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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 increased in the past two years. Specifically, methamphetamine treatment admissions reached their highest level ever in the first half of 2002, and amphetamine related deaths from 1999 through 2002 more than doubled over the prior four year time period. Also, local treatment clinicians say that some stimulant users have switched from cocaine to methamphetamine because of the price, availability and longer lasting high. 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 and declined slightly in the first half of 2002. Conversely, marijuana related hospital discharges climbed to their highest level in the 1996 to 2002 time period. Cocaine indicators were mixed in the past two years, with ADAM data and treatment admissions remaining relatively stable, while new users in treatment declined somewhat. However, cocaine related deaths increased in 2002, as did ED mentions, and hospital discharges. A mixed pattern is also the circumstance for heroin indicators; with hospital discharges, ED mentions, and deaths increasing, ADAM data stable, and treatment admissions and new users in treatment down slightly. Finally, limited indicator data, a recent treatment study, data from the 2002 Colorado Youth Survey and most anecdotal data point to a substantial 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 averaged 5.7 percent for 2002, up from 3.7 for 2001. Likewise, Denver's unemployment rate averaged 6.9 percent in 2002, compared to 4.4 percent in 2001.

2. Data Sources and Time Periods

Data presented in this report were collected and analyzed in April through June 2003. 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 1996 through the first half of 2002 are provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) through its Drug Abuse Warning Network (DAWN).
- **Drug-related mortality data** for the Denver metropolitan area for 1997 through the 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 1996-2002 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 second quarter FY 2003 report.
- **Death statistics and communicable disease data** are available from the Colorado Department of Public Health and Environment (CDPHE). Data are presented from 1996 to 2002.
- **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 1996 through 2002.

- **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 use percentages by drug type are indicated.
- **The Colorado Youth Survey** is an annual statewide survey of 6th through 12th 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

Cocaine indicators remained mixed in 2001 and 2002.

Denver metro cocaine emergency department mentions per 100,000 population increased steadily from 53 in 1996 to 87 in 1999, but declined slightly to only 69 per 100,000 for 2001. However, in the first half of 2002, the 47 cocaine mentions per 100,000 represented a significant 44.3 percent increase over the 33 per 100,000 reported in the first half of 2001.

Also, statewide hospital discharge data (exhibit 3) showed that cocaine mentions per 100,000 increased from 59 in 1996 to 62.8 in 1998, and remained relatively stable through 2001 (63.2 per 100,000). However,

in 2002 the cocaine rate increased sharply to 73.6 per 100,000.

In 1996 there were 47 calls to the Rocky Mountain Poison and Drug Center concerning cocaine. Calls remained at about this level through 1999 (i.e., 50 calls) and increased slightly to 59 calls in 2000. However, in 2001 cocaine calls more than doubled to 127, declining only slightly to 115 in 2002.

Conversely, 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 death mentions (single and in combination with other drugs) in the Denver metro area more than doubled from only 56 in 1997 to 126 in 2001. Statewide, cocaine deaths climbed from 102 in 1996 (27 per million) to 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), and to 153 in 2002 (34.1 per million), the highest number of deaths and the second highest rate 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 2001. These numbers were down slightly in CY 2002, with 32.7 percent of males and 44.6 percent of females testing positive.

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.

Seizure data from the Federal-wide Drug Seizure System (FDSS) also shows the widespread availability of cocaine in Colorado. According to the recent Colorado Drug Threat Assessment produced by the National Drug Intelligence Center (NDIC), federal law enforcement officials reported cocaine seizures in the following quantities; 59.8 kilograms in 1998, 88.6 kilograms in 1999, 132.7 kilograms in 2000, and 69.3 kilograms in 2001.

The DEA reports current cocaine prices as follows: \$18,000 to \$20,000 per kilogram, and \$700-\$1,000 per ounce in the Denver Metro area with purity in the 50 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.

Reports from clinicians, researchers, and street outreach workers around the State corroborate the continuing cocaine problems reflected in the indicator data. However, some qualitative reports indicate a shift to methamphetamine among some stimulant users. Clinicians in programs in **northeast** Colorado say that many of the new stimulant users are using methamphetamine rather than cocaine because it is cheaper and provides a “longer high”. On the other

hand, many in that part of the State report widespread cocaine availability. In addition, they report that cocaine is not just a “rich man’s drug” anymore and that there is increasing use by lower-income laborers (e.g., meat packing workers) so that they can work longer hours. This has furthered reports about increased use among Hispanics. For example, treatment programs in **southeastern** Colorado report increased use among Hispanics who have a history of family use. Likewise, some treatment programs in the **Denver metro area** report that Hispanics are “doing what they are bringing in—they’ve always had it now they are using it”.

Programs around the state report some new users, but mostly describe older clients (i.e., 35 and over) coming into treatment. In addition, programs across Colorado report cocaine/crack use in combination with other drugs like heroin (speedballs) and marijuana (primos).

2. Heroin

For 2001 and 2002, most heroin indicators are mixed with some increasing, some stable and some declining.

DAWN data show that the rate of heroin ED mentions per 100,000 nearly doubled from 1996 (22) to 2000 (41 per 100,000). This rate remained stable in 2001 at 40 per 100,000 population. However, in the first half of 2002, the 26 heroin mentions per 100,000 represents a significant 34.3 percent increase over the 20 per 100,000 reported in the first half of 2001.

Similarly, hospital discharge data (exhibit 3) indicate that opiate mentions per 100,000 population have climbed steadily from only 19.9 in 1996 to 58 in 2002 (a nearly two hundred percent increase).

Heroin related calls to the Rocky Mountain Poison and Drug Center were relatively steady between 1996 (20 calls) and 1998 (22 calls), but increased to 36 in 1999. This was followed by a decline in such calls to only 12 in 2000, an increase to 36 in 2001, and a decline to 18 in 2002.

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 of 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).

Heroin death mentions (single and in combination with other drugs) in the Denver metro area rose from 53 to 79 from 1997 to 1999, declined to 66 in 2000, and then increased to 77 in 2001. Statewide, opiate related deaths increased from 128 (33.5 per million population) in 1996 to 182 (45.9 per million) in 1998. From this peak, such deaths declined to 142 (35.2 per million) and 147 (34 per million) in 1999 and 2000, respectively. However, opiate related deaths

climbed to 160 (36.3 per million) in 2001 and 164 (36.5 per million) in 2002.

As to recent ADAM data for a sample of Denver arrestees, in CY 2001, 5.2 percent of males and only 2.4 percent of females tested positive for opiates. However, in CY 2002 the reverse was true with 5.4 percent of females and 4 percent of males testing positive for opiates.

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 for the first three quarters of FY 2002 reveal that the purity of Mexican heroin ranges from 14 to 29 percent (average purity around 20 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.

According to recently reported FDSS data in the NDIC Colorado Drug Threat Assessment, federal law enforcement officials seized 4.9 kilograms of heroin in 1998, 2.0 kilograms in 1999, 4.9 kilograms in 2000, and 1.2 kilograms in 2001.

Reports from clinicians, researchers, and street outreach workers around the State describe both similarities and variation in heroin and other opiate use. In **northeast** Colorado, clinicians say they do not “see a large number of heroin users”, but they do report a slight increase in inhaled heroin. However, at the same time, they describe increased levels of Hepatitis C among heroin injectors. In **the southeast and south central** part of the State, programs describe heroin as “easier to get”. For example, the San Luis Valley is considered a major dropping point for drugs from Mexico, including heroin. Clinicians in this part of the state are reporting increases in heroin inhalation and smoking because of clients’ fears of ‘infectious diseases’. However, they are also reporting some inhalers and smokers switching to injection because the high is “faster and more intense”.

In the **Denver metro area**, programs are also reporting more white users from suburban areas who are smoking or inhaling heroin because they don’t think they can get addicted, and because they are afraid of infectious diseases. However, they also report some conversion to injecting because of the faster and more intense high. Across the state, clinicians are reporting increased use of Vicodin and Oxycontin.

3. Marijuana

Most marijuana indicators are stable or decreasing for 2001 and 2002.

From 1996 to 2000, the rate per 100,000 of marijuana ED mentions increased more than 2 ½ fold from 19 to 51. The 2001 rate remained stable at 50 per 100,000 population. However, in the first half of 2002, the 22 marijuana mentions per 100,000 represents a small decrease from the 24 per 100,000 reported in the first half of 2001. Marijuana hospital discharge

occurrences per 100,000 (exhibit 3) have risen dramatically from 45.6 in 1996 to 67.2 in 2002.

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 2002. 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 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 2001 ADAM data indicated that 40 percent of the male arrestee sample and 33 percent of the female arrestee sample had positive marijuana urine screens. These percentages remained stable in CY 2002 with 40.3 percent of males and 33.3 percent of females testing positive.

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-\$4,500 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 \$1,500 to \$4,000 per pound and \$200 to \$500 per ounce.

Also, FDSS seizure data presented in the NDIC Colorado Drug Threat Assessment demonstrates the ready availability of marijuana across the state. Federal law enforcement officials seized 882.5 kilograms of marijuana in 1998, 901.6 kilograms in 1999, 718.1 in 2000, and 1591.5 kilograms in 2001.

Uniformly, **across the state**, programs describe two major aspects of marijuana use; it is readily available in a variety of prices and potencies, and it is “not taken seriously as a hard drug by society”. Moreover, many clinicians say that their clients talk about marijuana’s health properties (i.e., medicinal use) as proof that it should be legalized.

4. Stimulants

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

Methamphetamine ED mentions per 100,000 in Denver increased from 7 in 1996 to 19 in 1997, but then declined to only 5 in 2001. Further, the 3 methamphetamine mentions per 100,000 in the first half of

2002 is the same as that reported in the first half of 2001. Conversely, amphetamine ED mentions per 100,000 rose from 6 in 1996 to 21 in 2000 and remained at that level in 2001. Moreover, in the first half of 2002, the 13 amphetamine mentions per 100,000 represents a significant 54.4 percent increase over the 8 per 100,000 reported in the first half of 2001. Amphetamine-related hospital discharge occurrences per 100,000 (exhibit 3) have also shown a fluctuating pattern from 1996 to 2002. However, overall they have increased during that time period from 13.9 to 32.6 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.

Methamphetamine death mentions (single and in combination with other drugs) in the Denver metro area more than tripled from 6 in 1997 to 19 in 2001. However, amphetamine death mentions increased only slightly from 5 in 1997 to 8 in 2001. Though amphetamine related deaths in Colorado are far fewer than for opiates or cocaine, the number has increased sharply from only 16 between 1995 and 1998 to 38 between 1999 and 2002 (a 138 percent increase).

According to ADAM data, only a small percentage of positive methamphetamine urine screens were reported in CY 2001, 3.4 percent of the male arrestee sample and 4.3 percent of the female arrestee sample. These figures did not change for males in CY 2002 (3.4 percent), but increased slightly for females (6.8 percent).

The DEA describes widespread methamphetamine availability, with a majority of the drug originating from Mexico or from large-scale laboratories in California. However, methamphetamine lab seizures in Colorado increased significantly from around 25 in 1997 to 452 in 2001. 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 purity for methamphetamine ranges from 10 to 20 percent. The DEA reports that Colorado methamphetamine street prices are stable at \$80-\$120 per gram, \$700-\$1,000 per ounce, and \$4,500 to \$7,500 per pound.

Reports from clinicians, researchers, and street outreach workers around the State all describe the widespread and growing availability of methamphetamine. In **northeast and southeast Colorado**, programs talk of increased use among Hispanics for a drug that has more typically been seen as an “Anglo drug”. They also report more use among younger age groups (adolescents and early 20s). In the **Denver metro area**, one program described more gay, white men entering treatment for methamphetamine use. A clinician from another program stated “there may have always been a large number of Hispanic users, only now they are coming to America” (i.e., large influx of low-income

workers from Mexico). Some programs report more females using “speed” both for the psychotropic effects and for the weight loss. In general, across the State, clinicians attribute methamphetamine’s increased use to its cheap price and its “longer lasting high” (i.e., in comparison to cocaine).

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 mid 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, and from clinicians and researchers around the state.

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. Also, the 20 MDMA mentions in the first half of 2002 represents a small decline from the 27 reported in the first half of 2001.

Exhibit 4 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. Also, the 13 GHB mentions in the first half of 2002 represents a small increase over the 10 reported in the first half of 2001.

As to the Colorado Youth Survey (Exhibit 4), 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 mention from 1994 through the first half of 2002.

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, but there were 12 and 11 such mentions in 2000 and 2001, respectively. However, there were no ketamine mentions in the first half of 2002.

Interestingly, the Colorado Youth Survey results indicated greater lifetime ketamine use than GHB. As shown in Exhibit 4, 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.

In general, reports from clinicians, researchers, and street outreach workers around the State describe widespread use of the various club drugs, especially MDMA. However, it is uncommon to find clients entering treatment reporting a club drug as their primary drug of abuse.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AMONG INJECTING DRUG USERS

Of the 7,720 AIDS cases reported in Colorado through March 31, 2003, 9.1 percent were classified as IDUs, and 11.1 percent were classified as homosexual or bisexual males and IDUs (exhibit 5).

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%
TOTAL	12991	11757	14301	14511	13109	13183	6529

Source for Exhibit 1 & 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: CHA & CDPHE)
HOSPITAL DISCHARGE
MENTIONS PER 100,000 FOR
SELECTED DRUGS: 1996-2002**

DRUG	1996	1997	1998	1999	2000	2001	2002
AMPHETAMINES	532	959	815	682	942	1161	1463
RATE/100K	13.9	24.6	20.5	16.9	21.8	26.3	32.6
COCAINE	2255	2245	2492	2517	2732	2787	3305
RATE/100K	59.0	57.7	62.8	62.3	63.2	63.2	73.6
MARIJUANA	1740	2118	2227	2204	2455	2755	3016
RATE/100K	45.6	54.4	56.1	54.6	56.8	62.5	67.2
NARC. ANALGS.	760	1458	1566	1639	2053	2237	2605
RATE/100K	19.9	37.5	39.5	40.6	47.5	50.8	58.0
POPULATION	3819789	3892996	3966198	4039402	4324920	4407305	4487727

*Exhibit 4: Club Drug Use Among 6th Through 12th Graders
2002 Colorado Youth Survey:Lifetime Use*

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

Source: Omni Research and Training

**EXHIBIT 5: COLORADO CUMULATIVE AIDS CASES
BY EXPOSURE CATEGORY
THROUGH March 31, 2003**

ITEM	NUMBER	PERCENT
Number of confirmed cases	7720	100%
GENDER		
• Male	7139	92.5%
• Female	581	7.5%
EXPOSURE CATEGORY		
• Men/sex/men	5239	67.9%
• Injecting drug user (IDU)	705	9.1%
• MSM and IDU	860	11.1%
• Heterosexual contact	438	5.7%
• Other	184	2.4%
• Risk not identified	294	3.8%

Source: Colorado Department of Public Health and Environment