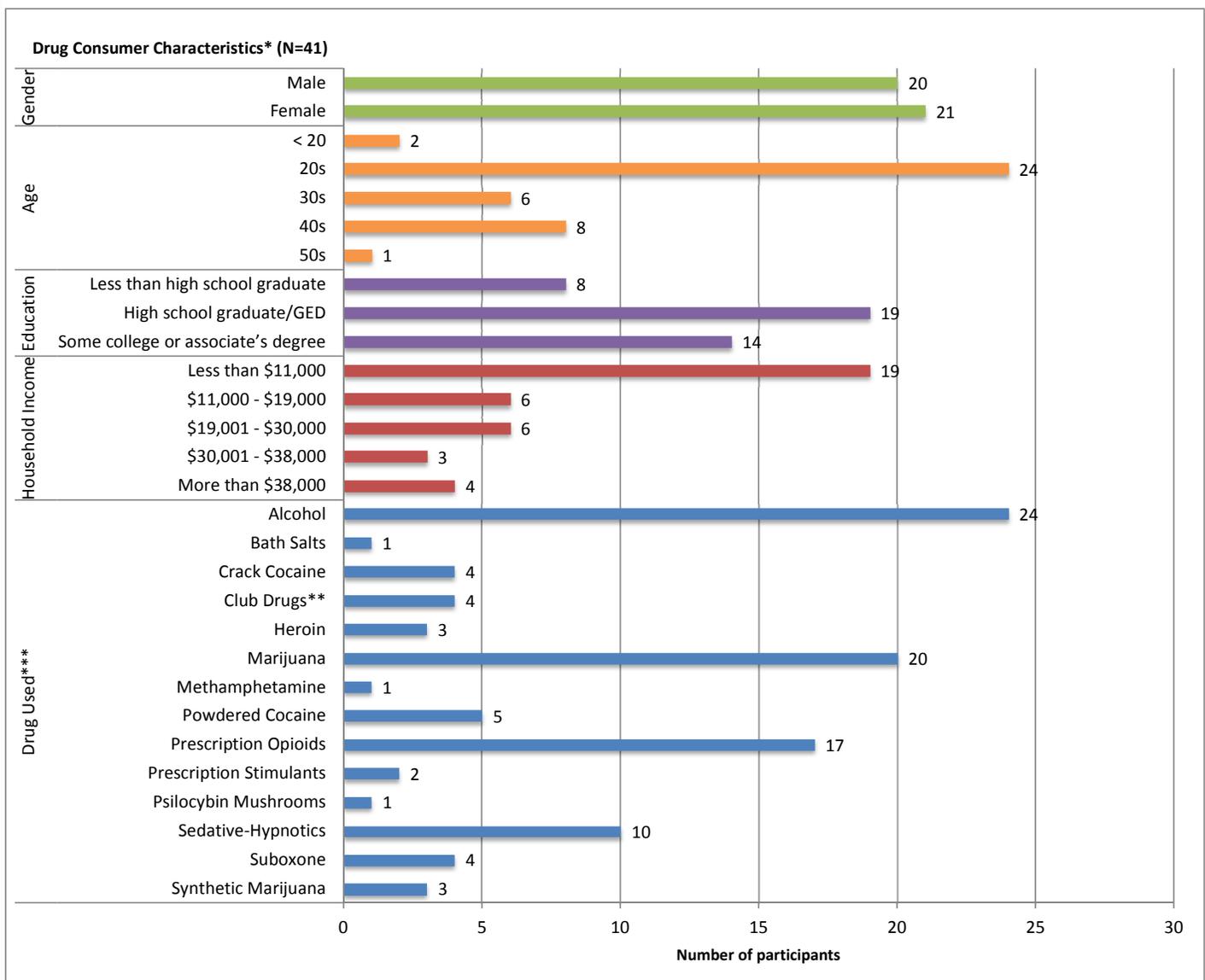
Athens Regional Profile

Indicator ¹	Ohio	Athens Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	587,004	41
Gender (Female), 2010	51.2%	50.4%	51.2%
Whites, 2010	81.1%	94.7%	85.4%
African Americans, 2010	12.0%	2.1%	2.4%
Hispanic or Latino Origin, 2010	3.1%	0.8%	4.9%
High school graduates, 2009-2010	84.3%	92.9%	80.5%
Median household income, 2010	\$45,151	\$37,381	Less than \$19,000 ²
Persons below poverty, 2010	15.8%	18.2%	68.4% ³

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

Respondents reported income by selecting a category that best represented their household's approximate income for 2011. Income status was unable to be determined for three respondents due to missing data.²

Poverty status was unable to be determined for three respondents due to missing or insufficient income data.³



*Not all participants filled out forms; therefore, numbers may not add to 41.

**Club drugs refers to Ecstasy and LSD.

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

Data Sources

This regional report was based upon qualitative data collected via individual and focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Athens, Gallia, Guernsey, Hocking, Jackson 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 January through June 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, all 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 July through December 2011.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Some participants reported that powdered cocaine was more easily found in cities (Columbus, Weirton, W.Va., Youngstown or Zanesville). Only participants in Athens County reported perceptions of low availability of powdered cocaine. Treatment providers most often reported availability as '6'. Most participants reported that the availability of powdered cocaine had remained the same during the previous six months. Most participants rated the quality of powdered cocaine as '2' 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 most powdered cocaine cases. Participants reported that a gram of powdered cocaine sold for between \$50-100, depending on quality. Participants consistently reported that powdered cocaine was cheaper if purchased "in the city," cheaper if bought in larger quantities (an "eight ball," or 1/8 ounce, versus a gram). Reportedly, the most common route of administration for powdered cocaine remained snorting. Some participants commented that using powdered cocaine by intravenous (IV) injection or by smoking (lacing a cigarette or marijuana blunt with powdered cocaine, aka "snow caps") were growing trends, with members of one focus group positing that IV use was

as common as snorting. Many participants continued to describe typical users of powdered cocaine as individuals with income. Many participants commented that it was common to use powdered cocaine with other drugs, more so than to use powdered cocaine by itself, usually to help the user come down from the stimulant high produced by powdered cocaine. In addition, participants reported that powdered cocaine use was common in bars.

Current Trends

The current availability of powdered cocaine remains variable in the region, with participants reporting differing availability scores by county. However, participants throughout the region most often reported the drug's current availability 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 '10'. Participants in Guernsey and Muskingum counties reported current availability of powdered cocaine as moderate, with a mean availability score of '7', whereas participants in Athens and Jackson counties most often reported current availability as '4'. A participant in Guernsey County reported, "Walk outside; every side of town [powdered cocaine is available]." An Athens County participant reported, "[Powdered cocaine is] nowhere immediately in the Athens area ... it's a drive [to obtain powdered cocaine]." Treatment providers and law enforcement most often reported the drug's current availability as '10' for Muskingum County and '5' for other counties in the region. A Muskingum treatment provider reported, "Never heard a client say they had a problem getting it [powdered cocaine]." Other county professionals suggested that powdered cocaine is not very available. A treatment provider reported, "During the assessment, maybe [a client will say], 'Yeah, I tried it [powdered cocaine] a couple of times' [or] maybe, 'I did [powdered cocaine] a few months ... I did it with some friends, but nobody, really, off the top of my head has had ongoing use."

Participants reported that the availability of powdered cocaine has remained the same during the past six months. A participant commented, "My dad does a lot of it [powdered cocaine]. He's been going to the same guy [dealer] forever." Participants indicated that a user has to get powdered cocaine before dealers "rock it up" (manufacture the drug into crack cocaine). A participant reported, "You can get hard [crack cocaine] easier than you can get soft [powdered cocaine] because a lot of people [dealers] want to take it [powdered cocaine] and cook it [manufacture crack cocaine] ... they make more money off it that way." Treatment providers and law enforcement reported that availability of powdered cocaine has remained the same during the past six months. 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 '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '2.' Participants reported that the quality of powdered cocaine has varied during the past six months: *"Sometimes [powdered cocaine] it's weak quality, and sometimes it's high quality."* Guernsey County participants reported quality to be low while participants in Athens, Jackson and Muskingum counties reported variability in quality. One participant said, *"It [quality] depends on who you're getting it from really ... like how long you're willing to wait or if you want it right then ... because if you call somebody and you're rushing them or whatever and you really ain't trying to spend that much with them, most likely they're taking some GNC® product or something and they're cutting [adulterating] it down. So you're only getting like half of what you're paying for it ..."* Participants reported that powdered cocaine in the region is cut with aspirin, baby laxative, baby vitamins, baking soda, bath salts, caffeine pills, GNC® products, lidocaine (local anesthetic), NoDoz®, Orajel®, prescription opioids and vitamin B12. A participant commented, *"Really any white powder that looks like it [powder cocaine] [can be used as a cutting agent]."* 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), lactose (disaccharide sugar), levamisole (livestock dewormer), local anesthetics (benzocaine, lidocaine and procaine) and mannitol (diuretic).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "coke," "powder" and "snow." Participants listed the following as other common street names: "blow," "cold weather," "cousin ya-yo," "girl," "Mexican Flu," "powder," "soft," "weather," "white," "white girl," "white lady," "winter" and "ya-yo." Current street prices for powdered cocaine were variable among participants with experience buying powdered cocaine. Participants reported that a 1/2 gram sells for \$50; a gram sells for between \$80-100, depending on the quality; 1/16 ounce, or "teener," sells for \$120; 1/8 ounce typically sells for \$150, but can sell for up to \$225 depending on quality; 1/4 ounce sells for \$275. Participants reported that the most common way to use powdered cocaine remains snorting. Out of 10 powdered cocaine users, participants reported that approximately eight would snort and the other two would either smoke or intravenously inject. A participant reported, *"Maybe two people who might put it [powdered cocaine] on a cigarette and smoke it; [I have] only known two people to shoot it [inject powdered cocaine]."* Guernsey County participants reported more intravenous use than did participants in Athens, Jackson or Muskingum counties. The consensus among participants was that there is a graduated way of using drugs

in general. A participant explained, *"At first I started snorting it [powdered cocaine], then I smoked it, and then I shot [sic] it. About every three or four years I went to something different ... to find a better way to get high."*

Although a general profile for a typical powdered cocaine user did not emerge from the data, there were two comments worth noting. Several participants mentioned people with occupations that require them to work long shifts might use powdered cocaine to help them stay awake. Some occupations mentioned included construction workers, doctors, iron workers and truck drivers. A participant reported, *"My dad and his friends, they're iron workers, and they mix [powdered] cocaine and meth [methamphetamine]. I think it keeps them awake on the job."* Community professionals described the typical user of powdered cocaine as primarily White: *"White crowd is more powder[ed] cocaine user – inhaling and snorting; Blacks [are] more of the crack [cocaine] users."* A couple of treatment providers mentioned hearing about powdered cocaine use among restaurant servers: *"The servers, you know, you got to be out there and happy and active and moving ... they can't stay home at night, so they go out and party, and then the way they stay awake is to do the cocaine so they can work all day."* A representative from a coroner's office suggested use by professionals and people of all ages: *"You'd be surprised. There are people in their older adult ages that are using it [powdered cocaine] that I'm just totally blown away by. Professionals, lawyers, people with degrees that I just totally wouldn't expect that behavior."* Law enforcement described typical powdered cocaine users as, *"upper-class and college kids."*

Reportedly, powdered cocaine is used in combination with alcohol, bath salts, heroin, marijuana, methamphetamine, prescription opioids and sedative-hypnotics. A participant reported, *"I just always had to drink [alcohol when using powdered cocaine] because that would always bring me down to go to sleep ... if not, I would be wired. I wouldn't be able to sleep. My eyes wouldn't be shutting for nothing."* Depressant drugs are often used to help users come down (sober up) from the stimulant high produced by powdered cocaine. A participant reported, *"Every time I've ever did coke, I've had either heroin or Xanax® to come down off with."* According to another participant, *"Some people are lacing their cocaine with opiates [crushing pills and snorting with powdered cocaine]. That's mostly the [drug] dealers that do that."*

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). Participants in Athens reported difficulty obtaining the drug, but said users would often travel to urban areas if they could not find it locally. Treatment providers in Athens and Belmont counties could not provide availability ratings for crack cocaine because few of their clientele abused the drug. The most common participant quality score for crack cocaine was '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut with other substances. According to the BCI London Crime Lab, levamisole (livestock dewormer) was used as a cutting agent for crack cocaine. Participants reported that a gram of crack cocaine sold for between \$80-100. However, the majority of crack cocaine users reported buying the drug in small quantities selling for between \$10-50. By far, the most common route of administration was smoking, with a minority of users reporting intravenous injection. Participants and treatment providers could not come to a consensus regarding a profile for the typical crack cocaine user.

Current Trends

Crack cocaine remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. However, within the region, availability is variable. Participants in Gallia, Guernsey and Muskingum counties reported higher availability of crack cocaine than did participants in Athens, Hocking and Jackson counties. Participants in Guernsey and Muskingum counties, respectively, commented, "About every fourth house [on] every street [is a 'crack house']; There are times where I could find no marijuana, but I could find coke [powdered cocaine] and crack [cocaine]." A participant in Athens commented, "I don't really hear about it [crack cocaine] much," and a participant in Hocking County said, "I think in this area, people aren't doing either [crack or powdered cocaine] it's pain pills, Suboxone®, Subutex® [and] heroin." Law enforcement and public health professionals most often reported the drug's current availability as '8'. A director of a youth educational program reported, "[Crack cocaine] seems readily available as a drug of choice for clients along with bath salts; [I] hear [about] crack and bath salts more than marijuana right now."

Participants reported that the availability of crack cocaine has remained stable during the past six months. A participant in Guernsey County stated, "Never heard of anybody not being able to get crack." Several participants mentioned variability in the presence of crack cocaine. A participant explained, "[The availability of crack cocaine] has

its ups and downs when people get busted, but someone else comes right back ... someone steps up and takes that spot." Public health professionals reported that the availability of crack cocaine has remained stable, or might have actually decreased during the past six months. A treatment provider commented, "I'm seeing less crack use. They [clients] may have tried it, but they went into something else besides that." The BCI London 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 '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Most participants reported that the quality of crack cocaine varied during the past six months depending on location. A participant reported, "Sometimes [crack cocaine quality] it's better in town, sometimes it's better out there [in the country] – just depends on what kind of stuff [cutting agents] they [dealers] get in." Participants reported that crack cocaine in the region is often cut with baking soda and can also be cut with bath salts, candle wax, dry wall, Orajel® and powdered soap. Guernsey County participants commented on the amount of "dummy dope" being made in the area: "Everybody's making the dummy dope now. I know people that melt candle wax down and put a little Orajel® and stuff with it." The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the primary cutting agent for 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: "boulders," "dope," "Hard Rock Cafe®," "stones" and "yea." A participant explained the naming differences between powdered cocaine and crack cocaine: "You can call crack everything you can call coke [powdered cocaine] except 'soft'." Current street prices for crack cocaine were somewhat consistent among participants with experience buying crack cocaine. A participant reported, "You can buy it [crack cocaine] by the 10s [\$10 increments]." Another participant explained that there are discounts for larger quantities: "Once you start getting into weight, half grams and stuff like that, the price will come down and you'll get more [crack cocaine] for your price." Participants reported 1/10 gram of crack cocaine sells for \$10 (aka 'one hit' or a 'blast,' consisting of one rock a bit smaller than an eraser on the end of a pencil); 1/2 gram sells for \$50; a gram sells for between \$50-100; 1/16 ounce sells for \$80-140; 1/8 ounce sells for between \$150-300 (typically sells for \$250). While there were a few reported ways of using crack cocaine, generally, the most common routes of administration were smoking and intravenous injection. Participants mentioned several ways of smoking crack cocaine: "Throw it [crack cocaine] on the char [coarse scrubbing pad used as a screen] and smoke it; chasing the dragon [using

crack with heroin.” A few participants mentioned intravenous use: *“Shoot it [inject crack cocaine] with vinegar or lemon juice.”* Only one participant mentioned snorting crack cocaine. A Guernsey County participant reported users parachuting crack cocaine, *“I’ve seen a couple people parachute it ... like wrap it up in toilet paper and swallow it. Some people say it does [increase the buzz]. I just say it’s a waste of money.”* A participant recognized a difference in methods due to age, *“Younger [less-experienced users] smoked it [crack cocaine], older [more-experienced users] shoot it.”*

A profile of a typical crack cocaine user did not emerge from the data. Participants commented that all ages are represented: *“I know teenagers that are smoking crack, and I’ve seen 60-year-old men that are still smoking crack.”* A participant noticed a difference in race when purchasing crack cocaine: *“Most the people I’ve ever bought crack off of have been Black, African-American.”* However, community professionals developed a different profile; public health professionals and law enforcement agreed that prostitutes tend to use crack cocaine more frequently. A law enforcement officer explained, *“Prostitutes tend to be involved with crack cocaine. It’s a reward and a way they tolerate their job.”*

Reportedly crack cocaine is used in combination with alcohol, heroin, marijuana, prescription stimulants and sedative-hypnotics. Except for prescription stimulants, most participants agreed that crack cocaine is used with, *“anything that will bring you down [from the stimulant high produced by crack cocaine].”* A participant spoke about using marijuana after using crack cocaine: *“I know people who smoke a joint [marijuana] after they run out [of crack cocaine] because they say it helps kill the cravings for wanting more [crack cocaine].”* A participant mentioned using crack cocaine as a substitute for prescription stimulants when they weren’t available: *“I’ve done it [crack cocaine] two different times in my life and it’s because I was doing a bunch of Ritalin® and Adderall® like through the whole day, and then the dude that was selling that to me left town and so I was like freakin’ out, and so I just decided like to keep the speed going I was going to do some crack.”*

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). However, it was also often stated that heroin was more readily available in cities (Columbus and Zanesville) than in other areas in the region. Participants and community professionals reported that heroin

availability had increased during the previous six months. In addition, treatment providers noted an increase in requests for detoxification services from intravenous heroin users. Treatment providers reported reasons for increased heroin availability and use to include: *“It [heroin] is cheaper [than prescription opioids]; It’s harder to get pills [prescription opioids].”* While there were different forms of heroin available in the region, participants continued to report the availability of black tar heroin as most available. Most participants generally rated the quality of heroin as ‘4’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants commonly noted that heroin found in cities was more pure than heroin found in rural areas. The BCI London Crime Lab continued to report that heroin was “very pure” in the region. Participants reported that the most common way to purchase heroin was by individual packets (1/10 gram, aka “bag,” “ball,” “balloon” or “stamp”) for \$20-50; participants also reported buying heroin in “bundles” (10-12 small packs of heroin, approximately a gram) for \$80-120. Reportedly, heroin was cheaper if purchased in Columbus. The most common way to use heroin remained intravenous injection. Participants reported that there was less stigma with drug injection than there once was; hence, more people from different backgrounds were “shooting” heroin. Participants and treatment providers also continued to report that heroin use was very common among young people, including high school-aged youth.

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’. A Jackson County participant reported, *“[Heroin is] more available than marijuana.”* Another participant reported, *“[Heroin] that’s all I hear people talking about.”* While many types of heroin are currently available in the region, participants continued to report the availability of black tar heroin as most available. A participant reported, *“Main thing around here is tar [black tar heroin] and some brown powder [heroin]; Heroin around here is black tar ... heard of powder [heroin] but have not seen it.”* Although participants had heard of white powdered heroin, no one claimed to have seen it in the region during the past six months. Community professionals most often reported current availability of heroin as ‘8’. A public health professional working in both Athens and Vinton counties commented, *“Heroin is incredibly available. It’s the most popular drug in this area right now.”* However, community professionals in Muskingum County had very little to comment on heroin and

rated its current availability as '3' or '4'; these professionals view prescription opioids as a greater problem than heroin in their county. One community professional said, *"Prescription opiates are number one, and they [users] will get heroin if they can't get the pills ... and then it's back to the pills."* Participants reported moderate availability of brown powdered heroin, rating its availability as '5'. Only participants in Guernsey and Muskingum counties reported actually seeing brown powdered heroin. Participants described powdered heroin as, *"brown powder; tan colored."* A participant commented, *"[Powdered heroin] looks like sand."* Media outlets in the region reported on significant heroin seizures and arrests during this reporting period. In December, two Marietta (Washington County) residents were arrested for possession of heroin, trafficking in heroin and possession of cocaine following a traffic stop in Morgan County; the arrests were part of an ongoing investigation into drug trafficking from Columbus into the region (www.mariettatimes.com, Dec. 13, 2011).

Participants reported that the availability of black tar heroin has increased during the past six months. The reasons provided for the increase included, *"Word is getting around and more people are selling it [black tar heroin]; More people are doing it [black tar heroin] ... pill people [prescription opioid users] are switching over because [heroin] it's cheaper and a better high; [Heroin is] cheap, easy to sell, and easy to get people hooked to it."* Community professionals also reported that the availability of heroin has increased during the past six months. A public health professional reported, *"[Heroin availability has increased] because of the use of the [prescription opioids] ... heroin is the back-up plan. It's increased because the demand has increased."* Participants reported that the availability of brown powdered heroin has also increased during the past six months. A Guernsey County participant reported, *"Powder [heroin] is a little bit easier to get."* Community professionals reported that the availability of powdered heroin has either remained the same or has increased during the past six months. Athens County law enforcement and coroner's staff reported that availability of powdered heroin has remained the same, while professionals in other counties were split with half of professionals reporting unchanged availability and half reporting an increase in availability. A drug court representative reported, *"What we've seen is a steady increase in the use of heroin ... at least we're detecting more of it."* The BCI London Crime Lab reported that the number of heroin cases it processes has remained the same during the past six months, while noting that the type of powdered heroin most processed is usually beige in color.

Participants most often rated the current quality of black tar heroin as '5' on a scale of '0' (poor quality, "garbage") to

'10' (high quality), while they rated the quality of brown powdered heroin most often as '4'. Participants most often reported that the quality of heroin has remained the same during the past six months, although there were a couple participants that reported a decrease because, *"people [dealers] got busted; dealers are cutting it [heroin] with [more] stuff."* Participants reported that black tar heroin in the region is cut with bath salts, coffee, fentanyl, hot cocoa and Tootsie Rolls®. According to the BCI London Crime Lab, heroin is, *"typically pretty pure."* However, when heroin is cut, the lab reported the following substances as cutting agents occasionally used: caffeine, diphenhydramine (antihistamine) and local anesthetics (lidocaine and procaine).

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "H." Participants listed the following as other common street names: "bag," "ball," "balloon," "dog food," "haron," "raisin" and "tar." Participants reported that black tar heroin is available in different quantities: a balloon sells for between \$20-50, or two balloons for \$50, depending on quality. The amount of heroin in a balloon (1/10 gram) was discussed and finally agreed upon in one focus group as being, *"maybe a little bigger than a Skittles® [candy], about the size of a Gobstopper® [candy];"* a gram sells for \$100. A participant clarified a difference between prices for dealers and prices for buyers, *"So it [price of heroin] depends on who you are ... if you're the dealer or you're the buyer. Dealer [pays] like \$10 a tenth [of a gram], but they [dealers] usually sell you a tenth for \$20. They double their money."* Participants reported that brown powdered heroin is available in paper and foil packs and sells for between \$20-30. A participant clarified that when discussing heroin, *"A pack of heroin is powder, and a balloon is tar."* A couple of participants mentioned hearing about capsules of heroin being sold, but neither of them had actually seen them in the Athens region. Heroin is reported as coming from outside the region including Columbus, Dayton and New Philadelphia. However, there is some heroin that seems to be coming from Washington County. A participant reported, *"[Heroin] balloons more likely the tar from Columbus and stamp bags from Marietta."* Participants reported that the most common way to use heroin remains intravenous injection. Reportedly, users also smoke and snort the drug. A participant explained, *"If they [users] don't have a needle, they'll snort it [heroin]."* However, reportedly, most users continue to prefer injection: *"When you snort it [heroin], you waste 40 percent of it; There are ways to snort tar. You can put tar in a nasal spray bottle mixed with hot water ... not very common, but it's done."*

There was no participant consensus regarding a profile of a typical heroin user, but one participant explained the economic effects for a typical dealer: *"I know a lot of dealers that don't use it [heroin]. Dealers aren't using it. It's the money. They're more addicted to the money ... I've had close friends that you just can't talk out of it [buying heroin to sell to others]. When their kids are hungry and they get \$100, they've just made rent. You hit the desperation point."* In an indirect way, this goes right along with what the community professionals had to say about a typical heroin user. Community professionals described typical heroin users as young, 18-30 years of age, and, *"not going to college ... not actively pursuing higher education ... we're not hearing [about heroin use] at the colleges ... definitely younger individuals who aren't in school [use heroin] ... those not working to improve their socio-economic status."* A law enforcement professional at the county level made a distinction between college kids and those in the city who are not pursuing higher education: *"Upper-class and college kids [are using powdered cocaine]. [We are] not finding heroin on campus. Heroin is outside [campus]."* Law enforcement also reported a new trend in transporting heroin: *"[There is a] growing trend on taking females for body carry to avoid the detection. Pull them over, a dog detects it [heroin] ... can't find it, [and] there's a female sitting there. I know where it goes, but unless you have probable cause to warrant a body cavity search, you aren't going to get it. That's probably the newest thing in the past six months to a year."* Reportedly, heroin is used in combination with crack cocaine, marijuana, powdered cocaine (speedball), prescription opioids and sedative-hypnotics (most reportedly Xanax®). A participant reported, *"[Heroin is used with] ... a lot of marijuana. Marijuana intensifies the buzz, and you don't get sick."*

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 described the obtainment of prescription opioids as follows: *"as easy as going to the store to get a gallon of milk; as easy as taking the trash out."* Participants and community professionals identified OxyContin®, Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use, with participants additionally naming morphine. Participants reported that the availability of prescription opioids had both increased and decreased during the previous six months, depending on specific drugs. The availability and use of OxyContin® and Percocet® was said to be decreasing, while

the availability of Opana® and oxycodone 30 mg (aka "perc 30") was said to be increasing. The BCI London Crime Lab noted increases in the number of Dilaudid®, Opana® and Percocet® cases that it had processed during the previous six months. In terms of street pricing, participants commonly asserted that those drugs that could be used intravenously were more valuable. As a result, the new formulation of OxyContin® (OxyContin® OP) was commonly described as worthless by many users. However, some participants continued to describe means by which OxyContin® OP was able to be used intravenously. 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 remained snorting and intravenous injection, with most participants continuing to identify snorting as generally the most popular means of using these medications. In addition to obtaining prescription opioids on the street from dealers, participants continued to report also getting them from emergency rooms, pain clinics (said to be found in Canton, Dover and Pittsburg, Pa.), doctors and family members and friends who have been prescribed these medications. A profile of a typical user of prescription opioids did not emerge from the data. Participants commonly held the perception that people from every demographic category were represented among prescription opioid users. Treatment providers continued to note an increase in use among young people (17-34 years).

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 reported, *"I can get them [prescription opioids] at my neighbors; All around town ... I wouldn't have to drive far [to obtain prescription opioids]."* A treatment provider stated, *"What I see is the prescription opiates are number one. If they [users] can't get that, then they'll use the heroin until they can get the prescription. The heroin is the second best."* 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 most popular. A treatment provider reported, *"I've had a couple clients in the past few months who had Dilaudid®. They just happened to get that while med [medication] seeking at the ER ... just what they were given. Still again though, Vicodin® and Percocet® are so far above everything else [in terms of availability]."* Collaborating data also indicated that prescription opioids are readily available in the region. The

Scioto County Coroner's Office reported that 28.6 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). Furthermore, the Coroner reported prescription opioids as present in 17.9 percent of all drug-related deaths.

Although participants throughout the region reported that the availability of prescription opioids has generally remained the same during the past six months, there were noted increases and decreases in availability of specific opioids. Participants currently rated Opana® a '10' on the availability scale, even more often than OxyContin®. Participants reported that Opana® has replaced the demand for OxyContin®: *"After the OC's [OxyContin® OC] went away [and was replaced with the reformulated OxyContin® OP], the Opana's came."* In general, participants rated the availability of OxyContin® OC as '2', while rating the reformulated OxyContin® OP's most often as '7'. Participants reported, *"It seems like the roxies [Roxicodone®] are a little more popular now than just a few months ago; Opana® is increasing in Perry County; The Opana®, they're real popular. Everything else has been about the same [in availability]; Old OC's [OxyContin®] are not around no more; Oxy's [OxyContin®] decreased because of the OP's [reformulated OxyContin®] that can't be abused. [The] dealer then switched to heroin and cocaine because of the loss of demand for Oxy's."* Muskingum and Guernsey County participants often mentioned Dilaudid as readily available and rated its availability an '8'. Community professionals also identified several drugs as increasing, while the top three identified prescription opioids have remained the same in availability during the past six months. A treatment provider reported, *"Dilaudid® is a niche to the RN's [nurses] ... that is often a drug of choice for them for they have access to it."* A Coroner reported, *"Kadian®, one of the newer drugs like Opana® [is] increasing [in availability]."* The BCI London 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 street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid® 8 mg (sells for \$10), fentanyl patches (sells for between \$30-50), Norco® (sells for \$6), Opana® (10 mg sells for between \$20-30; 40 mg sells for \$80), oxycodone (40 mg sells for \$20; 80 mg sells for \$40), OxyContin® (aka "oxy's"), OxyContin® (old formulation, aka "OC's"; 20 mg sells for \$20; 80 mg sells for between \$80-100), OxyContin® (new formulation, aka "OP's"; 40 mg sells for between \$50-55), Percocet® (aka "perc's"; 5 mg sells for \$5; 7.5

mg sells for between \$4-5; 10 mg sells for \$10), Roxicodone® (aka "roxie"; 15 mg sells for \$15; 30 mg, aka "perc 30," sells for \$30), Vicodin® (aka "V's" and "vikes"; 5 mg sells for \$3; 7.5 mg sells for \$4.50; 10 mg sells for \$6). 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. Participants reported, *"Snorting [prescription opioids] is more common; Shooting them [prescription opioids] and eating them are also popular."* There seem to be differences in methods based on age and/or experience of user: *"Younger kids eat them [prescription opioids] and pop [swallow] them; I've seen people chew them [prescription opioids] ... only someone who's been on them a while."* A participant explained that route of administration is determined by type of medication obtained: *"Opana® — snort, you can't do anything else with them; Perc 15 and 30s [Roxicodone® 15 mg and 30 mg]— inject; Perc 5 and 10s [Percocet® 5 mg and 10 mg] would get snorted; Vike [Vicodin®] would get snorted ... smoking [crushing and lacing into a cigarette or with marijuana] is also common."*

Participants continued to report obtaining prescription opioids on the street from dealers, and from doctors, emergency rooms and people with prescriptions. A participant reported, *"[Obtaining prescription opioids from] mostly dealers, but I know a lot of people that still get pain prescriptions that don't need them [and sell them]."* Drug seeking through injury is also a way to obtain drugs, although participants noted a decrease in obtaining prescription opioids through emergency rooms: *"The emergency rooms don't tend to give out prescription pain killers much, unless there's been tests or something that prove you really are in a lot of pain."* Participants also reported traveling out of the region to obtain prescription opioids. A profile of a typical user did not emerge from the data. A participant commented, *"Everyone [uses prescription opioids] ... no prejudice."* Besides the niche of nursing staff using Dilaudid® as pointed out by a treatment provider, community professionals did not offer any distinguishing characteristics to describe typical users of prescription opioids. Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with marijuana to, *"intensify the buzz."* Participants also named alcohol, heroin, powdered cocaine, sedative-hypnotics and other prescription opioids as being used with prescription opioids. A participant reported, *"I smoked weed [marijuana] or did even more pain pills. I didn't like downers or Xanax®."* Another participant said, *"I seen people that'll take Vicodin® [and] Percocet®, crush them up and do them with coke up the nose. You're mixing your upper and downer."*

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 the drug's availability as '6.' Participants reported that even if Suboxone® clinics were not present in their immediate area, they knew where they could go for Suboxone® (clinics in Columbus or West Virginia). Participants reported that Suboxone® 8 mg sold for between \$10-20; Suboxone® strips sold for between \$10-12. Participants reported that the most common route of administration for abuse of Suboxone® remained snorting, and they continued to report sublingual (dissolving it under the tongue) administration as the most common route of administration for both Suboxone® pills and strips. In addition to obtaining Suboxone® on the street from dealers, participants continued to report getting the drug from doctors and clinics. Participants reported knowledge of doctors who will prescribe Suboxone®. Reportedly, it was also easy to acquire Suboxone® from someone who had a prescription. Participants and treatment providers commonly recognized that many used Suboxone® illicitly. According to participants, heroin users used Suboxone® in between using other opioids, "to avoid being dope sick, 'til they get money for their next heroin."

Current Trends



Suboxone® remains 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 also '10'. A participant who indicated that Suboxone® is readily obtainable by incarcerated individuals stated, "If [Suboxone®] it's that easy to get in jail, I don't see why it would be hard to get on the street." Law enforcement and drug court staff agreed that Suboxone® is being abused and is highly available in the region. A drug court reported testing for Suboxone® as well as other drugs as part of its drug urinalysis testing procedures. However, other treatment providers and coroner staff had a different perception of the current availability of Suboxone®. Although treatment providers and coroner staff acknowledged some use of Suboxone®, they reported low to moderate abuse of the drug: "It [Suboxone®] must be available because I just had a client that said if he can't

get opiates, 'Suboxone® fills the bill' and keeps him calm, so he's been having to get it from the street; I think [Suboxone®] it's accessible, but at the same time [users] they're not needing to go that route because they're able to get them [prescription opioids] the Percocet® and the Vicodin® [are] so readily [available] those are the 'go-to' drugs."

Participants reported that the availability of Suboxone® has increased during the past six months. A participant reported, "[Suboxone®] seems to becoming a huge problem in known drug areas. I can think of a few places ... apartment complexes." Community professionals also reported that Suboxone® availability has increased: "We're seeing an increase in the people who are either legally or illegally participating in the Suboxone® program, so they can kick the heroin habit. So, we know those numbers are going up; When we first started testing for Suboxone®, we only saw it in the adults, but recently we started seeing Suboxone® use in the youth as well." The BCI London Crime Lab reported that the number of Suboxone® cases it processes has remained the same during the past six months.

No slang terms or street names were reported for Suboxone®. The most common reported prices for Suboxone® were as follows: Suboxone® 2 mg sells for \$5; Suboxone® 8 mg sells for \$20; Suboxone® 8 mg strips (aka "film") sells for \$15. Most often participants reported taking Suboxone® 8 mg pills. Among participants who reported on abuse of Suboxone®, snorting is the most common method of abuse followed by intravenous injection. Participants reported obtaining Suboxone® from doctors and clinics, but those who abuse the drug reported mainly obtaining it from people with prescriptions rather than from a third-party dealer. A participant reported: "[You] have to know someone who has it [Suboxone®] prescribed; from people who are prescribed it [Suboxone®] ... an older lady would get hers the first of the month and sell it within three days." Those who are prescribed Suboxone® often encounter users who want to purchase their medicine: "I get them [Suboxone®] prescribed. A lot of people get me to try to sell [it] to them; I'm prescribed Suboxone®. I know there are people that abuse the stuff ..."

A profile for a typical Suboxone® user did not emerge from the data. Participants and treatment providers continued to report that Suboxone® is used illicitly. A participant reported, "If you're a heroin addict, it [Suboxone®] just takes your sickness away." A treatment provider commented, "We have had clients that have been on maintenance Suboxone®. It [Suboxone®] blocks the effect of the opiates, and it keeps them from craving ... from wanting more of the drugs. It kind of makes them okay ..." Reportedly, Suboxone® is used in combination with alcohol, marijuana and sedative-hypnotics.

A participant reported, *"From what I know, if you do anything else with them [Suboxone®], it's supposed to counteract and make you go into withdrawals ... but I've heard people using Xanax® [with Suboxone®], but if you do any opiates with it, it's pointless."*

Sedative-Hypnotics

Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants and treatment providers 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 and treatment professionals continued to list the most common sedative-hypnotics in terms of widespread use as Klonopin® and Xanax®. The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processes had remained the same during the previous six months; however, a noted increase in cases occurred for Xanax®. In addition to obtaining sedative-hypnotics on the street from dealers, participants continued to report obtaining them from doctors, and friends and family members who were prescribed the drugs. The most common routes of administration remained oral consumption and snorting. A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants and treatment providers alike reported that people of all different population groups abused these drugs.

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 Klonopin®, Valium® and Xanax® as the three most popular sedative-hypnotics in terms of widespread use. A participant stated, *"[Sedative-hypnotics] they're like very popular. Everybody wants them, so as soon as they come around, they're gone."* Other participants thought these drugs to be popular because, reportedly, they are the type most often prescribed by physicians. Community professionals most often reported the current availability of sedative-hypnotics as '10' and identified Ativan®, Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. A treatment provider commented, *"It's almost like Xanax® is raining down from the sky in this area."* A public health professional added Ambien® and Soma® to the list of most available sedative-hypnotics in the region.

Collaborating data also indicated that sedative-hypnotics are readily available in the region. The Scioto County Coroner's Office reported that 28.6 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). Furthermore, the Coroner reported sedative-hypnotics as present in 10.7 percent of all drug-related deaths.

Participants reported that the availability of sedative-hypnotics has remained the same during the past six months except for Klonopin® and Librium®, which have increased in availability. Participants talked about the demand for Klonopin® in their community: *"Klonopin® are usually gone as soon as you hear about them; Everybody wants them, so as soon as they come around, they're gone."* Treatment providers in Washington County also noted an increase in availability and use of Librium® during the past six months. 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 (aka "benzo's," "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® (0.5 mg sells for \$0.50; 1 mg sells for \$1); Klonopin® (1 mg, aka "K's" and "forgot-o-pins;" sells for \$1; 2 mg, aka "green monsters," "greens" and "greenie meanies;" sells for \$2); Soma® (sells for between \$0.50-3); Valium® (aka "V's" and "V-cuts," 5 mg sells for \$2-3; 10 mg sells for \$4); Xanax® (0.25 mg, aka "xani's," sells for \$0.50; 0.5 mg, aka "5s;" sells for \$1; 1 mg, a.k.a., "10s," "blues," "footballs" and "purple footballs;" sells for \$2; 2 mg, aka "bars" and "xanibars;" 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 specific types, generally, the most common routes of administration remain oral ingestion and snorting. A participant described how he used sedative-hypnotics, *"Snort the first couple [sedative-hypnotics] and pop (swallow) the rest ... I always see people eat them like Skittles®, you know. It seems like almost like an impulse thing; they just keep eating more and more, like it's a snack or something."* Only one participant mentioned intravenously injecting sedative-hypnotics, but did not like the effects because he *"pretty much came out slobbering."*

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported getting them from friends and physicians. A participant spoke about the ease with which he obtained Xanax®: *"More people's getting prescribed them [sedative hypnotics]. You can go to the doctor*

and [say], 'You know, I'm real stressed out. I can't be in places where there's a lot of people stressing me out,' and you can get [Xanax®] prescribed. They [doctors] will start you off with doses of the little white ones [0.5 mg]. They'll start you off on those and you can go back in a month or so later, 'you know, all this isn't helping me. I'm taking five or six of those a day just to stay calm,' and they'll bump you up ... and you can work your way all the way up to xanibars [2 mg] ... I know people who get prescribed like 90 bars a month." Participants who obtained sedative-hypnotics from friends often obtained them for free: "Valiums®, I haven't bought a Valium® in forever. I always have them given to me."

Participants described typical users of sedative-hypnotics as, "20-22 years; younger kids." A public health professional expressed concern about prescriptions given to children: "It seems like younger and younger children are being prescribed the medication [sedative-hypnotics], including Risperdal®. We have a two-year-old that was just prescribed Risperdal® to help him sleep. My concern is that most of these drugs are not approved for children ... and a lot of times there's nothing hooked with it ... there's no counseling ... it's just take this ... and you'll act better in school."

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used with alcohol, heroin, marijuana, methadone, powdered cocaine and other sedative-hypnotics. Participants discussed the effects of mixing sedative-hypnotics with other substances: "Mix Klonopin® with beer and black out; Xanax® with heroin or coke with alcohol also end up in jail, beat up they don't mix; methadone and benzo's [benzodiazepines], every one of my [arrest] charges was this mix, and I'd black out." Coroner's office staff also talked about mixing sedative-hypnotics with other medications: "The murder I was just talking about, he just filled 120 [Valium®] and no pill bottles were found. That was a one-month supply ... there is often a combination of med taking ... Valium®, Percocet® and Flexeril® ... prescribed at the same time."

Marijuana

Historical Summary

In the previous reporting period, marijuana 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). The BCI London Crime Lab reported that the number of marijuana cases it processes had decreased during the previous six months. Participants reported that the quality of marijuana varied, with the most common quality score being '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that for commercial-grade marijuana, a "blunt" (cigar) sold for

between \$5-10, and 1/8 ounce sold for between \$25-30; for high-grade marijuana, a blunt sold for \$10, and 1/8 ounce sold for \$50. The most common route of administration for marijuana was smoking. A profile for a typical marijuana user did not emerge from the data. The prevailing thought was that marijuana was widely used. Treatment providers generally concurred, though some groups identified White males and "younger people" as being particularly represented within the marijuana-using population.

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 in all focus groups mentioned peak availability during harvest season. One participant said, "Availability [of marijuana] ... increases around the first of October because of harvesting [marijuana] plants, but by the end of October, it's back down to the normal rate for the rest of the year." Other participants talked about marijuana's seemingly ubiquitous availability, with one stating, "Everyone in my family smokes [marijuana], so it's everywhere, all the time. Even when you can't find good stuff [high-grade marijuana], you can always get the bad." Community professionals also most often reported the drug's current availability as '10'. A treatment provider spoke of the ease with which juveniles obtain marijuana: "I know some of my clients who are seniors in high school; they can get it [marijuana] at the high school whenever they want with no problem at all." Law enforcement also reported on the drug's high availability. One law enforcement official said, "[Marijuana] it's been accepted now. Everyone wants to say they ought to license it and tax it. One of the tough things for us [law enforcement] is [that] marijuana ... in order to get a stiff penalty, they have to buy a large quantity of it. Most are just minor misdemeanors, like speeding." Drug court staff reported on easy availability due to marijuana growing in the region: "Meigs County Gold [locally grown marijuana] said to be of high quality]. We're near Meigs County, [marijuana] it's pretty available. It truly is, and we have a family growing ... our male probation officer went out [and checked on], and they were growing it on their front porch."

Participants and professionals reported that the availability of marijuana has remained the same during the past six months, with the exception of harvest time in October when marijuana's availability increased. A minority of users believed marijuana decreased because the prevalence of other drugs has impacted the use of marijuana: "I think the use of marijuana has really dropped down. Before harvest this is weed-growing country, but say, during the summer, weed is hard to find if you're trying to buy it because no one's really smoking it

no more. They're into everything ... the pain pills [prescription opioids], the Suboxone® [and] heroin. [Marijuana] availability has increased right now because of harvest season, but overall [marijuana availability] has decreased." 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 varied from '2-10' with the most common score being '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was also '8'. Several participants explained that the quality of marijuana depends on whether the user buys, "commercial weed" (low- to mid-grade marijuana) or hydroponically grown (high-grade marijuana). A participant described high-grade marijuana as, "... you can hit a bowl and be good for one-and-a-half to two hours." Some participants described the characteristics of high-grade marijuana: "Dank [high-grade] weed has no seeds, smells better, tastes better, better high off it; [High-grade marijuana is] like weed that's got like purple hairs in it or orange hair and stuff like that. Smells good. All you want is to hit it a couple times; you don't want to smoke a whole joint. A couple hits, and you're high for two or three hours."

Current street jargon includes countless names for marijuana. The most commonly cited names were "dank" and "weed." Common street names for marijuana include: "buds," "ganja," "grass," "pot," "reefer" 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 the aforementioned street names, as well as "dumpster," "mids" or "middies." High-grade marijuana may be called "dank," "dro," "kush" or "hydro," but names for this grade of marijuana may also be related to the specific strand: "Afghan kush," "blueberry strands," "bubblegum strands" (aka "bubbakush" and "bubbalicious"), "deathstar," "fire," "go-go," "grape," "lemon G," "lemon skunk," "northern lights," "orange kush," "skunkbud," "white widow" and "wild white woman."

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 \$5-10; 1/8 ounce sells for \$25; 1/4 ounce sells for between \$25-30; 1/2 ounce sells for between \$50-55; an ounce sells for between \$100-160; 1/4 pound sells for \$375; a pound sells for between \$1,300-1,800. High-grade marijuana sells for significantly more: a gram sells for between \$20-25; 1/8 ounce sells for between \$40-50; 1/4 ounce sells for \$100; an ounce sells for between \$350-525; a pound sells for \$4,000. A participant talked about a marijuana product called "shake" (aka crumbs); he reported that he could get shake, the crumbs and pieces at the bottom of the bag: "Bottom of the bag is shake as well as dirt weed ... usually really cheap. Dank bud with all the crystals would be more expensive."

While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. A participant explained, "They smoke joints, bongs, bowls, vaporizers. That's the only ones I can think of. And honestly, you get a different THC [Tetrahydrocannabinol] level from all of those different [routes]; it just really depends on what you use." Another participant spoke about baking marijuana into food: "Some people will buy the shake ... the bottom of the bag and get like half buds and half shake, which is like the little crumbs and the little goodies and stuff that's fell off of it and bake with it. Like this woman I know ... she buys like tubs of butter and mixes it [shake] in with her butter, and like she eats it on toast ... and like anything she needs butter for she uses that, like if she's makin' brownies or if she's fryin' eggs or if she's making cookies."

A profile for a typical marijuana user did not emerge from the data. Participants and professionals alike described typical users of marijuana as, "everyone." However, both participants and professionals noted some important differences when considering users of marijuana. Participants noticed a difference in who is using the different types of marijuana and the methods chosen for ingestion: "I've noticed a lot of college students go for the higher grade [marijuana] as far as [compared to] other people who aren't in school and don't have a lot of money, they [those without a lot of money] usually get the commercial because it's cheaper and it basically does the same thing. It's just the more expensive stuff, just smells better, tastes better, has a cleaner finish to it." Another participant discussed differences among routes of administration: "Older [users] prefer the bowls and joints because the bongs hurt their throat; Vaporizers are good for older people." Community professionals noticed several differences in age group consumption. A treatment provider explained, "The referrals that we typically get for clients, especially the 18-25 [year-old] individuals, [have] either [been] pulled over with marijuana in a car or caught because of underage consumption [of alcohol]. They are pretty much ... both marijuana and alcohol ... for the most part they go hand in hand." Other treatment providers recognized frequency of use in different populations, with one stating, "I typically see frequency increases [of marijuana use] in the younger populations in the 18s-20s ... As I see older clients, they still use marijuana, but it's more sporadic. By now they've [older clients] probably moved to other substances ... they may still smoke marijuana, but not with the same frequency as I see with the younger population who do it on a daily or multiple weekly basis; I've noticed a lot of individuals diagnosed with bipolar [disorder] use marijuana. They say that it helps bring them off their manic state."

Reportedly, marijuana is used in combination with methamphetamine, powdered cocaine, prescription opioids and tobacco. A participant said, "It just really depends on what you use. It [marijuana] can be [laced with other drugs],

but generally it's not. Occasionally you will see it mixed with, like coke, but most of the time it's not mixed with anything. I know a lot of people that are cigarette smokers. They like to smoke a cigarette before [smoking marijuana] or afterwards." Lacing marijuana with other drugs was also mentioned, but rarely experienced, "I've heard about others [lacing marijuana with other drugs]: powder[ed] cocaine, angel dust [PCP (phencyclidine)], pain pills, dipped it [marijuana blunt or joint] in wet [embalming fluid]. It's more common just to smoke it [marijuana] the way it is." According to participants in Athens County, lacing marijuana is not as common as it used to be: "I don't feel like that's even very common anymore [lacing marijuana with powdered cocaine or methamphetamine]. It used to be a long time ago, but as of now, it's usually never ... 97 percent of the time if you want it laced, you have to do it yourself." A participant said that joint use of marijuana and prescription opioids is called, "bacon and eggs," and that users would invite each other over for bacon and eggs, "cause you're getting high and baked at the same time."

Methamphetamine **Historical Summary**

In the previous reporting period, methamphetamine was reportedly rare in most areas of the region while highly available in other areas of the region (Belmont and Muskingum counties). In counties where methamphetamine was highly available, participants most often reported its availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants with knowledge of methamphetamine reported that it was available in crystal and powdered forms, with the powdered form being more available. Most treatment providers did not think the drug was very available except for those in Muskingum and Perry counties, where they rated availability of methamphetamine as '7' and '5' respectively. The BCI London Crime Lab reported that the number of methamphetamine cases it processes had remained the same during the previous six months. Participants most often reported the quality of methamphetamine as '8' and '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that a gram of methamphetamine sold for between \$60-100. The most common routes of administration for methamphetamine continued to be smoking via a pipe and snorting. Participants reported that both routes were equally as common; less common was intravenous injection. A profile for a typical methamphetamine user did not emerge from the data. Participants reported that all groups were represented among users.

Current Trends

Methamphetamine remains relatively rare in 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). Previously, participants with knowledge of methamphetamine reported its availability as '10,' whereas, those with methamphetamine experience now report it as an '8.' A participant reported that there is methamphetamine availability in Hocking County. Participants reported that methamphetamine is available in crystal (a.k.a., "glass") and powdered forms. Participants explained, "There's two different types [of methamphetamine]: biker crank which is the cheaper, homemade, 'shake and bake' deal, and then there's stuff that people bring in that's chemist made [crystal]." Most participants knew little about the drug: "Haven't heard of anyone doing it [methamphetamine] for a long time. Someone blew their house up, but no one's been selling it." Community professionals reported moderate to high availability in the region. A treatment provider recognized an increase in treatment admissions for methamphetamine: "I've had four clients in recent months that the issue was crystal meth [methamphetamine], crystal meth and alcohol." Most community professionals (drug court staff, coroner's staff and law enforcement) seemed confident in reporting that there is methamphetamine in the region, but they do not see it often in daily practice, with one stating, "I'm sure there's meth in the area, but we haven't detected anything; I haven't heard of any [methamphetamine] ... we're not getting much in the way of meth labs either. We know they're out there; I hear them talking about it."

Respondents gave conflicting opinions about the change in availability of methamphetamine. Participants reported that the availability of methamphetamine has remained the same during the past six months. However, public health professionals and treatment providers suggested that there may have been an increase in methamphetamine during the past six months, which they based off recent news about mobile methamphetamine labs blowing up in cars and reports of children who were found in a house that had a lab. A medical director of a county health department suggested there has been an, "increase [in methamphetamine availability, especially] in mobile meth labs ... at least two in the last six months. On top of that, we had the house with the kids in it too, doing meth." A director of a youth educational program talked about methamphetamine-related news reports in the region: "It seems like there has been a change [an increase in availability of methamphetamine] because we've had arrests recently ... a gentleman who [had] a mobile meth lab explode in his lap as they were driving down the road. So, it feels like there's more [methamphetamine]." Reportedly,

the most common way of manufacturing methamphetamine is through mobile meth labs (aka “shake and bake” or “one-pot” method), which has become widely known. By using common household chemicals along with ammonium nitrate found in cold packs and pseudoephedrine (typically found in some allergy medications), users (aka “cooks”) can produce the drug in approximately 30 minutes at nearly any location by mixing ingredients in easily found containers, such as two-liter plastic soda bottles. A Coroner within the region reported that there has been an increase in methamphetamine use. The BCI London Crime Lab reported that the number of methamphetamine cases it processes has decreased during the past six months.

Most participants reported that the quality of methamphetamine is low, most often rating the current quality of methamphetamine as ‘4’ on a scale of ‘0’ (poor quality, garbage) to ‘10’ (high quality); the previous most common scores were ‘8’ and ‘10’. A participant commented, “I don’t think the quality [of methamphetamine] is very high; I think it all sucks.” The only exception was a participant connected with methamphetamine originating from outside the region, and he rated quality an ‘8’. Participants did not report knowledge of anything being used to cut methamphetamine.

Current street jargon includes a few names for methamphetamine. The most commonly cited names were “angel dust,” “(biker) crank,” “crystal(s),” “glass,” “ice” and “meth.” Prices for methamphetamine were consistent among those participants who were familiar with the drug. Participants reported that a gram sells for \$100; 1/8 ounce sells for roughly \$200. As with other drugs, discounts are given to customers who can buy quantity: “The more [methamphetamine] you buy, the cheaper you get it.” While there were several reported ways of consuming methamphetamine, according to the participants familiar with the drug the most common route of administration is smoking. Snorting was also reported as a common means of administration in the region. Although a couple participants said people could intravenously inject methamphetamine, no participants had experience using it that way. A participant explained, “They [users] either snort it [methamphetamine], smoke it, or shoot it ... I did it [snorted] a few times, but snorting it is so painful. It’s like me standing back here taking a railroad spike and jamming it up your nose with a sledgehammer. Yeah, I’ve never shot it ... I’ve only snorted it and smoked it out of a light bulb or pipe.” A treatment provider reported, “What I’m hearing clients equating is the methamphetamine with the bath salt ... [clients] they’re just like, ‘it’s [bath salts] a replacement for meth if you want to go that route.’”

Participants identified typical methamphetamine users as older than 40 years. Participants reported, “The generation above me [are using methamphetamine], I’d say people around 40 [years] ...; When I was in jail a couple people come in, and they were older ladies. They got treatment for meth ... the one lady was at least in her 60s.” Participants also reported occupational profiles: bikers, construction workers and truckers. A participant commented, “I know truckers use it [methamphetamine] to stay awake when they was driving. I would probably say a lot of construction workers would use it too.” Professionals from coroners’ offices identified younger population for use. Participants did not report methamphetamine being used in combination with other substances.

Prescription Stimulants Historical Summary

In the previous reporting period, prescription stimulants remained highly available in the region. Participants most often reported 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 BCI London Crime Lab reported that the number of prescription stimulant cases it processes had remained the same during the previous six months. The most common route of administration of prescription stimulants remained snorting. Reportedly, crushing and snorting prescription stimulants produces an effect similar to the high produced by snorting cocaine. Participants and treatment providers agreed that prescription stimulant use (especially Ritalin®) was very common among high school students and on college campuses.

Current Trends

Prescription stimulants are moderately available in the region. Participants most often reported the current availability of these drugs 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 ‘10’. A participant reported, “A lot of people are selling Ritalin®.” Community professionals did not rate the availability of prescription stimulants, but identified Adderall®, Risperdal®, Ritalin® and Vyvanse® as being available and abused within the region. The Athens News reported on Adderall® misuse at Ohio University during this reporting period. According to students interviewed, Adderall® is used for its stimulant properties either as a study aide or to party beyond what would normally be possible. A physician in the article discussed the major physiological effects: “The main side

effect is loss of appetite ... If too high a dose, it can cause lethargy and somnolence [drowsiness]. The other major risk is, if misused, it can cause hyperactivity, inability to sleep and even death." A 2009 survey conducted at Ohio University concerning drugs and alcohol found that, "Sixteen percent of the 1,211 students surveyed reported some type of stimulant use." Students familiar with the results thought that stimulant abuse was underreported, with one stating, "There's absolutely no way people are being honest. Every person I know here either uses Adderall® routinely or as a study aid during midterm and finals week." (www.athensnews.com, Nov. 16, 2011). Participants and community professionals reported that the availability of prescription stimulants has remained the same during the past six months. The BCI London Crime Lab reported the number of prescription stimulant cases it processes has remained the same during the past six months with one exception; the number of Adderall® cases has decreased.

Participants and community professionals often expressed concern over how these drugs are prescribed and obtained. A public health professional expressed concern for children (from preschool through high school ages) being prescribed prescription stimulants so easily: "Younger and younger children are being prescribed the Risperdal® and the ADHD [Attention deficit hyperactivity disorder] medicines, and I would bet you ... that 50 percent of those [prescriptions] are being diverted by the parents to be sold ..." A participant also talked about young parents obtaining prescription stimulants through their children: "I know a girl ... I've known her all my life, her and her sister. Their kids get [prescription stimulants prescribed], and they don't give it [the medication] to them. They sell it. And their kids are bad in school. Her little boy is out of control at school." Participants reported that prescription stimulants are selling for, "a couple dollars a pill."

Participants and community professionals continued to report that typical users of prescription stimulants are the younger population, including middle school and high school students, as well as college-age adults (18-25 years). A participant explained what he saw as a typical user: "Usually the people that like the crank [methamphetamine] like the Adderall®, the Vyvanse® and the Ritalin® or the coke [powdered cocaine] same effect. Usually young kids have Ritalin® prescribed to them. It works the opposite to someone that don't need it. If you needed it, it would calm you down. If you don't need it, it's going to send you through the roof." Treatment providers confirmed high school and college use of prescription stimulants: "I've heard cases [of prescription stimulant abuse] ... I haven't had any overdoses or anything ... [prescription stimulant abuse is] certainly in the high school; College kids use it [prescription stimulants] to stay awake at night to study." Participants did not report prescription stimulants being used in combination with other substances.

Synthetic Marijuana

Historical Summary

In the previous reporting period, synthetic marijuana ("K2" and "Spice") 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 frequently commented, "[Synthetic marijuana] it's super available. Just go into the store and buy it; You can get as much as you want." Participants who had tried synthetic marijuana most often rated its quality as '10' on a scale of '0' (poor quality, garbage) to '10' (high quality). The high from synthetic marijuana was said to not last as long as that of marijuana. Hence, participants commonly reported that while they knew many people who had tried synthetic marijuana, most did not know anyone to be a regular user of the drug. Participants reported that there were dozens of kinds of synthetic marijuana, with different flavors; reportedly, a gram of synthetic marijuana sold for between \$20-30. The primary route of administration remained smoking. Participants identified the typical user as an individual who wanted to avoid detection on urine drug screens, such as an individual on probation or who was drug tested at work. Participants and treatment providers agreed that use remained most common among teenagers and college students.

Current Trends

Synthetic marijuana ("K2" and "Spice") was highly available in the region before the ban on their sale went into effect in October 2011. Participants reported that synthetic marijuana could be easily purchased at convenience stores, head shops and gas stations. Participants did not comment on any change in availability, but professionals seemed to think that availability had decreased before the ban went into effect. A director of a youth educational program said (prior to ban legislation), "It [K2] seems to be just as easy [to obtain] as the bath salts. It's sold at gas stations and ... they [adolescent users] think they're not going to have the aroma [of smoking marijuana] on them ... they just smell like potpourri, different scents: cherry, grape." The BCI London Crime Lab reported the number of synthetic marijuana cases it processes has increased during the past six months. More recent data from the crime lab indicated that the five formally scheduled substances are almost never seen anymore; rather dozens of non-controlled structural analogs have taken their place.

Participants briefly discussed the quality of synthetic marijuana, with one stating, "I've heard that the 'Mad Hatter' stuff [brand of synthetic marijuana] makes you like trip out and stuff [hallucinate]; It says on the bag [of Mad Hatter] there's like six different ingredients, if not more, of stuff that you shouldn't be eating [or should not be] inhaled by humans."

You shouldn't be taking them. It says right on the bag: 'not for human consumption.' A treatment provider also commented on the effects of synthetic marijuana: *"It's a leafy material, a plant material, and it is sprayed with a synthetic THC, so it gives something similar to the high [of marijuana]; however, it doesn't seem to have the sedating effects that marijuana does, and what's showing up in the ER in the hospital is a lot more anger, a lot more aggression. I know security has had some problems with people coming into the hospital on K2. They've had to stand guard at the door because people were just nuts, just angry ... aggressive."*

Current street jargon is related to the name of synthetic marijuana on the package. Common brand names in the area include: "Bob Marley," "Dead Man Muffin," "Head Trip," "K2," "K3," "Mad Hatter," "Spice," "Super Nova," "Triple A's" and "Wizard of Oz." Participants reported that a gram of synthetic marijuana sells for \$5; three grams sells for \$10; 20 grams sells for \$20. The most common route of administration for synthetic marijuana remains smoking.

A participant stated, *"Weed was my drug of choice. Then, when I didn't have weed, [I could] get three grams of that Spice for \$10. It's a lot better deal, so I smoke a lot of that."* Participants did not report synthetic marijuana being used in combination with other substances.

Bath Salts Historical Summary

In the previous reporting period, bath salts (synthetic compounds containing methylone, mephedrone or MDPV) were highly available in the region. However, while participants described bath salts as very easy to find, treatment providers had not seen clients in treatment for bath salts abuse. The BCI London Crime Lab reported that the number of bath salts cases it processes had increased over the past six months. The crime lab also reported that most forms of bath salts contained MDPV and methylone, a relative of a chemical often found in Ecstasy. A participant reported that there were two different kinds of bath salts, referred to as "synthetic Ecstasy" and "synthetic cocaine." Participants with experience buying bath salts reported that the drug sold for \$30 per bag. Additionally, participants reported bath salts were sold for between \$75-90 in tubes similar in size to Chapstick® lip balm, containing 1/2 gram. Reportedly, the most common route of administration was snorting. No consensus was reached about the typical user profile, although bath salts were said to be used by individuals who needed to avoid detection of drug use on urine drug screens. Treatment providers commented that bath salts were primarily used by adolescents and college students.

Current Trends

Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) remain highly available in the region. Participants 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); previously, bath salts were highly available in the region although no specific score was reported. Prior to the current ban on the sale of bath salts, which went into effect in October 2011, participants reported that bath salts were commonly sold at many gas stations in the region. Community professionals also reported high availability of bath salts prior to legislation: *"We would say in June and July bath salts availability would probably be at a '9' or a '10' [availability rating]. You could easily get it anywhere you wanted to, but at this point in time, you actually do have to put in a lot more effort and thought into it. So ... I would say it's now at a '2' or a '3' [availability rating]."* Community professionals in Guernsey, Muskingum and Washington counties reported more of their clientele using bath salts than did professionals in Athens County. A treatment provider commented on the frequency of bath salts use among youth in their program: *"Half of our adolescents are using bath salts. Adults have decided to try bath salts and had been recovering from other drugs, but are back in treatment."* A community professional's statement concurred with other professionals: *"We have a huge problem with bath salts. We run an activities center and a lot of the kids [ages 9-17 years] introduced us to what bath salts were ... you can get it right up the street from where we are. It's very easy to get."* In contrast, Athens County seems to have had little availability of the drug throughout the past six months. A law enforcement professional explained, *"We've had a couple instances with bath salts [in Athens County], but it's rare for us right now ..."* His comments were supported by an Athens County public health professional, *"I hear [bath salts] it's coming. I know it's here, but I haven't heard anybody in the emergency department talk about it, but we're all prepared for it."*

Participants and community professionals agreed that bath salts availability has decreased during the past six months after statewide legislation banning certain ingredients found in bath salts went into effect. A participant said some store owners were proactive about taking down bath salts from their inventory: *"I knew a guy who took it [bath salts] off his shelves before it was even illegal because people were coming in there geekin' for it. Like they were wanting to buy it and stuff and whispering like they were at a dealer."* Law enforcement, public health professionals and treatment providers reported the availability of bath salts to be high before the



ban took effect. One stated, *"That spiked back in May, early June, and it's kind of declined since then with all the laws going into effect."* A treatment provider from Washington County said law enforcement intercepted a box at the post office containing bath salts after the ban went into effect. The *Ohio News Network* reported on bath salts during this reporting period. The Washington County Sheriff said he had seen a variety of consequences associated with the drug: *"A guy jumps out of a window and thinks he can fly, we found a seven-month pregnant woman who had overdosed on bath salts."* The owner of a business said he made \$4,000 a day with a 90 percent profit margin on the substance (www.onntv.com, July 19, 2011). A news article from the *Marietta Times* talked about the decreased availability of bath salts after the new legislation. Local officials said they had bath salts users in the emergency room, *"almost daily,"* but now they infrequently see anyone with health complications due to the drug. Currently, most bath salts cases come from individuals having the drug mailed to them, *"from other states, or even outside the country."* Law enforcement provided the example of a man who was being charged with possession of bath salts after 25 packets were shipped to his house (www.mariettatimes.com, Dec. 23, 2012). The BCI London Crime Lab reported the number of bath salts cases it processes has increased during the past six months. In addition, the crime lab noted that since the ban on the sale of bath salts went into effect the formally scheduled substances of MDPV and methylone are almost never seen any more in samples of bath salts, rather dozens of non-controlled analogs have taken their place.

While participants did not provide a rating for the quality of bath salts, they said the overall quality had decreased. According to participants, *"[With bath salts] everything was good until ban on chemicals, then everything was junk for a while. Seems like different stores have different qualities even if in the same package; [Bath salts quality] was good, then bad, and then went back to better. Posh [brand of bath salts] was better. They modified the ingredients, and it was not so good after that."* Current street jargon includes a few names for bath salts: "ivory wave," "posh," "rave," "white horse" and "zen." Few participants knew the current price of bath salts; a participant said the drug sold for \$20 a gram. Reportedly, the most common route of administration of bath salts remains snorting. A public health professional said there are also other ways to use the drug: *"We had individuals here who were snorting it [bath salts], other individuals who were making it into a tea. We actually had reports of some people trying to melt it down and shoot it intravenously ..."*

While participants and community professionals did not mention a specific gender or racial group that is more likely to use bath salts, many treatment providers said their clients fell into the 15-35 year age range. Prior to the new

legislation, a treatment provider commented, *"We have an adolescent program. Probably about half of our adolescents are using the bath salts."* Both participants and community professionals said bath salts are rarely used with any other substances. A participant commented on his friend's switch to bath salts: *"[My] friend went from cocaine to bath salts, nothing else ... [did not] even think about using anything else."* A public health professional concurred with sentiments of participants, *"One thing that also came up in [treatment] group the other day [early November] was do they use it with something else. And everybody in the room that used bath salts said, 'no.' They had no thoughts of using anything else. They were so caught up in using the bath salts that the thought of using it with something else did not cross their mind."* Another treatment provider reported, *"No, we didn't have reports of them using [bath salts] in addition to opiates or anything else. They weren't really trying to come down, so they weren't drinking to try to sedate themselves, so it was bath salts and pretty much that solely. Bath salts were so potent that they really didn't need anything else ..."*

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]. Participants in Belmont County reported availability of liquid LSD, used by placing drops in the mouth or the eyeball. Reportedly, LSD was found at festivals, though one participant said he had friends who used LSD daily. The BCI London Crime Lab reported that the number of LSD cases it processes had remained the same during the previous six months. Focus groups in Athens and Belmont counties reported that psilocybin mushrooms were available in the area, although participants disagreed on how easy they were to obtain. Those with knowledge of psilocybin mushrooms most often reported its availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While specific prices were not reported, a participant stated that psilocybin mushrooms were priced similar to marijuana. The typical psilocybin mushroom user was reportedly college aged. The BCI London Crime Lab reported that the number of psilocybin mushroom cases it processes had remained the same 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:

Ecstasy, hallucinogens [(LSD), psilocybin mushrooms and dimethyltryptamine (DMT)], inhalants and “moonshine” alcohol. Participants commented on the availability of alcohol to underage users: *“I am only 20 [years old], and I can think of a lot of places that sell me alcohol, and I’ve never once been ID’d. Never ever once ... and I’ve been buying my own alcohol since I was 18 [years old] ... I know of a lot of high school kids that buy their own alcohol because at certain places, there’s a specific [beverage] drive-thru that doesn’t card at all ... I was buying my own cigarettes when I was like 14, 15 [years old]. There’s quite a few places like that.”* Community professionals agreed that youth initiate alcohol use as young as 11 and 12 years of age. Participants and community professionals reported alcohol use with nearly every drug surveyed. Additionally, there seems to be some availability of homemade alcohol. A participant reported, *“I have a buddy that makes moonshine; [It’s] not common to make your own [alcohol], but [moonshine] it’s strong.”* Another participant mentioned, *“Sometimes you’ll find moonshine and hot apple pie [another homemade alcohol] here and there.”* Participants have also noticed an increase in different flavors of alcohol, and they believed flavored alcohol to be a marketing ploy. Participants also spoke about energy drinks: *“I think that [the development of energy drinks] was to hook young kids into drinking early because then the kids would think, ‘oh, this is cool and it tastes good.’ A lot of people don’t like the taste of beer, but if it tastes good, they’ll want to drink it.”* Participants were eager to point out new alcohol products in their grocery stores: *“They have vanilla and caramel [whipped cream with alcohol] in the store.”*

Ecstasy is rarely available in the region. Participants with knowledge of the drug most often reported its current availability as ‘3’ or ‘4’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Only one participant rated availability as ‘10,’ and he said the high score was due to his network of friends: *“The people that I was hanging out with, it [Ecstasy] was real popular. I mean, I know people ... that are going through Molly [high-grade Ecstasy] and Ecstasy and stuff like that on a daily basis.”* Law enforcement rated the availability of Ecstasy as ‘10.’ The BCI London Crime Lab reported the number of Ecstasy cases it processes has remained the same during the past six months; however, the lab noted an appreciable increase in cases containing the designer drug 5-MeO-DiPT (foxy methoxy). Current street jargon includes a few names for Ecstasy. The most commonly cited names were “Molly” and “X.” Participants said the route of administration varied for Ecstasy; users could swallow it or snort it depending on the type of high they wanted. A participant also spoke of combining Ecstasy and LSD together for an intense high.

Hallucinogens are rarely available in the region. Most participants who commented on hallucinogens reported the

current availability of these drugs as low because they are, *“difficult to get except during some times of the year [summer].”* Most participants listed LSD and psilocybin mushrooms as the most available hallucinogens, and some participants also included dimethyltryptamine (DMT). Participants gave conflicting opinions about availability: *“You have to find the right person, and then they’ve got it all! DMT is harder than the others to get; Mushrooms have been around occasionally. They’re kind of hard to find. The last time I did some was a couple weeks ago [early November 2011] ... I was looking for about a month. It’s not very common.”* Law enforcement reported high availability of hallucinogens in the area because of university students and rated 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); previously participants rated LSD’s availability as ‘10.’ When asked about hallucinogens, law enforcement explained, *“Those [hallucinogens] are huge, but they’re mostly a campus drug.”* The BCI London Crime Lab reported that the number of LSD cases it processes has increased and the number of psilocybin cases it processes has decreased during the past six months. According to participants from Guernsey County, DMT is locally made and of high quality. Two participants from Guernsey County talked about their experience using the drug: *“You can smoke it [DMT] in a bowl with some weed ... yeah, it’s the most intense buzz. One of the most intense trips, but it only lasts for 15 minutes ...”* Reportedly, the most common route of DMT administration is smoking. Current street jargon includes a few different names for hallucinogens. Psilocybin mushrooms are typically called “shrooms.” Participants reported the following prices for hallucinogens: DMT sells for \$10 a hit, which is about 1/10 of a gram; LSD sells for between \$10-20 a hit, with higher prices at concerts; 1/4 ounce of psilocybin mushrooms sells for between \$40-50.

Inhalants (aka “whippets”) are highly available in the region. Despite their availability, participants reported that they are rarely abused because they are not a preferred drug. One of the few participants with personal experience using inhalants said, *“I heard about whippets going around like in July, but it was at festivals. It wasn’t like out on the street ... other than at festivals, you really don’t hear about that kind of stuff.”* Another participant recalled, *“I’ve heard of a lot of people huffing gas, regular gasoline.”* Community professionals agreed that inhalants are rarely used in the region. Drug court staff reported familiarity with inhalants: *“We have some huffing [inhalant use] going on, yeah ... computer cleaner [duster] ... we do have huffing ... and [it is usually] boys, is what I hear younger boys. I’d say [ages] 14, 15 [years].”* A treatment provider also reported that three of her clients had reported abusing inhalants during the past six months.

Over-the-counter medications (OTC) are highly available in the region. However, according to participants and community professionals, these substances are rarely used by those over 18 years of age. Typically, participants mentioned high school youth between the ages of 16-18 years as abusing OTC's. One participant said, *"They eat a whole box of Sudafed® or drink a whole bottle of Robitussin®... [and call it] 'Robotrippin.'"* Participants agreed: *"Yeah, triple C's [Coricidin® Cold and Cough]. That's big around here. It's mostly among the teens; I know a lot of high schoolers that like the cough and cold medicines."* Community professionals had no current information on the abuse of OTC drugs.

Conclusion

Crack cocaine, bath salts, heroin, marijuana, prescription opioids, sedative-hypnotics and Suboxone® remain highly available in the Athens region; increases in availability exist for heroin and Suboxone®, as well as for some prescription opioids and some sedative-hypnotics; a decrease in availability exists for bath salts. While many types of heroin are currently available in the region, participants continued to report the availability of black tar heroin as most available. Participants and community professionals were in agreement in that the availability of heroin has increased during the past six months. Reasons provided for the increase include: increased selling of heroin and increased demand for heroin, as more prescription opioid-addicted individuals realize that heroin is cheaper and easier to obtain than prescription opioids, and many users maintain that heroin produces a, *"better high."* According to the BCI London Crime Lab, heroin is, *"typically pretty pure."* Reportedly, most users continue to prefer intravenous injection of the drug. Community professionals described typical heroin users as young, 18-30 years of age. Although participants throughout the region reported that the availability of prescription opioids has generally remained the same during the past six months, there were exceptions. There was almost universal agreement that the availability of Opana® has increased while the availability of OxyContin® has decreased; many participants identified Opana® as the replacement for OxyContin®, and attributed the rise in popularity of Opana® to fact that it can be crushed and snorted or intravenously injected with ease, which is no longer the case with OxyContin® since its reformulation. Participants continued to report obtaining prescription opioids on the street from dealers, and from doctors, emergency rooms and people with prescriptions; however, participants noted a decrease in obtaining prescription opioids through emergency rooms due to heightened scrutiny from hospital staff regarding drug seeking. Participants and community professionals were also in agreement in reporting increased availability of Suboxone® during the past six months. Among participants who reported on abuse of Suboxone®, snorting is the

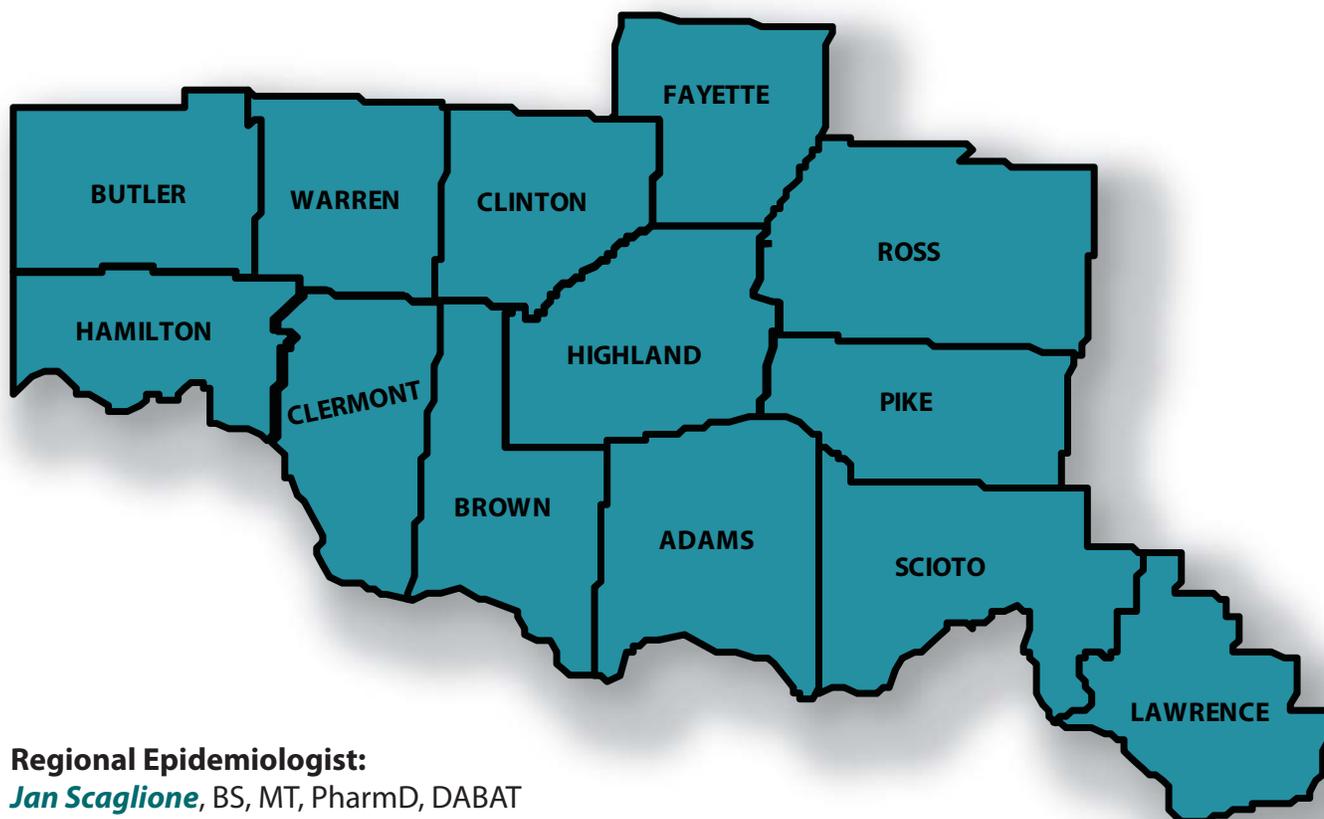
most common method of abuse followed by intravenous injection. Participants reported obtaining Suboxone® from doctors and clinics, but mainly from people with prescriptions. Those who are prescribed Suboxone® often encounter users who want to purchase their medicine. Law enforcement and drug court staff agreed that Suboxone® is being abused. Participants and community professionals were also in agreement regarding the decreased availability of bath salts during the past six months, following statewide legislation banning certain ingredients found in bath salts. Many community professionals reported that bath salts users typically fell into the 15-35 years age range. The BCI London Crime Lab reported the number of bath salts cases it processes has increased during the past six months. In addition, the crime lab noted that since the ban on the sale of bath salts went into effect in October 2011, the formally scheduled substances of MDPV and methylone are almost never seen any more in samples of bath salts, rather dozens of non-controlled analogs have taken their place.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Cincinnati Region

June 2011-January 2012

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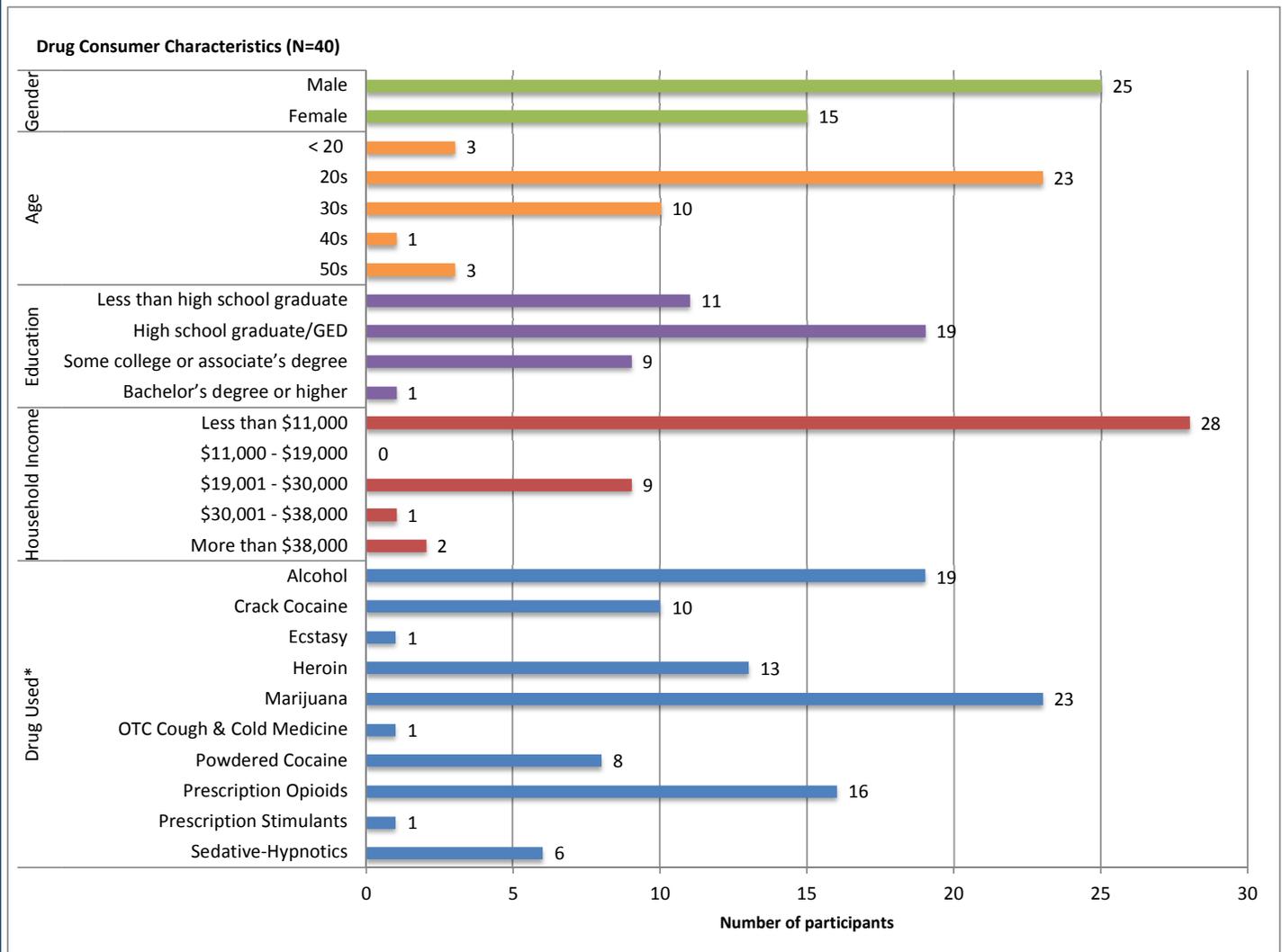
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Cincinnati Regional Profile

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%	37.5%
Whites, 2010	81.1%	81.3%	42.5%
African Americans, 2010	12.0%	12.5%	37.5%
Hispanic or Latino Origin, 2010	3.1%	2.3%	5.0%
High school graduates, 2009-2010	84.3%	88.0%	72.5%
Median household income, 2010	\$45,151	\$43,997	Less than \$11,000 ²
Persons below poverty, 2010	15.8%	15.2%	72.5%

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

Respondents reported income by selecting a category that best represented their household's approximate income for 2011.²



*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 located in Hamilton County. Participants were from Clermont, Hamilton and Warren 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 Hamilton County Coroner's Crime Lab 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 January through June 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, 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 July through December 2011.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was moderately available in the region. Participants most often reported the drug's availability as '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported powdered cocaine availability as highly variable throughout the region. Both law enforcement and treatment providers most often reported the drug's availability as '6'. Participants and treatment providers reported that the availability of powdered cocaine had remained the same during the previous six months. The Hamilton County Coroner's Crime Lab reported that the number of powdered cocaine cases it processes had also remained the same during the previous six months. Most participants rated the quality of powdered cocaine as '2' or '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that the quality of powdered cocaine had decreased slightly during the previous six months. The Hamilton County Coroner's Crime Lab continued to cite levamisole (livestock dewormer) as commonly used to cut (adulterate) powdered cocaine. Participants reported that a gram of powdered cocaine sold for between \$35-100, depending on the quality and connection to the dealer. Participants reported that the most common way to use powdered cocaine remained snorting. First-time users were more likely to snort powdered cocaine, and then progress to smoking or injecting as use continued

or increased. A profile for a typical powdered cocaine user did not emerge from the data. Treatment providers described typical users of powdered cocaine as those with the means to afford it. Powdered cocaine continued to be diluted and then injected with heroin by some users in a "speedball."

Current Trends

Powdered cocaine is 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 '5'. Participants continued to describe some varied availability throughout the region: *"It ran like water [powdered cocaine was highly available]; Finding the powder [powdered cocaine] was harder ... I could find crack [crack cocaine] [more easily]."* Treatment providers most often reported the availability of powdered cocaine as '8'. A treatment provider stated, *"I haven't had any complaints about not being able to find it [powdered cocaine]."* Law enforcement most often reported the drug's availability as '4'. A law enforcement officer stated, *"We see it [powdered cocaine], but not as much as we used to."* Participants reported that the availability of powdered cocaine has either remained the same or has decreased slightly during the past six months. Both law enforcement and treatment providers believed that the availability of powdered cocaine has remained the same during the past six months. The Hamilton County Coroner's Crime Lab reported that the number of powdered cocaine cases it processes has decreased during the past 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 previous most common score was '2' or '3'. Participants reported that the quality of powdered cocaine was highly variable during the previous six months. A participant stated, *"[Powdered cocaine] it's coming straight from Colombia; the bricks are stamped."* Participants who described low quality cited the following substances used as cutting agents: baby laxative, baby powder, creatine and Mini Thin 25/50® (ephedrine-based weight loss product). A participant stated, *"I know some people that cut it [powdered cocaine] with that s*** from GNC ... critadine ... creatine."* The Hamilton County Coroner's Crime Lab continued to cite levamisole (livestock dewormer) as commonly used to cut powdered cocaine.

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "blow" and "girl." Participants listed the following as other common street names: "booger sugar," "fish scale," "powder," "snow," "soft," "white girl" and "ya-yo." Current street prices for powdered cocaine reportedly continue to vary depending on the

closeness of the connection the user has with the dealer. A participant stated, *"It [price of powdered cocaine] depends on who you know."* Participants reported that a gram of powdered cocaine sells for between \$50-70, and up to \$100; 1/8 ounce, or "eight ball," sells for between \$80-150; an ounce sells for \$500-600 with a good connection and between \$1,100-1,200 without a good connection; a kilogram sells for \$16,000-20,000. Both participants and law enforcement described cheaper kilogram prices if high quantities of the drug are purchased. A participant stated, *"It [powdered cocaine] gets cheaper the more you buy."* A law enforcement official corroborated this, stating, *"[Powdered cocaine pricing] it's a quantity connection-based price structure."* Participants reported that the most common way to use powdered cocaine remains snorting. Smoking is common among users who "rock up" powdered cocaine to manufacture crack cocaine, while intravenous injection is a common route among those users who are injectors of any drug. A participant reported, *"Once I started injecting, that's the only way I do it [powdered cocaine]."*

Participants described typical powdered cocaine users in terms of age as being in their late teens and older, citing users of powdered cocaine as young as 16 years of age. A typical age of first use is between 17-18 years of age, according to participants. A participant reported, *"I started [using powdered cocaine] when I was 16 [years old] ... I turned a lot of people on to it."* Treatment providers described the typical powdered cocaine user as primarily middle-class, blue-collared workers between 26-33 years of age. A law enforcement official stated that many college-aged individuals experiment with powdered cocaine and that the drug is more commonly encountered among, *"upper-class, suburban kids."* Participants reported that dealers of powdered cocaine are more likely to be African-American than any other race or ethnicity.

Reportedly, powdered cocaine is commonly used in combination with alcohol, heroin, marijuana, sedative-hypnotics and tobacco. A participant described the use of heroin in conjunction with powdered cocaine (speedball): *"I follow cocaine with heroin, but I will absolutely not mix them ... putting them together takes away from each buzz [high]."* A participant explained that the use of benzodiazepines or Seroquel® in conjunction with powdered cocaine helps with *"coming down"* from the cocaine high, and that the use of powdered cocaine with alcohol reportedly enhances the effect of alcohol. A participant added, *"You can drink more [alcohol] with cocaine along with it."*

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). The Hamilton County Coroner's Crime Lab reported that the number of crack cocaine cases it processes had remained the same during the previous six months. Most participants rated the quality of crack cocaine as either '2' or '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The Hamilton County Coroner's Crime Lab cited levamisole (livestock dewormer) as commonly used to cut crack cocaine. Participants reported that a gram of crack cocaine sold for between \$40-60. Many participants also reported that they could easily purchase crack cocaine by the "rock" for between \$5-10. By far, the most common route of administration for this form of cocaine was smoking. Participants described first-time users of crack cocaine as getting younger, often 12-13 years of age. Treatment providers described crack cocaine as a social drug among younger users, appealing to this population because of the drug's low cost.

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 reported the drug's current availability as '9'. A treatment provider reported, *"We see more crack cocaine [users in treatment] ... there's a higher availability of crack than powder."* Law enforcement believed the drug's availability to be '10' in Hamilton County, but noted some geographic differences throughout the region. In Butler County, for instance, current availability was most often described as '6'. Media in the region reported on crack cocaine seizures and arrests during this reporting period. In October, during a routine traffic stop in Pike County, law enforcement found 100 grams of crack cocaine and 18 grams of powdered cocaine inside a fake coffee can (www.nbc4i.com, Oct. 13, 2011). Participants reported that while there has been variability in availability, overall availability of crack cocaine has remained the same during the past six months. A participant stated, *"[Crack cocaine] it's something that's gonna stay here."* Community professionals agreed that the availability of crack cocaine has remained the same during the past six months. The Hamilton County Coroner's Crime Lab reported that the number of crack cocaine cases it processes has remained the same during the past 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); the previous most common scores were '2' and '5'. Referring to the quality of crack cocaine, a participant stated, *"[Quality of crack cocaine] it's either really good or garbage."* Another

participant stated that quality is dependent on the time of month: *"First of month ... bad, middle of month ... better, end of month ... good quality ... it [crack cocaine] has cyclic quality."* Participants also reported commonly re-cooking crack cocaine with the intent to 'purify' the drug for smoking. One participant said, *"When you cook the crack down, it tastes better."* Participants stated that quality has either remained the same or has decreased slightly during the past six months. A participant said, *"[Quality of crack cocaine lately] it's been horrible; [dealers] they've been cuttin' it really bad with baking soda."* Participants reported the following substances as cutting agents for crack cocaine: baking soda, benzocaine (local anesthetic) and candle wax. Other substances sold to unsuspecting buyers in place of crack cocaine (aka fleecing) are reportedly the following: aquarium rocks, candle wax, drywall, gravel, macadamia nuts, Mini Thin 25/50® (ephedrine-based weight-loss product), peanuts, pool cue chalk and soap. The Hamilton County Coroner's Crime Lab continued to cite levamisole (livestock dewormer) as the primary cutting agent for crack 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: "base," "butter," "melt," "rock candy" and "work." Participants reported that a gram of crack cocaine sells for between \$30-60; an ounce sells for \$1,000. Similar to powdered cocaine, higher quantity netted better pricing; a purchase of four ounces of crack cocaine reportedly saves the buyer \$200 an ounce. While there are a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking from a pipe. Similar to powdered cocaine, injectors of crack cocaine are primary injectors of other drugs, and comprise fewer than an estimated two percent of crack users. Participants stated that lemon juice or vinegar is most commonly used to break down crack cocaine for the purpose of intravenous injection.

A profile of a typical user of crack cocaine did not emerge from the data. Participants believed that typical users of crack cocaine are more likely to be in their later teen years and that users may start 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. One treatment provider said, *"In the 80s people started [crack cocaine use] younger ... but now it seems like users are older."* Law enforcement described encounters with individuals as young as 15 years of age with crack cocaine, but they said typical use begins at 18 years of age. Law enforcement also stated that they encounter crack cocaine use most often among African-Americans or among economically disadvantaged Whites.

Reportedly, crack cocaine is commonly used in combination with alcohol, heroin, marijuana and sedative-hypnotics. A participant explained the rationale for using crack cocaine with other drugs: *"I won't smoke crack unless I have heroin to come down with."* Another participant described the use of Seroquel® for the same reason: *"Seroquel is great to come off the crack."*

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 were said to be available in the region, participants and law enforcement continued to name Mexican brown powdered heroin as most available. Participants in rural Lawrence and Jackson counties, however, reported black tar heroin as most available. Reportedly, the availability of heroin, regardless of type, had increased during the previous six months. The Hamilton County Coroner's 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 '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported heroin cut with fentanyl had been available in the previous six months, with several participants reporting of friends dying as a result. The Hamilton County Coroner's Crime Lab reported diphenhydramine (antihistamine) as commonly used to cut heroin. Participants reported that Mexican brown powdered heroin was available in different quantities: filled capsules sold for between \$10-15 per capsule; baggies labeled with "TNT" or "WMD" containing 1/10 gram sold for between \$10-15 in rural areas and \$20 in the city of Cincinnati; a gram sold for between \$70-130; a gram of black tar heroin sold for between \$100-150. Participants reported that the most common way to use heroin continued to be intravenous injection. Participants also continued to describe typical users of heroin as male and White.

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 were described in the region, participants continued to name both white powdered and Mexican brown powdered heroin



as most available. Treatment providers also reported high overall heroin availability, most often reporting current availability as '9' or '10'; the previous most common score was '10.' Law enforcement most often reported availability of white powdered and Mexican brown powdered heroin as '10'; and black tar heroin as '1' or '4.'

Throughout the region, participants reported that the overall availability of heroin has increased during the past six months. A participant reported, "[Black] tar or powder [heroin] ... I used to have to get downtown [Cincinnati] every day from Clermont County ... now I can get it delivered to my door." Another participant reported, "Lately I've seen more white powder [heroin]." Participants also reported an increase in the availability of black tar heroin during the past six months. A participant stated, "[Black tar heroin] it's exceptionally more available." Treatment providers and law enforcement noted an increase in availability of heroin during the past six months. Law enforcement cited that the demand for heroin has been driven by the reformulation of OxyContin® (less desirable than in the past) and the high cost for prescription opioids. The Hamilton County Coroner's Crime Lab reported that the number of heroin cases it processes has increased during the past six months.

Most participants generally rated the current quality of heroin as '7' or '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8.' Participants reported that the quality of heroin has been variable during the past six months. In general, substances cited as cutting agents for Mexican brown powder or black tar heroin included instant coffee and calcium powder. A participant stated, "They [dealers] cut it [heroin] with coffee ... you have to keep that bitter taste because if it doesn't have the bitter taste, then you know it's garbage." The Hamilton County Coroner's Crime Lab continued to cite diphenhydramine (antihistamine) as commonly used to cut heroin.

Current street jargon includes many names for heroin. The most commonly cited names were "boy" and "dog food." Participants listed the following as other common street names: "cheeva," "cheese," "China white," "cookies and cream" and "dope." Participants reported that a gram of powdered heroin sells for between \$100-150; black tar heroin sells in small balloons (1/10 gram) for between \$20-25. Law enforcement described heroin-filled capsules containing 1/10 gram selling for between \$10-20 per capsule or five capsules for \$100. Participants reported that the most common way to use heroin continues to be intravenous injection. To a lesser degree, participants also described smoking and snorting of

heroin. Participants cited that first-time heroin users or those described as, "needle-phobic" are more likely to snort or smoke heroin than intravenously inject. A participant commented, "I met someone who smoked it [heroin] for the first time a couple of months ago ... I was scared of that stuff ... needles ... I smoke it."

Participants continued to describe the typical heroin user as male and White. One participant said, "A lot of white boys use [heroin]." Participants stated that first-time heroin use typically occurs after prescription opioid use or abuse with the realization that heroin is, as one participant said, "cheaper; easier to get." According to participants, heroin use starts as young as 13-14 years of age. A participant reported, "Lots of young kids ... they told me heroin was the easiest to get ... prescription pills are overpriced; you can get high three to four times off \$20 heroin ... more economically feasible." Treatment providers also described the typical heroin user as White, and between 18-60 years of age, with more use being seen in the 18-25 age range. Treatment providers stated that increased use of heroin by young African-American males new to heroin is something that has changed during the past six months. Law enforcement reported higher use by Whites, aged 18-50 years, with dealers more likely to be African-American. Law enforcement also noted an increase in injection use during the past six months.

Reportedly, heroin is commonly used in combination with alcohol, crack cocaine, marijuana, powdered cocaine and sedative-hypnotics. Participants reported that both forms of cocaine are used with heroin to speedball. The use of methamphetamine and heroin together, while not common, was described as another form of speedball. A participant explained that speedball with methamphetamine makes, "the up and down lasts days."

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 Lortab®, OxyContin®, Percocet®, Roxicodone® and Vicodin® as the most popular prescription opioids in terms of widespread use. Participants and community professionals also reported an increase in availability and use of Opana®. The success of abuse-deterrent technology in the new formulation OxyContin® had pushed users to the prescription opioids Opana® and OxyIR® ("perc 30"), as well as to heroin. Participants reported that the availability of prescription opioids had remained the same, at high levels, during the previous six months. Participants also stated that the diversion of the 40 mg wafers of methadone

from treatment centers had increased. The BCI London Crime Lab reported that the number of prescription opioid cases it processed had remained the same during the previous six months; however, noted increases in the number of lab-processed cases existed for Dilaudid®, Opana® and Percocet®. In addition to obtaining prescription opioids on the street from drug dealers, participants also reported obtaining them through legitimate prescriptions written by their physicians, through hospital emergency rooms and pain clinics. 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 oral ingestion. Participants continued to describe typical users of prescription opioids as more likely to be White than any other race or ethnicity. Treatment providers reported that users of prescription opioids were more likely to be White and female. Participants described first-time users to be as young as 11-12 years of age, and more likely to obtain prescription opioids from medicine cabinets in their home or in the homes of relatives or friends.

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'. Community professionals also described high availability of prescription opioids, rating overall availability as between '9' and '10'. Participants identified Lortab®, methadone, Percocet®, OxylR® (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 has remained the same, at high levels, during the past six months. Participants reported increases in the availability of Opana® and Roxicodone® during the past six months. A participant stated, "Opana's getting real big." Law enforcement reported increases in OxylR® and Opana® and attributed the increase to the reformulation of OxyContin®. A law enforcement officer reported: "OxylR's have increased ... mostly used by those further along in their addiction ... they use the OxylR® 30 mg ... most dangerous ... also a large increase in Opana® seen since the OxyContin® reformulation." The BCI London Crime Lab reported that the number of prescription opioid cases it processes has remained the same during the past six months.

Many different prescription opioids are reportedly 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 (aka "dones;" 5 mg sells for between \$2-5; 10 mg sells for between \$6-10), Opana® (aka "OP's;" 20 mg sells for \$20; 40 mg sells for between \$35-40), OxyContin® (aka "hillbilly heroin" and "oxy's;" 40 mg sells for between \$20-30; 60 mg sells for between \$45-50, 80 mg, aka "green beans;" sells for between \$60-70), OxylR® (immediate release oxycodone and Roxicodone®, aka "IR's;" 15 mg, aka "perc 15;" sells for between \$12-15; 30 mg, aka "perc 30;" sells for between \$23-30), Percocet® (aka "P's," "perc's" and "pumpkins;" 5 mg sells for between \$3-5; 7.5 mg sells for between \$5-6; 10 mg sells for between \$7-10) and Vicodin® (aka "coffins," "V's" and "vikes;" 5 mg sells for between \$2-4; 7.5 mg sells for \$5; 10 mg sells for between \$6-10). While there were a few reported ways of consuming prescription opioids, the most common route of administration remains oral ingestion. Participants cited immediate-release oxycodone products as most likely to be snorted. Attempts to bypass the abuse-deterrent technology of the newly formulated OxyContin® included freezing the tablets, followed by cooking them in a microwave. Injection of prescription opioids was said to occur among users that inject other drugs.

Participants reported that initial access to prescription opioids is more likely from legitimate prescriptions written by physicians than from other sources. Once an individual becomes addicted, then other sources such as emergency rooms, pain clinics or street dealers are often used to obtain prescription opioids. Treatment providers also observed that addiction to prescription opioids is more likely to occur after legitimate use for a pain-related condition. A participant reported, "You can get 'em [prescription opioids] from Texas, Florida, Louisiana, and Mexico ... dealers, pill mills, doctor shoppers". Another participant described obtaining prescription opioids from older people who have legitimate prescriptions, "Can get them [prescription opioids] from older people who sell to younger people ... either they have a different drug they like or they hold back some and just sell part of it." A law enforcement official corroborated this statement: "Older people are selling prescriptions ... to pay rent, heating bills ... elderly sell the pills [prescription opioids] to younger people, maybe selling only one-half of the prescription." Obtaining prescription opioids from emergency rooms was noted as being more difficult now than in the past. One participant said, "Can't get [prescription opioids] as easy from ED [emergency departments] ... can't get as many [as in the past]."

Participants described the typical user of prescription opioids as White more than any other race or ethnicity, and also more likely to be female. A participant reported, "Girls do more prescription drugs." Treatment providers and law enforcement both described users as predominantly

White males and females. A participant described first use as early as 12-13 years of age, which was corroborated by law enforcement. Participants described first use access as, *"From the medicine cabinet or pharm [prescription drug exchange] parties with high school kids."* Law enforcement stated that an increase in pharmacy robberies is related to the theft of prescription opioids. Reportedly, prescription opioids are commonly used in combination with alcohol and sedative-hypnotics. Participants described the use of prescription opioids with crack cocaine, heroin and marijuana as less common.

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). Participants and community professionals reported that the availability of Suboxone® had increased during the previous six months. Law enforcement described Suboxone® as an emerging problem in jails. The BCI London Crime Lab reported a decrease in the number of Suboxone® cases it processed during the previous six months. Participants reported that Suboxone® 2 mg sold for \$5, and 8 mg sold for between \$8-25; Subutex® (containing only buprenorphine), 2 mg sold for \$10, and 8 mg sold for between \$15-20. Most often participants continued to report taking Suboxone® either sublingually (by dissolving it under the tongue) or by snorting. In addition to obtaining Suboxone® on the street from drug dealers, participants also reported getting Suboxone® from pain clinics, Suboxone® clinics and physicians trained to prescribe the drug. If street dealers had Suboxone®, they were more likely to be primarily heroin dealers. A profile for a typical Suboxone® user did not emerge from the data. Community professionals were not aware of Suboxone® users other than those who used the drug as part of substance abuse treatment.

Current Trends

Suboxone® is moderately to 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 also '10'. Both pill and film strip formulations are available. A participant stated, *"[Suboxone®] pills and strips are widely available."* Participants reported that Suboxone® availability is more likely to be from legitimate sources than through street purchase. A participant stated, *"Get [Suboxone®] from people that get them legit ... some off street dealers."* Treatment providers

described moderate availability of Suboxone in the region, reporting the drug's current availability as '6'. A treatment provider stated, *"A lot of people are trying it [Suboxone®] before trying to get their own prescription ... they hear that it's quicker [acting] than methadone."* Law enforcement reported the availability of Suboxone® as '4', noting an increase in availability during the past six months. A law enforcement officer stated, *"It [Suboxone®] wasn't there, but now it is ... most people on it have it legitimately."* Participants reported that Suboxone® availability has increased significantly during the past six months. The BCI London Crime Lab reported that the number of Suboxone® cases it processes has remained the same during the past six months.

Current street jargon includes a few names for Suboxone®, including "signs," "strips" and "subs." Participants reported that Suboxone® sells for between \$8-15 per pill or strip. While the Suboxone® strips are more likely to be put under the tongue, the route of administration for the pills also includes crushing the pill for snorting or dissolving it in water for injection. A participant noted, *"To use it [Suboxone® for injection] ... gotta be like 30 hours out [30 hours since last opiate use]."*

A profile for the typical illicit user of Suboxone® did not emerge from the data. However, law enforcement described more Whites than African-Americans as selling and trafficking prescription opioids, including Suboxone®. The age range of Suboxone® users is reportedly between 20-40 years. Treatment providers reported that some abuse was described by clients: *"I don't know how they [clients] are abusing it [Suboxone®], but they are; Some abuse it [Suboxone®] ... some take it to see if they want to use it to get off opioids ... others use it therapeutically to avoid dope sickness."* A law enforcement official also reported some abuse of Suboxone®: *"[Those with prescriptions] they're selling [Suboxone®] for abuse purposes or to replace what they had [for those already in a Suboxone® program]."* Similar to other prescription opioids, Suboxone® is reportedly used in combination with alcohol, marijuana and sedative-hypnotics.

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 '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 '10'. Participants and community professionals identified Xanax® as the most popular sedative-hypnotic in terms of widespread use. The BCI London Crime Lab reported that the number of sedative-hypnotic cases it

processed had remained the same during the previous six months; however, there was an increase in the number of cases processed for Xanax®. Participants reported several ways of consuming sedative-hypnotics, with the most common routes of administration being oral ingestion and snorting. Participants described typical users of sedative-hypnotics as more often female than male, but otherwise a typical user could not be defined.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported current availability of these drugs (especially Ativan®, Klonopin®, Valium® and Xanax®) 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 '8.' Law enforcement reported current availability of Klonopin® as '5,' and current availability of Valium® and Xanax® as '10.' Law enforcement reported that they do not encounter much Ativan® on the street. Participants reported that the availability of sedative-hypnotics has remained the same during the past six months. Both treatment providers and law enforcement also reported that availability of sedative-hypnotics has remained the same during the past six months. The BCI London Crime Lab also 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, prices are indicated in parentheses): Klonopin® (aka "Crazy K's," "K's" and "KP's," 1 mg sells for between \$0.50-1; 2 mg sells for \$2), Valium® (aka "blues," "V's" and "V-cut," 5 mg sells for \$1-2; 10 mg sells for between \$2-4) and Xanax® (aka "candy bars," "diving boards," "footballs," "Lincoln Logs," "logs" and "xani's," 1 mg sells for between \$2-3; 2 mg sells for \$5). While there were a few reported ways of consuming sedative-hypnotics, the most common route of administration remains oral ingestion. Less common routes of administration include crushing and snorting and intravenous injection after dissolving in liquid.

Participants described the typical user of sedative-hypnotics as most likely to be female and White, while citing first-time users of sedative-hypnotics as young as 14-15 years of age. A participant explained, "*Middle-schoolers use these [sedative-hypnotics].*" Participants described access to young users through medicine cabinets or friends as more likely than obtaining sedative-hypnotics from street dealers. Both law enforcement and treatment providers believed that

females, aged 20-60 years, are most likely to use sedative-hypnotics. According to participants, sedative-hypnotics are commonly used in combination with alcohol, heroin and prescription opioids (methadone) to "boost" the high. Treatment providers also reported that alcohol, marijuana and prescription opioids are commonly used in combination with sedative-hypnotics.

Marijuana

Historical Summary

In the previous reporting period, marijuana 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). Law enforcement reported that over-the-road truckers transported a lot of the marijuana into the region from Mexico by way of Indianapolis, Indiana. The Hamilton County Coroner's Crime Lab reported that the number of marijuana cases it processed had remained the same during the previous six months. Participant quality scores of marijuana varied from '7' to '10' 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, and an ounce sold for between \$100-150; for high-grade marijuana, a blunt sold for \$20, and an ounce sold for between \$300-450. The most common route of administration for marijuana continued to be smoking. Participants and community professionals reported that marijuana use was common among all groups of people.

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 is not a drug,*" meaning that the drug is so widely available that one would think marijuana to be legal. Treatment providers most often reported the drug's current availability as '10,' but they often gave much higher numbers to denote the extreme availability of the drug. One treatment provider said, "*[Availability of marijuana] it's a '20' [extremely available].*" Law enforcement also most often reported the availability of marijuana as '10.' Law enforcement described an increasing number of shipments of high-grade marijuana being transported by mail. Media outlets reported on several marijuana seizures in the region during this reporting period. In September, *USA Today* reported that a Cincinnati Bengals football player was arrested for receiving two and a half pounds of marijuana from California. Inside the player's

home, authorities also found six more pounds of marijuana and other drug paraphernalia. Law enforcement believed the player's residence was set up as a distribution center for a local drug ring (www.usatoday.com, Sept. 22, 2011). Also in September, *The Plain Dealer* reported on a marijuana seizure near the border of Pike and Scioto counties. Local law enforcement used helicopters to search for the marijuana plants and discovered 10 plots, or 565 plants, worth more than \$500,000. Officials believed Mexican cartels were growing highly potent marijuana in Ohio because of the temperate climate and good soil; however no one has been arrested in connection with the growing operation (www.cleveland.com, Sept. 29, 2011).

Participants and community professionals reported that the availability of marijuana has remained the same, at high levels, during the past six months. A treatment provider stated, "*The grades and varieties [of marijuana] have increased, but [marijuana] availability is about the same.*" A law enforcement official corroborated this belief: "*[Marijuana] it's all over the board ... it's never going to go away.*" The Hamilton County Coroner's Crime Lab reported that the number of marijuana cases it processes has decreased during the past six months. Most participants generally rated the quality of marijuana as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score varied from '7' to '10'. Participants described higher availability of high-grade marijuana in the region, accounting for the higher quality rating. Law enforcement and treatment providers corroborated the higher availability of high-grade marijuana in the region.

Current street jargon includes countless names for marijuana. The most commonly cited names were "bud," "dro," "green," "pot" and "weed." Participants listed the following as other common street names, primarily related to the potency of the drug: "dirt" and "downtown brown" for low-grade marijuana; "reggie," "regular" and "middies" for commercial-grade marijuana; "chronic," "dro," "flame," "kind bud," "kush," "loud," "medical trees" and "schwag" for high-grade or hydroponically grown marijuana. In addition, several high-grade strains were described by participants as having been available during the past six months: "AK-47," "blueberry," "blueberry nugget," "diamond kush," "G-13," "Jack the Ripper," "Maui wowie," "northern lights," "purple haze," "white rhino," "white Russian" and "white widow." The price of marijuana depends on the quality desired. Participants reported that low-grade marijuana is the cheapest form: a blunt sells for \$15; a gram sells for \$5; an ounce sells for between \$75-100; a pound sells for between \$700-800. A gram of commercial-grade marijuana sells for between \$8-10; an ounce sells for between \$100-120; a pound sells for between \$1,000-1,500.

High-grade marijuana sells for significantly more: a joint sells for between \$25-30; a blunt sells for between \$30-40; a gram sells for between \$20-35; 1/4 ounce sells for between \$90-100; an ounce sells for between \$225-500; a pound sells for \$5,000. While there were several reported ways of consuming marijuana, the most common route of administration continues to be smoking. Participants described eating marijuana by adding to butter, cookies or brownies as a less common route of administration.

A profile for a typical marijuana user did not emerge from the data. Participants commonly said statements such as, "*Everybody loves Mary Jane [marijuana].*" Participants described first time users to be as young as 10-11 years of age. Similarly, treatment providers described first time users of marijuana to be as young as 10-13 years of age, with people using marijuana up into their 70s. Law enforcement stated that traffickers of marijuana are usually people 14-15 years of age, but are more typically people ages 18-50 years. No gender or ethnic bias was noted by any of the groups interviewed. Participants stated that marijuana is commonly used in combination with alcohol, cocaine and tobacco.

Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was moderately to highly available in the region. Participants most often reported the availability of methamphetamine as '8' in rural areas of the region on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants continued to report low availability of methamphetamine in the City of Cincinnati. Participants also reported that methamphetamine was available in powdered and crystal forms, and continued to be locally produced. Treatment providers and law enforcement most often reported the drug's availability as '5'. The Hamilton County Coroner's Crime Lab reported that the number of powdered and crystal methamphetamine cases it processed had remained the same during the previous six months. Most participants rated the quality of powdered and crystal methamphetamine as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality) and reported that quality had either remained the same or increased slightly during the previous six months. Reportedly, a gram of locally produced methamphetamine sold for between \$60-100, with powdered methamphetamine on the low end of that range and crystal methamphetamine on the high end. Participants reported that smoking was the most common route of administration for methamphetamine. Participants described typical users of methamphetamine as White, in their mid-to-late 20s. Reportedly, methamphetamine was sometimes used in combination with heroin (speedball).

Current Trends



Methamphetamine availability remains variable in the region. Participants most often reported methamphetamine'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); the previous most common score was '8' in rural areas. Participants believed the higher rural availability is due to the manufacturing of methamphetamine in these areas. A

participant explained, *"They make it [methamphetamine] up in Clermont County."* Treatment providers and law enforcement also reported availability of methamphetamine in the city most often as '2' and '4,' and law enforcement also reported higher availability of '8' in rural communities. Participants and law enforcement cited that most methamphetamine is locally produced using anhydrous ammonia and pseudoephedrine. Law enforcement also stated that the labs discovered are typically small scale and mostly limited to the "one-pot method" of manufacture, where users (aka "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 (typically found in some allergy medications) in easily obtained containers, such as two-liter plastic soda bottles.

Participants noted that there has been an overall decrease in the availability of methamphetamine during the past six months, and cited that lower availability of precursor chemicals to manufacture methamphetamine as the driving force behind the move of methamphetamine manufacture out of the city. Treatment providers also believed there has been a decrease in methamphetamine availability during the past six months. A treatment provider stated, *"There was so much [media] coverage on the dangers [of methamphetamine manufacture and use] ... and it [methamphetamine availability] seemed to decrease after that."* Law enforcement also believed that there has been 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." The Hamilton County Coroner's Crime Lab reported that the number of methamphetamine cases it processes has increased during the past six months (The BCI London Crime Lab reported a

decrease in methamphetamine cases). Participants rated the general quality of methamphetamine most often as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '10.'

Current street jargon for methamphetamine includes "crank," "crystal," "dope," "meth" and "shards." A gram of methamphetamine reportedly sells for between \$100-175. Delivering a box of pseudoephedrine to the methamphetamine cook reportedly nets the buyer \$30 in cash or 1/2 gram of the finished product. A participant stated, *"In a seven-hour drive, you can hit up 12 counties to find pseudo [pseudoephedrine] to make meth."* Participants continued to describe smoking as the most common route for methamphetamine administration. Snorting of methamphetamine is a less common route of administration, and intravenous injection was noted to occur primarily among those users who inject other drugs.

Participants continued to describe the typical user of methamphetamine as more likely to be male and White; they described first-time users as late teens, approximately 18 years of age, but the typical user was described as, *"early-20s up to the 40s."* A treatment provider noted, *"Couples tended to use it [methamphetamine] together."* Law enforcement reported higher methamphetamine use among poor or Appalachian communities. Reportedly, methamphetamine is often used in combination with alcohol, heroin and marijuana.

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 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). The BCI London Crime Lab reported that the number of Ecstasy cases it processed had remained the same during the previous six months. The crime lab also reported that Ecstasy tablets usually contained multiple active substances including 5-MeO-DiPT (psychedelic and hallucinogenic drug; aka foxy methoxy), BZP, MDM, MDMA, P-FPP, TMFPP, caffeine, ketamine and methamphetamine. Reportedly, common pictures on Ecstasy tablets were lightning bolts, naked women, pistols, Playboy® bunnies, Scooby Doo, the Star of David and Transformers. Participants reported a "single stack" (low dose) Ecstasy tablet sold for between \$8-25; a "double stack" (moderate dose) sold for \$15; a "triple stack" (high dose) sold for between \$20-25. A profile for a typical Ecstasy user did not emerge from the data.

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 current availability of Ecstasy 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 the drug's current availability as '6'. In contrast, law enforcement did not report high availability of Ecstasy, citing current availability most often as '2'. Participants reported that the availability of Ecstasy has remained the same during the past six months. The BCI London Crime Lab reported that the number of Ecstasy cases it processes has remained the same during the past six months; however, the lab noted an appreciable increase in the number of cases containing the designer drug 5-MeO-DIPT (foxy methoxy).

Current street jargon includes several different names for Ecstasy. The most commonly cited names were "Ecstasy," "Molly" and "X." Common pictures reported on Ecstasy tablets are Osama bin Laden, four-leaf clovers, the Kool-Aid® man, lightning bolts, President Barack Obama, Pikachu, pistols and rainbows. Participants reported that Ecstasy sells for between \$5-10 per tablet. Four grams of Molly, the purest form of Ecstasy, reportedly sells for \$225. The most common route of administration is oral ingestion. Less common routes of administration include crushing and snorting of the tablets or intravenous injection after dissolving in liquid. A profile for a typical Ecstasy user did not emerge from the data.

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants were highly available in the region. Participants most often reported availability of these drugs as '9' 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 prescription stimulant cases it processes had remained the same during the previous six months. Participants and treatment providers described typical users of prescription stimulants as young adults between 18-26 years of age and likely to be enrolled on a college campus.

Current Trends

Prescription stimulants are moderately to 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); the previous most common score was '9'. Treatment providers

most often reported the drug's current availability as '4'; the previous most common score was '7'. A treatment provider reported, "I think [prescription stimulants] it's available on the streets because friends are giving it to friends." Law enforcement most often reported the availability of prescription stimulants as '5'. A law enforcement officer cited, "[Prescription stimulants] they're still out there ... but not as popular as [other] street drugs." The BCI London Crime Lab reported that the number of prescription stimulant cases it processes has remained the same during the past six months with one exception; the number of Adderall® cases has decreased.

Participants reported the following prescription stimulants as available to street-level users: Adderall® (5 mg sells for \$2; 10 mg sells for \$3; 20 mg sells for between \$5-8; 30 mg sells for \$10), Concerta® (18 mg sells for \$2; 36 mg sells for \$4; 54 mg sells for \$6), and Vyvanse® (70 mg sells for \$7). 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.

Other Drugs

Historical Summary

In the previous reporting period, 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: bath salts (synthetic compounds containing methylone, mephedrone or MDPV), inhalants and over-the-counter (OTC) cough medicines. Bath salts were highly available in the region. Treatment providers began to see clients abusing bath salts, and talked about some of the health complications, such as difficulty breathing, seen in users. The BCI London Crime Lab reported that the number of bath salts cases it processed had increased during the previous six months. The crime lab also reported that most forms of bath salts contained MDPV and methylone, a relative of a chemical often found in Ecstasy. Treatment providers said individuals on probation found these products attractive because they could be abused and did not show up in drug screens. Law enforcement reported that the use of bath salts was implicated in several deaths in the state. A minority of participants reported inhalant abuse among youth in high school, but did not provide any further information about inhalant abuse. Participants also reported abuse of OTC cough and cold medicines containing dextromethorphan (Robitussin® DM, Coricidin® HBP cough/cold). Treatment providers reported that users took high doses of OTC medicines to hallucinate. Participants and treatment providers reported that young adults in high school and college were most likely to abuse OTC cough and cold medicines.

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. Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) remain highly available in the region. Participants and community professionals agreed that these synthetic drugs continue to be highly available even though they were scheduled as controlled substances and banned for sale in Ohio in October 2011. A participant described the effects produced by bath salts as being, "as strong as cocaine." Another participant stated, "I heard people went to the nut ward and everything [after using these drugs]." The most common route of administration is snorting, with other routes (smoking, injecting, ingesting) seen as less common ways to abuse bath salts. The BCI London Crime Lab and the Hamilton County Coroner's Crime Lab reported the number of bath salts cases they process has increased during the past 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 are almost never seen any more in samples of bath salts, rather dozens of non-controlled analogs have taken their place. Synthetic marijuana is 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 in October. Treatment providers reported use of synthetic marijuana by individuals attempting to pass drug testing. A treatment provider explained, "It's hard to catch synthetic drug abuse because drug screens are expensive for them ... they [users] boldly tell you they're using because they know it won't show up on a normal drug screen." The BCI London Crime Lab and the Hamilton County Coroner's Crime Lab reported that the number of synthetic marijuana cases they process has increased during the past six months. More recent data from the BCI London Crime Lab indicated that the five formally scheduled substances are almost never seen anymore; rather dozens of non-controlled structural analogs have taken their place.

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 low inhalant abuse among their clients, but described computer duster products as most commonly used for inhalant abuse. 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. Participants described the ingestion of OTC cough and cold medicines as, "Robo-trippin'; sippin' on the syrup." Community professionals

also described prescription promethazine-codeine syrup as something that individuals in the 18-25 year age group have abused during the past six months. Reportedly, the street jargon, or slang, associated with the mixing of the pharmaceutical cough syrup and Jolly Ranchers candies is 'sizzurp.' While none of the participants mentioned steroid abuse, media reported on a steroid ring in Warren County. According to the *Toledo Blade*, steroids were imported from China, processed in Tennessee and later brought into Ohio. A grand jury indicted 32 people on various drug charges, and law enforcement, "seized more than \$600,000 in steroids, about \$300,000 in cash and vehicles, and a number of assault rifles and other firearms" (www.toledoblade.com, Nov. 7, 2011).

Conclusion

Bath salts, crack cocaine, heroin, marijuana, prescription opioids and sedative-hypnotics remain highly available in the Cincinnati region; also highly available is synthetic marijuana, which was not reported on during the past reporting period. An increase in availability exists for heroin; a likely decrease in availability exists for methamphetamine. Throughout the region, participants and community professionals reported that the overall availability of heroin has increased during the past six months. A participant reported, "[Black] tar or powder [heroin] ... I used to have to get downtown [Cincinnati] every day from Clermont County ... now I can get it delivered to my door." Law enforcement cited that the demand for heroin has been driven by the reformulation of OxyContin® and the high cost for prescription opioids. Participants reported that the most common way to use heroin continues to be intravenous injection, and law enforcement believed injection use has increased during the past six months. Participants stated that first-time heroin use occurs as young as 13-14 years of age, typically after prescription opioid use or abuse. Participants and treatment providers reported that the availability of prescription opioids has remained the same, at high levels, during the past six months. Participants reported availability increases for Opana® and Roxicodone®; law enforcement reported increases for OxyIR® and Opana®, and attributed the success of abuse-deterrent technology in the new formulation of OxyContin® as having pushed users to these drugs. Participants and treatment providers observed that addiction to prescription opioids is more likely to occur after legitimate use for a pain-related condition, or for adolescents from access through medicine cabinets and "pharm parties." Once an individual becomes addicted, then other sources such as emergency rooms, pain clinics or street dealers are used to obtain prescription opioids. Participants also continued to describe buying prescription opioids from older people who have prescriptions. Methamphetamine availability remains variable in the region. Participants and community professionals reported the availability of methamphetamine in the city to be low, while describing

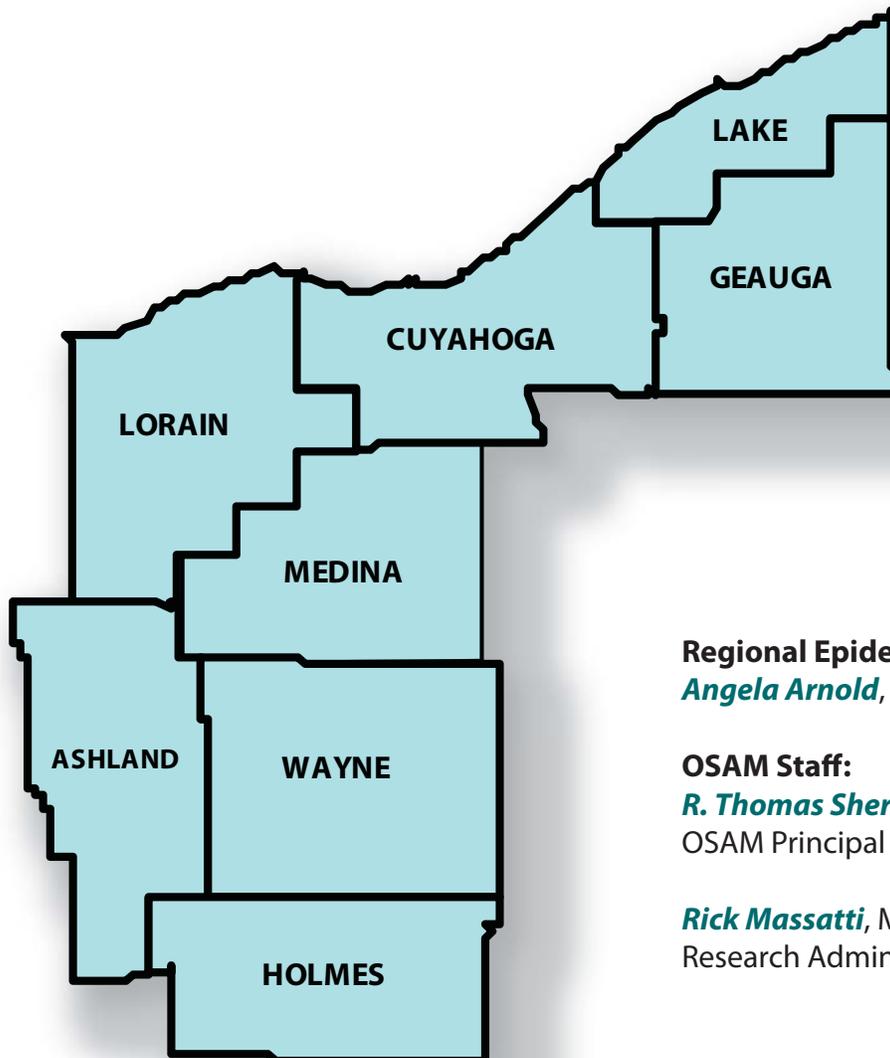
high availability in rural communities. Participants and law enforcement cited that most methamphetamine is locally produced using anhydrous ammonia and pseudoephedrine. Law enforcement also stated that the labs discovered are typically small-scale and mostly limited to the “one-pot” method of manufacture. Law enforcement believed the decrease in methamphetamine is linked to lower pseudoephedrine availability with increased scrutiny by pharmacies using MethCheck® (pseudoephedrine sales tracking system). Participants and community professionals agreed that bath salts and synthetic marijuana continue to be highly available even though they were scheduled as controlled substances and banned for sale in Ohio in October 2011. The BCI London Crime Lab and the Hamilton County Coroner’s Crime Lab reported that the number of bath salts and synthetic marijuana cases they process have increased during the past six months. In addition, the BCI London Crime Lab noted that since the ban on these designer drugs went into effect, the formally scheduled substances are almost never seen any more; rather dozens of non-controlled analogs have taken their place.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Cleveland Region

June 2011-January 2012

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Cleveland Regional Profile

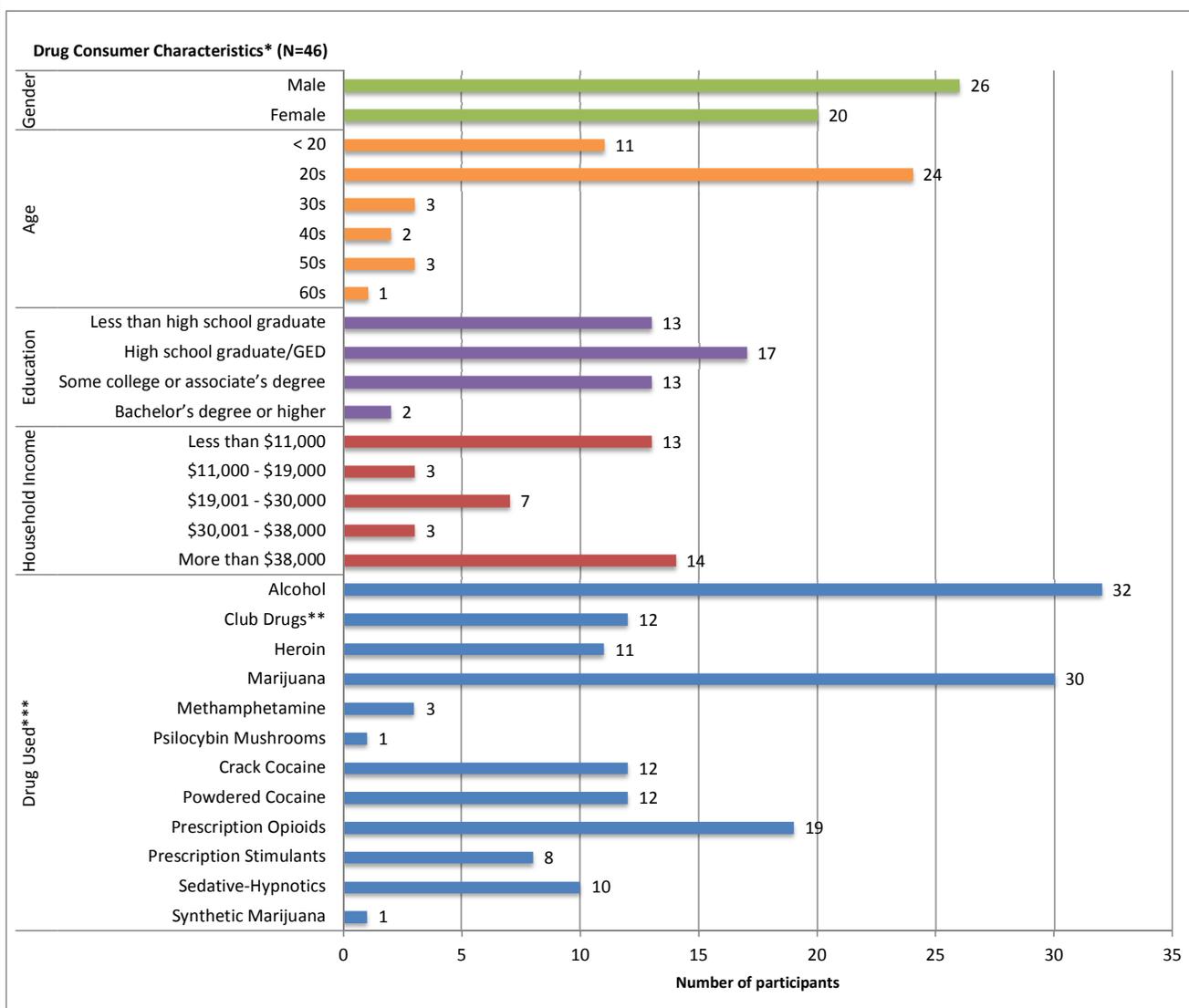
Indicator ¹	Ohio	Cleveland Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	2,287,265	46
Gender (Female), 2010	51.2%	51.8%	43.8%
Whites, 2010	81.1%	74.0%	52.2%
African Americans, 2010	12.0%	18.0%	37.0%
Hispanic or Latino Origin, 2010	3.1%	4.4%	4.3%
High school graduates, 2009-2010	84.3%	82.8%	71.1% ²
Median household income, 2010	\$45,151	\$49,864	\$19,001 - \$30,000 ³
Persons below poverty, 2010	15.8%	15.3%	38.5% ⁴

Ohio and Cleveland 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 2011. Income status was unable to be determined for six respondents due to missing data.³

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



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

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

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

Data Sources

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

Powdered Cocaine Historical Summary

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

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

Current Trends

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

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

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

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

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

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

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

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

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

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

Crack Cocaine

Historical Summary

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

Current Trends

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

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

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

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

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

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

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

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

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

Heroin

Historical Summary

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

Current Trends

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

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

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



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

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

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

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

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

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

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

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

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

Prescription Opioids

Historical Summary

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

Current Trends

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

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

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

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

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

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

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

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

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

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

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

Suboxone®

Historical Summary

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

Current Trends

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

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

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

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

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

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

Sedative-Hypnotics

Historical Summary

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

Current Trends



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

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

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

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

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

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

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

Marijuana

Historical Summary

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

Current Trends

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

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

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



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

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

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

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

Methamphetamine

Historical Summary

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

Current Trends



Methamphetamine remains highly available in the region. Participants with experience buying methamphetamine most often reported the drug's current availability as '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '8'. As was the case in the previous reporting period, participants who assigned an availability ranking usually qualified their scores to mean that methamphetamine is highly available to a limited number of users who are connected with a tight-knit

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

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

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

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

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

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

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

Ecstasy

Historical Summary

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

Current Trends

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

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

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

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

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

Prescription Stimulants

Historical Summary

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

Current Trends

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

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

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

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

Bath Salts

Historical Summary

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

Current Trends

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

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

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

Other Drugs

Historical Summary

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

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

Current Trends

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

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

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

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

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

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

Conclusion

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

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

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Columbus Region

June 2011-January 2012

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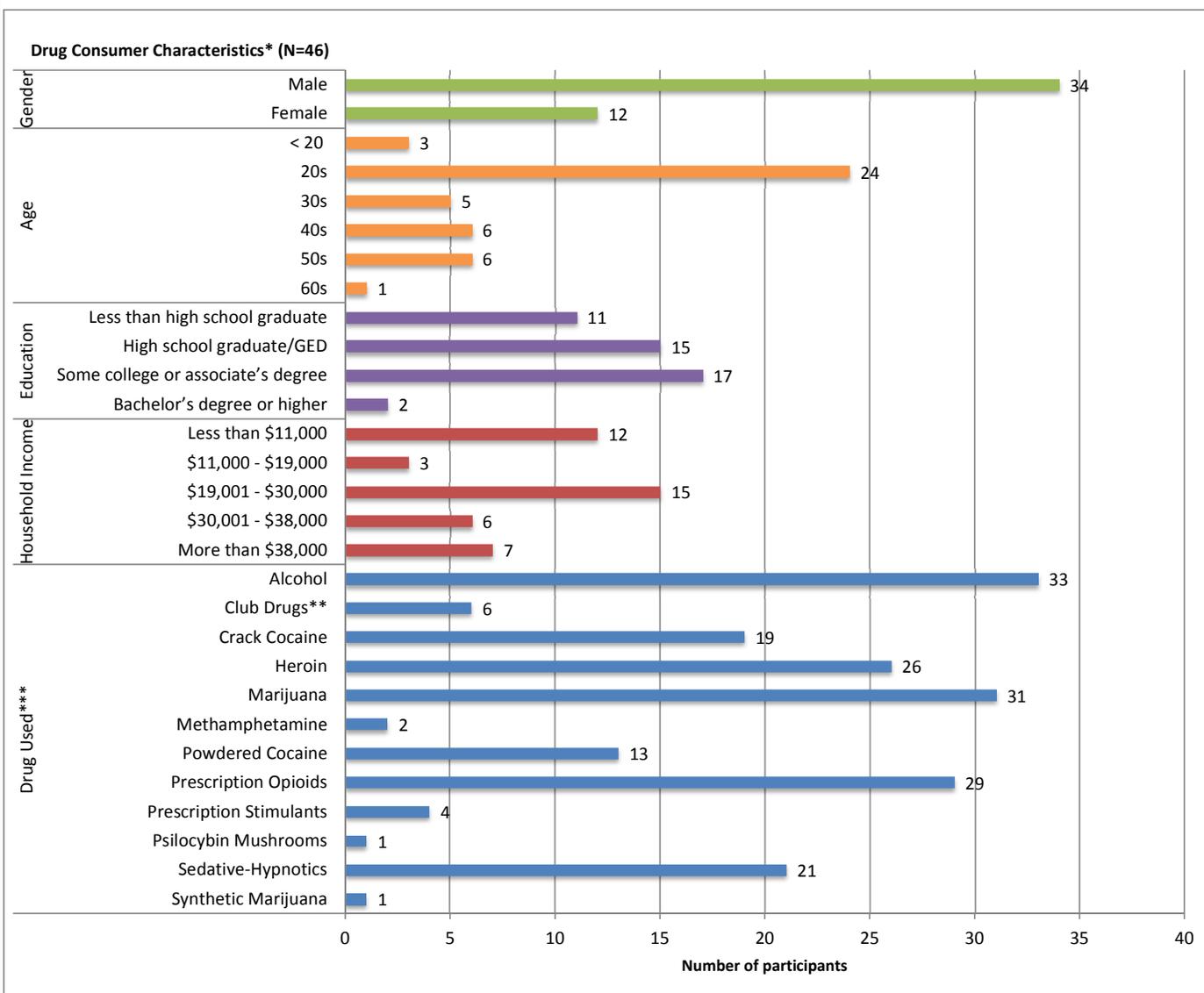
Columbus Regional Profile

Indicator ¹	Ohio	Columbus Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	2,132,217	46
Gender (Female), 2010	51.2%	50.7%	26.1%
Whites, 2010	81.1%	78.0%	69.6%
African Americans, 2010	12.0%	13.4%	23.9%
Hispanic or Latino Origin, 2010	3.1%	3.3%	2.2%
High school graduates, 2009-2010	84.3%	77.0%	75.6%
Median household income, 2010	\$45,151	\$51,501	\$19,000 - \$30,000 ²
Persons below poverty, 2010	15.8%	15.3%	39.5% ³

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

Respondents reported income by selecting a category that best represented their household's approximate income for 2011. Income status was unable to be determined for three respondents due to missing data.²

Poverty status was unable to be determined for three respondents due to missing or insufficient income data.³



*Not all participants filled out forms; therefore numbers may no add to 46.

**Club drugs refers to Ecstasy and LSD.

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

Data Sources

This regional report was based upon qualitative data collected via 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 (treatment providers and probation officers) in Fairfield and Franklin counties 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, and Fairfield County Municipal Drug Court. BCI data are summary data of cases processed from January through June 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, all 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 July through December 2011.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While participants described powdered cocaine as available, they reported that the drug did not have high street visibility, meaning one would have to make connections to buy it. Community professionals most often reported the drug's availability as '7'. The BCI London 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 '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that the quality of powdered cocaine had decreased 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 \$50-75, depending on quality; 1/8 ounce, or "eight ball," sold for \$100; an ounce sold for \$1,200. Participants reported that the most common way to use powdered cocaine remained snorting, although intravenous injection was also frequently mentioned. A profile of a typical powdered cocaine user did not emerge from the data. A participant noted, "All kinds of [powdered cocaine] users. Rich people get better quality and in larger quantities." Heroin and powdered cocaine continued to be injected together by some users in a "speedball."

Current Trends

Powdered cocaine is moderately to highly available in the region. Younger participants, those 25 years of age and younger, most often reported the drug's current availability as '6,' and those older than 25 years most often reported current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '8'. While younger participants described powdered cocaine as available, they reported that one would have to make connections to buy it: "It's harder [to obtain powdered cocaine] anymore because they [dealers] sell crack [cocaine]; People are doing harder drugs ... crack cocaine or heroin." Older participants commented that they could obtain the drug fairly easily: "If I was so inclined to buy it [powdered cocaine], I know three people ... I could go to their house and get it in a minute ... one call and the drive time to the house. It's never a problem for me to get; Very available. It all depends on where you live. Me ... I know so many people that sell powder [cocaine]. I could get some right now if I wanted to." Treatment providers most often reported the drug's current availability as '7'; the previous most common score was '10'. Media outlets in the region reported on significant arrests during this reporting period involving powdered cocaine trafficking. In August, police raided an apartment on Columbus' west side, netting bricks of cocaine, valued at about \$70,000, being readied for distribution in central Ohio. Police also seized heroin, weapons and cash; the drugs were said to have been supplied by Mexican cartels (www.10tv.com, Aug. 4, 2011). In December, state troopers seized nearly a pound of powdered cocaine, valued at \$36,000, during a traffic stop in Granville (Licking County) (www.nbc4i.com, Dec. 2, 2011). Also in December, Central Ohio Drug Enforcement Task Force detectives arrested a Newark (Licking County) man after he was found with large amounts of crack and powdered cocaine (www.newarkadvocate.com, Dec. 9, 2011). Participants and treatment providers reported that the availability of powdered cocaine has remained the same during the past six months. 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 '10'. Participants stated, "The powder [cocaine] is garbage nowadays, and the crack is much better. [Quality of powdered cocaine] it's way down from what it used to be; The quality [of powdered cocaine] depends on the dealer. If I go to a bar with mostly Mexicans, I know that I am going to get the best quality [powdered cocaine]. I know that." Participants reported that powdered cocaine in the region is cut with baking soda, coffee creamer, creatine, ether, flour, Orajel® and plant food. 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), lactose (disaccharide sugar), levamisole (livestock dewormer), local anesthetics (benzocaine, lidocaine and procaine) and mannitol (diuretic). Participants reported that the quality of powdered cocaine has remained the same during the past six months: *"It [quality of powdered cocaine] sucks. It has sucked for a long time."*

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," "pack" and "white." Current street prices were consistent among participants with experience buying powdered cocaine. Participants reported that a gram of powdered cocaine sells for between \$50-60, depending on the quality; 1/8 ounce sells for \$120; an ounce sells for between \$900-1,000. Participants reported that the most common way to use powdered cocaine remains snorting; however, intravenous injection and smoking are also common methods. Participants continued to state that new users are most likely to snort or smoke, but eventually progress to injection of powdered cocaine: *"I enjoyed snorting it [powdered cocaine] at first. Then I tried the needle, so of course I injected it; Seems like people who inject heroin also inject cocaine; Kids usually smoke it [powdered cocaine]. Older people usually inject it."*

A profile of a typical powdered cocaine user did not emerge from participant data. Most participants agreed with the comment of one participant: *"I've seen all kinds of people [use powdered cocaine]."* However, some participants noted that users appear to be getting younger: *"Seeing younger people shoot [inject powdered cocaine], I started when I was 15 [years old]."* Treatment providers characterized the typical user as, *"White, middle-class if you're looking at powdered cocaine ... at least the clients we see. We are seeing more of those non-traditional folks starting to use powdered cocaine for whatever reason, but the main group is White, middle-class."* Reportedly, powdered cocaine is used in combination with alcohol, used to mitigate the crash experienced from using cocaine; heroin (speedball); prescription opioids and sedative-hypnotics, both used to *"just to come down off of it [powdered cocaine]."* Combining powdered cocaine with other substances is common: *"People do that [combine other substances with powdered cocaine]. Almost everybody who shoots coke [cocaine] does 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). Participants also noted that crack cocaine paraphernalia was readily available in convenience stores and drive-thru beverage stores. Community professionals most often reported the drug's availability also as '10'. The BCI London Crime Lab reported that the number of crack cocaine cases it processes had remained the same during the previous six months. Most participants rated the quality of crack cocaine as '4' or '6' 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. Street prices for crack cocaine were consistent among participants with experience buying crack cocaine, with prices remaining fairly constant from the previous reporting period. Participants reported that a 1/10 gram of crack cocaine sold for \$10; 1/8 ounce sold for between \$75-125. The most common route of administration for crack cocaine remained smoking. A profile of a typical user of crack cocaine did not emerge from the data. Participants agreed that user characteristics were diverse: *"Crack doesn't discriminate."*

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, *"It would take me five minutes to get some [crack cocaine]."* Treatment providers most often reported the drug's current availability as '9'. However, drug court probation officers reported not seeing crack cocaine use in their clients. A probation officer reported, *"I've not seen it [crack cocaine use] hardly at all. It's not as popular as it was. The opiate demand is so great now that it's easier and cheaper to obtain [opiates]. Unless somebody can't get the opiate, then they revert back to crack."* Participants and treatment providers disagreed about the change in crack cocaine availability during the past six months. Participants reported that the availability of crack cocaine has remained the same: *"[Crack cocaine] it's always there."* On the other hand, treatment providers reported that availability of crack cocaine has increased during the past six months. A treatment provider stated, *"I would say [crack cocaine is] a little more available because looking at the nursing assessments that come through, their [clients'] drug of choice might still be alcohol or even marijuana, but a lot of times they're coming in positive for cocaine. It's the crack [cocaine] ... [they are] smoking primos [combination of crack and marijuana]."* The BCI London 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). Participants reported that crack cocaine in the region is cut with baking soda and vitamin B12. Oftentimes, participants said crack cocaine was cut with these substances to add volume to the product in order to fool the user into thinking that he or she is receiving a good amount of crack cocaine: *"It [cutting agents] blows it [crack cocaine] up."* Reportedly, Sprite® is used to remove impurities in crack cocaine before re-cooking it. Participants commented on the change in quality over time: *"I think it [quality of crack cocaine] depends on how long you've been doing it too. If you just started, it might be fine for you. But, if you [have] been doing it for years, it might be bulls***; If it [crack cocaine] tastes like butter, it's bad."* Participants reported that the quality of crack cocaine has remained the same over the past six months. The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the primary cutting agent for crack cocaine.

Current street jargon includes many names for crack cocaine. The most commonly cited names remain "hard" and "rock." Participants listed "work" as another common street name. 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 \$50, depending on the quality; 1/8 ounce sells for \$150. A participant explained, *"The price [of crack cocaine] is the same as powder [cocaine]."* It is common to buy powdered cocaine and then rock it up to create better quality crack cocaine: *"You cut down all the impurities before you rock it [crack cocaine] up. You can separate all the bulls*** that's in it [powdered cocaine], like baking soda, or whatever."* While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. According to participants, *"Most crack users are smokers."* There were only a few reports of intravenous (IV) injection, and participants reported that IV crack cocaine users are more likely to also be heroin users: *"Whoever does heroin, does crack. Mix [the compound of crack cocaine and heroin] with vinegar. [This process] breaks it [crack cocaine and heroin] down to liquid form [for injection]."* A participant spoke about the difficulty of using crack cocaine via other routes once someone has tried the IV method: *"Once a shooter, always a shooter."*

A profile of a typical crack cocaine user did not emerge from the data. Most participants said crack cocaine is popular with, *"Anybody and everybody."* Participants also noted that there are many young dealers: *"People are 12, 13 [years old] ... as long as they got a gun on 'em, they're selling it [crack cocaine]. If you're smart ... I mean if you're stupid, you're not going to carry one [a gun]."* Treatment providers characterized the typical crack cocaine user as, *"African-American; Equally male and female."*

Reportedly, crack cocaine is often used in combination with alcohol, marijuana, prescription opioids and sedative-hypnotics. Participants used other substances to mitigate the withdrawal from crack cocaine use. Participants explained, *"Xanax® keeps me level. Bring ya down a little bit; Weed [marijuana is used] to come down, [and] Xanax® [is used] 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 drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant stated, *"[Heroin] it's everywhere."* 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 heroin availability and use had remained high during the previous six months. Participants continued to attribute the increase in heroin's presence in the region to the reformulation of OxyContin® and to the lower cost of heroin. 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 '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that black tar heroin was cut with crushed aspirin. The BCI London Crime Lab continued to report that heroin was extremely pure in the region. Gas chromatography-mass spectrometry analysis typically showed that heroin was 80 percent pure; however, occasionally caffeine was used as a cutting agent. Participants reported that black tar heroin sold for \$10 a bag and \$90 a bundle (10-12 bags). Participants and community professionals reported that the most common way to use heroin remained intravenous injection; however, reportedly, snorting was also quite common. Many participants continued to report that users typically start with snorting heroin before eventually progressing to injection. Participants described typical heroin users as, *"younger people; all races; teens and young adults; a lot of college students."* Treatment providers also noted that heroin use had grown to include more young and suburban users.

Current Trends

Heroin remains highly available in the region. Participants and treatment providers most often reported the 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'. A participant reported, "[Obtaining heroin is] like going out and getting a bag of weed [marijuana] nowadays. I can't walk down the street without someone trying to shove that s*** down my throat." A treatment provider stated, "[Heroin] it's just highly available all the time." While many types of heroin are currently available in the region, participants continued to report black tar heroin as most available. Participants most often reported the availability of black tar heroin as '10'. A participant reported, "Most common [heroin] is tar [black tar heroin]. All I can find is tar; 80 percent tar, 20 percent powder [heroin]." Participants most often reported the availability of brown and white powdered heroin as '7'. Participants stated, "Powder [heroin]? Sometimes [available]; See powder every now and then; You have to know who to get it [powdered heroin] from." Probation officers most often reported the current availability of powdered heroin as '10'. Media outlets in the region reported on significant heroin seizures and arrests during this reporting period. In August, *Ohio News Network* reported on a heroin bust that took down a "major distributor" of heroin; three individuals were arrested in Shelby (Richland County) and charged with felony possession of heroin. Police seized 123 balloons of heroin, valued at \$3,000 (www.onntv.com, Aug. 18, 2011). In November, Ohio State Highway Patrol seized 1,283 small bags of heroin and 50 Ecstasy tablets, valued at \$12,000, during a traffic stop in Marion County (www.vindy.com, Nov. 3, 2011).

Participants reported that the availability of heroin has increased during the past six months: "Availability [of heroin] is up because more people are switching from pain pills [prescription opioids] to heroin, and you can make a lot of money off of it. Pills are just way too expensive; More available ... more Mexican drug dealers; More available ... 'cuz [heroin use] it's getting widespread. [Heroin] it's cheaper than pills, way cheaper ... [and] a quicker high [than OxyContin®]; When they [law enforcement] started busting a** [cracking down on pill mills] in Florida, which was all pill market, then everybody switched to heroin because it was so hard to get the pills." Participants reported that the availability of black tar heroin has increased during the past six months, while treatment providers reported that availability of black tar heroin has remained the same. Participants reported that the availability of brown and white powdered heroin has remained the same during the past six months, while treatment providers were unable to comment on the change in availability of powdered heroin. The BCI London Crime Lab reported that the number of heroin cases it processes has remained the same during the past six months, while noting that the type of powdered heroin most processed is usually beige in color. A crime lab staff member commented on the availability of the different types of heroin in the region: "As best as I can tell, Columbus has an abundant supply of black tar heroin. I-75

[Interstate-75] has powdered heroin coming from Detroit. By and large, which supply route is closer to the offense is predictive of which type of heroin will be seen."

Most participants generally rated the quality of heroin as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '6'. Participants reported that brown powdered heroin is cut with coffee and brown sugar. Black tar heroin was judged to be of better quality: "Brown and white [powdered heroin]? It's usually garbage. The reason I think [black tar heroin] it's better is because people have a harder time cutting tar up. People take that powder and use anything that's powder to cut it with." According to The BCI London Crime Lab, heroin is, "typically pretty pure." However, when heroin is cut, the lab reported the following substances as cutting agents occasionally used: caffeine, diphenhydramine (antihistamine) and local anesthetics (lidocaine and procaine). Participants reported that the quality of heroin has varied during the past six months: "[Heroin] quality goes up and down ... all depends on the package that just got into town. If [heroin] it's from out of town, it [quality] depends on how much they [drug distributors] stomped on [adulterated] it before they sent it."

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: "berries" and "H." Participants reported that black tar heroin is available in different quantities: a "baggie" (1/10 gram) sells for between \$10-15; a gram sells for \$100. Participants also reported that brown and white powdered heroin is available in different quantities and is priced the same as black tar heroin: "You usually pay the same price for tar as for powder." Participants reported that the most common way to use heroin remains injection. A participant stated, "It's a waste of time if you don't do that [inject heroin]." Several participants continued to mention that people often start out smoking or snorting heroin before progressing to injection: "If they [users] don't shoot it [heroin], they're smoking it first; You don't see that many Black people shooting it [heroin] up. They mostly snort it, but eventually, they will switch over when snorting doesn't do the job."

According to participants, there is not much concern about needle use. Needles are readily available at area pharmacies: "You can go to the pharmacy. As long as you know what you want and don't look like a junkie, they'll sell you a pack of 10 [needles]; Small-business pharmacies are the easiest. That's because they don't ask you for a prescription. You go in and tell them what size or gauge you need. If you know how to ask for them, 'I need a 30 gauge, 100 cc insulin syringe,' [the pharmacy will dispense needles]." Reportedly, needles sell for between \$2-3 on the street. Some participants reported sharing needles: "Worried [about sharing needles]? Not when you're high. I've shared. I think you think about it after, you know. But when you're sick ... I'll tell you ... it's not about who uses it

[needle], it's about how I'm getting it [high]; If you don't have a needle and you need one, and someone has it, and they're willing to let you use it, you will [share a needle]. I didn't care; I shared needles a couple of times and a few weeks later I was worried about it." Some injectors clean their needles when sharing: *"Some people [clean their needles] ... depends on the person. Some people don't care."* Treatment providers commented on needle use: *"They [users] don't start off with the needle [injection]. They'll try powder [heroin], snorting and smoking, and then it's eventually to the needle."* Regarding safer needle use, a treatment provider stated, *"I hear people say that [they don't share needles], and my perception is they want us to hear that. But, we have a lot of people [clients] who are Hep [Hepatitis] C positive, so [needle sharing] it's got to be happening. I think people are aware of it [the health risks of sharing needles], but in the midst of using, it's not a priority."*

A profile of a typical user of heroin did not emerge from the data; however, participants did note that users appear to be getting younger: *"There's a lot of young people using it [heroin], and it's probably because it kills everybody eventually. I've never met a 70, 80-year-old dope fiend. I've had too many people die who use that s*** to expect to make it very long; I started using when I was 18 [years old]. Kids in high school ... 15 or 16 [years old] shoot up heroin. A lot of young White girls are on it."* Treatment providers noted, *"Age [of heroin users] is going down. Tend to be Caucasian. We see a lot of people in their 20s ... early 20s to late 20s. It doesn't usually last very long. Either they find a way to get well, or they end up overdosing. I think it's because heroin is very powerful and can be laced with other things; We're hearing about it [heroin use] from the adolescent programs and having young people in need of detox at 16, 17 [years of age]."*

Treatment providers commented on the progression from prescription opioids to heroin. A provider reported, *"They [prescription opioid users] can't afford pharmaceuticals for very long. It tends to be the thing that hooks them into opiate use. You know, they'll have an injury or surgery or something and they start using that. Then, they'll start buying them off the street, and then they seem to learn about heroin ... and then it's cheaper ... and this is how you do it. That's most of the time the progression I see."*

Reportedly, heroin is used in combination with cocaine in a speedball and with marijuana. Participants explained, *"If you're doing cocaine, you're going to want to come down; I do a shot of heroin in the morning. Then if I have stuff to do, I want some crack so I can be up throughout the day. And then, when I'm ready to come back down, that's when I do another shot of heroin. It's a vicious cycle."* However, many participants reported not using other substances with heroin: *"I personally just use heroin because I like to spend all my money*

on heroin ... because in the future I know I'm gonna be sick ... and I've done it before. I've bought heroin, and then bought weed, and realized I wish I hadn't bought the weed. I could have spent that money on heroin, and now, I'm sick."

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 '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants 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 increased during the previous six months. Both participants and treatment providers again spoke of drug dealers sending people to Florida to purchase opioids to bring back to central Ohio. The BCI London Crime Lab reported that the number of prescription opioid cases it processes had remained the same during the previous six months; however, noted increases in the number of lab processed cases existed for Dilaudid®, Opana® and Percocet®. 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 remained swallowing and snorting. In addition to obtaining prescription opioids on the street from dealers, participants also continued to report getting them from doctors and emergency rooms. Participants described typical users of prescription opioids as young and White. Narcotics officers identified the typical user as White and middle-class. Treatment providers reported that opioid-using clients were typically 18-24 years of age.

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'. Participants continued to identify Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use; treatment providers identified OxyContin®, Percocet® and Vicodin® as the most popular. A treatment provider



stated, *"These drugs [prescription opioids] are very prevalent."* Media outlets in the region reported on arrests involving prescription opioids during this reporting period. In July, a Franklin County grand jury indicted two men in connection with a multi-state drug trafficking operation; according to prosecutors, the men sent "patients" to Jacksonville, Florida to visit a pain clinic and bring 1,000-3,000 prescription opioids, mostly oxycodone and Xanax®, back to Ohio each trip for sale in Columbus (www.10tv.com, July 14, 2011). In September, Westerville (Franklin County) police arrested two men in connection with a series of Kroger pharmacy robberies (www.nbc4i.com, Sept. 19, 2011). In November, Baltimore (Fairfield County) police arrested a husband and wife and charged them with drug trafficking and possession of prescription opioids (www.nbc4i.com, Nov. 4, 2011).

Participants reported that the availability of prescription opioids has decreased during the past six months. A participant stated, *"Availability [of prescription opioids] is way less because of the crackdown on pharmacies."* Another participant mentioned the higher cost of these drugs as prohibitive: *"But look at the cost of 30s [oxycodone 30 mg]! How much has that gone up? When I first started doing pills [prescription opioids], I could find 30s for \$17. Now you can't find them for any less than \$25. And you gotta twist arms and break legs for them."* Treatment providers reported that availability has slightly decreased during the past six months: *"Slightly gone down ... heroin has increased and pills have decreased. The effects of law enforcement are showing up."* The BCI London 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 street-level users (Note: When reported, current street names and prices are indicated in parentheses): fentanyl (patches sell for \$20), Lortab® 5 mg (sells for between \$2-3), Opana® 10 mg (sells for \$3), Oxycodone 30 mg (aka "perc 30;" sells for \$25), OxyContin® 80 mg (aka "80s;" old formulation sells for \$170), Vicodin® 5 mg (aka "vics;" sells for \$2). 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. Participants commented, *"Snort [prescription opioids] ... can't really shoot if it's got Tylenol® in it. You can't shoot it, so it's got to be a higher milligram. Like, you can't shoot up Vicodin® or perc 5s [Percocet® 5 mg]; To get the full effect, you got to shoot 'em [prescription opioids]."* There was one mention of smoking: *"Some smoking [prescription opioids] in a blunt, or put on foil and smoke."*

In addition to obtaining prescription opioids on the street from dealers, participants continued to report getting them from pain clinics: *"Get them [prescription opioids] on the street from people who get them in the clinics; People are going down to Florida [to obtain prescription opioids]. Every pain clinic they shut down in Florida, another one opens up right after."* A profile of a typical user of prescription opioids did not emerge from the participant data. Participant comments on typical prescription opioid use included: *"Doesn't discriminate; No typical user; The thing about pills [prescription opioids] in general is ... I know so many different types of people that use them. I literally buy pills from housewives ... from housewives to dealers in the street in the middle of Columbus ... it [prescription opioid use] has such a wide range."* Treatment providers described the typical user of prescription opioids as male and White. However, they also reported seeing, *"More females in the [prescription opioid user] group than in the heroin [user] group ... they [prescription opioid users] tend to be a little older than the heroin users. They don't think of themselves as real drug addicts."*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, crack cocaine and marijuana. Participants agreed that it is very common to mix prescription opioids with all of these substances. A participant noted, *"I think people coming out of high school [combine use of prescription opioids with marijuana] 'cause they've been smoking weed, and weed is a gateway drug, and then they go to pain pills."*

Suboxone® **Historical Summary**

In the previous reporting period, Suboxone® was highly available in the region. Participants and treatment providers most often reported the availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant reported, *"Anyone who comes in [to treatment] that they think has an opiate problem, they write out a script [prescription for Suboxone®]. Everybody's on 'em."* A narcotics officer commented, *"When they prescribe it [Suboxone®], they prescribe a lot of it, and people don't use the whole prescription. They [users] would then sell it on the street."* Participants reported that the availability of Suboxone® had remained the same during the previous six months. The BCI London Crime Lab reported a decrease in the number of Suboxone® cases it processed during the previous six months. Participants reported that Suboxone® 8 mg sold for between \$15-20; Suboxone® in the strip/film form sold for between \$10-20. Reportedly, Suboxone was typically dissolved under the tongue; however, intravenous injection was also reported. In addition to obtaining Suboxone® on the street from drug

dealers, participants also reported getting the drug from people selling their prescriptions. Participants described typical abusers of Suboxone® as 35- to 45-year-old Whites.

Current Trends

Suboxone® is moderately to highly available in the region. Younger participants, those 25 years of age and younger, most often reported the drug's current availability as '4,' and those older than 25 years most often reported the current street availability of Suboxone® 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 reported, *"It [Suboxone®] wasn't there when I wanted it; It wasn't available enough."* Treatment providers most often reported the drug's current availability as '7'. Participants reported that the availability of Suboxone® has remained the same during the past six months. Treatment providers reported that the availability of Suboxone® has increased during the past six months. A treatment provider reported, *"I think people are getting a little more educated about what Suboxone® can do for them. There are certainly many physicians who will prescribe it. You just need to find somebody and a way to pay for it."* The BCI London Crime Lab reported that the number of Suboxone® cases it processes has remained the same over the past six months.

There were no street names reported for Suboxone®. Participants reported that Suboxone® 8 mg sells for \$10. A participant reported, *"[Suboxone®] strips are cheaper because people don't like the strips as much as the pills. They taste disgusting ... in my opinion the pills work right off the bat. You let it dissolve and 20 minutes later you feel good. The strips, I feel like you got to take 'em a day or two before it builds up in your system."* Most often participants reported taking Suboxone® sublingually (dissolving it under the tongue): *"Usually dissolve [Suboxone®] under your tongue ... tablets and strips ... now mostly strips ... you know, like Listerine® strips that you would put under your tongue."* There were a few reports of injection: *"Some people say they've shot the [Suboxone®] strips before. Just dissolves in water. I've actually shot the pills before; People shoot the strips. I've heard it's weird ... messes you up."*

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 don't often sell Suboxone®: *"Sometimes they'll [dealers] sell it [Suboxone®], but they catch on that they shouldn't be selling it because they'll sell you some Suboxone®, and then you won't come back and buy good dope ... you don't get repeat buyers selling that stuff."* 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."* Reportedly,

Suboxone® is not used in combination with other drugs: *"If you're taking it [Suboxone®], that's 'cuz you're sick."*

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 availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals identified Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processes had remained the same during the previous six months; however, a noted exception was an increase in the number of Xanax® cases. In addition to obtaining sedative-hypnotics on the street from drug dealers, participants also reported getting the drugs from family doctors or emergency rooms. The most common route of administration for sedative-hypnotics was oral ingestion. However, snorting and intravenous injection also continued to be common routes of administration. Xanax®, in particular, was reportedly frequently snorted. Participants described typical users of sedative-hypnotics as young and White. Narcotics officers reported seeing an increase in young Black sedative-hypnotic users.

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 continued to identify Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Treatment providers most often reported the current availability of sedative-hypnotics as '7'. Community professionals identified Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Participants reported that the availability of sedative-hypnotics has increased during the past six months: *"More available. It's gotten a little easier for me to get 'em [sedative-hypnotics]; Xanax® has gone up in availability."* Treatment providers reported that availability of sedative-hypnotics has remained the same during the past six months. The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same over the past six months.

Reportedly, many different types of sedative-hypnotics are currently sold on the region's streets. Participants only reported the street price for one drug: Valium® 5 mg sells for \$2. 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 snorting and injecting. Participants mentioned snorting often: *"Snort [sedative-hypnotics] with other drugs, would never swallow it; If I'm swallowing it [sedative-hypnotics], I would chew it at least. I would never just swallow it."*

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported getting the drugs from pain clinics. A participant explained, *"People buy them [sedative-hypnotics] in pain clinics and sell on the street."* A profile of a typical user of sedative-hypnotics did not emerge from the participant data. Participants had a difficult time pinning down a typical user and most often said there was, *"no specific [sedative-hypnotics] user."* Treatment providers, however, characterized the typical user as female and White. A treatment provider reported, *"[Sedative-hypnotics users] tend to be a little older ... maybe late 20s, early 30s, Caucasian. Treatment is catching it [sedative-hypnotic dependence] now more often. People are able to sustain on these types of medications ... so they don't really realize that it [dependence] happens for several years. They don't really think they need to do anything about it."* Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, heroin, marijuana and prescription opioids. Participants said they commonly use these other substances, *"before, during and after [taking sedative-hypnotics] ... enhances the effect."* A participant stated, *"I use pills [sedative-hypnotics] with everything!"*

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). The BCI London Crime Lab reported that the number of marijuana cases it processes had decreased during the previous six months. Participants continued to report that marijuana quality as high for all grades of the drug, most frequently reporting the overall quality of marijuana as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The price of marijuana continued to depend on the quality desired. Participants reported that for commercial-grade marijuana, a blunt (single cigar) or two joints (cigarettes) sold for \$5; an ounce sold for between \$60-120. Higher-quality marijuana

("hydro") sold for significantly more: a blunt or two joints sold for \$10; an ounce sold for between \$200-400. The most common route of administration for marijuana was smoking. Participants and treatment providers continued to report that marijuana use was popular among all groups of people.

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 said marijuana use is very prevalent: *"It's like smoking a cigarette [smoking marijuana is as common as smoking tobacco]."* Treatment providers also most often reported the current availability of marijuana as '10', and also likened the widespread use of the drug to that of cigarettes: *"[Smoking marijuana] it's like smoking a cigarette. I'd rate it a 35 [extremely easy to get]!"* In addition to easily obtaining marijuana on the region's streets, a participant mentioned obtaining marijuana from Michigan's prescription marijuana program: *"[I get marijuana from] the weed clinics. You can always find some great stuff."* Media outlets in the region reported on seizures and arrests involving marijuana during this reporting period. According to 10TV News, law enforcement arrested a Bloom Township (Fairfield County) resident after they found, *"a million dollar growing operation"* inside his home; law enforcement found hundreds of plants along with sophisticated hydroponics equipment after receiving an anonymous tip (www.10tv.com, Aug. 4, 2011). In another incident, 10TV News reported that Knox County law enforcement found 40 marijuana plants after an aerial search; no one was arrested in connection with this growing operation (www.10tv.com, Aug. 24, 2011). Participants and treatment providers reported that the 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 varied from '4' to '10' with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '10'. Participants continued to explain that the quality of marijuana depends on whether the user buys "commercial weed" (low- to mid-grade marijuana), high-grade or hydroponically grown marijuana. Some participants discussed high-grade marijuana: *"Once you get into the good weed ... there's different kinds of it ... the best stuff is seedless, like it don't have no seeds. It's got red hairs."* Other participants warned that dealers try to pass off low-quality product as high-grade marijuana: *"Sometimes [high-grade marijuana] it's fake. It's fake stuff. Sometimes they [dealers] spray stuff on it to make it smell. It's weed, but it's not. Weed is a tricky thing"*

because you can do stuff like that. The real stuff's good, and the swag [low-grade marijuana] is just trash." Participants also thought quality varied throughout the year: *"Quality [of marijuana] depends on the time of the year. This summer everything was [expletive]. I couldn't find dro [hydroponically grown marijuana] to save my life."*

Current street jargon includes countless names for marijuana. The most commonly cited name remains "weed." Participants listed the following as other common street names: "mid" and "regular" for commercial-grade marijuana; "kush" and "purple haze" for high-grade marijuana; and "dro" and "hydro" for hydroponically grown marijuana. The price of marijuana depends on the quality desired. Participants reported commercial-grade marijuana as the cheapest form: a gram sells for \$5; an ounce sells for between \$90-120; 1/4 pound sells for \$120. Participants talked about the profit made off of low-grade marijuana: *"You make money off the [expletive] weed. It's called 'money maker.'"* For higher quality marijuana, a gram sells for \$20 and an ounce sells for \$350. Participants thought the price of high-grade marijuana to be relatively stable: *"Kush or whatever, the price is always steady because people are growing it inside."* The most common route of administration for marijuana remains smoking, with no other use methods mentioned.

A profile of a typical marijuana user did not emerge from the data. Participants and treatment providers agreed that there is no specific age or other demographic category associated with marijuana use. According to Fairfield County Municipal Drug Court, a low percentage of men and women involved in their court test positive for drugs. Among those testing positive during the past six months, 14.3 percent of the positive urine drug screens were related to cannabis. Reportedly, marijuana is used in combination with alcohol, crack and powdered cocaine, and prescription opioids, particularly Percocet®. Participants said marijuana blunts are dipped in embalming fluid (aka "sherm"). A participant reported using codeine syrup in concert with marijuana: *"You can put codeine syrup on the blunt skin and roll it up."* Marijuana also is used to "come down from" a crack cocaine high. Other participants believed marijuana to be the perfect drug to use with others: *"Weed goes with everything; Marijuana's the partner in crime to everything!"*

Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was moderately available in the region. While most participants had difficulty rating availability of methamphetamine, Fairfield County participants noted that methamphetamine availability had not suffered despite a number of

drug seizures. The only participant who had used methamphetamine reported the drug was available in crystal (aka "ice") and powdered forms. Narcotics officers reported that there were many "one-pot" users who make methamphetamine at home to feed their own habit (one-pot referred to the method of manufacturing methamphetamine whereby 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 BCI London Crime Lab reported that the number of methamphetamine cases it processes had remained the same during the previous six months. Reportedly, most of the cases the crime lab processed were for white to yellow powdered methamphetamine; however, crystal methamphetamine cases were said to be increasing. The only participant who used methamphetamine rated the quality of crystal methamphetamine as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Reportedly, the most common route of administration of methamphetamine was intravenous injection. Participants described typical users of methamphetamine as White, middle-class and often middle-aged. Narcotics officers agreed with participants and added that they had seen methamphetamine in homosexual clubs.

Current Trends



Methamphetamine is seldom found in 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), previously, participants did not assign a score to methamphetamine availability. Participants reported that methamphetamine is available in powder and crystal forms. Participants stated that methamphetamine is difficult to acquire: *"Even in the boondocks, [methamphetamine] it's more available than in the city; [Methamphetamine] it's just not very available; I'd have to work at it [locating methamphetamine]."* Treatment providers were unable to report on the drug's current availability. A treatment provider explained, *"It [methamphetamine availability] seems high based on what I hear from the community, but I don't know. Based on work experience, I don't see a lot of these types of patients [methamphetamine users] in treatment."* Media outlets reported on several methamphetamine arrests and seizures in the region during this reporting period. In every report, law enforcement found methamphetamine laboratories, both mobile laboratories and home-based laboratories. In one report, Columbus law enforcement stopped a

woman after a routine traffic violation and discovered crystal methamphetamine, along with the ingredients and means to manufacture the drug (www.nbc4i.com, Nov. 2, 2011). ABC6 News reported that 10 people were indicted in Madison County after equipment to manufacture methamphetamine and numerous weapons were found in a Mount Sterling home (www.abc6onyourside.com, Sept. 20, 2011). In December, Franklin County Sheriff's officers searched a home on Columbus' west side and found two people cooking methamphetamine (www.nbc4i.com, Dec. 29, 2011). Participants reported that the availability of methamphetamine has decreased during the past six months. According to one participant, *"All the people I know [who manufacture methamphetamine] are in prison."* The BCI London Crime Lab reported that the number of methamphetamine cases it processes has decreased during the past six months.

Most participants were unable to rate the quality of crystal and powdered methamphetamine. A participant explained, *"The purity [of methamphetamine] depends on who you get it from."* The BCI London Crime Lab reported that white powdered methamphetamine from personal labs is the most common form, and that methamphetamine trafficked on the street is usually crystal methamphetamine. Current street jargon includes a few names for methamphetamine. The most commonly cited names remain "crystal" and "ice." Current street prices for methamphetamine were consistent among participants with experience buying the drug. Participants reported that a gram of crystal methamphetamine sells for \$20. Reportedly, the most common route of administration of methamphetamine remains intravenous injection; participants cited smoking and snorting as less common routes of administration. A participant explained, *"Mostly inject [methamphetamine] but start out smoking."* A profile of a typical methamphetamine user did not emerge from the data. However, a participant reported that the drug is primarily found in homosexual clubs. Reportedly, methamphetamine is used in combination with marijuana. According to a participant, users prefer, *"weed because you can keep smoking weed and not even get high off the weed and still zoom on meth. It evens you out a little bit, but you're still really high."*

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants were moderately available in the region. However, participants were unable to rate the availability of prescription stimulants because none had actively abused the drug during the previous six months. Community professionals were also unable to comment on the drug's availability. The BCI London

Crime Lab reported that the number of prescription stimulant cases it processes had remained the same during the previous six months. In addition to obtaining prescription stimulants on the street from drug dealers, participants continued to report that these drugs were often prescribed by area doctors. Participants also continued to describe typical users of prescription stimulants as young, usually college students.

Current Trends

Prescription stimulants remain moderately available in the region. However, participants only mentioned Adderall® and were unable to rate its availability, although they said that the drug is readily available on college campuses and remains popular among young people. Participants reported that Adderall® 10 mg sells for \$3; 30 mg sells for \$7. Reportedly, the most common routes of administration of prescription stimulants are oral ingestion and snorting. A participant provided a description of how he would typically abuse prescription stimulants: *"Smash the balls [microcapsules] and sniff the powder."* The BCI London Crime Lab reported that the number of prescription stimulant cases it processes has remained the same during the past six months with one exception; the number of Adderall® cases has decreased.

Bath Salts

Historical Summary

In the previous reporting period, participants had heard of, but were not experienced with, bath salts (synthetic compounds containing methylone, mephedrone or MDPV); however, Fairfield County emergency room and police reports showed an increase in the use of the substance. The BCI London Crime Lab reported that the number of bath salts cases it processes had increased during the previous six months.

Current Trends

A few participants reported using bath salts (synthetic compounds containing methylone, mephedrone or MDPV), which were thought to be moderately available in the region, although participants were unable to rate availability. According to participants, bath salts can be purchased at gas stations and convenience stores: *"You get a little container [of bath salts]. It's like a gram to three grams, and depending on what [type of] quality you want, \$20-60 for that little container; [Bath salts] comes like in a little lip gloss thing. It's called 'Wild Horse' now, and it's used a lot. It comes out as methamphetamine in a drug test."* Other participants talked about the physiological effects of bath salts: *"I ended up in the emergency room [after using bath salts]. I thought I was gonna die. It felt like a big panic attack. I sat in the corner for two hours; if you keep doing it [bath salts], you'll lose your*

mind; [With bath salts use] you can hallucinate so bad. You get suicidal. [Bath salts] it's killing people." Treatment providers also discussed negative health consequences of bath salts: *"We are very concerned about what that [bath salts] does to people. We see them [bath salts users] most often from the methadone program. It seems to be a social thing for people to do, and it makes them paranoid. It makes them very hyper, and in some cases has made them psychotic ... and they have to be hospitalized. It seems to be such a hard cycle to break. We're constantly looking for guidance and direction on how to treat that."* Treatment providers believed that White males in their 20s and 30s are most likely to abuse bath salts.

Media outlets reported on several bath salts arrests and seizures in the region during this reporting period. *WBNS-10TV* reported that two men broke into a Reynoldsburg (Franklin County) gas station and stole bath salts a few months before the ban on bath salts went into effect. Neither man was apprehended (www.10tv.com, Aug. 7, 2011). In another incident, *ABC6 News* reported that police seized hundreds of bath salts and synthetic marijuana packets during an undercover investigation. Despite being warned about changes in the legislation, employees at a Reynoldsburg gas station still sold the drugs even after the ban went into effect (www.abc6onyourside.com, Dec. 12, 2011). The BCI London Crime Lab reported the number of bath salts cases it processes has increased during the past six months. In addition, the crime lab noted that since the ban on the sale of bath salts went into effect in October 2011, the formally scheduled substances of MDPV and methylone are almost never seen any more in samples of bath salts, rather dozens of non-controlled analogs have taken their place.

Other Drugs

Historical Summary

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 [LSD (lysergic acid diethylamide) and psilocybin mushrooms], khat and synthetic marijuana ("K2" and "Spice"). 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 drug's availability as '7' 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 Ecstasy cases it processes had remained the same during the previous six months. The crime lab also reported that Ecstasy tablets usually contained multiple active substances, including 5-MeO-DiPT (foxy methoxy), BZP, MDM, MDMA, P-FPP, TFMPP, caffeine, ketamine and

methamphetamine. Participants reported that the price of an Ecstasy tablet depended on the strength: a "single stack" (low dose) tablet sold for between \$10-15; a "double stack" or "triple stack" (high dose) tablet sold for between \$15-16. Participants and narcotics officers continued to describe typical users of Ecstasy as young club goers or drug dealers. The BCI London Crime Lab reported that the number of hallucinogen (both LSD and psilocybin mushroom) cases it processed had remained the same during the previous six months. Participants and treatment providers mentioned that synthetic marijuana could be purchased from head shops and gas stations. Both participants and treatment providers in Fairfield County described synthetic marijuana as increasing in availability; however, only a few participants reported that they had actually tried the drug. According to participants, the primary benefit of smoking synthetic marijuana was that the drug was not detected in standardized drug screens. There were several media reports of law enforcement seizures of khat over the reporting period. Khat, a drug unique to the Columbus region that is typically used by the Somali community, is a flowering plant native to the Arabian Peninsula and Northeast Africa that contains cathinone, an amphetamine-like stimulant. While no participants actively used the drug, the BCI London Crime Lab reported that khat was processed in its lab during the previous 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: Ecstasy and synthetic marijuana. Ecstasy appears to be highly available in the region. The only participant who knew about Ecstasy 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). According to the participant, "Molly," the powdered form of the drug is available: *"I can get Molly. It's pretty good ... I can get it with one phone call."* Reportedly, a triple stack of Ecstasy sells for \$50. The BCI London Crime Lab reported the number of Ecstasy cases it processes has remained the same during the past six months; however, the lab noted an appreciable increase in cases containing the designer drug 5-MeO-DiPT (foxy methoxy).

Synthetic marijuana is also available in the region. Before the change in the drug's legal status 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 drug screens: *"I wanted to still smoke [something like] weed and pass the drug test. Now they test for it [synthetic marijuana]; The only reason dudes smoke*

that [synthetic marijuana] is that they was real big potheads and needed [to pass] a drug test or something." The BCI London Crime Lab reported the number of synthetic marijuana cases it processes has increased during the past six months. More recent data from the crime lab indicated that the five formally scheduled substances are almost never seen anymore; rather dozens of non-controlled structural analogs are taking their place. While LSD was not reported by any participants or treatment providers this reporting period, a media outlet in the region mentioned the drug. According to *NBC4* reporters, a man was indicted on two felony counts for possessing LSD and then dropping it into a woman's drink at a concert in Columbus (www.nbc4i.com, Dec. 5, 2011). The BCI London Crime Lab reported the number of LSD cases it processes has increased and the number of psilocybin cases it processes has decreased during the past six months.

Conclusion

Crack cocaine, heroin, marijuana, prescription opioids and sedative-hypnotics remain highly available in the Columbus region; decreases in availability during the past six months exist for methamphetamine and prescription opioids. Participants reported that methamphetamine is difficult to acquire and attributed the drug's decreased availability to law enforcement's efforts in cracking down on producers of methamphetamine. Media outlets reported on several methamphetamine arrests and seizures in the region during the reporting period. The BCI London Crime Lab reported that white powdered methamphetamine from personal labs is the most common form and that methamphetamine trafficked on the street is usually crystal methamphetamine. The lab also reported that the number of methamphetamine cases it processes has decreased during the past six months. While still highly available in the region, prescription opioids have decreased in availability according to participants and treatment providers. Both groups attributed the decline to closings of physicians' offices that would liberally prescribe these medication, and increased regulation at pharmacies. A treatment provider observed that the availability of prescription opioids has, *"slightly gone down ... heroin has increased and pills have decreased. The effects of law enforcement are showing up."* While many types of heroin are currently available in the region, black tar heroin continues to be most available. Respondents continued to attribute the continual high availability of heroin to the cost-effectiveness of the drug relative to prescription opioids: *"[Heroin] it's cheaper than pills, way cheaper ... [and] a quicker high."* According to the BCI London Crime Lab, heroin is, *"typically pretty pure."* Despite the recent change in legislation, bath salts and synthetic marijuana remain available in the region. Bath salts in particular remained of serious concern to most

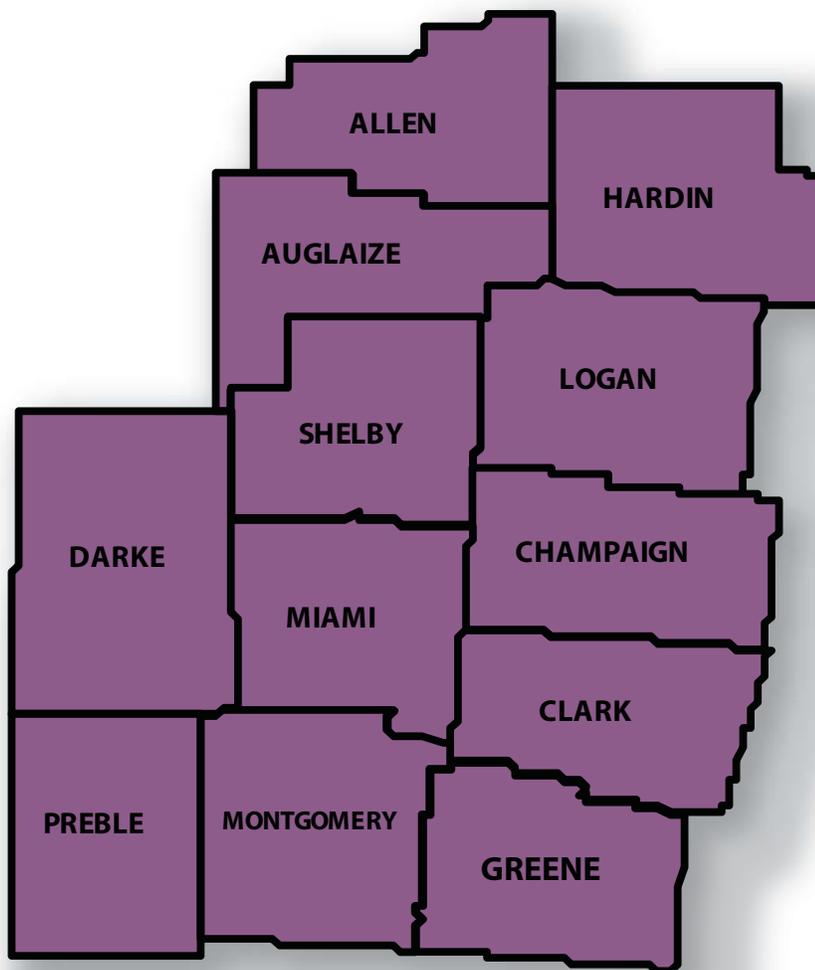
respondents due to the negative health consequences produced by their use. Participants reported having panic attacks and suicidal feelings while high on bath salts and treatment providers spoke about the extreme paranoia and symptoms of psychosis that accompany bath salts use. Many participants said they smoked synthetic marijuana because they thought it would allow them to test negative on drug screens. The BCI London Crime Lab reported that the number of synthetic marijuana cases and the number of bath salts cases it processes have increased during the past six months. In addition, the crime lab noted that since the ban on the sale of these synthetic substances went into effect in October 2011, the formally scheduled substances are almost never seen any more in samples, rather dozens of non-controlled structural analogs are appearing.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Dayton Region

June 2011-January 2012

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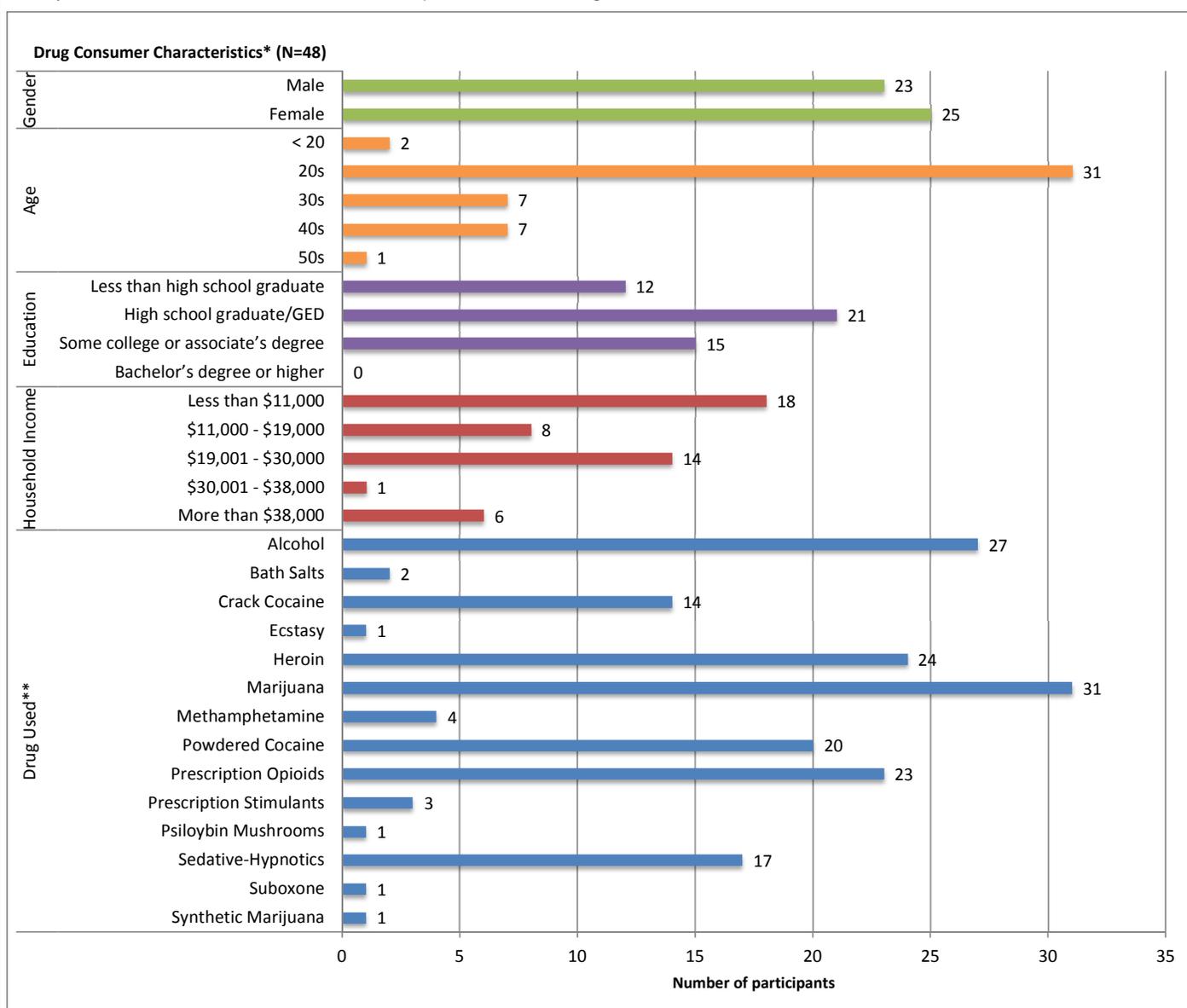
Dayton Regional Profile

Indicator ¹	Ohio	Dayton Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	1,352,510	48
Gender (Female), 2010	51.2%	51.2%	52.1%
Whites, 2010	81.1%	83.1%	85.4%
African Americans, 2010	12.0%	11.3%	14.6%
Hispanic or Latino Origin, 2010	3.1%	2.0%	0.0%
High school graduates, 2009-2010	84.3%	88.1%	75.0%
Median household income, 2010	\$45,151	\$45,115	\$11,000 - \$19,000 ²
Persons below poverty, 2010	15.8%	15.6%	59.6% ³

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

Respondents reported income by selecting a category that best represented their household's approximate income for 2011. Income status was unable to be determined for one respondent due to missing data.²

Poverty status was unable to be determined for one respondent due to missing or insufficient income data.³



*Not all participants filled out forms; therefore, numbers may not add to 48.

**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, Champaign, Logan, Miami, Montgomery and Shelby counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers, law enforcement, regional crime Lab and coroner's office staff) via individual and focus group interviews, as well as to data surveyed from the Miami Valley Regional Crime Lab and Montgomery County Juvenile Court. All secondary data are summary data of cases processed from January through June 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, 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 July through December 2011.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Many participants noted that in rural areas of the region more effort was required to obtain powdered cocaine. Law enforcement officers reported that powdered cocaine was readily available, but mostly as it related to the sale of crack cocaine. Participants reported that the availability of powdered cocaine had remained the same during the previous six months; although users and officers noted that heroin dealers were more likely to carry powdered cocaine than crack cocaine. There were two reasons cited for dealers to carry powdered cocaine: convenience for users who preferred to mix heroin with powdered cocaine (aka "speedball"), and since the quality of crack cocaine was reportedly so poor, some users preferred to obtain powdered cocaine to "rock up" (manufacture) their own crack cocaine. Most participants rated the quality of powdered cocaine as '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The Miami Valley Crime Lab continued to cite levamisole (livestock dewormer) as a cutting agent for powdered cocaine. Participants reported that a gram of powdered cocaine sold for between \$50-80, depending on quality. However, the most commonly purchased unit remained the "cap" (gelatin capsule prefilled with about 1/10 gram of powdered cocaine); caps sold for between \$10-12. Participants reported that the two most common ways to use

powdered cocaine were snorting and intravenous injection. Many users only consumed powdered cocaine when they used heroin to speedball. Participants continued to report that powdered cocaine use crossed all ages, races and socio-economic classes.

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'. Many participants commented that it would not take long to obtain powdered cocaine: *"An hour tops."* Participants in outlying areas reported that it may take longer for them to obtain powdered cocaine: *"In town [powdered cocaine] it's put on the backburner compared to some of the other drugs. Three to four phone calls [needed] to get a connection or to get a lead [on powdered cocaine for purchase]."* Community professionals most often reported the drug's current availability as '7'. A treatment provider reported, *"It's not that they [users] can't find it [powdered cocaine]; the need isn't there."* Media outlets in the region reported on powdered cocaine seizures and arrests this reporting period. In September, police found guns, cocaine, cash and drug paraphernalia inside a West Carrollton (Montgomery County) house (www.whiotv.com, Sept. 16, 2011). Also in September, a traffic stop in Preble County netted highway patrol two kilos of cocaine with a street value of \$200,000 (www.nbc4i.com, Sept. 29, 2011).

Participants reported that the availability of powdered cocaine has remained the same during the past six months. A powdered cocaine user reported, *"It [powdered cocaine availability] depends on if you have connections and middlemen. If you have connections, and you have credibility in the drug using community, you can get it faster and easier."* Community professionals reported that availability of powdered cocaine has decreased during the past six months. A treatment provider explained, *"When heroin took its big push and came back in, powdered cocaine slowed down a little bit, but especially among White people."* Law enforcement in an outlying area discussed a reduced focus on cocaine because of limited resources and a greater focus on heroin: *"With just two of us [law enforcement] working, your focus is just one area [one drug] at a time."* Treatment providers agreed that there is a reduced focus on cocaine: *"It [powdered cocaine] isn't as important as it used to be ... not in demand."* Heroin was identified as the substance that has reduced the demand for cocaine in the region. 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 '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '3.' Participants reported that powdered cocaine in Dayton is cut (adulterated) with baby laxatives, baby Tylenol®, creatine, ether, isotol, mouth numbing agents and Similac®. Mouth numbing agents are used by sellers to make the buyers think that the powdered cocaine is a higher quality. When a buyer puts powdered cocaine on his or her tongue, he or she expects higher quality cocaine to have a numbing effect. Participants reported that the quality of powdered cocaine has varied throughout the region. Participants closer to Dayton reported better quality, while those in more rural areas reported that powdered cocaine is cut more. When discussing quality of powdered cocaine, a user in the City of Dayton noted: "Stuff gotten has been good. [Powdered cocaine] it's gotten better in the past six months, clear and draws up good." Another participant in an outlying area observed: "[Powdered cocaine] it's being cut more because people aren't buying it as much." The Miami Valley Crime Lab continues to cite levamisole (livestock dewormer) as a common cutting agent for powdered cocaine.

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: "coke," "Christina Aguilera," "Lindsay Lohan," "powder," "white b****," "white girl" and "ya-yo." Current 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," sells for \$10; a gram sells for between \$30-95; 1/16 ounce, or "teener," sells for between \$50-100; 1/8 ounce, or "eight ball," sells for between \$110-300. Reportedly, the most common unit of purchase for powdered cocaine is by the gram, with a participant noting, "It's more common for teeners if you don't have as much money [to buy an eight ball of powdered cocaine]." Individuals in outlying areas reported higher prices. A participant reported, "People will buy [powdered cocaine at higher prices] when they feel like they can't go anywhere else." Participants continued to report that the most common ways to use powdered cocaine are snorting and intravenous injection. Snorting and injecting as routes of administration are reportedly about equal in occurrence among users, with participants reporting that roughly 10 percent of users obtain powdered cocaine for smoking. Participants continued to report that use varies depending on personal preferences. A participant stated, "Some people don't like needles."

A profile for a typical powdered cocaine user did not emerge from the data. Participants continued to describe typical users of powdered cocaine as younger and older, Black and White, and of different professions. A participant commented,

"I think everyone in this town wants to get high on coke. It's a party drug around here." Powdered cocaine was reported to have an elite status, with participants and community professionals identifying those in higher socio-economic classes as more likely to use powdered cocaine: "It [powdered cocaine] doesn't have the stigma that crack [cocaine] does." Treatment providers and law enforcement identified users of powdered cocaine as more likely White individuals in a higher socio-economic class. Participants reported that younger people (16-30 years) are getting into powdered cocaine, with 14 years reported as the youngest known user age among participants. A participant commented, "[Powdered cocaine] it's less [popular] than 10 years ago. You don't hear it that much when you talk to people. A whole lot of people got locked up. The younger generation, kids, are messing around with the hardcore drugs more than the actual adults; 17-23 [years] is a typical age of a lot of the [powdered cocaine] use." Community professionals agreed that the use of powdered cocaine is increasing in the 18-25 year age group. The Miami Valley Regional Crime Lab Coroner's Office identified cocaine as the fourth leading cause of death by overdose; however, it must be noted that the lab cannot differentiate between powdered cocaine and crack cocaine in toxicology reports. Deaths are mostly of males, and the common age range for overdose by cocaine is 35-50 years. In discussing the age range, the coroner's office reported, "Cocaine is a funny drug in that you can use it forever, but it takes such a toll on your heart . . . it won't actually kill you until you are older and have more heart issues."

Reportedly, powdered cocaine is used in combination with alcohol, heroin (speedball), marijuana and sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants). Most participants reported use of other substances with powdered cocaine to "come back down" from the stimulant high produced by cocaine. Participants reported: "More people are using pills [sedative-hypnotics] or heroin to come back down [from powdered cocaine]; I prefer to do my uppers and then downers." A participant highlighted the practice of speedball: "If you have the money to do both [powdered cocaine and heroin], you'll do both for the buzz."

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). Participants noted that drug dealers were switching from crack cocaine to heroin sales. Law enforcement and treatment providers agreed that crack cocaine was highly available in both urban and rural areas. However, due to the explosion of other drugs such as heroin and prescription opioids, community professionals felt that resources had been

shifted away somewhat from crack cocaine to the abuse-related problems of other substances. Most participants and community professionals reported that the availability of crack cocaine remained the same during the previous six months. The most common participant quality score for crack cocaine was '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut with other substances. The Miami Valley Regional Crime Lab cited levamisole (livestock dewormer) and phenacetin (analgesic) as cutting agents. Participants reported that a gram of crack cocaine sold for \$50, depending on quality. The majority of crack cocaine users reported buying the drug in small quantities called "dimes" (1/10 gram) for \$10. Most participants who used crack cocaine reported smoking it. Participants said that crack cocaine use crossed all ages, races and socio-economic classes.

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'. Most participants agreed that crack cocaine is more available than powdered cocaine. Participants often said things like, "I can make two calls right now, and I could have as much crack [cocaine] as we wanted." Some areas within the region identified that it is easier to get crack cocaine than heroin. Community professionals most often reported the drug's current availability as '10'. A treatment provider commented that there is, "more crack than powder [cocaine]." Participants reported that the availability of crack cocaine has remained the same during the past six months, and they believed crack cocaine has always been pretty available, but other drugs currently might be more popular. As one participant said, "We've always been known for crack." Community professionals reported that availability of crack cocaine has remained the same during the past six months. Although it was reported that the availability of crack cocaine has stayed consistent, a community professional stated, "More White users are going from powdered [cocaine] to heroin and Black users are staying with crack." Generally, community professionals thought this trend was common. 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 '7' 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 Dayton is cut with baking soda. Most participants reported that the quality of crack cocaine has remained the same during the past six months. The Miami

Valley Regional Crime Lab reported that crack cocaine continues to be cut most often with levamisole (livestock dewormer).

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: "butter," "stones" and "work." Current street prices for crack cocaine were consistent among participants with experience buying crack cocaine. Participants reported that a "rock" (1/10 gram) sells for between \$10-20; a gram sells for between \$100-120, depending on the quality; 1/8 ounce sells for between \$85-200. Participants across the region had different opinions about whether scales are typically used to weigh the product. Some participants reported, "You don't see it [crack cocaine weighed] on scales; it's not a sit-down type of deal." Others reported, "They weigh it [crack cocaine] in Bellefontaine and make sure it's on point." A participant discussed the variable size of crack cocaine: "It [size of crack cocaine] depended on how much money I had and how generous the dope man wanted to be. If I went with \$20 twice in a day, earlier in the day I might get a big 20 [rock] and the next time might be tiny." While there were a few reported ways of administering crack cocaine, the most common route of administration remains smoking. Participants reported that between 99-100 percent of users smoke crack cocaine, with a minority choosing to intravenously inject the drug. A participant commented, "I know people that will shoot it [crack cocaine]; they mix it with vinegar, but it's not common."

A profile of a typical user of crack cocaine did not emerge from the data. Most participants described typical users of crack cocaine as belonging to each gender and every racial and age group. However, a participant claimed to see women using more: "It's easier for them [women] to get [crack cocaine]. The ones I've seen [will] do anything to get the substance." Participants said that even those you would not expect to use crack cocaine, use the drug. In the experience of one participant, "My aunt chooses to sell her food stamps and cash assistance for crack." Professionals agreed that younger people are being introduced to crack cocaine earlier than in previous times. However, another community professional discussed an increase in the older age groups starting to use crack: "There does seem to be another population I've been noticing recently ... like the 45 year old that starts using crack after a long career of drinking or other things ... it's not that they've been using crack the whole time, but they've just picked it up in the past five to 10 years."

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana and sedative-hypnotics. Users reported that combining drugs with crack cocaine helps to, "take the edge off" and that it, "helps you not bite down so hard" in reference to the side effects of crack cocaine. Two

participants described crack as a drug used mainly by itself, with some agreement from other participants: *“Crack is crack ... it’s a solo drug; Once you’re smoking crack, you’re done.”*

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). Participants noted an emerging trend among dealers and their users of switching from crack cocaine to heroin. Dealers were said to be aggressively pushing heroin, often giving away testers (free samples). While many types of heroin were available in the region, participants reported brown powdered heroin as the most available, and most commonly obtained in caps (gelatin capsules prefilled with about 1/10 gram of powdered heroin) that sold for \$10 each. In addition to being widely available in the region, heroin was also identified as the region’s most urgent substance abuse problem by participants, law enforcement and treatment providers, all of whom reported an increase in heroin availability during the previous six months. Most participants rated the quality of brown powdered heroin as ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). According to the Miami Valley Regional Crime Lab, cutting agents for heroin continued to include diphenhydramine (antihistamine) and caffeine. Participants continued to report that the most common way to use heroin was intravenous injection. Law enforcement and treatment providers identified typical heroin users as, *“lower income, late 20s and White.”* Participants continued to note progression from prescription opioids to heroin. Participants also continued to recognize that new users were younger than previously and lacked knowledge about the drug.

Current Trends

Heroin remains highly available in the region. Participants most often reported current 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.’ While many types of heroin are currently available in the region, participants reported the availability of brown powdered and black tar heroin as most available. Participants most commonly described brown powdered heroin as a little lighter in color than brown sugar, white powdered heroin as off-white,



and black tar heroin as similar in appearance to the residue from a marijuana pipe. The Miami Valley Regional Crime Lab described the powdered heroin cases they process as white, off-white, tan and brown. Heroin type and availability varies throughout the region. The City of Dayton reported more brown powdered heroin; Lima (Allen County) reported more white powdered heroin; and smaller cities in Hardin, Logan and Shelby counties reported more black tar heroin. Participants in outlying areas reported, *“Tar [black tar heroin] is very available. I don’t have to make phone calls, dealers are calling me.”* Participants all agreed that heroin generally is, *“falling out of the sky.”* Community professionals most often reported the drug’s current availability also as ‘10,’ the previous most common score was ‘9’ or ‘10.’ A treatment provider observed that dealers are pushing heroin more: *“Dealers are actually marketing heroin by providing free samples to people who come to buy other drugs.”* Law enforcement discussed, *“If you go to buy prescription drugs from a drug trafficker, an illicit drug trafficker, they will actually give you one or two caps of heroin to try. Once you get your person hooked, they’ll come back, and they’ll bring more people with them.”* A participant remarked, *“[Dealers] know that once they [heroin dealers] get someone hooked, they’ve got their bread and butter every day.”* Media outlets in the region reported on heroin seizures and arrests this reporting period. In an August drug raid on a Dayton home, police found a stolen police-issued firearm, more than \$16,000 in cash and enough heroin to produce nearly 1,000 gel caps for sale to, *“geeks, White heroin addicts — and other dealers;”* police estimated the street value of the seized heroin at \$10,000 (www.daytondailynews.com, Aug. 5, 2011). Another drug bust in Dayton in September led to the arrest of at least one person; police reportedly seized an unspecified amount of heroin along with several guns (www.whiotv.com, Sept. 7, 2011).

Participants reported that the availability of powdered and black tar heroin has increased during the past six months. A participant linked the increase in heroin availability to the formulation change in OxyContin® that occurred in September 2010. Other participants discussed how heroin is cheaper than prescription opioids: *“I was doing pills [prescription opioids], and they got too expensive ... [with heroin I] got a longer high for half the money.”* Another participant remarked, *“It’s [heroin] cheap ... most of the time it’s good [quality].”* And still another participant discussed the economic climate and heroin use, *“Jobs have went down and a lot of people have gotten fired and going to selling dope. Also people losing jobs tend to gravitate to using drugs. Drug use goes up when unemployment goes up.”* Heroin was noted as being prevalent in the 18-25 year age group. Community professionals also reported that availability of heroin has increased during the past six months. A law enforcement officer in Dayton discussed that the increase is, *“not only in the*

heroin but in the violence that goes with the heroin." The officer observed, "Before you kinda had to know a [heroin] dealer, and now you can just drive up to a gas station, and you'll be directed to a dealer eventually." While heroin availability has increased in Dayton, participants and law enforcement reported that availability has decreased in some rural areas of the region during the past six months. A few participants in outlying areas reported that heroin availability has decreased because, "They've [law enforcement] been cracking down on it [heroin trafficking]; The availability coming from big cities has gone down." Law enforcement in outlying areas concurred with participant reports in that they too have noted a reduced amount of heroin as a result of their efforts to focus on heroin in the community, targeting heroin trafficked from Dayton. The Miami Valley Regional Crime Lab reported that the number of heroin cases it processes has increased during the past six months.

Most participants generally rated the quality of heroin as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was also '8'. Participants reported that the quality of heroin has decreased during the past six months. In reference to quality, a heroin user reflected, "[Heroin] quality is worse. [Dealers] stomp [adulterate] on it [heroin] and cut it more; Everyone that loves and likes heroin will say, 'I wish it was better.' Of course you're going to say the heroin sucks because you always want it to improve if you're addicted." Another participant noted, "[Dealers] know that you're dope sick, so you'll pay for it [heroin], no matter what [quality]." Participants reported that they were uncertain with what heroin is being cut. According to the Miami Valley Regional Crime Lab, cutting agents for heroin continue to include: caffeine, diphenhydramine (antihistamine) and lidocaine (local anesthetic).

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: "berries," "brown," "caps," "Charlie Brown," "dope" and "goat." Participants reported that brown and white powdered heroin are available in different quantities: "balloons" (1/10 gram) sell for \$25; a gram of heroin sells for between \$65-200. The most common way to purchase powdered heroin is by caps. The Miami Valley Regional Crime Lab reported that the most common form that they analyze is caps, but on occasion, they will see foil packets of heroin. A participant commented, "It's rare to buy grams or chunks [of heroin]." Caps sell for \$10-20, depending on location, with some participants reporting that some dealers sell three to four caps for \$20. Those who live further from Dayton or other larger cities pay more for the product

because the dealer is, "saving them a trip down and gas." The price for heroin in outlying areas is typically \$20 per cap while the price in Dayton is typically \$10 per cap. Participants reported that black tar heroin is most commonly purchased in single use amounts, or as one participant identified, "berries," that range from \$15-30. Overall, participants reported heroin pricing has increased during the past six months. Participants also reported that the most common way to use heroin remains intravenous injection. Out of 10 heroin users, participants reported that approximately nine would inject and one would snort. Most people identified injecting as popular because of the intensified effects: "I started out snorting it [heroin] for a month then someone said, 'You are wasting your money,' so I finally built up the courage to shoot [inject] it for the first time." Another participant identified, "Once you shoot it [heroin], you don't go back to snorting. The needles are addictive." On the progression from snorting to injection, a heroin user commented, "[Heroin users] they're gonna graduate to using the needle eventually." Another participant added, "If I see somebody snorting it [heroin], I'm like, 'man you're wasting it' ... especially if you don't have money."

According to participants with injection experience, 10 packs of needles are available for \$2 from popular retailers or are available from diabetics for \$5 a needle. Most participants reported that needles are usually purchased in 100 packs for \$20 from popular retailers. Participants also reported that dealers sell needles but are more likely to charge a higher price. When discussing needle use, some participants reported that they never used dirty needles, and others shared that they would use anything if they were "dope sick enough." A participant explained, "I never shared a needle, but I have sold my dirty needles to someone that is fiending [withdrawing from heroin]." Others remarked, "I've used [needles] after people. I cleaned them out with rubbing alcohol if I had it with me ... if not ... I'd rinse it out with water; I know lots of people that have shared needles. When you're using, you just want to get it [heroin] into your system, that's all that matters." Other participants would share needles if they knew the person; a participant stated, "I'd share [needles] with my boyfriend. If not [my boyfriend's needle], then I'd clean them out with bleach or burn the tips." Participants also reported increased difficulty in obtaining needles from certain pharmacies because of new store policies requiring them to show a prescription for needles. A participant remarked, "It's not against the law to buy needles. If you go to [the pharmacy], most of the time it's a store policy. They won't sell them to you if you don't have a prescription in their system for being a diabetic." This has caused some participants to reuse needles as a participant discussed, "I used the same one [needle] over and over because I was too embarrassed [to purchase needles

at a pharmacy]. I used three rigs like 50 times each because I was too embarrassed." Most participants identified that clean needles should be available because of the current heroin epidemic. A participant discussed the need for a needle exchange program in Dayton. Treatment providers discussed needle use among clients: Hepatitis and MRSA (Methicillin-Resistant Staphylococcus Aureus: a type of staph bacteria) cases are thought to be increasing. A treatment provider remarked, "Heard they [users] still share needles. They keep their needles; use the same needle over and over again." Participants admitted that they were not concerned about Hepatitis when actively using. One participant said, "At the time while I was using, no. After I got clean, it [needle sharing] scared me." Most participants reported an increased concern about contracting Hepatitis C and other blood-borne diseases. A participant explained, "I have Hepatitis C and a lot of people have Hepatitis. And, if people could get needles, we wouldn't have the problem [of Hepatitis infection]."

A profile of a typical user of heroin did not emerge from the data. Participants described typical users of heroin as any age: "Those you wouldn't think, would use it [heroin]. I've seen a 70-year-old man eat some Xanax® and do shots of dope [heroin]. I think the youngest person I've seen was probably a 15-year-old boy." Participants and community professionals agreed that there has been an increase in younger users of heroin, and both groups linked the increase in heroin use to prescription medications and prescribing patterns. A participant discussed the increase in younger users of heroin, "I have a 17-year-old cousin that's selling her body, shooting dope in her arm just to get high. When I was 17, I would never think of that. I'm 26, and I still don't like needles." Other participants remarked, "These younger generations will try anything. We weren't taught to try anything. Nowadays they don't care; There is a lot more prostitutes, and you see more needles at parks. In the past year, where I lived at ... I've lived there for five years ... in the past year, I can't even take my kids up to the park on the corner. There's so many needles and crack pipes and dirty condoms. It's disgusting." A treatment provider described typical heroin users as, "20-25, young, suburban, White folk." A treatment provider linked the use of heroin in younger users with prescription drugs: "They can get an introduction to prescription medications first before the street medications, and that can happen at home ... as 10 or 11 years old getting into the medicine cabinet." A law enforcement officer also highlighted the existence of a link between prescription opioids and heroin: "Especially now with the economic times we are in, a lot of these people are out of jobs ... they get depressed and start on prescription drugs for many different reasons, whether it be for depression, or they get on pain killers to numb the pain, so to speak. Then they'll be turned onto heroin because the word on the street gets around really quick. Sell your prescriptions and make money. You can use one

or two caps [of heroin] a day to do the same thing." Coroner's office staff reported that heroin is the leading cause of death by overdose and that heroin related overdoses have increased in the region. Of the heroin-related deaths there were more males identified with ages ranging from 20-60 years, with most between 30-40 years of age. Participants reported knowing people who have died from overdose, with one stating, "I lost a lot of people to heroin."

Reportedly, heroin is used in combination with cocaine (speedball), marijuana, prescription opioids and sedative-hypnotics. The Coroner's office reported that it is typical for heroin overdose cases to include a mixture of heroin with alcohol, cocaine, methadone or sedative-hypnotics. Participants reported that it is typical to mix other substances with heroin to intensify the effects, make the "rush" (high) last longer or to get a different effect: "Heroin will get you high the first time you get high that day, but with coke, every time you get the same rush." A participant discussed heroin use with sedative-hypnotics, "Benzo's [benzodiazepines] ... for some reason, those two [heroin and benzodiazepines] complement each other. One kicks the other one in." Another participant reflected, "[I] know a lot [of users] that use Xanax® with heroin, and a lot have OD'd [overdosed] because of it." Another participant commented on past use, "Back then my morning started with a shot of dope and a joint [marijuana], now it starts with a cup of coffee and a cigarette."

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported street 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 noted that prescription opioids were easily obtained from one of many known contacts, usually within a single phone call, and occasionally available from an unknown street-level dealer. Participants, law enforcement and treatment providers identified the most popular prescription opioids in terms of widespread use as methadone, Percocet® and Vicodin®. Only OxyContin® OC was reported to have decreased in availability in previous months. Opana® continued to be cited as gaining in popularity among users. While participants continued to report friends, family and other drug users as sources for prescription opioids, the most commonly reported source for these drugs remained through doctor visits. 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 remained oral ingestion and snorting. Participants and community professionals described typical users of

prescription opioids as White, lower income and young. A participant described prescription opioid abusers as, “future heroin users,” noting the pill-to-heroin abuse progression.

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 methadone, Percocet® and Vicodin®, along with OxyContin® and Roxicet®, as the most popular prescription opioids in terms of widespread use. Community professionals most often reported current availability as ‘10,’ and identified methadone, OxyContin® and Vicodin® as the most popular prescription opioids. Coroner’s office staff reported that methadone is the second leading drug in drug-overdose deaths (after heroin). Ages for methadone overdose ranged from 19-58 years. In addition, of those 18 years of age and younger, the majority of deaths by overdose were related to methadone. A participant discussed, “A lot of people start eating methadone and then go to heroin.” Another participant commented, “[Doctors] just actually gives them [users] free drugs at the methadone clinic.” A treatment provider commented about the increase in methadone use and availability: “If you’re a heroin addict, you blink your eye, and they’ll give you methadone.” Media outlets in the region reported on several crimes involving prescription opioids during this reporting period. In September, a Clark County Sheriff’s Deputy resigned from the sheriff’s department after her arrest for purchasing 60 Vicodin® pills from an undercover officer (www.whiotv.com, Sept. 16, 2011). In October, a Dayton doctor surrendered his medical license after federal, state and local law enforcement raided his offices in a pill-mill investigation (www.daytondailynews.com, Oct. 4, 2011). A West Carrollton (Montgomery County) man was arrested after robbing a Walgreens pharmacy, reportedly out of frustration from the repeated rejection of his requests for painkillers (www.daytondailynews.com, Oct. 13, 2011).

While participants reported that the availability of prescription opioids has decreased over the past six months, reportedly, the region experienced an increase in availability of methadone: “You can get methadone anywhere, just walk up to just about any house.” Participants attributed the perceived decrease in availability of prescription opioids to the rise in popularity of heroin. A participant reported, “Everyone I used to buy my pills [prescription opioids] off of got caught selling them or went to heroin.” Other participants commented on

the switch to heroin: “Your tolerance gets so high. You get tired of eating 30 Vicodin® HP’s a day and go to heroin; Vicodin® is weak compared to heroin.” Some participants in Dayton felt that doctors have cut back on prescribing: “Don’t see pills [prescription opioids] as much as used to ... increased monitoring of doctors, they are less available. However, a participant reported, “If I go to the hospital ... I can go right now ‘cause I just had a baby three months ago and pretend like I am in pain, and I bet you I get a script [prescription]. I can go get a script right now, and my baby’s three months. They’ll say, ‘hi, how’s your pain tolerance?’ And, ‘oh, I’m at a 10 ... I’m gonna pass out’ ... and there’s a script [prescription for an opioid] in two seconds.” Participants in outlying areas reported no change in availability: “We have a lot of family doctors, old school family doctors. I don’t think they are oblivious [to prescription opioid abuse], I just think that they don’t care.” Community professionals reported that availability of prescription opioids has remained the same during the past six months. However, they also reported that Vicodin® has always been easy to obtain, and methadone and Opana® are increasing. Coroner’s office counts prescriptions (they collect pill bottles of the deceased to aid in determining cause of death), and they are finding that, “Not only do people have multiple pain medications, but they also get an exorbitant amount for one prescription; We had a prescription bottle and somebody had been prescribed 80, 80 mg of oxy [OxyContin®].” A community professional identified a personal experience: “Just from having a C-Section [Caesarean Section], I was prescribed 50 Percocet®.” The Miami Valley Regional Crime Lab reported that the number of prescription opioid cases it processes has remained generally the same during the past six months; noted exceptions were a decrease in oxycodone hydrochloride (OxyContin®) and increase in oxycodone hydrochloride and acetaminophen (Percocet®, Percodan®), and hydrocodone and acetaminophen (Lortab®, Norco®, Vicodin®).

Reportedly, many different types of prescription opioids (aka “candy,” “ills,” “pills” and “poppers”) 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): Dialudid® 2 mg (sells for between \$3-4), methadone (sells for \$5 per pill), Opana® 40 mg (aka “panner;” sells for \$50), OxyContin® (aka “OC’s,” “Orange County” and “oxy’s;” new formulation sells for between \$0.50-1 per milligram), Percocet® (aka “P’s” and “perc’s;” sells for between \$4-15, with a common amount of \$1 per milligram); Roxicet® 30 mg (aka “roxi’s;” sells for \$15), Vicodin® 500 mg (aka “V’s,” “vikes” and “Vikings;” sells for \$2-5, with users paying as much as \$5 if they don’t have connections or if the

dealer is trying to make more profit). Price is a deterrent to using prescription opioids as a participant stated, *"I'm telling ya, top dollar [for prescription opioids]. That's why I went to dope."* 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 oral ingestion and snorting. Snorting was identified as the most common way to use prescription opioids with the exception of methadone. A participant commented, *"Some people don't realize that you can shoot a pain pill."* Parachuting, where a pill is crushed up and placed into a tissue, was mentioned by one participant. The tissue and crushed pill is then swallowed. A treatment provider discussed, *"I don't think they are using the medications right these days. They eat them, that's what they call it. They don't take medication, they eat them."*

In addition to obtaining prescription opioids on the street from dealers, participants continued to also report getting them from doctors, clinics and family or friends. A participant discussed how dealers obtain prescription opioids: *"Most people f*** themselves up and go to the doctor, and they have people on the waiting list ready to buy half of them [prescription opioids]."* Another participant reported, *"A lot of people get large amounts [of prescription opioids] and don't take that much of them ... [they] make sure they get enough for what they need and sell the rest."*

A profile of a typical user of prescription opioids did not emerge from the data. Participants described typical users of prescription opioids as, *"anyone."* A participant discussed the common use of prescription opioids: *"Prescription pills are regulated, so people feel more comfortable using them. They know what strength ... what they are getting."* Participants and treatment providers identified increased use among youth: *"A lot of younger kids are starting to get into the pills [prescription opioids]."* A participant remarked, *"I know people where I live at, they sell their baby's clothes just for the pills. They won't do nothing else but pills, but they are literally addicted like it is a hard drug."* A treatment provider commented, *"I don't think kids understand [that] prescription medications are just as dangerous as heroin or cocaine."* Community professionals agreed that prescription opioid users are, *"across the board; of all walks of life."* However, a profile of a typical seller emerged from reports from law enforcement and treatment providers: older adults are more likely to sell their prescriptions. Law enforcement observed: *"Sellers age range is going to be a lot higher than that [typical user age]. We've bought it from 60- and 70-year-old people."* An officer reported, *"The older population needs the money and that is the quickest and easiest way for them to support themselves. They get the misconception because [prescription opioids] it's not a street drug that they won't get in as much trouble for it."* A treatment provider

discussed the older age range of sellers of prescription pills and commented, *"Elderly people, who through their fixed incomes can't make their money match their bills, found that selling medications is a way to get extra income."*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, cocaine or other stimulants, marijuana and sedative-hypnotics. Most participants discussed using other substances with prescription opioids: *"Hand in hand, a joint [marijuana] and a pill."* A participant remarked, *"It says right on the bottle [of prescription opioids] that alcohol may intensify the effect."* And another participant reported, *"I rarely took pills without drinking or smoking [marijuana] with them."* A prescription opioid user agreed, *"If I had it [another substance], then I'd use it with it [prescription opioid]. If not, I'd use it by itself."* The coroner's office reported, *"Most pharmaceutical cases are polydrug submissions."*

Suboxone®

Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported street availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants with some knowledge of Suboxone® reported that its availability had increased during the previous six months and that the drug sold for between \$10-15 for an 8 mg pill. Participants most often reported taking Suboxone® as indicated, sublingually [dissolving it under the tongue]; however, snorting and intravenous injection of Suboxone® were also noted. In addition to obtaining Suboxone® on the street from dealers, participants continued to report getting it from doctors, friends and pain management clinics. Participants described typical users of Suboxone® as both people who wanted to address their heroin addiction and those who sought heroin but couldn't find any. A treatment provider noted that the demand for treatment was high among heroin users: *"We could have a doctor here prescribing Suboxone® full time, but there's no funding for that. There's demand for a full-service Suboxone® clinic ..."*

Current Trends

Suboxone® is moderately available in the region. Participants most often reported the current street 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 '10'. Some participants had never seen or heard of Suboxone®. A participant familiar with Suboxone® reported, *"More people are getting prescriptions for Suboxone® to sell to get money for heroin."* Other participants

discussed, “[Heroin users] only use it [Suboxone®] when they don’t have enough money for heroin; That’s what they use when they can’t find heroin.” Community professionals most often reported the drug’s current availability as ‘3.’ Treatment providers identified Suboxone® as not easy to obtain. A participant reported, “[Suboxone®] it is a very expensive drug versus methadone that they use for treatment. You’d have to have insurance. People that don’t have insurance, you’ll pay out the yin-yang.” Another participant noted the benefits of Suboxone®, “My perspective, I call it [Suboxone®] a wonder drug. It gives you energy, it cuts the withdrawals, it doesn’t make you nod out like the methadone.” Another participant commented, “They should offer Suboxone® like they offer methadone. It’s more safe. It’s got methadone beaten in all areas.” A treatment provider reported, “I don’t have any clients abusing it [Suboxone®], but I have a couple of clients who are on it.” Another treatment provider stated, “They [users] are really trying to wean themselves off methadone and the opiate use. They are really using it [Suboxone®] to better themselves.” Most treatment providers identified Suboxone® as being used as directed and for, “serious recovery.” Community professionals reported that availability of Suboxone® has remained the same during the past six months. 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®. The most common form of Suboxone® is an 8 mg pill or strip. Participants reported that Suboxone® 8 mg sells for between \$10-20 from dealers; however, “You can pay \$100 at treatment centers in Dayton and obtain enough [Suboxone®] for a month.” A participant reported, “I sold mine [Suboxone®] for \$5.” Most often participants continued to report taking Suboxone® sublingually. A participant commented, “I tried shooting it [Suboxone®], but it didn’t do anything, so I never did it again.”

In addition to obtaining Suboxone® on the street from dealers, participants also reported getting the drug from the pharmacy with a prescription or through a clinic: “I was prescribed [Suboxone®]; I never tried to buy it.” Another participant highlighted, “More people are getting prescriptions for Suboxone® to sell to get money for heroin.” Participants thought Suboxone® strips to be more widely available than the pill form.

Participants described typical users of Suboxone® as, “people who really need to use it [Suboxone®], or those who want to sell it to buy heroin.” Reportedly, Suboxone® is used in combination with alcohol, marijuana and sedative-hypnotics. Most participants were clear that they would not use opiates with Suboxone® and would not use other substances to intensify Suboxone® because, “[Suboxone®] just keeps you from being dope sick.” However, a participant commented that use

of sedative-hypnotics with Suboxone® produces a high: “It’s a really good high.”

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 and community professionals identified the most popular sedative-hypnotics in terms of widespread use as Ativan®, Klonopin® and Xanax®. Participants and treatment providers reported that the availability of sedative-hypnotics had remained the same during the previous six months. In addition to obtaining sedative-hypnotics on the street from dealers, participants most often reported obtaining these drugs from physicians’ offices, but they also obtained the drugs from family and friends when physicians were unavailable or unwilling to prescribe the medications. The most common route of administration was oral ingestion, followed distantly by snorting. Participants described typical users of sedative-hypnotics as opioid users who were generally 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 and community professionals identified Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. A participant explained, “A lot of doctors are prescribing them [sedative-hypnotics] now.” Another participant discussed the popularity of Xanax®, “If I took Xanax®, and I loved the way it made me feel, and I [told] a thousand people, ‘oh my God, it will make you feel like a million bucks’ [then its popularity spreads through] word of mouth.” Community professionals most often reported the current availability of these drugs as ‘10.’ A treatment provider reported, “It’s easy to get [sedative-hypnotics]. It’s all over the place.” Participants reported that the availability of sedative-hypnotics has remained the same during the past six months with the exception of Klonopin® which has increased. Many participants said the increase in availability of Klonopin® is due to doctors moving to that particular drug. A treatment provider identified Xanax® as increasing because, “Doctors won’t stop prescribing it [Xanax®].” Community professionals

reported that the availability of sedative-hypnotics has remained the same during the past six months. The coroner's office reported sedative-hypnotics, specifically alprazolam (Xanax®), as the third leading cause of death by overdose. Reportedly, the most common ages for sedative-hypnotic overdose death ranged from 23-55 years. The Miami Valley Regional Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months with a few exceptions; Ambien® and Valium® have increased, and Ativan® and Xanax® have decreased.

Reportedly, many different types of sedative-hypnotics (aka "downers," "little meanies" and "stuff") 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); Soma 500 mg (sells for \$5); Xanax® 1 mg (aka "footballs" and "peaches;" sells for between \$1-3) and Xanax® 2 mg (aka "xanibars;" sells for between \$3-5); Overall participants reported that most sedative-hypnotics sell for between \$0.50-1 per milligram, with most pills selling for between \$2-6. Reportedly, cost also varies depending on from whom the pills are purchased and the buyer's relationship with the dealer. While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, the most common routes of administration are oral ingestion and snorting. Participants did not identify intravenous injection as a route of administration for these drugs. Different participants preferred different methods. Some participants commented that snorting, "burned too much." A participant stated, "If you want to get every bang for your dollar, you'll go through that pain [of snorting sedative-hypnotics]." Reportedly, methods of use change with age; according to one participant, "When I was younger, I snorted them [sedative-hypnotics] a lot. But when I got older, I started eating them."

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported getting them from doctors (psychiatrists) and area emergency rooms. A participant stated, "Act like you are stressed out and can't manage, and doctors prescribe them [sedative-hypnotics]. It's easy to fake a bunch of anxiety." A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants described typical users of sedative-hypnotics as, "anyone." Community professionals agreed that sedative-hypnotic abuse is, "across the board." Participants and community professionals reported Xanax® 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.

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, heroin, marijuana and other "downers" (depressant drugs). Participants reported that it is common to mix other substances with sedative-hypnotics. Alcohol, marijuana and other sedative-hypnotics are used to intensify the drug's effect. Sedative-hypnotics are also used to "come down" from "uppers" (stimulant drugs) like bath salts (synthetic compounds commonly containing methylenedioxymethamphetamine or MDPV), crack cocaine and powdered cocaine. Alcohol and marijuana are the most popular substances used in combination with sedative-hypnotics. Participants explained, "You don't have to drink as much [alcohol] to get drunk." Another participant commented, "If they are using pills [sedative-hypnotics], [then] they are probably smoking weed [marijuana]." Treatment providers discussed the popularity of sedative-hypnotics among young adults: "Xanax® is popular for the young ones [18-25 years] to use with alcohol."

Marijuana

Historical Summary

In the previous reporting period, marijuana 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). Participants and community professionals described marijuana as the most available drug in the region. Participants and law enforcement reported that the availability of marijuana had remained the same during the previous six months. Participants reported that the quality of marijuana varied, with the most common quality score continuing to be '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Law enforcement continued to report a gradual increase in the quality of marijuana during the previous six months. Participants reported that for commercial (low- to mid-grade) marijuana, an ounce sold for between \$90-140; for high-grade marijuana, a "blunt" (cigar) sold for between \$20-40, and an ounce sold for between \$200-400. While there were a few reported ways of consuming marijuana, the most common route of administration was smoking, followed distantly by using vaporizers. When asked to describe the typical user of marijuana, participants were unable to be specific. They reported that virtually everyone uses marijuana, including all ages, races and socio-economic groups.

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 frequently agreed, *"It's everywhere; You walk outside your door, and you're gonna smell somebody smoking [marijuana]."* Community professionals most often reported the drug's current availability as '10'. Treatment providers discussed availability as, *"Everybody is on it [marijuana] ... that's all we need to say; Actually, we'd think it's legal ... the way they smoke it."* Marijuana appears to be the drug of choice for regional juveniles involved in the court system. Of the 395 juveniles who tested positive for drugs in Montgomery County Juvenile Court from Jan. 1 through June 30, 2011, more than 79 percent tested positive for marijuana at some point in their court involvement.



Participants reported that the availability of marijuana has increased during the past six months, but most noted that different grades fluctuate with different seasons; participants identified that the higher grades are becoming more available because of, *"harvest season."* A participant reported an increase in high-grade marijuana: *"A lot more dro [hydroponically-grown marijuana], mid- to high- [quality] coming around. Call it, 'Christmas weed.'"* A participant explained, *"In Sydney [Shelby County], you usually have so much reggie [mid-grade marijuana], and you can't find nuggets [high-grade marijuana], or so many nuggets and you can't find reggie."* In a rural area a participant commented, *"It [marijuana] used to take a day [to get] but [now I] seem to get it sooner."* Community professionals reported that availability of marijuana has increased during the past six months. Law enforcement in a rural area reported a decrease in cases because they, *"Have put more focus toward the heroin and the pills with the dealers coming up from Dayton."* The Miami Valley Crime Lab saw a slight decrease because some users switched to synthetic marijuana ("Spice" and "K2") when they were legal because, *"labs couldn't test for it [synthetic marijuana]."* Law enforcement and treatment providers both discussed an increase in "grow houses" (indoor marijuana-growing operations); some community professionals felt this increase in grow houses coincided with the increased availability in their area: *"I think [availability of marijuana] it's more because they are growing it in their basements and attics or whatever. They do hydroponics now, so it's year-round. It's no longer seasonal; it's a year-round harvest."* Law enforcement also reported on marijuana coming into the country: *"Mexican ditchweed [low-grade marijuana] is shipped to different areas by UPS® or FedEx®. It comes every day*

through the mail, and they only catch one-tenth of one-tenth of what's coming through the mail." Media outlets across the region reported on several marijuana seizures during this reporting period. Montgomery County law enforcement seized 92 plants, worth an estimated \$500,000 (www.whiotv.com; Aug. 25, 2011). In another incident, Ohio State Highway Patrol Officers stopped a Washington state man in Springfield (Clark County) for a routine traffic violation and discovered 28 pounds of marijuana, valued at \$63,000 (www.morningjournal.com; Nov. 17, 2011). The Miami Valley Regional Crime Lab reported that the number of marijuana cases it processes has increased during the past six months.

Participant quality scores of marijuana varied from '3' to '10' with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Low-grade marijuana was typically rated as '3', mid-grade as '5', and high-grade as '10'; previously, both low- and high-grade marijuana were most often rated '10'. Several participants explained that the quality of marijuana depends on whether the user buys "commercial weed" (low- to mid-grade marijuana) or hydroponically grown (high-grade marijuana). High-grade marijuana was described as having crystals and smelling more potent. Participants also commented that high-grade marijuana usually has different colored hairs, does not have seeds, and is typically fluffy, spongy and sticky. Usually, participants thought the color of high-grade marijuana to be light green or sometimes purple. On the other hand, low- to mid-grade marijuana was thought to have more stems and ranged from brown to a mint green in color. Participants also mentioned the physiological effects from the different grades. Mid-grade marijuana was thought to give a, *"drowsy and tired feeling,"* while higher quality gives a, *"whole body buzz."* The hydroponically and homegrown grades were seen as the most desirable marijuana among participants.

Current street jargon includes countless names for marijuana. Participants listed the following as common street names: "ditchweed," "reggie" and "regular" for commercial-grade marijuana; "chronic," "dank," "green," "homegrown," "kush" and "purp" for high-grade marijuana; and "dro" or "hydro" for hydroponically-grown marijuana. The price of marijuana depends on the quality desired. Participants reported commercial-grade marijuana to be the cheapest form: a joint (cigarette) sells for between \$5-10; 1/8 ounce sells for between \$15-30; 1/4 ounce sells for between \$25-50; 1/2 ounce sells for \$50; an ounce sells for \$100; a pound sells for between \$500-700. Higher quality marijuana sells for significantly more: a blunt or two joints sells for between \$20-30; 1/8 ounce sells for between \$45-50; 1/4 ounce sells for \$150; a pound sells for up to \$5,000. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Smoking methods

were reported to change with age: *"From 16 to 21 [years], they [marijuana users] roll up a blunt. As you get older, you want to smoke a bowl [from a pipe]. When you smoke a blunt, you waste most of it."* A participant identified that people selling or trafficking large amounts of marijuana experiment more and make edible items including butter, cookies, brownie and THC (tetrahydrocannabinol) tea.

A profile for a typical marijuana user did not emerge from the data. Participants continued to describe typical users of marijuana as being of any age, race, occupation and socio-economic group. Typically, participants said the popularity of marijuana is so great that, *"People you wouldn't expect are smoking [marijuana]."* Participants said the age range of marijuana users is wide: *"Fourteen-year olds to 75-year-old women [use marijuana];"* and treatment professionals agreed, *"[Marijuana users are] Black, White, 20 or 80 [years old]."* Treatment providers also discussed younger users: *"They [marijuana users] are starting young, nine or 10 [years] on up."* A group of treatment providers mentioned a news article involving a six-year-old girl who took marijuana to school and was trying to smoke it in the bathroom. When questioned if youth are being asked to traffic drugs, law enforcement responded, *"Not trafficking. They [youth] are working for someone bigger than them, but they are going out and selling [drugs]. It's not a big operation, more small stuff."* Law enforcement reported that drug traffickers typically choose someone they can trust – a girlfriend or another individual with a valid driver's license that doesn't look suspicious – to traffic drugs. A treatment provider reflected on youth selling marijuana: *"They [youth] choose to do it [sell marijuana] because it's good money."*

Reportedly, marijuana is used in combination with alcohol, crack cocaine, Ecstasy (methylenedioxyamphetamines: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP), heroin, powdered cocaine and prescription opioids to intensify the effect of the other substance(s) or to reduce the side effects produced by the other substance(s). A participant discussed soaking marijuana in embalming fluid and called this practice, *"getting wet."* Most participants commented that it is rare to lace (add another substance, usually illegal) marijuana, citing that some people are, *"scared to; it makes it [marijuana] taste horrible."* A participant in a rural area identified that lacing, especially with powdered cocaine, is, *"More of an inner city type thing. Don't see people do this [lace marijuana] in smaller towns."* A participant in Dayton reported that sometimes dealers lace marijuana: *"Now with 'loud' [high-grade marijuana], people be putting stuff in it. I smoked some awhile back and dropped dirty [tested positive on a urine drug screen] for pills, heroin all types of stuff."* Another participant commented, *"If you ever smoke a blunt and get to itching it's laced."*

Methamphetamine

Historical Summary

In the previous reporting period, participants reported infrequent use of methamphetamine; however, those who reported use during the previous six months 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 was available in a home-cooked, powdered form. Treatment providers reported that methamphetamine use was relatively rare among their clientele. The Miami Valley Regional Crime Lab reported that the number of methamphetamine cases it processed had decreased during the previous six months. Participants reported the street price of methamphetamine as \$100 per gram. Participants, law enforcement and treatment providers believed cookers (manufacturers) and users of methamphetamine most often to be White and living in rural areas of the region.

Current Trends

Methamphetamine is 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); the previous most common score was '10' among those few participants with first-hand knowledge of the drug. Participants did not differentiate between the availability of powdered and crystal methamphetamine. Community professionals reported that methamphetamine is rarely seen in the region. A treatment provider explained, *"For a moment it [methamphetamine] kind of came, but didn't catch on in the city [Dayton]."* Participants reported that the availability of methamphetamine has remained the same during the past six months. Among participants, most agreed that methamphetamine is not a popular drug in the region. Participants continued to report that methamphetamine is only available to a limited number of users with good connections: *"Those people [methamphetamine users] keep a tight circle."* A participant talked about the regional availability of the drug, *"[Methamphetamine is available] closer to Indiana, [and popular with] more younger people."* Community professionals reported that availability of methamphetamine has decreased during the past six months. They reported that the decrease in methamphetamine can be linked to one major factor: *"With the emergence of one-pot cooks, it's [methamphetamine] harder to find [cooks now primarily produce methamphetamine for personal use only]."* The one-pot method refers to mixing methamphetamine ingredients in a two-liter bottle or mason jar that cooks can throw away when finished. Participants talked about the

ease of the one-pot method, *"They [one-pot cooks] don't use as many ingredients; it's more for personal use, quick and easy."* A treatment provider surmised methamphetamine users are not frequently seen in treatment because, *"They [methamphetamine users] are not functioning well, so they are not following through on anything. If they have a case manager, they probably do not know that person's name."* Treatment providers in Dayton observed that methamphetamine labs are located in rural areas: *"[Methamphetamine] it's transported from the country to city and sold."* Increased monitoring by local pharmacies is also credited with the reduction in methamphetamine use. Treatment providers discussed a *"checks and balance system"* where pharmacies swipe driver's licenses when pseudoephedrine (a main ingredient in the manufacture of methamphetamine) is purchased into a statewide database as having been an effective prevention method because it limits the amount of the medicine that one person can purchase. The Miami Valley Regional Crime Lab reported that the number of methamphetamine cases it processes has increased during the past six months.

Participants that had knowledge of the quality of methamphetamine most often rated current quality as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported variable quality: *"You can have good meth [methamphetamine] or stomped on meth."* Participants discussed how they thought methamphetamine was cut: *"Sometimes I'll get crack and it [methamphetamine] will be mixed in, and [I] won't know until I'm up for 24 hours. Not told that is what I'm buying; I heard they are making out that they are selling crack, but it's meth."* The Miami Valley Regional Crime Lab reported that they typically see powdered tan, brown and off-white methamphetamine along with crystal methamphetamine in their labs.

Current street jargon includes a few names for methamphetamine. The most commonly cited names were "glass" and "ice." A participant reported that a gram of methamphetamine sells for between \$100-200. Reportedly, the most common route of administration of methamphetamine is smoking, especially for first-time users. Other routes of administration were cited as less common, including intravenous injection. However, those with knowledge of methamphetamine use agreed that route of administration varies: *"[Methamphetamine use] it's all over [the board] and [really about] personal preference."*

A profile for a typical methamphetamine user did not emerge from the data; however, participants and treatment providers agreed that older people and those with prison experience are more likely to use the drug. A participant reported, *"The youngest [methamphetamine user] I know is 24 [years old]. It's not like the 14-year-old heroin addicts."* Another participant

discussed her experience in prison, *"A lot of people in jail, their drug choice is meth and heroin, especially women, a whole lot of women."* Another participant related, *"When I was in jail, they was saying how they got hooked on it [methamphetamine] from making it. They end up testing their own product and that's how they get hooked on it."* Treatment providers identified that it is rare for those younger than 18 years of age to use methamphetamine, and one provider reported, *"Younger people ... are scared of it [methamphetamine]. They might be willing to try crack, but somehow or another, they got it through their head that meth is dangerous."* In addition, a treatment provider in the Dayton area observed that 80-90 percent of women soliciting sex in the area were believed to be methamphetamine users. Reportedly, methamphetamine is used in combination with alcohol and marijuana. A participant reported, *"They [methamphetamine users] need weed and alcohol to come down and not tweak out and have a heart attack."*

Ecstasy

Historical Summary

In the previous reporting period, Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) was available in the region. The Miami Valley Regional Crime Lab reported that the number of Ecstasy cases it processed had decreased during the previous six months. Participants reported that a single tablet of Ecstasy sold for between \$3-20, with the price of a tablet depending on a variety of factors and volume discounts being common. The only reported method of administration was oral ingestion.

Current Trends

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) is moderately available in the region. Participants most often reported the current availability of Ecstasy as '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, participants reported availability but did not assign an availability score. Most participants reported that availability of Ecstasy is limited to certain social circles: *"You have to know the right people [to obtain Ecstasy]."* Community professionals agreed with participants and thought that club drugs like Ecstasy are only available to well-connected users: *"You gotta know somebody that knows somebody [to obtain Ecstasy]."* Participants reported that the availability of Ecstasy has remained the same over the past six months. However, participants reported that *"Molly,"* the purest form of Ecstasy, as increasingly sought and used, especially at outdoor music

festivals. Treatment providers reported that the availability of Ecstasy has decreased during the past six months. A treatment provider explained that Ecstasy is sought after but, “[Drug seekers] actually can’t get it. They like to club with Ecstasy, but you can’t find it. It’s not easy to make.” The Miami Valley Regional Crime Lab reported that the number of Ecstasy cases it processes has increased during the past six months.

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 depends on a variety of factors: the size of the tablet and the picture that is imprinted on it. Participants reported a “single stack” (low dose) of Ecstasy sells for between \$5-10; a “double stack” or “triple stack” (high dose) sells for between \$40-50.

A profile for a typical Ecstasy user did not emerge from the data. Participants described Ecstasy as a, “party drug” or “club drug,” and also discussed its popularity with college students. A participant mentioned an alarming trend with Ecstasy, “People tend to walk by and put [Ecstasy] in drinks, using it to drug people.” Treatment providers also commented on Ecstasy’s popularity among young people; they explained they see Ecstasy, “in the younger generation and in the college scene.”

Reportedly, Ecstasy is used in combination with alcohol, marijuana (aka “candy flipping”) and nitrous oxide. Use of alcohol with Ecstasy varies. A participant preferred using alcohol because, “I’d like to get drunk [and use Ecstasy] because I wouldn’t feel hung-over the next day.” When mixing marijuana with Ecstasy a participant described, “For me, I got a different buzz when I mixed the two [marijuana and Ecstasy] rather than doing it [Ecstasy] by itself.” A participant also explained that nitrous oxide is sometimes used with Ecstasy to intensify the experience and reported that a hit (one dosage unit) of nitrous oxide sells for between \$10-15. Reportedly, users usually travel to Indiana to purchase 20 pound bottles of nitrous oxide.

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants were available in the region. However, law enforcement, treatment providers and participants did not see this class of drug as an urgent problem. 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.

Current Trends

Prescription stimulants are rarely available in the region although rural areas reported more desirability and availability of these substances. Participants rated the availability of prescription stimulants 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. A participant explained, “I get them [prescription stimulants] every now and then. Last resort type s***.” Participants and community professionals reported that the availability of prescription stimulants has remained the same during the past six months. The Miami Valley Regional Crime Lab reported that the number of prescription stimulant cases it processes has remained the same during the past six months with few exceptions; medications based on methylphenidate HCL (Ritalin® and Concerta®) have increased in availability.

No slang terms or common street names were reported for prescription stimulants. The following prescription stimulants are available to the street-level users: Adderall® and Concerta®. Participants reported that most brands of prescription stimulants sell for between \$2-3 a pill depending on the milligram. Participants also reported getting these drugs from people who had been prescribed them.

Participants described typical users of prescription stimulants as younger individuals in high school or college. Participants reported, “Mostly just high school kids [abuse prescription stimulants]. Younger kids or college kids that don’t want to do coke [cocaine] to stay up all night will do Adderall®.” Another participant talked about students using the drug before exams: “[Prescription stimulants are] big among college students. For my cousin, it’s supposed to be a focus drug. A lot of college student like it for that ... speeds them up so they up all day. It’s a different high ... it’s not like coke ... energy booster that helps you concentrate at the same time. At exam time you can make a lot of money on college campuses [selling prescription stimulants].” Community professionals concurred with participants and also reported prescription stimulants as popular among a younger age group: “Those [prescription stimulants] are done by the young kids; I think the young kids will test out those pills.” However, the Coroner’s office reported that they often observe middle-aged women in court for prescription stimulant abuse. Coroner’s office staff guessed these women were using the drugs for energy in order to complete housework or related tasks. No substances were reported to be used in combination with prescription stimulants. Participants did not report seeking out other substance to use in combination with prescription stimulants; they felt the drugs are often bought and used for their intended effect.

Bath Salts

Historical Summary

In the previous reporting period, bath salts (synthetic compounds commonly containing methyldone, mephedrone or MDPV) were highly available. Participants most often reported the availability of these drugs as '10,' and treatment providers as '9,' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Bath salts were particularly deemed an urgent problem by participants and community professionals in the northern portion of the region; three of eight participants in one focus group were in treatment for bath salts abuse. The Miami Valley Regional Crime Lab reported that the number of bath salts cases it processes had increased during the previous six months. Pricing for sealed packages varied; one brand sold for \$22 while another brand sold for \$35 for the same amount of product. Bath salts were also available in bulk or loose form, usually from a store that sold drug paraphernalia. Participants and treatment providers described typical users as young (teens to mid-20s) suburban or rural dwellers, White, male and with some financial means.

Current Trends

Bath salts (synthetic compounds commonly containing methyldone, mephedrone or MDPV) are moderately available in the region. Participants rated the availability of bath salts 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 '10'. Bath salts have decreased in availability because of the law banning their sale that took effect in October 2011. However, participants still can easily obtain them: *"People knew it [bath salts] was going out, so people stocked up on it. In gas stations in town if you know the right one, they have it behind the counter. One had a guy come in and spend \$800 [on bath salts]."* Treatment providers also felt that bath salts are, *"still out there somewhere, but it's under the table."* Staff from the Miami Valley Regional Crime Lab reported bath salts are 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."* Of the cases involving death related to bath salts, suicide was a common cause of death in the 18-25 age group. As the Coroner explained, *"We have had a couple of kids ... several hangings, suicides associated with the use of bath salts. The younger people are the ones having the hangings, [the] 18-25*

age group." Older individuals were also identified as dying from the use of bath salts, but these deaths were not linked with suicide. 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 substance, *"more toxic in older people."*

Media outlets in the region reported on abuse of bath salts. In an article from the *Dayton Daily News*, professionals from the Designer Drug Task Force sponsored by Greater Dayton Area Hospital Association discussed consequences related to bath salts use. Professionals from the hospital association said, *"There have been more than 500 bath salts-related hospital cases in the association's 10-county region."* In the same news article, the Montgomery County Coroner's Office also provided data that said there, *"have been 12 fatalities ... [that] have occurred in the rural and suburban areas and less in the urban areas"* (www.daytondailynews.com; Oct. 18, 2011). *WDTN TV* discussed ways that manufacturers of bath salts are trying to circumvent the law to sell bath salts. The station interviewed staff from the Miami Valley Regional Crime Lab who explained some of the now-illegal bath salts are sold in the same package, with a sticker covering the old label and replacing it with a new label that reads "Glass Cleaner" or "De-melting Ice Agents" (www.wdtn.com; Dec. 19, 2011). Another news outlet reported on crime related to bath salts. According to the news article, a man who confessed to snorting bath salts led The Miami County law enforcement on a car chase with speeds up to 100 mph after police attempted to stop his car in Piqua (www.whiotv.com; Sept. 18, 2011). The Miami Valley Regional Crime Lab reported that the number of bath salt cases it processes has increased during the past six months.

Participants and community professionals agreed that typical bath salts users are White. While no one age group is believed to be more likely to abuse these drugs, younger individuals were identified as more likely to try them. Some participants still had not heard of bath salts: *"I didn't hear about them [bath salts] until I was already locked up."* Others did not use them personally but had friends that used them: *"Everyone that I've heard that's done it [bath salts] went crazy on it."* In fact, participants reported negative stories about the substances caused them to avoid bath salts use. No substances were reported to be used with bath salts as most respondents did not have first-hand experience with them.



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: anabolic steroids, hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], salvia divinorum and synthetic marijuana. Synthetic marijuana was highly available throughout the region. Participants frequently mentioned its rising popularity due to the belief that the drug delivered a marijuana-like high and could not be detected by urine drug screens. The Miami Valley Regional Crime Lab reported that the number of synthetic marijuana cases it processes had increased during the previous six months. Participants observed that synthetic marijuana was available for purchase at convenience stores and gas stations, costing \$5-10 per gram. Depending on the brand, the quality of synthetic marijuana ranged between '7' and '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The primary method of administration for this product was smoking, but vaporizers were also used to ingest the drug. Hallucinogens like psilocybin mushrooms and LSD (lysergic acid diethylamide) were somewhat available according to law enforcement and participants. The Miami Valley Regional Crime Lab reported that the number of LSD cases it processes had increased while the number of psilocybin mushroom cases it processes had decreased during the previous six months. Prescription stimulants were also available in the region. The Miami Valley Regional Crime Lab also reported several other drugs that were not mentioned by the focus groups, including an increase in the number of processed cases for salvia divinorum and anabolic steroids (methandrostenolone, stanozolol and testosterone).

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 are 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"). A participant talked about the availability of anabolic steroids at a local workout facility: "[I] just got out of jail and met someone in there [at my gym] who can get deca. He does cycles and shoots them. It's very expensive; the pills are \$100 a cycle which is about 30 days, and if you are shooting, it's about \$250-300. Shooting is once a week for a month." The Miami Valley Regional Crime lab staff talked about the source of steroids: "The big issue with steroids is that most of them come from Mexico, Russia or China, so they are not

regulated at all. The dosage amounts are probably not correct ... what drug is in it is probably not correct." Most steroids are found in liquid form, but there are some powdered steroids available as well. The most common routes of administration for anabolic steroids are oral ingestion and intravenous injection. Reportedly, users who prefer intravenous injection typically mix the drug with olive oil or sesame oil before injection. A profile for a typical anabolic steroid user emerged from the data. Staff at the Miami Valley Regional Crime Lab said that typical users are White and male: "The [anabolic steroid] users were all White, male. Females were arrested, but they were just selling, not using ... [age] ranged from mid-20s to mid-50s. Most of them had regular nine-to-five jobs ..." The Miami Valley Regional Crime Lab reported that the number of steroid cases it processes has increased during the past six months, and they mentioned that 14 different types of anabolic steroids were processed in their lab.

Alcohol remains highly available in the region. Alcohol was identified as a major substance of abuse by community professionals and participants for those aged 18-25 years. A treatment provider remarked, "They [young users] don't see anything wrong with that because [alcohol] it's legal." A participant discussed the frequency of alcohol use in the community, "Most everybody drinks [alcohol]. That's what you do on weekends, weekdays. [This is] a very alcohol town." Participants reported new trends with alcohol including the alcohol-energy drink combinations (Four Loko) and an increase in drinking games like "beer pong." When discussing Four Loko a participant stated, "I drank three of them [Four Loko] and couldn't walk." Another participant reported, "Bars are even having beer pong tournaments." Participants also discussed creating syrups with alcohol: "A lot of people make syrups out of Xanax® or put Codeine with Xanax® and liquor ... and [you] can add Skittles® or something for flavor and to change the color. Put everything in it ... make their own little concoction."

Inhalants remain highly available in the region. Reportedly, aerosols (aka "duster" and "gas") are most popular among the youth in high school or people who cannot obtain other drugs. A participant spoke to the ease with which these chemicals are obtained, "More kids hear about it [inhalants], and it's a household item. They hear about it and want to try it." A participant reflected, "Some people even huff [inhale for a high] air fresheners. You can walk into [the store] and buy one for \$1. My friend didn't have any money and went to the grocery store and bought whipped cream with her food stamp money [to abuse by inhaling the nitrous oxide gas]."

Hallucinogens are 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). A minority of participants

reported using hallucinogens (LSD and psilocybin mushrooms). Some treatment providers felt that younger individuals are not as aware of these substances: *"The ones [younger individuals] that do know have been around someone that knows about it [hallucinogens]."* Participants reported that the availability of LSD has increased during the past six months, but did not explain why availability and use have increased. Participants also said availability of psilocybin mushrooms has remained the same in the region during the past six months. A community professional reported, *"Getting more people [in treatment] growing them [psilocybin mushrooms]."* The Miami Valley Regional Crime Lab reported that the number of hallucinogen cases it processes has increased over the past six months. Reportedly, LSD (aka "acid") sells for between \$10-20 a "hit" (dose, a microdot or blotter); an eye drop bottle full of liquid LSD sells for \$400. Participants reported that 1/8 ounce of psilocybin mushrooms sells for between \$20-25; 1/4 ounce sells for \$40; an ounce sells for \$150. Both LSD and psilocybin mushrooms are reportedly popular at outdoor music festivals. Participants believed the quality and purity of LSD and psilocybin mushrooms are high because dealers, *"can't stomp on them."* The most common route of administration for hallucinogens is oral ingestion. A typical user profile did not emerge from the data. A participant said typical hallucinogen users are, *"valley girls, younger college and high school students ... sheltered ... the ones you wouldn't expect [to use hallucinogens]."* In contrast, community professionals identified a typical hallucinogen user as White and male.

Over-the-counter (OTC) medicines 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 typical user was described by a participant as, *"Someone who is very susceptible. They don't know much about anything. They don't do it [abuse OTCs] too many times after a bad trip."* Participants also noted a new trend with OTC medications for motion sickness. According to one participant, medicine to alleviate motion sickness could be used as a hallucinogen: *"Take 15 [motion sickness pills] and it will make you hallucinate. [You] can barely walk, it messes you up."*

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids and sedative-hypnotics remain highly available in the Dayton region. Noted increases in availability during the previous six months exist for heroin, marijuana and some prescription opioids (methadone); noted decreases exist for bath salts and some prescription opioids (OxyContin®). While there was consensus among all data sources that overall heroin availability has increased, heroin

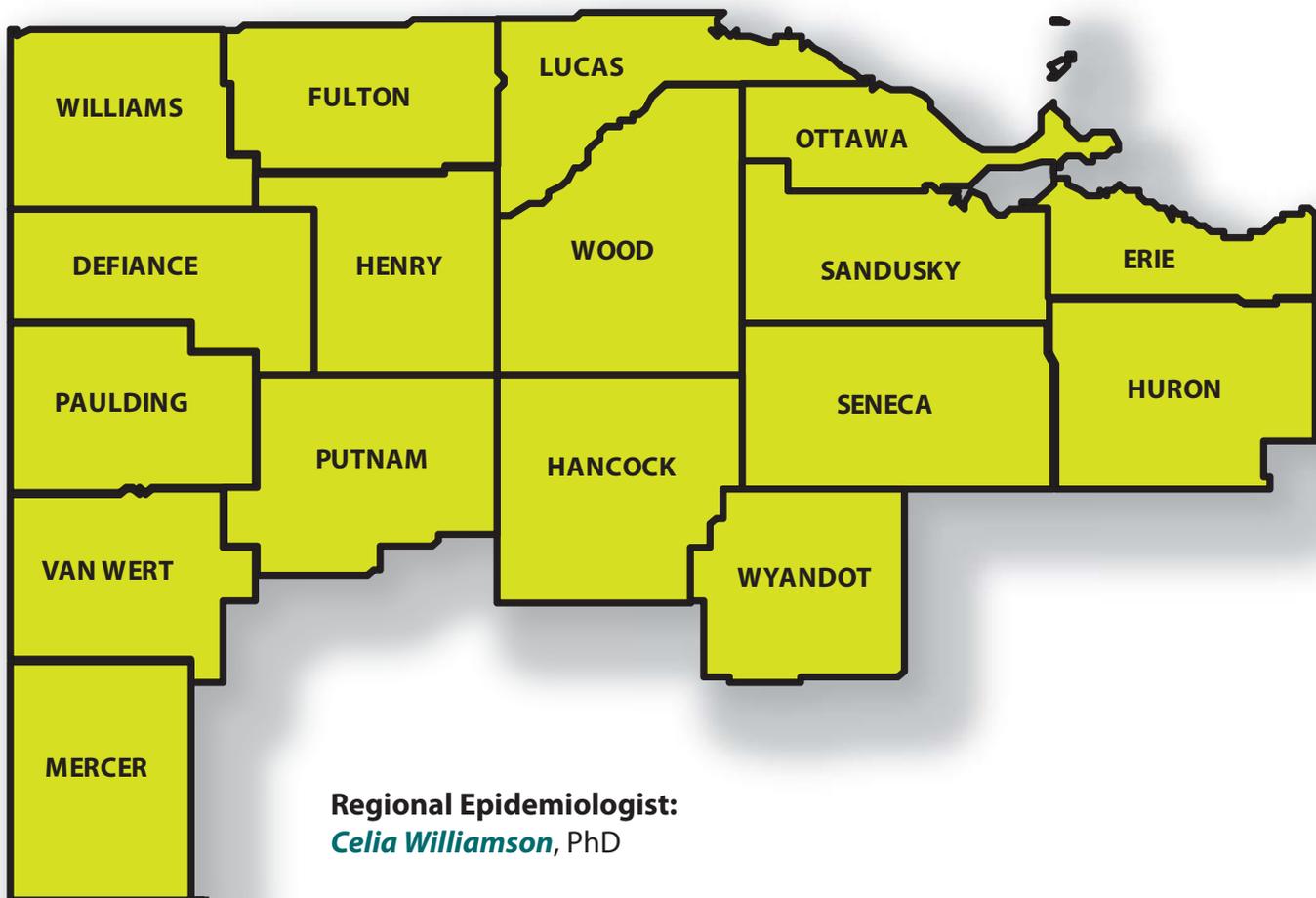
type and availability varies throughout the region. The City of Dayton reported more brown powdered heroin; Lima reported more white powdered heroin; and smaller cities in Hardin, Logan and Shelby counties reported more black tar heroin. Participants all agreed that heroin generally is, *"falling out of the sky."* However, while heroin availability has increased in Dayton, participants reported that availability has decreased in some rural areas of the region during the past six months. Law enforcement in outlying areas concurred with participant reports in that they too have noted a reduced amount of heroin because of their efforts to focus on heroin in the community, targeting heroin trafficked from Dayton. Participants and community professionals agreed that there has been an increase in younger users of heroin, and both groups continued to link the increase in heroin use to prescription medications and prescribing patterns; in addition, participants noted that heroin is cheaper than prescription opioids. Participants and community professionals identified methadone as an increasingly popular prescription opioid in terms of widespread abuse. Coroner's office staff reported that methadone is the second leading drug in drug-overdose deaths (after heroin). In terms of marijuana's increased availability, participants highlighted an increase in high-grade marijuana, and community professionals discussed an increase in "grow houses." Bath salts have decreased in availability because of the recent law banning their sale. However, participants still can easily obtain them. Treatment providers also felt that bath salts are, *"still out there somewhere, but it's under the table."* Staff from the Miami Valley Regional Crime Lab reported that bath salts are still being used in the region.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Toledo Region

June 2011-January 2012

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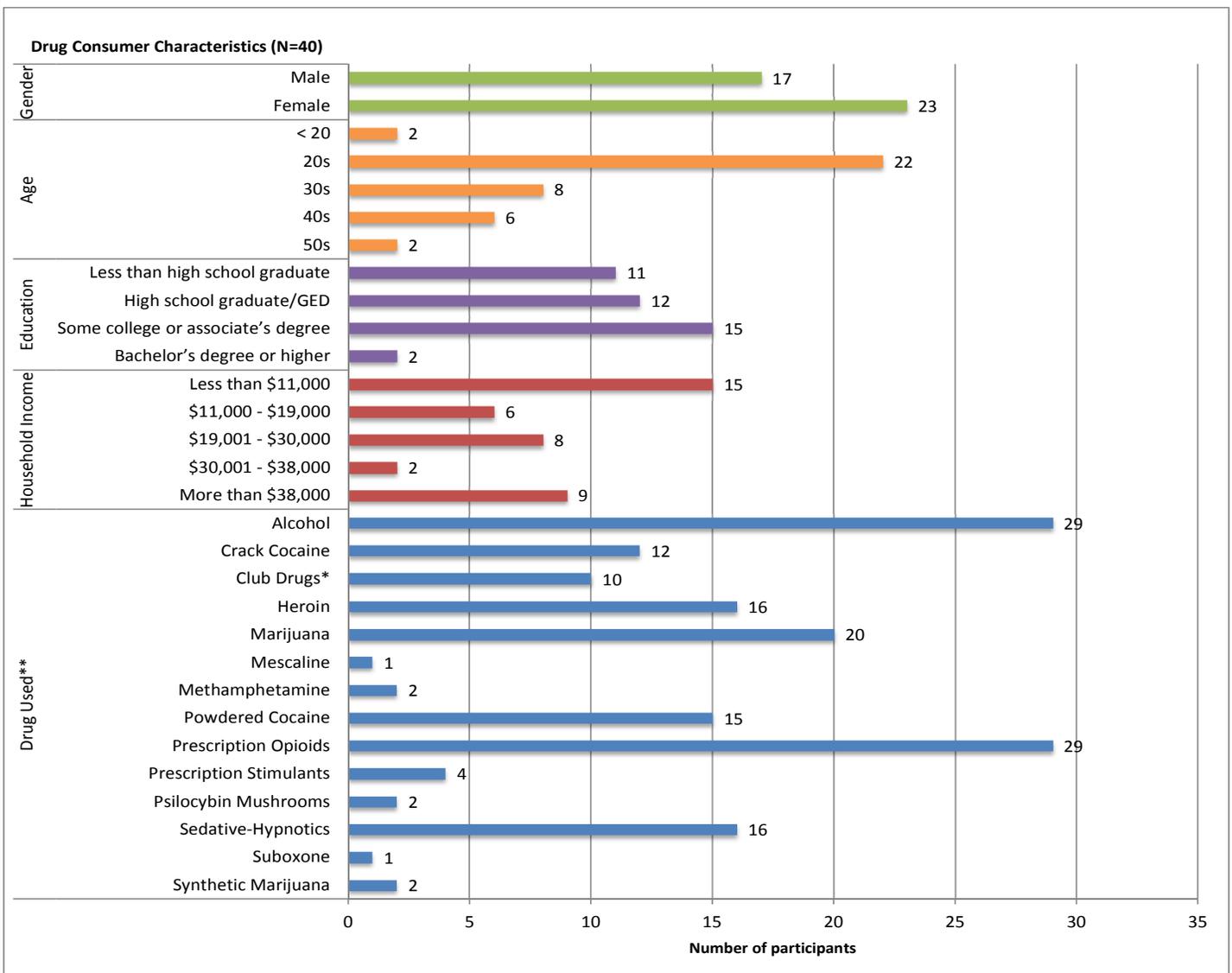
Research Administrator, OSAM Coordinator

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%	57.5%
Whites, 2010	81.1%	83.7%	85.0%
African Americans, 2010	12.0%	8.0%	7.5%
Hispanic or Latino Origin, 2010	3.1%	5.4%	2.5%
High school graduates, 2009-2010	84.3%	83.8%	72.5%
Median household income, 2010	\$45,151	\$46,040	\$11,001 - \$19,000 ²
Persons below poverty, 2010	15.8%	14.6%	55.0%

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

Respondents reported income by selecting a category that best represented their household's approximate income for 2011.²



*Club drugs refers to Ecstasy and LSD.

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Huron and Lucas 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 January through June 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current 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 July through December 2011.

Powdered Cocaine

Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Treatment providers and educators also rated availability as high. A treatment provider reported, "[Powdered cocaine] it's available, and it seems like over time the trend is getting younger [in terms of age of users]." The most common participant quality score for powdered cocaine was '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that if buyers could afford to buy larger quantities of powdered cocaine, they would receive a higher quality of the drug. The BCI Bowling Green Crime Lab continued to cite the following substances as commonly used to cut (adulterate) powdered cocaine: diltiazem (medication used to treat heart conditions/high blood pressure) and levamisole (livestock dewormer). For the first time in the region, participants reported that powdered cocaine was thought to be cut with crystal methamphetamine on occasion. Reportedly, a gram of powdered cocaine sold for between \$45-50. The most common route of administration for this form of cocaine was snorting. Participants continued to describe the typical user of powdered cocaine as those who had professional jobs during the day and were nightclub goers on weekends. In addition, participants reported that there were those on the street who purchased powdered cocaine in order to rock (manufacture) crack cocaine for sale or for personal use.

Current Trends

Powdered cocaine remains highly available in the region. In Lucas County, participants most often reported the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. Treatment providers and law enforcement reported current availability as '10'. In Huron County, powdered cocaine was thought to be less available; participants there most often rated current availability of powdered cocaine as '5', while treatment providers most often rated current availability as '3'. A participant reported, "You can't get it [powdered cocaine] directly here [Huron County], but you can get it from Fremont [Sandusky County]." A treatment provider commented, "[Powdered cocaine] it's never been a popular drug in Huron County." Media outlets in the region reported on powdered cocaine seizures and arrests during this reporting period: law enforcement seized 53 pounds of powdered cocaine with an estimated street value of \$2.4 million and 325 pounds valued at \$14 million during two traffic stops on the Ohio Turnpike in Maumee (Lucas County) (www.toledoblade.com, Sept. 22 and Oct. 7, 2011). The *Toledo Blade* quoted an agent with Toledo's Drug Enforcement Administration (DEA) office as saying, "The Toledo area is a big transit system for drugs and bulk currency. We've got a very good interstate system here with I-75 going north and south through Toledo and the turnpike, I-80, going east and west ... We call that key terrain ... we see a lot of movement of money or cocaine, or bulk drugs in general, passing through our area."

Participants and community professionals most often reported that the availability of powdered cocaine has remained the same during the past six months. However, participants reported that powdered cocaine is not often one's drug of choice because, "[Powdered cocaine] it's not a drug you can be happy with ... you wanna have more and more." Therefore, participants often find other drugs more appealing, but will use powdered cocaine as an enhancement to whatever drug they are already doing. As a participant put it, "I shot it [powdered cocaine] up, but I only got it when I got extra money, 'cause I bought my drug of choice first." The BCI Bowling Green Crime Lab reported that the number of powdered cocaine cases it processes has remained the same during the past six months.

Most participants in Lucas County rated the quality of powdered cocaine as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '7'. A participant commented, "[Current quality of powdered cocaine] it's nothing like it was when I first fell in love with it [powdered cocaine]." In Huron County, participants most often reported the quality of powdered cocaine as '10'. A participant responded, "It [quality] depends on who you go to [to purchase powdered cocaine]." Participants reported that

powdered cocaine is cut with baby laxatives, Benefiber®, ether, glutamine, lactose and vitamin B. A Toledo participant, a self-described “weekend warrior” (weekend drug user) reported, “In Texas it [powdered cocaine] works like jet fuel. You snort it, and ‘good times are a coming.’ Here [Toledo] it tastes like crap, and it’s just no good.” Participants reported that the quality of powdered cocaine has remained the same during the past six months. The BCI Bowling Green Crime Lab cited the following substances as commonly used to cut powdered cocaine: caffeine, inositol (dietary supplement) and levamisole (livestock dewormer).

Current street jargon includes many names for powdered cocaine. The most commonly cited name remains “soft.” Participants listed the following as other common street names: “Christina,” “fish scales,” “flake,” “girl,” “pow wow,” “snow,” “white” and “white girl.” Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine. While users 25 years and younger reported purchasing powdered cocaine, users older than 25 years were more knowledgeable about prices for “pure” powdered cocaine, called “raw” or “raw dog.” Participants reported the following prices for powdered cocaine: a gram sells for between \$40-50 for cut product and between \$70-100 for pure product; 1/16 ounce, or “teener,” sells for between \$60-80 for cut product and \$125 for pure product; 1/8 ounce, or “eight ball,” sells for between \$120-125 for cut product and \$150-175 for pure product. Participants reported that the most common way to use powdered cocaine remains snorting. Out of 10 powdered cocaine users, participants reported that approximately eight would snort, one would intravenously inject and one would smoke. A participant reported, “The more wealthy will snort it [powdered cocaine]. The poor will smoke rocked up crack [cocaine].” Those who injected intravenously reported the desire to inject all drugs they used. A participant described, “Once you shoot [inject] something, you don’t really like to go back to snorting it.”

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 clubs. A participant reported, “There’s always an area [in a bar], like a room ... you make your way from room to room ... and you might find one [room] where people are partaking [using powdered cocaine].” In Huron County, powdered cocaine is reportedly also accessible to high school students. A participant who is 18 years old and still in high school reported, “I was sitting at the lunch table and they [classmates] were talking about the party and doing all this coke [powdered cocaine].”

Reportedly, powdered cocaine is commonly used in combination with other drugs such as alcohol, heroin, marijuana and prescription opioids.

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’ (high availability, extremely easy to get). Treatment providers reported that while those in the drug culture could immediately obtain crack cocaine, the drug was also readily accessible to the general public. Educators reported that crack cocaine was accessible to young adults in high school and college, although the drug was said to be less desirable than other drugs among college students. The most common participant quality score for crack cocaine was ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that crack cocaine was most often cut with other substances. The BCI Bowling Green Crime Lab reported that crack cocaine was cut with several substances, including diltiazem (medication used to treat heart conditions/high blood pressure) and levamisole (livestock dewormer). Participants reported that 1/16 ounce of crack cocaine sold for between \$65-80. The majority of crack cocaine users reported buying the drug in small quantities, often called “rocks” that sold for between \$5-20. By far, the most common route of administration for this form of cocaine was smoking. Treatment providers reported seeing clients addicted to crack cocaine from all walks of life, who after crack cocaine addiction took hold, began living in poverty, sometimes for the first time in their life. Educators who work with high school- and college-aged youth described typical crack cocaine users as African-American males in their late teens or older females beyond traditional college age.

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.’ Toledo community professionals reported the current availability of crack cocaine as ‘7,’ with every professional stating that they see more cases of heroin and prescription opioid abuse than cases of cocaine abuse. Participants reported that the availability of crack cocaine has remained the same during the past six months. However, many in the 18-25 age group shunned crack cocaine; not many had experience with the drug, and most tried to avoid it. A participant reported, “It’s [crack cocaine] a non-social drug. It makes you very off-putting. The mood changes are very abrupt.” Community professionals reported that availability of crack cocaine has remained the same during the past six months. The BCI Bowling Green Crime Lab reported that the number of crack cocaine cases it processes has remained the same during the past six months.

Participants rated the quality of crack cocaine as '3' and '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8'. The discrepancy in quality was explained by connections and timing. A participant described, "It [quality of crack cocaine] all depends on who you know." Another participant described a decrease in quality over time, "The first two times you call the dope boy, they're gonna give you the good s***. The more you call the s***ier it [crack cocaine] gets." Participants reported that crack cocaine is cut with baking soda. In Huron County, users reported that the highest quality crack cocaine can be found outside of the county. A participant commented, "If you buy it [crack cocaine] here [Huron County], it's usually s***ty." Depending on one's connections and proximity, users preferred to obtain crack cocaine from the cities of Cleveland, Fremont or Sandusky. Participants reported that the quality of crack cocaine has remained the same during the past six months. A Toledo participant commented, "If I knew the guy making it [crack cocaine], I'd just smack him. Even though it's an illegal business, take pride in what you do for crying out loud." The BCI Bowling Green Crime Lab reported that crack cocaine is typically cut with levamisole (livestock dewormer).

Current street jargon includes many names for crack cocaine. The most commonly cited names were "butter," "hard" and "work." 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 \$40, depending on the quality; 1/16 ounce sells for \$60; 1/8 ounce sells for \$130. Participants reported that the most common way to use crack cocaine remains smoking. Out of 10 crack cocaine consumers, participants reported that approximately eight would smoke, one would intravenously inject and one would snort. Some participants reported that local carry-outs sell "\$5 kits" in brown paper bags that contain everything needed to smoke crack cocaine, including a rose stem (fake rose that is attached to a glass stem used as a pipe) with a Chore Boy® (stainless steel scrubbing pad used as a screen) and a lighter.

A typical user profile emerged from the data. Participants described typical users of crack cocaine as, "poor; no one with a good job; women prostitutes." A participant reported, "I started smoking crack [cocaine] and within a month I'd already stolen everything I could from my family." Treatment providers agreed that crack cocaine users are typically persons of low income. A participant who had experienced crack cocaine withdrawal reported, "I'd been hooked on coke [cocaine] for a couple of years, and then we got busted. So, we used it all up in one day and then never touched it again. The next day I was fine. Then I started using crack for like two months, and then I quit, and I was fine. So in my mind, being addicted was

something, 'oh, it's a feeling.' I mean I'd cry that I wanted to smoke crack, and I'd cry that I wanted to do drugs, but it wasn't like I'm finally puking my guts out and having diarrhea and uncontrollable sweats and cold."

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids and Seroquel®. With the exception of heroin, all of these substances are generally used to either "come down" from crack cocaine use or to smooth out some of the edgy effects of the drug. A participant reported, "I always have to have a pill to come down [from crack cocaine use]." Another participant reported that he once, "drank three beers real fast to try and come down."

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' (high availability, extremely easy to get). Participants reported, "[Heroin] it's dirt cheap, so you can find it anywhere; Even if you don't know where to get it [heroin], you can find somebody who knows somebody." While many types of heroin were available in the region, participants reported the availability of brown and "China white" powdered heroin as most available. Some participants reported buying heroin in Toledo while others preferred to buy heroin in Detroit. Either way, the heroin business was described as thriving. Treatment providers also reported the overall availability of heroin as high. The most common participant quality score for heroin was '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants continued to report that heroin was often cut with fentanyl. The BCI Bowling Green Crime Lab continued to cite the following substances as commonly used to cut heroin: caffeine, diphenhydramine (medication used to treat allergies) and quinine (medication used to treat malaria). Participants reported that a gram of heroin sold for between \$40-50. The most common route of administration for heroin was intravenous injection. Participants and treatment providers described typical users of heroin as, "in their 20s; White; suburban; somewhat affluent," who graduated from prescription opioids to heroin.

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'. A participant commented, "You can get it [heroin] anywhere in Toledo." Another participant, when speaking of availability of heroin types, reported, "You can get whatever [heroin type] you want." Participants attributed high heroin availability to recent arrests of area doctors who were prescribing prescription opioids, and to the recent change in the composition of OxyContin®, making it difficult to crush and use intravenously; both of these were said to have limited the availability of prescription opioids. A participant reported, "All my friends thought I was crazy for shooting up heroin, and now they're all doing it because they can't get their pills [prescription opioids] anymore." Community professionals also reported current heroin availability as '10'. A treatment provider commented, "Heroin is overrunning pills ... heroin seems to be more accessible to them [users] now. It's cheaper." Another provider reported, "We see a lot of younger kids, 18 to mid-20s ... and that's [heroin] really big with them." Another provider said, "Even our people [clients] that came here [for treatment], left, and came back. It seems that those people who come back are adding heroin on top of it [other drug abuse]." Law enforcement reported, "Heroin is more readily available than powder[ed] cocaine ... we had a lot more heroin than cocaine cases ... with across-the-board users." Media outlets in the region reported on heroin seizures and arrests during this reporting period. In December, the Ohio State Highway Patrol seized more than 17 pounds of heroin, valued at more than \$3 million during a traffic stop on the Ohio Turnpike in Wood County; the seizure set a patrol record as the biggest heroin seizure ever (www.nbc4i.com, Dec. 8, 2011).

While many types of heroin are currently available in the region, participants continued to report the availability of brown powdered heroin as most available. Reportedly, white powdered heroin is largely unavailable in Huron County. Toledo users reported that while they could buy white powdered heroin, many believed it is sometimes cut with fentanyl, providing a gray tinge to the normally white substance. However, participants and treatment providers reported that users who have reportedly used heroin cut with fentanyl have screened negative for prescription opioids through urine drug screens. Some participants reported that Toledo drug dealers are frequently marketing heroin as fentanyl, explaining that they believed this is done to lure buyers who would be leery to use heroin. A participant reported, "They [dealers] put it [heroin] in little packs and sell it as fentanyl. It sounds less dirty than heroin ..." Many longer term heroin users prefer to obtain the drug from Detroit dealers or occasionally from dealers in Columbus. A



participant reported, "Detroit people [dealers] are fighting over us ... the second we'd get off the highway we'd call somebody and then like our phone would ring constantly with all the people. If they're sitting in a room and we call, they would all run out and call us, 'Hey come get it [heroin] from me. I'll hook it up bigger ... come get a freebie.'"

Participants in Toledo reported the availability of black tar heroin to be low, rating its current availability most often as '1' or '3' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that Toledo heroin dealers typically cut black tar heroin into brown powdered heroin in order to boost profits. A dealer reported, "I'll buy an ounce of tar [black tar heroin] and turn it into five ounces of brown [powdered heroin]." Law enforcement reported seeing black tar heroin in the region with origins in Mexico. Community professionals thought the availability of black tar heroin to be higher than what participants reported. Treatment providers in Huron County rated the availability of black tar heroin as '10'. While no participant reported having used black tar heroin, many reported that they knew others within their network that had.

Participants and community professionals reported that the availability of brown and white powdered heroin as well as black tar heroin as having remained the same during the past six months. A Toledo participant, reporting on brown powdered heroin said, "We were getting it [brown powdered heroin] every day, but we only had a few connections." The DEA field office in Toledo reported that DEA agents have made, "[heroin] cases in the suburbs and cases involving teens," highlighting the widespread availability of heroin. The BCI Bowling Green Crime Lab reported that the number of powdered and black tar heroin cases it processes has increased during the past six months.

Participants generally rated the quality of brown powdered heroin as '6', white powdered heroin as '10', and black tar heroin as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous overall quality score for all types of heroin was '10'. Participants reported that brown powdered heroin is cut with baby laxative and lactose. A participant reported, "If they [dealers] hit it too hard [cut heroin too much], it's going to be light and puffy", otherwise users described the look and consistency of brown powdered heroin to be like, "dog food." Participants described heroin as sometimes resembling, "Play-Doh ... you can mold it around" and sometimes having the consistency of, "brown sugar, sandy ... even if you chop it up real fine, you can still see chunks." During the past six months, participants reported that the overall quality of heroin has remained the same. 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).

Current street jargon includes many names for heroin. The most commonly cited names for heroin generally were “dope” and “boy.” The most commonly cited names for brown powdered heroin were “Bobby Brown,” “dog food,” “mix” and “s***;” the most commonly cited names for white powdered heroin were “China,” “China white” and “Tokyo drift.” Participants reported that white powdered heroin is available in different quantities: a “pack” (1/10 gram folded into a pack using a lottery ticket) sells for \$10, or 5 packs sell for \$35. To measure 1/10 gram, a participant explained, “They [dealers] use a spoon from McDonald’s®, a mac spoon. They tell you, ‘oh that pack, that’s a full mac.’ They don’t make ‘em anymore, but you can buy them at head shops. It’s a little stir stick they used for coffee ... and that’s a half a point ... that’s how everybody in Detroit does it ... we each got a half pack and was puking out the door. I never been that high in my life.” Other dealers measure heroin using a “scoop” (the mini-sized scraper used at convenience store lottery counters to scratch off lottery tickets). A participant explained, “You know the little scratch off thing, the little window scraper thing ... there’s a little dip ... they fill that [with heroin] and that’s one scoop ... that’s \$10 [worth of heroin].” Reportedly, a gram of white powdered heroin sells for between \$100-150; 1/8 ounce sells for \$325; 1/4 ounce sells for between \$650-1,000. Participants reported that brown powdered heroin is available in different quantities: a gram sells for between \$30-50; 1/16 ounce sells for between \$45-70; 1/8 ounce sells for \$100; 1/4 ounce sells for between \$200-300. Participants also reported that if someone agreed to sell it, black tar heroin is available in larger quantities: 1/4 ounce sells for between \$600-800. Black tar heroin usually is sold in single dose units. Participants reported that overall 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 10 heroin users, participants reported that approximately seven would intravenously inject, two would snort and one would smoke. However, participants were quick to point out, “Ninety percent [of heroin users] would start out snorting it [heroin] ... and then end up straight shooting it.” Participants with experience injecting heroin reported getting needles from popular retailers, area pharmacies and from individuals with diabetes. A participant explained that if one were to purchase from a pharmacy, the purchaser would have to use the correct language so as to not evoke suspicion of drug use: “You can’t tell ‘em needles. You have to call them syringes.” Most everyone that reported using needles shared them with brothers, sisters and friends. A participant described, “You don’t think you would do something like that [share needles], but when you have the drug in front of you, and it took all day to get it, and you got one needle left, you’re not going to be like, ‘oh I’ll wait until we get back to Toledo and find

someone at one in the morning to get a needle from.” Another participant commented, “It’s really hard not to share needles when you’re sick ... If I don’t have no bleach, you’re in trouble ‘cause you’re going to use the needle.”

Participants continued to describe typical users of heroin as most commonly, “White; younger; in their 20s.” Participants older than 25 years of age described heroin users as anybody 18-70 years old. A user reported, “I been using [heroin] for 35 years.” Also unchanged from last reporting period is the noted progression from prescription opioids to heroin, which was commonly cited by participants. A Toledo participant described, “At first, for a year and a half, I was snorting it [prescription opioids], and I was only doing oxy’s [OxyContin®]. But, then I started shooting oxy’s, and I went from oxy’s to brown [powdered heroin] to white [powdered heroin] within six months ... I started when I was 16 [years old].” Most heroin users reported that first heroin use occurred between 18-19 years of age while reporting that first use of prescription opioids occurred before the age of 18 years when in high school. A participant explained, “That’s how you start [heroin use]. After doing oxy for a long time, bringing yourself down, spending money on it ... you’re going to get to the point of like, ‘what can I do that’s cheaper?’ So, I went to shooting it [oxy] first and then went to heroin.”

Reportedly, heroin is used in combination with Benadryl®, marijuana and prescription opioids to enhance the effects of the heroin. Participants reported use of crack cocaine and powdered cocaine in combination with heroin as, “speedballing,” and explained that the combination of cocaine and heroin produces the effects of an “upper” and “downer” simultaneously. However, most who used heroin echoed the sentiment of a participant who said, “If heroin is your drug of choice, you don’t really want anything else with it.”

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). Both participants and treatment providers continued to identify OxyContin® as the most desired prescription opioid in the region. However, because the original composition of the drug had been changed, making snorting or injecting difficult, participants cited Percocet® as the most popular prescription opioid in terms of widespread use. Educators reported that prescription opioid abuse had increased among youth, and they reported seeing an increase in the selling of these drugs. Reportedly, youth who abused the

drug Percocet® would use the term, “*perc’d out*” to indicate being high. The BCI Bowling Green Crime Lab reported that the number of prescription opioid cases it processes had increased during the previous six months. In addition to obtaining prescription opioids on the street from dealers, participants reported that these drugs were most accessible through people who were ill or from area senior citizens. A participant reported, “*Elderly people sell their scripts [prescriptions] to make ends meet.*” Participants also reported that drug dealers would often buy prescriptions from senior citizens. Reportedly, dealers would stand outside of drug stores and approach seniors about selling their prescriptions, or dealers would convince a senior to go to the doctor and fake pain to obtain a prescription to sell. Generally, the most common route of administration for prescription opioids continued to be oral ingestion. However, a majority of participants reported that users quickly moved from swallowing to snorting and then to injecting. Participants continued to describe the typical prescription opioid user as someone who had suffered chronic pain from a serious illness or injury, or someone who was young, White and middle-class.

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® as the most popular prescription opioid in terms of widespread use, followed by Opana®. Treatment providers in both Huron and Lucas counties concurred with participants in identifying the widespread popularity of these two drugs while adding that OxyContin® OP (new formulation) is also highly available: “*If they [users] can’t get anything else [they will abuse OxyContin® OP].*” A Toledo participant reported, “*Opiates are really in demand right now.*” Most participants reported experimenting with, having been prescribed, or regularly using prescription opioids prior to 18 years of age. A participant reported, “*I started when I was 17 [years old]. I hurt my ankle playing basketball, and I got a prescription of them [opioids], and I was headed downhill from there.*” Another Toledo participant reported, “*I was young, probably 11-12 years old. I took Vicodin®, Percocet®, anything I could get a hold of.*” An 18-year-old Huron County participant reported, “*I was drinking and smoking pot [marijuana], and someone was like, ‘here try this,’ so I did. I was like, d***! So, I stopped smoking and drinking so much and just got into pills.*” Treatment providers most often reported Percocet® availability as ‘9’, and Opana® availability as ‘7’, while law enforcement reported availability of both drugs as ‘10’. A participant seemed to reflect the

sentiment of others in the room when he said, “*everybody wants perc 30s [oxycodone 30 mg].*” Another participant commented, “*Opana® has become the new OC’s [OxyContin®].*” Other drugs such as methadone and Vicodin® are also highly available, but not as desirable. A participant reported, “*I had 10 Vicodin®. I would save those for an emergency and that would just get me enough to be able to get up and move and go find something else.*” Treatment providers identified Dilaudid®, fentanyl, methadone and Vicodin® as other prescription opioids that are highly available and used, although not as popular as Percocet®, Opana® and OxyContin®.

Media outlets in the region reported on arrests related to prescription opioids during this reporting period. In September, law enforcement seized nearly 3,000 oxycodone pills, 1,400 Xanax® pills and 200 Lortab® pills during two traffic stops in Hancock County (www.toledoblade.com, Sept. 2 2011). In December, also in Hancock County, law enforcement seized 999 oxycodone pills and 1,000 Xanax® pills, valued at \$30,000 (www.nbc4i.com, Dec. 15, 2011). Participants reported that the availability of prescription opioids temporarily decreased during the past six months after the arrest of an area physician who operated a pain clinic in Michigan from where many participants reportedly obtained prescription opioids. This arrest impacted users in Huron County as well, as a participant reported, “*Some doctor near Toledo got busted and nobody could get Percocet® ‘cause that’s where everyone was getting them.*” Another participant reported, “*A lot of people started coming here [treatment] ‘cause when that doctor got busted.*” Law enforcement reported that availability of prescription opioids has increased during the past few years and reported a current “*boom*” of illegal prescription opioid use in the region. The BCI Bowling Green 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 hydromorphone (Dilaudid®), morphine 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 street-level users (Note: When reported, current street names and prices are indicated in parentheses): fentanyl (50 mg patch sells for \$25; 80 mg patch sells for between \$40-50; 100 mg patch sells for \$50; powdered fentanyl sells for between \$10-20 for a “*pinch*”), Opana® (due to high demand, currently sells for \$1 per milligram), OxyContin® (aka “*oxy’s*,” OxyContin® OC, old formulation, aka “*OC’s*,” sells for between \$1-2 per milligram; OxyContin® OP, new formulation; 40 mg sells for between \$25-30; 60 mg sells for between \$30-40; 80 mg, aka “*80s*,” sells for between \$40-50; 160 mg sells for \$80); Percocet® (aka “*perc’s*,” 5 mg sells for between \$5-7; 7.5 mg sells for between

\$6-7; 10 mg sells for between \$10-12; 15 mg sells for between \$15-17; 30 mg sells for \$30), Vicodin® (5 mg sells for between \$2-3; 7.5 mg sells for \$6; 10 mg sells for \$10). While there were a few reported ways of consuming prescription opioids, the most common routes of administration are oral ingestion as well as pill crushing and snorting, with participants reporting that snorting is most common.

In addition to obtaining prescription opioids on the street from dealers, participants also reported getting the drugs from senior citizens. Participants described meeting seniors by standing behind them in line at the pharmacy and offering a drug deal, trading some crack cocaine addicted seniors for pills, arranging to meet seniors at their doctor's office, or obtaining them from their grandparents. A participant reported, "Junkies will trade them [prescription opioids] for dope [heroin]." Some users reported visiting doctors in Toledo and Michigan and pain clinics in Florida. A participant said, "I know a lot of people that go to Florida 'cause there is a lot of doctors in Florida to get them [prescription opioids] from." Participants explained that these Florida trips are usually done by middlemen in order to obtain prescription opioids for sale by area drug dealers. Law enforcement also reported prescription opioids regularly coming from Florida.

A typical user profile emerged from the data. Participants continued to describe typical users of prescription opioids as, "young; 18-25 [years old]; White females; White men." While many participants reportedly began using prescription opioids before age 18, no participant reported knowing about the withdrawal effects from these drugs. Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, marijuana and sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants). A participant reported, "I have mixed the two [Xanax® and an opioid]. You get a more calming effect and a nod." Another participant reported that he liked, "snorting perc's and coke together."

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' (high availability, extremely easy to get); treatment providers most often reported availability as '8'. Participants reported that Suboxone® 8 mg pills sold for between \$5-10 and that Suboxone® strips/film sold for \$7. Participants described the typical street user of Suboxone® as someone who wanted to avoid being "dope sick" and used the drug as a safety net until he could find and afford more heroin.

Current Trends



Suboxone® is highly available in the region. Participants most often reported current availability of Suboxone® 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 '7'. Treatment providers most often reported the drug's current availability as '10'; the previous most common score was '8'. Participants and treatment providers reported that the availability of Suboxone® has remained the same during the past six months. The BCI Bowling Green Crime Lab reported that the number of Suboxone® cases it processes has increased during the past six months.

Participants reported that Suboxone® 8 mg sells for between \$10-15. According to a participant, dealers buy Suboxone® in bulk for a reported \$3-5 per 8 mg pill. In addition to obtaining Suboxone® on the street from dealers, participants also reported getting the drug from those who are prescribed it. Participants reported that some users with Suboxone® prescriptions sell or trade the drug for other drugs. A Lucas County participant reported, "My boyfriend would get it [Suboxone®] ... people would trade him for dope [heroin]." 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 want to withdraw from the use of heroin without being sick and those who just desire to avoid dope sickness for the time being. Although most participants with experience reported not using anything with Suboxone®, a participant in Toledo reported using the drug with a small amount of heroin in order "to avoid being sick." A Huron County participant who used Suboxone® intravenously stated, "At first I would get high [using Suboxone®], then I would do it [use Suboxone®] not to get sick."

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants, treatment providers and educators identified Xanax® as the most popular sedative-hypnotic in terms of widespread use. The BCI Bowling Green Crime Lab reported that the number of sedative-hypnotics cases that it processes had remained the same during the

past six months. The most common route of administration was oral ingestion, followed by snorting. Treatment providers typically reported seeing younger adults who were White abusing these drugs, while participants described typical users of sedative-hypnotics as anyone who liked the feeling brought about by use of these drugs.

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 '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'. Treatment providers most often reported current availability as '10'; the previous most common score was also '10'. A treatment provider commented, *"In this county [Huron County], it's easier to get prescription drugs and marijuana than it is to get alcohol."* Participants identified Xanax® followed by Klonopin® as the most popular sedative-hypnotics in terms of widespread use. Reportedly, Ativan® and Valium® are moderately desirable among users older than 25 years if other brands cannot be found. Community professionals identified Xanax® followed by Ativan® and Klonopin® as the most popular sedative-hypnotics in terms of widespread use. Law enforcement reported that these drugs are most likely sold by those with prescriptions, with buyers consisting of neighbors, relatives and associates; there is no highly organized distribution system for sedative-hypnotics like there is for other drugs. Participants, treatment providers and law enforcement reported that the availability of sedative-hypnotics has remained the same during the past six months. The BCI Bowling Green Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months with some exceptions; Klonopin® and Xanax® have increased and Librium®, Restoril®, Lunesta®, Mebaral® and Nembutal® have decreased in frequency.

Reportedly, two main types of sedative-hypnotics are currently sold on the region's streets. (Note: When reported, current street names and prices are indicated in parentheses): Klonopin® (1 mg sells for \$0.50) and Xanax® (.5 mg, aka "peaches;" sells for between \$0.50-1; 1 mg, aka "footballs;" sells for between \$2-2.50; 2 mg, aka "xanibars;" sells for between \$5-7). Participants reported the following sedative-hypnotics as also available to street-level users: Ativan®, Soma® and Valium®, but these drugs were said to be less desirable and of little street value. While there were a few reported ways of consuming sedative-hypnotics, the most common routes of administration remain oral ingestion and snorting.

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported getting them from people with prescriptions. Participants indicated that it is easier to obtain sedative-hypnotics from people with prescriptions than it is to obtain them from physicians, as very few people discussed obtaining the drug from doctors. A participant reported, *"Those [sedative-hypnotics] they get in Bellevue, they get from someone who got it from a doctor."*

A profile of a typical user of sedative-hypnotics did not emerge from the data. However, participants noted it is most common to see White people in most age groups use sedatives-hypnotics. They also described users as people who can't sleep and people, *"on crack."* Treatment providers thought use of sedative-hypnotics crossed gender and racial boundaries and said users could be anyone. Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with crack cocaine to *"come down"* or with alcohol, heroin or prescription opioids to intensify the effects. A participant reported, *"I take Xanax®, wait for a little bit, and then shoot dope [heroin]."*

Marijuana Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants said that the availability of marijuana had remained the same during the previous six months. Participants reported that the quality of marijuana varied, with the most common quality score being '10' for high-grade marijuana and '6' for commercial-grade marijuana on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that for commercial-grade marijuana, an ounce sold for between \$25-30; for high-grade marijuana, an ounce sold for between \$150-200. The most common route of administration for marijuana remained smoking. Participants, educators and treatment providers continued to report that many different types of people smoke marijuana, and the prevailing thought was that marijuana was widely used and had become socially acceptable.

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, *"People*

will just go up and ask if you have any [marijuana] or where to get any." Treatment providers and law enforcement most often reported the drug's current availability as '10,' and both groups reported that marijuana is, "everywhere." Media outlets in the region reported on numerous marijuana seizures during this reporting period. The *Norwalk Reflector* reported that the Ohio State Highway Patrol stopped a man near Lucas County, and a search of the vehicle yielded 137 pounds of marijuana, valued at \$342,000 (www.norwalkreflector.com, Nov. 25, 2011). The *Toledo Blade* reported that the Ohio State Highway Patrol found 20 pounds of marijuana worth \$100,000 during a traffic stop in Sandusky County (www.toledoblade.com, Oct. 5, 2011). In another case, the *Columbus Dispatch* reported on a marijuana arrest during a routine traffic stop in Lucas County, during which police found 39 pounds of marijuana worth about \$39,000 (www.dispatch.com, Sept. 22, 2011). In another part of the region, a Toledo news outlet reported that the Hancock County METRICH (Metro-Richland County Drug Enforcement Unit) seized 341 marijuana plants, along with cash, drug paraphernalia and criminal tools (www.wtol.com, July 20, 2011).

Participants, treatment providers and law enforcement reported that availability of marijuana has remained the same during the past six months. The BCI Bowling Green Crime Lab reported that the number of marijuana cases it processes has remained the same during the past six months. Law enforcement reported that most commercial-grade marijuana comes through the southwest U.S. border; whereas, hydroponic (high-grade) marijuana usually comes from Canada or the northwest part of the country. The network transporting hydroponic marijuana was described as not as structured and not as organized as the network moving commercial-grade marijuana into the country.

Participant quality scores of marijuana varied from '5' for commercial grade to '10' for hydroponically grown on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common scores were '6' for commercial-grade marijuana and '10' for high-grade marijuana. Hydroponically-grown marijuana was described by a Toledo user as, "superb." A participant reported, "There is a considerable difference. I can blow through a bowl of reggie [commercial marijuana], and I'm ready to pick up another one ... If I had hydro [hydroponically grown marijuana], I can put it in a little glass pipe and just sort of puff on it throughout my day."

Current street jargon includes countless names for marijuana. The most commonly cited names were "weed" and "pot." Participants listed the following as other common street names: "reggie" and "regular" for commercial-grade marijuana; "AK-47," "blueberry yum-yum," "death star," "dro,"

"hydro," "pineapple express," "purple haze" and "white widow" for high-grade or hydroponically grown marijuana. A participant reported recently learning of a newly grown version of hydroponic marijuana called, "Alaskan thunderf***." The price of marijuana continues to depend on the quality desired. Participants reported commercial-grade marijuana as the cheapest form: a blunt (cigar) or two joints (cigarettes) sell for between \$5-10; 1/4 ounce sells for between \$30-40; 1/2 ounce sells for between \$50-60; an ounce sells for between \$75-100; a pound sells for between \$700-800. Higher quality marijuana sells for significantly more: a blunt or two joints sell for \$20; 1/4 ounce sells for between \$100-125; an ounce sells for between \$300-400; a pound sells for between \$2,500-3,000.

While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. In Toledo, a few participants talked about baking marijuana in brownies. Those with the means to purchase a vaporizer (\$190 according to a participant) reportedly use it to consume marijuana. Because smoke is replaced by vapors, consumers who used this method see it as a growing trend and a healthier alternative to ingesting smoke into the lungs. Drug consumers more likely to use vaporizers were described by a participant as, "those ... that go to Starbucks® and Barnes and Noble for the most part." The participant described inhaling the vapors from the marijuana in a vaporizer as, "very clean ... The THC [tetrahydrocannabinol] passes through the heat and that's what gets you high ... it doesn't turn into ash, so you still have some of the THC in it ... you can actually use that to cook, bake brownies [too]." A few Toledo participants described the use of hashish and kief. Hashish is collected from unfertilized buds from the marijuana plant and contains the same active ingredients as marijuana, but in higher concentrations. Kief is defined as either the crystals off marijuana buds or the yellow pollen from the male plant. A participant explained that he uses a grinder to make kief and hash: "I have a grinder ... THC crystals get sifted out and fall through ... looks like tan cocaine. Kief sifts through the screen. It's a process. It's sticky, dusty, almost like pollen from a flower. Kief is just the fine powder. Hash is the compounded kief. You can make hash last a lot longer. Kief burns so fast, like gun powder. You know when you smoke it that you're not just smoking bud."

A typical user profile did not emerge from the data. Participants continued to describe typical users of marijuana as, "anyone; everyone." A participant responded, "I look at it [marijuana use] as a sort of garnish on top of something that's already pretty great. It makes food better. It makes movies better. You know ... talking, sex, or whatever." Reportedly, marijuana is used in combination with nearly every drug: "[Marijuana]

it's a staple." Some participants reported sprinkling powdered cocaine in marijuana cigarettes for smoking ("cocoa puffing" or "primo"). Another participant reported seeing marijuana laced with embalming fluid ("wet").

Methamphetamine

Historical Summary

In the previous reporting period, methamphetamine was reportedly rare in Toledo but was said to be available to some extent in rural areas outside the city. Participants most often reported the availability of methamphetamine in Toledo as '1' and in areas surrounding Toledo as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get).

Participants and treatment providers disagreed about the availability of methamphetamine, with participants saying that it had increased and treatment providers saying that it had remained a rarity during the previous six months. Participants with experience in buying and using methamphetamine in Toledo indicated that young, White males in their 20s were most likely to use methamphetamine. An educator who worked in areas of risk reduction reported methamphetamine use also could be found in Toledo among the White homosexual male population.

Current Trends

Methamphetamine remains relatively rare in the region. Participants most often reported the drug's current availability in urban areas as '0' and '6' in rural areas outside of Toledo such as Fulton and Lenawee (Michigan) counties on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common scores were '1' for Toledo and '8' for areas outside of Toledo. Participants described methamphetamine use as, "*a country thing.*" Participants who reported seeing methamphetamine in Toledo reported finding methamphetamine in its crystal form. A Toledo participant reported, "*I saw it [crystal methamphetamine] once being sold to a guy in the north end.*" Treatment providers in Toledo most often reported the drug's current availability as '0'; the previous most common score was '1'. Treatment providers in Huron County rated current availability as '4'. A provider stated, "*[Methamphetamine] it's available, but you have to do some work [to obtain it].*" Treatment providers from Huron County reported, "*The meth [methamphetamine] here is 'dirty,' not as potent ... it's junk, and they [users] don't know how to make it here.*" The DEA field office in Toledo reported that methamphetamine is still fairly rare in the 22 counties it covers, but may be found sporadically in some rural counties in the region. Participants and community professionals reported that the availability of methamphetamine has remained the same during the past

six months. The BCI Bowling Green Crime Lab reported that the number of methamphetamine cases it processes has decreased over the past six months. Participants who have experience with methamphetamine reported seeing people combine methamphetamine use with alcohol and marijuana use to produce the upper and downer feeling of a speedball. A participant reported, "*[Mixing methamphetamine with alcohol and marijuana] it's kind of like coke and heroin mixed together. You get the upper of the coke, and you get kind of that easiness and good feeling of heroin.*"

Ecstasy

Historical Summary

In the previous reporting period, Ecstasy (methylenedioxyamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) was highly available in the region. Participants most often reported the drug's availability as '9' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Treatment providers most often reported the drug's availability as '5,' while educators reported availability most often as '8'. Treatment providers and educators reported that the availability of Ecstasy had decreased during the previous six months, but there was no consensus as to the reason for the decrease. The BCI Bowling Green Crime Lab reported a decrease in the number of Ecstasy cases processed. Participants reported a "single stack" (low dose) Ecstasy tablet sold for between \$10-15 and a "double stack" or "triple stack" (high dose) sold for between \$20-25. Participants continued to describe typical users as those who frequent the club or bar scene. Additionally, participants described a shift in use from young, White club goers to young, Black club goers, 15-21 years of age.

Current Trends

Ecstasy (methylenedioxyamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) 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 '9'. Community professionals most often reported the drug's current availability as '5'. Participants and community professionals reported that the availability of Ecstasy has remained the same during the past six months. The BCI Bowling Green Crime Lab reported that the number of Ecstasy cases it processes has remained the same during the past six months.

Participants reported that Ecstasy is often cut with one or more other drugs like crack cocaine, heroin,

methamphetamine or powdered cocaine. Unable to be certain of what type of experience they will have, some users have sought out MDMA known as “Molly” to use alone, independent of cut applied. “Molly” refers to the purest MDMA in crystalline or powdered form. A participant reported that she switched from Ecstasy to Molly because she was sick for two weeks after taking Ecstasy that was cut with a substance she believed was methamphetamine: *“I couldn’t sleep, couldn’t eat. I thought I was going to die.”*

Current street jargon includes several different names for Ecstasy. The most commonly cited name remains “X.” Participants reported that a single stack Ecstasy tablet sells for \$10, and a double or triple stack sells for between \$15-20. A participant whose boyfriend was a drug dealer reported, *“He would buy it [Ecstasy] for \$2-3, but he would buy a lot, like 2,500 pills, and he’d sell them for like \$10-15 a pill.”* Participants described typical users of Ecstasy as, *“people who go to clubs, concerts; ravers; strippers.”* Treatment providers reported that Ecstasy is used in social situations, and often with alcohol. Participants also reported that Ecstasy is often used in combination with alcohol and marijuana.

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants were highly available to school-aged youth, those 18 years of age and younger, and reportedly less available to adults in the region. Participants most often reported availability of prescription stimulants as ‘4’ for adults and ‘8’ for those under 18 years of age on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Educators reported the availability of prescription stimulants (Adderall® and Ritalin®) within school populations as ‘10’, while treatment providers reported the availability of these drugs as ‘8’. Both participants and treatment providers reported that the availability of prescription stimulants had remained the same during the previous six months. Participants reported that Adderall® 30 mg sold for between \$6-8 and continued to attribute the use of these drugs to high school or college students who needed to focus on studying, working or cleaning.

Current Trends

Prescription stimulants remain highly available in the region. Participants most often rated the current overall 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 scores were ‘4’ for adults and ‘8’ for those 18 years of age and younger. A participant reported, *“[Prescription stimulant use] it’s really*

big in high schools and colleges.” Nearly every participant with prescription stimulant experience mentioned its ability to help the user, *“focus.”* Huron county treatment providers who work with youth younger than 18 years of age reported current availability of prescription stimulants as ‘8’, and noted that many prescription stimulant users are teens. Toledo treatment providers who work with adults most often reported the current availability of these drugs as ‘9’, while they reported seeing younger populations, 18-30 years of age, presenting with prescription stimulants in their system. 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 that the number of prescription stimulant cases it processes has generally remained the same over the past six months, while noting existence of decreases in the number of cases of medications based on methylphenidate HCL (Concerta® and Ritalin®).

The only street term reported to refer to prescription stimulants was, *“poor man’s coke.”* While participants were familiar with Concerta® and Ritalin®, no participant reported using either of these drugs in the past six months. Reportedly, Adderall® continues to dominate in terms of widespread use in the region. Those who purchased Adderall® reported that Adderall® 20 mg sells for between \$1-3; Adderall® 30 mg sells for between \$5-6.

Those in the 18-25 age group reported that they obtained Adderall® from others who were prescribed it, usually friends. Participants explained that most everyone in high school and in the 18-25 year age range knows someone that will freely give the drug to them or will sell it to them at a cheap price. No one reported having to go to the doctor to fake symptoms in order to get the drug. However, a participant discussed bartering for prescription stimulants, *“Some kids got it [Adderall®] prescribed and sold it for another drug.”*

Participants continued to describe typical users of prescription stimulants as, *“high school and college kids”* who want to study, girls trying to lose weight or people who work long hours and like to go out and party without falling asleep. A participant reported, *“I’m trying to do so much off three of hours of sleep. I work 14 hours a day. I try to go to at least one club every night with open performances ... Then I got to clean my house, do laundry. I still gotta mow the grass. I still gotta maintain my house ... I’m tired of being tired. I need a pick-me-up.”* Exam time on college campuses is reportedly a time when Adderall® use spikes. A participant reported, *“I’ve been in school full-time ... I haven’t seen anyone that uses it [Adderall®] to get high. There is always a purpose ... it sort of zeros you in.”*

Reportedly, prescription stimulants are not used in combination with other drugs when the user is using to accomplish particular tasks. However, if used to stay awake while “partying,” the user most often combines Adderall® with alcohol and marijuana. A participant reported, “A lot of them [Adderall® users] are college students that have to work full-time ... they work full-time and go to school full-time and wanna have a life after that.”

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 (synthetic compounds commonly containing methylone, mephedrone or MDPV), psilocybin mushrooms and synthetic marijuana (“K2” and “Spice”). A few participants had experience with K2 during the previous six months, but reported it as not highly available. Treatment providers also reported that the availability and desirability for K2 had decreased. The BCI Bowling Green Crime Lab reported that new forms of synthetic marijuana had shown up in their lab that had not seen in the previous six months. Psilocybin mushrooms were reported to be periodically available. Reportedly, 1/8 ounce of psilocybin mushrooms typically sold for between \$25-45. The use of bath salts was mentioned by some participants, but no one interviewed had recent experience with the drug. A toxicology expert at the coroner’s office reported that Toledo recently had its first death likely attributable to bath salts use: a White adult male. The BCI Bowling Green Crime Lab reported that the number of bath salts cases it processes had increased during the previous 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. Despite the recent ban of synthetic marijuana, participants and treatment providers believed the drug would remain available for some time and rated the current availability of synthetic marijuana as ‘6’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Synthetic marijuana that was previously sold at local head shops sold for \$25 for a two gram bag, but users did not report the current street price of the drug. Synthetic marijuana is smoked using the same techniques used to smoke marijuana. Reportedly, participants continue to use synthetic marijuana as an alternative to marijuana to pass work-related drug screens. Some participants reported that they were at first curious and excited about smoking

something legal. A participant explained, “K2 was popular at first ‘cause you could use it and pass the drug test. But people don’t feel it’s worth it after all the tests that came out [that screen for synthetic marijuana use].” This participant also reported, “Six months ago I could name a dozen people that smoked K2. Today I don’t know anybody that smokes it.” However, another participant reported current use of synthetic marijuana: “I use it [synthetic marijuana] now ‘cause I can’t do anything else. I smoke on the weekends ... I got a bag in my car.” He reported that the high produced by synthetic marijuana lasts about one and a half to two hours. Other participants reported disliking the taste and the artificial nature of synthetic marijuana. Instead, these participants preferred marijuana because it is, “all natural.” Treatment providers agreed, as one reported, “They [users] don’t like it [synthetic marijuana]. I’ve had maybe a handful of people that said they disliked it reporting it made them feel anxious, with a headache ... and it’s just not as enjoyable as marijuana.” The BCI Bowling Green Crime Lab reported that the number of synthetic marijuana cases it processes has increased during the past six months.

Bath salts are moderately available in the Toledo area and highly available in Huron County. Participants in Toledo most often rated the drug’s current availability as ‘6’ and participants in Huron County a ‘7’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Treatment providers in Toledo rated bath salts availability as ‘1,’ while treatment providers in Huron County rated availability as ‘10.’ A Huron County provider reported that users are, “presenting psychotic and getting hospitalized in the psych ward [following bath salts use].” The concern for treatment, as identified by a treatment provider in Huron County, is often, “The detox centers are saying [bath salts use] it’s a psychiatric problem, and then the psychiatric hospital is saying, ‘no, it’s a detox, rehab problem,’ so we have these clients that are actively hallucinating, at risk of hurting themselves ... and it’s kind of like we don’t know which treatment to put them in.” A regional media outlet reported on a large seizure of bath salts in Wood County during this reporting period. The Ohio State Highway Patrol found five pounds of bath salts during a routine traffic stop, with a street value of over \$150,000 (www.northwestohio.com, Dec. 9, 2011). The BCI Bowling Green Crime Lab reported that the number of bath salts cases it processes has increased during the past six months. Additionally, the crime lab reported that it has processed many “analog substances” (substances whose chemical structure is similar to bath salts) found in evidentiary specimens submitted this reporting period.

Typically, participants who had used bath salts reported having used the drug because it was legal and could not be detected on work-related drug screens. However, as of Oct.

17, 2011, bath salts that were previously sold in convenience stores, head shops and online were banned as an illegal substance in Ohio. Participants reported that two grams of bath salts legally sold for between \$10-12 before the ban on bath salts went into effect. A Huron county participant who reported having used bath salts more than five times described the use of bath salts: *"You crush it [bath salts] down and put it on a can the same way you would smoke crack ... The high lasts all night, eight hours or longer. Sometimes [I] would stay up for days."* A Toledo participant reported that he snorted bath salts a few months ago: *"It [bath salts] was kinda sticky. It burned really bad ... then there was nothing for a half hour to 45 minutes. Then I was thinking, 'this is garbage.' Then all of the sudden I'm sitting there at the jukebox ... I'm chewing on my teeth ... it was crazy. It was awesome, like cocaine. It was a completely amplified feeling. Everything was more interesting. You wanna talk more. You wanna do more things, and you gotta be moving around. You just feel like a bolt of lightning ..."* Other participants reported on the negative health consequences of bath salts they or their friends have experienced. A participant explained, *"A friend of my friend's was on it [bath salts] all day ... he thought there was people in his house, and he shot up his entire house ... he shot up his house and then called work and said that he'd killed four people, and then he called the cops and said the same thing. They [police] showed up and no one was there."*

Hallucinogens like LSD (lysergic acid diethylamide) and psilocybin mushrooms are periodically available in the region. Participants most often rated LSD's current availability as '2' and the current availability of psilocybin mushrooms as '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers rated the availability of LSD as '1', reporting that many clients have reported that they have *"tried it [LSD]"* or experimented with it at some point, but had not engaged in regular use. However, while psilocybin mushrooms were reported to be low in availability in the Toledo area, treatment providers in Huron County rated current availability of psilocybin mushrooms as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A Huron county treatment provider reported, *"That's a common one [drug of use],"* when asked about hallucinogens. Treatment providers in Toledo and Huron County reported that they have not worked with clients reporting regular use of hallucinogens and that psilocybin mushrooms are typically not a drug of choice among their clientele. Reportedly, both types of hallucinogens continue to be more bountiful in the summer and most prevalent during concerts and music festivals. A participant reported, *"You can't go out and find it [hallucinogens]. It will find you ... It's big around a music festival or jam bands."* Participants reported

that psilocybin mushrooms sell for between \$25-30 for 1/8 ounce, or roughly 3.5 grams. Reportedly, some users chew psilocybin mushrooms which are said to have an awful taste. A user reported rolling psilocybin mushrooms in Fruit Roll-Ups to attempt to disguise their taste. Reportedly, LSD sells for between \$3-10 per "hit" (dose, a microdot or blotter) depending on the seller. Participants who used LSD reported that an LSD high can last for up to 21 hours. According to participants, the type of trip (high) depends on the state of mind the user is in prior to taking the drug: the experience can either be, *"hard to manage or great."* During what could be described as a great trip, a participant reported, *"I could visualize. Like I saw how human thoughts were created in the brain. What parts of the brain were making it happen because I was actually watching it happening in front of my face, and I was like this makes perfect sense."* Those who took LSD placed a gel tab of the drug under their tongue. The high was described as having, *"a third eye"* or perceiving things very differently. The BCI Bowling Green Crime Lab reported that the number of LSD cases it processes has decreased, and the number of psilocybin mushroom cases it processes has increased, during the past six months.

Salvia divinorum (psychoactive plant) is moderately available in the region. Participants most often rated the drug's current availability as '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). The most common way to use the drug is smoking. The high produced by salvia divinorum reportedly lasts two to eight minutes, and participants described it as, *"intense but brief."* A participant explained the high this way, *"I went from my couch to a universe of colors [after smoking salvia divinorum]."* Participants reported that the drug is typically purchased online for \$30 per gram, and it looks like potpourri. The BCI Bowling Green Crime Lab reported that the number of salvia divinorum cases it processes has decreased during the past six months.

Finally, inhalant use was mentioned only in Huron County. Not many participants engaged in the practice because, as a participant who used to inhale put it, *"People say it [inhalant use] will kill you."* Products used to inhale are 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"), a canned product used to clean VCRs. To use Rush, the user puts it into a balloon and inhales it. An inhalant high reportedly lasts just a few seconds, and as one user put it, *"[Inhalant use] it's supposed to intensify sex ... they sell it in adult bookstores."*

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids, prescription stimulants and sedative-hypnotics remain highly available in the Toledo region. Data indicate likely increases in availability during the past six months for heroin and Suboxone®. The BCI Bowling Green Crime Lab reported that the number of powdered and black tar heroin cases it processes has increased. A participant commented, *"You can get it [heroin] anywhere in Toledo."* A treatment provider commented, *"Heroin is overrunning pills ... heroin seems to be more accessible to them [users] now. It's cheaper [than prescription opioids]."* The DEA field office in Toledo reported that DEA agents have made, *"[heroin] cases in the suburbs and cases involving teens,"* highlighting the widespread availability of heroin. While many types of heroin are currently available in the region, participants continued to report the availability of brown powdered heroin as most available. Some participants reported that Toledo drug dealers are frequently marketing heroin as fentanyl, explaining that they believed this is done to lure buyers who would be leery of using heroin. Most heroin users reported that first heroin use occurred between 18-19 years of age, while reporting that first use of prescription opioids occurred before the age of 18 years when in high school. Participants identified Percocet® as the most popular prescription opioid in terms of widespread use, followed by Opana®; treatment providers identified Dilaudid®, fentanyl, methadone, OxyContin® OP and Vicodin® as other prescription opioids that are highly available and used. Law enforcement reported that the availability of prescription opioids has increased over the past few years and reported a current *"boom"* of illegal prescription opioid use in the region. The BCI Bowling Green Crime Lab reported increases in the number of hydromorphone (Dilaudid®), morphine and oxymorphone (Opana®) cases processed during the past six months. Suboxone® is highly available in the region. Participants most often reported current availability of Suboxone® as '8' 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 '10' (both scores higher than previously reported). The BCI Bowling Green Crime Lab reported that the number of Suboxone® cases it processes has increased during the past six months. Participants continued to describe typical street users of Suboxone® as heroin users who want to withdraw from the use of heroin without being sick and those who wish to avoid dope sickness for the time being. Lastly, despite the recent bans on synthetic marijuana and bath salts, participants and treatment providers believed the drugs

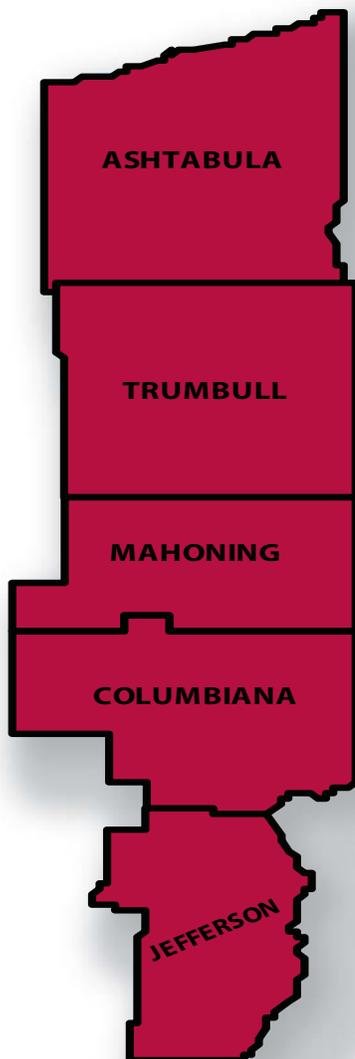
would remain available for some time. The BCI Bowling Green Crime Lab reported that the numbers of synthetic marijuana and bath salts cases it processes have increased during the past six months. Additionally, the crime lab reported that it has processed many "analog substances."

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Youngstown Region

June 2011-January 2012

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Youngstown Regional Profile

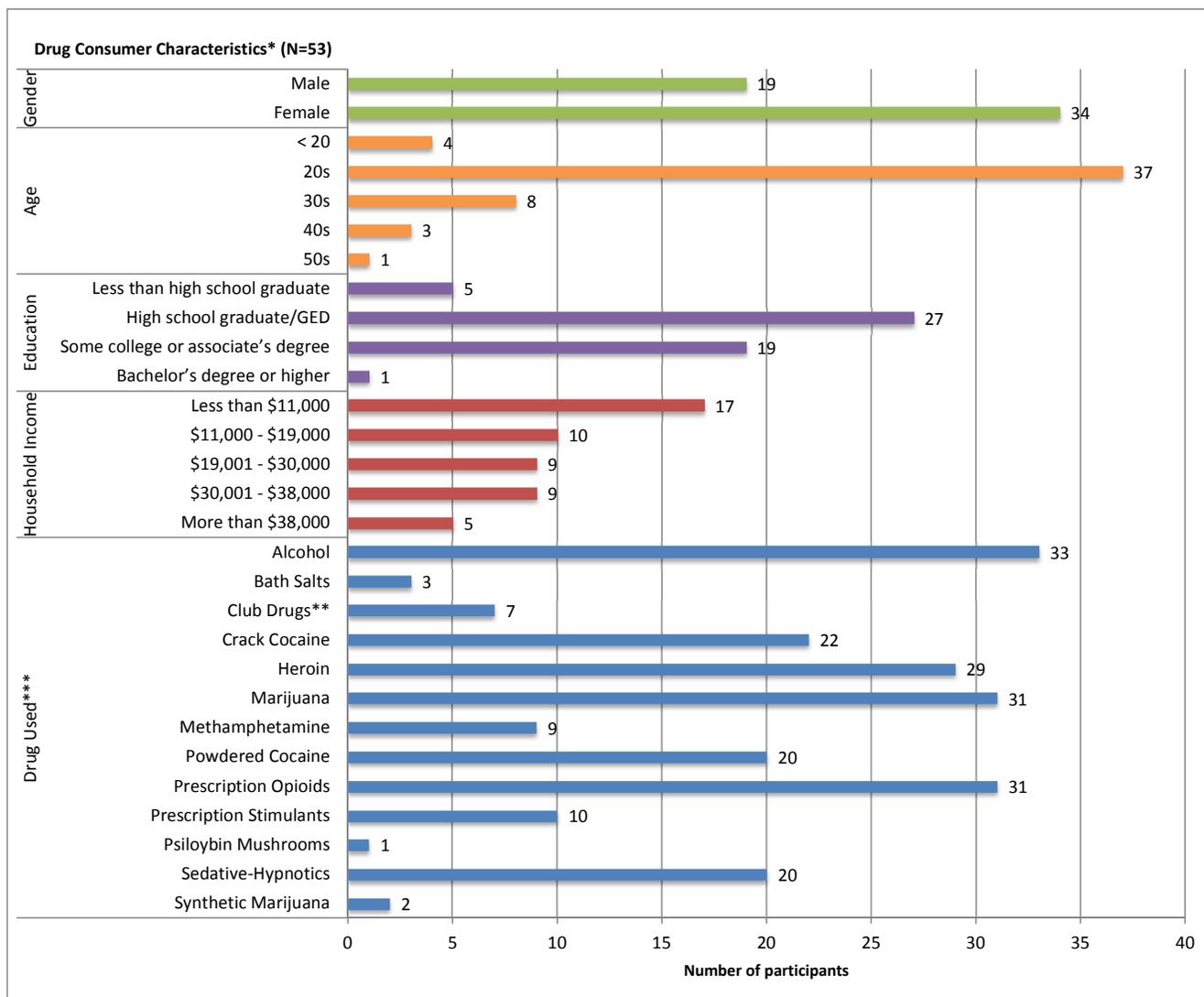
Indicator ¹	Ohio	Youngstown Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	728,182	53
Gender (Female), 2010	51.2%	51.1%	64.2%
Whites, 2010	81.1%	86.3%	86.8%
African Americans, 2010	12.0%	8.7%	9.4%
Hispanic or Latino Origin, 2010	3.1%	2.7%	3.8%
High school graduates, 2009-2010	84.3%	86.8%	90.4% ²
Median household income, 2010	\$45,151	\$38,228	\$11,000-\$19,000 ³
Persons below poverty, 2010	15.8%	16.9%	48.0% ⁴

Ohio and Youngstown 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 2011. Income status was unable to be determined for three respondents due to missing data.³

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



*Not all participants filled out forms; therefore, numbers may not add to 53.

**Club drugs refers to Ecstasy and LSD.

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Ashtabula, Columbiana, 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 Bureau of Criminal Investigation (BCI) Richfield Office, which serves the Akron, Cleveland and Youngstown areas. BCI data are summary data of cases processed from January through June 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current 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 July through December 2011.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While highly available, the consensus among participants was that crack cocaine remained easier to obtain on the street than powdered cocaine. Treatment providers and law enforcement most often reported the drug's availability as '8'. Many treatment providers named cocaine in the top three drugs used in the region. The vast majority of participants and community professionals reported that the availability of powdered cocaine had remained stable during the previous six months. The most common participant quality score for powdered cocaine was '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Universally, participants reported that the quality of powdered cocaine continued to be dependent on the source, the person from whom one buys. The BCI Richfield Crime Lab continued to cite the following substances as commonly used to cut (adulterate) powdered cocaine: caffeine, diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetics). Participants reported that a gram of powdered cocaine sold for between \$50-100, depending on the quality. While there were a few reported ways of consuming powdered cocaine, the most common route of administration for this form of

cocaine remained snorting followed by intravenous injection. Several participants reported, "cooking up" (manufacturing) powdered cocaine into crack cocaine and smoking the drug. Many participants continued to associate powdered cocaine use with the bar/club scene. Community professionals reported that users of powdered cocaine tended to be White and older than 30 years of age.

Current Trends

Powdered cocaine remains highly available in the region. Participants most often reported the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. A participant with experience using powdered cocaine reported, *"I wouldn't say [powdered cocaine] it's the easiest drug [to obtain], but it's pretty easy to find."* Other participants reported: *"[Powdered cocaine is] pretty easy to get but not as easy as crack cocaine [to obtain]; I think [powdered cocaine] it's harder to get . . . that's how I got introduced to crack [cocaine] because I couldn't get powder."* Participants also noted that powdered cocaine, along with other drugs, is more difficult to obtain in various areas of the region. A participant noted that many drugs, including powdered cocaine, are, *"much harder to get in rural areas and smaller towns."* Community professionals most often reported the current availability of powdered cocaine as '8'; the previous most common score was also '8'. A law enforcement official reported, *"Powdered cocaine and marijuana probably makes up about 20 percent of our [drug arrest] cases. It's just not as big of a problem as heroin."* A treatment provider recalled, *"I just don't see a preponderance of powdered cocaine in this area, I would say, in the last two years. I see crack users who can't find crack . . . will look for powdered cocaine."*

Participants and community professionals reported that the availability of powdered cocaine has remained the same during the past six months. A treatment provider described powdered cocaine as an "opportunistic" drug for teenagers, sometimes leading to dependency: *"[Powdered cocaine] it's opportunistic with teens . . . they'll do it if it's around. But if they develop that relationship with a stimulant then they might continue to use it in adulthood."* Another treatment provider described powdered cocaine abuse among adults: *"If someone is a heavy drinker, they might use cocaine to prolong their high, having a dependent relationship with alcohol and an abusive relationship with cocaine."* 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 '7'. Participants reported that powdered cocaine in the region is cut with

baby formula, baby laxative, baking soda, prescription opioids, sleep aids (NoDoz® and Sleepinol®), soap and vitamins such as B12. In addition, several participants reported that head shops sell products that can be used for cutting drugs. One participant said, *“Head shops sell their own cut for coke [cocaine]. It even makes your lips go numb, but you won’t get high from it. It’s expensive though, but some dealers do use it to trick people and make the coke stretch further.”* Another participant agreed reporting, *“Head shops sell ‘Goodie Powder.’ It’s like little packs of crushed Tylenol® that people use for cut.”* A third participant reported, *“It [powdered cocaine] can be cut with anything white really or slightly yellow. To be honest, you never know what you’re getting; you never know what you’re putting into your body.”* There was consensus among participants that the quality of powdered cocaine has decreased during the past six months. A participant reported, *“It [powdered cocaine] goes through so many hands before it gets to you. By the time you get it, it’s been cut so many times [that] it’s garbage.”* Participants continued to report that the quality of powdered cocaine depends on from whom one buys. Many participants agreed that drug dealers are getting younger, roughly between the ages of 16-18 years. Reportedly, quality seems better if powdered cocaine is purchased from older dealers who have been selling for many years. One participant said, *“If you buy [powdered cocaine] from old-school guys [dealers], they keep it right — they believe in quality over quantity. They don’t believe in cutting it.”* In addition, several participants agreed that dealers who sell cocaine often use powdered cocaine themselves before turning it into crack cocaine to sell. The BCI Richfield Crime Lab cited the following substances as commonly used to cut powdered cocaine: caffeine, benzocaine (local anesthetic), diltiazem (medication used to treat heart conditions/high blood pressure) and levamisole (livestock dewormer).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were “blow,” “girl” and “powder.” Participants listed the following as other common street names: “b****,” “christina,” “christine,” “coke,” “dope,” “fuel,” “nose candy,” “powder,” “soft,” “snow,” “white,” “white girl” and “ya-yo.” Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine. Participants reported that a gram of powdered cocaine continues to sell for between \$60-100, depending on the quality; 1/16 ounce, or “teener,” sells for \$70; 1/8 ounce, or “eight ball,” sells for between \$140-150; an ounce sells for between \$1,200-1,500. Participants reported that the most common way to use powdered cocaine remains snorting, followed by intravenous injection. Out of 10 powdered cocaine users, participants reported that approximately eight would snort and two would intravenously inject. A participant reported, *“I’ve always snorted it [powdered cocaine], but I’ve seen a few people inject it, mostly when they were using heroin to speedball.”*

Participants most often described typical users of powdered cocaine as, *“teenagers and people in their early 20s,”* confirming use among young adults between 18-25 years of age. Participants also noted that powdered cocaine is a more expensive drug, so people with money are more likely to use powdered cocaine. A participant stated, *“You have to have a big income to support that [powdered cocaine] habit.”* A participant reported seeing powdered cocaine as less of a problem than other drugs: *“Cocaine’s ‘not cool’ anymore, you know? For young people now, it’s either heroin or pills [prescription opioids]. Cocaine is maybe something you did when you were younger, a teen ... I really don’t see it now as much.”* Another participant reported, *“I messed with powdered cocaine more when I was a teen. I was 15 [years old] the first time I tried it. It wasn’t very available to me because I’m from a small town in Columbiana [County]. Now, crack cocaine is my drug of choice.”*

Reportedly, powdered cocaine is used in combination with alcohol, heroin and prescription opioids. Many users noted the practice of “speedballing” (mixing powdered cocaine with heroin for injection) as popular. Out of 10 heroin users, participants reported that three to four would speedball with powdered cocaine. Participants also noted that powdered cocaine is often used in combination with downers (depressant type drugs) in order to “come back up.” A participant reported, *“I would snort coke after using heroin if I had to get things done — it would bring me back up so I could get things done.”* In turn, a participant noted smoking marijuana with powdered cocaine, *“It [marijuana] helped me come back down so I could go to sleep [after using powdered cocaine].”* Another participant noted, *“My friends would do coke then pop ‘X’ [Ecstasy] and continue to do coke while they’re on X.”* Another participant noted that powdered cocaine can be bought at bars in the region: *“Alcohol and coke go hand-in-hand. Go to any bar downtown and you can get some coke.”* Another participant reported that, *“I would use powder then pop some Xanax® and drink [alcohol] to come down [from powdered cocaine].”* The Mahoning County Coroner’s office reported, *“Several drug-related deaths in the past year were a result of combining cocaine with ethanol [alcohol] or cocaine with narcotics.”*

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’ and community professionals reported it as ‘9.5’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants continued to describe crack cocaine as extremely easy to get. The majority of participants and community professionals reported that the availability of crack cocaine had remained the same during the past six months. The most

common participant quality scores for crack cocaine were '2' and '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut with other substances. The BCI Richfield Crime Lab continued to cite caffeine, diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetics) as common cutting agents for crack cocaine. Participants reported that a gram of crack cocaine sold for between \$40-150. Participants agreed that the price of crack cocaine varied due to the quality of the product. Reportedly, higher quality crack cocaine was available if one was willing to pay the price. By far, the most common route of administration for this form of cocaine remained smoking. Participants and treatment professionals stated that crack cocaine use was a far-reaching problem that affected every 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'. A participant reported, *"If you have never used crack cocaine, and you want to, go to any gas station in Youngstown. You will find a dope boy [dealer] outside trying to sell some crack [cocaine]."* However, there was consensus among participants in Columbiana County that crack cocaine is more difficult to obtain in smaller towns and rural areas. As one participant said, *"You have to take a drive to get it [crack cocaine] most of the time ... to Youngstown, Warren or Akron."* Another participant noted places where individuals can go to buy supplies for crack cocaine: *"My area has lots of [convenience stores and gas stations] that sell smoking devices and Chore Boy® [stainless steel scrubbing pad used as a screen] and a cheap lighter ... [you] just need to ask for a stem or rose [artificial rose that is attached to a glass stem used as a pipe]."* Community professionals most often reported the current availability of crack cocaine as '10'; the previous most common score was '9.5'. Law enforcement reported, *"Heroin is such a big problem. I know crack cocaine is out there, but the heroin ... heroin is such a raging fire; you're not going to worry about the guy cooking hotdogs [using crack cocaine]."* Media outlets in the region reported on several crack cocaine seizures during this reporting period. After local police resolved an altercation in Youngstown, they found one of the perpetrators was in possession of four grams of crack cocaine and two-and-a-half grams of marijuana (www.vindy.com, July 5, 2011). In another incident, police from the Ashtabula Group Law Enforcement Task Force found crack cocaine, marijuana, drug paraphernalia and weapons after a three-month investigation of a Youngstown resident (www.vindy.com, July 15, 2011). Participants reported that the

availability of crack cocaine has remained the same during the past six months. Many participants believed the drug is never going to leave the region. One participant said, *"Crack is out here ... in the last 22 years [that] I've been alive, it's been here. It's always going to be here."* Community professionals also reported that the availability of crack cocaine has remained the same during the past six months. 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 current quality of crack cocaine as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common quality scores for crack cocaine were '2' and '6'. Participants reported that crack cocaine in the region is cut with aspirin, baby laxative, baking soda and a powder sold in head shops called *"Come Back."* The BCI Richfield Crime Lab continues to cite the following substances as commonly used to cut crack cocaine: caffeine and diltiazem (medication used to treat heart conditions/high blood pressure). There was agreement among participants that the quality of crack cocaine continues to depend on where and from whom one buys the drug. Participants reported that the quality of crack cocaine has remained the same during the past six months. A participant who reported crack cocaine use within the past six months said, *"If [crack cocaine] it's yellow and it looks like butter, it's really good quality stuff. If it's soft, it melts ... it's really, really good,"* but noted that this type of crack cocaine is very difficult to find.

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: "bo-bo," "butter (for high-quality crack cocaine)," "candy," "dope," "girl," "trap" and "work." A participant noted that the nickname "trap" came from, *"the idea that it [crack cocaine] will trap you. It's that bad. It'll just trap you — can't get out if it."* Current street prices for crack cocaine are as low as \$10 but can go even lower. A participant stated, *"You can get crack cocaine for a dollar even."* Another participant noted, *"Whatever you got, [dealers] they'll work with you."* Participants reported that a gram of crack cocaine sells for \$70, depending on the quality. Most participants agreed that crack cocaine is sold in dollar amounts (\$50, \$60, \$100) and did not know prices for specific weights. A participant commented: *"If you have \$16, you can get \$16 worth of crack."* 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 seven would smoke and three would intravenously inject. A participant reported, *"People will shoot [inject] crack if they want to speedball with heroin, but people mostly smoke it."*

A profile for the typical user of crack cocaine did not emerge from the data. Participants described typical users of crack cocaine as “everybody and anybody.” However, several participants agreed that users of crack cocaine tend to have low incomes and live in lower-income neighborhoods. A participant commented, “Crack is for, like, I don’t wanna say lower-level ... you know people that are struggling ... because it’s cheaper, and you know, it’s more available.” Several participants reported that their crack cocaine dealers were typically African-American, while users of crack cocaine can be African-American or White. A typical comment was echoed by one participant: “In my area, in my experience, my dealers [for crack cocaine] have been Black, and the people I know who use [crack cocaine] are White.” Other participants reported that older individuals are more likely to use crack cocaine than the younger population. One participant said, “Older people use crack, males and females about 40 years old and up.” An adolescent treatment provider reported, “You get a lot of young African-American males who will start selling it [crack cocaine], depending on their geographical region and the circumstances they grow up in, so maybe they smoke weed and do their thing, but they are selling crack cocaine as means of earning income.”

Reportedly, crack cocaine is used in combination with alcohol, heroin and marijuana. A participant explained, “I’ve used it [crack cocaine] with heroin. Crack’s an upper and heroin is a downer. Use crack after [heroin use] to get you back up, if you got things to do.” Participants also reported using alcohol and marijuana with crack cocaine to help in coming down from the stimulant high produced by crack cocaine.

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 the availability of brown and white powdered heroin as most available. The majority of participants reported that the general availability of heroin had increased during the previous six months. The BCI Richfield Crime Lab reported that the number of powdered heroin cases it processed during the previous six months had increased. Participants most often rated the quality of heroin as ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). The BCI Richfield Crime Lab cited lidocaine and procaine (local anesthetics) as commonly used to cut powdered heroin. Participants reported that heroin was available in different quantities, selling for as little as \$10-20 for 1/10 gram quantities referred to as “bags,” “balloons,” “bindles,” “bundles” and “stamps;” a gram sold for between

\$50-160. While there were a few reported ways of consuming heroin, the most common route of administration remained intravenous injection, followed by snorting and then smoking. Participants estimated that 75-100 percent of heroin users intravenously injected heroin. Along with widespread reports of intravenous use of heroin were widespread reports of sharing of injection needles and Hepatitis C infections. The consensus among participant and community professional groups was that heroin users continued to be predominately White males and females between the ages of 20-35 years, although several community professionals also continued to report increasing heroin use among adolescents, particularly teenaged females.

Current Trends



Heroin is highly available in the region. Participants and community professionals most often reported the overall current availability of heroin as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10.’ While many types of heroin are currently available in the region, participants reported brown powdered heroin as most available. Participants from Ashtabula, Columbiana, Mahoning and Trumbull counties reported that brown powdered heroin is easier to obtain than many other drugs. Participants stated, “In

Columbiana County, it’s easier to get heroin than marijuana — and it’s cheaper; I can go to four different drug houses within a block of where I live to get it [heroin]; [Heroin] it’s the easiest drug I know of to find in Youngstown.” Law enforcement officials noted that brown powdered heroin is the most common drug they encounter; reporting that throughout the entire region, heroin is the primary drug problem. Media from the region reported on recent arrests related to heroin during this current reporting period. In October, a Mahoning County grand jury indicted 10 people on charges related to the operation of a heroin-distribution ring. These 10 people were alleged to be responsible for bringing \$1 million worth of heroin to the Mahoning Valley (www.vindy.com, Oct. 22, 2011). In July, the U.S. Attorney’s office released the names of 25 people wanted in a federal investigation into the sale of heroin in Youngstown (www.vindy.com, July 1, 2011).

Participants reported black tar heroin as rarely available, rating its current availability 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 ‘4.’ A participant reported, “I never see black tar [heroin]. It’s around. It’s just hard to find.” A participant with experience using heroin said, “I never been around black tar. I’ve always used

brown powder [heroin] ... never seen it [black tar heroin]. Participants noted that black tar heroin is the most potent of heroin forms. A participant stated, *"Black tar is the Ferrari® of heroin. But you really got to know someone to find it."* Community professionals also reported that black tar heroin is rarely available. A law enforcement official from Trumbull County reported, *"We haven't seen black tar at all ... always been brown powder [heroin]."* Law enforcement from Mahoning County reported having some cases involving black tar heroin, although brown powdered heroin is much more common.

Most participants and community professionals were not able to provide information on the availability of white powdered heroin. However, several participants older than 30 years of age reported that white powdered heroin is readily available: *"White powder ... [aka] China white ... is available in Youngstown and definitely [available in] Cleveland. I won't use brown powder ... it's crap; My dealer has a steady source of 'China white' so that's all I use. It definitely depends on who you know."* Most participants agreed that they had not specifically seen all-white powdered heroin, although some brown powdered heroin could include beige or cream-colored chunks or be light brown with "flecks" of white. Most participants agreed that they did not know if the white substance in brown powdered heroin is heroin itself or substances used to cut heroin. A participant described heroin as, *"Sometimes [heroin] it's real dark brown, almost cappuccino colored, and it varies to real light brown with flecks of dark brown or flecks of white or beige. It all depends."* Another participant described the consistency of brown powdered heroin as, *"wet, fine brown sand once you break it down."* The BCI Richfield Crime Lab described powdered heroin cases it processes as brown or white.

Participants reported that the availability of heroin has either remained the same during the past six months or has increased in some areas. One participant said, *"[Heroin availability] it's been a '10' [highly available] for a long while now."* Another participant with experience using heroin believed heroin to be more available: *"I think [heroin] it's more available now ... it did not use to be so available in some of the smaller towns out here."* Community professionals reported that the availability of heroin has remained the same during the past six months. A law enforcement official noted, *"Heroin over the past five years has been growing into a huge problem, and I don't know if it's growing steadily, but it's certainly not shrinking. So, now you have the old heroin users and the new ones."* The BCI Richfield Crime Lab reported that the number of heroin cases it processes has increased during the past six months.

Most participants generally rated the quality of heroin as an '8' on a scale of '0' (poor quality, "garbage") to '10' (high

quality); the previous most common score was '8'. A number of participants reported that quality can range from five to 10 as quality is said to depend on the dealer and from where the dealer's supply originates. A participant shared, *"This is going to sound crazy, but the girl that was with me [six months ago], she came with me to get heroin, and she overdosed on it. So, I went back to her dealer and bought it [heroin] off of him, because, well, it was obviously really good."* Participants reported that brown powdered heroin in the region is cut with antihistamines, baby laxatives, Benadryl®, sleeping pills and vitamins. A participant reported, *"Dealers will cut [heroin] with things to trick you ... heroin makes you nod off, so they'll cut it with Sleepinol® to increase your nod, you know, make you nod off a little faster, harder."* Another participant reported *"I know someone who used that bareMinerals® make-up ... it's very fine [in consistency] ... and it would make the [white] powder brown."* The Mahoning County Coroner's Office reported that out of roughly eight heroin-related deaths in the past year, two deaths were solely from heroin while the remaining six were from heroin mixed with narcotic pain relievers. The BCI Richfield Crime Lab cited caffeine and diphenhydramine (antihistamine) as commonly used to cut powdered heroin.

Current street jargon includes many names for heroin. The most commonly cited names were "boy," "dog food," "food," "H," "H-ron," "hard," "rock," "smack" and "Thai food." Participants reported that brown powdered heroin is available in different quantities: a "baggie" or "stamp" (1/10 gram) generally sells for \$20, however \$10, \$20 and \$30 stamps can also be purchased; participants reported buying heroin in "bundles" (10-12 small packs of heroin) for \$100, averaging \$10 per pack with each pack being the size of a dime, possibly a little larger or smaller depending on the quality; a gram of brown powdered heroin sells for between \$75-150, depending on the quality and county within the region. Participants noted that stamps are often folded within dense paper, specifically scratch-off lottery tickets. A participant with experience using heroin noted the price differences between smaller towns and rural areas of the region: *"People in Youngstown get more [heroin] for their money, and we get less [in Ashtabula]."* Participants reported that the most common way to use heroin remains intravenous injection. Out of 10 heroin users, participants reported that approximately nine would intravenously inject and one would snort. Law enforcement noted, *"We've seen younger people start with snorting it [heroin] then going onto injecting it."* Participants also reported this progression from snorting to injecting among heroin users, and treatment providers agreed. A treatment provider reported, *"It used to be alcohol, marijuana, some other things, and then opiates. Now, a lot of people are going from alcohol or marijuana straight to heroin, snorting and then injecting and sometimes, straight to injection"*

if other opiates are no longer doing it [producing a high] for them.” In addition, several participants described a process where heroin users will draw out residue from the cotton used to inject heroin and reuse it. Other participants agreed reporting, “Rinse’ is when you pull out the cotton with the residue on it. You can put more water on it and shoot it or snort it or people will eat the cotton too; I know lots of people who do [reuse cotton or eat cotton]; they don’t want to waste the residue on the cotton ...”

Most participants with experience using heroin reported obtaining needles from drug dealers and pharmacies: *“You can buy boxes of 500 [needles] at mom and pop pharmacies. They want the money, so they’ll sell them; I bought mine [needles] for \$2-3 from my dealer or went to Giant Eagle if my dealer didn’t have them ... told them [pharmacy staff] my grandpa is a diabetic.”* Another participant reported, *“My uncle was an addict, and he would go to Walgreens and sign the needle registry, and my friends would go through him [for needles], and so did I. I know places on the east side that are commonly-known houses that sell needles.”* Another participant also reported, *“Dope houses sell them [needles].”* There was consensus among participants that needle-sharing is a problem. One participant said, *“That’s rule number uno: never share needles and never use it [a needle] more than three times on yourself. I’ve seen people break needles off in their arms. You got to rinse them real good after you use them too — you can give Hep C [Hepatitis C] to yourself, most people don’t know that; almost everybody I know has Hep C. I’m waiting on my [Hepatitis C test] results.”* Participants universally shared concern over contracting Hepatitis C and HIV. A law enforcement official reported, *“It’s not uncommon to share needles. When I talk to users, most of them are extremely open about their use — they’ll show their track marks.”*

Participants described typical users of heroin as, *“all types of people.”* However, significant differences in age and race were noted. Most participants and community professionals agreed that heroin is a big problem among 18-25 year olds. A participant reported, *“I see younger people [using heroin], and then it skips a generation to older people who have been doing it for 30 years.”* Another participant noted, *“I think it’s the younger group now—teens and early 20s are using heroin. When I was growing up it was weed, Triple C’s [Coricidin®] we popped, than cocaine and meth [methamphetamine] got kind of big where I’m from, and then heroin has just completely taken over.”* Treatment providers agreed, with one reporting, *“Heroin has really become a bigger problem among the younger population. I would say maybe 40-50 percent of my adolescents/young adults use heroin.”* A law enforcement official reported, *“... We’re seeing young people from 17-25 [years] typically, who might have started with prescription drugs, and they are snorting heroin, but others who have been using for some time are injecting it. We see it more among Whites, a little more*

males but an increase in females using.” Law enforcement also noted that heroin affects all types of families. The Mahoning County Coroner noted, *“People dying from drug toxicity of heroin, and heroin and other substances, are Black, White, male and female.”* A treatment provider also reported, *“A lot of the women I work with are trauma survivors and most of them use either heroin or OxyContin® or now Opana® ... opiates.”*

Reportedly, heroin is used in combination with alcohol, crack cocaine, marijuana, powdered cocaine, prescription opioids and sedative-hypnotics. A participant reported, *“I never met anyone that just strictly does heroin.”* Crack cocaine and powdered cocaine are used in combination with heroin to speedball. Participants reported that four out of 10 heroin users might speedball using cocaine because it is said to intensify the high produced by heroin. Other participants noted that alcohol and marijuana are used to help level off or come down from the high of heroin. Other participants noted that crack or powdered cocaine is used by some after using heroin to, *“come back up.”* A participant reported injecting heroin and swallowing Xanax® to intensify her high: *“When you use Xanax® [with heroin], you get a lot higher, dangerously higher. I’ve overdosed using Xanax® with heroin.”* The Mahoning County Coroner reported that heroin-related deaths are typically from a combination of drugs: *“I’ve had two deaths in 2011 that were solely from heroin. We typically see heroin combined with other drugs, most commonly with other narcotic pain relievers. Anti-anxieties and alcohol are also typically mixed in with heroin deaths.”*

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 continued to identify OxyContin®, Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Participants also noted increasing popularity of Opana® and Ultram®. Treatment providers noted the increasing popularity of Ultram® among adolescents. Participants reported that the availability of prescription opioids had remained stable during the previous six months, with the exception of OxyContin® OC which had decreased in availability. Several participants continued to describe ways to abuse the reformulated, more tamper-resistant OxyContin® OP. Participants reported that prescription opioids continued to sell for a dollar per milligram with a few exceptions. In addition to obtaining prescription opioids on the street from dealers, participants continued to report getting them from doctors, dentists,

emergency rooms, friends, family members and others with prescriptions. However, the consensus among participants and community professionals was that the most common route for obtaining prescription opioids was through area physicians. There were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids. Common routes of administration continued to include the following in order of highest report: swallowing/chewing, snorting and intravenous injection. There was no consensus regarding a profile of a typical user of prescription opioids.

Current Trends

Prescription opioids remain highly available in the region. Participants 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'. Participants identified Opana®, Roxicodone® and Ultram® as the top three most popular prescription opioids in terms of widespread use. A participant reported, "Opana® is definitely the big thing now ... it's pretty potent—the 30s [30 mg pills]. Opana® replaced the old oxy's [OxyContin® OC], and no one wants the new oxy's [OxyContin® OP] now that they [Purdue Pharma] changed the make-up of them." A couple of participants with experience using heroin noted that prior to first heroin use, they used Ultram® before graduating to "stronger" prescription opioids: "I started [my drug use] with Ultram®, then went on to roxy's [Roxicet®] and oxy's [OxyContin®], and then started on heroin; Me too – exactly the same story." Another participant reported, "I don't know anyone who doesn't take Ultram®. They are so easy to get, and if you take enough of them, they'll get you to where you want to be." Community professionals most often reported the current availability of these drugs as ranging between '2' and '10', depending on the drug. Community professionals identified Opana®, oxycodone and Roxicodone® as the top three most popular prescription opioids in terms of widespread use. A law enforcement official noted that in Ashtabula and Trumbull counties, "Our search warrants primarily for heroin cases will reveal prescription opioids. Roughly five out of 10 [heroin] cases may include Opana®; nine out of 10 cases may include oxycodone and Roxicodone®." Another law enforcement official reported that in Mahoning County, "Opana® is just coming around. We haven't seen too, too much of it yet. Since the reformulation of the oxy's [OxyContin® OC], Roxicodone® has taken over ... 'blue boys' they call them ... have taken over."

Participants reported that the availability of prescription opioids, especially Opana®, has increased during the past six months. Participants also reported that OxyContin® OC is almost impossible to obtain now, and in turn, the availability

of Roxicodone® has seemingly increased as people seem to prefer it over the new reformulated OxyContin® OP. A participant reported, "I definitely think Opana® [availability] has increased in the last six months. I know a lot of people, especially heroin users, who use it, and I know three people I can call right now who have scripts [prescriptions] for them." Participants agreed that OxyContin® has decreased in availability and use. One participant said, "It's really easy to get the new oxy's [OxyContin® OP] now, but nobody really wants to bother with them. You can break them down and shoot them or peel the coating off and snort them, but it's a hassle." Several participants reported having seen an increase in Lortab® during the past six months. A participant reported, "This [Lortab®] was my drug. I brought mine from Alabama to sell up here. I bought them from somebody off the street there because they hadn't been up here much. That was my drug of choice ... the white ones." A treatment provider agreed, reporting, "There has been an increase of Lortab® in the last six months. I've been hearing about it a lot in my evaluations [intake procedure], but I don't think it's a drug of choice; something people will use if it's available." Community professionals reported that availability of prescription opioids has remained the same during the past six months with the exception of Lortab®. 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 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 100 mg patches (aka "patches;" sells for between \$50-70), Opana® 40 mg (aka "bears;" "pana's," "pandas" "panda bears" and "yellow stop signs;" sells for between \$60-70), 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 40 mg (new formulation, aka "little boys" and "oranges;" sells for between \$20-30), Percocet® (aka "blues;" "greens;" "peaches" and "perc's;" sells for between \$12.50-27.50 per pill, depending on milligram dose amount), Roxicet® (aka "IR 15's;" "IR 30's" and "roxy's;" 30 mg sells for \$20), Ultram® (aka "trims;" sells for between \$.50-1.50 per pill) and 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). Participants reported that Ultram® and Vicodin® are seemingly "given away" due to other prescription opioids being in higher demand. A participant reported "My aunt has a prescription and gives me those [Ultram®] ... nobody really wants those." Another

participant with experience using crack cocaine said, *“My dealer would just give those [Vicodin®] away ... asked me if I wanted any vic’s or perc’s.”*

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 swallowing. Most participants agreed that prescription opioids are more commonly snorted rather than swallowed among 18-25 year olds. Many participants agreed that the new formulation of OxyContin® can and are broken down to be snorted and injected. Many participants with experience injecting heroin reported injecting prescription opioids. One participant said, *“I would shoot pain killers to avoid getting dope sick.”* In addition, many participants distinguished between eating and swallowing prescription opioids, where participants reported either chewing the pills and then swallowing instead of swallowing the pill whole. Other participants reported crushing the pills first, putting them in their mouth, and then swallowing them. A participant reported, *“I’d crush them [prescription opioids] up and put them in my mouth or chew them. Once I figured out how to shoot [inject] them, I never really did that anymore [chewing pills.]”* Another participant reported *“Oh, I chew my pills up – definitely. They just get into your bloodstream a lot quicker and you get higher than if you swallowed.”* A participant also reported having smoked prescription opioids: *“I personally put them [prescription opioids] on tin foil and smoke them. That’s how I did my heroin too. I didn’t snort pills; I’d either shoot them or smoke them.”*

In addition to obtaining prescription opioids on the street from dealers, participants also reported getting them from pain management clinics, private physicians and hospital emergency rooms, as well as from family and friends who have prescriptions. Participants reported: *“I had three different people going to doctors and they would give me their scripts; I have back problems, so I have a script of Ultram®; I started at a very young age. When I was 12 [years old], I took oxy 80s [OxyContin® 80 mg]; I wasn’t prescribed them obviously. I was stealing them from my mom here and there; I bought them [Opana®] from old people in their 50s, 60s. They don’t know how much their worth, so I bought them from them for \$25 or so ... knowing I could get \$60 for one.”* Participants reported that many people know which doctors to go to for prescription opioids. One participant said, *“When you’re on the street, you know which doctors will write you a script.”* Most participants agreed that doctors will often take cash instead of insurance for prescription opioids. Several participants reported that some prescription opioids can be purchased online.

Generally, prescription opioid use seems to be very common among those 18-25 years old. However, participants agreed that all types of people take prescription opioids. One participant said, *“I think [prescription opioid use] it’s really common among young people. I’ve seen 14 and 15 year olds taking trims [Ultram®]. At the same time, you see older men, older dope dealers taking them.”* Another participant said, *“[Prescription opioid use] it’s definitely common among young people because it’s easier for them to get [prescription opioids]. They can take them from parents ... they can find them anywhere. I know kids who are 16 [years old] and they won’t go to school if they don’t got them.”* Several law enforcement officials agreed that primarily young people between the ages of 17-25 years use prescription opioids and most often in combination with heroin. One law enforcement official said, *“We [law enforcement] are seeing more Caucasians than other groups, younger people who are working, with minimum-wage jobs [abusing prescription opioids] ... some are college educated.”* Additionally, many treatment providers agreed that the older adult clients are introduced to prescription opioids due to a physical ailment, whereas adolescent and young adult clients are experimenting and accessing prescription opioids through friends and family.

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, heroin and marijuana. Participants who used prescription opioids with alcohol reported doing so to intensify their high. Participants agreed that heroin is commonly used with prescription opioids. A participant with experience using heroin noted, *“... I shoot roxy’s [Roxicet®] and Opana® with it [heroin].”* The Mahoning County Coroner’s Office reported that among drug toxicity-related deaths, *“The real common ‘cocktail’ [combination] most commonly, is one of the anti-anxiety drugs combined with one of the narcotics. Maybe a little bit of alcohol mixed in. That’s the common killer, and it is common among 18-25 year olds.”*

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 ‘5’. Participants and community professionals reported that the street availability of Suboxone® had increased during the previous six months, and that Suboxone® 8 mg sold for between \$10-30, with the most frequently reported price being \$20-25. Most often participants continued to report taking Suboxone® sublingually (dissolving it under the tongue); however, participants also continued to

report snorting and intravenous injection of the drug. In addition to obtaining Suboxone® on the street from drug dealers, participants continued to report getting the drug from doctors and from others in Suboxone® maintenance programs. While acknowledging that Suboxone® was tremendously beneficial to those who took the drug as directed for its intended purpose, participants continued to widely report abuse of Suboxone® by those addicted to opiates who used the drug to keep from experiencing withdrawal between opiate purchases, and by those not addicted to opiates who sought a high. Participants reported that benzodiazepine use with Suboxone® was very common.

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'. However, participants in Mahoning and Trumbull counties reported higher availability than participants in Ashtabula county. One participant said, "In Youngstown, [Suboxone® availability] it's a '10' [availability rating], but [availability in] Ashtabula, most times it's an '8.' It's a little bit harder to find." A participant reported, "I would go to a doctor and get 90 [Suboxone® pills] a month. You don't need that many at all. I'd sell them \$10 a piece and make 900 bucks. They're very accessible—huge demand. Nobody wants to be dope sick." Another participant reported, "Any user can get a Suboxone® prescription ... pretty easy. All you really need is half of one [Suboxone® pill] or a quarter of it at a time. I knew I could sell all but 15 for the month. I would sell mostly all of them to the dope boy [heroin dealer] ...". Community professionals most often reported the drug's current availability also as '10'; the previous most common score was '5'. A law enforcement official reported, "Our search warrants usually reveal heroin with prescription opioids, with some mixture of Suboxone®. About three cases out of 10 might include Suboxone®." Participants and community professionals reported that the availability of Suboxone® has remained the same during the past six months. A participant stated, "[Suboxone®] it's been really easy to get for a while now." A law enforcement official described the techniques of drug dealers who sell Suboxone®: "It's a good marketing strategy for oxy/roxy/heroin dealers to sell Suboxone®. You get people that want to recover but can't afford the script, or the doctor visit, or whatever. It's just a way to keep them on the line." The BCI Richfield Crime Lab reported that the number of Suboxone® cases it processes has increased during the past six months.

Participants did not report any known street names or jargon for Suboxone®. Participants reported that Suboxone® 8 mg most often sells for between \$10-15. A participant added, "If someone is really dope sick though, a dealer can get

away with charging \$20 [for Suboxone® 8 mg]." In addition to taking Suboxone® sublingually, participants reported taking Suboxone® via snorting and intravenous injection. Participants reported that at least six out of 10 Suboxone® abusers would snort Suboxone®. A participant reported, "People do snort them [Suboxone®], and I've seen people try to shoot the [Suboxone®] strips. I would puke every time I snorted Suboxone®. My boyfriend and I would split a pill and it would get us high for two days." Another participant reported, "I would stock up on them [Suboxone®]. I prefer strips, you can't taste them. The pills have a really bad taste. I'd cut the strips and take 2 mg." Other participants with experience using Suboxone® said: "Most people will snort the pills or shoot the strips ... it gets you much higher; I quartered the 8 mg [Suboxone®] and snorted a quarter and got so high; You can shoot the [Suboxone®] pills or the strips; Take about 2 mg of the strip ... and dilute it in water, mix it up."

In addition to obtaining Suboxone® on the street from dealers, participants also reported getting prescriptions from substance abuse treatment clinics and doctors: "Most people in recovery are on it [Suboxone®]. If you're not prescribed it, you can easily find someone who is." Participants described typical users of Suboxone® as heroin users, including young people between the ages of 18-25 years. Reportedly, Suboxone® is used in combination with crack cocaine, marijuana and powdered cocaine. A participant who had experience using Suboxone® reported, "I mixed it [Suboxone®] once with coke or crack but never with heroin or other opiates." A participant who used marijuana in combination with Suboxone® reported, "I would smoke weed with it [Suboxone®], to help with the withdrawals." Another participant warned, "Never combine [Suboxone®] with opiates, but I'd use benzo's [benzodiazepines] and marijuana with it. I did xani's [Xanax®] with it."

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Community professionals indicated that availability ranged from '6' to '10'. Participants and community professionals reported that availability had either remained the same or had increased during the previous six months and identified Klonopin® and Xanax® as the two most popular sedative-hypnotics in terms of widespread use. In addition to obtaining sedative-hypnotics from dealers, participants reported visiting area doctors to obtain prescriptions for these drugs. The most common routes of administration were oral consumption and snorting. Most

participants and treatment providers believed that sedative-hypnotic use was widespread and transcended race and socio-economic status.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported 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 continued to identify Xanax® as one of the most popular sedative-hypnotics in terms of widespread use, followed by Klonopin® and Valium®. A participant reported, "*Benzo's [benzodiazepines] are definitely a '10' [highly available]. Xanax is the most popular, and 2 mg Klonopin is a little less popular.*" Community professionals most often described the current availability of these drugs as '8'. Community professionals identified Klonopin® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. In addition, treatment providers reported an increase in the prescription Trazadone®. A treatment provider working with adolescents explained the increase: "*[Trazadone®] it's being prescribed a lot more, and it's been popular with the kids in the last year.*" Another provider reported, "*People do abuse Trazadone® a lot ... doctors prescribe it and say 20-60 mg as needed which can be refilled every 30 days, so it's like a 90-pill supply in 30 days ... I definitely think it's a triggering drug for people; they get a good buzz from it.*" There was consensus among law enforcement that sedative-hypnotics are not as common as other prescription drugs found in warranted searches. A law enforcement official explained, "*We see very little of Xanax® and Klonopin®. We're not specifically purchasing them, but we might come across these in the search warrants.*" However, the Mahoning County Coroner's Office reported that among drug toxicity deaths, "*Xanax® and Valium® are the top two [benzodiazepines] seen in sedative-hypnotics [related deaths].*" In addition, community professionals reported a decrease in Ambien® abuse during the past six months. A treatment provider explained, "*We've seen a lot less of Ambien® in the last six months. I don't know if it's being prescribed less or if less of it is being abused because other drugs take precedence ...*" The BCI Richfield Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months, with the exception of a decrease in cases related to Librium®.

Reportedly, many different types of sedative-hypnotics (aka "B's," "benzo's," "downers" and "skittles") 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;" sells for between \$1-2 per pill), Soma® (sells for \$2 per pill), Valium® (aka "V's;" sells for between \$1-2 per pill) and Xanax® (0.5 mg, aka "bars," "blues," "candy bars," "footballs," "greens," "ladders," "peaches" and "xani's;" sells for \$1; 1 mg, aka "footballs;" sells for between \$2-3; and 2 mg, aka "bars" and "xanibars;" sells for between \$3-5). In addition, participants and community professionals agreed that Xanax® 2 mg is more popular in terms of widespread use. A community professional reported, "*Everyone talks about the bars. It seems like people don't want the footballs anymore.*" A participant agreed, "*Bars are the most popular, the most in demand.*" 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 and snorting. A treatment provider reported on a new route of administration appearing to be more common among adolescents and young adults: "*I have heard of kids 'parachuting' more. We did have a kid that crushed up Xanax® and put it in a tissue and put it in his rectum. He was not from this area though but talked about how high he got doing it that way.*" Another treatment provider agreed, "*I did have a guy, an opiate addict that did use these [sedative-hypnotics] like a suppository.*"

In addition to obtaining sedative-hypnotics on the street from dealers, participants also continued to report getting them from family members and area physicians. A participant reported, "*Doctors hand them [sedative-hypnotics] out like candy. I go to the doctor and say, 'I have panic attacks every day.' It's really easy to get a script.*" Many participants agreed that dealers selling drugs such as heroin will give away sedative-hypnotics to heroin consumers at the time of purchase. Other participants agreed that they could obtain sedative-hypnotics for free from friends or family members with prescriptions. A participant reported, "*Really easy to get [sedative-hypnotics] ... people just give them away.*"

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. As one participant said, "*I've seen people in their 50s and 60s take them [sedative-hypnotics], and 15 year olds takin' them.*" Participants agreed that individuals 50 years old and older are more likely to use Soma® than younger people: "*Soma® is old school. My uncle has a script for those; Soma® is for the older crowd. You don't see young people messin' with it.*" Most participants agreed that Xanax® use is very common among young people. One participant said, "*Everybody uses these [sedative-hypnotics]; there's no profile. I think Xanax® is probably more popular among 18-25 year olds versus other benzo's.*" Another participant reported, "*I started with Valium® when I was 16 [years old], then went to Ativan®, then went to Xanax®*"

...“In contrast to participants, community professionals reported differences in gender with sedative-hypnotic use. A community professional said, “I just see so many more females who use these drugs [sedative-hypnotics] or have prescriptions for them. People who have anxiety or think they have anxiety.”

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: “I would take Soma®s only if I was going out to the bar [to drink alcohol], or if I was dope sick; Pretty much all benzo’s go hand in hand with alcohol. If you want to blackout, Xanax® is best for blackouts; I would use weed and alcohol with Xanax®. I snorted it ... the Xanax® ... just makes you that much more [expletive] up.” Other participants confirmed that Xanax® and other sedative-hypnotics are commonly used in combination with other drugs. A participant explained, “I combined it [Xanax®] with heroin, OC’s [OxyContin® OC], other opiates; All heroin addicts I know take Xanax® and Klonopin®.”

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). Community professionals believed that marijuana was the most available drug in the region. Law enforcement reported an increase in indoor growing operations and growing covertly on public and private property. The BCI Richfield Crime Lab reported that the number of marijuana cases it processed remained the same during the previous six months. Reportedly, the quality of marijuana varied, and participants said high-quality marijuana was the most prevalent form. Participants reported that for commercial-grade marijuana, a “blunt” (cigar) sold for between \$5-10, and an ounce sold for between \$130-140; for high-grade marijuana, a blunt sold for between \$10-20, and an ounce sold for between \$250-400. 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 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.’ Participants had various opinions on the availability of



marijuana in the region: “Weed is weed ... it’s everywhere; You can get dirt weed [commercial-grade marijuana] anytime, anywhere. The good stuff [high-grade marijuana] is a little harder to find; My whole family is a bunch of potheads [marijuana users], and we go to Canton to get our weed, a couple pounds at a time.” A law enforcement official agreed with participants, “Marijuana is one of our top three biggest drugs, and we always see it with other drugs ... frequently in cocaine houses, heroin houses ...”

Participants reported that the availability of marijuana has increased during the past six months. Many participants agreed that the end of summer/beginning of fall is peak time for marijuana distribution. A participant reported, “Right now it’s harvest time, a lot of good homegrown [marijuana] will be coming out. Summertime is usually dry, that’s the driest time when it’s hardest to find [marijuana].” Community professionals reported that the availability of medical marijuana has increased in some areas during the past six months. A law enforcement official reported, “In Mahoning County, law enforcement reported that within the last six months ... we’ve seen several instances of high-grade quality medical marijuana selling for huge profits at \$3,500-3,800 a pound. Medical marijuana from the West ... that movement is finding a retail market here in Mahoning County. We’ve had at least two cases and other seizures.” Another law enforcement official agreed, “There has been an influence from the medical marijuana movement in California. We just had a female who was having five to 10 pounds shipped here every month.” The BCI Richfield Crime Lab reported that the number of marijuana cases it processes has remained the same during the past 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); previously, participants did not give a score for marijuana quality, but said all grades of marijuana were available. Many participants explained that the quality of marijuana continues to depend on whether the user buys commercial (low- to mid-grade) marijuana or hydroponically grown (high-grade) marijuana. A participant reported, “You can find ‘downtown dirty brown’ ... that ‘Youngstown dirt weed’ [commercial marijuana] anywhere ... tastes terrible, but if you smoke enough of it though, it’ll get you high.” Another participant stated, “That brick weed [commercial marijuana] ... Mexican brick weed is bad. It’s all compressed, like in a brick, and when you break it open, it’s all seeds and stems.” Many participants reported that very high-grade marijuana is difficult to find: “If you got that nice bright green, crystals and red hairs—that’s some dank [high-grade marijuana]. It’s a lot harder to get [high-grade marijuana]”

though; Kids will say, 'oh I got that purple haze' [high-grade marijuana], [but I say] no you do not. You do not have purple haze."

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; "dank" and "fruity pebbles" for high-grade marijuana; and "AK-47," "Alaskan big bud," "Christmas bud," "exotic," "hydro," "orange kush," "pineapple express" and "white widow" for hydroponically grown marijuana. A participant reported a new type of marijuana: *"I've heard of 'Conrad Murray' making its way here. It's medical marijuana from California. They call it that because it will put you to sleep."* The price of marijuana depends on the quality desired. Participants reported that commercial-grade marijuana remains the cheapest form: a blunt, two joints or a "dimebag" (\$10 worth of 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; 1/4 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; prices for larger quantities of high-grade marijuana were not known by participants. 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, with many noting that five out of 10 people might eat marijuana in food products like brownies and cookies. A participant reported, *"My friend just got busted with the whole back of his trunk full of [marijuana] Rice Krispies™ treats."* Several participants reported using marijuana in food recipes. A participant explained, *"Mostly [people] who grow it [marijuana] take off the stems and seeds and simmer it in olive oil [and] use it to cook with."*

Participants described typical users of marijuana as having no profile in particular, with one saying, *"Weed does not discriminate."* Participants agreed with a fellow participant's comment that marijuana users can be, *"anybody and everybody, to elementary kids to grandparents and great grandparents."* A participant talked about early first use of marijuana: *"I was in fifth grade when I smoked weed for the first time; then sixth or seventh grade [I] started to smoke almost every day."* A law enforcement official agreed that it is difficult to identify a typical user of marijuana: *"Everybody and anybody uses weed."* A treatment provider reported, *"I often see people who started with marijuana but then came into treatment for something else, something harder, and go through treatment and return to using marijuana."* Several

other treatment providers reported that drug consumers use marijuana as a sleep-aid or to help relieve mental health symptoms: *"Almost all of my clients use marijuana. I hear, 'it's the only thing that puts me to sleep.'" Another provider reported, "With the dual-diagnosis clients I work with, I do believe that it [marijuana] helps ease their psych [psychiatric] symptoms ... but when they are on prescribed psych meds, marijuana compromises the efficacy of their psych meds, and they say, 'the meds aren't helping me."*

Reportedly, marijuana is used in combination with numerous different drugs including alcohol, crack cocaine, heroin, powdered cocaine, prescription opioids and sedative-hypnotics. A participant explained, *"Marijuana is the gateway [to other drug use]. You either drink [alcohol] first or you smoke pot or both, then start taking pills."* Several participants mentioned using cocaine or other drugs with marijuana: *"I would smoke weed after using coke ... to help come down so I could go to sleep; Most people I know either drink [alcohol] and smoke or use weed to help come down from another drug."*

Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was moderately available in the region, both in crystal and powdered forms. Participants rated the availability of methamphetamine as '6.5' (median score) on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Community professionals most often reported the drug's availability as '3'. Participants who reported personal methamphetamine use primarily lived west of Youngstown or in Ashtabula County. Participants believed that availability of methamphetamine had decreased in some areas of the region due to drug seizures, and had increased in other areas of the region due to increased demand. The BCI Richfield Crime Lab reported that the number of crystal and powdered methamphetamine cases it processes had increased during the previous six months. Participants reported that 1/2 gram of powdered methamphetamine sold for \$20 and that the most common route of administration was smoking. Treatment professionals described typical methamphetamine users as White males, between the ages of 30-50 years.

Current Trends

Methamphetamine is relatively rare in some parts of the region and highly available in other parts of the region. Participants most often reported the current availability of methamphetamine 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); the previous median score was '6.5'. Participants reported that methamphetamine is most often available in powdered form, which is homemade using the "shake and bake" or "one-pot" method (methamphetamine production in a single sealed container, such as a two-liter soda bottle). Some participants had not seen methamphetamine in Youngstown. As one participant said, methamphetamine is more common in neighboring counties: *"I've never seen meth [methamphetamine] in Youngstown really. It's more in Ashtabula, up in Geneva."* A participant with experience using methamphetamine reported, *"Ashtabula has a huge meth problem. I got mine in Conneaut. They call it the meth capital of Ohio."* Treatment providers most often reported the drug's current availability as '4', specifically in Mahoning and Trumbull counties. In addition, treatment providers also reported that clients with experience using methamphetamine reside outside of Mahoning and Trumbull counties. A treatment provider explained, *"We do have folks using methamphetamine or it's in their drug history, but they come from someplace else, Ashtabula or Lake County."* In addition, law enforcement reported that out of 10 drug cases, one might include methamphetamine. A law enforcement official explained the low incidence of methamphetamine-related arrests: *"About a year ago the federal government announced [that] they will no longer cover clean-up costs for meth labs. You have to find the money locally to do it. There might be more aggressive action for meth if we knew we had the funds and manpower to do it. We're not ignoring it, but we're not going after it as aggressively as we'd like."* Another law enforcement official said, *"We just don't see it [methamphetamine]. We did one lab this year. Other counties just have a huge meth problem, but we don't necessarily see it. Heroin is our raging fire."* Participants and community professionals reported that the availability of methamphetamine has remained the same during the past six months. The BCI Richfield Crime Lab reported that the number of methamphetamine cases it processes has remained the same during the past six months. The crime lab also reported that brown and white powdered methamphetamine were the most commonly processed types.

Current street jargon includes a few names for methamphetamine. The most commonly cited names were "basement born," "chicken feet," "crank," "glass," "go-fast," "go-go," "jib," "jimmy crank," "meth" and "tweak." A participant described the different forms of methamphetamine this way: *"Basement born meth is homemade with phosphorous; that's the most common. Then there are the actual crystals, and they're the best you can get, but it's harder to find. You smoke the crystals, and you can snort them too, but I wouldn't advise that. It burns. I've never seen anyone shoot them, shooting*

would be insane because you can kill yourself so easily." Participants reported that a gram of methamphetamine sells for between \$80-120, depending on the quality; 1/16 ounce sells for \$150; 1/8 sells for \$250. Participants also reported powdered methamphetamine (aka "shake and bake" or "basement born") sells in \$20 quantities. A participant reported, *"You can buy a 20-bag [of methamphetamine] for \$20. It's like two lines in the bag."* Participants also reported that crystal methamphetamine is almost impossible to find. As one participant explained, *"Crystal is more West Coast. I think maybe ten years ago there was more crystal but now, this method [shake and bake] is easier and safer. It's like a mobile lab, you can't find crystal anymore – it's all crank."* Crank is a term for lower-quality methamphetamine created through the "shake and bake" method.

Reportedly, the most common route of administration of methamphetamine remains smoking. Snorting and eating methamphetamine in capsule form were also cited as routes of administration. Participants commonly reported: *"You can get the [methamphetamine] capsules. Usually people will use those ... after your nose is too raw, you'll start eating it; I smoked it [methamphetamine] in foils or would clean out the inside of a light bulb and smoke it. I snort meth too sometimes ..."* Participants reported that out of 10 methamphetamine users, three would inject methamphetamine and "speedball" with heroin. A participant reported, *"Speedballing with meth and heroin is huge up here [Ashtabula County]."* Another participant agreed, *"I smoke meth, but my friends who shoot, they speedball with Adderall" or sometimes heroin. I would be like, 'How are you so mellow right now?' Until I found they were shooting with heroin too."* Participants described typical users of methamphetamine as Whites between 20-40 years of age, possibly from more rural areas of the region.

Reportedly, methamphetamine is used in combination with alcohol, heroin and marijuana. A participant explained that he used methamphetamine with several different drugs: *"I used it [methamphetamine] with weed sometimes to help come down ... I would drink [alcohol] to come down ... used it with heroin a couple times too, just to get really [expletive] up."* Other participants agreed that users typically smoked marijuana with methamphetamine. As one reported, *"Most people I know [who use methamphetamine] will smoke, mostly after using meth to come down [to] stop them from getting too low. Some people will use it while smoking meth just to level out a little bit."*

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 rated the drug's availability as '6.75' (median score) on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), while treatment providers most often rated availability as '7'. The availability of Ecstasy was thought to vary depending on the season; most participants considered Ecstasy a "summertime" drug. The BCI Richfield Crime Lab reported a decrease in the number of Ecstasy cases that it processed during the previous six months. Participants reported a "single stack" (low dose) Ecstasy tablet sold for between \$5-8 and a "double stack" or "triple stack" (high dose) tablet sold for between \$12-20. The BCI Richfield Crime Lab cited methcathinone analogs (psychoactive stimulants) and bath salts as cutting agents for Ecstasy. Participants and community professionals described the typical Ecstasy user as a young adult between 18-30 years of age.

Current Trends



Ecstasy (methylenedioxymethamphetamine; MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) continues to be moderately available in the region. Participants reported the current availability of Ecstasy as '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous median score was '6.75'. Many participants agreed that Ecstasy is highly available at a quarry in the region where spring, summer, and fall music festivals are held. A participant explained, "Nelson Ledges — if you want to trip, that's where you go. They have lots of Ecstasy, lots of acid, mushrooms. Mostly in the summertime, they have festivals, bands ... you camp out." Community professionals reported a decrease in Ecstasy among clients during the past several years. Treatment providers and other professionals explained, "We just don't hear about it [Ecstasy] anymore. A lot of the women I work with report using Ecstasy in their youth and [use it] every once in a while, maybe once a year or less; Ecstasy has kind of dropped off ... I see people wanting that hallucinogenic high will use OTC's [over-the-counter drugs] like triple C's [Coricidin® Cough and Cold]." The BCI Richfield Crime Lab reported that the number of Ecstasy cases it processes has decreased during the past six months.

Current street jargon includes few names for Ecstasy; the most commonly cited name was "X," and participants described "rolling" to mean a person high on Ecstasy. Participants reported that Ecstasy tablets typically sell for between \$15-20, but they also said users can get discounts for buying large quantities. A participant reported, "You can get a pack [of Ecstasy tablets]. The more you get, and the

cheaper per pill [it] will be." Another participant discussed the quality of Ecstasy: "The quality varies; some of it [Ecstasy] is just garbage. Out of 10 options, four would be good." The most common route of administration is oral consumption. A participant reported a less common method: "I've heard of people sticking pills [Ecstasy tablets] in their butts ... I have no idea why ... younger kids I'm guessing." Another participant also reported this trend: "My little brother stuck Ecstasy in his butt because it doesn't go through all the filtration system. It dissolves into your rectum and right into your bloodstream." Many community professionals reported that Ecstasy remains popular among young adults. A treatment provider reported, "I've had four or five young adults in the past year reporting Ecstasy use, but it wasn't their drug of choice"

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants 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). Vyvanse®, a newer drug to treat symptoms of attention deficit hyperactivity disorder (ADHD), was also mentioned as being available by a minority of participants. Participants reported that Adderall® sold for between \$1-6 per pill. While participants did not provide a profile for a typical user, they agreed with one participant who said the most likely person to abuse these medications was someone looking to "use it [prescription stimulants] as a substitute for methamphetamine." The BCI Richfield Crime Lab reported that the number of prescription stimulant cases it processes had remained the same during the previous six months.

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'. Generally, participants reported that Adderall® is highly available, followed by Concerta® and Ritalin®, which were both believed to be somewhat available. A participant explained, "I'd say Adderall® is the easiest to get, then Ritalin®, then Concerta®, but I don't think doctors are prescribing Ritalin® as much anymore." Treatment providers reported no change in the general availability of prescription stimulants during the past six months, but noted an increase in the generic form of Adderall®. A treatment provider explained, "I don't really see Ritalin® with the adolescents; I see more Vyvanse® and definitely an increase in generic Adderall®, that's been new." Law enforcement did not report seeing many prescription

stimulants in the region. The BCI Richfield Crime Lab reported that the number of prescription stimulant cases it processes has remained the same during the past six months, with the exception of a decrease in cases related to Dexedrine®.

The only reported street jargon for prescription stimulants was one name for Adderall®: “addies.” Participants reported that Adderall® typically sells for \$2 per pill. A participant explained the pricing of prescription stimulants: “The blue ones [generic Adderall® tablets] go for \$2. You can get Concerta®, Vyvanse® for cheaper.” Participants reported getting prescription stimulants from doctors or from people with prescriptions. A participant reported, “Doctors prescribe it [stimulants] pretty easy.” Many participants 25 years of age or younger with experience using prescription stimulants reported having been prescribed Adderall® or Vyvanse® for diagnosed ADHD.

Participants described typical users of prescription stimulants as teenagers or young adults: “I’ve seen college kids use it [prescription stimulants] to study. I used it to study; I’ve seen 18-25 year olds and younger — high school [use prescription stimulants].” Treatment providers also reported prescription stimulants as most common among adolescents and young adults. A treatment provider reported, “I do see it [prescription stimulants] with my younger population. I see opiates more with my older group.”

Reportedly, prescription stimulants are often used in combination with numerous other drugs including alcohol, bath salts, marijuana, sedative-hypnotics and synthetic marijuana (“K2” and “Spice”). Typically, participants reported using prescription stimulants to modify the effect of taking a sedative-hypnotic or other depressant. A participant explained, “I used Adderall® after taking a downer if I had s*** to do. People will take these [prescription stimulants] after taking downers to get back up.” Other participants reported, “I would swallow an Adderall® and then snort one why I was waiting for the other to kick in; to get that instant gratification; I used bath salts and smoked Spice [synthetic marijuana] while using Adderall®. I’ve only done that combo a few times — never again. I thought I was going to go crazy.”

Bath Salts¹

Current Trends

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; availability of bath salts since the ban went into effect is unclear. A participant commented about the popularity of bath salts among high

1 None of the participants had personal experience with bath salts in the previous reporting period; therefore, there is no historical summary.

school students: “My sisters are in high school, and they say a lot of friends are doing it [bath salts].” Other participants talked about the negative health effects of bath salts: “I had a friend who used them [bath salts]. She said she was up for two days after using just a little bit of them; I call it [bath salts] the devil. I went completely paranoid on it. It was traumatic for me ... you can see my arms; I’ve picked everywhere. I went to the psych [psychiatric] ward three times in five months.” The BCI Richfield Crime Lab reported that the number of bath salt cases it processes has increased during the past six months.

While participants did not speak about the quality of bath salts, they said bath salts are commonly used to adulterate other drugs. A participant explained, “I’ve seen it [bath salts] used to cut meth with. People were going crazy from it.” In addition, the Mahoning County Coroner’s Office reported that their office has had cases with bath salts and synthetic marijuana: “The ‘designer drugs’ ... the K2 [synthetic marijuana] ... the bath salts, salvia [divinorum] ... they only come to my attention when they are part of a multiple-drug toxicity ... you know, we’re looking for other things ... and, ‘Oh, what’s that?’ Now we’re finding in tests, or when we’re at the death scene ... we’ll see the packaging for salvia or bath salts, and then we’ll specifically test for that.” The most common routes of administration for bath salts are snorting and smoking. A participant discussed the routes of administration: “[Bath salts] it’s like meth or speed. You can snort it, smoke it, shoot it. You know, it’s like Spice [synthetic marijuana], same concept ... it’s ‘not for human consumption’ because it’s supposed to be incense.”

Treatment providers agreed that adolescents and young adults are more commonly using bath salts than other groups. A treatment provider reported, “I feel like the people who use bath salts are 18-20 [years of age] ... and I’ve heard about it more outside in the community, possibly because kids are not in treatment yet for it.” Reportedly, bath salts are often used in combination with several other drugs including salvia divinorum (psychoactive plant) and synthetic marijuana. A participant described the effects of combining bath salts and synthetic marijuana: “I was snorting bath salts and smoking Spice [synthetic marijuana] and started hallucinating ... I screamed for my sister and she came into the bathroom and that’s when she woke my parents up. I went into PHP [partial-hospitalization treatment] at that point.” A law enforcement official also reported that bath salts are commonly used with other drugs. An officer reported, “We have been getting complaints recently about bath salts in combination with heroin use.”

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: energy drinks, energy drinks with alcohol, hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], inhalants and synthetic marijuana (“K2” and “Spice”). Reportedly, synthetic marijuana continued to be used by a few participants for recreational use and as a substitute for marijuana when participants needed to pass a drug test. Treatment providers believed the abuse of synthetic marijuana was increasing, and law enforcement mentioned several synthetic marijuana overdoses in the region. Treatment providers reported inhalants as popular among a minority of their clients, typically those under 16 years of age. Participants reported abuse of 5-hour ENERGY® drinks and energy drinks with alcohol (“Four Loko”). Hallucinogens like psilocybin mushrooms and PCP (phencyclidine, aka “sherm” and “wet”) had limited availability in the region. Law enforcement reported that psilocybin mushrooms were most available in summer months when outdoor music festivals came to the area. The BCI Richfield Crime Lab reported that the number of LSD, psilocybin mushroom and synthetic cannabinoid cases it processes had increased while the numbers of processed cases for all other drugs mentioned in this section had remained the same during the previous 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. Alcohol is highly available to those under 21 years of age in the region and is 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. A participant reported, “*Those Four Loko drinks are crazy. You drink two of them, and you’re gone. I felt like I was at the bar all night.*” Another participant agreed, “*The Four Loko drinks ... young kids are using these. The Four Loko Challenge on the can says, ‘If you can drink four of these ... it’s on the Four Loko can ... they are huge cans and kids drink it so quick ... you don’t know how drunk you are until you have alcohol poisoning.’*” Participants also noted young people consuming alcohol mixed in with food and various other beverages. Participants typically said, “*Jell-o shots, pudding shots, jungle juice with Everclear® [pure grain alcohol that is illegal in Ohio] in it; Sparks® and Tilt® [both malt liquor beverages] are still popular ... you can always do cherry bombs, Jäger bombs [with Jägermeister]. It’s popular to mix [these drinks] with energy drinks.*” A treatment provider reported, “*My young people have reported that they soak gummy bears in vodka or tequila and take them to school – bypasses the whole beverage issue [no liquids] in school.*” Several participants confirmed a new route of administration

for alcohol among teenagers and young adults: “*They are soaking tampons in alcohol ... males and females ... and putting them [in the rectum] ... and you get drunker since it [alcohol] doesn’t have to pass through your kidneys and be filtered through your kidneys.*” Most participants agreed that alcohol is used in combination with almost every other drug.

Anabolic steroids are rarely available in the region. However, a participant reported that steroids are highly available at his gym. Several treatment providers reported having worked with young adults using anabolic steroids. A treatment provider reported, “*I had two young men in the past year I worked with using steroids. It’s just not very common.*” Most participants agreed that steroids are prohibitively expensive. A typical comment from participants was, “*Steroids are expensive. I never see those. Got to have money for that s***.*” Another participant spoke of combining anabolic steroids with other illegal drugs: “*My friend overdosed last year from combining steroids and heroin.*”

Cold and cough over-the-counter (OTC) medications are also highly available in the region. Several participants reported personally abusing Coricidin®, Robitussin DM® and medicines that contain codeine. Participants reported, “*I took Coricidin®. You take 12-20 [tablets], and you trip like you would with acid or shrooms. It’s common among teens; I see people take codeine and mix it with lemonade or Sprite®.*” Ingesting Robitussin DM® is referred to as “robo-tripping.” A participant explained, “*Kids 17, 18 [years of age] ‘robotrip’ or take the Triple C’s [Coricidin®]. You buy them at the pharmacy. Eat 16 of them or take the whole box or half box.*” Another participant reported abusing different types of OTC medicines: “*Dramamine®, Benadryl® ... Stackers [weight-loss pills/energy pills] ... kids abuse these. I used to take 30 Benadryl® pills at a time, and I would hallucinate.*” Participants reported that OTC medications are predominately abused by teenagers and young adults. Several participants agreed with a participant who described the typical illicit user of OTC medications this way, “*[OTC abuse] it’s a younger thing, 15 [years] and up. You think you’re cool, you know.*”

Lastly, inhalants are highly available in the region. Several treatment providers reported a decrease in inhalant-related admissions to treatment facilities during the past six months. A treatment provider said, “*Inhalants have decreased in the last six months. Last summer we had a bigger problem with inhalants, but it’s decreased quite a bit. We don’t hear about it among the kids very much.*” Most participants agreed these drugs are used primarily by adolescents and young adults. A participant commented, “*[Inhalant use] it’s like a rite of passage. Get your whippets [nitrous oxide] at the porn store — a rite of passage when you turn 18 [years].*” When asked why some young people choose inhalants, a participant explained, “*Kids huff [inhale] gasoline ... that’s when you’re at home, you’re broke and bored ... you’re huffing.*”

Conclusion

Powdered cocaine, crack cocaine, heroin, marijuana, prescription opioids, prescription stimulants, Suboxone® and sedative-hypnotics remain highly available in the Youngstown region; a decrease in availability exists for Ecstasy, and an increase in availability exists for heroin. Moreover, data indicate likely increases in availability for marijuana and some prescription opioids. Participants from Ashtabula, Columbiana, Mahoning and Trumbull counties reported that brown powdered heroin is easier to obtain than many other drugs. Participants stated, *"In Columbiana County, it's easier to get heroin than marijuana — and it's cheaper; [Heroin] it's the easiest drug I know of to find in Youngstown."* Law enforcement officials noted that brown powdered heroin is also the most common drug they encounter; reporting that throughout the entire region, heroin is the primary drug problem. Participants reported that the availability of heroin has increased in smaller towns in the region during the past six months. The BCI Richfield Crime Lab reported that the number of heroin cases it processes has increased during the past six months. Participants reported that the most common way to use heroin remains intravenous injection. In addition, several participants described a process where heroin users will draw out residue from the cotton used to inject heroin (aka "rinse") and reuse it. There was consensus among participants that needle sharing is a problem; participants universally shared concern about contracting Hepatitis C and HIV. Most participants and community professionals agreed that heroin is a serious problem among 18-25 year olds. Participants reported that the availability of prescription opioids has increased during the past six months, especially for Opana® and Roxicodone®. Participants also reported that youth as young as 14 or 15 years old are experimenting with prescription opioids, and said use of these drugs is common among 18-25 year olds. Several law enforcement officials agreed that primarily young people between the ages of 18-25 years use prescription opioids, and most often in combination with heroin. In addition, many treatment providers agreed that the older adult clients are introduced to prescription opioids due to a physical ailment, whereas adolescent and young-adult clients are experimenting and accessing prescription opioids through friends and family. Participants reported that the availability of marijuana has increased during the past six months, attributing recent increases in availability to the harvest season during the summer months. Community professionals reported that the availability of medical marijuana has increased in some areas during the past six months. A law enforcement official stated, *"There has been an influence from the medical marijuana movement in California. We just had a female who was having five to 10 pounds shipped here [Mahoning County] every month."* While methamphetamine remains relatively

rare in some parts of the region, reportedly, the drug is highly available in Ashtabula County. Participants reported that methamphetamine is most often available in powdered form, which is homemade using the "shake and bake" or "one-pot" method. Ecstasy remains moderately available in the region, but it is rarely a primary drug of choice. Community professionals attributed the decrease in Ecstasy availability and use to a general lack of interest in the drug. Bath salts were highly available in the region prior to the enactment of legislation in October 2011 banning their sale. Participants and community professionals mentioned bath salts use numerous times; availability of bath salts since the ban went into effect is unclear. The BCI Richfield Crime Lab reported that the number of bath salt cases it processes has increased during the past six months.