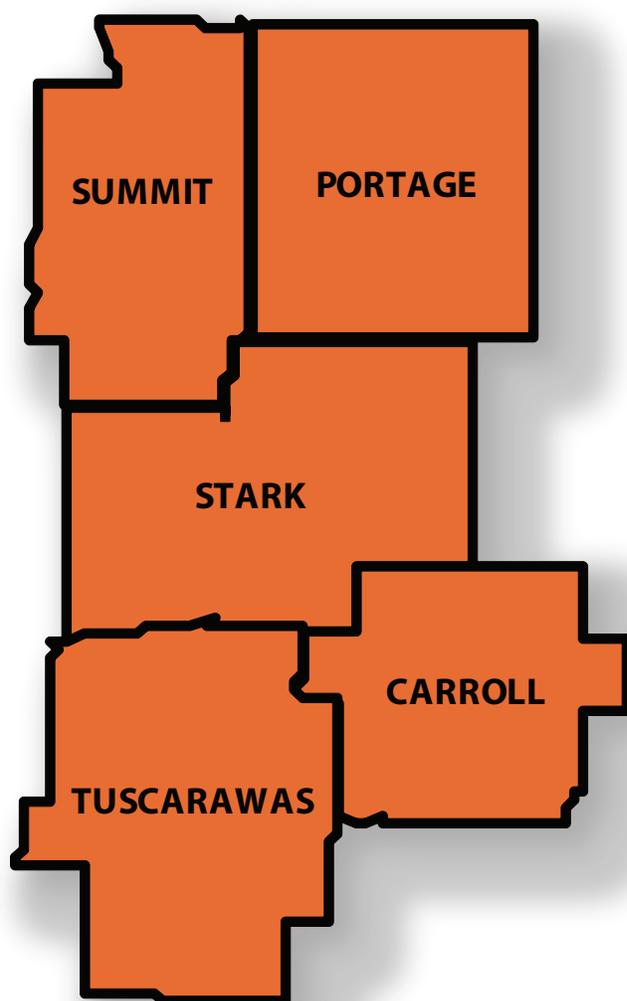


Ohio Substance Abuse Monitoring Network

Drug Abuse Trends in the Akron-Canton Region

January-June 2012

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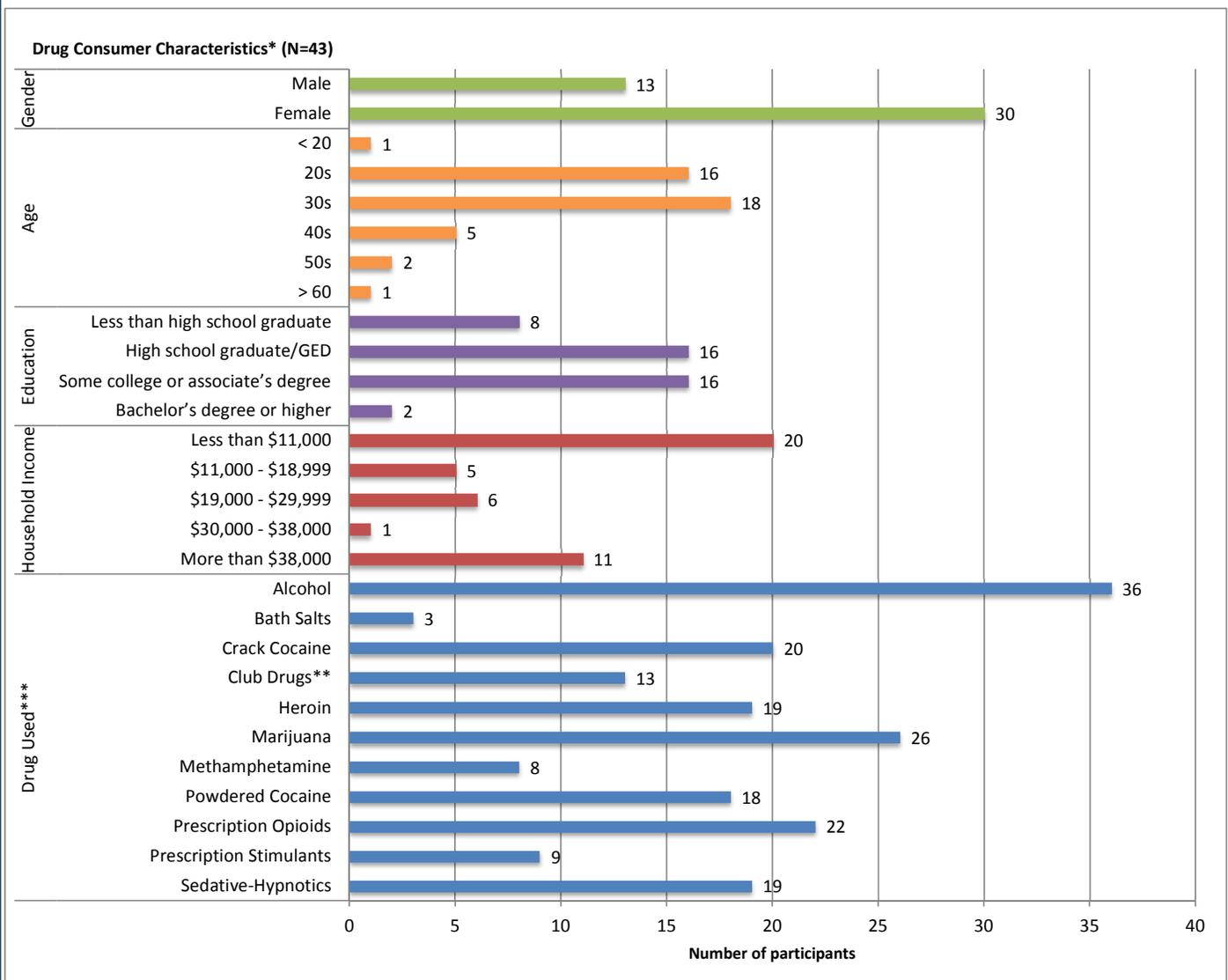
Akron-Canton Regional Profile

Indicator ¹	Ohio	Akron-Canton Region	OSAM Drug Consumers
Total Population, 2010	11,536,504	1,200,204	43
Gender (Female), 2010	51.2%	51.5%	69.8%
Whites, 2010	81.1%	85.4%	83.7%
African Americans, 2010	12.0%	9.4%	11.6%
Hispanic or Latino Origin, 2010	3.1%	1.6%	0.0%
High school graduates, 2009-2010	84.3%	86.3%	81.0% ²
Median household income, 2010	\$45,151	\$43,371	\$11,000 - \$18,999 ³
Persons below poverty, 2010	15.8%	14.7%	53.5%

Ohio and Akron-Canton statistics are derived from the U.S. Census Bureau.¹

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

Respondents reported income by selecting a category that best represented their household's approximate income for 2012.³



*Not all participants filled out forms; therefore, numbers may not equal 43.

**Club drugs refer to DMT, Ecstasy, LSD 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 Portage, Stark, Summit and Tuscarawas 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 Canton-Stark County Crime Lab and the Stark County Coroner's Office. All secondary data are summary data of cases processed from July through 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 secondary 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 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). Treatment providers and law enforcement most often reported the drug's availability as '8' and '7' respectively. Participants and treatment providers generally did not agree as to whether the availability of powdered cocaine had increased, decreased or remained the same during the previous six months. Law enforcement reported that availability had remained the same, while the Canton-Stark County Crime Lab reported that the number of powdered cocaine cases it processed had increased during the previous 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 Canton-Stark County Crime Lab cited the following substances as commonly used to cut (adulterate) powdered cocaine: levamisole (livestock dewormer), maltose (disaccharide sugars) and procaine (local anesthetic). Participants reported that the quality of powdered cocaine had decreased during the previous six months. The most commonly cited street names for powdered cocaine were "blow," "soft," "snow" and "white girl." Participants reported that 1/4 gram, or "baggie," of powdered cocaine sold for between \$25-40, depending on the quality; a gram sold for between \$40-60. The most common route of administration for powdered cocaine remained snorting. Many participants commented, however, that in some groups, intravenous use of cocaine was more common than snorting. A profile for a typical powdered

cocaine user did not emerge from the data, though some participants commented that the typical user of powdered cocaine was White. Treatment providers described typical users as "upper-middle class; Caucasian females between ages 20 and 30 [years]." Regarding typical age of users, treatment providers noted a "minimal increase" in powdered cocaine use among high-school-aged youth. Law enforcement reported that between the ages of 18 and 25 years, there was an "exponential jump" in powdered cocaine use.

Current Trends

Powdered cocaine remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants commented, "You can get it [powdered cocaine] anywhere in Akron. Just go down the street and get it; you can go to any part of Akron, you don't have to know anybody." Treatment providers most often reported current availability of powdered cocaine as '8'; the previous most common score was also '8'. However, many treatment providers noted that powdered cocaine is not commonly identified as a primary drug of choice. A treatment provider commented, "[Powdered cocaine is] easy to get, but my experience is that it is often not the drug of choice." Other treatment providers commented: "[Powdered cocaine is] very widely available, but the trend is more that powdered cocaine is mixed with other chemicals; I hear a lot of [powdered] cocaine being used with alcohol, marijuana, heroin ... not just cocaine itself." Law enforcement reported the drug's current availability as '8'; the previous most common score was '7'. The Stark County Coroner's Office reported that 24 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); in the last reporting period, 10.9 percent of all deaths were drug related. Furthermore, the coroner's office reported cocaine as being present in 23.2 percent of all drug-related deaths; in the last reporting period, cocaine was present in 16 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).

Participants most often reported that the availability of powdered cocaine has remained the same during the past six months. However, participants in Portage County reported an increase in availability, commenting, "More people I'd never expect [to sell cocaine] are selling it [powdered cocaine]; Heroin dealers are carrying cocaine also; There's less jobs, selling [cocaine] is a quicker way to make money. People are desperate to make money ..." Treatment providers and law enforcement also most often reported that the availability of powdered

cocaine has remained the same during the past six months. A law enforcement officer described availability as “pretty level.” The Canton-Stark County Crime Lab reported that the number of powdered cocaine cases it processed has decreased during the past six months.

Most participants rated the quality of powdered cocaine as ‘6’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality); the previous most common score was ‘5’. Participants reported that powdered cocaine in the region is cut with baby aspirin, baby laxatives, baby powder, baking soda, benzodiazepines, dietary supplements, ether, methamphetamine, NoDoz®, Orajel® and vitamin B-12. In terms of the quality of powdered cocaine, most participants agreed with the following comments, “It [quality of powdered cocaine] depends. It’s 50/50. Depends on where you are at, who you go to, if there is a middleman or not. It could be fine one time, shit another time.” A participant also reported that there are “a lot of new dealers on the street, trying to rip people off.” A participant noted, “I’ve been sold soap [fake/dummy cocaine] several times.” The Canton-Stark County Crime Lab cited the following substances as commonly used to cut cocaine: baking soda, levamisole (livestock dewormer), 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 “blow,” “snow” and “white girl.” Participants listed the following as other common street names: “bitch,” “coke,” “fire,” “fish scales,” “fuel,” “girl,” “powder,” “soft,” “white,” “winter time” and “ya-yo.” In addition, participants reported the phrase, “You want to go skiing?” as jargon to buy powdered cocaine. Current street prices for powdered cocaine were consistent among participants with experience buying powdered cocaine. Participants reported that 1/4 gram, or “baggie,” of powdered cocaine sells for \$20; a gram typically sells for between \$50-100; 1/16 ounce, or “teener,” sells for between \$70-120; 1/8 ounce, or “eight ball,” sells for between \$100-250; an ounce sells for between \$1,200-1,300. Participants reported different variables that affect the price of powdered cocaine. For example, a participant reported that, “really good cocaine,” cocaine cut with methamphetamine, known by the street name “fire,” sells for as high as \$250 for an eight ball. A participant also reported, “It [price of powdered cocaine] depends on how much you buy. If you work with someone [a particular dealer] consistently, they will hook you up for cheaper prices.” Most participants reported that for users, it is most common to purchase powdered cocaine by the gram, though it was reported that it is also common to buy quantities of \$20, \$40, \$50 or \$100. Participants continued to report that the most common route of administration for powdered cocaine remains snorting. Out of 10 powdered cocaine

users, participants reported that seven would snort and three would intravenously inject. A participant stated, “It [route of administration] depends on who you use it with.” In addition, a participant reported smoking powdered cocaine, mixing the drug with water on foil and smoking it off the foil, while another participant reported oral use of cocaine, sucking powdered cocaine into the mouth with a straw when the sinuses are blocked or irritated.

A profile for a typical powdered cocaine user did not emerge from the data, though some participants commented that the typical user of powdered cocaine is from the upper-middle class. A participant commented, “I know people you’d never expect to use drugs who use cocaine ... doctors, lawyers. There’s not as much stigma with [powdered] cocaine use as other drugs.” It was noted in one group that there are “a lot” of children (as young as 12 or 13 years old) who are using powdered cocaine. Treatment providers described typical users as Caucasian, middle- to upper-class, and generally older. Powdered cocaine was viewed by treatment providers to be more of a drug of abuse, rather than dependence, used by individuals with more resources (such as people who are “employed or in college with student loans, or have a significant other with resources,” as one treatment provider stated. However, it was cautioned by a treatment provider that powdered cocaine often serves as a “gateway drug to crack cocaine” or to intravenous drug use. Treatment providers reported that there has been an increase in powdered cocaine use among younger, college-aged individuals. A treatment provider reported, “College students have some extra funds [student loans] to dabble in powdered cocaine.” A treatment provider, who is also a graduate student, reported that at her school, “crack cocaine is looked down on, while powdered cocaine is more acceptable.” A law enforcement official reported, “Distributors tend to be African-American ... their customers tend to be a little bit of everyone.”

Reportedly, powdered cocaine is used in combination with alcohol, hallucinogens [LSD (lysergic acid diethylamide) and psilocybin mushrooms], heroin, marijuana and prescription opioids. Participants reported that alcohol is used to prolong the use and intensify the effects of powdered cocaine. A participant stated, “I would be drunk, and I would use [powdered] cocaine to keep me going. [Powdered cocaine] it gives you super human drinking power.” Individuals who use heroin with cocaine (“speedball”) expressed, “[Speedballing] it’s a different high with an upper and a downer ... You get the rush of heroin, but you still have energy ...” Other participants noted that prescription opioids provide a buffer, helping the user to come down from the stimulant high. In the same way, marijuana was reported by a participant to “calm me,” also serving as a buffer when used with cocaine. A participant reported “strange visions, hallucinations” when using powdered cocaine with hallucinogens. Participants continued

to agree that it is more common to use powdered cocaine with other drugs than to use it alone.

Crack Cocaine Historical Summary

In the previous reporting period, crack cocaine was highly available in the region. Participants and treatment providers most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), while law enforcement reported availability as '5' in Stark County and '7' in Summit County. Participants agreed that crack cocaine was easier to find than powdered cocaine. The Canton-Stark County Crime Lab reported that the number of crack cocaine cases it processed had remained the same during the previous 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 Canton-Stark County Crime Lab cited baking soda and procaine (local anesthetic) as commonly used to cut crack cocaine. Participants reported that 1/8 ounce sold for \$180. Reportedly, users most often purchased crack cocaine in \$20 "rocks" (pieces), but they also purchased smaller rocks (aka "crumbs") for as little as \$3-5. The most common route of administration remained smoking. Participants and treatment providers could not identify a typical user of crack cocaine, but said people of all socio-economic classes, races and ethnicities used the drug.

Current Trends



Crack cocaine remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Participants continued to report that crack cocaine is easier to obtain than powdered cocaine. A participant commented, "[Crack cocaine] it's everywhere ... very, very easy to find, every block ... one of the most easily accessible drugs in Akron." However, participants in Stark County commented that it is difficult to find crack cocaine at times. A participant stated, "Crack cocaine's availability] it's down one day, up the next. [Dealers] move from one side of town, they [police] clean it up ... they [dealers] go to the other side ... back and forth, back and forth." As in previous reports, participants noted that it is common for heroin dealers to also sell crack cocaine. Treatment providers most often reported the drug's current availability as '10'; the previous most common score was also '10'. Law enforcement reported the current availability of crack cocaine as '7'. As an officer explained, "Most crack cocaine is home-grown; they buy the powder [cocaine] and cook it."

Participants generally agreed that the availability of crack cocaine has increased during the past six months. Participants reported that dealers like to sell crack cocaine because of the high-profit margin. A participant said, "[Crack cocaine] it's easier to get. There's more money for dealers in selling crack." Participants also thought crack cocaine is more available because there are more users, as one participant said: "[Crack cocaine] it's attracting a younger crowd, so younger people are selling it." However, some participants in Stark County reported a decrease in availability of crack cocaine. A participant stated, "Around this 'hood [Northwest Canton], they [crack cocaine dealers] are either in jail or they moved." Overall, participants thought it is easier to obtain crack cocaine in Northeast Canton. Treatment providers and law enforcement reported that availability of crack cocaine has remained the same during the past six months. The Canton-Stark County Crime Lab reported that the number of crack cocaine cases it processed has increased during the past six months.

Most participants rated the quality of crack cocaine as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Participants typically reported that the quality of crack cocaine varies from dealer to dealer. A participant commented, "Some [dealers] have good stuff [crack cocaine], some have fake stuff." Participants reported that crack cocaine in the region is cut with baby laxative, baking soda and Orajel®. Participants who were disappointed with the quality of crack cocaine reported re-cooking it to remove the impurities. Overall, 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 remain "hard" and "rock." Participants listed the following as other common street names: "A1," "butter," "candy," "cookies," "crack," "crack-a-lacken," "Craig," "la roca," "pebbles," "snap-crackle-pop," "white," "white boy" and "ya-yo." Current street prices for crack cocaine were consistent among participants with experience buying the drug. Participants reported that a gram of crack cocaine sells for \$50; 1/8 ounce sells for between \$100-170. Participants agreed that users could purchase crack cocaine in any quantity; however, the drug is most commonly purchased as a "rock" for between \$10-50, depending on size. Participants reported \$20 rocks are most common. A participant noted, "Crack heads [users] don't have scales. They buy rocks, \$20, \$30 [and] \$50. They then just keep coming back, thinking they are going to save money in their pocket." Another participant stated, "I've seen people come up with a dollar and some change, looking to buy crumbs [of crack cocaine]." While there were a few reported ways of administering crack cocaine, generally, the most common route of administration remains smoking. Out of 10 crack cocaine users, participants reported that approximately eight would smoke and two

would intravenously inject. Some participants thought that intravenous injection is becoming more common. A participant reported, *"Shooting [injecting crack cocaine] is getting more popular."* Participants explained that some users prefer to inject crack cocaine because this method reportedly decreases cravings for more crack cocaine. A participant stated, *"I did not have that 'want more feeling' [after injecting crack cocaine]"* However, most participant groups cited that intravenous use of crack cocaine is relatively rare.

A profile of a typical user of crack cocaine did not emerge from the data. Many participants agreed with a participant who stated, *"[Crack cocaine] does not discriminate ... [its use] crosses all lines, white collar to the ghetto."* Treatment providers also did not believe that there is a typical crack cocaine user. A treatment provider stated, *"[Crack cocaine use] crosses all classes. It's just that the upper-class [is] able to hide it more. I see upper-class people come into the neighborhoods to purchase crack."* Another treatment provider commented that crack cocaine users are *"pretty diverse, educated registered nurses to high school drop-outs."* One treatment provider group noted an increase in a certain type of user. A treatment provider explained that he saw *"a spike in [the use of crack cocaine among] middle-aged Caucasian males, related to the use of prostitution."* Law enforcement thought that crack cocaine use is more common among some groups. An officer said, *"The majority [of crack cocaine users] we see are lower-class from African-American neighborhoods."*

Reportedly, crack cocaine is used in combination with alcohol, heroin and prescription opioids (both to "speedball") and marijuana. A participant reported, *"I wouldn't smoke crack unless I had some kind of downer [a way of coming down off crack cocaine] for after."* Another participant stated, *"I have to use heroin to come down, or I will freak out."* Participants could not agree whether it is more common to use crack cocaine by itself or with other drugs. However, one participant's comment seemed typical: *"Many people are too busy looking for more [crack cocaine] to use with anything else. But when you want to sleep, or feel normal, you will use Valium®."*

Heroin Historical Summary

In the previous reporting period, heroin was highly available in the region. Participants and treatment providers most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). While many types of heroin remained available in the region, participants continued to report brown powdered heroin as the most available. Participants rated the availability of black tar heroin as '2.' Law enforcement in both Stark and Summit counties reported high availability of heroin, and identified brown powdered heroin as the type of heroin law enforcement in the region most often encountered. Participants and community

professionals reported that the availability of heroin had increased during the previous six months. The Canton-Stark County Crime Lab reported that the number of heroin cases it processed had remained the same during the previous six months. Most participants rated the quality of heroin as '6' on a scale of '0' (poor quality, "garbage") to '10' (high quality). The Canton-Stark County Crime Lab cited the following substances as commonly used to cut heroin: caffeine, diphenhydramine (antihistamine), maltose (disaccharide sugar) and procaine (local anesthetic). Participants generally reported that the quality of heroin depended on where one got it. The most commonly cited street names for heroin remained "boy" and "dog food." Participants reported that powdered heroin was available most frequently in "bags" or "points" (1/10 gram), which sold for between \$10-20; a gram sold for between \$100-150. The most common route of administration for heroin remained intravenous injection. Many participants commented that individuals might start off snorting heroin, but would eventually use it intravenously. A profile for a typical heroin user did not emerge from the data. However, some participants reported that heroin users were more likely to be White, while others commented that heroin was more likely to be used by individuals younger than 35 years. Most participants recognized that heroin use was increasing among very young users, as young as 14-15 years. A number of community professionals also noted that heroin use was becoming more popular with younger people, particularly those between the ages of 18-25 years.

Current Trends



Heroin remains highly available in the region. Participants and treatment providers most often reported overall availability of heroin as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. The following participant comments were typical responses to heroin's availability: *"[Heroin] it's everywhere, everywhere, everywhere, more available than cocaine; It's a drug you get sick on, so everyone has to keep using it; Heroin is the new marijuana, everyone is getting high off it; In my apartment complex, I could walk to any building and get it."* While many types of heroin remain currently available in the region, participants overwhelmingly agreed that the most available type of heroin continues to be brown powdered heroin. Participants described heroin as, *"Usually chunky or powder, usually tan; Mostly powder, rock, white or tan ... can be gritty ... can be real hard; People want rock, but usually find powder."* Participants rated the availability of black tar heroin as '3,' the previous most common score was '2.' Participants noted, *"Tar [black tar heroin] is hard to find; If you find tar, you are lucky."* Law enforcement reported heroin's current availability as '8.' A law enforcement officer commented, *"[Heroin] it's pretty easy to get*

a hold of out there. We are still having a lot of OD [overdose] deaths as a result." Another officer reported that black tar heroin is available in the area: *"We've seen a few examples of tar ... from a big sale out of Dayton."* Collaborating data also indicated that heroin is readily available in the region. The Stark County Coroner's Office reported heroin as present in 17.9 percent of all drug-related deaths; in the last reporting period, heroin was present in 16 percent of all drug-related deaths.

Participants unanimously reported that the availability of powdered heroin has increased during the past six months. A participant commented, *"People get hooked on pills [prescription opioids] first, then found heroin is cheaper. Also, oxy's [reformulated OxyContin® OP] turn to gel [when crushed], so people turn to heroin."* Participants noted that the lack of availability of other drugs (OxyContin® OC) has contributed to the increase availability and use of heroin. Treatment providers most often reported that the availability of heroin has remained the same during the past six months, though all recognized that availability is much higher than it was two years ago. A treatment provider commented, *"We hit it high last year. Now, [heroin availability] it's just staying high."* However, treatment providers in Tuscarawas County noted a significant increase in availability of heroin in rural areas: *"Rural areas are attracting [heroin] dealers. They are recognizing there is a market. There has been a crackdown on prescription pills ... clients are marked at the hospital and pharmacies and no longer get their drug of choice [prescription opioids], and hence are turning to heroin. In our [treatment] groups, it used to be one person in the group reported heroin as their drug of choice ... today, it is three or four."* Law enforcement reported that availability of heroin has remained the same during the past six months. The Canton-Stark County Crime Lab reported that the number of heroin cases it processed has increased during the past six months.

Most participants rated the quality of heroin as '7' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '6.' Participants reported that heroin in the region is cut with brown sugar, cocoa powder, coffee, fentanyl, powdered milk, quinine powder, talcum powder, Valium®, vitamin B-12 powder and, as one participant stated *"whatever looks like the heroin."* A participant commented, *"My boyfriend almost died because of heroin cut with Valium®."* Participants continued to report that the quality of heroin depends on where one obtains the drug. A participant noted that the quality of heroin, *"could be good one week, could be bad. It's why people OD [overdose]. Sometimes it's too gummy to shoot, based on being cut wrong."* Others agreed with this comment, with one participant stating, *"If the dealer uses, [heroin quality] it's not as good, 'cause they will cut it more to get some for themselves. But if the dealer does not use, the quality is better."* The majority of

participants agreed that the quality of heroin has remained the same during the past six months. The Canton-Stark County Crime Lab reported that the heroin cases they process have been almost exclusively powdered heroin: tan, beige, white, off-white and brown in color. The crime lab also reported that heroin is cut with diphenhydramine (antihistamine) and lactose.

Current street jargon includes many names for heroin. The most commonly cited names remain "boy" and "dog food." Participants listed the following as other common street names: "Afghanistan," "brown," "dirty," "H," "junk," "knock out," "Mr. Brown," "puppy chow," "Ron" and "smack." Participants reported that powdered heroin is available in "bags" or "folds" (1/10 gram), which sell for \$20; 1/4 gram sells for \$50; 1/2 gram sells for between \$75-100; a gram sells for between \$100-150. Reportedly, the most common way to purchase heroin is by the bag, and usually for \$20. However, a few participants noted that it is common to buy a 1/4 gram or 1/2 gram, *"splitting it with a buddy because it's a rip off to pay for a bag,"* as one participant stated. Participants also noted that one can purchase heroin in larger quantities for a lower cost, (aka six grams of heroin sells for \$375). A participant commented, *"I used to get a gram [of powdered heroin] for \$70, then triple the profit [by selling the heroin]."* Participants did not report the price of black tar heroin, as it remains relatively rare in the region. Overall, participants reported that heroin pricing has remained the same during the past six months. 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 it and two would snort it. A couple of participants reported knowledge of smoking heroin off of aluminum foil. Many participants continued to comment that individuals may start off snorting heroin, but will eventually use it intravenously. A participant commented, *"Most [start off using heroin by] snorting ... but inevitably, you end up with a needle in your arm."* Most participants reported that needles are readily available in stores with pharmacies and can be purchased with few questions asked. A participant stated, *"I tell them [pharmacy staff] I need insulin needles for my grandmother. You can buy 100 needles for \$10."* Participants also reported that one can purchase needles from individuals with prescriptions, such as diabetics, or from some heroin dealers. Still, participants reported that it is common to share needles, with one stating: *"People share needles, use bleach [to clean them]. Sharing is prevalent. [People feel] it's better to share [needles] than to not use at all."* In addition to sharing needles, another participant noted, *"People use the same ones; I would use my needle until it was crooked, and there was not a point on it."* Very few participants had any knowledge of needle-exchange programs.

A profile for a typical heroin user did not emerge from the data. The following comment was typical among participants, *"It [heroin] does not discriminate. You can never tell who is using or not."* However, some participants agreed with one, who stated, *"I see more White people using heroin than Black people."* Many agreed that heroin use is becoming more prevalent among younger people: *"In the past five years, heroin is skyrocketing among young people. Most are between ages 20 and 35 [years]; Not many over the age of 35, unless they've been using a long time."* Community professionals also did not identify a profile of a typical heroin user. Many treatment providers agreed with one who stated: *"There is so much [heroin] use ... it crosses all lines, no sub-culture."* Likewise, a law enforcement official reported, *"[Heroin use] it's pretty widespread ... we see it everywhere."* While no profile for the typical heroin user was offered, there was consensus among community professionals that there has been a noted increase in the use of heroin among younger people, with some commenting that use begins as early as adolescence.

Reportedly, heroin is used in combination with alcohol, crack cocaine, marijuana, prescription opioids and sedative-hypnotics. While most participants reported that it is more common to use heroin by itself (not in combination with other substances), some use it with alcohol because *"one drug balances the other out,"* with crack cocaine (speedball) because *"you use crack first, gets you geeky, then use heroin to calm down,"* with marijuana because *"it [marijuana] amplifies the high, until you nod out,"* and with sedative-hypnotics because *"they made me real calm, and it makes me feel like it [the high] lasts longer."*

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 '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants identified Opana®, OxyContin® OP, Percocet®, Roxicet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Treatment providers most often reported availability as '9,' and identified OxyContin® OP, Percocet® and Vicodin® as most popular. Participants and treatment providers reported that the availability of prescription opioids had decreased during the previous six months. Many participants commented on the decline in availability of OxyContin® OC particularly, as the old formulation was no longer available; and while the new formulation, OxyContin® OP, was available, it was said to be not liked by users. A noted exception in the decline in availability was an increase in availability of Opana®, which many participants reported as

gaining in popularity. Generally, the most common routes of administration for these drugs remained swallowing, snorting and intravenous injection. In addition to obtaining prescription opioids on the street from dealers, participants also reported getting them from pain clinics, area doctors, emergency rooms and other individuals with prescriptions. Participants reported that it was most common to acquire these drugs off the street. Participants described the typical user of prescription opioids as a young person, teenaged or twenty-something years in age. Treatment providers also reported that prescription opioid use was more common among the younger population. A law enforcement official in Summit County reported that prescription opioid abuse was widespread *"across the board"* in terms of race, gender and socio-economic status.

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 also '10'. Participants identified morphine, Opana®, Percocet®, Roxicet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Treatment providers most often reported the current availability as '8,' the previous most common score was '9'. They identified Percocet® and Vicodin® as the most popular prescription opioids in terms of widespread use. Law enforcement reported current availability as '6,' and identified OxyContin® as most popular, though they reported a rising trend in the availability of Opana®. Collaborating data also indicated that prescription opioids are readily available in the region. The Stark County Coroner's Office reported prescription opioids as present in 50 percent of all drug-related deaths; in the last reporting period, prescription opioids were present in 44 percent of all drug-related deaths.

Participants reported that the availability of prescription opioids has increased during the past six months. However, some participants continued to comment on the decline of availability of Oxycontin® OC, reporting that the old formulation costs too much, or is, as one participant stated, *"not as easy to get and 'OP's' [OxyContin® OP, the new formulation] you really can't shoot [inject] them, people just went to heroin."* Treatment providers also reported a decrease in the availability of OxyContin® OC, but an increase in the availability of other prescription opioids, particularly methadone and Opana®. Overall, most participants reported that it is relatively easy to obtain

prescriptions of these medications, or purchase them on the street. While some participants echoed the sentiment of one participant who reported that *“hospital ER’s are red flagging [refusing to prescribe to certain individuals who may be abusing prescription opioids]”* to prevent abuse, more typical comments included ones similar to this participant who stated: *“[Prescription opioids are] easy to get. Just go to the hospital, say your back hurts, they give you Vicodin®. They cannot tell you are lying. They can’t tell you your back don’t hurt. They have to give you treatment. They will send you home with something.”* Other participants agreed with a participant who stated, *“I know people who go to the ER, saying they cannot be on narcotics, and leave with a prescription for narcotics.”* Treatment providers noted the ease by which prescription opioids are legally obtained by prescription. There was agreement among treatment providers that, as one stated, *“pain management docs are not held to the same standard as primary care physicians.”* In addition, treatment providers reported that it is very easy to obtain these medications on the streets, with one stating: *“People trade pain pills for marijuana, crack and [powdered] cocaine.”* Most treatment providers agreed with the following statement from a fellow treatment provider: *“Most clients we see have had some [prescription opioid] use. It’s not always extensive enough for a diagnosis. But, if you can’t find your drug of choice, they will use pain killers.”* A law enforcement official reported that the availability of Opana® is increasing: *“Opana® is taking over due to the new form of oxy’s [OxyContin® OP] ... users are either switching to Opana® or heroin.”* The Canton-Stark County Crime Lab reported that the number of prescription opioid cases it processed has increased during the past six months for fentanyl, morphine, Opana®, Tylenol® 3 and 4, and Vicodin®; decreases were noted for Dilaudid®, OxyContin® and Percocet®.

Reportedly, many different types of prescription opioids are currently sold on the region’s streets. Participants reported the following prescription opioids as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Dilaudid® (aka “D’s” and “dots;” 8 mg sells for \$20), methadone (5 mg sells for between \$3-5; 10 mg sells for between \$8-10; 40 mg sells for between \$10-20), morphine (aka “morphs;” sells for \$1 per milligram), Opana® (aka “OP’s,” “pans” and “pandas;” 10 mg sells for \$10; 20 mg sells for between \$15-25; 30 mg sells for \$35; 40 mg sells for between \$35-60), OxyContin® (old formulation, aka “OC’s;” 80 mg sells for between \$50-100; new formulation, aka “OP’s;” 80 mg sells for between \$25-40), Percocet® (aka “P’s,” “perc’s” and “perculators;” sells for between \$0.50-1 per milligram), Vicodin® (aka “V’s” and “vic’s;” 5 mg sells for \$2-3; 7.5 mg, aka “750’s;” sells for between \$3-5; 10 mg sells for between \$4-10). While there were a few reported ways of consuming prescription opioids, participants reported that whenever possible the preferred route of administration

is intravenous injection. A participant stated, *“Some pills [prescription opioids] are too much work to break down, so you eat them. If you are hooked, most people shoot them.”*

In addition to obtaining prescription opioids on the street from dealers, many participants also reported that it is easy to have them prescribed. The following participant comments were typical: *“Fake a broken wrist, a tooth ache, that’s what I did [to get a prescription for opioids]; I used to break my bones, to get them. I broke my wrist one time, four fingers, so I could get pain pills.”* Participants reported it is very easy to acquire these medications on the street: *“People who get prescriptions [for opioids], they know they can make a big profit [selling them]. People wait around, because people who get pain pills will sell them out; People steal them, from older people, or hospitals. Sometimes people are assaulted [and robbed of their prescriptions].”*

A profile for a typical prescription opioid user did not emerge from the data. Participants reported that prescription opioid use *“is an epidemic, across the board,”* as one stated. *“Older men and women who get hurt and prescribed these pills are getting addicted.”* Treatment providers also reported that prescription opioid use is present among any subgroup of the population. However, treatment providers noted that the use of Percocet® and Vicodin® is becoming more popular with high-school-aged youth. Treatment providers also expressed concern about pain management practices among older adults, with one making reference to *“the silent addiction.”* *Many [seniors] get involved for legitimate reasons, but they become addicted ...”*

Reportedly, when used in combination with other drugs, prescription opioids are most often used in combination with alcohol, heroin, marijuana and sedative-hypnotics (benzodiazepines). Participants reported that the combination of prescription opioids with a depressant drug, including alcohol, *“heightens the pills effect, intensifies the opioid buzz.”* When used with marijuana, participants reported, *“It [marijuana] kicks in the buzz more, intensifies it [prescription opioids] ten times,”* as one participant stated. Participants reported that they use prescription opioids with heroin when, as one stated, *“my heroin is not good.”*

Suboxone® **Historical Summary**

In the previous reporting period, Suboxone® was highly available in the region. Participants most often reported availability of Suboxone® as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Treatment providers most often reported availability as ‘9’ or ‘10.’ Treatment providers generally believed that Suboxone® was sought by users primarily for withdrawal maintenance. Law enforcement reported the availability of

Suboxone® as '4.' There was no participant data pertaining to availability status of Suboxone® compared to the previous six months. However, treatment providers reported that availability had increased while noting that there were more Suboxone® clinics opening in the region; law enforcement reported that availability had remained the same. The Canton-Stark County Crime Lab reported that the number of Suboxone® cases it processed had increased during the previous six months. Participants reported that a Suboxone® 8 mg pill sold for between \$10-20; Suboxone® strips/film sold for between \$9-12. Participants reported that sublingual (dissolved under the tongue) use of the drug was far more popular than either snorting or intravenous injection. A participant group cited that 80-90 percent of users used Suboxone® sublingually. In addition to obtaining Suboxone® on the street from dealers, participants continued to report getting the drug from pain clinics, doctors and Suboxone® clinics. Participants commonly reported that some individuals obtained prescriptions to sell Suboxone® and/or trade them for other drugs. A profile for a typical Suboxone® user did not emerge from the data.

Current Trends



Suboxone® remains highly available in the region. Participants most often reported current availability of Suboxone® as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' Participants reported that Suboxone® is used both to avoid withdrawal symptoms and as a drug to get high. A participant stated, *"I would use [Suboxone®] when I couldn't get heroin, to avoid getting sick, about once or twice a month."* Another participant reported, *"Non-heroin users will use it [Suboxone®] to get high. I used Suboxone® twice before I ever used heroin, and I got high."* Treatment providers most often reported the drug's current availability as '8'; the previous most common score was '9' or '10.' Treatment providers also reported that heroin users use Suboxone® when they can't obtain heroin. Law enforcement reported the current availability of Suboxone® as '3'; the previous most common score was '4.' A law enforcement official characterized the availability of Suboxone® as, *"We've seen a couple of cases, but nothing major."*

Participants reported that the availability of Suboxone® has increased during the past six months. Treatment providers also reported that availability has increased while noting that Suboxone® is being prescribed more often. A treatment provider reported, *"We've had several Suboxone® programs opening up ... There is advertising on billboards."* Treatment providers expressed a concern that many consumers are being offered treatment with Suboxone® without being

referred to substance abuse treatment. The Canton-Stark County Crime Lab reported that the number of Suboxone® cases that it processed has remained the same during the past six months.

Participants did not report any street jargon for Suboxone®. Participants reported that a Suboxone® 8 mg pill sells for between \$5-20; Suboxone® strips/film sell for between \$10-20. Participants reported that sublingual use of Suboxone® remains the most common route of administration for the drug, reporting that out of 10 users, eight would use sublingually and two would snort the drug. Reportedly "very few" users use Suboxone® by intravenous injection. A participant reported, *"When you shoot it [inject Suboxone®], it makes you feel weird."* Suboxone® strips continue to be mostly administered sublingually.

A profile for a typical Suboxone® user did not emerge from the data. Treatment providers reported that Suboxone® users are of the *"same group as heroin, across the board,"* as one stated. However, it was noted that one had to have the means to pay for Suboxone®, and one treatment provider posited that users are typically people *"with insurance or a medical card."* A participant noted, *"People with insurance go to the doctors. Others go to the streets."* Participants did not identify any other substances that individuals use in combination with Suboxone®.

Sedative-Hypnotics Historical Summary

In the previous reporting period, sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) were highly available in the region. Participants most often reported the availability of these drugs as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), while law enforcement reported availability as '5.' Participants and treatment providers identified Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Treatment providers most often reported availability as '9' for Xanax®, '8' for Klonopin® and '6' for Valium®. Most participants and community professionals reported that availability of sedative-hypnotics had increased during the previous six months. For the first time, users spoke of synthetic Xanax® in head shops, commonly sold as Zan-X. The most common routes of administration remained snorting and oral ingestion. In addition to obtaining sedative-hypnotics on the street from dealers, participants reported getting them from doctors, individuals with mental health issues and senior citizens. Participants and community professionals did not identify a typical user profile because they said abuse of sedative-hypnotics crossed age, racial and ethnic boundaries.

Current Trends

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) 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 also '10'. Participants and treatment providers identified Ativan®, Klonopin®, Valium® and Xanax® as the most popular sedative-hypnotics in terms of widespread use. Notably, most participants were not aware of the "synthetic Xanax," mentioned during the last reporting period; only one participant in Summit County reported having heard of this new substance. Treatment providers most often reported current availability of sedative-hypnotics as follows: '10' for Ativan®, Klonopin® and Xanax®, and '7' for Valium®. Treatment providers reported that sedative-hypnotics are readily available due to the frequency by which they are prescribed. A treatment provider noted, *"They [sedative-hypnotics] are highly prescribed, with plenty of refills. Doctors will prescribe them to our patients, knowing they cannot use them in treatment. Almost every woman I've worked with has been treated with Xanax® at some point, often as a means of treating anxiety related to drug use. Very few doctors will work with substance abuse treatment providers, there is very poor collaboration."* Law enforcement reported current availability as '5'; the previous most common score was also '5'. Law enforcement identified Valium® and Xanax® as the most popular sedative-hypnotic in terms of widespread use. Collaborating data also indicated that sedative-hypnotics are readily available in the region. The Stark County Coroner's Office reported sedative-hypnotics as present in 44.6 percent of all drug-related deaths; in the last reporting period, sedative-hypnotics were present in 60 percent of all drug-related deaths.

Participants were divided as to whether the availability of sedative-hypnotics has increased or remained the same during the past six months. A participant shared that availability of these drugs has increased *"due to the prevalence of cocaine and meth [methamphetamine]. You need something to bring you down. They [sedative-hypnotics] are so easy to get from doctors."* Treatment providers and law enforcement reported that availability of sedative-hypnotics has remained the same during the past six months. The Canton-Stark County Crime Lab reported that the number of sedative-hypnotic cases it processed has increased during the past six months; only Ativan® decreased in availability.

Reportedly, many different types of sedative-hypnotics are currently sold on the region's streets. Participants reported the following sedative-hypnotics as available to street-level users (Note: When reported, current street names and prices are indicated in parentheses): Ativan® (sells for \$0.50 per

milligram); Klonopin® (aka "klonies," "K-pins" and "pins;" sells for between \$0.50-1 per milligram); Valium® (aka "prince Valium®," "V's" and "v-cut;" sells for \$0.50 per milligram); Xanax® (aka "Professor Xavier" and "wagon wheels;" 0.25 mg, aka "white footballs;" sells for \$0.50; 0.5 mg, aka "peach footballs" and "peaches;" sells for \$1; 1 mg, aka "blue footballs;" sells for between \$1.50-3; 2 mg, aka "xanibars" and "bars;" sells for between \$4-5; and 2 mg generic Xanax® (alprazolam), aka "greens;" sells for between \$4-5). 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 snorting and oral ingestion. Participants reported that out of 10 sedative-hypnotic users, six or seven would snort the drugs, and three or four would take the drugs orally.

In addition to obtaining sedative-hypnotics on the street from dealers, participants also continued to report getting them from doctors. A participant discussed feigning anxiety symptoms for the drugs: *"[Sedative-hypnotics] are easy to get from doctors. I just have to say I have 'panic attacks.' They are very easy to get from doctors, and very easy to get off the streets. I used to get them from my doctor, but quit because it is easier and cheaper to get them off the streets."* Participants reported that users with prescriptions for sedative-hypnotics will sell them to obtain another drug.

A profile of a typical user of sedative-hypnotics did not emerge from the data. However, some treatment providers expressed the opinion that sedative-hypnotic use is more common with women. A treatment provider speculated that women are more prone than men to see a psychiatrist than men when they are experiencing emotional difficulty. Some treatment providers said that there seems to be an increase in the use of sedative-hypnotics among young people, especially among those who use heroin. Reportedly, when used in combination with other drugs, sedative-hypnotics are most often used in combination with alcohol, marijuana and *"any kind of upper [stimulant drug]."* Participants also reported that sedative-hypnotics are used to modify or "intensify the high" of alcohol. Some participants mentioned combining sedative-hypnotics with marijuana.

Marijuana Historical Summary

In the previous reporting period, marijuana was highly available in the region. Participants most often reported the drug's availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get), while law enforcement reported availability as '8' in Stark County and '10' in Summit County. Most participants reported that the availability of marijuana had remained

the same during the previous six months. Participant quality scores of marijuana varied from '5' to '10,' with the most common score being '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported commercial-grade marijuana as the cheapest form: a blunt or two joints sold for \$10; an ounce sold for between \$180-240. Higher quality marijuana sold for significantly more: a blunt or two joints sold for between \$20-50; an ounce sold for between \$300-350. Reportedly, the most common way of purchasing marijuana was by the bag, roughly 3.5 grams, which yielded two to three joints and sold for between \$10-20. The most common route of administration remained smoking. Participants and law enforcement continued to report that there was no typical user profile; people from every population used marijuana.

Current Trends

Marijuana remains highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10.' Participants commonly said marijuana was as close as *"a knock on the neighbor's door, easier to get than grass in your lawn,"* as one participant stated. Another participant explained, *"[Marijuana] is more easy [to obtain] than alcohol. Sometimes you can't get alcohol on Sunday, but you can always get marijuana."* Participants did not think of marijuana as a dangerous or addictive drug. A participant commented, *"Most [people] don't even consider it [marijuana] a drug. It's just as common as smoking cigarettes."* Treatment providers unanimously reported the drug's current availability as '10.' Many treatment providers also agreed with one who stated that marijuana is *"more accessible than alcohol."* Law enforcement reported the drug's current availability as '10,' reporting that in Summit County, more than 300 pounds of marijuana valued at \$1,500 per pound has been confiscated during the past six months. Collaborating data also indicated that marijuana is readily available in the region. The Stark County Coroner's Office reported marijuana as present in 12.5 percent of all drug-related deaths; in the last reporting period, marijuana was present in 24 percent of all drug-related deaths. Most participants reported that the availability of marijuana has increased during the past six months. A participant noted, with general agreement from others, *"You can grow it [marijuana] yourself. You can grow it in your basement."* The Canton-Stark County Crime Lab reported that the number of marijuana cases it processed has decreased during the past six months.

Participants reported that there are a number of grades of marijuana, explaining that the quality of marijuana depends

on whether the user buys "commercial weed" (low- to mid-grade marijuana) or higher-grade marijuana (hydroponic or home-grown marijuana). Most participants rated the quality of lower-grade marijuana as '3' and higher-grade marijuana as '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common scores were '5' for lower-grade and '10' for higher-grade marijuana. Regarding lower-grade marijuana, participants described it as frequently having seeds. Several participants agreed that the high produced on lower-grade marijuana is poor; a participant reported, *"You barely get high; it takes five joints to get a buzz."* Participants described higher grades of marijuana as tending to have, as one participant stated, *"crystals that sparkle."* Participants reported that the quality of marijuana continues to increase. A participant explained, *"People grow their own [marijuana]. They buy the seeds on the Internet. They are developing it, growing it with chemicals [and] nurturing it to make a better drug."*

Current street jargon includes countless names for marijuana. The most commonly cited name remains "weed." Participants listed the following as other common street names: "dirt weed," "mersh," "middies," "reggies," "skunk weed" and "swag" for commercial-grade marijuana; "blueberry yum yum," "chronic," "denk," "fire," "kush," "northern light," "nuggets," "red bud" and "tuff" for high-grade marijuana; "dro" and "hydro" for hydroponically grown marijuana. Participants identified medical-grade marijuana as, *"the best, an upgrade from hydro; the best kind of weed you can get."* Street jargon for medical grade marijuana included "loud." The price of marijuana depends on the quality desired. Participants reported commercial-grade marijuana as the cheapest form: a blunt or two joints sells for between \$3-10; 1/8 ounce sells for between \$15-30; 1/4 ounce sells for between \$20-25; an ounce sells for between \$80-150; a pound sells for between \$800-1,200. Higher quality marijuana sells for significantly more: a blunt or two joints sells for between \$15-20; 1/8 ounce sells for between \$35-60; an ounce sells for \$300; a pound sells for \$2,000. Prices for medical-grade marijuana are similar to high-grade marijuana: a gram sells for \$25; 1/4 ounce sells for between \$70-100; an ounce sells for \$300. While there were several reported ways of consuming marijuana, the most common route of administration, by far, remains smoking. In fact, most participant groups did not even make reference to any other route of administration, though one group referred to *"pot brownies"* and making tea with marijuana, both of which are reportedly common at *"hippie fests [festivals],"* as one participant said.

A profile for a typical marijuana user did not emerge from the data. Participants continued to report that people from every population use marijuana. Treatment providers and law enforcement agreed, describing the typical user as *"everyone"*

and his brother, age six to 60 [years old].” Treatment providers expressed that many clients report using marijuana for the first time at a very early age, beginning at age nine years. Reportedly, marijuana is used in combination with alcohol, crack and powdered cocaine, prescription opioids and sedative-hypnotics. Participants did not identify specific effects of using marijuana mixed with other drugs. Generally, participants posited that marijuana goes with any other drug. A participant commented, *“They smoke it [marijuana] because they do, and use other drugs.”*

Methamphetamine

Historical Summary

In the previous reporting period, methamphetamine was highly available in the region. Participants and treatment providers most often reported the drug’s availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Participants reported that methamphetamine continued to be most available in powdered form. Crystal methamphetamine (aka “ice”), the highest quality form of methamphetamine, was rare in the region. The Canton-Stark County Crime Lab cited brown, pink and white powdered methamphetamine as the most common forms of the drug found in the region. Reportedly, the most common way of manufacturing methamphetamine was through the “shake-and-bake” or “one-pot” method, which was widely known. Participants and treatment providers could not agree whether methamphetamine availability had increased, decreased or remained the same during the previous six months. Most participants rated the quality of powdered methamphetamine as ‘5’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants reported that a “rock” of methamphetamine sold for \$20; a gram of powdered methamphetamine sold for between \$50-100; a gram of crystal methamphetamine (when available) sold for \$100. Participant groups were divided on whether intravenous injection or smoking was the most common route of administration. Participants and community professionals could not agree on a typical user profile.

Current Trends

Methamphetamine 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 from Summit County commented, *“Everyone is shaking it,”* meaning users are producing methamphetamine in a single sealed container, such as a two-liter soda bottle (aka “shake-and-bake” or “one-pot” method of methamphetamine production). By using common household chemicals,

along with ammonium nitrate found in cold packs, and pseudoephedrine, typically found in some allergy medications, drug manufacturers (aka “cooks”) can produce the drug in approximately 30 minutes at nearly any location by mixing ingredients in easily found containers. While reportedly high in availability in Summit County, some participants from other counties did not believe methamphetamine to be very available; participants from Portage and Stark counties reported lower availability scores for the drug. Participants from Portage County thought methamphetamine to be occasionally available. Participants reported that methamphetamine continues to be most available in powdered form, produced by the “one-pot” or “shake-and-bake” method, as opposed to the more traditional method, described by one participant as *“the kind made with iodine and red phosphorous, cooked [and] not shook.”* Participants reported that crystal methamphetamine (aka “ice”), the highest quality form of methamphetamine, is, as one stated, *“rare around here.”* Treatment providers most often reported methamphetamine’s current availability as ‘7’; and they reported that it is common for users to make their own methamphetamine. Law enforcement reported that methamphetamine is highly available although they did not assign a numerical value to its availability. A law enforcement officer reported, *“People are cooking it [methamphetamine] for themselves and a buddy. If you are looking for it, it’s easier to get on the Internet and learn how to make it on your own. Many [methamphetamine cooks] are able to fly under the radar screen for a while.”*

Media from the region reported on recent arrests related to methamphetamine this current reporting period. In an April media report, the Summit County Drug Task Force reported that mobile meth labs have increased by 400 percent since 2010; law enforcement attributed the increase to user’s increasing knowledge of the “one-pot” and “shake-and-bake” manufacturing methods. (www.newsnet5.com, April 4, 2012).

The majority of participants and community professionals most often reported that the availability of methamphetamine has increased during the past six months. A participant commented, *“[Methamphetamine] it’s more prevalent ... more people know how to make it.”* A treatment provider stated, *“While there has been an overall decline [in methamphetamine availability] during the past couple years, I’m seeing a little surge due to the new way of doing [manufacturing] it.”* However, treatment providers in Tuscarawas County reported that methamphetamine seemed to be less available; a treatment provider commented, *“[Methamphetamine is] on the decline, based on the number of busts ... It was in the Amish areas, but the past six months, we’ve not heard much about methamphetamine. Bath salts are*



seen as safer, and legal. Hence, they seemed to have taken meth [methamphetamine] off the rack." The Canton-Stark County Crime Lab reported that the number of methamphetamine cases it processed has decreased during the past six months. Typically, staff from the crime lab reported methamphetamine in the form of tablets or pink and off-white powders.

Participants with experience using methamphetamine most often rated the quality of powdered methamphetamine as '4' on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '5'. Participants were split between reporting that the quality of methamphetamine has decreased or remained the same during the past six months, explaining quality typically varies. A participant said, "[Methamphetamine quality] depends on who you get it from. It [quality] could be '4,' could be '8.'" Another participant commented, "I think it [methamphetamine quality] has fallen off ... more people making it who don't know how to, but there is still good stuff out there. The longer it takes to make, the better." Participants commonly reported that the traditional form of powdered methamphetamine as better quality than the more common "shake-and-bake" form.

Current street jargon includes many names for methamphetamine. The most commonly cited names were "cousin crystal," "crank," "crystal," "dope," "embalm," "glass," "go fast," "ice," "meth," "old school," "red dope," "rocket fuel," "shake-and-bake," "shards," "soda pop," "speed" and "tweak." Current street prices for methamphetamine were variable among participants with experience buying the drug. Participants reported that an individual can purchase a "rock" or "vial" of powdered methamphetamine for \$20; 1/4 gram sells for \$25; 0.4 gram sells for \$40; 1/2 gram sells for \$50; 0.8 gram sells for \$100; a gram sells for \$80-150. Powdered methamphetamine made through traditional methods using iodine and red phosphorous or anhydrous ammonia is more expensive: 1/4 gram sells for \$50; 1/2 gram sells for \$100; a gram sells for \$200. Participants reported that the most common route of administration for methamphetamine is smoking. Participants reported that out of 10 methamphetamine users, eight would smoke, one would snort, and one would use by intravenous injection.

There was consensus among respondent groups that methamphetamine is predominately used by Whites. Treatment providers also generally reported that methamphetamine users are almost exclusively White, from lower- to middle-class, with some treatment providers adding that users tend to be younger. Law enforcement reported that users are most often White, but evenly distributed between gender and age groups. In addition, some participants noted that methamphetamine use is

higher in the gay community and among bikers, while other participants noted that methamphetamine is more common with "the working, middle-class."

While participants reported that it is most common to use methamphetamine by itself, they reported that the drug is used in combination with alcohol, bath salts, marijuana and prescription stimulants (Adderall®). Using methamphetamine with other stimulants was said to prevent "crashing" (getting really high and then coming down too fast). A participant explained that the combination of methamphetamine with prescription stimulants helped to "keep it [the high] going. You stay on a constant plateau." Another participant reported that users take methamphetamine to party longer.

Ecstasy Historical Summary

In the previous reporting period, Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) was highly available in the region. Participants most often reported the availability of Ecstasy as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Participants reported that Ecstasy came in two forms, tablet and powder, with tablets being the most available form. Treatment providers reported availability as '6' or '7'. Law enforcement in Summit County reported on several seizures of Ecstasy, one involving powdered Ecstasy that originated in Pennsylvania, and another involving Ecstasy tablets that originated in Canada. The Canton-Stark County Crime Lab reported that the number of Ecstasy (MDMA) cases it processed had remained the same, while the number of piperazine (typical components of Ecstasy) cases had increased during the previous six months. The most common route of administration was oral ingestion. Participants reported that a "single stack" (low dose) Ecstasy tablet sold for \$4; 1/10 gram (aka "tic") of powdered Ecstasy (aka "Molly") sold for between \$10-20; a gram of powdered Ecstasy sold for between \$100-130. Participants and treatment providers said Ecstasy users were typically young adults between 20-30 years of age who like to frequent bars, dance clubs and "raves" (underground dance parties).

Current Trends

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) remains moderately to highly available in the region. Participants most often reported current availability of the drug from '6' to '10' (median score '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 '10'. Participants in Portage County reported that availability of Ecstasy has increased during the past six months. A participant commented, *"Molly [pure, powdered form of Ecstasy] is becoming more popular."* Participants from Stark County reported that availability has remained the same during the past six months. Treatment providers also reported that current availability of Ecstasy has remained the same, while law enforcement reported that availability of Ecstasy varies throughout the year. A law enforcement officer stated, *"[Ecstasy availability] runs in cycles. We'll see a bunch, then nothing."* Law enforcement reported that most of the area's Ecstasy tablets originated in Canada. Reportedly, powdered Ecstasy occasionally comes from Pittsburgh and is marketed at area universities. The Canton-Stark County Crime Lab reported that the number of Ecstasy cases it processed has decreased during the past six months. Participants did not report on the quality of Ecstasy in the area. Current street jargon for Ecstasy is limited to "Molly" and "Skittles®." Participants were unfamiliar with current street prices for the drug. Reportedly, the most common route of administration remains oral ingestion. Participants continued to report that Ecstasy is most commonly used by people who like the club scene. A participant commented, *"[Ecstasy] it's very popular in discos and clubs."* Treatment providers agreed and reported that individuals who use Ecstasy tend to be young, most commonly college students.

Bath Salts

Historical Summary

In the previous reporting period, bath salts (synthetic compounds containing methyone, mephedrone or MDPV) were highly available in the region. Participants and treatment providers most often reported the availability of bath salts as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Before the ban on the sale of bath salts was instituted in October 2011, participants reported that they were able to purchase bath salts at drive-thru beverage stores, gas stations and head shops. A participant commented that some of these establishments even extended their hours of operation to meet demand. When questioned about the law designed to make the sale of bath salts illegal, most participants did not believe this law would affect availability. Participants believed that manufacturers would find ways around the law, either by changing formulations or changing product names. Treatment providers reported users often seek hospitalization and/or admission to residential treatment facilities in response to the many negative effects and withdrawal symptoms of bath salts. Participant quality scores of bath salts were unanimously '10' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants reported that 1/2 gram of bath salts sold for between \$16-20. The most common routes of administration for bath

salts were snorting and intravenous injection. Notably, participants with first-hand knowledge of bath salts use were exclusively younger than 25 years of age.

Current Trends

Bath salts (synthetic compounds containing methyone, mephedrone or MDPV) remain highly available in the region. Participants most often reported the drug's current availability as '10' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common score was also '10'. Despite the law that went into effect in October 2011 which banned their sale, bath salts continue to be readily available in the region. A participant reported, *"[Bath salts] it's still around at gas stations, just as available as it always was. You can still buy it in convenience stores, if you know where to go."* Other participants discussed the way in which manufacturers circumvent the law. A participant commented, *"They [bath salts] were out of the store, but put back under a new name. You can change one ingredient, change the name, and it's okay until they [make] it illegal."* Another participant agreed, *"Now [bath salts] it's called 'plant food' [and] sold in capsules."* Participants reported that bath salts are now commonly sold as glass cleaner and pipe cleaner and marketed by new names such as "Eight Ball" and "Rush."

Treatment providers most often reported the current availability of bath salts as '7'; the previous most common score was '10'. Most treatment providers believed that availability of bath salts has decreased during the past six months. Treatment providers stated that the reason for the decrease is the negative health consequences associated with the use of bath salts. A treatment provider explained, *"Increased knowledge of reported significant problems, such as permanent psychiatric problems, is deterring use [of bath salts]."* In addition, treatment providers generally felt that the new law and increased law enforcement efforts are having some positive effects. A treatment provider stated, *"Head shops have been hounded by the police [to remove bath salts from their stores]."* However, despite the threat of police raids, treatment providers said some stores and gas stations still sell bath salts illegally. A treatment provider noted, *"If you know what to say [at a store], they will trust you and sell it [bath salts]."* Law enforcement reported some availability of bath salts, with one law enforcement official commenting, *"We get some bath salts now and then."* A law enforcement officer explained that enforcement is difficult because these drugs are constantly being chemically re-engineered and producers remain ahead of the law. The Canton-Stark County Crime Lab reported that the number of bath salt cases it processed has increased during the past six months. The crime lab also reported that other substances similar to bath salts have been seen in the lab; some of these substances are controlled (4-Fluoroamphetamine and

4-Fluoromethamphetamine), while others are uncontrolled chemical analogues. Media outlets reported on law enforcement raids of businesses selling bath salts in the region this reporting period. In February, police raided three businesses in Kent and Streetsboro (both in Portage County) that were selling bath salts and synthetic marijuana; according to police, the raids came after a month-long investigation into the illegal sale of these substances (www.recordpub.com, Feb. 17, 2012).

There was no consensus among participants regarding quality of bath salts. Scores for bath salts quality ranged from '0' to '8,' (median score '6') on a scale of '0' (poor quality, "garbage") to '10' (high quality); the previous most common score was '10.' A participant who thought bath salts were high quality reported they are "better quality than meth." Participants reported that the most common way to buy bath salts is to purchase a "vial" (about 1/2 gram), which sells for between \$25-30. Participants also reported that larger quantities can be obtained: 1/2 ounce of bath salts sells for \$500. While there were several reported ways of consuming bath salts, the most common route of administration is snorting. According to participants, out of 10 bath salts users, five would snort, three would intravenously inject and two would smoke. Participants reported that typical users of bath salts tend to be younger than 30 years of age. Participants also said bath salt users are likely to be on probation, monitored through urine drug screens. A participant stated, "People who can't get meth, they use this [bath salts] as a replacement," or will use bath salts "to pass a pee test."

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: hallucinogens [lysergic acid diethylamide (LSD)] and synthetic marijuana ("K2" and "Spice"). LSD was moderately to highly available in the region. Participants most often rated LSD's availability as '5' or '8' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get). Reportedly, LSD availability increased in the spring and summer when there were more outdoor music festivals. Law enforcement, on the other hand, believed use of hallucinogens was rare. Participants who reported knowledge of LSD rated its overall quality as '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Synthetic marijuana remained highly available in the region (the law banning its sale had not gone into effect). Participants most often reported the drug's availability as '8,' while treatment providers most often

reported availability as '10.' Treatment providers explained the drug was commonly used by individuals on probation to avoid drug use detection on urine drug screens. Participants reported that brands like "K2" were easily purchased at drive-thru beverage stores and gas stations. As with marijuana, the most common route of administration for synthetic marijuana was smoking. Treatment providers reported that typical users of synthetic marijuana were young adults and by those on probation.

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: hallucinogens [lysergic acid diethylamide (LSD) and psilocybin mushrooms] and synthetic marijuana. LSD is rarely to moderately available in the region. Participants most often reported LSD's current availability as '5' or '6' on a scale of '0' (not available, impossible to get) to '10' (highly available, extremely easy to get); the previous most common scores were '5' or '8.' A participant from Portage County reported, "[LSD is] hard to find, uncommon ... but I know I can find it." Participants in Stark and Summit counties reported no availability of LSD. Law enforcement agreed with participants that spoke about the limited availability of LSD. The Canton-Stark County Crime Lab reported that the number of LSD cases it processed has decreased during the past six months. Psilocybin mushrooms are moderately available in the region; participants most often reported current availability as '5' or '6.' A participant in Tuscarawas County reported that psilocybin mushrooms are "a little easier to find [than LSD], but you have to know someone." Treatment providers throughout the region reported little knowledge regarding use of psilocybin mushrooms, other than to report that they are more available during summer months and that users tend to be young. The general view of treatment providers is that the availability of all forms of hallucinogens has remained steady over some time, viewed as relatively low. No participant reported recent use, and participants could not comment on the quality of hallucinogens in the region. The Canton-Stark County Crime Lab reported that the number of psilocybin mushrooms cases it processed has decreased during the past six months.

Synthetic 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 '8.' Despite the ban on its sale that went into effect in October 2011, participants reported they could easily obtain synthetic marijuana. A participant reported, "[Synthetic marijuana is] easy to find ... found in head shops, convenient stores [and] in the mall."

Another participant talked about techniques manufacturers use to circumvent the law: *“still get K2 in stores, [manufacturers] just changed it to a different name.”* The most common route of administration for synthetic marijuana remains smoking. Treatment providers also reported that synthetic marijuana is still available in the region, though there was no agreement regarding the level of availability. Some treatment providers reported that suppliers now call synthetic marijuana “potpourri.” Treatment providers in Tuscarawas County reported infrequently encountering users of synthetic marijuana. A treatment provider explained, *“[Synthetic marijuana is] rarely seen here. Marijuana is so available, and Spice is expensive compared to marijuana.”* These treatment providers also credited the new laws as having had an effect on the availability of synthetic marijuana. Law enforcement also reported that they infrequently encounter synthetic marijuana. An officer said in the past six months there have been *“a few examples [cases involving synthetic marijuana], but nothing to say, ‘we have a problem.’”* In February, regional media reported that Ravenna police (Portage County) raided two businesses that were selling synthetic marijuana; officers confiscated synthetic marijuana and other drug paraphernalia (www.recordpub.com, Feb. 7, 2012). The Canton-Stark County Crime Lab reported that the number of synthetic marijuana cases it processed has increased during the past six months. Participants and treatment providers continued to note that individuals who use synthetic marijuana tend to be people on probation who are using the substance to avoid screening positive on urine drug screens.

In addition, treatment providers reported concern over increased abuse of over-the-counter caffeine pills. These pills, referred to by users as “stackers,” reportedly are used primarily by cocaine users to, *“fill the void”* left by bath salts being taken off the market. While not mentioned by participants, the Canton-Stark County Crime Lab reported several other drugs as present in the region. Prescription stimulants are available: the crime lab reported having processed Adderall®, Dexedrine®, Ritalin® and Vyvanse® cases during the past six months. In addition, the lab reported having processed a few cases of a club drug similar to DMT (dimethyltryptamine): 5-MeO-DALT.

Conclusion

Crack cocaine, heroin, marijuana, methamphetamine, powdered cocaine, prescription opioids, sedative-hypnotics and Suboxone® remain highly available in the Akron-Canton region. Increases in availability exist for methamphetamine, prescription opioids and Suboxone®. Data also indicate likely increases in availability for crack cocaine and heroin. Participants and community professionals reported that methamphetamine availability and use have become more

prevalent during the past six months due to more people knowing how to make the drug through the “one-pot” or “shake-and-bake” method. There was also consensus among respondent groups that methamphetamine is predominately used by Whites. Prescription opioids, particularly methadone and Opana®, have increased in availability according to most participants and community professionals. In addition, the Stark County Coroner’s Office reported prescription opioids as present in 50 percent of all drug-related deaths. Participants reported that the availability of Suboxone® has increased during the past six months. Treatment providers also reported that availability has increased while noting that Suboxone® is being prescribed more often, citing the emergence of Suboxone® clinics in the region. Treatment providers continued to report that heroin users use Suboxone® when they can’t get heroin. Participants generally agreed that the availability of crack cocaine has increased during the past six months. Participants thought crack cocaine is more available because there are more users; the drug was said to be, according to a participant, *“attracting a younger crowd, so younger people are selling it.”* The Canton-Stark County Crime Lab reported that the number of crack cocaine cases it processed has increased during the past six months. Participants unanimously reported that the availability of powdered heroin has increased during the past six months. Participants continued to note that the lack of availability of other drugs (OxyContin® OC) has contributed to the increase in heroin availability and use. Treatment providers noted a significant increase in heroin availability in rural areas. There was consensus among participants and community professionals that heroin use is becoming more prevalent among younger people.