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ABSTRACT

This report is designed to inform the residents of Denver and the rest of Colorado about the dimensions of the problems caused by alcohol, tobacco, and other drugs in the state's capital city. The report focuses on: the prevalence of substance abuse and addiction in Denver; the adverse impact of substance abuse on the health and well-being of Denver residents; crime related to alcohol and illicit drugs; the economic costs of substance abuse; and city and state responses to these problems. It is noted that while substance abuse is a nationwide problem, its consequences are felt most acutely in individual neighborhoods, and policy responses play out in local settings that vary enormously. This report provides the latest available information on Denver, complemented whenever possible by national and state data to provide a comparative perspective. The report concludes with recommendations to guide future progress. (Contains 45 references)(GCP)

Denver

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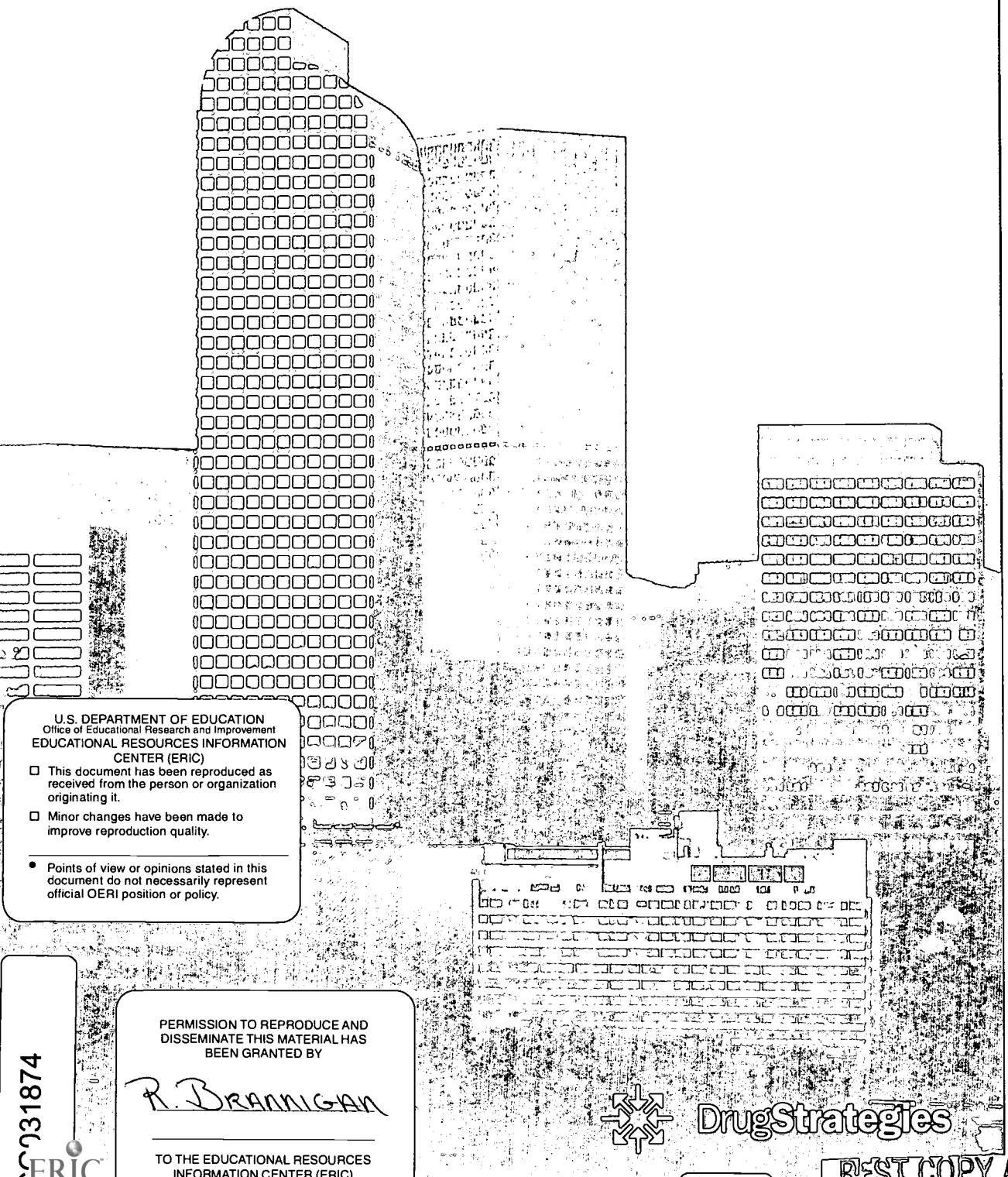
On the Horizon

Reducing Substance Abuse and Addiction



DrugStrategies

Denver: On the Horizon—Reducing Substance Abuse and Addiction was made possible by funding from the City and County of Denver. *Denver: On the Horizon* is part of a series of Drug Strategies reports on alcohol, tobacco and other drug problems in cities and states across the country. Other cities profiled by Drug Strategies include Baltimore, Maryland; Detroit, Michigan; Santa Barbara, California; and Washington, D.C. The states profiled include Arizona, California, rural Indiana, Kansas, Massachusetts, Ohio and South Carolina.

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Denver: On the Horizon—Reducing Substance Abuse and Addiction is available at www.drugstrategies.org

This report is designed to inform the residents of Denver and the rest of Colorado about the dimensions of the problems caused by alcohol, tobacco and other drugs in the state's capital city. The report focuses on:

- the prevalence of substance abuse and addiction in Denver
- the adverse impact of substance abuse on the health and well-being of Denver residents
- crime related to alcohol and illicit drugs
- the economic costs of substance abuse
- city and state responses to these problems

Denver: On the Horizon—Reducing Substance Abuse and Addiction is animated by the recognition that while substance abuse is a nationwide problem, its consequences are felt most acutely in individual neighborhoods, and policy responses play out in local settings that vary enormously. Indeed, cities differ remarkably from one another, each with its own particular history and spirit. Clearly, national and even state-level data are inadequate to capture the crucial distinctions required to shape effective local substance abuse strategies. This report provides the latest available information on Denver, complemented whenever possible by national and state data to provide a comparative perspective.

Drug Strategies, a nonprofit research institute, promotes more effective approaches to the nation's drug problems and supports private and public initiatives that reduce the demand for drugs through prevention, education, treatment and law enforcement. In preparing this report, Drug Strategies consulted numerous city, state and federal government agencies and non-governmental organizations. The project was guided by a distinguished Advisory Panel, convened by the Mayor's Office of Drug Strategy and composed of representatives from public and private agencies with substance abuse expertise and responsibilities. While we are grateful for the insight and wisdom of those who contributed to our research, Drug Strategies is solely responsible for the content of this report.

Since its incorporation more than 140 years ago, Denver has been the preeminent city of the Rocky Mountain West—politically, economically and culturally. Known as the "Queen City of the Plains," Denver sits at the western edge of the Great Plains and eastern front of the Rocky Mountain range. Denver today remains Colorado's largest city, with an impressive 18.6 percent growth rate during the 1990s. Only 24 cities in the country are more populous than Denver (554,636 residents, according to the year 2000 census). Denver is not only Colorado's political capital, it is also the anchor of a tremendously productive metropolitan economy. Between 1990 and 2000, the Denver metropolitan area's gross product more than doubled, rising to $91 billion—more than the gross product of a number of states, including neighboring Kansas ($86 billion) and Utah ($69 billion).

Denver took full part in America's prosperous 1990s. As per capita income rose 46 percent nationwide and 60 percent in Colorado over the course of the decade, per capita income in Denver rose 72 percent, to nearly $41,000. The proportion of Denver residents living in poverty fell from 17 percent in 1990 to 11 percent in 2000. Denver's strong economy and growing population translated into a 68 percent increase in total tax revenues between 1990 and 1999. As the national crime rate fell 19 percent from 1996-2000, crime in Denver declined by 28 percent. Along a range of social and economic indicators, Denver's performance compares favorably to most other big U.S. cities. When the American Hospital Association's "Deprivation Index" ranked the 100

largest cities according to poverty rate, educational attainment, unemployment rate, per capita income and crime rate, Denver ranked 30th best overall, with only nine comparably-sized cities scoring better.

Denver, nevertheless, is not without challenges. As this report documents, substance abuse generates an array of costly problems for Denver residents, businesses and government. According to a study sponsored by the U.S. Department of Health and Human Services, Colorado ranks second among the 50 states in the relative severity of its alcohol and drug abuse problems. In Denver, by many measures, substance abuse and addiction problems are considerably more severe than in the nation as a whole.

- Rates of binge drinking and chronic drinking are about 40 percent higher among Denver adults than among adults nationwide.
- Denver residents are hospitalized for alcohol-related illnesses at nearly twice the national rate.
- Drug-related hospital emergencies occur in Denver at 2½ times the national rate.
- Denver's alcohol and drug-related death rate is more than 50 percent higher than the national average.
- Drug-related AIDS cases are diagnosed in Denver at twice the national rate.
- Denver's crime rate is 15 percent higher than the national average, even after having fallen sharply in the late 1990s.
- Denver arrests and imprisons drug offenders at more than twice the rate nationwide.
- Substance abuse costs Denver residents, businesses and government at least $1.5 billion a year—in addition to the incalculable toll in human suffering.

Among the many challenges Denver faces in its efforts to reduce substance abuse, none is more crucial than closing the city's treatment gap. Drug Strategies estimates that between 45,000 and 60,000 Denver residents need treatment for substance abuse but that only 7,000 of them, at most, actually receive treatment in any given year. A large and growing body of scientific research attests to treatment's effectiveness in reducing substance abuse and its associated harms. Moreover, the benefits of treatment far exceed the costs. A landmark 1994 study in California found that every dollar invested in treatment saved taxpayers seven dollars in future costs.

Fortunately, Denver's resilient economy and track record of sound fiscal management mean that the city can bring to bear a wealth of human and economic resources to address substance abuse. To target those resources, city leaders are charting a promising strategy that emphasizes significant new investments in prevention and treatment. The state government has an obvious stake in the well-being of its capital city, and a major role to play. The residents of Denver and the rest of Colorado would benefit tremendously if state lawmakers moved policy and funding priorities toward prevention and treatment.

Voters in Denver and the rest of the state overwhelmingly endorse just such a policy shift. A statewide survey in July 2001 found that nearly 75 percent of active voters favor "increasing funding to greatly expand the availability of treatment." The great majority of Colorado voters (73 percent) also favor decreasing criminal penalties for people possessing small quantities of drugs and investing the prison cost savings in prevention and treatment. These preferences are especially pronounced

among Denver voters, but strong support for change spans demographic categories across the state.

To build on the progress already being made in Denver, Drug Strategies offers recommendations in five key areas: leadership; information; enforcement and criminal justice; prevention; and treatment.

Leadership

- Denver's next mayor should reaffirm the role of the Director of the Mayor's Office of Drug Strategy as a high-level official who reports directly to the mayor and is empowered to coordinate the city's overall response to substance abuse.
- Denver's elected representatives at the local and state levels should exercise their influence to reorient state legislative policy and budget priorities on substance abuse toward greater investment in prevention and treatment.

Information

- City leaders should move quickly to undertake a comprehensive household survey of Denver residents on alcohol, tobacco and other drug use. The information derived will inform policy planning and serve as a baseline for measuring the future impact of Denver's new strategies to reduce substance abuse.
- In setting substance abuse policy priorities, city leaders should take advantage of "Denver Benchmarks," a community information system designed to provide detailed neighborhood-by-neighborhood data on health and quality of life.
- Denver should establish its own interdisciplinary substance abuse policy research team, and coordinate its efforts with other research conducted in the state.

Enforcement and Criminal Justice

- A sharp enforcement focus on the most pernicious, flagrant offenders—those who engage in frequent violence and employ youth—would go far toward reducing the overall levels of crime perpetrated by drug offenders.
- Denver's elected representatives in the Colorado General Assembly should join the effort to lessen the state's costly reliance on imprisonment to punish low-level, nonviolent drug offenders.
- In concert with the state government, Denver should take advantage of the leverage afforded by the criminal justice system to reduce substance abuse among probationers and parolees through a mix of drug testing, incentives, sanctions and treatment.
- Denver's elected representatives, law enforcement officials and public health officials should work to amend Colorado's drug paraphernalia statutes so that state law would no longer impede the operation of city-licensed needle exchange programs in Denver.

Prevention

- Denver residents and their elected representatives should press Colorado's General Assembly for substantial increases in the state's tobacco and alcohol excise tax rates, which are currently among the lowest in the country.
- Denver should adopt school and community prevention programs with a sound theoretical basis and backed by research-based evidence of success.

Treatment

- The city should devote significantly more of its own revenues to treatment. As part of this increased investment, Denver should earmark funding for research to assess the effectiveness of local treatment services.

- The city's new investments in treatment should be geared toward strengthening the entire continuum of needed services.

Denver residents and elected officials should also seek to make state policies more supportive of substance abuse treatment. In particular, Denver should press state lawmakers to:

- Devote revenues generated by alcohol excise taxes to treatment.
- Seek a federal waiver to expand Medicaid coverage for treatment. Medicaid accounts for nearly one-third of public funding for treatment nationally, but currently plays only a negligible role in Colorado.
- Require private health insurers to cover substance abuse treatment on par with coverage for any other illness. In Colorado, 1.8 million adults are enrolled in employer-sponsored health insurance plans. At least 100,000 of these insured Coloradans need treatment for alcohol or drug abuse, so parity for treatment benefits could make a sizeable contribution to closing the treatment gap, in Denver and statewide.

Denver: On the Horizon brings together the latest information on substance abuse in Denver, providing a snapshot of a dynamic and evolving situation. Drug Strategies hopes that this report will help the residents of Denver and Colorado to concentrate resources where they will have the maximum effect in reducing substance abuse and the damage it inflicts on society.

Americans rank alcohol and drug abuse as the nation's most serious public health problem, ahead of cancer, heart disease and depression. In Denver, rates of smoking, drinking and illicit drug use are higher than they are in the rest of Colorado and the nation. The negative impact on the health of Denver residents is also greater.

This chapter presents the most currently available data on the prevalence and health consequences of substance abuse in Denver. Information comes from a variety of sources, such as self-report surveys, treatment admissions and hospitalization and death records. Whenever possible, trends in Denver are compared to those in the rest of Colorado and the country.

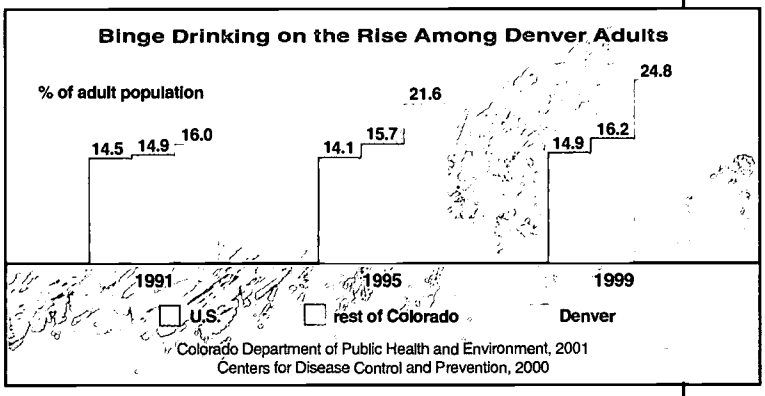
Prevalence of Substance Use in Denver

Tobacco Use

During the past decade, Denver adults have reported higher rates of smoking than in the rest of the state and the nation, according to the Behavioral Risk Factor Survey (BRFS) sponsored by the Centers for Disease Control and Prevention (CDC). Smoking rates, however, appear to have dropped recently. During the 1990s, the BRFS consistently found that one in four Denver adults said they were current smokers. But in 2000, less than one in five (19 percent) Denver adults reported themselves to be current smokers. By comparison, 26 percent of adults nationwide were current smokers in 2000, according to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Household Survey on Drug Abuse. The results of the 2001 BRFS, which are expected by Summer 2002, will confirm whether Denver has sustained this encouraging downward trend in smoking.

Binge Drinking and Chronic Drinking

Rates of binge drinking *(five or more drinks on one occasion at least once during the past month)* by Denver adults have generally ranged from 20 to 25 percent, which is considerably higher than in the rest of Colorado or nationally, where rates have hovered at around 15 percent. Far more men in Denver report binge drinking: in 1999, almost four times as many men (40 percent) as women (11 percent) said they were binge drinkers.



Rates of chronic drinking *(at least 60 drinks in the past month)* are also higher among Denver adults, ranging from 5 to 6 percent, compared to 3 to 5 percent in the rest of Colorado and the country. Like binge drinking, chronic drinking shows a persistent gender gap. One in ten men in Denver reported chronic drinking in 1999, compared to one in 45 women.

The high rates of binge and chronic drinking in Denver revealed by the BRFS are reinforced by other data showing high rates of drinking statewide in Colorado. According to the National Household Survey on Drug Abuse, in 1999 nearly two-thirds of Colorado adults were current drinkers, compared to half of adults nationwide. Based on alcoholic beverage sales data, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) reports that per capita alcohol consumption—beer, wine and spirits—is about 20 percent higher in Colorado than in the United States as a whole. (Some portion of Colorado's overall alcohol consumption is of course attributable to tourists and other visitors from out of

state, but the national figures with which Colorado is compared also include out-of-state drinkers.)

Nationwide and in Colorado, per capita alcohol consumption declined significantly over the course of the 1980s. But while the downward trend continued for the nation as a whole during the 1990s, per capita consumption in Colorado leveled off and began to increase. U.S. consumption averaged 2.28 gallons of pure alcohol per capita from 1991-1994, then fell by 4 percent to 2.18 gallons from 1995-1998. By contrast, consumption in Colorado rose slightly from 2.61 gallons in 1991-1994 to 2.62 gallons in 1995-1998. The state's 1995-1998 average alcohol consumption amounted to the equivalent of two six-packs of beer per person every week.

Illicit Drug Use

Colorado adults report higher rates of illicit drug use, including marijuana, than the nation as a whole. Although specific survey data for illicit drug use in Denver are not available, treatment admissions data for Denver residents give some sense of the extent of the problem. According to the Colorado Department of Human Services' Alcohol and Drug Abuse Division (ADAD), Denver residents accounted for one-quarter of all treatment admissions in the state for cocaine or heroin abuse from fiscal year (FY) 1998 through FY2002, even though the city made up only 13 percent of Colorado's population age 12 and older during this time. In addition, ADAD estimates that nearly half of Colorado's more than 15,000 injecting drug users live in Denver. These figures suggest that the prevalence of drug abuse in Denver is higher than in the rest of the state.

Youth Smoking, Drinking and Other Drug Use

The most recent data on substance use among Denver youth were collected in 1995, as part of the CDC Youth Risk Behavior Survey of high school students. The Denver public schools are currently conducting surveys on substance use and other risk behaviors among 7th, 8th and 9th graders, but this information is not yet available.

In 1995, 13 percent of Denver high school students reported smoking regularly *(20 or more days a month)*, lower than in the rest of Colorado and nationwide (16 percent). Recent cocaine use was also lower among Denver youth (2 percent, compared to 4 percent in Colorado and 3 percent nationwide). However, both drinking and marijuana use were substantially higher in Denver, where 57 percent of high school students reported past-month drinking, compared to 53 percent in the rest of Colorado and 52 percent nationally. Thirty-nine percent of Denver high schoolers reported past-month marijuana use, compared to 29 percent in the rest of Colorado and 25 percent nationally. Denver youth also were more likely to have started drug use at a young age. This is particularly troubling since youths who begin drinking or using drugs early are far more likely to develop serious problems later.

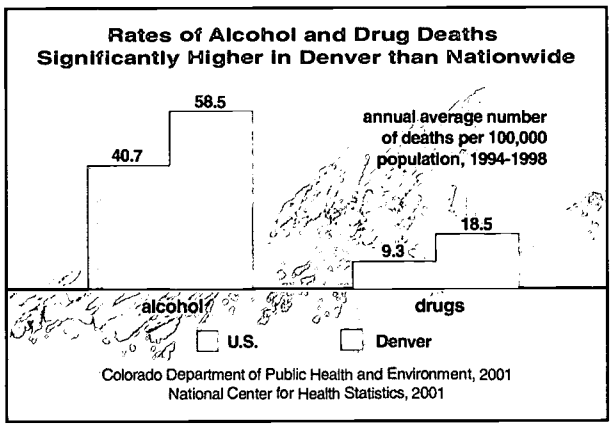
Smoking, Drinking and Other Drug Use Among Pregnant Women

Smoking during pregnancy is the most important preventable risk factor for low birthweight—which is a leading cause of fetal and neonatal deaths—and increases the risk of sudden infant death syndrome. Drinking during pregnancy can result in birth defects and mental retardation associated with fetal alcohol syndrome.

The CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) includes questions on smoking and drinking during pregnancy. According to PRAMS, Denver's rate of smoking among women who gave birth from 1997-1999 (12 percent) was lower than in the rest of Colorado as well as in 13 of the 15 other states participating in PRAMS. Only Georgia and New Mexico recorded lower rates.

Other data from the National Center on Health Statistics show that the proportion of all Denver births to mothers who smoked dropped by half in the past decade. Denver's rate has remained below the national average since 1997.

However, drinking rates among pregnant women in Denver (9.6 percent) and the rest of Colorado (9.0 percent) are considerably higher than in any of the other 15 states participating in PRAMS (which averaged 4.6 percent). Denver women account for almost a third of pregnant women in treatment for alcohol or other drug abuse in Colorado, according to statewide admissions records at treatment programs that report to ADAD.



Adverse Health Impacts

Alcohol, tobacco and other drugs affect the health and well-being of Denver residents who use them as well as those who do not, while adding to the city's health care costs. Smoking greatly increases the risk of premature death from a number of chronic diseases, including cancer and heart and respiratory diseases. Heavy drinking over prolonged periods can cause irreparable liver damage and a number of other often fatal diseases. Even mild alcohol and other drug intoxication can impair driving ability and lead to motor vehicle crash injuries and deaths. Acute alcohol and drug intoxication (overdose) can kill directly, and injection drug use is an important factor in the transmission of HIV and other types of infectious diseases. The Denver Health and Hospital Authority (DHHA) estimates that at least 12 percent of its annual operating budget is devoted to services related to alcohol, tobacco and other drug abuse. In FY2002, DHHA spent $35.9 million on medical care for patients with diagnoses directly attributable to smoking, drinking and other drug use, and another $9.1 million on alcohol detoxification and methadone maintenance treatment.

Substance abuse also undermines families and puts children at risk of harm. On any given day, an average of 1,900 Denver children are in out-of-home placements. According to the Denver Department of Human Services, 71 percent of these cases are the result of parental substance abuse.

The toll of substance use on Denver's health can be measured in deaths, illnesses and injuries, drawing on data from various health surveillance systems. One in every four deaths in the city is related to smoking, drinking or other drug use. Smoking is by far the leading killer, taking the lives of more than 800 Denver residents each year.

Alcohol-related diseases and injuries in Denver claim 300 lives annually, while other drug use is responsible for an additional 100 deaths, including deaths from AIDS where the virus was transmitted by contaminated drug injection syringes. Overall, Denver's death rate from alcohol and other drugs is double the rate in the rest of Colorado and 54 percent higher than the national rate.

Illnesses and Deaths Attributable to Smoking and Drinking

Denver's death rate from smoking is on par with the national average but is significantly higher than in the rest of Colorado. From 1994-1998, Denver's smoking-related death rate was 40 percent higher than in the rest of the state.

The severity of alcohol's impact on the health of Denver residents is evident in trends in illnesses and deaths associated with heavy or prolonged alcohol use. According to the NIAAA, the disease categories most closely associated with heavy and prolonged drinking are alcoholic psychoses, alcohol dependence syndrome, alcohol abuse, and chronic liver disease and cirrhosis. Measured in terms of hospital discharges and deaths, the toll taken by these diseases in Denver is considerably more severe than in the rest of Colorado and nationwide.

Alcohol-Related Hospitalizations and Deaths

From 1994 through 1998, Denver residents accounted for more than 25 percent of all hospital discharges statewide in which the primary diagnosis was an alcohol-related disease. During this period, the national rate of alcohol-related hospital discharges declined; however, Denver's rate rose, climbing to nearly double the national average by 1998 (35 per 10,000 residents age 15 and older, compared to 19 per 10,000). Denver's hospital costs also rose. In 1998, Denver's 1,500 alcohol-related hospitalizations amounted to more than 7,800 hospital days.

Denver residents accounted for 27 percent of deaths statewide from 1994-1998 in which the underlying cause was alcohol-related. During that time, Denver's death rate from drinking (24 deaths per 100,000 residents) was nearly double the rate nationwide (13 per 100,000).

Alcohol-Related Motor Vehicle Crash Fatalities

The NIAAA estimates that more than one in three accidental falls and one in four accidental shootings nationwide are alcohol-related. Nationally, motor vehicle accidents are the most significant cause of accidental alcohol-related fatalities. Crashes involving alcohol are usually more severe than other types of crashes, involving higher speeds and frequent failure by the driver and passengers to wear seatbelts. From 1996-2000, Denver averaged 27 alcohol-related crash deaths per year, accounting for 11 percent of the statewide total. In 1999, the most recent year for which comprehensive data are available, Denver's rate of alcohol-related crash fatalities was slightly higher than in the rest of the state but lower than the national average.

Illnesses and Deaths Due to Drug Abuse

As with alcohol-related diseases, the adverse consequences of drug abuse can be tracked through hospitalizations and deaths. In Denver, information on drug-related hospitalizations is gathered in terms of hospital discharges and in terms of emergency department episodes. The Colorado Department of Public Health and Environment manages the state's hospital discharge records. SAMHSA operates the Drug Abuse Warning Network (DAWN), which tracks drug-related hospital emergencies and drug-related deaths in metropolitan areas across the country.

Drug-Related Hospital Discharges

From 1994-1998, Denver averaged nearly 500 hospital discharges where the primary diagnosis was drug related (including drug overdose, drug dependence, drug psychoses and nondependent abuse of drugs). During this period, Denver's rate of drug-related hospital discharges was more than double the rate in the rest of the state (90 per 100,000 population, compared to 42 per 100,000). Drug overdose was the primary diagnosis in more than half of these discharges.

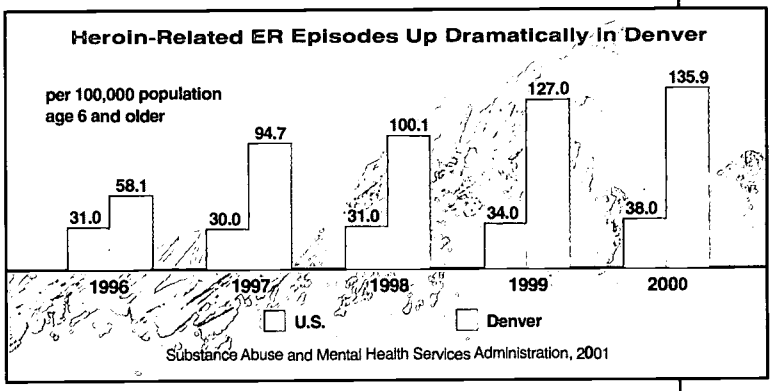
Drug-Related Hospital Emergency Department Episodes

DAWN tracks the total number of drug-related hospital emergency department (ED) episodes and mentions of particular drugs, including alcohol when it has been used in combination with another drug. DAWN's published reports provide information for entire metropolitan areas, including central cities and their surrounding counties. But for certain metropolitan areas, including Denver, DAWN data can be disaggregated to reveal trends in the central city itself. For Denver, DAWN shows considerably higher rates of drug-related hospital emergencies than the national average. From 1996-2000, Denver averaged 563 drug-related hospital ED episodes per 100,000 residents age 6 and older, nearly 2½ times higher than the national average (227 per 100,000). Denver's rates of mentions for alcohol-in-combination, cocaine, heroin, marijuana and methamphetamine were also well above the national averages.

Unlike the hospital discharge data discussed above, DAWN drug episodes are recorded according to the location of the hospital where they occur, not according to the patient's address. In the Denver metropolitan area (Denver and neighboring Adams, Arapahoe, Douglas and Jefferson counties), hospitals within the city handle far more drug cases than their suburban counterparts. While Denver accounted for less than 30 percent of the metropolitan area population in the year 2000, city hospitals recorded the majority (54 percent) of the area's 4,945 drug-related ED episodes, including 60 percent of cocaine mentions, 63 percent of methamphetamine mentions and 92 percent of heroin mentions. Marijuana was the most notable exception to the rule; city hospitals recorded 31 percent of total marijuana ED mentions in the year 2000, with the majority occurring in the surrounding counties.

Drug-Related Deaths

Based on reports from medical examiners, DAWN also tracks deaths due to drug abuse in metropolitan areas across the country, including Denver and its surrounding counties. The number of drug deaths recorded in Denver surged from 72 in 1996 to 135 in 1999, before declining slightly to 123 in 2000. Of the city's 123 drug-related deaths in 2000, 95 were the direct result of drug abuse, such as overdoses. In 28 other cases, drugs were a contributing factor but not the sole cause of death. The majority of Denver's drug-related deaths—61 percent in 2000—involved more than one type of drug, with cocaine, alcohol-in-combination and heroin predominating.



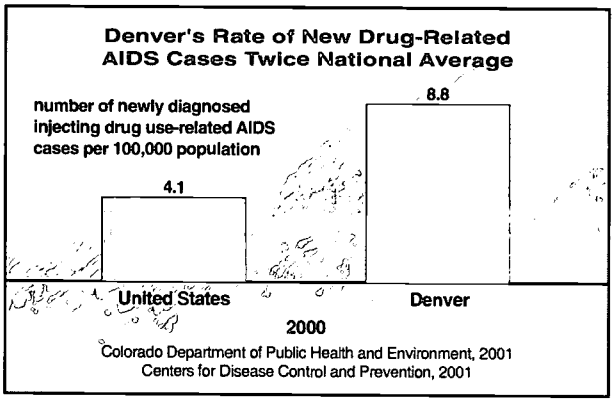
DAWN's drug-related mortality reports do not include a national average rate of drug-related deaths. However, DAWN does report on drug-related deaths in several cities comparable in size to Denver, including Baltimore, New Orleans, St. Louis and Washington, D.C. In 2000, Denver's drug-related mortality rate exceeded the rates in New Orleans, St. Louis and Washington, D.C., while Baltimore's rate far exceeded all the others.

HIV and AIDS Incidence and Mortality

Denver accounts for more than half of the injection drug use (IDU) related HIV and AIDS cases in

Colorado. Since the onset of the AIDS epidemic, 532 Denver residents diagnosed with IDU-related AIDS have died, accounting for more than half of such deaths statewide. The 370 Denver residents with IDU-related AIDS who remain alive constitute 42 percent of living IDU-related AIDS cases in the state.

The rate of new IDU-related AIDS diagnoses in Denver substantially exceeds the rates in the rest of Colorado and nationally. Although Denver's rate of newly-diagnosed cases declined significantly from 1995-2000, the city still has a new diagnosis rate nearly five times higher than the rest of Colorado and more than double the U.S. rate. In addition, Denver's death rate due to IDU-related AIDS remains substantially above the rate in the rest of the state and the nation. The city's IDU-AIDS death rate was nearly 14 times higher than the rate in the rest of Colorado and nearly double the U.S. rate.



Unmet Need for Treatment in Denver

No official estimate of treatment need exists for Denver. On the basis of state and local substance use survey results, treatment admissions data and indicators of adverse health consequences due to alcohol and drug use, Drug Strategies estimates that between 45,000 and 60,000 Denver residents age 12 and older need treatment for substance abuse and addiction. The fairly wide range of this estimate underscores that it is necessarily speculative, and based on extrapolations from a variety of different data sources.

About 2,000 Denver residents participate in community-based treatment annually, according to FY1998-2002 admissions data from programs that report to Colorado's Alcohol and Drug Abuse Division (ADAD). (Programs required to report to ADAD include all those that receive any public funding, as well as all methadone maintenance programs and all juvenile justice programs.) Another 1,500 Denver residents participate in treatment each year while on probation with the Denver Drug Court. In addition, 1,800 Denver residents take part in court-ordered drinking driver programs, and about 4,500 are admitted to detoxification programs. For many people dependent on alcohol or other drugs, detox is a critical first step in the treatment process. Without subsequent treatment, however, detox alone is unlikely to lead to sustained periods of reduced substance use or abstinence.

There is no recent estimate of the number of Denver residents participating in treatment at programs which are not required to report to ADAD and which do not serve Denver Drug Court probationers. Based on past estimates, if another 3,500 people are assumed to be in treatment, then the total number of Denver residents in treatment over the course of a year rises to about 7,000. By any measure, Denver has a very wide treatment gap. At least 35,000 people who would benefit from treatment are not receiving it.

Alcohol and illicit drugs are closely linked to crime. Two-thirds of adult arrestees in major U.S. metropolitan areas consistently test positive for at least one illicit drug, and more than one-third say they are heavy drinkers. Alcohol, drugs and crime are linked in at least three ways:

- Crimes are often committed by people under the influence of alcohol or other drugs. Nationwide, more than half of state prison inmates report having committed their offense under the influence of alcohol or drugs. Alcohol intoxication, in particular, reduces inhibitions against reckless and violent behavior. Neighborhoods with a high density of liquor stores suffer increased health and social problems, including violent crime.
- Drug users frequently commit crimes to get money to buy drugs. Nationwide, almost one in three state prisoners convicted of robbery, burglary or theft say they did so for drug money.
- Illicit drug markets are often violent. Drug dealers use force to defend territory, discipline employees and settle disagreements with buyers. According to the National Institute of Justice, crack cocaine markets in particular generate high rates of community violence.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) have jointly developed estimates of the extent to which alcohol and drug use are factors in violent and property crimes nationwide. Overall, according to NIAAA and NIDA, alcohol is involved in about 20 percent of FBI "index crime" violent offenses (murder, rape, aggravated assault and robbery), while illicit drugs are a factor in about 12 percent of violent crimes. With respect to FBI index crime property offenses (burglary, theft and motor vehicle theft), alcohol is involved in about 3 percent of offenses, and illicit drugs in about 25 percent. Based on these estimates, about 1,000 violent crimes (nearly three per day) and 7,200 property crimes (nearly 20 per day) linked to alcohol or drugs were committed in Denver each year from 1996-2000.[1]

Alcohol, Drugs and Crime in Denver

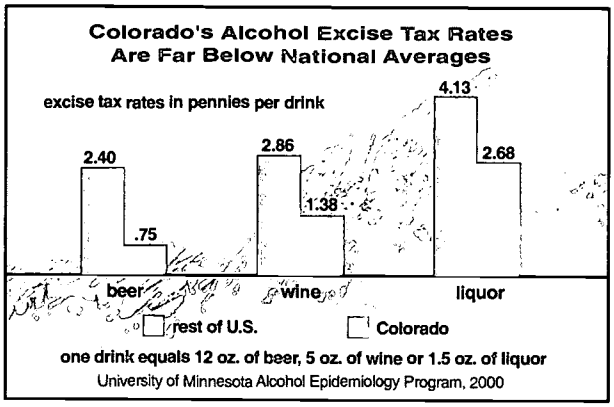
The data available for Denver indicate that alcohol and drugs play as important a role in crime locally as they do nationwide.

- Drinking and drug use is high in Denver compared to the rest of the country.
- Two-thirds of those arrested in Denver test positive for illicit drugs, regardless of the offense, and half of Denver arrestees are addicted to alcohol, other drugs or both.
- Nearly half of felony offenders on probation in Denver and about 80 percent of prisoners and parolees statewide need treatment for substance abuse.

Denver's high rates of binge and chronic drinking are reflected in alcohol-related illness and death rates in the city. Alcohol is readily available and inexpensive. The city's 1,259 licensed retail alcohol outlets amount to one outlet for every 440 Denver residents, a 58 percent higher concentration than in Denver's surrounding counties, where there is one outlet for every 696 residents. Bars and liquor stores are concentrated in Denver's poorer areas. For example, 25 percent of all the bars and liquor stores in the city are located within five neighborhoods (Auraria-Lincoln

[1] Denver's crime rate has declined steadily since the early 1990s. By 2000, Denver's crime rate was well below the average among 32 other comparably-sized U.S. cities. However, despite the steady drops in recent years, Denver's year 2000 crime rate—4,742 crimes per 100,000 residents—remained 15 percent higher than the national average and 23 percent higher than in the rest of Colorado.

Park, Baker, Five Points, Highland and West Colfax) which are home to only 8 percent of Denver residents. Average household income in these five neighborhoods is 42 percent lower than the citywide figure, while the crime rate is double the city average.



Colorado's alcohol excise tax rates are among the lowest in the country, making beer, wine and liquor cheaper than in most other states.[2] On a per-drink basis, Colorado's beer, wine and liquor excise tax rates are less than one-third, less than one-half and less than two-thirds the national averages, respectively. Because Colorado's alcohol excise taxes are not indexed for inflation, their value erodes over time. Colorado's current excise tax on beer (8¢ per gallon) is worth only 30 percent of its value in 1976, when the tax was last raised. The current excise taxes on wine (7.33¢ per liter) and liquor (60.26¢ per liter) are worth only half their value in 1981, when they were last raised.

Although general population survey data on illicit drug use in Denver are lacking, rising rates of hospital emergencies due to cocaine and heroin abuse, as well as continuing diagnoses of drug-related AIDS cases, indicate a substantial demand for drugs. The Denver Police Department considers heroin, cocaine, methamphetamine and marijuana all to be widely available in the city. Law enforcement officials point to several factors that make Denver both a prime destination and a convenient transshipment site for traffickers, particularly from Mexico. Denver is only 550 miles from the U.S.-Mexican border, with easy access north on Interstate Highway 25 (I-25). Tighter border controls have prompted traffickers to move their inventories directly to interior U.S. cities, including Denver. A major east-west highway, I-70, also runs through Denver, making it a distribution hub for drugs to other cities in the Mountain West and the Midwest.

The Denver Police Department estimates that roughly half of its $108 million operations budget for FY2001 was devoted to enforcement related to alcohol and illicit drugs. Denver's City Attorney, District Attorney and County Court spent another $6.7 million on legal matters involving alcohol and drug abuse.

Substance Abuse Widespread Among Denver Arrestees

The National Institute of Justice's Arrestee Drug Abuse Monitoring (ADAM) program measures illicit drug use among booked arrestees, including Denver adult arrestees (since 1990) and juvenile arrestees (since 1994).[3] Denver arrestees test positive for drug use at higher rates than do arrestees in more than a dozen other cities of similar size. More than 68 percent of arrestees in Denver from 1995-1999 tested positive for at least one illicit drug. For males, only Atlanta among similar-sized ADAM cities had a higher drug-positive rate over this period. For females, only Portland recorded a higher rate than Denver.

Cocaine and marijuana are by far the most commonly-used illicit drugs among male and female

[2] Beer accounts for the vast majority (85 percent) of alcohol sold in Colorado, and is lightly taxed even by comparison with Colorado's seven neighboring states. For example, the combined state tax (excise and sales) on a $6 six-pack of beer sold in Colorado amounts to 22¢, less than half the average combined state tax on the same product in neighboring Arizona, Kansas, Nebraska, New Mexico, Oklahoma, Utah and Wyoming.

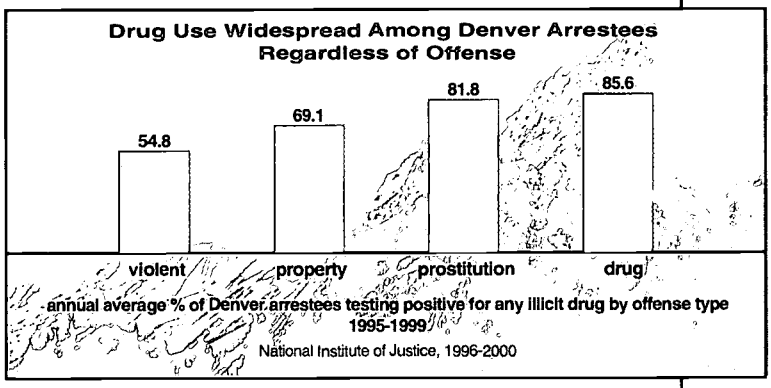
arrestees in Denver. Since 1995, rates of cocaine use among adult male and female Denver arrestees have been consistently higher than the average rates in cities of similar size. However, heroin and methamphetamine use rates are considerably lower among Denver arrestees, falling well below the average drug-positive rates in other cities.

Drug use is widespread among Denver arrestees across all types of offenses, not only those arrested on drug charges. From 1995 through 1999, 86 percent of adult drug offense arrestees tested positive for drugs (including 61 percent who tested positive for cocaine). At the same time, three out of four adults arrested for robbery tested positive, as did two-thirds of all theft arrestees.

Most male juveniles arrested in Denver also test positive for illicit drugs. As with adults, rates of drug use among juvenile arrestees are consistently higher than in comparably-sized cities. From 1995-1999, 60 percent of Denver juvenile male arrestees tested positive for at least one illicit drug, compared to 52 percent in five similar-sized cities over the same period. For juveniles in Denver and elsewhere, marijuana has been by far the leading drug. From 1995-1999, 58 percent of Denver juvenile male arrestees tested positive for marijuana, well above the positive rates for cocaine (9.3 percent), methamphetamine (0.7 percent) and opiates (0.1 percent).

Rates of Addiction High Among Denver Arrestees

In 1995 and 1996, Colorado's Alcohol and Drug Abuse Division (ADAD) measured the extent of addiction among arrestees statewide. ADAD found that slightly more than half of Denver arrestees (50.5 percent) were dependent on alcohol or illicit drugs, compared to about a third of arrestees in the rest of the state (34.5 percent). The difference in addiction rates between arrestees in Denver and elsewhere in the state was even more pronounced with respect to cocaine and heroin. Nearly one in five Denver arrestees (18.3 percent) was considered cocaine dependent, more than double the rate among arrestees elsewhere in Colorado (8.7 percent). One in 20 Denver arrestees (5.6 percent) was considered heroin dependent, eight times higher than the rate of heroin dependence among arrestees in the rest of Colorado (0.7 percent).



Nearly half of all felony offenders on probation in Denver are also considered in need of substance abuse treatment, regardless of the type of offense that led to their sentence. In FY2001, 47 percent of the 4,500 probationers under the supervision of the Denver district court were assessed as needing treatment, according to the Colorado Office of the State Court Administrator.

The Emphasis—and Burden—on Enforcement

Alcohol and drug-related crimes place a heavy burden on law enforcement and criminal justice resources. Police are continually responding to

[3] Denver is one of 38 ADAM sites nationwide, most of which are located in large urban areas. Arrestees are interviewed for information about their alcohol and other drug use patterns, and urinalysis is used to detect recent illicit drug use. Beginning with the year 2000, program sampling methods have been improved so that the findings can be generalized to all arrestees in each participating site. For Denver, preliminary results for the year 2000 appear to validate the data for prior years.

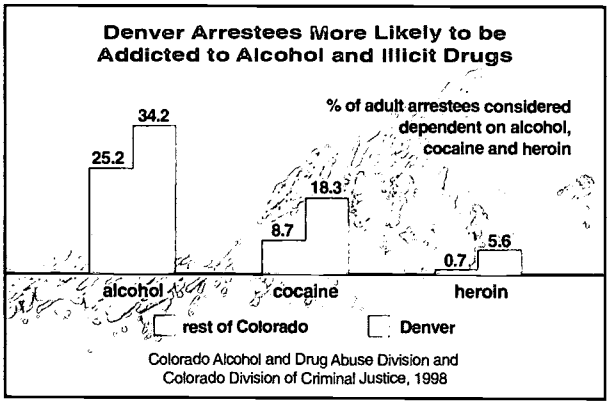
crimes in which the offender is involved in alcohol, illicit drugs or both. Based on the NIAAA-NIDA estimates of the role played by alcohol and drugs in crime, Denver police made nearly 2,500 arrests for FBI "index" violent and property crimes related to alcohol and drugs each year from 1997-2001. Over the same period, Denver police made an even greater number of arrests for driving under the influence (DUI), averaging more than 4,000 DUI arrests per year. Moreover, Denver police make arrests for drug sales and possession offenses in still greater numbers, averaging 6,400 such arrests annually from 1997-2001.

Beginning in the mid-1980s, the arrest and criminal justice processing of drug law offenders has come to command a substantial share of enforcement efforts and budgets nationwide. Increasing numbers of arrests, aggressive prosecution and tough sentencing have caused a dramatic rise in the number of drug offenders behind bars in state prisons across the country. This surge in the incarceration of drug offenders has been a major factor in the explosive growth in the overall U.S. incarceration rate. The trends toward intensified drug law enforcement evident nationwide over the past 15 years have been even more pronounced in Denver.

Drug Offense Arrests and Drug Felony Cases in Denver

Between 1991 and 1995, Denver arrests for drug possession and sales offenses more than doubled. Drug arrests peaked in 1998 and have declined since. However, the number of drug arrests in 2001 was still double the number made 10 years earlier. From 1996 through 2000, Denver police made drug arrests at an average rate of 1,234 per 100,000 city residents, more than twice the average nationwide and in the rest of Colorado. The vast majority of Denver's drug arrests (93 percent) are for possession offenses.

Denver's increase in drug arrests has been surpassed by an even sharper increase in the rate at which felony drug cases are brought to state district court in Denver. When drug charges are considered a defendant's most serious offense, the case is recorded by the court as a drug offense. The number of drug felony cases filed in Denver rose more than seven-fold between 1986 (398 cases) and 1996 (3,107 cases), before declining steadily to 2,265 in 2001. In 1986, drug cases represented only 14 percent of all felony cases filed in Denver district court. By 1990, they comprised one-quarter of all felony filings, and since 1995, one-half.



The surge in drug felony filings in Denver in recent years has been matched by rising numbers of convictions. From 1994 through 1998 (the most recent five-year period for which data are available), the number of drug felony convictions in Denver doubled, climbing from 1,109 to 2,240. Half of all drug convictions during this period were for possession.

State court conviction and sentencing data for the nation as a whole are available for 1994, 1996 and 1998, allowing for comparisons between Denver and U.S. rates. In 1994, Denver's drug conviction rate

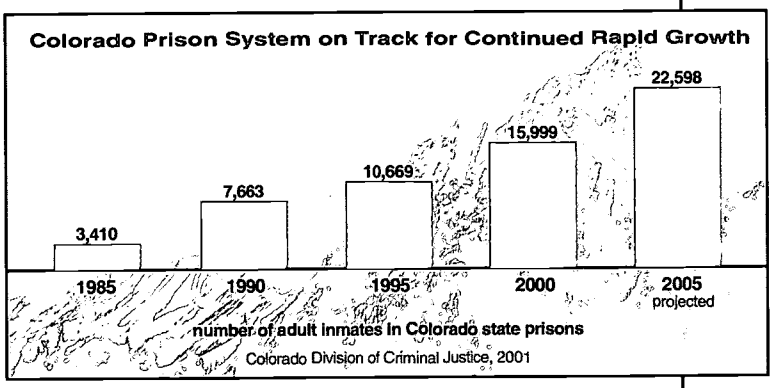
was nearly double the national average; by 1998, it was more than triple the national rate.

One explanation for the increase in drug arrests and convictions is the creation in 1994 of one of the nation's most comprehensive treatment drug courts. Since 1994, the Denver Drug Court has provided a treatment option to a majority of persons convicted in Denver on drug charges. Offenders who plead guilty or are found guilty of a felony drug charge are placed under strict supervision for treatment participation and tested frequently for drug use to monitor their compliance.

Denver's Drug Imprisonment Boom

The number of drug offenders from Denver sentenced to prison climbed rapidly during the 1990s. By 1996, Denver was sentencing more drug offenders to prison than the total number of drug felony cases filed only a decade earlier. The number of Denver drug offenders sentenced to prison continued to rise steeply; by 1998, Denver was imprisoning drug offenders at more than twice the national rate.

State prison populations nationwide have ballooned over the last two decades, led by explosive growth in the number of drug offenders put behind bars. Colorado's prison expansion has been exceptionally rapid. During the 1990s, only six states recorded faster prison population growth rates. The number of inmates in Colorado during this period rose by 119 percent, well above the national average growth rate of 72 percent. Moreover, the state's prison population is still growing. The number of inmates is projected to rise from 17,150 at the end of 2001 to 24,500 by the end of 2006, a rate of



increase on par with that of the 1990s. Nearly one in every three Colorado prison inmates is from Denver.

Colorado's unprecedented prison growth has been fueled in large part by rising numbers of incarcerated drug offenders. Drug offenders comprise a significant fraction of all new court commitments to prison in Colorado. From 1997 through 2000, 24 percent of all new prisoners were drug offenders, more than the total sentenced to prison for robbery, assault, theft, burglary and motor vehicle theft combined (23 percent). By June 2001, one in every five Colorado prison inmates was a drug offender.

Denver has consistently accounted for a disproportionately high share of drug offenders sentenced to prison. Thirty-seven percent of drug offenders sent to prison statewide from 1994-1998 were sentenced in Denver, even though the city comprised only 13 percent of Colorado's population. As of June 2001, Denver residents accounted for 42 percent of the nearly 3,200 drug offenders behind bars in Colorado prisons. The drug offense incarceration rate among Denver residents (308 state drug prisoners per 100,000 residents 18 and older) is nearly 2½ times the national rate (125 per 100,000).

Alcohol, tobacco and other drug abuse exacts a tremendous toll on Denver residents. The costs of the human suffering involved cannot be measured in dollars and cents. No monetary value can be placed on grief for a dead friend or family member; the trauma of a disfiguring car crash; the turmoil of those fighting addiction and the havoc experienced by their loved ones; or the fear of falling victim to a crime.

At the same time, many of the harms inflicted by substance abuse can be quantified economically, and the costs are steep. For the country as a whole, federal government estimates place the economic costs of alcohol and drug abuse at nearly $375 billion annually—a burden shared by individuals, businesses and all levels of government. Direct medical expenses and lost economic productivity due to smoking-related illness and premature death account for another $170 billion in costs each year. Extrapolating from these figures, Drug Strategies estimates that the economic costs of alcohol, tobacco and other drug abuse in Denver exceed $1.5 billion per year—about $2,600 per person.

Medical Costs and Lost Productivity Due to Smoking in Denver

In Colorado, more than $1 billion in direct medical expenditures are attributable to cigarette smoking each year, part of the $75 billion in such expenditures nationwide. Smoking-related illnesses and premature death cost Colorado another $1 billion in lost economic productivity each year, part of national losses totaling $93 billion. Given that Denver accounts for close to 18 percent of all smoking-related deaths in Colorado, Drug Strategies estimates that smoking-related medical expenditures in the city amount to about $185 million per year, and that smoking-related productivity losses cost Denver another $185 million each year. Smoking's economic toll in Denver, therefore, is about $370 million a year.

Economic Costs of Alcohol and Other Drug Abuse in Denver

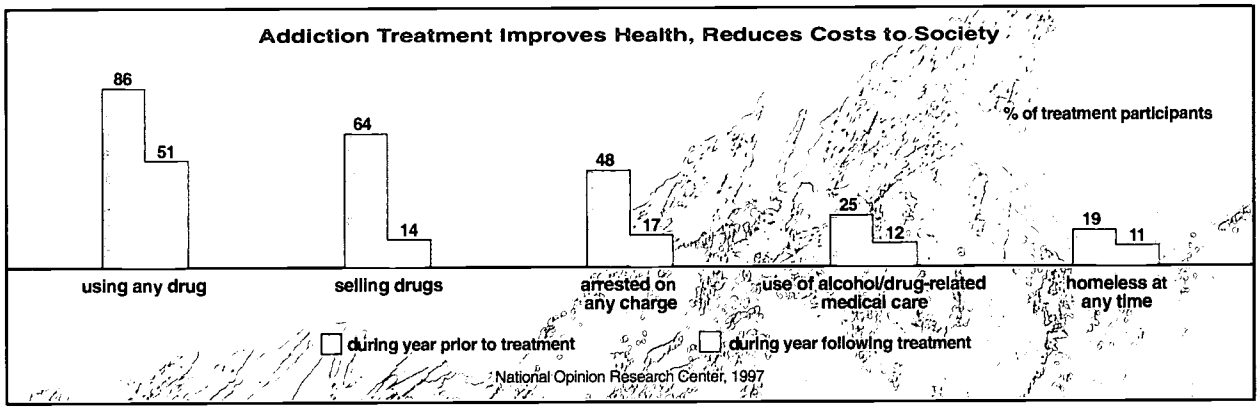
Alcohol and drug abuse cost the nation at least $375 billion each year. Published jointly by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA), the basis for this cost estimate includes spending on prevention, treatment, enforcement and criminal justice; medical expenditures resulting from alcohol and drug-related illness and injury; and lost earnings due to illness, premature death, criminal victimization and incarceration. The overall $375 billion nationwide cost figure should be understood as a conservative estimate, since some likely costs—such as the impact of employee substance abuse on a company's performance—cannot be calculated for lack of appropriate data.

If substance abuse problems in Denver were no more severe than they are on average nationwide, then the city's estimated economic costs would be directly proportional to Denver's share of the total U.S. population—about $735 million per year. However, as earlier chapters have documented, Denver's alcohol and drug-related problems are significantly more serious than the national average:

- Rates of binge drinking and chronic drinking are about 40 percent higher among Denver adults than among adults nationwide.
- Denver residents are hospitalized for alcohol-related illnesses at nearly twice the national rate.
- Denver's alcohol-related death rate is 44 percent higher than the national rate, while the city's death rate due to other drugs is nearly double the U.S. rate.

- Drug-related hospital emergencies occur in Denver at 2½ times the national rate.
- Drug-related AIDS cases are diagnosed in Denver at twice the national rate.
- Denver's crime rate is 15 percent higher than the national average.
- Denver arrests and imprisons drug offenders at more than twice the rate nationwide.

Drug Strategies estimates that alcohol and other drug abuse costs Denver between $1.1 billion and $1.5 billion per year. With an additional $370 million in annual economic costs attributable to smoking, substance abuse costs Denver residents, businesses and government at least $1.5 billion—and as much as $1.9 billion—each year.



Substance abuse has become an increasingly prominent concern of Denver policymakers in recent years. Momentum has been gathering in support of significant new investments to reduce alcohol, tobacco and other drug problems. In January 2002, Mayor Wellington E. Webb declared that the fight against addiction would be a major emphasis of his final year and a half in office. The Mayor proposed nearly $1 million in new spending on prevention and treatment initiatives, despite the recent economic downturn and the resulting budget constraints. Mayor Webb underscored his determination to keep the focus on substance abuse by moving the city's drug strategy coordinator from the public safety office into the mayor's office.

These announcements marked the culmination of deliberations set in motion in the Spring of 1998, when Mayor Webb established a commission to assess Denver's substance abuse needs and recommend appropriate strategies. In 1999, the commission called for a collaborative approach in which enhanced prevention programs and expanded treatment capacity would complement ongoing enforcement efforts. The commission also urged broad community involvement in shaping specific strategies, and counseled that each strategy should be research-based and include measurable goals. To guide the process, the commission advocated the creation of the city's own drug policy leader. In July 2000, the Mayor acted on this advice, naming Adam Brickner as Denver's first Drug Strategy Coordinator.

Since then, a task force of city officials, business leaders, service providers and community representatives convened by Mr. Brickner has met regularly to frame an overall substance abuse strategy for the city and to establish policy priorities. The task force has set five major goals:

- Educate Denver's diverse community to make healthy choices about substance use, abuse and the disease of addiction.
- Identify and reduce gaps in substance abuse and addiction services.
- Provide links to substance abuse prevention, intervention and treatment services.
- Support the enforcement of laws and policies to improve the quality of life in relation to the use and abuse of alcohol, tobacco and illegal drugs.
- Encourage employers to enact proactive substance abuse policies and programs.

The strong emphasis placed by the task force on improvements in prevention and treatment services is reflected in the Mayor's push for new funding in these areas.

Greater Investment in Prevention and Treatment Supported by Research

The growing support in Denver for enhancing local prevention and treatment efforts is animated by the recognition that city residents are already paying dearly for substance abuse problems. As the previous chapter documents, alcohol, tobacco and other drug abuse costs Denver residents, businesses and government at least $1.5 billion every year. A growing body of scientific research shows that prevention and treatment are cost-effective in reducing the burdens substance abuse imposes on society, and therefore they merit substantially increased investment.

The Case for Prevention and Early Intervention

To the extent that young people never begin using alcohol, tobacco or illicit drugs in the first place—or delay initiation of use until they are older—the number of people who eventually develop substance abuse and addiction problems can be

substantially reduced. Age of initiation is a powerful predictor of substance abuse problems later in life. Almost all first use of tobacco occurs before the end of high school. Those who do not begin smoking during their adolescent years rarely do so later. Youth who begin drinking early (before age 15) are four times more likely to develop alcohol dependence than those who begin at age 21. Each year's delay in initiation of drinking greatly reduces the likelihood of later alcohol problems. So, too, for marijuana. According to the 1999 National Household Survey on Drug Abuse, among adults who first used marijuana before age 15, 9 percent were dependent on an illicit drug in the past year, compared with fewer than 2 percent of adults who first tried marijuana at age 18 or older.

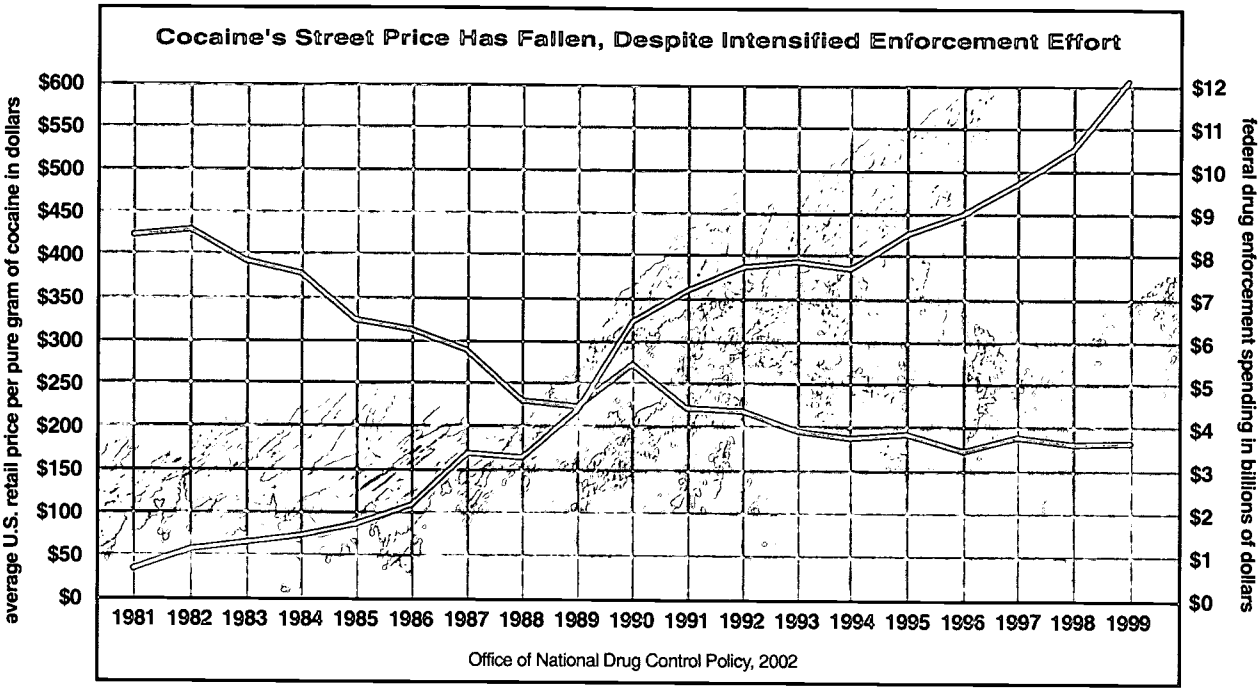
A wide range of policies and programs have proved effective in preventing or delaying substance use, and in discouraging experimental users from progressing to more frequent use. For example, research has shown that youths and young adults are especially sensitive to alcohol and tobacco price increases. Raising the price of cigarettes and alcohol through higher excise taxes reduces rates of youth smoking and drinking.

The Case for Treatment

Denver's increasing emphasis on treatment is supported by three decades of scientific research and clinical practice demonstrating treatment's effectiveness. By its nature, addiction cannot be fixed the way a broken leg can be set and healed. Once a broken leg is mended, we do not expect that the leg will break again. Because addiction is a chronic, recurring disorder, the ultimate goal of long-term abstinence requires ongoing management, as is the case with other chronic disorders, such as hypertension and diabetes. By reducing drug use and the corresponding social damage, treatment confers real benefits, especially when compared to the alternative—non-treatment and unchecked drug abuse.

The most recent national, multi-site evaluation—the National Treatment Improvement Evaluation Study (NTIES)—examined results for more than 4,400 patients in treatment between 1993 and 1995. The study found that the proportion of patients using any drug dropped by 41 percent in the year after treatment. Significant reductions also occurred in the proportion of patients selling drugs (down 78 percent), arrested on any charge (down 64 percent), requiring medical care due to alcohol or other drug use (down 54 percent), and being homeless (down 42 percent).

The benefits of treatment far exceed the costs. A landmark 1994 study, *The California Drug and Alcohol Treatment Assessment* (CALDATA), found that every dollar invested in treatment saved tax-payers seven dollars in future costs. CALDATA researchers concluded that "each day of treatment paid for itself ... on the day it was received, primarily through an avoidance of crime." In the NTIES treatment evaluation, treating low-income clients created a net savings of more than $6,200 per client—due to reduced spending on health care, welfare and crime-related costs—with a three-to-one ratio of benefits to costs. Based on these findings, NTIES researchers estimate that public treatment services supported by federal funds in 1994 generated a net benefit to society of $1.7 billion. Treatment is also cost-effective compared to other drug control strategies that compete for public funds. As a means of reducing cocaine consumption, the RAND Corporation has found that treatment for heavy cocaine users is 23 times more effective than drug crop eradication and other source-country programs, 11 times more effective than interdiction and 3 times more effective than mandatory minimum sentencing.



People typically enter treatment when the adverse consequences of alcohol or other drug abuse or addiction compel them to seek help. For many, this may be some personal calamity (job loss, marriage breakup, legal difficulties or health problems) if they fail to curtail their substance use. Those arrested for criminal activity may be compelled to enter treatment by court order, or offered the chance to participate in treatment rather than face full criminal prosecution and the threat of incarceration.

Treatment can work whether a patient enters freely or under coercion from the criminal justice system. Most of the research on treatment outcomes has dealt with patients who entered treatment voluntarily, but several recent studies have demonstrated the effectiveness of coerced treatment as well. Indeed, involvement in the criminal justice system presents a prime opportunity to engage drug users in treatment.

The Role of Enforcement

While emphasizing the need for greater attention to prevention and treatment programming, Denver's strategic goals do not neglect the important role of enforcement in limiting substance abuse. Laws prohibiting the use, possession or sale of many substances (such as cocaine), and legal restrictions on who can use alcohol (minimum legal drinking age laws), enjoy wide public support and undeniably limit the prevalence of substance abuse. For example, the vast majority of Americans (89 percent) have never used cocaine, according to the National Household Survey on Drug Abuse. Even marijuana, by far the most commonly-used illicit drug, has never been used by two-thirds of Americans. Researchers credit the shift to a minimum legal drinking age of 21 in all 50 states with having prevented some 700 to 1,000 traffic fatalities each year for the past decade, and with having contributed to a sizeable decline in past-month drinking and binge drinking among high school seniors nationwide.

At the same time, Denver's push for expanded treatment services recognizes the limits of the emphasis on intensified enforcement that has domi-

nated the American response to drug abuse since the 1980s. During this period, the number of casual users of illicit drugs has declined considerably; the number of occasional *(less than monthly)* cocaine users fell from an estimated 7.1 million in 1985 to 1.7 million in 2000. But in recent years, heavy drug use has remained fairly constant. The number of chronic cocaine and heroin users *(more than 10 times a month)* declined only slightly between 1995 and 2000, from 3.8 million to 3.6 million.

Tough-on-drugs rhetoric and policies have hardened attitudes toward heavy drug users, pushing them further to the margins of mainstream society, and increasing the adverse consequences of their drug use. This marginalization is borne out in the steeply rising rates of drug-induced deaths and drug-related hospital emergencies since the late 1980s. Since 1988, when intensified drug enforcement was well underway, the annual rate of drug-related deaths has risen by more than 55 percent, while the rate of cocaine and heroin-related hospital emergencies has climbed by 71 percent.

Putting more drug dealers behind bars was supposed to make illicit drugs harder to find, thereby reducing drug use and its related harms. Incapacitating enough dealers and deterring others from selling drugs would, in theory, make drugs more scarce and more expensive. But with an illicit commodity such as drugs, locking up one distributor simply creates a job opening for someone else. The openings created by incarcerating low-level street dealers are readily filled by replacements from the same drug organization or from a competitor. Even when replacement is not immediate, remaining dealers can pick up the slack in the local market by selling more drugs themselves.

Nationally, retail prices for cocaine and heroin are now about half and two-thirds their 1981 levels, respectively. Crack, singled out for particularly tough sentencing in federal law and in some states, is no more expensive at the retail level than powder cocaine. Moreover, high school seniors nationwide report that crack is as easy to obtain now as it was in 1987 at the height of the crack epidemic, and that heroin is significantly easier to get now. In Denver itself, the street prices of crack and heroin have essentially not changed since the mid-1990s.

Pursuing a Comprehensive Strategy

Denver has made significant strides in pursuing a comprehensive strategy that balances the historically predominant role of enforcement with new investments in prevention and treatment services. A variety of programs are already in place or being readied for implementation with the goal of ensuring access to the full continuum of substance abuse services—including prevention; early intervention; treatment; and transition and recovery. Illustrative efforts in each area (not an exhaustive catalogue of relevant city programs) are noted below.

Prevention

- Denver Public Schools utilize one of the nation's most extensively evaluated substance abuse prevention programs, Life Skills Training (LST). The LST curriculum focuses on providing upper elementary and middle school students with the personal and social skills to resist peer and media pressure to use alcohol, tobacco and marijuana.
- Denver high schools are launching a Social Norms Project (SNP) to accentuate the healthy behaviors of the vast majority of youth, and correct student misperceptions of the extent of alcohol, tobacco and other drug use among their peers.

Early Intervention

- Another school-based program, CASASTART, focuses on elementary and middle school children identified as being at especially high risk of substance abuse and delinquency. Case managers provide at-risk students with a variety of services geared toward improving school performance and expanding opportunities for positive engagement with school, peers and the community.
- Denver's Safe City Office intervenes with Denver youth at risk of involvement in the juvenile justice system. Youths who violate curfew or other municipal laws are offered counseling, assessment and referral services in lieu of facing charges in court.

Treatment

- The Denver Drug Court was created in 1994 to handle drug felony cases that do not also involve non-drug crimes. The Drug Court facilitates quick action on all drug cases, so that defendants can enter treatment programs rapidly and avoid being sentenced to jail or prison. Direct court supervision, regular appearances before a judge and weekly random drug tests encourage Drug Court offenders to remain in treatment. An estimated 1,500 Denver residents participate in treatment each year through the Drug Court. The number of Drug Court participants who successfully complete the program, test drug-free and graduate has risen steadily, while the number eventually sentenced to prison has declined. In 1995, only 19 percent of participants graduated and 81 percent were sent to prison. By 2001, 75 percent of participants graduated, and only 25 percent went to prison.
- Denver is one of 15 cities nationwide to win designation as a Demand Treatment site, with funding from the Robert Wood Johnson Foundation to support efforts to bring more people into treatment. The Denver Medical Center and its 11 family health centers are training physicians, nurses and other medical staff to recognize substance abuse problems and refer patients to assessment and treatment services. The city will also enhance its website with tools for self-evaluation, problem recognition and service referral.

Transition and Recovery

- In Spring 2002, Denver was awarded a federal grant to enhance treatment and other support services for women involved in the criminal justice system. The program, known as "Miracles," will provide 150 women with intensive outpatient treatment and case management designed to improve participants' self-sufficiency and overall health.
- Denver is also planning a program to target homeless youths involved in substance abuse who require a supportive environment to sustain the benefits of detoxification and treatment. Many treatment programs are geared toward older clients, and shelters are a difficult environment in which to avoid relapse. Through Starting Transition And Recovery (STAR), homeless young adults in recovery will have access to a transitional living facility conducive to remaining engaged in treatment and gaining the skills and confidence to eventually live independently.

The Deadlock Over Syringe Exchange

Despite a significant number of Denver residents who are injecting drug users (IDUs) and a rate of newly diagnosed drug-related AIDS cases that is double the national rate, Denver does not have a syringe exchange program (also known as needle exchange). Such programs curb the spread of HIV by decreasing syringe sharing and other HIV risk behaviors. Syringe exchange can also be an effective bridge to treatment. The National Institutes of Health, the National Academy of Sciences, the

Centers for Disease Control and Prevention and researchers at Johns Hopkins University have found that syringe exchange programs effectively reduce the spread of HIV and hepatitis-B *without* increasing drug use or other public safety risks.

In 1997, the Denver City Council authorized the operation of syringe exchange programs in the city, providing that programs register with and be regulated by Denver's Environmental Health Department. However, to date Denver has no licensed syringe exchange programs because the city authorization is in conflict with state law on drug paraphernalia (any device used to grow, manufacture or ingest illicit drugs). Under current Colorado law, distribution of drug paraphernalia—including syringes—is a misdemeanor punishable by three months to one year in jail and/or a fine of $150 to $1,000.

The Role of State Policy

Denver's ability to mount a comprehensive campaign to reduce substance abuse and addiction is strongly affected by the state government's priorities. As Colorado's largest city, Denver has the resources to pursue significant improvements in its prevention and treatment capabilities. But the active support of the state government—which can bring far more resources to bear—would provide a crucial boost to the city's efforts. In recent years, state legislative policy and budget priorities with regard to substance abuse have been oriented far more toward enforcement and criminal justice sanctions than toward treatment.

Tobacco Prevention and Control

The Centers for Disease Control and Prevention provides guidelines for all states to pursue comprehensive tobacco control programs. The strategies recommended to prevent initiation of tobacco use, promote quitting and eliminate non-smokers' exposure to environmental tobacco smoke are based on evidence from programs already underway in various states. According to the CDC, Colorado could mount a comprehensive tobacco control program based on best practices at a cost of about $24.5 million per year. In FY2002, Colorado spent slightly more than half this amount ($14.9 million). At $3.39 per capita, Colorado's FY2002 tobacco control spending was about 5 percent below average per capita spending in other states. Colorado was one of 42 states to appropriate some portion of their tobacco lawsuit settlement funds to tobacco prevention in FY2002. No other state funds were appropriated, with the balance drawn from federal and non-governmental sources.

Colorado could significantly improve its overall tobacco control efforts by raising the state's cigarette excise tax rate and investing the increased revenues in prevention. Numerous studies have shown that increases in the price of cigarettes reduce the prevalence of smoking and the number of cigarettes smoked, especially among youth. At 20¢ per pack of cigarettes, Colorado's tax is less than half the national average. Like the state's alcohol excise taxes, the cigarette tax is not indexed for inflation, so its value erodes over time. The current tax is worth only 60 percent of its value in 1986, when it was last raised. In only ten states do combined federal and state taxes account for a smaller percentage of the retail price of cigarettes than is the case in Colorado.

A substantial increase in Colorado's cigarette excise tax is long overdue, and would play a major role in reducing smoking. Whether or not Colorado raises the tax rate, some portion of the current revenues generated by the tax—$58 million in FY2001—should be dedicated to tobacco control. Five states, including neighboring Arizona and Utah, already devote some portion of their cigarette tax revenues to tobacco control activities. Under a 1991 amendment

to the Colorado Constitution known as the Taxpayers' Bill of Rights (TABOR), any increase in state tax rates requires the majority approval of Colorado voters on a ballot initiative. Dedicating the revenues from the cigarette excise tax at its current level, however, could be accomplished by executive order.

Alcohol and Illicit Drugs

With respect to alcohol and illicit drugs, the crucial challenge facing Denver—and the rest of Colorado—is closing the treatment gap. As described in Chapter II, Drug Strategies estimates that between 45,000 and 60,000 Denver residents need treatment for substance abuse in any given year, but at most only 7,000 actually receive treatment (not including those who enter drinking driver and detoxification programs). The unmet need for treatment is a pressing problem in the rest of the state as well. Among an estimated 200,000 to 250,000 non-Denver residents who need treatment, only 25,000 receive it.

Among Denver residents, the number of admissions to publicly-funded treatment programs has declined in recent years, according to data maintained by ADAD. During the five-year period FY1998-2002, treatment admissions among Denver residents averaged 2,397 per year, down 17 percent compared to the previous five-year period. Given the substantial growth in Denver's overall population in recent years, the declining number of treatment admissions is even more worrisome. For every 100,000 Denver residents age 12 and older, there were an average of 515 treatment admissions each year from FY1998-2002, 23 percent lower than in FY1993-1997 (668 per 100,000). Although it is too early to tell, an upswing in admissions during the first half of FY2002 may signal the beginning of a new trend of increased treatment participation among Denver residents.

In Colorado as a whole, admissions to publicly-funded treatment programs have been on the rise. The annual average of 16,910 admissions from FY1998-2002 was up 10 percent from the 15,409 average of the previous five years. However, given the state's overall population growth, Colorado still appears to be losing ground in the effort to close the treatment gap. For every 100,000 Coloradans age 12 and older, there were 473 treatment admissions per year from FY1998-2002, a 4 percent drop compared to the previous five-year period (492 per 100,000).

Spending on Treatment in Colorado

Treatment services are financed in four basic ways: government grants or government-financed health insurance; private health insurance (typically employer-sponsored); out-of-pocket payments by the treatment client or the client's family; and philanthropy. Treatment spending from all sources grew by just 1.6 percent per year from 1992-1997, only half the growth rate in health care spending overall. Treatment spending is also slight by comparison to the total economic costs that alcohol and drug abuse impose on the nation. In 1997, alcohol and drug abuse cost Americans an estimated $320 billion, of which treatment expenditures accounted for less than 4 percent. Even within this picture of meager spending on treatment nationwide, Colorado has lagged behind.

Public Funding for Substance Abuse Treatment

Governmental sources have accounted for an increasing share of total U.S. spending on treatment in recent years, rising from 50 percent in 1987 to 62 percent in 1997 (the most recent year for which comprehensive data are available). In 1997, the $7.345 billion in public dollars spent on treatment nationwide amounted to about $27 per U.S. resident. By comparison, FY2002 public funding for treatment in

Colorado—from federal and state sources—amounted to only $7.50 per Colorado resident. Colorado's comparatively low per capita spending on treatment reflects three major factors: relatively low investment of the state's own General Fund dollars in treatment; sharp limits on the extent to which Medicaid can cover treatment in Colorado; and failure to use state alcohol excise tax revenues for treatment.

Federal and State Grant Funds for Treatment

Colorado budgets roughly $22 million per year for community-based treatment services, with federal grants comprising about half the total. The state's Alcohol and Drug Abuse Division (ADAD) allocates the treatment dollars by region and contracts with managed service organizations to deliver treatment services through a network of local providers in each region. Denver and its five neighboring counties comprise one such region, and typically receive slightly more than half of ADAD's community treatment funds. In FY2001, treatment funding for the Denver region totaled $11.7 million, an 11 percent increase since FY1996. (By comparison, General Fund appropriations for the Colorado Department of Corrections rose 79 percent over the same period.) Of the ADAD funds allocated to the Denver region, 30 percent are targeted to detoxification and 70 percent to treatment.

Medicaid Coverage for Treatment

Medicaid, funded jointly by the states and the federal government, is the largest provider of health coverage in the United States, and the principal source of health coverage for Americans living in poverty. In Colorado, the state's contribution is complemented by nearly equal funding from the federal government.

Nationally, Medicaid accounts for nearly 20 percent of all expenditures on alcohol and drug abuse treatment, including nearly one in three public dollars spent on treatment. In Colorado, however, Medicaid has played a comparatively minor role in treatment funding, with coverage restricted to pregnant or postpartum women and to hospital-based medical detoxification.

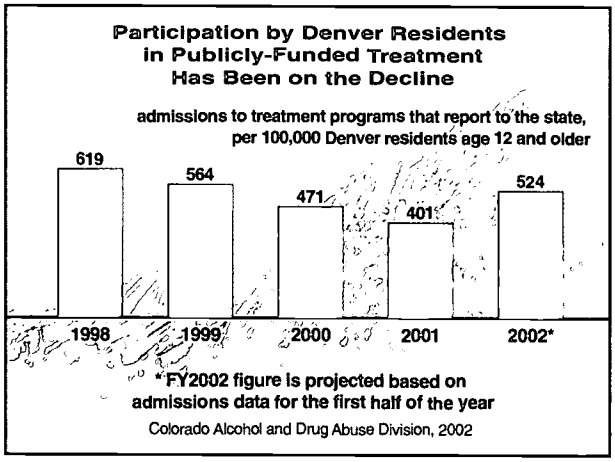
Since 1991, Colorado Medicaid has paid for outpatient treatment for women who are pregnant or within 60 days of having given birth; with some 300 clients a year, expenditures have averaged $200,000 annually. With the inclusion of Medicaid coverage for residential treatment beginning in FY2001, spending increased to nearly $350,000. In addition, Medicaid pays for $1.2 million in hospital-based detoxification services provided to about 375 patients per year. Colorado's annual Medicaid expenditures on treatment (including the federal match) total about 32¢ per resident, only a fraction of the U.S. average ($8.31 per capita).

Under federal rules, expanding substance abuse treatment coverage for a particular segment of Colorado's Medicaid population requires that the state apply for a federal waiver. In Spring 2002, the Colorado General Assembly considered a bill that would have authorized the state's Department of Health Care Policy and Financing to apply for a federal waiver to extend Medicaid treatment coverage to approximately 50,000 poor parents and their children. (Another 90,000 elderly poor and persons with disabilities enrolled in Medicaid would not have been included in the expansion of substance abuse coverage.) The Senate approved the waiver bill, but the provision died in the House of Representatives.

Alcohol Excise Tax Revenue

As described in Chapter III, Colorado has among the lowest alcohol excise tax rates in the country. Research has shown that increasing the price of alcohol reduces drinking and related problems, including accidents, violence and disease.

Youths and young adults are especially sensitive to alcohol price increases, as are heavy drinkers, who spend a large proportion of their personal income on alcohol. Colorado's revenue from alcohol excise taxes amounts to nearly $30 million per year. This revenue represents a logical, but as yet untapped, source of additional funding for treatment. Indeed, in 1976, when the Colorado General Assembly last raised the excise tax on beer, the explicit intent was that the increased revenues would fund alcohol treatment programs. The idea retains its appeal. According to a 1998 national survey sponsored by the Robert Wood Johnson Foundation, four in five Americans favor increasing alcohol taxes by 5¢ per drink if the revenue is used to prevent underage drinking and to fund alcohol treatment programs.



If Colorado increased its alcohol excise tax rates by as little as 1¢ per drink, the state could generate an additional $20 million annually. Larger alcohol excise tax increases would provide stronger prevention benefits as well as more funding for treatment. A new revenue stream of $20 to $30 million a year would provide an enormous boost to publicly-funded treatment in Colorado, with negligible impact on state budgeting flexibility. In FY2001, alcohol excise tax proceeds accounted for less than four-tenths of 1 percent of Colorado's $8.2 billion in net revenue collections. Raising Colorado's alcohol excise tax rates would require approval of the voters by ballot initiative, but devoting the revenues generated by the taxes their current levels could be achieved by executive order.

Private Health Insurance Coverage for Substance Abuse Treatment

According to the 1999 National Household Survey on Drug Abuse, nearly 9 million American adults meet the diagnostic criteria for addiction to alcohol or other drugs. Sixty percent of these people with addictions are employed full-time. To the extent that private health insurance policies provide coverage for substance abuse treatment on par with benefits for other illnesses, more people who need treatment are likely to receive it, without relying on public funds. Private insurers, though, have historically viewed their role as covering only medical care for the acute health problems that result from substance abuse and addiction, not rehabilitative treatment services.

When employer-sponsored insurance plans do cover alcohol and drug treatment, the services are typically subject to tighter restrictions than are applied to medical care for physical illnesses. The restrictions include: lower limits on the number of days of inpatient hospital care; limits on the number of outpatient visits per year and reduced coinsurance levels; and annual or lifetime maximum dollar amounts. Less than 5 percent of the nation's 38 million full-time employees at medium and large businesses have employer-provided insurance with equal coverage for substance abuse treatment. Another 60 percent of these 38 million employees have some form of substance abuse coverage, but with significant restrictions. From 1987-1997, insurance payments for all health services grew at an annual rate of 5.4 percent; by contrast, payments

for treatment actually fell by 0.6 percent per year. This trend toward an even further diminished role for private insurance in facilitating substance abuse treatment has prompted a wave of legislative efforts to mandate more extensive coverage.

Since the mid-1990s, seven states have passed "parity" laws requiring that insurers provide the same level of benefits for the treatment of substance abuse as for any other health disorder. Another eight states have enacted laws requiring some minimum level of coverage for substance abuse services, but still allowing for tighter restrictions on treatment compared to other health care benefits. In another 19 states, substance abuse parity was a high priority item on the Spring 2002 legislative agenda. As of 2001, all health plans that participate in the Federal Employees Health Benefits program have been required to provide substance abuse and mental health treatment parity.

The push for insurance parity has been based on a growing understanding that addiction is a chronic health disorder, and buttressed by strong evidence that treatment works. Concerns that parity would substantially raise insurance premiums have not been borne out. The most comprehensive study to date projects at most a 0.3 percent increase in the total family premium as a result of full parity.

In Colorado, 1.8 million adults are enrolled in employer-sponsored health insurance plans. An estimated 100,000 to 125,000 of these 1.8 million insured Coloradans need substance abuse treatment, so parity for treatment benefits could make a sizable contribution to closing the treatment gap, in Denver and statewide. Current Colorado law mandates parity for certain mental health diagnoses, but does not require insurers to offer benefits for substance abuse disorders, much less mandate that they be equal to benefits for other illnesses. A bill before the Colorado General Assembly in the Spring of 2002 would have mandated comprehensive mental health and substance abuse parity. The Senate passed the bill, but the measure eventually died in the House of Representatives Committee on Health, Environment, Welfare and Institutions.

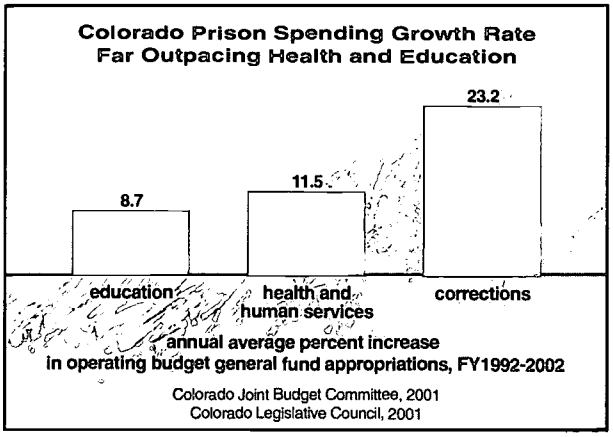
The Price of Incarceration, the Need for Treatment

As the incarceration statistics presented in Chapter III make clear, Colorado legislators have, without any doubt, been tough on drugs. Under current law, conviction for possessing or distributing an ounce or more of drugs such as cocaine, heroin or methamphetamine triggers mandatory minimum prison sentences. Possession offenders face prison terms between 2 and 8 years. First time distribution offenders face between 4 and 16 years, and repeat distribution offenders face 8 to 24 years. Putting more drug offenders behind bars and sentencing them to longer terms makes claims on state budgets for years to come. For example, the 2,640 drug offenders committed to prison in Colorado in FY1998 and FY1999 will cost the state more than $195 million in the ensuing years.

Between FY1992 and FY2002, the Corrections Department operating budget more than tripled, rising from $144 million to $478 million. In addition, the Corrections Department spent an average of $72 million a year on new prison construction, renovation and maintenance, accounting for nearly one-quarter of the state's total capital construction appropriations.

The rapid increase in prison spending has occurred despite the 1991 TABOR amendment and related statutes limiting the growth in total General Fund appropriations to 6 percent above the previous year's level. General Fund appropriations for the Corrections Department grew at an annual rate of more than 23 percent from FY1992-2002, not includ-

ing construction appropriations. Given the 6 percent restriction on the growth of total General Fund appropriations, the highly accelerated growth in prison spending over the last decade has left fewer dollars available for other public purposes. Spending on prison operations grew at twice the rate of health and human services spending, and at nearly three times the rate of education spending.



As has occurred in many other states, doubts about the efficacy of incarcerating scores of drug users have been sharpened by the recent economic downturn. The explosive growth in prison spending that took place during the economically-flush 1990s cannot be sustained in a new era of budget constraints. In an effort to rein in prison costs and at the same time increase funds for offender treatment, the 2002 General Assembly approved legislation reducing penalties for certain drug use offenses and for drug possession offenses involving one gram or less. With fewer low-level offenders being sentenced to prison, the cost savings (projected to be about $2 million a year) would have been invested in treatment for offenders. However, Governor Bill Owens vetoed the bill.

During the same session, as part of legislation reforming the state's asset forfeiture procedures, the General Assembly mandated that 50 percent of the proceeds from confiscated property be earmarked for detoxification and treatment. These new treatment funds, projected to total $1 to $2 million a year, will be distributed directly to the treatment managed services organizations in each region of the state.

The impact of substance abuse on the criminal justice system extends well beyond the issue of how to deal with drug law offenders. Substance abuse is pervasive among criminal offenders, regardless of offense. Half of Denver arrestees are dependent on alcohol or illicit drugs, as are one-third of arrestees in the rest of the state. As of June 2000, 77 percent of Colorado prisoners—nearly 11,000 inmates—were identified at intake as needing treatment for substance abuse. More than 80 percent of all state prisoners released during the year 2000 were in need of treatment. Of the 4,350 prisoners released in 2000 who had been identified at intake as needing treatment, 70 percent received no treatment at all while incarcerated.

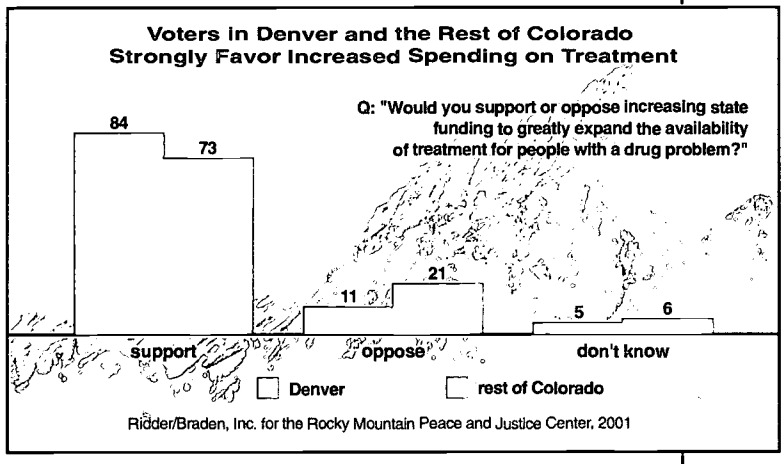
Given the expense of incarceration (nearly $27,000 per inmate per year) and the high proportion of Colorado prisoners with alcohol and drug problems, prison-based treatment followed by aftercare in the community is a critical means of reducing crime and spending on criminal justice. Failure to provide adequate treatment, including aftercare in the community, increases the likelihood that many drug-involved offenders will soon return to prison. According to the National Institute of Justice, between 65 and 70 percent of all untreated parolees with histories of cocaine or heroin use will return to drug use within three months of release. By achieving even modest reductions in the rate at which former prisoners return to drugs, treatment can help prevent crime and avoid millions of dollars in spending on public safety and criminal justice.

Public Opinion and State Policy Reform

A greater emphasis on prevention and treatment and a reduced role for incarceration would begin to lessen the costs of substance abuse in Colorado. The prospects for the comprehensive substance abuse strategy now being launched in Denver would be considerably brightened by a substantial increase in the state's investment in prevention and treatment. A July 2001 statewide survey found that Colorado voters favor just such a shift in emphasis, with strong support for change spanning all demographic categories.

Conducted for the Rocky Mountain Peace and Justice Center by Ridder/Braden, Inc., the survey of active voters found that few consider current policies effective in reducing drug use or the supply of illicit drugs. Statewide, only 2 percent of voters consider the "war on drugs" to have been "very effective" in reducing use, and only 3 percent consider it "very effective" in reducing supply. On the other hand, the vast majority of Colorado voters believe treatment is an effective way to reduce drug use (86 percent) and to reduce drug-related crime (80 percent). Consistent with this belief, 74 percent of Colorado voters favor "increasing state funding to greatly expand the availability of treatment." Support for increased treatment funding is especially pronounced in Denver (84 percent), but is consistently high across all major demographic categories in the state, including urban (79 percent), suburban (77 percent) and rural communities (75 percent). Significantly, support for more treatment funding is even stronger among Colorado's Republican voters (78 percent) than among Democrats and independents (66 percent).

Support is similarly strong (73 percent) in favor of decreasing criminal penalties for people possessing small quantities of drugs and investing the prison cost savings in prevention and treatment programs—as provided in legislation approved by the Colorado General Assembly in Spring 2002. Denver voters are especially supportive of such a reform (90 percent in favor), and voters in the rest of the Colorado were also firmly in agreement (70 percent). Virtually no voter support exists for reducing state spending on health, education or transportation in order to pay for more prisons—a pointed repudiation of the spending patterns of the past decade. Specifically, only 7 percent of voters favor reducing state spending on public health and substance abuse treatment services to pay for prisons.



In sum, a sizable majority of Colorado voters favors a considerable shift in state funding priorities toward treatment and away from incarceration. In light of these survey findings and the important policy changes considered during the 2002 legislative session, the momentum for constructive reform is growing in Denver and in the rest of Colorado.

The City and County of Denver has fared extraordinarily well over the course of the last decade. Denver took full part in the sustained economic expansion and the declining crime rate that characterized America in the 1990s. As per capita personal income rose an impressive 46 percent nationwide during the 1990s, it rose 72 percent in Denver, to nearly $41,000. As the national crime rate fell 19 percent from 1996-2000, crime in Denver fell by 28 percent. With the good news came new residents. The city added nearly 90,000 people between 1990 and 2000, an 18.6 percent increase that was surpassed by only seven other large U.S. cities.

But not all the news in Denver has been good. By many measures, the city's problems with substance abuse and addiction are considerably more severe than in the nation as a whole. Among the 50 states, Colorado ranks second in the relative severity of its alcohol and drug abuse problems, according to a 2001 study sponsored by the U.S. Department of Health and Human Services. As Colorado's largest city, Denver could be expected to share in the state's problems. Indeed, substance abuse and addiction weigh heavily on Denver residents:

- Denver's alcohol and drug-related death rate is more than 50 percent higher than the national average.
- Drug-related hospital emergencies occur in Denver at 2½ times the national rate.
- Substance abuse costs Denver residents, businesses and government at least $1.5 billion a year—in addition to the incalculable toll in human suffering.

Fortunately, Denver's resilient economy and sound fiscal management mean that the city can bring to bear a wealth of human and economic resources to address substance abuse. To target those resources, city leaders are charting a promising strategy that emphasizes significant new investments in prevention and treatment. The state government, for its part, has an obvious stake in the well-being of its capital city, and a major role to play. The residents of Denver and the rest of Colorado would benefit tremendously if state lawmakers shift their substance abuse policy and funding priorities toward prevention and treatment.

Voters in Denver and the rest of the state overwhelmingly endorse just such a policy shift. A statewide survey in July 2001 found that nearly 75 percent of active voters favor "increasing funding to greatly expand the availability of treatment." The great majority of Colorado voters (73 percent) also favor decreasing criminal penalties for people possessing small quantities of drugs and investing the prison cost savings in prevention and treatment. These preferences are especially pronounced among Denver voters, but strong support for change spans demographic categories across the state.

The following recommendations are intended to build on areas of recent progress while also addressing key areas of concern.

Leadership

The severe consequences of alcohol, tobacco and other drug problems in Denver require that the government's response be formulated at the highest level—including the mayor, the city council and agency heads. Mayor Wellington E. Webb appointed the city's first drug strategy coordinator in 2000 and has made combating substance abuse a high priority during his final year and a half in office.

- To sustain this level of attention, Denver's next mayor should reaffirm the role of the Director of the Mayor's Office of Drug Strategy as a high-level official who reports directly to the mayor and is

empowered to coordinate the city's overall response to substance abuse.

- Denver's elected representatives at the local and state levels should exercise their influence to reorient state legislative policy and budget priorities on substance abuse toward greater investment in prevention and treatment.

Information

Estimates of drug use rates and treatment needs extrapolated from data collected at the state or national level may provide a fair sense of the overall scope of the problems facing Denver. But such estimates are no substitute for local data gathered expressly to inform local policymaking. Denver is a geographically expansive and demographically diverse city; accurately identifying the most pressing problems will require correspondingly comprehensive and rich local data. As Denver moves to enhance its prevention programming and shore up its treatment system, it is especially critical to have accurate and detailed information on the prevalence of alcohol, tobacco and drug use and the need for treatment among city residents.

- City leaders should therefore move quickly to undertake a comprehensive household survey of Denver residents on alcohol, tobacco and other drug use. The information derived will inform policy planning and serve as a baseline for measuring the future impact of Denver's new strategies to reduce substance abuse.
- In setting substance abuse policy priorities, city leaders should take advantage of "Denver Benchmarks," a community information system designed to provide detailed neighborhood-by-neighborhood data on health and quality of life. Such data could be a key tool in targeting substance abuse policy interventions—including prevention, treatment and enforcement.
- Ongoing policy planning and evaluation will require a high level of expertise in data gathering and research. To make best use of the household survey findings and the wide variety of complementary data from other sources—substance use among students, illicit drug use among arrestees, drug-related hospital emergencies, drug-related AIDS, etc.—Denver should establish its own interdisciplinary substance abuse policy research team, and coordinate its efforts with other research conducted in the state.

Enforcement and Criminal Justice

Two decades of increasingly intense enforcement efforts to raise the price of illicit drugs by targeting supplies—at home, on the border and overseas—have achieved disappointing results. The street prices of cocaine and heroin have fallen, not risen, and are now only about half and two-thirds their 1981 levels, respectively. The arrest-and-incarcerate strategy used with good success to control other types of crimes is not a good fit for drug sales and possession offenses. Imprisoning a thief directly prevents theft, but with an illicit commodity such as drugs, locking up one distributor simply creates a job opening for someone else. Long prison terms for low-level, nonviolent drug offenders is counterproductive to crime control; expensive, limited prison capacity should be reserved for the most active and violent offenders.

- A sharp enforcement focus on the most pernicious, flagrant offenders—those who engage in frequent violence and employ youth—would go far toward reducing the overall levels of crime perpetrated by drug offenders.
- Denver's elected representatives in the Colorado General Assembly should join the effort to lessen the state's costly reliance on imprisonment to punish low-level, nonviolent drug offenders. As

Denver's own drug court has shown, more constructive and less expensive alternatives to prison exist.

- Regardless of offense, nearly half of probationers and 80 percent of parolees in Denver have substance abuse problems. In concert with the state government, Denver should take advantage of the leverage afforded by the criminal justice system to reduce substance abuse among this population through a mix of drug testing, incentives, sanctions and treatment.
- Denver's elected representatives, law enforcement officials and public health officials should work to amend Colorado's drug paraphernalia statutes so that state law would no longer impede the operation of city-licensed needle exchange programs in Denver. The City Council authorized the operation of needle exchange programs in 1997, but current state law makes its illegal to possess or distribute drug paraphernalia, such as syringes.

Prevention

While the goal of raising the price of illicit drugs through enforcement has proven elusive, raising the prices of legal substances—alcohol and tobacco—can be accomplished by raising excise tax rates. Research has shown that youths and heavy smokers and drinkers are especially sensitive to price increases, and that tax increases translate into reductions in consumption and associated health and crime problems.

- Denver residents and their elected representatives should press Colorado's General Assembly for substantial increases in the state's tobacco and alcohol excise tax rates, which are currently among the lowest in the country.

School and community-based substance abuse prevention programs have proliferated in recent years. While research has shown that prevention programs work, not all programs are equally effective.

- Denver should adopt school and community prevention programs with a sound theoretical basis and backed by research-based evidence of success.

Treatment

Drug Strategies estimates that between 45,000 and 60,000 city residents need treatment for alcohol and drug abuse and addiction, but that at most only 7,000 of them receive it. This unmet need for treatment costs Denver residents, businesses and government dearly every day in the form of health care costs, crime and lost economic productivity. Investments designed to close the city's treatment gap will more than pay for themselves by reducing these costs.

- The city should devote significantly more of its own revenues to treatment. As part of this increased investment, Denver should earmark funding for research to assess the effectiveness of local treatment services. Ongoing evaluation research will improve local services and will underscore the cost-effectiveness of treatment for Denver.
- The city's new investments in treatment should also be geared toward strengthening the entire continuum of needed services. Effective treatment cannot be a one-size-fits-all proposition; people's substance abuse problems vary considerably, so the appropriate array of services must be available.

Denver is not alone among communities in Colorado with serious substance abuse problems. The state legislature's support for treatment, however, has been inadequate. While Denver must boost its own spending on treatment, city residents and elected officials should also seek to make state policies more supportive. In particular, Denver should press the Colorado General Assembly and the Governor to:

- Devote the revenues generated by alcohol excise taxes to treatment. The case for raising the state's alcohol excise tax rates is clear, but even without raising rates the current revenues could be devoted to treatment.
- Seek a federal waiver to expand Medicaid coverage for treatment. Medicaid accounts for nearly one-third of public funding for treatment nationally, but currently plays only a negligible role in Colorado. More than 130,000 Colorado adults are enrolled in Medicaid, including poor parents, the elderly poor and persons with disabilities. Even if only 5 to 10 percent of them were to receive Medicaid-financed substance abuse treatment, it would constitute a major expansion of Colorado's public-sector treatment capacity.
- Require private health insurers to cover substance abuse treatment on par with coverage for any other illness. In Colorado, 1.8 million adults are enrolled in employer-sponsored health insurance plans. At least 100,000 of these insured Coloradans need treatment for alcohol or drug abuse, so parity for treatment benefits could make a sizeable contribution to closing the treatment gap, in Denver and statewide.

Substance abuse is a significant problem in Denver. As this report has documented, Denver residents bear a heavy burden in substance abuse-related diseases, crime and other social problems. The burden, however, is not so great that Denver cannot take steps to lessen it. Indeed, Denver is a rich and resourceful city, and the new emphasis being placed on prevention and treatment in the city bodes well for the future.

Denver's Alcohol-Induced Death Rate Nearly Double the U.S. Average

Death Rate Due to Heavy and/or Prolonged Use of Alcohol

(number of deaths per 100,000 population)

Denver	1990	1991	1992	1993	1994	1995	1996	1997	1998	*average 94-98*
total	**25.8**	**24.7**	**27.1**	**25.6**	**28.2**	**23.4**	**21.7**	**23.1**	**21.4**	***23.6***
chronic liver disease and cirrhosis	18.4	15.6	14.0	14.5	14.3	10.0	9.8	13.4	10.8	*11.7*
alcohol dependence syndrome	5.8	9.1	11.5	9.5	11.8	13.4	10.8	8.1	9.4	*10.7*
nondependent abuse of alcohol	1.0	0.0	1.1	1.0	0.8	0.0	1.1	0.8	1.2	*0.8*
alcoholic psychoses	0.6	0.0	0.5	0.6	1.3	0.0	0.0	0.8	0.0	*0.4*

United States	1990	1991	1992	1993	1994	1995	1996	1997	1998	*average 94-98*
total	**13.8**	**13.4**	**13.1**	**12.8**	**12.9**	**12.7**	**12.4**	**12.1**	**12.1**	***12.5***
chronic liver disease and cirrhosis	11.0	10.7	10.4	10.2	10.2	10.0	9.8	9.7	9.6	*9.9*
alcohol dependence syndrome	2.3	2.2	2.2	2.2	2.2	2.2	2.1	2.0	2.0	*2.1*
nondependent abuse of alcohol	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	*0.3*
alcoholic psychoses	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	0.2	*0.2*

Colorado Department of Public Health and Environment, 2001
National Center for Health Statistics, 2001

Number of Denver Residents Entering Publicly-Funded Treatment Has Been on the Decline

Participation in Publicly-Funded Treatment by Residents of Denver and Colorado

(number of individuals entering treatment at programs that report to the state, by primary drug of abuse and by fiscal year)

Denver	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002*	*average 93-97*	*average 98-02*	change 98-02 vs. 93-97
total	**2,985**	**2,581**	**2,402**	**2,409**	**1,989**	**2,271**	**1,967**	**1,646**	**1,503**	**1,978**	***2,473***	***1,873***	**-24.3%**
alcohol	1,396	1,077	879	960	727	861	658	580	514	662	*1,008*	*655*	-35.0%
marijuana	293	337	385	407	401	494	475	322	280	438	*365*	*402*	10.1%
heroin	503	444	405	402	332	288	391	374	314	412	*417*	*356*	-14.6%
cocaine/crack	671	617	577	514	419	431	320	260	268	252	*560*	*306*	-45.4%
methamphetamine	36	48	79	59	47	86	62	51	71	144	*54*	*83*	53.7%
other opiate	35	27	32	34	27	29	29	32	40	48	*31*	*36*	16.1%
other	40	26	35	22	29	30	30	27	16	22	*30*	*25*	-16.7%
unspecified	11	5	10	11	7	52	2	0	0	0	*9*	*11*	22.2%

Total Colorado	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002*	*average 93-97*	*average 98-02*	change 98-02 vs. 93-97
total	**15,081**	**13,984**	**13,229**	**13,592**	**11,223**	**14,335**	**14,430**	**12,785**	**12,203**	**13,278**	***13,422***	***13,406***	**-0.1%**
alcohol	8,873	7,642	6,522	6,446	5,194	6,700	6,180	5,385	5,014	5,246	*6,936*	*5,705*	-17.7%
marijuana	2,053	2,266	2,553	2,966	2,500	3,174	3,563	3,220	3,145	3,452	*2,468*	*3,311*	34.2%
cocaine/crack	2,132	2,023	2,023	1,832	1,516	1,633	1,666	1,512	1,368	1,420	*1,906*	*1,520*	-20.3%
methamphetamine	254	368	617	762	681	1,163	1,032	912	1,079	1,382	*537*	*1,114*	107.4%
heroin	1,167	1,177	1,046	1,154	948	991	1,127	1,126	1,050	1,156	*1,098*	*1,090*	-0.7%
other opiate	228	203	202	170	169	179	232	227	280	322	*194*	*248*	27.8%
other	331	260	221	197	167	215	393	375	267	300	*235*	*310*	31.9%
unspecified	43	45	45	65	48	280	337	28	0	0	*48*	*108*	125.0%

** FY2002 figures are projected based on admissions data for the fisrt half of the year*

"other" includes: amphetamines and other stimulants; benzodiazepine tranquilizers and other tranquilizers; LSD, PCP, and other hallucinogens; inhalants; non-prescription methadone; over-the-counter drugs; barbiturates and other sedatives/hypnotics; and anabolic steroids

Colorado Alcohol and Drug Abuse Division, 2002

More Than Two-Thirds of Adults Arrested in Denver Test Positive for Illicit Drugs

Percent of Adult Arrestees Testing Positive for Illicit Drug Use

The comparison cities range in size from St. Louis (population 348,189) to Washington, DC (population 572,059).

Males	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	*average 95-99*
Denver	**48**	**50**	**60**	64	**67**	**66**	**71**	**71.1**	**68.8**	**66.8**	***68.7***
8-city average	54	58	62	64	66	65	69	67.4	66.1	68.2	*67.1*
Atlanta, GA	62	63	69	72	69	74	80	71.6	65.7	76.7	*73.6*
Cleveland, OH	55	56	64	64	66	65	67	64.0	65.2	71.0	*66.4*
Miami, FL		68	68	70	66	57	67	60.6	61.5	66.0	*52.0*
New Orleans, LA	61	59	60	62	63	66	67	66.8	67.3	69.2	*67.3*
Omaha, NE	30	36	48	54	59	54	63	62.3	60.4	61.5	*60.2*
Portland, OR	62	61	60	63	65	65	66	71.4	71.5	63.8	*67.5*
St. Louis, MO	54	59	64	68	74	77	75	74.1	71.7		*74.5*
Washington, DC	56	59	60	60	64	64	66	68.6	65.3	68.9	*66.6*

Females	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	*average 95-99*
Denver	**55**	**54**	**61**	**66**	**68**	**66**	**69**	**69.0**	**68.7**	**69.1**	***68.4***
7-city average	66	66	68	69	66	64	63	61.2	62.9	66.7	*63.6*
Atlanta, GA	71	70	65	74	72	68	77	73.7		77.2	*74.0*
Cleveland, OH	73	79	74	77	82	71	70	56.5	58.1	67.5	*64.6*
New Orleans, LA	60	50	52	47	32	50	35	39.5	50.5	58.6	*46.7*
Omaha, NE					58	56	51	54.3	60.0	62.2	*56.7*
Portland, OR	61	68	73	74	74	68	74	77.6	74.3	68.2	*72.4*
St. Louis, MO	56	54	70	69	76	69	73	69.9	69.3		*70.3*
Washington, DC	73	75	72	71	67	65	58	57.1	65.3		*61.4*

National Institute of Justice, 1991-2000

Denver's Rate of Drug-Related Hospital Emergencies More than Double the U.S. Average

Drug-Related Hospital Emergency Department Episodes and Drug Mentions

(number of drug episodes and drug mentions per 100,000 population age 6 and older)

Denver	1994	1995	1996	1997	1998	1999	2000	*average 96-00*
Drug Episodes	**692.3**	**530.8**	**424.3**	**600.7**	**601.1**	**615.9**	**573.2**	***563.0***
Drug Mentions	**1,116.5**	**878.1**	**707.9**	**1,016.6**	**1,033.0**	**994.2**	**954.3**	***941.2***
alcohol-in-combination	217.6	187.1	131.3	216.6	233.1	209.4	206.0	*199.3*
cocaine	199.4	150.6	119.7	181.7	195.6	199.9	174.6	*174.3*
heroin/morphine	88.9	84.0	58.1	94.7	100.1	127.0	135.9	*103.2*
marijuana/hashish	46.5	37.7	29.8	76.1	90.0	64.2	55.4	*63.1*
methamphetamine	16.1	18.7	11.3	33.8	20.4	12.3	14.9	*18.5*
amphetamine	18.0	10.7	3.4	15.7	10.6	8.6	11.5	*10.0*
LSD	11.1	12.8	9.3	9.2	9.1	8.6	9.5	*9.1*

United States	1994	1995	1996	1997	1998	1999	2000	*average 96-00*
Drug Episodes	**225.2**	**220.8**	**218.6**	**221.5**	**225.4**	**228.2**	**243.4**	***227.4***
Drug Mentions	**391.0**	**387.4**	**385.7**	**396.8**	**408.3**	**417.5**	**445.1**	***410.7***
alcohol-in-combination	69.8	71.7	70.6	72.3	76.8	80.7	82.7	*76.6*
cocaine	62.0	58.4	64.8	67.7	71.5	69.4	70.7	*68.8*
heroin/morphine	27.8	30.4	31.4	30.3	32.3	34.7	39.3	*33.6*
marijuana/hashish	17.5	19.5	22.9	27.2	31.9	35.8	39.0	*31.4*
methamphetamine	7.7	6.8	4.7	7.2	4.8	4.3	5.5	*5.3*
amphetamine	4.2	4.0	4.0	4.3	4.9	4.9	6.5	*4.9*
LSD	2.2	2.4	1.9	2.2	2.1	2.1	1.6	*2.0*

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