

---

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

**Nancy E. Brace, R.N., M.A.**  
**Alcohol and Drug Abuse Division**  
**Colorado Department of Human Services**  
**January 2005**

*Alcohol remains Colorado's most frequently abused substance and tobacco is responsible for 4,200 deaths in Colorado annually. Excluding alcohol and tobacco, the use and trafficking of illegal drugs continues to be an expanding problem for Colorado with much of the transporting, distribution and selling of illegal substances supported by organized crime entities. Cocaine has consistently had the highest drug incidence rate per 100,000 population for emergency department mentions, drug-related hospital discharges and drug-related mortality rates since 1996 through the first six months of 2004. Cocaine also had the highest number of drug-related calls to the Rocky Mountain Poison and Control Center for calendar years 2001-2003. In the first half of 2004 methamphetamine exceeded cocaine in the number of these calls. In 2003 methamphetamine also surpassed cocaine in the number of treatment admissions. Drug enforcement officials and treatment providers have corroborated this increase in methamphetamine use and trafficking in Colorado. Marijuana use continues to result in the highest number of treatment admissions annually since 1997 and in the highest percentage of users entering treatment within 3 years of initial use. Methamphetamine takes second place in the latter category, surpassing both cocaine and heroin. Most indicators for heroin are decreasing, however experts in the field report an increase in OxyContin use, especially among adolescents. Initial use for most of these illegal substances seems to be occurring at a younger age.*

### **INTRODUCTION**

#### **1. Area Description**

Denver, the capital of Colorado, is located slightly northeast of the State's geographic center. Covering only 154.6 square miles, Denver is bordered by several large suburban counties and one smaller county: Arapahoe on the southeast, Adams on the northeast, Jefferson on the west, Broomfield (the smallest county) on the northwest and Douglas on the south. These areas make up the Denver Population and Metropolitan Statistical Area or PMSA. In recent years, Denver and the surrounding counties have experienced rapid population growth.

According to the 2000 census, the Denver PMSA population was 2,143,981. By the end of 2004, this was expected to increase by 7.0 percent to 2,292,834, and in 2005 by an 8.0 percent increase to 2,320,287. Colorado is third in the top five fastest growing States in the country. Statewide the population is expected to increase from the 2000 census figure of 4,339,549 to 4,706,754 by the end of 2005, or by 8.5 percent. The Denver metropolitan area accounts for 12 percent of Colorado's total population. The Denver PMSA accounts for 50 percent of the total state population.

The median age in the Denver area is 33.1. Males comprise 50.5 percent and females 49.5 of the population. Ethnic and racial characteristics of the area are: whites 65 percent, Black or African American 11 percent, American Indian 1 percent, Asian 3 percent and Native Hawaiian and Other Pacific Islanders 0.1 percent. Hispanics or Latinos of any race are 32 percent of the area's population.

The average household size is 2.27 and the average family size is 3.14. For the population 25 years of age and higher, 79 percent are high school graduates or higher, and 35 percent have Bachelor's degrees or higher.

The median household income is \$39,500 and the median family income is \$48,185. Eleven percent of families and 14 percent of individuals in the area are below the poverty level.

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;
- rapid population growth;
- remote rural areas ideal for the undetected manufacture, cultivation, and transport of illicit drugs;
- a young citizenry 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; and
- the preliminary Colorado unemployment rate was 5.0 percent as of November 2004, which is down slightly from 5.8 percent in November 2003. As for the Denver PMSA, the unemployment rate was 5.0 percent as of November 2004, a decrease of 1 percent from a year earlier.

## 2. Data Sources and Time Periods

Data presented in this report were collected and analyzed in December 2004 and January 2005. 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 December 13, 2004 were provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) through its Drug Abuse Warning Network (DAWN LIVE web-based data system).
- **Drug-related mortality data** for the Denver metropolitan area for 1997 through December 13, 2004 were provided by the Substance Abuse and Mental Health Services Administration (SAMHSA) DAWN data.
- **Hospital discharge data** statewide for 1997-2003 were provided by 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 from 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 licensed by ADAD. Annual figures are given for 1997 through the first half of calendar year 2004 (annualized unless otherwise noted). DACODS data are collected and analyzed by the Alcohol and Drug Abuse Division (ADAD), Colorado Department of Human Services. Some state fiscal year data has been taken from ADAD's annual report to the legislature, "The Costs and Effectiveness of Alcohol and Drug Abuse Programs in the State of Colorado, October 29, 2004."
- **Availability, price, and distribution data** were collected from local Drug Enforcement Administration (DEA) Denver Field Division (DFD) officials in their fourth quarter FY 2004 report, the Office of National Drug Control Policy (ONDCP), Drug Policy Information Clearinghouse, "Denver, Colorado, Profile of Drug Indicators, June 2004" and from the December 28, 2004 issue of Narcotics Digest Weekly, Volume 3, Number 52.
- **Death statistics and communicable disease data** were obtained 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 were 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.
- **Sentencing Data** on federal drug convictions in the state of Colorado for federal fiscal year 2002 were compiled by the United States Sentencing Commission, Office of Policy Analysis.
- **Information about offenders in the Colorado Correctional system** for substance abuse related crimes was supplied by The Colorado Department of Corrections, Overview of Substance Abuse Treatment Services Fiscal Year 2003 and by the Colorado Department of Corrections Statistical Report, Fiscal Year 2003.
- **Statistics on seized and forensically analyzed drug items** were provided by the Drug Enforcement Administration, Office of Diversion Control, National Forensic Laboratory Information System (NFLIS) Year 2003 Annual Report, from information reported by the Denver Police Department Crime Laboratory.

- **Alcohol data** were taken from the “U.S. Apparent Consumption of Alcoholic Beverages Based on State Sales” by the U.S. Department of Health and Human Services, June 2004, the Rocky Mountain Insurance Information Association (RMIIA), the Department of Transportation Fatality Analysis Reporting System (FARS) and Colorado State Patrol statistics.
- **Tobacco statistics** for 2003 were provided by “Colorado Health Watch 2004,” a publication of the Colorado Department of Public Health and Environment.
- **Population statistics** were obtained from the Colorado Demography Office, Census 2000 including estimates and projections, and factfinder.census.gov.

## DRUG ABUSE TRENDS

### 1. Alcohol

Alcohol continues to be the most abused substance in the state. Colorado ranks 19 percent higher than the national average and 5<sup>th</sup> in the nation in per capita consumption of beverage alcohol. Alcohol use disorders are medically based disorders related to abuse of or dependence on alcohol.

Alcohol was the most frequently mentioned drug in emergency room visits for the Denver area (83 per 100,000) (Exhibit 1).

During the first half of calendar year 2004, 40 percent of all clients admitted to treatment stated their primary drug of abuse was alcohol. Seven percent of these clients were under the age of 18. Of those 18 years of age or older, 64 percent began using alcohol before 18 years of age.

During state FY04 (July 1, 2003 through June 30, 2004) ADAD reported 44,514 detoxification discharges and 22,372 discharges from the Drinking Driver DUI education and therapy program. Untreated alcoholism accounts for some of Colorado’s greatest concerns, such as poverty, violent crimes, homelessness, domestic violence, vehicular crashes, overcrowded jails, overcrowded emergency and foster care systems. Each year Colorado spends \$4.4 billion in costs related to untreated substance abuse, adding a substantial financial burden to taxes and already stressed governmental resources.

Even though laws exist that prohibit selling alcoholic beverages to minors, alcohol is the number one drug of choice for adolescents in Colorado. It is readily available and inexpensive. Purveyors apparently target younger age groups. Two recent marketing trends are “jello shots,” a mixture of alcohol with fruit-flavored gelatin, and sweet soda-pop flavored alcoholic beverages.

Colorado’s Youth Risk Behavior Survey noted that almost 50 percent of students in grades 9-12 during 2003 currently were using alcohol, and 80 percent had one or more drinks of alcohol in their lifetime.

Abuse of alcohol at an early age is frequently a precursor to use and abuse of illegal substances. Recently deaths related to binge drinking on college campuses have brought national notoriety to Colorado, with 5 confirmed deaths of college age individuals from alcohol poisoning.

Moderate use of alcohol among adults is culturally acceptable and denial of abuse is particularly difficult to overcome. The average treatment client in Colorado with alcohol as a primary drug, uses or abuses it for 16 years before seeking treatment. For

detoxification clients that time period expands to 20 years.

In 2003, the Colorado State Patrol which deals with approximately 30 percent of all vehicular crashes in the state, reported 2,161 vehicular crashes directly caused by individuals driving under the influence of alcohol. FARS data indicated in 2003 that 39 percent (246) of the 632 individuals killed in Colorado in vehicular crashes involved alcohol.

The Colorado Department of Public Health and Environment reported 511 alcohol-induced deaths unrelated to motor vehicular accidents. In 2003 the Colorado Department of Corrections identified 82 percent (4,315) of all (5,276) court commitments, 20.2 percent of all inmates (18,636) and 85 percent (5,752) of all prison releases as substance abusers.

Emergency department mentions for alcohol for the Denver area peaked in 1999 and 2000 (107 per 100,000 and 109 per 100,000 respectively) and declined slightly with the rate remaining steady from 2002 through the first six months of 2004 (83 per 100,000, annualized) (Exhibit 1). Statewide drug-related hospital discharges rose yearly from 418 per 100,000 in 1998 to 518 per 100,000 in 2003 (Exhibit 2).

The number of alcohol-related calls statewide to the Rocky Mountain Poison Control Center increased markedly from 110 in 2001 to 223 in calendar year 2004 (Exhibit 3).

Alcohol-related mortality data for the Denver PMSA also increased steadily from 47 in 1996 to 86 in 2002 (Exhibit 4).

Treatment data from the Alcohol and Drug Abuse Division for the Colorado

Department of Human Services indicated alcohol was the primary drug in approximately 40 percent of all admissions from 1997 through the first six months of 2004 (Exhibit 5). Of the four “generations” of Colorado citizens (the Y generation, the X generation, Baby Boomers and Seniors), sedative and tranquilizers (including alcohol and marijuana) are the drugs of choice for Baby Boomers (Exhibit 6). The X generation is equally split between sedatives and tranquilizers and stimulants as their drugs of choice.

## **2. Tobacco**

Tobacco use is the leading cause of preventable death and disability in the state, and one of Colorado’s most serious public health problems. Tobacco use is responsible for more than 4,200 deaths and development of 130,000 tobacco related illnesses in adults annually. Smoking tobacco causes 30 percent of all cancer deaths, 21 percent of coronary heart disease-related deaths, and 18 percent of stroke deaths. 193,000 children in the state are exposed to secondhand smoke at home, resulting in asthma and respiratory illnesses.

Annual health care costs directly related to smoking exceed \$1 billion (or \$259 per capita) in the state. Every Colorado household incurs more than \$511 per year in state and federal taxes to pay for smoking-related health care costs.

Approximately 630,000 (19 percent) of all Colorado adults use tobacco products, compared to the 23 percent nationwide average. Sixty-eight percent of clients who received substance abuse treatment and/or detoxification services in state Fiscal Year 2004 used tobacco products daily.

Laws enacted in Colorado prohibit the sale of tobacco products to adolescents (less than 18 years of age). In spite of that, the Youth Risk Behavior Survey identified 27 percent of students in grades 9-12 as current cigarette smokers. Adolescents who smoke are more likely to smoke as adults and be at risk for tobacco-related illnesses.

The sale of tobacco products is monitored by Colorado's Department of Revenue Tobacco Enforcement Division, and tobacco prevention efforts fall primarily under the purview of the Department of Public Health and Environment.

### **3. Cocaine and Crack**

Cocaine indicators remained mixed with some increasing and some decreasing.

Denver emergency department mentions for cocaine increased steadily from 1996 (53 per 100,000) through 2002 (82 per 100,000). In 2004, however, annualized January through June data indicate a downward trend with 61 per 100,000. Cocaine was the most common illegal drug mentioned in Denver area emergency departments and second only to alcohol in all drug mentions.

Statewide hospital discharges showed that cocaine mentions per 100,000 rose steadily from 1997 (56 per 100,000) through 2003 (80 per 100,000).

The number of cocaine-related calls to the Rocky Mountain Poison and Control Center rose statewide from 2001 (59) through 2003 (68) and during that time period cocaine was the most frequent drug of concern second only to alcohol. In 2004 the number of calls regarding methamphetamine (66) exceeded those of cocaine (59).

Cocaine-related mortality data for the Denver PMSA rose from 1996 (68) to 2001 (126), then declined slightly in 2002 to 108. Throughout this entire time period, cocaine-related mortality was higher than any other drug in the area.

Statewide, cocaine deaths climbed from 92 in 1997 (23.6 per million) to 146 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). Data from 2003 places cocaine deaths at 179 (39.2), the highest number and rate in the time period indicated.

Reports from clinicians, researchers, and street outreach workers around the State corroborate the continuing cocaine problems reflected in the indicator data. However, qualitative reports indicate a shift to methamphetamine among some stimulant users.

Cocaine was primary drug for 20 percent of all treatment admissions (excluding alcohol), for the first six months of calendar year 2004 (annualized) (Exhibit 7). Marijuana and methamphetamine exceeded cocaine as primary drugs during this time period with 39 percent and 26 percent respectively. In 2002 cocaine as a primary drug was 20 percent of all drug admissions and exceeded methamphetamine (19 percent). In 2003 admissions with methamphetamine as primary drug (23 percent) overtook cocaine (20 percent).

The percentage of clients admitted to treatment with cocaine as their primary drug has decreased slightly from 1997 (24 percent of all drug admissions) to 2004 (20 percent).

The majority of cocaine clients in treatment had been using this drug for longer than 3 years. The proportion of "new" cocaine

users entering treatment, defined as those admitted to treatment within 3 years of initial cocaine use, continues to remain stable from 1997 (17 percent) through 2004 (18 percent) (Exhibit 8). It takes an average of 10 years after first use for the majority of those users with cocaine as their primary drug to seek treatment (Exhibit 9).

Percentages of clients who smoke cocaine declined steadily from 65 percent in 1997 to 58 percent in 2001, but rebounded in 2003 and in 2004 to 63 percent. Percentages of clients who inhale cocaine have been steadily increasing from 19 percent in 1997 to 26 percent in 2001 and 28 percent in 2004.

Whites accounted for the largest percentage of cocaine admissions in 2003 and 2004 (45 percent and 46 percent respectively). This is a small decline from 2000 (48 percent). Hispanic cocaine admissions increased dramatically from 19 percent in 1997 to 29 percent in 2000 and 30 percent in 2004. African American cocaine admissions dropped sharply from 33 percent in 1997 and 20 percent in 2001 with a mild increase in 2003 (24 percent) and then a decline in 2004 to 21 percent. However, crack cocaine is fairly well entrenched in the African American urban communities. African American percentages for all other drugs remain in single digits, with the exception of marijuana (13 percent).

In 1997, 56 percent of cocaine admissions were under the age of 35; this decreased to 50 percent in 2003 and rebounded to 57 percent in 2004. The majority (69 percent) of 2004 cocaine admissions were between the ages of 26 and 45. Nineteen percent of cocaine admissions in 2004 were under the age of 18, and only 12 percent were over the age of 45.

Cocaine admissions remain predominately male, growing slightly from 1997 (57 percent male) to 61 percent in 2004. Sixty-nine percent were admitted to treatment for cocaine dependence, and 26 percent for abuse. Thirty-five percent of cocaine users indicated they used alcohol and a secondary drug, and 24 percent used marijuana. Treatment providers indicated that marijuana is commonly used with cocaine to lessen the effects of withdrawal and to increase the effects of the cocaine.

In federal fiscal year 2002, 34 percent of those sentenced to federal correctional systems in Colorado had drugs as their primary offense category, compared with 41 percent nationally. Of the 34 percent, powder and crack cocaine were each involved at 18 percent. Thirty-one percent were sentenced because of drug trafficking.

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.

According to the National Forensic Laboratory Information System, Year 2003 Annual Report, in Colorado cocaine accounted for 49 percent of all drugs seized by law enforcement and submitted to a forensic laboratory for analysis.

According to the National Drug Intelligence Center, Colorado Drug Threat Assessment, May 2003, powdered cocaine is readily available throughout the state, and crack cocaine is more available in urban population centers. In general, whites prefer powdered cocaine, African Americans

prefer crack. Cocaine is the drug most often associated with violent crime in Colorado.

The ONDCP Profile of Drug Indicators for Denver Colorado, June 2004, cited the Denver police made 1,234 arrests per 100,000 city residents between 1996-2000. This was more than twice the national average. 93 percent of these arrests were for possession.

The majority of cocaine is Mexican, and is imported into Colorado by organized Mexican nationals or family groups who have connections to gangs on the west coast. In the last year two significant drug organizations began to compete to control the wholesale supply. They transport it from the Mexican border or from western states such as California and Arizona to Denver, using automobiles with hidden compartments, commercial and cargo airlines, delivery services and other mail carriers. Denver serves as a major distribution center for cocaine for the entire country, especially the Midwest and east coast states. Proceeds from cocaine sales are transported to Mexico or the western states via the same means.

In Colorado, street distribution is controlled by gangs. There are more than 10,000 gang members in the Denver area, with an average of 1,500 new members added each year. According to the Denver Drug Enforcement Agency and treatment providers, gangs also control the market for distribution of cocaine in the southern, northern and western slope areas of the state. Gangs are ubiquitous throughout Colorado, but are less dominant in the eastern region where the population is much less dense.

In the third quarter of federal fiscal year 2003 and in the second quarter of 2004 powdered cocaine sold for \$16,000-\$19,000 per kilogram and \$700-1,000 per ounce in

the Denver metropolitan area. Crack cocaine prices have remained relatively stable at \$650-\$1,000 per ounce, while “rock” prices on the street are \$20-\$50 in Denver. Prices are slightly higher outside of the Denver metropolitan area. Purity is approximately 66 percent throughout the front range and between 41 and 91 percent on the western slope. Treatment providers stated that crack is fairly rare on the western slope, and its use remains entrenched in the African American communities in southern Colorado.

Overall Colorado has seen a decrease in the wholesale price of powdered cocaine because these users have switched to methamphetamine. Treatment providers indicate this switch is due to cheaper prices and a longer lasting “high.” Both drugs are equally available throughout the state.

#### **4. Heroin and Other Opiates**

Heroin and other opiate use pose a considerable threat to Colorado, although indicators for both were mixed. The number of heroin mentions in emergency departments in Denver was 22 per 100,000 in 1996, with a gradual increase to 43 per 100,000 in 2002, and a decline in both 2003 and 2004 (23 per 100,000 and 26 per 100,000 respectively).

Opiates other than heroin include hydrocodone, hydromorphone, codeine and oxycodone. Emergency department mentions of narcotic analgesics for Denver rose steadily from 18 in 1996 to 41 in 2001, at which time they dropped to 34 in 2002 and rose again to 40 in 2004. Data for 2003 is excluded because only 3 months data for that year were collected by DAWN.



Hospital discharge data from 1997 – 2003 combined all narcotic analgesics, including heroin. These data have been steadily increasing, with the rate almost doubling in 7 years, from 37 per 100,000 in 1997 to 73 per 100,000 in 2003. Treatment providers indicated a rapid rise in popularity of prescription narcotic abuse such as OxyContin and Hydrocodone, and these data may reflect that.

Heroin/morphine-related mortality data for the Denver PMSA rose from 1996 at 34, to 79 in 1999, declined to 66 in 2000, rose again in 2001 to 77 and declined to 64 in 2002.

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. Data for 2003 show that opiate related deaths decreased slightly to 152, or 33.3 per million population.

Heroin and other narcotic analgesic-related calls to the Rocky Mountain Poison Control Center peaked in 2002 at 22, and declined slightly to 18 in 2004.

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 5.3 percent of females and 4 percent of males tested 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).

Among Colorado treatment admissions (excluding alcohol) clients with heroin as their primary drug of choice have steadily declined. In 1997, 16 percent of all drug treatment admissions identified heroin as their primary substance while in 2004 only 8.5 percent did so. It should be noted that while in 2004 the Alcohol and Drug Abuse Division expanded the number of DACODS by adding DUI clients into the DACODS database, figures used in this report exclude DUI clients.

Treatment admissions for clients who stated other opiates as their primary drug have been between 3 and 4 percent.

The number of “new” heroin and other opiate users entering treatment within 3 years of initial use rose from 1997 (18 percent) to 2000 (22 percent) and then declined to 16 percent in 2003. There was a very slight increase in 2004 to 17 percent. The majority of heroin users in treatment are long-time users. According to ADAD’s state fiscal year 2004 data, it takes these clients an average of 13 years from first use before they enter treatment.

Opiates (heroin and other opiates combined) ranked low for all four generations of users, from 2 percent for the Y generation, 8 percent for the X generation and seniors, and 12 percent for the Baby Boomers.

All heroin users were over the age of 18 at the time of admission; 61 percent were male and 71 percent lived in urban settings. Treatment providers have reported an increasingly young population in their early teens using OxyContin and any other drug they can obtain, usually stolen from their parents. Providers also state they’re seeing more polysubstance abuse in clients.

Sixty-nine percent of heroin and other opiate users were white, 19 percent Hispanic and 8

percent African American. Forty-two percent had achieved the 12<sup>th</sup> grade, and 34 percent college. Wages were the primary source of income for 45 percent. Twenty-eight percent had no prior treatment while 31 percent had 3 or more treatment episodes before this admission.

Fifty-three percent of these clients self-referred themselves into treatment. Eighty-six percent were dependent upon heroin or other opiates, with 12 percent receiving the diagnostic impression of abuse. Thirty percent had no use of heroin or other opiates in the 30 days prior to treatment, while 42 percent used daily. Sixty-two percent injected it and 29 percent took it orally. Twenty-six percent of these clients were under the age of 18 when they first tried heroin or other opiates and 48 percent were 21 years of age or older. Forty-two percent had no secondary drug, while 25 percent used cocaine as their secondary drug. Forty-nine percent of clients with a secondary drug began using it before the age of 18, and 34 percent began at or after the age of 21.

Seven percent of those in Colorado who were sentenced to federal facilities were heroin or other opiate users and this percentage mirrors the national percentage for federal fiscal year 2002. Heroin was only 6 percent of all items seized by law enforcement in Colorado and submitted to forensic laboratories for analysis.

Mexican black tar and brown powdered heroin are the most common types available in Colorado. Most new users are young adults who smoke or snort it. Mexican drug trafficking organizations transport heroin into Colorado and serve as the primary wholesale distributors and frequently as retail sellers, controlling the street level market for heroin. Gang related crimes are frequently associated with the sale of heroin. It is widely available in both urban and rural

settings. While the predominate users are older white males living in the lower downtown Denver area, new suburban users are emerging.

One ounce of Mexican heroin at 40 percent purity costs \$1,000-\$3,000. One gram of heroin that is 8-64 percent pure costs \$100-\$150. Costs in Denver are slightly lower than in the rest of the state. It can be obtained in Denver for \$440 per ¼ ounce. Purity is approximately 53 percent in the Denver area.

Pharmaceutical diversions of OxyContin and other narcotic analgesics are increasing, as they provide the abuser with reliable strength and dosage levels. A \$4 prescription dose of OxyContin sells on the street for \$40 or \$1 per milligram, ten times the legal prescription price. More abusers are using the internet to obtain prescription medications. Officials recently intervened when a physician from southern Colorado authorized 2,450 prescriptions on the internet within a three-month period, without establishing any doctor-patient relationship. Drug Enforcement Officials have found a severe, systemic failure to keep proper records, report thefts and maintain controlled substances in Colorado.

## **5. Marijuana**

Marijuana indicators are mixed. Marijuana is second to alcohol in the number of users in Colorado, yet emergency department mentions fall far below those for cocaine or narcotic analgesics. Emergency department mentions increased steadily from 1996 (19) through 2001 (50), and from then on declined to reach 29 in 2004.

Marijuana-related hospital discharges have increased steadily from 1997 (53 per 100,000) to 71 per 100,000 in 2003, while

marijuana-related called to the Rocky Mountain Poison and Control Center declined from 34 in 2001 to 29 in 2004.

Marijuana-related mortality data for the Denver PMSA has been quite small, from 1 in 1996 to a peak of 31 in 2001, with a decline to 5 in 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 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).

Colorado has more treatment admissions for marijuana (excluding alcohol) than any other drug. The percentage of clients admitted to treatment with marijuana as their primary drug has been holding fairly steady since 1997. In 1997 it was 41 percent; in 2004 it was 39 percent.

More “new” marijuana users seek treatment within 3 years of first use than for any other drug. This finding has been consistent since 1997 at 42 percent, through 2004 at 33 percent. Marijuana users take an average of 7 years from time of first use to first treatment. This is a shorter time frame than any other drug.

Males comprised 73 percent of treatment admissions in 2004, maintaining the historical male to female ratio of approximately 3 to 1 since 1997. Forty-two percent were under 18 years of age at time of admission to treatment. This figure has been fluctuating between 45 and 35 percent since 1997. Seventy percent of treatment admissions with marijuana as their primary drug were living in urban settings.

Race proportions remain relatively stable. In 2004 53 percent were white, 29 percent Hispanic and 13 percent African American. Whites were 56 percent in 2003, Hispanics were 27 percent and African Americans were 11 percent. Sixty-four percent used tobacco products daily. Fifty-five percent had no prior treatment episodes, while 27 percent had 1. Sixty-seven percent were unemployed and 62 percent were living in a dependent setting, the majority living with their parents. Only 9 percent self-referred to treatment, while 21 percent were referred by Social Services and 49 percent by non-DUI criminal justice.

Forty-seven percent were considered abusers while 40 percent were dependent on marijuana. Route of administration for 96 percent was smoking. Ninety percent of all clients stated they started using marijuana before the age of 18. Thirty-three percent had no secondary drug, while 45 percent used alcohol and 11 percent used methamphetamine as their secondary drug of choice. Of those with a secondary drug, 78 percent started using it before the age of 18.

Of those individuals sentenced to federal facilities in Colorado, 17 percent had use of marijuana as their primary offense which is lower than the national percentage at 29.

Cannabis was 16 percent of all items seized by law enforcement and submitted to forensic laboratories for analysis. Both Mexican imported and locally grown marijuana is readily available statewide.

The marijuana used in Colorado is primarily produced in and imported from Mexico. A small portion is grown in Colorado or other western states, particularly California. It is distributed primarily by Mexican drug trafficking organizations and criminal groups at the wholesale level and by

Hispanic and African American street gangs at the retail level. Caucasian criminal groups and local independent dealers are the primary distributors of the marijuana and sinsemilla produced in Colorado.

BC Bud, a Canadian import with a high THC, was available only in limited quantities and relatively hard to obtain in Colorado until 2003. Since then an increase in availability of BC Bud has contributed to an increased THC level in both the Denver and Boulder areas. BC Bud sells for \$700-\$1,000 per ounce and \$3,200-\$4,500 per pound. On the street BC Bud is \$10 per joint.

Locally produced sinsemilla sold for \$1,000-\$3,000 per ounce and \$50-\$200 per gram in 2002. Domestic marijuana grown indoors is preferred over Mexican grown marijuana and sells for \$1,000-\$3,000 per pound and \$200-\$300 per ounce. DEA officials report grow operations are becoming increasingly sophisticated and technical. Outdoor marijuana is most likely a product of eastern Colorado.

Prices of marijuana are slightly cheaper in Colorado than in surrounding states. Trafficking on the western slope is dominated by Hispanics importing it into Colorado from Mexico. Officials are noticing more individual Mexican nationals independent of the large drug organizations trafficking marijuana statewide.

Treatment providers almost uniformly indicated that marijuana use is socially accepted in their areas and that the perception of risk associated with marijuana use is declining. Treatment providers felt this decline is due to national media coverage of marijuana as a medicinal drug, and to a high frequency of parental use of marijuana.

## 6. Methamphetamine

Most indicators for methamphetamine have increased over the past few years, and this drug is a rapidly expanding social problem for Colorado.

Emergency department mentions have increased slightly, from 8 per 100,000 in 1998 to 14 per 100,000 in 2004.

Methamphetamine was not broken out from other stimulants for hospital discharge data, but overall amphetamine-related hospital discharges have increased since 1999 from 16 per 100,000 to 40 per 100,000 in 2003.

Statewide the number of methamphetamine-related calls to the Rocky Mountain Poison and Control Center has tripled from 20 in 2001 to 66 in 2004.

Methamphetamine has been steadily increasing in mortality mentions since 1996 (3). In 1999 there were 8 mentions, 10 in 2000, 19 in 2001 and 17 in 2002. 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).

Colorado treatment providers report that methamphetamine is the most popular illegal drug of choice, and it is frequently used in combination with alcohol, marijuana and cocaine. It is readily available, inexpensive and at times free. Potency is reported to be good. Providers are seeing an increasing problem with methamphetamine use statewide, and other amphetamine use has dropped in popularity.

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.

In Colorado treatment admissions for clients using methamphetamine as their primary drug have risen dramatically. Methamphetamine is now second only to marijuana in the number of treatment admissions (excluding alcohol). In 1997 there were 1,081 admissions for methamphetamine. This number has consistently increased each year since then to 3,300 in 2004.

The percentage of “new” users seeking treatment for methamphetamine within 3 years of initial use does not reflect this steady rise, with 34 percent in 1997, dropping to 22 percent in 2001, and rising slightly to 24 percent in 2004. According to state fiscal year 2004 data, methamphetamine users take on average 8.5 years from first use to first treatment.

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=2,022) 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).

Methamphetamines were combined with all other stimulants in the generational snapshot of treatment. Both the X generation and the Baby Boomers use stimulants more than the Y generation or seniors, at 37 percent and 27 percent respectively.

During the first 6 months of CY 2004 few adolescents (5 percent) under the age of 18 were in treatment for methamphetamine as their primary drug. The majority of those in treatment were between 18 and 35 years of age. Almost ¼ of the 36-45 year olds also

claimed methamphetamine as their primary drug.

In treatment admission data for both 2003 and 2004, there is little gender differentiation in methamphetamine, with female users being equal in number to male users. Similarly, methamphetamine use is found in both urban (61 percent) and rural (39 percent) areas of Colorado. Treatment providers stated they are seeing an increase in methamphetamine use in both rural and urban areas and an increase in the social and community problems related to this use.

Whites dominate the use of methamphetamine (83 percent) in Colorado. Few Hispanics (12 percent) and even fewer African Americans (2 percent) use methamphetamine as their primary drug. However, treatment providers have indicated that Hispanics, who have traditionally been involved in the trafficking of methamphetamine, are beginning to use it in greater numbers. Fifty percent of methamphetamine users were referred to treatment by the non-DUI criminal justice system, and 21 percent by Social Services.

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 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. Sixty-three percent smoked it while 22 percent injected it in 2004. Forty-one percent of clients began using methamphetamine before the age of 18. Most (72 percent) use a secondary drug in addition to methamphetamine, usually marijuana (36 percent) alcohol (21 percent) or cocaine (10 percent). Seventy-two

percent of those using a secondary drug initiated use of this secondary drug before the age of 18.

Federal sentencing data report for federal fiscal year 2002 that methamphetamine was the primary substance for 34 percent of the drug convictions. This is almost double the percentages of offenders sentenced because of cocaine (powder and crack) and marijuana and 4 times greater than heroin.

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. In spite of law enforcement pressure there has been an increase in the number of small, local methamphetamine labs with the occasional use of trucks for mobile labs.

Most lab operators are able to get the precursor chemicals from legitimate businesses (e.g., discount stores, drug stores, chemical supply companies, etc.). Treatment providers report that current practice is for separate individuals or groups to each acquire one of the key ingredients and then deliver it to the “cook,” thereby decreasing the risk involved when one party obtains all the ingredients.

The DEA also reports an increase in the number of Hispanic males marrying Native American women on reservations, with the intent of establishing their kitchens and supply depots with immunity from law enforcement.

A cocaine and methamphetamine trafficking organization has been transporting drugs from Phoenix to Denver. Methamphetamine from this organization has purity levels of 95 percent. An organization on the western slope employs a number of drivers who transport anywhere from 2-10 pounds from Sinaloa, Mexico or California. It can be obtained for \$500-\$1,500 per ounce, \$5,500-\$5,600 per ½ pound and \$13,500 per pound in the Denver area. In southern Colorado prices are \$600 per ounce and \$13,000 per pound. On the western slope it sells for \$1,000-\$1,200 per ounce. Purity ranges from 11-92 percent. In Denver “ice,” a smokable form of methamphetamine that looks like rock candy or rock salt, is nearly 100 percent pure and widely available. Street prices for methamphetamine in Denver are relatively stable at \$80-\$125 per gram.

## **7. Other Amphetamines and Stimulants**

Indicators for these drugs in Colorado are scant. Reported use of other amphetamines and stimulants (excluding cocaine and methamphetamine) is only a fraction of those for cocaine or methamphetamine.

For the time period January 2004 through June 2004, there were 10 emergency department mentions per 100,000 population for other amphetamines or stimulants. There were 4 calls to the Rocky Mountain Poison and Control Center.

In 1997 there were 100 (0.9 percent of all admissions) clients in treatment for using some other amphetamine or stimulant as their primary drug. In state fiscal year 2003 there were a total of 243 individuals using some other amphetamine or stimulant as their primary drug, representing 0.3 percent of the entire treatment population. During

the first six months of calendar year 2004 there were 26 clients, annualized to 0.2 percent of the entire treatment population.

In 2000 there were 9 fatalities related to other amphetamines or stimulants, 8 in 2001 and 13 in 2002.

## **8. Barbituates, Sedatives and Tranquilizers**

There are few indicators for the use of these drugs in Colorado. There were 13 emergency department mentions per 100,000 population for January through June 2004.

There were 152 admissions to treatment for clients indicating these as their primary drug of choice. Sixty-three percent were female, and 85 percent were adults (over the age of 18). Fifty-five percent were urban, and 85 percent were white. When comparing this group to all other clients who reported other primary drugs, this group used daily tobacco the least and had the highest percentage of: married clients; unemployment (the category “unemployment” includes those out of the workforce, such as students, homemakers, persons with disabilities, etc.); slight to moderate socialization issues or concerns; mental health problems; and visits to medical and psychiatric emergency rooms.

Sixty-eight percent administered their drug orally, 21 percent smoked it, 3 percent inhaled it and 3 percent injected it. Fifty percent were under the age of 18 when they began using this category of drugs, and 45 percent were ages 21 plus. Sixty-six percent used a secondary drug such as alcohol (26 percent), opiates (13 percent) and marijuana (11 percent), and 72 percent of those with a secondary drug were under the age of 18 when they first used it.

These drugs are frequently obtained as prescription medications and fall into the diverted pharmaceutical class as well. Local independent dealers and internet services are the principal distributors of diverted pharmaceuticals.

## 9. 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.

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.

MDMA is readily obtainable at raves, nightclubs, strip clubs, or private parties. The traffickers are typically white and in their twenties or early thirties. They obtain their MDMA from Nevada or California, with source connections in Europe and target young adults and adolescents as users. Mexican trafficking organizations are making inroads in the Colorado MDMA market. The DEA reports one tablet or

capsule costs \$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.

The DEA reports that the majority of GHB 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 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 Rohypnol among either the general population or the rave scene in Colorado. What use there is occurs in the adolescent to mid-thirties age range.

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.

Club drugs are primarily used by young adults and adolescents, and either these clients are not coming to the attention of indicator organizations or the number of users is still quite small. Certain club drugs



are also used as “date rape” drugs and their use in this manner may be underreported.

In 2003 emergency department data for club drugs was incomplete. There were 37 treatment admissions for clients with club drugs as their primary substance. In the first 6 months of CY 2004, there were 3 mentions of club drugs in emergency departments in Denver. Fifty-two treatment admissions occurred statewide. For CY 2004 in its entirety, there were 39 calls to the Rocky Mountain Poison and Control Center related to club drugs.

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

Of the 8,270 AIDS cases reported in Colorado through September 30, 2004, 9.3 percent were classified as IDUs, and 11.0 percent were classified as homosexual or bisexual males and IDUs (Exhibit 11).

### **CORRECTIONS: THE HIDDEN POPULATION**

The Colorado Department of Corrections reports annually on new court commitments and parole populations. Unfortunately data for substance abusers are not broken out by primary drug of choice. However, this population is large enough (20,144 for the adult population as of December 04) that to exclude it would mean giving a skewed picture of Colorado’s substance abuse problem. Seventy-seven percent of the prison population on June 30, 2003 were substance abusers. The total inmate population at that time was 15,365, so 11,831 were substance abusers.

There were 5,276 new court commitments during state fiscal year 2003. Eighty-two percent of new court commitments were identified as substance abusers.

Ninety percent of the general adult inmate population were male. Demographic characteristics for substance abusers and non-abusers were compared. This comparison indicated that substance abusers were less likely to be formally married, more likely to be Latino, common-law married and younger.

Substance abusers had significantly more crimes on their current incarceration than non-abusers, and they averaged 6 times as many drug crimes as non-abusers. Substance abusers were more likely to have had a prior correctional incarceration, and had more serious criminal histories than non-abusers. Substance abusers were less likely to be identified as sex offenders, and were less likely to have medical needs than non-abusers. Female offenders were identified as having higher treatment needs overall than males. Substance abusers had 3 times as many drug-related crimes as non-abusers.

Substance abusers comprised 85 percent of the parole returns during state fiscal year 2003. Parolees are returned to the correctional system either for a parole revocation or a new crime. Twenty-two percent of the returned substance abusers had committed a new crime while on parole.

**EXHIBIT 1: Drug Incidence Rates Per 100,000 Population from Emergency Department Mentions by Calendar Year for Denver, Colorado (Data source: DAWN and DAWN Live)**

Drug	1996	1997	1998	1999	2000	2001	2002	2003*	2004*
Alcohol in combination	77	98	98	107	109	96	80	65	83
Cocaine/crack	53	69	73	87	83	69	82	47	61
Heroin	22	30	31	40	41	40	43	23	26
Marijuana	19	32	37	43	51	50	38	18	29
Methamphetamine	7	19	8	6	7	5	5	8	14
Other Stimulants Amphetamines	6	14	7	15	21	21	24	10	10
Club Drugs	4	6	5	4	4	2	1	<1	3
Inhalants	2	4	2	2	2	2	4	<1	3
Narcotic Analgesics	18	24	27	33	38	41	34	13	40

\* Three months of data annualized; per 100,000 based on the 2004 population estimate from the Colorado Demography Office

\*\*Six months of data annualized; per 100,000 based on the 2004 population estimate from the Colorado Demography Office

**EXHIBIT 2: Drug-Related Hospital Discharges Per 100,000 for Selected Drugs, 1997-2003, for Colorado**

DRUG	1997	1998	1999	2000	2001	2002	2003
Alcohol	*	17154	18577	18744	20644	21433	23750
Rate/100K		418.0	440.6	432.3	464.3	474.02	518.0
Amphetamines	959	815	682	942	1161	1463	1814
Rate/100K	24.0	20.0	16.2	21.7	26.1	32.3	39.6
Cocaine	2245	2492	2517	2732	2787	3305	3658
Rate/100K	56.1	60.7	59.7	63.0	63.0	73.1	80.3
Marijuana	2118	2227	2204	2455	2755	3016	3246
Rate/100K	53.0	54.3	52.3	56.6	62.0	66.7	71.0
NarcAnalges	1458	1566	1639	2053	2237	2605	3368
Rate/100K	36.5	38.2	39.0	47.3	50.3	57.6	73.4
Population	3,995,923	4,102,491	4,215,984	4,335,540	4,446,529	4,521,484	4,586,455

\* Data not available

**EXHIBIT 3: Number of Drug-related Calls to the Rocky Mountain Poison and Control Center by Calendar Year\* for Denver, Colorado**

<b>Drug</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Alcohol	110	149	150	223
Cocaine/crack	59	66	68	59
Heroin/morphine	19	16	22	18
Marijuana	34	37	36	29
Methamphetamine	20	39	39	66
Other Stimulants Amphetamines	3	3	6	4
Club Drugs	30	55	40	39
Inhalants	4	16	10	4

\*Data for years previous to 2001 were unavailable

**EXHIBIT 4: Drug-Related Mortality Data for the Denver PMSA by Calendar Year**

<b>Drug</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Alcohol	47	49	61	74	75	99	86	*	*
Cocaine/crack	68	56	66	82	80	126	108	*	*
Heroin/morphine	34	53	51	79	66	77	64	*	*
Marijuana	1	4	3	20	20	31	5	*	*
Methamphetamine	3	6	3	8	10	19	17	*	*
Other Stimulants Amphetamines	2	5	3	5	9	8	13	*	*
Club Drugs	--	--	--	--	2	4	2	*	*
Inhalants	--	1	2	--	1	--	1	*	*

\* Data unavailable

**EXHIBIT 5: Numbers and Percentages of Treatment Admissions by Drug Type from 1997-2004, Including Alcohol**

<b>DRUG</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004*</b>
Alcohol N	6353	7833	6573	6577	6311	6839	7044	8580
%	45.4%	44.4%	40.3%	40.5%	38.6%	38.8%	37.5%	40.1%
Heroin N	1200	1418	1585	1577	1482	1415	1640	1090
%	8.6%	8.0%	9.7%	9.7%	9.1%	8.0%	8.7%	5.1%
Non-Rx Methadone N	4	15	15	16	9	17	15	28
%	.0%	.1%	.1%	.1%	.1%	.1%	.1%	.1%
Other Opiates N	195	230	274	304	386	394	519	510
%	1.4%	1.3%	1.7%	1.9%	2.4%	2.2%	2.8%	2.4%
Methamphetamine N	1081	1436	1214	1314	1659	2070	2744	3300
%	7.7%	8.1%	7.4%	8.1%	10.1%	11.7%	14.6%	15.4%
Other Amphetamines, Stimulants N	52	61	89	107	91	104	78	52
%	.4%	.3%	.5%	.7%	.6%	.6%	.4%	.2%
Cocaine N	1797	2309	2099	1916	1888	2193	2330	2614
%	12.9%	13.1%	12.9%	11.8%	11.5%	12.4%	12.4%	12.2%
Marijuana N	3152	4126	4061	4135	4248	4343	4159	4988
%	22.5%	23.4%	24.9%	25.5%	26.0%	24.6%	22.1%	23.3%
Hallucinogen N	40	56	68	72	71	38	23	22
%	.3%	.3%	.4%	.4%	.4%	.2%	.1%	.1%
PCP N	0	0	4	5	2	5	8	6
%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%
Barbiturates N	7	11	15	5	6	20	14	14
%	.1%	.1%	.1%	.0%	.0%	.1%	.1%	.1%
Sedatives N	4	17	16	21	13	89	63	16
%	.0%	.1%	.1%	.1%	.1%	.5%	.3%	.1%
Tranquilizers N	37	40	40	38	44	49	52	46
%	.3%	.2%	.2%	.2%	.3%	.3%	.3%	.2%
Inhalants N	28	50	28	26	31	21	20	28
%	.2%	.3%	.2%	.2%	.2%	.1%	.1%	.1%
Club Drugs N	NA	NA	NA	NA	NA	12	37	52
%	NA	NA	NA	NA	NA	.1%	.2%	.2%
Other N	31	51	218	123	119	37	54	58
%	.2%	.3%	1.3%	.8%	.7%	.2%	.3%	.3%
<b>TOTAL N</b>	<b>13981</b>	<b>17653</b>	<b>16299</b>	<b>16236</b>	<b>16360</b>	<b>17646</b>	<b>18800</b>	<b>21404</b>

\* First six months annualized

**EXHIBIT 6: Numbers and Percentages, Generational Drug Use, State Fiscal Year 2004**

Age Ranges	Sedatives Tranquilizers <sup>a</sup>	Stimulants	Opiates	Marijuana	Hallucin- ogens	Club Drugs	Total
Y Generation <sup>b</sup>	1079 26%	751 18%	90 2%	2241 54%	5 <1%	20 1%	4186 28%
X Generation <sup>c</sup>	2673 39%	2519 37%	537 8%	1062 16%	12 <1%	6 <1%	6809 46%
Baby Boomers <sup>d</sup>	2017 54%	1004 27%	462 12%	229 6%	1 <1%	4 <1%	3717 25%
Seniors <sup>e</sup>	123 84%	6 4%	11 8%	7 5%	0	0	147 1%
Total	5892 40%	4280 29%	1100 7%	3539 24%	18 <1%	30 <1%	14859 100%

<sup>a</sup> Sedatives Tranquilizers include alcohol

<sup>b</sup> Y Generation includes anyone born after 1981

<sup>c</sup> X Generation includes anyone born between 1965-1981

<sup>d</sup> Baby Boomers include anyone born between 1946-1964

<sup>e</sup> Seniors include anyone born before 1946

**EXHIBIT 7: Numbers and Percentages of Treatment Admissions by Drug Type from 1997-2004, Excluding Alcohol**

DRUG	1997	1998	1999	2000	2001	2002	2003	2004*
Heroin N	1200	1418	1585	1577	1482	1415	1640	1090
%	15.7%	14.4%	16.3%	16.3%	14.7%	13.1%	14.0%	8.5%
Non-Rx Methadone N	4	15	15	16	9	17	15	28
%	.1%	.2%	.2%	.2%	.1%	.2%	.1%	.2%
Other Opiates N	195	230	274	304	386	394	519	510
%	2.6%	2.3%	2.8%	3.1%	3.8%	3.6%	4.4%	4.0%
Methamphetamine N	1081	1436	1214	1314	1659	2070	2744	3300
%	14.2%	14.6%	12.5%	13.6%	16.5%	19.2%	23.3%	25.7%
Other Amphetamines, Stimulants N	52	61	89	107	91	104	78	52
%	.7%	.6%	.9%	1.1%	.9%	1.0%	.7%	.4%
Cocaine N	1797	2309	2099	1916	1888	2193	2330	2614
%	23.6%	23.5%	21.6%	19.8%	18.8%	20.3%	19.8%	20.4%
Marijuana N	3152	4126	4061	4135	4248	4343	4159	4988
%	41.3%	42.0%	41.8%	42.8%	42.3%	40.2%	35.4%	38.9%
Hallucinogen N	40	56	68	72	71	38	23	22
%	.5%	.6%	.7%	.7%	.7%	.4%	.2%	.2%
PCP N	0	0	4	5	2	5	8	6

<b>DRUG</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004*</b>
%	.0%	.0%	.0%	.1%	.0%	.0%	.1%	.0%
Barbiturates N	7	11	15	5	6	20	14	14
%	.1%	.1%	.2%	.1%	.1%	.2%	.1%	.1%
Sedatives N	4	17	16	21	13	89	63	16
%	.1%	.2%	.2%	.2%	.1%	.8%	.5%	.1%
Tranquilizers N	37	40	40	38	44	49	52	46
%	.5%	.4%	.4%	.4%	.4%	.5%	.4%	.4%
Inhalants N	28	50	28	26	31	21	20	28
%	.4%	.5%	.3%	.3%	.3%	.2%	.2%	.2%
Club Drugs N	NA	NA	NA	NA	NA	12	37	52
%	NA	NA	NA	NA	NA	.1%	.3%	.4%
Other N	31	51	218	123	119	37	54	58
%	.4%	.5%	2.2%	1.3%	1.2%	.3%	.5%	.5%
<b>TOTAL N</b>	<b>7628</b>	<b>9820</b>	<b>9726</b>	<b>9659</b>	<b>10049</b>	<b>10807</b>	<b>11756</b>	<b>12824</b>

\* First six months annualized

**EXHIBIT 8: Annual Percentage of Heroin, Methamphetamine, Cocaine and Marijuana Users Entering Treatment Within Three Years of Initial Use: 1997-2004**

<b>DRUG</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004*</b>
Heroin N	214	314	342	340	283	267	255	188
%	17.9%	22.3%	21.7%	21.6%	19.1%	18.9%	15.5%	17.2%
Metham N	362	472	308	311	367	475	676	790
%	33.6%	33.0%	25.5%	23.7%	22.1%	23.0%	24.6%	23.9%
Cocaine	310	423	390	374	348	394	438	472
%	17.3%	18.4%	18.6%	19.5%	18.4%	18.0%	18.8%	18.1%
Marij N	1326	1584	1434	1552	1505	1403	1464	1654
%	42.4%	39.1%	35.9%	37.7%	35.7%	32.3%	35.2%	33.2%
<b>Total New Users in Tx in 3 yrs</b>	<b>2212</b>	<b>2793</b>	<b>2474</b>	<b>2577</b>	<b>2503</b>	<b>2539</b>	<b>2833</b>	<b>3104</b>
%	30.8%	30.4%	27.9%	28.9%	27.1%	25.3%	26.1%	25.9%
<b>Total Users</b>	<b>7190</b>	<b>9188</b>	<b>8880</b>	<b>8915</b>	<b>9241</b>	<b>10016</b>	<b>10871</b>	<b>11992</b>

\* First six months annualized

**EXHIBIT 9: Average Number of Years For Treatment Clients Between First Use of Drug and Treatment, State Fiscal Year 2004**

<b>DRUG</b>	<b>Years</b>
Marijuana	7
Methamphetamine	8.5
Cocaine/crack	10
Other Opiates	11
Heroin	13
Alcohol	16

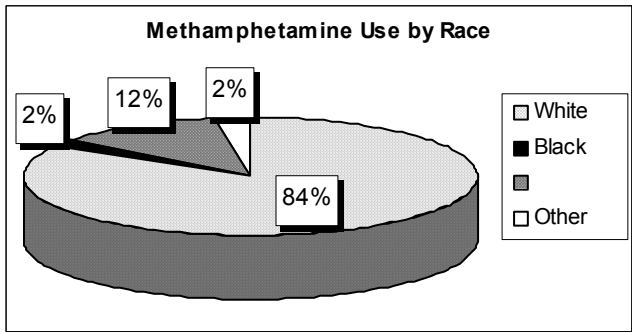
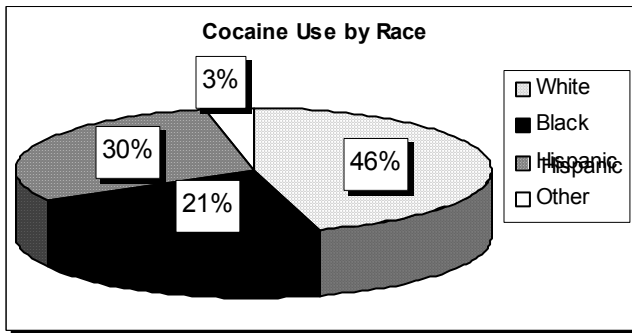
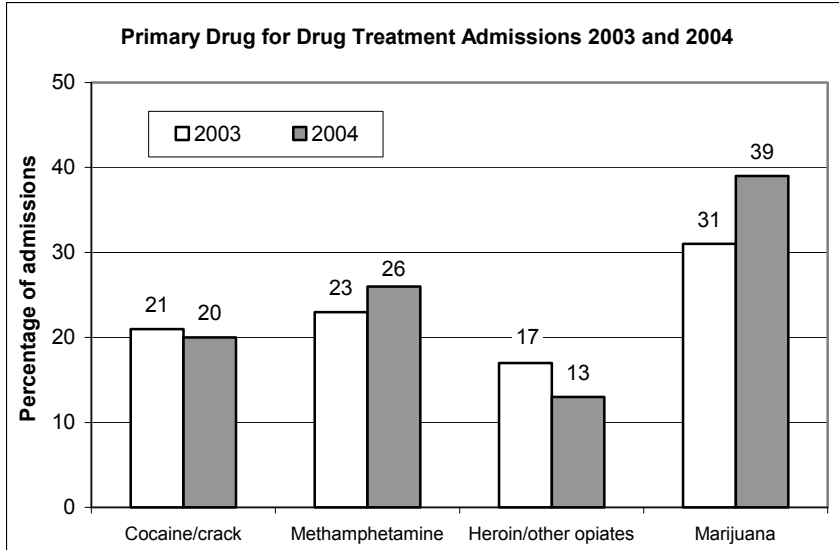
**EXHIBIT 10: Estimated/Projected Population by Denver PMSA and Statewide**

<b>Geographic Area</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004*</b>
<b>Denver PMSA</b>									
Adams	323,042	332,744	344,024	355,308	363,857	361,262	375,380	385,262	392,908
Arapahoe	451,065	459,058	472,399	481,306	487,967	503,833	513,932	520,501	525,508
Broomfield	NA	NA	NA	NA	NA	40,621	41,948	43,484	42,691
Denver	518,255	527,442	533,406	545,517	554,636	560,365	560,882	566,173	569,359
Douglas	114,713	129,331	144,354	162,323	175,766	200,385	213,526	225,694	230,944
Jefferson	498,046	504,234	512,483	520,810	527,056	529,743	530,847	529,479	531,424
<b>Total PMSA</b>	1,905,121	1,952,809	2,006,666	2,065,264	2,109,282	2,196,209	2,236,515	2,270,593	2,292,834
<b>State of Colorado</b>	3,902,448	3,995,923	4,102,491	4,215,984	4,335,540	4,446,529	4,521,484	4,586,455	4,642,589

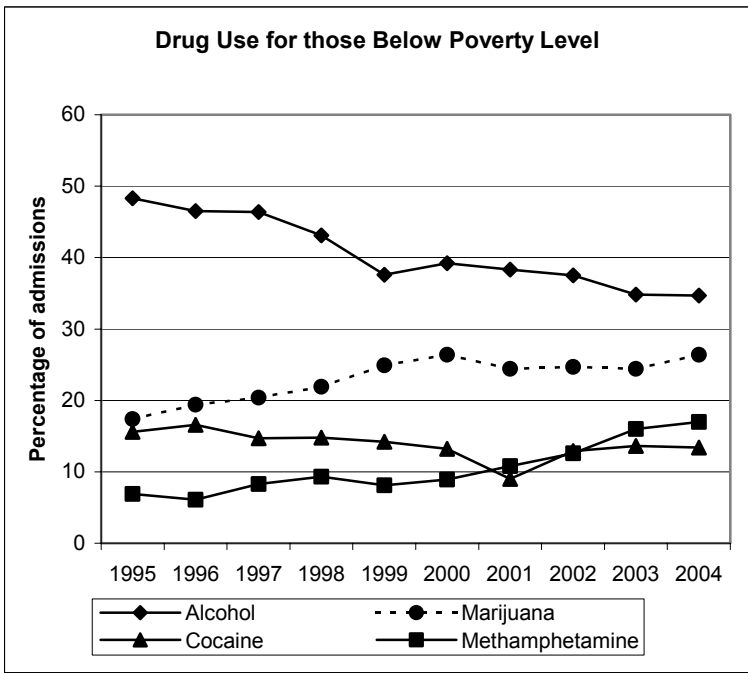
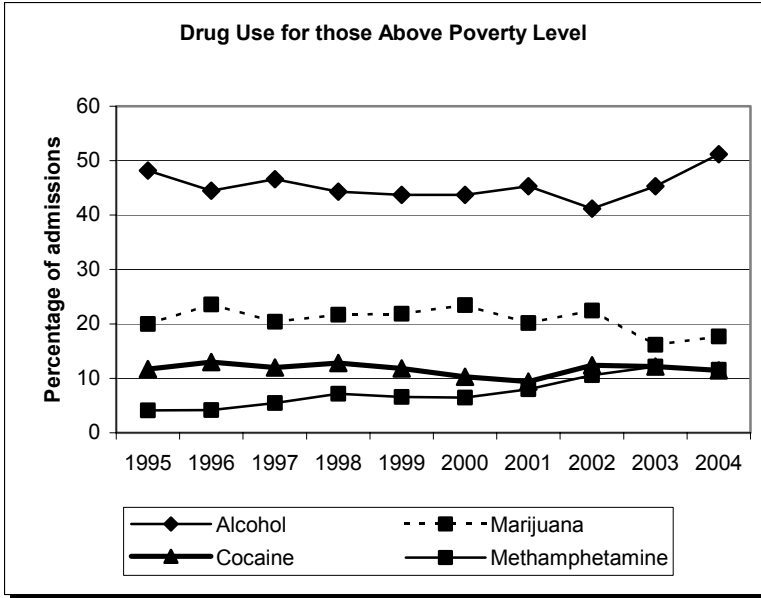
\* Projected

**EXHIBIT 11: Colorado Cumulative AIDS Cases by Exposure Category Through September 30, 2004**

	<b>Number of AIDS Cases</b>	<b>Percent of AIDS Cases</b>	<b>Number of Individuals with HIV who have not progressed to AIDS</b>	<b>Percent of Individuals with HIV who have not progressed to AIDS</b>
<b>Gender</b>				
Male	7618	92.1%	3403	90.2%
Female	652	7.9%	369	9.8%
Total	8270	100%	3772	100%
<b>Exposure Category</b>				
Men/sex/men	5558	67.2%	2402	63.7%
Injecting drug user (IDU)	768	9.3%	405	10.7%
MSM and IDU	900	10.9%	357	9.5%
Heterosexual contact	497	6.0%	317	8.4%
Other	186	2.2%	50	1.3%
Risk not identified	361	4.4%	241	6.4%







Acknowledgement: All ADAD treatment data for this report were run by Randall Deyle and Troy Evatt of the Evaluation and Information Services Section of ADAD.