

Ohio

Department of Alcohol &  
Drug Addiction Services

OSAM

Ohio Substance Abuse  
Monitoring Network

# OSAM Network



June 2011-January 2012

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

## Drug Abuse Trends Among Those Aged 18-25 Years: A Targeted Response Initiative



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**Recommended citation of this report:**

Ohio Department of Alcohol and Drug Addiction Services [ODADAS] (2012). *Ohio Substance Abuse Monitoring Network: Drug Abuse Trends Among Those Aged 18-25 Years: A Targeted Response Initiative*.

## **Abstract**

This Targeted Response Initiative (TRI) focused on drug abuse among those aged 18-25 years. The Ohio Substance Abuse Monitoring (OSAM) Network collected qualitative data from June 2011 to January 2012 via focus group interviews. Participants were 170 active and recovering drug users recruited from alcohol and other drug treatment programs, and 112 community professionals from each of OSAM's eight regions. Data analysis found that the vast majority of participants were poly-substance users: 81.5 percent of those reporting drug use (N = 147) reported using two or more drugs during the past six months. Participants reported marijuana use most often (75.2%), followed by alcohol use (67.5%), prescription opioid use (53.5%), heroin use (36.3%), powdered cocaine use (35%) and crack cocaine use (21.7%). Epidemiological data presented in this report have the potential to help shape and strengthen prevention measures targeted at those aged 18-25 years.

## **Introduction**

This drug-trend report presents findings from a Targeted Response Initiative (TRI) focused on drug abuse among those aged 18-25 years conducted by the OSAM Network. It is based upon qualitative data collected from the June 2011 through January 2012 reporting period via focus group interviews. Participants were 170 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 112 treatment providers and law enforcement officers throughout the regions via individual and focus group interviews. OSAM research administrators in the Division of Planning, Outcomes and Research at the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) prepared this report by isolating data that pertained only to those aged 18-25 years from the report: *Ohio Substance Abuse Monitoring Network: Surveillance of Drug Abuse Trends in the State of Ohio: June 2011-January 2012*, which is available for download on the [ODADAS website](#). The report presents findings based upon aggregate data of all 359 OSAM Network participants from the June 2011 through January 2012 reporting period: 170 participants included in this TRI, exclusive of those aged 18-25 years, and 189 non-TRI participants, inclusive of those aged 26 years and older. The aggregate report includes variables not presented in this TRI report (e.g., drug quality and drug pricing), as well as data surveyed from secondary data sources (e.g., coroner's offices and police and county crime labs) and from reports on drug abuse published by Ohio media outlets. For more in-depth information on the drugs reported here, please access the aggregate report using the web link provided above.

The OSAM Network designed this TRI to generate epidemiological data for Ohio's Strategic Prevention Framework State Incentive Grant (SPF SIG). The SPF SIG program is one of the Substance Abuse and Mental Health Services Administration's (SAMHSA) infrastructure grant programs. SAMHSA's infrastructure grants support an array of activities to help grantees build a solid foundation for delivering and sustaining effective substance abuse and/or mental health services. SPF SIG programs, in particular, provide funding to states, territories, and federally recognized tribes and tribal organizations to implement SAMHSA's Strategic Prevention Framework (SPF). The SPF uses a five-step process: 1) Assessment – assess prevention needs based on epidemiological data; 2) Capacity – build prevention capacity; 3) Planning – develop a strategic plan; 4) Implementation – implement effective community prevention programs, policies and practices; and 5) Evaluation – evaluate efforts for outcomes. The SPF SIG initiative allows state grantees to set priorities and goals that align with each state's identified prevention needs. Ohio has committed to combat alcohol and drug usage in those aged 18-25 years. Specifically, Ohio's SPF SIG goals are to: decrease the number of those aged 18-25 years engaged in high-risk use of alcohol; decrease the number of those aged 18-25 years engaged in the use of illicit drugs; and decrease the number of those aged 18-25 years misusing prescription medications. The demographics within Ohio are in striking support of this decision. In 2008, the United States Census Bureau estimated that 1,228,204 of Ohio residents were between the ages of 18-25 years. At almost double the national average, the size of this population, coupled with its high rates of drug and alcohol consumption in recent years presents a significant challenge for providers of alcohol and drug treatment services within Ohio. Thus, this TRI generates needed epidemiological data to assist Ohio's SPF SIG with the SPF's first process step of assessment. Please refer to the [ODADAS website](#) for more information about Ohio's SPF SIG initiative.

## **Methods and Results**

OSAM Network regional epidemiologists (REPIs) assigned to Akron-Canton, Athens, Cincinnati, Cleveland, Columbus, Dayton, Toledo and Youngstown conducted focus groups exclusive to those aged 18-25 years. REPIs administered a brief demographic survey, which included an inventory of all drugs used during the past six months, to all participants prior to

the beginning of each focus group. Table 1 illustrates the distribution in participant number (N = 170) throughout OSAM's eight regions, as well as aggregate data of participant demographic characteristics. Table 2 illustrates the frequency of each drug reported as having been used by participants during the past six months. As Figure 1 illustrates, the vast majority of participants were poly-substance users: 75.2 percent of study participants (N = 157) reported the use of two or more drugs during the past six months; of those reporting drug use (N = 147), 81.5 percent reported using two or more drugs. Note that of 170 participants, 10 reported no drugs used during the past six months, and 13 did not respond to the drugs-used inventory, which resulted in missing data for 13 cases; thus, exclusion of these 13 cases from analyses related to drugs used. All analyses of demographic survey data, conducted using SPSS (Statistical Package for the Social Sciences), were descriptive in nature, consisting of frequencies and crosstabs. An alpha level of .05 was used for all statistical tests. In addition to quantitative data collected via the brief demographic survey, REPIs collected qualitative data regarding current drug abuse trends from participants and community professionals following scripted OSAM protocols. Results of qualitative data analyses are presented in order of drug prevalence, starting with the drug most often reported by participants as used during the past six months.

### **Marijuana**

Marijuana is perhaps the most-used drug among those aged 18-25 years. Three-quarters of study participants reported marijuana use during the past six months (see Table 2). Participants in every region most often reported the current availability of marijuana as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Reportedly, marijuana is the most easily obtained illegal drug throughout regions. Participants frequently agreed, "[*Marijuana*] it's everywhere." Moreover, many participants discussed intergenerational use of marijuana. Reportedly, marijuana use is pervasive in some families, as well as in many peer groups of young users. Community professionals also most often reported the current availability of marijuana as highly available and reported that the availability of marijuana has remained stable at high levels during the past six months: "*The grades and varieties [of marijuana] have increased, but availability is about the same.*" A participant expressed a typical comment stated by many participants, "*Better quality [marijuana] is more common than it used to be.*" Participants throughout regions reported that the availability of high-grade marijuana has been dramatically increasing. Participants and community professionals believed that the current high availability of marijuana is due in part to an increase in indoor-grow operations.

Current street jargon includes countless names for marijuana. Participants most commonly cited the following names for marijuana: "bud," "dank," "green," "kush," "pot," "trees" and "weed." Reportedly, fruity-flavored marijuana is popular among those aged 18-25 years, and branding with creative names was said to help popularize certain strains. While there are several ways of consuming marijuana, the most common route of administration among those aged 18-25 years, by far, is smoking; baking marijuana into food items and the use of vaporizers were seldom mentioned. Those with the means to purchase a vaporizer reportedly use it to ingest marijuana. Since smoke is replaced by vapors, participants reported this method as a growing trend and a healthier alternative to ingesting smoke into the lungs. Drug consumers more likely to use vaporizers were described by a participant as, "*those ... that go to [coffee shops and bookstores] for the most part*" and most often "older" and White.

A profile for a typical marijuana user did not emerge from the data. Participants described typical users of marijuana as any age, race, occupation and socio-economic group. When marijuana use was examined among study participants based on gender, race, age and education, a significant association was found for gender only. A significantly higher proportion of male participants (83.3%) reported marijuana use during the past six months than did female participants (64.2%). In terms of race, 73.5 percent of White participants reported marijuana use; 84.6 percent of Black or African-American participants reported marijuana use; and 77.8 percent of Hispanic or Latino participants reported marijuana use. Participants commonly made statements such as, "*Everybody smokes weed.*" Participants most often described first time marijuana users as young as 12 years. Community professionals most often described first time users as young as 10-13 years: "*They [marijuana users] are starting young, nine or 10 [years] on up.*" A participant talked about personal first experience with marijuana: "*I was in fifth grade when I smoked weed for the first time; then [in] sixth or seventh grade [I] started to smoke almost every day.*" Participants said the age range of marijuana users is wide: "*Fourteen year olds to 75-year-old women [use marijuana];*" treatment providers agreed, "*[Marijuana users are] Black, White, 20 or 80 [years old].*"

Both participants and community professionals noted some important differences when considering users of marijuana. Participants noticed a difference in who is using the different types of marijuana and the methods chosen for ingestion: "*I've noticed a lot of college students go for the higher grade [marijuana] as far as [compared to] other people who aren't in school*

and don't have a lot of money. They [those without a lot of money] usually get the commercial [grade marijuana] because it's cheaper, and it basically does the same thing. It's just the more expensive stuff, just smells better, tastes better." Another participant discussed differences among routes of administration: "Older [marijuana users] prefer the bowls and joints because the bongs hurt their throat; Vaporizers are good for older people." Community professionals noticed several differences in age-group consumption. A treatment provider explained, "I typically see frequency increases [of marijuana use] in the younger populations in the eighteens through twenties [sic]. I don't know if it's because of the gateway drug or experimentation or just the access, but as I see older clients, they still use marijuana, but it's more sporadic. By now, they've [older clients] probably moved to other substances ... they may still smoke marijuana, but not with the same frequency as I see with the younger population who do it on a daily or multiple weekly basis."

Reportedly, marijuana is used in combination with alcohol, crack cocaine, Ecstasy, heroin, methamphetamine, PCP (phencyclidine), powdered cocaine, prescription opioids and tobacco. Most participant groups reported that marijuana is used with, "everything." Participants generally believed marijuana is to be used with other drugs. Among study participants, 84.7 percent of marijuana users reported using one or more drugs in addition to marijuana during the past six months. Of marijuana users, 75.4 percent also reported alcohol use. In addition, 61 percent reported prescription opioid use; 41.5 percent reported powdered cocaine use; 40.7 percent reported heroin use; 40.7 percent reported sedative-hypnotic use; and 26.3 percent reported crack cocaine use. Community professionals also noted that marijuana is typically used with other substances. A treatment provider reported, "The referrals that we typically get for clients, especially the 18-25 [year-old] individuals, [have] either [been] pulled over with marijuana in a car or caught because of underage consumption [of alcohol]. They are pretty much ... both marijuana and alcohol ... for the most part they go hand in hand." A law enforcement official reported, "Marijuana is one of our top three biggest drugs, and we always see it with other drugs ... frequently in cocaine houses, heroin houses. Although we usually see it on a smaller scale, an ounce we find maybe, but no matter what the drug is, we often see marijuana with it." Several participants mentioned using cocaine with marijuana: "I would smoke weed after using coke ... to help come down, so I could go to sleep." Other participants agreed, "Most people I know either drink [alcohol] and smoke [marijuana] or [just] use weed to help come down from another drug." However, some participants reported sprinkling powdered cocaine in marijuana cigarettes, called "cocoa puffing" or "primo" and smoking the drugs together. Participants also reported seeing marijuana laced with embalming fluid and called this practice, "getting wet." Some users reported using crushed pills with marijuana: "We would sprinkle pills on top [of marijuana] and call it a 'spicy joint,'" a participant said while describing the common use of Ecstasy, prescription opioids and sedative-hypnotics with marijuana. A participant commented that using lower-grade marijuana with Ecstasy "makes it [commercial-grade marijuana] feel like kush [high-grade marijuana]."

### **Alcohol**

Alcohol is popular among those aged 18-25 years. Slightly more than two-thirds of study participants (67.5%) reported alcohol use during the past six months (see Table 2), with nearly 70 percent of participants younger than 21 years of age reporting use. Participants and community professionals identified alcohol as a major substance of abuse for those aged 18-25 years. In fact, several study participants reported alcohol as their primary drug of choice. A treatment provider remarked, "They [young adult users] don't see anything wrong with that [using alcohol] because [alcohol] it's legal." A participant discussed the frequency of alcohol use in the community, "Most everybody drinks [alcohol]. That's what you do on weekends, weekdays." Alcohol is highly available to those under 21 years of age. Participants commented on the availability of alcohol to underage users: "I am only 20 [years old], and I can think of a lot of places that sell me alcohol ... and I've never once been ID'd [asked to show identification] ... never, ever once, and I've been buying my own alcohol since I was 18 [years old]; I know of a lot of high school kids that buy their own alcohol because at certain places ... there's a specific drive-thru [beverage store] that doesn't card [ask to see identification] at all ... there's quite a few places like that."

Participants and community professionals noted a few trends common among those aged 18-25 years, most involving flavored malt liquor beverages and the use of highly caffeinated energy drinks with alcohol. A participant reported, "Those Four Loko [premium flavored malt liquor beverage] drinks are crazy. You drink two of them, and you're gone. I felt like I was at the bar all night." Another participant agreed, "The Four Loko drinks ... young kids are using these. The Four Loko Challenge on the can says 'if you can drink four of these ...' it's on the Four Loko can ... they are huge cans, and kids drink it so quick ... you don't know how drunk you are until you have alcohol poisoning." Participants also noted young people consuming alcohol mixed in with food and various other beverages: "JELL-O shots; pudding shots; jungle juice with Everclear [pure grain alcohol]." Other participants said, "SPARKS and Tilt [both malt liquor beverages] are still popular ... you can always do cherry bombs, jager [Jägermeister] bombs. It's popular to mix [these drinks] with energy drinks." There also seems to be some availability of

homemade alcohol. A participant in the Athens region reported, *"I have a buddy that makes moonshine; [It's] not common to make your own [alcohol], but it's strong."* Another participant mentioned, *"Sometimes you'll find moonshine and hot apple pie [another homemade alcohol] here and there."*

Participants frequently noted an increase in different flavors of alcohol, and they believed flavored alcohol to be a marketing ploy to *"encourage trying more [alcohol]."* Participants explained, *"I think that [the development of flavored alcohol] was to hook young kids into drinking early because then the kids would think, 'oh, this is cool and it tastes good.' A lot of people don't like the taste of beer, but if it tastes good, they'll want to drink it."* Participants also reported an increase in drinking games like "beer pong." A participant reported, *"Bars are even having beer pong tournaments."*

When alcohol use was examined among study participants based on gender, race, age and education, a significant association was found for gender only. A significantly higher proportion of male participants (74.4%) reported alcohol use during the past six months than did female participants (58.2%). In terms of race, 73.5 percent of White participants reported alcohol use; 59 percent of Black or African-American participants reported alcohol use; and 44.4 percent of Hispanic or Latino participants reported alcohol use. Most participants agreed that alcohol is used in combination with many other drugs, with many participants reporting alcohol use with nearly every drug. Among study participants, 95.3 percent of alcohol users reported using one or more drugs in addition to alcohol during the past six months. Of alcohol users, 84 percent also reported marijuana use. In addition, 68.9 percent reported prescription opioid use; 47.2 percent reported sedative-hypnotic use; 46.2 percent reported powdered cocaine use; 43.4 percent reported heroin use; and 29.2 percent reported crack cocaine use.

### Prescription Opioids

Prescription opioids are frequently used among those aged 18-25 years. Slightly more than half of study participants (53.5%) reported use of prescription opioids during the past six months (see Table 2). Opana®, OxyContin®, Percocet® and Vicodin® are the most popular prescription opioids throughout regions. Participants in every region reported the current availability of prescription opioids most often as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants commonly said these drugs are "very prevalent" and "highly available." A common theme among those aged 18-25 years was echoed in this participant's statement, *"Everyone has a family member with a prescription [for opioids]. My aunt has a stock of pain pills. You don't even have to go on the street to get them because it's in the household."* Other participants commented about the move away from OxyContin® to other drugs due to the new abuse-resistant formulation of OxyContin®. Participants in several regions talked about the rise in popularity of Opana®: *"Opana® is definitely a big thing now ... it's pretty potent-the 30s [30 milligram pill]. Opana® replaced the old oxy's [OxyContin® OC], and no one wants the new oxy's [OxyContin® OP] now that they [Purdue Pharma] changed the make-up of them."*

Community professionals also most often reported the current availability of prescription opioids as highly available. A law enforcement officer noted that prescription opioids attract users who would not otherwise consider themselves drug users. The officer stated, *"They [drug users] think [prescription opioid use] it's safer. They'll snort an Opana® before they'd ever think of sticking a needle in their arm, but it's the same thing [as heroin]."* In some regions, treatment providers thought that prescription opioids have become cost prohibitive: *"[Clients] are leapfrogging to heroin; it's much cheaper [than prescription opioids]."* Generally, community professionals agreed with participants in that OxyContin® OP is not popular and that users are transitioning to other drugs like Opana® and Roxicodone®. Community professionals talked about the large quantities of prescription opioids being prescribed. Staff from the Miami Valley Regional Crime Lab reported, *"We had a prescription bottle and somebody had been prescribed 80, 80 mg of oxy [OxyContin®]."*

Current street jargon for prescription opioids (aka "candy," "pills" and "poppers") is related to brand names and is relatively consistent throughout regions. Participants reported the following prescription opioids with their common street names in parentheses as currently available: Dilaudid® (aka "dillys" and "dilly bars"), fentanyl, Lortab®, methadone, Opana® (aka "bears," "pandas" and "panda bears"), OxyContin® OC (aka "OCs," "old cars," "Orange County" and "oxy's"), OxyContin® OP (aka "OPs" and "oxy's"), Percocet® (aka "blues," "greens," "Ps," "peaches" and "perc's"), Roxicet® (aka "roxi's"), Vicodin® (aka "Vs," "vic's" and "vikes") and Ultram® (aka "trims"). While there are several ways of consuming prescription opioids, the most common routes of administration among those aged 18-25 years are oral ingestion (chewing or swallowing) and snorting. Only participants in Athens and Columbus reported intravenous use of prescription opioids as also common. Participants explained that preferred routes of administration are driven primarily by type of prescription opioid. A participant reported, *"If I had an Opana® or oxy [OxyContin®], I would snort it. If [the pill] had acetaminophen, I would pop [swallow] it."* Other participants said

that the fear of needles drives the route of administration. A participant explained, *"Those who are not fond of needles, snort. But if you are comfortable with needles, everything else you use will be a needle."* Participants also said that route of administration is driven by age. A participant explained, *"Younger kids eat them [prescription opioids] and pop [swallow] them."*

A profile for a typical prescription opioid user did not emerge from the data. Most respondents felt that *"anyone"* would use these drugs, including people from all income levels, ages and races. A participant stated, *"[Opiate addiction] doesn't discriminate; no typical [prescription opioids] user. The thing about pills [prescription opioids] in general is ... I know so many different types of people that use them ..."* However, several participants and community professionals described typical prescription opioid users as White males, aged 18-25 years. When prescription opioid use was examined among study participants based on gender, race, age and education, significant associations were found for race, age and education. Higher proportions of White and Hispanic or Latino participants (66.7% and 55.6%) reported prescription opioid use during the past six months than did Black or African-American participants (25.6%); a higher proportion of participants aged 21-25 years (58.9%) reported prescription opioid use than did participants aged 18-20 years (39.5%); and in terms of education, higher proportions of participants with some college or a college degree (70.2%) reported prescription opioid use than did participants with high school diplomas only (51.5%) and those participants reporting education less than high school (38.1%). Participants and community professionals described first time use of prescription opioids as occurring in adolescents as young as 14-16 years. A participant stated, *"I think [prescription opioid use] it's really, really common among young people. I've seen 14- and 15-year olds taking trims [Ultram®]."* Law enforcement felt younger users are unaware of the potency of these drugs. A law enforcement official said, *"The product [prescription opioids] is also very pure, so when they have other drugs in their system, they misjudge what they're doing ..."*

Reportedly, prescription opioids are used in combination with alcohol, bath salts, crack cocaine, heroin, marijuana, powdered cocaine, sedative-hypnotics and tobacco. Among study participants, 98.8 percent of prescription opioid users reported using one or more drugs in addition to prescription opioids during the past six months. Of prescription opioid users, 86.9 percent also reported alcohol use. In addition, 85.7 percent reported marijuana use; 56 percent reported heroin use; 56 percent reported sedative-hypnotic use; 54.8 percent reported powdered cocaine use; and 32.1 percent reported crack cocaine use. Participants frequently combined prescription opioids with sedative-hypnotics. According to a user, the combination of the two drugs *"strengthens the effect of pills [prescription opioids]."* Other participants discussed using alcohol and marijuana with prescription opioids. Many echoed the sentiment stated by one user, *"I rarely took pills without drinking [alcohol] or smoking [marijuana] with them."* A participant even mentioned using prescription opioids with bath salts, *"The only way to come down from bath salts is with opiates."*

### Heroin

Heroin use is becoming increasingly more prevalent among those aged 18-25 years. More than one-third of study participants (36.3%) reported use of heroin during the past six months (see Table 2). Almost all participants reported heroin as easy or very easy to get and perceived the high amount of heroin use as an *"epidemic."* Participants stated: *"In my area [heroin] it's readily available ... I'd be waiting for my dope boy [drug dealer] and get approached by three others. It's everywhere; [Obtaining heroin is] like going out and getting a bag of weed [marijuana] nowadays. [Heroin] it's the easiest drug I know of to find."* Community professionals also reported current heroin availability as *'highly available, extremely easy to get.'* Treatment providers commented: *"Heroin is overrunning pills [prescription opioids] ... heroin seems to be more accessible to them [younger users] now. It's cheaper; We see a lot of younger kids, 18 [years] to mid-20s ... and [heroin] that's really big with them."* A U.S. Drug Enforcement Administration (DEA) representative reported that DEA agents made, *"[heroin] cases in the suburbs and cases involving teens,"* highlighting the widespread availability of heroin. Furthermore, when asked to identify the most urgent or emergent drug trends, law enforcement consistently cited heroin trafficking as a primary concern: *"It [heroin] moves from city to town, town to city ... about 85 percent of our [law enforcement] work involves heroin now."*

Participants identified two trends involving heroin: increased competition among dealers to secure steady heroin users and increased demand for heroin. A participant stated, *"Dealers are readily available to serve you. I've seen the dudes and heard about kids as young as eight or nine years old to get into it [heroin sales]."* Other participants remarked, *"Dealers that used to sell just crack [cocaine] now sell both [crack cocaine and heroin]; [Heroin] it's extremely popular."* Many dealers have modified their inventory and techniques to attract and retain heroin users. A participant reported on being approached at a store to buy heroin: *"The last time the guy [dealer] tried to give me some heroin for free ... a little bag."* Others observed, *"There are more dope boys [heroin dealers] every single day."* A treatment provider also observed that dealers are pushing heroin more: *"Dealers are actually marketing heroin by providing free samples to people who come to buy other drugs."* A law enforcement official stated, *"If you go to buy prescription drugs from a drug trafficker, an illicit drug trafficker, they will actually give you one or two caps of*

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heroin to try. Once you get your person hooked, they'll come back, and they'll bring more people with them." A law enforcement officer observed, "Before you kinda had to know a [heroin] dealer, and now you can just drive up to a gas station, and you'll be directed to a dealer eventually." Participants attributed high heroin demand to recent arrests of area doctors who were prescribing prescription opioids, which limited availability of these drugs, and to the recent change in the composition of OxyContin®, which made it difficult to crush and use intravenously, causing more users to seek heroin. A participant reported, "All my friends thought I was crazy for shooting up [injecting] heroin, and now they're all doing it because they can't get their pills [prescription opioids] anymore."

Current street jargon includes countless names for heroin. Participants most commonly cited the following names for heroin: "boy," "dog food," "dope" and "H." It should be noted that among younger users, "dope" refers to a specific drug (usually heroin or crack cocaine), while among older users, dope can be any type of abused substance. While there are several ways of consuming heroin, the most common route of administration cited among those aged 18-25 years is intravenous injection. To a lesser degree, participants also described snorting and smoking of heroin. However, the consensus among this population was, "Everyone is injecting [heroin]." Participants explained that intravenous use is most effective in that heroin administered through injection is most potent. Participants reported: "I started out snorting it [heroin] for a month then someone said, 'You are wasting your money,' so I finally built up the courage to shoot it [inject heroin] for the first time; Once you shoot it, you don't go back to snorting. The needles are addictive." Many participants commented that individuals may start off snorting or smoking heroin, but will eventually use heroin intravenously: "It's a waste of time if you don't do that [inject heroin]; If they [users] don't shoot it [heroin], they're smoking it first; When you snort it [heroin], you waste 40 percent of it; But eventually, they [those who snort heroin] will switch over when snorting doesn't do the job." On the progression from snorting and smoking to injection, a heroin user commented, "[Heroin users] they're gonna graduate to using the needle eventually;" a treatment provider commented, "They [heroin users] don't start off with the needle [intravenous injection]. They'll try powder [heroin], snorting and smoking, and then it's eventually to the needle;" and a law enforcement official noted, "We've seen younger people start with snorting it [heroin] then going onto injecting it."

Participants most often described typical heroin users as, "White; younger; in their 20s." Community professionals concurred. A treatment provider described typical heroin users as, "Twenty to 25 [years of age], young, suburban, White folk." A law enforcement official reported, "We see it [heroin use] more among Whites ... a little more males, but [there has been] an increase in females using." When heroin use was examined among study participants based on gender, race, age and education, a significant association was found for race only. A significantly higher proportion of White participants reported heroin use during the past six months than did participants of other races: 51 percent of White participants reported heroin use; 11.1 percent of Hispanic or Latino participants reported heroin use; and 7.7 percent of Black or African-American participants reported heroin use. Most participants and community professionals agreed that heroin use is a big problem among those aged 18-25 years. A participant reported, "I see younger people [using heroin], and then it skips a generation, to older people who have been doing it for 30 years." Another participant noted, "I think it's the younger group now—teens and early 20s are using heroin ... heroin has just completely taken over." Law enforcement reported: "Young adults seem to like it [heroin], people in their 20s and 30s; We're seeing young people from 17-25 [years] typically [using heroin] who might have started with prescription drugs ..." In addition, a treatment provider described typical heroin users as "not going to college ... not actively pursuing higher education ... we're not hearing [about heroin use] at the colleges ... definitely younger individuals who aren't in school [use heroin] ... those not working to improve their socio-economic status."

Most participants recognized that heroin use is increasing among very young users. Participants noted: "I started using [heroin] when I was 18 [years old]. Kids in high school ... 15 or 16 [years of age] shoot up heroin; Younger [teens] is getting flooded with heroin use; I was shootin' [injecting heroin] when I was 15 [years of age]." A participant group reported that heroin use is fairly common in high schools. Participants most often described first heroin use to occur as young as 15 years of age. Participants stated that increased use of heroin by younger people is something that has changed during the past six months. Treatment providers noted, "Age [of heroin users] is going down; We're hearing about it [heroin use] from the adolescent programs and having young people in need of detox [from heroin] at 16, 17 [years of age]." A law enforcement officer reported, "The youngest [heroin user] we see is about 15-16 years old." Participants and community professionals agreed that there has been an increase in younger users of heroin, and both groups linked the increase in heroin use to high availability of prescription opioids. A treatment provider explained, "They [adolescents] can get an introduction to prescription medications first before the street drugs, and that can happen at home ... as [young as] 10 or 11 years old getting into the medicine cabinet."

Reportedly, heroin is used in combination with alcohol, crack cocaine, marijuana, methamphetamine, powdered cocaine, prescription opioids and sedative-hypnotics. A participant reported, "I never met anyone that just strictly does heroin." Among

study participants, 96.5 percent of heroin users reported using one or more drugs in addition to heroin during the past six months. Of heroin users, 84.2 percent also reported marijuana use. In addition, 82.5 percent reported prescription opioid use; 80.7 percent reported alcohol use; 71.9 percent reported sedative-hypnotic use; 64.9 percent reported powdered cocaine use; and 43.9 percent reported crack cocaine use. Participants reported that it is typical to mix other substances with heroin in order to intensify the effects, make the “rush” (high) last longer or to get a different effect. A participant stated, “Heroin will get you high the first time you get high that day, but with coke [cocaine], every time you get the same rush.” Participants reported use of crack and powdered cocaine in combination with heroin as “speedballing;” these drugs are used concurrently or successively to experience the effects of an “upper” and “downer.” Participants explained, “If you’re doing cocaine, you’re going to want to come down; I do a shot of heroin in the morning. Then if I have stuff to do, I want some crack so I can be up throughout the day. And then, when I’m ready to come back down, that’s when I do another shot of heroin. It’s a vicious cycle.” A participant also stated that a heroin dealer “would sometimes sell a 50 percent cocaine/50 percent heroin mix. He started doing that after recommendations from users who wanted that.” Another participant noted that methamphetamine and heroin together, while not common, is another form of speedball. Other participants noted that alcohol and marijuana are used in combination with heroin to help level off or come down from the high of heroin. Heroin is also used with marijuana because, “Potentiation ... it [marijuana] makes heroin seem stronger; Marijuana intensifies the buzz, and you don’t get sick.” In addition, a participant reported injecting heroin and swallowing Xanax® to intensify her high: “When you use Xanax® [with heroin], you get a lot higher, dangerously higher. I’ve overdosed using Xanax® with heroin.” The Miami Valley Regional Crime Lab reported that it is typical for heroin overdose cases to include a mixture of heroin with alcohol, heroin with cocaine, heroin with methadone or heroin with sedative-hypnotics. The Mahoning County Coroner reported that heroin-related deaths are typically from a combination of drugs: “I’ve had two deaths in 2011 that were solely from heroin. We typically see heroin combined with other drugs, most commonly with other narcotic pain relievers. Anti-anxieties and alcohol are also typically mixed in with heroin deaths.”

### Sedative-Hypnotics

Sedative-hypnotics are frequently used among those aged 18-25 years. More than one-third of participants (36.3%) reported sedative-hypnotic use during the past six months (see Table 2). Klonopin®, Valium® and Xanax® are the most popular sedative-hypnotics throughout regions. Participants in every region most often reported the current 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 commonly said these drugs are “very popular” and “really easy to get.” Generally, participants also reported that these drugs are very desirable. A participant stated, “As soon as they [sedative-hypnotics] come around [become available], they’re gone;” and another participant agreed, “Klonopin® are usually gone as soon as you hear about them. Everybody wants them ...” Other participants talked about the minimal cost of sedative-hypnotics. A participant reported, “It’s like candy; [sedative-hypnotics] it’s always just handed to me.” Other participants agreed and said that sedative-hypnotics are sometimes given away for free or as bonuses with the purchase of other drugs. Community professionals most often reported the current availability of sedative-hypnotics as moderately to highly available. Treatment providers talked about the astonishing availability of some sedative-hypnotics. Treatment providers talked about users turning to these drugs to help cope with life. A treatment provider said, “Society is passing more and more individuals, especially of lower-economic status. People are having trouble coping day to day, and so they turn to [sedative-hypnotics].”

Current street jargon for sedative-hypnotics (aka “benzo’s,” “downers,” “nerve pills” and “Skittles”) is related to the brand name or color of the pills and is relatively consistent throughout regions. Participants reported the following sedative-hypnotics with their common street names in parentheses as currently available: Ativan®, Klonopin® (aka “forget-a-pins,” “greenie meanies,” “green monsters,” “Ks,” “K-pins” and “pins”), Soma®, Valium® (aka “Vs” and “V-cuts”) and Xanax® (aka “bars,” “blues,” “footballs,” “peaches,” “xani’s” and “xanibars”). While there are several ways of consuming sedative-hypnotics, the most common routes of administration among those aged 18-25 years are oral ingestion (chewing or swallowing) and snorting. Only participants in Athens and Cleveland reported intravenous use of sedative-hypnotics, but this route of administration was said to be uncommon. Participants explained that route of administration is driven by several factors, including intensity of the high sought. Some participants thought the most intense high is from snorting the drugs. A participant explained, “If you want to get every bang for your dollar, you’ll go through that pain of snorting [sedative-hypnotics].” Participants also said that route of administration is driven by age. A participant explained, “When I was younger, I snorted them [sedative-hypnotics] a lot, but when I got older, I started eating them.” Other participants said they used multiple routes. A participant explained that he likes to, “snort the first couple [sedative-hypnotics] and pop the rest ... I always see people eat them like Skittles, you know. It seems like an impulse thing.”

A profile for a typical sedative-hypnotics user did not emerge from the data. Most participants felt that “anyone” would use these drugs, including people from all income levels, ages and races. A participant stated, “A typical [sedative-hypnotics] user

*can look like you or me ...* Most community professionals agreed with this assessment and said that sedative-hypnotic use is, “*across the board.*” A minority of treatment providers suggested a common user profile, but participants and law enforcement typically did not agree. Some treatment providers thought that “*middle-class, Caucasian males and females*” are most likely to use sedative-hypnotics. When sedative-hypnotic use was examined among study participants based on gender, race, age and education, a significant association was found for race only. A significantly higher proportion of White participants (50%) reported sedative-hypnotic use during the past six months than did Hispanic or Latino participants (22.2%) and Black or African-American participants (2.6%). Participants described first time use of sedative-hypnotics to occur as young as 15-16 years of age. A participant talked about personal first experience with sedative-hypnotics: “*I started with Valium® when I was 16 [years of age], then went to Ativan®, then went to Xanax® ... the footballs [low-dose Xanax®], then the bars [high-dose Xanax®].*” Community professionals largely agreed with participants and reported that sedative-hypnotic use often begins during the high school years.

Reportedly, sedative-hypnotics are used in combination with alcohol, bath salts, crack cocaine, heroin, marijuana, powdered cocaine and prescription opioids. Among study participants, 100 percent of sedative-hypnotics users reported using one or more drugs in addition to sedative-hypnotics during the past six months. Of sedative-hypnotics users, 87.7 percent also reported alcohol use. Additionally, 84.2 percent reported marijuana use; 82.5 percent reported prescription opioid use; 71.9 percent reported heroin use; 63.2 percent reported powdered cocaine use; and 40.4 percent reported crack cocaine use. Any of these drugs may be taken during or after the use of sedative-hypnotics to augment or extend the high. A participant reported, “*I would use weed and alcohol with Xanax®. I snorted it ... the Xanax® ... just makes you that much more f\*\*\*\*\* up.*” Another participant also reported on use of sedative-hypnotics with alcohol, “*You don’t have to drink as much to get drunk.*” Treatment providers discussed the popularity of sedative-hypnotic use with alcohol use among young adults: “*Xanax® is popular for the young ones [18-25 years of age] to use with alcohol.*” Participants and community professionals agreed that sedative-hypnotics are also frequently used to “come down” from “uppers” (stimulant drugs) like bath salts, crack cocaine and powdered cocaine.

### **Powdered Cocaine**

Powdered cocaine is frequently used among those aged 18-25 years. Slightly more than one-third of participants (35%) reported powdered cocaine use during the past six months (see Table 2). Participants in many regions reported the current availability of powdered cocaine most often as ‘9’ or ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants in the Athens and Cincinnati regions reported that it is more difficult to obtain powdered cocaine and most often rated availability between ‘4’ and ‘5’. Typically participants in regions with high availability made comments like the drug is “*pretty easy to find*” and available “*anytime*” of the day. A participant even went so far to say, “*I know so many people that sell powder [cocaine]. I could get some right now if I wanted to.*” However, participants in regions with high availability were also likely to point out that availability differs by locality. A participant noted that many drugs, including powdered cocaine, are “*much harder to get in rural areas and smaller towns.*” Other participants reported that powdered cocaine is highly available, but requires more work to obtain than other drugs, with one stating, “*Three or four phone calls [are needed] to get a connection or to get a lead [on powdered cocaine for purchase].*” Generally, participants from regions where powdered cocaine is said to be moderately available had to travel to obtain the drug. A participant said, powdered cocaine is, “*nowhere immediately in the Athens area ... it [requires] a drive ...*” Community professionals most often reported the current availability of powdered cocaine as moderately to highly available. Most community professionals agreed that powdered cocaine was, “*easy to get.*” Several law enforcement officials and treatment providers echoed the sentiment expressed by a treatment provider, “[I] never heard a client say they had a problem getting it [powdered cocaine].” The general thought among community professionals was that powdered cocaine is not as desirable as other drugs. As law enforcement officer reported, “*Powdered cocaine and marijuana probably makes up about 20 percent of our cases. [Powdered cocaine] it’s just not as big of a problem as heroin.*”

Current street jargon includes many names for powdered cocaine and is relatively consistent throughout regions. Participants most commonly cited the following names for powdered cocaine: “*blow,*” “*coke,*” “*girl,*” “*powder,*” “*snow,*” “*soft,*” “*white*” and “*white girl.*” While there are several ways of consuming powdered cocaine, the most common route of administration among those aged 18-25 years is snorting. Only participants in the Columbus and Dayton regions reported intravenous injection of powdered cocaine as equally as common as snorting. Participants from other regions said injecting and smoking of powdered cocaine is only performed by a minority of users. Participants explained that route of administration is driven by several factors. Reportedly, some users choose to snort powdered cocaine because they are fearful of injection. A participant explained, “*Some people don’t like needles.*” Typically, participants said injection

is most common among those who inject other drugs. A participant said, *"Seems like people who inject heroin also inject cocaine."* Other participants explained that powdered cocaine users progress from snorting to injecting the drug over time. A participant reported, *"At first I started snorting it [powdered cocaine], then I smoked it, and then I shooted [sic] it. About every three or four years, I went to something different ... to find a better way to get high ... more of the effect."* This assertion was also supported by other participants, with another participant stating, *"Kids usually smoke it [powdered cocaine]. Older people usually inject it."*

A profile for a typical powdered cocaine user did not emerge from the data. Participants often said that powdered cocaine appeals to a *"wide variety of users,"* and mostly agreed that the drug is typically used as *"a party thing; a social drug."* Most community professionals agreed with this assessment and said that powdered cocaine use is popular among many people regardless of gender, race and age. Several participants and community professionals noted that powdered cocaine use is common among young people: *"teenagers and people in their early 20s."* In addition, many noted that people of higher socioeconomic status and Whites are most likely to use powdered cocaine. A participant stated, *"You have to have a big income to support that [powdered cocaine] habit."* When powdered cocaine use was examined among study participants based on gender, race, age and education, a significant association was found for race only. A significantly higher proportion of White participants (46.1%) reported powdered cocaine use during the past six months than did Hispanic or Latino participants (22.2%) and Black or African-American participants (12.8%). Participants described first time use of powdered cocaine as typically occurring at 14-16 years of age and as young as 12 years. A participant talked about personal first experience with powdered cocaine: *"I messed with powdered cocaine when I was a teen. I was 15 [years of age] the first time I tried it. It wasn't very available to me because I'm from a small town ..."* Some participants thought that powdered cocaine is accessible to high school students. A participant who is 18 years of age and enrolled in high school said, *"I was sitting at the lunch table [at my high school], and they [classmates] were talking about the party and doing all this coke."*

Reportedly, powdered cocaine is used in combination with alcohol, bath salts, Ecstasy, heroin, marijuana, methamphetamine, prescription opioids, sedative-hypnotics and tobacco. Among study participants, 100 percent of powdered cocaine users reported using one or more drugs in addition to powdered cocaine during the past six months. Of powdered cocaine users, 89.1 percent also reported alcohol use and 89.1 percent also reported marijuana use. In addition, 83.6 percent reported prescription opioid use; 67.3 percent reported heroin use; 65.5 percent reported sedative-hypnotic use; and 41.8 percent reported crack cocaine use. Throughout regions, participants reported using sedative-hypnotics, marijuana, heroin and other depressants (aka "downers") to come down from a powdered cocaine high. A participant explained, *"It [marijuana] helped me come back down [from powdered cocaine use] so I could go to sleep."* Reportedly, powdered cocaine is used to "come up" after using depressant-like drugs. Mixing powdered cocaine with heroin, either using concurrently or successively (aka "speedball"), is also reportedly common. A participant stated, *"Almost everybody who shoots coke does heroin."* Other common practices among users include lacing marijuana with powdered cocaine (aka "primo") or lacing cigarettes with the drug. Some participants reported using powdered cocaine to "party" longer: *"You can drink [alcohol] all night if you are using powdered cocaine."*

### Crack Cocaine

Crack cocaine is sometimes used among those aged 18-25 years. Fewer than a quarter of participants (21.7%) reported crack cocaine use during the past six months (see Table 2). However, participants throughout regions most often reported the current availability of crack cocaine as '9' or '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants agreed that the drug is readily available anytime of the day or night. A participant summed up the availability of crack cocaine as follows: *"It would take me about five minutes to get some [crack cocaine]."* Crack cocaine is reportedly available from unknown dealers as well as from established connections. A participant in the Cleveland region reported, *"I had to call sometimes [to locate crack cocaine], but sometimes they [crack cocaine dealers] walk up to you on the street."* Another participant talked about how easy it is to obtain drug paraphernalia needed to smoke crack cocaine: *"My area has lots of [convenience stores] and corner stores that sell Choreboy® [stainless steel scrubbing pad used as a screen] and a cheap lighter ... you ... just need a stem or rose [artificial rose that is attached to a glass stem used as a pipe]."* Occasionally, participants pointed out that crack cocaine's availability differs by locality, with the drug more likely to be available in urban areas than rural areas. Community professionals also most often reported current availability of crack cocaine as highly available. Most community professionals believed users to have no trouble obtaining the drug, and many reported that this form of cocaine is more available than powdered cocaine.

Current street jargon includes many names for crack cocaine and is highly consistent throughout regions. Participants most commonly cited the following names for crack cocaine: “hard,” “rock” and “work.” While there are several ways of consuming crack cocaine, the most common route of administration among those aged 18-25 years is smoking. Participants in many regions also stated that a minority of users snort or inject crack cocaine, but they said this is typically uncommon. A participant said, *“I know people that will shoot it [crack cocaine]; they mix it with vinegar, but it’s not common.”* Some participants thought use practices differed with age. A participant reported, *“Younger [less-experienced] users smoked it [crack cocaine], older [more-experienced] users shoot it.”* However, injecting crack cocaine is perceived to be on the rise in several regions among those aged 18-25 years. A participant in Cleveland reported, *“People are shooting it [crack cocaine] more now. They used to just smoke it,”* and a participant in Akron-Canton agreed, *“[A] new trend is to shoot it [crack cocaine].”*

A profile for a typical crack cocaine user did not emerge from the data. Participants said that crack cocaine use is prevalent among all age groups. A participant stated, *“I know teenagers that are smoking crack, and I’ve seen 60-year-old men that are still smoking crack.”* Law enforcement also agreed that they are seeing people from all walks of life involved with crack cocaine use. An officer stated, *“It’s poor people to people with money [that use crack cocaine]. We’re getting it through the full [population] spectrum.”* However, a few participants identified crack cocaine use as particularly prevalent among people of low socio-economic status and among female prostitutes. A user said that her crack cocaine addiction led her into poverty, and then she turned to crime: *“I started smoking crack, and within a month I’d already stolen everything I could from my family.”* When crack cocaine use was examined among study participants based on gender, race, age and education, a significant association was found for age only. A significantly higher proportion of participants aged 21-25 years (85.3%) used crack cocaine in the past six months than did participants aged 18-20 years (11.8%). Participants described first time use of crack cocaine as occurring often at around 16 years of age. Community professionals agreed that younger people are being introduced to crack cocaine earlier than in previous times.

Reportedly, crack cocaine is used in combination with alcohol, bath salts, heroin, marijuana (aka “primo”), PCP (aka “wet” or “woo”), powdered cocaine, prescription opioids, prescription stimulants, Seroquel®, sedative-hypnotics and tobacco. Most participants reported that it is common to use crack cocaine with other drugs. Among study participants, 100 percent of crack cocaine users reported using one or more drugs in addition to crack cocaine during the past six months. Of crack cocaine users, 91.2 percent also reported alcohol use and 91.2 percent also reported marijuana use. In addition, 79.4 percent reported prescription opioid use; 73.5 percent reported heroin use; 67.6 percent reported powdered cocaine use and 67.6 percent reported sedative-hypnotic use. Frequently, participants reported using depressants with crack cocaine to *“take the edge off”* because of the intense high associated with the drug. A participant expressed a viewpoint heard from many others, *“I wouldn’t smoke crack unless I had some kind of downer for after.”* Using crack cocaine with heroin was also mentioned; a participant said, *“I’ve used it [crack cocaine] with heroin. Use crack after [heroin use] to get you back up if you’ve got things to do.”* Another participant explained how some users mix crack cocaine with other drugs: *“Some people put it [crack cocaine] in alcohol ... dissolve it with beer, liquor or whiskey ... called a ‘boiler’ ... it’s big in frat [fraternity] houses and motorcycle clubs.”*

### Other Drugs

Participants and community professionals throughout regions listed a variety of other drugs as being used by those aged 18-25 years, but these drugs were not mentioned by the majority of respondents interviewed and were infrequently used by study participants (see Table 2). A small minority of participants reported use of bath salts (synthetic compounds containing methylene, mephedrone or MDPV) and synthetic marijuana (“K2” and “Spice”) during the past six months. However, availability of these substances is reportedly moderate to high throughout regions. Participants reported that bath salts and synthetic marijuana remain widely available at most convenience and drive-thru beverage stores, gas stations and head shops despite recent legislation that banned their sale; a few participants noted decreases in availability since the ban went into effect in October 2011. Participants reported that the most common routes of administration are snorting for bath salts and smoking for synthetic marijuana. Profiles for typical bath salts and synthetic marijuana use did not emerge from the data. However, some participants and community professionals thought bath salts use to be most prevalent among Whites. Reportedly, bath salts are used in combination with alcohol, crack cocaine, heroin, prescription opioids and sedative-hypnotics. Typically, bath salts are used with these other substances to enhance the effect of the other substances or to *“come up”* after the use of depressant drugs. Many participants stated that they smoked synthetic marijuana because they believed it would allow them to test negative on urine drug screens. A user explained, *“I wanted to still smoke [something like] weed and pass the drug test.”* Reportedly, synthetic marijuana is used in combination with alcohol and marijuana.

Club drugs like Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMP) and hallucinogens [LSD (lysergic acid diethylamide), PCP, DMT (dimethyltryptamine) and psilocybin mushrooms] were infrequently used by study participants. Participants reported current availability of these club drugs as moderate to high throughout regions. Participants most commonly cited the following street names for Ecstasy: "X" and "Molly." Current street jargon for hallucinogens is drug specific with the most common terms including "shrooms" for psilocybin mushrooms and "wet" or "woo" for PCP. There are few reported ways of administering Ecstasy, but the most common routes of administration among those aged 18-25 years are snorting and "parachuting" (wrapping a crushed tablet in tissue and swallowing); the most common routes of administration for hallucinogens varied, with users reporting smoking, snorting and oral ingestion (chewing or swallowing). Profiles for typical Ecstasy and hallucinogen use did not emerge from the data. However, many participants and community professionals agreed that Ecstasy is a "party drug" and is often used by high school- and college-aged youth, and that hallucinogens are common with the "younger crowd" (those younger than 25 years). Reportedly, Ecstasy is used in combination with alcohol, marijuana, nitrous oxide, tobacco, VIAGRA® and other prescription drugs. Many users reported on the need to follow Ecstasy with a counteracting drug if it contained a stimulant or a sedative. A participant explained, "You take downers when [Ecstasy] is mixed with coke or meth [methamphetamine]." Another participant preferred using alcohol because, "I'd like to get drunk [and use Ecstasy] because I wouldn't feel hung-over the next day." Reportedly, hallucinogens are used in combination with alcohol, marijuana and tobacco.

Prescription stimulants were infrequently used by study participants. Participants throughout regions reported Adderall®, Concerta®, Ritalin® and Vyvanse® as popular prescription stimulants in terms of widespread use, with Adderall® cited as being the most available prescription stimulant in every region. Participants in most regions reported the current availability of prescription stimulants as moderate to high. Participants explained that most everyone in high school and those aged 18-25 years knows someone that will freely give prescription stimulants to them or will sell them at a cheap price. Current street jargon for prescription stimulants include "poor man's coke," which refers to all prescription stimulants and "addies" which refers only to Adderall®. Reportedly, the most common routes of administration among those aged 18-25 years are snorting and oral ingestion. In nearly every region, community professionals and participants described a typical user of prescription stimulants as teenagers and young adults aged 18-25 years. A participant described a typical user as, "high school and college kids" who want to study or people who work long hours and like to go out and party without falling asleep. Reportedly, prescription stimulants are used in combination with alcohol, marijuana and sedative-hypnotics. Participants generally reported using prescription stimulants to modify the effects of sedative-hypnotics or other depressants.

Methamphetamine was infrequently used by study participants. Reportedly, methamphetamine is highly available in the Akron-Canton and Cleveland regions and rarely to moderately available in other regions. Current street jargon includes many names for methamphetamine, including "glass," "crank," "crystal," "ice" and "meth." The most common routes of administration for this drug are smoking and snorting. Several participants noted that younger people tend to snort methamphetamine, while older users (those aged 21 years and older) tend to smoke or inject the drug. A profile for a typical methamphetamine user did not emerge from the data; however, most respondents felt that methamphetamine use is most common in rural and suburban areas. Reportedly, methamphetamine is used in combination with alcohol, heroin, marijuana and sedative-hypnotics. Many participants reported that these drugs are used in combination with methamphetamine to "come down" from the extreme high associated with methamphetamine.

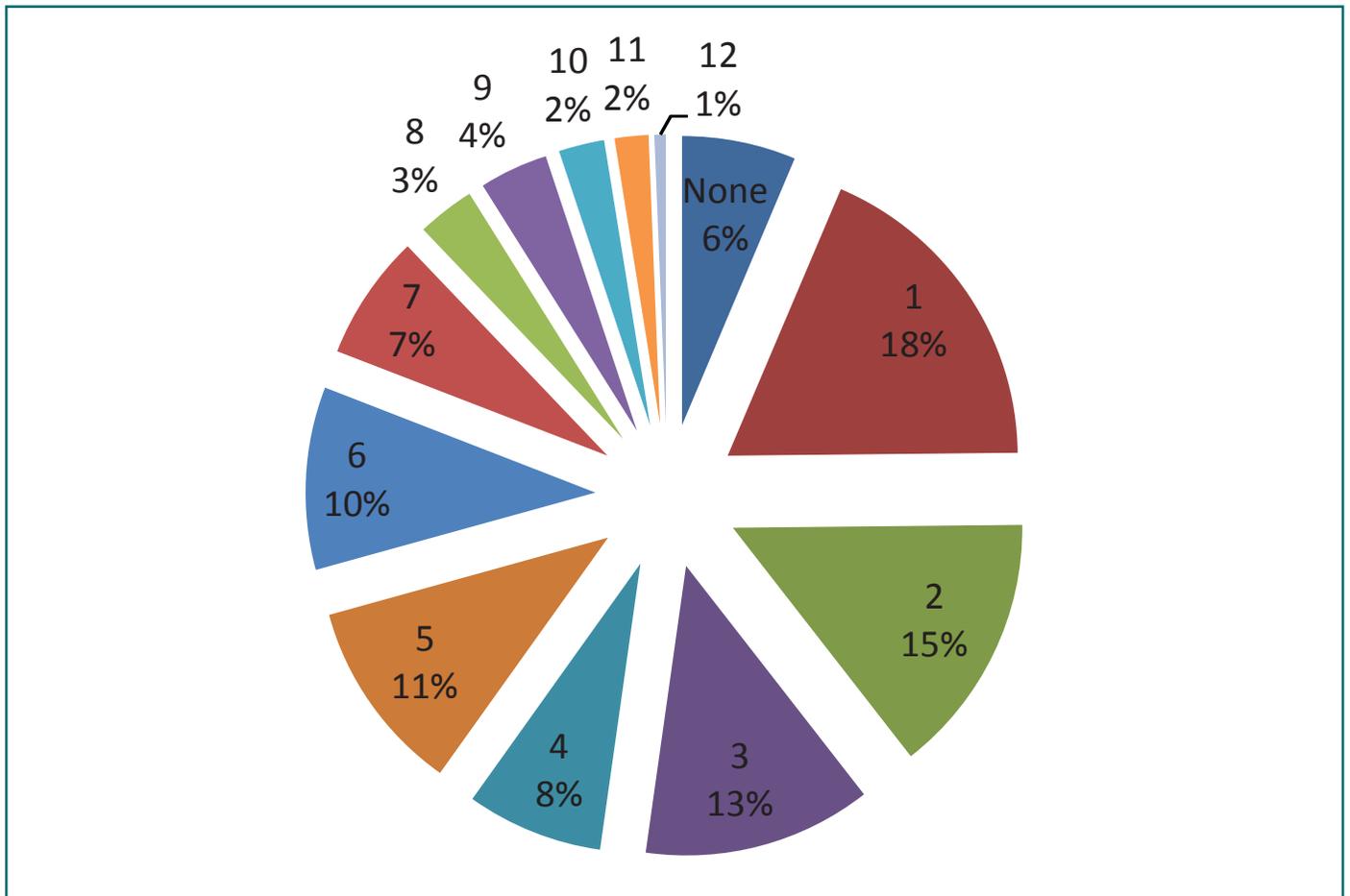
Suboxone® was infrequently used by study participants. Participants and community professionals reported Suboxone® to be moderately to highly available throughout most regions. According to a participant in the Akron-Canton region, Suboxone® is "very, very easy to get." A participant from the Athens region agreed, "Every day someone, somewhere will have a pocket full of Suboxone®." Only participants and community professionals in the Cincinnati region reported the current availability of Suboxone® as low. Sublingual (dissolving it under the tongue) administration of Suboxone® is the most common route of administration throughout the regions, with the exception of Youngstown, where snorting is reportedly the most common route of administration; most regions report some intravenous use of Suboxone®. Participants and treatment providers reported on the drug's popularity with heroin users aged 18-25 years who want to detox from heroin without being sick or who just desire to avoid withdrawal (aka "dope sickness") when heroin cannot be obtained. Reportedly, Suboxone® is used in combination with alcohol, crack cocaine, powdered cocaine, marijuana and sedative-hypnotics.

### Conclusion

Epidemiological data presented in this report have the potential to help shape and strengthen prevention measures targeted at those aged 18-25 years. Data indicate that poly-substance use is common among those aged 18-25 years who abuse alcohol and/or other drugs: more than 80 percent of participants who reported drug use during the past six months reported using two or more substances. Substances most commonly abused by this population appear to be marijuana, alcohol, prescription opioids, heroin, sedative-hypnotics, powdered cocaine and crack cocaine. Thus, prevention planning targeted at those aged 18-25 years should consider poly-substance use. In addition, study findings generated the following considerations when targeting specific drug use among this population: males appear more likely to engage in alcohol and marijuana use than females; Whites, aged 21-25 years, and those with at least some college, appear most likely to abuse prescription opioids; Whites appear more likely than those of other races to use heroin and powdered cocaine, and to abuse sedative-hypnotics; and those aged 21-25 years appear more likely to use crack cocaine than those aged 18-20 years. Data also indicate that many of those aged 18-25 years initiate drug use prior to age 18 years. Participants and community professionals most often described first-time marijuana use to occur at age 10-13 years; first-time prescription opioid use to occur at age 14-16 years; first-time heroin use to occur as young as age 15 years; and first-time crack cocaine use to occur around age 16 years. Thus, to fully accomplish the goals of decreasing the number of those aged 18-25 years engaged in high-risk alcohol use, illicit drug use and misuse of prescription medications, prevention strategists need to be mindful that initiation of drug use often occurs prior to age 18 years. Prevention targeted at those younger than 18 years is also important to affecting drug use in those aged 18-25 years. By also targeting prevention strategies at those younger than 18 years, the incidence of drug abuse is likely to decrease among those aged 18-25 years.

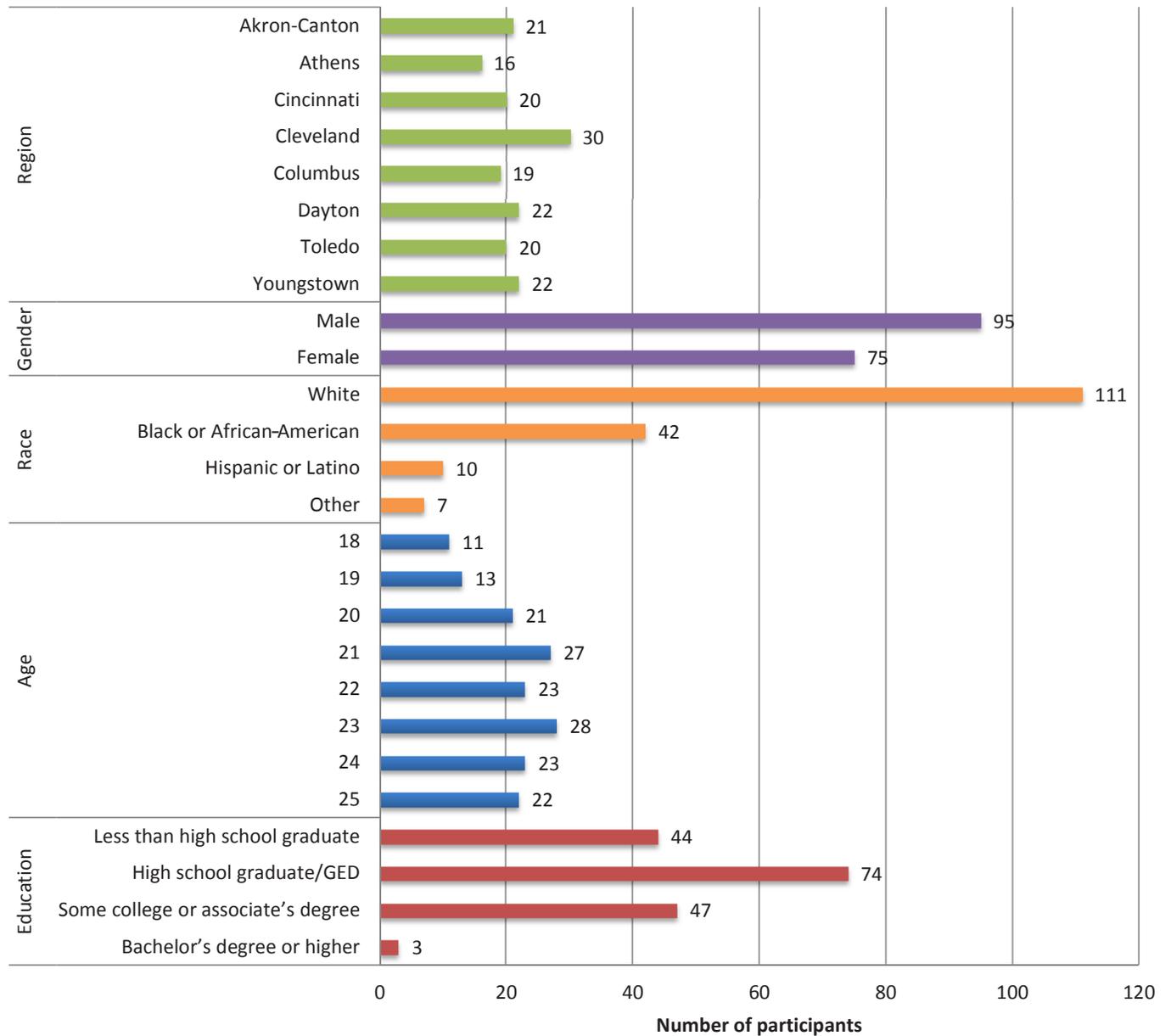
**Figure and Tables**

**Figure 1: Number of Drugs Used by OSAM Network Study Participants During the Past Six Months (N=157<sup>1</sup>)**



Thirteen respondents did not provide information on drugs used.<sup>1</sup>

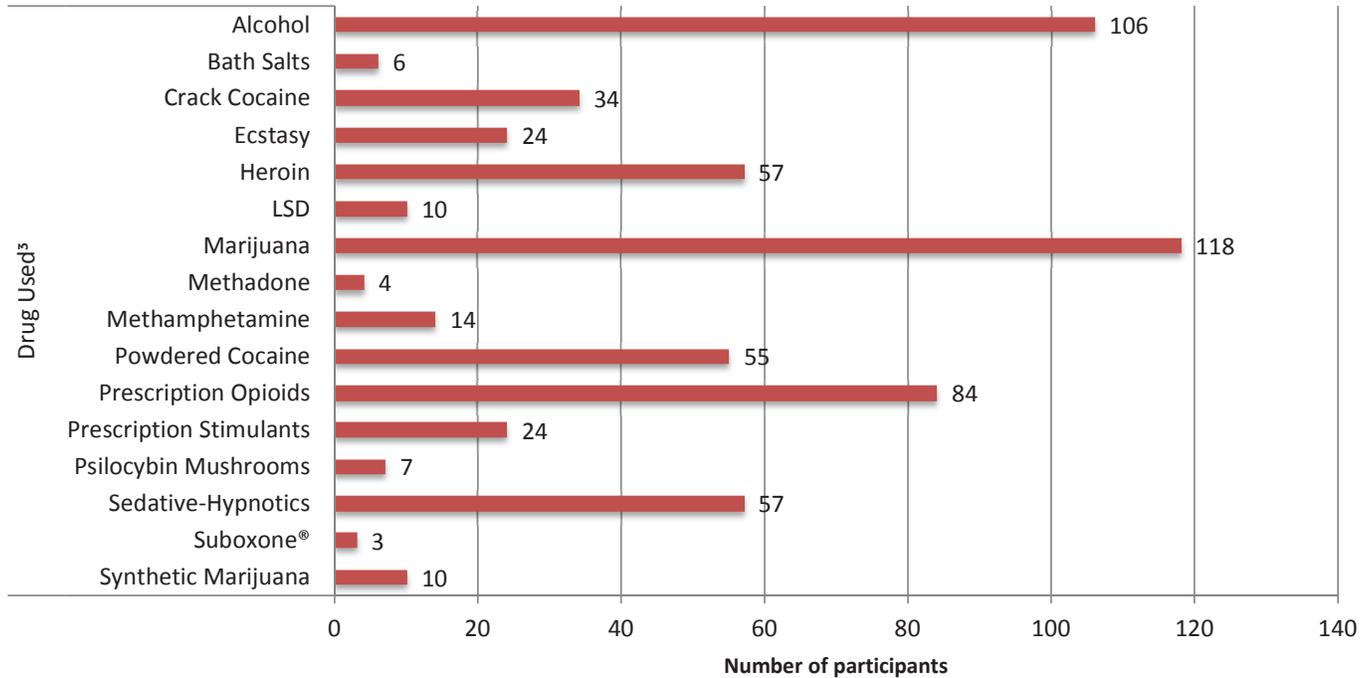
**Table 1: Characteristics of OSAM Network Study Participants (N=170<sup>1</sup>)**



Not all participants responded to every demographic survey question; thus, variable Ns may not equal 170.<sup>1</sup>



**Table 2: Drugs Used During the Past Six Months by OSAM Network Study Participants<sup>1</sup> (N=157<sup>2</sup>)**



Drugs used by only one respondent are not depicted in this table: DMT, ketamine, Lamictal<sup>®</sup>, mescaline, over-the-counter cough medicine and other (unspecified).<sup>1</sup>

Thirteen respondents did not provide information on drugs used.<sup>2</sup>

Some respondents reported multiple drugs of use during the past six months.<sup>3</sup>



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Department of Alcohol &  
Drug Addiction Services

**OSAM**

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