Ohio Substance Abuse Monitoring Network

Surveillance of Drug Abuse Trends in the State of Ohio

June 2018 - January 2019

Prepared by:

Ohio Department of Mental Health and Addiction Services

Lori Criss, Director • Mike DeWine, Governor

Office of Quality, Planning and Research

R. Thomas Sherba, OSAM Principal Investigator — PhD, MPH, LPCC
Sarah Balser, OSAM Coordinator — MPH, MSW, LSW, CHES
Jessica Linley, OSAM Quantitative Data Analyst — PhD, MSW, LSW

Table of Contents

OSAM-O-Gram ...........................................................................................................................................................3
Executive Summary ...................................................................................................................................................5

Drug Abuse Trends by Region

Akron-Canton Region ................................................................................................................................................29
Athens Region ............................................................................................................................................................51
Cincinnati Region ........................................................................................................................................................69
Cleveland Region ........................................................................................................................................................87
Columbus Region ......................................................................................................................................................111
Dayton Region ..........................................................................................................................................................133
Toledo Region ..........................................................................................................................................................153
Youngstown Region ...............................................................................................................................................173

Contact information:

R. Thomas Sherba
Office of Quality, Planning and Research
30 E. Broad St., 8th Floor
Columbus, OH 43215
P: 614.466.9020
Email: Tom.Sherba@mha.ohio.gov

Recommended citation for this report:

Toledo Region

- Fentanyl, marijuana, meth & synthetic marijuana availability
- Illicit prescription opioid availability
- Most users seek heroin-fentanyl mixtures
- Law enforcement noted overdose death due to access to Narcan®
- Crystal meth availability in urban areas
- Desirability for “dabs” among young people

Cleveland Region

- Meth, illicit Suboxone® & Neurontin® availability
- Illicit prescription opioid availability
- Heroin & fentanyl synonymous with one another
- Dealers in Cleveland actively pushing heroin/fentanyl
- Fentanyl cut into meth, cocaine & pressed into pills
- Fentanyl use continues to result in fatal consequences

Dayton Region

- Fentanyl & meth availability
- Drug dealers aggressively pushing heroin
- Most heroin is fentanyl or heroin-fentanyl mixtures
- Users seek fentanyl for its potency, more intense high than heroin
- Drug dealers pushing meth like heroin by actively soliciting customers
- Opiate users using meth to get off heroin

Akron-Canton Region

- Meth, marijuana, illicit Suboxone® & synthetic marijuana availability
- Illicit prescription opioid availability
- Unadulterated heroin difficult to find
- Users prefer fentanyl to heroin due to opiate tolerance
- Demand for meth due to opiate overdose fear
- Pills pressed with fentanyl sold as Xanax®

Cincinnati Region

- Fentanyl & meth availability
- Users prefer fentanyl to heroin due to “stronger” high
- Fentanyl used to cut other illicit drugs (cocaine, meth)
- Dealers & heroin users switching focus to stimulants
- Meth used to come off heroin
- in "speedballing" with heroin-meth combination

Columbus Region

- Fentanyl, marijuana ("dabs") & meth availability
- Illicit prescription opioids, stimulants & sedative-hypnotics availability
- Unadulterated heroin difficult to find; fentanyl-heroin mixtures widely available
- Fentanyl higher in availability than heroin due to demand for more potent opiates
- Meth most available drug in region; MAT clients using meth

Athens Region

- Marijuana ("dabs") & illicit Suboxone® availability
- Illicit prescription opioid availability
- "Straight fentanyl" difficult to obtain; heroin-fentanyl mixtures widely available
- ODPS reported seizing 73 lbs. of fentanyl in region in past 6 mos.
- Opiate users switching to cocaine & meth due to overdose fear
- Users overdosing on cocaine due to fentanyl cut
- Crystal meth availability in urban areas

Please note:

- Increase
- Decrease

Youngstown Region

- Marijuana ("dabs"), powdered cocaine availability
- ODPS reported seizing 59.4 lbs. of cocaine in region in last 6 mos.
- Opiate users switching to cocaine & meth due to overdose fear
- Users overdosing on cocaine due to fentanyl cut
- Crystal meth availability in urban areas

Ohio Department of Mental Health and Addiction Services • Office of Quality, Planning and Research
Ohio Substance Abuse Monitoring (OSAM) Network consists of eight regional epidemiologists (REPIs) located in the following regions of the state: Akron-Canton, Athens, Cincinnati, Cleveland, Columbus, Dayton, Toledo and Youngstown. The OSAM Network conducts focus groups and individual 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 epidemiological descriptions that policymakers need to plan appropriate prevention and intervention strategies.

This Executive Summary presents findings from the OSAM core scientific meeting held in Columbus, Ohio on January 25, 2019. It is based upon qualitative data collected from July through December 2018 via focus group interviews. Participants were 336 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 data collected from 102 community professionals via individual and focus group interviews, as well as to data surveyed from coroner and medical examiner offices, family and juvenile courts, municipal courts, common pleas and drug courts, Ohio Bureau of Criminal Investigation (BCI), Ohio State Highway Patrol (OSHP) Crime Lab, police and county crime labs, fire department EMS, OhioMHAS’ Screening, Brief Intervention and Referral for Treatment (SBIRT) program which operates in federally qualified health centers, and Ohio Department of Public Safety (ODPS), which logs drug task force seizures from across Ohio. Media outlets in each region were also queried for information regarding regional drug abuse for July through December 2018. OSAM research administrators 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 in this section.

**Powdered Cocaine**

Powdered cocaine is highly available in the majority of OSAM regions. In the Youngstown region where the availability of powdered cocaine has increased during the past six months, a participant remarked, “It’s everywhere.” ODPS reported seizing 26.9 kilograms (59.4 lbs.) of powdered cocaine from the Youngstown region during the past six months. Participants and community professionals discussed opiate users switching to cocaine use due to fear of overdosing on fentanyl. A treatment provider stated, “They’re thinking if they switch to cocaine [from opiates], they would be safer.” Treatment providers also noted a correlation with medication-assisted treatment (MAT) and cocaine use. Since MAT blocks an opiate high, they reported that powdered cocaine has become a substitute high for many MAT clients.

Corroborating data indicated that cocaine is readily available throughout OSAM regions. Coroner and medical examiner offices in three of Ohio’s largest counties, Cuyahoga, Hamilton and Montgomery, reported that 42.1%, 44.1% and 40.3%, respectively, of all drug-related deaths they recorded this reporting
period involved cocaine (powdered and/or crack cocaine). OSHP Crime Lab reported that of all cocaine cases processed by its lab during the past six months, 53.4% were powdered cocaine and 46.6% were crack cocaine.

Recovery Board informed of a deadly mixture of cocaine and fentanyl as circulating in Trumbull County (Youngstown region), reporting that users often unknowingly get cocaine laced with fentanyl; as of August 2018, there were 29 confirmed overdose deaths recorded in Trumbull County for 2018 (www.wkbn.com, Aug. 20, 2018).

Other cuts for powdered cocaine mentioned included: baby aspirin, baby formula, baby powder, diet pills, ibuprofen, isotol (dietary supplement), MSM (methylsulfonylmethane, a joint supplement), Miami Ice® (powder found at head shops and sold as carpet deodorizer), No-Doz® (caffeine supplement), “molly” (powdered MDMA), numbing agents (Orajel™), over-the-counter nutritional supplements (creatinine, whey), prescription stimulants (Ritalin®), sedative-hypnotics (benzodiazepines, sleep aids), steroids and water pills. Crime labs throughout OSAM regions noted the following cutting agents for powdered cocaine: atropine (heart medication), caffeine, levamisole (livestock dewormer), local anesthetics (benzocaine, lidocaine and procaine), phenacetin (banned analgesic) and triacetin (triglyceride).

Current street jargon includes many names for powdered cocaine. Street names often refer to the white color of the drug (“snow,” “sugar,” “white” and “white rabbit”) and often reference females (“Christina Aguilera,” “girl,” “white girl” and “white lady”). Columbus participants described names for more pure powdered cocaine. One participant said, “Fish scale is the one that will come in that’s pink, that’s pure cocaine. … It’s shiny, looks like fish scales.” A Youngstown participant shared, “Drip … just snorting it in general, [your nose is] going to drip … that’s when the party starts.”

Participants throughout OSAM regions most often rated the current overall quality of powdered cocaine as ‘5’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the regional modal quality scores ranged from ‘2’ for Cincinnati to ‘10’ for Toledo and Youngstown. Participants in Toledo and Youngstown reported on the potency of powdered cocaine, attributing the drug’s current “high quality” to the use of fentanyl as a common cut (adulterant). Participants in six regions noted that the overall quality of powdered cocaine has remained the same during the past six months, while participants in the Cleveland region reported decreased quality; participants in the Columbus region did not reach consensus on whether the quality of powdered cocaine has changed.

Participants continued to universally indicate that powdered cocaine is often cut with other substances and reported the top cutting agents for powdered cocaine as: baby laxatives, baking powder, baking soda, fentanyl, powdered sugar and vitamin B-12. With the exception of Athens and Columbus regions, participants noted fentanyl as a top cutting agent. One participant stated, “Everything’s being cut with fentanyl now.” In addition, participants discussed users overdosing on powdered cocaine due to fentanyl cut.

In August 2018, the Trumbull County Combined Health District and the Trumbull County Mental Health and Mental Health Disc

<table>
<thead>
<tr>
<th>Region</th>
<th>Current Availability</th>
<th>Availability Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron-Canton</td>
<td>High</td>
<td>No consensus</td>
</tr>
<tr>
<td>Athens</td>
<td>Moderate to High</td>
<td>No change</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Cleveland</td>
<td>Moderate to High</td>
<td>No change</td>
</tr>
<tr>
<td>Columbus</td>
<td>Moderate to High</td>
<td>No consensus</td>
</tr>
<tr>
<td>Dayton</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Toledo</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Youngstown</td>
<td>High</td>
<td>Increase</td>
</tr>
</tbody>
</table>

Throughout OSAM regions, reports of current prices for powdered cocaine were variable among participants with experience buying the drug. Participants noted that price varies depending on the dealer, desired quality, amount
of purchase and location. One participant shared, “It's subjective, it depends on where you get it.” Participants reported that users pay a higher price for better quality cocaine. A participant remarked, “The stronger, the more it costs.” Participants also discussed: “If you have the money to buy a large amount, it is cheaper; The dealer will give you a break the first time to get you hooked, then he increases the price; It really depends on if you go to Columbus, it is cheaper there around here [Allen County].”

Participants throughout OSAM regions reported that the most common quantity of purchase for powdered cocaine is a gram for $40-100, followed by 1/8 ounce (aka “eight ball”) for $100-300. Participants in half of the regions also noted 1/10-gram amounts for $10-25 as common. Participants in the Akron-Canton region reported that the overall price of powdered cocaine has decreased during the past six months, while participants in all other regions reported that prices have remained the same.

The most common route of administration for powdered cocaine remains snorting, followed by intravenous injection. Throughout OSAM regions, participants reported that most powdered cocaine users, most would snort the drug; only participants in the Cincinnati region thought intravenous injection (aka “shooting”) to be more common than snorting. Cincinnati participants noted the high prevalence of opiate users who intravenously inject drugs and reported: “If you shoot it, you normally shoot [other drugs]; Higher income people (social users) more likely to snort.” Participants in the Akron-Canton, Athens and Toledo regions indicated that snorting and shooting are equally common. Athens participants discussed: “People can start smoking or snorting, but they always graduate to shooting; People snort because it is easier, and you do not have track marks; They inject it for a better or instant high.”

Participants and community professionals continued to most often describe typical powdered cocaine users as of middle to upper socio-economic status, white people. In addition, much of the discussion of powdered cocaine use continued to relate to the drug’s status as a party drug. Comments included: “It’s still a party drug; A bar drug.” In addition, one law enforcement officer observed, “Some [powdered cocaine users] are opiate users, trying to get off the opiates.”

Many other substances are used in combination with powdered cocaine. Reportedly, using powdered cocaine with alcohol allows individuals to drink alcohol for a longer period. Comments included: “It prolongs my drinking. Instead of drinking for two hours and passing out … if I’m doing coke, then I’m going to go all night and still continue to drink; You can’t get drunk.” Participants continued to report that powdered cocaine is often used in combination with opiates to “speedball” (concurrent or consecutive stimulant and sedative highs). Participants discussed: “You mix an upper and a downer, so you don’t fall over; People like to use heroin with cocaine because a lot of people like to try to even themselves out … they’re so high off the cocaine that they have to bring themselves down.” Participants also noted that marijuana, prescription opioids and sedative-hypnotics (Xanax®) are used to bring a user down after cocaine use; crack cocaine, methamphetamine and MDMA (eczstasy/molly) combined with powdered cocaine intensifies one’s high.

### Substances Most Often Combined with Powdered Cocaine

- alcohol
- crack cocaine
- ecstasy/molly (MDMA)
- fentanyl
- heroin
- marijuana
- methamphetamine
- prescription opioids
- sedative-hypnotics

### Crack Cocaine

Crack cocaine remains highly available in the majority of OSAM regions. Participants continued to report drug dealers soliciting customers by offering free samples of the drug, and in many areas, home delivery of crack cocaine is available. Akron-Canton participants shared: “I can't tell how many times someone drove up and offered me ‘crack’ (crack cocaine); There’s a lot of new drugs coming in, but people still do crack, there’s a market for it; It’s intense and cheap.”

In most OSAM regions, participants and community professionals agreed that the high availability of crack cocaine has remained the same during the past six months. Respondents in Cleveland and Columbus did not reach consensus. Like powdered cocaine, those who perceived an increase in crack cocaine availability cited opiate users either switching to crack cocaine use out of fear of fentanyl fatal overdose or because they are receiving MAT and can no longer get high on opiates. Those who perceived decreased availability attributed the decrease to methamphetamine, which reportedly, is more potent and widely available.
Law enforcement in Cincinnati and Cleveland reported that heroin/fentanyl dealers market crack cocaine as a safeguard to opiate overdose. One law enforcement officer stated, "Drug dealers are telling people that in order not to overdose on fentanyl, use cocaine (a stimulant) to counter the effects of the depressant (fenatnyl)."

While addressing the reason that fentanyl is used as an adulterant for crack cocaine one participant explained, "To get you hooked on heroin. Now you’re coming and getting the heroin … they’ll make more money…. If you can buy cocaine from somebody, chances are you can buy heroin from them, too." Another participant commented, "[Crack] is being mixed with fentanyl, making it stronger and more addictive. That’s good for the ‘dope boy’ (drug dealer), but not for the users.”

Other cuts for crack cocaine mentioned included: ammonia, baking powder, creatine, ether, Fruit Fresh®, heroin, laxatives, MDMA (ecstasy/molly), methamphetamine, prescription stimulants (Ritalin®), rat poison, sedative-hypnotics (benzodiazepines), sheet rock (drywall), Sudafed® and vitamin B. Crime labs throughout OSAM regions noted the following cutting agents for crack cocaine: atropine (heart medication), caffeine, levamisole (livestock dewormer), local anesthetics (benzocaine, lidocaine and procaine), phenacetin (banned analgesic) and triacetin (triglyceride).

Current street jargon includes many names for crack cocaine. Participants explained that some of the most common street names, such as “hard” and “rock,” reference the appearance of the drug. In addition, a participant commented that crack cocaine is often referred to as “work,” offering, “Work that’s hard.”

<table>
<thead>
<tr>
<th>Region</th>
<th>Current Availability</th>
<th>Availability Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron-Canton</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Athens</td>
<td>Moderate to High</td>
<td>No change</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Cleveland</td>
<td>High</td>
<td>No consensus</td>
</tr>
<tr>
<td>Columbus</td>
<td>Moderate to High</td>
<td>No consensus</td>
</tr>
<tr>
<td>Dayton</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Toledo</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Youngstown</td>
<td>High</td>
<td>No change</td>
</tr>
</tbody>
</table>

Participants throughout OSAM regions most often rated the current overall quality of crack cocaine as ‘4’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the regional modal quality scores ranged from ‘3’ for Cincinnati to ‘7’ for Cleveland. However, participants continued to discuss that the quality of crack cocaine varies, with several saying that it is, “hit or miss.” They attributed varying quality to one’s dealer, or rather one’s relationship with a dealer, location of purchase, and the amount and type of adulterant in the drug.

Overall, participants in the majority of OSAM regions reported that the quality of crack cocaine has remained the same during the past six months, with the exception of Akron-Canton, Dayton and Toledo where participants reported decreased quality. Participants discussed adulterants that affect the quality of crack cocaine, and they continued to most often report baking soda as the top cutting agent (adulterant) for the drug. Other top cutting agents mentioned included: baby laxatives and vitamin B-12. In addition, participants in the Dayton region reported fentanyl as the top cutting agent for crack cocaine in that region; participants in five other regions also discussed fentanyl-cut crack cocaine. Athens and Columbus participants did not express knowledge of fentanyl mixed with cocaine.

Participants in the majority of OSAM regions continued to report that the most common quantity of purchase for crack cocaine is 1/10 gram (aka “rock”) for $20 (aka “20 piece”); for the Cincinnati region 1/2 gram for $30 is most common; and for the Youngstown region 1/2 gram for $50 is most common. Throughout OSAM regions, a gram continues to sell for $50-100. However, participants continued to report purchasing crack cocaine for whatever amount of money they had at the time of purchase. They commented: “[Dealers] usually just ask,
'What you got?… I asked for $25 worth; You can get a $2 hit if you want; Sometimes [dealers] take what they can get.” Participants throughout OSAM regions indicated that the price for crack cocaine has remained the same during the past six months, with the exception of the Columbus region where participants reported increased pricing.

Throughout OSAM regions, with the exception of the Cincinnati region, participants reported that the most common route of administration for crack cocaine remains smoking. A participant remarked, “You smoke crack … that’s how you do crack.” Participants estimated that out of 10 crack cocaine users, 8-10 would smoke and 0-2 would intravenously inject (aka “shoot”) the drug. Participants in Cincinnati estimated that 7 of 10 crack cocaine users in that region would shoot the drug. One participant explained, “If you don’t shoot your heroin, you probably don’t shoot crack either.” To intravenously inject the drug, another participant stated, “You melt it with vinegar.”

While participants and community professionals in half of the OSAM regions found it difficult to describe a typical crack cocaine user, respondents in the other half of regions most often described typical users as of low socio-economic status, with many treatment providers continuing to note crack cocaine use as more prevalent among their African-American clientele. A Columbus treatment provider commented, “I’ve noticed the majority of my African-American clients, their drug of choice, is crack…. I do have Caucasian clients who are also addicted to that … but, I would say a majority of [crack cocaine users] are of African-American descent.” Other providers added: “People in [homeless] shelters; Inner city.”

Many other substances are used in combination with crack cocaine. Participants continued to report that crack cocaine is most often used in combination with alcohol, heroin and marijuana. Participants reported using alcohol and marijuana primarily to come down from the stimulant high produced by crack cocaine use. A participant commented, “Alcohol … balances you out.” Participants reported using heroin with crack cocaine for the “speedball” effect (concurrent or consecutive stimulant and sedative highs). They discussed: “You don’t ‘fiend’ (intensely crave) for crack if you use it with heroin; Heroin, then the crack to wake you up; Crack goes hand-in-hand with heroin.”

Participants discussed crack cocaine as interchangeable with other stimulant drugs such as methamphetamine and prescription stimulants. One participant shared, “If it’s like five in the morning and my crack dealer is not picking up his phone, I would take Adderall® to bridge the gap ‘til I got more crack … if I was deciding to go on a bender.”

### Heroin

Heroin continues to remain widely available throughout OSAM regions. Toledo participants commented that they had 3-5 heroin dealers’ numbers in their phones, while other participants reported that even if you didn’t know any dealers, you could quickly locate one. Participants in several regions continued to discuss drug dealers aggressively pushing heroin. They said dealers seek out customers by profiling users, approaching people whom they suspect to be users and offering heroin for sale. Reportedly, all one has to do is drive slowly down certain streets in Dayton and Cleveland to find drug dealers giving away “testers” (free samples of heroin bundled with the dealer’s phone number). One Cleveland participant remarked, “People come up (approach you) [and ask], ‘You working for that boy?’ (looking for heroin).” Law enforcement in Cleveland also noted that heroin dealers drive around and look for customers. One officer commented, “They see people that they think are either becoming ‘dope sick’ (experiencing withdrawal) or look like they’re addicts, and basically, they’re just asking them if they’re looking to buy drugs….”

While heroin remains highly available throughout OSAM regions, respondents acknowledged that a lot of heroin contains fentanyl or is fentanyl substituted for heroin. Thus, Akron-Canton respondents reported that the availability of heroin has decreased during the past six months. Columbus participants also indicated difficulty in finding heroin not adulterated with fentanyl; they described heroin-fentanyl mixtures as having saturated the market. Many respondents noted that heroin is being replaced by cheaper substitutions (fentanyl and methamphetamine). Reportedly, many heroin users prefer and seek fentanyl over heroin due to increased...
tolerance to opiates, while other heroin users have become fearful of fentanyl overdose death and have switched to methamphetamine use.

<table>
<thead>
<tr>
<th>Region</th>
<th>Current Availability</th>
<th>Change</th>
<th>Most Available Heroin Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron-Canton</td>
<td>High</td>
<td>Decrease</td>
<td>Powdered</td>
</tr>
<tr>
<td>Athens</td>
<td>High</td>
<td>No change</td>
<td>Black tar</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>High</td>
<td>No change</td>
<td>Powdered</td>
</tr>
<tr>
<td>Cleveland</td>
<td>High</td>
<td>No change</td>
<td>Powdered</td>
</tr>
<tr>
<td>Columbus</td>
<td>High</td>
<td>No consensus</td>
<td>Powdered and Black tar</td>
</tr>
<tr>
<td>Dayton</td>
<td>High</td>
<td>No consensus</td>
<td>White powdered</td>
</tr>
<tr>
<td>Toledo</td>
<td>High</td>
<td>No change</td>
<td>Powdered</td>
</tr>
<tr>
<td>Youngstown</td>
<td>High</td>
<td>No change</td>
<td>Powdered</td>
</tr>
</tbody>
</table>

Participants reported that powdered heroin comes in many colors. They discussed: “Gray [powdered heroin] is popular now; Gray is with the fentanyl; Majority is gray [in Cincinnati region], sometimes an amber color; Black, tan, red, brown, white, blue … it could be any [color], depends on what you cut it with….“ During the past six months, BCI crime labs reported processing beige, blue, brown, gray, purple, tan and white powdered heroin as well as black tar heroin.

Participants throughout OSAM regions most often rated the current overall quality of heroin as ‘3’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the regional modal quality scores ranged from ‘0’ for Youngstown to ‘10’ for Cleveland. Quality ratings were dependent on personal preference towards fentanyl. Participants who desired the potency of fentanyl rated heroin adulterated (aka “cut”) with fentanyl high, while participants who assigned a low-quality rating were commenting on the low quality of heroin not adulterated with fentanyl. Participants explained: “It’s junk … that’s why they put all the stuff in it; [More fentanyl] makes heroin way better.” One participant shared that he found out a friend had overdosed and died on heroin before coming to the focus group. This participant stated, “Well, obviously it’s good [potent] … the Narcan® (naloxone, opiate overdose reversal medication) or whatever didn’t bring him back.”

Participants in the majority of OSAM regions reported that the quality of heroin has remained the same during the past six months. Akron-Canton and Cincinnati participants reported decreased quality, while Columbus participants reported increased quality. Participants discussed cuts that affect the quality of heroin and continued to universally report fentanyl as the top cutting agent for the drug. One participant remarked, “It’s not even really heroin … it’s mainly fentanyl.” A law enforcement officer in Toledo commented, “It’s about 3% [heroin] … and 97% is fentanyl or coke or any other drug they’re mixing in it.”

Participants throughout OSAM regions continued to discuss the risk for overdose. They said: “[Drug dealers] don’t know how to regulate it (cut fentanyl into heroin). They don’t know how much to give out. You can give a little tiny line to somebody and it’ll put them down (they will overdose); You’re getting fentanyl and you don’t know what milligram it is; Some people don’t take the time to do a warm up (tester of heroin) to see how it’s gonna affect them…. When you don’t use responsibly, or you’re careless about it … that’s why you’re seeing [overdose] happen so much.”

Additional cuts mentioned for heroin included: aspirin, baby formula (Similac®), baby laxatives, Benefiber®, brown sugar, carfentanil (synthetic opioid more potent than fentanyl, horse tranquilizer), cocoa powder, coffee, cosmetics, ecstasy (MDMA), lactose, laxatives, lidocaine (local anesthetic), methamphetamine, Neurontin® (gabapentin), powdered cocaine, powdered sugar, prescription opioids (Percocet®), salt, sedative-hypnotics (Xanax®), soda pop (Coca-Cola®, Dr. Pepper®, Pepsi®), sleep aids (Sleepinal®), sugar, tar, Tylenol®, trazodone (prescribed sedative and antidepressant), vinegar and vitamin B-12.

Crime labs throughout OSAM regions noted the following cutting agents for heroin: acetaminophen, caffeine, cocaine, diphenhydramine (antihistamine), fentanyl, inositol (dietary supplement), lidocaine (local anesthetic), mannitol (diuretic), methamphetamine, papaverine (vasodilator), quinine (antimalarial), sorbitol (artificial sweetener), tramadol and xylazine (animal sedative).

Current street jargon includes many names for heroin. Throughout OSAM regions, participants continued to note “boy” as the most common street name generally, followed by “dope.” One participant commented, “It’s so crazy … when I was a kid, ‘dope’ was crack … and now it’s heroin…. Not saying it’s any better, but you know, it
changes." Participants explained that street names can reference the appearance of the drug; for instance, brown powdered heroin is most often referred to as “dog food” because it looks like dog food. “Sticky” and “tar” reference the appearance of black tar heroin. Reportedly, “slow” references the feeling the user gets after heroin use. In addition, participants once again discussed that “fetty” is used in reference to both fentanyl and heroin due to the high prevalence of heroin-fentanyl mixtures.

### Current Street Names of Heroin

<table>
<thead>
<tr>
<th>General Names</th>
<th>Other Names for Black Tar</th>
<th>Other Names for Brown Powdered</th>
<th>Other Names for White Powdered</th>
</tr>
</thead>
<tbody>
<tr>
<td>boy, H, Hank, horse, man, medicine, Ron, slow, smack</td>
<td>black, chocolate, sticky, tar</td>
<td>D, dog, dog food, doggie, pup, puppy chow</td>
<td>china, china white, fatty</td>
</tr>
</tbody>
</table>

Participants in half of the OSAM regions reported that the most common quantity of purchase for heroin is 1/10 gram for $10-20. Participants in the Dayton and Youngstown regions indicated a gram for $100-120 as most common, while participants in Cleveland and Toledo indicated 1/2 gram and gram amounts as equally common. A Columbus participant observed, “Every time I’ve been in a ‘trap house’ (place where illicit drugs are bought and used), it’s like every other customer in front of me, it’s the same thing ... [they’re buying] either 20 ($20 1/10 gram) or a gram.”

With the exception of the Columbus region where participants noted a decrease in heroin prices, participants throughout OSAM regions reported that the price of heroin has remained the same during the past six months. However, Akron-Canton participants discussed that the price for heroin varies depending on the quality of the heroin and that heroin is purchased for lower prices in cities such as Akron and Cleveland.

The most common route of administration for heroin remains intravenous injection (aka “shooting”), followed by snorting. Participants estimated that out of 10 heroin users, 7-10 would shoot and 0-3 would snort the drug. Participants commented: “You only snort it for so long; Everyone will eventually shoot it; The high’s way better [when you shoot]; Smoking, it’s a waste.” One Cleveland participant observed, “[Certain drug houses] they call ‘shooting galleries.’ It’s a dollar to get in and a dollar to use the syringes. So, if you go there, everybody’s shooting…. At a bar, you go in the bathroom and snort [heroin].”

Participants reported that injection needles (aka “darts,” “harpoons,” “pens,” “pins,” “points,” “pokes,” “rigs,” “spikes,” “sticks,” “tools,” “twigs,” “utensils” and “works”) are most available from big box stores, drug dealers, needle/syringe exchange programs, people with diabetes, pharmacies, retail drug stores and through Internet purchase.

Participants discussed: “You can go to Walmart and get them without a prescription; I always got mine from the drug dealer; My dope boy gave it to me with each purchase; My mom is diabetic, got from her; A guy I used to work with, would have them … he got them off the Internet.” Reportedly, needles sell for $1-5 per needle on the street.

Participants throughout OSAM regions discussed sharing needles as common. They observed: “Sharing needles, yes, absolutely, that’s 100%; I knew a guy who had ‘Hep C’ (hepatitis C) and people would use the needle right after him knowing he has Hep C; I’ve seen people use bent needles, rusted needles, needles filled with blood they found on the street; If you don’t have your own needle, you don’t think twice about sharing.” Other participants added: “I didn’t really do it that much, I carried a bottle of water, alcohol wipes, and a bottle of bleach in my purse. I had a whole kit [to clean needles]; If you miss that noon to two [PM] (needle exchange operating hours), and it’s Friday night … you’ll use, reuse, go find [a needle somewhere].”

Participants acknowledged several health concerns regarding needle use: abscesses, amputations, cellulitis, clots, heart complications, hepatitis, HIV/AIDS, MRSA/staph infection and death. Despite these concerns, participants reported continued needle use. One participant shared, “There are no health concerns while you are using.”

Respondents in half of OSAM regions continued to describe typical heroin users as young, white people aged 20s to 30s, while respondents in the other half of regions could not provide a profile of typical use. They reported “anyone” could be a heroin user. Athens treatment providers stated: “It is hitting everyone … young, old, poor, rich; It goes across the board. I have seen every demographic.” Cleveland participants maintained: “I’ve been all over the place shootin’ dope … I don’t see a lot of African-American men shooting [heroin]; I just got released from the institution and I’ve seen more guys, 20-years old, white [heroin] addicts.”
Many other substances are used in combination with heroin. Participants reported that heroin is most often used in combination with crack/powdered cocaine, methamphetamine and sedative-hypnotics (Xanax®). Participants throughout regions discussed the popularity of using cocaine, and the increasing popularity of using methamphetamine, with heroin to “speedball” (concurrent or consecutive stimulant and sedative highs). Participants explained: “Heroin and crack for sure … it’s called ‘speedballing.’ I put my heroin and my crack in a spoon together … I’d shoot them up at the same time. I would do that, so I would get a real racing feeling and kind of feel down, too; Heroin’s a downer and crack’s like a picker upper; They literally go hand-in-hand; If I had one, I had the other. Always.”

Participants also discussed using heroin to come down from the intense stimulant high of cocaine and methamphetamine, or they would use stimulant drugs to come up from the down (depressed state) of heroin use. They said: “I would always use dope to come down because you’d be up for days on methamphetamine; Cocaine is pretty much the balancer that keeps you up and able to move … it’s just a cycle of getting low and getting high to get low again; You can feel the effect of the heroin without slumping over; If I was too high on meth, I’d come back with heroin.”

Reportedly, alcohol, marijuana, Neurontin® and sedative-hypnotics are combined with heroin use to intensify the heroin high. Participants commented: “Xanax® is a huge one, ‘benzos’ (benzodiazepines), they even call it the ‘death cocktail,’ but nobody cares. It intensifies that high; Xanax®. It’s another downer so it makes your high increase; Alcohol and heroin is a death cocktail … they both slow your body down. So, before you realize it, you’ve taken too much, and it shuts your body down and you ‘OD’ (overdose); I’ve almost died so many times doing that combo, alcohol and dope; You can smoke weed, get high on heroin … it makes your high stronger; [Neurontin®] makes the high of an opiate or fentanyl … like a million times stronger. It’s insane.”

Substances Most Often Combined with Heroin

- alcohol
- crack cocaine
- fentanyl
- heroin
- marijuana
- methamphetamine
- Neurontin®
- powdered cocaine
- prescription opioids
- sedative-hypnotics

Fentanyl

While respondents discussed speaking of fentanyl apart from heroin as challenging, the consensus throughout OSAM regions was that fentanyl remains highly available as evidenced in the high prevalence of fentanyl-cut drugs. Participants in the Athens region assigned a low current availability rating to fentanyl which is reflective of their viewpoint that “just fentanyl” is difficult to obtain. They stated: “I have only seen pure fentanyl once or twice in the last year … usually it is cut into the heroin; I never actually bought fentanyl, it was in my heroin.” Athens and Akron-Canton respondents were not in agreement as to whether the availability of fentanyl has remained the same or increased during the past six months.

Law enforcement in Columbus noted an increase in fentanyl availability, sharing: “It’s a little bit higher … we’re seeing more of the [fentanyl] analogues; There’s hundreds of different analogues.” One officer remarked, “There are a lot of users out there that want to come as close to death as possible. So, they want [fentanyl].” Participants in regions with increased availability of fentanyl reported increased demand for the drug. They discussed users seeking fentanyl for its potency, reportedly, a more intense high than heroin.

Corroborating data indicated that fentanyl is highly available throughout OSAM regions. ODPS reported seizing 164.2 pounds of fentanyl from across Ohio during the past six months; of which, 44.5% was seized from the Athens region and 40.6% was seized from the Cincinnati region. Columbus Fire Department reported administering 2,099 total doses of naloxone (opiate overdose reversal medication) to 1,446 individuals in the city of Columbus during the reporting period. In addition, coroner and medical examiner offices in Cuyahoga, Hamilton and Montgomery counties, reported that 68.7%, 77.7% and 86.0%, respectively, of all drug-related deaths they recorded this reporting period involved fentanyl/fentanyl analogues.
Participants most often rated the current overall quality of fentanyl as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). However, participants in the Athens region were unable to rate the current overall quality of fentanyl, as stated previously, they were unable to speak about fentanyl apart from heroin. The majority of participants reported on extremely potent fentanyl. Comments included: “There’s no gauge for [quality] … you get so high; You are gonna get really high or you are going to die; Everyone’s dying from it, [quality] must be ‘10.’”

Participants discussed adulterants (aka “cuts”) that affect the quality of fentanyl and reported that the top cutting agents for the drug are brown sugar, heroin and powdered sugar. Both participants and treatment providers in the Toledo region reported that users are most often looking for a heroin-fentanyl mix when seeking opiates. They request heroin but are expecting heroin and fentanyl. Participants reported that they most preferred the combination because heroin lasts longer than fentanyl, but fentanyl provides a stronger high. The combination of the two provides the user with what they desire.

Additional fentanyl cuts mentioned included: baby formula, beef bouillon, carfentanil, cocaine, coffee creamer, head shop products, heroin, laxatives, methamphetamine, sleeping pills, table sugar and vitamins. Participants continued to report that it is necessary to cut fentanyl due to its high potency. They stated: “They have to ‘step on’ (adulterate) it or everybody would be dying … they have to cut [fentanyl]; They cut it with cocaine to keep you alive. If you’re dead, they can’t make any money off you; [Fentanyl is] cut with powdered sugar, and you’re still going to get high.”

Crime labs did not report on adulterants for fentanyl. Overall, participants reported that the general quality of fentanyl has remained the same during the past six months, with the exception of the Dayton region where participants reported increased quality. Dayton participants explained: “The fentanyl is getting stronger as the high is lasting longer; The poor quality [fentanyl] wears out in 10 minutes.”

Current street jargon includes several terms for fentanyl. Throughout OSAM regions, participants continued to note “fetty” as the most common street name generally, followed by “fetty wop.” A participant reported hearing people say, “I want that fetty.” Reportedly, “gray reaper” is so named because of the usual color of the drug when mixed with heroin and because of its extreme potency which often leads to fatal overdose. Participants noted that since fentanyl is often mixed with heroin, many of the street names for heroin are also used to reference fentanyl. In terms of “china” and “china white,” users use these names for fentanyl because most fentanyl originates from China.

Participants in the majority of OSAM regions reported prices for fentanyl; only participants in the Athens region were unable to report on current pricing. In five of the seven reporting regions, a gram is the most common quantity of purchase. Participants continued to discuss that the pricing for fentanyl is the same as the pricing for heroin. They commented: “The price of fentanyl is the same as what you would pay for heroin; [Dealers] are buying [fentanyl] dirt cheap, but they’re selling it for the same [price as heroin].”

Throughout regions, a gram sells for $80-180; 1/2 gram sells for $40-60; and 1/10 gram sells for $10-20. In addition, Cleveland participants discussed fentanyl sold in capsules containing approximately a 2/10-gram amount, selling most often for $20. A participant remarked, “They put [fentanyl] in capsules and sell it by the capsule.” Overall,
participants reported that the price of fentanyl has remained the same during the past six months. However, participants in the Akron-Canton region indicated decreased prices due to an overabundance of the drug in that region. A participant commented, “It’s easier to get than heroin, so they lowered the price.”

The most common route of administration for fentanyl remains intravenous injection (aka “shooting”). Participants most often estimated that out of 10 fentanyl users, 8-9 would shoot and 1-2 would snort the drug. Most participants observed that fentanyl use mirrors that of heroin use. One participant added, “Snort and shoot. I don’t know anyone that smokes fetty.”

Participants and community professionals continued to describe typical fentanyl users as the same as heroin users, white people in their 20s and 30s. Treatment providers commented: “Many started with heroin in high school, and their tolerance is so high in their 20s [that] they are seeking the stronger opiate; High risk takers.” One participant added, “[A person who knows] the high potential for overdose and death and being okay with that, so more suicidal in that way.” However, participants noted the increasing use of fentanyl as a cut for other drugs meant: “Anybody can fall victim to it; Could be anybody.”

Many other substances are used in combination with fentanyl. Participants reported that fentanyl is most often used with heroin, crack/powdered cocaine, methamphetamine and sedative-hypnotics (Xanax®). Participant discussed “speedballing” (concurent or consecutive stimulant and sedative highs) with fentanyl and cocaine/methamphetamine. Reported, these stimulant drugs are used to counter the “nods” (passing out, extreme sedative state) produced by fentanyl use. Participants explained: “It’s common to do a shot of meth to bring you back [up after fentanyl use]; Crack counters, balances it out; If you get too high, use fentanyl. If you get too low, smoke crack; Fentanyl and crack, fentanyl and meth; I used meth [with fentanyl], that is the only way I survived.”

Regarding the use of Xanax® with fentanyl, participants discussed Xanax® as intensifying the fentanyl high and users taking the drug to help alleviate withdrawal symptoms experienced after fentanyl use. They said: “It’s more of a high; You shouldn’t do it [noting the lethality of this drug combination], but it’s a good high; When you come off of [a fentanyl high], [Xanax®] makes it easier; If you’re using cocaine [with fentanyl], you’ve been stabilized… and still taking care of your business during the day. At the end of the day, when you’re trying to knock all the way out (pass out), that’s when the Xanax® comes into play … to put you all the way out.” Lastly, there was limited discussion of fentanyl use with marijuana. Participants remarked that marijuana use accompanies all drug use. A participant said, “In some cases, people add [fentanyl] to weed [and smoke].”

### Prescription Opioids

Participants throughout OSAM regions reported that the current availability of prescription opioids for illicit use is at least moderate. Participants in the Columbus region reported high current availability, explaining that for users who actively seek prescription opioids and have established connections for obtaining them, the drugs remain highly available. One participant commented, “Once you find somebody that actually has what you want, it’s easy to get from that point.” Participants throughout OSAM regions confirmed that they are no longer being prescribed opioids and that when given the choice, many would choose heroin due to the ease of obtaining it and its significantly lower price. One participant stated, “I am going to pick the heroin because I’m going to need to spend three times as much on the prescription pills.” Another participant remarked, “I can get heroin quicker than anything compared to a pill.”

For the majority of OSAM regions, the street availability of prescription opioids has decreased during the past six months. Respondents most often attributed decreased availability to stricter prescribing guidelines and the expanded use of the Ohio Automated Rx Reporting System (OARRS, the state’s drug prescription monitoring network). Participants discussed: “The regulations, the laws are changing; They’re tightening up in pain management; Doctors are cracking down on the ‘scripts’ (prescriptions), you can’t go doctor shopping no more; Regular doctors can only give seven days’ worth.” One participant shared, “I couldn’t get [an opioid prescription] filled in one pharmacy. I was advised to just leave it alone ‘cuz I was on Suboxone®, so that little system
they're buying a Percocet® but it's pressed fentanyl and they don't know it ….

Current street jargon includes many names for prescription opioids. Participants discussed that street names are often shortened forms of the drug’s brand name or reference the pill’s color or milligram strength. For instance, Percocet® is generally shortened to “perk;” Percocet® 2.5 mg, which is pink in color, is referred to as “pinkie;” Percocet® 5 mg, which is blue in color, is referred to as “blueberries” or by its milligram strength, “5s;” Percocet® 10 mg, which is yellow in color, is referred to as “school buses” or “10s.”

In addition to the reporting on the current status of illicit use of prescription opioids, participants and community professionals in the Cincinnati, Columbus and Youngstown regions also discussed the increasing prevalence of pressed pills made to look like prescription opioids; reportedly, these clandestine pills actually contain illicit substances, most often fentanyl. Participants stated: “Sometimes they look perfect (just like prescription opioids); A lot of them mostly are fentanyl but … quality control isn’t there. So, one ‘perk’ (Percocet® lookalike) you may take and be faded (high) all day, but then the next day they take one and, ‘Oh, what was wrong with that one? I didn’t feel anything.’” A participant remarked, “It’s just a crazy time for pills.” Treatment providers discussed: “[Drug dealers are] making fake prescription pills … those are very accessible; Most of the fake pills are pressed fentanyl so they may think
has robbed a pharmacy; My friend knocked his teeth out to go get ‘perks’ (Percocet®); If all else fails, just crash your car into a telephone pole and go to the emergency room.”

Treatments providers in the Akron-Canton, Cleveland and Dayton regions noted dentists as a common source for prescription opioids. They discussed: “There’s the dentists, they are more likely to prescribe [opioids]; If you go to the dentist, they’ll offer Norco® before they even offer Motrin®; I have a patient and every time he goes to the dentist, he is getting opioids.”

The most common routes of administration for illicit use of prescription opioids remain snorting, followed by intravenous injection (aka “shooting”) and oral consumption. Participants throughout OSAM regions estimated that out of 10 illicit prescription opioid users, 8-10 would snort and the remainder would shoot or orally consume the drugs. Participants commented: “To get high quick, you snort; A lot of people do not try to shoot them … with the bonding agent [they are unable to break down the pill easily]; Snort … depending on which one it is … you can’t snort everything; If it doesn’t have Tylenol® (acetaminophen in it), snort it. If it does, eat it.”

A profile of a typical illicit prescription opioid user did not emerge from the data. One treatment provider stated, “Everyone’s at risk.” However, respondents continued to note that one would need money to afford buying prescription opioids. Comments included: “You gotta have money; People who make a bit more money are purchasing them, middle to upper class; People who have health insurance…. “In addition, participants and treatment providers in a couple of regions indicated illicit use as typical among older people (40s and older). One treatment provider observed, “Referrals wise, with that, I see an older age group coming in, anywhere from 40 to 60 [years of age]. A lot of it … referrals coming from surgeries, chronic pain, they were prescribed [and developed a dependence on opioids].” A participant added, “They are more available to older people.”

Many other substances are used in combination with prescription opioids. Participants reported that these drugs are most often used in combination with alcohol, marijuana and sedative-hypnotics (Xanax®). Reportedly, alcohol, marijuana and Xanax® are used with prescription opioids to intensify the effect of the opioids. Participants commented: “Marijuana intensifies the high, makes it last longer; [Alcohol] to embrace the high; Just like it says on the bottle, alcohol may intensify the effects; To get the nod off effect … they would use a Klonopin® [with prescription opioids].” Participants explained that stimulant drugs (cocaine and methamphetamine) are used with opioids to achieve a “speedball” effect (concurrent or consecutive stimulant and sedative highs). They shared: “You wanna party … speedball; Take [prescription opioids], then smoke crack; Adderall® for sure, It helps balance [the opioid high].”

Suboxone®

Suboxone® remains highly available for illicit use throughout OSAM regions. Participants and community professionals continued to discuss the ease in which a user can obtain a prescription for Suboxone® and divert all or part of the prescription to other users. They indicated Suboxone® clinics as a source for much of the diverted Suboxone®. Participants discussed: “You can go to any clinic now and say you are a heroin addict and get them the same day; Go there with $100, leave with 60 of them.” Treatment providers observed: “It’s as easy to get as heroin; There are so many clinics where people can just walk in and get a script; People get on Suboxone® and they use it for currency … they trade it for heroin.”

<table>
<thead>
<tr>
<th>Region</th>
<th>Current Availability</th>
<th>Availability Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron-Canton</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Athens</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>High</td>
<td>No consensus</td>
</tr>
<tr>
<td>Cleveland</td>
<td>Moderate to High</td>
<td>Increase</td>
</tr>
<tr>
<td>Columbus</td>
<td>High</td>
<td>No consensus</td>
</tr>
<tr>
<td>Dayton</td>
<td>High</td>
<td>No consensus</td>
</tr>
<tr>
<td>Toledo</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Youngstown</td>
<td>High</td>
<td>No change</td>
</tr>
</tbody>
</table>
Participants discussed that Suboxone® in sublingual filmstrip form (aka “strips”) is more desirable than Suboxone® in pill form. Participants shared: “Strips are more highly-valued than pills; It’s because [the filmstrips] dissolve quicker when you take them … and they come individually wrapped in paper … so, you know they’re not fake; Strips last longer and are easier to shoot (intravenously inject) [than pills].”

While participants expressed a preference for the filmstrips, many indicated that the pill form is becoming more common due to an increase in insurance plans now covering them. A participant stated, “The insurance company changed [and are now paying for pills], so the pills are coming back.” Many participants reported that the filmstrips are becoming more difficult to find. Participants commented: “My insurance would not cover strips; It’s hard to get strips nowadays.” Treatment providers also believed users are prescribed Suboxone® in pill form more often than previously, they too reported more insurance companies covering the pills. However, they noted that users can purchase Suboxone® at self-pay clinics where filmstrips remain an option. In addition, respondents in Akron-Canton, Cincinnati and Youngstown discussed availability of Suboxone® in jails and prisons, particularly the filmstrip form. Comments included: “They are really popular in jail; They are in the jails because they are easily transported; It’s profitable for the [person] taking (smuggling) it in, and it’s profitable to that person in prison who’s selling it to the other people.”

Current street jargon includes several names for Suboxone®. Throughout OSAM regions, participants continued to note “subs” as the most common street name for the drug generally. Participants explained that users typically use a derivative of the brand name or reference the form of the drug. For instance, Subutex® is referred to as “text” and filmstrips are referenced as “strips.” Additional street names reference the color or shape of the pill such as “oranges” and “stop signs.” Participants also reported that certain Suboxone® pills and Subutex® are called “moons” or “half-moons” due to the crescent insignia imprinted on them.

Reports of current street prices for Suboxone® were reported by participants with experience buying the drug. Overall, Suboxone® filmstrips and pills typically sell at similar prices: $15-25 per 8 mg dose. During the previous reporting period, the consensus among most participants was that pills often sold at higher prices than filmstrips. For the current reporting period, participants in several regions indicated that filmstrips often command higher prices than pills. Akron-Canton participants reported that the filmstrips are more expensive because they last longer, are easier to shoot and are harder to find due to supply and demand. A couple participants in this region also indicated that if a user bought a person’s whole prescription, they would be pay $10 per 8 mg dose. Participants in the Athens and Youngstown regions continued to report higher pricing for Suboxone® in pill form. Furthermore, participants in a couple of regions reported higher than street pricing for Suboxone® in correctional institutions. An Akron-Canton participant commented, “[Suboxone® is] huge in prison, one-eighth of a strip goes for $20. Most people don’t know, but if you use a small amount, you get high.” Throughout OSAM regions, participants reported that the overall street price of Suboxone® has remained the same during the past six months.

In addition to obtaining Suboxone® through doctors, clinics and individuals selling their prescriptions, participants reported getting the drug on the street from heroin dealers. A participant shared, “A lot of people will trade their [prescribed Suboxone®] for heroin. Then your heroin dealer has the Suboxone®.”

The most common route of administration for illicit use of Suboxone® remains oral consumption, followed by snorting. One participant stated, “Most people put it under their tongue and use it as a crutch to not get sick (experience withdrawal) from the heroin.” Regarding the snorting of Suboxone®, participants commented: “Snort it if in pill form; You can melt [the filmstrip] in a spoon (dissolve with water) and snort it; People in prison snort them.” A few participants also reported intravenously injecting (aka “shooting”) Suboxone®. They said: “There is a way to shoot the strips … you can dilute them in water to shoot them; It made me feel like I was gonna die when I shot it though.”
Participants and community professionals continued to describe typical illicit Suboxone® users as opiate users, or as one treatment provider stated, “chronic relapsers.” Reportedly, those who illicitly use Suboxone® do so to alleviate withdrawal symptoms. A participant explained, “I knew I could take a Suboxone® and get up and function ‘til I could go get some dope (heroin).”

Reportedly, other drugs are used in combination with Suboxone®. Participants continued to report that Suboxone® is often used in combination with cocaine and methamphetamine as the medication does not block the effects of stimulant drugs, allowing the user to continue to get high. Other drugs often combined with Suboxone® include: alcohol, marijuana and sedative-hypnotics (Xanax®). Participants commented: “I know a lot of people that drink [alcohol] with Suboxone® … and smoke crack because you can’t use opioids on it … I’ve done that; I know people who smoke ‘pot’ (marijuana) on top of it because it helps them relax; A lot of people do ‘benzos’ (benzodiazepines) with it, even though they say it is dangerous; You can mix it with whatever you want really, other than heroin and fentanyl.”

Sedative-Hypnotics

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) are moderately to highly available for illicit use throughout OSAM regions. Respondents shared that these drugs are typically used illicitly as a backup to one’s drug of choice when that drug is unavailable. Reportedly, sedative-hypnotics help alleviate opiate withdrawal symptoms and aid in the coming down from intense stimulant highs. Respondents also discussed that these medications are more readily prescribed than opioids. Comments included: “If people can’t find the other drugs, they’ll use [benzodiazepines] as a backup, they’re very easy to find; Increased [availability] because we have talked about the dangers of opioids, and doctors are saying maybe we can find something different….”

In addition to reporting on current street availability of sedative-hypnotics, respondents in a few regions discussed the presence of fake Xanax® pills, as was the case in the previous reporting period. Respondents in the Akron-Canton, Cleveland, Columbus and Youngstown regions discussed counterfeit Xanax® in circulation in those regions. A participant in the Youngstown region commented, “They use a pill press and it says Xanax®, and it looks like a ‘xanie bar’ (Xanax® 2 mg) … like one you get from the manufacturer, but it’s pressed with fentanyl or something else.” In the Cleveland region, Cuyahoga County Regional...
Surveillance of Drug Abuse Trends in the State of Ohio

Crime Lab reported having processed 10 cases of “designer benzos” (synthetic drugs that produce similar effects as benzodiazepines) during the past six months.

The availability of sedative-hypnotics for illicit use has remained the same for the majority of OSAM regions. In the Cincinnati region where there was no consensus as to a change in availability, participants and treatment providers reported decreased availability due to physicians prescribing sedative-hypnotics less and those with prescriptions keeping their medication and not sharing and/or selling/trading them; law enforcement reported increased availability based on their view that physicians are shifting from opioid to sedative-hypnotics prescribing. Respondents in the Columbus region reported that doctors are prescribing these drugs less often than previously.

Current street jargon includes many names for sedative-hypnotics. General street names include a shortened version of the group classification of benzodiazepines (“benzos”) and refer to the sedative effect of the drugs (“downers”). Klonopin® is often referred to as “forgot-a-pins.” A participant explained, “Using Klonopin®, I will forget days. I won’t remember anything…. “Street names for Xanax® often refer to the color of the pill (“blues,” “peaches”) and its shape (“footballs,” “ladders”).

Current street prices for sedative-hypnotics were consistent by region among participants with experience purchasing the drugs. Reportedly, Xanax® 1 mg most often sells for $2-3; Xanax® 2 mg most often sells for $5 but can sell as high as $10 in the Cleveland and Toledo regions. Participants reported that the overall price of sedative-hypnotics has remained the same during the past six months, with the exception of the Akron-Canton region where participants indicated increased pricing. Participants reported obtaining these drugs from drug dealers, doctors, people with prescriptions and through Internet purchase.

The most common route of administration for illicit use of sedative-hypnotics remains oral consumption, followed by snorting. Participants throughout OSAM regions estimated that out of 10 illicit sedative-hypnotic users, five would orally consume and five would snort the drugs. Participants and community professionals most often described typical illicit sedative-hypnotics users as females, abusers of other substances (alcohol, opioids), persons with a mental health disorder, younger people and drug dealers.

Many other substances are used in combination with sedative-hypnotics. Participants reported that sedative-hypnotics are most often used in combination with alcohol, followed by heroin. Additional substances mentioned included: crack cocaine, fentanyl, marijuana, methamphetamine, powdered cocaine and prescription opioids. Sedative-hypnotics are reportedly used to intensify the effect of alcohol and heroin. Participants shared: “It makes the alcohol effect better; I would use benzos [when consuming alcohol], so I wouldn’t have a hangover; A lot of people drop them in their shot glasses, wait for them to dissolve, and take the shot [of alcohol]; It’s just like, black out…. The last thing I remember was going to a bar. I don’t know what I did; Xanax® makes you feel the dope (heroin) more.”

Reportedly, sedative-hypnotics are used to aid sleep after the stimulant high of cocaine and methamphetamine. Participants commented: “I would use them when the crack was gone so I could sleep; If it’s in the evening, I’ll smoke the ‘meth’ (methamphetamine) and it’s kind of an insanity thing, a speedball thing almost … you need a couple pills, a little alcohol on top of that, then I can sleep.” A few participants mentioned combining LSD (lysergic acid diethylamide, aka “acid”) with benzodiazepines. One participant stated, “I’d use Xanax® coming down from acid.”

<table>
<thead>
<tr>
<th>Current Street Names of Sedative-Hypnotics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
</tr>
<tr>
<td>beans, beany, bennies benzos, downs, downers, forget-me-nots, Pez®, Skittles®, slow</td>
</tr>
<tr>
<td><strong>Klonopin®</strong></td>
</tr>
<tr>
<td>forgot-a-pins, green monsters, k-pens, k-pins, kingpins, klonies, klon, pins</td>
</tr>
<tr>
<td><strong>Valium®</strong></td>
</tr>
<tr>
<td>blues, Vs</td>
</tr>
<tr>
<td><strong>Xanax®</strong></td>
</tr>
<tr>
<td>bars, blues, footballs, green monsters, hulks, incredible hulk, ladders, logs, peaches, Tonka® toys, xanie bars, xanies, xans, yellows</td>
</tr>
</tbody>
</table>

Substances Most Often Combined with Sedative-Hypnotics

- alcohol
- crack cocaine
- fentanyl
- heroin
- marijuana
- methamphetamine
- powdered cocaine
- prescription opioids
Marijuana

Marijuana remains highly available throughout OSAM regions. Participants and community professionals continued to reason that legislative changes allowing for medicinal marijuana use in Ohio and recreational marijuana use in other states has contributed to societal acceptance and decreased stigma for marijuana use generally. A treatment provider shared, “That’s the treatment challenge we have, because we know if you don’t stay completely abstinent, you’re going to have a problem with [marijuana] or go back to your drug of choice.”

Respondents in the majority of the OSAM regions reported that the overall availability of marijuana has increased during the past six months. Seven of the eight regions continued to report an increase in high-grade marijuana extracts and concentrates (aka “wax” and “dabs”). OSHP Crime Lab reported that the incidence of concentrated THC (tetrahydrocannabinol oils, dabs) has increased during the past six months. In addition, ODPS reported seizing more than 7,800 pounds of marijuana from throughout OSAM regions during the past six months.

Participants throughout OSAM regions most often rated the current overall quality of marijuana as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Reportedly, the overall quality of marijuana has remained the same during the past six months, with the exception of the Akron-Canton and Cincinnati regions where participants indicated increased availability of high-quality marijuana coming from legal dispensaries in other states. These participants also noted a heightened demand for marijuana extracts and concentrates, and the growing popularity and sale of vape pens and other instruments used to consume dabs, as evidence of an overall increase in the availability of marijuana with higher THC content.

Current street jargon includes many names for marijuana. However, participants reported that street names for low-grade marijuana have become less common due to the widespread availability of high-grade marijuana. Current street names for high-grade marijuana include references to combustibles (“fire,” “gas”). One participant commented, “Even if it’s just their backyard (homegrown) stuff, [every drug dealer] is like, ‘This is that ‘fire’ (high-quality marijuana).’” Current street names for marijuana extracts and concentrates often allude to the appearance of the substances (“oil,” “shatter,” “wax”). One participant added, “You’re not cooking it, you put [oil] on paper [and] it shatters.” Reportedly, the oil is heated, and when it cools, it hardens into a glassy sheet; and when dropped, it shatters into pieces.

<table>
<thead>
<tr>
<th>Region</th>
<th>Current Availability</th>
<th>Availability Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron-Canton</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Athens</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Cleveland</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Columbus</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Dayton</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Toledo</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Youngstown</td>
<td>High</td>
<td>Increase</td>
</tr>
</tbody>
</table>

Participants throughout OSAM regions most often purchased low-grade marijuana in quantities ranging from a “blunt” (marijuana-filled cigar, usually a gram amount) to 1/4 ounce. For low-grade marijuana, a blunt remains $5; 1/8 ounce most often sells for $20; and 1/4 ounce most often sells for $50. For high-grade marijuana, a blunt remains $10-20; 1/8 ounce most often sells for $40-50; and 1/4 ounce most often sells for $100. Participants reported that marijuana extracts and concentrates are most often purchased in one-gram quantities for $50-100.

Participants throughout OSAM regions continued to report smoking as the most common route of
administration for marijuana and marijuana extracts and concentrates, followed by oral consumption. Participants and community professionals also continued to report the vaping of THC liquid and oils as common. All OSAM regions reported “edibles” (food products made with marijuana) as available.

Consistent with previous reports, respondents reported that marijuana users are of any age, race, gender, occupation and socio-economic status. One law enforcement officer commented, “Everybody … there is no social, economic difference there … it is across the board.” Additionally, participants and community professionals reported that marijuana extracts and concentrates are typically used by young people. A treatment provider shared, “I think the younger crowd. Thirteen [years of age] and up … mid-teens to late 20s. I was also thinking vaping has become a big thing, too. I think young people are using [dabs] more because of that.”

Marijuana is used in combination with many other substances. Participants explained that marijuana is typically used to intensify the high of other drugs or to come down from the effects of other drugs. Participants shared: “A lot of people smoke weed…. People use it to get off drugs, people use it to enhance other drugs; Heroin is used with dabs because it intensifies the down effect. They’re both downers and depressants and they just go good together.” However, many participants reported that they prefer using marijuana extracts and concentrates alone. One participant commented, “Usually, you do not want to do anything after smoking dabs except for eating or sleeping. You are usually too high to move. It is like total body relaxation … you don’t need to mess (combine any other drug) with [dabs].”

Methamphetamine remains highly available throughout OSAM regions. Participants and community professionals cited methamphetamine’s low price and a trend of opioid users receiving medication-assisted treatment (MAT) turning to methamphetamine for a high as reasons for the high availability. Law enforcement continued to note drug cartels directing large amounts of crystal methamphetamine along with heroin shipments to Ohio. There was consensus among most respondents that while methamphetamine is available in both powdered and crystal forms, crystal methamphetamine remains the more prevalent form of the drug.

Participants and community professionals in the majority of OSAM regions reported that the availability of methamphetamine has increased during the past six months. There was no consensus among respondents in the Athens and Youngstown regions on whether methamphetamine availability has increased or remained the same (highly available). Law enforcement in the Athens region perceived an increase in availability driven by opioid users on MAT turning to methamphetamine, while participants in the Youngstown region observed an increase in opioid users switching to methamphetamine out of fear of fentanyl overdose.

Corroborating data indicated that methamphetamine is highly available and has increased for most OSAM regions. ODPS reported seizing over 900 pounds of methamphetamine from throughout OSAM regions during the past six months. BCI and OSHP crime labs reported that the incidence of methamphetamine cases they process from throughout Ohio has increased during the past six months.

### Methamphetamine

<table>
<thead>
<tr>
<th>Substance Most Often Combined with Marijuana</th>
<th>Alcohol</th>
<th>Crack Cocaine</th>
<th>Ecstasy/Molly (MDMA)</th>
<th>Fentanyl</th>
<th>Heroin</th>
<th>Methamphetamine</th>
<th>Powdered Cocaine</th>
<th>Prescription Opioids</th>
<th>Sedative-Hypnotics</th>
</tr>
</thead>
</table>

### Reported Availability Change of Methamphetamine during the Past 6 Months

<table>
<thead>
<tr>
<th>Region</th>
<th>Current Availability</th>
<th>Availability Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron-Canton</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Athens</td>
<td>High</td>
<td>No consensus</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Cleveland</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Columbus</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Dayton</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Toledo</td>
<td>High</td>
<td>Increase</td>
</tr>
<tr>
<td>Youngstown</td>
<td>High</td>
<td>No consensus</td>
</tr>
</tbody>
</table>
Participants most often reported the current overall quality of methamphetamine as ‘7-10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants discussed adulterants (aka “cuts”) that affect the quality of methamphetamine and most often reported the following cutting agents for the drug: bath salts (synthetic cathinones), carfentanil, fentanyl, “molly” (powdered MDMA), prescription stimulants (Adderall®), salt and sugar. Other cuts mentioned included: albuterol, baking soda, brake fluid, bug spray (hornet killer), drain cleaner (Drano®), Epsom salts, mannitol (diuretic), morphine, MSM (methylsulfonylmethane, a joint supplement), rat poison, Suboxone® and vitamin B-12. Participants discussed that methamphetamine is cut to expand the quantity of the drug or to entice new business (with fentanyl), both increase dealer profit. Crime labs reported that methamphetamine is cut with dimethyl sulfone (DMSO, dietary supplement) and magnesium sulfate (Epsom salts).

Current street jargon includes many names for methamphetamine. General street names most often reference the stimulant effect of the drug (“gas,” “go,” “speed”), while street names for crystal methamphetamine specifically reference the appearance of the substance (“crystal,” “glass,” “ice,” “shards”). Participants discussed the usefulness of using street jargon. They shared: “Some people are paranoid [that] the feds are watching. When you’re talking to someone on the phone, you’re not going to say you want to go get some ‘ice’ (a well-known street name) either … some people go get ‘ice cream;’ ‘You got some water … ice water?”

Current prices for methamphetamine were provided by participants with experience purchasing the drug. Generally, the most common quantity of methamphetamine purchase is a gram for $40-80; 1/2 gram most often sells for $40; and an ounce most often sells for $500. Overall, the majority of participants reported that the price of methamphetamine has remained the same during the past six months.

Participants throughout OSAM regions continued to indicate that the most common routes of administration for methamphetamine remain intravenous injection (aka “shooting”), followed by smoking. Participants discussed that users most often shoot the drug primarily because they believe shooting produces a more intense high than smoking, while users who prefer smoking believe it is an easier and more socially acceptable route. Participants also noted snorting and “hot railing” (a process where the user places the drug in a glass pipe, heats the pipe and inhales the resulting vapors) as alternative methods for methamphetamine use.

Consistent with previous reports, respondents described typical methamphetamine users most often as white people, aged 20-30 years, of low socio-economic status. Participants and community professionals also continued to note methamphetamine use among those in the gay community as well as among opiate users. In addition, respondents in the Akron-Canton, Cincinnati, Columbus and Youngstown regions indicated an increase in methamphetamine use among African-American and other non-white people during the past six months.

Many other substances are used in combination with methamphetamine. Participants reported that heroin, prescription opioids and sedative-hypnotics (Xanax®) are used with methamphetamine to achieve a speedball effect, and like alcohol and marijuana, the aforementioned drugs are also used to bring the user down from the stimulant high of methamphetamine. Participants explained: “I’d go on a meth spree for a couple of days, and then when I was coming down off the meth, I’d take Percocet® or Xanax®, Xanax® and meth, I like that kind of speedball because that releases my inhibitions…. .” Reportedly, powdered cocaine is used in combination with methamphetamine to further intensify one’s stimulant high.
**Prescription Stimulants**

Throughout OSAM regions, prescription stimulants remain moderately to highly available for illicit use. Participants and community professionals agreed that these drugs are easily prescribed compared to other prescription drugs. Participants remarked: “I could get them so fast; I get prescribed, my kids also get it; A lot of parents have their kids on that stuff, and they sell their kids’ medicine; If you have kids, it’s real easy to obtain prescription stimulants; I’d rather do a [prescribed] stimulant than coke or meth, it’s a lot cleaner.”

Community professionals noted that they most often see people abusing their own prescription or illicitly using a child’s prescription. However, they also discussed individuals with prescriptions selling or trading their prescribed stimulants for profit or to buy other drugs. One law enforcement officer observed, “College students are being prescribed [Adderall®], and they have no issues sharing or selling off some pills to their friends.”

Respondents in a couple of regions noted methamphetamine users seeking prescribed stimulants. A treatment provider commented, “People use them … especially if they are using meth and they can’t get it, they will eat Adderall®.”

The majority of respondents reported that the availability of prescription stimulants for illicit use has remained the same during the past six months. However, respondents in the Columbus region reported decreased availability, while respondents in the Athens and Cleveland regions were not in agreement on whether availability has remained the same or decreased during the past six months. Those who reported decreased availability perceived doctors cutting back on prescribing stimulants. Participant comments included: “The doctors have pulled back on prescribing; They’re getting harder to get.” A treatment provider confirmed, “[Doctors are] not prescribing them as freely anymore.”

Current street jargon includes a few names for prescription stimulants. Street names commonly reference the stimulant effect of the drugs (“speed”) or are an abbreviation of the drug’s brand name (“addies” for Adderall®).

<table>
<thead>
<tr>
<th>Current Street Names of Prescription Stimulants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Names</strong></td>
</tr>
<tr>
<td>Adderall®</td>
</tr>
<tr>
<td>Ritalin®</td>
</tr>
<tr>
<td>Vyvanse®</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Current street prices for prescription stimulants were limited and provided by participants with experience purchasing the drugs. Participants in the Columbus, Toledo and Youngstown regions reported that these drugs most often sell for $0.50 per milligram. Throughout OSAM regions, participants reported that Adderall® 20 mg sells for $6-7. In addition, participants in the Dayton and Youngstown regions reported that Vyvanse® 30 mg most often sells for $5-10 and $10-20, respectively. Participants accounted for variations in price by explaining that if the user knows the person selling the drug, the price may be lower. Overall, participants reported that the price of prescription stimulants has remained the same during the past six months, with the exception of the Columbus region where participants indicated increased pricing.

The most common route of administration for illicit use of prescription stimulants is oral consumption, followed by snorting. Participants explained that users snort for a quicker effect. Additionally, participants in the
Youngstown region also reported “parachuting,” which is a form of oral consumption where the user wraps the pill in toilet paper/tissue, crushes the pill and swallows the tissue. A participant further explained the term “parachuting,” saying, “It looks like a little parachute, parachuting into your mouth.” Reportedly, if the drug is in bead form inside a capsule, some users open the capsule and orally consume the beads. One participant remarked, “You break it open and chew.”

Respondents described typical illicit prescription stimulant users as young adults, high school and college students. Respondents noted that these drugs are typically used to stay alert, focused and awake. One participant shared, “College students [use prescription stimulants] to study. You can sell a ‘script’ (prescription) for twice the price during exam week.” A treatment provider added, “There’s a lot of young people working a lot of hours out there.” Participants reported that other drugs are often used in combination with prescription stimulants. Participants explained that alcohol, heroin, marijuana and sedative-hypnotics (Xanax®) are used to reduce the stimulant high. A participant discussed, “You take the Adderall®, and when you start coming down from it, you take the Xanax®.” Participants also noted that prescription stimulants are often combined with alcohol to enable users to stay awake, drink more alcohol and party for longer periods of time. They said: “When I would take Adderall®, I could drink forever; You keep the party going, you don’t really get drunk.” However, some participants noted not combining prescription stimulants with any other drug. One participant explained, “They are not for getting high, per se. It’s to take for focus.”

BCI crime labs reported processing very few cases of MDMA (ecstasy/molly) for the Athens, Cincinnati and Youngstown regions during the past six months, while reporting slight increases in cases processed for the Akron-Canton, Cleveland, Columbus and Dayton regions, and a decrease in cases for the Toledo region. Miami Valley Regional Crime Lab in the Dayton region reported an increase in the number of ecstasy/molly cases it processes during the past six months.

Participants throughout OSAM regions, except for Athens and Cincinnati, reported on the current quality of ecstasy/molly. Generally, participants rated overall quality as ‘5-10’ for ecstasy and ‘4-10’ for molly on a scale from ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants discussed variations in molly. A participant stated, “It’s either cut with meth or ‘fetty’ (fentanyl) … you either get the ‘upper molly’ (molly cut with methamphetamine) or the ‘downer molly’ (molly cut with

<table>
<thead>
<tr>
<th>Region</th>
<th>Current Availability</th>
<th>Availability Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron-Canton</td>
<td>No consensus</td>
<td>No consensus</td>
</tr>
<tr>
<td>Athens</td>
<td>Moderate</td>
<td>No change</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>Low to Moderate</td>
<td>No change</td>
</tr>
<tr>
<td>Cleveland</td>
<td>Moderate</td>
<td>No consensus</td>
</tr>
<tr>
<td>Columbus</td>
<td>No consensus</td>
<td>No consensus</td>
</tr>
<tr>
<td>Dayton</td>
<td>Moderate to High</td>
<td>No change</td>
</tr>
<tr>
<td>Toledo</td>
<td>High</td>
<td>No change</td>
</tr>
<tr>
<td>Youngstown</td>
<td>Low to Moderate</td>
<td>No change</td>
</tr>
</tbody>
</table>

**Ecstasy**

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) availability is variable throughout OSAM regions. Reportedly, the powdered form of ecstasy, known as “molly,” is more available than the tablet form. Respondents throughout regions reported that ecstasy/molly are not widely used or sought like other drugs such as marijuana, although many participants in a few regions noted that the drugs are plentiful during music festivals and other arts events. Only participants in the Toledo region reported current high availability of both ecstasy and molly; however, these participants clarified that users have to have the right connections to obtain these drugs. One participant shared, “Molly … I would do that every day, spend $80 a day on it.” Generally, respondents reported that the availability of ecstasy/molly has remained the same during the past six months.
Participants expressed concern about how molly is being made, sharing: “The stuff that people sell ends up not being molly, so people are afraid to take it; Molly isn’t even molly anymore. Molly is every drug….” Participants reported that ecstasy/molly are often adulterated (aka “cut”) with fentanyl, heroin and methamphetamine. Other cuts mentioned included Adderall® and Kool-Aid®. Overall, participants reported that the quality of ecstasy/molly has remained the same during the past six months.

Current street jargon includes several names for ecstasy and few names for molly. Participants reported that powdered MDMA is almost always called, “molly.” Common names for ecstasy include abbreviated forms of the word “ecstasy” (“E,” “X”). Other names for ecstasy refer to the stamp (imprinted image) on the tablets (“Bart Simpsons,” “Obamas”).

Current prices for ecstasy/molly were provided by participants with experience purchasing the drugs. Participants reported that ecstasy is most often purchased as doses called “stacks,” including single, double and triple stacks. A low dose (aka “single stack”) of ecstasy continues to most often sell for $5-10; a medium dose (aka “double stack”) most often sells for $20; and a high dose (aka “triple stack”) most often sells for $20-30. For molly, generally, the most common quantity of purchase is a gram for $60-100. Reported prices were consistent throughout OSAM regions, except for the Toledo region, which reported significantly lower prices for a gram of molly ($20-60). Overall, participants reported that the price of ecstasy/molly has remained the same during the past six months.

The most common route of administration for ecstasy/molly remains oral consumption, followed by snorting. Participants reported that ecstasy/molly are most often obtained through drug dealers, at dance parties (aka “raves”), nightclubs and music festivals. Participants and community professionals continued to describe typical ecstasy/molly users as young people, high school and college students, those who like to party and “hippies.” Participants shared: “It’s a party drug or sex drug; I used to love the way it made me feel.”

Several other substances are used in combination with ecstasy/molly. Reportedly, marijuana and alcohol help accelerate/intensify the effects of ecstasy/molly. A participant stated, “They say you’re supposed to smoke weed to get it to kick in; Usually, people put [molly] in drinks (alcohol); Alcohol … intensifies [molly]. Like beer and pizza, they just go together.” Participants discussed that sedative-hypnotics (Xanax®) help reduce anxiety brought on by ecstasy/molly. Other substances mentioned as often used in combination with ecstasy/molly include heroin, powdered cocaine and prescription stimulants.
Surveillance of Drug Abuse Trends in the State of Ohio

Other Drugs in the OSAM Regions

Participants and community professionals listed a variety of other drugs as currently available, but these drugs were not mentioned by the majority of people interviewed. Several of these other drugs were not reported as present in every region. Note no mention/discussion of a drug does not indicate the absence of the drug in the region(s).

<table>
<thead>
<tr>
<th>Region</th>
<th>Other Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Akron-Canton</td>
<td>bath salts*, hallucinogens (lysergic acid diethylamide [LSD], psilocybin mushrooms), kratom, Neurontin*, synthetic marijuana</td>
</tr>
<tr>
<td>Athens</td>
<td>Neurontin*</td>
</tr>
<tr>
<td>Cincinnati</td>
<td>hallucinogens (LSD), kratom, Neurontin*, synthetic marijuana</td>
</tr>
<tr>
<td>Cleveland</td>
<td>hallucinogens (LSD, psilocybin mushrooms), Neurontin*, synthetic marijuana</td>
</tr>
<tr>
<td>Columbus</td>
<td>hallucinogens (psilocybin mushrooms)</td>
</tr>
<tr>
<td>Dayton</td>
<td>hallucinogens (LSD, psilocybin mushrooms), synthetic marijuana</td>
</tr>
<tr>
<td>Toledo</td>
<td>hallucinogens (psilocybin mushrooms), kratom, Neurontin*, synthetic marijuana</td>
</tr>
<tr>
<td>Youngstown</td>
<td>hallucinogens (LSD), inhalants*, kratom, Neurontin*, OTCs* (over-the-counter medications), synthetic marijuana</td>
</tr>
</tbody>
</table>

*For limited information on bath salts, inhalants and OTCs, please see regional report.

Hallucinogens

Respondents in seven of eight OSAM regions reported on the current availability of hallucinogens. Generally, participants and community professionals reported moderate availability of lysergic acid diethylamide (LSD) and psilocybin mushrooms. Respondents discussed that the use of hallucinogens is event-based, often found at concerts and music festivals, and related to one’s drug connections. Participants shared: “It’s a festival drug; You can get it all the time…. [It] depends on the group you hang out with [though]; It’s harder to get mushrooms, you have to know somebody who grows them; [Mushrooms are] available in season, more spring and summer; It’s hit or miss … it depends on the crowd you are with.”

BCI crime labs reported an increase in the incidence of hallucinogen cases it processes for the Akron-Canton, Cleveland, Dayton and Youngstown regions. Overall, respondents reported that the availability of hallucinogens has remained the same during the past six months, while some community professionals reported increased availability for LSD. A law enforcement officer in the Cleveland region responded, “We don’t see [LSD] all the time, but it has definitely increased.” Cuyahoga County Crime Lab in the Cleveland region reported that the incidence of LSD, psilocybin mushrooms and PCP (phencyclidine) cases it processes has increased during the past six months.

Participants from the Cleveland, Dayton and Youngstown regions reported on the current quality of LSD. Generally, participants rated overall quality as ‘5-9’ for LSD on a scale from ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Akron, Cleveland and Dayton participants reported on prices of hallucinogens. LSD single dose (aka “a hit”) most often sells for $10; 1/8 ounce of psilocybin mushrooms sells for $30. Participants shared that the most common route of administration for LSD and psilocybin mushrooms remains oral consumption. Respondents generally described typical users of LSD and psilocybin mushrooms as young people (adolescents, college-aged) and middle-aged hippies.
**Kratom**

Kratom (mitragynine, a psychoactive plant substance) was discussed in four OSAM regions: Akron-Canton, Cincinnati, Toledo and Youngstown. Due to its availability in head shops and online, respondents reported that kratom is highly available. Many participants maintained that kratom is a substitute for opioids, stating: “It’s a legal substitute for Vicodin® and Percocet®; It is the cure all. It helps you stay awake, it helps with your back pain … helps with opioid withdrawal.” Participants reported that the most common route of administration for kratom remains oral consumption. In addition to making tea with it, participants shared: “If I ate a bunch enough or drank a bunch enough, I wouldn’t be ‘dope sick’ (experience opiate withdrawal); I would take eight [capsules] at a time; I took it because I was trying to withdrawal myself [from opiates].” Participants and community professionals continued to describe typical kratom users as opiate users.

**Neurontin®**

Respondents in most OSAM regions reported on the current availability of Neurontin® (gabapentin, an anticonvulsant used to treat nerve pain) for illicit use; Columbus and Dayton were the only regions not to comment on the street availability of Neurontin® during the past six months. Respondents in the Akron-Canton, Athens, Toledo and Youngstown regions described Neurontin® as highly available. Overall, respondents indicated that the availability of Neurontin® for illicit use has increased during the past six months. Participants explained: “More doctors are giving out this medicine instead of pain pills; A lot of [programs/employers] don’t test for them … so you can take them and pass a drug test.”

Participants and community professionals throughout OSAM regions agreed that a prescription for Neurontin® is easy to obtain and that the drug is illicitly used most often to manage opiate withdrawal. One participant remarked, “So, if they don’t have Suboxone® and need something for their ‘dope sickness’ (opiate withdrawal) … if they take a handful of Neurontin®, they’re going to be okay.” In addition, some participants reported that users can experience a high effect if they take enough of the drug. They shared: “It gives you the buzz that you want … you feel drunk; Neurontin® is like a miracle drug to the junkie… If you take enough, you’re gonna ‘nod out’ (experience a high), but you have to take a handful.”

Reports of current street prices for Neurontin® were reported by participants with experience purchasing the drug. Respondents noted that this drug has little street value and typically sells for $0.50-2 per pill. The most common route of administration for illicit use of Neurontin® remains oral consumption, followed by snorting. Respondents continued to describe typical illicit users as opiate users who use the drug to alleviate opiate withdrawal symptoms. Participants discussed that Neurontin® is often used in combination with alcohol and opiates to enhance a high. A participant shared, “If you mix [Neurontin®] with opiates or even fentanyl, it just makes you higher.”

**Synthetic Marijuana**

Respondents in the majority of OSAM regions reported on the availability of synthetic marijuana (synthetic cannabinoids) during the past six months. Participants most often reported high current availability of this drug, while community professionals reported moderate to high availability, with the exception of the Youngstown region where community professionals reported low availability. BCI crime labs reported that the incidence of synthetic cannabinoid cases they process for the Akron-Canton, Dayton and Toledo regions has increased during the past six months.

Current prices of synthetic marijuana were reported by participants with experience purchasing the drug. Participants shared unknown or varying amounts for purchase at $35-40. Respondents reported purchasing synthetic marijuana at gas stations and corner convenience stores. The most common route of administration of synthetic marijuana remains smoking. Respondents continued to describe typical users as people involved in the criminal justice system (on probation) and those who are subjected to drug testing.

<table>
<thead>
<tr>
<th>Current Street Names of Other Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LSD</strong></td>
</tr>
<tr>
<td><strong>Neurontin®</strong> (gabapentin)</td>
</tr>
<tr>
<td><strong>Psilocybin mushrooms</strong></td>
</tr>
<tr>
<td><strong>Synthetic marijuana</strong></td>
</tr>
</tbody>
</table>