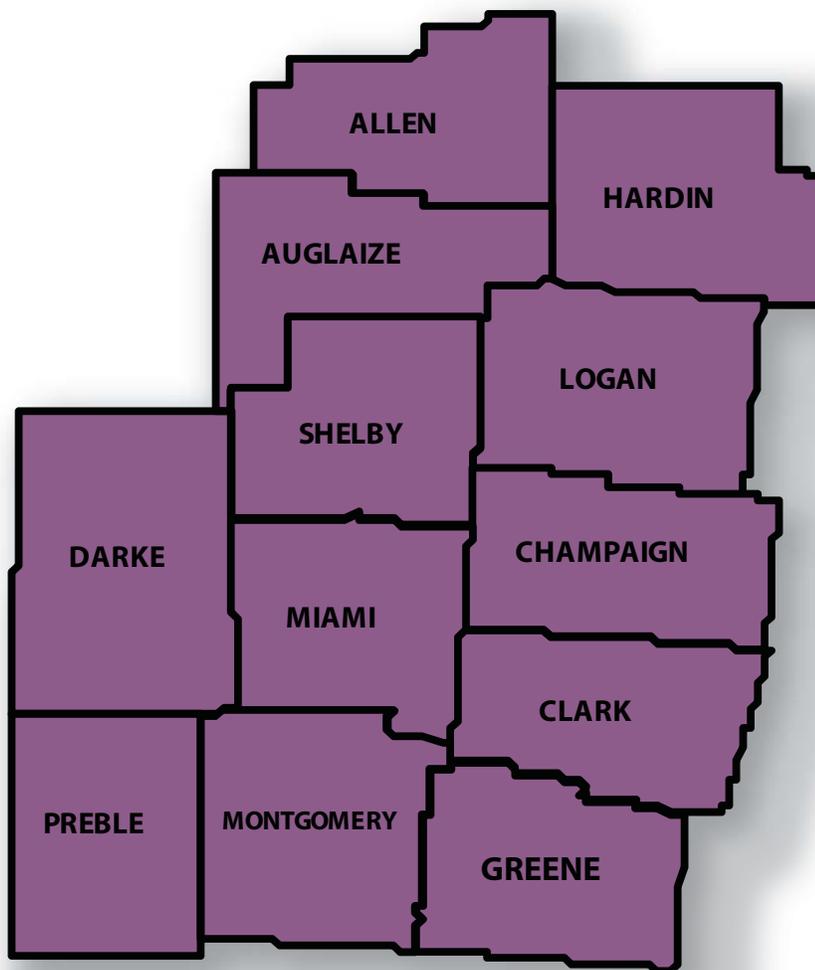


Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Dayton Region

June 2010-January 2011

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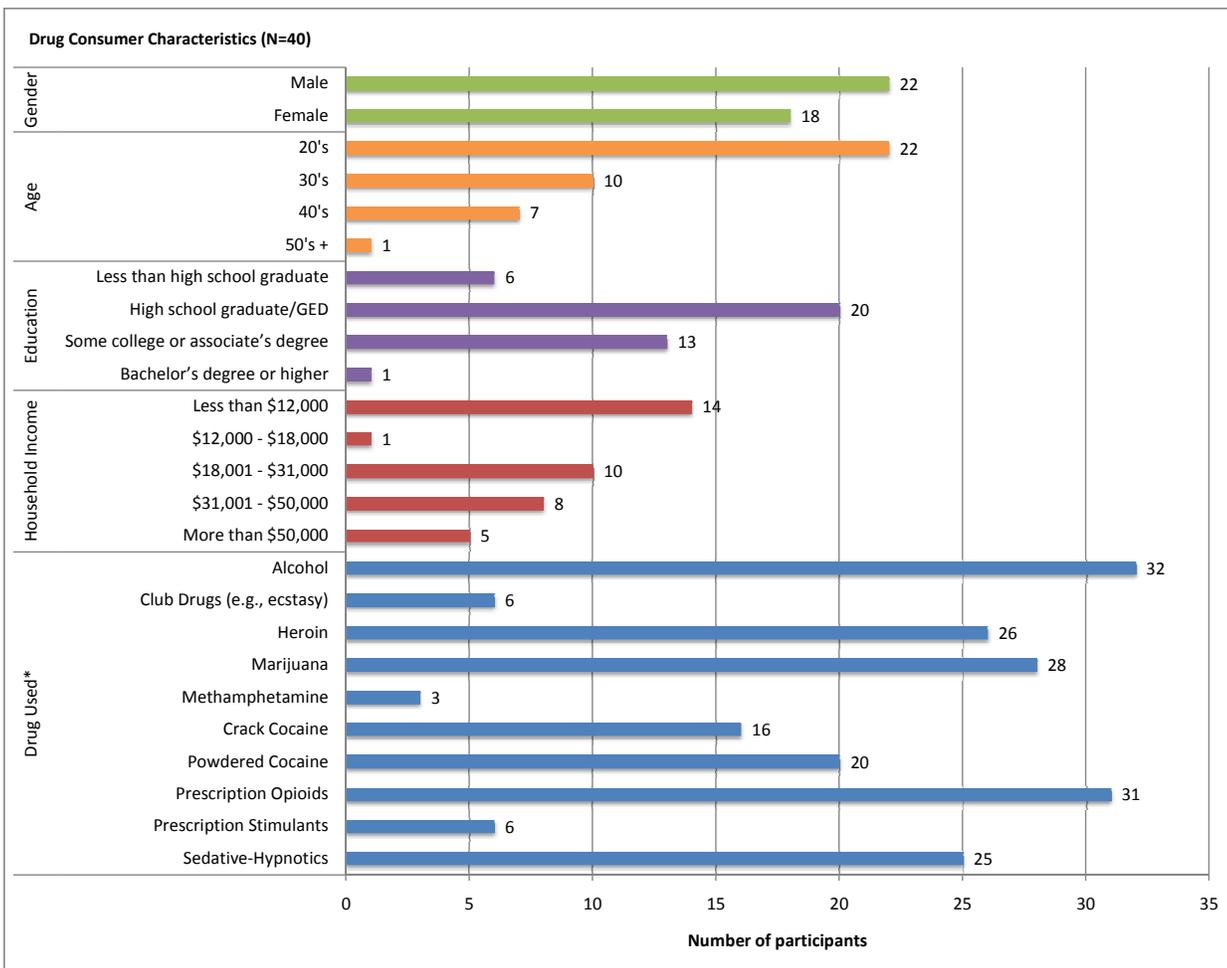
Regional Profile

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

Ohio and Dayton statistics are derived from the U.S. Census Bureau¹.

Respondents reported income by selecting a category that best represented their household's approximate income for 2009².

Poverty status was unable to be determined for two respondents due to missing or insufficient income data³.

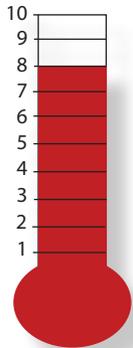


*Some respondents reported multiple drugs of use over the past six months.

Data Sources

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

Powdered Cocaine Current Trends



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

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

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

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

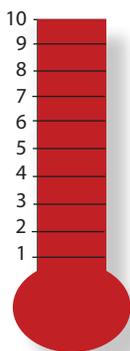
Current street jargon includes many names for powdered cocaine. The most commonly cited names were "blow," "girl" and "soft." Participants listed the following as other common street names: "booger sugar," "devil," "fish scale," "nose candy," "pearl," "powder," "snow," "that girl," "toot," "white" and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

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

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

Crack Cocaine Current Trends

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



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

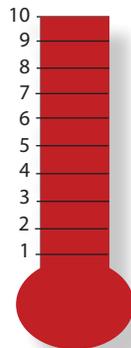
Current street jargon includes many names for crack cocaine. The most commonly used were "hard" and "rock." Other names included: "A1," "boulders," "butter," "cocoa puffs," "dope," "medicine," "shit," "yank," and "yay-yo." Participants reported that a 1/10 gram, or "dime," of crack cocaine sells for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

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

Heroin

Current Trends

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



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

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

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

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

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

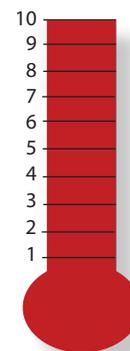
Beyond the many participants who indicated heroin use with powdered cocaine, the most common drugs reportedly used with heroin are benzodiazepines, particularly Xanax®. Other substances used in combination with heroin are alcohol, Dilaudid®, marijuana, methamphetamine and Opana®.

Prescription Opioids

Current Trends

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

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



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

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

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

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

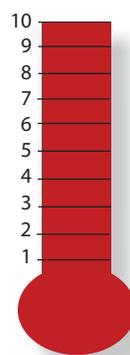
While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the most common route of administration is oral consumption,

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

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

Suboxone®

Current Trends



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

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

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

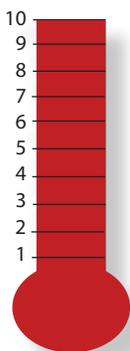
No slang terms or common street names were reported for Suboxone®. Participants reported current prices for Suboxone® 8 mg to range from \$7 – \$20, with the most frequently reported price being \$10. Reportedly, Suboxone® is most often taken sublingually, letting it dissolve under the tongue. Several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

Sedative-Hypnotics

Current Trends

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

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



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

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

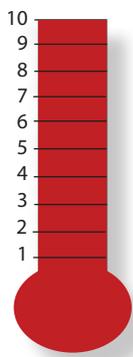
In addition to obtaining sedative-hypnotics on the street from dealers, participants reported visiting primary care physicians, emergency room physicians, psychiatrists and nurse practitioners to obtain prescriptions for these drugs. A participant reported, *“I get them [sedative-hypnotics] from my mom,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

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

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

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

Marijuana Current Trends



Marijuana is highly available in the region. Participants most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants and treatment providers described marijuana as being extremely easy to get. Marijuana appears to be the drug of choice for juveniles involved in court systems around the region. More than 40 percent of juveniles involved in the Logan County Family Court system reported use

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

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

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

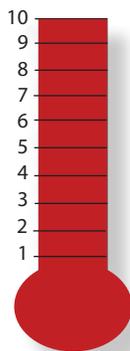
Current street jargon includes countless names for marijuana. The most commonly cited name was “weed.” Participants listed the following as other common street names: “cheap Mexican,” “commercial,” “ditch weed” and “seed weed” for low to mid-grade marijuana; “kush,” “Meigs County’s finest” and “purple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

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

Methamphetamine Current Trends

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

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



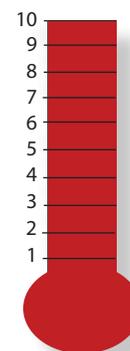
Participants reported that the quality of methamphetamine was very low, with the only score given by all participants who responded being '0' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants who were frequent users of the drug described it as "lithium-cut" and "eat-your-brain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

Ecstasy Current Trends

Ecstasy [Methylenedioxymethamphetamine (MDMA)] is highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants did not believe that the availability of ecstasy has changed over the last six months. A participant stated, "It's [ecstasy] always there, but

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

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



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

Other Drugs

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

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

Conclusion

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