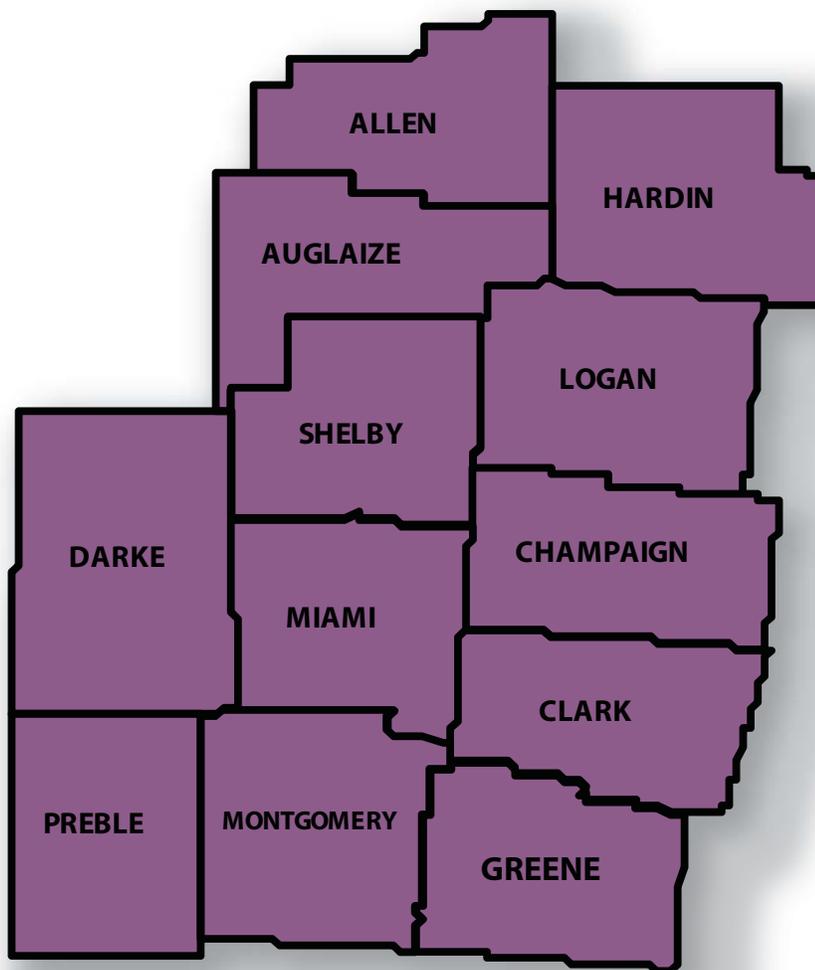


Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Dayton Region

June 2011-January 2012

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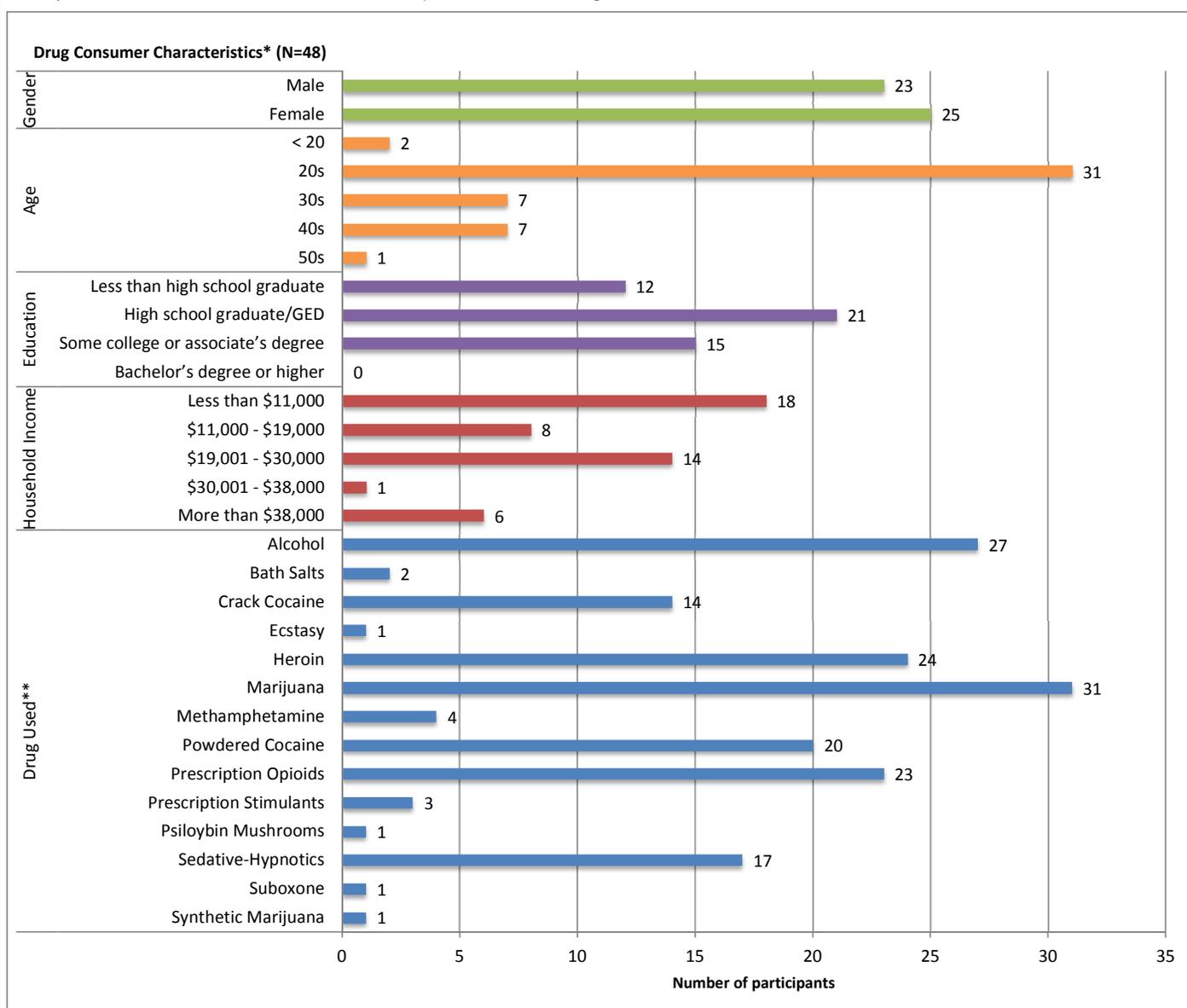
Dayton Regional Profile

| Indicator ¹ | Ohio | Dayton Region | OSAM Drug Consumers |
|----------------------------------|------------|---------------|----------------------------------|
| Total Population, 2010 | 11,536,504 | 1,352,510 | 48 |
| Gender (Female), 2010 | 51.2% | 51.2% | 52.1% |
| Whites, 2010 | 81.1% | 83.1% | 85.4% |
| African Americans, 2010 | 12.0% | 11.3% | 14.6% |
| Hispanic or Latino Origin, 2010 | 3.1% | 2.0% | 0.0% |
| High school graduates, 2009-2010 | 84.3% | 88.1% | 75.0% |
| Median household income, 2010 | \$45,151 | \$45,115 | \$11,000 - \$19,000 ² |
| Persons below poverty, 2010 | 15.8% | 15.6% | 59.6% ³ |

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

Respondents reported income by selecting a category that best represented their household's approximate income for 2011. Income status was unable to be determined for one respondent due to missing data.²

Poverty status was unable to be determined for one respondent due to missing or insufficient income data.³



*Not all participants filled out forms; therefore, numbers may not add to 48.

**Some respondents reported multiple drugs of use during 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 Allen, Champaign, Logan, Miami, Montgomery and Shelby counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers, law enforcement, regional crime Lab and coroner's office staff) via individual and focus group interviews, as well as to data surveyed from the Miami Valley Regional Crime Lab and Montgomery County Juvenile Court. All secondary data are summary data of cases processed from January through June 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, all current secondary data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for July through December 2011.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Many participants noted that in rural areas of the region more effort was required to obtain powdered cocaine. Law enforcement officers reported that powdered cocaine was readily available, but mostly as it related to the sale of crack cocaine. Participants reported that the availability of powdered cocaine had remained the same during the previous six months; although users and officers noted that heroin dealers were more likely to carry powdered cocaine than crack cocaine. There were two reasons cited for dealers to carry powdered cocaine: convenience for users who preferred to mix heroin with powdered cocaine (aka "speedball"), and since the quality of crack cocaine was reportedly so poor, some users preferred to obtain powdered cocaine to "rock up" (manufacture) their own crack cocaine. Most participants rated the quality of powdered cocaine as '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The Miami Valley Crime Lab continued to cite levamisole (livestock dewormer) as a cutting agent for powdered cocaine. Participants reported that a gram of powdered cocaine sold for between \$50-80, depending on quality. However, the most commonly purchased unit remained the "cap" (gelatin capsule prefilled with about 1/10 gram of powdered cocaine); caps sold for between \$10-12. Participants reported that the two most common ways to use

powdered cocaine were snorting and intravenous injection. Many users only consumed powdered cocaine when they used heroin to speedball. Participants continued to report that powdered cocaine use crossed all ages, races and socio-economic classes.

Current Trends

Powdered cocaine remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Many participants commented that it would not take long to obtain powdered cocaine: *"An hour tops."* Participants in outlying areas reported that it may take longer for them to obtain powdered cocaine: *"In town [powdered cocaine] it's put on the backburner compared to some of the other drugs. Three to four phone calls [needed] to get a connection or to get a lead [on powdered cocaine for purchase]."* Community professionals most often reported the drug's current availability as '7'. A treatment provider reported, *"It's not that they [users] can't find it [powdered cocaine]; the need isn't there."* Media outlets in the region reported on powdered cocaine seizures and arrests this reporting period. In September, police found guns, cocaine, cash and drug paraphernalia inside a West Carrollton (Montgomery County) house (www.whiotv.com, Sept. 16, 2011). Also in September, a traffic stop in Preble County netted highway patrol two kilos of cocaine with a street value of \$200,000 (www.nbc4i.com, Sept. 29, 2011).

Participants reported that the availability of powdered cocaine has remained the same during the past six months. A powdered cocaine user reported, *"It [powdered cocaine availability] depends on if you have connections and middlemen. If you have connections, and you have credibility in the drug using community, you can get it faster and easier."* Community professionals reported that availability of powdered cocaine has decreased during the past six months. A treatment provider explained, *"When heroin took its big push and came back in, powdered cocaine slowed down a little bit, but especially among White people."* Law enforcement in an outlying area discussed a reduced focus on cocaine because of limited resources and a greater focus on heroin: *"With just two of us [law enforcement] working, your focus is just one area [one drug] at a time."* Treatment providers agreed that there is a reduced focus on cocaine: *"It [powdered cocaine] isn't as important as it used to be ... not in demand."* Heroin was identified as the substance that has reduced the demand for cocaine in the region. The Miami Valley Regional Crime Lab reported that the number of powdered cocaine cases it processes has increased during the past six months.

Most participants rated the quality of powdered cocaine as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '3.' Participants reported that powdered cocaine in Dayton is cut (adulterated) with baby laxatives, baby Tylenol®, creatine, ether, isotol, mouth numbing agents and Similac®. Mouth numbing agents are used by sellers to make the buyers think that the powdered cocaine is a higher quality. When a buyer puts powdered cocaine on his or her tongue, he or she expects higher quality cocaine to have a numbing effect. Participants reported that the quality of powdered cocaine has varied throughout the region. Participants closer to Dayton reported better quality, while those in more rural areas reported that powdered cocaine is cut more. When discussing quality of powdered cocaine, a user in the City of Dayton noted: "Stuff gotten has been good. [Powdered cocaine] it's gotten better in the past six months, clear and draws up good." Another participant in an outlying area observed: "[Powdered cocaine] it's being cut more because people aren't buying it as much." The Miami Valley Crime Lab continues to cite levamisole (livestock dewormer) as a common cutting agent for powdered cocaine.

Current street jargon includes many names for powdered cocaine. The most commonly cited names remain "girl" and "soft." Participants listed the following as other common street names: "coke," "Christina Aguilera," "Lindsay Lohan," "powder," "white b****," "white girl" and "ya-yo." Current street prices for powdered cocaine were variable among participants with experience buying powdered cocaine, depending on quality and location of the buyer. Participants reported that 1/10 gram of powdered cocaine, or "cap," sells for \$10; a gram sells for between \$30-95; 1/16 ounce, or "teener," sells for between \$50-100; 1/8 ounce, or "eight ball," sells for between \$110-300. Reportedly, the most common unit of purchase for powdered cocaine is by the gram, with a participant noting, "It's more common for teeners if you don't have as much money [to buy an eight ball of powdered cocaine]." Individuals in outlying areas reported higher prices. A participant reported, "People will buy [powdered cocaine at higher prices] when they feel like they can't go anywhere else." Participants continued to report that the most common ways to use powdered cocaine are snorting and intravenous injection. Snorting and injecting as routes of administration are reportedly about equal in occurrence among users, with participants reporting that roughly 10 percent of users obtain powdered cocaine for smoking. Participants continued to report that use varies depending on personal preferences. A participant stated, "Some people don't like needles."

A profile for a typical powdered cocaine user did not emerge from the data. Participants continued to describe typical users of powdered cocaine as younger and older, Black and White, and of different professions. A participant commented,

"I think everyone in this town wants to get high on coke. It's a party drug around here." Powdered cocaine was reported to have an elite status, with participants and community professionals identifying those in higher socio-economic classes as more likely to use powdered cocaine: *"It [powdered cocaine] doesn't have the stigma that crack [cocaine] does."* Treatment providers and law enforcement identified users of powdered cocaine as more likely White individuals in a higher socio-economic class. Participants reported that younger people (16-30 years) are getting into powdered cocaine, with 14 years reported as the youngest known user age among participants. A participant commented, *"[Powdered cocaine] it's less [popular] than 10 years ago. You don't hear it that much when you talk to people. A whole lot of people got locked up. The younger generation, kids, are messing around with the hardcore drugs more than the actual adults; 17-23 [years] is a typical age of a lot of the [powdered cocaine] use."* Community professionals agreed that the use of powdered cocaine is increasing in the 18-25 year age group. The Miami Valley Regional Crime Lab Coroner's Office identified cocaine as the fourth leading cause of death by overdose; however, it must be noted that the lab cannot differentiate between powdered cocaine and crack cocaine in toxicology reports. Deaths are mostly of males, and the common age range for overdose by cocaine is 35-50 years. In discussing the age range, the coroner's office reported, *"Cocaine is a funny drug in that you can use it forever, but it takes such a toll on your heart . . . it won't actually kill you until you are older and have more heart issues."*

Reportedly, powdered cocaine is used in combination with alcohol, heroin (speedball), marijuana and sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants). Most participants reported use of other substances with powdered cocaine to "come back down" from the stimulant high produced by cocaine. Participants reported: *"More people are using pills [sedative-hypnotics] or heroin to come back down [from powdered cocaine]; I prefer to do my uppers and then downers."* A participant highlighted the practice of speedball: *"If you have the money to do both [powdered cocaine and heroin], you'll do both for the buzz."*

Crack Cocaine **Historical Summary**

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants noted that drug dealers were switching from crack cocaine to heroin sales. Law enforcement and treatment providers agreed that crack cocaine was highly available in both urban and rural areas. However, due to the explosion of other drugs such as heroin and prescription opioids, community professionals felt that resources had been

shifted away somewhat from crack cocaine to the abuse-related problems of other substances. Most participants and community professionals reported that the availability of crack cocaine remained the same during the previous six months. The most common participant quality score for crack cocaine was '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut with other substances. The Miami Valley Regional Crime Lab cited levamisole (livestock dewormer) and phenacetin (analgesic) as cutting agents. Participants reported that a gram of crack cocaine sold for \$50, depending on quality. The majority of crack cocaine users reported buying the drug in small quantities called "dimes" (1/10 gram) for \$10. Most participants who used crack cocaine reported smoking it. Participants said that crack cocaine use crossed all ages, races and socio-economic classes.

Current Trends

Crack cocaine remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Most participants agreed that crack cocaine is more available than powdered cocaine. Participants often said things like, "I can make two calls right now, and I could have as much crack [cocaine] as we wanted." Some areas within the region identified that it is easier to get crack cocaine than heroin. Community professionals most often reported the drug's current availability as '10'. A treatment provider commented that there is, "more crack than powder [cocaine]." Participants reported that the availability of crack cocaine has remained the same during the past six months, and they believed crack cocaine has always been pretty available, but other drugs currently might be more popular. As one participant said, "We've always been known for crack." Community professionals reported that availability of crack cocaine has remained the same during the past six months. Although it was reported that the availability of crack cocaine has stayed consistent, a community professional stated, "More White users are going from powdered [cocaine] to heroin and Black users are staying with crack." Generally, community professionals thought this trend was common. The Miami Valley Regional Crime Lab reported that the number of crack cocaine cases it processes has decreased during the past six months.

Most participants rated the quality of crack cocaine as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Participants reported that crack cocaine in Dayton is cut with baking soda. Most participants reported that the quality of crack cocaine has remained the same during the past six months. The Miami

Valley Regional Crime Lab reported that crack cocaine continues to be cut most often with levamisole (livestock dewormer).

Current street jargon includes many names for crack cocaine. The most commonly cited names remain "hard" and "rock." Participants listed the following as other common street names: "butter," "stones" and "work." Current street prices for crack cocaine were consistent among participants with experience buying crack cocaine. Participants reported that a "rock" (1/10 gram) sells for between \$10-20; a gram sells for between \$100-120, depending on the quality; 1/8 ounce sells for between \$85-200. Participants across the region had different opinions about whether scales are typically used to weigh the product. Some participants reported, "You don't see it [crack cocaine weighed] on scales; it's not a sit-down type of deal." Others reported, "They weigh it [crack cocaine] in Bellefontaine and make sure it's on point." A participant discussed the variable size of crack cocaine: "It [size of crack cocaine] depended on how much money I had and how generous the dope man wanted to be. If I went with \$20 twice in a day, earlier in the day I might get a big 20 [rock] and the next time might be tiny." While there were a few reported ways of administering crack cocaine, the most common route of administration remains smoking. Participants reported that between 99-100 percent of users smoke crack cocaine, with a minority choosing to intravenously inject the drug. A participant commented, "I know people that will shoot it [crack cocaine]; they mix it with vinegar, but it's not common."

A profile of a typical user of crack cocaine did not emerge from the data. Most participants described typical users of crack cocaine as belonging to each gender and every racial and age group. However, a participant claimed to see women using more: "It's easier for them [women] to get [crack cocaine]. The ones I've seen [will] do anything to get the substance." Participants said that even those you would not expect to use crack cocaine, use the drug. In the experience of one participant, "My aunt chooses to sell her food stamps and cash assistance for crack." Professionals agreed that younger people are being introduced to crack cocaine earlier than in previous times. However, another community professional discussed an increase in the older age groups starting to use crack: "There does seem to be another population I've been noticing recently ... like the 45 year old that starts using crack after a long career of drinking or other things ... it's not that they've been using crack the whole time, but they've just picked it up in the past five to 10 years."

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana and sedative-hypnotics. Users reported that combining drugs with crack cocaine helps to, "take the edge off" and that it, "helps you not bite down so hard" in reference to the side effects of crack cocaine. Two

participants described crack as a drug used mainly by itself, with some agreement from other participants: *“Crack is crack ... it’s a solo drug; Once you’re smoking crack, you’re done.”*

Heroin Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants and community professionals most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants noted an emerging trend among dealers and their users of switching from crack cocaine to heroin. Dealers were said to be aggressively pushing heroin, often giving away testers (free samples). While many types of heroin were available in the region, participants reported brown powdered heroin as the most available, and most commonly obtained in caps (gelatin capsules prefilled with about 1/10 gram of powdered heroin) that sold for \$10 each. In addition to being widely available in the region, heroin was also identified as the region’s most urgent substance abuse problem by participants, law enforcement and treatment providers, all of whom reported an increase in heroin availability during the previous six months. Most participants rated the quality of brown powdered heroin as ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). According to the Miami Valley Regional Crime Lab, cutting agents for heroin continued to include diphenhydramine (antihistamine) and caffeine. Participants continued to report that the most common way to use heroin was intravenous injection. Law enforcement and treatment providers identified typical heroin users as, *“lower income, late 20s and White.”* Participants continued to note progression from prescription opioids to heroin. Participants also continued to recognize that new users were younger than previously and lacked knowledge about the drug.

Current Trends

Heroin remains highly available in the region. Participants most often reported current overall availability of heroin as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10.’ While many types of heroin are currently available in the region, participants reported the availability of brown powdered and black tar heroin as most available. Participants most commonly described brown powdered heroin as a little lighter in color than brown sugar, white powdered heroin as off-white,



and black tar heroin as similar in appearance to the residue from a marijuana pipe. The Miami Valley Regional Crime Lab described the powdered heroin cases they process as white, off-white, tan and brown. Heroin type and availability varies throughout the region. The City of Dayton reported more brown powdered heroin; Lima (Allen County) reported more white powdered heroin; and smaller cities in Hardin, Logan and Shelby counties reported more black tar heroin. Participants in outlying areas reported, *“Tar [black tar heroin] is very available. I don’t have to make phone calls, dealers are calling me.”* Participants all agreed that heroin generally is, *“falling out of the sky.”* Community professionals most often reported the drug’s current availability also as ‘10,’ the previous most common score was ‘9’ or ‘10.’ A treatment provider observed that dealers are pushing heroin more: *“Dealers are actually marketing heroin by providing free samples to people who come to buy other drugs.”* Law enforcement discussed, *“If you go to buy prescription drugs from a drug trafficker, an illicit drug trafficker, they will actually give you one or two caps of heroin to try. Once you get your person hooked, they’ll come back, and they’ll bring more people with them.”* A participant remarked, *“[Dealers] know that once they [heroin dealers] get someone hooked, they’ve got their bread and butter every day.”* Media outlets in the region reported on heroin seizures and arrests this reporting period. In an August drug raid on a Dayton home, police found a stolen police-issued firearm, more than \$16,000 in cash and enough heroin to produce nearly 1,000 gel caps for sale to, *“geeks, White heroin addicts — and other dealers;”* police estimated the street value of the seized heroin at \$10,000 (www.daytondailynews.com, Aug. 5, 2011). Another drug bust in Dayton in September led to the arrest of at least one person; police reportedly seized an unspecified amount of heroin along with several guns (www.whiotv.com, Sept. 7, 2011).

Participants reported that the availability of powdered and black tar heroin has increased during the past six months. A participant linked the increase in heroin availability to the formulation change in OxyContin® that occurred in September 2010. Other participants discussed how heroin is cheaper than prescription opioids: *“I was doing pills [prescription opioids], and they got too expensive ... [with heroin I] got a longer high for half the money.”* Another participant remarked, *“It’s [heroin] cheap ... most of the time it’s good [quality].”* And still another participant discussed the economic climate and heroin use, *“Jobs have went down and a lot of people have gotten fired and going to selling dope. Also people losing jobs tend to gravitate to using drugs. Drug use goes up when unemployment goes up.”* Heroin was noted as being prevalent in the 18-25 year age group. Community professionals also reported that availability of heroin has increased during the past six months. A law enforcement officer in Dayton discussed that the increase is, *“not only in the*

heroin but in the violence that goes with the heroin." The officer observed, "Before you kinda had to know a [heroin] dealer, and now you can just drive up to a gas station, and you'll be directed to a dealer eventually." While heroin availability has increased in Dayton, participants and law enforcement reported that availability has decreased in some rural areas of the region during the past six months. A few participants in outlying areas reported that heroin availability has decreased because, "They've [law enforcement] been cracking down on it [heroin trafficking]; The availability coming from big cities has gone down." Law enforcement in outlying areas concurred with participant reports in that they too have noted a reduced amount of heroin as a result of their efforts to focus on heroin in the community, targeting heroin trafficked from Dayton. The Miami Valley Regional Crime Lab reported that the number of heroin cases it processes has increased during the past six months.

Most participants generally rated the quality of heroin as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was also '8'. Participants reported that the quality of heroin has decreased during the past six months. In reference to quality, a heroin user reflected, "[Heroin] quality is worse. [Dealers] stomp [adulterate] on it [heroin] and cut it more; Everyone that loves and likes heroin will say, 'I wish it was better.' Of course you're going to say the heroin sucks because you always want it to improve if you're addicted." Another participant noted, "[Dealers] know that you're dope sick, so you'll pay for it [heroin], no matter what [quality]." Participants reported that they were uncertain with what heroin is being cut. According to the Miami Valley Regional Crime Lab, cutting agents for heroin continue to include: caffeine, diphenhydramine (antihistamine) and lidocaine (local anesthetic).

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "dog food." Participants listed the following as other common street names: "berries," "brown," "caps," "Charlie Brown," "dope" and "goat." Participants reported that brown and white powdered heroin are available in different quantities: "balloons" (1/10 gram) sell for \$25; a gram of heroin sells for between \$65-200. The most common way to purchase powdered heroin is by caps. The Miami Valley Regional Crime Lab reported that the most common form that they analyze is caps, but on occasion, they will see foil packets of heroin. A participant commented, "It's rare to buy grams or chunks [of heroin]." Caps sell for \$10-20, depending on location, with some participants reporting that some dealers sell three to four caps for \$20. Those who live further from Dayton or other larger cities pay more for the product

because the dealer is, "saving them a trip down and gas." The price for heroin in outlying areas is typically \$20 per cap while the price in Dayton is typically \$10 per cap. Participants reported that black tar heroin is most commonly purchased in single use amounts, or as one participant identified, "berries," that range from \$15-30. Overall, participants reported heroin pricing has increased during the past six months. Participants also reported that the most common way to use heroin remains intravenous injection. Out of 10 heroin users, participants reported that approximately nine would inject and one would snort. Most people identified injecting as popular because of the intensified effects: "I started out snorting it [heroin] for a month then someone said, 'You are wasting your money,' so I finally built up the courage to shoot [inject] it for the first time." Another participant identified, "Once you shoot it [heroin], you don't go back to snorting. The needles are addictive." On the progression from snorting to injection, a heroin user commented, "[Heroin users] they're gonna graduate to using the needle eventually." Another participant added, "If I see somebody snorting it [heroin], I'm like, 'man you're wasting it' ... especially if you don't have money."

According to participants with injection experience, 10 packs of needles are available for \$2 from popular retailers or are available from diabetics for \$5 a needle. Most participants reported that needles are usually purchased in 100 packs for \$20 from popular retailers. Participants also reported that dealers sell needles but are more likely to charge a higher price. When discussing needle use, some participants reported that they never used dirty needles, and others shared that they would use anything if they were "dope sick enough." A participant explained, "I never shared a needle, but I have sold my dirty needles to someone that is fiending [withdrawing from heroin]." Others remarked, "I've used [needles] after people. I cleaned them out with rubbing alcohol if I had it with me ... if not ... I'd rinse it out with water; I know lots of people that have shared needles. When you're using, you just want to get it [heroin] into your system, that's all that matters." Other participants would share needles if they knew the person; a participant stated, "I'd share [needles] with my boyfriend. If not [my boyfriend's needle], then I'd clean them out with bleach or burn the tips." Participants also reported increased difficulty in obtaining needles from certain pharmacies because of new store policies requiring them to show a prescription for needles. A participant remarked, "It's not against the law to buy needles. If you go to [the pharmacy], most of the time it's a store policy. They won't sell them to you if you don't have a prescription in their system for being a diabetic." This has caused some participants to reuse needles as a participant discussed, "I used the same one [needle] over and over because I was too embarrassed [to purchase needles

at a pharmacy]. I used three rigs like 50 times each because I was too embarrassed." Most participants identified that clean needles should be available because of the current heroin epidemic. A participant discussed the need for a needle exchange program in Dayton. Treatment providers discussed needle use among clients: Hepatitis and MRSA (Methicillin-Resistant Staphylococcus Aureus: a type of staph bacteria) cases are thought to be increasing. A treatment provider remarked, "Heard they [users] still share needles. They keep their needles; use the same needle over and over again." Participants admitted that they were not concerned about Hepatitis when actively using. One participant said, "At the time while I was using, no. After I got clean, it [needle sharing] scared me." Most participants reported an increased concern about contracting Hepatitis C and other blood-borne diseases. A participant explained, "I have Hepatitis C and a lot of people have Hepatitis. And, if people could get needles, we wouldn't have the problem [of Hepatitis infection]."

A profile of a typical user of heroin did not emerge from the data. Participants described typical users of heroin as any age: "Those you wouldn't think, would use it [heroin]. I've seen a 70-year-old man eat some Xanax® and do shots of dope [heroin]. I think the youngest person I've seen was probably a 15-year-old boy." Participants and community professionals agreed that there has been an increase in younger users of heroin, and both groups linked the increase in heroin use to prescription medications and prescribing patterns. A participant discussed the increase in younger users of heroin, "I have a 17-year-old cousin that's selling her body, shooting dope in her arm just to get high. When I was 17, I would never think of that. I'm 26, and I still don't like needles." Other participants remarked, "These younger generations will try anything. We weren't taught to try anything. Nowadays they don't care; There is a lot more prostitutes, and you see more needles at parks. In the past year, where I lived at ... I've lived there for five years ... in the past year, I can't even take my kids up to the park on the corner. There's so many needles and crack pipes and dirty condoms. It's disgusting." A treatment provider described typical heroin users as, "20-25, young, suburban, White folk." A treatment provider linked the use of heroin in younger users with prescription drugs: "They can get an introduction to prescription medications first before the street medications, and that can happen at home ... as 10 or 11 years old getting into the medicine cabinet." A law enforcement officer also highlighted the existence of a link between prescription opioids and heroin: "Especially now with the economic times we are in, a lot of these people are out of jobs ... they get depressed and start on prescription drugs for many different reasons, whether it be for depression, or they get on pain killers to numb the pain, so to speak. Then they'll be turned onto heroin because the word on the street gets around really quick. Sell your prescriptions and make money. You can use one

or two caps [of heroin] a day to do the same thing." Coroner's office staff reported that heroin is the leading cause of death by overdose and that heroin related overdoses have increased in the region. Of the heroin-related deaths there were more males identified with ages ranging from 20-60 years, with most between 30-40 years of age. Participants reported knowing people who have died from overdose, with one stating, "I lost a lot of people to heroin."

Reportedly, heroin is used in combination with cocaine (speedball), marijuana, prescription opioids and sedative-hypnotics. The Coroner's office reported that it is typical for heroin overdose cases to include a mixture of heroin with alcohol, cocaine, methadone or sedative-hypnotics. Participants reported that it is typical to mix other substances with heroin to intensify the effects, make the "rush" (high) last longer or to get a different effect: "Heroin will get you high the first time you get high that day, but with coke, every time you get the same rush." A participant discussed heroin use with sedative-hypnotics, "Benzo's [benzodiazepines] ... for some reason, those two [heroin and benzodiazepines] complement each other. One kicks the other one in." Another participant reflected, "[I] know a lot [of users] that use Xanax® with heroin, and a lot have OD'd [overdosed] because of it." Another participant commented on past use, "Back then my morning started with a shot of dope and a joint [marijuana], now it starts with a cup of coffee and a cigarette."

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported street availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants noted that prescription opioids were easily obtained from one of many known contacts, usually within a single phone call, and occasionally available from an unknown street-level dealer. Participants, law enforcement and treatment providers identified the most popular prescription opioids in terms of widespread use as methadone, Percocet® and Vicodin®. Only OxyContin® OC was reported to have decreased in availability in previous months. Opana® continued to be cited as gaining in popularity among users. While participants continued to report friends, family and other drug users as sources for prescription opioids, the most commonly reported source for these drugs remained through doctor visits. While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the most common routes remained oral ingestion and snorting. Participants and community professionals described typical users of

prescription opioids as White, lower income and young. A participant described prescription opioid abusers as, “future heroin users,” noting the pill-to-heroin abuse progression.

Current Trends



Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10’. Participants continued to identify methadone, Percocet® and Vicodin®, along with OxyContin® and Roxicet®, as the most popular prescription opioids in terms of widespread use. Community professionals most often reported current availability as ‘10,’ and identified methadone, OxyContin® and Vicodin® as the most popular prescription opioids. Coroner’s office staff reported that methadone is the second leading drug in drug-overdose deaths (after heroin). Ages for methadone overdose ranged from 19-58 years. In addition, of those 18 years of age and younger, the majority of deaths by overdose were related to methadone. A participant discussed, “A lot of people start eating methadone and then go to heroin.” Another participant commented, “[Doctors] just actually gives them [users] free drugs at the methadone clinic.” A treatment provider commented about the increase in methadone use and availability: “If you’re a heroin addict, you blink your eye, and they’ll give you methadone.” Media outlets in the region reported on several crimes involving prescription opioids during this reporting period. In September, a Clark County Sheriff’s Deputy resigned from the sheriff’s department after her arrest for purchasing 60 Vicodin® pills from an undercover officer (www.whiotv.com, Sept. 16, 2011). In October, a Dayton doctor surrendered his medical license after federal, state and local law enforcement raided his offices in a pill-mill investigation (www.daytondailynews.com, Oct. 4, 2011). A West Carrollton (Montgomery County) man was arrested after robbing a Walgreens pharmacy, reportedly out of frustration from the repeated rejection of his requests for painkillers (www.daytondailynews.com, Oct. 13, 2011).

While participants reported that the availability of prescription opioids has decreased over the past six months, reportedly, the region experienced an increase in availability of methadone: “You can get methadone anywhere, just walk up to just about any house.” Participants attributed the perceived decrease in availability of prescription opioids to the rise in popularity of heroin. A participant reported, “Everyone I used to buy my pills [prescription opioids] off of got caught selling them or went to heroin.” Other participants commented on

the switch to heroin: “Your tolerance gets so high. You get tired of eating 30 Vicodin® HP’s a day and go to heroin; Vicodin® is weak compared to heroin.” Some participants in Dayton felt that doctors have cut back on prescribing: “Don’t see pills [prescription opioids] as much as used to ... increased monitoring of doctors, they are less available. However, a participant reported, “If I go to the hospital ... I can go right now ‘cause I just had a baby three months ago and pretend like I am in pain, and I bet you I get a script [prescription]. I can go get a script right now, and my baby’s three months. They’ll say, ‘hi, how’s your pain tolerance?’ And, ‘oh, I’m at a 10 ... I’m gonna pass out’ ... and there’s a script [prescription for an opioid] in two seconds.” Participants in outlying areas reported no change in availability: “We have a lot of family doctors, old school family doctors. I don’t think they are oblivious [to prescription opioid abuse], I just think that they don’t care.” Community professionals reported that availability of prescription opioids has remained the same during the past six months. However, they also reported that Vicodin® has always been easy to obtain, and methadone and Opana® are increasing. Coroner’s office counts prescriptions (they collect pill bottles of the deceased to aid in determining cause of death), and they are finding that, “Not only do people have multiple pain medications, but they also get an exorbitant amount for one prescription; We had a prescription bottle and somebody had been prescribed 80, 80 mg of oxy [OxyContin®].” A community professional identified a personal experience: “Just from having a C-Section [Caesarean Section], I was prescribed 50 Percocet®.” The Miami Valley Regional Crime Lab reported that the number of prescription opioid cases it processes has remained generally the same during the past six months; noted exceptions were a decrease in oxycodone hydrochloride (OxyContin®) and increase in oxycodone hydrochloride and acetaminophen (Percocet®, Percodan®), and hydrocodone and acetaminophen (Lortab®, Norco®, Vicodin®).

Reportedly, many different types of prescription opioids (aka “candy,” “ills,” “pills” and “poppers”) are currently sold on the region’s streets. Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dialudid® 2 mg (sells for between \$3-4), methadone (sells for \$5 per pill), Opana® 40 mg (aka “panner;” sells for \$50), OxyContin® (aka “OC’s,” “Orange County” and “oxy’s;” new formulation sells for between \$0.50-1 per milligram), Percocet® (aka “P’s” and “perc’s;” sells for between \$4-15, with a common amount of \$1 per milligram); Roxicet® 30 mg (aka “roxi’s;” sells for \$15), Vicodin® 500 mg (aka “V’s,” “vikes” and “Vikings;” sells for \$2-5, with users paying as much as \$5 if they don’t have connections or if the

dealer is trying to make more profit). Price is a deterrent to using prescription opioids as a participant stated, *"I'm telling ya, top dollar [for prescription opioids]. That's why I went to dope."* While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the most common routes of administration remain oral ingestion and snorting. Snorting was identified as the most common way to use prescription opioids with the exception of methadone. A participant commented, *"Some people don't realize that you can shoot a pain pill."* Parachuting, where a pill is crushed up and placed into a tissue, was mentioned by one participant. The tissue and crushed pill is then swallowed. A treatment provider discussed, *"I don't think they are using the medications right these days. They eat them, that's what they call it. They don't take medication, they eat them."*

In addition to obtaining prescription opioids on the street from dealers, participants continued to also report getting them from doctors, clinics and family or friends. A participant discussed how dealers obtain prescription opioids: *"Most people f*** themselves up and go to the doctor, and they have people on the waiting list ready to buy half of them [prescription opioids]."* Another participant reported, *"A lot of people get large amounts [of prescription opioids] and don't take that much of them ... [they] make sure they get enough for what they need and sell the rest."*

A profile of a typical user of prescription opioids did not emerge from the data. Participants described typical users of prescription opioids as, *"anyone."* A participant discussed the common use of prescription opioids: *"Prescription pills are regulated, so people feel more comfortable using them. They know what strength ... what they are getting."* Participants and treatment providers identified increased use among youth: *"A lot of younger kids are starting to get into the pills [prescription opioids]."* A participant remarked, *"I know people where I live at, they sell their baby's clothes just for the pills. They won't do nothing else but pills, but they are literally addicted like it is a hard drug."* A treatment provider commented, *"I don't think kids understand [that] prescription medications are just as dangerous as heroin or cocaine."* Community professionals agreed that prescription opioid users are, *"across the board; of all walks of life."* However, a profile of a typical seller emerged from reports from law enforcement and treatment providers: older adults are more likely to sell their prescriptions. Law enforcement observed: *"Sellers age range is going to be a lot higher than that [typical user age]. We've bought it from 60- and 70-year-old people."* An officer reported, *"The older population needs the money and that is the quickest and easiest way for them to support themselves. They get the misconception because [prescription opioids] it's not a street drug that they won't get in as much trouble for it."* A treatment provider

discussed the older age range of sellers of prescription pills and commented, *"Elderly people, who through their fixed incomes can't make their money match their bills, found that selling medications is a way to get extra income."*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, cocaine or other stimulants, marijuana and sedative-hypnotics. Most participants discussed using other substances with prescription opioids: *"Hand in hand, a joint [marijuana] and a pill."* A participant remarked, *"It says right on the bottle [of prescription opioids] that alcohol may intensify the effect."* And another participant reported, *"I rarely took pills without drinking or smoking [marijuana] with them."* A prescription opioid user agreed, *"If I had it [another substance], then I'd use it with it [prescription opioid]. If not, I'd use it by itself."* The coroner's office reported, *"Most pharmaceutical cases are polydrug submissions."*

Suboxone®

Historical Summary

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported street availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants with some knowledge of Suboxone® reported that its availability had increased during the previous six months and that the drug sold for between \$10-15 for an 8 mg pill. Participants most often reported taking Suboxone® as indicated, sublingually [dissolving it under the tongue]; however, snorting and intravenous injection of Suboxone® were also noted. In addition to obtaining Suboxone® on the street from dealers, participants continued to report getting it from doctors, friends and pain management clinics. Participants described typical users of Suboxone® as both people who wanted to address their heroin addiction and those who sought heroin but couldn't find any. A treatment provider noted that the demand for treatment was high among heroin users: *"We could have a doctor here prescribing Suboxone® full time, but there's no funding for that. There's demand for a full-service Suboxone® clinic ..."*

Current Trends

Suboxone® is moderately available in the region. Participants most often reported the current street availability of Suboxone® as '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. Some participants had never seen or heard of Suboxone®. A participant familiar with Suboxone® reported, *"More people are getting prescriptions for Suboxone® to sell to get money for heroin."* Other participants

discussed, “[Heroin users] only use it [Suboxone®] when they don’t have enough money for heroin; That’s what they use when they can’t find heroin.” Community professionals most often reported the drug’s current availability as ‘3.’ Treatment providers identified Suboxone® as not easy to obtain. A participant reported, “[Suboxone®] it is a very expensive drug versus methadone that they use for treatment. You’d have to have insurance. People that don’t have insurance, you’ll pay out the yin-yang.” Another participant noted the benefits of Suboxone®, “My perspective, I call it [Suboxone®] a wonder drug. It gives you energy, it cuts the withdrawals, it doesn’t make you nod out like the methadone.” Another participant commented, “They should offer Suboxone® like they offer methadone. It’s more safe. It’s got methadone beaten in all areas.” A treatment provider reported, “I don’t have any clients abusing it [Suboxone®], but I have a couple of clients who are on it.” Another treatment provider stated, “They [users] are really trying to wean themselves off methadone and the opiate use. They are really using it [Suboxone®] to better themselves.” Most treatment providers identified Suboxone® as being used as directed and for, “serious recovery.” Community professionals reported that availability of Suboxone® has remained the same during the past six months. The Miami Valley Regional Crime Lab reported that the number of Suboxone® cases it processes has increased during the past six months.

No slang terms or street names were reported for Suboxone®. The most common form of Suboxone® is an 8 mg pill or strip. Participants reported that Suboxone® 8 mg sells for between \$10-20 from dealers; however, “You can pay \$100 at treatment centers in Dayton and obtain enough [Suboxone®] for a month.” A participant reported, “I sold mine [Suboxone®] for \$5.” Most often participants continued to report taking Suboxone® sublingually. A participant commented, “I tried shooting it [Suboxone®], but it didn’t do anything, so I never did it again.”

In addition to obtaining Suboxone® on the street from dealers, participants also reported getting the drug from the pharmacy with a prescription or through a clinic: “I was prescribed [Suboxone®]; I never tried to buy it.” Another participant highlighted, “More people are getting prescriptions for Suboxone® to sell to get money for heroin.” Participants thought Suboxone® strips to be more widely available than the pill form.

Participants described typical users of Suboxone® as, “people who really need to use it [Suboxone®], or those who want to sell it to buy heroin.” Reportedly, Suboxone® is used in combination with alcohol, marijuana and sedative-hypnotics. Most participants were clear that they would not use opiates with Suboxone® and would not use other substances to intensify Suboxone® because, “[Suboxone®] just keeps you from being dope sick.” However, a participant commented that use

of sedative-hypnotics with Suboxone® produces a high: “It’s a really good high.”

Sedative-Hypnotics

Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were 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’ (highly available, extremely easy to get). Participants and community professionals identified the most popular sedative-hypnotics in terms of widespread use as Ativan®, Klonopin® and Xanax®. Participants and treatment providers reported that the availability of sedative-hypnotics had remained the same during the previous six months. In addition to obtaining sedative-hypnotics on the street from dealers, participants most often reported obtaining these drugs from physicians’ offices, but they also obtained the drugs from family and friends when physicians were unavailable or unwilling to prescribe the medications. The most common route of administration was oral ingestion, followed distantly by snorting. Participants described typical users of sedative-hypnotics as opioid users who were generally White.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported the current availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10.’ Participants and community professionals identified Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. A participant explained, “A lot of doctors are prescribing them [sedative-hypnotics] now.” Another participant discussed the popularity of Xanax®, “If I took Xanax®, and I loved the way it made me feel, and I [told] a thousand people, ‘oh my God, it will make you feel like a million bucks’ [then its popularity spreads through] word of mouth.” Community professionals most often reported the current availability of these drugs as ‘10.’ A treatment provider reported, “It’s easy to get [sedative-hypnotics]. It’s all over the place.” Participants reported that the availability of sedative-hypnotics has remained the same during the past six months with the exception of Klonopin® which has increased. Many participants said the increase in availability of Klonopin® is due to doctors moving to that particular drug. A treatment provider identified Xanax® as increasing because, “Doctors won’t stop prescribing it [Xanax®].” Community professionals

reported that the availability of sedative-hypnotics has remained the same during the past six months. The coroner's office reported sedative-hypnotics, specifically alprazolam (Xanax®), as the third leading cause of death by overdose. Reportedly, the most common ages for sedative-hypnotic overdose death ranged from 23-55 years. The Miami Valley Regional Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months with a few exceptions; Ambien® and Valium® have increased, and Ativan® and Xanax® have decreased.

Reportedly, many different types of sedative-hypnotics (aka "downers," "little meanies" and "stuff") 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): Klonopin® 1 mg (aka "forget-a-pins" and "forgets;" sells for between \$1-2); Soma 500 mg (sells for \$5); Xanax® 1 mg (aka "footballs" and "peaches;" sells for between \$1-3) and Xanax® 2 mg (aka "xanibars;" sells for between \$3-5); Overall participants reported that most sedative-hypnotics sell for between \$0.50-1 per milligram, with most pills selling for between \$2-6. Reportedly, cost also varies depending on from whom the pills are purchased and the buyer's relationship with the dealer. While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, the most common routes of administration are oral ingestion and snorting. Participants did not identify intravenous injection as a route of administration for these drugs. Different participants preferred different methods. Some participants commented that snorting, "burned too much." A participant stated, "If you want to get every bang for your dollar, you'll go through that pain [of snorting sedative-hypnotics]." Reportedly, methods of use change with age; according to one participant, "When I was younger, I snorted them [sedative-hypnotics] a lot. But when I got older, I started eating them."

In addition to obtaining sedative-hypnotics on the street from dealers, participants also reported getting them from doctors (psychiatrists) and area emergency rooms. A participant stated, "Act like you are stressed out and can't manage, and doctors prescribe them [sedative-hypnotics]. It's easy to fake a bunch of anxiety." A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants described typical users of sedative-hypnotics as, "anyone." Community professionals agreed that sedative-hypnotic abuse is, "across the board." Participants and community professionals reported Xanax® to be popular among the 18-25 year age group, with the highest use reported to be among those in their late 20s and early 30s.

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, heroin, marijuana and other "downers" (depressant drugs). Participants reported that it is common to mix other substances with sedative-hypnotics. Alcohol, marijuana and other sedative-hypnotics are used to intensify the drug's effect. Sedative-hypnotics are also used to "come down" from "uppers" (stimulant drugs) like bath salts (synthetic compounds commonly containing methylenedioxymethamphetamine or MDPV), crack cocaine and powdered cocaine. Alcohol and marijuana are the most popular substances used in combination with sedative-hypnotics. Participants explained, "You don't have to drink as much [alcohol] to get drunk." Another participant commented, "If they are using pills [sedative-hypnotics], [then] they are probably smoking weed [marijuana]." Treatment providers discussed the popularity of sedative-hypnotics among young adults: "Xanax® is popular for the young ones [18-25 years] to use with alcohol."

Marijuana

Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants and law enforcement most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals described marijuana as the most available drug in the region. Participants and law enforcement reported that the availability of marijuana had remained the same during the previous six months. Participants reported that the quality of marijuana varied, with the most common quality score continuing to be '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Law enforcement continued to report a gradual increase in the quality of marijuana during the previous six months. Participants reported that for commercial (low- to mid-grade) marijuana, an ounce sold for between \$90-140; for high-grade marijuana, a "blunt" (cigar) sold for between \$20-40, and an ounce sold for between \$200-400. While there were a few reported ways of consuming marijuana, the most common route of administration was smoking, followed distantly by using vaporizers. When asked to describe the typical user of marijuana, participants were unable to be specific. They reported that virtually everyone uses marijuana, including all ages, races and socio-economic groups.

Current Trends

Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most

common score was also '10'. Participants frequently agreed, *"It's everywhere; You walk outside your door, and you're gonna smell somebody smoking [marijuana]."* Community professionals most often reported the drug's current availability as '10'. Treatment providers discussed availability as, *"Everybody is on it [marijuana] ... that's all we need to say; Actually, we'd think it's legal ... the way they smoke it."* Marijuana appears to be the drug of choice for regional juveniles involved in the court system. Of the 395 juveniles who tested positive for drugs in Montgomery County Juvenile Court from Jan. 1 through June 30, 2011, more than 79 percent tested positive for marijuana at some point in their court involvement.

Participants reported that the availability of marijuana has increased during the past six months, but most noted that different grades fluctuate with different seasons; participants identified that the higher grades are becoming more available because of, *"harvest season."* A participant reported an increase in high-grade marijuana: *"A lot more dro [hydroponically-grown marijuana], mid- to high- [quality] coming around. Call it, 'Christmas weed.'"* A participant explained, *"In Sydney [Shelby County], you usually have so much reggie [mid-grade marijuana], and you can't find nuggets [high-grade marijuana], or so many nuggets and you can't find reggie."* In a rural area a participant commented, *"It [marijuana] used to take a day [to get] but [now I] seem to get it sooner."* Community professionals reported that availability of marijuana has increased during the past six months. Law enforcement in a rural area reported a decrease in cases because they, *"Have put more focus toward the heroin and the pills with the dealers coming up from Dayton."* The Miami Valley Crime Lab saw a slight decrease because some users switched to synthetic marijuana ("Spice" and "K2") when they were legal because labs were not testing for it. Law enforcement and treatment providers both discussed an increase in "grow houses" (indoor marijuana-growing operations); some community professionals felt this increase in grow houses coincided with the increased availability in their area: *"I think [availability of marijuana] it's more because they are growing it in their basements and attics or whatever. They do hydroponics now, so it's year-round. It's no longer seasonal; it's a year-round harvest."* Law enforcement also reported on marijuana coming into the country: *"Mexican ditchweed [low-grade marijuana] is shipped to different areas by UPS® or FedEx®. It comes every day*



through the mail, and they only catch one-tenth of one-tenth of what's coming through the mail." Media outlets across the region reported on several marijuana seizures during this reporting period. Montgomery County law enforcement seized 92 plants, worth an estimated \$500,000 (www.whiotv.com; Aug. 25, 2011). In another incident, Ohio State Highway Patrol Officers stopped a Washington state man in Springfield (Clark County) for a routine traffic violation and discovered 28 pounds of marijuana, valued at \$63,000 (www.morningjournal.com; Nov. 17, 2011). The Miami Valley Regional Crime Lab reported that the number of marijuana cases it processes has increased during the past six months.

Participant quality scores of marijuana varied from '3' to '10' with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Low-grade marijuana was typically rated as '3', mid-grade as '5', and high-grade as '10'; previously, both low- and high-grade marijuana were most often rated '10'. Several participants explained that the quality of marijuana depends on whether the user buys "commercial weed" (low- to mid-grade marijuana) or hydroponically grown (high-grade marijuana). High-grade marijuana was described as having crystals and smelling more potent. Participants also commented that high-grade marijuana usually has different colored hairs, does not have seeds, and is typically fluffy, spongy and sticky. Usually, participants thought the color of high-grade marijuana to be light green or sometimes purple. On the other hand, low- to mid-grade marijuana was thought to have more stems and ranged from brown to a mint green in color. Participants also mentioned the physiological effects from the different grades. Mid-grade marijuana was thought to give a, *"drowsy and tired feeling,"* while higher quality gives a, *"whole body buzz."* The hydroponically and homegrown grades were seen as the most desirable marijuana among participants.

Current street jargon includes countless names for marijuana. Participants listed the following as common street names: "ditchweed," "reggie" and "regular" for commercial-grade marijuana; "chronic," "dank," "green," "homegrown," "kush" and "purp" for high-grade marijuana; and "dro" or "hydro" for hydroponically-grown marijuana. The price of marijuana depends on the quality desired. Participants reported commercial-grade marijuana to be the cheapest form: a joint (cigarette) sells for between \$5-10; 1/8 ounce sells for between \$15-30; 1/4 ounce sells for between \$25-50; 1/2 ounce sells for \$50; an ounce sells for \$100; a pound sells for between \$500-700. Higher quality marijuana sells for significantly more: a blunt or two joints sells for between \$20-30; 1/8 ounce sells for between \$45-50; 1/4 ounce sells for \$150; a pound sells for up to \$5,000. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Smoking methods

were reported to change with age: *"From 16 to 21 [years], they [marijuana users] roll up a blunt. As you get older, you want to smoke a bowl [from a pipe]. When you smoke a blunt, you waste most of it."* A participant identified that people selling or trafficking large amounts of marijuana experiment more and make edible items including butter, cookies, brownie and THC (tetrahydrocannabinol) tea.

A profile for a typical marijuana user did not emerge from the data. Participants continued to describe typical users of marijuana as being of any age, race, occupation and socio-economic group. Typically, participants said the popularity of marijuana is so great that, *"People you wouldn't expect are smoking [marijuana]."* Participants said the age range of marijuana users is wide: *"Fourteen-year olds to 75-year-old women [use marijuana];"* and treatment professionals agreed, *"[Marijuana users are] Black, White, 20 or 80 [years old]."* Treatment providers also discussed younger users: *"They [marijuana users] are starting young, nine or 10 [years] on up."* A group of treatment providers mentioned a news article involving a six-year-old girl who took marijuana to school and was trying to smoke it in the bathroom. When questioned if youth are being asked to traffic drugs, law enforcement responded, *"Not trafficking. They [youth] are working for someone bigger than them, but they are going out and selling [drugs]. It's not a big operation, more small stuff."* Law enforcement reported that drug traffickers typically choose someone they can trust – a girlfriend or another individual with a valid driver's license that doesn't look suspicious – to traffic drugs. A treatment provider reflected on youth selling marijuana: *"They [youth] choose to do it [sell marijuana] because it's good money."*

Reportedly, marijuana is used in combination with alcohol, crack cocaine, Ecstasy (methylenedioxyamphetamines: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP), heroin, powdered cocaine and prescription opioids to intensify the effect of the other substance(s) or to reduce the side effects produced by the other substance(s). A participant discussed soaking marijuana in embalming fluid and called this practice, *"getting wet."* Most participants commented that it is rare to lace (add another substance, usually illegal) marijuana, citing that some people are, *"scared to; it makes it [marijuana] taste horrible."* A participant in a rural area identified that lacing, especially with powdered cocaine, is, *"More of an inner city type thing. Don't see people do this [lace marijuana] in smaller towns."* A participant in Dayton reported that sometimes dealers lace marijuana: *"Now with 'loud' [high-grade marijuana], people be putting stuff in it. I smoked some awhile back and dropped dirty [tested positive on a urine drug screen] for pills, heroin all types of stuff."* Another participant commented, *"If you ever smoke a blunt and get to itching it's laced."*

Methamphetamine

Historical Summary

In the previous reporting period, participants reported infrequent use of methamphetamine; however, those who reported use during the previous six months most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that methamphetamine was available in a home-cooked, powdered form. Treatment providers reported that methamphetamine use was relatively rare among their clientele. The Miami Valley Regional Crime Lab reported that the number of methamphetamine cases it processed had decreased during the previous six months. Participants reported the street price of methamphetamine as \$100 per gram. Participants, law enforcement and treatment providers believed cookers (manufacturers) and users of methamphetamine most often to be White and living in rural areas of the region.

Current Trends

Methamphetamine is relatively rare in the region. Participants most often reported the drug's availability as '2' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10' among those few participants with first-hand knowledge of the drug. Participants did not differentiate between the availability of powdered and crystal methamphetamine. Community professionals reported that methamphetamine is rarely seen in the region. A treatment provider explained, *"For a moment it [methamphetamine] kind of came, but didn't catch on in the city [Dayton]."* Participants reported that the availability of methamphetamine has remained the same during the past six months. Among participants, most agreed that methamphetamine is not a popular drug in the region. Participants continued to report that methamphetamine is only available to a limited number of users with good connections: *"Those people [methamphetamine users] keep a tight circle."* A participant talked about the regional availability of the drug, *"[Methamphetamine is available] closer to Indiana, [and popular with] more younger people."* Community professionals reported that availability of methamphetamine has decreased during the past six months. They reported that the decrease in methamphetamine can be linked to one major factor: *"With the emergence of one-pot cooks, it's [methamphetamine] harder to find [cooks now primarily produce methamphetamine for personal use only]."* The one-pot method refers to mixing methamphetamine ingredients in a two-liter bottle or mason jar that cooks can throw away when finished. Participants talked about the

ease of the one-pot method, *"They [one-pot cooks] don't use as many ingredients; it's more for personal use, quick and easy."* A treatment provider surmised methamphetamine users are not frequently seen in treatment because, *"They [methamphetamine users] are not functioning well, so they are not following through on anything. If they have a case manager, they probably do not know that person's name."* Treatment providers in Dayton observed that methamphetamine labs are located in rural areas: *"[Methamphetamine] it's transported from the country to city and sold."* Increased monitoring by local pharmacies is also credited with the reduction in methamphetamine use. Treatment providers discussed a *"checks and balance system"* where pharmacies swipe driver's licenses when pseudoephedrine (a main ingredient in the manufacture of methamphetamine) is purchased into a statewide database as having been an effective prevention method because it limits the amount of the medicine that one person can purchase. The Miami Valley Regional Crime Lab reported that the number of methamphetamine cases it processes has increased during the past six months.

Participants that had knowledge of the quality of methamphetamine most often rated current quality as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported variable quality: *"You can have good meth [methamphetamine] or stomped on meth."* Participants discussed how they thought methamphetamine was cut: *"Sometimes I'll get crack and it [methamphetamine] will be mixed in, and [I] won't know until I'm up for 24 hours. Not told that is what I'm buying; I heard they are making out that they are selling crack, but it's meth."* The Miami Valley Regional Crime Lab reported that they typically see powdered tan, brown and off-white methamphetamine along with crystal methamphetamine in their labs.

Current street jargon includes a few names for methamphetamine. The most commonly cited names were "glass" and "ice." A participant reported that a gram of methamphetamine sells for between \$100-200. Reportedly, the most common route of administration of methamphetamine is smoking, especially for first-time users. Other routes of administration were cited as less common, including intravenous injection. However, those with knowledge of methamphetamine use agreed that route of administration varies: *"[Methamphetamine use] it's all over [the board] and [really about] personal preference."*

A profile for a typical methamphetamine user did not emerge from the data; however, participants and treatment providers agreed that older people and those with prison experience are more likely to use the drug. A participant reported, *"The youngest [methamphetamine user] I know is 24 [years old]. It's not like the 14-year-old heroin addicts."* Another participant

discussed her experience in prison, *"A lot of people in jail, their drug choice is meth and heroin, especially women, a whole lot of women."* Another participant related, *"When I was in jail, they was saying how they got hooked on it [methamphetamine] from making it. They end up testing their own product and that's how they get hooked on it."* Treatment providers identified that it is rare for those younger than 18 years of age to use methamphetamine, and one provider reported, *"Younger people ... are scared of it [methamphetamine]. They might be willing to try crack, but somehow or another, they got it through their head that meth is dangerous."* In addition, a treatment provider in the Dayton area observed that 80-90 percent of women soliciting sex in the area were believed to be methamphetamine users. Reportedly, methamphetamine is used in combination with alcohol and marijuana. A participant reported, *"They [methamphetamine users] need weed and alcohol to come down and not tweak out and have a heart attack."*

Ecstasy

Historical Summary

In the previous reporting period, Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) was available in the region. The Miami Valley Regional Crime Lab reported that the number of Ecstasy cases it processed had decreased during the previous six months. Participants reported that a single tablet of Ecstasy sold for between \$3-20, with the price of a tablet depending on a variety of factors and volume discounts being common. The only reported method of administration was oral ingestion.

Current Trends

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) is moderately available in the region. Participants most often reported the current availability of Ecstasy as '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, participants reported availability but did not assign an availability score. Most participants reported that availability of Ecstasy is limited to certain social circles: *"You have to know the right people [to obtain Ecstasy]."* Community professionals agreed with participants and thought that club drugs like Ecstasy are only available to well-connected users: *"You gotta know somebody that knows somebody [to obtain Ecstasy]."* Participants reported that the availability of Ecstasy has remained the same over the past six months. However, participants reported that *"Molly,"* the purest form of Ecstasy, as increasingly sought and used, especially at outdoor music

festivals. Treatment providers reported that the availability of Ecstasy has decreased during the past six months. A treatment provider explained that Ecstasy is sought after but, “[Drug seekers] actually can’t get it. They like to club with Ecstasy, but you can’t find it. It’s not easy to make.” The Miami Valley Regional Crime Lab reported that the number of Ecstasy cases it processes has increased during the past six months.

Most participants rated the quality of ecstasy as ‘6’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that the price of an Ecstasy tablet depends on a variety of factors: the size of the tablet and the picture that is imprinted on it. Participants reported a “single stack” (low dose) of Ecstasy sells for between \$5-10; a “double stack” or “triple stack” (high dose) sells for between \$40-50.

A profile for a typical Ecstasy user did not emerge from the data. Participants described Ecstasy as a, “party drug” or “club drug,” and also discussed its popularity with college students. A participant mentioned an alarming trend with Ecstasy, “People tend to walk by and put [Ecstasy] in drinks, using it to drug people.” Treatment providers also commented on Ecstasy’s popularity among young people; they explained they see Ecstasy, “in the younger generation and in the college scene.”

Reportedly, Ecstasy is used in combination with alcohol, marijuana (aka “candy flipping”) and nitrous oxide. Use of alcohol with Ecstasy varies. A participant preferred using alcohol because, “I’d like to get drunk [and use Ecstasy] because I wouldn’t feel hung-over the next day.” When mixing marijuana with Ecstasy a participant described, “For me, I got a different buzz when I mixed the two [marijuana and Ecstasy] rather than doing it [Ecstasy] by itself.” A participant also explained that nitrous oxide is sometimes used with Ecstasy to intensify the experience and reported that a hit (one dosage unit) of nitrous oxide sells for between \$10-15. Reportedly, users usually travel to Indiana to purchase 20 pound bottles of nitrous oxide.

Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants were available in the region. However, law enforcement, treatment providers and participants did not see this class of drug as an urgent problem. The Miami Valley Regional Crime Lab reported that the number of prescription stimulant cases it processes had remained the same during the previous six months.

Current Trends

Prescription stimulants are rarely available in the region although rural areas reported more desirability and availability of these substances. Participants rated the availability of prescription stimulants as ‘3’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Generally, participants attributed low availability to low desirability. A participant explained, “I get them [prescription stimulants] every now and then. Last resort type s***.” Participants and community professionals reported that the availability of prescription stimulants has remained the same during the past six months. The Miami Valley Regional Crime Lab reported that the number of prescription stimulant cases it processes has remained the same during the past six months with few exceptions; medications based on methylphenidate HCL (Ritalin® and Concerta®) have increased in availability.

No slang terms or common street names were reported for prescription stimulants. The following prescription stimulants are available to the street-level users: Adderall® and Concerta®. Participants reported that most brands of prescription stimulants sell for between \$2-3 a pill depending on the milligram. Participants also reported getting these drugs from people who had been prescribed them.

Participants described typical users of prescription stimulants as younger individuals in high school or college. Participants reported, “Mostly just high school kids [abuse prescription stimulants]. Younger kids or college kids that don’t want to do coke [cocaine] to stay up all night will do Adderall®.” Another participant talked about students using the drug before exams: “[Prescription stimulants are] big among college students. For my cousin, it’s supposed to be a focus drug. A lot of college student like it for that ... speeds them up so they up all day. It’s a different high ... it’s not like coke ... energy booster that helps you concentrate at the same time. At exam time you can make a lot of money on college campuses [selling prescription stimulants].” Community professionals concurred with participants and also reported prescription stimulants as popular among a younger age group: “Those [prescription stimulants] are done by the young kids; I think the young kids will test out those pills.” However, the Coroner’s office reported that they often observe middle-aged women in court for prescription stimulant abuse. Coroner’s office staff guessed these women were using the drugs for energy in order to complete housework or related tasks. No substances were reported to be used in combination with prescription stimulants. Participants did not report seeking out other substance to use in combination with prescription stimulants; they felt the drugs are often bought and used for their intended effect.

Bath Salts

Historical Summary

In the previous reporting period, bath salts (synthetic compounds commonly containing methylone, mephedrone or MDPV) were highly available. Participants most often reported the availability of these drugs as '10,' and treatment providers as '9,' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Bath salts were particularly deemed an urgent problem by participants and community professionals in the northern portion of the region; three of eight participants in one focus group were in treatment for bath salts abuse. The Miami Valley Regional Crime Lab reported that the number of bath salts cases it processes had increased during the previous six months. Pricing for sealed packages varied; one brand sold for \$22 while another brand sold for \$35 for the same amount of product. Bath salts were also available in bulk or loose form, usually from a store that sold drug paraphernalia. Participants and treatment providers described typical users as young (teens to mid-20s) suburban or rural dwellers, White, male and with some financial means.

Current Trends

Bath salts (synthetic compounds commonly containing methylone, mephedrone or MDPV) are moderately available in the region. Participants rated the availability of bath salts as '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10.' Bath salts have decreased in availability because of the law banning their sale that took effect in October 2011. However, participants still can easily obtain them: *"People knew it [bath salts] was going out, so people stocked up on it. In gas stations in town if you know the right one, they have it behind the counter. One had a guy come in and spend \$800 [on bath salts]."* Treatment providers also felt that bath salts are, *"still out there somewhere, but it's under the table."* Staff from the Miami Valley Regional Crime Lab reported bath salts are still being used in the region and that the lab has processed cases involving bath salts. Of the cases involving death related to bath salts, suicide was a common cause of death in the 18-25 age group. As the Coroner explained, *"We have had a couple of kids ... several hangings, suicides associated with the use of bath salts. The younger people are the ones having the hangings, [the] 18-25 age group."* Older individuals



were also identified as dying from the use of bath salts, but these deaths were not linked with suicide. In contrast to younger users, the coroner's office explained that the combination of bath salts and people with age-related heart problems made the substance, *"more toxic in older people."*

Media outlets in the region reported on abuse of bath salts. In an article from the *Dayton Daily News*, professionals from the Designer Drug Task Force sponsored by Greater Dayton Area Hospital Association discussed consequences related to bath salts use. Professionals from the hospital association said, *"There have been more than 500 bath salts-related hospital cases in the association's 10-county region."* In the same news article, the Montgomery County Coroner's Office also provided data that said there, *"have been 12 fatalities ... [that] have occurred in the rural and suburban areas and less in the urban areas"* (www.daytondailynews.com; Oct. 18, 2011). *WDTN TV* discussed ways that manufacturers of bath salts are trying to circumvent the law to sell bath salts. The station interviewed staff from the Miami Valley Regional Crime Lab who explained some of the now-illegal bath salts are sold in the same package, with a sticker covering the old label and replacing it with a new label that reads "Glass Cleaner" or "De-melting Ice Agents" (www.wdtn.com; Dec. 19, 2011). Another news outlet reported on crime related to bath salts. According to the news article, a man who confessed to snorting bath salts led The Miami County law enforcement on a car chase with speeds up to 100 mph after police attempted to stop his car in Piqua (www.whiotv.com; Sept. 18, 2011). The Miami Valley Regional Crime Lab reported that the number of bath salt cases it processes has increased during the past six months.

Participants and community professionals agreed that typical bath salts users are White. While no one age group is believed to be more likely to abuse these drugs, younger individuals were identified as more likely to try them. Some participants still had not heard of bath salts: *"I didn't hear about them [bath salts] until I was already locked up."* Others did not use them personally but had friends that used them: *"Everyone that I've heard that's done it [bath salts] went crazy on it."* In fact, participants reported negative stories about the substances caused them to avoid bath salts use. No substances were reported to be used with bath salts as most respondents did not have first-hand experience with them.

Other Drugs

Historical Summary

In the previous reporting period, participants and community professionals listed the following other drugs as present in the region, but these drugs were not mentioned by the majority of people interviewed: anabolic steroids, hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], salvia divinorum and synthetic marijuana. Synthetic marijuana was highly available throughout the region. Participants frequently mentioned its rising popularity due to the belief that the drug delivered a marijuana-like high and could not be detected by urine drug screens. The Miami Valley Regional Crime Lab reported that the number of synthetic marijuana cases it processes had increased during the previous six months. Participants observed that synthetic marijuana was available for purchase at convenience stores and gas stations, costing \$5-10 per gram. Depending on the brand, the quality of synthetic marijuana ranged between '7' and '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The primary method of administration for this product was smoking, but vaporizers were also used to ingest the drug. Hallucinogens like psilocybin mushrooms and LSD (lysergic acid diethylamide) were somewhat available according to law enforcement and participants. The Miami Valley Regional Crime Lab reported that the number of LSD cases it processes had increased while the number of psilocybin mushroom cases it processes had decreased during the previous six months. Prescription stimulants were also available in the region. The Miami Valley Regional Crime Lab also reported several other drugs that were not mentioned by the focus groups, including an increase in the number of processed cases for salvia divinorum and anabolic steroids (methandrostenolone, stanozolol and testosterone).

Current Trends

Participants and community professionals listed a variety of other drugs as being present in the region, but these drugs were not mentioned by the majority of people interviewed. Anabolic steroids are rarely available in the region. Only two participants identified any knowledge of anabolic steroids, and both participants had not personally used steroids but had recently met a source that could link them with steroids, specifically Deca-Durabolin (aka "deca"). A participant talked about the availability of anabolic steroids at a local workout facility: "[I] just got out of jail and met someone in there [at my gym] who can get deca. He does cycles and shoots them. It's very expensive; the pills are \$100 a cycle which is about 30 days, and if you are shooting, it's about \$250-300. Shooting is once a week for a month." The Miami Valley Regional Crime Lab staff suggested that the steroids in the region are often coming from Mexico, Russia or China. Most steroids are found in

liquid form, but there are some powdered steroids available as well. The most common routes of administration for anabolic steroids are oral ingestion and intravenous injection. Reportedly, users who prefer intravenous injection typically mix the drug with olive oil or sesame oil before injection. A profile for a typical anabolic steroid user emerged from the data. Staff at the Miami Valley Regional Crime Lab said that typical users are White and male. The Miami Valley Regional Crime Lab reported that the number of steroid cases it processes has increased during the past six months, and they mentioned that 14 different types of anabolic steroids were processed in their lab.

Alcohol remains highly available in the region. Alcohol was identified as a major substance of abuse by community professionals and participants for those aged 18-25 years. A treatment provider remarked, "They [young users] don't see anything wrong with that because [alcohol] it's legal." A participant discussed the frequency of alcohol use in the community, "Most everybody drinks [alcohol]. That's what you do on weekends, weekdays. [This is] a very alcohol town." Participants reported new trends with alcohol including the alcohol-energy drink combinations (Four Loko) and an increase in drinking games like "beer pong." When discussing Four Loko a participant stated, "I drank three of them [Four Loko] and couldn't walk." Another participant reported, "Bars are even having beer pong tournaments." Participants also discussed creating syrups with alcohol: "A lot of people make syrups out of Xanax® or put Codeine with Xanax® and liquor ... and [you] can add Skittles® or something for flavor and to change the color. Put everything in it ... make their own little concoction."

Inhalants remain highly available in the region. Reportedly, aerosols (aka "duster" and "gas") are most popular among the youth in high school or people who cannot obtain other drugs. A participant spoke to the ease with which these chemicals are obtained, "More kids hear about it [inhalants], and it's a household item. They hear about it and want to try it." A participant reflected, "Some people even huff [inhale for a high] air fresheners. You can walk into [the store] and buy one for \$1. My friend didn't have any money and went to the grocery store and bought whipped cream with her food stamp money [to abuse by inhaling the nitrous oxide gas]."

Hallucinogens are moderately available in the region. Participants rated the availability of hallucinogens as '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A minority of participants

reported using hallucinogens (LSD and psilocybin mushrooms). Some treatment providers felt that younger individuals are not as aware of these substances: *"The ones [younger individuals] that do know have been around someone that knows about it [hallucinogens]."* Participants reported that the availability of LSD has increased during the past six months, but did not explain why availability and use have increased. Participants also said availability of psilocybin mushrooms has remained the same in the region during the past six months. A community professional reported, *"Getting more people [in treatment] growing them [psilocybin mushrooms]."* The Miami Valley Regional Crime Lab reported that the number of hallucinogen cases it processes has increased over the past six months. Reportedly, LSD (aka "acid") sells for between \$10-20 a "hit" (dose, a microdot or blotter); an eye drop bottle full of liquid LSD sells for \$400. Participants reported that 1/8 ounce of psilocybin mushrooms sells for between \$20-25; 1/4 ounce sells for \$40; an ounce sells for \$150. Both LSD and psilocybin mushrooms are reportedly popular at outdoor music festivals. Participants believed the quality and purity of LSD and psilocybin mushrooms are high because dealers, *"can't stomp on them."* The most common route of administration for hallucinogens is oral ingestion. A typical user profile did not emerge from the data. A participant said typical hallucinogen users are, *"valley girls, younger college and high school students ... sheltered ... the ones you wouldn't expect [to use hallucinogens]."* In contrast, community professionals identified a typical hallucinogen user as White and male.

Over-the-counter (OTC) medicines remain highly available in the region. Like inhalants, OTC cough and cold medicines were also identified as substances that younger individuals in middle and high school are more likely to abuse. A typical user was described by a participant as, *"Someone who is very susceptible. They don't know much about anything. They don't do it [abuse OTCs] too many times after a bad trip."* Participants also noted a new trend with OTC medications for motion sickness. According to one participant, medicine to alleviate motion sickness could be used as a hallucinogen: *"Take 15 [motion sickness pills] and it will make you hallucinate. [You] can barely walk, it messes you up."*

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids and sedative-hypnotics remain highly available in the Dayton region. Noted increases in availability during the previous six months exist for heroin, marijuana and some prescription opioids (methadone); noted decreases exist for bath salts and some prescription opioids (OxyContin®). While there was consensus among all data sources that overall heroin availability has increased, heroin

type and availability varies throughout the region. The City of Dayton reported more brown powdered heroin; Lima reported more white powdered heroin; and smaller cities in Hardin, Logan and Shelby counties reported more black tar heroin. Participants all agreed that heroin generally is, *"falling out of the sky."* However, while heroin availability has increased in Dayton, participants reported that availability has decreased in some rural areas of the region during the past six months. Law enforcement in outlying areas concurred with participant reports in that they too have noted a reduced amount of heroin because of their efforts to focus on heroin in the community, targeting heroin trafficked from Dayton. Participants and community professionals agreed that there has been an increase in younger users of heroin, and both groups continued to link the increase in heroin use to prescription medications and prescribing patterns; in addition, participants noted that heroin is cheaper than prescription opioids. Participants and community professionals identified methadone as an increasingly popular prescription opioid in terms of widespread abuse. Coroner's office staff reported that methadone is the second leading drug in drug-overdose deaths (after heroin). In terms of marijuana's increased availability, participants highlighted an increase in high-grade marijuana, and community professionals discussed an increase in "grow houses." Bath salts have decreased in availability because of the recent law banning their sale. However, participants still can easily obtain them. Treatment providers also felt that bath salts are, *"still out there somewhere, but it's under the table."* Staff from the Miami Valley Regional Crime Lab reported that bath salts are still being used in the region.