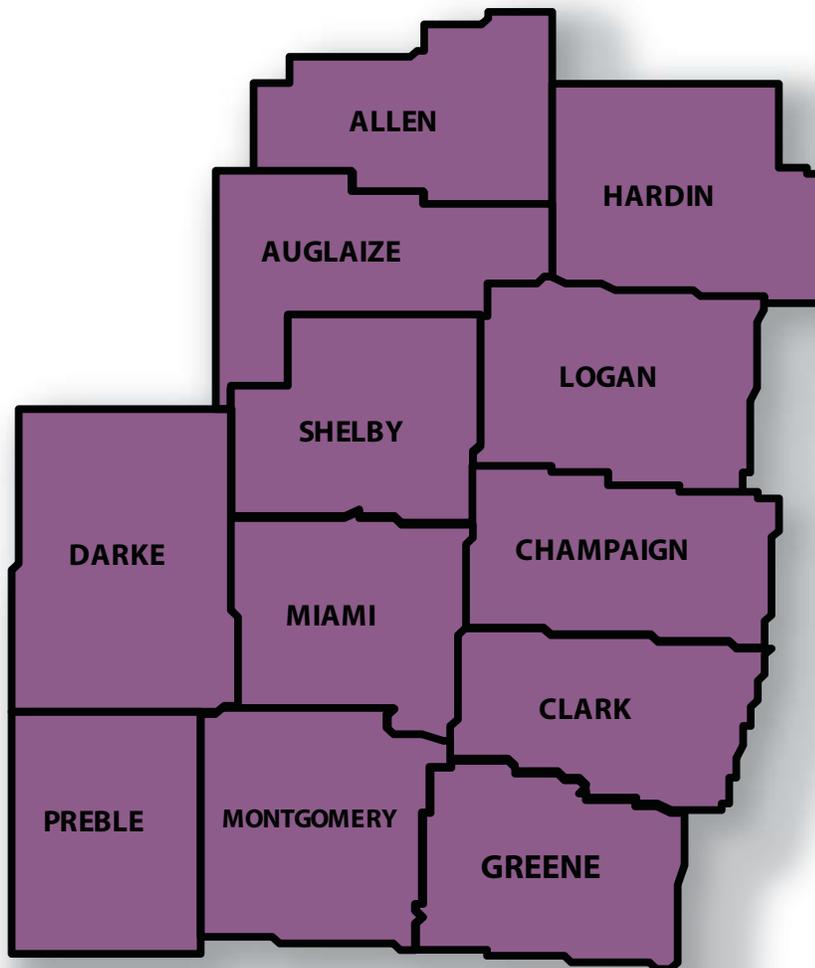


Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Dayton 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

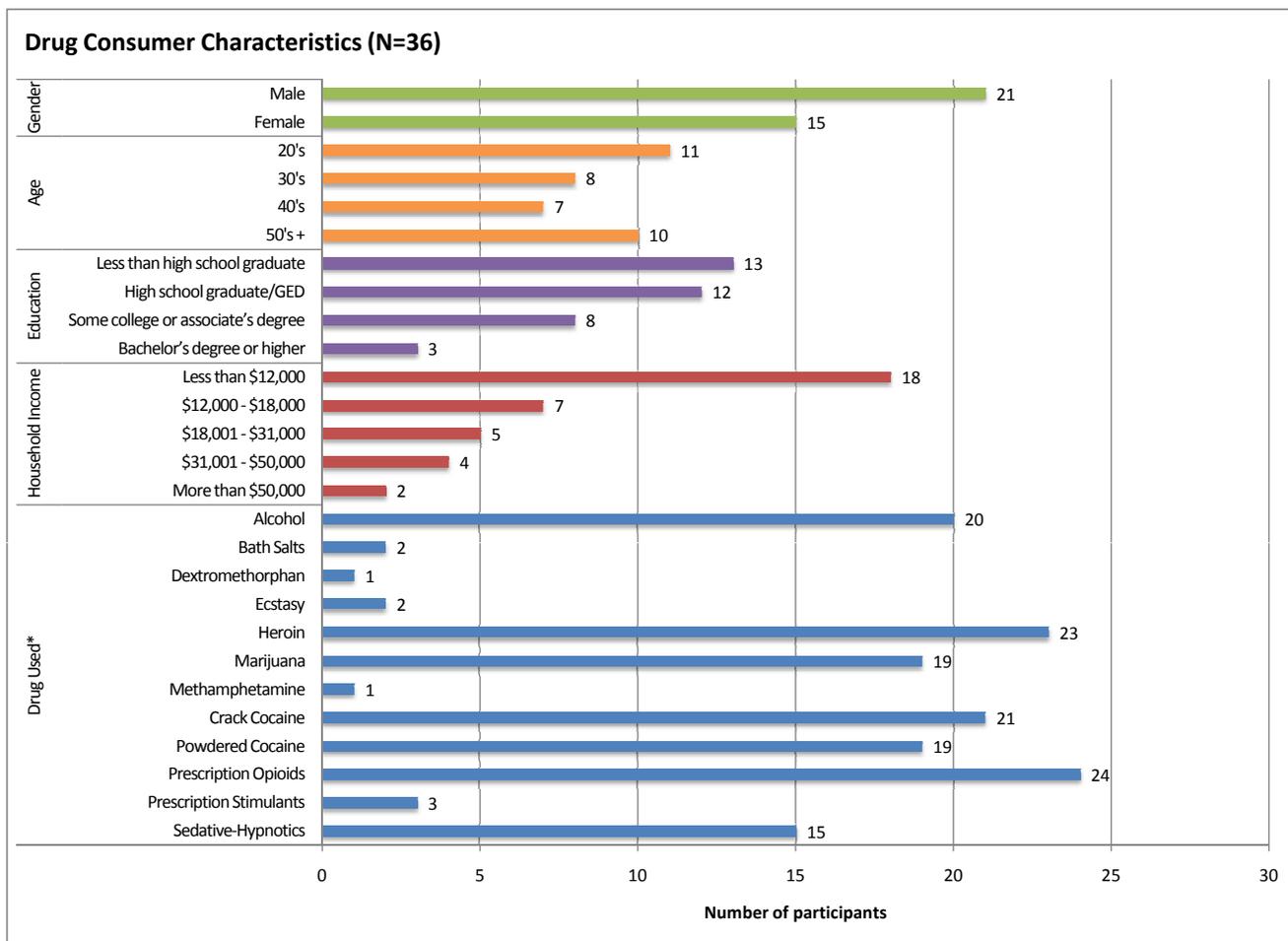
Regional Profile

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

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

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

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



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

Data Sources

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

Powdered Cocaine Historical Summary

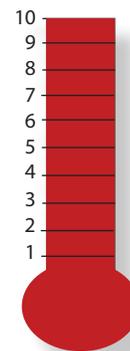
In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Most participants reported that availability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

Current Trends

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

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

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



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

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

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

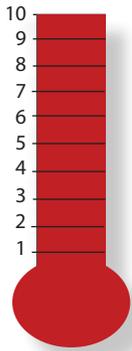
Reportedly, powdered cocaine is used in combination with alcohol, benzodiazepines (Xanax®), heroin (a.k.a., "speedball") and marijuana (a.k.a., "primo"). Users stated that these drugs help reduce the stimulating effects of cocaine. A participant explained, *"People that mix cocaine and benzos [benzodiazepines]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

Crack Cocaine Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described crack cocaine as extremely easy to get. Law enforcement also said the availability of crack cocaine was high: *"24/7, generally in the lower-income areas."* The most common participant quality score for crack cocaine was '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut (adulterated) with other substances. The Miami Valley Regional Crime Lab reported cutting agents for crack cocaine as: levamisole (livestock dewormer), nicotinamide (B vitamin used to treat acne) and phenacetin (analgesic), as well as, the local anesthetics: benzocaine, lidocaine and procaine. Participants reported that a gram of crack cocaine ranged in price from \$40–\$70. The majority of crack cocaine users reported buying the drug in small quantities called "dimes" (1/10 gram) for \$10. Most participants who used crack cocaine reported injecting it intravenously. Participants said that crack cocaine use crossed all ages, races and socioeconomic classes.

Current Trends

Crack cocaine remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. Participants described the high availability of this drug with comments such as: *"You could walk down the street and get it [crack cocaine]. I could*



make a phone call to 25-30 people that sell it; I get approached on the bus [by crack cocaine dealers]: If you are in a car somebody's gonna stop you and ask if you are looking [for crack cocaine]." Law enforcement and treatment providers agreed that crack cocaine is highly available in both urban and rural areas. However, due to the explosion of other drugs such as heroin and prescription opioids, community professionals felt that their resources had been shifted away somewhat from crack cocaine to the abuse-related problems of other substances. An officer

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

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

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

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

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

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

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

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

Heroin

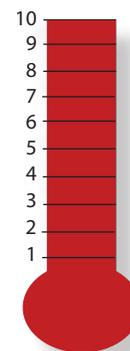
Historical Summary

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

Current Trends

Heroin remains highly available in the region. Participants most often reported the overall current availability of heroin as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10.’ Participants reported, “*Heroin is easy to get, just as easy as marijuana. Brown, white, tan [heroin available]. Not a whole lot of dark brown [heroin]. I’ve*

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



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

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

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

Nearly all participants reported that the availability of heroin increased over the past six months: "More people are coming in from the suburbs. The dealers will offer free [heroin] samples when they sell crack [cocaine]; It's [heroin] more available. There are more people you don't think would do it [use heroin]; It's [heroin] ruining all the towns. Older people, younger people [are using heroin] ... It's everywhere." Law enforcement and treatment providers unanimously stated that heroin availability has remained high. A treatment provider stated, "It's [heroin] been a huge issue, but it's about the same in the past six months." Miami Valley Regional Crime Lab reported that the number of heroin cases it processes has increased over the past six months.

Most participants rated the quality of brown powdered heroin as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '10'. Participants rated the quality of black tar heroin as '4'. Participants felt that over the past six months, the quality of powdered heroin has decreased. Many participants blamed an influx of new dealers and new users to the drug as a possible reason. Participants said, "It's [quality of heroin] getting worse. More people are trying it, and more people are cutting it; [Quality is] absolutely going down. Three years ago it was really good. Now people are banging four to six caps at a time [in order to get high]." Over the past six months, participants reported that the quality of black tar heroin has remained the same—that is, inconsistent. One participant commented about black tar heroin, "Quality [of black tar heroin] fluctuates. You can go to the same place, same guy, and get different quality each time. You could go spend \$25 and get well, then spend \$50 the next time and not feel good." Participants reported that powdered heroin in the region is cut (adulterated) with pharmaceuticals. A participant reported, "I even got some yellow shit [heroin] a while ago.

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

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

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

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

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

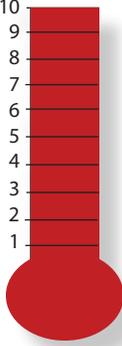
dope boys [drug dealers] who sold coke [cocaine] and heroin. People that speedball want both or we're going to someone else [to buy]."

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported street availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Treatment providers also reported very high availability of prescription opioids. The consensus among almost all participants across focus groups was that prescription opioids were more available than in the previous six months. Most participants agreed that the increased availability was due to increased prescribing in hospitals, private physician offices and occasionally pain clinics. Several participants reported that Opana® in particular had increased in demand and had become more available. Reportedly, the reformulation of OxyContin® OC into the more abuse resistant OxyContin® OP had little effect on the drug's widespread use. Participants in each focus group described different variations on how to get around the challenges posed by reformulation. The most common route of administration for prescription opioids was oral consumption, including wrapping crushed pills in bathroom or facial tissue and swallowing (a.k.a., "parachuting"). Participants and treatment providers alike stated that illicit use of prescription opioids in their communities was a far-reaching problem.

Current Trends

10
9
8
7
6
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2
1



Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. A law enforcement officer lamented, *"Opiate-related deaths have surpassed vehicle accident deaths in Montgomery County."* Participants noted that prescription opioids are easily obtained from one of many known contacts, usually within a single phone call, and occasionally available from an unknown street-level dealer. A participant reported, *"I could walk across the street and get some [prescription opioids] now."* A treatment provider reflected, *"More general things [common prescription opioids], things prescribed in the ER, like oxy's [OxyContin®], Vicodin®, Percocet®—those are easier to get. I don't hear so*

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

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

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

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

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

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

A profile of a typical user of prescription opioids emerged from the data. Participants and community professionals described typical users of prescription opioids as White, lower income and young. A participant described prescription opioid abusers as *“future heroin users,”* noting the pill-to-heroin abuse progression. Law enforcement also described that pattern: *“We’ve seen users switch over from oxy’s [OxyContin®] to heroin because it’s [heroin] cheaper.”*

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

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

Suboxone®

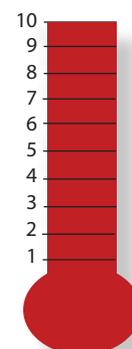
Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported street availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The consensus among participants was that Suboxone® was easy to get. While a few participants reported being either currently or previously prescribed Suboxone® by a physician in their community, through a treatment center or while incarcerated, most frequently participants reported obtaining Suboxone® on the street from drug dealers. Miami Valley Regional Crime Lab reported an increase in the number of Suboxone® cases it processed over the previous six months. Participants reported pricing for Suboxone® 8 mg to range from \$7 to \$20, with the most frequently reported price being \$10. Reportedly, Suboxone® was most often taken sublingually, letting it dissolve under the tongue. Several participants in each focus group reported snorting Suboxone®, and very few participants reported intravenous use.

Current Trends

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

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



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

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

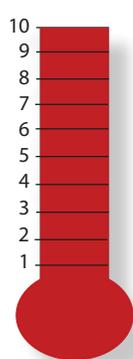
A profile for a typical Suboxone® user did not emerge from the data. Participants described typical users of Suboxone® as both people who wanted to address their heroin addiction and those who seek heroin but couldn't find any. A treatment provider said, *"It's [Suboxone®] for people who claim they want to get off heroin to help with the [withdrawal] symptoms."* Another treatment provider noted that demand for treatment is high among heroin users: *"We could have a doctor here prescribing Suboxone® full time, but there's no funding for that. There's demand for a full service Suboxone® clinic. We turn people away for Suboxone®, and when they can't get it here, they buy it off the streets."* Reportedly, Suboxone®

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

Sedative-Hypnotics Historical Summary

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

Current Trends



Sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants and community professionals identified the three most popular sedative-hypnotics in terms of widespread use as Ativan®, Klonopin® and Xanax®. A participant noted that sedative-hypnotics are easy to obtain through legal

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

treatment provider compared the availability of this class of drugs with pharmaceutical opioids by saying, "Yes, you can still get [sedatives-hypnotics]. They're not as available as oxy's [OxyContin®]. It's a different group of people looking for these." Miami Valley Regional Crime Lab reported that the number of sedative-hypnotic cases it processes has remained stable for most drugs, with the exception of Klonopin® and Restoril®, which have experienced an increase in the number of cases processed over the past six months.

Reportedly, many different types of sedative-hypnotics are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ativan® (a.k.a. "houses," "vans;" \$1 per pill), Klonopin® (a.k.a. "K's," "K-cuts," "klondikes," "klonies" and "pins;" \$1 per pill), Valium® (\$3 per pill); Xanax® (a.k.a. "basketballs," "footballs," "ladders," "wagonwheels" and "xani's;" 5 mg sells for \$2, 10 mg sells for \$3).

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

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

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

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

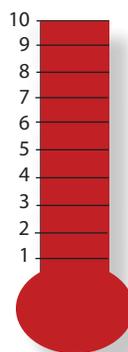
Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, crack cocaine, heroin and marijuana. One participant explained the heroin-sedative connection, "If you can't get any heroin, [sedatives] will help with the sickness." Another participant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

Marijuana Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants and treatment providers described marijuana as being extremely easy to get. Participants reported that the quality of marijuana varied with the most common quality score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that for commercial-grade marijuana, a "blunt" (single cigar) ranged in price from \$10-\$20 and an ounce ranged in price from \$100-\$120; for high-grade marijuana, an ounce ranged in price from \$300-\$400. While there were a few reported ways of consuming marijuana, the most common route of administration was smoking, followed distantly by eating, either by itself or baking marijuana into food. When asked to describe the typical user of marijuana, respondents were unable to be specific. They reported that virtually everyone uses marijuana, including all ages, races and socioeconomic groups.

Current Trends

Marijuana is the most widely available drug in the region. Participants most often reported the drug's current



availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants often commented that the scale used for ranking marijuana "didn't go high enough" to accurately reflect the availability of marijuana. A participant stated, "It's [marijuana current availability] a 10+ on your scale." Law enforcement most often reported the drug's current availability as '10'. An officer explained that marijuana is obtained easily from known acquaintances, "It's like two degrees of Kevin Bacon [the path to marijuana]. You can find [marijuana with] a friend." Another officer added, "It's so easy to get [marijuana] from friends, I think if you went up to a corner looking for weed [marijuana], they'd [dealers] think you were a cop. That's not what you'd do." Marijuana appears to be the drug of choice for regional juveniles involved in the court system. Of the 1,231 juveniles that tested positive for drugs in Montgomery County Juvenile Court from July 1, 2010 to December 31, 2010, more than 87 percent tested positive for marijuana. Participants and law enforcement reported that the availability of marijuana has remained the same over the past six months. However, certain trends were observed by law enforcement, one of which was an increase in high-quality and specialty varieties of marijuana. Law enforcement frequently talked about the increase in marijuana's quality: "Over the past two to three years, we've seen better grade [marijuana]. There's a lot more designer marijuana with flavoring, stuff that makes it less harsh. A lot of them [growers] will add things to the soil, a plant food added to soil. Also, we're seeing so many new strains of marijuana; The hybridization is very advanced. What works for corn or whatever, they're using that technology on the marijuana." Other trends in marijuana concern the price; there is a price decrease for low-grade marijuana and a price increase for the high-end marijuana product. One officer remarked, "Ditch weed [low-grade marijuana] is easier to get than hydro [hydroponically-grown or high-grade marijuana]. The price is a lot cheaper to get lower grade." Finally, the officers noted that there are increases in dealer inventory quantities. As one officer explained, "The [marijuana] availability is the same, but the amount is up. Instead of a dealer with half a pound, now it's one to two pounds. Grow operations that were 10 to 20 plants are now 100 to 200 plants." Regional media reported that several large marijuana seizures occurred during this reporting period. The *Vindicator* reported that Ohio State Highway Patrol Officers stopped a man on interstate 70 in Preble County for a traffic violation. After seeing marijuana in the truck cab, officers preformed a more comprehensive search at which time they found 871 pounds of marijuana worth an estimated \$2

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

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

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

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

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

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

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

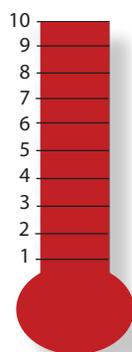
Methamphetamine Historical Summary

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

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

Current Trends

Methamphetamine continues to be infrequently used by participants. In fact, only three participants of 40 were able to supply an availability ranking for this drug. Those users with methamphetamine experience reported the current availability of methamphetamine as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10' among those few participants with first-hand knowledge of the drug. Participants reported that methamphetamine is available in home-cooked, powdered form. Treatment providers reported that methamphetamine use is relatively rare among their clientele. A treatment provider said, *"I have one current client in recovery for methamphetamine, but she's from Cincinnati."* Law enforcement officers believed that methamphetamine is not available in their area: *"We don't see it [methamphetamine] here in Montgomery County. We see it in outlying areas like Preble County. East of Montgomery County is all suburbia, so you have to get to the western part of the county to make a lab without the neighbors smelling it."* Of the few participants with knowledge of the drug, most felt that methamphetamine had become more available over the past six months, largely due to the belief that, *"They're [dealers] putting it [methamphetamine] in with the crack [cocaine]."* However, this idea was challenged by a participant, *"It [methamphetamine] costs more than coke [cocaine], so I don't know why they [dealers] would cut [adulterate] it [crack cocaine] with that [methamphetamine]."* Regional media reported that several methamphetamine labs were discovered during this reporting period. An area drug task force arrested three men in Darke County after police learned about an active methamphetamine lab. In addition to finding methamphetamine and the equipment to manufacture the drug, the police found marijuana, prescription pills, drug paraphernalia and more than \$1,110 in cash (www.whiotv.com; Feb. 7, 2011). *The Register Herald* also reported that police in Preble County found a methamphetamine lab in a man's home that included crystal methamphetamine along with the chemicals and equipment to manufacture the drug (www.registerherald.com; April 6, 2011). Miami Valley Regional Crime Lab reported that the number of methamphetamine cases it processes has decreased over

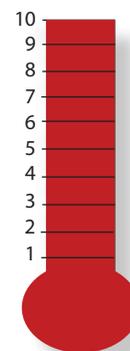


the past six months, and that the most frequent forms of methamphetamine that came through the lab were tan and blue powder/chunk along with crystal.

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

Bath Salts¹ Current Trends

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



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

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

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

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

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

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

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

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

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

Other Drugs

Historical Summary

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

Current Trends

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

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

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

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

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

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

Conclusion

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

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