

DRUG USE TRENDS IN DENVER AND COLORADO

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Almost all methamphetamine indicators, which had been increasing through 1997, declined in 1998 and 1999. Information from the DEA and the Denver Police suggests that this may be due to substantially lower purity resulting from reduced precursor availability, and from reduced supply due to extensive laboratory seizures. Conversely, some cocaine indicators have started to climb again, with increased ED mentions and the highest cocaine mortality level ever seen in the State. However, cocaine treatment admissions and new users in treatment continue to decline. Also, cocaine treatment client demographics have changed with decreased proportions of African-Americans, and increased proportions of Hispanics, males, and older users. Cocaine inhalers have been entering treatment in greater numbers, while smokers have been declining. DEA reports of greater cocaine hydrochloride availability at high purity may be driving some of these changes. Heroin ED mentions have been climbing since 1996, and 1998 opiate mortality was the highest ever in Colorado. While the proportion of new heroin users in treatment is up overall from 1993 levels, 1999 data showed a slight downturn. Also, heroin treatment client demographic proportions have changed somewhat with more males, whites, fewer Hispanics, and more younger users. Accompanying this has been a continuing small upward trend in the proportion of heroin smokers and inhalers. Marijuana continues to be a major problem in Colorado, representing the largest proportion of drug related treatment admissions. Marijuana ED mentions climbed in 1997 and 1998, with only a slight drop estimated for all of 1999. Marijuana treatment client demographic changes indicate more Hispanic and older users. Almost all ethnographic reports indicate availability of very potent marijuana.

INTRODUCTION

1. Area Description

Denver, the capital of Colorado, is located somewhat northeast of the State's center. Covering only 111.32 square miles, Denver is bordered by several large suburban counties: Arapahoe on the southeast, Adams on the northeast, Jefferson on the west, and Douglas on the South. In recent years, Denver's surrounding counties have experienced rapid population growth. Since the 1990 census, Colorado has been one of the top five fastest growing States in the country. The Denver metropolitan area accounts for a large percentage of Colorado's total population.

Several considerations may influence drug use in Denver and Colorado:

- Two major interstate highways intersect in Denver.
- The area's major international airport is nearly at the midpoint of the continental United States.
- The Denver metropolitan area is prospering economically. Denver's unemployment rate for 1999 was 2.4 percent, and for the State 2.9 percent.

- Its remote rural areas are ideal for the undetected manufacture, cultivation, and transport of illicit drugs.
- A young citizenry is drawn to the recreational lifestyle available in Colorado.
- The large tourism industry draws millions of people to the State each year.
- Several major universities and small colleges are in the area.

2. Data Sources and Time Periods

Data presented in this report were collected and analyzed in March through May, 2000. Although these indicators reflect trends throughout Colorado, they are dominated by the Denver metropolitan area.

- **Qualitative and ethnographic data** for this report were available mainly from clinicians from treatment programs across the state, local researchers, and street outreach workers.
- **Drug-related emergency department (ED) mentions** for the Denver metropolitan area for 1993–99 are provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) through its Drug Abuse Warning Network (DAWN).
- **Hospital discharge data** statewide for 1993-99 are available from the Colorado Hospital Association through the Colorado Department of Public Health and Environment, Health Statistics Section. Data included are diagnoses (ICD-9-CM codes) for inpatient clients at discharge for all acute care hospitals

and some rehabilitation and psychiatric hospitals. These data do not include ED care.

- **Drug/Alcohol Coordinated Data System (DACODS) reports** are completed on clients at admission and discharge from all alcohol and drug treatment agencies receiving public monies in Colorado under special reporting requirements. Annual figures are given for 1993-99. DACODS data are collected and analyzed by the Alcohol and Drug Abuse Division (ADAD), Colorado Department of Human Services.
- **Availability, price, and distribution data** are available from local DEA Denver Division officials and from the Denver Police Department Vice/Drug Control Bureau for the Spring of 2000; and ethnographically from treatment clinicians, local researchers and outreach workers.
- **Death statistics and communicable disease data** are available from the Colorado Department of Public Health and Environment (CDPHE). Data are presented from 1993 to 1998.
- **1995 ADAD Household Telephone Survey data** of 8,729 adult Colorado residents age 18–59 are made available from the Alcohol and Drug Abuse Division, Colorado Department of Human Services. The survey was conducted by the Survey Research Unit, Health Statistics Section, Colorado Department of Public Health and Environment. The survey timeframe was from September 1994 through June 1996.

- **Rocky Mountain Poison and Drug Center** data are presented for Colorado. The data represent number of calls to the center regarding "street drugs" from 1994 through 1999.
- **Arrestee Drug Abuse Monitoring (ADAM) Program** reports arrestee urinalysis results based on quarterly studies conducted under the auspices of the National Institute of Justice. ADAM data in Colorado are collected and analyzed by the Division of Criminal Justice. The most recent data were collected for the study period ending August 1999.

DRUG ABUSE TRENDS

1. Cocaine and Crack

Data from the 1995 ADAD Household Telephone Survey report cocaine as the second most used and abused drug in the State. More than 14 percent of Colorado respondents ($n=8,729$) reported lifetime use of cocaine, and 2 percent reported cocaine use in the last 30 days.

Though some indicators are declining, cocaine use remains a major concern throughout Denver and Colorado. Denver metro cocaine emergency department mentions per 100,000 population (exhibit 3) had increased from 52.5 in 1996 to 73.2 in 1998, but declined to an estimated 64 per 100,000 in 1999 based on information from the first half of the year. Similarly, statewide hospital discharge data (exhibit 4) show that cocaine occurrences per 100,000 increased from 45.5 in 1993 to 62.8 in 1998, but declined slightly to 62.3 in 1999. Additionally, ADAM data (exhibit 6) show that samples of Denver area arrestees continue to have substantial proportions of

positive cocaine urine screens, with 46 percent testing positive in 1999, as estimated from data for the first three quarters of the year.

In 1994 there were 71 calls to the Rocky Mountain Poison and Drug Center concerning cocaine. This dropped to 49 in 1995, and has remained at about that level through 1999.

Also, cocaine deaths in the State (exhibit 5) have continued to climb during the last six years from 73 in 1993 (2.0 per 100,000) to 109 in 1998 (2.7 per 100,000). The 1998 cocaine death total is the highest ever recorded in Colorado.

However, the proportion of cocaine treatment admissions has declined considerably since 1993 (exhibit 1). In 1993, admissions for primary cocaine abuse accounted for 40.5 percent of all drug abuse treatment admissions, compared with only 24 percent in 1999.

Treatment admission data indicate that injecting declined from 1993 (15.2 percent) through 1998 (10.7 percent) with a slight upturn in 1999 (13 percent). Smoking percentages had leveled from 1994 (67.7 percent) through 1996 (67.4 percent), but have declined slightly since then, accounting for 62.1 percent of cocaine admissions in 1999. Conversely, inhalation has been steadily increasing from 16.2 percent in 1994 to 21.3 percent in 1999. This is possibly due to the increased availability of cocaine hydrochloride (HCL).

Of the cocaine users entering treatment, the proportion of "new" cocaine users, defined as those admitted to treatment within 3 years of initial cocaine use, has declined from 18.1 percent in 1993 to 15.5 percent in 1999

(exhibit 2). This decrease represents an estimated 254 fewer new users over that time period.

Race/ethnicity proportions for **total** cocaine treatment admissions have been changing. In 1999, whites accounted for the largest percentage of cocaine admissions (46.2 percent), up slightly from 42.6 percent observed in 1993. African-American cocaine admissions have dropped sharply from 40.4 percent in 1993 to only 26 percent in 1999, while Hispanic cocaine admissions have been steadily increasing during the same time period from 15.4 percent to 25.5 percent.

Likewise, age categories have been changing since 1993. In 1993, 68.3 percent of cocaine admissions were under thirty-five, this decreased to only 48.5 percent by the end of 1999. Conversely, cocaine admissions 35 and over have climbed steadily during the same time period from 31.8 to 51.5 percent. Cocaine admissions remain predominantly male, with the proportion remaining relatively constant from 1993 (61 percent) through 1998 (59.9 percent). However, in 1999, males increased to 65.2 percent of treatment admissions. **As mentioned above, the increased availability of cocaine HCL may be bringing about changes in the cocaine user groups, and thus, in the population entering treatment.**

Reports from clinicians, researchers and street outreach workers around the state substantiate the continuing cocaine problems reflected in much of the indicator data. Clients in one **Denver** treatment program relate that cocaine is more available at higher purity levels, and that more users are "doing speedballs" (heroin and cocaine taken together). An outreach and research

agency in north Denver (where crack is more prevalent) reports that their "street information" indicates that most crack cocaine is poor quality. They also assert that the crack distribution methods are not as organized as in the past, and have moved from distribution systems to more of a "free-for-all" with individual dealers. **Boulder** treatment programs report more older users. **Northeast** Colorado treatment programs also report more older clients who, in some cases, have relapsed and have returned to treatment. Various clients in the Northeast mention that they used powder cocaine rather than crack because of lesser legal penalties.

Accounts from **southeast and south-central** Colorado indicate that cocaine, especially powder, is more available than methamphetamine, even in the very rural areas. One client from a treatment program in the area claimed availability of 80% pure powder cocaine that is brought across the Mexican/U.S border by, in his words, "wetbacks". **Western Slope** treatment programs also report wide cocaine availability. Their clients tend to be equally represented between crack smokers and powder inhalers.

The Denver Police Department (DPD) Vice/Drug Control Bureau report that cocaine HCL is readily available at high purity (74.8 percent), with gram prices in the metro area at \$100-125. Similarly, the Denver Field Division of the DEA reports the substantial availability of cocaine HCL across the state, with Mexican nationals reported as the primary traffickers. They also indicate that, despite declining use, crack cocaine trafficking in the Denver Metro area continues to be controlled by African-American gangs such as the Crip, Vice Lords, or Black Gangster Disciples.

Current price estimates supplied by the Denver DEA are \$16,000-22,000 per kilogram, \$800 per ounce and \$80 per gram in the Denver Metro area; \$15,000-25,000 per kilo, \$900-1,260 per ounce, and \$100-125 per gram in Colorado Springs (south of Denver on the Front Range); and \$18,000-22,000 per kilo, \$1,000 per ounce, and \$150 per gram in Glenwood Springs (Western Slope of Colorado). Crack cocaine prices remain stable at \$800-1,200 per ounce and \$10-20 per rock in both Denver and Colorado Springs.

2. Heroin

Any lifetime heroin use was reported by 1.2 percent of Coloradans surveyed in the 1995 ADAD Household Telephone Survey. This percentage is the same as reported in the National Household Survey on Drug Abuse (1995). Recent heroin use for the Colorado sample (0.6) is slightly higher than the national figure (0.2).

Over the past 3 years, the police and media have reported increasing heroin use in Denver and Boulder. Hospital data show that heroin ED mentions (exhibit 3) increased from 1993 (18.4 per 100,000) to 1994 (32.8 per 100,000), but then declined through 1996 (22.3 per 100,000). However, increases were again noted in 1997 (30.5 per 100,000) and in 1998 (32.3 per 100,000). Heroin ED mentions for 1999 are estimated at 28 per 100,000 based on data for the first half of the year. Similarly, hospital discharge data (exhibit 4) indicate that opiate occurrences per 100,000 population almost doubled from 21.1 in 1993 to 40.6 in 1999.

Opiate related deaths (exhibit 5) had nearly doubled from 60 (1.7 per 100,000) in 1993 to 119 (3.2 per 100,000) in 1995, but

declined to 89 in 1996 (2.3 per 100,000). However, increases were again noted with 98 deaths in 1997 (2.5 per 100,000) and a 38% increase to 135 deaths in 1998 (3.4 per 100,000). The 1998 opiate death total is the most ever recorded in the state.

As to ADAM data (exhibit 6), only a small percentage of positive opiate urine screens were reported with 4 percent in 1993 and '94, 6 percent in 1995 and '96, a decline to 4 percent in 1997 and '98, and only 3 percent positive in 1999 (based on data averaged for three quarters of the year). However, heroin related calls to the Rocky Mountain Poison and Drug Center, which had been steady from 1994 (21 calls) to 1998 (22 calls), increased to 36 in 1999.

Among Colorado treatment admissions (exhibit 1), the proportion and number of heroin admissions have remained relatively stable from 1993 (15.7 percent) through 1999 (14.4 percent). Despite static totals, the proportion and number of new heroin users entering treatment has increased in recent years, from 14.9 percent in 1995 to 17.1 percent in 1996, 16.6 percent in 1997, and 19.7 percent in 1998 (exhibit 2). However, there was a slight decline to 17.5 percent for 1999.

Like cocaine, there have also been changes in the demographic proportions of heroin users entering treatment. The proportion of females from 1993 through 1999 declined from 37.5 percent to 33.1 percent. As to race/ethnicity, whites have increased as a percentage of total (50.4 percent in 1993 to 60.7 percent in 1999), while Hispanics have decreased in the same time period (36.8 percent to 27.9 percent). Also, the 25 and under age group has increased as a percentage of heroin admissions from only 9.4 percent in 1993 to approximately 16

percent in 1998 and to 17 percent in 1999. Accompanying the heroin client demographic realignments, are small changes in route of administration, with heroin smoking and inhalation becoming more common. In 1993, only 3.5 percent of treatment admissions reportedly smoked or inhaled heroin, compared with 5.9 percent in 1996, 7.5 percent in 1997, 9 percent in 1998, and 8.5 percent in 1999.

A 1992 through 1999 cross-sectional analysis of heroin treatment clients by route of administration reveals some interesting differences among smokers, inhalers, and injectors. In general, heroin inhalers and injectors are more similar demographically than either group is to smokers. Two-thirds of heroin smokers are age 35 or younger, versus 42.5 percent of inhalers and 38.4 percent of injectors. Smokers are much more likely to be white (77.8 percent) than inhalers (53.1 percent) or injectors (55.9 percent); and to be employed full or part time (51.6 percent) as compared to inhalers (41.2 percent) or injectors (38.3 percent). In addition, half (49.7 percent) of smokers have at least some college versus 37.3 percent of inhalers and 29.1 percent of injectors.

Reports from clinicians, researchers and street outreach workers around the state indicate that there is a lot of good heroin available at relatively high purity. One **Denver** treatment program describes availability of high quality black tar at \$20 for an amount the size of a pencil eraser. This program also reports more younger users, and a small number of clients who are inhalers or smokers because of needle aversion. A north Denver outreach program reports that most of their clients (i.e., sample) are older heroin injectors, who would not consider smoking or inhaling the drug. This agency noted that 72 percent of

their sample is Hepatitis C positive. **Boulder** reports widespread heroin availability with cheaper prices and higher purity, and more use among the college population. They also describe a client group who inhales or smokes heroin because of a fear of needles and because they feel there is less stigma in a non-injection route of administration.

Southeastern and south-central treatment programs talk about competing dealers offering high quality heroin at cheaper prices. Like Denver and Boulder, they also describe area users getting “chieva” that they don’t have to inject, “so they won’t become junkies”. Programs in the **Northeast** also assert that there is a younger more affluent heroin using population who see smoking or inhaling as more “socially acceptable”, almost *chic* like cocaine use in the ‘80s. Reports from the **Western Slope** also indicate a small, but perhaps growing, group of young, white, non-injecting recreational heroin users. Clinicians are concerned that some smokers and snorters will become dependent and eventually convert to needle use.

The Denver Police report that black tar heroin is readily available with prices stable at \$125 to \$150 per gram, and 41 percent purity (also stable). Interestingly, several months ago the DPD seized 3.8 pounds of “China White” heroin at DIA, being body-packed from El Paso to New York. None of it was supposed to stay in Colorado.

The Denver DEA also reports that gram and ounce heroin quantities are readily obtainable in the Denver metro area, with marketing controlled by Mexican Nationals. Interestingly, the DEA asserts that “street level weight is usually sold in the form of black tar, whereas ounce or heavier weights

are primarily Mexican brown heroin. Sometimes black tar and Mexican brown are combined to make up negotiated weight.” The DEA Domestic Monitoring Program buys reveal that the average purity of black tar heroin is only 8 to 15 percent, and retails for \$100 a gram. Also, DEA lab analysts have identified Coca-Cola as a cutting agent, in which two liter bottles of Coca-Cola are poured into black tar heroin mixture resulting in significant levels of caffeine in lab analysis. On the other hand, the DEA reports that ounce purchases of Mexican brown heroin have an average purity of 74 percent, and a retail price of \$1,200-1,500.

3. Marijuana

According to the 1995 ADAD Household Telephone Survey, marijuana is the most used and abused drug of Colorado residents age 18–59; 5 percent of respondents reported marijuana use in the last 30 days, and 1 percent reported current abuse or dependence on the drug. Furthermore, in comparing the National Household Survey on Drug Abuse (1995) with Colorado data, the 18–25 age group had a much greater percentage of recent use in Colorado (20.5 percent) compared with the national average (12 percent).

Most marijuana indicators are increasing. From 1993 to 1998, the rate per 100,000 of marijuana ED mentions nearly tripled from 13.5 to 36.7 (exhibit 3). From data for the first half of the year, it is estimated that the rate of ED mentions will decline only slightly in 1999 to 32 mentions per 100,000. Likewise, marijuana hospital discharge occurrences per 100,000 (exhibit 4) rose dramatically from 30.4 in 1993 to 56.1 in 1998, and declined only slightly to 54.6 in 1999. Also, ADAM data (exhibit 6) show a dramatic increase in positive marijuana

urine screens from 32 percent in 1993 to 41 percent in 1999, based on averaging three quarters of 1999 samples.

Marijuana calls to the Rocky Mountain Poison and Drug Center were nearly non-existent between 1994 and 1998, with only one or two per year. However, in 1999 there were 47 calls related to marijuana effects.

Treatment data also show increases in marijuana admissions. Marijuana users have accounted for the largest proportion of all Colorado drug treatment clients since 1995 (exhibit 1). This trend continued in 1998 and 1999, with marijuana admissions accounting for 39.8 percent and 43.2 percent, respectively, of all admissions to treatment. These increases may be partly related to user accounts of increased drug potency.

The proportion of new users entering treatment for marijuana use had been increasing from 1991 through 1994, where it peaked at 37.2 percent (exhibit 2). However, from 1994 through the first half of 1999, this proportion has steadily declined to only 24.9 percent.

Data indicate some changes in the demographics of marijuana treatment clients, especially in race/ethnicity and age proportions. As to race, Hispanics have increased as a percentage of marijuana admissions, from only 25 percent in 1993 to 36.9 percent in 1999. Conversely, whites have declined from 63.9 percent to 51.9 percent of marijuana admissions during the same time period. Also, the proportion of 12 to 17 year old marijuana admissions declined sharply from 39.6 percent in 1998 to only 31.6 percent during 1999. In contrast, the proportion of those 35 and

older increased from only 17.2 percent in 1998 to 24.2 percent in 1999.

Reports from clinicians, researchers and street outreach workers around the state indicate that marijuana is in abundance. **Denver and Boulder** area programs report substantial availability of stronger marijuana. This is also reported by **southeast and south-central** Colorado programs, where supposedly “good stuff” is available for \$65 per quarter ounce, with some very potent marijuana selling for up to \$500 an ounce. However, they also say a lot of lesser quality marijuana is available at \$50 an ounce. Some clinicians in these programs assert that their older marijuana clients claim they are using the drug to deal with pain and medical conditions in their aging bodies. Clinicians from **Northeast** Colorado, though reporting substantial use among adolescents, also report increases in older clients, some of whom are alcoholics trying to switch to marijuana as a mood altering alternative. **Western Slope** programs echo reports from the rest of the State as to the extensive availability of marijuana, especially that of higher potency. One program reports that a number of methamphetamine users are smoking marijuana, as an alternative to alcohol, to come down from the “speed” high.

The Denver Police report that marijuana is in abundance in the metro area with prices in the \$20 to \$25 per gram range. The Denver DEA states that the most “abundant supply of marijuana is Mexican grown and is trafficked into the area by vehicles in shipments of varying quantities from 2 to 500 pounds”. They also indicate that marijuana from British Columbia, known as “BC Bud”, has appeared in Colorado at prices of \$500 an ounce and \$3,000 a pound.

In general, the DEA reports Denver area prices of \$600–\$1,000 per pound and \$50–100 per ounce for commercial grade marijuana. These prices are higher in Colorado Springs (\$800–1200 per pound; \$100–150 per ounce) and in Glenwood Springs (\$800–1200 per pound: ounce prices not available). For sinsemilla, pound prices are about the same across the State at \$1,500–\$3,500. However, ounce prices vary from \$100 in Denver and \$100–150 in Colorado Springs to \$200 in Glenwood Springs.

4. Stimulants

Nonmedical stimulant use rates in Colorado reported in the 1995 ADAD Household Telephone Survey were greater than those reported in the National Household Survey on Drug Abuse (1995). Nationally, 4.9 percent of respondents reported any lifetime nonmedical stimulant use, compared with 10.4 percent in Colorado.

Indicator data show that methamphetamine use had been increasing in Denver at an alarming rate from 1993 through 1997. However, almost all 1998 and 1999 data show declines for methamphetamine.

Methamphetamine ED mentions per 100,000 in Denver increased more than three-fold from 3.7 in 1993 to 11.5 in 1995. This rate declined to 6.8 in 1996, only to increase sharply to 18.7 in 1997. However, in 1998, the methamphetamine rate declined to only 7.6 mentions per 100,000 population, and it is estimated from six months of 1999 data that it will decrease to only 4 mentions per 100,000 (exhibit 3). This nearly identical pattern was also seen for **amphetamine-related** hospital discharge occurrences per 100,000 population (exhibit 4). These more than

doubled from 1993 (8.2) to 1995 (19.4), but declined to only 13.9 in 1996. They increased again to 24.6 in 1997, but decreased in both 1998 (20.5) and 1999 (16.9).

According to ADAM data (exhibit 6), only a small percentage of positive amphetamine urine screens were reported with 3 percent, 4 percent and 2 percent in 1994, 1995, and 1996, respectively. This increased slightly in 1997 (5 percent) and remained at this level in 1998. However, averaged data through the first three quarters of 1999 show a decline to only 3 percent positive amphetamine urine samples.

Amphetamine-related calls (street drug category) to the Rocky Mountain Poison and Drug Center had decreased from 1994 (36 calls) to 1996 (16 calls), but increased sharply in 1997 (38 calls). While such calls dropped to only 11 in 1998, they rebounded to an astounding 291 in 1999.

Methamphetamine treatment admissions more than quadrupled between 1993 and 1998 (exhibit 1). In 1993, primary methamphetamine use accounted for only 4.5 percent of total treatment admissions, compared with 13.5 percent in 1998. However, such admissions declined to 10.7 percent during 1999.

In 1993, 15.6 percent of primary methamphetamine users entering treatment were new users (exhibit 2). By 1997, new users accounted for 30.7 percent of primary methamphetamine treatment admissions. However, since 1997, the proportion of new users has declined to 27.4 percent in 1998 and to 20.2 percent in 1999.

Injecting has been the most common route of methamphetamine administration.

However, the IDU proportion has been declining from 1993 (49.6 percent) to 1999 (36.4 percent), while smoking has become increasingly common in the last 6 years. In 1999, 34 percent of methamphetamine treatment admissions smoked the drug, compared with only 8.5 percent in 1993.

Methamphetamine treatment admissions in 1998 and 1999 remained predominately white (87.5 and 88.9 percent, respectively) and male (56.6 and 57.2 percent, respectively). However, in 1999 there was a shift in age proportion. In 1998, 38 percent were age 25 or younger. However, this percentage declined to 31.7 percent in 1999, while the percentage of those 35 and older increased from 27.2 to 32.2 percent during the same time period.

Anecdotal reports from clinicians, researchers and street outreach workers around the state affirm the erratic, up and down pattern for methamphetamine shown in the indicator data. On the **Front Range**, treatment programs in the **Southeast, Northeast, Boulder and Denver metro area** report drops in methamphetamine use due to enforcement (lab busts), and lowered drug quality. Reports of not trusting “cookers” are common. In addition, many communities have distributed substantial information about the considerable physical and psychological problems brought about by methamphetamine use. **Western Slope** treatment programs are also reporting up and down usage patterns, mostly related to drug quality. They also describe the impact of increased interdiction, and widespread community publicity about methamphetamine consequences.

The Denver PD reports ready availability of methamphetamine, at prices of \$100 to \$125 per gram with low purity of around

20 percent. The Denver DEA also describes widespread availability, with a majority of the drug "originating from Mexico or from large-scale laboratories in California". However, the DEA is making extensive lab seizures. During the second quarter of FY 2000, 166 methamphetamine laboratories were seized in the Rocky Mountain West. The DEA also reports that methamphetamine street prices are \$80-\$125 per gram, \$800-\$1,400 per ounce,

and \$5,000-\$10,000 per pound in Denver(stable); \$90-125 per gram, \$800-1600 per ounce, and \$8,000-10,000 per pound in Colorado Springs: and \$80-125 per gram, \$1,000-1,100 per ounce, and \$8,000-12,000 per pound in Glenwood Springs.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AMONG INJECTING DRUG USERS

Of the 6,800 AIDS cases reported in Colorado through March 31, 2000, 8.8 percent were classified as IDUs, and 10.9

percent were classified as homosexual or bisexual males and IDUs (exhibit 7).

EXHIBIT 1: TREATMENT ADMISSIONS BY DRUG

TYPE

1993-99

DRUG	1993	1994	1995	1996	1997	1998	1999
Heroin	1669	1707	1936	1956	1611	1881	2038
%	15.7%	14.2%	15.4%	15.1%	13.7%	13.2%	14.5%
Non-Rx Methadone	33	33	41	38	16	29	31
%	0.3%	0.3%	0.3%	0.3%	0.1%	0.2%	0.2%
Other Opiates N	318	337	314	283	252	328	384
%	3.0%	2.8%	2.5%	2.2%	2.1%	2.3%	2.7%
Methamphetamine N	475	910	1412	1162	1746	1927	1508
%	4.5%	7.6%	11.2%	8.9%	14.9%	13.5%	10.7%
Other Stimulants N	118	113	142	90	100	96	150
%	1.1%	0.9%	1.1%	0.7%	0.9%	0.7%	1.1%
Cocaine N	4296	4629	3910	3976	3181	3783	3384
%	40.5%	38.6%	31.0%	30.6%	27.1%	26.6%	24.0%
Marijuana N	3223	3861	4429	5043	4450	5675	6092
%	30.4%	32.2%	35.2%	38.8%	37.9%	39.8%	43.2%
Hallucinogen N	83	46	62	73	54	83	67
%	0.8%	0.4%	0.5%	0.6%	0.5%	0.6%	0.5%
PCP N	9	9	8	3	2	2	8
%	0.1%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%
Barbiturates N	16	19	14	12	17	23	20
%	0.2%	0.2%	0.1%	0.1%	0.1%	0.2%	0.1%
Sedatives N	10	10	20	15	24	29	23
%	0.1%	0.1%	0.2%	0.1%	0.2%	0.2%	0.2%
Tranquilizers N	101	80	89	95	88	96	130
%	1.0%	0.7%	0.7%	0.7%	0.8%	0.7%	0.9%
Inhalants N	227	149	173	130	100	117	70
%	2.1%	1.2%	1.4%	1.0%	0.9%	0.8%	0.5%
Other N	41	91	49	112	99	181	200
%	0.4%	0.8%	0.4%	0.9%	0.8%	1.3%	1.4%
TOTAL	10619	11994	12599	12988	11740	14250	14105

Source for Exhibit 1 & 2: DACODS

EXHIBIT 2: ANNUAL PERCENTAGE OF HEROIN, METHAMPHETAMINE, COCAINE AND MARIJUANA USERS ENTERING TREATMENT WITHIN THREE YEARS OF INITIAL USE: 1993-99

DRUG	1993	1994	1995	1996	1997	1998	1999
HEROIN N	184	178	280	328	261	359	347
%	11.2%	10.7%	14.9%	17.1%	16.6%	19.7%	17.5%
METHAM N	72	221	412	296	513	515	299
%	15.6%	24.9%	29.7%	25.9%	30.7%	27.4%	20.2%
COCAINE N	764	752	607	599	432	583	510
%	18.1%	16.6%	15.8%	15.3%	14.0%	15.8%	15.5%
MARIJ. N	877	1416	1601	1784	1426	1649	1461
%	28.0%	37.2%	36.8%	36.0%	33.3%	30.6%	24.9%

EXHIBIT 3 (Source: DAWN)
EMERGENCY DEPARTMENT MENTIONS PER 100,000 FOR
SELECTED DRUGS: 1993-99

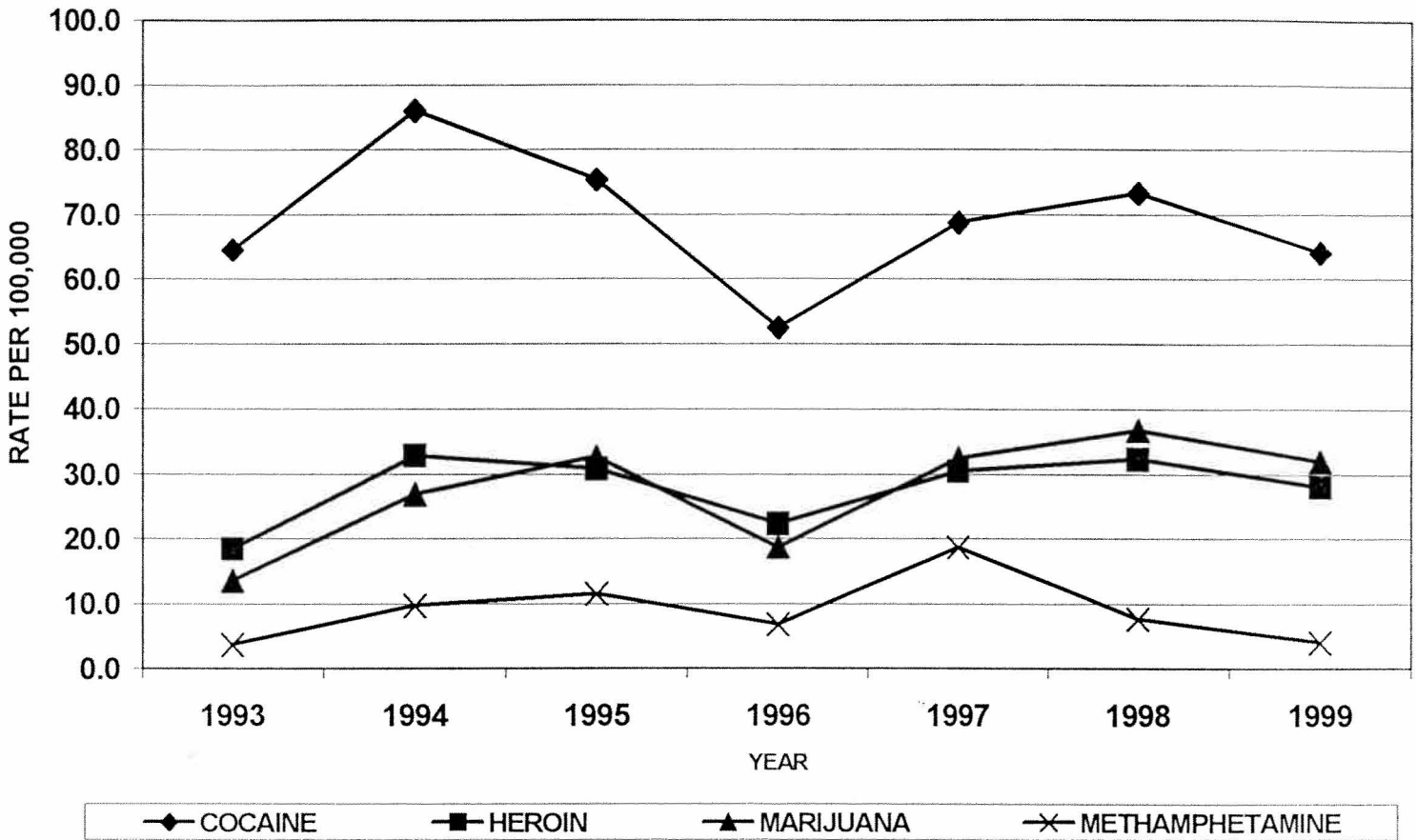


EXHIBIT 4 (Source: CHA & CDPHE)

HOSPITAL DISCHARGE
MENTIONS PER 100,000 FOR
SELECTED DRUGS: 1993-99

	1993	1994	1995	1996	1997	1998	1999
AMPHETAMINES	291	598	728	532	959	815	682
RATE/100K	8.2	16.3	19.4	13.9	24.6	20.5	16.9
COCAINE	1624	2200	2070	2255	2245	2492	2517
RATE/100K	45.5	60.1	55.3	59.0	57.7	62.8	62.3
MARIJUANA	1085	1533	1708	1740	2118	2227	2204
RATE/100K	30.4	41.9	45.6	45.6	54.4	56.1	54.6
NARC. ANLAG	752	1093	1103	760	1458	1566	1639
RATE/100K	21.1	29.8	29.4	19.9	37.5	39.5	40.6
POPULATION	3568218	3661665	3746585	3819789	3892996	3966198	4039402

EXHIBIT 5: (Source-CDPHE)
AMPHETAMINE, COCAINE & OPIATE RELATED DEATHS: 1993-98

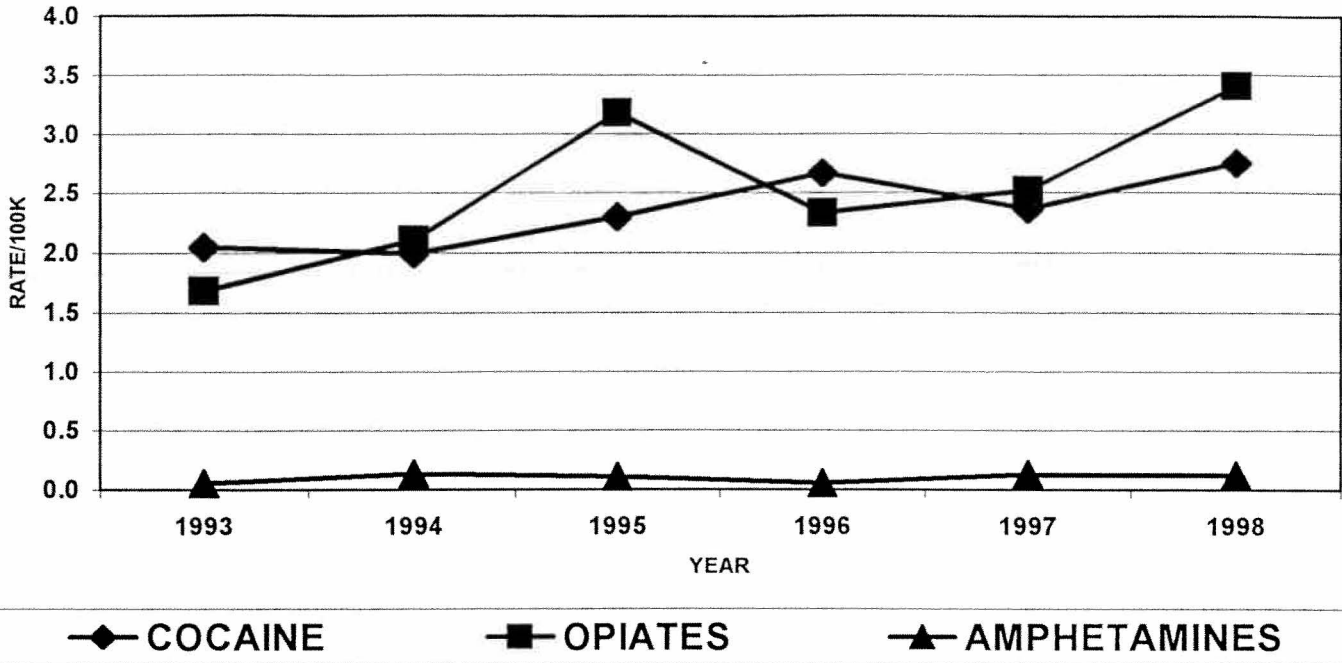


EXHIBIT 6: (Source-ADAM)
ARRESTEES WITH POSITIVE URINE SCREENS FOR SELECTED DRUGS: 1993-99

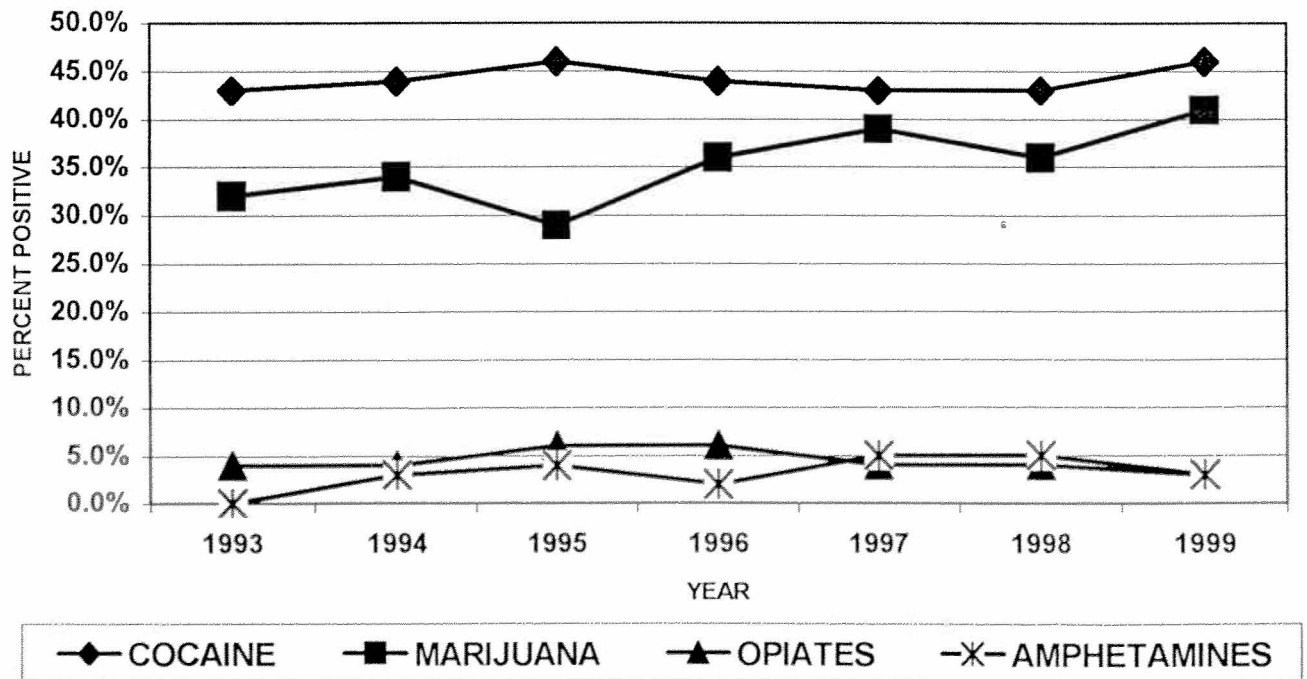


EXHIBIT 7

COLORADO CUMULATIVE AIDS CASES
BY DEMOGRAPHIC CATEGORY
THROUGH MARCH 31, 2000

ITEM	NUMBER	PERCENT
Number of confirmed cases	6,800	100%
GENDER		
▪ Male	6,330	93.1%
▪ Female	470	6.9%
RACE/ETHNICITY		
▪ White	5,041	74.1%
▪ African-American	722	10.6%
▪ Hispanic	965	14.2%
▪ Asian	28	.4%
▪ Native American	44	.6%
AGE AT DIAGNOSIS (years)		
▪ <13	28	.4%
▪ 13 – 19	27	.4%
▪ 20 – 29	1,159	17.0%
▪ 30 – 39	3,348	49.2%
▪ 40 – 49	1,628	23.9%
▪ 50+	610	9.0%
EXPOSURE CATEGORY		
▪ Men/sex/men	4,709	69.3%
▪ Injecting drug user (IDU)	596	8.8%
▪ MSM and IDU	740	10.9%
▪ Heterosexual contact	333	4.9%
▪ Other	180	2.6%
▪ Risk not identified	242	3.6%

Source: Colorado Department of Public Health and Environment