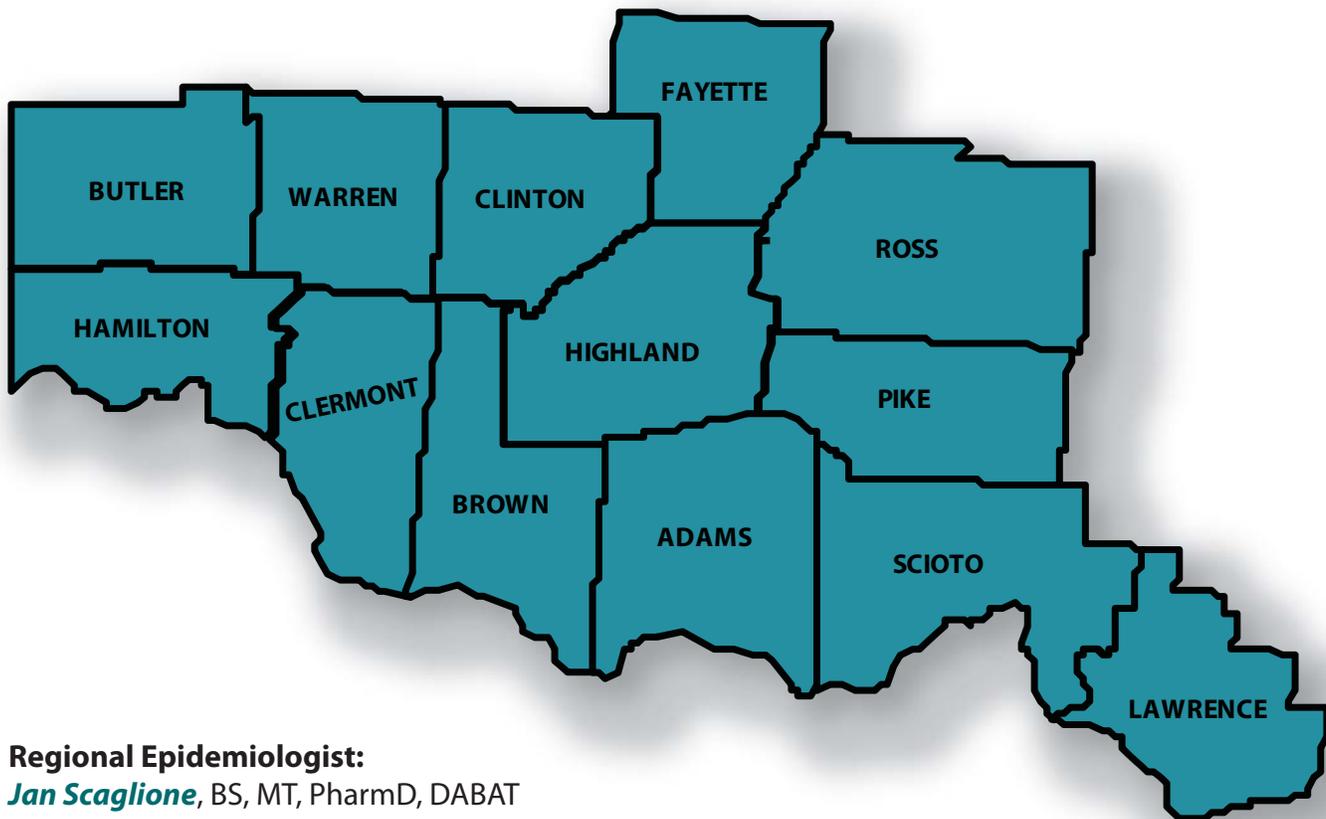


# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Cincinnati Region

June 2010-January 2011

John R. Kasich, Governor  
Orman Hall, Director



### Regional Epidemiologist:

**Jan Scaglione**, BS, MT, PharmD, DABAT

### OSAM Staff:

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

Principal Investigator

**Rick Massatti**, MSW

Research Administrator

### Regional Profile

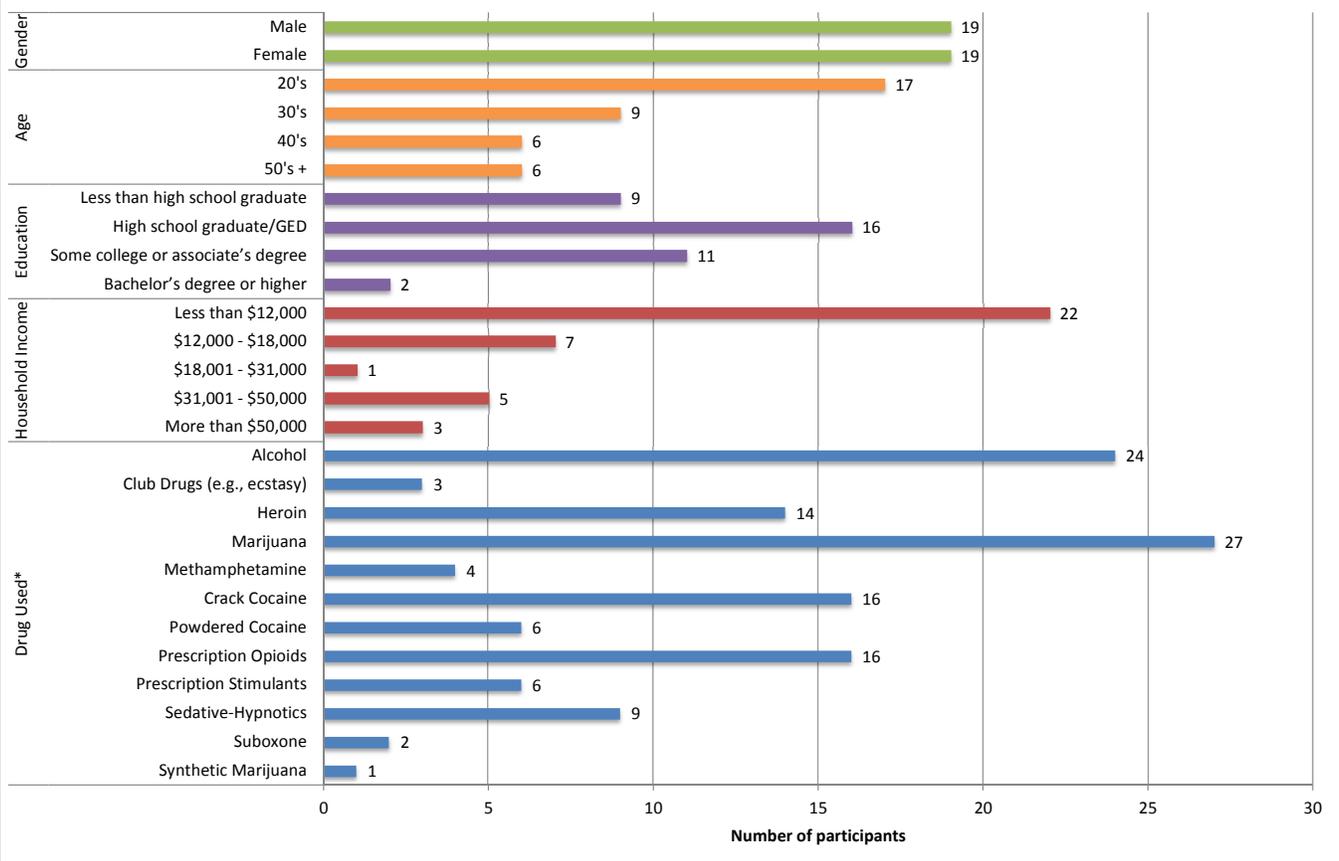
Indicator <sup>1</sup>	Ohio	Cincinnati Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	2,053,493	38
Gender (Female), 2009	51.2%	51.1%	50.0%
Whites, 2009	82.2%	83.2%	47.4%
African Americans, 2009	11.9%	12.6%	47.4%
Hispanic or Latino Origin, 2009	2.8%	2.0%	2.6%
High school graduates, 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)

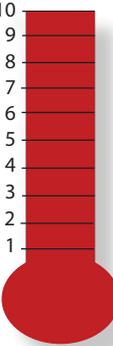


\*Some respondents reported multiple drugs of use over the past six months.

## 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

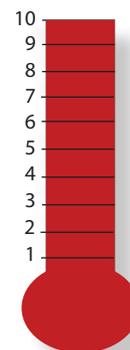
lower, ranging from \$20,000 – \$23,000. Several participants described intranasal inhalation (i.e., snorting) as a common route of administration for powdered cocaine. This route was described as a primary route that “beginners” use, as well as White professionals and college students. If a “snorter” 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.”*

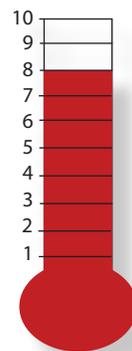
While there were a few reported ways of consuming crack cocaine, the most common route of administration by far is smoking. Many participants reported that it is very common for a user to break down and re-rock crack cocaine if there is a perception that the quality of the product purchased is low. As 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.

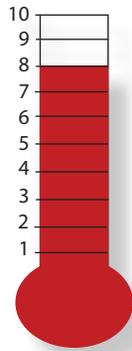
Reportedly, when used in combination with other drugs, heroin is most often used in combination with alcohol, benzodiazepines and marijuana. Participants reported the co-injection, or successive use, of cocaine with heroin (i.e., "speedball") as a common practice among participants.

## 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.

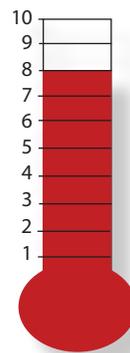
Overwhelmingly, both participants and professionals described the abuse of prescription opioids as beginning with legitimate use for pain conditions. Individuals that become dependent on opioids from legitimate use were not categorized to fit into a stereotype of a typical user by respondents. The first 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.

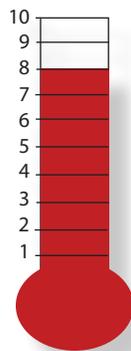
Most participants reported the use of Suboxone® on the street to be for primary prevention of withdrawal from prescription opioids or heroin. A shift to use of both Suboxone® and Subutex® for abuse purposes emerged after discussion with both participants and professionals. A participant stated, *"Suboxone® 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

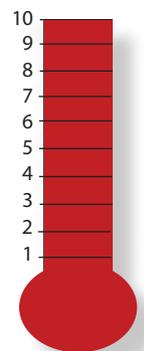
these medications. Participants reported first time users of sedative-hypnotics to be as young as 12 to 13 years of age, which was attributed to widespread availability in the home by a parent or other family member. Professionals also described sedative-hypnotic users as middle-to-upper income professionals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

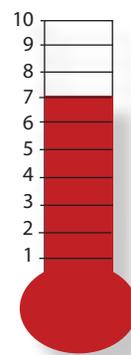
Current street jargon includes countless names for marijuana. The most commonly cited names largely depended on the grade of marijuana. Participants listed the following as other common street names: “Bobby Brown,” “bull crap,” “dirt weed,” “Mexican dirt weed,” “middies,” “regular good” and “schwag” 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

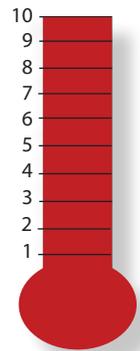
participant reported that a methamphetamine “cook” would pay \$20 per person to buy pseudoephedrine. Media reports over the past four months have shown methamphetamine to be available in the region. The *Cincinnati Enquirer* reported three methamphetamine labs found in Clermont and Warren counties (<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.”

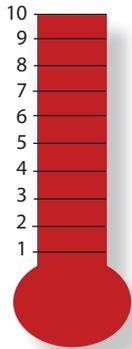


Slang terms used to describe ecstasy include “beans,” “beaners,” “cookers,” “eye fryers,” “rolls” and “sals.” Participants reported tablets with various imprinted pictures on them as the form of ecstasy available. Reportedly, the most common pictures on ecstasy tablets are of Superman and naked women. 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. Alarmingly, 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.