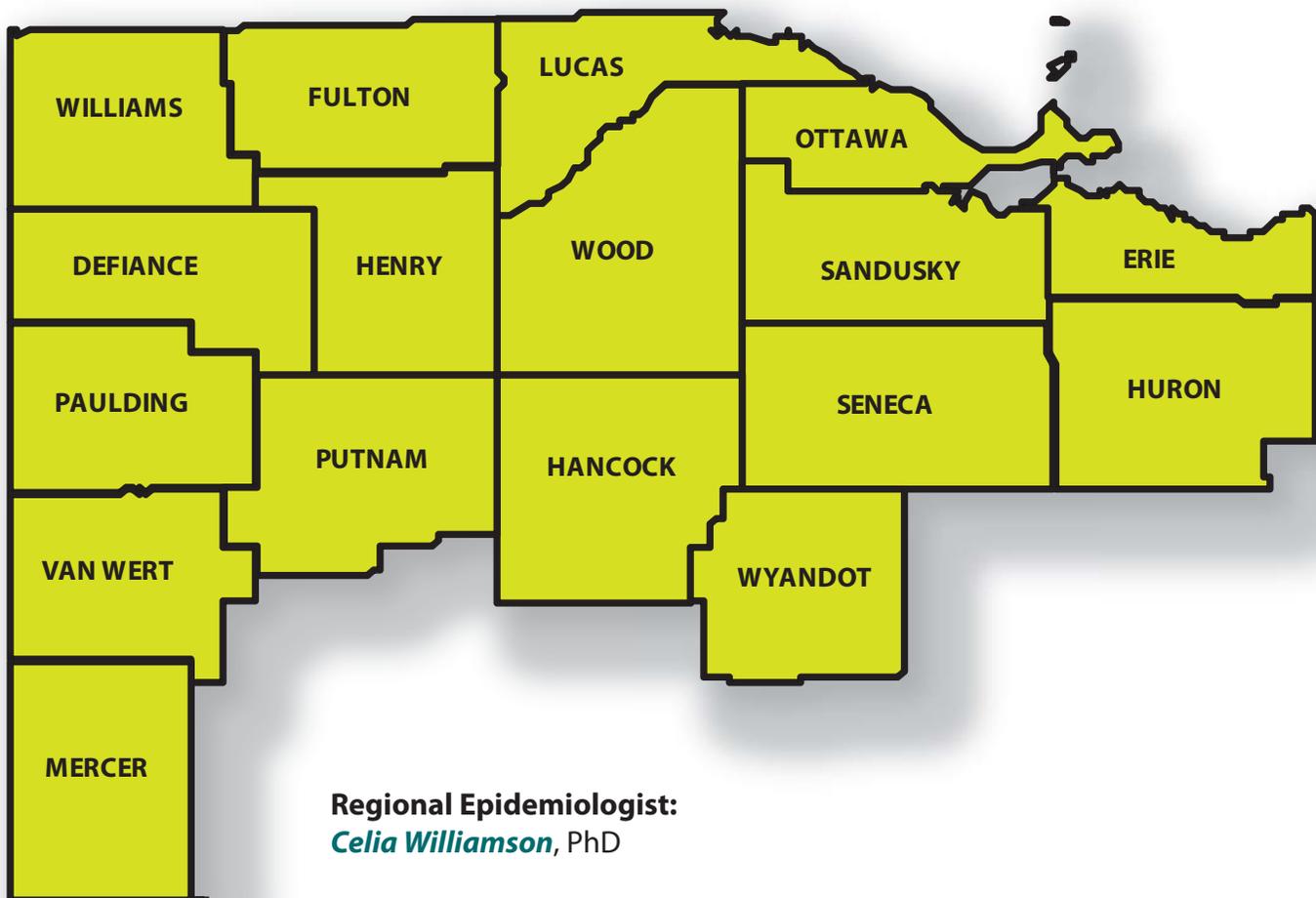


# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Toledo Region

January-June 2011

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**Orman Hall**, Director



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October 3, 2011

Dear Reader,

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

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

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

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

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

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

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

Sincerely,

**Orman Hall, Director**

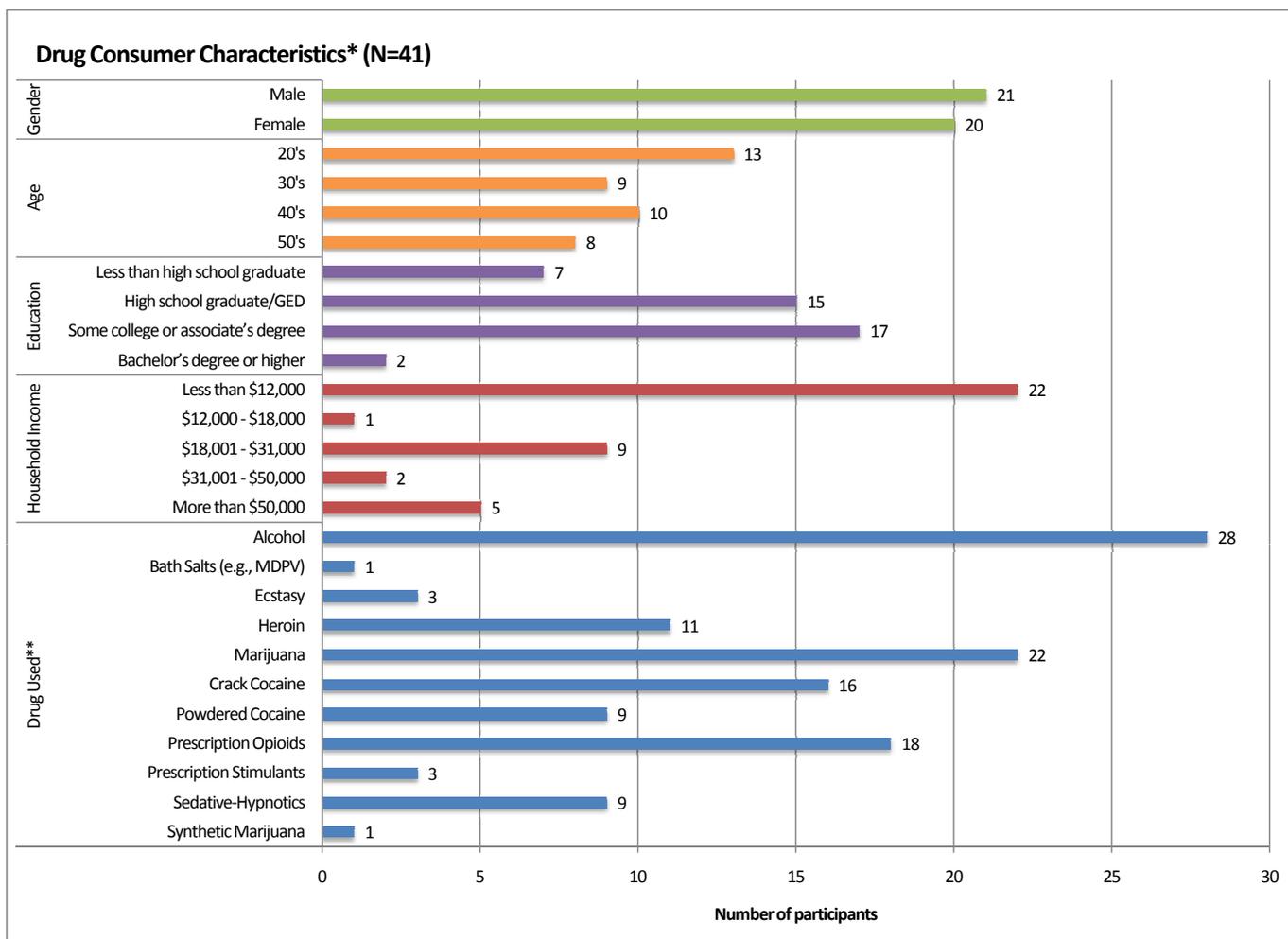
### Regional Profile

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

Ohio and Toledo statistics are derived from the U.S. Census Bureau<sup>1</sup>.

Respondents reported income by selecting a category that best represented their household's approximate income for 2009<sup>2</sup>.

Poverty status was unable to be determined for two respondents due to missing or insufficient income data<sup>3</sup>.



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

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

### Data Sources

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

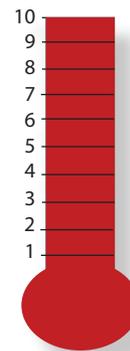
### Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was moderately available in the region. Participants most often reported the drug's availability as '7' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Reportedly, the availability of powdered cocaine mostly had to do with one's connections with cocaine dealers. The most common participant quality score for powdered cocaine was '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Generally, participants reported that the quality of powdered cocaine was not good because dealers either cut (adulterated) it too much or were more interested in using powdered cocaine to create and sell crack cocaine. BCI Bowling Green crime lab reported that powdered cocaine was cut with several substances including caffeine, diltiazem (medication used to treat heart conditions/high blood pressure), levamisole (livestock dewormer) and procaine (local anesthetic). Participants reported that a gram of powdered cocaine sold for \$50–\$75. The most common route of administration for this form of cocaine was intranasal inhalation (snorting). Participants described typical users of powdered cocaine as those with enough financial means to afford the drug.

### Current Trends

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

to get) to '10' (highly available, extremely easy to get); the previous most common score was '7'. A participant noted, *"It takes a minute [to locate powdered cocaine for purchase]. You might have to give them [dealers] a day's notice or something."* Treatment providers most often reported the drug's current availability as '8'. A treatment provider reported, *"It's [powdered cocaine] available, and it seems like over time the trend is getting younger [in terms of age of users]. Previously we'd hear about older powdered cocaine users."* High school and college educators also reported high availability of powdered cocaine, although one educator reported, *"My high schoolers can't really afford it [powdered cocaine]."* Media from the region reported on recent arrests related to powdered cocaine during which law enforcement seized six pounds of cocaine along with \$381,000 in cash and 12 firearms in Seneca County ([www.toledoblade.com](http://www.toledoblade.com), April 11, 2011) and 71 grams of cocaine along with 83 grams of heroin valued at \$40,300 during a traffic stop in Lucas County ([www.vindy.com](http://www.vindy.com), April 18, 2011). All participants and professionals reported that the availability of powdered cocaine has remained the same over the past six months. BCI Bowling Green crime lab reported that the number of powdered cocaine cases it processes has also remained stable over the past six months.



Most participants rated the quality of powdered cocaine as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '4'. Participants reported that the quality of powdered cocaine has remained the same over the past six months. Participants reported that if a buyer can afford to buy larger quantities of powdered cocaine, they would receive a higher quality of the drug. As one participant said, *"The more [powdered cocaine] you buy, the better it gets."* Another participant commented, *"If you get powdered cocaine over 60 percent pure, you're doing good."* Participants reported that powdered cocaine in Toledo is cut (adulterated) with baby powder, Lactaid®, flour, lactose, acetone, and more recently crystal methamphetamine. This is the first report in Toledo of anyone mixing powdered cocaine with crystal methamphetamine. One user who purchased powdered cocaine to use intravenously commented, *"I looked at the bottom of the spoon and saw crystals. I'm from California and I know what crystal meth [methamphetamine] looks like."* BCI Bowling Green crime lab continued to cite the following substances as commonly used to cut powdered cocaine: diltiazem (medication used to treat heart conditions/high blood pressure) and levamisole (livestock dewormer).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "powder" and "soft." Participants listed the following as other common

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

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

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

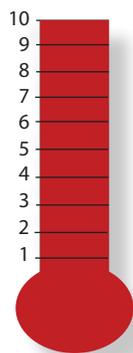
right mixture, ‘cause you always want to buy more coke or more heroin and that’s why it’s dangerous ...” In combining drugs, another participant reported, “I wouldn’t do any coke [cocaine] or speeders [stimulants] like that unless I had something to come down off.” The coroner’s office reported that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

### Crack Cocaine Historical Summary

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

### Current Trends

Crack cocaine remains highly available in the region. Participants most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10.’ Several participants commented, “You can get it [crack cocaine] anywhere,” with a participant adding, “You don’t have to ask people [for crack



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

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

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

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

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

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

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

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

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

## Heroin

### Historical Summary

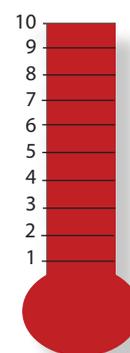
In the previous reporting period, heroin was highly available in the region. Participants most often reported the drug’s availability as ‘8’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants named white powdered heroin, which participants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

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

### Current Trends

Heroin remains highly available in the region. Participants most often reported overall heroin availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was ‘8’. Participants stated, *“It’s [heroin] dirt cheap, so you can find it anywhere; Even if you don’t know where to get it [heroin], you can find somebody who knows somebody.”* While many types of heroin are currently available in the region, participants reported the availability of brown and *“china white”* powdered heroin as most available. A treatment provider commented, *“All I hear them [clients] talk about is the brown or china white [heroin].”* Treatment providers reported the overall availability of heroin as ‘8’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get).

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



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

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

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

it caramelizes, and it looks black like the purer black tar heroin." BCI Bowling Green crime lab continued to cite the following substances as commonly used to cut heroin: caffeine, diphenhydramine (medication used to treat allergies) and quinine (medication used to treat malaria).

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

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

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

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

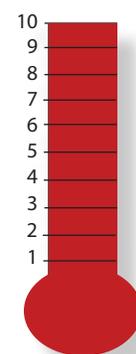
Reportedly, heroin is used in combination with crack cocaine, marijuana, powdered cocaine and sedative-hypnotics. For the most part, participants reported that heroin is generally used with *"more heroin."* As a participant put it, *"I didn't like to do any other drugs 'cause it messed up that drug [heroin]."*

### Prescription Opioids Historical Summary

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

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

### Current Trends



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

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

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

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

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

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

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

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

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

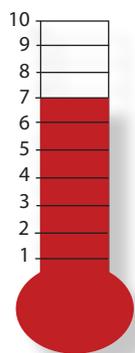
The coroner’s office reported that the biggest trend they see is prescription opioid related deaths. They reported that oxycodone is most prevalent in drug related deaths. However, it is highly uncommon to find any drug related death that involved the abuse of one drug alone. It is much more common to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

## Suboxone®

### Historical Summary

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

### Current Trends



Suboxone® remains moderately available in the region. Participants most often reported the street availability of Suboxone® as '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '4'. A participant commented, "It's [Suboxone®] sold on the street. My buddy buys them because he can't get into a clinic." Another participant also reported, "Nowadays clinics are pretty full." Treatment providers most often reported the drug's current availability as '8'. A treatment provider reported, "[Some users] don't want

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

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

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

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

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

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

## Sedative-Hypnotics

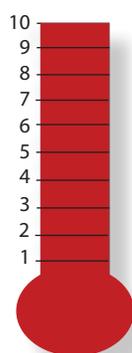
### Historical Summary

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

### Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) are highly available in the region. Both participants and treatment providers most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '4' to '5'. A participant reported that these drugs are extremely easy to get, exclaiming, "[It's] like going to McDonald's or going to the corner liquor store." Participants, treatment providers and educators identified Xanax® as the most popular sedative-hypnotic in terms of widespread use. A participant reported, "Xani's [Xanax®] get sold a lot." Reportedly, sedative-hypnotics are, "just so easy to get from a doctor, you can just get them yourself. And then if you get insurance, you don't even have to pay for them." Educators reported youth sometimes engage in mixing Xanax® with Flexeril® and call it "xanflex," or they would, "just take a bunch of Flexeril® or another muscle relaxer." A college educator talked about a student who used Xanax® and dropped out the school: "He [former student] was in class, I think two semesters, and was very open about using [Xanax®] and said he was using for fun." Treatment providers from one agency reported, "It [Xanax®] is more available ... There's not a whole lot of requirements that the doctors ask for to put you on Xanax® other than [a person saying], 'I have anxiety.'" Both participants and treatment providers reported that the availability of sedative-hypnotics has remained stable over the past six months. However, participants, treatment providers and educators mentioned that the recent arrest of an area physician for inappropriate distribution of prescription drugs had created a short-term decrease in the availability of prescription drugs, including sedatives-hypnotics. Educators reported that the availability of sedative-hypnotics has increased among their population, even reporting that youth and young adults are not necessarily hiding it: "They talk about it, put information on their Facebook about it, and say things like, 'I really need a xani [Xanax®] right now.'" Educators reported that they have also seen an increase in the number of teens and young adults who are selling. BCI Bowling Green crime lab reported that the number of sedative-hypnotic cases it processes has remained stable over the past six months.

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



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

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

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

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

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

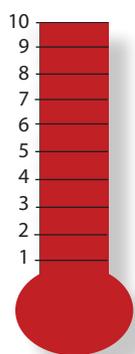
cocaine, marijuana and powdered cocaine. A participant reported, "The most common is alcohol because it intensifies the effects [of the sedative-hypnotics]." This same participant also reported, "You want to smoke marijuana because it's such a similar high."

## Marijuana

### Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants reported that the availability of marijuana had increased over the previous six months, attributing the increase mostly to the availability of medical marijuana in Michigan. Participants reported that the quality of marijuana varied, with the most common quality score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that for commercial-grade marijuana, an ounce ranged in price from \$75–\$80; for high-grade marijuana, an ounce ranged in price from \$275–\$575. The most common route of administration for marijuana was smoking. The prevailing thought was that marijuana was widely used and had become acceptable. Many participants thought typical users of marijuana could be anybody from any demographic of society. The youngest reported age of first use of marijuana was 12 years old.

### Current Trends



Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. A participant reported that marijuana was, "the highest [most available] out of any drug." Treatment Providers also reported the drug's current availability as '10'. A treatment provider summed up the sentiment of others in saying, "It seems like it's mostly all the good stuff [marijuana] or at least the good stuff has gotten around."

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

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

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

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

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

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

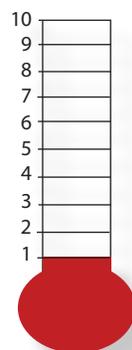
A profile for a typical marijuana user did not emerge from the data. Participants, educators and treatment providers continued to report that many different types of individuals smoke marijuana. A participant described, *"There's no real age range that's more common 'cause I know people all over. I started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

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

### **Methamphetamine** **Historical Summary**

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

### **Current Trends**



Methamphetamine reportedly continues to be relatively rare in Toledo, but was said to be highly available in rural areas surrounding Toledo, such as in Defiance, Fulton and Williams Counties. Participants most often reported the availability of methamphetamine in Toledo as '1' and in areas surrounding Toledo as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that methamphetamine is available in crystal form, which they described as looking like shards of glass. A participant who used methamphetamine on the south side of Toledo reported, *"I know a guy [there] that cooks it [methamphetamine] and sells it."* When asked how available it was for him, he reported, *"I can get it [methamphetamine] 24 hours a day, seven days a week. If you went on the street and asked [about purchasing methamphetamine] you'd come up short."* Treatment providers most often reported the drug's current availability as '1' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A regional newspaper, *The Advertiser-Tribune*, reported on methamphetamine lab arrests over this current reporting period in Seneca County. A detective with one of the drug task forces in the region said three methamphetamine labs had been dismantled so far this year. This detective stated, *"The use and manufacture of methamphetamine has increased in Seneca County"* ([www.advertiser-tribune.com](http://www.advertiser-tribune.com), April 7, 2011). Participants reported that the availability of methamphetamine has increased over the past six months. Treatment providers reported that the availability of methamphetamine has remained a rarity over the past six months. A provider reported, *"The [methamphetamine abusing] clients I've had, migrated to Toledo from other areas."*

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

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

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

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

### Ecstasy Historical Summary

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

### Current Trends

Ecstasy [methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] is highly available in the region, but the desire for the drug reportedly is waning. Participants reported the drug’s current availability as ‘9’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was ‘6’. A participant reported, “Oh yes, Ecstasy is everywhere.” Treatment providers most often reported the drug’s current availability as ‘5’ while educators reported current availability most often as ‘8’. In May, *The Advertiser-*

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

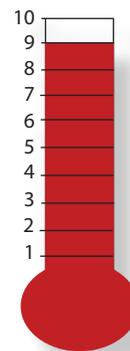
The consensus among educators was that Ecstasy is no longer popular. They believed it was popular for youth to use to enhance sex, and that youth are now having sex without needing the drug to enhance the mood or choosing to use alcohol instead of Ecstasy. Treatment providers and educators reported that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

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

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

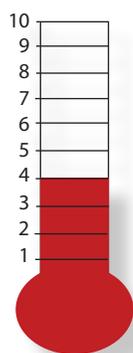
### Prescription Stimulants Historical Summary

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



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

### Current Trends



While participants did not report seeing prescription stimulants such as Concerta® or Ritalin® for sale of the streets of Toledo, they did report that Adderall® was moderately available among adults and highly available to teens and college students in the region. Participants rated the availability of Adderall® as '4' for adults and '8' for those under 18 years of age on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '6' for adults and '8' for those under 18 years of age. A participant reported, "I see a lot of teenagers that use it [Adderall®]." Participants reported that youth used the drug to accomplish tasks that required focus such as studying or cleaning. A participant called it the, "homework drug, because you want to read." Educators commented that they "absolutely" see prescription stimulant use among their high school age population and reported the use of Adderall® and Ritalin® as most popular in terms of widespread use. Educators reported the availability of prescription stimulants within their population as '10'. An educator reported, "I don't know that my kids are taking them [prescription stimulants], but they have them available if they want to." A high school educator reported that some parents that had access to prescription stimulants would sell them to make money. An educator reported, "Just because they're [parents] older, doesn't mean they're wiser." Treatment providers most often reported the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), commenting that both youth and adults commonly get the drugs from youth who are prescribed them. A treatment provider commented, "Some youth are smoking marijuana to self-medicate when they need their meds." Both participants and treatment providers reported that the availability of prescription stimulants has remained stable over the past six months. Educators were not sure if availability had gone up or remained stable, but recognized that availability is high among their population.

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

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

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

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

### Other Drugs Historical Summary

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

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

### Current Trends

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

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

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

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

### Conclusion

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

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