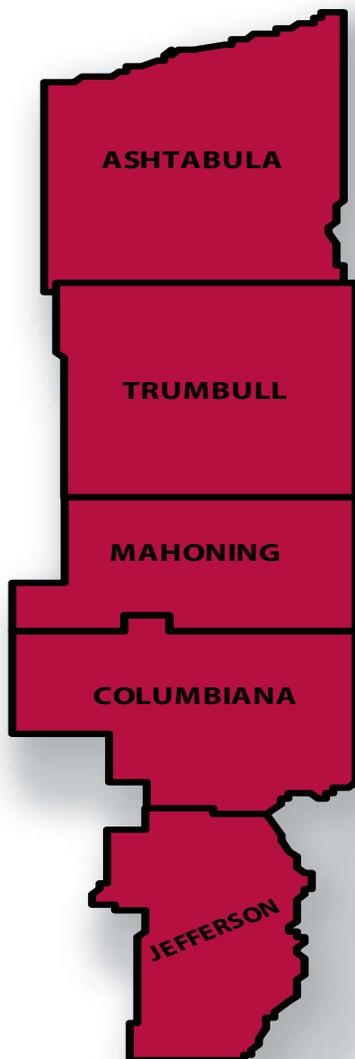


Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Youngstown Region

January-June 2011

John R. Kasich, Governor
Orman Hall, Director



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October 3, 2011

Dear Reader,

The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) is pleased to present its latest Ohio Substance Abuse Monitoring Network (OSAM) *Surveillance of Drug Abuse Trends in the State of Ohio* report covering the period January 1 - June 30, 2011. As you will see, this detailed document is full of qualitative data and first-hand accounts that accurately depict the drug abuse landscape in all regions of the state.

OSAM is a collaborative effort funded by ODADAS in association with stakeholders in the substance abuse and law enforcement community throughout Ohio. The primary mission of OSAM is to provide a dynamic picture every six months of substance abuse trends and newly emerging problems within Ohio's communities. The OSAM Network provides substance abuse professionals and policy makers with the information necessary to plan for alcohol and drug addiction prevention, treatment and recovery services, and to respond to previously unrecognized drug and alcohol problems among underserved populations.

Highlights of the June 2011 report include findings that opiates (prescription painkillers and heroin), cocaine and crack cocaine remain highly available in all regions. Evidence continues to show a progression from prescription opioid abuse to heroin abuse, earning the latter the reputation of being "one of the most available street drugs." In fact, OSAM researchers noted that many entrepreneurial dealers are now peddling prescription opiates in an effort to "cash in" on this increased demand.

For the first time OSAM tracked bath salts -- synthetic compounds that produce a high similar to a stimulant or hallucinogenic drug sold under labels such as *Cloud 9*, *Dove*, *Ivory Wave* and *Vanilla Sky* -- characterizing the substances as "highly available in all regions."

The report also examines patterns of abuse with Suboxone, an FDA-approved medication that has been proven to be effective in treating opioid addiction. Research has shown that most opiate-addicted clients relapse without a comprehensive treatment plan that includes medication-assisted treatment (MAT) and counseling. When appropriately used, Suboxone does not produce euphoria.

For opiate naïve individuals (those individuals who are not using heroin or prescription opiates), Suboxone has a potential for abuse when illegally diverted to the streets. ODADAS is committed to educating treatment providers and prescribers on the value of MAT and the importance of following established policies and practices designed to safeguard supplies and ensure successful outcomes for Ohioans with addiction.

I hope you find this report an informative and valuable tool as we continue to work together to promote health, safety and economic opportunity for all Ohioans.

Sincerely,

Orman Hall, Director

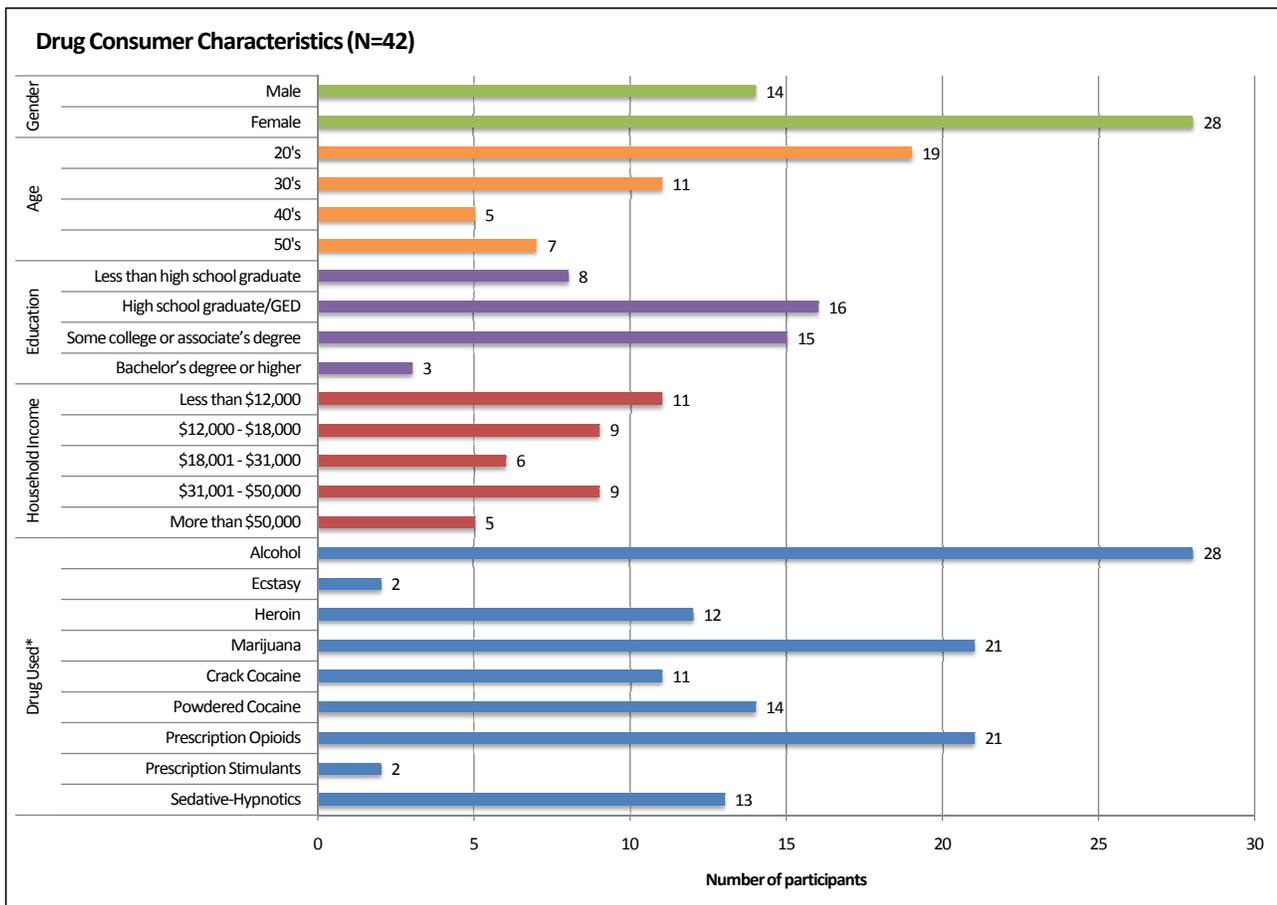
Regional Profile

Indicator ¹	Ohio	Youngstown Region	OSAM Drug Consumers
Total Population, 2009 estimate	11,542,645	723,072	42
Gender (Female), 2009	51.2%	51.4%	66.7%
Whites, 2009	82.2%	87.1%	73.8%
African Americans, 2009	11.9%	8.8%	14.3%
Hispanic or Latino Origin, 2009	2.8%	2.3%	9.5%
High school graduates, 2009	83.0%	87.2%	81.0%
Median household income, 2009	\$45,467	\$39,339	\$12,000 - \$18,000 ²
Persons below poverty, 2009	15.1%	16.7%	47.5% ³

Ohio and Youngstown statistics are derived from the U.S. Census Bureau¹.

Respondents reported income by selecting a category that best represented their household's approximate income for 2009².

Poverty status was unable to be determined for two respondents due to missing or insufficient income data³.



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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Ashtabula, Columbiana, Jefferson, 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 Identification and Investigation (BCI) Richfield Office, which serves the Cleveland, Akron and Youngstown areas. BCI data are summary data of cases processed from July to December 2010. 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 the aforementioned data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2011.

Powdered Cocaine Historical Summary

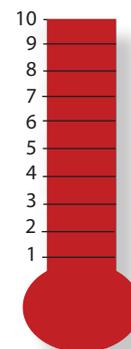
In the previous reporting period, powdered cocaine was moderately available in the region. Participants most often reported the drug's availability as '7' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The consensus among participants and community professionals was that powdered cocaine was not as available as crack cocaine. The most common participant quality score for powdered cocaine was '3' on a scale of '0' (poor quality, "garbage") to '10' (high quality). BCI Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine as common cutting agents for powdered cocaine. Participants reported a gram of powdered cocaine ranged in price from \$40-\$100. The most common route of administration for this form of cocaine was intranasal inhalation (snorting). Treatment providers reported that powdered cocaine was being used more intravenously than in the past, especially among heroin users. Law enforcement described a typical user as a 20 to 35-year-old, White, middle-class suburbanite.

Current Trends

Powdered cocaine is highly available in the region. Participants most often reported the drug's current

availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '7'. While highly available, the consensus among participants was that crack cocaine remains easier to come by on the street than powdered cocaine. Participants reported, "*Coke [powdered cocaine] you pretty much have to know somebody to get it. It seems it's not as available on the street; I always preferred using [powdered] cocaine above crack cocaine. The whole reason I decided to smoke [crack cocaine] my first time was because it was much more convenient to get, and it was a lot bigger of a buzz for a smaller amount of money.*" Treatment providers and law enforcement most often reported the drug's current availability as '8'. A law enforcement officer reported, "*Definitely [powdered cocaine] not as available as crack [cocaine]. They [dealers] are not advertising and selling powder. There's no demand for it. They are using it to make crack.*" The consensus among community professionals was that powdered cocaine can be purchased relatively easily; however, crack cocaine is the form of cocaine most available and mostly sought by users. Many treatment providers named cocaine as in the top three drugs used in the region. *The Vindicator* reported on significant arrests this year involving cocaine trafficking in the region. A Warren couple was found guilty of being suppliers of cocaine and heroin, coming into Trumbull County from Detroit (www.vindy.com, April 9, 2011). A group of Youngstown area residents were indicted for international drug trafficking, transporting powdered and crack cocaine, heroin, methamphetamine and marijuana from San Diego and New York to Youngstown (www.vindy.com, April 1, 2011). In reference to the aforementioned group of alleged drug traffickers, *The Vindicator* quoted a U.S. Attorney as saying, "*This drug-trafficking organization operated almost like a Costco. Moving wholesale, bulk and retail amounts of heroin, cocaine, crack, marijuana and methamphetamine from one coast to the other and then eventually to Youngstown, Ohio where it was sold on the streets and poisoned our community.*" The vast majority of participants and community professionals reported that the availability of powdered cocaine has remained stable over the past six months. BCI Richfield crime lab reported that the number of powdered cocaine cases it processes has remained stable.

Participant quality scores of powdered cocaine varied from '1' to '9' with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '3'. Universally, participants reported that the quality of powdered cocaine continues to be dependent on the source, the person from whom one buys.



Participants reported, *"Depends on who you get it [powdered cocaine] from, that, like real, it depends you know, who got the better ... I mean this person is selling for 60 bucks, and you know he's cutting [adulterating] it with whatever he has, and then you go to this other person. You're paying 100 bucks, but you are getting good quality; Hit or miss, some people got some really good powder [cocaine]. With some people, it's all cut up."* A law enforcement officer reported, *"[Quality of powdered cocaine] depends on which organization you're dealing with. We've seen high quality, 80 to 90 percent pure, and then we've seen organizations that are selling four and five percent pure."* BCI Richfield crime lab continues to cite the following substances as commonly used to cut powdered cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), procaine and lidocaine (local anesthetics) and caffeine.

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "girl," "soft," "snow" and "White girl." Participants listed the following as other common street names: "cola," "powder," "soft batch cookies," "smooth" and "white." Euphemisms having to do with snow and skiing are reportedly common when referring to powdered cocaine. Participants reported, *"Let's go skiing' means they [users] want to get some [powdered] cocaine; 'It's snowing outside' is lingo they [dealers] use when making a call to sell powder."* Current street prices for powdered cocaine were variable among participants with experience buying powdered cocaine, with overall prices slightly higher than previously reported. Participants reported that a gram of powdered cocaine sells for \$50–\$100, depending on the quality, the highest quality selling for upwards of \$200 a gram; 1/16 ounce, or "teener," sells for \$75; 1/8 ounce, or "eight ball," sells for \$100–\$200; 1/4 ounce sells for \$275–\$300; an ounce sells for \$800–\$1,400; a kilo sells for \$15,000–\$40,000. A law enforcement officer reported, *"We typically deal with larger quantities, ounce quantities and up. Ounces run anywhere from \$1,000 on low end to \$1,500 on high end. Kilos are ranging between \$25,000 and \$32,000 a kilo."* While there were a few reported ways of consuming powdered cocaine, the most common route of administration for this form of cocaine remains intranasal inhalation (snorting) followed by intravenous injection (shooting). Several participants reported "cooking up" powdered cocaine and smoking it. Participants stated, *"Shoot it [powdered cocaine], snort it, cook it up and smoke it; Most people snort [powdered cocaine]. I used to shoot it."*

A profile for a typical powdered cocaine user did not emerge from the data. Participants reported, *"All gamuts [sic] of society [use powdered cocaine] ... does not discriminate with job title or anything; Anybody, anywhere, anytime could be doing it [using cocaine]."* However, many participants continue to

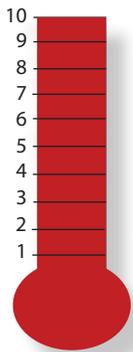
associate powdered cocaine use with the bar/club scene. A participant stated, *"People who like to party and go to bars and stuff [use powdered cocaine]."* Community professionals reported that users of powdered cocaine still tend to be White and over 30 years of age. A provider stated, *"A little bit older, maybe between 30 and 35 and even 50 or so ... mostly White. People that are using [powdered] cocaine usually do not use it exclusively. Usually they use it with heroin, with opiates."* Another provider provided the following description: *"blue-collar workers, most are White, mid 30's and male."* Reportedly, powdered cocaine continues to be used in combination with alcohol, benzodiazepines (Valium® and Xanax®), heroin (a.k.a., "speedball" when used in conjunction with cocaine), marijuana and prescription opioids. A participant explained the need for other drugs to help in coming down from the stimulant high of powdered cocaine as follows: *"When I do [powdered cocaine], I always liked to have weed [marijuana] also available, so that when you come down off cocaine, which is very, very scary ... it [marijuana] helps you not to go through that. It brings you down better."*

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' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants described crack cocaine as extremely easy to get. Law enforcement also rated the availability of crack cocaine as high. The most common participant quality scores for crack cocaine were '3' and '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that crack cocaine was most often cut (adulterated) with other substances. BCI Richfield crime lab cited diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetic) and caffeine as common cutting agents for crack cocaine. Participants reported a gram of crack cocaine ranged in price from \$50–\$100. The majority of crack cocaine users reported buying the drug in small quantities called "dimes" (1/10 gram) for \$10, and agreed that the price of crack cocaine had gone up over the course of the past six months. By far, the most common route of administration for this form of cocaine was smoking. Participants and treatment professionals alike stated that crack cocaine is far-reaching into every socioeconomic 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'. Many participants believed the drug was "readily available" and "very easy to get." One participant even went so far as to say, "You can't walk to the store without somebody offering you crack [cocaine]." Community professionals most often reported the drug's current availability as '9.5'. Law enforcement agreed that crack cocaine was highly available: "There's seldom a time when we cannot go out and buy [undercover] any [crack cocaine]. Sometimes there may be up to a half-hour wait on the person we are targeting or supplier to come up with it, but usually it's ready

on the spot." The majority of participants and community professionals reported that the availability of crack cocaine has remained stable over the past six months. BCI Richfield crime lab reported that the number of crack cocaine cases it processes has also remained stable over the past six months.

Most participants rated the quality of crack cocaine as either '2' or '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common scores were '3' and '4'. Participants agreed that the quality of crack cocaine varied widely and continues to depend on where one obtains the drug. Generally, participants thought that high quality crack cocaine was coming from Chicago. Drug users that did not have access to high quality crack cocaine said they had to "cook" or "re-rock" crack cocaine in order to increase the quality. One participant explained, "I was [cooking] it [crack cocaine] for better quality, and I was tired of getting ripped off." Other participants said their dealers had variable quality. A participant said, "Normally, if you have your own dealer, it's [crack cocaine] decent quality. If you go sometimes on the streets, sometimes it may be good, sometimes it may be a fake, period." As one participant's addiction got worse, she would buy anything she could get her hands on, but this only led to poor quality product: "As you smoke more crack cocaine you learn to get it from other places you normally wouldn't get it ... I was starting to get ripped off all the time." Over the past six months, participants reported that the quality of crack cocaine has gotten worse. Many participants agreed that the quality of crack cocaine was poor because of the economy: "It's [quality of crack cocaine] gotten worse. I would say because people are trying to get their money's worth 'cause, you know, everybody needs money these days." Participants reported that crack cocaine in Youngstown is cut (adulterated) with Anbesol®, baby laxative, baking soda and lidocaine (local anesthetic). As one participant said, crack cocaine can be, "cut with anything and everything." BCI Richfield crime lab continues to cite the following substances as commonly used to cut crack cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetic) and caffeine.

Current street jargon includes many names for crack cocaine. The most commonly cited names were "hard" and "rock." Participants listed the following as other common street names: "girl," "slab," "white" and "work." Current street prices for crack cocaine were variable among participants with experience buying crack cocaine, with overall prices slightly higher than previously reported. Participants reported that a gram of crack cocaine sells for between \$40-\$150, depending on the quality; 1/16 ounce, or "teener," sells for between \$75-\$100; 1/8 ounce, or "eight ball," sells between \$150-\$200; an ounce sells for between \$1,000-\$2,000; and a kilogram sells for \$23,000. Participants agreed that the price of crack cocaine varied due to the quality of the product, and that the higher quality was available if the interested party was willing to pay the price. While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. Users employed many methods to smoke crack cocaine, often using common objects found at convenience stores and supermarkets. In addition to glass rose stems and pipes, one participant explained, "We would always use tire pressure gauges [to smoke crack cocaine], empty out the middles, [and] go to the store and get chore [Chore Boy®], you know that you use to clean your house with." Another participant reported using "pop cans." Other participants reported using crack cocaine intravenously. Intravenous users of crack cocaine described needing to break down the drug in order to inject it: "You gotta break it [crack cocaine] down with vinegar and put it on a spoon. Cook it down with vinegar and you inject it." Participants stated that users who injected opiates were more likely to inject crack cocaine.

A profile of a typical user of crack cocaine did not emerge from the data. Participants and community professionals disagreed about the typical users of crack cocaine. Participants continued to emphasize the wide range of people that use crack cocaine, explaining that men and women of all races use the drug. As one participant put it, "Anyone can get addicted to it [crack cocaine] ... a judge, a librarian, a school kid." Community professionals disagreed with participants and each other about the user demographics. Some providers thought crack cocaine use was, "predominately Caucasian ... mid 20's to late 30's;" whereas, law enforcement thought crack cocaine was, "probably more in the Black community than in the White community ... [among those] 35 to 40 and older."

Reportedly, crack cocaine is used in combination with alcohol, antidepressants, Ecstasy, heroin, marijuana, prescription opioids and sedative-hypnotics. Most of these drugs are commonly used to "come down" from the crack cocaine high. As one participant stated, "Most definitely, you need a benzo [benzodiazepine] or an opiate to come down

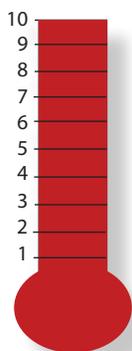
[from crack cocaine use]; You feel really, really shitty afterwards, so [I] always took some type of pill, an opiate." Participants also reported lacing their crack cocaine with marijuana, which they called a "primo" or a "geek." Other participants mentioned that they liked to "speedball;" that is, they enjoyed the roller coaster effect of using crack cocaine to feel high and then heroin to feel low. Using crack cocaine with the aforementioned substances is reportedly common.

Heroin Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants and treatment providers most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Law enforcement rated current availability as "better than ten." Participants named heroin as the most available drug in the region. While many types of heroin were named as available, the consensus among all participant groups was that brown powdered heroin was the most common form of heroin found. The most common participant quality score for heroin was '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that heroin was most often "cut" (i.e., adulterated) with prescription drugs. BCI Richfield crime lab reported that heroin was "very pure," and occasionally cut with diltiazem (medication used to treat heart conditions/high blood pressure). Participants reported a gram of heroin ranged in price from \$75-\$200 depending on quality. Many participants reported buying "baggies/stamps" for \$10-\$20 each. The most common route of administration for heroin was intravenous injection (shooting). Treatment professionals and participants alike noted an increase in younger people using heroin ("teens" and those in their early 20's) who were "mostly White."

Current Trends

Heroin remains highly available in the region. Participants most often rated 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.' While many types of heroin are currently available in the region, participants reported the availability of powdered heroin as most available. Participants stated, "There's all types of heroin on the streets. You have white, brown, you have gray, you have black tar, there's all kinds. I would say the white or the brown [powdered heroin is the most common]; if it's



your drug of choice [heroin], and you're from around here, it's very available." A participant stated, "The white and brown [powdered heroin] are both 10's." Treatment providers and law enforcement also most often reported heroin's current availability as '10'. A law enforcement officer reported, "I don't think there's been a day out here when we said, 'hey, we got a chance to buy heroin, and the deal has fallen through.' It's always available." A treatment provider reported, "Ten. It's [heroin] the most available drug out there now, and, um, everyone's using it, snorting it or shooting [injecting] it. And, they're using heroin more because of the unavailability of the pills [prescription opioids] they used to seek, and because it is a lower cost, the heroin, and it goes a lot further."

Participants reported the availability of black tar heroin to be limited, rating its availability most often as '4' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant reported, "Black tar is black and sticky ... like black top on the street, real sticky. [Black tar heroin] not really that common around here, just regular heroin most common, powder." Community professionals most often reported black tar heroin's current availability as '2'. A treatment provider reported, "I have had a couple of clients tell me, um, oh, they've heard the black tar stuff [heroin] is really nice, but nobody seems to get it much around here." A law enforcement officer reported, "From what we hear, there are people out there who know how to cut black tar heroin into brown powder, so they are converting it for what the normal use is, or what the market is here in Youngstown." In addition to powdered and black tar heroin, a participant and a treatment provider reported the presence of "raw heroin," which reportedly is high purity heroin sold in chunk or rock form. The participant reported, "What sells the easiest, is what they call 'raw,' which is chunks [of heroin] they [dealers] bring in, like a chunk. They'll cut off chunks and sell for \$50's or \$100's as opposed to the bags they bring in from Pittsburgh where it's already packaged, and the stamps they sell for \$10 to \$15. It [raw heroin] looks similar to ... like crack [cocaine]. Like a chunk of crack, but, uh, it's brown." A treatment provider stated, "I'm not as familiar as I should be with the different subspecies of it [heroin], but I hear people [clients] talk about rock."

The majority of participants reported that the general availability of heroin has increased over the past six months. Participants reported, "Lately, ... every drug dealer that has crack [cocaine] has heroin too; People that are into selling drugs are starting to realize that heroin is the money maker because the people that are strung out on it [heroin], absolutely have to have it, or they're not able to get out of bed or do nothing, you know." Participants attributed the increase in heroin over the past six months mostly to the price of prescription opioids: "The pills [prescription opioids], the OxyContin® are harder to get; they're harder to break down. They cost more money;

Can't afford the pills; It's [heroin] cheaper than, you know, other drugs, and there's a lot of heroin addicts." Community professionals reported that the general availability of heroin has increased over the past six months. Law enforcement reported, *"We are seeing a little more of it [heroin] here in Columbiana County the past six to eight months; increase in the transition from pharmaceuticals, the OxyContin®, to the heroin because of the price of addiction, so it kind of became an accepted transition."* BCI Richfield crime lab reported that the number of powdered heroin cases it processes has increased, reporting having processed approximately 1,500 heroin cases over the past six months up from 803 cases for the previous reporting period. The number of heroin cases has surpassed the number of marijuana cases, making powdered heroin the most processed drug through BCI Richfield crime lab. The lab reported a decrease in the number of black tar heroin cases it processed over the past six months.

Participants most often rated the quality of heroin as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '9'. Participants reported, *"Mahoning County, the quality of what I was doing, whether it was heroin or fentanyl ... it was strong. I'd say a good '9'; Like I said, the quality of the raw [heroin] from Chicago or Jersey or whatever, the quality of that, I'd give between a '7' and a '10.'" Over the past six months, participants reported that the quality (potency) of heroin has increased. Participants reported, "I'm an addict, Ashtabula County, it's [heroin] getting real strong; it [heroin quality] was good. I do not believe that it was all heroin. It was getting stronger. I believed it was cut [adulterated] with fentanyl because I overdosed a couple of times on amounts where I didn't before."* In addition to fentanyl, participants reported that powdered heroin is cut with Sleepinol®, Vitamin B and Vitamin E. A law enforcement officer reported, *"Recently, we had some [heroin] that was cut with ketamine. We had a number of overdoses here, an increase because of ketamine."* BCI Richfield crime lab cited procaine and lidocaine (local anesthetics) as commonly used to cut powdered heroin.

Current street jargon includes many names for heroin. The most commonly cited names remained "boy" and "dog food." Participants listed the following as other common street names: "dirty girl," "dope" and "H." Participants reported that heroin is 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." (Note: prices included here reflect current pricing for powdered heroin as very few participants had pricing information on black tar heroin. A participant reported, *"Black tar [heroin] was a little more expensive."* Prices vary depending on quality of heroin and location of purchase within the region, with

overall pricing remaining stable from the previous reporting period.) Reportedly, 1/2 gram sells for \$60–\$100; a gram sells for \$50–\$160; a finger (7–10 grams, distributed in a cut-off finger of a surgical glove) sells for \$700–\$1,000; 1/4 ounce sells for approximately \$600; and an ounce sells for approximately \$1,000. Most participants continued to report buying smaller quantities of heroin most often in \$10 and \$20 amounts. A participant reported, *"Most of the time I would buy mine [heroin] in \$20's. It's called bundles or balloons."* Law enforcement reported that stamps sell for \$20; and a gram sells for \$80–100. A law enforcement officer reported, *"In Youngstown we are seeing \$10 to \$20 bindles and \$100 per gram. Prices go up in the surrounding areas ... East Liverpool and Columbiana, not as many dealers."*

While there were a few reported ways of consuming heroin, the most common route of administration remains intravenous injection (shooting), followed by intranasal inhalation (snorting) and then smoking. Participants estimated that 75 to 100 percent of heroin users intravenously inject heroin. A participant explained, *"I think it [route of administration] all depends on if they just started doing it [using heroin] or not. They probably start off snorting it and then work their way up [to injection]."* Another participant reported, *"I'm an addict. I started snorting it [heroin] when I first started [using heroin]. Then everyone was telling me [that] I'm missing out on a good high, so I tried it [injecting heroin] and fell in love."* A treatment provider reported, *"Some IV [intravenously use] it [heroin] here—most common. Some snort. Some smoke."* Along with widespread reports of intravenous use of heroin were widespread reports of sharing of injection needles and hepatitis C infections. A participant reported, *"I would buy a clean bag of 1 CC syringes from the drug store. There was times I would reuse my needles, there were times I would use other people's needles if I was in a hurry to get a quick fix, and there was times my needles got mixed up with other people's [needles] as well. There is a possibility I have hepatitis C. I know somebody that had it, and I possibly used their needles."* Another participant reported, *"I'm an addict. I think I have hepatitis C."* A treatment provider reported, *"I see a lot of our clients testing positive for hepatitis C, as more so than in the past."* In addition to reports on hepatitis C, participants continued to report overdoses involving heroin as common. Participants reported, *"I know people who OD'd [overdosed]. I OD'd once on heroin. My best friend OD'd on heroin, and she died. I know lots of people who have OD'd; My father died of a heroin overdose when I was 17. I shot [injected] him up [with heroin], and he died in my arms; I know one girl that OD'd seven times on heroin, and she's still using [heroin]."*

A profile of a typical user of heroin emerged from the data. The consensus among participant and community

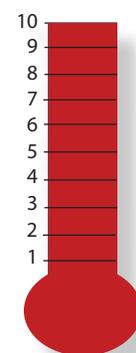
professional groups was that heroin users continue to be predominately White males and females between the ages of 20 and 35 years, although several community professionals also continue to report increasing heroin use among adolescents, particularly teenaged females. Law enforcement reported, *"We're seeing more high school and younger age [heroin] users; We're seeing more young females, high school and recently graduated coming into the inner city, 18 to 25 [year old] females."* A treatment provider reported, *"With the adolescent population it appears ... uh, it [heroin] appears to be becoming more available, more popular ... In this [treatment] program here as young as 15 years old. As far as like gender, female Caucasian, Caucasian female is what actually surfaced here."*

Reportedly, heroin is used in combination with alcohol, benzodiazepines (Xanax[®]), crack cocaine, powdered cocaine (a.k.a., "speedball" when used in conjunction with heroin), marijuana and prescription opioids (fentanyl, Opana[®] and OxyContin[®]). Participants reported that other drugs were used in combination with heroin primarily to intensify the high of heroin. Participants stated, *"I like heroin with Xanax[®]. It was good. That was my combination that I liked. I didn't use the Xanax[®] to come down. I used the Xanax[®] to increase it [the high of heroin]; I'm an addict. I'd use marijuana to increase it [the high of heroin]."*

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants and treatment providers most often reported street availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Community professionals identified OxyContin[®], Percocet[®] and Vicodin[®] as the three most popular prescription opioids in terms of widespread use. However, with the reformulation of OxyContin[®] OC into a more tamper resistant pill, participants noted a decreased presence of OxyContin[®] OC. Reportedly, many different types of prescription opioids were sold on the region's streets. In addition to obtaining prescription opioids from dealers, participants also reported getting them from friends, roommates, family members—others with prescriptions, buying "scripts" (prescriptions) or trading other drugs for the opioids, as well as, from area doctors and pain management clinics. Generally, the most common routes of administration were oral consumption and intranasal inhalation (snorting). Treatment professionals noted that current illicit use appeared more prevalent among suburban, middle class, White people.

Current Trends



Prescription opioids remain highly available in the region. Participants most often reported the current availability of prescription opioids 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 stated, *"Amazing how easy they [prescription opioids] are to get. Doctors are giving them away without hesitation; very available, just ask your doctor."* Participants and community professionals continue to identify OxyContin[®], Percocet[®] and Vicodin[®] as the most popular prescription opioids in terms of widespread use. A provider reported, *"Seeing mostly Vicodin[®], Percocet[®] and OxyContin[®] [in client use histories]."* Participants also noted increasing popularity of Opana[®] and Ultram[®]. Participants reported, *"A lot of people switched from oxy's [OxyContin[®]] to Opana[®]'s; Opana[®]'s a lot stronger [than OxyContin[®]]. I snorted them. It's one of the few pills [prescription opioids] that you can still snort; I was buying them [Ultram[®]] from, um, one of the girls that live in the building with me because they do not show up in the urine test where I was going [for treatment]; Um, I justified taking those [Ultram[®]] because they're non-narcotic ... when in all reality, they are very addictive."* Community professionals also most often reported current availability of prescription opioids as '10'. Treatment providers reported, *"Clients do not seem to have any problem getting them [prescription opioids]; very available."* Providers also noted the increasing popularity of Ultram[®], especially among adolescents. A provider reported, *"With the adolescents, what is common now, as I'm sitting here, is the marijuana, alcohol, and what is a growing trend now is Ultrams[®]."* Participants reported that the availability of prescription opioids has remained stable over the past six months, with the exception of OxyContin[®] OC which has decreased in availability. Participants reported, *"Oxy's [OxyContin[®] OC] are almost scarce, although I know a few people who had them last week as a matter of fact; A lot of people don't use them [reformulated OxyContin[®] OP] because of the gel in them."* Several participants described ways to abuse the reformulated, more tamper resistant OxyContin[®] OP. A participant explained, *"Microwave them [OxyContin[®] OP]. You can still use them. They [Purdue Pharma] tried to put ... they tried to do something to OxyContin[®] to stop you from being able to break them down. It's a known fact you can microwave them ... dries out the gel inside and you can still crush them and snort them. I know people do it every day."* Community professionals also reported that the availability of prescription opioids has remained stable over the past six months, again with the exception of OxyContin[®] OC, which

they also reported has decreased in availability. A provider reported, *"I haven't heard too much about oxy's [OxyContin®] lately; decreased due to new formulation ... [users] switched from oxy to Vicodin®, Percocet® and heroin."* A law enforcement officer reported, *"OxyContin®, it really seems like it's dropped off."* BCI Richfield crime lab reported that generally, the number of prescription opiate cases it processes has remained stable; a noted exception was a decrease in the number of OxyContin® cases over the past six months.

Reportedly, many different types of prescription opioids are currently sold on the region's streets. Participants reported that prescription opioids generally continue to sell for a dollar per milligram with a few exceptions. Participants stated, *"My drug of choice are [prescription] opiates. They are a dollar a milligram. Basically, everything is a dollar a milligram except for the Vicodin®. Vicodin® is a lot cheaper; if you can get a real oxy [OxyContin® OC 80 mg] now since they [Purdue Pharma] changed em' to OP's [reformulated OxyContin®], so yeah, a real OxyContin® is a hundred bucks. If you get an OP, you can get that for 45 bucks because they are not, you can't [crush and snort them], you can only eat them."* Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid®, fentanyl patch and lollipop (100 mg patch sells for \$50–\$100), methadone (10 mg sell for \$5–\$8; wafers sell for \$40 per wafer), morphine, Norco® (500 mg sell for \$3–\$4), Opana® (20 mg sell for \$25–\$40; 30 mg sell for \$60–\$70; 40 mg sell for \$50–\$80), oxycodone 30 mg (a.k.a., "perc 30;" sell for \$30–\$40), OxyContin® (a.k.a., "oxy's"), OxyContin® OC (old formulation, a.k.a., "OC's;" 40 mg sell for \$80; 80 mg sell for \$80–\$120), OxyContin® OP (new formulation, a.k.a., "OP's" and "chewies;" 60 mg sell for \$25–\$30; 80 mg sell for \$40–\$50), Percocet® (a.k.a., "perc's;" 5 mg sell for \$5; 7.5 mg sell for \$5–\$8; 10 mg sell for \$6–\$10; 15 mg sell for \$15–\$20), Roxicet® (a.k.a., "roxi's;" 30 mg sell for \$15–\$25), Tramadol® (a.k.a., "trams;" 5 mg sell for \$.50–\$2); Ultram® (50 mg sell for \$1–\$3), Vicodin® (a.k.a., "vikes;" 5 mg sell for \$1.50–\$3), Vicodin® ES (7.5 mg sell for \$4), Vicodin® HP (10 mg sell for \$5).

In addition to obtaining prescription opioids on the street from dealers, participants continue 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 is through area physicians. Participants reported, *"I went to a doctor, no problem; Doctors, dentists main source, then friends; The person I was buying Percocet® from actually told me which doctor to go to to get them. It was very easy;*

Going to doctors and emergency rooms. They give them out freely." A treatment provider reported, *"I know of two physicians who have been in the past extremely liberal about prescribing [prescription opioids]."* In terms of street purchase, participants reported, *"I've seen people get prescriptions they don't want, and then turn around and sell them. Most of the time, I see people getting [prescription opioids] from illegal transactions; Uh, there's a lot of elderly people that are living on a fixed income that are prescribed medication. That's the only way they can make ends meet [through the sale of their prescriptions]; I know quite a few elderly sell [prescription opioids]."*

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 continue to include the following in order of highest prevalence: oral consumption (swallowing and chewing), intranasal inhalation (snorting) and intravenous injection (shooting). Participants reported, *"I haven't seen any of the real ones [OxyContin® OC]. Like the only ones I've seen are the ones that they call the 'chewies' [OxyContin® OP]. You can't crush them, you can't snort them, you can't shoot [inject] them; Eat them [OxyContin® OP]. They made it [fentanyl] in a crushed form, so you could snort it ... and instantly, you're so high. It's outrageous how high you get off them; I've used fentanyl patches. I've shot [injected] them and chewed them up."* A treatment provider reported a high prevalence of intranasal inhalation among clientele: *"Mostly just snorting, snorting Vicodin®."*

A profile of a typical user of prescription opioids did not emerge from the data. Participants reported, *"Damn near everybody [uses prescription opioids]; I seen kids 10, 11, 12 popping pills; I've seen people 78 years old [abusing prescription opioids]; Nowadays, there's really no telling who's doing what anymore."* Community professionals were able to provide general descriptive information on users of prescription opioids. Providers reported, *"A fair amount of females [abuse prescription opioids] ... it seems to me that it is more male. Before they realize they have a problem ... age is 25 or 30 and older. Start because of legitimate pain and then realizing that they cannot stop; White, male and female, younger, 22 – 51 [years old]."* Community professionals noted changes in the profile of prescription opiate abuse. Treatment providers reported, *"For a long time we never got any Latinos, Latinas in the program, but now we are and many of them come in saying they're alcoholic, but later in treatment admit they are addicted to opiates; You know, like I said the younger crowd, but that's what I'm getting the most of [treatment referrals]."*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, crack and powdered cocaine, marijuana and sedative-hypnotics (Klonopin®, Valium® and Xanax®). Reportedly, it is common to use prescription opioids with the aforementioned drugs. Participants reported that the use of other drugs with prescription opioids intensifies the high. A participant reported that she liked to use benzodiazepines with prescription opioids because, *“It feels good.”*

Suboxone®

Historical Summary

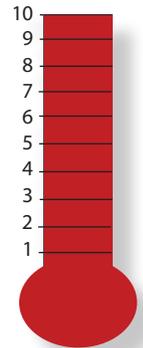
In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported street availability of Suboxone® as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (high availability, extremely easy to get). Law enforcement stated that Suboxone® was, *“rampantly available on the street.”* While a few participants reported being either currently or previously prescribed Suboxone® by a physician in their community, through a treatment center, or while incarcerated, most frequently, participants reported obtaining Suboxone® on the street from other users or from drug dealers. BCI Richfield crime lab reported an increase in the number of Suboxone® cases it had processed over the past six months. Participants reported pricing for Suboxone® 8 mg to range from \$5 to \$30, with the most frequently reported price being between \$10 and \$20. Participants and treatment professionals alike reported that Suboxone® was most often used illicitly by those addicted to heroin who either traded Suboxone® to dealers for heroin or used the drug to avoid withdrawal between highs. Treatment professionals noted that other users were also abusing Suboxone® to get high. Most often participants reported taking Suboxone® orally, letting it dissolve under the tongue. However, there were reports of snorting Suboxone®, and participant and professional respondents alike reported that intravenous use of the drug was becoming more commonplace.

Current Trends

Suboxone® remains highly available in the region. Participants most often reported the current street 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’. Participants reported, *“Suboxone® was easy to get, but it was expensive; We all use them [Suboxone®]. I mean anyone in Belmont [County]. You know, for our own, like, we are trying*

to get off pills [prescription opioids], so we are buying these ... these off the street to get off the pills, but usually, I don’t even know. It never worked.” Community professionals perceived Suboxone® to have moderate street availability. Community professionals most often reported the drug’s current availability as ‘5’. A provider reported, *“It [Suboxone®] is fairly available but not readily available. I know clients often look for it and not always finding it.”* A Law enforcement officer reported, *“I know it’s [Suboxone®] out there. I am seeing it.”* Another officer reported higher street availability than the majority of community providers: *“Very available. To me, the biggest trend out there is the use of Suboxone®, illegally. They [opiate addicts] were using it to get over their dope sickness [withdrawal symptoms].”* Participants reported that the street availability of Suboxone® has increased over the past six months. A participant reported, *“There are a lot of people getting on Suboxone® right now, and a lot of people that are on Suboxone® sell Suboxone®.”* Another participant reported that the availability of the film/strip form of Suboxone® has increased. Community professionals also reported that the availability of Suboxone® has increased over the past six months. A law enforcement officer reported, *“More available. There is a Suboxone® program in the county [Columbiana County] now, so that’s kind of maybe increased the [street] availability of Suboxone®.”* A treatment provider reported, *“It’s increased [Suboxone® street availability]. I mean ... you’ve got people at [12-step] meetings handing them [Suboxone®] off. They’re being sold like any other drug.”* BCI Richfield crime lab reported that the number of Suboxone® cases it processes has increased over the past six months.

No slang terms or common street names were reported for Suboxone®. Participants reported current street pricing for Suboxone® 8 mg to range from \$10 to \$30, with the most frequently reported price being between \$20 and \$25, an increase from \$10 to \$20 from the previous reporting period. Participants reported, *“The 8 mg Suboxones® are going for \$20–25 for what I was paying for them; 8 mg pills [Suboxone®] 20 bucks; in Mahoning County, 8 mg pills [Suboxone®] \$20–25; I sold mine [Suboxone®] for \$30 in Columbiana County. I was prescribed them as part of a [Suboxone®] maintenance program.”* Most often participants continue to report taking Suboxone® sublingually. Participants reported, *“People typically put them [Suboxone®] under their tongue, or they chew them up. I’ve actually witnessed a couple people shoot [inject] them up; I would eat the full 8 mg Suboxone®.”* Participants also continue to report intranasal inhalation (snorting) and intravenous injection (shooting). Participants reported, *“I snorted it [Suboxone®] when I would take it. It made me not sick;*



Well, I shoot [Suboxone®] in my neck, so, um, it goes straight to you, you know. You're not sick. Some people get high off it, I do not." Participants reported an increase in doctors prescribing of Suboxone® strips. There were reports of users injecting Suboxone® strips. A participant reported, "I do know a few people that when switched to the films [Suboxone® strips], they say that those are a lot easier to shoot up [inject]. Yeah, 'cause they dissolve in water; they dissolve completely, and I've heard people say that those actually work really well."

In addition to obtaining Suboxone® on the street from dealers, participants continue to report getting the drug from doctors and from others in Suboxone® maintenance programs. Participants reported, *"I got mine [Suboxone®] from my dealer, so I assume the doctor gave them to someone for the dealer to get them; I too sold Suboxone® on the street. I went to two Suboxone® maintenance programs to get them, and I would sell them for my heroin; I went to the doctor to get Suboxone®, so I really didn't have to get them on the street because ... I mean all you got to do is go to a Suboxone® doctor ... First time you go, you need to screen dirty [positive for opiates], and they're [doctors] all about giving you Suboxone®."*

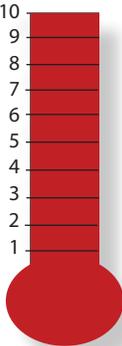
A profile for a typical Suboxone® user emerged from the data. While acknowledging that Suboxone® is tremendously helpful to those who take the drug as directed for its intended purpose, participants continue to widely report abuse of Suboxone® by those addicted to opiates that use the drug to keep from experiencing withdrawal between opiate purchases and by those not addicted to opiates who are seeking to get high. Participants reported, *"I quartered them [Suboxone®]. This is stupid. Because it's an opiate blocker, and I knew once I did the Suboxone®, I can't do another opiate for however many hours they say ... so I tried to take the bare minimum, so I wouldn't be sick, but that way I could still use an opiate; I would buy them [Suboxone®] to come off other stuff, but it never worked like that. 'Cuz you could get high off Suboxone® if you hadn't had any opiates in a couple of days; If you are not addicted to opiates and you take a Suboxone®, it's very, very strong. It can make you high for three days ... If you are addicted to opiates, you take the smallest piece of Suboxone®--it makes you feel normal."* Community professionals echoed what was reported by participants. A treatment provider summarized the sentiment of the professional group by stating, *"Heroin addicts, opiate addicts of all sorts use that [Suboxone®] as a standby drug, the hardcore ones to fend off any withdrawal 'til they get their true fix. However, a lot of people are being introduced to opioids through Suboxone® now because, if they were not Suboxone® users, the buprenorphine ... the active agent in Suboxone® is giving them the opiate effect, and now they're looking for stronger opioids. So, now it's [Suboxone®] a gateway drug to opioid addiction."* Reportedly, Suboxone® is used in combination with alcohol,

powdered cocaine and sedative-hypnotics (Klonopin® and Xanax®). Participants reported that benzodiazepine use with Suboxone® is very common.

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' (high availability, extremely easy to get). Treatment professionals listed the most common sedative-hypnotics in terms of widespread use as Ativan®, Klonopin®, Valium® and Xanax®. The consensus of participants and treatment professionals alike was that sedative-hypnotics had become more available over the past six months. In addition to obtaining sedative-hypnotics from dealers, participants reported visiting area doctors in order to obtain prescriptions for these drugs. Treatment professionals noted an emerging problem of young people being prescribed sedative-hypnotics without psychiatric care. The most common routes of administration were oral consumption and intranasal inhalation (snorting). Treatment professionals reported that illicit use of these drugs in their communities was a far-reaching problem that affected all age groups.

Current Trends

 Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain 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'. Participants and community professionals identified Klonopin® and Xanax® as the two most popular sedative-hypnotics in terms of widespread use. Participants all agreed that sedative-hypnotics were "easy to get." Community professionals reported the drug's current availability ranged from '6' to '10' with a median score of '8.5'. Treatment providers reported that sedative-hypnotics were, "pretty easy to get." Treatment providers continue to report concern over increased adolescent use of sedative-hypnotics. A provider who counsels adolescents reported, "[Sedative-hypnotics] becoming more popular with the adolescent population." A treatment provider from a different agency echoed this same sentiment: "With the adolescents, it's [sedative-hypnotic use]

more common ... the adolescents talk about the marijuana, but then after a while they start admitting that there's more use of the benzo [benzodiazepines]." Equal numbers of participants reported that the availability of sedative-hypnotics has remained the same/has increased over the past six months. Community professionals reported that availability has stayed the same. One treatment provider said he thought one sedative-hypnotic was on the increase because he was hearing more about Soma® recently. Another treatment provider reported that drug consumers were using sedative-hypnotics to fight withdrawal symptoms: "[Sedative-hypnotics] are being used when they can't find Suboxone® by the opiate addicts. However, they are finding it does not stop the opiate withdrawal." BCI Richfield crime lab reported that the number of sedative-hypnotic cases it processes has remained stable over the past six months.

Reportedly, many different types of sedative-hypnotics are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ativan® (.5 mg sell for \$0.50; 2 mg sell for \$2), Klonopin® 2 mg (\$2–\$3), Seroquel®, Soma®, Valium®, Xanax® (a.k.a., "footballs;" .25 mg sell for \$0.75; .5 mg sell for \$0.75–\$2; 1 mg sell for \$1–\$4; 2 mg, a.k.a., "xanibars" sell for \$4–\$7). In addition to obtaining sedative-hypnotics on the street from dealers, drug users continue to get them from physicians and friends or relatives. As one treatment provider explained, "It [a sedative-hypnotic] is ... [as] nearby as their medicine cabinet or grandparent's, cousin's, you know."

While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, the most common routes of administration remain oral consumption and intranasal inhalation (snorting). While most participants would typically use one method or the other, a combination of methods was also mentioned. A participant stated, "I would eat half and snort half." Only one participant said she had tried intravenous injection of sedative hypnotics: "I've tried to shoot them [inject sedative-hypnotics] as well and was unsuccessful."

A profile of a typical user of sedative-hypnotics did not emerge from the data. Most participants believed that sedative-hypnotic use transcended race and socio-economic status. As one participant said, "I think everybody [uses sedative-hypnotics], all age groups ... I know the elderly take them [and] you people [professionals] take them." Treatment providers could not come to any agreement about the typical users of sedative-hypnotics.

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, cocaine, Ecstasy, heroin, methamphetamine and prescription opioids. Most participants used sedative-hypnotics to "come down" from other drugs. This common theme was captured in statements like, "When I used to snort cocaine or do [Ecstasy] or an upper type of drug ... taking a Xanax® would help to free [me to] come down off of it better and more easily than if you had nothing at all; When [users] don't have opiates, they are using [sedative-hypnotics] to kind of mellow out." Other participants reported liking to use different drugs with sedative-hypnotics because it changed the high: "I was mainly using them [sedative-hypnotics] with methadone ... which enhances the buzz." Some participants expressed concern about combined prescription opiate and sedative-hypnotic use because it leads to, "a lot of overdoses." Using sedative-hypnotics with all of the aforementioned substances is reportedly common.

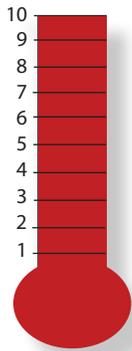
Marijuana

Historical Summary

In the previous reporting period, marijuana 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' (high availability, extremely easy to get). Participants rated marijuana's availability equal to that of heroin as the most available illegal drug in the region. BCI Richfield crime lab reported that marijuana cases made up the greatest proportion of drug cases it reviewed over the previous six months. Participants reported that the quality of marijuana varied with the most common quality score being '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that for commercial-grade marijuana, a "blunt" (single cigar) ranged in price from \$5–\$10 and an ounce ranged in price from \$75–\$120; for high-grade marijuana, a "blunt" (single cigar) sold for \$20 and an ounce ranged in price from \$180–\$400. The most common route of administration for marijuana was smoking. The prevailing thought was that marijuana was widely used. Several participants reported that marijuana blunts were rolled with Tussionex Pennkinetic® (a narcotic liquid cold remedy), and that this trend was common among those 20 to 40 years in age.

Current Trends

Marijuana 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.' Participants often stated that



they wished the availability scale went higher than '10' because they said marijuana was "very plentiful." Despite occasionally having dry spells where little marijuana was available, participants agreed: "Marijuana is the easiest drug to come across." Another participant talked about the ubiquitous nature of marijuana: "I've lived in six different places around on the east coast, and weed [marijuana] has always been abundant anywhere I went." Community professionals also most often reported the drug's current availability as '10'. Treatment providers said

marijuana was, "as available as getting a glass of water; more available than cigarettes." Other treatment providers laughed when one said, "I saw some [marijuana] out there the other day growing by that tree" to express the high availability of marijuana. Law enforcement agreed with statements from treatment providers, describing marijuana as, "the most available drug." Participants reported that the availability of marijuana has stayed the same over the past six months. However, a participant from Belmont County said marijuana was decreasing: "Weed is going away ... because coke and pills are taking over." Community professionals reported that availability of marijuana has stayed the same over the past six months. Law enforcement reported that there has been a transition to indoor growing operations and growing covertly on personal and private property. An officer reported, "Increase in Hispanic outdoor grows using public lands and private lands they sneak on. They live in tents and tend [marijuana] plants full time until harvest time." BCI Richfield crime lab reported that the number of marijuana cases it processes has remained stable over the past six months. Media reports from the region reported several marijuana busts over this reporting period. Police intercepted two pounds of marijuana valued at \$4,500 during a routine traffic stop in Belmont County (www.vindy.com, May 31, 2011), and state highway patrol discovered three pounds of marijuana during a routine traffic stop in Mahoning County (www.nbc4i.com, May 18, 2011).

Participants did not provide quality scores for marijuana because they said all qualities of marijuana were available; the previous most common quality score was '9' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Several participants continue to explain that the quality of marijuana depends on whether the user buys "commercial weed" (low- to mid-grade marijuana) or hydroponically grown (high-grade marijuana). Participant generally agreed that high quality weed was more prevalent: "There's some garbage [marijuana] out too, but mostly high-grade out there now." When describing the quality of marijuana, participants said

low-grade marijuana looked and smelled different from high grade marijuana. A participant described the two types of marijuana as follows: "Commercial [marijuana], which is seedy and stemmy, and then we have 'dro [hydroponically grown marijuana] which has a little bit of red tint and some crystals, and it's really fluffy." According to other participants, low-grade marijuana appeared, "dark brown, which ... looks like grass, like dirt weed," and high-grade marijuana, "has less seeds ... [and] smells better." Another participant discussed the different species of high-grade marijuana: "Indica gets you the high where you just want to sit and chill and watch TV or eat cookies or something you know. Sativa is an uppity high kinda weed [marijuana]. It makes you want to clean; it makes you want to do things, and, um, Afghan is a whole another breed of itself. It's kinda just ... that's just a really good high, and Ruderalis is the weed that only grows about a foot tall and that's just a whole another breed by itself too."

Current street jargon includes countless names for marijuana. The most commonly cited name remains "weed." Participants listed the following as other common street names: "brick," "mid's" and "reg's" for commercial grade (a.k.a., "regular" marijuana); "blueberry," "bubble gum," "purple haze" and "kryptonite" for high-grade marijuana; and "dro" or "hydro" for hydroponically grown marijuana. The price of marijuana continues to depend on the quality desired, with pricing remaining fairly stable from the previous reporting period. Participants reported commercial grade marijuana remains the cheapest form: a blunt (single cigar) or two joints (cigarettes) sell for between \$5-\$10; 1/8 ounce sells for between \$25-\$40; 1/4 ounce sells for between \$50-\$80; an ounce ranges in price from \$130-\$140; a pound sells for between \$400-\$800. Higher quality marijuana ("hydro") continues to sell for significantly more: a blunt (single cigar) or two joints (cigarettes) sell between \$10-\$20; a blunt of "kryptonite" sells for \$35; an ounce sells for between \$250-\$400; and a pound sells for between \$2,500-\$5,000. In general, participants said the high-grade marijuana consistently costs double that of low-grade marijuana in the region.

While there were several reported ways of consuming marijuana, the most common route of administration continues to be smoking. Other participants said some marijuana users consume marijuana baked into food. A participant reported, "I see people bake it [marijuana] in cakes, pies, brownies and stuff." Another participant talked about a slightly different baking method, reporting his friends, "make, like an oil out of it [marijuana]. They'd like cook up the oil and make brownies, cookies, just about anything." Vaporizing marijuana was also mentioned by several participants as a method of consumption. Participants said that method was

preferred by some people because, "it [marijuana] burns at a lower temperature than if you were to roll it and filter it. It is supposed to ... [burn] more of the THC rather than the weed itself."

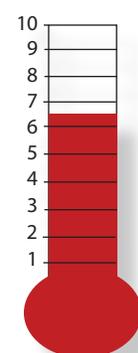
A profile for a typical marijuana user did not emerge from the data. Participants continue to report that marijuana use is prevalent for men and women across all races and ages. Commonly, participants stressed that "everyone" uses marijuana and that the age of first use is very young. One participant commented, "You'd be surprised ... I've seen 12 or 13 [start using marijuana]. My brother was 14 and was caught at school with marijuana." Other participants spoke from first hand-experience: "First time I smoked weed [marijuana] [I] was 13; then you smoke weed for a couple years. Then you get into, you know, cocaine ... and then the opiates." Treatment providers agreed with comments from users about the popularity of the drug: "More than any other substance, maybe even more so than alcohol, it [marijuana] seems to have universal appeal. I have 47 year olds who say if they wouldn't lose their job, they would pick up in a moment, and 13 year olds and Black folks and White folks." Law enforcement also agreed that the popularity of marijuana transcended boundaries, explaining it has the "biggest age range of all of them [drugs of abuse]: high school kids through those in their 60's."

Reportedly, marijuana is used in combination with alcohol, cocaine, Ecstasy, prescription opioids and sedative-hypnotics. Participants said that lacing a marijuana joint or blunt with cocaine continues to be fairly common: "People have done something called 'primo's' where you can put [powdered] cocaine or even crack [into marijuana], and it gives you this out of this world buzz." Other drug users called the combination of marijuana and crack cocaine, "woolie," and they said users can tell when marijuana is laced with crack because, "it stinks really bad; smells like burned toast." Sometimes marijuana is reportedly smoked after using crack cocaine and not at the same time. Participants said that smoking marijuana in this way helped to "come down" off of other drugs: "Like when you come off coke [powdered cocaine] or crack [cocaine], smoking a blunt of marijuana would really help to ease you coming down off that other buzz." It is also popular for users to dip their marijuana blunts and joints into liquid medicines like promethazine (an allergy medicine) and Tussionex® (a cough and cold medicine), reported in previous report. Reportedly, PCP (phencyclidine) continues to be occasionally used by participants along with marijuana. Users explained that they dipped their marijuana blunts and joints into liquid PCP, which they called "black water," "wet" and "wet stick." If they dipped their marijuana blunts and joints into embalming fluid, they called it a "love boat."

Methamphetamine Historical Summary

In the previous reporting period, methamphetamine was relatively rare in the region. Most participants knew little about the drug. Participants most often reported the drug's current availability as '1' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Law enforcement rated availability as "1 or 2." Treatment professionals agreed that there was little availability in the region except for one area; reportedly availability was '10' in Ashtabula County where methamphetamine was said to be popular. BCI Richfield crime lab reported an increase in both powdered and crystal methamphetamine cases that it had processed over the previous six months. Participants reported they could buy a gram of powdered methamphetamine for \$50 and a gram of crystal methamphetamine for \$150. The most common routes of administration for this drug were smoking followed by injecting. Treatment professionals described typical users of this drug as 18 to 38-year-old Whites.

Current Trends



Methamphetamine is moderately available in the region. Participant median score for this drug's current availability was '6.5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '1'. Participants reported that methamphetamine is available in powder and crystal forms. Participants with experience in buying methamphetamine in the past six months described the powder as, "white color, almost looked like coke [powdered cocaine]." Only one person had experience with buying the crystal form of the drug, which was described as looking like "glass." Law enforcement reported that some methamphetamine has been coming in from Mexico: "We have seen some Mexican meth [methamphetamine], powder form." Experience with methamphetamine varied widely around the Youngstown region, with most people with methamphetamine experience reporting from west of Youngstown (Leavittsburg and Windham) and from Ashtabula County. Even in those areas, users said that availability varied: "It's [methamphetamine] more of a rural type of setting than in the inner cities yet." Community professionals most often reported the drug's current availability as '3' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers did not believe methamphetamine

was a very popular drug: *"It's [methamphetamine] available, but not a highly requested drug."* Law enforcement agreed that they did not see it very often except in a few counties. As one officer said, *"Portage and Ashtabula counties [are] problem counties"* for methamphetamine. When asked why methamphetamine was not more popular in the area, a treatment provider pointed to those in charge of the drug trade. He explained, *"The drug brokers don't want crystal meth [methamphetamine] in because it causes too much commotion. There is too much violence behind it and too much crazy, too many crazy people, and it messes with business ..."* Participants reported that the availability of methamphetamine has decreased in the Ashtabula area due to drug busts over the past year. However, participants closer to Youngstown reported that availability of methamphetamine has increased because more people have been making it over the past six months. Law enforcement reported that the availability of methamphetamine has slightly decreased over the past six months but were not certain of the reason for the decrease. An officer explained, *"It might be a false [conclusion that methamphetamine's availability has decreased] because everyone is moving away from the traditional meth labs ... to these one-pot methods where you are making enough for you and your buddy on a daily basis."* BCI Richfield crime lab reported that the number of crystal and powder methamphetamine cases it processes has increased over the past six months.

Participants did not give one quality rating for methamphetamine, because they explained quality could range from a '0' to a '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Most often participants reported being dissatisfied with the quality of methamphetamine, whereas last reporting period, most participants reported the quality of methamphetamine as high. As one participant stated, *"Most of the stuff [methamphetamine] around here is like what I call bathtub shit. They're [cookers] not chemically inclined to be making a purer substance [like] you would see out west."* Another participant stated that the quality of methamphetamine depended on the recipe: *"When somebody cooks [methamphetamine], you can get the bottom, which is nothing or you can get the top, which is '10'."*

Current street jargon includes one common name for methamphetamine, that being "meth." Current street prices for methamphetamine were consistent among participants with experience buying the drug. Participants did not break down prices for powdered and crystal (a.k.a., "glass") methamphetamine but reported a half gram sells for \$20 and a quarter ounce sells for \$30. Reportedly, the most common route of administration of methamphetamine continues to

be smoking. Other routes of administration that were cited as less common include intranasal inhalation (snorting) and injection.

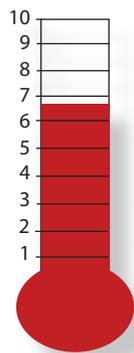
A profile of a typical methamphetamine user emerged from the data. Treatment professionals described typical users of methamphetamine as, *"mostly White males, 30 – 50."* Law enforcement officers concurred with treatment providers and said methamphetamine, *"Tends to be a Caucasian drug. We see it as more rural in terms of use."* Reportedly, methamphetamine is used in combination with alcohol, marijuana, prescription opioids and sedative-hypnotics. Participants reported using methamphetamine with these drugs to create the "speedball effect" in which users experience a high and then a low. A more common reason for combining methamphetamine with other drugs is to help in coming down from the methamphetamine high; reportedly, users *"will stay high for so many days, they'll need something to bring them down."*

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 most often reported the drug's availability as "5.5" on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). The availability of the drug was thought to vary depending on the season; participants considered Ecstasy a 'summertime' drug. BCI Richfield crime lab reported an increase in the number of Ecstasy cases that it had processed over the previous six months. Participants reported a "single stack" (low dose) Ecstasy tablet sold for \$8 – \$10 and a "double stack" or "triple stack" (high dose) sold for \$16 – \$30. The quality of Ecstasy was variable, with some users reporting moderate quality and others reporting low quality. The only reported method of administration was oral consumption.

Current Trends

Ecstasy [methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP] remains moderately available in the region. Participants reported the median score for Ecstasy as '6.75' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '5.5.' Participants continue to report that Ecstasy is more available in the summer and at certain other times of the year: *"Memorial Day, Halloween ... you know when people want to hangout and party."* Treatment providers most often



reported the drug's current availability as '7' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Treatment providers agreed that Ecstasy use is most often reported by the "adolescent population ... [but Ecstasy is] not as common or popular [as it once was]." Law enforcement agreed that Ecstasy was "very rare." An officer explained, "We see it [Ecstasy], not like we used to five years ago or eight years ago." Participants reported that the availability of Ecstasy has decreased over the past six months; however, they anticipated it will increase soon. As one participant said, "Right now, with summer and stuff, it's [Ecstasy] gonna become more available, and ... the last couple weeks before I come in here, there were a few people that had it." BCI Richfield crime lab reported that the number of Ecstasy cases it processes has decreased over the past six months.

Current street jargon for Ecstasy is limited; the only names reported for Ecstasy were "candy" and "skittles." Participants reported that Ecstasy comes in a variety of colors and looks like a "breath mint;" common pictures on Ecstasy pills include dollar signs, fish, naked ladies, Obama's head, Teenage Mutant Turtles and Transformers. Like other drugs, reportedly, Ecstasy prices are variable and largely depend upon, "who you know and how good of a deal they give you." Participants reported pricing that was slightly lower than last reporting period: a "single stack" (low dose) Ecstasy tablet sells for \$5–\$8 and a "double stack" or "triple stack" (high dose) sells for \$12–\$20. Bottles/jars of Ecstasy (100 dosage units) were reportedly available and cost anywhere from \$200–\$400. BCI Richfield crime lab cited methcathinone analogs (psychoactive stimulants) and other clandestine uncontrolled substances (bath salts) as cutting agents for Ecstasy.

A profile for a typical Ecstasy user emerged from the data. Participants said people interested in Ecstasy were "anyone 18–30 years old." One participant said that people who prefer Ecstasy also are, "the same people using the coke [cocaine] [and] the opiates." Law enforcement agreed with participants, and said Ecstasy users were typically, "college students [with] some high school [users]." Treatment providers reported that adolescents start experimenting with Ecstasy early, and use is not discriminate across gender and racial boundaries: "It [Ecstasy use] can go anywhere from any type of ethnicity ... 14–15 year-old African-American female[s] [or] male[s], to 14–15 year old Caucasian female[s] [or] male[s]." According to treatment professionals, young males use Ecstasy, "so they can stimulate [their] sex drive." Reportedly, Ecstasy is used in combination with crack cocaine and powdered cocaine.

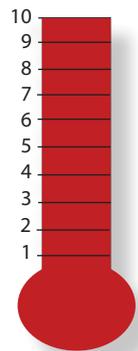
Prescription Stimulants

Historical Summary

In the previous reporting period, prescription stimulants (Adderall® and Ritalin®) were somewhat available in the region. Participants most often reported availability of these drugs as '4' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Participants believed that prescription stimulants were popular among all age groups while treatment providers believed they tended to be more popular with younger (< 26 years), White males and females. Aside from getting prescription stimulants from the streets, participants also reported getting them from friends and physicians. The most common reported method of administration was crushing and snorting the medicines.

Current Trends

Adderall® and Ativan® are highly available in the region. Participants rated the availability of prescription stimulants generally 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 '4.' VyVanse® was also mentioned as being available by a minority of participants. Much like Adderall®, VyVanse® is a newer drug to treat symptoms of attention deficit hyperactivity disorder. A treatment provider said his client was addicted to VyVanse®: "I had a lady who shot it [injected VyVanse®]. She said that it was new. She said that it was like Adderall®." BCI Richfield crime lab reported that the number of prescription stimulant cases it processes has remained stable over the past six months.



Current street jargon for prescription stimulants is limited; the only names for Adderall® reported were "poor man's coke" and "pumpkins." VyVanse® did not have any slang terms associated with it. The following prescription opioids are available to the street-level users (Note: When reported, current street prices are indicated in parentheses): Adderall® 10 mg; Adderall® 20 mg; Adderall® 25 mg; and Adderall® 30 mg (all pills sold between \$1–\$6); Ativan® (\$2 per pill, mg unspecified) and VyVanse®. While participants did not provide a profile for a typical user, they said the most likely person to abuse these medications was someone looking to, "use it [prescription stimulants] as a substitute for methamphetamine." When discussing the age drug users first abused prescription stimulants, participants had very dissimilar experiences. One participant said her parents abused her Adderall® and then encouraged her to abuse Adderall®. Another had a different

story, "When I was 15, the first thing I ever snorted was Ritalin®. I was prescribed it [but] I hung out with the older crowd ... and the older crowd was like 'we can snort these.'"

Prescription and OTC Cough Medicines

Historical Summary

In the previous reporting period, prescription and over-the-counter (OTC) cough medicines were highly available in the region. Participants most often reported the drug's current availability as '9' on a scale of '0' (not available, impossible to get) to '10' (high availability, extremely easy to get). Mahoning County law enforcement reported that the trend to abuse cough medicines was increasing. Participant and professional interviewees believed that illicit use of cough medicine was most popular among younger people (< 18 years) who did not have access to other substances. Participants reported that cough medicines containing DXM (dextromethorphan) were well liked because they caused users to hallucinate. The most often reported route of administration was oral consumption, but several participants also reported dipping tobacco cigarettes and marijuana "blunts" in cough medicine before smoking.

Current Trends

Prescription and over-the-counter (OTC) cough medicines appear popular among adolescent users. While none of the participants currently used these medications, some admitted to being addicted to them when they were younger. OTC cough medicines containing dextromethorphan (DXM), like Coricidin Cough and Cold®, Nyquil® and Robitussin® are reportedly the most sought after substances to abuse. The ingestion of prescription and OTC cough medicines, commonly called "Robo-tripping," is believed to be increasing. A participant stated, "The cough syrup thing is getting bigger with the younger crowd. My nephew, he's in high school and he knows quite a few people in his school that use cough syrup to get drunk, I'd guess you'd say." Treatment providers concurred that abuse of prescription and OTC cough medicines is increasing. A typical user profile did not emerge from the data among adolescents because providers reported that abuse of this class of drugs spans, "male, female; it doesn't matter if [you're] African-American or Caucasian." The most often reported route of administration remains oral consumption, but treatment providers also reported users dipping tobacco cigarettes and marijuana "blunts" in cough medicine before smoking. Treatment providers reported that adolescents "soak their Black & Mild® cigars in the [cough] syrup; dip it in there, and sometimes they talk of drinking it straight out of the bottle." In contrast, reportedly, young adults 18–21 are abusing less cough syrup according to counselors, but they are, "dipping their cannabis

joints or blunts into that substance [cough medicines] to make them stronger or sweeter."

Other Drugs

Historical Summary

In the previous reporting period, participants and 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 with alcohol, gamma-hydroxybutyric acid (GHB), hallucinogens [i.e., lysergic acid diethylamide (LSD) and psilocybin mushrooms], inhalants and synthetic marijuana ("K2" and "Spice"). LSD was mentioned by a few participants while others reported not having seen it in a while. Participants reported that the availability of LSD fluctuated with the seasons and that it was more of a "summertime" drug. A minority of participants also used psilocybin mushrooms and said they were available in a limited number of areas. The most commonly reported method of administration for mushrooms was oral consumption, eating or mixing them with tea. Reportedly, synthetic marijuana ("K2" and "Spice") was being used by a few participants for recreational use and as a stand-in for marijuana when participants needed to pass a drug test. Energy drinks with alcohol were used in combination with other drugs to modify the high experienced by users. Inhalants were mentioned as being popular with younger people (< 18 years), but none of the participants interviewed reported using them. Gamma-hydroxybutyric acid (GHB) was reportedly used by a few drug users to "come down" after using cocaine.

Current Trends

Participants and 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. Reportedly, synthetic marijuana (K2, "K3" and "Spice") continues to be used by a few participants for recreational use and as a substitute for marijuana when participants need to pass a drug test. A participant stated, "I know a couple of people that smoke K2 and K3 [because] it don't show up in a piss test. It's like weed [marijuana], but [it gives] you that high effect and don't show up in your pee." Treatment providers reported that they believed the abuse of synthetic marijuana is on the increase: "In the last six months, year [to a] year, we have heard a whole lot more about it [synthetic marijuana]. We had some clients using. We got a drug test that could screen for K2. Had some clients testing positive for that, but not a significant amount of clients who actually used it for any length of time." Law enforcement also spoke about synthetic marijuana and their significant concerns about its use. As one officer said, "I'm aware of at least three to four overdoses of young people

on K2 over the past six months—luckily no deaths.” Treatment providers mentioned that inhalants are popular among a minority of their clients, most of them under 16 years old. A treatment provider reported, *“One or two of my clients in the [past] six months with that duster ... I was surprised to see ... [a] female 52 years of age ... but she used it because she knew it wouldn’t come up in a drug screen.”* A minority of participants reported experience with inhalants, but most of this experience was not recent. A few participants reported abuse of five-hour energy drinks. A participant reported, *“I know people that take 10–15 [five-hour] energy drinks at a time and when you do it like that, I’m sure that’s abusing them.”* Caffeinated alcohol (“Four Loko”) was also abused by one participant, who explained that Four Loko gave him, *“a rush kinda, and I drank like seven of them and that’s the last thing I remember because I was drinking them so fast, and that I mean, I was severely sick.”* Hallucinogens like psilocybin mushrooms and PCP (phencyclidine, a.k.a., “sherm” and “wet”) had limited availability in the region. A law enforcement professional reported that mushrooms, *“are available in summer when bands come in and in camp grounds. I wouldn’t say it was mainstream.”* While most participants knew about bath salts (“White Lightening”), none of them abused the substance. Only one participant knew of someone who abused the substance for its cocaine-like effects. BCI Richfield crime lab reported that the number of LSD, psilocybin mushroom and synthetic cannabinoid cases it processes has increased while the numbers of processed cases for all other drugs mentioned in this section have remained stable over the past six months.

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids, sedative-hypnotics and Suboxone® remain highly available in the Youngstown region. Noted increases in availability over the previous six months exist for heroin, Suboxone®, methamphetamine and prescription stimulants; noted decreases exist for OxyContin® OC and Ecstasy. Participants and community professionals attributed the increase in heroin use and availability over the past six months mostly to the price of prescription opioids. BCI Richfield crime lab reported that the number of powdered heroin cases it processes has increased, reporting having processed approximately 1,500 heroin cases over the past six months, making powdered heroin the most processed drug through BCI Richfield crime lab. Participants reported that the quality (potency) of heroin has also increased. Along with widespread reports of intravenous use of heroin (most common route of administration) were widespread reports of sharing of injection needles, hepatitis C infections and overdoses involving heroin. The consensus among participant and community professional groups was that heroin users continue to be predominately White males

and females between the ages of 20 and 35 years, although several community professionals continue to report increasing heroin use among adolescents, particularly teenaged females. Participants and community professionals reported that the high availability of prescription opioids has remained stable over the past six months, with the exception of OxyContin® OC which has decreased in availability due to its discontinuation and replacement by the more tamper resistant OxyContin® OP. Participants noted increasing popularity of Opana® and Ultram®, and Norco® was reported as available when there were no reports of its use previously. The consensus among participants and community professionals was that the most common route for obtaining prescription opioids remains through area physicians. Participants and community professionals also continued to report an increase in Suboxone® street availability. Participants reported an increase in doctors prescribing of Suboxone® strips, with reports of users injecting these strips. While acknowledging that Suboxone® is tremendously helpful to those who take the drug as directed for its intended purpose, participants continue to widely report abuse of Suboxone® by those addicted to opiates that use the drug to keep from experiencing withdrawal between opiate purchases and by those not addicted to opiates who are seeking to get high. Participants reported that benzodiazepine use with Suboxone® is very common. Participants reported that the availability of methamphetamine has decreased in the Ashtabula area due to drug busts over the past year. However, participants closer to Youngstown reported that availability of methamphetamine has increased because more people have been making it. Law enforcement reported that some methamphetamine has been coming in from Mexico. Community professionals described typical users of methamphetamine as, *“mostly White males, 30–50.”* Adderall® and Ativan® are highly available in the region. Vyvanse®, a newer prescription stimulant, was also mentioned as being available by a minority of participants. The ingestion of prescription and OTC cough medicines, commonly called “Robo-tripping,” is believed to be increasing. Reportedly, synthetic marijuana (“K2,” “K3” and “Spice”) continues to be used by a few participants for recreational use and as a substitute for marijuana when participants need to pass a drug test. Treatment providers reported that they believed the abuse of synthetic marijuana is on the increase. Reportedly, some treatment providers have started to screen for synthetic marijuana in urine drug screens administered to clients. Lastly, while most participants knew about bath salts (“White Lightening”), none of them abused these synthetic cocaine substances.