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 2003, and amphetamine related deaths from 2000 through 2003 increased 85 percent 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 2003, even thought this percentage decreased from 2002. Also, marijuana ED mentions, which had increased by 55 percent from 1995 to 2000, stabilized during 2001 and declined in 2002. Conversely, marijuana related hospital discharges climbed to their highest level in the 1997 to 2003 time period. Cocaine indicators were mixed in the past two years. Both treatment admissions and new users in treatment remained relatively stable. However, cocaine related deaths increased in 2003, as did hospital discharges and the proportion of arrestees with positive cocaine urine screens. A mixed pattern is also the circumstance for heroin indicators; with hospital discharges and ED mentions increasing, ADAM data stable, and deaths, treatment admissions and new users in treatment down slightly. There is also some indication of a small but increasing problem with opiates other than heroin (e.g., Oxycontin). Finally, limited indicator and treatment data, statistics from the 2002 Colorado Youth Survey and most anecdotal data point to a continuing 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 2000 census, the Denver PMSA population was 2,143,991. By the end of 2004, this is expected to increase by 6.5 percent to 2,282,264. In general, Colorado has been one of the top five fastest growing States in the country.

Statewide the population is expected to increase from the 2000 census figure of 4,335,540 to 4,626,199 by the end of 2004, or by 6.7 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.

- The Colorado unemployment rate was 4.9 percent as of March 2004, which is down slightly from 5.6 percent in September 2003. As for the Denver metropolitan area, the unemployment rate was 5.9 percent as of February 2004, about the same as a year earlier.

2. Data Sources and Time Periods

Data presented in this report were collected and analyzed in April and May 2004. 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 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 2002 are provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) through its Drug Abuse Warning Network (DAWN).

- **Hospital discharge data** statewide for 1997-2003 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 1997 through 2003. 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 Field Division (DFD) officials in their second quarter FY 2004 report.

- **Death statistics and communicable disease data** are available from the Colorado Department of Public Health and Environment (CDPHE). Data are presented from 1997 to 2003.

- **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 2003.

- **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, CY 2002 and CY 2003 use percentages by drug type are indicated.

DRUG ABUSE TRENDS

1. Cocaine and Crack

Cocaine indicators remained mixed in 2001 through 2003 with some increasing, some stable and some declining.

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, they increased again to 82 in 2002, although the increase was not statistically significant.

Also, statewide hospital discharge data (exhibit 3) showed that cocaine mentions per 100,000 increased from 57.7 in 1997 to 62.8 in 1998, and remained relatively stable through 2001 (63.2 per 100,000). However, in 2002 and 2003 the cocaine rates increased sharply to 73.6 and 77.9 per 100,000, respectively.

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. Moreover, in 2003 RMPDC cocaine related calls increased to about the 2001 level (126).

The proportion of cocaine treatment admissions declined from 1997 (27.1 percent) through 2000 (21.1 percent) but then stabilized through 2003 (21.9 percent). Likewise, the proportion of "new" cocaine users entering treatment, defined as those admitted to treatment within 3 years of initial cocaine use, has remained relatively level during the 1997 to 2003 time period. As shown in exhibit 2, new cocaine users increased slightly from 13.8 percent in 1997 to 17 percent in 2000, declined to 14.9 percent by the end of 2002; but increased to 16.5 percent during 2003.

Treatment admission data indicate that cocaine injecting had remained relatively stable from 1997 (11.6 percent) through 2002 (11.4 percent), but declined to 9.4 percent in 2003. Smoking percentages had declined steadily from 65.4 percent in 1997 to 57.5 percent in 2001, but rebounded to 62.9 percent in 2003. Conversely, inhalation had been steadily increasing from 19.4 percent in 1997 to 26.1 percent in 2001, but declined slightly to 23.5 percent in 2003.

In general, the race/ethnicity proportions for cocaine treatment admissions have been changing somewhat. Whites accounted for the largest percentage of cocaine admissions in 2003 (44.7 percent). However, this is a small decline from their proportion of total cocaine clients in 2000 (48.2 percent). Hispanic cocaine admissions increased dramatically from only 19.3 percent in 1997 to 28.8 percent in 2000. While this proportion declined to 26 percent in 2001, it rose to 2000-levels in CY 2002 (28 percent) and stayed at that level in 2003 (28.9

percent). Conversely, African-American cocaine admissions dropped sharply from 33.2 percent in 1997 to only 19.5 percent in 2001, but this proportion increased slightly in 2002 (23 percent) and in 2003 (23.6 percent).

Likewise, age categories have been changing since 1997. In 1997, 56.1 percent of cocaine admissions were under thirty-five; this decreased to 49.9 percent in 2003. Conversely, cocaine admissions 35 and over have climbed relatively steadily during the same time period from 43.9 to 50.2 percent. Cocaine admissions remain predominantly male, with the proportion growing slightly from 1997 (56.9 percent) through 2003 (62.1 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. However, such deaths declined slightly to 108 in 2002. Statewide, cocaine deaths climbed from 92 in 1997 (23.6 per million) to146 in 1999 (36.1 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). Provisional data from 2003 places cocaine deaths at 179 (39.2), the highest number and 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 43.6 percent of females testing positive. However, in 2003, 38.3 percent of males and 52.5 percent of females tested positive for cocaine

The Denver Field Division of the DEA reports that Colorado "is an established distribution point for major cocaine organizations transporting large drug shipments from Mexico and distributing them throughout the United States."

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: $14,000 to $18,500 per kilogram, and $600-$700 per ounce in the Denver Metro area with purity in the 16 to 90 percent range (average 76 percent); and $14,000-18,000 per kilo, $500-900 per ounce with purity in 20 to 82 percent range (average 64 percent) in western Colorado.

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 through 2003, most heroin indicators are mixed.

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 2002, the 43 heroin mentions per 100,000 represents a significant 9.8 percent increase over the 40 per 100,000 reported in 2001.

Similarly, hospital discharge data (exhibit 3) indicate that opiate mentions per 100,000 population have climbed steadily from 37.5 in 1997 to 68.7 in 2003 (an 83.2 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 19 in 2002. However, in 2003 heroin RMPDC calls increased to 28.

Among Colorado treatment admissions (exhibit 1), the proportion and number for heroin remained fairly stable from 1997 (13.7 percent) through 2001 (14 percent), with a slight decline to 12.3 percent during 2002. Data from 2003 show heroin admissions remaining at about the prior year's level (13 percent). The proportion and number of new heroin users entering treatment, after increasing from 16.5 percent in 1997 to 20.3 percent in 2000, began a steady decline to 15.5 percent in 2003 (exhibit 2). This is the lowest such proportion in the time period shown.

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 relatively stable from 1997 (33 percent) through 2003 (32 percent). However, race/ethnicity proportions have changed slightly during this same time period. Whites have increased as a percentage of total from 61.5 percent in 1997 to 64.7 percent in 2003. Conversely, from 1997 through 2002, the proportion of Hispanics decreased from 27.2 percent to 22.8 percent. However, in 2003, the proportion of Hispanic clients rose somewhat to 24.2 percent. Also, the 25 and under age group has increased as a percentage of heroin admissions from only 15.1 percent in 1997 to 19.6 percent in 2002. Interestingly, during 2003, the proportion of heroin admissions that are 25 and younger declined to only 14.5 percent.

Accompanying the heroin client demographic realignments, are small changes in route of administration, with heroin smoking and inhalation becoming more common. In 1997, only 7.3 percent of treatment admissions reportedly smoked or inhaled heroin, compared with 8.9 percent in 1998, 8.6 percent in 1999, 8.5 percent in 1999, 10.1 percent in 2000, 9.6 percent in 2001, and 11.9 percent in 2002. However, in 2003, the combined percentage of smokers and inhalers declined slightly to 11.3 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. However, in 2002 such deaths decreased to 64. Statewide, opiate related deaths increased from 141 (36.2 per million population) in 1997 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. Provisional data for 2003 show that opiate related deaths decreased slightly to 152, or 33.3 per million population.

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 5.3 percent of females and 4 percent of males testing positive for opiates. In CY 2003, male arrestees again showed a slightly higher percentage of positive heroin urines (6.8 percent) than female arrestees (6.1 percent).

The DEA reports that heroin availability is increasing in Colorado. As stated in their most recent quarterly report, "there were significant heroin seizures in western Colorado in early 2004. In some instances, multi-pound quantities of heroin were discovered in vehicles traveling eastbound to Denver. Intelligence and investigative information gleaned from the seizures indicated that the heroin originated with sources of supply based in Mexico." Heroin can be obtained for about $1,050 to $1,200 per ounce in the Denver area, with purity placed at 25 percent (street level).

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.

3. Other Opiates

Opiates other than heroin (i.e., narcotic analgesics) include hydrocodone, hyromorphone, codeine, and oycodone. Denver metro emergency department mentions per 100,000 population for "narcotic analgesics and combinations" climbed from 22 in 1995 to 34 in 2002. Although the 2002 rate is a down from the 2000 (38) and 2001 (41) rates, it still constitutes a statistically significant 50.1

percent increase from 1995. Examining specific numbers, hyrocodone/combination ED mentions (i.e., number – not rate) climbed from 65 in 1995 to 150 in 2002, a statistically significant increase of 130.8 percent. Likewise, oxycodone/combination (which includes Oxycontin) increased from 57 ED mentions in 1995 to 116 in 2002 (a statistically significant increase of 103.5 percent). Also, as discussed above in the section on Heroin, statewide opiate related hospital discharges have increased 83 percent from 1997 to 2003.

As to treatment, other opiates admissions have more than doubled from 254 in 1997 (2.2 percent of total) to 573 in 2003 (4.2 percent). However, the percentage of new users during this time has remained relatively stable (e.g., 19.3 percent in 1997, 21 percent in 2000 and 21.5 percent in 2003).

Opiate related death mentions in the Denver metro area decreased from 71 in 1999 to 64 in 2000, but increased again to 106 in 2001. Data from 2002 place opiate related deaths at 94.

The DEA reports that diversion of Oxycontin continues to be a "major problem" in the Rocky Mountain West. It sells on the street for $1 per milligram, which is ten times the legal prescription price. The DEA also reports that pharmacy break-ins are common throughout the Rocky Mountains, with Oxycontin leading the list of drugs stolen. Also, across the state, clinicians are anecdotally reporting increased use of Vicodin and Oxycontin.

4. Marijuana

Marijuana indicators are currently mixed.

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 2002, the 38 marijuana mentions per 100,000 represents a substantial, but not statistically significant decrease from the prior year. Marijuana hospital discharge occurrences per 100,000 (exhibit 3) have risen dramatically from 54.4 in 1997 to 71.1 in 2003.

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. In 2002, the number of calls dropped slightly to 89, but climbed to 95 in 2003.

Marijuana treatment admissions increased from 37.9 percent in 1997 to 43.7 percent in 1999. However, since that time they have declined to 40.6 percent in 2001, to 36.4 percent in 2002, and to only 31.7 percent in 2003. However, during the time period described above, marijuana users have accounted for the largest proportion of all Colorado drug treatment clients (exhibit 1).

The proportion of new users entering treatment for marijuana had been declining steadily from 1997 (37.4 percent) through 1999 (27.8 percent). However, in 2000 this proportion climbed somewhat to 33.2 percent, remained at about that level (32.9 percent) during 2001, dropped slightly to 29.6 percent in 2002, but rose back to 32.9 percent in 2003 (exhibit 2).

Data indicate only slight changes in the demographics of marijuana treatment clients. Race proportions remained relatively stable from 1997 through 2003. Hispanics increased as a percentage of marijuana admissions from 29.6 percent in 1997 to 36.7 percent in 1999, but declined to only 27.5 percent through 2003. The

proportion of Whites has fluctuated up and down only slightly from 1997 (57.5 percent) through 2003 (56.8 percent). African-Americans had constituted between 6.5 and 9.4 percent of marijuana admissions between 1997 and 2001, but rose to 11.3 percent in 2003, the highest proportion during the seven-year time period. Male to female marijuana admission ratios have remained at approximately 3 to 1 from 1997 through 2003.

There have also been small changes in the marijuana age group proportions from 1997 through 2003. The proportion of those 12 to 17 has shown peaks and valleys during this time period, declining from 45.3 percent in 1997 to 36.3 percent in 1999, increasing to 44.6 percent in 2001, dropping again to 39.5 percent in 2002, but climbing to 43.3 percent in 2003. The18 to 25 year-olds showed smaller fluctuations during this time period, but overall this age group increased slightly from 26 percent in1997 to 28.2 percent in 2003. However, the 26 to 34 age group proportion has remained relatively stable from 1997 (15.4 percent) through 2003 (15 percent). On the other hand, the 35 and older age group proportion, which had increased from 12.9 percent in 1997 to 22.7 percent in 1999, has dropped to 13.2 percent through 2003.

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 32.6 percent of females testing positive, but increased slightly in CY 2003 (42.3 percent positives for males and 34.3 percent positives for females).

The Denver DEA reports widespread availability of marijuana; and that the "most abundant supply is Mexican grown and is trafficked into and through the area from California, Texas, New Mexico, and Arizona by Mexican poly-drug trafficking organizations." Mexican marijuana sells at a price range of $500 to $1000 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.

5. Stimulants

While methamphetamine and other stimulant use in Denver and across Colorado have fluctuated from 1997 through 2003, 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 and remained at that level in 2002. Conversely, amphetamine ED mentions per 100,000 rose from 6 in 1996 to 21 in 2000, remained at that level in 2001 and increased to 24 in 2002. However, this increase was not statistically significant. Amphetamine-related hospital discharge occurrences per 100,000 (exhibit 3) had shown a downward trend from 1997 (24.6) to 1999 (16.9). However, since 1999, they have more than doubled to 42.4 in 2003.

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. Also, in 2002 and 2003 amphetamine calls remained at a high level (247 and 239, respectively).

Methamphetamine treatment admissions had declined from 14.9 percent of drug admissions in 1997 to 10.7 percent in 1999. However, from that point they have risen to their highest level in 2003 (23.2 percent), and are now second only to marijuana as a primary drug reported by clients admitted to treatment. Other stimulant admissions are typically only a fraction of those for methamphetamine. However, from 1997 to 2002 they nearly tripled from 100 (.9 percent of admissions) to 276 (2 percent of admissions), and declined only slightly to 224 admissions (1.6 percent) in 2003 (exhibit 1).

In 1997, 30.7 percent of primary meth-amphetamine users entering treatment were new users (exhibit 2). This percentage declined steadily to only 20.8 in 2002. However, in 2003, the proportion of new methamphetamine users climbed to 23.1 percent, or about the same as in 1999 (23 percent).

A comparison of CY 2002 "new" methamphetamine users (i.e., entering treatment within the first three years of use – N=531) to "old" methamphetamine users (i.e., entering treatment after four or more years of use - N=2022) shows dramatic differences between these two groups. Demographically, the new users are more often female (53.3 percent) –vs.- old users (44.6 percent); and less often White/non-Hispanic (77 percent) than old users (83.2 percent). Also, somewhat expectedly, new users have a higher proportion of those 25 and younger (58.2 percent) as compared to old users (only 27.3 percent). Accordingly, new users are much more likely to have never been married (63.3 percent) than old users (44.7 percent). As to employment, old users are somewhat more likely to be employed full or part time (36.6 percent) than new users (30.1 percent).

Looking at "severity" data, old users are much more often methamphetamine injectors (33.7 percent) than new users (15.4 percent), while new users report a higher proportion of smokers (67 percent) than the old user group (48.1 percent). Also, old users are more likely to have a diagnosis of drug dependence (28.6 percent) -vs.- new users (23.2 percent). Interestingly, however, new users report a higher proportion of concurrent mental health problems (31.1 percent) than their old user counterparts (27.4 percent). Both new and old users averaged one arrest in the two years prior to treatment admission, while old users averaged 7 prior lifetime treatment episodes –vs.- 2 among new users. Also, about the same proportion of old and new users (23 percent and 20 percent, respectively) reside in the Denver metropolitan area. Similarly, a

like proportion of old and new users live on the "Western Slope" of Colorado (16 percent and 15 percent, respectively).

Injecting had been the most common route of administration for methamphetamine. However, the IDU proportion has been declining from 1997 (32.6 percent) to 2003 (23.5 percent), while smoking has become increasingly common in the last seven years. In 2003, nearly 61 percent of methamphetamine treatment admissions smoked the drug, compared with only 29.1 percent in 1997.

Methamphetamine treatment admissions for 2003 remain predominately White (82.4 percent), although the Hispanics have increased in treatment from 6.5 percent in 1997 to 12.7 percent in 2003. Females have accounted for slightly less than half of methamphetamine admissions from 1997 (47.2 percent) to 2003 (49.5 percent). As to age, from 1997 to 2003, those 25 and under have declined from about 41 percent of admissions to 37.8 percent, while those 26 to 34 have remained at about one-third of admissions during the entire time period. The 35 and over group proportion has increased slightly from 25.3 percent to 28.7 percent 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, and stayed at about that level in 2002 (N=17). 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 20 between 1996 and 1999 to 37 between 2000 and 2003 (an 85 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 increased slightly for males in CY 2002 (3.8 percent), and slightly more for females (6.6 percent). Again, only small changes were noted in CY 2003, with 4.7 percent of males testing positive and 5 percent of females.

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 464 in 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 purity for methamphetamine ranges all the way from 1 to 82 percent, averaging 26.2 percent in the Denver area. However, in western Colorado, methamphetamine purity ranges from 51 to 96 percent, averaging 62.3 percent.

Methamphetamine street prices are $700 per ounce, $3,800 per ¼ pound, $5,000 per ½ pound in the Denver area; and $1,200 to $1,250 per ounce and $18,000 per pound in western Colorado.

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).

6. 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, while still limited, is expanding. ADAD added club drugs to the enhanced DACODS data set in July 2002. Also, 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. Data from all the above sources is discussed below.

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. RMPDC data on MDMA were not available in 2000 and 2001; however, in 2002 and 2003 there were 42 and 27 MDMA calls, respectively. 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 33 MDMA mentions in 2002 represent a statistically significant 21.4 percent decline from the prior year.

In CY 2003, there were 38 clients admitted to treatment claiming MDMA as their primary drug of abuse. Twenty-eight of the MDMA admissions were male and 10 were female. Twenty-four of these clients were White (non-Hispanic), while 7 were Hispanic. Nine of the clients were 12 to 17, fifteen were 18 to 25, four were 26 to 34, and ten were 35 and over. Interestingly, 24 of the MDMA users took it orally, while 11 were smokers, 1 inhaled and 1 injected. Of the 25 MDMA users who used a secondary drug; 9 used marijuana, 5 used alcohol, 4 used cocaine and 4 used methamphetamine (3 used other drugs).

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 twenties or early thirties who get their MDMA from Nevada or California, with source connections in Europe. However, Mexican trafficking organizations are making inroads in the Colorado MDMA market. They place the one tablet or capsule price at $15 to $25, with larger quantities selling for $8 to $16 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. RMPDC data for GHB wasn't available in 2000, but in 2001, 2002 and 2003 there were 21, 22, and 6 GHB calls, respectively. 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 and 15 in 2002 (a statistically significant 65 percent decline from 2000 to 2002).

In CY 2003, there were 5 clients admitted to treatment claiming GHB as their primary drug of abuse. Four were female and only one was male. As to race, two were White, and one each was Black, Native American and Asian. Curiously, three of the five were 35 and older. Four had taken the drug orally, while one claimed they had smoked it.

The DEA reports that GHB is readily available in Colorado and that the majority of customers are white and in their twenties or thirties. Past DEA reports have placed the GHB price at $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 and there were no Rohypnol calls from 2000 through 2003. Also, there have been only two ED mentions from 1994 through 2002.

In CY 2003, there were 15 clients admitted to treatment claiming Rohypnol as their primary drug of abuse. Thirteen were male and only two were female. As to race, ten were White and five were Hispanic. Also, ten were 35 and older. Eleven had taken the drug orally, while two reported smoking, and two said they had injected

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 2003. 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 2002.

In CY 2003, there were seven clients admitted to treatment reporting Ketamine as their primary drug of abuse. Six were White and one was Hispanic, six were male, and five were under 35.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) AMONG INJECTING DRUG USERS

Of the 7,998 AIDS cases reported in Colorado through December 31, 2003, 9.3 percent were classified as IDUs, and 11.0 percent were classified as homosexual or bisexual males and IDUs (exhibit 4).

1997-2003 Exhibit 1: Treatment Admission by Drug Type

DRUG	1997	1998	1999	2000	2001	2002	2003
Heroin	1613	1894	2086	1896	1841	1701	1786
%	13.7%	13.2%	14.4%	14.5%	14.0%	12.3%	13.0%
Non-Rx Methadone	16	30	31	25	28	34	23
%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Other Opiates N	254	331	392	421	500	496	573
%	2.2%	2.3%	2.7%	3.2%	3.8%	3.6%	4.2%
Methamphetamine N	1748	1931	1554	1710	2058	2555	3189
%	14.9%	13.5%	10.7%	13.0%	15.6%	18.5%	23.2%
Other Stimulants N	100	97	153	202	158	276	224
%	0.9%	0.7%	1.1%	1.5%	1.2%	2.0%	1.6%
Cocaine N	3182	3798	3432	2768	2722	3013	3012
%	27.1%	26.6%	23.7%	21.1%	20.7%	21.8%	21.9%
Marijuana N	4459	5686	6339	5571	5357	5022	4362
%	37.9%	39.8%	43.7%	42.5%	40.6%	36.4%	31.7%
Hallucinogen N	75	99	108	108	97	51	26
%	0.7%	0.7%	0.7%	0.8%	0.7%	0.4%	0.2%
PCP N	2	2	8	9	6	6	12
%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%	0.1%
Barbiturates N	17	23	21	9	9	46	63
%	0.1%	0.2%	0.1%	0.1%	0.1%	0.3%	0.5%
Sedatives N	24	29	26	38	22	270	156
%	0.2%	0.2%	0.2%	0.3%	0.2%	1.9%	1.1%
Tranquilizers N	88	97	130	79	78	89	103
%	0.8%	0.7%	0.9%	0.6%	0.6%	0.7%	0.7%
Inhalants N	100	117	71	67	72	44	58
%	0.9%	0.8%	0.5%	0.5%	0.6%	0.3%	0.4%
Club Drugs N	N/A	N/A	N/A	N/A	N/A	32*	62**
						0.3%	0.5%
Other N	79	167	160	206	235	168	106
%	0.7%	1.2%	1.1%	1.6%	1.8%	1.2%	0.8%
TOTAL	11757	14301	14511	13109	13183	13803	13755

Source for Exhibit 1 & 2: DACODS

***Includes MDMA (11), GHB (9), Ketamine (3) and Rohypnol (9). Began collecting in July 2002.**

**** Includes MDMA (15), GHB (1), Ketamine (2) and Rohypnol (7).**

EXHIBIT 2: ANNUAL PERCENTAGE OF HEROIN, METHAMPHETAMINE, COCAINE AND MARIJUANA USERS ENTERING TREATMENT WITHIN THREE YEARS OF INITIAL USE: 1997-03

DRUG	1997	1998	1999	2000	2001	2002	2003
HEROIN N	250	327	359	374	322	292	271
%	16.5%	18.6%	18.3%	20.3%	18.0%	17.6%	15.5%
METHAM N	487	529	343	368	425	511	701
%	30.7%	29.0%	23.0%	22.3%	21.1%	20.8%	23.1%
COCAINE N	409	519	448	448	411	433	472
%	13.8%	14.6%	14.2%	17.0%	15.7%	14.9%	16.5%
MARIJ. N	1549	1685	1612	1752	1715	1434	1386
%	37.4%	32.5%	27.8%	33.2%	32.9%	29.6%	32.9%

EXHIBIT 3 **(Source: CHA & CDPHE)**
HOSPITAL DISCHARGE MENTIONS PER 100,000 FOR SELECTED DRUGS: 1997-2003

DRUG	1997	1998	1999	2000	2001	2002	2003
AMPHETAMINES	959	815	682	942	1161	1463	1936
RATE/100K	24.6	20.5	16.9	21.8	26.3	32.6	42.4
COCAINE	2245	2492	2517	2732	2787	3305	3588
RATE/100K	57.7	62.8	62.3	63.2	63.2	73.6	77.9
MARIJUANA	2118	2227	2204	2455	2755	3016	3246
RATE/100K	54.4	56.1	54.6	56.8	62.5	67.2	71.1
NARC. ANALGS.	1458	1566	1639	2053	2237	2605	3137
RATE/100K	37.5	39.5	40.6	47.5	50.8	58.0	68.7
POPULATION	3892996	3966198	4039402	4324920	4407305	4487727	4567642

EXHIBIT 4: **COLORADO CUMULATIVE AIDS CASES BY EXPOSURE CATEGORY THROUGH December 31, 2003**

ITEM	NUMBER	PERCENT
Number of confirmed cases	**7998**	**100%**
GENDER		
▪ **Male**	**7382**	**92.3%**
▪ **Female**	**616**	**7.7%**
EXPOSURE CATEGORY		
▪ **Men/sex/men**	**5393**	**67.4%**
▪ **Injecting drug user (IDU)**	**740**	**9.3%**
▪ **MSM and IDU**	**882**	**11.0%**
▪ **Heterosexual contact**	**468**	**5.9%**
▪ **Other**	**186**	**2.3%**
▪ **Risk not identified**	**329**	**4.1%**

Source: Colorado Department of Public Health and Environment