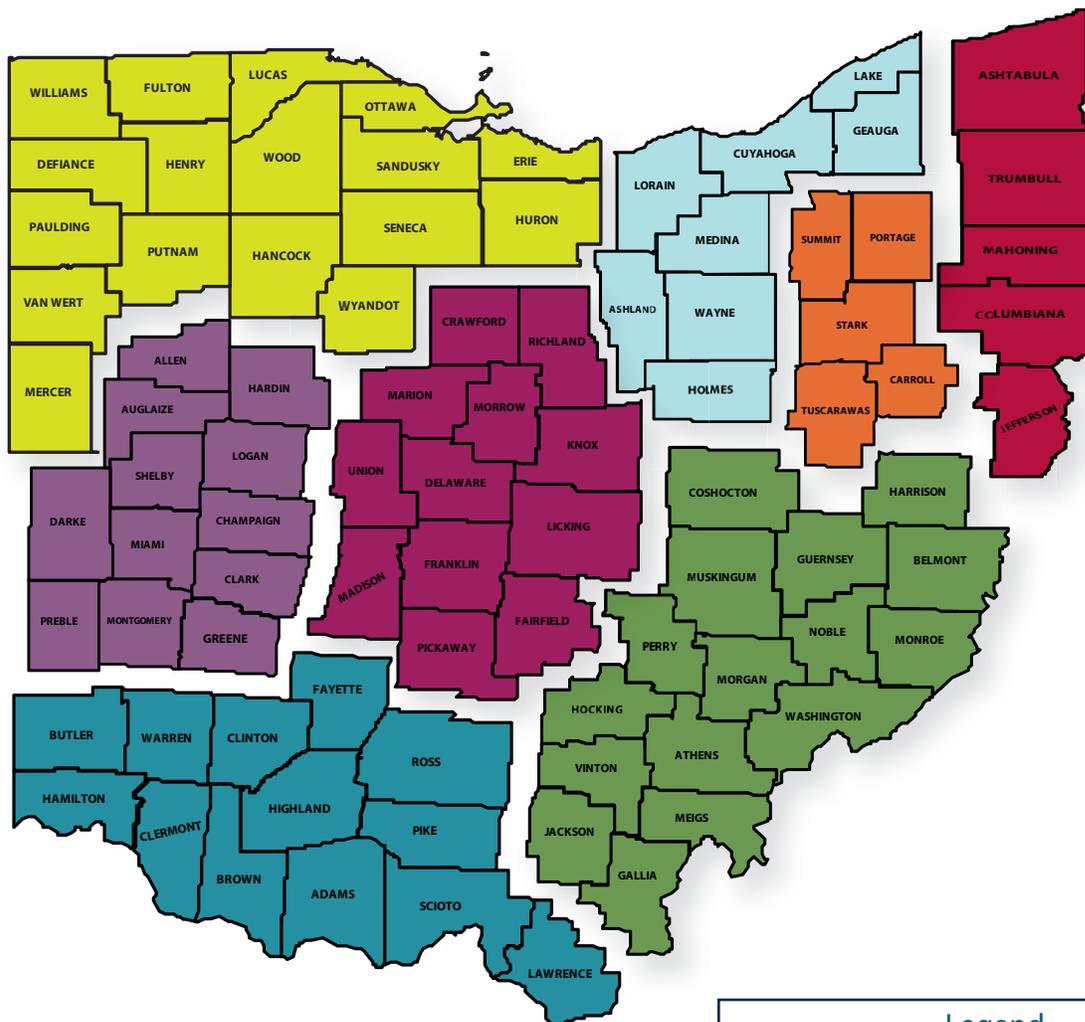


# Ohio Substance Abuse Monitoring Network

Surveillance of Drug Abuse Trends in the State of Ohio

June 2010-January 2011

John R. Kasich, Governor  
Orman Hall, Director



### Legend

- |                     |                   |
|---------------------|-------------------|
| Akron-Canton region | Columbus region   |
| Athens region       | Dayton region     |
| Cincinnati region   | Toledo region     |
| Cleveland region    | Youngstown region |

Ohio

Department of Alcohol &  
Drug Addiction Services

OSAM

Ohio Substance Abuse  
Monitoring Network

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## Ohio Substance Abuse Monitoring Network

### Surveillance of Drug Abuse Trends in the State of Ohio

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#### Toledo Region

- Increased availability of heroin and marijuana
- Heroin users primarily 16-25 year-old Whites with prescription opioid abuse history
- Heroin abuse increasing among Hispanics
- Many users have shifted from OxyContin® to heroin
- White powdered heroin and injection use most prevalent
- Marijuana availability increased due to resale of Michigan medical marijuana in Ohio

#### Cleveland Region

- Increased availability of heroin, prescription opioids and marijuana
- Heroin currently as available as crack cocaine
- Heroin becoming more popular among young people
- Brown powdered heroin and injection use most prevalent
- Marijuana more available today than ever before
- New ecstasy formulation containing MDPV (methylenedioxypyrovalerone) present

#### Dayton Region

- Increased availability of heroin, prescription opioids, Suboxone® and ecstasy
- Crack cocaine decreasing in availability as more users seek heroin
- More young people using heroin, starting at age 15 or 16
- Use of prescription opioids has gained popularity with those ages 12 and older
- Many users begin with prescription opioids before moving to heroin
- Brown/white powdered heroin and injection use most prevalent

#### Akron-Canton Region

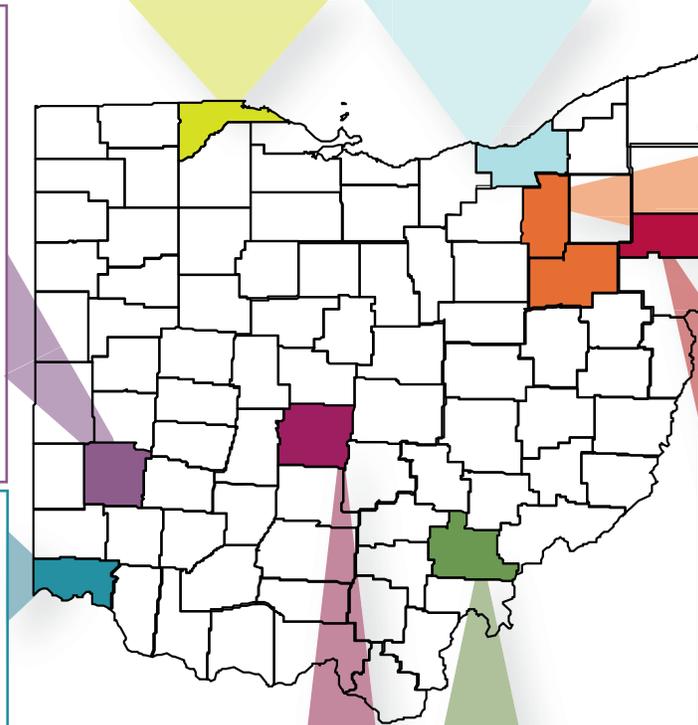
- Increased availability of heroin, prescription opioids and sedative-hypnotics
- Significant increase in heroin use in White teens and college students
- Brown powdered heroin and injection use most prevalent
- Dramatic increase in sedative-hypnotic use, called "hidden epidemic"
- One-pot method of cooking methamphetamine increasing
- Synthetic marijuana appears to be growing in popularity

#### Cincinnati Region

- Increased availability of heroin, prescription opioids and Suboxone®
- "Pill mills" believed to fuel prescription opioid epidemic in region
- First-time users of prescription opioids younger than first-time users of other drugs
- New heroin users likely to be 15-18 years old, White, and often female
- Brown/white powdered heroin and injection use most prevalent
- Suboxone®/Subutex® abuse emerging among those with no history of opioid abuse

#### Youngstown Region

- Increased availability of heroin, prescription opioids, sedative-hypnotics and ecstasy
- Heroin now as available as marijuana
- Users switching from crack cocaine and prescription opioids to heroin
- Heroin use increasing among teens to early 20's
- Brown powdered heroin and injection use most prevalent
- Popularity of over-the-counter (OTC) cough medicines increasing among young people



#### Columbus Region

- Increased availability of heroin, prescription opioids, Suboxone® and ecstasy
- Due to widespread use, heroin called the new "crack cocaine"
- 14-29 year olds coming into treatment for heroin addiction
- Users switching from prescription opioids to heroin, as heroin is cheaper
- Black tar heroin and injection use most prevalent
- Illicit use of Suboxone® is most common among heroin addicts using the drug to avoid withdrawal when heroin is not available

#### Athens Region

- Increased availability of heroin, prescription opioids and prescription stimulants
- Prescription stimulants popular among college students
- Heroin and prescription opioid use increasing among teens to early 20's
- Clinical assessments most often note heroin as primary drug of choice
- Black tar heroin and injection use most prevalent
- Popularity of over-the-counter (OTC) cough medicine increasing among young people

### **Executive Summary**

The Ohio Substance Abuse Monitoring (OSAM) Network consists of eight regional epidemiologists (REPIs) located in Akron-Canton, Athens, Cincinnati, Cleveland, Columbus, Dayton, Toledo and Youngstown. The OSAM Network conducts focus groups and individual qualitative interviews with treatment providers, active and recovering drug users, and law enforcement officials among others to produce epidemiological descriptions of local substance abuse trends. Qualitative findings are supplemented with available statistical data such as coroner's reports and crime laboratory data. Mass media sources such as local newspapers are also monitored for information related to substance abuse trends. Once integrated, these valuable sources provide the Ohio Department of Alcohol and Drug Addiction Services with a real-time method of providing accurate epidemiologic descriptions that policymakers need to plan appropriate prevention and intervention strategies.

This executive summary presents findings from the OSAM meeting held Jan. 27, 2011 in Columbus, Ohio. It is based upon qualitative data collected after June 2010 through January 2011 via focus group interviews. Participants were 327 active and recovering drug users recruited from alcohol and other drug treatment programs in each of OSAM's eight regions. Data triangulation was achieved through comparison of participant data to qualitative data collected from 100 community professionals (i.e., law enforcement, treatment providers and community outreach workers) via individual and focus group interviews, as well as to data surveyed from children's services, coroner's offices, family and juvenile courts, Bureau of Criminal Identification and Investigation (BCI&I), police and county crime labs. In addition to the aforementioned data sources, media outlets were queried for information regarding regional drug abuse for June 2010 through January 2011. OSAM research administrators in the Division of Planning, Outcomes and Research at ODADAS prepared regional reports and compiled this summary of major findings. Please refer to regional reports for more in-depth information on the drugs reported here.

### **Powdered Cocaine**

Powdered cocaine is moderately to highly available across all regions, and it is one of the most available street drugs in Akron-Canton and Cincinnati, with all other regions reporting powdered cocaine as not as available as crack cocaine. All regions report stable or decreasing availability.

Primary reasons for decreases in availability include increases in availability and use of heroin, as well as the decreasing quality of the drug. The most common participant quality score of powdered cocaine across regions varied from '3' to '7' with the most common score being '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Regional crime labs report that powdered cocaine is adulterated with many other substances, with levamisole (dewormer for livestock) the most frequently identified cutting agent. Current street jargon includes many names for powdered cocaine, with the most common names being "blow," "girl," "powder," "soft," "snow," "snow white" and "white girl." Participants note that while quality of powdered cocaine has decreased, prices have increased. Currently a gram of powdered cocaine sells for \$40 - \$100 across regions. The most common route of administration is intranasal inhalation (i.e., snorting), with increases in intravenous injection noted. Typical users are individuals with money/income, working professionals who tend to use recreationally, mostly young, White people in their 20's and 30's. The drug continues to be associated with the bar/club scene. Powdered cocaine is often used in combination with depressant drugs like alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics.

### **Crack Cocaine**

Crack cocaine is highly available across all regions, with the exception of Athens County, where reportedly users often need to travel to Columbus or Wheeling, W. Va for the drug. Crime labs in most regions report that the number of crack cocaine cases they process has remained stable, while labs in Akron-Canton, Columbus and Dayton report a decrease in the number of cases processed during the past six months. With the exception of Cleveland and Toledo, perceived quality of crack cocaine is low to moderate. Participants from all regions agreed that the quality of crack cocaine depends on factors like one's relationship with the dealer, the availability of high quality powdered cocaine; and generally, all agreed that the quality of crack cocaine has decreased. Participants report that crack cocaine is most often adulterated with other substances in order to "blow it up" (i.e., give crack cocaine more volume and mass). Regional crime labs report that crack cocaine is adulterated with many other substances, with levamisole (dewormer for livestock) the most frequently cited cutting agent. Current street jargon includes many names for crack cocaine, with the most common names being "butter," "hard," "melt," "rock" and "work." Prices for crack cocaine depend on the quantity desired; a "rock" of crack cocaine commonly sells for \$10 -

\$30, but can sell for as little as \$2. While crack cocaine users remain diverse, the drug appears to be more popular among people of lower socio-economic status. Treatment providers in Toledo report more women and people over 30 now presenting for crack cocaine addiction. The most common route of administration is smoking; however, intravenous injection of crack cocaine is reportedly more common than smoking in Dayton. Crack cocaine is often used in combination with alcohol, heroin, marijuana, prescription opioids, sedative-hypnotics and tobacco.

### **Heroin**

Heroin is highly available in all regions, and it is the most available street drug in the Youngstown region. Brown powdered is the most available type of heroin in Akron-Canton, Cleveland and Youngstown; white powdered heroin is most available in Dayton and Toledo; brown and white powdered heroin are most available in Cincinnati; and black tar heroin is most available in Columbus and Athens. During the last six months, availability has increased in every region. Many who became addicted to prescription opioids have progressed to heroin, citing pain doctors as bridges to heroin. Law enforcement cite increased heroin trafficking by Mexican drug cartels, many positing that heroin is an easy substitute for prescription opioids as reason for increased availability. Many dealers throughout the state have switched from selling crack cocaine to heroin because of increased demand for heroin. Many users attribute their switch from prescription opioids to heroin to the ease and affordability of obtaining heroin over prescription opioids. Users and professionals named the reformulation of OxyContin® OC into OxyContin® OP as a reason for the spike in heroin use statewide. Crime labs across regions report that current processed heroin is "very pure." Current street jargon includes many names for heroin, with the most common names being "boy" and "dog food." In every region heroin can be purchased for as little as \$10. There is a rapid progression from first heroin use to regular intravenous use of heroin, the most common mode of administration of heroin. Treatment providers report that young (teens through early 20's), suburban, White males with an opioid abuse history are those most often presenting for treatment for heroin abuse/dependence, with increases in admissions of females also noted. Overdose with heroin, particularly heroin with benzodiazepines, is reportedly very common. Other substances used in combination with heroin include alcohol, cocaine, marijuana and prescription opioids.

### **Prescription Opioids**

Prescription opioids are highly available in all regions. During the last six months, availability has remained high in Athens, Cincinnati and Toledo, while increasing in Akron-Canton, Cleveland, Columbus, Dayton and Youngstown. Increased availability is attributed to increased prescribing in hospitals, private physicians' offices and pain clinics. Opioids are most often obtained through prescription, with users reporting ease in feigning pain and knowing of physicians who write prescriptions for payment. Prescription opioids are also commonly obtained from street-level drug dealers, friends, family members, and others with prescriptions who either sell or trade opioids for other drugs. Across regions, participants report drug dealers sending people to Florida to obtain prescriptions for opioids to sell in Ohio. OxyContin®, Percocet® and Vicodin® are the most available for street purchase. Generally, prescription opioids sell for \$.50 - \$1.25 per milligram across regions. Reformulation of OxyContin® OC into OxyContin® OP has decreased the availability of OxyContin® OC while increasing its street value (\$1 - \$2 per milligram). OxyContin® OP, designed to have greater tamper-resistant factors, replaced OxyContin® OC in pharmacies. When users attempt to crush and dissolve OxyContin® OP, the pill breaks down into a gel instead of a powder, making intranasal inhalation (i.e., snorting) or intravenous injection extremely difficult. Although users report ways of manipulating the less desirable OxyContin® OP for snorting/injecting, OxyContin® OC remains the most desirable prescription opioid. Many in law enforcement are concerned that as OxyContin® OC becomes scarcer and more expensive, and users determine OxyContin® OP too difficult to abuse, more users will switch to heroin. Treatment providers refer to prescription opioids as, "the gateway drug to heroin." Users and professionals note an alarming increase in use among young people (teens through early 20's). The most common routes of administration are oral consumption and intranasal inhalation, with notable increases in intravenous injection recorded. Prescription opioids are commonly used in combination with alcohol, benzodiazepines (i.e., Xanax®) and marijuana.

### **Suboxone®**

Street availability of Suboxone® is high in all regions, with the exception of Akron-Canton and Toledo where it is moderately available. Street availability is generally perceived as increasing across regions. Those most currently using Suboxone® are prescribed it while in an alcohol and other drug rehabilitation facility or in conjunction with an outpatient treatment program. Those obtaining Suboxone®

on the street are primarily prescription opioid/heroin addicted who use the drug to fight withdrawal symptoms between highs. In terms of diversion, Suboxone® is often traded for another prescription opioid or heroin. Self-pay for prescribed Suboxone® is reportedly more costly than street purchase. A Suboxone® 8 mg dose most frequently sells for \$10 – \$20; users report paying more if they are “dope sick.” Although not common, there are widespread reports of users abusing Suboxone® as a means of getting high. Those who abuse are thought not to have an opioid abuse history. It is becoming common knowledge that standard drug screens do not screen for the presence of Suboxone®. Modes of abuse are swallowing as prescribed, crushing and then snorting/injecting (injection is rare but reportedly increasing). Suboxone® is not likely to be combined with other drug use, but when combined, it is used in conjunction with alcohol, benzodiazepines (i.e., Xanax®) and marijuana.

### **Sedative-Hypnotics**

Sedative-hypnotics are highly available in all regions, with the exception of Toledo where they are moderately available. In regions that experienced increased availability of sedative-hypnotics, Akron-Canton and Dayton, participants and professionals report that the increased availability represents “an outbreak” or “hidden epidemic.” The most commonly sold sedative-hypnotics across regions are Ativan®, Klonopin®, Valium® and Xanax®. Xanax®, the most popular sedative-hypnotic, often sells for \$1 – \$2.50 per milligram. The most common routes of administration are oral ingestion and intranasal inhalation (i.e., snorting), and most regions report a minority of users crushing and injecting the pills. Illicit use of these drugs appears to be a far-reaching problem that affects all age groups. However, it appears that women are more likely to abuse these drugs than men are, and sedative-hypnotic use is becoming more popular among young people as, “It mixes with binge drinking.” Combining sedative-hypnotics with alcohol intensifies the effects of the alcohol. In addition, sedative-hypnotics are widely desired for their ability to help modify the high of other drugs and are often used in combination with crack and powdered cocaine, ecstasy, heroin, marijuana and prescription opioids.

### **Marijuana**

Marijuana is highly available across all regions, and it is the most available drug in the state. Participants unanimously describe marijuana’s availability as extremely easy to get, available on nearly any street corner or available within minutes of a phone call to a dealer. Almost every region, with the exception of Athens and Dayton where availability

remains high, report increasing availability of marijuana, mostly due to the use of indoor hydroponic grow systems. Users in Toledo report marijuana availability increased due in part to medical marijuana in Michigan, which people are buying in Michigan and selling in Ohio. The most commonly cited names are “green,” “pot,” “reg,” “trees” and “weed.” Prices for marijuana depend on the quantity desired; a “blunt” (marijuana cigar) costs \$5 – \$10 for regular-grade marijuana and \$15 – \$30 for high-grade marijuana, and 1/8 ounce costs between \$15 – \$30 for regular-grade marijuana and between \$30 – \$75 for high-grade marijuana. The most common route of administration for this drug is smoking, with a minority of users baking it into food or using it with tea. Use of marijuana transcends age, gender and race. However, treatment providers in Akron-Canton report an increasing number of older adults using marijuana while respondents in Toledo report an increasing number of younger users becoming dependent on the drug, needing to begin and end each day with smoking a blunt. While marijuana is used in combination with any other drug a user may be using as, “marijuana goes with anything,” alcohol, crack and powdered cocaine are most often used when smoking the drug.

### **Methamphetamine**

Street availability of methamphetamine is relatively rare across all regions, and it has become even less available in Akron-Canton and Athens due to recent law enforcement efforts and the difficulty of obtaining necessary materials (i.e., having to sign for pseudoephedrine at pharmacies). Law enforcement in Akron-Canton report the one-pot method of cooking methamphetamine as becoming very popular, and participants in several regions report the formation of “buying groups” to gain access to higher amounts of precursor chemicals. Regional crime labs report an increase in the number of cases they process in Dayton, Cleveland, Columbus and Youngstown. Current street jargon includes many names for methamphetamine, with the most common names being “crank,” “crystal,” “glass,” “ice” and “meth.” Prices for methamphetamine depend on the quantity desired; a gram of powder costs \$50 – \$120, and a line of powdered methamphetamine can cost as little as \$10. The most common route of administration for this drug is smoking, but users frequently use the drug intravenously or through intranasal inhalation (i.e., snorting). Typical users are 18 to 40-year-old White males, primarily from rural counties. Participants in Toledo report the drug to be popular among bikers while participants in Columbus report methamphetamine to be popular in the gay community. Often methamphetamine is used in combination with alcohol, heroin and sedative-hypnotics.

### **Ecstasy**

Ecstasy is highly available in most regions of the state. The drug is most commonly available in dance clubs, nightclubs and strip clubs. Currently, ecstasy is not as in demand as other drugs in Cleveland and Toledo, as reportedly, users have, "moved on and there are other things they want to spend money on." Crime labs in Akron-Canton, Dayton and Youngstown report an increase in the number of ecstasy cases processed over the past six months. Current street jargon includes many names for ecstasy, with the most common names being "E," "molly" and "X." Prices for ecstasy depend on the quantity desired; a single tablet of ecstasy sells for \$3 – \$20, with price depending on a variety of factors including purity, size and imprinted image. Users report that ecstasy is often cut with other drugs, but admittedly, they have no way of being certain of what they are actually taking is ecstasy. Crime labs report that chemicals like MDMA (methylenedioxymethamphetamine), BZP (benzylpiperazine) and TFMPP (trifluoromethylphenylpiperazine) are commonly found in ecstasy. Law enforcement in Cleveland report that a new ecstasy formulation containing MDPV (methylenedioxypyrovalerone) is gaining popularity there. The most common route of administration for this drug is oral consumption, and participants report "parachuting" (i.e., crushing tablets in tissue and swallowing the tissue and its contents so as to avoid the taste of the crushed tablet). Typical users are teenagers and young adults, with first use starting as young as 15 years of age. Often ecstasy is used in combination with alcohol, erectile dysfunction drugs (e.g., Viagra®) and marijuana.

### **Other Drugs**

OSAM Network participants listed a variety of other drugs as being present in Ohio, but these drugs were not reported across all regions. Psilocybin mushrooms are moderately available in Akron-Canton, Cincinnati and Toledo, and highly available in Athens. Generally, mushrooms are seasonal, with availability higher during summer months. Regional crime labs report an increase in the number of psilocybin mushroom cases processed in Akron-Canton and Youngstown. Prices for mushrooms depend on the quantity desired; 1/8 ounce sells for \$25 – \$50. The most common route of administration is oral consumption, eating or drinking in a tea. While rare in Akron-Canton and Toledo, LSD (lysergic acid diethylamide) is moderately available in Athens, Cincinnati, Columbus and Youngstown. LSD is becoming more popular in the bar/club scene, and along with mushrooms, is reportedly becoming a drug of choice in Dayton. LSD is available in multiple forms to street-level

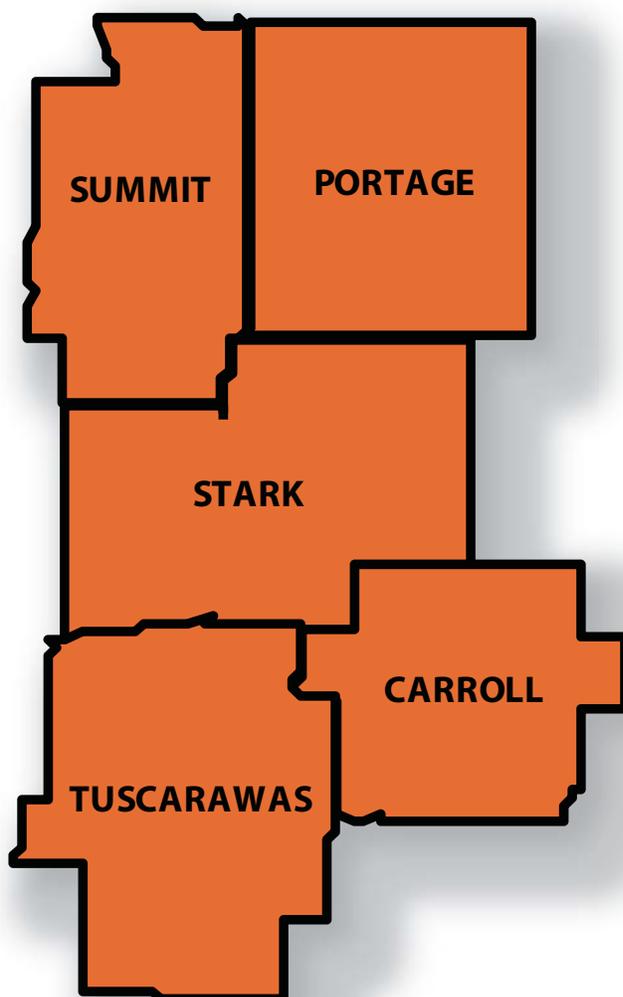
users including paper blots (\$5 – \$10 per hit), sugar cubes (\$7 – \$8 per cube) and gel tabs (\$5 – \$10 per tab). Synthetic marijuana (e.g., "K2", "Spice" and "Inferno") is highly available across the state in retail stores (i.e., gas stations and head shops). Sold as a form of incense, products like K2 produce a marijuana-like high and appear to be increasing in popularity with teenagers and college students. Synthetic marijuana is used recreationally and as a stand-in for marijuana when users need to pass a drug test. Prescription stimulants (e.g., Adderall® and Ritalin®) have moderate to high street availability in most regions of the state. College students use the drugs as study-aides, but users are getting high off the pills after crushing and snorting them. As reported in Dayton, Toledo and Youngstown, prescription cough medicines that contain codeine and over-the-counter cough medicines containing dextromethorphan (DXM), like Coricidin Cough and Cold® (a.k.a., "triple C's"), are popular among teenagers who have limited access to other drugs.

# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Akron-Canton Region

June 2010-January 2011

**John R. Kasich**, Governor  
**Orman Hall**, Director



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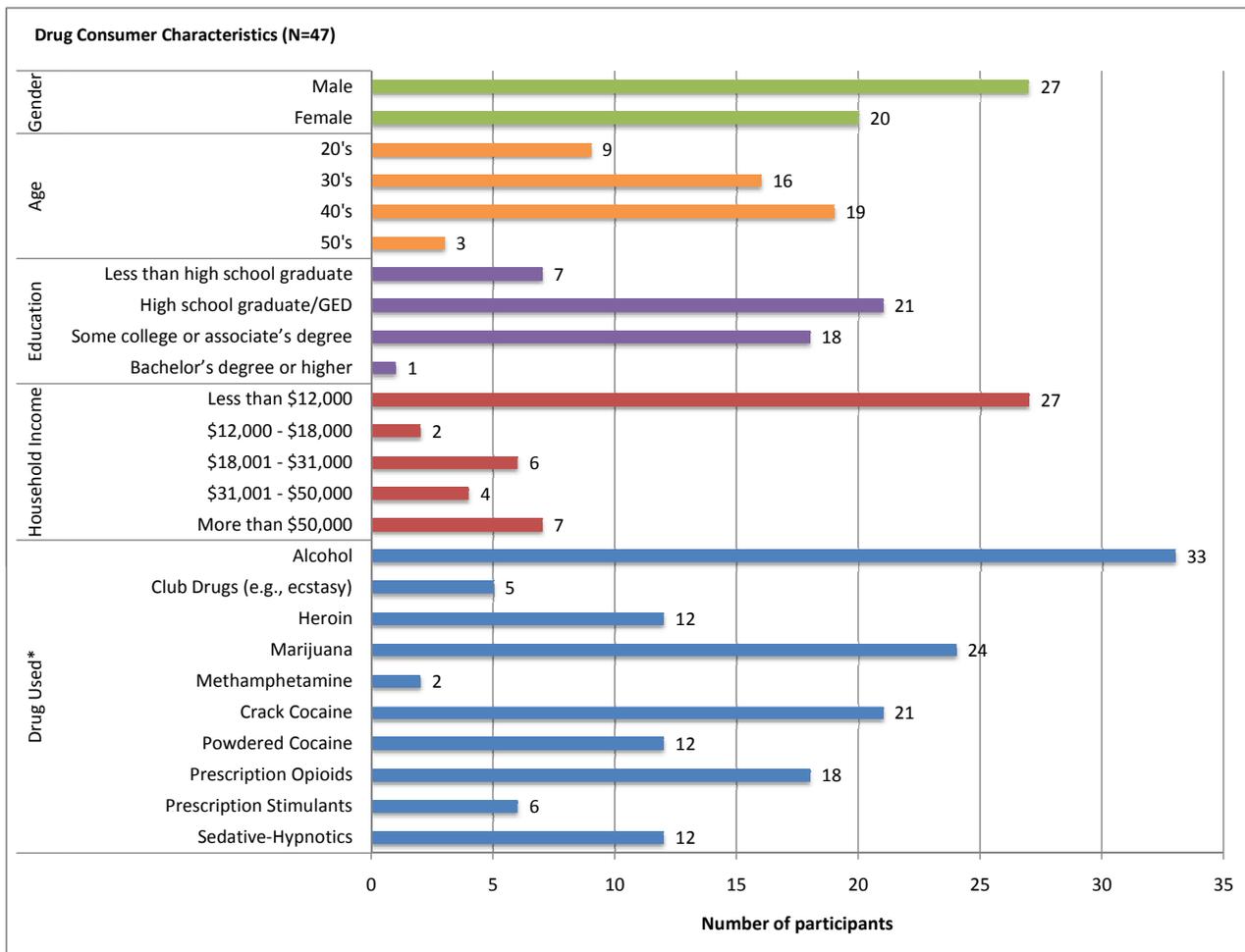
**R. Thomas Sherba**, PhD, MPH, LPCC  
Principal Investigator

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## Regional Profile

Indicator <sup>1</sup>	Ohio	Akron-Canton Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	1,199,077	47
Gender (Female), 2009	51.2%	51.5%	42.6%
Whites, 2009	82.2%	86.5%	68.1%
African Americans, 2009	11.9%	9.3%	23.4%
Hispanic or Latino Origin, 2009	2.8%	1.3%	2.1%
High school graduates, 2008	84.6%	89.3%	85.1%
Median household income, 2009	\$45,467	\$44,363	Less than \$12,000 <sup>2</sup>
Persons below poverty, 2009	15.1%	14.3%	25.5% <sup>3</sup>

Ohio and Akron-Canton statistics are derived from the U.S. Census Bureau<sup>1</sup>. Respondents reported income by selecting a category that best represented their household's approximate income for 2009<sup>2</sup>. Poverty status was unable to be determined for one respondent due to missing or insufficient income data<sup>3</sup>.



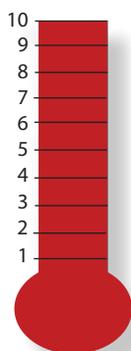
\*Some respondents reported multiple drugs of use over the past six months.

## Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Portage, Stark and Summit Counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (i.e., treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from Canton-Stark County Crime Lab, Stark County Coroner's Office and Summit County Juvenile Court. The aforementioned secondary data sources reported summary data for January to June 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the last six months (i.e., from time of interview through prior six months); thus, all current secondary data correspond to the current reporting period of participants. In addition to the aforementioned data sources, the following media outlets were queried for information regarding regional drug abuse for June 2010 through January 2011: *Akron-Beacon Journal*, *The Repository* and *The Plain Dealer*.

## Powdered Cocaine 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' (high availability, extremely easy to get), although participants in Portage County indicated lower availability, most often reporting availability as '5'. Overall, participants reported that availability depends on the quality of the cocaine desired; stating that "uncut" (i.e., pure) cocaine is rather difficult to find while "cut" (i.e., diluted) cocaine is highly available. Treatment and law enforcement professionals throughout the region echoed the above reported rates of availability. Participants generally identified no differences in the availability of powdered cocaine as opposed to six months ago. However, they reported that there have been brief periods over the past six months when powdered cocaine was more difficult to find, describing these periods as "droughts." Participants expressed the belief that there are times when law enforcement is more aggressive, in terms of incarcerating suppliers/dealers.



A participant commented, "During election time, people are afraid [of getting arrested]." Law enforcement concurred that there are periodic times when availability is affected by law enforcement, citing two major "take downs" in the past few months. *The Plain Dealer* reported in September that the Summit County Drug Unit found nine kilos of cocaine with an estimated street value of \$500,000 in an Akron home ([www.cleveland.com](http://www.cleveland.com); Sept. 1, 2010). In December, *The Repository* reported that FBI and local officials had arrested several men with believed ties to a drug ring that brought cocaine and marijuana to Stark County. These men allegedly were trying to establish Canton as a new cocaine distribution point ([www.CantonRep.com](http://www.CantonRep.com); Dec. 22, 2010). Participants also shared that much of the powdered cocaine that comes into the region is used to "cook" crack cocaine, making powdered cocaine less available on the streets, especially during "droughts." Participants also stated that when "good stuff" comes in, people are more likely to use it: "If using [powdered cocaine], they are not selling."

Participant quality scores of powdered cocaine varied from '2' to '9' with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that the quality of powdered cocaine is dependent on the following: who is selling it, how much one is willing to spend and from where the cocaine comes. A participant stated, "If [powdered cocaine comes] from the south, [i.e., Miami], it's as good as it ever was." Reportedly, higher quality cocaine can be found. A number of participants reported that cocaine today is "stepped down [cut] too much." A respondent stated, "If someone says they have pure cocaine, they are lying." Participants across the region disagreed in terms of whether the current quality of powdered cocaine has changed over the last six months. Again, a common theme was that quality is more a function of where one gets his/her cocaine, rather than any specific trend.

Current street jargon includes many names for powdered cocaine. Participants listed the following as common street names: "blow," "coke," "diddy," "girl," "num-num," "powder," "soft," "snort," "snow," "sweet lady," "t-shirts," "toot," "white girl," "yea," "yo" and "yo-yo." Participants reported a gram of powdered cocaine currently sells for \$40 – \$90, "depending on the quality or where it comes from;" 1/8 ounce, or "eight ball," sells for \$110 – \$175; an ounce sells for \$1,100 – \$1,300. It was also reported that a person could buy \$5 worth of powdered cocaine on the street. Law enforcement reported a kilo of powdered cocaine sells for \$25,000 – \$38,000. Participants reported that the most common method of using powdered cocaine

continues to be to intranasal inhalation (i.e., snorting), but a good number also reported injecting powdered cocaine. It was noted in one focus group in Portage County that *"IV [intravenous use] is getting more popular, period."* Reportedly, powdered cocaine is also being smoked. In addition, a few participants reported "gumming" or "chewing" cocaine.

While a profile of a typical user of powdered cocaine did not emerge in the data, respondents generally noted that consumers of powdered cocaine tend to be in their 20's or 30's. The consensus seems to be that *"all types of people"* (i.e., from all levels of economic status) use powdered cocaine. A participant stated, *"It [powdered cocaine] is no longer the White business man's drug."* While some providers noted an increase in powdered cocaine use among lower socioeconomic populations, it was widely reported that this form of cocaine is still primarily used by those who are employed and by individuals of mid- to upper-socioeconomic status. One perception is that because crack cocaine can be purchased more cheaply, crack cocaine is more popular with individuals from lower-socioeconomic status. As noted earlier, reportedly, there is an increase in cocaine use by injection. It was noted that individuals who inject tend to be male and individuals who are addicted to heroin. A provider noted that powdered cocaine use is popular among the gay population.

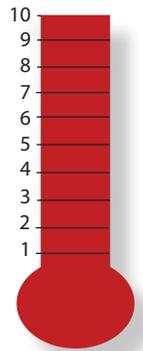
Powdered cocaine reportedly is used in combination with alcohol, benzodiazepines (i.e., Xanax®), ecstasy, heroin (a.k.a., "speedball" when "shot" together) and marijuana. Participants reported that the most popular drugs used with powdered cocaine are marijuana and alcohol, primarily because these substances tend to *"calm the rush"* or *"even it out."* The use of these substances is also perceived as allowing one to *"keep going"* (i.e., use over a longer period). A participant explained, *"Too high on cocaine, drink to come down. Too much alcohol, a line of coke [cocaine] lets you keep partying."* Another participant reported that marijuana *"extends the cocaine high."* Ecstasy and benzodiazepines (i.e., Xanax®) are also reportedly used for prolonging the "party." Heroin is used in combination with powdered cocaine, as participants said, *"It [heroin] intensifies the high of cocaine,"* as well as, *"balances the buzz."* Using powdered cocaine with all of the aforementioned is reportedly common.

### Crack Cocaine Current Trends

Crack cocaine is highly available in the region. Participants most frequently reported the drug's current availability as

'10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Across the region, it was widely reported that the popularity and use of crack cocaine is high. Participants reported, *"You can find it [crack cocaine] on every block; It is the most available drug there is; Every time you turn around, it's there."* The availability of crack cocaine was also reported as high by law enforcement and treatment providers, who ranked current availability as '10' and '8' respectively. However, while drug enforcement officers in Summit County noted that *"crack cocaine is available to whoever wants it,"* it was also reported that undercover officers have not bought as much as in the past, indicating, some officers believe, that selling on street corners is not as prevalent as it once had been. Drug enforcement officers in Stark County stated, *"We have some [crack cocaine], but it is not the upper echelon of drugs in this area."* Treatment providers across the region reported high availability of crack cocaine with the exception of Tuscarawas County. It was reported that users in that county generally travel to Canton to purchase crack cocaine. Nearly everyone interviewed said the availability of crack cocaine has remained about the same over the past six months while noting periods of fluctuation. A number of participants reported that there have been periods over the last six months when crack was more difficult to find. A participant commented, *"The 'big people' [suppliers/dealers] who couldn't find it [crack cocaine], they found it, sat on it for a minute, now they put it out. It's not a drought; it just controlling what's out there."* The Canton-Stark County Crime lab reported that the number of crack cocaine cases it processes has decreased.

Participant quality scores of crack cocaine varied across the region from '0' to '10' with the most common score being '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants noted that quality, much like availability, depends on *"who you are dealing with"* and fluctuated from time to time. The majority of participants reported a decrease in the quality of crack cocaine over the past six months, stating that there are times when *"you are not sure what you are getting."* Reasons for the decline in quality were summed up by participants as follows: high demand (i.e., dealers over cut/dilute crack cocaine in order to meet the demand); greediness on the part of dealers; and, *"More young kids are selling it [crack cocaine], breaking it down smaller."* Respondents reported that crack cocaine is typically "cut" (i.e., diluted) with baking soda and baking powder; the crime lab reported baking soda.



A participant commented that there were times when *"it [crack cocaine] would not even cook up,"* and others reported that they always *"re-cook"* their crack cocaine in order *"to make [crack cocaine] stronger."* Complaints about the quality of crack cocaine were echoed by treatment providers, who reported that clients have been complaining about the lower quality of crack cocaine during the past six months.

Current street jargon includes many names for crack cocaine. The most commonly cited names were *"boulders," "butter," "crack," "cream," "fruity pebbles," "girl," "hard," "scooby snacks"* and *"stones."* Participants reported a gram of crack cocaine currently sells for \$75; 1/8 ounce, or *"eight ball,"* sells for \$120 – \$130; an ounce sells for \$950 – \$1,100. Participants also consistently reported that crack cocaine sells for \$20 per *"rock"* (i.e., piece), with some reporting that crack cocaine can be bought for as little as \$2. Participants explained that crack cocaine is primarily smoked in a pipe or laced in a marijuana or tobacco cigarette. Crack cocaine can also be *"broken down"* (i.e., liquefied) and then injected, though this method is not as common. Participants reported breaking down crack cocaine with Sprite®, Kool Aid®, lemon juice or vinegar.

A profile of a typical user of crack cocaine did not emerge in the data. The consensus among treatment professionals and law enforcement alike was that many people from across all socioeconomic classes use the drug. As several treatment providers said, *"Drugs do not discriminate."* A minority of treatment providers though thought that individuals from lower-socioeconomic strata with less education, along with African-Americans, are more represented among crack cocaine users. It was posited by one group of providers in Portage County that the use of crack cocaine is on the rise again, due to the current economic situation (i.e., recession), as crack is now *"cheaper."* A Tuscarawas County provider noted that crack cocaine *"is more of a blue collar situation."*

Crack cocaine reportedly is used in combination with alcohol, heroin and marijuana in order to bring the user down from the high. Users reported that alcohol and marijuana *"balance [them] out,"* and a user cited that marijuana helped to *"get to sleep after using crack cocaine."* Participants reported that crack cocaine is used with heroin (i.e., *"speed balling"*) as this combination reportedly *"takes the edge off."* Other participants said they used heroin with crack cocaine because they enjoyed the *"roller coaster"* effect, going up (i.e., feeling high/euphoric) and coming down (i.e., feeling relaxed/mellow) which is achieved by using these substances together.

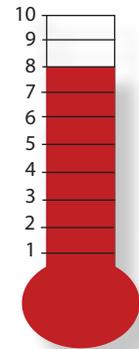
## Heroin

### Current Trends

Across the region, it was widely reported that the popularity and use of heroin is rising, although heroin's current availability rating was found to vary by county and by type. Participants in Summit County reported that heroin is fairly available, most frequently reporting the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Summit County law enforcement ranked the availability of heroin as an *"8 or 9"*.

These officers identified *"Mexican brown heroin"* as the most prevalent type of heroin found, noting a definite increase in the availability of brown powdered heroin in the county over the past one and a half years. Participants also reported brown powdered heroin as the most common type of heroin found in Summit County, describing it as tan, brown or yellowish in color, with respondents reporting *"The darker [in color], the better [quality]."* Brown powdered heroin was also described as *"chunky"* in texture and breaking apart easily. A participant described the drug as *"like brown cocaine"* and another as *"like cappuccino mix."* Black tar heroin, described by participants as *"like a resin"* in appearance, reportedly is also available in the county, *"found once in a while."* Law enforcement in Summit County described the current availability of black tar heroin as *"pretty fair,"* noting a significant arrest involving black tar heroin recently. Participants consistently reported that there has been an increase in the availability of heroin over the past six months, attributing this increase to the following: *"When they [law enforcement] put the meth [methamphetamine] labs out [of operation]; with cocaine being so hot right now [focus of law enforcement interdiction],"* and more dealers are selling heroin now as there is more money in the sale of it. In addition, a participant commented, *"In the past 12 years, OxyContin® was so popular, but now that oxy's [OxyContin®] are out of the picture [referring to change in formulation], people are turning to heroin."*

Participants in Stark County reported that heroin is *"pretty hard to find."* Participants commented that regular heroin users know how to find it, but otherwise, heroin is difficult to find. A participant stated, *"I don't hear about it [heroin] on the streets."* While the consensus among participants was that there has been no change in the availability of heroin



over the last six months, a participant stated, *"Heroin is even less available as more people are beginning to use it."* Canton-Stark County Crime Lab reported a decrease in the number of heroin cases it processes. Powdered heroin is described as brown or tan in color, sometimes green *"like topaz rocks,"* and reportedly, at times heroin comes in the form of small rocks. The crime lab reported processing tan or white powdered heroin. Participants reported that black tar heroin is very rare in Stark County, with some respondents stating that they have never seen it. In contradiction to participants, a treatment provider in Stark County reported that heroin is available, rating its availability as '8.' This provider cited heroin use as increasing, especially among young people (i.e., < 27), who are *"injecting it [heroin], right out of the gate."* The law enforcement focus group in Stark County also reported heroin use as increasing but still *"tougher to find"* on the streets. They ranked the availability of heroin as *"3 or 4"*. Similar to participants, law enforcement officers reported brown powdered heroin as the most common form of heroin in the area, with black tar heroin noted as being rather rare. An officer commented, *"I've seen it [black tar heroin] once in 14 years."* These officers attributed Mexican cartels for the increase in heroin trade in the region, positing that heroin is an easy substitute for prescription opioids.

Participants in Portage County ranked the availability of heroin as very high, most frequently reporting the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). These participants also noted that heroin's availability has increased *"quite a bit"* over the past year. They described powdered heroin as usually brown in color, though sometimes white, and even *"greenish blue"* and having a consistency ranging from *"chunky like sand"* to more *"powdery like brown sugar."* In terms of black tar heroin, this focus group reported black tar heroin as *"harder to come by"* in Portage County, most frequently rating the current availability of this type of heroin as '5'. The high availability of brown powdered heroin was similarly reported by treatment providers in the area, who reported a *"substantial spike"* in the number of individuals who reported heroin as their drug of choice over the past six months, a trend they cited as continuing. These providers noted that there is a significant increase in heroin abuse among younger individuals (i.e., < 29), as well as among college students. A provider stated that clients whose primary drug of choice is opioids now make up 80 percent of halfway house admissions. The availability of heroin was also ranked high by a treatment professional interviewed in Tuscarawas County who noted that during the past three years, admissions for heroin addiction have tripled.

Participant quality scores of heroin varied across the region from '5' to '7' with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The majority of participants reported no change in the quality of heroin over the past six months, although a few participants reported that heroin tends to be *"a little more cut"* as dealers *"stomp on it"* (i.e., add other substances to increase mass and volume) in order to make more money. Participants also noted that prescription opioids are used as a substitute for heroin by some users to avoid *"being dope sick"* (i.e., suffering withdrawal) when a user is not able to get heroin.

Current street jargon includes many names for heroin. The most commonly cited names were *"boy," "dog food," "H," "junk," "ron," "smack "* and *"white horse."* Participants consistently reported that heroin sells for \$20 a *"baggie"* (i.e., 1/10 gram), with some reporting that heroin can be bought for as little as \$10. It was generally identified (by both participants and law enforcement) that heroin sells for anywhere between \$120 and \$200 per gram. Users identified that 1/8 ounce or *"eight ball"* sells for \$350. While participants note that heroin can be injected, snorted, smoked, and *"chewed"* or *"eaten,"* the most common route of administration was intravenous injection (i.e., *"shooting"*), followed by intranasal inhalation (i.e., snorting), particularly among participants who *"do not like needles."*

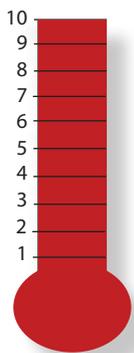
A profile of a typical user of heroin did not emerge in the data. The consensus among treatment professionals and law enforcement officers alike was that many people from across all socioeconomic classes use heroin, though some reported that users tend to be under the age of 30. Treatment professionals reported an increase in heroin use among younger people, with one focus group reporting that individuals entering treatment for heroin addiction seem to be *"much younger than a year or so ago."* A respondent also noted an increase in the number of pregnant heroin users involved in child welfare over the past six months while another respondent noted an increase in the number of women heroin users in general. Participants in the region concurred that heroin users *"can be anyone, from the top of the pile to the bottom,"* referring to socioeconomic status, but that heroin use is popular among young people (i.e., teens and college age individuals). Participants identified heroin use as most common among the following groups: White people, individuals coming out of the armed services, especially those who have served overseas, and individuals addicted to prescription opioids (i.e., OxyContin®) who are turning to heroin use as prescription opioids become increasingly more difficult to obtain and thus more expensive.

Heroin reportedly is used in combination with alcohol, benzodiazepines and marijuana in order to “increase the high.” These drugs are said to “intensify the nodding effect” of heroin and “enhance the buzz.” Some participants however reported that using other drugs, particularly alcohol, with heroin is dangerous as the potential for overdose is greater if a person has been drinking or using other depressant type drugs. It was also reported that motion sickness medication too increases “the buzz” (i.e., high) when used with heroin. Using cocaine and other stimulants with heroin reportedly causes a “see-saw effect,” some heroin users like to “balance the high” with stimulant type drugs.

## Prescription Opioids

### Current Trends

Prescription opioids are highly available in the region. Participants consistently reported street availability of these drugs as “very high.” Current availability ratings across the region for Dilaudid®, OxyContin®, Percocet® and Vicodin®



were most frequently reported as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Other prescription opioids highly available include codeine (‘10’), morphine (‘8’) and methadone (‘7’). The region’s treatment professionals and law enforcement officers reported high availability of OxyContin®, Percocet® and Vicodin® in particular. Law enforcement also noted fentanyl as available in the region, rating its availability as ‘3,’ and decreasing. A law enforcement officer

reported a few known overdoses involving fentanyl. The Stark County Coroner reported 16.6 percent of all deaths it investigated were drug related (i.e., had an illegal substance present or legal drug above the therapeutic range). Furthermore, the coroner reported prescription pain medication as the most common drug present in drug-related deaths; it was present in 60 percent of all drug-related deaths (this is an increase from 44 percent for the previous six-month reporting period). Treatment providers stated that prescription opioids are frequently prescribed; a treatment provider stated that some prescribers “hand them out like M&M’s® [i.e., candy].” Participants agreed that these medications are readily prescribed. These drugs also make it onto the street by people stealing medications from family members, individuals forging prescriptions, dealers bringing

prescription opioids in from other states (i.e., Florida) and Canada, as well as, individuals fraudulently purchasing prescription opioids on the Internet.

Overall, a number of participants identified a continued rise in the popularity of prescription opioid use, (save for OxyContin®) over the past six months. A participant commented that more people are “getting hip to the doctor scheme” (i.e., more people are feigning pain to acquire medication). A primary reason for this rise in popularity identified by participants is the nation’s current recession and individuals recognizing the profitability in selling prescription opioids. A participant reported, “Even the elderly are selling their medications.” Participants commented that individuals are having difficulty paying for their own prescriptions. Thus, if individuals were to sell some of their medication for profit, they would then be able afford all of their medications. A participant explained that one could purchase prescribed medication for \$35, and then sell the medication for \$250. Other users, however, cited that because of the popularity of prescription opioids, they are somewhat harder to find, and their price is increasing. Participants also commented that hospital emergency rooms are less inclined to prescribe them. In addition, pharmacies, per respondents, are “watching out.” Treatment professionals and law enforcement noted no change in the availability of prescription opioids, citing that availability has been rather consistent over the last six months. The Canton-Stark County Crime Lab reported increases in cases of codeine, Dilaudid® and OxyContin® that it processes.

Reportedly, many different types of prescription opioids (a.k.a., “candy,” “hillbilly heroin” and “jelly beans”) are currently sold on the region’s streets. In terms of current street names, participants explained that prescription opioids are often called by the first letter(s) of the drug’s name or by the color of the pill. In terms of current street prices, participants consistently reported that the price of prescription opioids depends on milligram and “on who you know.” 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® (\$5 – \$7 per pill), morphine (\$30 per patch), OxyContin® 80 mg (a.k.a., “oxy’s;” old formulation sells for \$1 per milligram; new formulation sells for \$50 – \$80), Percocet® (a.k.a., “perc’s” or “P’s;” \$2 – \$12 per pill), Ultram® (a.k.a., “trams”) and Vicodin® 500 mg (a.k.a., “vikes” or “V’s;” \$2 – \$5).

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 is oral consumption. In addition to swallowing pills, participants reported that pills are also crushed and injected. In addition, participants reported that some prescription opioids such as Dilaudid®, fentanyl, and OxyContin®, as well as higher dosed Percocet®, can be “cooked down” (i.e., liquefied) and injected. It was noted, however, that due to the newer formulation of OxyContin®, injecting it is less popular.

Descriptions of the typical user of prescription opioids varied. Some participants and treatment providers noted that prescription opioid users tend to be White. However, the consensus seemed to be that individuals from all ages, socioeconomic statuses and races are abusing these medications. Participants and professionals noted that addiction to prescription opioids often starts with legitimate treatment for pain management, then due to various reasons (e.g., loss of income, inability to access medical care, growth in tolerance), individuals develop an addiction, often turning to street purchase to self-medicate and supplement their addiction.

Many participants reported that alcohol, benzodiazepines and caffeine are often used in combination with prescription opioids as the addition of these drugs causes a user to “get higher, faster; maximizes the buzz.” A participant stated that marijuana is used with opioids simply because it “goes with everything.” Using prescription opioids with all of the aforementioned substances is reportedly very common.

### Suboxone®

#### Current Trends

Suboxone® is moderately available in the region. Participants most frequently reported the drug’s current availability as ‘5’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). There was participant disagreement regarding the street availability of Suboxone®. A participant commented, “People who have them [Suboxone®], need them,” asserting that street availability is rather low. Other users cited availability as rather high and increasing. Illicit users of Suboxone® were said to use Suboxone® because it is generally not tested for in many urine drug screens. However, participants questioned

whether Suboxone® could actually be abused. It was commonly held by users that “no one abuses Suboxone®. It’s a life saver.” Treatment providers, on the other hand, reported an increase in the abuse of Suboxone®. Reportedly, Suboxone® is primarily used to assist with managing withdrawal symptoms for individuals who are trying to quit heroin or who temporarily do not have access to heroin. A participant stated, “They [heroin addicts] use it [Suboxone®] when their dealer is out of town. They use to keep from getting sick.” Treatment providers in Portage and Tuscarawas Counties commented that the availability of Suboxone® seems to have increased over the past six months, citing that the street price of Suboxone® has reportedly decreased.

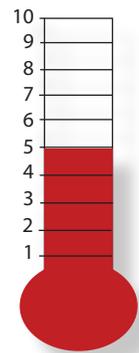
Participants reported that Suboxone® 8 mg generally sells for \$8 – \$15, but could sell for as high as \$25, depending on “how badly you need it.” Suboxone® is usually taken sublingually as prescribed. However, a few participants reported that some users snort and others inject the drug. Suboxone® is injected most often by intravenous heroin addicts as a means to manage withdrawal symptoms.

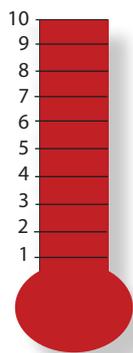
Reportedly, users rarely use Suboxone® in combination with other drugs, as one participant explained, Suboxone® “blocks out the effect of other drugs.” A participant commented that it is dangerous to take Suboxone® with other substances, especially benzodiazepines, stating, “It [combination of benzodiazepines and Suboxone®] will kill you.” Participants reported that Suboxone® is used with alcohol and marijuana, as combination with either drug “intensifies the high.”

### Sedative-Hypnotics

#### Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) are generally highly available in the region, although current availability ratings were found to vary by county and by type. Participants in Summit County reported the current availability of Xanax® as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Other forms of sedative-hypnotics are also widely available in Summit County: Ativan® (‘8’), Klonopin® (‘8’) and Valium® (‘8’). The response most often echoed by participants about the availability of sedative-





hypnotics was *“they are everywhere.”* A number of participants in Summit County reported that there has been a noted increase in the availability of sedative-hypnotics in the past six months, with a participant calling this increased availability *“an outbreak.”* Participants consistently attributed this increase to the following: *“They [sedative-hypnotics] are prescribed far more than ever.”* Participants in Stark County reported slightly less availability of these drugs than participants in Summit County, though one commented, *“They [sedative-hypnotics] are way easier to get than opiates.”* Stark County participants reported availability most often as: Ativan® (‘10’), Klonopin® (‘5’), Valium® (‘5’) and Xanax® (‘8’). In Portage County, participants reported availability most often as: Ativan® (‘10’), Klonopin® (‘10’), Valium® (‘6’) and Xanax® (‘8’). Participants in both Portage and Stark Counties reported no change in the availability of sedative-hypnotics over the past six months.

Treatment professionals and law enforcement throughout the region reported that there seems to have been a long-standing trend over the past number of years of increased prescribing of these medications, especially Ativan® and Xanax®. This event marked what one group of treatment providers called *“a hidden epidemic.”* Though few of their clientele are seeking treatment for sedative-hypnotic abuse, a provider commented that there is a perception that sedative-hypnotics are *“a safe alternative to harder drugs.”* It was noted by some treatment professionals that doctors seem *“less inclined to prescribe”* these medications, especially psychiatrists, who seem aware that these medications are being abused; therefore, many tend to use anti-depressant medications as an alternative. Still, the availability of these medications was most often ranked by treatment providers and law enforcement alike as ‘7’. Participants stated that these medications could be obtained from emergency rooms and physicians either by feigning illness, paying physicians for prescriptions (e.g., \$50), from other individuals to whom these medications were prescribed or through purchase over the Internet. Participants reported that sedative-hypnotics are easier than opioids to purchase on the Internet as they are *“not as controlled.”* In addition, participants stated that these drugs are often acquired by theft (i.e., *“robbing pharmacies”*). The Stark County Coroner reported 16.6 percent of all deaths it investigated were drug related (i.e.,

had an illegal substance present or legal drug above the therapeutic range). Furthermore, the coroner reported prescription sedative hypnotics as a common drug present in drug-related deaths; it was present in 57.1 percent of all drug-related deaths (this is an increase from 44 percent for the previous six-month reporting period).

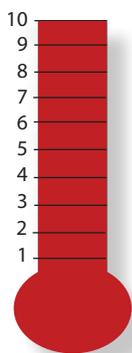
Reportedly, many different kinds of sedative-hypnotics are currently sold on the region’s streets. In terms of current street names, participants explained that sedative-hypnotics are often named by the color of the pill. In terms of current street prices, participants consistently stated that the price of sedative-hypnotics depends on milligram. 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 – \$2 per pill), Klonopin® (a.k.a., *“K-pins”* or *“pins”*; \$2 – 3 per pill), Xanax® 1 mg (a.k.a., *“bars,” “candy,” “footballs,” “mind erasers,” “xani’s”* and *“xanibars;”* \$1), Xanax® 4 mg (\$4 – \$7), and Valium® 5 mg (\$1 – \$2).

While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, generally, the most common route of administration is oral consumption. In addition to swallowing, participants reported that pills are commonly crushed and snorted. Also, participants commented that they have heard of individuals administering these drugs via injection.

Descriptions of the typical user of sedative-hypnotics varied. Some participants noted that sedative-hypnotic users tend to be younger women in their 20’s. Other participants identified that some young people *“who smoke a lot of weed [marijuana]”* lace their *“joints”* (i.e., marijuana cigarettes) with crushed sedative-hypnotic pills. Participants also mentioned that individuals on methadone maintenance tend to use sedative-hypnotics, one stating, *“I could pull into the parking lot of a meth [methadone] clinic right now ... 90 percent of them [clinic clients] are looking for benzo’s [benzodiazepines].”* On the other hand, most treatment providers believed that individuals from all ages, socioeconomic statuses and races are abusing these medications. The few providers who disagreed thought that older women are more likely to use/abuse sedative-hypnotics.

Reportedly, sedative-hypnotics are used in combination with alcohol, cocaine, ecstasy, heroin, marijuana and prescription opioids. Many participants reported that alcohol used in combination with a sedative-hypnotic intensifies the effect of the alcohol and hence takes less alcohol to achieve intoxication. A participant stated, *"I can use 12 beers or a xanibar [Xanax®] and two beers, it's the same thing."* Many users said that taking sedative-hypnotics with alcohol causes them to blackout. A number of participants also reported that it is common to use sedative-hypnotics with cocaine, as sedative-hypnotics assist with coming down from cocaine use. A participant reported liking the *"teeter/totter effect"* of cocaine and sedatives-hypnotics. Taking sedative-hypnotics with heroin is believed to intensify the effects of each, and it is said that the effect of Xanax® lasts longer when used with opioids. Ecstasy is said to increase the *"physical sensation, the 'body buzz'"* associated with sedative-hypnotics. It is widely held that using opioids with any of the aforementioned drugs is common.

### Marijuana Current Trends



Marijuana is highly available in the region. Respondents almost unanimously reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants thought the availability of marijuana was ubiquitous, and all agreed with comments like, *"It's everywhere; always around,"* and the availability is *"very, very high."* Law enforcement echoed participants when they described availability as *"off the hook"* and *"the easiest drug to find."*

Treatment providers also strongly agreed. While participants reported that the overall availability has not changed over the previous six months, they noted that there are periods when marijuana is more difficult to find, described by participants as *"droughts"*. Participants cited that typically for a few months before November elections, as well as for weeks prior to the Pro Football Hall of Fame inductions in August, it is more difficult to find marijuana. A participant stated, *"It is very dry, a lot of garbage [low quality marijuana] out there,"* implying that law enforcement targets substance abuse offenders during these times. Providers reported an increase over the past six months in the availability of higher, more potent grades of marijuana such as hydroponically grown marijuana (a.k.a., *"hydro"*).

Participants reported that the quality of marijuana varied from '3' to '10' with the most common score being '6' on a scale of '0' (poor quality, *"garbage"*) to '10' (high quality). Several participants explained that the quality of marijuana depends on whether the user buys *"commercial weed"* (i.e., low to mid-grade marijuana; usually ranked '3' – '6' in terms of quality) or higher-grade marijuana (i.e., hydroponically grown; usually ranked '8' – '10' in terms of quality). Some participants commented that the overall trend is that the potency of marijuana is increasing. A participant said, *"Every three or five years, a new grade of marijuana is developed with higher potency, based on cloning and mutation."*

Current street jargon includes numerous names for marijuana. The most commonly cited name was *"weed"*. Participants listed the following as other common street names: *"bank," "bud," "Christmas tree," "haze," "hydro," "kill," "kind," "kush," "pot," "purple haze," "reefer," "reg"* and *"trees."* The price of marijuana depends largely on the quality desired. Law enforcement reported that commercial (i.e., mid-grade) marijuana currently sells for \$1,100 – \$1,400 a pound. Participants reported that they could buy commercial-grade marijuana in many different quantities: a *"blunt"* (i.e., marijuana cigar) sells for \$5 – \$10; 1/4 ounce sells for \$25 – \$40; an ounce sells for \$75 – \$100. Higher grades of marijuana (i.e., *"hydro"* and *"kush"*) reportedly sell for \$40 for an 1/8 ounce; \$75 – \$100 for a 1/4 ounce; and \$250 – \$300 for an ounce. While there were a few reported ways of consuming marijuana, the most common route of administration is smoking. Some users reported eating marijuana in food (e.g., in brownies, spaghetti sauce, meat loaf, butter) or putting it in tea. Participants reported that eating marijuana produces *"a different high, a higher 'body buzz' ... not so much as a head buzz"* as when smoked.

When asked to describe the typical user of marijuana, participants were unable to identify specific characteristics. *"Everyone uses,"* was a typical response from participants. Patterns of use were different for age cohorts; participants noted, *"The older generation tends to bake [with marijuana],"* and the younger ones *"risk by mixing it [marijuana] with other drugs."* Treatment providers likewise reported that marijuana use is widespread across all population groups, though there seems to be an increase in use among older adults. A treatment provider said, *"Dope boys are making their rounds [selling marijuana] at the senior citizens' centers."* Another group of treatment providers noted an increase in marijuana use among adolescents in the region. According to Summit County Juvenile Court data, 41 percent of all

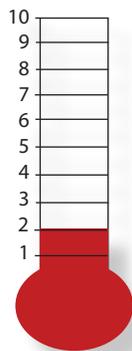
juveniles who were subjected to a court administered drug test for cannabis produced a positive result for the presence of cannabis.

A Stark County provider noted that the practice of using marijuana with cocaine is coming back: *"We are seeing the old 90's thing come back, everyone smoking primos [marijuana cigarettes laced with cocaine]. It's coming back, especially among African-Americans."* Marijuana is also reportedly used in combination with alcohol, formaldehyde and PCP (phencyclidine; a.k.a., "wet"), said to intensify the high.

### Methamphetamine Current Trends

Participants reported that methamphetamine is relatively rare in the region. Participants most often reported the drug's current availability as '2' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). When asked whether the powder form or the crystal form was more available, only a few participants were aware of the two forms of methamphetamine. These users reported that both forms are equally unavailable. However, treatment professionals and law enforcement had differing views regarding the availability of methamphetamine. Summit County professionals most often reported availability as '10' and Stark County law enforcement reported availability as '2' or '3' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Many participants and professionals alike, indicated that methamphetamine is less available, due to recent law enforcement efforts and the difficulty of obtaining necessary materials (i.e., having to sign for pseudoephedrine at pharmacies). As a participant noted, *"They [government] put the kibosh on it [methamphetamine production] ... regulated all the ingredients."* Other participants agreed, *"Drug stores make it more difficult to get the chemicals ... are monitoring the substances."*

Despite the decrease in availability, professionals and law enforcement reported an increasing popularity in individuals making their own methamphetamine: *"People are making it [methamphetamine] themselves, in their own homes or [setting up manufacturing] labs for personal use."* Summit County law enforcement reported a 200 to 300 percent increase over the



past year in the "one pot method" (i.e., methamphetamine production in a single sealed container, which is fast and portable; a.k.a., "shake and bake"). Media outlets across the region (i.e., *The Repository*, the *Beacon Journal* and Ohio News Network) have reported on methamphetamine lab arrests over this current reporting period (in Portage, Stark and Summit Counties).

Participants gave contradictory information regarding the quality of methamphetamine, quality ratings varied greatly from '1' to '10' on a scale of '0' (poor quality, 'garbage') to '10' (high quality). A user reported, *"I snorted it [methamphetamine] a few times, never felt it."* Another user stated, *"One line [of methamphetamine] keeps you up for the whole day ... can't stand the shit."*

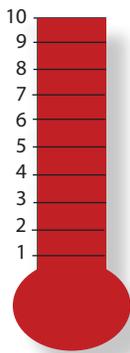
Current street jargon includes a number of names for methamphetamine, including: "crank," "crystal," "glass," "ice," "meth," "speed," "sugar," "that girl" and "the lady". Participants reported a gram of powdered methamphetamine sells for \$100 – \$120; 1/8 ounce of powdered methamphetamine sells for \$180; a gram of crystal methamphetamine sells for \$150. Smaller quantities of methamphetamine are reportedly also available. As a user said, *"Like crack [cocaine], it depends on what you got [amount of money available for purchase]."* A participant reported that methamphetamine sells for as little as \$10 *"for a couple of hits,"* or *"\$10 for a line."* The most common routes of administration for this drug include smoking, snorting and injecting. A participant stated, *"Mixing it [methamphetamine] with coffee is very popular."*

Participants and professionals alike reported that the typical user of methamphetamine was almost exclusively White, between the ages of 17 and 35, and of lower socioeconomic status. A participant noted, *"I have never met a Black person to use meth [methamphetamine]."* Different participants reported that methamphetamine use is common among exotic dancers, factory workers and truck drivers. Another participant commented that methamphetamine use is *"common in the gay community. Every gay bar I've been to ... they've all been high on it [methamphetamine]. The one guy [methamphetamine dealer] I know, that's who he sells it to."*

### Ecstasy Current Trends

Ecstasy [methylenedioxymethamphetamine (MDMA)] is highly available in the region according to participants

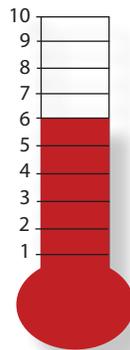
and moderately available according to professionals. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Professionals most often reported the drug's current availability as '6' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Professionals across the region reported that the use of ecstasy seems to be decreasing, with one focus group in Summit County noting, "You never hear about it [ecstasy] anymore." Summit County law enforcement noted that there appears to be "periodic cycles" by which availability "comes and goes." Canton-Stark County Crime Lab reported an increase in the number of ecstasy cases it processes.



Participants reported that there are various types, colors and doses of ecstasy pills. Some street names for the various types include: "blue girls," "footballs," "Obama" and "scooby doo's." Prices for the different pills vary based on dosage. Participants reported that some pills sell for as little as \$2 while higher dosed pills, (i.e., "blue girls") cost up to \$25. The quality of ecstasy varies, with some users reporting that quality is decreasing. Participants stated, "There is more speed [methamphetamine] than MDMA in them [ecstasy pills]; You can get some duds." The only reported method of administration is oral consumption.

**Hallucinogens**  
**Current Trends**

Participants provided varying opinions regarding the availability and popularity of hallucinogens (i.e., psilocybin mushrooms), some reported moderate popularity, and others reported minimal use in the past few years. Participants most often reported psilocybin mushroom's current availability as '6' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Users reported that availability is higher during summer months. A participant reported that in the summertime "mushrooms are just a pasture away." Stark County law enforcement indicated that while the



availability of mushrooms has not been very high lately, they have noted some increase in its use, citing that it is rather easy to cultivate. Canton-Stark County Crime Lab reported an increase in the number of psilocybin mushroom cases it processes. LSD (lysergic acid diethylamide) reportedly is much harder to find than mushrooms. A participant stated, "I haven't seen it [LSD] in ten years."

Participants reported an 1/8 ounce of psilocybin mushrooms currently sells for \$30 – \$50. Stark County law enforcement noted that mushrooms sell for \$100 for 10 grams. The most commonly reported method of administration is oral consumption, eating, or mixing with tea.

**Other Drugs**

Participants and professionals listed a variety of other drugs as being present in the region, but these drugs were not mentioned by the majority of people interviewed. Several participants and professionals reported the recent introduction of synthetic marijuana (i.e., K2) which is available in retail stores (i.e., gas stations and head shops) and sold as a form of incense. K2 is believed to be increasing in popularity. Participants and treatment providers reported that the "incense" produces a marijuana-like high when smoked. Providers expressed concern that individuals (i.e., adolescents) do not know what they are inhaling with this product. Participants reported that individuals in alcohol and drug treatment programs are using K2, as typical urine drug screens do not detect its use.

**Conclusion**

Powdered cocaine, crack cocaine, prescription opioids, sedative-hypnotics, marijuana and ecstasy are the most available drugs throughout the Akron-Canton region. Noted increases in availability over the previous six months exist for heroin (i.e., brown powdered), prescription opioids and sedative-hypnotics. In particular, the popularity and use of heroin has significantly increased among younger individuals, especially White teens and college students, who now comprise a larger number of new treatment admissions across the region. Law enforcement attribute Mexican cartels for the increase in heroin trade. Heroin is an easy substitute for prescription opioids (i.e., OxyContin® OC, which has become increasingly unavailable and more expensive due to its recent reformulation). Alarming, the most common

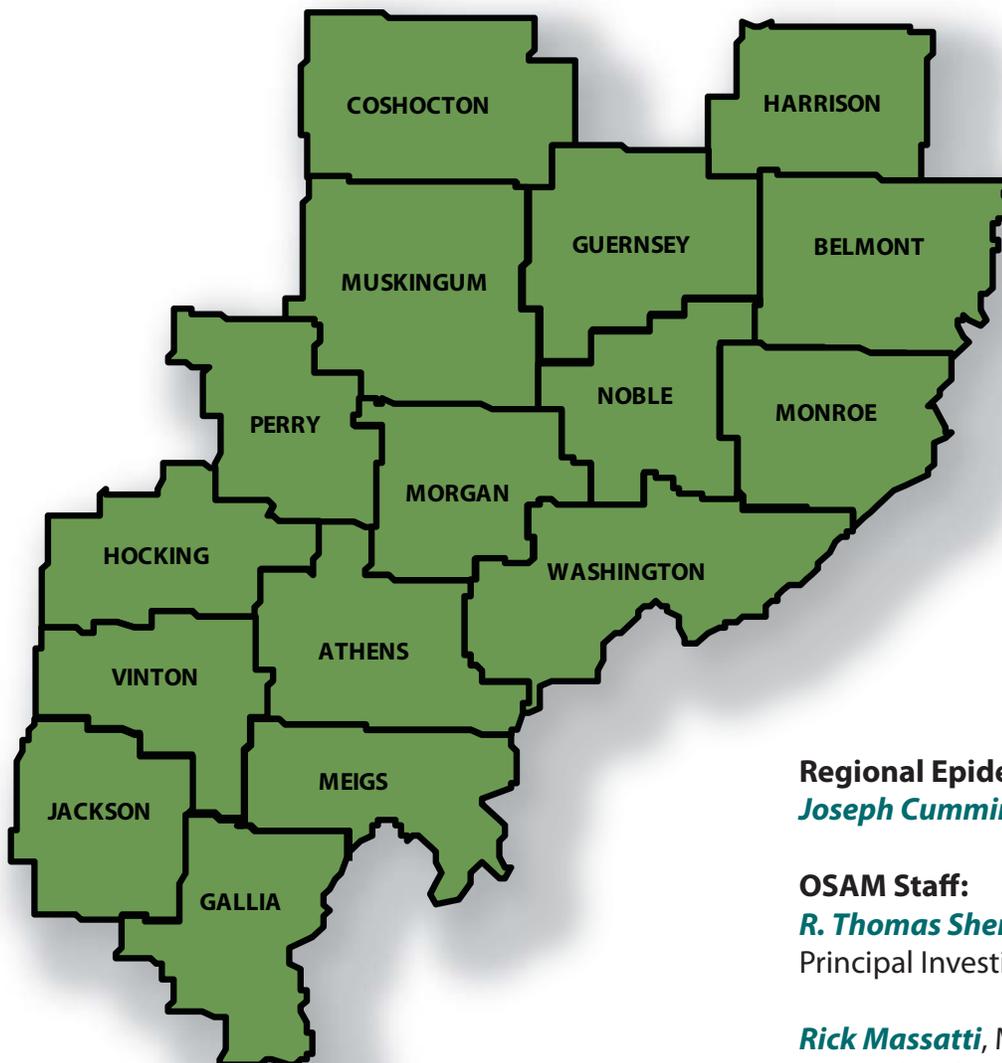
route of heroin administration is intravenous injection. In tandem with heroin, prescription opioids continue to rise in terms of popularity and use, with Dilaudid®, OxyContin®, Opana® and Percocet® leading the way as the most available and most popular. Sedative-hypnotics, especially Ativan®, Klonopin®, Valium® and Xanax®, have also dramatically increased in availability, leading some to posit that the region is experiencing a “hidden epidemic” or “outbreak” of sedative-hypnotic abuse. These drugs, believed to be “a safe alternative to harder drugs,” are widely desired for their ability to help modify the high of other drugs. Alcohol used in combination with a sedative-hypnotic intensifies the effect of the alcohol, and hence less alcohol is needed to achieve intoxication. Methamphetamine continues to be relatively rare in the region, but law enforcement report a dramatic increase in the one-pot method of cooking methamphetamine. Synthetic marijuana (i.e., K2) appears to be growing in popularity, used recreationally and by those in alcohol and drug treatment who wish to continue getting high while being able to pass drug urine screens.

# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Athens Region

June 2010-January 2011

**John R. Kasich**, Governor  
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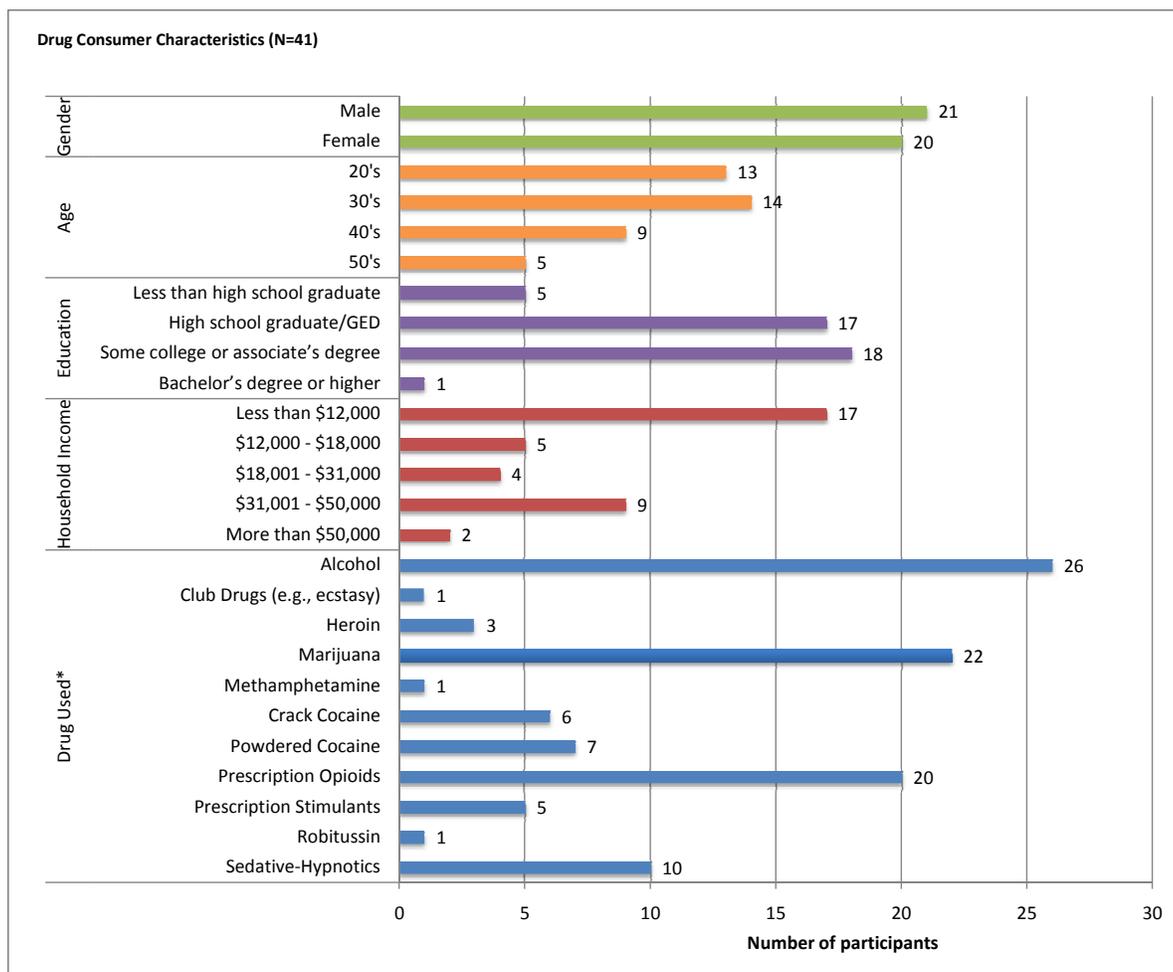
### Regional Profile

Indicator <sup>1</sup>	Ohio	Athens Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	575,241	41
Gender (Female), 2009	51.2%	50.8%	48.8%
Whites, 2009	82.2%	94.7%	87.8%
African Americans, 2009	11.9%	2.4%	7.3%
Hispanic or Latino Origin, 2009	2.8%	0.8%	0.0%
High school graduates, 2008	84.6%	90.4%	87.8%
Median household income, 2009	\$45,467	\$36,652	\$12,000-\$18,000 <sup>2</sup>
Persons below poverty, 2009	15.1%	19.2%	37.8% <sup>3</sup>

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

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

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



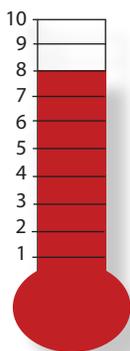
\*Some respondents reported multiple drugs of use over the past six months.

## Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Athens, Belmont, Meigs and Muskingum Counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (i.e., treatment providers) via focus group interviews, as well as to data surveyed from Athens County Children's Services and the Bureau of Criminal Identification and Investigation (BCI&I) London Office, which serves central and southern Ohio. The aforementioned secondary data sources reported summary data for January to June 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the last six months (i.e., from time of interview through prior six months); thus, all current secondary data correspond to the current reporting period of participants. In addition to the aforementioned data sources, the following media outlets were queried for information regarding regional drug abuse for June 2010 through January 2011: *Athens NEWS*, *Marietta Times* and *The Post* (newspaper of Ohio University).

## Powdered Cocaine Current Trends

Powdered cocaine ranges from difficult to find to moderately available in the region. Participants in Meigs County most often reported the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get), while participants in Athens and Belmont Counties most often reported current availability as '3' and '4', respectively. Meanwhile, treatment providers across the region reported that powdered cocaine is moderately to highly available, most often reporting current availability as '8'. Treatment providers across the region indicated that they believed availability of powdered cocaine has remained the same over the course of the last six months. While many participants also reported the availability of powdered cocaine to be the same, some (especially in Athens and Belmont Counties) indicated that powdered cocaine has become less available over the last six months. A participant commented, *"It's gone down over the past five years [availability of powdered cocaine],*



*it use to be about a '9' [availability rating], now it is a '5' or '6.'" Other participants noted that many users are turning to other drugs. A participant said, "People are changing their drug of choice, to pills. Adderall® is cheaper, easier to get, and has the same effect." Even those participants who reported no change in availability mentioned that there is monthly fluctuation in availability: "Middle to end of the month, it [availability of powdered cocaine], is down. It's how it is transported, many have no money." BCI&I London crime lab reported that the number of powdered cocaine cases it processes has remained stable. Participant quality scores of powdered cocaine varied from '1' to '9' with the most common score being '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality). A participant explained, "It's [powdered cocaine] pretty stomped down [diluted] by the time it gets here. Stuff here has very little actual cocaine in it." Several participants thought that cocaine is "cut" (i.e., diluted) more in the region as the result of economic factors. A participant stated, "Poor economy, everyone is cutting it [powdered cocaine]." Another participant thought that the dealers who sold the least adulterated drugs are gone: "All the good dealers are in jail. There are no good drugs around here." Participants reported that powdered cocaine is most often cut with other substances. Substances cited as commonly used to cut powdered cocaine include: baby aspirin, baby laxative, baby powder, baking soda, creatine, "headache powder," Vicodin®/Percocet®, vitamin B-12 and "speed you buy at the gas station." According to BCI&I London crime lab, levamisole (dewormer for livestock) is the cutting agent in 90 percent of cases, but other agents like boric acid (found in antiseptics and insecticides), inositol (vitamin-like health supplement), as well as, the following local anesthetics are also used to cut powdered cocaine: benzocaine, lidocaine, procaine and tropacaine.*

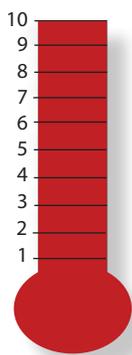
Current street jargon includes many names for powdered cocaine. The most commonly cited names were "blow," "snow" and "white girl." Participants listed the following as other common street names: "bitch," "dust," "powder," "snow," "soft," "sugar booger," "white candy," "white" and "yay." Participants reported a gram of powdered cocaine currently ranges in price from \$45 – \$100, with the most commonly reported price being \$100; 1/8 ounce, or "eight ball," sells for \$150 – \$250, with the most commonly reported price being \$200. While there were a few reported ways of consuming powdered cocaine, the most common route of administration is intranasal inhalation (i.e., snorting). Some users reported that they "cook it [powdered cocaine] down to make crack [cocaine]," while others reported that they "free-base" (i.e.,

heat the powder, inhaling the fumes). Participants reported, *"Only a few shoot it [inject powdered cocaine]."* A participant reported, *"Most of the time people who buy [powdered] cocaine are doing so to cook it [make crack cocaine]."*

There was a lack of consensus among participants as to the characteristics of typical users of powdered cocaine. Some participants cited that powdered cocaine continues to be used by individuals with money/incomes. A participant explained, *"People who work buy it [powdered cocaine] to enhance their work. There aren't many unemployed [powdered] cocaine users."* However, other participants disagreed, *"Money doesn't matter. It's how you hustle. Anyone who wants to use it [powdered cocaine] will use."* Treatment providers did not present a typical user profile for powdered cocaine, but they agreed that users tend to be individuals in their mid- to late-20's or older.

In addition to alcohol, powdered cocaine is reportedly used in combination with marijuana and sedative-hypnotics. Participants, who reported using alcohol with powdered cocaine, stated they did so to, *"stay out all night and drink."* Other participants reported using powdered cocaine with alcohol because it *"mellows you out, lessens the nervousness."* Marijuana is reportedly used to create a different effect. A participant said he would, *"... lace it [marijuana] with powdered cocaine, [and] get a 'hybrid high'."* Another participant reported using marijuana with powdered cocaine because it helps *"to get your appetite back."*

### Crack Cocaine Current Trends



Crack cocaine is highly available in the region, with the exception of Athens County. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). In the City of Athens, participants most often reported current availability as '4', where participants reported that users need to drive to Columbus to obtain crack cocaine. A participant commented on the demand for crack cocaine in Athens: *"When [crack cocaine] gets here, it goes fast."* However, in other parts of the region, participants reported availability of crack cocaine as, *"off the charts."* Treatment providers ranked

the availability of crack cocaine as high, most commonly reporting availability as '9'. Participants and treatment professionals agreed that the availability of crack cocaine has not changed over the course of the last six months. However, participants in Muskingum County reported an increase, at least in the use of crack cocaine. A participant attributed the increase in crack cocaine use to the lack of other drugs: *"There have been so many marijuana raids and drug busts, crack [cocaine use] has gone up."* Another participant said that crack cocaine has become more popular because it is more powerful than other drugs: *"You don't get high on some of the drugs, so you switch to crack [cocaine]."* BCI&I London crime lab reported that the number of crack cocaine cases it processes has remained stable.

Participant quality scores of crack cocaine varied from '2' to '9' with the most common score being '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants noted that the quality of crack cocaine is dependent on who is selling it and/or who is cooking it. Overall, it was reported that the quality of crack cocaine has decreased. A participant reported that crack cocaine is, *"not good quality, compared to what it [quality of crack cocaine] used to be, probably because the quality of [powdered] cocaine sucks."* Another participant echoed the same sentiment, *"I notice a difference. Dealers are trying to make money, so they cut it [dilute crack cocaine]. I cook it myself."* However, other participants disagreed, and said the *"good stuff"* can be found from "established dealers." A participant with experience selling crack cocaine said, *"If you sell good stuff, customers will be back."* According to BCI&I London crime lab, levasimole (dewormer for livestock) is used as a cutting agent for crack cocaine.

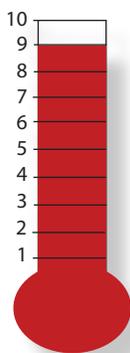
Current street jargon includes many names for crack cocaine. The most commonly cited names were "hard" and "rock." Participants listed the following as other common street names: "boy," "boulders," "butter," "candles," "chronic," "crack," "pebbles" and "work." Participants reported a gram of crack cocaine currently sells for \$100; 1/4 ounce sells for \$200 – \$350. However, most commonly, crack cocaine is purchased by the piece; reportedly, a typical piece sells for \$10 – \$30. A participant explained, *"Dealers keep portions [of crack cocaine] small. It's hard to get more than \$50 at a time."* While there were a few reported ways of consuming crack cocaine, the most common route of administration by far is smoking. Another popular method is intravenous injection (i.e., shooting). A participant stated, *"You cook it [crack cocaine] down and shoot [inject] it."*

There was no consensus regarding the profile of a typical user of crack cocaine, though a number of participants in the region consider crack cocaine to be, “*more of a poor man’s drug*.” Some treatment providers agreed, citing that the drug is used by individuals of lower income status because it was, “*cheaper to get [than most other street drugs]*.” There was disagreement regarding the age of the typical user; some participants reported that users are typically older than 30 years while others reported that individuals as young as their late teens are using crack cocaine. Participants in a couple of groups commented that crack cocaine users often tend to steal to support their addiction. A participant stated, “*Once you start using [crack cocaine], then you have to steal to keep using it*.” Treatment providers in Belmont County noted a marked increase in women using crack cocaine over the past six months.

Participants reported that crack cocaine is often used in combination with alcohol because one, “*can smoke more and use more [crack cocaine]*,” alcohol also “*helps you come down*.” Similarly, individuals reportedly use crack cocaine with benzodiazepines to “*get rid of the geeks, you know, how you are when you are crawling on the floor looking for more*.” Heroin and Seroquel® were also identified as other drugs used in combination with crack cocaine to help with “*coming down*.”

### Heroin Current Trends

Heroin is highly available in the region, although participants in Muskingum County reported that one must travel to Columbus to obtain it. Participants most often reported the drug’s current availability as ‘9’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants reported that the availability of heroin fluctuates: “*It [heroin] was up for awhile, now it is down again. A bunch of people are getting busted [arrested]. They [law enforcement] are cracking down*.” Law enforcement concurred that there are periodic times when availability fluctuates, citing several recent arrests. *The Post* reported in January that the Athens County Narcotics Enforcement Team found 82 balloons of heroin destined for Athens, Glouster and Nelsonville ([www.thepost.ohiou.edu](http://www.thepost.ohiou.edu), Jan. 31, 2011).



By far, the most common type of heroin available in the region is black tar, and many participants spoke about its widespread availability. A participant said, “*All I know about is black tar [heroin]*,” and another went even further, “*I’ve never seen powder [powdered heroin]*.” Participants described black tar heroin as black or brown. A participant stated that black tar heroin, “*looks like road tar*.” Participants described available powdered heroin as, “*light brown, very fine; pink tint, off-white; sandy looking*.”

Participants and treatment providers alike reported that availability and use of heroin has increased over the past year. A participant commented, “*In my home town, it [heroin use] is growing exponentially. Everyone is switching from pills [prescription opioids] to heroin*.” Another participant commented, “*Six months ago, it [the availability of heroin] was ‘3’ [in reference to the above availability scale] now it is ‘9’*.” They [law enforcement] are cracking down on the pills. It’s easier to get heroin.” A treatment professional stated, “*[Heroin] is a lot more prevalent. A lot more people with tar [black tar heroin] here than I thought I’d ever see*.” It was also cited by professionals that clinical assessments are now most often identifying heroin as a user’s primary drug of choice. All respondents commonly believed that the following factors have contributed to the steady increase in heroin use in the region: law enforcement “*crack down*” on street availability of prescription opioids, change in formulation of OxyContin®, which makes it difficult to use intravenously, and the relative cheap cost of heroin compared to prescription opioids. BCI&L London crime lab reported an increase in the number of powdered and black tar heroin cases it processes.

Participant quality scores of heroin varied from ‘4’ to ‘8’ with the most common score being ‘5’ on a scale of ‘0’ (poor quality, “*garbage*”) to ‘10’ (high quality). Participants reported that the quality of heroin varies depending on the dealer. A participant explained, “*It [quality of heroin] varies drastically. You could get heroin that is a ‘7’ or ‘8’ [quality scores], other times it’s a ‘3’ or ‘4’*.” This explains why people OD [overdose].” Overall, most participants reported that the quality of heroin has been going down over the past year. A participant said, “*Quality is going down. A year ago, I got stuff [heroin] that put you on your ass*.” Another participant commented, “*People are taking what they can get, they [dealers] stomping it [adulterating heroin]*.” A participant explained that “*good stuff*” looks different from poor quality heroin: “*If it’s [black tar heroin] good, it looks black, and it’s sticky. If not good, it’s hard, like coal*.” Participants reported that heroin is often “*cut*” (i.e.,

diluted) with substances like baby laxative, coffee grounds, marijuana resin and vitamins. A participant complained that dealers “will try to get people on it [addicted to heroin], then the purity will go down.” The heroin currently available in the region is very pure according to the BCI&I London crime lab, but benzocaine (local anesthetic) and metamizole (analgesic and antipyretic) are occasionally used as a cutting agents.

Current street jargon includes many names for heroin. The most commonly cited names were “boy,” “balloon” (as tar is most often packaged in balloons) and “H.” Participants listed the following as other common street names: “dog food,” “dope,” “horse,” “junk,” “mud,” “smack,” “stamps” and “tar.” Participants reported 1/2 gram of heroin sells for \$75, with a gram selling for \$100. The most common way heroin is purchased is by individual “balloons,” generally about 1/10 gram, or “one shot”; a balloon usually sells for \$15 – \$50, but most commonly sells for \$30 – \$40. Many focus group participants explained that, “in the city” (i.e., Columbus), individuals purchase balloons for half the price (\$10 – \$20). Participants said that the price of heroin has been increasing over the past year; however, they also said the price is still significantly cheaper than OxyContin®. While there were a few reported ways of consuming heroin, the most common route of administration is intravenous injection. A participant stated that injection “becomes inevitable” with heroin. Heroin is also consumed by snorting and smoking, and reportedly, each method of use “gives you a different buzz [high].”

Participants described the typical user of heroin as a person who is addicted to prescription opioids. A participant commented, “People who can’t afford to go to their doctors [to obtain prescription opioids] are going over to heroin. Even those who said they’d never shoot [inject heroin], they do.” A number of participants also said that younger people are using heroin, with one commenting, “I don’t know a heroin addict over 40.” Treatment providers agreed with participants that the population of users is getting younger: “The age [of heroin users] is dropping. Not a whole lot of old junkies [addicts].” Some participants noted that the typical heroin user is from a lower socioeconomic status. A participant commented that the heroin user is, “the very hard addict, who doesn’t work, who sells to support his habit.”

Heroin reportedly is used in combination with alcohol, benzodiazepines, marijuana and stimulant drugs. Participants said people use alcohol with heroin because the combination of the two drugs helps, “mellow you out.”

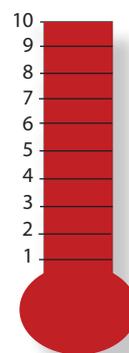
Reportedly, marijuana use with heroin is a preferred method because the combination of the two drugs intensifies the high. Participants mentioned that marijuana, “kicks it [heroin] in ... the buzz is 10 times better.” Stimulants like cocaine and Adderall® are also used in combination with heroin, allowing users to have “a good buzz” and “then you mellow out.” Using heroin with all of the aforementioned drugs is reportedly very common.

## Prescription Opioids

### Current Trends

Prescription opioids are highly available in the region. Participant most often reported the street availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants reported the following medications as highly available throughout the region: Dilaudid®, Opana®, OxyContin®, Percocet® and Vicodin®. The availability of other prescription opioids varied throughout the region. Participants in Athens County also reported high availability of Roxicet® while participants of Belmont County reported high availability of methadone and Ultram®. A participant stated, “There’s always some form of painkiller out there. Maybe not a specific one, but you can always find pain pills.” Treatment professionals in the region also reported that prescription opioids are highly available, most often reporting the street availability of these drugs as ‘10’. The consensus among treatment professionals was that prescription opioids are “over prescribed,” and their availability and use have increased over the past six months, correlating increases with the noted regional increase in heroin use. Several professionals nodded their heads when one said, “When heroin is difficult to find, users use pills.” Law enforcement reported that prescription opioids are commonly found during drug arrests. In January, police found 140 Roxicodone® pills during a routine traffic stop in Athens County ([thepost.ohiou.edu](http://thepost.ohiou.edu), Jan. 31, 2011).

Regarding changes in availability with OxyContin®, participants reported that the drug is decreasing in desirability since its reformulation. Participants said that substance abusers are seeking the old OxyContin® (i.e., OxyContin® OC), which is very difficult to find. A participant explained, “People are going out of state to get oxy’s



[OxyContin® OC].” As a result of the decrease in OxyContin® OC, other prescription opioids, including morphine, Opana®, Percocet®, and Roxicet, are increasing in use. Some participants reported an overall decrease in availability of prescription opioids. A participant stated, “[It] is more difficult to get prescriptions [because of] a lot of busts [arrests] in the last few months.” Yet, others reported the availability of prescription opioids to be at least the same, if not increasing. A participant said, “A lot easier to get [prescription opioids] than last year. Just go to the urgent care, you’ll get at least a Tylenol 3®.” Results from Athens County Children’s Services drug tests conducted between January and August 2010, indicated that 38 percent of parents tested, tested positive for an illegal drug, and two of the top three drugs were prescription opioids. The most common prescription opioids found in parents’ systems were oxycodone (i.e., OxyContin®; 16%) and morphine (11%). Participants also reported knowing about “fly-by-night” pain clinics in the area that dispense medication. A participant stated that with “pop-up clinics, it’s easy to get a script [prescription]. When it is closed down, they move.” BCI&I London crime lab reported an increase in the number of prescription opioid cases it processes. In fact, prescription opioids are the most commonly reviewed drug at BCI&I London.

Reportedly, many different types of prescription opioids (a.k.a., “beans,” “candy,” “clouds,” “goodies,” “orange slices,” “potatoes,” “skittles” and “yummies”) are currently sold on the region’s streets. In terms of current street names, participants explained that prescription opioids are often called by the first letter(s) of the drug’s name or by the color of the pill. Prices for these drugs vary by specific medication and dose amount. 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®, methadone (\$2 per milligram), OxyContin® (a.k.a., “OC’s,” “old cars,” “old coins,” or “oxy’s,” old formulation sells for \$2 per milligram; new formulation sells for \$0.50 – \$1 per milligram), methadone (a.k.a., “dones”), Percocet® 5 mg (a.k.a., “P’s” or “perc’s,” \$3 – \$4 per pill), Percocet® 10 mg (\$5 – \$7 per pill), Percocet® 15 mg (\$13 – \$15 per pill), Percocet® 30 mg (\$25 per pill), Roxicet® 10 mg (\$8 per pill), Vicodin® 500 mg (a.k.a., “V’s” or “vikes,” \$2 – \$3 per pill) and Vicodin® 1000 mg (\$3 – \$5 per pill). Participants reported that these medications are cheaper to purchase at the beginning of the month, becoming more expensive as the month goes by.

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 is intranasal inhalation (i.e., snorting). In addition, participants reported that pills are also crushed and injected. Participants in Meigs County reported that 70 percent of prescription opioid use is IV [intravenous] use. A participant also said that once a person begins IV drug use for other drugs “They will shoot [inject] pills. Once you shoot, you keep shooting.” There was a good deal of conversation in a number of focus groups regarding the difficulty of using OxyContin® intravenously, as the new formulation makes the process more difficult. However, participants of a focus group reported being aware of various methods to make the new OxyContin® (i.e., OxyContin® OP) injectable, which they said is becoming more popular. Participants also reported a new trend that is gaining popularity among university students: inhalation of vapors of OxyContin® or Opana® in order to become high.

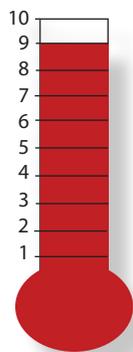
In addition to obtaining prescription opioids on the street from dealers, participants overwhelmingly commented on the relative ease of obtaining prescriptions from physicians, urgent care centers and emergency rooms. Participants reported that users know about clinics and physicians who are more apt to prescribe opiate medication. Some practices commonly employed to obtain prescription opioids include: going to more than one physician for the same injury/illness (including crossing state lines to see different doctors and pharmacies), feigning pain to get a prescription and then claiming to one’s primary physician to have lost, or that someone has stolen, the medication in order to receive a replacement prescription. In addition, participants reported obtaining prescription opioids from friends and family members.

A profile of a typical illicit user of prescription opioids did not emerge in the data, but participants and treatment providers agreed that the use of these drugs is very common throughout the region. Treatment providers said all age groups are using these medications, “from geriatric to pediatric.” The only group singled out was teenagers; treatment providers reported the use of prescription opioids as particularly increasing among young people. Treatment providers also spoke to how users are obtaining the drugs. A professional said, “The people who use [prescription opioids] are not the people who are being prescribed these medications. [Those with legitimate prescriptions] sell it to users.”

When used in combination with other drugs, prescription opioids reportedly are most often used in combination with alcohol and marijuana. Alcohol was reported to *"intensify the effect of the pills"* and *"make the effect stronger."* A participant spoke to the effects of alcohol and opioids: using one pill with a six-pack of beer would produce *"the effect of two or three pills."* Participants also reported using prescription opioids with benzodiazepines (i.e., Xanax®), which reportedly produces similar effects to using with alcohol. Participants explained, *"They [benzodiazepines] are sold by the same people [who sell prescription opioids] ... intensify the buzz"* while producing a calming effect. Products like over-the-counter cough medicine (i.e., those containing dextromethorphan) are also used with prescription opioids because they *"keep the pill buzz, but now you have energy."* Still, others reported using prescription opioids with *"just about anything. Pain pills take the edge off other drugs, for withdrawing or coming off them."* Participants reported that using prescription opioids with all of the aforementioned drugs is very common, though a participant noted, *"If I spend \$80 for a reason [a prescription opioid], I don't want to mess up [diminish the high]."*

### Suboxone®

#### Current Trends



Suboxone® is highly available in the region. Participants most often reported the street availability of Suboxone® as '9' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). A typical response about the drug's availability from participants was *"It's pretty easy to get a prescription [for Suboxone®]. It's easy to get off the street."* However, participants in Belmont County reported that Suboxone® was *"hard to get,"* and rated its availability as '5' on a scale of '0' (not available, impossible to get) to '10'

(high availability, extremely easy to get). Both participants and treatment professionals in Muskingum County reported that there are no licensed prescribers of Suboxone® in their county. Treatment professionals in Muskingum County reported, *"We used to have doctors prescribe Suboxone®, but now no one is prescribing because it ends up on the streets."* BCI&I London crime lab reported an increase in the number of Suboxone® cases it processes.

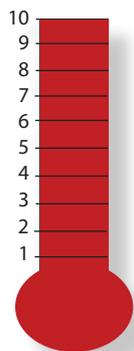
No slang terms or common street names were reported for Suboxone®. Participants reported that Suboxone® 2 mg sells for \$8 and Suboxone® 8 mg generally sells for \$8 – \$15. Participants reported that the price could vary depending on how badly the buyer needed the drug. As a participant noted, the price, *"depends on how sick you are."* Participants also commented that the new Suboxone® "strips" are available on the street for \$10 – \$15, but, *"no one wants" them because they are more difficult to abuse.*

Participants reported that individuals use Suboxone® for several reasons, stating that users occasionally need a few pills to avoid withdrawal symptoms between highs. As a participant explained, *"When you can't find your drug [of choice], at least there is Suboxone®."* Participants also reported that people without much experience with opioids are trying Suboxone®: *"Some [substance abusers] use it to get high."* A participant described the high from Suboxone® as *"an opiate high, not like OxyContin® or Opana®, but I know when I come off it."* While some participants reported acquiring Suboxone® via prescription, others reported that users frequently purchase Suboxone® on the street from other drug consumers or from drug dealers. Some participants reported greater ease in purchasing it off the street rather than obtaining a legitimate prescription: *"It's not easy to get a doctor, big waiting lists. So it is easier to get them [Suboxone®] from someone who has a prescription."*

The manner by which individuals use Suboxone® depends on the reason they are using. Those using to avoid withdrawal most often take Suboxone® orally, letting it dissolve under the tongue. However, those seeking to get high off the drug tend to snort Suboxone®. While not as common, participants also said they have *"heard of people trying to shoot [inject] them."* Participants reported that the Suboxone® "strips" are not preferred: *"They changed to [Suboxone®] strips; it's more difficult to snort or shoot."* Generally, no other substances are reportedly used in combination with Suboxone®. A participant stated, *"You don't use with any other drug. It [Suboxone®] blunts it. You won't get high from the other drug."* Only one participant mentioned that Suboxone® is used in combination with marijuana and Neurontin® by some users, though this individual described the experience as *"Getting messed up, [and] not a pretty sight."*

## Sedative-Hypnotics

### Current Trends



Sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) are highly available in the region. Respondents most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Many consumers said availability of sedative-hypnotics was, "very abundant" and "prescribed like skittles."

Participants described some sedative-hypnotics as more readily available than others. Across the region, Klonopin® and

Xanax® are said to be the most available while Ativan® and Valium® are reportedly less available. The use of Valium® seems to be decreasing; a professional stated, "Xanax® has taken the place of Valium®." The availability of Soma® varied from county to county; participants reported it highly available in Belmont County while treatment providers reported it highly available in Washington County. Participants reported no change in the availability of these medications over the last six months. BCI&I London crime lab reported that the number of sedative-hypnotic cases that it processes has remained stable.

Reportedly, many different kinds of sedative-hypnotics are currently sold on the region's streets. In terms of current street names, participants explained that sedative-hypnotics are often named by the color of the pill (e.g., "blues" or "peaches"). Other street names for sedatives include: "beans," "downers," "muscle relaxers," "nerve pills" and "vervies." In terms of current street prices, participants consistently stated that the price of sedative-hypnotics depends on dosage. 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 (\$0.50 per milligram), Klonopin® 1 mg (a.k.a., "green monsters" or "k-pins;" \$1 per pill), Xanax® (a.k.a., "bars," "blue boys," "xani's" and "xanibars;" \$1 – \$6 per pill) and Valium® 10 mg (a.k.a., "vitamins;" \$1 – \$2 per pill).

In addition to obtaining sedative-hypnotics on the street, participants reported there are physicians known by users who prescribe these medications liberally throughout the

region. Many participants agreed when one person said, "You hear from friends about a doctor who is more likely to prescribe [sedative-hypnotics]." However, participants in Athens County mentioned that doctors are being "more careful" with prescribing these medications, recognizing that they can be "too addicting." A participant stated, "Doctors are tightening up. It's harder to get a prescription." Many participants also reported getting sedative-hypnotics from friends and family members who have been prescribed these medications, as well as, ordering them online from Web sites like E-bay or Craig's List. Treatment providers stated concern that drug users are "very resistant" to coming off these medications, and put a lot of pressure on physicians to prescribe.

While there were a few reported ways of consuming sedative-hypnotics, the most common routes of administration are oral consumption and intranasal inhalation (i.e., snorting). Participants explained that the route of administration often depends upon the specific medication and drugs used in combination. For example, those that use sedative-hypnotics with alcohol tend to use the drugs orally while those who use with marijuana, often crush the sedative-hypnotic pill to lace into their marijuana "joint" (i.e., marijuana cigarette). Participants also said that users who prefer Ativan® and Xanax® are more likely to snort them. Still others stated that they "get a better high by eating them [sedative-hypnotics]." Most participants reported that intravenous use of these drugs is rare, very difficult to do, though some consumers have heard about other users abusing Xanax® this way.

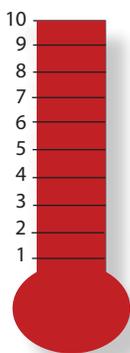
Descriptions of typical users of sedative-hypnotics varied. However, a common theme was that both participants and professionals noted an increase in the frequency of young people using benzodiazepines, especially Xanax®. Participants reported benzodiazepine use among teens is popular because it "mixes with binge drinking." A group of professionals reported that heroin users are using Xanax® to boost the effect of heroin, which they indicated has increased the number of heroin overdoses in the region. Participants identified typical users as "depressed people; people with a lot of stress, like students; a lot of people who use opiates." However, a participant stated, "Demographics widens with benzo's [benzodiazepines]." In addition, many participants reported that many different people of different ages and economic status use these medications. Treatment

providers disagreed slightly with participants and reported that women between the ages of 35 and 60 tend to be overrepresented among sedative-hypnotic users.

Reportedly, sedative-hypnotics are used in combination with alcohol, heroin, marijuana, prescription opioids and Suboxone®. Participants reported that it is very common to use these drugs with alcohol. A participant stated, *"Everyone I know uses them [sedative-hypnotics] with alcohol, in search for the ultimate high."* Consumers reported that alcohol intensifies the effect of both substances. Participants explained, *"You feel the buzz quicker; it [combination with alcohol] knocks you out."* A number of participants also mentioned using sedative-hypnotics with heroin is common. A participant stated, *"Xanax® intensifies the effect of heroin, but you need to be careful, it could cause a coma."* Participants also reported using sedative-hypnotics in combination with marijuana because it *"makes you sleepy"* and *"makes the buzz better;"* cocaine because it *"makes you feel able to get high, but not hyper;"* and methadone so that *"you get a lot higher."*

### Marijuana Current Trends

Marijuana is highly available in the region. Respondents most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants and treatment providers described marijuana as being extremely easy to get. A participant commented that marijuana was *"on any street corner around here;"* and another commented, *"You can grow it [marijuana] yourself, it's easy to grow."* Results from Athens County Children's Services drug tests conducted between January and August 2010, indicated that 38 percent of parents tested, tested positive for an illegal drug—marijuana was the most common drug found in a parents' systems (49% of all positive cases). Participants offered varying opinions on whether the availability of marijuana has changed over the previous six months, some participants (particularly from Muskingum and Athens Counties) asserted that the availability of marijuana has decreased. A participant commented that availability is *"down a lot. It [marijuana] used to be everywhere. Now you need to know the right people."* There were a couple



of reasons for the decrease in availability cited, including recent law enforcement activity. A participant commented, *"A lot [of marijuana] has been taken off the streets;"* and another explained, *"A lot of pot [marijuana] dealers and growers were busted lately."* Another participant commented that people are *"using different things. Marijuana went down when heroin went up."* This belief was affirmed in another focus group, where a participant commented, *"Heroin is easier to find than marijuana now."* Participants in focus groups held in Meigs and Belmont Counties reported no change in the availability of marijuana: *"It's [marijuana] been readily available as long as I can remember."* Treatment professionals reported that the availability of marijuana is consistent. A professional commented that the availability of marijuana decreased about a year ago *"due to big drug busts in Meigs County,"* but that it is now very available again. An article in the Marietta Times reported that there have been many recent marijuana busts. Law enforcement was quoted as saying, *"More marijuana has been confiscated in growing operations this month than in the past five years combined,"* with a recent bust bringing in 43 pounds of marijuana worth \$60,000 ([mariettatimes.com](http://mariettatimes.com), Sept. 1, 2010). Professionals also reported that more clients across the region are growing their own marijuana.

Participants reported that the quality of marijuana varied with the most common score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality) for high-grade marijuana, and '5' for low-grade marijuana. Several participants explained that the quality of marijuana differed with the different grades of marijuana. Low- to mid-grade marijuana is considered "commercial weed" while "hydroponic," "denk," "kush" and "home grown" (i.e., "Meigs County Gold") are considered high-grade marijuana. Participants reported that commercial marijuana looks brown and dull in color while high-grade marijuana is green, fluffier than commercial marijuana with *"the brighter the color, the better [quality marijuana]."*

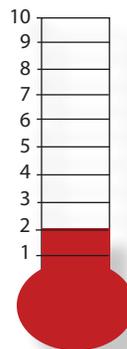
Current street jargon includes numerous names for marijuana. The most commonly cited names were "green," "pot," "trees" and "weed." Participants listed the following as other common street names: "dirt pot," "grass" and "mids" for low- to mid-grade marijuana; "kush," "red hair," "KB," "killer bud," "purple" and "purple haze" for high-grade marijuana; and "hydro" for hydroponically grown marijuana. Other general street names for marijuana include: "dope," "grass,"

“herb,” “jimmy,” “marilyn,” “smoke” and “sticky icky.” Reportedly, the price of marijuana depends on the quality desired. Participants reported they could buy commercial-grade marijuana in many different quantities: a “joint” (i.e., single cigarette; roughly a gram) sells for \$5; 1/8 ounce sells for \$15 – \$30. Participants also reported they could buy high-grade marijuana in many different quantities: 1/8 ounce sells for \$30 – \$65; and an ounce of “Meigs County Gold” sells for \$300 – \$400. While there were a few reported ways of consuming marijuana, the most common route of administration for this drug is smoking. Some users reported eating marijuana in food or mixing it with butter.

When asked to describe the typical user of marijuana, respondents were unable to be specific. Treatment providers summed up the attitude shared by other professionals and participants alike: “It’s [marijuana use] across the board.” Reportedly, marijuana is used in combination with numerous other substances, including alcohol, crack cocaine (a.k.a., “cocoa puffs” or “primo” when laced into a “blunt” (i.e., marijuana cigar), heroin, methamphetamine, PCP (phencyclidine) and psilocybin mushrooms. The consensus among participants was that it is very common to use marijuana with other drugs. One commented, “*Marijuana goes with anything.*” Another participant commented, “*Most people start using marijuana. They go to other drugs, but keep using marijuana.*” The most commonly cited reason individuals use marijuana with other substances, is as a participant put it: “*They intensify each other.*” Another participant commented that using marijuana with cocaine “*gives you two buzzes, it intensifies the high, gives you more energy.*” Lacing marijuana with psilocybin mushrooms increases the psychedelic effect: “*You see stuff.*” A participant reported that when using marijuana with PCP “*you don’t feel like you’re in your own body.*”

### Methamphetamine Current Trends

Methamphetamine is relatively rare in the region, with the exception of Muskingum County. Participants most often reported the drug’s current availability as ‘2’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). As a participant commented, “*If you don’t know how to make it [methamphetamine], you cannot find it.*” However, participants in Muskingum County most often reported the drug’s current availability as ‘8.’

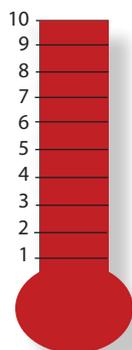


When asked whether the powdered form or the crystal form was more available, participants in Muskingum County said that both forms are equally available. Treatment professionals in Muskingum County agreed that methamphetamine is “*very available*” in their region. These professionals rated the availability as ‘8’ in Muskingum County, citing reports they have received from clients of a number of “meth” labs in an adjacent county. Most participants said the availability of methamphetamine has changed little over the last six months, though some participants reported that availability has decreased, citing difficulty in acquiring the ingredients (i.e., pseudoephedrine) needed to make methamphetamine. Participants in Muskingum County identified two types of methamphetamine: powdered and crystal. Reportedly, the powdered form is more locally made, whereas “ice” (a form of crystal methamphetamine, which “*looks like glass shard*”) is “*coming from out of state.*” These participants reported that the quality of crystal methamphetamine as “4 or 5,” and the quality of “ice” as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). A user commented that the quality of crystal methamphetamine has gone down, due to the “*shutting down of meth labs.*”

Current street jargon includes a number of names for methamphetamine. The most commonly cited names were “glass” and “ice,” but terms like “bitch,” “crank,” “diamonds,” “dope,” “girl” and “shards” were also mentioned. Participants reported that they could buy a gram of powdered methamphetamine for \$50 – \$75 and a gram of “ice” for \$140. The most common routes of administration for this drug include intranasal inhalation (i.e., snorting) and smoking. Participants reported that individuals also vaporize methamphetamine and inject it as well. A participant noted that many young people are “*switching from cocaine to meth,*” but otherwise, no user characteristics were noted among participants. Treatment professionals described typical users of this drug as being in their 20’s and 30’s, almost exclusively White: “*I’ve rarely heard of it [methamphetamine use] among African-Americans,*” and they mentioned that methamphetamine use was common “among the Appalachian population.”

### Prescription Stimulants

#### Current Trends



Adderall® and Ritalin® are 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’ (high availability, extremely easy to get). Participants also reported that the availability has increased over the past six months. Participants commented that these medications are “very easy to find; easy to get pills [prescription stimulants] on the streets.” Participants reported that these medications are “commonly prescribed.”

Another commented, “Parents are selling their children’s scripts [prescriptions] for added income.” A participant described these medications as, “a poor man’s cocaine.” Participants reported that prescription stimulants are very popular among college students (per Athens focus group).

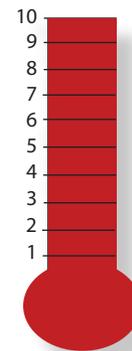
No slang terms or common street names were reported for prescription stimulants. Adderall® is commonly available to street-level users in the region, and Adderall® 30 mg sells for \$8 – \$10 per pill. The most common reported method of administration is crushing and snorting the medicines, followed by oral administration. Participants reported that prescription stimulants are often used with methamphetamine because “when you run out of meth, you take Adderall® to keep you high.” It was also reported by participants that users use these drugs with alcohol because “everything goes better with alcohol.”

### OTC Cough Medicines

#### Current Trends

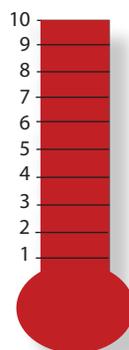
Over-the-counter (OTC) cough medicines are highly available and popular in the region, especially in Belmont County. Participants in Belmont County most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants reported that the use of dextromethorphan (DXM) is a, “growing practice.” A participant shared that the use of DXM is growing in popularity because its use is hard to detect, and it is relatively cheap to purchase. Treatment providers in Muskingum County identified the use of DXM

products as “a growing trend of abusive use.” Providers reported that the users of these products tend to be individuals in the teens or early 20’s. A participant described personal experience with this drug as “like a hallucinogenic high. You get tons of energy. Everything looks more colorful. It intensifies every other drug you use, so you buy less of the other drugs.” The only reported route of administration by participants in the region is oral consumption. Participants reported that it is common to use cough medications containing DXM with alcohol and marijuana.



### Hallucinogens

#### Current Trends



Hallucinogens are moderately available to very available in the region. Psilocybin mushrooms are the most available hallucinogen 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’ (high availability, extremely easy to get). A participant commented, “You can grow your own [psilocybin mushrooms].” Participants reported that 1/8 ounce of mushrooms sell for \$25 – \$50. The most commonly reported method of administration is

oral consumption. A participant reported, “It [psilocybin mushrooms] tastes bad, so we put it on pizza.” Participants also reported psilocybin mushrooms are boiled as a tea or smoked. Lysergic acid diethylamide (LSD) was mentioned by a few participants while others reported not having seen it in awhile. Participants most often reported LSD’s current availability as ‘5’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get), a participant commenting that its availability fluctuates: “It comes in spurts.” Reportedly, LSD is available in multiple forms to street-level users, including paper (\$10 per hit) and sugar cubes (\$7 – \$8 per cube).

## Other Drugs

### Current Trends

Participants and professionals listed a variety of other drugs as being present in the area, but these drugs were not mentioned by the majority of people interviewed. Participants reported that synthetic marijuana (e.g., "K2") is very popular among teenagers and college students. A treatment provider commented, "Every kid I've worked with has tried it [synthetic marijuana]." Providers expressed frustration with K2 because it is still available at head shops and gas stations. Providers commented on the dangerous side effects (e.g., hallucinations) and reported that there have been some deaths due to overdose in Washington County. Inhalants were also mentioned as being popular with younger people (< 18), although none of the participants interviewed reported using them. News reports about drug abuse in the Athens region mentioned inhalant use among teenagers. According to the *Marietta Times*, a 19-year-old girl had a car accident after inhaling from a can of air duster ([mariettatimes.com](http://mariettatimes.com), Sept. 15, 2010).

### Conclusion

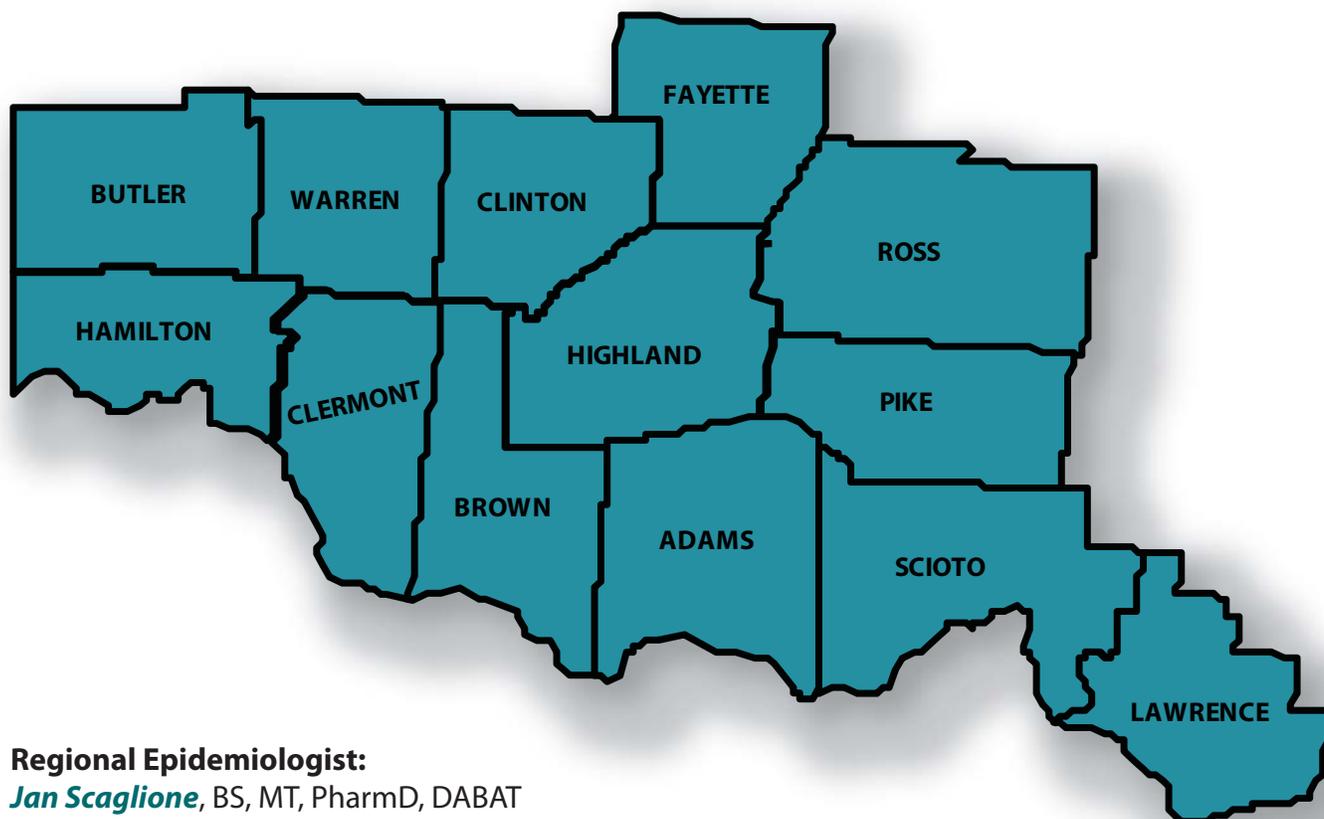
Heroin (i.e., black tar), prescription opioids, sedative-hypnotics, marijuana and prescription stimulants are the most available drugs throughout the Athens Region. Crack cocaine, with the exception of Athens County, also continues to be highly available. Noted increases in availability over the previous six months exist for heroin, prescription opioids and prescription stimulants. Referred to as "a poor man's cocaine," prescription stimulants (i.e., Adderall® and Ritalin®) are very popular among college students. The use of prescription opioids is particularly increasing among young people (teens to early 20's). OxyContin® remains the most popular prescription opioid, although decreasing in desirability due to reformulation; Dilaudid®, Opana®, and Percocet® are also popular. Suboxone® continues to be used when heroin is unavailable in order to avoid withdrawal, and to produce a high for non-opioid addicts. Clinical assessments are now most often identifying heroin as the primary drug of choice of users coming into treatment. Heroin too is becoming more popular among young people. Alarming, the most common route of heroin administration is intravenous injection. Sedative-hypnotics (i.e., Klonopin® and Xanax®) are widely desired for their ability to help modify the high of other drugs. OTC cough medicines are becoming increasingly popular among younger users because of their wide availability and the hallucinogenic effects they produce.

# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Cincinnati Region

June 2010-January 2011

John R. Kasich, Governor  
Orman Hall, Director



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Principal Investigator

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### Regional Profile

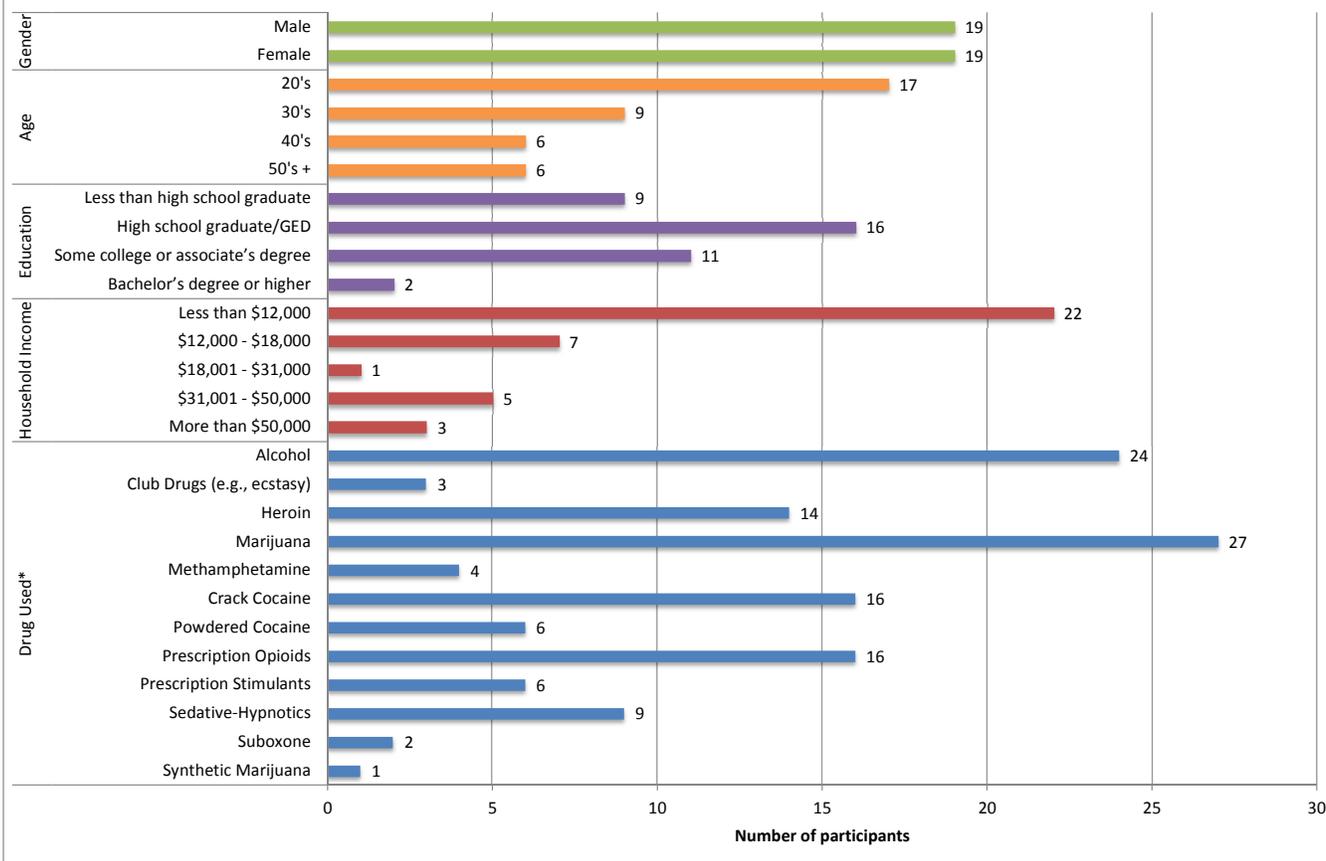
Indicator <sup>1</sup>	Ohio	Cincinnati Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	2,053,493	38
Gender (Female), 2009	51.2%	51.1%	50.0%
Whites, 2009	82.2%	83.2%	47.4%
African Americans, 2009	11.9%	12.6%	47.4%
Hispanic or Latino Origin, 2009	2.8%	2.0%	2.6%
High school graduates, 2008	84.6%	89.9%	76.3%
Median household income, 2009	\$45,467	\$41,672	Less than \$12,000
Persons below poverty, 2009	15.1%	16.2%	48.6% <sup>2</sup>

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

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

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

### Drug Consumer Characteristics (N=38)

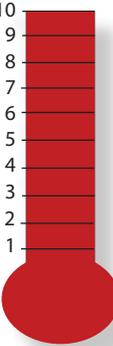


\*Some respondents reported multiple drugs of use over the past six months.

## Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Hamilton County. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (i.e., treatment professionals and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Bureau of Criminal Identification and Investigation (BCI&I) London Office, which serves central and southern Ohio. The aforementioned secondary data source reported summary data for January to June 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the last six months (i.e., from time of interview through prior six months); thus, current secondary data correspond to the current reporting period of participants. In addition to the aforementioned data sources, the *Cincinnati Enquirer*, along with other Ohio media outlets, was queried for information regarding regional drug abuse for June 2010 through January 2011.

## Powdered Cocaine Current Trends



Powdered cocaine is highly available in the region. Participants most often reported the availability of powdered cocaine as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get), with participants reporting geographic variation in availability, depending on exactly where in the region the drug is being sought for purchase. Current availability was described by participants as, *"Something got across the border; Can walk up to any corner and find it [powdered cocaine]; No dry spells [periods of unavailability] of late."* Law enforcement stated that Mexican cartels are getting more involved with the trafficking of powdered cocaine in the U.S., lowering the number of middlemen involved in the transport of the drug into the region. Another primary factor that influences availability is the relationship, or connection, the consumer has to the dealer. The closer the connection, the less likely there are problems getting the drug, and the more likely the consumer is to receive a good price point. Treatment professionals reported a moderate to high availability of powdered cocaine

over the last six months, noting that availability has remained relatively unchanged during this period. BCI&I London crime lab reported that the number of powdered cocaine cases it processes has remained stable.

Participant quality scores of powdered cocaine varied from '2' to '7' with the most common score being '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). As with availability, the quality of powdered cocaine is said to vary depending on geographic location within the region. Overall, participants reported that the quality of powdered cocaine has decreased over the last six months. Many participants reported the use of powdered cocaine to *"rock up"* (i.e., to form, process) crack cocaine to ensure a better idea of the quality of the drug they smoke. When describing the quality of powdered cocaine, a participant stated the following, *"Some of it [powdered cocaine] is just garbage ... can go to a 9/10 [quality rating], but you gotta get it from the main person."* Participants cited the following substances as commonly used to "cut" (i.e., dilute) powdered cocaine: B12 vitamins, baby laxative, baby powder, baking soda and benzocaine (local anesthetic), often referred to as "benzene" by participants. A participant stated that she always knew when there was baby laxative in the cocaine since she, *"would get high but then have to go to the bathroom right away."* According to BCI&I London crime lab, levamisole (dewormer for livestock) is the cutting agent in 90 percent of cases, but other agents like boric acid (found in antiseptics and insecticides), inositol (vitamin-like health supplement), as well as, the following local anesthetics of benzocaine, lidocaine, procaine and tropacaine are also used to cut powdered cocaine.

Current street jargon includes many names for powdered cocaine. The most commonly cited names were: "blow," "girl," "powder," "snow white" and "white girl." Less common slang terms include names of White celebrities such as "Britney Spears," "Paris Hilton" and "Lindsay Lohan." The price of powdered cocaine reportedly depends heavily on the connection the user has with the dealer. Participants reported a gram of powdered cocaine currently sells for \$25 – \$40 if dealer is known, and \$60 – \$100 if there is little connection between the buyer and seller; 1/16 ounce, or "teener," sells for \$75 – 150; 1/8 ounce, or "eight ball," sells for \$150 – \$250; an ounce sells for \$800 – \$1,500; and a kilogram of powdered cocaine commands \$28,000 – \$38,000. If a drug consumer is willing to take the risk of transporting the drug themselves, prices for a kilogram of powdered cocaine are reportedly

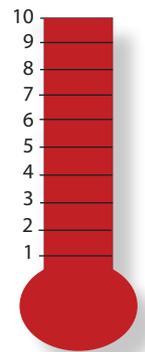
lower, ranging from \$20,000 – \$23,000. Several participants described intranasal inhalation (i.e., snorting) as a common route of administration for powdered cocaine. This route was described as a primary route that “beginners” use, as well as White professionals and college students. If a “snorter” progressed in their drug use, the next step is generally smoking, and then injecting. The route of administration is, *“All about the preference of the high; shooters shoot [inject], snorters snort.”* Participants noted that smoking occurs among primary crack cocaine users and *“college kids gone bad,”* while injection occurs among those individuals that inject drugs generally as a primary route of administration. A participant said, *“Once a shooter [injector], [you] never go back.”* Participants cited the route of administration as depending on the usual company that an individual keeps. As a participant explained, *“Snorters hang with snorters; People who shoot it [inject powdered cocaine] don’t want to hang out with people who snort because you feel inferior, it’s [injection] more taboo.”*

The typical user of powdered cocaine was described by many participants as a White, middle- to upper-class working professional male in his 20’s - 30’s. Professionals also described the average powdered cocaine user as a working professional who uses the drug for recreational purposes rather than daily use, often in the clubs or bars in the region. In addition, participants reported some use of powdered cocaine by the Latino population. Law enforcement stated that more White females between 18 – 30 years of age are now using powdered cocaine than in the past. Professionals also reported that there is little use of powdered cocaine in the homeless population. The higher cost of powdered cocaine versus the lower cost of crack cocaine was noted to be one of the driving factors in explaining the typical user. Substances often used in conjunction with powdered cocaine include alcohol, benzodiazepines, heroin, marijuana and prescription opioids. The term “speedball” applies to the concurrent or sequential use of heroin and cocaine and was noted to be a common practice among the injecting population.

### Crack Cocaine Current Trends

Crack cocaine is highly available in the region. Respondents most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants found no trouble getting the drug in the region: *“[You] can go to*

*any street corner and get it [crack cocaine] in 10 minutes.”* Universally, professionals and participants reported crack cocaine availability as steady, with relatively little change during the last six months, but a minority of respondents noted that there has been some increase over that same period. BCI&I London crime lab reported that the number of crack cocaine cases it processes has remained stable.



Participant quality scores of crack cocaine varied from ‘1’ to ‘5’, with the most common score being ‘5’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Only one participant stated being able to get high quality crack cocaine that would rate ‘10’ on the same scale, stating, *“I got heart attack shit.”* It was more common to hear that the quality was highly variable due to the product being “cut” (i.e., diluted) with other substances. Substances used as cutting agents included those also used to cut powdered cocaine: baby powder, baking soda and benzocaine (local anesthetic). Several participants reported being “fleeced” when attempting to buy crack cocaine. Substances being sold as crack cocaine (that contained no cocaine at all) included candle wax, pieces of drywall, peanuts, rocks picked up off the street, rock salt, soap and peppermints that had been sucked down to look like ‘crack rocks.’ The practice of duping the buyer by selling counterfeit crack cocaine was reportedly very common. A participant stated, *“Drug addicts are fleecing people ... dope boys will also fleece you.”* There were no repercussions cited either: *“If you get fleeced, you keep on moving and chalk it up to the game.”* According to BCI&I London crime lab, levasimole (dewormer for livestock) is used as a cutting agent for crack cocaine.

Current street jargon includes many names for crack cocaine. The most commonly cited names were “butter” or “butta,” “hard” and “melt.” Participants listed the following as other common street names: “crack,” “flame,” “rock,” “sizzle,” “ya-yo,” and “got dat” (as in *“Do you have that dollar amount of crack available?”*). Participants noted some slang terms are used interchangeably (i.e., terms are used to describe crack cocaine but also used to describe other drugs as well). Slang terms used in this way included “dope,” used more commonly to refer to heroin, and “snow white” which is used more commonly to refer to powdered cocaine. A gram of crack cocaine sells for \$50 – \$100; 1/4 ounce sells for \$200 – \$300; an ounce sells for \$800 – \$1,000. A participant stated that a

1/16 ounce, or “teener,” is not sold any longer since a dealer could not make money off that quantity. Many participants reported that they can easily purchase crack cocaine by the “rock” for \$2 – \$10. Reportedly, price is dependent on several factors, including the connection to the dealer, race, or perception of need on the part of the buyer, with higher prices offered to White buyers. A gram of crack cocaine sells to a Black buyer for \$50 – \$60, but the same amount sells to a White buyer for \$100. Participants stated, *“It’s all about who you know; The purchase of my drug is color based ... the White person pays more because they don’t have a choice; if I see a dope fiend [crack cocaine addict], I’m gonna charge him more.”*

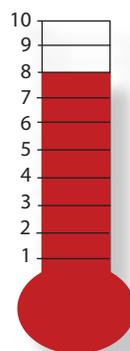
While there were a few reported ways of consuming crack cocaine, the most common route of administration by far is smoking. Many participants reported that it is very common for a user to break down and re-rock crack cocaine if there is a perception that the quality of the product purchased is low. As a participant said, *“Ya break it down [crack cocaine] and re-rock it ... with a spoon ... crushing it, then (adding) water and flame.”* A smaller number of users administer crack cocaine by breaking it down for injection purposes, predominantly seen among those who use injection as a primary route of administration of any drug.

The profile of a typical user of crack cocaine varied depending on who was being asked the question. The drug, due to its high availability, has become more accepted over time, being described by a participant as a, *“very democratic, non-discriminatory drug.”* However, treatment professionals explained, *“The young have a real disdain for ‘crack heads’ [crack cocaine users]; Crack [cocaine] users are not respected in the community.”* A participant described what he thought the typical stereotype of a crack cocaine user looked like, *“Skinny, homeless, short, [and always] begging for change.”* This person was more likely to be White than other races as the same individual stated, *“I’ve never seen a Hispanic or African strung out looking for change.”* Still another individual described crack cocaine use as *“more common with prostitutes and lawyers.”* Overall, several participants cited use among the Latino population as increasing in the region. New users were reported to be as young as 12 years of age. There was no clear consensus of gender bias for crack cocaine use. A treatment professional noted an increase in old injectors, mostly Black and over 50 years of age, shifting to smoking crack cocaine as a way to decrease their risk of contracting needle-associated infections.

Similar to powdered cocaine, crack cocaine is used with other substances. The most common of which include alcohol and marijuana. A participant said, *“Sprinkling crack [cocaine] on weed [marijuana] is how most people get hooked on crack cocaine ... also put on tobacco.”* The term “primo” describes the lacing of crack cocaine into either a marijuana or a tobacco cigarette. Professionals stated that young, primarily Black males use primo’s as a way to cover up their crack use: *“With marijuana they don’t consider it crack [cocaine] use.”* Less commonly reported in conjunction with crack cocaine is the use of prescription opioids or benzodiazepines.

## Heroin

### Current Trends



Heroin is moderately available in the region. Participants most often reported the availability of brown and white powdered heroin as ‘8’ and black tar heroin as ‘4’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Similar to other drugs, current availability is geographically variable across the region and dependent on relationships to the drug’s source. A participant reported having no trouble finding black tar heroin and described the availability as follows: *“The market is flooded with black tar [heroin] ... Hispanics are selling more ... [there’s] less selective sales now ... got through White males [instead of through a female go-between].”* Variability in availability over the last six months was noted among participants, with some individuals noting a decrease while others stated the amount of available heroin has increased overall. Law enforcement reported an increase in the amount of heroin being trafficked in the area, and similar to cocaine, stated Mexican cartels are more involved with the transport than in the past, with less middlemen getting involved in the distribution. Much of the heroin trafficked in the Cincinnati region is reportedly coming south from the Dayton region. More heroin is said to be available in rural and suburban areas of the region than in the urban core of the city. Dealers have reportedly switched from selling cocaine/crack cocaine to selling heroin. BCI&I London crime lab reported an increase in the processing of powdered and black tar heroin cases.

Participant quality scores of heroin varied from '4' to '10' with the most common score being '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Overall, the perception of participants is that the quality of heroin has decreased over the last six months. Several participants cited increased use of cutting agents as one reason for why quality has decreased, and while not confirmed, an individual stated, *"More people [are] going into treatment for heroin use due to the poor quality ... cut [diluted] with cocaine, elephant tranquilizer and rat poison."* Heroin currently available in the region is very pure according to the BCI&I London crime lab, but benzocaine (local anesthetic) and metamizole (analgesic and antipyretic) are occasionally used as cutting agents.

Current street jargon includes many names for heroin. The most commonly cited names were "boy," "dog food," "dog," "dope," "food" and "puppy." Less common slang terms include "brown," "chiva," "H," "horse" and "smack." Participants noted some crossover between terms with heroin, similar to that described for crack cocaine. The term "snow white" more typically refers to the drug cocaine, but if it is followed by a tap on the arm, it is interpreted by dealers to mean heroin. Other slang terms usually reserved for crack cocaine, "hard" and "fire," are also used to describe heroin. Participants reported that a gram of brown or white powdered heroin for \$100 – \$200, depending on quality and connection to the dealer. Bags containing 1/10 gram of brown or white powdered typically sell for \$20; these bags reportedly are often stamped with the words "self destruction" or with pictures of smiley faces or stars. Prices for 1/2 gram of brown or white powdered heroin range from \$65 – \$80, and 1/2 gram of black tar heroin sells for \$120 – \$125. A gram of black tar heroin sells for \$200 – \$250. Lower level users are less likely to see higher quantities of heroin, regardless of type. A participant stated, *"You gotta be working for somebody to ask for a quarter ounce ... they'll come at you with guns blazing."* An ounce of heroin sells for \$2,500 – \$3,600, and a kilogram sells in the range of \$50,000 – 80,000.

The route of administration of white or brown powdered heroin more commonly seen, especially among first time users, is intranasal inhalation (i.e., snorting). In addition, individuals that reportedly do not like needles are more likely to snort heroin, and thus are less likely to progress to injection. Participants commonly cited continuous use of heroin as a reason why participants progress from snorting to injecting of heroin. Participants reported injection of heroin

as the primary route of administration, and more commonly practiced by males than females. Females are more likely to be injected by males. An MSM (males who have sex with males) educator, returning from a national conference, reported that there are lower numbers of MSM injectors in Cincinnati than in other areas of the country. In addition, new heroin injectors from the suburbs are reportedly less educated about needle use. A professional explained, *"[People] can't get a new needle, what do [they] need to do to clean it? Suburb and rural injectors are less likely to know how to clean needles versus urban population ... city [users] more knowledgeable ... suburb and rural users would use alcohol, sometimes bleach if they knew about it ... something other than water should be used."* Participants that seek out and use black tar heroin primarily inject versus other routes of administration.

Typical consumers of heroin are reportedly divided between two camps: younger, predominantly White users and older Black users. Professionals explained, *"Heroin use is an epidemic in White suburban kids ... start with prescription opioids, [then] switch to heroin due to cheaper price ... more heroin sales than crack [cocaine]."* Overall, first time use reportedly is occurring in younger people, ranging in age from 16 to 18 years. Professionals see this as a problem: *"Younger users are not aware of the enormity of the problem with heroin."* Participants and professionals alike noted that previous prescription opioid use has contributed to a shift to heroin use. A professional said, *"People who used OxyContin® are turning to heroin as a result of the new formulation; Prices have dropped, [heroin is] dirt cheap compared to pills ... [users have] moved to using heroin since prescription opioids not so cheap anymore."* The switch to heroin from prescription opioid use was noted by a professional to be a growing problem: *"There are no prevention efforts for heroin, it's very scary ... no needle exchange is available. There are increases occurring in Hepatitis C infection rates ... HIV cases are mostly males."* The overall use of heroin was reported as increasing, and the user is more likely to be younger, White, and often female. A shift from alcohol to heroin use in the Latino population was reported by professionals as well. A program called MOM (Moms on Methadone) was started as a result of an increasing number of young pregnant females addicted to heroin in the region.

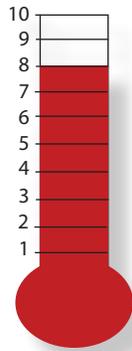
Reportedly, when used in combination with other drugs, heroin is most often used in combination with alcohol, benzodiazepines and marijuana. Participants reported the co-injection, or successive use, of cocaine with heroin (i.e., "speedball") as a common practice among participants.

## Prescription Opioids

### Current Trends

Prescription opioids are highly available in the region. Overall, participants most often reported availability of prescription opioids in the range of '8' to '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described some prescription opioids as more readily available than others. They reported methadone and Ultram® high in availability; Vicodin®/Lortab®, Percocet®/OxyContin®, MS Contin®/Kadian® and Duragesic® moderate to high in availability; and Opana® low to moderate in availability. Participants generally agreed that the availability of prescription opioids has remained stable over the last six months, with the exception of methadone, which reportedly has increased in availability, and OxyContin® OC (old formulation), which reportedly has decreased in availability. In April 2010, the U.S. Food and Drug Administration (FDA) approved a new formulation: OxyContin® OP, designed to have greater tamper-resistant factors. When an individual attempts to crush and dissolve the new formulation, it results in a gelling of the contents, rendering them extremely difficult to snort or inject. By September 2010, the old formulation had been removed from most pharmacy shelves, and the new formulation took its place. It did not take long for participants to notice the difference between the two formulations, and inundated retail pharmacies with calls in September and October, looking for the old OxyContin®. While availability of OxyContin® remains relatively high, the desirability of the new formulation has already dropped considerably, and users have started targeting other prescription opioids, as well as heroin, as substitutes. Several participants commented on the new formulation, saying things like, "I don't like them [OxyContin® OP]; [Purdue Pharma] changed it ... [it's] less desirable, can't inject anymore ... [so] people changing to heroin [expectation]. Opana® will be really big by next year."

Law enforcement expressed concern of potential increase in heroin use if the new formulation of OxyContin® becomes harder to find and determined to be more difficult to abuse. Participants reported Vicodin® to be less sought out as well: "Vicodin® is not as desirable anymore ... it's used as last



resort if others [other prescription opioids] are not available." In contrast, Opana® is gaining momentum as a drug sought by users for a desirable narcotic effect: "Opana® 40 mg feels like OxyContin® 80 mg." In addition to the previously listed available prescription opioids, participants also reported Dilaudid® and Suboxone®/Subutex® as available to street-level users in the Cincinnati region. Media reports confirmed the widespread availability of prescription opioids over the past six months. Eight "pill mills" in Scioto County are alleged to give out prescription medication to anyone who can pay; many believe these clinics fuel the prescription opioid epidemic in the region. The statistics out of Scioto County are staggering: "Nearly one in 10 babies were born addicted to drugs in the last year; admissions for prescription painkiller overdoses were five times the national average" ([www.ohio.com](http://www.ohio.com), Dec. 22, 2010). Prescription opioid-related crime has also been mentioned in recent media reports. In January 2011, the *Cincinnati Enquirer* reported that undercover police officers charged a man with selling 100 (30 mg) oxycodone pills, valued at \$3,000 (<http://news.cincinnati.com/section/NEWS>, Jan. 22, 2011). BCI&I London crime lab reported that the number of prescription opioid cases it processes has remained stable for most prescription opioids while reporting increases in the number of Percocet®, OxyContin® and Vicodin® cases.

Participants reported the following street prices for various prescription opioids as follows: Dilaudid® 8 mg (\$20), Duragesic® 100 mcg (\$50, typically \$.50 - \$1 microgram), Opana® 20 mg (\$20), Opana® 40 mg, (\$25 - \$45), OxyContin® 40 mg (old formulation sells for \$20 - \$35), OxyContin® 60 mg (old formulation sells for \$35 - \$40), OxyContin® 80 mg (old formulation sells for \$50 - \$80), OxyContin® 80 mg (new formulation, sells for \$20 - \$40 or \$0.50 per milligram), OxyContin IR® 5 mg (\$5), OxyContin IR® 15 mg (\$10 - \$15), OxyContin IR® 30 mg (\$15 - \$25), Percocet® 5 mg (\$3 - \$5), Percocet® 10 mg (\$6 - \$9), Vicodin® 5 mg (\$2 - \$3), Vicodin® 7.5 mg (\$4 - \$7) and Vicodin® 10 mg (\$6 - \$10).

While it is possible to gain access to prescription opioids through street level drug dealers in the region, it is more common for participants to get these opioids from people that have prescriptions for them. In Cincinnati, if certified as homeless, an individual is able to get Percocet® free. Several participants cited the misuse and abuse of prescription opioids as originating with legitimate use. According to a participant, "I was injured in football in high school, [prescribed a prescription opioid and] got hooked, and am still hooked." A

participant reported driving to Florida for OxyContin® and obtaining them through one of the pill mills (i.e., pain clinics) there, *"I'd go to Florida and get pills ... got 80 mg OxyContin®, get 3,000 pills for \$800, and I'd sell them for \$30 a pill."* While tramadol (i.e., Ultram®) reportedly is available at a high level in the Cincinnati region, participants stated that there is no market for it in the area. The most common routes of administration of prescription opioids are swallowing and intranasal inhalation (i.e., crushing and snorting of the powdered content). It was less commonly reported that consumers are crushing and dissolving opioids for injection purposes.

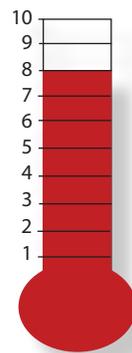
Overwhelmingly, both participants and professionals described the abuse of prescription opioids as beginning with legitimate use for pain conditions. Individuals that become dependent on opioids from legitimate use were not categorized to fit into a stereotype of a typical user by respondents. The first time user is reportedly younger than first time users of other drugs, beginning as early as 13 years of age. Several participants stated that the upper end of the age range for use of prescription opioids extends to people 80 years of age. Professionals stated that older individuals often participate in a *"senior swap,"* whereby they exchange medications with one another depending on an individual's need. There is no clearly defined ethnicity to misuse and abuse of prescription opioids, although younger users are reported to be more likely White. Participants reported an increase in use in the Latino population. Participants and professionals alike stated that the user of prescription opioids is more likely to be a part of the working class. A participant described the drugs used by this class: *"Demerol®, Percocet®, Vicodin® [you] see among old users ... middle age and working ... labor force ... factory workers."*

Reportedly, alcohol and benzodiazepines are the two substances most often used in combination with prescription opioids. Other substances include crack cocaine, heroin and marijuana.

### Suboxone®

#### Current Trends

Suboxone® is moderately available in the region. Respondents most often reported the street availability of Suboxone® as '7' or '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to



get). Participants reported the availability of Suboxone® as higher now than in the past. Participants and professionals alike attributed the increase in street availability to increased use by physicians and clinics, prescribing or dispensing Suboxone® for legitimate purposes. Users stated that initial use often resulted from legitimate use, but then they would obtain it from friends, other users or street dealers: *"First [you] get Suboxone® through a prescription, then through friends."*

Participants and professionals alike reported there is also street availability of Subutex® but at a much lower level than that for Suboxone®. BCI&I London crime lab reported an increase in the number of Suboxone® cases it processes.

Current street names for Suboxone® include "N8's," "orange stop signs" and "subs." Participants reported current prices for Suboxone® 8 mg to range from \$7 – \$20, with the most frequently reported price being between \$10 – \$15. Suboxone® 2 mg reportedly is also available and typically for \$3 – \$5 per tablet. Law enforcement reported being able to buy Suboxone® 8 mg tablets for \$9 – \$10 each and Subutex® for \$15 per tablet.

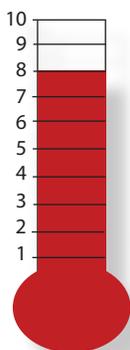
Most participants reported the use of Suboxone® on the street to be for primary prevention of withdrawal from prescription opioids or heroin. A shift to use of both Suboxone® and Subutex® for abuse purposes emerged after discussion with both participants and professionals. A participant stated, *"Suboxone® is being abused by those not on something else."*

Participants reported both swallowing and intranasal inhalation (i.e., snorting), as primary routes of administration of Suboxone®. A participant explained, *"Snorting produces a high with Suboxone."* While injection of Suboxone® was not reported, participants reported injection of Subutex®. When either Suboxone® or Subutex® is reportedly used for abuse purposes, consumers are less likely to use them in combination with other drugs. Substances that are reportedly used in combination with Suboxone® include alcohol, benzodiazepines and marijuana.

## Sedative-Hypnotics

### Current Trends

Sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) are moderately available in the region. Overall, participants reported that availability of Klonopin®, Xanax® and Valium® were '8,' Ativan® and Soma® were '5' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The street availability of sedative-hypnotic drugs has remained fairly stable over the last six months. Participants often cited gaining access to them through connection with others who sell a legitimate prescription. A participant categorized the potency of the primary benzodiazepines by saying, "In order of increased strength it's Valium®, then Klonopin®, then Xanax® ... they black you out [cause impairment to long term memory]." Participants cited Xanax® as the most desirable sedative-hypnotic, followed by Klonopin®, a close second. Law enforcement stated that they have recorded an increase in Klonopin® diversion over the last six months. BCI&I London crime lab reported that the number of sedative-hypnotic cases it processes has remained stable.



Participants reported the following sedative-hypnotics as available to street-level users: Ativan® .25 mg (\$0.25 – \$1), Ativan® 1 mg (\$1.50), Ativan® 2 mg (\$2), Klonopin® .50 mg (\$1 – \$1.50), Klonopin® 1 mg (\$2 – \$3), Klonopin® 2 mg (\$3 – \$5), Xanax® .25 mg (\$0.25), Xanax® .50 mg (\$1 – \$1.50), Xanax® 1 mg (\$2 – \$3), Xanax® 2 mg (\$4 – \$5), Xanax® 6 mg (\$6), Valium® 5 mg (\$1 – \$2), Valium® 10 mg (\$2 – \$4) and Soma® 350 mg (\$1.50 – \$2). While reportedly there is low demand for other sedative hypnotics on the street, participants indicated some street availability and sale of Desyrel® 200 mg (\$1) and Seroquel® 100 mg (\$2 – \$3).

Participants reported a few ways of consuming sedative-hypnotics, with the most common routes of administration being oral consumption and intranasal inhalation (i.e., snorting); few participants reported crushing and injecting sedative-hypnotics. According to participants, the typical abuser of sedative-hypnotics is a White female in her 20's to 30's raising a family at home. The use of sedative-hypnotics is not isolated to just one group of users however, although there were fewer reported Black or Latino consumers of

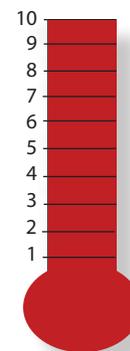
these medications. Participants reported first time users of sedative-hypnotics to be as young as 12 to 13 years of age, which was attributed to widespread availability in the home by a parent or other family member. Professionals also described sedative-hypnotic users as middle-to-upper income professionals that participate in the "party scene."

Substances reported as commonly used in combination with sedative-hypnotics include alcohol, heroin, marijuana and prescription opioids (i.e., methadone). Several participants stated that the combination of methadone and Xanax® gives the user a "heroin-like high." A participant explained, "Methadone is huge with Xanax® ... it boosts the effect ... [you] get close to a heroin high."

## Marijuana

### Current Trends

Marijuana is highly available in the region. Participants most often reported the availability of marijuana as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants reported that marijuana is one of the easiest drugs to obtain, citing the close proximity to Kentucky, where outdoor grows are common, along with an increase in indoor grow operations in the region, as reasons for marijuana's widespread availability. Media reports confirmed the widespread availability of marijuana over the past six months. In October 2010, the *Cincinnati Enquirer* reported that Sherriff's deputies found 1,050 marijuana plants with an estimated street value of over \$1 million in a Liberty Township home (<http://news.cincinnati.com/section/NEWS>, Oct. 28, 2010). In January, *WBNS-10TV* reported that Sherriff's deputies arrested one man after he reported a home invasion. Upon arrival, police found 850 pounds of marijuana valued over \$1 million in the man's home ([www.10tv.com](http://www.10tv.com), Jan. 3, 2011). In addition to high-grade marijuana, participants reported increased availability of low and medium-grade marijuana during the last six months. BCI&I London crime lab reported that the number of marijuana cases it processes has remained steady.



Participant quality scores of marijuana was high, with the most common score being '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Several participants

explained that the quality of marijuana depended on whether the user bought “commercial weed” (i.e., low to mid-grade marijuana) or hydroponically grown (i.e., high-grade marijuana). A participant complained that recent marijuana buys were “*too seedy, more stems added,*” but overall the participant stated that there was little change in quality during the last six months. The quality increased with the grade of marijuana being purchased, from low to medium to high-grade.

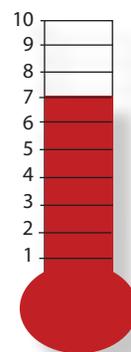
Current street jargon includes countless names for marijuana. The most commonly cited names largely depended on the grade of marijuana. Participants listed the following as other common street names: “Bobby Brown,” “bull crap,” “dirt weed,” “Mexican dirt weed,” “middies,” “regular good” and “schwag” for low to mid-grade marijuana; “Bin Laden,” “bud,” “chocolope,” “kush,” “pot,” “power ball,” “purple haze,” “silver haze,” “southern light” and “white rhino” for high-grade marijuana. Hydroponically grown marijuana universally was given the slang name “dro.” A participant referenced the plant species of marijuana: “*There were three basic types of marijuana ... you got your sativa, afghan and indica,*” all of which produce high-grade strains of marijuana. The price of marijuana depends on the quality desired. Participants reported they can buy commercial-grade marijuana in many different quantities: a “joint” (i.e., marijuana cigarette) sells for \$3 – \$5; a “blunt” (i.e., marijuana cigar) sells for \$10; a gram currently sells for \$5 – \$10; 1/4 ounce sells for \$25 – \$50; an ounce sells for \$50 – \$140; 1/4 pound sells for \$360; and a pound sells for \$400 – \$1,100. Participants also reported they can buy high-grade marijuana in many different quantities: a “joint” (i.e., marijuana cigarette) sells for \$7; a gram currently sells for \$15 – \$30; 1/4 ounce sells for \$60 – \$125; an ounce sells for \$200 – \$600; and a pound ranges in price from \$1,500 – \$6,000. Additionally, a gram of “kief” (i.e., the delta-9-tetrahydrocannabinol (THC)-containing crystallized material scraped from the flowering tops of high-grade marijuana) reportedly costs \$20 – \$30. The most common route of administration for marijuana is smoking of the plant material in either a rolled/wrapped paper (“joint” or “blunt”) or in a pipe. Some participants reported the baking of marijuana into brownies or cookies, but this is not a common practice.

Overall, participants and professionals alike were unable to define any particular group of people that use marijuana more frequently. A professional indicated that the number of people who use marijuana is quite large, stating, “*Almost as*

*many people that drink [alcohol] use marijuana.*” Participants echoed that same sentiment, “*Everybody uses it [marijuana].*” Participants reported that street dealers of marijuana are more likely to be young Black males, and they are seen commonly smoking their own supply on the streets where they sell. Another professional described the often seen open-air drug dealing of marijuana on the street saying, “*They think it’s [marijuana] legal.*” Professionals also reported that young people are getting ‘high’ on their way to school in the area, and this is becoming a problem for schools. Reportedly, the use of marijuana in the Latino population is almost to the same degree as use in the White and Black populations. First time users of marijuana are younger than what participants reported for any other drug use, as young as 8-10 years of age.

Reportedly, substances that are most commonly used in combination with marijuana include alcohol and powdered and crack cocaine. Other substances used with marijuana are benzodiazepines, ecstasy, heroin and LSD (lysergic acid diethylamide). A participant reported dipping marijuana in embalming fluid (a.k.a., “wet”), but this is not considered a common practice. Another participant reported, “*Dipping [marijuana] in honey after rolling in unflavored paper ... it burns slower and tastes sweeter ... use Optimo® or Swisher® papers.*”

### Methamphetamine Current Trends



Methamphetamine is moderately available in rural areas around the region, but rarely found in the City of Cincinnati. Participants most often reported the availability as ‘7’ in rural areas (i.e., Clermont and Brown counties) and ‘0’ in Cincinnati on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants reported that methamphetamine is available in both powdered and crystal forms, and that both are locally produced. None of the participants was aware of methamphetamine being transported into the area from other states, Canada or Mexico. In the areas where the drug reportedly is available, participants indicated that the manufacture of methamphetamine is increasing as buying groups form to gain access to higher amounts of precursor chemicals. A

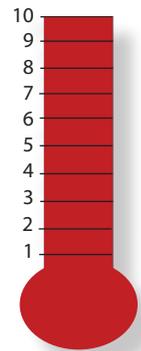
participant reported that a methamphetamine “cook” would pay \$20 per person to buy pseudoephedrine. Media reports over the past four months have shown methamphetamine to be available in the region. The *Cincinnati Enquirer* reported three methamphetamine labs found in Clermont and Warren counties (<http://news.cincinnati.com/section/NEWS>, Jan. 20, 2011). Law enforcement involved in the arrests corroborated what participants said about the production of methamphetamine, explaining users would, “obtain pseudoephedrine from various stores throughout the region and then supply the manufacturers or ‘cooks’ with the decongestants at an inflated price.”

Participants reported that the quality of methamphetamine is high in the area. The most common score reported for methamphetamine quality was ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). A participant stated that the quality was, “an ‘8’ [quality rating] unless you put too much battery acid in it [methamphetamine].” According to participants, the quality of methamphetamine relies heavily on the cook’s abilities to follow the recipe. Participants stated that the method primarily used in the region utilized anhydrous ammonia in the manufacture of methamphetamine. The appearance of available methamphetamine was reported to be either “dirty,” a brown colored product, or “clean,” a white colored product, also called “crystal.” Slang terms most often used to describe methamphetamine include “ice” and “meth.” Less commonly used terms include “crank,” “crystal,” “glass,” “go ease” and “go fast.” Participants reported that a gram of powder or crystal methamphetamine sells for \$80 – \$100. A participant stated that it did not take much of the drug to have a significant effect on her life: “\$40 [of methamphetamine] will keep you up 4-5 days ... but by the third day you hate your life.” Reportedly, the most common route of administration of methamphetamine is smoking. Other routes of administration that were cited as less common include intranasal inhalation (i.e., snorting) and injection. Participants described the typical user of methamphetamine as a White male, in his 30’s-40’s, and of lower socioeconomic class. Professionals described the population that uses methamphetamine as a small group that relies on the locally produced drug in the region where they reside.

### Ecstasy Current Trends

Ecstasy [methylenedioxymethamphetamine (MDMA)] is highly available in the City of Cincinnati where availability

has remained high over the last six months. Participants most often reported ecstasy’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants reported geographic variation in availability to occur across the region, with the drug available in moderate levels in other areas outside of Cincinnati. A participant stated, “Ecstasy went from the burbs to the hood.”

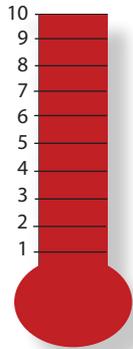


Slang terms used to describe ecstasy include “beans,” “beaners,” “cookers,” “eye fryers,” “rolls” and “sals.” Participants reported tablets with various imprinted pictures on them as the form of ecstasy available. Reportedly, the most common pictures on ecstasy tablets are of Superman and naked women. Participants described other pictures, including dolphins, handguns, kangaroos, President Obama’s head and Snoopy. Participants reported that ecstasy sells for \$7 – \$20 per tablet most commonly, with some dealers charging upwards of \$30 for a tablet in the suburbs. Most participants were aware that tablets sold as ecstasy are often mixed with other drugs, and that buyers are not guaranteed a pure product. Participants reported that the use of ecstasy tablets enhance the mood of the person using them. If a user is in a bad mood, however, this bad mood is also enhanced. Participants and professionals alike reported that ecstasy made aggressive people more aggressive, and ecstasy use is linked to increased gun violence in the City of Cincinnati.

Participants described the most common routes of administration for ecstasy to include swallowing the tablets or inserting them into the rectum. The placement of ecstasy tablets into the rectum was reported to be commonly practiced, and is referred to as “plugging.” Substances used commonly in combination with ecstasy include alcohol and marijuana. A participant explained that the combined use of alcohol or marijuana “enhanced the effect of the ecstasy.” A professional reported that ecstasy is also being used rectally in combination with the erectile dysfunction drugs Cialis® and Viagra® (both \$15 – \$20 per pill), along with marijuana. Reportedly, dealers of ecstasy are more likely to be young Black males. Participants described the typical user of ecstasy as young, between the ages of 18 to 25 years of age, with first use starting as young as 15 years of age. Professionals reported that ecstasy is attracting younger users, most of which are male.

## Prescription Stimulants

### Current Trends



Participants reported the availability of both Adderall® and Ritalin® at high levels in the region. Both of these drugs most often scored '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Professionals reported that prescription stimulants are more likely to be used by White or Asian individuals between the ages of 20 years to the early 30's, and while both genders use these substances, the typical user is more likely to be female. No slang terms were reported for prescription

stimulants. Prices for prescription stimulants included the following: Adderall® or Adderall® XR 15 mg (\$3), Adderall® 20 mg (\$3), Adderall® or Adderall® XR 30 mg (\$5) and Ritalin 20 mg (\$1.50). Participants reported that the most common routes of administration are swallowing or crushing for intranasal inhalation (i.e., snorting) of the tablets.

## Hallucinogens

### Current Trends

Hallucinogens are moderately available in the region. Lysergic acid diethylamide (LSD) and psilocybin mushrooms are seasonally available in the area. Participants most often reported LSD's availability as '5' and psilocybin mushrooms as '7' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). No prices were available for either LSD or psilocybin mushrooms. Professionals reported that the typical user of LSD and psilocybin mushrooms is more likely to be White, less than 30 years of age, comprised of both males and females. Ketamine was mentioned as being used in the MSM (men who have sex with men) community by both White and Black males less than 30 years of age.

## Other Drugs

Participants and professionals listed a variety of other drugs as being present in the area, but these drugs were not mentioned by the majority of people interviewed. Reportedly, synthetic marijuana (e.g., "K2" and "Inferno") is being used by a few participants for recreational use. Participants said synthetic marijuana is growing in popularity

among many users. A few participants reported use of prescription cough medicines that contain codeine and over-the-counter cough medicines containing dextromethorphan (DXM), like Robitussin®; they reported dipping tobacco cigarettes and marijuana "blunts" in cough medicine before smoking.

## Conclusion

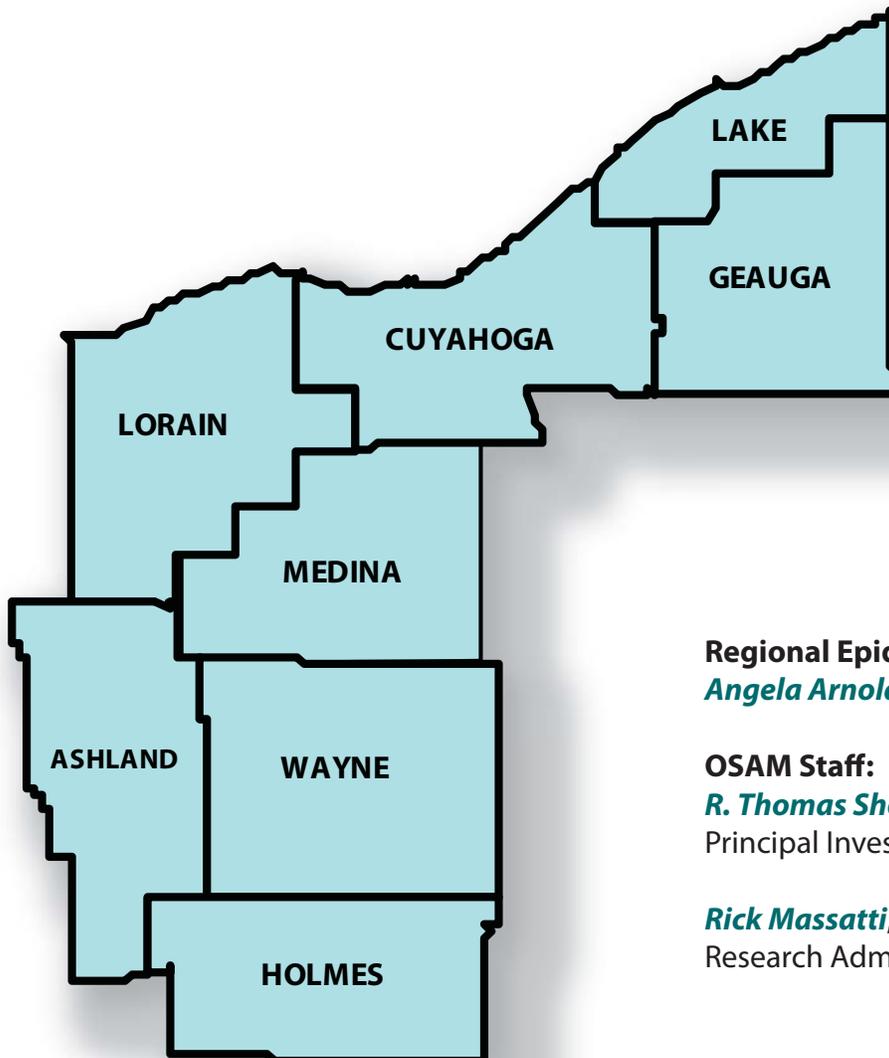
Powdered cocaine, crack cocaine, heroin (i.e., brown and white powdered), prescription opioids, marijuana, ecstasy and prescription stimulants are the most available drugs throughout the Cincinnati region. Noted increases in availability over the previous six months exist for heroin, prescription opioids (i.e., methadone, Percocet®, OxyContin® and Vicodin®) and Suboxone®. Eight "pill mills" in Scioto County are alleged to give out prescription medication to anyone who can pay; many believe these clinics fuel the prescription opioid epidemic in the region. While availability of OxyContin® remains relatively high, the desirability of the new formulation has dropped considerably, and users have started targeting other prescription opioids, as well as heroin, as substitutes. In particular, Opana® is gaining momentum as a drug sought by users. The first time user of prescription opioids is reportedly younger than first time users of other drugs, beginning as early as 13 years of age. More heroin is available in rural and suburban areas of the region than in the urban core of Cincinnati. Many dealers have switched from selling crack cocaine to selling heroin. There are two dominant groups of heroin users: younger, predominantly White users and older Black users. New users are more likely to be younger (16 – 18 years old), White, and often female. Alarming, the most common route of heroin administration is intravenous injection, with new heroin injectors from the suburbs reportedly less educated about needle use. Increases in both prescription opioid use and heroin use were also noted as existing in the region's Latino population. Opioid addicts continue to acquire Suboxone® on the street for primary prevention of withdrawal when they are unable to secure prescription opioids or heroin. A shift to use of both Suboxone® and Subutex® for abuse purposes is emerging among non-opioid addicted persons.

# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Cleveland Region

June 2010-January 2011

**John R. Kasich**, Governor  
**Orman Hall**, Director



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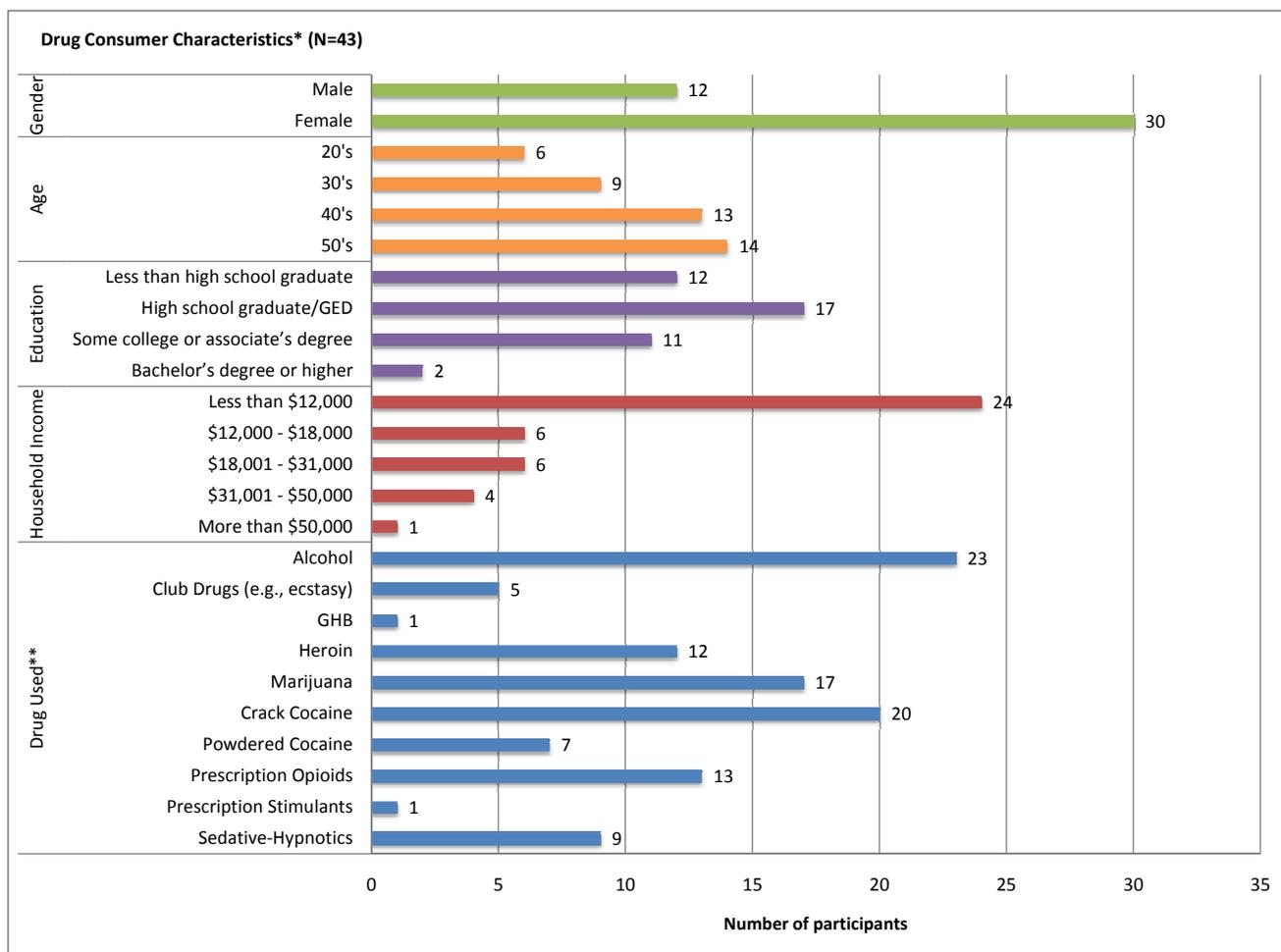
### Regional Profile

Indicator <sup>1</sup>	Ohio	Cleveland Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	2,302,406	43
Gender (Female), 2009	51.2%	51.8%	69.8%
Whites, 2009	82.2%	75.1%	46.3%
African Americans, 2009	11.9%	17.6%	53.7%
Hispanic or Latino Origin, 2009	2.8%	4.2%	0.0%
High school graduates, 2008	84.6%	90.6%	71.4%
Median household income, 2009	\$45,467	\$47,820	Less than \$12,000 <sup>2</sup>
Persons below poverty, 2009	15.1%	12.4%	56.1% <sup>3</sup>

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

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

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



\*Not all participants filled out forms; therefore numbers may not add to 43.

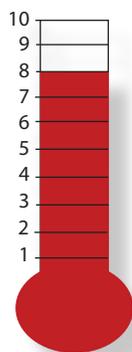
\*\*Some respondents reported multiple drugs of use over the past six months.

## Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Cuyahoga County. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (i.e., law enforcement officers) via focus group interviews, as well as to data surveyed from Cuyahoga County Coroner's Office and the Bureau of Criminal Identification and Investigation (BCI&I) Richfield Office, which serves the Cleveland, Akron and Youngstown areas. The aforementioned secondary data sources reported summary data for January to June 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the last six months (i.e., from time of interview through prior six months); thus, all current secondary data correspond to the current reporting period of participants. In addition to the aforementioned data sources, *The Plain Dealer*, Ohio's largest newspaper, was queried for information regarding regional drug abuse for June 2010 through January 2011.

## Powdered Cocaine

### Current Trends



Powdered cocaine is readily available in the region. Participants most often reported the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants indicated that the availability of powdered cocaine has decreased somewhat in recent months, with widespread agreement that powdered cocaine is not as easy to obtain as crack cocaine. A respondent reported, "The powder [powdered cocaine] is harder to get now than it was when I first started using drugs

*because crack [crack cocaine] took over. Everybody wants crack now instead of powder. Powder now is so broken down [diluted]. Now, when you re-cook it down, it don't even come back. So, people usually have rocks [crack cocaine] instead of powder."* Collaborating data also indicate that powdered cocaine is readily available in the region. The Cuyahoga County Coroner reported 10.7 percent of all deaths it investigated were drug related (i.e., had an illegal substance present or legal drug above the therapeutic range). Furthermore, the coroner reported cocaine as the most common drug present in drug-related deaths; it was present in 29.8 percent of all drug-related deaths (this is a decrease from 43.1 percent for

the previous six-month reporting period; Note coroner's data is aggregate data of powdered cocaine and crack cocaine and does not differentiate between these two forms of cocaine). *The Plain Dealer* reported police arrests of several individuals for cocaine possession and trafficking in the region. In July, the newspaper reported that an Arizona man was arrested with three kilos of cocaine in his vehicle while driving through Lake County ([www.cleveland.com](http://www.cleveland.com), July 13, 2010) while in September, it reported that police raids in Medina County resulted in two separate arrests for cocaine trafficking (one arrest for crack cocaine trafficking) ([www.cleveland.com](http://www.cleveland.com), Sept. 16, 2010). BCI&I Richfield crime lab reported that the number of powdered cocaine cases it processes has remained stable.

Participant quality scores of powdered cocaine varied from '0' to '10' with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). A common theme to emerge among participants is the belief that the quality of powdered cocaine is greatly dependent on factors such as when shipments arrive and how closely the supplier is connected to his/her source. For example, when a shipment arrives, and many dealers are able to obtain powdered cocaine, they are less likely to "cut" (i.e., dilute) their product. In addition, dealers who are higher in the distribution chain seem to offer a consistently higher quality product. A participant said, "You might have six months where you get nothing but garbage, then another six months where all the dope is good all over the city." Participants reported that powdered cocaine is "stepped on," or cut with, many other substances such as baby aspirin, baby laxative, baking soda, NoDoz®, prescription medications (e.g., local anesthetics such as procaine and Nubain®), rat poison, Similac® baby formula and Vitamin B12. A participant stated, "I know when I first started using powdered cocaine it was absolutely great. But, I had got some a couple months ago and it was garbage. I don't know what it was cut with. But it wasn't no powder cocaine." BCI&I Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine (e.g., NoDoz®). Police officers indicated a shifting demand away from powdered cocaine due to quality and purity inconsistencies. An officer noted, "We're finding that more of the dealers want to deal with the crack cocaine because when they deal with the powder, it's been cut [diluted] so many times it won't rock up, and the end purchaser is very leery. These guys are strictly working with crack even though the penalties are greater."

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "girl" and

"white girl." Participants listed the following as other common street names: "blow," "coke," "powder," "skirt," "snow," "soft" and "sugar." Participants reported that the price of a gram sells for \$40-\$80; 1/16 ounce, or "teener," sells for \$100-\$375; 1/8 ounce, or "eight ball," sells for \$120-\$375; 1/4 ounce sells for \$325-\$350. Participants in the region most commonly use powdered cocaine by intranasal inhalation (i.e., snorting). Both law enforcement and participants reported that cooking powdered cocaine to create crack cocaine is the other most common technique for administering cocaine. Smoking powdered cocaine after it has been "rocked up" is extremely common, due in part to concerns about the quality of the cocaine. A police officer stated, "A lot of these guys [users] wanna cook it [crack cocaine] up right then and there. Sometimes that assures the purchaser that they're getting the real thing." Intravenous injection and lacing cigarettes or marijuana with powdered cocaine were also cited as common methods.

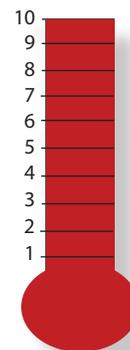
A profile of a typical user of powdered cocaine did not emerge in the data. While most participants were reluctant to ascribe powdered cocaine use to any particular race, age, or income level, they did indicate that use of powder was affected by social context. The drug continues to be popular for users in a club or party scene. A participant stated, "I bartended for 18 years, and powdered cocaine is like peanut butter and jelly, hand in glove at bars. All bars, you can find powdered cocaine." Several participants also indicated that older users tend to prefer to snort powdered cocaine, whereas younger users more often consume powdered cocaine intravenously or laced in tobacco and marijuana cigarettes as previously noted. Reportedly, powdered cocaine is often used in conjunction with "downers" like alcohol, heroin and marijuana. A participant reported, "I would blow coke [powdered cocaine] and have to come down. I would either snort an oxy [OxyContin®] or shoot up [inject] heroin."

### Crack Cocaine

#### Current Trends

Crack cocaine is highly available the region. Participants most often reported the drug's current availability as '10,' and law enforcement reported it as '9' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Universally, participants reported crack cocaine as being one of the easiest drugs to acquire. Unlike the dealers of other drugs, participants indicated that crack cocaine dealers are often actively soliciting new customers. As a participant said, "It's [crack cocaine] everywhere. And, I mean I walk out

of my apartment and I get approached by three people at least. And that's real." Another participant echoed the sentiment, "You walk in the liquor store, and the dope boy will ask you, 'Whatcha need? Whatchu want?' So, no matter where you go, somebody is going to have it [crack cocaine] 24-7." BCI&I Richfield crime lab reported an increase in the number of crack cocaine cases it processes. Law enforcement and participants indicated there has been no change in the availability of crack cocaine in the last six months.



Participants most often reported the quality of crack cocaine as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that the quality of crack cocaine depended on factors like their relationship with the dealer, and the availability of high quality powdered cocaine, but that in general, the average quality of crack has been decreasing. A participant commented, "I just recently had a relapse. It [crack cocaine] wasn't even worth my lapse. I thought it was going to be this big thing, but I thought afterward, I'm about to be sober, I'm just gonna stay sober. It was bad [quality], it was real bad." Participants cited numerous substances used to "cut" [i.e., dilute] crack cocaine. As a participant said, "It's horrible. They're cutting it [crack cocaine] with anything." More specifically, they listed baking soda, baby medicines, Sprite® and vitamins as cutting agents. Recently, police noted a few more sales of fake crack cocaine where they thought, "People [were] just trying to make money," and Westside participants reported crack cocaine being cut with heroin. BCI&I Richfield crime lab cited as cutting agents: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine (e.g., NoDoz®).

Current street jargon includes many names for crack cocaine. The most commonly cited names were "hard" and "rock." Consumers listed the following as other common street names: "butter," "chicken," "crack," "giddy-up," "ice," "scooby snacks," "work" and "yay-yo." Participants reported 1/4 gram of crack cocaine currently sells for \$40; 1/8 ounce, or "eight ball," sells for about \$150; 1/4 ounce sells for \$375 and up. The majority of crack cocaine consumers reported buying the drug in small quantities. For example, a "20 rock" is \$20 worth of crack cocaine, equivalent to a pinkie nail sized piece of crack cocaine or about six grams. The "20 rock" units can also be purchased in \$50 increments: three "20s" for \$50 worth of crack cocaine. A "50 rock" ranges in size from the equivalent

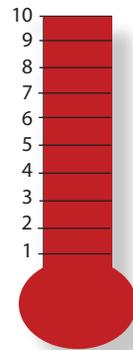
of one thumbnail plus a pinkie nail or a doughnut hole. As a participant said, *"The average for \$50 is about three clumps [rocks]. It depends on your relationship with the dope boy."* Pricing and rock size has remained stable for the last six months. Users also reported getting two-for-one specials from regular dealers: *"That's a dub. That's a double whatever. A fifty dub is two 50's for \$50."*

Reportedly, smoking is the most common way crack is consumed, with participants most frequently citing that "10 out of 10" crack users choose this method. Other ways mentioned included intranasal inhalation (i.e., snorting) and lacing it into marijuana or cigarettes. A few participants had observed intravenous injection of crack cocaine: *"I saw they [users] were melting it [crack cocaine] down with vinegar and using it like cocaine. They would draw it up in a syringe [and inject]."* Users who preferred smoking did not typically overlap with users who preferred injecting. As observed by one participant, *"The ones that would normally smoke [crack cocaine] never shot up [inject] heroin."* Indeed, many crack cocaine smokers reported never having observed other methods.

A profile of a typical user of crack cocaine did not emerge in the data. Participants tended to agree that crack users varied in age, race, and they were unable to identify a "typical" crack cocaine user. On the other hand, law enforcement noted that the majority of their crack cocaine arrests are comprised of poor Blacks and poor suburban Whites. An officer observed, *"[Whites] go in their house and they smoke their rocks so they don't get caught, but the people we deal with are wandering the streets at two in the morning ... It's not discriminatory. It's about where they are."* Police cited a growing number of older crack cocaine users, especially females aged 40 and above: *"From basic patrol, I've noticed more females in their fifties, more arrests for females with crack [cocaine]. I don't know if they're muling [transporting] it or if they're actually using it. But definitely more involved with it."*

In addition to alcohol, participants reported that crack cocaine is used in combination with heroin (a.k.a., "speedball" when "shot" together), marijuana (a.k.a., "primo") and prescription opioids. Using crack cocaine with all of the aforementioned is reportedly very common. Many participants explained that the use of these substances is necessary in order to "come down" from the crack cocaine high. A participant explained, *"For me personally, you would not catch me with a rock [crack cocaine] unless I had a beer and a shorty [marijuana]."*

## Heroin Current Trends



Heroin 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' (high availability, extremely easy to get). Law enforcement (area police officers) most often rated current availability as '9'. There was agreement among participants and community professionals that heroin is as available as crack cocaine. However, several participants noted that heroin's availability is relative to one's drug connections. A participant said, *"It [heroin availability] all depends on who you know."* This statement was recorded across all focus groups. Another participant said, *"It's [heroin] just as easy as getting crack [cocaine] ... I take that back, because I couldn't go stand on the corner and someone would come up to me."* Law enforcement agreed that while there is plentiful supply, the network of heroin dealers and users is much smaller. An officer stated, *"For every 20 crack [cocaine] dealers there's one heroin dealer. Crack dealers are all over the place. There aren't so many heroin dealers."*

Collaborating data also indicate that heroin is highly available in the region. The Cuyahoga County Coroner reported heroin as a common drug present in drug-related deaths; it was present in 28.2 percent of all drug-related deaths (this is an increase from 24.1 percent for the previous six-month reporting period). *The Plain Dealer* reported a couple of large heroin busts in the region. In September, the newspaper reported that federal prosecutors had charged 24 individuals in the Cleveland area in *"the largest-ever heroin bust in Ohio,"* during which police reportedly seized 44 pounds of heroin ([www.cleveland.com](http://www.cleveland.com), Sept. 21, 2010). In the same article, a Cleveland Police Detective was quoted as saying, *"It's [heroin use] real huge in the suburbs now."* In another *Plain Dealer* article published online in January entitled, *"Heroin Bust Points to Drug's Growing Popularity in Northeast Ohio,"* the U.S. District Attorney for the Northern District of Ohio was attributed with saying that heroin is the fastest growing drug problem in the region ([www.cleveland.com](http://www.cleveland.com), Jan. 13, 2011). BCI&I Richfield crime lab reported an increase in the number of heroin cases it processes.

The most common type of heroin available in the Cleveland region is brown powder. Some participants also reported

having encountered white powder. Black tar heroin, on the other hand, is reportedly rare. Law enforcement noted that they had not made an arrest for black tar heroin in over a year and a half. Many participants did not know what black tar heroin was. All participants stated that over the last six months, either heroin's availability has remained unchanged, or it has increased. In nearly all sessions, participants cited a link between prescription opioid abuse and an increase in heroin use. Participants noted that heroin is cheaper to buy than prescription opioids. A heroin user explained, *"When I went from using pain pills [to heroin], I was paying \$50 – \$60 for an 80 mg OxyContin® and you can go get five or six \$10 bags of heroin for that amount. You do one bag of heroin of good quality, and that's your day. So you figure one bag is \$10, one pill is \$60 and you need two pills for the whole day."* Law enforcement and participants both noted that heroin use seems to be growing in popularity among young people.

Participant quality scores of heroin varied from '5' to '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The most common score among participants was '10,' and '9' was most often scored by police. Both groups qualified their scores with the caveat, *"It [quality] all depends on who you know."* In addition, there seemed to be some discrepancy between the west side and the east side of Cleveland with regard to heroin's quality. For example, 'East sider' echoed the following participant comment: *"Yeah, there's been a big change [in quality]. Like I said, it's [heroin] the drug of choice now for a lot of people doing the heroin and OxyContin®. With the heroin, a lot of people are getting some really good stuff, chopping it down with baking soda, and taking the quality away from it. So I'd say it went down."* West sider reported an improvement in quality. Besides baking soda, participants did not have specific knowledge about cutting agents used with heroin. However, a user mentioned that buying rocks of heroin ensured better quality: *"Depending on who you get it [heroin] from, you can either get it rocked hard which is the best way to buy it because you know it's not as cut, or crushed up."* BCI&I Richfield crime lab reported that heroin is "very pure," and occasionally "cut" (i.e., diluted) with diltiazem (medication used to treat heart conditions/high blood pressure).

Current street jargon includes many names for heroin. The most commonly cited names were "boy" and "dog food." Participants listed the following as other common street names: "diesel," "food," "H," "heavy," heron, "nod" (denotes higher quality), "ron" (short for "heron"), "smack," and "slips" and "tickets" (named for the slim wax craft baggies heroin is

packaged in). Participants reported a gram of heroin currently sells for \$45-\$150, with 1/2 gram selling for \$80; 1/8 ounce sells for \$550; an amount about the size of a quarter coin reportedly sells for \$50 – \$200; bundles consisting of eight to 10 bags sell for \$80 – \$100, which equates to \$10 per bag (bags were reported to be 1/10 gram or approximately half of a McDonald's® coffee stir spoon). Smoking, intranasal inhalation (i.e., snorting) and intravenous injection were the most common ways reported to administer the drug. Across several focus groups, participants agreed that injection of heroin is preferred by 80 – 90 percent of users, with snorting being the second-most popular method. Users new to heroin begin with snorting. A participant said, *"Everybody I know nowadays is shooting it [injecting heroin]. The people who are sniffing [snorting] it are the people who are just starting out using it. It doesn't matter the ages—when you first start out, you start out sniffing it. Then, it could be a week or a few months later, you end up shooting it because it's a better rush."*

When asked who uses heroin, a police officer replied, *"Everyone: poor people, rich people, White people, Hispanics. All of them ... affluent kids. Middle class to lower-upper class kids into heroin. We know that poor inner city kids are into it too. It's a widespread drug."* Focus group participants agreed that heroin is gaining popularity among younger users, especially high school teens and very young adults. Heroin is also making inroads into the young, urban black population as dealers begin to offer both crack cocaine and heroin to inner city populations. The City of Cleveland continues to supply the eastern suburban population that drives in to obtain heroin. Use seems to be accelerating very quickly on the west side beyond Hispanics and into young, White populations. A former heroin dealer recollected, *"That dog food [heroin]—man, people on the west side, they be lovin' it. That's all they be wanting."* It also continues to be popular with older, functioning users over 50 who tend to prefer needles.

Heroin is reportedly used in combination with benzodiazepines (i.e., Valium® and Xanax®), cocaine (most commonly used drug with heroin; a.k.a., "speedball" when "shot" together), marijuana and prescription opioids (i.e., OxyContin®). A participant reported, *"I would use heroin with OxyContin®. It was like a cherry on top of it [heroin high]."* Another participant observed heroin used in combination with marijuana: *"I know a lot of the younger kids who do it [heroin] like to smoke marijuana when they come down. Actually some of them say that it gets their high going more by smoking marijuana ... Younger kids [use heroin with] marijuana."*

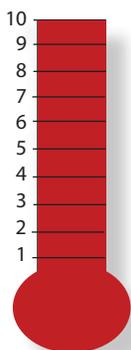
Mentions of overdose were cited more frequently with heroin than any other drug in the survey, and two participants said that an overdose situation would attract new business for the heroin dealer: *"I heard people say, 'Who got that killer D [drug]?' Somebody OD'd [overdosed] off it and that's what they want."*

### Prescription Opioids

#### Current Trends

Prescription opioids are highly available in the region. Participants most frequently reported the availability of prescription opioids as either '9' or '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). OxyContin® OC were once the most preferred prescription opioid, but this drug has become scarce and more expensive due to the manufacturer's replacement with a new formulation, OxyContin® OP, that resists use in any other method besides oral ingestion. A participant explained, *"Back when oxy's [OxyContin®] were the regular OC's, I would pay \$60 for an 80 mg ... But now if you can find a REAL OC, today, they're going for 80 mg for \$80 ... dollar per milligram. Because people want them, they don't want the new formula."* Darvocet®, Dilaudid®, fentanyl, morphine, Opana®, Percocet®, Roxicet® and Vicodin® were cited as readily available. Only a few participants reported that the availability of prescription opioids has decreased over the last six months, whereas the greatest number of participants reported that prescription opioids are now more available or that availability has remained about the same. Increased availability is thought to be tied to an increase in demand from heroin addicts who often begin drug use with prescription opioids and continue to seek them in order to supplement their heroin addiction. Collaborating data also indicate that prescription opioids are highly available in the region. The Cuyahoga County Coroner reported prescription opioids as very commonly present in drug-related deaths; prescription opioids were present in 29 percent of all drug-related deaths (this figure is similar to the 29.2 percent reported for the previous six-month reporting period).

Almost all groups noted that while these drugs are very available on the street through dealers, family and friends, they also had no trouble exploiting the legal avenues for



medical prescriptions. Hospital emergency rooms, pain clinics and certain physicians were cited as reliable sources of pills. As a participant noted, *"All you have to do is say your back hurt, or either pay the doctor an extra \$50 to write you a script [prescription]. Seriously!"* The names of such prescribing physicians are known and shared among the community of pill users. A police officer exclaimed, *"I think the problem with pills are the doctors. We had a search warrant for a lady; we had info that she was selling OxyContin® and everything else. We get over there and she has a whole table full of pills prescribed by the same doctor, and I'm thinking how did that happen?"*

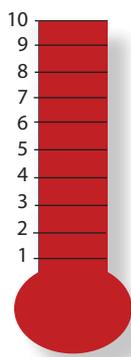
In the Cleveland region, prescription opioids are typically referred to by their full brand names or abbreviations of the brand. For example, "vikes" for Vicodin®, "perc's" for Percocet®, or "V10" and "P10" to indicate brand and strength. OxyContin® has several aliases: "big boys," "OC," "ocean's 11," "ocean city," "oxy" and "oysters." Participants reported the current per pill street pricing of prescription opioids as follows: morphine 200 mg sells for \$10 and higher; Opana® 20 mg sells for \$10; prices for original OxyContin® OC 80 mg reportedly sold for \$40 – \$60 prior to reformulation; currently OxyContin® OC sells for \$1 per milligram; OxyContin® OP, the new formulation, sells for \$20 for 80 mg, and \$10 for 40 mg; Percocet® 5 mg sells for \$3 – \$6, and 10 mg sells for \$5 – \$10; and Vicodin® 750/1,000 mg sells for \$5, and 500 mg sells for \$2 – \$5. The most common methods of pill consumption are oral administration and intranasal inhalation (i.e., snorting) of crushed pills. Snorting or chewing is preferred for a quicker effect as many of the prescription opioids are time-released formulas when taken orally. The Cleveland region did report some intravenous (IV) use; this use is mainly among IV heroin users.

Law enforcement officers perceived that prescription opioids have become an explosive trend over the last 24 months and that new groups of users now abuse or sell these substances. Namely, they cited young, street-level crack cocaine dealers, young people less than 20 years of age, heroin addicts, and older, unemployed people with pills. Officers also indicated that it is more common to see arrests of White males aged 20 – 60 years for illegal prescription opioids. An officer recalled, *"One guy in the second district had over 1,000 pills. He's working in some factory. He was 67 years old! He's not abusing the pills, just selling."* While a typical user did not emerge during discussion with participants, both groups noted a user's likely progression from use of prescription opioids to heroin. A participant said, *"People start off with the pills. Doctors*

*within the last six months or year have been restricted on what they can write as far as narcotics go. People get cut off of their pain pills and have that addiction, then go to heroin."*

Reportedly, prescription opioids are often used in combination with alcohol, crack or powdered cocaine and marijuana. A participant stated that OxyContin® and Xanax® are often combined: *"It's like mixing an upper and a downer. OxyContin® and heroin, or oxy and crack [cocaine]. You can pretty much mix the prescriptions with anything."* Other participants agreed that the combination of OxyContin® and Xanax® is popular.

**Suboxone®**  
**Current Trends**



Although Suboxone® is available through legal prescription channels as well as through illegal purchase, participants in both participants and law enforcement had limited knowledge of this drug. Of the three participants who had used Suboxone® in the last six months, they reported street availability scores of '8' and '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Most experience with and knowledge of Suboxone® derived from legal prescriptions.

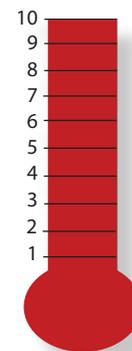
A respondent with some street knowledge of Suboxone® stated, *"It seems like when I didn't need it [Suboxone®], it was always there, but when I needed it, I couldn't find it. It was hit or miss whether or not somebody had it. And, it also depended on if you know people that are prescribed it and if they can sell you a few."*

A minority of the law enforcement personnel reported having experience with arrests involving Suboxone®. An officer said, *"Heroin's like a clique of people. You talk to one person on the west side and if they could hold hands with all the people they know ... you'll make it all the way across the city. They just know everybody; it's a net [network]. They all meet at the methadone clinics; they've all been in the hospital for it. For me to get Suboxone® might be difficult, but I would bet a large sum of money that any heroin user could pick up the phone and get it."*

No slang terms or common street names were reported for Suboxone®. Participants reported current prices for

Suboxone® 8 mg to range from \$5 – \$50, with the most frequently reported price being \$15. Participants and police officers alike reported that Suboxone® is most often used illicitly by those addicted to heroin. Consensus among participants was that those addicted to opioids mostly seek the drug, only on the occasions when their preferred opiate is unavailable in order to avoid withdrawal: *"Sometimes if I didn't have any dope [heroin] and I was dope sick [in withdrawal] I would take a quarter of an 8 mg [of Suboxone®] and two hours later I'd get dope."* The most common method of consuming Suboxone® is orally, as directed. Only one respondent had heard of, but not witnessed, intravenous Suboxone® use. Only sedative-hypnotics were reported to be used with Suboxone. A participant explained, *"If you're gonna use anything else you can only use like a benzo [benzodiazepine] or Xanax® or Valium® because it's [Suboxone®] an opium blocker. You can use as many opiates as you like, but you won't feel anything off it."*

**Sedative-Hypnotics**  
**Current Trends**



Sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) are highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Responses regarding these types of drugs centered on a few major brands that are widely available, including Klonopin®, Soma® Valium® and Xanax®.

When asked about trends within the region, some areas had more access to sedative-hypnotics than others. Participants living on the east side of Cleveland explained that these drugs were becoming less available: *"Because ain't nobody use them [sedative-hypnotics], ain't nobody want them."* An officer from the east side agreed, *"Valium® fell off. I don't see those as often as I used to."* On the other hand, all participants living on the west side of Cleveland indicated that these drugs' availability has remained the same—consistently high. Collaborating data also indicate that sedative-hypnotics are highly available in the region. The Cuyahoga County Coroner reported sedative-hypnotics as a common drug present in drug-related deaths; they were present in 21.8 percent of all drug-related deaths (this is an increase from 16.8 percent for the previous six-month reporting period).

Participants all indicated these drugs are referred to either by the generic term, “benzo’s,” or by their brand names. 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® .5 mg (\$1 – \$2.50); Valium® 10 mg (\$1 – \$2); and Xanax® 1 mg (a.k.a., “bars,” “footballs,” “totem poles,” “xani’s,” and “xanibars;” \$1 – \$2) and Xanax® 2 mg (\$2.50 – \$4). Both participants and law enforcement officers downplayed the relative impact of sedative-hypnotics versus other drugs. A law enforcement officer explained, “We’re seeing more of those pills [sedative-hypnotics]. Small possessions. Not large quantities. I think that’s always going to be an issue. Because they’re not even scheduled.” Police officers also described how most dealers of prescription pills will carry a bottle with their name on it to prove that the medication was legally prescribed to them. As a result, narcotics officers do not make an exceptional effort to attempt arrests for sedative-hypnotics: “When you look through a drug addict’s purse and you see a prescription pill sometimes you look at it, sometimes you don’t.”

Participants did not report buying sedative-hypnotics from street dealers. Most frequently participants obtained sedative-hypnotics from friends, family members and physicians. As one participant said, “At one point I was able to get ‘em [sedative-hypnotics] on my own, but I probably shouldn’t have.” Participants also noted that physicians seemed inclined to prescribe these pills to anyone who requested them, even to patients involved in inpatient and outpatient drug treatment programs.

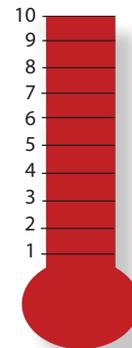
Intranasal inhalation (i.e., snorting) and oral consumption were the use methods most frequently cited, though two participants mentioned use by intravenous injection, with one participant saying, “I’ve shot [injected] xani’s before.” No typical user profile emerged from focus group participants, most likely because all agreed that nearly anyone could get these drugs prescribed from a physician. A participant said, “Everyone I knew was getting them [sedative-hypnotics] from friends or family members who had prescriptions.”

Reportedly, several other drugs are used in conjunction with sedative-hypnotics, which are typically used as an aid to “come down” from the high of other drugs. In addition to alcohol, drugs used in combination with sedative-hypnotics include heroin, marijuana, OxyContin® and other opiates, and Seroquel®.

## Marijuana

### Current Trends

Compared to all other drugs included in the survey, Marijuana was reported to be the most widely available drug in the region. Participants indicated an availability score of ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Although reported herein as ‘10,’ many participants gave a number higher than ‘10’ to indicate the extreme prevalence of the drug (e.g., ‘20,’ ‘50,’ etc.). Participants described marijuana’s availability as being extremely easy to get, available on nearly any street corner or available within minutes of a phone call to a dealer. A participant stated, “You can go to an elementary school and get weed [marijuana]. You can get that from anybody and everybody. Everybody sells weed.” Media outlets across the region (i.e., *The Plain Dealer* and the *West Geauga Sun*) have reported on marijuana arrests over this current reporting period in almost every county in the region.



Not a single participant indicated that marijuana is becoming less available. A few stated its availability has remained the same, but most participants said it was more available than ever, especially high-grade marijuana. A police officer commented, “The higher end stuff is more available. A few years ago, you [would] see the kush [high-grade marijuana] every now and then. Now, everyone out there has it.” When further questioned, both participants and police said the reason for the increase in high-grade marijuana is largely due to a surge in home-grow and commercial-grow operations. One officer explained, “In the past year we came across three commercial [marijuana] indoor grow operations in the City of Cleveland, and there’s more out there in the city that we’re working on.” Other contributing factors to the increase of high-grade marijuana include advancements in lighting technology, growing techniques and online sales in states where marijuana is legal. BCI&I Richfield crime lab reported that the number of marijuana cases it processes has remained stable, and noted that marijuana cases make up the greatest proportion of drug cases it reviews.

Police noted that large shipments of inexpensive, low-grade marijuana arrive in the Cleveland area via Lake Erie from Canada and other routes. Law enforcement explained,

*"They're coming straight across the lake [Lake Erie]. It's only 41 miles. Our border in Ohio is not patrolled like it should be. They come in drop it [marijuana shipments] off and they're gone." Another officer stated, "If we stop a truck that has 1,000 pounds [of marijuana], another truck drives by that's got 5,000. It's a decoy." Officers also expressed their concerns that limited budgets constrain them to focus more on heroin, crack cocaine, prescription opioids and other drugs more than marijuana. An officer commented, "Marijuana is not as detrimental to society;" and another added, "Since marijuana is so prevalent now, we would rather spend our time on the more dangerous drugs rather than marijuana."*

Consumers reported that the quality of marijuana varied from '7' to '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Several consumers explained that the quality of marijuana depends on whether the user buys "commercial weed" (i.e., low to mid-grade marijuana, also called "reg") or hydroponically grown (i.e., high-grade marijuana, also called "hydro"). High-grade marijuana was reported to be more potent, and to have a more pleasing aroma. One police officer explained, *"It's [high-grade marijuana] higher level of THC [tetrahydrocannabinol]. You don't have to smoke a lot of it to get where you need to go. We've run into a lot of people growing it in their houses. They've got the technique down, the lighting; they have the whole thing together. They're just growing the weed [marijuana]."* A user indicated that much of the marijuana product is available seasonally, saying that near the autumn, high quality "hydro" becomes available. While there seems to be a steady supply of commercial grade marijuana, one officer stated that it is sold after high grades have been exhausted: *"The lower quality [marijuana] is still the same. They'll sell that at the end ... I see 'kush' [high-grade marijuana]. Lotta the hydro. We got a guy with [British Columbian weed] not too long ago. About three months ago."* Given the competitive market for marijuana, it is unsurprising that participants reported no impurities or cutting agents included with marijuana.

Current street jargon includes countless names for marijuana. The most commonly cited names were "reg" and "weed." Consumers listed the following as other common street names: "backyard boogie," "brown," "dark weed," "garbage weed," "good," "mids," "nuggs," "rags," "skunk" and "swag" for low to mid-grade marijuana; and "chronic," "kush," "monkey paw," "orange crush," "purple haze" and "redbud" for high-grade marijuana; and "hydro" or for hydroponically grown marijuana. Pricing is fairly consistent across the city. Participants reported that they can buy marijuana in many

different quantities: a "blunt" (i.e., marijuana cigar, known as the "five-dollar holla") sells for \$5; a gram currently sells for \$7; 2.5 grams sells for \$20; 1/8 ounce sells for \$15 – \$20; 1/4 ounce sells for \$30; 1/2 ounce sells for \$45 – \$100, with high-grade marijuana at the upper end of that range. While there were a few reported ways of consuming marijuana, the most common route of administration is smoking. Some users reported eating marijuana in food or chewing on "weed sticks." As one participant explained, *"People make it [marijuana] in food like brownies and stuff. I chewed on weed sticks—never got me high but they said it should have."*

When asked to describe the typical user of marijuana, participants were unable to come to consensus. Participants were not able to establish a profile for the 'typical user,' and they explained marijuana use is so common that it defies limitation to one type of user, age group, race, etc. In contrast, law enforcement were able to identify categories of users through citing recent trends they've observed with marijuana arrests, obtained largely through traffic violations. One law enforcement officer explained, *"I work in the 4th district. It's 90 percent Black. About 98 percent of our arrests are African-Americans. With marijuana the age range is mid [to] lower 20's."* Another spoke to his experience with arrests for marijuana possession, *"The age range is going all the way from 13 years old to up to 30 ... Teenagers are really huge in it [marijuana] now."* A police officer who works on the west side of Cleveland had a slightly different opinion: *"Late teens, early 20's. It's Whites and Blacks both that we deal with [marijuana]. For older people, I think it's more prevalent with White males who are smoking marijuana that we run into on the west side."* Law enforcement and participants agreed that changing perceptions about marijuana account for its widespread use, especially among younger users. One officer observed, *"I've come across a ton of people that don't really think that marijuana's illegal. It's amazing to me. They hear a lot of talk on TV ... about the possibility of marijuana being legalized, and a guy [I arrested] saying 'I don't have any drugs.' He's got a pocket full of marijuana! No, it's drugs."*

In addition to alcohol, participants reported heroin, crack and powdered cocaine (a.k.a., "Primo"), prescription pills and PCP as substances commonly used with marijuana. Marijuana use among abusers of other drugs seems to be sought to aid in "coming down" from, or augmenting the high of, another drug.

## Methamphetamine

### Current Trends



Methamphetamine is relatively unknown in this region. None of the participants reported active methamphetamine use within the last year and most were unable to offer an opinion about its availability. All participants (except one) who did supply an availability score reported '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Only one participant had experience with methamphetamine, and he indicated that methamphetamine could be bought

on Cleveland's west side. Law enforcement also had very limited experience with this drug, with one officer stating, "It [methamphetamine] hasn't really hit. I've never arrested anybody with crystal meth [methamphetamine]. Thousands of arrests, and none [for methamphetamine]." Both groups of participants stated availability has remained unchanged within the last six months, and no one was able to offer information about its quality. BCI&I Richfield crime lab reported that the number of cases of both powdered and crystal methamphetamine it processes has increased.

Participants and law enforcement perceived use of methamphetamine to be limited to rural Whites, especially within the Appalachian region of Ohio. Participants were aware that it was smoked, and one reported a friend who preferred use by intranasal inhalation (i.e., snorting), but participants could not offer information about different types of methamphetamine available. Terms for this drug that have been heard in the Cleveland region include: "crank," "glass," "ice" and "meth." A participant reported that three grams of the drug could be purchased for \$80. Use of this drug was believed to be done in combination with sedative-hypnotics and crack cocaine. One participant reported that the drug had recently been used as a cutting agent in local crack cocaine. The participant explained, "[Crack cocaine users] probably haven't realized that that's what they were smoking [methamphetamine]. But, when you do that hit of crack [cocaine] and you got that extra zing and it didn't go away for quite some time, you weren't just smoking crack, you were smoking crystal meth. If you've ever got that zing that lasted, that was meth, and if you ever got sick with your crack it was mixed with heroin."

## Ecstasy

### Current Trends



Ecstasy [methylenedioxymethamphetamine (MDMA)] is highly available in the region. Participants most often reported the availability of ecstasy as '10' and law enforcement as '7' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Both participants and law enforcement groups agreed that the drug is most commonly available in dance clubs, nightclubs and strip clubs. Law enforcement noted that distribution of ecstasy is limited to a few dealers who deal in very large quantities. More specifically, one officer said, "We don't get many calls on [ecstasy] But when we do we're able to get a quantity—100, 200, 300 pills. It could be any side; east side, west side, suburbs; it's all over the place." Participants and law enforcement thought there was a slight decrease in the availability of ecstasy because the drug's popularity is on a slight decline. BCI&I Richfield crime lab reported processing a small number of cases involving club drugs.

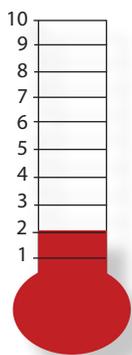
Current street jargon includes a few names for ecstasy. The drug is commonly referred to as "E," "ecstasy," "molly" or "X." Additional jargon for this drug seemed to be related to the imprint or stamped image on the pill itself, with one consumer observing, "They [dealers] got Scooby Doo, Bart Simpson, Obama Head ... naked ladies, Transformers, they got everything on x-pills ... They got Dora the Explorer, whatever you think of, they got it." Participants reported a "single stack" (i.e., low dose) ecstasy tablet sells for \$3 – \$7 and a "double stack" or "triple stack" (i.e., high dose) sells for \$10. The only route of administration noted was through oral consumption.

Law enforcement shared their observations about a third chemical variant that has recently appeared in the Cleveland region being sold as ecstasy. While chemicals like MDMA and BZP (i.e., benzylpiperazine) are commonly found in ecstasy, law enforcement said that a new ecstasy formulation containing, MDPV (i.e., methylenedioxypropylvalerone), had recently been involved in several recent drug busts. As one law enforcement officer explained, "We go to buy and they order it up, and the lab results say there are three different kinds [of ecstasy] now. I couldn't tell you what the difference is; they all give you the same high from what they [users] say." Another

officer also talked about the chemical makeup of the drugs: *"The ones [ecstasy tablets] the guy had, they all had the same logo stamps but they all had different lab results."* Police officers noted that ecstasy consumers are unaware of the chemical compounds included in their products. Law enforcement stated that the typical participant is younger (teenagers up to about 40 years of age), and that race does not seem to be a factor in the Cleveland area. One officer commented, *"I think [ecstasy] is the same, White and Black. When it first was introduced it was mainly White, but then it made its way into the Black community."*

## PCP

### Current Trends



PCP (i.e., phencyclidine) is somewhat available in the region. Police cited availability scores of '1' or '2' for the west side of Cleveland on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get), and they rated availability on the east side of Cleveland from '7' to '10'. Law enforcement said PCP is more available in the east side of Cleveland because of a one small area of the city known as "waterworld." A law enforcement officer explained, *"Waterworld, that whole area is pretty much what they do [make/use PCP]. I*

*work part time over there. I go over to my office and shut that door [because of the stench.]"* Citywide, this location seems to be the main source of the drug with a tight-knit network of suppliers. Street jargon for PCP include names like "wet" and "embalming fluid," and participants reported the highly odorous brown liquid is transported in vials. Both participants and law enforcement reported that the drug is sold by the "dip" (tobacco cigarettes and marijuana blunts/joints dipped in PCP) with pricing approximately \$20 – \$25 per dip. Officers report that they are most likely to encounter Black males between 20 – 40 years of age with PCP. An officer posted to the fifth district where "Waterworld" is located, stated that appearance of the drug has "picked up" within the last year.

### Other Drugs

Participants and professionals listed a variety of other drugs as being present in the area, but these drugs were not mentioned by the majority of people interviewed. Most participants did not have recent, personal familiarity with

abuse of prescription and over-the-counter (OTC) cold medicines. They believed that abuse of these drugs is popular among younger people, with a participant stating that these cold medicines are popular with school-aged students who cannot procure other substances: *"In elementary schools they are doing Robitussin®. They call it 'tussin.'" Prescription stimulants (i.e., Adderall® and Desoxsyn®), likewise, were perceived to be popular among younger users (>18) and shared among high school students. A participant said the availability of Desoxsyn® is '6' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get), stating, "Desoxsyn®, they don't prescribe too much anymore to ADHD kids but it's readily available."* A law enforcement officer assigned to a high school confirmed this belief, explaining use of prescription stimulants among students: *"We think there might be abuse in that group sharing, but what the hell are we going to do? There's 1,000 of them and at least 25 percent are on Individual Education Plans/Special Education. At least. They're giving them drugs [prescription stimulants] and an extra check. Their mothers are throwing them on workman's comp like water. And, they gotta take these meds to get this check ... it's the truth. They share it with their friends."* Most police officers noted that they do not normally encounter this class of drug as part of regular vice operations because they are legal and are sold infrequently by drug dealers in the Cleveland area.

### Conclusion

Crack cocaine, heroin (i.e., brown powdered), prescription opioids, sedative-hypnotics, marijuana and ecstasy are the most available drugs throughout the Cleveland Region. Noted increases in availability over the previous six months exist for heroin, prescription opioids and marijuana. Marijuana, the most widely available drug in the region, is reportedly more available today than it has ever been, especially high-grade marijuana due to a surge in home-grow and commercial-grow operations. Heroin is currently as available as crack cocaine, and its popularity is increasing, largely due to a decrease in availability of some preferred prescription opioids (i.e., OxyContin® OC). Heroin is becoming particularly more popular among young people. Alarming, the most common route of heroin administration is intravenous injection. Crack cocaine remains one of the easiest street drugs to acquire, although its overall quality has decreased. OxyContin® remains the most popular prescription opioid, but Darvocet®, Dilaudid®, fentanyl, morphine, Opana®, Percocet®, Roxicet® and Vicodin® are also

popular. Sedative-hypnotics (i.e., Klonopin®, Soma®, Valium® and Xanax®) are also highly available and widely desired for their ability to help in “coming down” from the high of other drugs. Ecstasy continues as a popular “club drug,” found most commonly in regional dance clubs, nightclubs and strip clubs. A new ecstasy formulation containing MDPV (i.e., methylenedioxypropylvalerone) has recently been involved in several drug busts.

# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Columbus Region

June 2010-January 2011

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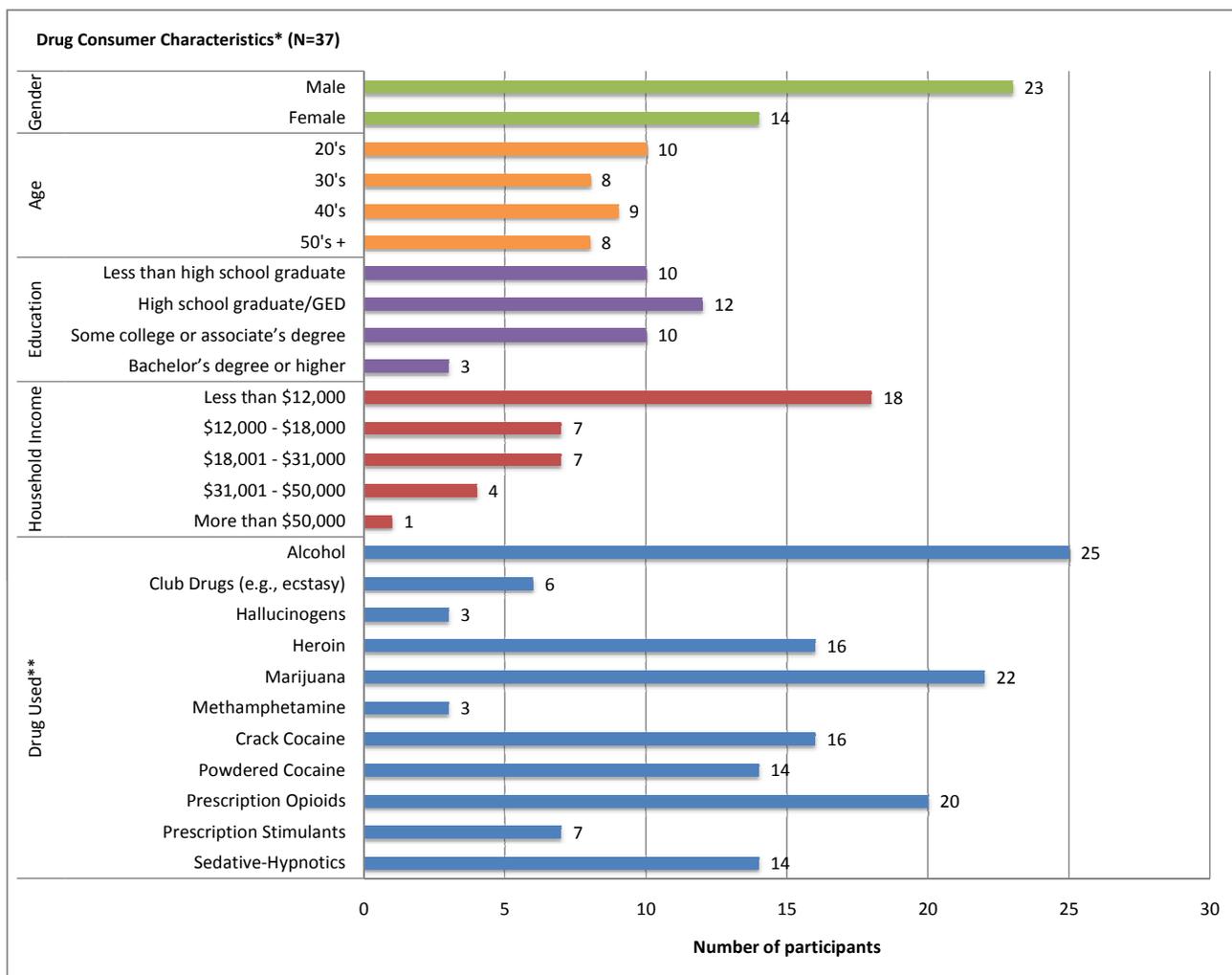
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### Regional Profile

Indicator <sup>1</sup>	Ohio	Columbus Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	2,095,033	37
Gender (Female), 2009	51.2%	50.1%	37.8%
Whites, 2009	82.2%	79.6%	54.1%
African Americans, 2009	11.9%	12.9%	55.6%
Hispanic or Latino Origin, 2009	2.8%	3.1%	2.7%
High school graduates, 2008	84.6%	87.6%	71.4%
Median household income, 2009	\$45,467	\$47,553	Less than \$12,000 <sup>2</sup>
Persons below poverty, 2009	15.1%	13.0%	43.8% <sup>3</sup>

Ohio and Columbus statistics are derived from the U.S. Census Bureau<sup>1</sup>. Respondents reported income by selecting a category that best represented their household's approximate income for 2009<sup>2</sup>. Poverty status was unable to be determined for five respondents due to missing or insufficient income data<sup>3</sup>.



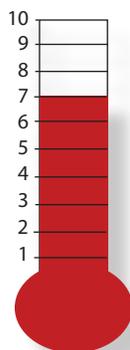
\*Some respondents reported multiple drugs of use over the past six months.

## Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Franklin County. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (i.e., treatment providers and law enforcement) via individual report or focus group interviews, as well as to data surveyed from the Columbus Police Crime Lab and the Bureau of Criminal Identification and Investigation (BCI&I) London Office, which serves Central and Southern Ohio. The aforementioned secondary data sources reported summary data for January to June 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the last six months (i.e., from time of interview through prior six months); thus, all current secondary data correspond to the current reporting period of participants. In addition to the aforementioned data sources, the following media outlets were queried for information regarding regional drug abuse for June 2010 through January 2011: *Mansfield News Journal*, *ThisWeek Community Newspapers* (online home to 22 newspapers serving Central Ohio) and *WBNS-10TV*, Central Ohio News.

## Powdered Cocaine Current Trends

Powdered cocaine is readily available in the region. Participants most often reported the drug's current availability as '7' and professionals as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Clinicians in a residential recovery center reported not seeing many clients in recovery for powdered cocaine. There was little consensus as to whether the availability of powdered cocaine has increased, decreased or remained the same over the past six months. Some current users felt the demand has increased: *"So many people are just getting on to it [using cocaine] and it's just catching on; In the Hudson Avenue area, you could pretty much just walk down the street and cop [obtain powdered cocaine] from someone."* Those who noted that availability has decreased attributed this to police crackdown and/or that other drugs are now more available and desirable: *"My experience is that all the people that do cocaine do Percocet® now because the effects*



*last longer; You gotta know somebody. It's [powdered cocaine] a little trickier [to obtain] than crack [cocaine]; It's [powdered cocaine] not a corner drug like crack – mostly in bars or the college scene."* Overwhelmingly, crack cocaine is considered the most obtainable form of cocaine. The Columbus Police Crime Lab reported a decrease in the number of powdered cocaine cases it processes.

Participants most often reported the current quality of powdered cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). A grade of cocaine identified as "fish scales," which is pearlescent in appearance, is considered high quality and was mentioned by several users. All users agreed that the quality of powdered cocaine is dependent upon the dealer. A participant stated, *"It's available [good quality powdered cocaine] if you know the right people. I have to search, search, search. I'm sure I could get it, but it wouldn't be that easy."* Powdered cocaine is often "cut" (i.e., diluted) with other substances to maximize profitability. A participant noted, *"They [drug dealers] trying to make a million dollars out of a quarter ounce."* Participants reported many substances used to cut powdered cocaine to include: B12, baby laxative, baking soda, coffee creamer, creatine, NoDoz® and Similac®. According to the Columbus Police Crime Lab, creatine and the local anesthetics of benzocaine and procaine are used as cutting agents for powdered cocaine.

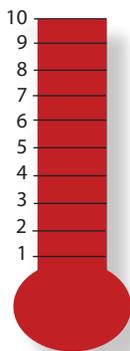
Current street jargon includes many names for powdered cocaine. The most commonly cited names were "girl" and "soft." Participants listed the following as other common street names: "blow," "christine," "coke," "fish scales," "girlfriend," "going skiing," "ivory snow," "lady fluff," "nose candy," "pow," "snow," "white bitch," "yo" and "yola." Participants reported a gram of powdered cocaine currently sells for \$50 – \$100; 1/8 ounce, or "eight ball," costs \$120 – \$125. Smaller amounts of powdered cocaine are available for \$10 – \$20. A participant reported, *"When you get down and dirty, for the shooters [intravenous drug users], it's \$10 bags and \$20 bags for powdered cocaine."* While there were a few reported ways of consuming powdered cocaine, the most common route of administration for this form of cocaine is intranasal inhalation (i.e., snorting). Many users reported a progression of methods, starting with snorting and then progressing on to smoking and intravenous injection. Those who are already injection drug users go straight to shooting (i.e., injecting). Participants explained, *"Most people just don't shoot coke [inject cocaine] but if they shoot heroin, they'll shoot coke; If you're already shooting something, you usually start off [a new drug] shooting. You're going to shoot whatever you get your*

*hands on; Those of us in the [methadone] clinic, most of us are, you know, bangers [injectors], so we would shoot."*

Use was perceived to differ according to class, race and age. Participants noted a trend toward younger users, age 20, and sometimes younger; "rich kids" typically snort the drug. Participants reported, "They're [new users] younger middle class. They got money in their pocket. To them it's like a party thing [cocaine use]. It's not an everyday occurrence." Differences in race were also noted: "Cocaine is a rich drug. White people do it. Black people sell it; Higher quantities are typically sold by White people – like kilos; On the lower end of the scale with the lower grade cocaine, you have Black dealers. On the higher end with the better cocaine because of accessibility, you have White dealers or Mexicans." Powdered cocaine is often injected concurrently with heroin (a.k.a., "speedball"). A participant stated, "A lot of opiate users speedball. They snort or shoot it. They put it [heroin and cocaine] in a syringe with water and shoot it up their nose. They don't think the habit will be as bad." Alcohol, benzodiazepines (i.e., Valium® and Xanax®) and marijuana are typically used after a "cocaine high" to soften the "crash." A user mentioned that cocaine is occasionally mixed with PCP (phencyclidine) and injected (a.k.a., "space base").

### Crack Cocaine Current Trends

Crack cocaine is highly available in the region. Participants and treatment providers reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to a '10' (high availability, extremely easy to get). Participants described crack cocaine as extremely easy to get. A participant said, "It's an epidemic, just go down the street. My whole neighborhood smoked crack [cocaine]." Another participant succinctly said, "As far as availability goes, I've never seen a 'crackhead' who said, 'damn, I wish I could find some crack.'" Comments from treatment professionals echoed the same sentiment, "Every time I hear people say 'the war on drugs' I have to laugh. People can get it [crack cocaine] any time of day they want it." Participants and treatment professionals could not agree on whether the availability of crack cocaine has changed over last six months. The Columbus Police Crime Lab reported that the number of crack cocaine cases it processes has decreased. Some participants felt the bad economy was influencing



an increase in availability of crack cocaine. As a participant explained, "The economy is bad ... and they want to get high because they're in pain and suffering." A group of treatment professionals noted that close to 100 percent of their clients had a history of crack cocaine use.

Participants most frequently rated the quality of crack cocaine as '4' on scale of '0' (poor quality, "garbage") to '10' (high quality). As with powdered cocaine, quality of crack cocaine is reportedly dependent on the user's relationship with the dealer. A participant stated, "There is a high level of variability [in quality of crack cocaine]." Many participants complained about the current quality of crack cocaine: "For the majority of people I've run into lately – it's all bad dope. You need to re-cook it [crack cocaine] to smoke it." Participants reported that crack cocaine is most often "cut" (i.e., diluted) with other substances to "blow it up" (i.e., to give crack cocaine more volume and mass).

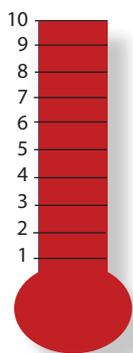
Participants reported many substances are used to cut powdered cocaine to include: ammonia, B12, baby laxative, Similac® and soap. A participant reported, "Some dealers out here they do got that quality [crack cocaine], but some of these young boys, they done stepped on [cut] it so many damn times, all you gonna smoke is Similac®." A participant mentioned a cutting agent called "Comeback" (a chemical agent sold at "head shops" that acts as an anesthetic). The same user explained, "It [Comeback] gives you energy and a numbing feeling too." According to the Columbus Police Crime Lab, levasimole (dewormer for livestock) is the cutting agent in 90 percent of crack cocaine cases it processes.

Current street jargon includes many names for crack cocaine, the most common of which are "hard" and "rock." Other common street names are "bump," "boulders," "butter," "champagne bubbly," "crumbs," "fire," "food," "ready rock," "yellow," "whip" and "work." Participants reported 1/8 ounce, or "eight ball," sells for \$110 – \$120; however, users consistently said, "You can buy any size you want," even in amounts as low as a few dollars. Reportedly, the prices for crack cocaine has remained stable over the last six months. While there were a few reported ways of consuming crack cocaine, the most common route of administration by far is smoking. Other methods described were intranasal inhalation (i.e., snorting) and intravenous injection. In order to inject it, participants reported that crack cocaine must be broken down by mixing it with an acidic substance like lemon juice or vinegar. Many participants reported that heroin is often mixed with crack cocaine during this process.

A profile of a typical user of crack cocaine did not emerge in the data. Participants noted that crack cocaine is used by all races and socioeconomic groups, as well as, by all ages (i.e., early teens to the elderly). Participants believed crack cocaine use is ubiquitous, commenting, "It [crack cocaine] doesn't discriminate; I know a 60-year-old grandmother using rock [crack cocaine]." Treatment professionals agreed with participants about the far-reaching popularity of crack cocaine. A professional explained that there was, "No typical user [of crack cocaine]. When it first came about there was, but now I've had crack cocaine users who are 60 years old, 22 year olds with all the money in the world, all races, all genders."

In addition to alcohol, participants also reported that crack cocaine is used in combination with heroin, marijuana in "blunts" (i.e., marijuana cigars) and sedative-hypnotics (i.e., Klonopin® and Vicoden®). Participants often drink to come down from an intense high. A participant said, "Some people 'get stuck' so the drink helps to even out the buzz [high]."

### Heroin Current Trends



Heroin is highly available in the region. Participants and clinicians most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). A treatment provider reported that nearly 65 percent of clients currently present for treatment with a history of heroin use. In December, *WBNS-10TV* reported in an online article entitled, "Police, Treatment Facility Dealing With Heroin Boom," that an estimated 80 percent of people seeking help at a

large Central Ohio treatment facility are addicted to either heroin or prescription drugs ([www.10tv.com](http://www.10tv.com), Dec. 9, 2010). In November, 10TV reported that heroin was becoming a problem of "epidemic proportions" in Delaware County ([www.10tv.com](http://www.10tv.com), Nov. 12, 2010). In this article, the Delaware County Sheriff reported that law enforcement seizures of heroin had increased 3,000 percent in one year's time. Also in November, *WBNS-10TV* reported that Columbus police had arrested 145 people and seized more than 68,000 doses of heroin since September 2009 ([www.10tv.com](http://www.10tv.com), Nov. 10, 2010).

Participants described heroin's current availability as follows: "It's the new crack [cocaine]; The dope dealers that was dealing crack is now dabbling into heroin; Sometimes it [heroin] just falls into your lap; I think it's the most available drug on the market today – more sought after. I can say this, when I went to purchase my crack [cocaine], they [dealers] wanted to know if I wanted heroin." A user reported that he switched from prescription opioids to heroin, explaining that it was much easier for him to buy heroin off the street than to go through the trouble of going to a drug store and dealing with the more stringent rules for prescription purchase. Also, cited as a reason for a switch to heroin was the change in formulation of OxyContin®, which now makes the drug difficult to abuse. A participant stated, "You can't abuse OxyContin®. They're going straight to dope [heroin]. It's cheaper [than OxyContin®] and you can get a buzz [high] off it." Another participant noted, "They used to sell it [heroin] till eight at night [at which time it was no longer available]. They just shut out everybody. But nowadays, it's 24/7, and they'll sell it all night [now heroin is sold 24 hours a day, seven days a week]."

In the Columbus region, black tar heroin is the most common form of heroin, and it is typically purchased from Mexican dealers. In October, *ThisWeek Community Newspapers* reported in an online article that a Northside Columbus community has become a hub for heroin sales, warning area residents of a Mexican cartel that is operating a black tar heroin delivery service in their neighborhoods. An officer was quoted as saying, "The buyers [of black tar heroin] are likely from out of the area. Arrests have been made of people from over 23 Ohio counties" ([www.thisweeknews.com](http://www.thisweeknews.com), Oct. 6, 2010). Participants also commented on the high prevalence of black tar heroin in the region; one stated, "It's [black tar heroin] one less process away from being powder [heroin] so, you know, it's quicker to make, easy to distribute and cheap." A professional reported that currently it's, "heroin, heroin, heroin," and typically black tar heroin in Central Ohio. This professional stated, "Tar [black tar heroin] is cheap cuz there's just so much of it, and like I said, the guy who was in this morning [for intake services], talking to me who's still struggling ... his words were the 'market's flooded.' There's so much [black tar] heroin out there." However, the brown and white powdered forms of heroin are reportedly more available in certain parts of Columbus. Brown powdered heroin is more available in the near Eastside of Columbus. Participants indicated that availability has increased or remained constant over the past six months. A participant stated, "You went through the crack [cocaine] stage and a lot of people was saying

*this crack make you crazy, so they would do the crack and take the heroin to come down you know. There's a lot of people that just boot [inject] it [heroin]."*

Quality was most commonly assessed as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Reportedly, the quality of heroin depends on the dealer. Some participants reported that quality has increased over the past six months: *"I think heroin's making a comeback cuz it's just so damn good; I'm scared of it [heroin]. I mean I used to sell it, but just to see how people are without it [referring to withdrawal sickness] ..."* Substances used to "cut" (i.e., dilute) heroin include fentanyl and coffee for black tar heroin. Fentanyl and heroin are perceived as very dangerous in combination. Participants stated, *"They [dealers] cut it [heroin] with fentanyl and it's a deadly combination; They [heroin users] have been dropping like flies [overdosing]."* Heroin currently available in the region is very pure according to the BCI&I London crime lab, but benzocaine (local anesthetic) and metamizole (analgesic and antipyretic) are occasionally used as a cutting agents.

Current street jargon includes many names for heroin. The most commonly cited names were "boy" and "dog food." Participants listed the following as other common street names: "balloons," "dog," "dope," "H," "johnny," "red dragon" and "smack." Participants reported a gram of heroin currently sells for \$80 – \$100, depending on quality, with an ounce selling for \$2,000; many participants reported buying "baggies/ stamps," or 1/10 gram (i.e., "balloon") for \$10. In October, *ThisWeek Community Newspapers* reported in an online article that according to a Columbus Police Officer, *"A balloon of black tar heroin sells for \$10 in Columbus. It would cost \$50 on the streets of, say, Marysville"* ([www.thisweeknews.com](http://www.thisweeknews.com), Oct. 6, 2010). Participants reported that all types of heroin (black tar, brown and white powder) are about the same price. While there were a few reported ways of using heroin, the most common route of administration is intravenous injection, followed by intranasal inhalation (i.e., snorting). Almost universally, participants noted a general use progression with users starting with snorting, and some smoking or rather "chasing the dragon," ending with injection use. Reportedly, younger people are said to smoke the drug.

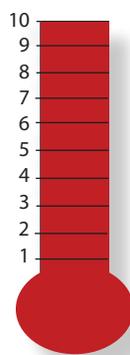
Typical new users of heroin were described as White and "younger," ranging in age from 14 – 29 years. Participants stated, *"It's gotten bad with the young kids nowadays cuz most kids start out doing opiates, and the next thing they're doing vikes [Vicodin®] or perc's [Percocet®], and the next thing they're doing heroin; Just from going to meetings and seeing how many*

*young people are out there that are heroin addicts. It's amazing."* Clinicians reported seeing very young people coming into treatment for heroin addiction, particularly young, White males who started using in high school and often come from suburban areas. A clinician stated, *"A lot of times they'll [high school students] start taking pills and then that leads pretty quickly to IV [intravenous] use. There doesn't seem to be the same fear of needles that there used to be. Now, it's no big deal. Now, it's a high school rite of passage."* In October, *ThisWeek Community Newspapers* quoted a Columbus Police Officer in an online article as saying, *"Because the drug [heroin] is so cheap, it's starting to make its way into high schools"* ([www.thisweeknews.com](http://www.thisweeknews.com), Oct. 6, 2010).

Heroin is often used in combination with cocaine (a.k.a., "speedball"). A participant noted, *"There's not a lot of drugs you use with heroin [concurrently] like there are a lot of drugs you do before heroin. After you do heroin, it's over."* Other drugs reportedly used in combination with heroin include: alcohol, benzodiazepines, crack cocaine and marijuana.

## Prescription Opioids

### Current Trends



Prescription opioids are highly available in the region. Participants and clinicians most often reported the street availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). When asked what drugs clinicians currently see in client drug histories, one answered, *"Opiates, opiates and opiates. I see oxycodone a lot."* According to an officer with the Franklin County Sheriff's Office, prescription opioid use is at epidemic levels in Central Ohio, and prescription opioids are the most frequently purchased street drug of the special investigative unit, and they have been for several months. This officer reported that in January the unit *"did a search warrant and seized 17,000 prescription pills."* Participants described some prescription opioids as more readily available than others. For example, OxyContin® OC is less available as it has been replaced in pharmacies by the less desirable OxyContin® OP. The formulation of OxyContin® OP now renders this drug difficult to abuse. A participant explained, *"It [OxyContin® OP] gels up, so you can't snort or inject it."* Franklin County Sheriff's Office reported that the most popular prescription opioids in Central Ohio are OxyContin®, Percocet® and Vicodin®.

Some participants felt that opioids are generally more available than they were six months ago. A participant stated, *"You go to the hospital and say you got a toothache and they'll give it [opioids] to you."* Some participants reported that dealers are paying users to go out of state (i.e., to Florida) to purchase opioids and bring them back to Columbus. They stated, *"You get 240 perc 30's [Percocet® 30 mg] and some perc 15's [Percocet® 15 mg] ... and anybody will pay for you to go. They'll [dealers] sponsor you to go and they'll put you on a plane and pay for everything; When you go down to Florida, all you see is Ohio license plates. I've known people who go down monthly and they take two to three people with them to say there's something wrong with their backs. They come back with a script [prescription]."* Franklin County Sheriff's Office reported that almost all of the prescription opioids available on the street are coming from *"the pain management clinics in Florida."* An officer said, *"There is not a day that goes by that our unit receives complaints of neighbors, friends or relatives going to Florida to obtain pills [prescription opioids] to bring back to Columbus for sale."*

Participants who reported availability as having decreased over the past six months cited several reasons for the perceived decrease. A participant stated, *"Before they [Purdue Pharma] did that oxy [OxyContin®] switch [reformulation], it was always pills, pills, pills, and then once they started switching up the oxy's and made them harder to get, you couldn't get the old OC's [OxyContin® OC] anymore."* Former OxyContin® OC users are switching to heroin. In addition to the reformulation of OxyContin®, pharmacies are instituting tracking systems that make abusing opioids more difficult. It has also become more difficult to get opioids prescribed by doctors. Participants reported, *"Harder to get [OxyContin®] from doctors but if someone is getting them, you better believe they're selling them; If you go into a doctor's office and they're prescribing you pills, they're dropping urines on people. You come up positive for anything else, they're cutting you off. You come up clean, then they're cutting you off because you should have pills in your body."* Opioids are reportedly more available at the end of the month. A participant said, *"... available at certain times of the month. Like you can get Percocet® right now. This is the end of the month. Everybody gets their refills about now."*

Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in

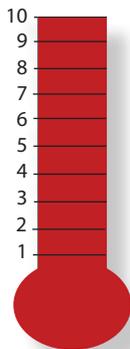
parentheses): Darvocet®, Darvon®, Demerol®, Dilaudid®, fentanyl, methadone (liquid and tablets), Opana®, OxyContin® (a.k.a., "footballs," "green turtles," "highway," "peaches," "OC's," "old cars," "Orange County" and "oxy's;" sell for approximately \$1 per milligram), Percocet® (a.k.a., "blueberries," "blues," "fat boys," "perc's" and "school buses"), Percocet® 5 mg (\$2 – \$3; however, this price reportedly varies by neighborhood and quantity purchased), Percocet® 10 mg (a.k.a., "yellows"), Percocet® 30 mg (\$20), Roxicet® (a.k.a., "rockies" and "roxi's"), Subutex®, Tylenol 3/4®, Ultram® and Vicodin® (a.k.a., "vikes;" \$1 – \$2). Participants reported that drug street names are often particular to a user and his/her dealer. A participant stated, *"... [users] develop a relationship with your dealer and develop nicknames for drugs."*

The most common way to obtain opioids is on the street followed by pain clinics, family members and friends. People who are more well off financially order online. A clinician commented, *"Who gets a prescription? There is so much [prescription opioids] on the streets."* 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 is oral consumption (i.e., swallowing) followed by intranasal inhalation (i.e., snorting, which reportedly carries some stigma) and intravenous injection. A participant reported that Percocet® 10 mg is snorted: *"Some people chop 'em [Percocet® 10 mg] down and snort."* The prescription opioids that are reportedly injected include Percocet® and OxyContin® OC.

A profile of the typical illicit user did not emerge although participants and clinicians noted that users are becoming younger and younger. A user noted, *"elementary school on up."* In November, WBNS-10TV reported in an online article entitled, *"Prescription Drug Abuse Increasing Among Teens,"* that according to the Ohio Attorney General, *"Prescription medication is becoming the drug of choice for teens"* ([www.10tv.com](http://www.10tv.com), Nov. 16, 2010). This article quoted the Attorney General as stating the following: *"At least one in four Ohio high school students report using prescription drugs."* Reportedly, other substances used in combination with prescription opioids include: alcohol, benzodiazepines, cocaine (powdered and crack), heroin and marijuana.

**Suboxone®**

**Current Trends**



Suboxone® is highly available in the region. Participants most often reported the street availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Availability is perceived to be increasing. Participants reported, *"Addicts is getting hip to them [Suboxone®]. Starting it with the idea that they're going to get off the drug they're using, and they're just getting hooked ... so, becoming more available."* Users often procure Suboxone® while participating in drug treatment, from a clinic or on the street. Participants reported, *"Get from people on Suboxone® maintenance. They sell Suboxone® to get their original drug of choice; People who used to do methadone clinics are now doing Suboxone® clinics."*

No slang terms for Suboxone® were reported. The price for Suboxone® 8 mg was consistently reported as \$10. Although there is no "typical" Suboxone® user, a clinician commented that there are two types of abusers: *"An opiate addict that is either serious about recovery ... or a person tricking themselves that they're going to do this [recovery] on their own. People found out they can get high on it [Suboxone®]. People hear that – they go back out [and use] and turn around and have that easy de-tox [detoxification] again."*

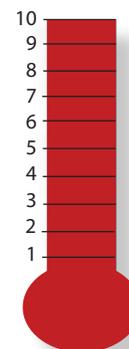
Most often participants reported taking Suboxone® orally, letting it dissolve under the tongue. Some intravenous injection use was also reported. Using other drugs with Suboxone® is considered wasteful and dangerous as Suboxone® blocks the effects of many other drugs. Participants reported, *"Can't take it [Suboxone®] with methadone. It will kick us into the hardest de-tox [withdraw sickness] we've ever been in. You've gotta be careful; If you use another opiate, it will make you sick; If you're using other drugs, you're just wasting it."* Reportedly, alcohol, marijuana and Xanax® are sometimes used with Suboxone®.

**Sedative-Hypnotics**

**Current Trends**

Sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) are highly available in the region.

Participants reported the overall availability of sedative-hypnotics as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described some sedative-hypnotics as more readily available than others. Overall, participants most often reported the availability of Klonopin®, Soma®, Valium® and Xanax® as '10'. Reportedly, drugs like Ativan®, Nembutol® and Restoril® are much less available, and sleep aides like Ambien® and Lunesta® are available but seldom abused. Participants judged availability in the past six months as staying steady or increasing. A participant explained, *"Soma's® are making a comeback. Soma's® become more available when the Florida trips come through. That's an extra bonus."* BCI&I London crime lab reported that the number of sedative-hypnotics cases it processes has remained stable.



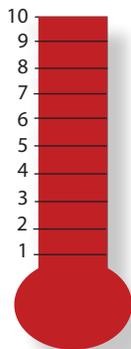
Reportedly, many different types of sedative-hypnotics are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ambien®, Ativan®, Klonopin®, Lunesta®, Nembutal®, Restoril®, Soma® (a.k.a., "stumble biscuits;" \$2 per milligram), Valium® (\$2 per milligram), Xanax® (a.k.a., peach or purple "footballs," "french fries," "ladders," "planks," "yellow school buses" and "xanibars;" \$2 per milligram). In addition to obtaining sedative-hypnotics on the street from dealers, participants reported visiting family members and area doctors in order to obtain these drugs. While there were a few reported ways of consuming sedative-hypnotics, the most common routes of administration are oral consumption and intranasal inhalation (i.e., snorting). A user commented, *"I used to crush up the Xanax® and the Vicodin® and snort them both at the same time."* A few users also mentioned "parachuting" sedative-hypnotics (i.e., crushing the drug, putting it in a piece of tissue paper, and then swallowing it). A participant talked about the effect of parachuting: *"In about ten minutes, you don't know what the hell happened."*

A profile of a typical illicit user of sedative-hypnotics did not emerge in the data. Participants stated that illicit use of these drugs in their communities is a far-reaching problem that affects all age groups. A few participants felt that

users in general are getting younger and younger. Alcohol, marijuana, heroin and cocaine are commonly used with sedative-hypnotics. A clinician remarked that sedative-hypnotics are very popular with methadone users.

**Marijuana**  
**Current Trends**

Marijuana is highly available in the region. Respondents, both participants and clinicians most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Marijuana is considered the most available illegal drug in the area, "the old standby" as some participants called it. Media reports confirmed the widespread availability of marijuana over the past six months. In November, *WBNS-10TV* reported that federal agents found thousands of pounds of marijuana with an estimated street value of \$5 million in a Columbus home ([www.10tv.com](http://www.10tv.com), Aug. 29, 2010). In January, *WBNS-10TV* reported that local police arrested several men during a traffic stop and discovered they had 1,000 pounds of marijuana in the car. Further investigation yielded 1,000 more pounds of marijuana at their Columbus residence and over \$1 million in cash ([www.10tv.com](http://www.10tv.com), Jan. 27, 2011). In the past six months, participants either said the availability of marijuana has stayed the same or increased somewhat. A user noted, "More [marijuana] being grown out there. It's a buyer's market."



Participants most frequently rated the quality of marijuana as '8' on scale of '0' (poor quality, "garbage") to '10' (high quality). Participants also reported that the quality of marijuana is increasing, and consistently stated that the current quality of marijuana is higher than in the past. A user stated, "It seems as if there is no low grade [marijuana]. It's all mid's and high's [grades]. The distinction is outdoor or indoor. Indoor is better." Another participant echoed this thought and said, "[Marijuana quality] not below a '7' anymore. It seems like the better stuff is easier to get. The new scale could actually be 7 – 10 instead of 0 – 10 [in reference to the above quality scale]."

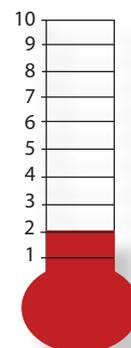
Current street jargon includes countless names for marijuana. The most commonly cited name was "weed." Participants listed the following as other common street names: "dirt"

and "swag" for low to mid-grade marijuana; "blueberry," "bubblegum kush," "chronic," "flame," "fire," "kush," "purple haze," "skunk" and "spongebob killer" for high-grade marijuana. Hydroponically grown marijuana is called "dro," "hydro" and "skunkweed," and it is seen as the most desirable form of marijuana. The price of marijuana depends on the quality desired. Participants reported they could buy low-grade marijuana in many different quantities: a "blunt" (i.e., marijuana cigar) sells for \$5; 1/8 ounce sells for \$20; and an ounce ranges in price from \$50 – \$75. Participants also reported they could buy high-grade marijuana in many different quantities: a "blunt" (i.e., marijuana cigar) sells for \$25; 1/8 ounce sells for \$50; an ounce ranges in price from \$100 – \$200; and a pound sells for \$5,500. The most common route of administration for marijuana is smoking, but there were a few mentions of putting marijuana in a tea called "Serenity," and occasionally in food.

A profile of a typical user of marijuana did not emerge in the data. Marijuana use is believed to transcend age, race and socioeconomic status. Participants also stated that marijuana could be used with any other drug, but that it is most frequently used with alcohol and crack cocaine (a.k.a., "woolie" or "primo" when laced into a "blunt"). Many agreed when a participant said, "It [marijuana] goes with everything." Users also reported dipping marijuana blunts in embalming fluid (a.k.a., "wet") or PCP (phencyclidine; a.k.a., "sherm").

**Methamphetamine**  
**Current Trends**

Methamphetamine is relatively rare in the region. Most participants knew little about the drug, and there were only a few former users of methamphetamine among focus group attendees. Reportedly, availability varies across the region, ranging from '2' to '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). A user summed up methamphetamine availability: "I have to drive an hour and a half just to get anything [methamphetamine] worth buying. People don't know what they're doing. It sucks." Media outlets across the region (i.e., *WBNS-10TV*) have reported on methamphetamine lab arrests over this current reporting period in Franklin and Fairfield Counties. In January, the



*Mansfield News Journal* reported that a man was charged with possession and manufacture in Richland County ([www.mansfieldnewsjournal.com](http://www.mansfieldnewsjournal.com), Jan. 20, 2011). Participants with knowledge of methamphetamine reported that availability of the drug has increased over the past six months. The Columbus Police Crime Lab corroborated comments from these participants, as the lab reported an increase in the number of off-white powdered methamphetamine cases it processes.

Only one participant was able to assign a quality rating to methamphetamine, and he said it was '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Current street jargon includes several names for methamphetamine. Commonly cited names for crystal methamphetamine include: "crystal," "glass," "tina" and "tweek." The street jargon "ice" was mentioned when speaking about the highest grade of methamphetamine. Participants reported they could buy a gram of the drug for \$80 – \$120, with "ice" at the top of the range. The most common route of administration for this drug is smoking with a glass pipe, although intravenous injection and intranasal inhalation (i.e., snorting) were also mentioned. Participants also said some users prefer to "parachute" methamphetamine. In this process, methamphetamine is wrapped in tissue or toilet paper and swallowed. A user explained, "When you snort it [methamphetamine], it burns like fire. When you're smoking it, you're just getting the smoke and all that. When you parachute it, it's going directly into your body."

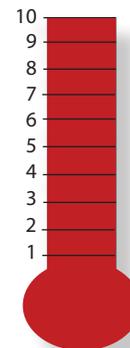
Participants described typical users of methamphetamine as White males. Many participants considered this drug a club drug. In addition, several users said, "It [methamphetamine] is huge in the gay community." Methamphetamine is occasionally used with other drugs including alcohol, cocaine, Soma® and Valium®. A combination of GHB (gamma-hydroxybutyrate) and methamphetamine, which is said to work like a "speedball" (similar to the combination of heroin and cocaine), is reportedly also popular among gay men.

## Ecstasy

### Current Trends

Ecstasy [methylenedioxymethamphetamine (MDMA)] is highly available in the region. Participants ranked availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, easy to get). Ecstasy is primarily considered a "party drug" and used among disc jockeys at night clubs.

A frequent user noted, "Dance parties, any world renown DJ [disc jockey] – that's where you can molly [use ecstasy] on the patio." The quality was viewed as a '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants perceived that both quality and availability have increased over the past six months.



Current street jargon includes several different names for ecstasy. Street names include "molly" and "X." Participants reported a capsule costs \$20, and the most common type sold is silver or bluish-gray in color. MDMA tablets are occasionally pressed into "candy flips" (i.e., ecstasy pills pressed with LSD (lysergic acid diethylamide), methamphetamine or mescaline). A participant talked about his preference for candy flips: "Those [candy flips] are amazing. You're tripping and rolling at the same time." However, the drug in this form is hard to find. A participant said, "Really good pressed ecstasy is rare." The only reported method of administration is oral consumption. A participant explained that users place a crushed pill in a tissue and "parachute" the drug (i.e., swallow the tissue and its contents). As the participant explained, users usually parachute the purest form of the drug: "Pure molly [ecstasy] is kind of like shards [crystal methamphetamine]. The shards I was getting were double capsualized. It was a capsule within another capsule. I was swallowing them, but you can get the pure shards and just parachute them. Or you can get a bag and just dip your finger in." In addition to alcohol, reportedly, ecstasy is also used with marijuana.

## Prescription Stimulants

### Current Trends

Adderall® and Ritalin® are available in the region. Participants said these drugs are available on the streets, but are also often prescribed by physicians for the treatment of ADHD (attention deficit hyperactivity disorder). Participants reported users taking their child to the doctor in order to obtain a prescription for a stimulant when their child has no real problem. A participant commented, "Everybody's taking their kid to the doctor [for a prescription for a stimulant drug]. The kid ain't the problem, it's the parent." Another participant described how easy it is to obtain the medication: "Once you know the diagnostic criteria, they have certain criteria for ADHD, and once you know it you can go to any doctor and tell him, 'I have trouble concentrating. I'm hyperactive,' or you know, 'I'm

*impulsive, things like that. They'll first give you Strattera® and after they give you that and you say it's not working, then they'll give you Concerta®, which is like Ritalin®, and the third time, they'll finally give you Adderall®, but they do that reluctantly."*

Participants reported that prescription stimulants are popular among younger (< 18) males and females.

### Other Drugs

Participants and professionals listed a variety of other drugs as present in the region, but these drugs were not mentioned by the majority of people interviewed. Participants often knew of these drugs, but were not active users. Lysergic acid diethylamide (LSD) is known to be present in the region, and participants typically rated availability as '6' on a scale of '0' (not available, impossible to get) to '10' (high availability, easy to get). A participant commented about the popularity of the drug, *"It's [LSD] become a club drug just like ketamine, ecstasy/molly and GHB [gamma-hydroxybutyrate]."* Clinicians reported not seeing current use of LSD in those seeking treatment; however, sometimes it is noted in drug use histories during the intake for younger (< 18) participants. The Columbus Police Crime Lab reported that the number of LSD cases it processes has remained stable. Participants had heard of synthetic marijuana (i.e., "K2" and "Spice"), but none of the participants had used it. While no participants or treatment providers in this region mentioned "bath salts" (i.e., methylenedioxypropylvalerone: MDPV), the *Mansfield News Journal* reported law enforcement arrested several people under the influence of the substance in Richland County, and reported that bath salts, commonly sold under names like Blue Silk, Posh Aromatherapy and White Lightening, are typically smoked or snorted and create symptoms of paranoia ([www.mansfieldnewsjournal.com](http://www.mansfieldnewsjournal.com), Jan. 30, 2011). An officer with the Franklin County Sheriff's Office named synthetic marijuana, salvia divinorum, kratom and MDPV as, *"some of the hottest things right now."* The officer explained that synthetic marijuana is sold in markets, carryouts and "head shops" as incense or potpourri, and when smoked, these products reportedly produce a high that is five times more powerful than traditional marijuana. He explained that salvia divinorum is a plant that is smoked and produces a high that causes laughter, delusions and paranoia; and very similar to salvia divinorum is kratom, which users buy in powder form also at "head shops" to mix with liquid in order to drink for a high. In terms of MDPV, the officer reported, *"MDPV is very new, but very dangerous ... Users say it is 10 times*

*more powerful than cocaine, and there have been horror stories all over the U.S. about users committing suicide while on the drug."*

### Conclusion

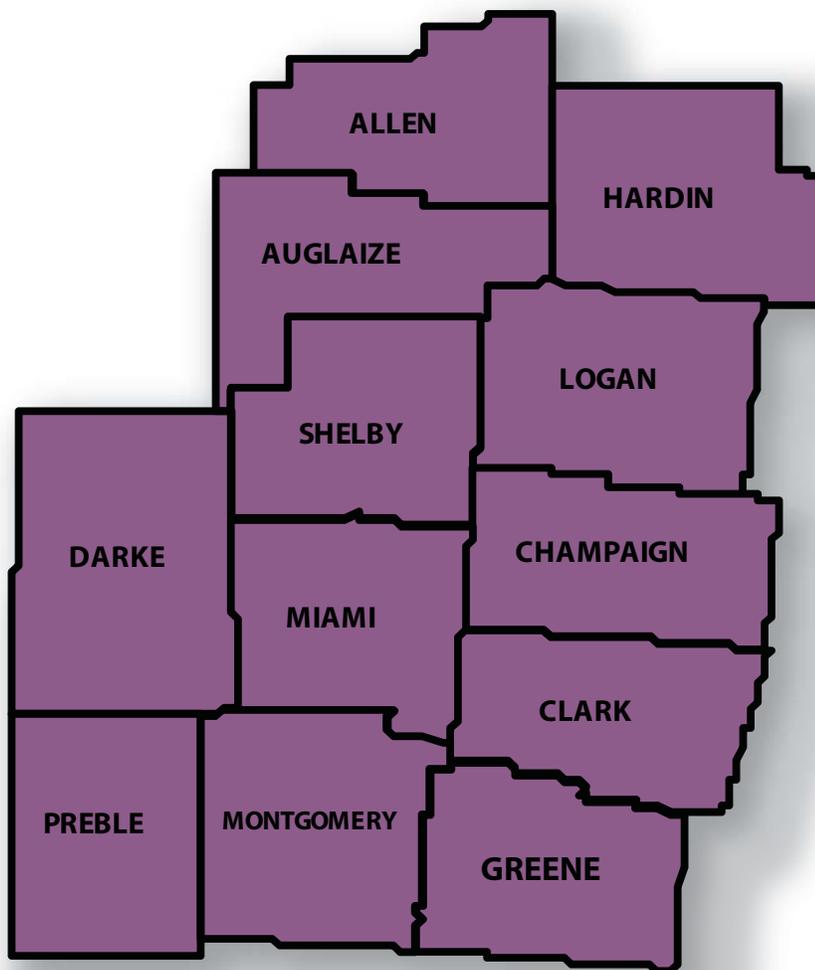
Crack cocaine, heroin (i.e., black tar), prescription opioids, Suboxone®, sedative-hypnotics, marijuana, ecstasy and prescription stimulants are the most available drugs throughout the Columbus region. Noted increases in availability over the previous six months exist for heroin, prescription opioids, Suboxone® and ecstasy. Heroin, referred to as "the new crack cocaine" because of its widespread street availability, has become a problem of epidemic proportions in the region. Young people (14 – 29 years) are coming into treatment for heroin addiction, particularly White males who typically start heroin use in high school and often come from suburban communities. Alarming, the most common route of heroin administration is intravenous injection. Prescription opioid use is also of epidemic proportions. However, users are switching from prescription opioid use to heroin use because heroin is cheaper and easier to obtain. The change in formulation of OxyContin®, which now makes the drug difficult to abuse, has also propelled those who preferred OxyContin® toward heroin use. The most popular prescription opioids in Central Ohio are OxyContin®, Percocet® and Vicodin®. Suboxone® continues to be used when heroin is unavailable for self-medication of withdrawal symptoms.

# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Dayton Region

June 2010-January 2011

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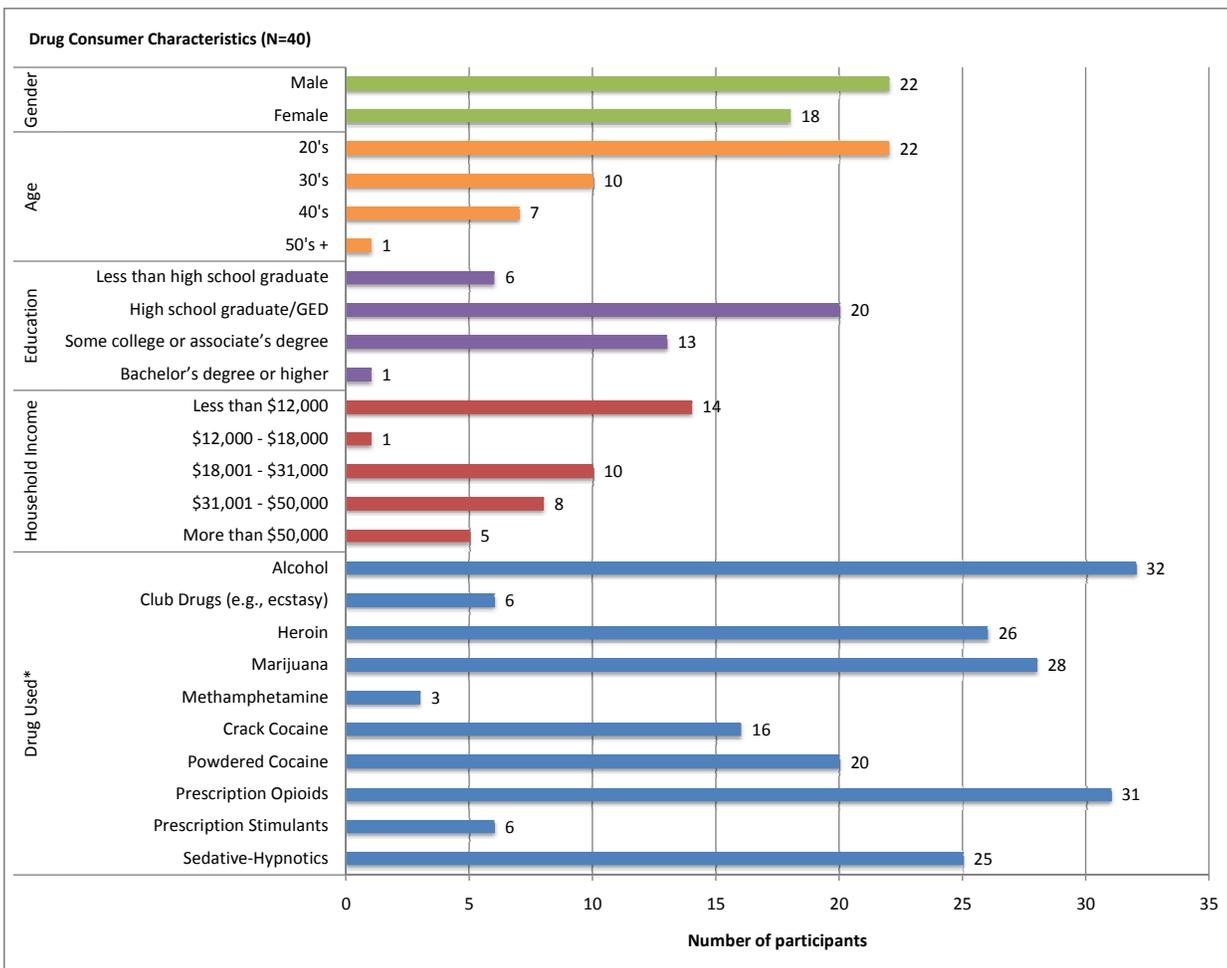
### Regional Profile

Indicator <sup>1</sup>	Ohio	Dayton Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	1,344,707	40
Gender (Female), 2009	51.2%	51.3%	45.0%
Whites, 2009	82.2%	84.2%	92.5%
African Americans, 2009	11.9%	11.1%	2.5%
Hispanic or Latino Origin, 2009	2.8%	1.8%	5.0%
High school graduates, 2008	84.6%	89.5%	85.0%
Median household income, 2009	\$45,467	\$46,387	\$18,000-\$31,000 <sup>2</sup>
Persons below poverty, 2009	15.1%	13.1%	42.1% <sup>3</sup>

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

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

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

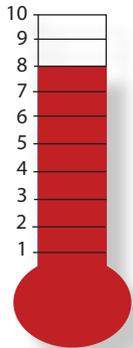


\*Some respondents reported multiple drugs of use over the past six months.

## Data Sources

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

## Powdered Cocaine Current Trends



Powdered cocaine is highly available in the region. Participants most often reported the current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The most common term used to describe current availability was "everywhere." Most participants reported that availability of powdered cocaine has increased over the last six months. Of the participants who believed that availability has increased, the reasons they offered varied from more supply

because of lower demand due to the increased popularity of heroin, to dealers who previously sold only heroin now also selling powdered cocaine, to the increased use of powdered cocaine with other drugs. Participants stated, "It's [powdered cocaine] still very available, but the price has doubled over the last few years. If you have the money, it's still around; Cocaine is so easy to get that you can get anything from a brick [kilogram] of cocaine to a cap [capsule] of cocaine. I never knew about a cap of cocaine until I started using heroin." Another participant disagreed, "Heroin has taken over from cocaine, and so, they [dealers] aren't selling it [powdered cocaine] as much." The few participants who reported decreased availability attributed

this to dealers selling more crack cocaine and less powdered cocaine, as well as, to less demand for cocaine due to the increased popularity of heroin. Miami Valley Regional Crime Lab reported a decrease in the number of powdered cocaine cases it processes.

Participant quality scores of powdered cocaine varied from '4' to '10' with the most common score being '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Most participants reported no change in the quality of powdered cocaine over the last six months. Participants universally reported that powdered cocaine is "cut" (i.e., diluted) with other substances. A participant reported, "Dealers mostly cut powdered coke [cocaine] to add bulk, so they can sell more." However, participants also stated that they believed cocaine is occasionally cut with other drugs (i.e., prescription opioids), which reportedly causes increased highs. Participants cited the following substances as commonly used to cut powdered cocaine: aspirin, B-13, baking soda, creatine, ether, mannitol, Oragel®, Similac® and Tylenol®. Participants reported the following prescription opioids as used to cut powdered cocaine: fentanyl, oxycodone and Vicodin®. According to Miami Valley Regional Crime Lab, cutting agents for powdered cocaine include: levamisole (dewormer for livestock) and phenacetin (analgesic), as well as, the local anesthetics: benzocaine, lidocaine and procaine.

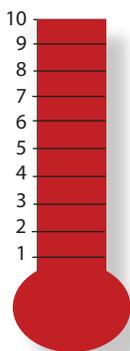
Current street jargon includes many names for powdered cocaine. The most commonly cited names were "blow," "girl" and "soft." Participants listed the following as other common street names: "booger sugar," "devil," "fish scale," "nose candy," "pearl," "powder," "snow," "that girl," "toot," "white" and "white bitch." Participants reported that ½ gram of powdered cocaine sells for \$25 – \$40; a gram sells for \$40 – \$65; two grams sell for \$80, 1/16 ounce, or "teener," sells for \$100 – \$125; 1/8 ounce, or "eight ball," sells for \$120 – \$150; and an ounce sells for \$500 – \$1,200. Participants also reported "caps," gelatin capsules filled with powdered cocaine, sell for \$5 – \$10; and a salt packet like those found in fast food restaurants emptied and filled with powdered cocaine sells for \$80. Most participants who used powdered cocaine reported injecting it intravenously (a.k.a., "slamming"). In one participant's words, "If I can't shoot it [inject cocaine], I don't use it." Other common routes are intranasal inhalation (i.e., snorting), smoking and eating.

The vast majority of participants reported no pattern to the demographics of powdered cocaine users. They said

that use crosses all ages, races and socioeconomic classes. A participant stated, *"There is no typical user [of powdered cocaine]. Black, White, old, young, I see them all."* A minority of participants believed more powdered cocaine users to be White and younger. A participant reported, *"I think that these young people snort and shoot [inject], and the older ones, they smoke it [powdered cocaine]."* The most common drug reportedly used with powdered cocaine is heroin. Participants frequently reported injecting "speedballs" (i.e., powdered cocaine mixed with heroin). The second most frequently used drug with powdered cocaine is Xanax®, used after cocaine to "come down" from the high and to avoid the "geeked" (i.e., wired, anxious) feeling. Participants reported the following substances as also used in combination with powdered cocaine: alcohol, Dilaudid®, marijuana, methamphetamine and OxyContin®. In addition, a participant reported using Nyquil® to come down after powdered cocaine use.

### Crack Cocaine Current Trends

Crack cocaine is highly available in the region. Participants most often reported the current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Most participants reported that availability of crack cocaine has not changed over the last six months. Of the participants who believed that availability has increased, reasons stated included more supply because of more people being out of work and turning to selling it. The few participants who reported decreased availability attributed this to recent drug arrests decreasing the supply. In November, *WHIO-TV* reported a mother and son in Dayton arrested for, *"running a major drug operation"* in which police seized 77 grams of crack cocaine ([www.whiotv.com](http://www.whiotv.com), Nov. 18, 2010). A law enforcement officer stated the availability of crack cocaine is, *"24/7, generally in the lower income areas, but there is decreased availability [of crack cocaine] in the last six months because more users are going to heroin."* A participant stated and others agreed, *"It's [crack cocaine] available all over, but people don't want it. Everyone's switching to heroin."* Miami Valley Regional Crime Lab reported a decrease in the number of crack cocaine cases it processes.



Participant quality scores of crack cocaine varied from '0' to '10' with the most common score being '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Most participants reported decreased quality of crack cocaine over the last six months. The reason given for the decrease in quality is that crack cocaine is reportedly "cut" (i.e., diluted) with more baking soda and baby laxative than previous. A participant reported that dealers sometimes drop a "dime" (1/10 gram) of crack cocaine into a bottle of Sprite®, causing the "rock" (i.e., piece) of crack cocaine to expand, and selling it for \$20 when it would otherwise have been sold for less. This participant also reported that users are savvy to these tricks and closely examine crack cocaine to look for small holes caused by carbonation. According to Miami Valley Regional Crime Lab, cutting agents for crack cocaine include: levamisole (dewormer for livestock), nicotinamide (B vitamin used to treat acne) and phenacetin (analgesic), as well as, the local anesthetics: benzocaine, lidocaine and procaine.

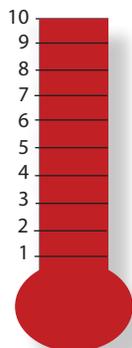
Current street jargon includes many names for crack cocaine. The most commonly used were "hard" and "rock." Other names included: "A1," "boulders," "butter," "cocoa puffs," "dope," "medicine," "shit," "yank," and "yay-yo." Participants reported that a 1/10 gram, or "dime," of crack cocaine sells for \$10; 1/2 gram sells for \$25; a gram sells for \$40 – \$70; 1/8 ounce, or "teener," sells for \$100 – \$125; and an ounce sells for \$600 – \$800. Participants also reported that "rocks" sell for \$20 and up and are the most common unit of size bought, second only to "dimes." Most participants who used crack cocaine reported injecting it intravenously or "shooting." The remaining participants reported smoking crack cocaine.

The vast majority of drug participants reported no pattern to the demographics of crack cocaine users. They said that use crosses all ages, races and socioeconomic classes. A participant believed that younger users smoke crack cocaine with marijuana or tobacco (a.k.a., "primo" when smoked together) while older users smoke crack cocaine in a pipe (i.e., "crack pipe"). In addition to marijuana and tobacco, the most common drugs reportedly used in combination with crack cocaine are alcohol, heroin and Xanax®. Participants frequently reported using these drugs to come down from a crack cocaine high.

## Heroin

### Current Trends

Heroin is highly available in the region. Participants most often reported the current availability of powdered heroin as '10' and black tar heroin as '2' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The most common term used to describe current availability of heroin generally was "everywhere." Participants stated, "If I drive down the right street right now, I can get a 'tester' [free sample of heroin] thrown in the car window; It [heroin] is out in the parking lot right now." A participant reported that dealers knock on windows at night of the drug treatment facility where the interview occurred and sell heroin to those in treatment. A law enforcement officer stated, "[A treatment facility] is right in the middle of one of the highest concentration of heroin availability in Dayton. The dealers know that and wait outside the door and give people their phone number."



Most participants reported that availability of heroin has increased over the last six months. Of the participants who believed that availability has increased, the reasons cited were: "more dealers, less jobs; pain doctors bridge to heroin; supply and demand; more people making trips to the city [Dayton from Bellefontaine]; more available in the suburbs." Participants indicated that different types of heroin are available at different times from different dealers. Reportedly, the most common types of heroin are an off-white, beige or white powder and black tar. Participants also reported encountering heroin that is peach colored, "goldish-red," red, caramel, gray, and gray and speckled called "P-chunk". Miami Valley Regional Crime Lab reported processing white, off-white, tan and brown heroin cases, as well as, an infrequent number of black tar heroin cases. The consensus among participants was that black tar heroin is much more difficult to find, but frequently available, or perhaps always available if one is willing to try multiple dealers. A participant stated, "I can always get some [black tar heroin], but I might have to take you to three or four guys to find it." Law enforcement reported that powdered heroin is readily available and has increased in availability over the last six months. Another officer stated, "Most of what's here is brown powder [heroin]; I've only seen tar [black tar heroin] twice." Another officer stated, "Generally in the winter, we see a decrease [in heroin availability]. This year we haven't seen a decrease. Usually it varies by season,

but to this point, it's holding its own." Treatment counselors stated that heroin is "easier to get than beer," inexpensive and ubiquitous in the community. A participant said, "More than crack [cocaine], it [heroin] is everywhere." In December, WHIO-TV in an online article entitled, "4 Men Arrested in Drug Sting in Wapakoneta," quoted the Auglaize County Sheriff as saying, "Heroin continues to be a problem in the county [Auglaize] and the surrounding counties with the majority of it [heroin] coming from the Dayton area" ([www.whiotv.com](http://www.whiotv.com), Dec. 17, 2010). A participant said, "It's [heroin] so available in Dayton that sometimes it's easier to get than weed [marijuana]." Miami Valley Regional Crime Lab reported a slight decrease in the number of heroin cases it processes.

Participant quality scores of heroin varied from '3' to '10' with the most common score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Most participants reported decreased quality of heroin over the last six months. Participants reported that the heroin is being "cut" (i.e., diluted) more with other substances, but did not routinely know what is used to cut heroin. According to Miami Valley Regional Crime Lab, cutting agents for heroin include: quinine (antimalarial), diphenhydramine (antihistamine), procaine (local anesthetic) and caffeine (e.g., NoDoz®).

Current street jargon includes many names for heroin. The most commonly used were "boy," "dog food" and "H." Other names included: "balls," "balloons," "berries," "blacks," "browns," "bubblegum," "caps," "dope," "drop," "fire," "flame," "hank," "horse," "junk," "smack," "vitamin," and in Spanish-speaking areas, "carga." Participants reported that 1/2 gram of powdered heroin sells for \$50 – \$70 (\$140 in Bellefontaine); a gram sells for \$70 – \$100; 1/4 ounce sells for \$500 – \$600; and an ounce sells for \$1,450 – \$1,700. Participants also reported "caps," or gelatin capsules filled with powdered heroin, sell for \$7 – \$12, or three caps for \$20 in Dayton and Urbana; in Bellefontaine, participants reported that caps sell for \$20. Few participants reported pricing for black tar heroin beyond two grams for \$200 and an ounce for \$2,000 – \$2,500. Most participants in the region who used powdered heroin reported injecting or "banging" it intravenously. Other common routes are intranasal inhalation (i.e., snorting), smoking and eating. An older participant reported, "I skin pop it [subcutaneously inject heroin]." Another participant reported seeing an older participant, who could no longer find suitable veins for injection, performing intranasal injection of heroin into the soft tissue of the nose: "I saw this one dude; he couldn't find a vein, so he was shooting it [heroin] into his nose."

The vast majority of participants reported no pattern to the demographics of heroin users. They said that use crosses all ages, races and socioeconomic classes. Many of the participants reported concern over their perception that users are starting younger than ever before, reportedly as young as 15 and 16 years. Many professionals also reported that heroin users have become younger over the last several years. A law enforcement officer said, *"In the high schools, the kids started off some years ago stealing grandparents' parents' pills [prescription opioids] ... and now the natural progression is to heroin, and most of those kids have hit that stage now, and they're in their 20's and hard-core heroin addicts."* Participants in different focus groups described a similar pattern to their own and others use of heroin. They described an injury or illness for which they were prescribed opioids; they reported becoming addicted to these "painkillers," and when their physician (eventually) cut them off, they began to buy prescription opioids on the street; eventually running out of money and no longer able to afford these drugs, they switched to heroin. After initiation of heroin use, participants reported a short progression of use from snorting to injecting heroin. This pattern was described throughout the region on multiple occasions. Law enforcement members also echoed this pattern of injury to heroin injection. An officer stated, *"Most of the time their story is a car wreck, then they were given prescription pills [opioids] and then got on heroin and got addicted. I hear it every time."* A treatment provider stated, *"At least 30 to 40 percent of our caseload are here because they were prescribed an opioid. They [doctors] start them on perc's [Percocet®] or vikes [Vicodin®], working up to oxy's [OxyContin®] and then [clients move] on to heroin. It's a steady progression."*

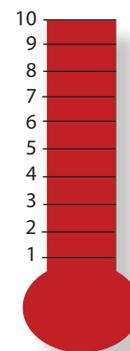
Beyond the many participants who indicated heroin use with powdered cocaine, the most common drugs reportedly used with heroin are benzodiazepines, particularly Xanax®. Other substances used in combination with heroin are alcohol, Dilaudid®, marijuana, methamphetamine and Opana®.

## Prescription Opioids

### Current Trends

Prescription opioids are highly available in the region. Participants most often reported the street availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described some prescription opioids as more readily available than others. The consensus among almost all of the participants across focus groups was that

prescription opioids are more available than six months ago. Most participants agreed that the increased availability is due to increased prescribing in hospitals, private physician offices, and occasionally, pain clinics. Overall, very few participants knew of a pain clinic, but most knew of a physician who would essentially write prescriptions to order for cash payments. There was widespread agreement that many ordinary people are selling their prescriptions to make money in the down economy. A participant stated, *"Everyone is selling their pills [prescription opioids]. They get them for pain or whatever, and when they need the money, they sell their extra."* Several participants reported that Opana® in particular has increased in demand and has become more available over the last six months. A participant reported, *"I see a lot more Opana®, more of them [dealers] have it when I buy."* Finally, a couple participants stated that the availability of opiates has decreased due to the popularity of heroin, and because people can't afford insurance to get the drugs. A participant stated, *"With the economy and stuff, nobody got a job and can't afford no insurance."* Treatment professionals reported very high availability of prescription opioids, noting very rare "droughts" (i.e., extended periods of time when street availability of a drug is extremely low). A participant stated, *"It seems like oxy's [OxyContin®] are a little less available now than before, but you can always get something."* A law enforcement officer stated, *"They changed the way oxy's [OxyContin®] are made and you can't crush them and shoot [inject] or snort them. However this information gets passed, word of mouth or whatever, people hear that they get the same high from heroin."* A counselor stated, *"They aren't using the oxy [OxyContin®] much. The older kind isn't around as much and is more expensive, and they can't use the new formula."* Miami Valley Regional Crime Lab reported that the number of prescription opioid cases it processes has remained steady while noting two exceptions: a slight increase in Percocet® and an increase in OxyContin® cases.



In August, *WHIO-TV* reported that members of the Clark County Sheriff's Office conducted an undercover drug investigation where detectives made several purchases of OxyContin® in Clark County townships ([www.whiotv.com](http://www.whiotv.com), Aug. 25, 2010). Reportedly, the reformulation of OxyContin® OC into the more abuse resistant OxyContin® OP has had little effect on the drug's widespread use. Participants in each focus group described different variations on how to

get around the abuse challenges posed by reformulation. A method reported is one involving “shocking” the OxyContin® OP gel pill with ice until it is solid, drying the surface, cutting it up, microwaving it, and then snorting it. Another method is heating the pills in the microwave, applying ice to the pills, followed by chopping the pills up for snorting or intravenous injection (participants reported that approximately 30 percent of the drug is lost using this method). Another method is to microwave the pills with water to loosen the coating, lick off the coating, and then chop the pills for snorting. Participants reported wide knowledge and use of these methods.

Participants indicated that an array of prescription opioids are currently sold on the region’s streets, reporting the following prescription opioids as available to the street-level user (Note: When reported, current street names and prices are indicated in parentheses): Darvocet® (\$1 per milligram), Dilaudid® (2 mg for \$7, 4 mg for \$10, 8 mg for \$15), fentanyl (25 mg for \$5 – \$7, 50 mg for \$12, 100 mg patches for \$20 – \$25), Lortab® (a.k.a., “coffins” and “blues;” \$5 – \$7 per pill), methadone (a.k.a., “mets” and “m&m’s;” 10 mg for \$5 – \$7), morphine (40 mg for \$20 – \$40), Opana® (a.k.a., “opies;” 30 mg for \$7 – \$12), OxyContin® (a.k.a., “OC’s” and “oxy’s;” \$0.50 – \$1 per milligram); Percocet® (a.k.a., “circus pets;” “perc’s” and “school buses;” \$0.50 – \$2 per milligram) and Vicodin® (a.k.a., “HP’s” and “vikes;” \$0.50 – \$1 per milligram).

In addition to most frequently obtaining prescription opioids on the street from dealers, participants also reported getting prescription opioids from friends, roommates, family members, “old ladies” with prescriptions, as well as, from buying “scripts” (i.e., prescriptions) from doctors (area primary care, emergency medicine and obstetrics/gynecology physicians). A participant stated, “You go to the ‘dope doctors.’ You go to any of these physicians with a wad of cash, and they’ll write whatever [prescription] you want.” Treatment professionals reported that there are many physicians and pharmacists providing prescriptions, both appropriately and inappropriately. A treatment provider stated, “These doctors [physicians over-prescribing prescription opioids] are coming out of the woodwork and they have the pharmacies right there in their offices.”

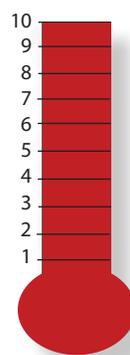
While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the most common route of administration is oral consumption,

including crushing and wrapping pills in bathroom or facial tissue and swallowing (a.k.a., “parachuting”). Many participants also reported intravenous injection (particularly OxyContin®), intranasal inhalation (i.e., snorting) and smoking of crushed prescription opioid pills.

A profile of a typical illicit user of prescription opioids did not emerge in the data. Participants and treatment professionals alike stated that illicit use of prescription opioids in their communities is a far-reaching problem. Participants reported that prescription opioids are used across all ages, races and socioeconomic classes. A few participants believed that it is easier for women than men to obtain a prescription for these drugs. Several treatment providers noted that use of prescription opioids seems to be gaining popularity among young people. A treatment provider stated, “I’m concerned about the number of teens and twenties that are using them [prescription opioids] recreationally.” Another provider continued, “They start with pills younger, and they eventually progress to heroin. People reporting that they started using pills at 12, 13, 14 years old.” Prevalence of prescription opioid use among adolescents is illustrated in data from the Logan County Family Court, which reported that 20 percent of juveniles involved in their court system reported illicit use of “painkillers” during their initial court screening. Reportedly, prescription opioids are used in combination with alcohol, benzodiazepines (i.e., Xanax®) and marijuana.

### Suboxone®

#### Current Trends



Suboxone® is highly available in the region. Participants most often reported the street availability of Suboxone® as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants agreed that Suboxone® was “easy to get.” A participant stated and others agreed, “They’re [Suboxone®] out there. A lot of people are going to the methadone clinic to get them and then selling them to get high. They’re so available that I was getting them in the county jail.” While a few respondents

reported being either currently or previously prescribed Suboxone® by a physician in their community, through a treatment center or while incarcerated, most frequently, respondents reported obtaining Suboxone® on the street

from drug dealers. A law enforcement officer stated, *“We run into Suboxone® and Methadone® a lot.”* Miami Valley Regional Crime Lab reported an increase in the number of Suboxone® cases it processes.

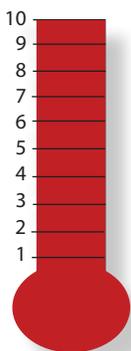
No slang terms or common street names were reported for Suboxone®. Participants reported current prices for Suboxone® 8 mg to range from \$7 – \$20, with the most frequently reported price being \$10. Reportedly, Suboxone® is most often taken sublingually, letting it dissolve under the tongue. Several participants in each focus group reported snorting Suboxone®. Only very few participants reported intravenous use, with a participant cautioning against it, stating to the focus group that if you shoot it (inject), you get, *“dope sick and cotton fever [body trembling accompanied by fever] when it hits your blood.”* Reportedly, Suboxone® is used in combination with benzodiazepines (i.e., Xanax®) and marijuana.

**Sedative-Hypnotics**

**Current Trends**

Sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) are highly available in the region. Participants most often reported the availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants described some sedative-hypnotics as more readily available than others, but this was not consistent across the region or within focus groups. Most participants stated that sedative-hypnotics have become more available over the past six months.

A participant stated, *“I just get them [sedative-hypnotics] prescribed. Most people I know get them from the pharmacy, not on the street.”* Another stated, *“Everyone knows which doc will write [prescriptions] for cash. You just go in with your money and tell them what you want.”* The reasons given for the increased availability were more frequent prescriptions being written and *“doctor-shopping.”* A treatment professional stated, *“It seems like Klonopin® seems to be more prescribed and that Xanax® are more [available] on the street.”* Another counselor expressed frustration with local prescribers, *“People are going to the psychiatrist and coming out with a script [prescription] for a benzo [benzodiazepine]. I don’t understand why doctors see that they’re on methadone and*



*give them a benzo anyway.”* Miami Valley Regional Crime Lab reported that the number of sedative-hypnotics cases it processes has remained stable.

Reportedly, many different types of sedative-hypnotics are currently sold on the region’s streets. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ambien®, Ativan®, Buspar® (a.k.a., “buzzbars”), Klonopin® 2 mg (a.k.a., “klonnies,” “K-pin” and “pens;” \$2 – \$3) Soma® (\$0.50 per pill), Valium® 10 mg (\$5) and Xanax® (a.k.a., “bars;” “beans;” “footballs;” “panty-dippers;” “peaches;” “purples;” “school busses;” “totem poles;” “wagon-wheels” and “xani’s;” \$0.50 – \$3 per milligram).

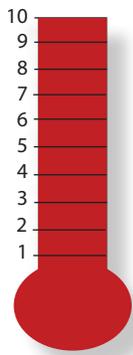
In addition to obtaining sedative-hypnotics on the street from dealers, participants reported visiting primary care physicians, emergency room physicians, psychiatrists and nurse practitioners to obtain prescriptions for these drugs. A participant reported, *“I get them [sedative-hypnotics] from my mom, my family, any old lady on the street. I mean not people who are dealers, but [people] who need that money at the end of the month and sell their own pills.”* Another participant stated, *“I don’t need to get a script [prescription] for them [sedative-hypnotics]. Anyone will sell you their pills, they are everywhere.”* Many reported getting sedative-hypnotics from friends and family members.

While there were a few reported ways of consuming sedative-hypnotics, the most common routes of administration are oral ingestion and intranasal inhalation (i.e., snorting). A few participants indicated that they shoot sedative-hypnotics intravenously, particularly Klonopin®. A profile of a typical illicit user of sedative-hypnotics did not emerge in the data. Participants believe that users cross all ages, races and socioeconomic groups. Treatment professionals reported that females use these drugs more frequently than males. A treatment professional stated, *“It seems like we see more women who get these scripts [sedative-hypnotic prescriptions] than men.”* A male participant echoed this believed increased availability to women: *“It’s easier for women to get a script [prescription] for a benzo [benzodiazepine], just go to the doctor and complain about something. They’ll look at me harder if I try that.”*

Reportedly, sedative-hypnotics are used in combination with alcohol, powdered and crack cocaine, marijuana and prescription opioids. Nearly all participants reported using

sedative-hypnotics to “come down” from other drugs. A participant stated, “Everyone I know uses Xanax® to come down off of coke [cocaine]. I always keep some in my pocket when I’m out.” Others in that focus group nodded in agreement. Another participant at a different location responded to a question about the frequency of sedative-hypnotic use by saying, “I think it’s very common. Mostly xani’s, [Xanax®] but whatever benzo [benzodiazepine] that you can get. Most people use them to help come down.”

### Marijuana Current Trends



Marijuana 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’ (high availability, extremely easy to get). Participants and treatment providers described marijuana as being extremely easy to get. Marijuana appears to be the drug of choice for juveniles involved in court systems around the region. More than 40 percent of juveniles involved in the Logan County Family Court system reported use

of marijuana during their initial court screening. A similar proportion of juveniles (42 percent) who were drug screened for marijuana, screened positive for marijuana use during alcohol and other drug screenings administered by the Miami County Juvenile Court. While participants reported that the availability of marijuana has not changed over the previous six months, they noted that occasionally the types or grades of marijuana vary from one dealer to another. Miami Valley Regional Crime Lab indicated that the number of marijuana cases it processes has remained stable, reporting it processed 2,715 marijuana cases.

Participant quality scores of marijuana varied from ‘1’ to ‘10’ with the most common score being ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Several participants explained that the quality of marijuana depends on whether the user buys “commercial weed” (i.e., low to mid-grade marijuana) or hydroponically grown (i.e., high-grade marijuana). Participants reported that both the lowest and highest grades of marijuana are always available, with the deciding factor for purchase being the amount of money the user would like to spend. A participant stated, “There’s

*everything from commersh [commercial marijuana] all the way up to hydro [hydroponically grown marijuana], you can buy the garbage at the same spot you buy the good.”*

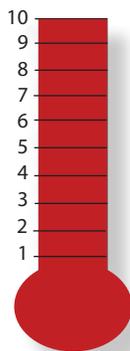
Current street jargon includes countless names for marijuana. The most commonly cited name was “weed.” Participants listed the following as other common street names: “cheap Mexican,” “commercial,” “ditch weed” and “seed weed” for low to mid-grade marijuana; “kush,” “Meigs County’s finest” and “purple haze” for high grade marijuana; and “hydro” for hydroponically grown marijuana. The price of marijuana depends on the quality desired. Participants reported they could buy commercial-grade marijuana in many different quantities: three “blunts” (i.e., marijuana cigars) sell for \$10 – \$20; 1/8 ounce sells for \$25; an ounce sells for \$100 – \$120; 1/4 pound sells for \$500; and a pound sells for \$900 – \$1,100. Participants also reported they could buy high-grade marijuana in many different quantities: 1/4 ounce sells for \$50 – \$100; and an ounce sells for \$300 – \$400. While there were a few reported ways of consuming marijuana, the most common route of administration is smoking, followed distantly by eating it, either by itself or baking it into food.

When asked to describe the typical user of marijuana, respondents were unable to be specific. They reported that virtually everyone uses marijuana, including all ages, races and socioeconomic groups. Participants reported dipping marijuana “blunts” (i.e., marijuana cigars) in PCP (phencyclidine) or embalming fluid (a.k.a., “wet”). In addition, participants reported using/lacing marijuana with cocaine and prescription opioids (i.e., morphine, Percocet® and Vicodin®). A participant stated, and others agreed, “Ain’t nobody stupid enough to lace this stuff [marijuana] before you buy it. If it’s laced, you’re doing it yourself. I don’t want that to get twisted, like they’re selling bad shit.”

### Methamphetamine Current Trends

Methamphetamine is relatively rare in the region. Most participants knew little about the drug, although almost all participants believed the drug’s popularity has waned over time. There were active users of methamphetamine in only one of the focus groups in this region. While infrequently abused, those respondents who were recent users most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability,

extremely easy to get). The few participants who reported regular use of the drug knew of reliable sources while the vast majority of the participants did not believe the drug to be available. When asked whether the powdered form or the crystal form was more available, participants said that both forms are equally available. Media reports over the past six months have also shown methamphetamine to be available in the region. *WHIO-TV* reported two methamphetamine labs found in Shelby County ([www.whiotv.com](http://www.whiotv.com), Jan. 11, 2011). Participants said the availability of methamphetamine has not changed in the last six months. Miami Valley Regional Crime Lab reported that the number of methamphetamine cases it processes has increased.



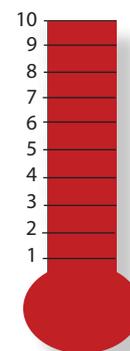
Participants reported that the quality of methamphetamine was very low, with the only score given by all participants who responded being '0' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants who were frequent users of the drug described it as "lithium-cut" and "eat-your-brain crank." Current street jargon includes very few names for methamphetamine. The most commonly cited names for crystal methamphetamine were "crank," "ice" and "glass." Participants reported that they could buy a gram of methamphetamine for \$25 – \$40. The most common routes of administration for this drug included smoking and intravenous injection, although intranasal inhalation (i.e., snorting) methamphetamine was also mentioned by several participants. Participants were not able to provide a typical user profile for methamphetamine. They reported that use falls across all ages, races and socioeconomic classes. A participant stated, "I know White guys, Black guys, White women, Black women, all kinds that use [methamphetamine]." In addition to alcohol, Xanax® and heroin are used in combination with methamphetamine, reportedly, to "come down" after methamphetamine use.

### Ecstasy Current Trends

Ecstasy [Methylenedioxymethamphetamine (MDMA)] 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' (high availability, extremely easy to get). Participants did not believe that the availability of ecstasy has changed over the last six months. A participant stated, "It's [ecstasy] always there, but

[the design] changes all the time. I can always find it." Miami Valley Regional Crime Lab reported an increase in the number of ecstasy cases it processes, reporting slightly more MDMA-based ecstasy cases than BZP-based (benzylpiperazine) ecstasy cases.

Current street jargon includes several different names for ecstasy. The most commonly cited name was "molly" for unpressed, pure powdered methamphetamine. Participants listed the following as other common street names: "apples," "green Christmas trees," "mitsubishi," "mike," "red Christmas" and "pink pistols." Several participants stated that heroin-cut MDMA was called "mercedes" while cocaine-cut MDMA was called "igloos" or "snowflakes." A participant stated, "They'll have pumpkins [etched into ecstasy pills] for Halloween, Christmas trees for Christmas, whatever to get you to buy something new." Participants reported that MDMA was often "cut" (i.e., diluted) with other drugs, but reportedly there is no way of knowing for sure what it is cut with. Participants explained that one never knows what one will get since everyone cooks ecstasy a different way. A participant stated, "It's [ecstasy] different from every dealer and every week. Somebody told me that their pills had mostly cocaine in them, not X [ecstasy]."



Participants reported a single tablet of ecstasy sells for \$3 – \$20, and that the price of the pill depends on a variety of factors, including quantity purchased with volume discounts being the norm. Reportedly, most ecstasy is coming from the Columbus and Cincinnati areas, although drug dealers coming from Canada are known to sell their drugs along the I-75 corridor en-route to larger cities. The only reported method of administration is oral consumption.

### Other Drugs

Participants and professionals listed a variety of other drugs as being present in the area, but these drugs were not mentioned by the majority of people interviewed. Reportedly, synthetic marijuana (e.g., "K2") is being used by a few participants for recreational use. A participant stated, "It's [synthetic marijuana] just as good as hydro [hydroponically grown marijuana]." Another countered, "It [synthetic marijuana] don't do nothing for me. I didn't feel anything." Participants reported that synthetic marijuana is widely available and that local gas stations advertise it in their windows. A participant noted forthcoming legislation, which

would make some synthetic cannabinoids illegal, reporting that the owner of the local gas station said, *"I've already got stuff that gets you twice as high, [for] when this [synthetic marijuana] is not legal."* Prescription cough medicines that contain codeine and over-the-counter cough medicines containing dextromethorphan (DXM), like Coricidin Cough and Cold® (a.k.a., "triple C's"), were mentioned by several participants. While none of the participants used this drug, they said that it was popular among teenagers who had little access to other drugs. Lysergic acid diethylamide (LSD) was mentioned by a few participants, but no one knew about pricing or availability. A participant said, *"The younger crowd is reverting back to mushrooms and/or acid. A lot of talk of those in the bar scene."* In addition, participants reported inhalants like air duster are also popular among teenagers. A participant reported that a young woman who was involved with a local drug court recently died after using inhalants.

### Conclusion

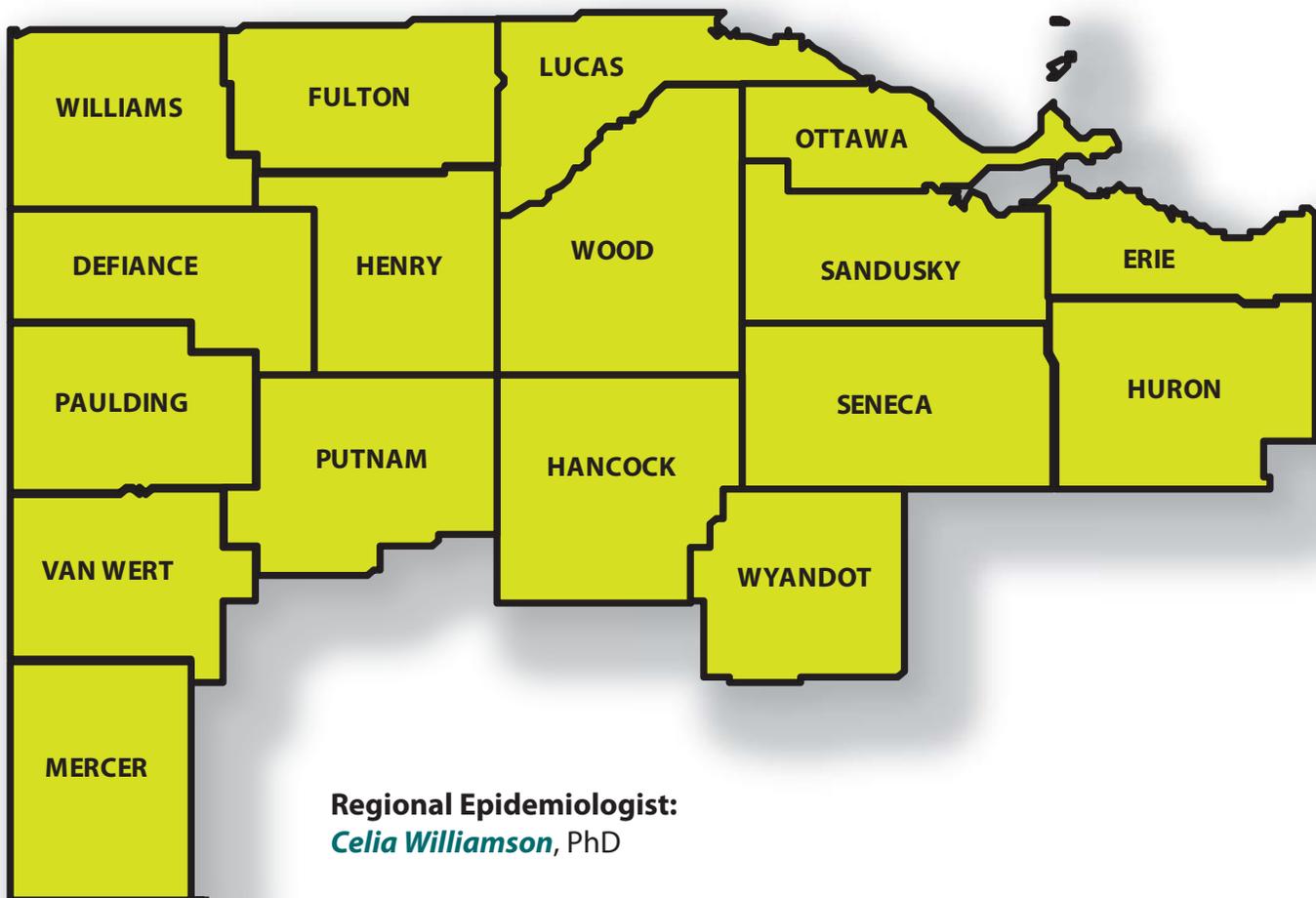
Crack cocaine, heroin (i.e., brown and white powdered), prescription opioids, Suboxone®, sedative-hypnotics, marijuana and ecstasy are the most available drugs throughout the Dayton region. Noted increases in availability over the previous six months exist for heroin, prescription opioids and sedative-hypnotics. While highly available, crack cocaine is decreasing in availability as more users are now seeking heroin. "Easier to get than beer" and ubiquitous in the region, more young people are using heroin, starting at age 15 or 16. After initiation of heroin use, users are progressing quickly from snorting to injecting heroin. The use of prescription opioids has also gained popularity with young people (12 years old and up). Many users start opioid use with prescriptions before moving to heroin. OxyContin® and Percocet® remain the most popular prescription opioids; Opana® has increased in popularity. Suboxone®, most often obtained from street dealers, continues to be used by heroin addicts as a means to avoid withdrawal when they do not have heroin. Sedative-hypnotic use is very common, especially Xanax®, which many users use to "come down" from highs produced by other substances.

# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Toledo Region

June 2010-January 2011

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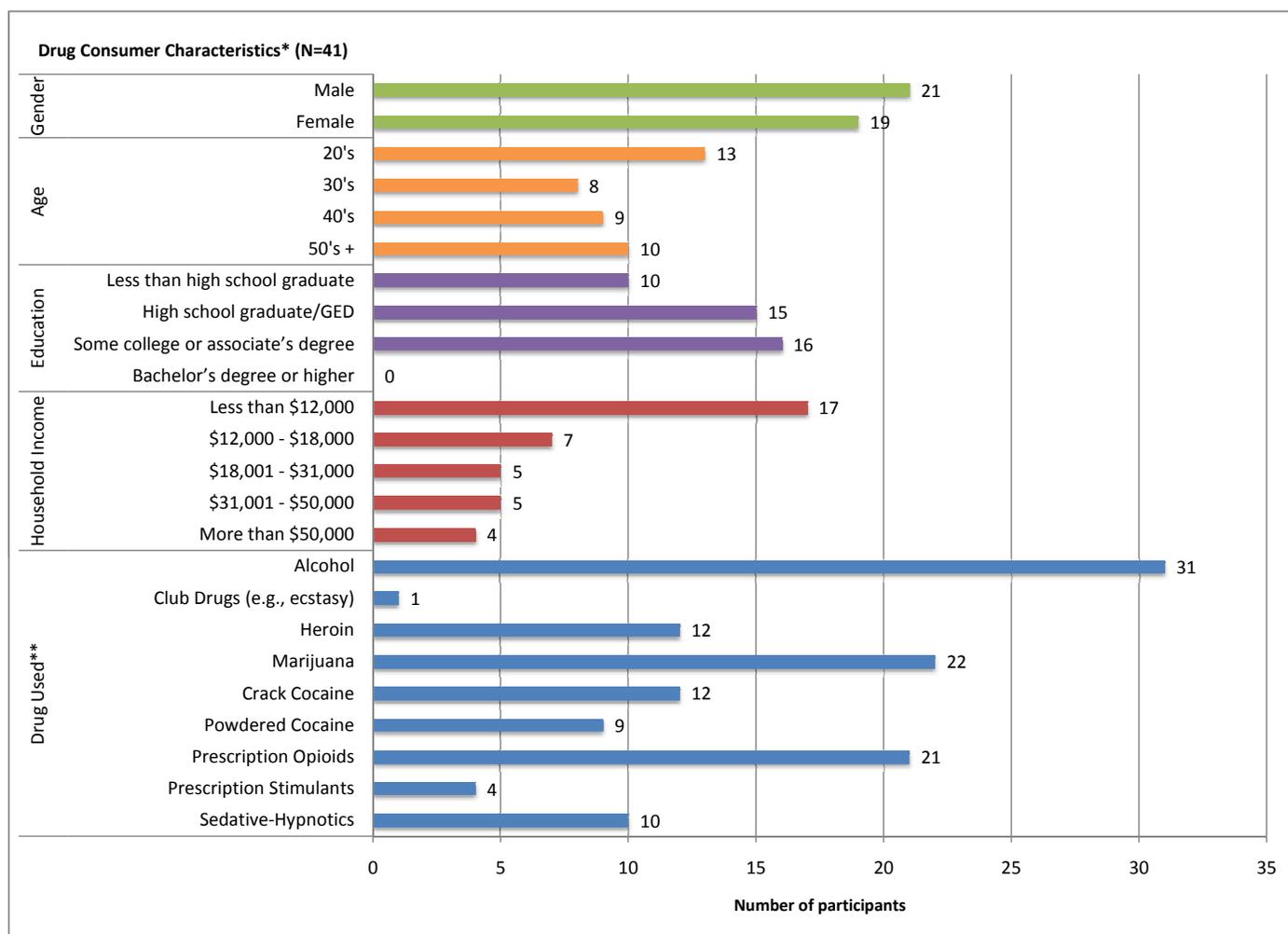
### Regional Profile

Indicator <sup>1</sup>	Ohio	Toledo Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	1,249,616	41
Gender (Female), 2009	51.2%	51.1%	46.3%
Whites, 2009	82.2%	84.6%	56.1%
African Americans, 2009	11.9%	7.9%	31.7%
Hispanic or Latino Origin, 2009	2.8%	5.1%	6.5%
High school graduates, 2008	84.6%	92.3%	75.6%
Median household income, 2009	\$45,467	\$45,659	\$12,000 - \$18,000 <sup>2</sup>
Persons below poverty, 2009	15.1%	11.5%	43.2% <sup>3</sup>

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

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

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



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

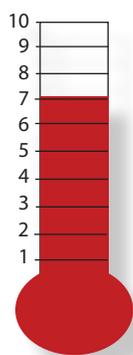
\*\*Some respondents reported multiple drugs of use over the past six months.

## Data Sources

This regional report was based upon qualitative data collected via individual and focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Lucas County. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (i.e., treatment providers) via focus group interviews, as well as to data surveyed from the Bureau of Criminal Identification and Investigation (BCI&I) Bowling Green, which serves Northwest Ohio. BCI&I data are summary data of cases processed from January to June 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the last six months (i.e., from time of interview through prior six months); thus, current BCI&I data correspond to the current reporting period of participants. In addition to the aforementioned data sources, the following media outlets were queried for information regarding regional drug abuse for June 2010 through January 2011: *FOX Toledo News*, *Sentinel Tribune Daily* (Bowling Green) and *Times Bulletin Media* (Van Wert).

## Powdered Cocaine

### Current Trends



Powdered cocaine is moderately available in the region. Participants and treatment providers most often reported the drug's current availability as '7' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Reportedly, the availability of powdered cocaine mostly has to do with one's connections with cocaine dealers. As a respondent commented, "[Availability] depends on what side of town you stay on, 'cause where I stay at, I know a lot of people that deal in it [powdered cocaine]."

Media reports from the region reported a recent arrest related to powdered cocaine during which law enforcement seized four kilos of powdered cocaine at a traffic stop, valued at \$40,000 ([www.foxtoledo.com](http://www.foxtoledo.com), Jan. 27, 2011). BCI&I Bowling Green crime lab reported moderate and stable availability of powdered cocaine.

Most participants rated the quality of powdered cocaine as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Generally, participants reported that the quality of powdered cocaine is not good because dealers either "cut [dilute powdered cocaine] it too much" or are more interested

in using powdered cocaine to create and sell crack cocaine. A participant reported, "Cut goes up, price goes up," clarifying that in the last six months even though the amount of non-cocaine ingredients has increased in powdered cocaine, so has the price. This view was shared by others, as participants commented, "[Powdered cocaine] probably been cut [diluted] about three or four times; "I would not do cocaine in Toledo. It's a waste of your money." Participants mentioned baking soda as commonly used to cut powdered cocaine. BCI&I Bowling Green crime lab reported that powdered cocaine is cut with several substances including levamisole (dewormer for livestock), caffeine (e.g., NoDoz®), diltiazem (medication used to treat heart conditions/high blood pressure) and procaine (local anesthetic).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "girl" and "white girl." Participants listed the following as other common street names: "Christina Aguilera," "Johnson and Johnson," "kizzle" and "tissue." Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine. Participants reported that a gram of powdered cocaine sells for \$50 – \$75, depending on the quality; 1/16 ounce, or "teener," sells for \$75; 1/8 ounce, or "eight ball," sells for \$125 – \$150; an ounce sells for \$900 – \$1,100. Participants reported that the most common way to use powdered cocaine is through intranasal inhalation (i.e., snorting). Out of 100-powdered cocaine consumers, participants reported that approximately 80 would snort it, 10 would intravenously inject it or "shoot it," and another 10 would smoke it. Reportedly, others see people who snort powdered cocaine as "cool." A participant summed up how others perceived powdered cocaine use: "It [powdered cocaine] doesn't have that 'crack head' stigma." While participants stated that not many people use powdered cocaine intravenously, a participant reported, "I shot mine [injected powdered cocaine]. I don't like the drain from my nose." In addition, participants reported that those who inject are more likely to be intravenous drug users who prefer to inject any drug they purchase. Smokers of powdered cocaine may sprinkle it along the top of a marijuana "joint" (i.e., marijuana cigarette) and "roll it up," which was identified as "cocoa puffing."

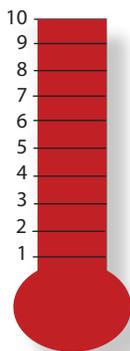
Participants described typical users of powdered cocaine as those with enough financial means to afford the drug such as "wealthier people; people with money; more business types" or "preppy people." Users were also described as "dancers, rollers/drug traffickers, suburb people who come in the inner city,

and doctors [or] lawyers.” Reportedly, those in business who can afford powdered cocaine may be in legitimate business or illegal business. A participant described those in illegal business: *“It’s a lot of hustlers that pretty much set it [powdered cocaine] out ... and party off of it. You know, trick with girls and, you know, just put it out there so everybody can party.”* Participants described powdered cocaine as being used by a “younger crowd.” A participant reported, *“Now-a-days it be like younger people [who use powdered cocaine] ... age 16 to 26 or something like that.”* Reportedly, powdered cocaine is used in combination with ecstasy, marijuana and opioids. Some participants also reported alcohol use after cocaine use: *“So they can go to sleep at night.”*

### Crack Cocaine Current Trends

Crack cocaine is highly available in the region. Participants and treatment providers most often reported the availability of the drug as ‘10’ on scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). A treatment provider joked, *“It [crack cocaine] might be in the building somewhere ... That’s how available it is.”* A participant at another facility echoed this same idea, *“You can walk out the door right here and before you get to the corner you gonna see people with rocks [crack cocaine] in their pockets.”* Many participants reported that crack cocaine is readily available in their neighborhoods. A participant explained, *“I can walk out the front door where I live with my children, and I can look this way, and look this way, and in each direction, I can see at least one of the little boys in the neighborhood that sells it [crack cocaine].”* Another participant agreed, *“You don’t have to walk a whole city block [to find crack cocaine], and it can be 10 degrees outside.”* Participants reported that the availability of crack cocaine has been consistent over the past six months. BCI&I Bowling Green crime lab reported moderate and stable availability of crack cocaine.

Other than marijuana, reportedly, crack cocaine is the only drug that may be accessed by anyone, whether or not one is connected to drug dealers. Participants reported that almost anyone could walk down a street where drugs are sold and be asked if they would like to buy crack cocaine. Participants talked about women being approached by younger drug



dealers and asked if they “were cool” (i.e., in need of crack cocaine). Young dealers use the term “auntie” to make initial contact with potential female buyers. Participants explained using this term helped to build a relationship with a potential buyer, but also reflected a certain respect in the age difference of the young dealer to the adult female buyer. A participant described the range in age of various crack cocaine dealers in her neighborhood: *“The dealers on my block ... the youngest is 15 and the oldest is his older brother who’s 45.”*

Most participants rated the quality of powdered cocaine as ‘7’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality), but as a participant stated, *“It [quality of crack cocaine] depends on who you dealing with.”* Participants reported that crack cocaine in Toledo is “cut” (i.e., diluted) with baking soda. The more baking soda added to the crack cocaine rock, the less potent the drug. A participant commented that dealers will “blow it [crack cocaine] up” with baking soda to make the buyer think they are “getting a heck of a deal.” Another participant commented that finding quality crack cocaine might be related to luck or being connected to someone of importance, stating *“If you luck up on it [crack cocaine] or know who you’re dealing with, you can get quality crack [cocaine].”* Participants reported that the quality of crack cocaine has varied over the past six months to a year. BCI&I Bowling Green crime lab reported that crack cocaine is cut with several substances including levamisole (dewormer for livestock), caffeine (e.g., NoDoz®), diltiazem (medication used to treat heart conditions/high blood pressure) and procaine (local anesthetic).

Current street jargon includes several names for crack cocaine. Participants listed the following as common street names or sayings from dealers: “butter,” “I got that A-1” and “I got that work.” Participants reported that 1/16 ounce of crack cocaine, or “teener,” sells for \$65 – \$80; 1/8 ounce, or “eight ball,” sells for \$125 – \$200; and 1/4 ounce sells for \$200 – \$300. Most participants reported buying small quantities of crack cocaine including rocks that cost anywhere from \$2 – \$20. A dealer stated, *“My main sales was dimes [1/10 gram or \$10 rocks] and twenties [\$20 rocks].”* While participants reported a gram sells for about \$60, one was quick to point out, *“If somebody calls you about a gram [of crack cocaine], you better watch them ... because that just don’t sound right, because on the street, you’re not going to ask for a gram ... normally it’s all cut up into dime pieces or 20 pieces.”* While participants reported that anyone could walk down the street and buy crack cocaine, it is very difficult to buy a larger quantity of crack cocaine. The buyer

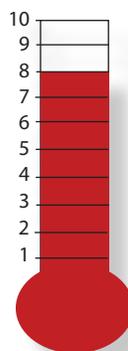
would have to be connected and trusted. As a participant put it, *"You have to have been a trusted person with that dealer ... you have to be an established person. They have to have seen or dealt with you at least a couple of months."* Another participant said, *"You have to have already 20'd yourself with them,"* meaning the user has to have purchased smaller quantities over time.

While there were a few reported ways of consuming crack cocaine, the most common route of administration by far is smoking. Most crack cocaine users reported they smoked the drug using makeshift crack pipes out of pop cans or other paraphernalia. Some respondents reported they knew people who *"broke it [crack cocaine] down"* (e.g., with vinegar) in order to liquefy and use intravenously. However, out of 100 people, participants reported that just about all of them would choose to smoke it. A participant said, *"There might be one or two people that shoot [inject] it [crack cocaine], but those people would smoke some too."*

A profile of a typical user of crack cocaine did not emerge in the data. Participants and treatment professionals alike stated that crack cocaine is far reaching into every socioeconomic class. Reportedly, crack cocaine is the drug of choice for older people described as being *"on assistance"* to people who drive in from the suburbs to get it. A treatment provider reported, *"It [crack cocaine use] crosses all socio-economic [classes]. It didn't use to be so, but now it is ... anybody is fair game at this point."* On the other hand, participants reported that the people who deal crack cocaine are usually young males; the perks from drug sales are said to lure them into selling the drug. As a participant reported, *"You see the kids going back and forth to school, and they see the dudes [dealers] on the corner with the fly shoes and jackets and stuff ... driving the nice cars. They see all the glitter and glamour ... I wanna be a part of that glitter and glamour, so what I gotta do. And, it's hard for a parent to keep telling them the downside when they see all of the upside. You see the perks, you don't see the prison."*

In addition to alcohol, participants reported that crack cocaine is typically combined with marijuana. Participants said they would add it to a marijuana cigarette and smoke it (called "cocoa puffing"), as a participant stated, *"You can break it [crack cocaine] down and put in a cigarette and 'cocoa puff it'."*

## Heroin Current Trends



Heroin is highly available in the region. Participants most often reported current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). While many types of heroin are currently available in the region, participants reported the availability of white powdered heroin, which participants often referred to as "china white," as the most available. A participant noted, *"That's [use of 'china white' heroin] blowing up."* Another participant stated, *"At*

*first it was the brown [heroin], but now I only know two people I can get that from. It's more the china [white heroin] now."* Even though white powdered heroin was reported to be highly available, finding it is said to be predicated on two factors: one's connections and one's proximity to the drug. A participant reported, *"[Availability] depends on what side of town you're on."* A respondent reported, *"I know I can get it [white powdered heroin] on the east side or south side anytime."* While interviewing a participant outside of his home on the east side, the interviewee pointed next door to indicate how close his heroin connection was. Brown powdered heroin is also available on Toledo's streets. Participants rated brown powdered heroin's availability as '6'. A participant described brown powdered heroin as, *"Mixed ... It's like tar and lactose ... It looks like a milk dud or something ... It's called 'dog food'."* Another participant said, *"If I wanted it [brown powdered heroin], I could have it dropped off in an hour."* When asked why brown powdered heroin is referred to as "dog food," a participant commented, *"cause it's the color of dog food and treats you like a dog."* Treatment providers generally reported heroin to be highly available, rating its current availability as '9'.

Participants reported the availability of black tar heroin to be low, rating its availability as '2' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). A participant said, *"I don't know anyone that has tar [black tar heroin]."* Participants reported that Hispanics, who they reported control the heroin markets in Toledo, hold the release of black tar heroin in order to decrease competition and to keep the particular "cut" (i.e., grade) they want in Toledo. In fact, many heroin consumers commented on the South American control of heroin in Toledo and distribution

by a few local families with connections. A participant stated, *"To be politically correct, it's the Mexicans, Cubans and Colombians [who control the distribution and sale of heroin]."* Another participant reported, *"It's really hard [to find black tar heroin]. You really have to know somebody to get that connect, and you have to know somebody in the family. They keep it pretty lock and key."* Another participant described why dealers are thought to be reluctant to release black tar heroin, *"because you could under-cut them [sell cheaper]."* Yet another active intravenous user stated, *"They're [cartels] putting it [heroin] out on the street cut a certain way. They're giving it to the dealers mixed a certain way and then the dealers are putting their cut on it."* BCI&I Bowling Green crime lab reported high and stable availability of heroin generally.

Many participants commented on the recent rise in heroin abuse. *"Heroin gotten a lot bigger in this city,"* stated an interviewee. Participants offered reasons for the surge in heroin use in Toledo. The first reason given was the drug's increased availability and "good" quality, as most current participants reported heroin to be plentiful and well worth the effort to purchase and use. Second, participants reported that heroin abuse is the end of a natural progression that typically begins with prescription opioid abuse, also reported to be high in Toledo. A participant explained the progression from tablets (prescription opioids) and the lure of heroin: *"Well what happened was everybody got addicted to tablet ... and then you know 'I can get no higher than five 80's a day' so what are you gonna do, you gonna save money and do dope [heroin] or you gonna pay for all them tablets."* A treatment provider agreed with this sentiment stating, *"It's more economics. The tablets are more expensive and they'll go to heroin because they can't afford the tablets."* Third, the recent change in the composition of OxyContin® that prevents participants from successfully breaking it down for either injection or intranasal inhalation (i.e., snorting) was also cited as a reason for an increase in heroin use in the region. Focus group participants reported themselves and others as having shifted from OxyContin® to heroin, Duragesic® (fentanyl transdermal system) or a fentanyl-heroin mix. Media reports from the region corroborate the increased prevalence of heroin abuse. *Times Bulletin Media* reported, *"Police statistics show that the huge upswing in heroin arrests that began in the latter part of 2008 has not stopped. In 2008, there were only 11 heroin-related arrests, but that number jumped to 30 in 2009 ... [and] has doubled [since]"* ([www.timesbulletin.com](http://www.timesbulletin.com), Jan. 15, 2011).

Most participants generally rated the quality of heroin as '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). However, participants commonly reported that the "china white heroin" they purchase was a mix of heroin and fentanyl. A participant commented, *"You can see it [that it is not just heroin] in the consistency of it, the mix of it. You can see the color, texture of it, 'cause it doesn't mix properly ... because the fentanyl is a grayish white and the china white [heroin] is a super, super light brownish color."* Participants did not agree on the quality of brown powdered heroin. A participant described brown powdered heroin as "pretty potent" while another reported the current quality of brown powdered heroin as "garbage." BCI&I Bowling Green crime lab reported heroin to be very pure, and that black tar heroin is occasionally "cut" (i.e., dilute) with substances like caffeine (e.g., NoDoz®), diphenhydramine (medication used to treat allergies) and quinine (medication used to treat malaria).

Current street jargon includes many names for heroin. The most commonly cited names were "boy," "brown," dog food," "lottery tickets" and "stamps." Participants reported that a gram of white powdered heroin sells for \$40 – \$60; "folds" or "papers" (i.e., 1/10 gram folded in corners of a piece of paper to keep the heroin from sticking to the baggie) sell for \$10 – \$20; participants also reported buying heroin in "bundles" (i.e., 10 – 12 small packs of heroin); a gram of brown heroin sells for \$130 – \$150; 1/2 gram sells for \$40 – \$60; a gram of black tar heroin reportedly sells for \$125 – \$175 (no one reported buying smaller quantities of black tar heroin). Overall, participants reported heroin availability and pricing have not changed in the last six months. While there were a few reported ways of consuming heroin, the most common route of administration is intravenous injection. Most participants reported transitioning from snorting to injecting heroin intravenously for a more intense high. As a participant noted, *"You can only use it [heroin] for so long before you start shooting [injecting] it. I would say most the people I've met ... out of 50 people that would normally use, only one snorted it through their whole heroin career. Everybody else went to shooting it eventually."* Other participants remarked, *"All the people I know shoot [inject] it. After a while you got to snort three to four [times] a day, you know, versus doing one shot and getting just as high."*

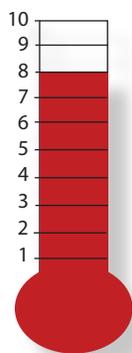
Typical users of heroin were described by both providers and participants as primarily young, White and having a prescription opioid abuse history. In reporting on the difference between heroin users of the past and today's

heroin users, a treatment provider stated, “Heroin addicts today are younger ... those 16 to 25 year olds.” Another provider commented, “Heroin was always an older people’s drug. A person on heroin would go for years without having dangerous issues, problems on their own, economic problems – and still be able to function. Nowadays it’s not happening like that. They’re [users] losing more stuff, [and experiencing] legal consequences.” A participant went further in stating, “It’s a epidemic. Young people, I mean really young people, 18 to 19 years old, even younger, really, really using this stuff [heroin] and, for me, that’s scary. When I was that age I was into beer, pot [marijuana], you know what I mean, and now it’s oxy’s [OxyContin®] ... and heroin ... it’s just around and people are getting younger and younger.” Another participant commented, “I started [heroin use] at 16, and I was using pretty heavy.” Treatment providers explained that once a user is introduced to heroin, heroin becomes the primary drug of choice and interest in other drugs decreases. A treatment provider who provides services to young people addicted to heroin and involved in the legal system, described young, mostly White users in treatment who, “once had means, now needing to break into garages and think of other ways to come up with money to buy heroin; they want that heroin and that’s how they end up in the legal system.” While providers noted heroin participants as being young and 60 to 70 percent White, they also reported recently seeing more Hispanics presenting with heroin abuse/dependence issues than previous. Heroin reportedly is used in combination with benzodiazepines, cocaine and marijuana. A participant reported, “I know people that speedball [inject a mix of crack cocaine and heroin].”

## Prescription Opioids

### Current Trends

Prescription opioids are highly available in the region. Participants identified the most popular as OxyContin®, Percocet® and Vicodin®, reporting the current street availability of these drugs as ‘8’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Treatment professionals most often rated availability of the aforementioned as ‘10.’ Participants reported Vicodin® as “a phone call away.” However, while the availability may be high, reportedly, the



demand for Vicodin® is low. As a participant put it, “Nobody wants Vicodin®.” Other participants commented, “You’ll have to take the whole script [prescription of Vicodin®]. You gotta understand that all these younger kids grew up taking Percocet® and OxyContin® and stuff like that to where that Vicodin® is just like an aspirin to ‘em. They don’t want it; I was taking 30 [Vicodin®] a day just to function.” These participants reported that opioid users eventually progress past Vicodin® and become more interested in stronger opioids such as OxyContin® and Percocet®. When discussing progression, a participant reported, “I started using prescribed medication [opioids] for a headache. I was only eating them at first and then gradually I got worse. I started using the OxyContin®. I would take the 20-milligram and I was eating them, and then eating them wasn’t good enough, and then I started smashing them down and snorting them, and then I think I got up to using three 80’s [OxyContin® 80 mg] a day and I just couldn’t afford it anymore. I went from using perc’s [Percocet®] on a daily basis up to oxy’s [OxyContin®] ... I was introduced to the fentanyl.”

Participants described prescription opioids as the gateway drug to heroin. A participant stated, “You don’t start off doing heroin ... If you start out using heroin you’re not going to go get an oxy [OxyContin®] unless you’re hard up; but you know if you’re doing oxy and you can’t get it, you’re gonna go get heroin.” A participant reported, “I started out snorting oxy’s [OxyContin®] for like a year and a half and then I was kind of on low times and didn’t have much money and my sister had started doing it [heroin] and she said it was good. One time I started [using heroin] and I was always ... like I don’t wanna do that ... and if you start, try it, it’s just, you’re going to do it all the time.” Media outlets in the region also talked about recent arrests due to prescription opioid trafficking. In July 2010, Fox Toledo News reported on a drug arrest during a routine traffic stop, leading to the confiscation of over 1,500 pills (i.e., mostly hydrocodone) with a street value of \$90,000 ([www.foxtoledo.com](http://www.foxtoledo.com), July 26, 2010). The Sentinel Tribune Daily spoke to availability of prescription opioids among young people, according to the Youth Survey of Alcohol and Other Drug Use conducted by the Lucas County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, prescription opioids “dropped in all of the high school grades except for 10th grade, where it rose nearly six percent” ([www.sent-trib.com](http://www.sent-trib.com), Aug. 17, 2010). BCI&I Bowling Green crime lab reported high and stable availability of prescription opioids, with oxycodone being the most frequently encountered opioid.

Both participants and providers described OxyContin® as the most desired opioid *“in the world of pharmaceutical abuse.”* The desire for OxyContin® in Toledo far outweighs the want for any other tablet. A participant commented, *“I was doing up to ten 80’s [OxyContin® 80 mg] a day, every day.”* However, since the making of traditional OxyContin® was recently altered, participants report finding it more difficult to purchase. As a respondent noted, *“You could go anywhere and get OC’s [OxyContin®] before, just like crack [cocaine] ... people just had them all the time.”* When commenting on the recent change, another respondent commented, *“That’s a big deal ‘cause the oxy’s [OxyContin®] were THE opiate.”* Participants described the new OxyContin® as different when attempting to crush them in order to snort or prepare them for intravenous use. A treatment provider explained, *“The thing with oxy [OxyContin®] right now is they [Purdue Pharma] changed the chemical make-up ... and they [users] can’t do what they used to. The OxyContin® are now the gel form so they can’t crush them up.”* A participant commented, *“It [OxyContin®] gels up so you can’t snort it and you can’t shoot [inject] it.”* Another participant noted that the new OxyContin® is like *“trying to snort bubble gum.”* In taking them orally, participants described a calm and tired effect. They also noted that the drug did *“take the sickness away [combat withdrawal sickness]”* but they were *“unable to feel the buzz [produce a high].”* Participants identified the availability of the new OxyContin® as ‘5’ and the demand for them as ‘1’ on a scale of ‘0’ (not desired) to ‘10’ (highly desired). A participant stated, *“Nobody wants the OP’s [new reformulated OxyContin®].”*

Because of the change in OxyContin®, participants described some people shifting to fentanyl and heroin abuse. A participant reported, *“That’s why fentanyl is coming up so hard because they’re getting the same feeling off the fentanyl as they did the OC’s [OxyContin®].”* Fentanyl powder was reported to be increasing in availability and was rated ‘9’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). A participant reported, *“Everybody I talked to can get fentanyl.”* Another participant said, *“We’ll see, you got all the fentanyl people now, like the china [china white heroin] people who snort it, who are used to snorting pills ... You have a whole new age of dope feinds coming up.”* The availability of fentanyl patches was most often reported as ‘3.’ A participant described how he prepared a patch for intravenous use: *“you scrape the gel out of it, put it in the spoon, shoot water in there and you cook it up, and you drop cotton in there and you draw it up.”* Although the availability of Ultram® was reported to be ‘8,’ there was no reported street

value or demand for Ultram® during this reporting period. Participants reported the following prescription opioids as less available for street purchase in the region: Demerol®, Dilaudid®, methadone, Opana®, Roxicet®, Subutex® and Tylenol 3®/Tylenol 4®.

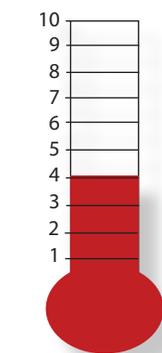
Participants reported the following prescription opioids (a.k.a., “beans”) as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): fentanyl (\$20 – \$50 for patches, depending on dosage; \$50 for a gram of powder; \$60 – \$70 for 1/16 ounce, or “teener”), Opana® 40 mg (\$30 – \$50), OxyContin® (a.k.a., “oxy’s;” “OC’s” refer to old formulation and “OP’s” refer to new formulation), OxyContin® 40 mg (a.k.a., “lemon”), OxyContin® 60 mg (a.k.a., “apple”), OxyContin® 80 mg (a.k.a., “lime;” old formulation sells for \$50 – \$80; new formulation sells for \$20 – \$25); Percocet® 5 mg (a.k.a., “perc’s;” \$3 – \$7); Percocet® 10 mg (\$6 – \$10); Percocet® 30 mg (\$15); and Vicodin® 500 mg (\$2 – \$3).

Participants reported that they obtained prescription opioids from dealers, doctors, friends and family. Those who obtained their drugs through doctors either engaged in *“doctor shopping”* (i.e., obtaining many different prescriptions from several doctors), or visited doctors who were well known for accepting cash for writing prescriptions. As a participant commented, *“There are doctors that will take \$200 cash and give you a script [prescription].”*

Prescription opioid consumers reported taking tablets orally, crushing them up and either snorting or cooking and then injecting them. A participant described taking the coating off a tablet, *“and you put it in your bottom [rectum; a.k.a., “plugging”] ... because they dissolve really fast and hits your bloodstream.”* Another participant described the practice of *“parachuting”* as *“just like when you grind it [prescription opioid tablet] up and snort it, it’s just like powder ... so you put it in a paper towel and swallow it, so when it hits your stomach, it’ll just burst open and hit you all at once like snorting it, but you can’t go through your nose anymore.”* Yet another participant talked about smoking tablets, particularly OxyContin®, *“I’ve never done it [smoked crushed prescription opioid tablets] but I’ve seen it. You mix it up into paste kind of, and you put it on a piece of foil and run a lighter underneath it [and smoke it] with a straw.”* Finally, participants described chewing fentanyl patches, sucking the gel, injecting the gel intravenously or wearing the patches.

The typical opiate abuser was described as a White young adult of some financial means. A participant reported, “Where I’m from it’s mostly White, ‘cause I live in Sylvania. They have a lot of money ‘cause their parents have money ... they start on OC’s [OxyContin®] and stuff.” Participants also discussed seeing pockets of under-aged opioid users who were more likely to be from the surrounding Toledo suburbs of Springfield, Sylvania, Perrysburg and Rossford. While those young adults and under-aged youth were described as the typical user, those among focus group participants who reported using opiates within the last six months ranged in age from 19 to 55. Participants reported liking to combine prescription opioids with alcohol, marijuana and stimulants (i.e., “speed balling”). In general, using prescription opioids is reportedly more socially acceptable than injecting heroin. A participant explained, “A lot of people are like, ‘man I’m just doing oxy’s’ [OxyContin®], but when you step over to heroin ... but it’s the same shit, but you’re paying more for the tablets to keep the social status and ... [avoid] the stigma.” Another participant chimed in, “You’re not looked at as a junkie [for prescription opioid use].” In addition, participants stated that those who maintain prescription abuse like knowing what they are getting. As a participant stated, “When you ask people why they do that [tablets], a lot of people will say it’s for the consistency. They know exactly what they’re gonna feel off that tablet. If they go out in the street and try and cop dope [obtain heroin] or whatever, they don’t know how they’re gonna feel off of that.”

**Suboxone®**  
**Current Trends**



Suboxone® is moderately available in the region. Participants reported the street availability of Suboxone® as ‘4’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). A participant stated, “You might have to make three phone calls [before securing Suboxone®].” Another respondent reported, “You can’t really get high with it [Suboxone®]. It’s just supposed to block your withdrawal symptoms.” Another commented, “My God, it [Suboxone®] saves your life.” Yet another participant

commented, “I’ve gone through treatment before and they put me on it [Suboxone®], but I know a lot of my dealers have it too.” A first time Suboxone® user reported using the drug to try to

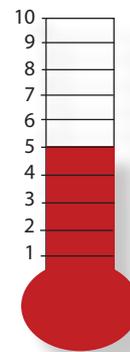
enhance the effects of a heroin high: “I mean I’m sitting there shooting \$80 worth of heroin and not getting high. I was pretty upset.” Treatment providers reported the street availability of Suboxone® as ‘7’. A provider stated, “They [opioid addicts] use it [Suboxone®] for a while, then they go back to their drug.” Another provider said, “I’ve seen people take them [Suboxone®] for maybe a year; not use any opiates, but their behavior doesn’t change. They’re still taking a pill and feeling panicked if they don’t have their Suboxone®, so their behavior is still the same.”

No slang terms or common street names were reported for Suboxone®. Participants reported current pricing for Suboxone® 8 mg to range from \$8 to \$10, or sometimes two pills for \$20. Most often participants reported taking Suboxone® sublingually. Some participants talked about the new Suboxone® strips that are placed on the tongue to dissolve, absorbing more medication into the body. The typical user was described as a young, twenty-something, White opioid user who does not want to be “dope sick.” However, a participant commented, “If you’re not on opiates, those things will get you f\*\*ked up.”

**Sedative-Hypnotics**

**Current Trends**

Sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) are somewhat available in the region. Participants described some sedative-hypnotics as more readily available than others. The availability of the benzodiazepines like Klonopin®, Soma® and Xanax® were reported to be ‘5’, and Valium® ‘4’, on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). By far Xanax® is the most popular sedative-hypnotic drug abused. Klonopin® is regarded as a second choice drug. A participant stated, “I would take those [Klonopin®] if I didn’t have any Xanax® and they’d get me through.” Generally, participants reported not encountering Valium® very often, but some of them preferred it when available. A participant stated, “There are times when they [Valium®] come in handy when you’re withdrawing from alcohol.” Another participant reported that he sought Valium® because it decreased anxiety and allowed him to sleep: “Valium knocks Xanax® right off the stage.” Treatment providers rated the availability of most sedative-hypnotics



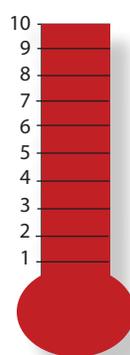
much greater than participants. Accordingly, they rated the availability of the benzodiazepines like Valium® and Xanax® as '10'; Klonopin® as '9'; and Soma® as '5'. Treatment providers disagreed about the availability of Ativan®; a provider said availability was '10', stating that use had "increased a lot" while other treatment providers reported that doctors are reluctant to prescribe Ativan® and rated its current availability as very low. Participants reported seeing Ativan® infrequently for sale on the street. BCI&I Bowling Green crime lab reported high and stable availability of sedative-hypnotics, with alprazolam (i.e., Xanax®) being the most frequently encountered form of sedative-hypnotics.

Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, branded names are used in the following, and prices are indicated in parentheses): Klonopin® (\$1 – \$2); Valium® 5 mg (\$1 – \$2); Xanax® 0.25 mg (\$0.25), Xanax® 0.50 mg (\$.50 – \$1.00), Xanax® 1 mg (\$1 – \$3) and Xanax® 2 mg (\$2 – \$5). Participants reported the following sedative-hypnotics as less available for street purchase in the region, primarily because there is little demand: Ambien®, Lunesta® and Restoril®. Participants reported that the most common routes of administration for sedative-hypnotics are oral ingestion (i.e., swallowing) or intranasal inhalation (i.e., snorting). While swallowing and snorting were reported to be equally common routes, fewer participants reported crushing and injecting sedative-hypnotics. As a participant stated, "I use to snort the Klonopin® and Xanax® or just chew them up." There were also reports of injection of sedative-hypnotics, participants crushing them, cooking them in a spoon and injecting them intravenously.

Many participants described typical users of sedative-hypnotics as young adults or older women who may have been prescribed sedatives-hypnotics and later progressed to abusing them. Other participants reported the typical user as to be simply a person who had access to sedative-hypnotics and started experimenting at a young age. A 28-year-old female participant stated, "I have a 14 year old sister. She came to me, and she was talking to me about the girls that she sat with at the lunch table, stealing their parents and grandparents prescriptions [sedative-hypnotics] and eating them." Frequently, participants stated that the typical Xanax® user minimizes the abuse of sedative-hypnotics. For example, participants would rationalize sedative-hypnotic abuse: "They're [users] not doing a bad drug; Well, I'm not smoking crack [cocaine]."

In addition to alcohol, participants reported that sedatives-hypnotics are used in combination with marijuana and opioids. A participant with experience drinking and taking sedative-hypnotics described the results of this combination by stating, "If you drink on it [sedative-hypnotics], it makes you feel like you don't want to move, and if you do walk, you'll fall down." Other participants explained those who regularly use stimulants might also use sedatives-hypnotics to "come down" from the intense high of stimulant drugs.

### Marijuana Current Trends



Marijuana is highly available in the region. Both participants and providers rated the availability of Marijuana as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants and treatment providers described all grades of marijuana as extremely easy to obtain. A participant in treatment joked, "You can go right outside the door and probably trip over a bag of weed [marijuana] somewhere." Participants reported that the availability of marijuana

has increased over the previous six months, attributing this increase mostly to the current availability of medical marijuana in Michigan. A treatment provider explained, "People are going on the line of Michigan/Ohio getting the medical marijuana card, going to buy the marijuana there [Michigan] and coming back here [Ohio] selling it." Participants corroborated this new trend, "When I worked ... right by the line [border with Michigan], a couple of people showing me their cards [medical marijuana cards], talking about 'I can get you a card.'" BCI&I Bowling Green crime lab reported high and stable availability of marijuana.

Participant quality scores of marijuana varied from '1' to '10' with the most common score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Quality marijuana is the most desired, but participants thought that quality marijuana was blended with lower quality marijuana at times. As a participant said, "For every gram of good shit [quality marijuana], there are three or four grams of bad shit."

Current street jargon includes countless names for marijuana. The most commonly cited name was "weed." Participants

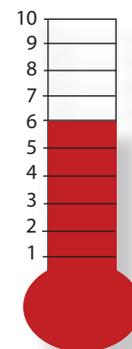
listed the following as other common street names: “reg” and “reggie” for commercial grade (a.k.a., “regular”) marijuana; “kush” and “purple” for high-grade marijuana; and “hydro” for hydroponically grown marijuana. The price of marijuana depends on the quality desired. A treatment provider in describing the amount that could be purchased in a baggy reported, “Twenty years ago it used to be three fingers [worth of marijuana]. Today, it’s one finger ... kush [high-grade marijuana] is shorter than that – the corner of the bag.” Participants reported commercial grade marijuana is the cheapest form: 1/4 ounce sells for \$20 – \$30; 1/2 ounce sells for \$40; an ounce ranges in price from \$75 – \$80; 1/4 pound sells for \$250. Higher quality marijuana (i.e., hydro) sells for significantly more: a “blunt” (i.e., marijuana cigar) or two “joints” (i.e., marijuana cigarettes) sells for \$5 – \$10; an ounce sells for \$275 – \$575; and 1/4 pound sells for \$2,500 – \$3,000. Medical marijuana sells for \$25 per gram. While there were several reported ways of consuming marijuana, the most common route of administration is smoking. Among those in the drug culture, smoking marijuana is not seen as stigmatizing behavior. As a participant reported, “Weed [marijuana] is considered ... acceptable.” Both participants and providers reported that while “old school users” (i.e., long time consumers) are satisfied with commercial-grade marijuana, younger participants prefer the potent high-grade marijuana. Despite the preference, a treatment provider commented that clients, both young and old, are more likely to report smoking commercial grade marijuana: “The kush and the medical marijuana costs more, so most of the people that I have smoke the regular.”

When asked to describe the typical user of marijuana, respondents were unable to be specific. Both participants and treatment providers described the typical user of marijuana as “anybody,” with the youngest known smoker being around age 12. A participant offered this opinion about current marijuana smokers, “[Today] you got 12 year olds, the ones that’s selling the crack [cocaine], 12 to 15, and they’re the ones smoking the weed [marijuana] and they’re smoking blunt after blunt after blunt and the weed is like their crack cocaine.” In describing the profile of a young person who abuses marijuana, a treatment provider with years of experience added, “They get out of bed, they reach for it [marijuana]; they hit it before they get moving. That’s like their cigarette and coffee in the morning. They smoke to eat. They smoke to get dressed. They smoke while they sitting on the porch watching the neighbors do what they do.” With the same sentiment in mind, another provider commented, “I’m

finding with a lot of younger people, it’s [marijuana] actually their motivator ... to get up and go every day.” In talking to a user group, a participant added, “I have a family member now she has to wake up with a blunt. A person that smokes crack [cocaine] they don’t have to wake up with that. But she goes to bed with it [marijuana] and she has to wake up with it.” Marijuana consumers may combine their smoking with alcohol use. However, participants reported that because marijuana smoking is so commonplace, drug consumers are likely to smoke “weed” with any other drug they may be using. A participant commented, “Some people smoke weed [marijuana], pop pills, and drink beers and stuff like that.” Another participant said, “You can mix marijuana with alcohol, heroin, pills, coke—anything.” However, a participant reported baking marijuana into a brownie recipe to receive what she described as “a nice body buzz.” Several participants reported that themselves or others would sprinkle powdered cocaine or crushed crack cocaine in a marijuana cigarette and smoke it [i.e., “cocoa puff”]. Finally, a treatment provider reported having a few clients this reporting period that dipped marijuana in opiates they had cooked down.

### Methamphetamine Current Trends

Methamphetamine is relatively rare in the region. While most participants reported no experience with this drug and no knowledge of where it can be found, a participant reported availability of methamphetamine (i.e., “crystal meth”) as ‘6’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get), adding that methamphetamine can be located on the east side of Toledo. This participant reported, “It’s [methamphetamine] in Toledo. You just gotta know the right person to get it.” While the participant did not discuss price, he stated that the quality is good. He also reported that most Toledo users are typically White, male bikers or those connected to bikers. The most common route of administration is smoking with a pipe. Reportedly, methamphetamine is often used with alcohol. FOX Toledo News reported on a recent arrest concerning a methamphetamine lab in Wood County ([www.foxtoledo.com](http://www.foxtoledo.com), Jan. 26, 2011). The Sentinel Tribune Daily reported on the availability of methamphetamine to young people, according to the Youth Survey of Alcohol and Other Drug Use conducted by the Lucas County Alcohol, Drug

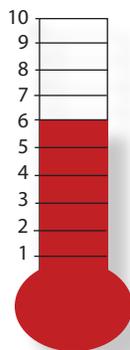


Addiction and Mental Health Services (ADAMHS) Board, methamphetamine use has increased for 9th and 10th-graders ([www.sent-trib.com](http://www.sent-trib.com), Aug. 17, 2010).

**Ecstasy**

**Current Trends**

Ecstasy [methylenedioxymethamphetamine (MDMA)] is moderately available in the region. Participants reported its availability as '6' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Most participants did not have current experience with the drug. As a participant reported, "I used to use it [ecstasy] a lot." A couple of treatment providers reported that most of their younger clients under 50 years old have tried ecstasy, indicating that ecstasy is available. However, another treatment provider framed the discussion about availability differently: "I don't think it's an issue of availability. I think it's more of an issue of, they've [users] moved on and there are other things they want to spend money on." Participants reported that those most interested in taking ecstasy (a.k.a., "X") are "party goers" and people who like to use ecstasy during intercourse. A participant reported that taking "X" for some people could be dangerous because many do not know their limits: "What's dangerous is people crushing up 5 and 6 [ecstasy] pills thinking they're superman and stuff." The *Sentinel Tribune Daily* corroborated the availability of ecstasy among young people, according to the Youth Survey of Alcohol and Other Drug Use conducted by the Lucas County Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, ecstasy use "increased in all of the high school grades" ([www.sent-trib.com](http://www.sent-trib.com), Aug. 17, 2010). BCI&I Bowling Green crime lab reported low availability of ecstasy.

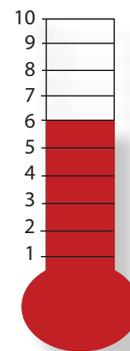


**Prescription Stimulants**

**Current Trends**

Adderall®, Concerta® and Ritalin® are moderately available in the region. Participants rated the availability of prescription stimulants generally as '6' for adults and '8' for those under 18 on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Out of all the prescription stimulants available, Adderall® is reportedly the most prevalent. When speaking of availability, a participant said, "You can get it [prescription stimulants] easily, because a lot of kids that go to school are prescribed it." Treatment providers

reported the availability of prescription stimulants as '8' for adults, based on those coming in for treatment. A treatment provider reported that a few clients used both Ritalin® and crack cocaine: "They were smoking the crack [cocaine] and taking the Ritalin® to come down a little bit." This provider reported that a client said, "Ritalin® to someone who doesn't have a diagnosis really does give you a good high." The *Sentinel Tribune Daily* corroborated the availability of prescription stimulants among young people, according to the Youth Survey of Alcohol and Other Drug Use conducted by the local ADAMHS board, prescription stimulant use (i.e., Ritalin®) increased for some high school groups. The survey found "students use of... [Ritalin®], belonging to 'someone else,' rose 3.4 percent for 10th-graders and 2.3 percent for 11th-graders to 10.7 percent and 18.1 percent respectively, while declining among 9th- and 12th-graders" ([www.sent-trib.com](http://www.sent-trib.com), Aug. 17, 2010).



Reportedly, prescription stimulants are most widely available in high schools but have little street value where they sell for \$1. A participant noted, "I use to see it [prescription stimulant use] a lot in high school and junior high ... a couple of my friends would just give it to me." Another 19-year-old white male participant talked about prescription stimulants being in his high school in Sylvania. Reportedly, he watched as another student abused Adderall®: "I knew this kid, just busted it [Adderall®] out, crushed it up and snorted it, right there at the lunch table ... I couldn't believe it."

Treatment providers identified the typical prescription stimulant abuser as young, White and male. The typical mode of administration for prescription stimulants is to take them orally or to crush and inhale (i.e., snort) them. A participant talked about the feeling after snorting Adderall®: "If you snort it [Adderall®], it's like coke [cocaine], but like all day." Other than youth under 18, participants reported that young adults in colleges desire prescription stimulants: "UT [University of Toledo students] and BG [Bowling Green State University students] will pay mad money for Adderall® to stay up all night." Participants also reported that stimulants are used to lose weight, to increase one's energy level when working out, or to stay awake and study.

### Other Drugs

Participants and professionals listed a variety of other drugs as being present in the region, but these drugs were not mentioned by the majority of people interviewed. A few participants reported using drugs such as synthetic cannabinoids (i.e., K2) and salvia divinorum. Informed participants reported that the high produced by the aforementioned did not last very long, *“about 10 minutes,”* and it is not as desirable as marijuana. BCI&I Bowling Green crime lab reported an increasing number of cases involving synthetic cannabinoids. A participant spoke about psilocybin mushrooms, rating its availability as ‘5’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). He talked about participants bringing mushrooms back from festivals and concerts along with LSD (lysergic acid diethylamide). Another participant talked about liking the effects of the Neurontin®, a drug taken to relieve nerve pain or to prevent seizures. In trying to refrain from heroin use, this participant discussed using Neurontin® to calm himself even though he admitted it did not fully take away withdrawal symptoms from heroin. Several participants also discussed drugs commonly used by youth. Reportedly, inhalants are popular with youth around ages 14 and 15; these youth buy and *“huff”* model glue from a bag, butane cans, whipped cream cans, and other aerosol cans. In addition, a group of participants discussed the abuse of codeine mixed with 7-up®, Sprite® or liquor, often called *“lean,” “syrup”* or *“drank,”* which reportedly is easily obtained and abused by under-aged youth.

### Conclusion

Crack cocaine, heroin (i.e., white powdered), prescription opioids and marijuana are the most available drugs throughout the Toledo region. Noted increases in availability over the previous six months exist for heroin and marijuana. The region has experienced a surge in heroin use due to increased availability and *“good”* quality heroin, high prescription opioid abuse that almost certainly leads a user to heroin abuse, and the recent change in the composition of OxyContin® that prevents users from successfully breaking it down for either injection or intranasal inhalation. Powdered fentanyl, which is readily available, is also becoming more popular due to OxyContin® reformulation. Prescription opioids are, *“the gateway drug to heroin.”* Many users have shifted from OxyContin® to heroin, and soon

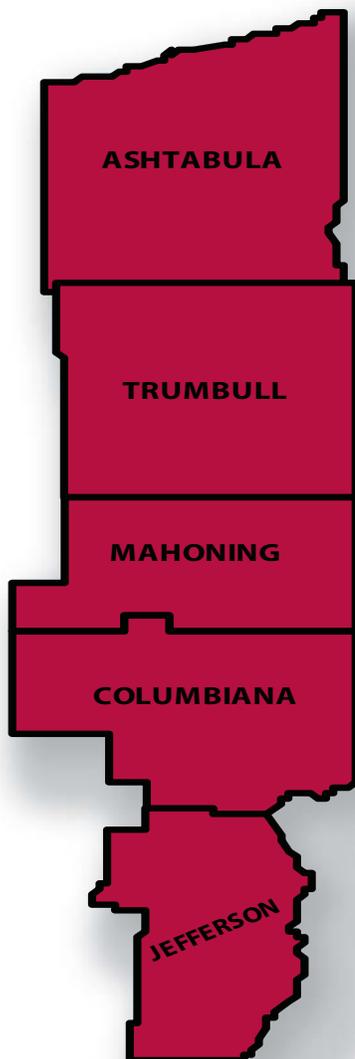
after progressing to heroin, users transition rather quickly to injecting heroin intravenously for a more intense high. Typical users of heroin are primarily young (16 – 25 years old), White and have a prescription opioid abuse history; and while heroin users are 60 to 70 percent White, abuse is increasing among Hispanics in the region. Marijuana availability has increased due to medical marijuana in Michigan, which people are buying in Michigan and selling in Ohio. Since marijuana smoking is so commonplace, users are likely to smoke it with any other drug they may be using. It is common to sprinkle powdered cocaine or crushed crack cocaine in a marijuana cigarette and smoke it (i.e., *“cocoa puff”*). Alarming, users start smoking marijuana as young as 12 years old. Many young users reportedly *“need”* marijuana in order to wake up in the morning and then to go to sleep at night. Other than marijuana, crack cocaine is the only drug that may be easily accessed by anyone, whether or not one is connected to drug dealers. Almost anyone could walk down a street where drugs are sold and be asked if they *“were cool”* (in need of crack cocaine).

# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Youngstown Region

June 2010-January 2011

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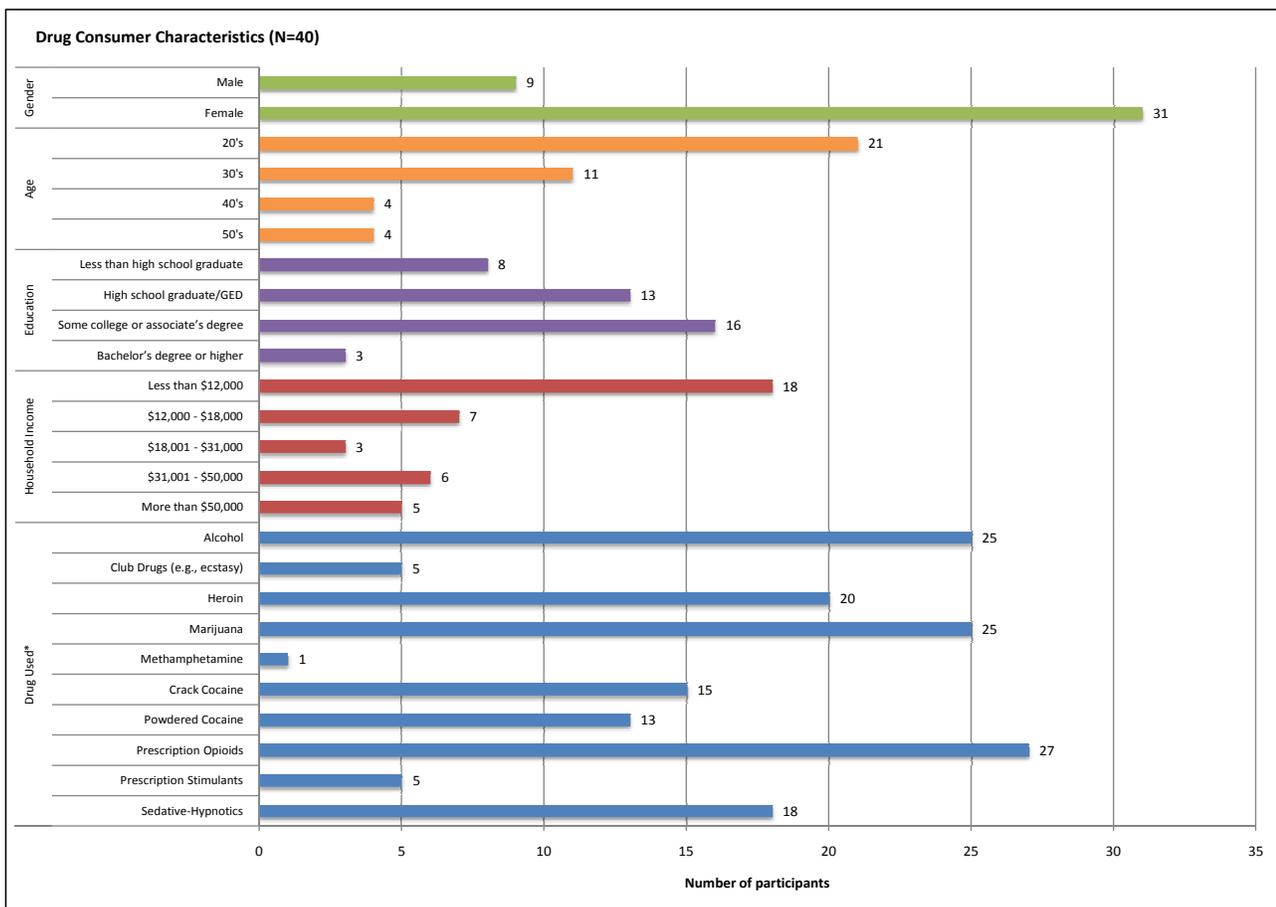
**Rick Massatti**, MSW

Research Administrator

### Regional Profile

Indicator <sup>1</sup>	Ohio	Youngstown Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	723,072	40
Gender (Female), 2009	51.2%	51.4%	75.6%
Whites, 2009	82.2%	87.1%	87.5%
African Americans, 2009	11.9%	8.8%	7.5%
Hispanic or Latino Origin, 2009	2.8%	2.3%	5.0%
High school graduates, 2008	84.6%	88.1%	80.0%
Median household income, 2009	\$45,467	\$39,339	\$12,000 - \$18,000 <sup>2</sup>
Persons below poverty, 2009	15.1%	17.2%	47.5% <sup>3</sup>

Ohio and Youngstown statistics are derived from the U.S. Census Bureau<sup>1</sup>. Respondents reported income by selecting a category that best represented their household's approximate income for 2009<sup>2</sup>. Poverty status was unable to be determined for seven respondents due to missing or insufficient income data<sup>3</sup>.



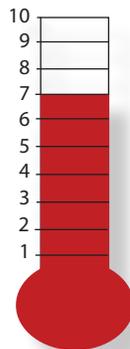
\*Some respondents reported multiple drugs of use over the past six months.

## Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Mahoning and Trumbull Counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (i.e., treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Bureau of Criminal Identification and Investigation (BCI&I) Richfield Office, which serves the Cleveland, Akron and Youngstown areas. BCI&I data are summary data of cases processed from January to June 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the last six months (i.e., from time of interview through prior six months); thus, current BCI&I data correspond to the current reporting period of participants. In addition to the aforementioned data sources, the *The Youngstown Vindicator* was queried for information regarding regional drug abuse for June 2010 through January 2011.

## Powdered Cocaine Current Trends

Powdered cocaine is moderately available in the region. Participants most often reported the drug's current availability as '7' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Law enforcement identified powdered cocaine as "in the top four of most available drugs—below heroin and crack [cocaine]." According to treatment providers, the availability of powdered cocaine has remained stable over the last six months, while according to an overwhelming number of participants, the drug's availability has decreased, with the consensus being that powdered cocaine is not as available as crack cocaine. A participant stated, "The powdered [cocaine] form is harder to come by because everybody buys up the powder form and cooks it up into crack [cocaine], so you know being able to find decent powder or any powder was zero to none because it's already been processed." BCI&I Richfield crime lab reported that the number of powdered cocaine cases it processes has remained stable.



Participant quality scores of powdered cocaine varied from '2' to '10' with the most common score being '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Several participants explained that the quality of powdered cocaine is dependent on who is selling it. A participant explained, "You may get two or three big suppliers, but as they distribute it to other people, once again, like I said, they [drug dealers] stomp on it. Some people stomp on it more than others." Participants reported that powdered cocaine is most often "cut/stomped on" (i.e., diluted) with other substances. A participant reported, "At the head shop, they have stuff that you can get that is numbing, and it numbs your mouth ... The people who are purchasing it [powdered cocaine] don't really know the purity because it makes your mouth numb, and it speeds you up still. It's more or less a fake." Participants cited the following substances as commonly used to cut powdered cocaine: baby aspirin, baby laxative, baking soda, creatine and NoDoz®. BCI&I Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine (e.g., NoDoz®).

Current street jargon includes many names for powdered cocaine. The most commonly cited name was "white girl." Participants listed the following as other common street names: "duff," "girl," "powder," "pow-wow," "snow," "soft," "sugar booger" and "white." Participants reported a gram of powdered cocaine currently sells for \$40 – \$100; 1/16 ounce, or "teener," sells for \$75 – \$120; 1/8 ounce, or "eight ball," sells for \$150 – \$180; 1/4 ounce sells for \$225 – \$240; an ounce sells for around \$800. While there were a few reported ways of consuming powdered cocaine, the most common route of administration for this form of cocaine is intranasal inhalation (i.e., snorting). Some users reported "cooking" and then smoking cocaine while a few cited taking the drug intravenously. A participant who reported snorting powdered cocaine described injecting as a common method: "People put it [cocaine] on a spoon, fill it up with water, and then inject it." Treatment professionals reported that powdered cocaine is being used more intravenously today than in the past, especially among heroin users.

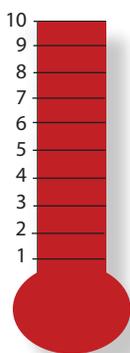
Typical users of powdered cocaine are described as different from those who generally use crack cocaine. A participant stated, "Crackheads and powdered users are completely different. In my experience, I would say crack cocaine users are people on welfare. Powdered cocaine users tended to have more money." Several participants reported that powdered cocaine use is thought to be a part of the bar scene: "A lot of people

*just associate it [powdered cocaine use] with social activity like going to the bar; People who drink like to do powder [cocaine].” A treatment provider stated, “It [powdered cocaine use] varies across the board ... probably more around the 30 age group, but we see it at all different ages.” Law enforcement described a typical user as a 20 to 35-year-old, White, middle-class suburbanite. In addition to alcohol, powdered cocaine is also reportedly used in combination with benzodiazepines (i.e., Xanax®), heroin, marijuana, prescription opioids (i.e., OxyContin®) and tobacco.*

### Crack Cocaine Current Trends

Crack 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’ (high availability, extremely easy to get). Participants described crack cocaine as extremely easy to get. A user said, *“It [crack cocaine] is everywhere in Mahoning, Trumbull and Ashtabula Counties ... especially in this area ... it is a half block from here [treatment center/site of interview]. It’s on every street. There is a crack house on every street if not more than one.”* Law enforcement also rated the current availability of crack cocaine as high. Participants and treatment professionals agreed that the availability of crack cocaine has not changed over the course of the last six months. A treatment professional stated, *“It seemed like when it [crack cocaine] came, it never left. It just stayed available everywhere in this area.”* However, law enforcement noted a slight decrease, hypothesizing that harsher sentencing laws for crack cocaine versus powdered cocaine has perhaps led to a slight decrease in the availability of crack cocaine. An officer stated, *“Some folks buy powder [cocaine] and produce their own crack. Also, now so many guys who were selling crack are switching to heroin in part because of current sentencing laws.”*

Participant quality scores of crack cocaine varied from ‘2’ to ‘7’ with the most common scores being ‘3’ or ‘4’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants noted that the quality of crack cocaine, like that of powdered cocaine, is dependent on who is selling it. A participant explained, *“It [the quality of crack cocaine] really depends upon who has it. There is anything from a ‘3’ [quality rating] around here to a ‘10’ ... depends on the batch—has always been*



*that way.”* Participants reported that crack cocaine is most often “cut” (i.e., diluted) with other substances. A participant reported, *“[Crack cocaine is] cut with anything ... rat poisoning, Easy Off®, ah, you name it—they [drug dealers] are putting anything in it.”* Participants cited the following substances as commonly used to cut crack cocaine: Ambesol®, baby laxative, baking soda and 7-Up® to “blow it [crack cocaine] up” (i.e., to give crack cocaine more volume and mass). BCI&I Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine (e.g., NoDoz®).

Current street jargon includes many names for crack cocaine. The most commonly cited names were “hard” and “work.” Participants listed the following as other common street names: “butter,” “cavy” (i.e., caviar), “crack,” “fire,” “girl,” “rock” and “white girl.” Participants reported a gram of crack cocaine currently sells for \$50 – \$100; 1/16 ounce, or “teener,” sells for \$75 – \$100; 1/8 ounce, or “eight ball,” sells for \$120 – \$175; 1/4 ounce sells for \$250 – \$280; an ounce sells for \$800 – \$1,000. The majority of crack cocaine users reported buying the drug in small quantities called “dimes” (i.e., 1/10 gram) for \$10, and agreed that the price of crack cocaine has gone up over the course of the last six months. A participant stated, *“I know that within the past probably year, cocaine has gone up [in price] twice what it was. Before, um, for \$10 you could get a dime and it was .2 [of a gram], now it is .1. You could get .4 for \$20, now you get .2.”*

While there were a few reported ways of consuming crack cocaine, the most common route of administration by far is smoking. A participant stated, *“I’ve smoked pipe; I’ve smoked woolies [crack cocaine with marijuana], um, anyway that I could smoke it [crack].”* Other methods described were intranasal inhalation (i.e., snorting) and intravenous injection. A participant said she would inject or smoke crack cocaine; it just depended on whatever she felt like or whether she had access to a pipe. Less common than smoking and injecting, snorting was also indicated as a method used in the region. When asked to give a percent breakdown of common routes of administration for crack cocaine, participants of one focus group determined that approximately 85 percent of crack cocaine users smoke the drug and 15 percent inject it. Like powdered cocaine, treatment professionals noted that intravenous use of crack cocaine appears to be increasing, again especially among heroin users.

A profile of a typical user of crack cocaine did not emerge in the data. Participants and treatment professionals alike stated

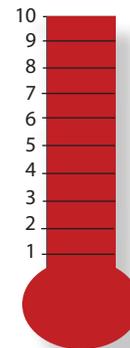
that crack cocaine is far reaching into every socioeconomic class. Participants reported the following: *"I've seen people from 15 to 70 and 80's smoke it [crack cocaine], and it doesn't matter what color [race]; I know attorneys in this area who use it, and I know lowlifes who use it; I believe everybody uses it."* Treatment professionals offered the following: *"It varies, we have all different ages come in from crack cocaine; Lately, we've had people over the age of 35 who are using crack cocaine, and they come from mostly lower middle class socioeconomic background. Some of them used to have good jobs that don't anymore ... jobs making at least \$28,000 to \$48,000 a year."* Treatment professionals noted an increase in older adults (those > 35 years), particularly women, and an increase in "alcoholics" coming to them for treatment for crack cocaine addiction. A law enforcement respondent noted, *"Crack [cocaine] is a big deal with older Caucasian and African-American women."*

In addition to alcohol, crack cocaine reportedly is used in combination with benzodiazepines (i.e., Xanax®), heroin (a.k.a., "speedball" when "shot" together; some reported shooting heroin and then following with a "hit" of/smoking crack cocaine), marijuana (a.k.a., "woolie" when smoked together, or "chocolate chip" when "rocked up" together), prescription opioids (i.e., OxyContin®) and tobacco (a.k.a., "primo" when smoked together). Using crack cocaine with all of the aforementioned is reportedly very common. Many participants explained that the use of alcohol, benzodiazepines and marijuana is necessary in order to "come down" from a crack cocaine high.

### Heroin Current Trends

Heroin is highly available in the region. Participants and treatment providers most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Law enforcement rated current availability as "better than ten." Area media quoted an officer from a local narcotics unit as stating, *"Heroin seems to be the number one drug of the time"* ([www.vindy.com](http://www.vindy.com); July 19, 2010). Participants also named heroin as currently the most available drug in the region. There was agreement in one focus group that Youngstown is experiencing a "heroin epidemic." A focus group participant stated, *"You can get it [heroin], wherever, whenever."* A treatment professional stated, *"The race is over and heroin won."* BCI&I Richfield crime lab reported an increase in the number of heroin cases it processes.

While many types of heroin were named as currently available for street purchase, the consensus among all participants was that brown powdered heroin is the most common form of heroin found. Participants reported, *"I think in Youngstown, you're most likely gonna get brown heroin. You're not gonna come across white or black tar [heroin] very often ... nine times out of 10 it's going to be brown; Brown powder [heroin] is most available and white powder is around more than tar."* Law enforcement reported, *"We primarily get a brown or grayish powder [heroin] when we buy [undercover]."* There was contradictory testimony as to the current availability of black tar heroin. Participants reported, *"I have never seen tar here; Tar is only available on the east side of Youngstown in the Hispanic district ... they're keeping it for themselves; Tar is still around—friends are using it."* A treatment professional stated that black tar heroin is making a "big comeback." All participants indicated that heroin's availability either has remained unchanged or has increased over the course of the last six months. Participants said, *"Everyone is getting away from oxy's [OxyContin®] and roxi's [Roxicet®] because heroin is so cheap; There's so many heroin addicts in Youngstown that a lot of dealers are switching over from selling whatever they were selling to just selling heroin."* Several participants noted that heroin use has especially increased among younger people. A participant stated, *"In younger kids and stuff, it's definitely increased. I've seen kids in meetings [12-step meetings] as young as 16—that's pretty bad."*



Participant quality scores of heroin varied from '2' to '10' with the most common score being '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants noted that the quality of heroin, like that of cocaine, is dependent on who is selling it. A participant explained, *"It [the quality of heroin] depends on what you cut it with. I've had from zero to ten."* Participants reported that heroin is often "cut" (i.e., diluted) with prescription drugs: *"They [drug dealers] cut it [heroin] with good, other drugs. You know they cut it with fentanyl or morphine. You know so even if the heroin wasn't at its greatest, you still had something else kicking your ass."* Participants also cited the following substances as commonly used to "cut" heroin: baby laxative, isotope powder, sleeping pills, soy baby formula and vitamin E. BCI&I Richfield crime lab reported that heroin was "very pure," and occasionally cut with diltiazem (medication used to treat heart conditions/high blood pressure).

Current street jargon includes many names for heroin. The most commonly cited names were “boy” and “dog food.” Participants listed the following as other common street names: “bag,” “dope,” “H,” “he,” “low ride,” “puppy chow,” “ron” and “white china.” Participants reported a gram of heroin currently sells for \$75 – \$200 depending on quality, 1/2 gram sells for \$50 – \$100; 1/4 ounce sells for \$500; 1/2 ounce sells for \$900; an ounce sells for \$1,800. Many participants reported buying “baggies/stamps” for \$10 to \$20 each, with a participant reporting buying three for \$50; a few participants reported buying \$20 “folds” (i.e., corners of a piece of paper made into a little envelopes to keep heroin from sticking to the baggie in which it is packaged). Law enforcement report that most street level users buy 1/20 gram of heroin for \$20 while noting that there has been “an overall increase in price because demand is going up.” While there were a few reported ways of consuming heroin, the most common route of administration is intravenous injection (i.e., shooting), followed by snorting and smoking. Many participants explained that when they first started to use heroin, they snorted: “I started snorting it [heroin], then within two to three months, I went to shooting; When others around me started to shoot, I saw how much more intense their high was; I believe that it [heroin] is like any other drug in the progression of it. After you do it for a while, it doesn't do what you want, so you resort to injecting it.”

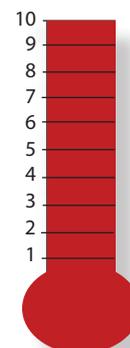
Participants described typical users of heroin as younger (i.e., “teens” and those in their early 20’s) and “mostly White.” The following statement was echoed by many participants, “I think you’re getting a lot of White teens and early 20’s from middle class families who have education starting to do it [use heroin], who are possibly starting out with Vicodin® and OxyContin®, and then moving on to heroin because it is cheaper ... I don’t know a lot of Black people or Hispanic people around here who use it.” Treatment professionals and participants alike noted an increase in younger people, with 13 being the youngest reported age among known heroin users. A law enforcement officer provided the following: “Our [drug] court is now 75 percent suburban heroin addicts, who typically started with pharmaceuticals [prescription opioids], but because of the cost of those went to heroin; it’s cheaper and it’s more available to them. So our clientele is primarily about 18 to about 28 years old, and they’re shooting up [injecting] heroin.” Another officer stated, “All of the ‘crackheads’ are becoming ‘heroinheads’ ... Also, increase in heroin use because of what they [Purdue Pharma] have done with OxyContin® [reformulation of]. Old ones [OxyContin®] are sky high [in price].”

Reportedly, heroin is used in combination with alcohol, benzodiazepines (i.e., Valium® and Xanax®), cocaine (a.k.a., “speedball” when “shot” together), marijuana (a.k.a., “woolie” when smoked together) and prescription opioids (i.e., OxyContin®; used “to make the high better”). Using heroin with all of the aforementioned is reportedly very common. Also, reportedly very common is heroin overdose. Several participants noted known overdoses with the combination of heroin and benzodiazepines. A participant stated, “A lot of people mix Valium® and Xanax® [with heroin]—a lot of benzo’s [benzodiazepines]—either snort, or a lot of people will shoot [inject] Xanax®. Very common and a lot of people are dying ... very easy to overdose.” A treatment provider stated, “There’s a lot of overdoses of young ones doing heroin, a lot of them. It’s either somebody died in their arms, or their boyfriend died, or they OD [overdose] and die.”

## Prescription Opioids

### Current Trends

Prescription opioids are highly available in the region. Participants and treatment providers most often reported the current street availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Law enforcement most often rated current availability as ‘8’ or ‘9.’ BCI&I Richfield crime lab reported an increase in the number of prescription opioid cases it processes. Participants described some prescription opioids as more readily available than others. They reported, “Vicodin® is available everywhere; Opana® is a real popular one, but hard to find. I’d say a ‘4’ [availability rating]; You cannot find any original oxy [OxyContin®] anymore, around a ‘3.’” Community professionals identified OxyContin®, Percocet® and Vicodin® as the three most popular prescription opioids in terms of widespread use. The consensus of one focus group was that prescription opioids are “harder to get” than six months ago—most others agreed while participants in one focus group reported a general increase in availability. Those who reported a decrease in availability attributed the decrease to the following: “I think people are getting addicted and not selling. They’re keeping them [prescription opioids] for themselves; ‘Oxy’ [OxyContin®] has gone down with the new gel pills that they have come out with; There’s more awareness that these pills [prescription opioids] are ‘legal heroin,’ so there’s more



*crack down.* Several participants noted the reformulation of OxyContin® as the reason for its decreased street presence in the region. Now when the protective coating of OxyContin® is removed, or when the OxyContin® pill is crushed, the pill breaks down into a gel and not a powder, making snorting or injecting the drug more difficult. A participant stated, *“People do not want to touch them [the “new” reformulated OxyContin®].”* Thus, the original OxyContin® has become scarce—more difficult and more expensive to obtain.

Reportedly, many different types of prescription opioids (a.k.a., “beans,” “candy” and “skittles”) are currently sold on the region’s streets. Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Darvocet®, Darvon®, Demerol®, Dilaudid®, fentanyl (\$15 – \$80 for patches, depending on dosage; \$20 – \$50 for Actiq® lollipops, depending on dosage), Kadian®, Lortab® (\$5 – \$7 per pill), methadone 10 mg (a.k.a., “done’s” and “happy pill;” \$5 – \$7), morphine, Opana® 30 mg (\$20), Opana® 40 mg (\$35 – \$50), Opana® 50 mg (\$60), OxyContin® (a.k.a., “OC’s,” “Old Cars,” “Orange County” and “oxy’s;” *old* formulation sells for \$1 – \$2 per mg), OxyContin® 40 mg (a.k.a., “little boys” and “oranges;” *new* formulation sells for \$25 – \$30), OxyContin® 60 mg (a.k.a., “big reds” and “mediums;” *new* formulation sells for \$35), OxyContin® 80 mg (a.k.a., “80’s,” “beans;” “big boys,” “big’s” and “green apples;” *new* formulation sells for \$50), OxyContin® 160 mg (a.k.a., “killers”); Percocet® 5 mg (a.k.a., “perc’s;” \$3 – \$5), Percocet® 10 mg (a.k.a., “school buses;” \$5 – \$10), Percodan®, Roxicet® (a.k.a., “IR’s” for instant release, “madden” and “roxi’s”), Roxicet® 15 mg (a.k.a., “green clover” and “greens;” \$5 – \$15), Roxicet® 30 mg (a.k.a., “blues;” \$15 – \$25), Subutex®, Tramadol® (\$.50 – \$1 per pill), Tylenol 3/4®, Ultram® (a.k.a., “trams;” \$.50 – \$1 per pill) and Vicodin® (a.k.a., “vikes”), Vicodin® 500 mg (a.k.a., “baby vikes;” \$2 – \$3), Vicodin ES® 750 mg (\$4 – \$5), and Vicodin HP® 1,000 mg (\$5 – \$6).

In addition to obtaining prescription opioids on the street from dealers, participants also reported getting prescription opioids from friends, roommates, family members—others with prescriptions, buying “scripts” (i.e., prescriptions) or trading other drugs for opioids, as well as, from area doctors and pain management clinics. Participants reported the following: *“A few doctors in Warren prescribe. You know who they are because there is a line outside their door to the corner at 5 a.m.; It’s really not hard to get [prescription opioids] from a doctor. Doctors do not have much training in alcohol and*

*drug abuse, and before you know it, you are given a gang of pills.”* A treatment professional stated, *“It just is amazing to me that there are so many doctors that are prescribing as many ... for a month 120 to 150 Vicodin® for a person, month after month.”* Another professional reported the following: *“A lot of them [drug users] are getting them [prescription opioids] from the medicine cabinet of their grandma or grandpa who is sick. They’ll act like they are going to visit ... and they’re stealing their medication—their pain medication ... they’re willing to do anything to get a hold of an opiate.”* All treatment professionals of one focus group agreed with the following assessment of clients addicted to prescription opioids given by a colleague: *“These users appear to be worse off and need to be detox’ed [go through detoxification] from multiple drugs, and [they] need multiple cures.”*

While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the most common routes of administration are oral consumption and intranasal inhalation, with a few reports of intravenous injection. Many participants explained that when they first started to use prescription opioids, they took them by mouth and swallowed them before progressing to snorting, and in some cases, “shooting” the drugs. Participants explained how they used prescription opioids as follows: *“By mouth orally, after a while I would snort some [prescription opioids]. I would also shoot [inject]; Oxy’s and roxi’s I have shot; Oxy’s I always snorted; Most people that abuse it [fentanyl], um, cut the patch and suck the gel stuff out. They suck on the patch basically ... I can very rarely say I’ve seen people wear the patch that have had it.”*

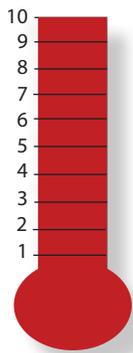
A profile of a typical illicit user of prescription opioids did not emerge in the data. Participants and treatment professionals alike stated that illicit use of prescription opioids in their communities is a far-reaching problem. Area media quoted an officer from a local narcotics unit as making the following statement related to the abuse of prescription opioids, *“Prescription drugs, painkillers, is a problem for all ages”* ([www.vindy.com](http://www.vindy.com); July 19, 2010). Participants reported the following: *“Vikes and perc’s a lot of young kids take them, but really there is not a range [age range]. Everyone is taking them [prescription opioids]—easy to get; People in early 20’s—all ages really; People in the 60’s usually take a couple and sell the rest.”* Treatment professionals noted that current illicit use appears more prevalent among suburban, middle class, White people and less prevalent among urban, poor

people; however, a provider noted an increase in abuse among African-Americans. A professional said that many of his clients were *“factory workers or in the tool and dye trade who got injured on the job, and then got addicted to opiates, 22-42 years old.”* Another treatment professional noted high use of Ultram® and Tramadol® among *“inner-city kids”*: *“For the inner-city kids, and I call it my ‘urban heroin,’ it’s the use of Ultram® and Tramadol®. We see a lot of that with that clientele ... people taking 20 or 30 of those a day ... that’s one I’m very concerned about because it is sold as a non-narcotic.”* Another professional stated that Ultram® is believed to be viewed by doctors as non-narcotic and that it is preferred by users because, *“You can test negative for opiates with Ultram®; You have to test specifically for Ultram®.”* Treatment professionals also reported that illicit consumers of prescription opioids are making new friends from across the state and using with these friends, traveling and staying together.

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol and marijuana. Participants also reported using prescription opioids with benzodiazepines (i.e., Xanax®), crack cocaine, heroin and powdered cocaine.

## Suboxone®

### Current Trends



Suboxone® is highly available in the region. Participants most often reported the street availability of Suboxone® as ‘10’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants agreed that Suboxone® was *“easy to get.”* Law enforcement stated that Suboxone® is *“rampantly available on the street.”* While a few participants reported being either currently or previously prescribed Suboxone® by a physician in their community, through a treatment center, or while incarcerated, most

frequently, participants reported obtaining Suboxone® on the street from other users or from drug dealers. Participants stated the following: *“I think what happens is you have somebody who, you know, really wants to get help, and they go to the doctor and get the prescription [for Suboxone®]. Then they end up selling some of their pills, perhaps at a weak moment when they want to use heroin or whatever; I’m prescribed them, but I have people who ask all the time about them and if I know*

*anybody who wants them.”* Reports of drug dealers acquiring and then selling Suboxone® were common. A participant reported, *“I had my drug dealers asking me at one point in time where to get them [Suboxone®]. They’d run out of dope, and they be like, well, I gotta give my customers something.”* BCI&I Richfield crime lab reported an increase in the number of Suboxone® cases it processes.

No slang terms or common street names were reported for Suboxone®. Participants reported Suboxone® 8 mg sells for \$5 – \$30, with the most frequently reported price being \$10 – \$20. There was consensus among participants that Suboxone® pricing is dependent on who is selling and who is buying. Participants stated the following: *“It [price of Suboxone®] depends on how bad person selling needs heroin. Person selling usually wants heroin; From my experience, it also depends on how bad somebody wants them to what the price will be.”* A participant reported Suboxone® being sold in treatment facilities for \$20. Another participant stated that Suboxone® was cheaper to buy on the street than through a pharmacy: *“I’m in the Suboxone® program. I have to pay for my prescriptions, and I could actually tell you that it is cheaper to buy Suboxone® on the streets than to buy in the pharmacy.”*

Participants and treatment professionals alike reported that Suboxone® is most often used illicitly by those addicted to heroin who trade Suboxone® to dealers for heroin, although treatment professionals noted that other users are now using Suboxone® to get high. They reported that users are teaching other users how to use Suboxone® intravenously. A treatment provider stated, *“They [clients] know we don’t test for that [Suboxone®] on a [drug] screen, so I think that they are using that [Suboxone®] even more than we know.”* A professional who works in an area homeless shelter reported, *“A young lady who stayed here ... she did admit to me that she does get high off Suboxone®.”* A law enforcement officer stated, *“Anecdotally, people have said unequivocally that if they have not used heroin or an opiate for a long time and they use Suboxone®, they do get high.”* A participant stated, *“I always got high from them [Suboxone®]. You can get addicted to Suboxone® like any other drug.”* While different types of participants are starting to abuse Suboxone®, the consensus among the vast majority of participants was that those addicted to opioids mostly seek the drug to avoid withdrawal between highs. Treatment providers stated the following: *“For those who were hardcore addicts, you know, Suboxone® was cornflakes. It’s a standby, the bridge over troubled waters until they can get in touch with their guy [drug dealer]; They keep some [Suboxone®] on hand so*

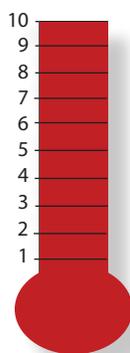
they don't get sick." A participant stated, "Most people use them [Suboxone®] when they don't have money and to not get sick or when there's a drought [period of time when drug availability is low]." Law enforcement stated that the same populations that use heroin and prescription opioids are also using/abusing Suboxone®.

Most often Participants reported taking Suboxone® sublingually. However, there were reports of snorting Suboxone®, and participant and professional respondents alike report that intravenous use of the drug is becoming more commonplace. Generally, no other substances are reportedly used in combination with Suboxone®. A participant stated, "I don't know of any other [substance used with Suboxone®] as you get violently sick if you do [use Suboxone® in combination with other substances]." Other participants stated that it is not worth it to take other drugs while on Suboxone® because the other drugs would not produce the desired effect. A treatment professional explained, "We're not finding Suboxone® is being used with other drugs, as much as it is a bridge until they [drug users] can get their opiates." There were reports of Suboxone® being used with alcohol, benzodiazepines (i.e., Xanax®), crack cocaine, marijuana ("for the bigger weed high") and powdered cocaine.

**Sedative-Hypnotics**

**Current Trends**

Sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) are highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described some sedative-hypnotics as more readily available than others. A participant reported, "I see a lot more Xanax®, Ativan® and Klonopin®. I do not see a lot of Valium®." Treatment professionals list the most common sedative-hypnotics in terms of widespread use as Xanax®, Ativan®, Klonopin® and Valium®. The consensus of participants and treatment professionals alike was that sedative-hypnotics have become more available over the past six months. Several users agreed with the following



statement, "I personally think with them [Purdue Pharma] changing all of the OxyContin®, people are getting more into the benzo's [benzodiazepines] for that, you know, that down kind of high." BCI&I Richfield crime lab reported that the number of sedative-hypnotics cases it processes has remained stable.

Reportedly, many different types of sedative-hypnotics are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ambien® (\$5 for an entire prescription), Ativan®, Klonopin®, Lunesta®, Nembutal®, Restoril®, Soma® (\$1 - \$2), Valium® 10 mg (\$1 - \$2), Xanax® .25 mg (a.k.a., "totem poles" and "xanibars;" \$.25 - \$.50), Xanax® .5 mg (\$.75 - \$1), Xanax® 1 mg (\$1) and Xanax® 2 mg (\$2 - \$5).

In addition to obtaining sedative-hypnotics on the street from dealers, participants reported visiting area doctors in order to obtain prescriptions for these drugs. Treatment professionals talked about the emerging problem of young people being prescribed sedative-hypnotics: "A lot of the younger ones have it [sedative-hypnotics] prescribed, and that's a new thing too ... and a lot of them will say, 'my doctor gave it to me, my family doctor,' and they're not even seeing a psychiatrist or anything, that's a big thing; Doctors are over prescribing ... giving them [clients] so many, so many [sedative-hypnotics] a day to take." A participant stated that Soma® is believed to be viewed by doctors as non-narcotic: "I believe doctors prescribe Soma's® because they believe that they are non-addictive, but they are very addictive." A treatment professional reported that Soma® is popular among the agency's clients, stating, "Soma's® are big here because we can't test for them." Many participants reported also getting sedative-hypnotics from friends and family members, or trading other drugs for them. A participant said, "Folks sell their scripts [prescriptions] to get what they prefer." Treatment providers were very concerned about the attitude users have toward sedative-hypnotics: "Users don't believe it's addictive [sedative-hypnotics] ... what I'm seeing more of is this connotation that it's just like going into your Aunt Martha's cupboard and taking a Tylenol® ... that's how nonchalant they talk about it." Another provider also expressed frustration with user's behavior: "A lot of them [are] what I like to call bathroom-medicine cabinet cowboys; they'll go in and take a handful of pills, and they don't even know what the hell they are."

While there were a few reported ways of consuming sedative-hypnotics, the most common routes of

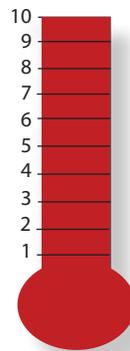
administration are oral consumption and intranasal inhalation (i.e., snorting). Many participants explained that when they first started to use sedative-hypnotics, they took them by mouth and swallowed them before progressing to snorting.

A profile of a typical illicit user of sedative-hypnotics did not emerge in the data. Treatment professionals believe that illicit use of these drugs in their communities is a far-reaching problem that affects all age groups. A few treatment professionals talked about specific groups with whom they have worked when treating addiction to sedative-hypnotics. A professional reported often treating clients with *"fibromyalgia and arthritis getting prescribed pain medications or anxiety medications."*

Reportedly, sedative-hypnotics are used in combination with alcohol, heroin, marijuana and prescription opioids (i.e., OxyContin®). Many participants reported using sedative-hypnotics to "come down" from other drugs. Several participants nodded their heads when one person commented, *"I use them [sedative-hypnotics] to come down from crack [cocaine] when I didn't have heroin or when I ran out of money."* Another participant said he used Xanax® *"to come down from coke [powdered cocaine] or crack [cocaine]."*

### Marijuana Current Trends

Marijuana 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' (high availability, extremely easy to get). Participants and treatment providers described marijuana as being extremely easy to get. A participant commented that marijuana was *"the most available illegal drug,"* and others compared it to the availability of heroin: *"It's neck and neck with heroin as most available."* BCI&I Richfield crime lab reported that the number of marijuana cases it processes has remained stable, and noted that marijuana cases make up the greatest proportion of drug cases it reviews. Participants said the availability has not changed over the past six months while treatment providers believed some types of marijuana are more readily available. A treatment provider reported, *"Hydro [hydroponically grown marijuana] has increased because of the advertisement of phototrons*



*[automated indoor growing systems] in High Times magazine and on the Internet. People are also building home grow units."* Law enforcement reported that the current high availability of marijuana in the region is not new; however, *"New in our area in terms of distribution ... people, more and more are sending marijuana in the mail. We've seized about 200 to 300 pounds in the past month through common carriers such as FedEx, UPS and U.S. mail. At \$500 to \$600 a pound if you send three [one-pound packages], you double your money if only one gets through; I just saw some [marijuana] this morning at FedEx."* Area media reported that police intercepted a package containing marijuana mailed to an area dealer who sold marijuana near Youngstown State University ([www.vindy.com](http://www.vindy.com); Sept. 8, 2010). Law enforcement also reported, *"A lot more people are growing their own [marijuana]. This is increasing. We did 10 to 15 home grown operations this past year in the city [Youngstown]. We seized a ton of marijuana grown out in the farmland of Mahoning County this year. This was the best year [for marijuana seizure] from among the last four [years]."*

Participants reported that the quality of marijuana varied with the most common quality score being '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Several participants explained that the quality of marijuana depends on whether the user buys "commercial weed" (i.e., low to mid-grade marijuana) or hydroponically grown (i.e., high-grade marijuana). Participants thought commercial marijuana looked like *"dried up leaves, like parsley"* or *"compressed buds with a lot of seeds"* while high quality marijuana had *"fluffier buds and less seeds;"* hydroponically grown marijuana was said to have *"few seeds and smells like a skunk."*

Current street jargon includes countless names for marijuana. The most commonly cited name was "weed." Participants listed the following as other common street names: "dirt" and "Youngstown brown" for low to mid-grade marijuana; "kush," "Hawaiian gold" and "purple haze" for high-grade marijuana; and "hydro" or "skunkweed" for hydroponically grown marijuana. Commercial marijuana is the most widely sold form of the drug. A participant stated, *"Commercial weed [marijuana] comes in by the half ton, and it's [sold on the street] anywhere from ounces ... to a nickel bag which is about a gram."* The price of marijuana depends on the quality desired. Participants reported they could buy commercial-grade marijuana in many different quantities: a "blunt" (i.e., marijuana cigar) sells for \$5 – \$10; a gram currently sells for \$5; 1/8 ounce sells for \$15 – \$30; 1/4 ounce sells for \$25 –

\$30; 1/2 ounce sells for \$40; an ounce sells for \$75 – \$120; 1/4 pound sells for \$300; 1/2 pound sells for \$600; and a pound sells for \$1,100. Participants also reported they could buy high-grade marijuana in many different quantities, a “blunt” (i.e., marijuana cigar) sells for \$20; a gram currently sells for \$20; 1/8 ounce sells for \$40 – \$75; an ounce sells for \$180 – \$400; 1/4 pound sells for \$800 – \$900; and a pound sells for \$2,000 – \$4,000. While there were a few reported ways of consuming marijuana, the most common route of administration is smoking. Some users reported eating marijuana in food or putting it in tea, and a few cited vaporizing marijuana.

When asked to describe the typical user of marijuana, participants were unable to be specific. Treatment providers summed up the attitude shared by other professionals and participants alike, “Everyone uses it [marijuana], no matter the gender or race.” While the prevailing thought is that marijuana is widely used, a couple of treatment providers noted an increase in use among young males, particularly African-American: “Recently, a lot of younger people, young males between 18 and 25 ... pretty much smoking [marijuana] daily and not believing it is a problem: ‘it’s just marijuana, it’s no big deal’; More of my African-American clients are using marijuana than my White clients, mostly young males 18 to 25.”

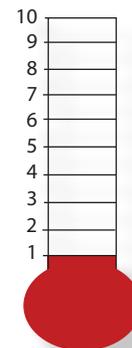
Marijuana is reportedly used in combination with alcohol, crack cocaine (a.k.a., “woolie” or “primo” when laced into a “blunt”), ecstasy, heroin (a.k.a., “woolie” or “primo” when laced into a “blunt”), LSD (lysergic acid diethylamide), prescription opioids and salvia. Many people agreed with a user’s statement about mixing prescription opioids with marijuana: “A lot of people that I know would take Vicodin® and Percocets® and smoke weed [marijuana].” Users also reported dipping marijuana blunts in embalming fluid (a.k.a., “wet”) or PCP (phencyclidine); and a participant reported spraying blunts with Febreze® air fresheners. Several participants also reported that marijuana blunts were rolled with Tussionex Pennkinetic® (a narcotic liquid cold remedy), and that this trend was common among those 20 to 40 years in age.

### **Methamphetamine** **Current Trends**

Methamphetamine is relatively rare in the region. Most participants knew little about the drug. Participants most often reported the drug’s current availability as ‘1’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high

availability, extremely easy to get). Law enforcement rated current availability as “1 or 2.” An area probation officer reported, “It [methamphetamine] exists, but I think with the change in the law regarding ephedrine products, that’s significantly changed the ability to make it.” A professional respondent with an area homeless shelter reported that four methamphetamine users have come through for services and that methamphetamine is reportedly available in Columbiana County. This professional stated, “If you want it [methamphetamine], you can get it.” When asked whether the powdered form or the crystal form was more available, participants said that both forms are equally unavailable. Treatment professionals agreed there is little availability in the region except for one area; availability was reported as ‘10’ in Ashtabula County where methamphetamine was said to be popular. A group of providers reported that four “cookers” (i.e., methamphetamine manufacturers) came through their treatment center recently. Participants said the availability of methamphetamine has changed little in the last six months, and they thought that the availability of the drug came in waves. BCI&I Richfield crime lab reported an increase in both powdered and crystal methamphetamine cases it processes.

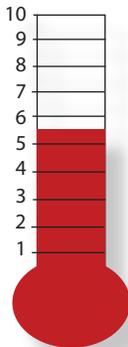
Participants reported that the quality of methamphetamine is high in the area, but did not assign a numerical score to their answers. One user commented that the drug is “pretty good” and another said, “Sometimes it [methamphetamine] was brown or white crystal looking. It always changed.” Current street jargon includes very few names for methamphetamine. The most commonly cited name was “glass” for crystal methamphetamine, but terms like “crystal” and “ice” were also popular. Participants reported they could buy a gram of powdered methamphetamine for \$50 and a gram of crystal methamphetamine for \$150. Methamphetamine powder is also sold in straws; \$50 for a small straw and \$100 for a large straw. The most common routes of administration for this drug include smoking and injecting, although heating methamphetamine and inhaling the vapor (a.k.a., “hot railing”) was mentioned by one participant. Treatment professionals described typical users of this drug as 18 to 38-year-old Whites.



## Ecstasy

### Current Trends

Ecstasy [methylenedioxymethamphetamine (MDMA)] is moderately available in the region. Participants most often reported the drug's current availability as "5.5" on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The availability of the drug is thought to vary depending on the season; ecstasy is considered a "summertime drug," and thus not as available now as at other times of the year. On the other hand, treatment providers reported ecstasy as being more available, most frequently reporting the drug's current availability as '7'. Oftentimes, treatment providers reported the availability as increasing, citing more people are learning how to make homemade ecstasy. BCI&I Richfield crime lab reported an increase in the number of ecstasy cases it processes.



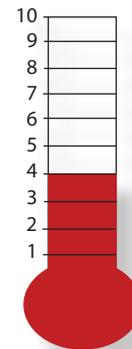
Current street jargon includes several different names for ecstasy. The most commonly cited name was "skittles." Participants listed the following as other common street names: "Chanel," "roller skates" and "shamrocks." Participants reported that a "single stack" (i.e., low dose) ecstasy tablet sells for \$8 – \$10 and a "double stack" or "triple stack" (i.e., high dose) sells for \$16 – \$30. Participants reported that the price of a pill depends on a variety of factors: "A lot of pills have different shapes and designs and that's how they price them and say what they are." The quality of ecstasy varies, with some users reporting moderate quality and others reporting low quality. As a drug user stated, "Ecstasy is a hard drug to speak on because no one pill is never the same ... you sometimes feel low, sometimes you feel high, sometimes you're sexually active, sometimes you're like slow-fast, hot-cold. There's never the same feeling." The only reported method of administration is oral consumption.

## Prescription Stimulants

### Current Trends

Adderall® and Ritalin® are somewhat available in the region. Participants most often reported the drug's current availability as '4' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Several treatment providers noted that some of their clients

are legitimately prescribed a prescription stimulant while also stating that these drugs are the drug of choice for some participants. A participant said, "[Other users] say it's like cocaine to them. To where it calms kids down, it speeds adults up. They say it's almost like a cocaine high." Participants believe that prescription stimulants are popular among all age groups, while treatment providers believe they tend to be more popular with younger (< 26), White males and females.

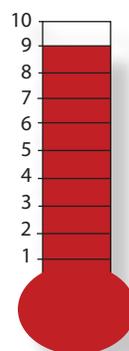


No slang terms or common street names were reported for prescription stimulants. The following prescription opioids are available to the street-level users: Adderall® 15 mg (\$2); Adderall® 20 mg (\$2 – \$4); and Adderall® 30 mg (\$5 – \$6). Aside from getting prescription stimulants from the streets, participants also reported getting them from friends and physicians. A participant reported, "I got it [Adderall®] from a friend who has four kids who gets scripts [prescriptions] for all her kids, so real easy. People would sell their kids' scripts. One friend would sell her kid's script to buy crack [cocaine]." The most common reported method of administration is crushing and snorting the medicines, although a person reported injection of prescription stimulants.

## Prescription and OTC Cough Medicines

### Current Trends

Prescription and over-the-counter (OTC) cough medicines are highly available in the region. Participants most often reported the drug's current availability as '9' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants and treatment professionals alike agreed the availability has remained about the same over the last six months due to the legal ways users can obtain these drugs. Mahoning County law enforcement reported that the trend to abuse cough medicines as increasing: "The biggest [new trend] we're seeing ... is cough medicine. We're getting a lot of reports from the southeastern part of the county ... where [users] were taking 10 at a time." Participant and professional interviewees believe that illicit use of cough medicine is most popular among younger people (< 18) who do not have access to other substances. Prescription cough

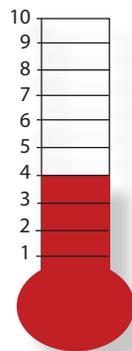


medicines that contain codeine and promethazine and OTC cough medicines containing dextromethorphan (DXM), like Coricidin Cough and Cold® (a.k.a., “triple c’s”), Nyquil® and Robitussin® are the most sought after substances to abuse. Participants reported that cough medicines containing DXM are well liked because they cause users to hallucinate. The most often reported route of administration is oral consumption, but several participants also reported dipping tobacco cigarettes and marijuana “blunts” in cough medicine before smoking.

### Hallucinogens

#### Current Trends

Hallucinogens do not appear particularly popular in the region. Lysergic acid diethylamide (LSD) was mentioned by a few participants while others reported not having seen it in awhile. Participants most often reported the drug’s current availability as ‘4’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). BCI&I Richfield crime lab reported an increase in the number of LSD and psilocybin mushrooms cases it processes. Participants reported that the availability of LSD fluctuated with the seasons and that it is more of a “summertime drug.” LSD is available in multiple forms to street-level users including paper blots (\$5 – \$10 per hit), sugar cubes and gel tabs (\$5 – \$10 per tab). A minority of participants also used psilocybin mushrooms and said they are available in a limited number of areas. Reportedly, 1/8 ounce of psilocybin mushrooms sell for \$35 – \$40. The most commonly reported method of administration is oral consumption, eating or mixing psilocybin mushrooms with tea.



### Other Drugs

Participants and professionals listed a variety of other drugs as being present in the area, but these drugs were not mentioned by the majority of people interviewed. Reportedly, synthetic marijuana (e.g., “K2” and “Spice”) is being used by a few participants for recreational use and as a stand-in for marijuana when participants need to pass a drug test. Mahoning County law enforcement expressed frustration with synthetic marijuana: “There’s K2, Spice, those kind of things ... the availability of that is everywhere.

*They can get it in stores; It’s in front of the law, just like salvia was. It [synthetic marijuana] got in front of the law and the law has to catch up.”* Reportedly, energy drinks with alcohol are used in combination with other drugs to modify the high experienced by users. Inhalants were mentioned as being popular with younger people (< 18), but none of the participants interviewed reported using them. Gamma-hydroxybutyric acid (GHB) is reportedly used by a few drug users to “come down” after using cocaine.

### Conclusion

Crack cocaine, heroin (i.e., brown powdered), prescription opioids, Suboxone®, sedative-hypnotics and marijuana are the most available drugs throughout the Youngstown region. Noted increases in availability over the previous six months exist for heroin, prescription opioids, Suboxone®, sedative-hypnotics and ecstasy. Heroin referred to as, “the number one drug of the time,” is now as available as marijuana. Users are switching from crack cocaine and prescription opioids to heroin because heroin is cheap and, “You can get it, wherever, whenever.” Use is increasing among young people (teens to early 20’s), with 13 years being the youngest reported age of known heroin users. The most common route of heroin administration is intravenous injection. Heroin use among young Whites, along with heroin overdose, is becoming very common. A regional drug court reports that 75 percent of defendants today are suburban heroin addicts who typically started abusing prescription opioids before developing heroin addiction. Illicit use of prescription opioids is also more prevalent among young, suburban, middle class, White people and less prevalent among urban, poor people; however, abuse appears to be increasing among African-Americans as well. OxyContin® remains the most popular prescription opioid, although decreasing in desirability due to reformulation; Opana®, Percocet® and Vicodin® are also popular. Suboxone® is most often used illicitly by those addicted to heroin who trade Suboxone® to dealers for heroin or use the drug when heroin is unavailable to avoid withdrawal, although other users are now using Suboxone® to get high. Alarming, sedative-hypnotics are increasingly being prescribed to teenagers without seeing a psychiatrist. Hydroponically grown marijuana continues to increase in popularity among all age groups, especially since people have become more educated about indoor grow units. Abuse of OTC cough medicine, well liked because it causes users to hallucinate, is increasing among young people who do not have access to other substances.