

Recent Drug Abuse Trends in the Seattle-King County Area

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ABSTRACT

Data for Seattle-King County, Washington, for the first half of 2005 revealed the following trends. Methamphetamine-involved deaths in the first half of 2005 (n=17) were nearly equal to the total for all of 2004 (18), representing a substantial increase and the highest level seen for such deaths in King County. Treatment admissions for which any use of methamphetamine was mentioned rose to their highest level—18 percent, double the proportion in 1999. Nearly one-third of local law enforcement drug seizures in the Seattle area tested positive for methamphetamine, up slightly since FY 2003, yet still lower than the 53 percent of samples from the rest of the State during FY 2005. Geographically, the pattern is reversed for cocaine, with 38 percent of tests in the Seattle area positive for cocaine, compared with 20 percent for the remainder of the State. Cocaine-involved deaths appear to be down slightly from the prior year, remaining in a range consistent with the prior 8 years. Forty-four percent of those admitted to treatment mentioned any use of cocaine, an increase to levels seen several years ago. Depressant-involved deaths, which had been increasing steadily since 1999, appear to have leveled off. Marijuana remained the most common illegal drug used by those entering drug treatment, with one-half of all people admitted to treatment noting marijuana as one of the top three drugs they use, a level consistent since 1999. Heroin deaths in the first half of 2005 (n=44) rose slightly compared with all of 2004 (76), but they were still well below the peak seen in 1998 (144). Prescription-type opiate-involved deaths continued to rise, with a first half of 2005 total of 67. This total suggests a higher annual total compared with the 118 in all of 2004 and possibly forecasting the sixth straight year of increases. Prescription-type opiates as the primary drug of abuse for those entering treatment increased to 3 percent of all admissions, up from 1 percent in 1999, and accounted for 4.4 percent of admissions excluding alcohol in the first half of

2005. Local law enforcement seizures testing positive for prescription-type opiates doubled to 5 percent in 2005 compared with 2003 in the Seattle area. In June 2005, 2,654 King County residents were receiving treatment at opiate substitution programs (for heroin and/or prescription-type opiates), up more than 10 percent from the same timeframe in 2004. Overall, the most striking trends involve the continued increases in indicator data for prescription-type opiates and methamphetamine.

INTRODUCTION

Area Description

Located on Puget Sound in western Washington, King County spans 2,130 square miles, of which the city of Seattle occupies 84 square miles. The combined ports of Seattle and nearby Tacoma make Puget Sound the second largest combined loading center in the United States. Seattle-Tacoma International Airport, located in King County, is the largest airport in the Pacific Northwest. The Interstate 5 corridor runs from Tijuana, Mexico, in the south, passes through King County, and continues northward to Canada. Interstate 90's western terminus is in Seattle; it runs east over the Cascade Mountain range, through Spokane, and across Idaho and Montana.

According to the 2000 census, the population of King County is 1,737,034. King County's population is the 12th largest in the United States. Of Washington's 5.9 million residents, 29 percent live in King County. The city of Seattle's population is 563,374; the suburban population of King County is growing at a faster rate than Seattle itself.

The county's population is 75.7 percent White, 10.8 percent Asian/Pacific Islander, 5.5 percent Hispanic, 5.4 percent African-American, 0.9 percent Native American or Alaska Native, 0.5 percent Native Hawaiian and Other Pacific Islander, and 2.6 percent "some other race." Those reporting two or more races constitute 4.1 percent of the population. Income statistics show that 8.0 percent of adults and 12.3 percent of children in the county live below the Federal poverty level, lower than the State averages of 10.2 percent and 15.2 percent, respectively.

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Data Sources

Information for this report was obtained from the sources described below:

- **Treatment data** were extracted from the Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse's Treatment and Assessment Report Generation Tool (TARGET) via the Treatment Analyzer system. TARGET is the department's statewide alcohol/drug treatment activity database system. Data were compiled for King County residents from January 1, 1999, through June 30, 2005. Data are included for all treatment admissions that had any public funding. Department of Corrections (only a few cases) and private pay clients (at methadone treatment programs) are also included. Methadone waiting list data for those seen at syringe exchange are administered and provided by Public Health-Seattle & King County.
- **Emergency department (ED) drug data** were obtained from the DAWN *Live!* system administered by the Drug Abuse Warning Network (DAWN), Office of Applied Studies (OAS), Substance Abuse and Mental Health Services Administration (SAMHSA). Preliminary data for the first half of 2005 are presented. Total eligible hospitals in the area totaled 22; hospitals in the DAWN sample totaled 22. A total of 24 emergency departments have been selected for inclusion in the sample (some hospitals have more than 1 ED), however, during this period, between 11 and 14 hospitals reported data each month. Data were incomplete, with less than 50 percent complete data for 0–2 of these hospitals in each month (exhibit 1). These data are preliminary, meaning that they may change. Data represent drug reports and are not estimates for the reporting area. Data are utilized for descriptive purposes only. Data cannot be compared to DAWN data from 2002 and before, nor can preliminary data be used for comparison with future data. Only weighted data released by OAS may be used for trend analyses. The first year of data weighted will be for 2004, so reasonable trend analyses will not be possible for several years. Available data are for King and neighboring Snohomish Counties combined; Pierce County is part of the statistical sample, but no EDs in Pierce were reporting during the first half of 2005. There are new case types in DAWN, with the primary one presented here being the "other" case type, which includes "all ED visits related to recreational use, drug abuse, drug dependence, withdrawal, and any misuse" not classified in other categories, such as overmedication and seeking detox/treatment. For the sake of clarity, "other" will be referred to as "drug abuse/other" in this report. Unless specifically stated, data presented are for the drug abuse/other case type.
- **Drug-related mortality data** were provided by the King County Medical Examiner (ME). Data for the first half of 2005 are preliminary. The data include deaths directly caused by licit or illicit drug overdose and exclude deaths caused by antidepressants in isolation and by poisons. Totals may differ slightly from drug death reports published by the King County ME's office, which include fatal poisonings. Testing is not done for marijuana. Because more than one drug is often identified per individual drug overdose death, the total number of drugs identified exceeds the number of actual deaths.
- **Drug-related helpline data** are from the Washington State Alcohol/Drug Help Line (ADHL), which provides confidential 24-hour telephone-based treatment referral and assistance for Washington State. Data are presented for January 2001 to June 2005 for calls originating within King County. Data presented are for drugs mentioned. A caller may refer to multiple drugs; therefore, there are more drug mentions than there are calls. The data exclude information on alcohol and nicotine, which account for more than one-half of the calls. Data are presented primarily for illicit drugs only, prescription drugs have not been coded consistently over time, therefore limiting trend analyses. The large number of unknown drugs in 2001 and 2002 may obscure some trends as well.
- **Forensic drug analysis data** are from the National Forensic Laboratory Information System (NFLIS), which distributes data from the Washington State Patrol's Toxicology Laboratory on drug test results on local law enforcement seizures. These data include the top 25 drugs identified in fiscal year (FY) 2003–FY 2005. Data are presented for the Seattle area lab in comparison to the rest of the State.
- **Heroin price and purity information** was obtained from the Drug Enforcement Administration's (DEA's) Domestic Monitor Program (DMP) for FY's 2000–2004.
- **Law enforcement data** were provided by the High Intensity Drug Trafficking Area (HIDTA) officials.

- **Methamphetamine production data** are from the Washington State Department of Ecology (DOE), which is mandated to respond to and document all “Methamphetamine Incidents,” including operating labs, dump sites, and other sites associated with the manufacture of methamphetamine.
- **Data on infectious diseases related to drug use and injection drug use**, including the human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and hepatitis, were provided by three sources. One source is “HIV/AIDS Epidemiology Report.” Data on HIV and AIDS cases (including exposure related to injection drug use) in Seattle-King County, other Washington counties, and Washington State (2001 through 2004) are provided by Public Health-Seattle & King County (PHSKC), Washington State Department of Health. HIV cases were reported to PHSKC or the Washington State Department of Health between 2000 and 2004. The third source of information, on 18–30-year-old injection drug users’ preferred drugs over time, was provided by the HIV epidemiology unit of PHSKC. These data are based upon four studies conducted from 1994 to 2003; they included the RAVEN (1994–1997), RAVEN II (1998), Kiwi (1998–2002), and DUIT (2002–2003) studies.
- **Key informant interview data** are obtained from discussions with treatment center staff, street outreach workers, and drug users.

DRUG ABUSE PATTERNS AND TRENDS

Cocaine/Crack

There were 6,120 treatment admissions for alcohol and drug abuse in the first half of 2005. The proportion of treatment admissions involving cocaine (i.e., cocaine was mentioned as the primary, secondary, or tertiary drug of abuse at the time of entry into treatment) was 44 percent (exhibit 2). It was the primary drug of abuse for 17 percent of all admissions.

Unweighted cocaine ED reports for all case types totaled 2,086 in the first half of 2005, which accounted for 37 percent of all major illicit substance reports. Cocaine-related reports were 76 percent higher than the number of reports for heroin, and more than twice the number of reports for marijuana or methamphetamine (exhibit 3). For cocaine, drug abuse/other represented the largest proportion of case types (83 percent), followed by those seeking detox/treatment (16 percent).

Almost two-thirds of cocaine ED patients were male (65 percent), with twice as many Whites as Blacks. (It should be noted that for 60 percent of patients, race is not documented). Eighty-two percent of patients were age 25–54, with the majority being in the 35–44 age range. Twenty-three percent were age 25–34, 37 percent were 35–44, and 22 percent were 45–54. Route of administration data were missing for 75 percent of reports; smoking was the most commonly reported (13 percent), followed by 7 percent for injecting and 3 percent for inhaled/sniffed/snorted.

Cocaine-involved deaths totaled 34 in the first half of 2005, lower than the 47 in the prior 6 months, but within the general range seen since 1997 (exhibit 4). The median age of decedents was 45.5 in the first half of 2005, similar to the prior 2½ years, but up from the late 1990s. The overall median age was 41 for the entire timeframe (1997 through June 2005), slightly less than the median of 42 for all drug-induced decedents (exhibit 5).

All cocaine-involved deaths were ruled accidental from January to June 2005, whereas the average was 93.9 percent for deaths since 1997. Women represented 35.3 percent of all cocaine-involved deaths, the highest proportion for any 6-month period since 1997 and higher than the overall average of 22.6 percent for this timeframe. Women represented 29.0 percent of all drug deaths from 1997 through June 2005. The majority of cocaine-involved decedents were Caucasian: 70.6 percent in the first half of 2005 and 72.6 percent overall. However, a substantial, and disproportionate, minority were African-American: 23.5 percent in the first half of 2005, a bit above the average of 20.8 percent since 1997.

In the first half of 2005, cocaine was the most common drug mentioned by adults calling the Helpline, accounting for 33 percent of calls. For youth, 14 percent of calls were for cocaine. Overall, cocaine represented 30 percent of all Helpline calls in the first half of 2005.

Accounting for 38.3 percent of seizures, cocaine was the most common substance identified in the Seattle area in FY 2005 according to NFLIS data on local law enforcement drug seizure testing (exhibit 6). In comparison, for the rest of the State, cocaine accounted for only 19.8 percent of seizures. Although cocaine remained the second most common drug detected in the laboratories statewide, cocaine seizures were substantially lower than methamphetamine seizures (53 percent).

Heroin

The proportion of treatment admissions involving any use of heroin totaled 22.1 percent in the first half of 2005 (exhibit 2). Heroin was the primary drug of abuse for 18 percent of total admissions, meaning heroin was the primary drug of abuse for 81 percent of heroin-related admissions.

Heroin was the third most frequently reported unweighted major illicit substance of abuse in the DAWN *Live!* system, after cocaine and prescription-type opiates (exhibit 3). Eighty-three percent of heroin reports were of the drug abuse/other case type; almost all of the remaining reports were for seeking detox/treatment (16 percent); and less than 1 percent were for suicide. Although ED reports for prescription-type opiates were 25 percent higher than reports for heroin, there are more actual drug-abuse cases for heroin than for prescription-type opiates. Sixty-one percent of heroin patients were male, with 39 percent of patients identified as White. (Fifty-six percent of reports did not have race/ethnicity documented.) Age distribution for heroin reports was very similar to that for cocaine: 30 percent of patients were age 25–34, 31 percent were 35–44, and 23 percent were 45–54. Injection was the most frequently reported route of administration (56 percent), although 42 percent of patients did not report on route of administration.

Heroin/opiate/morphine deaths totaled 44 in the first half of 2005, the highest total since the first half of 2002, but one-half the level seen at the peak during July–December 1998 (exhibit 4). (The category of heroin/opiate/morphine is the best approximation of heroin deaths, it excludes all deaths known to involve specific prescription-type opiates.) The most common manner of death for heroin-involved deaths was accidental, representing 93 percent of such deaths in the first half of 2005, similar to the 92 percent average since 1997 (exhibit 5). The proportion of women among heroin-involved deaths was 23 percent in the first half of 2005, a bit higher than the average of 19 percent.

Most decedents with heroin/opiate/morphine detected were Caucasian: 75 percent in the first half of 2005. This proportion is somewhat smaller than for any prior data since 1997 and, therefore, lower than the average of 83 percent over the entire timeframe. The proportion of Caucasian heroin decedents overall is similar to those without heroin/opiate/morphine detected. In the most recent timeframe, however, the proportion of African-Americans was higher for heroin/opiate/morphine than for the average for all

other drugs: 23 versus 7 percent. Note, however, that the actual numbers are relatively small.

Heroin mentions in calls to the Helpline accounted for 13.5 percent of adult cases and 3.2 percent of youth calls in the first half of 2005.

NFLIS results show similar levels of law enforcement seizures for heroin in the Seattle area (5.6 percent) and the rest of the State (5.2 percent) in FY 2005 (exhibit 6). Although heroin was the fourth most common substance detected in each of these regions, it constitutes a relatively small percentage of seizures compared to cocaine, methamphetamine, and marijuana.

The predominant form of heroin on the streets is Mexican black tar. All DEA DMP buys of heroin that have been positively identified were found to be Mexican in origin. China white, a common form in Vancouver, British Columbia, and on the east coast of the United States, is uncommon in the local area, according to regional HIDTA and DEA information.

The median heroin purity of DMP buys in the city of Seattle was 14 percent in FY 2004, similar to the prior year, higher than in FYs 2001–2002, and below the 17 percent seen in FY 2000.

Other Opiates/Prescription-Type Opiates

For the purposes of this report, “other opiates/prescription-type opiates” include codeine, dihydrocodeine, fentanyl, hydrocodone (e.g., Vicodin), methadone, oxycodone (e.g., Percocet and OxyContin), propoxyphene (e.g., Darvon), sufentanil, tramadol (e.g., Ultram), hydromorphone (e.g., Dilaudid, Palladone), meperidine (e.g., Demerol), pharmaceutical morphine, acetylmethadol, and the “narcotic analgesics/combinations” reported in the DAWN ED data. Source information for methadone, whether pain medication or opiate treatment program, is rarely available.

There were 182 treatment admissions for prescription-type opiates as the primary drug in the first half of 2005, representing 3.0 percent of all admissions (up from 1.0 percent in 1999).

Unweighted ED drug reports for prescription-type opiates totaled 1,480 in the first half of 2005, second only to cocaine reports, with the drug abuse/other case type representing the largest proportion (54 percent), followed by adverse reaction and overmedication (each at 15 percent) (exhibit 3). Some misclassification of case type may remain, but it is believed that the other/drug abuse case type is

likely the most accurate category, given that all other case types must be ruled out prior to assigning this case type. To understand more about those who are intentionally misusing prescription-type opiates, the drug abuse/other case type is discussed further below.

In 62 percent of prescription-type reports, route of administration was undocumented; 33 percent reported oral administration. Forty-three percent of patients were White, although it is important to note that race was not documented for one-half of the patients. Oxycodone accounted for 25 percent of prescription-type opiate reports, and hydrocodone represented 16 percent.

What constitutes a prescription-type opiate-related death is unclear, particularly among opiate-tolerant individuals. Issues of tolerance, potentiation with other drugs, and overlapping therapeutic and lethal dose levels complicate assigning causation in prescription-type opiate-involved fatalities. The source and form of prescription-type opiates involved in deaths are sometimes undetermined.

The increasing number of deaths involving prescription-type opiates appears to have slowed in the first half of 2005, during which time 67 such deaths were reported. This is up just slightly from 65 in the preceding half-year, but still substantially higher than the 38 reported in the first half of 2003 (exhibit 4).

Since 1997, deaths involving prescription-type opiates have been disproportionately White: 88 percent, compared with 81 percent for non-prescription-type opiate deaths (exhibit 5). The only other racial group with any substantial number of prescription-type opiate deaths is African-Americans, representing 8 percent of such deaths since 1997. No clear trends in racial groups for decedents involving prescription-type opiates are discernable.

Since 1997, females have consistently represented more of prescription-opiate involved deaths (41 percent) than deaths not involving these drugs (23 percent). A similar proportion of deaths were ruled suicide since 1997: 10 percent for prescription-type opiates and 11 percent for all other drug-involved deaths. No trends by manner of death are evident.

In the first half of 2005, for adults, 96 calls to the Helpline involved OxyContin, compared with 14 for youth. There were 160 adult calls for “prescription pain pills” in 2004, compared with 8 for youth. As a point of comparison, there were 208 calls about adult use of heroin in first half of 2005. Categorization of calls to the Helpline for other opiates and

“prescription pain pills” has changed over time, and categories are not mutually exclusive.

Three types of prescription-type opiates are among the top 25 substances reported in the FY 2005 NFLIS data: oxycodone, hydrocodone, and methadone (exhibit 6). For the Seattle area, these three substances totaled 4.1 percent, which is only slightly higher than the rest of the State (3.7 percent of seizures).

Stimulants

Stimulants include a range of drugs, including methamphetamine, which is available almost exclusively as an illicit drug. Amphetamines are primarily prescription drugs: dextroamphetamine (e.g., Dexedrine) for weight control and dl amphetamine (e.g., Adderall) for ADD/ADHD. Another prescription medication for ADD/ADHD is methylphenidate (e.g., Ritalin).

Eighteen percent of all treatment admissions involved methamphetamine in the first half of 2005 (exhibit 2). Methamphetamine as the primary drug represented 11 percent of treatment admissions, indicating that for the majority of methamphetamine-involved admissions, methamphetamine was the primary drug of use.

Unweighted DAWN *Live!* data indicated that 84 percent of methamphetamine ED reports were for the drug abuse/other case type, and 15 percent were seeking detox/treatment (exhibit 3). Seventy percent of methamphetamine patients were male. Most patients were White (47 percent). More than one-third (36 percent) of methamphetamine patients were age 25–34, which makes them generally younger than heroin and cocaine users.

Methamphetamine-involved deaths jumped from 11 in the second half of 2004 to 17 in the first half of 2005—the highest recorded number in King County (exhibit 4). For data for 1997 through June 2005, these decedents were the youngest of any of the major drugs, with a median age of 39.0, compared with 42.0 for all drugs. Almost all methamphetamine deaths, 95 percent, were ruled accidental during this period. A relatively high proportion (89 percent) were Caucasian. No notable trends in race, gender, or manner of death were evident for methamphetamine decedents during this period.

In the first half of 2005, the proportions of Helpline calls related to methamphetamine were 21 percent of adult calls and 16 percent of youth calls, placing it as

the second most frequent Helpline call (after cocaine for adults and after marijuana for youth).

A category of amphetamine was added to the Helpline data in 2003. There were 25 adult calls and 1 youth call about amphetamine in the first half of 2005, though there may be underreporting due to an overlapping category of “prescription drugs.”

NFLIS data indicate that methamphetamine was the most common drug seized by law enforcement in Washington, outside of Seattle, in FY 2005 (exhibit 6). It is found at a much lower level in Seattle, where cocaine is the most commonly seized drug. Nearly one-third (31.4 percent) of Seattle-area drug tests were positive for methamphetamine, compared with 53.2 percent of drug tests for the rest of Washington. Methamphetamine and cocaine account for 70 and 73 percent of all seizures in Seattle and Washington State, respectively.

Federal law enforcement sources report that less methamphetamine is being manufactured in Washington but that demand is being met by an increase in supply from Mexico and Mexican groups in California.

Methamphetamine incidents, a combination of active labs used for manufacturing and dump sites of lab equipment or inactive labs, continued to decline for the State as a whole in the first half of 2005. The peak in incidents for the State and the two most populated counties occurred in 2001. In King County, the number of incidents remained flat in 2003 and 2004; such incidents declined in the first half of 2005 with a total of 80, compared with 199 for all of 2004. The surrounding counties of Pierce, Kitsap, and Snohomish all experienced declines in the first half of 2005 as well.

It is important to note that these data do not indicate the manufacturing methods or the quantities manufactured at the site of individual incidents. Reports from law enforcement indicate that “super” labs, those capable of producing large amounts of methamphetamine quickly, represent a small minority of manufacturing labs in the State.

Marijuana

Almost one-half (48 percent) of those admitted to treatment in the first half of 2005 reported current marijuana use (exhibit 2). Seventeen percent reported it as the primary drug of use, equaling approximately one-third of marijuana-involved admissions.

Unweighted marijuana ED reports totaled 982 in the first half of 2005, with 86 percent drug abuse/other case type, followed by 12 percent seeking detox/treatment (exhibit 3). Seventy-three percent of marijuana patients were male, and patients were much younger than for other illegal drugs: 10 percent were age 12–17 and 42 percent were 18–29.

Calls to the Helpline for marijuana constituted 47 percent of youth calls and 17 percent of adult calls in the first half of 2005, similar to prior years.

Cannabis was the third most commonly identified substance in NFLIS data for both the Seattle area and the rest of Washington State in FY 2005 (exhibit 6). In the Seattle area, 15.7 percent of seizures tested positive, compared with 13.9 percent for the rest of the State.

Depressants

Barbiturates, benzodiazepines, and other sedative/depressant drugs in this analysis include alprazolam (Xanax), diazepam (Valium), lorazepam (Ativan), clonazepam (Klonopin), temazepam (Restoril), triazolam (Halcion), oxazepam (Serax), butalbital (Fioricet), chlordiazepoxide (Librium), diphenhydramine (Benadryl), hydroxyzine pamoate (Vistaril), meprobamate (Equanil), phenobarbital, promethazine (Phenergan), secobarbital (Seconal), and zolpidem (Ambien).

Depressants are rarely mentioned as a primary drug at intake to drug treatment. Less than 1 percent of admissions were for benzodiazepines, barbiturates, major tranquilizers, and other sedatives. Key informants report that these drugs are commonly used to enhance the effects of other drugs and are rarely taken as the primary drug recreationally.

Unweighted DAWN *Live!* ED drug reports for depressants (barbiturates, benzodiazepines, and anxiolytics/sedatives/hypnotics) totaled 948 for all case types (exhibit 3). The most common case type was drug abuse/other (45 percent), followed by overmedication (23 percent), and suicide attempt (16 percent). Note that because many visits are for multiple drugs, the case type may or may not reflect the reason for depressant use.

Deaths involving depressants have been level for the past 2 years, at the highest level since at least 1997, with 42 depressant-involved deaths in the first half of 2005 (exhibit 4). Overall, depressant-involved decedents were older than decedents for other drugs, with a median age of 43.5 from 1997 through June 2005 (exhibit 5). They also represented the largest

proportions of suicide, with almost one in four deaths ruled a suicide. Females were disproportionately found to have depressants in their blood: 44 percent, compared with 29 percent for all drugs overall.

A benzodiazepine category was added to the Helpline data in 2003; there were 38 adult calls and 2 youth calls for benzodiazepines in the first half of 2005.

NFLIS data showed that 1.5 percent of exhibits from the Seattle-area lab and 1.1 percent for the rest of the State were benzodiazepines (i.e., diazepam, and clonazepam) in FY 2005.

INFECTIOUS DISEASES RELATED TO DRUG ABUSE AND INJECTION DRUG USE TRENDS

Available data for people diagnosed with HIV infection between 1996 and 2004 are presented in exhibit 7. In King County, injection drug users (IDUs) and men who have sex with men (MSM) and also inject drugs (MSM/IDUs) both represent 7 percent of recent HIV cases. For Washington State as a whole, IDUs represent 10 percent and MSM/IDUs represent 6 percent.

Excepting MSM/IDUs, the rate of HIV infection among the 15,000–18,000 injection drug users who

reside in King County has remained low and stable over the past 14 years. Various serosurveys conducted in methadone treatment centers and correctional facilities and through street and community-targeted sampling strategies over this period indicate that 4 percent or less of IDUs who are not MSM in King County are infected with HIV. Data from a CDC-funded HIV Incidence Study (HIVIS 1996–2001) suggest that the rate of new infections among non-MSM/non-IDUs in King County is less than 0.1 percent per year.

Syringes exchanged and numbers of encounters have remained high in King County, with more than 2 million syringes exchanged and more than 60,000 encounters reported in 2004.

Hepatitis B and C are endemic among Seattle-area injectors. Epidemiologic studies conducted among more than 4,000 IDUs by Public Health's HIV-AIDS Epidemiology Program between 1994 and 1998 reveal that 85 percent of King County IDUs may be infected with hepatitis C (HCV), and 70 percent show markers of prior infection with hepatitis B (HBV). Local incidence studies indicate that 21 percent of non-infected IDUs acquire HCV each year, and 10 percent of IDUs who have not had hepatitis B acquire HBV.

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Exhibit 1. DAWN ED Sample and Reporting Information for King and Snohomish Counties: January–June 2005

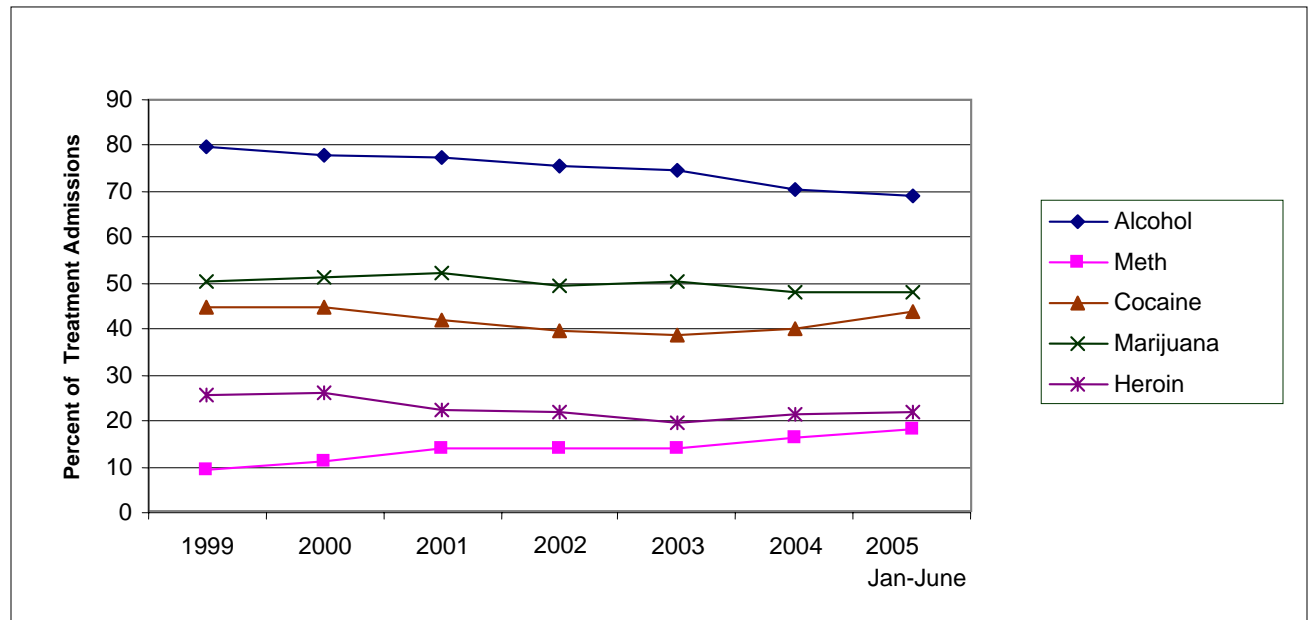
Total Eligible Hospitals ¹	No. of Hospitals in DAWN Sample	Total EDs in DAWN Sample ²	No. of EDs Reporting per Month: Completeness of Data (percent)			No. of EDs Not Reporting
			90–100 percent	50–89 percent	<50 percent	
22	22	24	8–12	0–2	0–2	11–14

¹Short-term, general, non-Federal hospitals with 24-hour emergency departments based on the American Hospital Association Annual Survey.

²Some hospitals have more than one emergency department.

SOURCE: DAWN Live!, OAS, SAMHSA, updated 2/16/05

Exhibit 2. Treatment Admissions¹ for Primary, Secondary, or Tertiary Use of Selected Drugs for Residents of King County, Washington, by Percent: January 1999–June 2005



	1999	2000	2001	2002	2003	2004	Jan–June 2005
Alcohol	79.9	78.1	77.4	75.7	74.4	70.3	68.9
Meth	9.1	11.4	14.0	13.9	13.9	16.3	18.0
Cocaine	44.5	44.6	42.0	39.9	38.7	40.1	44.0
Marijuana	50.6	51.3	52.4	49.5	50.3	47.8	48.1
Heroin	25.7	26.0	22.5	22.0	19.8	21.6	22.1
# of Admits	9,845	10,479	9,761	8,871	8,879	11,223	6,120

¹Data include all ages, all treatment modalities, department of corrections and private pay clients at opiate substitution treatment clinics.

SOURCE: Washington State TARGET data system—Structured Ad Hoc Reporting System

Exhibit 3. Number of Selected Drug Reports (Unweighted¹) in Drug-Related ED Visits and Patient and Case Information, by Drug Category and Percent: January–June 2005

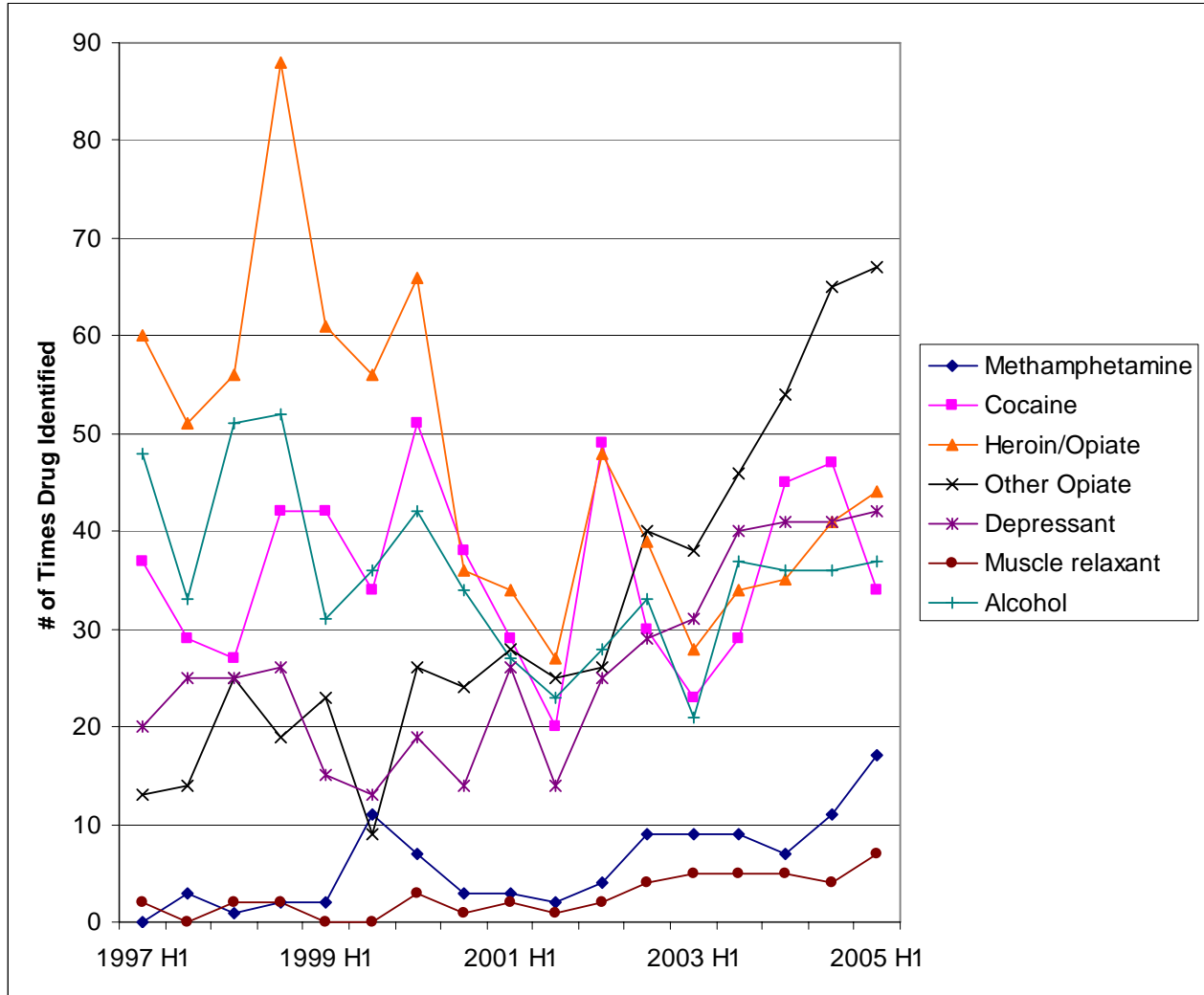
NUMBER OF DRUG REPORTS		SUBSTANCE OF ABUSE					
		Cocaine	Heroin	Marijuana	Rx Opiates	Sedatives	Meth
NUMBER OF DRUG REPORTS	January–June 2005	2,086	1,185	982	1,480	948	886
TYPE OF CASE	Suicide attempt	1.3	0.7	1.8	3.6	15.5	1.0
	Seeking detox	15.6	16.5	12.0	11.8	8.4	14.9
	Adverse reaction	0.0	0.0	0.0	15.3	7.1	0.0
	Overmedication	0.0	0.0	0.0	14.7	22.8	0.0
	Malicious poisoning	0.1	0.0	0.2	0.1	0.1	0.3
	Accidental ingestion	0.0	0.0	0.0	0.5	0.7	0.1
	Drug Abuse/Other	82.9	82.9	85.9	53.9	45.4	83.6
GENDER	Male	65.1	61.3	72.8	49.7	45.1	70.3
RACE	White	24.6	38.8	41.6	43.4	40.9	46.5
	Black	11.8	3.6	7.6	4.7	4.0	2.9
	Hispanic	1.2	0.6	1.6	0.7	0.8	1.9
	Race/ethnicity NTA ²	2.2	1.0	2.0	2.2	0.9	1.9
	Not documented	60.3	56.0	47.0	49.1	53.3	46.7
AGE	5 and younger	0.1	0.2	0.1	0.5	0.6	0.1
	6–11	0.0	0.0	0.0	0.1	0.5	0.1
	12–17	1.1	0.6	9.9	1.8	4.1	4.2
	18–20	3.3	4.1	11.5	4.1	5.5	9.3
	21–24	8.1	7.2	16.0	9.3	6.5	16.4
	25–29	11.9	14.9	14.8	9.9	8.8	20.1
	30–34	11.0	14.4	12.4	11.1	10.4	16.3
	35–44	36.7	30.7	20.6	24.3	30.4	23.3
	45–54	22.3	23.5	11.3	25.1	21.7	9.1
	55–64	4.7	4.0	3.1	7.8	7.8	1.2
	65 and older	0.7	0.5	0.3	6.1	3.2	0.0
Not documented	0.1	0.1	0.1	0.3	0.4	0.0	
ROUTE OF ADMINISTRATION	Oral	1.2	0.2	0.8	33.3	41.5	2.3
	Injected	7.3	55.7	0.0	2.2	0.3	11.7
	Inhaled, sniffed, snorted	2.6	0.8	0.1	0.4	0.0	1.0
	Smoked	13.3	0.9	19.2	0.1	0.0	10.3
	Other	0.1	0.4	0.1	1.3	0.0	0.5
	Not documented	75.5	42.0	79.7	62.7	58.2	74.3

¹The unweighted data are from 11–14 EDs reporting to the King and Snohomish Counties' hospitals reporting to DAWN in January–June 2005. All DAWN cases are reviewed for quality control. Based on this review, cases may be corrected or deleted and, therefore, are subject to change.

²NTA=Not tabulated above.

SOURCE: DAWN *Live!*, OAS, SAMHSA; accessed 02/14/06

Exhibit 4. Drug-Involved Deaths¹ in King County, Washington, Related to Illicit and Prescription Drugs: January 1997–June 2005



	1997 H1	1997 H2	1998 H1	1998 H2	1999 H1	1999 H2	2000 H1	2000 H2	2001 H1	2001 H2	2002 H1	2002 H2	2003 H1	2003 H2	2004 H1	2004 H2	2005 H1
Methamphetamine		3	1	2	2	11	7	3	3	2	4	9	9	9	7	11	17
Cocaine	37	29	27	42	42	34	51	38	29	20	49	30	23	29	45	47	34
Heroin/Opiate	60	51	56	88	61	56	66	36	34	27	48	39	28	34	35	41	44
Other Opiate	13	14	25	19	23	9	26	24	28	25	26	40	38	46	54	65	67
Depressant	20	25	25	26	15	13	19	14	26	14	25	29	31	40	41	41	42
Muscle Relaxant	2		2	2			3	1	2	1	2	4	5	5	5	4	7
Total Deaths	101	76	101	119	100	96	124	89	79	67	102	93	82	104	122	132	127

¹Data are duplicated, most deaths involve multiple drugs.
SOURCE: Medical Examiners Office, Public Health Seattle & King County.

Exhibit 5. Drug-Involved Deaths in King County, by Demographics, Manner of Death, and Percent: January 1997–June 2005

	All Drugs	Heroin/Opiate	Cocaine	Alcohol	Other Opiate	Depressant	Methamphetamine
Times Identified (N)	1,710	803	605	604	542	446	99
Median Age (Years)	42.0	41.0	41.0	41.0	44.0	43.5	39.0
Female	29	19	23	19	41	44	20
Manner of Death							
Accident	81	92	94	83	80	64	95
Suicide	11	2	1	9	10	23	1
Homicide	0	0	0	0	0	0	0
Undetermined	8	6	5	7	10	13	4
Race/Ethnicity							
White	83	83	73	83	88	88	89
African-American	11	10	21	9	8	7	4
Asian/Pacific Islander	1	0	1	1	1	1	2
Native American	3	3	2	4	2	2	2
Hispanic	1	1	1	1	0	0	0
Other/Mixed	1	1	2	1	1	2	3

SOURCE: Medical Examiners Office, Public Health Seattle & King County

Exhibit 6. Local Law Enforcement Seizure Drug Test Results in Seattle and the State of Washington: FYs 2003–2005

Seattle-Area Lab			
	FY 2003	FY 2004	FY 2005
Acetaminophen	0.3	0.2	
Alprazolam	0.3	0.1	0.2
Amphetamine	0.3	0.2	0.2
Buprenorphine			0.1
Caffeine	0.3	0.2	0.0
Cannabinol			
Cannabis	17.2	15.3	15.7
Carisoprodol	0.3		0.1
Cathinone	0.3		0.1
Clonazepam	0.5	0.3	0.5
Cocaine	40.5	40.4	38.3
Codeine	0.2		0.2
Diazepam	0.4	0.3	0.6
Dimethyl Sulfone			0.1
Heroin	5.0	4.7	5.6
Hydrocodone	0.7	0.9	1.1
Hydromorphone		0.1	0.1
Ibuprofen			
Ketamine	0.1		
Lorazepam		0.1	0.2
MDA	0.3	0.3	0.1
MDMA	1.4	1.0	
Methadone	0.4	0.7	1.2
Methamphetamine	27.2	29.4	31.4
Methandrostenolone (Methandienone)	0.1		
Methylphenidate		0.3	0.2
Morphine	0.2	0.3	0.5
Non-Controlled Non-Narcotic Drug	0.3	0.3	
Oxycodone	0.9	1.4	1.8
PCP	0.9	0.6	0.2
Propoxyphene		0.1	
Pseudoephedrine	0.7	0.4	0.5
Psilocin	0.7	0.6	0.3
Psilocybine		0.3	0.3
Sodium Bicarbonate			
Temazepam			0.1
Testosterone			0.1
Zolpidem			0.1
Total of Top 25 (#)	99.25 (3188)	98.83 (3454)	100.0 (3702)
Sub-totals			
Other opiates	2.43	3.55	4.97
Benzodiazepines	1.18	0.93	1.48

WA State Without Seattle-Area Lab			
	FY 2003	FY 2004	FY 2005
Acetaminophen	0.2	0.1	
Alprazolam	0.2	0.2	0.2
Amphetamine	0.3	0.4	0.3
Buprenorphine			
Caffeine	0.2	0.2	
Cannabinol	0.2		
Cannabis	15.5	15.6	13.9
Carisoprodol	0.2	0.1	0.1
Cathinone			
Clonazepam	0.3	0.3	0.3
Cocaine	20.6	18.2	19.8
Codeine	0.2	0.1	0.2
Diazepam	0.4	0.3	0.4
Dimethyl Sulfone			0.1
Heroin	6.5	4.8	5.2
Hydrocodone	1.1	1.3	1.3
Hydromorphone			0.1
Ibuprofen		0.1	0.1
Ketamine			
Lorazepam			0.2
MDA	0.1		
MDMA	0.5	0.5	0.1
Methadone	0.4	0.6	0.7
Methamphetamine	47.8	51.7	53.2
Methandrostenolone (Methandienone)			
Methylphenidate	0.1	0.1	0.1
Morphine	0.3	0.4	0.4
Non-Controlled Non-Narcotic Drug	0.5	0.7	
Oxycodone	1.2	1.1	1.7
PCP			
Propoxyphene		0.1	0.1
Pseudoephedrine	0.8	0.7	0.5
Psilocin	0.5	0.7	0.5
Psilocybine	0.3	0.2	0.2
Sodium Bicarbonate	0.2	0.2	
Temazepam			
Testosterone			
Zolpidem			
Total of Top 25 (#)	98.62 (12162)	98.63 (11926)	100.0 (12309)
Sub-totals			
Other opiates	3.25	3.51	4.39
Benzodiazepines	0.85	0.81	1.12

Source: National Forensic Laboratory Information System

Exhibit 7. New HIV Infections in King County and Washington State, by Demographic Characteristics and Year of HIV Diagnosis: 1996–2004

	King County			WA State		
	2002–2004 ¹		Trend ² 1996– 2004	2002–2004 ¹		Trend ² 1996–2004
	No.	(Percent)		No.	(percent)	
TOTAL	1,006	(100)		1,576	(100)	
HIV Exposure Category						
MSM	651	(65)		901	(57)	
IDU	67	(7)		153	(10)	
MSM/IDU	71	(7)		102	(6)	
Heterosexual contact	109	(11)	up	218	(14)	up
Blood product exposure	3	(0)		6	(0)	
Perinatal exposure	0	(0)		2	(0)	
Undetermined ³	105	(10)		194	(12)	
Sex & Race/Ethnicity						
Male	889	(88)		1,319	(84)	
White ⁴	571	(57)	down	877	(56)	down
Black ⁴	155	(15)	up	207	(13)	up
Hispanic	103	(10)		149	(9)	
Other ⁴	60	(6)		86	(5)	
Female	117	(12)		257	(16)	
White ⁴	33	(3)		103	(7)	
Black ⁴	62	(6)	up	95	(6)	
Hispanic	8	(1)		25	(2)	
Other ⁴	14	(1)		34	(2)	
Race/Ethnicity						
White ⁴	604	(60)	down	980	(62)	down
Black ⁴	217	(22)	up	302	(19)	up
Hispanic	111	(11)		174	(11)	
Asian & Pacific Islander ⁴	33	(3)		56	(4)	
American Indian/ Alaska Native ⁴	21	(2)		40	(3)	
Multi Race ⁴	16	(2)	up	16	(1)	up
Unknown	4	(0)		8	(1)	
Age at HIV Diagnosis						
0–19	10	(1)		19	(1)	down
20–24	72	(7)		129	(8)	up
25–29	141	(14)	down	218	(14)	down
30–34	191	(19)	down	277	(18)	down
35–39	244	(24)		343	(22)	
40–44	173	(17)	up	266	(17)	up
45–49	90	(9)		159	(10)	
50–54	47	(5)		84	(5)	
55–59	24	(2)	up	47	(3)	up
60–64	8	(1)		18	(1)	
65 and older	6	(1)		16	(1)	

¹Due to delays in reporting, data from recent years are incomplete.

²Statistical trends were identified from the chi-square test for trend, calculated for the periods 1996–98, 1999–2001, and 2002–04.

³Includes persons for whom exposure information is incomplete (due to death, refusal to be interviewed, or loss to follow-up), patients still under investigation, patients whose only risk was heterosexual contact and where the risk of the sexual partner(s) was (were) undetermined, persons exposed to HIV through their occupation, and patients whose mode of exposure remains undetermined.

⁴And not Hispanic. The groups Asian, Native Hawaiian, and Other Pacific Islanders were grouped due to small cell sizes. All categories are mutually exclusive.