

EXECUTIVE SUMMARY

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

This Executive Summary presents findings from the OSAM core scientific meeting held in Columbus, Ohio, on February 1, 2013. It is based upon qualitative data collected by six REPIs from July 2012 through January 2013 via focus group interviews (Note: two REPIs covered two regions each). Participants were 365 active and recovering drug users recruited from alcohol and other drug treatment programs in each of OSAM's eight regions. Data triangulation was achieved through comparison of participant data to qualitative data collected from 101 community professionals via individual and focus group interviews, as well as to data surveyed from coroner's offices, family and juvenile courts, common pleas and drug courts, the Ohio Bureau of Criminal Investigation (BCI), police and county crime labs. In addition to these data sources, media outlets in each region were queried for information regarding regional drug abuse for July 2012 through January 2013. OSAM research administrators in the Division of Planning, Outcomes and Research at ODADAS prepared regional reports and compiled this summary of major findings. Please refer to regional reports for more in-depth information about the drugs reported on in this section.

In addition to its primary responsibility for the prevention and treatment of substance use disorders, ODADAS is also responsible for the prevention and treatment of problem

and pathological gambling. For this reason, the OSAM Network amended its protocol in June 2011 to include collection of data related to problem and pathological gambling. The OSAM Network now collects data related to problem and pathological gambling, publishing its findings every six months in conjunction with its drug trend reports. A summary of gambling data is included in this executive summary. For previous gambling reports, please refer to Targeted Response Initiative (TRI) reports for January 2012 and June 2012 available for download via OSAM homepage on the ODADAS website: <http://www.odadas.state.oh.us/public/OsamHome.aspx>.

Powdered Cocaine

Powdered cocaine remains moderately to highly available in all regions; availability is currently high in Athens, Cleveland, Columbus and Youngstown and moderate in Akron-Canton, Cincinnati, Dayton and Toledo. Likely decreases in availability during the past six months exist for Akron-Canton, Athens, Cleveland and Dayton. Participants and community professionals in regions where availability has likely decreased attributed the following reasons for less powdered cocaine today: dealers not releasing powdered cocaine, but rather using it to manufacture crack cocaine to maximize profits; recent large scale police busts in the region involving the drug; large shipments being intercepted coming into the country; drug wars in Mexico impeding the flow of the drug across the border; and increased availability and popularity of other substances, such as heroin, decreasing the demand for cocaine. While participants noted a connection between heroin and powdered cocaine, discussing how many drug dealers now carry heroin and powdered cocaine for heroin users who like to use the two drugs together (aka "speedball"), treatment providers continued to note that powdered cocaine is not a primary drug of choice among clients entering treatment.

Participant quality scores for powdered cocaine varied throughout regions from '0' to '8', with the most common score being between '4' and '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants continued to report that the quality of powdered cocaine varies

depending on dealer of purchase. Regional crime labs reported the following substances as used to cut (adulterate) powdered cocaine: boric acid, caffeine, diltiazem (high-blood pressure medication), inositol (B vitamin), levamisole (livestock dewormer), local anesthetics (benzocaine, lidocaine and procaine) and a variety of sugars.

Current street jargon includes many names for powdered cocaine, with the most common names remaining “blow,” “girl,” “powder,” “soft,” “snow,” “white” and “white girl.” Depending on desired quality and from whom one buys, a gram of powdered cocaine currently sells for between \$40-100 throughout regions.

Participants reported that the most common route of administration for powdered cocaine is snorting, followed by intravenous injection. However, participants in Cleveland reported that the most common way to use powdered cocaine is to smoke it as “rocked up” crack cocaine. Most participants agreed that intravenous injection of powdered cocaine is most common among individuals who also use heroin. Participants and community professionals generally described typical users of powdered cocaine as being of higher socio-economic status, often professionals and often White. Also, participants noted that powdered cocaine use is popular among drug dealers, and use is common in bars and clubs, with several participants noting common use in gay bars and clubs in particular. Additionally, participants continued to note that the drug is appealing to those who work long hours, and some treatment providers in Cincinnati reported more African-American males recently coming into treatment who have had experience with powdered cocaine than previously.

Reportedly, other substances used in combination with powdered cocaine include alcohol, Ecstasy, LSD (lysergic acid diethylamide), heroin, marijuana, methamphetamine, prescription opioids, prescription stimulants, sedative-hypnotics and tobacco. Many participants reported that drugs often used in combination with powdered cocaine are used to “come down” from the stimulating effect of powdered cocaine. Participants and community professionals reported that it is common to pair powdered cocaine use with alcohol to allow a user to drink more alcohol and use more drugs. Common practices among users include lacing marijuana (aka “primo”) or lacing cigarettes with powdered cocaine. Mixing powdered cocaine with heroin, either together in the same syringe or in sequence, is called a “speedball.” A Toledo participant commented that crushing an Ecstasy pill and mixing it with cocaine is called a, “pixie stick.”

Crack Cocaine

Crack cocaine remains highly available in all regions. Participants in every region continued to most often report 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). Many participants noted an increase in the demand for crack cocaine during the past six months, explaining that more people are using crack cocaine because it remains a cheap drug. Participants also frequently noted that crack cocaine remains highly profitable to sell. For example, participants in Cleveland and Columbus reported walk-up or door service was common in certain urban neighborhoods, whereas a phone call is generally required in suburban or rural areas. Participants in Dayton reported distribution of free samples of crack cocaine (aka “testers”). Yet, while some participants and community professionals commented that even though crack cocaine is still widely available, it is now being outpaced by heroin.

The most common participant quality score for crack cocaine varied throughout regions from ‘0’ to ‘7,’ with the most common score being ‘5’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). There was consensus across participant groups that quality of crack cocaine continues to be dependent upon from whom and where (regionally) the drug is purchased. Moreover, several participants noted that when availability of powdered cocaine becomes scarce, buyers are more likely to get low-concentration crack cocaine or “fake crack” (a product devoid of any cocaine). Participants in Akron-Canton referred to poor quality crack cocaine, containing very little cocaine and mostly baking soda, as “soda balls.” Regional crime labs reported the following substances as used to cut crack cocaine: levamisole (livestock dewormer), local anesthetics (lidocaine and procaine) and sodium bicarbonate (baking soda).

Current street jargon includes many names for crack cocaine, with the most common names being “butter,” “crack,” “hard,” “rock” and “work.” Throughout regions, a gram of crack cocaine sells for between \$40-100, depending on quality. However, many participants continued to report buying crack cocaine in dollar increments instead of measured amounts. Most participants reported buying crack cocaine in \$10 or \$20 amounts, with nearly all participants reporting that crack cocaine is typically purchased by the amount of money a

user has available. Many users in Cleveland noted that the decreasing quality of crack cocaine compels them to buy larger sizes which can be cooked down; particularly popular is the "\$50 block," which reportedly is about the size of a quarter.

The most common route of administration for crack cocaine throughout regions remains smoking. Participants continued to note that a minority of users intravenously inject the drug; reportedly, those who inject are those who inject heroin. While there was no consensus throughout regions as to a profile of a typical crack cocaine user, several common themes emerged. Many respondents described typical users as being of lower socio-economic status, African American, often homeless, often unemployed, residing in an urban or inner city location and often involved in prostitution. Reportedly, other substances used in combination with crack cocaine include alcohol, Ecstasy, heroin, marijuana, prescription opioids and sedative-hypnotics. As is the case with powdered cocaine, typically, these other drugs are used with crack cocaine to help bring a user "down" from the intense high associated with cocaine.

Heroin

Heroin remains highly available in all regions. There was almost unanimous agreement among participant groups throughout regions that current availability of heroin is '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). During the past six months, heroin availability increased in Akron-Canton, and it likely increased in Athens, Cleveland, Columbus and Toledo. Many respondents continued to identify heroin as the primary drug problem and labeled its current status as "epidemic." Participants in Cincinnati reported that heroin is as easy to find as crack cocaine, which has consistently been among the easiest drugs to find in Cincinnati. In Cleveland, participants continued to cite many crack cocaine dealers as switching inventory to accommodate increasing demand for heroin.

Today, street-level dealers actively seek new clientele and encourage their existing clients to switch to heroin. Treatment providers in Athens, Cleveland and Toledo reported an increase in the number of users entering treatment who identify heroin as their primary drug of choice. Participants in Akron-Canton continued to note increased heroin availability and use in more rural areas.

Participants in Columbus explained that heroin is easily obtained by calling a dealer and arranging to meet in a parking lot. Participants continued to note that changes to the formulation of some prescription opioids, aimed at making them more difficult to abuse, has caused users to switch to heroin.

Treatment providers posit that the fact that heroin is cheaper than other opiates is due to the increase in popularity and availability of heroin. Many participants with experience using heroin reported using prescription opioids first which seemingly led to heroin use -- treatment providers also mentioned the glut of prescription opioids and the pill progression from prescription opioids to heroin users often undergo. While many types of heroin are currently available throughout regions, participants continued to report brown powdered heroin as most available in Akron-Canton, Cincinnati, Cleveland, Dayton and Youngstown; black tar heroin remains most available in Athens and Columbus; as white powdered heroin is currently most available in Toledo.

The most common participant quality score for heroin varied throughout regions from '3' to '10,' with the most common score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants also generally report that the quality of heroin has either remained the same or has varied during the past six months, some participants noted an increase in quality, particularly some participants in Athens who reported increased quality for the drug's "raw" form (aka "chunks" before it is broken up into "stamp bags" for sale, as it is at this point that heroin is often adulterated with other substances). Participants in Athens, Cincinnati, Cleveland, Columbus and Toledo believed heroin to occasionally or frequently be cut with fentanyl. Some participants in Toledo were convinced that in some cases "china white" heroin is dried and crushed fentanyl being sold as heroin. However, regional crime labs reported the following substances as used to cut heroin: caffeine, diphenhydramine (antihistamine), lidocaine (local anesthetic), noscapine (cough suppressant) and quinine (antimalarial). Current street jargon includes many names for heroin. The most commonly cited names were "boy," "dog," "dog food," "dope," "H" and "smack."

Participants continued to report that it is most common to purchase a single heroin "bag," "balloon," "berry," "fold" or "stamp" (1/10 gram), and then, once used to purchase another: 1/10 gram sells for between \$5-25; a gram sells

for between \$100-200, depending on location and quality of heroin. Participants in Dayton reported that brown and white powder heroin is primarily available in “caps” (capsules filled with approximately 1/10 gram of heroin) -- a cap typically sells for \$10. Many participants in Athens commented that there is a significant difference in price if one were to buy heroin locally or chose to travel to a large city, such as Columbus.

Throughout regions, the most common route of administration for heroin remains intravenous injection, followed by snorting. Participants continued to note a progression of use with heroin; typically first-time users snort heroin before progressing onto intravenous injection. Participants and community professionals most often described the typical heroin user as White and under 30 years of age. Reportedly, other substances used in combination with heroin include alcohol, bath salts, crack cocaine, Ecstasy, marijuana, methamphetamine, powdered cocaine, prescription opioids, prescription stimulants and sedative-hypnotics. Heroin is used with other drugs to help balance or intensify the effects of heroin, although many participants reported that it is common not to use other substances with heroin.

Prescription Opioids

Prescription opioids remain highly available in all regions. Participants and community professionals listed the following prescription opioids as most popular in terms of illicit use: Dilaudid®, fentanyl, Opana®, OxyContin®, Percocet®, Roxicet®, Roxicodone®, Ultram® and Vicodin®. High availability of prescription opioids has generally remained unchanged during the past six months throughout regions. However, there were more mentions of Dilaudid® availability and popularity than previously, particularly in Athens and Cleveland. Despite the perceptions of many treatment providers, participants reported that users are not as likely to use the new abuse resistant formulations of OxyContin® and Opana® -- the old formulations of these drugs can no longer be found on the streets of most regions.

Many prescription opioids have been “proofed,” or made resistant to crushing, putting other non-proofed opioids at a premium. This has reportedly impacted availability and given momentum to the pill-to-heroin progression. However, participants continued to report that many prescription opioids remain readily available through

prescription and street purchase, although a number of respondents in Athens, Cleveland and Dayton reported that physicians are now more cautious about their prescribing.

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 overall most common route of administration remains snorting, followed by intravenous injection and oral consumption (swallowing and chewing). In addition to obtaining prescription opioids on the street from dealers, participants continued to list the following other sources for prescription opioids: doctors, emergency rooms, family, friends and other people with prescriptions and pain clinics. Participants noted that prescription opioids are commonly traded through friends and family. A profile of a typical illicit user of prescription opioids did not emerge from the data. However, participants and community professionals continued to note growing popularity of prescription opioids abuse among younger people. Participants in Akron-Canton spoke about “pharm parties” as popular with adolescents (partygoers bring pills, put them into a bowl and swallow pills randomly).

Finally, There was almost universal agreement among respondents that illicit prescription opioids users are most often White. Reportedly, other substances used in combination with prescription opioids include alcohol, crack cocaine, heroin, marijuana, methamphetamine, powdered cocaine and sedative-hypnotics. Participants reported that the combination of prescription opioids with the aforementioned drugs increases the intensity, euphoria and length of their “buzz” (high). Many participants reported that it is more common to use prescriptions opioids in combination with other substances than to abuse the drugs alone.

Suboxone®

Suboxone® is highly available in all regions with the exception of Dayton where current street availability remains moderate. Changes in availability during the past six months include increased availability for Akron-Canton and Toledo, likely increased availability for Columbus and likely decreased availability for Dayton. Participants continued to report the drug to be easily available by prescription, through treatment centers, the Internet, or from dealers and friends who use heroin.

Many participant groups reported that it is a common practice to sell one's prescriptions. According to several participants, the film/strip form of Suboxone® is typically taken as part of a treatment program or obtained by heroin users as a last resort when heroin cannot be found, and Subutex® or Suboxone® tablets are the more desirable form among illicit users because they can be crushed, snorted or injected. Participants posited that as opiate use continues to increase, so too does the street availability of Suboxone®. Participants also reported that in some counties there are now more Suboxone® programs.

Treatment providers reported that there seems to be a demand for Suboxone®, noting billboards advertising, "Free Suboxone®," and individuals prescribed Suboxone® commonly sharing it with friends. In Athens, while treatment providers noted that there are few doctors in the region who prescribe Suboxone®, they reported that there is enough available Suboxone® that if a user were in withdrawal, he/she could find the drug with little effort. In addition to those who self-medicate with it, treatment providers also reported knowledge of users who get high off Suboxone®.

Participants reported that users are switching from methadone to Suboxone®. They also reported an increase in use at treatment centers. In Dayton, current prescribing patterns are attributed to the decrease in the region, as community professionals reported doctors trying to limit diversion. Collaborating data also indicated the high presence of Suboxone® throughout regions; for instance, the Mahoning County Coroner's Office reported buprenorphine as present in 16 percent of all drug-related deaths during the past six months.

Current street jargon includes few names for Suboxone®, including "oranges," "strips" and "subs." Participants reported that an 8 mg tablet or strip of Suboxone® sells for between \$5-25, with tablets generally selling for more as they can be crushed for snorting or injecting. The vast majority of participants continued to report most often taking Suboxone® sublingually (dissolving it under the tongue); however, in terms of illicit use, participants reported dissolving strips in water and injecting, and crushing tablets and snorting, as common. Suboxone® continues to be primarily acquired from doctors, friends and occasionally dealers who keep them to attract users to other inventory.

Participants and community professionals who had knowledge of illicit use of Suboxone® continued to describe heroin and prescription opioids addicts as those who typically abuse Suboxone® when they can't

get what they want. Reportedly, other substances used in combination with Suboxone® include alcohol, crack cocaine, marijuana, methamphetamine, powdered cocaine and sedative-hypnotics. However, many participants reported that it is not too common to use other substances with Suboxone®.

Sedative-hypnotics

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in all regions. Changes in availability during the past six months include likely increased availability for Akron-Canton and Toledo and likely decreased availability for Dayton. Participants throughout regions 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). Many participants in Akron-Canton agreed that it is easy to find a physician who will prescribe benzodiazepines and easy to find these medications on the street; in addition, a number of participant groups in the region knew of availability of these medications on the Internet. Treatment providers in Toledo reported that the availability of sedative-hypnotics has increased during the past six months, especially for Xanax®; both reporting crime labs in the Toledo region also reported increases in the number of Xanax® cases they process. Participants in Dayton suggested that the perceived decline in availability of sedative-hypnotics is due to fewer prescription holders selling their drugs. Participants and community professionals reported Klonopin® and Xanax® as the most popular sedative-hypnotics in terms of illicit use, followed by Ambien®, Soma® and Valium®.

Participants continued to report most often obtaining these drugs from individuals with existing prescriptions, or by feigning symptoms of anxiety and getting prescriptions from doctors. Participants reported that dealers often do not carry sedative-hypnotics, possibly due to their availability through other sources and their lower profitability; most of these drugs sell for no more than a few dollars per pill. While there were a few reported ways of consuming sedative-hypnotics, the most common routes of administration remain oral consumption and snorting, with some mention of intravenous injection and smoking. A few participants reported lacing marijuana with crushed sedative-hypnotics pills for smoking.

Participants and community professionals generally described the typical illicit user of sedative-hypnotics

as adolescent to “young” adult, White and female. The use of sedative-hypnotics with other drugs is common. Reportedly, other substances used in combination with sedative-hypnotics include alcohol, crack cocaine, heroin, marijuana, powdered cocaine and prescription opioids. Sedative-hypnotics are often used as a way of stabilizing from a high provided by stimulants such as cocaine. When used in combination with alcohol, participants in the Columbus region reported dissolving the drugs into beer and drinking.

Marijuana

Marijuana remains highly available throughout all regions. Participants from every region most often reported the overall availability of marijuana as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Community professionals commonly reported that many users do not consider marijuana a drug; many community professionals also noted that the marijuana currently available is far more potent and fast acting than in the past. In addition, treatment providers noted that for many young people, marijuana is easier to obtain than alcohol.

Treatment providers in Athens reported that 90 percent of adolescents entering treatment report marijuana as their drug of choice. Law enforcement reported that marijuana is both grown locally and imported. In Cleveland, and in most regions, marijuana remains, by far, the most easily-obtained illegal drug, available to every socioeconomic group, rural and suburban. The bifurcation of the drug into two distinct categories continues to deepen: commercial-grade (low- to mid-grade marijuana) or hydroponically grown (high-grade) marijuana.

Community professionals were in agreement with participants in reporting that commercial-grade marijuana is available “everywhere,” while purchase of hydroponic marijuana requires knowing whom to call and where to go to obtain it. In addition, several participants discussed either growing or having access to hydroponically grown marijuana; and participants in Toledo and Youngstown discussed having access to medical marijuana. Collaborating data also indicated that marijuana is readily available throughout regions. For instance in Dayton, the Montgomery County Juvenile Court reported that of the juveniles it drug tested during the past six months, 68.3 percent tested positive for the presence of an illicit drug;

and of those positive, 71.7 percent were positive for the presence of marijuana.

Every grade of marijuana is available throughout regions, and participants continued to explain that the quality of marijuana depends on whether the user buys commercial-grade or hydroponically grown marijuana. Participants commonly rated the quality of commercial-grade marijuana as between ‘2’ and ‘7’; while they rated the quality of high-grade marijuana most often as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). A Toledo participant commented on an increase in the quality of marijuana in that region since Michigan voted to legalize the use of medical marijuana.

Current street jargon includes countless names for marijuana. The most commonly cited names for marijuana generally were “green,” “pot,” “trees” and “weed.” Prices for marijuana continue to depend upon the quantity and quality desired: for commercial-grade marijuana, a “blunt” (cigar) or two “joints” (cigarettes) sells for between \$5-10; an ounce sells for between \$50-120. Higher quality (hydroponically grown) marijuana sells for significantly more: a blunt or two joints sells for between \$10-30; an ounce sells for between \$150-400.

The most common route of administration for marijuana remains smoking; however, participants again noted that marijuana can also be consumed in baked goods and by making tea. A profile for a typical marijuana user did not emerge from the data. Participants and community professionals continued to report that marijuana use is widespread across all population strata. Reportedly, other substances used in combination with marijuana include alcohol, crack cocaine, heroin, methamphetamine, PCP (phencyclidine), powdered cocaine, prescription opioids, sedative-hypnotics and Suboxone®.

Participants also reported that marijuana intensifies the high of other substances. A participant group in Akron-Canton reported knowledge of using marijuana with embalming fluid or PCP, describing marijuana with either of the aforementioned as causing one to hallucinate. Participants did not agree on whether it is more common to use marijuana by itself or to use it with other substances; some participants posited that marijuana goes with everything.

Methamphetamine

Methamphetamine availability remains high for Akron-Canton and Cleveland and variable for Cincinnati, Columbus and Youngstown; availability is also variable for Dayton, low to moderate for Toledo, and moderate to high for Athens. Changes in availability during the past six months include increased availability for Athens and likely increased availability for Akron-Canton, Cleveland, Columbus and Youngstown. In regions where availability of methamphetamine is variable, generally lower availability exists for urban areas and higher availability exists for rural areas. However, Dayton participants reported high availability for the drug within the city and much lower availability in outlying areas.

Participants throughout regions reported on the production of "one-pot" or "shake-and-bake" methamphetamine, which means users are producing the drug in a single sealed container, such as a two-liter soda bottle. By using common household chemicals along with ammonium nitrate found in cold packs and pseudoephedrine, typically found in some allergy medications, drug manufacturers (aka "cooks") can produce methamphetamine in approximately 30 minutes at nearly any location. Participants throughout regions reported "shake-and-bake" methamphetamine as the most prevalent form of available methamphetamine.

Participants also reported that higher quality methamphetamine, commonly referred to as "ice," is very rare; additionally, participants named the more traditional form of locally produced "red phosphorous" methamphetamine, which large amounts were manufactured previously for sale on the streets, as also rather rare. In Athens, some participants believed that some methamphetamine is being moved into the region from southern states, and law enforcement reported that the availability of methamphetamine coming from Mexico (aka "Mexican ice") has decreased since users can now make their own methamphetamine.

Participants generally noted that methamphetamine is cheaper and easier to make than previously. However, treatment providers have not experienced an uptick in methamphetamine abuse among their clientele. The overall quality of methamphetamine continues to range from '5' to '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality), with crystal methamphetamine being at the higher end of the scale. Participants in Columbus reported that the quality of methamphetamine

has decreased during the past six months; they reported methamphetamine to be cut with baby laxative, MSM (methylsulfonylmethane – a dietary supplement), a mixture of over-the-counter chemicals, as well as salt. A participant group in Athens reported that methamphetamine is being mixed with cocaine and that some users are unaware that their cocaine contains the drug.

Current street jargon includes a few names for methamphetamine. The most commonly cited names were "crank," "crystal," "glass," "ice," "meth," "speed" and "tweak." Prices for methamphetamine continue to depend on the quantity and quality of the drug: a gram sells for between \$50-150. However, participants in Akron-Canton and Athens reported buying small bags of methamphetamine (1/10-2/10 gram) for between \$20-30. Participants in Akron-Canton and Youngstown reported that methamphetamine is often traded for precursor ingredients, such as Sudafed®; many participants in the Youngstown region also discussed purchasing Sudafed® in exchange for other drugs, particularly heroin. While there were several reported ways of using methamphetamine, the most common route of administration remains smoking, followed by intravenous injection.

There was universal agreement among all respondent groups that typical methamphetamine users are almost exclusively White. In addition, participants noted the following groups of Whites as those most likely to use: "younger," rural, gay males, motorcycle gang members and truck drivers. Reportedly, other substances used in combination with methamphetamine include alcohol, crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids, prescription stimulants and sedative-hypnotics. Alcohol, marijuana and sedative-hypnotics assist the user in coming down from the extreme stimulant high produced by methamphetamine. Heroin is used in combination with methamphetamine for the "speedball" effect. The majority of participants noted that it is more common to use methamphetamine by itself, and if used with any other substance, it is used most often with alcohol.

Prescription Stimulants

Prescription stimulants are moderately to highly available in all regions; availability remains high in Athens, Cleveland, Columbus and Youngstown and moderate to high in Cincinnati; current availability is high in Akron-Canton and moderate to high in Dayton and Toledo. Participants explained that if prescription stimulants are desired, they can easily be found. A participant group

in Akron-Canton described extreme ease in being able to obtain prescription stimulants; they reported that a lot of school-aged children are prescribed Adderall® or Ritalin® and that many sell their medication. Participants reported that illicit users of prescription stimulants are not likely to obtain the drugs from a drug dealer. Many participants with use experience reported that the most convenient way to obtain prescription stimulants is by getting them from someone who is prescribed them; participants reported getting the drugs often from family members (younger siblings) who are being treated with the medication. Reportedly, Adderall® is the most popular prescription stimulant throughout regions in terms of illicit use, followed by Concerta®, Ritalin® and Vyvanse®. Community professionals reported that they do not typically see or deal with prescription stimulants abuse; however, many treatment providers reported that some individuals currently in treatment report past use of prescription stimulants.

Current street jargon includes a few names for prescription stimulants. The most commonly cited names were “addies” for Adderall®, as well as “kiddie coke,” “meth in a pill,” “poor man’s coke,” “speed” and “uppers” for prescription opioids generally. Participants reported that Adderall® 30 mg sells for between \$3-10, depending on location.

While there were several reported ways of using prescription stimulants, the most common route of administration for abuse remains oral consumption (swallowing and eating) and snorting. Participants also reported knowing of some intravenous injections of prescription stimulants, but this was said to be rare.

Participants described typical illicit users of prescription stimulants as high school and college aged. Community professionals also described typical illicit users as between 18-25 years of age, most often enrolled in college who take the drugs during exam time. A couple of treatment provider groups noted that abuse of prescription stimulants is higher among women; providers in Akron-Canton reported that many women use the drugs for weight control.

Reportedly, other substances used in combination with prescription stimulants include alcohol, cocaine, marijuana, prescription opioids and tobacco. Prescription stimulants are used in combination with alcohol and marijuana when the user wants to “party” longer and continue to consume alcohol and/or use marijuana; they are used in combination with prescription opioids to enhance the high of prescription opioids.

Bath Salts

Bath salts (synthetic compounds containing methylone, mephedrone, MDPV or other chemical analogues) remain available throughout regions despite legislation that banned its sale and use in October 2011. Current availability remains high in Akron-Canton and Columbus and moderate in Cleveland, Dayton, Toledo and Youngstown; availability is moderate to high in Cincinnati and appears to be low in Athens. Packaged products of bath salts continue to be available from some of the same convenience stores, beverage drive-thrus, head shops, gas stations and smoke shops that sold bath salts previously. They are now “behind the counter” and available only to known users. In addition, participants noted that bath salts can still be found on the streets, but a user would have to know someone who deals in the drug. No matter what the perceived level of availability, all participant groups agreed that availability was higher before bath salts were banned. Also, respondents universally noted that legislative action has had an effect on availability.

However, a DEA agent in Cincinnati stated that while there may have been a decline in the use of bath salts, the drug remains obtainable to those who desire it. Participants in Athens noted that bath salts are still readily available in West Virginia, and hence, users go across the state line to purchase the drug. In addition, participants commented that users can still purchase bath salts over the Internet. Canton-Stark County Crime Lab reported that other substances similar to bath salts have been seen in the lab during the past six months; some of these substances are controlled (4-Fluoroamphetamine and 4-Fluoromethamphetamine) while others are uncontrolled chemical analogues.

Most participants expressed an aversion for bath salts and did not report attempting to purchase them; many participants were repulsed by media stories of the negative consequences of bath salts use. New labels for bath salts are emerging to help circumvent the laws; participants said bath salts are currently sold under labels like, “hookah cleaner,” “incense,” “pixie dust,” “plant food,” “salt” and “zombie salts.” Prices for bath salts varied substantially between regions. A participant with experience purchasing the drug reported that the price of bath salts has recently increased. Participants reported that bath salts sell for between \$20-60 per gram within Akron-Canton, Cincinnati and Columbus regions. In contrast, participants in Athens reported bath salts selling for between \$40-180 per gram; participants within the remaining

regions reported current pricing as unknown to them. The most common routes of administration for bath salts are snorting and intravenous injection.

Participants and community professionals described typical bath salts users most often as younger than 30 years of age and likely on probation, monitored through urine drug screens. Reportedly, other substances used in combination with bath salts include alcohol, cocaine, heroin and marijuana. There was no consensus among participants as to whether regular bath salts users combined bath salts use with other substances. However, participants who had experimented with the drug reported using it with alcohol and marijuana.

New labels and names for synthetic marijuana are emerging to help circumvent the laws; however, the most commonly cited names continue to be "K2," "K3" and "Spice." Within most regions, a gram of synthetic marijuana currently sells for between \$20-25. The only route of administration for synthetic marijuana remains smoking. Participants and community professionals described typical users of synthetic marijuana as "young" and without connections or resources to obtain real marijuana, or users who wish to avoid the negative sanctions of a positive marijuana test, such as probationers. Participants reported that generally, synthetic marijuana is not often used in combination with other drugs besides use with alcohol and/or marijuana.

Synthetic Marijuana

Synthetic marijuana (synthetic cannabinoids, aka "K2" and "Spice") remains available throughout regions despite legislation that banned its sale and use in October 2011. Current availability remains high in Akron-Canton, Cleveland and Toledo; availability is moderate in Dayton and Youngstown; participants in Athens, Cincinnati and Columbus thought availability to be high, while community professionals in those regions viewed current availability as low to moderate. Likely increases in availability exist for Toledo and Youngstown.

As with bath salts, participants throughout regions reported that synthetic marijuana continues to be available on the street from dealers as well as from many convenience stores and head shops. However, participants and law enforcement reported that recent legislation has caused the drug to be far less available at retail outlets than previously, and those which continue to sell synthetic marijuana are much more discreet about it.

The general consensus among participants who have used synthetic marijuana was that the drug is not very desirable, as most users do not like the "high" produced from the drug, and thus most prefer to smoke marijuana. Law enforcement in Toledo and Youngstown regions believed that availability has slightly increased during the past six months. They cited that young people who use synthetic marijuana believe they will receive less of a penalty than being caught with marijuana. Additionally, some users reportedly smoke synthetic marijuana because they continue to believe that it will not show up on any drug screen.

Ecstasy

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMP) availability remains variable throughout regions. Current availability remains high in Cincinnati and Cleveland and moderate in Columbus and Youngstown; availability is moderate to high in Toledo, variable in Athens and appears to be low in Akron-Canton and Dayton. Changes in availability during the past six months include decreased availability for Akron-Canton and likely decreased availability for Cincinnati.

Participants generally reported regular use of Ecstasy to be uncommon, explaining that if there were a music festival in the area, one would hear about Ecstasy. Law enforcement in the Athens region reported on an annual festival where Ecstasy use is thought to be prevalent. A few participants with first-hand experience reported that if you know who deals Ecstasy, you can get it. Community professionals reported that Ecstasy use seems to be more uncommon than previously. Treatment providers noted that Ecstasy is sometimes heard about but mostly in the context of experimental use among high school and college students. Participants in Cincinnati reported that Ecstasy remains popular in the city but that a user would need a connection to buy the drug; Ecstasy is not a drug obtained on the street. However, participants in Cleveland thought dealers to carry Ecstasy as many dealers are believed to personally use the drug. Several participants in Youngstown noted an increase in pure MDMA, or "Molly," during the past six months.

Current street jargon includes a few names for Ecstasy. The most commonly cited names were "beans," "E," "Scooby snacks," "Skittles®" and "X." Participants reported that a "single stack" (low dose) Ecstasy tablet sells for between \$2-10; a "double-stack" (high dose) tablet sells for between \$10-20; a "triple stack" (highest dose) tablet sells for between \$10-25; 1/10 gram of "Molly" sells for \$15; a gram sells for between \$60-100. These drugs are obtained from friends and dealers, often via a phone call or at nightclubs. Higher pricing can be expected at events or at nightclubs.

While there are few reported ways of using Ecstasy, the most common route of administration remains oral consumption. In addition, a few participants discussed "plugging" Ecstasy (insertion of the drug rectally); MDMA is most often snorted. Participants described typical users of Ecstasy as African Americans, club goers, hippies, urban youth and "younger" people. Participants and treatment providers alike continued to identify Ecstasy as a "rave" (underground dance party) drug, popular with college students. Participants explained that users of Ecstasy like to use it to enhance the night club experience or to enhance a sexual experience. Reportedly, other substances used in combination with Ecstasy include alcohol, cocaine, hallucinogens, heroin and marijuana.

Other Drugs

OSAM Network participants listed a variety of other drugs as available in Ohio, but these drugs were not reported in all regions. Participants in Dayton continued to mention anabolic steroids as available at some fitness centers in the region. Hallucinogens [lysergic acid diethylamide (LSD), phencyclidine (PCP) and psilocybin mushrooms] remain available in many regions. In addition, the BCI London Crime Lab reported an increase in the number of cases involving 2C-E, 2C-I and 25I-NBOMe (psychedelic phenethylamines).

LSD is rarely to moderately available in most regions, with the exception of Akron-Canton where it is highly available, and Cincinnati, where the drug is moderately to highly available. Many participants indicated that LSD is considered a seasonal drug, with availability increasing in the spring and summer months, or at particular rock concerts. Current street jargon includes a few names for LSD. The most commonly cited names were "acid," "blotter"

and "blotter acid." Reportedly, LSD sells for between \$5-10 per "hit" (dose). The most common route of administration for LSD is oral consumption, followed by lacing a cigarette with the drug and smoking. While a typical user profile did not emerge in every region, respondents frequently reported LSD users as mostly White, hippies, teenagers and "young" adults.

Reportedly, PCP remains highly available in one area of the City of Cleveland, often referred to as "water world." Treatment providers in Cleveland reported an increase in the number of cases involving PCP during the past six months. Participants with experience purchasing the drug reported that one dip of a cigarette into liquid PCP sells for between \$10-20. The most common route of administration for PCP remains smoking. Outside of Cleveland, no other region reported on PCP use.

Psilocybin mushrooms are moderately to highly available in most regions. Like other hallucinogens, participants said psilocybin mushrooms are seasonally available, found most often in the spring and summer months. Current street jargon includes a few names for psilocybin mushrooms. The most commonly cited names were "blue caps," "caps," "gold caps," "magic," "mushies" and "shrooms." Participants reported that psilocybin mushrooms are available for \$8 per vial; 1/8 ounce of dried psilocybin mushroom material sells for between \$20-30; 1/4 ounce sells for between \$50-55; an ounce sells for between \$120-200. The most common route of administration for psilocybin mushrooms remains oral consumption, but participants also continued to report smoking and making tea with them. Participants reported getting psilocybin mushrooms from dealers, chemists, chemical engineers and professors. Participants reported typical users as "young" adults and college students.

Reportedly, other substances used in combination with hallucinogens include alcohol, cocaine, Ecstasy, inhalants and marijuana. Inhalants are highly available throughout most regions, but these substances are not preferred by most drug users. Inhalants are breathed into the lungs, or "huffed." Participants and community professionals identified the most commonly abused inhalants as computer duster (aka "duster") and Freon. Typically, inhalant users are junior- and high-school aged adolescents who have little access to other drugs. Reportedly, other substances used in combination with inhalants include alcohol and LSD. Over-the-counter (OTC) and prescription cough and cold medications remain highly available throughout most regions. Participants

mentioned using these medications, especially Coricidin®, to get high. Typically, users combine these medications with soda. Like inhalants, participants identified OTC and prescription cough and cold medicines as substances that individuals in middle and high school are more likely to abuse than others.

Gambling

Several themes regarding the popularity of particular gambling types are common to all OSAM regions. Lottery and scratch-offs are the most common forms of gambling within each region. Internet cafes also continue to grow throughout the state, and may be directly related to drug use in some areas. A Cleveland participant reported that drug dealers frequent Internet cafes and drugs are often obtained at these businesses.

Participants in every region reported participation in casino gambling during the past six months, with 20 percent of Columbus participants reporting casino gambling. Casino gambling may be more prevalent in regions closer to existing casinos in Indiana, Pennsylvania and West Virginia. Dice, poker and other street games are popular in the Cincinnati, Columbus, Dayton, Toledo and Youngstown regions. Bingo is also common, particularly in the Akron-Canton, Athens, Columbus, Dayton and Youngstown. Finally, while not as prevalent as other forms of gambling, sports gambling is available throughout regions.

There was no consensus among participants as to a relationship between alcohol and other drug (AoD) use and gambling. Participants in Athens, Cleveland and Dayton gave mixed reports on the topic. However, some patterns did emerge from the data. Participants in

Columbus generally agreed that AoD use and gambling are in some way related to one another. Most Columbus respondents who shared this viewpoint referred to alcohol use as very common among gamblers. Although participants in the Akron-Canton region were split as to whether or not a relationship between alcohol and gambling exists, some participants suggested that there is a significant relationship. The connection between alcohol use and gambling was also supported by participant reports in Athens, Toledo and Youngstown. Similarly, Cleveland participants suggested that both marijuana and alcohol use are prevalent among gamblers.

Several participants reported that there may be an indirect relationship between drugs and gambling. Specifically, the tendency to gamble in order to buy drugs was mentioned by several participants within Athens, Columbus and Youngstown especially. In addition, some participants in Athens, Columbus and Toledo reported gambling more when they used drugs. However, Cincinnati participants reported gambling as secondary to drug use, suggesting that they would only gamble with additional funds after obtaining their drug of choice.

Reports suggest that most participants believed that gambling is potentially addictive. In addition, some participants suggested that personality influences one's susceptibility to gambling addiction. However, very few participants reported struggling with problem or pathological gambling. No participants in Cincinnati or Columbus regions reported experiencing any problems with gambling. Most descriptions of problem and pathological gambling were made in reference to family members or friends. However, some participants reported borrowing money from others to cover gambling debts. In addition, two participants in Toledo reported seeking help for an addiction to gambling, with one receiving treatment.