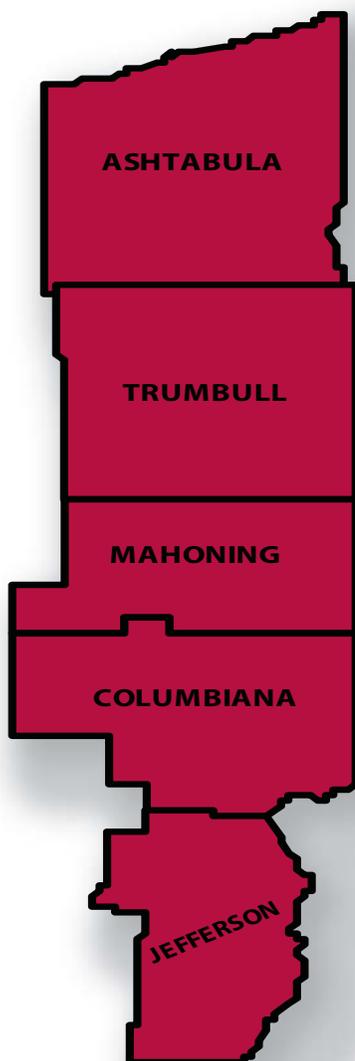


# Ohio Substance Abuse Monitoring Network

## Drug Abuse Trends in the Youngstown Region

June 2011-January 2012

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# Youngstown Regional Profile

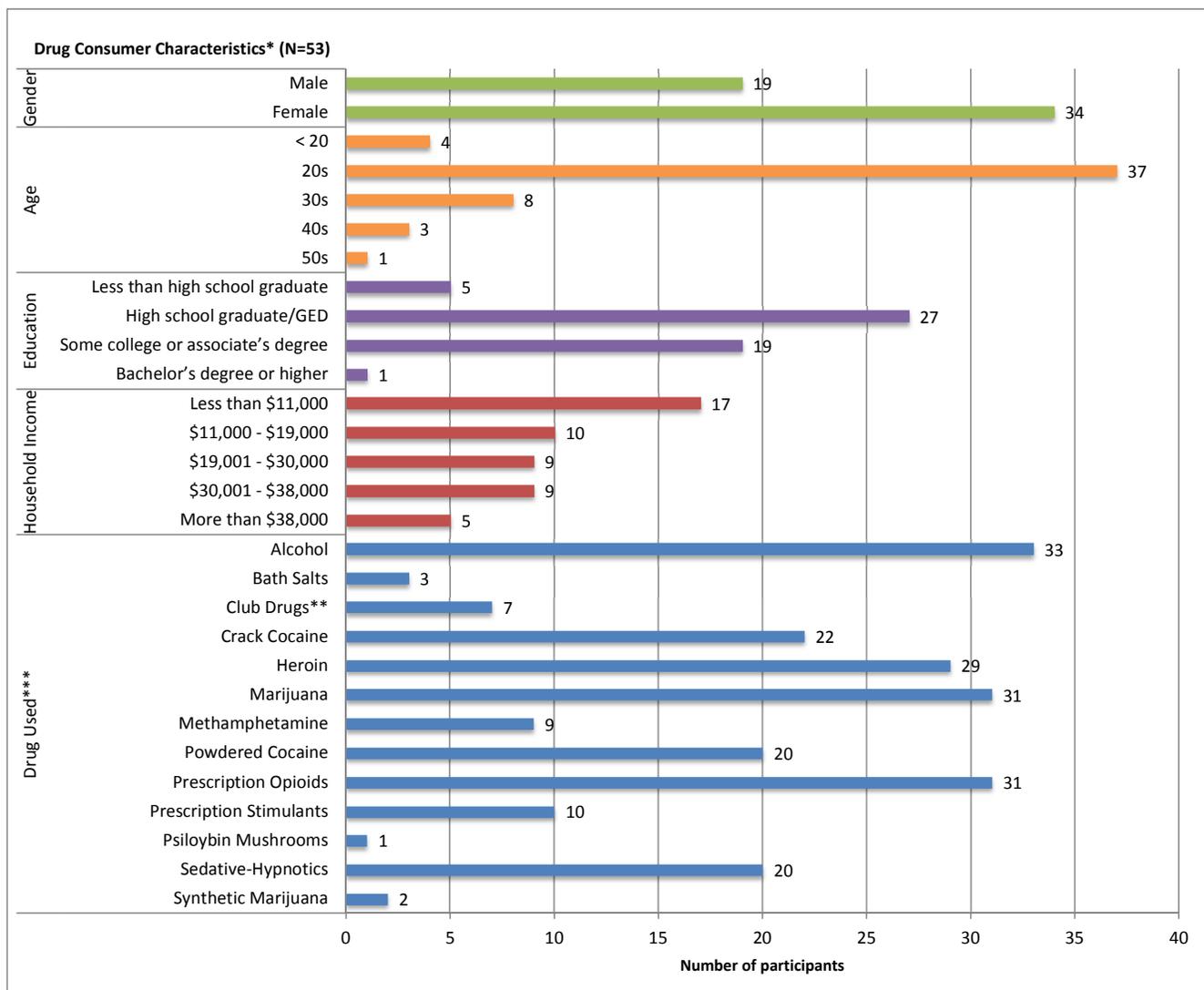
Indicator <sup>1</sup>	Ohio	Youngstown Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	728,182	53
Gender (Female), 2010	51.2%	51.1%	64.2%
Whites, 2010	81.1%	86.3%	86.8%
African Americans, 2010	12.0%	8.7%	9.4%
Hispanic or Latino Origin, 2010	3.1%	2.7%	3.8%
High school graduates, 2009-2010	84.3%	86.8%	90.4% <sup>2</sup>
Median household income, 2010	\$45,151	\$38,228	\$11,000-\$19,000 <sup>3</sup>
Persons below poverty, 2010	15.8%	16.9%	48.0% <sup>4</sup>

Ohio and Youngstown statistics are derived from the U.S. Census Bureau.<sup>1</sup>

Graduation status was unable to be determined for one respondent due to missing data.<sup>2</sup>

Respondents reported income by selecting a category that best represented their household's approximate income for 2011. Income status was unable to be determined for three respondents due to missing data.<sup>3</sup>

Poverty status was unable to be determined for three respondents due to missing or insufficient income data.<sup>4</sup>



\*Not all participants filled out forms; therefore, numbers may not add to 53.

\*\*Club drugs refers to Ecstasy and LSD.

\*\*\*Some respondents reported multiple drugs of use during 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 Ashtabula, Columbiana, Mahoning and Trumbull counties. Data triangulation was achieved through comparison of participant data to qualitative data collected from regional professionals (treatment providers and law enforcement) via individual and focus group interviews, as well as to data surveyed from the Bureau of Criminal Investigation (BCI) Richfield Office, which serves the Akron, Cleveland and Youngstown areas. BCI data are summary data of cases processed from January through June 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current BCI data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for July through December 2011.

### Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While highly available, the consensus among participants was that crack cocaine remained easier to obtain on the street than powdered cocaine. Treatment providers and law enforcement most often reported the drug's availability as '8'. Many treatment providers named cocaine in the top three drugs used in the region. The vast majority of participants and community professionals reported that the availability of powdered cocaine had remained stable during the previous six months. The most common participant quality score for powdered cocaine was '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Universally, participants reported that the quality of powdered cocaine continued to be dependent on the source, the person from whom one buys. The BCI Richfield Crime Lab continued to cite the following substances as commonly used to cut (adulterate) powdered cocaine: caffeine, diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetics). Participants reported that a gram of powdered cocaine sold for between \$50-100, depending on the quality. While there were a few reported ways of consuming powdered cocaine, the most common route of administration for this form of

cocaine remained snorting followed by intravenous injection. Several participants reported, "cooking up" (manufacturing) powdered cocaine into crack cocaine and smoking the drug. Many participants continued to associate powdered cocaine use with the bar/club scene. Community professionals reported that users of powdered cocaine tended to be White and older than 30 years of age.

### Current Trends

Powdered cocaine remains highly available in the region. Participants most often reported the drug's current availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. A participant with experience using powdered cocaine reported, *"I wouldn't say [powdered cocaine] it's the easiest drug [to obtain], but it's pretty easy to find."* Other participants reported: *"[Powdered cocaine is] pretty easy to get but not as easy as crack cocaine [to obtain]; I think [powdered cocaine] it's harder to get . . . that's how I got introduced to crack [cocaine] because I couldn't get powder."* Participants also noted that powdered cocaine, along with other drugs, is more difficult to obtain in various areas of the region. A participant noted that many drugs, including powdered cocaine, are, *"much harder to get in rural areas and smaller towns."* Community professionals most often reported the current availability of powdered cocaine as '8'; the previous most common score was also '8'. A law enforcement official reported, *"Powdered cocaine and marijuana probably makes up about 20 percent of our [drug arrest] cases. It's just not as big of a problem as heroin."* A treatment provider recalled, *"I just don't see a preponderance of powdered cocaine in this area, I would say, in the last two years. I see crack users who can't find crack . . . will look for powdered cocaine."*

Participants and community professionals reported that the availability of powdered cocaine has remained the same during the past six months. A treatment provider described powdered cocaine as an "opportunistic" drug for teenagers, sometimes leading to dependency: *"[Powdered cocaine] it's opportunistic with teens . . . they'll do it if it's around. But if they develop that relationship with a stimulant then they might continue to use it in adulthood."* Another treatment provider described powdered cocaine abuse among adults: *"If someone is a heavy drinker, they might use cocaine to prolong their high, having a dependent relationship with alcohol and an abusive relationship with cocaine."* The BCI Richfield Crime Lab reported that the number of powdered cocaine cases it processes has remained the same during the past six months.

Most participants rated the quality of powdered cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '7'. Participants reported that powdered cocaine in the region is cut with

baby formula, baby laxative, baking soda, prescription opioids, sleep aids (NoDoz® and Sleepinol®), soap and vitamins such as B12. In addition, several participants reported that head shops sell products that can be used for cutting drugs. One participant said, *"Head shops sell their own cut for coke [cocaine]. It even makes your lips go numb, but you won't get high from it. It's expensive though, but some dealers do use it to trick people and make the coke stretch further."* Another participant agreed reporting, *"Head shops sell 'Goodie Powder.' It's like little packs of crushed Tylenol® that people use for cut."* A third participant reported, *"It [powdered cocaine] can be cut with anything white really or slightly yellow. To be honest, you never know what you're getting; you never know what you're putting into your body."* There was consensus among participants that the quality of powdered cocaine has decreased during the past six months. A participant reported, *"It [powdered cocaine] goes through so many hands before it gets to you. By the time you get it, it's been cut so many times [that] it's garbage."* Participants continued to report that the quality of powdered cocaine depends on from whom one buys. Many participants agreed that drug dealers are getting younger, roughly between the ages of 16-18 years. Reportedly, quality seems better if powdered cocaine is purchased from older dealers who have been selling for many years. One participant said, *"If you buy [powdered cocaine] from old-school guys [dealers], they keep it right — they believe in quality over quantity. They don't believe in cutting it."* In addition, several participants agreed that dealers who sell cocaine often use powdered cocaine themselves before turning it into crack cocaine to sell. The BCI Richfield Crime Lab cited the following substances as commonly used to cut powdered cocaine: caffeine, benzocaine (local anesthetic), diltiazem (medication used to treat heart conditions/high blood pressure) and levamisole (livestock dewormer).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "blow," "girl" and "powder." Participants listed the following as other common street names: "b\*\*\*\*," "christina," "christine," "coke," "dope," "fuel," "nose candy," "powder," "soft," "snow," "white," "white girl" and "ya-yo." Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine. Participants reported that a gram of powdered cocaine continues to sell for between \$60-100, depending on the quality; 1/16 ounce, or "teener," sells for \$70; 1/8 ounce, or "eight ball," sells for between \$140-150; an ounce sells for between \$1,200-1,500. Participants reported that the most common way to use powdered cocaine remains snorting, followed by intravenous injection. Out of 10 powdered cocaine users, participants reported that approximately eight would snort and two would intravenously inject. A participant reported, *"I've always snorted it [powdered cocaine], but I've seen a few people inject it, mostly when they were using heroin to speedball."*

Participants most often described typical users of powdered cocaine as, *"teenagers and people in their early 20s,"* confirming use among young adults between 18-25 years of age. Participants also noted that powdered cocaine is a more expensive drug, so people with money are more likely to use powdered cocaine. A participant stated, *"You have to have a big income to support that [powdered cocaine] habit."* A participant reported seeing powdered cocaine as less of a problem than other drugs: *"Cocaine's 'not cool' anymore, you know? For young people now, it's either heroin or pills [prescription opioids]. Cocaine is maybe something you did when you were younger, a teen ... I really don't see it now as much."* Another participant reported, *"I messed with powdered cocaine more when I was a teen. I was 15 [years old] the first time I tried it. It wasn't very available to me because I'm from a small town in Columbiana [County]. Now, crack cocaine is my drug of choice."*

Reportedly, powdered cocaine is used in combination with alcohol, heroin and prescription opioids. Many users noted the practice of "speedballing" (mixing powdered cocaine with heroin for injection) as popular. Out of 10 heroin users, participants reported that three to four would speedball with powdered cocaine. Participants also noted that powdered cocaine is often used in combination with downers (depressant type drugs) in order to "come back up." A participant reported, *"I would snort coke after using heroin if I had to get things done — it would bring me back up so I could get things done."* In turn, a participant noted smoking marijuana with powdered cocaine, *"It [marijuana] helped me come back down so I could go to sleep [after using powdered cocaine]."* Another participant noted, *"My friends would do coke then pop 'X' [Ecstasy] and continue to do coke while they're on X."* Another participant noted that powdered cocaine can be bought at bars in the region: *"Alcohol and coke go hand-in-hand. Go to any bar downtown and you can get some coke."* Another participant reported that, *"I would use powder then pop some Xanax® and drink [alcohol] to come down [from powdered cocaine]."* The Mahoning County Coroner's office reported, *"Several drug-related deaths in the past year were a result of combining cocaine with ethanol [alcohol] or cocaine with narcotics."*

### Crack Cocaine Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants most often reported the drug's availability as '10' and community professionals reported it as '9.5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants continued to describe crack cocaine as extremely easy to get. The majority of participants and community professionals reported that the availability of crack cocaine had remained the same during the past six months. The most

common participant quality scores for crack cocaine were '2' and '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut with other substances. The BCI Richfield Crime Lab continued to cite caffeine, diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetics) as common cutting agents for crack cocaine. Participants reported that a gram of crack cocaine sold for between \$40-150. Participants agreed that the price of crack cocaine varied due to the quality of the product. Reportedly, higher quality crack cocaine was available if one was willing to pay the price. By far, the most common route of administration for this form of cocaine remained smoking. Participants and treatment professionals stated that crack cocaine use was a far-reaching problem that affected every socio-economic class.

### Current Trends

Crack cocaine remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. A participant reported, *"If you have never used crack cocaine, and you want to, go to any gas station in Youngstown. You will find a dope boy [dealer] outside trying to sell some crack [cocaine]."* However, there was consensus among participants in Columbiana County that crack cocaine is more difficult to obtain in smaller towns and rural areas. As one participant said, *"You have to take a drive to get it [crack cocaine] most of the time ... to Youngstown, Warren or Akron."* Another participant noted places where individuals can go to buy supplies for crack cocaine: *"My area has lots of [convenience stores and gas stations] that sell smoking devices and Chore Boy® [stainless steel scrubbing pad used as a screen] and a cheap lighter ... [you] just need to ask for a stem or rose [artificial rose that is attached to a glass stem used as a pipe]."* Community professionals most often reported the current availability of crack cocaine as '10'; the previous most common score was '9.5'. Law enforcement reported, *"Heroin is such a big problem. I know crack cocaine is out there, but the heroin ... heroin is such a raging fire; you're not going to worry about the guy cooking hotdogs [using crack cocaine]."* Media outlets in the region reported on several crack cocaine seizures during this reporting period. After local police resolved an altercation in Youngstown, they found one of the perpetrators was in possession of four grams of crack cocaine and two-and-a-half grams of marijuana ([www.vindy.com](http://www.vindy.com), July 5, 2011). In another incident, police from the Ashtabula Group Law Enforcement Task Force found crack cocaine, marijuana, drug paraphernalia and weapons after a three-month investigation of a Youngstown resident ([www.vindy.com](http://www.vindy.com), July 15, 2011). Participants reported that the

availability of crack cocaine has remained the same during the past six months. Many participants believed the drug is never going to leave the region. One participant said, *"Crack is out here ... in the last 22 years [that] I've been alive, it's been here. It's always going to be here."* Community professionals also reported that the availability of crack cocaine has remained the same during the past six months. The BCI Richfield Crime Lab reported that the number of crack cocaine cases it processes has remained the same during the past six months.

Most participants rated the current quality of crack cocaine as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common quality scores for crack cocaine were '2' and '6'. Participants reported that crack cocaine in the region is cut with aspirin, baby laxative, baking soda and a powder sold in head shops called *"Come Back."* The BCI Richfield Crime Lab continues to cite the following substances as commonly used to cut crack cocaine: caffeine and diltiazem (medication used to treat heart conditions/high blood pressure). There was agreement among participants that the quality of crack cocaine continues to depend on where and from whom one buys the drug. Participants reported that the quality of crack cocaine has remained the same during the past six months. A participant who reported crack cocaine use within the past six months said, *"If [crack cocaine] it's yellow and it looks like butter, it's really good quality stuff. If it's soft, it melts ... it's really, really good,"* but noted that this type of crack cocaine is very difficult to find.

Current street jargon includes many names for crack cocaine. The most commonly cited names remain "crack," "hard" and "rock." Participants listed the following as other common street names: "bo-bo," "butter (for high-quality crack cocaine)," "candy," "dope," "girl," "trap" and "work." A participant noted that the nickname "trap" came from, *"the idea that it [crack cocaine] will trap you. It's that bad. It'll just trap you — can't get out if it."* Current street prices for crack cocaine are as low as \$10 but can go even lower. A participant stated, *"You can get crack cocaine for a dollar even."* Another participant noted, *"Whatever you got, [dealers] they'll work with you."* Participants reported that a gram of crack cocaine sells for \$70, depending on the quality. Most participants agreed that crack cocaine is sold in dollar amounts (\$50, \$60, \$100) and did not know prices for specific weights. A participant commented: *"If you have \$16, you can get \$16 worth of crack."* While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. Out of 10 crack cocaine consumers, participants reported that approximately seven would smoke and three would intravenously inject. A participant reported, *"People will shoot [inject] crack if they want to speedball with heroin, but people mostly smoke it."*

A profile for the typical user of crack cocaine did not emerge from the data. Participants described typical users of crack cocaine as “everybody and anybody.” However, several participants agreed that users of crack cocaine tend to have low incomes and live in lower-income neighborhoods. A participant commented, “Crack is for, like, I don’t wanna say lower-level ... you know people that are struggling ... because it’s cheaper, and you know, it’s more available.” Several participants reported that their crack cocaine dealers were typically African-American, while users of crack cocaine can be African-American or White. A typical comment was echoed by one participant: “In my area, in my experience, my dealers [for crack cocaine] have been Black, and the people I know who use [crack cocaine] are White.” Other participants reported that older individuals are more likely to use crack cocaine than the younger population. One participant said, “Older people use crack, males and females about 40 years old and up.” An adolescent treatment provider reported, “You get a lot of young African-American males who will start selling it [crack cocaine], depending on their geographical region and the circumstances they grow up in, so maybe they smoke weed and do their thing, but they are selling crack cocaine as means of earning income.”

Reportedly, crack cocaine is used in combination with alcohol, heroin and marijuana. A participant explained, “I’ve used it [crack cocaine] with heroin. Crack’s an upper and heroin is a downer. Use crack after [heroin use] to get you back up, if you got things to do.” Participants also reported using alcohol and marijuana with crack cocaine to help in coming down from the stimulant high produced by crack cocaine.

## Heroin

### Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants and community professionals most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). While many types of heroin were available in the region, participants reported the availability of brown and white powdered heroin as most available. The majority of participants reported that the general availability of heroin had increased during the previous six months. The BCI Richfield Crime Lab reported that the number of powdered heroin cases it processed during the previous six months had increased. Participants most often rated the quality of heroin as ‘8’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). The BCI Richfield Crime Lab cited lidocaine and procaine (local anesthetics) as commonly used to cut powdered heroin. Participants reported that heroin was available in different quantities, selling for as little as \$10-20 for 1/10 gram quantities referred to as “bags,” “balloons,” “bindles,” “bundles” and “stamps;” a gram sold for between

\$50-160. While there were a few reported ways of consuming heroin, the most common route of administration remained intravenous injection, followed by snorting and then smoking. Participants estimated that 75-100 percent of heroin users intravenously injected heroin. Along with widespread reports of intravenous use of heroin were widespread reports of sharing of injection needles and Hepatitis C infections. The consensus among participant and community professional groups was that heroin users continued to be predominately White males and females between the ages of 20-35 years, although several community professionals also continued to report increasing heroin use among adolescents, particularly teenaged females.

### Current Trends



Heroin is highly available in the region. Participants and community professionals most often reported the overall current availability of heroin as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10.’ While many types of heroin are currently available in the region, participants reported brown powdered heroin as most available. Participants from Ashtabula, Columbiana, Mahoning and Trumbull counties reported that brown powdered heroin is easier to obtain than many other drugs. Participants stated, “In

Columbiana County, it’s easier to get heroin than marijuana — and it’s cheaper; I can go to four different drug houses within a block of where I live to get it [heroin]; [Heroin] it’s the easiest drug I know of to find in Youngstown.” Law enforcement officials noted that brown powdered heroin is the most common drug they encounter; reporting that throughout the entire region, heroin is the primary drug problem. Media from the region reported on recent arrests related to heroin during this current reporting period. In October, a Mahoning County grand jury indicted 10 people on charges related to the operation of a heroin-distribution ring. These 10 people were alleged to be responsible for bringing \$1 million worth of heroin to the Mahoning Valley ([www.vindy.com](http://www.vindy.com), Oct. 22, 2011). In July, the U.S. Attorney’s office released the names of 25 people wanted in a federal investigation into the sale of heroin in Youngstown ([www.vindy.com](http://www.vindy.com), July 1, 2011).

Participants reported black tar heroin as rarely available, rating its current availability as ‘2’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available extremely easy to get); the previous most common score was ‘4.’ A participant reported, “I never see black tar [heroin]. It’s around. It’s just hard to find.” A participant with experience using heroin said, “I never been around black tar. I’ve always used

*brown powder [heroin] ... never seen it [black tar heroin].* Participants noted that black tar heroin is the most potent of heroin forms. A participant stated, *"Black tar is the Ferrari® of heroin. But you really got to know someone to find it."* Community professionals also reported that black tar heroin is rarely available. A law enforcement official from Trumbull County reported, *"We haven't seen black tar at all ... always been brown powder [heroin]."* Law enforcement from Mahoning County reported having some cases involving black tar heroin, although brown powdered heroin is much more common.

Most participants and community professionals were not able to provide information on the availability of white powdered heroin. However, several participants older than 30 years of age reported that white powdered heroin is readily available: *"White powder ... [aka] China white ... is available in Youngstown and definitely [available in] Cleveland. I won't use brown powder ... it's crap; My dealer has a steady source of 'China white' so that's all I use. It definitely depends on who you know."* Most participants agreed that they had not specifically seen all-white powdered heroin, although some brown powdered heroin could include beige or cream-colored chunks or be light brown with "flecks" of white. Most participants agreed that they did not know if the white substance in brown powdered heroin is heroin itself or substances used to cut heroin. A participant described heroin as, *"Sometimes [heroin] it's real dark brown, almost cappuccino colored, and it varies to real light brown with flecks of dark brown or flecks of white or beige. It all depends."* Another participant described the consistency of brown powdered heroin as, *"wet, fine brown sand once you break it down."* The BCI Richfield Crime Lab described powdered heroin cases it processes as brown or white.

Participants reported that the availability of heroin has either remained the same during the past six months or has increased in some areas. One participant said, *"[Heroin availability] it's been a '10' [highly available] for a long while now."* Another participant with experience using heroin believed heroin to be more available: *"I think [heroin] it's more available now ... it did not use to be so available in some of the smaller towns out here."* Community professionals reported that the availability of heroin has remained the same during the past six months. A law enforcement official noted, *"Heroin over the past five years has been growing into a huge problem, and I don't know if it's growing steadily, but it's certainly not shrinking. So, now you have the old heroin users and the new ones."* The BCI Richfield Crime Lab reported that the number of heroin cases it processes has increased during the past six months.

Most participants generally rated the quality of heroin as an '8' on a scale of '0' (poor quality, "garbage") to '10' (high

quality); the previous most common score was '8'. A number of participants reported that quality can range from five to 10 as quality is said to depend on the dealer and from where the dealer's supply originates. A participant shared, *"This is going to sound crazy, but the girl that was with me [six months ago], she came with me to get heroin, and she overdosed on it. So, I went back to her dealer and bought it [heroin] off of him, because, well, it was obviously really good."* Participants reported that brown powdered heroin in the region is cut with antihistamines, baby laxatives, Benadryl®, sleeping pills and vitamins. A participant reported, *"Dealers will cut [heroin] with things to trick you ... heroin makes you nod off, so they'll cut it with Sleepinol® to increase your nod, you know, make you nod off a little faster, harder."* Another participant reported *"I know someone who used that bareMinerals® make-up ... it's very fine [in consistency] ... and it would make the [white] powder brown."* The Mahoning County Coroner's Office reported that out of roughly eight heroin-related deaths in the past year, two deaths were solely from heroin while the remaining six were from heroin mixed with narcotic pain relievers. The BCI Richfield Crime Lab cited caffeine and diphenhydramine (antihistamine) as commonly used to cut powdered heroin.

Current street jargon includes many names for heroin. The most commonly cited names were "boy," "dog food," "food," "H," "H-ron," "hard," "rock," "smack" and "Thai food." Participants reported that brown powdered heroin is available in different quantities: a "baggie" or "stamp" (1/10 gram) generally sells for \$20, however \$10, \$20 and \$30 stamps can also be purchased; participants reported buying heroin in "bundles" (10-12 small packs of heroin) for \$100, averaging \$10 per pack with each pack being the size of a dime, possibly a little larger or smaller depending on the quality; a gram of brown powdered heroin sells for between \$75-150, depending on the quality and county within the region. Participants noted that stamps are often folded within dense paper, specifically scratch-off lottery tickets. A participant with experience using heroin noted the price differences between smaller towns and rural areas of the region: *"People in Youngstown get more [heroin] for their money, and we get less [in Ashtabula]."* Participants reported that the most common way to use heroin remains intravenous injection. Out of 10 heroin users, participants reported that approximately nine would intravenously inject and one would snort. Law enforcement noted, *"We've seen younger people start with snorting it [heroin] then going onto injecting it."* Participants also reported this progression from snorting to injecting among heroin users, and treatment providers agreed. A treatment provider reported, *"It used to be alcohol, marijuana, some other things, and then opiates. Now, a lot of people are going from alcohol or marijuana straight to heroin, snorting and then injecting and sometimes, straight to injection"*

*if other opiates are no longer doing it [producing a high] for them.” In addition, several participants described a process where heroin users will draw out residue from the cotton used to inject heroin and reuse it. Other participants agreed reporting, “Rinse’ is when you pull out the cotton with the residue on it. You can put more water on it and shoot it or snort it or people will eat the cotton too; I know lots of people who do [reuse cotton or eat cotton]; they don’t want to waste the residue on the cotton ...”*

Most participants with experience using heroin reported obtaining needles from drug dealers and pharmacies: *“You can buy boxes of 500 [needles] at mom and pop pharmacies. They want the money, so they’ll sell them; I bought mine [needles] for \$2-3 from my dealer or went to Giant Eagle if my dealer didn’t have them ... told them [pharmacy staff] my grandpa is a diabetic.”* Another participant reported, *“My uncle was an addict, and he would go to Walgreens and sign the needle registry, and my friends would go through him [for needles], and so did I. I know places on the east side that are commonly-known houses that sell needles.”* Another participant also reported, *“Dope houses sell them [needles].”* There was consensus among participants that needle-sharing is a problem. One participant said, *“That’s rule number uno: never share needles and never use it [a needle] more than three times on yourself. I’ve seen people break needles off in their arms. You got to rinse them real good after you use them too — you can give Hep C [Hepatitis C] to yourself, most people don’t know that; almost everybody I know has Hep C. I’m waiting on my [Hepatitis C test] results.”* Participants universally shared concern over contracting Hepatitis C and HIV. A law enforcement official reported, *“It’s not uncommon to share needles. When I talk to users, most of them are extremely open about their use — they’ll show their track marks.”*

Participants described typical users of heroin as, *“all types of people.”* However, significant differences in age and race were noted. Most participants and community professionals agreed that heroin is a big problem among 18-25 year olds. A participant reported, *“I see younger people [using heroin], and then it skips a generation to older people who have been doing it for 30 years.”* Another participant noted, *“I think it’s the younger group now—teens and early 20s are using heroin. When I was growing up it was weed, Triple C’s [Coricidin®] we popped, than cocaine and meth [methamphetamine] got kind of big where I’m from, and then heroin has just completely taken over.”* Treatment providers agreed, with one reporting, *“Heroin has really become a bigger problem among the younger population. I would say maybe 40-50 percent of my adolescents/young adults use heroin.”* A law enforcement official reported, *“... We’re seeing young people from 17-25 [years] typically, who might have started with prescription drugs, and they are snorting heroin, but others who have been using for some time are injecting it. We see it more among Whites, a little more*

*males but an increase in females using.”* Law enforcement also noted that heroin affects all types of families. The Mahoning County Coroner noted, *“People dying from drug toxicity of heroin, and heroin and other substances, are Black, White, male and female.”* A treatment provider also reported, *“A lot of the women I work with are trauma survivors and most of them use either heroin or OxyContin® or now Opana® ... opiates.”*

Reportedly, heroin is used in combination with alcohol, crack cocaine, marijuana, powdered cocaine, prescription opioids and sedative-hypnotics. A participant reported, *“I never met anyone that just strictly does heroin.”* Crack cocaine and powdered cocaine are used in combination with heroin to speedball. Participants reported that four out of 10 heroin users might speedball using cocaine because it is said to intensify the high produced by heroin. Other participants noted that alcohol and marijuana are used to help level off or come down from the high of heroin. Other participants noted that crack or powdered cocaine is used by some after using heroin to, *“come back up.”* A participant reported injecting heroin and swallowing Xanax® to intensify her high: *“When you use Xanax® [with heroin], you get a lot higher, dangerously higher. I’ve overdosed using Xanax® with heroin.”* The Mahoning County Coroner reported that heroin-related deaths are typically from a combination of drugs: *“I’ve had two deaths in 2011 that were solely from heroin. We typically see heroin combined with other drugs, most commonly with other narcotic pain relievers. Anti-anxieties and alcohol are also typically mixed in with heroin deaths.”*

### **Prescription Opioids Historical Summary**

In the previous reporting period, prescription opioids were highly available in the region. Participants and community professionals most often reported availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants and community professionals continued to identify OxyContin®, Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Participants also noted increasing popularity of Opana® and Ultram®. Treatment providers noted the increasing popularity of Ultram® among adolescents. Participants reported that the availability of prescription opioids had remained stable during the previous six months, with the exception of OxyContin® OC which had decreased in availability. Several participants continued to describe ways to abuse the reformulated, more tamper-resistant OxyContin® OP. Participants reported that prescription opioids continued to sell for a dollar per milligram with a few exceptions. In addition to obtaining prescription opioids on the street from dealers, participants continued to report getting them from doctors, dentists,

emergency rooms, friends, family members and others with prescriptions. However, the consensus among participants and community professionals was that the most common route for obtaining prescription opioids was through area physicians. There were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids. Common routes of administration continued to include the following in order of highest report: swallowing/chewing, snorting and intravenous injection. There was no consensus regarding a profile of a typical user of prescription opioids.

### Current Trends

Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. Participants identified Opana®, Roxicodone® and Ultram® as the top three most popular prescription opioids in terms of widespread use. A participant reported, "Opana® is definitely the big thing now ... it's pretty potent—the 30s [30 mg pills]. Opana® replaced the old oxy's [OxyContin® OC], and no one wants the new oxy's [OxyContin® OP] now that they [Purdue Pharma] changed the make-up of them." A couple of participants with experience using heroin noted that prior to first heroin use, they used Ultram® before graduating to "stronger" prescription opioids: "I started [my drug use] with Ultram®, then went on to roxy's [Roxicet®] and oxy's [OxyContin®], and then started on heroin; Me too – exactly the same story." Another participant reported, "I don't know anyone who doesn't take Ultram®. They are so easy to get, and if you take enough of them, they'll get you to where you want to be." Community professionals most often reported the current availability of these drugs as ranging between '2' and '10', depending on the drug. Community professionals identified Opana®, oxycodone and Roxicodone® as the top three most popular prescription opioids in terms of widespread use. A law enforcement official noted that in Ashtabula and Trumbull counties, "Our search warrants primarily for heroin cases will reveal prescription opioids. Roughly five out of 10 [heroin] cases may include Opana®; nine out of 10 cases may include oxycodone and Roxicodone®." Another law enforcement official reported that in Mahoning County, "Opana® is just coming around. We haven't seen too, too much of it yet. Since the reformulation of the oxy's [OxyContin® OC], Roxicodone® has taken over ... 'blue boys' they call them ... have taken over."

Participants reported that the availability of prescription opioids, especially Opana®, has increased during the past six months. Participants also reported that OxyContin® OC is almost impossible to obtain now, and in turn, the availability

of Roxicodone® has seemingly increased as people seem to prefer it over the new reformulated OxyContin® OP. A participant reported, "I definitely think Opana® [availability] has increased in the last six months. I know a lot of people, especially heroin users, who use it, and I know three people I can call right now who have scripts [prescriptions] for them." Participants agreed that OxyContin® has decreased in availability and use. One participant said, "It's really easy to get the new oxy's [OxyContin® OP] now, but nobody really wants to bother with them. You can break them down and shoot them or peel the coating off and snort them, but it's a hassle." Several participants reported having seen an increase in Lortab® during the past six months. A participant reported, "This [Lortab®] was my drug. I brought mine from Alabama to sell up here. I bought them from somebody off the street there because they hadn't been up here much. That was my drug of choice ... the white ones." A treatment provider agreed, reporting, "There has been an increase of Lortab® in the last six months. I've been hearing about it a lot in my evaluations [intake procedure], but I don't think it's a drug of choice; something people will use if it's available." Community professionals reported that availability of prescription opioids has remained the same during the past six months with the exception of Lortab®. The BCI Richfield Crime Lab reported that the number of prescription opioid cases it processes has remained the same during the past six months.

Reportedly, many different types of prescription opioids are currently sold on the region's streets. Participants reported the following prescription opioids as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid® (aka "dilly's" and "dilly bars;" 4 mg sells for \$20; 8 mg sells for \$30), fentanyl 100 mg patches (aka "patches;" sells for between \$50-70), Opana® 40 mg (aka "bears;" "pana's," "pandas" "panda bears" and "yellow stop signs;" sells for between \$60-70), OxyContin® (aka "oxy's"), OxyContin® OC (old formulation, aka "OC's;" "Old Cars" and "Orange County;" sells for a minimum of \$1 per milligram), OxyContin® OP 40 mg (new formulation, aka "little boys" and "oranges;" sells for between \$20-30), Percocet® (aka "blues;" "greens;" "peaches" and "perc's;" sells for between \$12.50-27.50 per pill, depending on milligram dose amount), Roxicet® (aka "IR 15's;" "IR 30's" and "roxy's;" 30 mg sells for \$20), Ultram® (aka "trims;" sells for between \$.50-1.50 per pill) and Vicodin® (aka "vic's;" 5 mg sells for between \$1-2; 7.5 mg sells for between \$2-3; 10 mg sells for between \$4-7). Participants reported that Ultram® and Vicodin® are seemingly "given away" due to other prescription opioids being in higher demand. A participant reported "My aunt has a prescription and gives me those [Ultram®] ... nobody really wants those." Another

participant with experience using crack cocaine said, *"My dealer would just give those [Vicodin®] away ... asked me if I wanted any vic's or perc's."*

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 snorting and swallowing. Most participants agreed that prescription opioids are more commonly snorted rather than swallowed among 18-25 year olds. Many participants agreed that the new formulation of OxyContin® can and are broken down to be snorted and injected. Many participants with experience injecting heroin reported injecting prescription opioids. One participant said, *"I would shoot pain killers to avoid getting dope sick."* In addition, many participants distinguished between eating and swallowing prescription opioids, where participants reported either chewing the pills and then swallowing instead of swallowing the pill whole. Other participants reported crushing the pills first, putting them in their mouth, and then swallowing them. A participant reported, *"I'd crush them [prescription opioids] up and put them in my mouth or chew them. Once I figured out how to shoot [inject] them, I never really did that anymore [chewing pills]."* Another participant reported *"Oh, I chew my pills up – definitely. They just get into your bloodstream a lot quicker and you get higher than if you swallowed."* A participant also reported having smoked prescription opioids: *"I personally put them [prescription opioids] on tin foil and smoke them. That's how I did my heroin too. I didn't snort pills; I'd either shoot them or smoke them."*

In addition to obtaining prescription opioids on the street from dealers, participants also reported getting them from pain management clinics, private physicians and hospital emergency rooms, as well as from family and friends who have prescriptions. Participants reported: *"I had three different people going to doctors and they would give me their scripts; I have back problems, so I have a script of Ultram®; I started at a very young age. When I was 12 [years old], I took oxy 80s [OxyContin® 80 mg]; I wasn't prescribed them obviously. I was stealing them from my mom here and there; I bought them [Opana®] from old people in their 50s, 60s. They don't know how much their worth, so I bought them from them for \$25 or so ... knowing I could get \$60 for one."* Participants reported that many people know which doctors to go to for prescription opioids. One participant said, *"When you're on the street, you know which doctors will write you a script."* Most participants agreed that doctors will often take cash instead of insurance for prescription opioids. Several participants reported that some prescription opioids can be purchased online.

Generally, prescription opioid use seems to be very common among those 18-25 years old. However, participants agreed that all types of people take prescription opioids. One participant said, *"I think [prescription opioid use] it's really common among young people. I've seen 14 and 15 year olds taking trims [Ultram®]. At the same time, you see older men, older dope dealers taking them."* Another participant said, *"[Prescription opioid use] it's definitely common among young people because it's easier for them to get [prescription opioids]. They can take them from parents ... they can find them anywhere. I know kids who are 16 [years old] and they won't go to school if they don't got them."* Several law enforcement officials agreed that primarily young people between the ages of 17-25 years use prescription opioids and most often in combination with heroin. One law enforcement official said, *"We [law enforcement] are seeing more Caucasians than other groups, younger people who are working, with minimum-wage jobs [abusing prescription opioids] ... some are college educated."* Additionally, many treatment providers agreed that the older adult clients are introduced to prescription opioids due to a physical ailment, whereas adolescent and young adult clients are experimenting and accessing prescription opioids through friends and family.

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, heroin and marijuana. Participants who used prescription opioids with alcohol reported doing so to intensify their high. Participants agreed that heroin is commonly used with prescription opioids. A participant with experience using heroin noted, *"... I shoot roxy's [Roxicet®] and Opana® with it [heroin]."* The Mahoning County Coroner's Office reported that among drug toxicity-related deaths, *"The real common 'cocktail' [combination] most commonly, is one of the anti-anxiety drugs combined with one of the narcotics. Maybe a little bit of alcohol mixed in. That's the common killer, and it is common among 18-25 year olds."*

### **Suboxone® Historical Summary**

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers most often reported availability as '5'. Participants and community professionals reported that the street availability of Suboxone® had increased during the previous six months, and that Suboxone® 8 mg sold for between \$10-30, with the most frequently reported price being \$20-25. Most often participants continued to report taking Suboxone® sublingually (dissolving it under the tongue); however, participants also continued to

report snorting and intravenous injection of the drug. In addition to obtaining Suboxone® on the street from drug dealers, participants continued to report getting the drug from doctors and from others in Suboxone® maintenance programs. While acknowledging that Suboxone® was tremendously beneficial to those who took the drug as directed for its intended purpose, participants continued to widely report abuse of Suboxone® by those addicted to opiates who used the drug to keep from experiencing withdrawal between opiate purchases, and by those not addicted to opiates who sought a high. Participants reported that benzodiazepine use with Suboxone® was very common.

### Current Trends

Suboxone® remains highly available in the region. Participants most often reported current availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. However, participants in Mahoning and Trumbull counties reported higher availability than participants in Ashtabula county. One participant said, "In Youngstown, [Suboxone® availability] it's a '10' [availability rating], but [availability in] Ashtabula, most times it's an '8.' It's a little bit harder to find." A participant reported, "I would go to a doctor and get 90 [Suboxone® pills] a month. You don't need that many at all. I'd sell them \$10 a piece and make 900 bucks. They're very accessible—huge demand. Nobody wants to be dope sick." Another participant reported, "Any user can get a Suboxone® prescription ... pretty easy. All you really need is half of one [Suboxone® pill] or a quarter of it at a time. I knew I could sell all but 15 for the month. I would sell mostly all of them to the dope boy [heroin dealer] ...". Community professionals most often reported the drug's current availability also as '10'; the previous most common score was '5'. A law enforcement official reported, "Our search warrants usually reveal heroin with prescription opioids, with some mixture of Suboxone®. About three cases out of 10 might include Suboxone®." Participants and community professionals reported that the availability of Suboxone® has remained the same during the past six months. A participant stated, "[Suboxone®] it's been really easy to get for a while now." A law enforcement official described the techniques of drug dealers who sell Suboxone®: "It's a good marketing strategy for oxy/roxy/heroin dealers to sell Suboxone®. You get people that want to recover but can't afford the script, or the doctor visit, or whatever. It's just a way to keep them on the line." The BCI Richfield Crime Lab reported that the number of Suboxone® cases it processes has increased during the past six months.

Participants did not report any known street names or jargon for Suboxone®. Participants reported that Suboxone® 8 mg most often sells for between \$10-15. A participant added, "If someone is really dope sick though, a dealer can get

away with charging \$20 [for Suboxone® 8 mg]." In addition to taking Suboxone® sublingually, participants reported taking Suboxone® via snorting and intravenous injection. Participants reported that at least six out of 10 Suboxone® abusers would snort Suboxone®. A participant reported, "People do snort them [Suboxone®], and I've seen people try to shoot the [Suboxone®] strips. I would puke every time I snorted Suboxone®. My boyfriend and I would split a pill and it would get us high for two days." Another participant reported, "I would stock up on them [Suboxone®]. I prefer strips, you can't taste them. The pills have a really bad taste. I'd cut the strips and take 2 mg." Other participants with experience using Suboxone® said: "Most people will snort the pills or shoot the strips ... it gets you much higher; I quartered the 8 mg [Suboxone®] and snorted a quarter and got so high; You can shoot the [Suboxone®] pills or the strips; Take about 2 mg of the strip ... and dilute it in water, mix it up."

In addition to obtaining Suboxone® on the street from dealers, participants also reported getting prescriptions from substance abuse treatment clinics and doctors: "Most people in recovery are on it [Suboxone®]. If you're not prescribed it, you can easily find someone who is." Participants described typical users of Suboxone® as heroin users, including young people between the ages of 18-25 years. Reportedly, Suboxone® is used in combination with crack cocaine, marijuana and powdered cocaine. A participant who had experience using Suboxone® reported, "I mixed it [Suboxone®] once with coke or crack but never with heroin or other opiates." A participant who used marijuana in combination with Suboxone® reported, "I would smoke weed with it [Suboxone®], to help with the withdrawals." Another participant warned, "Never combine [Suboxone®] with opiates, but I'd use benzo's [benzodiazepines] and marijuana with it. I did xani's [Xanax®] with it."

### Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were 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' (highly available, extremely easy to get). Community professionals indicated that availability ranged from '6' to '10'. Participants and community professionals reported that availability had either remained the same or had increased during the previous six months and identified Klonopin® and Xanax® as the two most popular sedative-hypnotics in terms of widespread use. In addition to obtaining sedative-hypnotics from dealers, participants reported visiting area doctors to obtain prescriptions for these drugs. The most common routes of administration were oral consumption and snorting. Most

participants and treatment providers believed that sedative-hypnotic use was widespread and transcended race and socio-economic status.

### Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants most often reported current availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. Participants continued to identify Xanax® as one of the most popular sedative-hypnotics in terms of widespread use, followed by Klonopin® and Valium®. A participant reported, "*Benzo's [benzodiazepines] are definitely a '10' [highly available]. Xanax is the most popular, and 2 mg Klonopin is a little less popular.*" Community professionals most often described the current availability of these drugs as '8'. Community professionals identified Klonopin® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. In addition, treatment providers reported an increase in the prescription Trazadone®. A treatment provider working with adolescents explained the increase: "*[Trazadone®] it's being prescribed a lot more, and it's been popular with the kids in the last year.*" Another provider reported, "*People do abuse Trazadone® a lot ... doctors prescribe it and say 20-60 mg as needed which can be refilled every 30 days, so it's like a 90-pill supply in 30 days ... I definitely think it's a triggering drug for people; they get a good buzz from it.*" There was consensus among law enforcement that sedative-hypnotics are not as common as other prescription drugs found in warranted searches. A law enforcement official explained, "*We see very little of Xanax® and Klonopin®. We're not specifically purchasing them, but we might come across these in the search warrants.*" However, the Mahoning County Coroner's Office reported that among drug toxicity deaths, "*Xanax® and Valium® are the top two [benzodiazepines] seen in sedative-hypnotics [related deaths].*" In addition, community professionals reported a decrease in Ambien® abuse during the past six months. A treatment provider explained, "*We've seen a lot less of Ambien® in the last six months. I don't know if it's being prescribed less or if less of it is being abused because other drugs take precedence ...*" The BCI Richfield Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months, with the exception of a decrease in cases related to Librium®.

Reportedly, many different types of sedative-hypnotics (aka "B's," "benzo's," "downers" and "skittles") 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): Klonopin® (aka "pins;" sells for between \$1-2 per pill), Soma® (sells for \$2 per pill), Valium® (aka "V's;" sells for between \$1-2 per pill) and Xanax® (0.5 mg, aka "bars," "blues," "candy bars," "footballs," "greens," "ladders," "peaches" and "xani's;" sells for \$1; 1 mg, aka "footballs;" sells for between \$2-3; and 2 mg, aka "bars" and "xanibars;" sells for between \$3-5). In addition, participants and community professionals agreed that Xanax® 2 mg is more popular in terms of widespread use. A community professional reported, "*Everyone talks about the bars. It seems like people don't want the footballs anymore.*" A participant agreed, "*Bars are the most popular, the most in demand.*" While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, generally, the most common routes of administration remain oral consumption and snorting. A treatment provider reported on a new route of administration appearing to be more common among adolescents and young adults: "*I have heard of kids 'parachuting' more. We did have a kid that crushed up Xanax® and put it in a tissue and put it in his rectum. He was not from this area though but talked about how high he got doing it that way.*" Another treatment provider agreed, "*I did have a guy, an opiate addict that did use these [sedative-hypnotics] like a suppository.*"

In addition to obtaining sedative-hypnotics on the street from dealers, participants also continued to report getting them from family members and area physicians. A participant reported, "*Doctors hand them [sedative-hypnotics] out like candy. I go to the doctor and say, 'I have panic attacks every day.' It's really easy to get a script.*" Many participants agreed that dealers selling drugs such as heroin will give away sedative-hypnotics to heroin consumers at the time of purchase. Other participants agreed that they could obtain sedative-hypnotics for free from friends or family members with prescriptions. A participant reported, "*Really easy to get [sedative-hypnotics] ... people just give them away.*"

A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants continued to report that typical use transcended age, gender and race. As one participant said, "*I've seen people in their 50s and 60s take them [sedative-hypnotics], and 15 year olds takin' them.*" Participants agreed that individuals 50 years old and older are more likely to use Soma® than younger people: "*Soma® is old school. My uncle has a script for those; Soma® is for the older crowd. You don't see young people messin' with it.*" Most participants agreed that Xanax® use is very common among young people. One participant said, "*Everybody uses these [sedative-hypnotics]; there's no profile. I think Xanax® is probably more popular among 18-25 year olds versus other benzo's.*" Another participant reported, "*I started with Valium® when I was 16 [years old], then went to Ativan®, then went to Xanax®*"

...“In contrast to participants, community professionals reported differences in gender with sedative-hypnotic use. A community professional said, “I just see so many more females who use these drugs [sedative-hypnotics] or have prescriptions for them. People who have anxiety or think they have anxiety.”

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, heroin, marijuana and prescription opioids. Participants reported: “I would take Soma®s only if I was going out to the bar [to drink alcohol], or if I was dope sick; Pretty much all benzo’s go hand in hand with alcohol. If you want to blackout, Xanax® is best for blackouts; I would use weed and alcohol with Xanax®. I snorted it ... the Xanax® ... just makes you that much more [expletive] up.” Other participants confirmed that Xanax® and other sedative-hypnotics are commonly used in combination with other drugs. A participant explained, “I combined it [Xanax®] with heroin, OC’s [OxyContin® OC], other opiates; All heroin addicts I know take Xanax® and Klonopin®.”

## Marijuana

### Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants and community professionals most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Community professionals believed that marijuana was the most available drug in the region. Law enforcement reported an increase in indoor growing operations and growing covertly on public and private property. The BCI Richfield Crime Lab reported that the number of marijuana cases it processed remained the same during the previous six months. Reportedly, the quality of marijuana varied, and participants said high-quality marijuana was the most prevalent form. Participants reported that for commercial-grade marijuana, a “blunt” (cigar) sold for between \$5-10, and an ounce sold for between \$130-140; for high-grade marijuana, a blunt sold for between \$10-20, and an ounce sold for between \$250-400. The most common route of administration for marijuana continued to be smoking. Participants reported that marijuana use was prevalent for men and women of all races and ages.

### Current Trends

Marijuana remains highly available in the region. Participants and community professionals most often reported the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get); the previous most common score was also ‘10.’ Participants had various opinions on the availability of



marijuana in the region: “Weed is weed ... it’s everywhere; You can get dirt weed [commercial-grade marijuana] anytime, anywhere. The good stuff [high-grade marijuana] is a little harder to find; My whole family is a bunch of potheads [marijuana users], and we go to Canton to get our weed, a couple pounds at a time.” A law enforcement official agreed with participants, “Marijuana is one of our top three biggest drugs, and we always see it with other drugs ... frequently in cocaine houses, heroin houses ...”

Participants reported that the availability of marijuana has increased during the past six months. Many participants agreed that the end of summer/beginning of fall is peak time for marijuana distribution. A participant reported, “Right now it’s harvest time, a lot of good homegrown [marijuana] will be coming out. Summertime is usually dry, that’s the driest time when it’s hardest to find [marijuana].” Community professionals reported that the availability of medical marijuana has increased in some areas during the past six months. A law enforcement official reported, “In Mahoning County, law enforcement reported that within the last six months ... we’ve seen several instances of high-grade quality medical marijuana selling for huge profits at \$3,500-3,800 a pound. Medical marijuana from the West ... that movement is finding a retail market here in Mahoning County. We’ve had at least two cases and other seizures.” Another law enforcement official agreed, “There has been an influence from the medical marijuana movement in California. We just had a female who was having five to 10 pounds shipped here every month.” The BCI Richfield Crime Lab reported that the number of marijuana cases it processes has remained the same during the past six months.

Participant quality scores of marijuana ranged from ‘4’ to ‘10’ with the most common score being ‘7’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); previously, participants did not give a score for marijuana quality, but said all grades of marijuana were available. Many participants explained that the quality of marijuana continues to depend on whether the user buys commercial (low- to mid-grade) marijuana or hydroponically grown (high-grade) marijuana. A participant reported, “You can find ‘downtown dirty brown’ ... that ‘Youngstown dirt weed’ [commercial marijuana] anywhere ... tastes terrible, but if you smoke enough of it though, it’ll get you high.” Another participant stated, “That brick weed [commercial marijuana] ... Mexican brick weed is bad. It’s all compressed, like in a brick, and when you break it open, it’s all seeds and stems.” Many participants reported that very high-grade marijuana is difficult to find: “If you got that nice bright green, crystals and red hairs—that’s some dank [high-grade marijuana]. It’s a lot harder to get [high-grade marijuana]”

*though; Kids will say, 'oh I got that purple haze' [high-grade marijuana], [but I say] no you do not. You do not have purple haze."*

Current street jargon includes countless names for marijuana. The most commonly cited names were "buds," "green," "pot," "trees" and "weed." Participants listed the following as other common street names: "backyard," "commerish," "mids," "middies," "reggie" and "regular" for commercial-grade marijuana; "dank" and "fruity pebbles" for high-grade marijuana; and "AK-47," "Alaskan big bud," "Christmas bud," "exotic," "hydro," "orange kush," "pineapple express" and "white widow" for hydroponically grown marijuana. A participant reported a new type of marijuana: *"I've heard of 'Conrad Murray' making its way here. It's medical marijuana from California. They call it that because it will put you to sleep."* The price of marijuana depends on the quality desired. Participants reported that commercial-grade marijuana remains the cheapest form: a blunt, two joints or a "dimebag" (\$10 worth of loose marijuana sold in a plastic baggie) sells for \$10; 1/8 ounce sells for between \$20-25; an ounce sells for between \$90-120; 1/4 pound, or "QP," sells for between \$400-425; a pound sells for between \$750-1,000. Higher-grade marijuana sells for significantly more: a blunt, two joints or a dimebag sells for between \$20-30; prices for larger quantities of high-grade marijuana were not known by participants. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. All participants with experience using marijuana reported smoking it, with many noting that five out of 10 people might eat marijuana in food products like brownies and cookies. A participant reported, *"My friend just got busted with the whole back of his trunk full of [marijuana] Rice Krispies™ treats."* Several participants reported using marijuana in food recipes. A participant explained, *"Mostly [people] who grow it [marijuana] take off the stems and seeds and simmer it in olive oil [and] use it to cook with."*

Participants described typical users of marijuana as having no profile in particular, with one saying, *"Weed does not discriminate."* Participants agreed with a fellow participant's comment that marijuana users can be, *"anybody and everybody, to elementary kids to grandparents and great grandparents."* A participant talked about early first use of marijuana: *"I was in fifth grade when I smoked weed for the first time; then sixth or seventh grade [I] started to smoke almost every day."* A law enforcement official agreed that it is difficult to identify a typical user of marijuana: *"Everybody and anybody uses weed."* A treatment provider reported, *"I often see people who started with marijuana but then came into treatment for something else, something harder, and go through treatment and return to using marijuana."* Several

other treatment providers reported that drug consumers use marijuana as a sleep-aid or to help relieve mental health symptoms: *"Almost all of my clients use marijuana. I hear, 'it's the only thing that puts me to sleep.'" Another provider reported, "With the dual-diagnosis clients I work with, I do believe that it [marijuana] helps ease their psych [psychiatric] symptoms ... but when they are on prescribed psych meds, marijuana compromises the efficacy of their psych meds, and they say, 'the meds aren't helping me."*

Reportedly, marijuana is used in combination with numerous different drugs including alcohol, crack cocaine, heroin, powdered cocaine, prescription opioids and sedative-hypnotics. A participant explained, *"Marijuana is the gateway [to other drug use]. You either drink [alcohol] first or you smoke pot or both, then start taking pills."* Several participants mentioned using cocaine or other drugs with marijuana: *"I would smoke weed after using coke ... to help come down so I could go to sleep; Most people I know either drink [alcohol] and smoke or use weed to help come down from another drug."*

### **Methamphetamine Historical Summary**

In the previous reporting period, methamphetamine was moderately available in the region, both in crystal and powdered forms. Participants rated the availability of methamphetamine as '6.5' (median score) on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Community professionals most often reported the drug's availability as '3'. Participants who reported personal methamphetamine use primarily lived west of Youngstown or in Ashtabula County. Participants believed that availability of methamphetamine had decreased in some areas of the region due to drug seizures, and had increased in other areas of the region due to increased demand. The BCI Richfield Crime Lab reported that the number of crystal and powdered methamphetamine cases it processes had increased during the previous six months. Participants reported that 1/2 gram of powdered methamphetamine sold for \$20 and that the most common route of administration was smoking. Treatment professionals described typical methamphetamine users as White males, between the ages of 30-50 years.

### **Current Trends**

Methamphetamine is relatively rare in some parts of the region and highly available in other parts of the region. Participants most often reported the current availability of methamphetamine as '2' in Mahoning and Trumbull counties and as '10' in Ashtabula County on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy

to get); the previous median score was '6.5'. Participants reported that methamphetamine is most often available in powdered form, which is homemade using the "shake and bake" or "one-pot" method (methamphetamine production in a single sealed container, such as a two-liter soda bottle). Some participants had not seen methamphetamine in Youngstown. As one participant said, methamphetamine is more common in neighboring counties: *"I've never seen meth [methamphetamine] in Youngstown really. It's more in Ashtabula, up in Geneva."* A participant with experience using methamphetamine reported, *"Ashtabula has a huge meth problem. I got mine in Conneaut. They call it the meth capital of Ohio."* Treatment providers most often reported the drug's current availability as '4', specifically in Mahoning and Trumbull counties. In addition, treatment providers also reported that clients with experience using methamphetamine reside outside of Mahoning and Trumbull counties. A treatment provider explained, *"We do have folks using methamphetamine or it's in their drug history, but they come from someplace else, Ashtabula or Lake County."* In addition, law enforcement reported that out of 10 drug cases, one might include methamphetamine. A law enforcement official explained the low incidence of methamphetamine-related arrests: *"About a year ago the federal government announced [that] they will no longer cover clean-up costs for meth labs. You have to find the money locally to do it. There might be more aggressive action for meth if we knew we had the funds and manpower to do it. We're not ignoring it, but we're not going after it as aggressively as we'd like."* Another law enforcement official said, *"We just don't see it [methamphetamine]. We did one lab this year. Other counties just have a huge meth problem, but we don't necessarily see it. Heroin is our raging fire."* Participants and community professionals reported that the availability of methamphetamine has remained the same during the past six months. The BCI Richfield Crime Lab reported that the number of methamphetamine cases it processes has remained the same during the past six months. The crime lab also reported that brown and white powdered methamphetamine were the most commonly processed types.

Current street jargon includes a few names for methamphetamine. The most commonly cited names were "basement born," "chicken feet," "crank," "glass," "go-fast," "go-go," "jib," "jimmy crank," "meth" and "tweak." A participant described the different forms of methamphetamine this way: *"Basement born meth is homemade with phosphorous; that's the most common. Then there are the actual crystals, and they're the best you can get, but it's harder to find. You smoke the crystals, and you can snort them too, but I wouldn't advise that. It burns. I've never seen anyone shoot them, shooting*

*would be insane because you can kill yourself so easily."* Participants reported that a gram of methamphetamine sells for between \$80-120, depending on the quality; 1/16 ounce sells for \$150; 1/8 sells for \$250. Participants also reported powdered methamphetamine (aka "shake and bake" or "basement born") sells in \$20 quantities. A participant reported, *"You can buy a 20-bag [of methamphetamine] for \$20. It's like two lines in the bag."* Participants also reported that crystal methamphetamine is almost impossible to find. As one participant explained, *"Crystal is more West Coast. I think maybe ten years ago there was more crystal but now, this method [shake and bake] is easier and safer. It's like a mobile lab, you can't find crystal anymore – it's all crank."* Crank is a term for lower-quality methamphetamine created through the "shake and bake" method.

Reportedly, the most common route of administration of methamphetamine remains smoking. Snorting and eating methamphetamine in capsule form were also cited as routes of administration. Participants commonly reported: *"You can get the [methamphetamine] capsules. Usually people will use those ... after your nose is too raw, you'll start eating it; I smoked it [methamphetamine] in foils or would clean out the inside of a light bulb and smoke it. I snort meth too sometimes ..."* Participants reported that out of 10 methamphetamine users, three would inject methamphetamine and "speedball" with heroin. A participant reported, *"Speedballing with meth and heroin is huge up here [Ashtabula County]."* Another participant agreed, *"I smoke meth, but my friends who shoot, they speedball with Adderall" or sometimes heroin. I would be like, 'How are you so mellow right now?' Until I found they were shooting with heroin too."* Participants described typical users of methamphetamine as Whites between 20-40 years of age, possibly from more rural areas of the region.

Reportedly, methamphetamine is used in combination with alcohol, heroin and marijuana. A participant explained that he used methamphetamine with several different drugs: *"I used it [methamphetamine] with weed sometimes to help come down ... I would drink [alcohol] to come down ... used it with heroin a couple times too, just to get really [expletive] up."* Other participants agreed that users typically smoked marijuana with methamphetamine. As one reported, *"Most people I know [who use methamphetamine] will smoke, mostly after using meth to come down [to] stop them from getting too low. Some people will use it while smoking meth just to level out a little bit."*

### **Ecstasy** **Historical Summary**

In the previous reporting period, Ecstasy (methylenedioxymethamphetamine: MDMA, or other

derivatives containing BZP, MDA, and/or TFMPP) was moderately available in the region. Participants rated the drug's availability as '6.75' (median score) on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), while treatment providers most often rated availability as '7'. The availability of Ecstasy was thought to vary depending on the season; most participants considered Ecstasy a "summertime" drug. The BCI Richfield Crime Lab reported a decrease in the number of Ecstasy cases that it processed during the previous six months. Participants reported a "single stack" (low dose) Ecstasy tablet sold for between \$5-8 and a "double stack" or "triple stack" (high dose) tablet sold for between \$12-20. The BCI Richfield Crime Lab cited methcathinone analogs (psychoactive stimulants) and bath salts as cutting agents for Ecstasy. Participants and community professionals described the typical Ecstasy user as a young adult between 18-30 years of age.

### Current Trends



Ecstasy (methylenedioxymethamphetamine; MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) continues to be moderately available in the region. Participants reported the current availability of Ecstasy as '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous median score was '6.75'. Many participants agreed that Ecstasy is highly available at a quarry in the region where spring, summer, and fall music festivals are held. A participant explained, "Nelson Ledges — if you want to trip, that's where you go. They have lots of Ecstasy, lots of acid, mushrooms. Mostly in the summertime, they have festivals, bands ... you camp out." Community professionals reported a decrease in Ecstasy among clients during the past several years. Treatment providers and other professionals explained, "We just don't hear about it [Ecstasy] anymore. A lot of the women I work with report using Ecstasy in their youth and [use it] every once in a while, maybe once a year or less; Ecstasy has kind of dropped off ... I see people wanting that hallucinogenic high will use OTCs [over-the-counter drugs] like triple C's [Coricidin® Cough and Cold]." The BCI Richfield Crime Lab reported that the number of Ecstasy cases it processes has decreased during the past six months.

Current street jargon includes few names for Ecstasy; the most commonly cited name was "X," and participants described "rolling" to mean a person high on Ecstasy. Participants reported that Ecstasy tablets typically sell for between \$15-20, but they also said users can get discounts for buying large quantities. A participant reported, "You can get a pack [of Ecstasy tablets]. The more you get, and the

cheaper per pill [it] will be." Another participant discussed the quality of Ecstasy: "The quality varies; some of it [Ecstasy] is just garbage. Out of 10 options, four would be good." The most common route of administration is oral consumption. A participant reported a less common method: "I've heard of people sticking pills [Ecstasy tablets] in their butts ... I have no idea why ... younger kids I'm guessing." Another participant also reported this trend: "My little brother stuck Ecstasy in his butt because it doesn't go through all the filtration system. It dissolves into your rectum and right into your bloodstream." Many community professionals reported that Ecstasy remains popular among young adults. A treatment provider reported, "I've had four or five young adults in the past year reporting Ecstasy use, but it wasn't their drug of choice"

### Prescription Stimulants

#### Historical Summary

In the previous reporting period, prescription stimulants were highly available in the region. Participants most often reported availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Vyvanse®, a newer drug to treat symptoms of attention deficit hyperactivity disorder (ADHD), was also mentioned as being available by a minority of participants. Participants reported that Adderall® sold for between \$1-6 per pill. While participants did not provide a profile for a typical user, they agreed with one participant who said the most likely person to abuse these medications was someone looking to "use it [prescription stimulants] as a substitute for methamphetamine." The BCI Richfield Crime Lab reported that the number of prescription stimulant cases it processes had remained the same during the previous six months.

#### Current Trends

Prescription stimulants remain highly available in the region. Participants rated the current availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '10'. Generally, participants reported that Adderall® is highly available, followed by Concerta® and Ritalin®, which were both believed to be somewhat available. A participant explained, "I'd say Adderall® is the easiest to get, then Ritalin®, then Concerta®, but I don't think doctors are prescribing Ritalin® as much anymore." Treatment providers reported no change in the general availability of prescription stimulants during the past six months, but noted an increase in the generic form of Adderall®. A treatment provider explained, "I don't really see Ritalin® with the adolescents; I see more Vyvanse® and definitely an increase in generic Adderall®, that's been new." Law enforcement did not report seeing many prescription

stimulants in the region. The BCI Richfield Crime Lab reported that the number of prescription stimulant cases it processes has remained the same during the past six months, with the exception of a decrease in cases related to Dexedrine®.

The only reported street jargon for prescription stimulants was one name for Adderall®: “addies.” Participants reported that Adderall® typically sells for \$2 per pill. A participant explained the pricing of prescription stimulants: “The blue ones [generic Adderall® tablets] go for \$2. You can get Concerta®, Vyvanse® for cheaper.” Participants reported getting prescription stimulants from doctors or from people with prescriptions. A participant reported, “Doctors prescribe it [stimulants] pretty easy.” Many participants 25 years of age or younger with experience using prescription stimulants reported having been prescribed Adderall® or Vyvanse® for diagnosed ADHD.

Participants described typical users of prescription stimulants as teenagers or young adults: “I’ve seen college kids use it [prescription stimulants] to study. I used it to study; I’ve seen 18-25 year olds and younger — high school [use prescription stimulants].” Treatment providers also reported prescription stimulants as most common among adolescents and young adults. A treatment provider reported, “I do see it [prescription stimulants] with my younger population. I see opiates more with my older group.”

Reportedly, prescription stimulants are often used in combination with numerous other drugs including alcohol, bath salts, marijuana, sedative-hypnotics and synthetic marijuana (“K2” and “Spice”). Typically, participants reported using prescription stimulants to modify the effect of taking a sedative-hypnotic or other depressant. A participant explained, “I used Adderall® after taking a downer if I had s\*\*\* to do. People will take these [prescription stimulants] after taking downers to get back up.” Other participants reported, “I would swallow an Adderall® and then snort one why I was waiting for the other to kick in; to get that instant gratification; I used bath salts and smoked Spice [synthetic marijuana] while using Adderall®. I’ve only done that combo a few times — never again. I thought I was going to go crazy.”

### Bath Salts<sup>1</sup>

#### Current Trends

Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) were highly available in the region prior to the enactment of legislation in October 2011 which banned their sale. Participants and community professionals mentioned bath salts use numerous times; availability of bath salts since the ban went into effect is unclear. A participant commented about the popularity of bath salts among high

**1 None of the participants had personal experience with bath salts in the previous reporting period; therefore, there is no historical summary.**

school students: “My sisters are in high school, and they say a lot of friends are doing it [bath salts].” Other participants talked about the negative health effects of bath salts: “I had a friend who used them [bath salts]. She said she was up for two days after using just a little bit of them; I call it [bath salts] the devil. I went completely paranoid on it. It was traumatic for me ... you can see my arms; I’ve picked everywhere. I went to the psych [psychiatric] ward three times in five months.” The BCI Richfield Crime Lab reported that the number of bath salt cases it processes has increased during the past six months.

While participants did not speak about the quality of bath salts, they said bath salts are commonly used to adulterate other drugs. A participant explained, “I’ve seen it [bath salts] used to cut meth with. People were going crazy from it.” In addition, the Mahoning County Coroner’s Office reported that their office has had cases with bath salts and synthetic marijuana: “The ‘designer drugs’ ... the K2 [synthetic marijuana] ... the bath salts, salvia [divinorum] ... they only come to my attention when they are part of a multiple-drug toxicity ... you know, we’re looking for other things ... and, ‘Oh, what’s that?’ Now we’re finding in tests, or when we’re at the death scene ... we’ll see the packaging for salvia or bath salts, and then we’ll specifically test for that.” The most common routes of administration for bath salts are snorting and smoking. A participant discussed the routes of administration: “[Bath salts] it’s like meth or speed. You can snort it, smoke it, shoot it. You know, it’s like Spice [synthetic marijuana], same concept ... it’s ‘not for human consumption’ because it’s supposed to be incense.”

Treatment providers agreed that adolescents and young adults are more commonly using bath salts than other groups. A treatment provider reported, “I feel like the people who use bath salts are 18-20 [years of age] ... and I’ve heard about it more outside in the community, possibly because kids are not in treatment yet for it.” Reportedly, bath salts are often used in combination with several other drugs including salvia divinorum (psychoactive plant) and synthetic marijuana. A participant described the effects of combining bath salts and synthetic marijuana: “I was snorting bath salts and smoking Spice [synthetic marijuana] and started hallucinating ... I screamed for my sister and she came into the bathroom and that’s when she woke my parents up. I went into PHP [partial-hospitalization treatment] at that point.” A law enforcement official also reported that bath salts are commonly used with other drugs. An officer reported, “We have been getting complaints recently about bath salts in combination with heroin use.”

### Other Drugs

#### Historical Summary

In the previous reporting period, participants and community professionals listed the following other drugs as

present in the region, but these drugs were not mentioned by the majority of people interviewed: energy drinks, energy drinks with alcohol, hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], inhalants and synthetic marijuana (“K2” and “Spice”). Reportedly, synthetic marijuana continued to be used by a few participants for recreational use and as a substitute for marijuana when participants needed to pass a drug test. Treatment providers believed the abuse of synthetic marijuana was increasing, and law enforcement mentioned several synthetic marijuana overdoses in the region. Treatment providers reported inhalants as popular among a minority of their clients, typically those under 16 years of age. Participants reported abuse of 5-hour ENERGY® drinks and energy drinks with alcohol (“Four Loko”). Hallucinogens like psilocybin mushrooms and PCP (phencyclidine, aka “sherm” and “wet”) had limited availability in the region. Law enforcement reported that psilocybin mushrooms were most available in summer months when outdoor music festivals came to the area. The BCI Richfield Crime Lab reported that the number of LSD, psilocybin mushroom and synthetic cannabinoid cases it processes had increased while the numbers of processed cases for all other drugs mentioned in this section had remained the same during the previous six months.

### Current Trends

Participants and community professionals listed a variety of other drugs as being present in the region, but these drugs were not mentioned by the majority of people interviewed. Alcohol is highly available to those under 21 years of age in the region and is popular among 18-25 year olds. Several participants reported alcohol as their primary drug of choice. Participants noted a few trends common among young people between the ages of 18-25 years, most involving the use of caffeinated alcoholic beverages. A participant reported, “Those Four Loko drinks are crazy. You drink two of them, and you’re gone. I felt like I was at the bar all night.” Another participant agreed, “The Four Loko drinks ... young kids are using these. The Four Loko Challenge on the can says, ‘If you can drink four of these ... it’s on the Four Loko can ... they are huge cans and kids drink it so quick ... you don’t know how drunk you are until you have alcohol poisoning.’” Participants also noted young people consuming alcohol mixed in with food and various other beverages. Participants typically said, “Jell-o shots, pudding shots, jungle juice with Everclear® [pure grain alcohol that is illegal in Ohio] in it; Sparks® and Tilt® [both malt liquor beverages] are still popular ... you can always do cherry bombs, Jäger bombs [with Jägermeister]. It’s popular to mix [these drinks] with energy drinks.” A treatment provider reported, “My young people have reported that they soak gummy bears in vodka or tequila and take them to school – bypasses the whole beverage issue [no liquids] in school.” Several participants confirmed a new route of administration

for alcohol among teenagers and young adults: “They are soaking tampons in alcohol ... males and females ... and putting them [in the rectum] ... and you get drunker since it [alcohol] doesn’t have to pass through your kidneys and be filtered through your kidneys.” Most participants agreed that alcohol is used in combination with almost every other drug.

Anabolic steroids are rarely available in the region. However, a participant reported that steroids are highly available at his gym. Several treatment providers reported having worked with young adults using anabolic steroids. A treatment provider reported, “I had two young men in the past year I worked with using steroids. It’s just not very common.” Most participants agreed that steroids are prohibitively expensive. A typical comment from participants was, “Steroids are expensive. I never see those. Got to have money for that s\*\*\*.” Another participant spoke of combining anabolic steroids with other illegal drugs: “My friend overdosed last year from combining steroids and heroin.”

Cold and cough over-the-counter (OTC) medications are also highly available in the region. Several participants reported personally abusing Coricidin®, Robitussin DM® and medicines that contain codeine. Participants reported, “I took Coricidin®. You take 12-20 [tablets], and you trip like you would with acid or shrooms. It’s common among teens; I see people take codeine and mix it with lemonade or Sprite®.” Ingesting Robitussin DM® is referred to as “robo-tripping.” A participant explained, “Kids 17, 18 [years of age] ‘robotrip’ or take the Triple C’s [Coricidin®]. You buy them at the pharmacy. Eat 16 of them or take the whole box or half box.” Another participant reported abusing different types of OTC medicines: “Dramamine®, Benadryl® ... Stackers [weight-loss pills/energy pills] ... kids abuse these. I used to take 30 Benadryl® pills at a time, and I would hallucinate.” Participants reported that OTC medications are predominately abused by teenagers and young adults. Several participants agreed with a participant who described the typical illicit user of OTC medications this way, “[OTC abuse] it’s a younger thing, 15 [years] and up. You think you’re cool, you know.”

Lastly, inhalants are highly available in the region. Several treatment providers reported a decrease in inhalant-related admissions to treatment facilities during the past six months. A treatment provider said, “Inhalants have decreased in the last six months. Last summer we had a bigger problem with inhalants, but it’s decreased quite a bit. We don’t hear about it among the kids very much.” Most participants agreed these drugs are used primarily by adolescents and young adults. A participant commented, “[Inhalant use] it’s like a rite of passage. Get your whippets [nitrous oxide] at the porn store — a rite of passage when you turn 18 [years].” When asked why some young people choose inhalants, a participant explained, “Kids huff [inhale] gasoline ... that’s when you’re at home, you’re broke and bored ... you’re huffing.”

## Conclusion

Powdered cocaine, crack cocaine, heroin, marijuana, prescription opioids, prescription stimulants, Suboxone® and sedative-hypnotics remain highly available in the Youngstown region; a decrease in availability exists for Ecstasy, and an increase in availability exists for heroin. Moreover, data indicate likely increases in availability for marijuana and some prescription opioids. Participants from Ashtabula, Columbiana, Mahoning and Trumbull counties reported that brown powdered heroin is easier to obtain than many other drugs. Participants stated, *"In Columbiana County, it's easier to get heroin than marijuana — and it's cheaper; [Heroin] it's the easiest drug I know of to find in Youngstown."* Law enforcement officials noted that brown powdered heroin is also the most common drug they encounter; reporting that throughout the entire region, heroin is the primary drug problem. Participants reported that the availability of heroin has increased in smaller towns in the region during the past six months. The BCI Richfield Crime Lab reported that the number of heroin cases it processes has increased during the past six months. Participants reported that the most common way to use heroin remains intravenous injection. In addition, several participants described a process where heroin users will draw out residue from the cotton used to inject heroin (aka "rinse") and reuse it. There was consensus among participants that needle sharing is a problem; participants universally shared concern about contracting Hepatitis C and HIV. Most participants and community professionals agreed that heroin is a serious problem among 18-25 year olds. Participants reported that the availability of prescription opioids has increased during the past six months, especially for Opana® and Roxicodone®. Participants also reported that youth as young as 14 or 15 years old are experimenting with prescription opioids, and said use of these drugs is common among 18-25 year olds. Several law enforcement officials agreed that primarily young people between the ages of 18-25 years use prescription opioids, and most often in combination with heroin. In addition, many treatment providers agreed that the older adult clients are introduced to prescription opioids due to a physical ailment, whereas adolescent and young-adult clients are experimenting and accessing prescription opioids through friends and family. Participants reported that the availability of marijuana has increased during the past six months, attributing recent increases in availability to the harvest season during the summer months. Community professionals reported that the availability of medical marijuana has increased in some areas during the past six months. A law enforcement official stated, *"There has been an influence from the medical marijuana movement in California. We just had a female who was having five to 10 pounds shipped here [Mahoning County] every month."* While methamphetamine remains relatively

rare in some parts of the region, reportedly, the drug is highly available in Ashtabula County. Participants reported that methamphetamine is most often available in powdered form, which is homemade using the "shake and bake" or "one-pot" method. Ecstasy remains moderately available in the region, but it is rarely a primary drug of choice. Community professionals attributed the decrease in Ecstasy availability and use to a general lack of interest in the drug. Bath salts were highly available in the region prior to the enactment of legislation in October 2011 banning their sale. Participants and community professionals mentioned bath salts use numerous times; availability of bath salts since the ban went into effect is unclear. The BCI Richfield Crime Lab reported that the number of bath salt cases it processes has increased during the past six months.