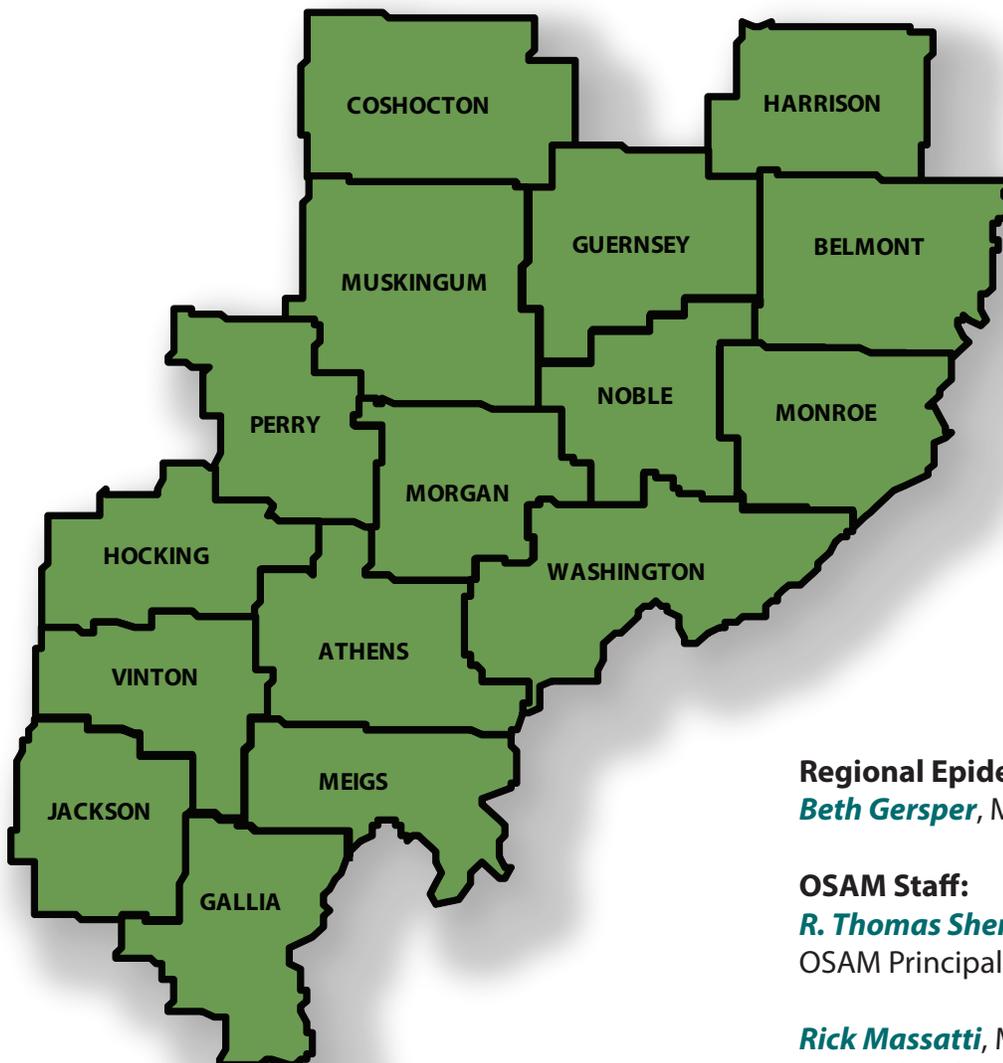


Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Athens Region

January-June 2012

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Athens Regional Profile

Indicator ¹	Ohio	Athens Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	587,004	40
Gender (Female), 2010	51.2%	50.4%	47.5%
Whites, 2010	81.1%	94.7%	100% ²
African Americans, 2010	12.0%	2.1%	0.0%
Hispanic or Latino Origin, 2010	3.1%	0.8%	0.0%
High school graduates, 2009-2010	84.3%	92.9%	73.7% ³
Median household income, 2010	\$45,151	\$37,381	Less than \$11,000 ⁴
Persons below poverty, 2010	15.8%	18.2%	72.2% ⁵

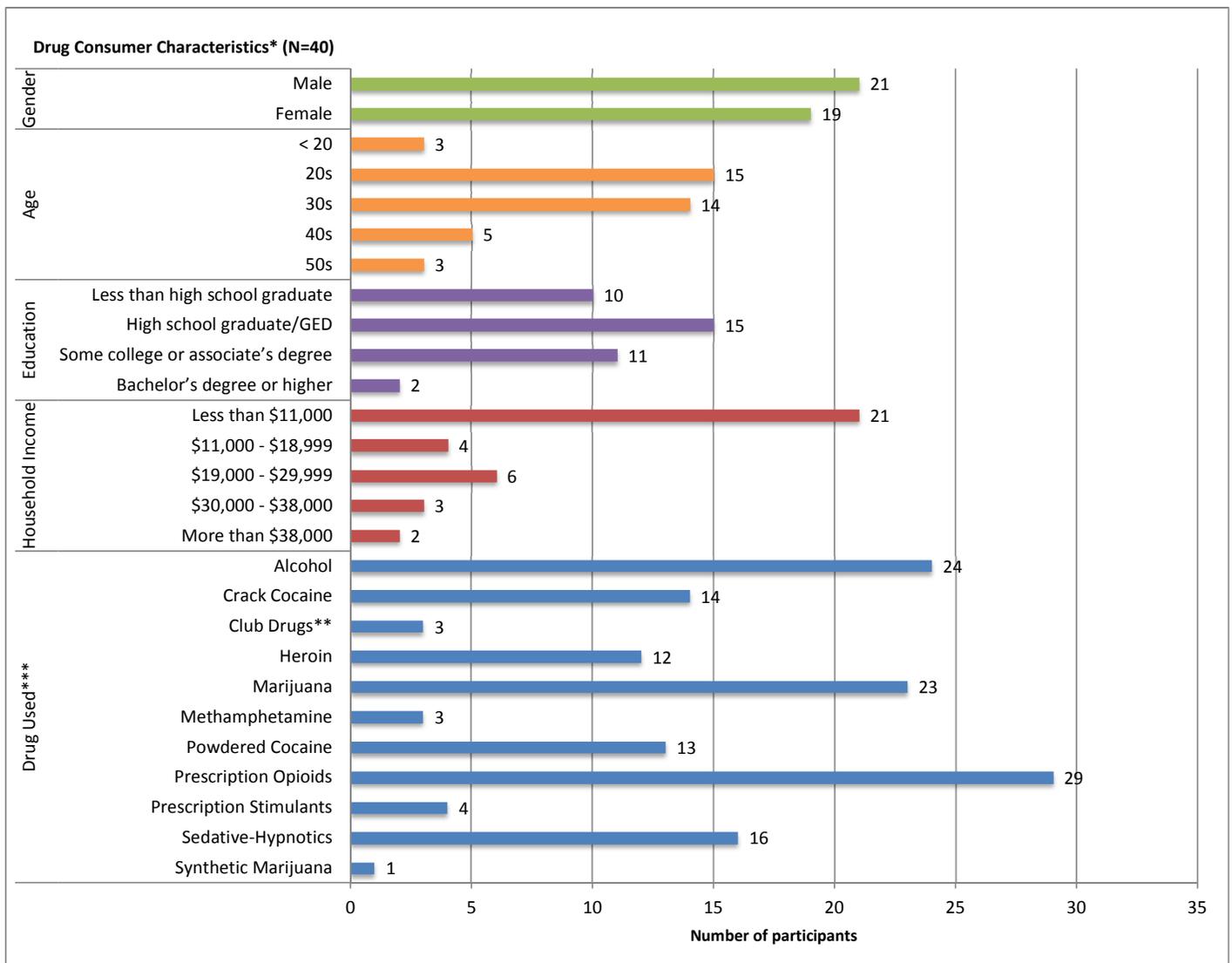
Ohio and Athens statistics are derived from the U.S. Census Bureau.¹

Race was unable to be determined for two respondents due to missing data.²

Graduation status was unable to be determined for two respondents due to missing data.³

Respondents reported income by selecting a category that best represented their household's approximate income for 2012. Income status was unable to be determined for four respondents due to missing data.⁴

Poverty status was unable to be determined for four respondents due to missing or insufficient data.⁵



*Not all participants filled out forms; therefore, numbers may not add to 40.

**Club drugs refer to Ecstasy and psilocybin mushrooms.

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

Data Sources

This regional report was based upon qualitative data collected via individual and focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Athens, Belmont, Hocking and Muskingum counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Scioto County Coroner's Office and the Bureau of Criminal Investigation (BCI) London Office, which serves Central and Southern Ohio. All secondary data are summary data of cases processed from July through December 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, all secondary data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2012.

Powdered Cocaine Historical Summary

In the previous reporting period, the availability of powdered cocaine remained variable in the region, with participants and community professionals reporting differing availability scores by county. Participants in Guernsey and Muskingum counties reported availability of powdered cocaine as moderate, with a mean availability score of '7'; whereas, participants in Athens and Jackson counties most often reported availability as '4' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals reported that the availability of powdered cocaine had remained the same during the previous six months. The BCI London Crime Lab reported that the number of powdered cocaine cases it processed had decreased during the previous six months. Most participants rated the quality of powdered cocaine as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the cutting agent in virtually every sample of powdered cocaine it processed. The most commonly cited street names for powdered cocaine were "coke," "powder" and "snow." Participants reported that a gram of the drug sold for between \$80-100, depending on quality. Participants reported that the most common route of administration for powdered cocaine remained snorting. Although a general profile for a typical powdered cocaine user did not emerge from the data, several participants mentioned that people with occupations that required them

to work long shifts might use powdered cocaine to help them stay awake. Community professionals described the typical user of powdered cocaine as primarily White.

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). A participant reported, *"I know a lot of people who are actually dealing powder [powdered cocaine]."* Another participant commented on the ease of obtaining powdered cocaine without even knowing a dealer directly: *"If you say you'll smoke your stuff [powdered cocaine] with somebody, they will get it for you in less than five minutes."* Most community professionals described current availability of powdered cocaine as low. The Hocking County Family Drug Court reported no cases involving powdered cocaine during the past six months. Community professionals generally reported opiates as the preferred drug over cocaine: *"Heroin has outpaced cocaine ... cocaine's taken a back seat to heroin; Just right now, the drug of choice is opiates. But we still are getting clients that are using cocaine, and I probably have heard more about powder lately than crack [cocaine]."* A few community professionals noted a current user preference for powdered cocaine over crack cocaine: *"Lately I've heard more about snorting [powdered cocaine] than crack [use] ... I still think there's prejudice in some circles that, 'I use cocaine and there's nothing wrong with that, but I would never touch crack because that makes you a horrible person' ... It's just the stigma in some circles with crack; They'll buy it [cocaine] in powder form, and when they need to cook it up, they'll cook it up [into crack cocaine]."* Collaborating data also indicated that cocaine is readily available in the region. The Scioto County Coroner's Office reported that 26.4 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range at time of death); in the last reporting period, 28.6 percent of all deaths were drug related. Furthermore, the Coroner reported cocaine as present in 21.4 percent of all drug-related deaths (Note: coroner's data is aggregate data of powdered cocaine and crack cocaine and does not differentiate between these two forms of cocaine).

Participants reported that the availability of powdered cocaine has increased during the past six months throughout the region. A participant commented, *"I think it [availability of powdered cocaine] increased because just more people have been wanting it. People have been using it, and the dealers are getting more of it."* Other participants speculated: *"Cocaine's on the rise again since the painkillers are down [decreased availability of prescription opioids]; I think there's an increase on the powder, but a lot of people take it and cook it and turn it*

into crack." In contrast, community professionals reported a decrease in availability of powdered cocaine during the past six months. A treatment provider reported, "I'm not seeing a lot of that [powdered cocaine use] anymore ... not in the last six months. I just don't hear [about powdered cocaine use]. Not that people aren't using it, but they're so focused on the opiates. It's like, 'Well, I've used cocaine, but my problem's opiates.'" A law enforcement officer reported, "I would say that cocaine is a little bit harder to get than it was. We have done a lot of arrests, a lot of raids for cocaine, and we get intelligence back to us that we have hit the cocaine distribution hard. By no means have we dampened it as far as it coming out, but we have done a lot of arrests, a lot of convictions with cocaine." The BCI London Crime Lab reported that the number of powdered cocaine cases it processed has decreased over the past six months.

Most participants rated the quality of powdered cocaine as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8'. However, participants continued to report on the variability of the quality of powdered cocaine. A participant reported, "[Quality of powdered cocaine] it ranges a lot ... it's crazy ... it's like a roller coaster. You can get good shit, you can get bad shit." Several participants added that quality depends on the dealer: "The powder [powdered cocaine quality] is just like heroin. It depends on the person [dealer] and how many hands it's been through before it gets to you; Seems you never know what you're gonna get ... I guess it's all with the dealer. If he's losing money, or if he's doing it [using the powder cocaine himself], he'll cut [adulterate] it up more ... it's kind of like a crapshoot." Participants reported that powdered cocaine in the region is cut with aspirin, baby laxative, baby powder, baking powder, baking soda, coffee creamer, Enfamil®, ether, isotol (diuretic), laundry soap, prescription opioids (Percocet® and Vicodin®), salt and vitamin B12. The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the cutting agent in virtually every sample of powdered cocaine it processed, while also citing the following substances as occasionally used to cut powdered cocaine: caffeine, inositol (B vitamin), local anesthetics (benzocaine, lidocaine and procaine), mannitol (diuretic), sorbitol (sweetener) and sucrose (table sugar).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "coke," "girl," "powder" and "snow." Participants listed the following as other common street names: "blow," "fish scale," "girlfriend," "johnny white," "melt," "nose candy," "pow pow," "white girl," "ya-yo" and "yea." Several participants reported common phrases for talking about powdered cocaine use, including "going skiing" and "Is it snowing?" Current street prices for powdered cocaine were variable among participants with experience buying powdered cocaine. Participants reported the smallest

amount of 1/10 gram (aka "a point") sells for \$10; 1/2 gram continues to sell for \$50; a gram of powdered cocaine sells for between \$80-100; 1/8 ounce, or "eight ball," sells for between \$180-320; 1/4 ounce sells for \$250; an ounce sells for between \$1,200-1,500. Participants reported that the most common way to use powdered cocaine remains snorting, with the second most common way being intravenous injection. A participant stated, "You can shoot it [inject powdered cocaine] ... you can melt it down with vinegar." In addition, several participants mentioned smoking powdered cocaine, with one stating, "You can also smoke that [powdered cocaine] on tin foil, just like inhaling the fumes." Reportedly, some users and dealers "take it [powdered cocaine] and cook it and turn it into crack," while others "put it [powdered cocaine] in a cigarette and smoke it." In addition, a participant reported, "I put it [powdered cocaine] on my teeth all the time. It numbs your gums, your mouth."

Although a general profile for a typical powdered cocaine user did not emerge from the data, several participants continued to note that people with occupations that require them to work long hours, such as truck drivers, will use powdered cocaine to help stay awake. Other user characteristics noted by participants included: Whites, older people and people who have money. Several participants agreed with one participant who said, "Coke's a rich man's drug." Treatment providers described the typical user of powdered cocaine as primarily professionals. A treatment provider commented, "Usually [powdered cocaine users are] people that are working because they want to pay for that [powdered cocaine] ... more professionals. It's those people who intellectualize things, [it] seems to me, that they are the people [who] are using it ... it just seems the majority of the people [using powdered cocaine] are very narcissistic. Like, 'I can do no wrong' and 'I know everything.'"

Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids, sedative-hypnotics and tobacco. Participants most often reported that marijuana is commonly used with powdered cocaine. One participant stated: "If you're somewhere and there's speed [cocaine, amphetamines, methamphetamine] there, there's almost definitely weed [marijuana] there. But, if there's weed there, that doesn't mean that there's necessarily speed there too. Weed is not an indicator that speed will be there, but speed is definitely an indicator of weed." Participants often reported smoking powdered cocaine by placing it on cigarettes and by mixing it with marijuana or crushed prescription opioids. A participant explained that powdered cocaine users typically use "downers [benzodiazepines] to come down off coke 'cause the crash from cocaine is extremely harsh." Another participant reported, "I would always have Xanax® to come down off of

it [powdered cocaine] or to even it out if I got too speeded ... I'd get paranoid and I'd take two Xanax® with it and drink alcohol." Likewise, heroin is also used to come down from the stimulant effects of powdered cocaine.

Crack Cocaine

Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). However, participants in Gallia, Guernsey and Muskingum counties reported higher availability of crack cocaine than did participants in Athens, Hocking and Jackson counties. Community professionals most often reported availability as '8'. Participants and community professionals most often reported that the availability of crack cocaine had remained the same during the previous six months. The BCI London Crime Lab reported that the number of crack cocaine cases it processed had decreased during the previous six months. Most participants rated the quality of crack cocaine as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the primary cutting agent for crack cocaine. The most commonly cited street names for crack cocaine remained "crack," "hard" and "rock." Participants reported 1/10 gram (aka "rock") of crack cocaine sold for \$10; a gram sold for between \$50-100. While there were a few reported ways of using crack cocaine, generally, the most common routes of administration were smoking and intravenous injection. A profile of a typical crack cocaine user did not emerge from the data.

Current Trends



Crack cocaine remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. A participant reported, "You know, crack [cocaine] you can find no matter who you are ... anywhere ... crack is everywhere in this town." There was no consensus among community professionals as to the current availability of crack cocaine. A law enforcement officer described what he saw

in Muskingum County: "I just think the crowd that is using it [cocaine] is going to prefer the soft [powdered cocaine] to the hard [crack cocaine]. [In] drug investigations ... [users] have powder cocaine, and they'll cook it up right there

while our person's waiting. So, a lot of these people [cocaine users] actually have both [forms] of it [cocaine]." The Vinton County Coroner representative said, "There's a mixture of both [powdered cocaine and crack cocaine]. I can't say which one's more prevalent than the other." Media from the region reported on an arrest related to crack cocaine during this reporting period. In June, a Columbus man was arrested at a hotel in Gallia County for possession of 25 grams of crack cocaine. He was charged with trafficking in crack cocaine after police found 48 individually wrapped rocks of crack cocaine in the air conditioning unit of his hotel room (www.mydaily sentinel.com, June 18, 2012).

Most participants reported that the availability of crack cocaine has slightly decreased during the past six months. Participants agreed when one participant mentioned that people are moving away from crack cocaine: "I think everybody's getting sick of geekin' [looking for crack cocaine]." Participants agreed that heroin has become more popular than crack cocaine. A participant stated, "There was a lot of dealers coming down from Columbus that had powdered [cocaine] or hard [crack cocaine], and it seems like, even they've stopped bringing that ... they bring more heroin than anything now; You can go get opiates easier and cheaper than you can buy cocaine." Overall, community professionals perceived a decrease in crack cocaine availability throughout the region. However, a treatment provider reported, "We still are getting clients that are using [crack] cocaine, and I probably have heard more about the powder [cocaine] lately than the crack [cocaine]." The majority of community professionals attributed the perceived decrease in crack cocaine to an increase in user preference for opiates. The BCI London Crime Lab reported that the number of crack cocaine cases it processed has stayed the same during the past six months.

Most participants rated the quality of crack cocaine as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '7'. Most participants reported that the quality of crack cocaine has remained the same during the past six months. Participants reported that crack cocaine in the region is often cut with aspirin, baby powder, baking soda, body soap, heroin, Orajel® and wax. There were continued reports of "dummy dope" (substances falsely sold as crack cocaine, yet containing little or no crack cocaine). A participant stated, "You better watch you ain't buying Dial® soap." The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as commonly used to cut crack cocaine.

Current street jargon includes many names for crack cocaine. The most commonly cited names remain "crack," "hard" and "rock." Participants listed the following as other common street names: "boy," "dope," "drop," "hard tack candy," "melt,"

"scale," "work," "yak" and "ya-yo." Current street prices for crack cocaine were somewhat consistent among participants with experience buying crack cocaine. Most participants reported that the lowest amount they would purchase crack cocaine for was \$10. Reportedly, crack cocaine sells for \$10 per 1/10 gram; 1/2 gram sells \$50; a gram sells for between \$80-100. Several participants commented on crack cocaine being a less expensive drug than other drugs: *"[Crack cocaine] it's a little cheaper [than powdered cocaine]; Crack's cheap ... crack's very cheap; You can do crack by the fives [in \$5 increments] ... from \$5 clear to whatever you want really. It's just number of rocks."* More participants related price to number of rocks or number of hits instead of to the weight of the drug: *"You can get three [crack cocaine rocks] for \$50, two [crack cocaine rocks] for \$30."* While there were a few reported ways of using crack cocaine, the most common routes of administration remain smoking and intravenous injection.

A profile of a typical crack cocaine user did not emerge from the data. However, a participant noted a socio-economic difference with which other participants agreed: *"Usually you don't see a rich person as a ... crack head."* Participants reported knowledge of users as young as 18 years old. A participant stated, *"I know an 18-year-old girl does it [crack cocaine]."* Participant described typical crack cocaine users to include motorcycle bikers, truckers and third-shift workers. Community professionals did not offer any typical user profile for crack cocaine. A treatment provider reiterated that cocaine in general has gone to the wayside because *"you can go get opiates easier and cheaper than you can go buy cocaine."*

Reportedly crack cocaine is used in combination with alcohol, Ecstasy, heroin, marijuana, prescription opioids and sedative-hypnotics. Participants cited marijuana and sedative-hypnotics (benzodiazepines) are used with crack cocaine *"to come down off it [crack cocaine] 'cuz the crash from cocaine is extremely harsh,"* as one participant said. Participants also said that using crack cocaine and heroin together (aka "speedballing") is common. A participant said heroin is also used with crack cocaine when users *"start geekin,"* which was explained as, *"You're out [of crack cocaine] and you need some more right now. You gotta have it and you will give your first-born child for some probably ... [heroin makes it] easier to cope with [that feeling of 'geeking']."*

Heroin

Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); community professionals most often reported availability as

'8.' While many types of heroin were available in the region, participants continued to report the availability of black tar heroin as most available. Participants and community professionals reported that availability had increased during the previous six months, while the BCI London Crime Lab reported that the number of heroin cases it processed had remained the same. Participants most often rated the quality of black tar heroin as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality), while they most often rated the quality of brown powdered heroin most often as '4.' Overall, participants most often reported that the quality of heroin had remained the same during the previous six months. Participants reported that black tar heroin in the region was cut with bath salts, coffee, fentanyl, hot cocoa and Tootsie Rolls®. According to a representative from the BCI London Crime Lab, heroin was *"typically pretty pure."* However, when heroin was cut, the lab reported the following substances as cutting agents: caffeine, diphenhydramine (antihistamine) and local anesthetics (lidocaine and procaine). The most commonly cited street names for heroin remained "boy" and "H." Participants reported that black tar heroin was available in different quantities: a balloon (1/10 gram) sold for between \$20-50; a gram sold for \$100. Participants reported that brown powdered heroin was available in paper and foil packs and sold for between \$20-30. Participants reported that the most common route of administration for heroin remained intravenous injection. There was no participant consensus regarding a profile of a typical heroin user; however, community professionals described typical heroin users as young, approximately 18-30 years of age.

Current Trends



Heroin remains highly available in the region. Participants most often reported overall heroin availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' Participants commented on the ease of locating heroin throughout the region: *"I know a lot of people have got it [heroin]. It don't seem like it takes 'em long to get it; I could probably just walk across my yard and get it [heroin]; You can find that [heroin] in Athens, Nelsonville, the Plains, Hocking County, Fairfield County, Franklin County, Perry [County] ... [heroin] it's everywhere."* Reportedly, several types of heroin are available. Participants described: *"Soft [powdered heroin] is in the baggies ... stamp bags ... it comes in every color ... it was purple, bluish, dark brown or light brown little packs. It got different stamps on it. It's like the stamps for envelopes ... and the raw [pure heroin], the*

tar [black tar heroin] is melted black looking." Participants reported both brown powdered and black tar heroin as the most available heroin types in the region, rating each type most often as '10' on the availability scale, while most often rating white powdered heroin as '4.' Participants reported white powdered heroin as difficult to find: *"[White powdered heroin] it's kind of hard to find. You gotta have your personal dealer for 'china white,' you really do; You have to really know somebody to get the [white] powdered stuff."* Several participants compared the availability of heroin to the availability of marijuana, with one participant stating: *"It's cheaper to get heroin than marijuana ... because no one wants to sell marijuana because they're not making as much money."*

Community professionals most often rated the overall current availability of heroin as '8'; the previous most common score was also '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers also recognized the ease of obtaining heroin on the street. A treatment provider reported, *"[Heroin] it's very available and very cost effective, meaning it's cheap."* A staff member from a regional coroner's office reported, *"They [users] can get it [heroin] in the county [Vinton County] as well as in Athens, Hocking, Jackson and Pickaway counties."* Collaborating data also indicated that heroin is readily available in the region. The Scioto County Coroner's Office reported heroin as present in 14.3 percent of all drug-related deaths during the past six months. In addition, media outlets in the region reported on significant heroin seizures and arrests during this reporting period. In February, the Athens County Sheriff's Narcotics Enforcement Team arrested a Nelsonville woman for possession of heroin and tampering with evidence when they found 14 grams of heroin concealed in a body cavity (www.newsandsentinel.com, Feb. 14, 2012). In March, the Major Crimes Task Force netted Washington County's largest-ever seizure of heroin when it confiscated 38.5 grams of heroin during a bust in Marietta (www.mariettatime.com, March 3, 2012).

Overall, participants reported that availability of heroin in the region has increased during the past six months. A participant stated, *"My [drug of] choice was marijuana, and I found my friends saying it was easier to get heroin than it is to get marijuana."* Participants reported that the availability of black tar heroin has increased during the past six months. A participant commented that black tar heroin is *"getting easier and easier [to find]."* Another participant explained the increase, *"From personal experience, there was a lot of dealers coming down from Columbus that had powdered [cocaine] or hard [crack cocaine], and it seems like even they've stopped bringing that and they bring more heroin than anything now."* All but one of the participants reported no change in

availability for brown powdered or white powdered heroin. Community professionals reported that the availability of heroin has increased during the past six months. Treatment providers reported that treatment facilities are noticing an increase in the amount of clients seeking treatment for heroin use: *"We've heard a lot more about the use of heroin, particularly in the past six months or so with the pill mills supposedly being shut down. We've had a lot more people call in saying they're trying to find treatment for heroin use; I've been a counselor for 20 some years now and I've been hearing more and more about heroin recently."* Concern about the increase in heroin use was also expressed by professionals in children's services, with one stating: *"Even though the numbers don't always reflect that we're higher, we're getting very intense abuse cases ... and they're almost always linked to some kind of drug use in the home ... and sometimes you find more of the traces of drugs [heroin and cocaine] in the kid's system ... even very young kids."* Health department staff speculated that the heroin increase is *"because the prescription drugs [opioids] aren't as easy [to obtain] and the move is to heroin to replace it,"* as one staff member said. The BCI London Crime Lab reported that the number of brown powdered and black tar heroin cases it processed has increased during the past six months, while noting that the type of powdered heroin most processed is usually beige, brown or tan in color.

Participants most often rated the current quality of black tar heroin as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5.' They rated the quality of brown powdered heroin most often as '7' and white powdered heroin as '8' or '9'; the previous most common score for brown powdered heroin was '4.' A participant commented, *"Black tar always [has] been the top heroin."* Another participant stated, *"I have experience with heroin, and I tell you what ... if you're getting black tar, you're getting good shit."* Another participant added, *"If you get it [black tar heroin] off Mexicans, it seems to be stronger."* Reportedly, the quality of brown powdered heroin varies more than that of black tar heroin. A participant reported, *"I guess when you do pills [prescription opioids], you always know what you're getting exactly, so heroin quality's like ... I just compare it to, 'do two bags [of brown powdered heroin] equal a 30 [Roxicodone® 30 mg]?' you know what I mean? That's how I always looked at it ... If it [brown powdered heroin] equals that, then it was a decent quality, and if it didn't equal that, then it wasn't; [Brown powdered heroin is] not real bad, but there's times ... it's crap ..."* Participants reported that the overall quality of heroin has decreased during the past six months due to the amount of substances cut into the drug: *"... You go to the wrong person, and hell, you're gonna get a bag of*

f*****' coffee; Yeah, because there's too many people getting high on their own supply and that's when the shit comes in like Tootsie Rolls® and chocolate and the other shit that they throw in it 'cause they cut their [heroin] down and then they got to put more shit in it to make money on it." Participants reported that brown powdered heroin is cut with brown sugar and coffee. Reportedly, black tar heroin is cut with "anything that's brown or black," chocolate, crayons, hamburger grease, instant coffee, marijuana resin, road tar spray, shoe polish, tea and tootsie rolls. According to a representative from the BCI London Crime Lab, heroin remains "reasonably pure." However, when heroin is cut, the lab reported that diphenhydramine (antihistamine) is occasionally used.

Current street jargon includes many names for heroin. The most commonly cited names were "boy," "dog food," "dope" and "H." Participants listed the following as other common street names: "balloons," "balls," "brown," "chocolate," "dog shit," "goodies," "heron," "horse," "H-town," "rail," "Ron," "smack" and "stomp." Participants reported that black tar heroin pricing varies depending on location: 1/10 gram (aka "berries") in Belmont County sells for between \$10-20; a gram sells for between \$80-90; while 1/10 gram (aka "balloons") in Athens County sells for between \$25-30. Reportedly, black tar heroin is less expensive in larger cities such as Columbus. Reportedly, brown powdered heroin is sold in individual dose packs (aka "stamps," "bags," "berries") which typically sell for between \$10-30 each; a gram sells for between \$80-100. Participants reported that white powdered heroin thought to be "china white" sells for about the same price as black tar heroin. Participants reported that heroin originates from outside the region, particularly from Columbus. Participants continued to report that the most common way to use heroin remains intravenous injection.

Participants reported obtaining needles used to inject heroin from regional pharmacies, from friends or from dealers on the street. Participants were eager to share their experiences of buying needles at pharmacies: "You go to [an area retail store or drug store] and tell them that you're a diabetic and you want needles – a ten pack of cc needles. Sometimes they'll ask you for your ID, but sometimes they don't; I've seen this one girl walk in and straight up be honest with them [pharmacy staff]. Like she'd be out there sharing if they didn't give them [sell needles to her], and they just sold them to her; My stepfather was a diabetic, and I know exactly how to get his, and they didn't ask for prescription ID." On the street, participants reported that needles sell for between \$2-6. A participant reported, "You can definitely get [needles] off the street. 'Cause people will buy them in bulk and then you can sell them or someone will just give you their dirty needle, so that would be free if it's a dirty needle, but if they're gonna give you like a new,

sealed needle in the little packaging and everything, it would be cheap ... they could charge you five bucks, or they could just give it to you." Sharing needles was rarely reported, but a participant reported, "I've seen people share – boil a needle and share a needle like that." Community health department professionals expressed concern about the rise of Hepatitis C in the region. A staff member from the health department stated, "Hep C [Hepatitis C] is on the rise ... we've been getting new cases, and they're young kids ... teenagers ... 16, 17, 18ish."

There was no participant consensus regarding a profile of a typical heroin user; however, participants noted those who use heroin include those who like to use needles and are already shooting up (injecting) drugs, lower socio-economic drug users and prescription opioid users. Participants stated, "I would say the lower socio-economic group would kind of go towards heroin as opposed to pills [prescription opioids] just because of the price; The funny thing is that the only times I did heroin [was] when I couldn't find pain pills and that was how a lot of people that were in my circle were, too." Community professionals reported that typical heroin users range in age from teens to those into the early thirties. A staff member from children's services commented, "It's not uncommon for teenagers to get involved with heroin anymore." In addition, a staff member from the health department commented on restaurant workers who use heroin: "I just know that when I was treating patients, a lot of them were waiters and waitresses ... there's at least two or three different restaurants here in town [Muskingum County] where I know people are using."

Reportedly, heroin is used in combination with alcohol, crack and powdered cocaine, marijuana, prescription opioids and sedative-hypnotics. It was not uncommon for participants to go back and forth between different drugs when using heroin. Participants explained, "I like to smoke crack and then do heroin ... heroin helps bring you down from the cocaine buzz ... I guess if I got a pocket full of pills, I'll eat them too; I just jump back and forth with whatever I can get. I mean, I can do heroin and then do pain pills ... depends on the money; Usually people snort Xanax® and then shoot dope [heroin] or vice versa; Crack ... you shoot your crack, you shoot your heroin, you're 'speedballing' ... some people smoke pot [marijuana] with it ... it gets you really high," with one stating. Several participants spoke of using sedative-hypnotic drugs to come down from the heroin high: "A lot of people tend to prefer to use the benzo's [benzodiazepines] to come off the high of heroin; ... I did the xani's so I could fade."

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants and community

professionals most often reported availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals also continued to identify OxyContin®, Percocet® and Vicodin® as the three most popular prescription opioids in terms of widespread use, with participants naming Opana® as also popular. Participants and community professionals throughout the region reported that the availability of prescription opioids had generally remained the same during the previous six months. The BCI London Crime Lab reported that the number of prescription opioid cases it processed had remained the same during the previous six months. While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the most common route of administration remained snorting. Participants continued to report obtaining prescription opioids on the street from dealers, as well as from doctors, emergency rooms and people with prescriptions. A profile of a typical user did not emerge from the data.

Current Trends

Prescription opioids remain highly available in the region. Participants and community professionals most often reported the current availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. Several participants commented on how quickly supplies of prescription opioids are depleted, with one stating: *"Whenever opiates [are] around, it's gone in no time flat."* Community professionals agreed that prescription opioids are highly available throughout the region. Treatment providers reported: *"Prescription pills, the opiates, are causing us the most problems; Opiates and bath salts are at the top of the list."* Law enforcement commented, *"It [prescription opioid addiction] causes a lot of problems with theft. People steal from their family members; they'll steal from their friends when they see the prescription pills."* Collaborating data also indicated that prescription opioids are readily available in the region. The Scioto County Coroner's Office reported prescription opioids as present in 50 percent of all drug-related deaths during the past six months. In addition, media outlets from the region reported on recent arrests related to prescription opioids during this reporting period. In February 2012, a local police chief's home in Nelsonville was raided after an undercover agent purchased 20 oxycodone pills there (www.wsaz.com, Feb. 16, 2012); 273 hydrocodone and OxyContin® pills were seized during a traffic stop on U.S. 33 in The Plains (www.10tv.com, Feb. 18,

2012); Meigs County Court officials reported that a Columbus man was charged with possession of 200 oxycodone pills in Pomeroy (www.knoxnews.com, Feb. 28, 2012).

Participants and community professionals continued to identify OxyContin®, Percocet® and Vicodin® as the three most popular prescription opioids in terms of widespread use, with participants also naming fentanyl and Opana® as popular. Individual drug availability ratings reflected similar results: methadone, Norco®, Opana®, OxyContin® OP [new formulation], Percocet®, Ultram® and Vicodin® were all rated highly available as '10' on the availability scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Most scores for Dilaudid® fell in the 'moderately available' range of between '5' and '7' on the availability scale. Fentanyl, Lortab® and OxyContin® OC [old formulation] were all ranked with low availability scores. A participant described the excessive availability of Vicodin® as *"I was swimming in them [Vicodin®]. I had prescriptions. Everyone I lived with had prescriptions. I had so many of them that the only time I would ever do them is if I didn't have anything else to do and I just wanted to feel something go up my nose 'cuz they wouldn't even get me high. I was literally sick of them. I could throw them away and still have more."* While availability of OxyContin® OC is low, a participant reported, *"Rare, but yes ... [OxyContin® OC] they're still around ..."* OxyContin® OP is highly available; however, participants reported that many participants do not want them because their abuse-deterrent formula makes them difficult to crush and snort.

Although participants identified a few prescription opioids that increased in availability, participants most often reported that overall availability has remained stable during the past six months. Community professionals also reported that availability has generally remained stable, with the exception of a noted increase in availability of Opana®. A treatment provider reported, *"I had just recently a client that identified Opana® [in his use history], and I wasn't real familiar with that one."* The BCI London Crime Lab reported that the number of prescription opioid cases it processed has generally remained the same during the past six months with the following exceptions: an increase in Opana® cases and a decrease in OxyContin® cases.

Reportedly, many different types of prescription opioids (aka "beans") are currently sold on the region's streets. Participants reported the following prescription opioids as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid® (aka "D8," "D's" and "Dilauda;" 2 mg sells for between \$5-20; 4 mg sells for between \$4-30; 8 mg sells for between

\$7-40), fentanyl patches (25 mg sells for \$20; 50 mg sells for between \$35-45; 75 mg sells for between \$50-65), Lortab® (aka “green beans;” sells for between \$6-7), methadone (10 mg sells for \$10); Norco® (7.5 mg, aka “750s;” sells for \$5; 10 mg sells for between \$5-7), Opana® (aka “banana,” “panas;” “pans;” “pink panthers” and “pinkies;” 5 mg sells for between \$7-8; 10 mg sells for between \$15-20; 20 mg sells for between \$30-35; 30 mg sells for between \$35-50; 40 mg sells for between \$70-120; 60 mg sells for between \$80-120), OxyContin® (aka “oxy’s;” OxyContin® OC, aka “OC’s” and “Ocean City;” 80 mg sells for between \$120-130; OxyContin® OP, aka “OP’s;” 40 mg sells for \$20), Percocet® (aka “P’s;” “Paul;” “p-dawgs;” “perc’s” and “pineapples;” 5 mg sells for between \$5-7; 10 mg sells for between \$5-12); Roxicodone® (aka “roxi;” 15 mg sells for between \$15-17; 30 mg sells for between \$30-40); Vicodin® (aka “V’s;” “Vicki;” “V-dawgs” and “vikes;” 5 mg sells for between \$3-5; 7.5 mg sells for between \$5-6; 10 mg sells for between \$7-12); Ultram® (sells for \$2 per pill). While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally the most common route of administration remains snorting. However, there was consensus among participants that there is a graduated way of using prescription opioids in general. A participant explained, “Depends on what stage of addiction you’re in. In the beginning you’d probably eat ‘em [prescription opiates]. Then, you’d snort ‘em and then you’d start shootin’ them up.” Other participants pointed out that there are differences based on the actual type of opioid: “I’d snort or shoot ‘em depending on what they are. I ain’t gonna shoot a vike [Vicodin®] or perc [Percocet®] ... but, like Opana® or an OC [OxyContin® OC] or Dilaudid® or roxy [Roxicodone®] ... people will shoot.” Several participants also reported smoking pills as well as parachuting them (crushing them and placing them in a small piece of toilet paper and swallowing or anally inserting them).

In addition to obtaining prescription opioids on the street from dealers, participants also continued to report getting the drugs from doctors, emergency rooms, pain clinics, friends and family members who have prescriptions. Drug seeking through feigning injury also continues to be a way to obtain drugs. A participant reported, “It’s easy ... all you gotta do is go to the pain clinics. There’s numerous pain clinics, you just walk in, you know. Medical card pays for the prescription; you just have to pay for a doctor’s visit.”

A profile of a typical prescription opioid user did not emerge from the data. However, participants noted the secrecy of people who abuse opioids: “There are more closet pill heads [than closeted crack cocaine users]; A lot of people secretly do it

[abuse opioids] ... like a soccer mom running in [to see a drug dealer] for like three minutes [to] get her pills and leave, and none of her family knew ... literally everybody.” Reportedly, some users begin using prescription opioids as a way of self-medicating. A participant explained, “How I started [doing prescription opioids] was I got back problems ... and I couldn’t find a doctor that would help me out. So what I did, I ended up going and buying it off the street and, you know, I was doing it for my pain ...” Community professionals also had difficulty developing a profile of a typical prescription opioid user, stating that someone of any race, ethnicity or socioeconomic status used prescription opioids.

Participants reported a variety of substances used in combination with prescription opioids: alcohol, crack cocaine, heroin, marijuana, powder cocaine and sedative-hypnotics. Also, reportedly common is mixing prescription opioids with other prescription opioids. Many participants reported poly-substance use. A participant reported, “I always, always, always started out with weed [marijuana], and then if it was a really good day, I would get a bottle of Jack Daniel’s [whiskey], and then I would do the pills [prescription opioids] – in that order.” Another participant reported, “I would start out in the morning by going to opiates [prescription opioids]. I did my opiates and I did heroin. Then I’d drink [alcohol]. If I was drinking, I’d start smoking crack. If I was smoking crack, I’d take xani’s [Xanax®] ... and then I’d do it all over again ...”

Suboxone® Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported availability of Suboxone® as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Law enforcement and drug court staff agreed that Suboxone® was being abused and was highly available in the region during the previous six months. Both participants and community professionals reported that the availability of Suboxone® had increased during the previous six months. The BCI London Crime Lab reported that the number of Suboxone® cases it processed had remained the same during the previous six months. The most commonly reported street prices for Suboxone® were as follows: 2 mg sold for \$5; 8 mg sold for \$20; 8 mg strips (aka “film”) sold for \$15. Most often participants reported taking Suboxone® 8 mg pills. Among participants who reported on abuse of Suboxone®, snorting was the most common route of administration followed by intravenous injection. Participants reported obtaining Suboxone® from doctors and clinics, but those who abused

the drug reported mainly obtaining it from people with prescriptions. A profile for a typical Suboxone® user did not emerge from the data.

Current Trends



Suboxone® remains highly available in the region. Participants most often reported the current availability of Suboxone® as '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. Participants had a lot to say about the availability of Suboxone®: *"Suboxone® is pretty popular; I think I hear more about Suboxone® around here than I do anything else; It's everywhere; I can almost find Suboxone® faster than I can anything else."* Community professionals most often rated the current availability of Suboxone® as '5' or '6'. A drug court officer expressed a great deal of concern over Suboxone® abuse: *"Suboxone® still continues to be an issue with our participants ... we have seen a lot of illegal use of Suboxone."* Treatment providers agreed that many are misusing Suboxone®: *"They're not taking it [Suboxone®] as prescribed ... from what I see, I think that probably more than 50 percent are not using it like they're supposed to ... selling it or abusing it."*

Participants reported that the availability of Suboxone® has increased during the past six months. A couple of participants noted a decrease in Suboxone® and a subsequent increase in Subutex®: *"I know people who are doing that Subutex® now. A lot of people switch from Suboxone® to Subutex® ... and you see more of it than you do the Suboxone® ...; They [users] are substituting Suboxone® for Subutex® because there is no opiate blocker, and they can take pain pills [prescription opioids] with it."* Community professionals had mixed perceptions regarding a change in Suboxone® availability during the past six months. A health care provider and a staff member from the coroner's office reported an increase in Suboxone® based on an increase in children obtaining the drug. *"In Athens County we had two accidental – not deaths – but young, young children [less than three years old] on Suboxone® [come into the hospital having ingested Suboxone®];"* said the staff member from the coroner's office. The BCI London Crime Lab reported that the number of Suboxone® cases that it processed has increased during the past six months.

No slang terms or street names were reported for Suboxone®. Reportedly, 8 mg Suboxone® sells for between \$15-20. No prices were provided for the Suboxone® 2 mg. However, a

participant noted inflated pricing if demand is high: *"I've seen them [Suboxone®] go for \$40 because there wasn't none, and people were sick, you know, they needed them."* Among participants who reported on abuse of Suboxone®, snorting remains the most common route of administration followed by intravenous injection. Community professionals reported on intravenous injection of Suboxone®. A staff member from the health department reported, *"I am aware of one client who is on the Suboxone® treatment [program] who is crushing it and shooting it ... he does it because he was a heroin addict and he likes this deal of putting needles in himself."* Participants continued to report obtaining Suboxone® from doctors and clinics, but mainly from people with prescriptions. A participant explained, *"You go to people you know get prescription for it [Suboxone®]."*

A profile for a typical Suboxone® user did not emerge from the data. However, treatment providers continued to report that opiate users use the drug when they cannot obtain heroin or a prescription opioid. A treatment provider stated, *"[Suboxone® is] used as a backup if you can't get your drug of choice that's an opiate. You use that to kind of help, you know, get you through 'til you can get it [your drug of choice]."* Reportedly, Suboxone® is used in combination with marijuana and sedative-hypnotics. A participant reported, *"It doesn't really do you much good to do anything else [with Suboxone®], but you can get a buzz with xani's [Xanax®] and Suboxone®."* Treatment providers also reported the combination of benzodiazepines and Suboxone® is fairly common.

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants and community professionals most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants identified Klonopin®, Valium® and Xanax® as the three most popular sedative-hypnotics in terms of widespread use. Collaborating data also indicated that sedative-hypnotics were readily available in the region. The Scioto County Coroner's Office reported that sedative-hypnotics were present in 10.7 percent of all drug-related deaths during the previous six months. The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processed had remained the same during the previous six months. The most common routes of administration remained oral ingestion and snorting. Participants said they frequently feigned symptoms of anxiety to obtain sedative-hypnotics, but they

also obtained the drugs from family and friends. Typical users of sedative-hypnotics were young adults in their 20s.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates, and muscle relaxants) remain highly available in the region. Participants and community professionals most often reported the current availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants continued to identify Klonopin®, Valium® and Xanax® as the three most popular sedative-hypnotics. Participants reported specifically on the availability of different benzodiazepines. One participant spoke about Klonopin®: *"I'd say Klonopin® are probably the easiest to get of all of those because more people get prescribed those than anything else."* Another participant discussed the popularity of Xanax®: *"More people want Xanax® than anything."* Generally, participants thought Ambien® is difficult to obtain; with one stating, *"You have to know someone for Ambien® ... If you know the person, you'll be able to get it. And if you don't, you might as well be looking for gold bars."* A participant spoke about ways in which users obtain Ambien®: *"You have to know someone with a prescription for Ambien® that will sell it. They're not necessarily gonna be like drug dealers. But I used to sell my Ambien®, and I would either trade it for pills that I wanted or I would just let it go for like a dollar a pill."*

Several participants mentioned that users do not want to share or sell their sedative-hypnotics, especially if users feel they "need" them. A participant explained, *"I think people are too stingy with xani's [Xanax®] now, 'cause most people like to use them."* Another participant shared her personal experience: *"I'm very stingy with my xani's [Xanax®] – I did not like to come off of them at all, but I will if I know you got a date ahead of me before I get mine ... I'll give you five if you give me 10."* Community professionals most often reported the current availability of sedative-hypnotics as '10'; the previous most common score was also '10'. Community professionals identified Ativan®, Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics. Collaborating data also indicated that sedative-hypnotics are readily available in the region. The Scioto County Coroner's Office reported sedative-hypnotics as present in 7.1 percent of all drug-related deaths during the previous six months.

Participants reported that the overall availability of sedative-hypnotics has remained the same during the past six months. However, participants noted a few exceptions and reported that Klonopin® and Xanax® have increased in availability, while Soma® and Valium® have decreased in availability. A participant commented, *"People's got a lot stingier with their*

benzo's [benzodiazepines] than they used to be ... you used to be able to get 'em really easy and now people will not come off of 'em." Community professionals agreed that overall sedative-hypnotic availability has remained stable during the past six months. However, treatment providers reported an increase of users with prescription sleep aides. A treatment provider explained, *"We're just hearing more clients that are coming into treatment that are on those other sleeping medications [Ambien®, Lunesta® and Restoril®]. We hadn't heard about those during the past years."* The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processed has stayed the same during the past six months.

Reportedly, many different types of sedative-hypnotics (aka "benzos," "downers" and "nerve pills") are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ativan® (1 mg sells for between \$1-3; 2mg sells for between \$4-5); Klonopin® (aka "forgot-o-pins" and "green monsters;" 0.5 mg sells for between \$1-2; 1 mg sells for between \$2-3; 2 mg sells for \$3); Soma® (aka "somatose" and "soma-coma;" sells for \$0.50 per pill); Valium® (2 mg sells for between \$4-5; 5 mg sells for \$1; 10 mg sells for between \$2-3); Xanax® (aka "bars," "basketballs," "blue boys," "blues," "bus bar," "busses," "footballs," "kiwis," "ladders," "peaches," "pies" and "xani's;" 0.5 mg sells for between \$1.50-2; 1 mg sells for between \$2-4; 2 mg sells for between \$5-6; 3mg sells for \$7).

While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among specific types, generally, the most common route of administration remains oral ingestion (aka "popping"). A participant spoke about the various routes of administration: *"I always know people eatin' them [benzodiazepines] by handfuls ... [but] it depends on the person. Some people will chew them up, some people just swallow them, some people just let them sit on their tongue and just dissolve."* Several participants mentioned intranasal ingestion [snorting] and smoking sedative-hypnotics, while only a couple of participants mentioned parachuting them. A participant described the parachuting technique: *"[You] crush it [benzodiazepines] up and put it in ... like break toilet paper or tissue ... and twist it up and swallow it."*

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported getting them from friends, doctors and locations outside the Athens region. Participants continued to discuss feigning symptoms of anxiety to obtain sedative-hypnotics. A participant explained, *"People fake it [anxiety], so they'll go in to see a psychiatrist just so they can get prescribed them [benzodiazepines]."*

Participants described typical users of sedative-hypnotics as people who are under a lot of stress or work in certain industries. A participant explained, *“Restaurant workers, like servers ... pretty much [use] any drug. I mean, because you’re dealing with the public constantly. You’re performing for the public ... it’s a high rate of drug and alcohol use ... you have to take something to deal with that shit.”* For the first time, participants also identified a subset of users who they referred to as *“pharmies,”* who are people who like to mix prescription opioids and sedative-hypnotics. A participant explained that *“pharmies”* are *“people who snort ... mix their pills. They’ll snort a Percocet® and then follow it up with a Xanax®. Lots of people do that.”* Community professionals described typical users of sedative-hypnotics as White men and women aged from early 20s through 50s. A treatment provider said, *“You’d be surprised ... people who use opiates and go back and forth on these things [between prescription opioids and benzodiazepines].”*

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with cocaine, heroin, marijuana, prescription opioids, prescription stimulants and other sedative-hypnotics. Participants reported that it is most common to use sedative-hypnotics with prescription opioids. A participant explained, *“Opiates stop working at some point if you’re a daily user. So, I’ll use Xanax® to actually get a buzz – or actually feel high.”* Another participant used sedative-hypnotics to black out: *“Typically, if you’re withdrawing from opiates, Xanax® really helps because you black out and you don’t really remember feeling terrible.”* A participant from Muskingum County discussed using Ambien® to come down off of other drugs: *“A lot of people want to have Ambien® around because it will help you no matter how jacked up [high] you are on stuff. If you take enough Ambien®, you’re going to be able to sleep for a while.”* Treatment providers and staff from an area coroner’s office also observed several combinations of drug use. A treatment provider explained some of the combinations: *“Perc’s [Percocet®] and Valium® go together. Klonopin® and oxycodone go together – it’s not like a gin and tonic, it’s just when they take those, they take the other.”* Another treatment provider mentioned the use of alcohol with sedative-hypnotics: *“A lot of individuals mix alcohol and Xanax® together.”*

Marijuana

Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants and community professionals most often reported the availability of marijuana as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Community professionals reported that users frequently

grew their own marijuana. The BCI London Crime Lab reported that the number of marijuana cases it processed had decreased during the previous six months. Participant quality scores of marijuana varied from ‘2-10’ with the most common score being ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported commercial-grade marijuana as the cheapest form: a blunt (cigar) or two joints (cigarettes) sold for between \$5-10; an ounce sold for between \$100-160. High-grade marijuana sold for significantly more: a gram sold for between \$20-25; an ounce sold for between \$350-525. The most common route of administration remained smoking. Participants and community professionals reported that men and women of all races and ethnicities used marijuana.

Current Trends

Marijuana remains highly available in the region. Participants and community professionals most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10.’ All participants believed that marijuana is very easy to obtain. A participant said, *“If someone doesn’t have it [marijuana], someone else is going to have it. You’re going to be able to find it somewhere ‘cause you just don’t know one person [who uses marijuana].”* Participants in all focus groups mentioned peak availability during harvest season (late summer and autumn). A participant said, *“We’re in an area where a lot of people grow it [marijuana]. They’re all starting their plants right now and getting ready for it to hit the ground. It [marijuana] might be a little less available [now] because all your growers are about to run out of their last year’s crops.”* Community professionals commented on the excessive availability of marijuana in the Athens region. A treatment provider stated, *“They’re growing it [marijuana] in their backyard or in their basement.”*

Most participant focus groups, as well as the groups of community professionals, reported stable availability during the past six months. A participant said, *“[Marijuana] it’s been here. It’s gonna stay here.”* A minority of participants and community professionals suggested a possible decrease in marijuana availability. A participant explained why he thought there had been a decrease: *“People are moving to different drugs. Where I live, there’s a lot of crack [cocaine] and pills [prescription opioids and benzodiazepines] and heroin.”* A treatment provider said marijuana use has decreased as a result of increase in prescription opioid use: *“I’m thinking probably use [of marijuana] has gone down because of the opiates. They don’t need it [marijuana].”* The BCI London Crime Lab reported that the number of marijuana cases it processed has decreased during the past six months.

Participants most often rated the overall quality of marijuana in the region as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8'. Participants noted a slight difference in quality between the two grades of marijuana, rating current quality of low- to mid-grade marijuana as '7' and that of high-grade marijuana as '10'. However, generally, participants believed all forms of marijuana in the area to be of high quality. One participant stated: *"Ever since them [sic] other states legalized it, you know, it's like all the [marijuana] brands are like '10' [high quality]. I can get better weed [marijuana] more than I can get dirt [low quality] weed."* According to participants, the quality of marijuana has remained the same during the past six months. Participants reported marijuana as occasionally being cut with Italian spices, oregano, pencil shavings and powdered cocaine. A Belmont County participant discussed cutting marijuana with other substances: *"If it was crappy weed, and I was trying to sell it to someone for more than it was worth, [I] put a little bit of coke [powdered cocaine] on it and they don't know the difference. Even if they don't do coke [powdered cocaine], you just don't tell them."*

Current street jargon includes countless names for marijuana. The most commonly cited names were "pot" and "weed." Other common street names for marijuana include: "beasters," "bud," "ganja," "green," "herb," "schwag," "smoke" and "trees." Street names may also be related to the quality of marijuana: low- to mid-grade marijuana may be referred to as any of these street names, as well as "commercial," "mersh," "mids," "middies" and "shake." High-grade marijuana is called "dank," "dro," "hydro," "kush," "loud," "neon buds" or "skunk." Names for this grade of marijuana may also be related to the specific strand: "blueberry," "bubbalicious," "bubblemum jubilee," "juicy fruit," "mango" and "train wreck." The price of marijuana depends on the quality desired. Participants reported commercial-grade marijuana as the cheapest form: a blunt or two joints sell for \$3; 1 or 2 grams sells for between \$5-10; 1/8 ounce sells for between \$15-30; 1/4 ounce sells for between \$25-60; an ounce sells for between \$125-150; 1/4 pound sells for \$350-400. Reportedly, high-grade marijuana sells for significantly more: 1 or 2 grams sells for between \$10-20; 1/8 ounce sells for between \$50-100; 1/4 ounce sells for between \$60-100; an ounce sells for between \$275-300; 1/4 pound sells for \$1,000; a pound sells for between \$8,900-9,000.

While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Participants reported smoking marijuana in a blunt, a joint, a bowl, a bong, a vaporizer and "cigarillo" [aka cigar]. Participants also discussed cooking with

marijuana in greater frequency than was reported during the last reporting period. A participant explained, *"You can bake it with brownies, cookies. You can eat it, you can smoke it in bowls, you can drink it – boil it up, drink it like tea."* Another participant agreed, *"I know a lot of people that's making butter, cookies [and] brownies."* Participants reported a change in marijuana use as occurring during the past six months: users are adding liquid flavoring to marijuana blunts and cigarettes. A participant explained, *"There's this stuff that people put in blunts now . . . it's liquid stuff and you squirt it in. It's just basically something for the flavor of it [marijuana]. Some people put that in weed [marijuana] just so they can sell it for more – like the brown weed that people call 'Mexican' and doesn't taste good and when you hit it, it burns too fast. If you add that [liquid flavoring], it will make it [marijuana] seem spongier, and it will taste better, so it will seem like higher quality."*

A profile for a typical marijuana user did not emerge from the data. Participants and professionals described typical users of marijuana as "everyone." Participants frequently commented on the diversity of users. A participant commented, *"I've seen uppity lawyers and judges smoke weed. And then, you know, the lowest homeless dude smoking weed."* Participants accepted marijuana as an assumed part of growing up. A participant reported, *"I smoked it [marijuana] when I was in high school, but you know, everybody smokes pot when they're in high school."* Participants also reported marijuana use by children as young as seven years. Community professionals reported that between 80-100 percent of their clients have used marijuana, and they said users come from a variety of labor professions such as factory workers, painters, construction workers and roofers. Typically, treatment providers said professionals only come into treatment when they are referred by the court. A family drug court staff noted that use of marijuana is highly acceptable in the community. A court official explained, *"All of our clientele uses marijuana, parents and juveniles. Parents use with their children."* In addition, law enforcement reported, *"[Marijuana is] so hard for us to enforce. People don't think there's anything wrong with it."*

Reportedly, marijuana is most often used in combination with alcohol and powdered cocaine. However, most participants reported that marijuana can be used with anything, including Ecstasy, embalming fluid, crack cocaine (aka primo), heroin, hallucinogens [LSD (Lysergic acid diethylamide), psilocybin mushrooms and PCP (Phencyclidine)], prescription opioids and tobacco. A participant explained, *"I mix weed with anything. If I had anything, I had weed first."* Participants were eager to share their personal experiences. A participant discussed

combining marijuana with cocaine to modify the high: *"I would sprinkle my coke on top of the weed and smoke the blunt with the coke ... it would sort of intensify [the high]."* Smoking marijuana with crushed prescription pills was also mentioned by several focus groups.

Methamphetamine

Historical Summary

In the previous reporting period, methamphetamine was relatively rare in the region. Overall, participants most often reported the availability of methamphetamine as '2' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that methamphetamine was available in crystal (aka "glass") and powdered forms. Community professionals reported moderate to high availability of methamphetamine in the region. There was disagreement among participants and community professionals about whether the drug's availability had increased, decreased or remained the same during the previous six months. Most participants reported that the quality of methamphetamine was moderate, most often rating its quality as '4' on a scale of '0' (poor quality, garbage) to '10' (high quality). Participants reported that a gram of methamphetamine sold for \$100; 1/8 ounce sold for roughly \$200. The most common route of administration was smoking, but snorting methamphetamine was reportedly also very popular. Participants and community professionals identified typical methamphetamine users as individuals older than 40 years, and said they worked in industries that required long hours and a high degree of concentration (such as construction and trucking).

Current Trends



According to participants, methamphetamine remains relatively rare throughout the region. Participants most often reported the current availability of methamphetamine as '2' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '2'. A participant explained why it is so difficult to find the drug: *"It's not the easiest drug to find, you have to be in a certain click. They [methamphetamine users] stick together, and they're very, very particular about who they're going to sell to 'cuz they're ... paranoid."* Another participant commented, *"I've seen it [methamphetamine] during the past six months, but it just really hasn't seemed to hit this area too hard ..."*

Participants reported that methamphetamine is available in powdered and crystal forms. A Belmont County participant reported on the most common form of the drug: *"You can get it [methamphetamine] in powder form, that's personal meth [aka 'shake-and-bake']."* Another participant stated, *"You can ask for crystal [methamphetamine], and they're still gonna give you shake-and-bake."* Contrary to the previous reporting period, more participants had knowledge about methamphetamine, but these stories were related to friend's experimentation with the drug and not personal accounts of drug use. In contrast, community professionals rated current availability of methamphetamine as '7' and '8'; previously, community professionals also reported moderate to high availability of methamphetamine. A law enforcement officer discussed a recent enforcement activity: *"There for six to eight straight weekends, our drug unit was called out for meth labs."* Media from the region reported on an increase in the popularity of the one-pot method (methamphetamine manufacture in a single sealed container, such as a two-liter soda bottle, aka "shake-and-bake"). The Central Ohio Drug Enforcement Task Force, serving Licking, Muskingum, Perry, and Coshocton counties, arrested 11 one-pot methamphetamine cooks (manufacturers) in 2012 www.coshoctontribune.com, March 9, 2012).

Most participants claimed no personal experience with methamphetamine, but many reported increased availability of the drug during the past six months based on what they heard from friends and in media reports. A participant explained, *"For me [methamphetamine availability] it's increased because I just recently seen it for the first time during the past six months."* Law enforcement reported an increase in methamphetamine. An officer said, *"Yes, we've seen an increase in [methamphetamine] the last six months. It used to be in more rural counties, such as Perry County. One of the things we're seeing now is the quick shakes that they can do with just a couple bottles of the material that they need to do it. So, it's readily available. It's so easy to do it in a moving vehicle, and so, we've seen a huge increase in it."* The BCI London Crime Lab reported that the number of methamphetamine cases it processed has increased during the past six months. The lab reported processing white to off-white powdered methamphetamine most often and crystal methamphetamine occasionally, and noted that the one-pot method of manufacturing the drug appears to be increasing.

The few participants with experience using methamphetamine reported current quality of the drug as high quality, most often rating quality as '10' on a scale of '0' (poor quality, garbage) to '10' (high quality); the previous most common score was '4'. As with previous reporting periods, participants said the quality largely depends on

the technical expertise of the “cook.” Participants reported methamphetamine being cut with wax.

Current street jargon includes a few names for methamphetamine. The most commonly cited street names for methamphetamine were: “crank,” “crystal(s),” “glass,” “ice,” “meth” and “shards.” Prices for methamphetamine were consistent among those participants who were familiar with the drug. Participants reported that a gram sells for \$100. In addition, a participant reported purchasing methamphetamine in smaller quantities for less money, but was unsure of the exact weight of the drug: *“If I wanted like \$25 or \$30 worth of it [methamphetamine] ... ‘cuz that’s what I would usually be prepared to spend on a pill [prescription opioid] ... I want to say [I would get] maybe like a quarter of a gram.”* Participants reported that there are several ways of consuming methamphetamine: smoking, snorting and intravenous injection. A participant explained, *“You smoke it [methamphetamine]. You can snort it too, but you’re better off just snorting.”* Another participant reported, *“You get more high off it [methamphetamine] when you smoke it.”* A participant explained her use of methamphetamine: *“I just always snorted it [methamphetamine], but people definitely shoot [inject] it up. It’s very easy to shoot up ...”*

A profile for a typical methamphetamine user did not emerge from the data. However, community professionals in the health care field identified typical methamphetamine users as prostitutes and people of low socio-economic status. A treatment provider described users of methamphetamine as *“people that may not have jobs or people [who are] more destitute.”* Reportedly, methamphetamine is used in combination with alcohol, prescription opioids and sedative-hypnotics. Participants said they used substances to come down from the intense high of the drug. A participant explained, *“You don’t really need to [use anything else with methamphetamine] ... maybe after the four days you are up, you might want to go to sleep, so you can probably take some xani’s [Xanax®] or heroin or something to bring you back down.”*

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants were moderately available in the region. Participants most often reported the availability of prescription stimulants as ‘5’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Community professionals did not rate the availability of prescription stimulants, but identified Adderall®, Ritalin® and Vyvanse® as being available and abused within the region. The BCI London Crime Lab reported that the number of prescription stimulant cases it processed had remained the same during the previous six months with one exception: the

number of Adderall® cases had decreased. Participants and community professionals often expressed concern about how these drugs were prescribed and obtained. According to participants and community professionals, typical users of prescription stimulants were young people, including middle school and high school students, as well as college-aged adults between the ages of 18 and 25 years.

Current Trends

Prescription stimulants are highly available in the region. Participants most often rated 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 ‘5’. Participants identified Adderall®, Concerta® and Ritalin® as the three most popular prescription stimulants in terms of widespread use. Participants commonly believed that these drugs are easily obtained. A participant explained, *“Adderall®’s easy, so is Ritalin® because every kid in America’s on that shit.”* A participant also spoke about the higher availability of Adderall® compared to other prescription stimulants: *“They’re prescribing Adderall® more than Ritalin® nowadays.”* Community professionals reported moderate availability of prescription stimulants in the region, although again they were not able to provide an availability score. Treatment providers and drug court staff identified the top available prescription stimulants as Adderall® and Vyvanse®. Staff from the Vinton County Coroner’s Office spoke about the drug’s availability throughout the region: *“I don’t see it [prescription stimulant use] in Vinton County, but working here [Athens County] in the hospital I see it as overdoses.”*

Participants reported an increase in the availability of the Adderall® during the past six months. A participant reported, *“I know a lot more people getting prescriptions for Adderall® [and diverting them].”* A staff member from the Hocking County Drug Court reported similar findings: *“I would say we’ve had an increase in the use of Adderall® here in the last six months.”* The BCI London Crime Lab reported that the number of prescription stimulant cases it processed has remained the same during the past six months.

Current street jargon for prescription stimulants is limited to “addies” for Adderall®. Prices for prescription stimulants were consistent among those who were familiar with the drugs. Participants reported the following prescription stimulants as available to street-level users: Adderall® 30 mg sells for between \$2-5; Ritalin® sells for between \$1-2. The most common route of administration is swallowing. Participants frequently mentioned diversion of the drugs, and they said users obtain prescription stimulants from family and friends as well as physicians. A participant explained, *“You’d be surprised at how many people’s selling their kids Adderall®.”*

A profile for a typical user of prescription stimulants emerged from the data. Participants and community professionals agreed that adolescents (12 years and older) and young adults in their twenties are the most likely people to use the drugs. A participant with a history of abusing prescription stimulants said, "I was hooked on it [Adderall®] when I was 14 [years old]." Drug court staff confirmed these findings and identified use of Adderall® with adolescents less than 18 years of age. In addition, health care workers in Athens County identified typical users as college students between the ages of 18 and 22 years. Participants also mentioned other categories of typical users, but these were not supported by community professionals. A participant said "speed freaks," people who enjoy using drugs like cocaine and methamphetamine, and truck drivers are typical users. A participant said women use the drugs to lose weight: "I know someone who gets prescribed Adderall®, and she buys 'em [from a dealer] when she runs out because she says they help her lose weight." Another participant said students use the drugs as a study aide: "When I used to go up to visit my brother in college, I would sell 30s [30 mg Adderall®] like crazy. So they [students] could stay up all night." Reportedly, prescription stimulants are used in combination with alcohol and crack cocaine.

Synthetic Marijuana

Historical Summary

In the previous reporting period, synthetic marijuana ("K2" and "Spice") was highly available in the region before the ban on its sale went into effect in October 2011. Participants reported that synthetic marijuana could easily be purchased at convenience stores, head shops and gas stations. Participants did not comment on any change in availability, but professionals believed that availability decreased before the ban went into effect. The BCI London Crime Lab data indicated that the five formally scheduled substances were almost never seen anymore; rather dozens of non-controlled structural analogs took their place. Participants reported that a gram of synthetic marijuana sold for \$5; three grams sold for \$10; 20 grams sold for \$20. The most common route of administration for synthetic marijuana remained smoking.

Current trends

Synthetic marijuana is moderately available in the region. Participants familiar with this drug most often rated its current availability as '4' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, participants did not assign an availability score to synthetic marijuana. Despite the ban that went into effect in October 2011, participants reported synthetic marijuana is still available from some convenience stores. According to a participant, "They're supposed to be not selling



it [synthetic marijuana], but they do it illegally." A participant in Athens County reported, "There are still designer drugs that are here, they're just calling them by different names and selling them kind of in secrecy. They are still available." Generally, participants agreed that interest in the drug is waning. Community professionals did not provide an availability rating, but recognized synthetic marijuana as available in the region. Community professionals also agreed with participants that synthetic marijuana continues to be available from places like convenience stores.

Participants and community professionals reported a decrease in availability of synthetic marijuana during the past six months. A staff member from the Hocking County Drug Court commented, "We went through a spell where K2 [synthetic marijuana] was really prevalent, but [after we began testing for it, our clients began] thinking, 'Well, you know, screw it. If we're gonna pop [fail the drug test] for K2 instead of the real thing, we're just gonna use the real thing.'" The BCI London Crime Lab reported that the number of synthetic marijuana cases it processed has increased during the past six months. The crime lab reported that as soon as one drug is banned (JWH-018) another chemical analogue is likely to take its place (AM2201).

Quality for synthetic marijuana was not rated by participants because few participants had experience with it during the past six months. Current street jargon includes several names for synthetic marijuana. The most common names were "K2," "K3," "plant food," and "mosquito repellent." An Athens County participant said the names of synthetic marijuana have changed to subvert the new law: "Like instead of calling it [synthetic marijuana] 'K2,' they're calling it 'plant food.' There's a couple of other different names they call it, one was like 'mosquito repellent' or something." Reportedly, a gram of synthetic marijuana sells for \$10; 3.5 grams sells for between \$30-40. The most common route of administration for synthetic marijuana remains smoking. Participants did not mention using any drugs in combination with synthetic marijuana.

Bath Salts

Historical Summary

In the previous reporting period, bath salts (synthetic compounds containing methylone, mephedrone or MDPV) were highly available in the region. Participants most often 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). Community professionals in Guernsey, Muskingum and Washington counties reported

more of their clientele using bath salts than did professionals in Athens County. Prior to the current ban on the sale of bath salts, participants reported that bath salts were commonly sold at many gas stations in the region. Participants and community professionals agreed that bath salts availability had decreased during the previous six months after statewide legislation banning certain ingredients found in bath salts went into effect in October 2011. While participants did not provide a rating for the quality of bath salts, they said the quality had decreased. Participants with knowledge of bath salts said the drug sold for \$20 a gram. The most common route of administration of bath salts remained snorting. While participants and community professionals did not mention a specific gender or racial group that was more likely to use bath salts, many treatment providers said their clients were in the 15-35 year age range.

Current Trends



Bath salts (synthetic compounds containing methylenedioxymethamphetamine, mephedrone or MDPV) remain available in the region. While most participants did not have personal knowledge of bath salts, community professionals most often rated current availability of bath salts as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A couple of participants had knowledge of bath salts and disclosed that replacement products are still available through retail stores, as well as through personal

connections. A participant described how manufacturers were trying to circumvent the law: "I heard they changed the name [of the bath salts], and they [the gas stations that sold it] still got it." Another participant spoke about Internet sales of bath salts: "I know [bath salts] still going around just 'cuz I have a friend right now ... his cousin is ... somehow ordering it [bath salts] from somewhere, and he's having [them] sent to my friend's house, and it's my friend's drug of choice." Law enforcement spoke about recent drug seizures in the region involving bath salts. An officer said, "[Bath salts are] still out there. We've [found] probably half a dozen gas-station-type businesses that were selling bath-salt-type substances behind the counter or behind the back wall. We've confiscated a lot of them." Treatment providers agreed with law enforcement. A treatment provider commented, "It [bath salts] seems to be really accessible. I hear clients are getting it without any problem." Staff from a health department concurred with other professionals, and reported users are still coming into emergency rooms high on bath salts. Media outlets in the region reported on new formulations of bath salts increasing in popularity since the statewide ban went into effect. A

official with the Muskingum Behavioral Health reported, "The new wave is 'K3' and 'Gen2' bath salts, which is also referred to as 'jewelry cleaner,' 'pipe cleaner' or 'Cosmic Blast'" (www.coshoctontribune.com, Jan. 22, 2012).

Participants reported the availability of bath salts has decreased during the past six months. They were familiar with the law that banned bath salts. A participant commented, "It is really hard to get [bath salts] because they have taken it off the shelves." However, community professionals reported an increase in bath salts availability. A treatment provider explained, "[Bath salts use] it's in the upswing, increasing. I hear more and more about [bath salts] than I did [prior to the October 2011 legislation] ... I've heard more about it in the last six months." The BCI London Crime Lab reported that the number of bath salt cases it processed has increased during the past six months. In addition, the lab reported that as soon as one drug is banned (MDPV), another chemical analogue is likely to take its place (alpha-PVP).

Participants were not familiar enough with bath salts to report on the drug's quality, nor were they familiar with current street jargon. Reportedly, bath salts sell for \$40. Participants were most concerned with the recent media reports of bath salts leading to hallucinations and paranoia. A participant talked about one user's experience with bath salts: "When I was in jail, there were a couple girls that also used it [bath salts], and they were warning people that like 'We've done a lot of drugs and I tell you what, I will never do bath salts ever again ...'" Participants did not report using bath salts with other substances.

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), psilocybin mushrooms and dimethyltryptamine (DMT)], inhalants, over-the-counter medications (OTC) and "moonshine" alcohol. Ecstasy was rarely available in the region. Participants with knowledge of the drug most often reported its availability as '3' or '4' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); law enforcement, however rated the availability of Ecstasy as '10'. The BCI London Crime Lab reported the number of Ecstasy cases it processed had remained the same during the previous six months; however, the lab noted a considerable increase in cases containing the designer drug 5-MeO-DiPT (foxy methoxy). Participants said the route of administration varied for Ecstasy; users

could swallow or snort it depending on the type of high they wanted. Hallucinogens were rarely available in the region. Most participants listed LSD and psilocybin mushrooms as the most available hallucinogens; some participants also included dimethyltryptamine (DMT). Law enforcement reported high availability of hallucinogens in the area, rating the availability of LSD as '10' and the availability of psilocybin mushrooms as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). The BCI London Crime Lab reported that the number of LSD cases it processed had increased and the number of psilocybin cases it processed had decreased during the previous six months. According to participants from Guernsey County, DMT was locally made and of high quality. Reportedly, the most common route of DMT administration was smoking. Participants reported the following prices for hallucinogens: DMT sold for \$10 a hit (about 1/10 gram); LSD sold for between \$10-20 a hit, with higher prices at concerts; 1/4 ounce of psilocybin mushrooms sold for between \$40-50. Inhalants (aka "whippets") were highly available in the region. Despite their availability, participants reported that inhalants were rarely abused because they were not a preferred drug. Most community professionals agreed that inhalants were rarely used in the region; however, a treatment provider reported that three of her clients reported abusing inhalants during the past six months. OTC medications (cold and cough syrups) were highly available in the region. However, according to participants and community professionals, these substances were rarely used by those older than 18 years of age. Typically, participants mentioned high school youth between the ages of 16-18 years as abusing OTC medications. Alcohol also was highly available in the region. Participants and community professionals said alcohol abuse was common, and users began using alcohol as young as 11 and 12 years of age. Participants have noticed an increase in different flavors of alcohol, and they believed flavored alcohol to be a marketing ploy. Participants also mentioned the availability of homemade alcohol (aka "moonshine" and "hot apple pie") in the region.

Current Trends

Participants and community professionals listed a variety of other drugs as being present in the region, but these drugs were not mentioned by the majority of people interviewed: Ecstasy, hallucinogens (psilocybin mushrooms) and inhalants. Ecstasy is moderately available in the region. Participants rated the current availability of Ecstasy as between '4' and '9' (average score 6.5) on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common scores were '3' and '4'. Participants familiar with Ecstasy reported that the drug can be difficult to obtain. A participant reported, "It's not like you can say

you want to do [Ecstasy] and set it up for like an hour later; give me three days and I can get it; it's an event drug." Another participant agreed, "You might find some of that [Ecstasy] if you go to a hookah festival, but you ain't gonna find no Ecstasy or anything like that on the street." Treatment providers reported rare availability of Ecstasy. A treatment provider explained, "Every once in a while you'll hear Ecstasy from clients, but it's not something they regularly do. It's [a] here or there thing that they do ... more so probably at a party or something like that." Participants and community professionals did not comment on any change of availability during the past six months; however, participants said that Ecstasy is not as prevalent as it was several years ago. The BCI London Crime Lab reported that the number of Ecstasy cases it processed has remained the same during the past six months. In addition, the lab reported that Ecstasy tablets contain a variety of substances including cathinones, dimethyltryptamine (DMT) and benocyclidine (psychoactive drug), which is usually in tablets with 5-MeO-Dipt and caffeine. Participants reported that the price of Ecstasy (aka "X") commonly depends on the pictures on the tablets. A participant said Ecstasy is priced "... according to what it is. I mean, like superman's [are] \$15 ... the black Mollies [are] \$30 ... you can get blue ones with red hearts, and they're like \$10." The most common route of administration remains oral ingestion. A participant described what witnessed concerning Ecstasy use, "I've seen people take 'X' [Ecstasy] pills, crush them up and put them in a piece of toilet paper and swallow them. It's called parachuting."

Psilocybin mushrooms are highly available in the region, reportedly because they came into season during the past six months. Participants rated current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant spoke about a dealer selling the drug: "I was just approached a couple nights ago [end of March 2012] about a guy with mushrooms being around." Generally, participants reported that psilocybin mushrooms continue to be seasonally available. A participant explained, "Every spring there's 'shrooms around." An Athens health care provider reported moderate availability of psilocybin mushrooms, and rated availability as '5'. Law enforcement did not comment on psilocybin mushroom availability this reporting period. The BCI London Crime Lab reported that the number of psilocybin mushroom cases it processed has remained the same during the past six months. Participants had limited direct experience with psilocybin mushrooms and were unable to rate current quality. A participant provided an anecdotal report: "A buddy of mine said he tried it [psilocybin mushroom], and they're pretty good." Current street jargon for psilocybin mushrooms is limited to "shrooms." Participants reported psilocybin mushrooms sell for between \$15-20 per bag; 1/4 ounce sells for \$40. Participants reported that psilocybin mushrooms

are orally consumed by eating them or drinking them in tea. A participant commented, *"I did them [psilocybin mushrooms] laced on weed. I crush 'em and make it like a powder."* An Athens health care provider spoke about the relationship of psilocybin mushrooms to other drugs: *"A lot of people who are really into marijuana also dabble in hallucinogens."* Participants reported typical users as college students between the ages of 18 and 20 years. Participants also mentioned frequent use at outdoor music festivals like "hippie festivals" and "hookahville" (an outdoor concert). While participants did not report on other hallucinogens, the BCI London Crime Lab reported that cases of LSD and powdered DMT have increased during the past six months.

Lastly, participants reported inhalants (aka "whippets") as available in the region. Participants frequently talked about the inexpensive nature and easy access of inhalants. A participant reported, *"[Inhalants] that's a big one. It's cheap ... if they were looking to get high, and they're broke, go get \$5 and you buy a can of air duster. You can be f***** up for hours."* Another participant talked about the benefits of using inhalants to avoid positive drug screens: *"[Inhalants are] not going to show up on any drug test ..."* Another participant shared, *"My sister be pumpin' my mom's gas – [and] with a rolled up bag she be on the gas tank going [making huffing sound] ... I'm like, 'you're embarrassing me!,' people looking at her and stuff."* Drug court staff reports an increase during the past six months of people using inhalants. Participants and community professionals described typical inhalant users as junior high and high school aged (teens to early 20s).

Conclusion

Crack cocaine, heroin, marijuana, prescription opioids, sedative-hypnotics and Suboxone® remain highly available in the Athens region. Noted changes in availability during the past six months are as follows: increase in availability for heroin and Suboxone®; likely increase in availability for bath salts and methamphetamine; likely decrease in availability for crack cocaine and synthetic marijuana. Overall, participants and community professionals reported that the availability of heroin in the region has increased during the past six months. Treatment providers reported that treatment facilities are noticing an increase in the number of clients seeking treatment for heroin use. Several participants compared the availability of heroin to the availability of marijuana. The BCI London Crime Lab reported that the number of brown powdered and black tar heroin cases it processed has increased during the past six months. Participants continued to report that the most common way to use heroin remains intravenous injection. Community professionals reported that typical heroin users range in age from teens to those into their early thirties. While participants and community professionals reported that the

availability of prescription opioids has generally remained stable, at a high level of availability, both respondent groups noted an exception, an increase in the availability of Opana®. The BCI London Crime Lab reported that the number of prescription opioid cases it processed has also generally remained the same during the past six months with the following exceptions: an increase in Opana® cases and a decrease in OxyContin® cases. Participants reported that the availability of Suboxone® has increased during the past six months, with a couple of participants also noting an increase for Subutex®. The BCI London Crime Lab reported that the number of Suboxone® cases it processed has also increased during the past six months. Treatment providers continued to report that opiate users use Suboxone® when they cannot obtain heroin or a prescription opioid. Contrary to the previous reporting period, more participants had knowledge about methamphetamine, but these stories were related to friend's experimentation with the drug and not personal accounts of using the drug. Many participants reported an increase in availability of methamphetamine during the past six months based on what they heard from friends and in media reports. Law enforcement reported an increase in methamphetamine. The BCI London Crime Lab reported that the number of methamphetamine cases it processed has increased during the past six months. While most participants did not have personal knowledge of bath salts, community professionals reported high availability of bath salts. A couple of participants disclosed that bath salts and replacement products are still available through retail stores, as well as through personal connections and the Internet. Staff from a health department concurred with other professionals and reported that users are still coming into emergency rooms high on bath salts. Media outlets in the region reported on new formulations of bath salts increasing in popularity since the statewide ban went into effect in October 2011. The BCI London Crime Lab reported that the number of bath salt cases it processed has increased during the past six months. In addition, the lab reported that as soon as one drug is banned (MDPV) another chemical analogue is likely to take its place (alpha-PVP). Lastly, while current availability remains high for crack cocaine, the majority of participants and community professionals noted a slight decrease in the availability and use of crack cocaine during the past six months. There was consensus that the decrease is due to an increase in preference for opiates. The BCI London Crime Lab reported that the number of crack cocaine cases it processed has remained the same during the past six months.