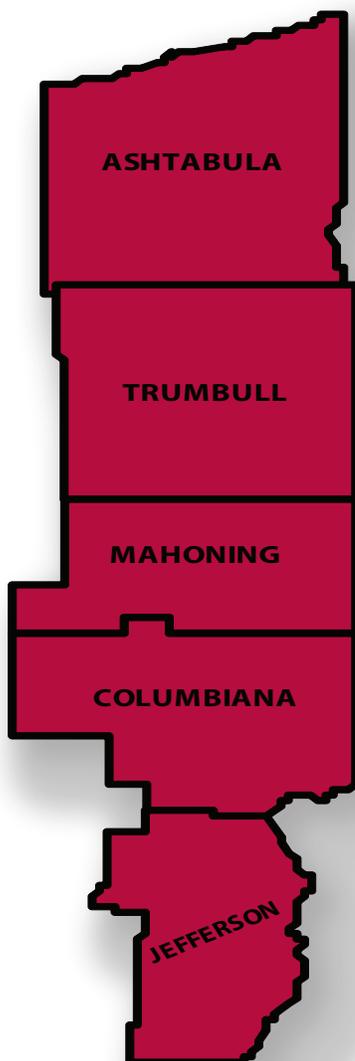


Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Youngstown Region

January-June 2012

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Youngstown Regional Profile

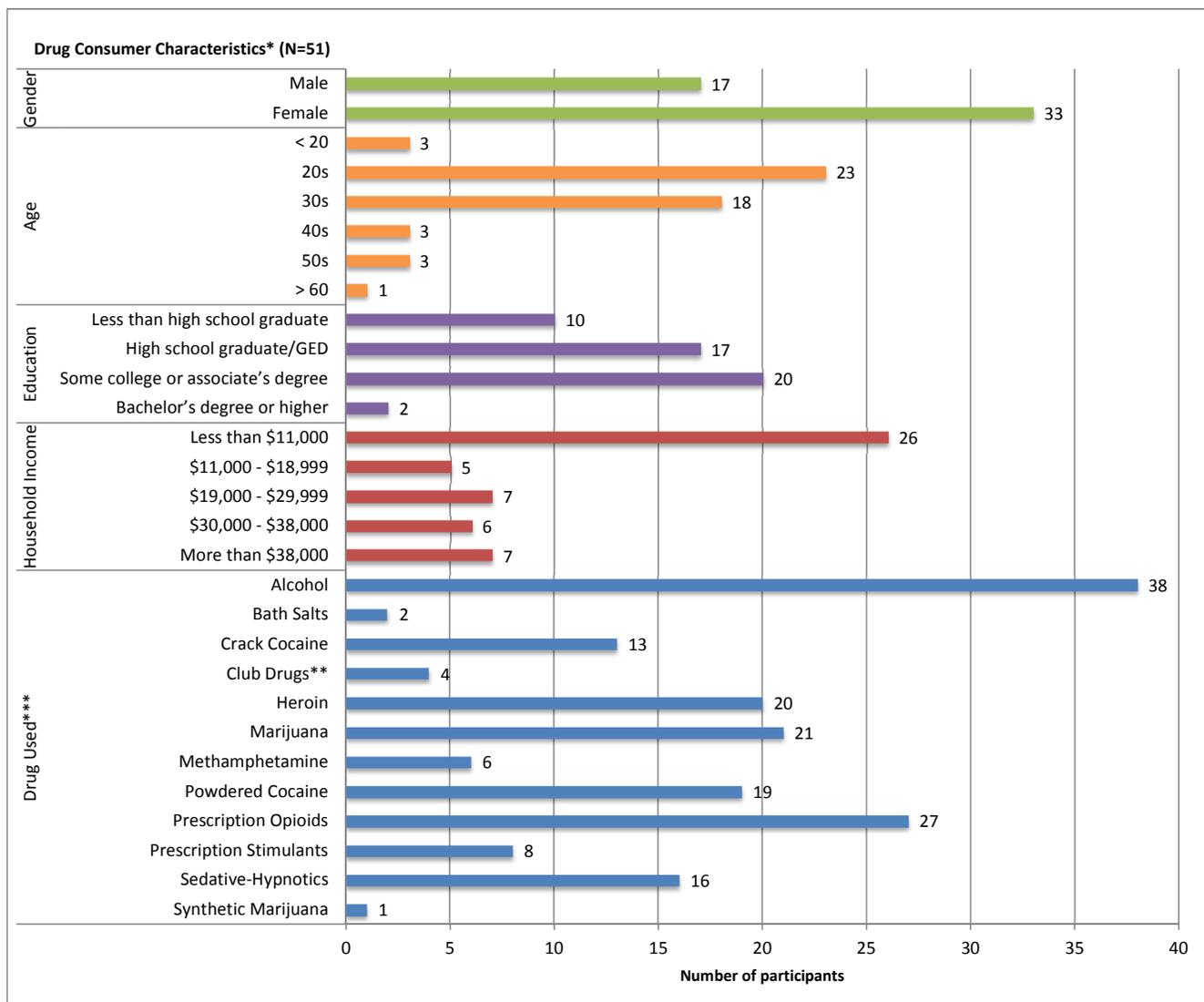
Indicator ¹	Ohio	Youngstown Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	728,182	51
Gender (Female), 2010	51.2%	51.1%	66% ²
Whites, 2010	81.1%	86.3%	86.3%
African Americans, 2010	12.0%	8.7%	3.9%
Hispanic or Latino Origin, 2010	3.1%	2.7%	3.9%
High school graduates, 2009-2010	84.3%	86.8%	79.6% ³
Median household income, 2010	\$45,151	\$38,228	Less than \$11,000 ⁴
Persons below poverty, 2010	15.8%	16.9%	66.70%

Ohio and Youngstown statistics are derived from the U.S. Census Bureau.¹

Gender was unable to be determined for one respondent due to missing data.²

Graduation status was unable to be determined for two respondents due to missing data.³

Respondents reported income by selecting a category that best represented their household's approximate income for 2012.⁴



*Not all participants filled out forms; therefore, numbers may not equal 51.

**Club drugs refers to Ecstasy and psilocybin mushrooms

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

Data Sources

This regional report was based upon qualitative data collected via focus group interviews. Participants were active and recovering drug users recruited from alcohol and other drug treatment programs in Ashtabula, 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 Mahoning County Coroner's Office and the Bureau of Criminal Investigation (BCI) Richfield Office, which serves the Akron, Cleveland and Youngstown areas. BCI data are summary data of cases processed from July to December 2011. Note: OSAM participants were asked to report on drug use/knowledge pertaining to the past six months (from time of interview through prior six months); thus, current BCI data correspond to the current reporting period of participants. In addition to these data sources, Ohio media outlets were queried for information regarding regional drug abuse for January through June 2012.

Powdered Cocaine Historical Summary

In the previous reporting period, powdered cocaine was highly available in the region. Participants and community professionals most often reported the drug's availability as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants and community professionals reported that the availability of powdered cocaine had remained the same during the previous six months. The BCI Richfield Crime Lab reported that the number of powdered cocaine cases it processed had also remained the same during the past six months. Most participants rated the quality of powdered cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality). There was consensus among participants that the quality of powdered cocaine had decreased during the past six months. The BCI Richfield Crime Lab cited the following substances as commonly used to cut powdered cocaine: caffeine, benzocaine (local anesthetic), diltiazem (medication used to treat heart conditions/high blood pressure) and levamisole (livestock dewormer). The most commonly cited street names for powdered cocaine were "blow," "girl" and "powder." Participants reported that a gram of powdered cocaine continued to sell for between \$60-100, depending on quality. Participants reported that the most common route of administration for powdered cocaine remained snorting,

followed by intravenous injection. Out of 10 powdered cocaine users, participants reported that approximately eight would snort and two would intravenously inject. Participants most often described typical users of powdered cocaine as "teenagers and people in their early 20s," as one participant stated, confirming use among young adults between 18-25 years of age.

Current Trends

Powdered cocaine remains highly available in the region. Participants and community professionals most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was '8.' However, most participants continued to report that crack cocaine is more available in the region than powdered cocaine. One participant stated, "Powder [cocaine] is definitely easy to find. You have to look for it though a little more than rock [crack cocaine]." Treatment providers also noted that crack cocaine is seemingly more available and used than powdered cocaine. One treatment provider stated, "You don't see it [powdered cocaine] as much as crack [cocaine], but it's pretty available. Clients talk about it in groups pretty frequently." A law enforcement official reported, "Powdered cocaine, we might find that in search warrants along with other drugs, but it's largely a suburban drug. Crack cocaine is largely an urban drug." Participants agreed that powdered cocaine, along with other drugs, is more difficult to get in various areas of the region. A participant from Ashtabula County reported, "Powder is harder to find, maybe a six to seven [on the availability scale], and more expensive here than in Youngstown." A participant from Trumbull County agreed, "I think Youngstown has a lot more powder than Warren." Collaborating data also indicated that powdered cocaine is readily available in the region. The Mahoning County Coroner's Office reported that 17.5 percent of all deaths it investigated during the past six months were drug-related (had an illegal substance present or legal drug above the therapeutic range at time of death). Furthermore, the coroner's office reported cocaine as present in 37.0 percent of all drug-related deaths (Note: coroner's data is aggregate data of powdered cocaine and crack cocaine and does not differentiate between these two forms of cocaine). Both participants and community professionals reported that the availability of powdered cocaine has remained the same during the past six months. The BCI Richfield Crime Lab reported that the number of powdered cocaine cases it processes has remained the same during the past six months.

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

is cut (adulterated) with baby laxative, baking soda, ether, NoDoz®, prescription opioids, sleeping pills (Sleepinal®) and vitamins (B12). Participants reported, *"I'd say Vitamin B12 is the most common [cutting agent] and baking soda. They are cheap; I used Ultram® to cut powder."* Several participants also reported that head shops (stores that sell drug paraphernalia) sell products that can be used for cutting drugs. One participant said, *"You can get that Bolivian Rock from the head shop that's pretty popular. But, it'll be more expensive than vitamins or something else."* During the past six months, participants reported that the quality of powdered cocaine has remained the same. Participants with experience using powdered cocaine reported, *"People cut the hell out of it [powdered cocaine]. It's garbage ... mostly baking soda; It's low quality because everything is cut. It's junk ... been stepped on [adulterated] so many times."* Participants also noted that the quality of powdered cocaine depends on who you buy it from: *"I've had it [powder cocaine] be a '3' [quality score] all the way through an '8-9'; depending on who you buy it from and how many hands it's gone through; By the time it gets to Ashtabula from Youngstown, and before that, it's just been cut, and it's just shit."* The BCI Richfield Crime Lab continued to cite the following substances as commonly used to cut cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine and procaine (local anesthetics). (Note: crime lab data is aggregate data of powdered cocaine and crack cocaine and no longer differentiates between these two forms of cocaine).

Current street jargon includes many names for powdered cocaine. The most commonly cited names were "girl," "powder" and "soft." Participants listed the following as other common street names: "bitch," "blow," "candy," "coke," "dirty white girl," "snow," "soft candy," and "white girl." Participants reported that a gram of powdered cocaine sells for between \$50-60, depending on the quality; 1/16 ounce, or "teener," sells for \$100; 1/8 ounce, or "eight ball," sells for between \$150-180; an ounce sells for between \$1,200-1,400. Participants reported that the most common route of administration for powdered cocaine remains snorting, followed less commonly by intravenous injection. In addition, many participants identified powdered cocaine as a drug commonly used in combination with heroin to "speedball." Many users noted the practice of "speedballing," or mixing powdered cocaine with heroin for injection, as producing, as one participant said, a "better high." Out of 10 powdered cocaine users, participants reported that approximately five would snort and five would intravenously inject or "shoot" it. A participant with experience using powdered cocaine reported, *"I don't know. I just don't see that many people using coke [alone]. If they do, it's with heroin [to speedball]."* Out of 10 heroin users, participants reported that eight would "speedball" with powdered cocaine.

A profile for a typical powdered cocaine user did not emerge from the data. Participants often described typical users of powdered cocaine as "anyone and everyone." However, participants also often noted that powdered cocaine users have money and tend to be from more affluent communities and families. Participants reported: *"I think people who are in higher class [with] more money use it [powdered cocaine]. It's more expensive; Powder is pretty expensive ... way more expensive than heroin."* Many participants also noted some age differences with powdered cocaine use: *"I think [powdered cocaine use] it's younger kids, maybe 14-18 [years old]. You don't see it a lot beyond that. You see crack with older people."* Several participants also agreed that some individuals will use powdered cocaine to stay awake and alert: *"I've known a lot of truck drivers that have gotten hooked on that [powdered cocaine] because they have deadlines to meet, so they try to stay awake; I used it [powdered cocaine] when I was younger. High-school and college-aged kids [use it]. I think kids use it to stay awake and study."*

Reportedly, powdered cocaine is used in combination with alcohol, heroin, marijuana, methamphetamine and prescription opioids. Participants agreed that other drugs are used in combination with powdered cocaine to "level-out" and help "come down" from the high of powdered cocaine. Participants reported using various "downer" drugs after having used powdered cocaine, although some participants reported using other drugs at the same time as powdered cocaine. A participant stated, *"I had to be drunk or have Xanax® to use [powdered] cocaine to balance it out, come down."* Other participants agreed that lacing marijuana with powdered cocaine is relatively common. One participant stated, *"I know a lot of people who will lace their [marijuana] blunts [with powdered cocaine] ... [called] 'woolies.'" Still other participants reported lacing tobacco/cigarettes with powdered cocaine, as one stated: "I've seen people lace their tobacco ... sprinkle it [powdered cocaine] in and roll up their own cigarettes." Several participants with experience using methamphetamine agreed that powdered cocaine is also commonly used with methamphetamine. One participant stated, *"I used it [powdered cocaine] with meth [methamphetamine]. I would shoot cocaine and meth together. Some people will snort coke and then smoke meth ..."**

Crack Cocaine **Historical Summary**

In the previous reporting period, crack cocaine was highly available in the region. Participants and community professionals most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10'

(highly available, extremely easy to get). However, there was consensus among participants that crack cocaine was more difficult to obtain in smaller towns and rural areas. Most participants rated the quality of crack cocaine as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI Richfield Crime Lab continued to cite the following substances as commonly used to cut crack cocaine: caffeine and diltiazem (medication used to treat heart conditions/high blood pressure). Participants reported that crack cocaine was sold in dollar amounts (\$10, \$20, \$50, etc.). The most common route of administration for crack cocaine remained smoking. Participants said that use of crack cocaine was wide-ranging throughout all demographic profiles, and they could not identify a typical user.

Current Trends

Crack cocaine remains highly available in the region. Participants and community professionals most often reported the drug's current availability as a '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' A participant explained, "[Crack cocaine] it's on every street corner." Another participant agreed, "Crack [cocaine] is a '12' [on the above availability scale] in this area ... a 20 [extremely available]." Participants reported that the availability of crack cocaine has remained the same during the past six months. A participant summed up the common belief concerning availability, "Crack [availability] will always be the same [highly available]." Treatment providers and law enforcement were divided on a status change in availability of crack cocaine. Treatment providers reported that availability of crack cocaine has remained the same during the past six months. A provider said, "Crack is our stand-by drug ... pretty consistent ... it's always out there." However, law enforcement noted a decrease in crack cocaine possibly due to the rise in heroin over recent years. A law enforcement officer explained, "Crack has definitely gone down in the last year I would say. You can make more money off of heroin, so we've seen a decrease [in crack cocaine]." The BCI Richfield Crime Lab reported the number of crack cocaine cases it processes has remained the same during the past six months.

Most participants rated the quality of crack cocaine as '5' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '6.' Participants reported that crack cocaine in the region is cut with Anbesol®, aspirin, baby laxative, baking soda and products from head shops (stores that sell drug paraphernalia) such as procaine (local anesthetic). Most participants agreed that quality depends on several factors. A participant explained, "It [quality of crack cocaine] completely depends on where you get it, from whom, and what they cut it with ... how many hands have touched

it before it gets to you." Participants reported that the quality of crack cocaine has remained the same during the past six months.

Current street jargon includes many names for crack cocaine. The most commonly cited names were "crack," "hard" and "work." Participants listed the following as other common street names: "A1," "cream," "girl," "hard work," "her" and "rock." Participants with experience buying crack cocaine reported that current street prices for the drug are as low as \$5. In addition, several participants reported that crack cocaine is priced at \$10 per tenth of a gram with one reporting, "Every tenth of a gram is \$10. So .2 on the scale is \$20, .3 is \$30, .4 is \$40." However, most participants continued to report that crack cocaine is sold in dollar amounts (\$10, \$20, \$50, etc.) and not by exact weight. Another participant explained, "They don't really sell it [crack cocaine] like that though or in a gram. It's like dollar amounts – \$15 or \$20 worth of crack ... \$15 rock, a \$20 bag." Participants who were able to identify prices for larger quantities reported that a gram of crack cocaine sells for between \$40-70; an ounce sells for between \$1,100-1,250. While there were a few reported ways of using crack cocaine, generally, the most common routes of administration are smoking and intravenous injection. Out of 10 crack cocaine users, participants reported that approximately five would smoke, and five would intravenously inject or "shoot" it. Some participants thought use patterns varied depending on age. A participant stated, "Your old-school crack users would [smoke]."

A profile of a typical user of crack cocaine did not emerge from the data. Overall, participants agreed with one participant who described typical users of crack cocaine as, "everybody and anybody." A participant reported, "I saw every type of person [use crack cocaine] ... all lifestyles." However, many participants agreed that a certain "stigma" is attached to users of crack cocaine; therefore, crack cocaine users may have low income and live in lower-income neighborhoods. A participant explained, "Crack is like ... [for] mostly people that's hit rock bottom. It's real cheap." Another participant noted, "Nowadays, it's more acceptable to be a heroin addict than a crack addict." Several participants mentioned race and age differences among users of crack cocaine. A participant explained, "I think it's old people ... like 40s and up [who use crack cocaine]. Younger people are doing heroin." Many participants reported use of crack cocaine to be more common among African-Americans than other racial groups.

Reportedly, crack cocaine is used in combination with alcohol, heroin, marijuana (aka "primo") and sedative-hypnotics. Participants reported using various drugs to help "come down" and level out the high from crack cocaine. A participant commented, "Heroin, alcohol, marijuana ...

anything to help to come down or level out [from crack cocaine use]. It levels you out, so you're not all tweaked out." Other participants used crack cocaine to simulate a "high-low" roller coaster effect (aka "speedball"). A participant stated, "It [speedballing heroin with crack cocaine] gives you a different kind of high, a body buzz." Many participants believed there has been an increase in this practice. A participant explained, "It [speedballing] has so increased ... so many people, and young too, are speedballing with heroin now."

Heroin

Historical Summary



In the previous reporting period, heroin was highly available in the region. Participants and community professionals most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While many types of heroin were available in the region, participants reported brown powdered heroin as most available. Participants reported that heroin was easier to get than many other drugs. Law enforcement officials noted heroin as the most common drug they encountered,

reporting that throughout the entire region, heroin was the primary drug problem. Participants reported black tar heroin as rarely available, rating its availability as '2.' Participants and community professionals reported that the availability of heroin had either remained the same or had increased in some areas during the past six months. The BCI Richfield Crime Lab reported that the number of heroin cases it processed had increased during the past six months. Most participants generally rated the quality of heroin as an '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The BCI Richfield Crime Lab cited caffeine and diphenhydramine (antihistamine) as commonly used to cut powdered heroin. The most commonly cited street names for heroin included "boy" and "dog food." Participants reported that brown powdered heroin was available in different quantities: a "baggie" or "stamp" (1/10 gram) generally sold for \$20; however, \$10, \$20 and \$30 stamps could also be purchased; a gram sold for between \$75-150, depending on quality and county within the region. Participants continued to report that the most common route of administration for heroin remained intravenous injection. Out of 10 heroin users, participants reported that approximately nine would intravenously inject it and one would snort it. Participants described typical users of heroin as "all types of people." However, most participants and community professionals

agreed that heroin was a significant problem among 18-25 year olds.

Current Trends

Heroin remains highly available in the region. Participants and community professionals most often reported overall availability of the heroin as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. While many types of heroin are currently available in the region, participants continued to report the availability of brown powdered heroin as most available. Law enforcement officials also noted brown powdered heroin as the most common type found in heroin cases. The BCI Richfield Crime Lab continued to describe powdered heroin cases it processes as brown or white. Participants from Ashtabula, Mahoning and Trumbull counties again reported that heroin is easier to obtain than many other drugs. Throughout the entire region, law enforcement reported heroin to be the primary drug problem: "We had four heroin overdoses in the last week; Everyone's getting into the [heroin] 'business' per se; Even some of the informants we've used in the past for crack [cocaine busts], they're not doing crack no more ... they're doing heroin. Everything's transferring over to heroin." Treatment providers also reported heroin to be the primary drug problem among clients: "Heroin is definitely our primary [treatment] problem; Heroin is reaching out the suburbs and people are coming from all over the place to get heroin here." Collaborating data also indicated that heroin is readily available in the region. The Mahoning County Coroner's Office reported heroin as present in 14.8 percent of all drug-related deaths. Media from the region reported on recent arrests related to heroin during this current reporting period. In February, four people were arrested in the Youngstown area for drug trafficking in crack cocaine and heroin, including fake heroin (www.tribtoday.com, Feb. 27, 2012). The following month, Steubenville Police (Jefferson County) arrested a woman for possession of heroin and possession of drug paraphernalia after paramedics found her passed out in a public restroom (www.heraldstaronline.com, March 20, 2012).

Participants reported black tar heroin to be rarely available, rating its current availability as '1' on a scale of '0' (not available, impossible to get) to '10' (highly available extremely easy to get); the previous most common score was '2.' Participants with experience using heroin reported: "I've never seen it [black tar heroin] ... you can't get it around here; Black tar comes in little balls sealed up in balloons ... but it's very hard to get; Black tar ... that's in bigger cities ... New York, Detroit." Treatment providers also reported that black tar heroin is rarely available in the region, but they again noted that clients do not typically identify what types of heroin are being used. Law enforcement reported having one black tar heroin case

during the past year. A law enforcement official stated, *"We haven't seen black tar at all. We've had one case in the last year, but we hadn't seen it in a long time, even at that point."* Most participants agreed that they have not specifically seen all-white powdered heroin, although some brown powdered heroin appears light beige in color or comes in cream-colored light brown or tan chunks. Participants with experience using heroin reported: *"White powder is available, but it's usually has just a little bit of brown or beige to it; [Powdered heroin] it's been about 50/50 brown and white. It varies ... you don't ask for white or brown [powdered] heroin ... you get what you get."* In addition, many participants with experience using heroin noted having used gray-colored heroin during the past six months. Most participants agreed that they did not know if the white or gray colors in brown powdered heroin is heroin itself or substances used to cut heroin. Participants also noted that heroin has been frequently bought in "chunks." A participant stated: *"[Heroin] it used to be more powdery, but now it's coming in chunk. It's white until you put it in water, and then it turns brown, orange, and oily."*

Participants reported that the availability of heroin has increased in the past six months. A participant with experience using heroin reported, *"Heroin is the most in-demand drug in this area. I think it's increased in the last six months because people can't afford pills [prescription opioids] anymore. They start with pills but can no longer afford it."* A second participant with experience using heroin reported, *"Heroin is like a 20 [on the availability scale.] It just keeps growing and growing. It's like a monster ..."* Another participant reported, *"I live in a crack neighborhood, and I'll say, like since last summer, most of them crack users, and now I'd say half of them are heroin users. They're switching to heroin."* Community professionals reported that the availability of heroin has remained the same during the past six months. The BCI Richfield Crime Lab reported that the number of powdered heroin cases it processes has increased during the past six months; the lab also reported that the number of black tar heroin cases seems to have increased as well.

Most participants generally rated the quality of heroin as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '8'. Many participants agreed that quality varies within the region. A participant stated, *"[Heroin quality] it's better in Youngstown than it is here [Ashtabula County]. It keeps getting cut and cut ..."* Most participants also agreed that quality varies "depending on who you know." A participant reported, *"I've gotten heroin that's been an '8' or a '9' [quality scores], and other times it's been a '2' or '3.' It depends on what it's been cut with ... how many times it's been cut until it reaches you, and who you*

know ... if they can hook you up." Another participant with experience using heroin reported, *"Heroin [quality] is never consistent. And it affects people differently."* Participants reported that brown powdered heroin in the region is cut with baby laxative, brown-colored baby formula (such as Similac®), cut products sold at head shops, sleeping pills, vitamins (such as Vitamin D) and Xanax®. A participant stated, *"[Dealers] they'll use brown baby formula, vitamin D, Seroquel®, sleeping pills, anything at all."* The BCI Richfield Crime Lab cited the following substances as commonly used to cut cocaine: diltiazem (medication used to treat heart conditions/high blood pressure), lidocaine (local anesthetics) and noscapine (cough suppressant).

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "dog food." Other common names include: "doo doo," "dog poop," "dope," "H," and "smack." Participants reported that brown powdered heroin is available in different quantities: a "baggie" or "stamp" generally sells for \$20, however \$10, \$20 and \$30 "stamps" can also be purchased; participants also reported buying heroin in "bundles" (10-12 small packs of heroin) for \$100, averaging \$10 per pack with each pack being about the size of a dime, possibly a little larger or smaller; a gram sells for between \$120-150, with a half-gram selling for between \$60-70. Participants again noted that "stamps" are often folded within dense paper, specifically scratch-off lottery tickets. Participants with experience buying heroin reported that prices vary. A participant reported, *"It [heroin pricing] varies and depends on who you know, but I would always get \$50 worth ... like, 'here's \$50 give me some heroin.'"* Participants reported that the most common route of administration for heroin remains intravenous injection. Out of 10 heroin users, participants reported that approximately eight would intravenously inject or "shoot" it. However, many participants agreed that heroin users usually start off snorting it first. Participants explained: *"Majority of people are going to shoot [heroin], but they usually start off snorting. But once you stop getting high [via snorting], you're gonna shoot ... no matter what people say; I think snorting [heroin] is common, but eventually they'll start shooting."*

Most participants with experience using heroin reported obtaining needles from drug dealers and pharmacies. A participant reported: *"Some pharmacies sell them [needles], but they are cracking down on that."* A participant with experience buying needles from drug dealers reported: *"Dealers sell needles too, for one to two bucks."* Other participants reported: *"Dealers just gave them [needles] to me; I know there's a house in Youngstown, and this lady sells her needles ... You just go there and buy your needles; I got mine [needles] from family members ... diabetics."* Most participants unanimously agreed that needle-sharing is a problem in the

region. Participants reported that nine out of 10 intravenous (IV) heroin users potentially share needles. Participants with experience using heroin reported: *"Needle sharing is definitely a problem here. Hep [Hepatitis] C is a big problem. You can't get needles sometimes, so you'll share; I would say 10 out of 10 [of those who use needles] people would share needles. If you're shooting up, you've shared a needle at least once; Nothing else matters ... you know? I know a girl that shares needles all the time, fiending ... like, 'let me use your needle!' ... I'm like, 'can't you wait until you get home?'"* Many participants also agreed that contracting Hepatitis C and HIV/AIDS are concerns in the region. Participants reported, *"Oh yeah ... I know lots of people ... there's lots of Hepatitis going around; I've seen people pick them [needles] up off the side of the street. I bleach mine before I reuse them; Hep C seems to be pretty common nowadays. I was in treatment three times last year, and most of the girls I was in treatment with had Hep C from needles."*

Participants and community professionals described typical heroin users as White. Generally, participants continued to describe typical users of heroin as "all types of people." However, participants noted younger people, females and Whites as using heroin: *"I definitely think younger people are shooting up more. And I've seen a lot more females doing it [heroin]; I've seen very few Black people [use heroin]. [Heroin users] it's mostly younger White people ... male and female."* A law enforcement official reported, *"We've seen teenagers and up [use heroin], but more White users and equal males and females."* Treatment providers agreed, with one reporting, *"We have a lot more White and female heroin users in treatment right now."*

Reportedly, heroin is used in combination with alcohol, crack cocaine, marijuana, methamphetamine, powdered cocaine and sedative-hypnotics (benzodiazepines). A participant reported, *"I'd smoke crack ... smoke it before [using heroin] and after."* Crack cocaine and powdered cocaine are most commonly used in combination with heroin to "speedball." Participants reported that eight out of 10 heroin users might speedball using cocaine because it "intensifies your high." Many participants agreed that injecting heroin with powdered cocaine has become increasingly more popular, and potentially has increased during the past six months. Participants stated: *"Speedballing with heroin and cocaine is definitely common. If I couldn't get powder to speedball [with heroin], I'd melt crack down with vinegar; I think [speedballing] it's becoming more and more common. Every heroin user I know will speedball with coke."* Other participants noted that alcohol and marijuana are used in combination with heroin to help "level off" or "come down" from the high. Benzodiazepines were also noted as commonly used in combination with heroin. Several participants reported injecting heroin and swallowing Xanax® to intensify highs. A participant with

experience using heroin reported, *"I would use Xanax®... any downer [with heroin] to intensify the high."*

Prescription Opioids Historical Summary

In the previous reporting period, prescription opioids were highly available in the region. Participants most often reported availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), while community professionals most often reported availability as ranging between '2' and '10,' depending on the drug. Participants and community professionals identified Opana®, oxycodone, Roxycodone® and Ultram® as the most popular prescription opioids in terms of widespread use. Participants reported that the availability of prescription opioids, especially Opana® had increased during the previous six months. Participants also reported that OxyContin® OC (original formulation) was almost impossible to get, and in turn, the availability of Roxycodone® had seemingly increased as people seemed to prefer it over the new reformulated OxyContin® OP. Community professionals reported that the availability of prescription opioids had generally remained the same during the previous six months. The BCI Richfield Crime Lab reported that the number of prescription opioid cases it processes had remained the same during the previous six months. While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the most common routes of administration were snorting and swallowing. Most participants agreed that prescription opioids were more commonly snorted rather than swallowed among 18-25 years old. Many participants with experience injecting heroin reported also injecting prescription opioids. In addition to obtaining prescription opioids on the street from dealers, participants also reported obtaining them from pain management clinics, private physicians, hospital emergency rooms, and from family and friends who have prescriptions. Generally, prescription opioid use seemed to be very common among those 18-25 year olds. However, participants agreed that all types of people abused prescription opioids. Several law enforcement officials agreed that primarily young people between the ages of 18-25 years used prescription opioids and most often in combination with heroin. Participants agreed that heroin was commonly used with prescription opioids.

Current Trends

Prescription opioids remain highly available in the region. Participants most often reported the current availability of these drugs 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 '8'. Participants identified Opana®, Percocet®, Roxicet® and Ultram® as the most popular prescription opioids in terms of widespread use. Participants with experience using prescription opioids reported: *"Opana's® are the new thing. They've been like steadily increasing for a while now; Opana® is pretty available but the price has increased about \$5-15 in the last six months. They are real expensive. That's why more people are just doing heroin now because it's*

so much cheaper." A participant with experience using heroin reported, *"Ultrams® are popular with heroin addicts. They will substitute out ... and you take a bunch of them, like 10-12 at one time."* Another participant reported, *"Some people love them [Ultram®]. In Youngstown, that's the going thing ... so easy to get."* In addition to these most commonly used prescription opioids, a participant reported for the first time abuse of Nubain® (nalbuphine), a semi-synthetic opioid used commercially as an analgesic: *"I did see something new in the last six months called Nubain®. [A client] was getting her own scripts through the Internet. [Nubain®] it's a synthetic opiate."* Community professionals 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 between '2' and '10'; depending on the drug. Community professionals identified Opana®, Percocet®, Roxicet®, Ultram® as well as oxycodone as the most popular prescription opioids in terms of widespread use.

Both participants and community professionals reported that the availability of prescription opioids has increased during the past six months. Specifically, law enforcement reported increases in Opana®, Roxicet® and Vicodin®. Treatment providers also reported increases in Opana® and Ultram® during the past six months: *"We've seen a return back to prescription opioids in the last six months. For a while, they kind of went away; Ultram is the new crack. They take about 20-30 a day ... mix it with weed [marijuana] ... a lot of weed. Lots of young kids [minors] are taking those [Ultram®]."* The BCI Richfield Crime Lab reported that the number of prescription opioid cases it processes has remained the same during the past six months. Collaborating data also indicated that prescription opioids are readily available in the region. The Mahoning County Coroner's Office reported prescription opioids as present in 77.8 percent of all drug-related deaths. Media from the region reported on recent arrests related to prescription opioids during this reporting period. In February,

a Youngstown corrections officer was arrested on four counts of drug trafficking of OxyContin® (www.wfmj.com, Feb. 27, 2012).

In addition to increases in availability of prescription opioids during the past six months, participants also continued to report that OxyContin® OC is almost impossible to get. Participants reported, *"There are no old ones [OxyContin® OC] around ... been way more than six months [since availability has decreased for them]. The reformulated [OxyContin® OP] you can't snort them, so no one wants them; The new reformulated pills are a '10' [highly available], but no one wants them; ... no one wants to go through the hassle to break them [OxyContin® OP] down, put them in the microwave, whatever."*

Reportedly, many different types of prescription opioids (aka "beans," "cookies," "poppers" and "skittles") are currently sold on the region's streets. Participants reported the following prescription opioids as available to the street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid® (aka "dilly's" and "dilly bars;" 4 mg sells for \$20; 8 mg sells for \$30); fentanyl (aka "patches;" 100 mg sells for between \$50-70); Opana® (aka "bears," "pana's," "pandas," "panda bears" and "yellow stop signs;" 40 mg sells for between \$40-70); OxyContin® (aka "oxy's"); OxyContin® OC (old formulation, aka "OC's," "old cars" and "Orange County;" sells for a minimum of \$1 per milligram), OxyContin® OP (new formulation, 40 mg, aka "little boys" and "oranges;" sells for between \$20-25); Percocet® (aka "blues," "greens," "peaches" and "perc's;" 7.5 mg sells for \$3; 10 mg sells for between \$5-7; 15 mg sells for between \$12.50-15); Roxicet® (aka "IR 15's," "IR 30's," "blues," "blue gills," and "roxy's;" 30 mg sells for \$20-30); Soma® (sells for \$2 per pill); Ultram® (aka "trims;" sells for between \$.50-1.50 per pill); Vicodin® (aka "vic's;" 5 mg sells for between \$1-2; 7.5 mg sells for between \$2-3; 10 mg sells for between \$4-7). In addition, some participants from Ashtabula County with experience using Opana® identified price increases during the past six months. One participant stated, *"It [Opana®] used to be a dollar per milligram here [Ashtabula County], but they've gone way up ... perc's [Percocet®] too. Opana's use to be \$40 for 40 mg, but they are \$60-65 now."* Another participant reported *"Opana's definitely got more expensive lately ... used to pay \$30-40."* Although low availability, fentanyl was identified as available in some parts of the region; however, most participants agreed that availability of fentanyl is dependent on "who you know." Participants with experience using fentanyl reported, *"They changed [the formation of] them, you can't cut them open no more. You got to put them on now. My buddy got them for surgery and gave them to me. I sold them \$20-25 apiece, but they are re-formulated. They're really hard to*

find; I think [availability of fentanyl] it's decreased in the last six months. You got to know someone ... they are available mostly by the state line [with Pennsylvania]."

While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the most common routes of administration are snorting and intravenous injection. A participant with experience using prescription opioids reported, *"Most people are shooting [injecting] or snorting [prescription opioids], no one is swallowing them. It's a waste."* Many participants reported that snorting is more common than swallowing; however, participants indicated that the route of administration depends on the drug(s) used in combination with prescription opioids. Participants reported, *"[Prescription opioids] they're definitely snorted most commonly. It's more common to snort than eat them. Perc's [Percocet®] and roxy's [Roxicet®] ... always snort those; I think if you're drinking [alcohol], than people are more likely to swallow and drink with them. It depends on your preference."* Many participants agreed that injecting prescription opioids are common. Out of 10 prescription opioid users, participants reported that approximately two to three would intravenously inject or "shoot," and seven to eight would snort. Most participants agreed that users who intravenously inject prescription opioids would also typically use heroin. A participant stated, *"The majority of those people shooting [prescription opioids] are also heroin users, so heroin users are gonna shoot, not snort or swallow."* In addition, participants reported crushing the pills, putting them in their mouth and then swallowing them, or "parachuting" them by crushing the pill, wrapping it in a tissue and then swallowing to avoid bad tastes. A participant reported, *"I would parachute them [prescription opioids]. Crush them up, put it in a piece of toilet paper and swallow them. It would work faster."* Other participants reported "chewing" the pills: *"I always chewed my pills. Chewed and then took them with coffee because I felt like it melted them faster but that might have been in my head; That's what I was taught – to chew [prescription opioids]."*

In addition to obtaining prescription opioids on the street from dealers, participants also continued to report getting them from pain management clinics, family and private physicians, emergency rooms, as well as from family and friends who have prescriptions. Participants with experience obtaining prescription opioids reported, *"I know doctors who will write you a couple scripts [prescriptions] at the same time; Either you go to doctor and pay them in cash or you go to someone who has a script, or the person with the script sells to the dealer, and you buy them from the dealer."* Another

participant reported, *"If you have insurance, they'll write them for you; I got mine like a mixture of ways ... bought off the street and had my own script. Dealers buy whole scripts or people with scripts sell individually."*

A profile of a typical prescription opioid abuser did not emerge from the data. However, many participants agreed that prescription opioid abuse is common among adolescents and young adults. Community professionals reported that "anybody and everybody" uses prescription opioids, with one stating, *"Everybody, professionals, unemployed, teenagers, older people [use prescription opioids.] It's easy to get."* Community professionals also reported an increase in Opana® during the past month specifically among adolescents and young adults: *"We've seen an increase in Opana®, specifically with our young kids 16-21 [years of age]. They're also using marijuana with it ..."*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, heroin, marijuana and methamphetamine. Participants, who used prescription opioids with alcohol, reportedly did so to intensify their high: *"I drank [alcohol] with mine [prescription opioids] ... that's pretty common."* Participants who used methamphetamine reported using prescription opioids to "level-out" or intensify highs: *"I did meth [methamphetamine] with these [prescription opioids] a lot. Back and forth ... smoke meth, pop pills, smoke meth ...; People use meth with this drug group ... injecting meth with opioids [to intensify their high]."*

Suboxone® **Historical Summary**

In the previous reporting period, Suboxone® was highly available in the region. Participants and community professionals most often reported availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). However, participants in Mahoning and Trumbull counties reported higher availability than participants in Ashtabula County. Participants and community professionals reported that the availability of Suboxone® had remained the same during the previous six months. The BCI Richfield Crime Lab reported that the number of Suboxone® cases it processes had increased during the previous six months. Participants reported that Suboxone® 8 mg most often sold for between \$10-15. In addition to obtaining Suboxone® on the street from dealers, participants also reported obtaining prescriptions from substance abuse treatment clinics and doctors. Participants described typical Suboxone® abusers as heroin users.

Current Trends



Suboxone® remains highly available in the region. Participants and community professionals most often reported the current availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' However, again participants in Mahoning and Trumbull counties reported higher availability than participants in Ashtabula County. Participants in Ashtabula County reported: *"[Suboxone® availability] it's decreased quite a bit in the last six months. It's hard to find ... I think people are trying to quit [heroin]; [Suboxone® availability] it depends on the time of the month ... when people get their prescriptions, but I think it's gotten harder to find."* Participants in Mahoning and Trumbull counties reported that availability of Suboxone® has remained the same during the past six months; whereas, participants in Ashtabula County reported a decrease in availability. Community professionals reported that availability of Suboxone® has increased during the past six months. Treatment providers reported, *"It [Suboxone®] has increased in the last few months. If they can't get heroin, they [heroin users] don't want to get sick, so they need it [Suboxone®]. With my clients, I'd say four out of 10 heroin consumers inject Suboxone®; We had a young guy here intimidate an older guy to cheek his Suboxone® and give it to him. The demand has increased."* Law enforcement reported, *"We seized it [Suboxone®] in search warrants. They are buying them and selling scripts to dealers; A lot [of users] will buy [Suboxone®] off the street because they can't afford them in the pain clinics, or they are still using heroin and use Suboxone® when they can't get it [heroin]."* The BCI Richfield Crime Lab reported that the number of Suboxone® cases (particularly the sublingual film form, which is dissolved under the tongue) it processes has increased during the past six months.

No slang terms or street names were reported for Suboxone®. Participants most often reported that Suboxone® 8 mg sells for between \$10-12. Participants did not report a price for Suboxone® 2 mg, and most reported that 2 mg is not commonly found. Many participants in all parts of the region reported that 8 mg strips of Suboxone® are more commonly found than 8 mg tablets. Participants with experience using Suboxone® reported, *"I haven't seen the [8 mg Suboxone®] tabs in a while ... it's mostly strips; I only see strips lately, no tabs; I've never seen the pills. The strips are most common ... you can quarter them up and it'll last you a while ... put it under your tongue."* Most often participants reported taking Suboxone® 8 mg orally and less commonly by injecting and snorting. Participants with experience using Suboxone® reported, *"You*

cut the [Suboxone®] strips in pieces and do one-fourth at a time; I would either put it under my tongue or shoot it. But it's a pain in the ass to shoot it. It doesn't even get you high when you shoot it." Some participants reported having snorted the pill: *"I've snorted it [Suboxone®] ... yuck ... it was gross; I know a lot of people that snort them [Suboxone®] – they get a better buzz by snorting."*

In addition to obtaining Suboxone® from prescriptions at substance abuse treatment clinics and doctors, participants also continued to report getting Suboxone® on the street from dealers. Many participants reported having obtained Suboxone® from a clinic using medical insurance. A participant stated, *"Most people I know get theirs [Suboxone®] from the clinic. I got my from the clinic ... but you gotta have insurance. Man, it's expensive."* Others reported having sold prescriptions and/or obtaining Suboxone® from a dealer. Participants reported: *"A lot of people will save them [Suboxone®] for when they can't find heroin ... or people will take them three days before they have to take a drug test; I do know a lot of people who take them [Suboxone®] for treatment, but they don't need their whole script, so they just sell the rest of them."*

Participants and community professionals continued to describe typical Suboxone® abusers as heroin users. A treatment provider reported, *"Suboxone® users are heroin users [ages] 18-29 [years] ... and White ... the same group as heroin users."* Reportedly, when Suboxone® is used with other substances, it is used in combination with alcohol, crack cocaine, marijuana and sedative-hypnotics (Xanax®). Participants with experience abusing Suboxone® reported, *"I didn't use any drugs with it [Suboxone®], but I used to drink [alcohol] on mine [while taking Suboxone®]; I would smoke crack and then shoot my Suboxone® afterwards ... to come down."* Many participants agreed that Xanax® is commonly used in combination with Suboxone®. A participant reported, *"I used Xanax® ... most people [on Suboxone®] I know used Xanax® with it [Suboxone®]."*

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants and community professionals most often reported the availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants continued to identify Xanax® as the most popular sedative-hypnotic in terms of widespread use, followed by Klonopin® and Valium®. The Mahoning County Coroner's Office reported

that among drug-related deaths, Xanax® and Valium® were frequently seen. The BCI Richfield Crime Lab reported that the number of sedative-hypnotic cases it processes had remained the same during the previous six months, with the exception of a decrease in cases related to Librium®. The most common routes of administration remained oral consumption and snorting. A treatment provider reported that parachuting sedative-hypnotics was becoming more common among adolescents and young adults. A profile of a typical user of sedative-hypnotics did not emerge from the data; participants continued to report that typical use transcended age, gender and race.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in the region. Participants and community professionals most often reported the current availability of these drugs 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 '8'. A participant reported, *"So many avenues [through which to obtain sedative-hypnotics], so many people pass them out."* A treatment provider stated, *"We have a good amount of people using benzo's [benzodiazepines] ... If you are using heroin or crack, you can use the benzo's in between as well."* Participants continued to identify Xanax® as the most popular sedative-hypnotic in terms of widespread use, followed by Klonopin® and Valium®. A participant explained, *"Xanax® is probably people's first choice ... then Klonopin® ..."* Community professionals identified Klonopin® and Xanax® as most popular. A law enforcement official reported, *"When we do our prescription pill pick-ups, those [Klonopin® and Xanax®] are the hot items. That's what people are turning in."* Collaborating data also indicated that sedative-hypnotics are readily available in the region. The Mahoning County Coroner's Office reported sedative-hypnotics as present in 55.6 percent of all drug-related deaths. Participants and community professionals most often reported that the high availability of sedative-hypnotics has remained the same during the past six months. The BCI Richfield Crime Lab reported that the number of sedative-hypnotic cases it processes has remained the same during the past six months.

Reportedly, many different types of sedative-hypnotics (aka "B's", "benzo's", "downers", "skittles", "wagon wheels" and "Z's") are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Klonopin® (aka "pins;" 2 mg sells for between \$2-3), Valium® (aka "V's;" 10 mg sells for between \$1-2) and Xanax® (aka "blues," "greens," "ladders," "peaches" and "xani's;" 0.5 mg sells for \$1;

1 mg, aka "footballs," sells for between \$2-3; and 2 mg, aka "bars," "candy bars" and "xanibars," sells for between \$3-5). In addition, participants reported that Xanax® 2 mg is most popular in terms of widespread use. While there were a few reported ways of consuming sedative-hypnotics, and variations in methods of use were noted among types of sedative-hypnotics, generally, the most common routes of administration remain oral consumption (swallowing and chewing) and snorting. Participants with experience using Xanax® reported, *"I chewed my Xanax®; I don't know anyone who would swallow Xanax®. Everyone snorts them ... or yeah, chew them."* Community professionals reported smoking as another route of administration. A treatment provider explained, *"There is a new trend, in detox, folks are saying they've started smoking different pills because they say it's faster and doesn't burn their nose like snorting does."* A participant with experience smoking sedative-hypnotics reported, *"I smoked mine in foil. I don't like putting anything up my nose."*

In addition to obtaining sedative-hypnotics on the street from dealers, participants also continued to report getting them from family, friends and physicians. A participant talked about the easy access he has to sedative-hypnotics at home: *"Ativan® is in my dad's cupboard, so I could go get it if I want ..."* Other participants supported this notion and frequently made comments such as, *"Most people I know either have a script or they know someone that does; I always got them [sedative-hypnotics] from family and friends who have prescriptions."* Another participant discussed getting Xanax® from physicians: *"Anyone can get Xanax® from a doctor."* Community professionals talked about the liberal prescribing practices in their community. A treatment provider reported, *"The problem is that [sedative-hypnotics] it's easily prescribed and physicians are not perhaps as discriminating as they should be. You go to the doctor and say you have anxiety [and you can obtain sedative-hypnotics] ..."*

A profile of a typical user of sedative-hypnotics did not emerge from the data. Participants continued to describe typical users of sedative-hypnotics as, *"all types of people."* Most participants had a difficult time developing a common category for users. A participant commented, *"I've seen young kids do them [sedative-hypnotics] ... Xanax® mostly, but then, I see older people too ... 40's and up."* Community professionals also described typical users of sedative-hypnotics as "across the board." However, some differences were noted. Law enforcement reported that they see a lot of high school students with sedative-hypnotics. An officer said, *"Mostly teens are using Xanax®."* Community professionals had a very different opinion. A treatment provider reported, *"I see young [sedative-hypnotic users], but also middle-aged 30-40's. For a while we were getting younger ones, but now [sedative-hypnotic use] it's pretty across the board."* Other treatment

professionals spoke about users seeking sedative-hypnotics for the roller coaster effect, with one stating, *"Because benzo's are a downer, we see a lot of crack users use this [drug] group [sedative-hypnotics] the most. They get high, and then they get down – high and then down. They need [sedative-hypnotics] to ... so they can sleep."*

Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, crack cocaine, heroin and marijuana. Many participants reported using these drugs in combination to either help "come down" or to intensify a high. A participant explained, *"Alcohol goes hand in hand [with sedative-hypnotics]; It [combining alcohol with sedative-hypnotics] gets you more f***** up."* Another participant reported that she used crack cocaine in combination with Xanax® and explained her rationale: *"I used Xanax® with crack ... it would help me come down."*

Marijuana **Historical Summary**

In the previous reporting period, marijuana was highly available in the region. Participants and community professionals most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Both groups also reported an increase in the availability of marijuana in the region during the previous six months. Participant quality scores of marijuana ranged from '4' to '10', with the most common score being '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that for commercial-grade marijuana, a "blunt" (cigar) sold for \$10; for high-grade marijuana, a blunt sold for between \$20-30. The most common route of administration for marijuana continued to be smoking. Participants reported that marijuana use was prevalent for men and women of all races and ages.

Current Trends

Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. A participant reported, *"On a scale of 1 to 10, [marijuana availability] it's a '30.'" Participants felt that high-grade marijuana is the most desired and available form of the drug: "Everyone likes high-grade weed – medical weed from Michigan. No one wants commersh [commercial-grade marijuana]; It's very easy to get high grade; You don't even see that Youngstown brown [local low-grade marijuana]*

no more ... it's kush [high-grade marijuana]." Community professionals also continued to most often report the current availability of marijuana as '10', while identifying marijuana as a primary drug in the region. A law enforcement official reported, *"Marijuana is one of our top three primary drugs [of abuse]. We're always seeing marijuana – it reaches out to a lot more people than heroin does."* Collaborating data also indicated that marijuana is readily available in the region. The Mahoning County Coroner's Office reported marijuana as present in 11.1 percent of all drug-related deaths. Participants and community professionals reported that the availability of marijuana has remained the same during the past six months. A participant explained, *"Weed has always been easy to get. Commercial is out there, but I don't know ... I see good weed all around."* The BCI Richfield Crime Lab reported the number of marijuana cases it processes has remained the same during the past six months.

Participant quality scores of marijuana varied from '6' to '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality), with the most common score being '6' for "commercial weed" (low- to mid-grade marijuana); the previous most common score was '7'. Participant quality scores for high-grade marijuana varied from '8' to '10', with the most common score being '10'. Generally, participants agreed that the quality of marijuana depends on the dealer; however, many participants agreed that overall quality has improved during the past six months. Participants with experience using marijuana frequently reported, *"The quality [of marijuana] is improving every day; Oh, it's high quality all around. Kush is easily a '10' [high quality score]. I think [quality of kush] it's increased."* Community professionals agreed with the assessments of participants. A treatment provider reported, *"What I'm hearing now from people in treatment – across the board – is that the weed is so good right now. It's really popular because it's so strong."* Law enforcement also spoke about the quality marijuana. An officer reported, *"Prices have gone up in the last six months and some of it seems like it's a bit higher in quality. There's been an increase in that [high-grade marijuana]."*

Current street jargon includes countless names for marijuana. The most commonly cited names were "buds," "green," "pot," "trees" and "weed." Participants listed the following as other common street names: "backyard," "commerish," "mids," "middies," "reggie" and "regular" for commercial-grade marijuana; "AK-47," "Alaskan big bud," "Christmas bud," "Christmas trees," "dank," "exotic," "fruity pebbles," "hydro," "orange kush," "pineapple express" and "white widow" for high-grade or hydroponically grown marijuana. The price of marijuana depends on the quality desired. Participants reported that commercial-grade marijuana is the cheapest form: a blunt, two joints (cigarettes) or a "dimebag" (loose

marijuana sold in a plastic baggie) sells for \$10; 1/8 ounce sells for between \$20-25; an ounce sells for between \$90-120; a quarter-pound, or "QP," sells for between \$400-425; a pound sells for between \$750-1,000. Higher-grade marijuana sells for significantly more: a blunt, two joints or a dimebag sells for between \$20-30; 1/8 ounce sells for between \$50-70; 1/4 of an ounce sells for \$100; an ounce sells for between \$200-400. While there were several reported ways of consuming marijuana, the most common route of administration remains smoking. All participants with experience using marijuana reported smoking it. Participants reported that out of 10 marijuana consumers, three might consume marijuana in food products such as brownies and cookies. A participant commented, *"Some people do brownies [bake with marijuana], maybe for a special occasion. I wouldn't say it's that common."* Several participants reported using marijuana to infuse olive oil, butter or to make tea. A participant explained, *"I've made tea before with it [marijuana] ..."* In addition, several participants reported on having used vaporizers to smoke marijuana, and they reported it is common to vaporize the drug. Participants agreed that five out of 10 people would use vaporizers. Participants commonly reported that users would implement this technique for the highest quality marijuana. A participant commented, *"People use vaporizers only with real good weed though, with high quality."*

A profile for a typical marijuana user did not emerge from the data. Participants continued to describe typical users of marijuana as transcending age, gender and race. A participant stated, *"Everybody and everyone smokes weed."* Law enforcement agreed with user's statements. A law enforcement officer stated, *"[Marijuana use] it's across the board ... everyone. Just about anybody can get marijuana."* Treatment providers discussed the problem of youth perceiving marijuana as a harmless drug. A treatment provider noted, *"We see it [marijuana use] with everybody, but it's by far the most popular drug with our adolescents, teens. They don't see a problem with it ... 'It's just weed' [they say]."*

Reportedly, marijuana is used in combination with alcohol, crack and powdered cocaine (aka "woolies"), heroin, over-the-counter (OTC) cough medication, prescription opioids and sedative-hypnotics. A participant discussed using crack cocaine with marijuana: *"I used crack to lace or cocaine to lace blunts ... 'woolies' ... it's pretty common. It [cocaine] intensifies your [marijuana] high."* Another participant gave several reasons users combine marijuana with other substances: *"I think weed [goes] in combination with everything. It helps mellow you out, intensify your high, whatever. Helps you sleep."* Participants also reported dipping or coating "blunts" in cough syrup and reported that three out of 10 people might use this technique to intensify their high. A participant

reported, *"I've seen people dip blunts in NyQuil® or codeine syrup ... prescription cough syrup. It f**** you up."*

Methamphetamine **Historical Summary**

In the previous reporting period, methamphetamine was rarely available in some parts of the region and highly available in other parts. Participants most often reported the drug's availability as '2' in Mahoning and Trumbull counties and as '10' in Ashtabula County on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that methamphetamine was most often available in powdered form, which was homemade using the "shake-and-bake" or "one-pot" method (methamphetamine production in a single, sealed container, such as a two-liter soda bottle). The BCI Richfield Crime Lab reported that the number of methamphetamine cases it processes had remained the same during the previous six months. The crime lab also reported that brown and white powdered methamphetamine were the most commonly processed types. Participants reported that a gram of methamphetamine sold for between \$80-120. Participants also reported powdered methamphetamine sold in \$20 quantities. Reportedly, the most common route of administration of methamphetamine remained smoking. Participants described typical users of methamphetamine as Whites, between 20-40 years of age, possibly from more rural areas.

Current Trends



Methamphetamine remains relatively rare in some parts of the region and highly available in other parts. Participants most often reported the current availability of methamphetamine as '2' in Mahoning and Trumbull counties and '10' in Ashtabula county on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, the most common scores were also '2' in Mahoning and Trumbull counties and '10' in Ashtabula County. Participants reported that methamphetamine is not available in crystal form but in powdered form produced by the "shake-and-bake" method. Participants from Mahoning County talked about difficulty in obtaining the drug. A participant stated, *"Meth [methamphetamine] is more common in the country. I don't even know where to get it."* On the other hand, participants in Ashtabula County noted availability

of “anhydrous,” a red crystal form of methamphetamine, and reported the current availability of anhydrous methamphetamine as ‘7’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). A participant said, *“Little red, little Annie [anhydrous] is available too ... it’s harder to get than shake-and-bake ...”* Some participants from Trumbull County noticed an increase of methamphetamine in the region. A participant spoke about co-workers using methamphetamine: *“I work in Niles [Trumbull County]. I’ve never done it [methamphetamine], but people at work, they’ve been talking about it a lot ... the anhydrous coming around.”* Community professionals most often described the current availability of methamphetamine as moderately to highly available depending on the area in the region. However, community professionals most often reported current availability as ‘10’ in Ashtabula County, while reporting that methamphetamine is less available in Trumbull County, and even less available in Mahoning County. Law enforcement reported, *“[Available methamphetamine] it’s all ‘shake-and-bake,’ ‘one-pot’ method in Trumbull. In Ashtabula, it’s mostly ‘shake-and-bake,’ but the ‘Red P’ [phosphorous-based methamphetamine] they can still get it ... and anhydrous is out there.”* Community professionals from Mahoning County reported, *“We just haven’t started seeing it [methamphetamine yet]. We had one guy ... our first meth client in the last six months.”*

Several media outlets reported on methamphetamine labs in the region during this reporting period. In February, the Trumbull-Ashtabula Group (TAG) Drug Taskforce seized methamphetamine and related drug paraphernalia during two home raids and a traffic stop. A law enforcement official stated, *“Three meth incidents in Trumbull County in one week is huge, considering they’ve only busted five meth labs in the county over the last five years”* (www.wfmj.com, Feb. 23, 2012). In March, a man accidentally started a fire in an Ashtabula nursing home when his methamphetamine lab blew up; the man was unaffiliated with the nursing home and there was no indication of how long he had been manufacturing the drug on the property (www.twincities.com, March 6, 2012).

Participants reported that the overall availability of methamphetamine has remained the same during the past six months, while community professionals most often reported that availability has increased. A law enforcement officer explained, *“We’ve had five or six [methamphetamine] labs in Trumbull in the last year, so there’s been increase in Trumbull in the last six months. Some cooks from Ashtabula have also relocated to Warren [Trumbull County] since then.”* The BCI Richfield Crime Lab reported that the number of methamphetamine cases it processes has increased during

the past six months, mostly due to an increase in “shake-and-bake” methamphetamine. The crime lab also reported that they most often process white-powdered, brown-grit, crystal and liquid methamphetamine. Most participants rated the quality of methamphetamine as ‘7’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). A participant said, *“It [quality of methamphetamine] goes up and down ... it [quality] really depends on who makes it, and how they make it.”*

Current street jargon includes several names for methamphetamine. The most commonly cited names were “crank,” “glass,” “go-go,” “go-fast,” “ice,” “jib,” “jimmy crank,” “meth” and “tweak.” Commonly cited names for anhydrous methamphetamine were “little Annie,” “little red” and “red.” Participants with experience using methamphetamine reported that 1/2 gram of the drug sells for \$50; a gram sells for \$100; 1/16 ounce, or “teener,” sells for \$150; 1/8 ounce, or “eight ball,” sells for \$250. Reportedly, some dealers offer special deals if a user brings the ingredients for methamphetamine. A participant reported, *“You can also buy some materials and trade them in to dealers [for a discount on methamphetamine]. I’ve had a couple [dealers] tell me that, so I’ve brought a box of Sudafed® [and] lithium batteries. They’ll lower the price.”* Reportedly, the most common route of administration of methamphetamine remains smoking; less common routes are snorting and intravenous injection. Participants with experience using methamphetamine reported, *“Smoking is most common. One-hundred out of 100 people would smoke [methamphetamine]; I know quite a few people that snort too. It’s easier to snort it than to find an instrument or something to smoke.”* Many participants said the route of administration depends on whether other substances are used in combination with methamphetamine. A participant explained, *“I think shooting meth is common if you’re going to ‘speedball’ [mix methamphetamine with other drugs.]”* Another participant noted, *“I would say people who shoot meth, like out of 10, five of them might also do heroin. I think it’s common though to shoot it [methamphetamine with heroin].”*

Participants and community professionals described typical users of methamphetamine as White. A participant stated, *“[Methamphetamine] it’s definitely White people [who predominately use it] ... both males and females ... about ages 18-40 [years] on average.”* Community professionals also described typical users of methamphetamine as White. A law enforcement official reported, *“White users – 100 percent, and usually under 30 [years of age]. It’s equal between males and females, although more cooks are males.”* A participant noticed a trend in younger people manufacturing the drug: *“I live in Warren, and I’ve seen older people baking [manufacturing methamphetamine], like 40-50 [years of age], and younger*

people using ... but lately I've seen more younger helping to make it ..."

Reportedly, methamphetamine is used in combination with alcohol, heroin, marijuana and prescription opioids. Participants frequently reported use of alcohol and prescription opioids as "downers" to assist in coming off methamphetamine. A participant stated, *"Any opiates I think people will use to come down [from methamphetamine use]."* Users also combine methamphetamine use with other drugs to modify the high produced by methamphetamine. Several participants talked about creating an up-down roller coaster effect. A participant said, *"I used heroin [with methamphetamine], injected ... speed-balled to intensify the high."*

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 availability of Ecstasy as '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Many participants agreed that Ecstasy was highly available at a quarry in the region where spring, summer and fall music festivals are held. Community professionals and the BCI Richfield Crime Lab reported a decrease in Ecstasy in the region. Participants reported that Ecstasy tablets typically sold for between \$15-20, but they also said users could get discounts for buying large quantities. The most common route of administration was oral consumption. Many community professionals reported that Ecstasy remained popular among young adults.

Current Trends

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) remains moderately available in the region. Participants reported availability of Ecstasy as '7' 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'. Most participants nodded their heads in agreement when one talked about the unpopularity of the drug: *"In January my friend used them [Ecstasy], but you really don't hear much about it."* Another participant with experience using Ecstasy explained, *"They [Ecstasy] are cut with all kinds of shit, so I don't think many people want them."* Many community professionals reported a decrease in Ecstasy use among clients during the past several years. Treatment providers frequently made comments like, *"It [Ecstasy use] comes up on the assessment ..."*

that they've done it in the past, but we don't get chronic users. They've move onto something else; I don't have it like I used to. Used to hear about it [Ecstasy] all the time but haven't in a long while." The BCI Richfield Crime Lab reported that the number of Ecstasy cases it processes has remained the same during the past six months.

Participants reported only one common street Ecstasy: "X." Participants also reported that Ecstasy tablets typically sell for \$15-20. The most common route of administration remains oral consumption. A typical user profile did not emerge from the data. A participant thought that drug dealers are the most likely group to use Ecstasy: *"I don't see a whole lot of it [Ecstasy]. I see [more] dealers using Ecstasy than anyone else ... crack, heroin dealers."* Other participants thought Ecstasy use is more likely with younger users: *"I feel like it [Ecstasy] used to be a big thing. When I was younger I did it ... I think maybe people will try it or do that first before they get into something else."*

Prescription Stimulants **Historical Summary**

In the previous reporting period, prescription stimulants were highly available in the region. Participants most often reported the availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that Adderall® was highly available, followed by Concerta® and Ritalin®, which were both believed to be somewhat available. Participants and community professionals reported that availability had remained the same during the previous six months. BCI Richfield Crime Lab reported that the number of prescription stimulant cases it processes had remained the same during the past six months, with the exception of a decrease in cases related to Dexedrine®. Participants reported getting prescription stimulants from doctors or from people with prescriptions. Typical users of prescription stimulants were described as teenagers or young adults.

Current Trends

Prescription stimulants remain highly available in the region. Participants most often rated the current availability of these drugs as '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '8'. According to participants, Adderall® remains the most available prescription stimulant followed by Concerta®. A community professional compared the availability of different prescription stimulants: *"I haven't seen Ritalin® in years, Adderall® is really easy to get."* However, a participant spoke of low demand for these drug: *"I don't*

think there's much a demand for it [prescription stimulants] ... there's plenty of meth around here." Community professionals did not report seeing many prescription stimulants in the field. A treatment provider explained, *"I'd say [Adderall®] it's popular with the younger ones. I think it's pretty available though. It's pretty easy to get prescriptions for it."* Participants and community professionals reported that the availability of prescription stimulants has remained stable during the past six months. The BCI Richfield Crime Lab reported the number of prescription stimulant cases it processes has remained the same during the past six months.

The only common street name for prescription stimulants was reported for Adderall®: "addies." Adderall® typically sells for \$2 per pill. In addition to obtaining prescription stimulants on the street from dealers, participants also continued to report getting them from doctors or other people who have prescriptions. Participants commonly made statements like, *"I think most people either have a prescription or they know someone that does; I have friends and people in my family who have been prescribed it [Adderall®]."* Participants continued to describe typical users of prescription stimulants as teenagers or young adults. A participant explained, *"[Prescription stimulant abuse] it's real big in college [and] any [place] that requires time and dedicated work, like food industries."*

Other Drugs

Historical Summary

In the previous reporting period, participants and community professionals listed the following other drugs as present in the region, but these drugs were not mentioned by the majority of people interviewed: alcohol, bath salts, cough and cold over-the-counter (OTC) medications and inhalants. Alcohol was highly available to those younger than 21 years of age and was especially popular among 18-25 year olds. Several participants reported alcohol as their primary drug of choice. Participants noted a few trends common among young people between the ages of 18-25 years, most involving the use of caffeinated alcoholic beverages. Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) were highly available in the region prior to the enactment of legislation in October 2011 which banned their sale. Participants and community professionals mentioned bath salts use numerous times, but availability of bath salts when the ban went into effect was unclear. A participant commented about the popularity of bath salts among high school students. While participants did not speak about the quality of bath salts, they said bath salts were commonly used to cut other drugs. The most common routes of administration for bath salts were snorting and smoking. Treatment providers agreed that adolescents

and young adults predominately used bath salts. Cold and cough OTC medications were also highly available in the region. Several participants reported personally abusing Coricidin®, Robitussin DM® and medicines that contain codeine. Participants reported that OTC medications were predominately abused by teenagers and young adults. Lastly, inhalants were highly available in the region; however, several treatment providers reported a decrease in inhalant-related admissions to treatment facilities during the previous six months. Most participants agreed these drugs were used primarily by adolescents and young adults.

Current Trends

Participants and community professionals listed a variety of other drugs as being present in the region, but these drugs were not mentioned by the majority of people interviewed: alcohol, bath salts, hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms], cough and cold over-the-counter (OTC) medications, inhalants and synthetic marijuana ("K2" and "Spice"). Several participants reported that alcohol was their primary drug of choice. Most participants agreed that alcohol is used in combination with many other drugs. Participants noted a few common trends with alcoholic beverages, most involving the use of caffeinated alcoholic beverages or brands that formerly combined alcohol and caffeine. A participant talked about his experience with these drinks: *"Those damn [Four] Loko's. I drank two of them and I was toast. And I shared them too."* Another participant talked about the drink's popularity: *"Four Loko's are pretty popular. They can hardly keep them on the shelf around here – they're pretty popular around here."* A participant spoke about a newer brand of drink that was also popular: *"The 'Blast' [fruity malt liquor] came out too. I think those are more popular now than the Four Loko's."*



Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) are moderately available in the region. Community professionals most often reported the current availability of these drugs as '4' or '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). A participant spoke about bath salts use in her community: *"I just came from Fairfield County Jail, and half of the women in my group were heroin [users] and half were bath salts and meth [users]."*

Bath salts have decreased in availability likely due to the law banning their sale that took effect in October 2011. Participants reported hearing less and less about bath salts from other users during the past six months. A participant reported, *"I think there's been a decrease in [bath salts] the last six months. You can still get*

them from the stores, but people don't want them anymore. I think teens and younger are using it." Some participants spoke about chemical analogues taking the place of banned bath salts. A participant reported, "Once they took the bath salts off the market, they came out with something new ... 'Pump-it Powder' ... or something and that's out there now." Another participant agreed that users are now using these new chemical analogues: "Now people are switching to 'pipe cleaner' you can get at head shops ..." Community professionals also agreed that the availability of bath salts has decreased during the past six months. A treatment provider reported, "They [bath salts] are mostly black market, so I think there's been a decrease." The BCI Richfield Crime Lab reported that the number of bath salt cases it processes has increased during the past six months. Participants mentioned several routes of administration for bath salts, but did not say whether one was more common than another. A participant reported, "I think [bath salts] it's popular among younger, teenagers ... you can snort it, smoke it [and] shoot it. I think people snort it really." No participant reported using bath salts with other substances.

Hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms] are moderately available in the region. Participants most often reported the current availability of hallucinogens as '4' or '5' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); previously, participants were unable to rate the availability of hallucinogens. Many participants indicated that psilocybin mushrooms and LSD are seasonal drugs and are more available at certain times of the year. A participant reported, "Mushrooms go up [in availability] in summer; it's a seasonal drug." Other participants said they could get psilocybin mushrooms at any time of the year. A participant indicated, "There are times of the year that you can get them [psilocybin mushrooms], but it's easy to grow them and you can still get them." Community professionals reported low availability of hallucinogens. A treatment provider commented, "We never really hear about it [hallucinogens]. It's on their [clients' assessments], that they've done it. They might have done it a few times but it's not chronic use." The BCI Richfield Crime Lab reported the number of LSD cases it processes has decreased, and the number of psilocybin mushroom cases it processes has remained the same during the past six months.

Inhalants remain highly available in the region. Reportedly, these drugs are primarily used among adolescents, teenagers and young adults. A participant said, "Young kids are doing it [inhalants] ... air duster, Freon, air conditioner stuff." Another participant spoke about a brand of inhalant that was popular among youth: "Rush – it's an inhalant – they sell it at head shops ... I see younger kids using it." A participant also spoke

about inhalants being sold at adult stores: "Whippets' [nitrous oxide] you can buy them up at the adult book store ... they're really easy to get."

Over-the-counter (OTC) cough and cold medications remain popular in the region. Participants noted various OTC medications used predominately among teenagers and young adults. A participant explained, "I think kids do the Triple C's [Coricidin®, cough and cold] and all that. I "robo-tripped" [drank an entire bottle of Robitussin®] when I was in high school ... [abuse of OTC cough and cold medications] it's [still] young kids." Treatment providers reported a slight increase in the abuse of OTC cough and cold medications with young adults. A provider commented, "We've seen a small increase with a couple of young adults, 18-19 [years of age], using cough syrup. Some of them have reported taking Jolly Ranchers® and will soak them in cough syrup."



Synthetic marijuana (K2, Spice) is highly available in the region; however, availability of synthetic marijuana was thought to have decreased due to the law banning their sale that took effect in October 2011. Participants reported users can obtain the same substances or newly reformulated substances of synthetic marijuana. A participant said, "There still are stores in [Trumbull County] that sell the legalized coke [bath salts] and Spice." Another participant said, "Spice is easy to get. Some brands you don't see as much anymore, but it's been getting harder to get [synthetic marijuana] I think." Law enforcement officials reported synthetic marijuana is moderately available. An officer said, "K2 and Spice is about a four or five [moderate availability ratings]. They're still selling the stuff that's labeled and doesn't contain anything illegal, but it's all behind the counter. We haven't had any reports on it in a while." However, treatment providers thought that there has been an increase in synthetic marijuana during the past six months. Participants and community professionals both reported the use of synthetic marijuana by those wanting to pass drug testing in courts and treatment programs. A participant reported, "I know a lot of people who are in the courts, drug court [and] mental health court, use that [synthetic marijuana] since they can't smoke weed." Treatment providers agreed with participants. A provider said, "We can't test for it [synthetic marijuana], so they use it ... anything we can't test for. But synthetic drugs are pretty popular." The BCI Richfield Crime Lab reported the number of synthetic marijuana cases it processes has increased during the past six months. The crime lab also reported that new chemical analogues to synthetic marijuana emerge monthly. While not reported by participants, the crime lab also mentioned that cases of

dimethyltryptamine (DMT; 5-MeO-DMT/DiPT) have increased and cases of salvia divinorum (psychoactive plant) have decreased during the past six months.

Conclusion

Crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids, prescription stimulants, sedative-hypnotics and Suboxone® remain highly available in the Youngstown region. An increase in availability exists for prescription opioids. Data also indicate likely increases in availability for heroin, methamphetamine and Suboxone®, and likely decreases in availability for bath salts and synthetic marijuana. Both participants and community professionals reported that the availability of prescription opioids has increased during the past six months, specifically for Opana®, Roxicet®, Ultram® and Vicodin®. In addition, participants continued to report that OxyContin® OC (original formulation) is almost impossible to obtain. The Mahoning County Coroner's Office reported prescription opioids as present in 77.8 percent of all drug-related deaths. Throughout the entire region, community professionals reported heroin to be the primary drug problem. Participants reported that the availability of heroin has increased; and the BCI Richfield Crime Lab reported that the number of heroin cases it processes has increased during the past six months. While many types of heroin are currently available in the region, participants and community professionals continued to report the availability of brown powdered heroin as most available. Participants also noted that heroin is frequently bought in "chunks." Out of 10 heroin users, participants reported that approximately eight would intravenously inject or "shoot" the drug. Participants and community professionals described typical heroin users as White, with participants further noting younger people and females as using heroin. Crack cocaine and powdered cocaine are most commonly used in combination with heroin to "speedball." Participants reported that eight out of 10 heroin users might speedball using cocaine. Community professionals reported that availability of Suboxone® has increased during the past six months. Treatment providers explained that heroin users do not want to get sick from withdrawal symptoms, so they need Suboxone® for when they cannot obtain heroin. The BCI Richfield Crime Lab reported that the number of Suboxone® cases (particularly the sublingual film form) it processes has increased during the past six months. Many participants agreed that Xanax® is commonly used in combination with Suboxone®. Participants reported that the overall availability of methamphetamine has remained the same during the past six months, while community professionals most often reported that availability has increased. The BCI Richfield Crime Lab reported that the number of

methamphetamine cases it processes has increased during the past six months, mostly due to an increase in "shake-and-bake" methamphetamine. Participants reported that methamphetamine is not available in crystal form but in powdered form produced by the "shake-and-bake" method. In addition, participants in Ashtabula County noted availability of "anhydrous," a red crystal form of methamphetamine, and reported the current availability of anhydrous methamphetamine as '7'. Participants and community professionals described typical users of methamphetamine as White. Bath salts (synthetic compounds containing methylone, mephedrone or MDPV) and synthetic have decreased in availability, likely due to the law banning their sale that took effect in October 2011. Participants reported hearing less about these synthetic substances from other users during the past six months; however, they reported that users can either continue to obtain the same substances or newly reformulated similar substances, such as Pump-it Powder, a designer drug similar to bath salts.