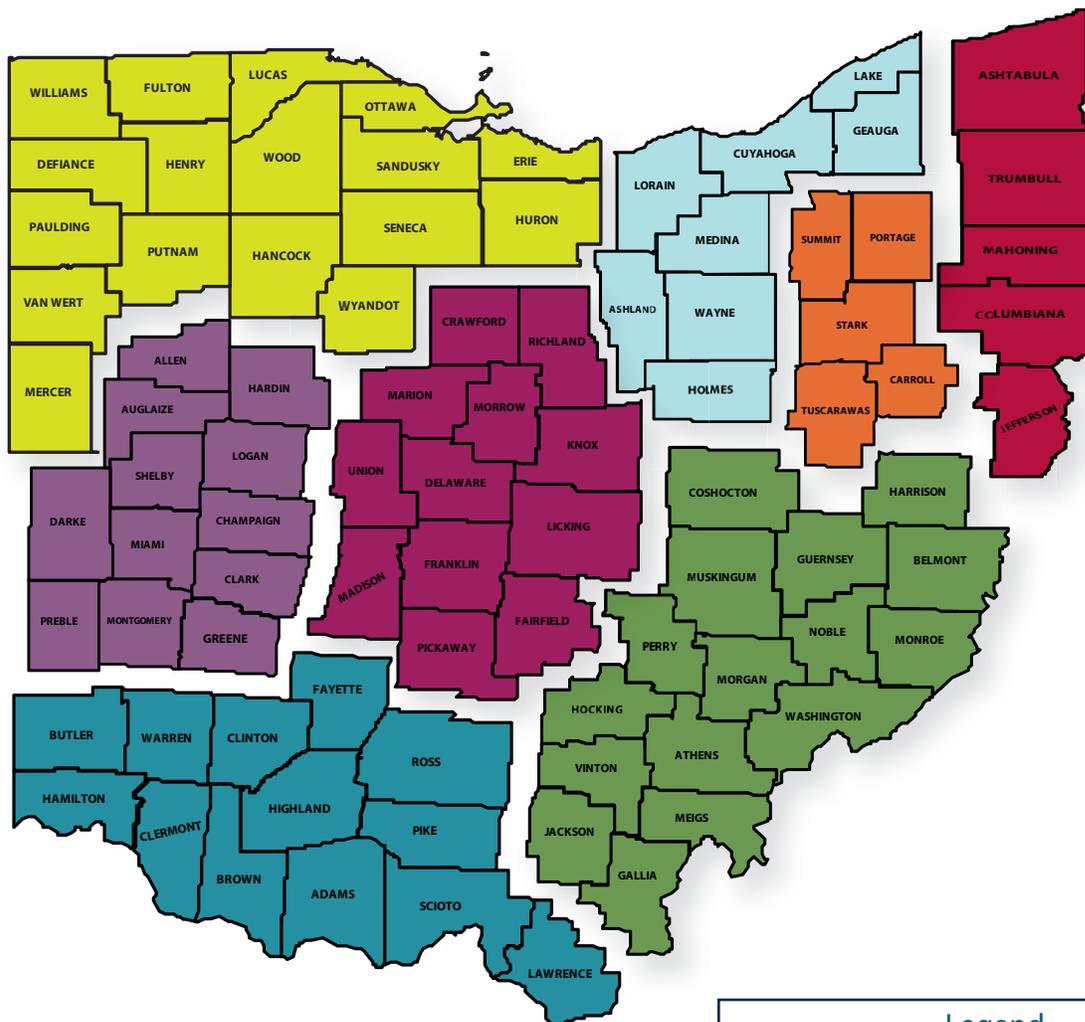


Ohio Substance Abuse Monitoring Network

Surveillance of Drug Abuse Trends in the State of Ohio

January-June 2011

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



October 3, 2011

Dear Reader,

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

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

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

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

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

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

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

Sincerely,

Orman Hall, Director

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Ohio Substance Abuse Monitoring Network

Surveillance of Drug Abuse Trends in the State of Ohio

January-June 2011

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Toledo Region

- Heroin business thriving; dealers often provide samples before purchase
- IV users report getting needles from diabetics, pharmacies and through street purchase
- Illicit Suboxone® use remains most common among heroin users to avoid withdrawal when heroin is unavailable
- Increasing sedative-hypnotic use among school-aged youth who do not necessarily hide use
- Crime lab reports new forms of synthetic marijuana not seen previously, along with increased number of bath salts cases

Cleveland Region

- High availability remains for heroin, prescription opioids and Suboxone®
- Pill progression to heroin extremely prevalent among those 16-30 years of age
- Users continue to obtain prescription opioids primarily from doctors
- Opana® and methadone cited as up-and-coming opioids of abuse
- Higher quality marijuana more available

Dayton Region

- Increased availability of bath salts and heroin
- Dealers aggressively push heroin, often giving away free samples
- Heroin dealers now carry powdered cocaine for convenience to users who “speedball”
- Bath salts rapidly gaining in popularity
- Synthetic marijuana remains popular due to the belief that it cannot be detected by urine drug screens

Cincinnati Region

- Increased availability of heroin, methamphetamine and Suboxone®
- Coroner’s office reports higher number of heroin-related deaths
- Opana® increasing in both desirability and availability
- Methamphetamine combined with heroin to “speedball”
- Bath salts highly available

Columbus Region

- Increased availability of prescription opioids, sedative-hypnotics and synthetic marijuana
- Young users do not view sedative-hypnotic use as dangerous
- Prescription opioid users continue to progress to heroin as heroin is cheaper and easier to obtain
- Anticipated increase in methamphetamine availability due to increased “meth” presence in border states
- Crime lab reports number of bath salts cases it processes has increased

Akron-Canton Region

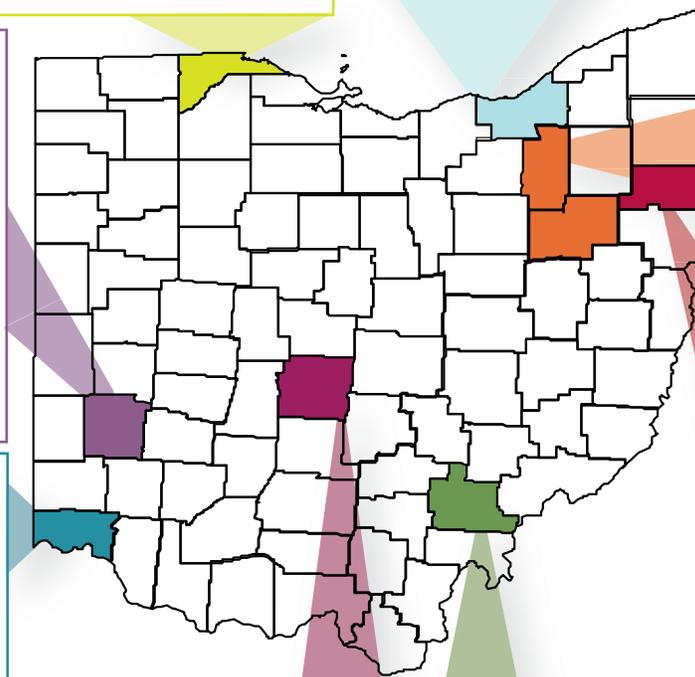
- Increased availability of heroin and methamphetamine
- Opana® becoming popular as replacement for OxyContin®
- Teenage males, as early as junior high school age, more commonly using heroin
- Greater access to methamphetamine now that “shake-n-bake” method widely known
- Greater number of users seeking and using high-grade marijuana

Youngstown Region

- Increased availability of heroin, methamphetamine, prescription stimulants and Suboxone®
- Heroin users report increased overdoses, widespread IV use and hepatitis C infections
- Users report increased Suboxone® prescribing, particularly of strips
- Increased availability of methamphetamine due to more people manufacturing the drug
- Increased abuse of synthetic marijuana; some providers have started to screen for the drug

Athens Region

- Heroin has become as accessible as marijuana
- Increase in requests for detox services from IV heroin users
- Crime lab continues to report heroin as “very pure”
- Obtaining prescription opioids “as easy as going to the store to get a gallon of milk”
- Opana® popularity and availability increasing



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 the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) with a real-time method of providing accurate epidemiologic descriptions that policymakers need to plan appropriate prevention and intervention strategies.

This Executive Summary presents findings from the OSAM meeting held in Columbus, Ohio, on June 20, 2011. It is based upon qualitative data collected February through June 2011 via focus group interviews. Participants were 362 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 103 community professionals (law enforcement, treatment providers and community outreach workers) via individual and focus group interviews, as well as to data surveyed from children's services, coroner's offices, family and juvenile courts, Bureau of Criminal Identification and Investigation (BCI), police and county crime labs. In addition to the aforementioned data sources, media outlets in each region were queried for information regarding regional drug abuse for January through June 2011. OSAM research administrators in the Division of Planning, Outcomes and Research at ODADAS prepared regional reports and compiled this summary of major findings. Please refer to regional reports for more in-depth information on drugs reported here.

Powdered Cocaine

Powdered cocaine is moderately to highly available across all regions, and it is one of the most available street drugs in Akron-Canton, Athens, Cleveland, Dayton and Youngstown. While participants described powdered cocaine as available, they reported that the drug does not have high street visibility, meaning one would have to make connections to buy it. The consensus was that crack cocaine remains easier

to come by on the street than powdered cocaine. Treatment providers reported that fewer clients are mentioning powdered cocaine use at intake for treatment, and of those clients who do mention use, powdered cocaine is usually a secondary or tertiary drug of choice. All regions reported stable availability over the past six months, with the exception of Akron-Canton, Athens and Columbus, where some data indicate a possible decrease. The primary reason for decreased availability is increased demand for the drug. Participants agreed that user demand for powdered cocaine is driven by the desire to obtain powdered cocaine to "rock" (manufacture) into crack cocaine, allowing users to improve the quality of their crack cocaine; thus, dealers are more tightly controlling the supply of powdered cocaine because of this trend. Both participants and law enforcement noted that heroin dealers are more likely to now carry powdered cocaine than crack cocaine for the convenience of users who prefer to "speedball" (mix heroin with powdered cocaine). The most common participant quality score of powdered cocaine across regions varied from '2' to '7' with the most common score being '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Universally, participants reported that the quality of powdered cocaine continues to be dependent on the source, the person from whom one buys. Users across regions reported that the current quality of powdered cocaine has either remained the same or has decreased over the past six months. Regional crime labs continue to report that powdered cocaine is adulterated with many other substances, with levamisole (livestock dewormer) remaining the most frequently identified cutting agent. In addition, users in Akron-Canton, Dayton and Toledo reported that they believed that bath salts and crystal methamphetamine are now used as cutting agents for powdered cocaine. Current street jargon includes many names for powdered cocaine, with the most common names being "blow," "girl," "powder," "soft," "snow," "White girl" and "ya-yo." Depending on desired quality and from whom one buys, a gram of powdered cocaine currently sells for \$30–\$120 across regions. While there were a few reported ways of consuming powdered cocaine, the most common route of administration for this form of cocaine remains intranasal inhalation (snorting) followed by intravenous injection (shooting). In Toledo, users also reported chewing the remaining contents left in the baggie that the powdered cocaine is purchased in, which is referred to as "nummy." The profile of the typical powdered cocaine user remains: individuals with money/income, those who have professional jobs during the day and are nightclub goers on the weekend. Powdered cocaine is often used in combination with alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics.

Crack Cocaine

Crack cocaine remains highly available across all regions. Crime labs in most regions reported that the number of crack cocaine cases they process has remained stable, while labs in Akron-Canton and Dayton reported an increase in the number of cases processed over the past six months. Treatment providers reported that not only can someone in the drug culture immediately obtain crack cocaine, but that crack cocaine is readily accessible to the general public as well; users reported that dealers commonly approach potential buyers. Law enforcement reported that the availability of crack cocaine has remained high over the past six months, but that the urgency to respond to crack cocaine has been eclipsed by the emergence of other drugs such as heroin and prescription opioids. Users noted that their dealers are switching from crack cocaine to heroin sales. With the exception of Toledo, perceived quality of crack cocaine is low to moderate; the most common participant quality score for crack cocaine varied across regions from '2' to '8' with the most common score being '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Reportedly, quality varies depending on from whom one purchases and on who, "the chef was in the kitchen" (the person who manufactured the crack cocaine). Across regions, users reported that crack cocaine quality has either remained the same or has decreased over the past six months. Participants reported that crack cocaine can be, "cut with anything and everything." Thus, in an effort to improve the quality of crack cocaine, many users "re-cook" the drug to eliminate impurities. Regional crime labs continue 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," "hard" and "rock." Participants continued to report that crack cocaine is most commonly sold as \$10, \$20 and \$50 "rocks." Typically, a \$20 rock is estimated to be .2 grams, and a \$10 rock is half of that. Participants said dealers will also sell "crumbs" for a few dollars. While there were a few reported ways of administering crack cocaine, generally, the most common route of administration continues to be smoking. Out of 100 crack cocaine users, participants reported that approximately 90 would smoke it, and 10 would break it down with lemon juice or vinegar to intravenously inject or "shoot it." While crack cocaine users remain diverse, participants described first-time users of crack cocaine as getting younger, as young as 12 and 13 years of age. 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, and it is now one of the most available street drugs in every region. Brown powdered is the most available type of heroin in Cincinnati, Cleveland and Dayton; brown and white powdered heroin are most available in Akron-Canton, Toledo and Youngstown; black tar heroin remains most available in Athens and Columbus. During the last reporting period, availability had increased in every region without exception; this reporting period, heroin continued to increase in availability in Akron-Canton, Athens, Cincinnati, Dayton, Toledo and Youngstown. Participants and community professionals across the OSAM Network described high and increasing availability of heroin: "Heroin is the most available drug out there now; Ohio is flooded with heroin. It's an epidemic." In addition to being highly available in every region, participants, law enforcement and treatment providers across almost every region identified heroin as the most urgent substance abuse problem. The vast majority of all network informants continued to attribute the rise in popularity of heroin to prescription opioid users who have switched to heroin use due to the ease and affordability of obtaining heroin over prescription opioids. Also, participants consistently reported a recent trend among dealers and their users of switching from crack cocaine to heroin. Participants noted that dealers are aggressively pushing heroin and will often give away free samples. Unlike other drugs that require a connection or phone call to obtain, dealers are more likely to approach users and offer them heroin. The most common participant quality score for heroin varied across regions from '4' to '10' with the most common score being '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Across regions, participants most commonly reported that the quality of heroin has remained the same over the past six months. Participants reported that heroin is commonly cut (adulterated) with other substances, with participants in six of eight regions reporting the belief that heroin was cut with fentanyl over the past six months; several participants reported friends dying from heroin/fentanyl overdoses. However, while the coroner's office in Cincinnati has seen a higher number of heroin-related deaths over the past six months, none were found with evidence of fentanyl. It is suspected that the heroin supply may have increased in potency, leading to more dire consequences to the user. BCI London crime lab continues to report that heroin is extremely pure; gas chromatography-mass spectrometry analysis typically shows that heroin is 80 percent pure. 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; across all regions over 70–90 percent of heroin users reportedly inject the drug. In Youngstown, along with widespread reports of intravenous use of heroin, were widespread reports of sharing of injection needles and hepatitis C infections. The consensus among the majority of participant and community professional groups was that heroin users continue to be predominately White, males and females, between the ages of 20 and 35 years, and more often than not addicted to other opioids; several community professionals also continued to report increasing heroin use among adolescents, particularly teenaged females. 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. Over the past six months, availability has increased further in Athens and Columbus. A treatment provider captured the sentiment of nearly every provider in describing Ohio's current opioid epidemic as, *"getting worse and worse, and it's scary."* Access to these drugs is very different than for other drugs due to their prescriptive nature; anyone can access prescription opioids, not just those in the drug culture. Increased availability continues to be attributed to increased prescribing in hospitals, private physicians' offices and pain clinics. These drugs continue to be most often obtained through prescription, with users continuing to report ease in feigning pain and of knowing physicians who write prescriptions for payment. In addition, both participants and treatment providers again spoke of dealers sending people to Florida to purchase opioids to bring back to Ohio. Participants identified Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Although still frequently named as the most desirable prescription opioid, OxyContin® has decreased both in use and availability over the past six months as a result of the drug's new abuse-deterrent formulation. In every region, with the exception of Columbus and Toledo, participants reported that Opana® has gained in popularity as a substitute for OxyContin®, given that it remains easy to use intravenously. An Akron-Canton participant reported that Opana® is, *"the most sought opiate medication now."* BCI London crime lab reported that the number of Dilaudid®, Opana® and Percocet® cases it processes has increased over the past six months. Common routes of administration continue to include the following in order of highest prevalence: oral consumption (swallowing and chewing), intranasal inhalation (snorting) and intravenous injection (shooting). The majority of participants and community professionals continued to describe the typical prescription

opioid user as someone who may have suffered chronic pain from a serious illness or injury, or someone who is young (17–34 years old) and White. 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 the homes of relatives or friends. 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®

Availability of Suboxone® remains high in all regions, with the exception of Toledo where it remains moderately available. Noted increases in availability exist for Cincinnati and Youngstown while a noted decrease exists for Athens. Many participants reported an increase in availability of the film/strip form of Suboxone® over the past six months. Those most currently using Suboxone® continue to be prescribed the drug through a Suboxone® maintenance program, often in conjunction with an outpatient treatment program. However, many users continue to purchase the drug on the street from dealers, heroin addicts and others with prescriptions. A treatment provider reported, *"You've got people at [12-step] meetings handing them [Suboxone®] off. They're being sold like any other drug."* Current street jargon includes a few names for Suboxone®: "oranges," "sobos" and "stop signs." Current street pricing for Suboxone® 8 mg varies widely from a low of \$5 to a high of \$30; participants again reported that those obviously "dope sick" pay higher prices. Participants also continued to report most often taking Suboxone® sublingually, with many participants noting growing popularity of intranasal inhalation (snorting) and intravenous injection (shooting) as routes of administration. Those most often obtaining Suboxone® on the street continue to be primarily prescription opioid/heroin addicted who use the drug to fight withdrawal when their opioid of choice is not available. As was the case in the last reporting period, there were widespread reports of users abusing Suboxone® as a means of getting high; those who abuse are thought not to have an opioid abuse history. Participants also reported that individuals who need to avoid detection of drug use on urine drug screens (probationers) use Suboxone® because it is often not screened. Reportedly, Suboxone® is used in combination with alcohol, crack cocaine, marijuana, powdered cocaine and sedative-hypnotics (benzodiazepines). Participants reported that benzodiazepine use with Suboxone® is very common.

Sedative-Hypnotics

Sedative-hypnotics (benzodiazepines, barbituates and muscle relaxants) are highly available across all regions. Seven of eight regions experienced stable availability of sedative-hypnotics

over the past six months, but an increase in sedative-hypnotic availability was noted in Columbus. Participants reported that these drugs have high street availability and are often sold or freely given away by dealers who sell crack and powdered cocaine. The most common way to obtain sedative-hypnotics is through friends, family members and physicians. Reportedly, users often memorize symptoms of anxiety disorders and feign symptoms in order to gain prescriptions; then, these drugs are either personally abused or traded for a more preferable drug. The most commonly sold sedative-hypnotics across regions are Klonopin®, Valium® and Xanax®. Xanax®, the most popular sedative-hypnotic, often sells for \$0.40–\$3 per milligram, while most other sedative-hypnotics sell for \$0.20 – \$2.50 per milligram. The most common routes of administration are oral ingestion (chewing or swallowing) and intranasal inhalation (snorting), with most regions reporting a minority of users crushing and injecting sedative-hypnotics. Illicit use of these drugs appears to be a far-reaching problem that affects all age groups, races and socioeconomic backgrounds. Dayton and Toledo were the only two regions to identify a specific user profile. Treatment providers in Dayton said the most likely user is an opioid user who is generally White; treatment providers in Toledo said the typical user includes younger adults, usually female. Combining sedative-hypnotics with other drugs is common among drug users. While nearly every drug is used with sedative-hypnotics, participants reported that this class of drugs is often used with stimulants (cocaine and methamphetamine) to help them “come down” from the stimulant high. Less frequently, participants mentioned using sedative-hypnotics to “enhance the buzz” of other drugs or to create a “blackout experience.” Participants were aware that concurrent prescription opioid use and sedative-hypnotic use meant a greater likelihood of overdose, and this knowledge caused many of them to refrain from combining the two.

Marijuana

Marijuana remains highly available across all regions. Participants and treatment providers alike commonly reported marijuana availability as, “off the charts; as available as a glass of water.” Participants and law enforcement stated that the availability of marijuana is high because of an increase in indoor grow operations and covert outdoor growing on personal and private property. Every region experienced stable availability of marijuana over the past six months. The most commonly cited names for marijuana were “dro,” “hydro,” “mid’s,” “reg’s” and “weed.” Prices for marijuana depend on the quantity and quality desired: for commercial grade marijuana (low- to mid-grade marijuana), a “blunt” (single cigar) sells for \$5–\$10; 1/8 ounce sells for \$20–\$40; an ounce sells for \$80–\$180. Higher quality marijuana sells for significantly more: a “blunt” (single cigar)

sells for \$15–\$25; 1/8 ounce sells for \$50–\$60; an ounce sells for \$200–\$400. The most common route of administration for this drug remains smoking, with a minority of users continuing to bake it into food or use it with tea. A minority of users in Cleveland, Dayton and Youngstown also reported vaporization of marijuana. According to these participants, this process is preferred by some because it, “[Vaporization] it is supposed to ... [burn] more of the THC rather than the weed [marijuana] itself.” Quality of commercial and high-grade marijuana remains high throughout the state. Law enforcement and participants agreed that high quality marijuana is prevalent because of high tech grow operations and more educated growers. Use of marijuana appears to be a far-reaching problem that affects all age groups, races and socioeconomic backgrounds. Nearly everyone interviewed believed that marijuana use is ubiquitous, and many suggested that marijuana is the most commonly used illegal drug in the state. Age of first use was most commonly reported as 12–13 years; however, participants and treatment providers in Athens and Cincinnati reported age of first use most often as nine years. Treatment providers and law enforcement lamented that marijuana is not seen as harmful any more by users. While nearly every drug is used with marijuana, participants reported that the drug is most often consumed with alcohol, crack cocaine and powdered cocaine (a.k.a., “primo” or “woolie”). In addition, participants in Athens, Cleveland and Columbus listed PCP (a.k.a., “loveboat” or “wet”) and embalming fluid (a.k.a., “sherm”) as also used in combination with marijuana. Participants reported overwhelmingly that marijuana is used to “come down” from stimulant highs or to intensify the effects of other drugs.

Methamphetamine

Methamphetamine is moderately available across all regions. Only a minority of participants had experience with methamphetamine, and they reported that the drug is most available in rural areas among a limited number of users who are connected with a tight-knit network of methamphetamine dealers and users. Powdered and crystal methamphetamine are equally available in most regions, but the powdered form of the drug is more available in Akron-Canton and Athens. Participants in most regions said that availability has remained stable over the past six months; however, participants in Akron-Canton, Athens and rural Cincinnati reported the drug’s availability as increasing. The biggest reason for the increase in methamphetamine availability is knowledge of the “one-pot” method or home-cooked method of creating methamphetamine. The most commonly cited names for methamphetamine were “crank,” “crystal,” “ice” and “meth.” Prices for methamphetamine depend on the quantity and type desired: for powdered methamphetamine, a “baggie” sells for \$10–\$20, and a

gram sells for \$40–\$60; for crystal methamphetamine, a gram sells for \$70–\$100, and 1/8 ounce sells for \$300. The most common routes of administration for this drug remain smoking and intranasal inhalation (snorting). Intravenous injection is the most common route of administration in Akron-Canton and Columbus, but participants in most other regions reported this practice as relatively rare. Quality of methamphetamine is variable across the state, with a majority of regions reporting moderate to high quality crystal and powdered methamphetamine. The crystal form of the drug is always rated as higher in quality than the powdered form of the drug. Typical users are 18 to 50-year-old White males. Treatment providers in Akron-Canton and Toledo reported the drug to be popular among the gay community. Often, methamphetamine is used in combination with alcohol, crack cocaine, heroin, powdered cocaine, prescription opioids and sedative-hypnotics (Xanax®). Participants reported that alcohol and sedative-hypnotics assist the user to “come down” off the high. Other participants also reported that they use these same drugs to “speedball” (experience an intense high followed by an intense low). Participants from rural parts of Cincinnati region spoke of methamphetamine used with heroin as the “ultimate speedball.”

Ecstasy

Ecstasy [methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] is highly available in Akron-Canton, Cincinnati, Cleveland and Toledo, and moderately available in Athens, Columbus, Dayton and Youngstown. While Ecstasy is one of the most available drugs in the Cleveland region, noted decreases in its availability over the past six months exist for Akron-Canton, Toledo and Youngstown. Many community professionals reported Ecstasy’s popularity as waning. Participants continued to describe typical users as those who frequent the club or bar scene. Additionally, participants in Akron-Canton and Toledo described a shift in use from the young, White club goers who are 15 to 21 years of age, to the young, Black club goers in that age group.

Bath Salts

Bath salts (synthetic compounds that produce a high similar to a stimulant or hallucinogenic drug) are highly available across all regions. These compounds commonly contain methylone, mephedrone or MDPV. The generic term, bath salts, is in and of itself 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. Readily available from drug stores, head shops and some convenience marts, bath salts were legally sold during this

reporting period. While not all participants had knowledge of bath salts, experienced users described bath salts as similar to synthetic cocaine or synthetic Ecstasy. Participants and treatment providers believed the availability and use of bath salts has increased over the past six months, and nearly every crime lab surveyed corroborated this belief. There were no slang terms associated with this drug reported, but participants often used the name on the package to indicate their preferred type/brand. Prices for bath salts depend on whether one buys a sealed package or in bulk form (loose crystals). Sealed packages of bath salts sell for \$22–\$40, and bulk bath salts sell for \$75–\$90 for 1/2 gram. Participants reported that bath salts can be more expensive than popular illegal drugs. The most common route of administration for bath salts is intranasal inhalation (snorting), and less common routes are drinking with soda and smoking (sprinkling the powder on a cigarette). Participants described typical users as adolescents and college students (teens to mid-20’s). Treatment providers from Columbus and Dayton reported that users are showing up in hospital emergency rooms on a regular basis. While some bath salts produce euphoric sensations and a “cocaine buzz,” participants also reported a variety of unwanted side effects, including difficulty breathing and seizures. Law enforcement reported the use of bath salts has been implicated in several deaths around the state.

Other Drugs

OSAM Network participants listed a variety of other drugs as being present in Ohio, but these drugs were not reported across all regions. Prescription stimulants (Adderall® and Ritalin®) remain moderately to highly availability across regions. They are among the most available drugs in Athens, Cincinnati, Cleveland and Youngstown. College students continue to use prescription stimulants as study-aides and to get high; increasingly, students are using Adderall® in conjunction with alcohol because it gives them the ability to drink more alcohol, and thus, party longer. Synthetic marijuana (“K2” and “Spice”) remains highly available across the state in retail stores (gas stations and head shops). The drug continues to be used by a few participants for recreational use and as a substitute for marijuana when participants need to pass a drug test. However, several treatment providers reported that they now screen for the presence of synthetic marijuana. Psilocybin mushrooms remain rarely to moderately available across regions, with the exception of Athens where they remain highly available. Generally, psilocybin mushrooms are seasonal, with availability higher during summer months. LSD (lysergic acid diethylamide) is rarely to moderately available across regions, with the exception of Cleveland where it is highly available. In Dayton, law enforcement described LSD as, “coming around again with college students,” while in Athens,

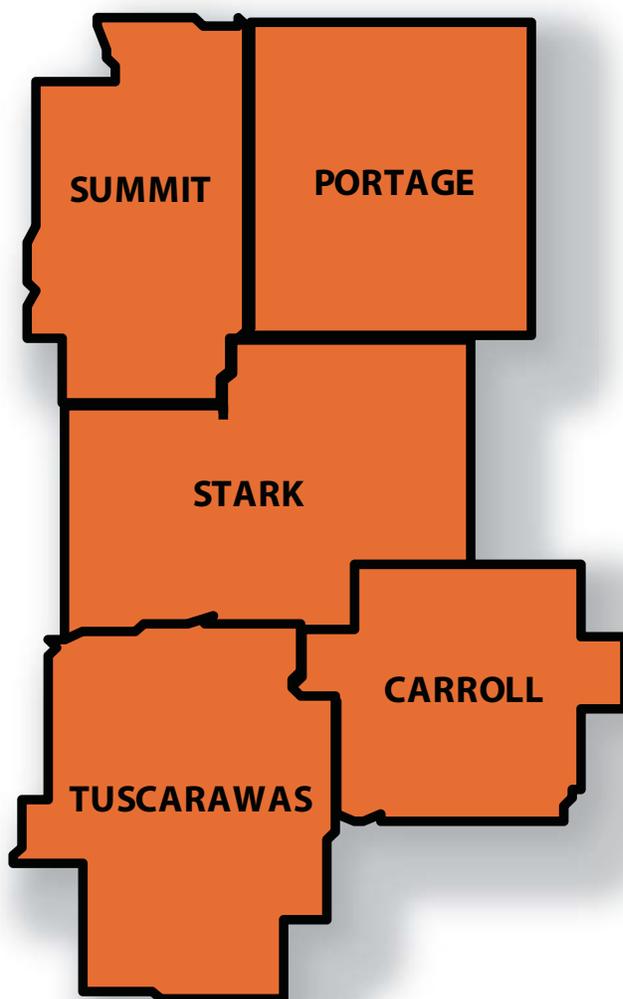
LSD is said to be found at festivals. BCI Richfield crime lab reported that the number of LSD cases it processes has increased over the past six months. As reported in Cincinnati and Youngstown, prescription cough medicines that contain codeine and over-the-counter cough medicines containing DXM (dextromethorphan), like Coricidin Cough and Cold®, remain popular among teenagers who have limited access to other drugs. In Youngstown, the ingestion of these cough medicines, commonly called “robo-tripping,” is believed to be increasing, and the use of inhalants also remains popular with adolescents. In addition to the aforementioned other drugs, the presence of ketamine was noted in Akron-Canton and Cleveland; GHB (gamma-hydroxybutyrate) was noted in Cleveland and Youngstown; and DMT (dimethyltryptamine) and PCP (phencyclidine) were noted in Cleveland.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Akron-Canton Region

January-June 2011

John R. Kasich, Governor
Orman Hall, Director



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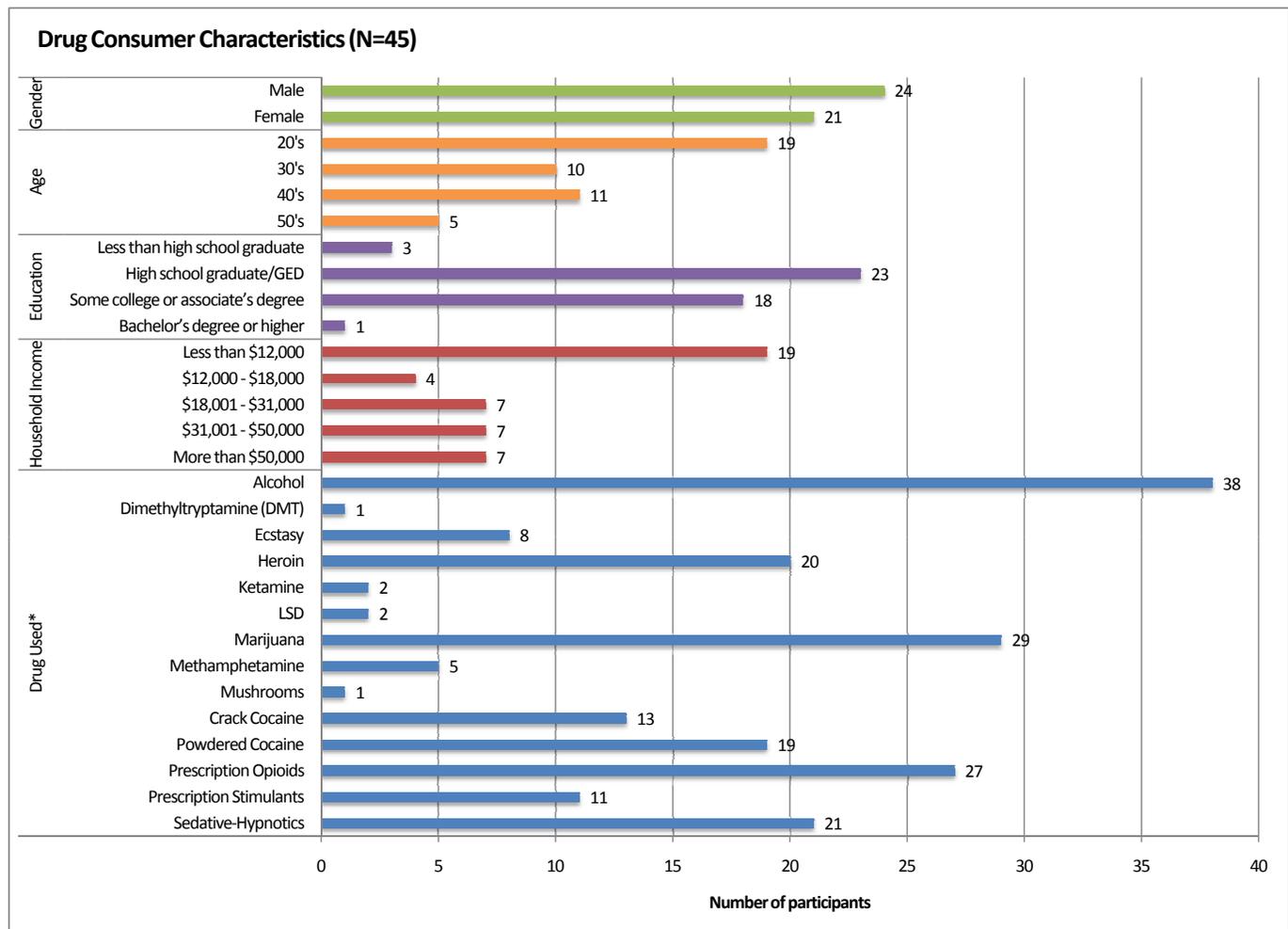
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Regional Profile

Indicator ¹	Ohio	Akron-Canton Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,542,645	1,199,077	45
Gender (Female), 2009	51.2%	51.5%	46.7%
Whites, 2009	82.2%	86.5%	88.9%
African Americans, 2009	11.9%	9.3%	6.7%
Hispanic or Latino Origin, 2009	2.8%	1.3%	2.2%
High school graduates, 2008	83.0%	89.4%	93.3%
Median household income, 2009	\$45,467	\$44,363	\$12,000 - \$18,000 ²
Persons below poverty, 2009	15.1%	14.3%	27.3% ³

Ohio and Akron-Canton statistics are derived from the U.S. Census Bureau¹.
 Respondents reported income by selecting a category that best represented their household's approximate income for 2009².
 Poverty status was unable to be determined for one respondent due to missing or insufficient income data³.



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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in 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 and the Stark County Coroner's Office. All secondary data are summary data of cases processed from July to December 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the last 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 the aforementioned data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2011.

Powdered Cocaine Historical Summary

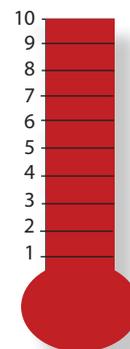
In the previous reporting period, powdered cocaine was highly available in the region. Participants and community professionals most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Overall, participants reported that availability depended on the quality of cocaine desired, stating that "uncut" (unadulterated) cocaine was rather difficult to find. Participants and law enforcement agreed that there had been brief periods over the previous six months when powdered cocaine was more difficult to find, describing these periods as "droughts." Participants expressed the belief that there were times when law enforcement was more aggressive in terms of incarcerating suppliers/dealers of powdered cocaine. Participants also stated that much of the powdered cocaine that comes into the region was used to "cook" (manufacture) crack cocaine, making powdered cocaine less available at times. 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 the quality of powdered cocaine was dependent on the following: who was selling it, how much one was willing to spend, and from where the cocaine came. Participants reported that a gram of powdered cocaine sold for \$40–\$90, depending on quality. Participants also reported that a person could buy \$5 worth of powdered cocaine. Reportedly, the most common method of using powdered cocaine was intranasal inhalation (snorting), but a good number of participants also reported injecting powdered cocaine. Respondents generally noted that

consumers of powdered cocaine tended to be in their 20's or 30's, and the consensus was that "all types of people" (from all levels of economic status) used powdered cocaine. However, participants noted that individuals who injected tended to be male and individuals who were addicted to heroin; a treatment provider noted that powdered cocaine use was popular among the gay population.

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'. However, a participant reported that low-quality powdered cocaine is more prevalent: "[Availability of powdered cocaine] it depends on the quality [of powdered cocaine sought], 'garbage' [low-quality] is a '10' [highly available], but better quality is lower, a '6' [moderately available]." Treatment providers and law enforcement most often reported the drug's current availability as '6'. Treatment providers reported that fewer clients are mentioning powdered cocaine use at intake for treatment, and of those clients who do mention use, powdered cocaine is usually a secondary or tertiary drug of choice: powdered cocaine is not a primary drug of choice. A treatment provider stated, "[Powdered cocaine] use is down but still very available. You need it for crack [cocaine]," implying that powdered cocaine is primarily used to manufacture crack cocaine. Collaborating data also indicated that powdered cocaine is readily available in the region. The Stark County Coroner reported that 17.9 percent of all deaths it investigated over 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, 16.6 percent of all deaths were drug related. Furthermore, the coroner reported cocaine as present in 30 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, media outlets across the state reported on significant arrests this reporting period involving powdered cocaine trafficking in the region. In June, the *Record-Courier* reported that the Ohio Highway Patrol arrested a Youngstown man on Interstate 76 in Rootstown (Portage County) with 100 grams of powdered cocaine (www.recordpub.com; June 5, 2011).

Participants reported that the availability of powdered cocaine has generally remained stable over the past six months. However, many participants noted that the use



of powdered cocaine is decreasing, citing that people are changing their drug of choice. A participant commented, *"People on powdered cocaine are either switching to crack [cocaine] for the intense buzz [high] or to prescription opioids because they are less risky, and they enjoy the buzz better—and it lasts longer."* Many participants noted that crack cocaine is more available, as one stated, *"Much of the [powdered] cocaine is already rocked [manufactured into crack cocaine]."* Treatment providers generally see the preference for powdered cocaine as going down, though it was stated that availability of powdered cocaine has remained stable over the past six months. A treatment provider noted that the availability of powdered cocaine is, *"definitely not going down. Nothing is going down."* Summit County law enforcement commented that the availability of powdered cocaine has decreased: *"[Powdered cocaine availability] is probably down, as we just took out a couple of drug trafficking organizations."* Canton-Stark County Crime Lab reported that the number of powdered cocaine cases it processes has remained stable over the past 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 previous most common score was also '7'. Participants reported that powdered cocaine in the region is cut (adulterated) with baby laxatives, baking soda, bath salts (synthetic cocaine), creatine, *"horse steroids,"* inositol (B vitamin), vitamin B-12 and *"more dirty dope."* Canton-Stark County Crime Lab continues to cite the following substances as commonly used to cut powdered cocaine: caffeine, levamisole (livestock dewormer) and procaine (local anesthetic). Many participants continued to report that the quality of powdered cocaine depends on from whom one buys it. A participant commented, *"Over half the people [buying powdered cocaine] are not happy; they believe they are being ripped off."* Participants generally reported that the quality of powdered cocaine has decreased over the past six months. Participants reported, *"[Quality of powdered cocaine] it keeps getting worse. They [dealers] cut it [adulterate powdered cocaine], and cut it, and cut it; Sometimes it isn't even [powdered] cocaine; [Quality] it's gotten so bad; it's not worth doing it [using powdered cocaine]. It [poor quality] moved me to quit [using powdered cocaine]."*

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "powder" and "White girl." Participants listed the following as other common street names: "blow," "Christine Aguilera," "fish scales," "girl," "snow," "soft," "white," "White lady" and "ya-yo." A participant group shared that the phrase "go skiing" refers to using powdered cocaine. Current street prices for powdered cocaine were varied among participants with experience buying powdered cocaine, with cited gram

prices slightly lower than the previous reporting period. Participants reported that a gram of powdered cocaine sells for \$30–\$70, depending on the quality and from whom one buys; 1/16 ounce, or "teener," sells for \$60–\$90; 1/8 ounce, or "eight ball," sells for \$120–\$250. Participants reported that the most common ways to use powdered cocaine remain intranasal inhalation (snorting) and intravenous injection. Out of 100 powdered cocaine users, participants reported that approximately 50 would snort it, and 50 would intravenously inject or "shoot it." A few participants continued to report that they had knowledge of individuals smoking powdered cocaine, and a few participants reported knowledge of people "parachuting" powdered cocaine (wrapping powdered cocaine in a piece of tissue and swallowing). Many participants commented that use via injection is a growing practice. A participant reported, *"The needle [injection] is becoming the way [route of administration] of choice [for powdered cocaine use]."*

A profile for a typical powdered cocaine user emerged from the data. Participants described typical users of powdered cocaine as more likely female than male and people with money. Many participants described powdered cocaine as, *"a rich man's drug,"* with a participant commenting, *"[Powdered cocaine use] it's more acceptable to higher-class people."* Additional participant comments included, *"People with hard labor jobs [construction workers], especially who work at night; and people who go clubbing [are more likely to use powdered cocaine than others]."* Regarding age, a participant commented, *"The older crowd tends to stick with powder [cocaine],"* though a number of participants commented that young Whites are trying powdered cocaine versus crack cocaine. Treatment providers also agreed that the powdered cocaine user is likely to be of a higher socioeconomic class, (attorneys and doctors). However, law enforcement viewed powdered cocaine use as pretty well distributed across the board, noting no specific user identifiers.

Reportedly, powdered cocaine is used in combination with numerous different drugs, with the practice of combining powdered cocaine use with other drug use cited as relatively common. Participants reported that powdered cocaine is used in combination with alcohol, heroin (a.k.a., "speedball," concurrent use of powdered cocaine and heroin), marijuana (a.k.a., "primo," concurrent use of powdered cocaine and marijuana), prescription opioids and sedative-hypnotics (Xanax®). Participants explained that powdered cocaine users who enjoy the *"up and down effect"* speedball with heroin. A participant stated that speedball produces, *"a hell of a high."* Participants also reported that heroin use, along with alcohol and sedative-hypnotic use, after powdered cocaine use helps the user to "come down" from the stimulant high of powdered cocaine. A few participants reported that alcohol used

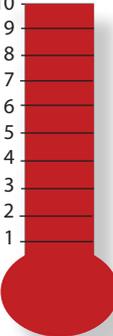
concurrently with powdered cocaine enables an individual to consume more alcohol: “You can drink, and drink, and drink and not be stumbling around.” Lastly, participants reported that concurrent use of powdered cocaine and prescription opioids will, “add to the speed buzz, and the opiate buzz lasts longer; it is cheaper to use pills [prescription opioids] with [powdered] cocaine than to have to go and buy another eight ball [of powdered cocaine].”

Crack Cocaine

Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Community professionals also rated the availability of crack cocaine highly; law enforcement rated it’s availability as ‘10’ and treatment providers rated it’s availability as ‘8.’ Nearly everyone interviewed said the availability of crack cocaine has remained about the same over the past six months while noting periods of fluctuation. The most common participant quality score for crack cocaine was ‘6’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that crack cocaine was most often cut (adulterated) with other substances. Canton-Stark County Crime lab reported that crack cocaine was most often cut with baking soda. Participants reported a gram of crack cocaine sold for \$75. However, the majority of crack cocaine users reported buying the drug in small quantities ranging in price from \$2–\$20. By far, the most common route of administration for this form of cocaine was smoking. A profile of a typical user of crack cocaine did not emerge in the data; the consensus among treatment providers and law enforcement alike was that many people from all socioeconomic classes use the drug.

Current Trends



Crack cocaine remains highly available in the region. Participants most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10.’ Participants reported, “[Crack cocaine is] the most available drug on the street right now; People [dealers] will approach you [on the street and solicit a crack cocaine sale].” Treatment providers most often reported the current availability of crack cocaine as ‘10’ while Summit County law enforcement reported current availability as ‘6.’ Law enforcement commented that availability of

crack cocaine is, “probably a little lower. Most crack [cocaine] is converted here [manufactured from powdered cocaine for personal use].” Regional media corroborated the high availability of crack cocaine in the region. In April, the *Record-Courier* reported that local and federal law enforcement arrested two Portage County men after several months of investigation into drug trafficking. The two men allegedly accepted stolen property in exchange for crack cocaine and marijuana (www.recordpub.com; April 6, 2011).

Most participants reported that the availability of crack cocaine has remained stable over the past six months, though participants of one focus group noted an availability increase: “The economy is so bad. People’s unemployment is running out, so they turn to selling drugs. People are buying [powdered] cocaine cheaper, they cook it up at home, and sell it [crack cocaine], and make a good profit.” Treatment providers were in disagreement as to whether the availability of crack cocaine has changed over the past six months. Most agreed that the use of crack cocaine has decreased due to the rise of other drug use, and while some believed this transferred to less availability, others commented that availability has remained high. Treatment providers explained crack cocaine is not usually a primary drug of choice of their clientele, but nonetheless, it is frequently used. Canton-Stark County Crime Lab reported that the number of crack cocaine cases it processes has increased over the past six months.

Most participants rated the quality of crack cocaine as ‘3’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the previous most common score was ‘6.’ Again, participants stated that the quality of crack cocaine depends on from whom one buys. Participants reported that the quality of crack cocaine has remained the same over the past six months, in that the quality has been poor for some time. Complaining of the degree to which crack cocaine is cut (adulterated), a participant commented, “By the time it [crack cocaine] gets out, it’s just baby powder.” Participants did not identify any other substance with which crack cocaine is commonly cut. Canton-Stark County Crime Lab continues to cite baking soda as commonly used to cut crack cocaine.

Current street jargon includes many names for crack cocaine. The most commonly cited names were “hard” and “rock.” Participants listed the following as other common street names: “blocks,” “crack,” “girl,” “heaven,” “stones,” “White boy” and “work.” Current street prices for crack cocaine were consistent among participants with experience buying crack cocaine, with cited prices slightly lower than the previous reporting period. Participants reported that a gram of crack cocaine sells for \$40–\$50, depending on the quality; 1/16 ounce, or “teener,” sells for \$60; 1/8 ounce, or “eight ball,” sells for \$100–\$110; an ounce sells for \$1,000–\$1,400. Participants

reported that the most common method of purchasing crack cocaine continues to be to buy a \$20 rock, and many participants reported that crack cocaine can be purchased for, *"whatever you have to spend, even a couple of dollars."* A participant commented, *"You can buy crack [cocaine] for as low as \$5 and as high as thousands of dollars."* Another participant commented, *"Most people try to save by buying a \$20 piece [of crack cocaine], but they then go get another \$20, and then another, and they do it again."* The most common route of administration for crack cocaine remains smoking. Out of 100 crack cocaine users, participants reported that approximately 90 would smoke the drug. Some participants reported knowledge of users who intravenously use crack cocaine, depending on the quality. A participant explained, *"If the quality [of crack cocaine] is really good, you can use vinegar to break it down, and shoot it."* Another participant had a different perspective: *"If you are already an IV [intravenous] user, you will shoot [inject] anything you can shoot."*

A consistent profile of a typical user of crack cocaine did not emerge from the data. There was disagreement between groups of participants as to whether individuals from lower socioeconomic status are still representative of the typical crack cocaine user. Many agreed with comments made from one participant, *"[Crack cocaine] it used to be a ghetto drug, but not now. Anyone uses it."* A participant focus group suggested that individuals from lower socioeconomic status, namely African-Americans and older White women are more representative of the typical crack user. Likewise, there was also disagreement among treatment providers regarding demographic descriptors of the typical user of crack cocaine. Many treatment providers felt that crack cocaine use is more common among females, and many reported crack cocaine use to be more common among individuals of lower socioeconomic status. Summit County law enforcement reported that from their perspective, crack cocaine use is more common among African-Americans. Law enforcement also said there is a lot of crack cocaine use in the area's public housing projects, but cautioned that people from all walks of life come into these projects to purchase crack cocaine.

Reportedly, crack cocaine is used in combination with alcohol, heroin, prescription opioids and sedative-hypnotics. Most participants agreed that the primary reason for using the aforementioned substances with crack cocaine is to, *"help bring you down"* from the stimulant high of crack cocaine. A participant reported, *"If you use crack [cocaine] by itself, you can't stop. So, you use other drugs to bring you down."* Participants also reported the practice of lacing a marijuana "blunt" (single cigar) with crack cocaine in order to, *"catch a quick speed."* Participants indicated all of these practices are relatively common.

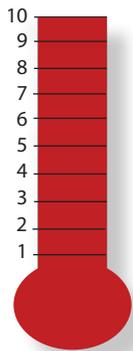
Heroin

Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants most often reported the drug's availability as '8' or '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants reported powdered heroin as the most common type of heroin found in the region, describing it as tan, brown or yellowish in color. Participants consistently reported that there had been an increase in the availability of heroin over the previous six months. Treatment providers reported a *"substantial spike"* in the number of individuals who reported heroin as their drug of choice over the previous six months, a trend they cited as continuing. The most common participant quality score for heroin was '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported no change in the quality of heroin over the previous six months, although a few participants reported that heroin tended to be *"a little more cut"* as dealers *"stomp on it"* (add other substances to increase mass and volume) in order to increase profits. Participants consistently reported that heroin sold for \$20 a *"baggie"* (1/10 gram), with some reporting that heroin could be bought for as little as \$10. While participants noted that heroin could be injected, snorted, smoked, chewed or eaten, the most common route of administration was intravenous injection (shooting), followed by intranasal inhalation (snorting). The consensus among treatment providers and law enforcement alike was that many people from across all socioeconomic classes use heroin, although treatment providers reported an increase in heroin use among younger people under the age of 30 years. Participants in the region concurred that heroin use was popular among young people (teens and college aged individuals). Participants identified heroin use as most common among the following groups: White people, individuals coming out of the armed services, especially those who have served overseas, and individuals addicted to prescription opioids (OxyContin®) who were turning to heroin use as prescription opioids had become increasingly more difficult to obtain and thus more expensive.

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 scores were '8' and '10'. While many types of heroin are currently available in the region, participants continued to report powdered heroin (white and brown powdered) as the most available. Participant comments on availability included: *"[Heroin] it's more available than anything else; I've been approached many times [to buy heroin]; [Heroin] it's made*



a big come back." In addition to powdered heroin, participants reported that black tar heroin also remains available in the region. As one participant summarized, *"Powder [heroin] is easier to find, but you can find tar [black tar heroin] very easily."* This participant described powdered heroin as, *"white, tan, or brown, usually fine, sometimes in chunks, but able to turn it into powder yourself. Tar [black tar heroin] comes in a ball; it's black, hard and sticky."* Treatment providers and law enforcement most often reported heroin's current availability as '10'. Treatment providers

described the availability of heroin as, *"very plentiful; just a phone call away."* All interviewed agreed that powdered heroin is far more available than black tar heroin in the region, though it was commented, *"the choice [preference] of most users is black tar [heroin]."* Law enforcement in Summit County reported, *"Most everything we [law enforcement] see is powder [heroin], Mexican variety. We saw a little tar [black tar heroin] last year."* Collaborating data also indicated that heroin is readily available in the region. The Stark County Coroner reported heroin as present in 22.5 percent of all drug-related deaths over the past six months. Regional media reported on heroin arrests and heroin deaths this reporting period. In February, the *Canton Repository* reported in an article entitled, *"Heroin Deaths Shoot Up in Stark,"* that heroin use claimed the lives of at least 11 people in Stark County in the previous year (www.cantonrep.com; Feb. 14, 2011). Also in February, *The Akron-Beacon Journal* reported that Akron police had arrested two people for drug trafficking when an Akron home was raided, seizing 40 grams of heroin with an estimated worth of \$28,000, along with a digital scale and a loaded .22-caliber handgun (www.ohio.com; Feb. 18, 2011).

Participants reported that overall availability of heroin has increased over the past six months. Participants stated, *"Heroin [availability] has skyrocketed; Instead of my calling a few people to find it [heroin], they call me, they [dealers] come to me."* 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 have increased: *"Because they [Purdue Pharma] changed oxy's [OxyContin®], pills [prescription opioids] are harder to get. People [users] are changing to heroin."* Treatment providers almost unanimously reported that the availability of heroin has increased over the past six months. Treatment providers stated, *"Each six months, it [heroin] gets easier to find. There are more [heroin] dealers; Years ago, people [users] went to Detroit or Pittsburgh, later to Cleveland [to purchase heroin]. Now, [heroin] it's very available here [Akron]."* Law enforcement in Summit County reported that there has

been a significant increase in the number of large-scale heroin seizures this year. Canton-Stark County Crime Lab reported that the number of powdered heroin cases it processes has increased while the number of black tar heroin cases has remained the same over the past six months.

Most participants generally rated the quality of heroin as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '7'. Participants reported that heroin in the region is cut (adulterated) with a number of cutting agents, including: aspirin, baby laxatives, coffee creamer, creatine, fentanyl, OxyContin®, powdered cocaine, Similac®, sleeping pills and vitamin supplements. Participants often commented that the quality of heroin depends on who you get it from, where it comes from, how it is cut, as well as, the kind of heroin sought (powdered versus black tar heroin). Brown powdered heroin was often rated lower than white powdered heroin in terms of quality. Participants reported that white powdered heroin, which is often referred to as "China white," is commonly cut with fentanyl, making its quality better (more potent). However, participants reported that black tar heroin is generally the highest quality heroin. Participants were evenly split as to whether the quality of heroin has remained the same or decreased over the past six months. A participant who noted a decrease in quality stated, *"There are so many stops before it [heroin] gets here,"* asserting that heroin is cut at each step of the way. 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).

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "dog food." Participants reported that heroin is available in different quantities: "folds" or "papers" (1/10 gram folded in corners of a piece of paper to keep the heroin from sticking to the baggie) sell for \$10–\$30; "bundles" (10–12 small packs of heroin), sell for \$70–\$80; a gram sells for \$100–\$200. However, a number of participants noted that one can purchase heroin for, *"whatever you have to spend."* A participant stated, *"Heroin used to be sold in bags. Now, [heroin sells for] what you have to spend; they [dealers] put it on scales."* Participants reported that heroin is less expensive in big cities. Participants reported that the most common way to use heroin remains intravenous injection. Other methods of administration continue to include intranasal inhalation (snorting), and less commonly, smoking. Most participants reported that how a person uses heroin most often depends on how long one has used the drug. Many participants similarly commented, *"Everyone starts out snorting it [heroin], and then, eventually, they shoot [inject] it."*

A profile of a typical user of heroin emerged from the data. 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 are, *"getting younger and younger,"* noting that teenage males, as early as junior high school age, are more commonly using heroin.

Reportedly, heroin is used in combination with alcohol, crack cocaine, marijuana, methamphetamine, powdered cocaine, prescription opioids and sedative-hypnotics (Xanax®). The stimulant drugs of cocaine and methamphetamine combined with heroin (a.k.a., "speedball") reportedly produce an up and down feeling which participants report as a desired effect. Drugs with depressant qualities, such as alcohol, marijuana, prescription opioids and Xanax®, reportedly are used in combination with heroin to, *"make the heroin [high] better; an okay quality of heroin becomes like a high-grade heroin,"* although some participants commented on the danger of using heroin with Xanax®, calling this combination a *"suicide cocktail."*

Prescription Opioids Historical Summary

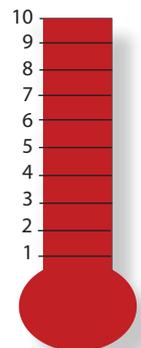
In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants and community professionals identified OxyContin®, Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use, with participants additionally naming Dilaudid® as also most popular. The Stark County Coroner's office reported prescription pain medication as the most common drug present in drug-related deaths; it was present in 60 percent of all drug-related deaths (this was an increase from 44 percent over the previous six months). Treatment providers stated that prescription opioids were frequently prescribed; participants agreed that these medications were readily prescribed. These drugs found their way onto the region's streets by people stealing medications from family members, individuals forging prescriptions (noted by Summit County law enforcement), dealers bringing prescription opioids in from other states (Florida) and Canada, as well as, individuals fraudulently purchasing prescription opioids on the Internet. Overall, a number of participants identified a continued rise in the popularity of prescription opioid use (save for OxyContin®) over the previous six months. Participants identified the primary reason for the rise in prescription opioid popularity as the nation's recession and individuals recognizing the profitability in selling prescription

opioids. Canton-Stark County Crime Lab reported an increase in the number of prescription opioid cases it processed over the previous six months (increases in codeine, Dilaudid® and OxyContin® cases). While there were a few reported ways of consuming prescription opioids, generally, the most common route of administration was oral consumption. In addition to swallowing pills, participants reported that pills were also crushed and taken via intranasal inhalation (i.e., snorting) and intravenous injection. Some participants and treatment providers noted that prescription opioid users tended to be White; however, the consensus seemed to be that individuals from all ages, socioeconomic statuses and races were abusing these medications. Participants and community professionals noted that addiction to prescription opioids often started with legitimate treatment for pain, then due to various reasons (loss of income, inability to access medical care, increase in tolerance), individuals developed an addiction, often turning to street purchase in order to self-medicate and supplement their addiction.

Current Trends

Prescription opioids remain highly available in the region. Participants and treatment providers most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. A participant stated, *"I can get pills [prescription opioids] in 10 minutes. I have a few doctors wrapped around my finger."* 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 also most popular. A treatment provider explained that the prescriptive nature of these medications contributes to the prevalence of prescription opioid abuse: *"Because it [pain medication] is prescribed [by a doctor], it [prescription opioid use] is mentally acceptable to the user."* Collaborating data also indicated that prescription opioids are readily available in the region. The Stark County Coroner reported prescription opioids remain the most common drug present in all drug-related deaths; they were present in 45 percent of all drug-related deaths (this is a decrease from 60 percent from the previous six-month reporting period).

Participants were not in agreement as to whether the availability of prescription opioids has increased, decreased or remained the same over the past six months, as all three positions were posited by different groups. A



participant that posited availability of prescription opioids has increased, stated, *"People are realizing 'I can sell my medication [prescription opioids] in this bad economy.'" Those who reported a decrease in availability were represented by another participant: "The FDA is cracking down [on over prescribing of prescription opioids]. If you go to the hospital, and they [hospital staff] see you are a repeat offender, they red flag you and give you a lower potency [medication] as a substitute."* An Akron participant group noted that certain doctors, *"got into legal trouble, which changed availability and supply [of prescription opioids]."* Participants agreed that OxyContin®, due to the changes in formulation that make it difficult to crush for intravenous use, is not as readily sought by users. A few participants commented that Opana® is becoming popular as a replacement for OxyContin® as it is easier to use intravenously. A participant stated that Opana® is, *"the most sought opiate medication now."* Treatment providers for the most part reported that the availability of prescription opioids has decreased over the past six months. A focus group of treatment providers speculated that a recent regional media campaign, which they described as, *"pretty intense, kind of graphic media campaign"* that highlighted the dangers of prescription opioid abuse, may have reduced the demand for these medications. Treatment providers cited other causes for their perceived decrease in availability: *"[Law enforcement] putting the squeeze on doctors"* and pharmacies becoming more connected. Canton-Stark County Crime Lab reported that the number of cases it processes for most prescription opioids has remained stable over the past 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 (a.k.a., "skittles") are currently sold on the region's streets. Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid® (\$8–\$10), morphine 60 mg (\$10), Opana® (10 mg sells for \$15; 20 mg sells for \$40; 40 mg sells for \$50–\$60), OxyContin® (a.k.a., "oxy's" and "oscars"), OxyContin® OP (new formulation, sells for \$0.50–\$1 per milligram; participants reported that the old formulation, OxyContin® OC, sells for two to three times that of the new formulation), Percocet® (5 mg, a.k.a., "perc 5's," sells for \$2–\$7; 10 mg, a.k.a., "perc 10's," sells for \$5–\$10), Vicodin® 50/500 mg (a.k.a., "vike 500's," sells for \$2–\$3).

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 are prescribed these medications. Participants reported that it is fairly easy to feign illness or injury in the emergency room in order to acquire these medications. Participants noted that some users may go to multiple emergency rooms in a single night: *"ER's give 120 pills [prescription opioids] to stop you from coming back."* Participants also noted that dealers reportedly hang out in parking lots outside of pharmacies and approach individuals, offering to purchase their 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, are intranasal inhalation (snorting), intravenous injection and oral ingestion (swallowing). However, participants reported that once an individual uses any drug intravenously, intravenous injection becomes the preferred method for any other drug: *"Once you shoot [inject] something up, it's the only way you want to use."* Participants identified additional routes of administration for prescription opioids to include "parachuting" (crushing pills, placing powdered content in a piece of tissue and swallowing) and smoking (crushing pills, placing powdered content on aluminum foil, heating underneath and inhaling fumes).

A profile of a typical user of prescription opioids did not emerge from the data, as descriptors of a typical user were wide-ranging and inconsistent. Some participants cited that prescription opioids are more common among population groups where there is still a stigma regarding intravenous use; some participants named, *"rich little White kids; older people; housewives; people in the suburbs."*

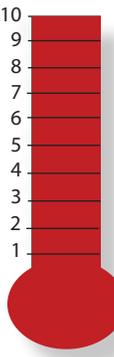
Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, heroin, marijuana and sedative-hypnotics (Xanax®). Participants reported that it is common to use all of the aforementioned substances in combination with prescription opioids to, *"intensify the buzz."*

Suboxone® **Historical Summary**

In the previous reporting period, Suboxone® was moderately available in the region. Participants most often reported availability of Suboxone® as '5' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). There was participant disagreement regarding the street availability of Suboxone®. Participants questioned whether Suboxone® could actually be abused. It was commonly

held by users that, *"No one abuses Suboxone®. It's a life saver."* Treatment providers, on the other hand, reported an increase in the abuse of Suboxone®. Reportedly, Suboxone® was primarily used to assist with managing withdrawal symptoms for individuals who were trying to quit heroin or who temporarily did not have access to heroin. Participants reported that Suboxone® 8 mg generally sold for \$8–\$15, but could sell for as high as \$25, depending on, *"how badly you need it."* Suboxone® was usually taken sublingually as prescribed. However, a few participants reported that some used the drug via intranasal inhalation (snorting) and intravenous injection. Participants reported that Suboxone® was used with alcohol and marijuana as Suboxone® with either drug, *"intensifies the high."*

Current Trends



Suboxone® is highly available in the region. Participants most often reported the current availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '5.' Participants continued to report that in addition to being used to support one's attempts to quit using opioids, individuals also use Suboxone® to avoid withdrawal during times when they lack access to their opioid of choice. A participant reported, *"People [heroin addicts] will wait three days in case they are able to find heroin, then use Suboxone® to maintain until they get heroin again."* Another participant stated, *"If you are clean [opioid free], you will get very high from Suboxone®."* Treatment providers also most often reported the current availability of Suboxone® as '10' while Summit County law enforcement reported the drug's current availability as '3.'

Treatment providers reported that the availability of Suboxone® has increased over the past six months. A treatment provider noted, *"It [Suboxone®] is becoming easier to get than methadone."* A focus group of treatment providers noted that users report that using Suboxone® with benzodiazepines breaks down the antagonist function: *"People [users] will use Xanax® a half-hour before Suboxone® and will get high. Some clients say the effects are as good as, or better than, that of OxyContin®."* Canton-Stark County Crime Lab reported that the number of Suboxone® cases it processes has decreased over the past six months.

Participants reported that Suboxone® 8 mg sells for \$10–\$30, and Suboxone® strips sell for \$10–\$20. Participants noted that strips are not as valuable as one is not able to

use them via intranasal inhalation (snorting). Most often participants reported taking Suboxone® sublingually or by snorting. Participant groups differed as to which of the aforementioned two methods is most common. A focus group noted that those who use Suboxone® to get high most often snort the drug. A participant reported, *"I got higher if I snorted them [Suboxone®]."* Participants reported that while doctors have started to prescribe Suboxone® strips more often, Suboxone® pills are still readily available. Suboxone® pills are preferable to many users as they can be crushed and snorted.

In addition to obtaining Suboxone® on the street from dealers, participants also reported getting Suboxone® from doctors and clinics, as well as from individuals with prescriptions. A participant commented that one can acquire Suboxone® from, *"someone who goes to a [Suboxone®] clinic. At the clinic, you get more [Suboxone®] than you need. They sell the rest."*

A profile for a typical Suboxone® user emerged from the data. Participants reported that individuals who need to avoid detection of drug use on urine drug screens (probationers) will use Suboxone® because it is often not screened. A participant remarked, *"[Suboxone® is] the institutional drug of choice."* Treatment providers reported that the typical user of Suboxone® tends to be a younger person, of at least middle-class status, or as one provider stated, *"[Someone] who can go to a doctor regularly for ongoing [Suboxone®] treatment."*

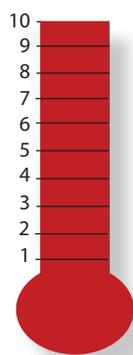
Reportedly, users rarely use Suboxone® in combination with other drugs, as one participant explained, *"Suboxone® makes you feel good, all over,"* implying that other drugs are not necessary. However, as reported above, some participants reported that those abusing Suboxone® for a high often combine the drug with sedative-hypnotics (Xanax®) as this combination reportedly exacerbates the high allegedly produced from 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 '8' or '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants in Summit County reported the availability of Xanax® as '10' while assigning an availability rating of '8' to Ativan®, Klonopin® and Valium®. Treatment providers and law enforcement throughout the region reported that there has been a longstanding trend of increased sedative-hypnotic prescribing, especially

for Ativan® and Xanax®. Participants stated that these medications could be obtained from emergency rooms and physicians either by feigning illness, paying physicians for prescriptions (\$50), from other individuals to whom these medications were prescribed or through purchase over the Internet. While there were a few reported ways of consuming sedative-hypnotics, the most common route of administration was oral consumption (swallowing). There was no consensus about the typical user profile of sedative-hypnotics. While some participants and treatment providers believed individuals from all ages, socioeconomic statuses and races were abusing these medications, others thought that women and marijuana users were more likely to abuse sedative-hypnotics.

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 scores were '8' and '10'. A participant noted, *"Everything is a phone call away."* Treatment providers also most often reported current availability as '10'. Participants continued to identify Ativan®, Klonopin®, Valium® and Xanax® as the most

popular sedative-hypnotics in terms of widespread use. Treatment providers identified Klonopin® and Xanax® as most popular in terms of widespread use. Treatment providers agreed that the use of these medications is very prevalent, in part because sedative-hypnotics are *"prescribed so freely,"* and because they are inexpensive. A treatment provider commented, *"Xanax® is the most acceptable prescribed drug by far."* Treatment providers reported that many of their clients are being treated with sedative-hypnotics, and that users do not see themselves as addicts because these medications are legally prescribed. Collaborating data also indicated that sedative-hypnotics are readily available in the region. The Stark County Coroner's office reported that sedative-hypnotics are the second most common drug present in all drug-related deaths; they were present in 40 percent of all drug-related deaths (this is a decrease from 57.1 percent from the previous six-month reporting period). Participants and treatment providers reported that the availability of sedative-hypnotics has remained stable over the past six months. Canton-Stark County Crime Lab reported that the number of sedative-hypnotic cases it processes has fluctuated over the past six months. While the number of cases has increased

(Ativan®, Ambien® and Xanax®) or decreased (Restoril®) for some sedative-hypnotics, overall the number of cases for most has remained stable.

Reportedly, many different types of sedative-hypnotics (a.k.a., "happy pills" and "tic tacs") are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to the street-level user (Note: When reported, current street names and prices are indicated in parentheses): Klonopin® (a.k.a., "k-pins," sells for less than \$1 per milligram); Valium (\$0.50 per milligram); Xanax® (0.5 mg, a.k.a., "footballs," "peaches" and "xani's," sells for \$1–\$1.50; 1 mg, a.k.a., "blues," "footballs" and "xani's," sells for \$2–\$3; 2 mg, a.k.a., "xanibars," sells for \$4–\$6).

In addition to obtaining sedative-hypnotics on the street from dealers, participants also continued to report getting them by prescription from doctors, and from family and friends who have prescriptions. Participants agreed that it is very easy to get a prescription by feigning anxiety symptoms. A participant stated he obtained a prescription even though he does not *"like that [sedative] high; I sell them [sedative-hypnotics] to get what I do like."*

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 intranasal inhalation (snorting) and oral ingestion (chewing or swallowing). Participants expressed differing views about which of these two methods is most common. According to participants, a less common route is to dissolve a pill in alcohol and consume the drink.

A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants and treatment providers were not in agreement regarding descriptors of the typical user. Many participants reported that sedative-hypnotics are common among young people (high school aged youth). A participant reported, *"Xanax® is the drug you take if you are afraid to do any other drug."* Other participants noted that older individuals, especially *"people on disability,"* use these drugs more commonly. Treatment providers noted that typical users tended to be *"suburban kids"* and that White individuals are more likely to use sedative-hypnotics.

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, crack cocaine, heroin, marijuana and powdered cocaine. Participants described a differing effect of sedative-hypnotic use when used in conjunction with the aforementioned. Sedative-hypnotics are used with alcohol

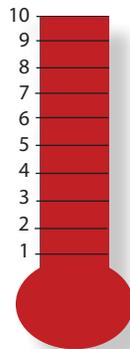
to, “boost the buzz; blackout experience;” with cocaine to, “help you to come down; I call Xanax® ‘landing gear;” with heroin to, “potentiate the effect of heroin;” with marijuana to, “give you a floating effect; makes you feel like you’re in heaven.”

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’ (high availability, extremely easy to get). Nearly everyone interviewed believed availability of marijuana was ubiquitous. Participants reported that the quality of marijuana varied from ‘3’ to ‘10’ with the most common score being ‘6’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants and treatment providers reported an increase in the availability of higher, more potent grades of marijuana such as hydroponically grown marijuana. Participants reported that for commercial-grade marijuana, a “blunt” (single cigar) sold for \$5–\$10, and an ounce sold for \$75–\$100; for high-grade marijuana, an ounce sold for \$250–\$300. By far, the most common route of administration for marijuana was smoking. A profile for a typical user of marijuana did not emerge from the data. Participants and treatment providers reported that marijuana use was widespread across all population groups, but some recognized an increase in use among adolescents and older adults.

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 stated that marijuana was, “very available; always available.” Treatment providers and law enforcement also most often reported the drug’s current availability as ‘10.’ Treatment providers noted that more people are growing marijuana, with a provider commenting, “[Marijuana] it’s easy to grow in our climate, unlike poppies and coca plants.” Summit County law enforcement also commented, “getting it [marijuana] is not a problem.” Collaborating data indicated that marijuana is readily available in the region. The Stark County Coroner’s office reported that marijuana is the third most common drug present in all drug-related deaths; it was



present in 30 percent of all drug-related deaths over the past six months.

Participants reported that the availability of marijuana has remained constant over the past six months. However, some participants reported that there are periods when marijuana is more difficult to find: “Election time ... [because] people get busted and are unwilling to sell it [marijuana].” The following statement reflects the participant majority position: “Marijuana is the one drug you can always get, no matter what. What does change is the number of grades and types [of marijuana].” Treatment providers reported that availability of marijuana has remained constant over the past six months. According to one focus group of treatment providers, the new trend in marijuana use is that the, “number of people smoking high-grade [marijuana] is going up greatly; More young people are talking about using more potent marijuana.” Canton-Stark County Crime Lab reported that the number of marijuana cases it processes has increased over 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); the previous most common score was ‘6.’ 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). Participants reported that lower grades of marijuana, commonly referred to as “dirt weed” originate in Mexico. Most participants said, “Only the old-school [users] smoke it [dirt weed].” Participants described commercial weed as slightly higher quality, “brownish, with seeds;” participants reported this grade to be the most available form of marijuana in the region. Participants described high-grade marijuana (hydroponic) as being, “fluffier, with less seeds;” it is often home grown. Participants commonly believed that the quality of marijuana has been increasing, with more individuals, “narrowing in on how to grow it [high-grade marijuana].” Participants said that growers are familiar with, “cloning new hybrids [of marijuana]” in order to “keep THC levels high.”

Current street jargon includes countless names for marijuana. The most commonly cited name remains “weed.” Participants listed the following as other common street names: “Bobby Brown,” “bud,” “devil’s lettuce,” “herb,” “mersh,” “reggies” and “regular” for low-grade and commercial-grade marijuana; “hydro,” “kind bud,” “killer” and “kush” for high-grade marijuana. The price of marijuana depends on the quality desired. Participants reported that commercial-grade marijuana is the cheapest type: a “blunt” (single cigar) or two joints (cigarettes) sell for \$5; 1/4 ounce sells for \$40–\$50; an

ounce sells for \$70. Higher quality marijuana (“hydro”) sells for significantly more: a blunt (single cigar) or two joints (cigarettes) sell for \$15–\$25; 1/4 ounce sells for \$100; an ounce sells for \$275–\$400. Reportedly, Marinol® (prescription marijuana) is available on the streets, but participants did not have pricing information.

While there were several reported ways of consuming marijuana, the most common route of administration continues to be smoking. The only other routes of administration involve baking and cooking with marijuana, but these methods are infrequently applied. A participant mentioned marijuana could be made into butter as well as used to make herbal tea.

A profile for a typical marijuana user did not emerge from the data. Participants unanimously agreed that, *“Marijuana is now acceptable to everyone; Marijuana is not considered to be a drug.”* A treatment provider noted, *“The stigma is not there anymore; the attitude is, ‘I don’t use drugs, I just smoke marijuana.’”* Treatment providers agreed that marijuana use is common among individuals from all walks of life (age, race and socioeconomic status). According to Summit County Juvenile Court data, a large percentage of juveniles involved in the court system use marijuana. Over the past six months, of the 1,155 juveniles who tested positive for the presence of drugs during court administered urine drug screens, 24.6 percent tested positive for the presence of cannabis (this is a decrease from 41 percent from the previous six-month reporting period).

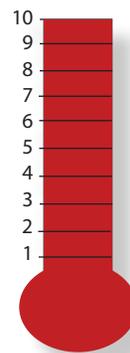
Reportedly, marijuana is used in combination with numerous different drugs, including alcohol, crack cocaine, Ecstasy and powdered cocaine. Most participants agreed that users smoke marijuana with, *“Any drug [because] when you use marijuana with other drugs, it intensifies the [effect of] other drugs.”* Participants reported it is equally common to use marijuana alone as it is to use marijuana with other drugs.

Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was reportedly rare in the region. Most participants knew little about the drug. Participants with knowledge of methamphetamine use most often reported the drug’s availability as ‘2’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants reported the powdered and crystal forms of methamphetamine as equally unavailable. However, treatment providers and law enforcement had differing views regarding the availability of methamphetamine. Summit County professionals most often reported

availability as ‘10’ and Stark County law enforcement reported availability as ‘2’ or ‘3.’ Participants and treatment providers alike indicated that the availability of methamphetamine had recently decreased, due to increased law enforcement efforts and increased difficulty in obtaining the necessary materials to manufacture the drug (pseudoephedrine). Treatment providers and law enforcement reported an increasing popularity in individuals making their own methamphetamine; Summit County law enforcement reported a 200 to 300 percent increase over the past year in the “one-pot method” (methamphetamine production in a single sealed container). Participants gave contradictory information regarding the quality of methamphetamine, quality ratings varied greatly from ‘1’ to ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that a gram of powdered methamphetamine sold for \$100–\$120, and a gram of crystal methamphetamine sold for \$150. A profile for a typical user emerged from the data; participants reported that the typical user of methamphetamine was almost exclusively White, between the ages of 17–35 years, and of lower socioeconomic status.

Current Trends



Methamphetamine is highly available in the region. Participants most often reported the drug’s current availability as between ‘5’ and ‘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 ‘2,’ according to the few participants who reported knowledge of methamphetamine use. Treatment providers and Summit County law enforcement most often reported the current availability of methamphetamine as ‘10.’ Law enforcement reported, *“A lot of the old-generation [methamphetamine] labs have disappeared. Now, it’s the one-pot cook. Most people are making it [methamphetamine] for themselves. There have been no meth [methamphetamine] lab busts in a while. We have not seen Mexican meth in a long time; most is home grown. If you are a meth fiend, you will make it yourself.”* Participants often indicated that methamphetamine is somewhat difficult to find in the region: *“[Methamphetamine] it’s available, but not very; You have to know somebody to find it; I know people who use it, but they go to Cleveland to get it.”* Some participants thought that methamphetamine is lower in availability than other drugs because, *“other drugs are easier to get.”* Other participants disagreed and believed that the drug is highly available: *“[Methamphetamine] it’s easy to make; With the new method of ‘shake dope’ [one-pot method], everyone has learned how to shake [make methamphetamine]. It’s very simple [to make] and very plentiful.”* Participants reported that methamphetamine is available in powdered and in crystal

forms. Reportedly, powdered methamphetamine is far more available, although crystal methamphetamine was said to be more pure (higher in quality). Regional media corroborated the availability of methamphetamine in the region this reporting period. In April, *The Suburbanite* reported on a methamphetamine-related arrest in Springfield Township. Firefighters were called to extinguish a fire that allegedly occurred after a methamphetamine lab exploded on the second floor of a home (www.thesuburbanite.com; April 11, 2011).

There was no consensus among participants as to whether the availability of methamphetamine has increased, decreased or remained the same over the past six months. A few participants felt that powdered methamphetamine (a.k.a., “shake dope” or “shake and bake”) has increased because it is reportedly, “easy to make.” However, other participants reported methamphetamine as less available because, “They [state legislature] passed laws making it [methamphetamine] difficult to make [difficult to buy large quantities of pseudoephedrine].” Treatment providers reported that availability of methamphetamine has decreased over the past six months, but they also believed, “If you want it [methamphetamine], you can get it pretty easily.” A treatment provider reported that he had been told that the shake-and-bake method is fairly easy, whereby methamphetamine can be made in a soda bottle. Law enforcement talked about the process of purchasing methamphetamine; they explained that the buyer needs to provide some of the controlled materials (pseudoephedrine) needed to make methamphetamine in addition to cash before he or she can purchase the drug. Canton-Stark County Crime Lab reported that the number of methamphetamine cases it processes has increased over the past six months (powdered methamphetamine cases).

The overall quality of methamphetamine is high. Participants who had used powdered methamphetamine most often ranked its quality as ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); previously, participants did not agree on quality. Only one participant was able to rank the quality of crystal methamphetamine, which he rated as ‘10’. Some participants believed that the quality of methamphetamine has decreased over the past six months because of the, “lack of availability of materials,” and the fact that it takes, “too much work to make the good stuff.”

Current street jargon includes a few names for methamphetamine. The most commonly cited names were “crank” and “crystal.” Other street names included: “bitch,” “dope,” “glass,” “go fast,” “ice,” “meth,” “shit,” “speed” and “tweak.” Current street prices for methamphetamine were consistent among participants with experience buying the drug, with prices cited as significantly lower than the

previous reporting period. Participants reported that a gram of powdered methamphetamine sells for \$40, and a gram of crystal methamphetamine sells for \$70–\$100. Participants also reported that methamphetamine can be purchased for as little as \$20. Reportedly, the most common route of administration of methamphetamine is intravenous (IV) injection, a practice said to be increasing among users. Other routes of administration included smoking (some participants felt that smoking is more common than IV use) and intranasal inhalation (snorting); participants reported that both smoking and snorting are relatively common.

A profile for a typical methamphetamine user emerged from the data. Participants described typical users of methamphetamine as Whites, between the ages 18–50 years. Participants also mentioned, “The gay community is very huge into meth [methamphetamine].” Treatment providers likewise reported the typical methamphetamine user as White and between the ages of 18–59 years. Participants did not identify other drugs commonly used with methamphetamine.

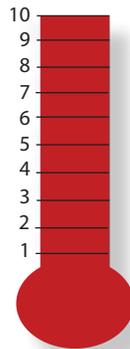
Ecstasy Historical Summary

In the previous reporting period, Ecstasy [methylenedioxyamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] was highly available according to participants and moderately available according to community professionals. Participants most often reported the drug’s availability as ‘10’ and community professionals as ‘6’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Canton-Stark County Crime Lab reported an increase in the number of Ecstasy cases it processed. Prices for Ecstasy pills varied based on dosage, with some selling for as little as \$2 while higher dosage pills sold up to \$25. The quality of Ecstasy varied, with some users reporting that quality had decreased over the previous six months. The only reported method of administration was oral consumption.

Current Trends

Ecstasy [methylenedioxyamphetamine: 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’. A participant reported, “[Ecstasy is] just a trip down the hallway.” Described as a drug, “mostly used by clubbers,” participants reported that Ecstasy can be obtained anywhere. A participant stated, “Go to a disco or a club, everyone has it [Ecstasy].” Treatment providers

generally reported that Ecstasy is rarely used by clients coming in for treatment. Treatment providers commonly held the belief that Ecstasy is, *“more of a college drug,”* with users being most often high school and college students. Summit County law enforcement reported the current availability of Ecstasy as ‘6’ or ‘7,’ and said that availability, *“ebbs and flows.”* Law enforcement also reported that a recent seizure picked up powdered Ecstasy, which is more common on the West Coast and a rarity in this region. Regional media corroborated the availability of Ecstasy in the region this reporting period. In March, The *Aurora Advocate* reported that several people were arrested for selling drugs in Streetsboro and Aurora. Over three months, undercover law enforcement officers bought Ecstasy and prescription medications from three area residents (www.auroraadvocate.com; March 23, 2011). Treatment providers reported that the use/availability of Ecstasy has decreased over the past six months. Canton-Stark County Crime Lab reported that the number of Ecstasy cases it processes has also decreased over the past six months.



Participants did not identify any street names for Ecstasy. Only one participant focus group reported knowledge of the different types and prices of Ecstasy currently available. Ecstasy pills generally sell for \$7–\$10 per pill, depending on the size of the pill. The powdered form of Ecstasy, often referred to as “highly pure,” generally sells for \$100 a gram.

A profile for a typical Ecstasy user emerged from the data. Participants described typical users of Ecstasy as young. A participant focus group reported that Ecstasy use is, *“common in the Black community.”* Treatment providers reported the typical Ecstasy user to be a young, high school or college student. Reportedly, Ecstasy is used in combination with alcohol. A participant explained that this combination, *“increases the buzz, and makes you horny.”*

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] and synthetic marijuana (“K2” and “Spice”). Participants reported the availability of psilocybin mushrooms as ‘6’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants also said that the availability of psilocybin mushrooms fluctuated with the seasons, classifying them as a “summertime” drug.

Stark County law enforcement indicated increasing abuse of psilocybin mushrooms over the previous six months. Canton-Stark County Crime Lab reported an increase in the number of psilocybin mushroom cases it processed over the previous six months. Reportedly, LSD was rarely available and much harder to find than psilocybin mushrooms. Synthetic marijuana was highly available in convenience marts, gas stations and drug paraphernalia shops; the drug was sold as a form of incense and believed to have been increasing in popularity. Participants reported that individuals in alcohol and drug treatment programs were using synthetic marijuana in order to keep getting high while being able to pass random urine drug screens (UDS) as most standard UDS were thought not to screen for synthetic marijuana use.

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. A few participants reported that prescription stimulants are moderately available in the region, although they did not identify specific medications available. Participants most often rated the availability of these drugs between ‘7’ and ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants did not view prescription stimulants as a commonly abused substance other than by, *“the younger crowd.”*

A few participants reported that lysergic acid diethylamide (LSD) is moderately available in the region. Those with knowledge of LSD 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). Typically, participants described LSD as, *“a casual drug; seen once in awhile.”* A participant reported that LSD is, *“not a street drug, but go to a festival [drug]; it is very available.”* Treatment providers reported that LSD is not commonly reported by clients as a primary drug of choice. A focus group of treatment providers described LSD users as, *“a sub-culture, different from the people [clients] we usually see.”* Overall, participants and treatment providers viewed LSD as more popular with younger people, such as college students. Participants reported a hit of LSD sells for \$5–\$10, or 100 hits for \$300–\$400.

Only two participant groups mentioned the availability of psilocybin mushrooms in the region. Participants in one group said psilocybin mushrooms are still popular, but described the quality as being *“real bad.”* Participants in the other group agreed that the quality is generally poor, but also said availability is low; they most often rated psilocybin

mushroom quality as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Treatment providers in Portage County reported psilocybin mushrooms seemed to be very popular. When asked why psilocybin mushrooms are so popular, treatment providers said they are easy to grow in this climate, with one provider commenting that there are, "a lot of cow pastures" in the region.

Synthetic marijuana (K2" and "Spice") remains highly available in the region. Canton-Stark County Crime Lab reported that the number of synthetic marijuana cases it processes has increased over the past six months. Reportedly, the drug continues to be sold in some gas stations and head shops as "incense," a few participants reported that they have tried synthetic marijuana, but none reported regular use. A participant noted, "K2 was more discussed than actually used." Participants reported synthetic marijuana as "cost prohibitive." Reportedly, a small pouch of about three grams sells for \$30; marijuana is cheaper. Participants reported that synthetic marijuana is more popular with adolescents, "people on probation" and other individuals who are subject to urine drug screens. The effect produced by synthetic marijuana use was described as, "head high, not a body high." A number of users reported that they, "did not like the taste [of synthetic marijuana]," and a few participants reported that use gave them a headache.

Canton-Stark County Crime Lab also reported several other drugs that were not mentioned by focus group participants. The crime lab reported an increase in the number of bath salts and ketamine cases it processes over the past six months. The crime lab also reported that it had received its first samples of bath salts this reporting period, which included samples of MDPV (3, 4-Methylenedioxypyrovalerone) found in an Ecstasy-type tablet and samples of mephedrone packaged in a baggy.

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids and sedative-hypnotics remain highly available in the Akron-Canton Region. Noted increases in availability over the past six months exist for heroin and methamphetamine; a slight decrease exists for Ecstasy. Participants, treatment providers and law enforcement agreed that the availability of powdered heroin has dramatically increased over the past six months. Most thought that heroin use has increased due to the reformulation of OxyContin®, which made users move to similar drugs. Participants reported that the most common way to use heroin remains intravenous injection. Unlike the previous reporting period, the majority of participants reported knowledge of methamphetamine use, with most participants and community professionals

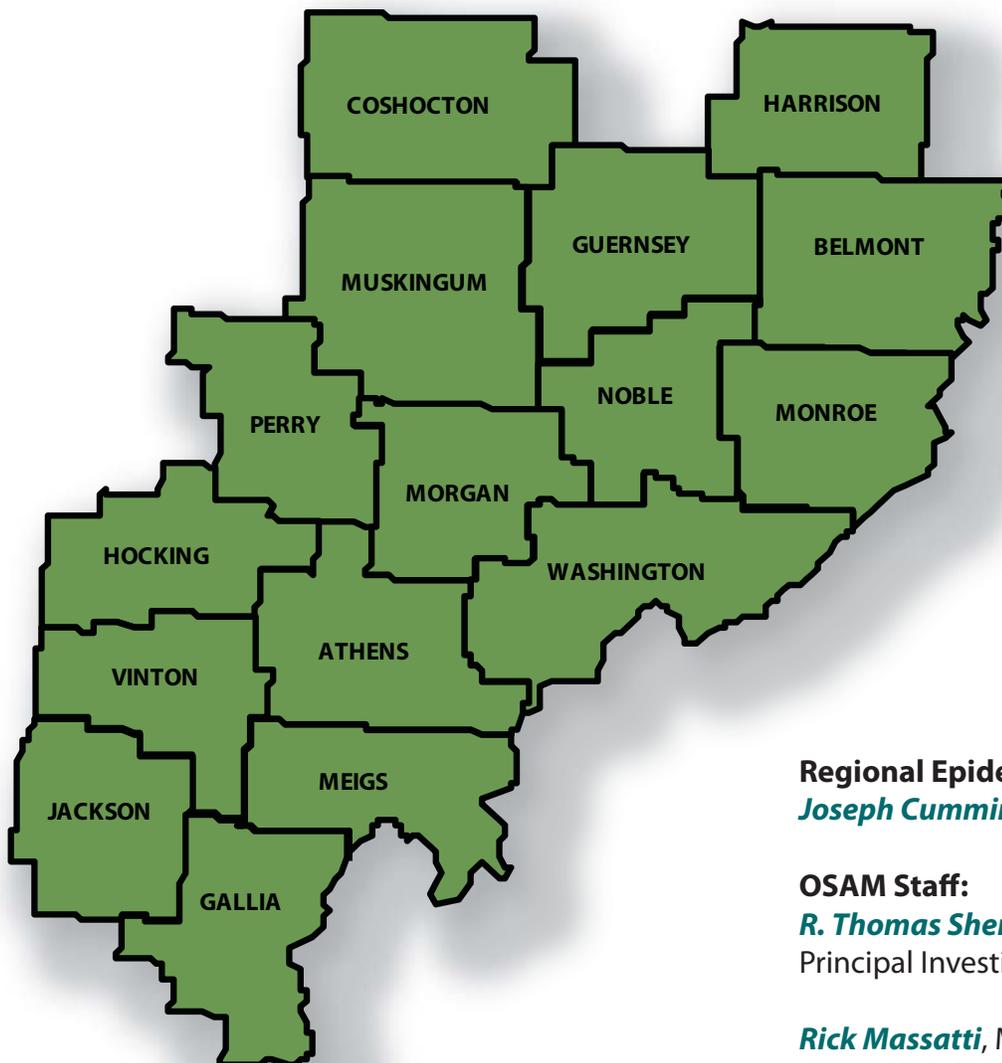
rating current availability of methamphetamine as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Reportedly, powdered methamphetamine is far more available than crystal methamphetamine, although the crystal form was said to be more pure (higher in quality). While treatment providers believed that street availability of the drug has decreased, they stated, "If you want it [methamphetamine], you can get it pretty easily." Treatment providers and law enforcement reported greater access to methamphetamine now that the "shake-and-bake" method is widely known, whereby methamphetamine can be made in a soda bottle. Canton-Stark County Crime Lab reported that the number of powdered methamphetamine cases it processes has increased over the past six months. While participants continued to report high availability of Ecstasy, community professionals noted a decrease. Treatment providers generally reported that Ecstasy is rarely used by clients coming in for treatment; they commonly held the belief that Ecstasy is, "more of a college drug," with users being most often high school and college students. Canton-Stark County Crime Lab also reported that the number of Ecstasy cases it processes has decreased over the past six months. Crack and powdered cocaine remain highly available in the region. Due to the current low quality of crack cocaine, powdered cocaine is most often purchased to "rock up" (manufacture) crack cocaine. Prescription opioids remain widely available in the region. 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 also most popular. Participants agreed that OxyContin®, due to the changes in formulation that make it difficult to crush for intravenous use, is not as readily sought by users. A few participants commented that Opana® is becoming popular as a replacement for OxyContin® as it is easier to use intravenously. A participant stated that Opana® is, "the most sought opiate medication now." Along with intravenous injection, intranasal inhalation and oral ingestion, participants this reporting period also named "parachuting" (crushing pills, placing powdered content in a piece of tissue and swallowing), as well as smoking (crushing pills, placing powdered content on aluminum, heating underneath and inhaling fumes), as routes of administration for prescription opioids. The Stark County Coroner's office reported that prescription opioids are the most common drug present in all drug-related deaths; they were present in 45 percent of all drug-related deaths over the past six months. Lastly, in terms of marijuana, what seems to be trending now is increased availability and use of high-grade marijuana. A greater number of young people are talking about using more potent marijuana, with a greater number of people generally seeking and using high-grade marijuana than previously reported.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Athens Region

January-June 2011

John R. Kasich, Governor
Orman Hall, Director



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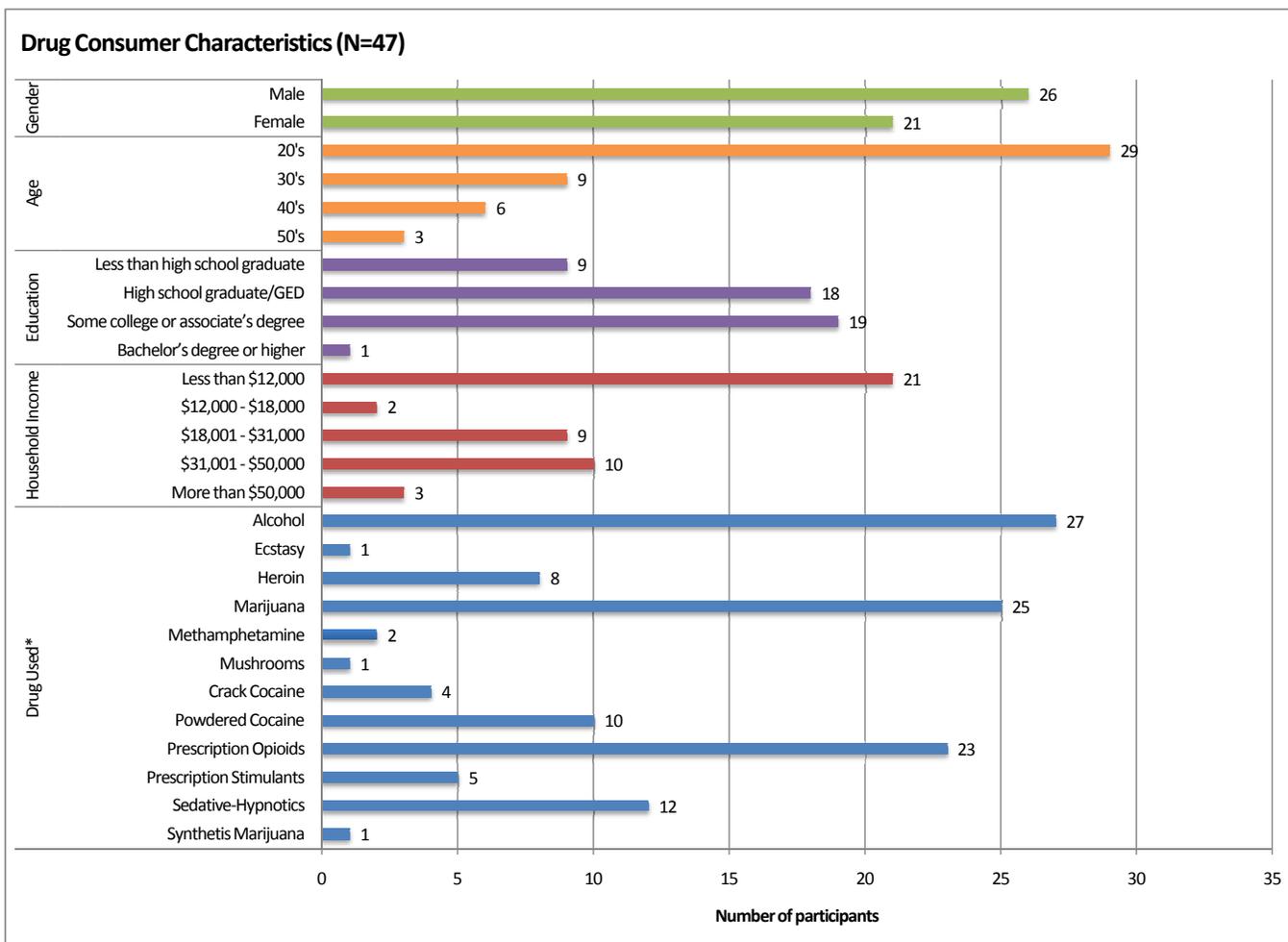
Regional Profile

Indicator ¹	Ohio	Athens Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,542,645	575,241	47
Gender (Female), 2009	51.2%	50.8%	44.7%
Whites, 2009	82.2%	94.7%	85.1%
African Americans, 2009	11.9%	2.4%	12.8%
Hispanic or Latino Origin, 2009	2.8%	0.8%	0.0%
High school graduates, 2009	83.0%	91.0%	80.9%
Median household income, 2009	\$45,467	\$36,652	Less than \$12,000 ²
Persons below poverty, 2009	15.1%	18.5%	55.6% ³

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

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

Poverty status was unable to be determined for two respondents due to missing or insufficient income data³.



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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Athens, Belmont, Guernsey and Muskingum Counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (i.e., treatment providers) via focus group interviews, as well as to data surveyed from the Bureau of Criminal Identification and Investigation (BCI) London Office, which serves Central and Southern Ohio. BCI data are summary data of cases processed from July to December 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (i.e., from time of interview through prior six months); thus, current BCI data corresponds to the current reporting period of participants. In addition to the aforementioned data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2011.

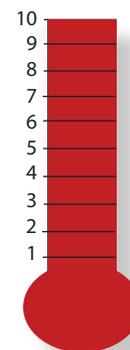
Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine ranged from difficult to find to moderately available in the region. Participants in Meigs County most often reported the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get) while participants in Athens and Belmont Counties most often reported availability as '3' and '4' respectively. Meanwhile, treatment providers across the region reported that powdered cocaine was moderately to highly available, most often reporting availability as '8'. The most common participant quality score for powdered cocaine was '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Several participants thought that cocaine was "cut" (i.e., adulterated) more often in the region as the result of economic factors. Participants reported that powdered cocaine was most often cut with baby aspirin, baby laxative, baby powder, baking soda, creatine, "headache powder," Percocet®, Vicodin®, vitamin B-12 and "speed you buy at the gas station." According to BCI London crime lab, levamisole (livestock dewormer) was the cutting agent in 90 percent of powdered cocaine cases it processes. BCI London crime lab also reported that the number of powdered cocaine cases it processed had remained stable over the previous six months. Participants reported that a gram of powdered cocaine ranged in price from \$45–\$100, with the most commonly reported price being \$100. Reportedly, the most common route of administration for this form of cocaine was

intranasal inhalation (snorting). Some users reported that they used powdered cocaine to make crack cocaine while others reported that they free-based (heated the powder and inhaled the fumes). Treatment providers agreed that users tended to be individuals in their mid to late 20's or older. Some participants cited that powdered cocaine continued to be used by individuals with money/incomes. Participants who reported using alcohol with powdered cocaine stated they did so to, "stay out all night and drink."

Current Trends

Powdered cocaine is highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported, "It's [powdered cocaine] everywhere; Not quite as easy [to obtain] as crack [cocaine]; Dealers are pushing it [powdered cocaine] hard, selling it cheap to get rid of it." Some participants reported that powdered cocaine is more easily found in cities, (Youngstown, Zanesville, Weirton, WV or Columbus, depending on the location of the focus group), but as a participant stated, "If the price is right, you can get someone to get it [powdered cocaine] for you." Only participants in Athens County reported perceptions of low availability of powdered cocaine. An Athens participant stated, "I haven't heard of it [powdered cocaine] being around here in a long time." Treatment providers most often reported powdered cocaine's current availability as '6'. A Perry County official reported the drug's current availability as '6'. Treatment providers in Muskingum County reported, "[Powdered cocaine is] not as popular as opiates and marijuana ... still out there, but it does not seem to be too much of a problem; available, but not one of the huge drugs." Treatment providers in Athens and Belmont Counties did not identify cocaine use as common. In Guernsey County, it was stated that powdered cocaine is not frequently used, people cannot afford it. Most participants reported that the availability of powdered cocaine has remained stable over the past six months. Participants of an Athens County focus group stated, "Heroin and opiates are the new players, and cocaine is stomped [adulterated] so much, people don't want to do it." Treatment providers differed as to whether availability of powdered cocaine has changed over the past six months, some reporting it has decreased, and others reporting that it has remained the same. Comments included, "[Powdered cocaine] it's there, but not the drug they [users] really want now; People can't afford it [powdered cocaine]." BCI London crime lab reported that the number of powdered cocaine cases it processes has increased over the past 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 previous most common score was '3'. Participants reported that powdered cocaine in the region is cut (i.e., adulterated) with baby laxative, baking soda, creatine, ether, inositol (B vitamin), Orajel®, Vicodin®, vitamin B-12 and "anything that will give a little energy." Participants reported, "[Quality of powdered cocaine] depends on where you go, how much you want to pay, and how hard you want to look; It [quality of powdered cocaine] depends on where I get it. If I get it here, [quality rating is] a '4' or '5'. If I get it in the city, [quality rating is] '8.'" Participants reported that the quality of powdered cocaine has remained the same over the past six months, though the general consensus was that over the years, powdered cocaine quality keeps, "getting worse and worse; it's nothing like it was five years ago." BCI London crime lab continues to cite levamisole (livestock dewormer) as the cutting agent in most powdered cocaine cases, with the following other agents also used: boric acid (found in antiseptics and insecticides), caffeine, inositol (B vitamin), local anesthetics (benzocaine, lidocaine and procaine) and sucrose (table sugar).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "powder," "soft" and "white girl." Participants listed the following as other common street names: "baby girl," "ball," "blow," "cane," "coke," "8-ball," "fire," "fish scales," "girl," "pearl," "Peruvian flake," "salt," "snow," "white" and "ya-yo." Current street prices for powdered cocaine were variable among participants with experience buying powdered cocaine, with prices remaining about the same from the previous reporting period. Participants reported that a gram of powdered cocaine sells for \$50–\$100, depending on the quality; 1/16 ounce, or "teener," sells for \$100 – \$140; 1/8 ounce, or "eight ball," sells for \$150–\$250; an ounce sells for \$1,200. Participants consistently reported that powdered cocaine is cheaper if purchased "in the city," and cheaper if bought in larger quantities (an "eight ball" versus a gram). Even so, participants reported that powdered cocaine is most commonly purchased by the gram or half gram: "People nickel and dime themselves to death. Instead of buying [powdered cocaine in] quantity, they will buy smaller amounts, and keep going back." Participants reported that the most common way to use powdered cocaine remains intranasal inhalation (snorting). Out of 100 powdered cocaine consumers, participants reported that approximately 80 would snort it, 10 would intravenously inject it or "shoot it" and another 10 would smoke it. Some participants commented that using powdered cocaine by intravenous (IV) use or smoking (lacing a cigarette or marijuana blunt with powdered cocaine, a.k.a., "snow caps") are growing trends, one group positing that

IV use is as common as snorting. A participant commented, "It depends on how hard core you are [whether or not to inject powdered cocaine]," reporting that while younger, newer users still prefer to snort powdered cocaine; "heavy users" tend to shoot or smoke the drug. Another participant commented, "A lot of people who snort it [powdered cocaine] in front of people, shoot [inject] it at home."

A profile for a typical powdered cocaine user did not emerge from the data. Many participants continued to describe typical users of powdered cocaine as individuals with income: "You have to have money to get [powdered] cocaine; Most people who use powder [cocaine] have money versus people who use crack [cocaine]." Treatment providers also noted this characteristic, one commenting that powdered cocaine is, "a rich man's drug, and this isn't a rich area." Otherwise, the use of powdered cocaine was characterized as, "indiscriminate; across the board."

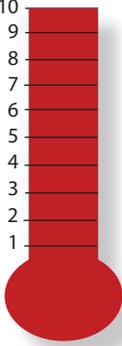
Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics (Seroquel® and Xanax®). Many participants commented that it is common to use powdered cocaine with other drugs (more so than to use powdered cocaine by itself) usually to help the user come down from the stimulant high produced by powdered cocaine when, "you are geeking [strung out]." Additionally, participants reported that when one combines powdered cocaine use with alcohol consumption, "you are able to drink longer. [Powdered cocaine] keep you awake to socialize longer; You can drink a case [of beer] and not be drunk." Participants reported that powdered cocaine use is common in bars: "If you go out drinking, there is always someone with [powdered] cocaine."

Crack Cocaine Historical Summary

In the previous reporting period, crack cocaine was highly available in most of the region. Participants most often reported the drug's availability as '10' with the exception of Athens County where it was reported as '4' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants that did not have easy access to crack cocaine usually drove to Columbus to obtain it. Treatment providers also rated the availability of crack cocaine highly; they scored it '9' across the region. The most common participant quality score for crack cocaine was '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut (adulterated) with other substances. According to 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 \$100. The majority of crack cocaine users reported buying the drug in small quantities, ranging from \$10–\$30. By far, the most common route of administration for this form of cocaine was smoking, but intravenous injection was also reportedly popular. Participants and treatment professionals could not come to a consensus regarding a profile for the typical user of crack cocaine.

Current Trends



Crack cocaine remains highly available in the region. Overall, 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); previously the regional most common score was also '10'. Generally, participants made comments reflecting high availability: "[Crack cocaine] It's everywhere; rolling like dice in the street, very common." Participants reported that even when not readily available, one can "always go to the city." However, participants from Athens County reported that they perceived crack cocaine as not readily available there: "You have to go to Columbus [to buy crack cocaine]." Treatment providers most often reported the drug's current availability as '10'; though treatment providers from Belmont and Athens Counties could not provide an availability rating as they reported that crack cocaine use is not commonly reported by their clientele. Regional media outlets reported on crack cocaine busts by law enforcement over this current reporting period. The *Chillicothe Gazette*, a regional newspaper, reported that three Columbus men were arrested in Jackson County during a routine traffic stop. According to the Ohio Highway Patrol, the men had 90 grams of crack cocaine along with several other drugs (www.chillicothegazette.com, April 13, 2011).

Participants disagreed as to whether the availability of crack cocaine has increased, decreased or remained stable over the past six months. Participants in Guernsey County reported that the availability and use of crack cocaine is increasing: "I know a lot of people I'd never think would use [crack cocaine]. Now they are 'f'd' up, selling their kids' things for it." Participants in Athens County reported that the availability of crack cocaine is down: "If [powdered] cocaine is down, then crack [cocaine] is down; I haven't seen much [crack cocaine]. I used to; People are turning [from crack and powdered cocaine] to pills [prescription opioids] and heroin. Heroin is cheaper than cocaine." Participants from Belmont County reported the availability of crack cocaine has remained stable over the

past six months. Treatment providers by and large reported that the availability of crack cocaine has remained stable over the past six months. BCI London crime lab reported that the number of crack cocaine cases it processes has remained stable over the past six months.

Most participants rated the quality of crack cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '9'. Participants reported that crack cocaine in the region is cut (adulterated) with baking soda, baby laxative, candle wax, soap and sugar. Members of a focus group agreed with one participant who commented, "[Crack cocaine] It's been cut 50 times by the time it gets here." By and large, it was reported that the quality of crack cocaine depends on where one gets it. A participant reported, "My dude [dealer] offers both ways [two quality options]. I can get less of a higher quality or more of a lesser quality. When you are a crack head, you believe more is better, does not matter the quality." A participant group described a cycle by which a dealer cuts the drug to the point that people will stop buying from him, at which time he will sell, "more pure stuff to get you hooked back in," and the cycle repeats itself. Participants reported that crack cocaine quality can, "cycle that day ... depending on how many times you go back that day. If he [the dealer] knows you can't get any higher, he'll cut it as much as he wants." Overall, participants reported that the quality of crack cocaine has stayed the same over the past six months. BCI London crime lab continues 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: "boy," "butter," "candle wax," "drop," "fire" and "rock star." Current street prices for crack cocaine were variable among participants with experience buying crack cocaine, with prices remaining about the same from the previous reporting period. Participants reported that a gram of crack cocaine sells for \$80–\$100, depending on the quality; 1/8 ounce, or "eight ball," sells for \$175–\$350. Participants reported that the price of crack cocaine depended on, "where you got it. In small towns, you pay double what you do in the city." The most common way to purchase crack cocaine continues to be by "rocks," ranging from \$10–\$50, depending on rock size, with \$20 being the most commonly cited figure. A participant noted, "[Crack cocaine] users don't have the money, so they buy a rock, use it, find money to get another, and on and on."

While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. Out of 100 crack cocaine users, participants reported that approximately 90 would

smoke it and 10 would intravenously inject or “shoot it.” A number of participant groups reported, that while still rare, intravenous use of crack cocaine is, “a growing practice.” Participants reported that crack cocaine is easily broken down with vinegar: “People used to using needles [like diabetics and junkies], would rather shoot it [inject crack cocaine].” A participant said he preferred intravenous injection: “Shooting is not as noticeable. You get blisters from smoking it [crack cocaine]. It’s also more potent [to inject crack cocaine].”

A profile of a typical user of crack cocaine did not emerge from the data. Participants disagreed regarding the socioeconomic characteristics of a typical crack cocaine user: “Poorer people use [crack] cocaine more frequently; Crack is not as socially acceptable as powder [cocaine] among some people.” However, most participants commented that there is no typical crack cocaine user. A participant said, “Anybody, from people who have Cadillacs to those who have no car [use crack cocaine].” Treatment providers also could not agree on the typical user of crack cocaine, but agreed, “A lot of people start powder cocaine, but as tolerance increases, they switch to crack cocaine. It’s cheaper.” Other treatment providers talked about the road to poverty once users consume crack cocaine: “By the time they [crack cocaine users] get here [treatment], they are pretty destitute.”

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics. Participants generally agreed that crack cocaine is most often used by itself. A participant reported, “Most people who smoke crack [cocaine] have no money to buy marijuana. Some people go days without eating on that.” Many participants commented on the need for users to purchase drugs to help them “come down” from the high of crack cocaine: “Usually, you use crack [cocaine] by itself. But when you run out or cannot get more, you need something to come down, to get to bed, so you are not ‘geeky’ [strung out].”

Heroin

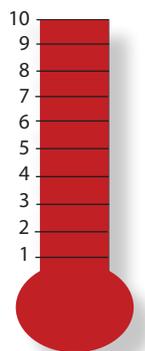
Historical Summary

In the previous reporting period, heroin 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). By far, the most common type of heroin available in the region was black tar. Participants and treatment providers alike reported that availability and use of heroin had increased over the past year. Treatment providers reported that clinical assessments were most often identifying heroin as a user’s primary drug of choice. All respondents commonly believed that the following factors had contributed to the steady

increase in heroin use in the region: law enforcement “crack down” on street availability of prescription opioids, change in formulation of OxyContin®, which made intravenous use difficult, and the relative cheap cost of heroin compared to prescription opioids. The most common participant quality score for heroin was ‘5’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Heroin available in the region was “very pure” according to the BCI London crime lab, but benzocaine (local anesthetic) and metamizole (analgesic and antipyretic) were cited as cutting agents. Participants reported that a gram of heroin most often sold for \$100; however, typically users purchased individual “balloons” of black tar heroin (1/10 gram, or “one shot”) for \$15–\$50, depending on location of purchase, with prices in Columbus cited as \$10–\$20 per balloon. The most common route of administration for heroin was intravenous injection. A participant stated that injection, “becomes inevitable” with heroin. Participants described the typical user of heroin as a person who was addicted to prescription opioids. Treatment providers agreed with participants that the population of heroin users was getting younger.

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 ‘9’. Generally, participants made comments reflecting high heroin availability: “[Heroin] it’s everywhere; It’s the main drug right now; [Purchasing heroin is] like getting a double cheeseburger at McDonald’s. It’s easier than anything.” However, it was also often stated that heroin is more readily available in cities (Columbus and Zanesville) than in other areas in the region. The following participant comments were common: “You must go to the city [to purchase heroin]. [There are] no dealers where I live; People run into the city [Columbus] to use it [heroin].” It is notable that participants in the Guernsey County focus group reported that heroin is rarely available to them. Most from this focus group agreed with one participant who commented, “I know people who talk about it [using heroin], but only recently have I started to hear about it [heroin use in Guernsey County].” Another participant from this same group commented, “A lot of people [in Guernsey County] don’t do it [heroin]. You must go to Columbus or Zanesville [for heroin].” Treatment providers most often reported the drug’s current availability as ‘10’. Treatment providers reported, “[Users] find it [heroin] very easily, it’s eating us alive; It used to be that in any house you could get



marijuana. Now, in any house, you can get heroin." Treatment providers also noted that heroin is more accessible in the bigger cities, but report dealers are willing to go and get it. A Perry County official described heroin's availability as '10,' reporting, *"Adults and kids say it [heroin] is cheaper to get, even cheaper than marijuana."* Regional media outlets reported on heroin busts by law enforcement over this current reporting period. In April, the *Zanesville Times Recorder* reported that a Perry County grand jury indicted nine people on drug charges; three of the nine indicted were New Straitsville residents involved in selling heroin obtained in Columbus. One individual allegedly sold heroin from her home in front of small children (www.zanesvilletimesrecorder.com; April 1, 2011).

Participants reported that the availability of heroin has increased over the past six months. Comments indicating an increase in availability included: *"When they [Purdue Pharma] turned [reformulated] 80's [80 mg OxyContin® OC] into wax, it up'd the heroin; Everyone who sells pills [prescription opioids] sells heroin. It's cheaper, [and] you don't have to go doctor shopping."* Treatment providers also reported that availability of heroin has increased over the past six months. In addition, treatment providers noted an increase in requests for detox services from intravenous heroin users. Treatment providers reported the reasons for the increase in heroin availability and use to include: *"It [heroin] is cheaper [than prescription opioids]; It's harder to get pills [prescription opioids]."* BCI London crime lab reported that the number of heroin cases it processes has remained stable over the past six months.

While there are different forms of heroin available in the region, participants continued to report the availability of black tar heroin as most available. Black tar heroin was described as being, *"like resin, like a Tootsie Roll®, like dried up barbecue sauce; like pavement tar, smells like vinegar."* Powdered heroin is also available, but generally described as, *"difficult to find."* Powdered heroin was described as, *"white to off-white, powdery, not chunky, with a brown tint; like cocoa."* Most participants generally rated the quality of heroin as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5.' Participants reported that heroin in the region is cut (i.e., adulterated) with baby laxative, cocoa powder, fentanyl, green tea, inositol (B vitamin); and specific to black tar heroin, barbecue sauce, instant coffee, instant tea, Tootsie Roll®, and *"anything that's brown."* It was commonly noted that the quality of heroin depends on where one gets it. Participants noted that in cities, heroin is more pure than in rural areas: *"It [heroin] has been cut [adulterated] as it goes down [moves from cities to rural areas]; It [heroin quality] depends on how far down the line you go ... Go to the city,*

just from Mexico, it's very high. By the time it gets here, '4' to '8' [in terms of quality rating], depends on how it is cut." Most participants reported that the quality of heroin has stayed the same over the past six months. BCI London crime lab continues to report that heroin is "very pure" in the region. Gas chromatography-mass spectrometry analysis typically shows that heroin is 80 percent pure; however, occasionally caffeine is used as a cutting agent.

Current street jargon includes many names for heroin. The most commonly cited names were "boy," "dog food," "H" and "tar." Participants reported that heroin is available in different quantities: "folds" or "papers" (powdered heroin) and "balloons" or "balls" (black tar heroin; each are 1/10 gram and sell for \$20–\$50, with the most commonly cited price being \$40; participants also reported buying heroin in "bundles" (10–12 small packs of heroin, approximately a gram); a gram sells for \$80–\$120, the most commonly cited price remains \$100; 1/8 ounce sells for \$400; an ounce of heroin reportedly sells for \$3,500. Participants continued to report that the most common way to purchase heroin is by individual packets (bag, ball, balloon or stamp). Participants also reported that heroin is cheaper if purchased in Columbus. The most common way to use heroin remains intravenous injection. Out of 100 heroin users, participants reported that approximately 80 to 95 would inject, the remainder would inhale (snort) it. Reportedly, a few users would smoke black tar heroin. Participants reported, *"People who snort [heroin] get off it. People who inject it are still doing it; People who snort it are not regular users."* Participants reported that there is less stigma with injecting heroin than there once was; hence more people from different backgrounds are "shooting" heroin.

A profile of a typical user of heroin did not emerge from the data. The only descriptor of typical use identified by participants remains, *"people addicted to other opiates."* Participants and treatment providers also continued to report that heroin use is very common among young people, including high school aged youth. A participant noted, *"At my old high school, [heroin use] it's ridiculous. It's hard to find marijuana in my old high school. Heroin is what's available."* Treatment providers commented that they are seeing an increasing number of college aged men and women who use heroin. A Perry County official reported that the majority of heroin users seeking emergency assistance are male with lower income.

Reportedly, heroin is used in combination with marijuana, powdered cocaine and sedative-hypnotics (Xanax®). Nearly all participants reported that heroin is more commonly used by itself. Those who reported using stimulants with

heroin referred to the practice as “speed ball,” experiencing both an up and down effect: “*speed and feel good*” at the same time. As one participant put it, “*I get so high off heroin; I need something to wake me up.*” Using heroin with Xanax® reportedly produces, “*a more laid back sensation.*”

Prescription Opioids Historical Summary

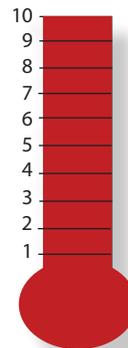
In the previous reporting period, prescription opioids were highly available in the region. Participants and community professionals most often reported street availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants reported the following medications as highly available throughout the region: Dilaudid®, Opana®, OxyContin®, Percocet® and Vicodin®. The consensus among treatment professionals was that prescription opioids were “*over prescribed,*” and their availability and use had increased over the previous six months, which correlated with the noted regional increase in heroin use. Law enforcement reported that prescription opioids are commonly found during drug arrests. BCI London crime lab reported an increase in the number of prescription opioid cases it processed. In fact, prescription opioids were noted as the most commonly reviewed drug at BCI London. While there were a few reported ways of consuming prescription opioids, generally, the most common route of administration was intranasal inhalation (snorting). Participants also reported that pills were crushed and injected. In addition to obtaining prescription opioids from dealers, participants overwhelmingly commented on the relative ease of obtaining prescriptions from physicians, urgent care centers and emergency rooms. Participants reported knowing about “*fly-by-night*” pain clinics in the area that dispense medication. Treatment providers said all age groups are using these medications, “*from geriatric to pediatric,*” they reported the use of prescription opioids as particularly increasing among young people.

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 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.*” A

participant stated, “*Any pain killer [prescription opioid] can and will be used around here. [Prescription opioid abuse] It’s the new epidemic.*” Treatment providers described availability as, “*highly available; through the roof; quite prevalent; so easy to get.*” A treatment provider stated, “*Over half of my case load is opiate addicted.*” Another treatment provider, who also serves on a county planning board, shared that a fellow board member, who is the CEO of the area hospital, reported that six out of the hospital’s nine ICU (intensive care unit) beds were presently occupied by people who overdosed on opioids. Participants and community professionals identified OxyContin®, Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread, with participants additionally naming morphine as also most popular. Regional media outlets reported on drug arrests involving prescription opioids over this current reporting period. In April, the *Zanesville Times Recorder* reported that a Perry County grand jury indicted nine people on drug charges; four of the nine were indicted for illegal possession of, or trafficking in, prescription opioids. A Junction City couple allegedly sold prescription opioids from their home (www.zanesvilletimesrecorder.com; April 1, 2011). Also in April, *NBC 4 News Columbus* reported that federal prosecutors in West Virginia charged two Ohio men involved in a large-scale, interstate prescription drug ring. The men were charged with possession and intent to distribute in Ohio and West Virginia oxycodone and other prescription drugs that they had acquired from pain clinics in Florida (www.nbc4i.com; April 7, 2011).

Participants reported that the availability of prescription opioids has both increased and decreased over the past six months, depending on specific drug. The availability and use of OxyContin® and Percocet® were said to be decreasing. A participant reported, “*No one likes the new oxy’s [reformulated OxyContin®].*” On the other hand, the availability of Opana® was said to be increasing. A participant reported, “*I’ve seen a lot of people get Opana®. It’s the best thing.*” Reportedly, oxycodone 30 mg (a.k.a., “*perc 30*”) is also increasing in availability. A participant reported, “*A lot of people are bringing ‘perc 30’s’ [oxycodone 30 mg] from Florida.*” Another participant referred to ‘perc 30’ as, “*the new oxy’s [OxyContin®].*” However, many participants commented on what they perceived to be a decrease in availability of prescription opioids as a whole. A participant stated, “*They [prescription opioids] are harder to get because everyone wants them. Supply is having a hard time keeping up with demand. It’s there, but they go fast, and the price keeps going up.*” Another participant commented, “*A lot of people who were getting*



[prescription opioids] are getting cut off. Even if you have a legitimate reason in the emergency room, if you look like an addict, you will not get opiates—you'll get Tylenol®. Treatment providers almost unanimously reported that availability of prescription opioids has increased over the past six months. Treatment providers stated, *"People are prescribed meds so easily, and if you have an addictive personality, it's easy to know how to get them. A lot of folks are doctor shopping; unemployment is up, people are depressed. People are making a living selling drugs [prescription opioids]. It beats [pays better than] McDonald's; People need money. If you can sell your prescription drugs, you make a lot of it [money]. People are willing to deal with pain to make money."* A Perry County official reported that prescription opioids are available from individuals who are being prescribed the medications: *"They are selling them [prescription opioids], not using them for their own personal use."* This official also commented, *"A lot [of prescription opioids] are being stolen. They [users] know people who have cancer, and break into their houses and steal them."* BCI London crime lab reported that the number of prescription opioid cases it processes has remained stable over the past six months; however, noted increases in the number of lab processed cases existed for Dilaudid®, Opana® and Percocet®.

Reportedly, many different types of prescription opioids (a.k.a., "beans," "candy" and "nose candy") are currently sold on the region's streets. Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid® 8 mg (\$30–\$40), morphine (sells for \$0.50 per milligram), Opana® (a.k.a., "pana;" sells for \$1.50–\$2 per milligram), oxycodone 30 mg (a.k.a., "30's," "perc 30's" and "roxies;" sells for \$25–\$30), OxyContin® OC (old formulation, a.k.a., "OC's," "oxy's;" sells for \$1–\$3 per milligram), OxyContin® OP (new formulation, a.k.a., "OP's;" sells for \$0.50–\$1 per milligram), Percocet® (a.k.a., "jerks's," "P's" and "perc's;" sells for \$1 per milligram); Vicodin® 5 mg (a.k.a., "V's" and "vikes;" sells for \$2–\$5). Participants commonly asserted that those drugs that can be used intravenously are more valuable. A participant commented, *"Any drug you can shoot up [inject], the price goes up."* As a result, the new formulation of OxyContin® (OxyContin® OP) was commonly described as *"worthless"* to many users. However, some participants continued to describe means by which OxyContin® OP is 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 remain intranasal inhalation (snorting) and intravenous injection. Most participant groups

identified snorting as the more popular means of using these medications as a whole. Out of 100 users, participants reported that approximately 60 to 80 would snort prescription opioids. However, it was noted that prescription opioids that can be used intravenously (Dilaudid®, morphine, Opana® and OxyContin®) are more likely to be injected. A participant reported, *"For most people, once they start using the needle, they will use it for anything."*

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), other doctors, and family members and friends who have been prescribed these medications. A participant reported, *"All you have to do is fake kidney stones [and a doctor will prescribe a prescription opioid]."* A few participant focus groups continued to report that trips to Florida to acquire larger quantities of these medications are still commonly occurring. A participant reported, *"I know a kid who drives to Florida every month. You have to be 26 [years old], have a Florida I.D. He goes to a cash doctor, gets an MRI for \$30, is prescribed 'perc 30's,' 'perc 10's,' and Lortab®."* Another participant stated, *"I know a whole family that does that [travels to Florida for prescription opioids]."* Also, as in the last reporting period, participants continued to report that dealers pay people to go to Florida: *"They [dealers] will pay for the doctor's bill and for the [opioid] prescriptions. You give 75 percent of the pills to the dealer, you keep the rest. They [dealers] make thousands of dollars."*

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 are represented among prescription opioid users, or as one participant noted, *"Anyone and their mother [could abuse prescription opioids]."* Treatment providers generally agreed, though many continued to note an increase in young people (17 – 34 years) who report use of these medications. It was also noted by treatment providers that a large percentage of users are either of lower socioeconomic status or people who descended into poverty due to the poor economy and unemployment. A Perry County official reported that the majority of rescue squad calls for assistance for people overdosing on prescription opioids are in regards to young people (18–26 years) of low economic circumstances.

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, crack cocaine, marijuana, powdered cocaine and sedative-hypnotics (Xanax®). Participants were evenly split,

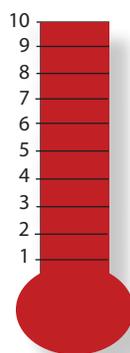
on whether it is more common to use prescription opioids in combination with other drugs or to use them by themselves. Participants reported that alcohol intensifies the effects of prescription opioids and gives a, “better buzz;” the same was said when using prescription opioids with marijuana. Those who used prescription opioids in combination with crack and powdered cocaine reported liking the “speed ball” effect (feeling up and down), and reported that this combination, “gives you energy.”

Suboxone® Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported street availability of Suboxone® as ‘9’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). BCI London crime lab reported an increase in the number of Suboxone® cases it processed over the previous six months. Participants reported that Suboxone® 8 mg sold for \$8–\$15, with price often varying depending on how badly the buyer needed the drug. Participants also reported that Suboxone® strips were available on the street for \$10–\$15, but “no one wants” them because they are more difficult to abuse. Participants reported that individuals use Suboxone® for several reasons, stating that users occasionally needed a few pills as a temporary substitute for heroin or other prescription opioids, and people without much experience with opioids were trying Suboxone® for a high. While some participants reported acquiring Suboxone® via prescription, others reported that users frequently purchased Suboxone® on the street from other drug users or from drug dealers. Some participants reported greater ease in purchasing Suboxone® off the street rather than obtaining a legitimate prescription. The manner by which individuals use Suboxone® depended on the reason they were using. Those using to avoid withdrawal most often took Suboxone® orally, letting it dissolve under the tongue. However, those seeking to get high off the drug tended to abuse Suboxone® through intranasal inhalation (snorting). Reportedly, no other substances were generally used in combination with Suboxone®.

Current Trends

Suboxone® remains highly available in the region. Participants reported the street availability of Suboxone® as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most



common score was ‘9’. Participants described the ease of obtaining Suboxone® as, “super easy; Like candy machines, a dime a dozen.” Treatment providers most often reported the drug’s current availability as ‘6’. Providers reported that Suboxone® is available and that clients are abusing it. Current availability was described as, “sporadic; Sometimes, clients state it [Suboxone®] is easy to find, and other times, it is difficult to find. Not sure why.” Some treatment providers pointed out that there are no physicians in their county currently prescribing Suboxone®. Participants reported that the availability of Suboxone® has increased over the past six months. A group of participants in Belmont County reported an increase in the number of Suboxone® clinics in their area. Other participants reported that even if Suboxone® clinics are not present in their immediate area, they know where they can go for Suboxone® (clinics in Columbus or West Virginia). Treatment providers reported that the availability of Suboxone® has decreased over the past six months. A treatment provider commented, “Some doctors have stopped prescribing [Suboxone®], as they found out their clients were selling it on the street.” BCI London crime lab reported a decrease in the number of Suboxone® cases it processes over the past six months.

No slang terms or common street names were reported for Suboxone®. Participants reported that Suboxone® 8 mg sells for \$10–\$20; Suboxone® strips sell for \$10–\$12. Pills are still preferred because they can be snorted or used intravenously. As one participant noted, “People on [Suboxone®] strips either need them or are trading them for oxy’s [OxyContin®].” Participants reported that the most common route of administration for abuse of Suboxone® remains intranasal inhalation (snorting). In addition, participants reported they have heard of people using intravenously, but only one reported injection use: “I’ve shot it [injected Suboxone®] before, made me so sick. I thought I was going to die.” Participants continued to report sublingual 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®. A participant commented, “Look up [withdrawal] symptoms on the Internet, and you go in and convince a doctor [to prescribe Suboxone®].” Another participant commented, “For \$18 you go to a clinic, tell them you are an addict, they will give you Suboxone® or

methadone®. Reportedly, it is also easy to acquire Suboxone® from someone who has a prescription. A participant reported, “Usually, people who are prescribed them are using other pain pills, so they sell their Suboxone®.”

A profile for a typical Suboxone® user did not emerge from the data. Participants and treatment providers commonly recognized that many use Suboxone® illicitly. A provider stated, “Some start off using it [Suboxone®] to assist with withdrawal, but find that they like how it feels and become addicted.” Others, according to participants, continue to use Suboxone® in between using other opioids, “to avoid being dope sick, til they get money for their next heroin.”

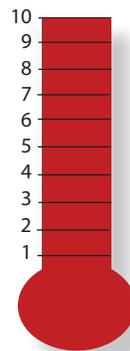
Reportedly, Suboxone® is used in combination with alcohol, crack cocaine, marijuana, powdered cocaine and sedative-hypnotics (Xanax®). However, most participants reported that it is more common to use Suboxone® by itself. A participant reported that using Suboxone® with “nerve pills” (Xanax®), “gives you a really strong heroin buzz.”

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (i.e., 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 and treatment professionals listed the most common sedative-hypnotics in terms of widespread use as Klonopin® and Xanax®. In addition to obtaining sedative-hypnotics on the street, participants reported that there were physicians known by users who prescribed these medications liberally throughout the region. Many participants also reported getting sedative-hypnotics from friends and family members with prescriptions, as well as from ordering them through the Internet. Treatment professionals noted an emerging problem of young people being prescribed sedative-hypnotics without psychiatric care. The most common routes of administration were oral consumption and intranasal inhalation (snorting). Descriptions of typical users of sedative-hypnotics varied; however, both participants and community professionals noted an increase in the frequency of young people using these drugs, especially Xanax®.

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 reported, “Doctors give [prescribe] ridiculous amounts [of sedative-hypnotics]; A lot of people I know get prescriptions [for sedative-hypnotics] that don’t need them.” Treatment providers also most often reported current sedative-hypnotic availability as ‘10’. Treatment providers reported that these medications are, “very available,” although one group of treatment providers asserted, “[Sedative-hypnotics] are not as readily available as pain pills [prescription opioids].” Participants and community professionals identified Klonopin® and Xanax® as the most popular sedative-hypnotics in terms of widespread, with participants additionally naming Valium® as also most popular.

The majority of participants reported that the availability of sedative-hypnotics has increased over the past six months. Many participants believed, “more people are selling them” due to the poor economy. A participant commented on the frequency with which doctors prescribed sedative-hypnotics, “Every time I meet someone who went to the doctor, they [doctor] put them on Xanax®.” One group of participants posited that the availability of sedative-hypnotics has decreased in the past six months because they have become less popular over time: “The opiate thing replaced the benzo’s [benzodiazepines].” Another participant disagreed, and commented, “Certain people buy them [sedative-hypnotics] up, so they are not as available at times.” Treatment providers reported that the availability of sedative-hypnotics has decreased over the past six months. A number of providers agreed, “Doctors are cutting back on prescribing [sedative-hypnotics] as they recognize [that] people are abusing and selling them.” BCI London crime lab reported that the number of sedative-hypnotic cases it processes has remained stable over the past six months; however, a noted increase in cases occurred for Xanax®.

Reportedly, many different types of sedative-hypnotics (a.k.a., “downers,” “forget-me-nots” and “happy pills”) are currently sold on the region’s streets. Participants reported the following sedative-hypnotics as available to the street-level user (Note: When reported, current street names and prices are indicated in parentheses): Klonopin® (a.k.a., “forget-a-pins,” “green monsters” and “k-pins;” sells \$1–\$2; 2 mg, a.k.a., “Klonopin® bars;” sells for \$4); Valium® (\$1–\$2 per pill); Xanax® (.25 mg, a.k.a., “footballs” and “xani’s;” sells for \$0.50–\$1.50; .5 mg, a.k.a., “footballs,” “peaches” and “xani’s;” sells for \$1–\$2; 1

mg, a.k.a., “blues,” “footballs” and “xani’s;” sells for \$2–\$3; 2 mg, a.k.a., “xani bars;” sells for \$4–\$5). Overall, many participants commented that sedative-hypnotics are, “*very cheap; a dime a dozen.*” Some participants reported that they received Xanax® for free: “*I never paid for Xanax®. When I would buy something else, like pain killers [prescription opioids], he [dealer] would give me some Xanax®.*” 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 intranasal inhalation (snorting). Out of 100 users, participants reported that approximately 50 to 75 would chew or swallow the pills while the remainder would snort the drugs. A participant commented, “*Sometimes you eat and snort [sedative-hypnotics] at the same time.*” Finally, it was reported by one participant focus group that some people inject sedative-hypnotics.

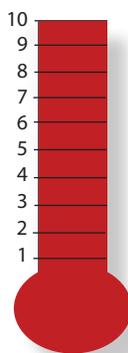
In addition to obtaining sedative-hypnotics on the street from dealers, participants continued to also report getting them from doctors, friends and family members who were prescribed the drugs. Many commented that it is easy to get sedative-hypnotic prescriptions. Participants stated, “*These pills [sedative-hypnotics] are easier to get from a doctor than opiates; Tell the doctor you have anxiety, and he will prescribe 120 ‘xani bars’ [Xanax® 2 mg] for the month.*” It was also commented that, “*A lot of veterans get them [sedative-hypnotics]. Many sell their monthly [sedative-hypnotic] prescriptions.*” 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 use these drugs.

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, crack cocaine, heroin, marijuana, methamphetamine, powdered cocaine and prescription opioids. Participants were evenly split as to whether it is more common to use sedatives with other drugs or to use them by themselves. When used in combination with alcohol, it was reported that the combination intensifies the effect of alcohol; as one participant described, “*Drink one beer, take one ‘xani bar’ [Xanax® 2 mg], that equals eight beers.*” Another participant stated, “*If you want to wake up and hear stories you don’t remember, take Xanax® with alcohol.*” Reportedly, sedative-hypnotics are used with stimulants to help with “coming down” from the stimulant high. A participant reported, “*When you are up for days and can’t sleep, Xanax® helps you sleep.*”

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 offered conflicting opinions about whether marijuana availability increased, decreased or stayed the same over the previous six months. Those who thought availability had decreased believed the decrease was due to an increase in heroin availability. Participants reported that the quality of marijuana varied with the most common quality score being ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that for commercial-grade marijuana, a “blunt” (i.e., single cigar) sold for \$5, and 1/8 ounce sold for \$15–\$30; for high-grade marijuana, 1/8 ounce sold for \$30–\$65. The most common route of administration for marijuana was smoking. The prevailing thought was that marijuana was widely used, and participants and treatment providers alike were unable to identify a specific group that was more likely to use the drug.

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 unanimously agreed, “[*Marijuana*] it’s everywhere,” and described the region as, “*The marijuana capital of the U.S.*” A participant remarked, “*Just stand on the front porch and yell, someone will bring it [marijuana] to me.*” Treatment providers most often reported the drug’s current availability as ‘10’. All treatment providers reported that marijuana is readily available: “[*Marijuana*] it’s everyone’s drug of choice; I could walk next door and get it right now.” Treatment providers also talked about how easy it was to find a secluded place to grow marijuana: “[*Marijuana*] it’s easy to grow here. There are a lot of rural spots for people to put a plot in.” A Perry County official reported the current availability of marijuana as ‘10’ in Perry County. However, this official stated, “[*Marijuana* is] easy to get, but if they don’t grow it themselves, it’s costly. Heroin is cheaper.” The *Marietta Times* reported on a large marijuana seizure in Morgan and Washington Counties that netted \$750,000 in cash along with 90 firearms. The alleged leader of the drug network was believed to have brought in 300 to 500 pounds

of marijuana every six to eight weeks for sale in Ohio and Kentucky (www.marieettatimes.com, April 25, 2011).

Participants reported that the availability of marijuana has increased over the past six months. A participant commented, *"High grade [marijuana] is more prevalent right now than it was a year ago."* It was generally posited that the availability of marijuana is, *"steadily going up."* Some groups noted that there are periods when *"home grown"* is more difficult to find based on growing season, but currently, it is very available. Community professionals reported that the availability of marijuana has remained stable over the past six months. BCI London crime lab reported that the number of marijuana cases it processes has decreased over the past six months.

Participant quality scores of marijuana varied from '2' to '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 '10'. Several participants explained that the quality of marijuana depends on whether the user buys "commercial weed" (low- to mid-grade marijuana) or higher grades of marijuana, including hydroponically-grown marijuana. Commercial-grade marijuana was reported to be available year round and to be imported from Mexico. Higher grades of marijuana were reported to be seasonal in terms of availability. A participant group referenced a three-month cycle of availability for higher grade marijuana: *"You can get it [high-grade marijuana] every three months. That's how long it takes to grow."* Other groups, however, commented that the higher grades are available in the autumn, when local home-grown grades are most available. In summary, as one participant put it, *"People will look for better [marijuana], but most pot heads [marijuana users] don't care ... just get a bag of dirt [commercial-grade marijuana]."*

Current street jargon includes countless names for marijuana. The most commonly cited name was "weed." Participants listed the following as other common street names: "dirt weed," "middies" and "swag" for commercial-grade marijuana; "chronic," "dumpster," "kind bud," "northern light" and "skunk" for high-grade marijuana; and "hydro" for hydroponically-grown marijuana. The price of marijuana depends on the quality desired. Participants reported commercial-grade marijuana as the cheapest type: a blunt (single cigar) or two joints (cigarettes) sell for \$5–\$10; 1/8 ounce sells for \$25–\$30; 1/4 ounce sells for \$40; an ounce sells for \$85–\$150. Higher-grade marijuana (e.g., "home grown") sells for significantly more: a blunt (single cigar) or two joints (cigarettes) sells for \$10; 1/8 ounce sells for \$50; 1/4 ounce sells for \$100; an ounce sells for \$250–\$300; 1/4 pound sells for \$1,200. Participants reported that the most common way to purchase marijuana is by the blunt. While there were several reported ways of consuming marijuana,

the most common route of administration remains smoking in a joint, blunt or in a "bowl" (pipe). Out of 100 users, participants reported that approximately 98 to 100 would smoke the drug. Oral ingestion (eating) was infrequently mentioned, but participants said that some users bake *"bud [marijuana] brownies"* and/or make tea from marijuana plant stems.

A profile for a typical marijuana user did not emerge from the data. Participants identified "everyone" as the typical users of marijuana. Treatment providers generally concurred, though two groups identified White males as being particularly represented within the marijuana-using population. Another group of treatment providers reported an increasing number of younger users of marijuana. A community professional reported, *"Younger kids, nine and 10 year olds, are saying they are addicted to it [marijuana]."* A treatment provider commented, *"One thing I do know, people have no trouble talking about using it [marijuana]. There is no shame. They have no problem saying they are using weed [marijuana]."*

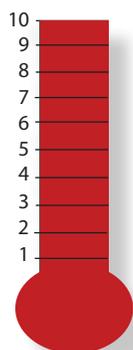
Reportedly, marijuana is used in combination with alcohol, crack cocaine, heroin, powdered cocaine, prescription opioids, and per one participant, *"embalming fluid."* A participant stated, *"Weed [marijuana] is one thing you can mix with anything and not worry about it killing you."* The majority of participants reported that marijuana is most commonly used by itself; although a couple of groups shared that about half of marijuana users combine it with other substances. When used with cocaine, it is usually done so as to help with "coming down" from the cocaine high. Some users preferred to use marijuana with alcohol to feel "dizzy" while others preferred to combine marijuana with prescription opioids to "keep the high lasting."

Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was reportedly rare in the region. Most participants knew little about the drug. Participants most often reported the drug's availability as '2', with the exception of Muskingum County where participants rated availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). While most participants reported that availability of methamphetamine had changed little over the previous six months, some participants reported that availability had decreased, citing difficulty in acquiring the ingredients (pseudoephedrine) needed to make methamphetamine. Participants reported that powdered methamphetamine was locally made; whereas, crystal methamphetamine ("ice") reportedly came from out of state. Participants most often reported the quality of crystal methamphetamine as '10' on a scale of '0' (poor quality,

“garbage”) to ‘10’ (high quality). Participants reported that they could buy a gram of powdered methamphetamine for \$50 – \$75 and a gram of crystal methamphetamine for \$140. The most common routes of administration for this drug were intranasal inhalation (i.e., snorting) and smoking. Treatment professionals described typical methamphetamine users as being in their 20’s and 30’s, and almost exclusively White.

Current Trends



Methamphetamine remains relatively rare in some areas of the region while highly available in other areas of the region. In counties where methamphetamine is reportedly high in availability, 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 ‘2,’ with the exception of Muskingum County where it was ‘8.’ Participants reported that methamphetamine is available in crystal

and powdered forms, with the powdered form being more available. Participant groups in Belmont and Muskingum Counties reported methamphetamine as, “easy to get.” A participant also reported high availability in Harrison County. Participants in Muskingum County shared that there were recently, “three [methamphetamine] labs busted in Zanesville.” Participants in Athens and Guernsey Counties reported having little knowledge of methamphetamine: “I haven’t seen it [methamphetamine] in years; once in a blue moon.” These participants generally thought that users needed to travel to Columbus to obtain methamphetamine. With the exception of the focus group in Muskingum County, treatment providers likewise indicated having little knowledge of the availability of methamphetamine. The group from Muskingum County most often reported the drug’s current availability as ‘7.’ Treatment providers reported little experience with methamphetamine users: “From reports, [methamphetamine] it’s all around us, but we do not have any clients who are users; it’s on the news ... but we do not see clients using it; clients seem afraid of it [methamphetamine]. You are really bad [hardcore] if you use meth [methamphetamine].” A Perry County official reported methamphetamine’s availability as ‘5.’ This official reported that all the methamphetamine in the area is homemade and was not aware of any crystal methamphetamine being available in the county. Several media outlets in the region reported on drug seizures related to methamphetamine. The Central Ohio Drug Enforcement Task Force arrested two

people who were manufacturing methamphetamine in a Perry County lab (www.whiznews.com, March 6, 2011). In Jackson County, the *Vindicator* reported that four men were arrested during a routine traffic stop when the Ohio State Highway Patrol found chemicals used to manufacture methamphetamine (www.vindy.com, April 7, 2011).

Participants with knowledge of methamphetamine reported that the availability of methamphetamine has increased over the past six months. A participant commented, “[Methamphetamine] it’s so easy to make. You don’t need a dealer if you are willing to make it yourself. There’s lots of ways to make it.” Treatment providers with knowledge of availability reported that methamphetamine availability has decreased over the past six months, citing a couple of significant lab busts in the area. BCI London crime lab reported that the number of methamphetamine cases it processes has remained stable over the past six months, noting that powdered methamphetamine cases (i.e., white to yellow in color) make up the bulk of all methamphetamine cases the crime lab processes; BCI London also noted an increase in the number of crystal methamphetamine cases it processes.

Only four participants interviewed reported firsthand knowledge of the quality of methamphetamine; these participants reported current quality as ‘8’ and ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the previous most common scores were ‘4’ to ‘5’ for powdered methamphetamine and ‘10’ for crystal methamphetamine. Participants stated, “[Quality] depends on what is used to make it [methamphetamine].” A participant reported that the quality of methamphetamine has decreased recently because, “the person I use to get it [methamphetamine] from is in prison.”

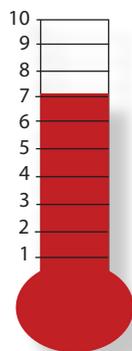
Current street jargon includes a few names for methamphetamine. The most commonly cited names were “crank,” “glass,” “ice,” “meth” and “speed.” Current street prices for methamphetamine were consistent among participants with experience buying the drug. Participants reported that a gram of methamphetamine sells for \$60–\$100. The most common routes of administration for methamphetamine continue to be smoking via a pipe (“bowl”) and intranasal inhalation (snorting); participants reported that both routes are equally as common; less common is intravenous injection.

A profile for a typical methamphetamine user did not emerge from the data. Participants reported that all groups are represented among users. A few participants offered descriptors of those that use methamphetamine: “People who use cocaine [are more likely to use methamphetamine]; All my rich, White friends are getting into it [methamphetamine].”

It used to be red necks [who mostly used methamphetamine].” Reportedly, methamphetamine is used in combination with heroin, prescription opioids and sedative-hypnotics (i.e., Xanax®). All of the aforementioned are primarily used to, “put you to sleep [after the extreme high of methamphetamine].”

Ecstasy¹

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 drug’s current availability as ‘7’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants reported that Ecstasy is more available and common in the city (Columbus). A participant focus group characterized availability as, “sometimes available, every once and awhile. If you want it [Ecstasy], go to Columbus.” Treatment providers most often

characterized the availability of Ecstasy as “rarely available,” and reported that they occasionally receive a referral for a young person who abuses Ecstasy. A provider reported having a current client: “First [time] in a long time that I’ve heard of someone using Ecstasy.” Media outlets in the region reported on drug seizures related to Ecstasy during this current reporting period. In May, NBC4 News Columbus reported on the seizure of Ecstasy during a routine traffic stop by the Ohio State Highway Patrol. In addition to 100 tablets of Ecstasy, state troopers found 28 grams of crack cocaine and 20 grams of marijuana, all of which were worth an estimated \$14,000 (www.nbc4i.com, May 6, 2011).

There was no report from participants or treatment providers as to whether the availability of Ecstasy has increased, decreased or remained stable over the past six months. BCI London crime lab reported that the number of Ecstasy cases it processes have remained stable over the past six months. The crime lab also reported that Ecstasy pills usually contain multiple active substances including 5-MeO-DiPT (foxy methoxy), BZP, MDM, MDMA, P-FPP, TMFPP, caffeine, ketamine and methamphetamine.

Current street jargon includes several different names for Ecstasy. The most commonly cited names were “mollies” and “skittles.” Participants reported that Ecstasy generally sells for \$20–\$25 per pill. A profile for a typical Ecstasy user did not emerge from the data. However, a participant reported,

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

“People who use acid, also use Ecstasy.” A focus group of treatment providers said that users tend to be young and, “tend to be the group that uses multiple drugs.”

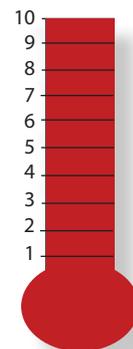
Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants (Adderall® and Ritalin®) 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’ (high availability, extremely easy to get). Participants reported that availability had increased over the previous six months. Adderall® was commonly available to street-level users in the region; Adderall® 30 mg sold for \$8–\$10 per pill. Reportedly, the most common route of administration of prescription stimulants was intranasal inhalation (snorting), followed by oral ingestion (swallowing). Participants reported that prescription stimulants were very popular among college students.

Current Trends

Prescription stimulants (Adderall® and Ritalin®) remain highly available in the region. Participants most often reported current availability of prescription stimulants as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10’. Participants and treatment providers agreed that prescription stimulants (especially Ritalin®) are very common among high school students and on college campuses. Treatment providers reported that they do not to see prescription stimulant users in their programs; hence, they had no knowledge of availability. Participants provided no data on whether the availability of prescription stimulants has increased, decreased, or remained stable over the past six months. BCI London crime lab reported that the number of prescription stimulant cases it processes has remained stable over the past six months.



Current street jargon includes a few names for prescription stimulants. The most commonly cited names were “poor man’s coke” and “yuppie cocaine.” Data regarding prices were not reported. A profile for a typical prescription stimulant user emerged from the data. Participants continued to describe typical users as high school and college students. Participants reported that these drugs are commonly used to help students focus before exams. The most common route of administration of prescription stimulants remains intranasal inhalation (snorting). Reportedly, crushing and

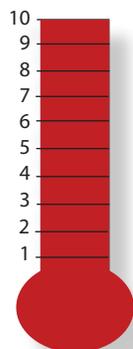
snorting prescription stimulants produces an effect similar to a cocaine high.

Synthetic Marijuana
Historical Summary

In the previous reporting period, while no participant reported use of synthetic marijuana (“K2” and “Spice”), participants reported that they had frequently heard talk about the drug. Treatment providers expressed frustration over the availability of brands like “K2” at local head shops and gas stations. Treatment providers also commented on the dangerous side effects (hallucinations) and reported that there were a few drug overdose deaths linked to synthetic marijuana use in Washington County. Participants believed that synthetic marijuana was very popular among teenagers and college students.

Current Trends

Synthetic marijuana (“K2” and “Spice”) is highly available in the region. Participants most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). 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.” Treatment providers most often reported the drug’s current availability as ‘10’. Treatment providers also reported synthetic marijuana to be readily available: “[Synthetic marijuana] very available at gas stations; still able to get easily, just have to ask.” A Perry County official reported, “The schools are seeing it [synthetic marijuana] a lot.” This official reported that synthetic marijuana is not available from area merchants but that individuals go out of town or go on the Internet to purchase synthetic marijuana.



Participants who have tried synthetic marijuana most often rated the quality of synthetic marijuana as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). A participant reported that quality is, “on the rise.” Overall, most participants reported that they do not like the effect produced by synthetic marijuana. A participant described his experience as, “very harsh, hard to inhale [synthetic marijuana]. You cough a lot, it burns. I couldn’t finish it, nasty taste.” Another participant described the experience as, “more intense than marijuana, weed [marijuana] times 10,” but he went on to describe that the effect is, “like weed, but [makes you] more paranoid and robotic; you feel stiff and twitchy.” Another had the same experience and described the

stiffness produced by synthetic marijuana use as, “like the tin man, hard to bend your knees.” Others reported that synthetic marijuana tastes bad: “[Synthetic marijuana] tastes like wood; like smoking potpourri.” 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 have tried synthetic marijuana, most did not know anyone to be a regular user of the drug.

Current street jargon for synthetic marijuana most frequently reflects the brand names available at the store (“Cloud 9,” “K2” and “Spice”). Participants reported that there are dozens of kinds of synthetic marijuana, with different flavors. Participants of one focus group reported that there is now a pill form of synthetic marijuana, named “Lifted,” available in head shops. Synthetic marijuana was reported to sell for \$20 – \$30 a gram, or \$60 for a three gram package. The primary route of administration remains smoking.

A profile for a typical synthetic marijuana user emerged from the data. Participants identified the typical user as an individual who wants to avoid detection on urine drug screens, such as an individual on probation or who is tested at work. Participants and treatment providers agreed that use remains most common among teenagers and college students.

Bath Salts²

Bath salts (synthetic compounds that produce a high similar to a stimulant or hallucinogenic drug) are highly available in the region. These compounds commonly contain methylone, mephedrone or MDPV. The generic term, bath salts, is in and of itself 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. Readily available from drug stores, head shops and some convenience marts, bath salts were legally sold during this reporting period. Participant focus groups in Belmont, Guernsey and Muskingum Counties described bath salts as very easy to find, and treatment providers from each of these three counties also reported knowledge about bath salts. While bath salts are readily available, treatment providers reported that they are not seeing clients that are using them. A treatment provider stated, “We are reading about it [bath salts], not seeing it here yet.” Other treatment providers agreed and reported that bath salts use is supposedly common on college campuses. BCI London crime lab reported that the number of bath salts cases it processes has increased over the past six months. The crime lab also reported that most forms of bath salts contain MDPV and methylone, which is a relative of a chemical often found in Ecstasy, MDMA.

² Bath salts were not mentioned in this region during the last reporting period; therefore, there is no historical summary.

A participant who acknowledged using bath salts reported that there are two different kinds of bath salts, referred to as “synthetic Ecstasy” and “synthetic cocaine.” A treatment provider focus group also noted knowledge of two different kinds of bath salts, one known as “Ivory,” which “gives you a mellow [feeling],” and the other known as “Dove,” which “gives you the buzz.” Only one participant reported experience using the synthetic Ecstasy form. The participant described using synthetic Ecstasy as, “the best trip I’ve ever been on.”

Participants with experience buying bath salts reported that bath salts sell for \$30 per bag. In addition, participants reported that bath salts are sold in tubes similar in size to Chap Stick® lip balm, containing 1/2 gram. Reportedly, these tubes sell for \$75–\$90. Generally, participants believed that bath salts are not popular because of their high price. Typically users were said to mix this form of bath salts with soda to drink. A few participants reported knowledge of the synthetic cocaine form of bath salts, which was reported to “look like cocaine” and described as having a “very fine baby powder texture.” Reportedly, the most common route of administration for this form of bath salts is intranasal inhalation (snorting). The effect produced through snorting the bath salts was described by a couple of participants as being similar to that of cocaine, “but without the numbing effect.” A participant stated, “[Bath salts] it speeds you up to the point that I could not focus, I felt very jittery.”

Participants did not identify the typical user of bath salts, though bath salts were said to be used by individuals who need to avoid detection of drug use on urine drug screens. Treatment providers commented that bath salts are primarily used by adolescents and college students.

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: over-the-counter (OTC) and prescription cough medicines and hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms]. OTC and prescription cough medicines were highly available and popular in the region, especially in Belmont County. Participants in Belmont County 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 reported the use of dextromethorphan (DXM) as growing in popularity, primarily because DXM was relatively cheap to purchase, and reportedly, its abuse was hard to detect. The most commonly reported route of administration for DXM

was oral consumption. Treatment providers reported that DXM users tended to be individuals in their teens or early 20’s. Reportedly, hallucinogens were moderately to highly available in the region. Psilocybin mushrooms were the most available hallucinogen in the region. Participants most often reported the availability of psilocybin mushrooms as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants reported that 1/8 ounce of mushrooms sold for \$25–\$50. The most commonly reported route of administration for psilocybin mushrooms was oral consumption. LSD was mentioned by a few participants. Participants with knowledge of LSD most often reported the drug’s availability as ‘5’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Reportedly, LSD was available in multiple forms to street-level users, including paper (\$10 per hit) and sugar cubes (\$7–\$8 per cube).

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 Belmont County reported seeing LSD, describing it as liquid in form, used by placing drops in the mouth or the eyeball. Reportedly, LSD is found at festivals, though one participant said he has friends who use LSD daily. The quality of LSD was said to be, “not as good as in the 70’s or 80’s.” BCI London crime lab reported that the number of LSD cases it processes has remained stable over the past six months.

Focus groups in Athens and Belmont Counties reported that psilocybin mushrooms are available in the area, with some participants reporting psilocybin mushrooms as, “easy to find; very popular,” and others reporting that psilocybin mushrooms are less common and, “brought in by college students.” 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); the previous most common score was also ‘10.’ Participants gave mixed information about the availability of psilocybin mushroom. A participant reported, “[Psilocybin mushrooms] It’s easy to grow. You can buy spore kits on the Internet,” yet another said that availability, “depends on the time of year.” A participant cautioned that caps of other mushrooms are sometimes sold as psilocybin mushrooms. While specific prices were not reported, a participant stated that psilocybin mushrooms roughly cost, “the same as weed [marijuana].” The typical psilocybin mushroom user is reportedly college aged. BCI London crime lab reported that the number of psilocybin mushroom cases it processes has remained stable over the past six months.

Conclusion

Bath salts, crack cocaine, heroin, marijuana powdered cocaine, prescription opioids, prescription stimulants, sedative-hypnotics and Suboxone® remain highly available in the region. Noted increases in availability over the previous six months exist for heroin and prescription opioids; a noted decrease exists for Suboxone®. With the exception of Guernsey County, black tar heroin has increased in availability across the region. Participants reported that heroin has become as accessible as marijuana, if not more so, and that dealers are often carrying heroin and prescription opioids together. Participants also reported that heroin is making its way into high schools in the region and that there is less stigma around using heroin intravenously. Treatment providers reported an increase in requests for detox services by intravenous heroin users. BCI London crime lab continues to report that heroin is extremely pure in the region. Gas chromatography-mass spectrometry analysis typically shows that heroin is 80 percent pure. Prescription opioid use has increased in the region to the point where participants and treatment providers alike are saying there's a prescription opioid epidemic. Participants reported that there are times when availability of prescription opioids is limited because supply is having a hard time keeping up with demand. Participants identified morphine, OxyContin®, Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use. In addition to obtaining prescription opioids on the street from dealers, participants also continued to report getting these drugs from emergency rooms, pain clinics (said to be found in Canton, Dover and Pittsburgh, Pa), other doctors, family members and friends who have prescriptions. Participants also reported users being paid by dealers to drive to Florida and acquire the pain medications. Treatment providers and BCI London crime lab reported a decrease in Suboxone® over the reporting period. Treatment providers explained that some doctors have stopped prescribing Suboxone® because they found out their patients were selling the drug. Participants reported that Suboxone® is frequently traded for prescription opioids (OxyContin®) or other drugs. Those who illicitly used Suboxone® explained that they used Suboxone® to avoid withdrawal symptoms from heroin, but a minority of opioid-naïve participants said they abused Suboxone® to become high. Crack and powdered cocaine are highly available throughout most of the region. Generally, participants commented on the poor quality of both forms of cocaine, citing that they are frequently adulterated with other substances. BCI London crime lab continues to cite the primary cutting agent for cocaine as levamisole (livestock dewormer). Availability of sedative-hypnotics remains high and stable from the previous reporting period. Participants identified Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics

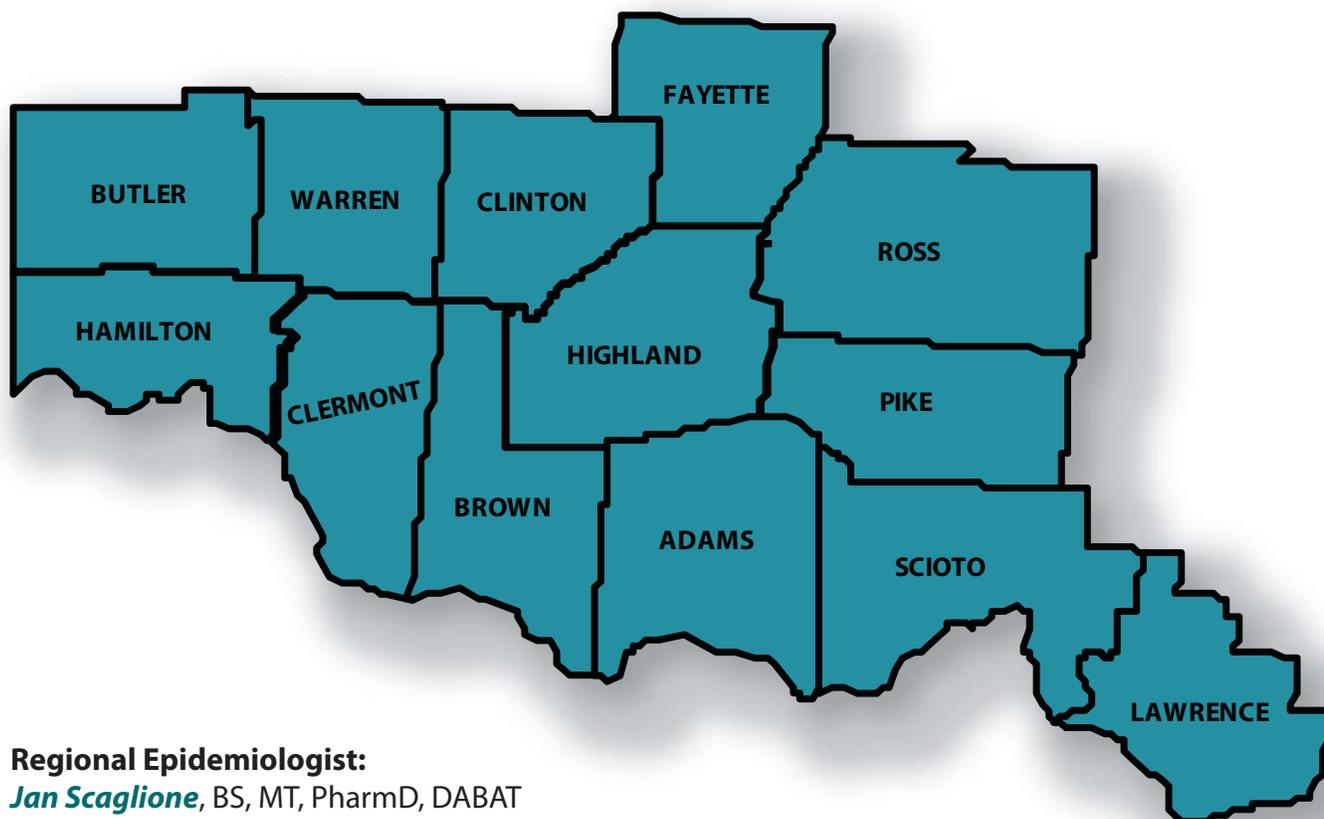
in terms of widespread use. While there were a few reports of doctors prescribing sedative-hypnotics less frequently, most participants reported that sedative-hypnotics continue to be readily available from physicians, family and friends. While participants reported infrequent use of bath salts, they are highly available in the region. According to the participants with experience taking the drug, some bath salts work like "synthetic Ecstasy" and other work like "synthetic cocaine." BCI London crime lab reported that the number of bath salts cases it processes have increased over the past six months. The crime lab also reported that most forms of bath salts contain MDPV and methylone, which is a relative of a chemical often found in Ecstasy, MDMA.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Cincinnati Region

January-June 2011

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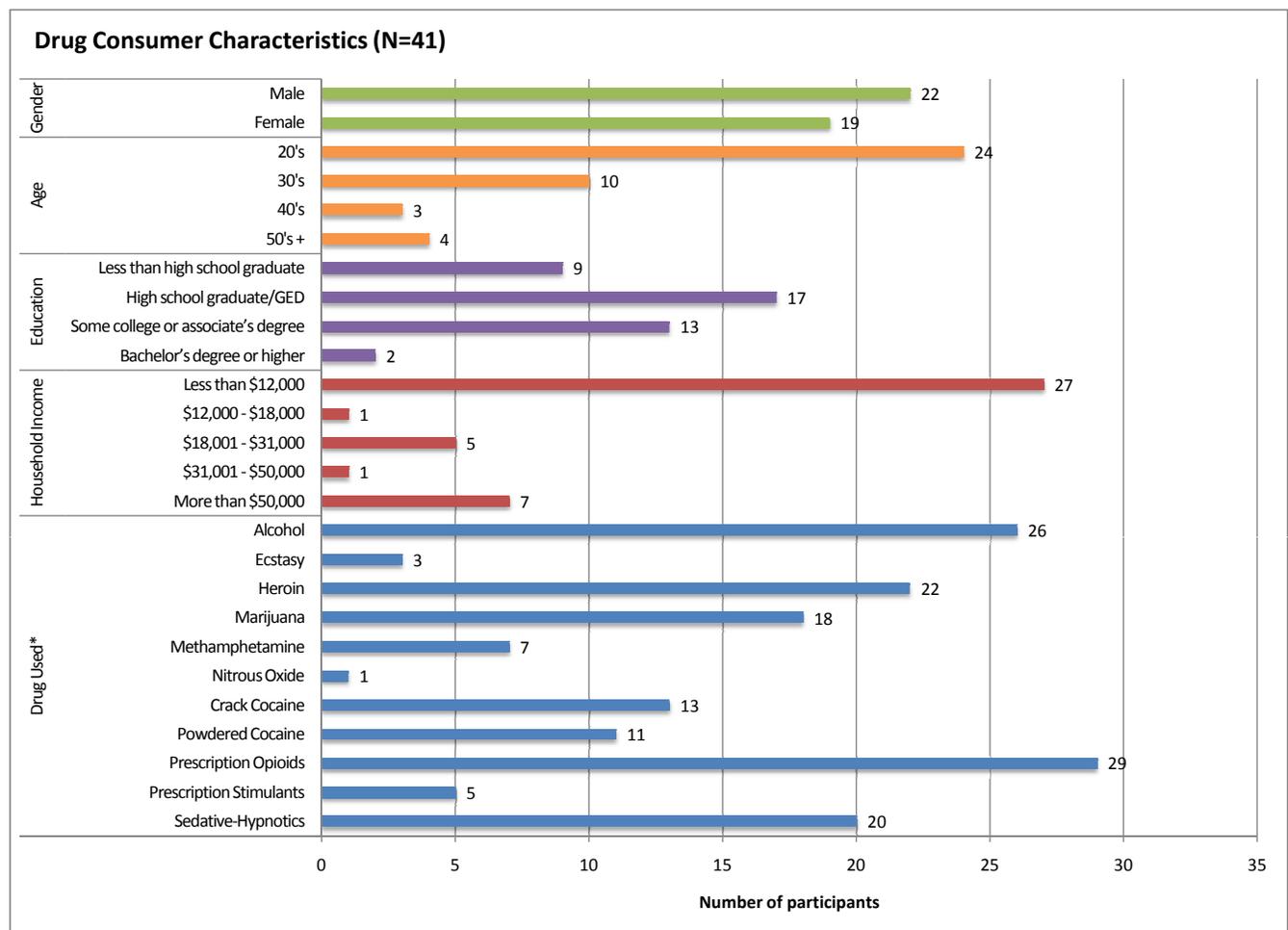
Research Administrator

Regional Profile

Indicator ¹	Ohio	Cincinnati Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,542,645	2,053,493	41
Gender (Female), 2009	51.2%	51.1%	46.3%
Whites, 2009	82.2%	83.2%	73.2%
African Americans, 2009	11.9%	12.6%	22.0%
Hispanic or Latino Origin, 2009	2.8%	2.0%	0.0%
High school graduates, 2008	83.0%	90.9%	78.0%
Median household income, 2009	\$45,467	\$41,672	Less than \$12,000 ²
Persons below poverty, 2009	15.1%	13.8%	53.70%

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

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



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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Hamilton and Lawrence Counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via focus group interviews, as well as to data surveyed from the Hamilton County Crime Lab and Bureau of Criminal Identification and Investigation (BCI) London Office, which serves Central and Southern Ohio. All secondary data are summary data of cases processed from July to December 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, all current secondary data correspond to the current reporting period of participants. In addition to the aforementioned data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2011.

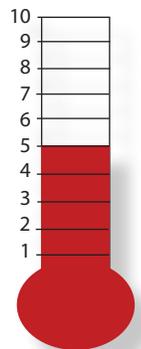
Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was 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). The most common participant quality score for powdered cocaine was '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Many participants reported the use of powdered cocaine to "rock up" (manufacture) crack cocaine in order to ensure a better idea of the quality of the drug they smoked. According to BCI London crime lab, levamisole (livestock dewormer) was the cutting agent in 90 percent of powdered cocaine cases. The price of powdered cocaine reportedly depended heavily on the connection the user had with the dealer. Participants reported a gram of powdered cocaine ranged in price from \$25–\$40 if dealer was known and \$60–\$100 if dealer was unknown. Reportedly, the most common route of administration for this form of cocaine was intranasal inhalation (snorting). The typical user of powdered cocaine was described by many participants as a White, middle to upper class, working, professional male in his 20's–30's. Law enforcement stated that more White females between 18–30 years of age were using more powdered cocaine than in the past. Participants reported that powdered cocaine was often injected concurrently with heroin (a.k.a., "speedball").

Current Trends

Powdered cocaine is moderately available in the region. Participants most often reported the drug's current availability 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'. Participants reported powdered cocaine availability as highly variable across Cincinnati. Both law enforcement and treatment providers most often reported the drug's current availability as '6'. A treatment provider reported, *"The availability [of powdered cocaine] is there. The interest is not there, unless you're talking about folks that are a little bit older, then there's interest."* Law enforcement cited increased drug seizure at the border between Mexico and the U.S. as a reason for lower availability. *WLWT News 5 Cincinnati* reported on several powdered cocaine busts by law enforcement over this current reporting period. In the City of Hamilton, police and federal agents seized two kilograms of powdered cocaine along with 700 grams of crack cocaine, believed to have come from Mexico (www.wlwt.com, March 17, 2011). Cincinnati police reported the arrest of a local man on federal charges of cocaine possession with the intent to distribute 55 pounds of powdered cocaine with an estimated street value of \$2.5 million. The police investigation revealed that the man traveled twice monthly over the past year to Chicago to obtain cocaine to distribute in Cincinnati. This cocaine seizure, *"will significantly impact the local supply of cocaine"* (www.wlwt.com, Feb. 24, 2011). Participants and treatment providers alike reported that the availability of powdered cocaine has remained stable over the past six months. A participant stated, *"Yeah, it [availability of powdered cocaine] hasn't changed much."* A treatment provider reported, *"It's [powdered cocaine] been harder to find for some people, some people it's not hard to find, depends on who you know, where you live."* Hamilton County Crime Lab reported that the number of powdered cocaine cases it processes has remained stable over the past 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), the previous most common score was '5'. The quality of powdered cocaine was reported as so poor that one participant asked, *"Can we do negatives [assign negative quality ratings]"*? Participants reported that the quality of powdered cocaine has slightly decreased over the past six months. Participants described the quality of powdered cocaine in many ways: *"It's all crap; it's gone down. It keeps goin' down; it's terrible."* Hamilton County Crime Lab continues to



cite levamisole (livestock dewormer) as commonly used to cut (adulterate) powdered cocaine.

Current street jargon includes many names for powdered cocaine. The most commonly cited names were “powder” and “ya-yo.” Participants listed the following as other common street names: “fish scale,” “girl,” “soft,” “white girl” and “ya.” Current street prices for powdered cocaine were variable among participants with experience buying powdered cocaine. Participants reported that a gram of powdered cocaine sells for \$35–\$100, depending on the quality and connection to the dealer; 1/16 ounce, or “teener,” sells for \$75–\$110; 1/8 ounce, or “eight ball,” sells for \$150–\$200; an ounce sells for \$1,000–\$1,200. Participants reported that the most common way to use powdered cocaine remains intranasal inhalation (snorting). Out of 100 powdered cocaine users, participants reported that approximately 60–90 would snort it, 25–75 would “rock it up” and smoke it, and 10–50 would intravenously inject it. Injection of powdered cocaine was reported among those participants that inject drugs in general only, and is not viewed as a primary route of administration of powdered cocaine. Route of administration of powdered cocaine is closely tied to experience. First time users are more likely to snort powdered cocaine, and then progress to smoking or injecting as use continues or increases. A participant described the variability in route as dependent on where a person is at the time of drug administration in this way: “[Route] depends on where you’re at, what area you’re in, the location. Well, if you’re at the bar, you’re snorting it [powdered cocaine].”

A profile for a typical powdered cocaine user did not emerge from the data. Treatment professionals described typical users of powdered cocaine as those with the means to afford it: “It’s the money, I don’t know if education or whatever, you know what I mean, or employment makes a difference. It’s those with access to money that use powder [cocaine].” A participant, backed up by the group, described a specific demographic of those that inject powdered cocaine: “I think just to be real about it ... I think more White people shoot it [inject powdered cocaine].”

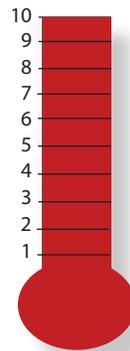
Reportedly, powdered cocaine is used in combination with alcohol, heroin (a.k.a., “speedballing” when injected together), marijuana and sedative-hypnotics. A participant reported, “It’s extremely common to use alcohol with cocaine. It’s mandatory ... It’s like the law ... like breathing, you got to come down.” Both alcohol and powdered cocaine were viewed by participants as substances used in social settings.

Crack Cocaine

Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Universally, community professionals and participants reported crack cocaine availability as steady, with relatively little change during the past six months. Participant quality scores of crack cocaine varied from ‘1’ to ‘5,’ with the most common score being ‘5’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). According to BCI London crime lab, levamisole (livestock dewormer) was used as a cutting agent for crack cocaine. Participants reported a gram of crack cocaine ranged in price from \$50 to \$100. Many participants also reported that they can easily purchase crack cocaine by the “rock” for \$2–\$10. By far, the most common route of administration for this form of cocaine was smoking. Participants and treatment professionals could not agree on a typical crack cocaine user profile.

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 ‘10,’ and they commonly said availability was, “Off the charts, it’s always off the charts ... [because it costs] less money for the drug [than for other street drugs].” Overall, participants reported that the availability of crack cocaine has remained stable over the past six months. In some of the more rural counties in the region (Ross County), availability of crack cocaine increased significantly from the previous six months. Media from the region reported on several drug arrests related to crack cocaine. In March, Hamilton County police found 260 grams of crack cocaine along with marijuana and other drug paraphernalia when they were serving an arrest warrant (www.wlwt.com; March 30, 2011). Law enforcement reported that availability of crack cocaine has decreased slightly over the past six months. Hamilton County Crime Lab reported that the number of crack cocaine cases it processes has remained stable over the past six months.

Most participants rated the quality of crack cocaine as either a '2' or '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Participants reported getting 'fleeced' or sold counterfeit crack cocaine that were subsequently identified to consist of the following substances: baking soda, candle wax, drywall, Orajel® mixed with flour, peanuts, rock salt and soap. Participants reported that the quality of crack cocaine has varied from stable to slightly decreased over the past six months: *"Ya gotta re-cook it [crack cocaine]; I used to smoke a lot a crack [cocaine] back in the '90s, and it [current quality] ain't even close. It's terrible now, that's why I just stopped."* Hamilton County Crime Lab continues to cite levamisole (livestock dewormer) as commonly used to cut (adulterate) crack cocaine.

Current street jargon includes many names for crack cocaine. The most commonly cited names were "hard" and "rock." Participants listed the following as other common street names: "base," "butter," "dope," "fire" and "melt." Current street prices for crack cocaine were consistent among participants with experience buying crack cocaine. Participants reported that crack cocaine is most often purchased by the 'rock,' ranging from \$5–\$10 per rock. Participants also reported a gram of crack cocaine sells for \$40–60, depending on the connection with the dealer or race of the buyer. As one participant explained, *"The price also changes depending on your race ... If it's a Black dealer, and you're a White purchaser, you're gonna pay more."* Law enforcement reported that an ounce of crack cocaine sells for \$700–\$900.

While there were a few reported ways of administering crack cocaine, generally, the most common route of administration continues to be smoking through the use of a pipe. Most participants that used crack cocaine reported re-cooking (reprocessing) crack cocaine before use in order to remove impurities: *"Yeah, cause you cook it up, and it takes out all the other stuff, so it just leaves it more pure."* Out of 100 crack cocaine consumers, participants reported that approximately 90 would smoke it, and 10 would break it down with lemon juice or vinegar to intravenously inject or "shoot it." Similar to powdered cocaine, injectors of crack cocaine are typically injectors of other drugs. A participant explained, *"Smokers do not shoot [inject] crack [cocaine]."* The only reports of snorting crack cocaine came from participants who talked about individuals in jail who have no access to a pipe: *"I've seen people snort it [crack cocaine]. It will come down to a powder ... that's in the jail ... they don't have a pipe."*

A profile of a typical user of crack cocaine did not emerge from the data. Participants described first-time users of crack cocaine as getting younger; in rural counties of the region,

participants explained, *"The kids are starting [crack cocaine use] young ... [at] 13 years."* In the Cincinnati area, participants also reported that first-time users of crack cocaine are often in the 12 – 13 year-old age range. Treatment providers described crack cocaine as a social drug among younger users, appealing to this population because of its low cost.

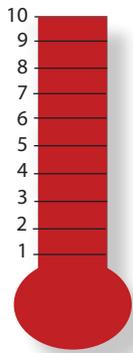
Reportedly, crack cocaine is commonly used in combination with alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics. Participants said many of these other drugs help to "come down" from the high of crack cocaine. Several participants reported, *"Most people that I know that smoke crack [cocaine], [also] drink [alcohol]."*

Heroin

Historical Summary

In the previous reporting period, heroin was moderately available in the region. Participants most often reported the availability of brown and white powdered heroin as '8' and black tar heroin as '4' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Much of the heroin trafficked in the Cincinnati region was reportedly coming south from the Dayton region according to law enforcement. More heroin was said to be available in rural and suburban areas of the region than in the urban core of the city. Many dealers reportedly had switched from selling crack and powdered cocaine to selling heroin. BCI London crime lab reported an increase over the previous six months in the processing of powdered and black tar heroin cases. The most common participant quality score for heroin was '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Heroin available in the region was "very pure" according to the BCI London crime lab, but benzocaine (local anesthetic) and metamizole (analgesic and antipyretic) were occasionally used as a cutting agents. Participants reported that a gram of powdered heroin ranged in price from \$100 – \$200, depending on quality and connection to the dealer. Bags containing 1/10 gram of brown or white powdered typically sold for \$20. The most common route of administration for heroin was intravenous injection. Typical consumers of heroin were reportedly divided between two camps: younger predominantly White users and older Black users. The overall use of heroin was reported as increasing, and new users were more likely to be younger, White and often female. The switch to heroin from prescription opioid use was noted by community professionals as a growing problem. Participants reported the co-injection, or successive use, of cocaine with heroin ("speedball") as a common practice among heroin users.

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). While many types of heroin were described in the region, participants and law enforcement continued to report Mexican brown powdered heroin as most available. A participant stated, *"Where I live the brown [powdered heroin] is a '10' [availability rating]."* Participants reported that the availability of brown and white powdered heroin has increased over the past six months,

most often reporting the availability of powdered heroin as '10'; the previous most common score was '8'. Reportedly, the availability of heroin, regardless of type, has increased over the past six months. Participants stated, *"It's an [heroin] epidemic, in suburbia ... city ... everywhere; All of it [types of heroin use] has gone up."* A law enforcement officer reported, *"Supply [of heroin] is up 1, 100 percent. It's hard keeping up with it."* Treatment providers also reported heroin's overall current availability as '10'. A treatment provider stated, *"Depending on the neighborhood ... it's [heroin availability] up there."* Law enforcement described an elaborate system for distribution where dealers are anonymous and names aren't used at any level of the trafficking process. Hamilton County Crime Lab reported that the number of heroin cases it processes has remained stable over the past six months.

Participants from rural areas in the region reported the availability of black tar heroin as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant reported, *"Like where I'm from [Lawrence County], tar [black tar heroin] is pretty easy to get."* In addition, media outlets reported on various drug busts on rural highways throughout the state and region. In April, ABC 6 News Columbus reported that a drug-detecting K-9 unit helped police officers bust four persons for possession of heroin after receiving a tip that individuals in Chillicothe (Ross County) were traveling to Columbus to buy heroin (www.abc6onyourside.com, April 6, 2011). Discussing the difference between brown powdered heroin and black tar heroin, a participant stated, *"Both are real good, but I think tar is best."* Overall, participants reported that availability of black tar heroin has increased over the past six months while also citing it as the predominant heroin type available in rural Lawrence and Jackson Counties.

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 '6'. Participants reported that powdered heroin in the Cincinnati region is cut (adulterated) with cocaine. In addition, participants reported that there has been heroin cut with fentanyl in the past six months, with several reports of friends dying as a result. A participant reported, *"Lost four friends to fentanyl; fentanyl's some powerful stuff."* The Coroner's office in Cincinnati has seen a higher number of heroin-related deaths, but none were found with evidence of fentanyl. It is suspected that the heroin supply may have increased in potency, leading to more dire consequences to the user. Over the past six months, participants reported that the quality of heroin has stayed the same. Hamilton County Crime Lab reported diphenhydramine (antihistamine) as commonly used to cut heroin.

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: "dog," "dope," "H," "pup," "puppy" and "smack." Participants reported that Mexican brown powdered heroin is available in different quantities: filled capsules sell for \$10–\$15 per capsule; baggies labeled with "TNT" or "WMD" containing 1/10 gram sell for \$10–\$15 in rural areas and \$20 in the City of Cincinnati; a gram sells for \$70 – \$130; an ounce sells for \$2,200–\$3,500, depending on quality; a kilo sells for \$45,000. Participants reported that black tar heroin is available in different quantities: a gram of black tar heroin sells for \$100–\$150; 1/4 ounce sells for \$450–\$550. Overall, participants reported that heroin pricing has decreased in the past six months as supply has increased over the same time frame.

Route of administration of heroin is closely tied to a user's experience with the drug. Participants reported that the most common way to use heroin continues to be intravenous injection. A participant stated, *"Shooting [heroin] is no doubt."* Out of 100 heroin users, participants reported that approximately 70–95 would intravenously inject it or "shoot it," 10 would snort it and another 5–10 would smoke it. If an individual was a first time user of powdered heroin, they would be more likely to snort heroin versus injecting it; thus, out of 100 new heroin users, 50–70 would reportedly use this route of administration. Black tar heroin is more likely to be injected than any other route of administration. However, there were several participants that described injecting heroin with first time use of the drug. When asked if they injected other drugs prior to injecting heroin, they answered in the negative. A participant stated, *"The first time I used it [heroin], I injected it ... it was black tar, and you can't snort black tar ... that was why I injected it."* Participants described getting needles primarily through one of two sources, neither of which involved getting them through a pharmacy.

Participants stated they obtained needles from people with diabetes that get them legitimately, and they also take them from healthcare facilities. A participant reported, *"You hug up to a diabetic to get needles ... diabetics sell needles ... can't get from the pharmacies anymore [for past year] ... they require a prescription."* Several participants had been employed in healthcare settings and had ready access to needles at work. Participants were asked whether or not they share needles with others if clean ones are not available, and responded, *"Cause like I said, you'll never go back to snorting it [heroin], so you'll do whatever for a needle ... well, maybe not, whatever,"* The reuse of needles was cited by participants as frequently done when a clean needle isn't available. A participant stated, *"Using dirty needles is getting bad,"* indicating that it was a commonplace occurrence and one that caused concern for safety.

A profile of a typical user of heroin emerged from the data. Participants continued to describe typical users of heroin as more likely to be male and White. A participant reported, *"I know when I was usin' [heroin] there was more dudes doing it."* Treatment providers described heroin use as being viewed as, *"glamorous, sexy, used by athletes, in the art scene, Hollywood celebrities, musicians, writers,"* and individuals are often, *"turned on [to heroin] by another person in a relationship setting."*

Reportedly, heroin is commonly used in combination with crack or powdered cocaine (a.k.a., "speedballs" when shot together), prescription opioids and sedative-hypnotics. Participants described concurrent use of methamphetamine with heroin; however, heroin use with methamphetamine was identified as more commonly practiced in rural areas of the region versus the City of Cincinnati. A participant stated, *"Best speedball in the world [combination of heroin and methamphetamine]."*

Prescription Opioids Historical Summary

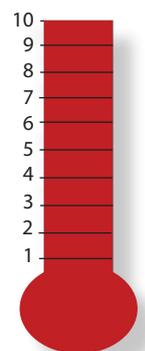
In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported street availability of these drugs in the range of '8' to '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described some prescription opioids as more readily available than others. They reported methadone and Ultram® high in availability. Reportedly, OxyContin® OC was less available as it had been replaced by the less desirable OxyContin® OP, a new formulation of OxyContin® which rendered the drug difficult to abuse. Law enforcement

expressed concern of potential increase in heroin use if the new formulation of OxyContin® was determined too difficult to abuse. Media reports confirmed the widespread availability of prescription opioids over the previous six months. Eight "pill mills" in Scioto County were alleged to prescribe opioids to anyone who could pay; many believed these clinics fueled the prescription opioid epidemic in the region. While it was possible to gain access to prescription opioids through street level drug dealers in the region, reportedly, it was more common for users to get these opioids from people that had prescriptions for them. The most common routes of administration of prescription opioids were swallowing and intranasal inhalation (crushing and snorting of the powdered content). Overwhelmingly, both participants and professionals described the abuse of prescription opioids as beginning with legitimate use for pain conditions. The first time user was reportedly younger than the first time user of other drugs, beginning as early as 13 years of age.

Current Trends

Prescription opioids remain highly available in the region. Participants most often reported the current availability of prescription opioids as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was in the range of '8' to '10'. Participants identified Lortab®, OxyContin®, Percocet®, Roxicodone® and Vicodin® as the most popular prescription opioids in terms of widespread use. A participant reported, *"You can get Vicodin® anywhere."* In addition, media outlets reported on various drug busts involving prescription opioids in the region over the past six months. In March, *The Oxford Press* reported that the Butler County Sheriff arrested three Harrison residents for operating an elaborate illegal prescription opioid scheme throughout Southwest Ohio. The trio allegedly used hundreds of aliases and fraudulent prescriptions to obtain thousands of doses of prescription opioids (mostly oxycodone) from multiple pharmacies across the region (www.oxfordpress.com; March 30, 2011). In April, *NBC 4 News* reported that a Pike County traffic stop turned up 198 oxycodone pills with an estimated street value of \$6,000 (www.nbc4i.com; April 21, 2011).

Participants identified Opana® as the prescription opioid whose popularity has risen the most in the past six months in terms of availability and use. A participant reported, *"For me it's [Opana® availability] a '10' ... Wow."* Oxymorphone (i.e.,



Opana[®]), an active metabolite of oxycodone, is a more potent narcotic, and has been increasing in both desirability and availability after the reformulation to a deterrent-enhanced OxyContin[®]. Treatment providers and law enforcement also reported an increase in availability and use of Opana[®]. Participants and law enforcement both reported that the change in formulation of OxyContin[®] has changed abuse patterns for users. OxyContin[®] was reformulated to reduce abuse by addition of deterrents in the fall of 2010, making it more difficult for the drug to be snorted or crushed and injected by users. Participants reported, *"They're [OxyContin[®]] OP's now ... you can still get it, but people just don't want it anymore; Demands gone down ... it [OxyContin[®] OP] gels up [when crushed]."* The success of the deterrents in the new formulation has led users away from OxyContin[®] to the prescription opioids Opana[®] and oxycodone ("perc 30"), along with heroin. Law enforcement described that the new formulation of OxyContin[®] as, *"hard to get rid of [sell] ... prices down"* at the street level. Prices for OxyContin[®] dropped as a result of lower desirability of the reformulated product. Participants reported that the availability of prescription opioids has remained stable at high levels over the past six months. Treatment providers and law enforcement reported that availability of prescription opioids has either remained stable or slightly increased over the past six months. Participants described that the diversion of the 40 mg wafers of methadone from treatment centers has increased over the past six months. BCI London crime lab reported that the number of prescription opioid cases it processes has remained stable over the past six months; however, noted increases in the number of lab processed cases existed for Dilaudid[®], Opana[®] and Percocet[®].

Reportedly, many different types of prescription opioids are currently sold on the region's streets. Participants reported the following prescription opioids as available to the street-level user (Note: When reported, current street names are indicated in parentheses): Dilaudid[®] (2 mg sells for \$4; 4 mg sells for \$7–\$10; 8 mg sells for \$10–\$20), methadone (a.k.a., "done," "dose," "doughnut," "liquid" and "met;" 5 mg tablet sells for \$5; 10 mg tablet sells for \$7–\$12; liquid sells for \$0.50–\$1 per milligram; 40 mg wafers sell for \$20–\$40), Opana[®] (20 mg sells for \$15–\$30; 40 mg sells for \$35–\$60), oxycodone (Roxicodone[®], a.k.a., "oxy IR" and "roxi's;" 15 mg, a.k.a., "15's;" sells for \$7–\$15; 30 mg, a.k.a., "30's" and "perc 30's;" sells for \$15–\$30), OxyContin[®] (a.k.a., "big dogs" and "oxy's," and by milligram strength, "80's" and "60's"), OxyContin[®] OC (old formulation, a.k.a., "OC's" and "Old Coins;" 80 mg sells for \$50–\$75), OxyContin[®] OP (new formulation, 40 mg sells for \$15–\$20; 60 mg sells for \$30; 80 mg sells for \$20–\$40), Percocet[®] (a.k.a., "5's," "10's," "perc's" and "sets;" 5 mg sells for \$3–\$5; 7.5 mg sells for \$5–\$8; 10 mg sells for \$7–\$10), Vicodin[®] (a.k.a.,

"vikes;" 5 mg sells for \$1–\$3, 7.5 mg sells for \$3–\$5; 10 mg sells for \$5–\$8).

In addition to obtaining prescription opioids on the street from dealers, participants also reported getting them through legitimate prescriptions written by their physicians, through hospital emergency rooms or pain clinics. Participants reported, *"I can go to the emergency room and get Vicodin[®] right now; Pain clinics will give you a drug screen first thing ... make sure you have the pain pill in your system ... give you a prescription for more pills for \$120–\$240 ... will also get a benzo [benzodiazepine] and muscle relaxer ... can only go to certain pharmacies to fill ... it's trial and error ... some won't fill the prescription."* Participants continued to describe getting prescription opioids from pain clinics in the region, as well as from Florida pain clinics in particular. A participant reported, *"A lot of people go to Florida with MRIs to get pain pills ... cost \$250 for the MRI, gotta get ahead of time ... doctor gets 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 remains oral ingestion (swallowing). Specific prescription opioids reportedly administered by injection include Dilaudid[®], immediate release oxycodone ("oxy IR" or Roxicodone[®]). Immediate release prescription opioids are more likely to be snorted if they are single entity products. A participant reported, *"Snorting all the ones [prescription opioids] that you can except for Vicodin[®]."*

A profile of a typical user of prescription opioids emerged from the data. Participants continued to describe typical users of prescription opioids as more likely to be White than other race/ethnicities. A participant reported, *"I'd say it's [prescription opioid user] more White than other races."* Treatment providers reported that users of prescription opioids are 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 the homes of relatives or friends: *"Kids raiding their grandparent's medicine cabinet [for prescription opioids] ... oh, yeah."* Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, marijuana and sedative-hypnotics.

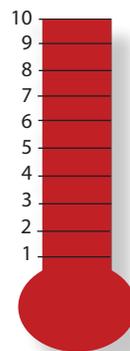
Suboxone[®] Historical Summary

In the previous reporting period, Suboxone[®] was moderately available in the region. Participants most often reported

street availability of Suboxone® as '7' or '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants reported the availability of Suboxone® as higher than in the past. Participants and community professionals alike attributed the increase in street availability to increased use by physicians and clinics, prescribing or dispensing Suboxone® for legitimate purposes. Participants stated that initial use often resulted from legitimate prescribing, but then they would obtain Suboxone® from friends, other users or street dealers. Participants reported prices for Suboxone® 8 mg to range from \$7–\$20, with the most frequently reported price being \$10–\$15. Most participants reported the use of street-purchased Suboxone® to be for primary prevention of withdrawal from prescription opioids or heroin. Participants reported both sublingual and intranasal inhalation (i.e., snorting) as primary routes of Suboxone® administration. When Suboxone® was used for abuse purposes, consumers were less likely to use it in combination with other drugs.

Current Trends

Suboxone® remains highly available in the region. Participants reported the current street availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '7' or '8'. Participants and community professionals reported that the availability of Suboxone® has increased over the past six months. Law enforcement described Suboxone® as an emergent problem in jails. Reportedly, Suboxone® is being shipped to the incarcerated under stamps or children's crayon drawings (crushed, mixed into a paste and covered by the stamps/drawings) so much so that some jails now only accept metered post cards. BCI London crime lab reported a decrease in the number of Suboxone® cases it processed over the past six months.



Current street jargon includes several names for Suboxone® including "oranges" and "stop signs." Participants reported that Suboxone® 2 mg sells for \$5 and Suboxone® 8 mg sells for \$8–\$25. Subutex®, containing just buprenorphine, sells for \$10 for 2mg and \$15–\$20 for 8 mg. Most often participants continued to report taking Suboxone® by either sublingual or intranasal inhalation (snorting). A participant stated, "For a buzz ... can snort Suboxone®, as long as you don't have other opiates in the system." There were also a few reports of use of the Suboxone® film this reporting period. Participants reported sublingual film use, with a few reports

of intravenous use, although a participant stated, "You can't shoot em [Suboxone®]. If you shoot em, it's gonna make you sick as hell."

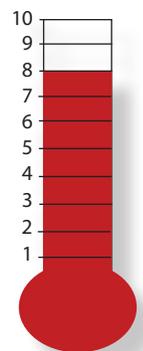
In addition to obtaining Suboxone® on the street from dealers, participants also reported getting Suboxone® from pain clinics, specific Suboxone® clinics and physicians trained to prescribe the drug. If street dealers have Suboxone®, they are more likely to be primary heroin dealers according to participants. 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 use it as a result of drug treatment. Participants did not name other drugs as being used in combination with Suboxone®.

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants reported that availability of Klonopin®, Valium® and Xanax® were '8'; Ativan® and Soma® were '5' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). BCI London crime lab reported that the number of sedative-hypnotic cases it processed remained stable. Participants reported a few ways of consuming sedative-hypnotics, with the most common routes of administration being oral consumption and intranasal inhalation (snorting). No profile of a typical user emerged from the data; however, participants reported first time users of sedative-hypnotics to be as young as 12 to 13 years of age, which was attributed to widespread availability of sedative-hypnotics in the home of parents and other family members.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) are highly available in the region. Participants and community professionals identified Xanax® as the most popular sedative-hypnotic in terms of widespread use. Participants and law enforcement most often reported current availability of Xanax® as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common participant score was also '8'. Treatment providers rated the drug's current availability as a '10'. Participants, law enforcement and treatment providers reported that the



availability of sedative-hypnotics has remained stable over the past six months. BCI London crime lab reported that the number of sedative-hypnotic cases it processes have remained stable over the past six months; however, a noted increase in sedative-hypnotics occurred for Xanax®.

Reportedly, many different types of sedative-hypnotics are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Klonopin® (a.k.a., "K's," "k-cuts" and "k-pins;" 0.5 sells for \$1, 1 mg sells for \$2–\$3, 2 mg sells for \$3–\$4), Valium® (a.k.a., "blues," "roaches," "V's" and "V-cuts;" 5 mg sells for \$1–\$3, 10 mg sells for \$2–\$5), Xanax® (a.k.a., "bananas," "footballs," "peaches," "purples" and "xani's;" 0.5 mg sells for \$1–\$2, 1 mg sells for \$1–\$3, 2 mg, a.k.a., "bars," "Lincoln logs" and "xani bars;" sells for \$3–\$6). 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 ingestion and intranasal inhalation (snorting). A participant explained, "*Eating them [sedative-hypnotics] and snorting them [are more common] ... people do shoot [inject] Xanax® a lot.*" Injection of sedative-hypnotics was only reported among those who injected other drugs.

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported getting them from doctors, the Internet, pain clinics and by robbing pharmacies. A participant reported, "*It's a lot harder to rob pharmacies now ... People go to West Virginia and Ashland, Kentucky to rob pharmacies now ... They doctor shop ... The further east you go, the more they doctor shop ... all the way out to Jackson County to doctor shop ... I know people who'll drive two hours just to go get a script [prescription].*" Participants also described how they convince doctors to write a prescription for the drugs: "*You just tell them [doctors] that you're anxious ... You just look it up on the Internet like what I'm supposed to be like feeling ... Like I'd go and memorize it [symptoms] before I went to the doctor.*"

A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants described typical users of sedative-hypnotics as more female than male, but otherwise typical use could not be defined. Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, marijuana and prescription opioids. A participant described how taking Xanax® impaired his judgment, "*when I was under the influence of Xanax®, I would take anything ... It didn't really*

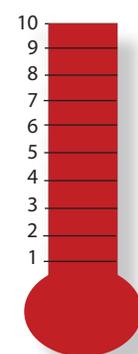
matter." Treatment providers described the amnesic effect of sedative-hypnotics in combination with alcohol as desirable among some users: "*They think that if you drink and take a Xanax®, you don't remember anything the next day, so it's the big thing to do in college ...*"

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 reported that marijuana was one of the easiest drugs to obtain, citing the close proximity to Kentucky, where outdoor grows were common, along with an increase in indoor grow operations in the region. BCI London crime lab reported that the number of marijuana cases it processed remained steady. Participants reported that the quality of marijuana varied with the most common quality score being '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that for commercial-grade marijuana, a "blunt" (single cigar) sold for \$10 and an ounce ranged in price from \$50–\$140; for high-grade marijuana, an ounce ranged in price from \$200–\$600. The most common route of administration for marijuana was smoking. Overall, participants and professionals alike were unable to define any particular group of people that use marijuana more frequently. First time users of marijuana were younger than what participants reported for any other drug use, as young as 8–10 years of age.

Current Trends



Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. A participant echoed a response heard by many others, "*People will come up to you at red lights to sell [marijuana].*" Treatment providers most often reported the drug's current availability as '10', and many said that marijuana availability was "*off the charts.*" Law enforcement reported that over-the-road truckers transport a lot of the marijuana into the region from Mexico by way of Indianapolis, Indiana. Participants and treatment providers reported that the availability of marijuana has remained stable at high levels over the past six months. Law

enforcement described an increase in the number of indoor-grow operations for marijuana: *"It's big ... We have had a huge increase in indoor manufacturing and production of marijuana ... Indoor grows are off the chart ... We think it's tied to the economy because there's people out of work ... They're looking for an income."* Hamilton County Crime Lab reported that the number of marijuana cases it processes has remained stable over the past six months.

Participant quality scores of marijuana varied from '7' to '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '9'. 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). Law enforcement described the quality of marijuana as a '10'. A law enforcement officer stated, *"The quality and purity [of marijuana] is so unbelievable, it's off the chart."*

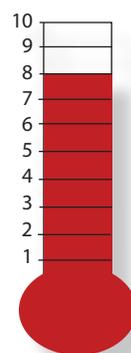
Current street jargon includes countless names for marijuana. The most commonly cited names were "dro," "nuggets," "piff" and "pot." Participants listed the following as other common street names: "brown," "dirt," "downtown brown" and "schwag" for low-grade marijuana; "commercial press," "mids," "middies," "reggie" and "regular" for mid-grade marijuana; "blueberry," "kush," "hydro," "purple haze," "northern lights" and "white rhino" for high-grade or hydroponically-grown marijuana. The price of marijuana depends on the quality desired. Participants reported commercial grade marijuana is the cheapest form: a blunt (single cigar) sells for \$10; a gram sells for \$10; 1/8 ounce sells for \$20–\$25; an ounce sells for \$100–\$150; a pound sells for \$1,000–\$1,100. Higher quality marijuana ("hydro") sells for significantly more: a blunt (single cigar) sells for \$20; a gram sells for \$15–\$25; 1/8 ounce sells for \$50; an ounce sells for \$300–\$450; a pound sells for \$2,500–\$5,000. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Participants described baking marijuana into brownies, but this was a less common route of administration.

A profile for a typical marijuana user did not emerge from the data. Participants continued to describe typical users of marijuana as, *"anyone and everyone; as young as 9 years up to 70 years."* Treatment providers also commonly said, *"I think it's anybody and everybody; There is no typical marijuana user."* Reportedly, marijuana is used in combination with alcohol, crack cocaine and powdered cocaine. The use of marijuana with crack and powdered cocaine was reported as common, with the term "primo" being used to describe lacing marijuana joints or blunts with cocaine.

Methamphetamine Historical Summary

Methamphetamine was moderately available in rural areas around the region, but rarely found in the City of Cincinnati. Participants most often reported the availability of methamphetamine as '7' in rural areas (Brown and Clermont Counties) and '0' in Cincinnati on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Methamphetamine was available in both powdered and crystal forms that were locally produced. Participants commonly reported the quality of methamphetamine as high, most often rating overall quality as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). A gram of powdered or crystal methamphetamine sold for \$80–\$100. Reportedly, the most common route of administration of methamphetamine was smoking. Participants described the typical user of methamphetamine as a White male, in his 30's–40's, and of lower socioeconomic class.

Current Trends



Methamphetamine is 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); the previous most common score was '7' in rural areas. Participants continued to report low availability in the City of Cincinnati. Participants reported that methamphetamine continues to be primarily available in powdered or crystal forms and continues to be locally produced and not brought into the region from outside sources. Treatment providers and law enforcement most often reported the drug's current availability as '5'. Law enforcement reported that lab busts and cleanups had increased in the region over the past year. Participants reported that the availability of methamphetamine has increased over the past six months. A participant stated, *"It [methamphetamine availability] had been a '4' or '5'; but now is at '8' [availability rating]."* Treatment providers also reported that the availability of methamphetamine has increased over the past six months: *"There's more demand [for methamphetamine]. It's cheap to make ... seeing a rise ... increase coming into city [Cincinnati] from rural areas."* Hamilton County Crime Lab reported that the number of powdered and crystal methamphetamine cases it processes has remained stable over the past six months.

Most participants rated the quality of powdered or crystal methamphetamine as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8'. Over the past six months, participants reported that the quality of methamphetamine has remained stable to slightly increasing.

Current street jargon includes a few names for methamphetamine. The most commonly cited names continued to be "crank," "crystal," "ice" and "meth." Current street prices for methamphetamine were variable among participants with experience buying the drug. Participants reported that a gram of locally produced methamphetamine sells for \$60–\$100, with powdered methamphetamine being on the low end of that range and crystal methamphetamine being on the high end of that range. Reportedly, the most common route of administration of methamphetamine remains smoking. Other routes of administration that were cited as less common include intranasal inhalation (snorting) and intravenous injection (shooting). Similar to other injected drugs, methamphetamine was administered through injection by those that used injection as a primary route of administration for other drugs.

A profile for a typical methamphetamine user emerged from the data. Participants described typical users of methamphetamine as White, in their mid-to-late 20's. Reportedly, methamphetamine is used in combination with heroin, (a.k.a., "speedball"). A user said the heroin–methamphetamine speedball was, "the best speedball ever" (as opposed to the heroin–crack cocaine speedball).

Ecstasy

Historical Summary

In the previous reporting period, Ecstasy [methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants reported geographic variation in availability, with citations of high availability within Cincinnati and moderate availability in areas outside of Cincinnati. Ecstasy sold for \$7–\$20 per tablet, with some dealers charging upwards of \$30 for a tablet in the suburbs. Most participants were aware that tablets sold as Ecstasy were often mixed with other drugs and that buyers were not guaranteed a pure product. Participants described the most common routes of administration for Ecstasy to include swallowing the tablets

or inserting them into the rectum. Participants described the typical user of Ecstasy as young, between the ages of 18 to 25 years of age, with first use starting as young as 15 years of age.

Current Trends

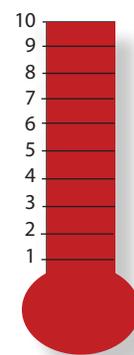
Ecstasy [methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] remains highly available in the region. Participants and treatment providers most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants and treatment providers reported that the availability of Ecstasy has remained stable over the past six months. As one treatment provider explained, "MDMA [Ecstasy] is very easy to get ... college scene, any club, bar scene, gay or lesbian scene." BCI London crime lab reported that the number of Ecstasy cases it processes has remained stable over the past six months. The crime lab also reported that Ecstasy pills usually contain multiple active substances including 5-MeO-DiPT (psychedelic and hallucinogenic drug; a.k.a., foxy methoxy), BZP, MDM, MDMA, P-FPP, TFMPP, caffeine, ketamine and methamphetamine.

No slang terms or common street names were reported for Ecstasy. Participants reported that users most often used the term "Ecstasy" or referred to the picture imprinted on Ecstasy tablets when speaking of the drug. Reportedly, common pictures on Ecstasy tablets are lightning bolts, naked ladies, pistols, Playboy® bunnies, Scooby Doo, Star of David and Transformers. Participants reported a "single stack" (low dose) Ecstasy tablet sells for \$8–\$25; a "double stack" (moderate dose) sells for \$15; a "triple stack" (high dose) sells for \$20–25. A profile for a typical Ecstasy user did not emerge from the data.

Prescription Stimulants

Historical Summary

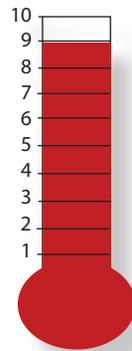
In the previous reporting period, prescription stimulants (Adderall® and Ritalin®) were highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Prices for prescription stimulants included the following: Adderall® sold for between \$3–\$5 per pill and Ritalin® sold for \$1.50 per



pill. Participants reported that the most common routes of administration were oral ingestion (swallowing) or crushing tablets for intranasal inhalation (snorting). Professionals reported that prescription stimulants were more likely to be used by White or Asian individuals between the ages of 20 years to early 30's, and while both genders use these substances, the typical user was said to be more likely female.

Current Trends

Prescription stimulants (Adderall® and Ritalin®) remain highly available in the region. Participants most often reported the availability of these drugs as '9' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get); the previous most common score was '10'. There was consensus among participants that prescription stimulants are popular among college students: *"You can easily find it [prescription stimulants] on the college campus; Adderall's big, college primarily."* Treatment providers most often reported the current availability of these drugs as '7'. Participants and treatment providers reported that the availability of prescription stimulants has remained stable over the past six months. BCI London crime lab reported that the number of prescription stimulant cases it processes has also remained stable over the past six months.



No slang terms or common street names were reported for prescription stimulants. The following prescription stimulants are available to the street-level users: Adderall® (20 mg sells for \$3–5; 30 mg sells for \$5–\$8). A profile for a typical prescription stimulants user emerged from the data. Participants described typical users of prescription stimulants as more likely to be enrolled on a college campus than anywhere else in the community. Treatment providers agreed and described prescription stimulant users as young adults between 18–26 years of age and again more likely to be enrolled on a college campus.

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, hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], over-the-counter (OTC) and prescription cough medicines and synthetic marijuana ("K2" and "Spice"). LSD and psilocybin mushrooms were moderately available in the region.

Participants most often reported LSD's availability as '5' and psilocybin mushrooms as '7' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Professionals reported that the typical user of LSD and psilocybin mushrooms was more likely to be White, less than 30 years of age and comprised of both males and females. Ketamine was mentioned as being used in the MSM (men who have sex with men) community by both White and Black males less than 30 years of age. Reportedly, synthetic marijuana was being used by a few participants for recreational use. Participants said synthetic marijuana was growing in popularity among many users. A few participants reported use of prescription cough medicines that contain codeine and OTC cough medicines containing dextromethorphan (DXM) (Robitussin® DM).

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. A few participants reported use of drugs such as dextromethorphan (DMX) (Robitussin® DM, Coricidin® HBP cough/cold) among high schoolers as well as inhalant abuse from air dusters in the same population. A treatment provider said, *"Air duster inhalants are very popular with high school students."* Treatment providers also reported abuse of the Coricidin® HBP cough/cold product as college aged young adults reportedly took enough to produce hallucinations. A treatment provider explained, *"I remember people taking Coricidin® 'cause it made them trip, like, I think if you take it with alcohol, it can make you hallucinate."*

Bath salts (synthetic compounds that can produce a high similar to a stimulant or hallucinogenic drug) are highly available in the region. These compounds commonly contain methylone, mephedrone or MDPV. The generic term, bath salts, is in and of itself 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. Readily available from drug stores, head shops and some convenience marts, bath salts were legally sold during this reporting period. Several participants and treatment providers said bath salts were highly available in the region. Participants in rural areas cited high bath salts availability in adult stores. Treatment providers described learning recently about the abuse of these products from complications seen in users (difficulty breathing or losing the ability to function "normally"). BCI London crime lab reported that the number of bath salts cases it processes has increased over the past six months. The crime lab also reported most forms of bath salts contain MDPV and methylone, which is a relative of a chemical often found in Ecstasy, MDMA. While these products have been

banned in a number of states in the U.S., they have not been controlled on a federal level at this point. Increasing reports of significant adverse effects, including death, have been reported with abuse of these bath salts. Treatment providers described that individuals on probation found these products attractive since they could be abused for a high and do not show up in current drug screens. Law enforcement reported that the use of bath salts has been implicated in several deaths in the state.

Conclusion

Bath salts, crack cocaine, heroin, marijuana, prescription opioids, prescription stimulants, sedative-hypnotics and Suboxone® remain highly available in the region. Noted increases in availability over the previous six months exist for heroin, methamphetamine and Suboxone®. Availability of all types of heroin (brown and white powdered and black tar) has increased from the previous reporting period. The Hamilton County Coroner's office saw a higher number of heroin-related deaths. While participants believed that many of these heroin deaths were related to heroin adulterated with fentanyl, the coroner's office did not corroborate these reports. It is suspected that the heroin supply may have an increased potency, leading to more dire consequences to the user. Methamphetamine availability also appears to be on the rise, and participants and treatment providers reported higher demand for the drug throughout the region. Participants mentioned using methamphetamine to "speedball" with heroin. Every group interviewed unanimously agreed that availability of Suboxone® has increased over the past six months. Law enforcement said Suboxone® is a problem in jails; the drug is being shipped surreptitiously (under stamps) so often that some jails now only accept metered post cards. While crack cocaine availability remains high, so do the number of reports of poor quality. Participants continued to report that they either "re-rock" crack cocaine to make it more potent or seek out powdered cocaine to manufacture their own crack cocaine. Prescription opioids remain popular throughout the region. Treatment providers and law enforcement said Opana® is increasing in both desirability and availability, due in part to the reformulation of OxyContin® OC. Participants identified hydrocodone-containing opioids (Lortab® and Vicodin®) and oxycodone-containing opioids (OxyContin® IR, Percocet® and Roxicodone®) as the most popular prescription opioids in terms of widespread use. Marijuana availability continues to remain high and stable in the region. Law enforcement described an increase in the number of indoor-grow operations for marijuana, which create higher quality plants for purchase. Ecstasy availability also remains high in the region. BCI London crime lab reported that Ecstasy pills usually contain multiple active substances including

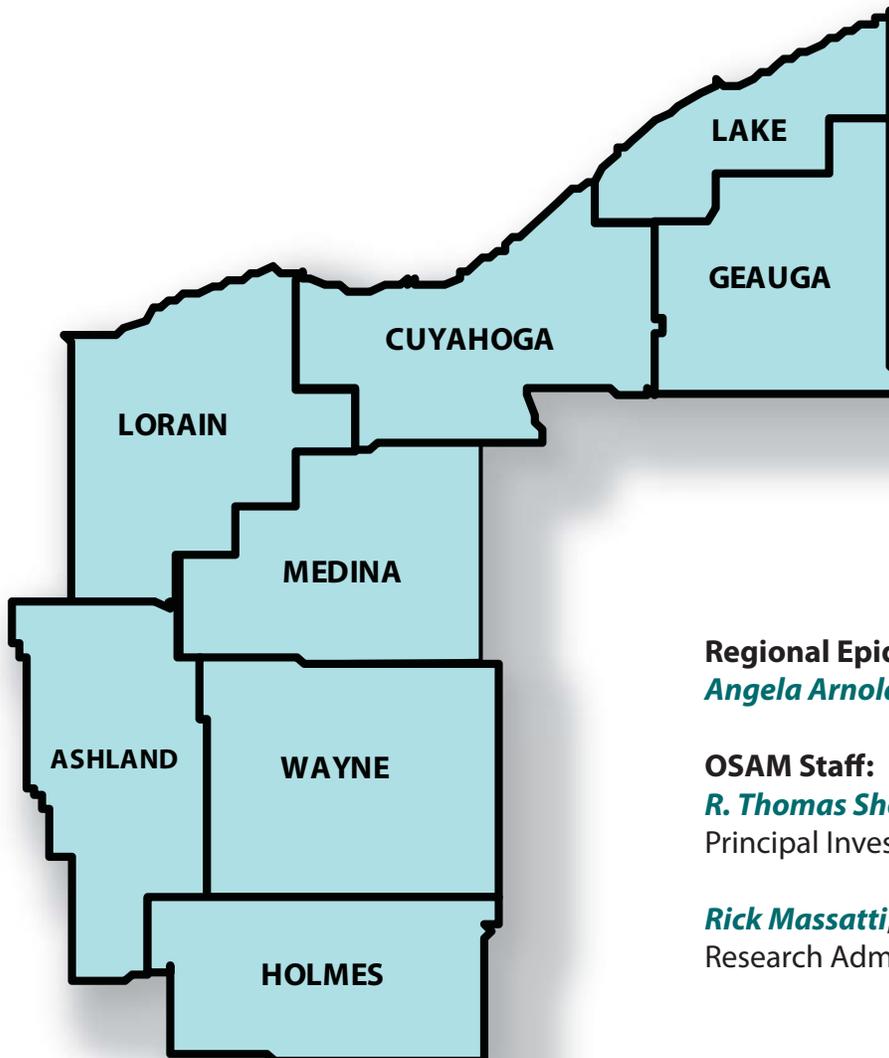
5-MeO-DiPT (psychedelic and hallucinogenic drug; a.k.a., foxy methoxy), BZP, MDM, MDMA, P-FPP, TMFPP, caffeine, ketamine, and methamphetamine. Finally, bath salts are highly available in the region. Treatment providers described recently learning about the abuse of these products from complications seen in users (difficulty breathing or losing the ability to function "normally"). BCI London crime lab reported most forms of bath salts contain MDPV and methylone, which is a relative of a chemical often found in Ecstasy, MDMA. Law enforcement reported that the use of bath salts has been implicated in several deaths in the state.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Cleveland Region

January-June 2011

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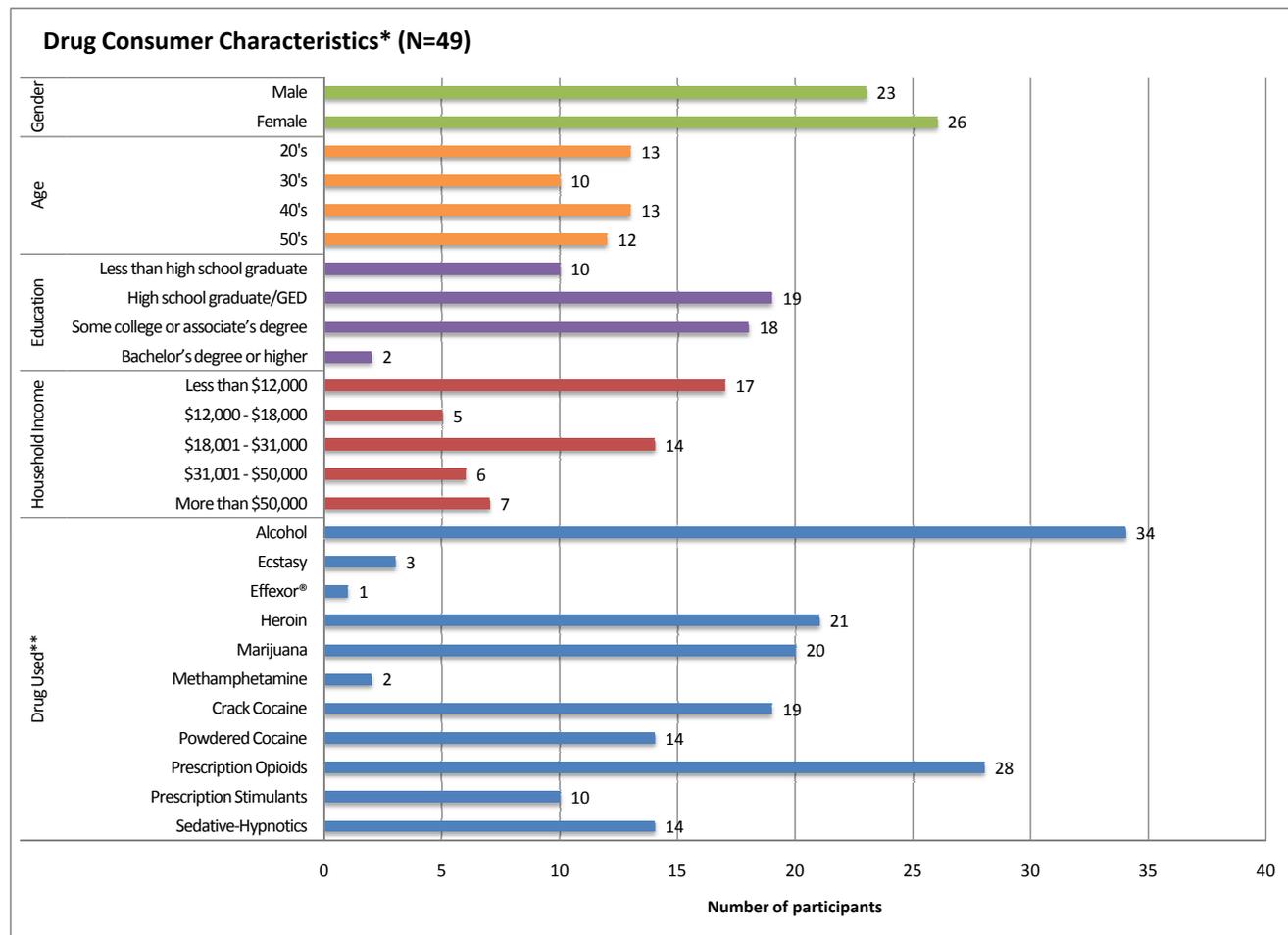
Rick Massatti, MSW
Research Administrator

Regional Profile

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

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

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



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

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Cuyahoga, Geauga and Lake Counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via focus group interviews, as well as to data surveyed from the Cuyahoga County Coroner's Office and the Bureau of Criminal Identification and Investigation (BCI) Richfield Office, which serves the Cleveland, Akron and Youngstown areas. All secondary data are summary data of cases processed from July to December 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current BCI data correspond to the current reporting period of participants. In addition to the aforementioned data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2011.

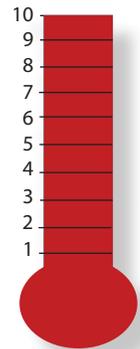
Powdered Cocaine Historical Summary

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

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

Current Trends

Powdered cocaine remains highly available in the region, but often perceived to be harder to get than crack cocaine. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '8'. Although it was perceived as a drug that would require connections to obtain, especially powdered cocaine of good quality, users still supplied high availability scores. A participant stated, "*Crack [cocaine] is guaranteed, powder [cocaine] is a little harder [to locate].*" Law enforcement most often reported the drug's current availability as '8'. A law enforcement officer said, "*I just got some [powdered cocaine] the other day. I worked one shift, and here's a guy walking down the street drunk. Shook him down and he had a dollar bill rolled up really tight, and there's cocaine all over it. I don't think it's hard to get.*" Collaborating data also indicated that powdered cocaine is readily available in the region. The Cuyahoga County Coroner's office reported 11.5 percent of all deaths it investigated were drug related (i.e., had an illegal substance present or legal drug above the therapeutic range); in the last reporting period, 10.7 percent of all deaths were drug related. Furthermore, the coroner reported cocaine as present in 35.7 percent of all drug-related deaths (this is an increase from 29.8 percent from the previous six-month reporting period; Note coroner's data is aggregate data of powdered cocaine and crack cocaine and does not differentiate between these two forms of cocaine). In addition to the coroner's data, media outlets across the State reported on significant arrests this reporting period involving cocaine trafficking in the region. In March, *The Columbus Dispatch* reported that 28 people were indicted in federal court in Cleveland on several charges, including conspiracy and cocaine dealing. Allegedly, the 28 were involved in smuggling \$6 million worth of cocaine to Ashtabula County via a stash house (house used for drug storage and distribution) in Eastlake (www.dispatch.com, March 15, 2011). In June, *The Plain Dealer* reported that Cleveland Police found 16 kilograms of powdered cocaine in a disabled tractor-trailer on Interstate 77 in the city (www.cleveland.com, June 8, 2011).



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

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

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

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

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

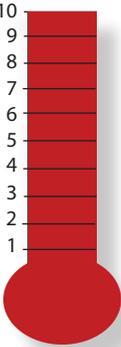
Reportedly, powdered cocaine is used in combination with alcohol, Ecstasy, heroin, marijuana and sedative-hypnotics. Specifically, heroin users will use powdered cocaine to “come back up,” as one participant explained, *“Personally, in my age group, junkies [heroin addicts] will use it [powdered cocaine]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

Crack Cocaine

Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described crack cocaine as one of the easiest drugs to acquire. Law enforcement also rated the availability of crack cocaine as high, reporting availability as '9'. The most common participant quality score for crack cocaine was '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut (adulterated) with other substances. BCI Richfield crime lab cited as cutting agents: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine. Participants reported 1/4 gram of crack cocaine sold for \$40; 1/8 ounce, or "eight ball," sold for about \$150. The majority of crack cocaine users reported buying the drug in small quantities ("20 rocks" for \$20). By far, the most common route of administration for this form of cocaine was smoking. Participants tended to agree that crack cocaine users varied in age and race, and they were unable to identify a "typical" crack cocaine user.

Current Trends



Crack cocaine remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Unlike other drugs, crack cocaine is readily available from unknown dealers at street corners. Several participants echoed these sentiments: "You can go to every corner, and someone's hollering to you [to buy crack cocaine]; You can go to that street corner and get it [crack cocaine, pointing to a corner outside the window of the interview location]." While crack cocaine has remained perennially available in the City of Cleveland, law enforcement and treatment professionals in rural southern and eastern locales of the region most often reported the drug's current availability as '9', indicating that crack cocaine is just as available in these areas. Participants overwhelmingly agreed that the availability of crack cocaine has remained the same over the past six months. A participant said, "The [crack cocaine] availability of six months ago is the same. Things just don't change." Law enforcement officers reported that the availability of crack cocaine has remained high over the past six months, but

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

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

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

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

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

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

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

Heroin

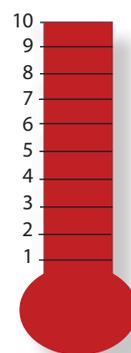
Historical Summary

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

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

Current Trends

Heroin remains highly available in the region. Participants most often reported overall current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10’. Almost all participants stated that heroin was easy or very easy to get. A participant reported, *“I’m from Detroit, and I was here in Cleveland, and in one day I found drugs [heroin].”* Law enforcement and treatment providers most often reported the drug’s current availability as ‘8’; the previous most common score was ‘9’. When asked to identify the most urgent or emergent drug trends in their purview, all professionals indicated that heroin is a concern for their service population. Law enforcement in Medina County reported, *“Availability is very easy to get ... 95 percent of what we buy [heroin] is in the powder form. We have a few*



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

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

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

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

Participants were equally divided on their opinions on whether the availability of brown powdered heroin has increased or remained the same over the past six months. Those who felt heroin is more available reasoned that increasing availability is due to 1) increased demand among younger users, 2) prescription opiate abuse and 3) pressure from dealers who desire to switch their clients from crack cocaine sales to more-profitable heroin. Said two users about this phenomenon: "*The new dealers, they have a baggy full [of heroin] and they'll just take a whole lot of junk, make up a piece of paper and throw it in. No measuring, they just give it away; I did [high-quality heroin] and I didn't want any crack [cocaine]. My dealer was trying to hook me on heroin.*" Another participant said, "*People started doing OxyContin® and opiates and getting hooked on it, and the withdrawals are really bad. People were introduced to heroin, and the dealers saw it as an opportunity.*" Law enforcement and treatment providers reported that the availability of heroin has remained highly available over the past six months. A provider reported, "*It's [heroin] easy to get, and it's cheap, so we're seeing it more in the poorer population because it's affordable. Someone said to me [that] the people that used to smoke crack [cocaine] are now using heroin because it's cheap.*" BCI Richfield crime lab reported that the number of powdered heroin cases it processes has increased, reporting having processed approximately 1,500 heroin cases over the last six months up from 803 cases for the previous reporting period. The number of heroin cases has surpassed the number of marijuana cases, making powdered heroin the most processed drug through BCI Richfield crime lab. The lab reported a decrease in the number of black tar heroin cases it processed over the last six months.

Most participants generally rated the quality of heroin as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '10'. Participants reported that heroin in Cleveland is cut (adulterated) with cocaine, fentanyl, paregoric (antidiarrheal agent), prescription opioids (OxyContin®), sleeping pills and vitamin B. A participant called heroin cut with fentanyl, "Mac 22." BCI Richfield crime lab cited procaine and lidocaine (local anesthetics) as commonly used to cut powdered heroin. Fake heroin was also more commonly reported as being bought by law enforcement agents. Over the past six months, participants reported that the quality of heroin has varied, even when purchased from the same source. Participants were equally divided on their perceptions of heroin quality improving, decreasing, or remaining the same, but most users agreed that high-quality, potent

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

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

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

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

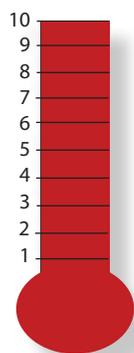
Reportedly, heroin is used in combination with alcohol, crack cocaine, ketamine, marijuana, powdered cocaine, prescription opioids (methadone, OxyContin® and Percocet®) and sedatives-hypnotics (Valium® and Xanax®). Stimulants such as crack cocaine are used to “come up” off heroin, and other opioids are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

Prescription Opioids Historical Summary

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

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

Current Trends



Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '9' or '10'. Participants identified OxyContin® OP, Percocet® and Vicodin® as the most available prescription opioids in terms of widespread use. OxyContin® OC (the discontinued crushable form) continues to become more difficult to obtain. A participant reported, "Oxy's [OxyContin® OC] are harder to get now.

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

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

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

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

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

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

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

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

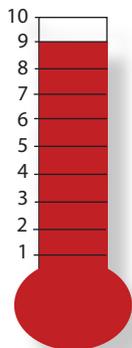
Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, crack cocaine, marijuana, powdered cocaine and sedative-hypnotics. Combining prescription opioids with these drugs is common, as the effects of prescription opioids are said to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

Suboxone® Historical Summary

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

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

Current Trends



Suboxone® remains highly available in the region. Participants most often reported the street availability of Suboxone® as '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '8' or '10'. While only a small number of participants had knowledge of the drug, only one participant reported that Suboxone® is difficult to obtain. Other participants echoed comments such as the following regarding the availability of Suboxone®: "They're everywhere. Get them [Suboxone®] from doctors, friends. They're

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

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

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

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

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

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

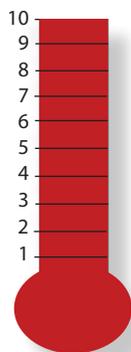
Sedative-Hypnotics

Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants listed the most common sedative-hypnotics in terms of widespread use as Klonopin®, Soma®, Valium® and Xanax®. There was little consensus among participants about the change in availability over the previous six months; participants on the east side of Cleveland thought that availability had decreased while participants on the west side thought that availability had remained the same. Participants did not report buying sedative-hypnotics from street dealers. Most frequently participants obtained sedative-hypnotics from friends,

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

Current Trends



Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. More specifically, participants most often reported the availability of Ativan® as '10', Klonopin® as '8', Soma® as '10', Valium® as '10' and Xanax® as '8'. Participants identified Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Law enforcement

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

Reportedly, many different types of sedative-hypnotics (a.k.a., "downers" and "willies") are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ambien® (\$2 per pill), Ativan® (\$1–\$2 per pill), Klonopin® (\$2 per pill), Lunesta® (\$3 per pill), Soma® (a.k.a., "same old same old;" \$2 per pill), Valium® (a.k.a., blue guys"

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

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

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

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

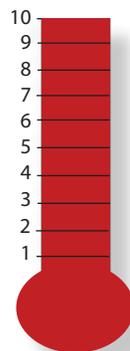
Marijuana

Historical Summary

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

Current Trends

Marijuana remains highly available in the region. Every participant that supplied a score reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. A participant said, *"It's easy to get [marijuana]. Very easy. You can get it 24/7."* Law enforcement and treatment providers also unanimously reported the drug's current availability as '10'. One professional quipped, *"If it was on your [availability] scale, it's [marijuana's current availability] an '11' or a '12.'"* Participants and community professionals reported that the availability of marijuana has remained the same over the past six months. However, higher quality marijuana was reported to be more available by both drug consumers and professionals. Media reports from the region reported several marijuana busts over this reporting period. In March, *The Plain Dealer* reported that during a routine traffic stop, the State Highway Patrol pulled over a Colorado man with \$1 million of high-grade marijuana. Police reported, *"The marijuana is an expensive kind that comes from British Columbia, Canada. It is one of the most potent strains of marijuana available, with a THC content of 30 percent compared with only 4 percent in traditional marijuana"* (www.cleveland.com; March 16, 2011). BCI Richfield crime lab reported that the number of marijuana cases it processes has remained stable over the past six months.



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

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

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

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

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

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

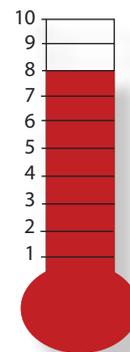
Methamphetamine Historical Summary

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

Current Trends

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

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



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

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

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

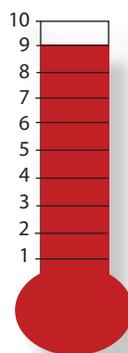
A profile for a typical methamphetamine user did not emerge from the data. A participant described typical users of methamphetamine as people with money who can afford a relatively expensive, high quality crystal methamphetamine. However, law enforcement and treatment providers thought that the typical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

Ecstasy

Historical Summary

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

Current Trends



Ecstasy [methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] remains highly available in the region. Participants most often reported the drug's current availability as '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. Participants frequently commented that the drug continues to be regularly used in night clubs: "Yeah, you can get it [Ecstasy], but that is more available in clubs and stuff like that." Participants reported that the availability of Ecstasy has remained stable over the past six months. Law enforcement was split as to whether the drug's availability has remained the same, increased or decreased. An officer that reported a decrease in Ecstasy availability over the last six months said, "We don't see Ecstasy in traffic stops as much anymore. It's fallen by the wayside. I'm sure it's out there a lot, but we're not seeing it nearly as much. Today it's Ritalin®, Adderall® and Xanax®." BCI Richfield crime lab reported that the number of Ecstasy cases it processes has decreased over the past six months.

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

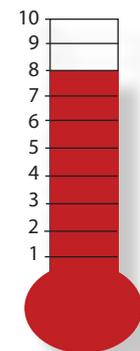
analog (psychoactive stimulants) and other clandestine uncontrolled substances (bath salts) as cutting agents for Ecstasy.

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

Prescription Stimulants
Historical Summary

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

Current Trends

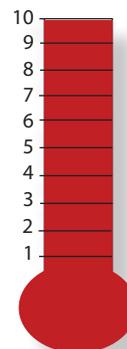


Prescription stimulants (Adderall® and Ritalin®) are highly available in the region. Participants rated the current availability of these drugs as ‘8’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was ‘6’. Participants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

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

Bath Salts¹

Bath salts are highly available in the region. Participants reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants gave a high availability rating because bath salts are sold legally in drug stores and convenience marts. Law enforcement and treatment providers also most often reported the drug’s current availability as ‘10’. The comments of a treatment provider summarize the opinions of both groups: *“You can still buy it [bath salts] in the head shops. It’s packaged pretty. It looks like crystal form. You crush them and you can snort them, inject them ... They’re like \$40. You can walk into a store, so they’re readily accessible.”* Both groups reported that the availability of bath salts has increased over the past six months. Drug consumers frequently cited this drug as up-and-coming. Two police officers described the rise in bath salt popularity as, *“It’s available, but it [bath salt cases] just doesn’t come across our desk because it’s not illegal yet. It’s everywhere around us, so it’s coming.”* The Plain Dealer reported that police were called on several occasions to investigate people high on bath salts. On one occasion, a Medina man was high on bath salts, and he hallucinated *“intruders disguised as chairs,”* and on another occasion, a 15-year-old girl in Willoughby went into seizures after smoking the drug (www.cleveland.com; March 23, 2011).



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

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

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

Other Drugs

Historical Summary

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

Current Trends

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

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

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

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

LSD (lysergic acid diethylamide) is highly available in the region according to the few participants with experience purchasing the drug. Participants most often reported LSD's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While most participants had not encountered the drug, those with experience said, *"It's [LSD] around. There's always one place you can get it."* Only three participants were able to rate the quality of LSD, and they gave scores ranging from '7' to '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants did not provide pricing information, but they said that LSD was available in microdots (small tablets) and sugar cubes. These respondents disagreed as to whether LSD quality has remained the same, increased or decreased over the past six months. As one participant said, *"It [LSD quality] fluctuates. Sometimes it's garbage. Sometimes it's one-hit wonders."*

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

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

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

Conclusion

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

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

use of vaporizers, which are devices that heat marijuana to precise temperatures and boil off marijuana compound's vapor for inhalation, whereby the user receives a higher dose of THC.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Columbus Region

January-June 2011

John R. Kasich, Governor
Orman Hall, Director



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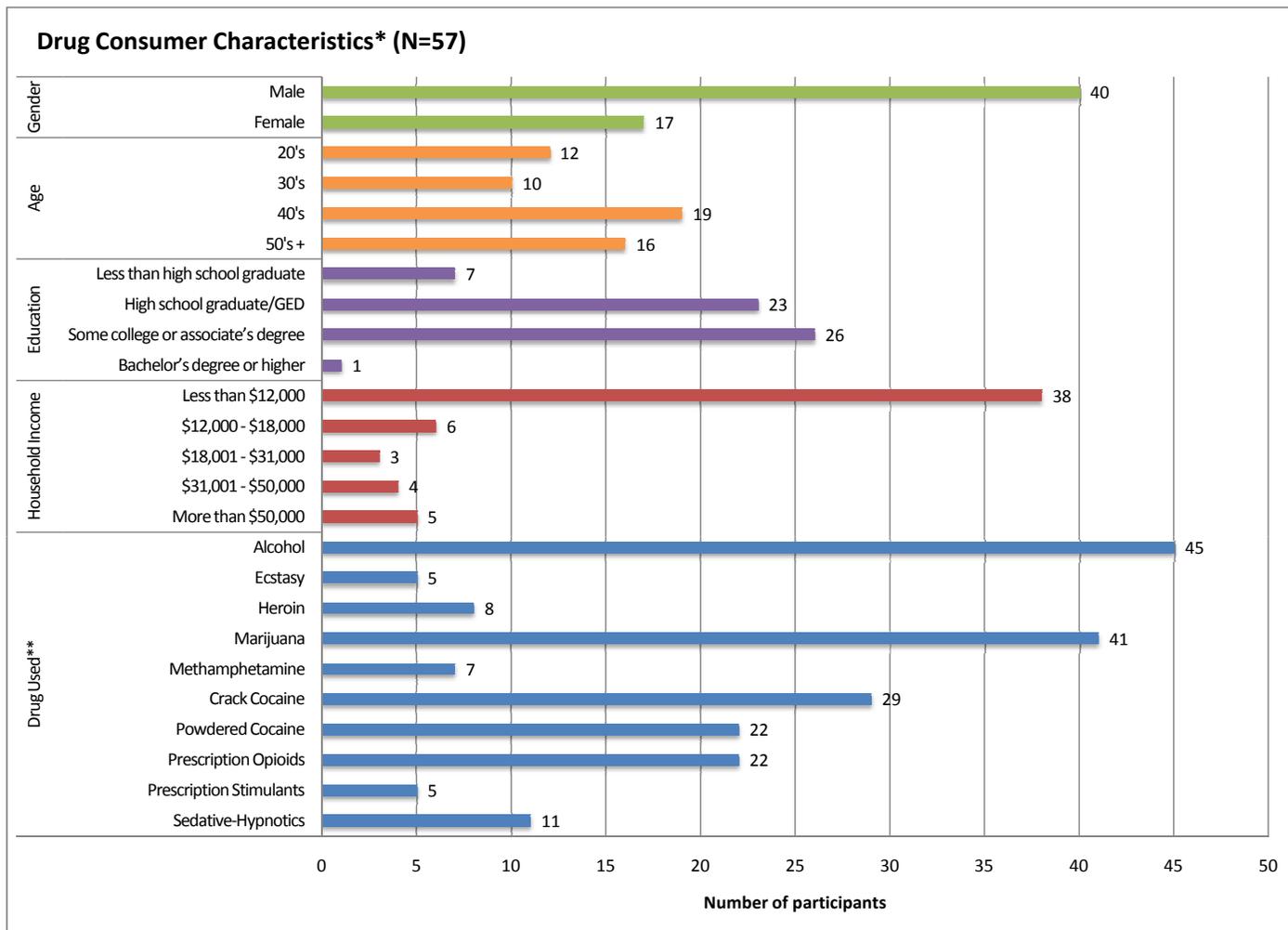
Regional Profile

Indicator ¹	Ohio	Columbus Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,542,645	2,095,033	57
Gender (Female), 2009	51.2%	50.1%	29.8%
Whites, 2009	82.2%	79.6%	49.1%
African Americans, 2009	11.9%	12.9%	42.1%
Hispanic or Latino Origin, 2009	2.8%	3.1%	3.5%
High school graduates, 2009	83.0%	86.1%	87.7%
Median household income, 2009	\$45,467	\$47,553	Less than \$12,000 ²
Persons below poverty, 2009	15.1%	14.9%	30.9% ³

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

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

Poverty status was unable to be determined for two respondents due to missing or insufficient income data³.



*Not all participants filled out forms; therefore numbers may not add to 57.

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

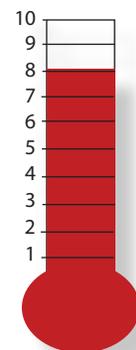
Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Fairfield and Franklin Counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via focus group interviews, as well as to data surveyed from the Bureau of Criminal Identification and Investigation (BCI) London Office, which serves Central and Southern Ohio. BCI data are summary data of cases processed from July to December 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current BCI data correspond to the current reporting period of participants. In addition to the aforementioned data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2011.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was readily available in the region. Participants most often reported the drug's availability as '7' and community professionals as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Overwhelmingly, crack cocaine was considered the most obtainable form of cocaine. The most common participant quality score for powdered cocaine was '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). All users agreed that the quality of powdered cocaine was dependent upon the dealer. Participants reported that powdered cocaine was often cut (adulterated) with other substances to maximize profitability. According to the Columbus Police Crime Lab, creatine and the local anesthetics of benzocaine and procaine were used as cutting agents for powdered cocaine. Participants reported that a gram of powdered cocaine ranged in price from \$50–\$100. Reportedly, the most common route of administration for this form of cocaine was intranasal inhalation (snorting). Many users reported a progression of methods, starting with snorting and then progressing on to smoking and intravenous injection. Use was perceived to differ according to class, race and age. Participants noted a trend toward younger users, age 20, and sometimes younger; "rich kids" typically snort the drug. Participants reported that powdered cocaine was often injected concurrently with heroin (a.k.a., "speedball").

Current Trends



Powdered cocaine remains readily available in the region. Participants most often reported the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '7'. While participants described powdered cocaine as available, they reported that drug does not have high street visibility, meaning one would have to make connections to buy it. Participants stated, *"I had to know somebody first. I know I couldn't go on the street and find it [powdered cocaine]; Drug dealers kept powder [cocaine] for themselves. You just have to know the right people."* Community professionals most often reported the drug's current availability as '7'; the previous most common score was '8'. Narcotics officers commented, *"The availability [of powdered cocaine] is there; When we're hitting the crack houses, it's common to find powder cocaine there also."* Participants reported that the availability of powdered cocaine has decreased over the past six months: *"You have to go to certain areas [to buy powdered cocaine]; Dealers are using it [powdered cocaine] [for] personal usage and to rock it up [to manufacture crack cocaine]; I used to work for this dealer, and he had nothing but powder [cocaine], but it's supply and demand, so he had to find a way to get it rocked. They make more [money] with crack [cocaine] than they do with powder [cocaine]."* A participant from Fairfield County noted, *"I haven't heard of it [powdered cocaine] for quite a while because of all the heroin. You can get it though."* Community professionals reported that the availability of powdered cocaine has remained the same over the past six months. A treatment provider reported, *"It's [availability of powdered cocaine] sporadic. Opiates are taking over."* BCI London crime lab reported that the number of powdered cocaine cases it processes has increased over the past six months.

Most participants rated the quality of powdered cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was also '5'. Participants reported that powdered cocaine in Columbus is cut (adulterated) with Enfamil®, lactose, mannitol (diuretic), Similac®, soda and vitamin B12. Participants reported that the quality of powdered cocaine has decreased over the past six months: *"Not really cocaine 'cuz it's cut so much, and it's went into a recession. It [powdered cocaine] costs more, you get less. Quality and amount has diminished; You might as well do something else [because the quality of powdered cocaine is so poor]; The stuff they [dealers] cutting it [powdered cocaine] with ... really they just make a chemical to make you think it's cocaine; If they [dealers] short [on powdered cocaine], they*

throw something in to make up the weight.” BCI London crime lab continues to cite the following substances as commonly used to cut powdered cocaine: levamisole (livestock dewormer) is the cutting agent in most cases, but other agents like boric acid (found in antiseptics and insecticides), inositol (vitamin-like health supplement), local anesthetics (benzocaine, lidocaine and procaine), caffeine (NoDoz®) and sucrose (table sugar) are also used to cut 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: “Christina Aguilera,” “critical,” “fire,” “good good,” “Peruvian flake,” “pow wow,” “sugar booger,” “sweet cousin” and “whip.” Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine, with overall prices slightly lower than previously reported. Participants reported that a gram of powdered cocaine sells for \$50–\$75, depending on the quality; 1/8 ounce, or “eight ball,” sells for \$100; an ounce sells for \$1,200. Some participants continued to report that dealers buy powdered cocaine to make crack cocaine in order to make a greater profit. A participant stated, *“That’s crazy [the price of powdered cocaine]. Why do that, buy ‘girl’ [powdered cocaine]? I’d rock it [powdered cocaine] up [into crack cocaine] and try to get more [profit] out of it.”* Participants reported that the most common way to use powdered cocaine remains intranasal inhalation (snorting), although intravenous injection (shooting) was also frequently mentioned. A heroin user in treatment in Fairfield County commented that injection of powdered cocaine is common, especially among heroin users: *“A heroin addict, they’re going to shoot anything, because they’re heroin addicts.”* Participants continued to explain that new users typically start use of powdered cocaine via intranasal inhalation, progress to smoking and finally to shooting.

A profile for a typical powdered cocaine user did not emerge from the data. Narcotics officers commented, *“So the old stereotypes aren’t true: Whites like powder [cocaine] and Black people like crack [cocaine]. I don’t think it’s ever really been that way; What we’ve seen from the tactical side is not a lot where it was the White, middle-class people doing powdered cocaine. Now it’s everything. You stop the guy, and he’ll have a little crack in his pocket and a little powder.”* A participant noted, *“All kinds of [powdered cocaine] users. Rich people get better quality and in larger quantities.”* A treatment provider said, *“They [powdered cocaine users] have more access to resources than our folks. They would just get crack [cocaine].”*

Reportedly, powdered cocaine is used in combination with alcohol, heroin and marijuana. All of the aforementioned

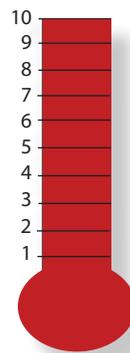
drugs are used to counteract the cocaine high and to help the user “come down.” Heroin and powdered cocaine continue to be injected together by some users in a “speedball” while alcohol and marijuana are used after powdered cocaine use. Participants indicated that all of the above practices are very common. Participants in Fairfield County reported using powdered cocaine with benzodiazepines (Xanax®) because these drugs, *“helps you sleep better.”*

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). Participants described crack cocaine as extremely easy to get. The most common participant quality score for crack cocaine was ‘4’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that crack cocaine was most often cut (adulterated) with other substances to “blow it up” or make it seem larger than it really was. According to the Columbus Police Crime Lab, levamisole (livestock dewormer) was the cutting agent in 90 percent of crack cocaine cases it processes. Participants reported that 1/8 ounce of crack cocaine, or “eight-ball,” ranged in price from \$110–\$120. However, crack cocaine users reported that users could *“buy any size [amount of crack cocaine] you want,”* even in amounts as low as a few dollars. By far, the most common route of administration for this form of cocaine was smoking. Participants noted that crack cocaine was used by all races and socioeconomic groups, as well as, by all ages (early teens to the elderly).

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 commented on the extreme availability of the drug, saying things like, *“Pull over to the side of the road, and it [crack cocaine] will come to you; I could go to Walmart® right now and get some. It’s [crack cocaine] always available.”* Participants also spoke of the common lingo crack cocaine dealers use to solicit their drug to interested parties: *“Are you straight? That’s how they [dealers] approach it. ‘You got a cigarette? Are you looking [for crack cocaine]?’”* Participants also noted that crack cocaine paraphernalia is

readily available in corner stores and drive-throughs. Several participants agreed when one said, *“You ask for a brown bag special: Crack [cocaine] stem with a rose, Chore Boy® and wire, sold as novelties.”* Some participants even talked about store owners allowing crack cocaine sales in their stores: *“If you standing outside a corner store, the police is gonna mess with you because they’re going to say that your store is attracting crack [cocaine] business. So what they [store owners] do is, they allow the crack dealers to come inside the store. The potato chip rack is famous on the east side. You buy yourself a little piece of candy and that way you’re going in the store instead of being outside the store buying drugs.”* Community professionals most often reported the drug’s current availability also as ‘10’. Crack cocaine was described as *“always available”* by clinicians and *“there if you want it”* by narcotics officers. Participants reported that the availability of crack cocaine has remained stable over the past six months. Treatment providers and narcotics officers also reported that the availability of crack cocaine has remained the same over the past six months. BCI London crime lab reported that the number of crack cocaine cases it processes has remained stable over the past six months.

Most participants rated the quality of crack cocaine as ‘4’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the previous most common score was also ‘4’. Fairfield County participants rated the overall quality of crack cocaine as ‘6’. Participants reported that crack cocaine in Columbus is cut (adulterated) with drywall, Enfamil®, Orajel®, Similac® and vitamin B12. A participant reported, *“No cocaine in it [crack cocaine]. It’s all chemicals. You don’t get no high, but you want some more. Just enough [cocaine in crack cocaine] to make you want more.”* Another participant agreed with that sentiment, *“I think the quality of everything is going down. The dope boys [crack cocaine dealers] are getting greedier. I’ve seen a lot of the boys ... what they do is start with the first trip you make, they’ll give you the really good shit, then each time you come to them that same night, the quality is going to go down a little bit.”* Many participants asserted that the quality depended on the dealer. Participants reported that the quality of crack cocaine has remained the same over the past six months. BCI London crime lab continues 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: “panty droppers,” “ready,” “ya-yo” and “work.” Current 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 sells for \$10, depending on the quality; 1/8 ounce,

or “eight ball,” sells for \$75–\$125. Crack cocaine continues to be most often purchased in small quantities for a few dollars. While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. As one participant explained, *“Most people are smokin’ it [crack cocaine]. Some people is injecting, but for the most part smoking.”* A few participants said that crack could be broken down with vinegar or lemon juice and intravenously injected.

A profile of a typical user of crack cocaine did not emerge from the data. Several participants agreed, *“Crack [cocaine] doesn’t discriminate.”* A treatment provider noted, *“We’ve had ‘em [crack cocaine users] 55 years old, younger and suburban. Crack or heroin gets them into treatment. The younger women, they don’t have the life skills that it takes to maintain that lifestyle. They’re coming in quicker with more consequences ... They come in a lot more beat up which is another reason they’re in sooner.”*

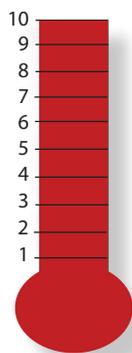
Reportedly, crack cocaine is used in combination with alcohol, heroin and marijuana. Crack cocaine is mixed with marijuana in a joint called a “primo” or with tobacco in a cigarette called a “cigmo.” Alcohol, heroin and marijuana are used to mitigate the negative effects of crack cocaine: *“You come down off of it [crack cocaine], you just blaze off some blunts [marijuana] and go to sleep.”*

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’ (high availability, extremely easy to get). Participants described heroin’s availability as *“the new crack [cocaine],”* highlighting the drug’s high popularity and widespread use. Participants reported that users were switching from prescription opioids to heroin because heroin was cheaper and easier to obtain; also cited as a reason for the progression to heroin use was the change in formulation of OxyContin®, which made the choice drug difficult to abuse. In the Columbus region, black tar heroin was the most common form of heroin, and reportedly, it was typically purchased from Mexican dealers. The most common participant quality score for heroin was ‘6’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Heroin available in the region was “very pure” according to the BCI London crime lab, but benzocaine (local anesthetic) and metamizole (analgesic and antipyretic) were cited as cutting agents. Participants reported that a gram of heroin ranged in price from \$80–\$100, depending on quality;

however, many participants reported buying “baggies/ stamps,” or 1/10 gram (“balloon”), for \$10. The most common route of administration for heroin was intravenous injection. Treatment providers reported seeing very young people coming into treatment for heroin addiction, particularly young, White males who started using in high school and often came from suburban areas.

Current Trends



Heroin remains highly available in the region. Participants and community professionals 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 stated, “It’s [heroin] everywhere.” Another participant reported, “A few years back, I would never see people [using heroin] in the crack house. Now in the crack house, you see heroin people in there shootin’ up [injecting heroin]. There’s more people doin’ it [using heroin].” A professional in Fairfield

County noted, “I had a nineteen year old tell me it’s easier for them to walk down the street and get heroin than it is for them to get beer [because they are underage].” While many types of heroin are currently available in the Columbus region, participants continued to report the availability of black tar heroin as most available, rating its availability as ‘10’. Black tar heroin is perceived as safer and powdered heroin as unpredictable, but a participant reported, “You can get anything you want.” Participants and community professionals reported that the availability and use of heroin has remained high over the past 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: “People was on opiate medication, and they can’t afford it anymore. That’s what happened to me.” Treatment professionals noted, “There is more demand and more dealers. Not just inner city. This is urban America. They have the resources to get it [heroin].” Regional media outlets reported on several heroin busts by law enforcement over this current reporting period. *The Delaware Gazette* reported, “The Delaware County Sheriff’s Office seized about \$67,000 in cash and about a pound and a half of heroin ... that highlights a growing heroin problem in Delaware County” (www.delgazette.com, Feb. 23, 2011). *The Columbus Dispatch* reported that 39 people in Fairfield County were arrested and charged with drug trafficking and related crimes. The 39 arrested were accused of selling, “a smorgasbord of illegal drugs, including heroin, crack cocaine, methamphetamine and prescription painkillers” (www.dispatch.com, April 21, 2011). Reportedly, among the drugs confiscated were 185 balloons

of heroin, which *Dispatch* reporters cited would probably sell for \$7–\$10 per balloon in bulk quantities and \$20–\$30 per balloon retail. Additionally, *WCMH NBC 4* in Columbus reported on two sensational heroin busts: “*Woman Hides 47 Heroin Balloons In Her Body*” (arrest made in Delaware County, www.nbc4i.com, May 6, 2011) and “*4 Accused of Smuggling Heroin Into Jail In Boxer Shorts*” (arrest made at Franklin County Jail, www.nbc4i.com, June 1, 2011). BCI London crime lab reported that the number of heroin cases it processes has remained stable over the past six months.

Most participants generally rated the quality of heroin as ‘6’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the previous most common score was also ‘6’. Participants reported that black tar heroin in Columbus is cut (adulterated) with crushed aspirin. A participant reported, “The quality [of heroin] is better. A lot of people know what they’re getting, and there’s so many dope boys [drug dealers] available to get it from. You know which ones have the best quality.” Over the past six months, participants reported that the quality of heroin has remained stable. BCI London crime lab continues to report that heroin is extremely pure in the region. Gas chromatography-mass spectrometry analysis typically shows that heroin is 80 percent pure; however, occasionally caffeine is used as a cutting agent.

Current street jargon includes many names for heroin. The most commonly cited names remain “boy,” “dog food” and “H.” Participants reported that black tar heroin is available in different quantities. (Note: prices included here reflect current pricing for black tar heroin as very few participants had pricing information on powdered heroin. Overall pricing remains stable from the previous reporting period.) Black tar heroin sells for \$10 a bag; \$90 a bundle (10-12 bags). Participants and community professionals reported that the most common way to use heroin remains by intravenous injection (shooting); however, reportedly, intranasal inhalation (snorting) is also quite common. Many participants continued to report that users typically start with snorting heroin and eventually progress to shooting, or “they shoot pills and go straight to [shooting] heroin.” A participant also reported seeing someone who took black tar heroin and shook it up with hot water to dissolve it: “Shake it up, and snort it up, so you can avoid needles and marks.” Narcotics officers noted that they had heard from informants that users were using the aforementioned method of heroin ingestion as well.

A profile of a typical user of heroin did not emerge from the data. Participants described typical users of heroin as, “younger people, all races, teens and young adults, a lot of college students.” A narcotics officer noted, “You get a little bit of everything. You have older [heroin] users, teenagers, high school aged, you know. I’ve been hearing it’s somewhat a rite of passage for high school aged children sometimes to do it intravenous;

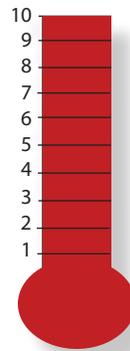
We're seeing a lot of average White people from the suburbs." Treatment providers also noted that heroin use has grown to include more young and suburban users: "We have seen the age drop from the mid-40's to the 20's. Most started using before 21; [Heroin use] spreadin' out into the 'burbs. Back when I was young, it was more adults, street people."

Reportedly, heroin is used in combination with alcohol, benzodiazepines (Xanax®), crack cocaine, marijuana and powdered cocaine. Some participants reported taking benzodiazepines to heighten the effects of heroin: *"Benzos [benzodiazepines] – my favorite buzz ... Intensifies the high."* Heroin is also mixed with powdered cocaine in a "speedball", and is said to help with the crash experienced by crack and powdered cocaine users. However, heroin is frequently used alone. A participant stated, *"When you're doing H [heroin], you're not too interested in anything else."*

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' (high availability, extremely easy to get). According to law enforcement, prescription opioid use was at epidemic levels in Central Ohio, and prescription opioids were the most frequently purchased street drug of the special investigative unit. Participants described some prescription opioids as more readily available than others. Reportedly, OxyContin® OC was less available as it had been replaced in pharmacies by the less desirable OxyContin® OP, a new formulation of OxyContin® which rendered the drug difficult to abuse. Law enforcement reported that the most popular prescription opioids in Central Ohio were OxyContin® OC, Percocet® and Vicodin®. Several participants reported that dealers were paying users to go out of state (Florida) to purchase prescription opioids to bring back to Columbus for street sale. Reportedly, the most common way to obtain prescription opioids was on the street followed by pain clinics, family members and friends. Participants reported that the most common route of administration for prescription opioids was oral consumption (swallowing) followed by intranasal inhalation (snorting, which reportedly carried some stigma) and intravenous injection. Participants and clinicians noted that illicit users of prescription opioids were alarmingly becoming "younger and younger."

Current Trends



Prescription opioids remain 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' (high availability, extremely easy to get); the previous most common score was also '10'. Participants identified Percocet® and Vicodin® as the two most popular prescription opioids in terms of widespread use. A participant noted, *"You can go through the beer drive-throughs and get those [Percocet® and Vicodin®]."* A treatment provider said, *"With our women, it's multigenerational [prescription opioid] use. No big deal. Completely normal. Sometimes it takes a little longer to come [to treatment] because it's been normalized."* Participants reported that the availability of prescription opioids has increased over the past six months: *"A lot of the veterans [abuse prescription opioids], it's gotten so bad. Doctors actually send that stuff [prescription opioids] in the mail. A lot of veterans with back pain, they'll get 90 perc's [Percocet®], 60 oxy's [OxyContin®]. That's one of the biggest things – chronic pain people. I have a back issue and they're [doctors] like, here, here's a script [prescription] for 90 Vicodin®. They'll give it out like a drop of a hat."* Community professionals also reported that the availability of prescription opioids has increased over the past six months: *"People see it's big money. They get it [prescription for an opioid], sell 240 pills, and they're raking in money hand over fist."* Both participants and treatment providers again spoke of dealers sending people to Florida to purchase opioids to bring back to Central Ohio. A participant reported, *"I went to Florida. I came back with 250 oxy's [OxyContin®]. Brought 'em right back here to Columbus, and they sold for like ... I made triple!"* A narcotics officer affirmed that this practice continues but noted, *"Now [pain clinics] moving to north of Atlanta because Florida is starting to crack down on it. Toward the fall of last year, some of the people we were investigating had moved to the suburbs of Atlanta."* Regional media outlets reported on several illicit prescription opioid operations that were busted by law enforcement over this current reporting period. *WBNS-10TV Columbus* reported that a Central Ohio couple in their 60's was arrested for allegedly selling pharmaceuticals out of their Delaware home (www.10tv.com, April 14, 2011). More recently, the news station reported that two UPS (United Parcel Service) employees were recently arrested for allegedly using their jobs to obtain prescription opioids sent through the courier (www.10tv.com, June 24, 2011). BCI

London crime lab reported that the number of prescription opioid cases it processes has remained stable over the past six months; however, noted increases in the number of lab processed cases existed for Dilaudid®, Opana® and Percocet®.

Reportedly, many different types of prescription opioids are currently sold on the region's streets. Participants reported the following prescription opioids as available to street-level users. (Note: When reported, current street names and prices are indicated in parentheses): oxycodone 30 mg (a.k.a., "perc 30;" sell for \$20), OxyContin® (a.k.a., "oxy's"), OxyContin® OC (old formulation, a.k.a., "OC's," "old cars," "old chickens" and "Orange County;" sell for \$1 per milligram), OxyContin® OP 40 mg (new formulation, a.k.a., "little boys" and "oranges;" sell for \$25–\$30), OxyContin® OP 80 mg (a.k.a., "80's," "beans," "big boys," "bigs" and "green apples;" sell for \$80), Percocet® (a.k.a., "perc's;" sell for \$1 per milligram), Vicodin® (a.k.a., "vikes;" sell for \$1 per milligram). 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 swallowing and intranasal inhalation (snorting). Swallowing continues to be the most common route of administration by far.

In addition to obtaining prescription opioids on the street from dealers, participants also continued to report getting them from doctors and emergency rooms: *"If you go into the emergency room, I can guarantee you, you are going to get a script [prescription] for Vicodin®; Some doctors really don't care. They're getting their money."* In addition to "doctor shopping," participants described other avenues for obtaining prescription opioids, including people using false prescriptions: *"People steal prescription pads. A prescription pad can go as high as \$6,000 on the street. They get people who know how to write scripts [prescriptions]."*

A profile of a typical user of prescription opioids emerged from the data. Participants described typical users of prescription opioids as young and White: *"White people buy pills [prescription opioids] like they candy canes! College white kids [use prescription opioids] because they [prescription opioids] relaxes you. That's what people is looking for!"* Narcotics officers also identified the typical user as White and middle-class. Treatment providers in Fairfield County reported that opioid using clients are typically 18–24 years old. Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, benzodiazepines (Xanax®) and marijuana: all used to *"intensify the high."*

Suboxone®

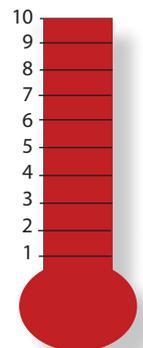
Historical Summary

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" (high availability, extremely easy to get). Users reported procuring Suboxone® while participating in drug treatment, from a clinic or on the street. The street price for Suboxone® 8 mg was consistently reported as \$10. Although no typical Suboxone® user was identified, treatment providers noted two types of Suboxone® abusers: Opioid addicts who used the drug for at-home detoxification or to fight off symptoms of withdrawal between highs, and users who believed Suboxone® could produce a high. Most often participants reported taking Suboxone® orally, letting it dissolve under the tongue. Some intravenous injection use was also reported.

Current Trends

Suboxone® remains highly available in the region. However, while participants in Fairfield County reported the street availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), none of the participants in Columbus reported using the drug, thus there is no current availability rating from city participants to report; the previous most common score for Columbus was '10'. A participant in Columbus reported, *"Anytime you go to court, and you test positive for opiates, they refer you to ... [treatment]."*

Anyone who comes in that they think has an opiate problem, they write out a script [prescription for Suboxone®]. Everybody's on 'em." Columbus-based professionals were also unable to comment on street availability of Suboxone®, although 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."* Treatment providers in Fairfield County, like participants there, reported the street availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant stated, *"Dude, they're [Suboxone®] everywhere!"* A treatment provider reported, *"They [users] all want to be on it [Suboxone®]. The dealers will give them [users] a free Suboxone® with their heroin. Customer satisfaction."* There was no consensus in the data as to whether the street availability has increased, decreased or remained the same over the last six months. Participants



reported that the availability of Suboxone® has remained stable over the past six months; community professionals reported that availability has increased over the last six months; BCI London crime lab reported a decrease in the number of Suboxone® cases it processes over the last six months.

No slang terms or common street names were reported for Suboxone®. Participants reported current street pricing for Suboxone® 8 mg to range from \$15-\$20, an increase from \$10 from the previous reporting period; Suboxone® in the strip/film form sells for \$10-\$20. A provider reported, *"The [Suboxone®] strips are harder to abuse."* Suboxone is typically dissolved under the tongue; however, injecting does occur: *"They'll [opiate addicts] even get the [Suboxone®] strips, wax 'em down and shoot 'em up."*

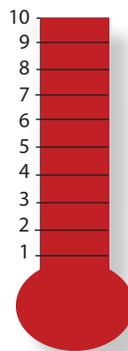
In addition to obtaining Suboxone® on the street from dealers, participants also reported getting the drug from people selling their Suboxone® prescriptions on the street. A treatment provider reported, *"They [opiate addicts] use it [Suboxone®] like Tylenol 3®, to use till they can get a fix. [Suboxone® is] a drug of convenience."*

A profile for a typical Suboxone® user emerged from the data. Participants described typical abusers of Suboxone® as 35-45-year-old Whites. A participant reported, *"A heroin addict will sometimes buy it [Suboxone®] just for the fact of getting well."* A treatment provider said, *"Hard to be titrated off [Suboxone®] when in treatment. They [clients] don't present it as a drug of choice."* As for combining Suboxone with other drugs, participants frequently responded, *"You couldn't use it [Suboxone®] with anything else."*

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants listed the most common sedative-hypnotics in terms of widespread use as Klonopin®, Soma®, Valium® and Xanax®. In addition to obtaining sedative-hypnotics from dealers and family members, participants reported visiting area doctors in order to obtain prescriptions for these drugs. The most common routes of administration were oral consumption and intranasal inhalation (snorting). Participants reported that illicit use of these drugs in their communities was a far-reaching problem that affected all age groups.

Current Trends



Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) are extremely available in the region. Participants most often reported 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'. Additionally, community professionals as well most often reported current availability of these drugs as '10'. Participants and community professionals continued to identify Valium® and Xanax® as two of the most popular sedative-hypnotics in terms of widespread use. A treatment professional reported that drug users do not see the use of sedative-hypnotics as dangerous; they explained drug abusers, *"use to keep from getting sick. They don't think of it [sedative-hypnotics] as drugs."* Participants reported that the availability of sedative-hypnotics has increased over the past six months: *"Doctors are prescribing them [sedative-hypnotics] more."* Community professionals also reported that availability of sedative-hypnotics has increased over the past six months because doctors are using the drugs *"to treat mental health."* A narcotics officer noted that Xanax® was very available while Valium® was not as available because it was less desirable: *"There's not as much Valium® or Ativan®."* BCI London crime lab reported that the number of sedative-hypnotic cases it processes has generally remained stable over the past six months; however, a noted exception was an increase in the number of Xanax® cases.

Reportedly, many different types of sedative-hypnotics (a.k.a., "benzo's" and "downers") are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ativan®, Klonopin®, Soma®, Valium®, and Xanax® (.5 mg, a.k.a., "footballs," sell for \$2; 2mg, a.k.a., "xanibars;" Xanax® XR 3 mg sell for \$5). In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported getting them from a family doctor or an emergency room. As one participant said, *"You say you have pain and they'll [doctors] give them [sedative-hypnotics] to you."*

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 route of administration remains oral ingestion. Many participants agreed when a participant said, *"People just eat*

them [sedative-hypnotics]." Intranasal inhalation (snorting) and intravenous injection also continue to be common routes of administration. Xanax®, in particular, is reportedly frequently snorted. One participant talked about her reason for injecting sedative-hypnotics, "I inject [sedative-hypnotics] because I inject everything."

A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants described typical users of sedative-hypnotics as young and White: "College White kids because they [sedative-hypnotics] relaxes, and that's what people is looking for." Narcotics officers reported seeing an increase in young Black sedative-hypnotic users. An officer also talked about seeing more middle-aged White women using them. Reportedly, sedative-hypnotics are most often used in combination with alcohol or marijuana in order to heighten the effect of the sedative-hypnotic. A participant explained, "Alcohol intensifies any pill [sedative-hypnotic] you take."

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 named marijuana the most available illegal drug in the region. 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); overall, participants believed the quality of marijuana had increased over the previous six months. Participants reported that for commercial-grade marijuana, a blunt (single cigar) was \$5 and an ounce ranged in price from \$50–\$75; for high-grade marijuana, a blunt (single cigar) was \$25 and an ounce ranged in price from \$100–\$200. The most common route of administration for marijuana was smoking. Marijuana use was believed to transcend age, race and socioeconomic status.

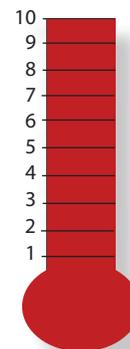
Current Trends

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 described marijuana as, "always available." Community professionals most often reported the drug's current availability as '10'. A treatment provider noted, "I don't hear anybody jumped off the roof 'cuz they couldn't find no weed [marijuana]!" Another

treatment provider quipped, "It's [marijuana availability] like catsup. Always on the table. Like a condiment." WCMH NBC 4 Columbus reported on several marijuana arrests during this reporting period. Police officers in Mansfield pulled over a California man for speeding and found four pounds of hydroponically-grown marijuana valued at an estimated \$18,000 (www.nbc4i.com, April 14, 2011). During another routine traffic stop, Delaware police found 33 pounds of marijuana valued at an estimated \$33,000 (www.nbc4i.com, April 18, 2011). Most recently, Bucyrus police seized 91 marijuana plants after a tip was called into area police (www.nbc4i.com, June 22, 2011). There was no consensus in the data as to whether the availability of marijuana had increased, decreased or remained the same over the past six months. Participants reported that the availability of marijuana has remained stable while community professionals reported that availability has increased over the past six months. A narcotics officer reported, "It's easier to get [marijuana]. Mexican and home grown. Every week we're [finding] home grows." BCI London crime lab reported that the number of marijuana cases it processes has decreased over the past six months.

Participants most frequently reported the overall quality of marijuana as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8'. Several participants explained that the quality of marijuana depends on whether the user buys "commercial weed" (i.e., low to mid-grade marijuana) or hydroponically grown (i.e., high-grade marijuana). Participants reported not often bothering with low-grade marijuana as high grade is readily available. Participants in one group said the quality of marijuana was, "Off the charts. You wouldn't believe how good it is. The THC is very high." Participants in other groups echoed the same sentiment: "There is no shitty weed [marijuana] no more. The stuff they [dealers] get now, you look at it, and you get high."

Current street jargon includes countless names for marijuana. The most commonly cited names remain "weed" for low-grade marijuana and "chronic" for high-grade marijuana. Participants listed the following as other common street names: "bonk," "dust," "regular," "sticky-icky" and "swag" for commercial grade (low-grade) marijuana; "AK47," "blueberry," "blue cheese," "critical" and "kush" for high-grade marijuana; and "dro" for hydroponically-grown marijuana. The price of marijuana continues to depend on the quality desired. Participants reported commercial grade marijuana as the cheapest form: a blunt (single cigar) or two joints (cigarettes) sell for \$5; an ounce ranges in price from \$60–\$120; 1/4



pound sells for \$80. Higher quality marijuana (“hydro”) sells for significantly more: a blunt (single cigar) or two joints (i.e., cigarettes) sell for \$10; an ounce sells for \$200–\$400; and a pound sells for \$2,000–\$5,000. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking in joints, blunts or from bongs. Sometimes marijuana is cooked in food, like brownies or spaghetti sauce, but this is uncommon.

A profile for a typical marijuana user did not emerge from the data. When answering the question about a typical user, participants, clinicians and narcotics officers all indicated, “It’s everybody!” However, a treatment provider added, “We’re seeing more women in treatment with marijuana as the only drug [of abuse in their histories].”

Reportedly, marijuana is used in combination with alcohol and crack cocaine (a.k.a., “primo” when marijuana is laced with crack cocaine) as these drugs are said to, “bring down the crack [cocaine] paranoia.” Also, joints/blunts are often dipped in embalming fluid (a.k.a., “sherms”) to intensify the marijuana high.

Methamphetamine **Historical Summary**

In the previous reporting period, methamphetamine was relatively rare in the region. Most participants knew little about the drug. Participants reported that the drug’s availability ranged from ‘2’ to ‘8’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants with knowledge of methamphetamine reported that methamphetamine availability had increased over the past six months. Columbus Police Crime Lab corroborated reports of increased availability, as the lab reported an increase in the number of powdered methamphetamine cases it processed over the previous six months. Participants reported that they could buy a gram of methamphetamine for \$80–\$120, with crystal methamphetamine at the top of that price range. The most common route of administration for this drug was smoking with a glass pipe. Treatment professionals described typical methamphetamine users as White males.

Current Trends

Methamphetamine is moderately available in the region. Again participants had difficulty in rating the current availability of methamphetamine on the availability scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). However, participants in Fairfield

County noted that current methamphetamine availability does not seem to have suffered despite a number of recent busts: “I seen the amount of houses working it [manufacturing methamphetamine] that are busted going through the roof, but it hasn’t affected availability.” A treatment provider commented, “Even when the meth [methamphetamine] lab busts happen here, we don’t get a lot [of methamphetamine addicts] in treatment. They’re all in jail, or they’re too paranoid to get engaged.” The only participant who had used the drug reported that methamphetamine is available in crystal (a.k.a., ice) and powdered forms: “I would do ice [crystal methamphetamine] and my house would be spotless. [If I used] Powdered, I would be stuck.” While narcotics officers most reported investigating methamphetamine use in gay clubs, they also reported that there are many ‘one pot’ users who make methamphetamine at home to feed their own habit. Reportedly, users on the street are not using methamphetamine; however, narcotics officers anticipate an increase in the street availability of this drug in the future: “What we’re anticipating, from what we’ve seen from surrounding states – meth [methamphetamine] is on our borders. In the last couple of years, for example, Indiana and [other] states just west of us have seen [methamphetamine lab] increases of 3,000 percent. It’s right there. I think you’re going to get a spike.” Statewide media outlets reported on several methamphetamine seizures. WCMH NBC 4 Columbus recently reported that over 40 people were indicted in the largest-ever methamphetamine seizure in Central Ohio. The drug seizure was part of a year-long investigation by the High Intensity Drug Trafficking Area (HIDTA) task force in cooperation with other Central Ohio law enforcement, and it netted over five pounds of crystal methamphetamine worth an estimated \$250,000 (www.nbc4i.com, June 22, 2011). WCMH NBC 4 also reported that Central Ohio drug enforcement agents made five arrests connected to a methamphetamine lab in Newark; it was alleged that two of those arrested purchased over nine grams of pseudoephedrine, which led to the investigation of a Newark home where the methamphetamine lab was found (www.nbc4i.com, May 6, 2011). Participants were unable to report on the current change in availability of methamphetamine; however, community professionals reported that availability of methamphetamine has remained stable over the past six months. BCI London crime lab reported that the number of methamphetamine cases it processes has also remained stable over the past six months. Reportedly, most of the cases the crime lab processes are for white to yellow powdered methamphetamine; however, crystal methamphetamine cases were said to be increasing.

The one participant who used methamphetamine rated the quality of crystal methamphetamine as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). He explained, "Out here, it [quality of methamphetamine] sucks. If you want good stuff, go along the coastline." Participants reported the belief that the quality of methamphetamine has remained stable over the past six months.

Current street jargon includes a few names for methamphetamine. The most commonly cited names remain "ice" and "crystal." Reportedly, the most common route of administration of methamphetamine is intravenous administration. Other routes of administration that were cited as common include smoking and intranasal inhalation (snorting). There is generally a progression as to method of administration. A participant reported, "You start off smoking or snorting, then shooting [methamphetamine]. They're [new users] afraid of the needle so they snort and in a few weeks, they're shooting."

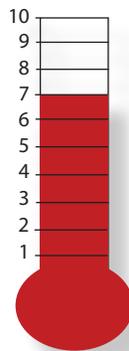
A profile for a typical methamphetamine user emerged from the data. Participants described typical users of methamphetamine as White, middle-class and often middle-aged. A treatment provider noted, "With my clients, their older family members use meth [methamphetamine]. They're not in treatment." Narcotics officers reported primarily conducting investigations at gay clubs: "We're looking primarily in the homosexual community. We've had some investigations going in that direction." Reportedly, methamphetamine is used in combination with alcohol, marijuana and Xanax® to mitigate the effects and come down from the high of the methamphetamine. A participant stated, "I use weed [to come down]. It's awful when you're coming off it [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 '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Ecstasy was primarily considered a "party drug" and used at night clubs. Participants perceived that both quality and availability had increased over the past six months. Participants reported a capsule cost \$20, and the quality of Ecstasy was high. The only reported method of administration was oral consumption, with many users reporting "parachuting" the drug (wrapping powdered Ecstasy in tissue paper and swallowing).

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 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 '10.' Participants described Ecstasy as a, "young, dope boy drug," and reported that they were "seein' Ecstasy in the crack [cocaine] houses." Community professionals were unable to report on the drug's current availability.

Participants reported that the availability of Ecstasy has remained stable over the past six months. A narcotics officer had a different opinion, "It's [Ecstasy use] kind of dropping off." BCI London crime lab reported that the number of Ecstasy cases it processes has remained stable over the past six months. The crime lab also reported that Ecstasy pills usually contain multiple active substances, including 5-MeO-DiPT (foxy methoxy), BZP, MDM, MDMA, P-FPP, TFMPP, caffeine, ketamine, and methamphetamine.

Current street jargon includes several different names for Ecstasy. The most commonly cited name remains "X." Participants listed the following as other common street names: "lucky charms," "smurfs" and "zooms." Participants reported that the price of a pill depends on the strength, with reported prices generally a little lower than previously reported: a "single stack" (low dose) Ecstasy tablet sells for \$10–\$15 and a "double stack" or "triple stack" (high dose) sells for \$15–\$16.

A profile for a typical Ecstasy user did emerge from the data. Participants and narcotics officers continued to describe typical users of Ecstasy as young club goers or street drug dealers. Participants were not able to identify other drugs typically used in combination with Ecstasy.

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants (Adderall® and Ritalin®) were available in the region. Participants reported that these drugs were available on the streets, but were most often obtained through physicians, who often prescribe the drugs as treatment for ADHD (attention deficit hyperactivity disorder). Participants reported users taking their child to the doctor in order to

obtain a prescription for a stimulant when their child had no real need. Participants reported that prescription stimulants were popular among younger males and females (< 18 years of age).

Current Trends

Prescription stimulants (Adderall®) are moderately available in the region. However, participants were unable to rate the availability of prescription stimulants because none of the participants reported actually using a prescription stimulant. A participant explained, *"They [prescription stimulants] are not a common 'look for' drug."* Community professionals were also unable to comment on the drug's current availability, although a narcotics officer noted, *"The perfect scenario is to go to your psychologist and get you some Ads [Adderall®]. You go to your permanent care physician, so you get double doses easily. You can get three prescriptions in a month because they [doctors] don't communicate."* In June, *The Lantern*, the campus newspaper of The Ohio State University, reported that students are using Adderall® in conjunction with alcohol because it gives them a *"euphoric sensation"* and the ability to party longer. As one of the students interviewed said, *"If you drink [alcohol], it tends to bring you down and slow you down, but if you take a stimulant, you can get drunk and stay energized."* Doctors with The Ohio State University's Younkin Success Center reported that the trend to abuse prescription stimulants has been rising over the past five years, which is troubling because prescription stimulant abuse can cause a number of long-term health complications (www.thelantern.com, June 21, 2011). BCI London crime lab reported that the number of prescription stimulant cases it processes has remained stable over the past six months.

No slang terms or common street names were reported for prescription stimulants, and participants were unable to comment on price. In addition to obtaining prescription stimulants on the street from dealers, participants also continued to report that these drugs are often prescribed by area doctors.

A profile for a typical prescription stimulants user emerged from the data. Participants continued to describe typical users of prescription stimulants as young, usually college students. The perception among participants was that Adderall® use is very high on college campuses and used as a study drug. A participant reported, *"I did it [Adderall®] all through high school to help me study."* Participants stated that they believed these medications were not typically used in combination with any other drugs.

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 [i.e., lysergic acid diethylamide (LSD)] and synthetic marijuana ("K2" and "Spice"). LSD was known to be present in the region, and participants typically rated availability as '6' on a scale of '0' (not available, impossible to get) to '10' (high availability, easy to get). Treatment providers reported not seeing current use of LSD in those seeking treatment; however, they reported that sometimes LSD use was noted in drug use histories during the intake of younger participants (< 18 years of age). Columbus Police Crime Lab reported that the number of LSD cases it processes had remained stable over the previous six months. Participants had heard of synthetic marijuana ("K2" and "Spice"), but none of the participants reported use. Finally, stories about bath salts abuse appeared in the region's newspapers several times, but no participant or treatment provider in this region spoke of bath salts use.

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. BCI London crime lab reported that the number of lysergic acid diethylamide (LSD) and psilocybin mushroom cases it processes has remained stable over the past six months. Participants and treatment providers mentioned K2, a synthetic marijuana-like substance that can be purchased from head shops and gas stations. Both participants and treatment providers in Fairfield County described K2 as increasing in availability; however, only a few participants reported that they had actually tried K2. A participant stated, *"It's [K2] expensive. You might as well just buy weed [marijuana]."* According to participants, the primary benefit of smoking synthetic marijuana is that it is not currently screened with most standard drug screens. A participant said, *"People on probation don't really stay clean, and everyone is on probation around here. It [K2] doesn't show up on a piss test [urine drug screen]."* Another participant agreed, *"It [K2] looks like weed [marijuana]. Gets you high like weed, but you can't detect it [with most drug screens]."* A narcotics officer expressed his frustration with synthetic marijuana: *"The crime lab does not have the equipment to test, and it's not cost-effective [to test through an outside lab]. Without legislation, there is no guidance for the police."*

Khat is a drug unique to the Columbus region that is typically used by the Somali community. A flowering plant native to the Arabian Peninsula and Northeast Africa, khat contains cathinone, which is an amphetamine-like stimulant. Ingestion of khat can increase energy and produce a euphoric state. While none of the participants reported any experience with khat, the *Columbus Dispatch* reported on a multi-state drug bust involving the drug. Drug traffickers in Ohio, Maryland, New York and Virginia were arrested for bringing more than 4.8 tons of khat into the country. According to law enforcement, “[Drug] couriers were paid about \$1,000 each time they brought khat into the United States in their luggage. Some had their children act as couriers” (www.dispatch.com, May 21, 2011). BCI London crime lab reported that khat was processed in their lab over the past six months.

Participants had heard of, but were not experienced with, bath salts; however, in Fairfield County recent emergency room and police reports show an increase in the use of the substance there. A treatment center director said, “We are working on an ordinance in communities to stop the sale of bath salts.” Bath salts have appeared in the news several times during this reporting period. The *Mansfield News Journal* reported on a disturbance with police involving bath salts. After a tip from a neighbor about gun fire, police arrived at a house where suspects were barricaded inside with an infant girl and 18-month-old boy. Law enforcement found suspects were exhibiting paranoia due to the influence of a bath salts called Posh Aromatherapy (www.mansfieldnewsjournal.com, April 25, 2011). The television station *WBNS-10TV* reported on an overdose involving White Horse bath salts. A Mansfield man ingested the bath salts, which “essentially shut down his organs.” Specialists who commented on this overdose from Nationwide Children’s Hospital Poison Control Center said that they receive “at least one bath salts call a day,” and that “there have [already] been 148 cases [of bath salts] reported so far this year” (www.10tv.com, June 21, 2011). BCI London crime lab reported that the number of bath salts cases it processes has increased over the past six months. The crime lab also reported that most forms of bath salts contain MDPV and methylone, which is a relative of a chemical often found in Ecstasy, MDMA.

Conclusion

Crack cocaine, heroin, marijuana, prescription opioids, sedative-hypnotics and Suboxone® remain highly available in the Columbus region. Noted increases in availability over the previous six months exist for prescription opioids, sedative-hypnotics (Xanax®) and synthetic marijuana.

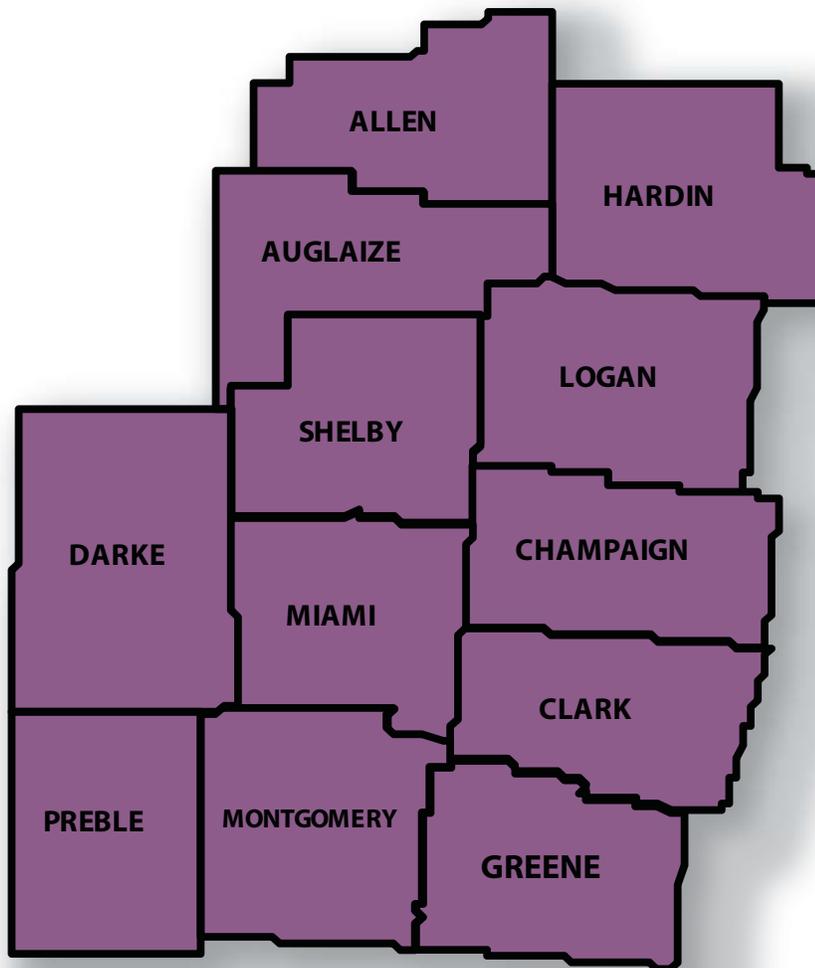
Participants and community professionals agreed that the availability of prescription opioids has increased over the past six months. Participants now identify Vicodin® and Percocet® as the two most popular prescription opioids in terms of widespread use. BCI London crime lab reported that the number of Dilaudid®, Opana® and Percocet® cases that it processes has increased over the past six months. In terms of popular sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants), community professionals identified Valium® and Xanax® as the two most popular in regards to widespread use. BCI London crime lab reported that the number of Xanax® cases it processes has increased over the past six months. Crack cocaine remains extremely easy to obtain, so much so that participants continue to say things like, “Pull over to the side of the road, and it [crack cocaine] will come to you; I could go to Walmart® right now and get some.” Participants also noted that crack cocaine paraphernalia is readily available in convenience stores and beverage drive-throughs. Black tar heroin remains the most common form of heroin in the Columbus region, and it continues to be highly available. Participants continued to report that prescription opioid users are progressing to heroin use because heroin is cheaper and easier to obtain; participants also continued to cite the reformulation of OxyContin®, which made the drug difficult to abuse, as a primary reason for the progression to heroin. BCI London crime lab continues to report that heroin is extremely pure in the region; gas chromatography-mass spectrometry analysis found that heroin is 80% pure, with caffeine being the primary cutting agent in adulterated heroin samples. Marijuana remains highly available across Columbus, and its extreme availability was best captured in this comment from a treatment provider, “It’s like catsup. Always on the table. Like a condiment.” While methamphetamine is moderately available in the region, narcotics officers reported that they anticipate an increase in methamphetamine availability in the future due to the drug’s increased street presence in border states (Indiana). Synthetic marijuana (“K2”) was described as increasing in availability by both participants and clinicians in Fairfield County; however, reportedly, only a few participants had actually tried it. Participants had heard of, but were not experienced with, bath salts; however, in Fairfield County recent emergency room and police reports show an increase in the use of the substance there. BCI London crime lab reported that the number of bath salts cases it processes has increased over the past six months. The crime lab also reported that most forms of bath salts contain MDPV and methylone, which is a relative of a chemical often found in Ecstasy, MDMA.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Dayton Region

January-June 2011

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Orman Hall, Director



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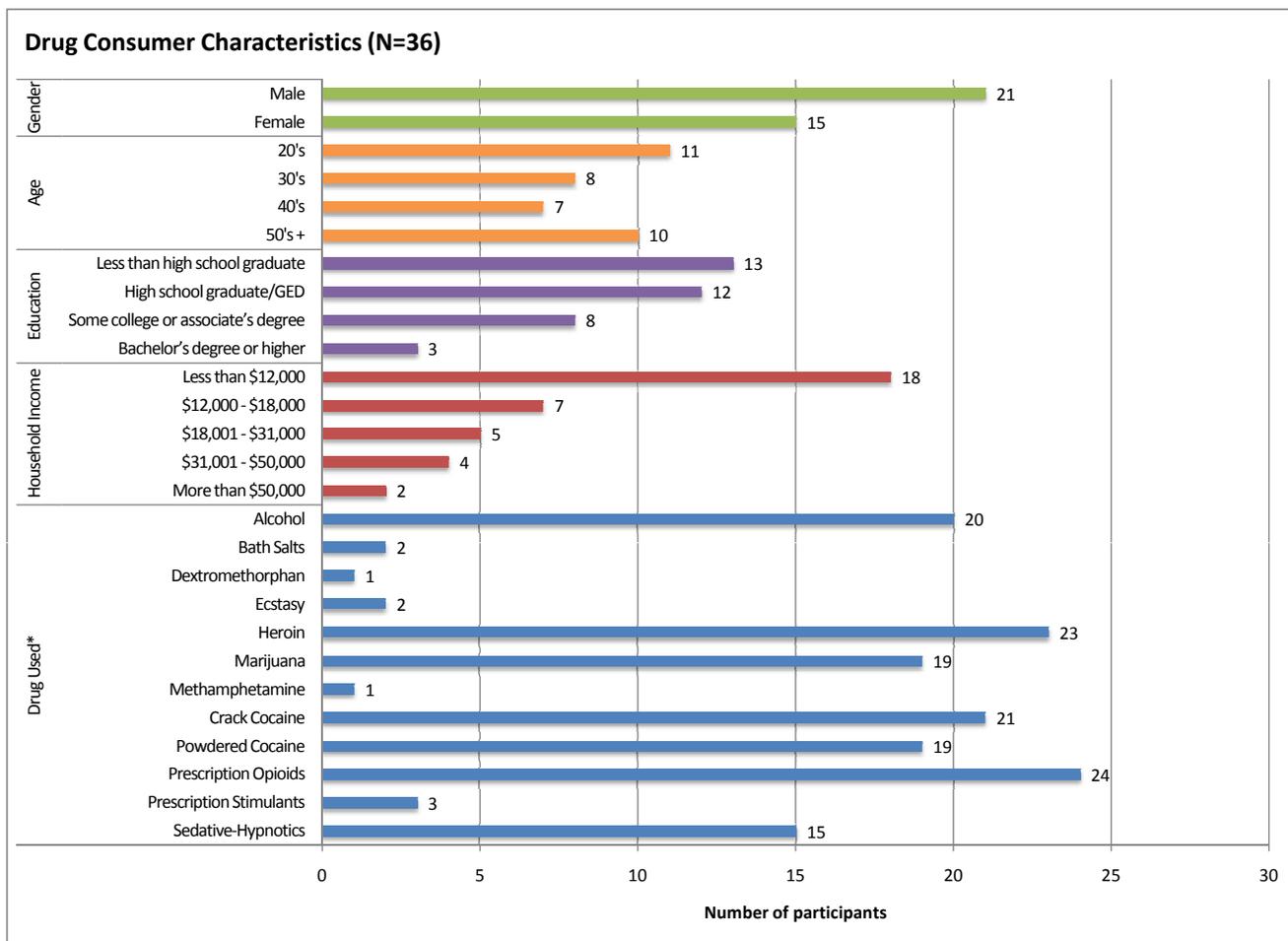
Regional Profile

Indicator ¹	Ohio	Dayton Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,542,645	1,344,707	40 ²
Gender (Female), 2009	51.2%	51.3%	41.7%
Whites, 2009	82.2%	84.2%	80.6%
African Americans, 2009	11.9%	11.1%	19.4%
Hispanic or Latino Origin, 2009	2.8%	1.8%	0.0%
High school graduates, 2009	83.0%	90.5%	63.9%
Median household income, 2009	\$45,467	\$46,387	\$12,000 to \$18,000 ³
Persons below poverty, 2009	15.1%	13.9%	61.1%

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

Four respondents did not complete demographics survey; thus this regional profile is based on 36 participants².

Respondents reported income by selecting a category that best represented their household's approximate income for 2009³.



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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Allen, Logan and Montgomery Counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via focus group interviews, as well as to data surveyed from Miami Valley Regional Crime Lab and Montgomery County Juvenile Court. All secondary data are summary data of cases processed from July to December 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, all current secondary data correspond to the current reporting period of participants. In addition to the aforementioned data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2011.

Powdered Cocaine

Historical Summary

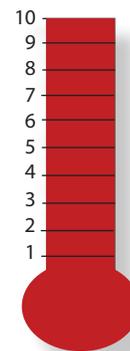
In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Most participants reported that availability of powdered cocaine had increased over the previous six months. The most common participant quality score for powdered cocaine was '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants universally reported that powdered cocaine was cut (adulterated) with other substances. According to Miami Valley Regional Crime Lab, cutting agents for powdered cocaine included: levamisole (livestock dewormer) and phenacetin (analgesic), as well as, the local anesthetics: benzocaine, lidocaine and procaine. Participants reported that a gram of powdered cocaine ranged in price from \$40 to \$65. Most participants who used powdered cocaine reported injecting it intravenously (a.k.a., "slamming"). Participants also reported that powdered cocaine use crossed all ages, races and socioeconomic classes.

Current Trends

Powdered cocaine remains highly available in the region, especially in urban areas. Participants most often reported the drug's current availability as '10' on a scale of '0' (not

available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '8'. However, nearly a quarter of all respondents gave an availability ranking of '5' or less, with many participants noting that in rural areas more effort is required to obtain powdered cocaine. Participants reported, "For suburban areas, no, you can't get it [powdered cocaine]. In the city [Dayton] it's easy to get; it's [powdered cocaine] available in both areas [suburbia as well as the city], but it depends on who you know." Law enforcement officers agreed that the drug is available, but mostly as it relates to the sale of crack cocaine. An officer reported, "We would see someone who wanted to buy powder [cocaine] to make into crack [cocaine]. Now, it [powdered cocaine] comes pre-processed from down south all ready to be rocked up instead of the powder form to snort." Participants reported that the availability of powdered cocaine has remained stable over the past six months; although users and officers both noted that heroin dealers are more likely to now carry powdered cocaine than crack cocaine. There were two reasons cited for dealers to carry powdered cocaine: convenience for users who prefer to mix heroin with powdered cocaine (a.k.a., "speedball"), and since the quality of crack cocaine is so poor, some users prefer to obtain powdered cocaine so as to "rock up" (manufacture) their own crack cocaine. A heroin user explained that powdered cocaine seems more available from dealers: "More dealers are selling both [powdered] cocaine and heroin. One-stop shopping is more common." An officer stated, "Dealers would give you heroin when you went to buy powder [cocaine]. They give away heroin to shape demand. Walmart® would be proud." Law enforcement reported that the availability of powdered cocaine has remained stable over the past six months: "It's [powdered cocaine] still coming in in bulk. Six to eight kilos at a time through UPS®, coming from Mexicans, but not like it used to be [years ago]." Miami Valley Regional Crime Lab reported that the number of powdered cocaine cases it processes has increased over the past six months.

Most participants rated the quality of powdered cocaine as '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Participants reported that powdered cocaine in Dayton is cut (adulterated) with baby laxative, baking soda, bath salts, crystal methamphetamine, inositol, PCP, prescription stimulants and vitamin B-12. Miami Valley Crime Lab continued to cite levamisole (livestock dewormer) as a cutting agent. Participants were mixed in their opinions on quality trends for powder cocaine over the past six months. Participants in the city of Dayton thought it recently had improved dramatically, again due to the influence of urban



heroin dealers. A participant commented, *"All of a sudden the [powdered cocaine] quality got better within the past year. It was garbage eight to nine months ago. Now it's much better. The dealers quit cutting it because it was messing up their [users'] heroin."* Participants in outlying areas said quality is much worse. One observed, *"People want to come back into recovery because it's [quality of powdered cocaine] just no good."* Another said, *"Dealers are gonna stomp on it [cut it] like crazy. You can spend \$150 in one night and not have a buzz."*

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," "fish scales," "powder" and "snow." Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine. Participants reported that a gram of powdered cocaine sells for \$50–\$80, depending on the quality; 1/16 ounce, or "teener," sells for \$40; 1/8 ounce, or "eight ball," sells for \$125–\$300; 1/4 ounce sells for \$250; an ounce sells for \$800–\$1,000; a kilo sells for \$18,000–\$23,000. However, the most commonly purchased unit remains the "cap," about 1/10 of a gram (a gelatin capsule prefilled with powdered cocaine); caps sell for \$10–\$12. Participants reported that the two most common ways to use powdered cocaine are intranasal inhalation (snorting) or intravenous injection (shooting). Out of 10 powdered cocaine users, participants reported that approximately four would snort it, four would shoot it, and another two would smoke it. It should be noted that when users discussed the popularity of smoking powdered cocaine, almost all of them meant that powder cocaine would be "rocked up" to create crack cocaine, and not smoked via the freebase method. A participant remarked, *"People either snort it [powdered cocaine], shoot it, or rock it up [to form crack cocaine]. I've never seen anyone freebase it."* Another participant spoke about snorting and injecting as more efficient methods of consuming powder cocaine: *"If I buy [powdered cocaine] in quantity, I would get stupid with it ... back when it was cheaper. But people get more efficient when the price goes up."*

A profile for a typical powdered cocaine user did not emerge from the data. Participants continued to describe typical users of powdered cocaine as rich and poor, older and younger, Black and White. Race was not a factor, and all groups mentioned how powdered cocaine is no longer an inner city drug that begins in the city and expands outward toward the suburbs: *"Lawyers, doctors, judges, all of them are [using powdered cocaine]. Everybody's doing it; race and income aren't a factor anymore."* Community professionals thought it was slightly preferred by wealthier users. An officer stated, *"Powder [cocaine] is pretty limited. It's an upper-echelon, rich-people drug."*

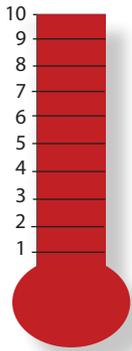
Reportedly, powdered cocaine is used in combination with alcohol, benzodiazepines (Xanax®), heroin (a.k.a., "speedball") and marijuana (a.k.a., "primo"). Users stated that these drugs help reduce the stimulating effects of cocaine. A participant explained, *"People that mix cocaine and benzos [benzodiazepines] do it to keep from geeking out."* Many users only consume powdered cocaine when they use heroin. This habit was reportedly more common, but not among newer users. Two participants agreed, *"Speedball is something that you work up to, you progress up to it; Speedball—it's not the first thing you do."* Almost every participant personally knew someone who had overdosed from this practice. Said one participant about speedballing, *"I've been nervous to do both [heroin and cocaine] at the same time. I get nervous to mix them together. I don't want to die from it."* Another said, *"Some heroin users will only speedball. That's the only way they do it."*

Crack Cocaine Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described crack cocaine as extremely easy to get. Law enforcement also said the availability of crack cocaine was high: *"24/7, generally in the lower-income areas."* The most common participant quality score for crack cocaine was '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut (adulterated) with other substances. The Miami Valley Regional Crime Lab reported cutting agents for crack cocaine as: levamisole (livestock dewormer), nicotinamide (B vitamin used to treat acne) and phenacetin (analgesic), as well as, the local anesthetics: benzocaine, lidocaine and procaine. Participants reported that a gram of crack cocaine ranged in price from \$40–\$70. 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 injecting it intravenously. Participants said that crack cocaine use crossed all ages, races and socioeconomic 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 '10'. Participants described the high availability of this drug with comments such as: *"You could walk down the street and get it [crack cocaine]. I could*



make a phone call to 25-30 people that sell it; I get approached on the bus [by crack cocaine dealers]: If you are in a car somebody's gonna stop you and ask if you are looking [for crack cocaine]." Law enforcement and treatment providers agreed that crack cocaine is 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 their resources had been shifted away somewhat from crack cocaine to the abuse-related problems of other substances. An officer

explained, *"It's [crack cocaine availability/use] gone downhill. For every ten heroin arrests, we see one crack [cocaine] arrest."* Participants noted that their dealers were switching from crack cocaine to heroin sales. A participant said, *"A lot of the people that sold crack [cocaine] saw what the heroin dealers were making. They started selling heroin because it's more of a sure thing with that clientele. Plus, the crack clientele can be troublesome--calls all times of the day."* However, all agreed that crack is a perennially available drug and still easy to get. Most participants reported that the availability of crack cocaine has remained the same over the past six months. According to one participant, *"It's [crack cocaine] always been very easy to get. Drive anywhere. You can get car service in some places."* Law enforcement and treatment providers agreed that availability of crack cocaine has remained the same over the past six months. A law enforcement officer stated, *"I wouldn't say crack is a close fourth [to heroin, prescription opioids and marijuana], but it's still relatively easy to get a hold of."* Miami Valley Regional Crime Lab reported an increase in the number of crack cocaine cases it processes over the past six months.

Most participants rated the quality of crack cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '4.' Participants reported that crack cocaine in the Dayton region is cut (adulterated) with baby laxative, baking soda, ether, procaine (local anesthetic) and vitamin B12. One participant remarked that cutting is common, and agents are readily available: *"They got stuff in head shops you buy that swells it [crack cocaine] up and smokes and burns like crack."* Another participant noted that crack cocaine is commonly cut with bath salts (synthetic hallucinogens and stimulants): *"They say the dealers are cutting crack [cocaine] with it [bath salts]. It's making people hallucinate real bad ... It's in there, and they don't even know that."* Miami Valley Regional Crime Lab cited levamisole (livestock dewormer) and phenacetin (analgesic) as cutting agents.

Over the past six months, most participants reported that the quality of crack cocaine has been decreasing. A

participant said about the quality of crack cocaine, *"That's why I cook my own [crack cocaine] because people were sick of buying garbage."* A few city dwellers thought the quality had remained good or had slightly improved, remarking, *"In the past six to eight months it's [quality of crack cocaine] gone up a little. A year ago you had to smoke an ounce to get high."*

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," "yank" and "ya-yo." Current street prices for crack cocaine were consistent among participants with experience buying crack cocaine. Participants reported that crack is often consumed in increments of \$10 "rocks" (1/10 gram) and \$20 "rocks" (2/10 gram). A gram of crack cocaine sells for about \$50, depending on the quality; 1/8 ounce, or "eight ball," sells for \$125–\$150 for low quality, \$350–\$400 for high quality; an ounce of low quality sells for \$800–\$950, high quality sells for \$1,200–\$1,300. Crack cocaine pricing was believed to be dropping as demand for heroin and prescription opioids has increased. A participant stated, *"It's because more people got it [crack cocaine]. People are lowering prices for competition."* Another participant commented, *"It's [crack cocaine] gotten cheaper because of heroin, bath salts. Seemed like they [dealers] sold less crack [cocaine] to push the heroin instead. You get more crack [cocaine] at a better price than heroin."* While there were a few reported ways of administering crack cocaine, generally, the most commonly reported route of administration is smoking. Out of 10 crack cocaine users, participants reported that approximately eight would smoke it, two would intravenously inject it or "shoot it," and none would snort it.

A profile of a typical user of crack cocaine did not emerge from the data. Participants continued to report that typical users of crack cocaine belonged to every racial group, age group and social class as summed by one participant, *"Who uses crack [cocaine]? Black, White, old, young. Coming from the suburbs, coming from everywhere."* A participant group in a rural area felt that crack cocaine use is more popular with younger people recently, with reported use as young as 14–15 years old: *"It's [crack cocaine use] trending younger—the parents are doing it."* Some users noted the connection between drug use and mental illness explaining, *"Bipolar people use crack [cocaine] to self-medicate."* Another user noted that the drug is also abused recreationally, *"You might have a working person who smokes [crack cocaine] and works. That's a weekend warrior."*

Reportedly, crack cocaine is used in combination with alcohol, heroin (a.k.a., "chasing the dragon" when smoked together), marijuana (a.k.a., "crack roll," "geek joint" or "primo" when smoked together), sedative-hypnotics (Xanax®)

and tobacco (a.k.a., “cigamo” or “pearl up” when smoked in tobacco cigarettes). Users stated that these drugs help reduce the stimulating effects of crack cocaine.

Heroin

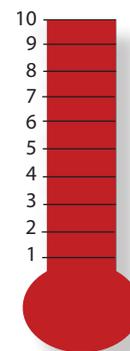
Historical Summary

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). The most common term used to describe current availability was “everywhere.” Most participants reported that availability of heroin had increased over the previous six months. Reportedly, the most common types of heroin were off-white, beige, tan, brown or white powdered. Treatment providers stated that heroin was “*easier to get than beer*,” inexpensive and ubiquitous in the community. The most common participant quality score for heroin was ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that heroin was being “cut” (i.e., adulterated) more with other substances, but did not routinely know what was used to cut heroin. According to Miami Valley Regional Crime Lab, cutting agents for heroin included: quinine (antimalarial), diphenhydramine (antihistamine), procaine (local anesthetic) and caffeine. Participants reported a gram of powdered heroin ranged in price from \$70-\$100. Participants also reported “caps,” or gelatin capsules filled with powdered heroin, selling for \$7-\$20, with pricing dependent on location within the region. Most participants who used powdered heroin reported injecting or “banging” it intravenously. The vast majority of participants reported that heroin use crossed all ages, races and socioeconomic classes. Many participants also reported concern over their perception that users were starting heroin use younger than ever before, reportedly as young as 15 and 16 years. Many community professionals also reported that heroin users had become younger over the last several years. After initiation of heroin use, participants reported a short progression of use from snorting to injecting. Many participants indicated that heroin use with powdered cocaine (a.k.a., “speedballing”) was fairly common.

Current Trends

Heroin remains highly available in the region. Participants 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.’ Participants reported, “*Heroin is easy to get, just as easy as marijuana. Brown, white, tan [heroin available]. Not a whole lot of dark brown [heroin]. I’ve*

never seen tar [black tar heroin]; Ohio is flooded with heroin. It’s an epidemic.” As mentioned previously in the crack cocaine section of this report, participants discussed the recent trend among dealers and their users switching from crack cocaine to heroin: “*Back in the ‘90s there were a lot more people selling crack [cocaine]. Now everyone that used to smoke crack now smokes heroin.*” Participants noted that dealers are aggressively pushing heroin and will often give away testers, or free samples. A participant reported, “*[Heroin samples] coming from a dealer who will flag you down and scream their phone number.*”



While many types of heroin are currently available in the region, participants reported the availability of brown powdered heroin as the most available, which is most commonly obtained in “caps,” gelatin capsules that sell for \$10 each. A participant explained that brown powdered heroin is most favored by dealers because it requires less knowledge to manipulate or adulterate: “*We have beige, brown powder [heroin]. Every once in a while tar [black tar heroin]. You can’t step on [adulterate] tar like powder, so it’s hard to get from dealers.*” A law enforcement officer confirmed this observation, “*[Brown powdered heroin], that’s what’s in the caps [capsules]. We recently ran into a dealer who’s had a kilo of black tar for a year because he can’t get rid of it.*” Another officer expounded on this topic: “*Mid-level drug dealers can’t cut tar [black tar heroin], so brown [powdered heroin] is more favored. Sniffers can still sniff and shooters can shoot it.*”

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. Treatment providers most often reported the drug’s current availability as either ‘9’ or ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Law enforcement reported, “*It’s [heroin] available. We see more of the unit doses [\$10 capsules] given away for free from heroin and crack [cocaine] dealers.*” Unlike other drugs that require a connection or phone call to obtain, dealers are more likely to approach users in the Dayton region to offer them heroin. Said an officer, “*A dealer was asked how he met a user, and he said she looked like an addict, so he stopped and sold her some [heroin]. You can stop at a red light and get offered some. It’s that easy to get.*” Participants, law enforcement and treatment providers reported high availability of black tar heroin, but agreed that the black tar form of heroin is not as readily available as powdered heroin; it requires a drive to an urban area or a closer connection to a source in order to obtain black tar heroin. A treatment provider stated, “*My understanding is that Mexicans [Mexican drug dealers] bring*

in tar [black tar heroin] to the streets of Columbus. And there are several street corners [where Mexican dealers sell black tar heroin], and you have to get it [black tar heroin] before they leave for the night. They [users] have to drive for it, but it's there." Another treatment provider added, "I've never heard of anyone not being able to get it [black tar heroin]." An officer agreed with this assessment, "It's a problem everywhere ... Wide across the state, as well as this county [Montgomery County]. Dayton and Cincinnati are feeder cities [for black tar heroin]." A participant stated, "I usually got brown [powdered heroin]. When it wasn't brown powder, it was tar [black tar heroin]. I would be disappointed because you can't snort that [black tar heroin]." Participants in Dayton reported that white powdered heroin is nearly as available as brown powdered heroin. A participant said, "It's white or tan [heroin]. Some stuff looked like crack [cocaine] for a while."

Nearly all participants reported that the availability of heroin increased over the past six months: "More people are coming in from the suburbs. The dealers will offer free [heroin] samples when they sell crack [cocaine]; It's [heroin] more available. There are more people you don't think would do it [use heroin]; It's [heroin] ruining all the towns. Older people, younger people [are using heroin] ... It's everywhere." Law enforcement and treatment providers unanimously stated that heroin availability has remained high. A treatment provider stated, "It's [heroin] been a huge issue, but it's about the same in the past six months." Miami Valley Regional Crime Lab reported that the number of heroin cases it processes has increased over the past 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); the previous most common score was '10'. Participants rated the quality of black tar heroin as '4'. Participants felt that over the past six months, the quality of powdered heroin has decreased. Many participants blamed an influx of new dealers and new users to the drug as a possible reason. Participants said, "It's [quality of heroin] getting worse. More people are trying it, and more people are cutting it; [Quality is] absolutely going down. Three years ago it was really good. Now people are banging four to six caps at a time [in order to get high]." Over the past six months, participants reported that the quality of black tar heroin has remained the same—that is, inconsistent. One participant commented about black tar heroin, "Quality [of black tar heroin] fluctuates. You can go to the same place, same guy, and get different quality each time. You could go spend \$25 and get well, then spend \$50 the next time and not feel good." Participants reported that powdered heroin in the region is cut (adulterated) with pharmaceuticals. A participant reported, "I even got some yellow shit [heroin] a while ago.

They [dealers] had cut it with pharmaceuticals. That pill that makes you hallucinate. It was bad." Heroin is also reportedly cut with powdered cocaine. A user reported, "Some people are speedballing and not even know it. Coke [cocaine] is cut in with heroin now." Black tar heroin was also said to be cut with brown sugar. Some participants speculated along these lines: "There are more dealers, more inexperienced dealers, and more competition. There's a lot of people not knowing how to cut it [heroin] or sell it." According to Miami Valley Regional Crime Lab, cutting agents for heroin continue to include: diphenhydramine (antihistamine) and caffeine.

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "dog food." Other names included: "brown," "dope" and "hank." Participants reported that powdered heroin is available in different quantities, with the most common unit sold being the \$10 clear gelatin capsule or "cap," which usually contain about 1/10 gram. Participants gave the following pricing, with higher prices indicated for rural areas, black tar, and higher quality powdered heroin: a gram sells for \$40–\$50 in the city, and \$80–\$150 in rural areas; 1/8 ounce sells for \$225–\$250; 1/4 ounce sells for \$500–\$700; an ounce sells for \$1,800–\$2,400; a "finger," approximately 27–32 grams of uncut powdered heroin, sells for \$3,200. Participants also reported that balloons or baggies (1/10 gram) of black tar heroin sell for \$10–\$25. Balloons of black tar heroin are available in increments of \$10, \$20, \$50 and \$100 bundles. Another trend cited by a few participants and community professionals was that syringes are sometimes available from dealers. A treatment provider reported, "I had heard that syringes were getting harder to get a hold of. They [dealers] were selling those along with the caps [capsules of heroin], too." Overall, participants reported that heroin pricing has remained stable over the past six months. Participants continued to report that the most common way to use heroin is intravenous injection. Out of 10 heroin users, participants reported that approximately two would snort it while eight would intravenously inject it or "shoot it." Only one participant mentioned smoking as an observed method for heroin use, saying, "They put tar [black tar heroin] on the foil and light it." Another participant discussed how some heroin users, "believe snorting the drug is less-addicting than needle use."

A profile of a typical user of heroin did not emerge from the data. Some participants noted that heroin is so ubiquitous that race and age do not appear to be factors. All participants continued to note progression from prescription opioids to heroin. A participant stated, "Pill [prescription opioid] users end up taking heroin. It's cheaper and stronger." Many participants noted that while use ranges across many

different groups, most users tend to be young and White. A participant reported, *"In the town I'm from, it's [heroin users] all White, young adults. It's a small town."* Participants also continued to recognize that new users are younger than previous and lacked knowledge about the drug. A participant reported, *"I've seen a range of different types of people using heroin, but the younger people seem like they are dying more [overdosing]."* Law enforcement and treatment providers were able to identify typical heroin users. Law enforcement said, *"When I picture a heroin user, it's a younger, Caucasian person from suburbs and rural areas."* Treatment providers agreed, with one stating that the users they see are typically, *"lower income, late 20s, and White."* An officer described the pathway of heroin as it travels through populations: *"The way it [heroin] gets here is very specific. Brown powder comes in to the US via Mexico. From there, it moves from Black dealers to White users."* Another officer agreed and recalled experiences in processing heroin arrests: *"I do all the interviews in the jails, and I have only had one African-American male say he was a heroin user. [African-Americans] are the dealers and they deal primarily to the Caucasians. I haven't had one Hispanic to interview as a user. A lot of the guys are from farm counties—Preble, Butler—we get a lot of that."* Treatment providers also continued to recognize the pill-to-heroin progression, and cited new heroin users to include: *"White females who are involved with a male who's done the progression; Somebody that starts off young with marijuana, into coke [cocaine] by age 13 or 14. They go right to shooting [injecting] heroin. They don't even mess around with the pills."* Providers also continued to note the recent trend of younger heroin users, with one adding, *"I think it's [heroin use] just getting younger. When I came here, I couldn't believe they [clients] were doing heroin here. I had all cocaine people in [my previous counseling job]. Then my first 20 people here were all heroin. Then it seemed to get younger and younger."*

Reportedly, heroin is used in combination with alcohol, antihistamines, crack cocaine (a.k.a., "chasing the dragon" when smoked together), marijuana, methamphetamine, powdered cocaine (a.k.a., "speedball" when injected together), promethazine (sinus allergy medication) and sedative-hypnotics (sleeping pills, Valium®, Xanax®). A user explained, *"I've seen people put it [heroin] on the stem [pipe] with the crack [cocaine]. That's called, 'chasing the dragon.' It's also called, 'peanut butter sandwich.'" Participants reported a preference for some drugs as they are believed to be narcotic enhancers. A participant reported, "I like Valium® because it stretches it [the high] out." Several participants noted how common speedballing has become. A participant said, *"Some people won't do one [heroin] without the other [cocaine]. They're either that kind of heroin user or they're not."* Participants noted that dealers will typically accommodate users who speedball; one said, *"On my old phone, I had 40**

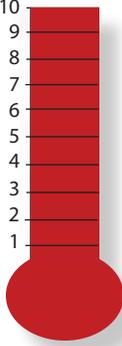
dope boys [drug dealers] who sold coke [cocaine] and heroin. People that speedball want both or we're going to someone else [to buy]."

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' (high availability, extremely easy to get). Treatment providers also reported very high availability of prescription opioids. The consensus among almost all participants across focus groups was that prescription opioids were more available than in the previous six months. Most participants agreed that the increased availability was due to increased prescribing in hospitals, private physician offices and occasionally pain clinics. Several participants reported that Opana® in particular had increased in demand and had become more available. Reportedly, the reformulation of OxyContin® OC into the more abuse resistant OxyContin® OP had little effect on the drug's widespread use. Participants in each focus group described different variations on how to get around the challenges posed by reformulation. The most common route of administration for prescription opioids was oral consumption, including wrapping crushed pills in bathroom or facial tissue and swallowing (a.k.a., "parachuting"). Participants and treatment providers alike stated that illicit use of prescription opioids in their communities was a far-reaching problem.

Current Trends

10
9
8
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2
1



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'. A law enforcement officer lamented, *"Opiate-related deaths have surpassed vehicle accident deaths in Montgomery County."* Participants noted that prescription opioids are easily obtained from one of many known contacts, usually within a single phone call, and occasionally available from an unknown street-level dealer. A participant reported, *"I could walk across the street and get some [prescription opioids] now."* A treatment provider reflected, *"More general things [common prescription opioids], things prescribed in the ER, like oxy's [OxyContin®], Vicodin®, Percocet®—those are easier to get. I don't hear so*

much about the other pills. The more folks that are longer term in the drug world, they can get methadone or something like that. Participants, law enforcement and treatment providers identified the three most popular prescription opioids in terms of widespread use as methadone, Percocet® and Vicodin®.

By a slight majority, participants reported that the availability of prescription opioids has remained stable over the past six months. Some participants cited the growth in heroin availability as a reason why prescription opioid use has not increased in availability: *“Heroin’s easier to get, and cheaper.”* Participants also noted that prescription opioids hold more appeal to some users over heroin because, *“You always know what you’re getting with pills—unlike heroin.”* Only OxyContin® OC was reported to have decreased in availability in recent months. Opana® continues to be a drug mentioned as gaining in popularity among users. Law enforcement and treatment providers also felt that prescription opioid availability has remained the same over the past six months. Miami Valley Regional Crime Lab reported that the number of prescription opioid cases it processes has remained generally the same over the past six months; noted exceptions were a decrease in the number of OxyContin® cases and an increase in the number of morphine cases. Media sources in the region reported on arrests this reporting period involving drug trafficking in prescription opioids. In March, *WHIO-TV Dayton* reported on the arrest of eight suspected drug dealers in Clark County, charged with trafficking in crack cocaine, oxycodone, heroin and marijuana (www.whiotv.com, March 31, 2011).

Reportedly, many different types of prescription opioids (a.k.a., “meds,” “candy”) are currently sold on the region’s streets. Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Darvocet® (2 mg sells for \$10, 4 mg sells for \$20–\$40; 8 mg sells for \$30), fentanyl (800 mcg buccal tablet sells for \$20; 50 mcg patch sells for \$10–\$15; 75 mcg patch sells for \$25, 100 mcg patch sells for \$35), methadone (a.k.a., “dones,” “M&M’s,” “wafers;” sells for \$.50–\$1 per milligram for pills and wafers), morphine (a.k.a., “morphs;” 15 mg and 30 mg sells for \$5–\$10, 60 mg sells for \$3–\$15, 100 mg and 200 mg sells for \$15–\$20), Opana® (sells for \$1–\$1.50 per milligram), OxyContin® (a.k.a., “oxy’s”), OxyContin® OC (old formulation, a.k.a., “OC’s” and any use of the initials ‘O’ and ‘C;’ sells for \$1.50–\$2 per milligram), OxyContin® OP (new formulation, a.k.a., “jellybeans,” “OP’s;” sells for \$.75 per milligram), Percocet (a.k.a., “perc’s;” sells for \$.50–\$1 per milligram), Roxicet® (a.k.a., “roxi’s;” 15 mg sells for \$7–\$10; 30

mg sells for \$10–\$15), Tylenol® 3 (\$1 per pill), Vicodin® (a.k.a., “jellybeans,” “V’s,” “vikes;” 5 mg sells for \$2–\$3), Vicodin® ES (a.k.a., “7.5ers,” “ES’s;” 7.5 mg sells for \$3.50), Vicodin® HP (10 mg sells for \$7–\$8).

In addition to obtaining prescription opioids on the street from dealers, participants continued to report friends, family and other drug users as additional sources. However, the most commonly reported source for these drugs remains doctors. A participant reported, *“I would get them [prescription opioids] from a dealer and pill mills [pain management clinics]. Those are the most common places.”* A law enforcement officer stated, *“In the past five years, it’s almost an epidemic [prescription opioid use]. It’s from the doctors. We’re all over-medicated, and the number of doctors who are pill mills is ridiculous.”* A treatment provider cited personal experience: *“I just had a small operation, and the doctor gave me 60 Vicodin® with a refill. I guess he thought, ‘She’s good, she won’t abuse it.’”* A participant noted that in certain areas, pills were not obtained, *“so much from dealers, they don’t typically carry them.”* Also, people who had suffered injury and the elderly who were given a legitimate prescription were identified as dealers. A treatment provider observed, *“There’s a lot of elderly people on a regular script [prescription] who sell them [prescription opioids] for income.”*

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 remain oral consumption (swallowing) and intranasal inhalation (snorting). Out of 10 prescription opioid users, participants reported that approximately four would take the pills by mouth (either chewing and/or swallowing), four would snort them, and two would intravenously inject or “shoot” them. Administration routes vary based on the nature and formulation of the drug, and creativity is employed to achieve an optimal high. In one session a participant recalled, *“I saw them [users] shooting methadone. They said it got them high instantly.”* Another participant responded, *“I’ve done that [injected methadone], too.”* A counselor commented about fentanyl patches: *“Users burn them [fentanyl patches] too. I think to inhale the smoke.”*

A profile of a typical user of prescription opioids emerged from the data. 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. Law enforcement also described that pattern: *“We’ve seen users switch over from oxy’s [OxyContin®] to heroin because it’s [heroin] cheaper.”*

That's the bulk of it. We've seen 40-year-old school teachers to 18-year-old kids [switch to heroin use]. It's a lot easier to switch from pain pills to heroin." Another participant described the typical user as well as the infrequent user: *"It's [prescription opioid users] predominantly White younger males. Then you have older White dudes. I haven't seen a lot of older Black dudes, Black chicks, or younger Black dudes eating pills. They probably do, but I don't see it. It's young White people."* Law enforcement agreed; an officer reported, *"White folks are higher on the list [of prescription opioid users]. It's tilted toward the lower income, but you can go into any rich mom's cabinet and find some [prescription opioids]."* Another officer remarked, *"More white people are who I see [using prescription opioids]. It's more socially acceptable in the lower income levels. You see the same people well-off doing the same thing. They just don't have the neighbors over to pop some vikes [Vicodin®]."*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, crack cocaine, heroin, marijuana, methamphetamine, powdered cocaine, sedative-hypnotics (i.e., Xanax®) and other prescription opioids. A participant noted how prescription opioids appeal to many different drug users: *"They [users] do pills [prescription opioids] when they can't get a hold of other drugs."*

Suboxone®

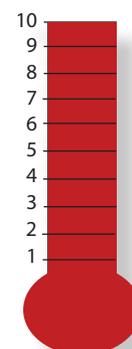
Historical Summary

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' (high availability, extremely easy to get). The consensus among participants was that Suboxone® was easy to get. While a few participants reported being either currently or previously prescribed Suboxone® by a physician in their community, through a treatment center or while incarcerated, most frequently participants reported obtaining Suboxone® on the street from drug dealers. Miami Valley Regional Crime Lab reported an increase in the number of Suboxone® cases it processed over the previous six months. Participants reported pricing for Suboxone® 8 mg to range from \$7 to \$20, with the most frequently reported price being \$10. Reportedly, Suboxone® was most often taken sublingually, letting it dissolve under the tongue. Several participants in each focus group reported snorting Suboxone®, and very few participants reported intravenous use.

Current Trends

Suboxone® remains highly available in the region. Participants most frequently reported current street

availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. A participant explained Suboxone® availability: *"It's [Suboxone®] pretty available, but you have to put the work in [locating it]."* Law enforcement and treatment providers did not supply detailed data about Suboxone®. Although awareness of the drug across all interview groups seemed to be low, participants with some knowledge reported that the availability of Suboxone® has increased over the past six months. A participant reported, *"I heard people in jail saying they're trying it to get off heroin. It's [Suboxone® availability] up a little bit."* Miami Valley Regional Crime Lab reported that the number of Suboxone® cases it processes has remained the same over the past six months.



No slang terms or common street names were reported for Suboxone®. Participants reported current street pricing for Suboxone® 8 mg to range from \$10-\$15. Most often participants reported taking Suboxone® as indicated (sublingually). Strips were mentioned more than the pill form of the drug. Out of 10 Suboxone® consumers, participants reported that approximately one would snort it, three would intravenously inject it or "shoot it," and six would take the pills or strips through oral consumption. In one session, a participant stated, *"I quit going [to the Suboxone® clinic] because I started shooting Subutex. I was shooting both. I was the only person there I knew that was doing it. You have to work at it [injection] to get it to work."* To which another participant responded, *"I've never seen the Subutex®. It's not real common to shoot that."*

In addition to obtaining Suboxone® on the street from dealers, participants continued to report getting it from doctors, friends and pain management clinics. A participant described Suboxone® as a drug requiring, *"a couple phone calls to friends of friends."*

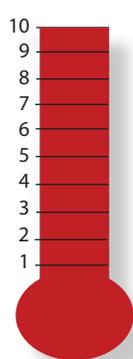
A profile for a typical Suboxone® user did not emerge from the data. Participants described typical users of Suboxone® as both people who wanted to address their heroin addiction and those who seek heroin but couldn't find any. A treatment provider said, *"It's [Suboxone®] for people who claim they want to get off heroin to help with the [withdrawal] symptoms."* Another treatment provider noted that demand for treatment is 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. We turn people away for Suboxone®, and when they can't get it here, they buy it off the streets."* Reportedly, Suboxone®

is used in combination with alcohol and sedative-hypnotics (benzodiazepines), both of which were reported to intensify the effects of Suboxone®.

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described some sedative-hypnotics as more readily available than others. Most participants stated that sedative-hypnotics had become more available over the previous six months. Miami Valley Regional Crime Lab reported that the number of sedative-hypnotic cases it processed had remained stable over the previous six months. In addition to obtaining sedative-hypnotics on the street from dealers, participants reported visiting primary care physicians, emergency room physicians, psychiatrists and nurse practitioners to obtain prescriptions for these drugs. Participants believed that sedative-hypnotic use crossed all ages, races and socioeconomic groups.

Current Trends



Sedative-hypnotics (i.e., 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 the three most popular sedative-hypnotics in terms of widespread use as Ativan®, Klonopin® and Xanax®. A participant noted that sedative-hypnotics are easy to obtain through legal

means: "People know what to say [to doctors] to get these [sedative-hypnotics] prescribed to them." A treatment provider reported, "Everybody wants Xanax®, Ativan® and Klonopin®. A lot of the time people will fake an anxiety disorder and come in here [treatment program] to get some. We have a reputation for not prescribing. But they can still get them from family doctors and the ER. They get a week's worth at the ER." Participants and drug treatment providers reported that the availability of sedative-hypnotics has remained stable over the past six months. Said one participant, "They're [sedative-hypnotics] still highly available, but availability is about the same." A

treatment provider compared the availability of this class of drugs with pharmaceutical opioids by saying, "Yes, you can still get [sedatives-hypnotics]. They're not as available as oxy's [OxyContin®]. It's a different group of people looking for these." Miami Valley Regional Crime Lab reported that the number of sedative-hypnotic cases it processes has remained stable for most drugs, with the exception of Klonopin® and Restoril®, which have experienced an increase in the number of cases processed over 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 the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ativan® (a.k.a. "houses," "vans;" \$1 per pill), Klonopin® (a.k.a. "K's," "K-cuts," "klondikes," "klonies" and "pins;" \$1 per pill), Valium® (\$3 per pill); Xanax® (a.k.a. "basketballs," "footballs," "ladders," "wagonwheels" and "xani's;" 5 mg sells for \$2, 10 mg sells for \$3).

In addition to obtaining sedative-hypnotics on the street from dealers on occasion, participants continued to report getting these drugs most often from doctors. Emergency rooms, family and friends remain secondary sources. A participant reported, "Sometimes you can get them [sedative-hypnotics] from the dope boys [drug dealers]." Another participant replied, "I got mine [sedative-hypnotics] from the hospital. They'll give you enough to leave with." Treatment providers agreed by saying, "They [users] get them from doctors and ERs."

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 route of administration is oral consumption. Out of 10 pharmaceutical opioid consumers, participants reported that on average, eight would take the pills by mouth (either eating and/or swallowing), two would snort it, and none would intravenously inject it or "shoot it." It was also noted that some users would mix the methods in a single session of use. When asked to imagine 10 users of sedative hypnotics and preferred methods of administration, a participant said, "All 10 are swallowing and snorting pills [sedative-hypnotics] while they're getting ready to shoot them."

A profile of a typical user of sedative-hypnotics emerged from the data. Participants described typical users of sedative-hypnotics as opioid users, generally White. A treatment provider said, "Typically it's our heroin users that use them [sedative-hypnotics] and mix them." A participant described how typical users of sedative-hypnotics closely mirror users of heroin: "You could say White. It's mostly White,

but 10 percent African-American." An exception was noted by a treatment provider, "No kids are using these drugs [sedative-hypnotics]." Both professionals and consumers recognized that users who were prescribed these drugs by mental health professionals constitute a large share of abusers. Said a treatment provider, "Also people with anxiety issues who are getting them [sedative-hypnotics] legitimately ... Mommies in their 30s, addicted to Valium®." To this comment another treatment provider responded, "I see it [with diagnosis of] mental health [disorders]; the doctor has prescribed them [sedative-hypnotics] too much for too long and now they want somebody else to fix it. We get a lot of that."

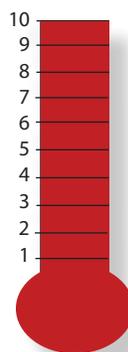
Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, crack cocaine, heroin and marijuana. One participant explained the heroin-sedative connection, "If you can't get any heroin, [sedatives] will help with the sickness." Another participant explained why Valium® and Xanax® are often preferred by heroin injectors: "They shoot whatever they can. If you add Xanax® to stuff for some reason, it helps stuff break down easier." Other users agreed that sedative-hypnotics assist users who want to come down from other drugs.

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 and treatment providers described marijuana as being extremely easy to get. Participants reported that the quality of marijuana varied with the most common quality score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that for commercial-grade marijuana, a "blunt" (single cigar) ranged in price from \$10-\$20 and an ounce ranged in price from \$100-\$120; for high-grade marijuana, an ounce ranged in price from \$300-\$400. While there were a few reported ways of consuming marijuana, the most common route of administration was smoking, followed distantly by eating, either by itself or baking marijuana into food. When asked to describe the typical user of marijuana, respondents were unable to be specific. They reported that virtually everyone uses marijuana, including all ages, races and socioeconomic groups.

Current Trends

Marijuana is the most widely available drug 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 often commented that the scale used for ranking marijuana "didn't go high enough" to accurately reflect the availability of marijuana. A participant stated, "It's [marijuana current availability] a 10+ on your scale." Law enforcement most often reported the drug's current availability as '10'. An officer explained that marijuana is obtained easily from known acquaintances, "It's like two degrees of Kevin Bacon [the path to marijuana]. You can find [marijuana with] a friend." Another officer added, "It's so easy to get [marijuana] from friends, I think if you went up to a corner looking for weed [marijuana], they'd [dealers] think you were a cop. That's not what you'd do." Marijuana appears to be the drug of choice for regional juveniles involved in the court system. Of the 1,231 juveniles that tested positive for drugs in Montgomery County Juvenile Court from July 1, 2010 to December 31, 2010, more than 87 percent tested positive for marijuana. Participants and law enforcement reported that the availability of marijuana has remained the same over the past six months. However, certain trends were observed by law enforcement, one of which was an increase in high-quality and specialty varieties of marijuana. Law enforcement frequently talked about the increase in marijuana's quality: "Over the past two to three years, we've seen better grade [marijuana]. There's a lot more designer marijuana with flavoring, stuff that makes it less harsh. A lot of them [growers] will add things to the soil, a plant food added to soil. Also, we're seeing so many new strains of marijuana; The hybridization is very advanced. What works for corn or whatever, they're using that technology on the marijuana." Other trends in marijuana concern the price; there is a price decrease for low-grade marijuana and a price increase for the high-end marijuana product. One officer remarked, "Ditch weed [low-grade marijuana] is easier to get than hydro [hydroponically-grown or high-grade marijuana]. The price is a lot cheaper to get lower grade." Finally, the officers noted that there are increases in dealer inventory quantities. As one officer explained, "The [marijuana] availability is the same, but the amount is up. Instead of a dealer with half a pound, now it's one to two pounds. Grow operations that were 10 to 20 plants are now 100 to 200 plants." Regional media reported that several large marijuana seizures occurred during this reporting period. The *Vindicator* reported that Ohio State Highway Patrol Officers stopped a man on interstate 70 in Preble County for a traffic violation. After seeing marijuana in the truck cab, officers performed a more comprehensive search at which time they found 871 pounds of marijuana worth an estimated \$2

million (www.vindy.com; Feb. 17, 2011). *The Urbana Daily Citizen* also reported on a large marijuana growing operation in Mechanicsburg. After a man was stopped during a routine traffic violation, an officer noticed a glass jar with marijuana and other cultivation tools. Further investigation of the man's home yielded 554 marijuana plants (www.urbanacitizen.com; April 2, 2011). Miami Valley Regional Crime Lab reported that the number of marijuana cases it processes has decreased over the past six months.

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). Participants did not agree if quality had increased, decreased or remained the same over the past six months. A participant outside of Dayton commented, "It's not as easy to get really good high-grade [marijuana] as it is in the city. They're not growing it for the quality." Another participant said, "Around here it's garbage [marijuana quality]." In a Dayton interview, a participant stated, "Out in the country they grow vast amounts of high-grade [marijuana]," but another Dayton participant said, "It's [marijuana quality] getting better, and it's getting stronger." Despite these comments, participants ranked the quality of both kinds of marijuana highly. Participant quality scores for high-grade marijuana varied from '4' to '10' with the most common score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participant quality scores for low-grade marijuana were either '5' or '10' with the majority of participants ranking it '10'. At first glance, current quality scores seem contradictory because they overlap and the range of scores for low-grade marijuana is slightly better than that of high-grade marijuana. It is possible that participants either experienced a rise in the quality of mid-grade products or had confusion as to the nature of the product they had actually received. As one participant said, "People just make up [high-grade marijuana] names too, or they'll tell you it's a grade. They don't know."

Current street jargon includes countless names for marijuana. Participants listed the following as common street names: "bammer," "brickweed," "dirt," "doo doo" and "low" for low-grade marijuana; "commercial," "middies," "reg" and "regular" for mid-grade marijuana; "AK-47," "blueberry pie," "dro," "dumpster," "home grow," "hydro," "juicy fruit," "kind bud," "kush," "lemon drop," "lemon skunk," "monkey paw," "purp," "pineapple express," "purple haze" and "skunk" for high-grade and hydroponically-grown marijuana. The price of marijuana depends on the quality desired. Participants reported that they could buy commercial-grade marijuana (regular to mid-grade) in many different quantities: 1/8th ounce sells for \$25–\$30; 1/4 ounce sells for \$30–\$50; an ounce sells for \$90–\$140;

1/4 pound sells for \$300. Participants also reported they could buy high-grade marijuana in many different quantities: a "one hitter" blunt of approximately 1.5 grams sells for \$20–\$40; 1/8 ounce sells for \$50; 1/4 ounce sells for \$100; an ounce sells for \$200–\$400 for hydroponic marijuana.

While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. According to participants, 10 out of 10 marijuana users would smoke the drug. Other administration routes were discussed, but used infrequently by participants. With regard to smokeless vaporizer devices, "They're selling those [vaporizers] everywhere. I've seen them," said a participant, but very few others had heard of them. Participants also continued to mention that it is possible to ingest marijuana in brownies or butter, but participants said these methods would never be employed for high-grade marijuana: "I would not eat no 'purp' [hydroponic marijuana]!"

A profile for a typical marijuana user did not emerge from the data. Participants continued to describe typical users of marijuana as anyone of any age, race or income level. Participants and law enforcement agreed that the stigma of this drug's use is gone among the general population. As one officer said, "We're close to legalization [of marijuana]."

Reportedly, marijuana is used in combination with crack cocaine, heroin, methamphetamine, powdered cocaine and PCP (a.k.a., "sherm" or "wet"). A participant also described observing marijuana used with a rolling paper that had been dipped in liquid hydrocodone and dried before being smoked. The participant said, "That's called a 'freaky blunt.'"

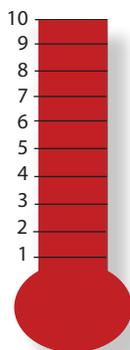
Methamphetamine Historical Summary

In the previous reporting period, while infrequently abused by any participant, those respondents who reported methamphetamine use over the previous six months most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). When asked whether the powdered or crystal form of the drug was more available, participants said that both forms were equally available. Miami Valley Regional Crime Lab reported that the number of methamphetamine cases it processes had increased over the previous six months. Participants reported that they could buy a gram of methamphetamine for \$25–\$40. The most common routes of administration included smoking and

intravenous injection. Participants were not able to provide a typical user profile for methamphetamine; they reported that use falls across all ages, races and socioeconomic classes.

Current Trends

Methamphetamine continues to be infrequently used by participants. In fact, only three participants of 40 were able to supply an availability ranking for this drug. Those users with methamphetamine experience 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 also '10' among those few participants with first-hand knowledge of the drug. Participants reported that methamphetamine is available in home-cooked, powdered form. Treatment providers reported that methamphetamine use is relatively rare among their clientele. A treatment provider said, *"I have one current client in recovery for methamphetamine, but she's from Cincinnati."* Law enforcement officers believed that methamphetamine is not available in their area: *"We don't see it [methamphetamine] here in Montgomery County. We see it in outlying areas like Preble County. East of Montgomery County is all suburbia, so you have to get to the western part of the county to make a lab without the neighbors smelling it."* Of the few participants with knowledge of the drug, most felt that methamphetamine had become more available over the past six months, largely due to the belief that, *"They're [dealers] putting it [methamphetamine] in with the crack [cocaine]."* However, this idea was challenged by a participant, *"It [methamphetamine] costs more than coke [cocaine], so I don't know why they [dealers] would cut [adulterate] it [crack cocaine] with that [methamphetamine]."* Regional media reported that several methamphetamine labs were discovered during this reporting period. An area drug task force arrested three men in Darke County after police learned about an active methamphetamine lab. In addition to finding methamphetamine and the equipment to manufacture the drug, the police found marijuana, prescription pills, drug paraphernalia and more than \$1,110 in cash (www.whiotv.com; Feb. 7, 2011). *The Register Herald* also reported that police in Preble County found a methamphetamine lab in a man's home that included crystal methamphetamine along with the chemicals and equipment to manufacture the drug (www.registerherald.com; April 6, 2011). Miami Valley Regional Crime Lab reported that the number of methamphetamine cases it processes has decreased over

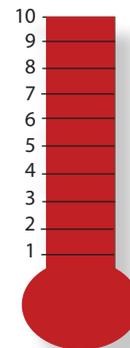


the past six months, and that the most frequent forms of methamphetamine that came through the lab were tan and blue powder/chunk along with crystal.

Current street jargon includes a few terms for methamphetamine. The most commonly cited names were "ice" and "one-pot meth," which refers to the home-cooked method of producing methamphetamine in a two-liter bottle. Current street prices for methamphetamine were cited as \$100 per gram. Participants did not discuss the common routes of administration of methamphetamine. A profile for a typical methamphetamine user did not emerge from the data, but participants, law enforcement and treatment providers believed cookers and users of methamphetamine are rural-dwellers, living in predominantly White areas of the region.

Bath Salts¹ Current Trends

Bath salts are highly available in the region. Participants reported the availability of bath salts as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Bath salts are synthetic compounds that can produce a high similar to a stimulant or hallucinogenic drug. These compounds commonly contain methylone, mephedrone or MDPV. The generic term, bath salts, is in and of itself 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. Readily available from drug stores, head shops and some convenience marts, bath salts were legally sold during this reporting period. In the Dayton region, this drug rapidly gained popularity, and was cited by professionals and participants alike as a growing problem. Bath salts use was 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 use. Participants from the southwestern portion of the region did not note bath salts use as an explosive trend but had encountered the substances. Some participants interviewed in Dayton locations had not yet heard of bath salts. Participants noted that despite local legislation to prohibit sale of bath salts in certain municipalities, bath salts continue to be: *"Very, very available. It's [bath salts] at gas stations, dairy marts and head shops. It's pretty cheap. The gas station is cheap. The smoke shop is more expensive, but they'll break it down in different quantities for you."* Treatment providers



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

most often reported the current availability of bath salts as '9.' A treatment provider stated, "It [bath salts] started out easy to get. A local store advertised it. Then, [city officials] yanked it off the counter. The kids were getting high and some of the community didn't like it."

Participants and treatment providers reported that the availability of bath salts has increased over the past six months due to its widespread availability and legal purchase. A participant reported, "Some of our friends have died from it [bath salts use.]" A treatment provider remarked on the uptick of bath salts-related calls and questions their program has received, "We're seeing new [bath salt] users coming in to the ER now. They're high for three days, and they're afraid. It scares them. They present as mentally ill. The ER wants us to come screen them. Then, they call ODADAS or Poison Control, and Poison Control says, 'We don't know.'" Media reports from the region mentioned the frequent abuse of bath salts during this reporting period. The *Dayton Daily News* discussed the number of people that were seen at area hospitals because of complications from bath salts ingestion. Teens and adults (ages 18–48 years) were regularly seen at hospitals like Dayton Children's Medical Center, Miami Valley Hospital and Wayne Hospital. A representative from Miami Valley Hospital said, "The emergency department has seen about one bath salts case a day since the second week of April" (www.daytondailynews.com; June 21, 2011). The news station 10TV also reported on the abuse of bath salts in the region. A nurse from Miami Valley Hospital reported that she had seen over 60 cases of bath salts poisoning in one and a half months. An official from Wilmington City Council explained, "The misconception is that because a businessman is selling it, that it's safe. That's the real concern that I have. There are those that don't realize how dangerous it [bath salt] actually is" (www.10tv.com; June 17, 2011). Miami Valley Regional Crime Lab reported that the number of bath salt cases it processes has increased over the past six months.

Bath salts are reportedly available in two forms: sealed packages or loose crystals for bulk sale. Quality of the packaged bath salts is reportedly "very good." A participant stated, "Every kind [of bath salts] I tried was outrageously powerful." Another said, "I only messed with one type [of bath salts], and mine was pure." Quality of the loose form varies. A participant reported, "The [bath salts] packages I've seen lately aren't sealed. They come in unsealed packages or canisters. It's unsafe; it could be anything. The sealed ones like Cloud Nine looked more trustworthy." A user described the drug this way, "The stuff in the beginning [bath salts] would keep you up for days and days. Then it seemed like it wasn't as potent ... A head shop had a big plastic bowl of it, and by the time they were done with [cutting] it, it looked like it was moist and fluffy and a

different color all together. They stepped on it [adulterated] right in front of you right there." Another participant agreed that the loose form was of dubious quality, "I just OD'd [overdosed] on bath salts, and I tested for having Ecstasy and GHB in my system. I don't do those drugs." A treatment provider noted that this is problematic for first responders: "One of the reasons they don't know a lot about it [bath salts] is because there are no ingredients on the package. There's no info about what's in it, what the stimulant is. They don't know how to treat it."

Bath salts that come in sealed packages are sold under names such as "Cloud Nine," "G14," "Locomotion," "White Girl Plus," "White Girl with Charlie Sheen," "White Horse," and "Vanilla Sky." Pricing for sealed packages varies; a particular brand may sell for \$22 while other brands may sell for \$35. Bath salts are also available in bulk, or loose, usually from a head shop. Participant pricing information for loose bath salts purchase varied widely. The most commonly reported methods of administration are smoking and intranasal inhalation (snorting). A user explained, "You can smoke it [bath salts] on foilies [aluminum foil squares], snort it. I've known people that shot it up [injected]. I preferred to smoke it on foilies." Because both forms of the drug are powdery or crystalline, bath salts can be sprinkled on cigarettes. A participant explained, "You put it [bath salts] on a car cigarette lighter, you get it hot and drop it in and take a nose hit, or dip your cigarette in it and light it." No name was given for these methods, though they are reportedly common. Another user explained intranasal inhalation: "I've only snorted [bath salts]. Dip a knife in there and snort it." Participants agreed that injection is not as common as the other methods: "You smoke it [bath salts] on a piece of foil or smoke it like a crack [cocaine] stem type of deal [in a pipe]. I've never heard of anyone injecting it; No, there's not a lot of injecting."

A profile for a typical bath salts user emerged from the data. Participants and treatment providers described typical users as young (teens to mid-20's) suburban or rural dwellers, White, male and with some financial means. A treatment provider reported, "The ones I see [bath salts users] are adolescents. They were smoking weed [marijuana], then they try bath salts because it was easy to access. They're White, middle income, 16–17 years old." Participants also agreed that young people are trying the drug because it's legally available to them: "Kids here were doing it [bath salts]. Two went to the ER on it."

Reportedly, bath salts are used in combination with alcohol, crack cocaine, heroin, prescription opioids and sedative-hypnotics (Xanax®). A user discussed how certain pills augment the effects of bath salts: "I'd use all kind of pills ... Vicodin's® [and] Percocet's®. Doing it along with bath salts

because then it's like a cocaine buzz. Percocet® gives you a buzz. Every time they did [bath salts], they did pills right afterwards." Another participant explained how other drugs helped to come down from bath salts, *"I did Xanax® to help me relax [after bath salts use] but that wasn't working, so I did heroin to sleep."* Participants and treatment providers both reported that marijuana is not typically mixed with bath salts use because according to a participant, *"It [combination of bath salts and marijuana] makes you paranoid. This is true for most users."* A treatment provider agreed, *"The marijuana kids [I treat] didn't like it [mixing bath salt use with marijuana]."*

Other Drugs

Historical Summary

In the previous reporting period, participants and community professionals listed the following other drugs as present in the region, but these drugs were not mentioned by the majority of people interviewed: Ecstasy, hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], inhalants, prescription and over-the-counter (OTC) cough medicines, and synthetic marijuana ("K2" and "Spice"). Ecstasy was highly available in the region. Miami Valley Regional Crime Lab reported an increase in the number of Ecstasy cases it processed over the previous six months, reporting slightly more MDMA-based Ecstasy cases than BZP-based (benzylpiperazine) Ecstasy cases. Participants reported a single tablet of Ecstasy sold for \$3–\$20 and that the price of the pill depended on a variety of factors, including quantity purchased with volume discounts being the norm. The only reported method of administration was oral consumption. LSD was mentioned by a few participants, but no one knew about pricing or availability. Synthetic marijuana was widely available and was being used by a few participants for recreational use. Prescription cough medicines that contain codeine and OTC cough medicines containing dextromethorphan (DXM), like Coricidin Cough and Cold® (a.k.a., "triple C's") were mentioned by several participants. While none of the participants used these drugs, they said cough medicines were popular among teenagers who had little access to other drugs. In addition, participants reported inhalants like air duster were also popular among teenagers.

Current Trends

Participants and community professionals listed a variety of other drugs as being present in the area, but these drugs were not mentioned by the majority of people interviewed. Synthetic marijuana ("K2" and "Spice") is highly available throughout the region. Participants frequently mentioned its rising popularity due to the belief that the drug delivers

a marijuana-like high but cannot be detected by urine drug tests. A participant reported, *"I know a lot of people who switched from marijuana to [synthetic marijuana] to pass a drug test."* Many participants had heard of synthetic marijuana, but could not supply personal knowledge of the drug. Miami Valley Regional Crime Lab reported that the number of synthetic marijuana cases it processes has increased over the past six months. Participants observed that synthetic marijuana is available for purchase at convenience stores and gas stations. A participant noted that the drug is available at the same stores where bath salts are sold. Pricing is reportedly \$5–\$10 per gram for brands like "Dead Man Walking." Other brands offer higher quality and thus cost more. A participant explained, *"Sonic is \$15 per gram, and you smoke a little, and you're higher than hell."* Flavored varieties are also available. Depending on the brand, a participant stated the quality of synthetic marijuana ranged between '7' and '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality), and that the effects of the high were similar to marijuana. A user questioned the contents and ingredient disclosures, *"It's [synthetic marijuana] sealed like a real package, but I don't trust it because you don't know what they're putting in it."* The primary method of administration for this product is smoking, but vaporizers are also reportedly used to ingest the drug. Prescription opioids and sedative-hypnotics were commonly cited as being used with synthetic marijuana, in the same ways and for the same reasons as with marijuana.

Ecstasy is also available in the region, but there was no agreement as to whether its availability is increasing, decreasing or remaining constant. In one focus group, participants cited Ecstasy as a popular drug, *"That's what we should have talked about. We have a lot of that [Ecstasy]."* However, this belief was not shared by everyone; all participants in a different focus group reported that availability of Ecstasy is decreasing. Law enforcement agents in the southwest region of Dayton stated, *"We used to have rave parties, like every week for a long time and 'X' [Ecstasy] was huge. With superman [depicted on Ecstasy tablets], colors and stuff, but we don't see that anymore."* Miami Valley Regional Crime Lab reported that the number of Ecstasy cases it processes has decreased over the past six months.

Hallucinogens like psilocybin mushrooms and lysergic acid diethylamide (LSD) are reportedly somewhat available by law enforcement and participants. Law enforcement was in agreement that while popularity ebbs and flows, *"We still see pretty minimal amounts of LSD."* A law enforcement officer said that the recent trend is toward an increase in hallucinogens, *"For a long time we never saw any mushrooms or LSD or anything. In the past year we've seen larger amounts*

of button LSD and psilocybin mushrooms. Not a huge issue, but coming around again ... with the college kids. They're experimenting with it." Miami Valley Regional Crime Lab reported that the number of LSD cases it processes has increased while the number of psilocybin mushroom cases it processes has decreased over the past six months.

Prescription stimulants are also available in the region. However, law enforcement, treatment providers and participants did not see this class of drugs as an urgent problem. Several treatment providers agreed when one said, *"It's [prescription stimulant use] minimal. Sometimes I see Adderall®."* Another treatment provider replied, *"I haven't seen anyone in for treatment with that [Adderall®]."* Miami Valley Regional Crime Lab reported that the number of prescription stimulant cases it processes has remained the same over the past six months. 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 cases it processes for salvia divinorum and anabolic steroids (methandrostenolone, stanozolol and testosterone).

Conclusion

Bath salts, crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids, sedative-hypnotics and Suboxone® remain highly available in the Dayton region. Noted increases in availability over the previous six months exist for bath salts and heroin. Heroin is believed to be an urgent substance abuse problem by participants, law enforcement and treatment professionals alike. Participants reported that the availability of brown powder heroin is significantly higher than that of black tar heroin, which is rarely seen. Brown powdered heroin is believed to be favored by dealers because it requires less knowledge to manipulate or adulterate. Participants noted that dealers are aggressively pushing heroin and will often give away testers, or free samples. Unlike other drugs that require a connection or phone call to obtain, heroin dealers are more likely to approach potential users. Powdered cocaine remains highly available in most areas of Dayton, but it is more difficult to obtain in some rural and suburban areas. Participants and law enforcement both noted that heroin dealers are more likely to now carry powdered cocaine than crack cocaine. There were two reasons cited for dealers to carry powdered cocaine: convenience for users who prefer to mix heroin with powdered cocaine (a.k.a., "speedball"), and because the quality of crack cocaine is so poor that users prefer to obtain powdered cocaine in order to "rock up" (manufacture) their own crack cocaine. Many different types of prescription opioids and sedative-hypnotics are currently sold on the region's streets. The most popular prescription

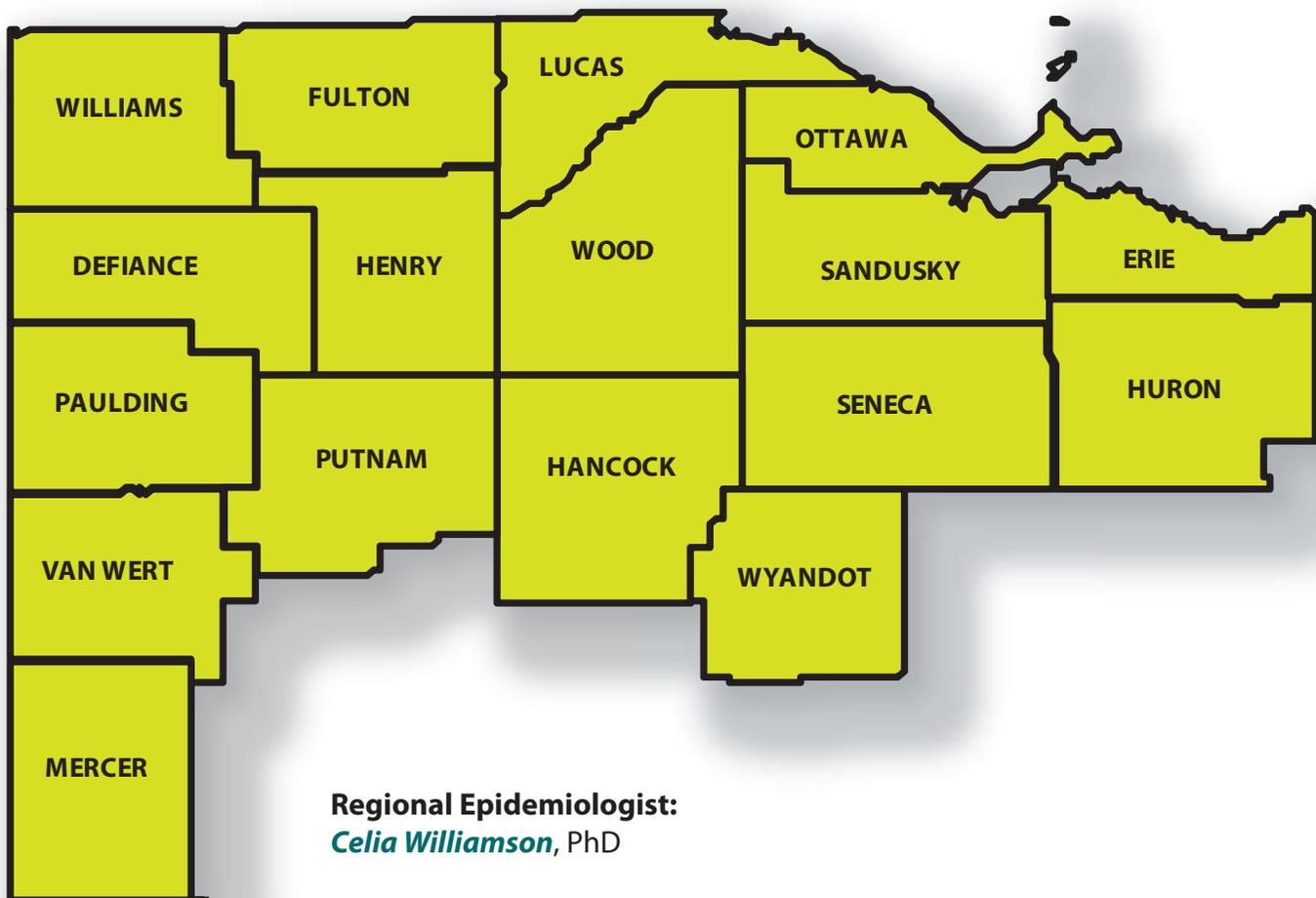
opioids in terms of widespread use are methadone, Percocet® and Vicodin®, and the most popular sedative-hypnotics are Ativan®, Klonopin® and Xanax®. In the Dayton region, bath salts are rapidly gaining in popularity, and were cited by professionals and participants alike as a growing problem. Miami Valley Regional Crime Lab reported that the number of bath salt cases it processes has increased over the past six months. Several media outlets reported on the increasing number of people overdosing on bath salts, with reports of at least three bath salts-related deaths. Synthetic marijuana ("K2" and "Spice") remains popular due to the belief that the drug delivers a marijuana-like high but cannot be detected by urine drug tests.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Toledo Region

January-June 2011

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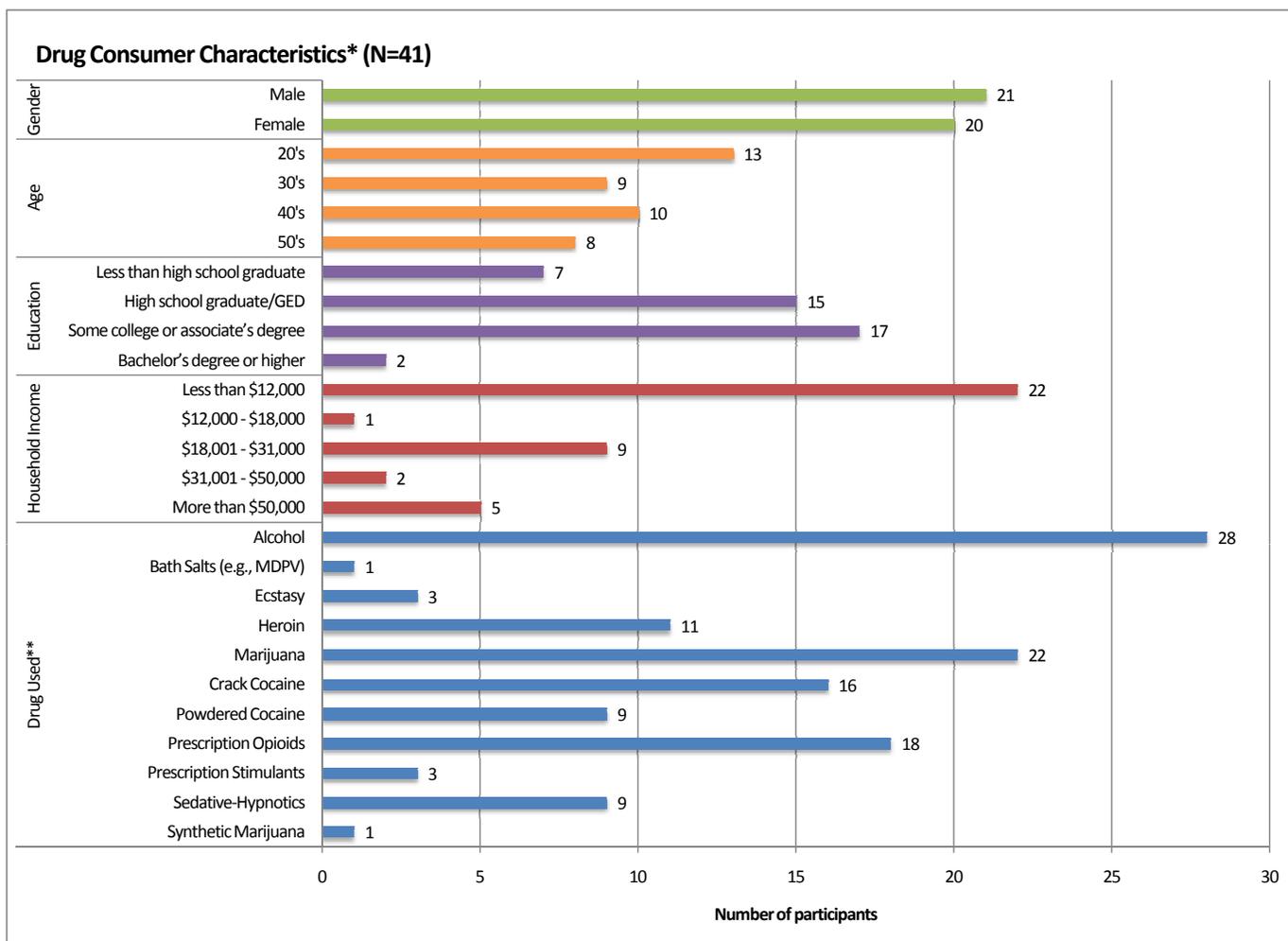
Regional Profile

Indicator ¹	Ohio	Toledo Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,542,645	1,249,616	41
Gender (Female), 2009	51.2%	51.1%	48.8%
Whites, 2009	82.2%	84.6%	72.5%
African Americans, 2009	11.9%	7.9%	17.5%
Hispanic or Latino Origin, 2009	2.8%	5.1%	5.0%
High school graduates, 2009	83.0%	92.3%	82.9%
Median household income, 2009	\$45,467	\$45,659	Less than \$12,000 ²
Persons below poverty, 2009	15.1%	13.9%	43.6% ³

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

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

Poverty status was unable to be determined for two respondents due to missing or insufficient income data³.



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

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Lucas County. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers, educators and coroner's office staff) via individual and focus group interviews, as well as to data surveyed from the Bureau of Criminal Identification and Investigation (BCI) Bowling Green Office, which serves Northwest Ohio. BCI data are summary data of cases processed from July to December 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current BCI data correspond to the current reporting period of participants. In addition to the aforementioned data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2011.

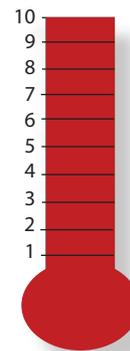
Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was 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' (high availability, extremely easy to get). Reportedly, the availability of powdered cocaine mostly had to do with one's connections with cocaine dealers. The most common participant quality score for powdered cocaine was '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Generally, participants reported that the quality of powdered cocaine was not good because dealers either cut (adulterated) it too much or were more interested in using powdered cocaine to create and sell crack cocaine. BCI Bowling Green crime lab reported that powdered cocaine was cut with several substances including caffeine, diltiazem (medication used to treat heart conditions/high blood pressure), levamisole (livestock dewormer) and procaine (local anesthetic). Participants reported that a gram of powdered cocaine sold for \$50–\$75. The most common route of administration for this form of cocaine was intranasal inhalation (snorting). Participants described typical users of powdered cocaine as those with enough financial means to afford the drug.

Current Trends

Powdered cocaine is highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible

to get) to '10' (highly available, extremely easy to get); the previous most common score was '7'. A participant noted, *"It takes a minute [to locate powdered cocaine for purchase]. You might have to give them [dealers] a day's notice or something."* Treatment providers most often reported the drug's current availability as '8'. A treatment provider reported, *"It's [powdered cocaine] available, and it seems like over time the trend is getting younger [in terms of age of users]. Previously we'd hear about older powdered cocaine users."* High school and college educators also reported high availability of powdered cocaine, although one educator reported, *"My high schoolers can't really afford it [powdered cocaine]."* Media from the region reported on recent arrests related to powdered cocaine during which law enforcement seized six pounds of cocaine along with \$381,000 in cash and 12 firearms in Seneca County (www.toledoblade.com, April 11, 2011) and 71 grams of cocaine along with 83 grams of heroin valued at \$40,300 during a traffic stop in Lucas County (www.vindy.com, April 18, 2011). All participants and professionals reported that the availability of powdered cocaine has remained the same over the past six months. BCI Bowling Green crime lab reported that the number of powdered cocaine cases it processes has also remained stable over the past 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 previous most common score was '4'. Participants reported that the quality of powdered cocaine has remained the same over the past six months. Participants reported that if a buyer can afford to buy larger quantities of powdered cocaine, they would receive a higher quality of the drug. As one participant said, *"The more [powdered cocaine] you buy, the better it gets."* Another participant commented, *"If you get powdered cocaine over 60 percent pure, you're doing good."* Participants reported that powdered cocaine in Toledo is cut (adulterated) with baby powder, Lactaid®, flour, lactose, acetone, and more recently crystal methamphetamine. This is the first report in Toledo of anyone mixing powdered cocaine with crystal methamphetamine. One user who purchased powdered cocaine to use intravenously commented, *"I looked at the bottom of the spoon and saw crystals. I'm from California and I know what crystal meth [methamphetamine] looks like."* BCI Bowling Green crime lab continued to cite the following substances as commonly used to cut powdered cocaine: 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 "powder" and "soft." Participants listed the following as other common

street names: “blow,” “booger sugar,” “girl,” “go fast,” “raw,” “snow” and “white girl.” Current street prices for powdered cocaine were consistent among participants with experience buying it, with overall prices remaining fairly consistent from the previous reporting period. Participants reported that a gram of powdered cocaine sells for \$45 to \$50, depending on the quality; 1/16 ounce, or “teener,” sells for \$75 to \$100; 1/8 ounce, or “eight ball,” sells for \$125 to \$150; an ounce, or “zip,” sells for \$800 to \$900. Participants reported that the most common way to use powdered cocaine remains intranasal inhalation (snorting), although some participants continued to report using powdered cocaine intravenously and by smoking it inside of a rolled marijuana cigarette (aka., “joints”) or cigar (a.k.a., “blunt”). When marijuana is smoked with powdered cocaine mixed with it, this is referred to as “cocoa puffing.” Powdered cocaine users also reported chewing the remaining contents left in the baggie that the cocaine was purchased in, which is referred to as “nummy.” A participant reported, “A lot of people like to chew the baggie.” Out of 100 powdered cocaine consumers, participants reported that approximately 90 would snort it, and 10 would intravenously inject or smoke it, with someone almost always chewing the baggie. A participant reported, “Younger people are more likely to smoke it [powdered cocaine] then snort it from the people I know.”

A profile for a typical powdered cocaine user emerged from the data. Participants continued to describe the typical user of powdered cocaine as those who have professional jobs during the day. As a participant explained, “My husband paid his attorney in powdered cocaine.” Participants also described typical powdered cocaine users as those who are nightclub goers on the weekends. A participant reported, “I have a buddy. He goes to the club and goes outside to snort [powdered cocaine].” Professionals agreed that powdered cocaine users seem to be more affluent than crack cocaine users. Finally, participants reported that there are those on the street who purchase powdered cocaine in order to rock it up into crack cocaine to sell or to personally use.

Reportedly, powdered cocaine is used in combination with alcohol, caffeinated energy drinks (Red Bull), heroin, marijuana, prescription opioids and sedative-hypnotics. When asked how common the practice of using other drugs along with powdered cocaine was, a participant responded, “It’s common if you have the money.” Educators reported that youth and young adults commonly mix the drink “Red Bull” with cocaine for an added boost. An educator reported, “They [high school students] like to mix Red Bull with everything ... they use it to double your high.” Using heroin and powdered cocaine together is known as a “speedball.” A participant reported, “I was always wanting to do speedball but it’s hard to get, to come up with enough heroin and enough cocaine for the

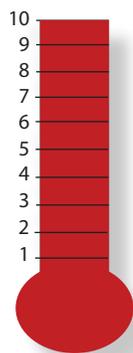
right mixture, ‘cause you always want to buy more coke or more heroin and that’s why it’s dangerous ...” In combining drugs, another participant reported, “I wouldn’t do any coke [cocaine] or speeders [stimulants] like that unless I had something to come down off.” The coroner’s office reported that they often saw alcohol having been used in combination with cocaine: “A metabolite of cocaine called coke-ethylene” is what can be fatal. A toxicologist with the coroner’s office explained, “Cocaine has a short half-life, so that means when you use the drug, it’s gone pretty quick. If you have a little alcohol – one beer – all of the sudden metabolism changes and you get this coke-ethylene which is active, and it’s actually better [more potent] than cocaine.”

Crack Cocaine Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants described crack cocaine as readily available throughout their neighborhoods. Treatment providers also rated the availability of crack cocaine as high. The most common participant quality score for crack cocaine was ‘7’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that crack cocaine was most often cut (adulterated) with other substances. BCI Bowling Green crime lab reported that crack cocaine was cut with several substances including caffeine, diltiazem (medication used to treat heart conditions/high blood pressure), levamisole (livestock dewormer) and procaine (local anesthetic). Participants reported that a gram of crack cocaine sold for about \$60. The majority of crack cocaine users reported buying the drug in small quantities, often called “rocks” that cost anywhere from \$2 – \$20. By far, the most common route of administration for this form of cocaine was smoking. Participants and treatment professionals alike stated that crack cocaine was far reaching into every socioeconomic 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.’ Several participants commented, “You can get it [crack cocaine] anywhere,” with a participant adding, “You don’t have to ask people [for crack



cocaine, they'll ask you [to buy crack cocaine]." Reportedly, dealers often approach potential buyers asking, "Are you cool?" or "You good?" both meaning, "Would you like to buy crack cocaine?" Treatment providers also reported the drug's current availability as '10'. Treatment providers reported that not only can someone in the drug culture immediately obtain crack cocaine but that crack cocaine is readily accessible to the general public as well. Educators reported that crack cocaine is accessible to high school-aged youth and readily available to college-aged youth,

although the drug was said to be less desirable than other drugs among college students. Participants reported that the availability of crack cocaine has varied over the past six months and is more available now. Both treatment providers and educators reported that availability of crack cocaine has either gone up or has remained stable over the past six months. No one believed availability has decreased. BCI Bowling Green crime lab reported that the number of crack cocaine cases it processes has remained stable over the past six months.

Most participants rated the quality of crack cocaine as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '7'. Reportedly, quality varies depending on from whom one purchases and on who the "chef was in the kitchen" (the person who manufactured the crack cocaine). Participants reported that crack cocaine in Toledo is typically cut (adulterated) with baby laxative, baking soda, Lactaid® or Similac®. A participant reported that he purchased blue crack cocaine, which was crack cocaine with added food coloring, used by a Toledo dealer to brand his mixture of crack cocaine so that buyers who liked his product could easily recognize the brand. A participant pointed out that when purchasing crack cocaine, a buyer "can be burnt quick," meaning the buyer may not be purchasing crack cocaine at all. Sometimes participants would unknowingly purchase "dummies," which are a piece of popcorn, a peanut, soap, rock salt or plaster being passed off as crack cocaine. When real crack cocaine is purchased, participants reported that the quality has been good, staying the same over the past six months. BCI Bowling Green crime lab continued to cite the following substances as commonly used to cut crack cocaine: diltiazem (medication used to treat heart conditions/high blood pressure) and levamisole (livestock dewormer).

Current street jargon includes many names for crack cocaine. The most commonly cited names were "hard" and "butter." The term "butter" was adopted because of

the yellowish tinge to crack cocaine in its purest form. However, a participant reported that dealers will sometimes mix crack cocaine with a small amount of cola, creating a yellow appearance to fool the buyer into thinking it's purer. Participants listed the following as other common street names: "Christina Aguilera," "crack-a-lack," "work" and "yak." Current street prices for crack cocaine were consistent among participants with experience buying crack cocaine, with prices remaining relatively unchanged from the last reporting period. Most users continued to report buying in small quantities: \$5, \$10 and \$20 rocks. A participant explained that the purchaser typically requests the size of the rock they want relative to the amount of money they have: "They say, can I get a 20 or a 30 [dollar piece of crack cocaine]? People don't say can I get a gram." However, participants reported 1/16 ounce, or "teener," sells for between \$65-\$80; 1/8 ounce, or "eight ball," sells for \$100-\$110; and 1/4 ounce sells for \$210. Participants had no knowledge of what an ounce of crack cocaine might sell for but one reported, "How much money you got in your pocket?" further commenting that if you would like to buy a larger quantity, someone would sell it to you.

While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. Out of 100 crack cocaine users, participants reported that approximately 85 would smoke it while 15 would cook it down to intravenously inject it. A participant reported that she witnessed people "cook down" crack cocaine using Kool-Aid, lemon juice and vinegar, explaining, "It's the acid in it that helps break it [crack cocaine] down." A crack cocaine user who preferred to use drugs intravenously described the difference between breaking down crack cocaine and breaking down heroin: "When you're shooting [injecting] heroin you can cook it down with water; when you're shooting crack [cocaine] you gotta cook it down with vinegar." Reportedly, an alternative to smoking crack cocaine is "huffing." A participant described huffing as follows: "You drop a piece [of crack cocaine] on a hot spoon, heat the spoon up, drop the crack on there [the spoon] with nothing on it and take the toilet paper roll over it and huff it." The participant described this practice as, "a rush!" Another crack cocaine user described "shot-gun" as inhaling crack cocaine and then blowing into a balloon or condom, and someone else inhaling the smoke from the balloon or condom. Participants also described lacing marijuana cigarettes or cigars (a.k.a., "blunts") with crushed crack cocaine and smoking the two drugs together (a.k.a., "cocoa puffing").

A profile of a typical crack cocaine user emerged from the data. Participants described users as either "smokers" or "crack heads." "Smokers" were described as those who use

crack cocaine and continue to perform within the various roles of their lives. *“Crack heads”* were described as, *“poor, bummy, skinny, raggedy, begging for money at a gas station.”* A self-professed *“crack head”* reported that in order to obtain money for crack cocaine she would either rob people on the first of the month or do a *“ho hustle,”* which she defined as prostitution. Treatment providers reported that they could no longer identify a typical profile of a crack cocaine user. These providers commented that for a time crack cocaine use seemed to be concentrated in poor, urban and minority communities. Treatment providers reported that they are now seeing clients addicted to crack cocaine from all walks of life, who after crack cocaine addiction takes hold, begin living in poverty, sometimes for the first time in life. Participants agreed with a self-proclaimed crack cocaine user’s comment: *“I’ve seen the preacher go from the pulpit to the crack house.”* A treatment provider commented, *“I think there was a time when it [crack cocaine use] was group specific, but I think what we see now, there are no surprises.”* Educators who work with high school- and college-aged youth described typical crack cocaine users as younger, African-American males in their late teens or older females beyond traditional college age.

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana and sedative-hypnotics. However, a participant reported, *“Most people just want more crack [cocaine]. They don’t want to spend money on nothing else ... they’re just chasing that high.”* Other drugs are typically used with crack cocaine to help bring the user down from the crack cocaine high, so the user can relax or sleep.

Heroin

Historical Summary

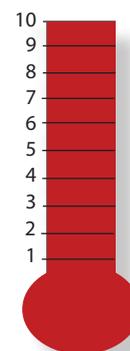
In the previous reporting period, heroin was highly available in the region. Participants most often reported the drug’s availability as ‘8’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants named white powdered heroin, which participants often referred to as *“china white,”* as the most available type of heroin. Treatment providers also reported heroin to be highly available, rating its availability as ‘9’. Many participants commented on the recent rise in heroin use, reporting that heroin use was the end of a natural progression that typically begins with prescription opioid abuse, also reported as high in Toledo. The most common participant quality score for heroin was ‘9’ on a scale of ‘0’ (poor quality, *“garbage”*) to ‘10’ (high quality). Participants reported that heroin was most often cut (adulterated) with what they believed was fentanyl. BCI Bowling Green crime lab reported that heroin was *“very pure.”* Participants

reported a gram of heroin ranged in price from \$40 to \$60. Many participants reported buying *“folds/papers”* for \$10 to \$20 each. The most common route of administration for heroin was intravenous injection. Typical users of heroin were described by both treatment providers and participants as primarily young, White and having a prescription opioid abuse history.

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 ‘8’. Participants stated, *“It’s [heroin] 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 are currently available in the region, participants reported the availability of brown and *“china white”* powdered heroin as most available. A treatment provider commented, *“All I hear them [clients] talk about is the brown or china white [heroin].”* Treatment providers reported the overall availability of heroin as ‘8’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get).

Some participants reported buying heroin in Toledo while others preferred to buy heroin in Detroit. Either way, the heroin business was described as thriving. A couple who are heroin users described, *“There’s so many people [dealers] fighting over us. As soon as we’d call one person, our phone would ring like ten more times. ‘Come get some [heroin] from me, come get some from me.’”* Reportedly, heroin has become so available and lucrative that Detroit dealers will, *“give you a nice big tester [of heroin],”* meaning that per request, dealers will provide a potential buyer with a sample to use before purchasing the drug. A few dealers among the group of participants noted that if they got a direct number to a customer, they would cut the middle man out and call the customer directly. A participant recounted, *“I was going through somebody [to buy heroin] and he used my phone to call the guy, and then that guy cut him out and started calling us.”* Both participants and treatment providers reported that the availability of powdered heroin has increased over the past six months; however, some participants reported increases of both black tar and powdered heroin within various pockets of the city. A participant described, *“Like some connections only get the brown powder [heroin], and like in the south end, they*



got the tar [black tar heroin]. People dealing in the north end seem to only have the [brown] powder.” A toxicology expert at the coroner’s office reported that in his 35-year career heroin related deaths were uncommon until about ten years ago. He reported, *“For years there really wasn’t much heroin in Toledo ... It’s been in the past ten [years] or so that we see heroin [deaths] fairly commonly.”* BCI Bowling Green crime lab reported that the number of heroin cases it processes has increased over the past six months.

Participants reported that the availability of black tar heroin, referred to as the most desirable of all heroin, was rarely available, rating its availability as ‘2’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Access to black tar heroin has remained unchanged over the past six months. A participant reported, *“Dealers don’t want to sell it [black tar heroin]. They want to cut it and sell brown [powdered heroin] ... to make more money.”* Treatment providers and educators were not knowledgeable about black tar heroin and reported not hearing of clients or students using it over the past six months. Participants continued to report that the journey to heroin most often is through prescription opioid addiction. A participant stated, *“Most people I know started [heroin] from using pharmaceuticals.”* Treatment providers also continued to highlight the relationship between prescription opioid addiction and heroin use. A provider described, *“A lot of times they [clients] start on pain pills of some sort. They get hooked on OxyContin® and they find out heroin is cheaper and strong.”*

Most participants generally rated the overall quality of heroin as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the previous most common score was ‘9’. Participants reported that the quality of heroin has remained the same over the past six months. Participants reported that heroin in Toledo is cut (adulterated) with baby laxative, baby powder, fentanyl and lactose. When asked how they could determine what heroin was cut with, a participant reported that he could tell when fentanyl was used by saying, *“Fentanyl is tan color and heroin is kind of gray. They call it [heroin] the ‘gray ghost.’”* Another participant reported that he could tell when baby powder was used: *“Cause your arm [where heroin was injected] swells up like a bee sting.”* Some dealers reportedly mix heroin with baby laxative or lactose together with water in a blender: *“It looks like a smoothie. Some people put it [cut heroin] in a baggie and iron it to dry it out or put it in the freezer [in order to remove the impurities].”* A participant who was a dealer talked about cutting black tar heroin, something that was thought to be sold uncut: *“They [dealers] take [black] tar [heroin] and put lactose in it and steam it, called ‘re-rocked tar.’ They both look the same, but one is better than the other ... When it’s steamed,*

it caramelizes, and it looks black like the purer black tar heroin.” 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).

Current street jargon includes many names for heroin. The most commonly cited names for heroin were “har-ron” and “dope.” Brown powdered heroin is typically referred to as “brown,” “dog food,” “food” or “mix.” The lure of heroin is that it is cheap, longer lasting, and satisfying. As a participant described, *“After a certain point you say, ‘I’m cool, I’m good’ ... you can get super high and say, ‘I’m done.’ You don’t need more and more and more like crack [cocaine].”* Heroin prices vary depending on type, quality and location of purchase within the region. Participants reported that white powdered heroin is available in different quantities: “packs” or “papers,” which equal a “half point,” sell for \$10. [The weight of a half point can be described by visualizing the old McDonald’s coffee stirrs that were white and had the small spoon at the end. Filling the spoon and leveling it off represented a half point. Since those are no longer available, red scrapers for lottery tickets found next to the lottery tickets and pencils in convenience stores are now used. The carved out section, where one can place a thumb to scratch off tickets, is used as a measure for a half point of heroin. To purchase 1/10 gram, the user would purchase two packs (1/10 gram folded in lottery tickets).] Participants also reported buying heroin in “bundles” (10–12 small packs of heroin). White powdered heroin is typically folded up and sold in lottery tickets with tape wrapped around them. Participants described the use of folded and taped-up lottery tickets to wrap and sell china white heroin as letting purchasers know that what they were buying was from Detroit, signifying greater quality and potency over Toledo’s heroin. Participants reported that brown powdered heroin is available in different quantities: a gram sells for \$40–\$50; 1/16 ounce, or “teener,” sells for \$60; 1/8 ounce, or “eight ball,” sells for between \$75–\$120. Participants reported that a 1/2 gram of black tar heroin sells for \$25; a gram sells for \$40–\$50; 1/16 ounce, or “teener,” sells for \$70. However, a participant reported that he consistently purchased heroin in balloons: *“Whenever I bought [black] tar [heroin], it was prepared in balloons.”* This participant reported paying \$100 for six balloons with .2 gram of heroin in each balloon, or three balloons for \$50. Reportedly, most heroin users continue to prefer to buy small quantities, as a participant commented, *“I think all of us heroin addicts know that if we buy more at once, we’d use it all.”*

Participants reported that the most common way to use heroin remains intravenously, often referred to as, “banging up.” Participants who used heroin intravenously reported getting their needles from diabetics and/or pharmacies.

They reported paying \$1 per needle from diabetics and/or \$10 per pack of needles from the pharmacy. A participant who sold needles for \$1 each reported, *"I use to sell needles. I got 'em from a diabetic. He didn't need them anymore, so he got 100 a month."*

A profile of a typical user of heroin emerged from the data. Participants and treatment providers described typical users of heroin as, *"in their 20's, White, suburban, somewhat affluent,"* who graduated from pharmaceuticals to heroin. A heroin user who fit the description commented, *"I would have never dreamed of doing heroin ... just the thought of the word. I couldn't do it, but then a friend came over and said, 'It's the same exact high, just try it. You're paying what \$50 for an 80 [mg] of oxy [OxyContin®]? Well, you can get a 20 [\$20 worth of heroin] for both of ya."* Educators reported typically seeing males, disproportionately Hispanic, in their 20's, *"who started out selling it [heroin], who over time became users."* An educator reported, *"It [sale and use of heroin] can be familial,"* handed down as like a family business. Educators also reported seeing female heroin users in the 18 to 24-year-old range who were *"young, sex workers"* in the community.

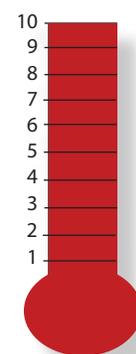
Reportedly, heroin is used in combination with crack cocaine, marijuana, powdered cocaine and sedative-hypnotics. For the most part, participants reported that heroin is generally used with *"more heroin."* As a participant put it, *"I didn't like to do any other drugs 'cause it messed up that drug [heroin]."*

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 '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants identified OxyContin®, Percocet® and Vicodin® as the three most popular prescription opioids in terms of widespread use. Treatment professionals most often rated availability of the aforementioned as '10'. Both participants and providers described OxyContin® as the most desired opioid; however, due to the change in OxyContin® formulation, participants described users shifting to fentanyl and heroin use. Moreover, participants named prescription opioids as a gateway drug to heroin. Reportedly, participants obtained prescription opioids from dealers, doctors, friends and family. Those who obtained their drugs through doctors either engaged in *"doctor shopping"* or visited doctors who were well known for accepting cash for writing prescriptions. Prescription opioid users reported taking tablets orally, or crushing them

and either snorting or cooking and then injecting them. The typical opioid abuser was described as a White young adult of some financial means.

Current Trends



Prescription opioids remain highly available in the region. Both participants and treatment providers most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '8'. A treatment provider captured the sentiment of others by saying, *"It's getting worse and worse [prescription opioid epidemic], and it's scary. We see it [a wave of clients addicted to prescription opioids] coming through our doors."* Treatment providers also reported that access to these drugs is very different than for other drugs. Prescription opioids can be accessed by anyone, and not just those in the drug culture. A treatment provider stated, *"Even my mom, who is not in the drug culture, could go and get these drugs [prescription opioids]."* In other words, devoid of the stigma, risk and chance typically associated with drug use, anyone who wanted to access these drugs could get them, and as a result, become addicted. 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 it difficult to snort or use intravenously, participants cited Percocet® as the most popular prescription opioid presently in terms of widespread use. Users who are interested in *"snorting"* or *"shooting"* opioids reportedly are not satisfied with the new OxyContin® OP as a replacement for the old OxyContin® OC. An intravenous user reported, *"Nobody wants an OP [OxyContin® OP] because you can't cook 'em down."* Another participant complained, *"They're [OxyContin® OP] like gummy"* when an attempt is made to cook them down to use intravenously. Participants discussed a long process they heard about involving microwaving or freezing new OxyContin® OP tablets to prepare them for intravenous use, but no one had tried it. Treatment providers varied in their thoughts about OxyContin® abuse. While some reported they didn't, *"hear a lot of people talking about it [OxyContin® OP],"* and users, *"don't desire it as much"*, some providers reported that OxyContin® OP was desirable as a second choice drug.

Educators reported that prescription opioid abuse is *"huge."* An educator in agreement with the others reported, *"It's an epidemic right now."* These community professionals

reported seeing more selling than before and that youth who abused the drug Percocet® used the term being “*perc’d out*” to indicate being high. They also reported knowing parents or foster parents that they suspected of taking the student’s medications for personal use or to sell. An educator reported, “*I have students in foster care, and the foster parents aren’t filling the scripts [prescriptions]. They’re just taking them [prescriptions] and selling them.*” This educator also reported an incident where an injured high school youth’s parent requested that the teacher fill the prescription given to the child from the doctor for her—a suspicious sign that the mother had been flagged and couldn’t fill it. When the teacher refused, the student reported that the family would lose a possible \$65 in revenue from the filled prescription of 30 Vicodin® pills. Given this situation and many other incidents with both high school and college aged youth, educators reported that they believed availability and desire for opioids was increasing, with the exception of OxyContin® OC. BCI Bowling Green crime lab reported that the number of prescription opioid cases it processes has increased over the past six months.

Reportedly, many types of prescription opioids are currently sold on the region’s streets. Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): fentanyl patch (\$40), Lortab®, methadone (10 mg sell for \$5), Opana®, oxycodone 30 mg (a.k.a., “perc 30;” sell for \$15), OxyContin® (a.k.a., “oxy’s”), OxyContin® OC (old formulation, a.k.a., “OC’s;” sell for \$1–\$2 per milligram), OxyContin® OP (new formulation, a.k.a., “OP’s;” sell for \$.50 per milligram), Percocet® (10 mg sell for \$8), Percodan®, Tylenol® 3 and 4, Ultram®, Vicodin® (5 mg sell for \$1–\$2), Vicodin® ES (7.5 mg sell for \$3.50), Vicodin® HP (10 mg sell for \$5).

In addition to obtaining prescription opioids on the street from dealers, participants reported that these drugs are most accessible through sick people and/or from area seniors. A participant reported, “*Elderly people sell their scripts [prescriptions] to make ends meet.*” Participants reported that drug dealers will often buy prescriptions from senior citizens. Reportedly, dealers stand outside of drugstores and approach seniors about selling their prescriptions, or dealers will convince a senior to go to the doctor and fake pain to get a prescription. If the senior agrees, the dealer will drive the senior to the doctor and to the pharmacy to fill the prescription and will then pay them.

While there were a few reported ways of consuming prescription opioids, variations in methods of use were noted among types of prescription opioids. Generally, the

most common route of administration continues to be to take prescription opioids orally. However, a majority of participants reported that users quickly move from oral use to intranasal inhalation (snorting), and then on to intravenous injection.

A profile of a typical user of prescription opioids emerged from the data. Participants continued to describe the typical user as someone who may have suffered chronic pain from a serious illness or injury, or someone who is young, White and middle-class. Others who might use opioids are reportedly those, “*Who look down on drug users, but feel alright about taking pills.*” Treatment providers reported that they saw a difference among those who abused Dilaudid®, for example, and those who abused Percocet® and OxyContin®. A treatment provider explained, “*An older population, a female population*” more commonly abuses Dilaudid® while younger populations seem to be most interested in OxyContin®, Percocet® and Vicodin®.

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, marijuana and sedative-hypnotics. According to one participant, alcohol is used to “*intensify the effect.*” However, the decision to combine opioid use with other drugs reportedly lies with finances. If a user’s finances are limited, a user is most likely to purchase their drug of choice alone, and in the quantity that most satisfies them. As a participant put it, “*If you’re out of money and that’s all you can afford. You’re gonna be buying heroin that’s it, or oxy’s [OxyContin®], or that pill whatever it is.*”

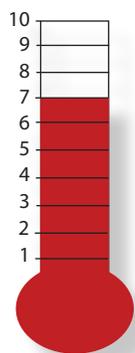
The coroner’s office reported that the biggest trend they see is prescription opioid related deaths. They reported that oxycodone is most prevalent in drug related deaths. However, it is highly uncommon to find any drug related death that involved the abuse of one drug alone. It is much more common to find poly drug abuse before death: “*When individuals die, you can’t say it was this drug and not the other five.*” The toxicology expert with the coroner’s office reported that methadone related deaths are the second most prevalent in the community and surrounding counties. However, this expert reported, “*It’s unbelievable ... my report may have 20 different drugs that are in their system at the time of death ... and you think, ‘they’re just taking handfuls of drugs.’*”

Suboxone®

Historical Summary

In the previous reporting period, Suboxone® was moderately available in the region. Participants most often reported street availability of Suboxone® as '4' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Treatment providers reported street availability of Suboxone® as '7'. Participants reported pricing for Suboxone® 8 mg to range from \$8 to \$10. Most often participants reported taking Suboxone® orally by placing it under the tongue. Some participants talked about the new Suboxone® strips that are placed under the tongue to dissolve. The typical user was described as a young, twenty-something, White opioid user who does not want to be "dope sick."

Current Trends



Suboxone® remains moderately available in the region. Participants most often reported the street 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 '4'. A participant commented, "It's [Suboxone®] sold on the street. My buddy buys them because he can't get into a clinic." Another participant also reported, "Nowadays clinics are pretty full." Treatment providers most often reported the drug's current availability as '8'. A treatment provider reported, "[Some users] don't want

to get off [opioids] for good. They just want to not be sick, so they have Suboxone® stashed away for when they feel sick." Both participants and treatment providers reported that the availability of Suboxone® has remained stable over the past six months.

Current street jargon includes few names for Suboxone®. The most commonly cited name was "sobos." Participants reported that Suboxone® 8 mg sells for \$ 5–\$10 for the pills and \$7 for the strips, slightly lower pricing than reported in the previous reporting period. Most often participants reported taking Suboxone® sublingually. A participant explained, "You put them [Suboxone®] under your tongue and they dissolve."

Some dealers on the street are reportedly reluctant to sell Suboxone® to users if they think a user may want to wean off of heroin. They are more likely to sell if they think a user needed to avoid immediate sickness instead. In addition to

obtaining Suboxone® on the street from dealers, treatment providers believed users got the drug from those who had been on Suboxone® treatment way too long, weaned themselves down, and could afford to sell some. A treatment provider who works in a Suboxone® clinic reported, "They [clients] stay on Suboxone® for more than two years when they no longer need it and sell it to others." This provider also discussed the opposite extreme, "On the other hand, I've seen people panic when they run out [of Suboxone®]. They become so dependent on the behavior [of taking the pill] ... They think they're going to relapse – when the doctor should be weaning them off."

A profile for a typical Suboxone® abuser emerged from the data. Participants described the typical user as someone who wants to avoid being "dope sick" and uses the drug as a safety net until they can find and afford more heroin. A participant involved in a legitimate Suboxone® program reported, "Well, I'm currently taking a half pill [of Suboxone®] a day and I started off a year ago taking three ... It's a miracle drug ... It's used to wean you down. It works great."

Reportedly, Suboxone® isn't used in combination with anything. Participants who had experience with Suboxone reported that if a user attempts to use drugs before they take Suboxone®, it will "throw you into withdrawal!" If a user takes a drug after they take Suboxone®, the drug will not have effect. One participant used heroin with Suboxone® and described, "I was the sickest I've ever been in my life. Violent reactions. I was so ill. I thought I was gonna die. I laid in the bed. I couldn't feel my legs. It's deathly."

Sedative-Hypnotics

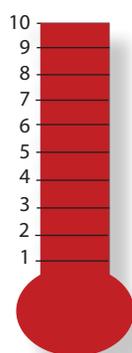
Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were somewhat available in the region. Participants most often reported the availability of these drugs as '4' to '5' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Treatment professionals listed the most common sedative-hypnotics in terms of widespread use as Klonopin®, Valium® and Xanax®. BCI Bowling Green crime lab reported stable availability of sedative-hypnotics. The most common routes of administration were oral consumption and intranasal inhalation (snorting). Many participants described typical users of sedative-hypnotics as young adults or older women who may have been prescribed sedatives-hypnotics and later progressed to abusing them. Other participants reported the typical user as simply a person who had access to sedative-hypnotics and started experimenting at a young age.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) are highly available in the region. Both participants and treatment providers 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 '4' to '5'. A participant reported that these drugs are extremely easy to get, exclaiming, "[It's] like going to McDonald's or going to the corner liquor store." Participants, treatment providers and educators identified Xanax® as the most popular sedative-hypnotic in terms of widespread use. A participant reported, "Xani's [Xanax®] get sold a lot." Reportedly, sedative-hypnotics are, "just so easy to get from a doctor, you can just get them yourself. And then if you get insurance, you don't even have to pay for them." Educators reported youth sometimes engage in mixing Xanax® with Flexeril® and call it "xanflex," or they would, "just take a bunch of Flexeril® or another muscle relaxer." A college educator talked about a student who used Xanax® and dropped out the school: "He [former student] was in class, I think two semesters, and was very open about using [Xanax®] and said he was using for fun." Treatment providers from one agency reported, "It [Xanax®] is more available ... There's not a whole lot of requirements that the doctors ask for to put you on Xanax® other than [a person saying], 'I have anxiety.'" Both participants and treatment providers reported that the availability of sedative-hypnotics has remained stable over the past six months. However, participants, treatment providers and educators mentioned that the recent arrest of an area physician for inappropriate distribution of prescription drugs had created a short-term decrease in the availability of prescription drugs, including sedatives-hypnotics. Educators reported that the availability of sedative-hypnotics has increased among their population, even reporting that youth and young adults are not necessarily hiding it: "They talk about it, put information on their Facebook about it, and say things like, 'I really need a xani [Xanax®] right now.'" Educators reported that they have also seen an increase in the number of teens and young adults who are selling. BCI Bowling Green crime lab reported that the number of sedative-hypnotic cases it processes has remained stable over the past six months.

Reportedly, many different types of sedative-hypnotics are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to the street-level users. (Note: When reported, current street names and prices are indicated in parentheses): Ativan® 5 mg (\$1),



Klonopin® 1 mg (\$1–\$2), Soma® 10 mg (\$2), Valium® (2 mg sell for \$1; 10 mg sell for \$2), Xanax® (.5 mg sell for \$1; 1 mg sell for \$3; 2 mg, a.k.a., "xanibars," sell for \$6). There is reportedly no street value or desire for Ambien®, Lunesta®, Nembutal® and Restoril®. When speaking about Ambien® and Lunesta®, a participant reported, "You can get free samples of that stuff."

In addition to obtaining sedative-hypnotics on the street from dealers, participants continued to report also getting them from senior citizens, those who have a chronic illness, or from doctors. A participant reported on the ease of getting prescriptions from doctors: "You can go to almost any doctor and say you need prescription strength sleep medication, and all you have to do is say you've taken the over the counter night time Tylenol® and all that stuff, and it doesn't work." Another participant discussed the convenience of reporting post-traumatic stress disorder (PTSD) symptoms in order to get sedative-hypnotics: "PTSD is a hard thing to prove. It's hard to prove that you have or don't have PTSD. Everybody has anxiety so ..." Another participant who has PTSD and abuses sedative-hypnotics said, "That's the exact reason they're [sedative-hypnotics] so readily available now. They [doctors] been slapping me with the PTSD diagnosis since I was young, and they're just handing it [sedative-hypnotics] out."

While there were a few reported ways of consuming sedative-hypnotics, variations in methods of use were noted among types of sedative-hypnotics. Generally, the most common route of administration remains oral ingestion, followed by intranasal inhalation (snorting) or intravenous injection (shooting). The coroner's office reported that sedative-hypnotic related deaths often occur when users mix for example, Valium® or Xanax® with other drugs such as opioids. The coroner's office also reported sometimes finding Benadryl® used in combination with poly drug use. Xanax® related deaths almost always involve other drugs or at least the use of alcohol.

A profile of a typical abuser of sedative-hypnotics emerged from the data. Treatment providers reported seeing younger adults who were White abusing these drugs. Additionally, a provider reported that she saw more female abusers. An educator concurred and reported that she saw mostly girls and commented, "I think women are prescribed it [sedative-hypnotics] more anyway, because we're supposedly more emotional creatures." However, participants described typical users of sedative-hypnotics as anyone who liked the feeling brought about by using benzodiazepines.

Reportedly, when used with other drugs, sedative-hypnotics are most often used in combination with alcohol, crack

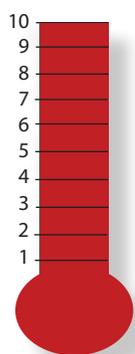
cocaine, marijuana and powdered cocaine. A participant reported, "The most common is alcohol because it intensifies the effects [of the sedative-hypnotics]." This same participant also reported, "You want to smoke marijuana because it's such a similar high."

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 reported that the availability of marijuana had increased over the previous six months, attributing the increase mostly to the availability of medical marijuana in Michigan. Participants reported that the quality of marijuana varied, with the most common quality score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that for commercial-grade marijuana, an ounce ranged in price from \$75–\$80; for high-grade marijuana, an ounce ranged in price from \$275–\$575. The most common route of administration for marijuana was smoking. The prevailing thought was that marijuana was widely used and had become acceptable. Many participants thought typical users of marijuana could be anybody from any demographic of society. The youngest reported age of first use of marijuana was 12 years old.

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 that marijuana was, "the highest [most available] out of any drug." Treatment Providers also reported the drug's current availability as '10'. A treatment provider summed up the sentiment of others in saying, "It seems like it's mostly all the good stuff [marijuana] or at least the good stuff has gotten around."

Educators reported that marijuana is also highly available among youth and young adults and reported its current availability as '10'. An educator commented, "They're [users] growing it [marijuana] in their own backyards." Educators believed youth have more access to commercial (low- to mid-grade marijuana) instead of high-quality marijuana. Educators reported that many youth have parents that smoke marijuana, commenting that they may or may not smoke with their children: "When your mamma and auntie,

and everyone is smoking [marijuana] too, then they get to talk about the purple [haze] and all that; It's [marijuana use] around them, and it's completely accepted." The Columbus Dispatch reported on a marijuana arrest during a routine traffic stop in Erie County, during which police found, "marijuana food products ... [including] cookies, granola bars, chocolate mints and other food bars ... [and] the items were wrapped like commercially packaged foods" (www.dispatch.com, May 3, 2011). Participants, treatment providers and educators reported that the availability of marijuana has remained stable over the past six months. A participant responded, "The availability of weed [marijuana] will not change in our lifetime." BCI Bowling Green crime lab reported that the number of marijuana cases it processes has also remained stable over the past six months.

Participant quality scores of marijuana were reported to be '6' for commercial marijuana and '10' for high-grade marijuana on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was generally '10'. Several participants continued to report that the quality of marijuana depends on whether the user buys "commercial weed" (low- to mid-grade marijuana) or hydroponically grown (high-grade marijuana). When describing high-grade marijuana, participants reported, "You can smell it [marijuana] and tell if it's good; sticky; no seeds in it." A participant reported that she didn't like when growers picked the marijuana plant too early, and it was light green, as she liked her marijuana "dark" and "matured."

Current street jargon includes countless names for marijuana. The most commonly cited names were "ganga," "green," "mary," "tea" and "weed." Participants listed the following as other common street names: "middies," "midgrade," "reg," "reggie" and "regular" for commercial-grade marijuana; "AK-47," "blueberry," "candy," "death star," "dumpster," "fire," "flame," "fruity," "hun-done," "hydro," "jack rabbit," "kush," "lavender," "lemon," "loud," "Mexican brick," "purple haze," "red hair sensimilla," "sativa" and "strawberry northern lights" for high-grade marijuana. The price of marijuana continues to depend on the quality desired. Participants reported commercial grade marijuana is the cheapest form: a blunt (single cigar) or two joints (cigarettes) sell for \$5–\$10; 1/4 ounce sells for \$25–\$30; 1/2 ounce sells for \$50–\$90; 1/4 pound sells for \$225–\$325; a pound sells for \$600–\$800. Higher quality marijuana ("hydro") sells for significantly more: a blunt (single cigar) or two joints (cigarettes) sell for \$20–\$25; 1/4 ounce sells for \$60; an ounce sells for \$150–\$200; 1/4 pound sells for \$1,200; a pound sells for \$4,800. Reportedly, quality and pricing largely depends upon the reputation of the particular type of marijuana being sold. In speaking of high-grade marijuana, a participant reported,

"It's [quality] getting better. It always gets better because every time you clone or mix it, the THC levels go up."

While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Some participants continued to report baking brownies and adding marijuana to the recipe. A participant who baked them reported, *"It's good to take [marijuana brownies] to concerts, that way you can't get caught."* A participant reported boiling the THC out of the marijuana and making butter.

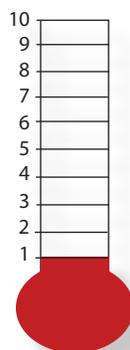
A profile for a typical marijuana user did not emerge from the data. Participants, educators and treatment providers continued to report that many different types of individuals smoke marijuana. A participant described, *"There's no real age range that's more common 'cause I know people all over. I started smoking [marijuana] in sixth grade, and I know people that have died of old age who smoked."* However, those who preferred to smoke high-grade marijuana were described as, *"dealers, young, older people with money."*

Reportedly, marijuana smokers like to combine its use with alcohol. This practice was reported to be very common. Marijuana can also be laced with powdered cocaine or crushed up crack cocaine, called "cocoa puffing." However, participants reported that cocoa puffing is not very common. A participant responded, *"When it's [marijuana] laced, it would be laced in a form of an already rolled blunt or something like that."* Reasons users may lace marijuana reportedly are, *"to try a different high or to get someone else high in a different way."*

Methamphetamine **Historical Summary**

In the previous reporting period, methamphetamine was reportedly rare in the region. Almost all of the participants reported no methamphetamine use within the past year, and most were unable to offer an opinion about its availability. Only one participant reported experience with buying crystal methamphetamine and reported the drug's availability on the east side of Toledo as '6' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The most common route of administration was smoking with a pipe. Reportedly, Toledo users were typically White, male bikers or those connected to bikers.

Current Trends



Methamphetamine reportedly continues to be relatively rare in Toledo, but was said to be highly available in rural areas surrounding Toledo, such as in Defiance, Fulton and Williams Counties. 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 reported that methamphetamine is available in crystal form, which they described as looking like shards of glass. A participant who used methamphetamine on the south side of Toledo reported, *"I know a guy [there] that cooks it [methamphetamine] and sells it."* When asked how available it was for him, he reported, *"I can get it [methamphetamine] 24 hours a day, seven days a week. If you went on the street and asked [about purchasing methamphetamine] you'd come up short."* Treatment providers most often reported the drug's current availability as '1' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A regional newspaper, *The Advertiser-Tribune*, reported on methamphetamine lab arrests over this current reporting period in Seneca County. A detective with one of the drug task forces in the region said three methamphetamine labs had been dismantled so far this year. This detective stated, *"The use and manufacture of methamphetamine has increased in Seneca County"* (www.advertiser-tribune.com, April 7, 2011). Participants reported that the availability of methamphetamine has increased over the past six months. Treatment providers reported that the availability of methamphetamine has remained a rarity over the past six months. A provider reported, *"The [methamphetamine abusing] clients I've had, migrated to Toledo from other areas."*

The one participant with experience using crystal methamphetamine made in Toledo rated the quality of the drug as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality) while pointing out that quality depends on *"the cook."*

Current street jargon includes a few names for methamphetamine. The most commonly cited names were *"ice," "meth" or "tweak."* Current street price for methamphetamine is \$10 for a "baggie" as reported by one participant with experience buying the drug in Toledo. Another participant reported that he believed prices for crystal methamphetamine are similar to powdered cocaine prices. Reportedly, the most common route of administration of methamphetamine remains smoking. A

participant explained, “You put it [methamphetamine] on tin foil, melt it, then use a straw to smoke it.” A participant reported that some used the drug intravenously, but he had snorted it: “When you snort it [methamphetamine], it will burn pretty bad, that’s why people prefer to smoke it. I mean it will burn a hole real quick in your nose.”

There was no typical profile for a methamphetamine user, but the one young, White male participant with experience buying and using in Toledo reported he used with other young, White males in their 20’s. An educator who also worked in areas of risk reduction reported methamphetamine use could be found in Toledo among the White, male, homosexual population reporting, “It’s [methamphetamine] in the club scene ... in the gay bars.” The participant with methamphetamine use experience reported that he used crystal methamphetamine in combination with alcohol and heroin. Another participant reported, “I think the first couple times you do it [methamphetamine], you need to drink [alcohol].” The coroner’s office, which serves 21 counties in Northwest Ohio, reported that methamphetamine related deaths are uncommon.

Ecstasy Historical Summary

In the previous reporting period, Ecstasy [methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] was moderately available in the region. Participants most often reported the drug’s availability as ‘6’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Treatment providers thought that the drug was not as available as other drugs because users preferred other drugs more. BCI Bowling Green crime lab reported a decrease in the number of processed Ecstasy cases over the previous six months. The typical user of Ecstasy was thought to be a partygoer and someone who likes to use Ecstasy during intercourse.

Current Trends

Ecstasy [methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] is highly available in the region, but the desire for the drug reportedly is waning. Participants 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 ‘6’. A participant reported, “Oh yes, Ecstasy is everywhere.” Treatment providers most often reported the drug’s current availability as ‘5’ while educators reported current availability most often as ‘8’. In May, *The Advertiser-*

Tribune reported that state troopers had seized 1,212 Ecstasy pills along with marijuana, crack cocaine and other drug paraphernalia worth over \$30,000 during a routine traffic stop (www.advertiser-tribune.com, May 3, 2011).

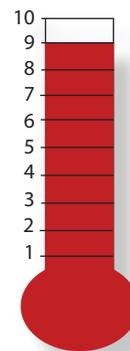
The consensus among educators was that Ecstasy is no longer popular. They believed it was popular for youth to use to enhance sex, and that youth are now having sex without needing the drug to enhance the mood or choosing to use alcohol instead of Ecstasy. Treatment providers and educators reported that the availability of Ecstasy has decreased over the past six months. A provider reported, “It [Ecstasy] seems to have been a fad drug about one to two years ago.” BCI Bowling Green crime lab reported that the number of Ecstasy cases it processes has decreased over the past six months.

Current street jargon includes several different names for Ecstasy. The most commonly cited name was “X.” Participants listed the following common pictures on Ecstasy pills: Bart Simpson, Batman, bunnies, elephants, green apples and Pokémon. Participants reported a “single stack” (low dose) Ecstasy tablet sells for \$10–\$15 and a “double stack” or “triple stack” (high dose) sells for \$20–\$25.

A profile for a typical Ecstasy user emerged from the data. Participants continued to describe typical users as those who frequent the club or bar scene. Additionally, participants described a shift in use from the young, White club goers, 15 to 21 years of age, to the young, Black club goers in that age group. Reportedly, when used in combination with other drugs, Ecstasy is used with alcohol and marijuana.

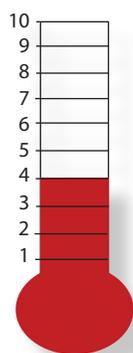
Prescription Stimulants Historical Summary

In the previous reporting period, prescription stimulants (Adderall®, Concerta® and Ritalin®) were somewhat available in the region. Participants most often reported availability of prescription stimulants as ‘6’ for adults and ‘8’ for those under 18 years old on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Adderall® was named the most sought after prescription stimulant. Participants reported that prescription stimulants were in circulation among school-aged children; thus, those under 18 years of age had greater access to the drugs, more so than adults who seek the drugs. Treatment providers most often reported availability as ‘8’ for adults. Participants reported that prescription stimulants had little street value



and sold for \$1 per pill. The typical mode of administration for prescription stimulants was to take them orally or to crush and inhale (i.e., snort) them. Participants believed that prescription stimulants were most popular among high-school and college-aged youth. Treatment providers identified the typical prescription stimulant abuser as young, White and male.

Current Trends



While participants did not report seeing prescription stimulants such as Concerta® or Ritalin® for sale of the streets of Toledo, they did report that Adderall® was moderately available among adults and highly available to teens and college students in the region. Participants rated the availability of Adderall® 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' (highly available, extremely easy to get); the previous most common score was '6' for adults and '8' for those under 18 years of age. A participant reported, "I see a lot of teenagers that use it [Adderall®]." Participants reported that youth used the drug to accomplish tasks that required focus such as studying or cleaning. A participant called it the, "homework drug, because you want to read." Educators commented that they "absolutely" see prescription stimulant use among their high school age population and reported the use of Adderall® and Ritalin® as most popular in terms of widespread use. Educators reported the availability of prescription stimulants within their population as '10'. An educator reported, "I don't know that my kids are taking them [prescription stimulants], but they have them available if they want to." A high school educator reported that some parents that had access to prescription stimulants would sell them to make money. An educator reported, "Just because they're [parents] older, doesn't mean they're wiser." Treatment providers 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), commenting that both youth and adults commonly get the drugs from youth who are prescribed them. A treatment provider commented, "Some youth are smoking marijuana to self-medicate when they need their meds." Both participants and treatment providers reported that the availability of prescription stimulants has remained stable over the past six months. Educators were not sure if availability had gone up or remained stable, but recognized that availability is high among their population.

No slang terms or common street names were reported for prescription stimulants. Those who purchased prescription

stimulants reported paying \$6–\$8 for Adderall® 30 mg. Adderall® users are reportedly more likely to get them from youth who were prescribed them than from drug dealers.

A profile for a typical prescription stimulant user emerged from the data. Participants continued to attribute the use of these drugs to high school or college students who needed to focus on studying, working, cleaning, or all three of the aforementioned. An educator responded, "It's legal coke [cocaine]." A participant described, "Kids in high school want them [prescription stimulants] because they can't be sitting in class ... nodding out." An educator also reported that college students will use them to study, clean their apartment, exercise and be able to work. In their opinion, prescription stimulant use really appealed to girls because, "You can be that wonder woman and not be hungry ... They can be smart, be skinny, and get the guys, and be perfect."

Participants continued to report that the most common way to take prescription stimulants is to take them orally or to crush and snort them. Reportedly, snorting a prescription stimulant produces a cocaine-like rush, and thus is called "hillbilly cocaine" by participants. Alcohol is often used to help "even the high" or to "bring the person down" from prescription stimulant use. Educators reported youth taking Ritalin® with coffee or Red Bull as very common.

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: inhalants, lysergic acid diethylamide (LSD), prescription and over-the-counter (OTC) cough medicines, psilocybin mushrooms, salvia divinorum (psychoactive plant) and synthetic marijuana ("K2" and "Spice"). A few participants reported experience with synthetic marijuana and salvia divinorum. BCI Bowling Green crime lab reported an increasing number of cases involving synthetic marijuana. A participant spoke about psilocybin mushrooms, rating its availability as '5' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Reportedly, users would bring mushrooms back from festivals and concerts along with LSD. Several participants also discussed drugs commonly used by youth. Inhalants were reported as popular with youth around ages 14 and 15; youth buy and "huff" model glue from a bag, as well as gases from butane cans, whipped cream cans and other aerosol cans. In addition, a group of participants

discussed the abuse of codeine mixed with 7-up®, Sprite® or liquor, often called “drank,” “lean” or *syrup*” by underage youth.

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. A few participants reported that they had used K2 (synthetic marijuana) within the past six months, but that it was not highly available. Treatment providers also reported that the availability and desirability for K2 has decreased. When obtained, users are most likely to smoke synthetic marijuana. A participant reported, “*I got strung out on K2. When I first started smoking it, it lasted me over an hour. Then it got to the point like crack [cocaine] where you would have to keep smoking it.*” Reportedly, this participant would buy three grams at a time at a beverage carryout for \$22. When this participant started smoking K2, a bag would last her a full week, but over time she began buying a bag a day. BCI Bowling Green crime lab reported that new forms of synthetic marijuana have shown up in their lab that had not been seen in the prior six months.

Psilocybin mushrooms were reported to be periodically available. Participants were not able to identify the availability of mushrooms because they are reportedly seasonal and are more available in the fall. Even when available, a participant reported, “*You have to know somebody who knows somebody [to obtain psilocybin mushrooms].*” Another participant responded, “*I looked for shrooms [psilocybin mushrooms] one time for a year and a half and couldn't find 'em. Then, when I wasn't looking for them anymore, they were there everywhere.*” Reportedly, 1/8 ounce of psilocybin mushrooms typically sells for \$25–\$45, and psilocybin mushrooms are often used in combination with marijuana. A participant reported, “*If you already smoke weed [marijuana], you wanna smoke weed with it [psilocybin mushrooms], even though it doesn't do anything, 'cause when you're on a hallucinogen there is no other effect, you're just hallucinating.*”

The use of bath salts (synthetic stimulant or hallucinogenic drugs) was briefly mentioned by some participants. No one interviewed reported using bath salts, but participants did report that it was a drug they knew is occasionally used in Toledo. Participants reported that those who use bath salts crush and ingest them through intranasal inhalation (snorting). A toxicology expert at the coroner's office reported that Toledo recently had its first death likely

attributable to bath salts use: a White male adult, who appeared from his history, and by evidence at the scene, had been using bath salts. BCI Bowling Green crime lab reported that the number of bath salts cases it processes has increased over the past six months.

Conclusion

Crack cocaine, heroin, marijuana, prescription opioids and sedative-hypnotics remain highly available in the Toledo region. A noted increase in availability over the previous six months exists for heroin; noted decreases exist for Ecstasy and OxyContin® OC. Both participants and treatment providers reported that the availability of powdered heroin has increased over the past six months; however, some participants reported increases of both black tar and powdered heroin within various pockets of the city. A toxicology expert at the coroner's office reported that in his 35-year career, heroin-related deaths were uncommon until about ten years ago; heroin-related deaths have become more common. BCI Bowling Green crime lab reported that the number of heroin cases it processes has increased over the past six months. OxyContin® was labeled the most desired prescription opioid in the region by participants and treatment providers; however, since the original composition of the drug has changed, making it difficult to inhale or use intravenously, participants cited Perocet® as the current most popular prescription opioid in terms of widespread use. Reportedly, other opioids are also available in the region (Opana®) but have more limited availability. Participants continued to describe the typical illicit user of Suboxone® as someone who wants to avoid being “*dope sick*” and uses Suboxone® as a “*safety-net*” until they can find and/or afford more heroin. Educators reported increasing sedative-hypnotic use among their population, and emphasized that youth and young adults do not necessarily hide their use of sedative-hypnotics. Ecstasy's desirability seems to be waning. Treatment providers and educators believed the drug was once popular among youth who reportedly used it to enhance sex. These professionals reported now believing that youth either are having sex without needing the drug or choosing to use alcohol instead of Ecstasy. Participants reported that Ecstasy use has shifted from young, White club goers, 15 to 21 years of age, to the young, Black club goers in that age group. BCI Bowling Green crime lab reported that the number of Ecstasy cases it processes has decreased over the past six months. Adderall® remains the most prevalent prescription stimulant and continues to be used primarily by teenagers and college students. Reportedly, synthetic marijuana (“K2”) continues to be used by a few participants, but it is not highly available. BCI Bowling Green crime lab reported that new forms of synthetic marijuana have shown

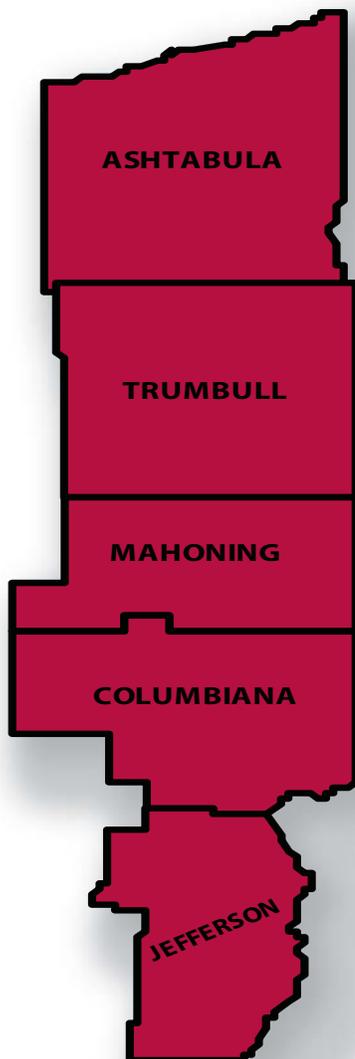
up in their lab that had not been seen in the prior six months. Finally, bath salts are occasionally used in Toledo. BCI Bowling Green crime lab reported that the number of bath salts cases it processes has increased over the past six months.

Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Youngstown Region

January-June 2011

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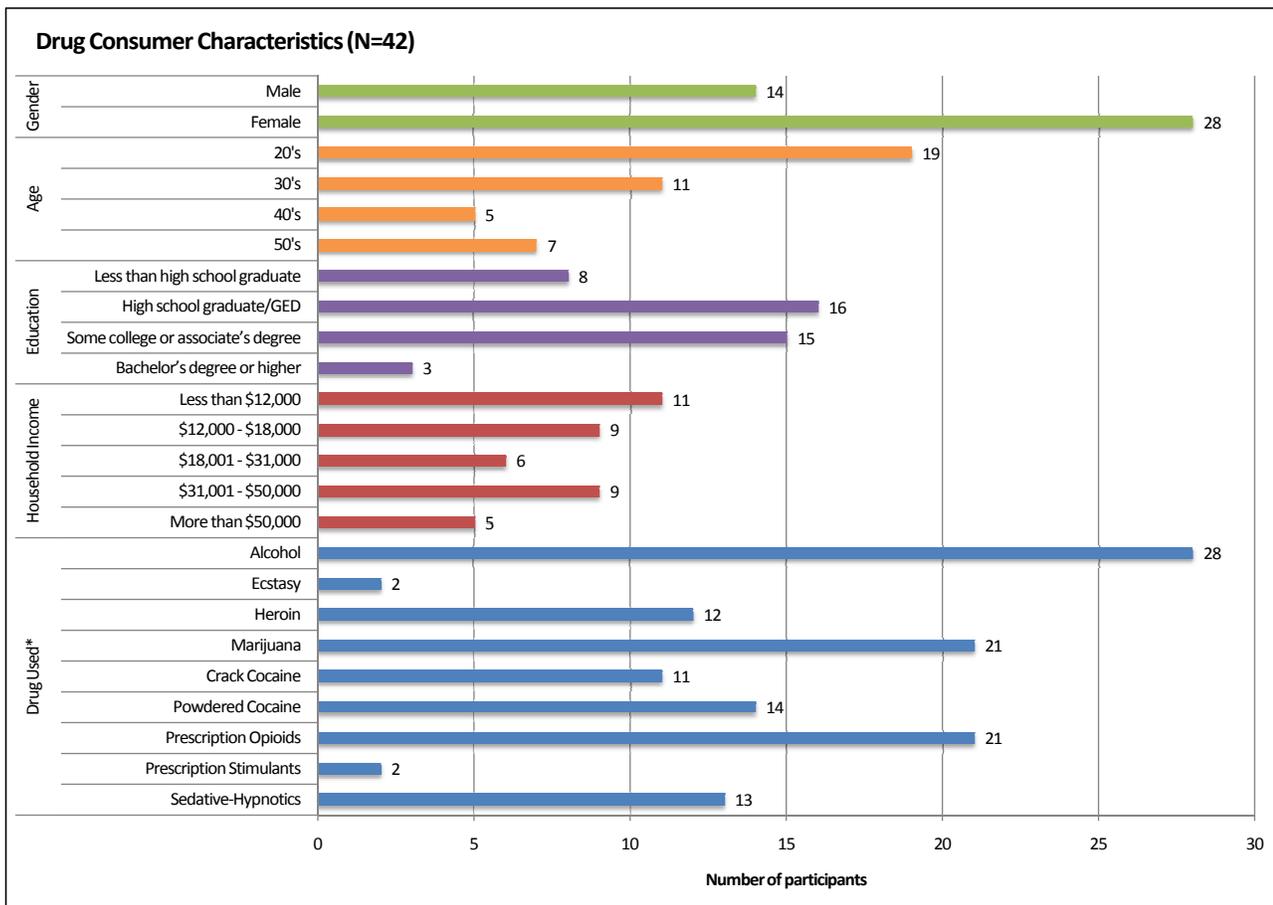
Regional Profile

Indicator ¹	Ohio	Youngstown Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,542,645	723,072	42
Gender (Female), 2009	51.2%	51.4%	66.7%
Whites, 2009	82.2%	87.1%	73.8%
African Americans, 2009	11.9%	8.8%	14.3%
Hispanic or Latino Origin, 2009	2.8%	2.3%	9.5%
High school graduates, 2009	83.0%	87.2%	81.0%
Median household income, 2009	\$45,467	\$39,339	\$12,000 - \$18,000 ²
Persons below poverty, 2009	15.1%	16.7%	47.5% ³

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

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

Poverty status was unable to be determined for two respondents due to missing or insufficient income data³.



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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Ashtabula, Columbiana, Jefferson, 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 Identification and Investigation (BCI) Richfield Office, which serves the Cleveland, Akron and Youngstown areas. BCI data are summary data of cases processed from July to December 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current BCI data correspond to the current reporting period of participants. In addition to the aforementioned data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2011.

Powdered Cocaine Historical Summary

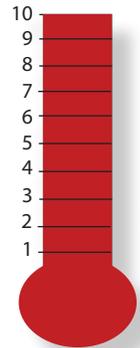
In the previous reporting period, powdered cocaine was moderately available in the region. Participants most often reported the drug's availability as '7' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The consensus among participants and community professionals was that powdered cocaine was not as available as crack cocaine. The most common participant quality score for powdered cocaine was '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality). BCI Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine as common cutting agents for powdered cocaine. Participants reported a gram of powdered cocaine ranged in price from \$40-\$100. The most common route of administration for this form of cocaine was intranasal inhalation (snorting). Treatment providers reported that powdered cocaine was being used more intravenously than in the past, especially among heroin users. Law enforcement described a typical user as a 20 to 35-year-old, White, middle-class suburbanite.

Current Trends

Powdered cocaine is highly available in the region. Participants most often reported the drug's current

availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '7'. While highly available, the consensus among participants was that crack cocaine remains easier to come by on the street than powdered cocaine. Participants reported, "*Coke [powdered cocaine] you pretty much have to know somebody to get it. It seems it's not as available on the street; I always preferred using [powdered] cocaine above crack cocaine. The whole reason I decided to smoke [crack cocaine] my first time was because it was much more convenient to get, and it was a lot bigger of a buzz for a smaller amount of money.*" Treatment providers and law enforcement most often reported the drug's current availability as '8'. A law enforcement officer reported, "*Definitely [powdered cocaine] not as available as crack [cocaine]. They [dealers] are not advertising and selling powder. There's no demand for it. They are using it to make crack.*" The consensus among community professionals was that powdered cocaine can be purchased relatively easily; however, crack cocaine is the form of cocaine most available and mostly sought by users. Many treatment providers named cocaine as in the top three drugs used in the region. *The Vindicator* reported on significant arrests this year involving cocaine trafficking in the region. A Warren couple was found guilty of being suppliers of cocaine and heroin, coming into Trumbull County from Detroit (www.vindy.com, April 9, 2011). A group of Youngstown area residents were indicted for international drug trafficking, transporting powdered and crack cocaine, heroin, methamphetamine and marijuana from San Diego and New York to Youngstown (www.vindy.com, April 1, 2011). In reference to the aforementioned group of alleged drug traffickers, *The Vindicator* quoted a U.S. Attorney as saying, "*This drug-trafficking organization operated almost like a Costco. Moving wholesale, bulk and retail amounts of heroin, cocaine, crack, marijuana and methamphetamine from one coast to the other and then eventually to Youngstown, Ohio where it was sold on the streets and poisoned our community.*" The vast majority of participants and community professionals reported that the availability of powdered cocaine has remained stable over the past six months. BCI Richfield crime lab reported that the number of powdered cocaine cases it processes has remained stable.

Participant quality scores of powdered cocaine varied from '1' to '9' 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 '3'. Universally, participants reported that the quality of powdered cocaine continues to be dependent on the source, the person from whom one buys.



Participants reported, *"Depends on who you get it [powdered cocaine] from, that, like real, it depends you know, who got the better ... I mean this person is selling for 60 bucks, and you know he's cutting [adulterating] it with whatever he has, and then you go to this other person. You're paying 100 bucks, but you are getting good quality; Hit or miss, some people got some really good powder [cocaine]. With some people, it's all cut up."* A law enforcement officer reported, *"[Quality of powdered cocaine] depends on which organization you're dealing with. We've seen high quality, 80 to 90 percent pure, and then we've seen organizations that are selling four and five percent pure."* BCI Richfield crime lab continues to cite the following substances as commonly used to cut powdered cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), procaine and lidocaine (local anesthetics) and caffeine.

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "girl," "soft," "snow" and "White girl." Participants listed the following as other common street names: "cola," "powder," "soft batch cookies," "smooth" and "white." Euphemisms having to do with snow and skiing are reportedly common when referring to powdered cocaine. Participants reported, *"Let's go skiing' means they [users] want to get some [powdered] cocaine; 'It's snowing outside' is lingo they [dealers] use when making a call to sell powder."* Current street prices for powdered cocaine were variable among participants with experience buying powdered cocaine, with overall prices slightly higher than previously reported. Participants reported that a gram of powdered cocaine sells for \$50–\$100, depending on the quality, the highest quality selling for upwards of \$200 a gram; 1/16 ounce, or "teener," sells for \$75; 1/8 ounce, or "eight ball," sells for \$100–\$200; 1/4 ounce sells for \$275–\$300; an ounce sells for \$800–\$1,400; a kilo sells for \$15,000–\$40,000. A law enforcement officer reported, *"We typically deal with larger quantities, ounce quantities and up. Ounces run anywhere from \$1,000 on low end to \$1,500 on high end. Kilos are ranging between \$25,000 and \$32,000 a kilo."* While there were a few reported ways of consuming powdered cocaine, the most common route of administration for this form of cocaine remains intranasal inhalation (snorting) followed by intravenous injection (shooting). Several participants reported "cooking up" powdered cocaine and smoking it. Participants stated, *"Shoot it [powdered cocaine], snort it, cook it up and smoke it; Most people snort [powdered cocaine]. I used to shoot it."*

A profile for a typical powdered cocaine user did not emerge from the data. Participants reported, *"All gamuts [sic] of society [use powdered cocaine] ... does not discriminate with job title or anything; Anybody, anywhere, anytime could be doing it [using cocaine]."* However, many participants continue to

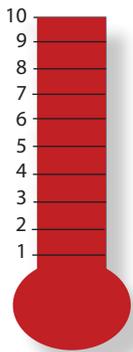
associate powdered cocaine use with the bar/club scene. A participant stated, *"People who like to party and go to bars and stuff [use powdered cocaine]."* Community professionals reported that users of powdered cocaine still tend to be White and over 30 years of age. A provider stated, *"A little bit older, maybe between 30 and 35 and even 50 or so ... mostly White. People that are using [powdered] cocaine usually do not use it exclusively. Usually they use it with heroin, with opiates."* Another provider provided the following description: *"blue-collar workers, most are White, mid 30's and male."* Reportedly, powdered cocaine continues to be used in combination with alcohol, benzodiazepines (Valium® and Xanax®), heroin (a.k.a., "speedball" when used in conjunction with cocaine), marijuana and prescription opioids. A participant explained the need for other drugs to help in coming down from the stimulant high of powdered cocaine as follows: *"When I do [powdered cocaine], I always liked to have weed [marijuana] also available, so that when you come down off cocaine, which is very, very scary ... it [marijuana] helps you not to go through that. It brings you down better."*

Crack Cocaine **Historical Summary**

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described crack cocaine as extremely easy to get. Law enforcement also rated the availability of crack cocaine as high. The most common participant quality scores for crack cocaine were '3' and '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut (adulterated) with other substances. BCI Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine as common cutting agents for crack cocaine. Participants reported a gram of crack cocaine ranged in price from \$50–\$100. The majority of crack cocaine users reported buying the drug in small quantities called "dimes" (1/10 gram) for \$10, and agreed that the price of crack cocaine had gone up over the course of the past six months. By far, the most common route of administration for this form of cocaine was smoking. Participants and treatment professionals alike stated that crack cocaine is far-reaching into every socioeconomic 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'. Many participants believed the drug was "readily available" and "very easy to get." One participant even went so far as to say, "You can't walk to the store without somebody offering you crack [cocaine]." Community professionals most often reported the drug's current availability as '9.5'. Law enforcement agreed that crack cocaine was highly available: "There's seldom a time when we cannot go out and buy [undercover] any [crack cocaine]. Sometimes there may be up to a half-hour wait on the person we are targeting or supplier to come up with it, but usually it's ready

on the spot." The majority of participants and community professionals reported that the availability of crack cocaine has remained stable over the past six months. BCI Richfield crime lab reported that the number of crack cocaine cases it processes has also remained stable over the past six months.

Most participants rated the quality of crack cocaine as either '2' or '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common scores were '3' and '4'. Participants agreed that the quality of crack cocaine varied widely and continues to depend on where one obtains the drug. Generally, participants thought that high quality crack cocaine was coming from Chicago. Drug users that did not have access to high quality crack cocaine said they had to "cook" or "re-rock" crack cocaine in order to increase the quality. One participant explained, "I was [cooking] it [crack cocaine] for better quality, and I was tired of getting ripped off." Other participants said their dealers had variable quality. A participant said, "Normally, if you have your own dealer, it's [crack cocaine] decent quality. If you go sometimes on the streets, sometimes it may be good, sometimes it may be a fake, period." As one participant's addiction got worse, she would buy anything she could get her hands on, but this only led to poor quality product: "As you smoke more crack cocaine you learn to get it from other places you normally wouldn't get it ... I was starting to get ripped off all the time." Over the past six months, participants reported that the quality of crack cocaine has gotten worse. Many participants agreed that the quality of crack cocaine was poor because of the economy: "It's [quality of crack cocaine] gotten worse. I would say because people are trying to get their money's worth 'cause, you know, everybody needs money these days." Participants reported that crack cocaine in Youngstown is cut (adulterated) with Anbesol®, baby laxative, baking soda and lidocaine (local anesthetic). As one participant said, crack cocaine can be, "cut with anything and everything." BCI Richfield crime lab continues to cite the following substances as commonly used to cut crack cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetic) and caffeine.

Current street jargon includes many names for crack cocaine. The most commonly cited names were "hard" and "rock." Participants listed the following as other common street names: "girl," "slab," "white" and "work." Current street prices for crack cocaine were variable among participants with experience buying crack cocaine, with overall prices slightly higher than previously reported. Participants reported that a gram of crack cocaine sells for between \$40-\$150, depending on the quality; 1/16 ounce, or "teener," sells for between \$75-\$100; 1/8 ounce, or "eight ball," sells between \$150-\$200; an ounce sells for between \$1,000-\$2,000; and a kilogram sells for \$23,000. Participants agreed that the price of crack cocaine varied due to the quality of the product, and that the higher quality was available if the interested party was willing to pay the price. While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. Users employed many methods to smoke crack cocaine, often using common objects found at convenience stores and supermarkets. In addition to glass rose stems and pipes, one participant explained, "We would always use tire pressure gauges [to smoke crack cocaine], empty out the middles, [and] go to the store and get chore [Chore Boy®], you know that you use to clean your house with." Another participant reported using "pop cans." Other participants reported using crack cocaine intravenously. Intravenous users of crack cocaine described needing to break down the drug in order to inject it: "You gotta break it [crack cocaine] down with vinegar and put it on a spoon. Cook it down with vinegar and you inject it." Participants stated that users who injected opiates were more likely to inject crack cocaine.

A profile of a typical user of crack cocaine did not emerge from the data. Participants and community professionals disagreed about the typical users of crack cocaine. Participants continued to emphasize the wide range of people that use crack cocaine, explaining that men and women of all races use the drug. As one participant put it, "Anyone can get addicted to it [crack cocaine] ... a judge, a librarian, a school kid." Community professionals disagreed with participants and each other about the user demographics. Some providers thought crack cocaine use was, "predominately Caucasian ... mid 20's to late 30's;" whereas, law enforcement thought crack cocaine was, "probably more in the Black community than in the White community ... [among those] 35 to 40 and older."

Reportedly, crack cocaine is used in combination with alcohol, antidepressants, Ecstasy, heroin, marijuana, prescription opioids and sedative-hypnotics. Most of these drugs are commonly used to "come down" from the crack cocaine high. As one participant stated, "Most definitely, you need a benzo [benzodiazepine] or an opiate to come down

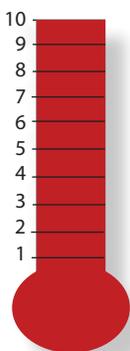
[from crack cocaine use]; You feel really, really shitty afterwards, so [I] always took some type of pill, an opiate." Participants also reported lacing their crack cocaine with marijuana, which they called a "primo" or a "geek." Other participants mentioned that they liked to "speedball;" that is, they enjoyed the roller coaster effect of using crack cocaine to feel high and then heroin to feel low. Using crack cocaine with the aforementioned substances is reportedly common.

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' (high availability, extremely easy to get). Law enforcement rated current availability as "better than ten." Participants named heroin as the most available drug in the region. While many types of heroin were named as available, the consensus among all participant groups was that brown powdered heroin was the most common form of heroin found. The most common participant quality score for heroin was '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that heroin was most often "cut" (i.e., adulterated) with prescription drugs. BCI Richfield crime lab reported that heroin was "very pure," and occasionally cut with diltiazem (medication used to treat heart conditions/high blood pressure). Participants reported a gram of heroin ranged in price from \$75-\$200 depending on quality. Many participants reported buying "baggies/stamps" for \$10-\$20 each. The most common route of administration for heroin was intravenous injection (shooting). Treatment professionals and participants alike noted an increase in younger people using heroin ("teens" and those in their early 20's) who were "mostly White."

Current Trends

Heroin remains highly available in the region. Participants most often rated the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' While many types of heroin are currently available in the region, participants reported the availability of powdered heroin as most available. Participants stated, "There's all types of heroin on the streets. You have white, brown, you have gray, you have black tar, there's all kinds. I would say the white or the brown [powdered heroin is the most common]; if it's



your drug of choice [heroin], and you're from around here, it's very available." A participant stated, "The white and brown [powdered heroin] are both 10's." Treatment providers and law enforcement also most often reported heroin's current availability as '10'. A law enforcement officer reported, "I don't think there's been a day out here when we said, 'hey, we got a chance to buy heroin, and the deal has fallen through.' It's always available." A treatment provider reported, "Ten. It's [heroin] the most available drug out there now, and, um, everyone's using it, snorting it or shooting [injecting] it. And, they're using heroin more because of the unavailability of the pills [prescription opioids] they used to seek, and because it is a lower cost, the heroin, and it goes a lot further."

Participants reported the availability of black tar heroin to be limited, rating its availability most often as '4' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant reported, "Black tar is black and sticky ... like black top on the street, real sticky. [Black tar heroin] not really that common around here, just regular heroin most common, powder." Community professionals most often reported black tar heroin's current availability as '2'. A treatment provider reported, "I have had a couple of clients tell me, um, oh, they've heard the black tar stuff [heroin] is really nice, but nobody seems to get it much around here." A law enforcement officer reported, "From what we hear, there are people out there who know how to cut black tar heroin into brown powder, so they are converting it for what the normal use is, or what the market is here in Youngstown." In addition to powdered and black tar heroin, a participant and a treatment provider reported the presence of "raw heroin," which reportedly is high purity heroin sold in chunk or rock form. The participant reported, "What sells the easiest, is what they call 'raw,' which is chunks [of heroin] they [dealers] bring in, like a chunk. They'll cut off chunks and sell for \$50's or \$100's as opposed to the bags they bring in from Pittsburgh where it's already packaged, and the stamps they sell for \$10 to \$15. It [raw heroin] looks similar to ... like crack [cocaine]. Like a chunk of crack, but, uh, it's brown." A treatment provider stated, "I'm not as familiar as I should be with the different subspecies of it [heroin], but I hear people [clients] talk about rock."

The majority of participants reported that the general availability of heroin has increased over the past six months. Participants reported, "Lately, ... every drug dealer that has crack [cocaine] has heroin too; People that are into selling drugs are starting to realize that heroin is the money maker because the people that are strung out on it [heroin], absolutely have to have it, or they're not able to get out of bed or do nothing, you know." Participants attributed the increase in heroin over the past six months mostly to the price of prescription opioids: "The pills [prescription opioids], the OxyContin® are harder to get; they're harder to break down. They cost more money;

Can't afford the pills; It's [heroin] cheaper than, you know, other drugs, and there's a lot of heroin addicts." Community professionals reported that the general availability of heroin has increased over the past six months. Law enforcement reported, *"We are seeing a little more of it [heroin] here in Columbiana County the past six to eight months; increase in the transition from pharmaceuticals, the OxyContin®, to the heroin because of the price of addiction, so it kind of became an accepted transition."* BCI Richfield crime lab reported that the number of powdered heroin cases it processes has increased, reporting having processed approximately 1,500 heroin cases over the past six months up from 803 cases for the previous reporting period. The number of heroin cases has surpassed the number of marijuana cases, making powdered heroin the most processed drug through BCI Richfield crime lab. The lab reported a decrease in the number of black tar heroin cases it processed over the past six months.

Participants most often 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 '9'. Participants reported, *"Mahoning County, the quality of what I was doing, whether it was heroin or fentanyl ... it was strong. I'd say a good '9'; Like I said, the quality of the raw [heroin] from Chicago or Jersey or whatever, the quality of that, I'd give between a '7' and a '10.'" Over the past six months, participants reported that the quality (potency) of heroin has increased. Participants reported, "I'm an addict, Ashtabula County, it's [heroin] getting real strong; it [heroin quality] was good. I do not believe that it was all heroin. It was getting stronger. I believed it was cut [adulterated] with fentanyl because I overdosed a couple of times on amounts where I didn't before."* In addition to fentanyl, participants reported that powdered heroin is cut with Sleepinol®, Vitamin B and Vitamin E. A law enforcement officer reported, *"Recently, we had some [heroin] that was cut with ketamine. We had a number of overdoses here, an increase because of ketamine."* BCI Richfield crime lab cited procaine and lidocaine (local anesthetics) as commonly used to cut powdered heroin.

Current street jargon includes many names for heroin. The most commonly cited names remained "boy" and "dog food." Participants listed the following as other common street names: "dirty girl," "dope" and "H." Participants reported that heroin is 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." (Note: prices included here reflect current pricing for powdered heroin as very few participants had pricing information on black tar heroin. A participant reported, *"Black tar [heroin] was a little more expensive."* Prices vary depending on quality of heroin and location of purchase within the region, with

overall pricing remaining stable from the previous reporting period.) Reportedly, 1/2 gram sells for \$60–\$100; a gram sells for \$50–\$160; a finger (7–10 grams, distributed in a cut-off finger of a surgical glove) sells for \$700–\$1,000; 1/4 ounce sells for approximately \$600; and an ounce sells for approximately \$1,000. Most participants continued to report buying smaller quantities of heroin most often in \$10 and \$20 amounts. A participant reported, *"Most of the time I would buy mine [heroin] in \$20's. It's called bundles or balloons."* Law enforcement reported that stamps sell for \$20; and a gram sells for \$80–100. A law enforcement officer reported, *"In Youngstown we are seeing \$10 to \$20 bindles and \$100 per gram. Prices go up in the surrounding areas ... East Liverpool and Columbiana, not as many dealers."*

While there were a few reported ways of consuming heroin, the most common route of administration remains intravenous injection (shooting), followed by intranasal inhalation (snorting) and then smoking. Participants estimated that 75 to 100 percent of heroin users intravenously inject heroin. A participant explained, *"I think it [route of administration] all depends on if they just started doing it [using heroin] or not. They probably start off snorting it and then work their way up [to injection]."* Another participant reported, *"I'm an addict. I started snorting it [heroin] when I first started [using heroin]. Then everyone was telling me [that] I'm missing out on a good high, so I tried it [injecting heroin] and fell in love."* A treatment provider reported, *"Some IV [intravenously use] it [heroin] here—most common. Some snort. Some smoke."* Along with widespread reports of intravenous use of heroin were widespread reports of sharing of injection needles and hepatitis C infections. A participant reported, *"I would buy a clean bag of 1 CC syringes from the drug store. There was times I would reuse my needles, there were times I would use other people's needles if I was in a hurry to get a quick fix, and there was times my needles got mixed up with other people's [needles] as well. There is a possibility I have hepatitis C. I know somebody that had it, and I possibly used their needles."* Another participant reported, *"I'm an addict. I think I have hepatitis C."* A treatment provider reported, *"I see a lot of our clients testing positive for hepatitis C, as more so than in the past."* In addition to reports on hepatitis C, participants continued to report overdoses involving heroin as common. Participants reported, *"I know people who OD'd [overdosed]. I OD'd once on heroin. My best friend OD'd on heroin, and she died. I know lots of people who have OD'd; My father died of a heroin overdose when I was 17. I shot [injected] him up [with heroin], and he died in my arms; I know one girl that OD'd seven times on heroin, and she's still using [heroin]."*

A profile of a typical user of heroin emerged from the data. The consensus among participant and community

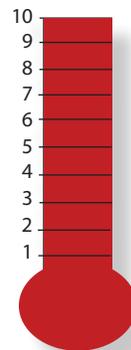
professional groups was that heroin users continue to be predominately White males and females between the ages of 20 and 35 years, although several community professionals also continue to report increasing heroin use among adolescents, particularly teenaged females. Law enforcement reported, *"We're seeing more high school and younger age [heroin] users; We're seeing more young females, high school and recently graduated coming into the inner city, 18 to 25 [year old] females."* A treatment provider reported, *"With the adolescent population it appears ... uh, it [heroin] appears to be becoming more available, more popular ... In this [treatment] program here as young as 15 years old. As far as like gender, female Caucasian, Caucasian female is what actually surfaced here."*

Reportedly, heroin is used in combination with alcohol, benzodiazepines (Xanax[®]), crack cocaine, powdered cocaine (a.k.a., "speedball" when used in conjunction with heroin), marijuana and prescription opioids (fentanyl, Opana[®] and OxyContin[®]). Participants reported that other drugs were used in combination with heroin primarily to intensify the high of heroin. Participants stated, *"I like heroin with Xanax[®]. It was good. That was my combination that I liked. I didn't use the Xanax[®] to come down. I used the Xanax[®] to increase it [the high of heroin]; I'm an addict. I'd use marijuana to increase it [the high of heroin]."*

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants and treatment providers most often reported street availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Community professionals identified OxyContin[®], Percocet[®] and Vicodin[®] as the three most popular prescription opioids in terms of widespread use. However, with the reformulation of OxyContin[®] OC into a more tamper resistant pill, participants noted a decreased presence of OxyContin[®] OC. Reportedly, many different types of prescription opioids were sold on the region's streets. In addition to obtaining prescription opioids from dealers, participants also reported getting them from friends, roommates, family members—others with prescriptions, buying "scripts" (prescriptions) or trading other drugs for the opioids, as well as, from area doctors and pain management clinics. Generally, the most common routes of administration were oral consumption and intranasal inhalation (snorting). Treatment professionals noted that current illicit use appeared more prevalent among suburban, middle class, White people.

Current Trends



Prescription opioids remain highly available in the region. Participants most often reported the current availability of prescription opioids as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants stated, *"Amazing how easy they [prescription opioids] are to get. Doctors are giving them away without hesitation; very available, just ask your doctor."* Participants and community professionals continue to identify OxyContin[®], Percocet[®] and Vicodin[®] as the most popular prescription opioids in terms of widespread use. A provider reported, *"Seeing mostly Vicodin[®], Percocet[®] and OxyContin[®] [in client use histories]."* Participants also noted increasing popularity of Opana[®] and Ultram[®]. Participants reported, *"A lot of people switched from oxy's [OxyContin[®]] to Opana[®]'s; Opana[®]'s a lot stronger [than OxyContin[®]]. I snorted them. It's one of the few pills [prescription opioids] that you can still snort; I was buying them [Ultram[®]] from, um, one of the girls that live in the building with me because they do not show up in the urine test where I was going [for treatment]; Um, I justified taking those [Ultram[®]] because they're non-narcotic ... when in all reality, they are very addictive."* Community professionals also most often reported current availability of prescription opioids as '10'. Treatment providers reported, *"Clients do not seem to have any problem getting them [prescription opioids]; very available."* Providers also noted the increasing popularity of Ultram[®], especially among adolescents. A provider reported, *"With the adolescents, what is common now, as I'm sitting here, is the marijuana, alcohol, and what is a growing trend now is Ultrams[®]."* Participants reported that the availability of prescription opioids has remained stable over the past six months, with the exception of OxyContin[®] OC which has decreased in availability. Participants reported, *"Oxy's [OxyContin[®] OC] are almost scarce, although I know a few people who had them last week as a matter of fact; A lot of people don't use them [reformulated OxyContin[®] OP] because of the gel in them."* Several participants described ways to abuse the reformulated, more tamper resistant OxyContin[®] OP. A participant explained, *"Microwave them [OxyContin[®] OP]. You can still use them. They [Purdue Pharma] tried to put ... they tried to do something to OxyContin[®] to stop you from being able to break them down. It's a known fact you can microwave them ... dries out the gel inside and you can still crush them and snort them. I know people do it every day."* Community professionals also reported that the availability of prescription opioids has remained stable over the past six months, again with the exception of OxyContin[®] OC, which

they also reported has decreased in availability. A provider reported, *"I haven't heard too much about oxy's [OxyContin®] lately; decreased due to new formulation ... [users] switched from oxy to Vicodin®, Percocet® and heroin."* A law enforcement officer reported, *"OxyContin®, it really seems like it's dropped off."* BCI Richfield crime lab reported that generally, the number of prescription opiate cases it processes has remained stable; a noted exception was a decrease in the number of OxyContin® cases over the past six months.

Reportedly, many different types of prescription opioids are currently sold on the region's streets. Participants reported that prescription opioids generally continue to sell for a dollar per milligram with a few exceptions. Participants stated, *"My drug of choice are [prescription] opiates. They are a dollar a milligram. Basically, everything is a dollar a milligram except for the Vicodin®. Vicodin® is a lot cheaper; if you can get a real oxy [OxyContin® OC 80 mg] now since they [Purdue Pharma] changed em' to OP's [reformulated OxyContin®], so yeah, a real OxyContin® is a hundred bucks. If you get an OP, you can get that for 45 bucks because they are not, you can't [crush and snort them], you can only eat them."* Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid®, fentanyl patch and lollipop (100 mg patch sells for \$50–\$100), methadone (10 mg sell for \$5–\$8; wafers sell for \$40 per wafer), morphine, Norco® (500 mg sell for \$3–\$4), Opana® (20 mg sell for \$25–\$40; 30 mg sell for \$60–\$70; 40 mg sell for \$50–\$80), oxycodone 30 mg (a.k.a., "perc 30;" sell for \$30–\$40), OxyContin® (a.k.a., "oxy's"), OxyContin® OC (old formulation, a.k.a., "OC's;" 40 mg sell for \$80; 80 mg sell for \$80–\$120), OxyContin® OP (new formulation, a.k.a., "OP's" and "chewies;" 60 mg sell for \$25–\$30; 80 mg sell for \$40–\$50), Percocet® (a.k.a., "perc's;" 5 mg sell for \$5; 7.5 mg sell for \$5–\$8; 10 mg sell for \$6–\$10; 15 mg sell for \$15–\$20), Roxicet® (a.k.a., "roxi's;" 30 mg sell for \$15–\$25), Tramadol® (a.k.a., "trams;" 5 mg sell for \$.50–\$2); Ultram® (50 mg sell for \$1–\$3), Vicodin® (a.k.a., "vikes;" 5 mg sell for \$1.50–\$3), Vicodin® ES (7.5 mg sell for \$4), Vicodin® HP (10 mg sell for \$5).

In addition to obtaining prescription opioids on the street from dealers, participants continue 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 is through area physicians. Participants reported, *"I went to a doctor, no problem; Doctors, dentists main source, then friends; The person I was buying Percocet® from actually told me which doctor to go to get them. It was very easy;*

Going to doctors and emergency rooms. They give them out freely." A treatment provider reported, *"I know of two physicians who have been in the past extremely liberal about prescribing [prescription opioids]."* In terms of street purchase, participants reported, *"I've seen people get prescriptions they don't want, and then turn around and sell them. Most of the time, I see people getting [prescription opioids] from illegal transactions; Uh, there's a lot of elderly people that are living on a fixed income that are prescribed medication. That's the only way they can make ends meet [through the sale of their prescriptions]; I know quite a few elderly sell [prescription opioids]."*

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 continue to include the following in order of highest prevalence: oral consumption (swallowing and chewing), intranasal inhalation (snorting) and intravenous injection (shooting). Participants reported, *"I haven't seen any of the real ones [OxyContin® OC]. Like the only ones I've seen are the ones that they call the 'chewies' [OxyContin® OP]. You can't crush them, you can't snort them, you can't shoot [inject] them; Eat them [OxyContin® OP]. They made it [fentanyl] in a crushed form, so you could snort it ... and instantly, you're so high. It's outrageous how high you get off them; I've used fentanyl patches. I've shot [injected] them and chewed them up."* A treatment provider reported a high prevalence of intranasal inhalation among clientele: *"Mostly just snorting, snorting Vicodin®."*

A profile of a typical user of prescription opioids did not emerge from the data. Participants reported, *"Damn near everybody [uses prescription opioids]; I seen kids 10, 11, 12 popping pills; I've seen people 78 years old [abusing prescription opioids]; Nowadays, there's really no telling who's doing what anymore."* Community professionals were able to provide general descriptive information on users of prescription opioids. Providers reported, *"A fair amount of females [abuse prescription opioids] ... it seems to me that it is more male. Before they realize they have a problem ... age is 25 or 30 and older. Start because of legitimate pain and then realizing that they cannot stop; White, male and female, younger, 22 – 51 [years old]."* Community professionals noted changes in the profile of prescription opiate abuse. Treatment providers reported, *"For a long time we never got any Latinos, Latinas in the program, but now we are and many of them come in saying they're alcoholic, but later in treatment admit they are addicted to opiates; You know, like I said the younger crowd, but that's what I'm getting the most of [treatment referrals]."*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, crack and powdered cocaine, marijuana and sedative-hypnotics (Klonopin®, Valium® and Xanax®). Reportedly, it is common to use prescription opioids with the aforementioned drugs. Participants reported that the use of other drugs with prescription opioids intensifies the high. A participant reported that she liked to use benzodiazepines with prescription opioids because, *"It feels good."*

Suboxone® Historical Summary

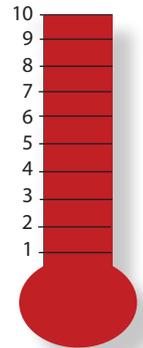
In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported street availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Law enforcement stated that Suboxone® was, *"rampantly available on the street."* While a few participants reported being either currently or previously prescribed Suboxone® by a physician in their community, through a treatment center, or while incarcerated, most frequently, participants reported obtaining Suboxone® on the street from other users or from drug dealers. BCI Richfield crime lab reported an increase in the number of Suboxone® cases it had processed over the past six months. Participants reported pricing for Suboxone® 8 mg to range from \$5 to \$30, with the most frequently reported price being between \$10 and \$20. Participants and treatment professionals alike reported that Suboxone® was most often used illicitly by those addicted to heroin who either traded Suboxone® to dealers for heroin or used the drug to avoid withdrawal between highs. Treatment professionals noted that other users were also abusing Suboxone® to get high. Most often participants reported taking Suboxone® orally, letting it dissolve under the tongue. However, there were reports of snorting Suboxone®, and participant and professional respondents alike reported that intravenous use of the drug was becoming more commonplace.

Current Trends

Suboxone® remains highly available in the region. Participants most often reported the current street availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants reported, *"Suboxone® was easy to get, but it was expensive; We all use them [Suboxone®]. I mean anyone in Belmont [County]. You know, for our own, like, we are trying*

to get off pills [prescription opioids], so we are buying these ... these off the street to get off the pills, but usually, I don't even know. It never worked." Community professionals perceived Suboxone® to have moderate street availability. Community professionals most often reported the drug's current availability as '5'. A provider reported, *"It [Suboxone®] is fairly available but not readily available. I know clients often look for it and not always finding it."* A Law enforcement officer reported, *"I know it's [Suboxone®] out there. I am seeing it."* Another officer reported higher street availability than the majority of community providers: *"Very available. To me, the biggest trend out there is the use of Suboxone®, illegally. They [opiate addicts] were using it to get over their dope sickness [withdrawal symptoms]."* Participants reported that the street availability of Suboxone® has increased over the past six months. A participant reported, *"There are a lot of people getting on Suboxone® right now, and a lot of people that are on Suboxone® sell Suboxone®."* Another participant reported that the availability of the film/strip form of Suboxone® has increased. Community professionals also reported that the availability of Suboxone® has increased over the past six months. A law enforcement officer reported, *"More available. There is a Suboxone® program in the county [Columbiana County] now, so that's kind of maybe increased the [street] availability of Suboxone®."* A treatment provider reported, *"It's increased [Suboxone® street availability]. I mean ... you've got people at [12-step] meetings handing them [Suboxone®] off. They're being sold like any other drug."* BCI Richfield crime lab reported that the number of Suboxone® cases it processes has increased over the past six months.

No slang terms or common street names were reported for Suboxone®. Participants reported current street pricing for Suboxone® 8 mg to range from \$10 to \$30, with the most frequently reported price being between \$20 and \$25, an increase from \$10 to \$20 from the previous reporting period. Participants reported, *"The 8 mg Suboxones® are going for \$20–25 for what I was paying for them; 8 mg pills [Suboxone®] 20 bucks; in Mahoning County, 8 mg pills [Suboxone®] \$20–25; I sold mine [Suboxone®] for \$30 in Columbiana County. I was prescribed them as part of a [Suboxone®] maintenance program."* Most often participants continue to report taking Suboxone® sublingually. Participants reported, *"People typically put them [Suboxone®] under their tongue, or they chew them up. I've actually witnessed a couple people shoot [inject] them up; I would eat the full 8 mg Suboxone®."* Participants also continue to report intranasal inhalation (snorting) and intravenous injection (shooting). Participants reported, *"I snorted it [Suboxone®] when I would take it. It made me not sick;*



Well, I shoot [Suboxone®] in my neck, so, um, it goes straight to you, you know. You're not sick. Some people get high off it, I do not." Participants reported an increase in doctors prescribing of Suboxone® strips. There were reports of users injecting Suboxone® strips. A participant reported, "I do know a few people that when switched to the films [Suboxone® strips], they say that those are a lot easier to shoot up [inject]. Yeah, 'cause they dissolve in water; they dissolve completely, and I've heard people say that those actually work really well."

In addition to obtaining Suboxone® on the street from dealers, participants continue to report getting the drug from doctors and from others in Suboxone® maintenance programs. Participants reported, *"I got mine [Suboxone®] from my dealer, so I assume the doctor gave them to someone for the dealer to get them; I too sold Suboxone® on the street. I went to two Suboxone® maintenance programs to get them, and I would sell them for my heroin; I went to the doctor to get Suboxone®, so I really didn't have to get them on the street because ... I mean all you got to do is go to a Suboxone® doctor ... First time you go, you need to screen dirty [positive for opiates], and they're [doctors] all about giving you Suboxone®."*

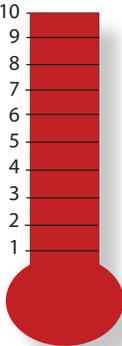
A profile for a typical Suboxone® user emerged from the data. While acknowledging that Suboxone® is tremendously helpful to those who take the drug as directed for its intended purpose, participants continue to widely report abuse of Suboxone® by those addicted to opiates that use the drug to keep from experiencing withdrawal between opiate purchases and by those not addicted to opiates who are seeking to get high. Participants reported, *"I quartered them [Suboxone®]. This is stupid. Because it's an opiate blocker, and I knew once I did the Suboxone®, I can't do another opiate for however many hours they say ... so I tried to take the bare minimum, so I wouldn't be sick, but that way I could still use an opiate; I would buy them [Suboxone®] to come off other stuff, but it never worked like that. 'Cuz you could get high off Suboxone® if you hadn't had any opiates in a couple of days; If you are not addicted to opiates and you take a Suboxone®, it's very, very strong. It can make you high for three days ... If you are addicted to opiates, you take the smallest piece of Suboxone®--it makes you feel normal."* Community professionals echoed what was reported by participants. A treatment provider summarized the sentiment of the professional group by stating, *"Heroin addicts, opiate addicts of all sorts use that [Suboxone®] as a standby drug, the hardcore ones to fend off any withdrawal 'til they get their true fix. However, a lot of people are being introduced to opioids through Suboxone® now because, if they were not Suboxone® users, the buprenorphine ... the active agent in Suboxone® is giving them the opiate effect, and now they're looking for stronger opioids. So, now it's [Suboxone®] a gateway drug to opioid addiction."* Reportedly, Suboxone® is used in combination with alcohol,

powdered cocaine and sedative-hypnotics (Klonopin® and Xanax®). Participants reported that benzodiazepine use with Suboxone® is very common.

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). Treatment professionals listed the most common sedative-hypnotics in terms of widespread use as Ativan®, Klonopin®, Valium® and Xanax®. The consensus of participants and treatment professionals alike was that sedative-hypnotics had become more available over the past six months. In addition to obtaining sedative-hypnotics from dealers, participants reported visiting area doctors in order to obtain prescriptions for these drugs. Treatment professionals noted an emerging problem of young people being prescribed sedative-hypnotics without psychiatric care. The most common routes of administration were oral consumption and intranasal inhalation (snorting). Treatment professionals reported that illicit use of these drugs in their communities was a far-reaching problem that affected all age groups.

Current Trends

 Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants and community professionals identified Klonopin® and Xanax® as the two most popular sedative-hypnotics in terms of widespread use. Participants all agreed that sedative-hypnotics were "easy to get." Community professionals reported the drug's current availability ranged from '6' to '10' with a median score of '8.5'. Treatment providers reported that sedative-hypnotics were, "pretty easy to get." Treatment providers continue to report concern over increased adolescent use of sedative-hypnotics. A provider who counsels adolescents reported, "[Sedative-hypnotics] becoming more popular with the adolescent population." A treatment provider from a different agency echoed this same sentiment: "With the adolescents, it's [sedative-hypnotic use]

more common ... the adolescents talk about the marijuana, but then after a while they start admitting that there's more use of the benzo [benzodiazepines]." Equal numbers of participants reported that the availability of sedative-hypnotics has remained the same/has increased over the past six months. Community professionals reported that availability has stayed the same. One treatment provider said he thought one sedative-hypnotic was on the increase because he was hearing more about Soma® recently. Another treatment provider reported that drug consumers were using sedative-hypnotics to fight withdrawal symptoms: "[Sedative-hypnotics] are being used when they can't find Suboxone® by the opiate addicts. However, they are finding it does not stop the opiate withdrawal." BCI Richfield crime lab reported that the number of sedative-hypnotic cases it processes has remained stable over the past six months.

Reportedly, many different types of sedative-hypnotics are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ativan® (.5 mg sell for \$0.50; 2 mg sell for \$2), Klonopin® 2 mg (\$2–\$3), Seroquel®, Soma®, Valium®, Xanax® (a.k.a., "footballs;" .25 mg sell for \$0.75; .5 mg sell for \$0.75–\$2; 1 mg sell for \$1–\$4; 2 mg, a.k.a., "xanibars" sell for \$4–\$7). In addition to obtaining sedative-hypnotics on the street from dealers, drug users continue to get them from physicians and friends or relatives. As one treatment provider explained, "It [a sedative-hypnotic] is ... [as] nearby as their medicine cabinet or grandparent's, cousin's, you know."

While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, the most common routes of administration remain oral consumption and intranasal inhalation (snorting). While most participants would typically use one method or the other, a combination of methods was also mentioned. A participant stated, "I would eat half and snort half." Only one participant said she had tried intravenous injection of sedative hypnotics: "I've tried to shoot them [inject sedative-hypnotics] as well and was unsuccessful."

A profile of a typical user of sedative-hypnotics did not emerge from the data. Most participants believed that sedative-hypnotic use transcended race and socio-economic status. As one participant said, "I think everybody [uses sedative-hypnotics], all age groups ... I know the elderly take them [and] you people [professionals] take them." Treatment providers could not come to any agreement about the typical users of sedative-hypnotics.

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, cocaine, Ecstasy, heroin, methamphetamine and prescription opioids. Most participants used sedative-hypnotics to "come down" from other drugs. This common theme was captured in statements like, "When I used to snort cocaine or do [Ecstasy] or an upper type of drug ... taking a Xanax® would help to free [me to] come down off of it better and more easily than if you had nothing at all; When [users] don't have opiates, they are using [sedative-hypnotics] to kind of mellow out." Other participants reported liking to use different drugs with sedative-hypnotics because it changed the high: "I was mainly using them [sedative-hypnotics] with methadone ... which enhances the buzz." Some participants expressed concern about combined prescription opiate and sedative-hypnotic use because it leads to, "a lot of overdoses." Using sedative-hypnotics with all of the aforementioned substances is reportedly common.

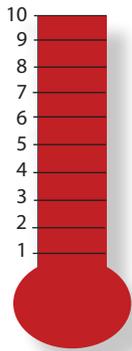
Marijuana

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 rated marijuana's availability equal to that of heroin as the most available illegal drug in the region. BCI Richfield crime lab reported that marijuana cases made up the greatest proportion of drug cases it reviewed over the previous six months. Participants reported that the quality of marijuana varied with the most common quality score being '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that for commercial-grade marijuana, a "blunt" (single cigar) ranged in price from \$5–\$10 and an ounce ranged in price from \$75–\$120; for high-grade marijuana, a "blunt" (single cigar) sold for \$20 and an ounce ranged in price from \$180–\$400. The most common route of administration for marijuana was smoking. The prevailing thought was that marijuana was widely used. Several participants reported that marijuana blunts were rolled with Tussionex Pennkinetic® (a narcotic liquid cold remedy), and that this trend was common among those 20 to 40 years in age.

Current Trends

Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' Participants often stated that



they wished the availability scale went higher than '10' because they said marijuana was "very plentiful." Despite occasionally having dry spells where little marijuana was available, participants agreed: "Marijuana is the easiest drug to come across." Another participant talked about the ubiquitous nature of marijuana: "I've lived in six different places around on the east coast, and weed [marijuana] has always been abundant anywhere I went." Community professionals also most often reported the drug's current availability as '10'. Treatment providers said

marijuana was, "as available as getting a glass of water; more available than cigarettes." Other treatment providers laughed when one said, "I saw some [marijuana] out there the other day growing by that tree" to express the high availability of marijuana. Law enforcement agreed with statements from treatment providers, describing marijuana as, "the most available drug." Participants reported that the availability of marijuana has stayed the same over the past six months. However, a participant from Belmont County said marijuana was decreasing: "Weed is going away ... because coke and pills are taking over." Community professionals reported that availability of marijuana has stayed the same over the past six months. Law enforcement reported that there has been a transition to indoor growing operations and growing covertly on personal and private property. An officer reported, "Increase in Hispanic outdoor grows using public lands and private lands they sneak on. They live in tents and tend [marijuana] plants full time until harvest time." BCI Richfield crime lab reported that the number of marijuana cases it processes has remained stable over the past six months. Media reports from the region reported several marijuana busts over this reporting period. Police intercepted two pounds of marijuana valued at \$4,500 during a routine traffic stop in Belmont County (www.vindy.com, May 31, 2011), and state highway patrol discovered three pounds of marijuana during a routine traffic stop in Mahoning County (www.nbc4i.com, May 18, 2011).

Participants did not provide quality scores for marijuana because they said all qualities of marijuana were available; the previous most common quality score was '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Several participants continue to explain that the quality of marijuana depends on whether the user buys "commercial weed" (low- to mid-grade marijuana) or hydroponically grown (high-grade marijuana). Participant generally agreed that high quality weed was more prevalent: "There's some garbage [marijuana] out too, but mostly high-grade out there now." When describing the quality of marijuana, participants said

low-grade marijuana looked and smelled different from high grade marijuana. A participant described the two types of marijuana as follows: "Commercial [marijuana], which is seedy and stemmy, and then we have 'dro [hydroponically grown marijuana] which has a little bit of red tint and some crystals, and it's really fluffy." According to other participants, low-grade marijuana appeared, "dark brown, which ... looks like grass, like dirt weed," and high-grade marijuana, "has less seeds ... [and] smells better." Another participant discussed the different species of high-grade marijuana: "Indica gets you the high where you just want to sit and chill and watch TV or eat cookies or something you know. Sativa is an uppity high kinda weed [marijuana]. It makes you want to clean; it makes you want to do things, and, um, Afghan is a whole another breed of itself. It's kinda just ... that's just a really good high, and Ruderalis is the weed that only grows about a foot tall and that's just a whole another breed by itself too."

Current street jargon includes countless names for marijuana. The most commonly cited name remains "weed." Participants listed the following as other common street names: "brick," "mid's" and "reg's" for commercial grade (a.k.a., "regular" marijuana); "blueberry," "bubble gum," "purple haze" and "kryptonite" for high-grade marijuana; and "dro" or "hydro" for hydroponically grown marijuana. The price of marijuana continues to depend on the quality desired, with pricing remaining fairly stable from the previous reporting period. Participants reported commercial grade marijuana remains the cheapest form: a blunt (single cigar) or two joints (cigarettes) sell for between \$5-\$10; 1/8 ounce sells for between \$25-\$40; 1/4 ounce sells for between \$50-\$80; an ounce ranges in price from \$130-\$140; a pound sells for between \$400-\$800. Higher quality marijuana ("hydro") continues to sell for significantly more: a blunt (single cigar) or two joints (cigarettes) sell between \$10-\$20; a blunt of "kryptonite" sells for \$35; an ounce sells for between \$250-\$400; and a pound sells for between \$2,500-\$5,000. In general, participants said the high-grade marijuana consistently costs double that of low-grade marijuana in the region.

While there were several reported ways of consuming marijuana, the most common route of administration continues to be smoking. Other participants said some marijuana users consume marijuana baked into food. A participant reported, "I see people bake it [marijuana] in cakes, pies, brownies and stuff." Another participant talked about a slightly different baking method, reporting his friends, "make, like an oil out of it [marijuana]. They'd like cook up the oil and make brownies, cookies, just about anything." Vaporizing marijuana was also mentioned by several participants as a method of consumption. Participants said that method was

preferred by some people because, "it [marijuana] burns at a lower temperature than if you were to roll it and filter it. It is supposed to ... [burn] more of the THC rather than the weed itself."

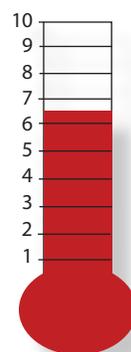
A profile for a typical marijuana user did not emerge from the data. Participants continue to report that marijuana use is prevalent for men and women across all races and ages. Commonly, participants stressed that "everyone" uses marijuana and that the age of first use is very young. One participant commented, "You'd be surprised ... I've seen 12 or 13 [start using marijuana]. My brother was 14 and was caught at school with marijuana." Other participants spoke from first hand-experience: "First time I smoked weed [marijuana] [I] was 13; then you smoke weed for a couple years. Then you get into, you know, cocaine ... and then the opiates." Treatment providers agreed with comments from users about the popularity of the drug: "More than any other substance, maybe even more so than alcohol, it [marijuana] seems to have universal appeal. I have 47 year olds who say if they wouldn't lose their job, they would pick up in a moment, and 13 year olds and Black folks and White folks." Law enforcement also agreed that the popularity of marijuana transcended boundaries, explaining it has the "biggest age range of all of them [drugs of abuse]: high school kids through those in their 60's."

Reportedly, marijuana is used in combination with alcohol, cocaine, Ecstasy, prescription opioids and sedative-hypnotics. Participants said that lacing a marijuana joint or blunt with cocaine continues to be fairly common: "People have done something called 'primo's' where you can put [powdered] cocaine or even crack [into marijuana], and it gives you this out of this world buzz." Other drug users called the combination of marijuana and crack cocaine, "woolie," and they said users can tell when marijuana is laced with crack because, "it stinks really bad; smells like burned toast." Sometimes marijuana is reportedly smoked after using crack cocaine and not at the same time. Participants said that smoking marijuana in this way helped to "come down" off of other drugs: "Like when you come off coke [powdered cocaine] or crack [cocaine], smoking a blunt of marijuana would really help to ease you coming down off that other buzz." It is also popular for users to dip their marijuana blunts and joints into liquid medicines like promethazine (an allergy medicine) and Tussionex® (a cough and cold medicine), reported in previous report. Reportedly, PCP (phencyclidine) continues to be occasionally used by participants along with marijuana. Users explained that they dipped their marijuana blunts and joints into liquid PCP, which they called "black water," "wet" and "wet stick." If they dipped their marijuana blunts and joints into embalming fluid, they called it a "love boat."

Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was relatively rare in the region. Most participants knew little about the drug. Participants most often reported the drug's current availability as '1' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Law enforcement rated availability as "1 or 2." Treatment professionals agreed that there was little availability in the region except for one area; reportedly availability was '10' in Ashtabula County where methamphetamine was said to be popular. BCI Richfield crime lab reported an increase in both powdered and crystal methamphetamine cases that it had processed over the previous six months. Participants reported they could buy a gram of powdered methamphetamine for \$50 and a gram of crystal methamphetamine for \$150. The most common routes of administration for this drug were smoking followed by injecting. Treatment professionals described typical users of this drug as 18 to 38-year-old Whites.

Current Trends



Methamphetamine is moderately available in the region. Participant median score for this drug's current availability was '6.5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '1'. Participants reported that methamphetamine is available in powder and crystal forms. Participants with experience in buying methamphetamine in the past six months described the powder as, "white color, almost looked like coke [powdered cocaine]." Only one person had experience with buying the crystal form of the drug, which was described as looking like "glass." Law enforcement reported that some methamphetamine has been coming in from Mexico: "We have seen some Mexican meth [methamphetamine], powder form." Experience with methamphetamine varied widely around the Youngstown region, with most people with methamphetamine experience reporting from west of Youngstown (Leavittsburg and Windham) and from Ashtabula County. Even in those areas, users said that availability varied: "It's [methamphetamine] more of a rural type of setting than in the inner cities yet." Community professionals most often reported the drug's current availability as '3' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers did not believe methamphetamine

was a very popular drug: *"It's [methamphetamine] available, but not a highly requested drug."* Law enforcement agreed that they did not see it very often except in a few counties. As one officer said, *"Portage and Ashtabula counties [are] problem counties"* for methamphetamine. When asked why methamphetamine was not more popular in the area, a treatment provider pointed to those in charge of the drug trade. He explained, *"The drug brokers don't want crystal meth [methamphetamine] in because it causes too much commotion. There is too much violence behind it and too much crazy, too many crazy people, and it messes with business ..."* Participants reported that the availability of methamphetamine has decreased in the Ashtabula area due to drug busts over the past year. However, participants closer to Youngstown reported that availability of methamphetamine has increased because more people have been making it over the past six months. Law enforcement reported that the availability of methamphetamine has slightly decreased over the past six months but were not certain of the reason for the decrease. An officer explained, *"It might be a false [conclusion that methamphetamine's availability has decreased] because everyone is moving away from the traditional meth labs ... to these one-pot methods where you are making enough for you and your buddy on a daily basis."* BCI Richfield crime lab reported that the number of crystal and powder methamphetamine cases it processes has increased over the past six months.

Participants did not give one quality rating for methamphetamine, because they explained quality could range from a '0' to a '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Most often participants reported being dissatisfied with the quality of methamphetamine, whereas last reporting period, most participants reported the quality of methamphetamine as high. As one participant stated, *"Most of the stuff [methamphetamine] around here is like what I call bathtub shit. They're [cookers] not chemically inclined to be making a purer substance [like] you would see out west."* Another participant stated that the quality of methamphetamine depended on the recipe: *"When somebody cooks [methamphetamine], you can get the bottom, which is nothing or you can get the top, which is '10'."*

Current street jargon includes one common name for methamphetamine, that being "meth." Current street prices for methamphetamine were consistent among participants with experience buying the drug. Participants did not break down prices for powdered and crystal (a.k.a., "glass") methamphetamine but reported a half gram sells for \$20 and a quarter ounce sells for \$30. Reportedly, the most common route of administration of methamphetamine continues to

be smoking. Other routes of administration that were cited as less common include intranasal inhalation (snorting) and injection.

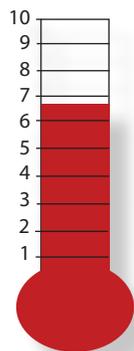
A profile of a typical methamphetamine user emerged from the data. Treatment professionals described typical users of methamphetamine as, *"mostly White males, 30 – 50."* Law enforcement officers concurred with treatment providers and said methamphetamine, *"Tends to be a Caucasian drug. We see it as more rural in terms of use."* Reportedly, methamphetamine is used in combination with alcohol, marijuana, prescription opioids and sedative-hypnotics. Participants reported using methamphetamine with these drugs to create the "speedball effect" in which users experience a high and then a low. A more common reason for combining methamphetamine with other drugs is to help in coming down from the methamphetamine high; reportedly, users *"will stay high for so many days, they'll need something to bring them down."*

Ecstasy **Historical Summary**

In the previous reporting period, Ecstasy [methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] was moderately available in the region. Participants most often reported the drug's availability as "5.5" on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The availability of the drug was thought to vary depending on the season; participants considered Ecstasy a 'summertime' drug. BCI Richfield crime lab reported an increase in the number of Ecstasy cases that it had processed over the previous six months. Participants reported a "single stack" (low dose) Ecstasy tablet sold for \$8 – \$10 and a "double stack" or "triple stack" (high dose) sold for \$16 – \$30. The quality of Ecstasy was variable, with some users reporting moderate quality and others reporting low quality. The only reported method of administration was oral consumption.

Current Trends

Ecstasy [methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] remains moderately available in the region. Participants reported the median score for Ecstasy as '6.75' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '5.5.' Participants continue to report that Ecstasy is more available in the summer and at certain other times of the year: *"Memorial Day, Halloween ... you know when people want to hangout and party."* Treatment providers 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). Treatment providers agreed that Ecstasy use is most often reported by the "adolescent population ... [but Ecstasy is] not as common or popular [as it once was]." Law enforcement agreed that Ecstasy was "very rare." An officer explained, "We see it [Ecstasy], not like we used to five years ago or eight years ago." Participants reported that the availability of Ecstasy has decreased over the past six months; however, they anticipated it will increase soon. As one participant said, "Right now, with summer and stuff, it's [Ecstasy] gonna become more available, and ... the last couple weeks before I come in here, there were a few people that had it." BCI Richfield crime lab reported that the number of Ecstasy cases it processes has decreased over the past six months.

Current street jargon for Ecstasy is limited; the only names reported for Ecstasy were "candy" and "skittles." Participants reported that Ecstasy comes in a variety of colors and looks like a "breath mint;" common pictures on Ecstasy pills include dollar signs, fish, naked ladies, Obama's head, Teenage Mutant Turtles and Transformers. Like other drugs, reportedly, Ecstasy prices are variable and largely depend upon, "who you know and how good of a deal they give you." Participants reported pricing that was slightly lower than last reporting period: a "single stack" (low dose) Ecstasy tablet sells for \$5–\$8 and a "double stack" or "triple stack" (high dose) sells for \$12–\$20. Bottles/jars of Ecstasy (100 dosage units) were reportedly available and cost anywhere from \$200–\$400. BCI Richfield crime lab cited methcathinone analogs (psychoactive stimulants) and other clandestine uncontrolled substances (bath salts) as cutting agents for Ecstasy.

A profile for a typical Ecstasy user emerged from the data. Participants said people interested in Ecstasy were "anyone 18–30 years old." One participant said that people who prefer Ecstasy also are, "the same people using the coke [cocaine] [and] the opiates." Law enforcement agreed with participants, and said Ecstasy users were typically, "college students [with] some high school [users]." Treatment providers reported that adolescents start experimenting with Ecstasy early, and use is not discriminate across gender and racial boundaries: "It [Ecstasy use] can go anywhere from any type of ethnicity ... 14–15 year-old African-American female[s] [or] male[s], to 14–15 year old Caucasian female[s] [or] male[s]." According to treatment professionals, young males use Ecstasy, "so they can stimulate [their] sex drive." Reportedly, Ecstasy is used in combination with crack cocaine and powdered cocaine.

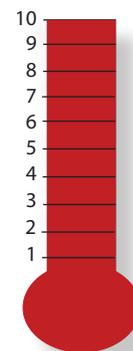
Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants (Adderall® and Ritalin®) were somewhat available in the region. Participants most often reported availability of these drugs as '4' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants believed that prescription stimulants were popular among all age groups while treatment providers believed they tended to be more popular with younger (< 26 years), White males and females. Aside from getting prescription stimulants from the streets, participants also reported getting them from friends and physicians. The most common reported method of administration was crushing and snorting the medicines.

Current Trends

Adderall® and Ativan® are highly available in the region. Participants rated the availability of prescription stimulants generally 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 '4.' VyVanse® was also mentioned as being available by a minority of participants. Much like Adderall®, VyVanse® is a newer drug to treat symptoms of attention deficit hyperactivity disorder. A treatment provider said his client was addicted to VyVanse®: "I had a lady who shot it [injected VyVanse®]. She said that it was new. She said that it was like Adderall®." BCI Richfield crime lab reported that the number of prescription stimulant cases it processes has remained stable over the past six months.



Current street jargon for prescription stimulants is limited; the only names for Adderall® reported were "poor man's coke" and "pumpkins." VyVanse® did not have any slang terms associated with it. The following prescription opioids are available to the street-level users (Note: When reported, current street prices are indicated in parentheses): Adderall® 10 mg; Adderall® 20 mg; Adderall® 25 mg; and Adderall® 30 mg (all pills sold between \$1–\$6); Ativan® (\$2 per pill, mg unspecified) and VyVanse®. While participants did not provide a profile for a typical user, they said the most likely person to abuse these medications was someone looking to, "use it [prescription stimulants] as a substitute for methamphetamine." When discussing the age drug users first abused prescription stimulants, participants had very dissimilar experiences. One participant said her parents abused her Adderall® and then encouraged her to abuse Adderall®. Another had a different

story, "When I was 15, the first thing I ever snorted was Ritalin®. I was prescribed it [but] I hung out with the older crowd ... and the older crowd was like 'we can snort these.'"

Prescription and OTC Cough Medicines

Historical Summary

In the previous reporting period, prescription and over-the-counter (OTC) cough medicines were highly available in the region. Participants most often reported the drug's current availability as '9' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Mahoning County law enforcement reported that the trend to abuse cough medicines was increasing. Participant and professional interviewees believed that illicit use of cough medicine was most popular among younger people (< 18 years) who did not have access to other substances. Participants reported that cough medicines containing DXM (dextromethorphan) were well liked because they caused users to hallucinate. The most often reported route of administration was oral consumption, but several participants also reported dipping tobacco cigarettes and marijuana "blunts" in cough medicine before smoking.

Current Trends

Prescription and over-the-counter (OTC) cough medicines appear popular among adolescent users. While none of the participants currently used these medications, some admitted to being addicted to them when they were younger. OTC cough medicines containing dextromethorphan (DXM), like Coricidin Cough and Cold®, Nyquil® and Robitussin® are reportedly the most sought after substances to abuse. The ingestion of prescription and OTC cough medicines, commonly called "Robo-tripping," is believed to be increasing. A participant stated, "The cough syrup thing is getting bigger with the younger crowd. My nephew, he's in high school and he knows quite a few people in his school that use cough syrup to get drunk, I'd guess you'd say." Treatment providers concurred that abuse of prescription and OTC cough medicines is increasing. A typical user profile did not emerge from the data among adolescents because providers reported that abuse of this class of drugs spans, "male, female; it doesn't matter if [you're] African-American or Caucasian." The most often reported route of administration remains oral consumption, but treatment providers also reported users dipping tobacco cigarettes and marijuana "blunts" in cough medicine before smoking. Treatment providers reported that adolescents "soak their Black & Mild® cigars in the [cough] syrup; dip it in there, and sometimes they talk of drinking it straight out of the bottle." In contrast, reportedly, young adults 18–21 are abusing less cough syrup according to counselors, but they are, "dipping their cannabis

joints or blunts into that substance [cough medicines] to make them stronger or sweeter."

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: energy drinks with alcohol, gamma-hydroxybutyric acid (GHB), hallucinogens [i.e., lysergic acid diethylamide (LSD) and psilocybin mushrooms], inhalants and synthetic marijuana ("K2" and "Spice"). LSD was mentioned by a few participants while others reported not having seen it in a while. Participants reported that the availability of LSD fluctuated with the seasons and that it was more of a "summertime" drug. A minority of participants also used psilocybin mushrooms and said they were available in a limited number of areas. The most commonly reported method of administration for mushrooms was oral consumption, eating or mixing them with tea. Reportedly, synthetic marijuana ("K2" and "Spice") was being used by a few participants for recreational use and as a stand-in for marijuana when participants needed to pass a drug test. Energy drinks with alcohol were used in combination with other drugs to modify the high experienced by users. Inhalants were mentioned as being popular with younger people (< 18 years), but none of the participants interviewed reported using them. Gamma-hydroxybutyric acid (GHB) was reportedly used by a few drug users to "come down" after using cocaine.

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. Reportedly, synthetic marijuana (K2, "K3" and "Spice") continues to be used by a few participants for recreational use and as a substitute for marijuana when participants need to pass a drug test. A participant stated, "I know a couple of people that smoke K2 and K3 [because] it don't show up in a piss test. It's like weed [marijuana], but [it gives] you that high effect and don't show up in your pee." Treatment providers reported that they believed the abuse of synthetic marijuana is on the increase: "In the last six months, year [to a] year, we have heard a whole lot more about it [synthetic marijuana]. We had some clients using. We got a drug test that could screen for K2. Had some clients testing positive for that, but not a significant amount of clients who actually used it for any length of time." Law enforcement also spoke about synthetic marijuana and their significant concerns about its use. As one officer said, "I'm aware of at least three to four overdoses of young people

on K2 over the past six months—luckily no deaths.” Treatment providers mentioned that inhalants are popular among a minority of their clients, most of them under 16 years old. A treatment provider reported, *“One or two of my clients in the [past] six months with that duster ... I was surprised to see ... [a] female 52 years of age ... but she used it because she knew it wouldn’t come up in a drug screen.”* A minority of participants reported experience with inhalants, but most of this experience was not recent. A few participants reported abuse of five-hour energy drinks. A participant reported, *“I know people that take 10–15 [five-hour] energy drinks at a time and when you do it like that, I’m sure that’s abusing them.”* Caffeinated alcohol (“Four Loko”) was also abused by one participant, who explained that Four Loko gave him, *“a rush kinda, and I drank like seven of them and that’s the last thing I remember because I was drinking them so fast, and that I mean, I was severely sick.”* Hallucinogens like psilocybin mushrooms and PCP (phencyclidine, a.k.a., “sherm” and “wet”) had limited availability in the region. A law enforcement professional reported that mushrooms, *“are available in summer when bands come in and in camp grounds. I wouldn’t say it was mainstream.”* While most participants knew about bath salts (“White Lightening”), none of them abused the substance. Only one participant knew of someone who abused the substance for its cocaine-like effects. BCI Richfield crime lab reported that the number of LSD, psilocybin mushroom and synthetic cannabinoid cases it processes has increased while the numbers of processed cases for all other drugs mentioned in this section have remained stable over the past six months.

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids, sedative-hypnotics and Suboxone® remain highly available in the Youngstown region. Noted increases in availability over the previous six months exist for heroin, Suboxone®, methamphetamine and prescription stimulants; noted decreases exist for OxyContin® OC and Ecstasy. Participants and community professionals attributed the increase in heroin use and availability over the past six months mostly to the price of prescription opioids. BCI Richfield crime lab reported that the number of powdered heroin cases it processes has increased, reporting having processed approximately 1,500 heroin cases over the past six months, making powdered heroin the most processed drug through BCI Richfield crime lab. Participants reported that the quality (potency) of heroin has also increased. Along with widespread reports of intravenous use of heroin (most common route of administration) were widespread reports of sharing of injection needles, hepatitis C infections and overdoses involving heroin. The consensus among participant and community professional groups was that heroin users continue to be predominately White males

and females between the ages of 20 and 35 years, although several community professionals continue to report increasing heroin use among adolescents, particularly teenaged females. Participants and community professionals reported that the high availability of prescription opioids has remained stable over the past six months, with the exception of OxyContin® OC which has decreased in availability due to its discontinuation and replacement by the more tamper resistant OxyContin® OP. Participants noted increasing popularity of Opana® and Ultram®, and Norco® was reported as available when there were no reports of its use previously. The consensus among participants and community professionals was that the most common route for obtaining prescription opioids remains through area physicians. Participants and community professionals also continued to report an increase in Suboxone® street availability. Participants reported an increase in doctors prescribing of Suboxone® strips, with reports of users injecting these strips. While acknowledging that Suboxone® is tremendously helpful to those who take the drug as directed for its intended purpose, participants continue to widely report abuse of Suboxone® by those addicted to opiates that use the drug to keep from experiencing withdrawal between opiate purchases and by those not addicted to opiates who are seeking to get high. Participants reported that benzodiazepine use with Suboxone® is very common. Participants reported that the availability of methamphetamine has decreased in the Ashtabula area due to drug busts over the past year. However, participants closer to Youngstown reported that availability of methamphetamine has increased because more people have been making it. Law enforcement reported that some methamphetamine has been coming in from Mexico. Community professionals described typical users of methamphetamine as, *“mostly White males, 30–50.”* Adderall® and Ativan® are highly available in the region. Vyvanse®, a newer prescription stimulant, was also mentioned as being available by a minority of participants. The ingestion of prescription and OTC cough medicines, commonly called “Robo-tripping,” is believed to be increasing. Reportedly, synthetic marijuana (“K2,” “K3” and “Spice”) continues to be used by a few participants for recreational use and as a substitute for marijuana when participants need to pass a drug test. Treatment providers reported that they believed the abuse of synthetic marijuana is on the increase. Reportedly, some treatment providers have started to screen for synthetic marijuana in urine drug screens administered to clients. Lastly, while most participants knew about bath salts (“White Lightening”), none of them abused these synthetic cocaine substances.