DRUG USE TRENDS IN DENVER AND COLORADO

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Marijuana continues to be a major problem in Colorado, constituting the largest proportion of drug related treatment admissions in the first half of 2000. The 1999 National Household Survey reported that Colorado was first among the fifty states in past month marijuana use. Also, marijuana ED mentions more than tripled from 1993 to 1999, with large increases also seen in marijuana related hospital discharges. Marijuana treatment client demographic changes indicate more Hispanic and older users. Almost all ethnographic reports indicate availability of very potent marijuana. Similarly, most cocaine indicators continue to climb, with increased ED mentions, hospital discharges and the highest cocaine mortality level ever seen in the State. However, cocaine treatment admissions and new users in treatment have decreased. Also, cocaine treatment client demographics have changed with decreased proportions of African-Americans, and increased proportions of whites and Hispanics, males, and older users. Cocaine inhalers have been entering treatment in greater numbers, while smokers have been declining. Denver PD and DEA reports of greater cocaine hydrochloride availability at high purity may be driving some of these changes. Heroin ED mentions and hospital discharges have also been climbing throughout the 1990s. Likewise, 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 and first half of 2000 data show a slight downturn. Also, heroin treatment client demographic proportions have changed somewhat with more males, whites, and younger users, but fewer Hispanics. Accompanying this has been a continuing small upward trend in the proportion of heroin smokers and inhalers. Methamphetamine indicators, which had been increasing from 1993 through 1997, mostly declined in 1998, 1999, and in the first half of 2000. 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

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.

- 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.

- The Denver metropolitan area is prospering economically. Denver's unadjusted unemployment rate for 2000 (through September) was 2.3 percent, and for the State 2.6 percent.

2. Data Sources and Time Periods

Data presented in this report were collected and analyzed in October and November 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 Colorado alcohol and drug treatment agencies receiving public monies. Annual figures are given for 1994-99, and for the first half of 2000. 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 Drug Enforcement Administration (DEA) Denver Division officials and from the Denver Police Department Vice/Drug Control Bureau for the fall 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 Research Unit, Health Statistics Section, Colorado Department of Public Health and Environment conducted the survey. The survey timeframe was from September 1994 through June 1996.

- **Rocky Mountain Poison and Drug Center (RMPDC)** data are presented for Colorado. The data represent the 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 November 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), after declining from 86 to 53 from 1994 to 1996, increased steadily to 87 in 1999, the highest rate for the1990s. 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 44 percent testing positive in 1999.

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 1994 (exhibit 1). In 1994, primary cocaine abuse accounted for 38.6 percent of all drug abuse treatment admissions, compared with only 21.3 percent for the first half of 2000.

Treatment admission data indicate that injecting declined from 1993 (15.2 percent) through 1998 (10.7 percent) increased slightly in 1999 (13 percent), and remained at about that level for the first half of 2000 (12.1 percent). Smoking percentages had leveled from 1994 (67.7 percent) through 1996 (67.4 percent), but have declined somewhat since then, accounting for 56.9 percent of cocaine admissions in the first half of 2000. Conversely, inhalation has been steadily increasing from 16.2 percent in 1994 to 26.6 percent in the first half of 2000. This is probably 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 slightly from 16.6 percent in 1994 to 15.1 percent in the first half of 2000 (exhibit 2.)

Race/ethnicity proportions for **total** cocaine treatment admissions have been changing. In the first half of 2000, whites accounted for the largest percentage of cocaine admissions (48.6 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 20.5 percent in the first half of 2000, while Hispanic cocaine admissions have been steadily increasing during the same time period from 15.4 percent to 29.2 percent.

Likewise, age categories have been changing since 1993. In 1993, 68.3 percent of cocaine admissions were under thirty-five, this decreased to 48.8 percent for the first half of 2000. Conversely, cocaine admissions 35 and over have climbed steadily during the same time period from 31.8 to 51.1 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, but this proportion declined again to 58.5 percent during the first half of 2000. As mentioned above, the increased availability of cocaine HCL may have brought about changes in the cocaine user groups, and thus, in the population entering treatment.

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. Vehicles are the primary means of transporting cocaine HCL from the southwest border and southern California on interstate and local highways. However, sources in western Colorado indicate smugglers are now utilizing various local airports for smuggling due to their minimal enforcement activity and oversight. The DEA also indicates that, despite declining use, crack cocaine trafficking in the Denver Metro area continues to be controlled by African-American gangs, with supplies coming from street gangs in Los Angeles and Chicago.

Current price estimates supplied by the Denver DEA are $18,000-22,000 per kilogram, $800-1,200 per ounce and $80 per gram in the Denver Metro area; $19,000-22,000 per kilo, $900-1,200 per ounce, and $100-125 per gram in Colorado Springs (south of Denver on the Front Range); and $18,000-22,000 per kilo, $600-1,000 per ounce, and $150 per gram in Glenwood Springs (Western Slope of Colorado). These prices show little change from the prior reporting period. Crack cocaine availability has been declining and is mostly limited to larger metropolitan areas in street level amounts (gram or less). Crack 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 percent) is slightly higher than the national figure (0.2 percent).

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 per 100,000) to 1994 (33 per 100,000), but then declined through 1996 (22 per 100,000). However, increases were again noted from 1997 (31 per 100,000) through 1999 (41 per 100,000), with the 1999 rate the largest seen throughout the decade. 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 percent 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. 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 1994 (14.2 percent) through the first half of 2000 (14.9 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 were slight declines to 17.5 percent in 1999 and 17.1 percent for the first half of 2000.

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 33.2 percent, but increased somewhat to 35.1 percent for the first half of 2000. As to race/ethnicity, whites have increased as a percentage of total (50.4 percent in 1993 to 63.1 percent in the first half of 2000), while Hispanics have decreased in the same time period (36.8 percent to 26.2 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 16.5 percent in the first half of 2000. 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, 8.5 percent in 1999, and 10.1 percent in the first half of 2000.

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.

The Denver DEA 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 16 to 18 percent, and retails for $100 a gram, although $20, $40 and $50 sizes can also be purchased. 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.

The DEA also reports that 'heroin, ***purported*** to be Colombian, was encountered in the Denver metro area in the fourth quarter of FY 2000. This appears to be a cooperative effort between Colombian and Mexican traffickers. However, in Denver, the Mexican traffickers are using African-American distributors in an attempt to open the market. To date, 15 ounces have been seized with a selling price of $2,500 per ounce and an average purity of 70-80 percent.

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, data from the 1999 National Household Survey on Drug Abuse placed Colorado number one among the 50 states in past month marijuana use (8.1 percent of the 12 and over population).

Most marijuana indicators are increasing. From 1993 to 1999, the rate per 100,000 of marijuana ED mentions more than tripled from 14 to 43 (exhibit 3). 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.

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). Th. trend continued in 1999 and the first half of 2000, with marijuana admissions accounting for 43.2 percent and 43.4 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. However, from 1994 through 1999, this proportion has steadily declined to only 24.9 percent, but showed a slight increase to 26.3 percent in the first half of 2000 (exhibit 2).

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 33.5 percent in the first half of 2000. Conversely, whites have declined from 63.9 percent to 56.2 percent of marijuana admissions during the same time period. Also, the proportion of 12 to 17 year old marijuana admissions declined somewhat from 39.6 percent in 1998 to 34.8 percent during the first half of 2000, although they still constitute the largest group in treatment for marijuana.

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 high THC marijuana from British Columbia, known as "BC Bud", has appeared in Colorado at prices of $500 an ounce and $4,000-$5,000 a pound.

In general, the DEA reports Denver area prices of $500–$1,200 per pound and $50-100 per ounce for commercial grade marijuana. These prices are about the same in Colorado Springs ($300-1,200 per pound; $100-150 per ounce) and in Glenwood Springs ($800 per pound and $150 per ounce). For sinsemilla, pound prices are about the same in Denver and Colorado Springs at $1,500–$3,500, but are slightly higher in Glenwood Springs ($4,000). Ounce prices vary from $100 in Denver and $100-150 in Colorado Springs to $200 in Glenwood Springs.

4. Stimulants

Non-medical 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 non-medical 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 three-fold from 4 in 1993 to 12 in 1995. This rate declined to 7 in 1996, only to increase sharply to 19 in 1997. However, in 1998, the methamphetamine rate declined to only 8 mentions per 100,000, and to only 6 in 1999 (exhibit 3). Conversely, amphetamine ED mentions per 100,000, after dropping from 14 to 7 from 1997 to 1998, rose to 15. Amphetamine-related hospital discharge occurrences per 100,000 (exhibit 4) 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), remained at this level in

1998, but again dropped to 3 percent in 1999.

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 nearly doubled from 1994 to1997 (exhibit 1). In 1994, primary methamphetamine use accounted for only 7.6 percent of total treatment admissions, compared with 14.9 percent in 1997. Such admissions declined to 10.7 percent during 1999, but rose again to 12 percent during the first half of 2000. **Amphetamine** admissions are typically only a fraction of those for methamphetamine. From 1994 to the first half of 2000 they accounted for only .9 to 1.1 percent of all drug treatment admissions, although there has been a small upward trend from 1998 (.4 percent) to the first half of 2000 (1.1 percent).

In 1994, 24.9 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, 20.2 percent in 1999, and to 17.1 percent in the first half of 2000.

Injecting had been the most common route of administration for methamphetamine and other stimulants. However, the IDU proportion has been declining from 1993 (49.6 percent) to the first half of 2000 (33.1 percent), while smoking has become increasingly common in the last 6 years. In the first half of 2000, 36.8 percent of methamphetamine and other stimulant treatment admissions smoked the drug, compared with only 8.5 percent in 1993.

Methamphetamine and other stimulant treatment admissions for the first half of 2000 remain predominately white (86.3 percent) and male (55.8 percent). However, beginning in 1999 and continuing into the first half of 2000, there has been a shift in age proportion. In 1998, 38 percent were age 25 or younger. However, this percentage declined to 32.2 percent in the first half of 2000, while the percentage of those 35 and older increased from 27.2 to 34.1 percent during the same time period.

The Denver DEA describes widespread methamphetamine 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 fourth quarter of FY 2000, 57 methamphetamine laboratories were seized in the Rocky Mountain West. These laboratories, generally capable of manufacturing an ounce or less per "cook", varied from being primitive to quite sophisticated. The ephedrine reduction method is the primary means of manufacturing methamphetamine. The DEA reports that methamphetamine street prices are $80-$125 per gram, $600–$1,100 per ounce, and $5,000-$8,000 per pound in Denver (stable); $90-125 per gram, $650-1,500 per ounce, and $8,000-15,000 per pound in Colorado Springs: and $80-125 per gram, $1,200 per ounce, and $8,000-12,000 per pound in Glenwood Springs.

5. Club Drugs

Club drugs are a group of synthetic drugs commonly associated with all night dance clubs called "raves". These drugs include methylenedioxymethamphetamine (MDMA, or ecstasy), gamma-hydroxybutyrate (GHB), rohypnol (roofies) and ketamine (Special K). Information on use of these drugs in Colorado is limited. Treatment, hospital discharge, ADAM, and DAWN data do not have separate breakouts for these drugs. Only the Rocky Mountain Poison and Drug Center (RMPDC) collects specific data on club drugs as part of their overall information on calls related to street drugs. However, substantial anecdotal information on club drugs is available from the DEA and the Denver Police Department.

MDMA, or ecstasy, originally developed as an appetite suppressant, is chemically similar to the stimulant amphetamine and the hallucinogen mescaline, and thus produces both stimulant and psychedelic effects. Taken orally in tablet or capsule form, it can produce significant increases in heart rate and blood pressure. It can also lead to dangerously marked increases in body temperature resulting in muscle breakdown, and kidney and cardiovascular failure. The handful of MDMA related calls to the RMPDC ranged from only 3 to 11 during the 1994 to 1999 time period. However, the DEA reports that ecstasy is readily obtainable by individuals involved in the rave scene, and is also being sold in many "singles bars" in the Denver metro area. They place the price at $15-20 per dosage unit (e.g., 1 capsule) in Denver and $15-25 in Colorado Springs. The Denver Police Vice/Drug Bureau detectives also report substantial MDMA sales in bars and at raves at prices of $25 per capsule.

GHB is a central nervous system depressant that can sedate the body, and at higher doses can slow breathing and heart rate dangerously. It can be produced in clear liquid, white powder, tablet, and capsule forms, and is often used in combination with alcohol making it even more dangerous. During the 1994 to 1998 time period the RMPDC reported only 1 to 6 calls about GHB. However, in 1999 the number of GHB calls jumped to 92. The DEA reports that GHB is readily available in the Colorado rave scene, and has been increasing in popularity. The price is $5-10 per dosage unit (i.e., one bottle cap full).

Rohypnol (roofies) is a benzodiazepine sedative (others include Valium, Xanax) approved as a treatment for insomnia in over 60 countries, but not in the U.S. Rohypnol is tasteless, odorless, dissolves easily in carbonated beverages, and its effects are aggravated by alcohol use. Even a small dose (i.e., 1 mg) can impair a victim for 8 to 12 hours. It is usually taken orally and can cause individuals not to remember what they experienced under the effect of the drug. It also causes dizziness, confusion, decreased blood pressure, drowsiness, and gastro-intestinal disturbance. There does not appear to be widespread use of this drug among either the general population or the rave scene in Colorado. The number of calls received by RMPDC about this drug jumped from 1 in 1994 and 1995 to 22 in 1998. However, such calls declined to only 7 in 1999.

Ketamine, often called Special K on the street, is an injectable anesthetic that has been approved for both human and animal use in medical settings. However, about 90 percent of the ketamine legally sold today is intended for veterinary use. Produced in

liquid form or white powder, it can be injected, inhaled, or swallowed. Similar to phencyclidine (PCP) in its effects, it can bring about dream-like states and hallucinations. At higher doses, ketamine can cause delirium, amnesia, impaired motor function, high blood pressure, depression and potentially fatal respiratory problems. The DEA and local law enforcement have reported a number of burglaries of veterinary clinics in the Denver metro area in which the only controlled substance taken was ketamine. Specifically, there have been nine such burglaries in Arapahoe County (south and east of Denver). This rise in burglaries corresponds with a rise in popularity of ketamine use at the raves. The Metro Drug Task Force puts the ketamine price at $25 "a hit". The RMPDC did not report any ketamine calls from 1994 to 1999.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AMONG INJECTING DRUG USERS

Of the 6,985 AIDS cases reported in Colorado through September 30, 2000, 8.7 percent were classified as IDUs, and 11 percent were classified as homosexual or bisexual males and IDUs (exhibit 7).

EXHIBIT 1:TREATMENT ADMISSIONS BY DRUG TYPE

1994-00*
(1ST HALF OF 2000)

DRUG	1994	1995	1996	1997	1998	1999	2000*
Heroin	1707	1936	1956	1611	1881	2038	985
%	14.2%	15.4%	15.1%	13.7%	13.2%	14.5%	14.9%
Non-Rx Methadone	33	41	38	16	29	31	11
%	0.3%	0.3%	0.3%	0.1%	0.2%	0.2%	0.2%
Other Opiates N	337	314	283	252	328	384	216
%	2.8%	2.5%	2.2%	2.1%	2.3%	2.7%	3.3%
Methamphetamine N	910	1412	1162	1746	1927	1508	796
%	7.6%	11.2%	8.9%	14.9%	13.5%	10.7%	12.0%
Other Stimulants N	113	142	90	100	96	150	103
%	0.9%	1.1%	0.7%	0.9%	0.7%	1.1%	1.5%
Cocaine N	4629	3910	3976	3181	3783	3384	1410
%	38.6%	31.0%	30.6%	27.1%	26.6%	24.0%	21.3%
Marijuana N	3861	4429	5043	4450	5675	6092	2876
%	32.2%	35.2%	38.8%	37.9%	39.8%	43.2%	43.4%
Hallucinogen N	46	62	73	54	83	67	56
%	0.4%	0.5%	0.6%	0.5%	0.6%	0.5%	0.8%
PCP N	9	8	3	2	2	8	4
%	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%	0.0%
Barbiturates N	19	14	12	17	23	20	6
%	0.2%	0.1%	0.1%	0.1%	0.2%	0.1%	0.1%
Sedatives N	10	20	15	24	29	23	23
%	0.1%	0.2%	0.1%	0.2%	0.2%	0.2%	0.3%
Tranquilizers N	80	89	95	88	96	130	40
%	0.7%	0.7%	0.7%	0.8%	0.7%	0.9%	0.6%
Inhalants N	149	173	130	100	117	70	31
%	1.2%	1.4%	1.0%	0.9%	0.8%	0.5%	0.5%
Other N	91	49	112	99	181	200	71
%	0.8%	0.4%	0.9%	0.8%	1.3%	1.4%	1.0%
TOTAL	11994	12599	12988	11740	14250	14105	6628

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: 1994-00**

DRUG	1994	1995	1996	1997	1998	1999	2000*
HEROIN N	178	280	328	261	359	347	167
%	10.7%	14.9%	17.1%	16.6%	19.7%	17.5%	17.1%
METHAM N	221	412	296	513	515	299	134
%	24.9%	29.7%	25.9%	30.7%	27.4%	20.2%	17.1%
COCAINE N	752	607	599	432	583	510	208
%	16.6%	15.8%	15.3%	14.0%	15.8%	15.5%	15.1%
MARIJ. N	1416	1601	1784	1426	1649	1461	746
%	37.2%	36.8%	36.0%	33.3%	30.6%	24.9%	26.3%

*First half of 2000

Exhibit 3 (Source: DAWN) Emergency Department Mentions for Selected Drugs

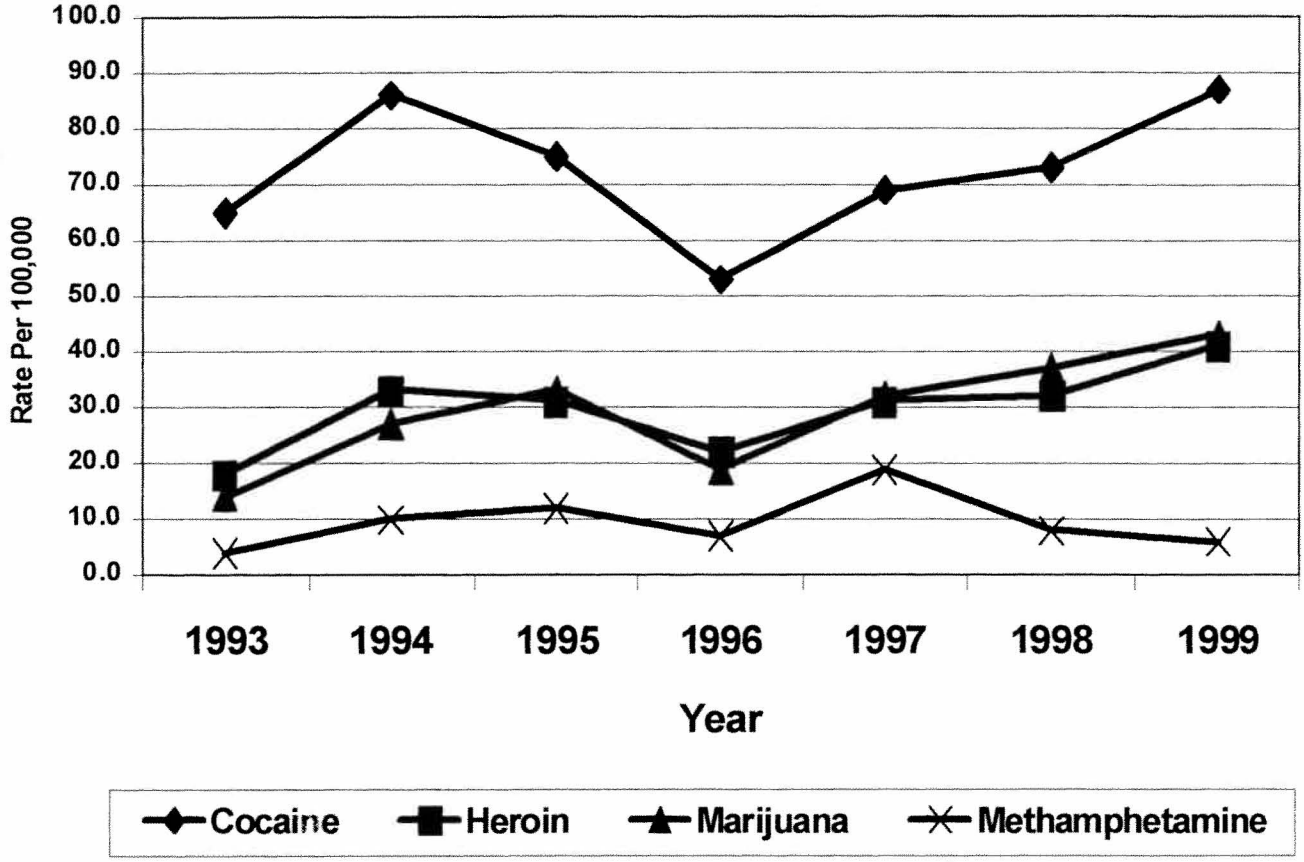

*EXHIBIT 4 (*Source: CHA & CDPHE)

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. ANALGS.	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

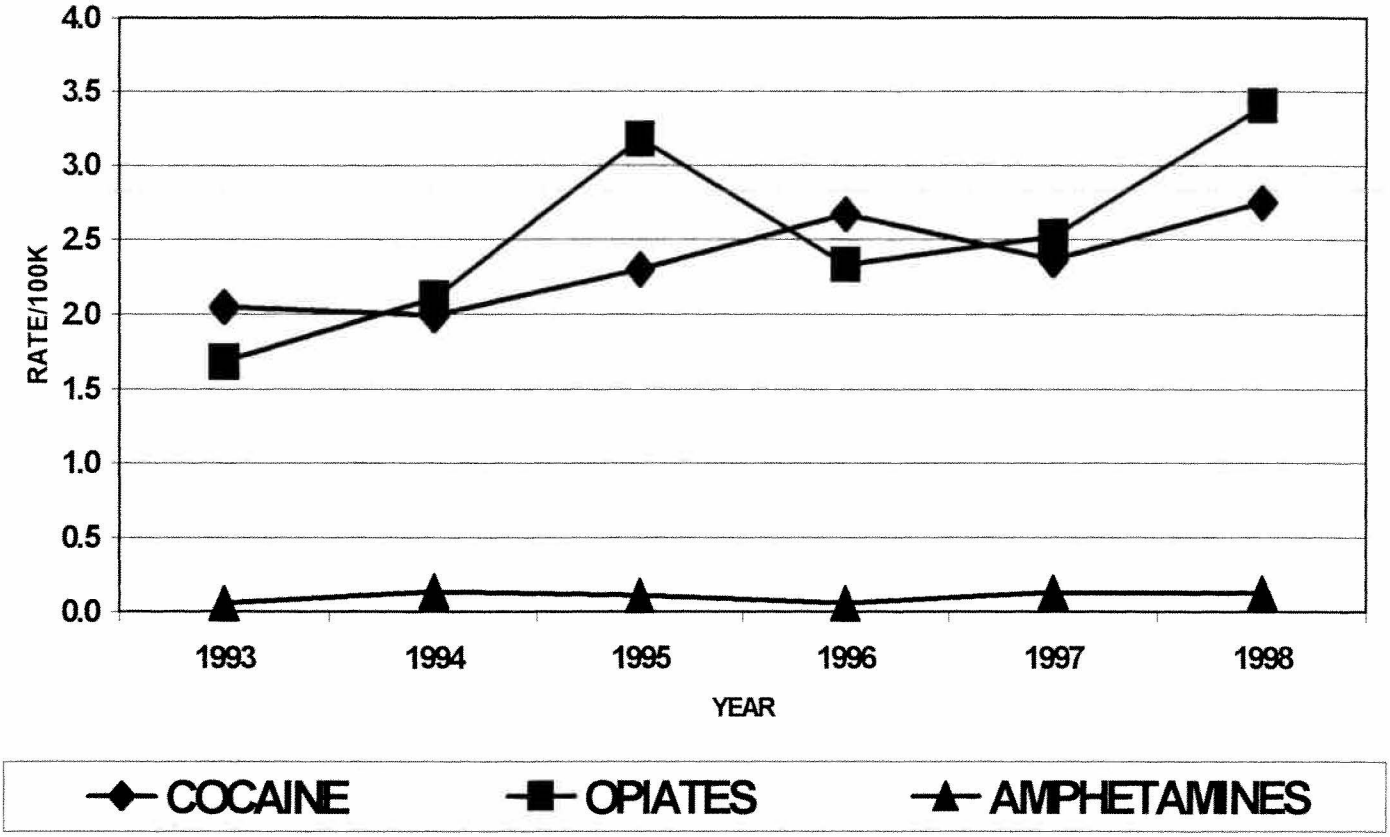

EXHIBIT 6: (Source-ADAM)
ARRESTEES WITH POSITIVE URINE SCREENS FOR SELECTED DRUGS: 1993-99

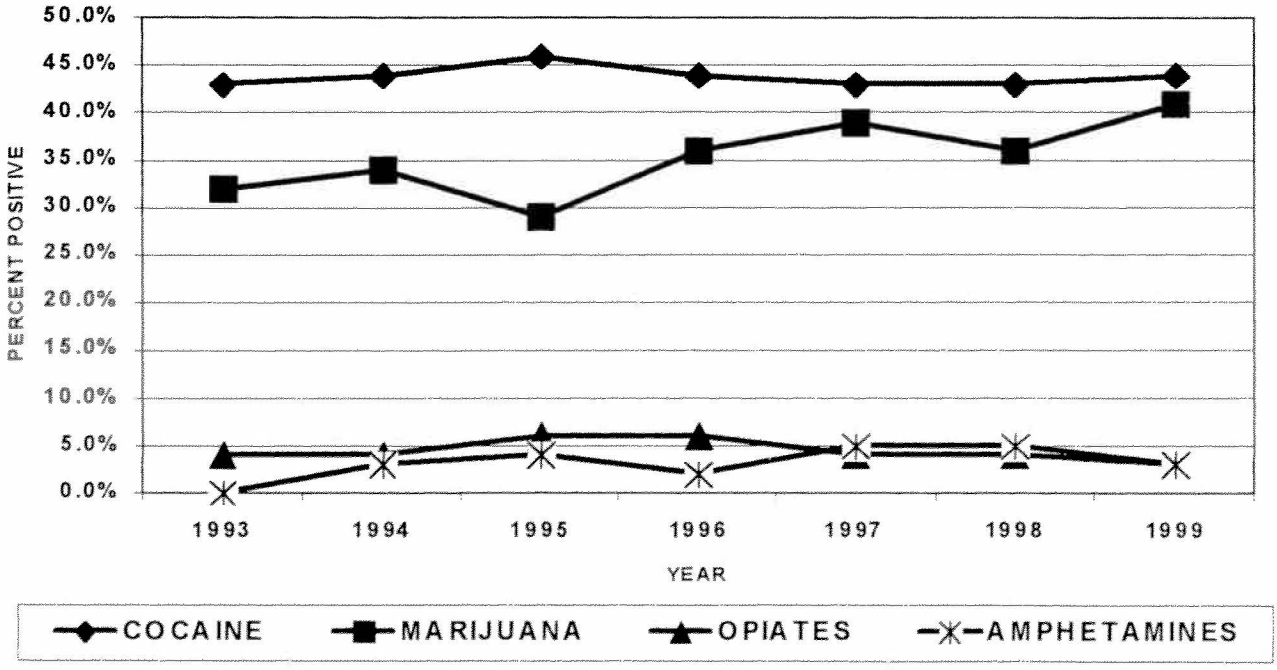

EXHIBIT 7

COLORADO CUMULATIVE AIDS CASES BY DEMOGRAPHIC CATEGORY THROUGH SEPTEMBER 30, 2000

ITEM	NUMBER	PERCENT
Number of confirmed cases	**6,985**	**100%**
GENDER		
▪ Male	6,503	93.1%
▪ Female	482	6.9%
RACE/ETHNICITY		
▪ White	5,154	73.8%
▪ African-American	752	10.8%
▪ Hispanic	1004	14.4%
▪ Asian	29	.4%
▪ Native American	46	.7%
AGE AT DIAGNOSIS (years)		
▪ <13	28	.4%
▪ 13 – 19	28	.4%
▪ 20 – 29	1,177	16.8%
▪ 30 – 39	3,429	49.1%
▪ 40 – 49	1,700	24.3%
▪ 50+	623	8.9%
EXPOSURE CATEGORY		
▪ Men/sex/men	4,826	69.1%
▪ Injecting drug user (IDU)	612	8.7%
▪ MSM and IDU	763	11.0%
▪ Heterosexual contact	352	4.9%
▪ Other	182	2.6%
▪ Risk not identified	250	3.7%

Source: Colorado Department of Public Health and Environment