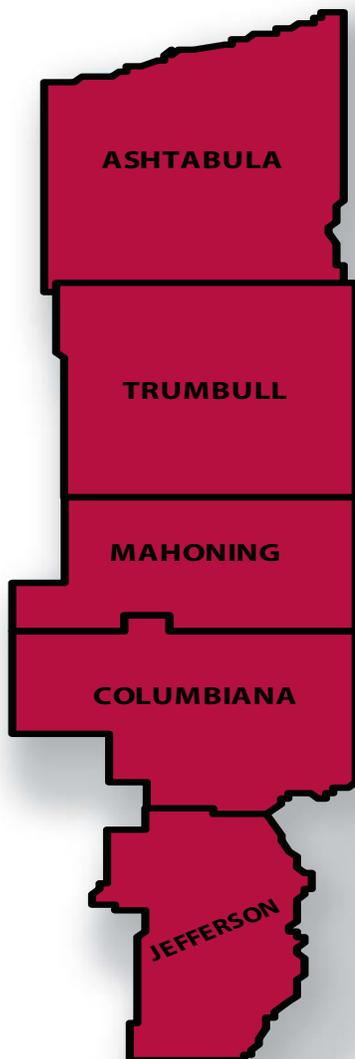


Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Youngstown Region

June 2010-January 2011

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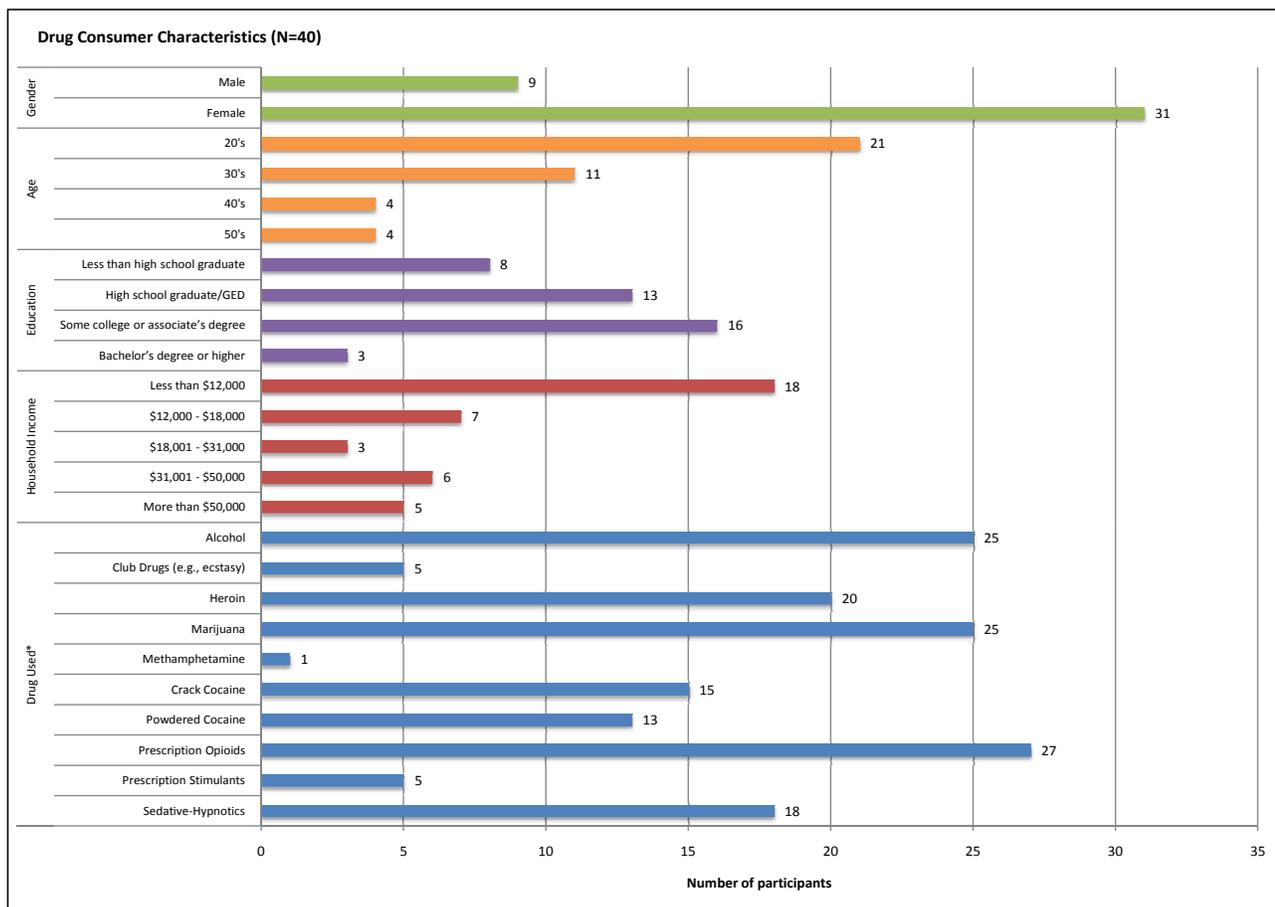
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Regional Profile

Indicator ¹	Ohio	Youngstown Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,514,603	723,072	40
Gender (Female), 2009	51.2%	51.4%	75.6%
Whites, 2009	82.2%	87.1%	87.5%
African Americans, 2009	11.9%	8.8%	7.5%
Hispanic or Latino Origin, 2009	2.8%	2.3%	5.0%
High school graduates, 2008	84.6%	88.1%	80.0%
Median household income, 2009	\$45,467	\$39,339	\$12,000 - \$18,000 ²
Persons below poverty, 2009	15.1%	17.2%	47.5% ³

Ohio and Youngstown statistics are derived from the U.S. Census Bureau¹. Respondents reported income by selecting a category that best represented their household's approximate income for 2009². Poverty status was unable to be determined for seven respondents due to missing or insufficient income data³.



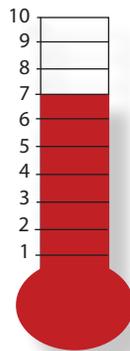
*Some respondents reported multiple drugs of use over the past six months.

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Mahoning and Trumbull Counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (i.e., treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Bureau of Criminal Identification and Investigation (BCI&I) Richfield Office, which serves the Cleveland, Akron and Youngstown areas. BCI&I data are summary data of cases processed from January to June 2010. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the last six months (i.e., from time of interview through prior six months); thus, current BCI&I data correspond to the current reporting period of participants. In addition to the aforementioned data sources, the *The Youngstown Vindicator* was queried for information regarding regional drug abuse for June 2010 through January 2011.

Powdered Cocaine Current Trends

Powdered cocaine is moderately available in the region. Participants most often reported the drug's current availability as '7' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Law enforcement identified powdered cocaine as "in the top four of most available drugs—below heroin and crack [cocaine]." According to treatment providers, the availability of powdered cocaine has remained stable over the last six months, while according to an overwhelming number of participants, the drug's availability has decreased, with the consensus being that powdered cocaine is not as available as crack cocaine. A participant stated, "The powdered [cocaine] form is harder to come by because everybody buys up the powder form and cooks it up into crack [cocaine], so you know being able to find decent powder or any powder was zero to none because it's already been processed." BCI&I Richfield crime lab reported that the number of powdered cocaine cases it processes has remained stable.



Participant quality scores of powdered cocaine varied from '2' to '10' with the most common score being '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Several participants explained that the quality of powdered cocaine is dependent on who is selling it. A participant explained, "You may get two or three big suppliers, but as they distribute it to other people, once again, like I said, they [drug dealers] stomp on it. Some people stomp on it more than others." Participants reported that powdered cocaine is most often "cut/stomped on" (i.e., diluted) with other substances. A participant reported, "At the head shop, they have stuff that you can get that is numbing, and it numbs your mouth ... The people who are purchasing it [powdered cocaine] don't really know the purity because it makes your mouth numb, and it speeds you up still. It's more or less a fake." Participants cited the following substances as commonly used to cut powdered cocaine: baby aspirin, baby laxative, baking soda, creatine and NoDoz®. BCI&I Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine (e.g., NoDoz®).

Current street jargon includes many names for powdered cocaine. The most commonly cited name was "white girl." Participants listed the following as other common street names: "duff," "girl," "powder," "pow-wow," "snow," "soft," "sugar booger" and "white." Participants reported a gram of powdered cocaine currently sells for \$40 – \$100; 1/16 ounce, or "teener," sells for \$75 – \$120; 1/8 ounce, or "eight ball," sells for \$150 – \$180; 1/4 ounce sells for \$225 – \$240; an ounce sells for around \$800. While there were a few reported ways of consuming powdered cocaine, the most common route of administration for this form of cocaine is intranasal inhalation (i.e., snorting). Some users reported "cooking" and then smoking cocaine while a few cited taking the drug intravenously. A participant who reported snorting powdered cocaine described injecting as a common method: "People put it [cocaine] on a spoon, fill it up with water, and then inject it." Treatment professionals reported that powdered cocaine is being used more intravenously today than in the past, especially among heroin users.

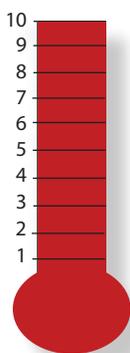
Typical users of powdered cocaine are described as different from those who generally use crack cocaine. A participant stated, "Crackheads and powdered users are completely different. In my experience, I would say crack cocaine users are people on welfare. Powdered cocaine users tended to have more money." Several participants reported that powdered cocaine use is thought to be a part of the bar scene: "A lot of people

just associate it [powdered cocaine use] with social activity like going to the bar; People who drink like to do powder [cocaine].” A treatment provider stated, “It [powdered cocaine use] varies across the board ... probably more around the 30 age group, but we see it at all different ages.” Law enforcement described a typical user as a 20 to 35-year-old, White, middle-class suburbanite. In addition to alcohol, powdered cocaine is also reportedly used in combination with benzodiazepines (i.e., Xanax®), heroin, marijuana, prescription opioids (i.e., OxyContin®) and tobacco.

Crack Cocaine Current Trends

Crack cocaine is highly available in the region. Participants most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants described crack cocaine as extremely easy to get. A user said, “It [crack cocaine] is everywhere in Mahoning, Trumbull and Ashtabula Counties ... especially in this area ... it is a half block from here [treatment center/site of interview]. It’s on every street. There is a crack house on every street if not more than one.” Law enforcement also rated the current availability of crack cocaine as high. Participants and treatment professionals agreed that the availability of crack cocaine has not changed over the course of the last six months. A treatment professional stated, “It seemed like when it [crack cocaine] came, it never left. It just stayed available everywhere in this area.” However, law enforcement noted a slight decrease, hypothesizing that harsher sentencing laws for crack cocaine versus powdered cocaine has perhaps led to a slight decrease in the availability of crack cocaine. An officer stated, “Some folks buy powder [cocaine] and produce their own crack. Also, now so many guys who were selling crack are switching to heroin in part because of current sentencing laws.”

Participant quality scores of crack cocaine varied from ‘2’ to ‘7’ with the most common scores being ‘3’ or ‘4’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants noted that the quality of crack cocaine, like that of powdered cocaine, is dependent on who is selling it. A participant explained, “It [the quality of crack cocaine] really depends upon who has it. There is anything from a ‘3’ [quality rating] around here to a ‘10’ ... depends on the batch—has always been



that way.” Participants reported that crack cocaine is most often “cut” (i.e., diluted) with other substances. A participant reported, “[Crack cocaine is] cut with anything ... rat poisoning, Easy Off®, ah, you name it—they [drug dealers] are putting anything in it.” Participants cited the following substances as commonly used to cut crack cocaine: Ambesol®, baby laxative, baking soda and 7-Up® to “blow it [crack cocaine] up” (i.e., to give crack cocaine more volume and mass). BCI&I Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine (e.g., NoDoz®).

Current street jargon includes many names for crack cocaine. The most commonly cited names were “hard” and “work.” Participants listed the following as other common street names: “butter,” “cavy” (i.e., caviar), “crack,” “fire,” “girl,” “rock” and “white girl.” Participants reported a gram of crack cocaine currently sells for \$50 – \$100; 1/16 ounce, or “teener,” sells for \$75 – \$100; 1/8 ounce, or “eight ball,” sells for \$120 – \$175; 1/4 ounce sells for \$250 – \$280; an ounce sells for \$800 – \$1,000. The majority of crack cocaine users reported buying the drug in small quantities called “dimes” (i.e., 1/10 gram) for \$10, and agreed that the price of crack cocaine has gone up over the course of the last six months. A participant stated, “I know that within the past probably year, cocaine has gone up [in price] twice what it was. Before, um, for \$10 you could get a dime and it was .2 [of a gram], now it is .1. You could get .4 for \$20, now you get .2.”

While there were a few reported ways of consuming crack cocaine, the most common route of administration by far is smoking. A participant stated, “I’ve smoked pipe; I’ve smoked woolies [crack cocaine with marijuana], um, anyway that I could smoke it [crack].” Other methods described were intranasal inhalation (i.e., snorting) and intravenous injection. A participant said she would inject or smoke crack cocaine; it just depended on whatever she felt like or whether she had access to a pipe. Less common than smoking and injecting, snorting was also indicated as a method used in the region. When asked to give a percent breakdown of common routes of administration for crack cocaine, participants of one focus group determined that approximately 85 percent of crack cocaine users smoke the drug and 15 percent inject it. Like powdered cocaine, treatment professionals noted that intravenous use of crack cocaine appears to be increasing, again especially among heroin users.

A profile of a typical user of crack cocaine did not emerge in the data. Participants and treatment professionals alike stated

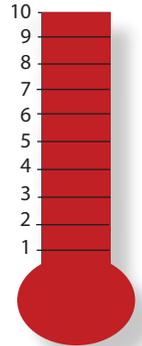
that crack cocaine is far reaching into every socioeconomic class. Participants reported the following: *"I've seen people from 15 to 70 and 80's smoke it [crack cocaine], and it doesn't matter what color [race]; I know attorneys in this area who use it, and I know lowlifes who use it; I believe everybody uses it."* Treatment professionals offered the following: *"It varies, we have all different ages come in from crack cocaine; Lately, we've had people over the age of 35 who are using crack cocaine, and they come from mostly lower middle class socioeconomic background. Some of them used to have good jobs that don't anymore ... jobs making at least \$28,000 to \$48,000 a year."* Treatment professionals noted an increase in older adults (those > 35 years), particularly women, and an increase in "alcoholics" coming to them for treatment for crack cocaine addiction. A law enforcement respondent noted, *"Crack [cocaine] is a big deal with older Caucasian and African-American women."*

In addition to alcohol, crack cocaine reportedly is used in combination with benzodiazepines (i.e., Xanax®), heroin (a.k.a., "speedball" when "shot" together; some reported shooting heroin and then following with a "hit" of/smoking crack cocaine), marijuana (a.k.a., "woolie" when smoked together, or "chocolate chip" when "rocked up" together), prescription opioids (i.e., OxyContin®) and tobacco (a.k.a., "primo" when smoked together). Using crack cocaine with all of the aforementioned is reportedly very common. Many participants explained that the use of alcohol, benzodiazepines and marijuana is necessary in order to "come down" from a crack cocaine high.

Heroin Current Trends

Heroin is highly available in the region. Participants and treatment providers most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Law enforcement rated current availability as "better than ten." Area media quoted an officer from a local narcotics unit as stating, *"Heroin seems to be the number one drug of the time"* (www.vindy.com; July 19, 2010). Participants also named heroin as currently the most available drug in the region. There was agreement in one focus group that Youngstown is experiencing a "heroin epidemic." A focus group participant stated, *"You can get it [heroin], wherever, whenever."* A treatment professional stated, *"The race is over and heroin won."* BCI&I Richfield crime lab reported an increase in the number of heroin cases it processes.

While many types of heroin were named as currently available for street purchase, the consensus among all participants was that brown powdered heroin is the most common form of heroin found. Participants reported, *"I think in Youngstown, you're most likely gonna get brown heroin. You're not gonna come across white or black tar [heroin] very often ... nine times out of 10 it's going to be brown; Brown powder [heroin] is most available and white powder is around more than tar."* Law enforcement reported, *"We primarily get a brown or grayish powder [heroin] when we buy [undercover]."* There was contradictory testimony as to the current availability of black tar heroin. Participants reported, *"I have never seen tar here; Tar is only available on the east side of Youngstown in the Hispanic district ... they're keeping it for themselves; Tar is still around—friends are using it."* A treatment professional stated that black tar heroin is making a "big comeback." All participants indicated that heroin's availability either has remained unchanged or has increased over the course of the last six months. Participants said, *"Everyone is getting away from oxy's [OxyContin®] and roxi's [Roxicet®] because heroin is so cheap; There's so many heroin addicts in Youngstown that a lot of dealers are switching over from selling whatever they were selling to just selling heroin."* Several participants noted that heroin use has especially increased among younger people. A participant stated, *"In younger kids and stuff, it's definitely increased. I've seen kids in meetings [12-step meetings] as young as 16—that's pretty bad."*



Participant quality scores of heroin varied from '2' to '10' with the most common score being '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants noted that the quality of heroin, like that of cocaine, is dependent on who is selling it. A participant explained, *"It [the quality of heroin] depends on what you cut it with. I've had from zero to ten."* Participants reported that heroin is often "cut" (i.e., diluted) with prescription drugs: *"They [drug dealers] cut it [heroin] with good, other drugs. You know they cut it with fentanyl or morphine. You know so even if the heroin wasn't at its greatest, you still had something else kicking your ass."* Participants also cited the following substances as commonly used to "cut" heroin: baby laxative, isotope powder, sleeping pills, soy baby formula and vitamin E. BCI&I Richfield crime lab reported that heroin was "very pure," and occasionally cut with diltiazem (medication used to treat heart conditions/ high blood pressure).

Current street jargon includes many names for heroin. The most commonly cited names were “boy” and “dog food.” Participants listed the following as other common street names: “bag,” “dope,” “H,” “he,” “low ride,” “puppy chow,” “ron” and “white china.” Participants reported a gram of heroin currently sells for \$75 – \$200 depending on quality, 1/2 gram sells for \$50 – \$100; 1/4 ounce sells for \$500; 1/2 ounce sells for \$900; an ounce sells for \$1,800. Many participants reported buying “baggies/stamps” for \$10 to \$20 each, with a participant reporting buying three for \$50; a few participants reported buying \$20 “folds” (i.e., corners of a piece of paper made into a little envelopes to keep heroin from sticking to the baggie in which it is packaged). Law enforcement report that most street level users buy 1/20 gram of heroin for \$20 while noting that there has been “an overall increase in price because demand is going up.” While there were a few reported ways of consuming heroin, the most common route of administration is intravenous injection (i.e., shooting), followed by snorting and smoking. Many participants explained that when they first started to use heroin, they snorted: “I started snorting it [heroin], then within two to three months, I went to shooting; When others around me started to shoot, I saw how much more intense their high was; I believe that it [heroin] is like any other drug in the progression of it. After you do it for a while, it doesn't do what you want, so you resort to injecting it.”

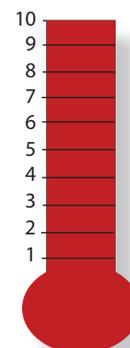
Participants described typical users of heroin as younger (i.e., “teens” and those in their early 20’s) and “mostly White.” The following statement was echoed by many participants, “I think you’re getting a lot of White teens and early 20’s from middle class families who have education starting to do it [use heroin], who are possibly starting out with Vicodin® and OxyContin®, and then moving on to heroin because it is cheaper ... I don’t know a lot of Black people or Hispanic people around here who use it.” Treatment professionals and participants alike noted an increase in younger people, with 13 being the youngest reported age among known heroin users. A law enforcement officer provided the following: “Our [drug] court is now 75 percent suburban heroin addicts, who typically started with pharmaceuticals [prescription opioids], but because of the cost of those went to heroin; it’s cheaper and it’s more available to them. So our clientele is primarily about 18 to about 28 years old, and they’re shooting up [injecting] heroin.” Another officer stated, “All of the ‘crackheads’ are becoming ‘heroinheads’ ... Also, increase in heroin use because of what they [Purdue Pharma] have done with OxyContin® [reformulation of]. Old ones [OxyContin®] are sky high [in price].”

Reportedly, heroin is used in combination with alcohol, benzodiazepines (i.e., Valium® and Xanax®), cocaine (a.k.a., “speedball” when “shot” together), marijuana (a.k.a., “woolie” when smoked together) and prescription opioids (i.e., OxyContin®; used “to make the high better”). Using heroin with all of the aforementioned is reportedly very common. Also, reportedly very common is heroin overdose. Several participants noted known overdoses with the combination of heroin and benzodiazepines. A participant stated, “A lot of people mix Valium® and Xanax® [with heroin]—a lot of benzo’s [benzodiazepines]—either snort, or a lot of people will shoot [inject] Xanax®. Very common and a lot of people are dying ... very easy to overdose.” A treatment provider stated, “There’s a lot of overdoses of young ones doing heroin, a lot of them. It’s either somebody died in their arms, or their boyfriend died, or they OD [overdose] and die.”

Prescription Opioids

Current Trends

Prescription opioids are highly available in the region. Participants and treatment providers most often reported the current street availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Law enforcement most often rated current availability as ‘8’ or ‘9.’ BCI&I Richfield crime lab reported an increase in the number of prescription opioid cases it processes. Participants described some prescription opioids as more readily available than others. They reported, “Vicodin® is available everywhere; Opana® is a real popular one, but hard to find. I’d say a ‘4’ [availability rating]; You cannot find any original oxy [OxyContin®] anymore, around a ‘3.’” Community professionals identified OxyContin®, Percocet® and Vicodin® as the three most popular prescription opioids in terms of widespread use. The consensus of one focus group was that prescription opioids are “harder to get” than six months ago—most others agreed while participants in one focus group reported a general increase in availability. Those who reported a decrease in availability attributed the decrease to the following: “I think people are getting addicted and not selling. They’re keeping them [prescription opioids] for themselves; ‘Oxy’ [OxyContin®] has gone down with the new gel pills that they have come out with; There’s more awareness that these pills [prescription opioids] are ‘legal heroin,’ so there’s more



crack down. Several participants noted the reformulation of OxyContin® as the reason for its decreased street presence in the region. Now when the protective coating of OxyContin® is removed, or when the OxyContin® pill is crushed, the pill breaks down into a gel and not a powder, making snorting or injecting the drug more difficult. A participant stated, *“People do not want to touch them [the “new” reformulated OxyContin®].”* Thus, the original OxyContin® has become scarce—more difficult and more expensive to obtain.

Reportedly, many different types of prescription opioids (a.k.a., “beans,” “candy” and “skittles”) are currently sold on the region’s streets. Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Darvocet®, Darvon®, Demerol®, Dilaudid®, fentanyl (\$15 – \$80 for patches, depending on dosage; \$20 – \$50 for Actiq® lollipops, depending on dosage), Kadian®, Lortab® (\$5 – \$7 per pill), methadone 10 mg (a.k.a., “done’s” and “happy pill;” \$5 – \$7), morphine, Opana® 30 mg (\$20), Opana® 40 mg (\$35 – \$50), Opana® 50 mg (\$60), OxyContin® (a.k.a., “OC’s,” “Old Cars,” “Orange County” and “oxy’s;” *old* formulation sells for \$1 – \$2 per mg), OxyContin® 40 mg (a.k.a., “little boys” and “oranges;” *new* formulation sells for \$25 – \$30), OxyContin® 60 mg (a.k.a., “big reds” and “mediums;” *new* formulation sells for \$35), OxyContin® 80 mg (a.k.a., “80’s,” “beans;” “big boys,” “big’s” and “green apples;” *new* formulation sells for \$50), OxyContin® 160 mg (a.k.a., “killers”); Percocet® 5 mg (a.k.a., “perc’s;” \$3 – \$5), Percocet® 10 mg (a.k.a., “school buses;” \$5 – \$10), Percodan®, Roxicet® (a.k.a., “IR’s” for instant release, “madden” and “roxi’s”), Roxicet® 15 mg (a.k.a., “green clover” and “greens;” \$5 – \$15), Roxicet® 30 mg (a.k.a., “blues;” \$15 – \$25), Subutex®, Tramadol® (\$.50 – \$1 per pill), Tylenol 3/4®, Ultram® (a.k.a., “trams;” \$.50 – \$1 per pill) and Vicodin® (a.k.a., “vikes”), Vicodin® 500 mg (a.k.a., “baby vikes;” \$2 – \$3), Vicodin ES® 750 mg (\$4 – \$5), and Vicodin HP® 1,000 mg (\$5 – \$6).

In addition to obtaining prescription opioids on the street from dealers, participants also reported getting prescription opioids from friends, roommates, family members—others with prescriptions, buying “scripts” (i.e., prescriptions) or trading other drugs for opioids, as well as, from area doctors and pain management clinics. Participants reported the following: *“A few doctors in Warren prescribe. You know who they are because there is a line outside their door to the corner at 5 a.m.; It’s really not hard to get [prescription opioids] from a doctor. Doctors do not have much training in alcohol and*

drug abuse, and before you know it, you are given a gang of pills.” A treatment professional stated, *“It just is amazing to me that there are so many doctors that are prescribing as many ... for a month 120 to 150 Vicodin® for a person, month after month.”* Another professional reported the following: *“A lot of them [drug users] are getting them [prescription opioids] from the medicine cabinet of their grandma or grandpa who is sick. They’ll act like they are going to visit ... and they’re stealing their medication—their pain medication ... they’re willing to do anything to get a hold of an opiate.”* All treatment professionals of one focus group agreed with the following assessment of clients addicted to prescription opioids given by a colleague: *“These users appear to be worse off and need to be detox’ed [go through detoxification] from multiple drugs, and [they] need multiple cures.”*

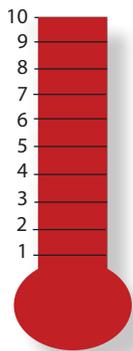
While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the most common routes of administration are oral consumption and intranasal inhalation, with a few reports of intravenous injection. Many participants explained that when they first started to use prescription opioids, they took them by mouth and swallowed them before progressing to snorting, and in some cases, “shooting” the drugs. Participants explained how they used prescription opioids as follows: *“By mouth orally, after a while I would snort some [prescription opioids]. I would also shoot [inject]; Oxy’s and roxi’s I have shot; Oxy’s I always snorted; Most people that abuse it [fentanyl], um, cut the patch and suck the gel stuff out. They suck on the patch basically ... I can very rarely say I’ve seen people wear the patch that have had it.”*

A profile of a typical illicit user of prescription opioids did not emerge in the data. Participants and treatment professionals alike stated that illicit use of prescription opioids in their communities is a far-reaching problem. Area media quoted an officer from a local narcotics unit as making the following statement related to the abuse of prescription opioids, *“Prescription drugs, painkillers, is a problem for all ages”* (www.vindy.com; July 19, 2010). Participants reported the following: *“Vikes and perc’s a lot of young kids take them, but really there is not a range [age range]. Everyone is taking them [prescription opioids]—easy to get; People in early 20’s—all ages really; People in the 60’s usually take a couple and sell the rest.”* Treatment professionals noted that current illicit use appears more prevalent among suburban, middle class, White people and less prevalent among urban, poor

people; however, a provider noted an increase in abuse among African-Americans. A professional said that many of his clients were *“factory workers or in the tool and dye trade who got injured on the job, and then got addicted to opiates, 22-42 years old.”* Another treatment professional noted high use of Ultram® and Tramadol® among *“inner-city kids”*: *“For the inner-city kids, and I call it my ‘urban heroin,’ it’s the use of Ultram® and Tramadol®. We see a lot of that with that clientele ... people taking 20 or 30 of those a day ... that’s one I’m very concerned about because it is sold as a non-narcotic.”* Another professional stated that Ultram® is believed to be viewed by doctors as non-narcotic and that it is preferred by users because, *“You can test negative for opiates with Ultram®; You have to test specifically for Ultram®.”* Treatment professionals also reported that illicit consumers of prescription opioids are making new friends from across the state and using with these friends, traveling and staying together.

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol and marijuana. Participants also reported using prescription opioids with benzodiazepines (i.e., Xanax®), crack cocaine, heroin and powdered cocaine.

Suboxone®
Current Trends



Suboxone® is highly available in the region. Participants most often reported the street availability of Suboxone® as ‘10’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Participants agreed that Suboxone® was *“easy to get.”* Law enforcement stated that Suboxone® is *“rampantly available on the street.”* While a few participants reported being either currently or previously prescribed Suboxone® by a physician in their community, through a treatment center, or while incarcerated, most

frequently, participants reported obtaining Suboxone® on the street from other users or from drug dealers. Participants stated the following: *“I think what happens is you have somebody who, you know, really wants to get help, and they go to the doctor and get the prescription [for Suboxone®]. Then they end up selling some of their pills, perhaps at a weak moment when they want to use heroin or whatever; I’m prescribed them, but I have people who ask all the time about them and if I know*

anybody who wants them.” Reports of drug dealers acquiring and then selling Suboxone® were common. A participant reported, *“I had my drug dealers asking me at one point in time where to get them [Suboxone®]. They’d run out of dope, and they be like, well, I gotta give my customers something.”* BCI&I Richfield crime lab reported an increase in the number of Suboxone® cases it processes.

No slang terms or common street names were reported for Suboxone®. Participants reported Suboxone® 8 mg sells for \$5 – \$30, with the most frequently reported price being \$10 – \$20. There was consensus among participants that Suboxone® pricing is dependent on who is selling and who is buying. Participants stated the following: *“It [price of Suboxone®] depends on how bad person selling needs heroin. Person selling usually wants heroin; From my experience, it also depends on how bad somebody wants them to what the price will be.”* A participant reported Suboxone® being sold in treatment facilities for \$20. Another participant stated that Suboxone® was cheaper to buy on the street than through a pharmacy: *“I’m in the Suboxone® program. I have to pay for my prescriptions, and I could actually tell you that it is cheaper to buy Suboxone® on the streets than to buy in the pharmacy.”*

Participants and treatment professionals alike reported that Suboxone® is most often used illicitly by those addicted to heroin who trade Suboxone® to dealers for heroin, although treatment professionals noted that other users are now using Suboxone® to get high. They reported that users are teaching other users how to use Suboxone® intravenously. A treatment provider stated, *“They [clients] know we don’t test for that [Suboxone®] on a [drug] screen, so I think that they are using that [Suboxone®] even more than we know.”* A professional who works in an area homeless shelter reported, *“A young lady who stayed here ... she did admit to me that she does get high off Suboxone®.”* A law enforcement officer stated, *“Anecdotally, people have said unequivocally that if they have not used heroin or an opiate for a long time and they use Suboxone®, they do get high.”* A participant stated, *“I always got high from them [Suboxone®]. You can get addicted to Suboxone® like any other drug.”* While different types of participants are starting to abuse Suboxone®, the consensus among the vast majority of participants was that those addicted to opioids mostly seek the drug to avoid withdrawal between highs. Treatment providers stated the following: *“For those who were hardcore addicts, you know, Suboxone® was cornflakes. It’s a standby, the bridge over troubled waters until they can get in touch with their guy [drug dealer]; They keep some [Suboxone®] on hand so*

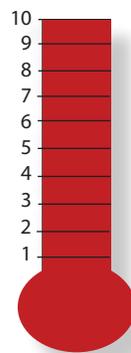
they don't get sick." A participant stated, "Most people use them [Suboxone®] when they don't have money and to not get sick or when there's a drought [period of time when drug availability is low]." Law enforcement stated that the same populations that use heroin and prescription opioids are also using/abusing Suboxone®.

Most often Participants reported taking Suboxone® sublingually. However, there were reports of snorting Suboxone®, and participant and professional respondents alike report that intravenous use of the drug is becoming more commonplace. Generally, no other substances are reportedly used in combination with Suboxone®. A participant stated, "I don't know of any other [substance used with Suboxone®] as you get violently sick if you do [use Suboxone® in combination with other substances]." Other participants stated that it is not worth it to take other drugs while on Suboxone® because the other drugs would not produce the desired effect. A treatment professional explained, "We're not finding Suboxone® is being used with other drugs, as much as it is a bridge until they [drug users] can get their opiates." There were reports of Suboxone® being used with alcohol, benzodiazepines (i.e., Xanax®), crack cocaine, marijuana ("for the bigger weed high") and powdered cocaine.

Sedative-Hypnotics

Current Trends

Sedative-hypnotics (i.e., benzodiazepines, barbiturates and muscle relaxants) are highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described some sedative-hypnotics as more readily available than others. A participant reported, "I see a lot more Xanax®, Ativan® and Klonopin®. I do not see a lot of Valium®." Treatment professionals list the most common sedative-hypnotics in terms of widespread use as Xanax®, Ativan®, Klonopin® and Valium®. The consensus of participants and treatment professionals alike was that sedative-hypnotics have become more available over the past six months. Several users agreed with the following



statement, "I personally think with them [Purdue Pharma] changing all of the OxyContin®, people are getting more into the benzo's [benzodiazepines] for that, you know, that down kind of high." BCI&I Richfield crime lab reported that the number of sedative-hypnotics cases it processes has remained stable.

Reportedly, many different types of sedative-hypnotics are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ambien® (\$5 for an entire prescription), Ativan®, Klonopin®, Lunesta®, Nembutal®, Restoril®, Soma® (\$1 - \$2), Valium® 10 mg (\$1 - \$2), Xanax® .25 mg (a.k.a., "totem poles" and "xanibars;" \$.25 - \$.50), Xanax® .5 mg (\$.75 - \$1), Xanax® 1 mg (\$1) and Xanax® 2 mg (\$2 - \$5).

In addition to obtaining sedative-hypnotics on the street from dealers, participants reported visiting area doctors in order to obtain prescriptions for these drugs. Treatment professionals talked about the emerging problem of young people being prescribed sedative-hypnotics: "A lot of the younger ones have it [sedative-hypnotics] prescribed, and that's a new thing too ... and a lot of them will say, 'my doctor gave it to me, my family doctor,' and they're not even seeing a psychiatrist or anything, that's a big thing; Doctors are over prescribing ... giving them [clients] so many, so many [sedative-hypnotics] a day to take." A participant stated that Soma® is believed to be viewed by doctors as non-narcotic: "I believe doctors prescribe Soma's® because they believe that they are non-addictive, but they are very addictive." A treatment professional reported that Soma® is popular among the agency's clients, stating, "Soma's® are big here because we can't test for them." Many participants reported also getting sedative-hypnotics from friends and family members, or trading other drugs for them. A participant said, "Folks sell their scripts [prescriptions] to get what they prefer." Treatment providers were very concerned about the attitude users have toward sedative-hypnotics: "Users don't believe it's addictive [sedative-hypnotics] ... what I'm seeing more of is this connotation that it's just like going into your Aunt Martha's cupboard and taking a Tylenol® ... that's how nonchalant they talk about it." Another provider also expressed frustration with user's behavior: "A lot of them [are] what I like to call bathroom-medicine cabinet cowboys; they'll go in and take a handful of pills, and they don't even know what the hell they are."

While there were a few reported ways of consuming sedative-hypnotics, the most common routes of

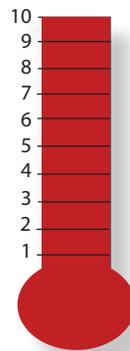
administration are oral consumption and intranasal inhalation (i.e., snorting). Many participants explained that when they first started to use sedative-hypnotics, they took them by mouth and swallowed them before progressing to snorting.

A profile of a typical illicit user of sedative-hypnotics did not emerge in the data. Treatment professionals believe that illicit use of these drugs in their communities is a far-reaching problem that affects all age groups. A few treatment professionals talked about specific groups with whom they have worked when treating addiction to sedative-hypnotics. A professional reported often treating clients with *"fibromyalgia and arthritis getting prescribed pain medications or anxiety medications."*

Reportedly, sedative-hypnotics are used in combination with alcohol, heroin, marijuana and prescription opioids (i.e., OxyContin®). Many participants reported using sedative-hypnotics to "come down" from other drugs. Several participants nodded their heads when one person commented, *"I use them [sedative-hypnotics] to come down from crack [cocaine] when I didn't have heroin or when I ran out of money."* Another participant said he used Xanax® *"to come down from coke [powdered cocaine] or crack [cocaine]."*

Marijuana Current Trends

Marijuana is highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants and treatment providers described marijuana as being extremely easy to get. A participant commented that marijuana was *"the most available illegal drug,"* and others compared it to the availability of heroin: *"It's neck and neck with heroin as most available."* BCI&I Richfield crime lab reported that the number of marijuana cases it processes has remained stable, and noted that marijuana cases make up the greatest proportion of drug cases it reviews. Participants said the availability has not changed over the past six months while treatment providers believed some types of marijuana are more readily available. A treatment provider reported, *"Hydro [hydroponically grown marijuana] has increased because of the advertisement of phototrons*



[automated indoor growing systems] in High Times magazine and on the Internet. People are also building home grow units." Law enforcement reported that the current high availability of marijuana in the region is not new; however, *"New in our area in terms of distribution ... people, more and more are sending marijuana in the mail. We've seized about 200 to 300 pounds in the past month through common carriers such as FedEx, UPS and U.S. mail. At \$500 to \$600 a pound if you send three [one-pound packages], you double your money if only one gets through; I just saw some [marijuana] this morning at FedEx."* Area media reported that police intercepted a package containing marijuana mailed to an area dealer who sold marijuana near Youngstown State University (www.vindy.com; Sept. 8, 2010). Law enforcement also reported, *"A lot more people are growing their own [marijuana]. This is increasing. We did 10 to 15 home grown operations this past year in the city [Youngstown]. We seized a ton of marijuana grown out in the farmland of Mahoning County this year. This was the best year [for marijuana seizure] from among the last four [years]."*

Participants reported that the quality of marijuana varied with the most common quality score being '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Several participants explained that the quality of marijuana depends on whether the user buys "commercial weed" (i.e., low to mid-grade marijuana) or hydroponically grown (i.e., high-grade marijuana). Participants thought commercial marijuana looked like *"dried up leaves, like parsley"* or *"compressed buds with a lot of seeds"* while high quality marijuana had *"fluffier buds and less seeds;"* hydroponically grown marijuana was said to have *"few seeds and smells like a skunk."*

Current street jargon includes countless names for marijuana. The most commonly cited name was "weed." Participants listed the following as other common street names: "dirt" and "Youngstown brown" for low to mid-grade marijuana; "kush," "Hawaiian gold" and "purple haze" for high-grade marijuana; and "hydro" or "skunkweed" for hydroponically grown marijuana. Commercial marijuana is the most widely sold form of the drug. A participant stated, *"Commercial weed [marijuana] comes in by the half ton, and it's [sold on the street] anywhere from ounces ... to a nickel bag which is about a gram."* The price of marijuana depends on the quality desired. Participants reported they could buy commercial-grade marijuana in many different quantities: a "blunt" (i.e., marijuana cigar) sells for \$5 – \$10; a gram currently sells for \$5; 1/8 ounce sells for \$15 – \$30; 1/4 ounce sells for \$25 –

\$30; 1/2 ounce sells for \$40; an ounce sells for \$75 – \$120; 1/4 pound sells for \$300; 1/2 pound sells for \$600; and a pound sells for \$1,100. Participants also reported they could buy high-grade marijuana in many different quantities, a “blunt” (i.e., marijuana cigar) sells for \$20; a gram currently sells for \$20; 1/8 ounce sells for \$40 – \$75; an ounce sells for \$180 – \$400; 1/4 pound sells for \$800 – \$900; and a pound sells for \$2,000 – \$4,000. While there were a few reported ways of consuming marijuana, the most common route of administration is smoking. Some users reported eating marijuana in food or putting it in tea, and a few cited vaporizing marijuana.

When asked to describe the typical user of marijuana, participants were unable to be specific. Treatment providers summed up the attitude shared by other professionals and participants alike, “Everyone uses it [marijuana], no matter the gender or race.” While the prevailing thought is that marijuana is widely used, a couple of treatment providers noted an increase in use among young males, particularly African-American: “Recently, a lot of younger people, young males between 18 and 25 ... pretty much smoking [marijuana] daily and not believing it is a problem: ‘it’s just marijuana, it’s no big deal’; More of my African-American clients are using marijuana than my White clients, mostly young males 18 to 25.”

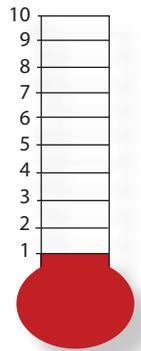
Marijuana is reportedly used in combination with alcohol, crack cocaine (a.k.a., “woolie” or “primo” when laced into a “blunt”), ecstasy, heroin (a.k.a., “woolie” or “primo” when laced into a “blunt”), LSD (lysergic acid diethylamide), prescription opioids and salvia. Many people agreed with a user’s statement about mixing prescription opioids with marijuana: “A lot of people that I know would take Vicodin® and Percocets® and smoke weed [marijuana].” Users also reported dipping marijuana blunts in embalming fluid (a.k.a., “wet”) or PCP (phencyclidine); and a participant reported spraying blunts with Febreze® air fresheners. Several participants also reported that marijuana blunts were rolled with Tussionex Pennkinetic® (a narcotic liquid cold remedy), and that this trend was common among those 20 to 40 years in age.

Methamphetamine **Current Trends**

Methamphetamine is relatively rare in the region. Most participants knew little about the drug. Participants most often reported the drug’s current availability as ‘1’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high

availability, extremely easy to get). Law enforcement rated current availability as “1 or 2.” An area probation officer reported, “It [methamphetamine] exists, but I think with the change in the law regarding ephedrine products, that’s significantly changed the ability to make it.” A professional respondent with an area homeless shelter reported that four methamphetamine users have come through for services and that methamphetamine is reportedly available in Columbiana County. This professional stated, “If you want it [methamphetamine], you can get it.” When asked whether the powdered form or the crystal form was more available, participants said that both forms are equally unavailable. Treatment professionals agreed there is little availability in the region except for one area; availability was reported as ‘10’ in Ashtabula County where methamphetamine was said to be popular. A group of providers reported that four “cookers” (i.e., methamphetamine manufacturers) came through their treatment center recently. Participants said the availability of methamphetamine has changed little in the last six months, and they thought that the availability of the drug came in waves. BCI&I Richfield crime lab reported an increase in both powdered and crystal methamphetamine cases it processes.

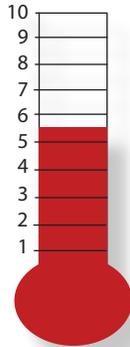
Participants reported that the quality of methamphetamine is high in the area, but did not assign a numerical score to their answers. One user commented that the drug is “pretty good” and another said, “Sometimes it [methamphetamine] was brown or white crystal looking. It always changed.” Current street jargon includes very few names for methamphetamine. The most commonly cited name was “glass” for crystal methamphetamine, but terms like “crystal” and “ice” were also popular. Participants reported they could buy a gram of powdered methamphetamine for \$50 and a gram of crystal methamphetamine for \$150. Methamphetamine powder is also sold in straws; \$50 for a small straw and \$100 for a large straw. The most common routes of administration for this drug include smoking and injecting, although heating methamphetamine and inhaling the vapor (a.k.a., “hot railing”) was mentioned by one participant. Treatment professionals described typical users of this drug as 18 to 38-year-old Whites.



Ecstasy

Current Trends

Ecstasy [methylenedioxymethamphetamine (MDMA)] is moderately available in the region. Participants most often reported the drug's current availability as "5.5" on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The availability of the drug is thought to vary depending on the season; ecstasy is considered a "summertime drug," and thus not as available now as at other times of the year. On the other hand, treatment providers reported ecstasy as being more available, most frequently reporting the drug's current availability as '7'. Oftentimes, treatment providers reported the availability as increasing, citing more people are learning how to make homemade ecstasy. BCI&I Richfield crime lab reported an increase in the number of ecstasy cases it processes.



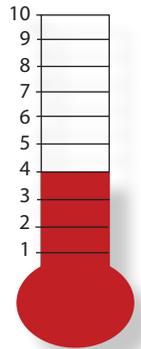
Current street jargon includes several different names for ecstasy. The most commonly cited name was "skittles." Participants listed the following as other common street names: "Chanel," "roller skates" and "shamrocks." Participants reported that a "single stack" (i.e., low dose) ecstasy tablet sells for \$8 – \$10 and a "double stack" or "triple stack" (i.e., high dose) sells for \$16 – \$30. Participants reported that the price of a pill depends on a variety of factors: "A lot of pills have different shapes and designs and that's how they price them and say what they are." The quality of ecstasy varies, with some users reporting moderate quality and others reporting low quality. As a drug user stated, "Ecstasy is a hard drug to speak on because no one pill is never the same... you sometimes feel low, sometimes you feel high, sometimes you're sexually active, sometimes you're like slow-fast, hot-cold. There's never the same feeling." The only reported method of administration is oral consumption.

Prescription Stimulants

Current Trends

Adderall® and Ritalin® are somewhat available in the region. Participants most often reported the drug's current availability as '4' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Several treatment providers noted that some of their clients

are legitimately prescribed a prescription stimulant while also stating that these drugs are the drug of choice for some participants. A participant said, "[Other users] say it's like cocaine to them. To where it calms kids down, it speeds adults up. They say it's almost like a cocaine high." Participants believe that prescription stimulants are popular among all age groups, while treatment providers believe they tend to be more popular with younger (< 26), White males and females.

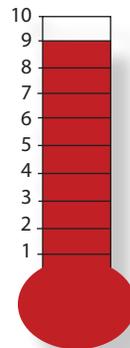


No slang terms or common street names were reported for prescription stimulants. The following prescription opioids are available to the street-level users: Adderall® 15 mg (\$2); Adderall® 20 mg (\$2 – \$4); and Adderall® 30 mg (\$5 – \$6). Aside from getting prescription stimulants from the streets, participants also reported getting them from friends and physicians. A participant reported, "I got it [Adderall®] from a friend who has four kids who gets scripts [prescriptions] for all her kids, so real easy. People would sell their kids' scripts. One friend would sell her kid's script to buy crack [cocaine]." The most common reported method of administration is crushing and snorting the medicines, although a person reported injection of prescription stimulants.

Prescription and OTC Cough Medicines

Current Trends

Prescription and over-the-counter (OTC) cough medicines are highly available in the region. Participants most often reported the drug's current availability as '9' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants and treatment professionals alike agreed the availability has remained about the same over the last six months due to the legal ways users can obtain these drugs. Mahoning County law enforcement reported that the trend to abuse cough medicines as increasing: "The biggest [new trend] we're seeing ... is cough medicine. We're getting a lot of reports from the southeastern part of the county ... where [users] were taking 10 at a time." Participant and professional interviewees believe that illicit use of cough medicine is most popular among younger people (< 18) who do not have access to other substances. Prescription cough

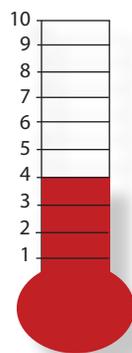


medicines that contain codeine and promethazine and OTC cough medicines containing dextromethorphan (DXM), like Coricidin Cough and Cold® (a.k.a., “triple c’s”), Nyquil® and Robitussin® are the most sought after substances to abuse. Participants reported that cough medicines containing DXM are well liked because they cause users to hallucinate. The most often reported route of administration is oral consumption, but several participants also reported dipping tobacco cigarettes and marijuana “blunts” in cough medicine before smoking.

Hallucinogens

Current Trends

Hallucinogens do not appear particularly popular in the region. Lysergic acid diethylamide (LSD) was mentioned by a few participants while others reported not having seen it in awhile. Participants most often reported the drug’s current availability as ‘4’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). BCI&I Richfield crime lab reported an increase in the number of LSD and psilocybin mushrooms cases it processes. Participants reported that the availability of LSD fluctuated with the seasons and that it is more of a “summertime drug.” LSD is available in multiple forms to street-level users including paper blots (\$5 – \$10 per hit), sugar cubes and gel tabs (\$5 – \$10 per tab). A minority of participants also used psilocybin mushrooms and said they are available in a limited number of areas. Reportedly, 1/8 ounce of psilocybin mushrooms sell for \$35 – \$40. The most commonly reported method of administration is oral consumption, eating or mixing psilocybin mushrooms with tea.



Other Drugs

Participants and professionals listed a variety of other drugs as being present in the area, but these drugs were not mentioned by the majority of people interviewed. Reportedly, synthetic marijuana (e.g., “K2” and “Spice”) is being used by a few participants for recreational use and as a stand-in for marijuana when participants need to pass a drug test. Mahoning County law enforcement expressed frustration with synthetic marijuana: *“There’s K2, Spice, those kind of things ... the availability of that is everywhere.*

They can get it in stores; It’s in front of the law, just like salvia was. It [synthetic marijuana] got in front of the law and the law has to catch up.” Reportedly, energy drinks with alcohol are used in combination with other drugs to modify the high experienced by users. Inhalants were mentioned as being popular with younger people (< 18), but none of the participants interviewed reported using them. Gamma-hydroxybutyric acid (GHB) is reportedly used by a few drug users to “come down” after using cocaine.

Conclusion

Crack cocaine, heroin (i.e., brown powdered), prescription opioids, Suboxone®, sedative-hypnotics and marijuana are the most available drugs throughout the Youngstown region. Noted increases in availability over the previous six months exist for heroin, prescription opioids, Suboxone®, sedative-hypnotics and ecstasy. Heroin referred to as, *“the number one drug of the time,”* is now as available as marijuana. Users are switching from crack cocaine and prescription opioids to heroin because heroin is cheap and, *“You can get it, wherever, whenever.”* Use is increasing among young people (teens to early 20’s), with 13 years being the youngest reported age of known heroin users. The most common route of heroin administration is intravenous injection. Heroin use among young Whites, along with heroin overdose, is becoming very common. A regional drug court reports that 75 percent of defendants today are suburban heroin addicts who typically started abusing prescription opioids before developing heroin addiction. Illicit use of prescription opioids is also more prevalent among young, suburban, middle class, White people and less prevalent among urban, poor people; however, abuse appears to be increasing among African-Americans as well. OxyContin® remains the most popular prescription opioid, although decreasing in desirability due to reformulation; Opana®, Percocet® and Vicodin® are also popular. Suboxone® is most often used illicitly by those addicted to heroin who trade Suboxone® to dealers for heroin or use the drug when heroin is unavailable to avoid withdrawal, although other users are now using Suboxone® to get high. Alarming, sedative-hypnotics are increasingly being prescribed to teenagers without seeing a psychiatrist. Hydroponically grown marijuana continues to increase in popularity among all age groups, especially since people have become more educated about indoor grow units. Abuse of OTC cough medicine, well liked because it causes users to hallucinate, is increasing among young people who do not have access to other substances.