



Drug Abuse Trends in the Cincinnati Region



Data Sources for the Cincinnati Region

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 Butler and Hamilton counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via focus group interviews, as well as to data surveyed from the Bureau of Criminal Investigation (BCI) London office, which serves central and southern Ohio. All secondary data are summary data of cases processed from July through December 2012. In addition to the data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2013.

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, current secondary data correspond to the current reporting period of participants.

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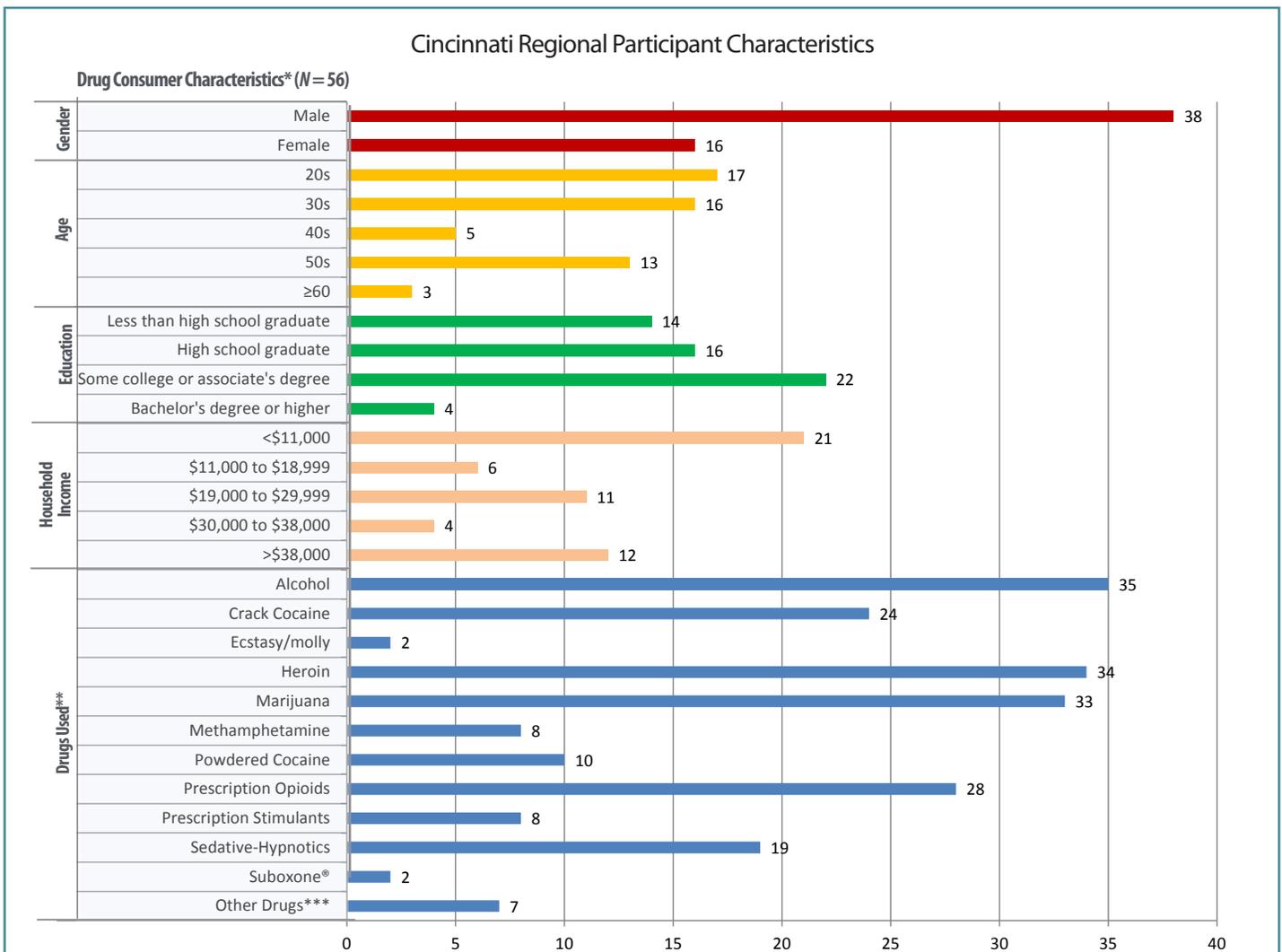
Regional Profile

Indicator ¹	Ohio	Cincinnati Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	2,017,337	56
Gender (female), 2010	51.2%	51.1%	29.6%
Whites, 2010	81.1%	81.3%	69.6%
African Americans, 2010	12.0%	12.5%	28.6%
Hispanic or Latino origin, 2010	3.1%	2.3%	0.0%
High School Graduation rate, 2010	84.3%	88%	75.0%
Median Household Income, 2011	\$45,803	\$44,046	\$15,000 to \$21,999 ²
Persons Below Poverty Level, 2011	16.3%	17.7%	48.1% ³

¹Ohio and Cincinnati statistics are derived from the most recent US Census, and OSAM drug consumers were participants for this reporting period: January 2013 - June 2013.

²Participants reported income by selecting a category that best represented their household's approximate income for 2012. Income status was unable to be determined for four participants due to missing data.

³Poverty status was unable to be determined for four participants due to missing data.



*Not all participants completed forms; numbers may not equal 56.

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

***Other drugs refer to LSD, psilocybin mushrooms, and synthetic marijuana.

Historical Summary

In the previous reporting period (July–December 2012), crack cocaine, ecstasy, heroin, marijuana, prescription opioids, Suboxone® and sedative-hypnotics remained highly available in the region. Changes in availability included: likely decreased availability for bath salts and ecstasy.

The demand for heroin reportedly remained high because of the high cost of abusing prescription opioids which encouraged users to seek a cheaper alternative. While many types of heroin were available in the region, participants reported the availability of brown powdered heroin as most available. However, the Drug Enforcement Administration (DEA), which investigates larger criminal enterprises, reported that they saw more black tar heroin coming into the region during the reporting period.

Participants and community professionals most often reported the street availability of Suboxone® as '10' (highly available). Treatment providers noted more doctors were able to prescribe Suboxone® than previously; they also reported opiate-addicted individuals were using the drug until they could get more heroin or get into treatment. Participants agreed that the typical illicit user of Suboxone® was someone addicted to heroin or prescription opioids who did not want to experience symptoms related to opiate withdrawal.

Methamphetamine availability remained variable in the region. Participants and community professionals reported low availability in the City of Cincinnati and high availability in rural areas around Cincinnati. The BCI London Crime Lab reported that the number of methamphetamine cases it processes had increased during the reporting period.

Availability of ecstasy remained high in the region, though participants and treatment providers alike reported that the availability of ecstasy had decreased. Participants described typical users of ecstasy as African-American, club goers, "hippies," urban youth and "younger" people. Participants explained that users of ecstasy liked to use the drug to enhance the night club experience or to enhance a sexual experience.

Lastly, participants throughout the region reported that despite legislation enacted in October 2011, bath salts and synthetic marijuana continued to be available from some retail outlets (convenience stores, gas stations and "head shops"), although these outlets were more discrete about

whom they sold to, not openly advertising the drug's continued availability. The BCI London Crime Lab reported that the number of synthetic marijuana cases it processes had increased during the reporting period, while the number of bath salts cases had decreased. Treatment providers reported availability of bath salts had decreased. While the DEA reported there may have been a decline in the use of bath salts, they also reported that the drug remained obtainable to those who desired it.

Current Trends

Powdered Cocaine

Powdered cocaine is moderately to highly available in the region. Participants most often reported the drug's current availability with a bimodal score of '7' and '9' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '4'. Community professionals most often reported the drug's current availability as '8'; the previous most common score was '6-9'. A treatment provider commented on the availability of powdered cocaine: *"It may not be the number one drug of choice, but it's certainly available."*



Media outlets in the region reported on powdered cocaine seizures and arrests this reporting period. The Ohio State Highway Patrol seized two ounces of cocaine along with two ounces of heroin during a traffic stop in Scioto County (<http://statepatrol.ohio.gov/media.stm>, Feb. 12, 2013). Chillicothe (Ross County) police arrested five people during a drug raid of a local hotel, seizing heroin, cocaine, drug paraphernalia and more than \$5,000 in cash (www.nbc4i.com, May 30, 2013).

Participants reported that the availability of powdered cocaine has decreased during the past six months. A participant observed, *"I'd say [availability of powdered cocaine] it's gone down for me at least in the past few years ... probably because of the prevalence of heroin, and also maybe people not spending ... not having as much money ... the economy and everything."* Although participants often commented on a perceived decrease in availability of powdered cocaine, a participant speculated, *"I really don't think that [powdered cocaine] availability's changed. I just think, like everybody else is saying, a lot of people's drug of*

choice has changed to heroin, but I don't think the availability [has changed]. If I want coke [powdered cocaine], I can get it in five minutes."

Community professionals reported that availability of powdered cocaine has remained the same during the past six months. A member of law enforcement explained current availability of powdered cocaine: *"It's interesting talking to some of the senior guys in the group that have been here [in law enforcement] for 10-15 years. It used to [be] 10 years ago, they weren't getting any heroin. It was all cocaine, and it flipped upside down where they weren't seeing cocaine ... and, I think, now in the past two years or so we're seeing cocaine again, and heroin certainly continuing to rise up."* The BCI London Crime Lab reported that the number of powdered cocaine cases it processes has decreased during the past six months.

Participants most often rated the current quality of powdered cocaine as '1-2' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. A participant explained that quality of powdered cocaine varies, but overall quality remains low in the region: *"There's always gonna be some fire [high-quality powdered cocaine] everywhere but the overall [quality is low] ... now [dealers] they're cutting heroin with cocaine, so that kind of tells you."* Participants reported that powdered cocaine in the region is cut (adulterated) with Adderall®, baby laxatives, baking soda, Enfamil®, ephedrine (appetite suppressant), ether, isotol (diuretic), lidocaine (local anesthetic), manitol (sugar substitute), methamphetamine, Orajel®, salt, sugar and vitamin B-12. A participant explained, powdered cocaine is cut with, *"Anything you can find under the kitchen sink."*

A participant commented on how the quality of powdered cocaine led him to use other substances: *"If I could've found good cocaine, I probably would've stuck with that and not gone to heroin."* Changes in the quality of powdered cocaine have also altered the method of using powdered cocaine, as a participant explained: *"It [powdered cocaine] used to be high [quality] around here, and I used to snort it. And then it started ... it was just bad. It would burn my head, burn my nose, burn the roof of my mouth, so instead of snorting it, I started smoking it because I didn't want to feel all that pain."* Overall, participants reported that the quality of powdered cocaine has decreased during the past six months. The BCI London Crime Lab reported the following cutting agents for powdered cocaine: boric acid, levamisole (livestock dewormer), local anesthetics (lidocaine

and procaine), sucrose (table sugar) and sugar substitutes (mannitol and sorbitol).

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: "candy," "christina aguilera," "bitch," "fish scale," "flake," "lady," "powder," "snowing" and "white girl." Current street prices for powdered cocaine were varied among participants with experience buying powdered cocaine. Participants reported that a gram of powdered cocaine sells for \$40-100, depending on the quality; 1/16 ounce (aka "teener") sells for \$75-250; 1/8 ounce (aka "eight ball") sells for \$150-400; 1/4 ounce sells for \$300-340; an ounce sells for \$1,300-1,400; a kilo sells for \$1,750.

Participants reported that the most common routes of administration for powdered cocaine are intravenous injection (aka "shooting") and snorting. A participant explained, *"You know, [if] you got powder, there was only one to two ways you was gonna do the powder ... and it was a waste to snort it, so you shot it."* A treatment provider commented on the link between powdered cocaine and intravenous (IV) heroin use: *"Very seldom have I had a client who is an IV heroin user who has not shot cocaine."*

Many participants identified older males as more likely to use powdered cocaine, but other participants identified younger people, exotic dancers, business people and restaurant workers. Participants agreed that use is more likely occurs in middle-to upper-class areas. A participant commented, *"I find because it [powdered cocaine] is a more expensive drug, you'll find more professionals do it. High end people who are more socio-economically up the ladder. It's ... socially a 'cooler' or 'cleaner' drug than the others."* Treatment providers observed that powdered cocaine users are getting younger, in part due to what they described as increased social acceptability for the substance. Another treatment provider commented on the link between powdered cocaine and gang activity: *"It's like peer pressure for some in the schools and everything with gangs ... you do this or we'll do this to you, so the kids find themselves [sic] doing those things."*

Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana and sedative-hypnotics. A participant commented on the practice of combining other substances with powdered cocaine: *"I'd take the alcohol and pot [marijuana] to level out the cocaine [high]."*

Crack Cocaine

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'. A participant quipped, "How about a block every way you go ... either way you go, one block either way [you'll find crack cocaine]." Another participant commented on the popularity of crack cocaine: "Cause once you take that first hit [of crack cocaine], you want more and more, so you'll keep going out and spend all your money ... that's where the dealers are making their money [on crack cocaine sales]." Community professionals most often reported the drug's current availability as '8,' the previous most common score was '10'.

Media outlets in the region reported on crack cocaine seizures and arrests during this reporting period. The Ohio State Highway Patrol reported confiscating 29 grams of crack cocaine during a traffic stop in Scioto County (<http://statepatrol.ohio.gov/media.stm>, Jan. 22, 2013).

Participants and community professionals reported that the availability of crack cocaine has remained the same during the past six months. However, treatment providers suggested that the popularity of the drug has decreased during the past six months, often commenting on how opiates are taking the place of crack cocaine. A treatment provider stated, "I mean crack cocaine ... it's available, but what I've really noticed is a lot of the referrals that we are getting, the clients that are coming in, it's a lot of them, they are turning towards the opiates." The BCI London Crime Lab reported that the number of crack cocaine cases it processes has decreased during the past six months.

Most participants rated the current quality of crack cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '6'. Participants reported that crack cocaine in the region is cut with baking soda. The BCI London Crime Lab continued to cite levamisole (livestock dewormer) as the typical cutting agent for crack cocaine.

Participants reported that the quality of crack cocaine has decreased during the past six months and linked this decrease with the reduced quality of powdered cocaine. A participant commented, "Well, the quality of [powdered] cocaine in the area is down, so then obviously, crack is gonna be down too." Another participant commented on his ex-

perience using crack cocaine: "You know I was using \$2,000 dollars [of crack cocaine] almost every other day, and it was so bad that I had to re-cook it, re-cook it again and re-cook it again just to get the good quality that I know it used to be. So, that's a lot of work when you're trying to get high."

Current street jargon includes many names for crack cocaine. The most commonly cited names were "hard" and "rock." Participants listed other common street names of "melt" and "yammers." Current street prices for crack cocaine were varied among participants with experience buying crack cocaine. Participants reported: 1/2 gram sells for \$30, depending on the quality; a gram sells for \$40-100. However, participants reported that crack cocaine sells for any dollar amount, from \$5 and up. Another participant shared that crack cocaine can even be traded for other items such as, "a pair of shoes, half pack of cigarettes, whatever you can trade for it."

While there were a few reported ways of ingesting crack cocaine, generally, the most common route of administration remains smoking. Participants estimated that out of 10 crack cocaine users, seven to nine would smoke and one to three would intravenously inject the drug. A participant commented on increased IV use of crack cocaine: "There's quite a few IV users on crack now."

A profile of a typical crack cocaine user did not emerge from the data. A participant stated that crack cocaine is "an equal-opportunity destroyer." However, a few participants felt that crack cocaine is more popular among an older generation. A participant reported, "[Crack cocaine users] it's like older black people, for real. Because, I mean, it just seems like the older people to me because that's their generation of drugs, you know. Yeah, like heroin is just like taking over for this generation."

A treatment provider commented on the variety of individuals using crack cocaine: "I would say the majority of clients do anything [any drug/poly-drug use], but I think you know crack is something that the African-American population typically uses, but construction workers who make good money, they can buy crack ... they can afford [to support a] crack [addiction]." Another treatment provider observed a shift from certain populations of users: "I just had a conversation with a young man the other day, and he was informing me that the African-American population in the predominately black area here in Hamilton [Butler County] ... more older black gentlemen are using heroin and that crack is fading."

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana and sedative-hypnotics to aid in coming down from the stimulant high produced by crack cocaine use. Participants reported that it is quite common to use heroin with crack cocaine. A participant commented, *"I can't do crack if I don't have heroin; I gotta have heroin when I'm coming down."*

Heroin

Heroin remains highly available in the region. Participants most often reported the 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 brown and white powdered heroin as most available. The BCI London Crime Lab agreed that powdered heroin is the most available heroin type in the region.

A participant reflected on the wide availability of heroin: *"It [heroin] seems to be on every street corner."* Community professionals also reported the overall current availability of heroin as '10'; their previous most common score was also '10'. A treatment provider said, *"In every neighborhood ... rural, city, everywhere [heroin is available]. It's in areas that it never was before."* Treatment providers also discussed the impact that high heroin availability has on individuals leaving treatment centers. A treatment provider reported, *"We have a lot of clients transitioning out of residential [treatment programs] [who] have a lot of fear because someone in the house is using [heroin], or their next door neighbor is a dealer, so I mean it is in the homes and down the street in the neighborhood."*

Media outlets in the region reported on heroin seizures and arrests during this reporting period. The Southern Ohio Drug Task Force arrested a Portsmouth (Scioto County) woman at a local residence, seizing heroin and \$500 in cash, busted three individuals in Portsmouth, seizing roughly 130 grams of heroin with a street value of \$18,200, and later arrested two more people in Portsmouth, seizing 17 grams of suspected heroin (www.herald-dispatch.com, Feb. 8, 2013; April 21, 2013; and April 30, 2013, respectively). A woman was arrested in Washington Court House (Fayette County) following a traffic stop, during which po-

lice found several suspected bags of heroin, marijuana and methamphetamine (www.10tv.com, April 19, 2013). Law enforcement in Portsmouth arrested 18 people for allegedly operating a heroin distribution ring, which brought heroin to Portsmouth from Dayton (www.10tv.com, May 23, 2013).

Participants reported the availability of black tar heroin to be low, rating its 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 '5'. A participant claimed, *"You can get it [black tar heroin] if you know the right people."* Community professionals most often reported the current availability of black tar heroin as '10'. A law enforcement officer commented, *"We've gotten some [black tar heroin] of late."*

Participants reported that the availability of heroin has generally increased during the past six months. A participant noted the ease of access with highway routes as a contributing factor to the increase of heroin: *"I mean we [Ohio] have the two main highways. We have 70 and we have 75, with 75 going from Florida all the way up [and] 70 going from California all the way [to the east coast], so there's a lot of drugs that come through Ohio."* Participants identified formula changes in prescription opioids, making them more difficult to abuse, as a reason for switching to heroin. A participant explained, *"OxyContin® was at an all-time high years ago, but they have manufactured OxyContin® now to the point where you can't break it down to use it, so IV drugs users is [sic] now like, 'there's a way around it' ... so we get heroin once again."*

Community professionals also reported that availability of heroin has increased during the past six months. Treatment providers agreed that the change in formulation of some popular prescription opioids, along with the lower price of heroin, has resulted in prescription opioid users switching to heroin use. A law enforcement professional reflected on the link between increased monitoring of prescription opioids and increased use of heroin: *"When we [law enforcement] really made the push on the oxy's [OxyContin®] and on the pain clinics, it really kinda pushed it [drug abusers] over into the heroin ... and you're seeing it almost as a national trend now. The more enforcement we do on the pain clinics ... that's pushing the folks [users] over into the heroin."* The BCI London Crime Lab reported that the number of powdered and black tar heroin cases they process has increased during the past six months.

Participants most often rated the current quality of heroin as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '10'. Participants reported that powdered heroin in the region is cut with aspirin, Benefiber®, fentanyl, mannitol (sugar substitute), methamphetamine, powdered cocaine and Tylenol®. A participant remarked on cutting agents, *"I know I only done [sic] heroin, and I got a drug test and tested positive for cocaine too."* A long-term user of heroin claimed that the practice of cutting heroin with other substances has increased: *"Personally I've been doing heroin for the past 13 years, and 13 years ago you could get better quality heroin ... Nowadays, I noticed that [dealers] they're cutting it with stronger pharmaceuticals or other drugs to make it better than it really, actually is."* Participants reported that the overall quality of heroin has decreased during the past six months. The BCI London Crime Lab reported the following cutting agents for heroin: diphenhydramine (antihistamine), boric acid, levamisole (livestock dewormer), local anesthetics (lidocaine and procaine), mannitol (sugar substitute) and sucrose (table sugar).

Current street jargon includes many names for heroin. The most commonly cited names were "boy" and "dog food." Participants reported that powdered heroin is available in various quantities: 1/10 gram (aka "bag") sells for \$15-20; 1/2 gram sells for \$70-80; a gram sells for \$100-120. A participant also reported purchasing two capsules (aka "caps") for \$20. However, most participants did not prefer to purchase heroin in capsules. A participant explained, *"cause they [dealers] rip you off selling it [heroin] in caps."* Participants reported that they can travel to Dayton and get 10 caps for \$60 or 15 caps for \$100. A participant commented on the difference in heroin sales between Cincinnati and Dayton: *"Down here [Cincinnati], [heroin] it's in the grams, up there [Dayton], it's in the caps."*

While there were a few reported ways of using heroin, the most common route of administration remains intravenous injection (aka "shooting"). Participants estimated that out of 10 heroin users, seven to nine would intravenously inject and another one to three would snort the drug. Participants explained a progression in heroin use from snorting to injecting. One participant reported, *"Most people snort [heroin] at first because ... you know, the stigma about the needle, but once somebody tells you, 'you're wasting your money' [users will progress to injecting heroin]."* A treatment provider also commented on the progression to IV use in the region: *"When they [users] say, 'I'm a heroin*

addict,' [and] we [treatment providers] ask if they're an IV [user], it's rare for them to say, 'no.'"

Participants reported that injection needles are available from diabetics, some regional stores and from drug dealers who sell needles for \$1-5 per syringe. A participant shared, *"My dude [dealer], you buy a gram [of heroin], and you get a free needle."* Reportedly, needle sharing is a common practice in the region. A participant remarked, *"[There's] lot of sharing. People just don't care anymore."* A participant reported that many users have a desire to use clean needles, but explained, *"It [using a clean needle] kinda goes to the wayside when you're sick [going through withdrawal] and you want to get well."* Individuals reported trying to clean needles with bleach, hydrogen peroxide and water.

Participants believed that Hepatitis C has increased throughout the region. Most participants reported knowing someone with Hepatitis C or contracting it themselves. A participant commented, *"Practically everybody in my circle [using network] got Hep [Hepatitis] C, and you know it's ... it's just a way of life."* Hepatitis C as a result of needle sharing was also a big concern with treatment providers in the region. A treatment provider commented, *"We're seeing a high percentage of our women who have Hepatitis C through needle using [sharing]. There's definitely not education and prevention in that aspect."* Treatment providers agreed that the number of treatment clients with Hepatitis C has increased. A treatment provider commented on the increasing numbers of women with Hepatitis C in treatment groups: *"In a room full of 30 women [users], probably about 20-25 [have Hepatitis C]."*

Participants and community professionals also observed that heroin overdose rates have increased in the region. Participants linked overdose deaths to combining heroin use with the use of benzodiazepines and to users returning to heroin use after a period of sobriety. A participant reported, *"It's people getting out of jail too [who are overdosing on heroin]. Their tolerance goes down real fast, and then there's no treatment in jail. So, the first thing they do when they get out [of jail] is shoot [inject heroin], and they try to shoot the same amount [they were doing before incarceration], and then they die."*

Participants also expressed reluctance in calling for assistance when someone overdoses. One explained *"Yeah, because a lot of times you call the ambulance [and] in order*

for them to hit [administer] you with Narcan,® the cops have to be there. A lot of people don't want to get into trouble because they haven't gotten rid of their [heroin] and won't get rid of their [heroin], so, you know, people that you think are your friends will just leave you lying there." Treatment providers shared trends in overdoses in populations that they did not previously see. A treatment provider stated, *"I've seen some of my pregnant clients who have overdosed, and I have never seen that before,"* Another treatment provider remarked, *"We're losing more clients [to overdose]."*

Participants described typical heroin users as white, primarily ranging in age from 18 to 26. Treatment providers also identified whites and pain-clinic patients as typical heroin users. A treatment provider commented, *"We [treatment providers] all have seen an increase in the number of ... kids that are using it [heroin] ... not only suburbia, but inner-city [as well]. The population of [heroin addicts in] our local treatment facilities, I would have to say would be somewhere in the neighborhood of 95 percent Caucasian ... females and males. It's gotten bad."*

Reportedly, heroin is used in combination with alcohol, crack and powdered cocaine, marijuana and sedative-hypnotics. Participants explained that alcohol and sedative-hypnotics are very popular with heroin use because they intensify the heroin effect. A participant explained, *"Once your tolerance goes up, a benzo [benzodiazepine] will help you get to where you want to be when you can't get there just off heroin anymore ... alcohol too."*

Prescription Opioids

Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs as '8' 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'. Participants identified methadone, Opana® and Percocet® as the most popular prescription opioids in terms of widespread use. Community professionals also reported the current availability of prescription opioids as '8'; the previous most common score was '10'. Community professionals identified Opana® and Percocet® as most available in terms of widespread use. A treatment provider commented, *"Let's face it ... you know the pharmaceutical companies are driving the medical profession, so the availability [of prescription opioids] is there."*

Media outlets in the region covered prescription opioid seizures and arrests during this reporting period. The Ohio State Highway Patrol reported seizing 1,004 oxycodone pills worth in excess of \$24,000 in Scioto County (<http://statepatrol.ohio.gov/media.stm>, Feb. 12, 2013). The Southern Ohio Drug Task Force confiscated \$5,000 in cash, a hand gun, hydrocodone, oxycodone and suspected Suboxone® from a residence in Portsmouth (www.herald-dispatch.com, Feb. 28, 2013). Law enforcement served a search warrant on a suspected "pill mill" in Ironton (Lawrence County) after investigating the clinic for more than a year (www.herald-dispatch.com, March 12, 2013). The Southern Ohio Drug Task Force arrested a woman in Wheelersburg (Scioto County) for trafficking and possession of drugs; authorities seized 120 oxycodone pills (www.herald-dispatch.com, June 21, 2013).

Participants reported that the availability of prescription opioids has decreased during the past six months. Participants often shared that prescription opioid users are turning to heroin because of its lower price. A participant stated, *"Heroin ... it's cheaper and easier to get [than prescription opioids]."* Participants attributed law enforcement and legislation for decreased availability. A participant explained, *"A lot of people used to go to Florida to get 'em [prescription opioids], and now they're getting busted doing that."* Another participant added, *"And the changed laws, too, ... The doctors don't prescribe like they used to."*

Treatment providers in Butler County reported that availability of prescription opioids has decreased, while treatment providers in Hamilton County felt that overall availability has remained the same during the past six months. A law enforcement professional reiterated what the participants said about cost as a factor in individuals seeking out heroin rather than prescription pain pills: *"I think [prescription opioids] they're still relatively available, but they're getting prohibitively expensive."* The BCI London Crime Lab reported that the number of prescription opioid cases it processes has generally remained the same during the past six months, with a couple of exceptions: a decrease in Vicodin® cases and an increase in Kadian® cases.

Reportedly, many different types of prescription opioids are currently sold on the region's streets. Current street prices for prescription opioids were consistent among participants with experience buying the drugs and were typically priced between 75 cents-\$1 per milligram. Participants reported the following prescription opioids as available to street-level users (Note: When reported, cur-

rent street names and prices are indicated in parentheses): methadone (5 mg sells for \$2), Opana® (40 mg sells for \$40), Roxycodone® (30 mg, aka “perc 30’s,” sells for \$25-30), Percocet® (aka “Ps” and “percs;” 5 mg sells for \$4-5; 10 mg sells for \$8-10) and Vicodin® (aka “Vs;” “vikes” and “vikings;” 375 mg, aka “baby vikes;” sells for \$2).

In addition to obtaining prescription opioids on the street from dealers, participants reported getting them from pain clinics, family members and friends. A participant said, *“Those [prescription opioids] were always free from my friend’s mom.”* Another participant shared his experience with trading to obtain prescription opioids: *“I had like four people, four or five people that lived [in] the same area as I do ... I’d just go [to] the one girl ... she would keep me supplied [with prescription opioids] for every day ... I would go and steal her the stuff that she needed, and ... you know, like face product [cosmetics], make-up, everything you could think of ... and every day she’d bring me one [prescription opioids].”*

While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted, generally, the most common routes of administration remain snorting and intravenous injection (aka “shooting”). Participants estimated that out of 10 illicit prescription opioid users, zero to three would orally ingest, two to five would intravenously inject and six to eight would snort the drugs.

A profile of a typical illicit user of prescription opioids did not emerge from the data. Participants described typical illicit users as all ages and those with previous injuries. A participant shared about younger students using prescription opioids: *“My son ... he said it was during class, and the one boy was like, ‘watch, watch out for me’ ... and he turned around ... he had a Percocet®. Crushed [it] right in the classroom ... like snorting it, and the teacher was right there.”*

Reportedly, when used in combination with other drugs, prescription opioids are most often combined with alcohol, crack and powdered cocaine, marijuana, prescription stimulants and sedative-hypnotics. A participant commented on the use of sedative-hypnotics with prescription opioids: *“Some people like to take benzos [benzodiazepines] with anything just because it levels them down to where they need to be or kicks in ... like the Percocet® buzz.”*

Suboxone®

Suboxone® remains highly available in the region. Participants reported the current street availability of Suboxone® as ‘8’ 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.’ Treatment providers most often reported the drug’s current availability as ‘10,’ while law enforcement reported it as ‘4;’ the previous most common score for community professionals was ‘10.’ Treatment providers commented on the way clients use Suboxone®. A treatment provider reported, *“You have some that take it [Suboxone®] as prescribed. They get in a routine, and they don’t defer from that routine. And then, you got others that think that [Suboxone®] is a miracle pill or strip and automatically abuse it and buy it on the street. I’ve had a client that bought it on the street for [sexual] favors.”*

Participants and community professionals reported that the availability of Suboxone® has increased during the past six months. A treatment provider expressed concern that clients are using Suboxone® for longer than intended: *“A lot of times people will come back the second or third time into treatment, so it will be a year or two or even three years later, and they’re still using Suboxone®.”* The BCI London Crime Lab reported that the number of Suboxone® cases it processes has remained the same during the past six months.

Participants did not report any current street names for Suboxone®. Current street prices for Suboxone® were consistent among participants with experience buying the drug. Participants reported that Suboxone® 8 mg strips sell for \$10-20; 8 mg pills sell for \$10-15. A participant explained that Suboxone® is more expensive through clinics: *“To go see the doctor initially [for Suboxone®], it costs you like a few hundred bucks or whatever.”*

Participants reported that common routes of administration for the abuse of Suboxone® include oral consumption, snorting and intravenous injection (aka “shooting”). Most often participants reported taking Suboxone® sublingually; however, participants reported abuse by snorting of pills and shooting for strips. Participants made the distinction that Subutex® is preferred for shooting. A participant explained, *“I was high off it [Subutex®]. I mean it was like doing dope [heroin]. I nodded out and everything when I*



shot [Subutex®].” Another participant shared about intravenously injecting Suboxone®: “I made that mistake once [shooting Suboxone®]. I shot it and . . . I felt it running from my feet all the way up my body, and I didn’t know what to do. I was scared and shit.”

Participants described typical illicit users of Suboxone® as white and addicted to heroin. Treatment providers described illicit users as someone who likes opiates. Reportedly, when used in combination with other substances, Suboxone® is combined with crack cocaine, heroin and sedative-hypnotics (specifically, Xanax®).

Sedative-Hypnotics

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.’ Treatment providers most often reported current availability as ‘7;’ the previous most common score was ‘10.’ Participants and treatment providers identified Klonopin® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Treatment providers reported that sedative-hypnotics remain easy to obtain through doctors. A treatment provider commented, *“It seems like doctors will prescribe the benzos [benzodiazepines] more than they will prescribe the opiates, so you can go and get Xanax® or whatever benzo . . . Ativan® . . . easier than you can go get your Vicodin®.”*

Participants reported that the availability of sedative-hypnotics has decreased during the past six months. Participants attributed reduced availability to increased communication among pharmacies. A participant explained: *“The pharmacies . . . all the computer systems tied into one, so people that were doctor shopping, in my instance, going out of town and getting them, we couldn’t go to other pharmacies and get ‘em filled now. So, we get multiple prescriptions and can’t get ‘em filled.”* Community professionals reported that availability of sedative-hypnotics has remained the same during the past six months. The BCI London Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months.

Reportedly, many different types of sedative-hypnotics are currently sold on the region’s streets. Current street

prices for sedative-hypnotics were consistent among participants with experience buying the drugs. 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 sells for \$1; 2 mg sells for \$3), Soma® (500 mg sells for \$2), Valium® (10 mg sells for \$2-3) and Xanax® (0.25 mg, aka “footballs” and “peaches,” sells for \$0.25; 0.5 mg, aka “footballs,” sells for \$1; 1 mg, aka “blues” and “footballs,” sells for \$2; 2 mg, aka “totem poles” and “xanibars,” sells for \$5). A participant commented that buying large quantities can help with pricing: *“I’d sell 120 [sedative-hypnotics pills] for \$100.”*

In addition to obtaining sedative-hypnotics on the street from dealers, participants reported getting them from doctors and family members. A participant shared, *“My grandma, she has bottles [of sedative-hypnotics] stacked up. That’s why I said my availability is easy ‘cause I’ll go grab a bottle up and be gone.”* Participants commented on obtaining prescriptions from doctors, with one participant claiming, *“My doctor was prescribing anything I wanted . . . and she still will.”*

While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of abuse were noted among types of sedative-hypnotics, generally the most common routes of administration remain snorting and oral consumption. Participants estimated that out of 10 illicit sedative-hypnotics users, approximately two to five would orally ingest and five to eight would snort the drugs.

A profile of a typical illicit user of sedative-hypnotics did not emerge from the data. Participants described typical users of sedative-hypnotics as, addicts and people with mental problems. A treatment provider discussed the use of sedative-hypnotics with heroin: *“And I just asked this question yesterday . . . I said, ‘How many of you guys who use heroin or opiates IV [intravenously] use benzos simultaneously with those drugs?’ And it was 100 percent across the board.”*

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often combined with alcohol, crack and powdered cocaine, heroin and prescription opioids. Participants explained that sedative-hypnotics are used with alcohol and opiates to intensify the effect of these drugs, and that cocaine is used with sedative-hypnotics to “speedball.”

Marijuana



Marijuana remains highly available in the region. Participants and community professionals most often reported current availability of marijuana 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'. A participant commented, *"I don't even smoke it [marijuana], but I know it's easy as hell to get."* A treatment provider commented, *"I just think that nowadays marijuana is like ... it's at an all-time high. I feel like that because everybody knows somebody that you can get it [from]."*

Media outlets in the region reported on marijuana seizures and arrests during this reporting period. The Ohio State Highway Patrol reported confiscating 45 grams of marijuana during a traffic stop in Scioto County (<http://statepatrol.ohio.gov/media.stm>, Jan. 22, 2013).

Participants reported that the availability of marijuana has increased during the past six months and noted that high-grade marijuana (aka "hydroponic") in particular is becoming more available. A participant reported, *"The availability of the high-grade [marijuana] has gone up because ... people are growing that shit indoors."* Multiple participants discussed a recent case of a teenager growing high-grade marijuana in the region. A participant commented, *"I know the dude in Fairfield ... he had a goddamn warehouse [full of marijuana] ... and he was only 17 years old. It was all straight medical-grade marijuana."* Community professionals reported that availability of marijuana has remained the same during the past six months. The BCI London Crime Lab reported that the number of marijuana cases it processes has increased during the past six months.

Participant quality scores of marijuana ranged from '1' to '5' for low-grade and '8' to '10' for high-grade with the most common score being '10' for high-grade on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previously reported most common scores were '7' for low-grade and '10' for high-grade. 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). A law enforcement professional commented on different qualities of marijuana: *"We're seeing certainly Mexican marijuana coming up in the [tractor] trailer for, you know, the large*

quantity ... and then we're seeing the high-grade marijuana coming from California, Washington, Oregon, you know, either in suitcases or packages being delivered here. You know ... 10, 20, 30 pounds at a time."

Current street jargon includes countless names for marijuana. Participants listed the following as common: "dirt," "middies" and "reggies" for commercial, low-grade marijuana; "dro," "kush" and "loud" for hydroponically grown, high-grade marijuana. The price of marijuana depends on the quality desired. Current street prices for marijuana were consistent among participants with experience buying the drug. Participants reported commercial grade marijuana as the cheapest form: a blunt (single cigar) or two joints (cigarettes) sells for \$5; 1/8 ounce sells for \$15-20; an ounce sells for \$90-100; 1/4 pound sells for \$375. Higher-quality marijuana sells for significantly more: a blunt or two joints sells for \$20-25; 1/8 ounce sells for \$50; 1/4 ounce sells for \$100; an ounce sells for \$350-400. A participant explained differences in pricing based on quality: *"I paid \$650 an ounce for real deal 'perp' [high-grade marijuana] not too long before I came in here [treatment]. Real deal 'perp,' so it all depends on how high quality you want it."*

While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. Participants estimated that out of 10 marijuana users, nine to 10 would smoke; and zero to one would consume the drug in baked goods or vaporize it. A participant identified that "rich people" might be more likely to vaporize marijuana. Another participant commented, *"If I spent \$400 on an ounce on some loud [high-grade marijuana], you better believe I'm not going to eat the whole ounce."*

A profile for a typical marijuana user did not emerge from the data. Participants described typical users of marijuana as everybody. A participant commented, *"I mean anyone from 10-year-olds to 80-year-olds smoking it [marijuana] for glaucoma."* A treatment provider commented on the trend of younger individuals using marijuana: *"We personally do a marijuana-specific group and 99 percent of our referees are from the local school system under the age of 17, and ... we've had eighth-graders as a part of our program. It has become a rite of passage in the clients and consumers that we're seeing. The growth and use of it [marijuana] is unprecedented."*

Reportedly, marijuana is used in combination with crack and powdered cocaine, heroin and PCP (phencyclidine).

Participants reported that lacing marijuana with cocaine is popular. However, participants varied on who was more likely to combine cocaine use with marijuana: A participant claimed, “*lower-class areas,*” while another participant claimed, “*I think it’s higher class. In suburbs they would lace joints with cocaine to bump it up [to increase the potency of the marijuana].*”

Methamphetamine

Methamphetamine is highly available in the region. Participants most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get)

to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10’. A participant explained that methamphetamine is advertised on Craigslist in “dating” profiles: “*The initials ‘PNP’ means party and play. You see the word party with a capital T, it means you’re getting ‘tina,’ crystal [methamphetamine]. That’s right as you’re posting your ads.*”

Law enforcement most often reported the drug’s current availability as ‘3’; the previous most common score was ‘4’. A treatment provider commented on availability in the region: “*[Methamphetamine] it’s available, but I don’t think in our area ... it’s not one of the top drugs of choice.*” Although participants rated methamphetamine highly available overall, they generally reported that the drug is not highly available within the city limits of Cincinnati. A participant commented, “*It’s not very available at all [in the city]. [Methamphetamine] it’s more or less available in the country.*”

Participants reported that methamphetamine is available in anhydrous and “shake-and-bake” forms. A participant claimed, “*There’s pink stuff and then there’s clear stuff, there’s all kind of shit.*” Participants from throughout the region commented about the production of “one-pot” or “shake-and-bake,” which means users are producing methamphetamine 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 the drug in approximately 30 minutes at nearly any location by mixing ingredients in easily found containers. A participant mentioned, “*[Methamphetamine] it’s so easy [to make].*” The BCI London Crime Lab reported that

the methamphetamine it processed during the past six months is mostly the powdered “*make-for-yourself*” type of low quality (aka “shake-and-bake”).

Media outlets in the region reported on methamphetamine seizures and arrests during this reporting period. Brown County authorities indicted 14 people for making, selling and bringing methamphetamine to southwest Ohio communities (www.herald-dispatch.com, March 2, 2013). The Southern Ohio Drug Task Force arrested two individuals in Portsmouth for the manufacture and possession of methamphetamine (www.herald-dispatch.com, March 7, 2013); and Middletown (Warren County) police busted a methamphetamine “one-pot” lab in a residential garage (www.daytondailynews.com, March 1, 2013). Chillicothe police raided a local residence, making the largest methamphetamine bust in that city’s history by seizing between 30-40 “one-pot” methamphetamine labs (www.10tv.com, April 25, 2013).

Participants reported that the availability of methamphetamine has remained the same during the past six months, while law enforcement reported that availability has increased. A law enforcement professional commented, “*[Methamphetamine] it’s a huge thing down south, and I think probably the next time we talk, it’ll start moving northbound because all of our intelligence from informants from the [Mexican] cartels ... are saying, you know, they’re trying to do what they did with heroin ... they’re trying to get a foothold with the methamphetamine trade up here and establish a market.*” The BCI London Crime Lab reported that the number of methamphetamine cases it processes has increased during the past six months.

Participants most often rated the overall quality of methamphetamine as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); participants did not rate quality of methamphetamine in the previous reporting period. This reporting period a participant commented, “*The best [quality methamphetamine] is in your rural areas.*”

Current street jargon includes a few names for methamphetamine. The most commonly cited names were “crank,” “crystal” and “ice.” Current street prices for methamphetamine were consistent among participants with experience buying the drug. Participants reported that a 1/4 gram of methamphetamine sells for \$25-30; 1/2 gram sells for \$50; a gram sells for \$100; 1/16 ounce (aka “teener”) sells for \$150; and 1/8 ounce (aka “eight ball”) sells for \$260-300. A participant mentioned purchasing methamphetamine in capsules (aka “caps”) at \$10 each.

While there were several reported ways of using methamphetamine, the most common route of administration remains smoking. Participants estimated that out of 10 methamphetamine users, seven to eight would smoke and the other two to three users would either intravenously inject or snort the drug.

Participants described typical methamphetamine users as bikers, lower-income individuals, gay people and “country folk.” A treatment provider commented, “[Methamphetamine] it’s like a biker drug.” Reportedly, methamphetamine is used in combination with alcohol, heroin, inhalants (amyl nitrate, aka “poppers”), prescription opioids and sedative-hypnotics. These other substances are used to relax and “come down” from the effects of methamphetamine.

Prescription Stimulants

Prescription stimulants are highly available in the region. Participants most often reported 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). A participant commented on ease of access: “[Availability of prescription stimulants is high] because a lot of kids are on it, and a lot of people are taking their children’s prescriptions” Treatment providers also reported prescription stimulants as highly available, but did not assign a score for current street availability.

Participants and community professionals reported that the availability of prescription stimulants has remained the same during the past six months. The BCI London Crime Lab reported that the number of prescription stimulant cases it processes has remained the same during the past six months.

Street jargon for prescription stimulants is limited. However, participants reported that prescription stimulants are referred to as, “cheap man’s coke.” Current street prices for prescription stimulants were consistent among participants with experience buying the drugs. The following prescription stimulants are available to street-level users: Adderall® (20 mg sells for \$5; 30 mg sells for \$3-6) and Ritalin® (20 mg sells for \$3).

Participants described typical illicit users of prescription stimulants as college students or individuals who are unable to get their drug of choice. Community professionals linked illicit use of prescription stimulants with the use of illegal stimulants. A community professional reported, “A

lot of people, their drug of choice will be crack cocaine and then somehow they get prescribed Adderall®.”

Reportedly, prescription stimulants are used in combination with alcohol, heroin, prescription opioids and sedative-hypnotics. Participants explained that alcohol is often combined with prescription stimulants because it allows the user to drink more alcohol. A participant commented, “If you speed [use stimulants], you drink alcohol . . . I smoke crack, take an Adderall® and some Xanax® together.”

Bath Salts

Bath salts (synthetic compounds containing methylone, mephedrone, MDPV or other chemical analogues) remain available in the region. Participants most often reported the drug’s current availability as ‘4’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous reporting period reflected variable ratings for bath salts from ‘3’ to ‘10.’ A participant commented on a perceived decreased interest in bath salts: “There was a lot more curiosity at first. Still, a lot of people use it [bath salts], but I think the market’s smaller.” Community professionals were unable to provide an availability rating for bath salts; the previous most common score was ‘10.’ The BCI London Crime Lab reported that the number of bath salts cases it processes has increased during the past six months.

Despite legislation enacted in October 2011, bath salts continue to be available on the street from dealers, as well as from some retail stores. A treatment provider said bath salts can be purchased “at any corner store.” Reportedly, bath salts sell for \$30 per gram. Participants described typical users of bath salts as teenagers and people on probation. Community professionals described the typical user as someone who uses methamphetamine. A treatment provider commented, “Clients that did bath salts were also the clients that did meth.” Reportedly, alcohol is the substance most typically combined with bath salts use.

Synthetic Marijuana

Synthetic marijuana (synthetic cannabinoids; aka “K2” and “Spice”) is highly available in the region. Participants most often reported the drug’s current availability as ‘9’ 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.’ A participant commented, “You can still find a lot of stores and stuff like that around here [that sell

synthetic marijuana]. *If you ask for it, they'll pull it up from out behind the counter.* Treatment providers most often reported current availability as '10'; in the last reporting period treatment providers were unable to provide an availability rating for synthetic marijuana. A treatment provider commented on easy access of the drug, *"You want to buy some [synthetic marijuana]? You can go up the street here."*

Participants reported that the availability of synthetic marijuana has decreased during the past six months. Community professionals were unsure about change in availability. A treatment provider commented, *"I don't know if [availability of synthetic marijuana] it's really increasing. I think [law enforcement] they've tried to target here lately and that's only been lately."* The BCI London Crime Lab reported that the number of synthetic marijuana cases it processes has remained the same during the past six months.

Participants did not agree on the overall current quality of synthetic marijuana. Some participants believed that the quality of synthetic marijuana continues to increase. A participant stated, *"[Synthetic marijuana] it's going up with quality because every time it gets illegal, they [manufacturers] change the molecule to make it better ... and it becomes like 1,000 times more powerful than it was before."* Other participants felt that quality has decreased during the past six months.

Despite legislation enacted in October 2011, synthetic marijuana continues to be available on the street from dealers, as well as from convenience stores. A treatment provider commented, *"You can walk right into just about any corner store and, you know [and purchase synthetic marijuana]."* Participants reported that synthetic marijuana sells for \$15-50 per gram or \$2 per joint on the street. Participants described typical users of synthetic marijuana as probationers and high-school aged. Community professionals described a typical synthetic marijuana user as, *"somebody trying to pass a urine analysis; somebody desperate; younger kids."* Reportedly, synthetic marijuana is used in combination with alcohol to even out the effects of synthetic marijuana.

Ecstasy

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMP) remains highly available in the region. Participants most often reported current availability as '8' 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'. Treatment providers most often reported current availability as '9'; the previous most common score was '8'. The BCI London Crime Lab reported that the number of ecstasy cases it processes has remained the same during the past six months.

Media outlets in the region reported on ecstasy seizures and arrests during this reporting period. Police were called to a Monroe (Warren County) business due to the suspicious behavior of a male customer; police arrested the man for possession of powdered ecstasy (www.daytondailynews.com, Mar. 18, 2013).

Participants reported that an ecstasy tablet sells for \$20-25; for "molly" ("pure" powdered MDMA) 1/10 gram sells for \$10-20; a gram sells for \$100-125. Participants described ecstasy users as people in the gay community, "hippies" and "ravers" (those who attend dance parties, aka "raves"). Treatment providers described typical users as, "kids" ranging from 15-30 years. A treatment provider explained, *"[Ecstasy/molly] that's the drug that a lot of the kids are using now. When you wake up and see all these crazy crimes on the news, that's what they [sic] on."* Reportedly, cocaine is used in combination with ecstasy to intensify the effects of ecstasy.

Other Drugs

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, inhalants, cough and cold medications and hallucinogens – dimethyltryptamine (DMT), lysergic acid diethylamide (LSD) and psilocybin mushrooms.

Participants reported that anabolic steroids are highly available in the region. A participant reported that these drugs are available for purchase through the Internet, stating, *"I get a vial of Deca® [anabolic steroid] ... Deca® bulks you up, Winstrol® [anabolic steroid] cuts you down, so there's different types. I usually get about a cycle, which is ... a cycle is a three-month supply for about \$225 which is a good price."* A treatment provider commented that anabolic steroid use is not popular among drug users. Participants described typical users of anabolic steroids as athletes and people who work out/weight train at area gyms. Media outlets in the region reported on illicit use of anabolic

steroids during this reporting period. The Greater Warren County Drug Task Force began investigating employees of the Lebanon Correctional Institution (state prison) for use and distribution of steroids (www.herald-dispatch.com, April 26, 2013).

Hallucinogens are moderately available in the region. Participants most often reported the current availability of these drugs 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 '8.' A participant commented, *"If you're on the streets, [hallucinogens] it's very difficult to find because your dealer usually doesn't have that kind of access."* Another participant added, *"If you don't know where [to obtain hallucinogens] it [availability] is ... it's pretty much a zero."* The BCI London Crime Lab reported that the number of hallucinogenic cases it processes has remained the same during the past six months, but added that they have seen an increase in hallucinogenic phenethylamine derivatives, both 2C-E and 2C-I, as well as the N-benzylmethylether of 2C-I (251-NBOMe).

Participants with experience purchasing hallucinogens reported pricing information for a variety of substances: DMT (1/10 gram sells for \$20), LSD (sells for \$5-15 a hit), and psilocybin mushrooms (1/8 ounce sells for \$25-30; 1/4 ounce sells for \$40-60). Participants described typical users of hallucinogenic drugs as "skateboarders," "hippies" and young people. Reportedly, hallucinogens are used with alcohol, heroin, marijuana and prescription opioids.

Inhalants are highly available in the region, particularly due to the legality of the substances and ease of purchasing them from retail stores; however, these substances were not desired by participants. A participant quipped, *"We're not 12 [years old] anymore."* Participants claimed that typical users of inhalants are often adolescents from lower-income families.

Cough and cold medicines remain highly available in the region, also due to the legality of the substances and ease of purchasing these from retail stores; however, these substances were not desired by participants. Participants and treatment providers identified typical illicit users of these medications as young people. Both groups of respondents identified promethazine (cough medication with codeine) as the most popular medicine of this type for abuse. A participant described how promethazine is typically abused: *"They [users] mix it with Jolly Ranchers® and orange pop or red pop ... they mix it together [and drink]."* Another partici-

pant commented, *"[Promethazine] it's called 'liquid heroin.'" Participants reported that this substance is often obtained from medical professionals. A participant remarked, "I got it [promethazine] from my doctor because I told him I couldn't sleep, and my cough was keeping me up at night."*

Conclusion

Crack cocaine, ecstasy, heroin, marijuana, prescription opioids, sedative-hypnotics and Suboxone® remain highly available in the Cincinnati region. Also highly available are methamphetamine, prescription stimulants and synthetic marijuana. Changes in availability during the past six months include increased availability for heroin; likely increased availability for marijuana, methamphetamine and Suboxone®; and likely decreased availability for powdered cocaine.

Participants reported that the availability of powdered cocaine has decreased during the past six months; many participants attributed the decreased availability to the increasing prevalence of heroin in the region. Participants reported that the overall quality of powdered cocaine has decreased during the past six months. Participants most often rated the current quality of powdered cocaine as '1-2' (poor quality, "garbage"). A participant commented on how the quality of powdered cocaine led him to using other substances: *"If I could've found good cocaine, I probably would've stuck with that and not gone to heroin."*

Changes in the quality of powdered cocaine have also altered the method of using powdered cocaine. A participant described snorting poor-quality powdered cocaine as painful, explaining that many users will smoke poor-quality product instead. Treatment providers observed that powdered cocaine users are getting younger, in part due to what they described as increased social acceptability for the substance.

While many types of heroin are currently available in the region, participants reported brown and white powdered heroin as most available. The BCI London Crime Lab agreed that powdered heroin is the most available heroin type in the region. Participants and community professionals identified formula changes in popular prescription opioids, making them more difficult to abuse, as a reason for switching to heroin. Both groups of respondents also noted the substantially lower price of heroin as another factor driving users to progress from prescription opioids.

Participants reported that the overall quality of heroin has decreased during the past six months. A long-term user of heroin claimed that the practice of cutting heroin with other substances has increased. The most common route of administration for heroin remains intravenous injection. Reportedly, needle sharing is a common practice in the region and as result of this practice, participants believed that Hepatitis C has increased. Most participants reported knowing someone with Hepatitis C or contracting it themselves. Treatment providers agreed that the number of treatment clients with Hepatitis C has increased.

Participants and community professionals also observed that heroin overdose rates have increased in the region. Participants linked overdoses to combining heroin use with the use of benzodiazepines. Participants also linked heroin overdose deaths to users returning to heroin use after a period of sobriety. Participants also expressed concern about calling for assistance when someone overdoses due to fear of law enforcement involvement. Participants described typical heroin users as white, primarily ranging in age from 18 to 26 years.

Participants reported that the availability of marijuana has increased during the past six months, particularly availability of high-grade marijuana (aka "hydroponic") due to an increase of individuals in the region now growing the drug indoors. The BCI London Crime Lab reported that the number of marijuana cases it processes has increased during the past six months. A treatment provider commented, *"I just think that nowadays marijuana is like ... it's at an all-time high. I feel like that because everybody knows somebody that you can get it [from]."*

Lastly, participants reported that methamphetamine is available in anhydrous and "shake-and-bake" forms. The BCI London Crime Lab reported that the methamphetamine it processed during the past six months is mostly the powdered *"make-for-yourself"* type of low quality (aka "shake-and-bake"). Law enforcement reported that methamphetamine availability has increased during the past six months. A participant explained that methamphetamine is advertised on Craigslist in dating profiles. The BCI London Crime Lab reported that the number of methamphetamine cases it processes has increased during the past six months. Participants most often rated the overall quality of methamphetamine as '10' (high quality).