

Surveillance of Drug Abuse Trends in the State of Ohio

January-June 2013

Executive Summary

The Ohio Substance Abuse Monitoring (OSAM) Network consists of eight regional epidemiologists (REPIs)* located in the following regions: 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 Mental Health and Addiction Services (OhioMHAS) with a real-time method of providing accurate epidemiologic descriptions that policy makers need to plan appropriate prevention and intervention strategies.

This Executive Summary presents findings from the OSAM core scientific meeting held in Columbus, Ohio, on June 24, 2013. It is based upon qualitative data collected by six REPIs from January through June 2013 via focus group interviews. Participants were 378 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 107 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 January through June 2013. OSAM researchers in the Office of Quality, Planning and Research at OhioMHAS 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, OhioMHAS is 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.

Powdered Cocaine

Powdered cocaine remains moderately to highly available throughout all regions. Data indicated changes in availability during the past six months for Cincinnati and Dayton only; likely decreasing in Cincinnati and likely increasing in Dayton. In both regions where availability has likely changed, respondents pointed to increased heroin use and availability as the possible reason behind the drug's availability change. In Cincinnati, participants felt that the current low quality of powdered cocaine along with the ever-increasing presence of heroin in the region has pushed powdered cocaine to the side, as more users are bypassing poor-quality cocaine for heroin. In Dayton, law enforcement speculated that the practice of cutting heroin with cocaine and the uptick in the popularity of "speedballing" (concurrent or subsequent use of heroin with cocaine) among heroin users have driven the increase in powdered cocaine availability there. Collaborating data for the Dayton region also indicated the presence of cocaine. The Logan County Family Court reported that 28.4 percent of all positive adult drug screens administered by the court during the past six months were positive for cocaine (crack and/or powdered cocaine).

*Note: Two REPIs covered two regions each.

Participants throughout the regions reported that the quality of powdered cocaine depends on location of purchase and from whom one buys. The most common quality scores varied by region from '1-2' to '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the most common quality score across regions was '5'. Participants in Akron-Canton, Athens, Cincinnati and Dayton reported an overall decrease in quality of powdered cocaine during the past six months, while participants in all other regions stated that quality has remained the same. A participant in Akron-Canton disclosed that because the quality of the cocaine was so poor, he switched to methamphetamine. Participants listed numerous agents used to cut (adulterate) powdered cocaine, including other drugs. Individuals in Cincinnati, Cleveland and Youngstown reported methamphetamine as a cutting agent, while participants in Columbus reported powdered cocaine cut with bath salts. Regional crime labs listed the following substances as cutting agents: boric acid, caffeine, levamisole (livestock dewormer), local anesthetics (benzocaine, 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 "blow," "girl," "powder," "snow," "soft," "white" and "white girl." Depending on desired quality and from whom one buys, a gram of powdered cocaine currently sells for \$40-100 throughout the regions.

Participants stated that the most common way to use powdered cocaine is snorting, followed by intravenous injection. Reportedly, powdered cocaine use varies and depends on the social group with which the individual associates. Participants in Akron-Canton noted that "recreational users" more often use powdered cocaine by snorting, while "addicts" more often intravenously inject the drug. Participants and community professionals generally described the typical powdered cocaine user as white and of middle- to upper- socio-economic status. However, many participants and community professionals noted an increase in use among individuals age 30 and younger; these respondents attributed increased social acceptance of powdered cocaine as the reason for the gain in popularity. In addition, participants continued to describe powdered cocaine as most often used in a social settings such as bars. Overall, participants viewed the drug as used occasionally, often on weekends, rather than every day.

Reportedly, other substances used in combination with powdered cocaine include: alcohol, crack cocaine, ecstasy, heroin, marijuana, prescription opioids, sedative-hypnotics and tobacco. Participants explained that it is very common to use powdered cocaine with alcohol because it allows the user to drink for longer periods of time. Alcohol and benzodiazepines used in combination with powdered cocaine help reduce withdrawal symptoms, such as jitters, as users come down off the stimulant high. Reportedly, heroin is commonly used with powdered cocaine by those users seeking the "speedball" (up and down) effect. Participants explained that smoking marijuana with powdered cocaine intensifies the cocaine high and helps in coming down from cocaine use.

Crack Cocaine

As was the case in the previous reporting period, crack cocaine continues to be highly available statewide. Participants in every region overwhelmingly stated that crack cocaine is easy to obtain. Moreover, there was consensus that crack cocaine is more available than powdered cocaine. While law enforcement in Athens reported mostly buying powdered cocaine in undercover deals, they said that most of the powdered cocaine is manufactured into crack cocaine for street sale. Reportedly, crack cocaine continues to be easily available with one or two phone calls to a dealer. Incidences of anonymous street transactions are reportedly less common in areas of Cleveland where "walk-up" service was previously available; and while the drug remains highly available in all regions, participants in rural communities report having to drive to cities to obtain crack cocaine. Treatment providers often commented that heroin is taking the place of crack cocaine as the most popular "hard" drug in terms of widespread use.

Participants statewide reported that, like powdered cocaine, the current quality of crack cocaine varies by purchase location and seller. The most common quality scores varied by region from '3' to '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the most common quality score across regions was '5'. Participants in Akron-Canton, Cincinnati and Cleveland reported an overall decrease in quality of crack cocaine during the past six months, while participants in all other regions reported that quality has remained the same. In Cleveland, almost all participants agreed it has become standard practice for crack cocaine users to "recook" the product they receive to remove impurities due to lower quality of the drug; treatment providers there have heard similar reports.

Many participants noted that when availability of powdered cocaine becomes scarce, buyers are more likely to get low-concentration crack cocaine or “fake crack.” Cleveland participants explained having received wax balls, candle wax, Stove Top Stuffing®, peanuts and knots of plastic in place of crack cocaine. Regional crime labs reported the following substances as cutting agents for crack cocaine: caffeine, diltiazem (high blood pressure medication), levamisole (livestock dewormer) local anesthetics (benzocaine, lidocaine and procaine) and mannitol (sugar substitute). Participants throughout the regions most often reported baking soda as a cutting agent, while participants in Youngstown also noted use of methamphetamine to cut crack cocaine.

Current street jargon includes many names for crack cocaine. The most cited names remain “butter,” “crack,” “hard,” “rock” and “work.” Depending on desired quality and from whom one buys, 1/8 ounce (aka “eight ball”) sells for \$80-200 throughout the regions, and 1/10 gram (aka “point”) generally sells for \$10. Participants universally continued to report that a user could buy any dollar amount of crack cocaine. They clarified that crack cocaine usually sells in smaller increments (\$10, \$20 and \$50 pieces), varying in size between a chocolate chip and a peanut. These smaller transactions are quick, and the drug is seldom measured by users. Larger quantities are more commonly weighed. In addition, participants in Cincinnati and Youngstown noted that crack cocaine can be obtained by trading items of value for the drug, including stolen packages of meat, sneakers, cigarettes or sex.

The most common route of administration for crack cocaine throughout the regions remains smoking. Participants also mentioned intravenous injection (aka “shooting”), snorting and eating the drug. Reportedly, vinegar and lemon juice are the agents typically used to prepare crack cocaine for shooting. While participants and community professionals consistently noted that drug use spans all demographic categories, the themes of the previous reporting period related to typical crack cocaine use again emerged from the data during this cycle: typical users are often of lower socio-economic status, African-American, residents of an urban or inner-city location and involved in prostitution. However, participants in Cleveland and Dayton noted “younger” individuals experimenting with the drug. In Cleveland, participants reported users as young as 13. Participants in Columbus associated theft with crack cocaine use.

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana, prescription opioids and sedative-hypnotics to aid in coming down from the stimulant high produced by crack cocaine. Participants said that it is quite common to use heroin with crack cocaine, and several individuals mentioned lacing marijuana with crack cocaine as a common practice. Participants in Akron-Canton also reported ecstasy was used with crack cocaine; one participant group in the region referred to this combination as “street Viagra®.”

Heroin

As was the case during the previous reporting period, heroin remains highly available throughout all regions. Participants were in unanimous agreement, most often reporting the current availability of heroin as ‘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, Athens, Cincinnati and Columbus, and likely increased in Toledo. The current sentiment throughout Ohio is that heroin is the easiest drug to obtain. A participant in the Akron-Canton region stated that heroin seems easier to get than alcohol. Moreover, many participants noted that heroin is available from crack cocaine dealers and can be found at “crack houses.” Treatment providers in Columbus discussed the high percentage of clients who are entering treatment addicted to heroin, with one provider estimating that 70 to 75 percent of clients are currently addicted to the drug.

Participants and community professionals continued to describe the progression of users graduating from prescription opioids to heroin. Respondents 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. Law enforcement noted a link between increased monitoring of prescription opioids and increased use of heroin, which many participants acknowledged made heroin the easier of the two to obtain. However, some Cleveland participants felt that the increase in heroin is slowing down due to prescription drug controls which are making it less likely for individuals to be prescribed opioids, and thus less likely to become addicted to opioids in the first place.

While many types of heroin are currently available throughout the regions, participants continued to report brown powdered heroin as most available in Akron-Canton, Cleveland and Youngstown; black tar heroin most

available in Columbus; and white powdered heroin most available in Toledo. Brown powdered and black tar heroin are both currently most available in Athens and Dayton, while brown and white powdered heroin are currently most available in Cincinnati. In addition, participants and community professionals reported the emergence of a gray-colored heroin called “gravel” because of its appearance.

Participants throughout the regions often noted that the quality of heroin varies from day to day. The most common quality scores varied by region from ‘6’ to ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the most common score across regions was ‘8.’ Participants in all regions except Athens and Toledo reported an overall decrease in heroin quality during the past six months. The Athens and Toledo participants reported that quality has remained the same.

Often, participants commented that increased demand has resulted in dealers cutting heroin more to increase sales/profit from the drug. A long-term user of heroin in Cincinnati claimed that the practice of cutting heroin with other substances has increased. Participants throughout regions reported heroin cut with the following drugs: methamphetamine, “molly” (powdered MDMA), PCP (phencyclidine), prescription opioids and sedative-hypnotics. In Cincinnati, Cleveland and Toledo, there was considerable debate concerning the use of fentanyl as a cutting agent. Some participants believed there is no use of fentanyl in heroin and that users are just purchasing potent heroin. The Cuyahoga County Medical Examiner’s Office (Cleveland region) reported no fentanyl in heroin after extensive scrutiny.

In Dayton, a few participants discussed cutting heroin with morphine. Participants in Youngstown noted the danger of overdose when mixing heroin with benzodiazepines. The Mahoning County Coroner’s Office (Youngstown region) reported that 42.4 percent of all drug-related deaths (N = 59) it processed during the past six months were caused either by acute heroin intoxication or by combined effects of heroin with another substance(s). The BCI London Crime Lab reported the following cutting agents for heroin: boric acid, diphenhydramine (antihistamine), levamisole (livestock dewormer), local anesthetics (lidocaine and procaine), mannitol (sugar substitute) and sucrose (table sugar). The BCI Richfield Crime Lab reported that there are few cutting agents in the heroin cases they process.

Current street jargon includes many names for heroin. The most commonly cited names were “boy,” “dog food,” “dope” and “H.” Participants reported that heroin is available in different quantities, most commonly sold in traditional balloons or chunks for black tar heroin, and baggies or bundles for powdered heroin. However, participants in Dayton reported that powdered heroin is most often available in capsule form (aka “caps”) containing approximately 1/10 gram. Participants reported a variety of pricing dependent on location: 1/10 gram of powdered heroin (aka “point”) sells for \$10-20; a gram sells for \$80-200. Reportedly, black tar heroin sells for significantly more: 1/10 gram for \$20-40.

While there were a few reported ways of using heroin, the most common route of administration remains intravenous injection (aka “shooting”). Participants mentioned other less popular routes of ingestion to include snorting and smoking. Participants and community professionals continued to report that individuals new to heroin use are more likely to snort it before progressing to shooting. However, a few participants added that the time span of progression is shortening. In addition, several Columbus participants talked about snorting heroin with water (aka “mud slide,” “mud water” or “monkey water”).

Participants described obtaining injection needles by posing as a diabetic patient at a chain pharmacy, by stealing them from hospitals/pharmacies or by purchasing them from drug dealers, other users or over the Internet. Reportedly, dealers sell needles for \$1-5. The Cleveland region has a needle exchange program operated by The Free Clinic of Greater Cleveland, and many users reported obtaining needles from there. Universally, there seems to be increasing use of and concern over dirty or shared needles. Many participants claimed to know people who use dirty needles and share needles and have contracted Hepatitis C.

Participants and community professionals continued to most often describe the typical heroin user as white and younger than age 30. However, several participants and professionals throughout Ohio reported an increase in use by adolescents and females. 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 its effects.

Prescription Opioids

Prescription opioids are moderately to highly available throughout Ohio. More specifically, availability remains high in all regions except Akron-Canton and Dayton where current availability is moderate to high. Data indicated that there were no regional changes in availability for prescription opioids during the past six months. However, many participants throughout regions believed the availability of these drugs has decreased during the past six months. Participants who held this viewpoint explained that decreased availability is mainly due to formulation changes that have made some popular prescription opioids more difficult to abuse. They also noted legal measures that have reduced the number of prescriptions a doctor can write and increased law enforcement efforts. Other common reasons provided for decreased availability are the high price of these drugs and the low cost of heroin as an alternative.

Participants and community professionals listed the following prescription opioids as most popular in terms of illicit use: fentanyl, Lortab®, methadone, Opana®, OxyContin® OP (new formulation), Percocet®, Roxicet®, Roxicodone®, Ultram® and Vicodin®. Participants also discussed the difference and availability of old versus new formula prescription opioids. They reported the old formulation of OxyContin® OC as unavailable and the old formulation of Opana® as still available, though increasingly difficult to find. In addition, participants in Columbus reported that there are fake prescription opioids selling in the region. They explained that dealers are pressing their own pills that look similar to actual prescription opioids. When asked what dealers are using to make fake prescription opioids, one participant named a powdered cleanser.

In addition to obtaining prescription opioids from street-level drug dealers, participants continued to report getting them from doctors, dentists, hospital emergency rooms, pain clinics, the Internet, family, friends and anyone who is being treated with these medications. Participants also reported that these medications are traded for other drugs and commented that legitimate patients sell their prescriptions. Participants in Athens shared that prescription opioids are far easier to obtain through a pain clinic than a hospital emergency room, while participants in Cleveland explained that medical channels, pill networks and personal connections are preferred to street dealers. Pill networks are reportedly formed to deal these drugs.

While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally the most common ingestion methods were snorting and oral consumption (swallowing or chewing). According to participant reports, there are only a few prescription opioids that can still be intravenously injected. Although rarely reported, smoking was also mentioned by a minority of participants as a route of administration.

With the exception of the Youngstown region, a profile of a typical illicit prescription opioid user did not emerge. In Youngstown, respondents reported typical illicit use to occur more often among whites under age 30. All other respondent groups felt that anyone can abuse these drugs. Reportedly, when used in combination with other drugs, prescription opioids are most often used with alcohol, crack and powdered cocaine, heroin, marijuana, methamphetamine, prescription stimulants, psilocybin mushrooms and sedative-hypnotics. The consensus among participants was that it is more common to use prescription opioids in combination with other drugs than it is to use them by themselves. Reportedly, alcohol, benzodiazepine and marijuana use increases the effect of the prescription opioids. Stimulants, such as cocaine and methamphetamine, are used with prescription opioids by those seeking the “speedball” effect.

Suboxone®

Suboxone® is highly available for street purchase throughout Ohio. During the past six months, availability has likely increased for Cincinnati, Dayton and Toledo, while remaining high in all other regions. Participants and community professionals continued to link illicit Suboxone® use to heroin use. There was consensus among respondent groups that heroin and illicit prescription opioid users seek Suboxone® when their drug of choice is unavailable. Moreover, these users will often obtain Suboxone® to sell or trade for opiates. However, treatment providers commonly reported that individuals who seek Suboxone®, even illicitly, often do so in an attempt to get off heroin and to avoid withdrawal.

Many community professionals attributed availability of Suboxone® to an increase in Suboxone® clinics and to private physicians who prescribe the drug and do not monitor its use. Collaborating data also indicated the presence of Suboxone®. American Court and Drug Testing Services reported that 11.6 percent of the 2,420 individuals

screened through its Columbus and Lancaster labs during the past six months were positive for buprenorphine (a chemical component of Suboxone®). Reportedly, the Suboxone® sublingual strip is now the most available form of the drug; the pill form has become difficult to obtain.

Current street jargon includes a few names for Suboxone®. Those most commonly cited were “boxes,” “oranges,” “stop signs,” “strips,” “subs,” “subway” and “tangerines.” Participants reported that an 8 mg tablet sells for \$10-30; an 8 mg strip sells for \$7-25. Participants reported that common routes of administration for Suboxone® include oral consumption, snorting and intravenous injection (aka “shooting”). Most often, participants reported taking Suboxone® sublingually (dissolving it under the tongue); however, participants reported abuse by snorting of pills and shooting for strips. A participant group in the Akron-Canton region also mentioned that Suboxone® strips are cut and then chewed. Further, participants in several regions specified that Subutex® is more likely to be intravenously injected due to its particular formulation without naloxone. Participants were also quick to note that both the pills and the strips can be intravenously injected. Nevertheless, these alternative practices were reported to be far less common.

Participants shared that Suboxone® continues to be primarily acquired by prescription from drug abuse treatment centers and pain management clinics, as well as from friends and dealers, particularly those connected with heroin. Participants and community professionals continued to describe typical illicit users of Suboxone® as heroin users who are trying to avoid withdrawal symptoms when heroin cannot be obtained. Reportedly, when used in combination with other drugs, Suboxone® is combined with alcohol, crack and powdered cocaine, marijuana, prescription stimulants and sedative-hypnotics. Participants reported that Xanax® or other benzodiazepines used with Suboxone® intensifies the effect of the benzodiazepine.

Sedative-hypnotics

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available throughout Ohio. Participants and community professionals listed the following sedative-hypnotics as most popular in terms of widespread use: Ambien®, Ativan®, Klonopin®, Lunesta®, Soma®, Valium® and Xanax®. Treatment providers noted

that sedative-hypnotics remain easy to obtain from physicians. Many participants throughout the regions reported an increase in use and availability of these drugs, paralleling an increase in use and availability of heroin. Reportedly, sedative-hypnotics and heroin use go hand in hand. Users will take benzodiazepines in particular to help with withdrawal symptoms from heroin.

Collaborating data also indicated the presence of sedative-hypnotics. The Cuyahoga County Medical Examiner’s Office (Cleveland region) reported Xanax® as commonly present in OVI (operating a vehicle under the influence of alcohol or drugs) test results. The Mahoning County Coroner’s office (Youngstown region) reported that 44.1 percent of all drug-related deaths it processed during the past six months were caused by acute intoxication from the combined effects of a benzodiazepine(s) with another substance(s). The Franklin County Coroner’s office (Columbus region) reported sedative-hypnotics as a contributor in 24.8 percent of all drug-related deaths it processed during the past six months.

Participants continued to report most often obtaining sedative-hypnotics from doctors, friends and family members with prescriptions. Reportedly, these drugs are not commonly obtained from street-level drug dealers. While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, generally the most common ingestion methods remain snorting and oral consumption (swallowing and chewing). Participants described typical illicit users of sedative-hypnotics as very diverse in terms of race, gender, geography and socio-economic class. Nevertheless, many participant groups reported that typical users are often under age 30 and addicted to other drugs (especially heroin). Many treatment provider groups agreed that users are typically “younger.”

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often combined with alcohol, crack cocaine, ecstasy, heroin, marijuana, methamphetamine, prescription opioids and Suboxone®. Participants reported that sedative-hypnotics are often used in combination with other drugs because the mix intensifies the effects of the other drug(s). Additionally, sedative-hypnotics are used to help come down from the high of stimulant drugs and to alleviate withdrawal symptoms from heroin.

Marijuana

Marijuana remains highly available throughout Ohio. 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). Participants and community professionals commonly reported that many users do not consider marijuana illegal or even unhealthy. Two distinct quality categories continue to be evident: commercial-grade (low- to mid-grade marijuana) or hydroponically grown (high-grade) marijuana. Users, even young users, prefer to purchase the high-grade marijuana. There are likely increases in high-grade (hydroponic or medical) marijuana in Cincinnati, Cleveland and Columbus regions. Participants reported that marijuana is often grown indoors throughout Ohio, and law enforcement agreed with participants that there has been an increase of high-grade marijuana, noting in particular medical marijuana being brought in from states in which the drug is legal.

Collaborating data also indicated the presence of marijuana. For instance, the Stark County Day Reporting Program of the Stark County Court of Common Pleas (Akron-Canton region) reported that 58.5 percent of its positive drug screens during the past six months were positive for marijuana. The Logan County Family Court (Dayton region) reported that marijuana was found in 24 percent of all positive adult drug screens and in 77 percent of all positive youth drug screens it administered during the past six months.

Every grade of marijuana is available throughout all regions, and participants continued to explain that the quality depends on whether the user purchases commercial-grade or hydroponically grown marijuana. Participants most commonly rated the quality of commercial-grade marijuana as between '2' and '5', while they rated the high-grade marijuana most often as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). In at least two regions, Dayton and Toledo, participants reported that they could no longer find lower-quality marijuana. Participants in Columbus reported that low-grade marijuana is progressively getting lower in quality while high-grade marijuana continues to increase in quality.

Law enforcement reported that THC (the mind-altering ingredient tetrahydrocannabinol) levels have increased dramatically and that the lower-quality marijuana typically originates from Mexico, while high-grade marijuana

is being sent through the mail or brought in by suitcase from states that have legalized the drug. Reportedly, in Cleveland, a synthetic cannabinoid is commonly sprayed on lower-quality marijuana to increase the potency and to deceive users into thinking they have purchased high-quality marijuana. This might contribute to the perception of increased availability of high-grade marijuana within this particular region.

Current street jargon includes countless names for marijuana, the most commonly cited being "weed." Participants listed the following as other common street names: "dirt," "reggie," "regular" and "swag" for low-grade marijuana; "dank," "drop," "hydro," "kush" and "loud" for high-grade or hydroponically grown marijuana. 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 \$5-10; an ounce sells for about \$100. High-grade marijuana sells for significantly more: about \$20 for a blunt or two joints, and between \$250-300 for an ounce.

The most common route of administration for marijuana remains smoking. Along with many smoking devices reported, an increased number of participants mentioned using vaporizers with the drug. Participants also noted marijuana can be consumed in edibles. Participants in Athens, Columbus and Dayton reported an increase in this method of consumption and explained that it provides a different type of buzz and is perceived as healthier than smoking marijuana. Participants also added that edibles are most often used during festivals and special events. Columbus participants specifically mentioned candies and treats containing marijuana as coming in from California and other states that have legalized the use of marijuana. Dayton participants reported an increase in use of marijuana in condiments, such as butter and oils.

A profile of a typical marijuana user did not emerge from the data. Participants and community professionals continued to report that marijuana use is widespread across all segments of the population. However, participants and community professionals often reported an increase in "younger" users, noting users as young as ages 8-10. Athens and Dayton regions particularly mentioned generational use of marijuana where children begin smoking marijuana with family members as early as age eight.

Reportedly, other substances used in combination with marijuana include alcohol, crack and powdered cocaine,

ecstasy, heroin, methamphetamine, PCP (phencyclidine), prescription opioids and sedative-hypnotics. Participants throughout Ohio reported lacing marijuana with crack or powdered cocaine. However, Youngstown and Cleveland participants most often reported lacing blunts; they recounted lacing marijuana with cocaine, prescription pills, promethazine codeine and Viagra®. Participants also reported that users will often use marijuana after whatever drug of choice they choose to enhance the high of the primary drug. In addition, participants in Cleveland reported using cough syrups, honey and synthetic cannabinoids on joints to make the joint burn more slowly. A treatment provider echoed the sentiment of many in stating that typically any client that uses any illegal drug also is using marijuana.

Methamphetamine

Methamphetamine remains highly available in Akron-Canton, moderately available in Toledo and variable in Cleveland; current availability is high in Athens and Cincinnati, moderate to high in Columbus, moderate in Dayton and variable in Youngstown. Changes in availability during the past six months include increased availability for Akron-Canton and Athens regions, as well as likely increased availability for Cincinnati, Dayton, Toledo and Youngstown regions. Cleveland and Youngstown noted variable availability because methamphetamine availability is reportedly higher in rural areas and lower in more urban areas.

Collaborating data also indicated that methamphetamine is available throughout many regions. Media outlets reported on methamphetamine seizures and arrests this reporting period. Authorities in Brown County (Cincinnati region) indicted 14 people for making, selling and bringing methamphetamine to Southwest Ohio communities (www.herald-dispatch.com, March 2, 2013). Chillicothe (Cincinnati region) police raided a local residence, making the largest methamphetamine bust in that city's history; police seized between 30-40 "one-pot" methamphetamine labs (www.10tv.com, April 25, 2013). In addition, the Toledo Police Crime Lab and the BCI Richfield Crime Lab reported increases in the number of methamphetamine cases they processed during the past six months.

Participants and community professionals connected increases in availability to ease of production of powdered methamphetamine. Participants and law enforcement continued to report on the production of "one-pot" (aka

"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 the regions reported "shake-and-bake" methamphetamine as the most prevalent form available. Treatment providers continued to report that methamphetamine does not seem to be a drug of choice for most of their clients. Law enforcement reported that Hispanic heroin cells are increasingly building a market for methamphetamine and compared it to how they built their customer base for heroin.

Participants with experience using methamphetamine shared that "crystal" methamphetamine and locally produced "red phosphorous" methamphetamine are not as available to users, but are reportedly higher-quality forms of the drug. Participants most often reported the current quality of these methamphetamine types as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality), while most often reporting the current quality of "one-pot" methamphetamine as '2' to '7'. Participants and law enforcement reported methamphetamine occasionally cut with bath salts.

Current street jargon includes a few names for methamphetamine. Those most commonly cited were "crank" and "ice." Prices for methamphetamine continue to depend on the quantity and quality of the drug (prices were not provided for the higher-quality methamphetamine): a gram of powdered methamphetamine most often sells for \$100; smaller quantities were also reported as available in several of the regions; for instance, 1/4-1/2 gram sells for \$25-50. Participants in Cincinnati and Athens reported that users can buy capsules of methamphetamine for as little as \$10 in those regions. Several participants and law enforcement throughout Ohio discussed the "meth-to-heroin" trend of users selling methamphetamine to support their own drug habits (typically heroin), or users exchanging boxes of Sudafed® or other pseudoephedrine products for methamphetamine or heroin. A participant in the Akron-Canton region reported that a box of Sudafed® could be exchanged for 1/4 gram of methamphetamine.

While there are several reported ways of using methamphetamine, the most common method remains smoking. Other routes of administration include snorting,

intravenous injection (aka “shooting”), taking the drug orally in a piece of toilet paper (aka “parachuting”) and letting the crystal methamphetamine dissolve under the tongue. The only region where smoking was not reported as the most common route of administration was Akron-Canton, where participants reported intravenous injection as the most common way to use methamphetamine.

Throughout the regions, respondents agreed that the typical methamphetamine user is white. Typical users were also described as rural, mostly male, of a lower socioeconomic level and ranging in age from 20-40. In a few regions, participants and law enforcement explained that methamphetamine users are often in very small social circles that are difficult to get into to obtain the drug. Others mentioned that methamphetamine is often found in trailer-park communities, Appalachian communities and gay communities. Treatment providers in the Toledo region reported an increase in female users.

Reportedly, many users choose to use methamphetamine by itself. However, the following other substances are reportedly used in combination with the drug: alcohol, bath salts, crack cocaine, heroin, inhalants, marijuana, prescription opioids and sedative-hypnotics. Participants explained that heroin is used in combination with methamphetamine for the “speedball” effect, while crack cocaine and bath salts are used to intensify the drug’s effects. Participants added that the remaining other substances are typically used to assist in “coming down” from the effects of methamphetamine use.

Prescription Stimulants

Prescription stimulants are moderately to highly available in all regions; they remain highly available in Cleveland, Columbus and Youngstown, and are currently highly available in Cincinnati and Dayton, moderately to highly available in Athens, and moderately available in Akron-Canton and Toledo. Data indicated that there were no regional changes in availability for prescription stimulants during the past six months. Adderall® is the number one prescription stimulant in terms of widespread use throughout all regions. Other prescription stimulants reported as available include Concerta®, Ritalin® and Vyvanse®. In addition, the BCI Richfield Crime Lab in northeast Ohio also reported cases of Dexedrine®. The Lake County Crime Lab (Cleveland region) reported an increase in the number of Adderall® cases it processes during the past six months.

Current street jargon includes many names for prescription stimulants. The most commonly cited were “kiddie meth,” “poor man’s coke,” “speed” and “synthetic coke.” In addition, Adderall® is often referred to as “adds” or “addies,” while Ritalin® is referred to as “ritz.” Pricing is similar for each prescription stimulant. However, participants reported the following prices specific to Adderall®: 20 mg sells for \$2-5; 30 mg sells for \$5-10; an entire prescription sells for \$100. Participants often stated that users can get prescription stimulants for free or for as little as 50 cents-\$3 a piece because users do not typically obtain these drugs from dealers. Rather, they’re obtained from friends and family or from individuals who have prescriptions or from physicians who prescribe them. As a result, users often can get prescription stimulants for a lot less than the street prices reported above.

While there were several reported ways of using prescription stimulants, the most common ingestion methods for abusers remain oral consumption (swallowing and chewing) and snorting. Participants in Athens also mention intravenous injection as popular, reporting that five out of 10 illicit users in that region would snort while the other five would inject the drugs. Additionally, participants in Athens and Cincinnati explained that prescription stimulants are often added to alcoholic beverages; the capsules are opened and their contents mixed into a drink.

Participants and community professionals described typical illicit users of prescription stimulants as high-school and college-age individuals who use the drugs to party or to study. Participants also reported that people who work long hours, like truck drivers, use prescription stimulants. Participants and law enforcement also noted that typical users are addicts of other stimulant drugs, particularly methamphetamine and cocaine; these users use prescription stimulants when their stimulant of choice cannot be obtained.

Reportedly, substances used in combination with prescription stimulants include alcohol, caffeine, cough syrup, crack and powdered cocaine, heroin, marijuana, methamphetamine, prescription opioids, sedative-hypnotics, Suboxone® and tobacco. Dayton region participants explained that crack cocaine, caffeine and alcohol all intensify the effects of the prescription stimulants. Participants from the Akron-Canton and Columbus regions explained that sedative-hypnotics are often used to “come down” from the high produced from the abuse of prescription stimulants.

Bath Salts

Bath Salts (synthetic compounds containing methylone, mephedrone, MDPV or other chemical analogues) remain available throughout all regions despite October 2011 legislation that banned its sale and use. Current availability is high in Cleveland and Toledo; availability is variable to low in all other regions. Reportedly, bath salts continue to be available from some convenience stores, beverage drive-thru stores and “head shops.” However, several participants shared that bath salts are typically behind the counter and the user has to know the person(s) selling them to purchase. Akron-Canton region participants said it is often easier to obtain bath salts from Pennsylvania or via the Internet. 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. Participants in Toledo specifically stated that the use of bath salts is stigmatized; treatment providers in Athens supported this notion when they reported that clients are not willing to talk about their use of bath salts.

Data indicated changes in availability during the past six months for the Akron-Canton, Columbus and Dayton regions only; availability has likely decreased in the Akron-Canton and Dayton regions and likely increased in the Columbus region. Hospital staff in Athens reported that they are still seeing a lot of bath salts users and remain concerned with limited treatment options; they reported that they still do not know what to do for bath salts users while they are in that state of aggression. Participants could not rate the current quality of bath salts, but participants and treatment providers in Cleveland discussed an increase of reports of “bad trips” with the drug. Also, Cleveland participants stated that bath salts are occasionally being sold as cocaine when powdered cocaine is unavailable and that heroin is often cut with bath salts with the buyer unaware.

Current street jargon includes a few names for bath salts. Participants shared that bath salts are sold under labels such as “incense,” “pipe cleaner” and brand names such as “Posh” and “White Horse.” Most participants, while uncertain as to the quantity of bath salts a common package contains (reportedly anywhere from 1/2 gram to a gram), said that packages of the drug sell for \$20-60.

Collaborating data also indicated that bath salts are available throughout Ohio. Media outlets reported on bath

salts seizures and arrests this reporting period. During March 2013, police raided a smoke shop in the Oregon District of Dayton and arrested two individuals on drug-trafficking charges; drugs seized included synthetic marijuana and 1,087 units of bath salts being sold under the name “Eight Ballz Ultra Premium Glass Cleaner” for \$40 per gram (www.daytondailynews.com, April 18, 2013).

The most common route of administration of bath salts remains intravenous injection and snorting, followed by smoking. Participants in the Akron-Canton and Toledo regions reported that more users inject than snort the substance. Participants and community professionals described typical bath salts users as between the ages of 20-40 years, white, individuals on probation, people who use stimulants (cocaine or methamphetamine) and laborers (construction workers and coal miners).

Reportedly, substances used in combination with bath salts include alcohol, crack and powdered cocaine, heroin, marijuana, methamphetamine, prescription opioids and synthetic marijuana. Participants explained that heroin and prescription opioids help the user to “come down” from the effects of the bath salts, and that people on probation use bath salts and synthetic marijuana to pass drug screens. Participants in Toledo said bath salts are mostly used alone without any other substances.

Synthetic Marijuana

Synthetic marijuana (synthetic cannabinoids, aka “K2” and “Spice”) remains available throughout regions despite October 2011 legislation that banned its sale and use. Current availability remains high in the Cleveland and Toledo regions, is high in the Cincinnati and Youngstown regions, is moderate to high in the Akron-Canton region, is low in the Dayton region and is variable in the Athens and Columbus regions. Participants in Athens and Columbus reported high availability of synthetic marijuana, while community professionals in those regions reported low availability. Changes during this reporting period include a decrease in availability for Dayton and likely decreases in availability for Akron-Canton and Athens.

As with bath salts, participants throughout the regions reported that synthetic marijuana continues to be available on the street from dealers, as well as from convenience stores, beverage drive-thru stores, tattoo parlors and “head shops.” However, participants and law enforcement reported that these outlets are much more discreet with

their sale of synthetic marijuana. As is the case with bath salts, the user has to be recognized by the seller to purchase the drug, which is most often sold from behind the counter. Participants added that synthetic marijuana can be purchased via the Internet. Law enforcement reported difficulty in enforcement of synthetic marijuana laws due to the number of chemical changes producers make to skirt the law. A media report revealed that, as a result of a three-month investigation originating in Parma (Cuyahoga County, Cleveland region), police seized synthetic marijuana and bath salts worth more than \$900,000; police reported that the confiscated synthetic marijuana filled more than 61,000 containers (www.cleveland.com, April 18, 2013).

There was a general consensus among participants who have used synthetic marijuana that the drug is not very desirable due to the bad smell and taste, and the negative effects (paranoia, hallucinations, memory loss, general “bad trips”). Thus, most prefer to smoke marijuana. Law enforcement professionals from the Akron-Canton and Athens regions noted that individuals are making their own synthetic marijuana using ingredients purchased through the Internet and by following instructions from videos posted online. Participants throughout most regions suggested that the quality of synthetic marijuana has remained the same during the past six months; only in Cincinnati did some participants suggest the quality of synthetic marijuana was increasing.

Current street jargon includes a few names/labels for synthetic marijuana. The most commonly cited remain “K2” and “Spice.” Other common street names/labels include “incense” and “scooby snacks.” The price of synthetic marijuana varies greatly throughout regions: a gram sells for \$15-50. Participants reported only one way of ingesting synthetic marijuana: smoking. Participants and community professionals continued to describe typical users as: experimental drug users, “younger” (teens, high-school aged, 12-20 years), marijuana users, people on probation/parole or residing in a halfway house, as well as anyone who has to pass any sort of drug test for employment.

Generally, participants reported that synthetic marijuana is not used in combination with other substances. However, they reported the following substances as occasionally used with the drug: alcohol, crack cocaine and prescription opioids. Participants in Cincinnati shared that using alcohol with synthetic marijuana assists users in balancing the effects of the drug.

Ecstasy

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA and/or TFMPP) is moderately to highly available throughout Ohio. Ecstasy (recognized as pressed pills that are stamped or have pictures on them) and “molly” (recognized as the powdered form of MDMA) remain highly available in the Cincinnati and Cleveland regions, are highly available in the Akron-Canton and Youngstown regions, are moderately to highly available in the Athens and Columbus regions, and are moderately available in the Dayton and Toledo regions. Changes in availability during the past six months include increased availability for the Youngstown region and likely decreased availability for the Akron-Canton region. Treatment providers in the Akron-Canton region said that clients are not reporting use.

Media reported arrests and seizures of ecstasy during this reporting period. The Ohio State Highway Patrol arrested two teenage girls during a traffic stop in Lima (Allen County, Dayton region) after a K-9 unit alerted the officers to drugs in the vehicle; police seized 155 ecstasy tablets worth \$5,000 (www.northwestohio.com, Jan. 16, 2013). Most participants throughout regions suggested a general increase in molly throughout the state, adding that in many areas molly is currently more available than ecstasy. Molly is described as a yellowish loose powder that is sold in a plastic bag, folded in paper or packed in capsules.

Few participants reported on the current quality of ecstasy or molly. However, in Akron-Canton, Cincinnati and Youngstown regions, participants reported that molly is of higher quality than ecstasy. Cincinnati and Youngstown participants added that molly is being cut with powdered cocaine and bath salts, which was verified by law enforcement professionals in the Youngstown region.

Current street jargon includes several names for each drug: Ecstasy is most often called “X” and “rolls” or referred to by the picture or stamp on the pill; powdered MDMA is most often called molly. Participants throughout Ohio reported on current pricing for ecstasy and molly. Ecstasy “single stack” (low dose) tablet sells for \$10-15; a “double stack” (higher dose) tablet sells for \$20-25. Reportedly, there are “triple” and “quadruple” stacks available in several regions, but pricing is not consistent. Cleveland participants reported pricing that was about \$5 below the other regions for all quantities of ecstasy. Columbus participants reported that a jar (100 ecstasy pills) sells for \$500.

Participant pricing for molly was variable: Akron-Canton and Athens participants reported 1/10 gram sells for \$10-20, while Cleveland participants reported the same amount sells for \$20-30. A gram of molly sells for \$50-125 throughout the regions. Cleveland participants also mentioned availability of liquid MDMA, which sells at two drops for \$30. These drugs are reportedly a social or event drug obtained and used most often at clubs, bars, raves and concerts.

Participants reported only a few ways of using these drugs. The most common routes of administration for ecstasy are oral consumption (swallowing) and anal insertion (aka "plugging"). Participants also noted that ecstasy is infrequently crushed and smoked with marijuana or snorted. The most common ingestion of molly is through oral consumption or snorting. Participants also noted that molly is infrequently intravenously injected, or mixed into food or beverages. Participants and community professionals described typical ecstasy and molly users as white, "younger" (between 15 and 30 years of age), drug dealers and individuals who go to parties, clubs or raves.

Reportedly, other substances used in combination with ecstasy include alcohol, crack and powdered cocaine, hallucinogens (LSD and psilocybin mushrooms) and marijuana. Molly is reportedly used in combination with alcohol, ecstasy, heroin, "lean" (promethazine codeine mixed into soft drinks), marijuana, prescription opioids and sedative-hypnotics. Participants explained that these combinations typically intensify the effects of ecstasy and molly.

Other Drugs

OSAM Network participants listed a variety of other drugs as available in Ohio, but these drugs were not reported in all regions. Participant groups in most regions reported availability of hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], as well as abuse of inhalants and cold/cough medications. Participants in some regions were more specific: Cleveland participants reported PCP (phencyclidine) as available; Cincinnati and Dayton participants reported high availability for anabolic steroids; Athens and Columbus participants reported abuse of Seroquel® (atypical antipsychotic).

Hallucinogens are currently available in most regions. Participants and community professionals shared that LSD and psilocybin mushrooms are typically obtained through

marijuana or ecstasy dealers or at festivals, concerts and raves. Typical users of hallucinogens were described as adolescent to college aged, "hippies," skateboarders, inexperienced/new drug users, marijuana users and drug dealers. A treatment provider in Athens described typical users as often unemployed and living with their parents. LSD and psilocybin mushrooms are used in combination with alcohol, ecstasy and molly, heroin, marijuana and prescription opioids.

While LSD is reportedly difficult to obtain in the Akron-Canton region, it is moderately available in the Athens, Cincinnati, Columbus and Youngstown regions. Availability of LSD has remained the same during the past six months. The drug comes in several forms: tabs, gel tabs, liquid and pill. Street names for LSD include "acid," "cid," "Lucy," "tabs" and "trip." Prices are variable throughout the regions: a "hit" (single dose) of paper tabs sells for \$5-15. Columbus participants reported that a sheet of paper tabs sells for \$300-400, while Dayton participants reported the sheet of tabs sells for \$150. Columbus participants also reported that a hit of liquid LSD sells for \$12.

Psilocybin mushrooms are available in the majority of the regions. Changes in availability during the past six months include decreased availability for Akron-Canton and increased availability for Toledo, specifically in the more rural areas of the region. Current street jargon includes a few names for psilocybin mushrooms. The most commonly cited were "boomers," "caps" and "shrooms." Participants throughout the regions reported that 1/8 ounce of psilocybin mushrooms sells for \$25-30; 1/4 ounce sells for \$50.

Inhalants remain highly available throughout most of the regions due to their legality and ease of purchase from stores; however, these substances are not preferred by most drug users. Participants and community providers identified several types of inhalants as being abused: aerosols, keyboard cleaners, gasoline and nitrous oxide. Athens participants reported increased use and cited "duster," "hippie crack," "rush" and "whippets" as the most common street names for inhalants. Inhalant use is most often found at festivals or in the privacy of a residence. Inhalants are breathed into the lungs, or "huffed." Participants and community professionals identified typical users of inhalants as in their teens to mid-20s, males more often than female, individuals on probation and people who have difficulty obtaining other drugs, or new and experimenting drug users.

Over-the-counter (OTC) medications and promethazine codeine syrups are commonly abused in several regions. Coricidin® and Robitussin® are the most popular. These drugs are easily obtained from retail stores and are likely to be abused by younger users. During this reporting period, there was increased discussion regarding the use of “lean” or “dirty Sprite™” (mixing promethazine codeine with beverages such as Kool-Aid®, Sprite® or alcohol). Athens participants reported that lean is sold on the streets at \$50 for seven to eight ounces. Reportedly, these cocktails are often used in combination with marijuana and sedative-hypnotics.

PCP remains highly available in one area of the City of Cleveland, often referred to as “water world.” The Cleveland Crime Lab reported that the number of PCP cases it processes increased during the past six months. Reportedly, PCP is obtained from a tight network of dealers and is sold for \$10-20 per dip (dip of a cigarette or joint into liquid PCP). The only route of administration reported by participants is smoking. PCP users were described as younger, smokers (of tobacco or marijuana) and more likely women than men. PCP is also used in combination with alcohol, crack cocaine, marijuana and tobacco.

Reportedly, anabolic steroids are highly available in the Cincinnati and Dayton regions and moderately available in the Youngstown region. Youngstown participants reported an increase in this drug during the past six months. Cincinnati participants provided a couple of brand names for anabolic steroids: Deca® and Winstrol®. Participants reported that anabolic steroids are purchased in cycles (three-month supplies). Participants in Cincinnati reported that one cycle of anabolic steroids sells for \$225, while Dayton participants reported that one cycle sells for \$70-150. Anabolic steroids are obtained at gyms and through the Internet. Participants did not comment on the route of administration for the drug. Participants and community professionals described typical users of anabolic steroids as 17-30 years of age, athletic males who work out (lift weights at a gym) or high school students who play football. Anabolic steroids are most often used in combination with creatine.

Lastly, Athens and Columbus participants reported limited abuse of Seroquel®, which is often obtained in jails and traded among inmates. Athens participants described Seroquel® as readily prescribed, but noted a decrease in street availability during the past six months. In addition

to obtaining the drug on the street, this medication is also obtained from inmates, friends or by prescription. Participants in Athens reported that Seroquel® pills sell for \$1-2 each. Participants in Columbus reported that Seroquel® is often crushed and smoked in cigarettes. In addition, participants explained that Seroquel® is often used to “come down” from a crack cocaine high.

Gambling

When participants were asked to describe gambling behaviors in their communities, several trends regarding the popularity of particular gambling types again emerged from the data. Lottery and scratch-offs remain the most common forms of gambling and are highly popular within each OSAM region. Reportedly, casino gambling is also popular in Athens, Cleveland, Columbus, Dayton, Toledo and Youngstown, while Internet cafés are common throughout all of the regions. Participants in Youngstown reported that the number of Internet cafés within that region continues to grow. This trend may be of particular concern, as participants in the Cleveland region identified Internet cafés as a source for illicit drugs.

In addition to Internet cafés, participants reported several common venues for both legal and illegal forms of gambling. Some participants reported having increased their casino gambling in recent months as a result of a casino opening in their region. Keno is popular among participants in Akron-Canton, Columbus and Youngstown. Dice, poker and other street games are currently popular within most of the regions, with the exception of Athens. Participants within the Athens, Cincinnati, Cleveland, Columbus and Youngstown regions reported betting on horse races. Bingo remains popular, particularly in Athens, Cleveland, Columbus and Youngstown. Sports betting is available in all regions, but is most popular in Cincinnati, Cleveland, Columbus and Youngstown.

There was no consensus among participants in regard to a relationship between gambling and drug use. However, some patterns did emerge from the data. Participants from several regions reported little or no relationship between gambling and drug use. In fact, the majority of participants within the Akron-Canton, Cincinnati, Columbus, Dayton and Toledo regions did not see a connection between gambling and drug use. Moreover, the majority of participants overall reported that their gambling is secondary to their drug use. Gambling was often seen as

a consumer of money and time which could be used to acquire drugs. Some participants reported not having sufficient funds for both gambling and drug use, reporting no regular gambling. On the other hand, the majority of participants within the Akron-Canton and Cleveland regions described a relationship between gambling and drug use. Akron-Canton participants generally reported gambling more frequently when they were high on drugs. Cleveland participants suggested that certain drugs are related to certain types of gambling. For instance, they noted marijuana use as common when shooting dice/craps and alcohol and cocaine use as common when participating in casino gambling. Finally, Dayton participants compared gambling to a drug-induced high.

In contrast to illicit drugs, there was consensus among participants that a relationship exists between gambling and

alcohol use. Participants continued to note that alcohol use is common within gambling venues, such as bars and casinos. Participants within the Youngstown region reported increasing their alcohol use when they gambled. Other participants reported spending more money on gambling when they drank alcohol. Participants in Athens, Cincinnati and Dayton reported that individuals in recovery are more likely to gamble than users who are not.

Lastly, some participants suggested that an “addictive personality” may be a factor determining one’s vulnerability to gambling addiction. However, within most regions, participants did not report struggling with problem or pathological gambling. Only one participant from the Toledo region reported selling drugs to support a gambling addiction. No participant reported seeking help for gambling addiction during this reporting period.