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# **Patterns and Trends in Drug Abuse: Denver and Colorado**

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# PATTERNS AND TRENDS IN DRUG ABUSE: *DENVER AND COLORADO*

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*Most amphetamine and methamphetamine indicators have fluctuated in the past six years. However, in 2002, methamphetamine treatment admissions reached their highest level ever. Marijuana continues to be a major problem in Colorado, although most current indicators are stable or decreasing slightly. For example, clients whose primary drug was marijuana constituted the largest proportion of drug related treatment admissions in the first half of 2002, even though this percentage was down slightly from 2001. Also, marijuana ED mentions, which had increased by 55 percent from 1995 to 2000, stabilized during 2001. Conversely, marijuana related hospital discharges climbed to their highest level in the 1995 to 2001 time period. Similar to marijuana, most cocaine indicators were stable or down slightly in the past year and a half; with deaths, ADAM data, and treatment admissions remaining stable, while ED mentions and new users in treatment declined somewhat. The proportion of cocaine smokers entering treatment had been declining, but increased slightly in the first half of 2002. Curiously, this was attributable to Hispanic rather than African-American clients. A mixed pattern is also the circumstance for heroin indicators, with hospital discharges and deaths increasing, ADAM data and ED mentions stable, and treatment admissions and new users in treatment down slightly. Also, heroin treatment client demographic proportions have changed somewhat with more white and younger users, but fewer Hispanics. Accompanying this has been a continuing small upward trend in the proportion of heroin smokers and inhalers. Finally, limited indicator data, a recent treatment study, data from the 2002 Colorado Youth Survey and most anecdotal data point to an increasing club drug problem in Colorado, mostly among adolescents and young adults.*

## **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 (Denver PMSA). In recent years, Denver and the surrounding counties have experienced rapid population growth. According to the 1990 census, the Denver PMSA population was 1,622,980. By the 2000 census, this had grown by 30 percent to 2,109,282. In general, Colorado has been one of the top five fastest growing States in the country increasing from

3,294,394 in 1990 to 4,324,920 in 2000, or by 31.3 percent. 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.
- Colorado and the Denver metropolitan area, though prospering economically, have seen small increases in unemployment rates. Colorado's unemployment rate for September 2002 was 5.0 percent, up from 3.9 in September 2001. Likewise, Denver's unadjusted unemployment rate for September 2002 was 6.1 percent, compared to 4.8 percent in September 2001.

## 2. Data Sources and Time Periods

Data presented in this report were collected and analyzed in October and November 2002. 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 1995 through 2001 are provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) through its

Drug Abuse Warning Network (DAWN).

- **Hospital discharge data** statewide for 1995-2001 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 1996 through the first half of 2002. 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 in their third quarter FY 2002 report.
- **Death statistics and communicable disease data** are available from the Colorado Department of Public Health and Environment (CDPHE). Data are presented from 1995 to 2001.
- **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 2001.

- **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. In CY 2000, NIJ changed its procedures from a convenience to a probability sample. Thus, no ADAM data trend analysis is presented. Rather, CY 2001 and CY 2002 (first two quarters) use percentages by drug type are indicated.
- **The Colorado Youth Survey** is an annual statewide survey of 6<sup>th</sup> through 12<sup>th</sup> graders with questions organized around risk and protective factors, and drug use. The CYS has been conducted in 1998, 2000, and 2002. The 2002 sample included more than 26,000 students.

## DRUG ABUSE TRENDS

### 1. Cocaine and Crack

Most cocaine indicators remained stable or declined in 2001 and the first half of 2002. Denver metro cocaine emergency department mentions per 100,000 population (exhibit 3), after declining from 75 to 53 from 1995 to 1996, increased steadily to 87 in 1999, but declined slightly to 83 per 100,000 in 2000 and to only 69 per 100,000 for 2001.

Also, statewide hospital discharge data (exhibit 4) showed that cocaine occurrences per 100,000 increased from 55.3 in 1995 to 62.8 in 1998, but have remained relatively stable through 2001 (63.2 per 100,000).

In 1994 there were 71 calls to the Rocky Mountain Poison and Drug Center concerning cocaine. This dropped to 49 in

1995, remained at about that level through 1999, but increased to 59 in 2000 and more than doubled to 127 in 2001.

However, the proportion of cocaine treatment admissions has declined considerably over the past seven years (exhibit 1). In 1996, primary cocaine abuse accounted for 30.6 percent of all drug abuse treatment admissions compared with only 21.6 percent for the first half of 2002.

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, had remained relatively level from 1996 (15.3 percent) to 15.7 percent in 2001, but declined to 13.8 percent during the first half of 2002 (exhibit 2).

Treatment admission data indicate that cocaine injecting has remained relatively stable between 11 and 13 percent from 1996 through the first half of 2002. Smoking percentages had declined steadily from 67.4 percent in 1996 to 57.9 percent in 2001, but increased to 62.1 percent in the first half of 2002 (the same proportion as in 1999). Conversely, inhalation had been steadily increasing from 17.6 percent in 1996 to 25.9 percent in 2001, but declined to 21.5 percent in the first half of 2002.

Curiously, a cross sectional analysis of route by race/ethnicity reveals that the very recent increase in cocaine smoking is attributable to Hispanic rather than African-American clients. From 1996 to 2001 the percentage of Hispanics who inhaled cocaine increased from 26.7 percent to 37.9 percent. However, in the first half of 2002 the Hispanic inhalation proportion dropped to only 27.2 percent. Conversely, the percentage of Hispanics smoking cocaine had declined somewhat from 54.4 percent in 1996 to 50.2 percent in 2001, but increased sharply to

60.8 percent in the first half of 2002. On the other hand, the percentage of African-Americans smoking cocaine has declined steadily from 89.5 percent in 1996 to 78.5 percent in the first half of 2002, while the percentage inhaling cocaine has increased from 6.1 percent in 1996 to 12.8 percent in 2002. This occurrence may relate to the inter-twining of crack and powder cocaine distribution networks (see discussion of cocaine trafficking below).

In general, the race/ethnicity proportions for cocaine treatment admissions have been changing somewhat. Whites accounted for the largest percentage of cocaine admissions in the first half of 2002 (41.3 percent). However, this is a substantial decline from their proportion of total cocaine clients in 2001 (47.3 percent). Hispanic cocaine admissions had increased dramatically from only 17.5 percent in 1996 to a high of 28.8 percent in 2000. However, this proportion declined to 26.3 percent in 2001 and stayed at that level (26.4 percent) through the first half of 2002. Conversely, African-American cocaine admissions had been almost cut in half dropping from 36.3 percent in 1996 to only 19.7 percent in 2001, but this proportion increased slightly to 22.7 percent in the first half of 2002.

Likewise, age categories have been changing since 1996. In 1996, 57 percent of cocaine admissions were under thirty-five; this decreased to 45.2 percent in the first half of 2002. Conversely, cocaine admissions 35 and over have climbed steadily during the same time period from 43 to 54.8 percent. Cocaine admissions remain predominantly male, with the proportion remaining relatively constant from 1996 (59.6 percent) through the first half of 2002 (59.5 percent).

Cocaine deaths in the State climbed from 86 in 1995 (23 per million) to a peak of 146 in

1999 (36 per million). While they declined to 116 in 2000 (27 per million), they increased again to 134 in 2001 (30.4 per million), the second highest number of deaths in the time period indicated.

As to recent ADAM data for a sample of Denver arrestees, 35.4 percent of males and 46.5 percent of females had cocaine positive urine samples in CY 2000. These numbers were stable in CY 2001, with 33.8 percent of males and 45 percent of females testing positive. Provisional data for the first quarter of CY 2002 shows a substantial decline in positive cocaine urines for both males (27.1 percent) and females (33.3). However, these numbers substantially increased during the second quarter of CY 2002 to 33.7 percent of males and 51.7 percent of females.

The Denver Field Division of the DEA reports the substantial availability of cocaine HCL across the state in ounce, pound, and kilogram quantities. Mexican poly-drug trafficking groups control the majority of cocaine distribution in the Denver metro area through Hispanic, White and African-American distributors. For the most part, cocaine is brought into Colorado in vehicles from the southwest border and southern California on interstate and local highway systems. Kilograms of cocaine are often sold in bricks covered in industrial tape. Smaller amounts of cocaine are usually packaged in zip-lock plastic bags with no special markings. The DEA also indicates that, despite declining use, crack cocaine remains stable in Colorado with supplies continuing to come from street gangs in Los Angeles and Chicago. The crack is transported in passenger vehicles, commercial buses or airlines from the aforementioned cities. Upper level crack organizations are primarily Mexican with gang affiliations and are intertwined with

African-Americans who control street level distribution.

The DEA reports current cocaine prices as follows: \$17,000 to \$20,000 per kilogram (down from \$20,000), and \$500-\$900 per ounce (down from \$500 to \$1,100) in the Denver Metro area with purity in the 30 to 90 percent range; \$15,000-25,000 per kilo, \$500-1,100 per ounce, and \$100-125 per gram (50 percent purity) in Colorado Springs (south of Denver on the Front Range); and \$21,000 per kilo (60 to 70 percent purity) and \$800 to \$1,000 per ounce (65 to 85 percent purity) in Grand Junction (Western Slope of Colorado). Crack prices remain relatively stable at \$900-1,000 per ounce and \$10-20 per rock in Denver.

## 2. Heroin

For 2001 and the first half of 2002, most heroin indicators are mixed with some increasing, some stable and some declining. DAWN data show that the rate of heroin ED mentions (exhibit 3) declined from 1995 (31 per 100,000) through 1996 (22 per 100,000), but nearly doubled from 1996 to 2000 (41 per 100,000). This rate remained stable in 2001 at 40 per 100,000 population.

Conversely, hospital discharge data (exhibit 4) indicate that opiate occurrences per 100,000 population, after dropping from 29.4 to 19.9 from 1995 to 1996, have climbed steadily to 50.8 per 100,000 by 2001 (an overall increase of 73 percent).

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, but declined to only 12 in 2000. However, in 2001 the heroin related calls increased to the 1999 level of 36.

Among Colorado treatment admissions (exhibit 1), the proportion and number of heroin admissions remained fairly stable from 1996 (15.1 percent) through 2000 (14.5 percent), with a slight decline to 14 percent in 2001 and to 12.5 percent during the first half of 2002. Likewise, the proportion and number of new heroin users entering treatment, after increasing from 17 percent in 1996 to 18.7 percent in 2000, declined to 16.6 percent in 2001 and to 14 percent in the first half of 2002 (exhibit 2).

Like cocaine, there have also been some changes in the demographic proportions of heroin users entering treatment. The proportion of female heroin admissions has remained stable from 1996 (32.3 percent) through the first half 2002 (31.6 percent). However, race/ethnicity proportions have changed during this same time period. Whites have increased as a percentage of total from 57.6 percent in 1996 to 65.5 percent in the first half of 2002, while Hispanics have decreased (29.4 percent to 19.7 percent). Also, the 25 and under age group has increased as a percentage of heroin admissions from only 10.9 percent in 1996 to 16.9 percent in the first half of 2002.

Accompanying the heroin client demographic realignments, are small changes in route of administration, with heroin smoking and inhalation becoming more common. In 1996, only 5.9 percent of treatment admissions reportedly smoked or inhaled heroin, compared with 7.5 percent in 1997, 9 percent in 1998, 8.5 percent in 1999, 10.2 percent in 2000, 9.6 percent in 2001, and 12.1 percent in the first half of 2002.

The heroin smoker, inhaler, and injector groups in treatment are distinctly different from each other demographically. The heroin smokers are much more likely to be White (78 percent) –vs.- inhalers (59 percent) or injectors (62 percent). Also,

smokers are younger than the other heroin users with nearly 20 percent being 25 or under compared to 14 percent of inhalers and 15 percent of injectors. Accordingly, more than 3 in 5 smokers have abused heroin for four years or less compared to only 41 percent of inhalers and 31 percent of injectors. Gender differences are small, however, with females constituting 36 percent of the smokers, 32 percent of inhalers, and 34 percent of injectors. As to educational levels, half of smokers have at least some college –vs.- only 39 percent of inhalers and 32 percent of injectors. Thus, not surprisingly, smokers are more likely to be employed full or part time (55 percent) compared to inhalers (50 percent) or injectors (42 percent). Conversely, a much greater proportion of injectors have a prior arrest (48 percent) –vs.- their smoking and inhaling counterparts (39 percent and 36 percent, respectively). Finally, smokers are somewhat more likely (78 percent) to live outside the City and County of Denver than inhalers (71 percent) or injectors (67 percent).

From 1990 through 1996 opiate related deaths averaged 85 per year. However, this average increased dramatically to 150 deaths per year from 1996 through 2001, an increase of 76 percent.

Interestingly, CY 2000 ADAM data showed females (5.8 percent) with a higher positive opiate urine screen than males (3.4 percent). However, in CY 2001, the reverse was true with 5.2 percent of males and only 2.4 percent of females testing positive for opiates. Provisional data for the first two quarters of CY 2002 shows a continuance of this seesaw pattern. In the first quarter of CY 2002, 1.9 percent of females and 2.1 percent of males tested positives for opiates. However, in the second quarter, 5.2 percent of females and 2.7 percent of males tested positive.

The Denver DEA reports that heroin is widely available in the large metropolitan areas. In the Denver metro area, the majority of heroin sales take place in the lower downtown area. Marketing is controlled by Mexican Nationals. They also control the street level heroin market in the form of small autonomous distribution cells. Street level heroin is usually packaged in balloons, plastic sandwich bags, or tin foil for gram and ounce quantities. Larger seizures have encountered heroin wrapped in wax paper, further contained within foil paper and clear plastic wrap, and then flattened out to fit in hidden compartments. Street level weight is usually sold in grams selling for \$100 to \$150 with ounces going for \$1500 to \$3000. The DEA Domestic Monitoring Program (DMP) buys reveal that the purity of Mexican heroin ranges from 8 to 64 percent (average purity around 18 percent).

In Colorado Springs, quantities of heroin are selling for \$1800 to \$3500 per ounce and \$75 to \$300 per gram. The average purity is around 40 percent.

### 3. Marijuana

Most marijuana indicators are stable or decreasing for 2001 and the first half of 2002.

From 1995 to 2000, the rate per 100,000 of marijuana ED mentions increased by 55 percent from 33 to 51 (exhibit 3). The 2001 rate remained stable at 50 per 100,000 population. However, marijuana hospital discharge occurrences per 100,000 (exhibit 4) have risen dramatically from 45.6 in 1995 to 62.5 in 2001.

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,

2000, and 2001 there were 47, 58, and 97 calls, respectively, related to marijuana effects.

Marijuana treatment admissions increased from 38.8 percent in 1996 to 43.7 percent in 1999. However, since that time they have declined slightly to 40.6 percent in 2001 and to 39.1 percent in the first half of 2002. In general, marijuana users have accounted for the largest proportion of all Colorado drug treatment clients since 1996 (exhibit 1). These increases may be partly related to user accounts of increased drug potency and a more casual attitude about marijuana use in society in general.

The proportion of new users entering treatment for marijuana had been declining steadily from 1996 (35.8 percent) through 1999 (25.4 percent). However, in 2000 this proportion climbed slightly to 29.9 percent, remained at that level (29.2 percent) during 2001, but dropped to 25.5 percent in the first half of 2002 (exhibit 2).

Data indicate only slight changes in the demographics of marijuana treatment clients. Race proportions remained relatively stable from 1996 through the first half of 2001. Hispanics increased as a percentage of marijuana admissions from 31.4 percent in 1995 to 36.3 percent in 1999, but have declined since then to only 26.1 percent through the first half of 2002. The proportion of Whites has fluctuated up and down only slightly from 1996 (57.3 percent) through the first half of 2002 (53.8 percent). African-Americans had constituted between 6.5 and 9.2 percent of marijuana admissions between 1996 and 2001, but rose to 10.7 percent in the first half of 2002, the highest proportion during the six and one half year time period. Male to female marijuana admission ratios remained at approximately 3 to 1 from 1996 to the first half of 2002. There have also been small changes in the

marijuana age group proportions from 1996 to through the first half of 2002. Those 12 to 17 decreased slightly from 41 percent in 1996 to 38.3 percent in 2001, but dropped sharply to only 31 percent in the first half of 2002. Conversely, the 18 to 25 age group, which had been fluctuating between 27 and 31 percent from 1996 through 2001, increased to 33.2 percent during the first half of 2002. Similarly, the 26 to 34 age group proportion grew slightly from 15.4 percent in 2001 to 17.9 percent in 2002, the highest percentage in the six and one half year time period. Likewise, the 35 and older age group proportion, which had increased from 12.4 percent in 1996 to 23.8 percent in 1999 and then dropped to 15.6 percent in 2001, increased to 18 percent in the first half of 2002.

CY 2000 ADAM data indicated that 40.9 percent of the male arrestee sample and 38.5 percent of the female arrestee sample had positive marijuana urine screens. These percentages remained relatively stable in CY 2001 with 40 percent of males and 33 percent of females testing positive. Likewise, positive test proportions remained constant in the first and second quarters of CY 2002 for males (41.5 and 38 percent, respectively) and females (33.3 and 31.3 percent, respectively).

The Denver DEA states that the most 'abundant supply of marijuana is Mexican grown and is trafficked into the area from the border areas of Texas, New Mexico, and Arizona by Mexican poly-drug trafficking organizations. Vehicles with hidden compartments are used to transport shipments weighing from pound to multi-pound quantities.' Mexican marijuana sells at a price range of \$500 to \$800 per pound. They also indicate that high THC, seedless marijuana from British Columbia, known as "BC Bud" or "Triple A", continues to be increasingly available and popular in



Colorado at prices of \$600 an ounce and \$3,200-\$4,000 a pound.

Further, according to the DEA, locally-grown marijuana is almost always grown indoors by independent operators with grow equipment varying from basic to elaborate operations with sophisticated lighting and irrigation systems. Domestically grown marijuana prices range from \$1,000 to \$3,000 per pound and \$200 to \$300 per ounce.

#### 4. Stimulants

While methamphetamine and other stimulant use in Denver and across Colorado has fluctuated from 1996 through the first half of 2002, most indicators have increased during the last few years.

Methamphetamine ED mentions per 100,000 in Denver decreased from 11 in 1995 to only 5 in 2001. Conversely, amphetamine ED mentions per 100,000, after dropping from 18 to 7 from 1995 to 1998, rose to 21 in 2000 and remained at that level in 2001. Amphetamine-related hospital discharge occurrences per 100,000 (exhibit 4) have also shown a fluctuating pattern from 1995 to 2001. However, overall they have increased during that time period from 19.4 to 26.3 per 100,000.

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 sharply to 291, 269, and 581 in 1999, 2000, and 2001 respectively.

Methamphetamine treatment admissions have shown peaks and valleys over the past six and one half years. However, overall they have doubled from only 8.9 percent of

drug admissions in 1996 to 17.9 percent in the first half of 2002. Amphetamine admissions are typically only a fraction of those for methamphetamine. However, from 1996 to 2000 they increased from 65 to 171, or from .5 percent to 1.3 percent of all drug treatment admissions, but declined slightly to 128 admissions (1 percent) during 2001 and to only 52 (1 percent) during the first half of 2002.

In 1996, 25.8 percent of primary methamphetamine users entering treatment were new users (exhibit 2). This percentage rose to 30.5 in 1997. However, by 2002, the proportion of new users has declined to only 18.6 percent.

Injecting had been the most common route of administration for methamphetamine. However, the IDU proportion has been declining from 1996 (40 percent) to the first half of 2002 (30.6 percent), while smoking has become increasingly common in the last seven years. In the first half of 2002, about 52 percent of methamphetamine treatment admissions smoked the drug, compared with only 22 percent in 1996.

Demographically, the methamphetamine smokers in treatment tend to be somewhat younger and more often Hispanic than their inhaling or injecting counterparts.

Methamphetamine treatment admissions for the first half of 2002 remain predominately White (80.2 percent), although the Hispanics have increased in treatment from 6.9 percent in 1996 to 12.9 percent in the first half of 2002. Females accounted for slightly less than half of methamphetamine admissions in 2001 and the first half of 2002 (45.9 and 47.3 percent, respectively). As to age, from 1996 to the first half of 2002, those 25 and under have remained at about one-third of admissions, those 26 to 34 have declined from 40 percent to 32.1 percent of

admissions, and those 35 and over have increased from about one-fourth to one-third of methamphetamine admissions.

Though amphetamine related deaths in Colorado are far fewer than for opiates or cocaine, the number has increased sharply from only 15 between 1994 and 1997 to 34 between 1998 and 2001 (a 127 percent increase).

According to ADAM data, only a small percentage of positive methamphetamine urine screens were reported in CY 2000, 2.6 percent of the male arrestee sample and 5.3 percent of the female arrestee sample. These figures changed only slightly in CY 2001 and the first quarter of CY 2002 with 3.4 and 4.3 percent of males, respectively and 4.3 and 3.7 percent of females, respectively testing positive for methamphetamines. However, in the second quarter of CY 2002 only 3.3 percent of males had positive methamphetamine urines while 8.6 percent of females tested positive.

The 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 in the Rocky Mountain West (i.e., 147 in April through June 2002). These laboratories, generally capable of manufacturing an ounce or less per "cook", varied from being primitive to quite sophisticated. The ephedrine reduction method remains the primary means of manufacturing methamphetamine in the area. Most lab operators are able to get the precursor chemicals from legitimate businesses (e.g., discount stores, drug stores, chemical supply companies, etc.) The average purity for methamphetamine is 8 to 12 percent. The DEA reports that Colorado methamphetamine street prices are stable at \$80-\$110 per gram, and \$700-\$1,000 per ounce.

## 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 still limited. While ADAD has added club drugs to an expanded treatment client data set, the new information won't be available until early 2003. Also, hospital discharge, and ADAM data do not have routinely collected separate breakouts for these drugs. However, there are currently two sources of institutional indicator data that include the club drugs (DAWN and the Rocky Mountain Poison and Drug Center (RMPDC). In addition, ADAD has worked with OMNI Research and Training, a Denver-based firm, to add club drug questions to the Colorado Youth Survey.

Also, in the summer of 2001, ADAD conducted a survey on club drug use among young adults and adolescents admitted to selected treatment programs across the State (N=782). Some results of this study are presented in this section along with DAWN RMPDC, and CYS data. In addition, some anecdotal information on club drugs is provided from the DEA.

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. The handful of MDMA related calls to the RMPDC ranged from only 3 to 11 during the 1994 to 1999 time period. MDMA ED mentions, however, jumped from 6 in 1998 to 15 in 1999 to 57 in 2000, but declined to 42 in 2001.

Exhibit 5 shows data from the 2002 Colorado Youth Survey. As indicated,

lifetime MDMA use was reported by .7 percent of sixth graders, 1.1 percent of seventh graders, 3.0 percent of eighth graders, 4.4 percent of ninth graders, 5.2 percent of tenth graders, 10.8 percent of eleventh graders, and 9.8 percent of twelfth graders.

In ADAD's treatment survey sample of 782, 267 or 34 percent, reported lifetime use of ecstasy, with 4.5 percent having used in the past 30 days. The average age of the users was 17.3 years and the average age of first use was 15.9 years.

The above information still does not come close to providing a complete view of MDMA prevalence in Colorado. The DEA reports that ecstasy has emerged as a popular drug in the Rocky Mountain Region. It is readily obtainable by individuals at raves, nightclubs, strip clubs, or private parties. The traffickers are typically white and in their late teens or twenties who get their MDMA from Las Vegas, Nevada and various cities in California and on the East Coast, with source connections in Europe. They place the one tablet or capsule price at \$15 to \$20, with larger quantities selling for \$8 to \$12 per tablet.

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. GHB ED mentions had also increased from 7 in 1997 to 13 in 1998 to 71 in 1999. However, such mentions dropped to 43 in 2000, with only 16 mentions being reported in 2001.

As to the Colorado Youth Survey (Exhibit 5), lifetime GHB use was reported by .4 percent of sixth graders, .6 percent of seventh graders, 1.2 percent of eighth graders, 1.3 percent of ninth graders, 1.5 percent of tenth graders, 1.4 percent of eleventh graders, and 1.2 percent of twelfth graders.

In ADAD's treatment survey sample of 782, 73 or 10 percent, reported lifetime use of GHB, with .5 percent having used in the past 30 days. The average age of the users was 17.8 years, and the average age of first use was 16.1.

The DEA reports that GHB is increasing in popularity in Colorado and is readily available at raves, nightclubs, strip clubs, and private parties. The price is \$5-10 per dosage unit (i.e., one bottle cap full).

Rohypnol (roofies) is a benzodiazepine sedative (others include Valium and 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. 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. Also, there have been only two ED mentions from 1994 through 2001.

In ADAD's treatment survey sample of 782, only 14 or 2 percent, reported lifetime use of Rohypnol with .3 percent having used in the past 30 days. The average age of the users was 19 years, and the average age of first use was 16 years.

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. The RMPDC did not report any ketamine calls from 1994 to 1999. There were only 3 ketamine ED mentions from 1994 to 1999. However, there were 12 and 11 such mentions in 2000 and 2001, respectively.

Interestingly, the Colorado Youth Survey results indicated greater lifetime Ketamine use than GHB. As shown in Exhibit 5, lifetime Ketamine use was reported by .5 percent of sixth graders, 1.0 percent of seventh graders, 1.7 percent of eighth graders, 3.0 percent of ninth graders, 2.5 percent of tenth graders, 4.8 percent of eleventh graders, and 3.3 percent of twelfth graders.

In ADAD's treatment survey sample of 782, 139 or 19 percent, reported lifetime use of ketamine with 2.2 percent having used in the

past 30 days. The average age of the users was 17 years, while the average age of first use was 15.6 years.

Dextromethorphan (DXM) is an opioid agent used as a cough suppressant in a number of over-the-counter cough and cold products. Most products contain 10 to 15 milligrams (mg) of DXM. However, Coricidin HBP contains 30 mg, the largest dose on the market. DXM produces a dissociative high, like an out of body experience. Large doses can cause a fast heart, slurred speech, confusion, hallucinations, and possibly seizures.

In ADAD's treatment survey sample of 782, 78 or 11 percent, reported lifetime use of DXM with 2.2 percent having used in the past 30 days. The average age of the users was 16 years, while the average age of first use was only 14.9 years.

## **ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AMONG INJECTING DRUG USERS**

Of the 7,560 AIDS cases reported in Colorado through September 30, 2002, 9.0 percent were classified as IDUs, and 11.2 percent were classified as homosexual or bisexual males and IDUs (exhibit 6).

1996-2002\*

**Exhibit 1: Treatment  
Admission by Drug Type**

DRUG	1996	1997	1998	1999	2000	2001	2002*
Heroin	1957	1613	1894	2086	1896	1841	817
%	15.1%	13.7%	13.2%	14.4%	14.5%	14.0%	12.5%
Non-Rx Methadone	38	16	30	31	25	28	23
%	0.3%	0.1%	0.2%	0.2%	0.2%	0.2%	0.4%
Other Opiates N	283	254	331	392	421	500	236
%	2.2%	2.2%	2.3%	2.7%	3.2%	3.8%	3.6%
Methamphetamine N	1162	1748	1931	1554	1710	2058	1168
%	8.9%	14.9%	13.5%	10.7%	13.0%	15.6%	17.9%
Other Stimulants N	90	100	97	153	202	158	81
%	0.7%	0.9%	0.7%	1.1%	1.5%	1.2%	1.3%
Cocaine N	3978	3182	3798	3432	2768	2722	1410
%	30.6%	27.1%	26.6%	23.7%	21.1%	20.7%	21.6%
Marijuana N	5042	4459	5686	6339	5571	5357	2553
%	38.8%	37.9%	39.8%	43.7%	42.5%	40.6%	39.1%
Hallucinogen N	95	75	99	108	108	97	33
%	0.8%	0.7%	0.7%	0.7%	0.8%	0.7%	0.5%
PCP N	3	2	2	8	9	6	2
%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%
Barbiturates N	12	17	23	21	9	9	6
%	0.1%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%
Sedatives N	15	24	29	26	38	22	13
%	0.1%	0.2%	0.2%	0.2%	0.3%	0.2%	0.2%
Tranquilizers N	95	88	97	130	79	78	27
%	0.7%	0.8%	0.7%	0.9%	0.6%	0.6%	0.4%
Inhalants N	131	100	117	71	67	72	17
%	1.0%	0.9%	0.8%	0.5%	0.5%	0.6%	0.3%
Other N	90	79	167	160	206	235	143
%	0.7%	0.7%	1.2%	1.1%	1.6%	1.8%	2.2%
<b>TOTAL</b>	<b>12991</b>	<b>11757</b>	<b>14301</b>	<b>14511</b>	<b>13109</b>	<b>13183</b>	<b>6529</b>

Source for Exhibit 1 &amp; 2: DACODS

\*First half of 2002

**EXHIBIT 2: ANNUAL PERCENTAGE OF HEROIN, METHAMPHETAMINE,  
COCAINE AND MARIJUANA USERS ENTERING TREATMENT  
WITHIN THREE YEARS OF INITIAL USE: 1996-02\***

DRUG	1996	1997	1998	1999	2000	2001	2002*
HEROIN N	328	262	362	356	352	301	113
%	17.0%	16.6%	19.6%	17.6%	18.7%	16.6%	14.0%
METHAM N	296	514	517	312	347	406	217
%	25.8%	30.5%	27.3%	20.5%	20.5%	20.0%	18.6%
COCAINE N	599	433	587	516	447	418	193
%	15.3%	14.0%	15.8%	15.5%	16.5%	15.7%	13.8%
MARIJ. N	1783	1430	1669	1547	1644	1538	648
%	35.8%	33.1%	30.5%	25.4%	29.9%	29.2%	25.5%

\*First half of 2002

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

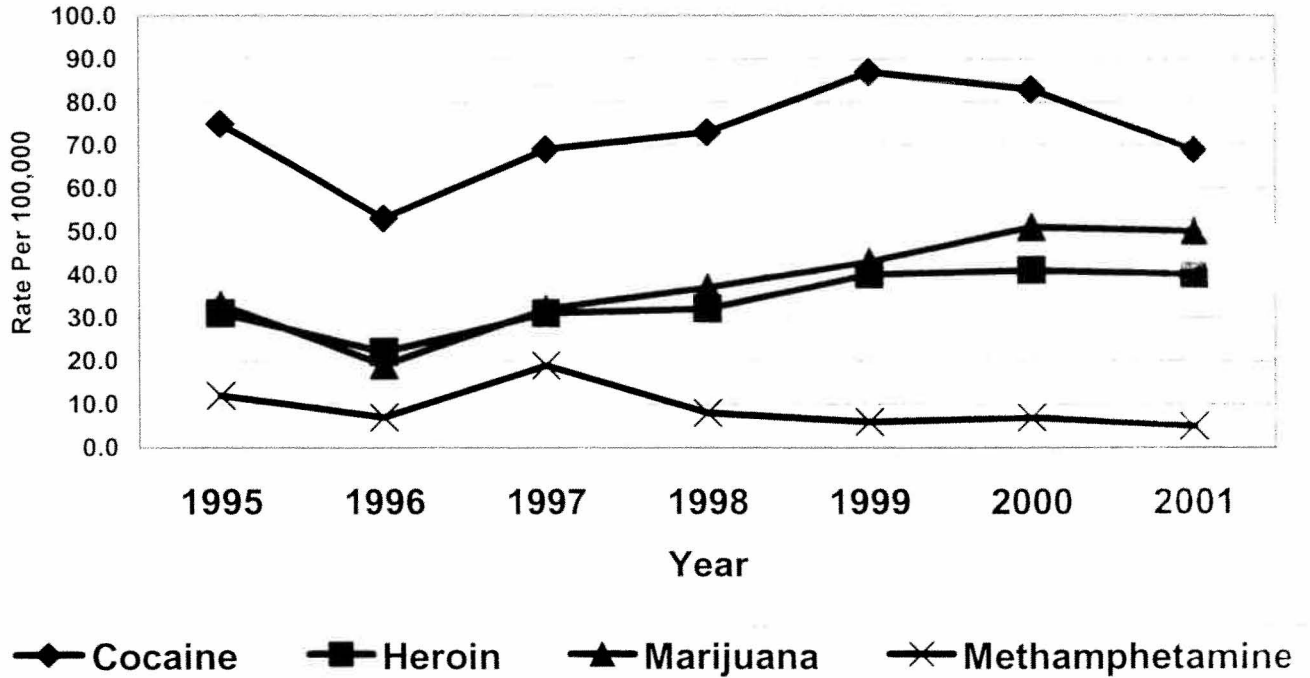


EXHIBIT 4 (Source: CHA & CDPHE)

HOSPITAL DISCHARGE MENTIONS PER 100,000 FOR SELECTED DRUGS: 1995-2001

DRUG	1995	1996	1997	1998	1999	2000	2001
AMPHETAMINES	728	532	959	815	682	942	1161
RATE/100K	19.4	13.9	24.6	20.5	16.9	21.8	26.3
COCAINE	2070	2255	2245	2492	2517	2732	2787
RATE/100K	55.3	59.0	57.7	62.8	62.3	63.2	63.2
MARIJUANA	1708	1740	2118	2227	2204	2455	2755
RATE/100K	45.6	45.6	54.4	56.1	54.6	56.8	62.5
NARC. ANALGS.	1103	760	1458	1566	1639	2053	2237
RATE/100K	29.4	19.9	37.5	39.5	40.6	47.5	50.8
POPULATION	3746585	3819789	3892996	3966198	4039402	4324920	4407305

**Exhibit 5: Club Drug Use Among 6<sup>th</sup> Through 12<sup>th</sup> Graders  
2002 Colorado Youth Survey  
Lifetime Use**

<b>GRADE</b>	<b>MDMA</b>	<b>KETAMINE</b>	<b>GHB</b>
<b>Sixth Sample N</b>	<b>5651</b>	<b>5673</b>	<b>5664</b>
Use N	57	30	25
Use %	.7	.5	.4
<b>Seventh Sample N</b>	<b>3079</b>	<b>3108</b>	<b>3102</b>
Use N	35	31	18
Use %	1.1	1.0	.6
<b>Eighth Sample N</b>	<b>7112</b>	<b>7136</b>	<b>7139</b>
Use N	215	124	89
Use %	3.0	1.7	1.2
<b>Ninth Sample N</b>	<b>847</b>	<b>853</b>	<b>848</b>
Use N	37	25	11
Use %	4.4	3.0	1.3
<b>Tenth Sample N</b>	<b>3705</b>	<b>3710</b>	<b>3709</b>
Use N	194	93	54
Use %	5.2	2.5	1.5
<b>Eleventh Sample N</b>	<b>1047</b>	<b>1052</b>	<b>1051</b>
Use N	113	50	14
Use %	10.8	4.8	1.4
<b>Twelfth Sample N</b>	<b>2240</b>	<b>2247</b>	<b>2241</b>
Use N	219	75	27
Use %	9.8	3.3	1.2

Source: Omni Research and Training

**EXHIBIT 6: COLORADO CUMULATIVE AIDS CASES  
BY DEMOGRAPHIC CATEGORY  
THROUGH September 30, 2002**

<b>ITEM</b>	<b>NUMBER</b>	<b>PERCENT</b>
<b>Number of confirmed cases</b>	<b>7560</b>	<b>100%</b>
<b>GENDER</b>		
▪ Male	6999	92.6%
▪ Female	561	7.4%
<b>RACE/ETHNICITY</b>		
▪ White	5483	72.5%
▪ African-American	852	11.3%
▪ Hispanic	1145	15.1%
▪ Asian	30	.4%
▪ Native American	50	.7%
<b>EXPOSURE CATEGORY</b>		
▪ Men/sex/men	5138	68.0%
▪ Injecting drug user (IDU)	683	9.0%
▪ MSM and IDU	843	11.2%
▪ Heterosexual contact	436	5.8%
▪ Other	184	2.3%
▪ Risk not identified	276	3.7%

Source: Colorado Department of Public Health and Environment