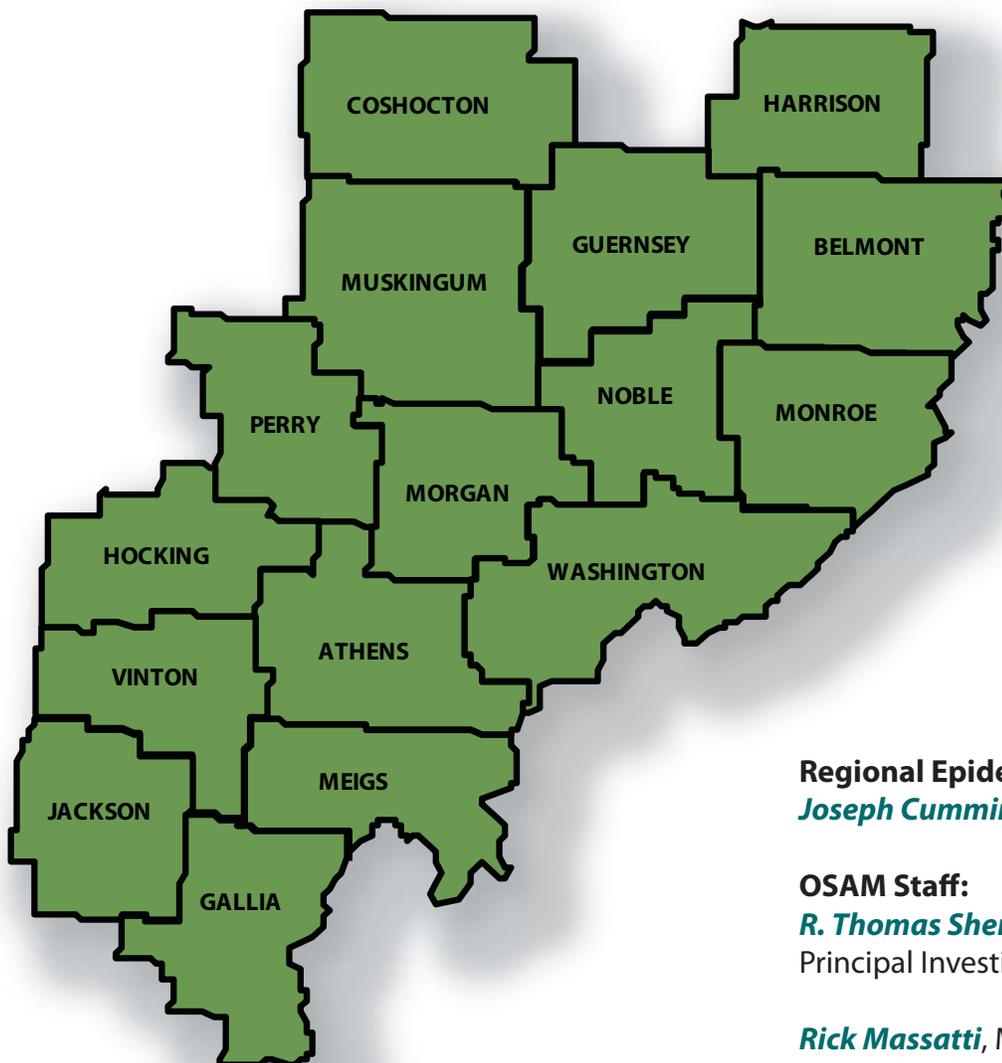


Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Athens Region

January-June 2011

John R. Kasich, Governor
Orman Hall, Director



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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

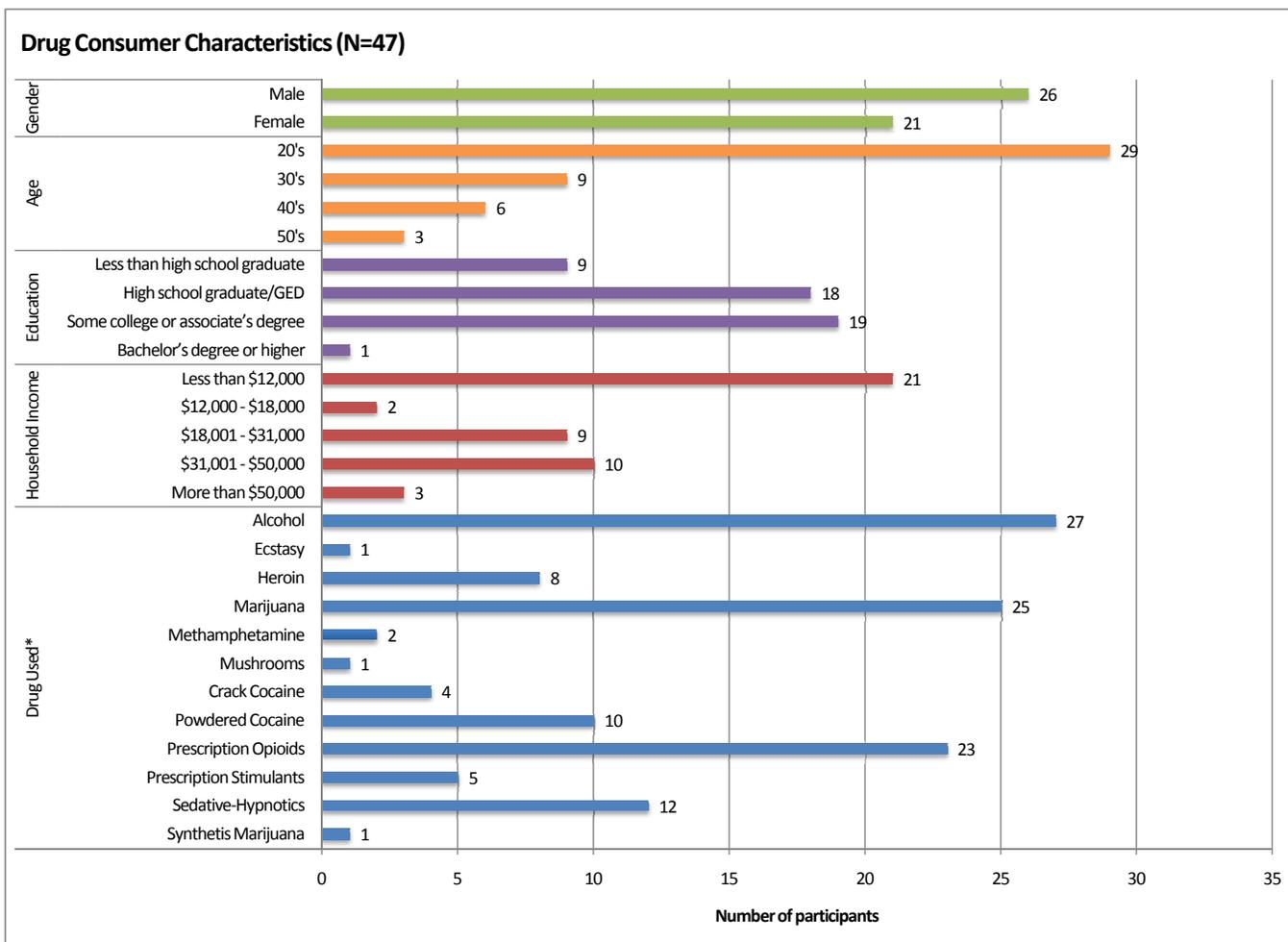
Regional Profile

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.

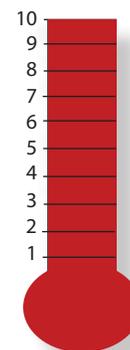
Powdered Cocaine Historical Summary

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."

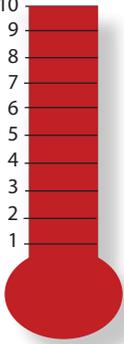
Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics (Seroquel® and Xanax®). Many participants commented that it is common to use powdered cocaine with other drugs (more so than to use powdered cocaine by itself) usually to help 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

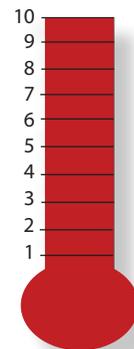
Historical Summary

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

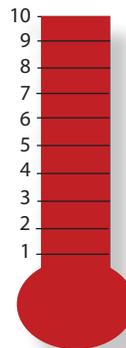
In the previous reporting period, prescription opioids were highly available in the region. Participants and community professionals most often reported street availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). 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,

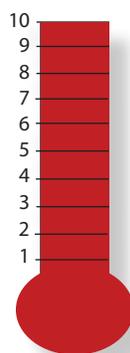
on whether it is more common to use prescription opioids in combination with other drugs or to use them by themselves. Participants reported that alcohol intensifies the effects of prescription opioids and gives a, “better buzz;” the same was said when using prescription opioids with marijuana. Those 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.”*

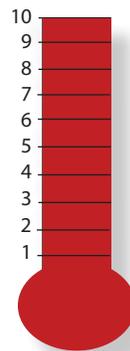
Reportedly, Suboxone[®] is used in combination with alcohol, crack cocaine, marijuana, powdered cocaine and sedative-hypnotics (Xanax[®]). However, most participants reported that it is more common to use Suboxone[®] by itself. A participant reported that using Suboxone[®] with “nerve pills” (Xanax[®]),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

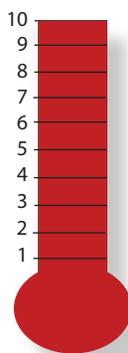
In addition to obtaining sedative-hypnotics on the street from dealers, participants continued to also report getting them from doctors, friends and family members who were prescribed the drugs. Many commented that it is easy to get sedative-hypnotic prescriptions. Participants stated, “*These pills [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]."*

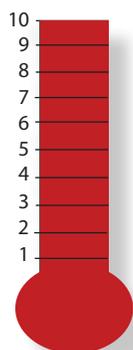
Reportedly, marijuana is used in combination with alcohol, crack cocaine, heroin, powdered cocaine, prescription opioids, and per one participant, *"embalming fluid."* A participant stated, *"Weed [marijuana] is one thing you can mix with anything and not worry about it killing you."* The majority of 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.

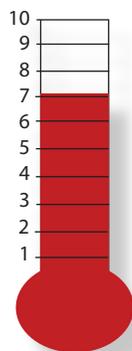
A profile for a typical methamphetamine user did not emerge from the data. Participants reported that all groups are represented among users. A few participants offered descriptors of those that use methamphetamine: “People who use cocaine [are more likely to use methamphetamine]; All my rich, White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

“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.”

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.

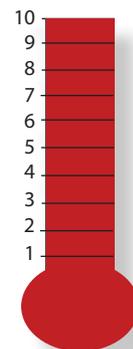
Prescription Stimulants

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.

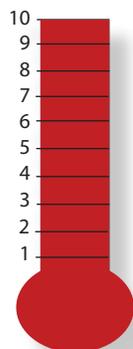
Synthetic Marijuana
Historical Summary

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.