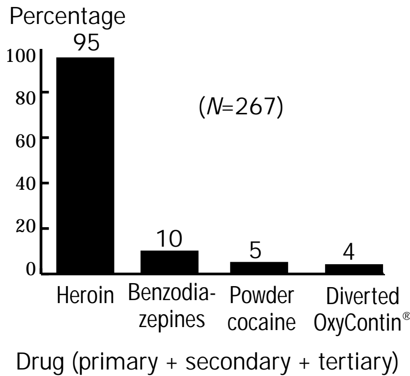
DENVER PRIMARY METROPOLITAN STATISTICAL AREA PROFILE:

- Total population: . . . 2,109,282
- Median Age: . . . . . . 34.1 years
- Race:
  - White 79.4%
  - Black 5.5%
  - American Indian/ Alaska Native 0.9%
  - Asian/Pacific Islander 0.4%
  - Other race 8.1%
  - Two or more races 3.0%
- Hispanic (of any race): 18.8%
- Unemployment rate: 2.8%
- Median household income: $51,191
- Families below Poverty Level with Children <18 years: 8.3%

*Source: U.S. Census 2000**

What drugs do clients in a methadone program use+? (Fall 2002)



+Includes any use, whether as a primary, secondary, or tertiary drug; responses for crack, methamphetamine, and ecstasy were "0"; response for marijuana was "don't know."

Source: Methadone treatment respondent

THE BIG PICTURE: WHAT'S CHANGED? (SPRING 2002 VS FALL 2002)

All four *Pulse Check* sources believe the overall drug problem in Denver has remained stable. A few changes, however, are reported:

- According to the non-methadone treatment source, treatment percentages there have remained relatively stable between spring and fall 2002, with slight decreases in heroin and powder cocaine as primary drugs of abuse and a decrease in the abuse of prescription drugs.
- According to one treatment source, after increasing substantially last year, methamphetamine use and admissions may be leveling off.[N] However, other sources report that methamphetamine use has increased substantially as the drug has become more available, and the availability and use of ice (high-purity, smokable methamphetamine) may be increasing.[L,E] According to one source, methamphetamine has replaced crack as the second most widely abused drug.[L]
- Local meth labs continue to increase, especially those using the "cold method" with anhydrous ammonia and the "Nazi" or quick-cooking method that can produce higher purity methamphetamine.[E]
- Use of club drugs, especially methylenedioxymethamphetamine (MDMA or ecstasy), but also including dextromethorphan (DXM), ketamine, and gamma hydroxybutyrate (GHB), continues to increase.[E,L]
- Abuse of OxyContin® (oxycodone hydrochloride controlled-release) continues to emerge.[M]

Three sources[L,E,N] consider the illegal drug problem very serious, and one[M] considers it somewhat serious. The drug associated with the most serious consequences varies by source: two sources[L,M] name methamphetamine as contributing to the most serious consequences, one source[E] names powder cocaine, and one[M] names heroin. Two sources[L,E] believe that marijuana continues as the most widely abused drug, another[N] names methamphetamine, and the methadone treatment source—not surprisingly—names heroin.

Most widely abused drug:
Marijuana[L,E]
Methamphetamine[N]
Heroin[M]
No reported changes between spring and fall 2002[L,E,N,M]

Second most widely abused drug:
Powder cocaine[E,M]
Methamphetamine[L]
Crack[N]
Changes between spring and fall 2002: Methamphetamine has replaced crack .[L]

Drug related to the most serious consequences:
Methamphetamine[L,N]
Powder cocaine[E]
Heroin[M]
No reported changes between spring and fall 2002[L,E,N,M]

Drug related to the second most serious consequences:
Crack[L,N]
Heroin[E]
Powder cocaine[M]
No reported changes between spring and fall 2002[L,E,N,M]

Emerging drugs:
Ecstasy activity continues to increase.[L]
Club drug activity continues to increase.[E]
Diverted OxyContin®[M]

Sources: [L]Law enforcement, [E]Epidemiologic/ethnographic, [N]Non-methadone treatment, and [M]Methadone treatment respondents
Note: These symbols appear throughout this city profile to indicate type of respondent.

**The census data in this table are provided as a frame of reference for the information given by* Pulse Check *sources. Whenever possible the data given by the law enforcement and epidemiologic/ethnographic sources reflect the metropolitan area.*

HEROIN

The heroin problem may be dissipating, according to several indicators:

- The number of primary heroin admissions to treatment has declined, and the number of primary heroin users new to treatment has declined substantially.[N]
- Heroin use and sales on college campuses have declined.[E]

COCAINE

Overall, the powder and crack cocaine problems appear relatively stable. The non-methadone treatment source reports a slight decline in powder cocaine use.

MARIJUANA

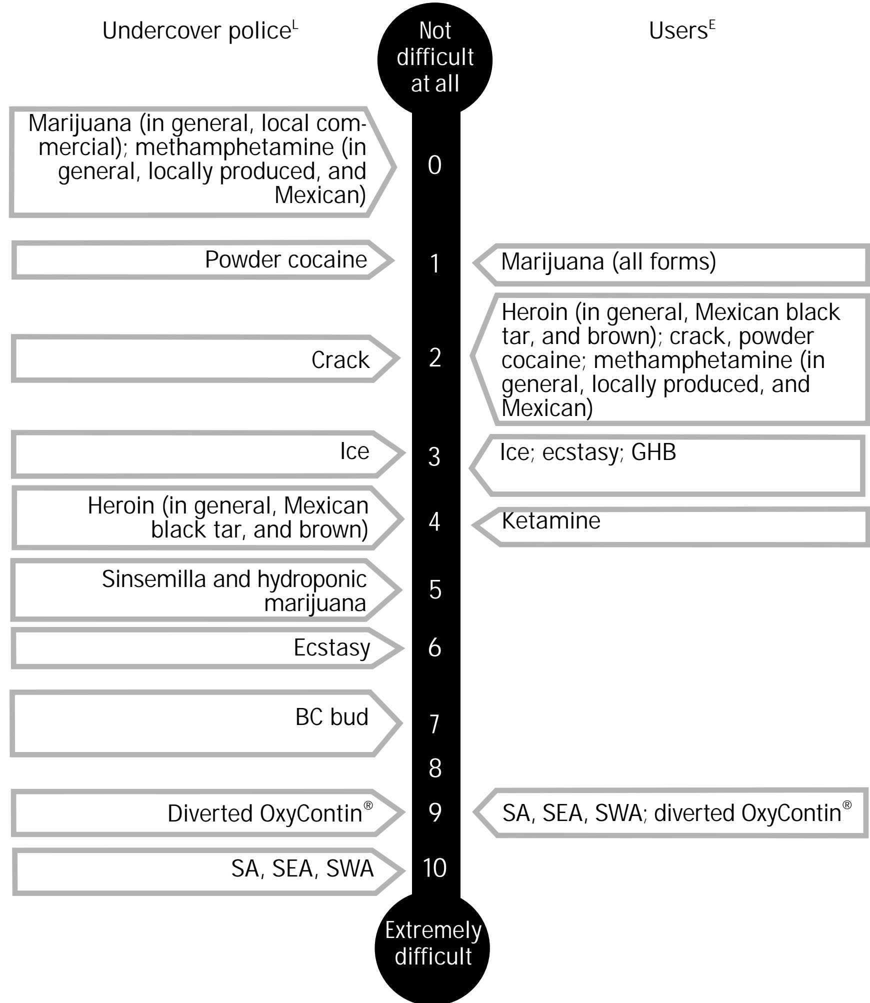
Marijuana sales and use remain relatively stable.[L,E,N,M] Marijuana remains widely available and is considered the most abused drug by two sources.[L,E]

METHAMPHETAMINE

Methamphetamine use indicators are mixed:

- After increasing dramatically in spring 2002, methamphetamine treatment admissions seem to be leveling off.[N]
- Methamphetamine use has increased, and there are more mentions of ice.[E]
- Local labs manufacturing methamphetamine using the "Nazi method" have increased in the past 6 months and are making a higher purity form of the drug. Local labs that manufacture ice have also increased.[E]

How difficult is it for undercover police and users to buy drugs? (Fall 2002)



Sources: [L]Law enforcement respondent; [E]Epidemiologic/ethnographic respondent
Note: SA=South American (Colombian) heroin; SWA=Southwest Asian heroin; SEA=Southeast Asian heroin; Ice=highly pure methamphetamine in smokable form; GHB=gamma hydroxybutyrate; and BC bud=British Columbian marijuana.

- *As reported in the majority of* Pulse Check *cities, marijuana is not difficult at all for users and undercover police to purchase.[L,E] Mexican heroin, powder and crack cocaine, and methamphetamine are also relatively easy to purchase.*
- *Since spring 2002, sources report no changes in the difficulty of purchasing drugs.*

MDMA (ECSTASY)

The methadone treatment source reports no use among clients, and the non-methadone treatment source reports low levels of secondary and tertiary use among clients. However, two sources report increasing club drug activity.[L,E]

DIVERTED OXYCONTIN®

Although diverted OxyContin® remains difficult to buy on the street, abuse has increased since spring 2002 (as it has in 14 other Pulse Check *cities):*

- The methadone treatment source reports an increase in primary and secondary OxyContin® abusers, nearly all of whom are new to treatment for any drug.[M]
- Of the 2–3 percent of admissions in the methadone treatment clinic who were primary OxyContin® abusers, most were older than 30, White, and split evenly between genders. Clients tend to be suburban residents of middle socioeconomic status who abuse OxyContin® only and take it orally.[M]

OTHER DRUGS

- GHB and ketamine: GHB and ketamine are relatively easy to buy, and availability remains stable. GHB sells for $5–$10 per capful.[E]
- Benzodiazepines: No clients at the methadone treatment program are primary benzodiazepine users, but about 10 percent (a relatively stable proportion) use the drug as a substitute for heroin.[M]

THE USE PERSPECTIVE

WHAT'S HAPPENING IN TREATMENT?

- The *Pulse Check* non-methadone treatment respondent, whose 20-bed inpatient facility operates at maximum capacity, reports methamphetamine as the primary drug of abuse among the majority of clients. Treatment percentages there have remained relatively stable between spring and fall 2002, except for slight decreases in heroin and powder cocaine as primary drugs of abuse, a leveling off in methamphetamine as a primary drug of abuse (after increasing dramatically during the previous 6 months), and a decrease in the abuse of prescription drugs.
- The methadone treatment respondent is with a facility that is nearly at maximum capacity (267 slots filled of 300), with capacity based on funding and staff. Nearly all clients (95 percent) abuse heroin as their primary drug, and 4–5 percent abuse OxyContin® as their primary drug. *(See bar chart on the first page of this chapter.)* Common secondary and tertiary drugs abused include benzodiazepines (among 10 percent of clients) and powder cocaine (among 5 percent of clients).
- Methadone treatment is available only in selected parts of the metropolitan area. Public and private methadone treatment facilities reportedly have adequate capacity, and treatment availability has remained stable between early and late 2002.[E]
- The non-methadone treatment provider reports a recent increase in drug abuse admissions (especially among female clients) who report suicidal thoughts and attempts. Lack of trained staff to treat comorbidity remains a common problem, as does limited slot capacity. The non-methadone treatment provider also believes that the recent decline in the Federal and State economies has limited the services that drug treatment facilities are able to provide.
- As reported by many methadone treatment sources across P*ulse Check* cities, hepatitis C has increased among drug abusers. The increase is most likely due to improved testing. The methadone source also reports an increase in severe abscesses among heroin injectors, most likely caused by a change in the way heroin has been adulterated or processed by distributors. Mood disorders, especially depression and bipolar disorders, are a common problem and have increased in the last 6 months. The methadone source explains that more people are being screened for the disorders; thus, more are being diagnosed and treated.

WHO USES ILLICIT DRUGS?

The *Pulse Check* epidemiologic, non-methadone treatment, and methadone treatment sources were asked to describe the populations most likely to use heroin, cocaine, marijuana, methamphetamine, and ecstasy. They were also asked to depict any emerging user groups and to report on how the drugs are used. As shown in the following pages, user characteristics vary by drug. Further, because of the different perspective each brings, the three sources sometimes describe quite different populations and use patterns for each drug. For example, all methadone clients are primary opiate users who may use drugs other than opiates in a secondary or tertiary manner.

Who's most likely to use heroin?

Characteristic	E	N	M
Age group (years)	>30	18–30	>30
Mean age (years)	37	NR	30–35
Gender	68% male	Split evenly	60% male
Race/ethnicity	66% White; 20% Hispanic (any race)	White	White
Socioeconomic status	Low and middle	Low	Low
Residence	Central city and suburbs	Suburbs	Suburbs
Referral source	N/A	Alcohol/drug abuse or other health care providers	Individual
Level of education completed	N/A	High school	High school
Employment at intake	N/A	Part time	Unemployed

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

- *Two sources report heroin users as most likely to be White, non-Hispanic males over 30 of low to middle socioeconomic status.[E,M]*
- *Predominant user characteristics appear stable between spring and fall 2002.[E,N,M]*
- *Heroin users new to treatment have a much younger mean age than those among the overall treatment population (28.2 versus 37 years); furthermore, a higher proportion of heroin users new to treatment are White compared with users among the general treatment population (72 versus 66 percent).[E]*

How do users take heroin?

Characteristic	E	N	M
Primary route of administration	Injecting	Smoking	Injecting
Other drugs taken	Powder cocaine (speedball)	Powder cocaine (speedball)	Powder cocaine (speedball); benzodiazepines (as a substitute)
Publicly or privately?	Privately	Privately	Privately
Alone or in groups?	Alone and in groups	Alone	Alone

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent; [M]Methadone treatment respondent

Use patterns appear stable with two exceptions:

- *Snorting and injecting (versus smoking) heroin continue to increase, especially among heroin users new to treatment.[E]*
- *Heroin users new to treatment tend to either snort or smoke (evenly split). Among heroin users in general, injection as a route of administration continues to decline.[N]*

Who's most likely to use cocaine?

Characteristic	Crack E	Crack N	Powder cocaine E	Powder cocaine N
Age group (years)	<30	18–30	<30	18–30
Mean age (years)	34.9	NR	35	NR
Gender	55% male	70% female	67% male	Male
Race/ethnicity	37% White; 29% Black; 26% Hispanic (any race)	Black	48% White	Black
Socioeconomic status	Low	Low	Low and middle	Low
Residence	Central city	Central city	Distributed equally among all areas	Central city
Referral source	N/A	Criminal justice and social services	N/A	Criminal justice, other health care providers, and social services
Level of education completed	N/A	Junior high	N/A	High school
Employment at intake	N/A	Unemployed	N/A	Full time

Note: The methadone treatment source reported no primary, secondary, or tertiary crack admissions to treatment, no primary powder cocaine admissions to treatment, and 13 secondary and tertiary powder cocaine admissions (5 percent of total admissions).

Sources: [E] Epidemiologic/ethnographic respondent; [N] Non-methadone treatment respondent

Sources report several shifts in cocaine user characteristics between spring and fall 2002:

- *Among powder cocaine users in general, Blacks have increased slightly. Among powder cocaine users new to treatment, Whites have decreased as Hispanics and Blacks have increased.[E]*
- *Heroin admissions who use powder cocaine as a secondary drug tend to be younger than heroin-only users.[M]*
- *Among crack users new to treatment, Whites and those of middle socioeconomic status are increasing, and the mean age is rising.[E]*

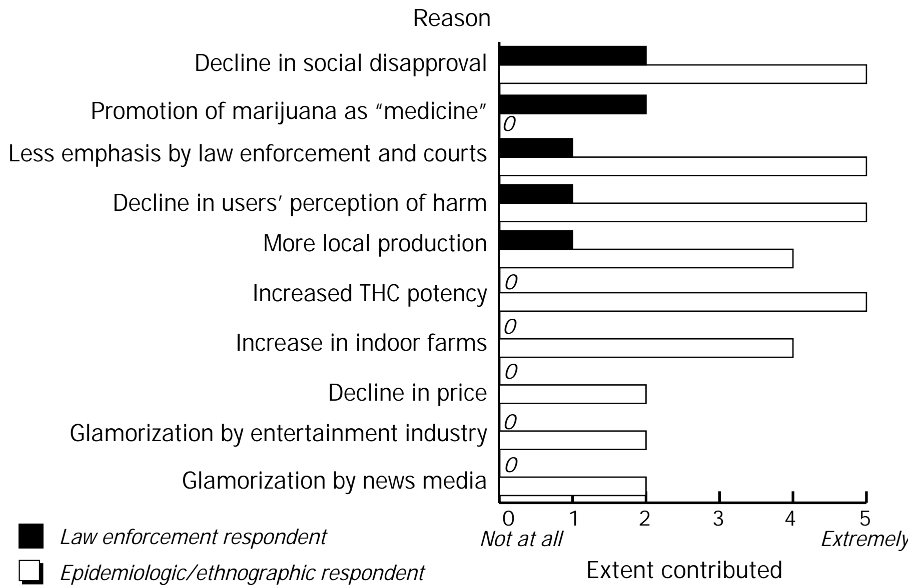
Who's most likely to use marijuana?

Characteristic	E	N
Age group (years)	18–30	18–30
Mean age (years)	24.8	NR
Gender	75% male	Split evenly
Race/ethnicity	54% White; 11% Black; 26% Hispanic (any race)	White and Black split evenly
Socioeconomic status	Divided evenly among all	Middle
Residence	Divided evenly among all areas	Suburbs
Referral source	N/A	Criminal justice and other health care providers
Level of education completed	N/A	High school
Employment at intake	N/A	Full time

Sources: [E] Epidemiologic/ethnographic respondent; [N] Non-methadone treatment respondent

- *Marijuana use continues to span all races, ethnicities, socioeconomic strata, and geographic areas of the city.*
- *Marijuana users new to treatment tend to be much younger (mean age of 16.7 years) than marijuana treatment admissions in general (mean age of 24.8 years).[E]*
- *Increased THC potency and earlier initiation of marijuana use have complicated treatment for marijuana-using clients. This source believes that glamorization of marijuana use by both the entertainment industry and news media has decreased in the past 10 years.[N]*

Widespread marijuana availability and use over the past 10 years: To what extent have the following contributed?



What they have to say...

- *Indoor farms: Indoor growth is becoming more difficult to detect, with larger quantities of marijuana grown in smaller spaces.*[E]
- *Increased THC: The increase of high-quality BC bud ("kind bud") on the market has contributed to the increased THC level of marijuana in Denver. In addition, certain varieties of marijuana from Alaska have a THC content of up to 29 percent.*[E]

WHAT ELSE DO USERS TAKE WITH MARIJUANA?

As in other cities, users often take many other drugs with or around marijuana. For example, methamphetamine is often taken sequentially after marijuana, and a new practice has emerged of dipping marijuana joints in formaldehyde (the dipped joints are called "wets").[N] Another source reports that some marijuana joints are laced with crack cocaine and referred to as "premos."[E]

WHAT ARE THE NEGATIVE CONSEQUENCES OF MARIJUANA USE?

Respondents associate marijuana, used either alone or with other drugs, with the following consequences, which appear stable between spring and fall 2002:

- Drug-related deaths (in which one of the drugs is marijuana)[E]
- Drug-related emergency room visits[E]
- Drug-related arrests[E,N]
- Automobile accidents[E]
- Short-term memory loss[E,N]
- Deteriorating family/social relationships[E,N]
- Poor academic performance[E,N]
- School absenteeism, truancy, or dropping out of school[E]
- Poor workplace performance[E]
- Workplace absenteeism[E,N]

Who's most likely to use methamphetamine?

Characteristic	E	N
Age group (years)	>30	18–30
Median age (years)	30	NR
Gender	53% male	Split evenly
Race/ethnicity	80% White; 13% Hispanic	White
Socioeconomic status	Low and middle	Middle
Residence	Divided evenly among all areas	Suburbs and rural
Referral source	N/A	Individual and social services
Level of education completed	N/A	High school
Employment at intake	N/A	Full time

Sources: [E]Epidemiologic/ethnographic respondent; [N]Non-methadone treatment respondent

Sources report several shifts in user characteristics between spring and fall 2002:

- *Females as a proportion of methamphetamine treatment admissions are increasing, and the gender split is now even.*[N]
- *Methamphetamine use is spreading from rural and suburban areas to all areas, including the central city.*[N]
- *The proportion of Hispanic methamphetamine users has increased as the proportion of Whites has declined.*[E]
- *Many blue collar workers use the drug to stay awake and work longer hours.*[E]

HOW ARE PEOPLE USING METHAMPHETAMINE?

Methamphetamine is primarily smoked and is often used sequentially with marijuana.[E,M] The epidemiologic source notes that smoking (52 percent) and injecting (31 percent) have increased as routes of methamphetamine administration, while snorting (14 percent) has declined.

WHO'S USING ECSTASY?

Ecstasy users tend to be adolescents and young adults of both genders. Whites are more likely to use ecstasy than other races/ethnicities and are overrepresented compared with the general population. Ecstasy users are primarily of middle or high socioeconomic background and reside mostly in central cities and suburbs. Common combinations include "candy flipping" (ecstasy combined with lysergic acid diethylamide [LSD]) and "kitty flipping" (ecstasy combined with ketamine).[E] Sources report no changes in user or use characteristics.

THE MARKET PERSPECTIVE

WHERE ARE DRUGS USED AND SOLD?

Heroin, crack and powder cocaine, marijuana, and methamphetamine are sold in a variety of public and commercial venues including the following:[L,E]

- Streets/open-air markets
- Crack houses/shooting galleries (excluding methamphetamine)
- Public housing developments
- Around drug treatment clinics (excluding crack and methamphetamine)
- Playgrounds/parks
- Around supermarkets
- Parking lots (excluding cocaine)

Drugs are also sold through prearranged meetings via cell phones in more private areas:[L,E]

- Private residences
- Hotels/motels
- Nightclubs and bars
- College campuses
- Inside cars

Additionally, methamphetamine and ecstasy are sold at raves and concerts, and marijuana is sometimes sold via the Internet. Although most sales settings have remained similar between spring and fall 2002, sales of heroin in open-air markets and on college campuses have declined.[E]

The majority of these sales settings also serve as use settings.

WHO SELLS ILLEGAL DRUGS, AND HOW DO DRUGS GET FROM SELLER TO BUYER?

Most dealers in Denver are polydrug dealers likely to distribute heroin, powder and crack cocaine, marijuana, and methamphetamine. Most are associated with Mexican trafficking organizations.[E] However, the trafficking organizations don't have much oversight on street sales and street-level dealers (who are organized into autonomous "street cells"). Drugs sold by these polydrug dealers are sold hand-to-hand in streets or through meetings prearranged via cell phones.

Moreover, Mexican trafficking organizations transport adolescents and young adults from Mexico and Central America to Denver and provide them with cheap motel rooms and cars from which to sell the drugs.[E] If these sellers are apprehended by the police they are deported, and no leads connect them to the trafficking organizations.

Which drug sellers are associated with which crimes?

Crime	Heroin	Powder cocaine	Crack cocaine	Marijuana	Methamphetamine	Ecstasy
Prostitution	✓		✓			
Gang-related activity	✓	✓	✓		✓	✓
Violent criminal acts: assaults	✓	✓	✓	✓	✓	✓
Non violent criminal acts: fraud and theft					✓	
Domestic violence					✓	
Drug-assisted rape						✓
No crimes associated		✓		✓		

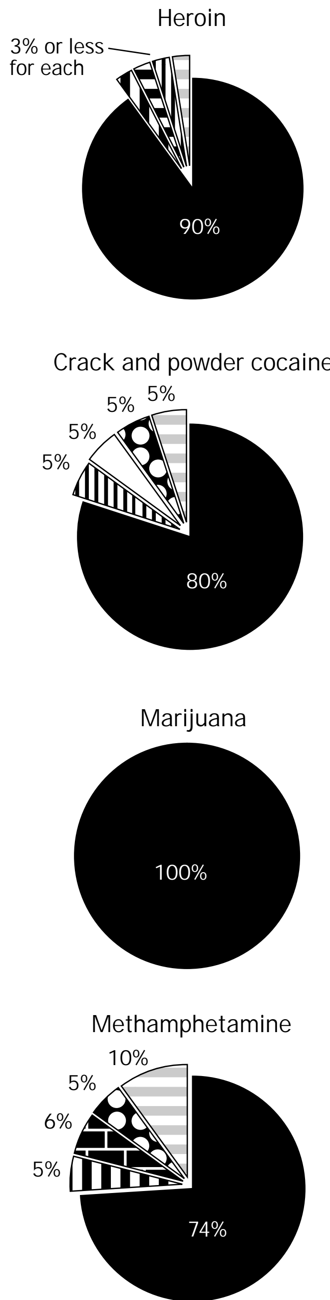
Source: [L] Law enforcement and [E] Epidemiologic/ethnographic respondents

- *Dealers who sell primarily methamphetamine tend to be associated with more types of crime—including domestic violence—than other drug dealers.*
- *Heroin and crack dealers continue to be associated with prostitution, street gangs, and violent assaults.*

Based on the drug sold, several differences in sales persist:

- Dealers who sell primarily crack are more independent than heroin or powder cocaine dealers, and crack distribution is becoming more intertwined with street gangs.[E]
- Dealers who sell primarily marijuana tend to be less sophisticated in communication techniques than heroin and cocaine dealers.[E] Marijuana dealers are also less likely than other dealers to be involved in gangs and prostitution.
- Two tiers of methamphetamine sellers exist: (1) independent lab owners who distribute methamphetamine only, and (2) distributors involved in polydrug sales (mentioned above) who are connected to Mexican meth labs and trafficking organizations.[E]
- Dealers involved primarily in methamphetamine sales tend to be "harder to deal with" than dealers who primarily sell heroin, cocaine, or marijuana. Buyers trying to purchase methamphetamine are said to be "chasing the bag." Moreover, methamphetamine sales are less likely to occur on the street than heroin or cocaine sales.[E]
- Unlike sellers of other drugs, ecstasy sellers tend to sell only ecstasy. Ecstasy sales are run both by independent sellers and street gangs, and sales are often venue-oriented (at nightclubs, raves, and concerts) as they are in many cities. However, some sales do occur on the streets hand to hand. According to the epidemiologic source, Asian gangs who sell ecstasy have emerged in fall 2002 and have nearly taken over the ecstasy market.

Beyond cash: What else is accepted in exchange for drugs?



What they have to say...

- *One source states that when it comes to exchanges for drugs, "cash is king"—particularly in the case of marijuana.[E] This pattern is more prounced in Denver than in the majority of other* Pulse Check *cities.*
- Pulse Check *sources report that goods and services exchanged for drugs have remained relatively stable over the past 10 years in Denver.*
- *Merchandise is second to cash as the most common item exchanged for drugs, followed by other drugs, sex, guns, and transporting the drug.[E]*

Note: The epidemiologic/ethnographic and methadone treatment sources did not respond to this question.

Source: Mean of response ratings given by law enforcement and non-methadone treatment respondents

HOW PURE ARE ILLEGAL DRUGS, AND HOW MUCH DO THEY COST?

How pure is Mexican black tar heroin, and how much does it cost?

Unit	Purity	Price
1 g	NR	$100[L]
	8–64%	$100–$150[E]
1 oz	40%	$1,500–$3,000[E]

Sources: [L]*Law enforcement respondent;* [E]*Epidemiologic/ethnographic respondent*

- *The most common form of heroin is Mexican black tar, and its purity on the street varies widely.*
- *Since spring 2002, purity and most prices have remained stable, with the exception of prices at the ounce level, which have declined slightly.*[E]

How pure is cocaine, and how much does it cost?

Form	Unit	Purity	Price	Change?
Crack	One rock ("yay")	NR	$20[L] $10–$20[E]	None Prices down from $20–$30 since spring 2002
	1 oz	NR	$900–$1,000[E]	Prices down from $900–$1,250 since spring 2002
Powder	1 g	NR 30–90%	$100[L] $100–$125[E]	None None
	1 oz	65–85%	$500–$900[E]	Purity up since spring 2002

Sources: [L]*Law enforcement respondent;* [E]*Epidemiologic/ethnographic respondent*

- *Powder cocaine prices were stable between spring and fall 2002, but purity increased at the ounce level.*[E]
- *Crack prices declined at lower (rock) levels and higher (ounce) levels.*[E]
- *Most crack cocaine is processed from powder locally.*[L,E] *The epidemiologic source states that much more of it is being processed locally than during the last reporting period.*

How potent is marijuana, and how much does it cost?

Form	Unit	THC content	Price
Commercial grade	1 oz	NR 3–10%	$100–$200[L] $200–$300[E]
"Kind bud" (high-quality hydroponic), BC bud	1 oz	16–20%	$700–$1,000[E]

Sources: [L]*Law enforcement respondent;* [E]*Epidemiologic respondent*

- *Most sources report stable marijuana prices in fall 2002, with one exception: pound prices for commercial grade marijuana declined slightly since spring.*[E]
- *Marijuana in general is not difficult to purchase. Local commercial grade is the most common form available, followed by sinsemilla and hydroponic, both of which are somewhat difficult to purchase.*[L]
- *A wide variety of marijuana is available for purchase, including commercial grade, sinsemilla, BC bud, and hydroponic.*[E]

How pure is methamphetamine, and how much does it cost?

Unit	Purity	Price
1 g	NR	$100[L]
1 g	8–12%	$80–$100[E]
1 oz	8–12%	$700–$1,000[E]

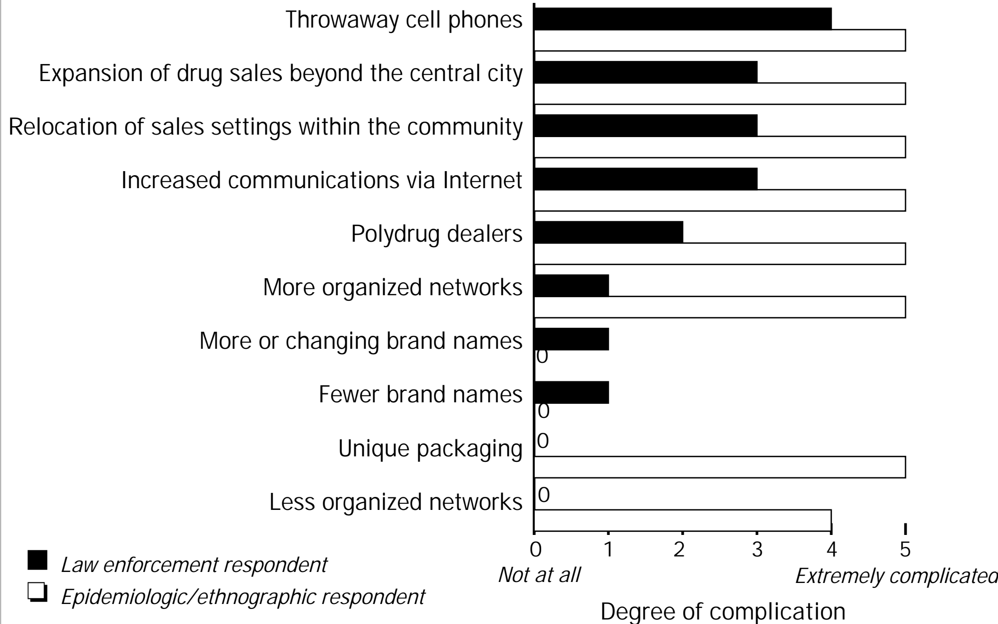
Sources: [L]*Law enforcement respondent;* [E]*Epidemiologic/ethnographic respondent*

- *Mexican methamphetamine is low quality and looks like peanut brittle, while local methamphetamine has a higher purity and is mostly powder.*[E]
- *Locally produced and Mexican varieties of methamphetamine are not difficult at all to buy, and ice is only slightly more difficult to buy than the lower purity form.*[L,E]
- *Purity at the gram and ounce levels declined between spring and fall 2002 (from 10–20 percent to 8–12 percent).*[E]

How much does ecstasy cost?

Ecstasy prices are stable at $15–$25 per pill[L,E]***. When sold in large quantities, pills cost $10–$12 each.***[E]

THE MARKET PERSPECTIVE: A 10-YEAR VIEW



What they have to say...

- *As reported in many* Pulse Check *sites, throwaway cell phones have created problems for law enforcement because they cannot be wiretapped.*[E] *Also, they tend to complicate efforts for tracing high-level dealers more than those for locating street-level dealers.*[L]
- *According to the law enforcement source, unique packaging of drugs is rare in Denver. The epidemiologic source agrees, with one exception: in the past 10 years, the compression of marijuana into tighter packages helps conceal the drugs.*

COMMUNITY INNOVATIONS AND TOOLS OVER THE PAST 10 YEARS

Several innovations over the past 10 years have helped combat illegal drug activity and use:

- Increased use of task forces:[L,E] Additions of larger task forces have increased law enforcement's ability to investigate large criminal drug operations.[L] Small police departments often have small budgets, but task forces have helped. For example, if a task force obtains a drug seizure, the amount of money involved is split among those agencies involved in the task force.[E]
- Precursor laws: New State laws have increased penalties for small, clandestine labs. Child abuse and neglect laws have been expanded to address the manufacturing of methamphetamine around children.[L,E] Additionally, there is now a civil fine for companies that sell large amounts of methamphetamine precursors to individuals.[E]
- Drug-free zone laws: Selling within 1,000 feet of a school enhances sentencing, and probationers must stay away from certain "risk areas."[E]
- Drug courts: Only one drug court exists in the metropolitan area. Although the drug court is seen as very effective by the epidemiologic source, it will be phased out to a regular court of law within the next year.[E]
- Air reconnaissance support from the National Guard: Air surveillance operations in conjunction with counterdrug operations have allowed narcotics enforcement to fully identify drug source and supply routes.[L]

SEPTEMBER 11 FOLLOWUP

None of the four Denver *Pulse Check* sources believes that the September 11 attacks and their aftermath have had any continuing effects on the drug abuse problem.